How Mobility Challenges Complicate Achievement of Healthy Lives and Healthy Communities

Scott Bogren, moderator

Scott: Let me introduce the folks on the panel. And I'll start with Shawn Schaefer. Shawn is the Director of the University of Oklahoma's Urban Design Studio. So for the last six years he has worked with OU's School of Community Medicine to explore improving community health. Remember we talked about outcomes. Improving community health through environmental design. So welcome Shawn.

To my right and your far left is Julie Wilke. She is the COO with Ride Connection in Portland, Oregon. Julie has been working in human services transportation since 1991, and we talked about some of the grounding. She began as a volunteer driver, which I think is a very good entree into better understanding the transportation we provide. And as a COO, she is involved in development, implementation and oversight of services and special projects, many of which relate directly to health care transportation.

Barb Cline to my immediate right is the president of CTAA's board of directors. She has 25 years in thi business, and is the director of Prairie Hills Transit which is in Spearfish, South Dakota. And I know we've been engaging in a discussion this morning about what really is rural. Well let me tell you that Spearfish in far western South Dakota, operates in over 12,500 square miles is very rural. Prairie Hills has a lot of public transit. There's a lot of services that are medical. She does some contracts that she can talk about with medical services, ADA type trips, you name it. When it comes to mobility in that part of South Dakota, I think you can be assured that Prairie Hills and Barb and I think some of her staff as well are here today are all deeply involved and very committed to it.

Troyce agreed to stand up and represent passengers and I think health care recipients. I did not have a card prepared for Troyce, but hopefully you have a good feel for who he is. Anybody who was thinking about skateboarding over here this morning, we have to give a big thumbs up to and particularly in light of some of the injuries this panel has taken in the last couple days, that would have been a very bad thing.

Scott Bogren: Before we start I asked each of the panelists to kind of summarize why they are up here so you can get a sense for their passion and their advocacy, and we'll start with you, Shawn.

Shawn Schaefer: Okay. Thank you, Scott. And let me just first say that I'm really bummed out that I can't be there with you in person. I just want to report that all the doctors here at the community medicine think it's some sort of subconscious effort by my brain to make me experience mobility issues in a more visceral way and not in such an academic way. But I definitely look forward to the discussion. And I want to just start out by saying I come from sort of an unusual situation. A college campus.

I'm looking at the OU Tulsa campus. And unlike many other universities, we have our medical schools co-located with a host of other academic programs, including social work, education, engineering, public health, and my college, the College of Architecture. And recognizing that health care only accounts for about 10 percent of an individual's health outcome, the School of Medicine has broadened its efforts and its faculty to include experts in the social and environmental determinants of health. In fact, the school's mission and focus has changed drastically since 2008 after an independent research study, the Lewin report, showed that there was a 14 year life expectancy disparity between residents living in the

north part of Tulsa and those living in the south part of Tulsa. Since then the school has been renamed as the OU School of Community Medicine, and it focuses explicitly on improving the health and the health care of the entire community by addressing health disparities and preparing health care practitioners for service in vulnerable populations.

I was fortunate to be selected to participate in the school's first summer institute bringing together faculty and students for many different disciplines to help transform the school. I've been involved in a variety of research studies and creative projects with the school ever since. A few of these projects may interested today's audience, and I hope we get to talk about some of them. I've been involved in a large community-based, participatory research study examining attitudes and behaviors related to health of Tulsa residents that we call Tulsa PhotoVoice.

I've also conducted with my students a neighborhood planning effort in conjunction with the establishment of the school's specialty health clinic in north Tulsa. And since then, since the clinic is now open, we've continued our work there at an invented community health and environmental design studio which we just shorten to call the SHED. So if you hear me reference the SHED, it's a studio that's actually located in the health clinic, and we've studied patient transportation patterns and needs there. We've designed community health facilities, we've hosted community events including walkability audits and workshops for improving homes and neighborhoods in the area. So I've had the opportunity to participate in the panel and I hope I can share some of our experiences at the SHED while bringing the perspective of an urban design soccer city planner to the discussion.

Julie Wilke: Okay. I work for an incredible social service transportation agency. I have for the last 14 years. And our mission is to link accessible responsive transportation with community need. So throughout our history, we have involved the community recipients of our service as well as partner agencies in designing, planning and implementing services for what the community really needs. But over the last 9 months, I've been given the opportunity to manage a project that really has kind of changed our mindset in what involving our community members really means. It really is all about engagement now. It's really about listening to those that you serve, identifying who can help with the cause, and hearing from them what we need to do to effect change. And I think a quote that I heard from one of our active community members that has been involved since the beginning really kind of says it all for me for where we are now from 9 months ago. I've had the opportunity to hire two wonderful people, Troyce being one of them, that have been engaged since the beginning. And another individual Elizabeth said to me just last week. She had just gotten back from going to 21 clinics, the dialysis clinics in our region with a fact sheet that our advisory council put together that really explained what the options were. And you know, I was thanking her because we had gotten a bunch of new opportunities with her visiting all of these clinics. And you know I was oh, thank you Elizabeth for all of this hard work that you've been doing, and she said Julie, it's okay. We're just helping you help us. And to me that really says it all. That we're in this together trying to create solutions and I guess that's what I'm talking about when I say revolutionizing. It's more than involvement. It's engaging your community members, and I think that that's what I'm trying to bring to this panel is that passion about engagement and what that means.

Scott: I like that word revolutionizing. There's a lot of what we're going to hopefully be doing in the next day and-a-half in this room and with your colleagues around your tables, that is, going to ask you to think differently and be a revolutionary. So I think that's a good phrase.

Troyce, we heard a lot from you earlier, and I think we've got a good sense. But I'll ask a question that I think can maybe get to the heart of why you're here. How long into your dialysis when you were originally going through that before transportation, that light bulb went off and you said this is a problem, from a patient's perspective.

Troyce: You know, when I initially started in 1987, it was a much smaller population and I was just a kid. So I wasn't nearly as aware and I think because it was a smaller population it was more efficient at that time and easier. It was really when I lost my first transplant and had come back to dialysis, and they had started a process they called high flux dialysis, which is to do it real fast and efficient and have less time. Didn't work well at all. But that was when I noticed that when I would be done with treatment there could be people waiting. So it was really back in the early '90s.

Scott: Thanks. Barb, I know you've done a lot of work, and you and your colleagues at Prairie Hills have definitely committed yourselves to health care, transportation, and those outcomes that we talked about. But tell us a little more about that.

Barb Cline: Well, I like to think that because we do cover such a large area we're already working with just about anybody that needs transportation. The key thing that happened a couple years ago was the transportation directory of the largest hospital in our area called, and said I would like to set up a meeting with you and talk about some discharge transportation for the hospital. And I thought well, great I would have initiated the dialogue but I was pretty sure they would have said, no, we don't need that. Happens quite often.

I always tell people, never accept no. Just keep going back. But as we got into the discussion he said we have been using your transportation for the last 22, 23 years. As I heard earlier this morning, this was one of those partnerships that came to us with somebody that had money. So we were doing the happy dance go, all right, we can do a lot for people, and we're going to make some money doing this. The best thing, of course, is helping people, but the regional hospital in Rapid City is a very small urbanized area but they also have other health care hospitals in about five different communities. So we provide transportation for any of their individuals who have difficulty finding a way home. They either can't go by taxi -- we're talking not just across the street, you guys. We're talking hundreds of miles. And it's not just taking the mom home from the hospital who just had a baby after completing a drug addiction program. We're taking the husband and the other child home with her. They have been there that whole time. So it's every time we take somebody home, my drivers come back to me with a totally new story about, Barb, you can't believe what we did yesterday, you can't believe the story that I was told yesterday, and I think Troyce can compete with all of these, you guys, but we're touching people's lives every day.

We're able to touch more people's lives because we have a contract that we're able to generate the dollars to help those other folks. It's no longer just public transportation. It's medical transportation. It's getting people to those hard to fill dialysis needs. And for us in South Dakota, dialysis isn't always just a couple blocks away. Oftentimes it's over an hour's drive. And we do a lot of them.

And I don't know if Scott wants me to tell you this or not, but we do a medical run between Spearfish and Rapid City, which is 50 miles every day. The biggest challenge we see is also an opportunity, always keep that in mind. With challenges you always have opportunities. We have over six people calling for transportation going into Rapid City. That's no big deal. But they are all in wheelchairs and they are all going to dialysis. So you guys tell me who you're going to pick up in a bus that only has three

securement stations. Who are you not going to take. Those are challenges. The opportunity is you get another bus. You get another driver. You do another run. You accommodate the need because it's not a social outing. And so from the discharge standpoint, those people are often folks who have been hospitalized unbelievably long times. Up to two years. One of the first things that we did when we took over this contract was to -- they were able to admit a gentleman into a 24-hour care facility who had been hospitalized for over two years. He had a few other things going on with that, of course. But he had a new quality of life. He was still going to 24-hour care facility. But he wasn't living at the hospital any more. We see more and more of that in particular because they can't discharge people unless they have a care facility that will admit them. And without dialysis transportation and many other things besides dialysis, but they have to be able to know that transportation is going to get those people where they need to go back to.

Scott Bogren: I was thinking earlier this year Barb testified before the Senate banking committee, and the key Senators were there from New Jersey and New York, and the good Senator from Illinois that really pays most attention to Chicago, and when she would start to talk about those distances it was just really funny to see them go, oh, my God, I had no concept. In these sessions, I think a big part of what we want to get out of this is a vision. You know, what is the vision? And so I want to start this by talking about when we talk about a healthy community, what is that goal we're seeking? And what does it look like? Because if you don't know that, it's hard to put the pieces together to create it. And I'm going to ask Shawn to kind of start off this part. Shawn, what's your vision based on the work you've done in Tulsa of a healthy community?

Shawn: As you know, here in Tulsa, our environment is almost completely dominated by automobiles. And we need a better way to interconnect transportation and land use. We need more of a human scale environment that is walkable. I think that not everyone is fortunate and can get around. It's an equitable issue where there are maybe a third of the population cannot access a car. They are too young. They are too old. They are disabled. So I would like to see an environment that is easier to navigate in that way. I also think that our communities need to give the citizens a voice and provide feedback mechanisms, so what Julie was saying about engaging people. Every community has a unique geography and the concerns of the community are unique. And so it's imperative to begin with listening and researching, involving the community in the design of your solutions. So to me it's really the intersection of land use, transportation, and the social equity issues.

Julie Wilke: I would say a healthy community for me is, well, you want a high quality of life and standards. And in order for that to happen, you need economic opportunities, you need an environment where there is equal access, where there's walkability and bikability. Then there's last mile options for individuals that can't easily get to a bus system. There is opportunity for personal growth and social networking. I think there's a component of isolation that connects with healthy living. And I really think you need the ability to have a good health care system. You were talking about the food deserts. So healthy living opportunities are important, also. I think all of that makes up for a healthy community where everyone can be engaged in their community with equal access.

Barb: I would just chime in with this: Spearfish has been working on the healthy community initiative. And we were actually one of five agencies that were selected to help with that simply because we have educated enough, you talk to anybody that will listen to you, and you say we have transportation, how can we connect with what you need. I think the biggest thing we do is that we allow people to remain living independently or living in their community with a healthier lifestyle because we can connect them to those major medical appointments. They can't always get them in Spearfish. They can't always get

them in the other communities, but we can get them to those appointments so they can maintain the quality lifestyle and a healthier lifestyle.

Scott: And it cuts across the artificial boundary as we all know are out there. County boundaries, city boundaries. None of those necessarily match up with the way people actually access health care any more but we all kind of view those as things that get in the way of these outcomes, and I think that's an important point you make .

Julie Wilke: Can I add? I thought of it when Barb was saying it, accessible transportation options. I think in this day and age we're way beyond the public bus system and the ADA service and that's all you need in a community for people to be mobile. So we were talking at our table about a menu of options. And I think that in this day and age and moving forward we can't silo individuals, not even for each individual on a certain mode, but it needs to go down to modes that are available for individual trips. And so when we're talking about accessible transportation and healthy communities I think a menu of options where people can get where they need to go on that particular day.

Scott Bogren: Yes, which certainly fits with the basic tenets of mobility management, right? The more mobility you have to manage, the better. A skill set that many of us probably need to improve and constantly hone is an interesting one--it's listening. We all tend to talk about our challenges, we want to talk about the reasons why we haven't been able to do this and that. But the skill of listening and taking what you're actually hearing and doing something with that is something that I know Julie mentioned. Talking to patients. Talking to health care providers. Talking to clinics. Listening to what they are telling us and working that into a system. Let's talk about that for a second. So, Shawn, part of what you're doing is absolutely listening and building upon that. How important is that?

Shawn: Well, I think it's very important because nobody knows their community better than the residents. No outside expert, no planner can possibly completely understand the community. And I'd just like to share a couple of techniques that we've used that I think the audience can use, and it doesn't require any specialized skills.

One is the photo voice technique. One of the things that we did in our community was we gave patients and members of the community cameras and we asked them to go out into the community and to tell us how they get around. We asked them things like where do they get their food? Where they go for their health care? What sort of barriers they face? Where are unhealthy places, and if you can see that slide there's a couple of views of really ordinary streets in Tulsa. You can see what the environment is like. You can see if you were on foot or trying to get to a bus stop. This is a very good way to get sort of the vision of the community as opposed to a lot of times you can make assumptions of things like that that aren't really correct.

Another technique that we've used is basically a mapping technique, is used at our Tisdale Clinic, which is a new clinic. And we wanted to find out how people were getting to the clinic and where they were coming from. So we basically put up a big map and we had stickers and they could pick the way they used to get to the clinic. If they drove their car they got a red sticker. If somebody else drove them, a yellow sticker; a bus, they got a blue sticker. And then they just put it on the map. And it's really interesting for us to listen to.

Tulsa is a relatively large city. About a million people in the metro area. But we were seeing a lot of rural patients. And this is not what was expected. The reason the clinic was put on the north side of Tulsa was

to address the health disparities that are showing up in the ZIP codes there. And I really think it was well intentioned, but health care is provided on a regional basis now. And people were coming from all around the city. And luckily we included a map that showed the surrounding towns and we had people putting stickers -- some were coming from out of state to come to our specialty clinic. So it really is a regional problem. And you know, but I think this technique is fairly simple and something that your audience could also replicate.

Scott Bogren: And I think it's a good point, too. Part of what Shawn is talking about is understanding demographics. And we looked at the 2010 census and you see that there's a rapid urbanizing of the American population right now. It is unprecedented, in fact. Where is the fastest growing segment of the rural population? Right up against the urban areas. Regional thinking. It has to be a part of what you're building because that's how people are living and working.

We talked a little bit about talking with people, empowering people. I would like Troyce to talk about what did it mean to be asked these questions. Maybe for the first time where the transit provider is saying, “Tell us about this.” How does that make you feel as both a client and as just a person?

Troyce: Well, I think probably the best illustration. When we put our advisory council together, which was made up of patients and some providers, some drivers, to listen to the individual stories and realize how lacking that we had things, had a tremendous impact. I mean, I would see it in my dialysis unit. But when you start looking that it's not my unit, it is happening in this unit, it happens in this one unit, these people see it, these people see it, these people see it, and then when the patient surveys come back and you start seeing these consistencies, it becomes very evident that we've got some very clear problems. And the frustrating thing is that I see all the pieces of the puzzle there to put together to make it work. It's just a matter of getting to that point and getting everybody on board. We've got a great plan to educate our drivers and make people understand what's going on. But it's going to be the challenge of getting everybody together to do that.

Scott Bogren: Barb’s system within the last three or four years built a large transit facility that connects varying forms of mobility within the community. And one of the most unique aspects of that facility is it has a built-in day care center. I'm sure that was in reaction to what you were hearing from people. Talk about that.

Barb Cline: I was questioned about why do you want to put a day care center in your transit facility. There's nobody around the state that has one, and probably other states as well. But for many years, I would interview very promising young candidates for positions with our company. And we would be ready to make the job offer dependent on all the other things that you need, but the response would be I'm sorry, I don't have day care after 4:00 pm. I don't have day care before 8:00 in the morning. So what we decided was is it wasn't just a need for our own staff, our own employees, but the community in general needed additional seats or positions, if you will, for children in the community if they needed child care assistance.

With that, I think one of the most important things that we have done is to have a nutrition program, so every one of our children gets a hot meal every day, or two hot meals depending on when they are there, how long they are there. We're helping with the healthy community. We're giving back to the community. But we're also generating little tiny riders, you guys. They are going to school, and their little brothers and sisters are seeing the bigger ones get on the bus and they are going we want to ride.

Grandma can you take us to that bus stop and can we ride the bus with everybody? So it's a win-win. Besides when transit gets tough you guys go rock a baby and life is good.

Scott Bogren: We should adopt for the next 2 days. We're going to call this the build a boat theory from what we heard earlier. You know? There's the challenge, and there's often times very obvious answers to these things but someone just has to do it. Well, we've got to cross this body of water, hey, what about a boat. Hey, we've got to deal with health care, hey let's put a child care facility right in the transit facility. In retrospect it seems pretty common sense. But at the time, working with Barb, I know it was viewed as why would you do that. And you're going to run into a lot of things when you're working in mobility management on well that's never been done before. Or why would anybody want to do that. So let's just call that, hey, build a boat. You can say that to your colleagues around the table when they hit one of those things. Think about it in that way. We're using technology very well today. Shawn do you have something to add?

Shawn: I just wanted to add that there's also a lot of opportunities for community partnerships. Awhile back we were approached by a church here in town that wanted to build a health clinic to provide essentially services to the homeless and uninsured. And the church already had a large infrastructure. They were providing some meals. They had a day care center. I hadn't thought of that at the time.

And so we tried to convince them that what they really needed was not to build a clinic because the clinic would be very expensive and it would be difficult to fully staff. There wouldn't be good economy of scale with building the clinic. But we tried to convince them to build basically a transit center for patients that could come to the church. And they would have a place to wait, maybe a place to get a meal. The church would provide scheduling services so that they could make their appointments at existing clinics and doctor's offices that were willing to see these patients and already have the infrastructure.

Scott Bogren: Exactly. Again, same principle applies. The next little bit of discussion here I would like to focus on is technology, because technology is a great opportunity. Sometimes I think it's a crutch as well that we fall back on, well, we'll use social media for that. Or there's an app for that. But there are common sense, non-costly ways to apply technology into this concept of both mobility management but also the health care. I remember when we were discussing dialysis transportation in our offices with some providers and we started to think, would there be a way that the chair or the technology could start to tell when the patient was almost done and make that call ahead itself to the vehicle in you know. Take some of these things out. There's ways to look at these things.

And my question to the group then is what do you see with technology? And how do you see that working? Shawn, do you want to launch into that because I know you've got some ideas on technology.

Shawn: Well I think that probably the most important thing for us right now here in Tulsa is just constructing a health information exchange. So like many cities our size, we have really three medical systems: St. John, St. Francis, our Catholic hospitals and then our other hospital is a for profit, actually, Hillcrest Hospital. And you know, they all have different information systems and different health records. And you know, we want to see a better coordination between them in sharing information between the patients as well as if the patients being referred to different facilities, they can do that efficiently, not only from a health care perspective but from a transportation perspective.

I also think that the practice of medicine is changing in such a way that maybe we can eliminate some trips. And you know, right now, a lot of doctors have the ability to see patients remotely. And not all patients have to come in obviously for something like dialysis and that sort of thing. You have to come in, but you know, if we can make things more efficient using the technology to see the patients, the real challenge becomes getting reimbursed for it. So a lot of the insurance coverage now will not pay the same amount for a telemedicine visit as they do for one in person.

Scott Bogren: Anyone else on the panel want to hit on technology? Anything you've seen in use that changes the game?

Barb: I would let Lisa speak because she would know more what we're doing. We're just implementing the voice callout to our riders and I think that that's going to be a huge improvement. We don't have the volume of drivers or riders that probably a lot of agencies do. But it's still very important for them to have that reminder. We've got lots of grandmas and grandpas that kind of need that reminder because they don't always remember when their appointment is. And I think it's just the more you delve into the technology, the better you situate your community and your riders to do a better job for them. Health care loves the fact that we can do so much to notify riders, get them to those appointments.

Julie: And you know, I'll just add. I think Shawn's point about billing mechanisms is an important one that we will see in transportation. With this evolution of the Affordable Care Act and going to managed care , we now have coordinated care organizations in Oregon. They are not only responsible for all Medicaid recipients' health care costs but also transportation. So I think we'll see changes not only in technology but with the ability to be reimbursed in different ways also. So I think that that was a really important point. And also, I have to call out our IT guy who is in the audience, and I think will be on a couple panels tomorrow, Kevin Chambers is working on some phenomenal new technology.

That's really looking at making sure that we access every seat on every vehicle that's traveling within our community, even though we're on different scheduling software. And I think it's an incredible project and he can speak more towards that. I also think Uber was mentioned earlier, and I think that there's lot of things that we can learn by that business model.

I think as we are seeing this influx of not only new riders but riders with different needs. I think there's a a lot more individuals in our communities now that are savvy about technology. And I think we need to think about that as we're moving forward. They are going to want to manage their own care as well as manage their own trips. And I think we need to be prepared for that, too.

Scott Bogren: So before we open it up for questions because we're going to do that in such a second I'm going to take the host prerogative in a minute. I'm going to jump into the lightning round here. That's going to be in answer to the question that came up earlier. Who do we have this conversation with? Right? We're going to be armed with a lot of new information, good ideas, innovative ideas, and you're going to go back to your desks and your offices next week, and you're going to have to have a conversation with somebody. And so in literally one word, I'm going to ask each of the panelists to say who they think the most important person is in their community to have this conversation with right now. Shawn, you go first.

Shawn: Boy, that's tough. I guess I will say the mayor.

Julie: Those that are receiving services.

Troyce: Drivers.

Barb: Everyone that will listen to you.

Audience question: Hi there. I'm Cathy from Mason Transit in Washington state. Very small, rural transit. I'm going to go a little bit different direction because of something that Barb said. We're opening a new transit community center in January, and so it's the first of its kind in the nation. It's a community center and transit hub together. So I'm now finding tenants and we've talked about a day care, so my question to Barb is, do you guys manage the day care or did you have a private entity come in and bring the day care services into your facility?

Barb: Interesting question. It was a brand new facility. We did put out an RFP to see if we had any providers in the area that would like to lease the space. They did not. They didn't want to make that kind of an investment in a building that they did not own because it's a huge investment. So what we ended up saying is we can do this. We manage senior meals program. Day care is just little people with needs. We were doing big people with needs. So we have a manager. I oversee -- I think she's got 14 staff people. So we do it in-house.

Scott: I can follow up having been in Shelton, Washington, and I know the community center. It's a great old building. It's an armory, if I'm not mistaken. And if you ever want to see that building has the strongest wood floor that has ever been built in the United States. Am I correct?

Audience question: Yes. From 1956, they built it to bring tanks on to it. And I watched that when I was little. I watched the tanks go on to that floor. It's a mill end floor. So it's two by sixes four feet deep. So we're keeping the gym floor. It's very popular. We've got people that want to use it right now even though there's no windows in the building. I loved that when I heard it. That was an existing facility locally that transit and the town and the community center came together and said how can we use this. Those are those important -- And we did that through FTA grants, state grants and opening in January.

Audience question: My name is Brooks Jennings. I'm from Martinsville, Virginia. I'm the Mobility Manager. I guess I'm a toddler. I've been going on about three years now. But I actually have two questions. The first one is for Troyce. Have you seen any partnerships with funding with the dialysis centers as far as which transportation? I know you said you're trying to make that kind of partnership. Have you seen them reach out their hand in any way as far as funding sources.

Julie Wilke: And I will add to that. So we have been trying for the last three months to have a clinic commit to a pilot project with us. And we actually have state dollars to provide transportation in a pilot project form to see what we can learn. We just wanted to be able to have one clinic buy into it. We've spent the last three months working with legal at the national level. We had a social worker from that clinic that was on our advisory council. She was very committed to the project but it’s taken three months, and we just got the okay last week. So not are they not receptive at this point to put in money to provide the trips, they believe that they can't from a legal standpoint. But they don't even really want to be supportive of a project that will provide better access. So that's where we are now. Thanks to Troyce and Elizabeth talking to 21 social workers at a meeting last week I'm at I think that's why we finally got the okay.

Audience question: You can get an idea of the barriers that we're facing. We're not asking for personal manufacturings. We want to do a simple survey. How long have you been on dialysis? How has your transportation been the last month? How many projects have you had? Do the project for a month. How did your transportation improve? But the current climate is just instant fear that you're meddling into the corporate way, and this is going to somehow affect profits and we don't want to do that. Thinking like a broker or something? Is that what you're scared of that you're going to become a broker in between somehow or a middle man is going to take profit from them? When I first started mobility management everybody thought what it was going to be like Logistic Care, for me or anyone like that I was coming into the city to be a broker and take money from all the private companies. It took me a year to explain to them what I was doing.

Troyce: My personal opinion is that these companies want to minimize their output to focus strictly on dialyzing the patient. Transportation is not their responsibility. A blanket on my chair is not their responsibility. An ice machine in the unit so that somebody can have some ice to suck on for the four hours they have to sit there with no fluid -- and these are all things we used to have. So if they are not going to put a blanket on the little 80-year-old lady's chair next to me they are not going to get too concerned about paying for transportation, which is considerably more. I don't know what the secret is to get the buy in. I really think it's showing them that there's potential profit improvement by embracing these programs. That's at this point my clearest vision.

Shawn: You know, one of the things that we've been looking at here with our clinics, and of course we're University clinics, so it's not so much of a private motive, but looking at cost recovery because of missed appointments due to transit issues. So in our clinics, 21 percent of appointments are missed. And of that, 12 percent of the patients account for those 21 percent, and each one of those missed appointments on average costs $100. So it's costing our clinics well over $4 million a year right now. And so one of the things you can do is if you can approach the clinics and show them how you might be able to recover some of their costs by making sure the patients get to those appointments it can be a powerful argument.

Audience question: I'm from northern rural Michigan, and we're a picture of things to come for the rest of our state. Our community is made up of 25.9 percent senior citizens where the rest of our state is 14 percent. We're dealing with that baby boomer retirement. Many of our specialist doctors, we have no hospitals in our county. We have no dialysis centers and no treatment or long-term treatment facilities. Our specialists are coming up from downstate in our rural area, a three-hour drive one way, and they will schedule follow up care for these individuals who come downstate to do follow-up care. I don't know how to frame this into a question but I think you understand my issue, and being in a rural community like you're dealing with and having limited resources, trying to bring these schedulers to the table has been our dilemma. How do we open this conversation so they hear how we can be successful helping them be successful?

Barb Cline: Do you have anybody that has someone in those senior centers? Any elected officials that are really impacted because mom and dad can't get to appointments? They all do. So this would be my take because I like everybody at the party. Start having some community meetings. Some listening sessions. Start bringing people in and don't just do your local officials. I mean get your city council people, your county commissioners, get your legislators, your Senators, your congressional folks. They are going to send staff people. A lot of them. They are busy people, they are in the going to be able to be there, but you know, it's not what you know, it's who you know. So keep inviting people. Get that feedback.

Carol Wright: I'm with Easter Seals Project Action in D.C. One of the things that I thought was really remarkable about the comments that all of you on the panel made goes back to your initial slide, Scott, and that is it's all about costs, it's all about outcomes, and what each of you brought to the table as you've been summing this up is how can we talk to the kidney dialysis centers, how can we talk to the clinics and show them that it's in their best interests because they can save costs so that they can see what's in it for me. And certainly what's in it in the outcomes for what are some of the patient outcomes, what happens to the people who are able to get those rides? And I think if we concentrate on those efforts and find solution that is deal with two things that you started this all out with, it ties into everything that each of you have said in terms of the direction that we need to go. So I want to thank you for making Scott's point in terms of showing us what we need to do as we're trying to sell the message.