ICAM FINAL REPORT

Submitted to

Mr. Steve Yaffe, FTA Consultant

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For the Reporting Period:

January 1, 2022 to November 30, 2022

Submitted By:

The C. W. Williams Community Health Center, Inc.
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This report summarizes activities of The C.W. Williams Community Health Center, Inc. (CWWCHC) pertaining to the Innovative Coordinated Access and Mobility Program (ICAM) grant from the Federal Transit Administration (FTA). Located in Charlotte, NC, CWWCHC is a is a private 501(c)(3), nonprofit, Federally Qualified Health Center (FQHC), Patient-Centered Medical Home (PCMH) and healthcare safety net founded in 1981. Through the $112,000 ICAM grant, two (2) cutaway vehicles were procured to increase access to high quality healthcare in Mecklenburg County and surrounding communities for underserved individuals attending appointments at CWWCHC and other health and human services (HHS) organizations.

CWWCHC greatly appreciates assistance and support provided by the National Aging and Disability Transportation Center (NADTC), which provided advice and oversight on behalf of the Federal Transit Administration (FTA), Mr. Steve Yaffe, Easterseals contractor for NADTC, as well as Mr. Arlanda Rouse of the City of Charlotte's Charlotte Area Transit System (CATS). CATS assisted CWWCHC in developing and adopting necessary policies and procedures and acted as CWWCHC's fiscal agent to access ICAM funds and upload reports in the TrAMS system.

A. ACTIVITIES DURING THE REPORTING PERIOD

Key activities completed during the grant period include:

Task #1: Established and roles and responsibilities for all project team members.

Task #2: Established policies and procedures for non-emergency transportation services.

Task #3: Established protocols regarding scheduling staff to arrange transportation for patients and non-patients who request transportation services.

Task #4: Notified patients and staff regarding the availability of expanded non-emergency transportation services, including wheelchair access.

Task #5: Provided transportation services to CWWCHC patients, as well as for patients who needed transportation to specialty providers, to pick-up medications at a non-CWWCHC pharmacy, or to attend HHS appointments outside of CWWCHC to address social determinants of health.

Task #6: Integrated adherence to medication and treatment plans into the data tracking system.

Task #7: Tracked and logged routine vehicle maintenance, mileage, and daily safety inspections.

Task #8: Monitored ridership and unique patients serviced; entered data into the tracking system.

Task #9: Established agreements with program partners through Memoranda of Agreement (MOAs).

Task #10: Recruited, hired, and trained 2.0 FTE transportation drivers.

Task #11: CWWCHC’s Continuous Quality Improvement Committee reviewed and approved project policies and procedures and reporting forms.

Task #12: Program coordinators received training as recommended by the NCDHHS Division of Medical Assistance for the provision of Non-Emergency Medical Transportation (NEMT) Booklet for Providers & NEMT Toolkit.

Task #13: Established a coordinated transportation scheduling system with CWWCHC's Outreach Team, Front Desk schedulers, and providers (Medical, Dental, Behavioral Health, Pharmacy, et. al.).

Task #14: Developed and distributed informational flyers; provided patient notifications via CWWCHC's Patient Portal, website, and social media.

Task #15: Refined patient and mileage tracking mechanisms to ensure accurate reporting.

Task #16: Posted Title VI signage in vehicles.

B. GOALS AND OBJECTIVES COMPLETED

The table below provides an overview of results for program goals and objectives.

Indicator	Target	Final
a. Number of Underserved Individuals Receiving Non-Emergency Transportation Services	360	720
b. Percent of Program Participants Keeping Appointments with Primary Care Provider 80% of the Time	75%	78%
c. Percent of Program Participants Reporting Improved Adherence to Medication and Treatment Plans	75%	76%
d. Percent of Program Participants Reporting CWWCHC as their medical home	75%	82%
e. Improved Health Outcomes	75%	93%

C. ADMINISTRATIVE TASKS

1) Tracked program data, including ridership, mileage[1], maintenance, and data to complete items "a" through "e" above.
2) Recruited and hired two additional transportation coordinators (drivers).
3) Advertised the expanded services and began transporting Medication-Assisted Treatment (MAT[2]) patients for services.
4) Continuous Quality Improvement (CQI) Committee reviewed and approved new transportation logs, vehicle maintenance form, and patient scheduling form.

[1] Note: Average of approximately 2,000 miles per month.
[2] Medication Assisted Treatment (MAT) is used to assist patients with substance use disorders, specifically opioid use disorders.

D. PROGRAM CHALLENGES

1) No show/no call cancellations: No shows/No call cancellations happen occasionally when a pickup is scheduled and the person being picked up does not answer the door or call ahead of schedule to cancel the trip. CWWCHC addressed this challenge to the extent possible by having staff call in advance to confirm the scheduled pick-up. CWWCHC staff also continued to remind passengers to notify CWWCHC in advance when possible if they need to cancel or reschedule a pick-up.

2) Price of Gas: As the entire country is experiencing high gasoline prices, CWWCHC has had to ensure that its Transportation Coordinators follow best practices with regards to transportation scheduling and routing.

E. DESCRIBE/EXPLAIN ANY ENVIRONMENTAL CHANGES TO THE PROJECT (VEHICLE MAINTENANCE, TECHNOLOGICAL OR FACILITY UPDATES, ETC.)

During the reporting period, CWWCHC's Transportation Staff performed routine vehicle checks and inspections to ensure that the vehicles had proper tire air pressure, sufficient gas to make the scheduled trips, that the lifts and seat belts were functioning properly, and that no damage had been done to the vehicles. CWWCHC also maintained full insurance coverage during the reporting period.

F. COORDINATION EFFORTS WITH OTHER ORGANIZATIONS

CWWCHC's Case Managers and Behavioral Health staff worked closely with other organizations to schedule and coordinate transportation services for underserved patients, including seniors and the disabled. These organizations include Inlivian (formerly the Charlotte Housing Authority), Pinnacle Point, Daymark, Dove's Nest, McLeod Addictive Disease Center, Safe Alliance, Mecklenburg County Department of Social Services, Loaves and Fishes, Crisis Assistance Ministries, Monarch, CMC Mercy Horizons, Camino Community Center, Charlotte Treatment Center, A Safe Place Community Housing, the Mecklenburg County Transportation program, Charlotte Rescue Mission, as well as various other HHS agencies and assisted living facilities.

G. PROJECT SUSTAINABILITY PLAN

Following is a description of the CWWCHC's project sustainability plan:

Task #1: Continue to notify patients of non-emergency transportation services with wheelchair access.

Task #2: Continue marketing and advertising activities for CWWCHC's non-emergency transportation services, especially to facilities serving disadvantaged, low-income, senior, and disabled individuals.

Task #3: Continue to track trips that include additional stops or drop-offs for appointments at other healthcare providers and pharmacies for prescription pick-ups for the purposes of route coordination.

Task #4: Continue to brainstorm and implement strategies to increase ridership to 80+ trips per month, on average.

Task #5: Continue to collect and report program data.

Task #6: Solicit input from staff and riders regarding program improvement ideas.

Task #7: Continue to share program data/information with CWWCHC's Quality Improvement Committee.

H. REVIEW OF PROGRESS MADE TO ADDRESS CHALLENGES

To increase ridership for disadvantaged seniors, disabled, and any other underserved individuals, CWWCHC plans to continue to market/advertise the program via its patient portal, flyer distribution, word of mouth, as well as through its case managers and referral coordinator. CWWCHC also will: utilize novel scheduling technology and route planning applications; continue to coordinate passenger transportation schedules with program partners; utilize evaluation instruments to track progress on performance measure and patient satisfaction; and implement the Plan, Do, Study, Act (PDSA) methodology for program improvements.

NOTES

1) The two vehicles were delivered in January 2022. There was no project data to report prior to that time.

2) Plan-Do-Study-Act is a user-friendly method to test a change that is implemented in the program. The process breaks down tasks into steps and allows project staff to evaluate outcomes and make improvements, if necessary.

See photos on next page.


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