

# The RURAL MONITOR

*A Publication of the Rural Assistance Center*

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## Partnerships Pay Off in Rural Transportation

by Candi Helseth

Many public transportation programs in urban and rural areas have been burdened with high costs and low ridership, which threaten the programs' viability.

The reason? "Everyone was doing their own thing," said Charles Rutkowski, assistant director of the Community Transportation Association of America. "Transportation programs were limited to specific client groups or programs. Two or three vans would follow one another down a road to pick up passengers. They'd all have empty seats and be heading to the same areas, but they were funded by different agencies receiving public monies. It doesn't take a rocket scientist to figure out it is more efficient and economical to coordinate those rides and run one vehicle."

In rural areas especially, coordinated public transportation improves efficiency while reducing duplication and costs for community agencies and organizations responsible for providing transportation for constituents. Both state and federal programs funding rural public transportation strongly encourage coordination of programs.

Riders and providers alike in northwest Minnesota began reaping the benefits of coordinated transportation four years ago when Tri-Valley Opportunity Council, a social services agency based in Crookston, Minn., assumed responsibility for coordinating a public transportation and volunteer driver system to serve a sparsely populated, very rural five-county area covering 6,500 miles in northwest Minnesota.



*As a volunteer driver for Tri-Valley Opportunity Council in northwest Minnesota, MaryLou Tucker has helped riders get to medical appointments and other services.*

Tri-Valley, which had provided transportation for human service needs since 1975, was one of several area agencies involved in public transportation. Funding from the Minnesota Department of Human Services was used to develop a Rural Transit Collaborative that put all agencies' vehicles under one coordinator. The system is available to anyone who wishes to use it, regardless of income level. Users can call a central number to schedule a ride, and can also access buses that follow a published schedule of stops throughout the five-county area. Volunteers, driving their own vehicles, fill in the gaps to provide rides unavailable through the scheduled bus system.

Program Director Michael Frisch said the coordinated system has



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resulted in increased ridership and decreased costs. Users and volunteers both benefit from the volunteer driver program.

“We have a lot of small communities with elderly people,” Frisch said. “The young people have moved away, the population has dwindled and there aren’t many services left in the town. The transit system allows people to remain in their home community and still get services. Some of these small towns don’t even have a grocery store anymore. Having volunteer drivers helps these people get to medical appointments and other services that are only available in some bigger cities that are a ways away. The volunteer drivers feel needed and valuable because they can help.”

MaryLou Tucker, of Euclid, Minn., is among the 42 drivers who donated about 14,000 volunteer

hours in the last fiscal year. In that time, Tucker added 31,320 miles on the odometer of her trusty red Mercury Sable. She volunteers, she says, because she likes to drive and to help people.

She has impacted a lot of people with her kindness; spending hours together in a car helps create new friendships. She recalled a young man with cancer that she transported to medical appointments more than 100 miles from his home. He had no family. Eventually he told Tucker he loved her like a mother. When he died, “the floodgates opened,” she said. “You get really attached sometimes. I just try to be there for my riders. If they want to talk, I listen. If they don’t, we listen to the radio. I enjoy being able to help.”

Tri-Valley’s volunteer drivers receive mileage expenses, but no pay.

They must meet certain standards, including a background check and successful completion of an educational program. Tri-Valley carries extra insurance coverage on them.

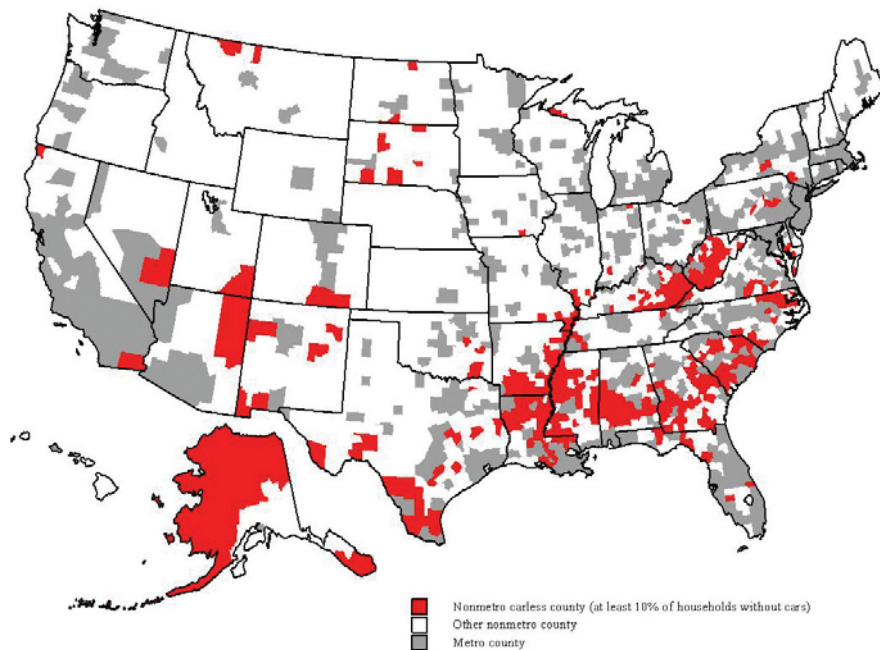
In 2005, Tri-Valley’s buses and volunteer drivers provided 70,514 rides, with 33 percent of riders being older adults, 53 percent adults, and 14 percent students and young adults. Riders most often used the system for work and job transportation, medical appointments and volunteer activities. However, Frisch said, surveys also indicated a wide variety of other reasons, such as court dates, children attending religion classes after school, transportation to Head Start facilities, shopping, socializing, etc.

“Positioning ourselves to be able to adapt to changing factors is vital on behalf of the clients we serve,” asserted Dennis DeMers, Tri-Valley’s CEO. “We must work together. Partnership is where the future directs us.”

Their partnership with area agencies has reaped unforeseen benefits, Frisch said. For instance, Tri-Valley provides transportation for Foster Grandparents with the Rural Senior Volunteer Program (RSVP) by transporting seniors to schools where they volunteer in classrooms. Some RSVP volunteers have cross-trained as Transit Collaborative drivers, increasing the driver pool. As RSVP members, these senior citizens benefit from educational training, a federally funded benefit program and public recognition for their volunteerism.

Like Tri-Valley, most agencies successfully providing public transportation keep their passenger pool open to anyone who wishes to ride, said David Barr, the national director of the Rural Transit Assistance Program (RTAP). Some federal funding programs require ridership

### Non Metro Counties with High Populations of Carless Households, 2000



Source: Calculated by USDA using Census Bureau data.

A map from the Economic Research Service shows non-metro counties with low car ownership rates. Highly carless rural communities are characterized by persistent poverty and have high concentrations of minorities. Source: “Rural Transportation at a Glance,” <http://www.ers.usda.gov/publications/AIB795/>

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# A Much Needed “JAUNT” for Seniors in Rural Virginia

by Candi Helseth

According to the National Rural Transit Assistance Program (RTAP), 36 percent of regional rural riders are elderly and 24 percent are disabled.

“Limited transportation programs can isolate these individuals from the very government programs that are designed to assist them,” said Charles Rutkowski, assistant director of the Community Transportation Association of America.

Thanks to a regional transportation system known as JAUNT, many disabled and elderly people living in rural Virginia are able to live independently or with their families while participating in day services provided by the Jefferson Area Board for Aging (JABA) Adult Day Healthcare Center in Louisa County.

“JAUNT has been just a godsend,” said Sarah Copeland, senior services manager at the center and a member of the JAUNT board. “People who normally would be in a nursing facility can stay in this community and in their homes. During the day, they come to the center for therapy, nutritious meals, socialization and other activities. JAUNT brings them to the center and takes them home. I’d say 99 percent of our clients use JAUNT. They either live alone and have no transportation or with family members who work during the day.”

Continuity of care is improved because JAUNT drivers check on clients if they don’t get on the bus at their scheduled times. JAUNT shares resources too, Copeland said. The center uses a JAUNT minivan for “special outings,” driven by an employee of the center who completed the specialized training that JAUNT requires for its drivers.

While JAUNT mainly serves the elderly and disabled, all members of the public are welcome to use the system, according to executive director Donna Shaunesey. “Three-



*The JAUNT bus has been a “godsend” for user Rosemary Funn and JAUNT board member Sarah Copeland, left, who says people with disabilities are dependent on public transportation to access services.*

fourths of our riders have a disability of some kind,” she said. “About one-third are riding back and forth to work, and another one-third use the service for medical trips. Overall, about 55 percent are adults, 40 percent seniors and 5 percent are children.”

JAUNT provides about 250,000 rides each year to residents in five counties and the city of Charlottesville. Begun in 1975 specifically to meet the needs of human service agencies, JAUNT continues today to meet those needs through contracts with the agencies while also providing public transportation without income or need stipulations. Riders pay fares ranging from \$1.00 to \$12.50, depending on the type of service used.

Rutkowski’s observation that individuals needing government assistance programs may not receive services because of inadequate transportation is confirmed by Copeland, who said, “If it wasn’t for JAUNT, I don’t think the adult day

care center could stay open. Most of our clients’ family members work and can’t transport them. Or the clients live alone and are unable to drive. What really makes JAUNT such an asset to this area is that everyone from these various agencies all know the schedules, and join together to provide continuity of care for these riders with special needs. I can’t say enough good about the difference this service makes in the lives of our clients. I did considerable research on transportation for my thesis, and I found that what we have going here in Virginia is a pretty unique approach.”

JAUNT’s current 70-vehicle mini-bus fleet, which covers 2,500 square miles, operates seven days a week. The system is owned by the local governments it serves, and funded by a combination of local, state and federal sources.

*For more information on JAUNT, visit their web site at: <http://www.ridejaunt.org/>.*



# Rethinking Human Services

by Tom Corbett, Ph.D.

## Poverty in Rural America

Each year in late summer, the U.S. Census Bureau updates the nation's profile regarding earnings and poverty. This is always a good moment to pause and reflect on how we are doing.

These days, we enjoy an additional weapon in our data arsenal. The American Community Survey (ACS) is a data collection tool of the Census Bureau that, in effect, replaces the functions of what was called the Census "long form." The ACS is administered on an ongoing basis, thus allowing us to update our poverty profiles both more often and at a finer level of geographic detail.

On the surface, the numbers seem rather benign. The 2005 aggregate poverty rate of 12.6 percent, representing some 37 million Americans, is virtually unchanged from the 2004 rate of 12.7 percent. Being poor in 2005, by the way, meant living in a household where income fell below a pre-established annual threshold—about \$15,600 for a family of three. Median household income was \$46,326, up slightly from the 2004 figure of \$45,817.

Are these numbers good or bad? Should we be concerned? As we all well know, aggregate statistics can mislead or obscure important dimensions of any social challenge. Comparative data, on the other hand, can turn numbers into meaningful information.

Let us quickly look at some comparisons. First, what has poverty looked like *over time*? In 1960, some 40 million Americans, 22.2 percent of the population, were classified as living in poverty.<sup>1</sup> By 1973, as the economy continued to expand and government assistance aimed at the disadvantaged exploded, the number of poor fell to less than 23 million

and the rate was halved to 11.1 percent. Then, the fight to lower poverty stalled and further progress proved elusive.

What about comparisons across *racial and ethnic groups*? Last year, only 8.3 percent of non-Hispanic Whites were considered to be poor. For Hispanics, the rate jumped to 21.8 percent. For Blacks and Native Americans, about one in four experienced poverty (24.7 and 25.3 percents, respectively). Obviously, historic disparities in economic opportunity persist.

What about *international comparisons*? Though a somewhat different measure is used, the bottom-line message is clear. Poverty and inequality are higher in the U.S. than in like countries around the world where similar economies make such comparisons reasonable.

There is a very old saying that the best test of a nation's character is how it treats its most vulnerable citizens—the young and the old. The *child poverty* comparisons are particularly striking. Over the past decade, child poverty in the U.S. has run some two to four times higher than what is found in most comparable countries. Scandinavian countries do a remarkable job of protecting children from economic want, with child poverty often being measured at less than 5 percent. In the U.S., the 2005 child poverty rate was 17.6 percent—affecting some 13 million children.

What about the *elderly*? In 1959, the official poverty rate among the elderly (65 years or older) was more than twice that of prime-age adults, those 18-64. In 2005, the elderly were less likely to be poor than prime-age adults. Now, as we have seen, children are the most vulnerable age group.

And, of course, *where someone lives* makes a difference. In 2005, median

household income for those living inside metropolitan statistical areas (urban residents) was \$48,474. For those living outside metropolitan areas (rural residents), the median figure was \$37,564. Not surprisingly, the overall poverty rate is higher in rural areas by some 2.3 percentage points.

Again, aggregate statistics may not fully reflect what is going on. If anything, rural poverty may have deepened in recent years. According to the Carsey Institute at the University of New Hampshire, more than one rural child in five is poor (22.5 percent) and economic want in rural America may be getting worse. They estimate that, between 2000 and 2005, rural child poverty increased in 41 of 46 states where data are available.

In some states, rural child poverty borders on the horrific. Five states (Alabama, Arizona, Louisiana, Mississippi and New Mexico) experience rates that exceed 30 percent. Perhaps this should not surprise us since 48 of the 50 counties with the highest concentrations of poverty are considered rural.

Children are our future, both of the country and of our rural communities. How concerned ought we to be? Officially measured poverty, after all, is widely believed to be a flawed measure of economic want. Moreover, there is much evidence that access to basic necessities has improved over time, even as our battle against poverty has stalled or even suffered some reversals.

Footnote:

<sup>1</sup> According to the U.S. Census Bureau (see <http://www.census.gov/hhes/www/poverty/histpov/hstpov1.html>), the poverty threshold for a family of three was \$2,359 in 1960. In real dollars,

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## Look What's Coming

by Wayne Myers, M.D.

### Critical Access, Yes; Hospital, Maybe.

One decade's solution becomes the next decade's problem. We "solved" the problem of survival of small rural hospitals by designating Critical Access Hospitals (CAHs). Now what shall we do with them?

The Medicare Prospective Payment System, adopted in 1984, is dangerous for small hospitals. They are paid what a deliberative body, currently called MedPAC (Medicare Payment Advisory Commission), tells Congress they should be paid. The formulae used to set these rates arguably favor large hospitals. Very small numbers of patients mean there is little chance for good luck and bad luck to "average out." A few unusually costly cases can wipe out a small hospital.

Some small hospitals closed in the 1980s. Over the following years Congress tried to moderate the impact of prospective payment on small rural facilities. It tried out a scheme devised in Montana that evolved, through demonstration projects, into the Critical Access Hospital.

The idea is that some specific small rural hospitals must exist to give safe, reliable access to urgently needed care, whether or not they make financial sense in MedPAC's terms. These Critical Access Hospitals should be paid what is necessary to keep them open. Worried hospitals could find fault with any single formula proposed to identify the critical geographic measures. "It's less than 30 miles from the nearest hospital but the roads are bad!" or "The pass is closed by snow in the winter." So governors were given the authority to decide which hospitals were critically needed.

The predictable result was that many governors certified any

supplicant hospital as critically necessary. We now have about 1,300 Critical Access Hospitals getting paid what they spend (plus 1 percent) to care for Medicare inpatients. That is about one-fourth of all the hospitals in the U.S. Some are medically necessary as inpatient hospitals. Some aren't. MedPAC and policy wonks realize that a lot of hospitals have gotten around the cost constraints of prospective payment. The fact that they are too small to cost much seems irrelevant.

Some of the host communities need these hospitals. Others don't. But many do need a center within the community providing a range of services including at least some of the following: ambulance and emergency care, with occasional overnight observation; mental health and substance abuse services; offices for traveling specialists; telemedicine consultation facilities; oral health care, whether provided by a dentist or a hygienist; a place for health promotion activities such as senior exercise get-togethers; primary care with shared ancillary services (lab, x-ray, etc.); a site for outpatient Veterans' care; and case management for people with chronic disease. Each community should have its own list.

Within a couple years we will probably see an effort to roll back the Critical Access Hospital payment mechanism. It will be very sad if we lose some truly essential hospitals, and a lot of other institutions struggling to serve their communities, by squeezing them into an inpatient model that doesn't really fit.

Smart rural people should be trying to define the services that belong on the menu of what I'd like to call a "Critical Access Community Health Center." "Aha!" says the acute reader. "What you're talking

about really is just a glorified Community Health Center with some Veterans Affairs, an ambulance and extended care clinic stirred in." Fair enough. If the community has a CHC then pull it together with the Critical Access Hospital and work to add the still-needed elements.

Convergence may make for healthier communities and more return on investment, but negotiating it will be tough—tough in the community, and tougher in Washington. Hospitals have their culture and Community Health Centers have theirs as do their funding agencies, representative organizations and the other potential collaborators. Can the commitment to cultural competence bridge these divides?

This scheme may not be the only one or the right one. That should not obscure the underlying factors: The CAH designation has been overextended. It is likely to come under attack. Many rural communities need basic health services more urgently than they need hospital rooms. It would be unfortunate to lose all CAHs, even the necessary ones, and lose a chance to do better at meeting community needs, by trying to defend all the current designations.

*Wayne Myers, a pediatrician, founded the University of Kentucky Center for Rural Health and served as its director. He also served as director of the Office of Rural Health Policy in the Department of Health and Human Services' Health Resources and Services Administration. He is a past president of the National Rural Health Association and currently serves on its Board of Trustees.*

**Opinions expressed in this column are those of the author and do not necessarily reflect the views of the Rural Assistance Center.**

### Special Series: Technical Assistance Centers

*Editor's note: This is the fifth in a series of articles on rural health technical assistance resources around the country that are funded by the federal Office of Rural Health Policy (ORHP). The first article (see *The Rural Monitor*, Fall 2005) gave an overview of what is meant by technical assistance. For a complete list of technical assistance resources available through ORHP, see <http://ruralhealth.lhrsa.gov/links/TACenters.asp>.*

#### Rural Health Works

by Candi Helseth

The National Center for Rural Health Works (RHW), located at Oklahoma State University at Stillwater, assists communities in revitalizing struggling local health systems. Since it was formed in 1998, the technical assistance center has provided training for community leaders in 45 states, and 32 states currently have active programs, according to its director, Dr. Gerald Doeksen.

RHW helps communities keep their health care dollars and services working for their home communities, Doeksen said. Essentially, RHW builds federal, state and local partnerships by teaching professionals how to conduct and present economic impact studies, demonstrating how impact studies can be used in a community assessment process, and providing budget tools for assessing and expanding community health services.

RHW can develop data from a variety of perspectives. It can do regional analyses, state analyses and analysis specific to certain cities, counties and zip codes, or a combination of any of them. Small, rural hospitals typically don't have access to this type of information, and generally can't afford to hire market research to provide it. RHW

provides resources to these communities at no cost.

The data is crucial in helping the community understand the importance of keeping its health care system, Doeksen said, adding that as much as 20 percent of the local economy disappears when a hospital closes.

"Once you lose your hospital, you also lose supporting services," he said. "Research clearly documents that. You lose your doctors, pharmacist, nursing home—eventually, a lot of things in a community simply disappear after a hospital closes."

RHW has enjoyed considerable success working with hospitals to help them obtain designation as a Critical Access Hospital (CAH), which Doeksen calls "a definite financial benefit for rural hospitals" since 60 to 80 percent of their patients are on Medicare and CAH status offers them a higher reimbursement rate.

In addition to working with communities on an individual basis, RHW sponsors two "Train the Trainer" workshops each year, which take place on the West and East coasts and are open to interested state teams from across the nation. There is no charge for participants, but states are responsible for providing their transportation costs. Doeksen said typical participants are community members involved in economic development, local or state health care agencies and other state agencies such as commerce. Attendance is limited to 20 participants because the workshops are so intensive that effectiveness can be jeopardized if the group is too large. The next workshop will be held in March in Oregon.



*Dr. Gerald Doeksen, director of Rural Health Works, says the technical assistance center helps communities keep their health care dollars and services working in their communities.*

Besides sessions that equip participants to measure the economic impact of the health sector on counties, communities or medical service areas in their state, they also learn how to conduct specific health feasibility studies in areas such as primary care physician recruitment and retention, and emergency medical services.

"We like to build the infrastructure at the state level," Doeksen said. "The model we provide is quite complex, so typically the state's model is provided to rural counties, hospitals and communities. The goal is to develop the infrastructure so that the people attending the workshops implement the program in their states, and the infrastructure is in place even if they experience turnovers."

In addition, RHW offers its Community Tool Box at the workshops, which includes strategic health planning materials and instructions, a health survey instrument, materials for local and statewide media outlets, and videos on the Critical Access Hospital program and using health economic impact information to support local health care.

"Every year we're developing new tools we hope states will use," Doeksen said.

One model the center developed has particularly demonstrated the

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## Success Stories Available

by Holly Gabriel

Are you looking for innovative ways to improve services and address challenges in your community? Or would you like to share the details of a successful project with other communities? The Rural Assistance Center can help. The Success Stories section (<http://www.raonline.org/success/>) of the RAC web site features a database of successful rural projects that could serve as model projects for other communities. For rural communities and future grant applicants, these success stories may serve as examples for ways to organize, fund, and deliver rural health and human services.

Summaries of successful rural projects on our web site are searchable by topic or by state. Success stories are categorized into 42 different topics. Below are examples of telehealth success stories on our web site. More information about these success stories is available online (<http://www.raonline.org/success/>).

• **Appal-Link: The Southwestern Virginia Telepsychiatry Project** ([http://www.raonline.org/success/success\\_details.php?success\\_id=238](http://www.raonline.org/success/success_details.php?success_id=238))

A state psychiatric hospital in southwestern Virginia is using interactive video teleconferencing to provide medication management to rural patients at seven remote outpatient facilities.

• **Dakota Network of Community Health Centers: North Dakota and South Dakota** ([http://www.raonline.org/success/success\\_details.php?success\\_id=276](http://www.raonline.org/success/success_details.php?success_id=276))

This program has an Electronic Health Information Management Network with interactive video conferencing in place and it is being utilized to the benefit of the Dakota Network Collaborating Organizations and the patients served.

• **TelEmergency-Mississippi** ([http://www.raonline.org/success/success\\_details.php?success\\_id=245](http://www.raonline.org/success/success_details.php?success_id=245))

In response to a lack of emergency care and physicians in many rural areas of Mississippi, the University of Mississippi Medical Center (UMC) has developed and directs the operation of a rural health telemedicine initiative called TelEmergency. Rural hospitals have contracted with UMC to allow the Emergency Medicine specialist backup for the nurse practitioners who completed the program and were hired by the local facility. When

these nurse practitioners staff the rural Emergency Department, they communicate with Emergency Medicine physicians at UMC via T-1 lines and a sophisticated telemedicine setup.

Rural communities and future grant applicants can use these telehealth success stories as examples for ways to deliver services in rural communities. In addition to the telehealth success stories on the RAC web site, there are also similar success stories regarding technology

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The screenshot shows the Rural Assistance Center website interface. At the top, there is a navigation menu with categories: Funding, Information Guides, News & Events, Experts & Organizations, Publications & Maps, Success Stories (highlighted), and State Resources. Below the menu, there is a breadcrumb trail: Home > Success Stories >. The main content area displays the details for the 'Appal-Link: The Southwestern Virginia Telepsychiatry Project'. The page includes a 'Print Page' button in the top right corner. The project details are organized into sections: Topics (Mental health, Telehealth), States served (Virginia), Description (Staff psychiatrists at Southwestern Virginia Mental Health Institute use the technology to provide follow-up care to mentally ill patients who have been treated in the hospital and then discharged into the care of the community service board in their community. The Appal-Link Network serves the poorest and most rural section of Virginia. A shortage of psychiatrists (only one per 16,000 people) has contributed to a high relapse rate for chronically mentally ill patients residing here. Before this project began, the region had the highest hospitalization rate in the state.), Services offered (Patients treated through the Appal-Link Network have chronic and severe mental illnesses, including major depressive disorder, schizophrenia, bipolar disorder, and schizoaffective disorder. The network provides an opportunity for these patients to remain in their communities while still receiving long-term medication management from the same psychiatrist. The project also uses the network for treatment planning conferences, discharge planning, family visits, and commitment hearings. Generally, the hospital treatment team and a case manager from the local community service board conduct a discharge planning conference with the patient over the network to introduce all the participants to the technology.), Results (By May 1997, consortium members had conducted 1,023 medication management appointments over the Appal-Link Network, as well as 357 case conferences addressing treatment plans, 60 family visits, 42 commitment hearings, and two forensic evaluations. The telepsychiatry clinic currently follows 83 patients.), and Source (The Outreach Sourcebook, Vol. 4, 1994-1997, Office of Rural Health Policy).

to be unrestricted; more simply, he noted, restricting ridership simply doesn't make good business sense.

Partnership arrangements among agencies across the United States vary widely.

"It's difficult to measure the magnitude of human service agencies' programs nationwide because transportation costs are often bundled with the overall cost of providing service to clients," said Dennis Brown, a regional economist with the U.S. Department of Agriculture's Economic Research Service. "But there's no doubt that coordinated transportation avoids duplication by encouraging the usage and sharing of existing resources."

However, systems that coordinate across city or county lines, like Tri-Valley, are still in the minority. According to Brown, about two-thirds of rural systems operate in single counties or one city or town. "Public transportation is available in 60 percent of rural counties, but only one out of four providers operate in a multi-county area. And 28 percent of those areas that do have transit have limited services."

### Who Uses Public Transportation?

Getting back and forth to work or to job training accounts for about one-third of all trips in rural public transportation systems.

"Lack of transportation, or unreliable transportation, means people can't get to work or they miss work," Brown said. "That makes it difficult to hold a job, resulting in long-term poverty and dependence on government programs."

Health care appointments constitute about one-fourth of all trips nationwide. Needs don't differ greatly from rural to urban areas, but in rural areas distance can be formidable, Rutkowski said. "Medical care is becoming increasingly specialized. People in many rural communities have to travel a long ways for specialty treatment such as radiation or dialysis. Individuals needing these services are more likely to be elderly and may not drive anymore. Inability to get transportation for daily living activities may necessitate moving from their homes into long-term care facilities or to a larger community."

"We had a gentleman whose wife was in a nursing home and he couldn't drive," Frisch affirmed. "He took the bus from their home to see her every day for two years until he went into a retirement home. Public transit allowed him to remain in his own home, which he preferred and which was also a cost savings. We've seen those kinds of examples a lot."

Non-metro or rural areas also have higher levels of poverty and larger shares of people who are disabled and elderly, Brown noted.

"We also have more low-income individuals entering the work force as a result of welfare reform, and they are less likely to have their own transportation," Rutkowski said. "And the fact that we have an increasingly aging population means the number of seniors needing services is much higher than it's been in the past."

Less than 20 percent of users nationally list shopping and recre-

### FACTS ABOUT RURAL TRANSPORTATION

- Rural roads comprise 80 percent of national road miles (3.1 million rural road miles) and carry 40 percent of vehicle miles traveled.
- Some 50 percent of rural roads are paved; 90 percent are two-lane or less.
- City and county governments are responsible for 95 percent of unpaved and 55 percent of paved roads. Approximately 40 percent of county roads are inadequate for current travel.
- Fatalities on rural roads occur at a rate of 2 ½ times greater than on all other routes. The five states with the largest number of rural, non-Interstate traffic deaths between 1999 and 2003 were: Texas, California, Florida, North Carolina and Pennsylvania.
- More than 1.6 million rural U.S. households do not have access to a car. The highest proportion of carless households is in the south, southwest and parts of Alaska.
- Nationwide, over 90 percent of individuals on public assistance do not have a car.

#### Sources:

Federal Highway Administration. "Planning for Transportation in Rural Areas." <http://www.fhwa.dot.gov/planning/rural/planningfortrans/2ourrts.html>.

The Road Information Page (TRIP), "Growing Traffic in Rural America: Safety, Mobility and Economic Challenges in America's Heartland." March 2005. <http://www.tripnet.org/RuralRoads2005Report.pdf>.

Economic Research Service, "Rural Transportation at a Glance." January 2005. [http://www.ers.usda.gov/publications/AIB795/AIB795\\_lowres.pdf](http://www.ers.usda.gov/publications/AIB795/AIB795_lowres.pdf).

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ation as primary public transportation needs, and rides for children account for less than 15 percent.

## What Are the Challenges?

Keeping transportation affordable for riders and, at the same time, operating a solvent system seems to be the biggest challenge, Barr speculated.

Challenges in rural areas are compounded by sparse resources (time, money, personnel, training, etc.) and a more dispersed population, Barr said. Small transit systems

try to cover large geographic areas with a minimal number of vans or buses, a handful of personnel and very small budgets. Rural systems also face challenges in applying for state and federal grant assistance as they often have a lack of time or qualified personnel to fulfill the application process.

Other challenges include variables, such as fuel costs, which were a major impact this last year, Rutkowski said. "Insurance varies greatly year to year, liability issues can be a huge variant and there are many variables that can threaten a program's economics."

Since the start of its collaboration in 2002, Frisch said, Tri-Valley has increased usage, eliminated duplicative services and is operating in the black. Rider fees average out to about 10 cents per mile, but subsidized state and federal funding programs cover the bulk of actual expenses.

"Today it takes a combination of federal, state and local funds to support rural public transit," Rutkowski said. "These programs are not self-sustaining from user fees. The economics aren't there. They all require governmental support."

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## Continued from *Rural Health Works*, page 6

importance of local health care, he said, by measuring "typical physician" impact in a community. Factors calculated include the number of physician offices, hospital admissions, revenue to local hospital, number of prescriptions written, etc. Doeksen said generally RHW can demonstrate that a typical physician generates more than \$1 million in revenue in a community, as well as having impact in other areas.

Rural Health Works operates as a partnership among the involved states, the federal Office of Rural Health Policy, Department of Health

and Human Services, USDA Cooperative Extension Service and Rural Policy Research Institute. Initially, there were five pilot states: Kentucky, Missouri, Nevada, Oklahoma and Pennsylvania. A steering committee consisting of professionals from the five pilot states and associated national organizations now direct the project.

The true reward of running the program, Doeksen said, comes from seeing community leaders, equipped with their new knowledge, going back home to sponsor fundraisers, raise awareness of elected officials,

establish clinics and health centers, and get personally involved in efforts such as physician recruitment, board service and finding funding.

For more information on RHW, write RHW c/o Oklahoma Cooperative Extension Service, Oklahoma State University, 513 Ag Hall, Stillwater, OK 74078; phone Gerald A. Doeksen at (405) 744-6083; visit <http://www.ruralhealthworks.org/>; or e-mail Doeksen at [gad@okstate.edu](mailto:gad@okstate.edu) or Cheryl St. Clair at [cheryl@okstate.edu](mailto:cheryl@okstate.edu).

# Focus on Funding

A guide to rural funding opportunities and how to access them

## Finding the Funds for Rural Transportation

by Beth Blevins

This guide looks at funding for rural public transit and car ownership programs for low-income residents.

For more information on funding for rural EMS and other emergency medical transportation, see the RAC's **Emergency Medical Services** information guide at: [http://www.raconline.org/info\\_guides/ems/](http://www.raconline.org/info_guides/ems/).

### Overview

While car ownership programs are straightforward in their focus—to provide a car to a low-income resident to get to work, etc.—rural public transportation includes a broader range of programs:

- Bus or van service for all residents, no matter the income level or need
- Targeted bus or van service offered for the elderly or disabled, or to get low-income people to work sites
- Volunteer driver programs, coordinated and funded under the auspices of a social service agency or other organization, sometimes part of a larger public transportation effort

Many communities have found that using a combination of these services, and coordinating them among human service agencies to avoid duplication of resources, presents the most beneficial and cost-effective way to offer to public transportation (see cover story, Page 1).

For more information on coordinating transportation services, see:

• **Toolkit for Rural Community Coordinated Transportation Services** from the Transportation Research Board, which examines

strategies and practices used to coordinate rural transportation services, and identifies model processes used for local coordination efforts in rural communities. [http://www.trb.org/publications/tcrp/tcrp\\_rpt\\_101.pdf](http://www.trb.org/publications/tcrp/tcrp_rpt_101.pdf).

• **Coordinated Transportation Systems**, by Jon E. Burkhardt, AARP Public Policy Institute (November 2000). A paper that analyzes eight coordinated transportation systems in seven states across the U.S. <http://www.aarp.org/research/housing-mobility/transportation/aresearch-import-122-2000-16.html>.

• **Rural Transportation.org** offers links to information on workshops for rural community transportation coordination, as well as general information and useful web links for rural transportation planning and development issues. <http://www.ruraltransportation.org/>.

### General Federal Funding

Nine federal departments (a total of 62 agencies) provide funding for human service transportation, making them too numerous to list here. However, they can be accessed via the web site of the federal interagency, **United We Ride**, <http://www.unitedweride.gov> (see “Federal Program Guide.”)

The publication, **Opportunities for Federal Investment**, from the Community Transportation Association of America (CTAA), identifies all federal investment opportunities for transportation and mobility partnerships, with a listing by department/agency. It includes programs that are not traditionally used to help support community

transportation services. It is available at: <http://www.ctaa.org/pdfs/informationstation.pdf>.

### Federal Funding for “Rural” Transportation

The definition of “non-metropolitan” is broader in some federal transportation programs than it is for federal programs in other subject areas. For instance, the Federal Transit Administration provides funding for rural transit with its 5311 program for “non-urbanized areas” (urbanized areas are eligible for assistance through the 5307 program); in the 5311 program, non-urbanized is defined as “areas of less than 50,000 population.” For the purposes of the 5311 program, the terms “nonurbanized areas” and “rural and small urban areas” are used synonymously to mean any area outside of an urbanized area, as designated by the Bureau of the Census. The grant also allows projects that may include transportation to and from urbanized areas.

For more information on FTA rural programs, contact your state Department of Transportation. For a list of **State Transportation Web Sites**, see <http://www.fhwa.dot.gov/webstate.htm>.

For a discussion on how the Federal Highway Administration defines “rural,” see **Planning for Transportation in Rural Areas**, <http://www.fhwa.dot.gov/planning/rural/planningfortrans/2ourrts.html>.

### Public Transit Funding

Rural communities interested in developing transportation programs may want to begin by contacting CTAA or their state Rural Transit Assistance Program (RTAP) office.

CTAA supports the **Information Station** (<http://www.ctaa.org/NTRC/>), a web site that provides community transportation news, on-line publications, access to a peer-to-peer network and links to web sites by such topics as coordination, medical transportation, seniors and rural. They also have a toll-free telephone (800-891-0590) with extensions for these specific transportation topics.

All states have a RTAP office. They can provide technical information to help start transit programs, identify successful transportation programs within each state and provide all the training materials developed by the National Rural Transit Assistance Program (NRTAP). A list of state RTAP offices can be accessed from the **National NRTAP** web site, at: <http://www.nationalrtap.org/statecontacts.asp>.

### Transit Funding for Specific Populations

CTAA has a web page devoted to **Non-Traditional Funds for Community Transportation** (<http://www.ctaa.org/ct/janfeb99/funding.asp>), including funding for specific populations such as people with HIV through the Ryan White CARE Act. The page also gives examples of how communities in different parts of the country have funded their transit programs. CTAA also offers **Toolkits** for transportation planning for specific populations including senior and medical transportation, available at: [http://www.ctaa.org/ntrc/is\\_toolkits.asp](http://www.ctaa.org/ntrc/is_toolkits.asp).

A recent report from the Easter Seals, **Transportation Services for People with Disabilities in Rural and Small Urban Communities**, includes examples of innovative state and community funding strategies,

such as a paratransit program in New Jersey funded with casino revenues and a voucher program for visually impaired riders in Nebraska achieved with a combination of federal and private funds. It also includes a discussion of human service transportation coordination. A summary of the report is available at the organization's **Project ACTION** (Accessible Community Transportation in Our Nation) web site at: <http://projectaction.easterseals.com/>.

### Car Ownership

Most state and community car ownership programs are primarily geared to low-income individuals who are enrolled in the Temporary Assistance to Needy Family (TANF) program. Types of programs include car donation programs (often operated by private organizations); loans to individuals from states or counties to purchase cars or repair existing cars; and direct funding for car purchases. In addition, some areas also provide assistance in maintaining cars obtained through their programs, such as low-cost insurance programs and money for car repairs.

The National Economic Development and Law Center (NED&LC) maintains a **Low Income Car Ownership (LICO) Clearinghouse** (<http://www.nedlc.org/center/copc/>), which includes a guide to creating a car ownership program, and a searchable database of 162 LICO programs it has identified. Programs listed on the web site include the **Good News Garage** program (<http://www.goodnewsgarage.org>), a community garage program that began in Vermont, and now also operates in Massachusetts, New Hampshire and Connecticut, which provides

eligible, low-income residents with used but reliable cars.

### Additional Resources

- The Rural Assistance Center's **Transportation** information guide ([http://www.raconline.org/info\\_guides/transportation/](http://www.raconline.org/info_guides/transportation/)) provides a general overview of rural transportation, FAQs, links to tools, a list of active and inactive funding sources, a bibliography of related publications, forms and other documents, and contacts. RAC also offers a list of transportation Success Stories at [http://www.raconline.org/success/success\\_topic\\_details.php?topic=Transportation](http://www.raconline.org/success/success_topic_details.php?topic=Transportation).
- For a general overview of rural transportation issues, see the brochure, **Rural Transportation At A Glance**, available from the Economic Research Service, at: [http://www.ers.usda.gov/publications/AIB795/AIB795\\_lowres.pdf](http://www.ers.usda.gov/publications/AIB795/AIB795_lowres.pdf).

### GENERAL FUNDING INFORMATION

For general information on all kinds of funding sources, see RAC's Funding Guide: <http://www.raconline.org/funding>.

You may also call the information specialists at the RAC, who can assist you in your search for information on transportation or other kinds of funding. Contact them at (800) 270-1898 or by email at [info@raconline.org](mailto:info@raconline.org). Please include the following information in your request: your name and organization; the type of project you are interested in funding; and the location for your project: city, county and state.

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using the Consumer Price Index inflation calculator (<http://www.bls.gov/cpi>), that amount would be \$16,170 in 2006, slightly more than the figure currently in use.

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**Opinions expressed in this column are those of the author and do not necessarily reflect the views of the Rural Assistance Center.**



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available online ([http://www.raconline.org/success/success\\_topic\\_details.php?topic=Technology](http://www.raconline.org/success/success_topic_details.php?topic=Technology)).

The RAC success stories database currently has approximately 250 success stories. Sources of these success stories include submissions from rural health and human service professionals, the *ORHP Outreach Sourcebook, Volumes from 1994 through 2002*, and the *ORHP*

*Network Sourcebook, Volume 1: Rural Health Demonstration Projects, 1997-2000.*

The success stories section of the RAC web site also contains links to other resources featuring success stories including journals, publications, bibliographies, and tools such as other web sites and databases.

For more information regarding success stories, contact Holly

Gabriel, Information Specialist, Rural Assistance Center, at (800) 270-1898 or [holly@raconline.org](mailto:holly@raconline.org).

### Do you have a success to share?

If you have a success to share, we would like to hear from you! You can send us your success story suggestion online at: [http://www.raconline.org/success/success\\_suggestion.php](http://www.raconline.org/success/success_suggestion.php).

### Current Success Story Topics

- Abuse and domestic violence
- Aging
- Agriculture
- Child welfare
- Community development
- Dental health
- Economic development
- Emergency services
- Faith-based
- Family planning
- Health insurance & uninsured
- Health promotion and disease prevention
- Housing and homelessness
- Job training and adult education
- Limited English proficiency
- Mental health
- Migrants
- Minorities
- Networking and collaboration
- People with disabilities
- Pharmacy and prescription drugs
- Public health
- Schools
- Substance abuse
- Technology
- Telehealth
- Transportation
- Wellness
- Women
- Workforce
- Youth