NOTES
Transit CEO Rides to Wellness Summit
10AM-noon on Saturday, October 3, 2015
Hilton San Francisco Union Square
San Francisco, CA

Introduction

The Federal Transit Administration (FTA) Acting Administrator, Therese McMillan, hosted an information exchange on the Rides to Wellness Initiative with key transit CEO's the weekend that the American Public Transportation Association began its annual meeting. The purpose of the summit was to share thoughts and experiences about developing partnerships between health and transportation providers in local communities. FTA's Rides to Wellness Initiative seeks to enhance these partnerships through activities that build commitment, provide investment, and drive change so people can get to the health and wellness services they need, and we can reduce the effects of chronic conditions – both in terms of a better quality of life through better health for people, and reduced costs within the healthcare system. With the changing nature of healthcare – moving from an acute care model to a wellness model – access to all health and medical services are essential. There is an increased need to leverage resources across the health, wellness and transportation sectors to help people avoid unnecessary hospital readmissions; reduce missed appointments; ensure access to free health screenings; and other important health/wellness services.

Participants were engaged to help FTA craft the messages and focus of Rides to Wellness. The event began with a welcome, overview of goals for the discussion, and introduction of the panelists by Acting Administrator McMillan. The three panelists from the health sector shared thoughts to help frame perspectives then an open forum engaged the audience. Associate Administrator Henrika Buchanan-Smith moderated the discussion using some probing questions and with some Rides to Wellness Planning Grantees sharing their experiences to date with their projects.

Attendees

Panelists:
Tyler Norris, Vice President, Total Health Partnerships, Kaiser Permanente, Oakland, CA
Lori Gerhard, Director, Administration for Community Living/HHS
Mike B. Roaldi, VP of Policy and Product Design, United Healthcare, Denver, CO

Transit executives:
Barry Barker, Transit Authority of River City (TARC), Louisville, KY
Edgar Benning, Mass Transportation Authority, Flint, MI
Donna DeMartino, San Joaquin RTD, Stockton, CA

Holly Edinger, Lehigh and Northampton Transportation Authority, Allentown, PA
Kelly Fairless, Valley Metro, Boise ID
Jeff Hamm, CTRAN, Vancouver, WA
Tom Hicks, Monterey-Salinas Transit, Monterey, CA
Michael Hursh, AC Transit, Oakland, CA
Christian Kent, WMATA, Washington, DC
Ron Kilcoyne, Lane Transit District, Springfield, OR
Jeanne Krieg, Eastern Contra-Costa Transit, Antioch, CA
Farhad Mansourian, Sonoma Marin Area Rail Transit, Marin, CA
Kenneth McDonald, Long Beach Transit, Long Beach, CA
Neil McFarlane, TRI-MET, Portland, OR
Kimberlee A. Morton, Norwalk Transit District, Norwalk, CT
Ed Reiskin, San Francisco Municipal Transportation Agency, San Francisco, CA
Gary Thomas, Dallas Area Rapid Transit, Dallas, TX
Carol Merrill, King County Metro, Seattle, WA
Louwana Oliva, Centre Area Transportation Authority, State College, PA
Rick Ramacier, Central Contra Costa Transit Authority, Concord, CA
Cain Williamson, Atlanta Regional Commission, Atlanta, GA

Other attendees:
Flora Castillo, Vice President Community and Strategic Engagement, United Healthcare, Philadelphia, PA

Department of Transportation Participants:
Therese McMillan, FTA Acting Administrator
Henrika Buchanan-Smith, FTA Associate Administrator, Office of Program Management
Kimberly Sledge, Director, FTA Office of Transit Programs
Mary Leary, FTA Division Chief, Rural and Targeted Programs
Ellen Partridge, FTA Chief Counsel
Jeremy Furrer, FTA Special Assistant to the Acting Administrator
Stephanie Gidigbi, Deputy Director for Public Engagement at the U. S. Department of Transportation (DOT) Office of the Secretary

NCMM Staff
Judy Shanley, NCMM – Easter Seals
Amy Conrick, NCMM – CTAA
Rich Weaver, NCMM-APTA

Invitees who did not attend:
Richard DeRock, Link Transit, Wenatchee, WA
Nuria Fernandez, Santa Clara Valley Transportation Authority, Santa Clara, CA
Barbara Murdock, Birmingham-Jefferson County Transit, Birmingham, AL
Opening Remarks

Panel Notes:

Therese McMillan (Acting Administrator, FTA)

Rides to Wellness is a ground breaking initiative and there is a lot going on right now in our joint industries to connect the dots between transit service and access to healthcare and health, in essence we are redefining health! Today I'd like to accomplish three things:

-Share with a cross section of transit agencies information about our Rides to Wellness program and how it can help your communities;
-Provide an opportunity for health providers to share their perspectives
-The important role access plays in healthcare outcomes.

This intersection of health and transit has been around for many years, but mostly in a narrowly defined area of coordination of non-emergency medical transportation (NEMT) between DHS-funded programs and DOT-funded agencies. Now with the Affordable Care Act and the changes occurring in the health system around prevention, we need to be broader and solutions need to be more creative than just determining how to share costs between programs. We want to hear what communities are already doing in this area, as well as your expectations regarding how Rides to wellness can help you.

Post the Affordable Care Act, there are hundreds of people who now have insurance but we need to be sure everyone can get access the care provided by these opportunities. We have an important role as the transportation community to be sure everyone can leverage these resources. The numbers are staggering in terms of how lack of access affects the healthcare. Over 50 million people need access to health care in many categories. One pivot point for me is that missed appointments are a major cost driver in medical community. Approx. 3.6 million people miss preventive care because of a lack of access to transportation access. The scale of what we are trying to do is impactful. We know from anecdotal stories about patient readmission that it is a huge cost driver. We also know that when people use the emergency room as their vehicle for standard access to health care, it becomes a major cost to the industry. How can we address that particular issue? Other issues include care for chronic conditions, maintaining people's health, helping people access supportive networks and services (e.g., healthy food). So, we want to see how we can address the issue. Maintaining health is not just getting to a doctor when you are sick but how do you remain healthy by being able to access to healthy foods, preventive services, and others. We need to be rethink our perspectives and solutions.

What I am excited about is Tyler Norris participated on the March 11 Summit where in the same room we had federal officials, the healthcare industry and transit providers, a eureka moment with inclusive dialogue that helped us redefine how we should approach this challenge.

Rides to Wellness is a strategic initiative to drive change, increase partnerships, and leverage investments to identify what works. At the end of the day, our goal is to

improve health care access. This is an opportunity for us to define access and communicate the importance of access. After passage of the Affordable Care Act, thousands more people have had access to health insurance. But if they can't get there, that's a problem. At the federal level, we are interested in leveraging what is happening at the local level.

What I am excited about is that Tyler Norris participated on the March 11 Summit where in the same room we had federal officials, the healthcare industry and transit providers, a eureka moment as we had never had that inclusive dialogue before so it was an important moment to redefine how we should approach this challenge

Henrika Buchanan-Smith (Associate Administrator, FTA)

We are used to talking about NEMT and cost allocation as a paratransit issue, so one of the things I will ask is that you set that aside that perspective. What we are talking about is much broader. At our March 2015 transportation/health care summit, Maureen Pero from CareSource showed a graphic of the spectrum of patients who need access to care, from the healthy child to the person who needs ambulatory care, and at each level, what they need to stay healthy. There is an opportunity for public transportation to be part of the picture and step up. In the communities, we see hospitals starting transportation services, nurses paying for patients' taxis. We see communities jumping in to be part of the solution. We'd like to see how the federal government can encourage these types of partnerships and what you need from us to stimulate these partnerships.

(Henrika introduces the 3 panelists)

Mike Roaldi (United Health Care)

Mike Roaldi, Esq. Vice President of public policy and product design at United Health Care (UHC). Focuses on the link between innovation and public policy.

At UHC, we are aware of the link between transportation and health care costs and outcomes. UHC is the 14th largest company in the United States, and the largest health insurer in the world. Our mission is to tailor programs and service options to meet the needs of Medicaid patients. Transportation is a huge piece of our structure and our strategic planning to deliver services. We believe that engaging our members in this issue can lead to lower costs. Engagement is a key piece. There is a link between transportation and health care costs. Our mission is to provide health care that is person centered.

Our initial focus is on a small sample size of high utilizers: the top 5% of these high utilizers is where the opportunity for innovation is, where we can see the greatest cost savings. We want to track patient care through the services of a care manager who will help to manage these patients. We will use care managers to deliver services better and track the impact of doing so on cost and health outcomes. We want to talk to transit.

Less than 5% of our members use NEMT. Those services are underutilized for many reasons, from a lack of awareness about them to the actual product itself to wait times, scheduling, and even the stigma associated w/NEMT. We believe there is underlying capacity in the NEMT system we can access through partnerships and innovation. This can impact heath.

Before coming here, I sent an email to several of our case managers, asking them to respond with anecdotal accounts of the impact of connecting our members to transportation. I received many responses, some of which I haven't had a chance to read yet. I do recall one response from a care manager in Arizona who recounted this story. She was connected to the father of a wheelchair-bound individual w/multiple diagnoses. For years he couldn't get transportation to get to his neurological exams. One result was that he was hospitalized 7 times within a recent 12-month period. She was then able to organize a van for him that was outfitted for his needs. Once he entered our program, it allowed him to access the services he needed. The stigma associated w/his difficulties began to disappear. The father had told our case manager, "Our son had a huge smile on his face the first time he had access to the van. And then the anxiety related to getting to medical visits washed away. As a result, he was hospitalized only once in the next twelve months. This story demonstrates the impact of transportation on the folks we are serving.

Mike's further comments focused on:

- How UHC mission is tailored to services to meet the needs of Medicaid members;
- Transportation is a key part of engagement;
- Transportation is one of the social determinants of health;
- There is a link between transportation and health outcomes;
- Provide services in a person-centered way;
- We are uniquely positioned to pilot/prototype because we have an enormous about of data; If we can create strategic partnerships – we can prototype;
- UHC has a person-centered care model – a client is assigned a care manager who coordinates services, including transportation , and UHC we can then track outcomes for any intervention, including transportation;
- How UHC wants to start talking with transportation providers – less than 5% of our members use non- NEMT; there are many obstacles – lack of awareness – lack of product (wait times, social stigma). There is underlying capacity that we can leverage;
- We don't want to lose the person focus of this as sometimes it all seems so clinical. So, I want to share an example: this is from a care manager in AZ – she was connecting with the father of someone who used a wheelchair – the person didn't have transportation – he was hospitalized 7 times; the care worker then organized a van so that he was able to access services. The result was his anxiety and stigma disappeared; In his father's words – his son had a huge smile and had access to a van so he could be mobile. And he was hospitalized only once in next 2 months (versus 7 times in the previous year).

Lori Gerhard (Administration of Community Living-ACL)

I'd like to talk about three things. First, our long-standing partnership with the FTA. ACL is a new department, and was formed by combining agencies that worked on aging and disabilities issues and the administration on intellectual disabilities. We recently had 3 new additions to our agency—the assistive technology program, the National Institute for Disability Research, and Centers for Independent Living. These additions round out our program; all are very people-centered. Now we can leverage our collective work.

Our mission is to maximize the independence and wellbeing of people with disabilities and older adults. One of the things we have done to accomplish this is that we have clarified policies—for example, that Title IIIB money can be used as match for FTA 5310 funds. We collaborate with communities through grant programs to support local programs on access issues, with FTA and ACL as co-leads. In fact, we have partnered with FTA for over 20 years. We want to look at how we can involve people with disabilities, their parents, and their caregivers in their care and transportation planning. We are using a continuous quality improvement approach to see how that works. We have also been able to tap into FTA's Section 5317 funding.

Second, I will discuss our shift to home- and community-based services (HCBS) and why that shift makes our partnerships so important. No one really wants to go into a nursing home even though they are good places – I am a nursing home administrator by trade. We are coming to an apex in the shift from institutional to HCBS. Now we are refining this so we can be more responsive to consumers. As we begin to learn about what people are seeking, transportation is the lynchpin. People want to stay engaged in their community, but people cannot engage in the community if they cannot get out of their home.

We know there have been breakthroughs in coverage, innovations in care. The public payer system was earlier engaged in building out infrastructure to provide care. We are now tweaking that system based on feedback from the people we serve. People cannot engage in their communities if they cannot leave their homes. Transportation is critical.

We want to learn how we can do more together. Truven, a CMS contractor, in April 2014 announced that HCBS spending had increased by 2.4%, whereas spending in institutional care had decreased by 2.3%. These were 2012 figures. And the trend continues to play out, and as a result of this shift, states are changing their systems with no wrong door systems.

Often people need more than one service and more than one funding stream to put their plan together. We see the value of person-centered counselors who don't take over but who interface with the system to help match people to the services they need. Person-centered planning is not just about putting the person in the middle; it is really a culture shift. We've forced people to fit into funding streams, and often this don't help, and may even lead them to change their goals and become more rather than less dependent. One-call/one-click centers and mobility management are key to accomplishing these goals.

The veterans flexible service system was created to respond to where needs are burgeoning. Here's a story to illustrate how it could be tweaked to help. This involves a veteran and her husband, who was also a veteran with a traumatic brain injury that occurred when he served in Afghanistan. Both are in their late 20s. Her husband is a marathon runner, but now cannot run on his own because he gets lost. They went to the VA for support. She is his primary caregiver. The VA told her that it could provide her husband with adult day services and home health services. He replied, "I don't want to go to a kennel and I don't need babysitter. What I need is just an Army buddy to run with me so I don't get lost. " So we need to do a better job matching services with people. The VA program changed to make dollars flexible to help people with disabilities that need transportation to jobs, social activities, etc.

Third, I want to share some success stories. We develop state plans and local plans. In Prince William County we see an example of transportation coordination within the county, where the Council on Aging connects people to a voucher program. In Knoxville, Tennessee, there is a demonstration program. It seemed that people with disabilities and bus drivers were not communicating well. The community brought in the University of Tennessee, who developed a communications app, so now people with disabilities and bus drivers can communicate in real time on the bus. This innovation has improved the quality of the trip and experience of both passengers and drivers.

Lori's comments focused on:

- Partnership with FTA – new organizations – very people centered agencies – now under ACL.
- Bringing funding streams together;
- We know solutions are at local level;
- Grant programs – inclusive coordinated transportation planning;
- Tapping into 5317 funds and match with OAA funds;
- ACL shift from institutional long-term supports to community care;
- Now we are responsive to individual consumers;
- Transportation is the lynchpin…people can't engage in the community if they can't get out of the home;
- Trends show increased spending on community care – as a result – states are changing systems…no wrong door system;
- People with long-term care need more than one funding stream;
- Use person-centered counselors – listen to needs and hear how people want to solve problems – help people blend funding streams;
- Person centered planning is a cultural shift;
- Mobility managers – one-call – one click – are useful and similar models to what HHS is trying to do.

Tyler Norris (Kaiser Permanente)

I want to broaden our focus here to think about multiple views of health care including equitable, accessible mobility as a key social determinant of health. Without it, we drive up costs. Equitable, accessible mobility is essential to the economy and vitality of our communities and an arm of economic development. Equitable, accessible mobility is a prerequisite for full participation in society, and is a determinant of health. Active transportation is a key piece of this. Recently the Surgeon General called for more walking and walkable communities. The health care–transportation partnership can lead to systemic strategy that leverages all of the elements of equitable, accessible mobility.

Health care expenditures represent 18% of our economy. Kaiser is accountable to our members, not Wall Street. We are also a large company with over 20 thousand employees. We're not only an insurance provider, but also a care provider. We do better when we have a healthy population. Only 10% of people's health is related to their access to care. We look at mobility as a key driver to activities that are key determinants of health, such as access to food, jobs, etc.

What is the business model? Our goal: best quality at best cost for the best population health outcomes. How do we do this? Mobility for our employees. This has to do with where we locate our offices and facilities. For example, we located our new IT campus, where we have 900 new jobs, in central Atlanta between two MARTA stops so that our employees could access transit. We know that those short trips walking to and from transit can lead to better health outcomes for our employees.

We also give people access to preventive and wellness care as well as access to care for chronic conditions. We look to provide "care anywhere." We promote active transportation. At every single visit to our care centers, where we serve 10 million members, our providers ask them about their physical activity. We actually write walking, bicycle prescriptions. Walkability has everything to do with vitality. We have a "walk initiative. " We are working closely w/Smart Growth America on Complete Streets, and are deeply involved w/Safe Routes to School programs. We are also working closely w/cities to improve bike/pedestrian safety working closely with cities around vision zero to improve bike/ped safety as well as working with heel cities and mayors in how we can design these strategies.

Our special focus is around two populations: 1) older members who are no longer driving and have no access to transportation. Many of them live in the income gap in which they can't access free NEMT, but do have not enough money for a taxi. They want to age in place, reduce their social isolation. 2) Low income people who are not elderly who fall into gaps. We now have 8000 Medicaid members, and we lose money on each of those. But we need to deliver the highest quality care and if reimbursement keeps getting cut we need to be ever more thoughtful on our partnerships. But we accept that. If we want to deliver the highest care to them, we need to be thoughtful about how to get them here and manage their care in partnership. They are providing transportation to those members who qualify for it. They are talking about expanding their benefits to be sure there is a transportation benefit tied to health.

We are talking about expanding our benefits, especially with Medicare recipients, to ensure there is access to transportation. It is unique to our model, trying to have access to where all our members live. Sometimes we need to move a member to a hub through transportation, moving people among our facilities. We work with community transportation but need to be creative in doing so (e.g., working with agencies that can't/won't cross county lines). Our medical centers provide taxi vouchers on the spot when needed, but we are trying to build this much more systematically.

We have launched a transportation pilot w/CMS, for those members who have to go out of pocket for their transportation to see how we can meet the needs of their members for whatever needs those members have. We still look at the need for curb to curb services, affordable rides, addressing scheduling conflicts, isolation of members, and protecting against fraud. We are addressing some of these issues by coordinating with Logisticare to get smarter access and to create opportunities for members in our community. We are accessing this care and how we access this network with vetted transportation providers in a networked way that can provide accessibility at reduced cost. It is safe to say that we have great starts to this conversation, but we are still at the beginning of what needs to occur to have a coherent transportation system that delivers on the business realities that we face to build a transportation system that delivers on not only the health care needs but also the healthy living side and how that undergirds economic development and prosperity.

Tyler's comments focused on:

- Multiple views of health sector;
- Equitable and accessible transportation – 1) drives costs; 2) enhances vitalities of communities – transit can become part of economic development; 3) Prerequisite participation in society – reduce health disparities;
- Active transportation – starts with walking or biking – focus on walkable communities;
- We need to look at systemic strategy;
- Health sector – 18% of economy – how are we getting a return on health?
- Kaiser focused on what creates health – what is benefit to members?
- We are not only an insurance provider – we are a care provider;
- Only 10% of creating health is access to medical care; Focus on education, housing, food, jobs.
- What is the logic model 1) Best quality care; 2) Best care; 3) Best population outcomes.
- Mobility for our employees – drives where we locate our businesses; Transit links are a primary part of business locations.

Discussion Notes:

Therese

We sometimes talk in different languages. What we heard from our speakers is that the issue of transportation as a social determinant of health is fundamental. We understand this intuitively, but I want us to think about it more deliberately. The engagement of the community and person-centered delivery are models that reflect our mobility management model (e.g., how can we use trip planning services to better connect people to services). Mobility Managers can ask patients: What are your travel needs? Do you know about what's available? Simple things like a trip making app. This is person-associated focus is a change and ground breaking. There are alignments between all of us with these changes with a delivery system that asks about a person's travel needs then provides an application [on either a stationary or mobile web-based platform] that helps to connect transportation resources to meet these needs. If we can do this, it will be a huge step forward.

One thing I want to underscore: transportation reduces healthcare costs but it does not entail shifting the cost to transit. Transit has incremental value to add, for example, through connecting existing services to health facilities. In this regard, it is important for transportation to be at the table to co-develop service delivery solutions for things that are mutually important to health and transportation, simple things like deliberate siting of transit lines to access healthcare facilities, and we are beginning to see this happening more often. Place-based decisions, last mile connections between services, and other factors can be barriers that prevent access to healthcare. Together, we can think creatively to reduce barriers if we talk to each other more often.

We're not coming to this access to health care solely as a public transit problem. We want to know what the most effective use of public transportation is. We are re-looking at what transit looks like within the changing nature of transportation and new emerging trends.

Holly Edinger (Lehigh and Northampton Transportation-Allentown, PA)
I work for a hospital. I want to say that this does not only rest on transportation's shoulders. I give a lot of credit to Kaiser for placement of its clinics near transit. There are significant challenges for seniors in places where transit systems do not exist.

Therese
Suburban and rural residents still have major healthcare needs. What can we do to fill the gaps with what we have?

Barry Barker (TARC-Louisville, KY)
I like the discussion focusing on the customer—moving beyond health care to healthy living, health and wellness.

Henrika

What is different about the conversation is that we are now engaging with the health care field. The Affordable Care Act has had a huge impact. Transit is uniquely positioned to help. There is a market opportunity here.

Question 1:

Henrika to NCMM health care transportation grantees: What trends are you seeing?

Carol Merrill (King County-Seattle, WA)
King County now has a program for low income residents. Many years ago with employment transportation, we went to the state and pushed transportation reimbursement for employees who use alternative modes. Now all large employers in Washington offer the transit benefit program. They tell us they can't hire if a transit option is not offered. $ 60 million of our revenue comes from business accounts—including social service and human service agency employers. We have had contracts w/Catholic Charities, Hopelink, YMCA, etc.

One challenge we have is unnecessary administrative costs with one or our providers – Hopelink. Hopelink does both NEMT and emergency transportation to the tune of about a half a million dollars. Every person who needs a ride gets a ride. So individuals call Hopelink, tell them they need to make a trip, Hopelink approves the trip and adds the funds they need on their transit card. This happens over and again, trip by trip. How much does it cost Hopelink staff in administrative costs to approve a $5.00 trip? Can't we give them monthly passes? One of the difficulties is that the regulations say that we must report these cost trip by trip, so this is how we have to do it. Yet it takes so much time and money for administration.

Ed Benning (Mass Transportation Authority-Flint, MI)
About 3 years ago, we began looking at health care transportation because people are living longer. The senior population is growing, plus there is the impact and opportunity of the Affordable Care Act. When we looked at the needs and realized that what we have to work with is paratransit, we realized it was not going to work in its present configuration. The NCMM Challenge grant came at good time for us. We were already working with groups in the field on behavioral health.

We have set aside Medicaid and Medicare as one option, and we are looking at other partnership options including private providers, hospitals, Area Agencies on Aging (AAA), and consumers, meeting with them as well as working with brokers. We realize that we can best serve the community as a vendor, not as a broker. We are currently working through seven contracts (e.g., AAA, Medicaid). Medicaid is paying a capitated rate that almost equals our fully allocated cost.

We are working with the hospital to help it meet PACE[1] requirements (a fully wrap-around program that helps to prevent readmissions). We are the only transit agency that provides door-through-door service to PACE participants. We do 500 trips per day to the PACE program. Top officials in the hospital are very interested in transportation, so they are willing to pay us a rate for it. We are also looking at using sedans and not buses to provide services.

Our NCMM Challenge project will have a navigator or a mobility manager so people with disabilities are able to use them so they don't have anxiety about transportation. We may lease some vehicles. In our community, we also have food deserts; so they started a new service to get people to healthy food. In fact, we are being featured in a story on food deserts. For me and for my employees, this allows people to be independent and live in their home with access to community-based services. Our viewpoint is let's provide the service and then provide the funding piece. It is much easier than we anticipated. We are not trying to do it all; we are just trying to make a difference in our community. We will be mixing private and transit resources. It is not a one size fits all. We need to use all modes. We have brokers who bring in providers who are not well monitored and not providing quality service and those are issues that have to be addressed.

We also have a Rides to Groceries program. We have food deserts-where grocery stores closed – there is a documentary being made about this right now. Funding here is not a problem, again as I shared earlier, driving these partnerships are much easier than we expected.

Kelli Fairless (Valley Metro-Boise, Idaho)
For us this has been a capacity-building project. We are one of two states that does not have dedicated transit funding. Our counties have had major budget restrictions. Our hospital's satellite clinics are outside of the urban core. We participated in the Healthy Communities Initiative and saw for the first time that health care was interested in the transportation issue. United Way invited healthcare folks to talk to Valley Regional Transit, and we began meetings with them about their needs and identifying their social determinants of health. Then the challenge grant opportunity arose, and it was a perfect fit. The partnerships in the project were easier than we thought they would be. People were open to the new ideas required to for these partnerships, and it matters who is sitting at table. The Design-thinking process helped us build the capacity to solve transportation issues that we didn't know we had tools for.

Here is one of our biggest unintended challenges. We have a great relationship with our FTA regional office. But sometimes the initiatives at the federal level do not filter down

[1] For more information on the PACE program see the following links off of the Medicare and Medicaid websites: https://www.medicare.gov/your-medicare-costs/help-paying-costs/pace/pace.html; http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Program-of-All-Inclusive-Care-for-the-Elderly-PACE/Program-of-All-Inclusive-Care-for-the-Elderly-PACE.html

to the regional office. The regional staff often goes right to the regulations and says why it cannot work. It took the regional office 1.5 years to get us our 5310 funds 5310 funding changes needed to do what they wanted to do, and that did not happen until the funds were about to lapse. They focus on regulations, grant administration, and sometimes cannot see how this might be a value-added opportunity. How can you help us stay within the intent of the regulations without being held to the letter of the regulations?[2]

Cain Williamson (Atlanta Regional Commission, Atlanta)
We've been working on human services transportation for 10-12 years. Our aging division came to the transportation division 10 years ago and said we see a big problem coming, can you become engaged. The MPO was initially reluctant. Then 5 years ago the MPO got funds from the FTA for a one call/one click project, the VTCLI grant. It was a lot of fun. We recently began working with 5310 funds and are acting as a service provider. We are building capacity in our organization and still do that every day.

We are using the challenge grant in DeKalb County to provide dialysis. We are focusing around a volunteer driver service but it only operates between 10-2. So they are trying to figure out how to pair this with services provided by family caregivers. That is where we are now, and we hope to wrap up as a business plan. Some of the issues they are facing are institutional in nature - different organizations administering the various funding streams. They are doing a locally developed plan that they hope will help address some of these differences. We are doing an update of our human services transportation coordination plan, and hope to have a policy update to hang some of these things on in the future.

A challenge is that in Atlanta…so many organizations are involved in administering different funds such as 5310, 5311, CMS, etc.

Question 2:

Henrika: What specific outcomes would lead you to partner with health care? What is the win-win for you?

Mike Hursh (Contra Costa)
Transit agencies are also customers of health care providers. To the extent health care can help us with wellness programs and savings in premiums; l would be willing to put the money saved back into service.

Rick Ramicer

[2] We successfully followed up this comment with Kelli and with Region X and found it was primarily an issue of education and more communication on all sides and it took time before the changes in MAP-21 were able to be accommodated and communicated effectively. There was a delay but it was not a regional issue.

We have been trying to engage Kaiser for years, now I have a contact. Our biggest issues are the physical locations of health care services, and also the types of services that are provided there. Kaiser told us that they took a poll 20 years ago, the results of which indicated that "seniors want to drive" so Kaiser put in a facility with plenty of parking. It's not just about money. It's about how do we plan services cooperatively?

Kelli Fairless (Idaho)
The primary objective is to coordinate because transit has so many constituents – Chambers of Commerce – I started to talk with human service providers – united way – they all have boards – same people that are on the Chambers of Commerce. This project opened up opportunities to talk about the value of public transportation for many purposes such as the opportunity to look at social determinants of health. Transit finds advocates in many places. I am now talking the language of businesses, board members. After the economic downturn, business stopped talking about transportation. I then realized the social safety nets were falling apart. That's when I began conversations with United Way, social service agencies, and others whose board members were those same business members. We are now talking about the value of transportation in conservative state.

Mike Roaldi: The social determinants of health have become a bigger issue and are seen as a way to cost savings. We are increasingly seeing human service agencies as health care agencies, as they provide many of the services (e.g., employment, nutrition, banking, etc.) that are social determinants. We need to expand our world of partnerships. We have claims history data on members – we can create risk analyses pictures – it allows us to track outcomes so we can compare what we expect to happen if there were not interventions such as transportation – what difference this makes.

Therese
Funding always an issue. If you want to do something new or you want to change something that exists many ask, show me the data to demonstrate the benefit side of this equation. We probably have not had good data to demonstrate the benefit side of this equation and our new partners have access to data that if the transit industry had it we could make a better business case.

Mike Roaldi
From our claims history, we can run a predictive analysis. We expect your health care to cost X and our risk of this chronic condition is Y. This allows us to track outcomes as we haven't been able to do before, to see the results of intervention.

Tyler
You should be able to have those conversations. What if we drove it to some locales then learned to scale up, sharing data.

At the strategy level, we all want the same thing. We may say that there are divergent missions or purposes but at the strategy level we want to same thing. We need to move off our individual North Star directions. Health care is flipping the question "What is the

matter with you" to "What matters to you" so we can connect members to wrap-around services.

Mike Roaldi: RWJ Foundation, health analytics report, estimates that 40% of health outcomes are driven by social determinants.

Lori
With data we can we can track what is working. As managed care plans get to know their consumers, know their challenges. We can have great conversations by asking "What are your challenges?" With these data – not only can we show what is working – we can also use data from managed care plans related to what their challenges are.

Therese
Kamillah Wood is a pediatrician and her point was that what she was trying to crosswalk the idea of mutual decision making. Here I have a challenge of children w/single parent, so the clinic hours of 8-5 don't work for well child appointments. On the health care side, we are seeing that we will be having evening appts. But what about transportation? We have joint needs and need to fulfill all of them together. How do I reach out in a coordinated fashion? This is illustrative of systems integration to get all of us at the table at the planning stage, at the provision stage, and at the funding stage.

Kenneth McDonald, Long Beach
We have been working with a children's clinic and helping patients understand their transportation options.

Jeff Hamm
We are struggling w/paratransit. There is client shedding going on with the Rhode Island Medicaid broker. It changed how it deals w/RPTA which put an $8.4 million hole in RPTA's budget.

Christian WMATA
It's not just a paratransit issue. How do you define the customer? These discussions allow us to redefine the riding public as a whole, not just as a paratransit issue. The issue is general public health.

We are also playing a game of hot potato. The MPO does not want to endorse a particular approach. They say "We are studying and planning, but don't want to endorse any actions." Then there is the transit agency trying to keep its ADA service compliant, DC is using its taxi service with a user side subsidy, customers love it, it is autonomous, the customers are happy, taxis are happy, and some business that did not get lost to Uber. But when you go to the states, they say it sounds like bureaucracy with another administrative layer or administrative burden we have to manage. At WMATA, if we can define what we partner with other agencies on that is not ADA like what we heard earlier with full reimbursement, if we use paratransit we make that service the most expensive option. We want to help the human service agencies when they apply for

grants to merge these funding streams so they can be used in a way that it is not paratransit but the on demand services people need.

The Human services transportation coordination plan is only on paper.

Merrill (Hopelink)
It is bigger than health care or transportation; it is the social fabric of our society. Our public health people said we already work w/Hopelink, YWCA shelter programs - transportation is the missing link for all of our services.

Question 3

Henrika: The FTA commits to moving this dialogue forward. We have a three-part strategy. Partner, invest, drive change. We are hoping the solutions we need will bubble out from these challenge grants. What would you recommend as the FTA's next step?

Christian
Have regional dialogues like this in each regional office.

Mike Roaldi
Let us be a part of the discussions and help ease the path for how to work together that improves delivery but that does not add any burden.

Ed Benning (Flint)
Transit can make a difference. The money spent on brokerage is almost same as is spent statewide on other types of transit.

Kelli Fairless (Idaho)
I'd like to see HHS people at the table of regional meetings as well. Another partner is the AAA, COA.
Christian
The periodic review of human service transportation plans probably needs to go further than having a plan. We need to connect these plans to execution. When grants are awarded, there is sometimes money left on the table. Several small human service agencies don't believe they can do the work necessary to win the grant. We need to bring in those small agencies into the plan Plans need to have accountability for implementation.

Therese: Human service transportation plans could be the very platform to spur creative discussions. We can fundamentally rethink the human service transportation plans requirement to use it better.