Summer Edition

eNEWSLETTER

SECOND QUARTER 2017

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NEED TRAINING?

Call our office to schedule training for your agency at 1.573.341.6155

National RTAP is a program of the Federal Transit Administration dedicated to creating rural transit solutions through technical assistance, partner collaboration and FREE training.

National RTAP
Rural Transit Assistance Program

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LETTER FROM THE MANAGER

DEAR TRANSIT FRIENDS,

Heath Pickerill, *Missouri RTAP Manager*

With summer in full swing, we eagerly anticipate seeing all of you at our annual rural transit providers' session in August. Hopefully you have marked your calendar for the 2017 Missouri Public Transit Agency Conference scheduled for August 6th to the 8th at the University Plaza Hotel in Springfield. As in years past, we will be presenting program updates at the rural transit session for all 5311 recipients. We will also be discussing changes to the training schedule for 2018 and want your feedback. We are considering some slight modifications in an effort to lessen the burden on John Rice by reducing his number of travel days to a reasonable amount. He recently reported that he is training more now than before he retired from MoDOT. We want to be mindful of John's need for time on his farm to make his life a little less hectic. We ask that you wait to send your training requests for next year until after the session at MPTA. Once we have had an opportunity to consider everyone's input, we will finalize our recommendations to all rural transit agencies for scheduling classes in 2018. Even though there is still more than half of the year left, we are already thinking ahead to next year. As we plan for 2018, we will continue looking for opportunities to improve our services.

In addition to the MPTA Conference, you may want to consider attending the National RTAP Technical Assistance Conference being held in Omaha, NE from October 29 through November 1. This is the third annual conference and promises to provide great information that will appeal to transit providers as well as technical assistance personnel. It is held every two years in various locations. I had the opportunity to attend the 2015 conference in Denver. I was surprised by the number of sessions that related directly to transit agencies and not just RTAP centers. There was a strong level of involvement from transit providers from several states, so I encourage our agencies to represent Missouri rural transit at this upcoming event.

If you would like me to attend one of your transit meetings, please let me know of any upcoming dates. Agency and regional meetings allow me to stay connected with what is going on in your agency and others in your area. Additionally, I can provide an update on the Missouri RTAP program and answer any questions the group has in a smaller setting.

Remember to share any events or updates that you have for your agency. Please feel free to contact me at pickerillh@mst.edu or by phone at 573-341-7637 with any questions, comments, or suggestion you have. If you know someone who would like to start receiving the newsletter, they can call our office or go to the Missouri RTAP website at www.mortap.com and sign up.

Best wishes,

Heath Pickerill
Missouri RTAP Manager

MPTA
MISSOURI PUBLIC TRANSIT ASSOCIATION
2017 STATE CONFERENCE & EXPO

MPTA's 2017 Annual Conference will be held August 6-8, 2017 at the University Plaza Hotel in Springfield, Missouri.

Join us for exciting speakers, interesting vendor exhibits, and practical workshops on topics like "Building Better Together with your Local Planning Organization" and "The Key Role of TRANSIT in crisis management." This year's conference will focus on issues of interest to transit providers, but also of interest to local planners, community building networks, offices of sustainability, and more. Register at: http://mopublictransit.org/mpta-annual-conference/

*****Please note, your Application for Training Assistance must be submitted to Doreen, no later than 30 days prior to the conference for approval*****

REGISTRATION DEADLINE: August 8, 2017

SAVE TIME AND REGISTER ONLINE @ WWW.MORHA.ORG FOR CREDIT CARD PAYMENTS

Please join The Missouri Rural Health Association, Missouri Hospital Association, Missouri Primary Care Association and Missouri Department of Health and Senior Services, Office of Primary Care, as Collaborating Partners on the 2017 Missouri Rural Health Conference. These organizations are combining forces to bring the most up-to-date information and trends to Missouri's rural health providers.

THIRD ANNUAL NATIONAL RTAP TECHNICAL ASSISTANCE CONFERENCE:

TRANSPORTATION AT THE CENTER

REGISTRATION IS NOW OPEN for National RTAP's 2017 Technical Assistance Conference! Join us in Omaha, Nebraska October 29 to November 1 for this conference focused on training, tools, and practical solutions for rural and tribal transportation.

The program includes free half-day pre-conference workshops; breakout sessions with presentations and panels; keynote speakers, including updates from FTA; an EXPO of 30+ vendors; and plenty of networking opportunities. See the Conference Website for the schedule and tentative sessions.

The conference will officially kick off with a welcome reception on Sunday night and we invite you to attend the Big Night Out on Tuesday for a Masquerade at the Joslyn Art Museum.

In Omaha, we will feature "Routes" on Administration and Planning, Operations, Compliance, Coordination, and Technology. If you are a rural or tribal transit manager, state program manager, training specialist, or are interested in National RTAP tools or transit hot topics, register now to join in on the training and fun!

To register contact conference@nationalrtap.org or call 303.839.5197. For more information on the conference, visit nationalrtap.org/conference2017.

3rd
National RTAP
Technical Assistance Conference
TRANSPORTATION AT THE CENTER

DOT PUBLISHES NOTICE OF PROPOSED RULE MAKING

Written by:
U.S. Department of Transportation
John A. Volpe National Transportation

THE DEPARTMENT OF TRANSPORTATION IS

proposing to amend its drug testing program regulation to add four opioids (hydrocodone, hydromorphone, oxymorphone, and oxycodone) to its drug-testing panel; add methylenedioxyamphetamine (MDA) as an initial test analyte; and remove methylenedioxyethylamphetamine (MDEA), as a confirmatory test analyte. The proposed revision of the drug testing panel is intended to harmonize with the revised Mandatory Guidelines established by the U.S. Department of Health and Human Services for federal drug-testing programs for urine testing. This proposal also adds clarification to certain drug-testing program provisions where necessary, removes outdated information in the regulations that is no longer needed, and proposes to remove the requirement for employers and Consortium/Third Party Administrators to submit blind specimens.

FTA DRUG AND ALCOHOL MANAGEMENT INFORMATION SYSTEM (DAMIS) REPORTING

DAMIS reports with 2016 testing results were to be submitted by all FTA covered employers by March 15th of this year. Late letters will be sent out shortly to all FTA grantees who did not complete their submissions or who have contractors/sub recipients who did not report. Should you have any questions, please call the FTA Drug and Alcohol Project Office at 617-494-6336 or email fta.damis@dot.gov.

DRUG & ALCOHOL TRAINING

FTA sponsors free training sessions that provide essential information to facilitate covered employers' compliance with the drug and alcohol testing regulations (49 CFR Part 655 and Part 40). These one-day trainings are available on a first-come, first-serve basis and are led by the FTA Drug and Alcohol Program and Audit Team Members.

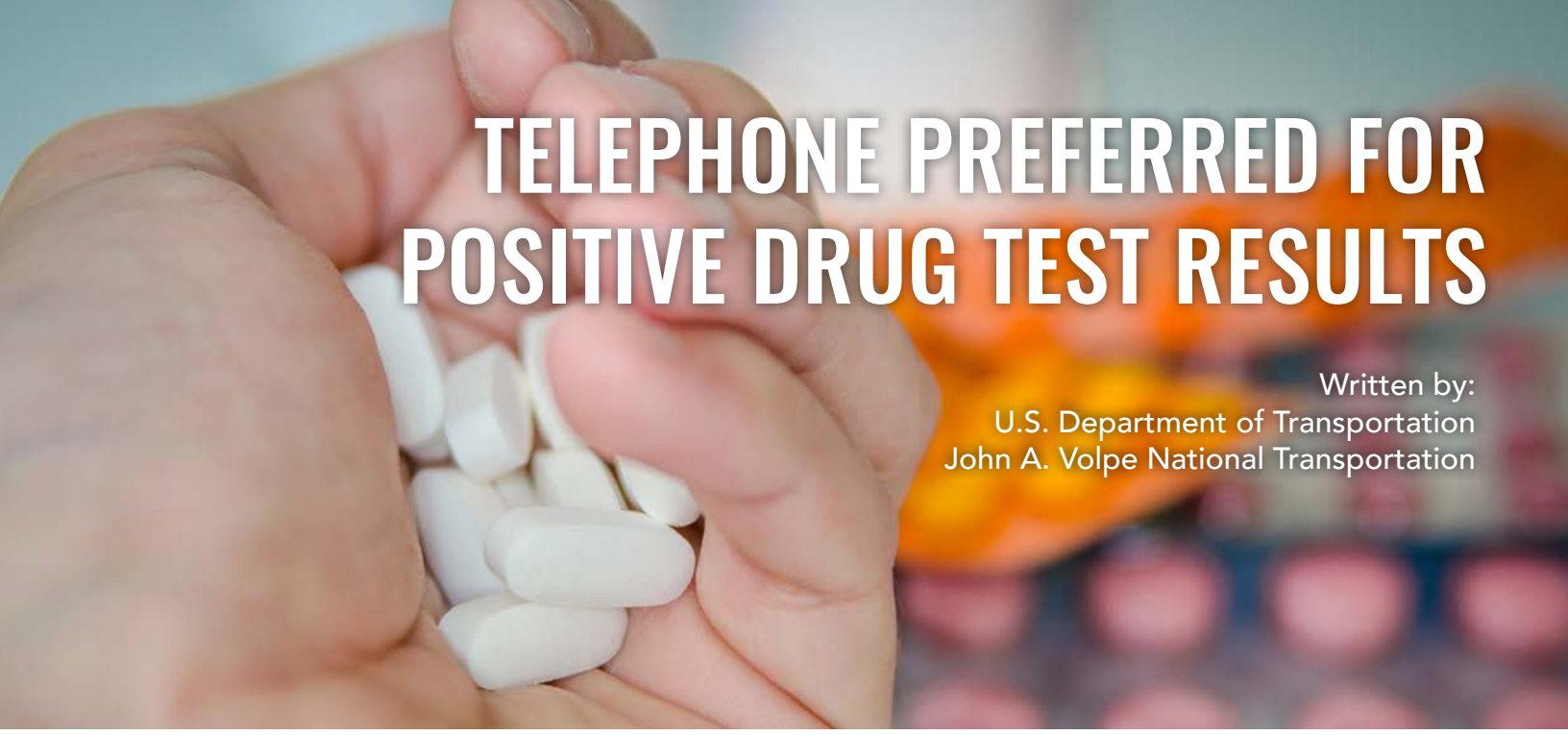
For more information about available training sessions and to register, go to: ransit-safety.fta.dot.gov/DrugAndAlcohol/Training.

If you are interested in hosting a one-day training session, contact the FTA Drug and Alcohol Project Office at fta.damis@dot.gov or (617) 494-6336 for more information.

FTA's strategic training partner the Transportation Safety Institute (TSI), will offer the following upcoming courses:

- Substance Abuse Management and Program Compliance. This three-day course for DAPMs and DERs will show how to evaluate and self-assess an agency's substance abuse program and its compliance with FTA regulations.
- Reasonable Suspicion Determination for Supervisors. This half-day seminar educates supervisors about the FTA and DOT regulations requiring drug and alcohol testing of safety-sensitive transit workers, and how to determine when to administer reasonable suspicion drug and/or alcohol tests.

There is a small attendance/materials fee. For more information, please call (405) 954-3682. To register, go to: www.tsi.dot.gov.



TELEPHONE PREFERRED FOR POSITIVE DRUG TEST RESULTS

Written by:
U.S. Department of Transportation
John A. Volpe National Transportation

WHEN A MEDICAL REVIEW OFFICER (MRO) reports a positive drug test result to an employer, telephone is the preferred method of contact (49 CFR Part 40.167(b)(1)). Use of the telephone allows for immediate and unambiguous delivery of important information, enabling the Designated Employer Representative (DER) to promptly remove the employee from safety-sensitive duties. Delivery by other methods (e.g., fax, email) can cause a delay between the time the result is sent and he time the DER reads it.

It is a best practice for an employer to pro-actively provide their MRO with the "Employers' written drug and alcohol policies often misuse the term SAP." DER's direct contact information including, their office phone number, mobile number, and any alternative phone numbers. If there is a backup DER, the MRO should have their direct contact information as well.

While a DER should wait for documentation of the MRO's verified result before taking official disciplinary action relating to the employer's stated policy concerning a positive drug or alcohol test result, DERs must remember no documentation is required to remove an employee from safety-sensitive duties once they receive a verified result verbally from an MRO.

RANDOM ROSTERS— ACCURACY COUNTS

FTA requires random selections be conducted no less frequently than quarterly. Whether an employer chooses to perform selections on a quarterly, monthly, weekly, or even daily basis, they must ensure the random rosters are accurate at the time the selection list is created. Thus, every employer must have a method to ensure rosters are consistently updated to include newly hired employees and to remove terminated or retired employees. Depending on your company's policy, employees on extended leave (those who will not return to safety sensitive duties for one or more selection periods) may also be removed from the random pool.

Roster accuracy ensures all safety sensitive employees are subject to random testing and have an equal chance of being selected.

REMOVAL OF AN EMPLOYEE FROM SAFETY SENSITIVE DUTY FOLLOWING A POST-ACCIDENT OR REASONABLE SUSPICION OCCURRENCE

Part 655 does not prohibit an employer from automatically removing an employee from safety sensitive function following an occurrence resulting in a post-accident or reasonable suspicion test. If the employer chooses to do so, it must be done consistently, and be done immediately following the completed test (i.e., prior to the start of the Medical Review Officer [MRO] verification process). An employer may have different policies for different test types and/or different safety-sensitive functions. For instance, an employer may have a policy to remove a revenue vehicle operator from a safety-sensitive function following an FTA-defined accident until a verified test result is received, but may decide not to do so for a dispatcher found to have contributed to the same accident. In any case, this decision must be clearly stated in the employer's FTA drug and alcohol policy.

"It must be done consistently and immediately."

The above policy is based on a testing event due to an occurrence which results in a post-accident or reasonable suspicion tests and differs for a stand down. Part 40 defines a stand down as the practice of temporarily removing an employee from the performance of safety-sensitive functions based only on a report from a laboratory to the MRO of a confirmed positive test including: a drug, drug metabolite, adulterated test, or a substituted test, before the MRO has completed verification of the test result. A stand down policy is not allowed, unless the employer petitions FTA and receives a waiver.

"It must be clearly stated in the employer's policy."

THE ANTI-DRUG AND ALCOHOL MISUSE POLICY

The FTA allows an employer to make available, by electronic distribution, the FTA anti-drug and alcohol misuse policy statement to their covered employees and employee representatives. The policy can be individually distributed to an individual employee's company e-mail account or can be posted on a company website when accessible to all covered employees.

A new or revised policy posted on a company web site requires the employer to provide individual notice of the policy's location.

POLICIES AND THE TERM "SUBSTANCE ABUSE PROFESSIONAL"

FTA-covered employers' written drug and alcohol policies often misuse the term Substance Abuse Professional (SAP) by referencing SAP referrals which might occur after events that are not legitimate DOT violations. Part 40 explicitly defines SAPs as gatekeepers for the DOT return-to-duty process, and the term SAP is understood in the transportation and health industries to refer only to DOT testing. For these reasons, only FTA -covered employees with DOT drug or alcohol violations may be referred to a SAP; a technical point that must be reflected in written policies.

Many FTA-mandated policies discuss referrals after non-qualifying events, such as an employee with a confirmed alcohol concentration of 0.02 or greater but less than 0.04, employees who voluntarily seek help for a drug and/or alcohol problem, and employees who fail or refuse a non-DOT test. Such a policy must refer employees in these circumstances to a professional/ organization other than a SAP (e.g., a substance abuse counselor, Education Assistance Program (EAP), etc.), even if that professional is the same individual who would act as a SAP after an actual DOT violation.

FREE DRUG & ALCOHOL RESOURCES

FTA's Office of Transit Safety & Oversight provides many useful–and free–resources to help covered employers implement their drug and alcohol programs. These resources may be found at transit-safety.fta.dot.gov/DrugAndAlcohol/Tools_Default.aspx.

Among the most popular items are FTA's policy builder, where an employer can answer several simple questions to develop a customized and FTA-compliant drug and alcohol policy; forms to document post-accident and reasonable-suspicion testing decisions; and a convenient collection of guidance from the Office of Drug and Alcohol Policy and Compliance (ODAPC), such as the publication What Employers Need to Know about DOT Drug and Alcohol Testing.

TOOLS

POLICY TOOLS

- All anti-drug and alcohol misuse programs must have a statement describing the employer's policy on prohibited drug use and alcohol misuse in the workplace.
- Use the Policy Requirements Checklist to ensure your own policy includes all required elements.
- Starting from scratch? Use the Policy Builder to develop a customized policy statement for your organization.

SAMPLE FORMS AND OTHER USEFUL TOOLS

PRE-EMPLOYMENT/NEW HIRE

- Pre-Employment Notification and Acknowledgement Form
- Previous Employer Release of Information Form
- Acknowledgment of Policy Form
- Acknowledgement of Prohibited Awareness Training for Safety-Sensitive Employees Form

RANDOM

- Random Testing Charts (Generate Random Testing Charts in Excel)

POST-ACCIDENT

- (New) Post-Accident Testing Chart
- Decision-Making Form
- Order Post-Accident Threshold Cards

WHY DOCTORS SHOULD CONSIDER GIVING THEIR PATIENTS A RIDE

Our Missouri pilot project showed that free trips to the doctor pay off for everyone

By Suzanne Alewine

IN 2014, LEO HARALSON'S BIG TOE TURNED black, a casualty of his battle with diabetes. A veteran and a former software developer for the U.S. Navy, he had insurance through both Medicare and the Veterans Affairs Department, so getting good health care shouldn't have been a problem. But after the toe was amputated, he developed an infection that spread to his bones. Haralson needed daily oxygen treatments at a hospital to halt the infection.

Haralson and his wife, 65, motorcycle enthusiasts originally from Wisconsin, had retired to southern Missouri, seeking a warmer climate and a home in the middle of the country so they could drive off in any direction. They built their dream home on the outskirts of the town of Mountain View, named for its commanding view of the Ozarks. But his wife could no longer drive, and with his foot in bandages, Leo couldn't either. The hospital was 30 miles down Highway 60 from his home, and the local transit provider has bus service only on Wednesdays. Without a way to get to the hospital every day for a month, Haralson faced losing his leg—and his ability to live independently.

Transportation comes up in virtually every conversation about rural health care, particularly in the past few years as hospital closures have increased the distances many patients need to travel. Missouri has closed three hospitals since 2010, victims of cutbacks in reimbursement from insurers and the government. Distances patients must travel are increasing.

As policymakers look at ways to improve the health of rural Americans, it's becoming increasingly clear that transportation is a critical missing link between patients and providers.

The problem isn't necessarily a lack of rides; many places, like Missouri, have a variety of transportation options for people who can't drive. Medicaid provides some non-emergency transportation for eligible patients. Some local communities run van services, particularly for seniors. The Southern Missouri Transportation System and OATS, a nonprofit transit company, provide van services, as well. And there are medical transportation services including emergency ambulances.

But all of those systems have problems and gaps. For Medicaid, rides must be ordered five days in advance, and cannot include secondary stops, even just to visit a pharmacy to fill a prescription after the doctor visit, without prior approval. Van and bus services run once or twice a week on fixed schedules and routes that may not match a patient's appointment times. And ambulances are expensive.

There's a bigger problem, too: The current system puts the burden of navigating those options and schedules on patients, even as they are struggling with illness and symptoms like pain, confusion and fatigue. In Missouri, we have found that when getting a ride isn't simple and affordable, patients will forgo care. And that means that their conditions can worsen until they become acute and result in an ambulance ride to the ER instead—the most expensive option of all.

Clearly, the existing system doesn't work well for anybody. Patients are overwhelmed and often give up. Doctors and hospitals lose time and revenues because of "no-shows." And ambulance companies are transporting patients who didn't know whom else to call—and then don't get paid if an insurance company or Medicaid decides it wasn't an actual emergency.

As a health care consultant and the executive director of the Missouri Rural Health Association, I helped develop a program to test whether there was a better way. We got seed money to hire a "mobility coordinator" who could arrange rides for patients who needed them. Our program, called HealthTran, trained clinic and hospital staff to ask patients at the time they made appointments whether they needed a ride. And if they did, they alerted the HealthTran coordinator who would contact them, assess their transportation needs and figure out a cost-effective solution.

Leo Haralson was one of HealthTran's first patients. In his case, the coordinator determined that because of his infection, he needed private rides from his home in Mountain View to Ozarks Medical Center in West Plains, 30 miles away. She arranged 70 rides for him at a cost of $6,000. That wasn't cheap, but it paid off. The hospital benefited by being able to bill Medicare $13,000 for the oxygen treatments and avoiding penalties for a hospital readmission. Medicare saved the cost of a leg amputation and possible transfer to a nursing home.

As always in health care, a key question is, "Who pays"? What HealthTran learned is that it's actually cost-effective for clinics and hospitals to provide the service at no cost to the patients because providing rides reduced the number of no-shows.

Here was how it played out at one hospital system: In just 17 months, HealthTran provided 2,470 rides for patients receiving services, at a cost of just over $66,000. Including staffing, the total cost of coordinating and paying for transportation was approximately $95,000, an average of $33 per ride. These patients resulted in over $730,000 in payments to the hospital and its clinics. In short, for every $1 invested in transportation, the hospital earned $7.68 in reimbursement.

The return on investment in transportation is so strong that it can pay off even for individual doctors. A missed appointment means missed revenue, loss of provider productivity, patient rescheduling and most likely a sicker patient. If 20 percent of scheduled appointments are missed on a weekly basis, and the average charge for that primary care visit is $150, a provider who typically sees 20 patients per day will miss out on $3,000 each week (or 1 entire day's worth of revenue), while staffing costs remain constant. At $225 per visit for specialty care, the provider misses out on $4,500. Over the course of a year, the health care provider is missing out on $156,000 to $234,000. Considering the average cost of a ride for these patients at $33, the annual cost of paying for transportation and mobility coordination would be about $45,000. This is a $3.46 to $5.20 return for every $1 invested in transportation.

And that doesn't even consider the improved patient outcomes and those long-term savings to the health care system.

Perhaps the biggest payoff is that it helps senior citizens like Haralson and people with disabilities to live successfully in homes of their own rather than move to nursing homes or assisted-living facilities, placements that can erode their health and cost the government and other insurers much more money in the long run. If Haralson had required a leg amputation, that would not only have cost Medicare and Medicaid upward of $1 million, but left him disabled and likely forced to move to a nursing home. Instead, Haralson was able to continue to live at home and fend for himself. These days, he's spending his retirement helping deliver meals to homebound seniors in his community.

So, why aren't more hospitals offering no-cost transportation to their patients? One reason is that well-intentioned federal regulations have created unnecessary hurdles. In an effort to avoid a practice known as "self-dealing," hospitals are not allowed to directly provide transportation to patients. While there were a few instances in the past of hospitals unfairly profiting by providing transportation between nursing homes and hospitals, the practice was not widespread. Still, the rules designed to eliminate that practice now make it difficult for providers to take on the transportation problem directly. That's why the HeathTran model offers a solution: By using an outside coordinator to make the arrangements, HealthTran helps hospitals maintain an arms-length relationship from transportation services.

In theory, driverless cars could someday address some of the need for medical transportation. But I'm skeptical that will solve the problem for most patients because a key factor in health care is human interaction. Many patients who need transportation are seniors, or have a disability that can make it hard to get to and from their front door and the vehicle without assistance. At least in Missouri, and I would venture to say in many other areas of rural America, people need a human connection—a person in the community, familiar with the community—to connect the health, transportation and payer systems in a way that makes good, common sense. And besides, we can't wait for a driverless future. Patients in rural America need a solution now.

Missouri's HealthTran was designed to bridge the transportation gap between patients and providers in a way that works for all sides. Rural America needs more of these solutions. If we can't make it easier for rural patients to get to and from their homes and their doctors, the whole country will pay for it down the road in greater medical costs and poorer health outcomes.

Suzanne Alewine is a health care consultant and executive director of the Missouri Rural Health Association.

AVAILABLE TRAINING PROGRAMS

The following is a list of the training programs and a course description of each that are currently available to rural transit providers through Missouri RTAP. Requests for training can be made by contacting Doreen Harkins, MO-RTAP Program Specialist, at *harkinsd@mst.edu* or 573-341-6155.

1. **AGGRESSIVE DRIVING —1 hour.**
2. **BACKING SAFETY — 1/2 hour.**
3. **BASIC FIRST AID — 1 hour.**
4. **BLOOD BORNE PATHOGENS — 1 hour.**
5. **CPR & BASIC FIRST AID — 4 hours.**
6. **DEFENSIVE DRIVING — 3 hours.**
7. **DISTRACTED DRIVING — 1 hour.**
8. **DIVERSITY & AWARENESS TRAINING - *PROVIDING QUALITY CUSTOMER SERVICE FOR TRANSPORTATION PASSENGERS WHO HAVE DISABILITIES* — 2 hours.**
9. **DRIVEN TO EXTREMES — 1 hour.**
10. **DRUG ABUSE AWARENESS IN RURAL TRANSIT — 1 hour.**
11. **EMERGENCY PROCEDURES — 1 hour.**
12. **ENTRY LEVEL CDL DRIVER TRAINING — 2 hours.**
13. **FATIGUE AWARENESS FOR DRIVERS — 2 hours.**
14. **HIPAA — 1 hour.**
15. **OPERATION LIFESAVER – HIGHWAY-RAIL CROSSING SAFETY — 1 hour.**
16. **PASSENGER ASSISTANCE/MOBILITY AID SECUREMENT— 2 hours.**

17. **REASONABLE SUSPICION TRAINING FOR SUPERVISORS— 2 hours.**
18. **REVERSING THE TREND – *BACKING SAFETY* — 1 hour.**
19. **SAFE & SECURE PROPER INFANT AND CHILD SEAT INSTALLATION — 2 hours.**
20. **SENSITIVITY AWARENESS — 1 hour.**
21. **WHEELCHAIR SECUREMENT — 2 to 3 hours depending on number of participants.**
22. **WINTER DRIVING SAFETY — 1 HOUR.**

For more information on classes and to register please visit: mltrc.mst.edu/mortaphome/mortaptraining/

RESOURCES

National RTAP – Rural Transit Assistance Program
www.nationalrtap.org/

Transportation Safety Institute – Transit Safety & Security Training Division
www.tsi.dot.gov/Transit.aspx

Federal Transit Administration – Rural Transit Assistance Program Page
www.fta.dot.gov/funding/grants/grants_financing_3554.html

National Transit Institute
www.ntionline.com/

Kansas RTAP – Kansas University Transportation Center
www.kutc.ku.edu/cgiwrap/kutc/rtap/index.php/index.html

Transportation Research Board's (TRB) Transit Cooperative Research Program (TCRP)
www.tcrponline.org/