



MARYLAND HEALTH CARE COMMISSION

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Transportation/Access to Care & Special Needs/Vulnerable Populations Joint Advisory Group Meeting Summary

Monday, May 15, 2017

10:00 a.m. – 3:00 p.m.

206 North Commerce Street
Centreville, Maryland 21617

Welcome and Meeting Overview

The Joint Advisory Group meeting consisting of members from the Transportation & Vulnerable Populations Advisory Groups began at approximately 10:00 am. Following a brief welcome from the Vulnerable Populations Advisory Group Leader, Mark Luckner, and Work Group Co-Chair Dr. Joe Ciotola, the group members, speakers, and guests introduced themselves. The Advisory Group was informed that concrete recommendations from this and the previous joint meeting would be presented to the full Work Group at the next meeting on May 24th, 2017.

Building Healthy Military Communities

Purpose of the Pilot Program

The first presentation, Building Healthy Military Communities (BHMC), was given by the BHMC State Coordinator, Joy Ashcraft. Ms. Ashcraft informed the group that BHMC is a three year pilot program taking place in seven states, which was developed by the Department of Defense (DoD). The purpose of the pilot program is to better understand the challenges of accessing services and supports that face many military families who are not living near a military base. Some barriers, as well as the lack of services, may impact the health of families, or may impact service members' readiness for deployment. Ms. Ashcraft described several health-related problems for which there is a high incidence in the military population, including: suicide, smoking, obesity, and sexual assaults. She then pointed out the location of the family assistance centers throughout Maryland, and noted that there were none on the Eastern Shore except in Salisbury, Maryland. Ms. Ashcraft also presented information and gave the Joint Advisory Group members a packet of materials on the demographics of military families and health rankings for each county in the Mid-Shore region.

Framework and Timeline

Ms. Ashcraft explained the DoD program framework for identifying gaps in community services as well as the approximate timeline for collecting information and creating an action plan for improving the health of military families in Maryland. The BHMC pilot program will collect information about medical and dental care services in the Mid-Shore region. It will also collect data regarding environmental, nutritional, spiritual, psychological, behavioral and social factors that impact physical health. A 'Rapid Needs Scan' will be conducted in July/August 2017 to evaluate service capabilities and community awareness; with the aim of coordinating a network of resources to support military families. In November/December, BHMC staff will meet with public entities in the region to discuss issues of concern. Ms. Ashcraft said that this is necessary, because each of the seven pilot states has different issues and levels of concern. The goal is to tailor interventions to match the needs of each state. At the end of the three year pilot, staff will evaluate outcomes for service capacity.

Advisory Group Discussion

Work Group Co-Chair Deborah Mizeur asked Ms. Ashcraft to what extent BHMC is identifying gaps in services, and how the Rural Health Work Group can partner with the program. Ms. Ashcraft identified gaps in health outcomes as well gaps in areas such as affordable housing, job training, health behaviors, and social & economic factors. She discussed the importance of coordinating services and sharing information with other organizations including those represented by members of the Work Group.

Holly Ireland, the Executive Director of the Mid-Shore Mental Health Association, asked Ms. Ashcraft about the continuity of care for service members when transitioning from active duty status to veteran status. She gave the example of behavioral health and asked if an individual could keep their same behavioral health therapist following such a transition. Ms. Ashcraft admitted that this could present a problem since the ability to keep the same therapist may depend on an individual's type of discharge from the military, as well as their length of service and other factors.

Dr. Ciotola addressed Ms. Ashcraft's previous statement about the need to coordinate services. He suggested using the Health Departments (such as the use of their websites) as a way to centralize and identify the availability of services. Additional suggestions from Advisory Group members for identifying services for this population included using AHEC and using peer veterans who are familiar with the services in the area.

Susan Johnson, the VP of Quality and Population Health for Choptank Community Health System remarked that Choptank has had many veterans who are interested in connecting with services, but don't have transportation to get to the services. Dr. Dushanka Kleinman said that when the University of Maryland held a Mission of Mercy dental clinic, the University had to find transportation to get people who wanted to utilize the dental services, to the clinic.

Deborah Mizeur told Ms. Ashcraft that the Advisory Group had previous discussions about program sustainability and delivering care as close to home as possible. She asked if it was possible for Mid-Shore programs to partner with the DoD to provide services to veterans. Ms. Ashcraft said that service providers can register to get paid through the VA. Ms. Ireland said that getting payments from the VA can be difficult.

Ms. Mizeur then reminded the Group about their recommendation from a previous meeting of developing a Rural Health Council for regional health planning. She suggested that

one of the members of that Council should be someone who has a regional commitment to serve veterans. Patti Willis, Senior VP of University of Maryland Shore Regional Health agreed with Ms. Mizeur about including someone from the VA, and noted that the next step is coordination of the Council.

Mr. Ben Steffen followed up on the issue of VA payments and asked Ms. Ireland if there had been payments for behavioral health services. Ms. Ireland said that payments to providers had not been made to her knowledge, and noted that many providers now do not provide services that are paid through the VA. She said some providers continue services out of a commitment to the military population. The group briefly discussed VA payments, the challenge of not getting paid, and what type of provider status was necessary. Ms. Ashcraft said that providers who registered to receive payments must be Tri Care providers. Before Ms. Ashcraft's presentation ended, Mr. Steffen asked about the turnover of the military population. Ms. Ashcraft said there was a high turnover, but some personnel such as ROTC instructors live in the area.

Long Term Care Issues

Types of LTC Services and Supports

The next presentation was given by Garret Falcone, the Executive Director of Heron Point Senior Living Community. Mr. Falcone began the presentation by describing the various types (and numbers) of long term care (LTC) services and living arrangements in the U.S. and in Maryland. These included: nursing homes, assisted living, retirement communities, CCRCs, home health, and residential service associations (RSAs). He talked about some of the regulatory bodies that are responsible for existing regulations of these facilities and services. He then presented demographics of the five County Mid-Shore region and gave the percentage of the population utilizing the various facilities and services.

Existing Capacity in the Mid-Shore Region

Mr. Falcone presented an assessment of the existing capacity of LTC providers in the five jurisdictions and discussed the challenges in meeting the demands for LTC in the region due to the growing population of elders. Another group member mentioned the expense of end-of life care. Mr. Falcone noted that there has not been construction of additional skilled nursing facilities in the region but the number of assisted living facilities continues to grow. He said that staffing the LTC facilities in the region is going to be a significant issue in the future. Dr. Ciotola added that continuity of care is also a problem.

Options that may Address Future Needs

The Advisory Group discussed some possible options that address the future needs of the aging population in the Mid-Shore region including family caregiving, RSAs, telehealth, and naturally occurring retirement communities (NORCs). Monica White, from the MTA Office of Local Transit told the group that there was a NORC in Anne Arundel County. The expansion of home health services and bringing care to the patients were mentioned as possible solutions to caring for the growing elderly population. Ms. Johnson asked if there are some elderly residents in the Mid-Shore region who don't go to a long-term care facility because of financial reasons. She was informed that this may be true. In addition, some people who want to remain at home as they age are unable to do so because their caregivers are unable to continue to care for them.

Dr. Leland Spencer, the Health Officer in Kent County, said that using Adult Daycare may be an option in this situation.

Dr. Ciotola asked the Advisory group to think of a model of LTC that would be appealing to rural areas with limited providers and limited transportation. Mr. Falcone mentioned that nursing homes must have physicians so this model of care would require incentives for doctors to practice in a rural area. Ms. Johnson said there are not many Geriatricians in the Mid-Shore region. Anna Sierra, the Transportation Advisory Group Leader and Director of Emergency Services for Dorchester County, stated that mid-level professionals could be used effectively if we allow for reimbursement. In addition, she said that expanding telehealth may address the shortage of physicians. Ms. Johnson noted that telehealth should also be mobile for use with mobile health care delivery. Ms. Ireland agreed that this would be especially helpful with behavioral health care delivery which should also be embedded in primary care.

The group continued to discuss various models of care as well as alternative payment models. Ms. Johnson stated that much of the primary care is fee-for-service rather than ACOs. Mr. Steffen noted that there is a shortage of care managers; especially experienced care managers. Educational programs to expand the number of care managers have not taken root. Ms. Mizeur asked Mr. Steffen about the PACE model of care. He explained that Programs of All-inclusive care for the elderly coordinate care (using interdisciplinary teams) including primary, acute and LTC services so older individuals can continue to live in the community. Ms. Mizeur noted that one area the group has yet to discuss is palliative care. This should be discussed in the future. The final part of the discussion centered on the impact of the American Health Care Act (AHCA) on LTC and older adults, including increased insurance charges for older individuals and decreased matching Medicaid funds.

Presentation by the Maryland Transit Administration Office of Local Transit Support

Public Transportation System

Following a short break for lunch, the Advisory Group shifted the discussion from vulnerable populations to transportation. The first presentation was given by Jim Raszewski, from the Maryland Transit Administration, Office of Local Transit Support. Mr. Raszewski explained to the Joint Advisory Group that every county in Maryland has a public transportation system funded by eight Federal transportation funding programs. He noted that the public transportation system in Maryland has both a “fixed route” (such as the bus service) and a “demand response” (door to door service for elderly and disabled) component.

Mr. Raszewski then explained federal and state funding for transportation including: 5310 operating grants for private human services non-profits, SSTAP state funding for transportation of elderly and disabled individuals, and 5311 county operating grants which provide funds specifically for rural fixed and demand response transportation. Mr. Raszewski explained the funding for Maryland for FY 18- FY19 in Maryland in terms of the amount requested and the amount given. He provided the group with a handout which explained the transit system, ridership, and funding (federal & state) for the counties in the Mid-Shore region. He noted that Kent, Caroline and Talbot counties provide transit through a regional approach, and contract with Delmarva Community Transit. He also explained the transit in other Maryland rural areas.

Need for Greater Coordination of Transportation in Rural Areas

Mr. Raszewski explained to the Joint Advisory Group how the system of demand-response and “medical purpose” transportation currently works; with disabled and elderly individuals given a scheduled window of time for their transportation. The window of time is often significant; and Mr. Raszewski emphasized that there is a need for greater coordination of transportation in rural areas. Ms. Johnson remarked that the transportation is not scheduled around the needs of patients. Margie Elsburg, one of the residents in the community, agreed that there was a need for greater coordination. She told the group that scheduling to get back from a trip to the hospital requires 24 hour notice.

Ms. Ireland asked if transportation providers are obligated to promote specific services, and was told “yes”. Monica White from the MTA explained that travel- training is part of the grant requirements for non-profits providing services for seniors and individuals with disabilities. She noted that she will send a list to the Advisory Group of approximately 40 organizations in the State that provide such services, including the Department of Aging and the Central Maryland TRIP program. Ms. Johnson asked about the reporting that is required for 5310 funding and was told that most of the reporting centers around the vehicle used for transportation (maintenance records, number of trips made, and number of people transported).

The Advisory group then discussed the need in rural areas for transportation for both medical and non-medical needs. Many non-medical needs for transportation can impact health such as the need to travel to work or for grocery shopping. Mr. Raszewski agreed and said that Maryland would like to work towards improving transportation for non-medical needs. He then discussed the Governor’s Taskforce for improving transportation and asked if a member of the Advisory Group would be willing to attend a future meeting of this Taskforce.

Non-emergency Transportation Costs and Volume in the Mid-Shore Region (By County)

In an effort to understand the magnitude and variation in non-emergency transportation costs for transporting rural Medical Assistance (MA) beneficiaries and others in the Mid-Shore region, the MHCC sent a questionnaire to the Health Officers of each of the five study counties. Each county was requested to provide the following information (for FY 2015- FY2016):

- **Total transportation expenses for non-emergency MA**
- **Total number of MA patients transported**
- **Total number of MA Trips**

The counties were also asked to provide information on non-emergency trips for individuals that were not MA beneficiaries. The results of the questionnaire were compiled and were presented to the Joint Advisory Group by Dr. Kathy Ruben who works for the MHCC in the Center for Acute Care Policy and Planning.

Total Transportation Expenses for Non-Emergency Medical Assistance

Dr. Ruben explained that the expenses for transporting Medical Assistance (MA) patients for non-emergency medical treatments (from CY 2015 to CY 2016), increased for each County in the Mid-Shore region. The greatest increase in total expenses was seen in Caroline County (with an increase of \$375,940), while Queen Anne’s County had the smallest increase (\$32,594). The total increase in expenses for the five county area for transporting MA patients for non-emergencies was \$684,155.

Total Number of Medical Assistance Patients Transported for Non-Emergencies

Despite significant increases in transportation expenses, Dr. Ruben noted that the number of non-emergency MA patients transported remained approximately the same in Dorchester, Kent, and Queen Anne's County, and actually decreased in Caroline County by 122 patients. Talbot County was the only County where there was an increase in the total number of MA patients (increase of 92 patients) transported for medical treatment.

Total Number of Medical Assistance Trips for Non-Emergency Transport

Although the number of MA patients transported in Kent and Queen Anne's County remained fairly constant (CY 2015- CY2016), the number of trips for non-emergency transport increased greatly in both counties. There was an increase of 2,809 trips in Kent County and an increase of 5,220 non-emergency trips in Queen Anne's County. Dorchester and Talbot Counties also increased their non-emergency transport by 931 (Dorchester) and 608 (Talbot) trips. The number of MA trips for non-emergency medical treatment decreased in Caroline County by 1,298 trips.

Average Cost per Patient for MA Non-Emergency Transportation

Dr. Ruben reported that Caroline County had the greatest average cost per patient transported in the Mid-Shore region for 2016 (\$1,978.70). The lowest average cost per patient (2016) was \$632.06 in Dorchester County. The average cost (per patient transported) for MA non-emergency transportation increased in 2016 (from 2015), in the Mid Shore region. The greatest difference was seen in Caroline County, where the cost increase for non-emergency transportation per MA beneficiary in 2016 was \$1,063 more than 2015.

Average Cost per Trip for MA Non-Emergency Transportation

The average cost per trip for MA non-emergency transportation varied greatly among the four Mid-County regions from a high of \$94.82 per trip in Caroline County to a low of \$17.44 in Queen Anne's County (in 2016). The change in the cost per trip between 2015 and 2016 also varied. In Caroline County, the average cost per trip increased by \$45.88 while the increase in in Talbot County was \$10.78, in Kent County was \$1.35, and in Dorchester County was only \$1.20. The average cost per trip for MA non-emergency transportation in Queen Anne's County actually decreased by \$7.42 per trip in 2016.

County Limitations on MA Non-Emergency Transportation

Dr. Ruben noted that the Mid- Shore counties had various limitations on MA non-emergency transportation, but most followed the DHMH regulations. Talbot County reported that dually enrolled (Medicaid & Medicare) patients are not eligible for transport under the NRMT program if the transport is covered by Medicare. Dorchester and Kent Counties reported that while most clients can go to any provider of their choice in Maryland, transport for psychiatric services must go to the closest provider.

Limitations of the Questionnaire

Dr. Ruben explained to the Advisory Group that while we can tell the total expenses for MA non-emergency transportation for each county (from the data that was collected), there are

many unanswered questions. For example, we do not know where these individuals live or what these individuals are being transported for (Doctor's visit, behavioral health, dialysis treatment, cancer treatment). We also do not know how far they travel for medical services or if their services are on a weekly basis.

Dr. Ciotola, the Health Officer for Queen Anne's County informed the group that there are many patients in QA County that are being transported out of the county (across the Bay Bridge) for daily methadone treatments. Out-of-county transport is more expensive than in-county. Dr. Leland Spencer told the Group that much of the increase in expenses in Caroline County was due to the purchase of new vehicles for in-house transportation. The Advisory Group suggested that more information is needed before we can understand the magnitude and variation in non-emergency transportation costs for transporting rural Medical Assistance (MA) beneficiaries in the Mid-Shore region. The data should also be compared to Medicaid health data. The group concluded that the proposed Regional Planning Council should have someone with a background in transportation among its members to address transportation issues.

Dorchester County Transportation Working Group

The final presentation of the afternoon was a discussion by Angela Mercier, from the Dorchester County Transportation Working Group. She was joined by Advisory Group member Holly Ireland. The goal of the presentation was to explain the role of current regional transportation organizations and to identify gaps or barriers in the region. Ms. Mercier and Ms. Ireland described some of the challenges facing Dorchester County's web of services including: a growing need for services and service coordination, educating the public about services, understanding certain policies, and system inefficiencies.

Ms. Ireland described the growing need in the area for local alcohol and drug abuse services as well as a need for transportation education to help residents understand their options for transportation to various services. Certain regulations also make it difficult for residents to obtain transportation services. Examples she provided to the Group included: dual eligible Medicaid/Medicare beneficiaries being ineligible for services, and individuals being disqualified from receiving MA transportation because their health care providers state that the person is physically able to use public transportation. The group then discussed the many inefficiencies in the transportation system. The system is not flexible, so individuals often call 911 for transportation services. In addition, people must go out of the county to receive health care services. Dr. Ciotola asked: How we can eliminate duplicated services or inefficiencies since most counties contract transportation for MA services? The group agreed that a regional approach using mobile integrated health services would be beneficial in the Mid-Shore area.

Rural Hospitals

When considering potential concrete recommendations (listed below), Mr. Garrett Falcone, Dr. Spencer and other members of the Group raised the issue of preserving access to inpatient hospital services in the Upper Shore region. Following a brief discussion, the importance of this topic was acknowledged collectively by the Group. Dr. Ciotola pointed out to the Group that another Advisory Group, Economic Development, had a detailed discussion on this issue. The Group agreed to revisit this issue and potential recommendation at the next meeting of the Advisory Group, later this summer. Rachael Faulkner from the Maryland Dental Action Coalition recommended improving access to adult dental care by expanding capacity in the safety net provider and private practice community to serve adults who are uninsured or

enrolled in Medicaid. The Joint Advisory members were informed of the dates and times for the next Work Group meeting and the Public Hearings. The meeting ended at approximately 3:10pm.

The following were identified as recommendations by the Joint Advisory Group; to be presented to the larger Rural Health Work Group:

RECOMMENDATIONS BY THE JOINT ADVISORY GROUP

(Transportation & Vulnerable Populations)

Recommendations	Other Considerations for the Recommendations
<p>A Regional (Cross-Jurisdictional) Health Planning Council</p> <ul style="list-style-type: none"> a. One member of the Planning Council should be someone with a regional commitment to Veterans. b. Another member should be someone with a background in Transportation. 	<ul style="list-style-type: none"> • VA Funding Mechanisms for sustainability • Who else should be on the Council?
<p>Expansion of Mobile Integrated Health Care and other ways to link residents to existing resources and help reduce non-emergency 911 calls</p>	<ul style="list-style-type: none"> • Continuing education for residents and efforts to promote health literacy • Team approach (for better care coordination) with Health Departments, care managers, EMS, nurse, social worker (use of interdisciplinary teams) • Increase the role of EMS • Incorporate Mobile Telehealth (may be especially helpful with care for elderly and other vulnerable populations as well as behavioral health) • Integrate with mobile crisis program • Promote use of community health workers
<p>Rural Scholarship for Maryland</p> <ul style="list-style-type: none"> • Medical Students • RN/NP • EMT/Paramedic (at rural Community Colleges) • Dental/Dental Hygiene 	<ul style="list-style-type: none"> • Structure a tuition or scholarship program that incentivizes remaining in the community • Funding • Explore creation of Rural Residency Program
<p>Expansion of Home Health Services</p>	<ul style="list-style-type: none"> • Use of Family Caregivers
<p>Increased utilization of mid-level healthcare professionals (NPs, PAs) as well as Community Health Workers (CHW)</p>	<ul style="list-style-type: none"> • Allow for reimbursement • Nurse Practitioner Program on the Eastern Shore • AHEC training for CHW • Use of “peer veterans”
<p>Enhancement of behavioral health services in the community</p>	<ul style="list-style-type: none"> • Enhance Assertive Community Treatment (ACT) teams

	<ul style="list-style-type: none"> • Telehealth training for health care providers • Medication Assisted Treatment (MAT) training for primary care providers
Coordination for medical transit and streamlining of transportation programs	<ul style="list-style-type: none"> • Transportation for Rural non-Medicaid population • Transportation for non-medical needs that may impact health
Rural Model (initial discussion) a. must provide a continuum of quality services (primary care is essential) b. Short term inpatient capabilities may be needed	<ul style="list-style-type: none"> • Integration of services • It will take time to develop such a system
Primary Care Model	<ul style="list-style-type: none"> •

**Transportation & Vulnerable Populations Advisory Group
Areas for Future Discussion and Questions from Work Group Members**

1. Presentation by Choptank Community Health System on Federally Qualified Health Centers
2. Examine various palliative care models
3. Further Development of the role of the Health Planning Council/Committee
 - Funding Mechanisms?
 - Membership? (see list from Western Maryland Regional Council)
4. Continue to examine county non-emergency Medical Assistance transportation. Look at information such as: What are MA beneficiaries being transported for? Where are they going? Where do they live? In addition to total transportation expenses, total number of MA patients transported and total number of trips.
5. What should a hospital look like in rural areas?
 - What services should be available?
 - How can a hospital provide services that will decrease chronic conditions and keep people healthy (especially our aging population)?
6. How should the public be educated about the role of others (PAs, NPs, CHWs) in healthcare (especially in primary care)?

7. With payment reform, what additional incentives should there be for physicians in rural areas?
8. How to improve access to adult dental care by expanding capacity in the safety net provider and private practice community to serve adults who are uninsured or enrolled in Medicaid.

Attachment:

General listing of the members on the Western Maryland Rural Health Planning Council:

County Economic Development Director and staff members

Representatives from School system

School superintendent

Hospital Wellness Center representative

Health Officer

Health Medical Officer

Health Planner for the health department

Health Connect (local entity)

FQHC CEO and staff representation

County Commissioners

DHMH representatives from Dept of Social Services

6 community representatives

1 philanthropist

3 local practicing physicians

Community Action CEO

Drug Free Council Representatives

Cancer Coalition Leader

Hospital Emergency Department Physician

Dental Clinic representative

Local Dentist

Town Mayors from the county

AHEC representatives

CEO of Chamber of Commerce

Ambulance Company representative

Representative from the college

Hospital CEO