The Alaska FESC Consortium
Year One Report to ORHP

Report Period: September 1, 2004 through August 31, 2005

PROJECT INFORMATION

Title of Project	Staff Person	Contact Information
Frontier Extended Stay Clinic Cooperative Agreement	Patricia Atkinson	Phone: 907-966-8662 Patricia.Atkinson@searhc.org

SECTION 1: PROJECT OVERVIEW

Grantee will provide an overview of the project including specified research area, key activities, goals, and objectives.

One of the most pressing health care issues in rural Alaska is the issue of non-reimbursed extended stay primary care. Because of unavoidable terrain, weather, and transportation issues, many primary care clinics are providing extended services to patients who under “normal” clinic circumstances would be transferred to a tertiary care provider. In some cases, providers may choose to offer extended observation time for patients who can reasonably be expected to get better within a short period of time. Without recognition as a provider type that is permitted to offer extended stay services, many Alaskan clinics are not adequately compensated for these necessary services. Consequently, they frequently find it necessary to care for patients without needed staff, equipment, or facility, and without the benefit of established quality protocols.

The Alaska Frontier Extended Stay Clinic (FESC) Consortium was established to examine and demonstrate the effectiveness and appropriateness of a new type of provider for frontier areas. The Consortium has worked throughout the year to develop appropriate protocols and standards for FESC services. They have worked closely with the State of Alaska to draft new FESC regulations, and have upgraded their facilities, staffing, and equipment as needed to effectively deliver extended stay services to patients. A meticulous evaluation process, guided by the Steering Committee, has been implemented at the demonstration sites.

There are two overarching goals which describe the purpose of the Alaska FESC Consortium:

1. Demonstrate the viability and sustainability of the FESC provider type and service in Alaska;
2. Ensure that FESC patients receive high quality services consistent with their medical conditions.

The objectives of the Alaska FESC Consortium are outlined in the Work Plan in the next section.

SECTION 2: WORK PLAN

Grantee will document progress in relation to its goals, objectives, and activities in the application and determine if progress to date is within stated expectations.

Objective 1: Establish a Steering Committee consisting of an executive level administrator and clinical representative from each Consortium site to provide oversight on the project implementation.

A working Steering Committee was originally established in the spring of 2004, and a Memorandum of Agreement was signed in June 2004. The original Steering Committee was composed of administrators from each of the sites, and the evaluation team. The Steering Committee was expanded to include an administrator and a provider from each site early in September 2004.

Members of the Steering Committee include:

Mark Gorman, Vice President of Community Health Services, SEARHC
David Vastola, M.D., Medical Director of Community Health Services, SEARHC
Sonia Handforth-Kome, Administrator, Iliuliuk Family and Health Services, Inc.
Donna Detweiler, R.N., Iliuliuk Family and Health Services, Inc.
Bruce Cain, Executive Director, Native Village of Eyak
Marilyn Eaton, P.A., Native Village of Eyak, Ilanka Clinic
Bill Riley, Administrator, Cross Road Medical Center
Melodye Gilbert, P.A., Cross Road Medical Center
Beth Landon, UAA Alaska Center for Rural Health
Mariko Selle, UAA Alaska Center for Rural Health

Guests at all Steering Committee meetings include:
Pat Carr, Department of Health and Social Services, State of Alaska
Noel Rea, Department of Health and Social Services, State of Alaska

Activity A. Steering Committee will meet monthly by either teleconference or face-to-face beginning within one month of receiving funding.

The Steering Committee met throughout the year. Following is a list of all meetings held:

October 5, 2004 – Teleconference
November 14, 2004 – Unalaska/Anchorage (only two people were able to fly to Unalaska due to weather problems. The rest convened in Anchorage and the meeting was conducted by teleconference with the two sites.)
December 14, 2004 – Teleconference
January 18, 2005 – Teleconference
February 15, 2005 – Teleconference
February 28 -March 1, 2005 – Glennallen
April 29, 2005 – Teleconference
May 9 - 10, 2005 –Cordova
June 14, 2005 – Teleconference
August 9, 2005 – Teleconference
September 6 - 7, 2005 – Klawock

Activity B: Program/Protocol Development Coordinator will be hired with input from the Steering Committee.

Donna Detweiler, R.N., from Iliuliuk Family and Health Services in Unalaska, was designated the Protocol Development (aka Provider Workgroup) Coordinator. Her selection as Provider Workgroup Coordinator was approved by the early Steering Committee by June 2004.

Activity C: Steering Committee will meet at all FESC sites included in this agreement in order to obtain a balanced and realistic view of the challenges of FESC and the capabilities at each site.

As detailed above, the Steering Committee attempted to meet in Unalaska in November 2004, but was partially foiled by weather. They did meet at each of the other sites during the year; Glennallen on February 28 and March 1, Cordova on May 9 and 10, and Klawock on September 6 and 7.

The Steering Committee's experience trying to get out to Unalaska highlighted for everyone the unreliability of the transportation services and the isolation of the clinic, reinforcing the necessity of providing FESC services.

Meeting at the sites provided the Steering Committee with an opportunity to evaluate in person each of the sites, to experience the transportation difficulties faced by each site, and more importantly, to engage in constructive, thoughtful, detailed conversation about the activities, direction and future of the project.

Activity D: Steering Committee will develop administrative protocols for proposed FESC services and review and approve clinical protocols developed by the provider group.

The Steering Committee formulated a workgroup to specifically address administrative protocols with the State of Alaska. The workgroup included Donna Detweiler, David

Vastola, Marilyn Eaton, and Bill Riley. This workgroup consulted with the larger steering committee or provider workgroup as needed.

The Steering Committee reviewed and either approved or revised all recommendations made by the Provider Workgroup. Donna reported at each Steering Committee meeting on the activities of the Provider Workgroup.

Objective 2: Establish a Provider Workgroup with representation from each Consortium site to ensure quality assurance and provider buy-in for the FESC protocols and model.

The Provider Workgroup was established in the fall, and met together in Anchorage on October 21 and 22, 2004. The rationale behind the Provider Workgroup is that providers need to have an active role in developing protocols for FESC services to ensure acceptance of services and the ability to implement at a variety of sites in Alaska. The goals of the Provider Workgroup include the following:

- Create FESC Vision
- Define Minimum Standards
- Guide Evaluation Process
- Discuss Quality of Care
- Describe Scope of Practice
- Identify Hazards/Risks/Criticisms

The Provider Workgroup held a second face-to-face meeting in Anchorage on February 7 and 8, 2005. They have actively participated via e-mail when asked for comments on proposed regulations, policies, scope of practice, or other matters.

Activity A: Form Provider Group with up to four providers from each site and representatives from the Alaska Office of Facility Certification and Licensing and the Alaska Primary Care and Rural Health Unit.

The Provider Workgroup is composed of the following individuals who met together on October 21 and 22, 2004, and again on February 7 & 8, 2005:

Donna Detweiler, R.N., Iliuliuk Family and Health Services (Unalaska)
Jessica Ambrose, P.A., Iliuliuk Family and Health Services (Unalaska)
Juvy Magalong, X-Ray/Lab Technician, Iliuliuk Family and Health Services (Unalaska)
Marilyn Eaton, P.A., Native Village of Eyak (Cordova)
George Nickerson, CHP, EMT, SEARHC (Klawock)
Matt Dinon, D.O., SEARHC (Klawock)
Jennifer Allen, M.D., Cross Road Medical Center (Glennallen)
Rachel Burkhart, R.N., Cross Road Medical Center (Glennallen)
Monica Fields, R.N., Cross Road Medical Center (Glennallen)
Shawn Sorenson, Environmental Health Director, SEARHC (Sitka)
David Vastola, M.D., Medical Director, SEARHC (Sitka)
Patricia Atkinson, FESC Program Manager, SEARHC (Sitka)

Noel Rea, Office of the Commissioner, DHSS (Anchorage)
Beth Landon, Director, Alaska Center for Rural Health (Anchorage)
Mariko Selle, Research Associate, Alaska Center for Rural Health (Anchorage)
Shelby Larsen, Administrator, Certification and Licensing Section, DHSS (Anchorage)
Pat Carr, Manager, Primary Care and Rural Health Unit, DHSS (Juneau)

Activity B: At first face-to-face meeting, form sub-groups based on content areas and expertise to allow Provider Workgroup (PW) to productively accomplish work.

It was determined at the first meeting that sub-groups were unnecessary, at least initially. All providers have participated in all of the discussions.

Activity C: Review regulations from RHC, CAH, and other relevant regulations to determine appropriate FESC services and corresponding conditions of participation (quality standards).

Shelby Larsen, State of Alaska Division of Public Health Certification and Licensing Unit, worked closely with the Provider Workgroup, culminating in a submission of the draft regulations to the providers for comments. The PW spent considerable time reviewing the proposed regulations and comparing the relevant regulations pertaining to RHCs and CAHs. The PW submitted comments to the State.

The Provider Workgroup also worked closely with the Steering Committee to review proposed regulations and Conditions of Participation from CMS, for the CMS demonstration. Their input helped shape the COPs from CMS.

Activity D: Develop a rationale for selection for each selected FESC service and condition of participation.

The rationale for selection of FESC services was the subject of intense discussion at each meeting of the Provider Workgroup and the Steering Committee. These discussions were conveyed to the appropriate federal and state partners.

Activity E: Forward proposed protocols to the Steering Committee for review and approval.

The PW Coordinator is a member of the Steering Committee, and she regularly reported at Steering Committee meetings on the activities of the PW, soliciting feedback and direction.

Objective 3: Demonstrate the FESC model by implementing and evaluating the FESC services and protocols at the selected Consortium sites.

Activity A: Implement FESC services based on the protocols developed for a demonstration period sufficient to assess viability and sustainability of the FESC model. The duration of service delivery may vary by site.

All of the sites (Klawock, Unalaska, and Glennallen) are already providing FESC services, which was a primary impetus for applying for the grant. They are all experienced providers of FESC services. Facility, staff, and equipment upgrades are essentially complete for official demonstration of the FESC model. The evaluation of the model began at three sites in March 2005. The evaluation will officially continue until March 14, 2006.

Activity B: Utilize the reporting/evaluation tool for documenting FESC services by all sites admitting FESC patients.

A web-based Outcome Log was developed with extensive discussion and input from providers. Personnel at the demonstration sites have all been trained in-person and are currently utilizing the outcome log to report all FESC encounters.

Activity C: Monitor number and quality of services provided to patients served using the FESC protocols.

Monitoring is being accomplished by utilization of the Outcome Log.

Activity D: Collect financial data on FESC services provided during the demonstration to document resources needed to provide FESC. A cost report will be the primary financial data collection tool.

Financial data is being collected as part of the Outcome Log. A preliminary financial feasibility analysis, based on the first three months of data collection, is in process.

Objective 4: Develop an evaluation plan to ensure the Cooperative Agreement produces meaningful information on the viability and sustainability of a FESC provider type/service.

Activity A: Establish a contract with Alaska Center for Rural Health (ACRH) to develop and implement an evaluation protocol.

A contract was established with ACRH. An additional contract with the Cecil G. Sheps Center for Health Research at the University of North Carolina in Chapel Hill, to provide support to the ACRH, was also established.

Activity B: Present the evaluation plan to the Steering Committee.

ACRH has continued to work closely with the Steering Committee and the Provider Workgroup to refine the evaluation plan. Approval for the structure of the evaluation was granted by the Steering Committee.

Activity C: Present monthly reports on progress of the evaluation to the Steering Committee.

ACRH presented reports at each Steering Committee meeting. An analysis of the first three months of data collection has been prepared and shared with the Steering Committee.

Activity D: Develop a reporting/evaluation tool for documenting FESC stays at the FESC sites to be approved by the Steering Committee.

Data from each FESC encounter is being collected in a clinic-customized version of the Outcome Log. Each site enters the data into a web-based database. The unit of analysis is the patient encounter. Data collected includes quantity of FESC services provided, the duration of services, FESC effect on staff schedules, the array of services, and how extended stay status impacted quality of care issues.

Qualitative interviews with representative clinic staff occurred in February and March 2005, to provide data prior to official implementation of the model.

Activity E: Provide input during the demonstration based on evaluation measures to allow for alterations in the implementation.

Preliminary results of the Outcome Log encounters were shared with the Steering Committee, and some slight modifications in the data collection were subsequently made.

Activity F: Complete a final evaluation report within two months of the completion of the grant activities.

The preliminary evaluation report, which documents the first three months of data collection, is appended to this report. Because of the preliminary nature of the data, we ask that this report not be shared outside of the Office of Rural Health Policy.

Objective 5: Develop financial sustainability plans for continuation of FESC services at each site.

The rationale or purpose is to help ensure sustainability of FESC services at all sites.

Activity A: Conduct a financial analysis of the cost of providing FESC services at each site.

The Alaska Center for Rural Health has contracted with Eric Shell (Stroudwater and Assoc.) and David Mather (Mather and Associates) to conduct the financial evaluation at each site. ACRH has designed the data collection tool, and is collecting the data. Selected variables include staff time, specific services provided, ICD-9 codes, payor, and amount paid.

The financial evaluation will be completed at the end of the evaluation period, spring 2006.

Activity B: Develop staffing plans for the cost of providing FESC services at each site.

A model staffing plan is included in the preliminary financial analysis, and can be easily changed to reflect alternate staffing plans.

Activity C: Determine resources necessary to sustain FESC services as implemented in the demonstration at each site.

The preliminary financial analysis analyzes the resources needed to sustain FESC services. This information, when complete, will be reviewed by the Steering Committee.

Objective 6: Provide HRSA, CMS, the State of Alaska and health care policy makers with meaningful data and information so they can make informed decisions about further development of a FESC provider type/service.

Activity A: Invite representative health care policy makers to the FESC quarterly meetings.

The ORHP has been invited to Steering Committee meetings, and has participated by teleconference. A representative of the Board of Alaska Native Tribal Health Consortium participated in our meeting in Glennallen. The State of Alaska, represented by Pat Carr and Noel Rea, has participated in all Steering Committee meetings, including teleconferences.

Activity B: Interested members of the Steering Committee will travel and meet with representatives of agencies to discuss FESC model development.

Presentations were made at the following meetings and conferences during the year:

FESC National Partners meeting in Seattle December 9 & 10, 2004.
Alaska State Hospital and Nursing Home Association January 12, 2005.
Northwest Regional Rural Health Conference in Spokane on March 24, 2005.
FESC National Partners meeting in Seattle on April 7 & 8, 2005.
Board of Directors of the Alaska Center for Rural Health on April 30, 2005.
Northwest Regional Primary Care Association in Anchorage May 24, 2005.
ORHP All Programs Meeting in Washington DC on August 25, 2005.

Activity C: Provide stakeholders with objective and quantifiable data via quarterly reports.

This report is being provided to the ORHP. Continual contact with the state of Alaska, and participation in the Alaska FESC Workgroup, which is coordinated by the State of Alaska, ensures that representative stakeholders are informed. Reports are also published on the Alaska FESC Consortium website.

Activity D: Each site will provide a report on the costs of providing FESC services.

This data is being collected as part of the financial evaluation of the project.

Activity E: Submit a final report summarizing the project.

This report summarizes the project for the year. The preliminary evaluation report (on the first three months of data) is included in the appendix.

Activity F: Work with stakeholders on mechanisms for disseminating information to states and entities interested in the FESC model.

The Steering Committee approved a Communication Plan with specific methods for disseminating information. These methods include presentations, meetings, newsletter, using e-mail, fact sheets, and talking to the media as appropriate.

A website documenting activities of the Alaska FESC Consortium, and providing historical and contact information, became operational in January 2005. The website address is: www.alaskafesc.org. Consortium members, ORHP, and other agencies provide links to our website. From January through August 2005, 308 unique visitors accessed the website, for a total of 460 visits.

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SECTION 3: SIGNIFICANT CHANGES

Grantee will address any major changes in goals, objectives, methodology, budget, and staffing.

In September, the Consortium received an additional award of $250,000. The terms of the award included $169,742 to implement and evaluate FESC services at an additional site in Alaska. Discussion about an additional site at the November 2004 Steering Committee meeting yielded the conclusion that there was no benefit to adding another site at this time. The money was instead used to strengthen the existing sites' capacity to provide FESC services, including authorization to Cross Road Medical Center to hire an additional midlevel provider.

As the Alaska FESC Consortium partners have proceeded with the project, various changes in budgets, timeline, and costs have been encountered. Construction at the Alicia Roberts Medical Center was slower than anticipated and was not completed until May 2005. However, FESC services were still being provided. Although the SEARHC demonstration site in Klawock is now fully staffed, it took longer than expected to fill the staff positions, which were budgeted for six months. The midlevel position was filled in May 2005, resulting in four months of time by the end of the grant. The physician was hired in July, resulting in just under two months of time charged to the grant. Nursing positions were filled in May and June, and experienced turnover. Full staffing levels were not achieved until May as well, and turnover in the fall resulted in vacancies in the FESC positions.

Cross Road Medical Center lost their FESC physician in June. A midlevel provider was recruited to take her place. Nursing vacancies were also experienced.

IFHS' renovation was not completed until September 2005, and the monitoring system is still being installed. When the demonstration started in the spring, IFHS had hired a new RN and a mid-level from grant funds and were fully staffed. However, over the summer

and early fall they lost a mid-level and several nursing staff members for a variety of reasons. They were able to hire a physician and are trying to recruit two RN's to return to the full staffing level they had in the spring.

Because the entire project took longer at each of the sites to implement than initially planned, there was $423,472 in unspent funds at the end of the project period. A no-cost extension has been requested.

SECTION 4: CONCERNS/BARRIERS

Grantee will address any concerns or barriers that have arisen and report if adequate steps have been identified to address the anticipated barriers.

Difficulty recruiting staff for demonstration sites – As detailed in Section 3 above, each of the sites experienced difficulty in recruiting and maintaining optimum staffing levels. These staffing difficulties represent a real, ongoing concern for frontier clinics. The evaluation is designed to measure the degree of staff satisfaction with increased staffing levels, but the variability may make the evaluation less valid. Vigorous recruiting efforts are ongoing.

Equipment needs became more apparent once project developed – It became obvious as the project progressed that additional equipment was needed to provide optimal services. For example, since personnel are on duty twenty four hours a day, seven days a week, the security system at Alicia Roberts Medical Center in Klawock needs to be improved.

Evaluation required additional expertise –Subcontractors were procured to assist with the financial analysis, a critical part of the evaluation. UAA subcontracted with Stroudwater and Associates and David Mather and Associates. UNC will utilize a current staff person to focus on the financial evaluation. This increased capacity is necessary to properly analyze the data, and to set up the analysis for the final evaluation report.

Recruitment and relocation expenses – Ongoing turnover in personnel at Klawock necessitated spending more for recruitment and relocation than previously anticipated.

SECTION 5: NEXT PERIOD ACTIVITIES

Grantee will identify continuing and new activities that will occur during the next period.

This is the final report for the first year of the Alaska FESC Consortium demonstration. As stated above, a no-cost extension has been requested to continue the activities of demonstration at each site.

A new Cooperative Agreement funds the activities of the Alaska FESC Consortium from September 1, 2005 through August 31, 2006.