

A Primer on Rural and Human Services Transportation in Georgia

Report 1 of 2 for the 2011 Reporting Year

Prepared for The Governor's Office of Planning and Budget

**Developed by the Governor's Development Council and the Georgia
Coordinating Council for Rural and Human Services Transportation
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Purpose

House Bill 277 calls for the Governor’s Development Council (GDC), with assistance from the Georgia Coordinating Committee for Rural and Human Services Transportation (RHST Committee), to provide the Governor’s Office of Planning and Budget (OPB) with a report identifying means to increase the coordination of Georgia’s rural and human services transportation (RHST) system. The purpose of the legislation and the resulting report is to ensure the most cost-effective delivery of RHST services in Georgia, and to best serve the clients utilizing the system. This report is to be provided no later than September 1, 2011.

This primer is the first of two products developed by the GDC in the 2011 reporting year to meet the requirements of HB 277. In briefly answering key questions about what RHST is, how it is administered in Georgia, and what coordination of RHST delivery seeks to accomplish, this primer helps close an information gap that stakeholders, decision makers, and the general public have identified during the 2011 reporting year. Additionally, this primer helps pave the way for a greater understanding of the second report developed by the GDC.

The second document addresses the nine reporting tasks assigned to the GDC in HB 277 and contains recommendations for improving RHST coordination. Upon completion of a final draft on or before September 1, 2011, both documents can be accessed via the RHST Committee’s webpage at the following address:

http://www.grta.org/rhst_home/rhst_home.html

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Primer Summary

What is Rural and Human Services Transportation?

Who does the RHST program transport?

Human service transportation provides services for the transportation-disadvantaged; primarily persons of low-income, persons with physical and/or mental disabilities, children/youth, and seniors.

Demographic information across all RHST programs in Georgia is currently not tracked. However, given the fact that federal funding drives the RHST delivery system in the State, a reasonable estimate of end users can be made based on the primary beneficiaries of the various RHST federal programs. Based on this set of information, low-income populations, persons with physical and/or mental disabilities, and children/youth would constitute 24% *each* of total RHST users, and seniors would comprise an additional 23%.¹ In contrast to HST, rural transportation (aka FTA 5311) is available to any citizen residing in a county or region with a system. Although open to the general public, 47% of rural transit riders statewide are HST populations (i.e., not general public).²

What trips are provided?

Information on trip ends across all RHST programs in Georgia is currently not tracked. However, given the fact that federal funding drives the RHST delivery system in the State, a reasonable estimate of trip ends can be made based on the primary beneficiaries of the various RHST federal programs. Based on this set of information, most RHST trips would be to medical appointments (62%). Medical trips range from preventive care to dialysis treatments. Trips to education and job training (16%), employment (12%) and social services (6%) would constitute the majority of the remaining trip ends.³

Who provides RHST?

Services are provided by a mix of public, private and non-profit transit providers. Where urban or rural public transit systems are present, they are often utilized by human service agencies and thus are the backbone of the delivery system. Most RHST vehicles are handicap-equipped small vans and buses that operate on a demand-response basis (i.e., rider must reserve a trip ahead of time, generally 24 hours or more).

How is Georgia's RHST program funded?

Total RHST funding in FY 2010 is over \$137.8 million. The majority of these funds are from federal sources (66%), of which there are more than 60 programs that fund RHST. State dollars provide 23% of

¹ Coordinating Council on Access and Mobility, *Report to the President – Human Service Transportation Coordination*, 2005, p.21., GDC Analysis.

² KFH Group, *Evaluation of the Georgia Rural Public Transportation Program (Section 5311)*, April 29, 2004.

³ CCAM, 2005, p.22, GDC Analysis.

annual funding, and for the most part, are used to match federal funding sources.⁴ The remainder of the funds are provided from local or county sources. The primary agencies that administer RHST delivery in Georgia are the Georgia Department of Transportation (GDOT), the Department of Human Services (DHS), and the Department of Community Health (DCH). Key funding sources include DCH's Medicaid Non-Emergency Transportation (NET), GDOT's FTA 5311 Nonurbanized Area Formula Program, and DHS's suite of human services funds.

Why does Georgia provide RHST services?

Human services transportation is a means to an end. That end is to provide access to critical services to populations that likely would have no other reliable means of access. RHST service allows clients to live independently, improves their quality of life, and helps prevent additional investments in assisted living facilities and welfare programs. A study by Florida State University showed that Florida's investment in their transportation-disadvantaged program (what Georgia calls the RHST program) produced a return of 835%, or \$8.35 for each dollar invested.⁵

What is coordination and what are the benefits?

What is coordination?

According to a report of the Transit Cooperative Research Program (TRCP):

“Coordination is a technique for managing resources. Fundamentally, coordination is about shared power among organizations that are working together...Coordinating transportation means doing better (obtaining more results, like trips) with existing resources by working together with persons from different agencies and backgrounds. Coordination helps to address transportation problems such as duplication of effort and low transportation resource efficiency.”⁶

What are the benefits of coordination?

From a qualitative perspective, coordinating RHST delivery maximizes the use of fixed and operating capital and maximizes the achievement of economies of scale. Quantitative benefits are more difficult to find, due in large part to a lack of data prior to coordination. Despite this, there are a few coordination efforts in Georgia from which quantitative benefits can be derived. For example, the

⁴ Georgia R/HST Coordination Plan 2.0, presented to the Georgia Behavioral Health Coordinating Council (GDOT Consultant Team, March 24, 2011).

⁵ Dr. J. Joseph Cronin, Jr, et al., *Florida Transportation Disadvantaged Programs Return on Investment Study* (Tallahassee: Florida State University, 2008), p. ii.

⁶ Jon E. Burkhardt, David Koffman and Gail Murray, *TCRP Report No. 91 Economic Benefits of Coordinating Human Services Transportation and Transit Services* (Washington DC: Transportation Research Board, 2003), p.13.

Southwest Georgia Regional Commission has successfully coordinated all three major RHST funding streams yielding a DHS per trip cost that is 17 percent lower than the state as a whole.⁷

Why is coordination needed today?

Coordination seeks in part to minimize areas of overlap and duplication in RHST delivery. Overlap and duplication is driven by the plethora of RHST federal funding streams and the fact that several state agencies are responsible for administering them. The result is three unique RHST delivery systems among the three primary agencies that administer RHST in Georgia. This results in certain inefficiencies, such as multiple vehicle inspections for the same vehicle, and (in lesser coordinated regions) three different networks of providers covering similar ground (and similar types of trips).⁸

The need for increased coordination in Georgia is underscored by the expected growth in RHST populations. Senior populations are expected to nearly double by 2030⁹ while Medicaid enrollment is expected to increase by 40.4% by 2019.¹⁰ During the 2012 reporting year, the RHST Committee and GDC will refine these estimates, project additional growth in RHST populations, and provide perspective on the subsequent increase in costs if RHST cost structures remain as they are today.

⁷ GDC Analysis. Data from DHS, 2/9/11.

⁸ GDOT RHST Plan 2.0, *Alternatives Analysis Technical Memo (DRAFT)*, p.7.

⁹ U.S Census Bureau, Population Division, Interim State Population Projections, 2005.

¹⁰ The Kaiser Family Foundation, *statehealthfacts.org*. Data Source: Medicaid Expansion to 133% of Federal Poverty Level (FPL): Estimated Increase in Enrollment and Spending Relative to Baseline by 2019. Accessed 8/4/11.

What is Rural and Human Services Transportation?

Who does the RHST program transport?

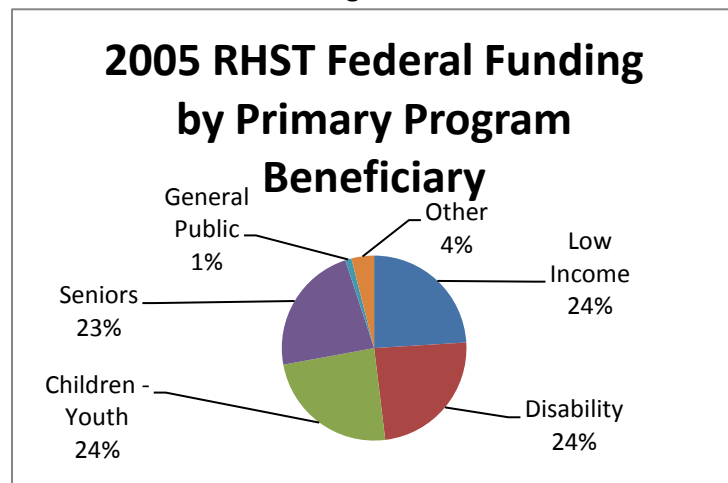
Human services transportation is defined as transportation services provided to disadvantaged populations including the elderly, low-income citizens, children/youth and people with mental and/or physical disabilities. Furthermore, federal guidelines state that most recipients of HST funds must have no other means of transportation. Figure 1 provides a breakdown of all federal funding programs that target RHST populations and groups dollars according to the primary beneficiary eligible to receive such funds. Although this figure provides federal data, and shows populations that are eligible to receive funds rather than end users of the system, it is expected that Georgia's RHST beneficiaries would be substantially similar due in large part to the fact that federal dollars comprise the majority of Georgia's RHST funds. Based on this set of information, low-income populations, persons with physical and/or mental disabilities, and children/youth would constitute 24% *each* of total RHST users, and seniors would comprise an additional 23%.¹¹

Rural transportation is an optional transit service provided in non-urban parts of the state that have provided local match dollars to receive federal assistance. Georgia has 114 rural transit systems, the vast majority of which are administered by, and operated within, a single county. While open to the general public, many users of rural transportation lack adequate access to a car or fall into one or more of the HST categories shown in Figure 1.

Rural transportation is a critical part of Georgia's HST coordination efforts not only due to this demographic similarity, but also because rural transit systems often serve as the capital backbone of Georgia's HST network in rural areas. One RHST provider estimates that 70% - 80% of rural transit system riders are HST populations on coordinated systems.¹²

Statewide, a GDOT study in 2004 found that 47% of all rural transit riders are HST

Figure 1



Source: Coordinating Council on Access and Mobility, Report to the President – Human Service Transportation Coordination, 2005, GDC Analysis.

¹¹ CCAM, 2005, p.21., GDC Analysis.

¹² Three Rivers Regional Commission, 4/7/11.

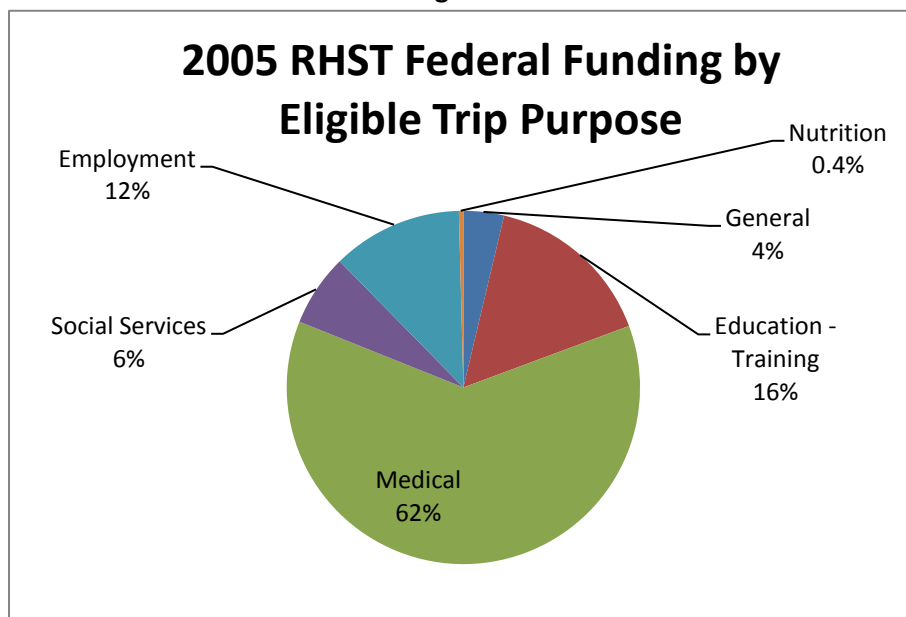
populations (i.e., not general public).¹³

What trips are provided?

HST services are provided for specific trip purposes; rural services can provide any trip requested, but given that HST trips constitute almost half of all trips on rural transit systems, rural trip ends are often times consistent with HST trip ends. Information on trip ends across all RHST programs in Georgia is currently not tracked. However, given the fact that federal funding drives the RHST delivery system in the State, a reasonable estimate of trip ends can be made based on the primary beneficiaries of the various RHST federal programs. Based on this set of information, most RHST trips would be to medical appointments (62%). Medical trips range from preventive care to dialysis treatments. Trips to education and job training (16%), employment (12%) and social services (6%) would constitute the majority of the remaining trip ends.¹⁴

The prevalence of medical trips is due in large part to the size of the Medicaid Non-Emergency Medical Transportation (NET) program which provides funds for medical trips to low-income citizens with no other means of transportation. In Georgia, the NET program alone is well over half of all RHST funding. Medical trips, whether provided by the NET program or other federal sources, are largely for preventive care, but can serve such purposes as dialysis treatment as well.

Figure 2



Source: Coordinating Council on Access and Mobility, Report to the President – Human Service Transportation Coordination, 2005, GDC Analysis.

¹³ KFH Group, *Evaluation of the Georgia Rural Public Transportation Program (Section 5311)*, April 29, 2004.

¹⁴ CCAM, 2005, p.22, GDC Analysis.

It is important to note that both during the yearlong reporting process and during the public comment period stakeholders have identified additional trip purposes as a need for RHST populations. GDOT's RHST Plan 2.0 Needs Assessment indicates that multiple regions in the state have identified restrictive trip purposes as an issue.¹⁵

Who provides RHST transportation?

Georgia's human services transportation trips are provided by a broad range of transit operators including public transit operators, human service agencies, private providers, and private nonprofit agencies. Where public transit systems exist, whether urban or rural, such systems often provide many trips for human service agencies. In rural areas without public transit, private and non-profit providers may provide service, though in some parts of Georgia no transit is available for HST populations.

Both rural and HST services typically operate as a demand response service. That is, to get a ride a customer must call ahead of time and schedule a trip. Typically trips need to be reserved at least 24 hours ahead of time. The service provided is often door to door in which the customer is picked up at his or her residence and transported to the eligible trip end (e.g., medical appointment, job, etc).

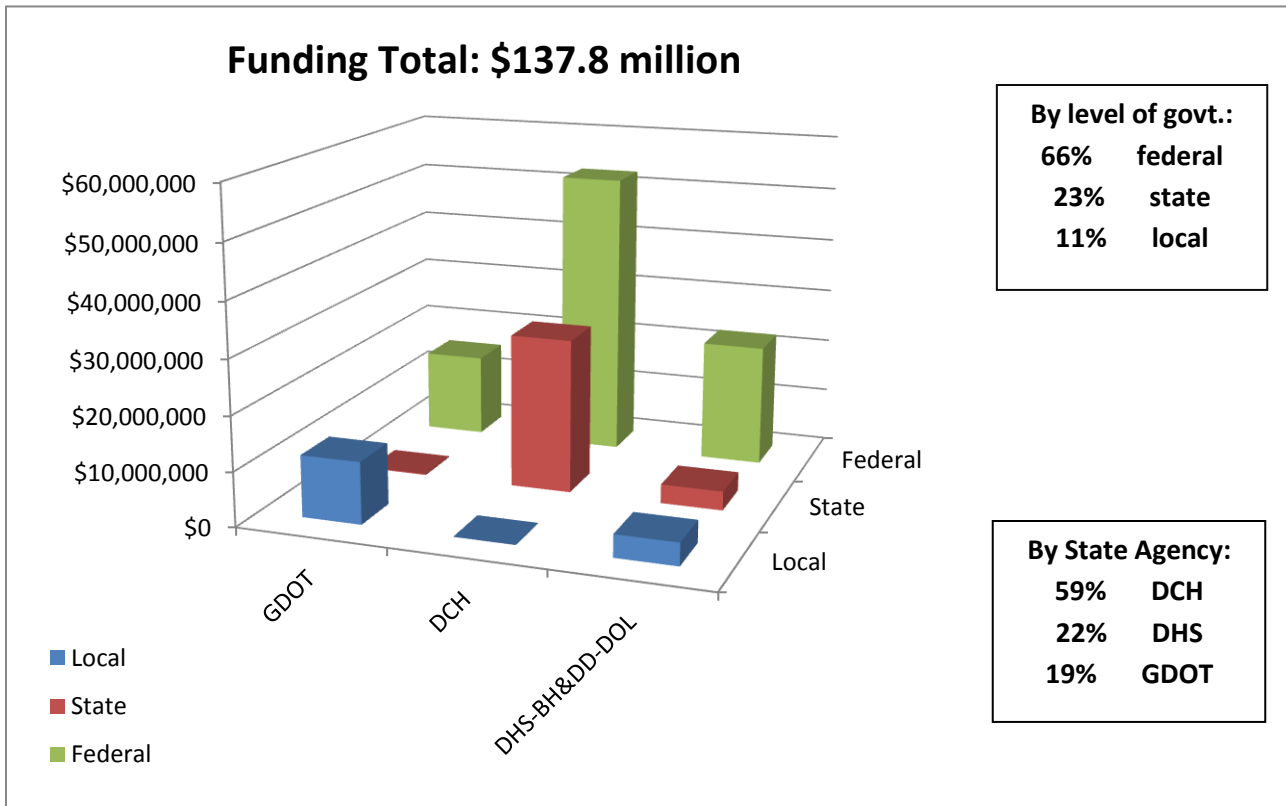
How is Georgia's RHST program funded?

In Georgia, over \$137.8 million goes to providing RHST service annually, the majority of which comes from the federal government. Figure 3 provides a breakdown of funding by level of government (e.g., federal, state, local) and by state administering agency. The majority of funding at 66% of funding is from the federal government, followed by 23% from the State and 11% from local governments. According to GDOT, the majority of state funds utilized are used to match federal dollars and a state funding reduction of \$1 leads to a \$3 reduction in federal funds.¹⁶

¹⁵ GDOT RHST Plan 2.0, *Needs Assessment Technical Memo (DRAFT)*, Chapter 4, Regional Needs Assessment.

¹⁶ GDOT Consultant Team, March 24, 2011. Additional RHST funds over this \$137.8 million are difficult, if not impossible, to quantify since many federal programs allow HST transportation as an eligible expense, but transportation budgets are not tracked separately.

Figure 3: FY 2010 RHST Funding Breakdown



Source: GDOT Consultant Team, March 24, 2011.

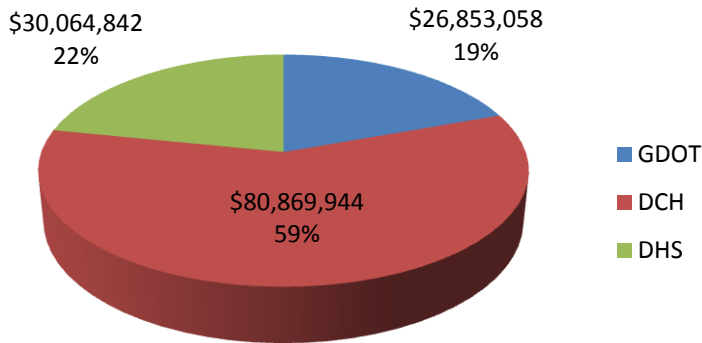
Three state agencies in Georgia administer the majority of RHST funding: the Georgia Department of Transportation (GDOT), the Department of Human Services (DHS), and the Department of Community Health (DCH).¹⁷ Figure 4 shows the total funding administered by each of the “big three” agencies. DCH administers the majority of RHST funds at 59%, followed by DHS at 22% and GDOT at 19%.

Also shown are the primary funding sources that are administered by each agency. These federal funding sources, while comprising a small percentage of the 60-plus federal funding programs with RHST components, constitute the majority of the \$137.8 million in RHST funds administered annually in Georgia.

¹⁷ DHS contracts with the Department of Behavioral Health & Developmental Disabilities and the Department of Labor to administer their HST funds. DHS administers several funding sources and contracts them together as part of their coordinated transportation system.

Figure 4: Total RSHT Budget and Primary Funding Sources

Total Budget FY 2010: \$137.8 million



- GDOT Primary Funding Sources
- FTA 5311 Nonurbanized Area Formula Program
- FTA 5316 Jobs Access & Reverse Commute
- FTA 5317 New Freedom
- DCH Primary Funding Sources
- Medicaid NET
- DHS Primary Funding Sources
- Title XX – Social Security Block Grant Program
- Temporary Assistance for Needy Families
- FTA 5310 Elderly and Disabled
- Revenue contracts w/local governments
- Title IIIB Older Americans Act

Source: Georgia R/HST Coordination Plan Update, presented to the Georgia Behavioral Health Coordinating Council (GDOT Consultant Team), March 24, 2011.

Why does Georgia provide RHST services?

Transportation for HST populations is a means to an end. That end is to provide critical services to populations who have no other reliable means of transportation. The need for such a transportation service is often greater in rural areas, where limited or no public transit exists (49 of Georgia’s 159 counties lack public transportation¹⁸). RHST is provided for many reasons, but primary reasons include allowing individuals to live independently (i.e., out in the community rather than permanently staying in medical facilities), improving quality of life and reducing the costs associated with assisted living, extended hospital stays, and unemployment.

Trips provided for mental health and developmentally disabled citizens are an example of trips that allow persons to live independently. Many individuals with mental illnesses, addictive diseases and developmental disabilities rely heavily on human services transportation to get to necessary doctor's appointments, clinical/social services and to obtain prescription medications and refills. A substantial number of people also rely on RHST to get to work and back in their communities. With no other means of transportation, if RHST were not provided, many people would be unable to live successfully in their communities, resulting in the need for more intensive, and costly, medical crisis or institutional services.

¹⁸ GDOT RHST Transportation Plan 2.0, *Needs Assessment Technical Memo (DRAFT)*, p.11.

Trips provided for seniors to congregate meals can be considered an example of trips that improve quality of life. Without such trips there may be no opportunities for some seniors to get a nutritious meal each day. Trips to senior centers also allow for increased socialization, information on aging and more.

Some RHST trips help prevent or reduce larger costs that could result from a loss of access to needed services. For example, DHS administers the Temporary Assistance to Needy Families (TANF) program that seeks to allow families to achieve economic self-sufficiency by providing trips to work or training. A reduction in these services could lead to greater costs associated with unemployment benefits. Further, many medical trips are provided for preventive medical care, which can lead to a reduction in hospital stays. Additionally, medical trips for seniors can often prevent the need for program beneficiaries to rely on assisted living facilities.

A study conducted by Florida State University examined the economic effects of RHST funding and found the following benefits that accrue to the State of Florida from their transportation-disadvantaged program:

- **Medical Trips:** If one percent of trips funded result in the avoidance of a hospital stay, the payback to the State is 1108%, or about \$11.08 for each dollar invested. Additional benefits include healthier citizens and a reduction in spending for programs such as Medicare and Medicaid.
- **Employment Trips:** If transportation-disadvantaged clients earn \$6.79 per hour (minimum wage) and work six hours per day, the payback to the State is 571%, or \$5.71 for each dollar invested. An additional benefit to the State is a reduction in welfare costs.
- **Educational Trips:** If a 30 day training program results in 30 days of employment at \$6.79 per hour, the payback to the State is 585%, or \$5.85 for each dollar invested. An additional benefit is a reduction in unemployment benefits funded by the State.
- **Nutrition Trips:** These trips allow clients to shop for groceries or otherwise satisfy their nutritional needs. If 1 out of 100 nutritional trips results in the avoidance of a hospital stay, the payback to the State is 1252%, or \$12.52 for each dollar invested.
- **Life-Sustaining/Other Trips:** These trips allow clients to pay bills and fulfill other shopping needs such as purchasing clothing and medications. If each trip generates \$20 in incremental spending on taxable items, the return to the State is 462%, or \$4.62 for each dollar invested. The State also benefits by reducing the need to fund assisted living facilities, as these trips allow clients to live independently.

- Overall, Florida invested over \$370 million in transportation disadvantaged programs in 2007. A conservative return on this investment is 835%, or \$8.35 per each dollar invested.¹⁹

¹⁹ Dr. J. Joseph Cronin, Jr, et al., *Florida Transportation Disadvantaged Programs Return on Investment Study* (Tallahassee: Florida State University, 2008), p. i. The majority of the benefits derived from this study are direct benefits associated with not having to provide alternative services (assisted living costs, unemployment benefits, etc.). However, some “indirect” benefits are included. Indirect benefits include multiplier effects such as a return to the State in sales tax revenues resulting from purchases of taxable items as a result of employment.

What is coordination and why is it needed?

What is coordination?

According to a study of the Transit Cooperative Research Program:

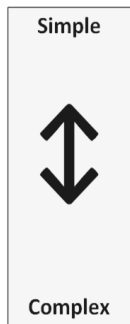
“Coordination is a technique for managing resources. Fundamentally, coordination is about shared power among organizations that are working together...Coordinating transportation means doing better (obtaining more results, like trips) with existing resources by working together with persons from different agencies and backgrounds. Coordination helps to address transportation problems such as duplication of effort and low transportation resource efficiency.”²⁰

Transportation coordination has many forms as Figure 5 shows. Coordination can range from the sharing of information and policies to consolidating functions and/or operations of different agencies into a single coordinated system. Several steps have been taken in Georgia to increase coordination. Examples include:

- The DHS coordinated transportation system merges numerous funding streams, including those received by the Department of Behavioral Health and Developmental Disabilities and the Department of Labor, into one funding stream. This reduces the need for multiple contracts and assists in obtaining economies of scale by streaming more funding to fewer transportation providers. Further, in many parts of the state, DHS places HST clients on public transit systems, thus combining their resources with local transit agencies and making fuller use of system capacity.
- The Southwest Georgia Regional Commission (SWGRC) is the prime contractor for all three of the major RHST funding streams (GDOT’s 5311, the DHS suite of funds, and DCH’s Medicaid NET). SWGRC administers all RHST funds together allowing them to have fewer, and larger, contracts and service providers. This type of delivery model makes possible the achievement of

Figure 5
The Coordination Continuum

- Providing information and referrals
- Sharing policies and practices
- Sharing staff resources
- Sharing vehicles, software
- Joint procurement and co-sponsorship
- Allowing the co-mingling of trips
- Informally swapping trips
- Purchasing service from another operator
- Consolidating functions and/or operations into one coordinated system



Source: GDOT RHST Consultant Team.

²⁰ TCRP Report No. 91, p.13.

economies of scale in administration, vehicle purchase and maintenance, and serves to increase volume on transit vehicles (see the next section for quantitative benefits).

- In the Three Rivers and Coastal RC's, individual county-based rural transportation systems have been consolidated into regional systems, serving all or part of those regions and reducing administrative costs and overlapping services (see the next section for quantitative benefits).

What are the benefits of coordination?

According to a study of Florida's coordinated system, RHST coordination is desirable because:

"It affords the greatest opportunity for maximizing the use of fixed and operating capital, human resources, and bulk purchasing, and generally maximizing the achievement of economies of scale. The alternative would be the provision of transportation-disadvantaged services via a number of disparate human services programs throughout the state providing their own transportation services or requiring their particular service providers to provide or acquire transportation services in addition to the provision of the human services they presently provide."²¹

Few sources have quantitative data, particularly above the local level (e.g., most benefits are calculated for a city, county or a single transit system). This quantitative data gap is due in large part to the lack of "before" coordination data in areas that have implemented significant coordination strategies.

While there have been a number of RHST coordination efforts in Georgia, only a few have produced readily available, quantifiable benefits that can be related back to the coordination effort. Two examples include:

- In southwest Georgia all three major RHST funding streams have been combined and are administered by the SWGRC. This has resulted in DHS trip costs in FY 2010 that are 17% lower than the rest of the state.²²
- In the Three Rivers Regional Commission, four separate county-based rural systems were combined into a regional system that now serves five counties. An analysis of before and after coordination data shows that this coordination has assisted in lowering the per trip costs of the system from \$10.11 in 2001-2002 to a projected \$6.48 in 2012 (2012 figure in 2002 dollars). This represents an overall cost reduction of 56%.²³

Why is coordination needed?

Coordination seeks in part to minimize areas of overlap and duplication in RHST delivery. Overlap and duplication is driven by the plethora of RHST federal funding streams and the fact that several state

²¹ Government Services Group, Inc, *Standard Rate Structure Report* (Florida Commission for the Transportation Disadvantaged, March 2003), p.56.

²² GDC Analysis. Data from DHS, 2/9/11.

²³ GDC Analysis. Data from Three Rivers Regional Commission, March 2011. Assumed inflation rate = 2%

agencies are responsible for administering them. The result is three unique RHST delivery systems among the three primary agencies that administer RHST in Georgia.

For example, each agency has a different regional network; DCH has five regions, DHS has twelve, and GDOT has seven. Additionally, none of these networks fully matches the boundaries of the twelve regional commissions in the State. Further, each of the three agencies has its own payment system and there are over 100 transportation providers that each agency contracts with (some providers oversee services for more than one agency). Such differences serve as challenges in coordinating services.

Thus, the presence of multiple agencies with unique delivery systems, and the sheer number of RHST transportation providers, cause a lack of efficiency in service provision and administration and a lack of consistency and central information for customers. Some, but not all of the problems that Georgia experiences in RHST delivery include:

- Vehicles and other resources that are not used to capacity, while some resources are at or above capacity;
- Numerous transportation providers, each with their own administration and vehicle fleet;
- Economies of scale that are not taken advantage of in areas such as vehicle purchase and maintenance;
- Redundant administration;
- Duplicative services/trips;
- Clientele confusion over available services;
- Vehicles that stop at county lines.

The need for additional coordination is also driven by the expected growth in RHST populations and their overall level of access to public transportation. In terms of demographic growth, the senior population (65 and over) is projected to grow by 95% by 2030.²⁴ Further, recent healthcare legislation is projected to increase Medicaid enrollment by 40.4% by 2019.²⁵ During the 2012 reporting year, the RHST Committee and GDC will refine these estimates, project additional growth in RHST populations, and provide perspective on the subsequent increase in costs if RHST cost structures remain as they are today.

Not only will demographic growth strain existing resources, but so too will a growing senior population that by some accounts, has poor access to fixed route transit. In fact, a recent study comparing Atlanta's fixed route transit systems to that of comparably sized regions found that 90% of Atlanta's seniors will have poor access to bus stops, bus routes, and rail transit by 2015. This percentage of

²⁴ U.S Census Bureau, Population Division, Interim State Population Projections, 2005.

²⁵ The Kaiser Family Foundation, *statehealthfacts.org*. Data Source: Medicaid Expansion to 133% of Federal Poverty Level (FPL): Estimated Increase in Enrollment and Spending Relative to Baseline by 2019. Accessed 8/4/11.

seniors with poor access far exceeded that of Atlanta’s peers; in fact that next closest region was Riverside-San Bernardino, CA with 69% of their seniors having poor access.²⁶

It’s important to note that this study does not include demand response services (vehicles that vary their routes unlike a large urban system that operates on “fixed” routes) and thus, seniors have additional transportation options and access than the study accounts for. However, this study underlies the importance of human services transportation, particularly in filling the many gaps in the state where fixed route systems do not exist. Taken together with expected growth in demographic populations, the importance of improved coordination becomes increasingly clear.

²⁶ Transportation for America, *Aging in Place, Stuck without Options: Fixing the Mobility Crisis Threatening the Baby Boom Generation*, 2011, p.16.

Conclusion

Rural and human services transportation is provided to the transportation disadvantaged. For the most part, these are persons of low-income, seniors, and/or persons with mental and physical disabilities. Typically these populations have no other means of reliable transportation but have needs to visit medical appointments, go to work or training, or be brought to other social services. In large part Georgia's RHST delivery system is driven by federal funding. No specific source of state funding exists for RHST delivery. Where state resources are used, they generally match federal dollars.

Just as the federal government drives funding for RHST in Georgia, its 60 plus federal programs with RHST funding components contribute to the fractured delivery system seen in the State. It is the sheer number of funding sources that are at the root of Georgia's coordination issues and are a primary cause of inefficiencies in RHST delivery. The fact that several state agencies administer these programs with their own unique RHST delivery models perpetuates some of these inefficiencies.

While there are federal guidelines that encourage coordination, it is not required. No requirement for coordination exists at the state level either. Despite this, there are numerous examples of RHST coordination from the state to the provider level. These examples, detailed in the sections above, demonstrate that coordination and enhanced efficiencies are possible.

To achieve coordination on a more widespread basis, greater state leadership is needed. The GDC's second report for the 2011 year, entitled "House Bill 277 Report: Coordinating Rural and Human Services Transportation in Georgia", addresses possible options for coordination and provides recommended directions for state leadership.