

## **Access ADA Eligibility Process Comprehensive Review Report**

### **1. Introduction:**

In February 2015, Access Services (Access) contracted with Delta Services Group, Inc. (Delta) to conduct a comprehensive operations review of the passenger eligibility processes currently used by Access. After more than 9 days of on-site observations and interviews, along with dozens of additional hours of research and investigation, we have completed this effort and report our findings in the following pages.

Access initiated this effort to get a fresh, outside look at their current processes. In very broad terms, Access wanted to know:

- Is the process still fully ADA compliant?
- Are the decisions being made correctly and appropriately?
- How is the transportation process working?
- Are the system costs appropriate?
- What changes should be made to improve the process and serve the Access program into the future?

In this report, we will address these questions and provide specific short, medium and long-term recommendations.

### **2. Executive Summary:**

In February and March of 2015, Delta conducted an assessment of the process used by Access to determine eligibility for ADA Paratransit. Our assessment consisted of two sets of observations and interviews of staff, a covert mock application for service and review of hundreds of pages of reports and procedures. At the conclusion of this process, Delta made the following findings:

- The current Access process is fully ADA compliant;
- The current process involves a major focus on medical conditions of applicants, rather than an exploration of their specific mobility needs;
- Approximately 29% of eligible passengers only use their free bus pass, while another 20% use both Access and fixed route bus;
- Virtually all eligibility decisions are made immediately after the interview, without verification of information provided by applicants;

- Access's costs for eligibility assessments are reasonable to low, when compared to their peer systems;
- The current contractor performs only anecdotal quality review of decisions;
- Coordination of transportation for eligibility interviews is a significant task that can impact the volume of applicants processed; and,
- Eligibility appeals are comprehensive and thorough.

Based on these and other observations, Delta recommends that Access implement a number of changes to the program:

In the medium term, we recommend:

- Access should conduct a detailed and ongoing analysis of fixed route use by Access passengers and applicants to facilitate the use of fixed route in the future;
- We recommend that the current contractor develop formal forecasts for eligibility demand, and that they plan, staff and budget to meet these forecasts;
- Applicants should be encouraged to prepare better for interviews and should be required to bring completed applications and supporting documentation with them when they apply;
- Applicant medical and other supporting documentation should be spot-checked for validity prior to decisions;
- The eligibility contractor should develop and implement systematic evaluation of eligibility decisions and performance of staff; and,
- The "transit walk" course at both of the contractor's locations should be synchronized so that the course at these locations contains the same elements.

Over the longer term, we recommend that Access:

- Redesign the eligibility assessment process to include a full mobility needs assessment, not just a focus on paratransit eligibility, so passengers can be more effectively paired with the mode of accessible transit that will best meet their needs;
- Access should work more closely with Metro and other fixed-route providers to synchronize Access fare policies with fixed route reduced fare programs, to maximize passenger access to all fixed route modes;
- Take over ownership of the current contracted process and seek multiple contractors and assessment sites within Los Angeles County to execute eligibility assessments under the management and control of Access.

### 3. Existing Conditions and Financial Analysis

The most significant task of this project was a comprehensive assessment of the current eligibility processes in use by Access. In general terms, Access has fully contracted for these services. The largest contractor, C.A.R.E. (CARE), is responsible for nearly all of the initial applications for eligibility of Access paratransit. An additional contractor, Lemus Medical (Lemus), has completed a handful of application assessments and is also contracted for appeals. Because Lemus was a temporary eligibility provider and their contract has now ended, we did not formally evaluate their operation. Other appeals are handled by additional contractors, which we will discuss further below.

By design, the Access approach to eligibility for paratransit places the entire responsibility for all aspects of the enterprise onto the shoulders of the contractor. Both CARE and Lemus were responsible for the development of the processes they are using, their execution and all other support and administrative functions of the processes. This model was adopted by Access many years ago in an effort to give the contractors the most flexibility possible to develop (and evolve) the best systems they could.

In the early days of ADA paratransit eligibility, many systems made the mistake of focusing most of their effort on paratransit operations, while using a paper, by-mail, application to determine eligibility. Not surprisingly, many of these approaches ended up being more systems to “register” passengers, rather than true assessments of eligibility, based on need. The US DOT’s regulations of ADA paratransit eligibility are very specific and clearly state:

*49 CFR, Part 37.125 (a) The process shall strictly limit ADA paratransit eligibility to individuals specified in §37.123 of this part.*

In other words, the eligibility process shall ensure that passengers using ADA paratransit actually need it, based on the eligibility criteria delineated in part 37.123 of the regulations. Access was determined to avoid the mistake of signing people up without truly assessing their mobility needs, and chose to contract for the development of the best in-person process that it could find. This was a good approach at the time and established Access as an early leader in the industry.

While the contractors working for Access have developed what seem to be competent processes, the fully contracted nature of their models created an unintended problem; their procedures are owned by the contractors and are therefore fully (and understandably) proprietary. This created a particular problem for Delta when executing a project like the current assessment. To do a true assessment of the performance of a process, one must understand what is supposed to be happening in the process, and then examine how the intended process is actually being executed. For the financial aspects of this type of review, Delta would similarly want to look at not just what is

being spent on the process, we would also want to understand where and how this money is being spent. Unfortunately, we were limited in our ability to do this. The details of the contractors' finances and the details behind many of their decision making processes were said to be proprietary and we were only provided with a summary of much of this data. We have done what we could with what we were able to access, but in many cases, the limitations of our conclusions will be clear.

### **3.1. Applying for Eligibility**

3.2. The Current Process: Any person wishing to use Access paratransit in the greater Los Angeles area must first apply for this service. Passengers can do this, totally free of charge, by contacting Access, obtaining a registration number and then making an appointment for an application interview. The interview involves a discussion of the applicant's mobility needs and may also involve physical testing (asking the applicant to walk through a streetscape and several physical and cognitive tasks) if the interview deems these tests to be necessary. Passengers may get a free ride to their interview or they may use their own means of transportation to and from the eligibility assessment site. All of this can be arranged fairly easily with two phone calls, and there is no cost to the applicant for any of these services. Applicants can generally get an appointment for an eligibility interview within a week to ten days of calling, and the entire process of traveling in for the interview and going back home takes about half of a day. Once the interview is complete, the contractor makes a decision and the passenger is notified of the outcome within 21 days.

3.2.1. CARE Downtown: More than 90% of all applications are taken by CARE at their downtown LA office. This impressive facility is located in a light industrial area, within a large warehouse that has been converted to its current purpose. Within the facility, there is a large simulated streetscape that includes sidewalks of different types, curbs, traffic signals, ramps, signs and transit buses. Although there are several full-size transit buses and vans within the building, only one is used as part of the eligibility screening process. As applicants arrive at the facility, they are checked in and their identity is verified by a Transit Mobility Specialist (TMS), while a photo of them is taken for an ID card. This initial process is actually a covert screening and sorting process to evaluate a person's mobility and to estimate how extensive an assessment they will need.



Entrance to the CARE assessment facility in downtown LA.

Applicants then move on to the full evaluation, made by a trained Transit Evaluator (TE). We were told that TMS is normally the first step for a person to become a TE, giving them several weeks to learn the process at the front end before conducting full evaluations.

The TE's work in cubicles, lined across the rear wall of the facility. Applicants are asked to proceed to these cubicles and are watched by the evaluators as they do this. Once in the cubicle, the TE works through a series of questions, prompted by a software program that allows TE's to record responses that are given. The TE normally starts by asking for medical information and asks to see medications, followed by some questions about the applicant's mobility and their past use of public transit. At the end of this interview, the TE will decide if the applicant needs to take the "transit walk," as it is called by CARE. This decision depends entirely on the observations of the applicant by the TMS during initial intake and by the TE during the interview. If a transit walk is needed, the applicant will be asked to walk/roll through the artificial streetscape, including the steps of getting on and off a static transit bus with a ramp extended. The TE may ask the applicant to execute the full course up to 4 times, depending on his/her performance. The applicant's performance executing the transit walk is observed and timed. Applicants repeatedly have their blood oxygen measured at different points during the walk and the walk includes instances where applicants are given modest strings of specific instructions to measure their cognitive abilities and to see if their performance and mental acuity remains constant throughout the test.

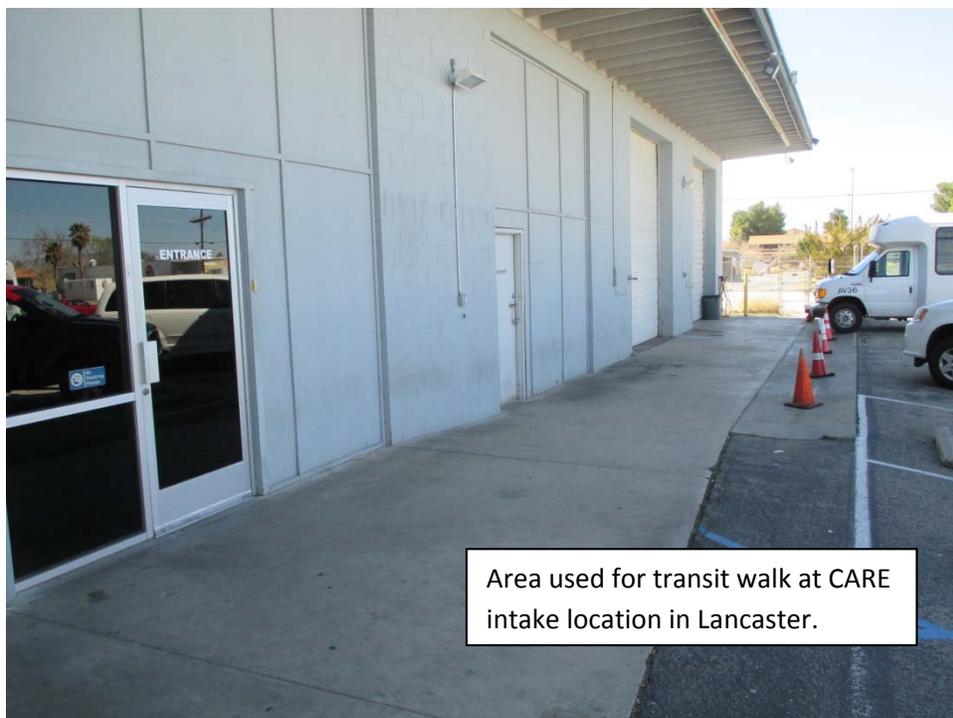


After the transit walk is completed (or after the interview for applicants who do not perform the transit walk), the applicant is escorted to the front of the building, where they receive an orientation concerning the Access program, its basic rules and a vehicle safety orientation. When this is complete, the applicant is transported home.

After the interview and transit walk, the TE returns to their cubicle, adds notes to the computer record and usually makes the eligibility decision at that moment. Applicants are never told their decision during the interview.

3.2.2. CARE Lancaster: Because of a sustained demand for Access applications from the Lancaster/Palmdale area, CARE was asked to open a small satellite facility in Lancaster. This facility was reported to use the “same procedure” as that used at the downtown facility, and normally has 1-2 TE’s to conduct interviews.

The first part of the process is mostly the same as that used downtown, with an initial intake, followed by an interview with the TE. The TE uses the same interview process and the same computer system to guide the interview and record the applicant’s responses. If the TE feels that a transit walk is needed, the applicant is asked to follow the TE as they make several laps around the building. Below is a photo of part of the area where applicants walk.

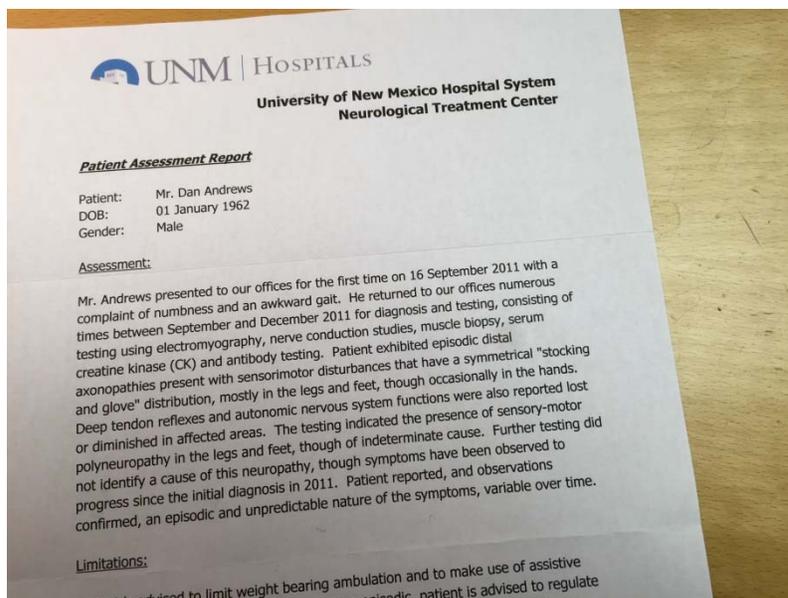


The path of travel for this transit walk contains some moderately uneven surfaces and a small step in and out of the building, but it is nothing like the course downtown. There are no crossing signals, there is no bus entrance and there are no ramps or steps to climb. The TE does duplicate a task of asking applicants to count and manipulate a series of different coins, but there is no fare box to drop them into in Lancaster.

3.3. Posing as an Applicant: As a first step in evaluating this process, our principal investigator used a false name, false medical documentation and a false address to apply for Access himself. He reported that he had recently moved from Albuquerque, NM and used a completely fictitious “ABQ Ride” paratransit identification card as his only form of identification. Delta designed this card following only our imagination, and using graphics clipped from the ABQ ride and City of Albuquerque web sites. This card was not designed to be a true copy of the real ABQ Ride ID; it was a unique fabrication. In addition to false identification, Delta also fabricated a letter from the University of New Mexico Hospital. The letter, from a fictitious department at the hospital, contained a description of a neurological condition found in Wikipedia and was written almost entirely by cutting and pasting excerpts from the website. The letter contained made-up diagnostic codes and other diagnostic information. It was printed on similarly fictitious letterhead that contained an intentionally incorrect telephone number, so it would not be possible to contact UNMH for verification.



False identification card and medical verification letter used by Delta for our first-hand assessment of the Access eligibility process.



Delta was able to easily use this false identity and medical report, along with a street address located near our LA hotel (found using Google Street View), to obtain an Access ID number, schedule an appointment and experience the entire interview process, including transportation. Though Access was aware of this ruse, CARE was not advised that we would be doing this. Our investigator played the role of this fictitious person throughout the process and went through all of the physical screening required by CARE. During the test, our investigator exhibited difficulty walking, though he did not use any type of mobility or assistive device. He also used his knowledge of ADA paratransit eligibility to be sure to “say and do the right things” to gain eligibility, so long as he was taken at his word. This first hand assessment of the process was completed on February 23, 2015.

The following were our key observations from this first hand assessment:

- We were picked up at 9:23 AM (20 minutes early) and arrived for our assessment at 9:55.
- The bus taking us to the interview was clean and in very good condition.
- There were two others on the bus when it arrived and one additional person was picked up along the way.
- The bus driver was very polite and friendly and seemed to be skilled at his job.
- During the ride, the bus driver talked at length about the Access program and how great it was. This conversation went so far as to almost coach applicants on what to say to become eligible. He also spoke about the fact that the Access ID allows people to ride for free on all buses and remarked that most people applying now were doing so for the free bus pass.

- When we arrived for the assessment, we were initially questioned about other forms of ID besides the ABQ Ride ID card. When we replied that we had none, a supervisor was consulted and we were allowed to continue.
- When we went for the interview, we were not asked for our Access application.
- During the interview, we showed the false medical letter to the interviewer and told her she could keep it. She said she didn't need it and returned it to us after reading it over quickly.
- We were asked to walk through the evaluation course and made two laps. During the second lap, our applicant increased the difficulty of his gait and the interviewer concluded the assessment.
- After the interview, we were supposed to have received an Access orientation briefing, but the person who was to do this did not, and instead escorted our applicant to the waiting area for transport home<sup>1</sup>.
- We waited from 12:00 to 1:13 for a bus home.

Following our application, we were found the next day to be eligible for Access in instances where long ambulation would be required. Our medical information was obviously never verified (as it was not collected and copied).

3.3.1 Items of Concern: We did not find it surprising that we were able to successfully complete the application interview but we were concerned about a number of other items we observed:

- The driver should not be coaching applicants on how to attain eligibility.
- No effort was made to verify our identity, even though we used a completely false ID card that could have been easily checked with the system that supposedly issued it.
- No effort was made to collect or verify our medical information, which was the basis of our application.

3.4 Observations of Interviews: Following our first-person application, we met with personnel from CARE and observed actual application interviews at the downtown and Lancaster CARE facilities. Overall, we observed 19 applicant interviews conducted by 8 different staff members and interviewed 6 different supervisors at all facilities. Our protocol for these observations was to identify ourselves as an Access contractor, to explain that we were evaluating the eligibility process and then ask the applicants if we could observe their interview. Every applicant gave us permission to observe. During the interviews, we sat off to the side and took notes but did not ask questions or participate in any way in the interview or evaluation process. Our efforts were entirely passive.

Based solely on our observations, we noted the following items worth mention:

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<sup>1</sup> On 24 February, we met with officials at CARE and informed them of our covert application and the failure of the employee to provide us with an Access overview briefing. We were later informed that this employee, who was a supervisor, was subsequently terminated.

### 3.4.1 CARE Downtown:

- Very few applicants bring in completed applications and many are not prepared for the interviews. CARE's TE's said this was not important and that they didn't really use the applications.
- The procedure for receipt and handling of medical documentation was not consistent among TE's. Some TE's made copies of multiple documents while others hardly glanced at volumes of information that applicants brought in for their interview and kept no copies of anything.
- Though it was reported that information from bus drivers (from the trip to the assessment) was sometimes used in the process, this was never observed and there was no reported process for such a thing to occur. Most likely, if it did occur, it was anecdotally in an exceptional situation where a driver suspected fraud, but driver was not observed to be a routine part of the process.
- Interviews always started with a discussion of the applicants' medical conditions and medications. This was often an extensive discussion, constituting the vast majority of the interview. In several instances, the interview concluded after this part of the conversation, before mobility had been discussed to any substantive measure.
- Current mobility and use of transit was discussed to varying degrees with applicants and often varied significantly between different TE's. Some hardly spoke about it, while others always talked about it.
- Some TE's asked about applicants using Metro buses and wrote down the MTA trip planning phone number on a scrap of paper and gave it to the applicants. There did not seem to be any printed reference materials available to provide applicants about MTA or other regional fixed route bus services.
- We observed TE's driving the conversation and, at times, almost suggesting answers by their questions, rather than asking truly open ended questions and allowing applicants to articulate their needs. This was particularly true concerning passengers who reported that they were frequently and currently using Metro or other fixed route transportation. TE's rarely engaged applicants in a conversation about *why* they felt they *needed* Access if they were currently and regularly riding the fixed route bus.
- One of the criteria that was often discussed with applicants was whether or not a person had ever fallen and, if so, when and how often. TE's then used this information speculatively in their decision making, often granting eligibility if they felt a person might have a chance of falling.
- In all cases we observed, the TE's made their decision by the end of the interview. Of the application interviews we observed downtown, all applicants were approved for eligibility, either unconditionally or conditionally.

After the interviews, we discussed the decision making process with TE's and other managers. There was consensus that it was rare for anyone to delay making a decision at the conclusion of the

interview. There was no routine checking of passenger reported medical information, even though it formed the basis of most decisions.

CARE's current maximum daily capacity was reported to be 270 applications per day at the downtown facility. Managers reported that they set goals of 14-17 applications per day by the TE's, which works out to about 2 applications an hour. We discussed this with TE's and they were aware of these goals, but did not seem to be reporting any problems or pressure applied if they did not meet these goals because of unusual numbers of applicants requiring transit walks. From our observations, we saw interviews that were as short as 12 minutes and as long as 47 minutes, so this would seem to be a reasonable average figure.

3.4.1.1 Items of Concern: Following this assessment, we noted the following items of concern concerning interviews at the downtown CARE facility:

- Procedures concerning applications and medical documentation were inconsistent.
- Interviews were very heavily weighted toward medications and medical history and not on mobility.
- No effort is made to independently verify verbal information provided by applicants before decisions are made.
- High quality information concerning accessible fixed route options is not provided to applicants who would benefit from such information.

3.4.2 Care Lancaster: In Lancaster, we only observed a single TE evaluating 4 different applicants, so our sample is quite small and we were unable to compare how she did things, compared with others at that facility. Her approach to the interview was substantially similar to that used downtown. The differences became clear when passengers were asked to do the transit walk. We observed the following:

- There is no transit bus mock-up to test an applicant's ability to board a bus or fit into a securement area.
- There are no pedestrian ramps.
- There are no steps that simulate stepping up into a transit bus.
- There is no street crossing.
- There are no varied types of walking surfaces apart from concrete and blacktop.

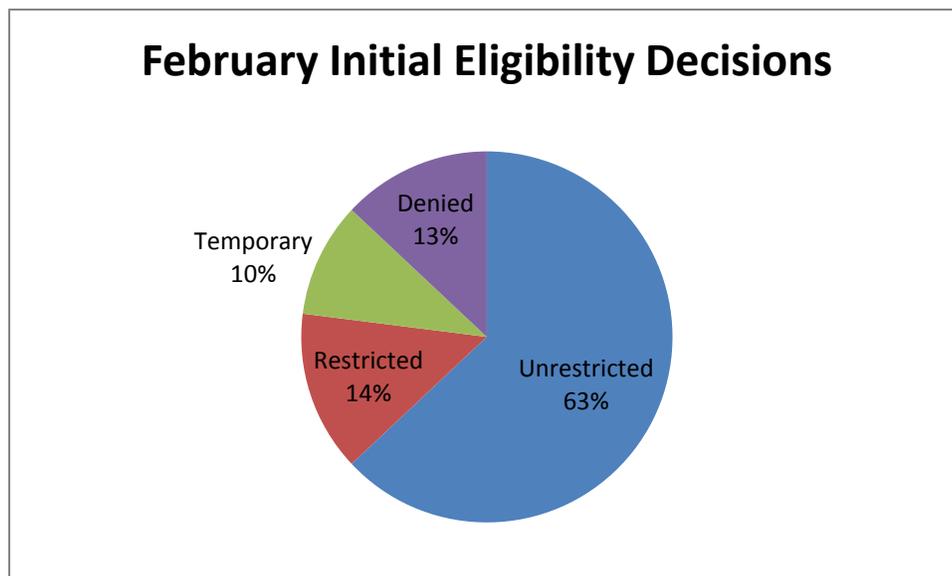
3.4.2.1 Items of Concern:

- In general, though the intake interview is similar to that performed downtown, the Lancaster transit walk is fundamentally different from that used at the main facility, so much so that the results may not be comparable.
- There is no way in Lancaster to let a person using a wheeled mobility device to test getting on a transit coach.

### 3.5 Outcome Decisions

3.5.1 Normally, as part of our assessment of an eligibility process, we would use the agency's decision making criteria to evaluate whether decisions were being made according to these guidelines. Unfortunately, this is an area where we were not granted access to the detailed CARE decision making guidelines. While we discussed this with management at several meetings, we were only given general verbal responses. CARE indicated that there existed more detailed written guidance covering this area, but this was something that could not be shared outside of the company, because it was proprietary. While this is understandable, it unfortunately makes any qualitative evaluation of the CARE decisions impossible.

3.5.2 Although we could not evaluate the actual quality of the decisions, we were able to get data concerning the decisions made by all of the TE's for a February 2015. This information indicated that the overall distribution of application decisions for new applicants was as follows:



This distribution of outcomes does not appear to be unusual, based on our experience with other transit systems around the country.

#### 3.5.3 Items of Concern:

- We were unable to evaluate CARE's decision making criteria for eligibility and therefore cannot substantively comment on the appropriateness of the eligibility decisions being made.
- Because of the differences in the eligibility process and transit walk experience at the two assessment centers, it is possible that applicants are receiving different outcome decisions based on where they apply. This is a question that deserves further investigation.

#### 4. Staffing and Training

4.1. For this analysis, we examined how CARE recruited and trained staff, what their staffing levels were and how they intended to grow to meet future growth.

##### 4.2. Current Staffing

4.2.1. Care reported a maximum daily capacity of 270 applications. We requested specific information regarding current staffing and were told that there are currently 24 TE's on the payroll. According to CARE's stated daily goals, these 24 personnel could be expected to complete an theoretical maximum of 408 interviews in a day, if all were working and all achieved their goal of 17 interviews in a day. More realistically, some of these people would not be working and not everyone would be able to reach the daily goal of 17 completed applications. Though CARE did not provide any detail concerning the derivation of their stated maximum daily capacity of 270, it must be based on some logic of presumed absenteeism and more realistic performance. For example, normal absenteeism might be 10%, and additional staff may also be on vacation or be scheduled off, making it reasonable to assume that only 20 TE's might be working on any given day. If each of these achieved an average of 14 applications in a day, this would yield a realistic daily figure of 280, which is close to CARE's stated maximum of 270. This does not seem unreasonable. All other staffing is presumed to be, and appears to be, proportionate to the staffing of TE's and the daily throughput of applications, but we did not receive any information regarding this and so cannot evaluate it.

##### 4.3. Training

4.3.1. We interviewed staff at CARE to determine how TE and other interview staff are trained to make eligibility decisions. Here again, though we received general information concerning the types of things covered and the general duration of training, we were not provided with any detailed training materials, schedules of candidate evaluation materials, so it is impossible for us to provide a qualitative evaluation of the process. In general terms, we were told that the recruitment and training process looks like this:

Week	CARE Training Activity
One	Place advertisement, receive applications
Two	Screen candidates, interview, select
Three	Begin training: <ul style="list-style-type: none"> <li>➤ Company overview</li> <li>➤ Eligibility overview</li> <li>➤ Training videos on HR topics, people with disabilities, customer service</li> <li>➤ Computer system training</li> <li>➤ Observe interviews conducted by trainer, discuss</li> </ul>

Week	CARE Training Activity
	<ul style="list-style-type: none"> <li>➤ Trainer interviews and trainee types answers into computer</li> <li>➤ Conduct first direct interview</li> </ul>
Four	Begin independent interviews of easier clients, trainer observing and feedback
Five	Independently interviewing applicants, with spot checking
Six	Trainee given more difficult clients, observed and given feedback
Seven	Additional harder clients, receive feedback from Quality Assurance department
Eight	Most trainees begin mainstream work and are gradually given more difficult clients over time.

We talked with CARE about how trainees are evaluated and what kinds of records are kept to show that trainees have learned what is necessary and that they are performing in a manner that warrants their working independently. The instructor indicated that this burden rests mainly with her and her judgement. She reported that they kept notes on trainee performance and reported that these were placed in the employee's file (whether employee or training file was not clear). The trainer came across as a capable and conscientious employee. However, placing so much faith in the judgment of one key employee is not a recommended business practice, particularly in the area of employee training and performance relating to the primary task of the contract.

4.3.2. We also talked with CARE about what sort of person they are looking for as a TE. They indicated that they were trying to hire applicants with a 4 year degree in Psychology or related allied health field, and also wanted people with some experience in a clinical setting. This would seem to be appropriate, but we had questions about the ability of a person with that type of background to review and interpret various medical reports and to understand and evaluate the meaning of the numerous medications that applicants reported taking. We highlight the medications particularly because many TE's seemed to place great weight in the inferences they were able to gain by a discussion of the meds an applicant reported taking.

#### 4.4. Future Staffing

4.4.1. Under their contract with Access, CARE is responsible for meeting demand for eligibility assessment appointments. As such, it is incumbent upon CARE to use historical data and current trends to project demand for applications, and to then plan staffing accordingly. Though we discussed this at length with CARE management, they did not have any such formal projections. For some time, CARE has been concerned about the performance of the transportation contractor in terms of them delivering the right number of people at the right time for the available appointment slots available. We will address this issue separately later in this report, but from CARE's perspective, this confusion over applicant transport has led them to have a muddled view of the true trends in applicant growth. While we acknowledge and agree that the transport coordination issues have painted a

somewhat confusing picture of growth, it does not seem reasonable that CARE would therefore simply not develop a growth forecast and accompanying staffing plan. CARE should do its best to come up with its best estimate of how eligibility is going to grow, and should then develop a recruitment and training plan to meet this growth projection. By its own indication, CARE has reported that it generally takes about 8 weeks from when they know they need another TE to when they would have such a person in place and functioning even moderately competently. Such a long training pipeline requires planning and forethought if CARE expects to be able to meet future growth in the demand for application interviews.

#### 4.5. Areas of Concern:

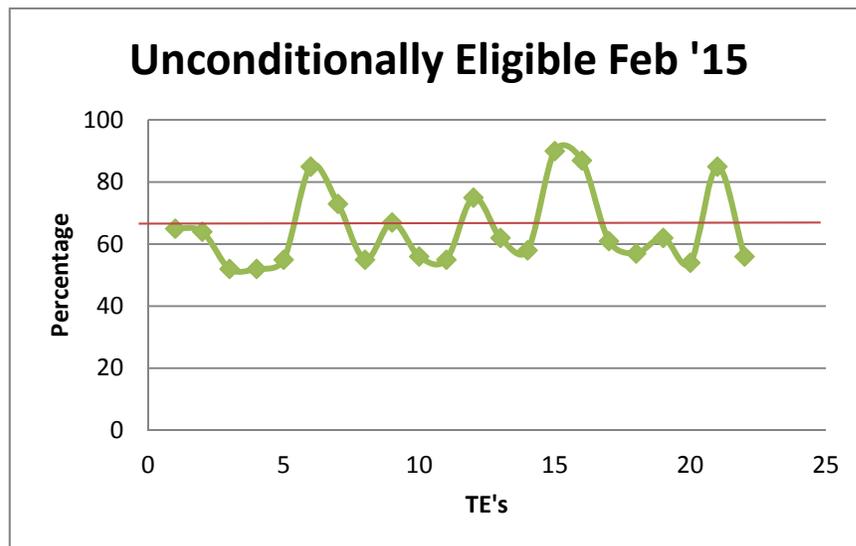
- It is impossible for us to evaluate the CARE employee training process because we were not permitted access to proprietary training materials and performance records used in this process.
- We have general concerns that the training process outlined verbally for Delta had no more than 1-1.5 days dedicated to providing trainees with the technical information needed to perform this job. This would seem to be a rather short period of time to cover so much material.
- We have concerns that the type of candidates currently being sought by CARE as TE's may not have the professional training and experience to evaluate and understand the medical documentation and the medication information that is collected from applicants and that seems to form the basis of most eligibility decisions.
- We are concerned that CARE does not have at least a working projection of the growth in eligibility applications, and accompanying recruitment and staffing plan, beyond some very informal estimates we were provided. Such information is essential to guide their decisions of when they need to add employees and how many they need to add to meet the growth in eligibility demand.

## 5. Quality Assurance

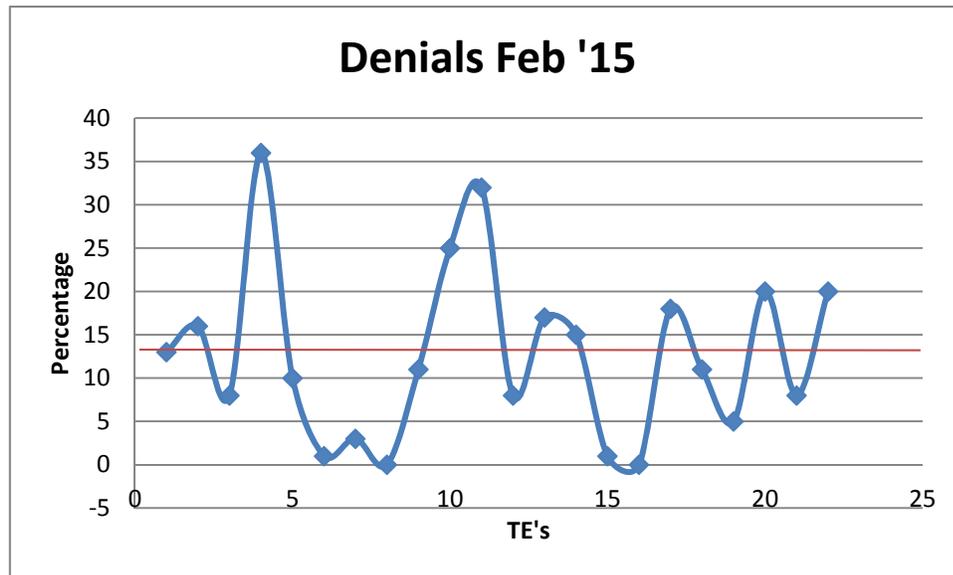
5.1. One of the tasks reportedly performed by CARE is a quasi-independent Quality Assurance (QA) review of all decisions rendered by the TE's. This review consists of a page by page review of each decision, completed by one of three to five staff members, depending on volume. Here again, though we asked for formal written criteria used in this review, we were not provided with any because of the proprietary nature of the process and the materials being reviewed. In general terms however, it was reported that the QA team looked for both qualitative errors (decisions that the QA team just did not agree with) and quantitative errors (missing information, spelling errors, misplaced information, etc.) relating to the decision. We were permitted to glance at reports of QA reviews and paperwork related to reviews that were currently in progress, and it was clear that this was a substantial process that was undoubtedly catching errors and improving the quality of the records (the quantitative review). However,

we cannot say if the QA process is having any meaningful impact on the quality of the decisions being made by the TE's (the qualitative review), since we had no access to the decision making criteria nor were we able to review any substantial documentation relating to the QA process or its detailed findings. We asked about any systematic reporting and tracking of employee performance that was created by the QA unit, based on their history of evaluating various staff. We were told that no such reports existed and that feedback was provided to staff members on an informal, as-needed basis.

5.2. As an area of specific interest, we asked if any analysis had ever been done concerning the consistency of evaluations among and between TE's. CARE responded that they did not systematically conduct such analyses but did so informally, especially with new TE's. Because of this response, Delta conducted our own modest evaluation of TE decision making. Using data from February 2015, we charted the four eligibility decision types made by each of the TE's and compared them to the averages for those decision types. If CARE's employees had all been trained well and all were making decisions in the same way, one would expect that the various TE's would have a distribution of decisions that were similar to the average. We did not find this to be the case. In the case of the largest type of outcomes, Unrestricted Eligibility, the monthly average for new applicants was 65%. In other words, 65% of all new applicants were found to warrant unrestricted eligibility for Access. When we looked at how each of the TE's was making decisions for unrestricted eligibility, we found that decision groupings varied considerably. The scatter plot graph below indicates the eligibility decision for each TE in February (the red line is the 65% monthly average).



Four TE's granted Unconditional Eligibility to more than 85% of their applicants, while 8 others were granting unconditional eligibility in the 50% range. When we looked at decisions of outright denials of eligibility, the distribution away from the average was even more pronounced, as indicated in the graph below (red line indicates the monthly average).



Five of the TE's reported 0-5% denials, while three others denied more than 25% of applicants. Without addressing the question of what the "right" number of denials and unconditionally eligible decisions there ought to have been, we should see that the process is delivering consistent results no matter who is doing the interview. This simple analysis raises questions about how consistent decision making by TE's really is. When considering this issue, one must keep in mind that we only looked at a small cross section of data and we acknowledge that CARE routinely sends different applicants of different types and complexity to specific people for review. This, alone, could account for some of the variance between evaluators. However, without more information, we cannot evaluate this further. We can, however, note that this type of comparative analysis should be done by CARE on a routine basis, particularly because the data for such an analysis is readily available and the analysis is easy to conduct.

### 5.3. Areas of Concern:

- We were unable to evaluate the precise nature and standards used by CARE in their QA reviews because of the proprietary nature of their process.
- We are concerned that no comparative review of TE decision making is routinely conducted to ensure consistency of decisions among and between TE's.

## 6. Appeals

6.1. During this assessment, Delta observed two appeals of eligibility denials. One appeal was conducted by Lemus Medical and the other was conducted at the Olympic Medical Center. This was a very cursory review of the appeals process, but provided a look into the approach and process for the appeals, which we will discuss below.

- 6.2. Access uses a network of appeals specialists that are scattered around the region geographically and specialize in different disability subject areas. Transport is provided to and from appeals by Access, at no charge to applicants. We did not find any problems with timeliness of the scheduling or completion of appeals.
- 6.3. The appeals themselves include a full review of the applicant's record, with an additional exploration of the applicant's reasons for appeal and additional diagnostic tests, where necessary. Appellants have the opportunity to say anything and to bring anything they wish to the appeal. Depending on the extent of the appeal, they can take from 30 to 90 minutes. The appeal officer does not inform the applicant of the results of the appeal, this is done later, in writing, by Access.
- 6.4. Areas of Concern: We had no areas of concern with regard to appeals.

## 7. Transportation to Assessments

- 7.1. One of the areas we spent particular time examining was applicant transport to and from the downtown CARE assessment site. This function had previously been the responsibility of CARE, but it was moved to a subcontractor (one of Access's current providers, San Gabriel Transportation or SGT) in April 2014 to bring a more transportation-focused approach to the scheduling and management of trips. Since then, CARE has asserted that both the volume and the timing of trips to their downtown assessment center have not met their needs, leaving staff either under-utilized or bringing in more applicants than CARE could handle at various times of the day. Furthermore, CARE has stated that, by losing visibility of calls for information about Access eligibility and the scheduling of trips, they have lost a valuable source of information regarding the trending demand for eligibility. We will examine these two issues below.

### 7.2. Trip scheduling

- 7.2.1. The task of scheduling trips for eligibility appointments is one that appears to be straightforward yet has historically been difficult. The base of this scheduling effort is a combination of the demand of applications and the theoretical throughput capacity of CARE on any given day. CARE determines their capacity on an almost daily basis, based on personnel available to conduct interviews. Once they know how many time slots to fill at different times of the day, trips can then be scheduled for people to come in for interviews, based on demand. A further complication is that certification trips have traditionally had an extremely high and volatile rate of no-shows, sometimes as high as 40%. Since there are absolutely no consequences for passengers cancelling or no-showing for eligibility trips, applicants appear to pay little regard to missing trips. Of course, with

such a dynamic and high rate of no-shows, schedules are often intentionally overbooked during periods of high demand to ensure that certification slots are not left unused. As one can imagine, the precise level of over-booking of trips can be difficult to manage. Though rates of past cancellations are the primary guide, there could be times when there were still too many or too few passengers scheduled.

7.2.2. A recent study commissioned by Access provided additional insight regarding customer attitudes toward the area of eligibility transportation. The study, conducted by The Fairfax Research Group and released in March 2015, examined all manner of questions about customers' certification trips. Among some of the more interesting and illuminating statistics from this research included:

- About 1/3 of applicants (31%) reported that they never received the information packet that explained the Access application (and transportation) procedures;
- 38% of passengers were unhappy with their certification trip time;
- One quarter of applicants (25%) did not recall getting a phone call confirming their appointment;
- About half of applicants (47% reported actually confirming their appointments;
- After scheduling their appointments, almost half of applicants (49%) reported that they needed to cancel or reschedule it;
- About two in ten applicants (22%) admitted that they never called to cancel their appointment and were no-shows.
- Only one quarter of applicants actually called to cancel their appointments; and,
- Only 10% of applicants admitted that they successfully called, spoke with a person, and cancelled their appointment.

One must be mindful that this was a survey of applicant's *perceptions and memories*, not of objective facts, but the responses clearly indicate that the process of sending out information, and passengers then scheduling and confirming rides is not working well, which correlates directly with the data on actual cancellation and no show rates with this service.

7.2.3. The task of matching transportation schedules to available interviewers was difficult when CARE was directly managing it and it has remained difficult since being moved to a third party (SGT). A review of records comparing CARE's maximum theoretically available booking slots, compared against records of passengers actually transported in for interviews, indicates a consistent lagging of actual applicants transported. Of course, actual demand for interviews often does not call for the maximum available interview slots, but between October 2014 and March 2015, it appeared that CARE's staff was under-utilized about 7% of the time on average, but there did seem to be times when 1/4 of CARE's reported available capacity was not being used. It is important to emphasize

that the data on utilization did not clearly indicate if it was demand for interviews of transportation scheduling that were the cause of leaving CARE staff idle, but it was surely a combination of a lack of applicants to fill the available slots, combined with the established high rates of cancellations the evening before and no-shows the day of the trips. This variance should be cause for concern and deserves further scrutiny and attention.

7.2.4. An issue related to the overall numbers of applicants scheduled in for interviews is the distribution of those applicants during the day. CARE has reported that applicants have been delivered in morning and afternoon clusters and must wait, in some cases, 2-3 hours for their interviews. During our multiple visits to the CARE facility, we observed this phenomenon, with groups of applicants delivered first thing in the morning by a number of buses that all arrived at roughly the same time. We subsequently visited the offices of SGT to discuss how eligibility trips were managed and scheduled. During this visit, the contractor acknowledged that they were trying to group trips to achieve economies of scheduling that could be gained by maximizing the shared-ride capacity of their fleet, rather than making a lot of expensive, individual trips. This management of the trip workload was understandable, based on the per-hour reimbursement provided to the contractor. Transportation has become as significant a cost for eligibility as the cost of the assessment itself, so such attention to economical scheduling makes sense. However, these efforts to gain efficiency should be weighed against the negative effects of applicants being faced with long waits at the CARE facility, which has been a source of complaints by applicants. CARE also noted that their facility is not designed or equipped to accommodate passengers waiting for hours before and after their assessments. The timing and distribution of trips during the day was clearly seen as an issue and needs further attention.

### 7.3. Growth Trend Data

7.3.1. A final point raised during our assessment was the loss of visibility of passenger application rates experienced by CARE when trip scheduling was removed from their tasking. Prior to October 2014, CARE managed a call center that received all calls for information and to sign up for Access. This reportedly gave them a source of data concerning fluctuations in demand that they were able to use to plan for changes in volume. This visibility was lost in October 2014 when the call center and transportation tasks were given to SGT. In the interval between October 2014 and March 2015, CARE had only limited information regarding call activity. This complaint from CARE was valid, as they pointed out that the number of inquiry calls as well as actual appointment calls helped them to project demand, as inquiry call volume was a good foreshadowing of appointment calls that would likely follow a week or two later. Not having this information meant that their guess of future demand was consistently lagging. Since the end of February 2015, Access has worked with SGT and CARE to better share data

concerning the numbers of all types of calls. This seems to have improved CARE's ability to forecast demand and this problem should be solved if this data sharing can continue.

#### 7.4. Items of Concern:

- The extraordinary rates of cancellations and no-shows is making scheduling and planning for assessments very difficult and is wasting resources.
- Passenger reports of not receiving application packets and subsequent problems with the scheduling, confirmation and attempted cancellation of trips indicates a significant problem with these processes.
- The scheduling of trips without regard to the per-hour throughput capacity of CARE is resulting in applicants waiting a long time before and after the process, but the cost savings in transportation may make this practice worthwhile.
- CARE needs access to all types of data concerning inquiries and trip scheduling to enable them to forecast application rates and plan to meet capacity.

### 8. Peer Research

8.1. At the start of this project, we identified several peer systems that we would compare to Access's eligibility process. Our initial list of systems contacted included the following:

- New York City Transit
- New Jersey Transit (the entire state of NJ)
- Washington Metro (greater Washington DC)
- The Massachusetts Bay Transit Authority (Boston area)
- The Southeastern Pennsylvania Transportation Authority (Philadelphia area)
- Dallas Area Regional Transit
- The Regional Transit Authority (ADA eligibility for Chicagoland)
- The San Francisco Municipal Transportation Authority
- Seattle Metro

When we contacted these systems, most were willing to participate in the study but several made a similar, specific request. In a number of cases, these systems were in the midst of their own eligibility reviews and some of their procedures were being evaluated and changed. Because some aspects of their operations and costs were current points in discussion with some of their own local stakeholders, as a condition of their participation, they asked that their information not be specifically identified. As a solution to this dilemma, we agreed to amalgamate the responses and not attribute any specific fact or service/cost aspect back to any individual authority. For this reason, our results below will be provided in terms of the numbers of systems doing a particular thing or a range of costs etc. We will not identify which particular system has a particular policy or cost.

8.2. Of the 9 systems contacted, 7 agreed to participate in this project and provided some or all of the information we requested. Below are the relevant responses:

8.2.1. Type of Application: All systems require passengers to complete a fairly lengthy application as a first step for eligibility. Applications ranged from 3 to 14 pages, with most being 4-6. None of the systems surveyed permitted passengers to apply without a completed application, except for rare circumstances where an applicant's disability prevented them from being able to complete it.

8.2.1.1. Several systems had a process of sending out information explaining the rules of the system as a first step. If, after receiving and reading this information, applicants still wished to apply, there were instructions in these packets explaining how to do so. This was seen as helping applicants avoid applying for the service if they would not qualify or were no longer interested.

8.2.2. Assessment: All but one system required in-person assessment for most, if not all, of their applicants, most systems required in person assessment for all applicants. Two systems conducted some type of phone interview, in lieu of bringing some applicants for an in-person review. All systems requiring an in-person interview provided transportation.

8.2.3. Functional vs. Medical: All applications focused on questions about transit use and mobility first, with medical information asked later in the process. About half of the systems contacted medical professionals for verification of medical information and did not consider the application to be complete (and ready for review) until this was accomplished. For a few systems, if an application never had the medical verification finished, then it was not considered complete and was not processed by the agency.

8.2.4. Ownership: No systems used an application process that was developed and owned by a third party, though many used contractors to help execute the process.

8.2.5. Denial Rates: Outright denial rates ranged from 1 to 17%, with most systems denying 5%-7% of applicants. The distribution of unrestricted and restricted applications was approximately the same as Access. Some systems did not count temporary eligibility separately so we could not compare those statistics.

8.2.6. Appeals: There was no consensus with the rate of appeals or the tendency of the initial decision to be affirmed or overturned. Some systems affirmed most initial decisions, while many overturned 2/3 of their initial decisions. Some systems also used appeal boards, while others used a single individual. There was considerable variability concerning appeals.

8.2.7. Costs: Per application costs ranged from \$190.00 to \$50.00 per application, not inclusive of transportation. Even with our assurance that their data would be kept confidential, several systems refused to provide a per-application cost in their responses, which suggests that these systems were on the expensive side. These costs compared very favorably with Access's cost of about \$29 per application.

8.2.8. Growth: The majority of systems reported flat growth and even decreases in application rates. Only two systems reported an increasing rate of applications.

8.2.9. Recertification: Every system had some type of abbreviated process to handle some of their recertifications. These ranged from a simple re-verification of existing information through mail or by phone, to the completion of an abbreviated application through the mail. No system required everyone to come in for re-certifications.

## 9. Financial Analysis

9.1. By far, the most difficult task of this project has been our efforts to conduct a robust financial analysis of CARE's operation. Because their model is entirely proprietary, and all of their staffing, salaries, scheduling and other business aspects of their service are not available for scrutiny, we were simply not able to conduct these analyses. However, looking at basic bottom line figures, we were able to gain some insights, when looking at Access' costs compared to systems we identified as peers for this project.

9.2. At a fundamental level, Access's per-unit cost for assessments is reasonable. Though Access's costs have varied at different times during the history of CARE's tenure, the costs have generally stayed below \$30.00 per assessment. With the exception of the paper-only system we contacted, this puts the Access program as the least expensive in the group.

9.3. Having said this, one must be very careful when costs are compared and considered. All of the reported costs provided by other systems are doubtless calculated in a way to look as favorable as is reasonable. None of the reported costs involved transportation (as is the same with Access's costs) and it did not appear that any of them included other staff overhead (in cases where a contractor did the assessment and the agency administered the program). It also appeared that capital and other costs (such as computer systems) were not included in many estimates, though no system was entirely forthcoming in the details of what was included in their costs.

9.4. An item we observed that may be having a financial impact on eligibility is the free bus fare feature of the Access ID Card. During our assessment, we often heard applicants talking about getting the free bus fare as a reason for applying for access. These were folks with disabilities

who might be able to ride fixed route or paratransit. According to staff and applicants, the free bus pass was a very popular option and was clearly a driving factor to apply for some. Based on this feedback, we sought to investigate the free bus pass further.

- 9.5. In the abstract, the idea of eligible Access riders taking fixed route instead of paratransit is a clear winner. Bus fares generally cover less than half of the actual cost of a bus ride, meaning that each fixed route ride given to passengers with disabilities for free only costs the fixed route operators a few dollars in lost revenue. Much of these losses can even be offset by reimbursements from the federal government through reduced fare programs that are actually subsidized by the US DoT. In the end, the losses experienced by the fixed route provider ought to be relatively small, if the fixed route operators are taking full advantage of what is available.
- 9.6. In many cities, fixed route transit operators, support and sponsor programs that move people from paratransit to fixed route. They do this not just because mainstream services are the goal of the ADA, the fixed route transit agencies are legally obliged to provide and pay for all ADA paratransit, so any net cost savings of moving folks to the bus from paratransit benefit them. During our study, we learned that some of the smaller fixed route transit providers in the LA service area were asking Access to reimburse them for paratransit passengers riding fixed route. Such requests seemed to make no economic sense, since it is the fixed route providers that are legally obligated to pay the majority of the cost of providing Access. A required payment by Access back to fixed route providers would lead to Access' costs going up, which would likely result in those very providers being required to increase their subsidy of Access. Furthermore, making Access pay fixed route providers every time a paratransit rider took fixed route would create a disincentive to Access to make this happen. Such a thing is not in the financial interests of the fixed route systems and it is not what the ADA had hoped to achieve, which is mainstream transit for all. Fortunately, METRO, the largest fixed route operator in the region, clearly understands the self-defeating dynamic of asking Access to pay for fixed route trips and has been working to ensure that this does not happen. The bottom line in these situations is that passengers wishing to take a bus instead of paratransit represent a true win-win situation. The passenger is happy because they want to use fixed route, which is less expensive for both the passenger and the transit agency. This type of outcome is, frankly, the goal of the ADA, when passengers with disabilities choose mainstream accessible fixed route services over paratransit, thereby fully integrating with all other passengers and using the lowest cost service option. This is the ADA "home run" that benefits everyone.
- 9.7. There is another interesting and positive conclusion that can be drawn from the current trend of passengers opting for fixed route, rather than paratransit: accessible fixed route must be working. When the ADA was passed in the early 1990's, many fixed route services were far from accessible or usable. Many buses did not have lifts, buses that had lifts were often broken, and bus operators were unevenly trained. Only the heartiest and most independent passengers with disabilities braved the inevitably problematic fixed route system at the start of

the ADA era. Today, the landscape is entirely different. Lift equipped buses are gone; replaced by low floor buses with more reliable vertical access, wider aisles and bigger securement areas with much more reliable securements. Bus operators are much better trained and are more familiar with the use of accessibility equipment than they used to be. Passengers on buses have now become accustomed to seeing people with disabilities on buses, and they increasingly know the routine of vacating priority seating, etc. Finally, bus stops and city streetscapes have become far more accessible and usable than they once were, improving mobility options for passengers with disabilities of all kinds. In simple terms, the accessible fixed route network seems to really be working now, and passengers are beginning to make the choice on their own to use fixed route instead of paratransit. Here again, this is just what the ADA had hoped to achieve.

9.8. Even considering the merits of free or highly subsidized bus service for ADA paratransit passengers, there is one potential downside to offering this option. If the easiest path for a passenger with a disability to get a free or reduced fare on the bus is to apply for paratransit, then that may become a driving reason for paratransit applications. In fact, an analysis of TAP data for February 2015 indicated the following breakdown:

- 10% of customers ride Access paratransit exclusively.
- 19% of customers ride Access and Free Fare.
- 29% of customers ride Free Fare exclusively.
- 42% of customers do not use Access or Free Fare.

These statistics are both positive and negative. On the positive side, they indicate that accessible fixed route is a viable option that is being used by passengers who would otherwise be using paratransit. On the negative side of the equation, it could be argued that the 29% of passengers using free-fare fixed route could have avoided the Access application process altogether if there were a better or easier means of receiving subsidized bus fares. These are people with disabilities who don't want to ride paratransit, they want to ride the bus. If a different avenue to get free or subsidized fares existed for passengers who just wanted to ride the bus, this could significantly reduce demand of Access eligibility applications and those associated costs.

## 10. Recommendations

As a result of the various findings reported above, we generally conclude that the eligibility processes contracted by Access are adequate to meet current needs. We, of course, found a number of items that should be addressed in the immediate and short term, but these are not issues that indicate any sort of critical flaw with the current process. CARE seems to be doing a fair job processing assessments and we observed what appeared to be a genuine desire to do the best job possible from both CARE management and staff.

Below, we present our specific conclusions and recommendations:

**10.1. Immediate Actions:** These are items of immediate importance that should be addressed within the next month.

10.1.1. ADA Compliance

- ✓ There were no immediate concerns we observed relating to the overall ADA compliance of the program. The processes cover all of the required items, inform customers of the required determinations and rights and the data indicated that all timeframe requirements are being met. So long as CARE can keep up with the demand for scheduling appointments, we did not see any areas that needed immediate attention.

10.1.2. Applying for Eligibility

- ✓ Drivers for eligibility trips should cease coaching applicants about how to get approved.

10.1.3. Staffing and Training

- ✓ CARE should be required to develop specific projections of demand for eligibility and an associated staff recruitment and training plan. This plan can be modified as needed, but it should be developed and used as a management tool of both CARE and Access.

10.1.4. Quality Assurance

- ✓ No Immediate concerns

10.1.5. Appeals

- ✓ No Immediate concerns

10.1.6. Transportation

- ✓ CARE must have immediate and continued access to all data concerning applicant inquiries and scheduled interviews, and should be required to use this data for demand forecasting.

#### 10.1.7. Financial

- ✓ Access should continue to track trends in paratransit and fixed route usage by Access passengers, and should further study this behavior to gain a better understanding of the factors driving modal split decisions.

### 10.2. **Short Term:** These items should be addressed within the next six months.

#### 10.2.1. ADA Compliance

- ✓ CARE's lack of a demand and staffing forecast could put the program at risk of having unacceptable delays scheduling applicants for interviews. This area is not an immediate problem but could become one in the short term. It must be watched closely so that it does not become a problem.

#### 10.2.2. Applying for Eligibility

- ✓ The transit walk course in Lancaster should be brought more in line with the one at the main facility downtown. There should be steps that approximate a transit bus step, some kind of ramp and some equivalent of a bus securement area that can be used for testing. Also, to the extent that they are seen as truly useful, street signs and pedestrian crossing signs and signals should also be added.
- ✓ Passengers should be expected to bring in their completed applications when they arrive for an assessment. The information packet that included the extremely modest application for Access contains a great deal of information about the service, what it is and what it isn't, how to use it and how to apply for it. It is reasonable for Access to expect applicants to take responsibility to review this packet and to complete the application before coming in for their interview. Such a requirement will undoubtedly speed up the interview process, as passengers will be much more prepared for their interviews. Of course, in cases where a passenger's disability makes completing the application an undue burden, allowances must be made. However, the overwhelming majority of applicants can and should read the information packet and complete their application before coming in for their assessment.
- ✓ CARE should begin to spot-check medical information provided by applicants. We were concerned by the dual realities that the CARE TE's relied very heavily on the medical information provided by applicants, yet the information provided was rarely checked or verified. The purpose of a 21 day application period, under the ADA

regulations, was to allow transit providers to conduct a thorough review of applicant information. In virtually every case, the TE's made the decision on eligibility right after the interview and/or transit walk. We observed a number of interviews where we had some questions about the consistency and validity of what some applicants told interviewers during their assessment. In situations such as this, it would be appropriate for these applications to be flagged for further verification of medical information before a decision is made.

#### 10.2.3. Staffing and Training

- ✓ Using the demand and staffing forecast listed under Immediate Actions, CARE should be required to begin recruiting and training of personnel needed to meet the growing demand for eligibility. The fact that it takes a minimum of 6-8 weeks to have a minimally competent TE in place, indicates that needed recruitment must not be delayed.

#### 10.2.4. Quality Assurance

- ✓ CARE should modify their TE evaluations to begin to analyze and compare decision making among and between TE's. Allowances can be made for groups of TE's that may be handling applicants of different backgrounds, but TE's should otherwise have their decision making consistency evaluated. This is something that should be monitored, tracked and reported to Access as a matter of routine.
- ✓ In view of the questions raised by our analysis, we also suggest that Access require the development of an independent audit of CARE decisions, involving a statistically significant sample of applicants, to be reviewed by someone from Access or by a third party. This would provide Access with reassurance that appropriate decisions are being made consistently. Such a program should involve application decisions made by any and all contractors performing the service.

#### 10.2.5. Appeals

- ✓ No Short-term concerns

#### 10.2.6. Transportation

- ✓ The problem of applicant cancellations and no-shows should receive immediate attention. The time and effort wasted by this phenomenon makes this an important area for examination. Access should consider the feasibility of different incentives and disincentives to manage passenger behavior and should actively

experiment to improve this area. Furthermore, Access should more deeply review the current processes to ensure that application packets are mailed out and that SGT staff are available to confirm appointments and receive cancellation calls.

- ✓ CARE should provide SGT with a more precise statement of their daily capacity, identifying not just the total applicants that can be handled but should break this down to reflect actual expected throughput; providing the number of applicants that should be arriving and departing at different hours of the day. Such a schedule should be accurately projected continuously for three weeks forward of the current week, based on CARE's expected staffing. It should be SGT's obligation to provide a flow of applicants to efficiently meet CARE's staff availability plan. There is no question that the schedule of availability of TE's for assessments should be the driving factor in this process and the transportation provider should be obligated to meet CARE's schedule. The critical factor in this equation is the relatively inelastic supply of trained TE's for assessments. Their availability should be clearly identified and their utilization maximized.

#### 10.2.7. Finance

- ✓ Access should work with the major fixed route providers in the service area to ensure that existing reduced fare programs for passengers with disabilities are synchronized with Access free fare policy. These other fixed route programs should be adjusted to ensure that they are *the preeminent* avenue for free/reduced fare access to fixed route for passengers with disabilities. The apparent fact that Access is seen as the way to obtain free or reduced fixed route fares indicates the ineffectiveness of the fixed route reduced fare programs. This policy synchronization should involve all aspects of the programs, including the question of whether passengers are offered a completely free fare or just a reduced fare.

### 10.3. Long Term

#### 10.3.1. ADA Compliance

- ✓ Over the last several years, Federal regulators have been evolving their definition of what constitutes a proper ADA eligibility process. At the start, the process was assumed to be fine if it rendered a simple yes/no decision. This began to change as Federal officials began to push transit systems to consider path of travel, seasonal variances and other considerations that might introduce some variability in the initial yes/no decision process. Delta's work with officials from the US Department of Justice's Civil Rights Section have even indicated that—in theory at

least—they believe that almost everyone could theoretically need paratransit at one time or another, even if they could normally take the bus. Adding to this evolution, in March of 2015, the US Department of Transportation issued a long awaited and controversial requirement for ADA paratransit providers to permit “reasonable modification” of existing policies to enable passengers to better use ADA paratransit. These regulations indicate a host of areas where a passenger’s request should be weighed against the transit systems policies and detailed information about the passenger that was presumed to have been collected as part of their eligibility assessment. The bottom line in all of this is that the current Access screening process is simply not designed to collect this level of detail. A great deal of time is spent during interviews establishing the existence of an applicant’s eligibility and medical condition, rather on making a detailed evaluation of what passengers can and can’t do, and under what circumstances. The current process should be redesigned to focus less on medical verification and much more on this type of detailed functional needs evaluation that will provide Access with a more robust passenger profile that will be necessary to properly implement the new reasonable modification rules.

### 10.3.2. Applying for Eligibility

In general terms, the mechanics of the current process are sound. Access should stick with an in-person interview and assessment model, executed by a contractor. However, we believe that the details of the current model should be changed in a number of ways:

- ✓ The assessment process should be designed and owned by Access. The inherently closed nature of the current model—using a contractor with a proprietary process—is not in Access’ long term interests. It worked well to get the program through the growth and initial maturity phases of Access’ development, but the future is going to require a more open and collaborative process that may be under constant refinement, at least for the next several years. Leaving that entirely up to a contractor leaves Access too far “out of the loop” and makes it entirely too difficult to effectively oversee the performance of the process.
- ✓ Move away from a yes/no paratransit eligibility decision mindset and more toward an open ended mobility needs assessment. As Access’ passengers are demonstrating, mobility for people with disabilities in the LA region has become a series of modal choices based on needs, timing, cost and other factors. Fixed route accessibility options have improved exponentially and are likely to continue to get better. The simple reality is that passengers applying for Access need an accessible ride. They may just be thinking in terms of paratransit, but there are many options that might be easier, faster and less expensive than paratransit,

about which passengers may not be aware. To the extent possible, the local fixed route providers should work more closely with Access to help transform the eligibility assessment from a paratransit application to a process that helps the applicant and the agency understand the applicant's abilities and then matches them to the most appropriate modes of transportation for different trips and different situations.

- ✓ While it makes sense for Access to have a single major assessment site, based on the distribution of demand for eligibility, it appears to also make sense to consider several satellite sites similar to the one in Lancaster. Transportation has become an expense that is almost as much as the assessments themselves. Assessment sites located closer to demand clusters could reduce the cost of transportation and make the scheduling of rides for assessments far less complicated. When considering the needs of satellite facilities, Access should evaluate the key components of the CARE downtown site that are functionally necessary for a proper assessment. The current CARE facility is certainly impressive, but it is also possible to achieve the goals of the transit walk with a less sophisticated and elaborate facility.
- ✓ Though we were only able to make a modest review of the requirements for recertification of passengers, there seems to be room to both extend the intervals between assessments for some passengers and to simplify and possibly even eliminate the need for an applicant to travel to an assessment site, in some cases. It is common for the rules governing re-assessment and re-certification to vary depending on a passenger's personal situation, the reason for their disability, their age and their history of using various modes of service. Such a flexible review process should be developed for the future.

### 10.3.3. Staffing and Training

- ✓ Our review of the current staffing and training processes was so cursory that we can't offer much in the way of substantive recommendations, other than to open it up to greater Access control and scrutiny. Although we were not able to see what TE's are taught, we find it difficult to imagine that two days of classroom instruction are sufficient to teach evaluators what will be necessary for the redesigned assessment processes we have recommended above. In addition to making the training more transparent and more robust, employees should have formal, structured and objective performance evaluation and testing to provide a comprehensive and documented record of their readiness and skill, before they are placed into independent service.

#### 10.3.4. Quality Assurance

- ✓ As recommended earlier, the current Quality Assurance practices—while a good start—should be expanded to formally address both quantitative (the “dotting of I’s and the crossing of T’s”) and qualitative (appropriateness and consistency of decision making among and between TE’s) performance. This will become even more important as multiple facilities are opened and there are a number of independent teams performing assessments at different sites.

#### 10.3.5. Appeals

- ✓ We have no long term recommendations concerning appeals.

#### 10.3.6. Transportation

- ✓ As previously discussed, the entire area of transportation to assessments needs to be strengthened. There appeared to be deficiencies in most steps of the process, resulting in combined no-show and cancellation rates of nearly half of passengers. We recommend that this entire area be overhauled and redesigned. In the context of this redesign, we recommend that transportation scheduling be returned to the organization that is executing the certification process. This makes the most sense, as they can then book trips based on demand and their own known capacity.

#### 10.3.7. Finance

- ✓ Over the long term, we would recommend that whatever policy Access eventually adopts concerning reduced or free fixed route fares, it should be entirely synchronized with the reduced fare programs of the local fixed route providers. Access should not be seen as the primary means of getting reduced cost or free fixed route bus service. The application and screening requirements for paratransit eligibility are far more detailed than those required for a reduced fare card and it is a waste of resources to conduct that level of screening for passengers who don’t actually want to ride paratransit. If a passenger just wants to ride a bus at a reduced fare, there should be an easy and quick referral process to direct them to these other programs that don’t require a paratransit eligibility assessment. Even if this more robust approach to providing reduced or free fares to fixed route costs fixed route operators more money in the short term, they will almost certainly save money in the long term as more passengers adopt and see fixed route as a permanent, viable accessible transit option.

- ✓ The various recommendations we have made here may actually increase the per-unit cost of making paratransit eligibility assessments, but this should not automatically be seen as a bad thing. If better access can be made to reduced fare or free fixed route service, it is likely that a large proportion of people applying for Access will no longer do so. Also, a more robust assessment and referral process that matches passengers with a host of different accessible modes will reduce overall demand for paratransit, thereby reducing overall program costs. Passenger behavior is already telling us that accessible fixed route transit may have finally come of age and a new approach to assessing passenger mobility needs that looks beyond ADA paratransit, could better serve passengers and reduce overall program costs, even if it costs a bit more up front.