

**Accessing Health Services: Transportation Resources in the
Hamilton Niagara Haldimand Brant (HNHB)
Local Health Integration Network (LHIN)**

*Moving Towards a Model for Community Coordinated Transportation
Services*

Approved By: Transportation Advisory Working Group (TAWG)
March 2011

TABLE OF CONTENTS

INTRODUCTION	2
1. BACKGROUND	2
1.1 Transportation Workshop	2
1.2 Transportation Advisory Working Group (TAWG).....	3
2. CURRENT STATE	4
2.1 Asset Inventory: Current status	4
2.2 Methodology	4
2.3 Vehicles.....	4
2.4 Human Resources	5
2.5 Demand Profile.....	6
2.6 Who Uses Transportation and for What Purpose?	6
2.7 Unmet Ride Requests and Projected Demand.....	10
3. MODELS FOR COORDINATING ACCESS TO TRANSPORTATION	11
3.1 Continuum of Models	11
3.2 Benefits of Coordinated Transportation Models	12
4. FUTURE STATE	14
4.1 Recommended Model.....	15
4.2 Best Practices for Coordinated Transportation.....	15
4.3 Next Steps - Implementation/Transition Planning.....	16
5. REFERENCES	17
6. APPENDICES	18
Appendix 1: Transportation Advisory Working Group.....	18
Appendix 2: HNHB LHIN Transportation Advisory Working Group Common Eligibility Criteria	19
Appendix 3: Transportation Survey Respondents.....	21
Appendix 4: Summary of Transportation Resources*	22
Appendix 5: Onward Trips by Origin and Destination	23
Appendix 6: Transportation Coordination Models in Other Communities	24
Appendix 7: HNHB LHIN Framework for Decision-Making.....	25

INTRODUCTION

Transportation is one of the top three health system challenges for residents in the HNHB LHIN. Community transportation services provide access to health services and enable people to participate in community life, thereby enhancing their health, well-being and independence. Transportation services are important supports for seniors, persons with short or long-term activity limitations and other disabilities, and for families with young children.

HNHB LHIN-funded transportation services make a small contribution, alongside other non-profit services and specialized municipal services to help people to access health and social supports. More frequently, people depend on family, friends or accessible transportation programs in their communities, if available. Accessible and affordable transportation promotes people's social and economic inclusion, independence, choice and well-being. Alone, no single transportation provider can assure equitable access to "getting around." It is a shared and complementary responsibility.

Among LHIN-funded transportation programs, there is considerable variation in their distribution, eligibility criteria, user fees, and daily/hourly availability. Persons with mobility issues, behavioral challenges and children and youth under the age of 16 are not eligible for many services. There is a lack of affordable regional transit which is a barrier to getting to specialized health services either within or outside a region. Rural communities tend to have less well-developed accessible transportation systems and residents often rely on the "underground transportation system" comprising family members, friends, and neighbours.

1. BACKGROUND

1.1 Transportation Workshop

Improved access to transportation is one of several priorities in the HNHB LHIN Integrated Health Service Plan (IHSP), 2010/11 to 2012/13. On July 27, 2010, the HNHB LHIN hosted a transportation workshop to begin to identify options for improved access to LHIN-funded transportation services that benefit the client, optimize current resources and are sustainable. Participants included transportation service providers (LHIN-funded and others); funders including Trillium and the United Way; and organizations whose clients rely on transportation to access health services (e.g., Alzheimer Society, Adult Day Programs, Kidney Foundation, hospitals).

Three recurring themes emerged in group discussions exploring optimum strategies for equitable and sustainable LHIN-funded transportation services:

- Single point of access: a one-number to call for transportation to promote ease of access.
- Common assessment and decision making tools: standardizing eligibility for LHIN-funded services promotes timely and equitable access to transportation services.
- Integrated technology: electronic systems for supporting coordinated access, assessment, and scheduling. These may be linked to a common data set to improve planning, utilization review and quality management.

Solutions to our transportation challenges will require a shared approach as no single agency or community service can meet all the transportation needs that will be required for an aging population. All stakeholders must work

Looking ahead the long-term goal of the HNHB LHIN is proactive collaboration among transportation providers – municipal, regional, volunteer, and assisted programs, to plan affordable, accessible, coordinated, safe and timely transportation across the LHIN geography. More broadly, transportation strategies should be linked with a basket of local services that together support independent living. Coordinated planning among current providers and funders will build on existing assets that should be leveraged LHIN-wide.

1.2 Transportation Advisory Working Group (TAWG)

TAWG was established to advise the HNHB LHIN on strategies to improve transportation (Appendix 1). Its primary purpose is to optimize existing LHIN-funded transportation resources to improve resident access to health services (working and linking with non-LHIN-funded transportation providers to achieve this goal). The primary deliverables of the TAWG would be a report/business case to the HNHB LHIN Board of Directors outlining a plan, with specific recommendations, for optimizing existing LHIN-funded transportation resources to improve access to health services. The plan would consider the following components:

- coordination function
- common assessment
- role of technology
- current capacity and gaps.

To inform its work, a number of key tasks were identified and incorporated into the work plan. These tasks included the following:

- asset inventory: describing current supply of LHIN-funded transportation services to help close continuity gaps in access, service coverage, boundary spanning, etc
- demand profile: to describe the current utilization based on trip information including purpose, distribution by geography, client demographics, and special needs
- common intake and eligibility framework – to develop common assessment and decision making tools that promote timely and equitable access to transportation services
- coordination models: to review transportation coordination models that may serve to optimize existing LHIN-funded transportation resources to improve resident access to health services (e.g., single point of access, one-number-to-call, system navigator role, brokerage) for their applicability to the HNHB LHIN population.

When considering the demand for LHIN-funded transportation, three over-riding principles were established:

- system improvement needs to be organized within current resources – that the LHIN funding envelope will stay the same
- LHIN-funded transportation services will continue to focus on the needs of persons who are the frailest or most vulnerable who need access to health services
- LHIN funded transportation services are intended primarily for the conveyance of individuals to health and related services (e.g. medical, diagnostic, rehabilitation), and will focus increasingly on population health needs downstream in the health continuum.

The initial task completed by the TAWG was the development of common eligibility and decision making tools to promote timely and equitable access to transportation services across the HNHB LHIN (Appendix 2). The development of the eligibility criteria was informed by the *Accessibility for Ontarians with Disabilities Act (AODA)*, 2005. The goal of AODA is to achieve accessibility for all Ontarians with disabilities with respect to goods, services, facilities, accommodation, employment, buildings, structures and premises on or before January 1, 2025. The AODA uses the Ontario Human Rights Code's definition of "disability." The definition of disability is inclusive of physical, mental health, developmental and learning disabilities. Overall the AODA broadens the concept of disability and identifies a wider range of persons who may require transportation to access health and medical services (Appendix 2).

2. CURRENT STATE

2.1 Asset Inventory: Current status

The HNHB LHIN funds 12 organizations (\$2.5 million projected 2010-11) to provide agency and/or volunteer-based transportation for frail adults and persons with disabilities. This investment will provide in excess of 100,000 one-way trips for 4,600 individuals. The majority of these trips will provide access to medical appointments (42.5%) or health related programs such as adult day programs (29%) and congregate dining (5.7%). About 15% will comprise trips to social recreational activities (e.g., shopping, work, social centres) which enables persons to access their local social networks and other supports to maintain independent living.

In the context of the overall supply of public, voluntary and private sector transportation services across the LHIN, the HNHB LHIN's legacy is to provide a small but important transportation component through its community support services investments. Organizations in the community such as municipal specialized transit services share similar riders, address similar rider needs and share common destinations (e.g., adult day programs, medical appointments, etc).

2.2 Methodology

An asset inventory survey was compiled of LHIN-funded and other community-based transportation programs across the LHIN. The inventory included LHIN funded programs that do not provide transportation but incorporate a significant transportation component within their programs to enable their residents or clients to access other supports in the community ie. Haldimand Abilities Centre, Haldimand-Norfolk Resource Centre and Participation House. Data on municipal-based specialized transit services was obtained from the Ontario Specialized Transit Services Fact Book, 2009 published by the Ontario Ministry of Transportation. Inventory Survey respondents appear in Appendix 3.

2.3 Vehicles

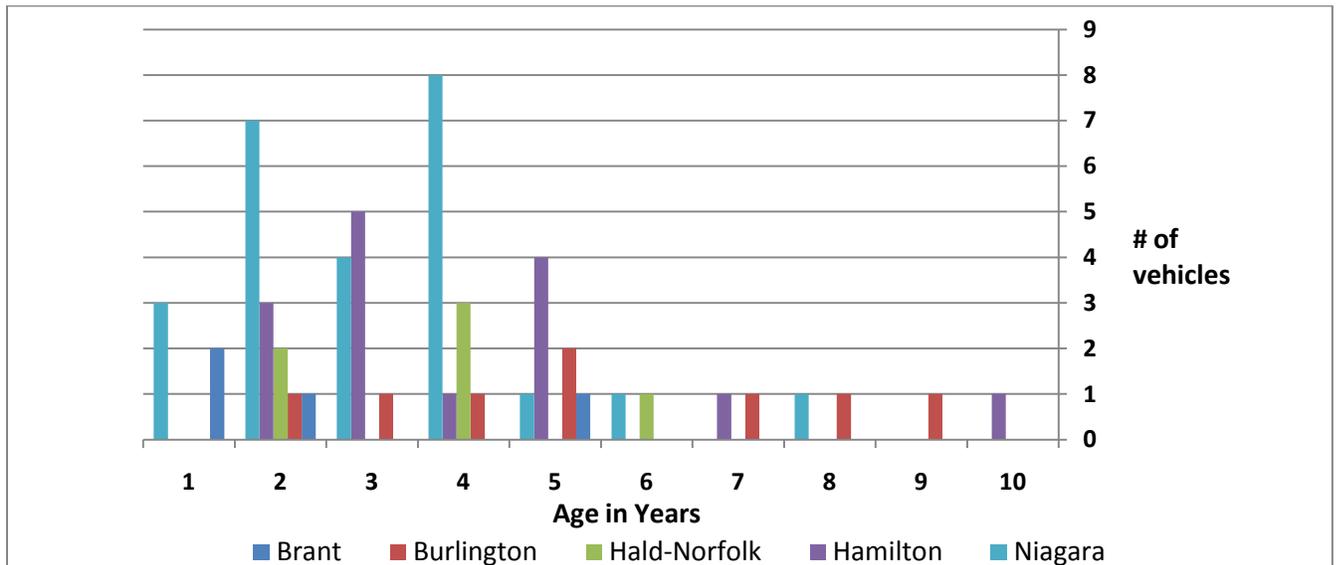
An overview of LHIN-funded transportation assets by sub-LHIN area appears in Appendix 3. The vast majority of vehicles comprise 908 volunteer non-accessible vehicles across the HNHB LHIN, representing 83% of all vehicles. Agency owned wheelchair accessible vehicles comprise three percent of the resources as well as an additional 47 non-accessible agency-owned vehicles (4%). Based on overall population totals, the five sub-LHIN areas have similar levels of vehicle resources per 1,000 seniors over 65. For its small population base, Haldimand-Norfolk has come to rely on a much larger volunteer base of drivers with personal cars. Further analysis of the service inventory a discussions with TAWG members reveals a number of gaps in the continuity of services well-know to these local communities:

- No municipal accessible services in Brant County (outside Brantford) and overall lack of accessible vehicles across Brant County provided by community sector agencies.
- Municipal specialized services across the LHIN do not provide inter-regional accessible transportation. In some jurisdictions there is also a challenge for intra-regional transit.
- Municipal specialized transit programs report a high number of unfilled ride requests – medical or health related rides account for about 56% of all rides.
- About 57% of survey respondents (which excludes municipal transit) indicate that they are unable to meet all requests for rides on a weekly basis.
- There are no municipal transit services (nor municipal funding) in Haldimand-Norfolk. Three community accessible vehicles support the entire population and geography.
- Rural areas face unique challenges of large geographic areas, fewer services and isolated towns lacking municipal transportation. Seniors are potentially at risk to becoming isolated.
- There are few options and limited capacity for seniors and frail elderly to access volunteer and/or accessible transportation in smaller urban communities in the periphery of larger urban centres ie., Dundas, Ancaster and Glanbrook.

- While some transportation services serve registered program clients, discussions for creative use and/or sharing of vehicles in most sub-LHIN communities are welcome.

A common concern for transportation providers is the aging of their fleets. The ages of agency owned vehicles (not volunteer) appear in Figure 1. The median age is about three years. However, there is a wide range (16 vehicles are five years of age and older). Some vehicles have outlived their useable lives and require significant maintenance and upkeep to avoid becoming unsafe for use. Eight vehicles have over 200,000 km, and one vehicle has over 500,000 kms. Regardless of age or kilometers, in the service sector there tends to be considerable wear and tear on these vehicles.

Figure 1: Vehicle Analysis Age



Source: HNHB LHIN Transportation Inventory - October 2010

2.4 Human Resources

The volunteer sector comprises that largest investment of human resources for transportation across the HNHB LHIN. While it was reported that 908 volunteer cars comprise the sector, it is difficult to estimate the actual amount of time devoted by volunteers. Organizations face the challenge of volunteer shortages, ongoing recruitment and training. This sector also faces rising costs for insurance, vehicle maintenance, parking costs, etc. Higher acuity of clients has required more emphasis on personal support. As a trend volunteers appear to be shortening their commitments to volunteering. Volunteers also identify with the needs and clients of their local areas – a system of regional coordination must ensure that services supported by volunteers continue to be locally responsive (e.g., familiar voice, consistent provider, ease of access, trustworthiness).

Approximately 93 individuals 67 full-time equivalent (FTE) paid staff were identified supporting transportation programs. The majority represent paid drivers (N=52). The next broad categories of staff (aside from “dispatcher”) include coordinator, administrative support and manager.

These categories comprise approximately 31 individuals with various full time equivalents across the HNHB LHIN (23 individuals when excluding management). The extent of human resources deployed to various functions within agencies is not provided (e.g. scheduling, dispatch, taking calls, intake registration, filing, computer data entry). Nine

(9) discrete dispatchers were identified; however, agency staff could be involved in a variety of activities spanning the entire process flow. A common benefit described in models of transportation coordination is the ability to streamline functions of disparate services and to free up local agency staff to fill gaps and provide more direct service (e.g., extending daily and weekend service hours, responding to more requests, and providing other responsive community supports).

2.5 Demand Profile

To identify the current demand for transportation services, a two-week census was conducted from October 19 to November 1, 2010. The census involved LHIN-funded transportation services or LHIN-funded agencies with a major transportation component accessible to the broader community or program clients. A census tool was developed and endorsed by a sub working group of the TAWG. The census results provided a comprehensive data set in which to document peak days and peak periods (i.e. purpose of trip, geographic origin and destination, and duration time of the trip). Information on client demographics included age, special needs, mobility devices and escorts. The unit of analysis was the one-way trip.

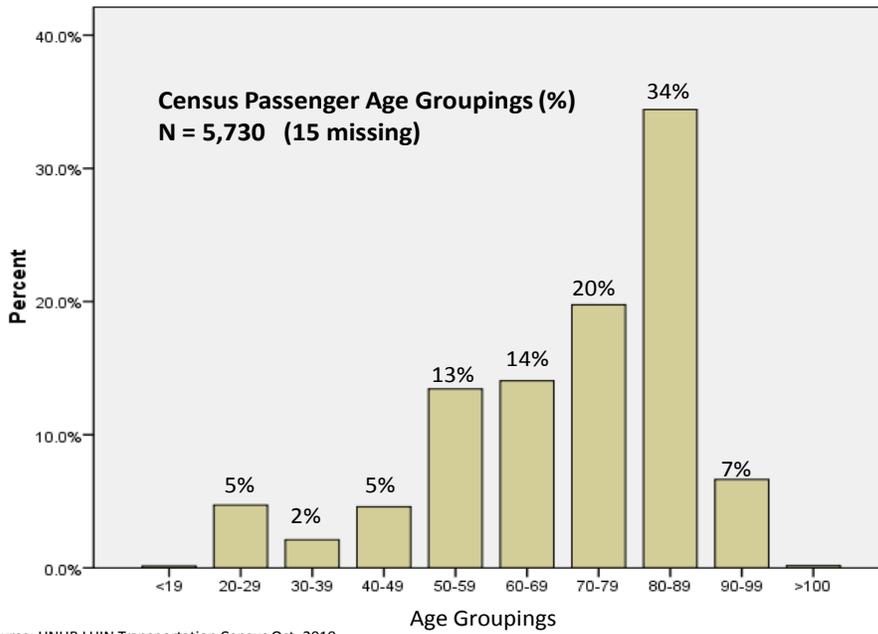
The two-week census captured information on 5,745 one-way trips – these trips comprised both “onward” trips (to service destinations) and return trips. The distribution was approximately even (2882 onward trips and 2841 return trips). Daily volumes were more pronounced on Tuesdays and Thursdays relating to the service hours of adult day programs. Two peak hourly trends were noted – morning and late afternoon. These patterns reflect the clients’ onward and return trips to and from appointments or programs. Trips were noticeably absent on weekends (when medical or health services are closed), and fewer trips occurred in the evening hours (two percent after 6pm).

2.6 Who Uses Transportation and for What Purpose?

Figure 2 categorizes client age groups that use LHIN-funded transportation. The peak age group is 80-89 (34%) and the median age is 76. Of significance was the fact that 34% of clients were under age 65. LHIN-funded transportation services not only provide support for persons well into their senior years but also support younger adults to access services. This aligns more accurately with the TAWG’s common eligibility criteria that do not limit services to specific age groups who are eligible for service.

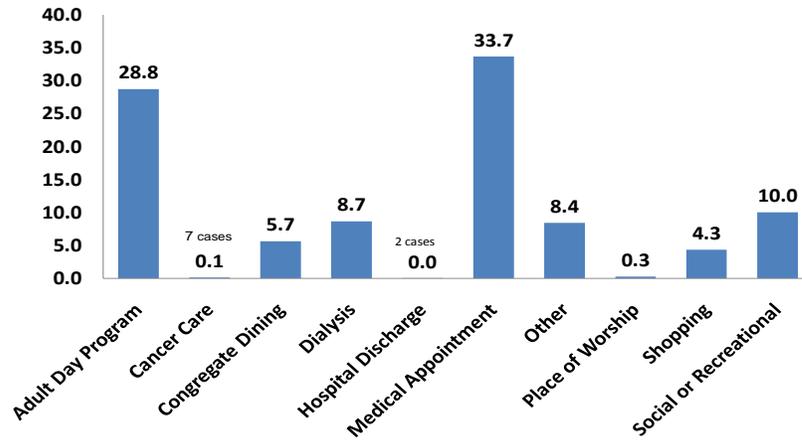
The primary reasons why clients require assistance with transportation include medical appointments (42%), adult day programs (29%), social and recreational services (15%) and congregate dining (6%). Variation was noted community by community particularly for adult days programs, dialysis, and social recreational programs. In-town destinations to access health and social programs were more common (61%). However out-of-town destinations (37%) were more common for residents of smaller and rural municipalities – this reflects population base and the distribution of services in larger communities and regional centres of excellence. Exceptions noted were adult day programs which tended to be more local. Further analysis is possible at the regional and lower tier municipal levels to identify the specific services clients are accessing and in which geographic destinations they access them (Appendix 5).

Figure 2: Passenger Age Groupings



Source: HNHB LHIN Transportation Census Oct, 2010

Figure 3: Purpose of Trip

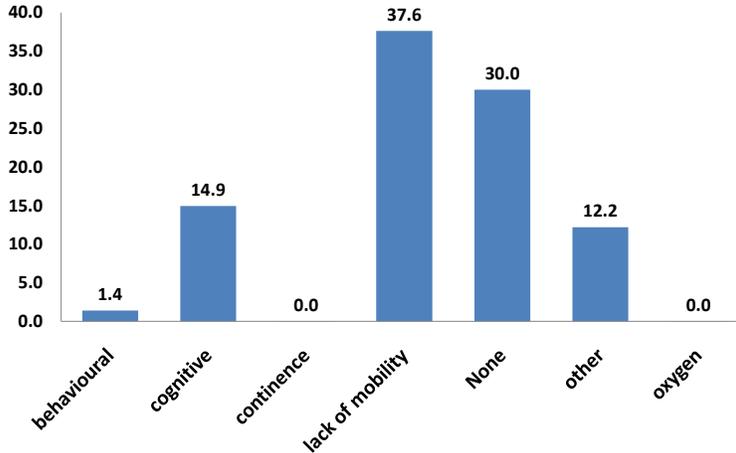


Source: HNHB LHIN Transportation Census, Oct. 2010

N = 5,525

The census provided information on the client groups served and their special needs. Personal mobility was the primary need of persons transported (38%). About 15% were noted to have cognitive issues as their prime concern (Figure 4).

Figure 4: Special Needs



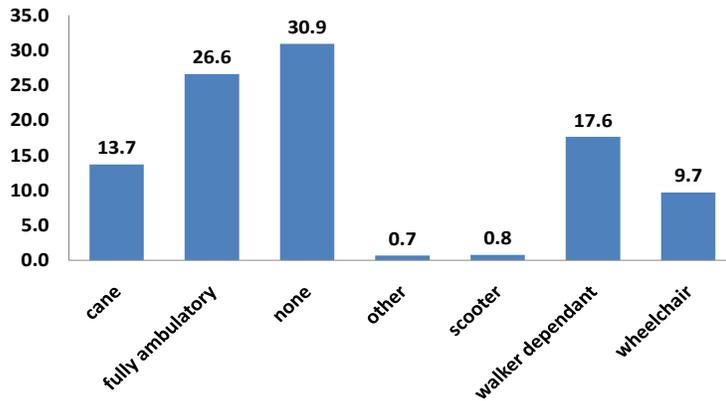
Source: HNHB LHIN Transportation Census, Oct. 2010

N = 5,525 (220 missing)

The TAWG believes that clients who are incontinent or require oxygen are underrepresented. These clients often do not fit local eligibility criteria. The Red Cross is developing a collaborative proposal to ensure that oxygen can be secured and transported safely.

Figure 5 corroborates the earlier findings indicating that approximately 38% of clients transported are challenged with the lack of personal mobility – a similar proportion (42%) require an assistive device to aid mobility such as a walker, cane or wheelchair. About 12% were assisted by an escort or companion. Clients used an accessible vehicle for 43% of all trips, and this also corresponds to the level of personal mobility problems of individuals transported.

Figure 5: Special Needs of Clients - Devices



Source: HNHB LHIN Transportation Census, Oct. 2010

N = 5,739

2.7 Unmet Ride Requests and Projected Demand

During the two-week census, there were relatively few unmet ride requests (N=49). This equates to approximately two unfilled ride requests per week per agency - this is consistent with the service inventory data where 57% of all respondents stated they were unable to meet all requests for service on a weekly basis. It is unknown however, how many of these individuals were able to find alternate transportation. Across all municipal specialized transit services there were 21,000 unaccommodated trip requests in 2009. It is estimated that approximately 50-55 % of these unfilled requests were medical or health related.

Draft projections of the future demand for medical or health related rides were developed based on the demand for these trips in the census for each age group. This demand was adjusted upward to reflect the 49 unmet ride requests. By 2014, based on the projected increase of the senior age cohorts, there will be a need to generate 111,280 one-way trips – this represents an 11% increase in the current level of LHIN budgeted trips for 2010-11. This demand projection does not include what we currently understand to be the level of trips for social and recreational rides (about 10-15%).

The various sources of information inform us that meeting current demand is a challenge across the sectors, and that this demand will increase as the HNHB LHIN population ages. Many communities across Ontario have explored models of improving the coordination of their transportation resources to maximize capacity and improve access, to improve quality and to realize efficiencies. The transportation service providers in the HNHB LHIN provide a critical and much needed service for their communities. When these stakeholders are engaged however, transportation overall is not viewed as a coordinated system or network.

3. MODELS FOR COORDINATING ACCESS TO TRANSPORTATION

3.1 Continuum of Models

The TAWG conducted a scan to learn how other Ontario communities coordinate their transportation systems. Similar to the HNHB LHIN, these communities for some time identified gaps in access to transportation. Community discussions identified limited coordination among community support services including transportation.

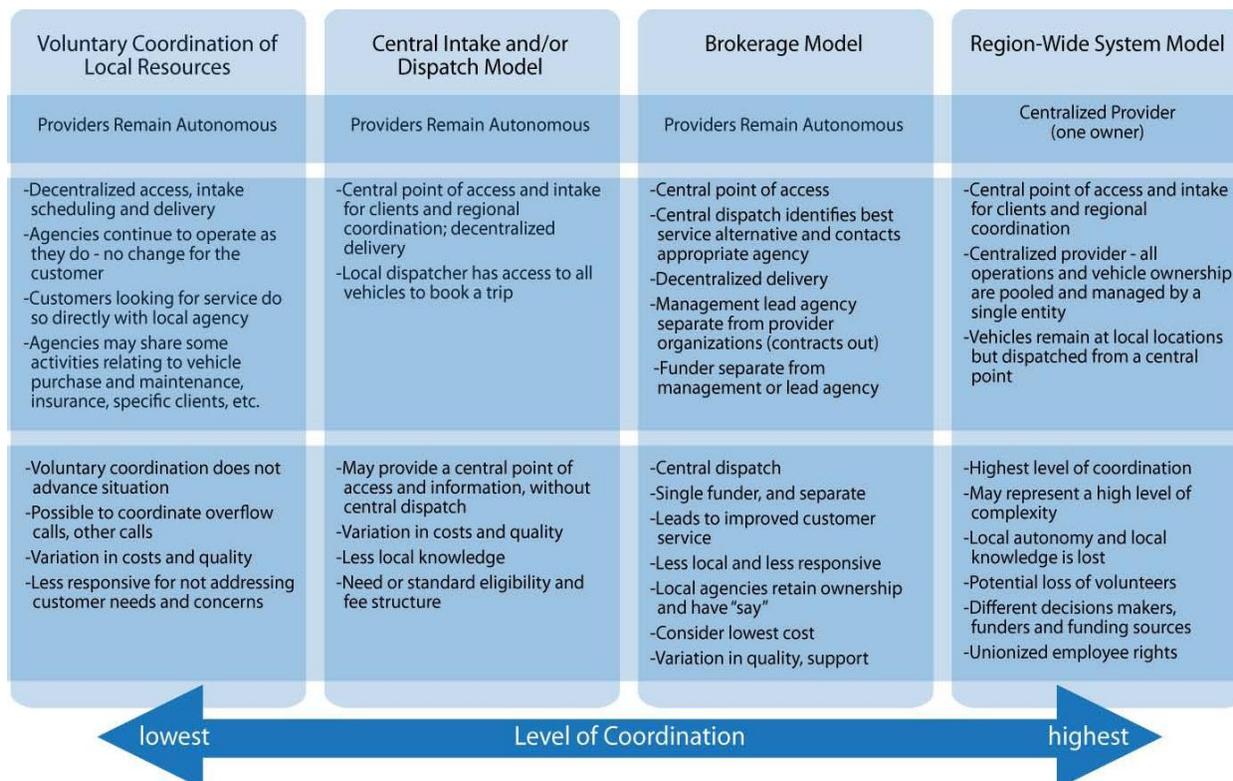
Four coordination models currently in use appear in Appendix 5. Common to all four models is the concept of a one-number-to-call for ease of access to a range of transportation services including information, referral, intake, scheduling, and assignment to the most appropriate service. Two of these models function mainly as referral services (TorontoRide and Transportation in Rural Wellington). These agencies work with a collaborative of transportation providers to connect the client to the appropriate service (usually based on geography). One of these programs however (TorontoRide), provides the additional function of posting rides that agencies are unable to fill. These “overflow” rides are viewed by all agencies over web based technology and attempts are made to accommodate these rides if there is room in the schedule. In this way TorontoRide facilitates access through collaboration and maximizing available resources.

The next two models (EasyRide and CrossWheels) provide centralized intake, booking and scheduling of all ride requests for all partner agencies. Along with a central one-number-to-call these models have the added function of scheduling requests into the system. The central intake and web-based scheduling allows for the most appropriate agency and vehicles to respond and to provide the best routing of vehicles to maximize efficiencies.

All four models share common features, but differ along the continuum of coordination (Figure 6). Individual transportation services remain autonomous, however as one progresses through the various models some functions become more centralized such as the central access number, intake and scheduling.

In all coordination models, a lead agency works on behalf of a consortium of collaborative providers. Several positive outcomes have been reported across these models including increased efficiencies, increased capacity and positive customer feedback. Most important is the ability to work and provide service as a “system” – this effectively positions these organizations to meet future challenges and opportunities.

Figure 6: Continuum of Transportation Coordination Models



Source: Dillon Consulting Limited.

3.2 Benefits of Coordinated Transportation Models

The potential benefits of better coordination among transportation providers are well documented. They include the ability to free up resources and apply them transportation. More cost-effective use of resources can result in expanded service, more trips provided, and potentially lower costs to clients. Cost savings for participating agencies often come about through more centralized functions and management over certain processes. When transportation providers are able to coordinate their operations, citizens often benefit from the increased availability of transportation and higher quality services (Burkhardt, 2000).

Ontario LHINs have adopted a consistent framework to support their decision-making processes – LHIN Priority Setting & Decision Making Framework Toolkit, 2010 (Appendix 6). This framework provides a useful tool in which tool to assess the merits of coordinated transportation models. The framework spans 4 domains:

- Alignment with local and Ministry of Health and Long Term Care (ministry) priorities(IHSPs)
- System performance (accessible, integrated, quality, sustainable).
- Local and system values – (equity, efficiency, client-focused, innovation, partnerships and engagement)
- Population health (improves health outcomes, reduces prevalence or severity of disease, promotes well-being through health promotion and disease prevention). Using these broad domains, the following table provides a summary of the key outcomes of coordinated transportation models as they align with the Framework.

Table 1: Alignment of Attributes with HNHB LHIN Decision-Making Framework

Framework Domain	Attributes of Coordination Models
Alignment – Strategic Fit	<ul style="list-style-type: none"> • HNHB LHIN IHSP 2 establishes the transportation priority to advance equitable access and efficient transportation • Integrate transportation requirements with HNHB LHIN clinical services planning • Transportation aligns with LHIN vision, mandate, mission and values.
System Performance	<ul style="list-style-type: none"> • Ease of access and reduced client/agency confusion over who to call • Supports system navigation, coordination and matching client needs to appropriate level of service – right service at the right time and in the right place • Frees local agency staff to do other work and allow reinvestment of resources in service delivery. Reduces duplication of services. • Increased efficiencies and coordination improves capacity and access to more vehicles, drivers, volunteers • Potential to extend service coverage and service hours, and fill services gaps through planning, coordination with partners, and leveraging other sectors.
System Values	<ul style="list-style-type: none"> • Focuses on equity of access and simplified access, common eligibility and process flow • Strives for efficiencies and most effective use of resources • Coordination maximizes provision of services • Relies on partnerships, collaboration and customer-focused services • Uses innovative technology for coordination of services, planning and evaluation. • Engages other sectors to achieve mutual objectives: quality, efficiency and access.
Population Health	<ul style="list-style-type: none"> • Improves access to health and social supports for those who are most vulnerable • Transportation supports wellness and capacity for independent living • May delay early onset of chronic conditions through connections to social supports, early care and intervention.

Burkhardt (2000) identified the following benefits of coordinated transportation systems based on eight case studies. Across the eight sites coordination resulted in one or more of the following benefits:

- lowered trip costs for older persons and for human service agencies
- extended service hours
- services to new areas or new communities
- more trips made by older persons
- services more responsive to schedules, points of origin, and destinations of customers
- greater emphasis on safety and customer service
- more door-to-door service.

A unifying theme of all coordinated transportation models is “one-number-to-call” to access informational resources and navigation to the best appropriate transportation option (Burkhardt et al, 2004). The centralized phone number initiates a process for one or more trips for medical or social purposes. Clients are required to register with a participating transportation agency and would book their trips by calling the central phone number. Appropriate policies, procedures and process flow need to be established to ensure that agency staff and client communications are consistent and easy to understand.

A well coordinated system will maximize the use of pooled resources from all partnering organizations. These resources can include agency vehicles and staff, community volunteers, software and training programs. By maximizing resources, service levels may potentially be increased. For example, coordination of trip requests can yield the most optimum route and may identify opportunities to accommodate more passengers (vehicles with multiple-seating capacity).

There are other by products of coordination (Burkhardt, 2004). When organizations work together on behalf of the transportation needs of their clients, organizations may find that they are now sharing other information with each other. By building relationships the people in these organizations will communicate more frequently. As they learn more about the programs, practices, policies and services of the partnering organizations, staff from the individual organizations may update their own “best practices”). These activities may serve to further improve other client services beyond those of transportation (Burkhardt, 2004).

In time a community’s coordinated transportation system becomes branded as its access point to “transportation” and is more readily integrated by agencies into the health care continuum.

4. FUTURE STATE

The HNHB LHIN currently funds 12 agencies, a total of \$2.5 million to provide health/medical related transportation. A review of the system by the HNHB LHIN in collaboration with transportation providers, concludes that a LHIN-wide coordinated model is required. The goal of a coordinated transportation model is to improve access and the quality of the client experience.

The model supports population health and is provided efficiently and is sustainable. The model will lead to improved outcomes and equity of access for all eligible calls for transportation. A coordinated transportation model will also address immediate gaps in transportation and will address current and future demand within current operating funds or re-allocated funds across the system.

4.1 Recommended Model

A unifying theme of all coordinated transportation models is “one-stop-shop” access for information and navigation to the best appropriate option. The models provide an easy one-number-to-call for clients registered with a transportation provider in the system. A well-coordinated system will maximize use of pooled resources across the partnering organizations thereby maximizing existing resources and service levels.

The HNHB LHIN review of our transportation system in collaboration with members of the TAWG and other service providers LHIN-wide concludes that a coordinated transportation model should be supported for implementation in the HNHB LHIN. A coordinated transportation model will improve access to medical and health services and improve the quality of the client experience. It supports population health, is provided efficiently and effectively and is sustainable in the longer term. A coordinated transportation model will address immediate gaps in transportation and will be well positioned to address future demand within current operating funds and/or re-allocated funds across the system.

The model reviewed by the TAWG, whose components most closely align with the needs of the HNHB LHIN is EasyRide based in Stratford. The model was presented to the TAWG in December 2010. Relative to the number of agencies, the size of the service, the population and area served, this model is most transferable to the HNHB LHIN.

The model is viewed as a hybrid and falls within the continuum of coordination models. In the model certain functions are coordinated by a lead agency on behalf of all providers (e.g. one-number-to-call, intake, information, common eligibility, scheduling). Seven (7) community transportation agencies are members of the collaboration and together the system coordinates over 25 agency owned vehicles and 200+ volunteer vehicles. The model is governed by a memorandum of understanding and maintains local responsiveness, autonomy of providers and ownership of vehicles. Functions that can be coordinated are streamlined and centralized. Individuals that call for a ride are linked back to the most appropriate provider using web-based scheduling. The service is provided to all of Perth and Huron Counties including Stratford (135,000 population). Approximately 3,400 individuals are served by the system and 65,000 trips were provided in 2009/10. There are approximately 4,300 calls per month. Key outcomes monitored have been an increase in service capacity, client satisfaction and efficiencies.

4.2 Best Practices for Coordinated Transportation

The common elements considered best practice for a coordinated transportation model include:

- ✓ centralized access (one-number-to-call)
- ✓ centralized intake software
- ✓ common eligibility criteria
- ✓ common database and scheduling software
- ✓ standard Policies and Procedures
- ✓ centralized Marketing/ Public Awareness
- ✓ standard Fares (a broader system issue).

Additional planning will be required to implement the model. This is best achieved by the transportation providers and their clients the model is intended to serve. Agencies together should develop a business plan to implement the model. The business plan should consider as a minimum the following specifications:

- Clear statement of vision, goals, deliverables and timelines (e.g. coordinated model must generate sufficient efficiencies to meet current gaps and expand capacity to meet future demand).
- Business plan (e.g. to include funding for the model; plan for re-allocation of resources; streamlining functions and back office efficiencies; harmonization of fees; plan for capital replacement, etc).
- Services processes (e.g. central intake; common eligibility; client 'flow'; scheduling; referrals; etc).
- Leadership (e.g. mechanisms to formalize central coordination and roles of partners such as MOU)
- Communication/engagement plan.
- Accountability – expectation of working with LHIN to develop performance and outcome measures.

It is recommended that this future state for transportation services be reviewed by members of the TAWG with the experience in transportation systems, best practices and management expertise. It is preferred to build on the experience of providers with the aid of a lead agency to develop the future model.

4.3 Next Steps - Implementation/Transition Planning

The HNHB LHIN is committed to openness, transparency and “real conversation”.

The new innovative direction for HNHB LHIN transportation should be planned with all LHIN funded, subscription and non-LHIN funded transportation and complementary services across the LHIN.

The HNHB LHIN invites comment on the future direction for transportation. The report will initiate the start of a process to engage providers in collaborative planning to implement a best practice coordination model.

5. REFERENCES

Mitchell, G. Home and Community-Based Service Providers Live and Breathe Innovation. Best Practices Spring 2002. American Association of Homes and Services for the Aging.

HNHB LHIN Improving our Health Care Experience: Integrated Health Service Plan 2010-2013

HNHB LHIN Transportation Workshop July 27, 2010: Summary Outcomes

Hamilton Niagara Haldimand Brant Local Health Integration Network. Dialogue on Age Friendly, Sustainable Transportation: Session Proceedings, June 2008

HNHB LHIN Clinical Services Plan: Final Report from the Clinical Services Plan Steering Committee to the Hamilton Niagara Haldimand Brant Local Health Integration Network Board of Directors, November 23, 2009

HNHB LHIN (2008) Let's Talk: Aging at Home – Listening and Learning about Healthy Aging and Independent Living, July 2008.

Burkhardt, J. Coordinated Transportation Systems. The Public Policy Institute – Research Group of the AARP, 2000.

Burkhardt, J. Toolkit for Rural Community Coordinated Transportation Services. Transportation Research Board of the National Academies (2004).

Ontario Ministry of Transportation. Ontario Specialized Transit Services Fact Book – 2009 Operating Data Ontario. Accessibility for Ontarians with Disabilities Act, 2005

6. APPENDICES

Appendix 1: Transportation Advisory Working Group

NAME	TITLE	ORG.
Debbie Christie	Manager of External Relations	VON Canada Ontario – Hamilton
Trish Campbell	Executive Administrative Assistant	DARTS (Disabled & Aged Regional Transportation System), Hamilton
Janice Ferguson	Program Director	Mountberry Adult Day Program, Hamilton
Janie Fraser	Director of Regional Operations, West Central Region	Canadian Red Cross – Burlington Branch
Janice Gumbley	Executive Director	Glanbrook Home Support Programme Inc
Sandra Harding	Director of Finance	Brain Injury Community Re-Entry (Niagara) Inc
Cheryl Martinello	Executive Director	Community Support Services of the Niagara Region
Mark Mindorff	Executive Director	DARTS (Disabled & Aged Regional Transportation System), Hamilton
Judy Mintz	Executive Director	Dundas Community Services
Kumar Ranjan	Transportation Engineer	Niagara Region
Carole Taylor	Manager, Transportation	Glanbrook Home Support Programme Inc
Leila Thompson	Program Manager	Haldimand-Norfolk Community Senior Support Services Inc.
Patricia Verdone	Executive Director	Haldimand-Norfolk Community Senior Support

Appendix 2: HNHB LHIN Transportation Advisory Working Group Common Eligibility Criteria for LHIN-funded Transportation (October 15, 2010)

Introduction:

The following provides a draft framework for common eligibility criteria for LHIN funded transportation services, and forms part of the work of the TAWG. The draft framework is driven by the overall principles adopted by the TAWG.

- LHIN funded transportation services will continue to focus on the needs of persons who are the frailest or most vulnerable
- LHIN funded transportation services are intended for the conveyance of clients primarily to health and related services and will focus increasingly on population health needs downstream in the health continuum.
- The system needs to be organized within current resources

The draft framework is also informed by the *Accessibility for Ontarians with Disabilities Act, 2005*, a portion of which is included below, for reference.

Framework for Common Eligibility Criteria:

The priority for LHIN-funded transportation services will include:

1. Transportation to medical or health related services.
 - The priority for LHIN funded transportation services is transport to medical or health service destinations located within the HNHB LHIN or, where appropriate, to a destination outside the Region (e.g., London, Toronto). Examples of destinations may include a community-based health service, a hospital, independent health facility or other destinations within the continuum of primary care, therapy and diagnostic services. Some examples are provided below:
 - Medical appointments with traditional or non-traditional health care providers (e.g., family doctor, primary care, specialist, chiropractor, nurse practitioner, dentist, dietitian, acupuncturist, naturopath).
 - Diagnostics services (e.g. x-ray, laboratory, ultrasound, CT, MRI).
 - Therapeutic Services (e.g. dialysis, cancer care, physiotherapy, occupational therapy, speech, audiology, chiropody, methadone or pain clinics, other community or hospital services).
 - Hospital to Home (e.g., discharged home following an inpatient stay).
 - Prevention/Health Promotion (e.g. public health programs such as STDs, HIV, stroke/diabetes/falls prevention clinics, pre-natal services, immunization clinics).
 - Adult day and congregate dining programs (subscriptions).

2. Transportation for :

- persons with early onset aging or disabled persons who are unable to use conventional local transportation due to frailness or disability and do not have access to an appropriate alternative within their community (e.g., lack of specialized transit, unable to drive, lack of family members to assist).
- Special needs populations that traditionally lack access to transportation services (e.g., children that require access to specialized health services, residents of rural areas, persons with mobility problems, persons with mental health and addiction issues, persons that require supportive equipment such as a wheelchair, oxygen).

Accessibility for Ontarians with Disabilities Act, 2005

On June 13, 2005, the Ontario government passed the *Accessibility for Ontarians with Disabilities Act, 2005*. The Act makes Ontario the first jurisdiction in Canada to develop, implement and enforce mandatory accessibility standards. It applies to both the private and public sectors. The goal of the Act and standards is to make Ontario accessible by 2025. The Accessibility Standards for Customer Service became law on January 1, 2008. All businesses or organizations that provide goods or services to the public or to other third parties in Ontario are legally required to comply with the requirements of the standard.

The Act provides guidance in defining a disability and provides direction for the types of disabilities that require transportation services. Disability refers to:

Persons with any degree of physical disability, or infirmity, or malformation or disfigurement that may have been caused by injury, birth defect or illness.

- without limiting the generality of the foregoing, specific causes or attributes that can cause disability can include diabetes, epilepsy, brain injury, paralysis, amputation, lack of physical coordination, blindness or visual impairment, deafness or hearing impairment, muteness or speech impairment.

A public service is required to accept:

- persons that have physical reliance on a dog or other animal or sighted guide due visual impairment or total blindness
- persons assisted by a wheel chair or other remedial or assistive device
- persons assisted by a support person that may accompany a person with a disability to assist with communication, mobility, personal care or medical needs or with access to medical and/or health services. persons with transport/mobility concerns due to a condition of mental impairment or a developmental disability. persons with a learning disability, or a dysfunction in one or more of the processes involved in understanding or using symbols or spoken language
- persons, as a result of their injury or disability, that claimed or received benefits under the insurance plan established under the Workplace Safety and Insurance Act

Source: AODA, 2005

Appendix 3: Transportation Survey Respondents

AbelLiving – Hamilton
Alzheimer Society of Brant
Ancaster Community Services
Brain Injury Community Re-Entry
Canadian Cancer Society
Canadian Red Cross
Cancer Assistance Program
Community Support Services of Niagara
De DwaDa Des Nye>s – Aboriginal Health Centre
Dundas Community Services
Glanbrook Home Support Programme Inc
Haldimand Abilities Centre
Haldimand Norfolk Senior Community Support Services Inc.
Haldimand-Norfolk Resource Centre
Joseph Brant Wellness House
John Noble Centre Day & Stay Program and Transportation
Multi-Service Centre Tillsonburg
Ontario March of Dimes – Niagara
Participation House – Brantford
Pelham Cares Inc.
Salvation Army – Mountberry and Meadowlands
Senior Outreach Services – Stoney Creek

Appendix 4: Summary of Transportation Resources*

	Brant	Burlington	Haldimand Norfolk	Hamilton	Niagara	HNHB LHIN
Organizations	5	3	4	12	13	37
Vehicles	122	126	227	255	362	1092
- accessible	- 3*	- 6	5	- 10	- 13	- 37
- Not WA	- 2	- 7	2	- 20	- 16	- 47
- Cars	- 117	- 113	220	- 225	- 333	- 908
Vehicles per 1,000 65+ population	7	5	15	3.5	5	5
Paid Staff	7	6	12	29	39	93 (67 FTE approx)
	- 4 drivers (2 FTE) - 1 coordinator - 1 admin - 1 manager	- 4 drivers (2.6 FTE) - 2 admin	11 drivers (4.5 FTE) - 1 admin	- 11 drivers (8 FTE) - 2 dispatch (1.5 FTE) - 6 coordinators (5 FTE) - 8 admin (5 FTE) - 3 managers	- 22 drivers (16.5 FTE) - 7 dispatchers (5.5 FTE) - 3 coordinators (2.5 FTE) - 2 attendants (1 FTE) - 4 management (3.25 FTE) - 1 admin (.25 FTE)	
Population 65+	18,165	25,360	14,915	75,390	74,160	207,990
Fees:	Yes 1 No 4	Yes 2 No 1	Yes 3 No 1	Yes 7 No 5	Yes 9 No 4	Yes 22 No 15
Able to meet all demand?	Able 1 Unable 4	Able 0 Unable 3	Able 0 Unable 4	Able 8 Unable 4	Able 7 Unable 6	Able 16 Unable 21

*Excludes Municipal Specialized Transit Services

Appendix 5: Onward Trips by Origin and Destination

Origin	In-town	Out of Region	Out of Town	Total
#N/A	36	3	31	70
	51.4%	4.3%	44.3%	100.0%
BRANT COUNTY	10		1	11
	90.9%	.0%	9.1%	100.0%
BRANTFORD	60		2	62
	96.8%	.0%	3.2%	100.0%
BURLINGTON	175	2	78	255
	68.6%	.8%	30.6%	100.0%
FORT ERIE	215	2	65	282
	76.2%	.7%	23.0%	100.0%
GRIMSBY	58	18	22	98
	59.2%	18.4%	22.4%	100.0%
HALDIMAND COUNTY	230	2	186	418
	55.0%	.5%	44.5%	100.0%
HAMILTON	412	11	38	461
	89.4%	2.4%	8.2%	100.0%
LINCOLN	16	2	93	111
	14.4%	1.8%	83.8%	100.0%
NIAGARA FALLS	25	5	115	145
	17.2%	3.4%	79.3%	100.0%
NIAGARA-ON-THE-LAKE	2		32	34
	5.9%	.0%	94.1%	100.0%
NORFOLK COUNTY	161	9	186	356
	45.2%	2.5%	52.2%	100.0%
PELHAM	4	1	8	13
	30.8%	7.7%	61.5%	100.0%
PORT COLBORNE	96		31	127
	75.6%	.0%	24.4%	100.0%
ST. CATHARINES	188	7	73	268
	70.1%	2.6%	27.2%	100.0%
THOROLD	5		17	22
	22.7%	.0%	77.3%	100.0%
WAINFLEET			10	10
	.0%	.0%	100.0%	100.0%
WELLAND	62	6	57	125
	49.6%	4.8%	45.6%	100.0%
WEST LINCOLN	3		11	14
	21.4%	.0%	78.6%	100.0%
TOTAL	1758	68	1056	2882

Appendix 6: Transportation Coordination Models in Other Communities

Model	Description
<p>EasyRide (Southwest LHIN)</p>	<p>A central transportation information and coordination service providing one number to call that was established in 2008 among seven Community Support Services (CSS) agencies in Huron & Perth Counties. Clients that call for service are linked to the most appropriate transportation service. The client population is seniors without access to public transportation (or family support), and have physical or cognitive limitations. The central office uses web-based scheduling to book trips based on what makes best use of vehicles. The schedules (manifests) are sent to each service the next day and each service allocates and routes its vehicles to the appropriate locations. Coordination and sharing of drivers and vehicles offers flexible and frequent door-to-door service for medical appointments and other services. CSS partners retain ownership of their vehicles. http://www.stratfordmowandns.ca/easyride.html</p>
<p>Transportation in Rural Wellington (TRW) (Waterloo Wellington LHIN)</p>	<p>TRW is a one number to call “referral service” for rural Wellington residents. It is a collaborative of transportation service providers working with a volunteer driver model. A transportation coordinator is part of the staff team of the Community Resource Centre. Clients are assessed using standard criteria/questions, and then are referred to the most appropriate service provider who can meet their needs. The client calls the individual service provider directly for future service requests after the initial contact. http://www.wellingtonadvertiser.com/index.cfm?page=detail&itmno=625</p>
<p>Crosswheels (Mississauga Halton LHIN)</p>	<p>Crosswheels is a one number to call program established among three providers (Red Cross, VON, and Etobicoke Services for Seniors). Through the use of satellite offices and scheduling software, coordinators provide centralized scheduling and dispatch. A comprehensive software program is used for utilization review to optimize vehicle use and capacity. A Memorandum of Understanding (MOU) was developed among the three agencies, inclusive of standard eligibility criteria and fee schedule, use of IT for advanced scheduling, and vehicle routing. Red Cross was chosen as the lead agency. http://news.halinet.on.ca/Newspaper/ob/2010_01/ob2010JA0717.pdf</p>
<p>TorontoRide (Toronto Central LHIN) (working collaboratively with Central LHIN to address cross boundary trips).</p>	<p>A partnership of 14 not-for-profit CSS agencies (based on an MOU) that provide assisted transportation to frail elderly and adults with disabilities to attend healthcare and other appointments. The service provides access through a central one number to call, and is based on an “overflow” model. This means that when an agency is unable to fulfill a ride request, ride requests are posted and monitored by all partner individual agencies. In this way TorontoRide facilitates the sharing of transportation resources to better meet the needs of the community. Resources and expertise are shared to maximize capacity. The model incorporates standardized eligibility criteria and driver education. Future enhancements under review include coordinated scheduling and a new IT system. The new model would also target all existing and new clients and all ride types (not only overflow rides). Work will also consider back office efficiencies and integrations. http://www.torontoride.ca</p>

Appendix 7: HNHB LHIN Framework for Decision-Making

Domains	Criteria
<p>System Alignment: Determines alignment with both Ministry and local priorities</p>	<p>Alignment: Degree of impact on advancing Integrated Health Services Plan and Annual Service Plan goals and priorities</p> <p>Strategic Fit: Alignment with provider system role. Extent to which program/initiative is consistent with the provider(s) mandate and capacity compared to other providers in Ontario.</p>
<p>System Performance: Contributes to the meeting of system goals and objectives</p>	<p>Sustainability: Impact on health service delivery, financial, and human resources capacity over time. The health system should have enough qualified providers, funding, information, equipment, supplies and facilities to look after people’s health needs.</p> <p>Integration: Extent to which program/initiative improves coordination of health care among health service providers, including LHIN funded and non-funded providers and community providers to ensure continuity of care in the local health system and provision of care in the most appropriate setting as determined by patient/client’s needs.</p> <p>Quality: Extent to which program/initiative improves safety, effectiveness, and client experience of health services(s) provided.</p> <p>Access: Extent to which program/initiative improves physical, cultural, linguistic and timely access to appropriate level of health services for defined population(s) in the local health system.</p>
<p>System Values: Ensures local and system wide attributes are being met including equity, innovation and community engagement</p>	<p>Equity: Impact on the health status and/or access to service of recognized sub-populations where there is a known health status gap between this specific population and the general population as compared to current practice/ service. The absence of systematic and potentially remediable differences in one or more aspects of health across populations or population groups defined socially, economically, demographically, culturally, linguistically or geographically.</p> <p>Efficiency: Extent to which program/initiative contributes to efficient utilization of health services, financial, and human resources capacity to optimize health and other benefits within the system.</p> <p>Client-Focused: Extent to which program/initiative meets the health needs of a defined population and the degree to which patients/clients have a say in the type and delivery of care.</p> <p>Innovation: Impact on generation, transfer, and /or application of new knowledge to solve health or health system problems; encouraging leading practices and innovation, building on evidence and application of leading practices.</p> <p>Partnerships: Degree to which appropriate levels of partnership and/or appropriateness of partnerships, both LHIN funded and non-LHIN funded, will be achieved in order to ensure service quality</p>

Domains	Criteria
	<p>enhancement, improved comprehensiveness, optimal resource use, minimal duplication, and/or increased coordination.</p> <p>Community Engagement: Level of involvement of target population and other key stakeholders in defining the project and planned involvement in evaluating its impact on population health and key system performance.</p>
<p>Population Health: Determines contribution to the improvement of the overall health of the population</p>	<p>Health status (Health outcomes & Quality of Life): Impact on health outcomes for the patient/client and/or community, including risk of adverse events, and/or impact on physical, mental or social quality of life, as compared to current practice or service.</p> <p>Prevalence: Magnitude of the disease/condition that will be directly impacted by the program/initiative as measured by prevalence (i.e., # of individuals with the condition in the population or subpopulation at a given time).</p> <p>Health promotion & disease prevention: Impact on illness and/or injury prevention and promotion of health and well-being as measured by projected longer term improvements in health and/or likelihood of downstream service.</p>

L:\C. Initiatives (Operations)\P - I (Ihsp)\Transportation\Transportation Advisory Working Group\Report Writing - Draft\Master Transportation Report February 14 2011.Docx