

**TRANSPORTATION TO HEALTH CARE FOR POPULATIONS AT RISK:
A TOOL FOR ASSESSING AVAILABLE RESOURCES**

by

Lorna Marie Shea

A professional paper submitted in partial fulfillment
of the requirements for the degree

of

Master of Nursing

MONTANA STATE UNIVERSITY
Bozeman, Montana

July 2001

P378
Sh 314

APPROVAL

Of a professional paper submitted by

Lorna Marie Shea

This professional paper has been read by each member of the graduate committee and has been found to be satisfactory regarding content, English usage, format, citations, bibliographic style, and consistency, and is ready for submission to the College of Graduate Studies.

Teresa K. Henry, MS, RNCS, ANP
Chairperson
Graduate Committee

Teresa K Henry 7-12-01
(Signature) (Date)

Approved for the Department of Nursing

Lea Acord, PhD, RN
Dean, College of Nursing

Lea Acord 7/17/01
(Signature) (Date)

Approved for the College of Graduate Studies

Bruce R. McLeod, PhD
Graduate Dean

Bruce R. McLeod 7-19-01
(Signature) (Date)

STATEMENT OF PERMISSION TO USE

In presenting this paper in partial fulfillment of the requirements for a master's degree at Montana State University, I agree that the Library shall make it available to borrowers under rules of the Library.

If I have indicate my intention to copyright this paper by including a copyright notice page, copying is allowable only for scholarly purposes, consistent with "fair use" as prescribed in the U.S. Copyright Law. Requests for permission for extended quotation from or reproduction of this paper in whole or in parts may be granted only by the copyright holder.

Signature Lorna Marie Shea

Date 7/09/01

ACKNOWLEDGEMENTS

I would like to express my gratitude to the members of my project committee, Jean Shreffler-Grant, Doris Henson, and Susan Horlick for the support and guidance provided to me during the entire process. Most especially, my sincere appreciation goes to my project chairperson, Teresa Henry who was tireless in her support, direction, and positive attitude. The project was a positive experience for me because of the genuine concern and thoughtful direction of my committee.

I also wish to thank my husband, Michael, for his support and his confidence in my abilities to achieve my goals, and my children, Colin and Katelyn for their technical support with computer applications, their encouragement, and the sacrifices made to help me complete this project successfully.

TABLE OF CONTENTS

LIST OF FIGURES.....	vii
ABSTRACT.....	viii
1. INTRODUCTION.....	1
Purpose.....	2
Problem Statement.....	3
Definitions.....	6
Conceptual Framework.....	7
2. REVIEW OF THE LITERATURE.....	10
Introduction.....	10
Access to Health Care.....	11
Populations at Risk.....	13
Urban Vs Rural Access to Care.....	19
Funding Sources and Community Resources.....	21
The Role of Advocacy.....	24
Summary.....	27
3. PROJECT DESIGN.....	30
Introduction.....	30
Planning.....	32
Tool Development.....	32
Field Test.....	35
4. PROJECT OUTCOMES.....	37
Introduction.....	37
Evaluation.....	37
Limitations.....	39
Implications and Recommendations.....	40

REFERENCES CITED.....	44
APPENDICES.....	50
Appendix A -- Eligibility Flowcharts.....	52
Appendix B -- Possible funding Sources.....	55
Appendix C -- Instructions and Rationale for Use of Transportation Resource Tools.....	62
Appendix D -- Evaluation Form for Resource Tool.....	65

LIST OF FIGURES

Figure	Page
1. Framework for the Study of Access to Medical Care.....	9
2. Rural Area Population.....	18

ABSTRACT

Access to medical care is impacted when the person does not own or is not able to drive a personal vehicle. If that person also has no access to public transportation, there is additional limitation to ability to reach the site of medical care. This is the case in a significant segment of the population of elderly, poor, and frail individuals. Absence of public transportation is particularly relevant to these populations who live in rural areas. Although the United States government has recognized and addressed this issue, there is still a large number of people who list transportation problems as a major obstacle to obtaining regular medical care.

This project addressed this issue by searching the literature to establish which population groups were at risk for finding lack of transportation a barrier to health care access. Further research revealed which government agencies were funded to assist people with transportation problems. A resource list of these funding sources was compiled as well as a flow chart type tool to help quickly determine which eligibility criteria a prospective client might have. These tools were field tested for three weeks by six nurses in a rural family practice clinic.

An evaluation tool was provided to assess the success of the tool. Actual use during the test period was low, however, a small number of rides were arranged as a result. Limitations included the small sample of test subjects, the short period of time allotted for testing and difficulty incorporating a new routine into an already busy schedule.

In spite of the limitations, this project has implications for incorporating this type of tool into the primary care workplace as well as in promoting more advocacy by nurses and advanced practice nurses on behalf of the client without transportation to health care sites. This will require that nurses stay informed about the available resources in a community and share that information with their clients.

CHAPTER 1

INTRODUCTION

The mission of the health care industry generally has a focus on providing high quality, compassionate health care to the public at large. This has often been interpreted as "being there" for those who need the specialized, technical, professional skills, and facilities of modern health care. The holistic nurse practitioner may be aware that "being there" is not enough for the segment of the population whose first concern may be something as basic as "getting there." These are the poor, the frail, and the elderly for whom transportation to a health care facility is often not available. Reasons may include that they are no longer able to drive, have no local family or friend who can transport them for regular care, or are not able to afford to own and operate a personal vehicle.

Typically, in the rural setting, there is no public transportation service or even a private taxi service. In addition, a patient's need for portable oxygen, wheel chair transfers, and/or assistance with ambulation, transferring, toileting, etc., make asking a neighbor or friend seem a great imposition for all but emergent situations or very rare occasions. Consequently, routine preventative care is neglected and treatments requiring regular, frequent visits such as chemotherapy or radiation treatments are not pursued. Much attention has been directed to making services available to rural or underserved populations but much less toward overcoming the barriers of transporting the patient to

these services, whether the distance is one block or 100 miles. Transportation barriers observed in a small northern Montana community, were this author's impetus for seeking a community-based solution.

Purpose

Obviously, there is no benefit to the availability or presence of the most complete and sophisticated array of medical services if those services are not accessible to the people who need them. Lack of transportation is a barrier that prevents some people from gaining that access. The United States government has attempted to address the problem through legislation on numerous occasions for over 50 years. In 1944, amendments to the Social Security Act mandated transportation be provided to elderly, blind and disabled persons (Smith & Riggan, 1988). In 1964, the Urban Mass Transportation Act (UMTA) was passed and provided federal financial assistance to preserve deteriorating transit systems and, in 1970, it was amended to provide that elderly or disabled persons would be able to utilize mass transit facilities and services just the same as other Americans. It did not, however, specify how that utilization was to be accomplished. In 1976 and again in 1979, the Department of Transportation issued regulations that all public transit be physically accessible to disabled persons. Further legislation has addressed specific implementation of such policies with advances being made, especially in urban areas. The cost was, and still is, high and the results less than perfect (Smith & Riggan, 1988). A particularly wide gap exists in the rural areas where there is often little or no public transportation (Braden & Beauregard, 1994). Another

barrier is a lack of knowledge about what options are available and how to make use of the systems currently in place for assisting with transportation problems.

The purpose of this professional project was to improve health care access by:

- 1) learning what resources were available for assisting persons needing transportation,
- 2) developing a tool for assessing a person's eligibility for transportation assistance from federal, state, or local sources, and
- 3) developing a worksheet for use by health care providers and their staff members to use in directing patients to transportation assistance and services.

Problem Statement

Lack of transportation can present barriers to some people in accessing health care services. Limited access to affordable, high-quality health care results in delay in seeking care with subsequent delay in diagnosis, treatment initiation in later stages of illness, and resulting poorer prognosis (Gordon-Bradshaw, 1987). Traveling outside one's immediate geographical area to access needed health care is a difficult problem for the frail, elderly, disabled, indigent, and dependent children (Stevens, 1992). Marketing research targets these populations and their problems partly because they are a growing entity.

Considerable energy and money have gone into bringing the services closer to the rural and frontier areas in the form of outreach programs, satellite clinics, mobile diagnostic and treatment units, and computerized diagnostic and consultation services. The fact remains that face to face, hands on care is an integral part of health care delivery and the physical distribution of these services tends to be in urban areas (cities and towns).

Data from the 1990 Census classify 76 million people in the United States as "transportation dependent." These are persons who do not have personal transportation because they are poor, disabled, or elderly. Twenty-nine million of those, or 38 percent, are from rural areas. Thirty-two percent of rural residents are classified as transportation dependent compared to 30 percent of urban residents (Transportation Resource Center, 2000). Horner, Ambrogne, Coleman, Hanson, Hodnicki, Lopez, and Talmadge (1994) found that problems traveling to distant and/or unfamiliar cities for health care were great enough to prevent some people from traveling for care. Barriers to prenatal care in low-income and inner-city communities include lack of transportation. Inability to drive and dependence on others for transportation, private or public, is a constraint on accessing needed services. Failure to receive definitive therapy for cancer by persons 65 years or older and for economically disadvantaged persons has been found to be a result of impaired access to transportation and poor social support. Compliance with treatment is usually good if transportation is available.

Transportation limitations may be related to cost, physical handicaps or discomforts, lack of another person available to assist with driving or other related problems, but it has been cited as having rendered services inaccessible (Schoenberg and Coward, 1988). While a number of barriers to accessing health care are not amenable to change, available, affordable transportation may well be one that has reasonable solutions. In urban communities with a large population base, government funding and resources can often be coordinated to offer solutions. In Detroit, Michigan, a transportation service called Healthy Baby Services provides 1500 rides a month to pregnant women and

children. The service is funded by several sources including the Michigan Department of Community Health, Michigan State Medicaid, and the March of Dimes. In Minneapolis, Minnesota, a private, for-profit transportation provider called Mobility of the Disabled and Elderly (MODE) serves a seven county area. MODE is funded by contracts with state and local governments through Medicaid, a county Health Maintenance Organization (HMO), and privately paying clients. It delivers 400 trips daily and offers 24-hour service. And in Philadelphia, Pennsylvania, Wheels, Inc. is a non-profit medical transportation brokerage that offers services such as volunteer car service, taxi service, fixed route public transit, and demand-response door-to-door service. Wheels, Inc. provides 4000-5000 trips daily and is funded by a complex contract with the Commonwealth of Pennsylvania (Transportation Resource Center, 1994).

The fact that urban areas have a large number of households without cars is partly due to the availability of public transportation. All of the large urban areas in the United States have public transportation systems but two-fifths of America's rural households are located in areas without any public transportation service (Transportation Resource Center, 1994). Government funding is available in the form of grants to establish public transit in small urban and rural areas. However, the requirements of management, maintenance and operating personnel, the overhead of a physical plant as base of operation and the capital expenditure of acquiring vehicles make this type of plan too expensive to be workable. There is simply not a large enough population base to generate sufficient revenue to support the continued operation of such a service in most rural communities. Often the rural population is sparsely distributed over a large

geographical area making conventional fixed route transit impractical. The population utilizing the service cannot likely afford to pay more than a nominal fee. Support for transportation services can sometimes be found in local HMO's, clinics or hospitals in the form of subsidies. Unfortunately, there are hundreds of communities in which the medical facilities operate on a break-even budget plan and would not be able to contribute significantly to the operating costs of such a plan.

If a formal public transit system is not feasible in small urban and rural communities, other possibilities must be explored. The people of the community itself may be the most logical resource. Community based services tend to be well accepted by rural elderly users in a study that compared rural and urban participants (Schoenberg & Coward, 1988). Helping networks exist in many small towns to assist vulnerable individuals who would be less likely to travel to services independently. Exploring transportation resources available to assist persons who have difficulty accessing healthcare and coordinating entry into the systems offering these resources offers a possible solution.

Definitions

Definitions are included to clarify usage and provide operational definitions of terminology used in the text of this project.

Transportation. A means of carrying a person from a place of residence to the location of a health care service.

Lack of Transportation. Being without a means of carrying a person to the location of a health care service because one does not own a car, is not able to afford to operate a car, is not able to drive, lacks access to public transportation or lacks someone to assist in accessing transportation.

Transportation Dependent. Being without a personal vehicle or unable to afford the operating costs of a vehicle, or being unable to drive.

Urban. Areas with a minimum population of 50,000 residents (Office of Management and Budget, 2000).

Rural. Places with 2,500 or fewer residents and all other areas outside urbanized areas (Office of Management and Budget, 2000).

Frontier. Areas with fewer than 6 residents per square mile.

Conceptual Framework

The conceptual framework chosen to guide this project is the Model of Health Services Utilization developed by Andersen and Aday in the late 1970's (Andersen & Aday, 1978). This model assumes that a certain set of conditions contribute to whether or not people use a particular healthcare service and the volume of services they consume. The set of conditions includes:

- ◆ (1) predisposing variables, or the factors that predispose a person to use health care, such as demographic and social characteristics, the individual's beliefs about health services, the state of illness as perceived by the individual and as evaluated by the practitioners treating him/her.

- ◆ (2) enabling variables, or factors that enable a person to use health care, which include the individual's ability to secure services due to personal resources and availability of health services in her/his community.
- ◆ (3) need, or state of illness perceived by the individual and by practitioners treating him/her.

Predisposing factors such as race and social class have been studied for at least three decades and addressed by a variety of social programs. Evidence continues to demonstrate that 87.8% of low income and 32.6% of minority persons have difficulty accessing medical care. Similarly, 40% of the elderly population experience trouble getting to medical care. As many as 71% of the elderly miss appointments because of lack of transportation to or from a facility site (Paul & Hanna, 1997). The elderly population has increased in size by 15-30% over the last 10 years and is projected to continue increasing over the next 2 decades (Hastings Center Report, 1994).

Enabling factors describe the means an individual has available for the use of healthcare services. Some of these resources are specific to the individual and his/her family such as income, insurance coverage, and access to personal or public transportation. Others are specific to the community in which the individual lives such as whether it is a rural, frontier, or urban region and the distance between dwelling and medical facility (Aday & Andersen, 1995).

Need for medical care is a major determining factor in the Health Services Utilization Model and implies that a condition exists that subjectively is perceived to create a substandard level of health. This condition of illness, injury, or disability is

termed "morbidity". The World Health Organization International Collaborative Study of Medical Care Utilization defined perceived morbidity as either restricted activity or high level of discomfort (Hulka & Wheat, 1985). These morbid conditions may prompt a person to seek medical care.

Another component of the Health Services Utilization Model that is important to this project is the concept of "mutability" or the extent to which a component can be altered to influence health care utilization. Certainly demographic variables and distance to health care do not fit this category. The more mutable beliefs and enabling variables such as lack of knowledge about available services and lack of transportation to and from a facility are characteristics that can be addressed to affect change in a population's access to care. In doing so, the individual or population at risk, rather than the health care delivery system, is assessed as a component in the problem of access to healthcare.

The following framework for the study of access (Fig. 1) conceptualizes the interrelated nature of the components.

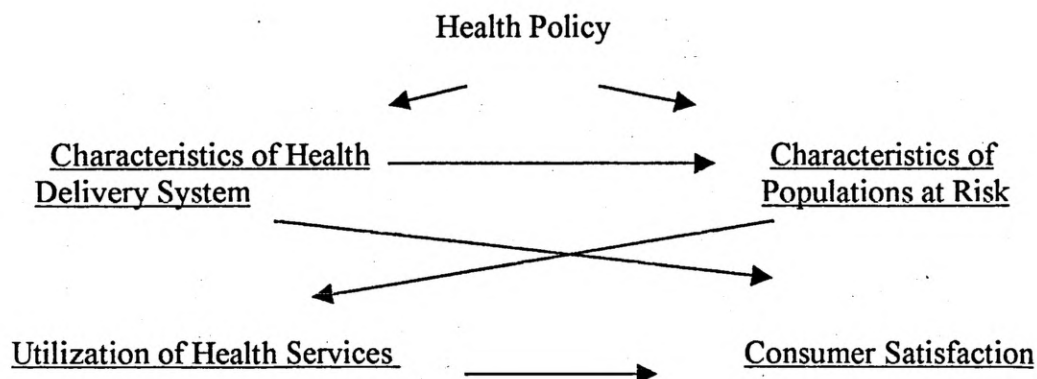


Figure 1. Framework for the Study of Access to Medical Care

CHAPTER 2

REVIEW OF THE LITERATURE

Introduction

The barrier presented when a person lacks access to transportation is not unique to the rural population, but is encountered by disadvantaged people in general. The rural population, however, often has fewer options for overcoming this barrier because of the relative lack of public transportation in rural areas. People who live in rural communities do so for a variety of reasons and one of those reasons is often the distance from metropolitan communities with their impersonal crowds, traffic, noise, crime, and fast paced lifestyle. Generally, traveling to obtain commercial or specialty services is accepted as part of the cost of living in a less populated area. Unfortunately, when circumstances make that travel a hardship, the distance, and the physical exertion or discomfort involved may actually prevent or hinder access to needed services such as medical care. The purpose of this project was to investigate available resources for transportation assistance, develop a tool to assist primary care providers and their staff members in assessing a patient's transportation needs and their eligibility for assistance through various federal or community programs, and to compile a resource list to be used to match patients with possible services and/or funds.

The literature reviewed covered the topics related to a conceptual framework that addressed the components impacting access to medical care. The access to health care issue was explored as a concept with regard to its application to the transportation issue. Lack of transportation was examined specifically as a barrier to health care access and literature related to populations at risk for lacking transportation in both rural and urban settings was reviewed. Advantages to using community based resources, funding possibilities and general public knowledge of available resources and gaining access to these systems was investigated. Finally, research was studies regarding the role of the Advanced Practice Registered Nurse as an advocate for transportation to health care.

Access to Health Care

The concept of "access" to healthcare has been studied for many years and addressed in a wide variety of ways. Access has many components including physical availability of a provider and facility, ability to afford services, knowledge of availability and how to enter the system, ability to travel to the site of care and satisfaction with or trust in the care provider. For the purposes of this paper, the act of physically traveling to the site of care is the access component considered. The formal definition implies an approach to or use of a given service or object and the factors that affect or impede this process (Aday & Andersen, 1995). Webster's Dictionary defines access as "permission, liberty, or ability to enter, approach, communicate with, or pass to and from or make use of." It has been described as a measure of the "fit" between characteristics of providers and health services and characteristics and expectation of clients. The same authors note

that a dimension of access, accessibility, describes a relationship between the location of supply and the location of clients, taking into account the clients transportation resources, travel time, distance and cost (Penchansky & Thomas, 1981). It is noted that variations in access influence patient satisfaction, service utilization and provider practice patterns. Access is, or should be, a goal of health policy and a guide to monitoring the effectiveness of health care programs (Aday & Andersen, 1974). The proof that care is accessible is use of the service, so access can be measured by the level of use in relation to "need " (Aday & Andersen, 1995).

Many national programs have been formulated to improve equity of access to medical care in this country. Medicare, Medicaid, nutrition programs, and health education are aimed at supplying and financing care and educating the consumer. These are health policy considerations. Other programs address the need to improve the availability of facilities and medical personnel equally to all areas and these are delivery systems issues. Access also depends on the characteristics of the population at risk; the predisposing, enabling and need factors applicable to the individuals

In addressing access to primary care, Davis, McAdams and Tilden (1994) note that primary care access assumes a system of linkages; it assumes a system. Although this statement refers to the existence of primary care services in an area, specifically rural areas, it also applies to a client's ability to travel to the site of care. Conversely, barriers to access have been described as factors external to the potential client that prevent the person from using a service. One factor is the client's ability to get to where the service is

being offered. If the location of the service is beyond the potential client's means of transportation, the client is less likely to use the service (Yeatts, Crow, & Folts, 1992).

Finally, appropriate use of formal health care and social services is affected by the client's knowledge of those services. Consequently, to improve availability and utilization, there must be awareness of the services by the health care providers and the consumers (Hassinger, Hicks, & Godino, 1993). Elderly clients in particular often do not know who to contact, what eligibility requirements are, or how to go about gaining entry to the systems offering services (Roberto, Richter, Bottenberg & MacCormack, 1992). The missing links in the system of linkages may often be lack of knowledge. Providing this information and advocating for a client by assisting him/her to gain entry to the systems offering services would be likely to improve access to health care.

Populations at Risk

Implicit in the discussion of the access concept is that certain categories of people have more or less "access" to medical care than others based on certain characteristics. Biological or social characteristics such as age, sex, race or some community characteristics such as rural or urban help define these groups (Aday & Andersen, 1995). Populations considered to be at risk for finding lack of transportation a barrier to accessing health care include the poor, elderly, frail, or disabled. Within these categories are subgroups such as minorities, migrants, women and children, substance abusers and

those with chronic disabling diseases such as HIV/AIDS. These populations have been recognized by the United States government as having special needs and problems accessing medical care.

With the possible exception of walking, transportation generally costs money. Owning, maintaining and supporting a private automobile is considered a cost of living to most of the working population but becomes a luxury to the unemployed, poor, and elderly on a fixed income. Illness and disability may affect ones ability to drive a car. Public transportation available in urban areas offers an alternative but also is limited for those with disabilities or illnesses that limit endurance, eyesight, or mobility. And, there may be safety issues in the use of public transportation in areas where the frail are victimized by criminals or delinquent youth.

Poverty affects all areas of living including education, employment, housing, nutrition, lifestyle and behavior, and access to health care. Economically disadvantaged patients typically seek health care later than do other patients and consequently their disease is more advanced or their condition (i.e. pregnancy) has been lacking necessary supportive care. A study of disadvantaged cancer patients in an Indiana county assessed transportation problems encountered by these patients. One fifth stated they needed help with transportation and 22% reported missing appointments because of transportation problems. The study further noted that 36% had some sort of compromised ambulation ability making the use of public transportation difficult or impossible, and that lack of knowledge about available transportation alternatives and how to apply for services also hampered access (Bryan, Greger, Miller, Weinberger & Loehrer, 1991).

those with chronic disabling diseases such as HIV/AIDS. These populations have been recognized by the United States government as having special needs and problems accessing medical care.

With the possible exception of walking, transportation generally costs money. Owning, maintaining and supporting a private automobile is considered a cost of living to most of the working population but becomes a luxury to the unemployed, poor, and elderly on a fixed income. Illness and disability may affect ones ability to drive a car. Public transportation available in urban areas offers an alternative but also is limited for those with disabilities or illnesses that limit endurance, eyesight, or mobility. And, there may be safety issues in the use of public transportation in areas where the frail are victimized by criminals or delinquent youth.

Poverty affects all areas of living including education, employment, housing, nutrition, lifestyle and behavior, and access to health care. Economically disadvantaged patients typically seek health care later than do other patients and consequently their disease is more advanced or their condition (i.e. pregnancy) has been lacking necessary supportive care. A study of disadvantaged cancer patients in an Indiana county assessed transportation problems encountered by these patients. One fifth stated they needed help with transportation and 22% reported missing appointments because of transportation problems. The study further noted that 36% had some sort of compromised ambulation ability making the use of public transportation difficult or impossible, and that lack of knowledge about available transportation alternatives and how to apply for services also hampered access (Bryan, Greger, Miller, Weinberger & Loehrer, 1991).

Adequate prenatal care is important to the birth outcome of a pregnancy and lack of transportation is a barrier to receiving prenatal care for low-income women. One study questioned women who had been admitted in labor through the emergency rooms of eight Sacramento hospitals during a two-month period in 1991. Those with no physician of record, 53% of the sample, reported lack of transportation as a major barrier to receiving prenatal care. Of those who had no care and had not even tried to secure care, lack of transportation was listed as the most important barrier (Aved, Irwin, Cummings, & Findeisen, 1993). A study of women on Medicaid in Tennessee identified lack of private transportation, poor quality of public transportation or lack of knowledge of transportation provided by a health center as a major barrier to receiving prenatal care. The transportation barrier for low-income women is a multifaceted one. Respondents to a qualitative study of barriers to prenatal care among women of low socioeconomic status conducted in Arizona cited transportation problems. They reported that they either did not have reliable transportation to attend prenatal clinics, did not have enough money to maintain or buy fuel for their car, or found public transportation unreliable and inconvenient (Gazmararian, Schwarz, Amacker, & Powell, 1997).

Low-income women tend to neglect routine health maintenance if transportation presents a barrier to access. In a Los Angeles Health Department setting, barriers of not having health insurance, not being able to take time off work, and inability to pay for the service were not identified as significant problems. Lack of transportation to obtain a screening mammogram, however, accounted for 39% of those who did not adhere to referral for the test (Crane, Kaplan, Bastani, & Scrimshaw, 1996)

The effect of poverty is not limited to young women. Very poor elderly women represent approximately 28% of the population living in poverty. Conservative U.S. Census Bureau estimates indicate as many as 4 million elderly people may now live below the poverty level. Men are twice as likely to have earned income in addition to Social Security benefits whereas women may depend on Social Security as their only source of income (Rittner & Kirk, 1995). Regardless of gender, poverty affects the ability to own and maintain an automobile or to pay for public transportation and so may impact access to medical care.

Another factor that affects a person's ability to utilize transportation methods is health status and/or frailty. Serious chronic illness such as advanced Chronic Obstructive Pulmonary Disease (COPD), debilitating illnesses and treatments such as cancer and chemotherapy, and conditions that affect mobility are all barriers either to driving or using public transportation. A study using a network of cancer treatment facilities throughout the state of Texas found that more than 63% of all respondents to the study survey reported needing someone else to drive them to receive chemotherapy or radiation therapy. Sixty-two percent of the Hispanics, 55% of the blacks, and 37% of the whites reported that finding someone to drive them for cancer treatment was a barrier that could cause one to forgo needed treatment (Guidry, Aday, Zhang, & Winn 1997).

Persons living with HIV/AIDS were surveyed using a Barriers to Care Scale to delineate the severity of factors that impede access to care in Wisconsin. This sample population faced not only physical hardship barriers due to debilitating illness, but also

social stigma barriers. Among the most significant barriers rated were the need to travel long distances to medical facilities and personnel and the lack of personal or public transportation (Heckman, et al. 1988).

Psychologically vulnerable elderly are much less likely to have an independent means of transportation, other than walking, to access community services and the majority are dependent on others for rides (Windley, & Scheidt, 1983). This group includes those with mental illnesses and those with developmental disabilities.

There is considerable overlap in the classifications of frail and elderly. Advancing age is often accompanied by a general decline in strength, fitness, and health. Additionally, a serious, chronic or malignant disease or disability limits use of services that require traveling. Most forms of social service such as education, senior citizens' activities, and food stamps are not accessible to those who lack transportation (Clark & Dellasega, 1998). Figure 2 illustrates the large numbers of people in rural areas who are at risk for finding lack of transportation a barrier for accessing health care.

According to U.S. Census data, the availability of personal transportation declines with age. Eighty-six percent of persons 65-69 years of age owned a vehicle while 54% of those 85-89 years of age had their own transportation. Of all people 65 years of age and older, 87% of the males and 69% of the females owned cars. In this same age group, 65% of central city residents owned cars while 94% of rural farm dwellers owned cars. These figures highlight the critical role of the car in meeting the mobility demands of older rural dwellers.

RURAL AREA POPULATION

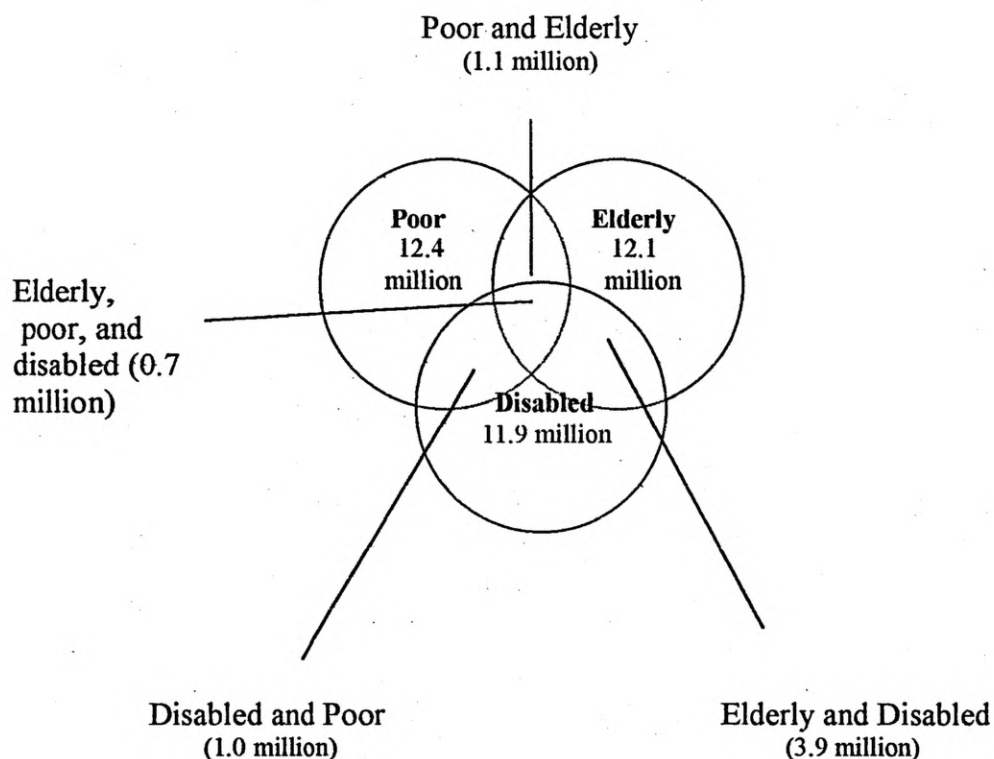


Figure 2. From "Status Report on Public Transportation in Rural America", 1994, Online Rural Transit Assistance Program Publications, U.S. Department of Transportation Association of America publication

In addition to the infirmities of age (declining strength, hearing, vision, and reaction time), many older people suffer chronic, debilitating, and/or malignant illnesses. These conditions or the treatments for them can adversely affect the ability to drive or use a public transportation service if it were available. A study of 593 cancer patients 65 years

and older living in New Mexico found that impaired access to transportation and poor social support resulted in failure to receive definitive therapy for cancer. One-third of the patients in this study depended on others for transportation and those who did not live with a driver were very unlikely to receive radiation treatment. Those who did drive or lived with a driver were more than four times as likely to receive this treatment (Goodwin, Hunt, & Samet, 1993).

Urban Vs Rural Access to Care

In general, the need for transportation options is greater in the rural than the urban areas. Being without a car in an urban area has partly been a reflection of the availability of public transit reducing the need for a personal vehicle. All of the large urban areas have public transportation systems in the United States while two-fifths of the rural households are located in areas without any public transportation services.

Based on 1990 Census data, there are 76 million "transportation dependent" persons in the United States and 29 million, or 38%, are in rural areas. Thirty-two percent of rural residents are classified as transportation dependent compared to 30 percent of urban residents. One indicator of need for transportation assistance evaluated by the federal government is the number of households who lack access to a car or similar vehicle for personal travel. The 1990 Census reported 10.6 million households without any vehicle. The majority of those were found in the largest urban areas (one million or more people), however nearly one-fourth were outside urbanized areas (at least 50,000 people). One in

13 rural households is dependent on others for transportation compared to one in ten small to medium urban area households and one in six in the large urban areas (Zeilinger, Jeskey, & Bogren, 1994).

In 1973, The U.S. Department of Agriculture reported that "rural and urban people do not have equal access to health services. Rural areas are deficient in professional medical personnel, physical health care facilities, and the ability to afford the financial costs of illness" (Aday & Andersen, 1974, p. 209). Twenty years later, the U.S. Department of Health and Human Services reported that "for specialized medical care and for technology-intensive inpatient procedures, they (rural elderly) frequently had to travel to urban areas or rural referral centers (Braden & Beauregard, 1994). Access to care in rural areas is perceived as an important factor in predicting use of medical services. Resources and scope of services in small rural hospitals are often limited and rural elderly may have to travel to receive care. There is a concern that difficulty in traveling may cause particular access problems. Non-metropolitan elderly are almost twice as likely to travel more than 30 minutes to reach their usual source of care (U.S. Health and Human Services, 1993).

Specialized medical care such as that needed by persons with HIV/AIDS is often not available in rural areas. It may be necessary to travel to metropolitan medical centers to receive services of specialists and technology intensive treatments. Compared to those in urban areas, persons with HIV/AIDS living in rural areas cited significantly more problems traveling long distances to medical facilities and noted a lack of personal or public transportation as a major barrier (Heckman et al. 1998).

Funding Sources and Community Resource

Review of the literature has established that an access problem exists when a potential health care client does not own or is unable to operate a personal vehicle. If that person also lacks access to public transportation, as is true in many rural areas, the available options are even fewer. Federal funding has been appropriated to numerous agencies to address transportation services. Every state is funded to set up a Rural Transit Assistance Program and develop services as the state government sees fit. Those funding sources that are available specifically for health care transportation include the U.S. Department of Transportation through the Transit Capital Assistance Program for Elderly and Persons with Disabilities and the U.S. Department of Health and Human Services through the Temporary Assistance for Needy Families, Supportive Services and Senior Centers, Programs for American Indian, Alaskan Native and Native Hawaiian Elders and the Medicaid Program. Many others have funding available that may be secured for development of transit systems through grants for startup and capital expenses (Zeilinger, 2000). Most grants and foundation sources are looking for start-up programs to be sustainable after the start-up dollars are gone, however (Lindsay, 1999). This means that the community must be able to support a service through fees, subsidies from local health care facilities, industry contributions, or other funding sources. Operating a transportation program typically has a high overhead with capital expenses of vehicles and a physical plant, plus maintenance, wages for drivers and office staff, insurance, and utilities. Survival of such an operation depends on a consistent and high

level of customers to provide a constant stream of revenue. In areas where the population is small and widely distributed, such as rural communities, such a system is simply not practical from a financial standpoint.

Community-based services to meet the needs of poor, elderly and frail persons are needed and appropriate (Coward & Krout, 1998). In communities where a transit system is not sustainable, agencies must be creative with funding available for transportation. Area Agencies on Aging may enlist volunteer drivers to provide rides using donated vehicles. Senior Citizens Centers may use agency vans for transportation to medical appointments. Churches may maintain a pool of volunteer drivers who provide rides using their own vehicles with expenses reimbursed through the Medicaid program. Any of these community-based services could help meet the transportation needs of persons unable to drive themselves. It has been noted, however, that even when services are available for meeting the needs of the underserved, they are frequently underutilized (Calsyn, 1989). Reasons for under utilization of federally funded programs include the perception of need as cited in Andersen's Utilization of Health Services Model. Other reasons were lack of awareness about the services, geographical barriers, cost, mistrust of government-funded services, or negative attitudes associated with being the recipient of services (Calsyn, 1989; Krout, 1998; Yeatts, Crow, & Folts, 1992)

In a culture that values individual self-reliance, there is a tendency to prefer informal support and service systems over formal services. These informal support systems, however, are just as dependent on human and financial resources as the formal systems. In settings where persons have experienced an erosion of these resources as

their incomes shrink and friends and family die, relocate, or become disabled, the option to call upon a family member or neighbor for assistance or transportation may no longer be available or adequate. These people will find it increasingly difficult to travel to receive health care (Ludke, 1991). A study on overcoming barriers to services use by low-income minority elderly suggested several strategies to make transportation available or easier for clients to obtain. These strategies included getting the local transit authority to grant lower fares for senior citizens, getting organizations such as churches, volunteer groups, and civic and fraternal groups to provide transportation and getting other clients in the senior center who could drive their own cars to provide rides to those who needed them (Yeatts, Crow, & Folts, 1992).

A study of community service utilization among psychologically vulnerable and well elders in eight rural small towns in Kansas determined that those who were vulnerable or "at risk" were less likely to be able to travel independently to services than those in the well group. Sixty-one percent of these vulnerable persons rode with someone else to the clinic or hospital. Such transportation patterns reveal the helping networks that exist in many small towns (Windley & Scheidt, 1983).

Research into the caregiving and support systems of the frail elderly points to a strong preference for informal helping networks with family taking a major role when possible followed by friends and neighbors. The tendency was to seek help from social service professionals only when the problem was very severe or when help was not available from members of the informal social network (Auslander & Litwin, 1990; Magilvy, Congdon & Martinez, 1994; Weinert & Long, 1993). Informal helping

networks fit into the category of enabling characteristics in Aday and Andersen's Health Services Utilization Model by providing a service and also by providing support. They can also be a source of information and affirm the perception of need and the necessity to seek assistance (Auslander & Litwin, 1990). There are, then, advantages in strengthening these community ties by supporting established and naturally occurring helping systems. Persons familiar and significant to those using the systems can be included in the delivery process whenever possible. These measures may increase the impact of the intervention program and provide a more efficient system for delivering services (Coward, 1979).

The Role of Advocacy

Advocating for health promotion, wellness, and health care is integral to the role of the nurse and nurse practitioner. Traveling to the site of care is a basic pre-requisite to receiving that care, and, in many instances, it is necessary for the continuation of that care. If progress is to be made in decreasing the barriers that lack of transportation presents to certain populations, leadership in initiating that change process may well be found in the advocacy role of the Advanced Practice Registered Nurse (APRN). From the inception of the first nurse practitioner demonstration project 35 years ago, the intent of the role included meeting the unmet health needs of people of all ages in the community by facilitating access and promoting continuity and coordination of care. Design components of that project included care that is person and family centered; clinically directed practice and study; and an orientation toward health and self-care (Ford, 1979). Since inception to the present, the role has developed and become fully

integrated into the healthcare delivery system. It is difficult, however, to obtain accurate statistics about the populations served and the types of services delivered by APRNs. Because services provided by APRNs are often billed under a physician or hospital name, there is no comprehensive aggregate data describing primary care delivered by this discipline (Edmunds, 2000). Over the years, legislation has mandated reimbursement to APRNs through the Federal Employee Health Benefit Package, school health programs, Medicaid, and Champus as well as some private insurers. A recent effort (1997-1998) to extend Medicare reimbursement to APRNs, for care delivered to the poor, gained authorization and resultant modification in the Medicare regulations. Because these agencies are funded to cover health care delivered to the poor, the young, and the elderly, it is evident that a significant portion of the patients cared for by APRNs are included in these categories (Edmunds, 2000). Since these persons constitute a major portion of the population at risk for having problems accessing health care, the access problem falls squarely in the APRN's scope of practice. The standards of practice of the American Nurses Association outline patient education, health promotion and management, and a leadership role as integral to the APRN role. Specifically, regarding leadership, the measurement criteria state "The advanced practice registered nurse brings creativity and innovation to nursing practice to improve care delivery ...[and] works to influence policy making bodies to improve client care" (American Nurse Association, 1996, p. 18).

Leadership is often a key ingredient in bringing about change. As the health care system evolves from an acute care focused system to one that emphasizes community based primary care, the nurse's role will require expanded knowledge of community

resources and community networks. Community development will become a focus of the RN and APRN practice. This will include developing skills in networking with community agencies, groups and leaders; identifying and mobilizing natural helpers in the community, and empowering community members with involvement and ownership in health promoting behaviors (Courtney, 1996). These skills and this knowledge are closely tied to the patient advocacy role necessary to address the transportation barrier problem.

Advocacy in nursing practice "is the support of an individual to promote his or her own well-being as understood by that individual" (Gaylord & Grace, 1995). The underlying philosophy of nursing views the patient as a whole and this multidimensional awareness of the individual is the natural precursor to advocacy. Advocacy in nursing is based on a moral responsibility that is taught in the ethics portion of nurse's basic education and must then be incorporated into active practice. The advocacy role has been long accepted and widely discussed in the literature but in actual practice has suffered from the "downsizing" trend. Advocacy takes time, energy, and effort. It requires the nurse to know the patient and the patient's life situation very well. In the modern health care setting, there is a premium placed on speed and high volume in rendering services and this is in direct conflict with the advocacy role at times (Hamric, 2000). In considering solutions to the transportation problem for clients of primary care providers, there is no shortcut to knowing a client and his/her needs. Working with government agencies may be time and labor intensive. Organizing and operating community based volunteer services requires considerable effort as well. A creative approach to the

problem begins with recognition of the value of practicing advocacy and a willingness to accept the active advocacy role. If services are not addressing the needs of the populations at risk, the first step is educating the government officials responsible for allocating funding. No change will occur if the needs of persons with transportation problems are not brought to the attention of the agencies that offer services.

Empowerment is a product of advocacy. By educating clients about the services and resources available to them and facilitating an initial entry into the systems providing services, the client gains a tool to help manage his/her healthcare and wellness.

Finally, review of literature addressing utilization of health services also pointed out that the use of formal health care and social services is affected by the client's knowledge of those services. Consequently, to improve availability and utilization, there must be awareness of the services by the health care providers and the consumers (Hassinger, Hicks, & Godino, 1993). Elderly clients in particular often do not know who to contact, what the eligibility requirements are, or how to go about gaining entry to the systems offering services (Roberto, Richter, Bottenberg, & MacCormack, 1992). Providing this information and advocating for a client by assisting him/her to gain entry to the systems offering services is a function of the APRN and nurses in general.

Summary

In considering approaches to the problem of lack of transportation creating a barrier to health care system access, insight is gained by surveying the literature for information

on current and historical approaches to the issue. Decades of legislation and implementation have nurtured programs that have proven successful in areas supported by larger population bases. Special needs of populations at risk have been addressed and transit solutions found for many in urban areas where population, tax base, business sponsorship, and government funding help insure their success.

Much attention has been directed toward bringing health care services to rural or under served populations but much less toward transporting the patient to these services, whether one block or 100 miles away. It is the frail, the poor, the elderly, and the ill who feel the effects of this barrier both in urban and rural locations. In more than a few instances, the lack of knowledge about the services that are available to transport people to appointments is a factor. In very small towns and rural areas there is, clearly, a lack of any organized transportation resource public or private. The funding sources available to help with transportation needs such as Medicaid, are not often used because recipients do not know how to apply for them (Bryan, 1991). Often, medical personnel are not aware of the problems or of possible solutions that are available.

The holistic philosophy of the APRN suggests that a patient's medical condition and needs be viewed in terms of how they impact that persons overall life and situation. Clients in a family practice would include persons from across the life span and with all levels of functional ability and economic status. A practicing APRN is in a position to encounter the patient with transportation needs on a regular basis and might consider routinely asking if a planned referral or treatment regimen would present problems with physically accessing the location. Interventions would, then, include investigating the

person's eligibility for transportation assistance/funding, providing information about services and advocating for him/her with service providers, social services, and community resources. As a client advocate the APRN takes a leadership role in promoting health and wellness in the population by addressing barriers to accessing health care and actively seeking solutions.

CHAPTER 3

PROJECT DESIGN

Introduction

This chapter describes the process of developing tools to assist health care professionals in the assessment of transportation dependent clients and matching the client to available resources. In the initial phases of this project, existing research was searched and reviewed to establish that there was a problem accessing health care that was directly related to lack of transportation. Then each factor contributing to the problem of access due to lack of transportation and to possible solutions was reviewed. The literature was also explored for a conceptual framework that addressed the various components that affect access to medical care. The Health Services Utilization Model was chosen because it addresses enabling variables as characteristics of populations at risk and also the factor of mutability. These concepts are particularly relevant to the problem of transportation being a barrier to accessing health care and helped guide the project through the development, assessment, and evaluation phases.

The concept of access to health care was explored to define it as it applies to the problem of transportation. Lack of transportation, either private or public was examined as a barrier to access. Literature addressing populations at risk was searched as well as differences between urban and rural members of these populations. Community-based resources as possible solutions were reviewed. Funding possibilities, general public knowledge of existing services, and how to gain entry to the systems offering the services were also investigated in existing published works.

Finally, research was studied pertaining to the role of the Advanced Practice Registered Nurse as an advocate in issues of access to health care.

From the literature review, it was determined that many rural communities have a recognized need for help with non-emergency transportation to medical care. Further review revealed that provisions had been included by several federal, state, and local government agencies to provide funding for such transportation. Every state in the country, for instance, is funded to set up it's own Rural Transit Assistance Program and develop services for their particular state (National Transit Resource Center, 1995). In addition, Medicaid programs have funds to pay eligible clients' travel expenses. Clients quite often were not aware of such assistance being available and did not know how to apply for entry into the system (Roberto, Richter, Bottenberg, & MacCormack, 1992).

This chapter details the process of developing tools to allow primary care providers and their staff members to quickly explore the eligibility of clients for transportation resources and direct them to the agency personnel who could facilitate entry to the appropriate programs. Because these tools would be resources generally used by busy office or agency staffs, it was important that the tools be easy to use and flexible enough to be adapted to different communities. A simple flow chart format, adapted from quality improvement applications, was constructed for the purpose of exploring eligibility based on individual client criteria. The flow chart was supplemented with a resource worksheet to be completed by individual health care agencies with information specific to their particular community (telephone numbers and contact persons of local agencies).

Planning

Development of the tools for this project began with consideration of the people who would be using the tools. They include nursing and office staff (clerical), primary care providers, and possibly social workers and discharge planners. The design was intended to be simple to use, however, some introduction and instruction was needed to promote the success of the tools. Basic tenets of adult learning were reviewed for clues to formulating an effective presentation and tool. According to an adult learning theory proposed by Malcolm Knowles in 1973:

- ◆ Adults tend to prefer self-direction.
- ◆ Adults learn more effectively through experiential techniques such as problem solving.
- ◆ Adults are aware of specific learning needs generated by real-life events.
- ◆ Adults are competency-based learners, meaning that they want to learn a skill or acquire knowledge that they can apply to their immediate circumstances.

Knowles further noted that adult learning tends to be problem centered and that adults who see a need or have a desire to know something are motivated to learn. In keeping with these points, the tools were designed to be largely self-explanatory and applicable to situations that arise in the primary care setting when encountering a patient with transportation problems.

Tool Development

The first tool designed for this project was based on the flowchart format often used in Quality Improvement or Total Quality Management (TQM) processes. This type of tool helps make a

process “visual” to the reader. A flowchart depicts a process that leads one through basic steps to an outcome. There may be variables included in the process (Gordon, Dahl, & Stevenson, 1996; Macchia, 1993). It is a simple diagrammatic model which illustrates the basic critical thinking process focused on problem solving (Garren, et al. 1993). In this application, the flowchart is used to identify the eligibility of the client and then match the client with a possible solution or funding source.

In developing the resource guide that accompanies the flow chart, information on available government funding was found in a publication from the Community Transportation Association of America titled *Federal Funding Resources* (2000). While this agency promotes primarily community based and grant funded transportation services, it also provides information on resources that can be applied to individual circumstances. This is important in small rural communities that do not have a large enough population base to support transit services on a continuous basis. Many of the funding sources provide start-up funding for capital expenses with the expectation that the service will become self-sustaining or find some local source of funding. As previously stated, this is not always a reasonable expectation in communities with a struggling economy and a small population.

The review of the literature on the populations at risk revealed a large portion of the general population was elderly (40%), poor (87.8%) or both (Paul & Hanna, 1997). Not surprisingly, the major federal funding sources were directed at helping these same groups. Other populations who qualified for funding assistance were persons who were physically disabled, independently living blind persons, veterans, developmentally disabled, Native Americans, Native Alaskan and Native Hawaiian elders, mentally ill, substance abusers and homeless, refugees and recent entrants to the

country, migrant workers, women, infants and children, persons with HIV/AIDS, and residents of public housing. Funding resources were explored for each of these groups and included in the resource guide.

The flowchart developed for this project, Client Eligibility Flowchart (Appendix A) allows for quick exploration of the possible qualifying characteristics of the client by the staff of a health care facility. Each community will have different population mixes and needs so not all characteristics and funding sources will apply to all locations. Characteristics of the patient population such as age classification, race, gender, economic status, or disability status, are listed in boxes down the left side of the page. To the right of this list are the most likely sources of funding for transportation for each particular group. The sources are numerically coded to allow quick location of the corresponding resource agency on the accompanying list (Resource Guide, Appendix B).

The companion tool (Appendix B) is a list of the resources, which includes the address, telephone and fax numbers, and web site location of the national headquarters of each agency. It is intended to be a central resource from which individual primary care sites can access information about local funding. The usual funding paths originate at the national level and are then funneled to the state and then local levels. In many instances, local agencies may be located in the local telephone directory. If that is not the case, accessing the web site of these agencies often allows for locating the nearest sites as well as helpful information regarding services. There is often a contact person to whom a communication may be directed. This may be helpful when there is no local office of an agency or the agency does not address the needs of a population group in need. It is hoped that staff members will direct an e-mail message to the manager or director of a state or national agency about specific needs of a population group or area as a simple form of advocacy.

Just as a letter to ones congressperson supplies information on the wishes and needs of the constituency, communication with service agencies provides input as to what and where the need is.

A blank column to the right of the list of resources provides space to write in the local or state location, telephone numbers, and names of contact persons. This will allow the list to be individualized for different communities. It is intended to serve as a worksheet where notes about approaches that were or were not successful, valuable contacts, and application procedures may be made.

Field Test

To gain information about the usefulness of these tools and to generate input from nurses in a primary care setting, it was decided to field test the tools in a rural area of Northwest Montana. The site is a physician owned Family Medicine clinic with five physicians, one nurse practitioner, and seven nurses on staff. It is a teaching facility and generally also has at least one Family Medicine resident and/or 3rd year medical student and often a nurse practitioner student on site. Although situated in a county designated as frontier by population density (less than six people per square mile), it is located in the largest town (population 3,000) in the county. Because of the remoteness of the town, however, the clinic serves a wide radius with an estimated population of 12,000-14,000. The nearest medical facility outside the area is 87 miles to the east. There is no public transportation.

Six of the seven nurses were asked to test the tool and agreed to do so. The seventh nurse was not included because she was on an extended medical leave at the beginning of the test. Permission was secured from the managing partner of the clinic as well. Staff nurses were selected for the testing process because they are generally the persons who make such arrangements for follow-up care and for giving referral details to the clients (directions to the referral site, appointment date and time, specific preparation for appointment or procedure).

Brief written instructions were provided (Appendix C) as well as a short oral in-service on the intent and use of the tool. The in-service was conducted by the author prior to the start of business on a regular work day in the employee break room. Time was allowed during the in-service for questions and clarification of the tool's use and also provided a forum for discussing the role of advocacy in providing this type of information and service to the clients of the primary care clinic. Each nurse participating was supplied with a copy of the flow chart and the resource list. An evaluation form was supplied (Appendix D) for comments and suggestions, for recording the number of times the tool was consulted or employed, and the outcomes of these uses. The nurses were contacted weekly to provide an opportunity for questions or feedback. To enhance the likelihood that the tool would be used during the short trial period (3 weeks), local agency information was supplied with their copies of the tools.

CHAPTER 4

PROJECT OUTCOMES

Introduction

In this chapter the results of field testing and evaluation of the tool are described. Limitations, implications, and recommendations are also discussed.

Evaluation

The process of developing an evaluation tool and resource guide is incomplete until the product has been tested in the setting for which it has been designed. The process of evaluation requires feedback or results from this sort of testing to allow for assessment of the efficacy of the tool. A determination can then be made as to the usefulness of the tool and revisions can be incorporated based on information gained through actual use or testing

Field testing of the Eligibility Flowchart and Resources Guide was conducted in a family practice clinic setting. Six staff nurses were instructed in the use of the tools and agreed to use them when client situations warranted. A testing period of 3 weeks was allowed after which the nurses' evaluation sheets were collected and each was asked for comments or suggestions. One of the nurses had taken an unexpected leave before the end of the 3 weeks so only completed two weeks of the test time.

Of the six nurses, two had occasion to use the flowchart and resource guide. A total of three contacts were made resulting in two rides being arranged. One of these was with the Veteran's Administration and the other through Medicaid. A nurse who did not use the tool commented that she had not encountered any patients needing transportation during that time period but felt that she could make use of the tool in the future. Two nurses admitted that they had not remembered to consult the resource, as they were not accustomed to using it. All stated that they had encountered clients in their practice in the past who had been in need of transportation assistance. A nurse who had used the tool, found that some of the information on the Medicaid web site was not current and that a new Director of Operations was now in place. She commented that her contacts were generally helpful and directed her to a resource person who was able to help her locate funding for her client's transportation. In general, all the nurses who used the tool stated that they thought it was easy to use and a valuable resource. There was some confusion initially about the use of the resource guide in that the local contacts were included on a separate page and one nurse thought that she would have to contact a federal office to try to arrange transportation help locally. Another nurse had additional information about a local contact for the Veteran's Administration who was helpful in arranging rides through the Veterans of Foreign Wars local association. This information was shared with the other nurses.

All six nurses stated that they were somewhat confused as to how the federal office information was to be used. Except for the nurse who had contacted the federal headquarters of the Health Care Financing Administration for assistance with a Medicaid patient, none of the nurses made such contacts.

When asked whether they had received adequate instructions for using the tool, all stated that they had. One, however was not able to locate her copy of the instrument and evaluation form at the end of the 3 weeks, and two admitted that they might have been preoccupied with other thoughts when the information was being presented. The author noted that there was some difficulty getting all six nurses together for the presentation, as there is often one nurse off and one nurse working in a satellite clinic on any given day of the week. On the day the field test was initiated, one nurse was also out of the office due to illness. As a result, only three nurses received the information in a planned presentation, the other three received the information individually during the lunch break while at their workstations.

Based on input from the nurses, who took part in the field test, the resource guide was revised to include the more current information on contact personnel for two national agency offices and one local contact person. More specific wording was added to the instruction details as well.

Limitations

In evaluation of the results of this project, certain limitations were noted. First, the short period of time allotted for the field test likely resulted in a small number of encounters with clients who could benefit from the employment of the tool. Second, the number of nurses asked to test the tool was small and contributed to the small number of nurse/client encounters. Third, presentation of the field test instruction was poorly attended and may have contributed to lack of understanding of how the tool should be used. Fourth, there seemed to be a failure to incorporate the tool into the

resources commonly used by the staff nurses, possibly due to lack of reinforcement or lack of understanding of how the tool was to be utilized. Fifth, the “bulkiness” of the tool (eight pages) may have limited its use as it required time to become familiar with the components of both the flow sheet and resource guide to make use of them.

Another limitation that was recognized is that the tool is only of benefit to those clients who, at least once, either telephone or present to the health care facility for an appointment or care. It does not address the members of the population who, because of lack of transportation, are never able to make contact with a care provider or staff member and do not otherwise attempt to secure help (by telephoning).

Implications and Recommendations

Even though the field test of the tool and resource list had limited success, each of the nurses interviewed stated that they recognized a definite need for transportation resources for certain members of their client population. It was also the consensus that there was generally a lack of knowledge by both nurses and clients as to how to secure assistance for transportation. The nurses were all in agreement as to the need to act as advocates for their clients and all expressed willingness to assume that role even if it required spending more time and added to their already busy schedules. Each stated that she had attempted to obtain rides for clients by various means in the past with limited success and considered it part of her role as a nurse to advocate for this type of assistance for clients if it was within her power.

One implication of the project is that a more thorough training session may be needed for the personnel using the resource and tool to provide a better understanding of both the process and desired outcome. Presenting the information at a time when there was less pressure to be brief and take as little time from the daily schedule as possible would be helpful. Perhaps this could be done during a regular staff meeting. Presenting the information more than one time to accommodate the variable schedules of personnel would have provided better exposure plus reinforcement for those who had heard the in-service previously. Another implication of the project is that establishing a new procedure or habit may take more time and more frequent reinforcement than was allowed in a 3-week trial. It often takes several weeks to incorporate a new habit or procedure into daily practice and a longer trial period may well have revealed a higher use rate.

It may be that, in an attempt to create a tool with a broad applicability, it simply became too complex or too bulky to be easily referenced during a typical busy schedule. One recommendation might be to design a more tailored version using only the data applicable to a specific area. This would limit the scope of each tool. In the practice setting, however, it is likely that the original resource guide would be consulted infrequently once the local contacts were made and a pattern of use established.

The limited success does not detract from the fact that two rides were arranged for clients who otherwise would not have had access to needed care. While the tools may not be the answer to every transportation dependent person's problem, they have potential to be of value if incorporated into the resources regularly consulted in advocating for better patient access to care. The author has encouraged the nurses who participated in the field test to keep and use the tools and tailor them to

be as useful to them as possible. Should the tools prove to be helpful over time, they could be shared with others in the healthcare professions through articles or advertisements in the newspaper of the state nurses association.

Future projects might detail the organization of a volunteer driver pool to assist persons without transportation to access medical care. Pilot projects of this sort have been successful in some communities. Another project would be to develop a fact sheet or resource for clients to use to seek transportation assistance. It could be made available at Senior Citizens centers, Medicaid offices, Food Pantries, Libraries, and other public agencies and advertised in the local newspapers as available by mail from some of the same sources.

One clinical implication that became evident to the author in implementing this project is that negotiating the circuitous route through federal agencies to funding resources is a daunting process. It is likely that few members of the general public would undertake the necessary research and follow-up necessary to secure the information and financial assistance researched here. Nurses and others in the helping professions are perfectly positioned to assume the role of advocate in managing this aspect of health care access. The field of health care revolves around rapidly expanding technology in all areas and demands that those in practice keep pace in order to deliver the most up to date care modalities. Unfortunately, portions of the population are left behind because of their life circumstances. This has always been the case with the luxuries of life but health care is not a luxury. It is a basic and humane right to be able to receive treatment and preventive health care. Informed nurses and FNPs can address this access issue by staying informed and providing necessary information and assistance to clients.

REFERENCES CITED

REFERENCES CITED

- Aday, L. & Andersen, R. (1995). A framework for the study of access to medical care. In L.A. Aday & R. Andersen (Eds.), Access to medical care (pp. 1-23). Ann Arbor, MI: Health Administration Press.
- Andersen, R., & Aday, L. A. (1978). Access to medical care in the U.S.: realized and potential. Medical Care, 16, 533-546.
- Auslander, G. K., & Litwin, H. (1990). Social support networks and formal help seeking: differences between applicants to social services and a nonapplicant sample. Journal of Gerontology, 45(3), 112-119.
- Aved, B. M., Irwin, M. M., & Cummings, L. S. (1993). Barriers to prenatal care for low-income women. The Western Journal of Medicine, 158(5), 493-498.
- Braden, J., & Beauregard, K. (1994). Health status and access to care of rural and urban populations. Agency for Health Care Policy and Research: National Medical Expenditure Survey, Research Findings 18, Rockville, MD: Public Health Services.
- Branch, L. G., & Nemeth, K. T. (1985). When elders fail to visit physicians. Medical Care, 23(11), 1265-1275.
- Bryan, J. L., Greger, H. A., Miller, M. E., Weinberger, M., & Loehrer, P. J. (1991). An evaluation of the transportation needs of disadvantaged cancer patients. Journal of Psychosocial Oncology, 9(3), 23-35.
- Callahad, D. (1994). What do we owe the elderly? Allocating social and health care resources. Hastings Center Report, 24(2), S3-S12.
- Calsyn, R. J. (1989). Evaluation of an outreach program aimed at increasing service utilization by the rural elderly. Journal of Gerontological Social Work, 14(1), 127-135.
- Clark, D., & Dellasega, C. (1998). Unmet health care needs. Comparison of rural and urban senior center attendees. Journal of Gerontological Nursing, 24(12), 24-33.
- Coe, R. M., Wolinsky, F. D., Miller, D. K., & Prendergast, J. M. (1984). Complementary and compensatory functions in social network relationships among the elderly. The Gerontologist, 24(4), 396-400.

- Courtney, R. (1996). Nurse roles in primary care: providing leadership for health care reform. In K. Kelly & M. Maas (Eds.), Outcomes of effective management practice (pp. 37-53). Thousand Oaks, CA: Sage.
- Coward, R. T. (1979). Planning community services for the rural elderly: implications from research. The Gerontologist, 19(3), 275-282.
- Coward, R. T., Duncan, R. P., & Netzer, J. K. (1993). The availability of health care resources for elders living in nonmetropolitan persistent low-income counties in the south. The Journal of Applied Gerontology, 12(3), 368-387.
- Crane, L. A., Kaplan, C. P., Bastani, R., & Scrimshaw, S. C. M. (1996). Determinants of adherence among health department patients referred for a mammogram. Women & Health, 24(2), 43-63.
- Cutler, S. J., & Coward, R. T. (1992). Availability of personal transportation in households of elders: age, gender, and residence differences. The Gerontological Society of America, 32(1), 77-81.
- Davis, R., McAdams, R., & Tilden, N. (1994). Primary care access. In J. E. Beaulieu & D. E. Barry (Eds.), Rural health services: a management perspective (pp. 203-227). Ann Arbor, MI: AUPHA/Health Administration Press.
- Gaylord, N., & Grace, P. (1995). Nursing advocacy: an ethic of practice. Nursing Ethics, 2(1), 11-18.
- Gazmararian, J. A., Schwarz, K. S., Amacker, L. B., & Powell, C. L. (1997). Barriers to prenatal care among Medicaid managed care enrollees: patient and provider perceptions. HMO Practice, 11(1), 18-24.
- Goeppinger, J. (1993). Health promotion for rural populations: partnership interventions. Family and Community Health, 16(1), 1-10.
- Gombeski, W. R., & Smolensky, M. H. (1980). Non-emergency health transportation needs of the rural Texas elderly. The Gerontologist, 20(4), 452-456.
- Goodwin, J. S., Hunt, W. C., & Samet, J. M. (1993). Determinants of cancer therapy in elderly patients. Cancer, 72, 594-601.
- Greenberg, S. (October 18, 1996). Administration on Aging. Retrieved January 2, 2001 from the World Wide Web: <http://www.aoa.dhhs.gov/napis/definspr.html>

- Guidry, J. J., Aday, L. A., Zhang, D., & Winn, R. J. (1997). Transportation as a barrier to cancer treatment. Cancer Practice, 5(6), 361-366.
- Hamric, A.B. (2000). What is happening to advocacy? Nursing Outlook, 48(3), 103-104.
- Hassinger, E. W., Hicks, L. L., & Godino, V. (1993). A literature review of health issues of the rural elderly. Research Reviews, 9(1), 68-75.
- Heckman, T. G., Somlai, A. M., Peters, J., Walker, J., Otto-Salaj, L., Galdabini, C. A., & Kelly, J. A. (1998). Barriers to care among persons living with HIV/AIDS in urban and rural areas. Aids Care, 10(3), 365-375.
- Horner, S. D., Ambrogne, J., Coleman, M. A., Hanson, C., Hodnicki, D., Lopez, S.A., & Talmadge, M. C. (1994). Traveling for care: factors influencing health care access for rural dwellers. Public Health Nursing, 11(3), 145-149.
- Hulka, B.S., & Wheat, J. R. (1985). Patterns of utilization: the patient perspective. Medical Care, 23, 438-460.
- Johnson, J. L., Primas, P. J., & Coe, M. K. (1994). Factors that prevent women of low socioeconomic status from seeking prenatal care. Journal of the American Academy of Nurse Practitioners, 6(3), 105-111.
- Krout, J. A. (1998). Services and service delivery in rural environments. In R. T. Coward, & J. A. Krout (Eds.), Aging in Rural Settings: Life Circumstances and Distinctive Features (pp. 247-265). New York: Springer Publishing.
- Lassiter, P. G. (1992). A community development perspective for rural nursing. Family and Community Health, 14(4), 29-39.
- Lindsay, O., Newel, B., Caggese, L., Imbrogno, M., & Young, L. (1999). National Transit Resource Center: Medical Transportation. Retrieved March 28, 2000 from the World Wide Web: <http://www.ctaa.org/ntrc/medical/practices>
- Ludke, R. L. (1991). Surviving in rural America. Health Progress, 72(7), 60-64.
- Macchia, P. (1993). Assessing educational processes using total-quality-management measurement tools. Educational Technology, 33(5), 48-54.

- Magilvy, J. K., Congdon, J. G., & Martinez, R. (1994). Circles of care: home care and community support for rural older adults. Advances in Nursing Science, 16(3), 22-33.
- McCulloch, B. J., & Lynch, M. S. (1993). Barriers to solutions: service delivery and public policy in rural areas. The Journal of Applied Gerontology, 12(3), 388-403.
- McGlynn, J. (January 1999). Community Transportation Magazine. Retrieved January 22, 2001 from the World Wide Web:
<http://www.ctaa.org/ct/janfeb99/funding.shtml>
- McKenna, R. J. (1994). Clinical aspects of cancer in the elderly. Cancer, 74, 2107-2117.
- Paul, J., & Hanna, J. B. (1997). Applying the marketing concept in health care: the no-show problem. Health Marketing Quarterly, 14(3), 3-17.
- Penchansky, R., & Thomas, J. W. (1981). The concept of access. Definition and relationship to consumer satisfaction. Medical Care, 19(2), 127-139.
- Preston, D. B., & Bucher, J. A. (1996). The effects of community differences on health status, health stress, and helping networks in a sample of 900 elderly. Public Health Nursing, 13(1), 72-79.
- Ricketts III, T. C., Johnson-Webb, K. D., & Randolph, R. K. (1999). Populations and places in rural America. In T. C. Ricketts, III (Ed.), Rural Health in the United States (pp. 7-37). New York: Oxford University presses.
- Rittner, B., & Kirk, A. B. (1995). Health care and public transportation use by poor and frail elderly people. Social Work, 40(3), 366-373.
- Roberto, K. A., Richter, J., Bottenberg, D. J., & MacCormack, R. A. (1992). Provider/client views. Health-care needs of the rural elderly. Journal of Gerontological Nursing, 18(5), 31-37.
- Roberts, R. O., Yawn, B. P., Wickes, S. L., Field, C. S., Garretson, M., & Jacobsen, S. J. (1998). Barriers to prenatal care: factors associated with late initiation of care in a middle-class midwestern community. The Journal of Family Practice, 47(1), 53-61.
- Rosenbloom, S. (1993). Transportation needs of the elderly population. Clinics in Geriatric Medicine, 9(2), 297-310.

- Smith, E.R., Riggat, T.F. (1998). Accessible transportation: Human rights...versus...costs. Journal of Rehabilitation, 54(2), 13-17.
- Schoenberg, N.E., & Coward, R. T. (1998). Residential differences in attitudes about barriers to using community-based services among older adults. Rural Health Research, 14(4), 293-304.
- Shaw, J. K. (1997). An Assessment of two upstate New York rural counties to determine unmet health needs of the Medicaid population. Journal of the New York State Nurses Association, 28(1), 12-15.
- Stevens, P.E. (1992). Who gets care? Access to health care as an arena for nursing action. Scholarly Inquiry for Nursing Practice, 6(3), 185-200.
- Taylor, P., Puskin, D., Cooley, S. G., & Braden, J. (1993). Access. In U. S. Department of Health and Human Services (Ed.), Vital and health statistics. Common beliefs about the rural elderly: What do national data tell us? (pp. 43-44). Rockville, MD: Public Health Services.
- Weinert, C., & Long, K. A. (1990). Rural families and health care: refining the knowledge base. Marriage and Family Review, 15(1/2), 57-75.
- Weinert, C., & Long, K. A. (1993). Support systems for the spouses of chronically ill persons in rural areas. Family and Community Health, 16(1), 46-54.
- Williams, J. M. (1993). Simplifying a process with flowcharts. New Directions for Institutional Research, 78, 89-93.
- Windley, P. G., Department of Architecture, Kansas State University, & Scheidt, R. J. (1983). Service utilization and activity participation among psychologically vulnerable and well elderly in rural small towns. The Gerontologist, 23(3), 283-287.
- Windley, P. G., & Department of Architecture Kansas State University (1983). Community services in small rural towns: patterns of use by older residents. The Gerontologist, 23(2), 180-183.
- Yeatts, D.E., Crow, T. & Folts, E. (1992). Service use among low-income minority elderly: strategies for overcoming barriers. The Gerontologist, 32(1), 23-32.
- Zeilinger, C. (2000). Federal funding resources. Community Transportation, summer, 8-28.

- Zeilinger, C., Jeskey, C., & Bogan, S. (1994). Resource Center: Status of rural public transportation. Retrieved July 17, 2000 from the World Wide Web: <http://www.ctaa.org/ntrc/rtap/pubs/status/ch2.shtrm>
- Zemke, R., & Zemke, S. (1995). Adult learning what do we know for sure? Training, 32(6), 31-40.

APPENDICES

APPENDIX A

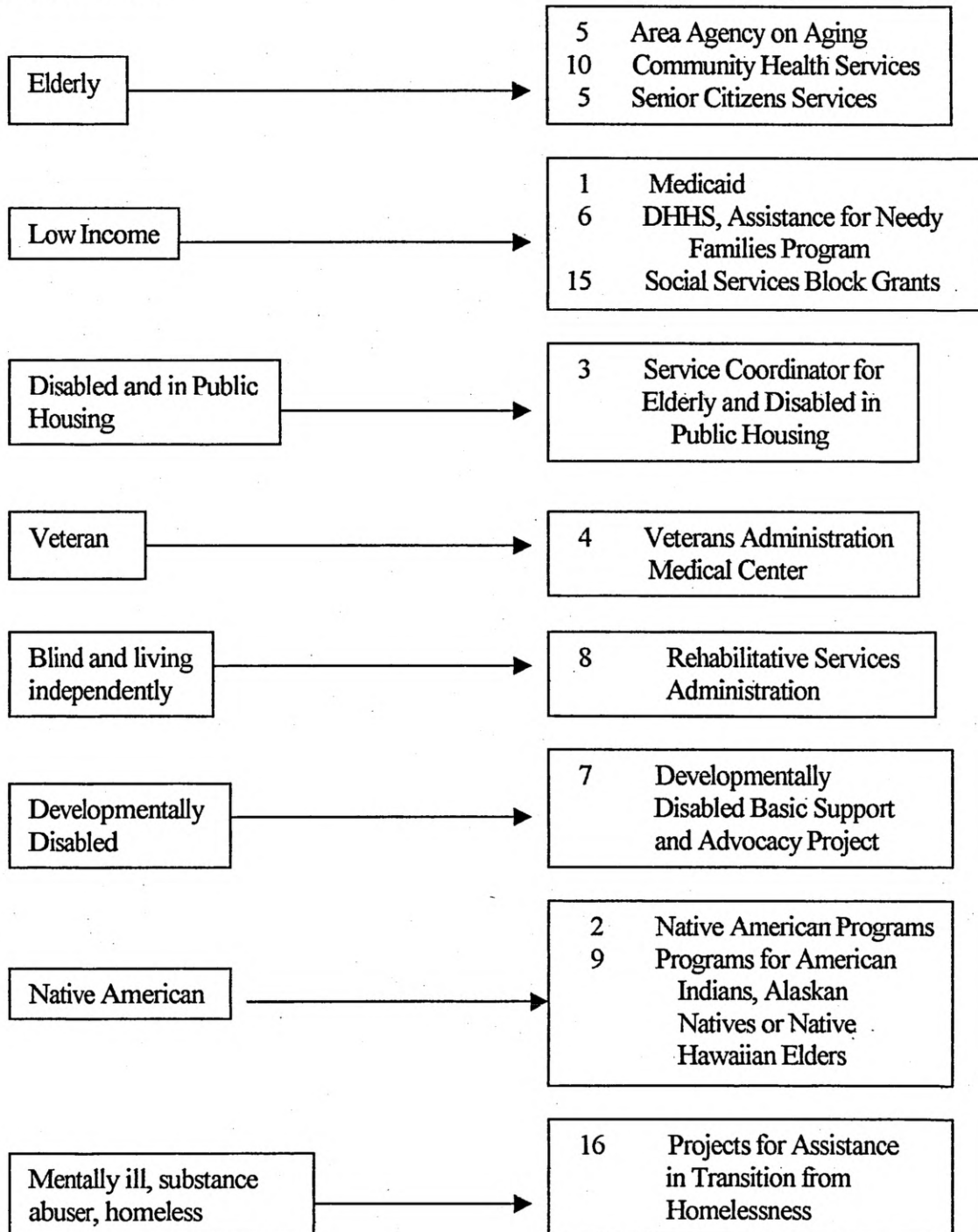
ELIGIBILITY FLOWCHART TOOL

APPENDIX A

Eligibility Flowchart for Clients 65 years and Older

If client criteria is:

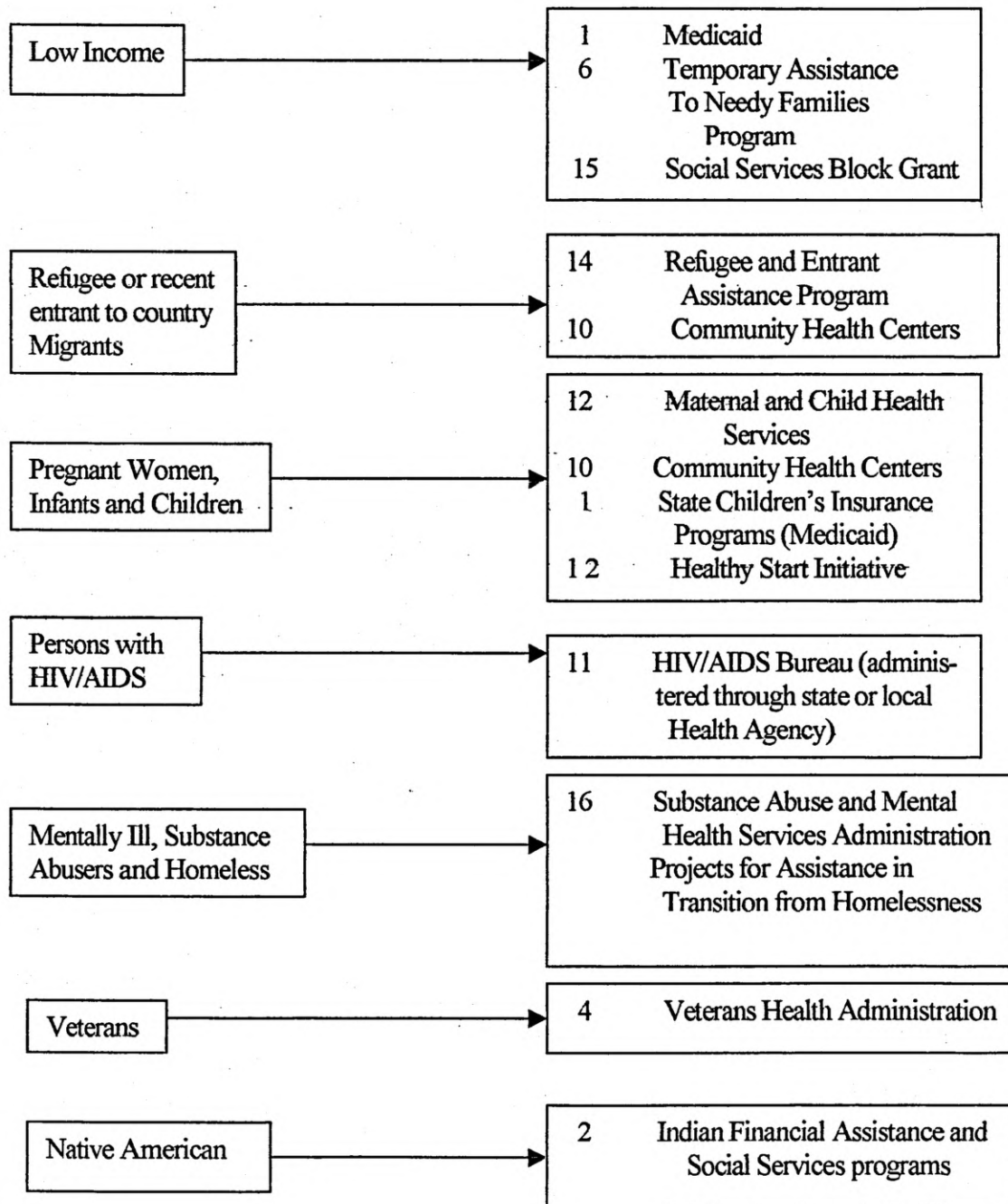
Try contacting:



Eligibility Flowchart for Clients Less Than 65 Years Old

If client criteria are:

Try contacting:



APPENDIX B

POSSIBLE FUNDING RESOURCES

APPENDIX B

POSSIBLE FUNDING RESOURCES

1. Health Care Financing Administration
Medicaid
Sally Richardson, Director of Medicaid and
State Operations
Health Care Financing Administration, DHHS
7500 Security Blvd.
Baltimore, MD 21244-1850
Tel: 410.786.3870
Web: www.hcfa.gov/medicaid/medicaid.htm

2. Department of the Interior
Bureau of Indian Affairs
Indian Financial Assistance and Social
Services Programs
1849 C Street N.W.
MS-4641-MIB
Washington, DC 20240
Contact : Larry Blair, Chief, Division of
Social Services
Ph: 202.208.2479
Fax: 202.208.5113
Web: www.doi.gov/bia/childw~2.htm

Local Tribal Official

Tribal government is funded for supportive services
which may include transportation.

3. Department of Housing and Urban Development
Service Coordinators for the Elderly and
Disabled in Public Housing
Carissa Janis, Housing Project Manager
Office of Portfolio Management
Dept of Housing and Urban Development
451 Seventh Street S.W.
Washington, DC 20410
Ph: 202.708.3944 ext. 2487
Fax: 202.708.1778
E-mail: [Carissa L. Janis@hud.gov](mailto:Carissa.L.Janis@hud.gov)
Web: www.hud.gov:80/progdesc/8coord.html

Service coordinators for federally assisted housing assist elderly and disabled persons obtain needed supportive services such as transportation. Services are intended to prevent premature and inappropriate institutionalization.

4. Veterans Health Administration
Attn: Dr. Thomas Garthwaite, M.D.
Office of Under Secretary for Health
810 Vermont Ave. N.W.
Room 934
Washington, DC 20420
Ph: 202.273.6309
Web: www.va.gov/health/index.htm

Find nearest VA Medical Center listed on web site by state to arrange for transportation services for veterans.

5. Department of Health and Human Services
Administration of Aging
Supportive Services and Senior Centers
Carol Crecy, director, Office for State and Community Programs
Administration of Aging
330 Independence Avenue S.W. Room 4735
Washington, DC 20201
Tel: 202-619.2617
Fax: 202.260.1012
E-mail: carol.crecy@aoa.gov
Web: www.aoa.dhhs.gov

6. Department of Health and Human Services
Administration for Children and Families
Temporary Assistance for Needy Families
Alvin Collins, Director of Family Assistance
370 L'Enfant Promenade, S.W. 5th Floor
Washington DC 20447
Tel: 202.401.9275
Fax: 202.205.5887
E-mail: acollins@acf.dhhs.gov
Web: www.acf.dhhs.gov/programs/ofa

Local TANF

7. Department of Health and Human Services
Developmental Disabilities Basic Support and Advocacy Grant
Raymond Sanchez, Program Operations Division Director
Administration on Developmental Disabilities
Administration for Children and Families
200 Independence Avenue, S.W. room 337-D
Washington, DC 20201
Tel: 202.690.5962
Fax: 202.690.6904
Web: www.acf.dhhs.gov/programs/add

State DD Council

8. Office of Special Education and Rehabilitative Services
Independent Living Services for Older Individuals
Who are Blind.
Rehabilitation Services Administration
Office of Special Education and Rehabilitative Services
330 C Street, S.W. Room 3416
Washington, DC 20202
Attn: Edna Johnson
Tel: 202.205.9320
E-mail: Edna_Johnson@ed.gov
Web: www.ed.gov/offices/OSERS/RSA

9. Department of Health and Human Services
 Administration on Aging, Title IV
 Programs for American Indian, Alaskan Native
 And Native Hawaiian Elders
 Yvonne Jackson, Director
 Administration of Aging
 330 Independence Avenue S.W., Room 4257
 Washington, DC 20201
 Tel: 202.619.2957
 Fax: 202.260.1012
 E-mail: Yvonne.Jackson@aoa.gov
 Web: www.aoa.dhhs.gov

Local AAA

Contact local Title VI agency

10. Health Resources and Services Administration
 Community Health Centers
 Richard Boher, directory of Community and Migrant Health
 Bureau of Primary Health Care
 4350 East-West Highway, 7th Floor
 Bethesda, MD 20814
 Tel: 301.594.4300
 Fax: 301.480.7225
 Web: www.bphc.hrsa.gov

Program supports primary health care centers in medically under-served areas, migrant communities, public housing sites and at organizations providing medical care to homeless persons.

Funds may be used to provide transportation services as necessary to provide health care services.

11. HIV Care Grants
 Dr. Joseph O'Neill, MD, Associate Administrator
 HIV/AIDS Bureau, Health Resources and Services Admin.
 5600 Fishers Lane, Room 7A-55
 Rockville, MD 20857
 Tel: 301.443.1993
 Fax: 301.443.9645
 Web: www.hrsa.dhhs.gov/hab
 Contact state or local health agency

12. Healthy Start Initiative

Maribeth Badura, Division of Perinatal Systems and
Womens Health Director
Maternal and Child Health Bureau
Health resources and Services Administration, DHHS
5600 Fishers Lane, room 11-A-05
Rockville, MD 20857
Tel: 301.443.0543
Fax: 301.594.0186
Web: www.healthystart.net

Locate Healthy Start site on web site to arrange for
transportation services to participants.

13. Health Resources and Services Administration

Maternal and Child Health Services Grants
Samuel Kessel, Systems, Education and Science Division Director
Maternal and Child Health Bureau
5600 fishers lane Room 18-A-55
Rockville, MD 20857
Tel: 301.443.2340
Web: www.mchb.hrsa.gov

Contact state health agency to arrange for provision
of transportation services to program participants.

14. Refugee and Entrant Assistance programs

Lavinia Limon, Director, Office of Refugee Resettlement
Administration for Children and Families
370 L'Enfant Promenade D.W. 6th Floor
Washington, DC 20447
Tel: 202.401.9246
E-mail: llimon@acf.dhss.gov
Web: www.acf.dhhs.gov/programs/orr

Contact state refugee assistance agency via web site for
information on how to apply for assistance and to
contract for provision of transportation services to program participants.

15. Department of Social and Health Services
Social Services Block Grants (Title XX)
Margaret Washnitzer, State Assistance Div. Director
Office of Community Services
Administration for Children and Families
370 L'Enfant promenade S.W. 5th floor
Washington, DC 20447
Tel: 202.401.9342
Web: www.acf.dhhs.gov/programs/ocs

Program funds state agencies to provide social services including transportation services that help individuals achieve self-sufficiency or forestall unnecessary use of institutional care.

16. Substance Abuse and mental Health Services Administration
Projects for Assistance in Transition from Homelessness (PATH)
Michael Hunter, PATH Program director
Center for mental Health Services, Substance Abuse and Mental health Services Administration
5600 Fishers Lane, Room 11C-05
Rockville, MD 20857
Tel: 301.443.3706
Fax: 301.443.0256
Web: www.mentalhealth.org

Provides support services including mental health services, substance abuse treatment, and transportation.
Contact state administering agency.

APPENDIX C

**INSTRUCTIONS AND RATIONALE FOR USE
OF TRANSPORTATION RESOURCE TOOLS**

APPENDIX C

Instructions and Rationale for Use of Transportation Resources Tools

Nurses and practitioners who work in primary care settings often encounter the client who has difficulty keeping appointments or following through with referrals or diagnostic tests because he or she lacks personal transportation and has no access to public transportation. These persons are designated “transportation dependent” by the government. At the federal level, there has been a great deal of legislation to make funding available to assist these people with transportation. It has been most successful in the large metropolitan areas where the larger populations support transit solutions on a large scale allowing service providers to apply for grants for capital expenses, salaries and operating expenses. In areas with smaller population bases and little or no public transportation, it is necessary to seek out providers and funding through various agencies.

It is rare for federal money to be allocated directly to individuals without being first channeled through state and county agencies. In very rural areas the “local agency” may be 75 miles away from the person who needs the service. It is also very common for people who need services to have no idea that the services exist or how to gain access to the system that offers help.

The purpose of this project is to test a tool designed to determine a clients eligibility for a service based on the criteria used by the federal government to award funding to state and local agencies. It is a flowchart listing client criteria in the left column and possible resources for assistance or funding on the right. The companion piece is a list of federal agencies. This is designed as a worksheet to be tailored to an individual primary care setting. By using a local phone directory, the website listed for the federal agency, or the telephone number or address, one can

locate the nearest agency which might be funded to assist a particular client. There are few programs in place that are truly user-friendly from the client's standpoint and it will often be necessary for the nurse to go the extra steps to get a person started on gaining entrance to the system. Making the phone call, establishing contact, learning what is required to qualify for assistance, helping the client navigate the first few hurdles are all familiar forms of advocacy for nurses. It is hoped that care providers and staff personnel will not only attempt to contact these agencies on their client's behalf, but will communicate the specific needs of the transportation dependent populations in that area to the agencies on the state and national level. This can be done by sending an e-mail to those with e-mail addresses and letting them know that there are people in areas without public transportation that need help getting to their medical care provider. This is the type of advocacy that can bring about change in the way in which programs are operated. Transportation funding is currently not reaching those among the 12.1 million rural elderly or the 12.4 million rural poor who have no way to get to their primary care provider.

APPENDIX D

EVALUATION FORM FOR RESOURCE TOOL

APPENDIX D

Evaluation of Resource Tool

Number of times this resource was consulted for possible assistance/funding sources for non-emergency transportation to medical care.

Week 1

Week 2

Week 3

Was contact successful in securing transportation help for your client?

yes

no

Week 1

Week 2

Week 3

Were instructions for using this tool clear to you?

Suggestions for improving this resource.