REPORT TO THE LEGISLATURE PURSUANT TO ACT 43 OF 2025, SECTION 28

Report on Coordination of Health Care and Transportation Services

January 2026

submitted to

The Vermont House Committees on Transportation and Health Care
The Vermont Senate Committees on Transportation and Health and Welfare

Vermont Agency of Transportation
Policy, Planning, and Intermodal Development Division

VERMONT
AGENCY OF TRANSPORTATION

EXECUTIVE SUMMARY

As the most rural state in the nation, many Vermonters rely on demand response transit to reach medical appointments. These trips are expensive to operate (more than $50 per passenger trip on average) especially when there is just one passenger in the vehicle at a time. Over the years, transit providers have seen numerous examples of "missed opportunities" for grouping trips. They see people who live in the same town, or along a transportation corridor, destined for a local or regional medical center, but their appointments are scheduled for different times or for different days.

Section 28 of Act 43 of 2025 established a working group comprising public transit and healthcare leaders to identify opportunities to maximize the use of shared rides for healthcare appointments and improve coordination and communication between healthcare organizations and public transit agencies. The group met five times between October and December 2025.

Results

UVM Health and Tri-Valley Transit began working together in July 2025 to coordinate more dialysis trips from the Middlebury area to South Burlington and Rutland. While both the healthcare staff and public transit staff had long worked separately to coordinate appointments and travel for clients, this initiative, spurred by the legislation, was a concerted effort to identify individuals who could pair up into shared rides and make adjustments to their treatment schedules to allow for coordinated travel. This effort yielded four new pairings of riders, resulting in significant savings, likely more than $1,300 per month.

The Working Group also began outreach efforts to health centers to identify untapped volunteer populations at several hospitals that could help meet the needs of patients at very low cost. The hope is that these hospital volunteers can supplement the services performed by volunteer drivers at public transit agencies.

Recommendations

The focus thus far has been on trips for kidney dialysis because they occur frequently (typically three times per week) and can entail long distances given the limited number of dialysis treatment centers in Vermont. The Working Group agreed that focusing on long and frequent trips made the most sense in the immediate term, with long-infrequent trips and short-frequent tripsas the next priorities. Additional longer-term recommendations include the following:

- Incorporate screening for transportation needs into the patient scheduling process for all medical providers in Vermont.
- Establish communication channels between all medical providers and their regional transit provider to facilitate coordination.
- Investigate how transit scheduling software can be made available to medical scheduling staff so that they can easily see when existing trips are available to their facility.
- Continue efforts at trip coordination for dialysis and other long-distance trips with a goal of three new shared rides per transit provider per calendar quarter.
- Continue Working Group meetings on a quarterly basis. The Working Group will be responsible for setting outreach goals and reporting results to the Public Transit Advisory Committee quarterly and to the Vermont Legislature every January.
- The Vermont Legislature should monitor the progress of the Working Group and coordination efforts. It should also consider holistic accounting of healthcare and public transit costs since cost-saving changes in the healthcare sector can result in increased costs for public transit.

1. INTRODUCTION

The Problem and Potential Solution

Vermont is the most rural state in the nation in terms of the percentage of its population (64.9%) residing outside of census-defined urbanized areas and urban clusters. Because traditional bus routes are only cost effective in densely developed areas—where there is enough population, employment and other destinations to generate sufficient demand for a scheduled bus service—the majority of Vermonters who cannot drive, or easily get a ride from family or friends, rely on demand response transit services. These services, often called dial-a-ride services, are expensive to operate on a per-passenger-trip basis (over $50), but they are essential to the health and wellbeing of these Vermonters who face mobility challenges.

Transit providers make every effort to carry passengers in the least costly way so that they can operate the maximum number of trips with the finite resources they have available. In most cases, this means a volunteer driver using their own automobile, since the only operating expense for that trip is the reimbursement for mileage at the current federal rate (72.5 cents in 2026). However, if multiple passenger trips can be grouped together in a single vehicle, an agency-operated van can be the most cost-effective means. Transit agencies maximize the number of trips carried by volunteers, essentially filling every timeslot that the volunteers make available, while reserving van trips for group trips and passengers who need wheelchair-accessible vehicles.

Over the years, transit providers have seen numerous examples of "missed opportunities" for grouping trips. They see people who live in the same town, or along a transportation corridor, destined for a local or regional medical center, but their appointments are scheduled for different times or for different days. This missed opportunity is most obvious when the riders make repetitive trips to the medical facility, such as for kidney dialysis. If those trips had been coordinated, they could have been operated at a lower cost and the transit resources used for the individual trips (volunteers' time) could have been used to provide other trips.

This report documents new efforts to coordinate medical appointments and transportation and the initiation of a process to expand and institutionalize these efforts statewide. As described below, new communication and cooperation between public transit and healthcare providers stand to improve the cost efficiency of demand response transportation and expand the benefits provided by this limited resource.

Legislative Requirement

Section 28 of Act 43 passed by the Vermont Legislature in its 2025 session called for greater coordination of healthcare and transportation services. It established a working group to address this issue and required the present report. The language in the law is as follows:

> Sec. 28. COORDINATION OF HEALTH CARE AND TRANSPORTATION SERVICES; WORKING GROUP; REPORT (a) The Secretary of Transportation, in consultation with the Commissioner of Vermont Health Access, shall convene a working group to improve the coordination of health care and transportation services in relation to individuals enrolled in the State's demand response transportation programs. The working group shall be composed of stakeholders identified by the Secretary in consultation with the Commissioner of Vermont Health Access, including representatives of the Vermont Association of Hospitals and Health Systems, independent dialysis and methadone facilities, and the Vermont Public Transportation Association. (b) The working group shall examine various options for improving the coordination of health care and transportation services, including: (1) opportunities to coordinate the scheduling of health care appointments and treatments to maximize the use of shared rides; and (2) opportunities to improve communication between the public transit agencies and health care providers to facilitate

coordination of health care and transportation services for individuals enrolled in the State's demand response transportation programs. (c) On or before January 15, 2026, the Secretary and Commissioner shall submit a written report to the House Committees on Transportation and on Health Care and the Senate Committees on Transportation and on Health and Welfare with the working group's findings and any recommendations for legislative action.

The legislature recognized that this is not a problem that can be quickly solved. Rather, the focus is on establishing communication between the two sectors and encouraging them to work together to increase coordination.

Working Group

Through the summer of 2025, the organizations named in the law collaborated to establish the Working Group. The first meeting of the group occurred on October 2, 2025. The members of the Working Group, organized by agency, are as follows:

- Vermont Agency of Transportation
  - Michele Boomhower
  - Ross MacDonald
  - Dan Currier
  - Jeremy Whiting
- Vermont Agency of Human Services
  - Peter McNichol
  - Kelli Rhodes
  - Grace Johnson
  - Alicia Cooper
  - Stephanie Beck
  - Anthony Folland
- Vermont Public Transportation Association
  - Caleb Grant
  - Elaine Haytko
- Vermont Association of Hospitals and Health Systems
  - Devon Green
- University of Vermont Health
  - Karen Vastine
  - Natasha Withers
- Bi-state Primary Care Association
  - Mary Kate Mohlman

As of the end of December 2025, the Working Group has met in whole or in part five times. Notes from these meetings are included in the appendix to this report.

2. COORDINATION EFFORTS TO DATE

Overview of Braided System

Demand Response Programs

In Vermont, demand response service is funded by two major programs plus a variety of smaller programs using a mix of federal, state, local and private sources. The two major programs are Medicaid transportation, also known as non-emergency medical transportation (NEMT), which costs about $16 million annually, and the Older Adults and Persons with Disabilities Transportation Program (O&D), which costs nearly $8 million annually. ADA Complementary Paratransit is the next largest form of demand response transportation, but it is not a funding program, *per se,* since the money to pay for these trips is part of the regular urban (federal section 5307) or rural (federal section 5311) funding streams, matched by state and local dollars.

Beyond these three large components of demand response service, most transit providers carry passengers under other statewide or local programs. The Recovery and Job Access (RJA) program is a cooperative effort between VTrans and the Vermont Department of Health to assist people get to substance use recovery centers and to help anyone in need of access to job training, job interviews or regular employment (for a limited time). It began as a pilot project with the two state agencies sharing the nonfederal match so that the transit providers did not need to supply local funds. Rural Community Transportation (RCT) in the Northeast Kingdom was the first pilot site and it remains the largest supplier of trips in this program, but over the last two years, the RJA program has rolled out statewide. The annual funding for RJA is under $150,000. Examples of other local demand response programs are a contract between the Department for Children and Families and Green Mountain Community Network (GMCN) in Bennington to carry children to daycare services, a collection of contracts operated by RCT known as Community Organizations, Departments and Schools (CODS), and various "incidental" services operated by Marble Valley Regional Transit District. Several providers offer "private pay" trips, in which the client/rider pays the full cost of the service out of pocket.

In the braided system, transit providers try to group as many passengers as possible into single vehicle trips. There are some exceptions, such as when GMCN carries children to daycare centers, when an agency may not put riders from different programs on the same vehicle, but otherwise filling seats on transit vehicles reduces the cost for all program partners and extends the availability of transit resources to more riders. Vermont is unusual among the states in having transit providers supply NEMT on their own vehicles (plus a limited number of subcontractors); most states use taxicabs or other dedicated fleets for NEMT and do not mix Medicaid riders with other transit programs. As the largest demand response funding program, having NEMT as part of the braided system operated by transit agencies is critical to achieving efficiencies through shared rides. In addition to reducing costs, the braided system also makes it easier for riders to obtain service because their local transit provider is a "one-stop shop" for all of their mobility needs.

Ridership and Cost Data

For State Fiscal Year 2025, 524,507 passenger trips were carried on demand response services at a total cost of $27,510,981 for an average cost per rider of $52.45. O&D trips had the highest average cost at $58.09 while NEMT trips cost $52.88 on average. The share of riders by program is shown below in Figure 1. The cost for each program is shown in Table 1.

Figure 1 – SFY25 Demand Response Ridership

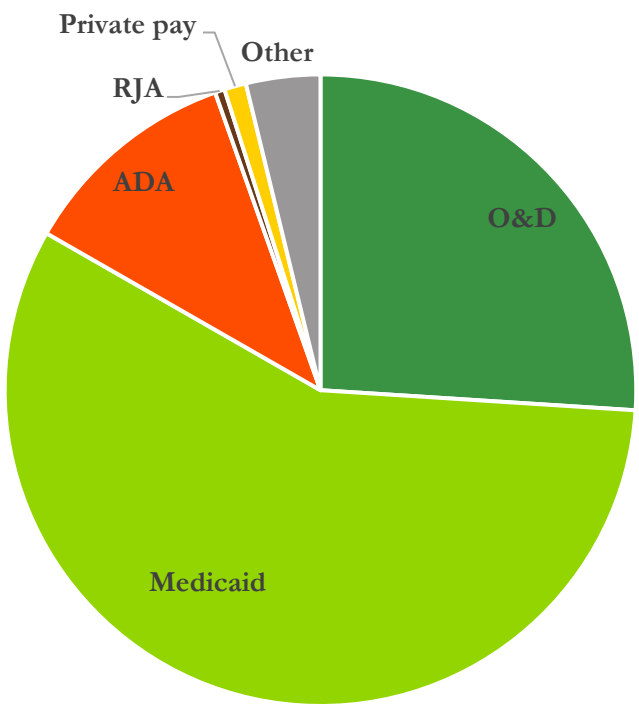


Table 1 – SFY25 Demand Response Cost and Ridership

	SFY25 Cost	SFY25 Rides	Cost per Ride
O&D	$7,927,132	136,452	$58.09
Medicaid	$15,883,364	300,346	$52.88
ADA	$2,543,199	59,321	$42.87
RJA	$121,258	2,599	$46.66
Private pay	$269,469	5,860	$45.98
Other	$766,559	19,929	$38.46
TOTAL	$27,510,981	524,507	$52.45

Rides to Wellness Program

Prior to the present effort at coordination between public transit and the healthcare sector, the most recent significant collaboration was the Rides to Wellness Program. The program ran for about five years, from April 2018 through June 2023. There were five pilot sites for the program: Mt. Ascutney Hospital and Health Center, Northeast Kingdom Human Services, Gifford Hospital, Lamoille Health Partners and Porter Medical Center.

The Rides to Wellness Program sought to eliminate the transportation barrier to health care. It was intended to be a short-term backstop to other programs, such as Medicaid and O&D, so that no one fell through the cracks. The goals of the program were the following:

A. To improve health outcomes for the vulnerable populations that use community health centers
B. To reduce the use of emergency services, thereby saving additional resources
C. To improve financial performance for health centers, hospitals and funding programs

The original intention of the program was to demonstrate to health centers that minimal investment in increased transportation services would not only improve health outcomes, but that the program would pay for itself, through cost savings (from a reduced need for emergency services), increased utilization of labor resources (caregivers would have more appointments due to decreasing no-shows), and revenue increases (with more patients being served, a portion of them would be eligible for federal draw-down dollars). The investment would reap a positive return so that the program could be sustained with financial support from the health centers themselves. Expanding the pool of funding beyond the traditional federal, state and local sources increases access for all and helps to stretch taxpayer dollars further.

Beyond the programmatic goals, the pilot project was also intended to establish more robust communication between regional transit providers and health care providers. Hypothetically, this communication would lead to clients becoming more aware of and making better use of existing funding programs, building community support for public transportation, and boosting ridership and efficiency as the number of shared rides increased.

The model for this effort was HealthTransit, an initiative of the Community Health Team (CHT) at Springfield Medical Care Systems. The CHT worked with frontline staff at the medical center to educate them about transportation barriers that patients may face and the array of possible ways for patients to get to their appointments. The CHT trained all frontline staff to ask patients proactively if they need transportation assistance. If the answer was yes, then the CHT staff could help the patient find a ride through various means, which could include a gas card, a taxi trip, or a ride with the public transit provider. The method used in Springfield was translated into a "Roadmap" for each of the pilot sites, which served as a guide for healthcare staff on the transportation options available in their region. A sample Roadmap is shown below in Figure 2.

Over its five-year span, the program provided over 2,300 trips. Table 2 shows the number of trips by region and by type.

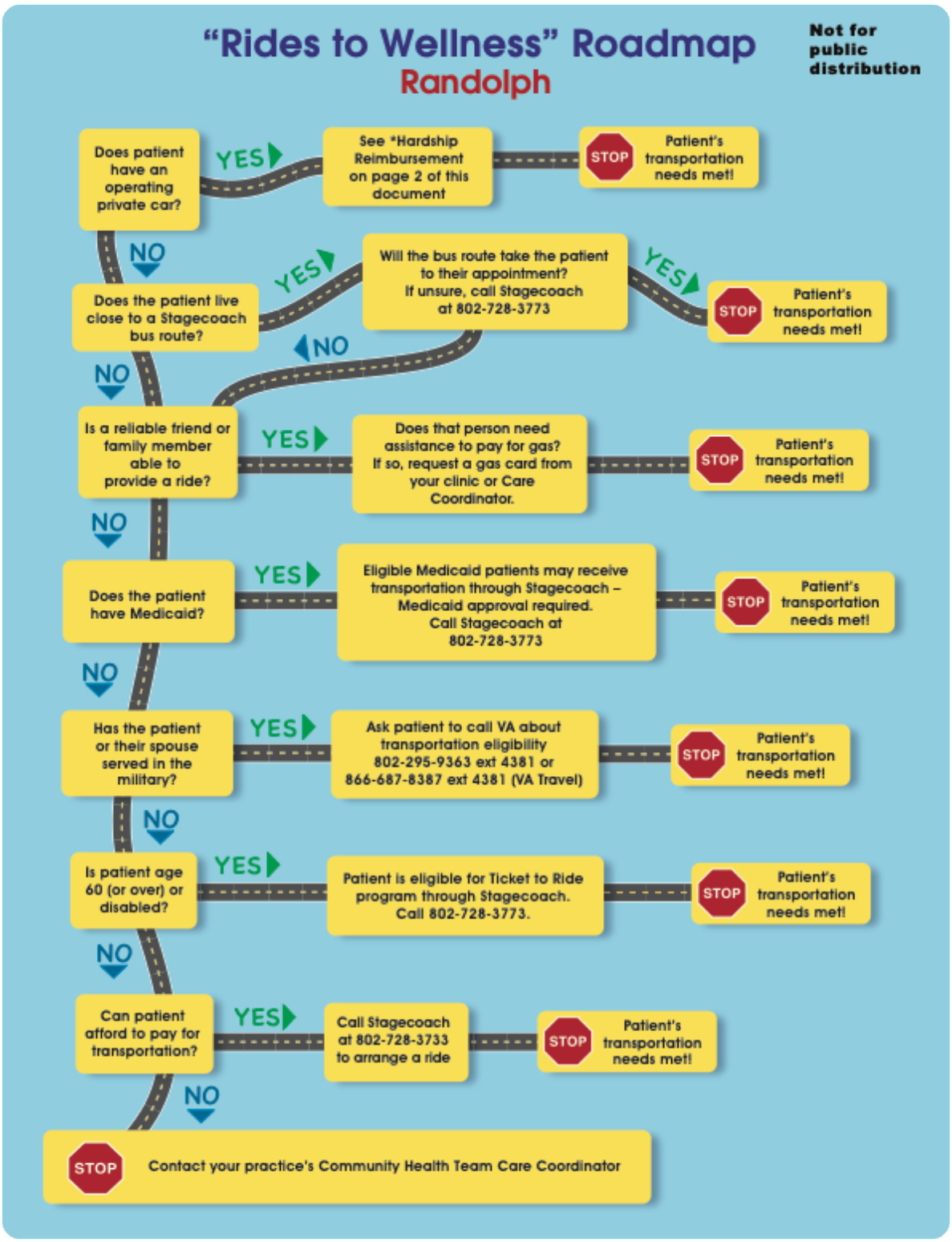
Table 2 – Rides to Wellness Results by Region and Type of Assistance

Region	Gas Card	Taxi	Volunteer Driver	Bus/Van
MAHHC	88	397	341	0
NKHS	19	4	190	36
Gifford	408	1	37	9
Lamoille	379	5	29	9
Other TVT	197	0	183	0
Total	1,091	407	780	54
Percentage	47%	17%	33%	2%

In the Northeast Kingdom, virtually all of the rides were provided by RCT, either using vans or volunteer drivers. In the Mt. Ascutney area, the majority of trips were provided by taxis or by volunteer drivers associated with Volunteers in Action. Toward the end of the program, many more trips were facilitated using gas cards.

One of the lessons of Rides to Wellness is that information sharing is nearly as important as the availability of transportation resources. In this way, Rides to Wellness set the stage for the present effort.

Figure 2 – Sample Rides to Wellness Roadmap



UVM Health Care Management

In 2021, UVM Health established a Care Management program designed to provide a consistent approach to meeting the needs of its most vulnerable patients. This program is embedded within primary care

practices and works collaboratively with providers to ensure patients have access to Care Managers, Diabetes Educators, Health and Wellness Coaches, and Resource Coordinators. The Care Management team focuses on individuals with complex medical and social needs, helping optimize care and connect patients to available resources.

In January 2025, UVM Health implemented standardized screening for Health-Related Social Needs (HRSN) across all primary care practices. This initiative began with the selection of a standardized screening tool, integration of the tool into UVM Health's Electronic Health Record (EHR), comprehensive training and education for system-wide use, and the development of a structured pathway to address positive screenings indicating patients may benefit from additional resources. This effort is analogous to the work described above in Springfield to incorporate questions about transportation barriers into all patient interactions.

With the implementation of HRSN screening across its primary care network, positive results trigger a referral to the Care Management team for follow-up. Transportation challenges remain one of the most common reasons for referral. Resource Coordinators typically serve as the first point of contact for these cases, working closely with patients to navigate available options. Because each patient—and each county or town in Vermont—has unique systems and resources, having a dedicated team to guide patients through these processes is essential. Whether the need involves transportation to medical appointments, grocery shopping, childcare, or other services, the UVM Health team partners with patients and coordinates with transportation providers and payers to ensure access and support.

TVT, Porter Medical Center, and UVM Medical Center

Following the passage of Section 28 during the 2025 legislative session, Tri-Valley Transit (TVT) and UVM Health took the initiative to pursue the goals of the law. While each of these partners had been working separately for years to coordinate medical appointments on the healthcare side and trips on the public transit side, in July 2025, TVT and UVM Health began to work *together* to strategize how identified dialysis patients who traveled individually to the dialysis clinics in South Burlington and Rutland might be able to travel together. The initial focus was on dialysis patients because these riders make frequent trips (up to 13 per month) on a long-term basis, and for people in the Middlebury area, the trips are long due to the lack of a dialysis clinic in Addison County.

This effort was the first instance of the transit provider and dialysis clinics strategizing how barriers could be removed to enhance their ability to adjust treatment schedules to promote more ridesharing. Both dialysis clinics worked with several patients over the summer and fall to coordinate rides with TVT (and other special transportation providers). This involved adjusting the appointment times of the patients so that they were coordinated with other dialysis patients who resided in the same area. This effort resulted in four patients transitioning from individual trips to shared trips. While that may seem like a small number, the savings from having those four people pair up saves almost $1,300 per month. Furthermore, the volunteer drivers who were occupied with taking those individuals to dialysis are now freed up to carry other passengers. In some cases, this means that a trip elsewhere can be performed by a volunteer driver rather than a TVT van with a professional driver, leading to further savings.

TVT identified patients who lived in close proximity to a group of patients already engaged in ride sharing and asked the dialysis clinic if it would be possible to adjust the additional patients' schedule to facilitate their joining a group trip. The group discovered that this effort was not without hurdles to overcome—the syncing of appointments was only one element that needed to be addressed. TVT's policy only guarantees 12 trips per month for dialysis, and so at least one patient chose an appointment time that would work best

for their family to provide the 13th trip in one month. When TVT offered to waive the 12-trip limit for the patients engaging in group trips, this cleared the hurdle for their participation.

> *Since our meeting, the schedule was adjusted to increase ride-sharing opportunities among our patients. Following this change, there have been no reported concerns or issues related to patient transportation to Joy Drive for scheduled dialysis appointments. Eliminating the restriction on the 13th ride proved to be especially impactful, significantly easing the burden on patients—particularly those who lack the financial resources to absorb the additional costs that would have resulted. I recently checked in with several patients who would have been affected by this change and who utilize TVT for transportation. I'm happy to report that things appear to have stabilized, and there have been no issues with their rides.* – *UVMMC Renal Social Worker*

The TVT-UVM Health collaboration is a promising start and an example of how enhanced communication between healthcare and transportation providers can result in the more efficient use of resources. Further benefits will be realized when these considerations are built into standard operating procedures. UVM Health is exploring opportunities for further coordination of patient appointments beyond these dialysis trips.

Outreach to Medical Facilities

Members of the Working Group representing UVM Health and the Vermont Association of Hospitals and Health Systems have begun outreach to medical facilities across Vermont. Thus far, four regional health systems have responded positively to the outreach:

- UVM Health (includes UVM Medical Center in Burlington, Central Vermont Medical Center in Berlin and Porter Medical Center in Middlebury)
- Northeastern Vermont Regional Hospital (St. Johnsbury)
- Springfield Hospital
- Rutland Regional Medical Center

This outreach has involved two aspects of collaboration between healthcare providers and transit providers discussed below.

Volunteer Sharing

As mentioned earlier, volunteer drivers are an extremely valuable resource for transit providers as they are in most cases the lowest-cost means of providing a trip. In addition to avoiding the wages, benefits and overhead associated with staff drivers, volunteers are especially valuable for longer medical trips where the driver will usually wait for the patient/rider to complete their appointment and then take them home. Within the O&D program, this waiting time costs nothing when there is a volunteer driver (except in cases of waits longer than an hour at which point the driver receives some extra payment expressed in additional miles), but is charged at the full hourly rate (more than $100/hour for most agencies) if it is a staff driver. (Costs for Medicaid transportation claims are accounted for differently, based on Medicaid rules.)

Hospitals and health centers often have networks of volunteers who participate in patient care in a variety of roles. This element of the outreach seeks to involve hospital volunteers in transportation. While the transit providers would be thrilled if some of these hospital volunteers became "regular" volunteer drivers, there would still be a huge benefit if the hospital volunteers just expanded the range of their service to include some transportation of patients they are assisting at the medical facility. The transit providers have procedures in place to conduct the necessary background checks for transportation (which may exceed the required background check to serve as a hospital volunteer) and can cover the volunteers under their existing umbrella insurance policies. The transit providers are also set up to process and pay mileage

reimbursement if the volunteer wishes to receive it. To the extent the hospital volunteers can fulfill some of the transportation needs of patients, the transit providers' regular volunteers will be freed up to serve other riders.

Travel Coordination

The second element of outreach is to pair the medical facilities with their regional transit provider to coordinate travel following the example of TVT and Porter Medical Center. As discussed in the next section, data analysis is underway to identify opportunities statewide where riders can be paired up or join larger groups in order to reduce the transportation resources used to get them to dialysis appointments. Further, as discussed below, dialysis is just the starting point for this collaboration.

Efforts toward centralizing specialty care and eliminating some practices at regional hospitals will only increase the important of trip coordination. While the concentration of some forms of care at centers of excellence, as suggested by the consultant study presented to the Green Mountain Care Board in October 2024, may reduce costs in the healthcare sector, they will undoubtedly increase costs for transportation. Coordinating these longer trips can help mitigate this cost increase.

3. POTENTIAL EFFICIENCIES

As both the healthcare sector and public transit are under constant pressure to limit the growth of costs while also facing constant increases in the demand for service, the efficient use of resources is a key objective. As mentioned earlier, coordinated schedules and shared rides can result in significant savings, and filling more seats on a vehicle while obviating the need for separate trips is a clear gain in efficiency.

At present, schedule coordination is a labor-intensive process. For example, managing these cases within UVM Health one patient at a time presents several challenges:

- Resource Fragmentation: Transportation programs differ by region, payer, and eligibility criteria, requiring extensive coordination and verification for each patient.
- Time-Intensive Navigation: Resource Coordinators must invest significant time in understanding local systems, contacting providers, and confirming coverage for every referral.
- Dynamic Patient Needs: Patients often have multiple overlapping needs, which can change rapidly, necessitating ongoing follow-up and adjustments to plans.
- Limited Automation: Current processes rely heavily on manual intervention, as there is no universal platform to streamline transportation arrangements across all payers and regions.

Given these challenges, it is necessary to take a measured approach to increasing trip coordination while efforts are made to build communication channels and relationships, centralize information, and find ways to make the coordination easier and smoother. In thinking about transportation, it is useful to divide the universe of trips into four quadrants.

Four Quadrants

The four quadrants described below divide trips based on their length and their frequency. Some of the quadrants offer much greater rewards than others.

Long-Frequent

Trips that are long and frequent are the primary target of coordination efforts. These trips account for the greatest share of the cost of transportation and because they are repetitive by nature, offer large potential savings for the initial effort of coordination. The best example of trips in this quadrant are trips for people with kidney disease who reside far from a dialysis treatment center. The TVT-UVM Health collaboration described earlier addresses trips in this quadrant.

Long-Infrequent

While there are hospitals all over Vermont, there are just two facilities that offer tertiary care (that is, highly specialized medical care that involves advanced procedures and treatments performed by specialists in state-of-the-art facilities): UVM Medical Center in Burlington, and Dartmouth Health in Lebanon, NH. Smaller numbers of trips are destined for medical centers in the Boston or Albany metro areas (though many Bennington County residents travel to Albany for specialized care). Brattleboro Retreat also offers special services that entail long trips from northern and central Vermont. While patients in Bennington, say, may not individually need to make frequent trips to Dartmouth Health, Green Mountain Community Network (Bennington's transit provider) ends up making nearly daily trips to Lebanon, carrying many different riders to their infrequent appointments.

Short-Frequent

For dialysis patients living in the Burlington metropolitan area, or for people with substance use disorder living near a treatment facility, trips for treatment can occur multiple days per week, but each trip may be under 15 minutes. These types of trips offer coordination opportunities, but the potential savings are not as great simply because the cost of short trips is much less than the cost of long trips.

Short-Infrequent

Trips in this quadrant account for a small percentage of the overall expense for demand response transportation. Other than the routine and standard efforts transit providers make to group trips together in a single vehicle, special efforts to schedule a patient's appointment when it would be more likely they could ride in a group trip would only be worthwhile when technology has evolved to make the needed information ready at hand without extra phone calls and labor-intensive human interactions. Within the context of this project, this quadrant is clearly the lowest priority.

Near-term Targets

While long-frequent trips are clearly the highest priority and short-infrequent trips the lowest, the ranking of the other two quadrants is not as clear. Any frequent trips should be considered for coordination, but at the same time, long trips are much more costly. Once the transit and healthcare partners have coordinated as many of the long-frequent trips as possible, they should likely address both of the middle quadrants together, seeking to coordinate the most frequent short trips and the longest infrequent trips. Strategies for each of these efforts are discussed below.

Dialysis

All of Vermont's transit providers were queried about trips to dialysis clinics in October 2025. At the time of the survey, the responses indicated that there were 188 riders at the time who took frequent trips for dialysis. Of these, 57, or just under a third, were already transported in group trips, meaning that there are about 130 dialysis patients who still might be grouped together some or all of the time. It is already the case that some of the 130 patients ride with other passengers some of the time. The section below on potential savings will consider in more detail what would need to happen to better coordinate these trips.

It must be noted that not all of the trips taken by these riders are long trips. People living in St. Albans, Rutland, Burlington-South Burlington, Montpelier-Berlin, Bennington, St. Johnsbury, and Newport have dialysis treatment centers in their communities. Two of Vermont's transit providers—Tri-Valley Transit and Southeast Vermont Transit—have no dialysis treatment centers within their direct service areas, but all of the providers serve rural towns that are distant from the cities and towns listed above. Thus, there are coordination opportunities for every provider.

Substance Use Disorder Treatment

The other type of medical trip that occurs with even greater frequency than dialysis treatment is substance use disorder (SUD). In recent years, nearly 40% of trips funded by the Medicaid program have carried passengers to a treatment facility, often on a daily basis. Because of the volume of these trips and because many of them happen early in the morning, the transit providers and clinics have already worked hard to coordinate these trips. Over 90% of these trips are grouped together, sometimes with 8 or more riders on a van at once. Whenever a new client with SUD starts riding, the transit provider seeks to add them to an existing group trip. These riders only travel alone when there are behavioral issues preventing them from being part of a group trip, or when their residence is nowhere near those of riders on existing trips. Thus, there is not a great deal of opportunity for additional grouping of trips to SUD clinics.

Trips to Major Regional Facilities

When Vermonters need specialized medical treatment that may not be available at the nearest hospital, they are typically sent to one of the two major regional facilities: UVM Medical Center or Dartmouth Health. People in the southern half of the state and the eastern counties in the mid and northern parts of Vermont (Orange County and the Northeast Kingdom) are generally sent to Dartmouth Health in Lebanon, while residents of Addison, Washington, Lamoille, Franklin and Chittenden Counties are typically sent to UVM Medical Center in Burlington. Rutland County residents could go either way. An individual patient may only need to travel there a few times a year, but collectively, each county sends patients to these facilities nearly every day. It should be noted that Dartmouth Health has not yet been engaged in this process; that is a priority for the Working Group over the coming year.

By narrowing the scheduling windows by geography, these coordination opportunities become easier to recognize and implement. As an example, from a transportation perspective, it would be ideal if patients of Dartmouth Health who live in Bennington County were scheduled for appointments only on certain days, such as Tuesdays and Thursdays, while patients from, say, Caledonia County were scheduled on Mondays and Wednesdays. While this would put some limits on the flexibility of doctors to schedule patients, it would create much better opportunities for trip coordination and could result in substantial savings since each time a van or volunteer driver is sent from Bennington to Lebanon, it costs the system hundreds of dollars. Doing those trips twice a week rather than five times a week would free up resources to operate many other trips in the Bennington region. In theory, Windham County residents could also be scheduled on Tuesdays and Thursday, and if GMCN vans from Bennington had space, they could pick up passengers along VT-9 or US-5 along the way to Dartmouth. Note that such an initiative would not prevent patients from scheduling appointments on any day that was necessary for care, but would rather serve as a starting point, indicating a preference for some days over others, assuming no medical impact.

A second consideration, which is relevant to all hospitals, applies to patients with complex care who have periodic appointments with multiple doctors. Unless there is a medical reason to space out these appointments, it would be more efficient to schedule them on the same day so that the patient needs to make only one trip to the facility. This would imply that there is a centralized scheduling database at the medical center so that front line staff at various doctors' offices would be able to see what other appointments the patient has at the facility. This coordination could also come under the purview of Care Managers.

Longer-term Goals

The short-term goals of this project are to increase communication and collaboration between public transit and healthcare providers to promote shared rides and make the most efficient use of available resources. These goals will only become more important in the longer term as Vermont's population continues to age and greater percentages of Vermonters will have needs for medical care and transportation to take them to appointments.

According to the *Demographic and Economic Trends & Forecasts Report,* produced in support of the *2040 Vermont Long-Range Transportation Plan,* Vermont's population is forecast to increase by 0.17% on average annually between now and 2046, resulting in a total population of 660,000 in that year.[1] In contrast to that slow overall growth, the number of residents age 65 or older is forecast to increase quickly, from 18% of the population in 2015 to 27% of the population in 2030, reaching a plateau at that level for the remainder of the forecast period.[2] These percentages translate into an increase from about 140,000 older adults today to

[1] *Demographic and Economic Trends & Forecasts Report,* RSG and Economic & Policy Resources, Inc., p. 5.
[2] Ibid., p. 19.

175,000 in the year 2030, an increase of 25%. These older adults will not only need additional medical care, but they will be less likely to be able to drive themselves than younger cohorts.

Some specific longer-term goals to enhance efficiency are discussed below.

Patient Scheduling Process

As discussed above, UVM Health instituted a screening process for new patients to identify people who face transportation challenges. Care Managers assist these patients with their care and help arrange transportation. At present, this is a labor-intensive process, but new technology and communication channels, discussed below, can help reduce the friction in this process.

While not all facilities may have the resources to have dedicated Care Managers, screening for transportation needs by all healthcare providers would benefit both the healthcare and public transit systems. These frontline staff members could receive and be trained in using a Roadmap such as the one shown on page 6, but at a minimum, they should have the phone number and web address of the regional transit provider immediately on hand to give to any patient who says they need assistance to make it to their appointment. Beyond that minimum step, the frontline staff member should be able to work with the patient and the transit provider to adjust appointment times whenever feasible, to allow for shared rides. This adjustment could result from a follow-up phone call from the transit provider with the assent of the patient.

Established Communication Channels

To the extent that there is a lack of coordination today between healthcare facilities and regional transit providers, it may be due largely to a lack of information. Some frontline staff may be unsure of whom to call or be hesitant to call because they do not know what to ask for. Following UVM Health's lead, all health care providers can and should establish a connection with a transit agency.

Establishing this connection would involve a meeting between the medical office staff and the likely the community relations manager and a representative from the call center or dispatchers of the transit agency. One meeting should suffice to explain the various programs that can assist patients in reaching their medical appointments, steps that need to be followed to establish eligibility, and the process for reserving rides, including the names of all of the call center/dispatch staff. This direct contact should eliminate any hesitancy the medical staff may feel in seeking transportation assistance for patients.

Scheduling Software

An established communication channel can overcome one barrier to coordination, but picking up the phone and making a call is still more labor intensive and time consuming than a quick glance at a screen. The new automated paratransit scheduling software being installed at all transit agencies in Vermont has multiple portals available to allow users to view data about scheduled demand response trips. With all of the data being based in the cloud, it should be technically possible to allow staff at a medical office to view upcoming transit vehicle trips updated in real time. The medical staff could not make any changes to trips or schedule new trips, and patient confidentiality would require that some detail about the trips is obscured, but at a basic level, the medical frontline staff could see if a van or volunteer is already scheduled to come from a given town to their facility (or nearby) and use that information to schedule the appointment for their patient to allow for a shared ride. This change presumes that the transit information could be integrated with electronic health records, or that a staff member could easily click out of the EHR system to a web browser.

Having this information at a glance rather than requiring a phone call will make it much easier to schedule appointments efficiently in the first place. A call to the transit provider will still be necessary to schedule a

ride for the patient, but one phone call requires less time than two or more calls and rescheduling the appointment after it has already been put on a calendar.

There will certainly be some technical challenges to this initiative. One or two locations should be selected as pilot sites to work out the details and figure out how this functionality can work best for both the medical office staff and the transit provider.

Estimates of Potential Savings

As mentioned above, about one third of the 188 dialysis patients who use public transit to reach their appointments share their rides with other patients. Most of these shared rides are pairs, but some of them are larger groups with three or even four riders. Unlike SUD treatment where a van may carry eight or more riders at a time, the capacity constraints at dialysis clinics,[3] the amount of time dialysis treatment takes, and the higher likelihood of patient discomfort following treatment limit the potential grouping of trips to three or at most four riders at a time.

All of the transit providers listed their current dialysis riders and the current schedules they follow, including the days of the week they get treatment (typically Monday-Wednesday-Friday or Tuesday-Thursday-Saturday) and the time of day their treatment begins. These times range from early in the morning (before 6:00 a.m.) to late in the afternoon.

The initial review tallied up those riders who could potentially be grouped together without significant changes to their current schedule (meaning adjusting times by less than an hour):

- GMT Berlin – On M-W-F, two additional riders could join the existing shared trip or form a separate shared trip, all with appointment times starting between 5:40 a.m. and 6:30 a.m. On T-Th-S, three trips with appointments starting between 10:20 a.m. and 11:40 a.m. could be grouped.
- GMT Franklin County – On M-W-F, there are seven trips that could form three groups with essentially no changes in appointment times. On T-Th-S, there are four trips that could form two pairs with little or no changes in times.
- MVRTD – There are three riders in one town who receive treatment early on M-W-F (between 5:30 a.m. and 6:30 a.m.)
- RCT – All dialysis trips operated by RCT occur on M-W-F. There are five new pairings that could be made with small changes in appointment times.

It is important to note that there could be complications with the above-suggested pairings that were not obvious from the data presented, and some of the pairings may have been attempted unsuccessfully in the past, but these suggestions are a starting point for new coordination efforts.

Beyond these possibilities, many other possibilities for grouping trips arise if changes are made to either the days treatment occurs, the time of the appointments, or even the location of the dialysis treatment. There are a few cases for each transit provider where the current dialysis treatment location is not the closest available one to the patient's residence. It is possible that the closest treatment center did not have any available slots at the time the patient started dialysis, or the patient may have relocated at some point but chose to stay with the same treatment center.

Among all currently unshared trips, the following indicates how many of them could join a shared trip if their day, time or location changed:

[3] Indeed, some dialysis clinics have no waiting room space, and this may prevent transit providers from grouping trips there.

- Day: 8 riders
- Time: 33 riders
- Location: 11 riders

Between the 30 riders described earlier who could be grouped with minor changes to their schedule and these 52 riders who could be grouped with more significant changes to their schedule, the total number of dialysis riders who could take shared rides would more than double from 57 to about 140. It is doubtful that all of these riders could be grouped consistently because of various limiting factors, but if the number of shared rides could increase from 57 to 100, there would still be enormous savings of resources that could be reinvested in the system to provide other types of trips that are now denied because no driver or no money is available.

Performance Targets

Rearranging schedules and coordinating rides will require staff time and effort from both the transit providers and the dialysis clinics. There could be some resistance to these changes because some people like their current schedules while others prefer to ride without other passengers sharing the vehicle. Dialysis treatment often results in significant discomfort, and patients may be understandably opposed to anything that delays their trip back home. It is inevitable that anyone who is part of a group trip will face the additional burden of some extra waiting time and travel time. Riders who accept this extra burden could receive incentives such as additional subsidized trips for other purposes. There will undoubtedly be some negotiation and readjustment as the transit providers try to coordinate these new group trips. Outreach to the riders will be necessary to explain the broader benefits of shared rides.

It is recommended that the Working Group set a performance target of three new shared trips per quarter for each transit provider. Each transit provider would need to submit a quarterly report documenting their efforts to create new group trips for dialysis and other medical appointments and explanations of factors that prevented them from meeting the target if they did not produce three new shared rides.

4. RECOMMENDED NEXT STEPS

This final chapter sets out recommended next steps to continue the progress already made since Section 28 was made law in June 2025. The first set of recommendations applies to the Working Group and the second set are offered for consideration by the Vermont Legislature in its 2026 and future sessions.

Working Group

Since being convened in October 2025, the Working Group has met monthly. After completion of this report, it is recommended that the Working Group set a schedule of quarterly meetings in March, June, September and December, and that representatives of the Working Group provide updates to the Public Transit Advisory Committee at its quarterly meetings in those same months. These updates should include information on how the transit providers are meeting the performance targets described above.

In addition, the Working Group should produce an annual report that is submitted to the legislature in January of each year. The report should describe the progress made in coordinating trips, barriers encountered and ongoing outreach efforts.

Besides meeting and reporting, the Working Group will also be responsible for continuing outreach to medical facilities all over Vermont as well as Dartmouth Health in Lebanon, NH. UVM Health has taken a leading role thus far, and should continue to do so, but Dartmouth Health needs to be more fully integrated into this effort. Eventually, all medical offices, including dental and mental health, need to be included, though such comprehensive outreach may take several years. Within its first year, the Working Group should set outreach goals and report on those to the legislature as part of its annual report.

Vermont Legislature

The primary responsibility of the Vermont Legislature in the first year of implementation is to monitor progress and continue to encourage greater cooperation between the healthcare and public transit sectors. As it did in 2025, the legislature should hold at least one joint session of the transportation and health committees so that all can hear and comment on progress being made in the coordination of healthcare and transportation service.

A future initiative for consideration would be a study of holistic accounting of publicly borne transportation costs and health care costs. For less affluent Vermonters, the public bears a significant cost both for healthcare and for transportation to reach medical appointments. Changes in one of these two sectors have impacts on the costs in the other sector, and thus these impacts should be considered together.

Initiatives that may be pursued to rein in the cost of healthcare can have significant impacts on transportation costs. Primary among these are the 2024 recommendations to the Green Mountain Care Board regarding hospital consolidation and the creation of centers of excellence for healthcare specialties. Reducing the services available at existing regional hospitals will almost certainly increase transportation costs as patients will need to be transported longer distances to a centralized facility.

A final consideration is further investment in mobility management at Vermont's transit providers. Some federal funding is available for mobility management, but as documented in this report, working with patients to coordinate schedules can be labor intensive. Analogous to the Care Managers at UVM Health, who see that patients' needs are attended to in a coordinated way, Mobility Managers at a transit agency can assist with coordinating rides and helping to ensure that whenever possible, a patient's needs are taken care of together on a single day of travel, rather than having that patient take multiple rides in a given week. These needs may extend beyond healthcare to include shopping, errands and other activities. A Mobility

Manager can help riders and their neighbors meet those needs in the most efficient way possible, stretching the limited resources as far as they can go.

APPENDIX: MEETING NOTES

Section 28 – COORDINATION OF HEALTH CARE AND TRANSPORTATION SERVICES; WORKING GROUP

Oct. 2nd Meeting notes:

Attendees: Kelli Rhodes (DVHA), Mary Kate Mohlman (Bi-State PCA), Michele Boomhower (VTrans), Alicia Cooper (DVHA), Devon Green (VAHHS), Grace E. Johnson (AHS), Tony Folland (VDH), Stephanie Beck (VDH), Elaine Haytko (VPTA)

Welcome and introductions

Purpose of Sec. 28 of the T-bill and Initial Perspectives (language posted below)

This section was created as a response to testimony at the House and Senate Transportation Committees, where Vermont Public Transportation Association (VPTA) members shared a willingness and potential opportunity to better coordinate trip demand and healthcare services. With over 600k annual demand response (or "dial-a-ride"), increasing costs, and a reduced number of volunteer drivers, the transit providers are struggling to meet the demands of the demand response programs (Non-Emergency Medical Transportation (NEMT), Older Adults and Persons with Disabilities (O&D), and Recovery and Job Access Program (RJA)).

While disparate attempts at cursory coordination have been tried in the past several years, this effort may allow this group and our respective partners to dive a little deeper and truly assess if enhanced coordination and communication can fill empty seats in vehicles already going to these origins/destinations, allowing for fewer drivers and vehicles to cover more trip demand.

Given the fiscal challenges we all face, this may be a more pressing need than ever before. Elaine Shared Tri-Valley Transit is currently speaking with UVM Health on how to coordinate demand response trips. There are also ongoing efforts and successes in working with VDH/DVHA to group clients who need daily medications, and many times there is more than 1 person in these vehicles. The question is, can we do more?

An example is how Southern Vermont Hospital is now owned by Dartmouth, which is causing more demand for trips to Hanover, NH.

Devon mentioned the regionalization of services and the impact that can have on people having to travel further for healthcare. Transportation for people from the ER is also a known issue… once someone is stabilized, it is a hard thing to make them wait a few days for transportation to a mental health facility.

Stephanie mentioned that we should also consider the origins as well as the destinations, as many people frequently change addresses or are unhoused... And while she understands the issue with vehicles passing one another, it very well may be appropriate and not efficient to combine those trips.

Mary Kate offered that for FQHCS a primary challenge is helping people schedule their medical appointments, and a large portion of the clients are socially and economically challenged people. Anything that can help reduce those barriers and help people get the preventative primary care they need.

Tony echoed these sentiments so far and would add many clients are going through several transitions at once housing, addiction treatment, personal issues).

Possible approaches to address these issues

Elaine – is there a way for us to have each transit providers (there are 7 regional transit providers covering most of the demand response trips) identify the top 4 destinations and look at those as low-hanging fruit to address scheduling opportunities? Maybe there are other organizations that would be willing to work with VPTA members on this issue. If there were some level of flexibility, additional trips could be provided by those who would otherwise be waiting at a facility for their client to be transported back home.

Grace said she would investigate that.

Ross mentioned that, in addition to the 4 top destinations, could we also look at the top 4 areas of origin? Is there a way to apply "mobility management" practices to group those origins/destinations and try to align services during those same windows of time?

Michele asked about the ability for trips to take on additional clients as they move through other regions. While this has long been a goal and desire by v/trans and DVHA, there has been limited success in inter-regional coordination. It happens, but not as much as we would like.

Michele also mentioned her recent discussion about the reality that many times, people are not informed of their actual procedure time until the day before, which makes scheduling and coordination a challenge. This is a reality for the healthcare system, and Devon confirms the specialties are much more apt to schedule this way than primary care offices.

Stephanie mentioned it is important to identify the population and percentages we are trying to address. The VT population is aging, but what is the percentage of people who rely on these services to access healthcare? The subset may be more manageable when one considers the percentages. Most people "self-pay" so let's assume there may not be a demand for those empty seats for those trips serving the rest.

Elaine offered that the biggest issue is for the longer trips, more than an hour or two each way… the idea that we could better coordinate those trips could really impact the number of drivers and capacity it takes to transport those clients. Maybe the software and data review could be part of this Working Group's consideration.

Michele asked about any mechanisms in place for us to work with our healthcare partners to help us promote the Volunteer Driver programs and possibly help us add more drivers and also ensure people know these services even exit. Ross mentioned the other Section in the t-Bill (Sec. 24) where the legislature has made available $600k for our providers to increase the amount of volunteer drivers.

Deon said she would be happy to work with us and coordinate the possible distribution of materials to her organizations and is aware the volunteer numbers at the hospitals took a hit during and since covid.

Elaine thought we may be on to something and cited several initiatives where we are asking organizations with clients who need transportation to have some of their own staff go through the background checks and processes to become volunteer drivers themselves. This could place volunteers where they are needed, reduce scheduling conflicts and provide some "windshield therapy" time during the transition between locations. The results have been few, and it's challenging, but this is an area for us to address. The Brattleboro Retreat is one place where there has been some interest in the facility working with us to share and reimburse volunteers to expand capacity, bringing on drivers from within the organization.

Ross will reach out to Devon to determine how we can proceed with those outreach and promotional efforts.

Next steps

We will send out a doodle poll and set meetings for the end of Oct., mid-November, and again in December. VTrans will also provide a consultant to join us and prepare the required report. Michele offered it may be important to cover the investigation of the issues/challenges, some case studies and ongoing efforts, and how we can create better communication and get more people in the empty seats on some of these trips. Maybe the consultant can work with Devon and identify a provider or people in the system that would be willing to help with these considerations. Devon was again amenable to this suggestion.

Ross mentioned this initial discussion has already proved to be helpful and potentially valuable, and will be in touch with the notes, doodle poll, and thanked everyone for their time and participation.

Section 28 – COORDINATION OF HEALTH CARE AND TRANSPORTATION SERVICES; WORKING GROUP

October 30th Meeting notes:

Ross MacDonald

- Thanks to Devon and those involved in the initial follow-up from the "kick off" meeting.
- We are reaching out and/or are scheduled to meet with RRMC, Springfield, NE Regional and are seeking an update from Karen.

Karen Vastine:

- All volunteer coordinators willing to help
- Way to grow pie bigger through coordination effort – recovering from COVID losses
- Dig into where transportation is an issue so that patients don't get care that they need
- Transport from assisted living facilities to dialysis
- Ross – TVT reports they only have one dialysis patient that isn't sharing a ride to and from those related services.

Natasha Withers

- Dialysis first focus
- Will collect lessons learned from our work with transportation coordination to dialysis and see how this may apply to other areas of the organization.e

Data

- Elaine Haytko (VPTA) has collected the most frequent destinations for most of the agencies and we can begin looking to coordinate those trips first.
- We may also benefit from looking at the top 5 "origins" and review for potential coordination

Stephen Falbel (Steadman Hill Consulting)

- He will be rolling up the discussions, outreach to date, and capturing the recommendations for the required Legislative Report.
- He will be doing a literature and case study search.

Section 28 – COORDINATION OF HEALTH CARE AND TRANSPORTATION SERVICES; WORKING GROUP

Notes from Meeting with Rutland Regional Medical Center, November 4, 2025:

- RRMC and MVRTD meet on a quarterly basis.
- MVRTD has enough Volunteer/Community Driver hours to cover almost all of the trips not requiring a wheelchair accessible vehicle.
- Primary care providers were not on this call but would likely be an important partner in these discussions.
- RRMC cited evenings and weekend (off hours) trips as being a long-standing issue for their patients (this is a statewide issue).
- RRMC is collecting data on cancellation and missed appointments. This is in the early stages of data collection and RRMC is moving to minimize free text. Meredith – please let us know if RRMC is collecting or planning to collect and analyze additional data as it relates to transportation/transit issues. MVRTD is also more than willing to share any data that could help RRMC better understand their patient's transportation needs.
- Seems these two entities are prepared to work together to better coordinate trip and healthcare services. Briefly discussed UVM Health dialysis coordination. The Pediatric services may be ending at this hospital and I'm wondering if this could be a good opportunity to assess the transportation impacts and costs related to this consolidation of healthcare services.
- These organizations are well-suited to explore and institute improved communication and coordination, and by way of this email, ask Steve to consider this info along with the outcomes from the other several discussions related to these efforts.

Section 28 – COORDINATION OF HEALTH CARE AND TRANSPORTATION SERVICES; WORKING GROUP

November 20th Meeting notes:

- Met with RRMC along with MVRTD
  - Use savings from spinning off pediatric unit to help pay for transit?
- Jeremy working with Springfield Hospital and NVRH
  - Take lessons learned and incorporate into report
- Elaine:
  - Looked at data
  - Set goals (long and short) for coordination
  - Check about flexibility of arrival and departure time for appointments – can they arrive earlier and leave later to allow for more joint trips
    - Medical offices prefer patients not be dropped off early and leave when appointment is done
    - Looking to have "waiting rooms" for some sitting around
  - What are patient rights about refusing to change appointment times?
- SUD trips
  - Tony said already get 95% of the trips coordinated
  - Getting last 5% is a work in process