COMMUNITY-WIDE INTERVENTIONS THAT HAVE HEALTH IMPACT IN 5 YEARS

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REMOTE CART Captioning

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>> Dave Clark: Greetings and welcome to today's Dialogue4Health web forum, A Look at Public Transportation Expansion, brought to you by Public Health Institute and the CDC.
My name is Dave Clark. I will be your host for today's event. Before we get started as usual there are a few important things that I would like you to know about. First of all, realtime captioning is available for today's web forum. This is provided by Home Team Captions. The captioning panel is located on the right side of your screen. You can toggle it on and off by clicking the Media Viewer icon. If you are on a Mac you'll see it on the bottom right of your screen. If you would like to use captioning during the web forum you'll see a link in the captioning panel that says show hide header. If you click that link, the show/hide header link you will be able to see the captioning easily. If the captioning disappears during the web forum, click the icon, Media Viewer icon at the top right of your screen to bring it back again.
Concerning the audio, today's web forum is listen only. You can hear us but we won't be able to hear you. That doesn't mean that today's event won't be very interactive and engaging. We will have a Q&A session at the end of the web forum. You can type your questions at any time into the Q&A panel. The Q&A panel is also located on the right side of your screen. You can toggle it on and off by clicking the Q&A icon you will see at the top right. Again on a Mac you'll see all of the icons on the bottom right of your screen.
This is important. We are showing this on the screen right now. In the Q&A panel make sure that at the bottom right it says "all panelists" make sure that that option is chosen. That will ensure that your question gets sent to the right place. If it doesn't say all panelists and you type something into the chat, it may go out into the ether. Feel free to submit as many questions today as you want.
We are really interested in your thoughts and questions and all of your feedback. Make sure to get all of that into the Q&A panel. We'll try to answer as many questions as we can.
By the way you can use the Q&A panel to communicate with me and my colleague, Laura Burr. We are behind the scenes today. If you have technical issues, let us know about it.
In fact we thought we would get interactive right off the bat today. We will bring your voice into the conversation right now. We do this at the start of the web forums. It would be interesting to see who else. There is a poll. You can tell us whether you are attending alone or in a group. That poll will appear. It has already appeared on the right side of your screen. Go ahead and select from one of the four choices. This is important. Make sure after you made your selection you click the submit button to the right. If you don't do that, your answer won't be submitted.

Make your choice, click submit. Are you attending today's event alone? In a small group of two to five people, maybe in a larger group of say six to ten people? Perhaps you are in a large conference room with your colleagues, ten or more people.
We will have a couple more interactive polls later on in the web forum. This is a good practice poll to make sure you understand how to use the interactive polling. Let's take a look at the results and see who is attending today's Dialogue4Health web forum. Give the results to tabulate. It sometimes takes a few seconds for them to click on the screen. If you haven't clicked submit, you may see that right now. Make sure your answer gets submitted.
A very high percentage of you, not surprisingly, are attending alone today. 92 percent. Smaller groups of you are attending in groups of smaller sizes, two to five people, about 3 percent. 1 percent of you are attending in a group of six to ten people.
This might make things go a little bit easier for you if you are in a group today. What you might want to do is assign a single person the responsibility of submitting questions on behalf of either the entire group or even for individual group members. That might make things go a little bit easier for you if you are in a group.
On the other hand if you are attending alone today, we don't want you to feel like you're there all by yourself. We want this to be a group event. Don't be shy. Make sure you submit all your questions into the Q&A panel like I explained and join in on the conversation today.
All right! Let's get started with today's presentation on public transportation expansion. Today the moderator is Adam Lustig, Senior Manager at Health Systems Transformation, National Network of Public Health Institutes. He works with funders and partner organizations to implement the bridging portfolio. He provides content expertise and strategies for improving systems and supporting people centered health systems. Before joining NNPHI he was Senior Policy Analyst at the Advisory Board Company and Research Manager at the National Pharmaceutical Council. He will be leading us through today's web forum. Adam, over to you.
>> Adam Lustig: Thanks, Dave. And welcome, everyone, to the webinar. We are pleased to have you join us for the third in our series of webinars highlighting the CDC's Health Impact in 5 Years initiative. Before today's content we want to provide you information on who is attending today's webinar.
So these numbers are based on those who have registered for the webinar. There are 1500 people who have registered for the webinar. As you can see we have attendants from all 50 states, the District of Columbia and attendees from around the globe.
Additionally looking at different sectors represented as with our previous webinars there's a strong interest among city or county government agencies, nonprofits, state governments and a wide range of other stakeholders.
Now that you know the type of stakeholders attending today's webinar, let's transition to what you are here for. I'm pleased to introduce Dr. Von Nguyen, Acting Associate Director for policy are and Elizabeth Skillen, Senior Policy Advisor for CDC. Dr. Nguyen is Acting Associate Director for Policy for the CDC. He supports the CDC and manages their efforts to promote collaboration between public health and healthcare systems. Prior to joining CDC Dr. Nguyen worked for the state innovation models, population health projects and the larger healthcare delivery system reform agenda. He's a primary care provider at a federally certified health center. In addition to experience in public health and healthcare delivery, Dr. Nguyen worked for Fortune 500 companies, medical underwriter and medical director for doctors without borders.
Dr. Elizabeth Skillen serves as the teal lead and senior advisor in the policy, research and analysis and development office in the office of the associate director for policy at the CDC, providing advice on the development of evidence-based approaches to accelerate the best prevention science into policy. She lead teams to identify evidence based approaches, including the CDC web portal of CDC data resources, tools for action, programs and policy.

Dr. Skillen previously served as the Associate Director of Policy in the Division of Healthcare Quality Promotion, leading strategic budget formulation, performance measurement and policy analysis and partnership for healthcare associated, blood, organ and tissue safety, adverse drug events, immunization safety, and anti-microbial resistence. During her years at the CDC, she was design review administrator, acting administrator for OEDP and leading the immunization safety office scientific agenda and HHS action plan for healthcare associated infections.
And with that, I am pleased to hand it over to Drs. Nguyen and Skillen.
>> Von Nguyen: Thank you for introduction and thank you for joining today's webinar. I want to provide background on our health impact. HI-5 initiative. This depends on community-wide approaches improving the health of entire populations. Today we want to speak about the interventions that address the conditions in places where we live, learn, work, play that have the greatest impact on our health. By focusing on these Social Determinants of Health and the changing context to make healthier choices we can help improve the health of everyone living in our communities. The CDC Health Impact in 5 Years highlights nonclinical community-wide approaches that have evidence doing three things, it shares positive health impacts, shares results within five years and three, it shows cost effectiveness and/or cost savings over the lifetime of the population or earlier.
So the healthcare system is changing and there is a shift in payment, and payment models from fee for service world to value based payment. As a result of this, there's an increased focus on prevention and wellness. Some healthcare systems are exploring the shift from the focus on coordinated care for the individual patient to accepting real responsibility for improving the health of entire populations. A lot of players such as insurance companies, hospitals, health systems, engaging in finance of populations creating the possibility for partnerships with traditional health entities. The emerging clinical care models link clinical care and communities.
So I want to introduce the three buckets of prevention framework, released from the CDC about a year, year and a half ago. And what we learned at CDC is as we were talking to different folks in different communities and partners in the real world, everybody thought about population health very differently because they had different populations. We realized there wasn't one right answer to this question.
When you look across the three buckets there is a spectrum. It moves from individually focused care for patients in the healthcare system to bucket three, more community-wide.
Bucket one focuses on interventions in the healthcare system such as immunizations or screening for blood pressure. Bucket two still looks at individual patients but takes the innovation and the interventions into the community. So this might be self monitoring of blood pressure the a home for individuals.
And in contrast, today we will spend more thing thinking about bucket three, which is where the focus of Health Impact in 5 Years is. Focused on interventions intended as community-wide measure, way to improve and protect the health in the populations of the community as a whole. The substream interventions affect the health decisions people make and the social, environmental and risk factors where people live, learn, work and play.
prevention of the existing diseases exist outside of the healthcare setting and require a new set of strategies.
I want to introduce the 6/18 Initiative which is also run here at CDC. This is the CDC which refers to the 6/18 Initiative that you see on the slide. Those are asthma, unintended pregnancy and diabetes and tobacco use and control of blood pressure. Within the 6/18 Initiative we identified the evidence for public health and the healthcare delivery system to work closely together to improve the population or the health of individuals who are within the healthcare system.

We want to focus on prevention for communities. They need a different way to make the case for working in bucket 3. They need to know which interventions have health impact and can improve the cost of care. Today we'll focus on that.
So why is CDC focusing on the Health Impact in 5 Years initiative? We are listening to the requests from our constituencies. States and local public health partners asked us for evidence and cost data on the bucket 3 interventions. Maybe I work for a leader than wants positive results before they run for the next reelection. And the leader may ask if we have any of these initiatives. Or in a different situation I may be asking how do I make the business case for my community-wide health strategies to a hospital board. I need to present within my hospital and work with the local hospital system.
A third situation I might lead a small health department. How do I address the Social Determinants of Health. All of these groups asked us for the initiatives that work and are cost efficient. That's what HI-5 is attempting to do. I want to turn it over to Eli now to talk a little bit more about the HI-5 initiative.
>> Elizabeth Skillen: Thanks, Von. I appreciate that. What is the HI-5 initiative? As Von said in response to the request from our colleagues in the field for state and local health departments CDC developed evidence briefs for community-wide in bucket 3 like for the two buckets under 6/18 Initiative.
In provides, aimed at improving the larger health of the community, not focusing on individual patients but they each have positive impact and evidence of cost savings or cost effectiveness.
So how do we develop the list? How do we get to the 14? We started with the evidence. We selected those interventions that earned the highest rating from our very own community guide that were recommended or the Robert Wood Johnson Foundation Roadmaps, what works for health website that were scientifically supported. We also consulted our experts here at CDC. We excluded those interventions in bucket 1 or 2 and assessed the evidence on several criteria including evidence of Health Impact in 5 Years, economic evidence and importantly that they were implemented at the policy level.
Through the application of these criteria, we developed the HI-5 list that you see here on the screen, the 14 community-wide interventions. Today we are going to focus on public transportation system introduction and expansion.
And one important point that I would like to make before we get into the transportation example is about how we organize the larger list. The public health impact pyramid is a framework for public action that visually depicts the impact of different types of public health interventions. At the base of the pyramid are those that have the greatest impact on health because they reach entire populations of people at once and require less individual effort. They include the Social Determinants of Health. As you move towards the top of the pyramid there are interventions that change the context to make easier choices -- good choices easier. More limited contact but confirm longer term impact like vaccinations. Health and education counseling.
The HI-5 intervention maps to the lowest two tiers with the greatest potential for impact. On the left, the public health interventions mapped to changing the context piece you may recognize including school based activity. And on the right those that address Social Determinants of Health such as poverty reduction, improved education and transportation expansion.
So today let's drill down on today's topic around public transportation system expansion or introduction. The purpose here is to expand public transit, to increase use to the public systems while simultaneously reducing Vehicle Miles Traveled and traffic congestion. In Social Determinants of Health literature, transportation is typically discussed as a feature of the physical built environment. A recent report that came out by the national academies of communities in action pathways to health equity highlights transportation as a separate determinant of health because of the multifaceted nature, contribute to pollution, mobility and access to public health, and vehicular mortality and active transportation.

There's clear evidence on the use and expansion of public transit to improve health through increased physical activity, reduce air pollution and reduced injuries. For example, studies show that people using public transit walk more, eight to 30 minutes a day in accesses services.
Typical American transit system high quality, fast, convenient and comfortable, urban bus service would result in a health benefit of $355. How do health practitioners get involved in this important work? One tool I would like to highlight is use by state and metropolitan area managers, this is jointly developed by the CDC and our colleagues at the Department of Transportation. This tool provides access to data on 14 public health indicators and describes evidence, 25 evidence based strategies that practitioners can use. I encourage you to visit the site.
Another important tool is a CDC health transportation toolkit. Public health can provide a wide range of services and roles in transportation expansion. Early stages, public health provides health behaviors and status and help planning through a health lens and prioritize local -- state projects by identifying that health value. So I encourage you to visit both of these tools for your work in expanding transportation.
But now what I would like to do is turn it back to Adam so we can get to our speakers. Thanks.
>> Adam Lustig: Great. Thanks, Eli. Thanks to Drs. Nguyen and Skillen for their presentation. Now we are looking to further engage the audience. Laura if you can initiate the poll, we are going to ask you which of the HI-5 interventions you are currently working or partnering on. We will wait 30 seconds for you to respond. You can click as many of these interventions that you are currently working or partnering on. While the poll is open I will also introduce our next speaker, Therese McMillan, chief planning officer for the LA County metropolitan transportation authority. She assumed the position as chief planner in April 2016. In that capacity she provides executive leadership for Metro's grant funding and real estate financial key development, recent tax ballot measure and the county wide long range plan. Active transportation programs, strategic fund and emerging community initiatives, public health and transportation access.
Prior to joining LA Metro, Therese served as acting administrator for the federal transit administration of the U.S. Department of Transportation. During almost seven years at FTA Therese led reforms in transit safety, emergency response and resiliency investment, Civil Rights program development and oversight.
Before her career at FTA, Therese was Deputy Executive Director of Policy at the Metropolitan Transportation Commission, regional planning and funding agency for the nine-county San Francisco Bay area. During the time with MTC she was instructor in funding and finances at the Institute at San Jose State University.
And now as you can see on the right side of the screen we can see the results for the types of interventions that everyone is involved in that is attending the webinar today. As we can see we have a lot of people who are attending today's webinar who have been involved and partnering with public transportation. We also have work site obesity prevention, tobacco control interventions, Safe Routes to School, and I invite you to go to that webinar we had on that. And with that I'm happy to hand it over to Therese McMillan, Chief Planning Officer for the LA County.
>> Therese McMillan: Good morning or good day depending on where you are in the country. It's a pleasure to be here. What I would like to do in this presentation is illustrate in the time we have allowed how LA Metro is really working within the third bucket that was discussed by our prior panelists. And perhaps give a sense of not only what we are doing now but where we are headed in terms of reimagining how public health can be worked into our larger portfolio.
So just to give you a sense of LA Metro for those of you familiar with Los Angeles you may be surprised to know we operate the third largest public transit system in the United States behind New York and Chicago. Our public transit system is diverse, buses, heavy rail, light rail, we have greatly expanded our rail system one of the things that is quite exciting that was alluded to by Adam, the voters of LA County voted in measure M in November of 2016. It is a dedicated half cent sales tax on

top of sales tax revenue we already have at our disposal, but the scale is really tremendous. It is anticipated in the ballpark to raise $120 billion over 40 years.
So quite an investment opportunity, but it brings with it accountability as well. That is a challenge that is not solved, a mobility challenges in L.A. are not solved by measure M by any means. With a population of 10 million people there is a lot we need to do.
So one of the things, though, that we are trying to do in this larger context of looking forward under these new opportunities is to better connect the dots of public transit and public health. Our portfolio embraces many intersections in mobility and public health. Not only are we a provider of public transport but we are a planner, builder, and major construction entity as well. But one of the many thing that we are orienting ourselves to in terms of identifying this intersection between mobility and public health is the many faces that it can take. For example, first mile/last mile issues have been a major focus here in LA County. We are known, I think, for our sprawling development as opposed to the concentrations that are more characteristic of other major urban centers.
While there has been, quite frankly, an up surge in more dense development of housing and commercial development we still are dealing with getting to and from our public transit system.
Another aspect at a community level is this opportunity to think about public transit as being integrated into the community, to design neighborhoods in such a way that public transit can be used often, safely, and reliably. And importantly we need to address the needs of those most depend ant on transit. Those populations are the most vulnerable.
Linking all of these, of course, must be with an eye towards funding. We can plan all we want, but if we don't invest in it there's not much change that can happen.
Here is an example, one example of public transit and public health intersecting. That is public transit and Vision Zero. Key mobility and health facts here in LA County. Motor vehicle fatalities in the City of Los Angeles, by far the biggest city in the county, is up 20 percent since 2014. Pedestrians represent nearly half of motor vehicle fatalities and something that is quite headlining is that it is the leading cause of death among children 5 to 14 years old.
This has led the City of L.A. to really aggressively look at this and start out with the fact that traffic does, severe injuries are predictable and preventible. You need to be deliberate in how you deal with it. They have developed a Vision Zero program with a commitment to eliminate all traffic deaths by 2025. It is a multidisciplinary partnership to deal with this issue. It focuses on the most vulnerable folks, children, older adults, Walkers and cyclists. When you're dealing in the bucket 3 paradigm that was described, one key thing is to know that you are not dealing with homogeneous populations. You have to understand the distinctions of those populations when you are dealing with any particular issue. Absolutely true in this case.
Increased public transit can reduce vehicle use and, transfer, decrease risk of motor vehicle fatalities and injuries. You need to ensure that getting to transit is safe, too. Thus the need to connect Vision Zero with public transit first and last mile policies.
Now, a second example is connecting the dots with respect to planning for particular populations. This is something that many of us in the describe have done for some time. Related to federal planning requirements, but in this case the first start again is understanding who your population really comprises. In LA County we have 11 percent of our population are seniors. 37 percent with a disability. 13 percent living at or below the poverty level. All of these are reflective of Social Determinants of Health, particularly the incidence of poverty has been highlighted. We know for a fact seniors and those with disabilities have a higher need for medical services. All of that points to the requirement to develop a comprehensive plan of serving the mobility needs of these populations. We have developed this plan again periodically and over really some time. But what was very interesting about the last update when we were serving the needs of these populations was a highlight that 50 percent of our consumers and stakeholders here were flagging medical trips as the

most difficult to make when trying to use, among other things, our public transit system or para-transit system or any other option that wasn't a personal car.
This pointed to a very important focus area that we want to turn our attention to, which is that public transportation as access to preventive health services is a key strategy towards enabling the public health of communities to advance. And when I was with the federal transit administration on a national stage we made this connection and developed and overall initiative, the Rides to Wellness program which among other things established important new partnerships between not only transportation agencies and working among ourselves but with governmental agencies and public health and extremely importantly looping in healthcare providers and insurance providers who now recognize that access to their services and for those who don't have a car, public transit access is something we need to focus on.
Let me wrap up with where we think we are going in the future. This is an important opportunity for us, our long range transportation plan. We are looking to do a very different type of plan going forward. Essentially breaking up this massive look at everything activity into discernible modules with focuses. As an example, a real look at a plan for communities who we serve, what they need, a plan for partners, who needs to work with us as LA Metro to deliver the services that are required, and a plan for outcomes, really looking at what are the objectives to obtain. This is where improved public health could be wrapped up very forward-thinking into the outcomes we are seeking to achieve.
We would also then look to a plan of how to achieve those outcomes, a plan to manage our existing system, to serve those who are most in need through specific targeted programs, very clear funding program to ensure that top priorities are dealt with and trade-offs are assessed. And how to build infrastructure often to achieve these goals.
Public engagement will be incredibly necessary throughout our long-range planning effort. Meaningful engagement including those in the public health industry is something we will seek. And we are very much looking forward to an exciting and advance intersection in our County between the public health needs of our communities and how public transit can help us get there.
With that I am going to turn it over to our next speaker.
>> Adam Lustig: Thanks, Therese. Before I introduce Joe Calabrese, we do have one more poll for all of you to respond to. So the poll will be launched now. We are asking you to please rate your familiarity with the health impacts of public transportation expansion. We have four different options: Not familiar, somewhat familiar, familiar, and very familiar.
While you are completing that and the polls close I will introduce Joe. Joe Calabrese is named as one of public transportation most influential people of the decade bringing 30 years of experience in public and private sectors of the transportation industry to the Greater Cleveland Regional Transit Authority. Since 2000, Joe Calabrese is succeeding in significantly increasing RTA customer base and role in the mobility and economic of the region. Under his leadership RTA is strategically focused on outstanding customer service, maintaining a positive image and having a strong financial management. And as a result RTA has become one of the most respected transit agencies in the nation. Recent years RTA was named best large sized transit system in America. Calabrese was recently named outstanding transit manager of the year. Appointed by two Secretaries of Transportation he serves on the U.S. Intelligent Transportations Systems Advisory Committee, past president of both the New York State and Ohio Public Transit Authorities. Calabrese is in leadership at the American Public Transportation Association as well. Before coming to here, he served as president of the New York RTA.
Before I hand it to Joe we will take a look at poll results. As you can see there seems to be an even split between those who are somewhat familiar and familiar with the health impacts of public transportation expansion.
Thank you for all of those who participated. I just wanted to remind everyone to continue to submit questions. We will address those at the end of the webinar.

With that I will hand it over to Joe.
>> Joseph Calabrese: -- Therese, it's great to talk with you again even over the wire.
I'm involved very much in workforce development on a day-by-day basis. Working with employers and prospective employees. When I say often, you can't work if you can't get to work. I can certainly say the same thing about healthcare. You can't get healthcare if you can't get to healthcare. Public transit is all about that access.
Our mission is to provide safe, clean, reliable and courteous public transportation. I hope we do. A little about our area. We are certainly not as big as Los Angeles. Although we were at one time, back in the '40s, '50s, '60s. Today our population is half of what it was 40 years ago. Not only do we have less people, the will people we have are more spread out and more sprawled than we were before.
Our service population, primarily in the major County we serve is 1.5 million. We serve 200,000 customers on a typical weekday. We have 500 buses and BRT vehicles, 75 rail cars, heavy rail, more subway-like an light rail.
We have 160 vehicles in our para-transit fleet which serves people with physical or cognitive disabilities honest can't use the regular trains or buses we have. That's a very important part of what we do. The majority of our customers using the bus and train system are going to work. That's number one by far in trip destination. The number one destination for those using para-transit is medically related services.
We have 2500 employees, a budget of $300 million. When I started we had many more employees, but we have had to down size or right size, depending on your perspective because of budgetary situations. Much of that is a function of a smaller population base. And even a smaller population base, the population basis getting more poor and more dependent on public transit.
Public transit is for health, predominant links. Therese talked about safety. Surely riding public transit is safe, one of the safest modes of transportation, along with aviation.
Certainly compared to automobiles. Every day in Ohio, every day in Ohio three individuals die in automobile accidents. That is an epidemic. If that ever happened in public transit, there would be investigations. Obviously if there's an accident on public transit we are on the front page. If three die in Ohio on the roadways, that's just another day on the roadways in Ohio.
In the Cleveland market we reduce vehicles on the roads by about 50,000 vehicles a day. That does make the roads safer. It also reduces congestion and improves air quality, another major positive result of public transit. As we all know, dirty air is less healthy than clean air.
Also mentioned was physical activity. We do force our customers to walk to bus stops and train stations. Don't get credit for forcing them to walk more and get more exercise. Also important is equitable access. 30 percent of the individuals in the Cleveland city limits do not have automobiles. So the only way for them to get to healthcare is by public transportation, a very important mission that we must play.
The relation between physical activity and the built environment is well documented. We try to encourage that walkable city that supports transit. That is the win-win. We need to encourage people to walk. Need to walk for a number of functions but also be there for individuals who can walk to the bus stop or the rail station to get to the healthcare that may not be in walking distance from their facility.
Our bus network is pretty comprehensive. Most services are focused into the downtown area which is the major employment center.
The second biggest, the biggest employment center not only in Cleveland but in the State. The second biggest employment concentration in Cleveland is university circle, which is the home of two major hospitals. I'll talk about that a little bit later, the Cleveland Clinic and University Hospital. Number one and number two employers in our region and the number two and number three employers in the State.

Walmart, of course, being the number one employer in the state of Ohio.
Our rail network is extensive, especially for a city our size. The light rail system, the blue and green line began operation in 1914. The red line, the heavy rail or more subway oriented system began operation in the 1950s. Again these systems were built during Cleveland's hey day. I'm not saying it's over, but when the population was again approaching a million people and the anticipation was that population would increase. Our population is hovering now around 400,000 people within the city limits. We have a lot of infrastructure per capita to help that connection between our customers and healthcare.
Public transit, we do connect the dots. Therese stole that saying from me, I have been using it for years. North Americans do not walk as much. Those using public transit use a lot -- walk a lot more than those who don't. That is a fact we don't often get credit for.
The typical stops are 18 of a mile apart. Light rail, a quarter of a mile apart. Typical heavy rail, more than in the half mile territory. We have the ability to connect those with other public transit, but the good news is people do walk more when they use public transit.
Major trip purposes. Again on our bus and rail system the number one trip purpose is work. 60 percent. Number two is school, 23 percent of our customers are going to and from school. And healthcare is the number three purpose of public transit in Ohio. 90 percent of our customers are going to access -- 9 percent of our customers are going to access healthcare.
The para-transit service is robust and well utilized, 50 percent of those are going for healthcare related activities. From a financial perspective, it costs us and I think this is pretty much an industry average about $40 per trip to serve somebody in our para-transit service, where the average fare collected is $2.50. It's a great service, but we do it because we should and we must and we are grateful for it. There is a limit to how much we can afford to provide. We haven't had a denial in eight years on our para-transit service but that caused us to reduce some bus and rail service to pay for that very expensive service.
I would like the group to think about through better coordination of our services we could provide a better service for less cost. Very often, I'm sure you'll see in front of a medical facility three or four vans there at the same time all dropping or picking up one person. A better coordinated system could be three to four times more productive, something we need to think about and do something about. Money is always going to be an object.
Cleveland is very involved in our discussion today. Remember, the World Health Organization global network for age-friendly cities, transportation is certainly as we are talking about here, identified as a domain of city life that will might influence the health and quality of life, age friendly Cleveland is very involved as is the AARP and the Cleveland Department of Aging. We work with the city to become an age friendly city by 2020.
We also work with the bicycle community. Bicyclists are very often using their two wheeled vehicle to access that public transit, the first or last mile of rolled. We recently had to convert all of our buses had two-bike bike racks on them. We had to convert them to three-bike bike racks because of space. That's great news. We allow bikes on our rail vehicles and BRT vehicles at all times. We used to not allow them during commuter hours, but we have found that they coexist in an active way. We are involved in helping develop walking paths and bike paths and exercise facilities. We think that is an important role that public transit can play, not just for better access to public transit, but better access to health.
We talk about safety. We talk about clean air quality. I think the industry has done an awful lot in the last several years to get the buses cleaner, first going from primarily diesel to clean diesel. Right now compressed natural gas is a rapidly growing fuel for buses, which is much, much cleaner than diesel. You see many cities looking at and experimenting with electric vehicles, although the range is somewhat limited but growing exponentially.

Several systems are often experimenting, as we did here in Cleveland, with fuel cell vehicles that are not yet commercially viable because of their price but we think some day they certainly, I think, will be.
The other thing that healthcare has done is allowed us to develop some tremendous partnerships. RTA inaugurated the nation's premiere bus rapid transit system in 2008. Bus Rapid Transit or BRT is a combination between rail, a rail service and bus service. It has the permanence and some of the service and operating qualities of rail, but at a lower, more flexible cost, similar to a bus system. We were going to launch what was going to be named the silver line. We went out and looked for naming right sponsors to help us with that.
The two firms that stepped up first were the two major hospital chains I previously mentioned, University Hospital and the Cleveland Clinic. The silver line quickly became the health line under a 25-year sponsorship agreement. The health line provides tremendous access to their facilities. They are also using the vehicle itself, the interior of the vehicle to give health-related tips to the many, many customers that we serve.
So this is one of our branded services. Ridership went up 40 percent the first year. That's over the service it replaced which was the highest bus route. The customers have responded very well to that. Additionally, we just made a recent announcement about two weeks ago that Metro health, the major public health institution in Cleveland, entered into a 25-year agreement with RTA for the Metro health line, not to be confused with the health line. That will be our next BRT service connecting downtown with Metro healthy main campus, which is undergoing a 1 billion-dollar renovation. The same service will branch off and hit five of their satellite facilities. Providing great connectivity, not just for the public to their facilities but the public between their facilities which is really, really important.
We also participate in a ground breaking, for UH that is building a children and women's primary care clinic right on Euclid avenue at the 59th street stop. There is tremendous connection between us and public transit. We value that. We know we play a very important role in that. We are pleased to do so.
>> Adam Lustig: Great. Thank you so much, Joe. That was a wonderful presentation. Thanks to all of our speakers. We have received quite a number of questions so far. So I'll address the first couple with both Therese and Joe. The question that we got in says: What are some recommendations to the typical healthcare organization to begin engaging with the public transit sector to connect and advocate for health impact in transit?
>> Therese McMillan: Well, I think the first thing to do, and it seems -- this is Therese McMillan -- what I found at FTA and certainly what I am doing here in Los Angeles is basically calling people together literally to talk. One of the things we found out was that the healthcare industry and the transit industry have not been at the same table talking about these issues until very, very recently. Part of the motivation was with the passage of the Affordable Care Act and the new ways that was mentioned again in the first, Drs. Skillen and Von Nguyen, how the health industry it self is looking at the value-based approach as opposed to volume-based approach. And when it was found, for example, that there is real value or disvalue when an appointment is missed and if that appointment is missed because someone couldn't get there, that becomes a real bottom line issue that serves as a way to have a conversation about how the health industry and public transit industry can meet together and work together. But even identifying those areas of intersection and common goals and objectives really meant that people had to sit down and talk to each other and introduce ourselves to each other. Frankly in my first year at LA Metro I have been spending time talking with nonprofits that serve the health industry and constituents working with some healthcare providers in advance of our long range transportation plan. That is the very first really critical important step, getting representatives around the same table to introduce themselves and speak to each other about the potential of shared goals.

>> Joseph Calabrese: I'll jump in. Certainly not much different to talk about, but I think healthcare is getting a better understanding of the role public transit plays, even when we reached out to clinics and UH in 2007 on the naming rights agreement. It was really much more initially a marketing, branding program. After we had a chance to sit down with the two CEOs, on a project, number one -- let me say these are two hospital complexes that are very, very competitive. And it was just great to see them work together cooperatively on this venture. But to sit down and talk about what this program could be, how this program could be so much more than a marketing program, how that connectivity is very important. How it's an opportunity to better educate many of our customers on health-related tips.

So I think it is great. I think because of that, there might have been a different perception from the public hospital, the Metro health, the more public oriented hospital that probably serves more inner city individuals than the clinic or UH do, but that is so very important.

The realization in many parts of our region that those they need to get to and have access are economically disadvantaged people who might not have access if it wasn't for public transit.

>> Adam Lustig: Thank you so much. The next question that we have is for Drs. Nguyen and Skillen. Could you talk about what role public transit can play in public health?

>> Elizabeth Skillen: Thank you, Adam. I mentioned that public transit can play a role in the early planning stage. They can provide data on health behaviors and health status. Thinking about our behavioral risk factor surveillance system and 500 cities data and transportation health tool I identified that has those metrics. The public health practitioners and can have that lens on transportation planning.

In Nashville, public health practitioners helped transportation colleagues at health related questions on physical activity and general health status to have a travel survey. Having that health lens.

There's other tools, I mentioned the health impact assessment on the last one of my slides. So that can help walk through a process of evidence based recommendations to sort of think about travel and health.

Do you have anything to add, Von?

>> Von Nguyen: I think the one other additional comment I would make is that the public health in many communities is seen as a neutral convener. The ability to bring people together as Therese mentioned, creates the safe place for transportation and the healthcare delivery system to get together is sometimes important.

The other piece I think that public health can do, in addition to creating a table, there's an opportunity to bring evidence to the table. And that's where the Health Impact in 5 Years and the evidence summary you can find at the website might be important.

So one, the role of public health is creating that space and secondly when you are at the table show them that there is a shared goal, a shared opportunity to really both improve public transportation while simultaneously improving the health of the individuals within the community. To boot on top of that there's cost effectiveness data behind it. It's a good investment on top of the health investment.

>> Adam Lustig: Great. And I know we are running a little short on time. So we have one last question and I'll just ask for the panelists to keep their answers as brief as possible.

What are some recommendations you have for areas that are more rural or even suburban that have minimal to no public transportation available?

>> Joseph Calabrese: Adam, let me jump in quickly and briefing briefly. One of things I didn't mentioned before which ties into this question is location, location, location. We need to encourage those in charge of locating healthcare services to locate where public transit can most easily serve them because just because the bus is on wheels doesn't mean it can get everywhere or get everywhere cost effectively. Our industry is experiencing the same if not worse financial pressures on the funding at a federal and state level. We work with a lot of rural systems. Again the number one purpose for rural systems is getting people to healthcare, but they need more resources to do it.

In many cases, where the people are located, just as many places where healthcare services are located as well.
>> Therese McMillan: Just a quick add. I think particularly for rural areas again largely from my experience at the FTA. You think about very different models of public transportation or think about a mobility connection that may look very different from the classic bus route or rail line in an urban setting, and design a fix that fits with the resources and the location and the partners in your particular rural area.
And we saw some really interesting funding and service provision partnerships between regional medical centers, say in Fargo, North Dakota, that had worked with their entities to get to outlying areas 40, 50 miles away. But it was very targeted, which made sense given the layout of where the need was.
Think creatively and out of the box. Rural areas often did that incredibly well.
>> I would have one quick thing, the National Rural Assistance Program has webinars and toolkits on tribal transit and other programs and also the Federal Transit Administration has rural transit assistance page which you can get resources there for funding.
>> Adam Lustig: Great. And Dr. Skillen, you just want to go over what is upcoming with the Health Impact in 5 Years initiative?
>> Elizabeth Skillen: Sure. I would like to thank our speakers today. I got so much out of the presentation from Therese McMillan and Joe Calabrese. Special thanks to my team, Meghan Kelly, Wendy Heaps, Adam Lustig and Dave Clark for making that possible. Please stay tuned to see how public transportation is expanding around the country. We want to learn from you. Email us at health policy news. Lastly, visit our website for more information on HI-5 interventions at www.CDC.gov/HI-5.
I think that's a wrap, Adam.
>> Adam Lustig: Great. Dave, do you want to make any concluding remarks?
>> Dave Clark: Thanks so much, Adam and thanks to all of our presenters today for their insights, Joe and as always the National Network of Public Health Institutes and the Centers for Disease Control and Prevention. We did record today's session. So that recording as well as the presentation slides will be available shortly at Dialogue4Health.org. We are going to be send you an email with the link to the recording and slides. Check your inboxes for that. That email will include a link to a brief survey we would like you to take. We would like your thoughts concerning today's web forum as well as what you would be interested in for future Dialogue4Health web forums. Take a couple of moments to complete the survey.
Thank you for being with us today. That concludes today's web forum. Have a great day.
(The webinar concluded at 2:00 o'clock p.m. EDT.)