



# Health Access Non-Emergency Medical Transportation:

Issues of Statewide Planning Significance

*MARCH 22, 2005 ONTARIO, CALIFORNIA CONFERENCE*





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## Welcome

◆ **TANYA LOVE, RIVERSIDE COUNTY TRANSPORTATION COMMISSION** welcomed participants indicating this conference is the culmination of a two-year effort to understand non-emergency medical transportation [NEMT] in Riverside and San Bernardino Counties. Funding for this conference and preceding are from the Federal Transit Administration S. 5313 planning funds and from local health care organizations and transportation agencies in the two counties.

◆ **MAYOR-PRO TEM ALAN WAPNER, ONTARIO CITY COUNCIL**, in welcoming visitors to the City noted that it is easier to get people to shopping at Ontario Mills and area tourist destinations. It is much more difficult and complex to find non-emergency medical transportation resources and services.

## Opening Comments

◆ **DR. ERIC FRYKMAN, HEALTH OFFICER SAN BERNARDINO COUNTY DEPT. OF PUBLIC HEALTH**

- Public policy discrepancy between funding emergency transportation and non-emergency transportation.
- San Bernardino County spends about **one hundred million dollars** annually on emergency transportation services (e.g. ambulances).
- Persons **use emergency services more** because they are not able to receive regular medical attention.
- In Loma Linda non-emergency medical transportation need exists among different hospitals and health facilities (e.g., VA hospital, east hospital, numerous clinics, and other facilities). It is difficult for people to figure out how to get from one to another to meet medical needs.

◆ **JERRY SMITH, STATE LEGISLATIVE CHAIR OF THE CALIFORNIA SENIOR LEGISLATURE**

- NEMT is a continuing policy problem that should have been solved years ago.
- NEMT Solutions must address key factors:
  - Availability** of the right and appropriate services
  - Accountability** in relation to transportation quality
  - Accessibility** to transportation by consumers – information
  - Affordability** to consumers and payors
  - Connectability** between medical locations and consumers' residences
  - Sustainability** of services, with reduced dependence on grants

## Key Note: *The Future of Healthcare – Issues and Impacts for Transportation and Urban Design*

◆ **FUTURIST DR. IAN MORRISON** described continuing changes in healthcare as a backdrop to the dilemma of resolving NEMT challenges, commenting that health care services are often NOT located in the areas where population and need exist.

Four paradigm shifts are anticipated in delivery of health care:

1. From Just Say No....to Just Say Yes...But...
2. Floors and Ceilings
3. Continuing conservative Federal fiscal policies
3. From chemistry to molecular biology

Three mega trends will impact delivery and costs of health care: 1) aging and the **increasing numbers of seniors**; 2) the **relentless march of technology**; and 3) **increasing consumer responsibility** for payment, reversing a 40 year trend. These and other trends are resulting in a backlash against the health care industry, evidenced by declining satisfaction in drug companies and hospitals with consumers trusting supermarkets significantly more than health care services. Health care tops list of industries that consumers want to see more regulated.

In **California** we have:

- Big deficit and very diverse population and needs.
- Sixth largest proportion of uninsured in the nation at 20.6% of population and largest number of uninsured residents nationally at 6.5 million.
- Texas is the closest in number of uninsured residents at 5.3 million and 27.1% of population.
- Very high number of uninsured and growing, particularly in rapidly growing counties such as San Bernardino and Riverside.
- Higher relative dependence on county direct funding here than elsewhere.
- MediCal managed care as an opportunity.
- Number of Medicare beneficiaries soars beginning in 2010.

Issues of **cost, quality and the quest for value** can drive health care re-design. While consumer exposure to health care costs is about to increase, there are many problems with assumption that if consumers spend more of their own money for services that improved quality and efficiency of health care will result.

**Breakthroughs in health benefit value** can occur with plan, provider and vendor design oriented to accountability and incentives.

## The Future of Healthcare, continued

Four scenarios likely for health care in 2004 – 2010:

	Individual	Government
Minor Delivery System Reform	Tiers R' Us	Bigger Government
Major Delivery System Reform	Market Nirvana	National Rational Healthcare

**Scenario 1 - Tiers 'R Us:** The SUVing of American Healthcare: we pay more for choice and control. MediCare becomes more market driven. Chronically ill and low income beware. Catastrophic coverage exists for the very sick. Employers save money in benefit design packages and trading down happens more often than trading up. World of opportunity AND risk; the private sector is celebrated.

**Scenario 2 - Bigger Government:** Major backlash against cost shifting to consumers. The 2008 election runs on the retirement and health security issues of the middle class. Stated desire to protect baby boomers at all costs: Medicare Advantage for All versus "pay or play." Will require living with the consequences, likely to include: politicization of healthcare spending, rationing and restriction, lower innovation, lower profits, equity over efficiency with rising costs and taxes.

**Scenario 3 - Market Nirvana:** This breaks the entitlement culture; consumers learn to discriminate and pay so we buy care and not cars. Incentives for health and personal responsibility. Catastrophic coverage and retail medicine for all. Utilization is based on ability to pay with the rise of inexpensive plans and delivery systems. Reaching high end customers is key. Delivery reform is market-based and not evidence-based. Opportunities abound for the entrepreneurial. Private sector health care as national economic base with high quality, high service and low equity.

**Scenario 4 - National Rational HealthCare:** Involves: universality and delivery system redesign; evidence-based floors and ceilings; paying for performance; financial rewards for clinical redesign. Universal mandated coverage with employer/ individual mandates OR expanded Medicare Advantage OR expanded safety net delivery floor. Delivery system innovation rewarded and all enabled by a 21<sup>st</sup> century IT and bioscience infrastructure.

### Transportation-Related Issues:

- Budgets are tight for sure
- The uninsured and low-income young families with chronic conditions are especially vulnerable.
- Non-compliance exists due to costs, cultural preferences and NEMT issues.
- Lack of attention by stakeholders
- Need for incentives and infrastructure [capitation for NEMT, free pick-up services, different health clinic hours, use of telehealth]
- Public/Private Partnerships are key.
- Stop whining about lack of resources and focus on solutions.

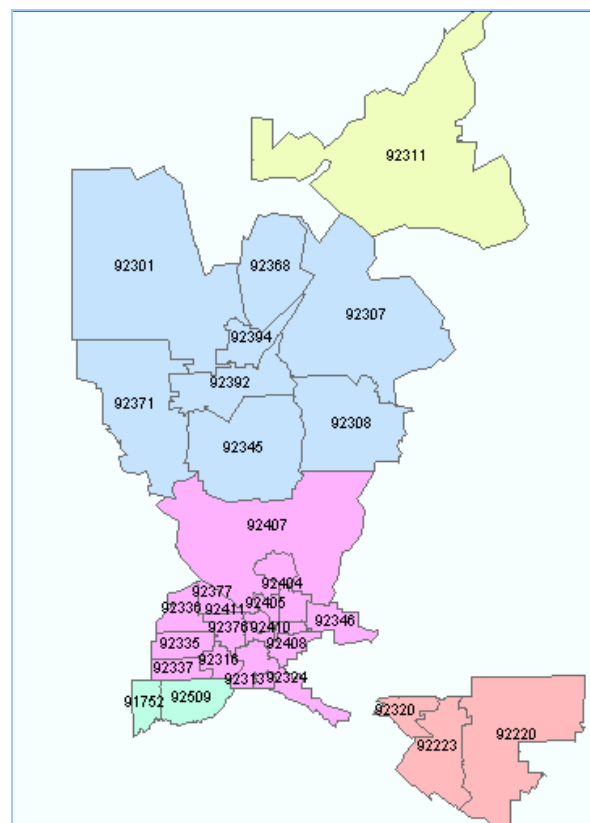
## Inland Empire Health ACCESS Project

- ◆ JUDITH NORMAN, JUDITH NORMAN TRANSPORTATION CONSULTING, PROJECT MANAGER
- ◆ TODD REMINGTON, FAIRFAX RESEARCH GROUP

**Study Goal:** To identify solutions to NEMT transportation in these two expansive counties, by rigorously documenting issues and devising solutions, refined by community input and implementable through partnership between the transit and health care industries.

Only selected components of an extensive two-year study of non-emergency medical transportation [NEMT] are reported here. The full study text is available on the SANBAG web page [[www.sanbag.ca.gov](http://www.sanbag.ca.gov)]. Implementation of HIPAA [Health Insurance Portability and Accountability Act] concurrent with this study greatly constrained our opportunity to examine NEMT needs across comparative populations, namely those of the health care Project Management Team member agencies. Unfortunately, the hoped-for solutions and pilot projects could not be developed. Instead a deeper understanding of the nature of NEMT need was developed. Key findings are reported here and the directions they suggest.

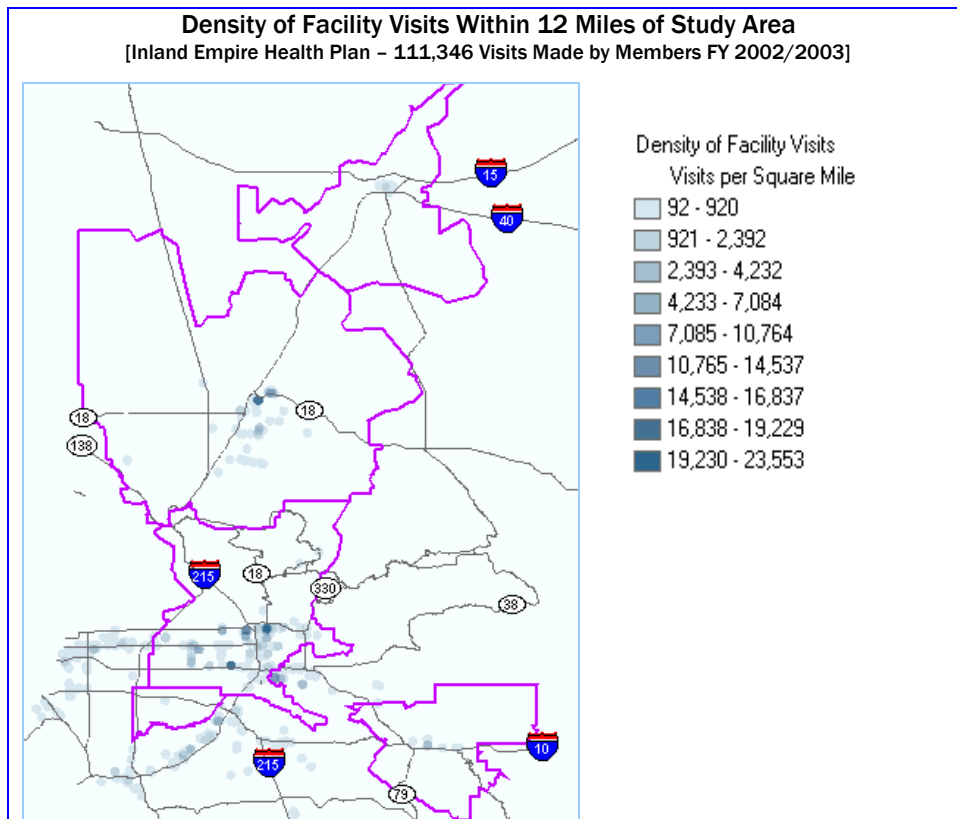
NEMT Study Area by Zip Code Within San Bernardino and Riverside Counties



## Inland Empire Health ACCESS Project, continued

### About Those Needing NEMT – Who They Are and Where They Live:

- Population segments are **missing medical appointments due to lack of transportation**, including those with their own transportation and those depending upon others for transportation, estimated at 5% of the study area population at any one time.
- Those missing medical appointments due to transportation are:  
**Women, ages 25 to 34, often single mothers, household income less than \$20,000, MediCal recipients and Spanish speakers.**
- **Seniors** appear to be getting to scheduled medical appointments, missing or rescheduling less than other age groups; data was not available on appointments NOT MADE due to transportation difficulties.
- Those missing medical appointments due to transportation are most likely, but not exclusively, **residing in the rural areas of the two counties**; the San Bernardino Valley is the destination target area for most trips.
- **Trip types** are often long-distance to regional medical facilities, may be repeating for chronic medical treatments and highly individualized, e.g. not the classic many-to-one pattern that transit easily serves.



## Inland Empire Health ACCESS Project, continued

### Health Care Issues In Relation To NEMT:

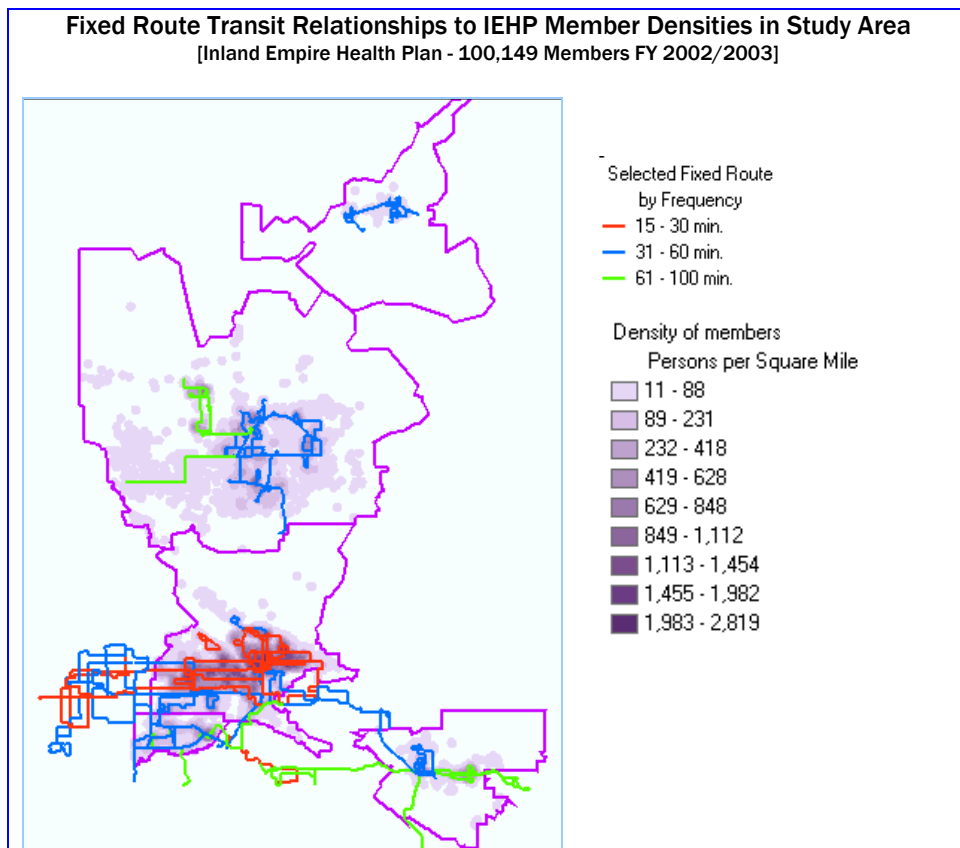
- **California's MediCal NEMT policies** are not on par with those of other states: eligibility for trip reimbursement is based upon physical ability and not economic need or availability of transportation services.
- Nationally, **health care organizations are most likely to operate NEMT** due to Medicaid funding policies and the trips' individualized nature.
- **Identifying NEMT expenses** by health care organizations in California is made difficult by the wide variations in levels and methods of reporting.
- **Missed appointment data** is the most important variable in assessing the severity of NEMT need but this is NOT currently collected by health care.
- **Lack of funding** the number one barrier to direct NEMT provision.
- **Perceived success of NEMT services** nationally appears to relate not to the cost-per-trip but: 1) to the ability to focus on the target population; 2) to consolidate administration; and 3) to obtain adequate, ongoing funds.

### Public Transportation Findings in Relation to NEMT:

- Data shows that **access to public transit services is good for over half** the IEHP members (57%) within the study area; in most cases public transit is within ¼ mile walking distance between home and a bus stop.
- **Service frequencies and inter-regional service are not adequate:** only 31% of the study area population on high frequency routes; little service exists between communities to access regional medical facilities.
- **Dial-a-ride and ADA services** are operating in each subarea for eligible seniors and persons with disabilities; although not the demographic that emerges as in need of NEMT services brokerage opportunities may exist..
- **Public transit connections** outside the local area are limited. Inter-regional connective needs significant improvement.

**Conclusions:** Addressing the complexity of NEMT issues will require understanding the issues, cooperation and on-going commitment. Examining the cost implications associated with missed medical appointments was not within the scope of this study, yet clearly financial burdens of missed medical appointments exist, both for **appointments made and missed** and routine or preventative **appointments not made** by consumers due to lack of transportation.

- **For health care**, service delivery organizations have the opportunity to adopt a "new vision" and approach to addressing NEMT needs. While the responsibilities associated with delivering medical services day-to-day limit the ability of any one health care organization to address the NEMT issue for those other than their own members., collective effort holds promise.
- **For public transit**, opportunities exist in meeting this need but will require innovation and additional infrastructure to support and supply these interjurisdictional and highly individualized trips.



**Conclusions and Recommendations:**

1. The State of California should consider the overall impacts of its current funding policies and practices relative to NEMT and MediCal reimbursement.
2. The State's policies for funding medical transportation under MediCal are inconsistent with other states and contrary to federal regulation.
3. Allowing expenditure of MediCal funding for low-income MediCal recipients transportation must be recognized and accepted as a critical core issue in the State's responsibility to further local efforts to address need.
4. Rapidly changing socioeconomic conditions of the Inland Empire suggest that in-depth "destination-based" information about missed appointments would enable transit operators to develop services that better replicate the travel patterns of study area participants.
5. Destination-type data can be collected by both health care and transit organizations to serve as valuable tools in designing more effective service.

There is no one answer, no one-time answer but clearly **partnerships between health care organizations and transit are critical** to addressing NEMT need.

**Lassen/ Modoc/ Plumas Counties  
Non-Emergency Medical Transportation Studies**

◆ **PAM COUCH, EXECUTIVE DIRECTOR MODOC COUNTY TRANSPORTATION COMMISSION**

This NEMT project is now in its implementation phase, in the far northeastern corner of California, a region described as **frontier rural**. There are no passenger carrier services and limited health care; the closest medical care is often in another state. This NEMT study, funded with a Caltrans 5313 Environmental Justice grant, developed a strategic plan for coordinating NEMT transportation in Lassen, Modoc and Plumas Counties. Key to this study was an **inclusive participatory process targeting low-income and minority groups**.

**Study Recommendations:**

- **Separate coordination models** for each county as each county is in a different situation in terms of transportation resources.
- Continuing to **develop tools and improve options**, at a pace consistent with local resources and priorities.
- **Nurture relationships**, both management and staff levels among health care and transportation providers
- Evolve to **centralized coordination** in Modoc County thru *Coordinated Transportation Services Agency* and "Ride Guide Center"

**Rural California Trip Planner:**

A second study effort involves constructing a web-based trip planner for Modoc, Lassen and Plumas Counties, as well as Inyo and Mono. Also funded with State Transit planning funds, this will deploy and evaluate a web-based system that connects with Los Angeles MTA's *Trip Master* and the Oregon-Washington *TripCheck*. Such a system will help individuals get from point A to point B by identifying what resources may exist and how to determine what to charge.

Also planned is a Client Referral Ridership and Financial Tracking (CRRAFT) project, as part of a Mobility Management Center, continuing development of coordination tools for non-emergency medical transportation.

**Points to Ponder:**

- Preventative health care is critical to individuals' health and well-being:  
**Getting there (transportation) is the first step to getting care**
- NEMT is an environmental justice issue in that it deals mostly with under-served, minority and indigent persons.



## Panel Discussion and Comments

### ◆ PAUL PAGE, FEDERAL TRANSIT ADMINISTRATION, REGION IX

Federal Transit Administration is establishing mobility networks through the **United We Ride Initiative** which focuses on coordination of human service transportation. The national *Coordinating Council on Access and Mobility* brings federal-level agency heads together to develop joint planning efforts.

**Mobility manager concept** discussed under federal transit reauthorization; possibly funded through S. 5307 federal transit operating dollars may bring a new use of funds available to transit operators. In California, the **United We Ride Summit** (Sacramento, March 2005) explored the mobility manager models.

### ◆ DR. RON GRAYBILL, LOMA LINDA UNIVERSITY MEDICAL CENTER

**Relationships** between the medical centers and the surrounding areas – and the individuals within each – are important. Loma Linda is located in an area of low-income neighborhoods. The key to certain access issues is to get together, getting good people together....resources exist but they are not in the right areas. Each person in every neighborhood is gifted. How can we help each other.

The **Transit Guide Way Finding Tool** was one product of the San Bernardino/Riverside Health Access study, an easily-reproduced map of large medical facilities to show the transit services and the specific bus stops serving particular medical buildings. The **Loma Linda Way Finding tool** can be viewed at the SANBAG website [[www.sanbag.ca.gov](http://www.sanbag.ca.gov)]. This is a **destination-oriented tool**, describing transit services in relation to where patients need to travel and where to go when they get off the bus.

### ◆ ANDREW HOLTZ, ASSOCIATION OF HEALTH CARE JOURNALISTS

Looking at the transportation that we have is only **one-half the equation**. We also need to consider what the health care system is doing to get people to health care. We need to examine carefully the notion that “**we need these trips just because we’ve always had these trips.**” It is important to consider which trips are necessary. Can services happen at different times? Can the need for some trips be eliminated through communications rather than an individual trip to a health care facility? Focus on helping people get what they really need, where they are...part of this involves what do people really need? How does the **system change** to address this? The system involves both health care and transportation.

### ◆ LUVERNE MOLBERG, RIVERSIDE COUNTY OFFICE ON AGING, MODERATOR

It’s important to consider that looking at **missed medical appointments** is also only one-half the equation. **Who is not making appointments** in the first place, possibly because they do not know how to get there? We need to change the system, sometimes one individual at a time. We must broaden our outlook to focus not on “either/or” but “both/and.” We need as many types of resources and strategies of response to NEMT needs as possible.

## Panel Discussion and Comments, continued

### ◆ PETE SPAULDING, CALIFORNIA ASSOCIATION FOR COORDINATED TRANSPORTATION

- Federal transit funding reauthorization and the Older Americans Act reauthorization must support these notions of coordination and joint efforts around resolving complex specialized transit needs.
- At the State level, redesign of MediCal and the Olmstead Act plan holds potential to break down individual funding silos to address NEMT needs. Local initiative remains critical to NEMT problem-solving.
- Another participant mentioned the new 211 information resource as a point for collecting data and communicating local resources.

### ◆ MUNICIPAL FIRE BATTALION CHIEF

Of that \$100 million spent locally on emergency transportation: what proportion of emergency medical transports can be reduced or removed by reliable non-emergency medical transportation? Reliable is service within 60 minutes or less.

- EMT [emergency medical transport] are scarce resources
- EMT are highly costly; high public subsidy; NEMT could cost less.
- EMT are limited in distribution and not easily able to match need to resources
- NEMT utilization of EMT overburdens emergency rooms and first responders – we need better systems.

### ◆ LENWOOD LONG, RIVERSIDE COUNTY COUNCIL OF AGING

Increasing numbers of seniors, and seniors no longer driving or drivers’ licenses are taken by new DMV rules, ensures that the need for NEMT will only increase. What will happen to these seniors and their health needs?

## Closing Comments

### ◆ DR. GARY FELDMAN, DIRECTOR, RIVERSIDE COUNTY DEPT. OF HEALTH

One missing piece involves **bringing medical care to local communities**: we need to consider bringing the health care system to the people and not just bringing the people to the system. In some areas health care specialists travel to an outlying area instead of individual patients traveling to a medical facility.

Health outcomes show a preponderance of value in **prevention** and therefore the contribution of **public health**. Dollars now go 98% into delivery of health care services and only 2% into prevention. There are ethical entitlement questions: What is a right in health care? How much health care is enough? How do we measure quality in health care? What are the barriers? Transportation is a barrier but not the only barrier. The **built environment** contributes to the struggle that transportation and service delivery confronts. Good planning is key.

For more information, please see [www.sanbag.ca.gov](http://www.sanbag.ca.gov). Search for **NEMT Health Access Study**. Or contact Heather Menninger-Mayeda (909) 621-3101 [menninger@earthlink.net](mailto:menninger@earthlink.net)

## Conference Sponsors & San Bernardino/ Riverside Health Access Study -- Project Management Team Members

**Caltrans Hdq. & Dist. 8** – Garth Hopkins, Dr. Paul Fagen, Gary Green  
**Southern California Association of Governmtns.** - Sina Zarifi  
**San Bernardino Associated Governments** – Michael Bair, Victoria Baker, Heather Menninger-Mayeda  
**Riverside County Transportation Commission** – Tanya Love  
**Inland Empire Health Plan** – Gary Melton, Joyce McShane  
**Kaiser Permanente** – Jennifer Resch-Silvestri, Phillip Percy  
**Molina Healthcare of California** – Margie Akins, Robert Hanson  
**Health Net** – Vergia Slade  
**Community Hospital of California** - Jerri Smith, Randy Hill

## Conference Participants

*Approximately 125 individuals participated, representing the following agencies and organizations:*

ACCESS Services, Inc.	Los Angeles, CA
A-M-M-A	Claremont, CA
Antelope Valley Transportation Authority	Lancaster, CA
Association of Health Care Journalists	Portland, OR
Barstow Area Transit	Barstow, CA
Beaver Medical Group	Redlands, CA
California Association of Coordination Transportation	Sacramento, CA
California Polytechnic University	Pomona, CA
California Senior Legislature	Alturas, CA
Caltrans District 8	San Bernardino, CA
Care Connexus, Inc.	Riverside, CA
City of Banning	Banning, CA
City of Banning Council Member	Banning, CA
City of Barstow Mayor	Barstow, CA
City of Barstow Police Department	Barstow, CA
City of Indio Council Member	Indio, CA.
City of Moorpark Transportation	Moorpark, CA
City of Ontario Fire Chief	Ontario, CA
City of Ontario Mayor Pro Tem	Ontario, CA
City of Redlands Council Member	Redlands, CA
City of Redlands Fire Battalion Chief	Redlands, CA
Comfortline Transportation Services	Upland, CA
Community Access Center	Riverside, CA
Community Health Systems	Bloomington, CA
Community Hospital of San Bernardino Foundation	San Bernardino, CA
County of San Bernardino Dept. of Public Health, CCS	San Bernardino, CA
County of San Bernardino, Supervisor Ovits' Office	Chino, CA
Epic Management	Redlands, CA
Fairfax Research Group	Ontario, CA

## Conference Participants, continued

First 5 Riverside	Riverside, CA
Goodfaith Medical Transportation	Rancho Cucamonga, CA
Health Net, Inc.	San Bernardino, CA
Healthlink MediVan	Anaheim, CA
Inland Counties Emergency Medical Agency	San Bernardino, CA
Inland Empire Health Plan	San Bernardino, CA
Inland Mediation Board	Ontario, CA
Inyo Mono Transit	Bishop, CA
Judith Norman Transportation Consulting	Carson, CA
Kaiser Permanente	Fontana, CA
LifeSigns	Riverside, CA
LogisticCare Solutions, L.L.C.	San Francisco, CA
Loma Linda University Medical Center	Loma Linda, CA
Los Angeles County Dept. of Public Works	Alhambra, CA
MED-CAB	Victorville, CA
Modoc County Transportation Commission	Alturas, CA
Modoc Regional Hospital	Alturas, CA
Molina Health Care of California	Colton & Long Beach, CA
Morongo Basin Transit Authority	Joshua Tree, CA
Mountain Area Regional Transit Authority	City of Big Bear Lake, CA
MV Medical Management	Los Angeles, CA
Omnitrans	San Bernardino, CA
Orange County Office on Aging	Santa Ana, CA
Orange County Transportation Authority	Orange, CA
Pacific Shore Insurance Services, Inc.	Costa Mesa, CA
Palo Verde Hospital	Blythe, CA
Primary Provider Management Company	Riverside, CA
Primecare Medical Group	Rancho Cucamonga, CA
Redlands Community Hospital	Redlands, CA
Riverside County Dept. of Public Health	Riverside, CA
Riverside County Office on Aging	Riverside, CA
Riverside County Transportation Commission	Riverside, CA
Riverside County\ Supervisor Tavaglione's Office	Riverside, CA
Riverside Emergency Medical Services	Riverside, CA
Rolling Start Inc.	San Bernardino, CA
RouteMatch Software	Redmond, WA
San Bernardino Associated Governments	San Bernardino, CA
San Bernardino County Dept. of Aging and Adult Services	San Bernardino & Ontario, CA
San Bernardino County Dept. of Public Health	San Bernardino, CA.
San Diego Associated Governments	San Diego, CA
Secure Transportation	Whittier, CA
Shawna Hampton Enterprises	Rancho Cucamonga, CA
Southern California Association of Governments	Los Angeles, CA
Strategic Health Perspectives	Menlo Park, CA
T.L.C. Enterprise	Menifee, CA
Transportation Planning & Policy	Costa Mesa, CA
Trapeze Group	Scottsdale, AZ
U.S. DOT, Federal Transit Administration, Region IX	San Francisco, CA
Victor Valley Community Services Council	Victorville, CA
Victor Valley Transit Authority	Victorville, CA
West End Community Health Action Network	Ontario, CA
West End Medi-Trans, Inc.	Pomona, CA