Meeting Summary
Rural Health Care Delivery Workgroup: Transportation and Access to Care Advisory Group
October 18, 2016
MHCC, 4160 Patterson Avenue, Baltimore, MD 21215

Advisory Group Member Attendees:

Jennifer Berkman
Mark Boucot
Lisa Myers
Anna Sierra (advisory group leader)
Dr. Leland Spencer
Lara Wilson

Other Attendees:
Joe Ciotola, M.D. (Workgroup chair)
Marjorie Elsberg
Dr. Luisa Franzini
Commissioner Stephen Thomas
Dr. Min Qi Wang

Commission Staff Attendees:

Erin Dorrien
Kathy Ruben
Ben Steffen

Welcome and Introductions

The meeting convened at approximately 10:00 am. Anna Sierra, Director at Dorchester County Department of Emergency Services, who was serving as the advisory group leader, welcomed everyone and asked for a roll call of attendees. Ms. Sierra thanked everyone and noted that the advisory group would try to come up with core ideas regarding transportation in order to improve healthcare delivery in rural areas in Maryland. She remarked that the Advisory Group on Transportation and Access to Care has broad representation on the topic as well and the members have extensive knowledge and experience with transportation and access issues.

Guided Discussion

The following discussion questions were given to the advisory group as the basis for their guided discussion:

1) In terms of health care delivery, what are the greatest transportation/access to care barriers in the rural Maryland/five jurisdictions of interest?
2) In terms of current programs, what is working and what is not working? How is "success" or "what is working" determined or evaluated?
3) Can the public transportation system be improved to meet the health needs of the population?
4) What are the essential components to creating, implementing and sustaining successful programs to improve access issues created by transportation barriers? Are there current models that could be explored/replicated?
5) How can innovative programs that improve access be sustained?
6) How has the Freestanding Medical Facility in Queenstown impacted the EMS system?

Ms. Sierra suggested that for the facilitated discussion, the group run through more of a SWOT type approach, asking each person to relay their thoughts on the strengths, weaknesses, opportunities and threats related to general transportation/access to care issues, but from their own area of expertise. She asked Dr. Leland Spencer, the Health Officer of Kent and Caroline Counties, to lead the discussion.

Dr. Spencer began the discussion by describing the population of Kent and Caroline Counties. He noted that the counties have a large number of vulnerable individuals with many people who are uninsured and unemployed. Dr. Spencer said that the two counties not only have a problem with transportation and access to care, they also have a shortage of primary care physicians and a lack of care specialists.

Dr. Spencer remarked that Caroline County often stands out because of the access to care issues. Residents must often travel to Baltimore to get health care services or they go to an urgent care center. At times an ambulance is used just to go for routine services. Dr. Spencer noted that even though transportation for Medicaid patients is funded, there is a lack of providers for transportation services. Residents must then find a way back from their appointments. He said that in the county, the Health Department took over the transportation. However, the bottom line is that here is a lack of providers; and many people still prefer to go to the emergency department for their care.

Dr. Spencer then answered questions from the advisory group. Ms. Sierra asked Dr. Spencer to clarify his statement about the health department taking over transportation services. Dr. Spencer replied that most of the counties have several vendors that will provide transportation. However, Caroline County had only one vendor that could not provide the services needed, so the Health Department now serves as the transportation vendor. He noted that

this arrangement was made recently and that they can meet the needs of the population better than the previous vendor.

Commissioner Stephen Thomas asked Dr. Spencer if Uber was ever considered as an option for transportation. Dr. Spencer said that Uber is not an option in Caroline County. Ms. Sierra remarked that Uber is not even available in that area on a Friday or Saturday night.

Ben Steffen, the Executive Director of the Maryland Health Care Commission asked Dr. Spencer how the Health Department received Medicaid funding for transportation. Dr. Spencer replied that they estimated the amount and received a lump sum grant annually. The Health Department must reapply for funding annually. Mr. Steffen stated that this option is not for non-Medicaid patients. Dr. Spencer replied "correct".

Commissioner Thomas asked Dr. Spencer if the Health Department had figured out any type of pattern as to why people are going to the emergency department. Dr. Spencer said they don't know what people are going to the emergency department for, but they certainly know when they are going. He noted that the time individuals go to the ED is after 5pm, and on weekends and holidays. Dr. Spencer said that at least 50% of the ED visits could probably be avoided if there were providers in the community who could care for these patients. Mark Boucot, the CEO of Garrett Regional Medical Center asked Dr. Spencer which were the main towns that were involved. Dr. Spencer mentioned Denton and Federalsburg.

Anna Sierra asked if there were additional questions for Dr. Spencer. Since there were no additional questions, she asked Jennifer Berkman from the Eastern Shore Area Health Education Center (AHEC) to provide a SWOT analysis from her perspective.

Ms. Berkman described several strengths, including Health Enterprise Zones, and care coordination by Community Health Care Workers. Caroline and Dorchester Counties are one of five Health Enterprise Zones in Maryland. These Health Enterprise Zones utilize diverse partnerships that integrate medical care, disease prevention and public health to address the social determinants of health specific to each zone. The efforts have improved health outcomes in the area. Ms. Berkman noted that one stumbling block is that many providers don't understand the role of Community Health Care Workers. The Choptank Health System is working to get individuals trained to become Community Health Workers.

Next, Ms. Berkman described several challenges and opportunities regarding access to care. She explained that behavioral health, and getting residents into the behavioral health care system are real challenges in the area. Providing transportation for populations other than Medicaid patients is also a barrier to care access. Ms. Berkman noted that telehealth is an opportunity to expand access to care but it is very limited and expensive ($250 dollars/hour or more). In addition, health care providers need training on how to use telehealth. Finally, Ms. Berkman mentioned that the area needs a residency program to attract needed providers.

Commissioner Thomas asked Ms. Berkman if her area has Meals-on Wheels and if faith-based organizations play a role in providing access to care. Ms. Berkman said that faith-based organizations do play a role and that AAA provides Meals-on Wheels but usually in the higher populated areas. Dr. Spencer noted that many faith-based organizations are involved as Community Health Workers.

Ms. Sierra asked if there were additional questions for Ms. Berkman, and then moved on to the next member of the advisory group, Mark Boucot from Western Maryland. She asked if Western Maryland had the same issues as the Mid-Eastern Shore area.

Mr. Boucot said that western Maryland was a little different. He then described the Garrett Regional Medical Center. The Hospital has built a significant primary care base and people in western Maryland view the hospital as an epicenter for primary care. He said the hospital takes steps to mitigate problems by bringing care to the people. For example, a cancer center was opened on the hospital campus for care and infusion services. This is affiliated with an academic medical center. In addition, a satellite of the West Virginia Heart and Vascular Institute has signed an agreement with the hospital to provide care. The hospital is proactive in providing chronic disease management but also stays within the global budget.

Mr. Boucot then described some of the other initiatives of the Garrett Regional Medical Center. He told the group that they received a grant from HRSA to purchase a van to take patients to their radiation services. He noted that this would not have been possible from a capital investment. Mr. Smith discussed the problem with transportation services and the long lead time for services. He said the county wants to coordinate a group to look at grant opportunities for areas of access to services.

Another Community Health Worker program that is being looked at in the Garrett Regional Medical Center is a peer navigation program called 'The Well Patient Program'. This is a program that also utilizes nurses, home health, and social workers to help patients manage their chronic diseases. Mr. Boucot described the use of paramedicine to help with issues in the community. He gave an example of helping patients at home change their compression stockings so they don't have to end up going to the wound center. He summed up Garrett Regional Medical Center's approach of taking services to the people and providing transportation.

Ms. Sierra asked Mr. Boucot if the program was only for Medicaid patients or if it was a public service for everyone. Mr. Boucot replied that they cater to Medicaid patients but are available to all patients. Ms. Sierra asked about the use for well patients. Mr. Boucot said that structured use for well patients exists. Discharge planning groups in the hospital coordinate community services. He noted that Garrett Regional Medical Center tries to apply resources for anyone that needs them. He mentioned treating patients in appropriate settings and using loan repayments for recruiting. Dr. Spencer asked if a well patient would apply to behavioral health. Mr. Boucot replied yes. He noted that for substance abuse, they do not use methadone. Subutex treatment is used with behavioral health treatment.

Ms. Berkman said that the Maryland AHEC is working to build a state-wide program with a 160 hour training program. All individuals will be trained collectively as Community Health Workers. Mr. Steffen asked who would be doing the training. Ms. Berkman said all three centers in Maryland would follow the in-house model of the AHEC in Camden, New Jersey. Mr. Steffen asked how many Community Health Workers are trained. Ms. Berkman explained that Community Health Workers are trained in cohorts of 10-15. She stressed the importance of reimbursement for these workers and discussed various sources of funding.

Ms. Sierra than asked Lara Wilson to introduce herself and provide her SWOT analysis for the advisory group.

Ms. Wilson is the Executive Director of the Maryland Rural Health Association. She told the group that she lives in Garrett County and is very familiar with the issues in rural counties. She said she is learning a lot about the other counties in Maryland through the Workgroup. Ms. Wilson noted that transportation is a barrier that comes up in every conversation. She then described some of these problems. She said that patients must schedule appointments in the middle of the day in order to get transportation, and that the weather is a big problem with the snow in Western Maryland. Services are so spread out on the Eastern Shore that transportation is a huge problem. Transportation that will only provide for Medicaid patients is also problematic. Ms. Wilson described a situation where mothers who are with children that are covered by Medicaid but do not have Medicaid themselves, cannot take certain transportation services to get their children medical care.

Ms. Wilson remarked that one strength she has noted is that each county is trying to come up with initiatives to improve access to care. The Office of Rural Health and the Robert Woods Johnson Foundation are collaborating with each other to go to each region in the state to find out what the issues are in each area. She also mentioned the opportunity of going to the Rural Health Conference which took place two weeks ago on Solomon's Island. She encouraged advisory group members to attend next year when the meeting will be held in western Maryland.

Mr. Steffen asked Ms. Wilson if she could provide a state-wide perspective on access to care. He asked her if there was any jurisdiction where they have made significant progress with transportation issues. Ms. Wilson told Mr. Steffen that she will have a better idea in about six to eight weeks after the initiative with the Robert Woods Johnson Foundation begins. She hopes to find out what programs are going on in the different counties and find out what is unique to each area. Ultimately, the Office of Rural Health would like to look at best practices for the Rural Health Plan.

Ms. Sierra asked if there were any other questions for Ms. Wilson, and then asked the next advisory group member, Lisa Myers, to introduce herself.

Lisa Myers has worked for Maryland Institute for Emergency Medical Services Systems (MIEMSS), for the last seventeen years. This agency oversees and sets protocols for EMS throughout Maryland. Ms. Myers is the Director of Cardiac and Special Programs at MIEMSS. She told the group that MIEMSS is conducting a study on the Eastern Shore of Maryland that is examining the 'Challenges for Drive Times'. Ms. Myers noted that many rural areas depend on volunteers. The group also discussed the problem of EMS driving a long distance to another jurisdiction get a patient to the care they need, and then their own jurisdiction is without services. Ms. Myers mentioned that it is not only the distances on the Mid-Eastern Shore that EMS must travel, but also the traffic on Rt. 50 and 404 in the summer and on weekends. Dorchester County is very large with significant transportation issues and residents of Caroline County will often go to Delaware for their health needs.

Mr. Steffen asked Ms. Myers if all of the EMS in the Mid-Shore region are volunteers. Ms. Myers replied that most counties have both paid and volunteer EMS. Ms. Sierra agreed that most of the five of the Mid-Eastern Shore counties have a combination, and in addition, most have their own transportation unit. Kent County is one of the most challenging because they are all volunteer and they do not have their own transportation unit. There is a great deal of concern about the hospital closing and volunteer EMS having to go an hour away. Paid systems have some of the same problems but not as many since the unit is paid.

Mr. Steffen then asked about the situation of hospital diversions on the Eastern Shore. Ms. Myers replied that the diversions are not as great in this area, however Easton has been using red and yellow alerts and Dorchester has on occasion. Ms. Sierra told the group that travel to Peninsula Regional Medical Center can take an hour and a half. Mr. Steffen asked if there are any commercial transportation systems that serve the shore area. He was told that commercial systems are very limited. From Chester River to Easton for a stemi that must be transferred out, the EMS will stay at the hospital to then transport the patient. Dr. Joseph Ciotola, the Health Officer and the EMS Medical Director for Queen Anne's County, said the lack of commercial services and the lack of specialists are major issues for receiving the best care and for transportation. Ms. Berkman said that transportation to a level of care is especially challenging for neonates and PICU patients. She described 'baby pods' or mini isolettes that are used for transfer of this population. Helicopters are not always available for use.

Ms. Sierra was the last advisory group member to provide a SWOT analysis for access to care. She noted that the advisory group is all in agreement that transportation is a significant barrier. Ms. Sierra is the Director for the Dorchester County Department of Emergency Services, and she told the group that they are a combination of paid and volunteer workers. She then explained some of the strengths of the EMS in Dorchester County. These EMS providers are mid-level providers in that they can intubate patients and give certain medications. They have a wide range of abilities and they get to see people in their own surroundings, which many

primary care physicians don't see. The EMS can see the living environment and living conditions. Another strength is that the county can use Mobile Integrated Community Health in a more robust way to bring care to the patients.

Ms. Sierra said that one of the most significant issues is that Dorchester County is the largest County with almost no highways. She described the EMS being out of service in the area for up to three hours when they have to take patients to other hospitals. Ms. Sierra noted that everyone works together, but should the area lose any resources, it would have a significant impact.

Commissioner Thomas asked if telemedicine had any opportunity in the area since Uber is out. Ms. Sierra said that telemedicine will not work in the area because of the cost and because many areas have no high speed internet service. Commissioner Thomas mentioned grants that are available to provide access and asked if there was a map available of the 'internet desert' in Maryland. Ms. Berkman said that Senator Adelaide Eckardt has been working on internet access with the Mid Atlantic Telehealth Center. However, there still has to be a lot of education about the best practices in telemedicine. She added that she thought Maryland law doesn't allow services to be reimbursed. Mr. Steffen said that the Maryland law was changed three years ago, but there has not been an uptake in private payers for reimbursement. He noted that reimbursement is not enough. We also have to invest in technology and have a commitment by providers. Mr. Steffen commented that we have made some progress in this area, but not enough. He said we are in our fifth wave of telehealth grants and we have learned that telehealth has been used very effectively in New Hampshire. Also, HSCRC is interested in funding.

Mobile Integrated Community Health

Jared Smith a manager with the Queen Anne's County Department of Emergency Medical Services gave an overview of Mobile Integrated Community Health (MICH). Mr. Smith talked briefly about the program from its beginnings in the county in 2012. He described the mission and vision statements of this team approach to population health. The mission is to improve health outcomes in Queen Anne's County through integrated, multi-agency, and intervention-based healthcare. Mr. Smith described the demographics of Queen Anne's County, which is one of the largest counties on the Eastern shore. Mr. Smith mentioned that while Queen Anne's County does have a free-standing emergency center in Queenstown, Queen Anne's County and Caroline County are the only two counties in Maryland without a hospital. He mentioned that the County has five EMS transportation units. If one or more of these units has to leave the county to transport patients across the Bay Bridge, a large portion of the county may be without EMS services.

Mr. Smith showed the group a list of partners that were involved with the MICH project, including both county and state partners. He noted that it was important to bring in these partners

to gather their input and have them involved in the project from the beginning. He mentioned that initial funding of $50,000 for the project came from UMMS Shore Regional Health. Additional funding came from Anne Arundel Medical Center, the Queen Anne's Co. Department of Health, DHMH, the Queen Anne's County Addictions and Prevention Services program, as well as the Queen Anne's County Government. Recent funding of $130,000 came from a CareFirst Telehealth Grant.

Mr. Smith then described MICH inclusion and exclusion criteria as well as the performance measures for the program. Participants must be residents of Queen Anne's County, who are 18 years or older, who have made five 911 calls in any six month interval. Exclusions for the program are anyone receiving home health care or Visiting Nurse Agency services, or those who refuse to participate. Performance goals for the program include reducing the number of 911 calls by program participants by 25% during the fiscal year, ensuring that 75% of participants have a primary care provider, and ensuring that 90% of program participants receive at least one referral to a community resource as the result of a MICH home visit.

Mr. Smith then described the four referral phases for the MICH project, as well as the nature of the 911 referrals. He noted that the EMS personnel are the best source of referrals. He also informed the advisory group of who was on the MICH team. This team is comprised of a Department of Health nurse/nurse practitioner, a Queen Anne's County paramedic, and a behavioral health professional from the addictions program. Since Dr. Joseph Ciotola is the Health Officer and the EMS Medical Director for Queen Anne's County, he is responsible for the overall management of the team. Mr. Smith then described the role and function of the team members during the MICH home visit. Visits include a health history and physical examination, a home safety assessment, an assessment of health literacy and the patient's support system, and referrals to community services. He noted that the patient is included in the discussion about the community services that are needed, and most referrals are made on site.

Mr. Smith discussed the evidence-based scales that are used by the EMS provider to determine the home and personal safety of each patient. These assessment scales are used to determine fall risk, evaluate the physical environment, and determine the risk for alcohol and drug use disorders. He also provided data associated with the program, including the total time spent on home visits (211.2 hours), the average time spent per home visit (78 minutes), referral sources, and the percentage in growth in home visits per year for the program. He then described the patient demographics, including patient age, gender, and the breakdown of patient insurance coverage. Additional data that was presented included the ten leading diagnostic codes for patients and the average number of comorbidities. He also told the group that the average number of medications per patient was almost ten.

The patients in this program have been linked to approximately 376 services and have been evaluated for many safety hazards in their homes. Many safety hazards are removed the day of the visit. In addition, there has been a 35.4% reduction in 911 transport for patients who have

been in MICH for at least one year, as well as approximately 136 avoided ED visits. Patients indicate that they are doing well and are satisfied with the program.

Despite the positive aspects of this project, there are many challenges that must be considered including data collection issues, dealing with declinations, social isolation and mental health issues, financial sustainability, and medically complex patients. Mr. Smith briefly discussed each of these challenges as well as the next steps for the project. Finally, Mr. Smith asked the group if there were any questions about the program.

Questions Pertaining to Mobile Integrated Community Health

Ms. Berkman asked Mr. Smith if they ever referred patients to the Chronic Disease Self-Management program, and offered to share that information. Mr. Smith said he would like to have that information. Mr. Steffen asked about the number of visits to each patient; if it was just one visit or more. He asked "is there a maximum number of visits?" Mr. Smith replied that that determination is made on a case by case basis. Patients are classified as high, moderate, or low risk. However, all patients are enrolled in CRISP and phone calls are often made to patients. Finally, Ms. Berkman asked about the integration of the Mobile Crisis Program with this program. Mr. Smith described the integration.

Wrap Up and Next Steps

Erin Dorrien, the MHCC Chief of Government & Public Affairs thanked the entire advisory group for a productive session and described some of the next steps for the advisory group and for the Workgroup in general. The next Workgroup meeting will be held November 1st in Cambridge, Maryland. Some of the ideas generated during this advisory meeting may be expanded on in future meetings. Advisory group members will be contacted by email about the next meeting. The meeting adjourned at approximately 12:20 pm.