

HEALTH OUTREACH PARTNERS

OVERCOMING OBSTACLES TO HEALTH CARE

Transportation Models that Work



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TABLE OF CONTENTS

Executive Summary	3
Overcoming Obstacles to Health Care: Transportation Models that Work	9
Introduction	9
Transportation Models that Work Project	11
Case Study Organizations	13
Helping Our Women	13
Seniors First	15
Finger Lakes Community Health	17
Morton Comprehensive Health Services	19
El Rio Community Health Center	21
Kōkua Kalihi Valley Comprehensive Family Services	23
Key Findings, Recommendations, and Policy Strategies	25
Key Findings	25
Recommendations	27
Policy Strategies	30
Conclusion	35



“Without the transportation program, I wouldn’t be alive today.”

-Helping Our Women Client

EXECUTIVE SUMMARY

For too many Americans, the lack of transportation limits access to jobs, childcare, social services, and critical health care services. Several studies cite transportation as a common barrier to accessing health care services particularly among the elderly, children, those living in rural areas, and low-income individuals and families. Health Outreach Partners' (HOP) "*Outreach Across Populations: 2013 National Needs Assessment of Health Outreach Programs*" identifies transportation as the second most prevalent barrier to accessing health care services among underserved populations served by health outreach programs at Community Health Centers (CHCs). Respondents indicated that the top four barriers preventing access to transportation services are: (1) living in a rural area; (2) cost; (3) limited or a lack of transportation options; and, (4) the inability to obtain a driver's license.¹ As access to and funding for public transportation declined due to the 2007-2009 economic recession,² transportation expenses continued to account for a growing portion of U.S. household budgets, making access to affordable transportation options even more challenging.

The intersection of health and transportation is taking a daily toll on the quality of life of low-income individuals and families. According to a 2005 study, in any given year at least 3.6 million Americans do not obtain medical care because of a lack of transportation.³ Of that, those that are most likely affected are female, low-income, older, less educated, members of a minority group, and those experiencing co-morbid conditions. Reduced access to transportation appears to lead to the decreased use of preventive and primary health care services and an increased use of the emergency department; however, there is little research or data to demonstrate this impact beyond anecdotal accounts.

CHCs and other community-based organizations (CBOs) are often tasked with providing a wide range of enabling services, including transportation. However, this task can prove difficult. Many organizations are ill-equipped to address the vast array of challenges that providing transportation presents. For example, providing transportation services often requires addressing liability issues, dealing with the high cost of gas and vehicles, securing adequate funding, ensuring such services are linguistically and culturally competent, and integrating transportation into health and social service programs.

It is impossible to come up with a one-size-fits-all solution to overcome transportation barriers. Communities vary widely in terms of demographics, physical environment, transportation infrastructure, and available resources. Nevertheless, there are important lessons to be learned from CHCs and CBOs already providing patient-centered transportation. These lessons can be used to help other organizations develop or expand their own transportation services. In 2011, HOP launched its "Overcoming Obstacles to Health Care: Transportation Models that Work" project in order to identify successful patient-centered transportation models, establish recommendations and strategies for how to impact relevant state and federal transportation policies, and provide guidance on improving health care access by addressing transportation barriers.

PROJECT OVERVIEW

In 2011, HOP launched “Overcoming Obstacles to Health Care: Transportation Models that Work”, a three-year project funded by The Kresge Foundation. The project is intended to address transportation as a barrier to health care access. HOP has five project goals including:

- **Case Studies:** Identify and distribute successfully applied patient-centered transportation policies and practices at CHCs and CBOs that increase access to care for the most marginalized and underserved populations across the nation.
- **Policy Advisory Council:** Convene a diverse group of policy advisors and service providers from private, public, and consumer stakeholder organizations to ensure that the project is grounded in community-led strategies.
- **Policy Analysis:** Conduct policy analyses to assess existing laws, make policy recommendations, and inform advocacy agendas.
- **Policy Campaign:** Disseminate information to broad audiences including community organizations, coalitions, advocacy groups, funders, and federal agencies working to improve transportation as a means for increasing health care access.
- **Training and Technical Assistance (T/TA):** Institutionalize information, resources, and experiences gained from the examination of case study sites into HOP’s training and technical assistance activities.

TRANSPORTATION CASE STUDY COMMUNITIES

In order to provide examples of patient-centered transportation models with the potential to be replicated, HOP identified and investigated six case study communities. Communities included in this project demonstrate diversity in transportation models used, populations served, geographic location, and regional context. The case study sites include the following organizations:

- **Helping Our Women (HOW)** is a nonprofit organization located in rural Provincetown, Massachusetts. HOW collaborates with the local airline and regional transit authority for longer trips (normally to Boston) and operates a volunteer program for local rides for clients living with life-threatening and chronic illnesses.
- **Finger Lakes Community Health (FLCH)** is a CHC serving rural upstate New York with administrative offices located in Penn Yan, New York. FLCH provides basic transport, in-camp mobile services, and school-based dental services to migrant and seasonal farmworkers and their children. In addition, FLCH offers telehealth services to all community members.
- **Seniors First** is a nonprofit organization located in suburban Auburn, California. Seniors First runs Door to Door Rides, a volunteer driver transportation program. They also collaborate with the regional transit authority and two hospital systems to operate Health Express, a free, door-to-door transportation service to and from non-emergency medical appointments for seniors, the disabled, and other low-income individuals (as a ride of last resort).

- **El Rio Community Health Center (El Rio)** is a CHC located in urban Tucson, Arizona. El Rio established a community collaboration to operate the “Van of Hope”, a mobile medical unit that serves people experiencing homelessness, and a free door-to-door van service to the health center for low-income individuals.
- **Morton Health Services (Morton)** is a CHC located in urban Tulsa, Oklahoma. Morton operates a curb-to-curb service for patients and two free fixed-route bus services for people who are low-income, elderly, uninsured, experiencing homelessness, and unemployed. The service also reaches Tulsa’s highest concentration of Medicaid recipients living primarily in public housing.
- **Kōkua Kalihi Valley Comprehensive Family Services (KKV)** is a CHC located outside of urban Honolulu, Hawaii. KKV operates free shuttle routes to their main clinic for low-income, immigrants with Limited English Proficiency (LEP), and seniors living in public housing; door-to-door shuttle services for Kalihi Valley seniors to access exercise, socialization, and health management programs; and free shuttle services to referral appointments.

KEY FINDINGS, RECOMMENDATIONS, AND POLICY STRATEGIES

Many of the case study organizations involved in the project significantly strengthened and grew their transportation efforts over the years based on experience, changing needs, and lessons learned. Throughout HOP’s work with these organizations, common themes emerged regarding how to build and maintain successful transportation models. HOP identified six key findings based on themes that emerged across sites. In conjunction with Simon & Company, a Washington D.C. based health care policy contractor, HOP used the key findings and relevant literature, policies, and guidelines to develop five community-level recommendations and four state and federal health and transportation policy strategies to help support effective transportation models.

KEY FINDINGS

HOP identified six key findings that enable the overall success of the patient-centered transportation models involved in this project, including:

- **Diverse Strategies:** Case study organizations use more than one strategy to overcome transportation barriers facing their respective communities.
- **Customized Approaches:** Case study organizations do not take a “one-size-fits-all approach” to providing transportation. Instead they customize services depending on the need of the population served and resources available.
- **Organizational Commitment:** Case study organizations cultivate strong organizational commitment—particularly from leadership staff and Board of Directors—to provide solutions to transportation barriers.
- **Dedicated, Competent Staff:** Case study organizations hire staff and recruit volunteers who are committed, competent, professional, and reliable.
- **Diversified Funding Streams:** Case study organizations are creative in pulling together funding and continually looking for opportunities to solicit financial support.

- **Expansive Partnerships:** Case study organizations take an expansive approach to developing partnerships by working with community, governmental, and business partners to offer transportation services.

RECOMMENDATIONS

For organizations that are interested in establishing or expanding existing transportation services, HOP recommends considering the following:

- **Evaluation:** Improve evaluation methods in order to show the impact of transportation services on health outcomes, use of the emergency department, and use of preventive and primary health care services.
- **Funding:** Develop a diverse funding stream to ensure core transportation operations are sustainable when funding is reduced, redirected, or delayed.
- **Coordination:** Create more opportunities to coordinate and bridge the gap between health care and transportation industries and local, state, and federal transportation programs.
- **Leadership:** Encourage CHCs and CBOs to emphasize transportation leadership.
- **Focus on Health Care Utilization:** Offer increased transportation services in order to ensure that remaining uninsured populations and low-income individuals receiving insurance coverage in the Health Insurance Marketplaces will be able to access health care services.

STATE AND FEDERAL POLICY STRATEGIES

Simon & Company and HOP established four state and federal policy-focused strategies. These policy strategies are intended to: (1) support the replication of case study models in other communities and (2) enhance the quality and efficiency of established state and federal transportation programs. Strategies include:

- Improve coordination of transportation service programs at the federal level.
- Protect Medicaid Non-Emergency Medical Transportation (NEMT) benefits.
- Enact a Medicare NEMT benefit for partial dual eligibles (low-income seniors who qualify for both Medicaid and Medicare).
- Encourage volunteer drivers by improving liability laws and mileage reimbursement rates.

NEXT STEPS

HOP's "*Outreach Across Populations: 2013 National Needs Assessment of Health Outreach Programs*" and case study findings establish that transportation remains a persistent barrier to accessing health care services. Many communities engage in seeking solutions but are in need of successful examples, funding sources, and supportive policies to aid efforts. The barriers preventing transportation access are contextual and no single solution is applicable to all communities and all populations.

In the coming months and years, the national conversation around health care access will shift from enrollment into affordable health insurance to ensuring access and utilization of health care services. As this occurs, CHCs and CBOs should take the opportunity to learn from each other's successes and challenges providing patient-centered transportation. Advocacy to support, develop, and expand transportation solutions at the organizational and community level will be needed to help meet the unique needs of marginalized, underserved populations.



OVERCOMING OBSTACLES TO HEALTH CARE: TRANSPORTATION MODELS THAT WORK

INTRODUCTION

Transportation as a Barrier to Services: For too many Americans, the lack of transportation limits access to jobs, childcare, social services, and critical health care services. Several studies cite transportation as a common barrier to accessing health care services particularly among the elderly, children, those living in rural areas, and low-income individuals and families.

- In a 2004 study on barriers to health care access among the elderly, researchers found transportation to be the third most commonly cited barrier (21.1%). They found that among Medicare beneficiaries, the persons at the greatest risk of confronting barriers are “those with the lowest incomes, those in the oldest age group, females, the less educated, and those lacking insurance beyond Medicare.” For instance, their analysis shows that participants earning less than \$12,000 annually are 2.6 times more likely to report a barrier to seeing a doctor than those earning \$50,000 or more.⁴
- According to a 2005 study, at least 3.6 million Americans do not obtain medical care because of a lack of transportation in a given year. Of that, those that are most likely affected are female, low-income, older, less educated, members of a minority group, and those experiencing co-morbid conditions. The study notes that as many as 15.5 million people are potentially at risk for missing care because of transportation barriers in a given year, since nearly 12 million people either did not need care in the study year or managed to obtain transportation when it was needed, despite difficulties in doing so.⁵
- A 2011 report issued by the Children’s Health Fund concluded that low-income children face

significant barriers to health care access, especially in rural areas. Researchers found that, overall, 7% of children living in households with annual incomes of less than \$50,000 miss or do not schedule a medical appointment because transportation is inaccessible. In rural areas, 10% of children in similar households face this difficulty. The study attributes this to longer travel distances and a lack of available public transportation; only 25% of rural residents report its availability. The study also found that families in rural areas have more difficulty finding pediatric care providers, which correlates with increased use of emergency departments for routine care.⁶

Finally, HOP’s “*Outreach Across Populations: 2013 National Needs Assessment of Health Outreach Programs*” identifies transportation as the second most prevalent barrier to accessing health care services among underserved populations served by health outreach programs at Community Health Centers (CHCs). Respondents indicated that the top four barriers preventing access to transportation services are: (1) living in a rural area; (2) cost; (3) limited or a lack of transportation options; and, (4) the inability to obtain a driver’s license. Respondents noted that their respective organizations most commonly address transportation barriers by offering van services, mobile health units, and transportation vouchers. Respondents also reported commonly

partnering with other non-profit and CBOs, county or city agencies, and Head Start programs to offer transportation services. However, many factors continue to prevent organizations from offering or increasing transportation services. The costs associated with transportation services, lack or shortage of funding options, liability concerns, staff shortages, and high insurance rates all prevent CHCs from offering or expanding existing transportation services.⁷

Reduction of Access to Public Transportation:

Access to public transportation declined in recent years due to the 2007-2009 economic recession. In 2011, public transportation agencies saw flat or decreased local, regional, and state funding, according to the American Public Transportation Association (APTA). In a survey of 117 transit agencies, the APTA found that half of the transit agencies (51%) cut services or raised fares. Nearly eight in ten transit agencies (79%) cut services, raised fares, or were considering either of those actions.⁸

Increased Costs of Transportation: As access to and funding for public transportation declined, transportation expenses continued to account for a large and growing portion of U.S. household budgets. The U.S. Department of Labor, Bureau of Labor Statistics (BLS) reported that in 2011, all major components of household spending increased, but transportation rose 8%, the largest

percentage increase among all major components of household spending. The average annual transportation expenditure by consumer unit in 2011 was \$8,293. The BLS found that for those in the lowest quintile of income (below \$18,439), transportation consumes 14.8% of household income and 16% for the second lowest quintile (\$18,439–\$35,208).⁹

Access to Transportation Correlates with Improved Health Outcomes:

The idea that poor access to transportation decreases use of preventive and primary health care and increases use of the emergency department is commonly accepted. However, there is little research or data to demonstrate this impact beyond anecdotal accounts. One 2009 study does demonstrate that the provision of and access to reliable transportation increases the likelihood of primary care physician visits for children, HIV-positive adults, and frequent emergency room users. Researchers also found a correlation between transportation and expenditures for certain health services when examining how transportation brokerage service affects patients' access to care, expenditures, and health service use. For instance, even though NEMT costs increased for children with asthma, these costs were accompanied by both an increased use of health services and a decreased total monthly expenditure for health services, thereby offsetting transportation costs.¹⁰

KEY TRANSPORTATION DEFINITIONS

Non-Emergency Medical Transportation (NEMT) is transportation provided to Medicaid or Medicare beneficiaries. The 1966 Handbook of Public Assistance Administration (Supplement D) defines transportation as follows:

“Transportation, including expenses for transportation and other related travel expenses necessary to securing medical examinations and/or treatment when determined by the agency to be necessary to the individual case. ‘Travel expenses’ are defined to include the cost of transportation for the individual by ambulance, taxicab, common carrier or other appropriate means; the cost of outside meals and lodging en route to, while receiving medical care, and returning from a medical resource; and the cost of an attendant to accompany [them], if medically or otherwise necessary.”

Patient-Centered Transportation: This report uses the term “patient-centered transportation” to describe transportation services provided by non-governmental organizations, outside of Medicaid and Medicare programs. Examples of patient-centered transportation may include taxicabs, public transit, other shared-ride services, or airplanes.

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) AND MEDICAID EXPANSION

The full implementation of the Patient Protection and Affordable Care Act (ACA) introduces an opportunity to highlight the role that transportation plays in increasing access to health care services. The ACA included a provision for states to expand Medicaid to all individuals with incomes under 133% of the federal poverty level (FPL) (138% after an income deduction). However, the U.S. Supreme Court found that provision to be unconstitutional. As a result, states may choose whether to expand their Medicaid programs without losing federal matching funds for their existing programs.

HOP's case study communities are located across the U.S. in states with varied responses to implementing health reform. As of March 2014, 27 states including DC had expanded Medicaid (including case study states of Arizona, California, Hawaii, New York, and Massachusetts), 19 had not expanded Medicaid (including Oklahoma), and 5 were still analyzing the option. The extent to which each state implements health reform will impact how many individuals will have access to Medicaid benefits, including NEMT.

TRANSPORTATION MODELS THAT WORK PROJECT

CHCs and CBOs are often tasked with providing a wide range of enabling services, including transportation. However, this task can prove difficult. Many organizations are ill-equipped to address the vast array of challenges that providing transportation presents. For example, providing transportation often requires addressing liability issues, dealing with the high cost of gas and vehicles, securing adequate funding, ensuring such services are linguistically and culturally competent, and integrating transportation into health and social service programs.

It is impossible to come up with a one-size-fits-all solution to transportation. Communities vary widely in terms of demographics, physical environment, transportation infrastructure, and resources available. Nevertheless, there are important lessons to be learned from CHCs and CBOs already providing patient-centered transportation. These lessons can be used to help other organizations develop or expand their own transportation services. In 2011, HOP

launched its "Overcoming Obstacles to Health Care: Transportation Models that Work" project in order to identify successful transportation models, establish recommendations and strategies for how to impact relevant transportation state and federal policies, and provide guidance on improving health care access by addressing transportation barriers.

Methodology: In order to provide examples of transportation models with the potential to be replicated, HOP used the following criteria to identify and investigate six case study communities. Selected organizations:

- Have at least one patient-centered transportation service that increases access to health care services;
- Vary in size, scope, and focus in terms of the transportation model used;
- Are diverse in organizational size; location; demographic served; and urban, suburban, or rural context;
- Are able to demonstrate the impact of transportation services on users; and,
- Are able to demonstrate plans for sustainability.

Between October 2012 and February 2013, two HOP staff visited each case study organization for three days. Prior to the site visit, HOP conducted a desk review of relevant organizational materials and worked with the site visit coordinator to identify potential interviewees. The goal of the site visits was to learn more about each organization's approach to overcoming transportation barriers to accessing health care services. HOP collected data through key informant interviews and focus groups with over 100 total individuals across sites. All participants had a vested interest in the transportation services provided and included key personnel; volunteers; transportation users; and community, corporate, and government partners. Upon completion of the site visits, HOP coded and analyzed the qualitative data and compiled a 20 page case study report for each organization about their respective transportation program.

Since impacting transportation and health care policy is a primary objective of the project, HOP subcontracted with Simon & Company to analyze current laws affecting transportation and health access and develop state and federal policy strategies based on case study findings. In addition, HOP established a seven-person Policy Advisory Council (PAC) representing policy advocates and CBOs to guide the project. The PAC assisted by providing feedback on policy recommendations and members were invited to increase case study visibility by sharing project information with their respective constituencies. The analyses completed by Simon & Company were used to further drive discussions between HOP and the PAC, ultimately resulting in an advocacy agenda that specifically addresses transportation as a health care barrier.

HELPING OUR WOMEN

Case Study Organization

The Outer Cape Cod area in Massachusetts consists of a series of four small towns located in a remote, rural, and medically underserved area. Coordinating transportation to and from necessary medical care is burdensome for many residents. The most remote town, Provincetown, is 50 miles from the closest hospital. Many people living with life-threatening and chronic medical conditions must travel even further to Boston to receive specialized treatment. Helping Our Women (HOW), a nonprofit organization, offers free transportation services for women diagnosed with serious conditions in order to enable them access to health care services and enhance their wellbeing through the duration of their illness.

“Without the transportation program, I wouldn’t be alive today.”

- Helping Our Women Client

HOW offers the following transportation services to their clients:

- 1. Volunteer-driver program:** Approximately 20 volunteer drivers transport clients to and from local medical appointments on Cape Cod. The volunteer base is largely comprised of retirees or young seniors. All volunteers sign a liability release and confidentiality forms and agree to use their own vehicles for client transport. HOW carries a liability policy that covers staff, board, and volunteers. Ongoing volunteer training is informal and provided on an as needed basis.
- 2. Collaboration with the Cape Cod Regional Transit Authority (CCRTA):** For specialized medical treatment in Boston, HOW will arrange and pay for clients to take the Boston Hospital Transportation (BHT) operated by CCRTA.
- 3. Collaboration with Cape Air:** If the client is not physically capable of enduring the day-long trip to Boston via the BHT, then HOW will elect

to use an airline ticket provided courtesy of Cape Air. Since 1995, Cape Air has donated over \$225,000 in tickets to HOW.

Over 50% of HOW’s clients are elderly women, often living with multiple illnesses and limited financial resources. Many of the women are struggling to pay for regular household expenses such as heat, food, and other daily needs. Arranging and paying for transportation to medical appointments can be difficult and sometimes impossible. Without transportation services provided by HOW, these women are more likely to miss appointments or fail to comply with their medical treatment.

ABOUT HELPING OUR WOMEN



Location: Provincetown, MA

Geographic Context: Rural

Population Served: Women living with chronic/ life-threatening and/or disabling illnesses

Website: www.helpingourwomen.org

In 2012, HOW carried an average caseload of 200 clients. HOW primarily relies on two full-time employees, including the Executive Director and the Office Administrator/Client Advocate, to manage the caseload. In addition to the two full-time staff members, one licensed mental health professional is contracted to facilitate the weekly support groups and a part-time driver is available for client transport as needed.

HOW is funded by a combination of foundation grants, fundraiser proceeds, private donations, and Human Services Grants through annual Request for Proposals (RFPs) issued by four towns within HOW's service area. HOW does not receive state or federal grant funding. The transportation program receives a portion of their funding from Cape Cod Healthcare, the parent organization to Cape Cod Hospital and Falmouth Hospital, which

covers \$7000 for direct costs and five hours a week of staff time.

This transportation model has been successful for more than 15 years because it is flexible and allows clients to make informed decisions about where and when to receive medical care without having to worry about how they will get to appointments. HOW's services are well-known by local primary care providers. Referrals for services often come from these local providers and the local Visiting Nurse Association. The success of the transportation model is also based on collaboration with all of the client's providers, including specialists, to ensure that appointments for check-ups, diagnostics, and treatments are attended. Finally, HOW enjoys strong partnerships with other community agencies and local businesses.

SENIORS FIRST

Case Study Organization



Many senior residents of Placer County, California, have reduced transportation options due to financial or physical limitations. "Getting transportation for errands or medical appointments" ranked as the top need identified by seniors in the area. Transportation increases independence, provides connection with the community, ensures access to life-sustaining activities, and provides adults with access to resources in their communities.

In order to respond to challenges faced by seniors and their need for transportation, Seniors First, a non-profit organization located in Auburn, California, developed a transportation model that consists primarily of three programs:

- 1. Door to Door Rides:** a volunteer-driver program which provides seniors with rides to medical and dental appointments, labs, pharmacies, grocery stores, shopping centers, banks, salons, and other locations to help complete small errands. Volunteer drivers provide over 600 trips per month and 7,200 trips per year.
- 2. Health Express:** a professional transportation service that brings seniors and people with

"If I'm too sick to take the bus then I have to ask friends for help. I don't do it often. I hate that. It's my pride. A big part of aging is not wanting to give up that independence."

- Seniors First Client

disabilities to and from non-emergency medical appointments. Seniors First collaborates with the Placer Collaborative Network, which includes Kaiser Permanente Medical Center, Sutter Auburn Faith Hospital, Sutter Roseville Medical Center, and Western Placer Consolidated Transportation Services Agency (WPCTSA) to operate Health Express. The service provides 48 one-way trips per day and a total of 12,672 trips per year.

3. **My Rides:** a volunteer-driver program that serves small children (0-5 years old), seniors, and disabled individuals living in more rural areas of the county. My Rides also includes the Rural Mileage Reimbursement Program and the First 5 Rural Mileage Reimbursement Program, which allow eligible residents to enlist a neighbor or friend to provide transportation to nonemergency medical appointments where volunteers drivers may not be available.

There are three full-time staff dedicated to all three programs, including a Transportation Coordinator who provides direction and oversight and two Transportation Schedulers. In addition to coordinating transportation for eligible clients and volunteers, these staff collect and input client and volunteer tracking data and give information to callers on all available transportation options in Placer County, including those offered by Seniors First.

Seniors First has a variety of funders and supporters that sustain their transportation program, including:

- The Door to Door Rides and My Rides programs are funded through the WPCTSA (\$92,500), the Area 4 Agency on Aging (A4AA) (\$55,000), and Placer First 5 (\$13,000). Voluntary client contributions make up around \$11,200 of the

program's budget.

- Health Express is funded primarily through the PCTPA (\$375,000), Sutter Hospital (\$100,000), and Kaiser Permanente (\$25,000). Voluntary client contributions make up about \$8,000-\$10,000 of the program's annual budget.

The goal of the transportation program is to help the seniors in Placer County be as active and independent as possible. Unlike many other Medicaid NEMT programs, Seniors First offers person-centered services through a community-based, non-profit organization. Senior First is improving their clients' lives by providing them with affordable, reliable, and flexible transportation in order to access health care services and complete other daily activities.

ABOUT SENIORS FIRST



Location: Placer County, CA

Geographic Context: Suburban/Rural

Population Served: Seniors, the disabled and other clients as a ride of last resort

Website: <http://seniorsfirst.org/>

FINGER LAKES COMMUNITY HEALTH

Case Study Organization

The western central part of New York is a rural area with rich expanses of farmland and few large population centers. This area is the location of the Finger Lakes, which offer scenic beauty, support the destination tourism industry, and contribute to a climate ideal for growing crops like grapes, apples, and cabbage. The local agricultural economy employs many migrant and seasonal farmworkers who live in largely isolated areas with few transportation options. This geographic isolation and lack of reliable transportation limits the opportunities to receive health care services. Even when a vehicle is available or public transportation can be used, traveling to medical appointments can be expensive and time consuming. Many vulnerable, underserved populations like migrant and seasonal farmworkers do not seek care for illness because of these challenges.



Finger Lakes Community Health, a Federally Qualified Health Center serving thousands of community members and farmworker patients, developed several modalities to overcome transportation as a barrier to health care for its migrant and seasonal farmworker patients as well as for other underserved community members. These modalities include:

- 1. Basic transport:** FLCH provides basic transport as needed to farmworker patients as part of its overall case management services. Patients pay a transportation co-pay of \$5.00 round-trip, regardless of the distance traveled. During the winter months, both transporters and case managers provide transportation for two to three patients per day on average; in

the summer, the number may rise to eight or nine each day.

- 2. Mobile in-camp services:** FLCH provides mobile in-camp services including screening services, health education and referrals, and arranging for clinic appointments and transportation as needed. The teams generally try to see 20 people in one day. In 2011, across the organization, a total of 3,995 migrant and seasonal farmworkers received 7,261 encounters through in-camp services.

- 3. School-based dental services:** FLCH offers comprehensive dental services to farmworkers at Migrant Head Start sites, Migrant Education summer school sites and at community Head Start sites. This program allows children to receive comprehensive dental care with permission from their parents. These school-based services eliminate the need for parents to miss work to transport their children to appointments.

- 4. Telehealth:** FLCH's telehealth program increases access to care for patients located in rural communities by connecting them to primary care providers, specialty providers,

“Transportation is one of the largest problems. The challenge is how to mobilize people so they can do it on their own, but also feel safe.”

-Finger Lakes Patient Navigator

and counselors via teleconferencing equipment, thereby reducing the need for travel.

FLCH recognizes that regardless of where the providers are located, without transportation assistance many migrant and seasonal farmworkers would not be able to access provider appointments. FLCH uses bilingual, bicultural staff members that serve as case managers to transport migrant and seasonal farmworkers to primary care visits, specialty care visits, and local pharmacies. Mobile in-camp services are provided in over 31 counties by a team consisting of a medical provider and a community health worker. Case managers coordinate these visits with both patients and farm owners and assist the providers on-site, including serving as interpreters. A team consisting of a dentist, dental hygienist, and dental assistant provides oral health services to children at Migrant and Seasonal Head Start sites, Migrant Education summer school sites, and community Head Start sites. Finally, a clinical telehealth coordinator reports directly to the CEO. Staff coordinating telehealth appointments use block scheduling and a provider is typically in the room with the patient.

In 2012, FLCH paid out approximately \$72,000 for mileage to case managers, approximately \$11,700 for mileage to providers for in-camp services, \$24,700 in gas for company vehicles,

and \$8,500 for liability insurance. This financial support is funded largely through state and federal grants and patient co-pays. Equipment for the telehealth program was purchased through a grant from the United States Department of Agriculture under a program for rural health providers. FLCH sets up contracts with each provider that does telehealth consultations and has recently started billing insurance for telehealth visits.

FLCH offers a variety of solutions to transportation barriers experienced by their patients. FLCH facilitates farmworker patients' access to services through transporters and case managers, brings the health care services to the farmworker patients via in-camp services, and offers telehealth to bridge the distance gap to all patients. FLCH is successful in part because of the trusting relationships they build with patients and partners. Leadership has an expansive view of partnerships, shares resources, and is open to new ideas. FLCH has developed a strong team including internal advocates to help make changes and implement new strategies and programs. This multi-faceted approach to addressing the transportation barrier has increased health care access for thousands of people.

ABOUT FINGER LAKES COMMUNITY HEALTH



Location: Penn Yan, New York

Geographic Context: Rural

Population Served: General Community and Migrant and Seasonal Farmworkers

Website: <http://flchealth.org/>

MORTON COMPREHENSIVE HEALTH SERVICES

Case Study Organization



The city of Tulsa, located in northeast Oklahoma, is home to over 390,000 people including a sizeable population of people experiencing homelessness and a growing senior population. While Tulsa has a thriving health care industry and a number of health services available to underserved communities, accessing these services can be challenging. Tulsa is spread out over 196 square miles with many areas of the city being car-dependent. Those without a personal vehicle must rely on walking, biking, cab services, public transportation services, or other transportation programs offered by safety net providers.

Morton Comprehensive Health Services (Morton), a Federally Qualified Health Center with Health Care for the Homeless designation serving thousands of Tulsans annually, has provided transportation

“Morton provides transportation to people and, without that, people wouldn’t get served.”

-Jack Henderson, Tulsa City Councilor

services since 1987 to help address this pressing need. Today, with a fleet of four 18-passenger buses and four 14-passenger buses (13 vehicles in total, ten of which are wheelchair accessible), Morton’s free transportation services consist of three primary programs:

- 1. Curb-to-curb Program:** The curb-to-curb program provides home pickups for patients with appointments at Morton. The program began in 1987 and today operates Monday through Friday from 8:30am to 5:00pm, with extended hours on Tuesdays until 7:00pm. This on-demand service requires 24-hour advance notice for pickups (same day transportation can be made upon special request of the medical provider). All Morton patients are eligible for the curb-to-curb service. The

program provides an average of 25 medical trips per day.

2. **Fixed social service route:** The fixed route service is essentially a free shuttle provided by Morton Transportation Service geared towards people experiencing homelessness and other underserved populations in need of social services. The service has two separate designated routes (A and B), each with Morton as the central hub. Each route makes stops at selected social service agencies according to a carefully designed route guide. The fixed route service began in 2007 and currently operates Monday through Friday from 7:30am to 3:30pm.
3. **Contracted transportation services:** Morton leverages its fleet of vehicles to provide contracted transportation for a handful of partner agencies. Specifically, Morton provides regular and as-needed transportation for local schools and universities, senior services programs, domestic violence shelters, workforce development, behavioral health programs, and others as requested.

The Morton Transportation System currently has nine staff including one part-time and three full-time health care drivers for the curb-to-curb service, two full-time drivers for the social service route, a dispatcher, a transportation coordinator, and a transportation manager. Morton's Social Services Coordinator provides additional assistance in route planning and communications with external agencies, and the organization's Chief Financial Officer, Larry Tease, provides oversight for the program.

Morton's transportation program has received funding for operations and capital expenses from various sources. Currently, administrative staff estimate that 60% of overall funding for the transportation program comes from one major federal funding source, with the remaining 40% generated through episodic private foundation grants, local funding, revenue from contracted transportation service delivery, or supplemented by Morton itself. Morton also has a variety of funders and supporters that sustain various parts their transportation program, including:

- **Curb-to-Curb Program:** For the last 26 years, the curb-to-curb service has also been funded in part by the City of Tulsa, which administers

the distribution of Community Development Block Grants (CDBG) for the U.S. Department of Housing and Urban Development (HUD).

- **Fixed-route service:** In June 2007, the Henry Zarrow Foundation provided \$370,000 in seed funding over two years to the fixed route program as part of a larger transportation study. Yet, since its inception, the fixed route service has received the majority of its funding (today around \$226,000 per year) from the Indian Nations Council of Governments (INCOG), a Tulsa-based transportation and regional planning agency that administers JARC (Job Access and Reverse Commute) and New Freedom program funds for the U.S. Department of Transportation, Federal Transit Administration.

Since its inception, the transportation program has evolved into the second largest transportation system for health care in the region. It is estimated that up to 75% of Morton's patients use the transportation services offered, and as many as 1/8 of Tulsa's residents benefit from the program. Over the years, Morton has developed a solid and intricate transportation system to help their patients and community members have better access to a variety of health and social services. The transportation provided has effectively eliminated the transportation barrier for Morton's patients, thereby increasing health access while simultaneously addressing a variety of other social and economic needs.

ABOUT MORTON COMPREHENSIVE HEALTH SERVICES



Location: Tulsa, OK

Geographic Context: Urban

Population Served: General Community, Homeless, and Seniors

Website: <http://www.mortonhealth.org/>

EL RIO COMMUNITY HEALTH CENTER

Case Study Organization



Tucson, Arizona is a heavily car-reliant city, with a large number of seniors and retirees, uninsured and low-income individuals and families, people experiencing homelessness, and a significant resettled refugee population. The city has a well-developed public transportation system, and a host of nonprofits that offer transportation services specifically geared toward seniors. However, for people experiencing homelessness and other low-income patients that cannot utilize public or private transportation services, the lack of appropriate transportation options severely impacts their access to health care.

“Healthwise I think it’s done me good. I’ve been able to come when I need to. It’s kept me out of the hospital.”

—El Rio Patient

El Rio Community Health Center (El Rio) has developed a robust transportation program that focuses on connecting patients to the transportation service for which they are eligible that best serves their needs. They connect patients to public transportation, paratransit options, and taxi vouchers when possible. For those unable to utilize these options, El Rio offers the following:

- 1. Door-to-door van service:** El Rio operates a free door-to-door van service for patients as well as a pharmacy delivery service. The program has one patient route, which picks

patients up at home or at a shelter and brings them to the clinics. The program also provides clinic-to-clinic transportation. In order to target transportation services as efficiently as possible, the program prioritizes patients with no other means of transportation and with no access to free or subsidized transportation through other programs. Transportation services are available from 8:00 a.m. to 5:00 p.m., Monday through Friday. The transportation program's capacity is ten people per day, or 20 total round-trip rides.

2. **Van of Hope Mobile Unit:** El Rio, in partnership with Carondelet Health Network and the Southern Arizona Health Village for the Homeless, operates the "Van of Hope," a 38-foot modified recreational vehicle that has been equipped to provide a range of very basic to highly sophisticated health services. The van visits shelters, churches, meal programs, and other locations where homeless individuals or families may spend time. In addition to medical treatment, the Van of Hope provides health assessments, case management, community referrals, medications, and some specialty care. The van uses electronic medical records (NextGen) to ensure seamless transitions for patients and is equipped with telehealth equipment.

The door-to-door van service program has eight drivers: one driver is assigned to patient transport, two to pharmacy delivery, and the remaining five function as couriers between El Rio's clinic sites. All drivers receive training on strapping in wheelchairs and other safety measures. The Van of Hope is staffed by a nurse practitioner (NP), a medical assistant (MA), and a Care Coordinator.

El Rio purchases vehicles through the Federal Transit Authority Section 5310 program. They rely on 80% federal funding to match the 20% Arizona Department of Transportation (ADOT) funds to support capital assistance, the purchase of vehicles, related equipment, and operating costs statewide. The funding specifically supports

transportation for people who are elderly or disabled. The Van of Hope was initially developed through a \$2 million donation from a private donor. The donation provided critical seed money and operating support, but another key feature of the funding structure for this collaborative is that it strategically leverages each of its partners' resources, including other grant money or staff time.

Transportation has been a priority for El Rio for over 20 years. El Rio's door-to-door services provide a mechanism for low-income patients to get to appointments and also receive medications through their pharmacy delivery program for patients who otherwise may be unable to fill a prescription. The Van of Hope reduces barriers to accessing primary care services by bringing services directly to patients in order to catch and treat conditions before they worsen. The goal for both programs is to reduce hospital stays, reduce emergency department use, and see an improvement in the quality of life for low-income patients and those experiencing homelessness.

ABOUT EL RIO COMMUNITY HEALTH CENTER



Location: Tucson, Arizona

Geographic Context: Urban/Suburban

Population Served: Some Low-Income and/or Uninsured Clinic Patients and People Experiencing Homelessness

Website: <http://www.elrio.org/>

KŌKUA KALIHI VALLEY COMPREHENSIVE FAMILY SERVICES

Case Study Organization

Kalihi Valley, a region close to Honolulu on the island of O’ahu, has historically been poorly served by public transit, in part because of the geography. The narrow streets are difficult for most vehicles and public buses to navigate. Many people do not have access to vehicles, either because of the costs associated, because they share one vehicle between many family members, because of lack of insurance or public benefits due to their immigration status, or because they are unable to afford public transportation. Cultural and linguistic barriers also prevent individuals from accessing transportation and health care services.

Kōkua Kalihi Valley Comprehensive Family Services (KKV), a community health center and with designation as a 330(i) grantee to serve local public housing residents, offers transportation services to connect local patients to health care services. These transportation services include:

- 1. Shuttle services:** KKV has a fleet of vans that transport clients to and from medical appointments and to and from sanctioned program activities connected with wellness, exercise, and access to basic health screenings. KKV’s shuttle service runs year-round with regular runs provided throughout the day between the health center, satellite offices including the Elder Care Center, and public housing developments. The shuttle is offered during regular operating hours Monday through Saturday with pickups and drop offs at each of the four nearby public housing communities. For elders, the pick-up and drop-off points are at personal residences and/or easily accessible bus stops throughout Kalihi Valley. Transportation is provided free of charge for residents of public housing sites accessing medical appointments at KKV and clients of the Elderly Service Program.
- 2. On-demand transportation:** KKV also offers on-demand van transportation for clients to and from specialist services as well

as medical referrals from KKV providers to three Honolulu hospitals.

KKV has a fleet of eight vehicles including two 14-passenger buses, two 14-passenger vans, two 7-passenger vans, and two 2-passenger trucks. Each vehicle has a different priority for usage and services different KKV programs. While transportation services are available for medical appointments to all KKV clients, the majority of the transportation users are either accessing elder services or residents of public housing. In

“More people would want to come [to the elderly exercise program] if there was more transportation... to enjoy life, before it’s too late.”

-KKV Client

2011 KKV's drivers served 993 elderly clients, 80% of whom were disabled and 96% of whom were classified as Asian and Pacific Islanders.

KKV Transportation Services Department receives oversight from the KKV Administration/Operations Department, specifically the Chief Operations Officer. The services are coordinated by the Communication Liaison and executed by three drivers. All staff members perform their duties and responsibilities according to the guidance and parameters set forth by KKV's Transportation Policies and Procedures. The policies and procedures cover topics including safety, priority usage, van requests, transportation log completion, and care and maintenance of the vehicles.

KKV is a Federally Qualified Health Center that receives grant support from the federal Public Housing Primary Care Program. KKV's income and revenue, including federal and state grants, support the expenses associated with maintaining driver salaries, gas, vehicle insurance, and other indirect costs. For example, the majority of the shuttle services available to residents of public housing is funded by a Public Housing Primary Care grant that KKV receives every year from Human Resources Services Administration (HRSA), while the remainder of the program is funded through the state or KKV general operating funds.

From its inception as an organization, KKV has understood the important role that transportation plays in increasing access to health care services. Beyond that role, they also have an important grasp of the connection between keeping people healthy, minimizing barriers, and maximizing prevention to contain health care costs. Without the transportation service offered by KKV, it would

be very difficult for the vast majority of clients to make it to their medical appointments and to attend KKV's exercise programs on a regular basis--leaving them feeling disempowered and isolated rather than connected.

ABOUT KŌKUA VALLEY COMPREHENSIVE FAMILY SERVICES



Location: Kalihi Valley, HI

Geographic Context: Urban

Population Served: Kalihi Valley residents living at or below 200% of poverty, including Seniors, Immigrants, and Residents of Public Housing

Website: <http://www.kkv.net/>

KEY FINDINGS, RECOMMENDATIONS, & POLICY STRATEGIES

Many of the case study organizations involved in the project significantly strengthened and grew their transportation services over the years based on experience, changing needs, and lessons learned. Throughout HOP's work with these organizations, common themes emerged regarding how to build and maintain successful transportation models. HOP identified six key findings based on themes that emerged across sites. In conjunction with Simon & Company, a Washington D.C. based health care policy contractor, HOP used the key findings and relevant literature, policies, and guidelines to develop five community-level recommendations and four state and federal health and transportation policy strategies to help support effective transportation models.

KEY FINDINGS

HOP identified six key findings that enable the overall success of the transportation models involved in this project, including:

■ DIVERSE STRATEGIES

All of the case study sites use more than one strategy to overcome the transportation barriers facing their respective communities. Multiple strategies are used together to effectively increase access to health care and other social services. For example, several organizations have both curbside services and fixed-route services, each serving a different need. Other sites offer mobile health services provided in conjunction with other transportation assistance, such as individual transport via paid staff or volunteers and transportation vouchers for a local public transportation option or taxicab service.

■ CUSTOMIZED APPROACHES

Strategies that work well in one location and for one population may not work well elsewhere for a number of reasons. Organizations do not take a "one-size-fits-all approach" to providing patient-centered transportation services. From partnering with local airlines to using telehealth, a wide variety of approaches are selected based on the unique needs of the service population, geography, and gaps in available resources and transportation options. Each of the models addresses a well-documented, established transportation gap experienced by individuals in their respective communities.

■ ORGANIZATIONAL COMMITMENT

All of the case study sites have a strong organizational commitment to providing solutions to transportation barriers. Across the board, the case study sites are willing to make a substantial financial and personnel commitment to building, executing, and growing transportation services. It was repeatedly noted that providing transportation is expensive, time-consuming, and complicated; however, it is considered necessary at an organizational level and, therefore, a priority. Building internal support, including with upper management or the Board of Directors, for any proposed new or expanded transportation service is critical to the long-term sustainability and success of any effort.

■ DEDICATED, COMPETENT STAFF

All of the case study sites provide transportation services to vulnerable, underserved populations. Building trust and offering services in a respectful, culturally competent manner is key to the success of the models. It is not enough to offer transportation services; the right staff members with a specific skillset are needed as well. Every case study site emphasized the importance of having staff and volunteers who are committed, competent, professional, and reliable. Often the relationship between the driver, the schedulers, and the riders is vital to ensuring access to quality services. This relationship has the added benefit of helping individuals feel cared for and comfortable with the organization overall.

■ DIVERSIFIED FUNDING STREAMS

Providing transportation services requires a significant investment in vehicles, personnel to coordinate or provide the service, liability insurance, and equipment maintenance. For many of the case study sites, a large portion of

transportation expenses are not reimbursable. Therefore, financial support comes from grants, foundations, donations, contracted service income, or general operating funds. All of the case study sites use some combination of the above to financially support their transportation programs. In many instances, the organizations are creative in pulling together funding and are continually looking for opportunities to solicit additional financial support. The process of obtaining adequate financial resources requires networking, organizing, maximizing relationships, and, in many cases, going outside of established funding sources and partnerships. For example, several of the case study sites secure funding for contracted services from hospitals to assist with transportation needs of patients. Other sites have extensive fundraising efforts, foundation support, and funding from a variety of federal agencies. All case study sites invest time, effort, and creativity when planning for financial sustainability.

■ EXPANSIVE PARTNERSHIPS

All case study sites have an extensive partner network that includes some combination of government agencies, health and social service providers, elected officials, transportation authorities, private transportation providers, volunteers, and educational institutions. Many of the sites organize transportation services in conjunction with other agencies to avoid duplication of services. In addition, several sites involve these agencies in the planning and execution of their own services in order to ensure a strong collaboration. All of the organizations are actively involved with a wide variety of key stakeholders regarding transportation. This expansive approach to partnerships was often cited as a key component of the success of the individual models.

RECOMMENDATIONS

For organizations that are interested in establishing or expanding existing transportation services, HOP recommends considering the following:

■ EVALUATION

Evaluating efforts and establishing health outcomes is a common element that proved elusive for many of the case study sites. It is important to note that the sites varied in level and type of evaluation practices. The case study sites elicit feedback through a variety of means including surveys, focus groups, and informal conversations with transportation users. All of the case study sites report that clients indicate the transportation services are essential and, in many cases, life-changing. However, understanding the true impact the services have on health outcomes, reduced hospitalizations, and quality of life is more difficult. In order to advance transportation as an important priority, more effort should be made to establish the health impact of transportation access.

■ FUNDING AND SUSTAINABILITY

Patient-centered transportation programs are expensive to initiate and sustain; oftentimes,

they involve sizeable purchases like vans or buses and require ongoing maintenance costs. The financial investment of offering transportation services includes staff salaries, vehicle maintenance, liability insurance, and fuel. At the same time, funding opportunities to support transportation services are limited. Most case study sites report that the lack of sustainable and dependable funding streams is a significant barrier to establishing new programs. Each funding source has limitations or funding is restricted to a specific population.

Because of funding restrictions and limitations, it is not advisable to rely on one source for the majority of a program's funding. Multiple funding sources can help financially sustain transportation services. The transportation programs developed by the case study sites are funded by a number of sources—federal, state, local and private—through grant programs, payment for services, or donations. Developing a diverse funding stream ensures organizations can maintain core operations when funding is reduced, redirected or delayed.

OPPORTUNITIES FOR FUNDING AND COLLABORATION

Leveraging Non-Profit Hospitals' Charity Care Requirements

Four of the HOP case study organizations receive financial support from non-profit hospitals or health systems serving the same geographic area. The case study organizations noted that hospitals understand that transportation influences health outcomes and result in cost savings. More than half (50.72%) of community hospitals nationwide are non-profit. In return for their tax-exempt status, non-profit hospitals are expected to provide benefits to their communities, including charity care and community benefits. And, at the federal level, the ACA requires non-profit hospitals to conduct a community health needs assessment every three years and adopt an implementation strategy to address the identified needs.

Given the recent Congressional interest in the amount of charity care and community benefits non-profit hospitals provide in exchange for their tax-exempt status, organizations seeking transportation solutions should request support from their local non-profit hospitals and health systems. Organizations seeking transportation solutions should participate in the hospitals' community health needs assessments and emphasize transportation as a barrier to care in the community.

■ COORDINATION

Throughout the interviewing process during HOP's case study site visits, there was a noticeable gap in understanding between individuals involved in public transportation planning and those involved in providing health care services. Depending on the level of program interactions, a lack of coordination may lead to duplicative services or unaddressed needs. In addition, transportation service providers often do not fully understand patients' needs, which may result in disconnected programs with little focus on patient access to health care. There are opportunities for better coordination of programs.

All case study organizations educate clients about public transportation options and eligibility for local, state, and federal programs. For example, patients are educated about NEMT programs offered through Medicaid and other city or county operated dial-a-ride programs. Still, several of the organizations anecdotally told HOP researchers that federal programs are too complicated for both the organizations and beneficiaries to use. Transportation services operated by case study organizations are often used to fill in gaps for vulnerable, underserved populations who need patient-centered transportation services outside those existing services and programs.

Organizations seeking to develop patient-centered transportation service programs should coordinate with other transportation programs, such as Veterans Affairs, senior centers, or job access centers in the community to identify gaps in service and to leverage programs. Moreover, organizations offering transportation service programs should participate in state and regional transportation coordinating councils or planning meetings to optimize available services.

■ LEADERSHIP

CHCs and CBOs should have senior staff members with transportation knowledge and

expertise or invite transportation leaders to serve on their governance boards. There are no requirements for CHCs to include transportation consumers or experts in their leadership, but the case study sites indicate that having committed and knowledgeable leaders is important to the success of their transportation models. Case study sites also noted that the following key factors contribute to transportation model success: "shared goals and commitment," "community support," "leadership," and "organizational priority/commitment." Adding such individuals to the governing boards may ensure transportation is central to discussions about enabling services and health care access and may provide leadership when focusing on organizational priorities.

To ensure transportation is included in discussions about enabling services and health care access at the governance level, CHCs and CBOs should be encouraged but not required to include on their governing board either (1) an individual that has a need for transportation services or a representative from stakeholder groups knowledgeable about transportation-disadvantaged populations, or (2) a representative of the community who supplies NEMT or patient-centered transportation services including public transit authorities, area agencies on aging, or religious organizations.

Leaders should also emphasize the organization's commitment to providing transportation to the executive staff and new employees and consider hiring staff committed to providing transportation. In addition, to assist with strategic planning and gap analysis, CHC and CBO leaders should solicit assistance from federal, state, and community experts on transportation services to better understand local transportation systems and policies.

■ FOCUS ON HEALTH CARE UTILIZATION

While an additional 20 million people are expected to obtain health insurance coverage as a result of the ACA, there is no guarantee

INCREASING HEALTH ACCESS AND UTILIZATION

Using Telehealth Technology to Overcome Transportation Barriers

In addition to providing direct transportation services, two of the HOP case study sites use telehealth to bring services to geographically isolated service areas. One case study site provides services to migrant and seasonal farmworkers and other community members in rural areas and the other case study site serves individuals experiencing homelessness in a more urban area. Telehealth is the use of technology to deliver health care services, information, or education at a distance. This technology uses real-time communication with real-time video and audio links or store-and-forward transmission of digital images. Telehealth is both cost-effective and clinically successful, and augments organizations' transportation programs by improving access to health care services.

In addition to hardware, software, and networks, establishing a telehealth program requires personnel training and education. However, there are a number of federal resources available to start a telehealth program. Unfortunately, not all telehealth costs are reimbursed. Medicare set the standard for reimbursement, but states have various rules by which their Medicaid programs will reimburse for telehealth expenses. In the private payer market, some insurance companies value the benefits of telehealth and will reimburse a wide variety of services. Others have yet to develop comprehensive reimbursement policies.

Although establishing a program may seem cost prohibitive, Medicare and a growing number of Medicaid programs reimburse for services provided through telehealth. Organizations seeking to improve access to their health care services should consider augmenting their transportation efforts with telehealth programs.

that these individuals will have adequate transportation to health care services. Transportation options are still needed for many low-income individuals who purchase insurance plans through the Health Insurance Marketplaces, for those living in states that do not expand Medicaid coverage and fall into the coverage gap, and for the remaining individuals ineligible for coverage due to factors such as immigration status.

Uninsured individuals with incomes 133-400% FPL are eligible for the Marketplaces and premium tax credits that vary by income level. The qualified health plans available through the Marketplaces are not required to offer transportation services. Therefore, many receiving insurance through the Marketplaces will still need transportation assistance in order

to access health care services. Additionally, there will still be as many as 6.4 million individuals that will remain uninsured.¹¹ Many of these individuals will continue to rely on safety net providers for assistance in accessing health care and patient-centered transportation services.

Organizations need to offer transportation programs using available resources in order to ensure that remaining uninsured populations and that low-income individuals receiving coverage through the Marketplaces will be able to access health care services. Strategies identified in the case study sites such as using volunteer drivers, working with hospitals networks, and implementing telehealth are potential options.

STATE AND FEDERAL POLICY STRATEGIES

Simon & Company and HOP established four state and federal policy-focused strategies. These policy strategies are intended to: (1) support the replication of case study models in other communities and (2) enhance the quality and efficiency of established state and federal transportation programs. Strategies include:

1 IMPROVE COORDINATION OF TRANSPORTATION SERVICE PROGRAMS AT THE FEDERAL LEVEL

The funding sources used by the case study organizations have different target populations and program requirements, and only a few of the case study organizations accessed federal programs to any large degree. In fact, several of the organizations anecdotally told HOP researchers that benefits like Medicaid NEMT are too complicated for both the organizations and beneficiaries. State and federal transportation program coordination remains a barrier preventing organizations from more efficiently using existing resources.

The Government Accountability Office (GAO) found that 80 federal programs are authorized to fund transportation services for the transportation disadvantaged.¹² The interagency Coordinating Council on Access and Mobility, which the Secretary of Transportation chairs, has led federal government wide transportation coordination efforts since 2003. The Moving Ahead for Progress in the 21st century (MAP-21) law authorizes funding for more effectively and efficiently providing public transportation service through coordination

requirements. Generally, however, federal transportation officials have little input into state and local funding or evaluation of programs.

Federal agencies are not empowered to regulate local transportation programs, but can make recommendations and offer guidance. The federal programs also have different funding mechanisms, planning requirements, and requirements for federal matching funds. Additionally, states often report that there are limited options for coordination as Medicaid NEMT has restrictive rules for authorizing transportation that do not permit sufficient coordination with other programs. Depending on the level of program interactions, a lack of coordination can lead to duplicative services or unaddressed needs. The GAO notes that people in need of transportation often benefit from greater and higher quality services when transportation providers coordinate their operations. In addition, coordination has the potential to reduce federal program costs.

FEDERAL LEVEL STRATEGIES

Organizations, stakeholders, members of Congress, and patient advocates should encourage federal agencies on the Coordinating Council on Access and Mobility to:

- Issue a strategic plan, policies, and grantee guidance for coordinating transportation services;
- Reinvigorate the Council and suggest that it play a role in analyzing a foregone cost model of transportation, such as impact on access and health outcomes without transportation services.

2 PROTECT MEDICAID NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) BENEFITS

Health plans include NEMT benefits for the Medicaid expansion population in states expanding their Medicaid program to all individuals with incomes under 138% of FPL. Medicaid's NEMT has been a basic feature of Medicaid since the program's inception and the assurance of transportation has been clarified and strengthened through guidance, administrative requirements, and judicial affirmation.

Currently, a few states are considering offering a "Premium Assistance" model in lieu of traditional Medicaid, meaning they would purchase qualified health plans through the Marketplace for those that are eligible for Medicaid expansion. As the Centers for Medicare and Medicaid Services (CMS) explains, under premium assistance arrangements, "beneficiaries remain Medicaid beneficiaries and continue to be entitled to all benefits and cost-sharing protections." This means that premium assistance arrangements are required to provide "wrap-around" plans including NEMT.

However, Iowa submitted a waiver request to CMS that specifically seeks to waive NEMT for the

expansion population. In December 2013, CMS agreed to "relieve the state from the responsibility to assure non-emergency transportation to and from providers" for the Medicaid expansion population. The waiver authority will end after one year unless further legislation is taken and the state will collect data to evaluate the impact. Several other states are examining the "Premium Assistance" model for Medicaid expansion and they may also seek to waive the NEMT assurance.

Healthcare reform is expected to provide health insurance coverage to an additional 20 million people through Marketplaces and Medicaid expansion. While the ACA increases health insurance coverage, access to the covered services will be key to the success of the ACA. To not provide transportation services in a premium assistance model is to immediately limit access to services for the vulnerable Medicaid expansion population, placing a greater burden on CHCs and CBOs to increase transportation services. If populations lose this benefit, it places more strain on the community and local level to create or expand programs to fill this gap.

FEDERAL AND STATE LEVEL STRATEGIES

- **CHCs and CBOs:** Ensure that current transportation options are protected and continue to explore alternatives for those without insurance, such as those described in the case studies.
- **Transportation advocates and stakeholders:** Submit comments, attend public hearings and speak to Congressional representatives to ensure that states seeking waivers to use premium assistance programs do not consider eliminating NEMT for the Medicaid expansion population.
- **Transportation advocates:** Monitor the state Medicaid NEMT program to ensure it meets federal requirements.
- **Congress:** Enact legislation to write the current NEMT requirement regulation into law to protect the benefit for current Medicaid beneficiaries.

3 ENACT A MEDICARE NEMT BENEFIT FOR PARTIAL DUAL ELIGIBLES

A distinct group of Medicare beneficiaries are called the “partial dual eligible,” meaning those who are also eligible for Medicaid-sponsored assistance with Medicare premiums and cost sharing but are not eligible for full Medicaid benefits. As partially dually eligible Medicare-Medicaid beneficiaries are not eligible for Medicaid NEMT benefits, there is a gap between Medicaid’s premium and cost sharing assistance and access to Medicare’s restorative and preventive care benefits. This incongruence makes transportation services for partial dual eligibles a prime opportunity for program alignment to advance seamless and cost-effective care by creating an NEMT benefit for partial dual eligibles.

The 2009 Consumer Expenditure Survey found that the average person age 65 and older spends \$5,409 on transportation costs, including vehicle costs, gasoline, maintenance and repairs, and public transportation¹³. However, in order to qualify for the partial dual eligible program¹⁴, Medicare beneficiaries need to have incomes between 100% (\$10,890 for a single) to 135% (\$14,701.50) of FPL. Additionally, the ACA provides all nonelderly persons below 138% FPL with full Medicaid benefits including NEMT but not the partial duals whose incomes are 75-135% of

FPL. Clearly, partial duals beneficiaries will have difficulties with \$5,000 in annual transportation costs, as this equals one-half to one-third of their incomes.

Four of the case study sites served a significant number of seniors through transportation services. For instance, one case study organization provides services to county residents 60 years of age or older, but specifically aims to target older adults who are transportation-disadvantaged, medically needy, ethnic minorities, low-income, living in rural areas, non-English speaking, or living alone. Another has developed a program that provides a variety of services including transportation with pickups or drop-offs at personal residences or easily accessible bus stops. As the overall senior portion of U.S. population continues to increase, transportation services will be increasingly in demand. Eliminating this transportation gap experienced by Medicaid partial dual eligibles will help enable more access to health care services, and reduce the burden on CHCs and CBOs offering services to seniors. CHCs and CBOs will financially benefit from this, as Medicare would reimburse transportation for these seniors and disabled individuals.

FEDERAL LEVEL STRATEGIES

- **Congress:** Create a new Medicare NEMT benefit for partial dual eligibles. To restrain spending and rationalize the rides in the Medicare Administrative Contractor service areas, this benefit should be managed and paid on an at-risk basis.
- **CHCs and CBOs:** Educate legislators about the transportation gap experienced by Medicaid partial duals that do not receive Medicaid NEMT benefits and suggest a Medicare benefit for this population.

4 ENCOURAGE VOLUNTEER DRIVERS BY IMPROVING LIABILITY LAWS AND REIMBURSEMENT RATES

Volunteer drivers can reduce patient-centered transportation programs costs, but there are also barriers to using volunteers. Two of the HOP nonprofit case study organizations use volunteers to provide local transportation. Both organizations identified liability insurance, immunity, and mileage reimbursement as issues impacting their ability to use volunteer drivers.

Liability and Insurance Coverage: Some insurers offer volunteer auto liability coverage, but much confusion and concern arises from differences in federal and state laws. The Federal Volunteer Protection Act offers volunteers some protections from liability, but not if the operation of a motor vehicle caused the damage. Although every state has a law pertaining to the legal liability of volunteer drivers, the statutes lack uniformity and consistency. The National Council of State Legislatures (NCSL) conducted a survey¹⁵ to examine state laws and practices related to volunteer driver liability and insurance laws. NCSL analysis found that immunity protections are not uniform. In many examples, volunteer protections vary within states depending on whether the volunteers' services are engaged by a government agency, nonprofit organization, religious charity, or for-profit company." In fact,

NCSL found 26 states expressly exclude acts committed in motor vehicles from volunteer immunity protections.

Allowable Reimbursement for Volunteer Mileage: The Internal Revenue Service (IRS) has the authority to regulate mileage rates for business, medical, and moving purposes, but not for charitable activities. The charitable rate can only be adjusted by Congress and has remained unchanged since 1997 at 14 cents per mile driven. However, some organizations reimburse volunteers more than 14 cents per mile, which volunteers must report as taxable income.

Federal legislation has been introduced to encourage more volunteers to provide transportation. If allowable reimbursement for charity transportation was increased or reimbursement from nonprofit organizations was exempt from volunteers' taxable income, more individuals might consider volunteering to provide transportation. However, most legislation has either died in committee (for example, The Giving Incentives to Volunteers Everywhere Act and The Recruiting Individuals to Drive Our Elders of 2012) or is still pending action (for example, The Charitable Driving Tax Act of 2013).

STATE AND FEDERAL STRATEGIES

- **CHCs and CBOs:** Speak with state officials and encourage them to enact laws requiring insurance companies to offer policies covering volunteer driver activities in states without such laws.
- **CHCs and CBOs:** Speak to local lawmakers about the state's liability laws and how they help or impede the organization's efforts to use volunteers to provide transportation.
- **CHCs and CBOs:** Contact members of Congress to encourage them to enact legislation to either update the reimbursement rate for charitable activities or allow volunteers to exempt any reimbursements they have received for driving a passenger vehicle as part of their volunteer work from their taxable income.

“Transportation is one of the largest problems. The challenge is how to mobilize people so they can do it on their own, but also feel safe.”

-Finger Lakes Community Health Patient Navigator



CONCLUSION

It is impossible to come up with a one-size-fits-all solution to transportation, as communities vary widely in terms of underserved population demographics, physical environment, transportation infrastructure, and resources available. Nevertheless, there are important lessons to be learned from CHCs and CBOs already providing patient-centered transportation services. These lessons can help other organizations develop or expand their own transportation services. The six successful transportation models featured in this brief can offer much-needed support and guidance to other organizations and communities facing similar transportation challenges.

Now that the first open enrollment period into affordable health insurance has closed, many people will gain access to NEMT benefits through Medicaid expansion and many more will have access to insurance benefits for the first time. With more individuals receiving coverage, CHCs and CBOs need to focus not only on enrolling the remaining eligible uninsured but also on patient activation, education, and empowerment. The newly insured need to understand how to use health services, and CHCs and CBOs need to work to ensure that newly insured populations can access health care services. At the same time, there will still be a number of remaining uninsured people that will not have access to Medicaid NEMT benefits and will still experience transportation barriers. Enabling services like patient-centered transportation provided through CHCs and CBOs will be vital to ensuring health care access.

In the coming months and years, the national conversation around health care access will shift from enrollment into affordable health insurance to ensuring access and utilization of health care services. As this occurs, CHCs and CBOs should take the opportunity to learn from each other's successes and challenges providing patient-centered transportation. Advocacy to support, develop, and expand transportation solutions at the organizational and community level will be needed to help meet the unique needs of the individuals they serve. In addition, advocacy will be needed to further strengthen and protect available transportation benefits at the state and federal level.

Health Outreach Partners
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ENDNOTES

¹ Health Outreach Partners. "Outreach Across Populations: 2013 National Needs Assessment of Health Outreach Programs." Oakland, CA, 2013.

² APTA. "Impacts of the Recession on Public Transportation Agencies; 2011 Update: Survey Results." August 2011.

³ Wallace, R, Hughes-Cromwick, P, Mull, H, Khasnabis, S. "Access to Health Care and Nonemergency Medical Transportation Two Missing Links." 2005.

⁴ Fitzpatrick, A., Power, N., Cooper, L., Ives, D., & Robbins, J. "Barriers to Health Care Access Among Elderly and Who Perceives Them." American Journal of Public Health. 94(100). Page 1793.

⁵ Wallace, R, Hughes-Cromwick, P, Mull, H and Khasnabis, S. "Access to Health Care and Nonemergency Medical Transportation Two Missing Links." 2005.

⁶ Grant, Roy et al. "Transportation Shortages are Barriers to Child Health Access." Children's Health Fund. 2011.

⁷ Health Outreach Partners. "Outreach Across Populations: 2013 National Needs Assessment of Health Outreach Programs." Oakland, CA, 2013.

⁸ APTA. "Impacts of the Recession on Public Transportation Agencies; 2011 Update: Survey Results." August 2011.

⁹ BLS. "Consumer Expenditures—2011." Economic News Release. 9/25/2012. <http://www.bls.gov/news.release/cesan.nr0.htm>.

¹⁰ Kim, J, Norton, E, & Stearns, S. "Transportation Brokerage Services and Medicaid Beneficiaries: Access to Care." Health Services Research. 44:1. February 2009.

¹¹ Kaiser Family Foundation. "The Cost of Not Expanding Medicaid." July 17, 2013.

¹² GAO. Transportation-Disadvantaged Populations: Federal Coordination Efforts Could Be Further Strengthened. GAO-12-647, Jun 20, 2012.

¹³ U.S. Bureau of Labor Statistics, Consumer Expenditure Survey, October 2010, Table 3.

¹⁴ QMB -- income must be at or below 100% of the annual level; SLMB -- income must be between 100% and 120% of the annual federal poverty level [between FPL and (FPL x 1.2)]; QI-- incomes between 120% and 135% of the federal poverty level [between (FPL x 1.2) and (FPL x 1.35)].

¹⁵ "Volunteer Driver Liability and Immunity, A 50-state Survey." NCSL. December 2006.

ABOUT HEALTH OUTREACH PARTNERS

Since 1970, Health Outreach Partners (HOP) has been the leading organization for the promotion, delivery, and enhancement of health outreach and enabling services to underserved populations, including farmworkers and their families. The mission of Health Outreach Partners is to build strong, effective, and sustainable grassroots health models by partnering with local community-based organizations across the country in order to improve the quality of life of low-income, vulnerable, and underserved populations. HOP's vision is a country in which all people are valued and in which equal access to quality health care is available to everyone, thus enriching our collective well-being.

HOP focuses on six priority areas that aim to increase access to care, quality of health services, and organizational sustainability:

- Health Outreach and Enabling Services
- Program Planning and Development
- Needs Assessment and Evaluation Data
- Health Education and Promotion
- Community Collaboration and Coalition Building
- Cultural Competency

HOP provides consultation, training, and information services to enhance community-based organizations' outreach services delivery. Contact us to see how we can help build your program's capacity in serving low-income, vulnerable, and underserved populations. Learn more at our website: www.outreach-partners.org.



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