

FRONTIER EXTENDED STAY CLINIC DEMONSTRATION

Medical Staffing Requirements Discussion

EXECUTIVE SUMMARY

Frontier Extended Stay Clinic (FESC) demonstration sites cannot always maintain staffing levels currently required by the Centers for Medicare and Medicaid Services (CMS) FESC Demonstration Conditions of Participation due to severe medical staffing shortages in remote locations. The Alaska FESC Consortium requests CMS amendment of the Conditions of Participation to allow for the utilization of a broader range of medical providers for patient care. Concurrently, the Alaska FESC Consortium suggests competency levels be developed and instituted for all FESC providers, regardless of certification levels, in the interests of patient safety and quality improvement. These proposed amendments will encourage the effective utilization of scarce frontier health resources and ensure appropriate proficiencies for all staffing levels involved in the provision of FESC services.

Project Definition

The Alaska FESC Consortium, led by the SouthEast Alaska Regional Health Consortium (SEARHC), is testing the operational viability and financial sustainability of a hybrid system for the provision of emergency and extended stay services in frontier communities. The demonstration is authorized under cooperative agreements with HRSA's Office of Rural Health Policy (ORHP) and with the Centers for Medicare and Medicaid Services. Five clinics participate in the ORHP demonstration, including the Haines Medical Center in Haines, the Alicia Roberts Medical Center in Klawock, the Iliuliuk Family and Health Services in Unalaska, the Cross Road Medical Center in Glennallen, and the Inter-Island Medical Center in Friday Harbor, Washington. These five clinics, along with the Powder River Medical Center in Broadus, Montana, also plan to participate in the CMS FESC demonstration.

Project Findings to Date

FESC project evaluation is by the Alaska Center for Rural Health (ACRH), at the University of Alaska, Anchorage. A report produced by ACRH after the first three years of the demonstration noted positive impact to clinic services for both emergency level and primary care through FESC sponsored staffing enhancements, upgraded emergency communications, and the addition of specialized emergency equipment. The evaluation further noted overall quality of care improvement resulting from increased provider confidence in diagnostic decisions through FESC training opportunities and equipment purchases.

Problem Statement

Difficulties cited by FESC participants during the evaluation process and during Consortium meetings largely center on the challenges of medical staff recruitment and retention for sparsely populated and remote geographical regions. The discussion

especially notes frontier site inability to maintain continual 24-hour registered nurse coverage. Per FESC Conditions of Participation (COP) B(6): “Any time there is an extended stay patient in the FESC, a qualified registered nurse, nurse practitioner, physician assistant, or MD/DO must be immediately available for the bedside care of the patient.”

Barriers to Success

One of the more significant barriers to FESC certification for most of the sites is the inherent difficulty in meeting and maintaining nursing staff requirements per COP B(6). The entire State of Alaska is designated by HRSA as either a HRSA Health Professional Shortage Area or a Medically Underserved Area.

Research conducted during 2007 by the Alaska Center for Rural Health (ACRH) analyzed health occupations most critically affected by medical provider shortages in Alaska. A group of key health workforce stakeholders, including the Alaska Mental Health Trust Authority, the Alaska Native Tribal Health Consortium; the Alaska Primary Care Association; the Alaska State Hospital and Nursing Home Association; and the UAA School of Nursing, provided direction for the ACRH study.

Four hundred seventy six Alaska healthcare organizations of all types, representing over 18,000 healthcare positions, responded to the extensive ACRH study survey measuring both vacancies and mean vacancy lengths for the entire state. The sample represented 35.3% of the entire statewide sampling frame of 1349 organizations. In addition to the survey data, statistical information analyzed included:

- The Alaska Department of Labor and Workforce Development (*Alaska's Health Care Industry and Alaska Economic Trends; Alaska's Occupational Forecast to 2014*);
- HRSA's Bureau of Health Profession's National Center for Health Workforce Analysis (*The Alaska Health Workforce: Highlights from the Health Workforce Profile, 2004 and Projected Supply, Demand, and Shortages of Registered Nurses: 2000-2020*);
- The Alaska Dept. of Health and Social Service's Primary Care/Rural Health Care Unit (*Alaska Health Professional Shortage Areas*);
- Previous ACRH studies (*Alaska's Allied Health Workforce: A Statewide Assessment, 2001; Status of Recruitment Resources and Strategies: 2003- 2004*).

ACRH's resulting "Alaska Health Workforce Vacancy Study", released in 2007, quantified critical shortages in a wide range of health occupations, including family physician, nursing specialties, and physician assistants, by both geographic region and healthcare organization type. Existing national shortages of key health workers for a steadily growing and aging population were found to be exacerbated in Alaska, where remoteness, harsh climate, rural isolation, low population density and scarce training resources adversely affect organizational recruitment and retention efforts

The ACRH findings confirmed and quantified trends noted in other studies and accumulating anecdotal evidence that, despite progress in training and deploying health personnel, critical shortages persisted. The average statewide vacancy rate for key primary care occupations such as Family Physician, Nurse Practitioner, and Physician Assistant, was reported to be between 15% and 20%, with more acute vacancy rates in

the rural areas. The Family Physician shortage was at an overall 15.8% estimated vacancy rate for the state, with rates 10- 20% higher for the rural areas. The mid-levels often employed in their stead were equally in demand, despite Alaska having the country's highest PA to population ratio. The estimated PA vacancy rate was 19.0% for the state, and 26.8% for the rural.

The highest number of vacancies and vacancy rates found by the ACRH study were for key specialized nursing occupations, particularly for Nurse Case Manager, Nurse Practitioner, and Critical Care Nurse. The estimated vacancy rate for Family Nurse Practitioners was 19.5% (36.4% in rural areas). Alaska's rural regions reported vacancy periods of between 7-18 months for nursing positions, especially for the frontier regions. Frontier locations reported "critical medical provider shortages", with annual provider vacancy rates anecdotally approaching 40 and 50% and documented vacancy rates of around 20% for all health care professions, higher than any other occupational group in the state. Official data for the study period reported the highest regional vacancy rates for the nursing specialties as follows:

Family Nurse Practitioners - North/West, 33.3%; Southwest, 35.7%; Interior, 31.3%; Anchorage Mat-Su, 18.3%; Gulf Coast, 16.7%

Nurse Case Managers – Anchorage Mat-Su, 47.5%; Southwest, 40.0%; Interior, 33.3%; Southeast, 33.3%; North/West, 25.0%; and Gulf Coast, 13.3%

Critical Care Nurses – North/West, 100%; Anchorage Mat-Su, 18.6%; Southwest, 18.2%

Registered Nurse - Northwest, 26.5%; Southwest, 16.5%; Statewide, 16.1%.

The Alaska Primary Care Association, at its September 2008 annual legislative planning meeting, continued to identify workforce development as its top state legislative priority. Support for workforce incentives to promote adequate levels of medical staffing in frontier and rural areas was listed as a top federal legislative priority, second only to securing adequate levels of funding for all health centers. Adequate funding levels for Alaska's community health centers is a major challenge due to the relatively low numbers of patient encounters, as compared to health centers in the densely populated urban areas of the Lower 48. The necessitated use of traveling nurses because of vacancy factors is another significant factor impacting rural health center budgets.

Further compounding the medical staffing situation is the stress placed on existing providers to work longer hours in the face of the nursing shortages. The American Nursing Association (ANA) has long voiced concerns for patient safety, given the well-documented relationship between nurse fatigue and an increased risk of nurse error. The publicly advocated ANA position is that employers of registered nurses should ensure sufficient resources to allow for adequate rest and recuperation between scheduled work, and sufficient compensation and appropriate staffing systems to foster a safe and healthful environment. Compelling registered nurses to work overtime and extra shifts contributes to worker fatigue and burnout, resulting in frequent turnover, extended vacancy periods, and compromised patient care and safety. An overemphasis on RNs for FESC site use thus ultimately places all patients at risk.

Previous Attempts to Address Staffing Concerns

After lengthy evaluative discussion of the first three years of the project and of the staffing challenges involved, the Alaska FESC Consortium formally appealed the CMS Conditions of Participation for amendment to allow for LPNs, EMTs, and CHAs to provide extended stay patient monitoring in the frontier settings, and asked for alignment with State of Alaska FESC regulations (DHSS Title 7, Part I: 12.9.470), which state:

A physician, a physician assistant, an advanced nurse practitioner, a registered nurse, a licensed practical nurse, a primary community health aide, or an emergency medical technician must be on duty whenever the clinic has one or more extended stay patients. The number of clinic staff and the level of training required to provide treatment to an extended stay patient is at the discretion of the clinic and the practitioner involved in the patient's care, after determining what is required to meet the patient's needs.

State FESC regulations mandate appropriate and timely physician notification, and address the responsibility of a site to maintain staffing capacity necessary to provide the care and services required for FESC qualification.

The CMS staffing appeal filed by the Alaska FESC Consortium in July 2007 further noted that CMS Conditions of Participation for Critical Access Hospitals (CAH) already permit clinical nurse specialists and LPNs for inpatient monitoring and services.

The CMS response to the FESC Consortium appeal was denial of the request to amend the Conditions of Participation to allow for the utilization of LPNs, Community Health Aides, and EMTs. CMS further positioned that CAH staffing Conditions of Participation were not applicable to clinic situations because of perceived facility infrastructure variances, even when the emergency and extended stay services provided are often similar in nature.

Continuation of the Appeal to Amend CMS Staffing Condition of Participation

The Alaska FESC Consortium wishes to exhibit evidence of the appropriateness of LPNs, Community Health Aides, and EMTs for utilization by the participant sites, continuing its appeal to amend CMS Condition of Participation B(6), with added provisions for the establishment and maintenance of provider competencies.

Alternative Medical Certifications for Emergency and Extended Stay Care

State of Alaska Statutes for LPN Scope of Practice (AS 08.68.100, Appendix A) acknowledge the initial necessity of direct supervision for LPN performance by an RN, physician or dentist; however, the statute goes on to say that continuing direct supervision may not be necessary once the LPN has been determined to be competent. The Statutes allow for competency to be determined by a conscious decision making process that includes the development of policies and procedures for performance of specific activities, the provision of structured educational programs and supervised clinical practice, and an individual evaluation of clinical competence for a particular situation

(not automatically transferable to a new employment situation). LPNs practicing in an expanded role must recognize their personal accountability for acts they perform, with accompanying RN recognition for a responsibility to provide continuing evaluation, and additional direction and supervision as needed.

State of Alaska Statutes for Emergency Medical Technicians and Mobile Intensive Care Paramedics authorize blood draws; the start and administration of IVs; approved airway management techniques; the application of electrodes; the monitoring of cardiac activity; the application of counter-shock for ventricular defibrillation and pulseless ventricular tachycardia; the administration of lidocaine, atropine, morphine, epinephrine, and other department approved medications; and other department approved emergency procedures. This Scope of Practice may be provided under either the direct or indirect supervision of a physician.

Alaska's federally authorized Community Health Aide Practitioners (US Code Title 25) are trained under accredited University of Alaska curriculum, with a formalized certification and review process. Community Health Aide Practitioners (CHA/Ps) work within the guidelines of the Alaska CHA/P Manual, 2008 Revised Edition, which outlines assessment and treatment protocols for "Patient Care While Waiting to Transport to Hospital", and extensive emergency patient procedures. A certified CHA/P must also maintain distance communications with a collaborating physician for emergency and extended stay patient care.

Proposed Resolution

State certified LPNs, EMTs, Paramedics, and CHA/Ps should be authorized by CMS for bedside care of FESC patients in the remote frontier situations where clinic staff levels are such that a qualified RN, nurse practitioner, physician assistant, or MD/DO is not always available for extended stay monitoring. CMS should essentially adopt the existing State of Alaska FESC regulations allowing for the utilization of LPN, EMT, Paramedics, and CHA/Ps in certain frontier situations, under indirect physician and nursing supervision.

Concurrent with CMS amendment to the Conditions of Participation for FESC staffing, each participant site should be obligated to establish and maintain core competency levels to approve individual providers for active participation in the FESC demonstration, regardless of certification level, with clear guidelines established for professional medical supervision and consultation. The development of core competency levels should reflect intent similar to existing Alaska State guidelines for a conditionally approved expanded LPN Scope of Practice, with conscientious and continuing individual and situational evaluation. Other examples of established competency-based systems include CLIA certification processes for the performance of lab tests, and pharmaceutical regulations for formulary review. Competency demonstrations for these professional medical services are required on a quarterly basis, with no acceptable margin of error.

An example of FESC provider competencies as drafted by the Alicia Roberts Medical Center in Klawock, based on established nursing competencies currently maintained by the Iliuliuk Family and Health Services in Unalaska, is attached for CMS consideration.

This solution proposed by the FESC Consortium addresses CMS concerns for patient safety in clinic settings; institutes formalized quality of care standards; and offers broader extended stay staffing options for the challenging medical personnel issues encountered by the frontier locations. The suggested methodology will effectively utilize scarce health resources and seek maximum proficiencies for all FESC provider levels to achieve best practice for unique frontier settings.