

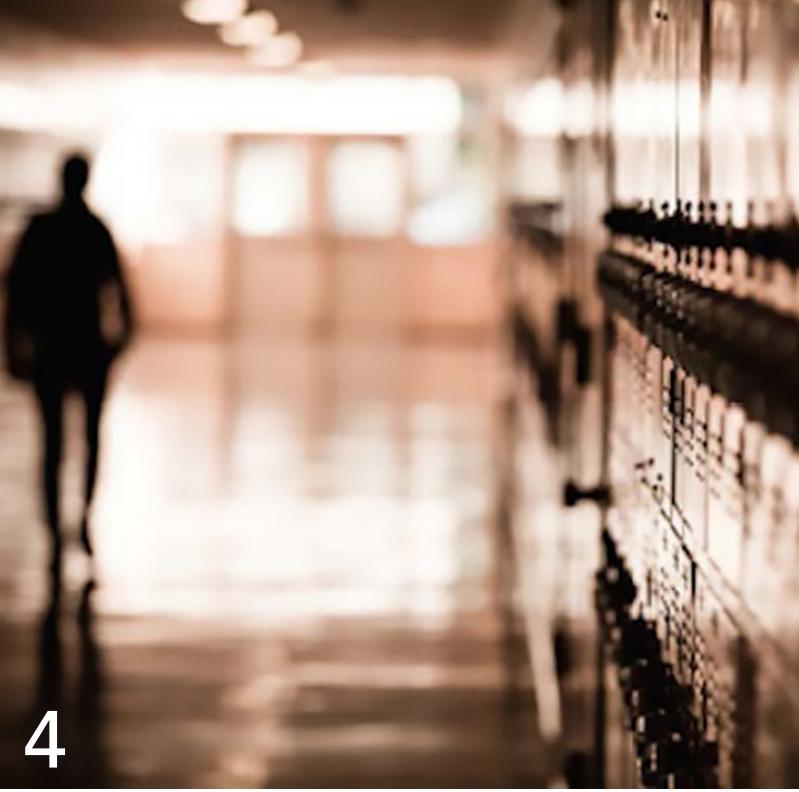


*Early Spring Edition*

# eNEWSLETTER



FIRST QUARTER 2017



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## NEED TRAINING?

Call our office to schedule training for your agency at 1.573.341.6155

National RTAP is a program of the Federal Transit Administration dedicated to creating rural transit solutions through technical assistance, partner collaboration and FREE training.



### CONTACT INFORMATION

#### MISSOURI RTAP

710 University Drive, Suite 121  
Rolla, MO 65409

Phone: 1.573.341.6155

Fax: 1.573.341.7245

Email: [mrtap@mst.edu](mailto:mrtap@mst.edu)

Web: [mrtap.com](http://mrtap.com)

### MISSOURI RTAP/LTAP STAFF

Heath Pickerill

Director

Kristi Barr

Program Coordinator - LTAP

Doreen Harkins

Administrative Assistant - LTAP

Program Specialist - RTAP

Shelby O'Keefe

Graphic Designer

John Rice

Contract Instructor

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Missouri University of Science and Technology

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# LETTER FROM THE MANAGER

## DEAR TRANSIT FRIENDS,

Welcome to another year of the Missouri RTAP eNewsletter. The first quarter of 2017 is quickly drawing to a close. If you have any training needs for 2017 that you have not yet scheduled, please contact Doreen soon. John Rice's calendar is already booked for much of the year. She will assist in finding available dates. You can also go on the MO RTAP website at [www.mortap.com](http://www.mortap.com) and see an up-to-date calendar with all of the trainings scheduled for the next several months. This is just one of the recent changes to the website. Doreen has been busy working with our student assistant, Miggy Santos-Tankia, on various updates. Miggy, a computer science major on campus, has been very helpful in assisting with managing a variety of technology related projects. All of the new travel request and reimbursement forms reflecting the changes made for 2017 have also been posted. Be sure to go online and check out the updates or find the new travel forms.

I also want to encourage you to plan any anticipated travel well in advance. Remember that we now require flying versus driving comparisons with rates secured at least 30 days in advance. The conference season will be upon us before we know it. Please submit travel requests as early as possible. Also mark your calendars for the 2017 Missouri Public Transit Agency conference scheduled for August 6 – 8 at the University Plaza Hotel in Springfield, Missouri. As in years past, we will be presenting program updates at the rural transit sessions for all 5311 recipients.

I will be attending the Creating Innovative Transportation Solutions workshop on April 5 and 6 at the Kansas City Airport Homewood Suites. This is training in applying design thinking strategies for healthcare-related transportation challenges. Participants are welcome from Iowa, Kansas, Missouri, and Nebraska. MoDOT shared the information with mobility providers throughout the state. It is also open to transit agencies. The deadline for registration was March 15; however, we have a couple of seats left for representatives from Missouri. If you have an interest in attending, please contact me. The course is being offered for free with FTA funding through the National Center for Mobility Management. The cost of travel and lodging can be reimbursed through the Missouri RTAP scholarship reimbursement.

I would like to attend transit meetings throughout the state on a regular basis to stay connected to all of the agencies we serve. If the agencies in your area are planning to meet later this spring or summer, I would be eager to attend and provide an update on the Missouri RTAP program. This would also allow me to answer in person any questions any of you may have on changes to the scholarship reimbursement. Remember that we always want to hear from you. Please feel free to contact me at [pickerillh@mst.edu](mailto:pickerillh@mst.edu) or by phone at 573-341-7637 with any questions, comments or suggestion you have. If you know someone who would like to start receiving the newsletter, they can call our office or go to the Missouri RTAP website at [www.mortap.com](http://www.mortap.com) and sign up.

Best wishes,



Heath Pickerill  
Missouri RTAP Manager



Heath Pickerill, Missouri RTAP Manager



Ripley County Transit on January 20, 2017 at the Child & Infant CPR Training.



# MOBILITY & BEHAVIORAL HEALTH CONDITIONS

*Trends Suggest New Ridership Wave Similar to Dialysis Transportation a Decade Ago*

*By Rich Sampson*

**IN 2002, THE MEDICAL TRANSPORTATION EDITION OF CTAAS printed predecessor to DigitalCT Magazine—Community Transportation Magazine published an article entitled “True Dialysis Stories.”** The piece – authored by CTAAs then Communications Director and now current Executive Director Scott Bogren, along with Jordan Nichols – profiled passengers utilizing community and transportation services to reach life sustaining dialysis treatment. Between then and now, the need for dialysis treatment has skyrocketed and is a major and ongoing source of work for non-emergency medical transportation (NEMT) providers across the country.

In 2015, we’ve reached a similar precipice for another new – and potentially substantial – stream of people who’ll depend on the services offered community and public transportation providers: those with behavioral and developmental health conditions. While these operators have certainly helped move people with behavioral health conditions throughout their inceptions, the responsibility of the education-based system that saw to the mobility needs of many of these people until they turned 21 now will be seeing alternative ways to reach where they live, work, access services and more. This trend is only becoming more pronounced as children diagnosed with conditions along the autism spectrum – which began growing in 1991 – start to age out of the education system. Due to the challenging nature of some of these conditions, safety for the affected rider, transit employees and fellow passengers becomes an increased concern.

## TRANSITION OF RESPONSIBILITY

For a long period of our nation’s history, people with behavioral health conditions were often shunned from society. They were sent away to state-run psychiatric hospitals and other institutions, considered by many to be out of sight, out of mind, to pardon the unfortunate pun. Some received exemplary care, while many experienced difficult and counter-productive treatment. At the peak of institutionalization in 1955, it is estimated that more than 560,000 people were confined in these facilities.

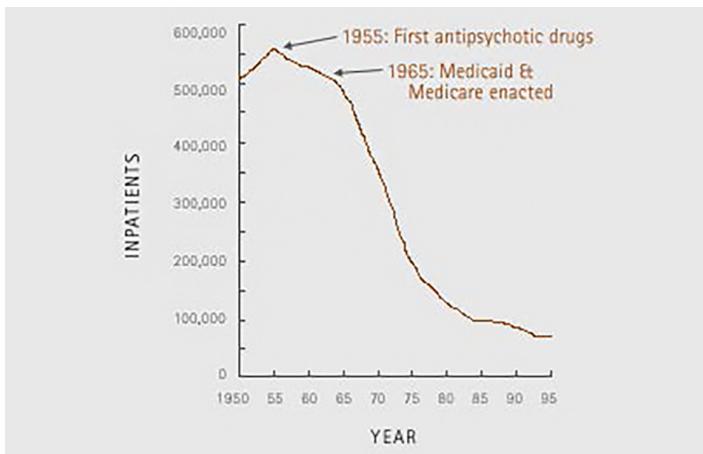
The twin, federal policy mechanisms of the Community Mental Health Act of 1963 and Medicaid in 1965 began a shift away from institutionalization towards community services, group homes and other programs. Unfortunately, public funding never matched the level of need to support these efforts, and the public education system – including Head Start programs – began assuming a greater share of the responsibility to care for children diagnosed with behavioral health issues. This framework was established via the federal Individuals with Disabilities Education Act (IDEA) of 1975.

The objective of an active role for the public education system in addressing many of the needs of children with behavioral health conditions is to provide an environment where these children have the same access to learning opportunities, socialization and other experiences as children without such conditions. Supplemental health programs, therapy, counseling and other assets are then deployed through this framework. Ideally, this structure provides greater prospects for employment, stable interpersonal relationships and transition to independent living in adulthood. IDEA and its subsequent modifications stipulate the public education system assumes this responsibility until children reach adulthood, defined in this case as age 21. Among the elements of this approach is inclusion of transportation services, often using school buses.

Upon reaching adulthood, other programs assist in the transition to independent living or provide more extensive support for people with more impactful behavioral health conditions. Many of these services depend on community and public transportation options to link people with housing locations, employment destinations and community programs.

## RESPONDING TO THE NEEDS OF ADULTS WITH AUTISM

Before we examine any potential safety impacts on the nation’s mobility network from behavioral health conditions, it’s important to understand the largest single condition generating the growth in such diagnoses: people



assessed as falling within the autism spectrum. The understanding of autism – that of a person who is, to some degree, withdrawn into their own self – is relatively new in relation to other physical or psychiatric conditions. It was first termed by psychiatrist Eugen Bleuler in 1908, and refined significantly by the work of Hans Asperger and Leo Kanner in the 1940s, the former of which is known best for the high-functioning set of patients with autism he studied. Attention and research into autism then intensified in the 1970s and '80s.

Beginning in the early 1990s, rates of autism diagnosis began to increase, as awareness of the condition began to increase among the medical community and the general public.

Between 1992 and 2002, the prevalence of autism among children doubled from 7.5 per 1,000 children to more than 14 per 1,000. In 2013, the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) codified these trends with diagnostic criteria for autism spectrum disorder (ASD) and the related diagnosis of social communication disorder (SCD). While the reasons for the growth in autism diagnoses remains a subject of much debate among those who observe the community, the fact remains is there are many more people today diagnosed along the autism spectrum than ever before. Inasmuch growth has occurred in autism incidences, there are just as many ways the condition impacts those identified as people with autism. The care needs for people with autism – physical, psychological, emotional, academic, vocational and much more – range from minimal to intensive. As we are fond of reminding policymakers within the community and public transportation industry, one size rarely fits all. The same is true for programs, treatment, expectations and trends in relation to autism. At the same time, since the condition is relatively new, theories, concepts and services are under a constant state of revision, improvement and criticism.

Autism spectrum conditions are by no means the only behavioral health issues that transportation providers – and especially drivers – encounter. While many persons who receive transportation services due to behavior health eligibility are ambulatory and have a hidden disability, the

front line staff – drivers – need to be informed of any need for special consideration. Training programs are crucial to help drivers learn about the characteristics of hidden disabilities and know how to recognize passengers' needs. The special needs will include persons with dementia – such as Alzheimer's – post-stroke recovery and other traumatic brain injury conditions, as well as drug addiction and learning disabilities. Each of these categories of passenger requires different levels of attention and treatment. The challenge for mobility providers of all kinds is to become and stay cognizant of the changing needs of their passengers.

## PROVIDING SAFE SERVICE WHILE SERVING RIDERS WITH BEHAVIORAL HEALTH CONDITIONS

Delivering a travel experience that is safe to all riders is paramount to every mobility provider. Riders would quickly disappear if they felt insecure in their safety while traveling on any kind of vehicle. Meanwhile, no behavioral or psychological condition predisposes people to act violently as an inherent and unavoidable effect of their clinical diagnosis. As medical doctors Marie E. Rueve and Randon S. Welton wrote in the May 2008 edition of Psychiatry Magazine, "most patients with stable mental illness do not present an increased risk of violence." The overwhelming majority of people with these conditions are able to interact with people and their surroundings on a regular basis, much like anyone else.

Nonetheless, as the number of riders with behavioral health conditions is expected to increase in coming years, now is the time to begin a discussion of the kind of impacts these conditions will present for those who depend on community and public transportation services will have on themselves, transit workers and their fellow riders.

*"It's important that we talk about the challenges and impacts of the situation or behaviors, and not the people affected by them," says Eileen Collins Mastel, Director of Quality Assurance for Ride Connection in Portland, Oregon. "These conditions offer our industry opportunities to be inclusive. There's a range of situations – from fellow riders with loud music, or people talking loudly on cell phone – that can have impacts on riders experiencing behavioral health conditions. If we plan for the safety and security of all operators and riders, we will account for the needs of riders with behavioral health, mental health, and physical challenges."*

By definition, traveling on a community or public transportation vehicle implies that sharing a trip with other people is a likelihood or possibility. Some people – whether they live with behavioral health issues or not – react differently to sharing spaces with others. These

reactions could range from slight annoyance to significant agitation, with variables including stimuli, emotional state and condition presenting myriad potential situations. Conversely, some behavioral health conditions cause people to thrive when they are exposed to more people, with communal activities preventing isolation.

Another aspect inseparable from the reality of transit service that has the potential to affect people with behavioral health issues is the need for some level of scheduling or time keeping in order for service to function. This is true for demand-responsive and ride-sharing options as much as it is for tightly scheduled fixed-route bus and rail lines. The stress of adhering to a timetable or trip reservation, or the unease of reacting to a late-arriving bus or van can introduce discomfort to some people with behavioral health conditions that could escalate a routine situation to one where effects of that condition become apparent. At the same time, others with certain behavioral health conditions find comfort in the predictability and nuances of transit networks.

### REFRESHING THE CUSTOMER SERVICE & TRAINING MINDSET

With so much gray area and potential scenarios to consider as more people with behavioral health conditions are expected to board our vans, buses, sedans and trains in coming years, how can the community and public transportation industry be best prepared to serve the needs of all riders?

The answers are concepts fundamentally ingrained in how the best mobility providers meet the needs of all their passengers: creating and maintaining an employee training culture that prioritizes customer service in all its applications.

By preparing all its workers and representatives – from general managers and board members to drivers and dispatchers – to interact with and respond to people with behavioral health issues, the first and most crucial element in ensuring the safety and comfort of all riders has a firm foundation.

*"In our operation, we spend a lot of time training the professional staff of treatment centers on how to use our system so they can train their clients on how best to use the system," says John McBeth, President & CEO of the Brazos Transit District in Bryan/College Station, Texas. "My bottom line is that we want to keep the riding experience as close to a normal bus ride as possible, so the affected riders learn how to use public transit and that no matter where they go, they will have access."*

"We seek to ensure all riders have the same type of access and experience on our services," says McBeth.

Admittedly, attending to the needs and possibilities of transporting people with behavioral health conditions is likely to be a new aspect to training programs at many organizations and agencies. Attending to these customers – and their interactions with other riders and employees – requires new sets of procedures, practices and habits. The Community Transportation Association of America (CTAA) is beginning outreach to the communities most familiar with these issues: groups representing those with behavioral health conditions, medical and psychiatric practitioners, public educators and others. The ideas and feedback shared by these experts and advocates will be shared within and beyond our industry to better inform transit-training programs and customer service to best serve people with behavioral health issues.

In the meantime, CTAA's Passenger Service and Safety (PASS) driver certification program – available as both in-person training and online – emphasizes engaged, responsive assistance to all passengers. PASS emphasizes essential customer service components such as communication, stress management, individual awareness and hidden disabilities that provide strategies and mechanisms likely to help assist many passengers with behavioral health conditions.

### AN ONGOING RESPONSE

Community and public transportation networks have always been intended to move people who need mobility options the most. Whether that is reaching health care, employment, social programs or any other destination, these systems exist to help people carry out their lives, however they best see fit. Although there's likely to be more people with behavioral health conditions accessing these services in the years ahead, the responsibility to attend to their needs is exactly the same.

"There has to be a community transportation response with person-centered selections, things that mobility managers already know about and are doing," says William McDonald, who spent his career serving passengers with a ride range of needs at Medical Motors Service in Rochester, N.Y.

Like the need for dialysis transportation that emerged as a trend for our industry more than a decade ago, providing mobility for those with behavioral health issues requires the very best in service. CTAA will support community and public transportation providers in this important work, through the sharing of ideas and best practices, engagement with passengers and advocates and informing policy-makers and elected officials about the realities of these crucial connections.



# DISTRACTED DRIVING CAN CAUSE “INATTENTION BLINDNESS”

By Anne Lowder

**IMAGINE** an experienced pilot attempting to land an airplane on a busy runway. He pays close attention to his display console and carefully watches the airspeed indicator on his windshield to make sure he does not stall; yet he does not see that another airplane is blocking his runway!

You'd think an attentive pilot would notice the airplane. However, in a study by Haines (1991), a few experienced pilots training with in-flight simulators proceeded with their landing when a clearly visible airplane was blocking the runway and it was too late to avoid a collision. Makes you glad for air traffic controllers!

This is an example of what psychologists call “inattention blindness” or IB for short. (Mack & Rock, 1998). IB is the failure to see a highly visible object in your direct line of sight when your attention is elsewhere. IB may account for many vehicle crashes. Here's another example of IB, this time with real-life consequences involving a transit vehicle. In 2012 a DART van slammed into the back of a sedan, leading to a five-vehicle wreck on the Dallas North Tollway. Investigators are still looking into the crash, but a preliminary report from DART reveals the van's driver, a paratransit operator for 11 years, failed to control his speed and wasn't paying attention.

This is why it is a bad idea to talk on a cell phone (or listen to your passengers talk on their cell phones), text, or even thinking about your grocery list while driving. Most people assume the human eye functions like a camera and you see whatever is in front of you by merely opening your eyes and looking. Perhaps this is why events like the van and the airplane crash scenarios seem so astonishing. However, minor instances of IB occur every day, such as when you pass by a friend without seeing her, or can't find your car keys when they are right in front of you.

## THE PROBLEM

**United States.** In 2011, 3,331 people were killed in crashes involving a distracted driver, up from 3,267 in 2010. In addition, 387,000 people were injured in motor vehicle crashes involving a distracted driver, down from 416,000 injured in 2010. Eighteen percent of injury crashes in 2010 were reported as distraction affected crashes. (NHTSA, 2012).

## WHAT'S GOING ON?

What “other” things do you do while driving? Text? Adjust your radio? Talk with passengers? Talk with the dispatcher? Use GPS technology? These distractions can lead to inattention blindness. Any

mental task, such as just thinking about what to make for dinner, can also reduce available attention.

Our inability to multi-task was illustrated by a study in which observers watched a video of a group of people in white and black shirts passing basketballs to each other. The observers were instructed to count how many times the white team passed the ball. After 30 seconds of observation and while the balls are still in play, a gorilla walks across the screen for approximately four seconds. The results indicated that only 21 percent of the observers actually noticed the gorilla, or in other words 75 percent of the observers had inattention blindness. (Daniel Simmons, Trends in Cognitive Sciences). Most of the observers' attention was devoted to one task, and they did not see what was right in front of them.

Multitasking is valued in today's culture, and our desire for increased productivity makes it tempting to do other tasks (such as your passenger list or agency paperwork) besides driving while behind the wheel. However, multitasking is a myth. Human brains do not perform two tasks at the same time. Instead, the brain handles tasks sequentially, switching between one task and another. Brains can juggle tasks very rapidly, which leads us to believe we are doing two tasks at the same time. In reality, the brain is switching attention between tasks, performing only one task at a time.

Multitasking can bring risks when unexpected driving hazards arise. Under most driving conditions, drivers are performing well-practiced, automatic driving tasks. For example, without thinking about it much, drivers slow down when they see yellow or red lights, and activate turn signals when intending to make a turn or lane change. These are automatic tasks for experienced drivers. Staying within a lane, noting the speed limit and navigation signs, and checking rear- and side-view mirrors also are automatic tasks for most experienced drivers. During the vast majority of road trips, nothing bad happens. But that also can lead a driver to feel a false sense of security when driving.

A driver's response to a sudden hazard, such as another driver's errant behavior, a disruptive passenger, or animals or objects in the roadway, is often the critical factor between a crash and a near crash. When a driver is multitasking, the ability to process the information slows, and he or she is much less likely to respond to an unexpected hazard in time to avoid a crash.

## WE KNOW IT'S DANGEROUS, BUT WE DO IT ANYWAY!

Why do we do things that distract us while we are driving? One reason is that we do not think our own behavior (cell phone use, texting or checking the manifest) poses a safety risk. AAA surveyed drivers and found that 83 percent of the respondents thought using cell phones is a "serious" or "extremely serious" problem, but over half of the respondents did not believe that their cell phone use was a problem.

The other reason is the "pleasure center" theory of researchers James Olds and Peter Milner in 1954. More recently, in 2010, neurologist Michael Seyffert showed that multitasking (texting and cell phone use) stimulates the "pleasure center" in our brains by releasing the chemical dopamine. Dopamine delivers a sense of pleasure to an individual so that he or she is motivated to repeat the behavior.

## SO WHAT CAN BE DONE?

The first thing you can do is get into the habit of putting your phone on silent while driving. Second, download a mobile app that will send an automatic reply to someone calling you, such as: "I can't respond. I am driving." AT&T DriveMode is one example of a free app available to Android and Blackberry users. This app automatically sends a customized reply to incoming texts. It also disables all incoming and outgoing calls and Web browsing. Users manually enable the app before driving.

DriveSafe.ly is another app available for \$3.99 per month. Instead of shutting down communications entirely, this app reads text messages and emails out loud in real time, including shortcuts like LOL, and sends an auto response. You can even choose whether to have texts read to you with a male or female voice, based on the gender of the text sender. However, be cautious about using this type of app, because it can be a distraction in itself.

There are also apps that detect motion such as "The Drive First" app from Sprint that sends calls to voicemail and silences email and text alerts when a vehicle reaches 10 mph.

Finally, enforcement of laws and education about the dangers of distracted driving need to be ongoing to change behaviors. It is well known fact that when it comes to things like impaired driving, speeding, and not using safety belts, even when people are aware of the risks, they may not readily change behaviors to reduce the risks.

## SUMMARY

Most drivers are not aware that their minds cannot really multitask. At any given time, a person's working memory is limited in the amount of information it can hold and the number of operations it can perform. The risky behaviors of pushing that capacity to its limit by texting, talking on a cell phone, eating, —or doing anything but driving while driving —need to stop. Understanding what's happening on the road only 35 percent of the time is not what anyone can call responsible driving.

Reprinted from the July 2013 issue of the Kansas TransReporter, a publication of the Kansas Rural Transit Assistance Program (RTAP) at the Kansas University Transportation Center.



# GET THE FACTS: DISTRACTED DRIVING

**DISTRACTED DRIVING** is any activity that could divert a person's attention away from the primary task of driving. The three types of distractions are manual (taking your hands off the wheel), visual (taking your eyes off the road), and cognitive (taking your mind off driving). All distractions endanger driver, passenger, and bystander safety.

Examples of distractions include:

- Texting
- Using a cell phone or smart phone
- Eating and drinking
- Talking to passengers
- Grooming
- Reading, including maps
- Using a navigation system
- Watching a video
- Adjusting a radio, CD player, or MP3 player

Make sure you are also aware of your company's policies regarding communication devices.

*\*\*Information taken directly from National Highway Traffic Safety Administration and US DOT's Distraction.gov website.*

## GET THE FACTS

- In 2010, 3,092 people were killed in crashes involving a distracted driver, and an estimated additional 416,000 were injured in motor vehicle crashes involving a distracted driver.
- Text messaging creates a crash risk 23 times worse than driving while not distracted. (Virginia Tech Transportation Institute)
- Driving while using a cell phone reduces the amount of brain activity associated with driving by 37% (Carnegie Mellon)
- Headset cell phone use is not substantially safer than hand-held use. (Virginia Tech Transportation Institute)
- Sending or receiving a text takes a driver's eyes from the road for an average of 4.6 seconds, the equivalent- at 55mph- of driving the length of an entire football field, blind. (Virginia Tech Transportation Institute)

Use the following tips to combat distraction while you're on the road.

## PHYSICAL FATIGUE

Maintain a lifestyle that includes a healthy diet and sufficient rest to ensure you report to work well-rested and alert each day.

Hold the steering wheel firmly with both hands. Each hand should be on opposite sides of the steering wheel at the positions of 3 o'clock and 9 o'clock or 4 o'clock and 8 o'clock on the face of a clock. This allows you to smoothly steer left by pulling the wheel with the left hand and pushing it with the right hand and vice versa. You should never hook your thumbs under the wheel.

## MENTAL/EMOTIONAL DISTRACTIONS

When you arrive to work, make sure you are 100% engaged in the tasks at hand. When you experience personal problems or stress, ensure that you leave those problems on the curb each time you enter your bus. When you report to work cool, calm and in control you are able to provide safe and efficient service to your passengers.

You should also work to maintain good passenger relations so that emotions do not interfere with safe driving.

## QUIZ: WORKING TO BE DISTRACTION FREE

Please answer the following questions:

1. Which of the following are recommended positions for the placement of your hands on the steering wheel? (circle all that are correct)
  - (a) 3 o'clock and 9 o'clock
  - (b) 3 o'clock and 7 o'clock
  - (c) 2 o'clock and 6 o'clock
  - (d) 4 o'clock and 8 o'clock
2. When you are experiencing personal problems or stress, your time driving the bus is a good, quiet opportunity to think these issues through.  
True or False (circle one)
3. Maintaining a healthy lifestyle will ensure that you are well-rested and alert when you report to work each day.  
True or False (circle one)

# AVAILABLE TRAINING PROGRAMS

The following is a list of the training programs and a course description of each that are currently available to rural transit providers through Missouri RTAP. Requests for training can be made by contacting Doreen Harkins, MO-RTAP Program Specialist, at [harkinsd@mst.edu](mailto:harkinsd@mst.edu) or 573-341-6155.

1. AGGRESSIVE DRIVING —1 hour.
2. BACKING SAFETY — 1/2 hour.
3. BASIC FIRST AID — 1 hour.
4. BLOOD BORNE PATHOGENS — 1 hour.
5. CPR & BASIC FIRST AID — 4 hours.
6. DEFENSIVE DRIVING — 3 hours.
7. DISTRACTED DRIVING — 1 hour.
8. DIVERSITY & AWARENESS TRAINING - PROVIDING QUALITY CUSTOMER SERVICE FOR TRANSPORTATION PASSENGERS WHO HAVE DISABILITIES — 2 hours.
9. DRIVEN TO EXTREMES — 1 hour.
10. DRUG ABUSE AWARENESS IN RURAL TRANSIT — 1 HOUR.
11. EMERGENCY PROCEDURES — 1 hour.
12. ENTRY LEVEL CDL DRIVER TRAINING
13. FATIGUE AWARENESS FOR DRIVERS — 2 hours.
14. HIPAA — 1 hour.
15. OPERATION LIFESAVER – HIGHWAY-RAIL CROSSING SAFETY — 1 hour.
16. PASSENGER ASSISTANCE/MOBILITY AID SECUREMENT — 2 hours.

For more information on classes and to register please visit: [mltrc.mst.edu/mortaphome/mortaptraining/](http://mltrc.mst.edu/mortaphome/mortaptraining/)



17. REASONABLE SUSPICION TRAINING FOR SUPERVISORS — 2 hours.
18. REVERSING THE TREND – BACKING SAFETY — 1/2 hour.
19. SAFE & SECURE PROPER INFANT AND CHILD SEAT INSTALLATION — 2 hours.
20. SENSITIVITY AWARENESS — 1 hour.
21. WHEELCHAIR SECUREMENT — 2 to 3 hours depending on number of participants.
22. WINTER DRIVING SAFETY — 1 HOUR.

## RESOURCES

**National RTAP – Rural Transit Assistance Program**  
[www.nationalrtap.org/](http://www.nationalrtap.org/)

**Transportation Safety Institute –  
Transit Safety & Security Training Division**  
[www.tsi.dot.gov/Transit.aspx](http://www.tsi.dot.gov/Transit.aspx)

**Federal Transit Administration –  
Rural Transit Assistance Program Page**  
[www.fta.dot.gov/funding/grants/  
grants\\_financing\\_3554.html](http://www.fta.dot.gov/funding/grants/grants_financing_3554.html)

**National Transit Institute**  
[www.ntionline.com/](http://www.ntionline.com/)

**Kansas RTAP – Kansas University  
Transportation Center**  
[www.kutc.ku.edu/cgiwrap/kutc/rtap/  
index.php/index.html](http://www.kutc.ku.edu/cgiwrap/kutc/rtap/index.php/index.html)

**Transportation Research Board's (TRB) Transit  
Cooperative Research Program (TCRP)**  
[www.tcrronline.org/](http://www.tcrronline.org/)

