

Frontier Extended Stay Clinic Cooperative Agreement Program Non-Competing Continuation Application – Second Year

Program Narrative

1. PROGRESS TO DATE

A. Project Goal: The goal of this project is to examine the effectiveness and appropriateness of a new type of provider, the Frontier Extended Stay Clinic (FESC), in providing health care services in remote locations in Alaska and other states. The project works to demonstrate the viability and sustainability of the FESC provider type and to ensure that FESC patients receive high quality services consistent with their medical conditions. This Cooperative Agreement builds on previous Cooperative Agreement work, continuing a substantial partnership with the HRSA Office of Rural Health Policy. Following is a progress report on each of the objectives and activities for the cooperative agreement.

B. Current Project Objectives and Activities:

Objective 1: Manage the Cooperative Agreement and all associated activities through the project period to September 2011.

As the lead agency, SEARHC is responsible for providing project leadership, oversight, and continuity to ensure project success. SEARHC engages in all activities necessary for the successful implementation of the demonstration. These include:

a. Maintain the Steering Committee consisting of an executive level administrator and clinical representative (when appropriate) from each of the five Consortium members.

The Steering Committee meets monthly by teleconference or in person. During the first year of the project, the Steering Committee met on September 18, October 16, November 20, December 18, January 15, April 15, and May 20 by teleconference, and in person at Friday Harbor on March 5, 2008. Future meetings are planned on June 17, July 15, August 19, and an in-person meeting in Unalaska on September 10.

b. Invite other participants to Steering Committee meetings when appropriate.

Representatives from the Native Village of Eyak, the Powder River Medical Center, the Alaska State Hospital and Nursing Home Association, The Alaska Department of Health and Social Services, and the Washington State Department of Health are invited to all Steering Committee meetings.

c. Continue working with representatives from the Alaska State Hospital and Nursing Home Association (ASHNHA) and the Alaska Small Hospital Performance Improvement Network (ASHPIN).

Randall Burns has continued to participate actively in Steering Committee and other FESC activities.

d. Establish and monitor subcontracts annually with each member of the Consortium and other significant subcontractors.

Subcontracts have been established with all members of the Consortium: Cross Road Medical Center, Iliuliuk Family and Health Services, Inter Island Medical Center, and the University of Alaska Anchorage. Subcontractors submit triannual reports on their activities, and send invoices for their expenses.

e. Ensure compliance with the HIPAA Final Privacy Rule.

A Business Associate Agreement was developed and signed by representatives of the consortium and associates. The Business Associate Agreement delineates clearly the expectations for the health care providers (“covered entities”) and the other interested parties (“business associates”) working together on this project.

f. Provide information when requested by the Office of Rural Health Policy.

All requests for information have been met in a timely manner.

g. Manage communications among Consortium members.

SEARHC serves as the lead agency to ensure that communications are accurately, completely, and effectively disseminated. The primary means of communication are e-mail and telephone. Communication is a critical component of the project, since the Consortium members are separated by vast physical distances.

h. Continue to work with state and federal policy makers to develop Medicare, Medicaid and third party payments for FESC encounters.

The Consortium continues to work with CMS on the development of the CMS FESC demonstration. The State of Alaska is identifying potential Medicaid reimbursement strategies, and the Program Manager provides information upon request. Preliminary discussion with Blue Cross/Blue Shield indicated that they would not be interested in conversation about potential reimbursement until the CMS demonstration takes effect.

i. Continue facilitating the activities of the Provider Workgroup.

The Provider Workgroup did not meet during the first year of the Cooperative Agreement. The Steering Committee was polled on whether to convene a meeting of the Provider Workgroup, and decided not to do so at this time. There are provider representatives on the Steering Committee, and it is believed that they adequately represent the providers’ point of view.

Objective 2: Implement and test FESC protocols by continuing to provide high quality FESC services at the current demonstration sites.

a. Continue to demonstrate the FESC model.

The demonstration is ongoing at the following five sites: Klawock, Haines, Unalaska, and Glennallen in Alaska; and Friday Harbor, Washington.

b. Maintain staff, equipment, and facility to provide high-quality FESC services.

Each of the demonstration sites has upgraded their capacity to provide high quality FESC services, and is committed to maintaining that level of service throughout the duration of the project. The demonstration sites in Klawock, Glennallen, and Unalaska are each utilizing grant funds primarily for salaries for two nurses and a midlevel provider. This staffing allows the provision of extended stay services without depleting the resources of the other staff. The demonstration sites in Haines, Alaska and Friday Harbor, Washington are utilizing funds to add nursing and provider staff as needed to the staffing mix. Each of the five demonstration sites has experienced significant turnover and/or vacancies in provider and nursing staff over the past year. There is aggressive recruitment to fill vacant positions.

Results of a preliminary investigation by state fire marshals into the readiness of facilities to meet the required life safety codes indicated that some of the sites might need to remodel their facilities to some degree in order to meet the criteria. Inter Island Medical Center, Cross Road Medical Center, and the Haines Health Center are investigating the need for facility changes to meet the life safety code required for ambulatory health care occupancy.

Monitoring visits to the sites are conducted annually (or more often if there is a concern) by the program director. This year, visits were made in February 08 to Friday Harbor and Glennallen. A visit to Alicia Roberts Medical Center was conducted in November 07, a visit to Haines is planned in May 08, and to Unalaska in September 08. The monitoring visits follow an established procedure, including meetings with provider staff, director, financial director, and appropriate partners. No problems have been identified with program operations.

c. Provide in-kind services, staff, space, and equipment as needed.

Staffing increases that are funded by the Cooperative Agreement comprise a small but important part of the clinic operations as a whole. Maintenance of all other features, including diagnostic equipment, space requirements, and other services and equipment is routinely provided.

d. Participate in program evaluation activities approved by the Steering Committee.

Each of the sites is continuing to participate in the online data collection efforts, which are the backbone of program evaluation activities. Each site also participated in detailed interviews, conducted by ACRH, about the first three years of FESC operation.

Objective 3: Evaluate program and financial activities at the participating sites.

a. Continue management of the web-based outcome log as required by the Steering Committee and the Office of Rural Health Policy.

The Alaska Center for Rural Health trained staff at each site to complete the outcome logs. They also monitor the quality and timeliness of site submissions, and manage the technical aspects of the data collection. The outcome logs provide detailed clinical and financial information about each encounter. Close to 800 outcome logs have been completed in the first 8 months of the project.

A revision to the outcome log was implemented after much discussion between ACRH, the program manager, and the Steering Committee during April 2008.

b. Provide intermittent analyses upon request.

The Alaska Center for Rural Health has provided analyses when requested.

c. Provide monthly evaluation report to the Steering Committee.

Alaska Center for Rural Health (ACRH) has provided verbal updates on the evaluation at each Steering Committee meeting. At the Steering Committee meeting in March 08 in Friday Harbor, Beth Landon and Sanna Doucette presented the results of “The First Three Years” report, and an analysis of the data collected to date.

d. Provide annual and final evaluation reports.

ACRH submitted a report in November 2007. This report presented an analysis of the first two years of data collection for Klawock, Unalaska, Friday Harbor and Glennallen, and one year of data for Haines, which joined the project in 2006.

The executive summary from this report is included in the attachments.

e. Additional activities to be determined in consultation with the Steering Committee. The following additional activities were included in the Scope of Work in the contract between ACRH and SEARHC:

Emergency Services: ACRH will analyze ER services tracked in the FESC database and apply ER billing codes to them. The purpose of this activity is to understand the reimbursement value of these encounters. After a trial effort during summer 2008, ACRH and the Program Manager will determine how to continue and enhance this activity.

QA/QI Activities at FESC Sites: Each of the sites makes a preliminary report on their QA/QI activities in the triannual site report. In addition to these reports, ACRH will conduct qualitative interviews with clinic directors to assess the depth and breadth of QA and QI activities being conducted at each site. These may occur in-person during a Steering Committee meeting, or via phone. Information will be organized into a brief report to document clinic work in this arena. The reported activity does not need to be linked to FESC activities directly.

Add Hospitals to Database: In consultation with the FESC Project Officer, Steering Committee, and partners in Montana, ACRH will engage up to three hospitals selected for participation in the FESC project. ACRH is responsible for in-person training at their site approximately one month prior to official data collection, ensuring they are appropriately added to the database, and providing technical assistance as they develop comfort with the system. This activity is scheduled for completion by September 1, 2008.

Analyze Financial Information Collected in Database: ACRH is responsible for analyzing the payer mix of encounters collected in the FESC database. ACRH will provide a breakdown of the FESC payor mix in June 08, and thereafter upon request.

Conduct Additional Analyses of Encounters Between 4 and 48 Hours: The scope of data will be determined in collaboration with the FESC Program Manager. ACRH will provide a list of possible data analyses for the Project Officer to review before the end of July 08. It will include financial information.

Objective 4: Conduct an inventory and develop a narrative of the demonstration activities from previously HRSA-funded FESC demonstrations.

a. Conduct an inventory of the major capital items, infrastructure, and staffing enhancements funded by the HRSA grants in previous years, with an analysis of the effect of these enhancements on the provision of extended, emergency, and primary care at each FESC demonstration site.

ACRH conducted this research by examining records kept by the Program Manager in Sitka, and by conducting extensive interviews with clinic directors and clinical staff at each site.

b. Develop a narrative of the demonstration activities from previously HRSA-funded FESC demonstrations. Utilizing a combination of interviews and written documentation of activities, a retrospective analysis of “lessons learned” from the demonstration will be developed.

A report entitled “Equipment and Infrastructure, Staffing, and Professional Isolation within the Frontier Extended Stay Clinic Demonstration Program: The First Three Years” was submitted to the Steering Committee in April 2008. The executive summary of this report is included in the attachments.

Objective 5: Provide technical assistance to Centers for Medicare and Medicaid Services (CMS) Frontier Extended Stay Demonstration and its participating organizations through the project period.

a. Provide technical assistance to CMS upon request.

The Program Manager has provided information to the CMS Demonstration Project Officer frequently during the reporting period.

b. Provide technical assistance to other CMS demonstration sites.

Technical assistance has been offered to the Powder River Medical Center in Broadus, MT, and a site visit is planned for summer 2008 to determine opportunities for collaboration. The director has been invited to participate in Steering Committee meetings, and she attended the National Partners meeting in Spokane.

Objective 6: Develop and continue the implementation of Health Information Technology (HIT) and quality initiatives.

a. Continue implementation of the telepharmacy program at Alicia Roberts Medical Center in Klawock.

The telepharmacy continues to operate successfully at Alicia Roberts Medical Center. The telepharmacy is directly monitored by a designated pharmacist at Mt. Edgecumbe Hospital in Sitka whenever the telepharmacy is open. In addition, a Pyxis unit has been ordered for additional telepharmacy capability.

b. Continue to utilize the web-based outcome log for data collection and analysis.

Sites are continuing to collect detailed encounter data, and enter it into the online database. Sites are collecting information on all transfers, and on extended stays greater than two hours. Almost 800 encounters were recorded at the five demonstration sites from September through April. This data can be used to demonstrate the high quality of the patient care.

c. Develop and test quality measures for clinical performance.

During a meeting between SEARHC and ORHP in late November 2007, it was determined that the Outcome Log encounter database would suffice as the primary measurement for quality. Each of the sites is including in their reports a count of the number of FESC encounters during the reporting period. In addition, an inventory of QI/QA activities, which are already occurring at each clinic, is reported by each site.

d. Develop and test quality measures for financial performance at the participating demonstration sites.

It was determined at the ORHP/SEARHC meeting that this activity will be met by participation in the CMS demonstration. It is anticipated that a QAPI program will be required by CMS.

Objective 7: Explore the potential development of the FESC model in other states, including the relationship with critical access hospitals.

a. Formulate a Working Group with the Montana Health Research and Education Foundation, the Alaska State Hospital and Nursing Home Association, select members of the Steering Committee, and other interested entities to explore the relationship of FESC to critical access hospitals and other possible models of rural health care.

The Working Group met in Spokane on March 17, 2008, prior to the National Partners meeting. There was much discussion about optimal systems of rural health care. It was decided that two Montana hospitals and one Alaskan hospital would be invited to join the data collection efforts. Another meeting to determine appropriate criteria for hospital selection, how to approach them, and other details occurred May 20, 2008. The anticipated start date is September 1, 2008. The purpose of collecting encounter information from three hospitals is to compare volume, scope, and quality of services.

b. Identify and offer assistance to rural clinics that meet the statutory requirements for FESC, but are not participating in the HRSA or CMS demonstration.

The State of Alaska and the ORHP are developing a list of sites that may meet the criteria above. When that information is shared with the Steering Committee, we will determine what assistance we could offer.

Objective 8: Continue additional activities that support the development of FESC.

a. Maintain a dialogue and cooperative working relationship with the Alaska State Office of Rural Health and the Division of Public Health Certification and Licensing Unit.

Both the Alaska and Washington Offices of Rural Health are participating in Steering Committee meetings. They continue to actively support the FESC project on the state level. The Alaska State Medicaid Director indicated at the National Partners meeting that a Medicaid rate-setting process is in process.

Alaskan sites are currently working on their state licensing applications; Cross Road Medical Center was the first site to submit an application.

b. Represent the Alaska FESC Consortium at various state and national meetings, conferences, and workgroups.

Representatives traveled to the National Partners meeting held in Spokane in March 2008.

The CEO at Cross Road traveled to Juneau in January and to Washington, DC in March with Alaska Primary Care Association teams and had the opportunity to talk about FESC with elected officials.

The FESC program director, the ACRH director, and the director from Iliuliuk Family and Health Services presented at a session of the National Rural Health Association in New Orleans in May.

c. Facilitate communication with partner agencies.

The Alaska Primary Care Association, ASHNHA, the Native Village of Eyak, and other potential partners have been supportive of the FESC project.

d. Maintain Alaska FESC Consortium website.

The website was updated in January 2008, and has remained functional and informative since its inception.

e. Pursue publication and presentation opportunities.

Presentation opportunities are detailed above. No publication opportunities have been pursued.

C. Significant Changes:

No significant changes are expected.

D. Concerns or Barriers

No concerns or barriers are noted.

B: FUTURE BUDGET PERIOD ACTIVITIES

See the attached Work Plan for a description of proposed activities during the second budget period.

WORK PLAN

Project Goal: Examine the effectiveness and appropriateness of the Frontier Extended Stay Clinic.			
Objectives	Activities	Responsible Person or Entity	Timeframe
Objective 1: Manage the Cooperative Agreement and all associated activities.	a. Maintain the Steering Committee consisting of an executive level administrator and clinical representative from each Consortium site. Meet by teleconference at least monthly and face-to-face two times/year.	Program Manager and Alaska FESC Consortium Members	Monthly from September 2008 through August 2009. Face to face meetings two times each year.
	b. Establish and/or maintain and monitor subcontracts with each member of the Consortium and other significant subcontractors.	Program Manager	September 2008 through August 2009
	c. Ensure compliance with the HIPAA Final Privacy Rule.	Consortium Members and Business Associates	September 2008 through August 2009
	d. Provide information when requested by the Office of Rural Health Policy.	Program Manager	September 2008 through August 2009
	e. Work with state and federal policy makers to develop Medicare, Medicaid, and third party payment methodology for FESC.	Program Manager and Steering Committee	September 2008 through August 2009
Objective 2: Implement and test FESC protocols by	a. Continue to provide high quality extended stay services and other services, staff, space, and equipment as needed to meet community needs.	Each HRSA demonstration site.	September 2008 through August 2009

continuing to provide and document high quality FESC services at the current demonstration sites.	b. Participate in program evaluation activities approved by the Steering Committee.	Each HRSA demonstration site.	September 2008 through August 2009
Objective 3. Evaluate program and financial activities at the participating sites.	a. Continue management of the web-based outcome log, including the addition of up to four additional sites.	ACRH	September 2008 through August 2009
	b. Provide intermittent data analyses upon request.	ACRH	September 2008 through August 2009
	c. Present monthly reports on progress of the evaluation to the Steering Committee.	ACRH	September 2008 through August 2009
	d. Provide update to annual report, including additional analyses of encounters 4-48 hours in length.	ACRH	November 2008
	e. Determine the potential reimbursement value of emergency services tracked in the FESC database.	ACRH	January 31, 2009
	f. Provide a breakdown of the payor mix at each site.	ACRH	September 30, 2008 and upon request

<p>Objective 4.</p> <p>Conduct an inventory and develop a narrative of the demonstration activities from previous HRSA-funded FESC demonstrations.</p>	<p>Utilizing the research and report developed by ACRH during 2008 on “The First Three Years” and additional input from the Steering Committee, create a White Paper analyzing “lessons learned” from the Frontier Extended Stay Clinic demonstration, and potential future directions.</p>	<p>Program Manager</p>	<p>December 2008</p>
<p>Objective 5.</p> <p>Provide technical assistance to CMS and participating sites.</p>	<p>a. Provide technical assistance to CMS upon request.</p>	<p>Program Manager</p>	<p>September 2008 through August 2009</p>
<p>Objective 6.</p> <p>Develop and continue the implementation of Health Information Technology (HIT) and quality initiatives.</p>	<p>a. Conduct and report an analysis of the effect of the telepharmacy program at Alicia Roberts Medical Center.</p>	<p>Program Manager</p>	<p>December 2008</p>
<p>Objective 6.</p> <p>Develop and continue the implementation of Health Information Technology (HIT) and quality initiatives.</p>	<p>b. Continue utilization of the web-based outcome log to document all extended stays and transfers.</p>	<p>Demonstration sites</p>	<p>September 2008 through August 2009</p>
<p>Objective 6.</p> <p>Develop and continue the implementation of Health Information Technology (HIT) and quality initiatives.</p>	<p>c. Assist sites with the development of appropriate quality measures to meet the requirements of the CMS demonstration.</p>	<p>Program Manager</p>	<p>September 2008 through August 2009</p>
<p>Objective 6.</p> <p>Develop and continue the implementation of Health Information Technology (HIT) and quality initiatives.</p>	<p>d. Document and report the quality assurance and quality improvement measures already in place at each demonstration site.</p>	<p>ACRH</p>	<p>November 2008</p>
<p>Objective 7.</p> <p>Explore the potential</p>	<p>a. Continue development of a working group to explore the relationship of FESC to CAH.</p>	<p>Program Manager</p>	<p>September 2008 through August 2009</p>

development of the FESC model in other states, including the relationship with CAH.	b. Add three hospitals to the web-based outcome log data collection effort.	ACRH	September 2008
	b. Identify and offer assistance to frontier clinics outside Alaska that meet the statutory requirements for FESC, but are not participating in the HRSA or CMS demonstration.	Program Manager and Steering Committee	September 2008 through August 2009
Objective 8. Continue additional activities that support the development of FESC.	a. Invite other participants to Steering Committee meetings when appropriate, e.g. AHSNA/ASHPIN, Native Village of Eyak, FESC/CAH Workgroup participants, Powder River Medical Center staff, state officials.	Program Manager	September 2008 through August 2009
	b. Represent the Alaska FESC Consortium at appropriate state and national meetings and workgroups.	Program Manager and Steering Committee	September 2008 through August 2009
	c. Maintain Alaska FESC Consortium website: www.alaskafesc.org	Program Manager	September 2008 through August 2009
	d. Pursue publication and presentation opportunities.	Program Manager and Steering Committee	September 2008 through August 2009