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"It's Part of Dialysis": Lived Experiences of Transportation Challenges Among Patients and Staff in In-Center Hemodialysis

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ABSTRACT

Transportation insecurity significantly affects dialysis care, yet little research examines its impact from both patient and provider perspectives. This qualitative study explored how transportation challenges influence the experiences of patients receiving in-center hemodialysis and dialysis clinic staff. We conducted 78 semi-structured interviews with patients (n = 49) and staff (n = 29) across four Northern California dialysis clinics. Participants described challenges of navigating two systems, healthcare and transportation, and how this creates emotional distress for patients and staff, disrupts clinic workflows, and compromises treatment adherence. Transportation services are a major part of the patient and staff experience in dialysis clinics. Our findings highlight the need to improve transportation for dialysis patients through collaboration between healthcare systems, transportation providers, and community stakeholders.

INTRODUCTION

Though compelling evidence has demonstrated that transportation insecurity impacts health, we lack effective methods on how to best address transportation barriers to improve health (Solomon et al., 2020). More than five million Americans miss or delay medical care due to transportation barriers (Wolfe et al., 2020). People from lower socioeconomic status backgrounds, racial minorities, and those with chronic conditions face even greater transportation challenges (Hughes-Cromwick et al., 2005; Jiang et al., 2022; Syed et al., 2013). Transportation may be particularly impactful for patients with end-stage kidney disease (ESKD), since a large majority (82%) of these people in the United States initiate kidney replacement therapy at in-center hemodialysis (HD) facilities (USRDS, 2024).

Typically, in-center HD requires patients to travel three times per week to dialysis. Yet, 10% of patients miss at least one dialysis session monthly, and 35% miss a treatment every three months (Chan et al., 2014; Iacono, 2004). Prior research has shown that transportation barriers contribute to missed dialysis treatments, which are associated with increased morbidity, including higher rates of emergency department visits and hospitalizations, and mortality (Balhara et al., 2020; Chan, et al., 2014; Leggat et al., 1998; Obialo et al., 2012, Razon et al., 2025). While transportation is not the only reason for missed treatments, the frequent-visit schedule makes this population especially vulnerable to transportation insecurity. Transportation is also a barrier to patients' access to kidney transplantation, which is the optimal type of kidney replacement therapy for patients with ESKD (Browne et al., 2021).

Patients with ESKD who are unable to drive or don't have a family member or friend to drive them to dialysis rely on services, like public transportation, paratransit (a door-to-door service mandated under the Americans with Disabilities Act for individuals who cannot use fixed-route transit), or Medicaid's non-emergency medical transportation (NEMT) (U.S. Department of Justice, Civil Rights Division, 2025). While prior research has described transportation challenges in dialysis clinics, no study to date has qualitatively provided both patient and clinic staff members' lived experiences of transportation (National Academies of Sciences, Engineering, and Medicine, 2019; Tian et al., 2023). This study qualitatively explored how people with ESKD and dialysis clinic staff were affected by transportation in the in-center HD setting. We used qualitative interviews to better understand the patient-, organizational- and systemic-level challenges facing patients and staff and aimed to identify more holistic strategies to bridge healthcare and transportation sectors for future interventions and research.

METHOD

We collaborated with a non-profit dialysis organization to recruit both staff and patients from four dialysis clinics in Northern California between May and September 2023. Study sites were selected based on county-level prevalence of ESKD and the Housing and Transportation (H+T®) Affordability Index, which considers county-level housing and transportation costs (Center for Neighborhood Technology (CNT), 2022; CMS, 2022;). We prioritized sites that had higher prevalence of ESKD, showed transportation costs exceeding 10% of monthly household income, and were willing to participate in the study. To capture geographic diversity, we recruited participants from urban, rural, and suburban locations.

The UC Davis Institutional Review Board (IRB) reviewed the study and deemed it exempt (1891097-1). We developed separate, semi-structured interview guides for patients and staff. The patient interview guide included domains related to transportation behavior and context, planning and cost, awareness and use of transportation resources, and non-medical transportation needs. The staff interview guide covered professional background, awareness of patient transportation needs, transportation's impact on patient care, outcomes, operations, community resources, and recommendations. Community partners, including dialysis patients and two dialysis social workers, reviewed the guides and provided feedback prior to data collection.

An MA-level researcher with experience in qualitative interviewing and a PhD-trained anthropologist (B.B.H and N.R.) visited each dialysis clinic for 2–3 days to meet with and recruit participants. Both researchers identify as female. Participants were eligible if they were over the age of 18 years old and either a patient with ESKD receiving treatment or a staff member at a participating clinic. We used consecutive sampling by approaching patients during their dialysis session, introducing ourselves and the study aims. Patients were invited to participate during their dialysis session or complete the interview over the phone at a separate time. Fewer than 5 people declined participation. For staff recruitment, we conducted a 15-minute presentation to each dialysis clinic. Staff were invited to either participate during their break or to schedule an interview over the phone. All participants provided verbal informed consent.

The same two qualitative researchers (B.B.H. and N.R.) conducted one-time interviews, lasting 30 to 60 minutes. Five patient interviews required interpreters, four in Spanish and one in Tagalog (an Austronesian language spoken mostly in the Philippines). Interviews were audio-recorded and professionally transcribed, and all identifying information was removed from transcripts. We created field notes after each day of interviews to capture reflections. Data collection continued until thematic saturation was achieved (Strauss & Corbin, 1990).

Our analytic approach involved inductive thematic analysis, grounded in emerging participants' perspectives, rather than a predefined framework (Strauss & Corbin, 1990). An additional researcher with experience in dialysis and qualitative methods (N.S.) joined the coding team. Three researchers (B.B.H., N.R., and N.S.) independently coded transcripts from three patient and three staff interviews to develop separate codebooks for each group based on key interview domains and recurring ideas. To ensure consistency, the first six transcripts were double coded to assess intercoder agreement and refine the codebooks. The remaining 72 transcripts were coded independently using the finalized codebooks. All coding was conducted using ATLAS.ti version 24.1.1 (2024). While coding each transcript, each researcher created a memo to address reflexivity and coding discrepancies. Reflections and code discrepancies were discussed and resolved through consensus during weekly meetings.

After coding was completed, we identified themes through an iterative review of codes across transcripts, grouping codes into broader conceptual categories that captured key patterns in the data for both patients and staff. We presented preliminary findings to staff from participating study sites, including some former participants, to validate for accuracy and ensure alignment with participants' experiences. We also presented key findings to a community advisory board (CAB) of current and former dialysis patients to assess the resonance of the findings with other patients and refine our interpretations. CAB members were not study participants. We also solicited their feedback on the impact of the findings, and identifying research priorities and stakeholders to engage with regarding future solutions. This study was reported in accordance with the COREQ (Consolidated Criteria for Reporting Qualitative Research) checklist (Tong et al., 2007), which is provided in **Appendix A**.

RESULTS

We interviewed 78 participants, including 49 patients and 29 staff members. The mean age of patients interviewed was 65 years; 61% (*n* = 30) of patients identified as male. The mean age of staff interviewed was 42 years; 83% (*n* = 24) of participating staff identified as female. Thirty-seven patients and staff were treated or working in a rural geographic setting, 21 in a suburban setting, and 20 in an urban community. **Tables 1 and 2** include additional demographic data on participants, including self-reported race and ethnicity.

Participants viewed transportation as essential to accessing in-center HD but described challenges of navigating the interface of two systems, transportation and healthcare. Below, we explored patients' experiences with transportation service complexity and quality, highlighting the impact of transportation on participants' emotional well-being. Then, we discussed staff perspectives, focusing on how transportation affected clinic operations, extended staff's scope of work, and added emotional labor to their patient support activities. Finally, we reported how both groups explained the broader impact of these misaligned systems on treatment.

PATIENT PERSPECTIVES

People with end-stage kidney disease (ESKD) who were interviewed identified three key challenges with transportation to dialysis: *service complexity*, *poor service quality*, and *emotional distress*.

Service Complexity

Participants utilized a patchwork of services to get to and from dialysis treatment, including family-provided rides, paratransit, public transit, insurance-based NEMT, and other services. While patients frequently acknowledged the benefit of having access to transportation services, many expressed significant frustration with the complexity of navigating services. Key challenges included: service limitations (such as paratransit start times or operating days that do not align with dialysis schedules), long wait times, late pick-ups, short waiting periods, and the need to schedule rides in advance. One patient who relied on paratransit explained the impact of short waiting periods: "If I tell them an early time and I'm not ready when they're here, three minutes and they're gone. I'm left with no transportation" (Patient #20).

Patients also recounted the stress of communicating with various transportation providers, including companies contracted to provide insurance-based NEMT, public transit agencies/systems, and others. They described the difficulty of long phone wait times, lack of responses, and complex phone trees. When asked about communicating with their insurance-based transportation one patient said, "I want to get in contact with the actual transportation team, but they're untouchable. You can't get in contact with them at all" (Patient #40).

The majority (55%, *n* = 27) of patients interviewed relied on insurance-based NEMT as their primary mode of transportation to dialysis. For patients whose insurance companies contracted with third-party NEMT providers, this further fragmented communication and meant frequent changes in service. One patient explained, "It's a third party. To change something, you have to call up to New Jersey; New Jersey has to find out what state you're in and then mobilize. It's 15–20 minutes just to find out they're not going to do anything anyway" (Patient #1). Patients also reported issues when insurers contracted with ride-hailing companies (also known as Transportation Network Companies (TNCs, e.g., Uber or Lyft), with rural patients facing even greater challenges, due to limited availability. As one patient explained, "We are a small village. So, for them to come through here and to pick us up, you have a better chance of winning the lottery" (Patient #18).

Poor Service Quality

Patients also expressed concerns about transportation service quality, particularly regarding reliability, safety, and a need for driver training specific to supporting dialysis patients.

Many reported that, despite sharing their treatment schedule with the transportation provider, rides frequently arrived late or not at all. This lack of reliability was especially challenging for patients managing post-dialysis symptoms such as dizziness and fatigue, as well as other age-related and medical conditions beyond kidney disease, including vision impairment and mobility limitations. One patient explained: "They were picking me up late, or were not picking me up at all…. I was sitting out there for three hours waiting to get home…. I walked out and it was like a desert. Nobody was there and I was like, 'Well, what do I do?'" (Patient #14).

Drivers played a key role in patients' transportation experiences. Many reported difficulties stemming from poor relationships with drivers and a lack of driver training. Beyond late arrival times, additional concerns included unsafe driving behaviors and communication barriers. One patient who used insurance-based transportation shared, "One day, I was going home with [ride-hailing company], and I had a bleeder, these things gush when they come out. We were in the fast lane when the driver suddenly slammed on the brakes…. He wanted to leave me on the roadside to wait for the firemen.

I refused because I couldn’t let go of my arm…. I didn't want to be with that guy another minute. I thought he was trying to kill me" (Patient #12).

For visually impaired patients, trust in drivers was especially crucial. One patient explained, “That's why the trust comes with a big issue. If I feel like you're sturdy, and you know how to guide me, and you know how to talk to me, I feel comfortable. But if I know that they're just trying to get a paycheck, and you don't know what the heck you're doing, and you're not fit, and this and that, then no. Trust is not there at all” (Patient #18).

Emotional Distress

Many patients described the added emotional toll added to their lives from navigating unreliable transportation services. “I never used to have anxiety in the morning. ‘Are they coming? Are they not coming?’... I’m still trying to get ready, [and then] the phone call, ‘Oh, we're not going to be able to pick you up’…. It all creates anxiety” (Patient #1). For many patients the stress of transportation exacerbated the emotional burden of dialysis itself. As one patient explained, “This is really stressful, and it turns your life upside down” (Patient #34).

Despite the challenges posed by navigating two systems, transportation and healthcare, many patients were fearful of the negative health impacts of missed treatments and therefore expressed a strong commitment to attending treatment.

STAFF PERSPECTIVES

Beyond seeing the impact of transportation on their patients, dialysis clinic staff emphasized that transportation issues *affected clinic operations*, *required them to work beyond their scope of practice*, and *had an emotional impact*.

Operations and Workflow Impact

Staff conveyed how a misalignment between transportation services and dialysis care creates significant operational challenges. Staff shared how issues such as late arrivals, inflexible waiting periods, and lack of driver training—which patients experienced as poor quality—also disrupted clinic workflows, leading to shortened treatment times and requiring rescheduling appointments. One staff member explained, “It frustrates the floor staff because this patient is late; they're supposed to be here at this time. Now they're supposed to be putting someone else on and this patient shows up, so the staggering is off. That patient who is late, now we can't run them with their full treatment, if someone's coming right behind them, that's going to impact their Kt/V [a quality metric used to assess the adequacy of dialysis treatment and used as a quality measure] and their fluids and their blood pressures and whatnot. They may be misusing the emergency room because they’re fluid overloaded. Patients are stressed. We do have some time to keep them over. [But the patient says,] ‘I can't stay over. My ride's going to leave, then I'm going to be here for an hour and 45 minutes after.’ So it's the snowball effect” (Staff # 2).

Staff highlighted the lack of flexibility in many transportation services to account for the unpredictable nature of dialysis. As one staff member shared, “I've had them [paratransit] leave patients before, flat out leave, because they're tired of waiting. Well, things happen in dialysis; it's not, ‘Okay, your treatment ended, you can leave.’ If they bleed, if they got on late, if they have low blood pressure, you can't send them out to transportation that way…. Or sometimes they'll come back, but it might be a while. They could be sitting here for an hour waiting” (Staff #21).

Transportation delays at the end of the day were particularly challenging for staff, who must remain on-site until every patient is picked up. One staff member described this: “It was just me and my nurse, and we were waiting and waiting. We tried calling transportation, never picked up. Two hours later, here they come. It's frustrating for us as techs and nurses because we want to go home, too. It's not fair for us or the patient to wait upon the transportation to get here whenever they feel like it” (Staff #4).

Expanded Roles

Despite transportation having a significant impact on patients and staff, the coordination of transportation was not designated to one particular staff member with expertise or training in navigating the transportation system. All staff expressed a commitment to supporting patients and reported spending a significant amounts of time addressing transportation issues, often at the expense of other duties. One staff member described the impact of transportation coordination on staff: “Today we have six patients that were not picked up. And so when she [social worker] reaches out to the transport company, she's often on hold for 30, 45 minutes before even speaking to somebody... half of her day is spent with transportation or follow-up with transportation” (Staff #9).

Social workers reported how the additional workload necessary to coordinate transportation for patients limited time they can dedicate to their core responsibilities. As one social worker explained, “That impacts us by taking time away from other needs. We didn't get master's degrees to be transportation coordinators or insurance coordinators. We could be dealing with other things, like coping and counseling” (Staff #2).

Additionally, many staff members expressed concerns about working beyond their defined roles. For a bilingual staff member, additional responsibilities arose when assisting patients who face language barriers with transportation: “If it's a Spanish-speaking patient they're directed to me," shared a technician. "That's where I get stuck. Because I already have so much going on… to make those phone calls for them... which I don't mind, but at the same time am I allowed to do that? Because I don't want to go off my scope of practice and get in trouble" (Staff #4).

Emotional Impact

Staff shared how transportation challenges add emotional labor to their work. Hochschild (1983) coined the term "emotional labor" to characterize the added, and often invisible, emotional effort that is part of an individual's professional work, but that is rarely acknowledged as labor. Hochschild, highlighted this term in the context of labor conducted by women, and inspired a large sociological literature on the essential, and yet unrecognized, aspect of women's labor (Wharton, 2009). It is therefore particularly important to highlight that women made up the majority (83%, *n* = 24) of staff participating in our study. Staff expressed frustration at being the primary point of contact for patient concerns about transportation, despite transportation issues being outside their control or scope of practice. As one staff member explained: "It's just a domino effect. Very stressful for the staff because the patients are angry at them. We've had the transport service come out one-on-one with the patients and explain, 'Nope, it's not the center level. If you have a grievance or concern, please address it to us.' But still, we're the face that's in front of them" (Staff #9).

Staff also recounted the emotional strain of witnessing the direct effects of transportation challenges on patients. One staff member shared, "We had a patient here who couldn't get transportation. He finished treatment at 7:00 or 8:00 at night, and we all asked, 'Do you need a ride home? Can we call you a cab?' He said no—he walked home. But we all felt like, 'What else could we have done to help him?' The social worker had already left, so there was no one to contact his transportation. It tugs on your heartstrings" (Staff #15).

PATIENTS AND STAFF REFLECT ON THE IMPACT OF TRANSPORTATION ON DIALYSIS TREATMENT

Participants emphasized the serious consequences resulting from the misalignment between transportation and dialysis. They described how unreliable transportation led to delayed, missed, or shortened dialysis treatments, increasing risks of volume overload and emergency care. A staff member described how a patient frequently cut treatment short due to transportation anxiety, "He says, 'My driver's waiting. I got to go.' He gets anxious, so he cuts his time every single treatment, and that adds up. They're not getting the full dialysis that they need, and it could be dangerous for them" (Staff #21).

A patient described the impact of missing dialysis, recalling: "Sometimes I'll call them [transportation] in the middle of the night…. Two hours later, they'll show up. I'll be [volume] overloaded like crazy. I felt like I couldn't breathe all the time... Half the time, it's because they didn't show up to take me to dialysis....It is what it is. It's part of dialysis" (Patient #32).

Staff clarified that even small reductions in treatment time have serious long-term consequences: "Every minute counts in dialysis…. And if we have to cut 30 minutes, one hour, that's a lot. And they're only coming here for what, three days a week? Our kidney[s] works 24/7, normal kidneys. So, it's going to really impact over time" (Staff #1).

Staff also explained how unreliable transportation and missed appointments can impact transplant eligibility—the only path to ending dialysis treatment: "If you come in late or cut your time, at the end of the year, it's a lot of time lost. And it affects them for their transplant also. That's one of the requirements— they expect for you to be here every single treatment, get your four hours done…and keep going until your number's called" (Staff #4).

DISCUSSION

This study explores the impact of transportation on people with end-stage kidney disease (ESKD) and their care teams. Our findings suggest that a misalignment between healthcare and transportation systems affects both patient and staff emotional health, as well as clinic workflows and treatment outcomes in HD. Understanding these challenges and identifying solutions remains critical given the serious health consequences associated with missed dialysis (Balhara et al., 2020; Leggat et al., 1998; Obialo et al., 2012; Razon et al., 2025). As the first study to share both patient and staff perspectives on transportation in dialysis care, we hope these findings describing lived experiences will help identify the patient-, operational-, and systemic-level transportation challenges and bridge the gap between healthcare and transportation sectors to improve patient experiences. Two recent reviews on transportation and health have more generally highlighted significant gaps in the design and delivery of transportation interventions, as well as high quality research on these systems (Shekelle et al., 2022; Solomon et al., 2020). While prior research on transportation has primarily focused on access to vehicle-based solutions for medical appointments, our findings highlight additional opportunities to improve transportation experiences: 1) improved communication between transportation services, patients, and staff; 2) establishing transportation quality measures to motivate reliable and transparent services and require driver training; and 3) shifting service coordination away from patients (Berkowitz et al., 2022; Chaiyachati et al., 2018; Vais et al., 2020). Reflecting on the perspectives of staff and patients who view transportation as a core component of dialysis care, we advocate for better integration of transportation into healthcare, rather than treating it as an "added service." For example, the healthcare sector might better support coordination by scheduling patients from the same region at the same dialysis clinic, considering clinic locations relative to public transportation, and leveraging insurance-based funding to invest in transportation infrastructure. The transportation sector could contribute expertise in service coordination and support establishment of systems of accountability and transparency—especially for NEMT and paratransit services.

Recent policy initiatives, such as the Centers for Medicare & Medicaid Services (CMS) 2026 ESRD Proposed Rule, add uncertainty to whether social risk screening will be integrated into quality measures for dialysis clinics in the future (Department of Health and Human Services (HHS); Centers for Medicare & Medicaid Services (CMS), 2025). While screening is an important step for identifying social risks like transportation insecurity, more research is needed to determine the most effective interventions and to understand how reimbursement mechanisms such as community health worker and illness navigation can be harnessed (Tummalapalli et al., 2024). Screening and referrals are insufficient if the available services are difficult to navigate and/or of poor quality. We hope our study findings will contribute meaningfully to efforts to improve existing and develop new services.

A strength of this study is its grounding in the lived experiences of patients and staff, captured through in-depth qualitative interviews. However, these findings should be interpreted in the context of the study's limitations. Most participants primarily relied on Medicaid transportation services, though the majority of patients receiving in-center HD still rely on driving themselves or having a family member or friend drive them. Although we attempted to recruit a diverse sample by age, gender, race/ethnicity, and urbanicity, additional factors, such as employment, education, immigration status, and geographic region, influence transportation access. Future research should also include perspectives from transportation providers.

Conclusion

Transportation plays a key role in patient and staff experiences in dialysis clinics. Our findings highlight opportunities to strengthen transportation services in support of health, and underscore the importance of incorporating community perspectives into intervention design and research. Healthcare systems and transportation providers will need to develop meaningful, shared outcomes—e.g., healthcare utilization, quality of life, depressive symptoms, and transportation quality (such as timeliness and standardization of training and licensing)—to better assess and improve services. Coordinated solutions should be designed by multidisciplinary teams from the healthcare, transportation, and community sectors.

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APPENDICES

Appendix A. Consolidated Criteria for Reporting Qualitative Studies (COREQ) 32-Item Checklist (Tong et al., 2007)

No. Item	Guide questions/description	Reported on Page #
Domain 1: Research team and reflexivity		
Personal characteristics		
1. Interviewer/facilitator	Which author/s conducted the interview or focus group?	2
2. Credentials	What were the researcher's credentials? e.g., PhD, MD	2
3. Occupation	What was their occupation at the time of the study?	2
4. Gender	Was the researcher male or female?	2
5. Experience and training	What experience or training did the researcher have?	2
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	2
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g., personal goals, reasons for doing the research	2
8. Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	2
Domain 2: Study design		
Theoretical framework		
9. Methodological orientation and theory	What methodological orientation was stated to underpin the study? e.g., grounded theory, discourse analysis, ethnography, phenomenology, content analysis	2
Participant selection		
10. Sampling	How were participants selected? e.g., purposive, convenience, consecutive, snowball	2
11. Method of approach	How were participants approached? e.g., face-to-face, telephone, mail, email	2
12. Sample size	How many participants were in the study?	3
13. Non-participation	How many people refused to participate or dropped out? Reasons?	2
Setting		
14. Setting of data collection	Where was the data collected? e.g., home, clinic, workplace	2
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	2

16. Description of sample	What are the important characteristics of the sample? e.g., demographic data, date	3
Data collection		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	2
18. Repeat interviews	Were repeat interviews carried out? If yes, how many?	2
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	2
20. Field notes	Were field notes made during and/or after the interview or focus group?	2
21. Duration	What was the duration of the interviews or focus group?	2
22. Data saturation	Was data saturation discussed?	2
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	NA
Domain 3: Analysis and findings		
Data analysis		
24. Number of data coders	How many data coders coded the data?	2
25. Description of the coding tree	Did authors provide a description of the coding tree?	2
26. Derivation of themes	Were themes identified in advance or derived from the data?	2
27. Software	What software, if applicable, was used to manage the data?	2
28. Participant checking	Did participants provide feedback on the findings?	2
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g., participant number	3–5
30. Data and findings consistent	Was there consistency between the data presented and the findings?	5–6
31. Clarity of major themes	Were major themes clearly presented in the findings?	3–5
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	NA

AUTHOR NOTE

This work is dedicated to Francine Williams (1955 – 2025), a fierce advocate for people with kidney disease and an inspiring community advisor on this study.

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Table 1. Self-reported Demographic Characteristics of Patient Participants

Demographic Variables	**Total (%) (*N* = 49)**
Age (Mean)	65
< 40	4 (8%)
40–49	5 (10%)
50–59	6 (12%)
60–69	12 (24%)
70–79	8 (16%)
80+	11 (22%)
Not provided	3 (6%)
Gender	
Female	15 (31%)
Male	30 (61%)
Not provided	4 (8%)
Mode of Transportation	
Combination	4 (8%)
Donation-based county program	2 (4%)
Drives self	6 (12%)
Family drives	3 (6%)
Non-emergency medical transportation (NEMT)	27 (55%)
Paratransit	6 (12%)
Private pay transportation	1 (2%)

Race/Ethnicity[a]	
Asian	2 (4%)
Black orAfrican American	11 (22%)
Hispanic orLatino	9 (18%)
Multiracial	4 (8%)
Other	4 (8%)
Native Hawaiian or Pacific Islander	5 (10%)
Prefer not to answer	4 (8%)
White	10 (20%)
Geography	
Rural	23 (47%)
Suburban	12 (24%)
Urban	14 (29%)

[a] Race/ethnicity categories are understood as social constructs that reflect the multiple ways racism impacts particular populations (interpersonal, structural, cultural, and individual) and are included since transportation access has been shaped by racism.

Table 2. Self-reported Demographic Characteristics of Staff Participants

Demographic Variables	**Total (%) *N* = 29**
Age (Mean)	42
< 30	1 (3%)
30–39	8 (28%)
40–49	16 (55%)
50–59	3 (10%)
60+	1 (3%)
Gender	
Female	24 (83%)
Male	5 (17%)
Race/Ethnicity[a]	
Asian	9 (31%)
Black or African American	2 (7%)
Hispanic or Latino	6 (21%)
Other	2 (7%)

Native Hawaiian or Pacific Islander	1 (3%)
Prefer not to answer	2 (7%)
White	7 (24%)
Role	
Administrative	4 (14%)
Dietitian	5 (17%)
Nurse	4 (14%)
Social Worker	5 (17%)
Technician	11 (38%)
Geography	
Rural	14 (48%)
Suburban	9 (31%)
Urban	6 (21%)

[a] Race/ethnicity categories are understood as social constructs that reflect the multiple ways racism impacts particular populations (interpersonal, structural, cultural, and individual) and are included since transportation access has been shaped by racism.