Transcript for RHIhub Webinar: Improving Access to Transportation in Rural Communities 2/12/18

Kristine Sande: Hello everyone, I'm Kristine Sande, and I'm the program director of the Rural Health Information Hub. I'd like to welcome you to today's webinar on improving access to transportation in rural communities. I'll quickly run through some housekeeping items before we begin.

We do hope to have time for your questions at the end of today's webinar. If you have questions for our presenters, we ask that you please submit those at the end of the webinar using the Q and A section that will appear on the lower right-hand corner of the screen following the presentation. We have provided a PDF copy of the presentations on the RHIhub website, and that's accessible through the URL on your screen. If you have any technical issues during today's webinar, please call WebX support at 866-229-3239.

It is my pleasure to introduce our speakers for today's webinar. First, we will hear from Tricia Stauffer. She is the Principal Research Analyst at the NORC Walsh Center for Rural Health Analysis. And she will introduce the rural transportation toolkit that was produced by the NORC Walsh Center in collaboration with the Rural Health Information Hub.

The second speaker today will be Katherine Freund. She is the founder and president of ITNAmerica, the first national non-profit transportation network for older people. She will present ITNCountry, a flexible low-cost transportation model that's ideal for small and rural communities. ITNCountry expands the resources available for transportation, and integrates social capital, especially volunteer efforts with public and private resources.

And finally, we will hear from Mary Gordon, the HealthTran program manager and Doris Boeckman, Principal Partner of Community Asset Builders LLC. They will present on HealthTran, a flexible system that can coordinate and schedule rides within minutes or a month in advance. HealthTran works with communities using existing transportation providers, creating new service options to improve access to care. HealthTran is moving funder-driven silos to people-driven solutions.

And with that, I will turn it over to Tricia.

Tricia Stauffer: Thank you Kristine, and thanks everybody for joining us today on the webinar. I'm happy to be introducing the rural transportation toolkit. The toolkit was developed as part of the Rural Health Outreach Tracking and Evaluation Program, which was funded by the Federal Office of Rural Health Policy within the Health Resources and Services Administration.

The project is conducted by the NORC Walsh Center for Rural Health Analysis, in partnership with the University of Minnesota Rural Health Research Center. NORC and the University of Minnesota are also working with the National Organization of State Offices of Rural Health, and National Rural Health Association to disseminate findings from the evaluation.

The Rural Health Outreach and Tracking Evaluation Program is designed to monitor and evaluate the effectiveness of programs funded under the outreach authority of section 330A of the public health service act. Outreach authority grantees seek to expand rural healthcare access, coordinate resources, and improve quality. Grantees work as part of a consortium with healthcare providers, schools, tribal health programs, and other community-based organizations.

A key focus of our work has been on establishing a rural evidence-base, which includes developing evidence-based toolkits, based on the experiences of grantees and other rural communities. Evidence-based toolkits are an important step in disseminating successful programs.

Our toolkits have three aims. The first, to identify evidence-based and promising programs, second to study the experiences of these programs, to figure out what's working in rural communities and why, and third to disseminate best practices from their experiences through evidence-based toolkits, so that future grantees in other rural communities can learn from their experiences and replicate them.

A key focus of our work this past year has been to identify evidence-based and promising practices for addressing transportation in rural communities. Access to transportation contributes to the economic development, health, and quality of life of rural communities. Reliable transportation is needed for rural residents to access healthcare services, employment and educational opportunities, and social services. It's also important for accessing recreation and other activities of daily life.

Rural communities have been using innovative and diverse programs to address transportation issues. These programs aim to improve access to transportation, to overcome transportation barriers, and improve transportation safety and infrastructure. Their experiences suggest promising practices that can be adapted in other rural communities. And we developed this toolkit to share these promising practices and resources.

Our activities included reviewing the literature and grantee applications to identify evidence-based and promising practices, conducting telephone interviews with nine rural programs and four experts in the field, and then developing a toolkit that includes these resources about how to implement transportation programs.

The toolkit is now live and available on the Rural Health Information Hub community health gateway website. You can find a link directly to the transportation toolkit at the bottom of your screen.

Next, I want to show you how to navigate through the toolkit. This is a snapshot of the main page of the toolkit. It's organized into the different modules, as you can see on the left-side of the screen. Each module focuses on different considerations for planning, implementing, evaluating, sustaining, and disseminating programs in rural communities. Each module includes various resources and information. There's also a program clearinghouse that contains information about promising rural programs.

Module two is our program model section, and that's what I'm gonna focus on today. It describes evidence-based and promising program models that are being implemented in rural communities. Next I'll kind of briefly go over each of the models, but you can find more detailed information in the toolkit itself.

The first set of models focus on how agencies and community organizations can improve access to transportation. First, introducing or expanding public transportation, like fixed-route bus systems, increases access and use of public transit. However fixed-route services don't always meet the needs of rural residents, so typically other models are used along with public transportation efforts.

The second model is volunteer models. And these play a really large and vital role in rural communities. The toolkit goes over three types of volunteer models. Volunteering without

reimbursement, trip and time banking where volunteers can bank the time they spend providing transportation, then use it at another time, and mileage reimbursement where drivers track their mileage, then receive reimbursement.

The voucher models, which are sometimes referred to as taxi-vouchers use tickets or coupons that eligible riders can offer to participate in transportation providers in exchange for a ride. This can consist of dial-a-ride services, taxi, and other on-demand services. Coordinated service models involve the coordination of individual service programs in a community to improve the efficiency of limited transit resources. Partnerships play a key role in this model.

Mobility on demand is a model that integrates and connects pre-existing modes of transportation. This typically involves a private company or a local agency working to match client needs with available resources. These services often use smart phone technology or payment apps.

Ridesharing can refer to several different types of services. One example is vehicle sharing, where one or more organizations operates the same vehicle during different periods of time. There's also carpooling or vanpooling where passenger trips are combined for passengers with a common destination. And lastly, there is real-time ridesharing, or ridehailing, which uses global positioning systems to calculate a driver's route and arrange a ride. And you might know these better as kind of the Lyft or Uber type services.

Connector services, also called theater services provide transportation to and from another transit system or another mode of transit. This kind of service typically accesses a particular destination, such as a health center, that might be located beyond a transit system service area.

Then lastly, there's mobility management. Mobility management programs help customers learn how to use and connect to transit in their community.

The next set of models are models for overcoming transportation barriers. For some populations, such as people with mobility issues or complex medical conditions or people living in frontier communities, it might not be feasible to provide safe, affordable and appropriate transportation to and from service providers. To meet these particular needs, agencies have implemented innovative models including mobile clinics, telehealth, school and workplace based health programs, and home visiting programs.

Mobile clinics are typically self-contained units that can deliver services to geographically isolated areas or to small towns that might not have a healthcare provider. While a full range of healthcare services can't typically be delivered in a mobile unit, services like immunizations, screenings, and oral health services can be offered.

Telehealth is a particularly valuable tool for areas where it might not be easy to travel. Using tools like video conferencing, services such as mental health treatment, consults with specialists, obstetric care and chronic disease management can be provided.

School and workplace based healthcare can help to reduce barriers to care, due to lack of transportation. There's an evidence-based for school-based health centers, and workplace-based clinics providing care to school children and employees respectively. These types of services are designed to make care more easily accessible for people who might not be able to take time off of work.

Lastly, home visiting programs are especially beneficial for connecting people who are high risk, such as seniors, pregnant or post-partum mothers, and families with infants or young children.

Bringing healthcare directly to the patient can support healthy child development, and it can help seniors to remain independent. Community health workers are often employed in these types of models to conduct home visits.

More than 95% of rural households do have a personal vehicle. Because of the importance of personal vehicle transportation in rural communities, these models address the importance for rural communities to balance efforts of increasing accessibility and affordability of public transportation, with investments in road infrastructure and other needs of drivers.

This toolkit describes three models that are designed to improve transportation, safety, and infrastructure.

The first active transportation models are useful for communities who are interested in investing in infrastructure to support walking, biking, and other forms of human-powered transportation. Having a dedicated infrastructure like bike lanes and cross walks is important for ensuring physical safety of residents.

Next, models of increased access to public transportation involve better integration between bikes, pedestrians, and transit systems to improve the safety and accessibility of various modes of transit. Types of integration might include adding bike storage at transit stops, adding back racks to buses, and building paths that lead to transit stops.

Lastly, road safety models involve strategies like lowering traffic speeds or traffic volume in order to improve the safety of pedestrians, bicyclists or all-terrain vehicle users who share the roads with cars and other motorized vehicles.

I want to conclude my part of the presentation with some lessons that we learned. First, some of the key barriers facing transportation efforts in rural areas typically involve safety and infrastructure issues, coordination between programs and long distances. The lower population density in rural areas often leads to lower ridership for fixed or out transit, and a smaller tax base to fund maintenance and repair for transportation systems.

Long distances are an especially salient barrier for many people living in rural areas. The average trip for medical and dental services is about nine miles longer in rural regions. So even when someone has access to a personal vehicle, these long trips can become really expensive.

Coordination of programs and services is key, with several federal agencies and various local and regional organizations involved in coordinating transportation systems. Rural communities can face challenges related to fragmentation and duplication of services. Coordinated transportation programs can reduce duplication of services, and improve overall efficiency.

Regular maintenance of vehicles and equipment, as well as performing repairs on the overall system are necessary for implementing transportation programs. The terrain and environment in some rural areas, the long distances that many routes span make maintenance even more important to ensure a safe and smooth operating system.

Marketing transportation programs can be an effective way of building ridership and community buy-in, especially for new programs. Oftentimes, community members might not be aware of what transportation services are available, or might not be fully educated on how to use those services. Information on eligibility, cost, hours, and other key details should be widely disseminated, so that potential users may more easily use the service.

Then lastly, it's especially important that rural transportation programs be tailored in order to meet the needs of different populations. This toolkit includes considerations for different populations, including older adults and people with disabilities.

My contact information is here. Please feel free to contact me if you have any questions about the toolkit. You can reach me at Stauffer-Patricia@NORC.org. I also wanted to mention upcoming projects that the Walsh center is working on. We want to hear about how local-level healthcare service providers are implementing transportation programs, or addressing transportation issues. If you're a local-level healthcare provider, and would like to participate by taking a survey, please send me an email and we would love to get your input. Thanks again for your time today, and we hope you'll visit the toolkit and find it useful. Now I will turn things over to Katherine Freund

Katherine Freund: Hey everybody. See if my slides are next ... Yep. Okay, first I want to thank the Rural Health Information Hub for inviting me to speak with you about ITNCountry, which is ITNAmerica's new rural transportation program.

I'll say a few words about what ITNAmerica is, so you have the context for understanding this new rural transportation program, then I'll speak about what exactly the program is and how it might help small and rural communities, then there'll be a little information on how you can connect with this effort if you are interested.

ITNAmerica, actually we gave our first ride in 1995. And we promote life-long mobility for older people. We not only do transportation, but we work on public policy, we have a number of very large national databases on senior transportation, and we work on education for the public, so we're not just independent transportation network, there's a lot of different aspects of understanding mobility and how to improve it here at ITNAmerica.

This is a map of our affiliates across the country. We have 13 affiliates, then we have 34 trusted transportation partners and we'll be adding 10 more partners next year. TTPs as we call them are services that provide transportation that we feel is really good quality, and they are in fact grantees and they provide free eye healthcare rides through those grants from ITNAmerica.

We also run a website called Rides in Sight and we have people answering phones from 8:00 AM 'till 8:00 PM eastern time. Rides in Sight is the largest database of all senior transportation in the United States. There are approximately 15,000 transportation services in it. The website and database are cleaned regularly for very accurate information, and it is free to the public. It's searchable online, and there's no charge to call the center and get information if you're an older person, for example, and you don't use the computer, you can just call a phone number.

I'd like to talk a little bit about Independent Transportation Network or ITN and what are the characteristics of that transportation model. ITN uses automobiles, and it's designed to recreate the comfort and convenience of private automobile ownership. 90% of trips that older people take are in the automobile, so ITN was created to provide the kind of service that people prefer.

Service is available for any purpose without restriction. People who use this service become a member, and they set up what's called a personal transportation account, and that's a real important concept for us, because ITN does not just use money to pay for rides. We've created a number of ways for people to access resources other than public funding, and other than private dollars.

For example, we have a program called Car Trade, where people can trade their car and get credit for it, and put that credit in their personal transportation account. People who volunteer

to drive for ITN can get a cash reimbursement for the miles when they have a passenger in their car, but for all of their unoccupied miles and for their occupied miles if they choose to, they can get a credit and put it into their account. That way, when they are older, someone else can drive them, or because all ITNs across the country are part of the same system, they can give their credits to a family member in another city, they can give their credits to an older person who cannot afford to pay for their trip, we call that transportation social security. So in other words, we have found a way to capture social capital as well as traditional capital, and we've found a way to take an operating asset, excuse me, a capital asset and turn it into an operating asset.

All of these programs actually increase the resources available for transportation. They're resources that were there all along, but nobody was capturing them, quantifying them, storing them and redistributing them.

We also have programs where merchants in the community can help to pay for rides, or healthcare providers can help to pay for rides. Those are called Ride & Shop and Healthy Miles, then we also contract with organizations through a program called ride services, so they can pay for rides. All of these different programs are built into the IPN rides software program, which we built for this.

What's important about that is that the software that we built is for non-profit community-based volunteer transportation. It's not traditional ride share software, and it's not the same as the kind of software that either a transit agency uses or Lyft or Uber use. It's specifically designed for non-profit community-based services. That'll become important later on.

This system has now done a million rides, or it will as of May. We're at ... We'll go to the next slide here. We're at actually 975,000 rides. I'm gonna go through the next series of slides really quickly so I don't run out of time and I can talk about ITNCountry for you, but I want you to see that about 40% of trips of these million rides have been done by volunteers, and about one in five trips is done for people who are visually impaired, which is the other population that we serve.

You can see that the people who use the service are pretty old. The average age is 80, the most common age is 85. But 80% of the riders are women, and their health varies. It's actually a pretty traditional bell curve there with most people in the middle. Income is not a bell curve, it's skewed toward lower-income people. This is a surprise, really, because about 41% of the people have an income of less than $25,000 a year. Most of the people using this service are paying for their own rides. But a lot of the innovative programs, trading a car and credits and so forth also come into play and are helpful.

These are some numbers on the people having a drivers license. About half the people have a license, and about 40% own their car, and about 25% still drive. ITN creates a safe and comfortable environment for people to make a voluntary transition from a drivers seat to the passenger seat, and most people when they use this service are no longer driving, and yet their mobility is maintained.

These numbers came out really tiny. These just show the rides by purpose. You can't see it, but about 40%, 41% of the trips are for healthcare. These are some numbers to show you customer satisfaction with the service, and you can see here that about between 95 and 98% of people are very, very happy with the service. I think these slides got a little deformed by this web presentation.

This is a diagram to show you all the different ways that revenue in the community can be accessed for transportation. Here is cash, here is the ride services account where somebody in

the community will pay for a ride. There's ride and shop where a merchant will help to pay for a ride. There's healthy miles, where a healthcare provider will help. Here is the community road scholarship, this is where volunteers will give their credits to lower-income people to help them with transportation. Birthday credits that all ITN affiliates give to their riding members, road scholarships for lower-income people, volunteer driver credits, this is where volunteers can use their credits for their own mobility. Gift certificates and car trades. So a lot of different ways to access resources, and that's really important, because as you all know resources are very scarce.

How is ITNCountry different than ITN? Well we created the ITN model and it works. But it is not scaling as fast as we want it to scale, and it's not really accessible, because of the cost, for small and rural communities, which we know cannot afford an expensive system.

We're changing a whole bunch of things. ITN affiliates, there will always be ITN affiliates and we'll be adding more. But for small and rural communities, ITN can be a program rather than a separate organization. We will be upgrading the technology and moving it to Sales Force, so we're gonna take this non-profit platform and add it to the Sales Force non-profit success pack. So ITN service will be available by smart phone. It's going to be very low-cost, so small communities can afford it. We're still pricing it out, but I want it to be affordable through bake sales and car washes. I want local people to be able to take the resources in their own community, pick and choose the ITN programs that work for them, and configure the model to their own local community. It does not have to be a 24/7 service in smaller and rural communities. It is designed so that you can run it with 100% volunteers if you want to, you can have paid drivers or volunteer drivers or both, you can have paid ride coordinators or volunteer ride coordinators, or both. And we have built an online learning system so that it will be more affordable for us to teach communities how to do this. So we're using technology more.

Who can be part of ITNCountry? Any charitable organization, any non-profit organization, and any government organization. The only kinds of organizations that can't are for-profit organization, but if they want to do it, they can start a non-profit, but this is a non-profit model.

Here are the different phases. The online learning system, we have built it, it is done, it is ready to go. We are in the process of moving ITN rides to the Sales Force platform. That's going to take about 10 months, and we are now also applying for a national AmeriCorps grant. That's a transportation infrastructure grant, and if anyone is listening and interested in participating with us, we are looking for more partners, especially in the Midwest.

We have many states that have already signed up to be pilot tests, but we are looking for more, and we are looking for partners for the national roll out.

Here's a quick summary. ITNCountry has the advantage of all of the tried and true, tested for a million rides now, ITN program. I like to call ITNCountry a do-it-yourself Uber, local Uber, or a do-it-yourself transportation network company, that's what ITN is actually. So it's a non-profit local do-it-yourself transportation network company. But it's not a standalone, it's part of a connected national network, so it has the advantages of national support, but all of the local connections that everybody loves so much in their communities. And as I said, everybody can configure it the way they want it in their community, and we are looking for partners to work with us on this.

So I think that's it for me. And this is my contact information. Yep, here it is. You can email you or you can call me, and I'll give you my cell phone too. It's 207-415-1630. And that's it for me. I hope I made my time limit. Now I'm gonna turn it over to Mary and Doris for their presentation.

Mary Gordon: Hello, this is Mary and Doris is with me. I'm the program manager from HealthTran, but before I get started, I want to thank everyone for being on the line. We appreciate your interest, and we hope that our information will be of some use for you guys in the future.

Okay, just starting off, HealthTran was built as a solving barriers with people-driven solutions, something that our mission was always centered, patient-centered, and we have always put the patient first. And that's what drove our program from the beginning, and what we have continued to try to stay focused on. Not the transit providers or the health providers, but the patient, the rider, and providing that quality of what they need.

I will not be reading everything from our slides, because I know you all have the ability to get those later. I just kind of want to hit the fine points, and be able to share some of the newer options that are happening with HealthTran.

We started off as a pilot, and the pilot was extremely successful. What we found in the pilot really helped us move towards the same ability. We started in December of 2014 with the pilot, and the pilot ended December of 2016. In that time, you can see we served 4,729 rides, 733 patients. We gained a lot of information on that, but as we were gaining that information, we were looking for the future on how we could not just be a pilot with grant dollars, but how to become sustainable. So that's what we looked for in 2018.

Here's what we learned mostly from all of the assessments. We did a pre-assessment and a post-assessment on each rider, and what we learned was that data drives change. We are hoping to focus the information that we gather to address policy changes and bring more awareness to people, so that they can address those changes nationally and locally to increase access to care. We've always listened, as I said, we put the patients first. We try to stay true to our mission.

We had a lot of help along the way. FTA Rides to Wellness gave us lots of direction. We had great support from them, and Missouri was actually I think the first state to host a Rides to Wellness collaborative meeting. Judy Shanley from National Center for Mobility Management was key in bringing information to us and helping us kind of move forward. And CTAA was again, another key partner in helping us build the program that we had.

We're very adaptable. We don't get stuck in a rut. If we see that something's not working, we move forward. We worked on building community focus and not on silos. Actually the communication for the first two years really was focused on just breaking down those silos between transit providers and health providers. We found that they both had the same goal, they just didn't communicate those goals the same way. It was a hard connection to make. But I think everyone is a little bit more on board here in rural Missouri, and focused more on what we need to do.

As I said, we're focusing on community outreach, and trying to build an online training curriculum, because it makes it much easier. And we are about ready to launch our sustainable program ...

Doris Boeckman: This is Doris Boeckman. At the beginning, I think it might help just to have a little bit of a sense of the breadth of the project. We started out the pilot in a 10 county area in southern rural Missouri, a very poverty-stricken, economically challenged area, knowing that there were a lot of healthcare barriers. So that was kind of the premise behind developing this system and looking now toward trying to roll that out to reach other folks. We've been very fortunate to engage state-level partners that support the Missouri Rural Health Association, as well as the HealthTran concept in general.

The Missouri Rural Health Association is a state-wide rural association, a very small membership. And we've really been challenged to identify resources to tackle such a big issue, but fortunately we've had some good partners come to the table. I think as more and more healthcare providers understand that transportation really does impact their ability to get patients to care or for patients to come to them for care, they're becoming greater advocates for not just public transportation, but looking for ways to actually address transportation barriers as a whole.

And what we are doing with our state level partners is trying to develop a flexible system that will allow us, much like ITN, to coordinate rides on a very local level in a rural setting. Things that work in an urban setting don't work in a rural setting. Some of our riders, they have to travel 90 miles. And when you're paying by the hour or even by the mile, it is just not affordable. So looking for ways to ride share, it's helpful, but also looking at ways to identify resources to subsidize some of that cost for patients. And it's not just for people who are low-income or vulnerable population, it can be people with insurance that just have no one to take them to their appointments. They've utilized all their resources for multiple rides over a period of time.

We're just really trying to be creative, increasing transportation options throughout, looking at all of our public transportation providers, the faith-based community, we're reaching out to ambulance districts. They've been great partners on our pilot. There are just a lot of resources that are untapped or if they're tapped, they're not fully tapped.

Obviously in rural Missouri, we don't have taxi service, and our public transportation is very limited. We had demand service that covers all of our 114 counties, but that, again, when you have the on-demand service is a lot more expensive than if you can get something on a fixed route. When fixed route service may only be available once or twice a week, or once, twice a month in some areas, it's very challenging for people to get to multiple medical appointments if they've got a chronic illness.

With that, we've really been looking at how do we sustain the pilot that we put in place. And kind of like the ITN model, it very much is a membership model supported by other resources. And what we found, in order to really launch an initiative, we really need to have ... what we've learned, and we're getting ready to roll out in several other communities with some resources from United Healthcare, who has become one of our state level champions, but what we have found is it really takes a local health provider or community champion to really get something off the ground and to stay on top of things and keep people convening, help identify just the service area that can be served. Our model is not based on ... It's really based on a community. So what's the hub? Who are the health providers that provide the greatest care, and where do people come from to access that care? It's not always a market share, because sometimes you have multiple providers in an area, but where's the draw come from? And that sort of defined the service area.

Once that's established, we look at all the different options in those areas and try to identify the gap. Then the next step is to really work with the community to really identify the resources to help support moving some type of transportation initiative forward using the technology that we're about to undertake. And again, we are in the early stages, so we're looking forward to actually having a conversation with Kathleen at some point to see how we might be able to network as well.

We look at the populations that access the services or need the service. We have a huge retirement population in our rural areas, and of course the aging baby boomers, everybody has a lot of those boomers in their areas, how to address their needs. And have spent really a lot of time looking at what it's gonna cost, because we don't actually provide transportation, we do

not have vehicles. Everything we do is through coordination of existing services. So it could be very challenging if the service doesn't exist, and there has to be some resources identified to help cover the cost of not just providing the service, but also assist some of the patients who just have no other resource. Without that, they can't get their care, which drives up the healthcare costs, which we all end up paying for in higher insurance premiums, and it's just a cyclical problem that we're really hoping that we can undertake. At the end of the day, what we really want is for all of our residents to be healthy and have good health outcomes, and no one should be prevented from accessing care just because they don't have a ride.

And I'm gonna turn it back over to Mary to talk a little bit about the MRHA memberships as she is much more involved and engaged in that arena.

Mary Gordon: Our new sustainable model, as Doris mentioned, is based on memberships. Our priority is health and wellness providers, but we also are looking at expanding into non- and for-profit members as well. When you get into transportation, it's to make somebody who is stable and healthy and also takes employment, it takes them getting to the grocery store and so much more. We're trying to look at a bigger picture for that.

We really are looking at a membership, and it's based on the utilization of our HealthTran program. We have a technology platform that is getting ready to launch, and that platform is based on usage. A HealthTran, someone can become a HealthTran member. Our memberships begin at $37.50 a month, then there's a $99 per login set up fee. We're trying to make it extremely affordable, and what that technology and the membership allows is for you to be on the technology and to get in there and look and you can see what kind of local transit, available transit already is there. Is there a fixed-route route, is there a taxi, is there ... then we will be recruiting local volunteer drivers, so you can send out a request for a ride to any one of those, the ones that meet your need of the rider.

We also are looking forward to recruiting ambulance districts, ambulance providers and others who can also offer that above real healthcare and transport, without it being as a 911 call or an ambulance call.

Our launch fees are based on need, and they start at $15,000 and go up. It's just a one-time cost. Because that includes about 120 days of really getting everything set up, site visits, webinars, working with your service area, the marketing, just the driver recruitment and doing the training and the background checks, the drug testing, the insurance, and just so much more. The software installation, and the training for that. Then we like to end it with a community presentation and invite the community so they can kind of know who's involved, what's going on, how they access that.

And then with United Healthcare's assistance, we're going to be able to offer a grant opportunity for the launch champions. We only have four per year, but it will help with some reimbursement of transportation in that first 90 days, so they can reinvest that money back.

What our service has, and we've mentioned it before, it's the adaptability and flexibility to meet the needs. We really try to focus on quality of service. In our pilot, we had 100% ride satisfaction, which we are extremely proud of. And part of that was because we were very aware of the quality of the transportation. So we're continuing with what we've learned, whether it was good or whether it was bad, but we're taking what we learned and we're moving forward.

What we have is an online portal. There's no software to install on your computer, and everything is built as a tool for community health worker or a care manager. It gives them the

tools to be able to do their jobs in a very quick, efficient way. We haven't launched yet, but I would suspect that within a couple of minutes, you would be able to have a ride scheduled, and within another few minutes you would be able to know if that ride has been accepted and taken care of, and it's done. You can always go back into the system, and you can see where that rider is and know if they're even actually going to arrive on time. It's very beneficial, especially to health providers who are saying, "Okay, so-and-so's not here for their appointment, are they gonna get here? Yep, here they are, they're just a minute or two out, here they come."

We worked very hard to make sure that it is HIPAA compliant, and forgive me, I have it spelled wrong. We also know how important it is, specifically for health providers, that you have the ability to run reports and be able to connect those reports to someone who has gotten rides to see, "If I provided rides, is that person's health improving? Am I seeing a difference in health? Are they adhering to their appointments because we're providing transportation?" So the reporting ability will be by organization client and more. That little caveat will be coming in a little bit after we do our first launch. I think it'll be another 60 days before their reporting ability will be up and going, but pretty quickly.

Our volunteers, they have all the background checks, drug testing, vehicle inspection and training, and it's pretty selective to make sure that we have quality drivers who want to provide a service for their community, and that's what we're looking for.

The other part of that is wrapping it up with good service support. That is basically the program. And I've just got a couple minutes, so I'm gonna go through this pretty quick. What we visit with our health providers with is the value of access to health, and I'm gonna turn this over ... Do you want me to turn it over to you?

Doris Boeckman: Yeah that's fine.

Mary Gordon: Just pretty quick. Go ahead.

Doris Boeckman: In terms of healthcare access, what we learned from our pilot was, you know, many health clinics, including community health centers had a lot of missed appointments. They can range from 20 to 40%. And that's important to note if you're a health provider, because that's lost revenue. You're missing out on revenue that you could generate if you were getting those folks in for care, as well as improving their health outcomes, which then on the flip side will help reduce the cost of the higher cost care through an emergency room or uncompensated care for a hospital stay. It's really getting them in for the preventative care for those chronic conditions that escalate if they go untreated. And sometimes in rural areas it doesn't just escalate, there are fatalities because they don't have transportation.

We have developed a calculation to help our healthcare providers really look at this based on their missed appointments, and almost come to a pretty good assessment of their foregone revenue. And I think many already do this on a regular basis and recognize that it's an issue, but I don't think that they clearly understand that by providing the cost of the transportation through support of an organization that can coordinate the service, not paying for their patients to come to them, but supporting a service that provides transportation for the community as a whole, regardless of where they go. It's gonna have a huge impact on their bottom line. And just by the look on this slide, you can kind of see that if you were supporting transportation and increasing your bottom line, that gives you more dollars to put into either prevention services or other direct care or hiring a staff to help do the coordination yourself. So there are a lot of benefits.

Obviously for us, our program, the biggest benefit is improving patient outcomes, that's what we want to see. Then for the health systems, it's to really improve their bottom line. We really like to see those silos break down and communities work together so that you have multiple partners working together, identifying resources, pooling resources to really address the needs of the entire population, so that those population health indicators improve. And I think when everybody comes to the table to really work on transportation, and especially as a barrier to healthcare, there is a lot of opportunities identified local revenue that may not be tapped. So it's really just building that safety net with a very specific focus in mind, and not just thinking of health as healthcare, but thinking of it as a very broad employment, health, grocery, nutrition, all of those things. Because if you can't get all of those things together, it really does impact the patient's health outcomes.

Mary Gordon: And that's the end of our presentation. It was hard to squeeze all of that information in on a short period of time, but I will turn it back over.

Kristine Sande: Thank you so much. Those are great presentations. I learned a lot, and hopefully the rest of our audience did as well. At this time, we will open the webinar up for questions. You should see a Q and A box on the lower right-hand corner of your screen, and you can enter your questions there. As you enter your questions, please do select the option to send the question to all panelists, or your question might get missed.

We do have a couple of questions that came in via email during the webinar, so we can start with those. We actually have two questions that relate to liability issues, so I'll ask those together. The first is how do you address the issue of liability insurance with volunteer drivers, and the other one was asking if someone could speak to liability aspects associated with providing transportation and the issues of when patients need assistance from the drivers to get in and out of the vehicles. So if somebody would like to address that, the liability issues.

Katherine Freund: Hi, this is Katherine. Can you hear me?

Kristine Sande: Yes.

Katherine Freund: Okay. Liability issues are handled in different ways in different states, because insurance is a state policy issue, so there isn't one answer for the whole country, but there are a couple of general answers. But most volunteers, insurance will cover them for passengers in their cars. That's why cars have seats so you can put passengers in them.

In some states, laws have been passed that prohibit insurance companies from increasing the premium or refusing to ensure people just because they use their car to volunteer. ITNAmerica has a database of policies that's available from our website. We just built a new website and the link isn't up yet, but if anybody's interested in the policies in different states, they can just email me and I'll connect them to those policies for their particular state. That's how we've dealt with that.

Kristine Sande: Great, thank you.

Tricia Stauffer: And this is Tricia Stauffer, I'd like to just add on that in the toolkit, we have a section in module four called liability insurance and other legal issues that might have a few resources that can help you out as well.

Kristine Sande: All right. Another question we had is, "Is there a limit on how far the rides can go with the different services?"

Doris Boeckman: This is Doris with the HealthTran project. We really don't set a limit. Our project that we have in place now is actually an 11 county area now in south central Missouri, and we have transported folks as far as St. Louis and over to Springfield, often to Springfield from the area we're in. I think it's a matter of if there's a shortage of providers and there is a need that needs to be met, we try to figure out how to accommodate that need in the most cost-efficient way possible, yet meeting the patient's mobility needs. Sometimes that may be connecting them on a fixed-route on a specific day, or connecting them. And we haven't had to do a lot of this yet, but actually having a ride from in-county to the border to get on a fixed-route that'll take them on a regional leg of the trip, we've had to do that.

It's a lot of coordination, and having to know what all the transportation providers provide and what their routes are and what their costs are, and that's why the technology is so important. We were doing it pretty much manually when we first started, and didn't even recognize some of the gaps that they were as critical as they were, or that there were a lot more resources as well than what we had anticipated. There's just a lot to it, but there is no ... at least there hasn't been for us, there's no limit.

Kristine Sande: All right, thank you. The next ... Let's see, there's a question about whether the webinar is being recorded. Yes it is being recorded and it will be available for later viewing within the next couple of days.

The next question is how do you address handicap accessibility needs? If somebody has a wheelchair that needs to be stowed and that sort of thing?

Mary Gordon: Katherine may have a different way. In our system, you need to put the mobility concern in the system, then just the drivers that have the ability to take care of that mobility concern would receive the ride request.

Katherine Freund: Yeah, it's not that different for ITN. In the ITN classic system, we can transport anyone who can transfer on a sideboard from a chair to a vehicle, a car, and we fold their chair up and put it in the back. And we just signed up a woman who is a double leg amputee, and she's riding just fine. Most people can be served that way, the only people who can't are people who have to stay in the motorized chairs, then we refer them to another service that has a vehicle with a lift.

Doris Boeckman: And this is Doris with HealthTran. The way we do that is our public transit providers, the paratransit providers, provide that service for us.

Kristine Sande: Alright. The next question asks, "In our state, we have a good number of folks in rural areas who do not have broadband or cell access. You mentioned that smart phone access is part of your model. Is it an essential part of the model or are there alternatives?"

Katherine Freund: I think that's for me, and the answer is it is absolutely not an essential part of the model, and we really understand that broadband access is an issue, and also for a lot of older people they just really want to use a traditional telephone line, and they want to speak to a person with a heartbeat. They just want human contact. So every ITNCountry is designed so that there are many different ways of communicating. And you absolutely can just run the software off a desktop computer, and you can call in by telephone, and you can access the system that way.

Kristine Sande: Great.

Mary Gordon: In the HealthTran model, we have a local HealthTran coordinator who can do that. Most of the referrals come through members who are paying for those rides, so they have access to the

internet, of course. We have a call center and an app availability, so we're kind of like the ITN. We have multiple options.

Kristine Sande: Great, and here's a question specifically about HealthTran. Who actually provides the rides in the HealthTran model?

Doris Boeckman: We have a number of contracts with various providers, so first and foremost, HealthTran was set about on the premise of utilizing public transportation, because generally that is the form of transportation in Missouri that was available in rural areas. Now we are moving towards a combination of rides with public transportation providers, ambulance district providers, a lot of times folks are using ambulances for non-emergency or non-acute rides, and the ambulance districts are actually purchasing vehicles to do regular route and other service type rides to prevent over-utilization of their ambulances because it's very costly and they don't always get reimbursed for those services.

And we also are moving toward very similar to ITN, having the volunteer drivers with paid per mile. They'll get mileage reimbursement. So it's a combination, because there's just a lack, and you really need all of it. We are also looking at other options as well like organizations that have vehicles that are under-utilized.

Kristine Sande: Great.

Katherine Freund: This is a general statement.

Kristine Sande: Go ahead.

Katherine Freund: I just wanted to say in our experience, the biggest issue is actually not coordinating existing services in rural communities, the biggest issue is that there is no service. So it's very important to understand that resources is the underlying reason for that. There's just not enough money to pay for the rides that people need. So if you can find useful flexible ways to help people access the existing capacity that is in their community in a way that works for the provider, which is the person with the car, and works with the rider, which is of course the person who needs the ride, that's the best way to increase the available capacity to provide, excuse me, to provide the rides. That's the big underlying issue.

Kristine Sande: All right. Katherine, there's a question here about is there a reason that Texas has only one ITN outlet?

Katherine Freund: That's actually a trusted transportation partner, and actually we do have a pre-affiliate that is just starting up in the Dallas area, so that'll be popping up on the map pretty soon. That's the only reason. No, there's no ... I mean we don't have one in New York either. We have trusted transportation partners, but no affiliates. And I don't know, it's an anomaly to me. They pop up in some places and not in others. We don't go search them out, we just respond to demand.

But if that question is being asked by someone in Texas who would like to start an ITNCountry, they should contact me.

Kristine Sande: Okay. Let's see, the next question is, "I have heard that some hospitals are concerned about violating Stark Laws by using transportation programs. Do any of you know if that's something that they should be concerned about or aware of?"

Doris Boeckman: Yeah, HealthTran has actually done a lot of work in this arena. The Missouri Rural Health Association has been working with the National Rural Health Association to address that very

issue. And there has been a lot of progress made. Community Health Centers, which are the Federally Qualified Community Health Centers, they have safe harbors and it's not an issue for them, and hospitals have really been concerned about Stark, because they can't obviously pay to bring patients to their facilities.

That's why HealthTran has been so well accepted in Missouri, it's because the health providers are actually joining MRHA as a HealthTran member, and the resources then are utilized to provide transportation for the population in that region. So it's not necessarily them paying to bring a patient to their facility. It really kind of puts the transportation for the patient at arms length, and it's not them going out and picking up a patient and bringing them in. And we don't just address the needs of getting patients to their care, which is to their benefit, we also address taking them home from their care.

Kristine Sande: Great. Another question is, "How do you overcome dead head miles, such as completing the return trip, especially using a ride-sharing or volunteer driver pool?"

Katherine Freund: That's a tough one. One of the ways we've done it is by just giving people transportation credit rather than cash for those miles. That's one of the reasons the transportation credits were actually created. Another way is by coordination among ITNCountry services. If someone is going from a small community into say a county seat that's typical where services will be at the county seat. If you know that there's someone returning from that county seat, either part of the way or along the way, then you can utilize those miles. That's the best way we've been able to figure out doing it.

Doris Boeckman: And I would say HealthTran is probably right there equally so, and our HealthTran coordinators really play a role in that in trying to double up rides so that you're not paying as much. But it is a tough issue, and there isn't an easy solution for it.

Mary Gordon: Part of that is in the figuring out where the hubs of people are going, and where the pockets of need are, then trying to establish a volunteer in that area, so that you don't have a lot of dead head miles.

Doris Boeckman: Then if you've got a long trip that you need to make, using that volunteer driver to get them on a regional or some fixed-route transport to keep the cost down.

Katherine Freund: A lot is accomplished by, as Mary was saying, not having silos. If you're not sharing information among providers, then you could have someone literally driving right by someone who needs a ride, and if you're not sharing information, you don't know it. So you run at maximum inefficiency if you don't share information, and maximum efficiency if you do.

Doris Boeckman: Amen.

Mary Gordon: That's so true Katherine, so true.

Kristine Sande: All right. And I think I'll ask just one more question, we are about 10 minutes over our time already. For those of you who we maybe didn't get to your questions, we will try to get those questions to our speakers so that they can respond to you. This has to do with reimbursement for mileage expenses for volunteer drivers. How do you reimburse those volunteer drivers for their mileage? Is it a minimum rate, is it the IRS rate or average per mile rate? How do you compute that?

Katherine Freund: I'll take a stab at that. Every ITN community decides on your own, how they would like to reimburse volunteers for their mileage. At a national level for all ITN affiliates, I think the most

common rate is 25 cents a mile for rides when there is someone literally in the vehicle. And we don't reimburse for miles in cash when people are not in the vehicle, that's when you get transportation credits. Some affiliates reimburse at the IRS rate, but most do not.

Having said that, I think it's important not to think of volunteers as being uniform any more than we should think of older people as being uniform, and rural communities as being uniform, and so forth. People volunteer for a lot of different reasons. Only 8% of ITN volunteers even ask for a mileage reimbursement, most of them don't even take it. So I think when you are recruiting, think about the people that you're recruiting, and think about why they're participating. They may be very willing to take credit in the system. It's very powerful, actually, and store it for a family member or store it for someone else in the community. So if you get creative about how you cover that, and think beyond cash. Some people want the cash, but many people volunteer in their community for many, many, many other reasons. That's how we approach it, and it's worked very well, actually. It's worked well for a million rides.

Kristine Sande: Great. Mary or Doris, do you want to weigh in on that one?

Doris Boeckman: We're in the development stage, but we are looking at an 80 cent per mile reimbursement rate, and that's just for what we call as loaded miles, when there is someone in there, then that kind of covers for the other mileage, as they said, the dead head miles.

Kristine Sande: Great. Well with that, I think we will wrap up. On behalf of the Rural Health Information Hub, I'd like to say a special thank you to our speakers for the great information that you've shared with us today. I'd also like to thank all of our participants for joining us. A survey will automatically open at the end of today's webinar. We encourage you to complete the survey to provide us with some feedback that we can use in hosting future webinars. The slides used in today's webinar are currently available at www.ruralhealthinfo.org/webinars. In addition, a recording and transcript of today's webinar will be made available on the RHIhub website and sent to you all by email in the near future, so that you can listen again and share the presentation with your colleagues.

Thank you again, and have a great day.