

**MOBILITY FOR PERSONS WITH DISABILITIES: EXAMINING SERVICE AND PLANNING
INNOVATIONS OF THE U.S NEW FREEDOM TRANSPORTATION PROGRAM**

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Abstract: The U.S. New Freedom (NF) program seeks to expand mobility options available to persons with disabilities beyond those required by the Americans with Disabilities Act of 1990 and secondly, to address barriers to work faced by such persons. The program was stimulated by a presidential order emphasizing the role of community-based alternatives for persons with disabilities (Executive Order 13217, 2001). Using data from 10 NF-funded services, the objective of this paper is to examine program targeting, mobility and perceptual outcomes experienced by users and to briefly present a methodology to connect users with services that are appropriate to their mobility needs. We also examine the benefits of a planning process, the Coordinated Human Services Transportation Plan, by means of which NF transportation services are jointly developed and prioritized by transportation, human services, disabilities organizations, agencies for aging and a myriad other organizations including community-based non-profits organizations and municipal governments.

1. Introduction

Mobility for persons with disabilities in the U.S. is a key aspect of transportation policy. Current statistics suggest that the number of people with disabilities living in communities around the U.S. or in institutional settings now totals more than 40 million (between 13 and 14 percent of the population) and perhaps as many as 50 million, if a more expansive definition of disability is used (Committee on Disability in America, 2007). These numbers are expected to grow significantly in the next 30 years as the Baby Boom Generation ages and the risk of age-related disability increases. Since 1980, the percentage of Americans aged 65 and older has grown from 11.3% to approximately 12.6% in 2008 (Census.gov) for an increase of more than 13 million. These statistics have led transportation for persons with disabilities to continue to be an important aspect of public policy debate.

Overall, a very large segment of older Americans report having a disability (51.8 percent), with 37 percent indicating that they have a severe disability, and close to 16 percent needing assistance with daily activities (U.S. Census Bureau, 2005), leading to dependence upon family, caregivers or neighbors for transportation assistance. Several authors have also noted that mobility impairments are positively associated with dependence in Activities of Daily Living (ADL) in adults over the age of 65 (Shumway-Cook, et al, 2002; Metz, 2002). While age is an important ingredient in the challenges posed by disabilities, there are millions of younger people who also live with disabilities. In 2004, the total number of younger adults with disabilities exceeded the total for the population ages 65 and over (Committee on Disability in America, 2007).

In an effort to address the importance of transportation, the New Freedom (NF) transportation program was established by the Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users (SAFETEA-LU, 2005), as a formula program to provide funding for transportation projects designed to reduce mobility barriers experienced by persons with disabilities. Regulations stipulate that NF-funded transportation projects be developed through Coordinated Human Services Transportation Plans (CHSTP), that are developed jointly by organizations in transportation, human and social services, workforce development, labor and economic development, private employers, faith-based organizations and other organizations involved in the well-being of persons with disabilities, seniors and low-wage workers.

Using data from 10 NF-funded services, the objective of this paper is to examine program targeting, mobility and perceptual outcomes experienced by users and to briefly present a methodology to connect users with services that are appropriate to their mobility needs. We also examine the benefits of a planning process (the Coordinated Human Services Transportation Plan or CHSTP process) by means of which NF services are developed and prioritized.

The paper is organized as follows: in Section 2, we present background information on disability trends in the U.S. and policy information on the NF program. In Section 3, we describe the NF services surveyed and the research approach used in the paper. Program targeting is presented in Section 4. Mobility and perceptual outcomes self-reported by NF users are summarized in Section 5 – this section also presents two indices of mobility independence: functional ability and perceptual ability. We present a method to connect mobility deprivation with transportation and travel services appropriate to the person's context in Section 6. Findings regarding the CHSTP process are given in Section 7. Conclusions are given in Section 8.

2. Policy Background

The Americans with Disabilities Act provided a significant stimulus to recognizing the special mobility needs of persons with disabilities. The National Council on Disabilities noted that: "As a result of the ADA, the past decade has brought about real improvements in access to transportation for people with disabilities, and access to public transportation has improved significantly since implementation of the ADA transportation provisions" (National Council on Disabilities, 2005). While much has been done to adapt current transportation services, vehicle design, paratransit services, accessible design and universal design and other strategies to serve the needs of persons with disabilities, there was no transportation program at the federal level that uniquely focused on the mobility needs of these persons and for the funding needed to make systems accessible "beyond ADA".

The New Freedom Initiative (NFI) is a federal initiative addressing the concerns of persons with disabilities and was established on February 1, 2001 by then President George W. Bush as part of a nationwide effort to remove barriers to community living for people with disabilities. The Initiative emphasizes access to assistive technologies, work, education, and other opportunities for people with disabilities and was followed up by Executive Order 13217, titled "Community-Based Alternatives for Individuals with Disabilities", on June 18, 2001. Title II of the Americans with Disabilities Act, which proscribes discrimination in the provision of public services, specifies, *inter alia*, that no qualified individual with a disability shall, "by reason of such disability," be excluded from participation in, or be denied the benefits of, a public entity's services, programs, or activities. §12132. One regulation that resulted from the US Congress instructing the Attorney General to issue regulations implementing Title II's discrimination proscription is known as the "integration regulation." This regulation requires a "public entity (to) administer ... programs ... in the most integrated setting appropriate to the needs of qualified individuals with disabilities."

Although not originally one of the six federal agencies targeted by the Executive Order, the US Department of Transportation has also joined this implementation effort, by means of the New Freedom (NF) transportation program, so as to bring about community-based alternatives to mobility options. One component of the NF transportation program is an emphasis on connecting persons with disabilities to employment. Only 60 percent of people between the ages of 16 and 64 with disabilities are employed. The NF formula grant program seeks to reduce barriers to transportation services and expand the transportation mobility options available to people with disabilities.

To date, the Federal Transit Administration (FTA), the agency responsible for administering the NF program, has funded services that give persons with disabilities options that are "beyond ADA". Three categories of projects have been funded: trip-based services (such as shuttles, feeder, route deviation, point deviation), information-based NF service (such as one-stop centers, mobility management, travel training, trip planning) and capital programs (vehicles for individuals, agencies or vanpools, elevators, and accessible taxis).

For example, the NF program has funded services that expand ADA complementary paratransit services, by expanding paratransit service parameters beyond the three-fourths mile required by the ADA and the current hours of operation for ADA paratransit services, and programs to cover the incremental cost of providing same day service and the incremental cost of making door-to-door service available to all eligible ADA paratransit riders. In addition, the program has funded door-to-door or door-through-door (escort programs), volunteer driver programs and aide/escort assistance; travel training, mobility management and driver training for individuals where vehicle operators may receive training to use specially equipped vehicles for persons with disabilities. The NF program also funds capital projects such as elevator purchases, large capacity wheelchair lifts that are added to vehicles, and addition of

wheelchair securement areas, which improve mobility conditions for persons with disabilities. Between 2006 and 2009, the department expended \$338.2 million (capital programs require a 20 percent match, whereas operating programs require a 50 percent match; 10 percent of the apportionment may be used to support program administrative costs including administration, planning, and technical assistance).

3. Services Studied and Research Approach

We have used four sources of primary data for the study. The data were collected during the period from 2008 to 2010: (i) surveys of the lead and partner agencies involved in developing the CHSTP plans at the 10 sites which were selected for the study; (ii) a census of lead and partner agencies involved in the CHSTP across the US (with 749 lead agencies and 16,431 public, private and non-profit organizations involved in the CHSTP process nationally) that was collected by the researchers as part of an earlier study; (iii) surveys of managers of the services; and finally, (iv) surveys of service users. The census was completed towards the end of 2008, while the surveys were administered between spring of 2009 and summer of 2010. We also utilized published CHSTP plans available from the web sites of the lead agencies. The 10 services were selected using a sampling process given in Thakuria, et al (2012a).

Table 1 summarizes the major attributes of the services studied. six of the 10 service providers surveyed for this study are non-profit social services centers, one is city government-operated senior service center and the remaining three are transit agencies. Four of the six social-service centers focus exclusively on seniors, whereas two focus on seniors and younger persons with disabilities. The stated purpose of most of these organizations is independent living. Four of the 10 service areas we surveyed had a higher percentage of seniors than the US average of 12.6% (American FactFinder, 2000); however, within these large service areas, there are geographical clusters with a higher density of seniors, forming “Naturally Occurring Retirement Communities”, with areas of older people comprising a population density greater than 50% (Ormond, et al., 2004).

The senior service centers provide comprehensive services targeting functional, emotional and financial needs of seniors. For example, one senior service center offers volunteer medical and health transportation, phone calls to seniors, grocery shopping, hot meal delivery, visual assistance, friendly visits, prescription pick-up and volunteer companion sitting. Another service offers in-home care including professionally-trained home care aides who assist in laundry assistance, light housekeeping, bathing assistance and medication reminders. Several programs offered “enrichment programs” including adult art, recreation, sports and healthy living courses, dining tours and walks and hikes. To these centers, transportation options increase the ability to enhance independence and integration to the community, but are one of many services provided to seniors towards achieving these goals.

We surveyed users of car-based or van-based services offered by the above providers with partial funding from the NF program. The transportation options offered to seniors by these organizations cover a wider range of services, including volunteer driver services in passenger cars or vans, shuttle (van) services, taxi subsidy programs, travel training and American Association of Retired Persons (AARP) driving classes. However, not all options are being partially funded by NF in these locations. The NF funds are financially matched by a variety of sources, but most commonly, by the centers providing the service. In the case of services operated by transit agencies, matching funds were mostly from social and human services agencies. We surveyed NF-funded door-through-door assisted volunteer driver services where volunteers drive their own cars or the organization’s cars or vans; van services operated by transit agencies; taxi subsidy programs; and integrated van and taxi services.

The NF-funds are being used to expand volunteer driver mileage reimbursement and secondary liability coverage and administrative activities relating to screening and training volunteers; to operate new van services or to expand existing van programs to expand ADA options either spatially or temporally and to make payments to taxi companies. These are not services that are covered by traditional sources of transportation funding and the services offered options to persons with disabilities that are not available from ADA paratransit service.

Many services, especially non-traditional services that the NF program funds at the survey sites existed previously. For example, several human service-oriented, non-traditional organizations operate volunteer driver programs. The benefit derived from the NF program is their continued existence, and in some cases, their enhancement (with greater service frequency, larger number of volunteers and so on). Aside from the funding derived from the NF program, an additional benefit that was identified by program managers is the ability to learn more about transportation planning and funding, through the CHSTP process and to be better socialized in the mobility aspects of their clients' well-being.

4. Program Targeting

The results showed that the program has reached a variety of persons with disabilities. We found that NF transportation services are being used by younger individuals with disabilities, who perceive themselves as being in good health but have difficulty functioning independently, as well as by seniors, who are more likely to report being in poor health but who self-report experiencing greater levels of independence in performing everyday activities. The majority of the respondents self-reported living alone (54.2%), with over 70% of seniors reported living alone. Respondents were likely to be of low income with the majority earning less than \$20,000 per year.

Services for seniors with disabilities constituted the majority of our sites. Close to 68% of the respondents were above 65 years of age and about 44% of the respondents in our sample were 80 years or older representing the "oldest of old". Close to 47% of persons in the sample less than 65 years reported working for pay. Less than 1% of seniors reported being employed (in response to the question: "Are you currently working for pay"?)

Over 53% of respondents do not have a vehicle in their household. Close to 65% of the respondents reported not having a valid driver's license. Younger respondents in our sample were more likely to report not having a driver's license (79%), compared to those above 65 years of age (55%).

Overall, approximately 64% of respondents reported that they had to stop driving a car, or drive less frequently than they used to. These respondents tend to be over 65 years of age. In terms of the reasons for why the respondent had to stop driving, declining vision is a key issue, as is reduced coordination or reaction time and chronic illness. Respondents also reported being advised by doctors to give up or to limit driving and not being able to pass or renew driver's license.

5. Outcomes Experienced

We examined two types of outcomes: perceptual outcomes and mobility outcomes experienced by NF service users. Nearly 70% reported difficulties with using public transportation such as buses and trains. The reasons ranged from difficulties in accessing subway stations or bus stops, to difficulties in boarding and getting off transit vehicles. Overall, 57% of the NF service users perceived the quality of the services to be "Excellent", whereas 34% perceived service quality to be "Good" and only 9% of the respondents rated the service as fair, poor or very poor.

Table 1: Characteristics of NF Transportation Programs Surveyed

Type of Service	Service Provider Category	Service Provider Function	Other transportation Service	Percent over 65 Years in Service Area (US: 12.6%)	Use of Program Funds
Door-through-door assisted volunteer drivers driving their own personal cars	City government	Comprehensive senior services center	Taxi service (Senior Taxi Scrip); AARP driving classes	15.5	To expand volunteer driver reimbursement, screening, training and secondary liability coverage
Door-through-door assisted shuttle/van service using volunteers driving organization's van	Non-Profit	Comprehensive senior services center	Volunteer driver services (about 400 volunteers); nutrition mobility coordination	10.7	New DR service; additional NF to expand volunteer driver programs
Door-through-door assisted van service using organization's own drivers or volunteers driving organization's vans	Non-Profit	Comprehensive community organization serving seniors and persons with disabilities	Meals on Wheels	13.6	Increase coverage of existing DR service
Taxi coupon service	Transit Agency	Transit Agency	Volunteer driver program	13.3	Cab payments
Reserved curb-to-curb bus service with point deviation with (currently) no assistance	Transit Agency	Transit Agency	Regular transit programs	5.7	Service operation
Door-through-door assisted service using either paid drivers or volunteers	Non-Profit	Comprehensive senior services center	Volunteer driver program	22.5	Used to administer and operate DR service and to screen train and reimburse volunteers
Integrated transportation services - taxi and van	Non-Profit	Comprehensive senior services center	Volunteer driver program	8.4	Used to pay Taxi companies and van providers
Integrated transportation services - taxi and van	Non-profit	Comprehensive senior services center	None; coordinates multiple services for seniors	10.6	Used to pay Taxi companies and van providers
Taxi rides	Non-profit	Comprehensive community organization serving seniors and persons with disabilities	Van programs; medical transportation	10.7	Used to pay taxi companies
Curb to curb service for any purpose within the county; travels outside county for medical trips only.	Transit Agency	Transit Agency	Regular transit programs	10	Service operation.

Irrespective of the level of perceived quality and reliability, a very large share of respondents (84%) noted that the service is “Very Important” to them, while an additional 11% noted the service to be “Moderately Important”. Although close to 64% reported never having problems with scheduling their trips with the NF-funded services, others were likely to report mild to significant levels of problems with scheduling. Overall, younger individuals who take the service to work tended to report difficulties at a greater rate. Additionally, close to 34% of respondents determined that there were always problems with on-time arrival with the service, with an additional 18% noting that on-time problems occur most of the time.

Lack of adequate equipment such as wheelchair lifts and their maneuverability, length and securement were noted to be a problem by few respondents and 17% noted that affordability is sometimes a factor of concern. More than 65% of the respondents use the services to access medical or health-care related destinations and close to 46% use the service for shopping. About 25% use the services to travel to work and a smaller share of respondents (15%) use the services for social visits. About 46% of younger respondents use the services to go to work (mostly work for pay), while 6% of seniors do so (presumably some travel to volunteer work locations). Close to 74% of workers make 5 or more trips per week using the service.

Self-reported one-way travel times to work have decreased from a mean value of 28 minutes prior to using the service to a mean value of 25 minutes, when using the service. The share of respondents making 6 or more medical trips per week increased from 14% before starting to use the service to 18% after using the service - this could be the result of a deterioration in the health condition of those with chronic illness or due to health concerns that arose as a natural part of the aging process.

The overall mean travel time for medical and health trips has decreased from 78 minutes prior to using the service to 54 minutes after using the service. The travel time savings are greater for seniors (31 minutes), compared to younger persons, before and after travel time differences for whom was negligible.

We assessed respondents with disabilities on two measures of mobility independence in order to understand how travel and overall living conditions are correlated with feelings and perceptions of being able to travel independently. Details are given in Thakuria et al (2012b). The objective is to obtain a holistic picture of the mobility attributes of persons with disabilities and their ability to travel independently. Two measures were used to determine the level of mobility independence. The first, Perceived_Ability, is a self-reported measure on a Likert-type ordinal scale ranging from 1 (“never being able to travel to places such as work, shopping, health care, etc., on your own”) to 5 (“always” being able to do so). The Functional_Ability scale reflects the “Mode of Transportation” and “Shopping” aspects of the Lawton-Brody IADL and is constructed from several survey items, ranging from 0 (extreme lack of ability to travel independently) to 6 (strong ability to travel independently). Previous studies have focused on “hard” measures such as the number of trips made, particularly shopping and medical trips, whereas we examine a measure of perceived independence and a proxy measure for overall functional independence in travel. Table 2 gives the particulars of the two scales.

Table 2: Two Indices of Mobility Independence

Measure	Description	Scale	Mean
Perceived_Ability	Perceived ability to travel independently	5-point Likert scale: 1=Never to 5=Always	2.62
Functional_Ability	Composite of the following questions measuring functional ability to travel: Can drive car (=1); Can access and board public transport stations and stops, pay fares, understand schedules, have no difficulty finding a place to sit, with station crime and with bringing a service animal (=1); No perceived difficult in using public transportation overall (=1); Able to shop independently (=1); Do not need assistance from another person outside home (=1); Able to sometimes or always go outside the house, ie, not home-bound (=1)	7 point composite scale: 0 – No ability in any of the 6 functional measures to 6 – Ability in all 6 functional measures	2.50

Perceived_Ability and Functional_Ability measure different aspects of the respondents' travel situation (although significant at the .01 level, the magnitude of the Pearson's correlation coefficient between the two scales is small, at $r=0.36$). Pearson's coefficients indicate evidence of significant positive correlation between Perceived_Ability and number of shopping trips ($r=0.11$), and significant negative correlation with number of medical trips ($r=-0.04$), number of work trips ($r=-0.08$), needing a personal assistant inside the house ($r=-0.32$), ability to travel independently outside the house ($r=-0.17$) and wheelchair use ($r=-0.13$). Interestingly, we did not find a statistically significant association between Perceived_Ability and Rate_Health or self-reported health status, indicating that the health status question ("Overall, how would you rate your health") possibly elicited responses relating to transient ailments, so even those in relatively poor health at the time of reporting may have viewed themselves as being able to generally travel independently.

Functional_Ability significantly, positively correlates with self-rated health ($r=0.11$) and number of shopping trips ($r=.16$), and significantly negatively correlates with medical trips ($r=-0.04$), work trips ($r=-0.008$), needing personal assistance inside ($r=-0.53$) and outside ($r=-0.62$) the house, needing crutches and canes ($r=-0.25$), manual ($r=-0.21$) and electric wheelchair ($r=-0.29$) and difficulty communicating while traveling ($r=-0.20$).

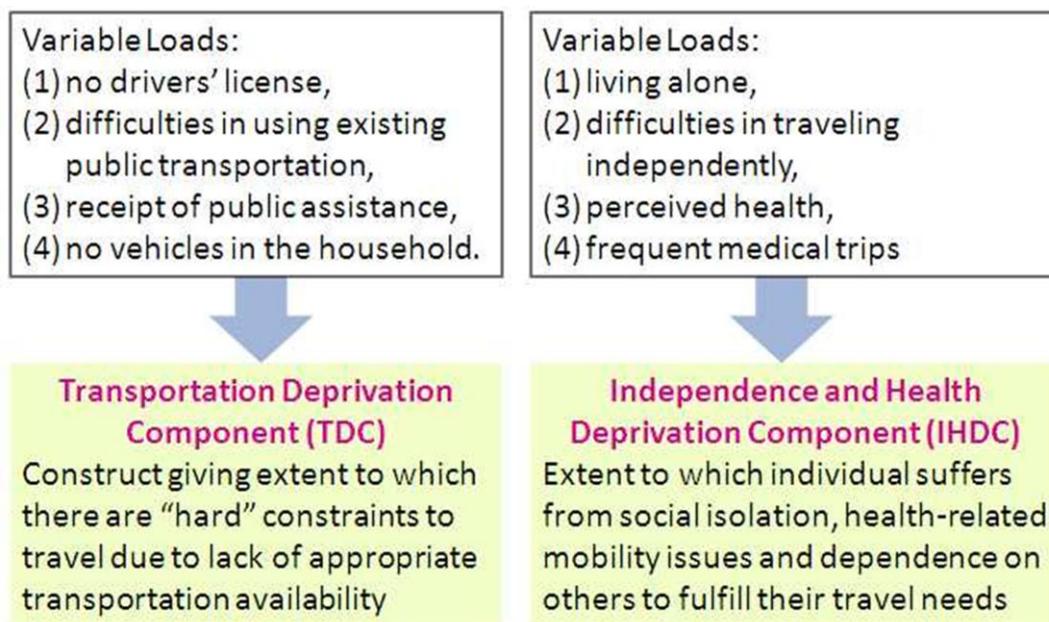
These results indicate that the perceptual measure reflects actual functional travel and trip-making abilities and patterns to a certain degree, although the modest size of the correlations indicate that other factors are taken into consideration in the perception of independence in travel. On the other hand, while the functional ability measure reflects underlying travel and mobility conditions it is also significantly related to a greater number of specific aspects of the activity of travel, as impacted by the person's disability situation. Health status may interfere with some of the elements of functional ability to travel independently, such a driving or being able to shop, thereby leading to a positive association between the two variables.

6. Measures of Mobility Deprivation and Method to Connect to Appropriate Services – Seniors Only

A special analysis was conducted for the subset of respondents older than 65 years of age to demonstrate a methodology to connect persons with specific mobility deprivation attributes with transportation services that are appropriate to their needs. We used Principal Component Analysis for this purpose.

We identified two dimensions that account for the majority of the variation in senior mobility needs. These dimensions are given below in Figure 1. The results are given in detail in Thakuria et al (2012a). Four items were found to load on the first component or dimension: (1) no drivers' license, (2) difficulties in using existing public transportation, (3) receipt of public assistance, and (4) no vehicles in the household. We call this the Transportation Deprivation Component (TDC) and a respondent's composite score on this component gives the extent to which transportation is a challenge (with a high score indicating more deprived). Four items also loaded on the second component: (1) living alone, (2) difficulties in traveling independently, (3) perceived health issues, and (4) medical visits (which is a count of person medical trips per week). We call this the Independence and Health Deprivation Component (IHDC), and a respondent's composite score on this component gives the extent to which the individual suffers from social isolation, health-related mobility issues and dependence on others to fulfill their travel needs, with a higher score indicating more deprived.

Figure 1: Two Dimensions of Mobility Deprivation



We next correlated the TDC and IHDC components to the mobility outcomes considered earlier, in order to draw implications for the types of transportation services that may best serve mobility needs. The results indicated that those ranking high on the first component would require reliable transportation services to a variety of destinations, including shopping and social visits, and their needs may be serviced with more traditional transportation services such as van programs, ridesharing and fixed-route services with deviation. Those ranking high on the second component would need frequent and reliable medical trips, information about travel options, greater care and support in making trip arrangements and assistance in actually undertaking the trip. Volunteer driver programs, door-through-door services, travel planning and travel training, and perhaps, non-emergency medical transportation would be useful to seniors scoring high on this second component.

7. Findings regarding the CHSTP process

As mentioned earlier, the CHSTP process is required as a part of the NF program, ie, NF-funded transportation projects are to be developed through this process jointly by organizations in numerous

sectors associated with travel and well-being of persons with disabilities. We found innovative partnerships have developed among myriad governmental agencies (for example, among transportation, disabilities, aging, social services, workforce development and other agencies, as well as non-profit organizations) that have improved community-based planning to address the mobility needs of persons with disabilities. These organizations participated in various degrees in jointly developing services and in prioritizing projects in regions within the US examined.

Lead organizations responsible for the CHSTP process conducted extensive outreach to organizations serving persons with disabilities and seniors. A number of different organizations were involved with the well-being of persons with disabilities participated at these sites, including health and human services organizations, area agencies for aging, independent living centers, non-profit senior advocacy groups and adult day or health centers.

Although some organizations previously participated in regional transportation planning, our documentation indicated that the CHSTP process provided a formal way to bring mobility concerns of persons with disabilities to the table. In general, lead organizations tended to view the CHSTP process as very useful and important to outcomes, as well as to overall organizational goals. Some organizations felt the process was cumbersome to set-up and time consuming and that “coordination is best done organically and not forced”.

Program managers who manage the transportation services were also appreciative of the CHSTP process for its innovative service funding and for providing options beyond the ADA provisions. They did not, however, find it to be particularly useful in resolving their immediate concerns relating to finding the 50% required match or the lengthy grant implementation process.

10. Conclusions

The NF program has reached persons with many different types of disabilities ranging from young persons looking for reliable transportation to access jobs to older persons who reported being chronically ill as well as those with age-related functional disabilities. The program supports three broad project categories: trip-based NF services (for example, expanded ADA services, volunteer driver programs and shuttle or feeder services), information-based NF services (for example, mobility management and ride matching programs), and capital investment services (for example, programs to sell vehicles or wheelchairs to individuals, sale of elevators or large capacity wheelchairs to lifts and related programs). Funded by a federal transportation agency, services have been developed with the cooperation of transportation agencies, human services agencies including disabilities organizations, agencies for aging, workforce development and myriad others most important of which are community-based non-profit or municipal government organizations. This has brought a community-based, social service perspective into the resulting transportation services. Many of the services funded have existed previously having been developed and operated by community organization or agencies for aging; NF has funded their continuation. This has allowed funding to be used effectively without expending much effort in starting new services in some cases.

The analysis showed that NF service users have experienced a variety of beneficial mobility and perceptual outcomes. Persons who did well on “hard” measures of mobility as assessed by our function ability measure did not necessarily perceive themselves as being independent. This raises the question of using a mix of perceptual and objective measures in assessing the mobility independence of persons with disability. We also identified two dimensions of mobility deprivation (Transportation Deprivation Component and Independence and Health Deprivation Component) and derived services that would be appropriate for persons who ranked high on one versus the other dimension. The results indicated that those ranking high on the TDC component would require reliable transportation services to a variety of

destinations, including shopping and social visits, and their needs may be serviced with more traditional transportation services such as van programs, ridesharing and fixed-route services with deviation. Those ranking high on the IHDC component would need frequent and reliable medical trips, information about travel options, greater care and support in making trip arrangements and assistance in actually undertaking the trip. Volunteer driver programs, door-through-door services, travel planning and travel training, and perhaps, non-emergency medical transportation would be useful to seniors scoring high on this second component.

Regarding the CHSTP process, participants noted that it was useful in stimulating innovative partnerships to serve the needs of persons with disabilities and provided a formal way to bring their mobility concerns to the table. Overall participants felt that the process has improved community-based planning and service provision to meet the mobility needs of persons with disabilities. However, some organizations felt the process was cumbersome to set-up and time consuming and while others felt that the process could be better streamlined to help service operators address their immediate concerns. These concerns open up areas for improvement in the planning process.

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