The Rural Maryland Council's Rural Health Roundtable on Maryland's Health Care Workforce Shortages in Rural Areas

October 2-3, 2008

Summary and Outcomes

Introduction and Background: Maryland's rural residents are older, poorer, and sicker than the rest of the State's population, and they continue to be underserved by the State's health care professionals. Nearly 30 percent of all Marylanders reside in the state's 18 designated rural counties where fewer health care professionals and organizations exist, where a growing proportion of uninsured or under-insured Marylanders are aging in place and suffering from chronic disease and illness, and where health disparities with their urban/suburban counterparts continue to grow to crisis levels. More than 15 percent of rural Marylanders are aged 65 or over, which is 38 percent higher than the state average. Medicaid enrollment is 27 percent higher in rural jurisdictions than in the rest of Maryland. And 34 percent fewer primary care providers serve rural areas than the state in general.

At least a decade ago, rural communities, organizations and advocates identified the *geographical shortage* of health care professionals. Over the years, those communities have seen shortages impact the costs of, quality of, and access to health care. They have noted *occupation-wide shortages* (i.e., nurses, allied health care workers, pharmacists and pharm techs) and developed programs and plans to begin to deal with them. They have acknowledged *shortages of personnel with particular skills and training* (i.e., primary care physicians) and developed programs to bring primary care to rural Maryland (i.e, Area Health Education Centers and Federally Qualified Health Centers). Still the crisis continues to worsen.

The Maryland Rural Health Plan, released in June 2007 by the State Office of Rural Health, describes clearly and concisely the health care disparities and critical health issues faced daily by rural Marylanders. It also lays out priority recommendations and strategies for attention by policy makers, funders and rural health stakeholders across Maryland's rural regions.

> Of three priority strategies laid out in the *Plan* to deal with rural Maryland's critical health concerns, the one listed first is: **Increase efforts to improve recruitment and retention of rural health providers.**

For more than a decade, the Rural Maryland Council (RMC), Maryland's designated rural economic development council, has served as the "voice of Rural Maryland" on issues important to quality of life and standards of living in Western Maryland, Southern Maryland and on the Eastern Shore. Recognizing the essential role of health care in the economy and quality of life of rural communities, the RMC co-hosted an annual Rural Summit with the State Office of Rural Health and the Maryland Rural Health Association, with support from other rural stakeholders, for the past ten years. Each year, the Summit brought those interested in healthy rural communities together for networking and to hear about, discuss and seek solutions to rural problems.

In late 2006, during a strategic planning retreat, the RMC Executive Board revisited rural Maryland's health care needs and their impact on the rural economy, and affirmed health care as a major priority of the Council, particularly in relation to workforce, the aging rural population, transportation and the health industry as a driver of rural economic development. A revised and updated *Strategic Plan* for the Council was approved in February 2007. The *Strategic Plan* lays out the roles of Board leaders as well as the new Executive Director in making quality, affordable health care services for rural Maryland a top priority. The Board appointed a Health Resource Team to collaborate with the Maryland Rural Health Association. In addition, they decided that new partnerships should be forged with community colleges, four-year colleges and professional schools to attack the serious problem of the shortage of rural health care workers, focusing on access to primary care, specialty care and pharmacy services. Finally, the Board voted to collaborate with the State Office of Rural Health on

how to implement the State's new Rural Health Plan, and to find ways to educate policy makers, rural community leaders, and rural health providers about the importance of removing barriers to quality health care in rural Maryland.

The Maryland Rural Health Plan was presented to rural leaders and state officials throughout the summer and fall of 2007. A series of Listening Sessions hosted by the Maryland Rural Health Association and made possible by a RMC grant from its Maryland Agricultural Education and Rural Development Assistance Fund was held in several rural areas of the state. The State Office of Rural Health also presented the Plan and initial feedback from the listening sessions during the October 2007 Maryland Rural Summit. Discussions of the *Plan* and its priority recommendations, strategies and objectives continued throughout the fall and into the winter. At those sessions, rural folk provided feedback on the *Plan* and identified action items to help implement the Plan's recommendations and strategies. Eight goals ultimately emerged. Not surprisingly, Goal One from those attending the Listening Sessions was to: ***Increase efforts to improve recruitment and retention of rural health providers.***

Six objectives for implementing Goal One came out of the Listening Sessions and those objectives continue to guide the State Office of Rural Health as it works with rural stakeholders on strategies and action steps to improve the recruitment and retention of rural health care providers.

The Rural Health Roundtable

By early 2008, the focus of the RMC, the State Office of Rural Health, several rural Regional Councils and the MRHA was on how to solve the rural health care workforce shortage, with each group working on its own agenda; however, the groups were working together with no cohesive coordinated effort only superficially. In an effort to bring all concerned parties together, the RMC's Health Care Working Committee, which is comprised of members from all of these stakeholders groups and others, came together in tightly focused, intense discussions to organize the Rural Health Roundtable around implementation of the *Rural Health Plan*.

The Rural Health Roundtable was held October 2-3 in Annapolis and focused on implementing the top priority of the *Maryland Rural Health Plan:* ***t*o increase efforts to improve recruitment and retention of rural health care providers.** Co-hosted by the RMC and the SORH with support from other rural stakeholders, the Roundtable was designed to bring attention to the state's rural health care worker shortages by assembling interested experts to deliberate about strategic solutions to the problem. Their aim would be to evolve a list of concrete action steps to help bring health care workers to and keep health care workers in rural Maryland.

The partners formed a Planning Committee. They pooled mailing lists and made special effort to invite those stakeholders who are most knowledgeable about and interested in rural health care worker shortages. The Committee reviewed the progress of statewide task forces, commissions, and committees which were examining pieces of the workforce puzzle; and developed a list of speakers who could, in a concentrated series of presentations at the Roundtable, report cogently and intelligently on what has been learned and recommended by the various working groups appointed by state policy leaders. The Committee decided to invite a key state legislative leader and rural senator to attend as luncheon speaker to share the progress of a major task force on the shortage of rural physicians and to provide his advice about the upcoming 2009 Session of the Maryland General Assembly. Finally, they outlined an agenda for the day-and-a-half event, and picked a facilitator to help with the substance and processes of finalizing the agenda and conducting the Roundtable. The final Roundtable Agenda and related materials are included in Appendix I.

Ultimately, 70 participants attended the Roundtable that began with presentations intended to provide everyone with a modicum of baseline information. Everyone learned about the studies, commissions, task forces and working groups currently investigating, examining and reporting on aspects of the

rural health care workforce shortage in Maryland. Following that series of presentations, Roundtable members learned how West Virginia and Alabama developed their health care workforce pipelines through "grow your own" programs that have gained national prominence and offered practical approaches for other states. Attendees ended their day with a panel of presenters on telehealth and pilot telemedicine projects; the speakers summarized their universities' e-health initiatives, and talked about the barriers and issues related to connecting medical specialists with rural medical needs via tele-networks.

On the second day of the Roundtable, participants began with a review of Maryland's "grow your own" programs, and revisited key points from the prior day's presentations. Essential information for the break-out sessions to follow was included in that opening session, when the State Office of Rural Health provided a clear list of barriers as well as what is currently lacking in three strategic solutions to Maryland's rural health care workforce shortage: Grow Your Own Health Care Workforce Programs; Recruitment and Retention Programs; and Telehealth as A Solution.

Roundtable members then moved into three self-selected break-out sessions. A member of the Roundtable Planning Team facilitated each of the group discussions, using a prepared discussion outline to move quickly through the issues. An assigned recorder took notes in each session, helped keep the discussions on time, and prepared a report for the closing session. Each group was asked to reach consensus on the top priority action step from its session by the end of the hour-long discussion. Materials used to by the facilitators are included in Appendix I.

Small Group Session Reports and Priorities

Each break-out session included at least 11 participants. During the hour, the facilitators led each group through a series of questions intended to help the participants clarify the issues, consider the available choices, identify next steps to be taken over the short- and long-term, and finally, make a choice about what should be done next and who should lead that effort.

Each small group deliberated enthusiastically with every participant having a chance to speak. Each group completed quick but thoughtful reviews of the issues and gave careful consideration to the range of choices from which the group's priorities would be chosen. Each group:

- Recognized the state's financial and political realities and were cautious of any recommendation to implement expensive new programs and/or expansions;
- Understood the importance of communication and partnerships, with all participants supporting efforts to share information about who's doing what about the health care worker shortage and to improve partnerships and collaborations in order to overcome the "silo" mentality often prevalent in health care shortage discussions by rural stakeholders.
- Assumed that quality health care and strong economies were interconnected in rural Maryland, and all accepted the basic assumption that a healthy rural economy requires adequate health care and healthy people.
- Recognized that more information and/or data may be needed to make the best decisions about next steps and decided that, before moving forward to action, additional focused discussions with others and/or examinations of data/information may be necessary.
- Tried to include priorities from the Roundtable in the work-plans of others. For instance, the RMC, the State Office of Rural Health, the MRHA, the rural regional councils and other stakeholders have very limited financial and human resources and cannot do everything they are called upon to do. Matching the Roundtable's priorities with the priorities of others working on aspects of the rural health care workforce shortage will be key to successful outcomes.

Copies of the break-out session reports are included in Appendix I. The following priorities were reported from the three sessions:

Session 1: **Grow Your Own Health Care Workforce Programs**

Action: By October 21, provide a clear blueprint for a "Grow Your Own" model that groups students in cohorts similar to the Alabama model program with elements of the West Virginia model.

Leadership: Maryland Area Health Education Center (AHEC)

Next Steps:

a. The Maryland AHEC will develop a model Grow Your Own program and provide that model for consideration by the Task Force to Review Physician Shortages in Rural Areas by October 21.
b. The Grow Your Own model will by provided to the Rural Maryland Council for consideration by the Health Care Working Committee and/or RMC Executive Board on or after October 21.

Session 2: **Recruitment and Retention Programs**

Action 1: As quickly as possible, develop financial incentives to recruit and retain health care professionals in rural areas. Financial incentives were broadly defined to include: loan assistance, loan forgiveness, higher salaries, signing bonuses, and spousal support.

Leadership: Coalitions of rural stakeholders advocating specific financial incentives locally, regionally or statewide.

Action 2: Within the next three years, create of a statewide Center for Health Care Workforce to focus on rural health care issues

Leadership: State Government, including DHMH, SORH, the Area Health Education Centers, with support and assistance from the Maryland Hospital Association, the Governor's Workforce Investment Board, and others..

Session 3: Telehealth as a Solution

Action: Develop statewide telehealth consortium to support state level telehealth adoption to include the sharing and pursuit of resources; educating stakeholders on advancing of telehealth; and facilitating the development of statewide model policies, procedures, and protocols.

Rationale: Telehealth is the use of information technology in diagnosing, treating, and monitoring patients. Maryland's rural areas have vast primary care and specialty care shortages. There is evidence telehealth can reduce overall costs to health systems due to better management of chronic diseases, fewer hospital visits, and health system transportation savings. (Nesbitt et. Al, 2006). Maryland is one of only 16 states that have no level of Medicaid reimbursement for health services provided through telemedicine (Whitten & Buis, 2007). With the limited supply of specialists in rural areas, linking urban providers with rural populations can be invaluable to improve access to care and support the limitations to of health care delivery in rural areas (Speedie et. al., 2008). Many rural communities in Maryland are using innovative practices to deliver healthcare via remote technology. Mid Shore Mental Health Systems received a federal grant to pilot telementalhealth on the Eastern Shore, Garrett County uses telehealth technology to monitor home bound patients; and urban neurologists are exploring ways to remotely reach stroke patients in rural emergency rooms. These innovative pilots have no cohesive statewide integration or promotion assessing the feasibility of actually providing services via distance technology and encouraging reimbursement mechanisms statewide.

Leadership: The Rural Maryland Council and State Office of Rural Health

Action: Support the development of electronic health records (EHR) through the Maryland Health Care Commission (MHCC) and Centers for Medicare and Medicaid Services (CMS) demonstration projects and other initiatives.

Leadership: Collaborations of rural stakeholders, including hospitals and providers interested in moving forward on ERH**.**

Clarifying Notes: In 2005, the Maryland General Assembly passed legislation calling for the MHCC to support the newly appointed Task Force to Study Electronic Health Records as it investigated electronic transfer of health data and information, electronic prescribing, computerized physician order entry and related costs; and the impacts on school health records and patient safety. The Task Force also studied the benefits of using electronic health records, barriers to expanded use, and risk, as well as state-level policy changes affecting adoption of electronic health records. The Task Force's Final Report, conveyed to the Governor and General Assembly in December 2007, contained financial, technology, regulatory/legal, health information technology consumer education, and school health record recommendations. A copy of the Final Report is included in Appendix III.

The Centers for Medicare and Medicaid Services (CMS) is in the process of implementing a nation wide, five-year demonstration project to encourage small and medium-sized primary care physician practices to use electronic health records to improve patient care and change the way health care information is managed. Ultimately financial incentives will be provided to as many as 1,200 physician practices that can demonstrate improved quality health care. Twelve demonstration sites were chosen in June 2008, including one that involves Maryland. CMS awarded a community partnership to MedChi (the Maryland State Medical Society), MHCC, and the Medical Society of the District of Columbia. MHCC developed an Electronic Health Records Product Portfolio including product information from 23 EHR certified vendors who will provide discounts to physician practices. Applications from primary care physician practices interested in participating in the project are due November 26, 2008 for demonstrations from June 1, 2009 to May 31, 2014. Eighteen applications were received by mid-October 2008.

Roundtable Outcomes

In the final hour of the Roundtable, participants came together to hear the reports and the priorities from each of the three small groups and to try to reach consensus on the Roundtable's top priority for action. Roundtable participants considered each priority and selected one as a top priority for further action by the assembled representatives. Immediately, there was general agreement on the top priority for action:

Begin immediately to develop financial incentives to recruit and retain health care providers. Incentives were broadly defined to include: loan assistance, loan forgiveness, higher salaries, signing bonuses, and spousal support.

This priority will be a major focus of the Rural Maryland Council and the collaborative partnership that includes the State Office of Rural Health, Roundtable sponsors and other involved organizations and agencies.

Immediately following the Roundtable, the RMC's staff posted presentations from the workshop on the Council's website (www.rural.state.md.us/) and provided summary reports from the three break-out sessions to the Roundtable facilitator, Dr. Annie Kronk. Her biography is included in the Appendix. From Dr. Kronk's research and review of the Roundtable materials, from the notes recorded during the discussions, and from suggestions made during the three break-out sessions, the facilitator developed the following immediate, short-term and long-term action steps for the partners to consider as they move forward to incorporate the Roundtable's top priority into their own strategic plans and annual work plans. (Note: The RMC developed its own Action Plan, based on Roundtable outcomes. To review that plan, see: http://www.rural.state.md.us/Roundtables/RRT2_08.html)

> **Goal**: To develop financial incentives to recruit and retain health care providers. Incentives were broadly defined to include: loan assistance, loan forgiveness, higher salaries, signing bonuses, and spousal support.

Immediate Action Steps – 2008-2009

- Monitor the work of the Task Force on Physician Shortages in Rural Areas, particularly recommendations related to loan assistance, loan forgiveness and other financial incentives for the recruitment and retention of physicians. Consider supporting these and related initiatives during the 2009 Session of the Maryland General Assembly.

- Collaborate with those at the Department of Health and Mental Hygiene and the Maryland Higher Education Commission who were responsible for the work of the Maryland Commission on the Shortages in the Health Care Workforce; track recommendations related to pipeline training programs for rural students, scholarships and stipends for rural students entering health professions programs, licensing reciprocity with other states, and funding for professional development of rural practitioners.

- Monitor the expansion of the Eastern Shore AHEC into Southern Maryland, taking the opportunity to talk with regional businesses and others about the need for financial incentives to help solve rural Maryland's health care worker shortages.

- Meet with the Governor or the Governor's representative to share results from the Roundtable and discuss the critical shortage of health care workers in rural Maryland, asking for support and advice in dealing with recruitment and retention concerns and help in funding a financial incentives program.

- Meet with Senator Middleton and other health leaders of the Maryland General Assembly to provide information about the Roundtable and its outcomes, including the top priority related to financial incentives.

- Engage the legislative Rural Caucus in discussions related to rural Maryland's health care workforce shortage, asking for their support and leadership on workforce legislation during the 2009 Session of the Maryland General Assembly and their involvement in other initiatives.

Short-Term Action Steps - 2009-2011

- Develop a compelling marketing message to communicate about rural Maryland's health care workforce needs, applauding those (SORH, GWIB, hospitals, health centers, universities, etc.) working on the financial incentives and inviting others to join.

- Initiate conversations with the Maryland Association of Community Colleges and the rural community colleges regarding their need for/interest in clinical training sites in rural Maryland, with the aim of establishing partnerships to make those sites available.

- Form coalitions of businesses and stakeholders (hospitals, community health centers, primary care practices, etc.) in each rural region to develop and begin to fund incentive programs appropriate to the region's health care workforce needs.

- In each rural region, form advocacy groups to engage local and state officials in planning for sustainable funding and partnerships that ensure appropriate salaries, signing bonuses and spousal support for health professionals recruited to practice there.

- Identify state agencies already involved in providing financial incentives for workforce initiatives, and investigate opportunities for collaborations.

- For each rural region of Maryland, initiate a process of narrowing the scope of financial incentives related to health care providers and identifying the incentives that will work best in that region.

Long-Term Action Steps (2012-2020)

- Form partnerships with the University of Maryland, Johns Hopkins University and other four-year colleges that have health professions training programs to encourage early exposure of students to rural practice settings, requesting that the programs formally identify students originally from rural areas for such exposure.

- Using the Maryland Hospital Association's model *Who Will Care?* initiative, form a Work Group of health and higher education leaders to initiate planning for a major funding initiative to triple the number of health care providers practicing in rural Maryland by 2020.

- Support the establishment of a Coordinated Healthcare Workforce Center that pays attention to rural workforce issues.

- Create a statewide partnership of community leaders, higher education leaders, health care providers and government entities to continue to explore concrete ways to address recruitment and retention of rural health care professionals, similar to the West Virginia Rural Health Education Partnerships.

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