Final Progress Report - Foundation Directed

Program Information and Status

Instructions

Thank you for complying with the reporting requirements under your grant contract. The Foundation recommends that you save information regularly when filling out this report. To prevent data loss, you may wish to type responses into a word processing format first, copy them to the online report, and then save the word processing file. Some fields can expand to accommodate the information typed by the applicant. To expand these fields, click and drag the shaded triangle in the lower right corner of each field.

This report is due no later than: Friday, July 20, 2018 at 12 p.m. (noon).

Program Information

Organization Name
Olde Towne Medical & Dental Center

Program Title
Chronic Care Collaborative

Grant Amount
250000.0000

Grant Number
2017023

Project Start Date
7/1/2017

Project End Date
6/30/2018

Program Status

Describe the program goals for the grant period.
(Response from Grant Application).
1. The plan is to continue to exceed current Medicare benchmarks for standards of diabetes care. To accomplish this, each provider will continue to facilitate group medical visits and monitor patient compliance with the assistance of our CDE. Additionally, we have completed an analysis of 712 diabetic patients at Olde Towne, in an attempt to identify risk factors for poor diabetic control. We were pleased to note that 30.2% of our diabetic patients participated in educational group classes with our diabetic educator and provider staff, as compared to the medical literature rate of 3-18%. Data were analyzed utilizing descriptive, bivariate inferential statistics. Significant findings are associated with age, number of comorbidities, polypharmacy* ($p<0.05$) and marital status* ($p<0.10$). Among those with uncontrolled diabetes, the majority are over age 50 (58.9%), single (62.5%), have ≥4 comorbidities (50.7%) and take ≥5 prescription medications (88.7%). Further studies are needed to determine barriers and facilitators to diabetes control among group and non-group participants. Going forward, identifying patients with these risk factors for poor disease control will allow the clinic to manage them more intensively.
2. We continue our group medical visits for hypertensive patients. Our participation in the Heart of Virginia Healthcare program facilitates data extraction and monitoring of clinical indicators and decrease the potential risk of heart attack and stroke in this population. We are developing computer fields to allow our providers better documentation of care. We are also participating in the CHC Leadership program which focuses on improving the efficiency of care, and strengthening the team approach.
3. We will continue to offer spirometry to all of our asthma, COPD and smoking patients as a baseline screening of lung function. Knowing their status will assist our providers in choosing appropriate treatment plans and making proper referrals to our volunteer pulmonologist who sees patients at his private office without charge.
4. We will continue to offer in house exercise options for our obese, chronically ill patients who are unable to utilize other gym facilities. We also plan to encourage increased participation in our Spring/Summer walking program as it was well received last year. Additionally, we will refer eligible patients to the YMCA's Diabetes Prevention Program.
5. We will continue to offer group medical visits and education classes in Spanish. Having Spanish translators available on a daily basis, utilizing certified medical translators contracted from CDR, will allow us to expand this program this year by adding a Spanish cooking class and grocery tour. At this year's Virginia Rural Health Association meeting, Olde Towne was the only facility complying with federal requirements to have certified medical translators.
6. We continue to use our retinal camera to improve the percentage of patients screened for diabetic retinopathy. This year one of our goals is to pursue retinal photography certification for at least one staff member. This will help ensure accuracy of retinal photos and decrease the potential for missed diagnoses of diabetic retinopathy. We did 272 retinal screenings in 2016.
7. Free oral health screenings continue to be offered to all diabetic patients. Of the first 71 diabetic patients referred for free screening oral health examinations, 25 cancelled, 9 no showed and 37 were seen. Of those 37 seen, 33 were found to need additional dental care. This year, the goal is to streamline this in house referral process, and ensure that dental screening is included as a component of routine diabetic management. We are increasing our paid dentist hours to provide more appointments. We will also begin to track patients who refuse dental services and investigate their reasons for not accepting dental services from OTMDC.
8. Open access scheduling, which allows us to accommodate walk-in patients, will continue to be offered on a daily basis. We now have ~50% of our patients using open scheduling, and Sentara Williamsburg Regional Medical Center has informed us that since the advent of our open scheduling program they have seen a significant decrease in the use of their ER by uninsured patients.
9. Collaboration with Hampton University School of Pharmacy will continue. Pharm D students will counsel patients, provide medication therapy management, perform medication reconciliation and review provider charts. The counselling sessions typically last one hour, and patient acceptance has been excellent.From January 2016 to January 2017, 42 adult patients with chronic disease who were on multiple medications and not at their desired goals of therapy were referred to our PharmD by medical providers for a patient-centered medication therapy management (PCMTM) consult. Most patients were female (64.3%), black (57.1%), between 35-85 years of age (mean =52.4). Of these patients 28 (66.7%) patients completed a face-to-face an initial comprehensive medication therapy review (CMTR) to determine if medications were appropriately indicated, were the most effective, the safest possible

and whether the patients were adherent to their medication regimen. Using evidence-based practice guidelines, individualized care plans were developed to optimize drug therapy. A follow-up evaluation was also conducted evaluation to determine if the goals of therapy had been achieved. The most common medical conditions were hypertension, Type II diabetes mellitus, and obesity. The most frequent drug therapy problems (DPTs) per condition were: Needs additional drug therapy (48.9%), Dosage too low (23.4%) and Non-adherence (16.6%). The majority (82.3%) of DPTs were resolved directly between the PharmD and the patient while the remainder (19.3%) required consultation with the medical provider. The collaborative effort between our PharmD and the providers produced positive outcomes in 90% the patients at follow-up regardless of the patient's age, medical condition or initial drug therapy problem present. The preliminary data demonstrates the value of integrating PCMTM into the current medical services at OTMDC. Further studies are needed to evaluate the impact of a collaborative effort between a dedicate PharmD FTEs and Medical providers on improving quality measures of care associated with improved health outcomes

10. We continue to try to increase our panel of medical specialist volunteers to provide consultations on our chronic disease patients. Despite our on site specialists, we continue to also refer patients to providers in our community. Sentara Williamsburg Regional Medical Center is a wonderful partner in this regard, providing radiology services to our patients. See attachments "Copy of Volunteer Specialist Visits 2016" and "Copy of Referrals 2016."

Were these goals for the grant period met?
Yes

If any of these goals for the grant period went unmet, please explain the reason(s) why.
(Please limit responses to 200 words or less).

Did your organization exceed program expectations by making progress greater than what was outlined in its short-term goals?
Yes

If your organization did exceed program expectations, please describe in what ways it surpassed the short-term goals and what factors contributed to those achievements.

1. We have a WHF funded grant in place supporting two health coaches who are targeting our diabetic patients who do not achieve therapeutic goals. Quality data is shown in attachment "7-17 to 6-30-18 quality data."

4. We were able to purchase thirteen 30 day passes to hand out to patients actively engaging with the nurse educator to use the JCC Rec Center. This has made a huge difference for a small number of patients who otherwise did not have access to exercise facilities that remained open when the clinic is not (weekends, every evening etc)

5. Our group visits were down as a result of provider turnover. We lost one provider in November and one in December, and their replacements were not hired until February and May, and each had a 30-40 day orientation period during which they did not see patients on their own. We now have 5 nurse practitioners, one of whom sees our open scheduling patients each day. This frees the remaining four to see primary care chronic disease patients, and has reduced new patient appointment waits to two-three weeks, down from over 6 weeks.

6. With a grant from the Lions Club of James City we expanded our eye clinic, and this year performed 369 retinal exams, and provided 270 patient visits. We are also able to obtain free glasses for patients through our medication assistance program.

7. We continue to integrate oral health exams into diabetic management, and are identifying a significant number of patients with dental problems. See attachment "OTMDC Diabetic Oral Health Project..."

Describe the long-term goals of the program.
(Response from Grant Application).
The success of the Chronic Disease Program at Olde Towne Medical and Dental Center lies in our ability to remain flexible, embrace collaboration and explore cutting-edge, evidenced based practices to adopt and incorporate into our clinical practice. We are cultivating an attitude of flexibility and designing a team based, transformational environment that will foster health promotion and wellness for our chronically ill patients and surrounding community. Our participation in the CHC Leadership program and Heart of Virginia Program is of help with this. Additionally, an interminable goal for Olde Towne is to make a conscious effort to identify our patient population and investigate the needs of those with chronic disease. Understanding our population will help us to ensure that our programs and services meet the exigencies of our patients. It is our expectation that our efforts will help decrease the healthcare costs to the community and healthcare system by equipping people with the knowledge and tools required to improve their health. We have also found that in addition to chronic disease, 88% of our patients also have behavioral health problems. Consequently, we are exploring how to improve the mental health services and access to mental health professionals at Olde Towne. We are happily referring patients to the case manager for CBH as we hope this improve the health outcomes of our patients with chronic illness and behavioral health problems. We also our increasing our collaboration with our two local hospitals to improve providing patients with primary care providers, and hopefully this will lead to less ER and inpatient stays for these patients. Our medication therapy management (MTM) program with Hampton University School of pharmacy is working well, and we believe this can be developed into an MTM pharmacy, and ultimately this will evolve into a dispensing pharmacy as well. Significant funding challenges exist, however, and we are collaborating with Rx Partnership to have OTMDC become an alternate delivery site, receiving generic prescription medications from a centralized dispensing pharmacy which then can be given to our patients for free. This will supplement our Medication Assistance Program, which provides free brand name drugs supplied by the manufacturers. In fiscal year 2015-16, our MAP program served 635 patients, 229 of which were new, and requested 4,362 medications valued at $5,771,473.

Describe the progress made on each of these long-term goals during this grant period.
(Please limit responses to 150 words or less).
From January to June 2018 72% of our patients had chronic medical diseases. We have completed CHC program and are partnering with Colonial Behavioral Health in SYNC program using learning strategies to aid our patients and have added health coaches.
OTMDC is a certified alternative delivery site, and our generic fill program is supplementing our MAP brand name program and provided 5694 prescriptions for 559 patients. MAP aided 925 patients obtain 5565 prescriptions worth $6,865,018. Hampton University School of Pharmacy pharmD students are running a medication therapy management program for our patients.
Our pregnant patients are screened for depression three times during their pregnancy, all new patients are screened at their initial visit (PHQ-9), and established patients are screened annually.
Our Lions Club eye clinic is running smoothly, we provide free glasses through Needy Eyes program, and have a waiting list of patients to be seen by our volunteer providers.

Has the program progressed as anticipated in the last six months?
Yes

If the program has not progressed as anticipated in the last six months, please explain what has changed and why.
(Please limit responses to 150 words or less).

If the program has not progressed as anticipated in the last six months, please explain how the organization plans to proceed.
(Please limit responses to 150 words or less).

Sustainability and Collaboration

Sustainability

Will the program continue after this grant period?
Yes

If the program will not continue after the grant period, please explain.
(Please limit responses to 200 words or less).

Have any additional sources of funding been identified in the last six months?
Yes

If yes, list the source(s) of funding, the amount(s), and whether they are anticipated or committed.
We received increases in funding from the three jurisdictions, and are requesting increases in the next budget. JCC made major and significant improvements in our building. See attachment "Jurisdiction Funding."
We are seeing a slight increase in revenue from insured patients, primarily employees of JCC and York County.
Major grant funding has been flat.
Personnel costs have markedly increased, and we anticipate withdrawing $247,803 from our endowment/investment fund.
Our optimism about Medicaid expansion is tempered by our experience with the ACA, which after being passed was associated with a paradoxical significant decrease in our patient revenue.
We are approaching the Rapoport, Huston and Clark Foundations, and also Bank of America, Newport News Shipbuilding, Wells Fargo and Ferguson.
We are holding a gala to celebrate our 25th anniversary, and anticipate $55,000 revenue from this.

Collaboration

Please list the agencies that the organization collaborates with and briefly describe how that collaboration is taking place.
(Please limit responses to 150 words or less).
We are expanding our collaboration with James City County Social Services (JCCSS), through a WHF grant for a Child Health Initiative. We will provide medical and dental care to participating families, assist in hiring and supporting the grant funded nurse case worker and will provide office space. Our collaboration with JCC/Williamsburg Head Start is expanding to include York County. We now train ODU student nurse practitioners.
We continue to collaborate with the three jurisdictional human services departments, two local hospitals, TPMG, local safety net clinics, CDR, Peninsula Agency on Aging, Literacy for Life, Faith in Action and other community faith based organizations, Sentara Women's Auxiliary, United Way, Avalon, Bacon Street, College of William and Mary, VCU medical school, EVMS, CHKD, Hampton University School of Pharmacy (HUSP), Thomas Nelson Community College, Junior Women's League, Peninsula Food Bank, Virginia Department of Health, Olde Towne Pharmacy, Lawanga and Natasha Houses and Colonial Williamsburg.

If applicable, please indicate which of these partners are in the organization's referral network and indicate how many referrals were both made to and received from each partner in the grant period.
Our collaboration with VCU, EVMS, W&M, ODU, HUSP and Thomas Nelson involves training their students on site, exposing them to the experience of functioning in a safety net clinic. We are also exploring research opportunities with HUSP and W&M.
All of our other collaborators utilize OTMDC as a resource for referring patients in need of our services, but we do not track where are patients come from and our patient surveys indicate ~97% of our patients are referred "by word of mouth, friends or family."
We have begun tracking Head Start and last fiscal year saw 292 children from JCC/Williamsburg and 62 from York County. Our goal for the next year is to expand services offered to these children to include immunizations, physical exams, fluoride applications and oral health exams, and possibly testing for lead poisoning. With Head Start and Colonial Williamsburg we are exploring bringing OTMDC staff off site to reach out to patients.

How has the program or the organization worked to facilitate health related improvements through partnerships and increased collaboration with community organizations? Please be as specific as possible and cite data and descriptive statistics when applicable.
(Please limit responses to 300 words or less).
We continue to accept referrals from all of the organizations listed above, as well as from other safety net clinics. Our dental service has expanded to 40 hours a week, and we are now working with JCC/Williamsburg Head Start and are beginning to work with Head Start from York County. These efforts are part of an outreach into the community by our clinic, wherein our staff goes off site to the patients. We are also in the process of scheduling an outreach to the uninsured employees of Colonial Williamsburg. And we are supporting and providing space and clinic access to JCC Human Services for their child health initiative.

Grant Conditions and Foundation's Mission

Grant Conditions

Grant Conditions (From Grant Contract, if applicable).
Active participation in the CCC including meeting attendance and adherence to reporting requirements, such as quality measurement, as agreed upon in meetings and specified on the extranet.
Share challenges as well as tried and promising practices and thereby help ensure coordination and continuous quality improvement across the Collaborative.
Work with Rx Partnership and GWMAP, as well as additional sources to assist patients with obtaining prescribed medications.
Continue the commitment to delivering the Chronic Care Model for safety net patients.
Work with area health systems on models of care and a health information exchange.
Fully engage with the Collaborative's Quality Improvement initiatives including the ongoing efforts to support patient activation.

Report on the above grant conditions.

We continue to participate in CCC meetings, and adhere to reporting requirements. See attachment "7-17 to 6-30 quality data."
We have shared challenges and practices with CCC members.
We continue to work with Rx Partnership and GWMAP to provide both generic and brand name medications to our patients free of charge. Our generic fill program provided 5694 prescriptions for 559 patients. MAP aided 925 patients obtain 5565 prescriptions worth $6,865,018.
We continue to work with area health systems on models of care and information exchange, but are disappointed with their non-responsiveness to our request for creating a system for specialist referral for indigent patients.
We engage in QI improvements including efforts to support patient activation.

Relation to the Foundation's Mission

Please answer question 1(A), or 1(B), or 1(C). While many programs serve many purposes, the Foundation asks that you just answer one question based on your Foundation-assigned category of Wellness, Access, or Advocacy.

This grant is coded as:
Access

1(A) For Wellness Grants:

How has this program promoted healthy lifestyles and informed individual choices for all people who live in our community? Please be as specific as possible and cite data and descriptive statistics when applicable.
(Please limit responses to 300 words or less).

1(B) For Access Grants:

In what ways has this program met the healthcare needs of our most vulnerable community members? Please be as specific as possible and cite data and descriptive statistics when applicable.
(Please limit responses to 300 words or less).
A review of the Clinical Services Report FY 17/18, which contains data for our entire clinical service, reveals that 76% of our patient visits were for the 73% of our patients who are uninsured. On our dental service, 98% of patients are uninsured. Fifty-six percent of our total patients are below 200% of the federal poverty level, and 36% below 100%. From July through December 2017 76% of our patients had chronic medical diseases, while from January through June 2018 72% of patients had chronic illnesses. For our patients with chronic disease, 73% are below 200% of the federal poverty level, and 53% are below 100%. See attachments "17-18 FY pt profile."
In addition to primary medical and dental care provided by our employed staff, our volunteer providers had over 500 patient visits for specialty medical care and over 800 visits for dental care. Our dental service is now open 40 hours a week, and our medical service 48 hours a week with evening hours two days a week. However, we continue to refer patients out for specialty consultations and diagnostic studies in large numbers. Sentara Regional Medical Center provides us outstanding support for diagnostic radiology and other studies. See attachments "Volunteer Provider Visits..." and "referral report 2016-18."

1(C) For Advocacy Grants:

In what ways has this program advocated for health opportunities to be considered in decisions and policies affecting the Foundation's service area?
(Please limit responses to 300 words or less).

Program Services Data

Program Services Data

Please provide the following information for the program.

For the purposes of this program the Unit of Service is: (Please contact your Program Officer if you need assistance).

UNIT OF SERVICE
Clinical encounters with a medical professional

How many units of service were provided over the grant period?
15765

How many units of service were provided over the grant period to individuals living in the WHF service area (City of Williamsburg, James City County, York County, and City of Poquoson)?
13827

How many unduplicated individuals received that service over the grant period?
4832

How many of those unduplicated individuals served live in the WHF service area (City of Williamsburg, James City County, York County, and City of Poquoson)?
4227

Of the unduplicated individuals living in the WHF service area (City of Williamsburg, James City County, York County, and City of Poquoson) who received that service; how many were: (Please contact your program officer if you need assistance).

Male	Female
1352	2875

Unknown Gender
0

Of the unduplicated individuals living in the WHF service area (City of Williamsburg, James City County, York County, and City of Poquoson) who received that service; how many were: (Please contact your program officer if you need assistance).

0 to 17 years old	18 to 29 years old	30 to 44 years old	45 to 64 years old	65 plus years old
676	761	1074	1302	414

Unknown Age
0

Of the unduplicated individuals living in the WHF service area (City of Williamsburg, James City County, York County, and City of Poquoson) who received that service; how many were: (Please contact your program officer if you need assistance).

Asian	Black/African American	Hispanic/Latino	Other	White/Caucasian
154	1395	798	138	1742

Unknown Race
0

Of the unduplicated individuals living in the WHF service area (City of Williamsburg, James City County, York County, and City of Poquoson) who received that service; how many were from households: (Please contact your program officer if you need assistance).

Below 200% of the federal poverty level	Above 200% of the federal poverty level
2367	803

Unknown 200% of the federal poverty level
1057

Provide an example of the typical client served by this program.
(Please limit responses to 100 words or less).
A typical patient served by this program would include a middle aged female patient with multiple chronic diseases requiring several medications to manage her illnesses. She participates with the Access to Medications program to obtain free generic medications and she utilizes the Medication Access program to obtain her insulin. In addition to chronic medical illnesses the patient also requires behavioral health services to treat her depression and anxiety. She utilized services via the Lions donated eye clinic and she participates in chronic disease group medical visits to improve her health and increase her social interactions with her peers.

Additional Information

The Foundation would like to know more about this program. Please attach as an addendum on the next page any relevant program data you would like to share in a format convenient to your organization.

Lessons

Lessons

If your organization was beginning this program today, what, if anything, would it do differently?
(Please limit responses to 75 words or less).
We would have in place agreements with medical specialists to accept our uninsured patients. We continue to try to establish these referral lines, but with great difficulty.
What were the major accomplishments of the program over the last year?
(Please limit responses to 75 words or less).
We have expanded our dental service by adding a fourth part time dentist, which allows us to now be open 5 days a week. We have also expanded our efforts to incorporate oral health exams into diabetic management. See attachment "OTMDC Diabetic Dental..." This has been quite frustrating, since only ~20% of referred diabetic patients take advantage of this free oral health exam, but those that do have significant dental problems requiring care.
Please share at least one anecdote highlighting the achievements this program.
(Please limit responses to 75 words or less).
Care for the chronically ill requires access to comprehensive health care. With holistic care in mind, we are cultivating relationships with community partners to better understand our population and meet the needs of these complex patients. By providing patient education, daily open scheduling, links to community resources and increasing access to free medications, dental and behavioral health services onsite, we are attempting to provide "wrap around" services to this complex population.
Please share any feedback your organization may have for the Foundation.
We had concerns about the impact of open scheduling on our ability to care for our patients with chronic medical problems, but have now the percentage of walk in patient visits has levelled off at ~25%. The addition of a 5th NP positions has also reduced patient waiting time for scheduled visits to ~two weeks.
Our personnel costs have greatly increased. While two years ago we were able to hire a nurse practitioner (NP) for ~$65,000 a year, we are now having to pay $95,000 as an annual salary, and our benefits costs hover between 34-37%. There is tremendous competition from the health care systems and physician groups for NPs.

Attachments

Title	File Name
Final Progress Report Expenditure Form (online submission required)	Final Progress Report Expenditure Form FY 18.xlsx
Final Progress Report Expenditure Form (online submission required)	7-17 to 6-30-18 quality data.docx
Final Progress Report Expenditure Form (online submission required)	Jurisdiction funding.docx
Final Progress Report Expenditure Form (online submission required)	CSR Totals FY 18.pdf
Final Progress Report Expenditure Form (online submission required)	Volunteer Provider Visits Fiscal Year 17-18.xlsx
Final Progress Report Expenditure Form (online submission required)	Referral Report 2016-2018.xlsx
Final Progress Report Expenditure Form (online submission required)	OTMDC Diabetic Oral Health Project Jan to Dec 2017 and Jan-Jun 2018.docx
Additional Information 1	17-18 FY pt profile.docx
Final Progress Report Expenditure Form (online submission required)	CCC+Prog+Rpt+-Breakthroughs+Challenges+Ideas+for+7-20-18.docx

Files attached to this form may be deleted 120 days after submission.