Making Connections Table Discussion Notes November 7, 2014

Table 1

Question 1

Billboards, Social Media, Appointment scheduling, PCPs etc.

Medical Providers and hospitals

Social Workers- instruct- educate patients

City government- Health Department and having evening service

Senior Centers- Non- emergency ambulance using 911

Local Fire –ambulance will respond to local needs such as Homeless shelters, Bus/Rail shelters.

Veteran’s Vehicles

Using churches and food banks via Insurance and co-pays

Use 211, use access channels/radios, social welfare issues/impacts

Question 2

Central dispatch with computer track.

Tracking needs by Medical Specialty – coordinate with providers

Working w/ or educating dialysis centers- coordinate with centers

Use of non-emergency, private providers

Interfacing medical offices/practices/ hospitals-shared info, regarding needs

Vouchers  
more education regarding available resources on how pooling with benefit profits

Have will-call for medical

Volunteer’s drivers, have ride sharing for public and private

Use of Appointments

Mobility education –use packs w/food or other

Use of Meals on Wheels format funding or points for future use

Grant for Bristol Elders

Used of DAR brochures with reminders/check insurance carriers

Increase coordinating with dialysis, neck pillows

Question 3

Need a dispatcher with data base via medical facility or other –central

Shared data bases with geography-info shared software –RTA have a Log in

If state and federal funds –maybe a central vehicle dispatch regional

Tiered payments

Incentives for cost share -collaboration

**OTHER NOTES**

* To make this work- we need to relax the standard
* Assets need to be made available-but there is always a cost associated.
* A designated card for medical transportation card- with all the clients information on this card.

**Table 2**

**Discussants:** Stacy from GATRA, Gale from Mansfield COA, Lisa from Providence VA, Steve from SSCAC, Rachel from MassMobility

**Question 1 – Communication**

* Mansfield put out a social services newsletter, sent to every person in the town through the town electric dept – fuel assistance went up 30% - we could do this for transportation so ppl know about what services are available
* Send a newsletter to medical facilities
* Put information in medical waiting rooms
* Medical facilities need to know about PT-1 forms but there are other options too
* Get the info to the medical facilities
* Get info to the homeless shelters
* Get info to the social service agencies that are working with the homeless families in motels
* Put info at the motels where homeless families are living
* Keep “street sheets” at the motels - info about all homeless services available in the area
* Get info to social service depts.
* Get info to fire & police departments
* Local municipalities
* DTA just changed their system, have a 1-800 number so you get a live person, make sure the DTA call-takers have transp info
* Tell everyone about Ride Match!
* Libraries – people use the computer there or go there for a warm place – get info about Ride Match there & other transp info
* Put info about Ride Match up on library bulletin boards so people know to look there
* Local career centers
* Get info to DTA (SE Mass locations in Brockton, Fall River, New Bedford, Plymouth and Taunton)
* Get help from other orgs to market Ride Match & get the word out about transp services
* Get transp on the agenda at community forums where soc service ppl learn about services
* Put Ride Match on local towns websites (GATRA has worked with them to do this)
* Local Cable
* Get a grant to contract with local taxi agencies to help homeless families who are stranded without safe walk to bus stop – with automatic qualification if you are a homeless family – just a few rides not long-term
* Get info to community centers

**Question 2 – Scheduling & Wait Times**

* You can take a PCA with you but a lot of ppl don’t have them
* Volunteers to go with a person, could go get a snack for the person – volunteer medical escort
* Hard to align schedules
* GATRA does call-back instead of scheduling for rides home, always will call bc the timing is never what you expect & then it’s next available vehicle but it can be a long wait depending on traffic, etc.
* There is a need above & beyond curb to curb for medical – maybe closer to the ADA definition of origin to destination would be more reasonable/realistic – change in HST policy
* Managing consumers’ expectations
* Ask the client a lot of questions about their medical issues
* Let them know they might have to wait & see if that’s possible &
  + Maybe medical facility can do this – when they confirm an apt with someone
  + Medical facility can tell the transp provider if the consumer needs a ride asap & then dispatcher can prioritize that
* Improved communication betw med facility & transp provider
* Patient get priority in line for doctor apt
* Empower patients to advocate for themselves at the doctor’s office if appts are running late to try to get seen sooner
* When trip is booked – give info to consumer that there might be a wait & to prep for that just in case – bring extra food, something to read
* Dispatchers call doctor’s office to check on how someone is doing to see if they will be on time
* Medical facilities can make waiting more comfortable – eg. make a snack available
* Dispatchers don’t know what a person’s disability is
* Consumer expectation – this isn’t a taxi so there might be a wait
* MWRTA shuttle worked out a system with JP VA so that passengers on the van are sure to be done by 2
* Social workers coach consumers on how to schedule appts so they can get transp
* Transp for vets from SE MA to Providence VA is tough
* Volunteer medical escorts
* Ridesharing – consumers might expect a direct trip but have to make a stop
* All services should know about the waiting & ridesharing so they can help set expectations
* Will call is hard for transp providers
* Change HST brokerage rules so that if you miss your scheduled trip you go into a pool of available providers in the area so you could get a one-way on one provider & the other way on the other provider – separate it out so that transp providers can do one-way on a trip but maybe another provider does the other way instead of just one provider doing the whole round trip

**Question 3 – Commingling Passengers & Pooling Funds**

* If it’s a VA-funded transp service there are strict eligibility rules so this could be hard but would be great if it worked out
* Everyone has different regulations
* Commingling
* Insurance, vehicle standards, funding, etc. is different
* UNIVERSAL SET OF VEHICLE STANDARDS (& driver standards & consumer standards)
  + This could deter smaller operators
  + E.g. relax the 90 min DDS standard in some cases
* Ultimately it’s all state funding so why can’t we do commingling?
* “Fill up the vehicles! Give us the best price!” – Jim Flanagan
* Commingling would improve cost effectiveness
* There used to be a regulation that you couldn’t take an indiv consumer for less than you are charging a MH consumer – is this still a regulation???
* Get a small grant for COAs to help w transp
* Pool state funds so it doesn’t matter which agency is paying for the trip instead of each agency having its billing
* Not all vets use VA services – some are on MH etc.
* People who aren’t eligible for state programs but still need transp = a challenge
* Fill up empty seats with general public for a reasonable price
* Centralized repository of all consumers with trip requests – then transp providers go in & select clients & create routes/fit new requests into existing routes

**Easel Info**

Q1

* Medical facilities 🡪 lists of providers
* Info 🡪 desks/reception areas/common areas
* Local municipalities – ie. Fire/police/library
* DTA
* Local government involvement, ie town website

Q2

* Determine client suitability/client ability
* Communicate with client – expectations
* Education of consumer
* Sharing provider assets – merge fleet

Q3

* Universal vehicle standards
* Pooling of funds

**Table 3**

**Question 1 – Communication**

* Work with the state-wide 211 system and get them to refer calls to a local level
* Education is key – medical facilities don’t really know what’s available and don’t really care
* Educate the receptionists or person making reservations – but it is often difficult to identify this individual within the organization
* CEO to CEO education – educate about transportation at the highest level in the organization and it will trickle down to the right people
* Provide materials to all social service agencies, town offices, medical facilities, councils, etc.
* Utilize social media to get the word out
* Do more advertising to promote services and resources such as Ride Match

**Question 2 - Scheduling & Wait Times**

* Central state dispatch – Calls go into a central dispatch number and the closest vehicle goes to pick the person up.
* Have the medical facility reserve the transportation – ask when they make appointment if they have transportation and set up the transportation for them. Especially for seniors.
* Enforce a state-wide policy where medical facilities are responsible for their patients transportation – Talk to the boards of the Mass Hospital Association, Mass Medical Society, Mass Nurses Association
* Utilize vouchers – give emergency vouchers to medical centers to use when needed
* Utilize volunteer programs
* Guaranteed ride home policy at larger medical centers
* Utilize police and fire departments for emergency rides

**Question 3 – Commingling Passengers & Pooling Funds**

* Centralized repository of all consumers with trip requests – then transportation providers go in & select clients & create routes/fit new requests into existing routes
* Magic Medical Transportation Card – has all the information (person’s eligibility, disability, insurance, ) medical facility just swipes the card and puts in the reservation times and then the information is sent to the centralized repository and dispatch
* Improve coordination efforts between public and private providers and also community-based organizations
* Have a special “Ride Match” price for vendors in the database – for medical trips only – a discounted self-pay rate that the vendors agree to

# **SERCC Medical Forum**

## Nov 7, 2014

## Table 4

Response to scenario #1 (Scenario is not listed here)

Overarching theme: **Provider education about available transportation resources**

* Providers are open to learning about available resources. The main question is whom to target. Although medical offices are too busy, every office has a point person, either an office manager or head nurse to contact
* Larger practices and hospitals have periodic staff meetings. Get on the agenda of a staff meeting to talk about transportation resources
* Attend health fares which are organized a few times a year and provide information at those events
* Involve faith-based organizations to disseminate transportation information
* Doctors’ offices affiliated with hospitals need information about available transportation services in the region
* Such information also has to include what insurance product convers what transportation service (e.g. PT-1) and who is the payer.

Response to scenario #2

Overarching theme: **There is a need to manage consumer expectations about wait time associated with community transportation services. Sometimes the wait can negatively affect the health of patients that just finished treatment, e.g. dialysis. The question is how to make wait time more comfortable for the patien**t?

* Staff admitting patents at medical facilities will have to prioritize patents based on their scheduled ride home. Return ride information should be communicated with office staff during admission
* Many COAs provide medical transportation to out-of-town locations. In many instances volunteer drivers will go into the medical office with the patients and can take them home immediately. This is the desired scenario but rare
* MassHealth patients are more prone to missing their rides home if treatment runs beyond schedule. Medical staff has to establish a good working relationship with the transportation service provider to alleviate this problem mostly because PT-1 transportation is less flexible
* Educate patients about possible long wait time for the ride home and how best they can prepare (e.g. bringing snacks, drinks) for unforeseen health consequences such as a drop in blood glucose level
* Find out about patients’ anxiety with respect to transportation before medical appointments.

Response to scenario #3

Overarching them**e: Expand RideMatch**

* Using vehicles more efficiently requires constant communication and prompt scheduling between medical office staff and transportation providers
* Expand RideMatch into a statewide resource on available services

Expand RideMatch into a one-call/one-click center (interactive trip plan

Table 6

1. Share Ride match with doctor’s office-ask them to share this information with their in service days   
   Schools k-12 and higher education –have brochures and pamphlets. Train receptionist at a dr. office to offer info.

Agencies providing services to elders, homeless, soup kitchens, food partners, COAs- insurance training

Connect with health fairs, and libraries.

211 needs to be better utilized – monitored 24-7 anytime, anyplace- they know about Ride Match  
  
Put brochures in dr. offices, and shelters, etc.  
  
Sharing on a state level with other RCCs –train other RCCs on ride match so they can market in their communities.

How can you see what is missing and add services in their communities- current information

Sharing with municipalities, Police, and Dept. of Human Services.

Marketing and training across ALL sectors.

1. People should have a different perception on Boston- change the perception that they have to go to Boston. They should look more locally.

Educating consumer from the beginning, improve communication at dispatch offices with staff.   
  
\*Dr. Office’s could have a designated day/time for people using transportation so they can ride together.  
  
\*Patients waiting for a ride could take priority, what if appointments are running late.

Medical escort programs –they could be helpful. Volunteer Medical Escorts –This is available in other areas. (Jewish Family Services-Located in Framingham) Do we have something like this in our area?

Transportation service needs to be up front about pick-up time.

Dr. Office could let patient know if they are late when the patients checks-in.

Dr. Office maybe should have a type of schedule if they are running late, on-time to let patients know if the appointment is on-time. They may need to change their ride appointment.

Information to the patients if they sign up for DAR maybe a pamphlet explaining it maybe late, etc.

Maybe handout goodie bags so consumers have a snack for the ride home or while they are waiting if their appointment is long/delayed.

Coordination has to be at the State level.  
medical centers could have vouchers- if something did go wrong.  
  
\*Consumers need to self-advocate making sure you do not miss their ride.

***\*important key points***

1. **Vehicle:**

Creation of Rideshare for medical facilities –e.g. Mass Rides  
  
Could there incentives when riding more people? Example- 1-person costs $15.00 2 people costs $10.00 and 3 people costs $5.00- the more people the less it will cost. (Tiered –payments)  
  
Mass Rides come into educate how people can share rides.

A ride board and have an incentive for lower costs if there are several rides.

Agencies should post this information in their offices

Create a phone App

Agencies that provide transportation throughout the Community to provide services during their “off” time. Each will be assigned a day and time slot. Agencies will work together to fill the “ride board” with their client (Problems- insurance, liabilities, regulations are barriers.)

**Funds:** Take an inventory of what vehicles are available and works together with all providers to fill the gap in transportation issues.