Community Leaders’ Perspectives on Health and Health Care Assets, Challenges and Solutions for the Mid-Shore Region: Guided Conversations with Stakeholders and Key Professionals

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This is one of six Technical Reports prepared for the Maryland Health Care Commission by the University of Maryland School of Public Health and the Walsh Center for Rural Health Analysis at NORC at the University of Chicago as part of their study, entitled Health Matters: Navigating an Enhanced Rural Health Model for Maryland, Lessons Learned from the Mid-Shore Counties.
Introduction

To better understand the health and health care needs of community members in the Mid-Shore region of Maryland, the Maryland Health Care Commission (MHCC) requested the University of Maryland School of Public Health (UMD SPH) in partnership with the Walsh Center for Rural Health Analysis at NORC at the University of Chicago to conduct a mixed-methods study, pursuant to Senate Bill 707, Freestanding Medical Facilities—Certificate of Need, Rates and Definition. The purpose of the study was to assess the health care of residents of the five county area and the capacity of the health system, and to propose options for enhancing health and health care delivery. One component of the study included interviews with community leaders. This report describes the purpose, methods and findings of interviews with 26 community leaders (15 stakeholders and 11 key professionals).

The goals of the interviews were to: obtain information from community leaders in the five-county area on strengths and challenges in promoting health on the Mid-Shore, and to understand their views, opinions and preferences for a regional health care system. The premise of the interviews was to gather direct feedback from community leaders and key professionals and their views and opinions about issues related to the needs, wants, availability and accessibility of health care for residents in the five-county area. The interview process was selected as a method of inquiry because it is well suited to gaining insight into the knowledge and opinions of individuals.

Methods

Between February 21 and March 21, 2017, 26 community leader interviews were conducted with stakeholders (15 interviews) and key professionals (11 interviews) in each of the five Maryland counties in the Mid-Shore region: Caroline, Dorchester, Kent, Queen Anne’s and Talbot.

Stakeholders were recruited from community leaders who were identified with the help of the MHCC, workgroup members, the University of Maryland Extension and others. Stakeholders selected were leaders active in directing programs/initiatives in health care, education, social services, economic development, transportation, faith community, technology and community advocacy. In addition, 11 key professionals with experience directing programs at the level of the Mid-Shore region, including: five health officers (one for each Mid-Shore county), a director of a county department of emergency services, leaders of a major health care system, a dental officer in a health system, the director of a mid-level training program, a Maryland Extension specialist and an internet provider specialist.

Interviews were designed to get broad-based perspectives on the strengths and assets as well as the challenges in addressing population health on the Mid-Shore. Interviewees were also asked to provide potential solutions.

It is important to note that the interview results reflect the perceptions of community leaders, but may not necessarily represent the full range of opinions of all members of the Mid-Shore region. They do, however, provide an opportunity to record participants’ beliefs, perceptions, attitudes and opinions.
and to gain insight and direction that can guide further understanding of related quantitative research findings.

Twenty-six interviews, each lasting approximately one hour, were conducted. Fourteen of the 15 stakeholder interviews were conducted in person on the Mid-Shore. One stakeholder interview and the 11 key professional interviews were conducted on the phone. Two research team investigators conducted all the interviews and took independent notes. All interviews were audio-recorded.

**Institutional Review Board (IRB) Review**

The research methodology was submitted to the University of Maryland Institutional Review Board and approved on January 30, 2017, with IRBNet ID 990078-1. Participants interviewed in person signed a consent form that included approval for audio-taping the interview (Appendix 1). Participants interviewed on the phone gave verbal consent for the interview and for audio-taping the interview.

**Recruitment**

Twenty-six potential stakeholders were emailed about the project and asked for their willingness to be interviewed. Fifteen individuals agreed to be interviewed. The research team felt it was important to become familiar with the Mid-Shore communities and to meet stakeholders in their working environment, thus stakeholder interviews were on mutually agreeable dates and times at stakeholders’ work locations. Fourteen stakeholder interviews were successfully completed in person in the Mid-Shore county where the stakeholder worked. One in-person stakeholder interview had to be postponed and was then completed on the phone.

All 11 key professionals who were invited to participate agreed to be interviewed. Given that most of the key professionals were known to members of the workgroup and advisory groups, and for convenience, all key professionals were interviewed on the phone.

Exhibits 1 and 2 provide information on the number of community leaders interviewed by county (Exhibit 1) and by area of expertise (Exhibit 2).
Exhibit 1: Stakeholder and Key Professionals: Number by County

<table>
<thead>
<tr>
<th>COUNTY</th>
<th>NUMBER OF STAKEHOLDERS</th>
<th>NUMBER OF KEY PROFESSIONALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caroline</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Dorchester</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Kent</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Talbot</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Queen Anne’s</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Mid-Shore</td>
<td>–</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>11</td>
</tr>
</tbody>
</table>

Exhibit 2: Stakeholders and Key Professionals: Areas of Expertise

<table>
<thead>
<tr>
<th>AREA OF EXPERTISE</th>
<th>NUMBER OF STAKEHOLDERS</th>
<th>NUMBER OF KEY PROFESSIONALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care / Public Health</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Emergency Medical Services</td>
<td>–</td>
<td>1</td>
</tr>
<tr>
<td>Education / Social Services</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Economic Development</td>
<td>5</td>
<td>–</td>
</tr>
<tr>
<td>Community Advocates</td>
<td>2</td>
<td>–</td>
</tr>
<tr>
<td>Internet</td>
<td>–</td>
<td>1</td>
</tr>
<tr>
<td>Faith Community</td>
<td>1</td>
<td>–</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>11</td>
</tr>
</tbody>
</table>

Interview Procedures

Two senior research team members carried out the in-person and phone interviews. Each interviewer asked questions and took independent handwritten notes. First, consent to be interviewed and for audio-recording was obtained in writing (in-person interview) or verbally (phone interview). After introductions, interviewers gave a structured summary of the study, including its history, purpose and key issues of interest (health services and access to care, health workforce capacity, health-related technology use, transportation availability, economic impact and needs of vulnerable populations). Interviewers asked stakeholders and key professionals about their professional backgrounds, time lived in rural areas generally and on the Mid-Shore specifically, and former and current professional roles. The interviewers briefly reviewed the format and structure of the interview, the questions and expectations. Interviews lasted approximately one hour.
Interview Questions

The interview guide was developed with input from the UMD SPH and Walsh Center research team members. The guide focused on answers to the following three research questions:

(1) What works well in supporting the health of Mid-Shore residents?
(2) What are the challenges to improving health and health care for Mid-Shore residents?
(3) What recommendations and suggestions do you have to improve the health of Mid-Shore residents?

Stakeholders and key professionals were asked to answer these three questions from their personal perspectives and from their areas of expertise. Interviewers purposely asked broad questions that allowed interviewees to draw on their experiences with and knowledge of the key issues of interest.

Interview Analysis

The recorded interviews were stored on a secure computer, but they were not transcribed. One interviewer typed her handwritten notes, and the second interviewer edited the typed notes and added her notes. Both interviewers reviewed the content of the notes and did a line-by-line analysis to identify themes and similarities. The findings from the analysis were then synthesized into a spreadsheet and carefully reviewed by the team. Recurrent themes that transcended interviewee areas of expertise were identified. A presentation of preliminary findings was presented at the Rural Health Care Delivery Workgroup meeting on May 24, 2017. The findings of this analysis are presented in this technical report.

Findings

The following findings summarize key themes and points identified through interviews with stakeholders and key professionals. While the interviews were generally structured according to the three research questions, discussions covered a broad range of topics that addressed the study’s key issues of interest.

WHAT WORKS WELL IN SUPPORTING HEALTH AND HEALTH CARE FOR THE MID-SHORE COUNTIES

General Experience

Input from stakeholders and key professionals about what works well in supporting the health of Mid-Shore communities and residents reflected positive attributes of the populations who live there as well as of the programs and services that support them. One stakeholder’s succinct comment summarizes what works well: “People live here because they want to, so they are engaged in the community.” Comments reinforced the solid commitment and dedication of residents to support each other. Specific examples demonstrated a deep culture of volunteerism, a strong sense of community and a willingness to work together to nurture and support creative solutions. Highlights and themes of comments cover the topics of health and health care, health workforce, economic development, as well as others.
Health Services and Access to Care

Attributes of health and health care services include existing and growing partnerships among institutions, creative programs to meet needs and provide care where “people are,” and the expansion and value of health and wellness programs beyond traditional medical care.

The development and growth of partnerships between health institutions and programs were viewed as assets. Examples included the partnership between University of Maryland Shore Regional Health (Shore Health) and Choptank Community Health System (Choptank Health) to support care transitions and case management; between emergency medical services (EMS) and Shore Health to address care coordination and reduce emergency department visits; between the Supplemental Nutrition Assistance Program Education (SNAP-Ed) program administered by the Maryland Extension Service and local schools for wellness; and between case managers and care coordinators for seniors and individuals with disabilities in Talbot County. The latter program represents a collective approach to programs and funding streams that include financial support from the county, the Maryland Department of Aging, and church donations as well as Medicaid for eligible residents. One stakeholder commented: “You can’t do much without partners.” Routine meetings and collaborative efforts between county health officers were provided as additional examples of collaborative partnerships. In addition, their involvement with the Maryland Rural Health Association provided support for advocacy and programs such as the recent Health Enterprise Zone. It was mentioned that they are “like-minded and work together.”

Many examples were provided of the resilience and contributions of individuals and existing outreach in the spirit of what “works well.” These examples included a full range of support programs, such as transportation for the elderly by HomePort Village; a home visiting program for new mothers; extended behavioral health services; efforts by the YMCA; and partnerships between and among social service programs that are maintained and nurtured through personal contacts. The Kinera Foundation was described as an example of leadership by residents. The founder of the Kinera Foundation attracted health specialists and therapists to the Mid-Shore and fostered agreements with the Maryland Center for Developmental Disabilities, housed at Kennedy Krieger Institute and with the Maryland Department of Health’s Office of Genetics and Persons with Special Health Care Needs (See Kinera Foundation Eastern Shore Regional Hub, [www.kinera.org/kinera-foundation-eastern-shore-regional-hub.html]).

The existing school-based programs were recognized as assets by health center and social service leaders. The importance of providing on-site care for Streptococcal infections, asthma and dental conditions was mentioned. Specific programs cited that work well include dental programs in Dorchester, Caroline and Talbot County Public Schools; the SNAP-Ed program on community gardens; programs for parents of newborns to five-year-olds; and neighborhood services. Mention also was made of the “comeback” of home visiting services. In addition, interviewees recognized that the health care system works well for residents who are economically advantaged and in good health, even though they may have to travel to access care.

Both economic development and health care stakeholders noted the growing presence of complementary medicine services and lifestyle programs as assets. It was suggested that
complementary medicine services can attract tourism and stimulate the local economy. The emergence of programs and services focused on wellness was also viewed as a sign that the community valued services that promote health and quality of life.

**Health Workforce**

Stakeholders from all categories referred to their existing primary care physicians as “excellent.” Comments from economic development stakeholders mentioned the recruitment and growth in primary care providers affiliated with Choptank Health and with Shore Health were assets. Specific to the need to increase health care providers on the Mid-Shore, Anne Arundel Medical Center’s (AAMC’s) presence was mentioned as an asset, both for primary care and for their management of access to specialty care. However, AAMC’s presence also was viewed as a challenge to health planning for entities that were responsible for population health in the counties.

All categories of stakeholders and the key professionals highlighted the contributions of EMS and the positive aspects of the EMS Mobile Integrated Health pilot project. Another health care workforce attribute mentioned was the increase in physician assistants in the region, and the support for their training by University of Maryland School of Medicine and Anne Arundel Community College, and their internship experiences at Shore Health.

**Economic Development, Technology and Transportation**

The symbiotic relationship between the economic welfare of a city or county and residents’ health was emphasized by all stakeholders and key professionals. In that context, the adoption of wellness programs by companies was viewed as an asset, benefitting the employees and the company alike. Another noted attribute was the existence of jobs in the communities for those who are qualified. The expansion of broadband internet was viewed as supporting economic development and increasing options for health care delivery.

While stakeholders were not selected to be representative of specific counties, comments reflect that what works well in supporting health and health care varies to some degree by county. The differences were raised by the key professionals who had responsibility for entire programs for a given county, multiple counties or the Mid-Shore region. A county’s geographic proximity to health care facilities, opportunities for employment and population sociodemographic characteristics were mentioned as prime reasons for these differences. An example cited several times included the potential negative impact of a hospital closure in Chestertown versus a less detrimental effect of a similar event in Dorchester County. The differential impact is mainly due to the geographic distance of the two hospitals from other acute care facilities. This variation also has an effect on the economic development of the counties.

Although transportation was not raised as an attribute, it was mentioned that transportation was not as problematic in Queen Anne’s County because of county buses and ready access to community services.
WHAT CHALLENGES EXIST

General Experiences

Stakeholders and key professionals mentioned a difference in how individuals were perceived based on whether they were born and raised on the Mid-Shore. Mention was made of the often-used phrases of “born here” as compared to those who “come here.” This type of distinction could be viewed as a challenge to those who were not born on the Mid-Shore, as acceptance of new programs may vary based on who is perceived as leading the change.

Challenges for Vulnerable Populations

Both key professionals and stakeholders voiced that the health care system does not work well for vulnerable groups, such as older adults, individuals with low incomes, individuals with disabilities or those with behavioral health needs. For low-income residents, health care costs are unaffordable. Comments highlighted that providers are not readily accepting new adult Medicaid or uninsured patients, appointment times are limited and unavailable after work hours, and the waiting time for appointments and related travel are additional barriers. Other challenges included underfunded local agencies and a general lack of care coordination for vulnerable populations.

Limitations in the public’s understanding of and ability to use health and health care information and to navigate the health and social service “institutions, systems and services” are overarching themes in comments from both stakeholders and key professionals. The need to educate children, adults, families and caregivers about their personal health, and also about how to use existing services, was emphasized. The challenge of limited health literacy, the term used by many, was recognized by all stakeholders and key professionals and is mentioned in the Mid-Shore community health needs assessment.

Mental health/behavioral health care is a major need across the age spectrum. The need for a dedicated effort to address the opioid epidemic was highlighted. Comments reflected concern about the lack of a sufficient response capacity for children with mental health issues despite having school programs that address mental health. Early intervention was recommended to address the growing developmental and behavioral problems noted. There was strong concern and recognition that the causes of addiction are not being addressed. More behavioral health/mental health providers are needed as well as wrap-around services and care coordination to decrease the incidence of relapse. Mention was made of grants that support behavioral health and substance use program activities, but provide limited funding for services. Limitations of this type are viewed as barriers to the flexibility required to meet local needs.

Health Programs/Services/Access to Care

Multiple stakeholders emphasized that the community’s trust in the hospital system is lacking. There is the perception of poor quality of care. In addition, the long-term effects of segregation, including on health care services delivery, are still alive in some communities and contribute to this lack of trust. Another comment noted the lack of a clear definition of a hospital was a challenge, especially in the
context of a hospital serving a rural population. There is recognition of the unique challenges faced by hospitals in rural communities and the variation in hospital-type services needed by communities.

The competition and the perceived lack of cooperation between Shore Health and AAMC was raised as a challenge to establishing a sustainable health care system. The expressed concern was the potential effect of that competition on coverage of care for Mid-Shore residents, especially for vulnerable populations. It was hypothesized that plans and related fiscal capacity to expand population health by one health care system can be undermined by competition with another system that may not have an interest in or a commitment to the broader community.

A few comments by stakeholders and key professionals reflected on the development and use of community health improvement plans, including the community health needs assessment led by Shore Health. Continued efforts to gain further input from residents were proposed. The Mid-Shore Health Improvement Coalition was mentioned as a regional approach for health improvement.

For health care institutions, the different payment models for health care services were raised as additional challenges in the context of regulated and unregulated care provision. The regulated global budget reimbursement for hospitals versus the unregulated fee-for-service reimbursement for Federally Qualified Health Centers (FQHCs) and private health care services have been noted as issues that warrant further discussion to address care coordination partnerships among systems. One comment reflects this challenge: “How systems reimburse determines how we do business.”

Additionally, the increased reliance on health services revenue for health departments was mentioned as a challenge, especially given there is limited funding to support billing and related management support. A comment was made that this shift in health department policies/practices has made residents feel that they are asked to pay twice—one through their taxes to support the health department and again through fee-for-service for services rendered—and reflects a need for more education on the use of tax dollars. In addition, concern was expressed that cuts to programs, such as adult day care provided by health departments, do not make sense given that ultimate costs will be incurred through nursing home care.

Emergency medical services (EMS) are trusted and respected; however, the challenges the system faces are substantial, and resources and challenges vary by county. There is a need for additional emergency medical technicians (EMTs) to ensure adequate coverage, as well as a need for additional vehicles. Given the distance traveled and related time, a sufficient workforce and vehicles are required to meet the current and anticipated future demand. In addition, comments highlighted that overall, there is a high call volume, much of which should be diverted to other services/needs, such as an urgent care center or other access to medications. One comment noted that call volume reflects a lack of health literacy.

The continuum and levels of needed care were identified as challenges to health and health care. The need for programs focused on health promotion, wellness and disease prevention was emphasized by all community leaders. Additional outreach by health care institutions for prevention was mentioned often. The need for care coordination, case management and care transitions was widely noted and emphasized as especially critical for vulnerable populations. While program directors are undertaking
partnerships across health programs (primary and tertiary care), and among social, primary care and public health services, these partnerships are voluntary and not funded. The challenge mentioned by stakeholders and key professionals is the lack of formal and fiscal supports for these care interfaces.

**Health Workforce**

Changes in how health care is delivered and the approach to care taken by younger providers were raised as examples of challenges for residents. Mention was made that older residents recall a time when the “family doctor” was available to visit them in their homes during evenings and weekends and served as the primary provider who oversaw their care. Now there are other levels of health care providers, such as nurse practitioners and physician assistants, who are not familiar to older residents. Several key professionals mentioned that residents want to see a physician and are reluctant to see mid-level providers. In addition, younger providers have a different approach to their work and prefer a better work-life balance that does not include working long hours and weekends. Questions and clarification about changes in the health care system also came from community leaders. They commented on the need for further details and information about the Maryland Comprehensive Primary Care Redesign Proposal (now the Maryland Primary Care Plan) to understand its implementation and impact in the counties.

Recruiting physicians, especially in the last five years, was mentioned as a major concern and challenge. While stakeholders expressed satisfaction with the existing primary care providers, they recognized that many of these providers are approaching retirement. They also mentioned that physicians are overwhelmed and are not accepting new patients. Recruitment difficulty was attributed to low reimbursement levels for services and the perception that Maryland is not a good state for private practice. Other reasons included weak general supports in the community: the perceived low quality of public schools; lack of jobs for spouses; and poor community social supports for younger recruits. The limited exposure of health care professional students to the rural community environment was noted as a barrier to recruitment as well as a limitation of their professional training. Work experience in rural areas was viewed as an essential aspect of overall professional development and could serve to support ultimate recruitment.

Several examples were given about attempts to recruit providers who were raised on the Eastern Shore and who wanted to come back to practice. In one case, a family medicine provider wanted to offer obstetrics services, but the hospital system did not give the provider these privileges. In another case, better benefits were offered by rural communities in other states. In the latter case, given personal network knowledge, an intervention resulted in securing formal support from the Maryland Department of Health and Mental Hygiene and the Area Health Education Center (AHEC), and the provider was successfully recruited. Retention of successfully recruited health care providers is another challenge. This appears to vary according to the recruitment mechanism. Those attracted by the loan repayment program and J1 visa incentives tend to leave the area upon program completion. It was mentioned that the timing of their program completion often coincides with a stage of family life, such as marriage and raising young children.
Beyond the need for primary care providers, mention also was made of the need for specialists and for care extenders, such as community health workers. Specialists needed include geriatricians, psychiatrists, pediatricians, obstetric/gynecological specialists, nutritionists, therapists and health educators. While training programs for community health workers (CHW) exist, there are challenges mentioned in attracting individuals to pursue this training. In addition, the need to convince physicians to use CHWs was mentioned. The lack of reimbursement for CHW services is an additional barrier. CHWs were described as the “eyes and ears” of the community and serve to coordinate social and health services.

Economic Development and Transportation

Stakeholders and key professionals stressed that the availability of high-quality, accessible health care services is an important factor in attracting businesses and new residents to the rural communities. As such, the continually changing landscape of health care services, and particularly of potential and actual hospital closures, raises real concerns about recruiting new businesses and potential job losses. There is a general concern about the ability to sustain needed businesses and institutions, given the limited operating margins. Support for business viability was mentioned, and Queen Anne’s County was cited as an example: Nearly half of the employed population works outside the county, which affects all services, including health services.

The public school system, challenged by reductions in population size and decreasing budgets, was noted as an additional barrier affecting the ability to recruit new businesses and residents and maintain a vibrant, economically strong community. Teacher recruitment has been a challenge due to low salaries. In addition, further demands on the school system include accommodations for children of the growing immigrant population, such as support for non-English speaking students.

Both stakeholders and key professionals agree that there is a need for enhanced transportation. The currently available transportation is not well used or understood, and available transportation services have limitations due to funding sources and regulations. As a result, the general perception is that current services are not sufficient and do not meet needs of residents, particularly vulnerable groups.

WHAT SOLUTIONS CAN SUPPORT HEALTH AND HEALTH CARE

When asked about recommendations for solutions to support health and health care for the Mid-Shore, stakeholders and key professionals provided a range of suggestions to address the challenges and to meet the needs of residents. Their responses included several cross-cutting themes as well as proposed solutions (activities, structures and processes) to support health and health care for the Mid-Shore counties (Exhibit 3).
### Exhibit 3: Community Leaders’ Themes and Solutions to Improve Health and Well-Being of the Mid-Shore Region

<table>
<thead>
<tr>
<th>THEMES / ISSUES</th>
<th>SOLUTIONS</th>
</tr>
</thead>
</table>
| Cross-cutting Themes  | Build trust.  
Engage residents.  
Focus on quality.  
Invest in local and regional capacity.                                                                                                  |
| Health and Health Care| Develop a community-wide program to enhance health literacy and prevention.  
Create a regional health planning entity.  
Develop a rural model that provides a continuum of quality services as close as possible to where people live with co-located services.  
Create a rural hospital designation.  
Maintain inpatient care in Kent County.  
Increase access to a network of providers.  
Expand use of telehealth.  
Increase coordination across health and social services.  
Enhance mental and behavioral health capacity by integrating clinical and social service programs.  
Expand EMS capacity for all counties.                                                                                                     |
| Health Care Workforce | Incentivize providers to come and stay.  
• J1 visa  
• State Loan Repayment Program  
“Grow our own” program.  
• Rural scholarships for physicians, dentists, nurse practitioners, etc.  
Expand educational opportunities in the Mid-Shore region.  
• Rural residency  
• Elective rotations                                                                                                                     |
| Economic Development  | Enhance apprenticeships and training in the Mid-Shore region.                                                                                   |
| Transportation        | Coordinate medical transit and streamline transportation systems.  
Use public/private partnerships for regular and emergency transport.  
Allow families on medical assistance transportation.                                                                                      |
Themes

The following themes were mentioned by the majority of community leaders.

**Build trust.** Stakeholders and key professionals commented that solutions will require activities and programs to build trust between community residents and organizations and the health and health care systems. The recent changes in available health care services and the plans for hospital closures have heightened general awareness and concerns among the residents. Specific comments included the need to build trust in health care services with a focus on hospital services. Several individuals commented that the existing lack of trust is a barrier to care, and enhanced trust could lead to more appropriate use of care services and adoption of recommended care behaviors. There was an emphasis on building trust among vulnerable populations, including; racial/ethnic groups who remember experiences that included discrimination in hospital practices policies; immigrant populations who are concerned about current immigration policies; and elderly populations who have experienced challenging individual and family experiences. In addition to building trust in hospital services, comments mentioned the need to build understanding and trust in care provided by mid-level health providers, such as nurse practitioners and physician assistants. The reason for some of the concern, primarily expressed on behalf of older adults, was that “new” providers who are not physicians are indications of reduced access (and perceived reduced quality) to the traditional care that older residents have received in the past.

**Engage residents in health care planning.** Stakeholders and key professionals stressed the need to listen to residents and give residents a voice in contributing to initiatives to support health and health care delivery (both regulated and unregulated). They emphasized the need for patient-centered solutions. By involving residents in the planning and oversight for health and health care programs, the resulting programs are more likely to meet their needs and be used. More than half of Choptank Health’s Advisory Board members are community members, which was cited as an example of how a system gains input for addressing the changing health needs of the population it serves. Comments highlighted the changing needs in the Mid-Shore due to the continuing increases in the number of older adult residents and the growing number of immigrants with young families and challenges facing youth. It was suggested that input from residents is needed at the town, county and regional levels as well as from health care delivery and community organizations.

**Focus on quality.** There is a common understanding among community leaders that quality of care is a prime criterion for supporting the health and health care for residents and to achieve it will require solutions at the local and regional levels. Both stakeholders and key professionals mentioned that health and health care solutions must meet the routine needs of residents. They commented that, in addition to quality of care, consideration should be given to the efficiency of services and fiscal realities when organizing services and programs.

**Invest in local and regional capacity.** Community leaders emphasized the need for a regional perspective that would be coordinated with local efforts to support the health of the Mid-Shore population. They acknowledged that while individual residents would like all services as close to them
as possible, residents generally understand this type of response is not possible. Residents want to see flexibility in programs and services and to limit travel for themselves and their families as much as possible. The types of local services proposed included: primary care (behavioral health and dental services); ambulatory diagnostic and select outpatient surgical services; emergency services; select specialty care based on unique population needs; routine access to other specialty care (it was suggested that this could be on a rotation basis possibly through telehealth/telemedicine); and needed social services that support health. Stakeholders and key professionals recognize that each county does not need a hospital. However, they also mentioned that due to distance and travel standards for care, and population characteristics some local communities need hospital services.

**PROPOSED SOLUTIONS**

Community leaders proposed “solutions” to address health and health care, health care workforce, economic development and transportation needs.

**Health and Health Care**

Stakeholders and key participants proposed a variety of approaches and entities to build capacity and to improve health and health care with community input, transparency and a focus on quality and care coordination/integration. They also stressed the importance of enhancing the knowledge and capacity of residents to support their own health. Suggestions included:

*Develop a communitywide program to enhance health literacy and prevention.* Both stakeholders and key professionals commented that formal efforts are needed to enhance the health literacy capacity of both residents and the health providers and health systems. There was general agreement that residents of all ages, especially those from vulnerable populations, would benefit from access to information regarding health promotion and disease prevention tailored to their personal needs. Interviewees described the need for guidance to increase residents’ and providers’ understanding of available resources and how these resources can be accessed and used to support personal and family health and coordinate services and care. Proposed solutions included a more structured approach to enhancing health literacy and prevention and incorporating health literacy strategies in pre-school, elementary and high school curricula. Partnering with existing community organizations and programs to provide residents with formal orientations to existing health care delivery and services and practices was mentioned. An additional approach was proposed to create a single accessible source of existing health and health care resources.

*Create a regional health planning entity with representation from the community and all health care services, social services and transportation.* Experiences reflect that planning for health service needs should incorporate the unique nature of each locale and its population. At the same time, there is a realization that each county cannot fiscally support all levels of health care and maintain quality. There is a call for an action-oriented process with broad representation to oversee and continue the regional planning started by the workgroup and to oversee program implementation to address the common needs across the Mid-Shore area. The region’s past efforts could inform and guide a renewed approach. The process should involve the community in all solutions and focus on sustainability. Linking
community-based advisory entities at the local and county levels to the regional entity was recommended to facilitate and leverage cross-county efforts. The regional entity also was described as a forum that could support the formalization and recognition of informal networks among sectors (health and social service, etc.) for case management and problem solving. A proposed goal of the entity is to ensure that the unique demands and conditions of rural counties are considered in statewide planning, regulatory initiatives and program planning. The regional system coordinates and integrates local primary care, community health center programs, specialty care and tertiary care with community-based programs and services. The regional health care system includes high-quality hospitals and providers accessible to all residents with sufficient capacity to serve all residents.

**Develop a rural model that provides a continuum of quality services as close as possible to where people live.** The health care needs of the population are met by closely integrated local and regional systems. Primary care, with a focus on pediatrics, women’s health, geriatrics and special needs, is provided at the local level. Routine specialty care is also provided locally on a rotating basis, except for select services, which are unique to special population needs and require tertiary care. Emergency care services 24/7 and dental services are part of the local system. The local health care system includes coordination of health services with social and educational services with a patient-centered holistic approach to wellness and health as well as investments in the local economy, educational programs and job training. It was proposed that creating central, local one-stop locations for all health care and social services would be ideal. The one-stop shopping health and social complex addresses the majority of ambulatory health needs and integrates primary care, behavioral health services, dental services and social services with a focus on population health. The scope and size of the complex could vary depending upon location and resources. The model has the potential for improving patient outcomes, decreasing health care costs, and improving all patients’ experiences with health and social services.

**Create a rural hospital designation that allows for some flexibility.** There was a consensus on the need for innovation in supporting rural hospitals. A new rural hospital designation could strengthen financial stability for rural hospitals through several mechanisms. Potential changes include: negotiating higher rates for rural hospitals, regulating unregulated activities in rural areas, and/or requiring that unregulated revenue in a hospital secondary market is reinvested in the rural region where it originated.

**Maintain inpatient care in Kent County.** There was strong support for a health care facility in Chestertown that would provide inpatient beds, particularly to meet the needs of older adults. For this facility, several stakeholders recognized the need to increase the community’s trust in the current hospital through greater transparency and through hospital outreach to the community. More substantial community involvement could be achieved by creating a community advisory board, having local boards feed into the system, and partnering with the community for the community health needs assessments and follow-up. Existing community resources in Kent that can be leveraged include the Chester River Medical Foundation Board and the Leh Women’s Center.

**Increase access to a network of providers.** Several strategies were recommended to improve residents’ access to providers: increasing use of mid-level providers, such as nurse practitioners, physician assistants and community health workers, at all levels of care, including the FQHC, hospitals and private
practitioners to address physician shortages and support disease prevention; expanding hours of operation; locating primary care facilities to meet community needs; providing bilingual capacity support; and offering greater access for vulnerable populations. Greater access to specialists can be provided in person through scheduled rotations at specified locations and days and/or through enhanced telehealth.

**Expand use of telehealth** by improving training for providers, educating the public about using telehealth and changing reimbursement models to fairly compensate both the specialist and the local site.

**Increase coordination across health and social services.** The critical need for coordinated health care and social service programs, with a strong and supported interface to support care management, was often mentioned. This care continuum includes services and programs to support health and wellness, primary and specialty clinical care, acute care, palliative services and hospice. As an essential part of this continuum, investments in workforce and programs were proposed to address vulnerabilities in care coordination and care transitions, such as supports for caregivers, for personal and home health care, and for organizations that service these transitions and needs, such as hospice and palliative care, and transportation programs. Help with navigation among these programs and services and increasing overall awareness of residents of the existing services were highlighted. Beyond investments in trained individuals and formal programs, stakeholders and key professionals emphasized the importance of programmatic and fiscal flexibility for creating partnerships among programs. However, it was acknowledged that this may not be possible for federally funded programs due to existing regulations. The benefits of community-based programs that focus on the promotion of health and wellness for all ages, and programs that support physical, mental and cognitive development of children and youth, were recognized.

**Enhance mental and behavioral health by integrating clinical and social service programs.** Both stakeholders and key professionals mentioned that mental and behavioral health needs are overwhelming in the Mid-Shore area and cannot wait. The expanding epidemic of substance abuse and the health department shift away from providing clinical services have severely limited access to mental and behavioral health services and needed social service supports in the five-county area. Current programs and their funding streams compartmentalize needed acute services, related transition care and housing to manage addictions, to provide medical and behavioral services over time, and to limit access and exposure to illicit substances. Specific activities were proposed:

- **Enhance Assertive Community Treatment (ACT).** ACT is a health services delivery model that provides comprehensive, community-based mental and behavioral health services and support. The approach uses multidisciplinary teams of providers (psychiatrists, case managers, social workers, peer counselors, etc.) who provide care around the clock in the patient’s home or neighborhood location.

- **Provide Medication-Assisted Treatment (MAT) training for primary care providers.** MAT, including opioid treatment programs, combines behavioral therapy and medications to treat substance use disorders.
• **Expand telehealth** by improving training for health care providers and improving collaboration with universities in mental health telemedicine. Specifically, tertiary providers ask for payment in full before the local site has been paid for a visit, forcing the local site to make up-front payment. It is recommended that the payment mechanism be modified to place less burden on the local site.

• **Create new urgent care clinics for addiction and build more shelters and transitional living facilities in the Mid-Shore.** The need for more resources on the Mid-Shore to address addiction and the opioid epidemics was highlighted. Current transitional living and shelters are overwhelmed, and there are no urgent care clinics for mental and behavioral health.

• **Remove barriers to access to mental and behavioral health care** by enforcing parity payments for mental and behavioral health, promoting better Medicaid reimbursement, offering a sliding scale for fee-for-services, and restoring funding for county health departments to provide services. Health departments should work with partners to expand hours and provide more education and prevention.

• **Develop community-based programs and coalitions to fight opioid addiction** similar to MADD (Mothers Against Drunk Driving). An example is the THP Project Purple, an initiative of The Herren Project (http://thpprojectpurple.org/the-project/).

Pilot programs and initiatives developed to solve specific challenges show promise for expansion. Successful pilots, such as the Mobile Integrated Community Health program in Queen Anne’s County and the outcomes of the Health Enterprise Zone initiative in Caroline and Dorchester counties, are examples of initiatives designed to extend care and address health care needs of vulnerable populations.

**Expand EMS Capacity.** Stakeholders and key professionals acknowledge the important role of EMS in the Mid-Shore. Specific recommendations to strengthen and broaden EMS services include:

• **Expand the EMS Mobile Integrated Community Health program currently operating in Queen Anne’s** to other counties (https://health.maryland.gov/qah/health/sitelistpages/community-health/MICH.aspx)

• **Develop a protocol for EMS to access a Mobile Crisis Team (MCT)** when addressing mental or behavioral health issues. EMS personnel are not specifically trained for mental health cases and would benefit from working with an MCT.

• **Increase the number of units and improve equipment.** Specifically, it was recommended to incorporate mobile telehealth in ambulances.
• **Address the dwindling volunteer EMS model.** Counties on the Eastern Shore have both paid and volunteer EMTs, often located together in volunteer fire departments. The system has worked well in the past but the volunteer model is dwindling. Both paid and volunteer EMTs require the same certification, which is a barrier for volunteers and makes the EMS more reliant on paid personnel.

• **Improve health literacy** to educate the public about when to call 911. Lack of health literacy is a main reason for high call volume and a large percentage of calls that do not require transport to a hospital.

**Health Care Workforce**

All community leaders mentioned the need for innovative and multipronged approaches to attract and retain health care providers to the Mid-Shore. A full range of provider types were mentioned to address basic care needs, including behavioral health, dental health, allied services (nutrition, health education, etc.) and specialists such as geriatricians and obstetricians. Suggestions include:

**Incentivize providers to practice and stay in the Mid-Shore.** Existing programs such as the J1 visa and the state loan repayment program need to be realigned and reformed to bring more providers to the five counties. Broadening existing loan repayment options or creating new options for mid-level providers, such as nurse practitioners and physician assistants, will support expanding providers in primary care. Because of the difficulties in moving providers to rural areas, health care leaders at the highest level must be involved in wooing potential recruits, and every effort should be made to support newly recruited providers, for example by providing professional social groups and finding job opportunities for spouses.

**Nurture and expand workforce programs that support “growing our own.”** Stakeholders and key professionals recognize that supporting the medical education of residents increases the chance of developing a more permanent workforce. Individuals who grow up on the Mid-Shore are more likely to come back after their education is completed to be close to family and friends. The recommendations include the development of rural scholarships for Maryland medical students, with preference for students from the Mid-Shore, as well as rural scholarships for mid-level providers (registered nurses/nurse practitioners, physician assistants and EMT/paramedics). All scholarships would have a pay-back commitment of practicing for five to 10 years in the Mid-Shore areas.

**Expand educational opportunities in the Mid-Shore.** Expanded local training programs offer the opportunity for enhanced recruitment. The seven-year-old “primary care track” for University of Maryland School of Medicine students was mentioned as an opportunity to increase the number of graduating medical students that choose primary care versus specialty care. Recent legislation to provide income tax incentives to licensed providers in health care shortage areas who meet eligibility to serve as preceptors for medical and nurse practitioner students was highlighted. The evidence shows that physicians are likely to locate where they completed their residency. Stakeholders and key professionals recommend developing a rural residency program. Furthermore, elective rural rotations for primary care and specialists at sites on the Mid-Shore give health professional students a chance to
experience work and life in rural counties and may enhance recruitment. To expand the mid-level workforce, recommendations include broadening local programs that educate nurse practitioners, physician assistants and community health workers as well as nutritionists and health educators. Several successful examples of “growing our own” across different types of provider groups were mentioned, including approaches that addressed challenges in training and incentives. The existing Middle Shore and Eastern Shore training programs, such as Chesapeake College (a broad range of programs including a registered nurse A.S degree, http://www.chesapeake.edu/health-professions), Washington College (bachelor’s and master’s degree nursing programs in collaboration with the University of Maryland School of Nursing and University of Delaware, www.washcoll.edu/departments/nursing/), and University of Maryland Eastern Shore were viewed as assets to help increase the training of mid-level providers. The nurse practitioner programs at Salisbury University (http://www.salisbury.edu/nursing/dnp/) and the University of Maryland School of Nursing (http://www.nursing.umaryland.edu/), and community health worker training programs at the Eastern Shore AHEC (https://esahec.org/services/community-health-worker-training/) and with the Association of Black Churches were also suggested. The physician assistants program sponsored through a partnership between Anne Arundel Community College and the University of Maryland School of Medicine, that includes internships at Shore Health, was also highlighted.

**Economic Development and Transportation**

**Economic Development:** There is a clear recognition that more than health care is needed to address the health needs of rural community residents. Investments in economic development are essential. Stakeholders and key professionals emphasized the need to attract economic engines to the Mid-Shore. Several counties, including Queen Anne’s and Kent, are actively promoting development by attracting hotels, nursing homes and businesses through initiatives such as Chestertown’s Main Street program (http://www.mainstreetmaryland.org/visit/chestertown/), Chester River Wellness Alliance, a 501c3 (for alternative medicine), and Kent Forward (http://www.myeasternshoremd.com/news/article_f02c6c24-be55-11e2-b88c-0019bb2963f4.html) started by Dixon Valve, the largest employer in Kent County. In rural areas, hospitals and health care facilities are important economic engines. The case of Kent County illustrates how the hospital is viewed by residents as essential to the economic development of the county. Suggestions include:

- **Develop apprenticeships and training opportunities in the five counties.** There is a need to build on existing successful programs such as the Dixon Valve Apprenticeship program, which partners with Washington College, and cooperative education programs with high schools. Training programs addressing trades, such as those offered at the Dorchester Career and Technology Center (dcctc-sc.org/) and Chesapeake College (www.chesapeake.edu) need to be strengthened.

**Transportation:** A comprehensive transportation system is essential in rural areas. Transportation is needed both for accessing health care and for accessing resources that impact social determinants of health, such as grocery stores, jobs and social services. Stakeholders and key professionals emphasized
the need for transportation solutions with a focus on vulnerable populations who are less likely to use private vehicles. Recommendations to enhance transportation options include:

- **Coordinate medical transit and streamline transportation programs.** For example, Queen Anne’s County has a “one-stop” committee for all transportation needs in the county.

- **Use public/private partnerships for regular and emergency transport.** In addition to enhancing public transit systems, stakeholders and key professionals emphasized the need to coordinate public and private options and leverage private transportation initiatives on the Mid-Shore. For example, some social services providers offer mobility options to their clients. Delmarva Community Services offers childcare, adult care and senior housing (www.dcsdct.org). Local groups such as Partners in Care (www.partnersincare.org/) and HomePort Village in Chestertown (homeports.org/) have volunteers drive individuals to medical appointments.

- **Allow families on medical assistance transportation.** Medical assistance transportation is for Medicaid recipients who have no other means of transportation to medical appointments. Strict rules allow for only one qualified person to accompany the patient. ([https://health.maryland.gov/talbotcounty/TRANSPORTATION/Pages/Home.aspx](https://health.maryland.gov/talbotcounty/TRANSPORTATION/Pages/Home.aspx))

**Discussion**

Interviewed community leaders represented a broad range of roles and depth of experiences with programs on the Mid-Shore. The majority had lived on the Mid-Shore several decades, and some were born there. Some of the individuals also had worked in other rural communities before settling in Maryland. Because of their leadership responsibilities for essential services and programs, they were familiar with state and federal agencies that fund similar programs and the related regulations. Thus, they were in a position to comment on related regional, state and national issues as well as local programs.

Given their roles and responsibilities, it was not unusual that comments from community leaders about the challenges for health and health care are aligned with reports from Maryland and other rural communities. The Maryland Health Care Commission’s 2014 evaluation of regional health delivery and health planning in rural areas resulted in similar findings (Maryland Health Care Commission, 2014). Community leaders reported challenges, such as those including: the concern about hospital care availability; the lack of primary care providers and specialists; the ever-present trials with limited public and medical transportation, and the needs of vulnerable populations. Their insights about the needs of vulnerable populations reflect findings or recent Morbidity and Mortality Weekly Reports that highlighted differences between urban and rural areas for the leading causes of death (Moy, 2017), the potential to reduce excess deaths in rural communities (Garcia, 2017), and differences in factors contributing to mental, behavioral and developmental disorders among children (Robinson, 2017).

According to the Health Resources and Services Administration report on mortality and life expectancy in rural America, efforts to address improvements in rural health will need to focus on strengthening the
health care delivery system and increasing the integration of primary, specialty and substance abuse services (HRSA, 2015).

Community leaders commented on the unique aspects of Maryland’s approach to global budgeting and that the state should acknowledge the health care facility needs, including hospitals, located in rural counties. The Maryland Total Cost of Care (TCOC) Model, previously referred to as the Maryland All-Payer Model, includes a focus on the need for “local accountability and the needs for geographic value-based incentives” with a commitment to the “sustainability of rural health care (Maryland Department of Health and Mental Hygiene, 2016c).” Other main strategies of the Maryland TCOC Model also are relevant to addressing rural health needs, as is the Maryland Primary Care Program (MDPCP). The MDPCP extends the state’s global budgeting approach to primary care with a focus on “person-centered homes with “patient designated providers,” designed to provide more “seamless coordination of care (Maryland Department of Health and Mental Hygiene, 2016a).”

Community leaders provided concrete suggestions to improve health and health care. They emphasized focusing on individual patients and their caregivers as well as the population as a whole. They mentioned that addressing the social determinants of health, not only medical care, was needed. A recent MMWR report using the Behavioral Risk Factor Surveillance System data, reported on five self-reported health behaviors by urban and rural status (Matthews, 2017). Findings highlight that adults living in rural areas differed from their urban counterparts for four of five health-related behaviors (higher prevalence of nondrinking or moderate drinking; and lower prevalence of current nonsmoking, maintaining a normal body weight, and meeting aerobic leisure time physical activity recommendations). To support healthy life-style behaviors, initiatives that complement and go beyond traditional health care delivery have shown to be effective. Two recent white papers by the Maryland Rural Health Association and the Maryland Community Health Resources Commission further describe examples from rural Maryland that address social determinants of health and providing care to patients (Maryland Rural Health Association, 2016, 2017). In addition, the state of Maryland has recently released a population health improvement plan that proposes using a social determinants of health approach (Maryland Department of Health and Mental Hygiene, 2016b) that goes “into the innovative non-medical healthcare space” to address all aspects of health and to invest in and sustain health equity. This plan builds on a framework and process that uses existing state and county data available from the Maryland State Health Improvement Process, and recognizes that each locality must play a leadership role and establish their priorities, targets, strategies and plans for sustainability.

Given their familiarity with programs in other regions and states, and their experiences with past efforts in the Mid-Shore, suggestions provided by community leaders are both structural and process-oriented. They highlighted the resilience and commitment of the residents and the importance and creativity of existing programs and partnerships. Their solutions acknowledge the importance of maintaining quality of care at all levels, building trust with community residents, in addressing health and health care needs at both the local and regional levels and investing in community wide health literacy efforts and prevention. The challenges facing rural communities are aptly described in the 2005 Future of Rural Health report (Institute of Medicine, 2005) that recommended five strategies for addressing quality
challenges in rural communities (Exhibit 4). The specific solutions proposed by community leaders emphasize that these strategies are still relevant today.

**Conclusion**

Community leaders voiced the need for innovation and flexibility in promoting rural health. They reiterated that traditional approaches to health care delivery do not work. They emphasized residents’ interest in taking an active part in developing plans with community input and in experiencing immediate action. All interviewees expressed their interest in taking action now and continuing the momentum created by the workgroup.
References


https://doi.org/10.15585/mmwr.ss6601a1

https://doi.org/10.15585/mmwr.ss6608a1
## APPENDIX 1: CONSENT FORM

<table>
<thead>
<tr>
<th>Project Title</th>
<th>Rural Health Needs and Opportunities in the Maryland Mid-Shore Region: A Series of Focus Groups to Inform the MHCC Rural Health Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose of the Study</td>
<td>Drs. Luisa Franzini, Jie Chen, Min Qi Wang, Lori Simon-Rusinowitz, Dushanka Kleinman and Alana Knudson are doing this research study. They are from the University of Maryland College Park School of Public Health and the NORC Walsh Center for Rural Health Analysis at the University of Chicago. We are asking you to be in this study because you live and/or work in Kent, Caroline, Dorchester, Talbot, or Queen Anne counties, Maryland. The goal of this project is to learn your thoughts about the healthcare in the Mid Shore Region.</td>
</tr>
<tr>
<td>Procedures</td>
<td>There will be a group discussion with an experienced leader. It will last about 90 minutes. The group will talk about possible ways to deliver healthcare in this area. The discussion will be recorded and transcribed. Only members of the study team will be allowed to take notes.</td>
</tr>
<tr>
<td>Potential Risks and Discomforts</td>
<td>There may be very few risks from taking part in this study. We do not expect anything more than stress that comes with regular conversation. It is possible that talking about healthcare might make you upset or sad. To lower the chances of this, the group will balance talking about challenges and strengths. Everyone will be asked to respect the privacy of all group members by not sharing anything discussed in the group. It is important to understand that other people in the group may not keep everything private and confidential.</td>
</tr>
<tr>
<td>Potential Benefits</td>
<td>Being in this study will not help you, but it may help to improve how healthcare is delivered in the Mid-Shore Region. We hope that in the future, you or other people might benefit from this study because of your perspectives on the unique healthcare issues here. Discussion group members will be given dinner and $25 for travel.</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>We will do our best to make sure no one outside the study will know that you are a part of the study. No one’s name will be shared or linked to the results. Everything gathered in this study will be kept safely and securely. These include notes and audio recordings. They will be stored in a secure location in the Health Services Administration Department on a computer with a password for protection. Only study team members will be allowed to use the files. If we write a report or article about this project, your name and any identifying information will not be shared. Your information may be shared with representatives of the University of Maryland, College Park or governmental authorities if you or someone else is in danger or if we are required to by law.</td>
</tr>
<tr>
<td>Right to Withdraw and Questions</td>
<td>Being in this study is your choice. You may choose not to take part at all. If you decide to take part, you may stop at any time. If you decide not to take part or if you stop at any time, you will not be punished or lose any benefits. If you decide to stop being in the study, if you have questions, concerns, or complaints, or if you need to report an injury related to the study, please contact the head of the study: Dr. Luisa Franzini University of Maryland School of Public Health 3310D School of Public Health (Bldg #295) 4200 Valley Drive College Park, MD 20742-2611 Email: <a href="mailto:franzini@umaryland.edu">franzini@umaryland.edu</a> Phone: 301 405 2470; Fax 301 405 2542</td>
</tr>
<tr>
<td>Participant Rights</td>
<td>If you have questions about your rights or feel you have been injured in any way by being in this study, please contact: University of Maryland College Park Institutional Review Board Office 1204 Marie Mount Hall College Park, Maryland, 20742 E-mail: <a href="mailto:irb@umd.edu">irb@umd.edu</a> Telephone: 301-405-0678 This study has been reviewed by the office in charge of research at the University of Maryland, College Park.</td>
</tr>
<tr>
<td>Statement of Consent</td>
<td>Signing below says that you are at least 18 years old. You have read this consent form or we have read it to you. We have answered all of your questions. You agree to be in this study. We will give you a copy of this signed consent form. If you agree to be in this study, please sign your name below.</td>
</tr>
<tr>
<td>Signature and Date</td>
<td>NAME OF PARTICIPANT ____________________________________________________________ [Please Print] SIGNATURE OF PARTICIPANT ___________________________________________ DATE ___________</td>
</tr>
</tbody>
</table>