Care Mobility Rewards Program Evaluation Report

February 2021

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Acknowledgments

The planning, implementation, and delivery of the Care Mobility Rewards Program could not have been completed without its partners' guidance and support. We extend the greatest thank you and share the success of this pilot alongside these individuals.

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Thank you to all the individuals and partnerships that made this work possible!

Executive Summary

The Care Mobility Rewards Program (CMRP) sought to connect members of the South King County community to vital medical and wellness care by providing non-emergency medical transportation using an incentive-based model. This program's planning began in 2015 with developing a business plan and was actualized in September 2019 through funding from the National Center for Mobility Management (NCMM). A pilot ran from February 2020 to October 2020 and served 23 enrolled patients completing 376 trips.

The CMRP pilot represented an innovative partnership between the Hopelink Mobility Management team, Hopelink's Non-Emergency Medical Transportation (NEMT) Brokerage Team, and Valley Medical Hospital. The CMRP pilot provided transportation assistance for follow-up medical care and wellness appointments outlined at discharge. The pilot targeted Medicare and dual Medicare/Medicaid-eligible patients to reduce preventable and costly emergency readmissions. This report includes an analysis of program structure and usage, findings related to programmatic goals, and recommendations for future engagements of this type. Recommendations are informed by a compilation of stakeholder and client (hospital partners and enrolled patients) interviews, a review of relevant literature, and budgetary feasibility analysis.

Summary Findings:

- Partnership with the Non-Emergency Medical Transportation (NEMT) Department **allowed for a quick and efficient enrollment process and reliable transportation access**. NEMT providers' diversity created some confusion for customers and NEMT staff alike, leading to **care providers becoming the primary schedulers on behalf of enrolled patients**.
- **Patients enrolled in the CMRP experienced fewer emergency readmissions** than Valley Medical patients with similar admission risks and age, especially in the crucial 30-day post-discharge timeframe. CMRP saw a readmission rate of 20% within 30-days of a discharge compared to the 2019 Valley Medical rate of 30.65%. With the average cost of readmission at approximately $14,400, such a reduction poses significant **cost savings for hospital partners**.
- The CMRP was an attractive option for healthcare partners because **it met a need for their patients**. Partners at Valley Medical noted the program's efficient ability to fulfill a gap, particularly during the waiting period for patient enrollment into other long-term services. The CMRP did not sufficiently test the incentive-based rewards model due to the impacts of COVID-19; however, **consistent usage from enrolled patients** demonstrates a need for this or a similar service.

Program Recommendations:

- A future longstanding program should **continue to partner with NEMT**. NEMT's brokerage model is efficient, low cost, and adaptable to individual patients' mobility needs.

- A long-term program should include **increased training** and information sharing. Hospital partners, NEMT staff, and enrolled patients need to be well-informed on the program and service expectations. Increased training for NEMT will support the **scalability of this service**. Information clarity and more training will help hospital partners **identify eligible patients** and **prepare patients for program use**. Specifically, discussing the scheduling and day-of procedures with the patients will hopefully result in higher comfort and clarity of program benefits.
- To address patient use, comfort, and knowledge of this program, we recommend that **each patient is contacted after their first use of the service**. This call will be an opportunity for a patient to ask questions and be reminded of the program benefits outside of the stressful or information-dense discharge process.
- We recommend each hospital partner assess where the program fits best into their care structure to best serve the patients who most need the program. It may be the case that this program needs to be offered in several departments. We believe that a healthy place to start is **within the social work department or a similar support services location**. The ideal location is where the patient can enroll and receive the support service before an otherwise preventable medical emergency.
- To support the implementation of these recommendations, we suggest the contracting of **an on-site transportation coordinator**. This person is a consistent presence at the hospital and can support healthcare staff in scheduling trips and connecting with providers. The position would be able to **support this program and other mobility services**. We believe on-site coordinators are essential in the ongoing process of connecting healthcare and mobility sectors, resulting in stronger partnerships between organizations and positive community impacts.

Introduction

The Care Mobility Rewards Program (CMRP) pilot received funding in September of 2019. After completing planning, stakeholder engagement, and staff training, the program pilot ran from February to October 2020. This brief section will provide context for the program's structure and founding justifications established in the 2015 business plan and refined in 2019 meetings with partners and planning teams. Namely, this section will provide context for the need for a program that supports the transportation needs of recently discharged hospital patients, the process of establishing the CMRP, and its founding structure, assumptions, and goals.

Problem Statement and Connection to Care

CMRP was designed to reduce the rate of emergency re-hospitalization for recently discharged medical patients in South King County. Research conducted by Hopelink staff for the 2016 Business Plan[1] notes that residents of South King County, a mix of suburban and rural areas, experience a relative lack of transportation services compared to other, more dense parts of King County. This underserved area poses challenges for older adults who are unable to drive. According to a 2014 report published by King County, neighborhoods most impacted by inequities, predominantly located in South King County, experience higher poverty rates and shorter life expectancies. The same study found residents of these neighborhoods face higher rates of preventable hospitalizations and illnesses at about 2.5 times the rate of the least impacted communities in other parts of the county[2].

As of 2018, 15% of Medicare patients discharged from South King County hospitals were readmitted within 30-days[3]. Many of these readmissions were caused by missing post-discharge health check-ups, leading to relapses of severe medical conditions. Transportation is consistently in the top five barriers to healthcare delivery identified by local providers.[4]

Transportation is an essential and necessary step for ongoing health care and medication access, particularly for individuals with chronic diseases. Chronic disease care requires clinician visits, medication access, and changes to treatment plans to provide evidence-based care. Without access to reliable and consistent transportation, delays in clinical interventions result. Such delays in care may lead to a lack of appropriate medical treatment, chronic disease exacerbations, and unmet health care needs, which can accumulate and worsen health outcomes.

Financial Concerns for Care Providers

Frequent readmissions of transportation vulnerable patients are not only associated with adverse health outcomes, but the readmission of Medicare patients within a 30-day window also poses a significant financial burden to the hospitals providing care.

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[1] Operation Easy Access Business Plan, Hopelink, (2016).
[2] Operation Easy Access Business Plan, Hopelink (2016).
[3] Readmission Reduction Program, (2018).
[4] King County Community Health Needs Assessment, King County Hospitals for a Healthier Community Collaborative (2018/2019).

According to the Centers for Medicare and Medicaid Services (CMS), the Hospital Readmissions Reduction Program (HRRP) is designed to incentivize stronger connections between care team and patient by strengthening discharge plans and communication to reduce unnecessary readmissions. The HRRP reduces payments made to hospitals that have excess readmission rates over a rolling three-year measuring period. "Acceptable rates" are calculated by CMS and incorporate regional demographics and patients served. The payment reduction is applied to all services billed to Medicare fee-for-service base operating diagnosis-related group payments during the fiscal year. Although capped at 3%, these payment reductions are costly to the hospitals in question. According to the Becker Hospital Review, the average cost in 2016 for readmission of any diagnosis was $14,400.

In this pilot program, our primary partnering hospital was Valley Medical Center in Renton, Washington, a city in South King County. In the measuring period of 2015 to 2018, like many hospitals in the region, Valley Medical exceeded the predicted readmission rate for each category for which the HRRP reduces payments. Although the excesses were slight, the 411 readmissions decreased revenues to Valley Medical from CMS.

By providing transportation for medical and wellness care appointments, CMRP should reduce emergency readmissions and reduce partnering hospitals' costs. The following report sections will detail the financial impact of this intervention.

Program Goals

The goals of our program are as follows:

1. Provide for the non-emergency medical and wellness related transportation needs of recently discharged hospital patients with a high risk of readmission.
2. Reduce emergency readmissions for the enrolled patients by providing support for enrollees to attend follow-up care appointments.
3. Reduce Medicare-related readmission financial penalties for the partnering hospital.

Care Mobility Rewards Program

Original Pilot Design

The CMRP pilot was an innovative and collaborative healthcare transportation program to help Medicare patients continue their medical care following discharge from Valley Medical Center, a hospital in South King County, Washington. It was designed to provide transportation assistance for follow-up medical and wellness care appointments that a patient and hospital care team collaboratively determine are essential to improved health outcomes during the discharge process. Transportation to follow-up medical appointments was covered by the program, while wellness appointments were listed on an enrollee's Action Plan, described in detail later in this report. Patients had an opportunity to earn additional free rides by completing the Action Items.

Eligibility Requirements

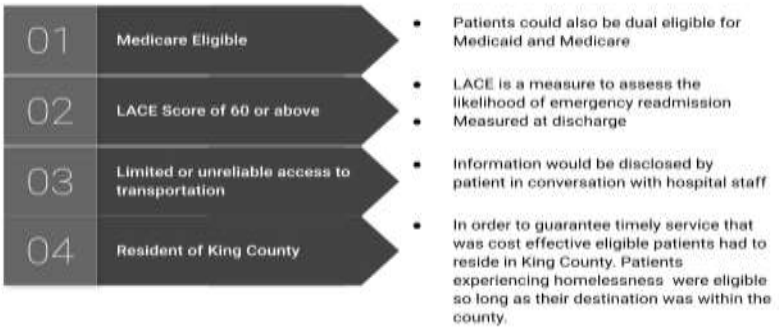
To be enrolled in the CMRP program, patients needed:

- Medicare eligibility, including patients who were duel eligible for Medicare and Medicaid enrollment;
- To be a resident of King County;
- To have been deemed high-risk for readmission. For Valley Medical, this meant receiving a LACE index score of 60 or above; and
- To disclose they have unreliable access to transportation for their medical care.

LACE is an assessment tool assigned at the time of discharge to measure the likelihood of emergency readmission within 30 days by evaluating (L) length of stay, (A) acuity of admission, (C) co-morbidities or existing diagnoses or chronic diseases, and (E) number of emergency admissions in the last six months. Measures influencing a LACE score include the length of stay, the severity of diagnoses, and the number of emergency admissions in a recent timeframe.

Discharge planners and hospital staff at Valley Medical were in charge of identifying and enrolling patients during discharge if they met the above criteria.

Figure 1 Program Eligibility Requirements



When a patient was identified by a Valley Medical Discharge Planner to be enrolled in the program, the patient and care attendant would work together to fill out an Action Plan. The Action Plan was a place on the enrollment form where the patient and their care planner could collaboratively determine locations the patient could travel to support their wellness. At the time of program design, eligible sites were thought to include the grocery store, pharmacy, chiropractor, or other locations determined by the patient and

planner together. All follow-up medical appointments were provided to patients for free upon enrollment in this program.

The rewards model of this pilot applied to a patient's Action Plan, where wellness trips were detailed, as mentioned above. Upon enrollment, patients received three roundtrip ride "credits." If the patient used these credits by taking three trips included on their Action Plan within 30 days of enrollment, they received additional credits to take more trips on their Action Plan. If they took trips to all destinations on their Action Plan, patients would receive a credit at the end of the pilot for a ride to any destination of their choosing. Patients were intended to be enrolled for a total of 90 days. CMRP's initial pilot with Valley Medical was designed to last from February 2020 through May 2020 but was later extended until October 2020 due to COVID-19 impact flexibilities in funding.

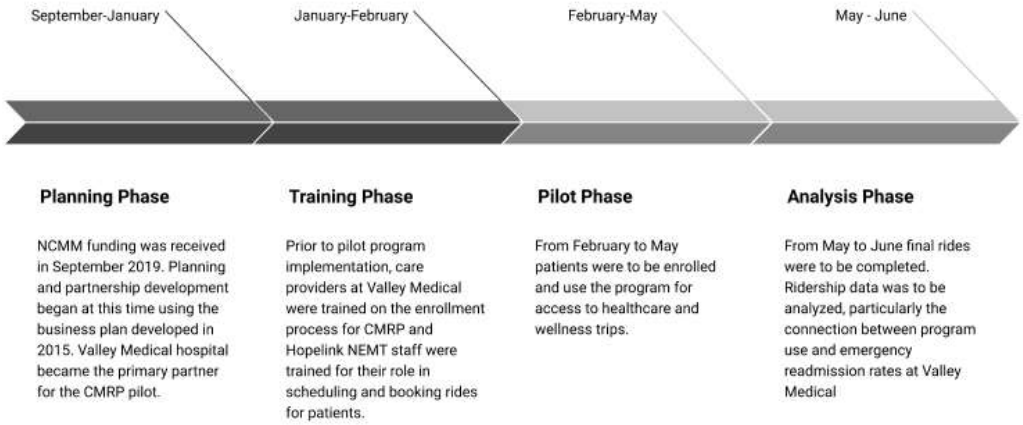


Figure 2 Original Project Timeline

Provision of Transportation

For the CMRP pilot, the CMRP team partnered with Hopelink's Non-Emergency Medical Transportation (NEMT) Brokerage to process, schedule, and provide rides. The Hopelink NEMT Brokerage hosts a call center and contracts with transportation providers to give rides to Medicaid patients in King and Snohomish counties, along with multiple other transportation programs. The Brokerage served 43,000 clients for 1.5 million trips in 2019.

There are many benefits to partnering with a brokerage system such as the Hopelink NEMT department. To start, the scale at which the Hopelink NEMT operates means the program has all the software, staff, and logistics in place to adopt this program. As the manager of multiple contracts to provide transportation, the NEMT Brokerage is equipped with the structural capacity to efficiently and quickly support this program with additional costs to establish staff support. This institutional capacity is a critical benefit of working with the Brokerage. When it comes to transportation providers, the Brokerage contracts with 20 providers to fulfill trips. This means that once a ride is requested, the Brokerage can draw from this large pool of providers to adequately accommodate differing mobility needs and reliably provide a cost-effective ride. Throughout the pilot, we received feedback from Valley Medical enrollment staff that a tricky

part about the existing transportation options pre-CMRP is that they were limited in providing consistent rides. With the Brokerage's extensive network, a provider is always available to fulfill a trip need. The Brokerage model also prioritizes cost savings for a program that are difficult to find elsewhere.

The partnership between Hopelink NEMT and this program is discussed in greater detail in this report's findings section.

COVID-19 Impact and Program Adjustments

The Coronavirus Pandemic of 2020 impacted the implementation of this program. In March of 2020, Valley Medical hospital closed to the public in response to the Pandemic and the emergency shut down of King County and the Puget Sound region. With the onset of the Pandemic coinciding with the pilot's original timeline, several adjustments were made to CMRP to support vulnerable patients' transportation needs served by Valley Medical.

In June 2020, the Hopelink Mobility Management team received an extension for the CMRP pilot. The extension adjusted the project timeline through the end of November 2020. With this additional time, the Mobility team could extend the enrollment period for CMRP and moved the last day for trips to be completed to October 15, 2020.

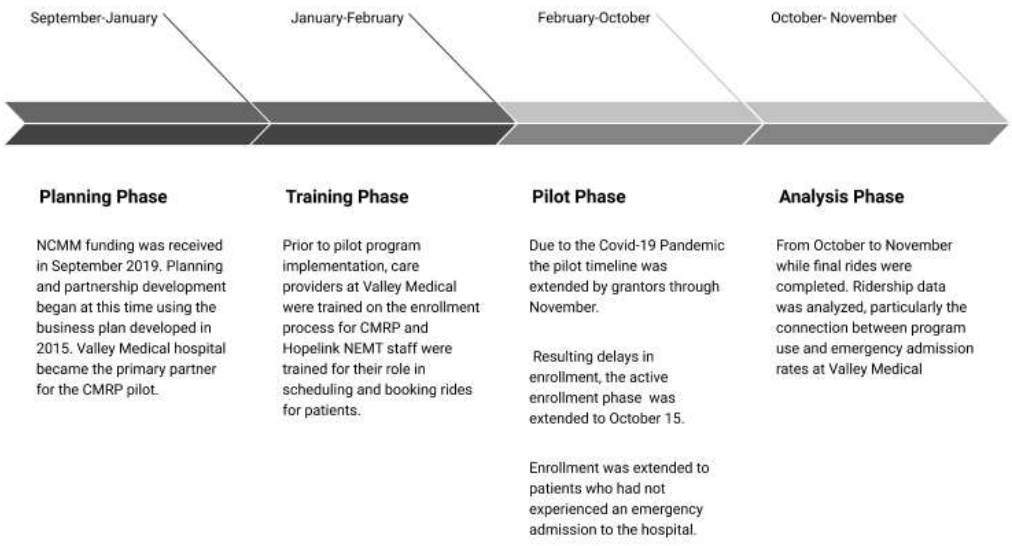
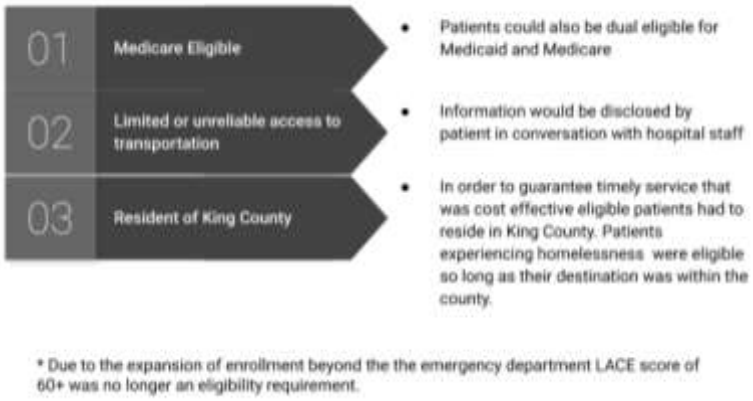


Figure 3: Project Timeline Adjusted for COVID-19 Impacts

The COVID-19 pandemic impact extended into the enrollment process and scope of the CMRP pilot. The original design defined eligibility to patients identified at discharge from the emergency department and given a 60 or higher LACE score. The Pandemic changed how many community members accessed care. With this adjustment to the healthcare landscape came an adjustment to patient eligibility for CMRP. Since COVID-19, patients eligible for this program no longer needed to have experienced an emergency admission to Valley Medical Hospital.

Figure 4 Eligibility Requirements Adjusted for COVID-19 Impacts



Expansion beyond the emergency department allowed CMRP transportation services to become available to other departments within Valley Medical, and therefore more patients. Social Workers, particularly those working with the Oncology Department, played an essential role in expanding access to patients in need of transportation. Below is a chart depicting CMRP pilot enrollments and the care providers' departments that connected patients to the resource.

Hospital Department	**Number of Patients Enrolled**
Case Management	8
Cancer Support Services	11
Senior Care & Internal Medicine	1
Discharge Planner	3

Finally, the Coronavirus pandemic impacted this pilot project's operation in that it limited our enrolled patients' ability to access wellness care outlined in their Action Plans. Indeed, the Action Plan played a much smaller role in this pilot's operation than the original design outlined. Community members throughout our region were encouraged to limit their interactions and travel due to COVID-19. Unfortunately, these limits included a reduced emphasis on wellness care. Without the incentive structure that the wellness trips would have provided, the rewards model of CMRP remains untested.

Evaluation Findings

Despite the challenges of implementing a medical transportation program during a pandemic, we were able to test many of our priority assumptions through our pilot.

The following sections detail data received by the Hopelink Mobility Management team from our partners at the Hopelink Non-Emergency Medical Transportation Brokerage department, Valley Medical staff, program planning team, and enrolled patients. The findings are organized into three sections:

1. Operational Feasibility
2. Financial Viability
3. Client Desirability

These three metrics will then be used to discuss recommendations for the pilot's transition from a limited to a sustainable program.

Findings Related to Program Goals

Feedback from partners at Valley Medical is overwhelmingly positive and notes their support for this program and the service it provided.

1. Provide for the non-emergency medical and wellness related transportation needs of recently discharged Valley Medical patients with a high risk of readmission.

The high-level impact of this program points to the necessity for a service like Care Mobility Rewards. At the end of the pilot period, CMRP enrolled 23 patients, 19 of whom completed trips, an active participation rate of 82%. Those 19 participants completed 364 trips to and from medical follow-up care appointments. The average trip occurred nine days after initial enrollment and traveled roughly 15 miles. Details found in the Operational Feasibility section of this report will highlight enrollment trends and program usage rates. Broadly, the pilot has been able to meet its first goal.

Unfortunately, the pilot program could not test our assumptions related to wellness trips due to COVID-19 impacts to travel.

2. Reduce emergency readmissions for the enrolled patients by providing support for enrollees to attend follow-up care appointments.

The data show a positive impact that our program had on readmission reduction within the crucial period of 30 days post-discharge.

For this assessment, we used the number of enrolled patients who had experienced a discharge in the 90 days before program enrollment as our assessment sample. Of our 23 enrolled patients, 19 made use of the transportation service. Of those 19, we received the base number of 10 discharges from Valley Medical. The following table compared the readmission rate for this group of patients who were actively enrolled and experienced a discharge to the emergency readmissions at Valley Medical from 2019 of a population of similar readmission risk and age.

	VM 2019	CMRP**
IP Discharges with Risk Score 60+	62	10
30-Day Readmission Count	19	2
30 Days Readmission %	30.65%	20.00%

**This number is a count of discharges experienced by patients who completed at least one trip with the program

At the time of receiving this data, full 2020 data was not available from Valley Medical – additionally, the overall 2020 data reflects impact of the CMRP program. The crucial 30-day window demonstrates some positive impact of this transportation program. The 30-day window is tied to the financial penalties and presents a strong indication of this service's financial viability. Overall, readmission data is not standardized, and this assessment is to the best of our ability when publishing this evaluation report.

An important note regarding this data not shown through the measures above is that two separate patients experienced six total readmissions. Other sections of this report will discuss program usage, patient experience, and dive into the details of how CMRP impacted health outcomes.

3. Reduce Medicare-related readmission financial penalties for Valley Medical Hospital.

With the reduction in the frequency of unnecessary readmissions to Valley Medical, we can reasonably assume that the penalties and reductions in payments from the Hospital Readmissions Reduction Program would decrease. Preliminary data demonstrate a trend downward for costly readmissions in high-risk patients.

Potential Cost Savings – 30 Day Program

12-Month Program - 30 Days		Impact Level			
Discharged Patients Enrolled in Rewards Program *Target: Estimated 30% of 30-day readmits as high and rising risk*	48	1%	2%	3%	5%
Estimated # of 30-day readmissions	157				
Potential Readmissions Prevented*		2	3	5	8
Avg. Cost Per Readmission	$14,400.00				
Potential Savings		**$ 22,551.39**	**$45,102.77**	**$67,654.16**	**$ 112,756.93**

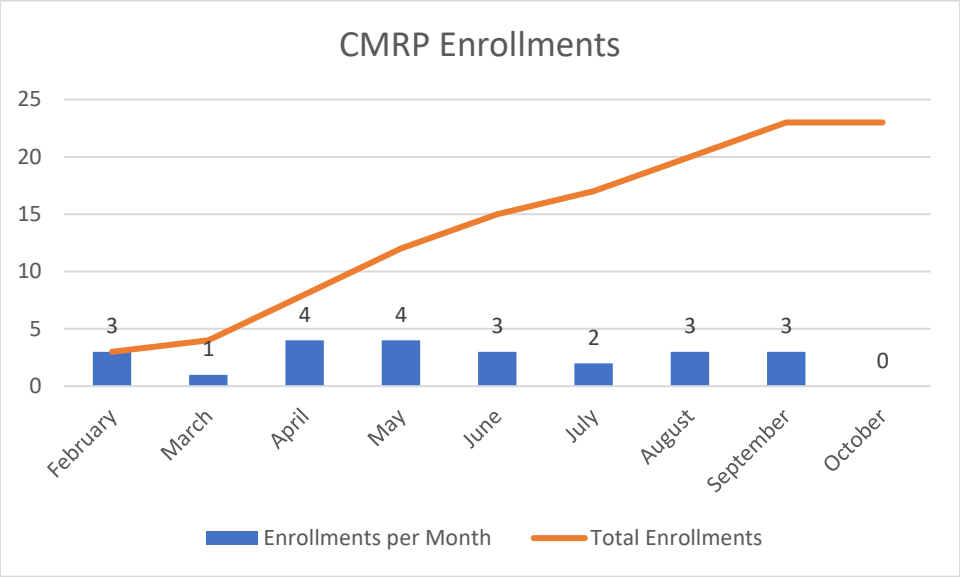
We anticipate preventing between 1-5% potential Medicare readmissions through the CMRP intervention. With an average cost per readmission of $14,400, this equates to between a $22,500 to $112,750 cost savings annually.

Operational Feasibility

The CMRP enrolled 23 patients to our transportation services, 19 of whom completed trips using the service. Our program was made possible through a partnership with staff from Valley

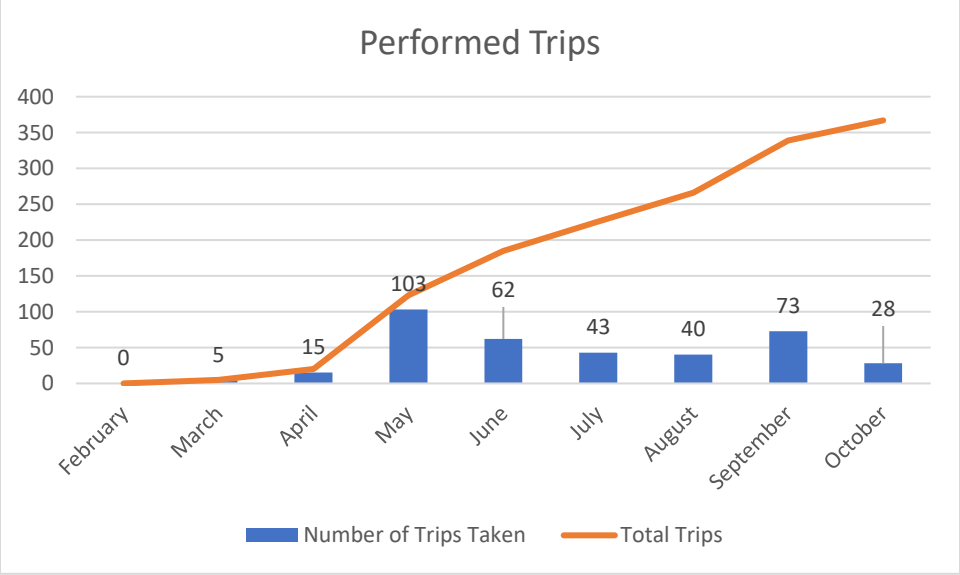
Medical Center. By the end of the program, six staff members from four hospital departments had completed patient enrollments. This section will detail operational data related to trips scheduled and performed and feedback from partners regarding program improvements.

Enrollment in the CMRP began in February 2020 and remained open throughout the extended pilot. Enrollment remained relatively steady throughout the pilot.



The decrease seen in March can reasonably be attributed to the partial closure of Valley Medical to elective procedures, which occurred in response to the Coronavirus pandemic.

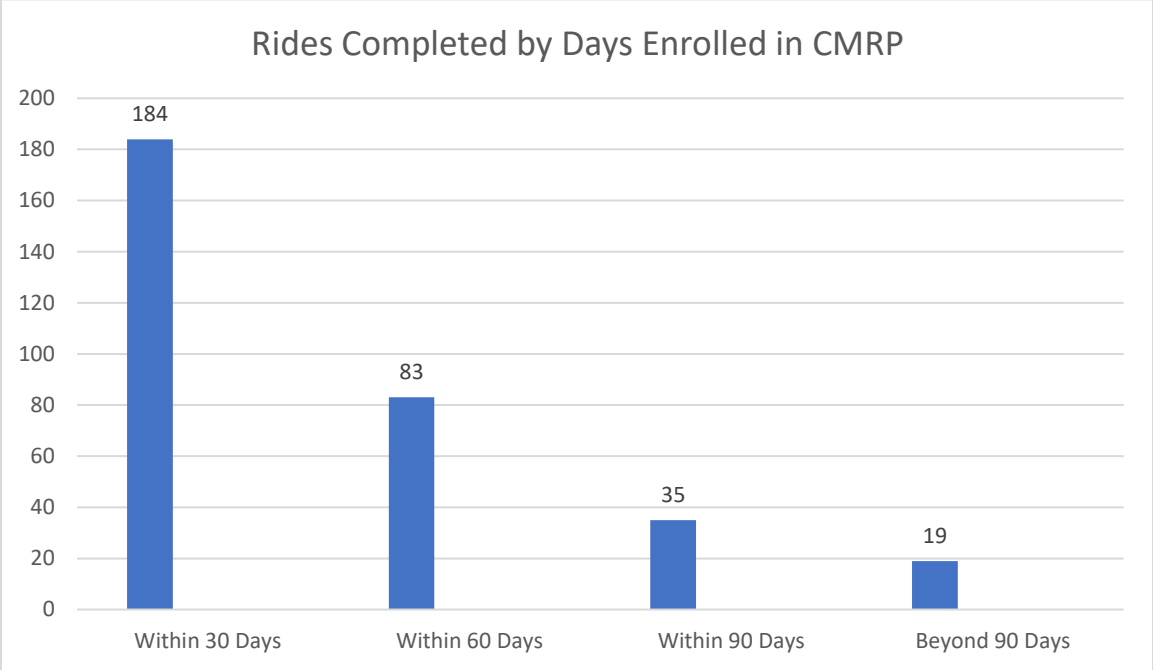
The 19 CMRP active enrollees completed 364 trips by the end of the program on October 15, 2020.



The chart depicts these trips over time. The highest usage month for this program occurred in May, with a total of 103 trips. This spike can be attributed to the reopening of Valley Medical in

April and the rescheduling of delayed or missed appointments. Completed trips averaged 14.7 miles and primarily were for the patients traveling alone.

The chart below depicts rides scheduled within 30, 60, 90, and beyond 90 days of enrollment. This breakdown demonstrates patients most often used CMRP within the first 30 days of enrollment. The 30-day period is the same timeframe in which emergency readmission is most costly for hospitals.



NEMT Program Desirability

The Hopelink Mobility Management team connected with our partners in the Non-Emergency Medical Transportation (NEMT) department in a series of conversations that discussed their experience in the pilot. The questions used to guide these conversations are available in Appendix B.

Regarding training and programmatic understanding, the NEMT staff mentioned overall comfort with implementing this service. The training was robust and prepared Customer Service Representatives well for engaging with patients.

One point of clarification arose when discussing program changes. Our NEMT partners mentioned a desire for a transparent information chain and identifying an internal point person who could communicate programmatic adjustments.

Limitations and Opportunities of a Brokerage Model

There were also limitations to partnering with a brokerage model. Since the program functioned as a liaison between end-user and contracted transportation providers, the Brokerage itself lacks the flexibility or control to administer changes on a provider-level beyond what is included

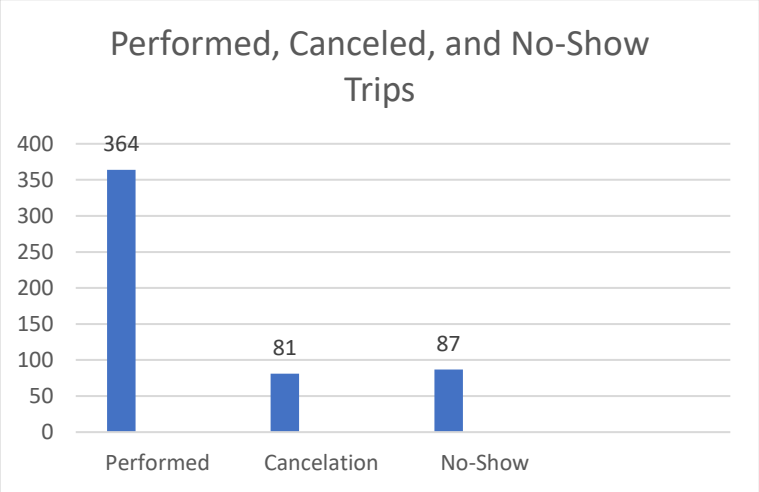
in standards outlined through their original contract agreements. Some providers go above and beyond what is asked of them within a contract, which creates a discrepancy between other providers that operate purely at the contract level. To apply this to the Care Mobility Rewards Program context, hospital care staff reported that providers' lack of standardization could be confusing to patients. For example, a patient may receive a trip through one provider and then be served by a different provider for a second trip. This could cause them to miss their trip entirely if they were not anticipating this and did not receive the same support, like a reminder call, that they may or may not have received for a previous trip.

Similarly, there was a lack of standardization in how different providers could reach out to patients to ensure they access services. While some providers would call patients to let them know they are looking for them, others would not. NEMT does send automated reminder calls the day before booked trips, which will transfer into reminder texts in 2021; however, there is no consistent practice for reaching a patient on the day of a trip. In both examples, the patient expects the same level of service they receive initially, but this is not always the case due to the brokerage model.

Staff from our hospital partnership also shared feedback they received from patients about discomfort calling to book trips for themselves due to lack of support from some call center staff. Since the Hopelink NEMT Brokerage Call Center Agents are most familiar with fielding Medicaid calls, they would often ask questions that confused CMRP enrollees and made them feel like they didn't have the accurate information necessary to book their trips. This led to enrollees asking Valley Medical staff to call on their behalf.

CMRP experienced a relatively high rate of same-day cancelations and no shows, nearly 11% for each of these types of cancelation or 23% of total scheduled trips. Our partners in Hopelink NEMT in their standard Medicaid contracts experience a rate of around 11% for both no-shows *and* cancelations combined. In discussion with our Valley Medical and planning team partners, it was suggested that due to the health concerns and specific challenges experienced by the target population, the Care Mobility Rewards Program might see a high cancelations rate. Patients in our target group often have unforeseen health developments or challenges which rapidly change their needs. They may change their care schedule due to a development in their diagnosis. These factors may lead them to change their transportation needs without necessarily alerting Hopelink NEMT or the transportation provider. In the pilot's ridership data, it appears no shows and cancellations took place in clusters, which may indicate a point in time when the patient was not feeling up to travel. We also speculate the rise in telehealth medicine

during COVID-19 could have led to higher cancellations of in-person visits and, therefore, transportation cancellations.



Working with the Hopelink NEMT Brokerage offers reliability that is hard to match in partnering with a smaller number of providers. The infrastructure to support scheduling, call staff, and booking is also already in-place. Advantages of working with one or a smaller group of providers include more flexibility in implementing feedback, like personalized reminder calls or vehicle standardization; however, this scenario would also mean it is more likely for trips to go unfulfilled. This model is even more aligned with what hospitals currently do in piecemealing different transportation providers together to serve a patient. This leads to uncertainty about availability and a lack of consistency, exposing the need for a more reliable program. Other programs offer a similar brokerage model, such as a partnership with Lyft for non-emergency medical transportation. But while this partnership covers the reliability of receiving a ride, it does not account for the unique training or mobility needs needed to accommodate a high-risk population.

In an ideal partnership, the provider would offer dependable and reliable trips, a degree of standardization in their services, supportive customer service, and optimize cost savings. Like any partnership, both the practical and lacking qualities must be taken into consideration amongst other options.

Financial Viability

For this pilot, we spent the following on direct costs for operating the program:

Expense Item	**Total**
Administration	$3,406.92
Transportation	$25,373.03
Total	**$28,779.95**

Nineteen patients actively used the program for an average cost of $1,514.73 per patient. This cost is higher than our future calculated ROI for the program given the COVID-19 pivots by allowing transportation beyond the 90-day window. Nevertheless, we can presume that by spending less than $1,500/enrollee, we reduced the readmission rate for high-risk patients by nearly 6%.

Valley Medical ROI (12 Month)						
Care Mobility Rewards Program	Original Model			On-Site Transportation Coordinator		
Impact Level on Estimated # of Readmissions	2%	3%	5%	2%	3%	5%
Discharged Patients Enrolled in Rewards Program	48	48	48	48	48	48
# of Patients Impacted - NOT Readmitted	3	5	8	3	5	8
Savings						
Cost Savings from Potential Readmissions Prevented ($14,400/patient)	$45,102.77	$67,654.16	$ 112,756.93	$ 45,102.77	$ 67,654.16	$112,756.93
Care Mobility Rewards Provider Training						
Patient Navigator & Care Team Group Training + Ongoing Support (Hopelink)	Included			Included		
Materials						
Transportation Brochures	$300	$300	$300	$300	$300	$300
Dedicated Staffing						
Hopelink Desk Personnel	N/A			$73,265	$73,265	$73,265
Trip Costs						
Hospital Provider Transportation Costs for Post Discharge Trips	$33,022.08	$33,022.08	$33,022.08	$33,022.08	$33,022.08	$33,022.08
Potential Savings	$11,780.69	$34,332.08	$ 79,434.85	$(61,484.31)	$(38,932.92)	$ 6,169.85

Includes design & implementation, service & support, fechical support, account management, and reporting. Trip cost estimates includes avg. 5 free round-trip rides/patient, 28 miles/roundtrip, and blended average cost of $61/one-way ride + $6.38/scheduled ride Care Mobility Center administration fee.

In our ROI calculations, we incorporated the potential costs associated with operating CMRP on an annual basis per hospital. While trip costs per patient will vary depending on the severity of need and distance from destinations, we estimate each enrolled patient to use an average of ten one-way trips, at about $61/one-way. The trip cost is comparable to paratransit services and appears higher-than-average given the longer distances traveled by our enrolled patients.

The ROI calculation includes the cost savings from the original model plus anticipated costs if hospitals adopted an on-site transportation coordinator per site. While this ROI demonstrates a net loss, this calculation does not incorporate the added benefit of timed saved by hospital staff in booking transportation for both Medicaid and non-Medicaid patients.

For the next steps, Hopelink NEMT plans to meet with Valley Medical and subsequent hospitals in South King County to establish a sustainable program to support transportation post-discharge for Medicare-eligible patients. As the program scales, we will dedicate more resources to this program's administration, including training, oversight, and evaluation. We anticipate hospitals supporting the partnership with internal funds or healthcare foundation grants in the local community.

Customer Desirability

The CMRP pilot had two groups that fell under the customer classification: healthcare providers enrolling patients at Valley Medical and the end-users who completed rides in the pilot. Findings regarding the desirability for this program differ across these two groups. Primarily, our partners at Valley Medical provided vital positive feedback for the service provided during this pilot and the relative ease of implementing it. It was challenging to connect with our second customer

base, the end-user. However, usage rates and secondary feedback from care providers on behalf of their patients provide insight into their experience.

Hospital Partner Program Desirability

The Hopelink Mobility Management team connected with our partners at Valley Medical at several points throughout the pilot. The care providers gave feedback via email and phone conversations with our group related to patient experience and program use as they enrolled eligible patients. At the end of the pilot period, care providers were invited to complete a survey that asked questions regarding program structure and efficacy. The results from that survey, the earlier, more informal conversations, and listening sessions are gathered here.

Overwhelming, the feedback received from care providers regarding the service provided by CMRP was positive. At several check-in conversations and in the post-pilot survey, care providers expressed this service existed to "fill the gap" in transportation programs for which their patients are often ineligible or going through the application process. For the care providers from the Cancer Care and Oncology Departments, our team learned this service filled a need left with the temporary but indefinite closure of one prominent cancer-care transportation service. American Cancer Society's Road to Recovery Program ceased operation with the onset of COVID-19 and, as of November 2020, has not come back online. Care teams also shared how the program offered reliability that piecemealing other, less-scalable programs could not.

Care providers noted the quick application and enrollment process as a strength of this program as they were able to answer their patient's need for transportation the same day that it was identified.

As detailed in the Operational findings section, end-users found the NEMT Brokerage experience somewhat confusing. This led many of our care provider partners to be the primary schedulers on behalf of their patients. Care providers noted the experience could be misleading. Many NEMT customer service providers' initial question is for a Provider One identification while CMRP used the Medical Record number as a primary identifier. After this initial confusion, care providers and NEMT staff could schedule and cancel rides for the patients successfully.

In the post-pilot survey, care providers noted that the enrollment process could be improved by allowing for online enrollment or another form that did not depend on a fax machine. Other program improvements included clarifying the Action Plan's role and the patient's ability to access wellness care. Suggestions include allowing patients or care providers to adjust the plan and add locations after initial enrollment, adding language to clarify the benefit of wellness trips, and how credits for trips may be earned. Many care providers mentioned their belief that the Coronavirus pandemic, more than anything, interfered with their patients' ability to use this element of CMRP.

Appendix B includes the full results from the end of the pilot survey. Key responses and themes are summarized in the following charts.

Figure 5: How effective do you think our criteria for eligibility reflected patients who need our program most? Our criteria were patients enrolled in Medicare, King County residents, have LACE score of 60+, and need reliable transportation.

Figure 6: How would you rate the overall effectiveness of this program?

Figure 7: For the patients you interact with on a daily basis, how important do you believe transportation is for reducing the likelihood of readmission?

Customer Program Desirability

Connecting with the end-users of this program proved quite tricky. The Hopelink Mobility Management team planned to survey end-users to gain clarity on customer experience related to the trips themselves, cancelations, scheduling, and the potential for this program to support positive health outcomes; however, the effort to reach patients was mostly unsuccessful. The survey questions are included in Appendix B.

The Hopelink Mobility Management team was able to reach two total clients of the nineteen who took rides. Due to the difficulty in connecting with CMRP patients, many of the findings related to their use of the program are based on data provided from Hopelink NEMT regarding calls,

scheduled, and canceled rides. The other data source for customer experience comes from anecdotes and information shared by care providers on their patients' behalf. These limits to these findings offer an opportunity for future programs to build more robust systems of contact and reconnection with eligible patients to guarantee their input and feedback.

The end of program survey was successfully administered to two enrolled patients, one of whom had experienced several emergency readmissions. In conversation with a client, Hopelink Mobility Management learned that the program was useful for that patient who frequently *chose* to access emergency care, which contributed to "readmission," as the progression of their diagnosis was difficult to predict and resulted in frequent unplanned trips to the hospital. Without CMRP, the patient reported that they would often pay out of pocket for private transportation services, which were incredibly costly. The patient said they could interface well with NEMT's call center, although there was initial confusion regarding the information the call center employee needed from the patient. Although the CMRP did not result in fewer emergency admissions for this patient, the program could support their access to necessary care.

The second patient surveyed mentioned that access to CMRP allowed them to have more freedom and comfort regarding accessing their medical care. They reported CMRP was a useful service for them as a curb to curb service. This patient relied on their healthcare team to schedule their transportation as they were uncomfortable with the call center. They also reported sometimes electing to cancel trips when they were feeling healthy enough to drive themself.

Beyond these two conversations, we have limited data directly from patients. However, the scheduling software used by NEMT allows our team to understand the typical use of CMRP. Of the 364 completed trips, the typical patient completed 19. An average of roughly 10 of those trips was completed in the first 30 days of enrollment.

Through this data and the supplemental qualitative information, we heard from care teams and with limited client interactions, we can infer that the program's great use implied strong customer desirability. Room for improvement in customer interaction with the pilot is listed in the recommendations section of this report.

Recommendations

This section details recommendations for a future and scaled program and lessons learned for a broader conversation around the programmatic purpose.

Program Recommendations

1. This program, or a future iteration of this service, should remain a partnership with Hopelink NEMT.

A future longstanding program should continue to partner with NEMT. NEMT's brokerage model is efficient, cost-effective, and adaptable to the mobility needs of individual patients. It would be difficult to achieve this efficiently and reliability with other models; therefore, leveraging NEMT partnerships and infrastructure works well for a scalable model. Further training to smooth over client-and-call-center incongruities is needed, as addressed in the recommendation below.

2. The program should implement a greater emphasis and investment in training and information clarity.

A long-term program should include increased training and information sharing. Hospital partners, NEMT staff, and enrolled patients all need to be well-informed on the program. Increased training for NEMT so they are better prepared to uniquely serve clients of this program will support this service's scalability.

Care teams have requested a one-stop-shop training resource for their use. Inherent in our recommendation for more training is the centralization of training resources that can be referenced and looked upon after program launch. Information clarity and increased training will help hospital partners identify eligible patients and prepare patients for program use.

Increased training will also be essential at the enrollee-and-care-team interaction level. Care teams should communicate enrollment and service expectations to enrollees, so the end-user knows what kind of transportation they will receive from this program.

3. An On-Site Transportation Coordinator should be hired to aid this program.

To support the implementation of these recommendations, we suggest the contracting of an on-site transportation coordinator. This NEMT employee would have a desk at the main hospital and serve as a resource for all hospital departments handling transportation needs. The position would be able to support this program and other mobility services, like Medicaid services. The On-Site Transportation Coordinator will also serve as a point-person for both the NEMT and hospital staff who have questions about the program and transportation needs. We believe on-site coordinators are essential in the ongoing process of connecting healthcare and mobility sectors, resulting in stronger partnerships between organizations and positive community impacts.

4. Invest time planning and collaborating with hospitals beforehand to get their unique input and buy-in for where the program would best be located and leveraged.

Hospitals are best suited to understand their needs and unique clients; therefore, they will be most knowledgeable about where within their departments, the program makes the most sense to be located. Our findings uncovered that screenings for vulnerabilities like transportation vary significantly across hospitals. So, it will be necessary to understand the distinct variables of each hospital to best position the program. These conversations also allow the hospital to communicate if they are interested in expanding the program scope to serve clients beyond Medicare readmission.

5. Contact enrollees after discharge.

To address patient use, comfort, and knowledge of this program, we recommend that each patient is contacted after discharge. This call will be an opportunity for a patient to ask questions about their care and be reminded of the program benefits outside of the stressful or information-dense discharge process. We believe this will lead to a more effective and well-used program.

Programmatic feedback will be more likely achieved after receiving a call from their familiar hospital care team, and such an expectation of follow-up is set during training.

Broader Learnings

The Care Mobility Rewards Program was piloted to address an unmet need. Our efforts to confront this need have provided us insights into the larger context in which the gap of transportation for high-risk patients occurs. From this, we've outlined the following recommendations for transportation providers, mobility managers, hospital and care teams, and other agencies with a stake in reducing hospital readmissions through transportation support.

Transportation Providers

Standardization Helps Vulnerable Patients: Providers should consider implementing more standardized practices to serve vulnerable patients better. This may mean implementing more rigorous expectations during contracting. For example, reliable processes in which riders get notified of an upcoming ride or if a provider is waiting on them or will arrive soon. Not only will this reduce confusion and no-show trips, but it will help patients who need additional support in accessing the service. When it comes to broker models, agencies should value this standardization enough to represent a contract requirement. This may require supporting the transportation provider with infrastructure that will allow them to meet standardization requirements. We have learned this is a crucial factor in customer experience, and we advocate for its significance in program design.

Hospitals, Care Staff, and Healthcare Authorities

Care Should Continue Beyond the Hospital: Hospitals should consider supporting individuals and care teams' capacity to perform follow-up check-ins with patients' post-discharge. This will help prevent re-hospitalization, as patients can express concerns before being readmitted or meeting again in the hospital. It also allows care staff to interact with the patient outside of the hospital when they may have more headspace to process information separate from the overwhelming discharge process. We recommend hospital care teams integrate this into their holistic care duties.

Transportation is an Important Variable to Care: After performing multiple interviews and research on the screening processes that patients go through to assess risk and the presence of their support systems, CMRP staff learned that secure transportation is a variable not often considered. We recommend that transportation to follow-up medical care questions be better integrated into these already existing screening processes. It is an essential element in assessing a patient's ability to follow through on care plans.

Medicaid and Medicare Authorities Need to Consider Insights that will Better Serve their Recipients: Findings from a program like ours directly contributes to a better understanding of Medicaid and Medicare patient needs. We learned a lot about how transportation can contribute to a patient's support system and how to deliver this service to these patients. Factors like standardization of rides, ride comfort, and the strategy of leveraging care team support are all feedback we received that can have more enormous implications to Medicaid and Medicare authorities.

Mobility Managers

Transportation Itself is a Value-Add: We learned there is value in merely providing a service for patients in need. In the context of a hospital, care staff and the patients themselves are the experts in determining where the need is to improve health outcomes. Therefore, providing a service that can fill in for a transportation gap can bolster health outcomes on its own without the need to incorporate an incredibly innovative or more complex usage system. In some cases, adding "innovative" elements to service can add complexity and dilute usefulness. We recommend having in-depth conversations about the need to understand what degree of innovation is necessary to fill a gap.

Hospitals Need Transportation Support: This partnership with a hospital was unfamiliar for the Hopelink Mobility Management team. Through it, we learned just how important it is to breakdown the silos. Both parties stand to benefit immensely from further understanding of how each other's operations and infrastructure work. In doing so, a better pipeline is facilitated for patients to be served in their healthcare and transportation needs when they intersect. Therefore, it is beneficial for either party to engage in regular convening – through conversations, coalitions, stakeholder groups, and project partnerships – so that relationships and learning are developed.

All Kinds of Older Adults in Suburban and Rural King County Need Transportation: Our program used a narrow set of criteria – going through discharge process, LACE score 60+, and has Medicare – to enroll patients for transportation support. However, during our pilot's length, we learned about older adults across the hospital who needed our program; for example, in the oncology department, the need for reliable, dependable transportation was strong. Therefore, we believe programs that can serve older adults regardless of insurance type are necessary to meet this vulnerable population's needs and avoid hospital admission in the first place.

Appendix A – Glossary of Terms

Action Plan: The Action Plan is the list that a hospital care team staff fills out in collaboration with a patient that details wellness-related trips that positively impact health outcomes. It is the destinations they are eligible to receive rides and then earn rewards through the incentive model.

Care Mobility Rewards Program (CMRP): The Care Mobility Rewards Program is the project to reduce hospital readmissions in South King County by providing transportation to eligible Medicare clients for follow-up medical appointments.

CMRP Planning Team: The group of participating individuals and organizations committed to the Care Mobility Rewards' Program's success.

Care Team: this generalized term refers to hospital staff who contribute to a patient's healthcare; it can include social work staff, nursing, doctors, and other kinds of care coordinators who assess and support a patient during hospital interactions.

CMS: Centers for Medicare and Medicaid Services - a part of the Department of Health and Human Services.

CSR**:** Customer Service Representative; the call-taker interacting with the discharge planners, clients, and transportation providers to book trips.

Customer Desirability: this term measures how valued a program or proposed solution is for stakeholders impacted by the solution.

Financial Viability: this term refers to how financially sound and cost-feasible is a program.

HealthierHere: serves as the Accountable Community of Health (ACH) for King County. There are nine regional ACH's in Washington State.

HIPAA: Health Insurance Portability and Accountability Act; a US law designed to provide privacy standards to protect patients' medical records and other health information provided to health insurers, doctors, hospitals, and other health care providers.

Hopelink Mobility Management: the Hopelink Mobility Management team provided administrative support and coordination for this pilot as the mobility managers of King County. This internal team organized partnerships and managed the pilot for this period.

Hopelink Non-Emergency Medical Transportation (NEMT): this department within Hopelink operates a call and scheduling center that contracts with 20+ providers throughout King and Snohomish County to provide transportation services.

Hospital Readmissions Reduction Program (HRRP): a value-based purchasing program that encourages hospitals to improve communication and care coordination to engage patients and caregivers in discharge plans better and, in turn, reduce avoidable readmissions. The program supports the national goal of improving Americans' health care by linking payment to hospital care quality.

LACE+ Index Scoring Tool: Used to identify patients at high risk for readmission or death within thirty days of discharge. It's a strategy promoted by the Institute of Health Improvement. The LACE scores range from 1-100. The index identifies four parameters:

"L" stands for the patient's length of stay of the index admission
"A" stands for the acuity of the admission. Specifically, if the patient is admitted through the Emergency Department versus an elective admission.
"C" stands for co-morbidities, incorporating the Charlson Co-morbidity index that scores the presence of two or more chronic diseases or conditions.
"E" stands for the number of Emergency Department visits within the last six months.

Medicare: Medicare is a federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with end-stage Renal disease that may cover hospital insurance, medical insurance, and prescription drug coverage depending on patient qualification.

National Center for Mobility Management: this organization is a national technical assistance center funded through a cooperative agreement with the Federal Transit Administration and operated through a consortium of three national organizations—the American Public Transportation Association, the Community Transportation Association of America, and Easterseals Inc.

Operational Feasibility: this term refers to the long-term value of the process, infrastructure, and logistics of a project or proposed solution. It seeks to evaluate how sustainable the administration, coordination, and support systems of a program are to justify investments.

Patient (or client): The individual who is enrolled in the program and receiving rides. A caregiver may also act on behalf of the patient/client.

ROI: Return on Investment; performance measure used to evaluate the efficiency of an investment.

Transportation Providers: The companies who are contracted to provide transportation for this program.

Valley Medical: this is a University of Washington Medicine branch hospital located in Renton in King County, Washington.

Appendix B – Evaluation Tools

A. **Individual calls with Hopelink NEMT Customer Service Representatives**

- What role did you have in supporting the CMRP program?
- Do you feel like the training you received to support this program was adequate?
- Do you feel like anything could have been changed about the training that would have made things easier on your end?
- Did you notice anything unique or any patterns in interacting with clients for this program?
- Have you had to field any complaints from people calling with this program?
- Have you had to deny any trips?
- Are there any policies or adjustments that would have made your participation in this pilot easier?
- Who trained you?

B. Discussion with Hopelink NEMT Coordinating Staff

- Do you think that the training you received to support this program was adequate?
- Did any concerns come up between CSRs who were working with this program?
- Did any concerns come up in administering this program in general?
- How do you think enrollment notification could be more streamlined?
- Could any process improvements be made in the way that program changes were communicated to you?
- Do you have additional feedback on anything that could be improved on your side of things?

C. **Care Mobility Rewards Program – Pilot End Survey**

Thank you for partnering with Hopelink Mobility Management during the pilot of our Care Mobility Rewards Program. Please complete this survey to share your feedback with us. We will use your responses to inform our final report and recommendations.

This survey is anonymous, so your name will not be recorded. This survey has a total of 20 questions within three sections; it should take no more than 15 minutes to complete. If you do not have any answers to share in open-ended questions, please write "n/a."

For any questions or comments, contact Bebhinn Gilbert at bgilbert@hopelink.org

Section 1: Training and Enrollment

This section will ask questions about your training on the Care Mobility Rewards Program and the process to enroll patients.

1. Please share the name of your department.
2. How many patients did you enroll in the Care Mobility Rewards Program?
   If unsure, please estimate.
3. Do you think anything about the process to enroll a patient can be improved?
4. Did you participate in the in-person training hosted by the Hopelink team for this pilot in February 2020?

    a. Yes
    b. No
5. Do you feel the training you received made you feel knowledgeable about the program? This includes training from Hopelink or other Valley Medical Staff.
    a. Strongly agree
    b. Agree
    c. Disagree
    d. Strongly disagree
6. What did you like or dislike about the training you received?

Section 2: Program Structure

Questions in this section seek to understand your use and knowledge around specific program elements.

7. Did you understand the process to secure discharge transportation for a client?
    a. Yes
    b. No
8. Did you make use of the discharge transportation option for your clients?
    a. Yes
    b. No
9. Please provide any additional comments regarding the discharge transportation offer and its utility.
10. The Care Mobility Rewards Program originally sought to provide transportation to wellness-related trips in addition to medical follow-up appointments. This included destinations like grocery stores, community centers, health-related classes, and other locations that would allow enrolled patients to become holistically healthier. These destinations were to be written into an Action Plan by the patient and discharge staff member at the time of enrollment. How confident were you in your understanding of the Action Plan portion of the enrollment process?
    a. Very confident
    b. Confident
    c. Somewhat confident
    d. Not confident
11. How useful was it to utilize the Action Plan on the brochure during the enrollment process?
    a. Very useful
    b. Useful
    c. Somewhat useful
    d. Not useful
12. Please provide your comments on the Action Plan and how this may have been strengthened or made more useful for you and your patients.

Section 3: Program Efficacy

This section asks questions on foundational metrics for a sustainable program.

13. How effective do you think our criteria for eligibility (Medicare enrollment, King County resident, LACE score of 60+, in need of reliable transportation) reflected patients who need our program most?
    a. Very effective
    b. Effective
    c. Somewhat effective
    d. Not effective
14. Please share your thoughts on our program criteria and if you believe there are other factors we could include to serve clients in need.
15. How confident are you that this program can be utilized well within your department?
    a. Extremely confident
    b. Confident
    c. Somewhat confident
    d. Not confident
16. Please share your thoughts on other departments or positions that may be well suited for connecting patients to the Care Mobility Rewards Program.
17. The Care Mobility Rewards Program sought to reduce emergency readmissions for high-risk patients by providing reliable transportation to their follow-up care appointments and other non-emergency medical transportation needs. How would you rate the overall effectiveness of this program?
    a. Very effective
    b. Effective
    c. Somewhat effective
    d. Noneffective
18. For the patients you interact with on a daily basis, how important do you believe transportation is for reducing the likelihood of readmission?
    a. Very important
    b. Important
    c. Somewhat important
    d. Not important
19. For the patients eligible for the Care Mobility Rewards Program, how important do you believe transportation is for reducing their likelihood for readmission?
    a. Very important
    b. Important
    c. Somewhat important
    d. Not important
20. Please share any other feedback you have for this pilot.

D. Valley Medical Feedback Discussion Questions

- How did you feel about the pilot program? What are your largest thoughts or concerns?
- Do you feel the program was easy or difficult to explain to patients?
    - Why or why not? What can be improved?
- Our program had a higher number of no-show and canceled trips than the average Medicaid operations. Do you think there is a reason for this?
- What feedback loop or way of connecting would be most useful to you in a long-term program when there is less changes happening?

- Is there anything else you'd like to share about this program?

E. Client Survey Questions

All questions were asked to be asked on a scale of 1 – 4, from Strongly Agree, Agree, Disagree, and Strongly Disagree. They were also open-ended to allow the client to provide more detail.

1. The discharge process from the hospital was clear
2. I understood how to use this transportation program
3. I understood the rewards (benefits) of The Care Mobility Rewards Program
4. I, or someone on behalf, was able to schedule rides to my medical appointments
5. Clarify if it was self or another person
6. I, or someone on my behalf, was able to schedule rides for other uses (wellness appointments? Non-medical trips?)
7. I was able to successfully take my scheduled rides
8. I knew how to access this resource, I knew who to call
9. I was able to attend my follow-up medical care appointments
10. Getting to and from my appointments (with this program) helped me maintain my health
11. Using this program, I didn't have to worry about how to get to my appointments
12. The COVID-19 Pandemic changed how I used this program
13. Yes/no I had to cancel one or more of my trips

Appendix C – Enrollment Brochure Focus Group Feedback

These focus groups' goal was to hear from future clients' peers, older adults in south King County if the collateral is clear and understandable. We used the indicators to gauge if the focus groups' participants could explain the program to us after reviewing the document. We also asked direct questions about each version's elements to understand participants' opinions on the documents further.

Overall takeaways from all versions:

- Fewer words & simplified language
- Bigger font
- Better graphics to explain that this is a transportation program
    - We know what the "Care Mobility Rewards Program" is, but that doesn't mean anything to potential clients
- Have the phone number to call and the words "free transportation" at the top/front of the document
- Include Valley Medical branding
- A brochure format will grab a client's attention better than a sheet of paper
- Have the most important information stand out with framing or bolding

Version 1

This iteration of the discharge collateral is a replica of the form in the business plan that was created in 2015. Version 1, shown below, has programmatic information on the front and frequently asked questions on the back. The Client's Care Action Plan is prominent in this version, which would lay out the client's locations to travel to using the program. It also has a "voucher" at the bottom that awards the client two initial Care Mobility Credits and their expiry date.

In general, this version was not received well. Participants shared that the document was too text-heavy, and the program was challenging for participants to understand.

Critical takeaways for this version:

- The voucher element is confusing. Participants were unsure if they would have to exchange the voucher for something or show it to someone.
- Questions participants asked about the program were answered on the sheet, but it seemed like they preferred to ask questions and receive information verbally instead of reading through all the text.
- The word "congratulations" at the top of the first page did not resonate with participants, one saying, "I don't have context for that."
- The information included in the voucher section should be larger and across the top of the first page, but the word "voucher" should be removed.
    - Hours of line operation could also be added next to the phone number.
- It was unclear to participants how additional credits could be earned, even though it is bold and high up on the first page.
- Valley Medical branding should be added to the top of the document.
- Some participants were confused by the Care Action Plan section. They did not understand that it was a list of locations they could travel to using the program.
    - A recommendation was offered to reduce the number of action items in the list to maybe 3 or 4. This section is taking up a lot of room.

Version 2

This iteration of the discharge collateral is somewhat simplified. Version 2, shown below, has frequently asked questions on the *front*. The Client's Care Action Plan is removed. This was to test if the collateral is better received without the Action Plan. The word "voucher" was removed, but otherwise, the same section was moved to the bottom of page 2. This section still explains that the client was given two initial Care Mobility Credits and the date they expire. A faxable trip request form was added as a new element to this version to test how the target audience would perceive such a form.

This version was better received by participants, but there were still complaints about the document's format and wordiness.

Critical takeaways for this version:

- Removal of the Care Action Plan removed the confusion about what it is and how the client can track the use of their rides.
- The "congratulations" at the top was replaced with "free transportation," and the groups better received this.
- The one-page collateral should be single-sided. Having information on the back is too much, and some people may never look there.
- Removing the Care Action Plan was well received. Participants shared that having this list is repetitive from the information they will receive in their discharge packets.
- Participants reiterated that Valley Medical should be prominently displayed, along with the basic "how to use" information right at the top of the page.
- The participants liked the idea of the discharge planner booking the first ride. However, the form was confusing. They do not need to see this. It should only be a resource for the hospital staff. Participants shared that they wouldn't necessarily know all the form asks for while being discharged.

Version 3

This final iteration of the discharge collateral is in the form of a brochure to test if this style would be better received. Version 3, shown below, was almost unanimously voted the preferred version (with one stand out). The information contained is mostly the same. The FAQs section was removed, and a step-by-step process explanation was added. A blurb about Hopelink's Transportation Resource Line (TRL) was added to test if it were something the participants would understand and be interested in using.

Critical takeaways for this version:

- Participants believed the brochure style would stand out more than another single sheet of paper. They already get so many documents during the discharge process, and a brochure might help this program stand out in the shuffle.
- The Hopelink logo was confusing. Participants asked if this was an extension of the existing Medicaid service.
- The blurb about the TRL was confusing. It wasn't clear when participants would use that and added confusion to understanding the CMRP.

- Additional non-NEMT ride as an extra incentive was well received, but its explanation in the brochure was unclear.
- Participants liked the bigger font.