Testimony to the Honorable Peter A. DeFazio and the U. S. House of Representatives Committee on Transportation and Infrastructure; Subcommittee on Highways and Transit

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Medical Motor Service

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Washington, D.C.

Good Morning Chairman DeFazio and members of the Subcommittee. My name is Bill McDonald and I am executive director of Medical Motor Service, a community-based, nonprofit transportation agency located in Rochester, New York, that serves urban, suburban and rural upstate New York. It is a privilege to have this opportunity to speak to you on the issues facing an agency such as mine as we endeavor to coordinate and provide a wide range of transportation services to older persons and people with disabilities and special mobility needs.

Medical Motor Service of Rochester and Monroe County is one of this country's first charitable organizations dedicated to the provision of non-emergency medical and social services transportation. We began during the influenza pandemic of 1919; formed by an interdenominational group of Catholic, Protestant and Jewish Women who recognized the importance of linking people to critical services during a challenging time in the development of public health services and programs. Run by a handful of volunteers until World War II — when gas shortages and fuel rationing limited the ability of unpaid drivers to provide services — we have evolved into an agency that provides a wide range of transportation to children, adults and senior citizens. We now employ nearly 150 drivers and 50 staff who together provide nearly 500,000 trips a year. And the demand for our transportation is growing; up 14 percent from last year — in part due to the expansion of our shopping shuttle services and other programs

that serve the elderly and adults with developmental disabilities — demographic groups that are growing and challenged by high fuel costs and medical, social and therapeutic needs.

Today, Medical Motor Service is playing an expanded local role as a nonprofit, community-based transit provider. More than ever before, our service is viewed as an augmentation to the local public transit network. I want to discuss the environment in which we operate today and highlight some key issues that are impacting our services, and those provided by my colleagues across the country.

As you are no doubt aware, the price of fuel, particularly diesel fuel, is severely impacting the operating budgets of transit providers. In fact, this issue is more than a mere difficulty or impediment. In many cases gas prices are forcing public and nonprofit transit providers alike to scale back service — which is particularly trying when it comes at a time that more people than ever before are looking to our services for their access to community services. The additional cost of fuel for our agency just this past year has been overwhelming. The increased cost alone could provide full health care coverage for 100 of our drivers or outright purchase two new cars each month. And that is with just the additional amount we are paying on the approximately 30,000 gallons of fuel we use monthly. Revenue increases are not keeping pace. For many systems, the fuel price increases have consumed all of the federal investment gains congress designated

for public transit in SAFETEA-LU. The price of gas is much more difficult for systems like mine, because we do not enjoy the relief from federal gas taxes that my public agency colleagues have.

We are challenged by fuel tax policies that are applied in an inconsistent manner for community transportation agencies that are not "public" authorities or government bodies. The fact that school bus services, both public and private, are exempt from federal fuel taxes but publicly funded services to adults and seniors with special needs are not is inequitable. It suggests that transportation to children is valued more highly and we encourage public policies that support all community transportation systems. I encourage the development of a real, comprehensive energy policy that explores new sources of revenue for all types of public and community transit — one that takes into account the expanded public transportation role of systems like Medical Motor Services that serve a growing population with cost-effective, efficient service.

Medical Motor Service has been at the forefront of the human services coordination arena. We operate a number of services in conjunction with agencies such as the Office for the Aging, Foster Care and Child Protective Services, Senior Living Centers, Developmental Disability Organizations, Early Childhood Centers, Health Clinics and Medicaid Managed Care providers, the United Way, Mental Health Clinics and other not for profit health and social

service groups. We also work with faith-based organizations, and helped to create and operate FaithLink which serves Irondequoit, N.Y. Coordinated transportation is much more than meeting the needs of government programs, it is working with local private-sector groups providing service to people who do not qualify for government programs, but who need mobility nonetheless. Another private sector partnership that we have is with Wegmans Food Markets whereby they fully subsidize shopping shuttles for persons with disabilities and the elderly.

We are the only nonprofit agency in our community whose sole mission is community transportation. We operate as a supplement to and not in competition to our local public transit authority. I have attached to this testimony an excerpt from *Community Transportation* Magazine's Fall 2007 edition that covers the Community Transportation Association of America's Institute for Coordinated Transportation.

Our agency was an active participant in the development of our local Coordinated Public Transit/Human Services Transportation Plan recently created to comply with federal SAFETEA-LU planning and funding requirements for the Federal Transit Administration's (FTA) Section 5310 program for seniors and people with disabilities. Medical Motor Service is a major participant in the Section 5310 program, thanks to support from the New York State Department

of Transportation. This federal planning requirement is a good thing. But we need more than planning, we need partners.

In recent months, one of our most vital partners in the transportation coordination environment — Medicaid — has sought to either scale back or eliminate its role in supporting coordinated, community-based non-emergency transportation for its recipients. A series of proposed new rules emanating from the Centers for Medicare and Medicaid Services (CMS) has sought to mitigate the long-standing non-emergency transportation benefit that connects so much of our nation's Medicaid population with the routine, preventative care that reduces more costly emergency transportation and care costs. Though I know that Medicaid does not fall under the authority of this subcommittee or committee, it is important to understand that Medicaid provides the foundation for many of the coordinated human service and public transportation services that improve the lives of millions of Americans every day, and that any weakening of the Medicaid non-emergency transportation benefit weakens the overall public transit network. I have included a research report from the Community Transportation Association of America that covers the vital role of non-emergency transportation in the health care system.

The very nature of health care provision in this country is having a profound impact on all forms and types of public transportation, including my agency. The

increasing trend toward outpatient medical services by the health care industry creates increased demand for transit. Patients who once spent days in the hospital are now discharged in a single day. But they must return for regular therapies and treatment in order to maintain their health. Public transit — often in the form of community-based nonprofit providers like Medical Motor Services — is the key link for patients to access this ongoing care and my agency's experience is that trips like dialysis, chemotherapy and physical therapy are top priorities. In SAFETEA-LU, we first saw language acknowledging what many in our field have known for years — that non-emergency medical transportation is public transportation and that a coordinated, efficient transportation network at the local level can cost-effectively manage these often life-saving trips.

As our population ages and as people with disabilities seek inclusion in community settings, the demand for community-based non-fixed route transit services will continue to grow. Medical Motor Services has reached beyond government programs to achieve a broader definition of transportation coordination that includes everyone in our community. Today's high prices for fuel only increase demand for our service. Our passengers need affordable door-to-door service, often pre-scheduled with no geographic limitations based upon fixed transit routes. They want to travel seven days a week, sometimes 16 or more hours per day. These travel needs and requirements differentiate our kind

of service from traditional transit, but in no way change the fact that we are part of the local transit network.

Looking forward, we are entering a period where crucial decisions will be made here in Washington regarding the future of surface transportation in our nation. We need our elected officials to further their outstanding work in ISTEA, TEA-21 and SAFETEA-LU and to invest in a fully developed local and regional transportation network that includes both traditional and non-traditional transit operators. We'll need flexibility and innovation in this bill. And of course, we'll need additional forms and sources of revenue in order to meet the growing demand for public transportation.

To help us manage these challenges, we urge Congress to reauthorize a transportation bill that embraces and continues the philosophy of the flexible transfer of money between the "silos" of transit and highway funding as well as within the programs. We need our states and local planning areas to be empowered to set local priorities and to flex funds to areas where most needed. In Rochester, for example, we have the support of our local MPO and county government to flex funds and we have been successful in garnering local private funding for match requirements. But we need this to become the rule and not the exception. With additional capital dollars we can help offset the escalating operating costs of our services.

Medical Motor Services and other nonprofits need access to better technology to improve the coordination of human services transportation programs and to maximize fuel efficiency in scheduling and real-time dispatching. We were fortunate to participate in a recent Transportation Coordination Institute sponsored by Easter Seals here in Washington. With a local team we developed a blueprint for action to coordinate services among agencies serving the elderly and Medical Motor Service. The centerpiece of our plan is technology such as GPS/AVL equipment and electronic linking off intake/ referral and transportation agencies. We believe we can increase the capacity of existing vehicles if we can find a way to obtain technology—a difficult budget item as fuel costs consume all of our discretionary dollars. Using flex monies for technology to improve coordination will be a win/win.

Medical Motor Services began in 1919 in response to a medical crisis. Our service was launched because it was essential to maintaining the health or our passengers and the communities we serve. That essential nature of non-emergency medical transportation trips exists today. We serve people who are part of governmental programs, and just as importantly, we serve those who have a very similar need but lack the financial backing of federal, state and local programs. We serve them all with safe, affordable, efficient transportation. And we keep them healthy. This vital role is one ideally suited to nonprofits and

highlights exactly where such entities fit within a region's public transportation network.

The century of progress that Medical Motor Services represents in meeting the transportation needs of our passengers is now in very real danger. We need your help on this committee with rising fuel prices and rising demand. We need your help in maintaining vital partnerships, like Medicaid. Thank you for inviting me and for your time this morning.

Transportation as a Foundation for Better Healthcare

By Jon E. Burkhardt

The finest medical services are of little value to individuals who cannot access them. As noted by a local alliance of community leaders in North Carolina, "A lack of mobility and access to services results in:

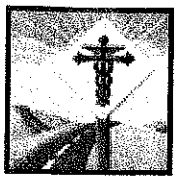
- A delay in receiving medical attention and/or obtaining necessary medications. This results in: illness which is more serious, reduced quality of life; and increased cost of care to the patient, medical providers and the community.
- A significant use of the emergency room for non-emergency care, resulting in increased cost and less efficient use of emergency services.
- An increased dependence on ambulance services for non-urgent care, resulting in increased cost and less availability for true emergencies.
- Decreased use of preventive care opportunities, health improvement programs and public and private human services.
- Isolation from the community, particularly for those who are economically disadvantaged, on fixed incomes or who are part of the growing population of elderly."

Transportation helps surmount the barriers to opportunity. In the case of access to medical services, transportation helps to achieve longer lives of higher quality.

Transportation Services in the Medicare Program

By law, Medicare can only reimburse patient transportation to Medicare-approved medical services when that transportation is provided by ambulance. And in order to receive Medicare reimbursement for ambulance transportation, a determination must be made that an ambulance is the only means by which the patient can be transported without serious health risk.

Data indicate that the Medicare program is reimbursing some clients and ambulance operators for many trips that do not require ambulance transportation, and thus could be provided more cost-effectively by other means of transportation. Furthermore, some medical services now being provided by emergency departments could more cost-effectively be provided elsewhere. Legislative changes to the current restrictions could allow alternative transportation and medical services and, at the same time, save millions of dollars for the Medicare program and provide much needed funding for community transportation services.



Medicare is one of the key federal health insurance programs in the United States. The Medicare program is administered by the Centers for Medicare and Medicaid Services (CMS) of the U. S. Department of Health and Human Services (DHHS). This program has two distinct components: hospital insurance (known as Part A) and supplemental medical insurance (Part B).

Part A covers hospitalization, some hospice care and a limited amount of post-hospital skilled nursing and home health care. Part B covers physicians' services, outpatient hospital care, physical therapy and other specified services, such as ambulance transportation. Both parts of the program provide insurance protection for covered services to almost all persons age 65 or older, certain disabled persons and individuals with chronic renal disease who elect this coverage. In 1998, Medicare paid for nearly 58 percent of all healthcare expenses incurred by persons 65 and older in the United States.

Transportation costs are allowable expenses under Medicare Part B, but there are serious restrictions on their usage. By statute and regulation, Medicare will provide reimbursement only for transportation services provided by ambulance. Both emergency and non-emergency ambulance trips may be reimbursed through Medicare, but reimbursement for ambulance transport is limited to severe medical situations such as a life-threatening emergency, a need for restraints or emergency treatment while in transit or confinement of the patient to bed before and after the trip.

CMS's Medicare Carriers Manual provides that reimbursement may be made for expenses incurred for ambulance service provided that certain conditions are met:

- Vehicle and crew requirements of at least two crew members with specified training;
- Medical necessity: When the use of any other means of transportation is not possible without endangering the individual's health;
- Reasonableness: Ambulance service must be reasonably needed for the treatment of the illness or injury involved; and
- Destination: Local transportation only, and to the nearest institution with appropriate facilities for the illness or injury involved.

The Medicare program is not authorized to provide reimbursement for trips other than those made in ambulances. There are no circumstances that qualify as exceptions to this rule. Furthermore, ambulance trips are only to be reimbursed when conditions of medical necessity can be confirmed, regardless of whether or not any alternative form of transportation was available for that trip.

Current Ambulance Transportation Costs

In 2000, Medicare program data files (Medicare Part B Physician/Supplier Data) show a total allowed expense for emergency ambulance services of $2,221,895,701. For 1999, allowed Medicare ambulance expenses were $2,074,180,935.

Research has shown that not all trips reimbursed by the Medicare program are for conditions that meet reasonable definitions of medical emergencies. This leads to expenses that are higher than necessary for transportation and for medical treatments. While it is important to remember that certain strictly defined non-emergency or prescheduled ambulance trips may be reimbursed by Medicare, a major issue is the degree to which non-emergency ambulance trips could have been provided by other providers. Various sources have examined this issue.

Medicare Patients Need Transportation

In 1994, DHHS's Office of Inspector General (OIG) issued a report entitled "Ambulance Services for Medicare End-Stage Renal Disease Beneficiaries: Medical Necessity." End-stage renal disease (ESRD) Medicare patients are especially likely to have a critical need for transportation support to access life-extending dialysis treatments. Missing dialysis treatments can lead to serious medical problems, even death.

Transportation access problems are particularly severe in rural areas, which often lack local dialysis facilities and may lack long-distance transportation services to urban dialysis treatment centers. Persons with disabilities and low-income individuals also typically have problems finding sufficient transportation services for dialysis. Medicare patients seeking dialysis transportation via ambulance must present a written order from their doctor stating that any other form of transportation would be harmful to their health. In some parts of the country, there may be no other means of transportation to dialysis except by ambulance but, according to regulations, such situations do not qualify for Medicare reimbursement for travel costs. According to CMS's Office of Information Services, there were 270,000 Medicare patients receiving dialysis as of December 31, 1999.

The OIG report concluded that, in 1991, 70 percent of ambulance trips involving dialysis (representing about $44 million in ambulance allowances) did not meet Medicare guidelines for medical necessity. This report found that, in many instances, other means of transportation could have been used for dialysis trips because there was no evidence that travel other than by ambulance would have been unsafe for the patient on the date of travel. The report showed that relatively few dialysis patients (2 percent of the ESRD Medicare beneficiaries sampled) were incurring 75 percent of the ambulance transportation costs.

Further, in 1998 another OIG report concluded that in 1996 Medicare spent $104 million for medically unnecessary ambulance transportation — a figure that many in both the transportation and health care communities concede is dramatically conservative.

Emergency, or Non-Emergency?

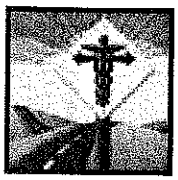
In July 2000, the Government Accounting Office (GAO) released a report entitled "Rural Ambulances: Medicare Fee Schedule Payments Could Be Better Targeted." The report was based on meetings with more than 50 ground and air ambulance providers, both free-standing and hospital based, in North and South Dakota, and correspondence with ambulance service providers in Minnesota and Wyoming. GAO also examined claims data provided by (then) Health Care Finance Administration, observed the ambulance claims processing system of a major Medicare insurance carrier and attended meetings on Medicare ambulance fee schedules. The main focus of the report was the recommendation for an improved fee schedule for rural ambulance providers, but the report also noted that almost one-half of Medicare ambulance trips (48.2 percent) are not taken for emergency medical care, which questions the need for ambulance transportation.

Emergency, or Non-Emergency, Part II

The National Hospital Ambulatory Medical Care Survey (NHAMCS) is a national probability sample survey of ambulatory care visits to hospital outpatient and emergency departments. It is conducted by the National Center for Health Statistics of the Centers for Disease Control and Prevention and looks at actual patient records and medical information. The 1999 NHAMCS examined more than 21,100 patient records from a probability sample survey of hospital emergency departments across the nation. The data are used to create national estimates of emergency department usage, including detailed patient information. The NHAMCS provides information on patient arrival at the hospital — including mode of transportation, payment source and the level of urgency with which the patient should be seen. Using this information, the NHAMCS can provide accurate national estimates of the number of Medicare patients who arrived at hospital emergency rooms via ambulance, and the level of urgency of treatment for those patients.

Data on the immediacy with which patients need to be seen are divided into four categories: emergent — less than 15 minutes, urgent — 15 to 60 minutes, semi-urgent — between 1 and 2 hours and non-urgent — between 2 and 24 hours. By combining data from the semi-urgent and non-urgent categories, the NHAMCS provides accurate national estimates of the numbers and percentages of non-emergent ambulance arrivals reimbursed by Medicare in 1999. For trips in which immediacy of care was reported in 1999, 459,653 of the 3,491,578 trips, or more than 13 percent of all ambulance trips reimbursed by Medicare, were for non-emergent patients.

If one assumes that the proportion of trips shown as non-emergency also applies to those trips for which the immediacy of care needed was not reported, the total number of non-emergency Medicare trips is really 13.2 percent of 4,782,847 or 631,336 ambulance trips, not 459,653.



Non-Emergency Ambulance Emergency Department Visits, 1999

Statistic	Number	Percent
Medicare		
Total Ambulance Arrivals	4,782,847	100.0
Immediacy of Care Needed Not Reported	1,291,269	27.0
Immediacy of Care Needed Was Reported	3,491,578	73.0
Care Needed Was Not Emergent or Urgent	459,653	13.2*
Medicaid		
Total Ambulance Arrivals	1,894,843	100.0
Immediacy of Care Needed Not Reported	474,292	25.0
Immediacy of Care Needed Was Reported	1,420,551	75.0
Care Needed Was Not Emergent or Urgent	297,152	20.9*

* Percent shown is of those cases where immediacy of care was reported.
Source: Tabulations by Westat based on data from 1999 National Hospital Ambulatory Medical Care Survey.

Potential Transportation Cost Savings

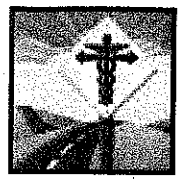
By dividing the total Medicare ambulance trips in 1999 by the total Medicare ambulance costs, an average ambulance trip cost of about $434 is calculated. Multiplying this per trip figure times the number of trips shown by NHAMCS to be non-emergency trips, the 1999 Medicare non-emergency ambulance cost is estimated at just under $200 million. This means that the potential cost estimate for these non-emergency trips rises nearly $75 million to $274 million.

If the non-emergency Medicare trips could be provided by community transportation services instead of by ambulances, substantial cost savings could be realized. According to National Transit Database (NTB) reports, the national average cost of a paratransit trip is $16.75. Note: Because these NTD figures focus on ADA paratransit trips, it is likely that the $16.75 figure overstates the per trip paratransit costs that would be applicable in many communities. For example, 2002 costs of non-emergency medical transportation providers in upstate New York are $11.00 per one-way trip. Using these various average cost figures, the cost to provide non-emergency Medicare transportation via paratransit and the cost savings of paratransit versus ambulance transportation can easily be calculated.

The average of these estimates, made by using 1999 data, is $265 million per year. Clearly, were the Medicare program to allow the use of paratransit services for non-emergent Medicare trips, a substantial cost saving would be realized in contrast to the exclusive use of ambulances. Including non-hospital trips and non-emergency trips that could have been provided by other than ambulance transportation, total unnecessary ambulance use in the Medicare program could well exceed $400 million per year.

With Medicare ambulance transportation costs now in excess of $3.3 billion annually, the Medicare legislation's insistence on the exclusive use of ambulance transportation is driving the program's costs skyward. A conservative estimate of Medicare transportation dollars that are not now being used cost-effectively is $230 million. Compared to other programs that fund transportation services, this is really a large amount.

In 1999, Medicare paid for nearly 4.8 million ambulance trips at an average cost of $434 per trip. Using an average one-way trip cost for paratransit services of $16.75, one could get almost 26 paratransit trips for the cost of one Medicare-reimbursed ambulance trip. If the $11 per trip cost figure is used, then one could get 39 paratransit trips for the cost of one ambulance trip. If the non-emergent Medicare trips that are currently being provided via ambulance could be provided with paratransit vehicles, massive cost savings could result. These savings could be invested in more transportation services, or more medical services, or both.



Estimates of Non-Emergency Medicare Ambulance Transportation Trips and Costs

Factor	Value
Total Medicare Ambulance Trips, 1999 (NHAMCS)	4,782,847
Total Cost of Medicare Ambulance Trips, 1999 (CMS)	$2,074,180,935
Average Cost of Medicare Ambulance Trips	$433.67
Estimate of Non-Emergent Medicare Ambulance Trips, 1999 (NHAMCS)	631,366
Total Cost of Medicare Ambulance Trips Estimated as Non-Emergent, 1999	$273,791,398

Source: Tabulations by Westat based on data from 1999 National Hospital Ambulatory Medical Care Survey.

Potential Emergency Department Cost Savings

The Medicare legislation's insistence on transportation provided for medical emergencies is also contributing to a growing healthcare crisis. Emergency rooms, which are in short supply and provide costly care, are becoming increasingly over-burdened as their numbers decrease and the number of annual emergency room visits increases. This problem is especially serious in rural areas, where the number of emergency rooms decreased by 11 percent from 1990 to 1999, but the volume of patients served increased 24 percent over the same period. Non-emergent Medicare patients arriving via ambulance require emergency staff to diagnose and admit, which makes an unnecessary contribution to this problem of emergency room over-crowding. Shifting non-emergent Medicare patients to paratransit services would allow them to bypass the emergency room and go directly to a physician, thus providing some measure of relief to overburdened emergency rooms.

According to the American Council of Physicians (ACP), the average charge for a non-urgent emergency room visit is approximately 2.3 times higher than the cost of an office- based visit. The ACP calculates the average non-urgent emergency room visit costs $103.25, while the average office-based visit to the doctor costs only $44.89. Applying ACP's cost savings of office-based visits ($58.36) to the national total of non-emergent Medicare patients provided by the NHAMCS, one can calculate total nationwide estimated cost savings of using office-visits versus emergency department (ED) visits, which is nearly $37 million. Were other figures used for the cost of emergency room visits, the cost savings could rise more than 50 percent, to a level exceeding $57 million.

Cost Savings from Improved Access to Preventive Health Care

Healthcare is a large issue in the United States. Healthcare expenses accounted for 13.5 percent of the U.S. gross domestic product in 1998, and healthcare costs are increasing much more rapidly than the overall cost of living index. In 1998, total healthcare expenses in the United States were

Estimates of Non-Emergency Medicare Trip Cost Savings by Using Paratransit

Factor	Value
Estimate of Non-Emergent Medicare Ambulance Trip Costs, 1999	$273,791,398
Estimate (NTD) of Cost to Provide Non-Emergent Trips via Paratransit	$10,575,381
Potential Savings (NTD) of Using Paratransit for Non-Emergent Trips	$263,216,017
NYS Estimate of Cost to Provide Non-Emergent Trips via Paratransit	$6,644,694
Potential Savings (NYS) of Using Paratransit for Non-Emergent Trips	$266,846,704

Source: Tabulations by Westat based on data from 1999 National Hospital Ambulatory Medical Care Survey.

said to be nearly $561 billion.

Health services are not distributed equally across the United States in terms of geography or access to services by specific population groups. Persons in urban areas, higher-income individuals and workers generally consume more healthcare services than persons living in rural areas, lower-income individuals, persons who are not employed and members of minority groups.

Benefits of Preventive Health Care

The Economic Benefits to Prevention

Applying preventive medical measures would generally seem to be a logical course of action. The most recent work on this subject seems to agree: spending money to prevent disease and injury and promote healthy lifestyles makes good economic sense (Centers for Disease Control and Prevention, 1999). But analysts have argued for a long time about the cost-effectiveness of preventive medical measures. Whether or not the costs of preventive care are justified inevitably depends on the type of health maintenance involved. Some forms of prevention, generally primary prevention, pay and pay very well.... For secondary prevention, it is not possible to generalize.

One argument has sometimes been expressed as the so-called paradox of health: highly effective preventive measures for some conditions could prolong life, increasing the chances that costly unrelated diseases could occur in the future and increasing the life span over which health insurance must be paid. If a preventive medical treatment were to both improve health and reduce healthcare costs, it would obviously be desirable, but the long-term health or cost effects of many treatments are difficult to predict. Various measures for evaluating the value of preventive services include impacts on health status, health effects versus net healthcare costs, reductions in net healthcare outlays and net economic benefits.

In the face of such analytical challenges, some policymakers have argued for a simple policy solution.

"It is a goal to be healthy for as long as possible and no more time should be spent on this economic question," said the Norwegian Ministry of Health, rather succinctly, in 1998. If one accepts this empowering approach to a controversial question, the question then becomes how can analysis be used to choose between several preventive practices? Part of the answer is to evaluate and compare the cost-effectiveness of certain preventive measures.

Access to Care Reduces Overall Costs

In 1998, $105 billion was spent on hospital inpatient services for patients age 65 and older, and Medicare was responsible for covering almost 80 percent of that cost. Some of these hospital costs easily could have been avoided with appropriate preventive healthcare — something as simple as scheduling a periodic health examination to check a patient's height, weight and blood pressure. Unfortunately, there are tens of millions of Americans living in rural areas, many of whom are elderly Medicare beneficiaries who lack the transportation necessary to access a medical provider for regular health checks. If improved access to preventive health care could reduce these hospital costs by only 1 percent (a conservative goal) it would save Medicare almost $1 billion each year. The economic effect of increased preventive care access would be far greater when applied to the entire health budget. All else aside, this would lead to the ultimate goal of bettering the general health and welfare of Americans.

Studies have shown that a small proportion of patients consume the largest portion of medical resources. Zook and Moore's study showed that, for a given year, the high-cost 13 percent of patients consumed as many medical resources as the low-cost 87 percent of patients. Factors noted in skewing the distribution of costs to the high-cost patients included potentially harmful personal habits like alcoholism, heavy smoking and obesity, unexpected complications during treat-

Projected Nationwide Cost Savings of Shifting Non-Emergency Medicare Patients to Office Visits Rather than Emergency Rooms

Factor	Value
Estimate of Non-Emergent Medicare Trips (NHAMCS, 1999)	631,366
Cost Savings of Office Visit vs. ED Visit	$58.36
Estimate of Total Nationwide Cost Savings of Office Visits vs. ED Visits	$36,846,520

Source: Tabulations by Westat based on data from 1999 National Hospital Ambulatory Medical Care Survey.

Team Tales

Profiles from Communities Participating at the Institute for Transportation Coordination

To give readers a clear idea of what issues ITC teams are tackling and how their efforts have fared thus far, we provide capsulized profiles of eight teams.

California State

ITC Year: 2006

Team Participants

Peter Steinert
Formerly of CalTrans

Linda Campbell-Deavens
Deputy Executive Director of Operations, Technology, and Maintenance
Paratransit, Inc.

Jacqueline Hood
Transportation Coordinator
Sacramento County Department of Human Assistance

Clay Kempf
Executive Director
Seniors Council of Santa Cruz and San Benito Counties

Vision

To bolster coordinated transportation efforts among state agencies and in local communities. The California team's primary focus was the development of strategies and a preliminary timeline for the implementation of a 12-month Mobility Action Plan (MAP) to improve human services transportation coordination in the state. The team's plan called for the development of training and outreach modules to educate transportation providers about state coordination efforts. Through the Action Plan workshops – implemented at one statewide conference and five local workshops – the California Association for Coordinated Transportation identified more than 100 community stakeholders willing to support transportation coordination activities in their region. The workshops also provided many resources that agencies could use to assist them with coordination and planning projects.

Innovative Approach

The California team planned that, through the Mobility Action Plan training and outreach sessions at the CalACT Spring Conference, participants would develop the skills and receive the supporting materials to advocate for coordination and the project effort in their communities. Those participants will also serve as emissaries to facilitate the hosting of regional workshops to address the specific needs of selected communities. The impact of these efforts will be the building of an active partnership of community stakeholders in developing and supporting coordinated transportation processes and planning activities, including the development and enhancement of coordinated services in those communities, and support of the statewide implementation effort.

Next Steps

The Mobility Action Plan advisory group is now working on a Memorandum of Understanding between state agencies and a charter for the advisory committee. A subcommittee is reviewing current state laws that obstruct or prohibit coordination efforts in the state. The advisory committee will then disseminate the information and projects developed to all the community agencies that attended the MPA workshops funded by the Community Transportation Association of America.

El Paso/West Texas

ITC Year: 2006

Team Participants

Robin A. Roberts
Human Services Transportation Coordinator
El Paso County Rural Transit

Janet Bono
Plans Manager
Upper Rio Grande at Work

Xavier Bañales
Chief Executive Officer
League of United Latin American Citizens Project Amistad

Robert Schwab
Human Services Transportation Coordinator
El Paso County Rural Transit

Vision

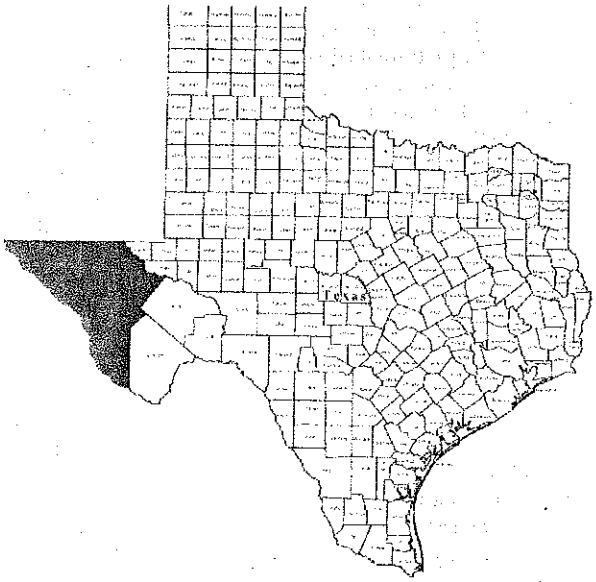
To create customer-centered, attractive, dependable, convenient, and safe transportation choices for all people in this six-county, 18,000–square mile region that stretches across two time zones. Five of those counties have no form of public transportation at all.

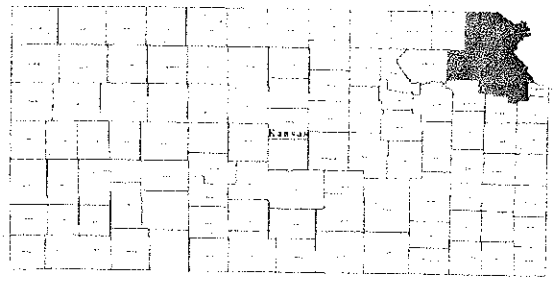
Innovative Approach

To support its efforts in fulfilling its mission, the team was awarded a grant from the Community Transportation Association to research the process of creating a rural transit district that could offer a regional inter-city transit system, which was identified by those communities as their highest mobility priority. In the true spirit of coordination, the team worked with all the local communities and achieved the approval of governmental authority in five of those six counties to adjust its plans slightly and instead of creating a new rural transportation district, to join the adjacent Permian Basin Rural Transit District. This has led to the creation of public transit services for the first time in four of the five unserved counties.

Next Steps

The team will continue to work toward its vision of transportation for all by facilitating the efforts of the sixth county to join the Rural Transit District.





Kansas City Metropolitan Area, Kansas/Missouri

ITC Year: 2006

Team Participants

Marge Vogt
Council member
Olathe City Council

Tiffany Jasper
Strategic Project Manager
Full Employment Council/Missouri Career Center

Jake Jacobs
Executive Director
Jackson County Board of Services for the Developmentally Disabled

Jim Courtney
Executive Director
Mr. Goodcents Foundation

Leslie Ober
Transportation Coordinator
Johnson County Mental Health-Community Support Services

Sharon Bryant
Director, ADA Compliance & Customer Relations
Kansas Area Transportation Authority

Vision

To improve access to regional mobility services. The first step toward achieving that vision is to identify available resources and mobility needs, providing the foundation for enabling legislation and ballot initiatives.

Innovative Approach

The team modified the Federal Transit Admnistration-developed United We Ride Community Self-Assessment Guide into a tool that focused less on daily operations of local transportation services and more on community policy issues. This revised guide was then introduced to – and used by – local elected officials and their key staff to communicate their priorities for transportation in their community. Simultaneously, the transportation stakeholders in the community completed the non-modified guide, with more detailed information on local operational issues. The two sets of answers were then merged into one report, which was then discussed with both groups at a single meeting.

Next Steps

This self-assessment process stimulated a valuable discussion on local mobility issues within the two communities in which it was implemented. In one community, an existing task force was re-energized to look at the transportation needs of the local community and in the other community, a new task force was formed to look at these same issues.

Montrose County, Colo.

ITC Year: 2007

Team Participants

Eva Veitch
Executive Director
Montrose County Senior Citizens Transportation, Inc.

Dale Ann Suckow
Disability Program Navigator
Colorado Workforce Center, Western Region

Peter Crowell
President, Board of Directors
Montrose County Senior Citizens Transportation, Inc.

Lacey Anderson
Former Program Manager
Aspen Diversified Industries, Inc.

Vision:

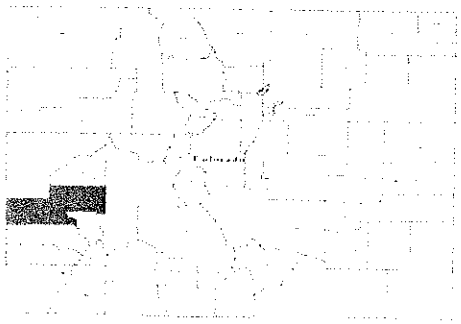
To provide public transportation for all residents in Montrose County, located in western Colorado.

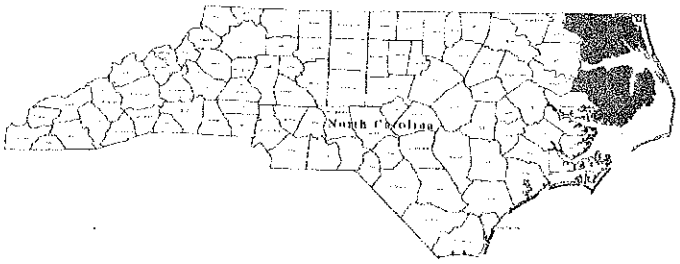
Innovative Approach

Following the Institute, core players formed the community-based group *All Aboard Montrose* and hosted a public forum, facilitated by the Association's Charles Rutkowski and Region 8 Coordination Ambassador Jeanne Erickson. Attendees included local and state officials, public service agencies, citizens and local employers who voiced support for meeting more of the county's mobility needs through the establishment of a public transit system. Following the public forum, the *All Aboard* team met separately with county, city and Chamber of Commerce officials to request that each entity designate a staff person to be assigned to the team, which will function as a task force in the planning to establish a public deviated, fixed-route transportation system by January 2009. Those meetings also resulted in discussion of creating a transportation district tax base for secured funding.

Next Steps

The *All Aboard Montrose* team attended a City Council Work Session in December to present the comprehensive marketing plan and action steps being developed by the task force. An action plan for the new transportation service that garners the commitment of the key stakeholders, including area businesses and public officials – and that pursues federal, state and local private and public dollars to initiate and sustain the new system – will be fully developed. The *All Aboard Montrose* team will continue to enhance local government support and explore possible tax-based funding options. In addition, the task force is working to enhance collaborative relationships with existing transportation service providers.





Northeastern North Carolina Region

ITC Year: 2006

Team Participants

Patrice Taylor-Lassiter
Director
Gates County Inter-Regional Transportation System

Carter C. Dozier
Workforce Development Director
Northeastern Workforce Development Board

Beverly Paul
Director
Hyde County Transit Authority

Sue Scurria
Director
Albemarle Commission Area Agency on Aging

Kenny Kee
Dare County JobLink Career Center Manager
NC Employment Security Commission &
Northeastern Workforce Development Board

Vision

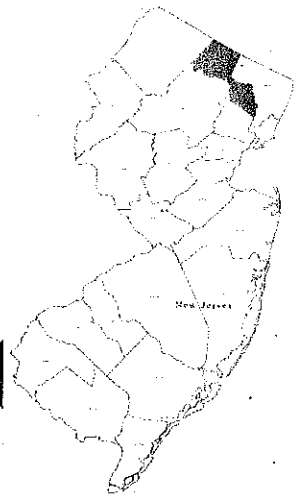
To develop a regional transportation coalition whose systems are seamless and adequately serve the citizens throughout the 10-county northeastern region of North Carolina.

Innovative Approach

To promote coordination among all transportation providers in this region, the team determined that one of its most important activities was to create a common vision among all stakeholders, beginning with a coordinated view of transportation needs and potential additional transportation corridors in the region. The team, led by its workforce development partner, will be one of the first to use *Google Earth/PowerPoint* technology in its presentations to local stakeholders. The technology is being used to visually demonstrate major trip generators, residential and commercial corridors, and current transportation routes.

Next Steps

The team has identified two counties—Washington and Tyrell—as priorities for the development of coordinated services. This process will be an excellent example of cross-county coordination, reflecting a need to focus on people's needs rather than geographic boundaries. The Northeastern North Carolina team is also receiving assistance through the Community Transportation Association's Rural Passenger Transportation Technical Assistance program.



Passaic County, N.J.

ITC Year: 2007

Team Participants

John McGill
Work First NJ – Transportation Coordinator
Passaic County Department of Human Services

Natalie Provenzale
Executive Director
Passaic County One-Stop Career Center
Workforce Development Center

Madeleine Soriano
Disability Services
Passaic County Department of Senior Services, Disability and Veterans Affairs

Shirley Force
Passaic County Information and Assistance Supervisor
Passaic County Department of Senior Services, Disability and Veterans Affairs

Rich Felsing
Transportation Planner
Meadowlink Transportation Management Association

Vision

To develop a strategy that combines innovative technology with a mobility manager and community partnering to create a centralized transportation resource clearinghouse within a call center. This technology strategy will enable Passaic County to effectively coordinate services for customers thereby providing greater mobility and independence. It will also give customers a single phone number to call for rides and ride information.

Innovative Approach

To ensure improve mobility options through coordination, the Passaic County collaborative will reach out to partners who have traditionally been outside the county's transportation planning process. The collaborative's leaders will undertake outreach to involve the business community as well as to Freeholders (elected county officials), local towns, and health care providers, and craft a common focus and county-wide vision for meeting transportation needs.

Next Steps

To convene several meetings – large group and one-on-one – with core stakeholders, businesses and Freeholders to discuss the importance of a coordinated approach to meet transportation needs and services, share ideas for moving toward this mobility vision and establish strong bonds among these community members.

Snohomish County, Wash.

ITC Year: 2007

Team Participants

Jerri Mitchell
Director of Housing and Program Development
Catholic Community Services

Mary Jane Brell Vujovic
Director of Strategic Initiatives
Workforce Development Council Snohomish County

Deanna Dawson
Snohomish County Executive Director
Snohomish County Office of the Executive

Darren Brugmann
Transportation Director
Senior Services of Snohomish County

Cheryl Jones
Mobility Coordination Manager
Volunteers of America Western Washington

Vision

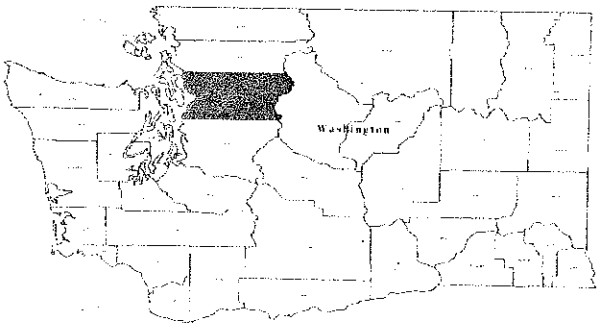
To develop a coordinated transportation plan that serves Snohomish County veterans by removing barriers to medical care, job training, employment, and other services.

Innovative Approach

The Snohomish County team shares the Association's concern with meeting the mobility needs of veterans. Snohomish County is larger than the state of Delaware and consists of urban, suburban, and rural areas. While many areas of the county are served by various public and private transportation agencies and programs, the eastern half of the county is largely unserved. Additionally, many services for veterans are located in neighboring counties. These factors present significant challenges to ensuring seamless mobility and access to services for many of our community's veterans. The Snohomish County team is working at three levels to launch its *Coordinated Transportation for Veterans* effort.

Next Steps

To make final governance decisions by the end of January, 2008. Additionally, the partners plan to finalize their logic model and strategies for service delivery planning by March, 2008 with the development of a comprehensive plan as an eventual deliverable. Finally, the team will collectively continue to seek out resources to support its shared efforts.



Washburn and Sawyer Counties, Wisc.

ITC Year: 2007

Team Participants

Bob Olsgard
Transportation Coordinator
Northwest Center for Independent Living

Carl Krantz
Director
Washburn County Veterans Service Office

Kristin Frane
CEO
Ventures Unlimited, Inc.

Bruce Miller
Board of Supervisors
Sawyer County

Vision

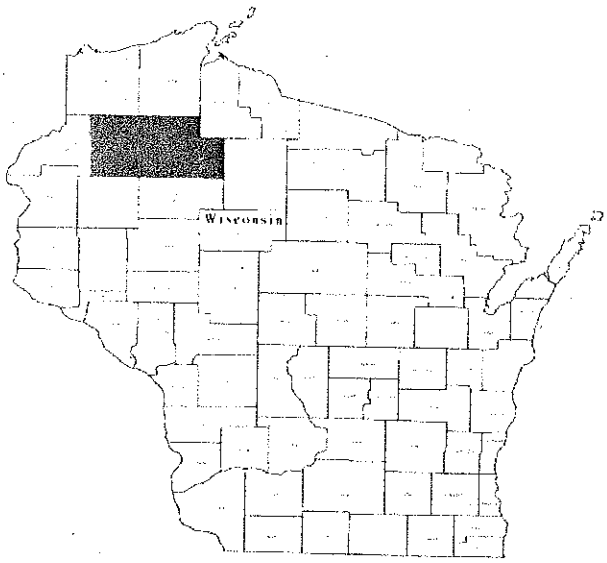
To build a regional multi-modal, multi-state transportation system for all local residents.

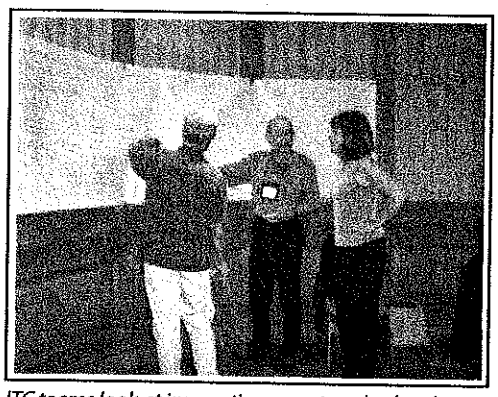
Innovative Approach

The area's current transit system – Sawyer County/Lac Court Oreilles Transit – is already an excellent collaboration example between two entities. Sawyer County and the Lac Court Oreilles Tribe boasts equal ridership from both the tribal nation and the surrounding county. Now the Washburn/Sawyer Counties Institute team is working with both counties to expand the human services transportation system to provide a combination of demand-response and fixed-route service into Washburn County, which currently has no transit system. Funding for the expanded service is being sought from the Wisconsin Department of Transportation's Supplemental Transportation Rural Assistance Program, which requires an 80/20 match. The contracted service provider, Ventures Unlimited, Inc., will provide the service while Sawyer Co./LCO Transit will operate a centralized call center and implement scheduling software. Also, the expanded system will help the region's veterans reach new regional medical facilities in nearby communities. The Washburn/Sawyer Counties Institute team included a Sawyer County Supervisor who also chairs the Sawyer County Transit Commission. This team member was instrumental in discussing the benefits of a regional transportation system with the Washburn County governance bodies.

Next Steps

In 2008, the team will implement expanded service in both Washburn and Sawyer Counties, facilitated through a one-call center. The team will also lead efforts in 2008 to more effectively market the availability of current and new services, beginning with a "name the bus" campaign.





ITC teams look at innovative ways to solve local mobility challenges.

Every beginning has a barrier built into it. Don't entertain your barriers — by that we mean get creative. It's much more fun to think of solutions than to sit around and complain. Coming up with creative ways to overcome perceived barriers is a true delight!

-Cathy Brown, Executive Director
St. John's County Council on Aging

Each team has an opportunity to discuss its goals.