GETTING THERE TOGETHER

New Hampshire's Community Transportation Action Plan

Prepared for the New Hampshire State Commission on Aging by Impact Consulting

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About This Action Plan

A quick guide to the terms, data, and companion documents used throughout this action plan.

Why community transportation matters in a driving state

New Hampshire is one of the most car-dependent states in the country. Nearly 80% of New Hampshire workers drove alone or carpooled to work in 2023. Fewer than 1% used public transit. Only 34 of New Hampshire's 234 communities are served by regular public transit routes (NHFPI, 2025; NH Transit Association, 2022). For most New Hampshire residents, on most days, transportation is something they handle themselves.

> **That dependence on personal vehicles is exactly why community transportation matters.**

Driving changes before it ends. Most New Hampshire drivers do not stop driving all at once. They change how they drive in stages: at night, in bad weather, on highways or in unfamiliar areas, on long trips, and eventually for daily errands. The CTNA found that 43.1% of respondents aged 65 and older reported already driving less than they used to (CTNA-B; 313/727), and 38.4% of respondents overall reported the same (CTNA-B; 447/1,165). Each transition creates a moment when a ride from someone else becomes the difference between staying connected and falling behind. The system that catches a person at that moment is community transportation. When that system is missing, the alternative is premature placement in a higher-cost setting that the State is already overspending on.

The fiscal arithmetic is direct. New Hampshire's median annual cost for a semi-private nursing home room is $149,650, and for a private room, $157,680 (Genworth and CareScout, 2025). New Hampshire ranks 49th in the country for Medicaid spending on home- and community-based services (AARP Public Policy Institute, 2023), and the State's Choices for Independence Medicaid waiver was underfunded by $153.2 million between 2011 and 2021 relative to inflation-adjusted need (NHFPI, 2022). Every older adult who loses access to the pharmacy, the clinic, or the adult day program because no ride exists is moving sooner toward the most expensive setting the State pays for.

Community transportation is also workforce infrastructure. The CTNA found that 27.4% of employed respondents lost work or income in a single month because of transportation barriers (CTNA-B). For young adults with disabilities, transportation is often the binary variable that determines whether a job is possible at all. The Commission on Aging has identified the growth of the direct care workforce as one of its three top policy priorities, citing projections that direct care workers will account for approximately 23% of all job growth in the State over the next decade (CTNA-D). Direct care workers cannot reach the homes of the people they support without dependable transportation.

What community transportation includes

Community transportation is the set of trip-providing services that help residents reach essential destinations when they cannot drive themselves, do not have a vehicle, or need a level of assistance a typical taxi or rideshare cannot provide. Six service categories make up the field: fixed-route transit and shuttles; demand-response and paratransit (including ADA paratransit); volunteer driver programs; Non-Emergency Medical Transportation (NEMT); intercity bus and rail; and mobility management and information services. For the transit-desert determination reported in §2.5, only the four provider-delivery categories that deliver community-accessible local rides count toward documented coverage: fixed-route, demand-response, volunteer driver, and NEMT serving the general public or named priority populations. Intercity bus, rail, and mobility management are documented in the inventory but are not counted in the desert determination. The Gap Report (CTNA-C) carries the full inventory, definitions, and provider counts for each category.

What New Hampshire already has

The State is not starting from zero. Most New Hampshire residents are unaware that any of the following exists.

- **Keep NH Moving** is the State's public-facing transportation information platform. The CTNA found that 87.1% of survey respondents had never heard of it (CTNA-B).
- **The State Coordinating Council for Community Transportation (SCC)** is the interagency body for transportation coordination. The SCC produced the 2022 *Statewide Mobility Management Blueprint.*
- **Eight Regional Coordination Councils (RCCs)** organize transportation coordination at the local level. Each produces a Coordinated Public Transit-Human Services Transportation Plan, which is required for FTA Section 5310 funding.
- **32 Volunteer Driver Programs (CTNA-I)** operate across all eight RCC regions, of which 14 have documented funding sources.
- **Transportation providers and Mobility Managers** in every region deliver the services riders use today.

The recommendations in this action plan do not replace any of this infrastructure. They connect these assets under a designated coordinating function with the authority, staffing, pooled or braided funding, shared data, and public reporting that have been missing. The systemic conditions for success have not been in place. This action plan puts those conditions in place.

How to read this report

The Community Transportation Needs Assessment (CTNA) is a statewide study commissioned by the New Hampshire Commission on Aging. The Commission asked for a plan that starts where the harm is greatest and works outward. This report, *Getting There Together: New Hampshire's Community Transportation*

Action Plan is the result. Older adults, people with disabilities, veterans, caregivers, rural residents, and other statistically relevant portions of the population are treated as priority populations throughout. Subgroup findings are quantified where sample size supports them, and sample constraints are named where the data should not be overclaimed.

To keep the action plan readable, the report uses short internal citations such as CTNA-A through CTNA-I. Each one links to a companion document that documents the underlying data, methods, and definitions. The two reference subsections below identify what each citation means and define the acronyms used across the chapters.

Companion Documents at a glance

The CTNA produced a connected set of deliverables alongside this action plan. The table below identifies each one, lists the data and methods it includes, and points readers to the supporting documentation for every recommendation that follows.

Citation	Title of the Cited Document	What it contains
CTNA-A	Community Engagement Report	Listening sessions, focus groups, and stakeholder interviews. The qualitative ground for everything that follows.
CTNA-B	Data Companion and Headline Statistics Crosswalk	Authoritative source for all survey statistics, denominators, weighting status, and Transportation Security Index scoring.
CTNA-C	Gap Report	Service-coverage gaps, transit-desert determination, and regional breakdowns by RCC region.
CTNA-D	Impact and Policy Analysis	Economic, fiscal, and health-system implications of the access gap, with policy levers.
CTNA-E	Master Quote Catalog	Source of truth for attribution and subgroup labels on every pull-quote used in this report.
CTNA-F	Qualitative Workbook	Coded themes, subgroup analyses, and the full set of supporting quotations behind §3.
CTNA-G	Systematic Review and Meta-Analysis	Foundational evidence from the published literature, used to test whether New Hampshire findings align with broader patterns.
CTNA-H	NH Community Transportation Braiding Toolkit	The convening manual: layered authority architecture, named-contact roster, 90-day outreach sprint, and model templates for compelled participation.
CTNA-I	CTNA Provider Inventory	Comprehensive registry of providers, programs, and coverage by municipality. Built throughout the project and referenced as supporting evidence.

Citation	Title of the Cited Document	What it contains
Conversion Playbook	Implementation Stand-up Manual	Draft Executive Order, model interagency agreements, 100-day calendar, 10-measure scorecard, 8-lens equity dashboard, Keep NH Moving RFP scope, and Pooled Fund pilot charter.
CHSTP	Coordinated Human Services Transportation Plan	First-ever statewide coordinated plan, jointly developed with NHDOT. Satisfies FTA §5310 and Circular 9070.1H requirements and demonstrates the coordination this report recommends.

How the CTNA documents fit together

Each document answers a different question. Together they become the action plan.

Community voice + service gaps + impact analysis + national evidence = a statewide action plan.

Acronyms used in this report

Community transportation touches on aging, disability, Medicaid, public health, veteran services, workforce, federal transit, and local planning, and the report uses many acronyms drawn from those fields. The most important are defined at first use in the chapter text. The list below is a consolidated reference for readers moving between chapters or companion documents.

A consolidated reference. First-use definitions are also embedded in the chapter text.

ACS
American Community Survey (U.S. Census)

ADA
Americans with Disabilities Act

ADRC
Aging and Disability Resource Center

ARPA
American Rescue Plan Act

DMAVS
Department of Military Affairs and Veterans Services (NH)

EO
Executive Order

FQHC
Federally Qualified Health Center

FTA
Federal Transit Administration

RFP
Request for Proposals

RHT
Rural Health Transformation Program (CMS)

RSA
NH Revised Statutes Annotated

RSVP
Retired and Senior Volunteer Program

A consolidated reference. First-use definitions are also embedded in the chapter text.

ASL
American Sign Language

BAAS
Bureau of Adult and Aging Services (NH DHHS)

BEA
NH Department of Business and Economic Affairs

BFA
Bureau of Family Assistance (NH DHHS)

BIPOC
Black, Indigenous, and People of Color

CCAM
Coordinating Council on Access and Mobility (federal)

CCSNH
Community College System of New Hampshire

CDFA
Community Development Finance Authority (NH)

CMS
Centers for Medicare & Medicaid Services

COA
NH State Commission on Aging

CTNA
Community Transportation Needs Assessment

DAV
Disabled American Veterans

DCYF
Division for Children, Youth and Families (NH DHHS)

DHHS
Department of Health and Human Services (NH)

GACIT
Governor's Advisory Commission on Intermodal Transportation

GAO
Government Accountability Office (federal)

GO-NORTH
Governor's Office of New Opportunities and Rural Transformational Health

LTSS
Long-Term Services and Supports

MCO
Managed Care Organization

MOU
Memorandum of Understanding

NCMM
National Center for Mobility Management

NEMT
Non-Emergency Medical Transportation

NHDOT
New Hampshire Department of Transportation

NHEP
NH Employment Program (DHHS)

NHFPI
NH Fiscal Policy Institute

NOFO
Notice of Funding Opportunity

OAA
Older Americans Act

RCC
Regional Coordination Council

SCC
State Coordinating Council for Community Transportation

SDOH
Social Driver of Health

SHIP
State Health Improvement Plan

SILC
Statewide Independent Living Council

SMM
Statewide Mobility Management

SPIL
State Plan for Independent Living

TSI
Transportation Security Index

TTO
Transportation Transformation Office (proposed)

VA
U.S. Department of Veterans Affairs

VDP
Volunteer Driver Program

VSO
Veterans Service Organization

WIOA
Workforce Innovation and Opportunity Act

Executive Summary

A roadmap New Hampshire can fund, build, and use.

A seventy-eight-year-old in Coös County stretches a prescription for three weeks because she cannot reliably get to the pharmacy. A veteran in Cheshire County stops going to dialysis after the ride falls through for the second time in a month. A mother in Hillsborough County loses a shift and the week's grocery money because the van never came. A caregiver in Grafton County turns down a part-time job because her mother's medical trips are unpredictable and nobody else can cover them.

These are not rare stories. They are the daily arithmetic of a state where 42.8% of survey respondents have missed, delayed, or avoided medical care because of transportation, where 41.5% feel isolated or stuck at home, where 87.1% of survey respondents have never heard of the statewide program designed to help, and where 65.4% of veterans have never used any veteran-specific transportation service. This plan is about community transportation; the trip-providing services New Hampshire residents rely on when driving themselves is not an option.

Transportation is the quiet infrastructure underneath almost every other goal New Hampshire has set for itself. When it works, daily life holds together, but when it fails, the failure spreads quickly across health, work, caregiving, and connection. The CTNA built the statewide evidence base that the State now needs to act on, drawing on 2,824 survey responses, 72 stakeholder interviews, 11 focus groups with 76 participants, and 5 public forums across all 10 counties.

The problem with community transportation is understood. New Hampshire has produced studies, recommendations, and councils, but no one was ever designated to run the system they described. This action plan delivers the operating layer that decades of analysis have been waiting for: a coordinating role the State assigns, funds, and measures; an investment sequence with timed phasing; a funding strategy that stops asking local providers to solve state-level fragmentation; and an implementation roadmap that can begin without another planning cycle. Existing agencies, regional councils, mobility managers, providers, and clinical partners keep their roles. What changes is the framework they operate inside.

Table ES-1. *Survey scope and key findings.*

2,774 cleaned survey responses	**72** stakeholder interviews	**11** focus groups 76 participants	**10** counties represented
60% experienced transportation insecurity	**42.8%** missed, delayed, or avoided medical care	**41.5%** felt isolated or stuck at home	**27.4%** of employed respondents lost work or income

Note. The 2,774 figure is the cleaned analytic sample, screened from 2,824 raw responses for consent, geographic validation, and data completeness. Denominators vary by question because not all respondents answered every item. Exact numerators and denominators for every statistic are published in the CTNA Data Companion and Headline Statistics Crosswalk.

The evidence base leaves little room for ambiguity. The headline figures appear in Table ES-1. The pattern is sharpest at the subgroup level: under-65 respondents living with a disability reported the highest missed-care rate documented in the CTNA, at 67.6%. People with disabilities overall reported missed care at 54.7%, veterans at 42.9%, and older adults at 36.4% (CTNA-B).

These failures concentrate and fall hardest on older adults, people with disabilities, veterans, caregivers, rural residents, and others for whom transportation is often the deciding factor in whether medical care, work, food access, and community life remain possible.

Getting There Together turns the CTNA findings into an operating model, six statewide recommendations, a three-tier investment sequence, a funding strategy, and a 100-day implementation roadmap. The companion *Conversion Playbook* carries draft Executive Order language, model interagency agreements, contract provisions, and scorecard fields. The *Braiding Toolkit* carries the convening playbook for getting partners to the table and keeping them there.

The urgency is measurable. Transportation failure already drives missed care, lost wages, caregiver exhaustion, and avoidable deterioration today. Access is limited across much of the State, and 87.1% of CTNA respondents had never heard of Keep NH Moving, the State's central platform for community transportation (CTNA-B).

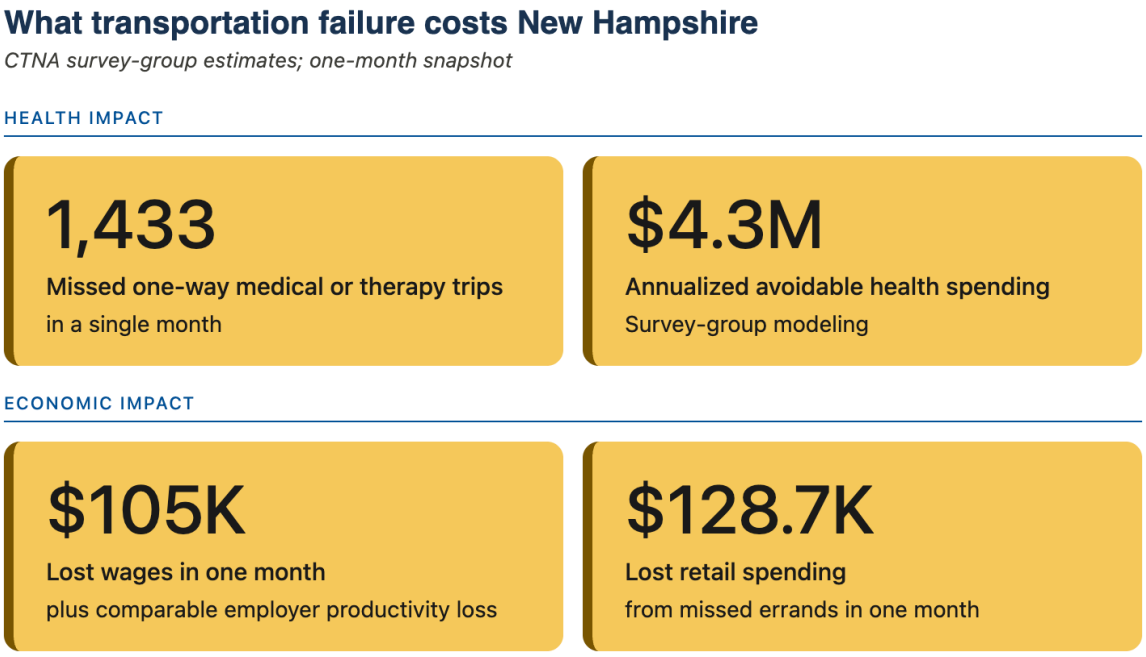


Figure ES-1. *One month of transportation failure, modeled for the CTNA survey group. Source: CTNA survey counts (CTNA-B, cleaned sample n=2,774) × unit-cost assumptions documented in CTNA-D. The $4.3 million annualized figure is a model output, not an observed outcome, and applies only to the CTNA survey group. The model combines reported missed one-way medical and therapy trips with an escalation-rate assumption (the share of missed care that progresses to avoidable emergency department visits and hospitalizations) and peer-reviewed unit-cost assumptions for those downstream outcomes. Full modeling inputs, escalation rate values, unit cost sources, and sensitivity ranges are disclosed in CTNA-D §1.7 and CTNA-B §1.7.*

Transportation failure is already costing New Hampshire. The bill is paid one way or another.

The arithmetic is direct. In a single month, the CTNA survey group reported 1,433 missed one-way trips to medical and therapy appointments, about $105,000 in lost wages, and about $128,720 in foregone local retail spending (CTNA-B). When missed care escalates to emergency department visits and hospitalizations, the CTNA impact analysis estimated roughly $4.3 million in annualized avoidable spending for the survey group alone (CTNA-D). The bill is paid one way or another. The only question is whether New Hampshire pays for the system that prevents the loss or for the loss itself.

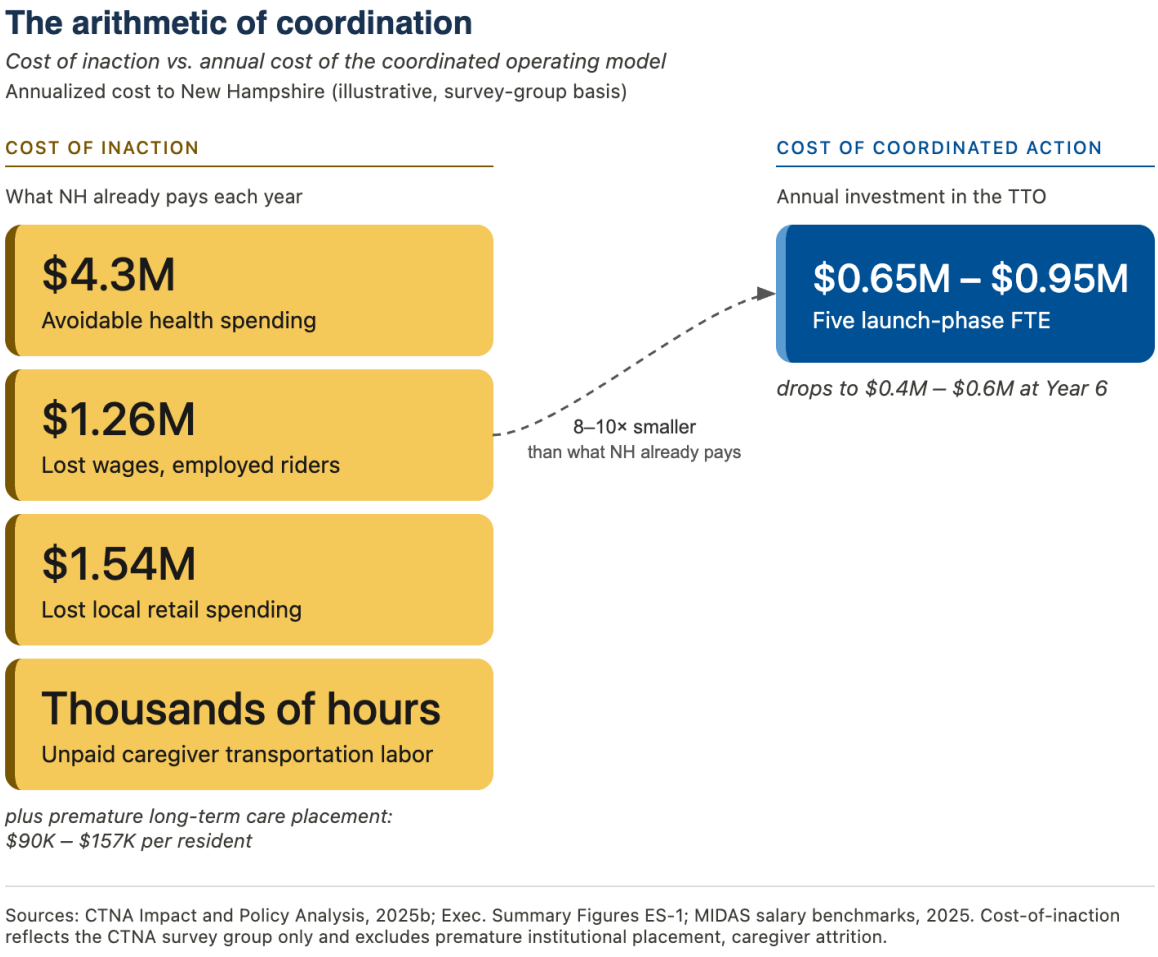


Figure ES-2. *The arithmetic of coordination: cost of inaction compared with the annual cost of the coordinated operating model. The graphic compares modeled annualized costs from transportation failure in the CTNA survey group with the estimated launch-phase staffing cost of the statewide coordinating function.*

New Hampshire already pays a premium when access fails. The 2024 median annual cost of nursing home care in New Hampshire reached $149,650 for a semi-private room and $157,680 for a private room, while assisted living reached $89,175 (Genworth and CareScout, 2025). Medicaid carries a substantial share of that bill. Every older adult pushed into these settings prematurely because mobility loss went unsupported represents a cost that the State, families, and private payers already absorb in the most expensive form of care available.

The cost of delay is no longer lower than the cost of action.

Table ES-2. *One-month transportation failure for the CTNA survey group, paired with what a coordinated system would change.*

What happens each month of delay (CTNA survey group)	What a coordinated system would change
Approximately 1,433 one-way medical or therapy trips missed	Critical medical trip completion would become a tracked, published, improving measure
Approximately $105,000 in lost wages among employed respondents	Transportation would stop being the reason a shift, a job, or a promotion is forfeited
Approximately $128,720 in lost local retail spending	Pharmacy, grocery, and essential errands would be protected as part of the trip definition
41.5% of respondents report isolation or being stuck at home	Social, religious, and community trips would be treated as illness prevention, not extras
Thousands of unpaid caregiver hours absorbed by New Hampshire families	The unpaid dispatching labor currently carried by families would return to them
Roughly $4.3 million annualized in avoidable health spending when missed care escalates	Avoidable health deterioration would be prevented at a fraction of the downstream cost

Note. The table lists one-month survey-group impacts where measured directly and annualized modeled avoidable health spending where indicated. Source: CTNA Data Companion and Headline Statistics Crosswalk (2025b) and CTNA Impact and Policy Analysis (2025d).

New Hampshire has already committed to transportation as essential infrastructure. This plan provides the operational layer that makes those commitments deliverable.

The policy rationale for coordinated community transportation already exists in New Hampshire law and adopted state plans. Five standing commitments name transportation as essential to aging in place, access to healthcare, disability independence, community living, and long-term care rebalancing. The 2027–2036 Ten-Year Transportation Improvement Plan opens the active capital and multimodal investment window, where eligible community transportation recommendations can be aligned. The commitments are made. The investment window is open. What has been missing is the operating layer that connects them, and this plan provides it.

Table ES-3. *State commitments and investment windows this plan operationalizes.*

State commitment or investment window	Authority	What it commits the State to	What this plan delivers
NH State Plan on Aging 2024–2027	BAAS, approved by the federal Administration for Community Living	Comprehensive, coordinated statewide LTSS with rebalance to home and community	*The community transportation layer LTSS rebalance requires*
System of Care for Healthy Aging	NH statute (2023); operational framework under BAAS and DHHS	Person-centered system delivering on the State Plan on Aging year over year	*Transportation coordination inside the operational system*
NH State Health Improvement Plan 2023–2028	RSA 126-A:87; 40-member SHA-SHIP Advisory Council	Reliable transportation as one of four urgent health infrastructure priorities	*The transportation infrastructure the SHIP identifies as urgent*
State Plan for Independent Living	Federal Rehabilitation Act §704(a); NH SILC at the Governor's Commission on Disability	Cross-sector coordination across five domains, including transportation	*The transportation coordination that the SPIL mandates*
AgeWellNH Multisector Plan for Aging	NH State Commission on Aging (in development)	Ten-year Multisector Plan: Independence, Wellness, Care	*The commissioned transportation foundation for the Multisector Plan for Aging*
2027–2036 Ten-Year Transportation Improvement Plan	NHDOT under RSA 228:99 and RSA 240; Governor's Advisory Commission on Intermodal Transportation (GACIT) review cycle	Capital and multimodal investment window under legislative review at the time of this writing	*Eligible community transportation capital, vehicle, passenger-access, technology, and enabling infrastructure candidates timed to the current review cycle*

Note. The first five entries are standing state commitments. The Ten-Year Transportation Improvement Plan is included as an investment window, not counted as a sixth commitment. The CTNA connects the State's existing transportation-related commitments to the funding, capital, coordination, and implementation tools needed to act on them.

Top recommendations at a glance

No one is in charge of community transportation in New Hampshire. Responsibility for the trips that get residents to medical appointments, work, food, and community life is split across NHDOT, DHHS, eight Regional Coordination Councils, dozens of providers, a network of volunteer driver programs, and the riders and families left to assemble it for themselves. Each part does its job. The job that no one is assigned is running it as a system.

The six recommendations below close that gap. They are designed as system changes, not stand-alone programs. Together, they assign statewide accountability, create a single public place for residents to find

transportation information, connect transportation to medical care and public health, protect essential trips, stabilize volunteer-driver capacity, and make funding work as a single system.

- Designate one entity to coordinate New Hampshire's community transportation system, with statewide responsibility for implementation oversight, public navigation, common reporting, funding alignment, and cross-agency follow-through.
- Make Keep NH Moving the statewide starting point for transportation assistance, with live help, low-tech access, regional handoffs, and partner referral pathways.
- Put healthcare, public health, transportation providers, mobility management, regional coordination partners, and people with lived experience at the same operational table.
- Adopt essential access standards and close the biggest trip gaps, including return trips.
- Stabilize volunteer driver programs and create paid backup for critical-need trips.
- Make the money work like one system through pooled or braided mobility management funding and state-led coordination.

Priority investments at a glance

The investment plan runs in three parallel tiers, not in strict sequence, because the State cannot wait for a fully built coordination system before protecting the trips people depend on today.

Tier 1. Stabilize.
Protect the trips and programs most at risk now, including critical-trip backup, volunteer driver stability, and rural and off-hour gap-filling.

Tier 2. Integrate.
Fund the statewide coordination layer, including shared data and reporting, Keep NH Moving upgrades, regional mobility management, healthcare referral integration, and contracting alignment.

Tier 3. Transform.
Lock in durable policy and funding reform, including recurring state investment, statutory and procurement reform, long-term service expansion, and Ten-Year Plan multimodal access improvements.

Chapter 6 advances this work through identifying six investment packages, each with a lead agency, a timed sequence, a best-fit funding path, and a weighted scoring rubric with equity and sustainability guardrails. The six packages are: Keep NH Moving and statewide navigation; Health access and return-trip reliability; Volunteer driver stability and critical-trip backup; Regional backbone and shared data; Rural and cross-county connectors; and Accessibility, language access, and driving transition and cessation.

The roadmap at a glance

Timing	What must happen	Public proof point
First 100 days	Name statewide responsible parties, adopt the common data package, and confirm Keep NH Moving as the statewide starting access point.	A responsible entity for community transportation in New Hampshire will exist, published accountability chart, and first implementation calendar.
0 to 6 months	Staff the single entry point, launch healthcare and public health referral pilots, complete the braiding map, and stand up volunteer-driver stabilization support.	Live phone/help path, referral workflows, baseline scorecard fields.
6 to 18 months	Relaunch Keep NH Moving statewide, launch critical-trip backup and early rural or cross-county connectors, and publish the first public scorecard.	Updated and reliable statewide single access point goes live, first quarterly dashboard, first regional gap-response actions.
18 to 36 months	Move to common reporting, align contracts and funding rules, and scale connector pilots and evaluate whether the statewide access model is working.	Fewer denials, fewer failed return trips, and stronger essential-trip completion.
3 to 5 years	Make coordination permanent through recurring financial support, mature public reporting, and long-term investment.	A statewide system that no longer depends on luck, family capacity, or one-off funding.

What success looks like

An older adult in Coös County can fill a prescription, buy groceries, and attend worship on a schedule. A veteran in Cheshire County can finish dialysis instead of stopping after a second missed ride. A mother in Hillsborough County can hold a shift because the van comes when it's supposed to. A caregiver in Grafton County can keep her job because her mother's medical trips are dependable.

Behind each of those scenes is a State that has clear, shared visibility into how often trips are denied and where. The coordination layer that makes all of that possible is funded as infrastructure rather than reinvented every budget cycle.

The CTNA documents, through statewide engagement reaching 2,774 respondents across all ten counties, that transportation shapes health, work, aging in place, and community life for the older adults, people with disabilities, veterans, and caregivers at the center of this work. New Hampshire now has the evidence, the structure, and the implementation sequence to move from isolated partial success to a coordinated system. The Commission on Aging created the opening. This plan shows the State how to use it. What remains is the decision to lead.

The Decision before New Hampshire

The recommendations in this plan are grounded in the CTNA data and in what New Hampshire's residents reported about their own lives. The State now has those recommendations, an open funding window, the executive authority, and the coordination infrastructure already in place. What it does not yet have is the decision to use them.

What remains is the decision to act on the evidence while the conditions for action are aligned. The State has the executive authority. It has a Rural Health Transformation funding window open through 2030.

It has the coordination infrastructure already in place. It has a Commission on Aging that has built statewide legitimacy on this question and stands ready to support implementation.

The seventy-eight-year-old in Coös County, the veteran in Cheshire County, the mother in Hillsborough County, and the caregiver in Grafton County have waited long enough. The evidence is on the table. The structure is on the table. The window is open. The decision is the State's.

CHAPTER 1

THE MANDATE FOR CHANGE

Transportation underpins the outcomes the State is trying to protect and improve. It shapes whether people can age in place, reach healthcare, stay employed, help family, buy food, and remain connected to community life. When transportation works, daily life holds together. When it fails, the effects spread quickly across health, caregiving, finances, and isolation. Through statewide listening and companion analyses, New Hampshire's Community Transportation Needs Assessment (CTNA) built the evidence base the State now needs to act.

Why transportation belongs in the conversation about health.

Public health and healthcare partners often describe transportation as a *social driver of health* (SDOH), one of the non-medical conditions that shape whether people stay well, recover from illness, and live independently. The CTNA findings align with that research. Transportation access influences chronic disease management, behavioral health engagement, and avoidable emergency department use.

1.1 The charge from the Commission on Aging

The Commission asked for so much more than a descriptive study. They wanted an examination of transportation gaps affecting older adults, people with disabilities, veterans, and other underserved residents, along with an analysis of the health, economic, and social consequences of those gaps. They also asked for policy, systems, and investment recommendations to support a long-term vision for public and human services transportation in New Hampshire.

In an aging state, older adults are not a peripheral population. Their needs are a leading indicator of the systems and support more residents will need in the years ahead. The same is true for people with disabilities, veterans, caregivers, and rural households whose daily lives already show where the system is thin, fragmented, or simply absent. This work was built around the people who experience the system most directly.

The New Hampshire Community Transportation Action Plan is a decision package. It specifies what the State must decide, who is accountable, and how progress will be measured publicly.

> *"You can't age in place if you can't get anywhere."*
>
> — Focus group participant (CTNA-F)

1.2 Why transportation keeps rising to the top

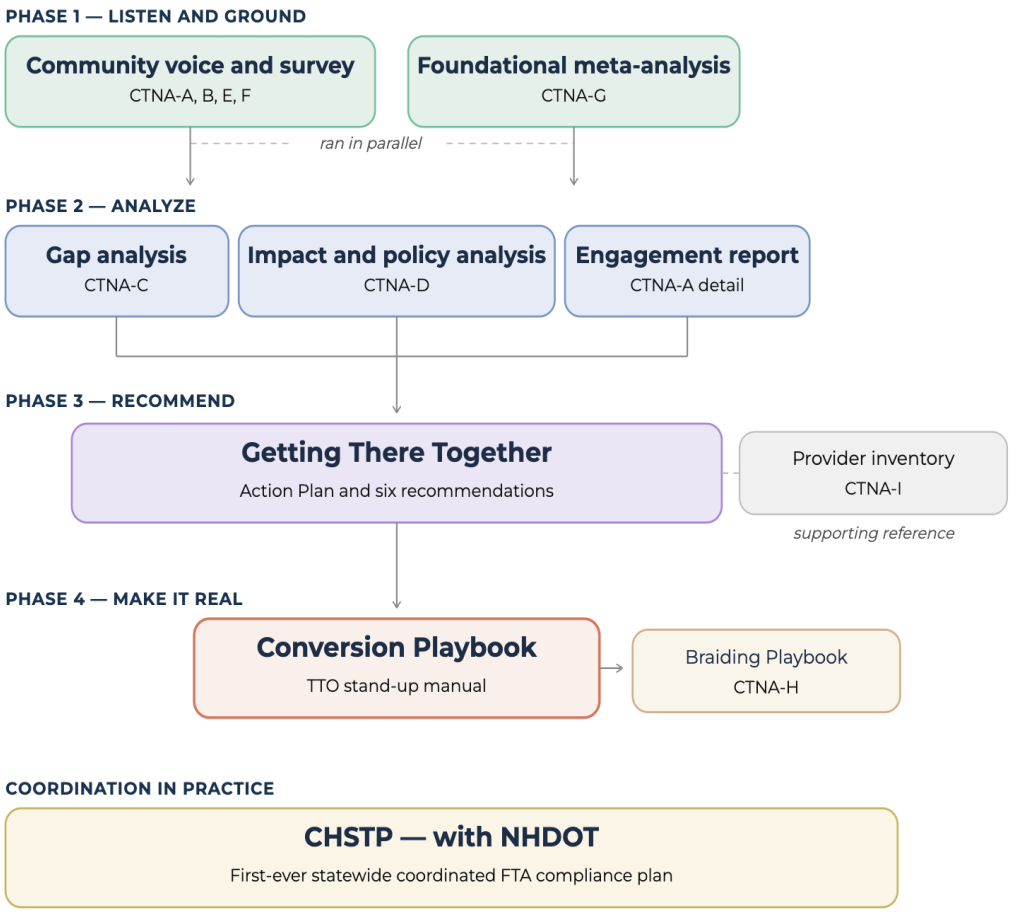
What the Commission's listening surfaced is a pattern, not a collection of complaints. Transportation determines whether an older adult in Berlin can keep her cardiology appointments. It determines whether a veteran in Claremont can complete chemotherapy. It determines whether a mother in Rochester can hold a shift, whether a caregiver in Lebanon can keep a job while caregiving, and whether a rural resident in the North Country can fill a prescription before it runs out. When transportation works, these daily arrangements hold together. When it does not, the consequences spread quickly across health, caregiving, household finances, and the slow tightening of social isolation that the CTNA documented in community after community.

Health access Missed appointments, delayed prescriptions, and a harder recovery	**Aging in place** Losing the ability to drive should not mean losing daily life or premature relocation
Caregiving and work Families absorb the driving, time, and strain when rides fail	**Community life** Food, worship, volunteering, friendship, and belonging all depend on mobility.

> *"It's easy to disappear when you stop driving in a rural place."*
>
> — Focus group participant (CTNA-F)

1.3 How the CTNA work fits together

The CTNA was built in four sequenced phases. Community voice and a foundational meta-analysis ran in parallel, grounding the work. A gap analysis, an impact and policy analysis, and an engagement report then built on that foundation to produce focused studies. Those products produced this Action Plan and the six recommendations that follow. To make the recommendations implementable, the *Conversion Playbook* was developed as the operational stand-up manual, with the *NH Community Transportation Braiding Toolkit* as a dedicated offshoot for the funding design. Alongside this work, the Commission on Aging is partnering with NHDOT to produce the first-ever statewide Coordinated Human Services Transportation Plan, demonstrating in practice the coordination this report recommends.



Companion documents are cited throughout this report in abbreviated form (CTNA-A through CTNA-I). The section titled "How to Use This Report" contains the full companion-document key.

1.4 Why this moment creates a real opening for transformation

The pressure on New Hampshire's transportation system is converging on the populations least able to absorb it. The Commission on Aging's leadership, paired with the work of regional and local partners across all ten counties, has built a strong public record of where the system is failing and who is bearing the consequences. What remains is a practical question. How will the State organize responsibility, align funding, strengthen coordination, and make access more dependable across regions and populations?

Policy	What needs to change in rules, roles, and decision-making
Responsibility	Who is assigned to organize the system and answer for results
Funding	What should be funded first, and through which channels
Coordination	How agencies, regions, and providers work more like one system
Access	How dependable the system is across regions and populations

Who is bearing the pressure?
Working-age adults with disabilities are facing the sharpest disparity. 67.6% of under-65 respondents living with a disability have missed, delayed, or avoided medical care because of transportation, the highest subgroup rate documented in the CTNA (CTNA-B; n=466). The same population reports the deepest transportation insecurity in the State, with no statewide system designed to meet it.
Older adults are in a driving transition the State is not yet structured to support. 43.1% of respondents aged 65 and older are already driving less than they used to, and 41.5% of all respondents report feeling isolated or stuck at home in the past month because of transportation barriers (CTNA-B). New Hampshire has no statewide infrastructure for transition planning, no triage pathway when driving stops, and no consistent backup capacity when informal help falls away.
Veterans are not connected to the services designed for them. 42.9% of veteran respondents have missed, delayed, or avoided medical care because of transportation, and 65.4% have never used any veteran-specific transportation service (CTNA-B; n=289 for missed care; n=237 for service use, n=328 full veteran respondent pool). The infrastructure exists. The connection between veterans and the services designed for them does not.

1.5 Why this community transportation action plan carries unusual weight

Most needs assessments end where this one begins. The Commission on Aging initiated the Community Transportation Needs Assessment with action as the stated goal. The quantitative evidence, community voice, gap analysis, impact analysis, implementation playbooks, and systematic review are already assembled. What the State now has is a single integrated action plan, grounded in statewide community engagement and explicitly designed for execution. Residents, providers, regional partners, advocacy organizations, and healthcare systems participated in this work because the Commission promised it would lead to action. Adopting the plan as written keeps that promise, and the Commission's continuing role in implementation governance keeps the State accountable to it.

1.6 How New Hampshire's Community Transportation Action Plan advances New Hampshire's State strategies

New Hampshire does not need to invent a new policy rationale for coordinated community transportation. It already has one. Five standing state commitments identify transportation as essential to aging in place, access to healthcare, disability independence, community living, and long-term care rebalancing. The CTNA connects those commitments New Hampshire has already made and the implementation tools available to act on them.

Table 1.1. *These entries are not all the same kind of instrument.*

State planning document	Authority	What it commits the State to	What the CTNA delivers
NH State Plan on Aging 2024–2027 (standing state commitment)	BAAS, approved by the federal Administration for Community Living	Comprehensive, coordinated statewide LTSS with rebalance to home and community	*The community transportation layer LTSS rebalance requires*
System of Care for Healthy Aging (standing state commitment)	NH statute (2023); operational framework under BAAS and DHHS	Person-centered system delivering on the State	*The transportation coordination function inside the operational system*
NH State Health Improvement Plan 2023–2028 (standing state commitment)	RSA 126-A:87; 40-member SHA-SHIP Advisory Council	Reliable transportation as one of the four urgent health infrastructure priorities	*A statewide build path for the transportation priority that the SHIP identifies as urgent*
State Plan for Independent Living (standing state commitment)	Federal Rehabilitation Act §704(a); NH SILC at the Governor's Commission on Disability	Cross-sector coordination across five domains, including transportation	*The cross-sector transportation coordination structure SPIL calls for*
AgeWellNH Multisector Plan for Aging (emerging plan / standing state commitment)	NH State Commission on Aging (in development)	Ten-Year Multisector framework for independence, wellness, and care, with transportation as a foundational domain	*The commissioned transportation foundation for the Multisector Plan for Aging*
2027–2036 Ten-Year Transportation Improvement Plan (investment window)	NHDOT under RSA 228:99 and RSA 240; Governor's Advisory Commission on Intermodal Transportation (GACIT) review cycle	Multimodal capital frame for New Hampshire transportation through 2036	*Community transportation recommendations timed to the current cycle*

Note. The State Plan on Aging, System of Care for Healthy Aging, SHIP, SPIL, and AgeWellNH are treated as standing state commitments. The Ten-Year Transportation Improvement Plan is treated as an active investment window for eligible capital and multimodal access improvements. This distinction matters because operating support, workforce capacity, coordination, and the reliability of recurring services require funding strategies beyond the Ten-Year Plan.

Read together, the five standing commitments establish transportation as essential infrastructure for aging, health, disability, community living, and the rebalancing of long-term care. The Ten-Year Transportation Improvement Plan provides the active investment window for eligible capital and multimodal access improvements. The commitments are made, the authorities are in place, and the implementation work is what remains.

Workforce, family self-sufficiency, veteran, and disability coordination structures already treat transportation as infrastructure. Transportation reimbursement is already an allowable support service

under WIOA, the NH Employment Program, and the NH Child Care Scholarship Program. The Military Leadership Team and the Ask the Question initiative coordinate transportation for veterans across DMAVS, VA Manchester, and partner organizations. The Governor's Commission on Disability, Granite State Independent Living, and the Statewide Independent Living Council coordinate disability-related transportation under SPIL.

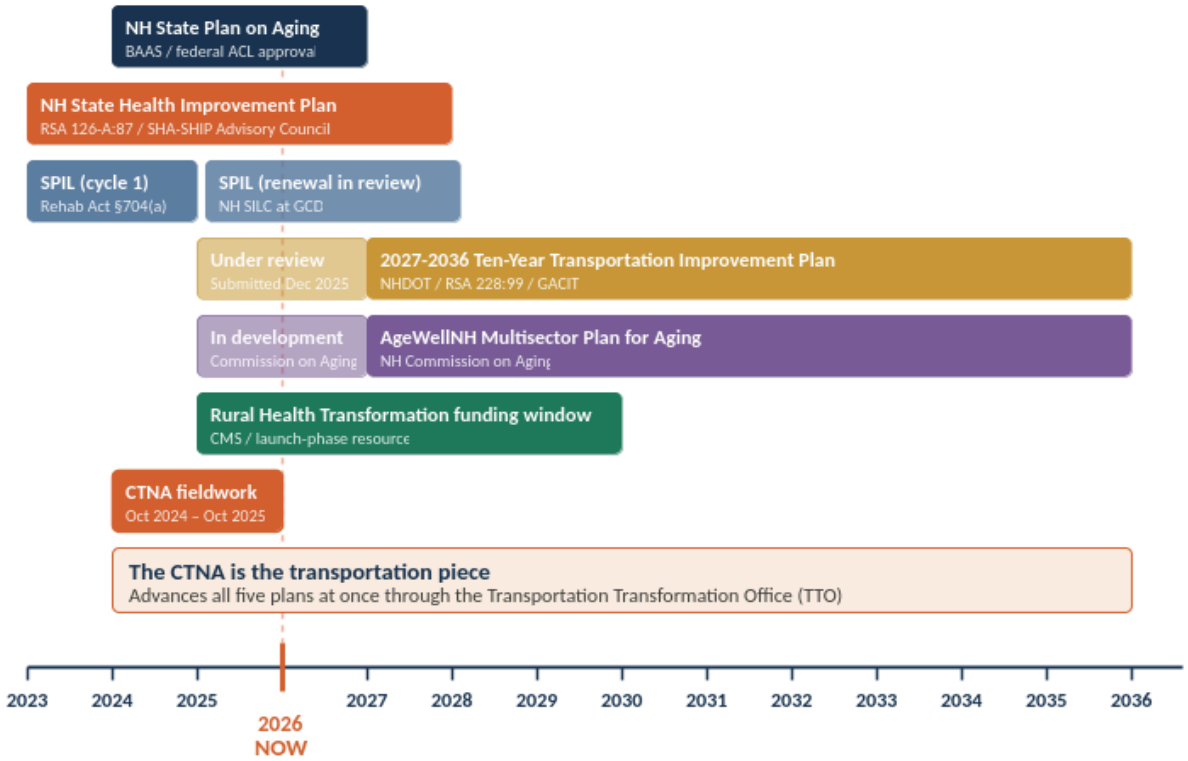
> **New Hampshire does not need more proof that transportation matters. It needs a state decision about what comes next.**

The State has made the commitment

The State has the authority to act. The coordinated system would run on assets New Hampshire already uses: 211 NH, the ADRC network within NHCarePath, NH Care Connections, the Regional Coordination Councils, Keep NH Moving, the State Coordinating Council, the NH Works Consortium, the Military Leadership Team, the Governor's Commission on Disability, and the Statewide Independent Living Council. The recommendations connect these assets under a designated coordinating function, with authority, staffing, funding alignment, and a public reporting structure, to make coordination operational across the standing state commitments. Chapter 2 presents the evidence base behind that decision.

Five state planning cycles converge in 2026

Each plan was developed independently. The CTNA is the single transportation build that advances all of them.



CHAPTER 2

THE FOUNDATIONAL EVIDENCE

The evidence is unambiguous. In New Hampshire, 86% of working-age adults living with a disability report transportation insecurity. 67% of them have missed, delayed, or avoided medical care in the past year due to transportation issues. That is the highest documented subgroup rate in the study. 69% of New Hampshire's incorporated municipalities lack dependable, general-public transportation. This is the foundational evidence the State now has to act on.

Across the CTNA survey, companion engagement work, and stakeholder interviews, the pattern holds in four frames: transportation as medical care, economic, aging-in-place, and equity infrastructure. Two measurement categories carry most of the analytic weight in this chapter, and both are defined below before they appear in the findings.

Transportation insecurity is the condition of being unable to regularly get from place to place in a safe or timely manner due to a lack of the resources needed for transportation. The CTNA measures this condition using the Transportation Security Index (TSI), developed by Murphy, Gould-Werth, and Griffin at the University of Michigan and modeled after the USDA's Food Security Index. The CTNA administered the validated six-item version (TSI-6), which scores respondents across access, reliability, affordability, and consequence dimensions and places them in one of three categories: secure, low/minimal insecurity, or moderate/high insecurity. The CTNA is among the first community transportation needs assessments in New Hampshire to apply the TSI, producing comparable measurement infrastructure that the State can use to track change over time.

Reliable public transportation is the kind of ride any resident can use without having to qualify based on age, disability, program enrollment, or trip purpose. The CTNA classifies a municipality as covered if at least one documented provider serves the town with fixed-route transit or with demand-response transit open to the general public. Services restricted by age, disability, program enrollment, or trip purpose are documented in the CTNA Provider Inventory but do not satisfy this test. Volunteer driver programs, NEMT, intercity bus and rail, and mobility management are documented but not counted toward the coverage determination. A municipality without reliable public transportation is a transit desert. The CTNA's methodology is consistent with peer-state coordinated transit plans (MassDOT; PennDOT; Nebraska Rural Transit Gap Analysis 2025) and with transit equity literature (Jiao and Dillivan, 2017). No federal or industry-wide definition of "transit desert" exists; the CTNA's methodology is documented in CTNA-I and applied consistently throughout this report.

How to read the data in this report. *The CTNA cleaned analytic sample is 2,774 respondents drawn from 2,824 raw submissions across all ten New Hampshire counties, with 72 stakeholder interviews and 11 focus groups providing qualitative depth. The Commission on Aging deliberately oversampled older adults (54% age 65+), people with disabilities (58%), and veterans (13%) — the populations the Commission is mandated to serve. Because that oversampling was a design choice to center priority populations, not a sampling bias to correct, no weighting was applied, and the findings throughout this report are unweighted and descriptive of the sampled respondents rather than projected to the state population. That intentional centering is what gives the CTNA its analytical power for the Commission's policy questions. Subgroup statistics are reported with sample-size flags: full reporting at n ≥ 30; directional only at n = 20–29; preliminary at n = 10–19; and suppressed below n = 10. Exact numerators, denominators, and question-specific universes are published in the CTNA Data Companion (CTNA-B). The Provider Inventory (CTNA-I) includes full provider-by-municipality detail and the transit desert methodology applied below.*

2.1 Transportation is healthcare infrastructure

Transportation is a fundamental determinant of healthcare access in New Hampshire. It defines whether care happens at all. The TSI pattern shown in the chapter introduction is sharpest where care is at stake. Respondents who reported missing medical care are overwhelmingly concentrated in the Moderate/High TSI category (77.3%), an independent cross-check that strengthens confidence in both measures (CTNA-B, §3.6). Healthcare access is where that insecurity bites first.

In the CTNA survey, 42.8% of respondents reported missing, delaying, or avoiding medical care because of transportation barriers (CTNA-B, MC-1; n=2,065). The 2023–2028 New Hampshire State Health Improvement Plan, adopted under RSA 126-A:87 by a 40-member cross-sector council, identifies reliable transportation as one of four urgent infrastructure priorities to improve population health, alongside healthcare access, healthy food, and safe housing (NH DHHS, 2023). The SHIP treats transportation as part of the same infrastructure level as housing. The CTNA documents what happens when that infrastructure is missing.

These are not abstract inconveniences. In a 30-day period, respondents reported 1,433 missed one-way trips to medical or therapy appointments (CTNA-B). Among those who detailed which types of care were disrupted, the most commonly affected trips were for routine or follow-up care, prescription pickups, specialist or diagnostic care, and therapy. A subset of respondents reported that the disrupted care included life-sustaining treatment such as dialysis, cancer treatment, or major surgery; those accounts are documented in the qualitative companions (CTNA-A; CTNA-F).

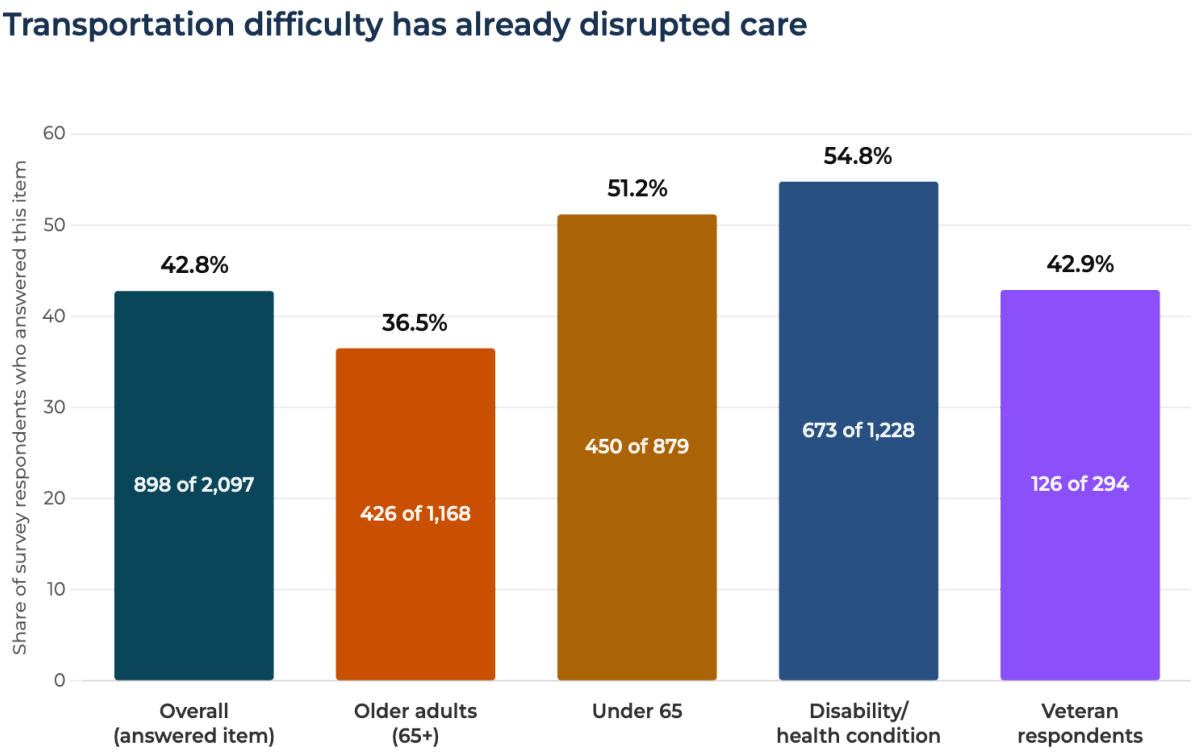


Figure 2.1. *Transportation difficulty has disrupted medical care for 42.8% of CTNA respondents. Source: CTNA-B Denominators vary by group. Overall: n = 2,097; Older adults (65+): n = 1,168; Under 65: n = 879; Disability/health condition: n = 1,228; Veteran respondents: n = 294.*

Transportation barriers are not distributed evenly across the population. **The disparity is sharpest at the working age.** Among under-65 respondents living with a disability, 67.6% reported missing, delaying, or avoiding medical care because of transportation, compared to 36.4% among all respondents aged 65 and older. The under-65-with-disability rate is the highest subgroup rate documented in the CTNA (CTNA-B; n=466 for under-65 with disability; n=1,155 for age 65+).

This aligns with national evidence. The Centers for Medicare & Medicaid Services has identified transportation as a significant contributor to missed medical appointments, with transportation barriers accounting for a substantial share of missed care across populations (CMS, 2023). In New Hampshire, this matters particularly for people who require recurring treatment, accessible transportation, or coordinated return trips, for whom reliability is critical to health outcomes.

The qualitative evidence makes the numbers impossible to ignore. Vets Count staff described veterans missing dialysis and chemotherapy because of difficulties getting a ride. Story bank interviews described medically fragile riders for whom a missed ride could mean hospitalization or death. One focus group participant described stretching a prescription instead of trying to solve the ride problem again. Another described postponing therapy for weeks after surgery because reliable transportation was unavailable. These are failures of access to healthcare with preventable consequences, with transportation as the proximate cause.

> **Transportation is part of the infrastructure that makes access to healthcare, wellness, and aging in place possible.**

The coordination infrastructure to act on these findings already exists. The New Hampshire Department of Military Affairs and Veterans Services, established under Senate Bill 208 of 2019, convenes the Military Leadership Team, chaired jointly by the VA Medical Center Director and the DMAVS Division of Community Based Military Programs, and is a co-founding partner of NH Care Connections, the State's closed-loop referral platform (NH DMAVS, 2024; NH DHHS NH Care Connections, 2024). The "Ask the Question" initiative, led by DMAVS, has been adopted by providers across sectors as the trigger for routing veterans to tailored services. The CTNA documents what the State is now structured to act on.

2.2 Transportation is economic infrastructure

Transportation failures do not stop at the clinic door. They show up as payroll costs, missed shifts, caregiver strain, and lost sales for local businesses. Among employed respondents, 27.4% said transportation problems caused them to miss work or lose income in the past month (CTNA-B, WORK-1; n=453). Those missed rides translated into approximately 656 lost workdays and about $105,000 in lost wages for the survey group in one month, with an estimated comparable loss in employer productivity (CTNA-B, WORK-3).

The spillover reaches beyond the workplace. Respondents reported 3,218 missed errands in one month. The CTNA impact analysis estimated that missed grocery, pharmacy, and other essential trips resulted in about $128,720 in lost retail spending for the survey group alone (CTNA-D). These are dollars not spent in New Hampshire communities.

Figure 2.2. *Estimated one-month economic impacts reported by the CTNA survey group. Three modeled dollar measures (lost workdays, lost wages, lost retail spending) are reported with their denominators. The fourth dimension, unpaid caregiver labor, is established in qualitative testimony rather than modeled as a dollar amount. Source: CTNA-B (n=453 employed respondents for workdays/wages; n=2,774 for retail); unit-cost assumptions documented in CTNA-D.*

Family labor is propping up the system. In the survey, 26.5% of respondents reported usually getting around with help from family or friends (CTNA-B, n=1,980). When formal transportation is unavailable, unpaid caregivers fill the void. Adult children rearrange work, neighbors make long medical trips, and

families absorb the risk. Today, New Hampshire is paying for transportation failures through lost productivity, reduced economic activity, and family stress. Funding a coordinated public transportation system would support stability for patients, employers, and families.

Transportation is also a workforce and economic resilience issue for New Hampshire. Approximately 30% of the State's workforce was age 55 or older as of 2024, increasing the importance of transportation systems that support both continued employment and caregiving roles (NHFPI, 2024). Nationally, the Coordinating Council on Access and Mobility identifies transportation as a key enabler of access to jobs, education, healthcare, and community life (USDOT, 2022). In New Hampshire, the CTNA data shows what happens when that system fails: missed shifts, lost wages, reduced productivity, and lost local economic activity (CTNA-B).

> *"When I miss a shift, my kids miss groceries."*
>
> — Focus group participant (CTNA-F)

2.3 Transportation is aging-in-place infrastructure

Aging in place without mobility is often just isolation in place. The clearest measure is the mobility gap: across the three priority populations, respondents make roughly 25 one-way trips per month, but the trips they wanted to make but could not due to transportation constraints differ sharply. People with disabilities miss an average of 8.22 trips per month, veterans miss 6.42, and older adults miss 4.67 (CTNA-B, §PP.2). In the CTNA survey, 41.5% of respondents who answered the question reported feeling isolated or stuck at home in the past month because of transportation barriers (CTNA-B, n=2,024).

Eight missed trips a month, the gap for people with disabilities, translates into two missed grocery runs, two missed medical appointments, and four missed connections to community life. These are not "nice-to-have" trips at stake. They are the trips that keep people connected to worship, friendship, food, routines, and the social connections that support mental and physical health. The same pattern appears in missed community life. In the survey, 25.9% of respondents reported that transportation barriers had prevented them from participating in social, religious, or recreational activities (CTNA-B, n=1,926). Transportation supports more than medical access. It is essential for maintaining connection, dignity, and health.

> *"If you can't drive, you're basically stuck at home."*
>
> — Focus group participant (CTNA-F)

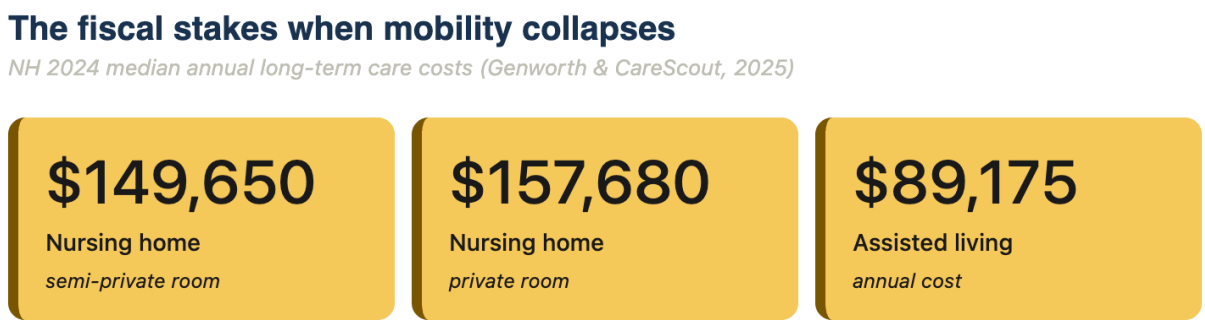


Figure 2.3. *NH 2024 median annual costs for long-term care. Nursing home care reached $149,650 per year for a semi-private room and $157,680 for a private room. Assisted living reached $89,175 per year, and home health aide services reached $86,996 per year. Source: Genworth and CareScout (2025), Cost of Care Survey: New Hampshire 2024.*

The driving transition is already visible in New Hampshire. In the survey, 43.1% of respondents aged 65 and older reported already driving less, and a quarter of older respondents who answered the confidence scale (25.5%) said they were not very confident in their ability to drive themselves (CTNA-B; 233/915). Focus group participants described the fear behind those numbers with painful clarity: they know the day is coming when driving will no longer be safe, and too many do not see a dependable system waiting on the other side.

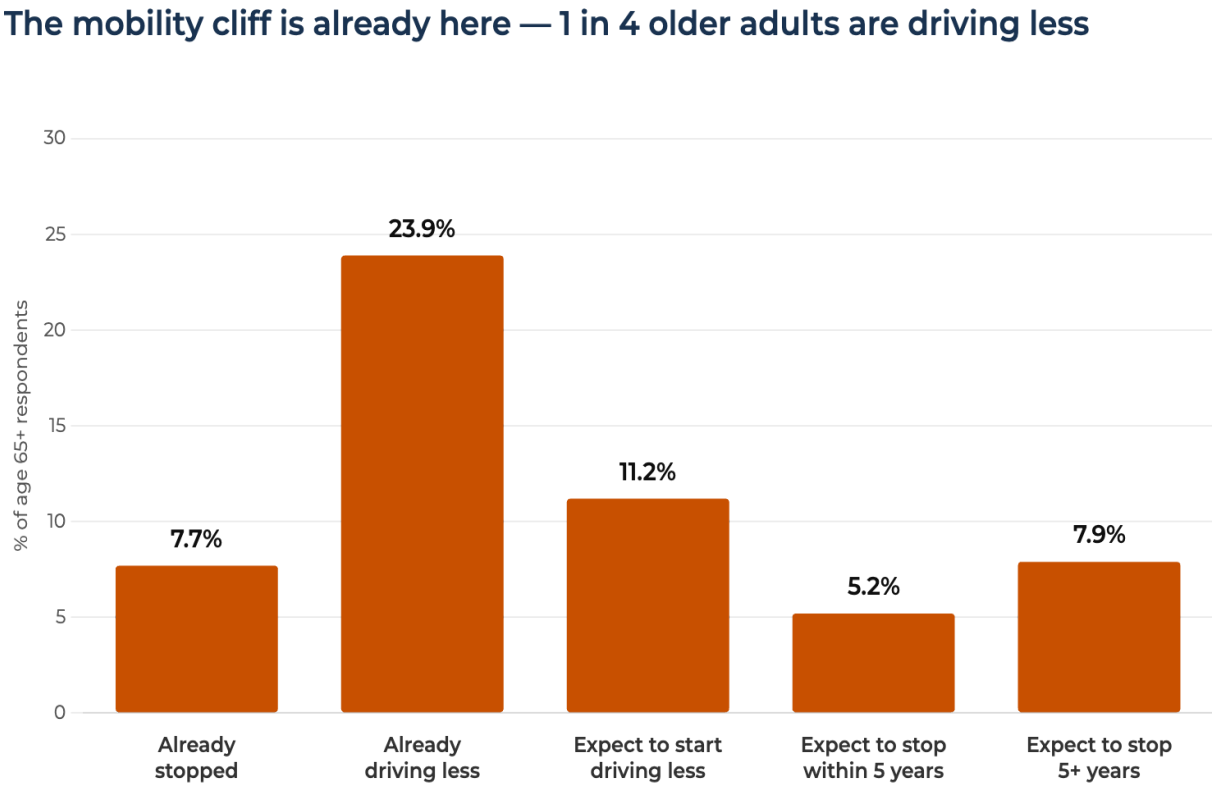


Figure 2.4. *More than 4 in 10 older adults (43.1%, 313 of 727 respondents aged 65+ who answered the driving-change question) report already driving less. CTNA-B §PP.3. Multi-select question; responses are not mutually exclusive. Question denominator n = 727; full 65+ subgroup n = 1,308. Source: CTNA Data Companion, §PP.3.*

The stakes are clear if New Hampshire does not build mobility supports before driving loss becomes a crisis. AARP's 2024 Home and Community Preferences Survey found that 75% of adults aged 50 and over want to remain in their homes and 73% want to remain in their communities as they age (AARP, 2024). New Hampshire is aging faster than the national average, and the loss of mobility without reliable alternatives drives social isolation, caregiver attrition from paid work, and higher-cost care (NHFPI, 2024). In 2024, the median annual cost of nursing home care in New Hampshire was $149,650 for a semi-private room and $157,680 for a private room, while assisted living cost $89,175 per year (Genworth and CareScout, 2025). That is the cost context surrounding the collapse of mobility in an aging state.

The State's own 2024–2027 Plan on Aging acknowledges the gap documented in the CTNA. While New Hampshire has one of the fastest-growing older adult populations in the country, the Plan notes that the State ranks nearly last in providing a balanced system of care (BAAS, 2023). AARP's 2023 Long-Term Services and Supports State Scorecard puts the number in the sentence: New Hampshire ranks 49th in the nation on Medicaid spending for home- and community-based services that allow people who qualify for nursing home care to remain at home or in community settings, and last among New England states (AARP Public Policy Institute, 2023). Community transportation is the infrastructure that lets the aging-in-place commitment actually happen.

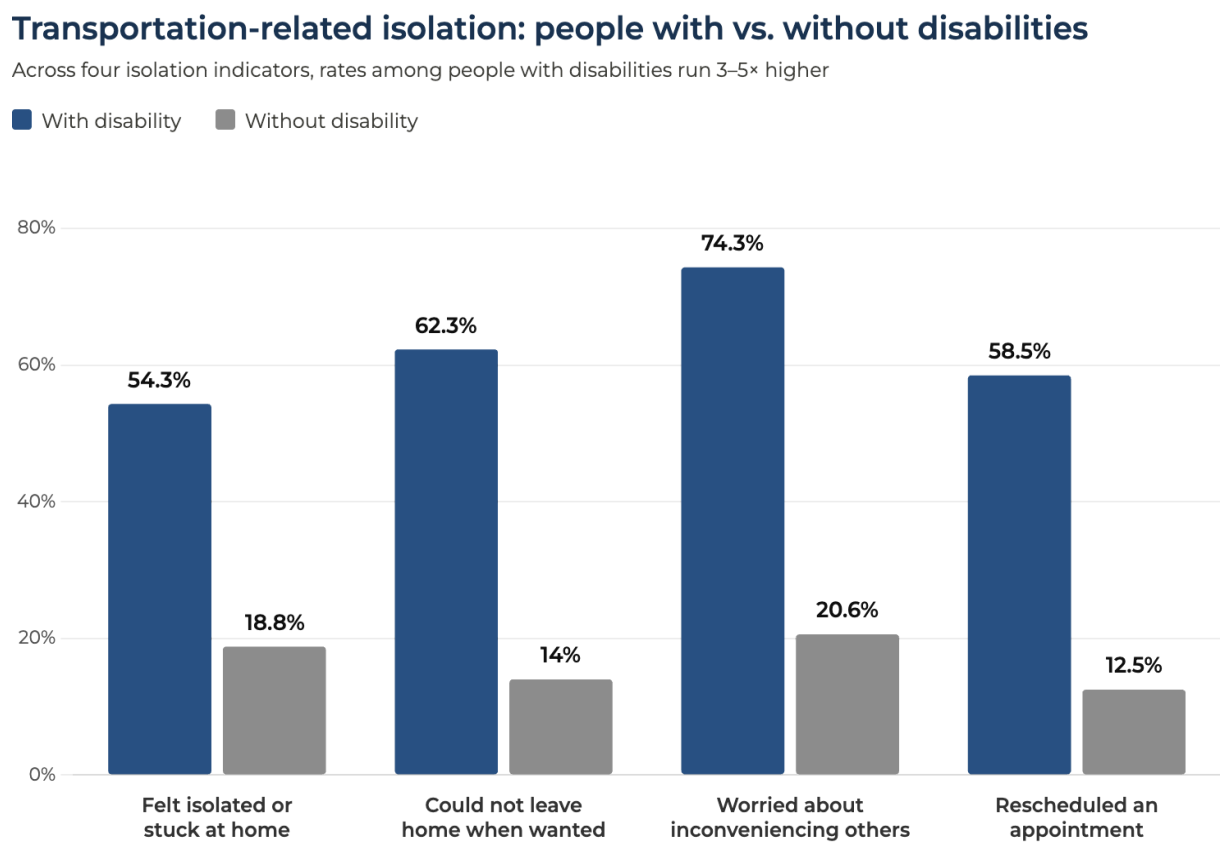


Figure 2.5. *Transportation-related isolation indicators by disability status. Source: CTNA-B. With disability: n = 1,189 to 1,200; without disability: n = 712 to 1,189. Denominators vary by item.*

The mobility cliff shows in a near-reversal of how people get around. More than three in four respondents without disabilities drive themselves. Among respondents with disabilities, fewer than a third do, and 4.8% rarely or never leave home. That 4.8% is the smallest bar on the chart and the most consequential finding, identifying a population that no transportation service currently reaches and for whom the downstream health and social effects documented earlier in §2.3 will be most severe.

> *"The inability to drive or not have a car leads to isolation. Devastating depression, a downward health spiral, loneliness, and poor access to food. It's not a simple issue, it can be life-threatening."*
>
> — Focus group participant (CTNA-F)

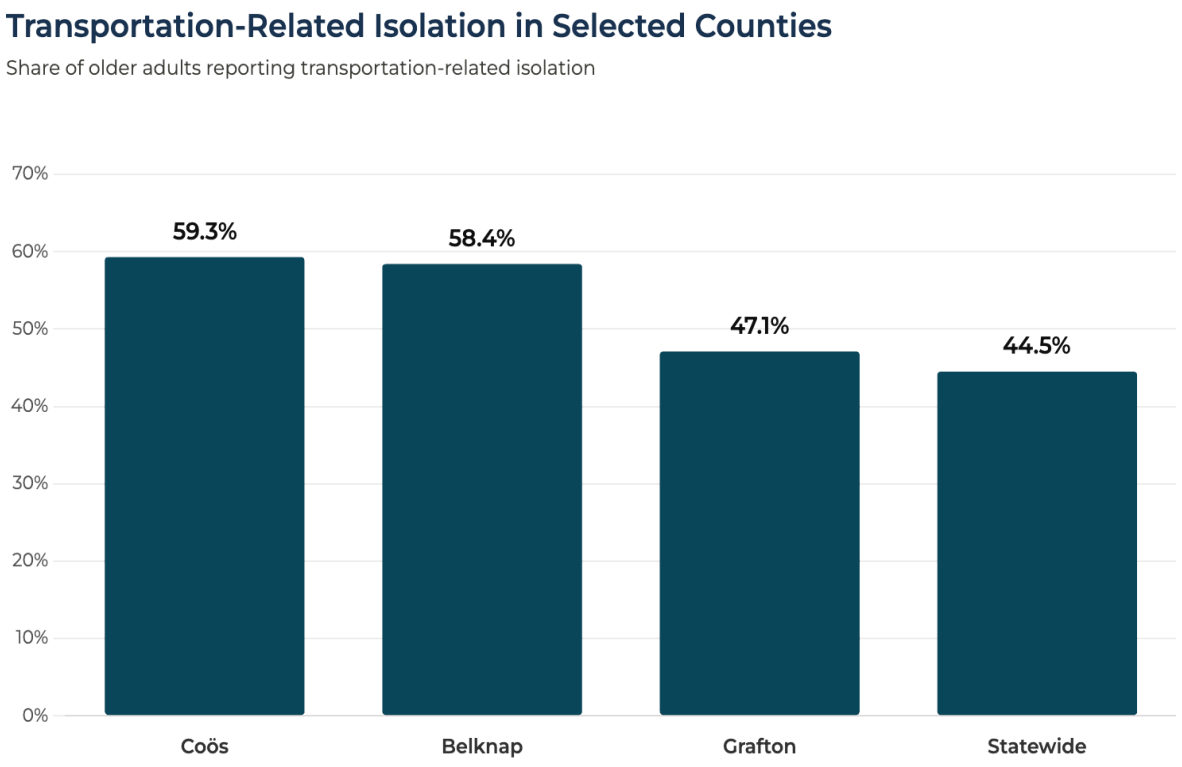


Figure 2.6. *Transportation-related isolation in selected counties and statewide. The figure shows the share of respondents reporting transportation-related isolation in selected counties and statewide. (CTNA-B, n=2,024 for statewide isolation question).*

Isolation is not a single experience. Respondents with disabilities showed isolation at rates three to five times higher than respondents without disabilities in four different areas. The four areas are being stuck at home, unable to leave when they want, worried about inconveniencing others, and having to reschedule appointments.

These isolation patterns are not evenly distributed across the State and map onto a broader equity geography that the next section traces.

2.4 Transportation is equity infrastructure

Transportation in New Hampshire is not experienced evenly. The CTNA shows that access is patterned by geography, disability, veteran status, income, and system literacy. The patterns compound. **Three findings define the equity picture.** Finding 1 measures the structural coverage gap by asking what every town has on the ground, regardless of who lives there. Finding 2 pairs that connect coverage views with lived experience to show where coverage on paper does not translate into dependable mobility. Finding 3 looks inside priority populations to show that even the coverage funded to serve them is not consistently reaching them. Table 2.2 synthesizes the three measures on a common regional grid.

Finding 1: Most of New Hampshire lacks dependable public transportation.

General-public dependable transportation means a service that any resident can use without having to qualify by age, disability, program enrollment, or trip purpose — a walk-up ride, in plain terms. 161 of New Hampshire's 234 incorporated municipalities (69%) lack it. No documented provider in those towns serves any resident regardless of age, disability, program enrollment, or trip purpose.

The other 31% have some form of community transportation, but the majority of that coverage is restricted to older adults, individuals with disabilities, program enrollees, or specific trip purposes. Coverage exists; general-public coverage does not. The pattern is sharpest in Sullivan (Region 4), where 14 of 15 municipalities are transit deserts (93%); in Monadnock (Region 5), where 29 of 33 municipalities are transit deserts (88%); and in Mid-State (Region 3), where 34 of 40 municipalities are transit deserts (85%). Coös County is a partial exception. Tri-County Transit serves 16 of 20 Coös towns and is open to the general public, leaving 4 transit deserts (20%). But Coös residents still report the second-highest county-level transportation insecurity rate in the state, reflecting that coverage on the map and dependable rides in practice are not the same thing.

How to read Table 2.1. *A municipality is counted as having dependable general-public transportation if at least one documented provider serves the town with fixed-route transit or with demand-response transit open to the general public. The chapter opener defines this measurement category in full, including which services are documented but not counted. Full provider-by-municipality detail and the methodology are in CTNA-I.*

Table 2.1. *Dependable general public community transportation coverage by the Regional Coordination Council region.*

RCC Region	Municipalities	Transit Deserts	Transit Desert Percent
Region 4 (Sullivan)	15	14	93%
Region 5 (Monadnock)	33	29	88%
Region 3 (Mid-State)	40	34	85%
Region 10 (ACT)	38	28	74%
Region 1 (Grafton-Coös)	59	36	61%
Region 8 (Southern NH)	20	9	45%
Region 2 (Carroll)	16	7	44%
Region 7 (Greater Nashua)	13	4	31%
Statewide	**234**	**161**	**69%**

Note. A transit desert is a municipality with no fixed-route transit and no demand-response transit open to the general public. Eligibility-restricted services, volunteer driver programs, NEMT, intercity bus and rail, and mobility management are documented in CTNA-I but are not counted in the desert determination. The statewide total reflects the 234 incorporated municipalities across the eight RCC regions. Source: CTNA-I (May 2026).

Finding 2: Even where coverage exists, lived experience contradicts it.

The Transportation Security Index pairs with the coverage map to show two stories on the same regional grid. Figure 2.7 plots the transit desert percentage from the CTNA Provider Inventory alongside the TSI moderate or high insecurity rate from CTNA-B for each RCC.

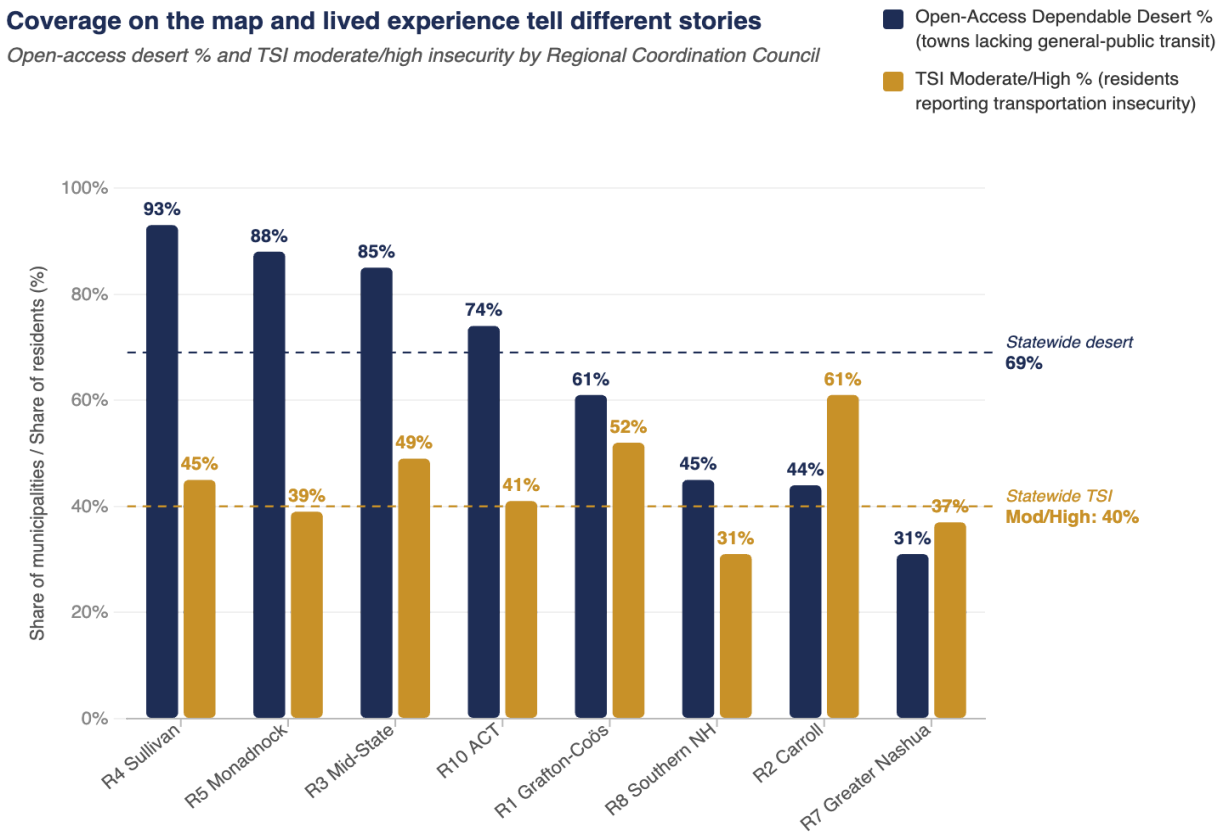


Figure 2.7. *Coverage and lived experience by the Regional Coordination Council region. Transit desert percentage shown in navy; TSI moderate or high insecurity in gold. Dotted lines mark statewide averages (69% transit desert, 40% TSI moderate or high).*

The general alignment holds: regions with the largest coverage gaps tend to show high lived insecurity. Sullivan (93% coverage gap, 45.0% TSI moderate/high) and Mid-State (85% coverage gap, 49.0% TSI moderate/high) are the clearest cases. But the exceptions are also revealing. Carroll County's TSI moderate/high rate (60.6%) is the highest in the state despite a moderate coverage gap (44%). Coverage exists, but it is not landing as dependable mobility for residents. Conversely, Coös County's coverage gap is low (20%) because Tri-County Transit covers 16 of 20 Coös towns, yet its overall TSI rate is among the highest. The under-65-with-disability column in Figure 2.8 helps explain why.

The TSI broken out by the Regional Coordination Council and by priority population, newly available in CTNA-B §3.5b and §3.5c, reveals the within-population disparity that single-region or single-population analyses can obscure.

Finding 3: Within-population disparity is the sharpest signal.

The most consequential pattern in the CTNA data is hidden inside priority populations, not between them. Across every RCC region where the sample permits reporting, under-65 adults with disabilities report TSI moderate or high insecurity at 54.4% to 87.7%, far higher than the overall regional rate and far higher than the rate for older adults in the same region. Figure 2.8 maps this disparity directly.

Where coverage exists, lived experience still diverges

Transportation Security Index moderate/high insecurity by RCC × priority population

TSI Moderate/High Insecurity

20% 35% 50% 65% 86%

RCC	Overall	With Disability	Veteran	Older Adult (60+)	Under-65 + Disability
Region 1 Grafton-Coös	52%	68%	58%*	41%	76%
Region 2 Carroll	61%	63%**	— (n<10)	68%**	— (n<10)
Region 3 Mid-State	49%	56%	31%**	44%	54%
Region 4 Sullivan	45%	65%	— (n<10)	39%	86%**
Region 5 Monadnock	39%	56%	20%**	28%	79%
Region 7 Greater Nashua	37%	54%	39%	33%	67%
Region 8 Southern NH	31%	45%	24%	27%	57%
Region 10 ACT	41%	48%	46%	40%	55%
Statewide	40%	52%	35%	35%	64%

Figure 2.8. *Transportation Security Index moderate or high insecurity by the Regional Coordination Council region and priority population. Cells follow a three-tier sample-size reporting standard: no mark = full reporting (n ≥ 30); * = directional only (n = 20-29); ** = preliminary (n = 10-19); — = suppressed (n < 10). Source: CTNA-B Data Companion §3.5c. Base n = 1,921 valid-TSI respondents with documented RCC.*

Across the dataset, 83.6% of under-65 adults with disabilities report any TSI insecurity statewide (376 of 450), and 63.6% report moderate or high insecurity. In Region 5 (Monadnock), where the overall TSI moderate/high rate is 38.5%, the under-65-with-disability rate is 78.6%. That is a 40-percentage-point disparity. In Region 7 (Greater Nashua), the disparity is likewise substantial (36.6% overall vs. 67.3% for under-65 disabled). The pattern holds even in regions with the strongest priority-population services. Senior shuttles, ADA paratransit, and other 60+ or disability-restricted services serve the populations they are funded to serve, but they leave working-age adults with disabilities without dependable transportation, and the data shows it.

Veteran sample sizes are insufficient for precise regional inference in five of eight RCCs. Only Regions 7, 8, and 10 have veteran subsamples of n ≥ 30. Where reportable, veteran TSI moderate/high rates range from 23.9% (Region 8) to 45.6% (Region 10). The smaller-sample regions show widely varying rates and are reported with the sample-size flag. This limitation is itself a finding: veteran-specific transportation needs in rural New Hampshire cannot be precisely measured at the regional level with the current sample.

The combined picture

The CTNA's foundational equity finding is that two distinct gaps compound. The first is a coverage gap: most of the state lacks dependable, general-public transportation. The second is a within-population gap: even where some form of coverage exists, the populations that coverage is funded to serve still report deep insecurity, and the populations not centered by existing services, most consistently working-age adults with disabilities and, where measurable, veterans, report the deepest gaps. Table 2.2 brings the two views together on a common regional grid.

Table 2.2. *Coverage gap and lived insecurity, aligned by RCC region.*

RCC Region	Transit Desert % (towns)	TSI Mod/High % (residents, overall)	TSI Mod/High % (under-65 + disability)
Region 4 (Sullivan)	93%	45.0%	85.7%**
Region 5 (Monadnock)	88%	38.5%	78.6%
Region 3 (Mid-State)	85%	49.0%	80.7%
Region 10 (ACT)	74%	41.0%	54.7%
Region 1 (Grafton-Coös)	61%	52.1%	76.1%
Region 8 (Southern NH)	45%	30.5%	57.0%
Region 2 (Carroll)	44%	60.6%	— (n=7)
Region 7 (Greater Nashua)	31%	36.6%	67.3%

RCC Region	Transit Desert % (towns)	TSI Mod/High % (residents, overall)	TSI Mod/High % (under-65 + disability)
Statewide	**69%**	**39.7%**	**63.6%**

*Note. Three measures derived from two data sources: transit desert percentage from CTNA-I (share of incorporated municipalities); TSI moderate/high overall from CTNA-B §3.5b (share of valid-TSI respondents); TSI moderate/high for under-65 adults with disabilities from CTNA-B §3.5c. The pairing shows where the structural coverage gap (Finding 1) and the lived-experience gap (Findings 2 and 3) compound, where they offset each other, and where coverage exists on paper but is not delivered as dependable mobility for the populations this plan centers. Cell footnotes: ** = preliminary (n = 10–19). Carroll County under-65-with-disability cell suppressed because n < 10. Transit Dependable Desert % is reported as whole numbers reflecting municipality-level coverage classifications; TSI moderate/high rates are reported to one decimal place reflecting survey-derived calculations.*

What the qualitative evidence adds

Focus groups and stakeholder interviews surface what statistical patterns cannot. Several older adults in New American households described transportation as the responsibility of their adult children, a cultural frame that works when family capacity is present and leaves people isolated when it is not. Language access and stigma came up repeatedly, including experiences of service staff assuming a respondent could not speak English or speaking down to them.

People with disabilities described inaccessible vehicles, a lack of curb-to-curb service that fails to meet the real door-through-door needs, phone-based scheduling barriers, and rides that fail when a transfer breaks down. For many participants, "accessible" existed on paper but not in reality. New Hampshire's own State Plan for Independent Living, produced every three years by New Hampshire's Statewide Independent Living Council under §704(a) of the federal Rehabilitation Act, names transportation as one of five cross-sector collaboration domains essential to independent living for Granite Staters with significant disabilities (NH SILC, 2024). These CTNA findings are evidence directly responsive to the SPIL's coordination mandate.

Veterans revealed a different but equally important pattern. Among veterans who answered the veteran-services question, 65.4% reported they have never used any veteran-specific transportation service, and 42.9% reported that transportation difficulties had caused them to miss, delay, or avoid medical care (CTNA-B; n=237 for service use, n=289 for missed care). Focus groups and stakeholder interviews suggest this is partly a service issue and partly an awareness issue. One participant said he did not even know the VA van would take people from his town. Others described frustration and the disconnect of being able to reach one kind of appointment but not the others needed to keep a life functioning. Information access is itself an equity issue.

Veteran transportation services: awareness and use

Nearly two-thirds of NH veteran respondents have not used any veteran transportation service

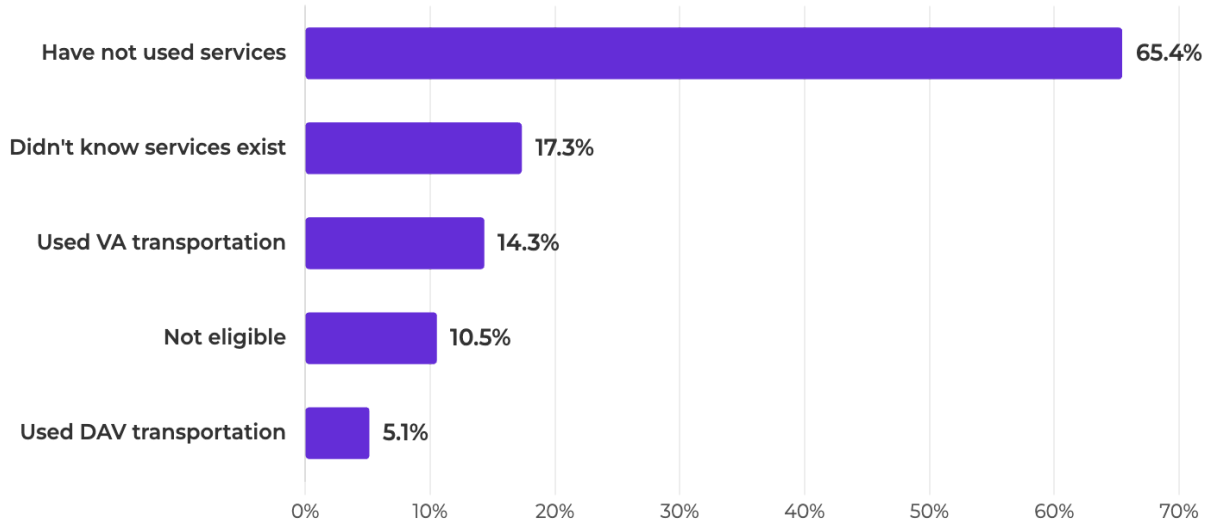


Figure 2.9. *Veteran transportation services. Among veterans who answered the question (n=237), 65.4% report they have not used any veteran-specific transportation service, 14.3% have used Veterans Affairs (VA) transportation, 5.1% have used Disabled American Veterans (DAV) transportation, and 10.5% report they are not eligible. Source: CTNA-B, §PP.5.1.*

The awareness gap is actionable. Outreach that reaches veterans through channels they already use, such as Veteran Service Organizations (VSOs), primary care, and American Legion posts, is likely to move uptake faster than expanding service capacity alone.

Community-based organizations are filling the gaps. In 2023, Victory Women of Vision in Manchester partnered with the Manchester Transit Authority and the Southern New Hampshire Planning Commission to deliver hands-on travel training for New American elders. Regional Coordinating Councils in other parts of the State have developed similar customized trip support and travel training. The design principle these examples point to is that solutions are co-designed with the communities most affected and build capacity within them. The equity dashboard and shared data infrastructure recommended in this plan are the structural commitments that ensure underrepresented populations remain visible throughout implementation.

> *"Transportation isn't just medical, it's food, family, connection, dignity."*
>
> — Focus group participant (CTNA-F)

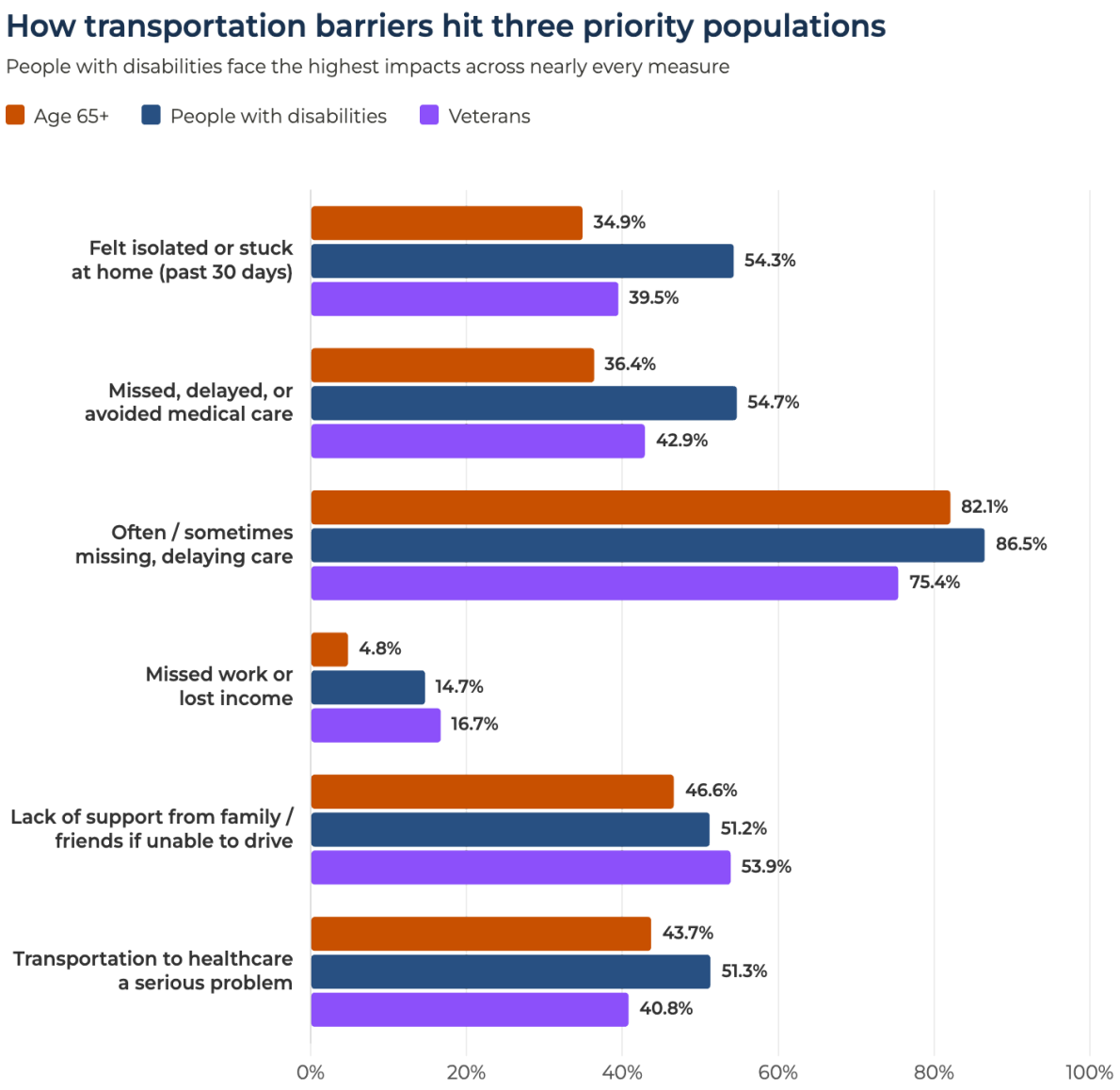


***Figure 2.10**. Impact of transportation barriers across three priority populations. Source: CTNA-B. Age 65+: n = 418 to 1,155 | People with disabilities: n = 657 to 1,213 | Veterans: n = 118 to 289. One extreme outlier in trip counts was excluded (winsorized at the 99th percentile).*

The figure shows two patterns the priority populations share. First, "often or sometimes missing care" exceeds 75% across all three groups. Transportation-related care disruption is not a marginal phenomenon for any of them. Second, the gap between people with disabilities and the other two populations narrows on the measure of whether respondents have someone to turn to for a ride. Social support networks are a shared vulnerability across all three groups, not a distinguishing feature of any one. The disparities Finding 3 documents are real, but they sit on top of a baseline of shared transportation hardship that the priority populations experience together.

2.5 Why the current system is too fragile for what is coming

The current system is built on assumptions that no longer fit New Hampshire's demographic reality. The deepest transportation insecurity in the State is reported by working-age residents, even as the aging-in-place demand grows underneath them. Figure 2.10 shows the pattern by age band.

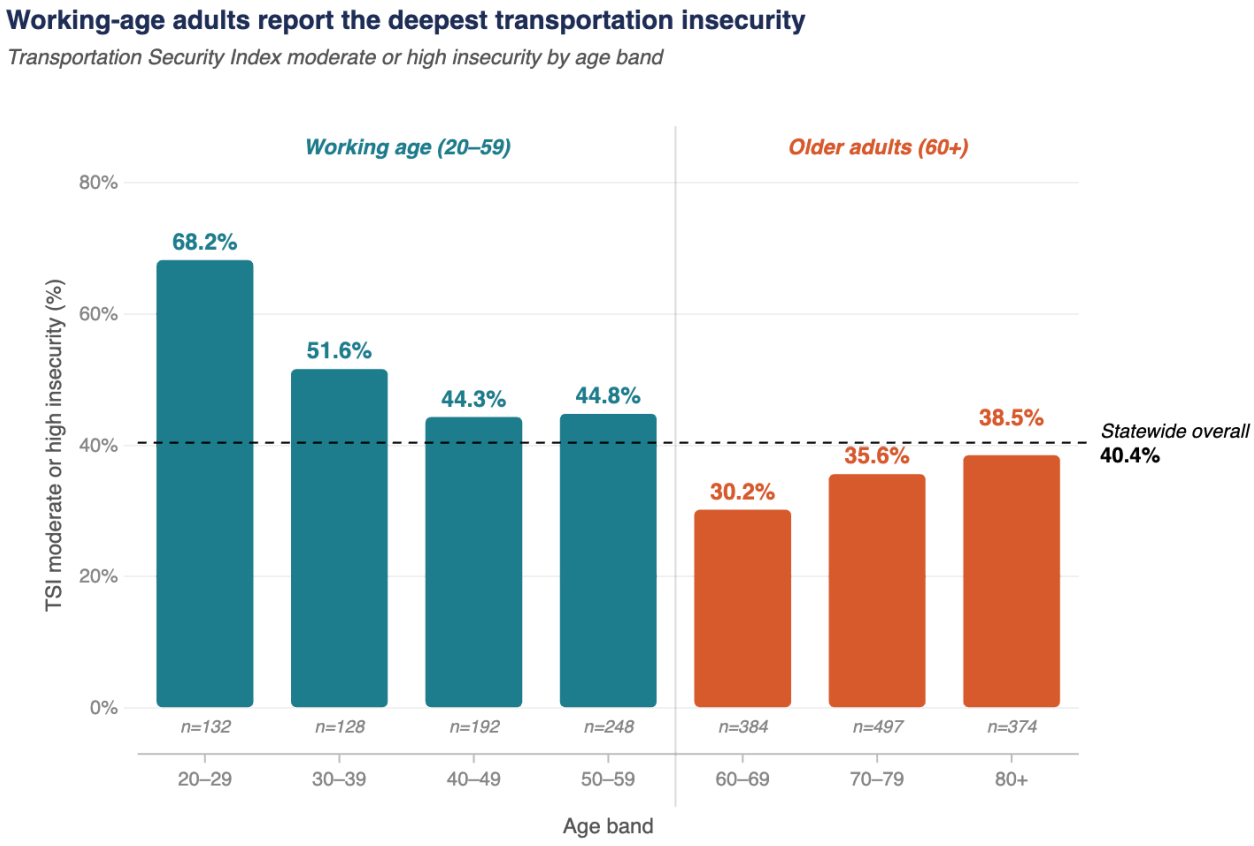


Figure 2.11. *Transportation Security Index moderate or high insecurity by age band. Working-age respondents (20 to 59 years, shown in teal) report TSI moderate or high insecurity at 44.3% to 68.2%. Older adult respondents (60+, shown in orange) report TSI moderate or high insecurity at 30.2% to 38.5%. The dotted line shows the statewide overall rate of 40.4%. Source: CTNA-B Data Companion §3.3a (proposed). Base n = 1,955 valid-TSI respondents with documented age band. The 10–19 age band is suppressed for a small sample size (n = 7).*

The age pattern points in two directions. First, respondents aged 20 to 29 report the highest TSI moderate- or high-insecurity rate among age bands, at 68.2%. The 30-39 band accounts for 51.6%. Working-age insecurity is not concentrated in a single life stage. It is the modal experience of adults under 60 in the CTNA sample. Second, the 60 to 69 band scores the lowest at 30.2%, likely reflecting both the existence of senior-priority transportation services and the fact that this cohort still drives at high rates. The 80+ band ticks back up to 38.5% as driving cessation accelerates. A coordinated system has to serve both ends of that pattern: working-age adults whose insecurity is acute today, and older adults whose insecurity will grow as the driving transition advances.

The aging trend sits underneath it. Adults aged 65 and older make up 20.8% of New Hampshire's population, one of the highest percentages in the country (U.S. Census Bureau, 2023), and the CTNA companion reports make clear that the number of residents aging into transportation vulnerability will continue to rise. As earlier sections show, the transition away from driving is already underway. More older adults are driving less, more residents are living with chronic conditions, and many households do not have dependable backup once informal help falls away.

Transportation capacity is not growing at the same pace, or in the same places, as the need. Fixed-route coverage remains limited. 32 distinct active volunteer driver programs operate across the State, with full funding-mix data verified for 14 (CTNA-I). Stakeholder interviews consistently described aging volunteers, driver shortages, unstable funding, limited administrative capacity, and a lack of funded backup for medically fragile riders when a trip is at risk. These programs are critical in many communities, but they are being asked to absorb essential-trip shortfalls without the staffing, infrastructure, and redundancy that essential access requires.

The system is also too fragmented to manage rising demand well. Medicaid rides, VA and DAV services, local senior transportation, volunteer driver programs, public transit, and private or informal supports operate under different rules, referral pathways, geographic boundaries, and expectations. Riders, caregivers, and even providers are still left to piece together solutions one trip at a time. That is a structural design problem.

What has long operated as a patchwork of programs is increasingly being asked to function as core infrastructure. New Hampshire's current model is not built for the scale, complexity, or reliability the next decade will require.

Sequencing implication

The pattern in Table 2.2 matters for sequencing. Stabilization investments in volunteer driver programs and rural connectors are most consequential in Sullivan, Monadnock, Mid-State, and ACT, where the dependable, general-public test fails for the largest share of municipalities (74 to 93%) and where the under-65-with-disability TSI rate exceeds 54% across all regions. Coordination investments in mobility management, shared data, and Keep NH Moving pay off fastest in regions like Greater Nashua and Southern NH, where coverage gaps are narrower, but the fragmented rider experience across multiple operators is well-documented. Carroll County stands out as a region where TSI insecurity is high despite moderate coverage, suggesting that even where services exist, they are not landing as dependable rides. That finding points to service reliability, scheduling, and integration rather than coverage expansion as the primary need. The plan's three-tier investment sequence is structured to address all three patterns. Five conditions follow directly from the evidence above.

2.6 The five conditions to address

Five conditions follow directly from the evidence above. Each is a binding requirement for any transportation system New Hampshire chooses to call coordinated.

1. **Healthcare access that holds.** Dependable outbound and return trips, including for recurring treatment, discharge, and high-consequence appointments where a missed ride has clinical consequences.

2. **Workforce and household economic stability.** Reliable rides to work, training, child care, and caregiving responsibilities, so that transportation does not determine whether a shift, a paycheck, or a job is forfeited.

3. **Aging-in-place capacity.** Mobility support before and after the driving transition, so that the loss of a driver's license does not trigger isolation or premature placement in long-term care.

4. **Equitable access across geography, disability, veteran status, language, and digital access.** A system that closes the gaps the current arrangement widens, with particular attention to working-age adults with disabilities and veterans, where the data shows the deepest gaps.

5. **Volunteer driver programs are treated as a community strength, not an emergency fail-safe.** Trusted, locally rooted programs stabilized with paid backup for the highest-consequence trips, so that a single missed volunteer ride does not result in a hospitalization. Respondents named volunteer driver programs as their #3 most-wanted improvements (CTNA-B, IMP-3).

Each of these conditions is a rider-side requirement. None of them can be met within the State's current operating arrangement. The CCAM Program Inventory identifies 130 federal programs that fund human services transportation across nine federal agencies (CCAM, 2024). No statewide office in New Hampshire is accountable for coordinating any of them.

Chapter 3 describes what a working system looks like for the people this plan prioritizes. Chapter 4 names the six state decisions that get New Hampshire there.

CHAPTER 3

THE STATEWIDE VISION

A working New Hampshire transportation system should be understandable, dependable, and centered on human need. It should help people access healthcare, groceries, work, caregiving, faith, and community life without having to decode eligibility rules, regional boundaries, or funding silos on their own. This system prioritizes older adults, people with disabilities, veterans, caregivers, rural residents, and people with limited English proficiency or limited digital access. New Hampshire already has a solid foundation of trusted providers, volunteer driver programs, regional coordination, and mobility management. The work ahead is to connect and strengthen those pieces so riders experience one system rather than a patchwork.

3.1 A shared statewide vision

> VISION
>
> **New Hampshire will build a coordinated community transportation system that allows people to reach healthcare, food, work, caregiving, education, social connection, civic life, and recreation with dignity, reliability, and reasonable effort in every region of the State.**

This vision responds directly to what Granite Staters asked for: more routes and service areas, more rural and on-demand options, more volunteer driver capacity, and clearer information about what is available (CTNA-B). At its simplest, it is about getting people where they need to go and making the ride home just as dependable. In an aging and rural state, designing transportation around older adults, people with disabilities, veterans, caregivers, and rural residents is sound statewide planning.

3.2 Design principles

A few basic tenets should guide the future system. They are simple enough to hold in mind and strong enough to guide policy, funding, procurement, and everyday operations.

- **Design for the person who needs the most help, not the average user.** A system that works for older adults in rural counties, people with disabilities, veterans, New American families, and caregivers will work for everyone else by default. The reverse is not true.
- **Treat coordination as infrastructure, not a program.** Coordination is not a grant, a pilot, or a convening. It is a permanent function of state government and should be funded, staffed, and measured as such.
- **No single point of failure for essential trips.** Medical, dialysis, workforce, and critical errand trips require redundant pathways. When one option falls through, a backup should activate without the rider absorbing the failure.

- **The State handles the policy complexity so providers can focus on riders.** When the State aligns funding rules, reporting requirements, and contracting standards once, savings multiply across every provider and every funding stream.
- **Measure what matters, publish what you measure.** Public performance reporting is not an add-on. It is the mechanism that keeps a coordinated system honest over time.

3.3 The mobility promise

Meaningful access means a trip completed safely, reliably, and with the right level of help. A working statewide system should deliver on six promises to every New Hampshire resident who depends on it.

1. **A ride you can count on.** Scheduled trips run on time, and the return trip is as dependable as the outbound trip.
2. **A door you can reach.** Assistance between the curb and the door is available when needed, including for wheelchairs, walkers, and riders who cannot be left unattended.
3. **A starting point that is easy to find.** Anyone can reach a trained person, a paper option, or a single web pathway to learn what is available and how to use it.
4. **A system that works for the people it was built for.** Older adults, people with disabilities, veterans, caregivers, and New American families see their needs reflected in how the system operates.
5. **Information that matches your language and literacy.** Interpretation, plain language, and cultural competency are built in, not added on.
6. **Accountability, the public can see.** Performance is measured, reported quarterly, and used to improve service over time.

3.4 What should be statewide, regional, and local

The strongest New Hampshire model is statewide in its standards, regional in its coordination, and local in its delivery. Too much centralization eliminates local knowledge. Too little centralization leaves riders navigating unique details and providers facing a slate of administrative inefficiencies.

Statewide	Regional	Local / Program Level
Keep NH Moving as the statewide starting point	Coordination across providers	Geographically relevant and reliable trips and trusted customer service
Shared data metrics	Tallied regionally for comparisons that can support resource management	Collected locally using technology and analytics that roll up statewide
Accessibility expectations	Corridor design and gap response	Volunteer recruitment
Public reporting and accountability	Mobility management	Place-based problem-solving

3.5 What success looks like for those this plan prioritizes

Success should be visible first in the lives of the people this assessment was built to center. The Commission on Aging asked for a plan that starts where the harm is greatest and works outward. The descriptions below translate the statewide vision into concrete experience for each priority population. They function as operating standards against which the coordinated system should be measured. Each standard reflects a documented finding that the coordinated system will measurably resolve.

For older adults. The CTNA documents the driving transition already underway and the fear behind it (§2.3). Success means the day driving stops is not a private crisis. A trusted and accessible ride to the clinic, the pharmacy, the grocery store, the senior center, the place of worship, and a grandchild's school event is a phone call away. Travel training and mobility transition support are available before driving ends, not weeks after. Aging in place is possible because mobility in place is possible.

For people with disabilities. The CTNA documents disability as one of the strongest predictors of transportation insecurity in New Hampshire (§2.4). Among under-65 residents living with a disability, 67.6% miss, delay, or avoid medical care because of transportation. Success means the rate falls year over year and is transparently reported on the public scorecard. Focus group participants described inaccessible vehicles, a lack of door-through-door support when curb-to-curb fails, scheduling barriers for non-app users, and rides that collapse when a transfer breaks down.

Success means accessibility exists in practice as well as on paper. Vehicles arrive with the lift working. Door-through-door support is available when curb-to-curb would leave someone stranded. Requests made by phone or on paper receive the same quality of service as those made online. Accommodation needs are recorded once, respected consistently, and not re-explained at every booking. Transportation is not the barrier that determines whether a person with a disability can work, receive care, or participate in community life.

For veterans. The CTNA documents the awareness gap and missed-care rate among veterans (§2.4). One veteran put it directly: *"I didn't even know the VA van would take people from my town. Turns out it doesn't come here anyway"* (CTNA-F). Success means specialty care reached outside the region is not a month-long logistics puzzle. Return trips are as dependable as outbound trips. Veteran-specific services are known to the veterans who would benefit from them, and when a ride falls through, a statewide pathway connects to a replacement without starting over. The veteran in Lancaster who needs oncology care in Lebanon gets there and gets home every time.

For caregivers. The CTNA documents the unpaid transportation labor families absorb when formal options fail (§2.2). Success means the daughter who drives her mother to three weekly medical appointments does not have to start from scratch each time. The husband managing his wife's dialysis is not the unpaid dispatcher of last resort. When a caregiver calls for help, a single statewide number connects them to a trained navigator who finds the right service, confirms the trip, and follows up if it fails.

For rural residents. Most of New Hampshire lacks general-public dependable transportation. As Table 2.1 documents, 161 of New Hampshire's 234 incorporated municipalities (69%) have no fixed-route transit and no demand-response transit open to the general public (CTNA-I). The pattern concentrates in rural regions: 93% of Sullivan, 88% of Monadnock, and 85% of Mid-State municipalities are transit deserts. Where coverage exists, it is often restricted by age, disability, program enrollment, or trip purpose and does not serve as the dependable infrastructure rural residents can build a life around.

The Coös County exception illustrates the gap between coverage on the map and dependable mobility in practice. Tri-County Transit serves 16 of 20 Coös towns and is open to the general public, leaving only 4 transit deserts in the county (CTNA-I). Coös residents nonetheless report the second-highest county-level transportation insecurity rate in the state (§2.4), reflecting that geographic coverage and reliable rides are not the same thing. 32 distinct active volunteer driver programs cover key areas of the rural map (CTNA-I), with stakeholder interviews consistently describing aging volunteers, driver shortages, and a lack of funding for backup for medically fragile riders.

Geography should not determine whether a person can reach care, food, work, or community. Success means off-hours, weekend, and short-notice trips are possible through right-sized service models that match the density and distances of rural New Hampshire rather than forcing urban assumptions onto rural places. Cross-county medical trips are not the structural failure point they are today. Volunteer driver programs, which rural communities have built and trust, are stabilized with paid backup for the highest-consequence trips, so that a single missed volunteer ride does not result in a hospitalization.

For residents with limited English proficiency or limited access to digital resources. The CTNA documents that 87.1% of respondents had never heard of Keep NH Moving and that BIPOC respondents report transportation insecurity at substantially higher rates than White respondents (§2.4). Success means language is not the barrier that keeps a resident from the ride they need. Interpreter support and translated materials are standard. Phone, paper, and in-person help are first-class options, not consolation prizes for people who cannot use an app. Trusted community partners, including libraries, senior centers, faith organizations, and resettlement partners, are onboarded as referral points so residents can start where they already trust. Solutions are co-designed with the communities most affected, including peer models in which community members serve as bus buddies or trusted information sources, paired with cultural competency training for transportation professionals.

When the coordinated system is working, these priority-population standards read as the baseline rather than the aspiration. They define the rider-side promise New Hampshire is being asked to meet. The public scorecard turns that promise into measurable accountability.

Why is this plan different from previous ones?

The importance of transportation in New Hampshire is well known, and statewide coordination efforts are already underway. What this plan adds is the operating design, executive ownership, funding framework, and implementation sequence to turn existing pieces into a governable statewide system. New Hampshire already has a statutory coordination structure (RSA 239-B), a mobility-management framework (the Blueprint, the statewide mobility management function, regional mobility managers), a set of trusted service assets (public transit, volunteer driver programs, senior transportation, hospital-linked services, Medicaid and veteran transportation, TripLink), and a statewide clear place for help with transportation in early form (Keep NH Moving).

New Hampshire has the foundation.

It is moving from **a collection of programs to a coordinated system that can be governed, measured, and improved.**

CHAPTER 4

THE SIX RECOMMENDATIONS

What New Hampshire now requires is focused, systemic change: clear authority, aligned funding, shared implementation, and public accountability. The six recommendations below name what the Governor's Office, NHDOT, DHHS, BAAS/Title IIIB, Medicaid, the Commission on Aging, the State Coordinating Council, the Regional Coordination Councils, and participating partners must carry together. The question before the State is whether those agencies will commit the collective authority needed to move from fragmentation to a coordinated system.

Each recommendation is a decision the State is positioned to make now. Each one answers the same question: what must those agencies do now so that older adults, people with disabilities, veterans, caregivers, and rural residents are not still expected to absorb the consequences of fragmentation?

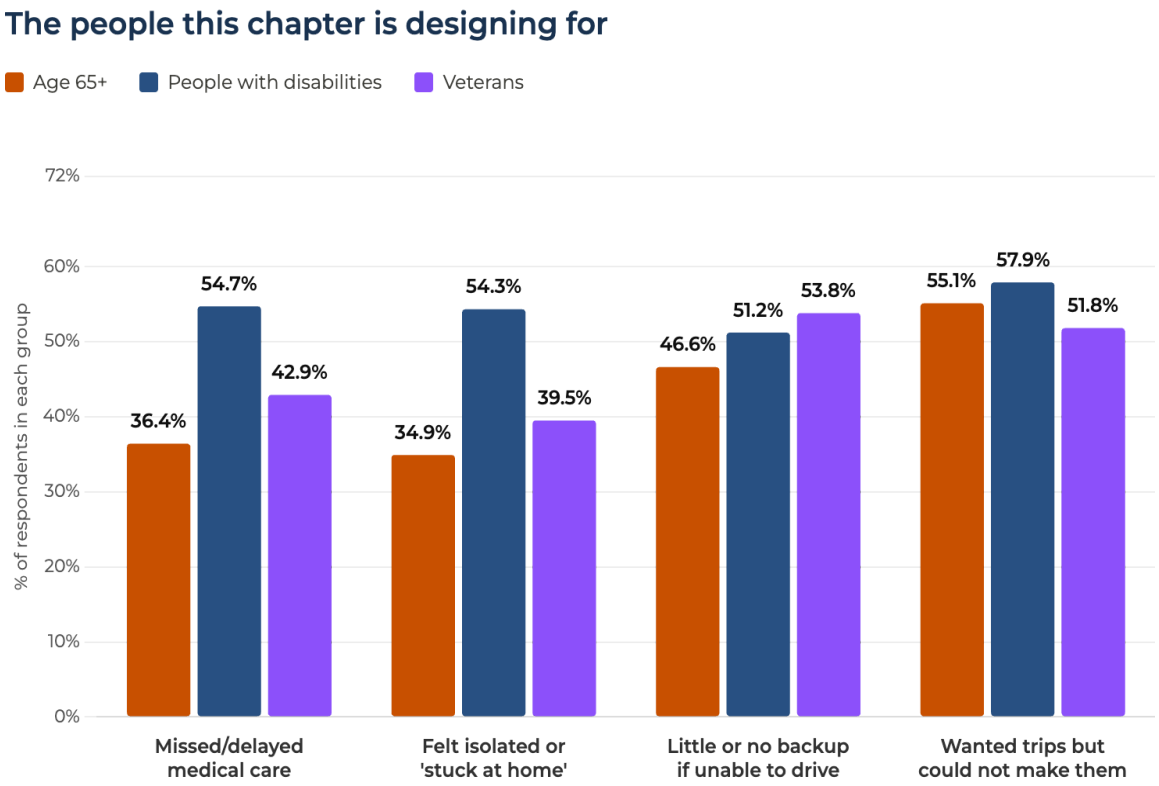


Figure 4.1. *People with disabilities experience every barrier at the highest rate. Source: CTNA-B. Denominators vary by question and by group. People with disabilities report the highest impact rate on most measures.*

4.1 Designate one entity to coordinate New Hampshire's community transportation system

Community transportation responsibilities currently sit across NHDOT, DHHS, BAAS, Medicaid, veteran services, the eight Regional Coordination Councils, mobility managers, providers, local partners,

healthcare systems, and human service programs. New Hampshire has capable people in each of these places. What it lacks is a single entity designated by the State to integrate its work into a single operating system.

For an older adult whose ride was denied last month, accountability means there is one state-level entity whose job is to know the denial happened, understand the pattern behind it, and work with the right agencies, regions, and providers to fix the conditions that caused it. The State, through a designated coordinating entity, should hold responsibility for implementation oversight, public navigation, shared reporting, funding alignment, healthcare referral coordination, regional technical assistance, and follow-through when system failures span agencies, regions, or providers.

The designated coordinating entity does not absorb the statutory authority of participating agencies. NHDOT, DHHS, BAAS, Medicaid, DMAVS, the Foundation for Healthy Communities, hospitals, Federally Qualified Health Clinic (FQHCs), the SCC, the RCCs, and providers each continue to hold the authorities and responsibilities they already have. The coordinating entity's role is to make the system visible, aligned, and accountable across them.

> **Without one entity designated to do this work, the system remains fragmented, and no single body can fix failures that span agencies, funding streams, and regions.**

One recommended structure. The State chooses where to assign this function. The *Conversion Playbook* describes one recommended structure, the Transportation Transformation Office, in operational detail, including draft Executive Order language, the staffing model, and the funding curve. The function described in this section does not depend on adopting that specific structure.

What current best practice is signaling

Federal coordination strategy is converging on shared, cross-agency ownership of transportation systems (CCAM Strategic Plan). The findings of the New Hampshire Community Transportation Needs Assessment identify fragmentation across programs as a primary barrier to access (NH State Commission on Aging, CTNA, 2025).

National best practice is converging on a clear operating model:

- Cross-sector, multi-agency ownership of transportation access
- Mobility management as core public infrastructure
- Formal state-level coordination roles with shared accountability

Federal implementation examples reinforce this shift. Mobility Ohio demonstrates that pilot-to-statewide deployment works best when agencies share ownership, data, and responsibility. The 2023 NCMM case study describes Mobility Ohio as a seven-agency ODOT-led collaboration addressing a state transportation landscape in which agencies collectively invest at least $500 million annually in client transportation. The initiative piloted a Regional Transportation Resource Center in southeast Ohio before applying lessons learned to a statewide model (National Center for Mobility Management, 2023).

4.2 Make Keep NH Moving the statewide starting point that New Hampshire can depend on

Keep NH Moving should be funded and built as core access infrastructure, including live phone support, a single web-based intake pathway, paper options, partner referral workflows, relay and interpreter access, regional content ownership, and clear escalation protocols for requests that cannot be fulfilled. For a caregiver calling for help at seven in the morning, a working Keep NH Moving means a trained person answers, knows the options, confirms the trip, and follows up if it fails. That is what a statewide starting point has to do.

This approach is already working as parts of the State are demonstrating what coordinated access can look like. In Region 10, TripLink functions as a shared intake and referral system that connects riders to multiple providers through a common application and a coordinated screening process. It reduces confusion for riders and improves how providers allocate limited capacity. The statewide goal should be to build from that model and extend it, while ensuring it works for rural areas and for people who cannot rely on digital tools.

Current CCAM implementation guidance also emphasizes locally specific, accessible, culturally and linguistically appropriate transportation communications campaigns to improve awareness, access, and ridership, thereby making statewide promotion and community-based outreach part of the operating model from its inception (Federal Transit Administration, 2026a).

The State should also adopt a digital governance rule. Any new health-funded transportation portal, application, or vendor procurement should be required to integrate with Keep NH Moving, follow common intake and reporting standards, preserve low-tech access, and strengthen the regional mobility management network. The fastest way to waste new transportation funding is to build another entry point that does not connect to Keep NH Moving, the RCCs, existing providers, and statewide performance reporting.

A common application and more advanced matching tools should follow once staffing, intake, measurement, and referral processes are functioning consistently. The foundation comes first.

Table 4.1. *Keep NH Moving roles and accountabilities.*

Role of Keep NH Moving	Who holds it	What that means in practice
Platform ownership and procurement	The designated coordinating body, with NHDOT providing procurement and fiscal services	Platform decisions, vendor management, content direction, and statewide technical standards. NHDOT runs state procurement and fiscal infrastructure, the same fiscal-anchor role it plays for the Pooled Mobility Management Fund.
Health, aging, and disability integration	DHHS / BAAS / Medicaid	Healthcare referral rules, discharge workflows, privacy alignment, aging, and disability access requirements.

Public standards and accountability	SCC	Statewide access and intake standards, reporting rules, and public review of whether the platform is working.
Daily operator	Contracted vendor	Phone, paper, online, and partner-referral intake; content discipline; partner onboarding; usage analytics; outreach; troubleshooting; and training.
Regional current data and person-to-person handoffs	RCCs, mobility managers	Keep provider records accurate, resolve referrals that would otherwise go unanswered, and make regional inter-provider referrals work.
Healthcare and community referrals	Hospitals, FQHCs, public health, ADRCs, veteran partners	Refer to the same statewide starting point instead of creating separate side systems.

4.3 Put healthcare, public health, and transportation in one operating partnership

Transportation should be treated as a core component of access to care, not as a separate responsibility addressed after appointments are scheduled. New Hampshire should establish a Transportation and Healthcare Implementation Cabinet within the statewide coordinating function and require active participation from GO-NORTH, DHHS, BAAS, Medicaid, NHDOT, the Foundation for Healthy Communities, hospitals, FQHCs, public health networks, RCCs, disability partners, and veteran partners. For a dialysis patient in Berlin whose treatment cannot be missed, integrating healthcare and transportation into a unified system means the ride, the return trip, and the follow-up appointment are coordinated rather than reinvented every week.

The structural case for this cabinet is both programmatic and statutory. New Hampshire's State Health Improvement Plan names reliable transportation as one of four urgent infrastructure priorities the State must address to improve population health (NH DHHS, 2023). A cross-sector cabinet is the operational structure required by the SHIP's four-priority framework. The cabinet is also consistent with the System of Care for Healthy Aging, the statutory framework through which DHHS delivers on the State Plan on Aging year over year (NH DHHS, 2025).

That cabinet's role should be operational. It should address recurring referral failures, align transportation with discharge and continuity of care, establish reliable pathways for recurring high-need trips, and resolve gaps that no single agency or institution can address alone. Hospital, FQHC, public health, aging, disability, veteran, and Medicaid referrals should move through Keep NH Moving and a shared reporting framework to strengthen a single, coordinated system.

A clear boundary applies here. New Hampshire should not use health-related funding to develop a separate transportation system that duplicates existing community transportation providers. Doing so would further fragment service delivery and weaken the coordination that the State has already invested in building.

Instead, health sector investments should be directed toward strengthening and expanding the current system. Any hospital, FQHC, public health, Medicaid, or philanthropic transportation initiative should be expected to work through existing providers and coordination structures. At a minimum, initiatives should engage RCCs, align with SCC priorities, and, where feasible, demonstrate formal partnerships with transportation providers.

As the Foundation for Healthy Communities or hospital partners make transportation-related grants, they should prioritize proposals that include formal agreements with existing providers, participation in RCCs, shared referral processes, and alignment with the statewide access model over standalone approaches.

New Hampshire should use the Rural Health Transformation opportunity to strengthen statewide access, referral pathways, care coordination, and data standardization and transparency. If new technology is introduced, it should integrate with Keep NH Moving, adhere to common intake and reporting standards, preserve low-tech access, and reinforce the existing mobility management network rather than create parallel systems.

4.4 Adopt essential access standards and close the biggest trip gaps

New Hampshire should clearly define what residents can count on. Essential access goes beyond a ride to a doctor. It includes dialysis, cancer care, wound care, pharmacy trips, food access, work, adult day, behavioral health, caregiving, veteran care, and the everyday trips that keep people connected to community life. Transportation that only works for a narrow slice of weekday appointments is not enough. The State should also treat return trips as part of the trip, not as a standalone element. One of the clearest patterns across the CTNA was that getting there and getting home are not equally dependable. That gap creates missed care, caregiver strain, delayed discharge, and avoidable fear. For a person with a disability whose accessible vehicle fails to arrive for the return trip, essential access standards require the State to identify the problem, measure it, and commit to fixing it, rather than treating the missing ride home as someone else's problem.

Essential access means treating food, pharmacy, work, adult day, worship, volunteering, and social connection as illness prevention rather than extras. Four steps make that concrete.

- Adopt essential trip access standards, including reliability targets for recurring and high-consequence trips.
- Build regional specialty care and veteran transportation networks that span county and RCC boundaries to align with existing care travel patterns.
- Expand rural, evening, weekend, and short-notice access by using right-sized service models rather than a single model deployed everywhere.
- Launch statewide driver-to-rider transition and travel training supports before mobility becomes a crisis for individuals and families.

4.5 Stabilize volunteer driver programs and create paid backup

Volunteer driver programs are one of New Hampshire's strongest assets. They are trusted, flexible, relationship-based, and often the only realistic options for communities with little or no transit or fixed-route service. They are also carrying too much of the system on unpaid labor and unstable funding. For a rural community where a trusted volunteer has driven the same neighbor to dialysis for six years, stabilization means the program survives the volunteer's retirement, and the rider does not lose the ride that keeps her alive.

Federal guidance already supports stronger investment in volunteer driver programs and related coordination activities. Section 5310 explicitly identifies travel training, volunteer driver programs, wayfinding, same-day or door-to-door service, and mobility management as eligible activities, and FTA separately identifies Section 5310 as a program that may support non-emergency medical transportation (Federal Transit Administration, 2025; Federal Transit Administration, 2026b).

The State should create a statewide volunteer driver support package that includes recruitment assistance, background-check support, insurance guidance, training, mileage reimbursement support, volunteer retention tools, and shared administrative resources. It should also fund dependable, paid backup for critical-needs trips so that life-sustaining care does not collapse when a volunteer is unavailable. Any stabilization package should be designed with the volunteer driver programs themselves, not imposed on them, and made available rather than mandatory. The local relationships and routines that make these programs work are what the State is trying to protect, not standardize.

New Hampshire should set a clear rule for when a volunteer model is appropriate and when a paid service must be available. The point is to protect volunteer programs from being used as the emergency fail-safe for the entire healthcare system. Goodwill is precious, and it cannot carry the weight of a business model.

4.6 Make the money work like one system

Community transportation in New Hampshire is funded through a layered set of programs: FTA Section 5310 and 5311, Title IIIB of the Older Americans Act, Medicaid Non-Emergency Medical Transportation, Veterans Affairs travel, state general funds, and others. Each has its own eligibility rules, allowable uses, reporting requirements, and reimbursement timelines. Local providers are left to assemble these programs themselves, contract by contract, rider by rider. Most of the rides residents need are eligible for funding from more than one of these programs at once.

Braiding is the technique that allows the State to coordinate these funding streams without merging them. Each program retains its identity, eligibility rules, and reporting requirements. The strands stay separate. What changes is that the State aligns them at the front end so that a single trip can draw on the right combination of programs without the provider having to do that work alone. The federal Coordinating Council on Access and Mobility published a Federal Fund Braiding Guide in 2020 specifically because this technique reduces administrative duplication while preserving accountability for each federal program.

Braiding is not blending. Blended funds are pooled and lose their identity, raising real concerns about program accountability and often not being legally permitted for federal grants. Braided funds remain distinct, traceable, and reportable in accordance with each program's original rules. The distinction matters because the State is not asking any program to give up its purpose or its oversight. It is asking the State to do the coordination work that local providers are currently doing alone.

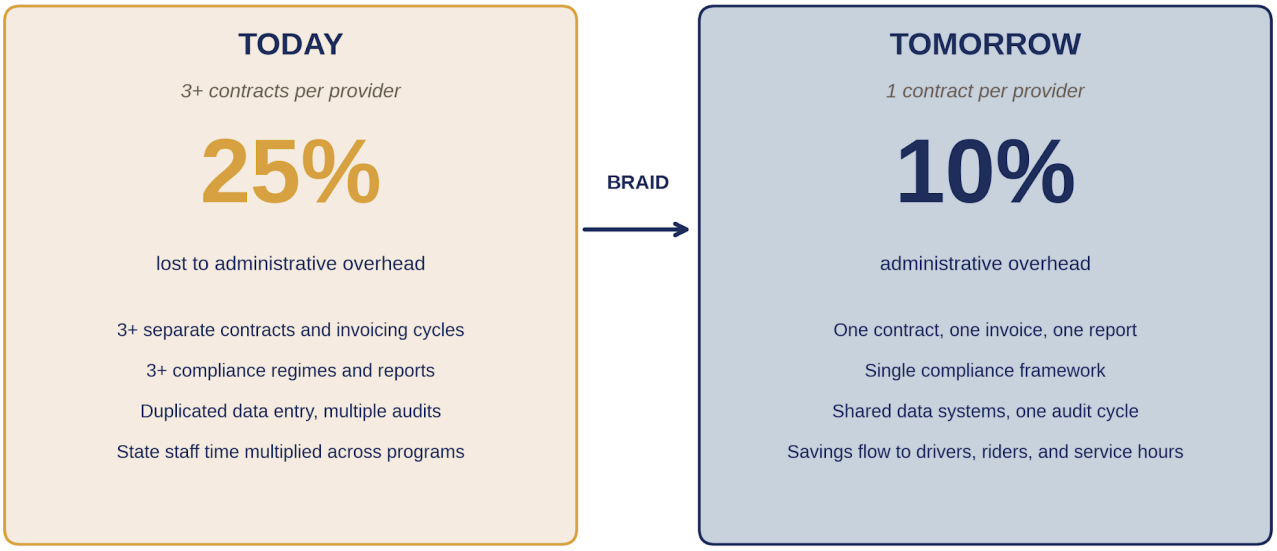
For a mobility manager who spends a third of her week reconciling three contracts to dispatch the same vehicles for the same riders, braiding is the difference between hours spent on paperwork and hours spent helping people get where they need to go. For every priority population, making the money work like one system means the rides they need get purchased once, paid for once, and reported on once, rather than reconstructed by local providers from overlapping contracts that the State could align. The cost of the current arrangement is measurable. For a single New Hampshire provider holding $1 million across three state contracts, the difference between roughly 25% and roughly 10% of grant value spent on administration is approximately $150,000 per year, dollars that could fund rides currently not being delivered. Multiplied across the provider network, the cost of fragmentation becomes a recurring, structural loss of service that no single provider can solve alone. Braiding is how the State recovers that margin and directs it back into trips.

For it to be effective, it must be a state-level effort that reduces administrative duplication and strengthens the public system. New Hampshire should create a Pooled Mobility Management Fund, stewarded by the assigned statewide coordinating body, with designated fiscal and program participation by NHDOT, DHHS, BAAS/Title IIIB, Medicaid, and other participating agencies. SCC should review and advise, but not manage the fund. This fund should purposely not replace ride dollars. It should make permanent the statewide function people have been asking for: coordination, mobility management, Keep NH Moving operations, shared data, technical assistance, and the contract work required to braid funds responsibly (CTNA-H; SCC Blueprint, 2022).

> **The CTNA engagement work repeatedly surfaced the challenge of disaggregated funding. Providers described the funding landscape as a patchwork they had to assemble themselves, rather than a system that delivered resources to them.**
>
> (CTNA-B)

Where the money actually goes

Fragmented contracts burn administrative time on both sides. Braiding puts more money into rides.



Same federal money. Same provider. Different administrative overhead.

What these recommendations make possible

Taken together, the six recommendations ask New Hampshire to be more operational than aspirational. They create the conditions under which the State's existing strengths, including the Commission on Aging's leadership, the SCC and RCC structure, the Mobility Management Blueprint, trusted providers, volunteer driver programs, and stronger regional models such as TripLink, can be joined into a system people can use more easily. The harder work comes first. Clear accountability, real authority, a single public access pathway, stable and braided funding, simpler rules, measurable performance, and a program design grounded in the experience of people closest to the issue. Once those conditions happen, service and investment decisions become executable.

CHAPTER 5

THE COORDINATED OPERATING MODEL

The recommended statewide coordinating function would operationalize the commitment to the six recommendations. It would draw clear lines between state, regional, and local responsibilities; make Keep NH Moving the statewide place to connect with transportation help; own the shared data infrastructure that makes performance visible; integrate with healthcare and public health; and be staffed and funded to last beyond its launch window. The sections below describe what that system would look like and what it should feel like for the people who use it, deliver it, are referred to it, and fund it. The State chooses where to assign this function; the *Conversion Playbook* describes one recommended structure, the Transportation Transformation Office, in operational detail, including draft Executive Order language, the staffing model, and the funding curve.

> ***"There is no point creating new systems when we can fix and connect the ones we already have."***
>
> — Focus group participant (CTNA-F)

5.1 One statewide coordinating function

A statewide coordinating function is what holds a transportation system together. In its absence, coordination remains voluntary, episodic, and fragile, as documented by the CTNA.

The coordinating function serves a structural purpose. It ensures that providers, regional bodies, and local knowledge operate under shared standards, toward shared objectives, and with access to shared infrastructure. It supplies governance and the statewide view that no single provider, region, or program can maintain on its own, with the staffing and authority to identify and resolve recurring breakdowns. It does not add a new ride-delivery layer.

Under the recommendation, the State, through a designated coordinating body, would perform this function. The body would be selected because it can act, convene participating agencies, manage implementation, oversee common reporting, align contracts and funding, and publish performance. §4.1 describes the function. The *Conversion Playbook* describes one recommended structure in operational detail. NHDOT, DHHS (including Medicaid, BAAS, the Bureau of Family Assistance, the Bureau of Child Development and Head Start Collaboration, and DHHS Housing), DMAVS and VA Manchester, Public Health, the Governor's Commission on Disability, the NH Office of Workforce Opportunity within the Department of Business and Economic Affairs, the Department of Education and Vocational Rehabilitation, and CDFA would all participate as program-coordination partners, coordinating allowable-use transportation funding as appropriate.

The Commission on Aging would hold public reporting and scorecard accountability. The roles of the State Coordinating Council and the Regional Coordination Councils are described in §5.2.

Four design conditions

Four conditions would have to hold for the coordinating body to function. Each corresponds to a capacity that prior coordination efforts in New Hampshire have lacked.

Authority. The coordinating body would be formally designated by the State and would have the authority to set statewide rules and hold participating agencies to those rules through contracts or interagency agreements, where legally feasible. Voluntary interagency agreements alone have been tested and proven insufficient.

Pooled or braided funding. Participating agencies would align eligible dollars within a funding structure that supports coordination, mobility management, shared data, Keep NH Moving, and the contract work required by braiding. NHDOT and DHHS would serve as core design partners. The SCC would advise and review, but not manage the fund.

Public accountability. Performance reports would use measures that the State commits to maintaining. The Commission on Aging would oversee the public reporting schedule and scorecard, with input from the SCC, the RCCs, providers, and public partners.

Dedicated staff capacity. Coordination cannot be an unfunded side task. The coordinating body would require dedicated staff or contracted capacity for leadership, data and performance, Keep NH Moving oversight, healthcare integration, funding alignment, regional technical assistance, and public reporting. The *Conversion Playbook* specifies a recommended staffing structure tied to the recommended organizational form.

These conditions are interdependent. A coordinating body constituted without any one of them would reproduce the failures of the current arrangement. The design that follows satisfies all four.

What the evidence supports, and what it will take time to prove. The case for a designated state coordinating body rests on structural logic. Federal reviews of human services transportation coordination consistently find that fragmentation cannot be resolved through voluntary alignment alone (GAO, 2014; FTA, 2025c). New Hampshire's evidence shows the same. Riders experience failure across program boundaries while providers and regional partners absorb complexity they did not create. The coordinating body would be the infrastructure required for accountable progress; it would not, on its own, guarantee specific outcomes. The public scorecard, reported quarterly and disaggregated by region and priority population, is how the State builds the outcome record over time. Peer offices in Ohio, Maine, and Vermont are still maturing and have not yet published rider-level outcomes at sufficient scale to support a numerical projection for New Hampshire.

Federal direction and peer states are converging on this model.

The Coordinating Council on Access and Mobility (CCAM), established by Executive Order 13330 in 2004, identifies cross-sector ownership, mobility management as core public infrastructure, and formal state-level coordination roles as the converging model across eleven federal departments with transportation-related programs (Federal Transit Administration, 2025b). Mobility Ohio is the clearest large-scale example: a seven-agency collaboration coordinating roughly $500 million in annual investment, established by Governor's directive and scaled from a regional pilot to statewide over seven years (National Center for Mobility Management, 2023, CTAA, 2023).

At a closer scale, Maine passed LD 1451 in 2025, directing MaineDOT to establish the Maine Coordinating Council on Access and Mobility, with mobility-management hubs across eight regions; Maine's legislative testimony cited New Hampshire as a model for statewide coordinating councils and regional mobility managers (Maine Legislature, 2025; Reinauer, 2025). Vermont has operated a Public Transit Advisory Council under 19 V.S.A. § 7(f)(5) for years, coordinating with eleven Regional Planning Commissions and using regional public transit providers as transportation brokers across Medicaid NEMT and the Older Adults and Persons with Disabilities Program (Vermont Agency of Transportation, 2020, 2023).

Federal reviews consistently find that voluntary advisory councils without staff and pooled funding cannot resolve fragmentation; the states making durable progress have moved toward staffed coordinating offices with delegated authority (GAO, 2014). New Hampshire has the advantage of starting with a completed needs assessment, a funded Rural Health Transformation opportunity, and an existing SCC/RCC structure.

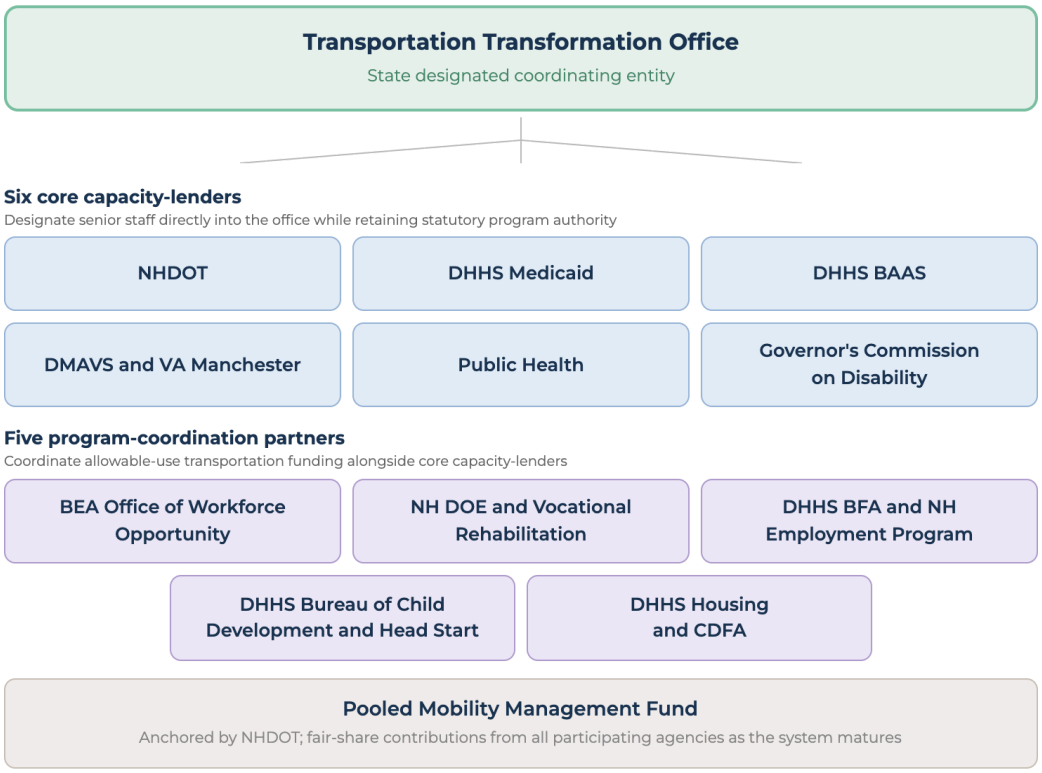


Figure 5.1. *The statewide coordinating function in its governance and operating context. The Commission on Aging holds the public reporting and scorecard accountability. Participating state agencies contribute senior staff capacity while retaining their statutory program authority. Program-coordination partners coordinate allowable-use transportation funding alongside. A pooled or braided funding structure supports the coordination layer as the system matures.*

5.2 What belongs at the state, regional, and local levels

A coordinated system requires each level of government to have a defined role and the authority to carry it out. New Hampshire's existing structure already contains the levels. What the existing structure lacks is clarity about where decisions are made and where accountability lives. The coordinating body sharpens those boundaries while building on New Hampshire's existing infrastructure.

State level

At the State level, the coordinating body carries out the work that no single region or provider can do alone. The coordinating body sets statewide standards, operates Keep NH Moving through the Statewide Mobility Management contract, anchors the Pooled Mobility Management Fund at NHDOT, maintains shared data infrastructure and the public scorecard, and convenes the Transportation and Healthcare Implementation Cabinet. Participating state agencies retain their statutory program authority while contributing senior staff capacity to the coordinating body. The Commission on Aging holds public reporting and accountability scorecards. The SCC advises on statewide standards and reviews performance.

Regional level

The regional level, composed of the 8 Regional Coordination Councils and the regional mobility managers, is responsible for cross-county coordination, partner relationships, gap response, service pattern troubleshooting, and local system improvement. RCCs would report up through the SCC, giving each regional council a clear path to the State level and providing the coordinating body with a single governance partner for regional questions. Regional mobility managers would operate as a distinct professional network. The coordinating body's Statewide Mobility Manager function would provide direct technical assistance, continuity, and shared infrastructure to that network, separate from the SCC/RCC governance pathway.

Local and program level

The local and program level, composed of providers and volunteer driver programs, is responsible for delivering rides, supporting riders, and contributing agreed-upon data. The coordinating body would operate upstream of this level, setting the standards and providing the infrastructure that enables providers to focus on their service role.

Referral and design partners

Hospitals, FQHCs, public health networks, Aging and Disability Resource Centers, BAAS contractors, veteran service offices, recovery organizations, disability partners, and other community entities function as referral and design partners. Their role is to identify recurring access problems, route residents into the system, and flag points of failure. The State should treat information from these partners as system-level

evidence. Recurring reports of access failures from multiple referral partners constitute data on system performance and should inform the State's operational response.

Table 5.1. *Division of labor across levels in the coordinated operating model.*

Division of labor

Level	Core responsibility	What that means in practice
Statewide	Set rules, braid funding, and publish accountability.	Operate Keep NH Moving through the Statewide Mobility Management contract, adopt common intake and reporting standards, braid federal and state funds into the Pooled Mobility Management Fund, maintain the public scorecard, and hold agency participation through the Executive Order.
Regional	Coordinate across regional lines and solve the problems geography creates.	Lead cross-regional coordination, partner relationships, gap response, corridor design, and local system troubleshooting through the 8 RCCs and regional mobility managers. Report up through the SCC. Receive direct technical assistance from the coordinating body's Statewide Mobility Manager function.
Local and program	Deliver rides and provide trusted rider support on the ground.	Provide service, support riders, recruit and retain volunteers, manage day-of-trip realities, and contribute shared data for regional and statewide aggregation.

The operating principle is clear. The State sets standards. The regions coordinate. The local and program level delivers. When standards remain consistent across jurisdictions, and delivery remains close to the geography, the system functions. The CTNA shows that the current arrangement often inverts this pattern, with local providers absorbing coordination burdens that belong at the State level (CTNA-A; CTNA-C). The coordinating body corrects that inversion.

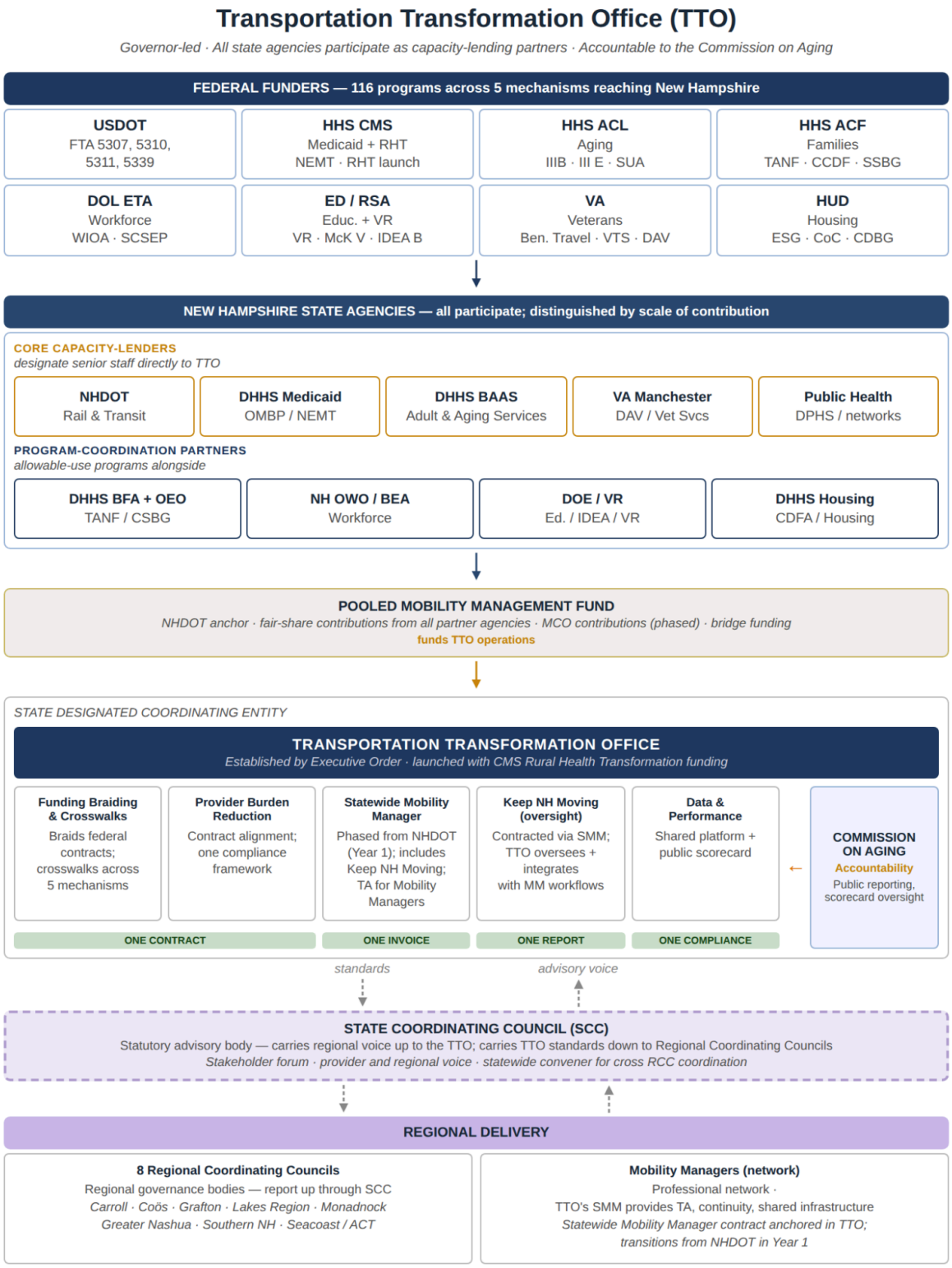


Figure 5.2. *Proposed Transportation Transformation Office structure. The diagram shows how federal funders, New Hampshire state agencies, the Pooled Mobility Management Fund, the Commission on Aging, the State Coordinating Council, the eight Regional Coordinating Councils, and the Mobility Managers network connect in the recommended coordinating structure.*

Note: The "116 programs" label refers to the CTNA-screened subset of federal human services transportation programs with documented New Hampshire applicability. The full 2025 CCAM inventory includes 132 programs nationally; more than 100 reach New Hampshire under the broader screen used in the CTNA. CTNA-H carries the program-by-program crosswalk.

5.3 One clear statewide starting point

New Hampshire operates multiple disconnected points of entry to community transportation. The CTNA finds that multiple entry points, each with distinct eligibility rules, hours, and referral pathways, transfer the coordination burden to the rider, the caregiver, or the referring partner. A caregiver arranging dialysis transport for a parent should be able to reach a navigator via a single statewide number and resolve the request on a single call. Keep NH Moving should become that single statewide point of entry. It exists today as a resource directory. The work ahead is to convert it into a staffed public service that is current, simple, and sufficiently connected so that residents and referring partners can use it with confidence.

Keep NH Moving exists. It has not had a clear operational owner. NHDOT holds the platform within its broader mobility management portfolio. The contract that staffed the day-to-day work has lapsed. The SCC has provided strategic guidance through the 2022 Statewide Mobility Management Blueprint. Regional Mobility Managers carry pieces of the work in their regions. No single party has been in charge of running Keep NH Moving as a public service. The platform's current state reflects that absence, not the absence of effort by the partners who have kept it going.

Keep NH Moving operates under contract rather than being staffed in-house by the coordinating body. It is most naturally nested within the Statewide Mobility Management contract that transitions from NHDOT to the coordinating body in Year 1. Nesting Keep NH Moving within the Statewide Mobility Management contract reinforces integration with the regional Mobility Manager network, since the contractor supports both functions. The coordinating body holds itself accountable for oversight, standards, and performance. The contractor handles day-to-day intake, referral, and follow-through. This arrangement is largely the nominal structure already. Housing it explicitly under the coordinating body enforces what has been assumed.

What the next phase of Keep NH Moving should include

The next phase of Keep NH Moving should include one statewide phone number, one online pathway, one common intake structure, live help during standard hours, relay and interpreter support, paper-friendly options, and a referral portal for hospitals, medical and mental health providers, Aging and Disability Resource Centers (ADRCs), libraries, senior centers, veteran services, social workers, and public health organizations. This model is consistent with current Federal Transit Administration mobility management guidance, which treats trip planning, travel training, call centers, transportation brokerages, stakeholder convening, and coordination technologies as core components of a coordinated access system (Federal Transit Administration, 2026a).

Two pieces of operational infrastructure sit beneath the public-facing channels and have to be built alongside them. First, provider information has to be kept current. The CTNA Provider Inventory is the starting point, but a directory ages out the day after it is published. Keeping Keep NH Moving accurate has to be a continuous Mobility Manager workflow, with named verification cadences and a clear rule for how

providers found to be inactive, out of date, or no longer serving the public are flagged and removed within a defined window. The regional Mobility Manager network is best positioned to carry this work in their regions, with the central Keep NH Moving function consolidating and publishing the verified record.

Second, operational definitions for the platform still need to be finalized. The CTNA establishes analytic definitions for dependable general-public transportation, priority populations, and transportation insecurity. Operational use may require adjustments to those analytic definitions. The platform's working definitions of what counts as an available ride on a given day, which eligibility data is displayed, and how trip categories are labeled for residents are decisions that the coordinating body should finalize with the regional Mobility Managers and the provider network during the launch period.

Keep NH Moving should be built in four sequenced stages.

- **Statewide intake and live help.** Clear intake procedures, live staffing during standard hours, access to relay and interpreters, and direct connection to regional problem-solving when a request cannot be fulfilled immediately.
- **Person-to-person handoffs and follow-through.** Status updates, trip-completion verification, and accountability for whether requested rides were completed.
- **Common application and provider matching.** A single core application, supplemented by program-specific addenda only where particular funding streams, eligibility rules, or reporting requirements require them. The Alliance for Community Transportation's TripLink, operating in the Seacoast region, provides a working example.
- **Shared dispatch or ride scheduling.** Implementation should proceed only after governance, provider participation, and operating readiness are in place. Shared dispatch is a later-stage capability.

A caution is warranted. New technology alone will not correct a fragmented system. If the underlying structure remains disconnected, additional platforms compound complexity rather than resolve it. The cost is concrete. A caregiver calls the wrong portal first because she does not know which one the patient's payer uses, and she loses the morning. A referring nurse routes a discharge through one platform, and the return trip through another, and both fail. A volunteer coordinator runs three intake systems in parallel because each of the three funders built their own. Every dollar spent building a parallel portal is a dollar that doesn't reach a ride. Every duplicate intake point teaches riders, caregivers, and referring partners that the system does not function as a single system.

Any new health-funded transportation portal, navigation tool, or vendor-built platform should be required to integrate with Keep NH Moving, route requests through the common intake structure, preserve low-tech access, and contribute to statewide performance data. One statewide point of entry is a core requirement. A second point of entry fragments the system, frustrates the people it serves, and spends scarce coordination dollars on duplication.

5.4 Shared data, reporting, and follow-through

The recommended coordinated system would demonstrate its performance through shared data, including counts of requested, completed, and denied or unmet trips; average time to completion; geographic and demographic distributions; and referral pathways. A Data and Performance Lead within the coordinating body would maintain the platform and publish a statewide scorecard on a regular schedule. The scorecard would be the public evidence New Hampshire uses to evaluate whether the system is working.

The CTNA recommends a common set of denial codes, a common definition of unmet need, and disaggregation rules that make the equity picture visible. Providers would contribute agreed-upon data through the contract structure held by the coordinating body. The RCCs would aggregate regional information. The coordinating body would aggregate and publish statewide. The Commission on Aging would review the scorecard and hold the coordinating body accountable for both data quality and the rate of improvement.

Reporting timing matters for action. Monthly operating dashboards would inform the coordinating body's day-to-day coordination work. Quarterly reports would inform the RCCs and participating agencies. An annual public report would inform the legislature and the public. The sequencing is intentional. The closer to the operation, the more frequent the reporting. The closer to public accountability, the more stable the reporting window.

5.5 Transportation inside healthcare and public health

Transportation functions as core infrastructure for healthcare access. It belongs inside the conversations that determine how New Hampshire delivers care, not alongside them. The coordinating body would be the operating home for the Transportation and Healthcare Implementation Cabinet recommended in §4.3. The Cabinet would sit within the coordinating body's operating model so that referral failures, discharge breakdowns, and high-consequence trip failures move through the same data, standards, and accountability structure as the rest of the coordinated system. The membership, charge, and authority of the Cabinet are described in §4.3.

Within the recommended operating model, the Cabinet would be the channel through which hospital, FQHC, public health, aging, disability, veterans, and Medicaid referrals flow through Keep NH Moving and a shared reporting framework, strengthening a single coordinated system rather than producing parallel systems.

The boundary on health-sector investment described in §4.3 would also apply within the recommended operating model. The Foundation for Healthy Communities, hospitals, FQHCs, public health, Medicaid, and philanthropic transportation initiatives should work through existing providers and coordination structures rather than standing up parallel systems.

The recommended system would operate alongside New Hampshire's existing Medicaid Non-Emergency Medical Transportation (NEMT) infrastructure. NEMT is federally required under 42 CFR 431.53. New Hampshire delivers NEMT through DHHS-contracted brokers serving the Medicaid Fee-for-Service population and the three Medicaid Care Management organizations. Current broker assignments are published in the DHHS NEMT Quick Summary Guide (NH DHHS, 2024). The coordination interaction between NEMT and the broader community transportation system would include return-trip reliability, denial coding and data sharing, behavioral health and access to recurring treatment, and referral handoffs for riders whose needs extend beyond Medicaid-covered medical trips. The recommendations would strengthen rider outcomes at that coordination interface and keep Medicaid dollars focused on the trips Medicaid is supposed to cover.

The Rural Health Transformation opportunity is particularly well-suited to this approach. RHT funds are designed to strengthen existing rural health systems and the infrastructure that connects residents to them. They are not intended to build parallel clinical systems. Launching the coordinating body with Rural Health Transformation resources would use the funding for exactly the transformation work it was appropriated to support. Rural Health Transformation funding would build the braiding, data, and contract alignment. Ongoing coordination would be sustained through state resources in the Pooled Mobility Management Fund once the federal funding opportunity closes.

5.6 How the coordinating function is staffed and funded over time

The coordinating function would do its heaviest work in the first years and then settle into a smaller, permanent operating footprint. Recruiting the Director, mapping the structural crosswalks between funding sources, contract regimes, eligibility frameworks, and reporting systems, standing up the data platform and compliance architecture, and converting providers to a unified compliance regime are finite projects with a beginning, a middle, and an end. Once that work is done, the coordinating body would run the coordinated system, sustained by state, partner, and pooled mobility-management funding. The design aligns with the catalytic-investment standard CMS requires for the Rural Health Transformation Program, in which federal investment transforms the system during the funding window and continues beyond it, funded by what the transformation builds (Centers for Medicare & Medicaid Services, 2025b).

The annual operating cost falls in the low-seven-figure range, which is modest relative to the scale of what coordination is asked to deliver and to the fragmentation costs the CTNA has already documented in Chapter 2 and the Executive Summary's cost-of-delay table. The *Conversion Playbook* carries the illustrative cost ranges, New Hampshire salary benchmarks, and year-by-year operating budget assumptions.

Staffing and funding are designed to transition together. A small permanent core would continue indefinitely on Pooled Fund and state coordination resources, while a launch-phase team would add the capacity required by finite startup work. The launch-phase team would be funded through Rural Health Transformation during the federal window, with role-by-role sunsets and conversions specified in the *Conversion Playbook*. The total new-FTE footprint depends on how much senior capacity the core

capacity-lenders choose to lend directly. The *Conversion Playbook* carries the full staffing model, the launch-phase role descriptions, the sunset and conversion schedule, and the model interagency MOU shell.

When the federal launch window closes, MCO contributions would phase in under updated managed-care requirements, and the Pooled Mobility Management Fund would fully sustain the coordinating body. The *Conversion Playbook* carries the year-by-year funding curve and the list of activities eligible under federal launch sources at the time of publication.

5.7 Workforce alignment and cross-training

A coordinated transportation system depends on two workforces, and New Hampshire is short of both. The first is the delivery workforce that moves riders. Drivers, dispatchers, mobility managers, volunteer driver coordinators, and NEMT operators carry the system out day to day. Stakeholder interviews across the CTNA consistently described aging volunteers, persistent driver shortages across transit, NEMT, and volunteer driver programs, unstable funding, and a lack of paid backup capacity for medically fragile riders when a trip is at risk (CTNA-C). The shortage is a question of supply and, equally, of system design. A driver who would gladly serve transit, NEMT, and volunteer programs across a single workweek today must qualify separately for each. The cost of multi-program certification, insurance, and inspection blocks a provider from expanding into adjacent service types. The result is parallel service silos that cannot share workforce, vehicles, or backup capacity, and a State that is rationing its existing driver pool across structures that were never designed to share.

The second workforce is the healthcare and human services workforce that arranges trips today because the system does not. Hospital discharge planners, primary care nurses, FQHC care coordinators, social workers, ADRC staff, public health nurses, behavioral health case managers, and the community navigators that hospitals and FQHCs increasingly employ all spend hours each week tracking down rides for patients, calling family members, troubleshooting failed pickups, and, in some cases, driving patients themselves. Each of those hours is an hour when the nurse is not nursing, the social worker is not assessing, and the navigator is not closing a referral loop. Coordinated transportation is a workforce strategy for healthcare. When Keep NH Moving offers a single statewide number with a trained navigator who completes the trip and follows up if it fails, hospital and FQHC staff would be able to practice at the top of their licenses. The State would recover the clinical capacity it is paying for but not receiving.

Two existing systems would make that recovery practical. Keep NH Moving, and the regional Mobility Manager network would serve as the statewide access points. New Hampshire's closed-loop referral platform, NH Care Connections, powered by Unite Us and PointClickCare, is the system already adopted by NH DHHS, NH DMAVS, and Harvard Pilgrim/Point32Health for cross-sector referrals across healthcare, housing, food, mental health, employment, and veteran services (NH DHHS NH Care Connections, 2024). When Keep NH Moving integrates with NH Care Connections rather than building alongside it, a hospital discharge planner would send one referral, the trip would be arranged, the closed loop would return confirmation, and the rider's care team would see that the ride happened. The same would be true for an

FQHC navigator coordinating a wraparound referral that includes transportation, food, and behavioral health. One system, one referral, one closed loop. This integration also addresses the CTNA's concern in §5.3 that new transportation portals risk fragmenting the system rather than unifying it. NH Care Connections is the platform the State has already chosen. Keep NH Moving plugs in.

The coordinating body's role would be to make both workforces work together. It would work with the structures New Hampshire already operates, including the NH Works Consortium chaired through the Office of Workforce Opportunity, NH Vocational Rehabilitation, the Commission on Aging's direct care workforce priority, the Community College System of New Hampshire, the Military Leadership Team and Ask the Question initiative coordinating veteran transportation across DMAVS, VA Manchester, and partner organizations, the Governor's Commission on Disability, and Granite State Independent Living and the Statewide Independent Living Council coordinating disability-related transportation under SPIL (NH BEA Office of Workforce Opportunity, 2024; CTNA-A; CTNA-D). Transportation reimbursement is already an allowable support service under WIOA, the NH Employment Program, and the NH Child Care Scholarship Program (NH DHHS NHEP, 2024; NH DHHS, 2025).

In Year 1, the coordinating body should publish a Workforce and Cross-Training Blueprint covering a statewide community transportation driver credential with reciprocity across programs, a shared training curriculum delivered regionally, mobility-manager career pathways and backfill plans, a consolidated annual safety and compliance inspection accepted by all participating funders, and the integration plan between Keep NH Moving and NH Care Connections. The *Conversion Playbook* §1.8 carries the full implementation design. Workforce alignment is a coordinating-body function rather than a stand-alone investment package. The staffing to produce and maintain the Blueprint is funded within Tier 2's coordination infrastructure (Package 4: Regional backbone and shared data). The program-specific workforce supports the Blueprint enables, including driver recruitment for volunteer driver programs, travel training, and mobility-manager career pathways, are funded within the Tier 1 packages where those staff actually deliver rides (Packages 1, 3, and 6).

5.8 What this should feel like for riders and referring partners

A coordinated system would produce a different experience for its users. The CTNA documents the current experience (SCC Blueprint, CTNA-C), and the recommended operating model answers each of those experiences with a specific structural response.

For a rider or caregiver

Today, arranging a ride often begins with uncertainty about which program applies and ends with multiple phone calls, inconsistent information, and no follow-through if something goes wrong. Under the coordinated community transportation system, Keep NH Moving offers one statewide number, one website, one referral path, and one person who follows through. The rider or caregiver does not see the braiding. They see the ride.

For a provider

Today, participating in multiple federal funding streams means multiple contracts, invoices, reports, and compliance regimes. Under the recommended system, the coordinating body builds crosswalks among categories of federal funding mechanisms. It creates one contract, one invoice, one report, and one compliance framework that covers the shared coordination requirements. Providers retain program-specific reporting only where federally required, eliminating the duplicative state-level layer.

For a state agency

Today, each agency carries its own transportation function alongside its primary mission, with limited visibility into what other agencies are doing and limited ability to coordinate with them. Staff at DHHS, NHDOT, BAAS, Medicaid, DMAVS, Public Health, the Governor's Commission on Disability, and the Office of Workforce Opportunity each maintain their own informal referral lists and workarounds that rely on the institutional memory of whoever has held the seat longest. When that staff member leaves, the referral map leaves with them.

Under the coordinated system, participating agencies lend staff capacity to the coordinating body while retaining their statutory program authority. Each contributes to the Pooled Mobility Management Fund in proportion to client benefit. Each retains decision authority over its own program. The practical change for an agency is that it no longer maintains a parallel stack of transportation referrals. Keep NH Moving becomes the one place staff point riders and families for help, fed by the existing infrastructure New Hampshire already operates: 211 NH, the ADRC network within NHCarePath, NH Care Connections, the Governor's Commission on Disability, Granite State Independent Living; supporting SILC, the Military Leadership Team, and the Ask the Question initiative. §1.6 describes how this advances the State's existing commitments under the State Plan on Aging, the System of Care for Healthy Aging, the State Health Improvement Plan, the State Plan for Independent Living, AgeWellNH, and the 2027–2036 Ten-Year Transportation Improvement Plan.

For agencies with employment, workforce, or family self-sufficiency missions, the alignment is equally direct. Transportation reimbursement is already an allowable support service under the NH Employment Program, WIOA, and the NH Child Care Scholarship Program. The CTNA finding that 27.4% of employed respondents lost work or income due to transportation barriers in a single month is both a workforce finding and a family economic security finding (CTNA-B). For an agency whose program depends on its participants reaching work, training, or child care, coordinated transportation is the household-level infrastructure that makes participation possible.

For a referring partner

Today, a hospital discharge planner, public health nurse, or ADRC staff member arranging a follow-up ride often lacks reliable visibility into whether the ride will occur. Under the coordinated transportation system, referring partners route requests through Keep NH Moving and receive follow-through confirmation. Recurring failures inform the coordinating body's operational response rather than accumulating invisibly.

For the public

Today, New Hampshire invests substantial public resources in community transportation through more than 100 federal programs, and the public cannot easily tell what those investments yield. Under the coordinated system, the Commission on Aging publishes a statewide scorecard on a regular schedule. The public can see what the system delivers, where it falls short, and how performance changes over time. Public accountability becomes a fact rather than an aspiration.

CHAPTER 6

THE PRIORITY INVESTMENT SEQUENCE

With the coordinating system in place, the next question is what to fund first. This chapter sets out a three-tier investment sequence. Tier 1 stabilizes what is most fragile. Tier 2 integrates the pieces that should work together. Tier 3 transforms community transportation into durable infrastructure.

Figure 6.1. *Investment sequencing logic for the New Hampshire Community Transportation Action Plan.*

Tier 1: Stabilize	Tier 2: Integrate	Tier 3: Transform access
Protect the trips and programs most at risk: critical-trip backup, volunteer driver stability, and rural and off-hours gap-filling.	Fund the statewide coordination layer: shared data, Keep NH Moving upgrades, regional mobility management, healthcare referral integration, and contracting alignment.	Secure recurring state support, statutory and procurement reform, long-term service expansion, and Ten-Year Plan multimodal access improvements.

Note. The three-tier investment sequence used throughout the action plan.

A coordinated operating system is the precondition for the work that follows: a designated coordinating body, a re-tasked Keep NH Moving, and the State commitment that stands both of them up. Chapter 5 recommends an Executive Order as the cleanest path to that commitment under existing authority.

What the current system already costs New Hampshire

The case starts with what New Hampshire is already paying for fragmentation. The Coordinating Council on Access and Mobility's 2025 program inventory identified 132 federal programs nationally that may fund some form of community or human services transportation. The number itself can mislead. Most of these are not transportation programs in the conventional sense. They are programs like TANF, CDBG, and SNAP Employment and Training, where transportation is one of many eligible uses and accounts for a smaller share of the program's total spending. A much smaller set is the primary federal transportation streams that flow through state contracts in New Hampshire: Section 5310, Section 5311, Title IIIB of the Older Americans Act, Medicaid Non-Emergency Medical Transportation, Veterans Affairs travel, and a handful of others.

The CTNA's New Hampshire analysis, documented in the *Braiding Toolkit* (CTNA-H), describes both layers: the small set of primary streams and the larger set of programs in which transportation is an eligible use but is currently not coordinated into the State's community transportation system. Each primary stream flows to a specific state agency with its own rules, contracts, invoices, and compliance regimes. In most cases, the eligible-use programs are not flowing to community transportation at all. Providers carry the burden of reconciliation across the primary streams. Riders fall through the seams.

Fragmentation costs the State real money in three ways. First, providers carry an administrative burden that scales with the number of separate contracts they hold. A single small provider may hold a Section 5310 contract with NHDOT, a Title IIIB contract with BAAS, and a NEMT contract with Medicaid, each with its own application cycle, invoicing rules, reporting templates, compliance audits, and reimbursement timelines. The hours an executive director spends reconciling three contracts are hours not spent on dispatch, driver coordination, or rider intake. The administrative margin recovered through coordinated contracting is approximately $150,000 per year for a single $1 million provider (CTNA-D), and that margin returns as time on the road, not as a paper saving. Second, the lost opportunity of eligible-use programs whose transportation dollars never get organized into the community transportation system. Third, the downstream costs of missed dialysis, discharge failures, and care abandonment compound on top of both. This sequence recovers margin from the first two and reinvests it in trips. The sequence protects access today, builds the coordination layer next, and locks in durable reform for the long term.

Why the Rural Health Transformation Program is the recommended launch path

New Hampshire has an unusual opportunity to stand up this coordination layer with federal dollars rather than state dollars. The CMS Rural Health Transformation (RHT) Program, authorized by Section 71401 of Public Law 119-21, provides $50 billion over five years (FY2026 through FY2030) to help states transform rural health delivery. New Hampshire received $204 million in the award's first year. Unspent funds must be returned to the Treasury by October 1, 2032. The window is open now and will not stay open.

Using RHT to launch the coordinating body is consistent with the program's statutory authority and with CMS's published strategic goals. The case rests on four pillars, and the launch funding plan honors all four.

Statutory fit. CMS names care coordination, new access points, and regional collaboration as explicit strategic goals of the RHT Program. Approved uses of funds include technical assistance, software, and hardware to advance information technology and improve efficiency and outcomes, as well as additional uses to promote sustainable access to high-quality rural healthcare services.

Peer validation. Texas, Oregon, Alaska, and Maine have already incorporated transportation support and coordinated care platforms into their CMS-approved RHT plans. New Hampshire's use of RHT to establish the coordinating body and strengthen the healthcare referral layer falls squarely within the envelope CMS has already approved for peer states.

Catalytic-to-sustainable alignment. CMS describes RHT as a catalytic investment intended to transform rural health systems during the five-year funding window. The launch funding plan is built to that standard, with the federal share tapering as partner contributions assume a larger share of the ongoing costs. The Pooled Mobility Management Fund, anchored at NHDOT and supported by fair-share contributions from partner agencies, sustains the work after the time-limited federal funding ends. The *Conversion Playbook* carries the year-by-year share table and the launch-phase staffing detail.

No supplantation, proper positioning. RHT dollars fund genuinely new coordination work, not a substitution for existing NEMT, Title IIIB, or transit operating funds. The coordinating body is a program activity serving rural access and care coordination, not state administrative overhead, and the plan honors CMS's 10% state administrative expense cap.

There is also a strategic argument for moving early. Peer states are defining, in real time, what rural health transformation transportation could look like. States that act now help shape the CMS reporting categories, evaluation frameworks, and successor program priorities that will govern the next round of federal rural health investment. States that wait will adopt a definition already written by others. New Hampshire's CTNA gives the State a stronger evidence base than most peers. Acting early positions New Hampshire to shape that evidence base rather than follow it. If New Hampshire chooses not to use RHT for this purpose, the coordinating body still needs to stand up, and the State pays for it with state dollars. That choice would compress Tier 1 stabilization efforts, extend the timeline for Tier 2 integration, and delay Tier 3 reforms. The coordinating body is the prerequisite either way. The question is whether New Hampshire uses this time-sensitive federal opportunity designed for exactly this kind of work or funds the same outcome later at a higher cost to state revenue.

Investment packages

Table 6.1. *Priority investment sequence, with lead, timing, and best-fit mechanisms for each package.*

Package	What it pays for	Best-fit funding mechanisms	Lead	Timing
1. Keep NH Moving and statewide navigation	Live phone help, provider portal, current data tracking, low-tech access, partner onboarding, analytics, person-to-person referrals, and public promotion.	State operating coordination funds; mobility management; health partners; RHT and GO-NORTH during the launch window.	NHDOT, DHHS, SCC, and the coordinating body	0 to 12 months
2. Health access and return-trip reliability	Hospital, FQHC, public health, ADRC, aging, disability, and veteran referrals; discharge planning; return trips; recurring specialty-care paths.	DHHS, Medicaid, health partner contracts; RHT during the launch window.	Medicaid, DHHS, GO-NORTH, Foundation for Healthy Communities, NHDOT	0 to 18 months
3. Volunteer driver stability and critical-trip backup	Recruitment, insurance support, screening, reimbursement, shared	State support, transportation funds, hospital and community benefit, and philanthropy.	Commission on Aging, NHDOT,	0 to 18 months

Package	What it pays for	Best-fit funding mechanisms	Lead	Timing
	tools, and paid backup for critical need trips.		RCCs, VDP leaders	
4. Regional backbone and shared data	Regional mobility management capacity, shared data and reporting, annual scorecard, referral protocols, cross-county coordination.	State coordination funds; mobility management contract; DHHS administrative braid; RHT during the launch window.	NHDOT, DHHS, SCC, RCCs	6 to 24 months
5. Rural and cross-county connectors	Specialty-care connectors, veteran access, rural and off-hour pilots, essential-trip corridors, right-sized service models.	Transit funds; state operating support; hospital co-investment; capital companions.	RCCs, providers, hospitals, veteran partners	6 to 36 months
6. Accessibility, language access, and mobility transition	Accessibility supports, companion assistance standards, language translation, and driver-to-rider transition planning and travel training for non-drivers.	Aging, disability, transportation, health education, and community benefit.	Commission on Aging, SCC, BAAS, NHDOT	0 to 24 months

Note. Source: Author analysis based on CTNA findings and companion documents.

Accessibility, language access, and mobility transition. The CTNA documents the disparity in transportation insecurity experienced by BIPOC, New American, immigrant, and refugee communities, as well as the qualitative patterns of language access and service staff assumptions about English fluency (§2.4). Package 6 carries the community-built peer models, bus-buddy programs, travel training, and cultural competency training into the investment plan. The §9.3 equity dashboard disaggregates performance by interpreter need, language, and referral source, with race and ethnicity disaggregation where data quality and privacy rules allow.

> ***Transportation is already part of New Hampshire's rural health transformation story.***
>
> The coordinating body uses that opening to strengthen the statewide system rather than to build a second one inside healthcare. The table below shows where RHT and GO-NORTH resources yield the strongest returns during the launch, as well as where they should not be directed.

Table 6.2. *How the RHT and GO-NORTH launch should be used.*

The RHT / GO-NORTH launch should fund	The RHT / GO-NORTH launch should not fund
• Keep NH Moving upgrade to a staffed statewide single entry point connected to health providers • Hospital, FQHC, public health, and veteran referral workflows • Discharge transportation and return-trip reliability improvements • Shared data, reporting, and performance measurement infrastructure • Regional coordination pilots tied to access and outcomes	• Consumer-facing transportation technology procured before Keep NH Moving, common intake, and mobility-manager escalation are in place • Standalone hospital transportation applications • One-off technology pilots without live staffing or integrated data tracking • Vendor procurements that bypass the SCC, RCCs, or statewide reporting • Capital or software purchases without an integrated operating plan

Note. Source: Author analysis based on CTNA findings, CTNA-H, and CMS RHT Program NOFO (2025).

Why this is different from earlier plans

New Hampshire already holds many of the assets that strong statewide plans are built around, including the State Coordinating Council for Community Transportation, the eight Regional Coordination Councils, the Mobility Management Blueprint, Keep NH Moving, volunteer driver programs, and a network of trusted local providers (SCC Blueprint, 2022; CTNA-A; CTNA-C). The step New Hampshire has not yet taken is to fund the conditions necessary for those assets to operate as a single, accountable, durable system. This sequence is what that funding looks like.

Five Reasons this investment strategy is different	
1	It organizes the work. The sequence rests on executive action first, then runs three parallel investment tiers: stabilizing critical trips, integrating the coordination layer, and transforming access through durable policy and funding reform.
2	It funds the coordination layer. Mobility management, shared data, and the rider access point are treated as infrastructure, as they are in every coordinated system in the country.
3	It gives each package a natural funding source. Each package is routed to the funding mechanism that fits best. Chapter 7 describes how those mechanisms work together.
4	It gives the SCC and RCCs a common operating framework. Statewide measures, statewide standards, and a single point of access with statewide authority give every region the same baseline to work from.
5	It ties money to measurable outcomes. Every package is framed around what changes for riders and what the State counts: denied rides, unmet need, critical-trip reliability, rural reach, accessibility, and return on investment.

6.1 Tier 1: Stabilize

Tier 1 would protect the trips and programs most at risk right now, so the current system would hold steady while the coordinating body and the coordination layer come online. These investments would fund the people and routes that communities already depend on, along with the backup capacity the State needs when a volunteer or scheduled ride cannot cover a necessary trip.

These are the investments a rider would feel first. A volunteer driver program would stay staffed. A person on dialysis would have a backup ride when their regular driver is unavailable. A rural town would have an evening or weekend option that did not exist before. Tier 1 is where the plan keeps faith with the people the system is currently letting down, while the rest of the plan would build around them.

6.2 Tier 2: Integrate

Tier 2 would fund the statewide coordination layer that the coordinating body would build. These investments would be less visible than a vehicle ribbon-cutting, and they are what would turn six or seven parallel systems into one. They would make every ride-dollar in every other tier work harder because riders, providers, and referring partners would stop navigating the fragmentation that the current system forces on them.

Tier 2 is where the coordination would become operational. One phone number. One website. One referral path. One contract, one invoice, one report, and one compliance standard for providers. The data every agency needs to improve, delivered from a shared infrastructure rather than rebuilt inside each program.

6.3 Tier 3: Transform

Tier 3 is what would turn a good plan into a system that outlasts any single administration or federal funding window. The State should secure recurring operating revenue for the coordination function, update the statutes and procurement rules that force providers to navigate around fragmentation, move successful pilots into permanent service, and use the Ten-Year Plan to invest in capital and infrastructure that round out the multimodal picture. By the time Tier 3 is fully underway, the RHT launch window would be closing, and the system would be ready to sustain itself on state, local, and partner resources.

6.4 How the State chooses what to fund first

New Hampshire will still have to make choices. Not every strong proposal can be funded at once, and not every urgent need can move through the same funding path. This plan gives the State a clearer way to choose: one that is harder to dismiss, easier to explain, and less vulnerable to anecdote, inertia, or whoever gets to the table first.

The tiers identify the State's investment sequence: stabilize what is most fragile, integrate the pieces that should already work together, and transform the parts of the system that require longer-term policy and funding change. Within each tier, the State still has to choose among specific proposals. Which volunteer driver programs receive stabilization support first? Which rural corridors receive connector investment? Which healthcare referral projects move in the launch window?

Those choices should be made using a single decision-making method. This does not take authority away from GACIT, NHDOT-administered programs, DHHS, the SCC, or regional partners. Each keeps its statutory role. What changes is that the State and its partners use the same investment language: who will benefit, what gap will close, how the proposal strengthens the system, whether it can be implemented, and whether it advances equity and long-term sustainability.

The decision method runs in two steps. First, a six-condition eligibility screen confirms that a proposal is complete, aligned with the statewide coordinated transportation plan, and ready for serious consideration. Second, eligible proposals are scored using a 100-point rubric across four dimensions: population and equity, access need, system value, and operational feasibility. An equity and sustainability guardrail prevents a proposal from advancing on a strong total score if it is weak on either of those core tests.

The *CTNA Conversion Playbook* carries the full eligibility screen, scoring rubric, point weights, and decision thresholds. The SCC should adopt the rubric as a statewide prioritization tool and update it annually so investment decisions remain transparent, comparable, and tied to the conditions residents actually face.

Table 6.3. *Proposal evaluation framework and decision safeguards.*

Decision step	Purpose	What it prevents
Eligibility screen	Confirms the proposal is complete, aligned, and ready	Funding ideas that are not yet implementable
Weighted rubric	Compares proposals across shared criteria	Choosing based on politics, habit, or volume
Equity and sustainability guardrail	Checks whether the proposal helps the right populations and can last	High-scoring projects that leave priority residents behind or collapse after launch funding

CHAPTER 7

THE FUNDING STRATEGY

The funding strategy rests on four working assumptions. The statewide coordinating function is financed as infrastructure through pooled or braided state support, anchored at NHDOT, with fair-share contributions from partner agencies. Ongoing coordination is funded from sources designated for ongoing operations, rather than from a rotating sequence of short-term grants. Each investment package is funded by the source that best fits it, and braiding is handled by the designated coordinating body at the State level rather than pushed down to local providers. Federal launch funding, including the Rural Health Transformation Program, is one of several sources that can accelerate the build in the first years, where allowable. The *NH Community Transportation Braiding Toolkit* (CTNA-H) carries the operational details.

A funding rule New Hampshire should adopt now.

Fund core operating functions from sources designed for ongoing operations, and fund local providers to deliver rides rather than to solve state-level fragmentation on their own. When coordination, data, and navigation are essential for access, they are infrastructure and should be financed accordingly.

Why these recommendations pay for themselves

New Hampshire is already paying for the absence of a coordinated community transportation system. The CTNA documents three distinct fiscal patterns that the recommendations in this plan address.

First, the avoidable health spending. The CTNA survey group reported approximately $4.3 million annualized in avoidable health spending when missed care escalates to emergency care or hospitalization (CTNA-D). Each missed primary care or therapy visit increases the likelihood of a downstream emergency visit, hospitalization, or skilled nursing admission, all of which cost the State more than the visit would have.

Second, the long-term care premium. New Hampshire ranks 49th in the country for Medicaid spending on home- and community-based services (AARP Public Policy Institute, 2023), while paying $149,650 per year for a semi-private nursing home room (Genworth and CareScout, 2025). The State's Choices for Independence Medicaid waiver was underfunded by $153.2 million between 2011 and 2021 relative to inflation-adjusted need (NHFPI, 2022). Every older adult who is pushed into a nursing facility prematurely because mobility loss went unsupported represents a cost that the State, families, and private payers absorb in the most expensive form of care available.

Third, the administrative margin is lost to fragmentation. For a single New Hampshire provider holding $1 million across three state contracts, the difference between spending roughly 25% and roughly 10% of the

grant value on administration is approximately $150,000 per year (CTNA-D). Industry research on nonprofit grants management documents that fragmented contracting drives administrative costs up across the sector, and that funder-imposed indirect-cost caps systematically fall short of nonprofits' real costs (The Bridgespan Group, 2016; U.S. Government Accountability Office, 2010). The same pattern recurs in human services transportation specifically, where each federal program flows to a separate state agency with its own rules, contracts, invoices, and compliance regimes (FTA, 2025a; U.S. Government Accountability Office, 2014).

Each of these costs is current expenditure. The recommendations in this plan do not ask the State to spend new money. They ask the State to redirect what it is already spending toward the system that prevents loss rather than on the loss itself. The funding strategy that follows operationalizes that redirection.

7.1 Funding strategy overview

Coordination is the only category that requires permanent state ownership. The other six already have funders; they just need to point in the same direction.

New Hampshire pays for the coordination layer as infrastructure rather than as a project. Durable state-anchored funding sustains it. Federal launch funding accelerates it during the first years, where allowable. The seven categories below describe what each kind of dollar should buy and which funders carry which work. Federal transit guidance already supports key parts of the coordination layer, and the full model combines state, health, MCO, local, hospital, community benefit, philanthropic, and federal funding, working together as a coordinated system (FTA, 2026a, 2026b).

The seven funding categories

1. **State operating support and the Pooled Mobility Management Fund.** The backbone of the coordination layer. Funds the statewide coordinating function, Keep NH Moving live navigation, statewide mobility management, scorecard reporting, regional mobility management capacity, and volunteer driver program support. Financed through dedicated state support and fair-share contributions from partner agencies whose clients benefit from coordinated transportation. NHDOT anchors the fund. DHHS Medicaid, DHHS BAAS, VA, Public Health, and other program coordination partners contribute at levels that increase as the system matures. §5.6 and §7.5 describe the contribution structure in detail.
2. **RHT, GO-NORTH, the Foundation for Healthy Communities, and hospital partners.** Health-aligned funding for transportation investments that improve access to care, discharge reliability, prevention, workforce participation, and coordination. During the RHT window, this category accelerates the healthcare referral layer, discharge, and return-trip reliability, CTNA baseline measurement, and public health-to-hospital integration. After the Rural Health

Transformation Program closes, hospital and FQHC community benefit, MCO contract requirements, and ongoing health partner participation continue the work.

3. **Federal transit and mobility management funds.** Service delivery, vehicles, regional mobility management, and eligible operations or capital. Includes FTA Sections 5307, 5310, 5311, and 5339. These are the funds that pay for the rides themselves, the vehicles, and the dispatch capacity that make them possible. They are not designed to pay for the statewide coordination layer, which is why the Pooled Fund exists.
4. **Federal aging, disability, veteran, and Medicaid channels.** Recurring access for older adults, people with disabilities, and veterans. Title IIIB, OAA, Medicaid NEMT, VA Veterans Transportation Service, DAV, and BAAS resources cover senior transportation, adult day access, dialysis and specialty care trips, veteran medical travel, ADRC-linked rides, and travel training. Each program serves a specific population under its own rules. The designated coordinating body's job is to help those rules work together rather than against each other.
5. **Municipal support, local match, and dedicated local revenue.** Town-funded senior shuttles, municipal match for regional and federal programs, local ADA paratransit contributions, and dedicated local revenue for community transportation. The Local Option Transportation Fee (described below) is the most significant underused tool in this category. Local investment is where community priorities show up, and it is often the piece that unlocks larger federal and state drawdowns through match.
6. **Ten-Year Plan, GACIT, and state capital.** Durable capital assets and enabling infrastructure with multi-year public value. Accessibility capital, technology backbone, facilities, vehicles, passenger amenities, stops, shelters, and last-step access improvements. The Ten-Year Plan is New Hampshire's primary capital planning tool for major transportation infrastructure, and §7.3 outlines the criteria for a strong candidate for the Ten-Year Plan.
7. **Local, employer, philanthropic, and community match.** Flexible local problem-solving and targeted co-investment. Volunteer support, community pilots, employer-sponsored routes, hospital community benefit contributions, philanthropic grants, and small gap-fillers where a modest amount of flexible funding completes a larger investment. Includes the community benefit obligations of nonprofit hospitals and FQHCs that align well with the transportation access work they already depend on.

For the operating mechanics of how dollars actually combine across these categories, including the seven-step braiding protocol and payment-cycle alignment, see the NH Community Transportation Braiding Toolkit (CTNA-H). The Conversion Playbook carries the master contract templates and model MOUs. Together, the two companion documents are the operating manual for the strategic-level approach described in this chapter.

A local revenue tool hiding in plain sight.

Roughly 30 of New Hampshire's 234 municipalities use the Local Option Transportation Fee for community transportation, typically set at $5. State legislative action could broaden eligibility and raise the fee ceiling, giving towns a dedicated, recurring local revenue stream.

The revenue stays local. Towns use it to fund senior transportation, meet the local match on federal transit and state grants, and build the mobility pieces their communities need. A small local fee can unlock substantially larger federal drawdowns that currently go unclaimed in New Hampshire communities without dedicated match funding. The *Braiding Toolkit* includes more specific information on this.

7.2 Operating support versus capital support

A central policy choice in funding community transportation is to treat operating support and capital support as distinct tools. Operating support buys time, labor, reliability, and continuity. Capital support buys assets with multi-year public value. Hybrid investments combine the two and require both a build plan and a sustain plan from the start. They solve different problems, are approved on different timelines, and are subject to different rules, timelines, and approval paths. Treating one as a substitute for the other is the most common reason good transportation plans stall after the first year.

Table 7.1. *New Hampshire needs both operating and capital support, and each should be used for what it is designed to do.*

Funding type	What it buys	Hard rule	Typical examples
Operating support	Staff time, service continuity, and reliability.	If the value depends on staff being on shift or the monthly invoice being paid, it is operating support.	Driver wages; dispatch and call-center staffing; mobility management; VDP coordination; fuel; translation and navigation support; recurring critical-trip backup.
Capital support	Assets with multi-year public value.	Capital means an asset that holds value over time. An investment that fails without ongoing staff and service support belongs in operational.	Vehicles; passenger amenities; hubs and transfer points; accessibility improvements; durable scheduling and dispatch infrastructure.
Hybrid investments	Projects that need both a	Approve the build only when the operating path and the	Keep NH Moving and one-call, one-click platforms; dashboards; referral

Funding type	What it buys	Hard rule	Typical examples
	build plan and a sustain plan.	accountable owner are named up front.	technology; corridor pilots that combine capital and ongoing operating needs.

Note. Source: Author analysis based on CTNA findings and companion documents.

7.3 What belongs in the Ten-Year Plan

The 2027–2036 New Hampshire Ten-Year Transportation Improvement Plan, developed by NHDOT under RSA 228:99 and RSA 240, was submitted to the Governor by the Governor's Advisory Commission on Intermodal Transportation on December 17, 2025, and is in legislative review at the time of this writing (NHDOT, 2025). The Commission on Aging is coordinating directly with NHDOT on updating the Statewide Coordinated Transportation Plan to support the Ten-Year Plan (NH State Commission on Aging, 2024). The Ten-Year Plan is New Hampshire's primary capital planning tool for major transportation infrastructure, managed by GACIT. It is often associated with roads and bridges, and it also supports multimodal investments that improve access, including vehicles, facilities, and enabling infrastructure for community transportation. The Ten-Year Plan is treated as one of seven funding categories, specifically designed for durable capital investments rather than ongoing operating support. The recommendations inform the current 2027–2036 cycle while the statutory period is open.

A strong Ten-Year Plan candidate passes four tests. It creates a public asset or enabling infrastructure with multi-year value; it improves the statewide or regional transportation network; it has a plausible public sponsor with implementation authority; and it is not a disguised request for recurring operations.

Table 7.2. *The four tests for Ten-Year Plan candidates.*

Test	Question
Public-asset test	Does the investment create an asset or enable infrastructure with multi-year public value?
Useful-life test	Is the investment reasonably expected to serve riders beyond one budget cycle?
Network-value test	Does it improve the statewide or regional transportation network rather than only one isolated service?
Sponsorship test	Is there a named public or regional sponsor with implementation authority?

Note. Source: Author analysis based on CTNA findings and companion documents.

These tests mean that accessible vehicles, passenger facilities, hubs, wayfinding, and public-facing technology are stronger Ten-Year Plan candidates than daily staffing, ongoing ride subsidies, or routine administrative expenses. The table below shows the candidates that fit New Hampshire's current needs.

Table 7.3. *Illustrative Ten-Year Plan candidates for community transportation.*

Candidate	Why it fits	Examples
Accessible vehicles and fleet replacement	Classic transportation capital needs are easier to justify when paired with clear operating plans.	Lift-equipped vehicles, replacement vans, and spare accessible capacity for high-need trips.
Stop, shelter, and waiting-area improvements	A ride is only as usable as the place where a person boards or waits.	Benches, lighting, weather protection, safer pickup zones, and accessible transfer points.
Sidewalk and last-steps access near key destinations	Many older adults and riders with disabilities can reach the stop only if the final few hundred feet are safe.	Short sidewalk gaps, curb cuts, safer crossings near clinics, senior housing, pharmacies, and adult day sites.
Corridor connectors where capital supports service reliability	Some cross-county medical and work connections need capital support to become stable.	Vehicles, dispatch technology, transfer hubs, and shared staging locations.

7.4 Investment packages for health-aligned funding

Transportation shows up in health and human services systems every day. New Hampshire should deliberately finance that reality, starting with the RHT launch window and continuing through the ongoing health-aligned pathways. Health and human services channels are strongest where transportation is integral to access, prevention, continuity of care, or support for populations who depend on reliable rides to stay healthy and connected (CTNA-D, CTNA-G; Centers for Medicare & Medicaid Services, 2025).

During the RHT window, the Foundation for Healthy Communities, GO-NORTH, hospital community benefit, and FQHC investment are the primary partners for healthcare-linked transportation work. After the window, MCO contract requirements, ongoing hospital community benefit, Medicaid NEMT coordination, and public health network partnerships carry the work forward. The table below outlines the packages in which health-aligned funding yields the strongest return.

Table 7.4. *Health-aligned investment packages.*

Package	Why health partners should care	Likely partners
Recurring treatment access	Dialysis, oncology, wound care, and therapy trips that fail to happen are transportation failures with direct clinical consequences.	Hospitals, FQHCs, dialysis and oncology providers, DHHS, and Medicaid.

Package	Why health partners should care	Likely partners
Discharge and follow-up support	A discharge plan works only when the trip home and the trip back to care are both reliable.	Hospitals, care managers, and public health partners.
Behavioral health and recovery access	The current system struggles to support trips that happen off-hours or require flexible routing. Behavioral health and recovery access depend on both.	Behavioral health providers, recovery organizations, and DHHS.
Data on missed care and denied rides	Health-aligned funding is easier to justify when the State can show who is missing care and what changed after investment.	NHDOT, SCC, hospitals, and public health networks.

Note. Source: Author analysis based on CTNA findings, CTNA-D, CTNA-G, and CMS guidance.

The Rural Health Transformation Program is named for what it is supposed to deliver.

A state earns the word "transformation" when the coordination, referral pathways, data discipline, and public accountability built during the federal grant funding remain in place on the day the infusion of funding ends. New Hampshire's Community Transportation Action Plan is built to pass that test.

7.5 Sustaining the coordinating function over time

The durable funding structure is what sustains the statewide coordinating function over time. NHDOT anchors a pooled or braided state contribution, and partner agencies whose clients benefit from coordinated transportation contribute fair shares that grow as the system matures. The combined state-and-partner contribution is the foundation of the ongoing system. Federal launch funding accelerates the build in the first years, where allowable, and tapers as partner contributions assume a larger share of ongoing costs.

Two roles work in parallel here, and it helps to keep them distinct. The designated coordinating body runs the work and convenes the contributing partners. NHDOT holds the largest state contribution and serves as the fiscal agent for the Pooled Fund. The distinction matters for three reasons. NHDOT is the state agency with statutory authority to receive, hold, and disburse state and federal transportation funds, including FTA Sections 5307, 5310, 5311, and 5339, so anchoring the Pooled Fund there keeps federal eligibility clean from day one. Partner agencies whose clients benefit from coordinated transportation can cleanly contribute fair shares to a transportation fund, whereas contributions to a Governor's office would be

harder to characterize and audit. And anchoring the fund at NHDOT means the funding mechanism survives across administrations, even if the coordinating body's form evolves.

Health-aligned launch funding is currently available through the Rural Health Transformation Program, which is designed to be catalytic. During its five-year window, the program contributes to launch-phase activities that build the coordination layer, healthcare referral pathways, data discipline, and public reporting capacity on which the system depends. After the window closes, MCO contract participation, hospital and FQHC community benefit, ongoing Medicaid coordination, and public health network partnership carry forward the health-aligned share of the work.

The State designs the contribution structure with its partner agencies, and the designated coordinating body convenes the participating partners and reports annually on contribution levels, eligible activities, and the launch-to-sustainability transition. The *Conversion Playbook* includes operational details, including the launch-phase staffing plan, the year-by-year share table, the list of activities eligible under current federal launch sources, and the facilitated process for negotiating annual contributions.

CHAPTER 8

THE IMPLEMENTATION ROADMAP

New Hampshire does not need perfect conditions to begin. It needs named owners, signed agreements, shared measures, and the discipline to fund coordination as seriously as it funds vehicles. The State already has enough evidence. What has been missing is the decision to make coordination mandatory, measurable, and permanent. That decision is now sitting on the table.

This chapter assigns the hard part to the State and stops leaving the burden of coordination on riders, families, and local providers (CTNA-A; CTNA-D; SCC Blueprint, 2022).

8.1 Implementation rules

- The State should run transportation, healthcare integration, state funding design, and regional delivery as one program of work, not four parallel workstreams. The coordinating body holds the single operating agenda. Participating agencies report to it on the work, not around it.
- Technology should enter through Keep NH Moving. Any health-funded transportation app, portal, or vendor procurement should connect to the statewide transportation access point, use common intake fields and reporting rules, preserve phone and paper access, and include live escalation to regional mobility management. Parallel entry points will lead to further fragmentation instead of coordination.
- No unfunded provider mandates. If the State expects common reporting, stronger coordination, or greater partner participation, it should fund or streamline the required work.
- No stranded technology. Shared tools should follow staffing, governance, and integration decisions rather than race ahead of them.
- Pay people with lived experience and frontline providers to test major tools, scripts, policies, and workflows before and after launch.

8.2 The first 100 days

The first-100-days actions are presented in the CTNA *Conversion Playbook* in tabular form, with named, accountable leads and the public deliverables the State should expect to see for each.

8.3 The first 18 months

By month 6, three workstreams should be visibly underway.

1. **The Keep NH Moving upgrade plan.** NHDOT, the coordinating body, and DHHS finalize the Keep NH Moving upgrade plan and staffing model, including live phone support, regional content ownership, low-tech access, the provider portal, and the public launch plan.

2. **Healthcare and community referral pilots.** DHHS, GO-NORTH, the Foundation for Healthy Communities, and partner hospitals, FQHCs, and public health networks launch referral pilots covering discharge planning, return trips, recurring specialty-care pathways, and referral feedback loops.

3. **The braiding map and Pooled Mobility Management Fund design.** NHDOT, DHHS, the Department of Administrative Services, the Attorney General, and the SCC draft the braiding map and the design for the Pooled Mobility Management Fund.

By month 18, three deliverables should be public.

1. **Keep NH Moving relaunched.** The coordinating body, NHDOT, SCC, and RCCs upgrade and relaunch Keep NH Moving statewide as a staffed resource for community transportation, with phone and web support, warm handoffs, public outreach, and current provider data.

2. **Critical-trip backup and rural connector pilots.** RCCs, providers, hospitals, and NHDOT/DHHS stand up critical-trip backup and early rural connector pilots, prioritizing dialysis, oncology, wound care, veteran, and cross-county access.

3. **First statewide scorecard.** The SCC, NHDOT, and DHHS data leads, and the coordinating body publish the first statewide scorecard against the CTNA baseline.

The *Conversion Playbook* §1.3 (100-day calendar template), §2.3 (Keep NH Moving RFP), §3.3 (Cabinet templates), and §6.4 (Pooled Fund pilot charter) carry the working documents. The *Braiding Toolkit*'s 90-day outreach sprint provides the day-by-day outreach sequence.

8.4 Years 2 through 5

Between 18 and 36 months, three workstreams should move from launch to operation.

1. **Master contracting and common reporting.** NHDOT, DHHS, the Department of Administrative Services, and the Attorney General adopt master contracting and common reporting where legally feasible, so providers see less duplicated paperwork and riders see fewer unanswered referrals.

2. **Regional specialty care and veteran connectors.** RCCs, providers, veteran partners, and hospitals expand regional specialty care and veteran connectors in areas where early pilots show demand.

3. **Health-aligned funding strengthens the statewide system.** DHHS, GO-NORTH, the Foundation for Healthy Communities, and NHDOT use health-aligned funding to strengthen the statewide system rather than creating side systems, with health-funded transportation work appearing in Keep NH Moving and on the public scorecard.

Between three and five years, two workstreams complete the transformation.

1. **Common application and provider-matching.** NHDOT, the SCC, the coordinating body, and providers move toward a common application and provider-matching model, then, where appropriate and only where the operating backbone is already working, to shared dispatch or scheduling tools.

2. **Single statewide planning and reporting cycle.** The SCC, RCCs, NHDOT, and DHHS run the system through a single statewide planning and reporting cycle with RCC regional annexes, making funding decisions easier to explain and compare over time.

The *Conversion Playbook* §1.6 (consolidating mobility management under the coordinating body), §6.4 (Pooled Fund operating agreement), and the *Braiding Toolkit*'s escalating compliance model carry the operational detail for this period.

8.5 Who holds the pen

The *Conversion Playbook* includes a deliverable-by-deliverable accountability table that shows the lead entity and reporting line for each launch-window product. It also carries the mechanism-by-mechanism breakdown showing which actions move through executive order, contract, GACIT/Ten-Year Plan, legislative, or federal/health-system channels.

This roadmap assigns the hard part to the State and turns the recommendations into a sequence of state-level implementations. It translates the long-term coordination vision, the statewide coordinated-planning obligations under federal Section 5310, the performance expectations described in Chapter 9, and the dissemination architecture described in §8.6 into concrete action steps.

The roadmap is built on one practical principle: the State must do the hard upstream work. If governance, contracts, data, and funding rules remain unresolved, local providers will continue to absorb the complexity, and riders will continue to absorb the failure. If the State names owners, deadlines, and public measures, the existing SCC/RCC and mobility-management infrastructure can finally operate at scale (New Hampshire State Coordinating Council for Community Transportation, 2022; NHDOT SMM Contract).

This time is different because the State finally has the pieces in the same room: baseline data, a statutory coordination structure, a statewide blueprint, an active mobility-management backbone, and a live rural-health implementation opportunity.

8.6 Why this is in the State's best interest

This plan asks the State to govern the assets it already has, described in Chapters 1 and 2, rather than build new ones. What is missing is a clear operating model that provides those assets with shared rules, shared data, and shared accountability. The costs of drift are now visible.

In the CTNA, nearly half of respondents reported missing or delaying medical care due to transportation barriers; more than one in four employed respondents reported missing work or income; and nearly half reported transportation-driven isolation. The same evidence base showed that New Hampshire is already paying for fragmentation through missed trips, unpaid caregiver labor, lost wages, and preventable medical escalation. The fundamental decision facing the State is whether to invest intentionally in system coordination or continue incurring the predictable, accidental costs of system fragmentation (CTNA-B, n=2,065; n=453; n=2,024).

The State has a current health policy incentive to get this right. CMS has approved New Hampshire's RHT funding, and the federal framework emphasizes prevention, integrated care, workforce strengthening, and technology-enabled access. Transportation is part of each of those goals, whether explicitly named or not.

Coordination has been discussed in New Hampshire for years without producing systemic change. That is not a failure of vision or commitment. It is a failure of conditions. Voluntary advisory structures without staff, pooled funding, shared data, or public accountability cannot deliver coordination, no matter how capable the people within them are. Federal reviews of human services transportation reach the same conclusion across multiple states (GAO, 2014; FTA, 2025c).

This plan changes what's possible. It designates one accountable statewide home for coordination, names the participating agencies, anchors the work in pooled and braided funding, treats data and contracts as core infrastructure, and commits to public quarterly reporting. Coordination is funded, governed, and measured permanently because that is what it takes for coordination to actually happen.

8.7 Milestones and public reporting

This section identifies the implementation milestones the State should publicly commit to. Together, the milestones below and the reporting schedule in §9.4 form New Hampshire's public commitment to track and report progress on this plan. Chapter 9 develops the full performance and accountability framework, including additional measures and reporting formats that the Commission on Aging and the participating agencies may require as the system matures.

Table 8.1. *Milestones and public reporting.*

Milestone window	Expected result
Within 100 days	Executive sponsor named; interagency table launched; data package defined; 12-month calendar published.

Within 6 months	Implementation charter issued; scorecard baseline established; Keep NH Moving design upgrade approved; Tier 1 sponsors named.
Within 18 months	Single statewide starting point operating; first corridor/connectors launched; shared reporting operating statewide.
Within 36 months	Braiding rules and master contracts in use; successful pilots scaled; funding decisions linked to performance.
Within 5 years	Recurring support established; statewide access infrastructure mature; coordinated planning cycle routine.

> **If this roadmap is followed, New Hampshire will not just have better transportation. It will have a better governing system for older adults, people with disabilities, veterans, caregivers, and communities that depend on them.**

CHAPTER 9

PERFORMANCE AND PUBLIC ACCOUNTABILITY

The State should make progress visible in public, use that information to fix what is failing, and let it shape future investment. The SCC's 2022 *Statewide Mobility Management Blueprint* calls for measurable outcomes, shared accountability, and performance tools that support statewide and regional improvement.

The framework below defines the statewide measures that should appear on a public scorecard, the regional and equity measures that should guide problem-solving, the reporting rhythm that makes progress visible, and the way performance should shape future investment decisions. The *Conversion Playbook* carries the technical specifications, standard definitions, code sets, and data dictionary that support this framework.

9.1 Statewide measures

Statewide measures are the headline indicators that tell New Hampshire whether the coordinated system is delivering on its core promises. They appear on the public scorecard, get reviewed quarterly or annually, and form the commitment against which progress should be measured publicly. If unmet trip requests do not fall, return-trip reliability does not improve, navigation through Keep NH Moving does not become more effective, and critical medical trip completion does not move toward the target, then the plan has not delivered on its promise.

Among the headline indicators, three deserve special emphasis in New Hampshire. Unmet trip requests should be a headline indicator, as delivered rides alone do not capture those who were never served. Return-trip reliability should stand on its own because a trip is only successful when the rider gets there and gets home. Completion of critical medical trips should be closely monitored because missed dialysis, oncology, wound care, discharge, and therapy trips constitute transportation failures with health consequences (CTNA-B, CTNA-D).

The statewide scorecard should publish both counts and rates whenever possible. A rate without a denominator can hide as much as it reveals. New Hampshire should also adopt a common statewide definition before comparing regions, providers, or programs. "Denied," "unmet," "completed," and "failed" need to mean the same thing statewide, or the scorecard will become a comparison of local interpretations rather than actual performance.

Table 9.1. *Statewide measures for the CTNA public scorecard.*

Measure	What it should show	Lead	Schedule
CORE QUARTERLY MEASURES			
Unmet trip request rate	Whether people who asked for transportation ultimately went without a ride or a confirmed alternative.	Coordinating body / NHDOT	Quarterly
Denied trip rate, with reason codes	Why the system turns requests away: geography, hours, notice, capacity, eligibility, or accommodation mismatch.	Providers and RCCs, consolidated statewide	Quarterly
Missed or failed trip rate	Whether scheduled rides are failing because of no-shows, incomplete trips, or missed return legs.	Providers / lead agencies	Quarterly
On-time pickup rate	Whether the system is dependable when the rider actually needs it.	Providers	Quarterly
Return-trip reliability	Whether riders can count on getting home as well as getting there.	Providers, reviewed statewide	Quarterly
Critical medical trip completion	Whether dialysis, oncology, wound care, discharge, therapy, and other high-consequence trips are being protected.	Providers with NHDOT / DHHS review	Quarterly
Navigation resolution rate	Whether Keep NH Moving and related referral pathways lead to a booking, a match, or a successful warm handoff.	Keep NH Moving / coordinating body director	Quarterly
Volunteer driver fill rate	Whether volunteer driver requests are being covered and whether backup capacity is working.	VDP leads and RCCs	Quarterly
ANNUAL MEASURES			
Customer satisfaction and trust	Whether riders report that the trip was respectful, safe, understandable, and useful.	Coordinating body director / SCC	Annual
Public awareness of the statewide access point	Whether residents and referring partners know where to start and are actually using Keep NH Moving.	NHDOT / SCC / Commission on Aging	Annual

9.2 Regional measures

The statewide scorecard should not be the whole measurement system. It should be the public top line. Regions need a second layer of diagnostics to explain why performance varies across different parts of the state. That matters in New Hampshire because geography is part of the problem the system is trying to solve. A region with long travel distances, sparse service, fewer drivers, thinner evening coverage, limited backup capacity, and regular cross-county medical travel will not look identical to a more densely served region. Good regional measures help the State distinguish structural challenges from operational weaknesses and target support where it will matter most. Each RCC should submit a quarterly regional review packet built around the diagnostic measures shown in Table 9.2.

Table 9.2. *Regional diagnostic measures for the quarterly review packet.*

Regional diagnostic	Why it matters	Primary use
Evening, weekend, and holiday availability	Shows whether access exists outside weekday daytime hours	Regional service-gap review
Accommodation match rate	Reveals whether riders needing accessible vehicles, language support, door-through-door help, or companion assistance are actually being matched correctly	Accessibility and equity review
Cross-county handoff success	Surfaces where regional and county boundaries are still breaking trips	Corridor and referral design
Referral turnaround time	Shows how quickly requests move from referral to confirmation, match, or documented inability to serve	Keep NH Moving and partner workflow review
Municipal service coverage	Shows which towns have regular practical options and which remain functionally outside the network	Rural and structural access review
Volunteer driver network status	Tracks the health of regional VDP capacity and backup supports	VDP stabilization planning
Outreach and awareness activity	Captures whether the system is becoming visible as well as operational	Public-facing accountability
Referral partner participation	Shows whether hospitals, FQHCs, NHCarePath/ServiceLink, public health, veteran partners, and community agencies are using the shared system	Cross-sector coordination review

These regional diagnostics should support problem-solving, technical assistance, and regional planning. They should help a region say, with evidence, "our unmet need is rising because our evening gap is real," or "our critical-medical completion rate is weak because cross-county handoffs are failing," or "our volunteer-driver fill rate is falling because recruitment and funded backup are both too thin." That is the level of visibility a statewide system needs.

9.3 Equity dashboard

The equity dashboard exists because statewide averages can mask exactly the people the CTNA was asked to center. Overall improvement in unmet need, reliability, or navigation resolution does not mean anything to an older adult in Coös County whose rides are still being denied, to a veteran in Carroll County whose specialty-care trips are still failing, or to a resident with a disability in Cheshire County whose accessible vehicle requests are still unmet. The dashboard is designed to surface the moment when a statewide trend line is moving in the right direction while a priority population is not.

The CTNA baseline already shows the geographic pattern the dashboard should track. Three counties (Carroll 72.7%, Coös 72.4%, Sullivan 70.0%) show insecurity rates more than 20 percentage points higher than the lowest county (Grafton 52.4%) (CTNA-B §3.5). The dashboard should report whether that gap narrows over time.

Every core statewide measure should be reviewed through eight equity lenses: age, disability and accommodation need, veteran status, geography, trip purpose, referral source, language and low-tech access, and caregiver-managed requests. Table 9.3 names each lens; the full disaggregation values, code lists, and data schema are specified in the *Conversion Playbook* §0.4 to keep the operational fields synchronized across the CTNA and the implementation manual.

Table 9.3. *Equity lenses for performance disaggregation.*

Equity lens	Why it matters
Age	Makes the mobility transition and aging-in-place risks visible
Disability and accommodation need	Shows whether the system is working for riders who need more than a seat in a vehicle
Veteran status	Supports review of specialty care and return-trip access
Geography	Surfaces regional and rural inequities
Trip purpose	Shows which kinds of trips are still falling through
Referral source	Shows which entry points are functioning well and which need improvement
Language and low-tech access	Makes language and navigation barriers visible
Caregiver-managed requests	Helps show where caregiver burden is highest

Where data quality and privacy rules allow, New Hampshire should also review results by race and ethnicity, income proxy, and other indicators of structural disadvantage. Public reporting should protect privacy by applying suppression rules when counts are small, while still making disparities visible enough to manage.

The dashboard also supports the federal compliance framework that any coordinated system receiving FTA funding must operate within. Title VI of the Civil Rights Act, Executive Order 13166 on Limited English Proficiency, and Section 504 of the Rehabilitation Act establish the legal floor for nondiscrimination, language access, and accessibility. The equity lenses above surface where those obligations are being met in practice and where corrective action is needed. The *Conversion Playbook* carries the operational compliance language for contracts and procurement.

The equity dashboard should help New Hampshire answer concrete questions. Are older adults experiencing lower navigation resolution than the general public? Are people with disabilities facing higher denial rates because accommodation needs are not being met? Are veterans still seeing poor completion rates for specialty care or return trips? Are rural riders facing much higher unmet need because geography, timing, or cross-county failures remain unresolved? Are riders who need phone, paper, or interpreter-supported pathways falling out of the system earlier than riders who are comfortable using online services? (CTNA-B, CTNA-A, CTNA-D)

A simple corrective-review trigger should accompany the dashboard. If a priority population or geography performs materially worse than the statewide benchmark for two consecutive quarters on unmet need, denial rate, return-trip reliability, or critical medical completion, the State should require a corrective review and a clear improvement plan.

9.4 Public reporting schedule

Public accountability works best when different audiences receive the right amount of information at the right time. Providers and RCCs need more frequent operational data. The public and state leaders need a smaller scorecard, a plain-language explanation of what changed, and a clear statement of what happens next. New Hampshire should use the reporting schedule shown in Table 9.4.

Table 9.4. *Public reporting schedule and audience.*

Product	Frequency	Primary audience	Minimum contents
Operational dashboard	Monthly	Providers, RCCs, coordinating body, NHDOT, DHHS	Core measures, denial reasons, critical-trip failures, return-trip failures, data-quality issues
Regional review packet	Quarterly	RCCs, lead agencies, and regional partners	Trend lines, structural gaps, VDP status, cross-county failures, and regional access patterns
Statewide public dashboard	Quarterly	Public, Commission on Aging, SCC, state agencies	Compact statewide scorecard with regional breakout and equity highlights
Annual statewide scorecard	Annual	Governor's Office, Legislature, GACIT, agencies, public	Year-over-year trends, equity dashboard, implementation progress, persistent gaps, next actions

Funding and action memo	Annual, aligned with budget and GACIT cycles	NHDOT, DHHS, SCC, Legislature, GACIT	Performance implications for stabilization, expansion, corrective action, and future investment

This schedule aligns with the implementation plan. Scorecard fields and the baseline dashboard come first; statewide shared reporting and the first full public scorecard follow as the system stabilizes; visible links between performance and funding come once enough data is in hand to support them.

A coordinated system needs a common set of definitions, required fields, a public scorecard, and the discipline to publish what it can see. The tools can get more sophisticated over time.

9.5 How performance should shape future investment

Performance data should guide future investment in a transparent, consistent, and fair way across regions. The *New Hampshire Statewide Mobility Management Blueprint* cautions against performance-credit approaches that reward regions already positioned to perform well while leaving structurally constrained regions with fewer resources to improve (NH Blueprint).

A region with thin service, long travel distances, weak backup capacity, and fragile volunteer coverage should not be set up to lose twice, once in the field and once in the funding cycle. Performance should guide support, technical assistance, and future investment toward the need and the potential payoff, not away from them.

The *Conversion Playbook* carries a scorecard interpretation guide that pairs these principles with specific data patterns and recommended State responses.

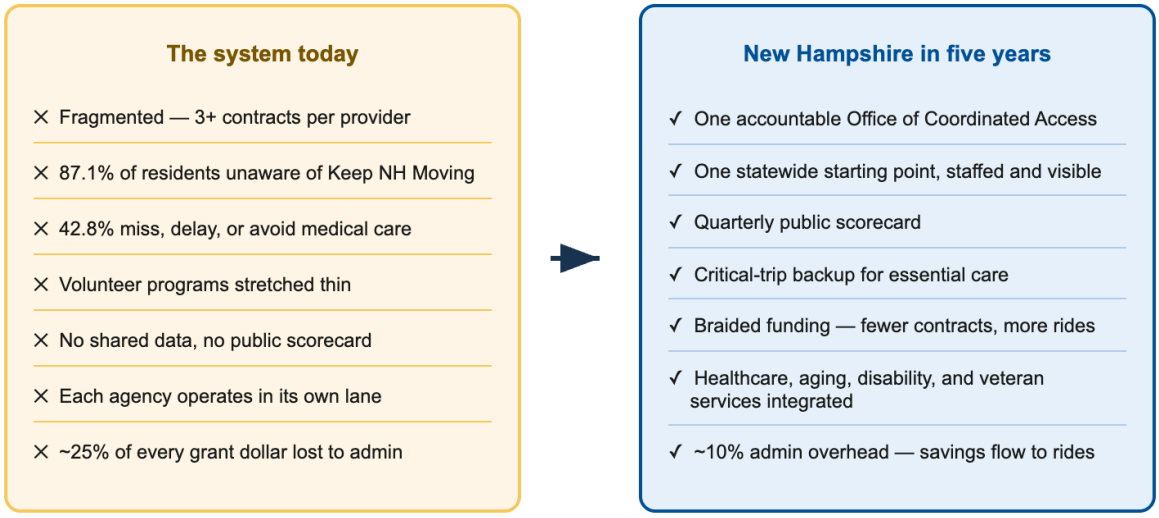
New Hampshire should use the funding rubric together with this scorecard. Readiness, leverage, statutory fit, and sponsor capacity still matter. Performance evidence matters too. Future investments should fund proposals that address documented unmet needs, fix specific denial or reliability patterns, improve outcomes for priority populations and geographies, protect fragile, high-value services before they collapse, and strengthen the statewide system people are supposed to use.

Performance should also shape technical assistance. Some regions will need money. Some will need service redesign. Some will need data coaching, accessibility troubleshooting, or shared back-office support. A good performance system helps the State match the response to the problem.

The scorecard gives New Hampshire a way to identify problems earlier, discuss them publicly, and adjust funding, management, and services in response. That is how accountability should work in a statewide community transportation system.

THE DECISION BEFORE NEW HAMPSHIRE

Why this moment is different, and why acting now is in the State's best interest.



The statewide Community Transportation Needs Assessment was commissioned to study community transportation needs in New Hampshire and to develop a long-term vision for public and human services transit. It was built from 2,824 survey responses across all ten counties, 72 stakeholder interviews, 11 focus groups, and 5 public forums. It draws on seven companion documents that examine the engagement record, gaps in service, the impact on health and economic life, qualitative testimony from riders, and a systematic review of comparable state efforts. It carries forward the framing of five active state planning instruments that already commit New Hampshire to a coordinated community transportation system.

The recommendations are specified. The coordinated system is named. The investment sequence is set. The funding strategy is mapped. The implementation plan is scheduled. The performance framework is established. The templates are written.

What remains is the decision to act on the evidence, while the conditions for action are aligned. The State has the executive authority. It has a Rural Health Transformation funding window open through 2030. It has the coordination infrastructure already in place: 211 NH, the ADRC network within NHCarePath, NH Care Connections, the Regional Coordination Councils, Keep NH Moving, the State Coordinating Council for Community Transportation, the NH Works Consortium, the Military Leadership Team, the Governor's Commission on Disability, and the Statewide Independent Living Council. It has a Commission on Aging that has built statewide legitimacy on this question and stands ready to support implementation.

The decision now sits with the Governor, the participating agencies, the Legislature, and the partners across the State. The seventy-eight-year-old in Coös County, the veteran in Cheshire County, the mother in Hillsborough County, and the caregiver in Grafton County have waited long enough. The evidence is on the table. The structure is on the table. The window is open. The decision is the State's.

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APPENDIX A

Contract Fulfillment Crosswalk

This appendix tracks how Getting There Together: New Hampshire's Community Transportation Action Plan satisfies the scope of work signed by the New Hampshire State Commission on Aging and Impact Consulting (Contract 2024-COA-2-Community Transportation Needs Assessment, signed October 10, 2024). It is intended as a quick review tool for the Commission, the Governor's Office, the Executive Council, state partners, auditors, and implementation partners.

Each row names the contract requirement, identifies where it is addressed in this report and in the companion CTNA deliverables, and provides the proof text demonstrating that the requirement is met or exceeded. Administrative deliverables that belong in the Commission project file, such as meeting notes, invoices, approved workplans, and approved budgets, are listed as project-file items rather than repeated in the public report.

Contract requirements crosswalk

Organized by contract section. Every row is marked Met or Exceeds. No contract deliverable is left unresolved in this crosswalk.

Status	Contract expectation	Where addressed	Proof text / why this meets or exceeds the requirement
Governor and Executive Council cover letter - five named deliverables			
● **Exceeds**	Engage program and policy leaders from state agencies and transportation stakeholders in partnership with the State Coordinating Council to advise project work and build commitment to implementation of final findings.	Executive Summary; The Decision Before New Hampshire; §4.1; §4.3; §5.1; *Braiding Toolkit* (layered authority, named-contact roster, 90-day outreach sprint).	The final package documents engagement with state agencies, transportation stakeholders, healthcare partners, RCCs, mobility managers, providers, and people with lived experience. The report is built from 72 stakeholder interviews, 11 focus groups, and 5 public forums, with the SCC named as a project advisor and continuing advisory structure. The *Braiding Toolkit* extends this from engagement to implementation through a named-contact roster, authority architecture, a 90-day outreach sprint, and an escalation pathway.
● **Exceeds**	Conduct quantitative and qualitative data collection to grow understanding of consumer needs, with an eye toward improving capacity to capture valuable data on an ongoing basis.	Executive Summary; Chapter 2; §5.4; §9; CTNA Data Companion; CTNA Qualitative Workbook; Quote Catalog.	The contract target was an evidence base strong enough to understand consumer need. The work exceeded that with 2,824 raw survey responses, 2,774 cleaned analytic responses, 72 stakeholder interviews, 11 focus groups with 76 participants, and 5 public forums across all

Status	Contract expectation	Where addressed	Proof text / why this meets or exceeds the requirement
			10 counties. Ongoing data capacity is addressed through shared data infrastructure, standardized denial and unmet-need definitions, a 10-measure statewide scorecard, and an 8-lens equity dashboard.
● **Exceeds**	Conduct a comprehensive assessment of transportation needs and gaps for older adults age 65+, people living with disabilities, veterans, and other vulnerable populations, including BIPOC, immigrant, and refugee communities.	Chapter 2; §2.4; §3.5; §4.2-§4.5; §6 Package 6; §9.3; Data Companion priority-population sections; Qualitative Workbook.	The report treats older adults, people with disabilities, veterans, caregivers, rural residents, and New American, immigrant, refugee, and BIPOC residents as priority populations, not side notes. It quantifies subgroup findings where sample size supports it, names sample constraints where the data should not be overclaimed, and carries those needs into operating standards, investment packages, Keep NH Moving design, language access, and equity-dashboard disaggregation.
● **Exceeds**	Conduct an analysis of economic, health, and social impacts of addressing or not addressing identified transportation gaps.	Executive Summary; §2.1; §2.2; §2.3; §2.4; The Decision Before New Hampshire; CTNA Impact and Policy Analysis.	The report analyzes transportation as healthcare, economic, aging-in-place, and equity infrastructure. It ties missed medical and therapy trips, lost wages, lost retail spending, caregiver burden, isolation, and long-term-care risk to the cost of inaction. The Executive Summary and Decision Before New Hampshire section translates those findings into a cost-of-delay argument the State can use in funding and implementation decisions.
● **Exceeds**	Identify and analyze current policies, systems, environments, and investments resulting in a long-term intra-agency vision for public and human services transit options, including an investment plan with prioritized projects and strategies.	§1.6; Chapter 3; Chapter 4; Chapter 5; Chapter 6; Chapter 7; Chapter 8; *Conversion Playbook*; *Braiding Toolkit*.	The report delivers the long-term vision and the tools to act on it: a statewide coordinating function, Transportation Transformation Office design, Keep NH Moving as the statewide starting point, healthcare and transportation partnership, essential access standards, volunteer-driver stabilization, Pooled Mobility Management Fund, three-tier investment portfolio, scoring rubric, funding strategy, and implementation roadmap. The *Conversion Playbook* and *Braiding Toolkit* turn that vision into executable templates, governance language, and convening tools.
Exhibit B §2.1.1 - Community engagement activities and deliverables			

Status	Contract expectation	Where addressed	Proof text / why this meets or exceeds the requirement
● **Met**	Submit and implement a Commission-approved workplan for the community engagement and assessment scope.	Commission project file; Appendix A project-management rows; quarterly workplan reporting.	This is an administrative deliverable rather than public-report content. The crosswalk identifies it as a Commission project-file item, supported by the approved work plan, progress reports, meeting notes, and final transmittal materials. The final report demonstrates that the work plan was implemented through the completed survey, focus groups, interviews, forums, analysis, inventory, companion products, and recommendations package.
● **Exceeds**	Identify and engage key target audiences: older adults, people living with disabilities, veterans, and historically marginalized populations such as immigrant, refugee, and BIPOC communities.	Chapter 2; §2.4; §3.5; Qualitative Workbook; Quote Catalog; engagement summaries.	The engagement record includes the contract's named populations and adds caregivers, rural residents, medical transportation users, providers, RCCs, mobility managers, aging and disability partners, veterans' organizations, and healthcare partners. Population-specific findings are carried into the recommendations and performance framework rather than left in the engagement appendix. That is the difference between listening and actually doing something with what people said.
● **Exceeds**	Design, implement, and analyze online and paper surveys with a target of approximately 2,000 responses to estimate transportation trip needs.	Executive Summary Table ES-1; Chapter 2; CTNA Data Companion; harmonized survey workbook.	The final analytic file includes 2,774 cleaned survey responses, screened from 2,824 raw responses for consent, geography, and data completeness. The work exceeded the 2,000-response target and produced statewide, subgroup, and trip-impact findings usable for implementation, and well beyond narrative description.
● **Met**	Conduct public forums and/or focus groups across regions and target populations, with a target of 15-20 sessions.	Executive Summary; Qualitative Workbook Master Log; Quote Catalog; Chapter 2 qualitative findings.	The project completed 11 focus groups and 5 public forums, for 16 engagement sessions across regions and target populations. That falls squarely within the 15-20 session target. Findings from those sessions are reflected in the qualitative workbook, quote catalog, population findings, and recommendations.
● **Exceeds**	Conduct stakeholder interviews with transportation coordinators and providers, including supports needed to capture unmet need.	Executive Summary; Qualitative Workbook Master Log; Chapter 2; §5.4; §9.1; provider and mobility-management findings.	The project completed 72 stakeholder interviews, including transportation providers, coordinators, public agencies, healthcare partners, aging and disability partners, and regional planning entities. The report converts the unmet-need problem

Status	Contract expectation	Where addressed	Proof text / why this meets or exceeds the requirement
			into scorecard measures, denial codes, shared data architecture, and public reporting requirements, which directly answers the contract's instruction to improve the ability to capture unmet need.
● **Met**	Develop a robust promotion and outreach plan and communications/outreach materials to raise awareness and maximize participation.	Commission project file; Strategic Communication and Dissemination Kit; *Conversion Playbook* communication templates.	The engagement-stage outreach materials supported survey, forum, focus group, and stakeholder participation. The final-stage dissemination is carried in the Strategic Communication and Dissemination Kit, and *Conversion Playbook* templates, including letters, outreach emails, public-facing implementation language, scorecard materials, and partner-facing tools.
● **Met**	Provide inclusive and accessible engagement, including translation/interpretation, ASL/English, Communication Access in Real Time, disability accommodations, and varied times/locations.	Engagement project file; §3.5; §5.3; §9.3; *Conversion Playbook* Appendix C.	The public report embeds language access, interpreter access, relay access, low-tech access, disability accommodation, and lived-experience compensation as operating standards for implementation. *Conversion Playbook* Appendix C carries the engagement protocol forward, requiring plain language, large print, translation, audio formats, ASL on request, hybrid participation, and compensation for lived-experience participants.
● **Exceeds**	Collect, synthesize, and analyze all community input through an effective system for documenting feedback.	CTNA Qualitative Workbook; CTNA Master Quote Catalog; CTNA Data Companion; report Chapter 2; Appendix A.	The project created an auditable qualitative record and quote catalog rather than relying on informal recollection. Community input was coded into themes, linked to focus groups, interviews, and story-bank records, and then tied to the final recommendations, scorecard, equity dashboard, and investment packages.
● **Exceeds**	Prepare a final community engagement report and recommendations summarizing key findings, major themes, recommendations, and participation patterns.	Final report: Executive Summary; Chapter 2; Qualitative Workbook; Quote Catalog; Appendix A; Strategic Dissemination Kit.	The final report incorporates engagement findings throughout the evidence base and recommendations. Companion qualitative tools preserve the engagement record, while the final action plan turns the themes into policy recommendations, an operating model, implementation roadmap, scorecard, and investment strategy.
Exhibit B §2.1.2 - Analysis, reporting, and recommendations			

Status	Contract expectation	Where addressed	Proof text / why this meets or exceeds the requirement
● **Exceeds**	Inventory and map existing local and regional transportation services statewide.	§2.4; §2.5; CTNA Provider Inventory; Coverage_By_Municipality; Coverage_Evidence_Log; Providers_Master; Information_Referral_Resources .	The CTNA Provider Inventory covers all 234 New Hampshire municipalities and preserves source evidence by provider, region, service type, and coverage. It documents 239 distinct canonical providers/resources, 161municipalities with no documented dedicated provider coverage across the four local provider-delivery categories, 45 municipalities with fixed-route or shuttle coverage, and a reconciled statewide count of 32 distinct active New Hampshire volunteer driver programs.
● **Exceeds**	Conduct a gap analysis using survey and focus group data, ACS/Census data, other repositories, and the inventory of existing resources.	Chapter 2; §2.5; CTNA Gap Report; Provider Inventory; Data Companion; Qualitative Workbook.	The gap analysis combines survey findings, qualitative evidence, Census and ACS context, provider inventory coverage, transit-desert analysis, regional patterns, and priority-population findings. The report names the gaps by trip type, geography, population, referral pathway, service hours, return-trip reliability, and regional coverage.
● **Exceeds**	Assess economic, health, and social impacts of action versus inaction on addressing transportation gaps.	Executive Summary; §2.1-§2.4; The Decision Before New Hampshire; CTNA Impact and Policy Analysis.	The impact analysis links missed medical care, missed therapy, long-distance specialty care, lost wages, lost local spending, caregiver time, social isolation, aging-in-place risk, and long-term-care exposure to transportation failure. It gives the State a defensible choice frame: pay for coordination and prevention, or keep paying downstream costs because the ride never came.
● **Exceeds**	Review current federal and New Hampshire policies, systems, and investments supporting public and community transportation, including the overall funding mix for volunteer driver programs.	§1.6; §2.5; §4.5; Chapter 6; Chapter 7; Provider Inventory VDP_Funding_Mix_Statewide; *Braiding Toolkit*; *Conversion Playbook* Chapter 6.	The policy and investment analysis covers federal transit, aging, Medicaid/NEMT, rural health, state strategies, NHDOT, DHHS, SCC/RCC infrastructure, and funding fragmentation. The Provider Inventory now includes a VDP funding mix tab with three tiers: 14 of 32 distinct active NH VDPs have documented funding mix, 9 verified active programs lack documented funding detail, and 7 supplementally identified programs remain unverified. The data gap is reported as a finding and converted into an implementation recommendation for a maintained statewide inventory.

Status	Contract expectation	Where addressed	Proof text / why this meets or exceeds the requirement
● **Exceeds**	Summarize key findings from the analysis and highlight major themes and recommendations.	Executive Summary; Chapter 2; Chapter 4; Chapter 6; The Decision Before New Hampshire.	The report distills the evidence into clear statewide findings: transportation is healthcare, economic, aging-in-place, and equity infrastructure; Keep NH Moving is under-known; return trips and critical medical trips require protection; volunteer driver programs are fragile; and funding fragmentation is a state-level problem, not a local-provider weakness.
● **Exceeds**	Recommend policy changes.	Chapter 4; Chapter 5; Chapter 8; *Conversion Playbook* Chapters 1-6.	The report recommends six state-level policy decisions with owners, mechanisms, and timing: designate one statewide coordinating entity, make Keep NH Moving the statewide starting point, establish a healthcare and transportation partnership, adopt essential access standards, stabilize volunteer driver programs with paid backup, and make funding work like one system. The *Conversion Playbook* supplies draft EO language, MOUs, contract provisions, scorecard fields, and implementation templates.
● **Exceeds**	Provide a prioritized list of recommendations for future public investment, with intent for potential inclusion in the Ten-Year Transportation Plan and other funding opportunities, plus criteria for funding decisions.	Chapter 6; §6.4; §7.3; §8.7; Provider Inventory Investment_Priority_Matrix.	The priority investment sequence is organized into three tiers - Stabilize, Integrate, Transform - with six named investment packages, lead agencies, timing, best-fit funding paths, eligibility screens, and a 100-point weighted scoring rubric. §7.3 adds the four tests for what belongs in the Ten-Year Plan.
● **Exceeds**	Include recommendations for intra-agency coordination and braiding funds to support meaningful access and a seamless end-user experience.	§4.1; §4.6; §5.1; Chapter 7; *Conversion Playbook* Chapter 6; *Braiding Toolkit* (authority architecture, escalating compliance model, fiscal conversation guidance).	The report establishes a Pooled Mobility Management Fund, state-led braiding, agency fair-share contributions, and a statewide coordinating function. The *Conversion Playbook* provides Pooled Fund governance, fair-share calculation, allowable uses, and public reporting templates. The *Braiding Toolkit* adds the authority architecture, fiscal conversation scripts, and escalation model needed to get agencies to the table with enough accountability to prevent participation from becoming optional.
● **Exceeds**	Name opportunities for collaboration, shared and cross-trained workforce, more	§4.3; §5.2; §5.5; §5.6; *Braiding Toolkit* named-contact roster;	The report names the Transportation and Healthcare Implementation Cabinet, statewide and regional roles, healthcare

Status	Contract expectation	Where addressed	Proof text / why this meets or exceeds the requirement
	robust, sustainable, and integrated services.	*Conversion Playbook* §1.8 and Chapter 3.	referral integration, workforce alignment, cross-training, mobility-manager career pathways, driver shortage strategies, and coordinated service delivery. The *Braiding Toolkit* names roughly 30 positions across agencies, providers, healthcare, RCCs, mobility managers, and community partners for launch-year convening.
● **Exceeds**	Include equity considerations in analysis and recommendations.	§2.4; §3.5; §6.4; §9.3; *Conversion Playbook* §0.2 and §0.4; *Braiding Toolkit* engagement framing.	Equity is embedded in the evidence base, population-specific operating standards, scoring rubric, lived-experience compensation, and public accountability system. The 8-lens equity dashboard covers age, disability and accommodation need, veteran status, geography, trip purpose, referral source, language and low-tech access, and caregiver-managed requests, with race, ethnicity, income proxy, and other sensitive indicators added where data quality and privacy allow.
● **Exceeds**	Provide written reports, or a combined report, for the gap analysis, impact analysis, and policies/systems/investment analysis, plus the second comprehensive recommendations report.	Getting There Together final report; CTNA Data Companion; Gap Report; Impact and Policy Analysis; Provider Inventory; *Conversion Playbook*; *Braiding Toolkit*.	The final action plan functions as the second comprehensive recommendations report. The named companion products provide the supporting analyses and implementation materials. Together they exceed a normal report package by pairing findings with ready-to-use implementation language, templates, scoring fields, governance shells, and a funding-braiding toolkit.
Exhibit B §2.1.3 and §2.2 - Project management, reporting, and closeout			
● **Met**	Develop a project workplan within 30 days and use it to confirm progress toward project objectives.	Commission project file; quarterly workplan progress reports; Appendix A.	This is a contract-administration item housed in the Commission project file. The completed final report, companion playbooks, provider inventory, data products, engagement outputs, and updated crosswalk demonstrate that the workplan was carried through to final deliverables.
● **Met**	Develop a project budget within 30 days aligned to the $293,601 funding amount.	Commission project file; invoices and payment documentation.	This is a contract-administration item rather than public-report content. The crosswalk identifies it as met through the approved project budget and invoice documentation held in the Commission project file.

Status	Contract expectation	Where addressed	Proof text / why this meets or exceeds the requirement
● **Met**	Provide sufficient staff, oversee assessment components and subcontractors, and supervise report writing.	Commission project file; final report; companion deliverables; Appendix A.	The completed package demonstrates sufficient capacity: final action plan, data companion, qualitative workbook, quote catalog, provider inventory, *Conversion Playbook*, *Braiding Toolkit*, and dissemination materials. Multiple workstreams were completed and reconciled into one implementation-ready plan.
● **Exceeds**	Review best practices from other states' transportation needs assessments.	Chapter 5; Chapter 7; references; *Conversion Playbook* Foundations and templates; systematic review cited as CTNA-G.	The plan draws from federal coordination guidance, peer-state examples, GAO findings, CCAM, NCMM, NADTC, and comparable state models. The *Conversion Playbook* also names peer-state implementation references, including Ohio, Maine, and Iowa, for CCAM technical assistance follow-up.
● **Exceeds**	Engage project advisors including the SCC, the mobility management network, and other stakeholders.	Executive Summary; §4.1; §5.2; *Braiding Toolkit* named-contact roster; *Conversion Playbook* Foundations.	The SCC, RCCs, Statewide Mobility Manager, Regional Mobility Managers, providers, agency partners, and healthcare partners move beyond consultation. They are assigned clear advisory, operational, and implementation roles in the final recommendations and companion tools.
● **Met**	Coordinate and collaborate with NHDOT both using and supporting work on the Statewide Coordinated Transportation Plan required for FTA Section 5310 funding.	How to Use This Report; §4.5; §7.1; §7.3; §8.6; Provider Inventory; *Conversion Playbook*; *Braiding Toolkit*.	The report explicitly names RCC Coordinated Public Transit-Human Services Transportation Plans as required for FTA Section 5310 funding and aligns recommendations with NHDOT's FTA role. It references Sections 5307, 5310, 5311, and 5339, uses the provider inventory to support statewide coordinated planning, and frames the Commission's direct coordination with NHDOT around the Ten-Year Plan and statewide coordinated transportation framework.
● **Exceeds**	Supervise dissemination and strategic communication plans, including a strategic dissemination and communication plan for sharing findings.	Strategic Communication and Dissemination Kit; §8.7; §9.4; *Conversion Playbook* communication templates; *Braiding Toolkit* templates.	The dissemination deliverable is met through a standalone Strategic Communication and Dissemination Kit, plus public-facing implementation language in the report, a 12-month implementation calendar, reporting schedule, and companion templates for launch letters, outreach, Cabinet participation, Keep NH

Status	Contract expectation	Where addressed	Proof text / why this meets or exceeds the requirement
			Moving co-design, and Pooled Fund reporting.
● **Met**	Meet quarterly Workplan Status Report requirements, including workplan status, outreach activities, people engaged, outcomes, deliverable progress, stakeholder feedback, and process/outcome measures.	Commission project file; quarterly progress reports; Appendix A; final report evidence base.	Quarterly workplan reports and meeting records are Commission project-file materials. The public report carries the final synthesis of those reporting streams through the engagement counts, evidence base, public scorecard, equity dashboard, and implementation roadmap.
● **Met**	Provide any additional ARPA SFRF reporting required and maintain audit-ready records.	Commission project file; invoices; data workbooks; source-preserved inventories; Appendix A.	ARPA reporting and invoice documentation belong in the project file. The final products are also audit-ready: the survey data, qualitative logs, quote catalog, provider inventory, source evidence log, and this crosswalk preserve the connection between contract requirements, deliverables, and final outputs.
● **Met**	Submit a Final Status Report within 30 days of contract completion summarizing services provided, goals, objectives, and deliverables achieved.	Final transmittal package; Appendix A; final report; companion deliverables.	Appendix A now functions as the public-facing deliverable summary. The formal Final Status Report remains a contract-closeout document for the Commission project file and can use this crosswalk as its backbone. It names every scope requirement and the proof that it was met or exceeded.
● **Met**	Meet with the Commission on Aging Executive Director every two weeks for the first two months, then quarterly thereafter, with meeting notes and attendance lists as required by Exhibit C.	Commission project file; Exhibit C deliverable documentation.	Meeting cadence, notes, and attendance lists are administrative deliverables held in the Commission project file. They are appropriately referenced here rather than reproduced in a public-facing report.
● **Exceeds**	Author a comprehensive recommendations report and presentation on recommendations as outlined in Exhibit B §2.1.2.5.	Getting There Together final report; Chapter 4; Chapter 6; Chapter 8; Chapter 9; *Conversion Playbook*; *Braiding Toolkit*.	The final report is the comprehensive recommendations report. It does more than recommend: it assigns owners, sequences the first 100 days, creates a five-year roadmap, scores investments, defines public measures, and provides companion implementation tools. Presentation and briefing materials are supported by the dissemination kit.
Exhibit B §1.1 and §4 - Compliance, access, ownership, and required statements			

Status	Contract expectation	Where addressed	Proof text / why this meets or exceeds the requirement
● **Met**	Submit language-assistance approach and provide meaningful access for persons with limited English proficiency.	Commission project file; §3.5; §5.3; §9.3; *Conversion Playbook* Appendix C.	Language access is treated as a system requirement in the final plan, not a courtesy add-on. The report and playbook name interpreter access, relay access, low-tech access, multilingual materials, and language-access disaggregation in the equity dashboard.
● **Met**	Include required credit statement acknowledging the Commission on Aging contract and funds provided by the State of New Hampshire and/or the United States Department of Treasury.	Cover page credit block.	The cover page includes the required contract funding acknowledgment: the preparation of the report was financed under contract with the State of New Hampshire, Commission on Aging, with funds provided in part by the State of New Hampshire and/or such other funding sources as were available or required, including the United States Department of Treasury.
● **Met**	Obtain Commission approval for written materials before printing, production, distribution, or use.	Commission approval workflow; final transmittal package.	This is a process requirement managed through the Commission's approval workflow. The final report and companion tools are submitted for approval before public use, printing, or distribution.
● **Met**	Respect Commission ownership and copyright for original materials produced under the contract.	Cover page copyright notice.	The cover page states © 2026 New Hampshire State Commission on Aging. All rights reserved. That corrects the old crosswalk's ambiguity and makes ownership visible in the document itself.
● **Met**	Maintain records and support audit access consistent with contract requirements.	Commission project file; data companion; qualitative workbook; quote catalog; provider inventory; Appendix A.	The deliverable package is source-preserved and auditable. Administrative records remain in the project file, while the public-facing analysis preserves source evidence through the data companion, qualitative workbook, quote catalog, provider inventory, and this contract fulfillment crosswalk.

Table A.1. Crosswalk between the Commission on Aging scope of work and the sections of this report and companion CTNA deliverables that address each requirement. The proof text identifies the exact basis for treating each requirement as met or exceeded.

What the plan delivers beyond the contract

New Hampshire's Community Transportation Action Plan exceeds the contracted scope in eight material ways. These additions do not alter the contract requirements above; they reflect the Commission on Aging's decision to produce a plan that supports execution alongside analysis.

Addition beyond contract	What it adds
Transportation Transformation Office design	Specifies the office structure, capacity-lenders, Pooled Mobility Management Fund, staffing and funding curve, agency roles, and Commission-on-Aging governance connection.
Conversion Playbook	Provides draft Executive Order language, model MOUs, contract provisions, scorecard fields, RFP scopes, funding pathways, implementation calendars, and templates for all six recommendations.
Braiding Toolkit	Adds the authority architecture, named-contact roster, audience-specific pitch logic, 90-day outreach sprint, escalation sequence, templates, and long-term accountability model for keeping partners at the table.
Provider Inventory and VDP funding mix	Delivers an audit-ready statewide inventory for all 234 municipalities, a coverage evidence log, information and referral resources, and a reconciled volunteer driver funding mix analysis.
Public scorecard and equity dashboard	Creates a 10-measure statewide scorecard, regional diagnostics, standardized denial codes, common definitions, and an 8-lens equity dashboard with corrective-review triggers.
Rural Health Transformation integration	Uses the RHT window as catalytic launch funding where allowable and names the path from federal launch dollars to durable state, agency, partner, and pooled funding support.
National and peer-state best-practice alignment	Grounds the plan in CCAM, FTA, GAO, mobility-management best practices, peer-state examples, and the NH Mobility Management Blueprint so the plan builds from proven models rather than starting from scratch.