Pine Ridge South Dakota Chronic Care Clinic Access

South Dakota Division of Medical Services

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As evidenced by the letter attached to the state's application, this proposal is supported by Larry Iversen, Director, South Dakota Division of Medical Services

Applicant Preference Request

Serving Rural or Underserved Medicaid Beneficiaries
This proposal will provide services to Medicaid beneficiaries in Shannon and Todd counties in South Dakota. Both counties are designated primary medical care Health Care Shortage Areas, and are Medically Underserved Areas by the Health and Resource Services Administration.

HPSA	ID#	Type	Score
113-Shannon County	146113	Single County	23
071-Jackson County	146071	Single County	23
007-Bennett County	146007	Single County	12
MUA/MUP	**ID#**	**Type**	
Shannon County	03151	MUA	
Jackson County	07591	MUA	
Bennett County	07026	MUA	

Partnership with Local Community Hospital
Delivery System Description
Regional Health is an integrated community based health care system of more than 40 health care facilities serving South Dakota, Wyoming and Nebraska. Regional Health offers a variety of specialized service through five community hospitals, eight senior care facilities, twenty-two clinics and 87 physicians, 64 mid-level providers, 4,200 employees and three centers of excellence including cancer treatment, rehabilitation, and behavioral services along with a multitude of other service. The system employs 87 employed physicians and 64 employed mid-level providers representing 15 different specialties including Audiology, Cardiac Surgery, Cardiology, Endocrinology, ENT, Family Medicine, General Surgery, Gynecology/Obstetrics, Internal Medicine, Nephrology, Neurosurgery, Pediatrics, Podiatry, Pulmonology, and Urology. The 22 clinics are in 15 separate locations located in the towns of Belle Fourche, Custer, Edgemont, Hill City, Lead-Deadwood, Newell, Rapid City, Spearfish, Sturgis, and Summerset in western South Dakota.
Length of Operation
Regional Health is a new company with a long history of healthcare in Rapid City South Dakota. The company's heritage began in 1910, with the founding of Methodist Deaconess Hospital. The heritage continued in the 1920's with the founding of St. John's Hospital. In 1979 a new single hospital facility was built, merging the two previous facilities. The system continued its growth acquiring several other healthcare facilities less than 10 years ago. More recently, Regional Health was founded as the "parent" company of Rapid City Regional Hospital, Regional Health Network, Western Health and Regional Health Physicians. The formation of Regional Health reflects the broadening of services available to the citizens of western South Dakota.
Impact to the Current Emergency Services Delivery System
It is anticipated there will be a 50% reduction in emergency room visits for emergent and non-emergent care for symptoms of diabetes, COPD, and CHF by people served by the specialty clinics. The reduction in emergency room visits will translate to lower costs for the Medicaid system.

Pine Ridge South Dakota Chronic Care Clinic Access
Abstract

Geography, lack of health care providers, poverty, reliance on public financing for health care, and health factors all converge in South Dakota and result in many areas of the state, particularly areas with a high concentration of American Indian people, where improvements in non-emergency health care access will provide fiscal and health outcome benefits.

According to the U.S. Census Bureau per capita income data, four of the top five poorest counties in the nation are in South Dakota (1. Buffalo; 2. Shannon; 4. Ziebach; 5. Todd). This proposal seeks to serve people in Shannon, Jackson, Bennett and surrounding counties that are part of the Pine Ridge Indian Reservation. These counties have a large per capita American Indian and Medicaid enrolled population. While the state average for emergency room use is not above the national rate, residents of certain counties including Todd have extremely high rates of emergency room use.

American Indians in South Dakota have several disparate health statuses compared to whites. According to the 2005 Behavioral Risk Factor Surveillance System survey, American Indians rate their general health status as “Fair” or “Poor” at a rate of 20%, compared to 13% of white South Dakotans. South Dakota American Indians had the highest death rate of any race/ethnic group in the nation. According to South Dakota Department of Health vital statistics, leading causes of death for American Indians in 2005 include heart disease (17%), cancer (15%), accidents (15%) diabetes (9%), lower respiratory illnesses (4%) and suicide (3%).

This project will increase access to non-emergency health care services that will result in less use of inpatient and emergency room services and improved health status for South Dakotans on the Pine Ridge Indian Reservation in Shannon and Todd Counties. Regional Health System will provide chronic disease management clinics for Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Diabetes and Warfarin management will be held twice a month staffed by a Board Certified Cardiologist, Endocrinologist or Internal Medicine physician, Registered Nurse and a P. C. Technician. Between clinics a Physician Assistant will accomplish follow-up visits through the aid of telemedicine functionality. On-site wellness classes will be available to all patients.

The project will impact approximately 210 individuals. The project will provide increased access to regular, non-emergency health care through specialized clinics to address chronic diseases that are prevalent in the American Indian population in South Dakota and cause unnecessary emergency room visits.

Pine Ridge South Dakota Chronic Care Clinic Access

Statement of Project Need

Geography, lack of health care providers, poverty, reliance on public financing for health care, and health factors all converge in South Dakota and result in many areas of the state, particularly areas with a high concentration of American Indian people, where improvements in non-emergency health care access will provide fiscal and health outcome benefits.

South Dakota is a geographically large state with an estimated population of 781,919 people. There are approximately 10 persons per square mile, compared to about 80 per square mile across the United States. It is also one of the least urbanized states; more than 50 percent of South Dakotans live in rural areas. In fact, only four counties in the state have more than 30,000 people. Nine Indian reservations are also located in the state, some of which are located in the poorest counties in the nation.

Access to most health care services, including primary care, is limited due to health care professional shortages in the state. Primary care Health Professional Shortage Areas exist in 55 of South Dakota's 66 counties, or 83% of all counties. Furthermore, 47 entire counties are considered by the Health and Resource Services Administration to be Medically Underserved. This represents 71% of the counties in the state. An additional 9 counties have Medically Underserved communities.

According to the U.S. Census Bureau per capita income data, four of the top five poorest counties in the nation are in South Dakota (1. Buffalo; 2. Shannon; 4. Ziebach; 5. Todd). This proposal seeks to serve people in Shannon, Jackson, Benentt and surrounding counties that are part of the Pine Ridge Indian Reservation. These counties have a large per capita American Indian and Medicaid enrolled population.

County	Total Pop.	AI Pop.	% AI	Medicaid Clients	% Pop on Medicaid	AI Medicaid Clients	% Medicaid
Buffalo	2,109	1,739	82.5%	848	40.2%	817	96.3%
Shannon	13,824	12,230	88.5%	6,436	46.6%	6,351	98.7%
Ziebach	2,706	1.970	72.8%	996	36.8%	962	96.6%
Todd	10,088	8,364	82.9%	4,925	48.8%	4,846	98.4%
Corson	4,288	2,832	66.0%	1,526	35.6%	1,412	92.5%
Dewey	6,112	4,538	74.2%	2,158	35.3%	2,044	94.7%
Jackson	2,900	1,547	53.3%	912	31.4%	811	88.9%
Bennett	3,543	2.157	60.9%	1,344	37.9%	1,244	92.6%
Mellette	2,099	1,211	57.7%	686	32.7%	632	92.1%
Charles Mix	9,224	2,989	32.4%	2,188	23.7%	1,720	78.6%
Statewide	781,919	72,298	9.2%	101,867	13.0%	36,641	36.0%

In state fiscal year 2007, 128,400 different people were covered by Medicaid for at least one month. American Indians are the largest racial minority in the state and comprise 9.2% % of the population and 36% of total Medicaid eligibles. Put another way, Medicaid covered 50% of all American Indians in South Dakota, and 80% of American Indian youth under age 20. The rate of emergency room use by South Dakota Medicaid eligibles is 74.2 per 100 eligibles for the latest twelve months available. This compares to a national rate of 80.3. 40% of all emergency room claims were for non-emergency care. This represents $5,713,666 in dollar value of claims.

The state rate of emergency room use has declined with the implementation of primary care case management in the state in 1996. Emergency room utilization, measured as a percentage of total claims to total eligibles, is 7% less today than it was prior to the implementation of primary care case management. While the state average for emergency room use is not above the national rate, residents of certain counties have extremely high rates of emergency room use. See table below.

County	Percent of eligibles with emergency room claim	Claim rate per 100 eligibles	Medicaid emergency room claim costs
Charles Mix*	69%	219.2	$1,087,043
Todd	58%	134.8	$1,523,052
Bennett	40%	64.9	$314,193
Shannon*	38%	65	$1,158,170
State	38%	74.2	$17,160,307

*Counties where Indian Health Service hospital and emergency room is currently located.

Actual use of emergency room services by Medicaid eligibles is likely understated due to IHS claim coding practices.

American Indians also have several disparate health statuses compared to whites. According to the 2005 Behavioral Risk Factor Surveillance System survey, American Indians rate their general health status as “Fair” or “Poor” at a rate of 20%, compared to 13% of white South Dakotans. South Dakota American Indians had the highest death rate of any race/ethnic group in the nation. According to South Dakota Department of Health vital statistics, leading causes of death for American Indians in 2005 include heart disease (17%), cancer (15%), accidents (15%) diabetes (9%), lower respiratory illnesses (4%) and suicide (3%).

The lack of access to primary care in South Dakota is serious. The lack of health care providers in South Dakota is aggravated by the vast geography that many people must travel to receive health care and reliance on public financing for payment for health care. This proposal will increase access to non-emergency health care services that will result in less use of inpatient and emergency room services and improved health status for South Dakotans on the Pine Ridge Indian Reservation in Shannon and surrounding counties. The project will provide increased access to regular, non-emergency health care through specialized clinics to address chronic diseases that are prevalent in the American Indian population in South Dakota and cause unnecessary emergency room visits.

Project Justification

Uncontrolled chronic disease creates significantly increased usage of hospital emergency rooms for what can be considered non-emergency care. Secondly, as the chronic disease progresses, the usage of the hospital emergency rooms shift from non-emergent to emergent with in some cases extended hospitalization. The key is the management of the chronic disease.

Three of the most prevalent chronic diseases include

1. Chronic Obstructive Pulmonary Disease (COPD)
2. Congestive Heart Failure (CHF)
3. Diabetes

One of the major treatments particularly in the elderly population is the use of oral anticoagulants specifically warfarin (Coumadin). Those individuals must undergo periodic blood tests to determine specific dosage requirements. The impact of non-compliance is significant medical problems with emergency room usage and hospitalization.

All three chronic diseases and the use of warfarin can be successfully managed through periodic visits with the appropriate specialist physician. The following is an in-depth look at each of the diseases and warfarin.

Chronic obstructive pulmonary disease (COPD) is a collective term for a group of chronic lung conditions, which obstruct the airways in the lungs. COPD normally refers to airway obstructions caused by chronic bronchitis and emphysema. It can also be caused by damage from chronic asthmatic bronchitis. With each of these diseases there is damage within the tubes and air sacs that comprise the lungs, which reduces the patient's ability to exhale, trapping air within the lungs making it difficult for the patient to breathe.

COPD is the fourth leading cause of death in America, with approximately 122,000 Americans dying of the disease every year. Early in this decade the number of women dying from the disease surpassed the number of men. In 2004, 11.4 million Americans were estimated to have COPD. It is estimated that close to 24 million U. S. adults have evidence of impaired lung function, indicating an under diagnosis of COPD. The economic cost of COPD is significant. In 2004, the cost of COPD was estimated to be $37.2 billion including healthcare expenditures of approximately $20.9 billion. The major cause of COPD is long-term smoking and can be prevented by not smoking or quitting. There is no reversal for the damage that has been done and no cure for the disease. COPD treatment is primarily controlling the symptoms and preventing further damage.

The management of this disease will be addressed through a COPD specialty clinic at or near the Pine Ridge Indian Reservation. The clinic will be held twice a month staffed by Board Certified Pulmonolgist, Registered Nurse and a Pulmonary Function Technician. Between clinics a Physician Assistant will accomplish follow-ups through the aid of telemedicine functionality. On-site wellness classes will be available to all patients.

Congestive heart failure (CHF) results from the inability of the heart to function enough to meet the body's needs. It is caused by any number of heart conditions such as coronary artery disease or high blood pressure. The heart condition damages the heart, leaving it too weak or stiff to fill and pump efficiently. CHF is a disabling chronic disease and the leading principal diagnosis for hospitalization among older adults. In the United States, approximately 5.0 million people have been diagnosed with CHF with 550,000 new cases diagnosed every year. The lifespan after diagnosis of these individuals are relatively short.

Newly diagnosed patients under the age of 65, approximately 80% of the men and 70% of the women will die within eight years.

In many cases, the conditions that lead to CHF cannot be reversed, but medications can improve the signs and symptoms of the disease and can lead to increased survival. Lifestyle changes can also help to alleviate CHF and improve the patient's quality of life.

The management of this disease will be addressed through a CHF specialty clinic at or near the Pine Ridge Indian Reservation. The clinic will be held twice a month staffed by Board Certified Cardiologist, Registered Nurse and a P. C. Technician. Between clinics a Physician Assistant will accomplish follow-ups through the aid of telemedicine functionality. On-site wellness classes will be available to all patients.

Diabetes specifically Type 2 is a chronic disease that affects the way a body metabolizes glucose which is the main source of fuel for the body. Known as adult onset or non-insulin dependent diabetes normally strikes the patient during their adult years and is strongly affected by their diet, physical activity and maintaining a health weight. Diabetes is the sixth leading cause of death in the United States. The Centers for Disease Control and Preventions estimates that 20.8 million people, 7% of the population, have diabetes and it's estimated that approximately 6 million of the 20.8 million are not aware that they have diabetes. Another 41 million people have prediabetes. Of the American Indian and Alaska Native populations, 12.8 percent aged 20 years or older who received care from the Indian Health Service in 2003 had diagnosed diabetes. Taking into account population age differences, American Indians and Alaska Natives are 2.2 times as likely to have diabetes as non-Hispanic whites. Type 2 diabetes is similar to Type 1, which is far less common and normally strikes adolescents. The pancreas producing little or no insulin causes Type 1 diabetes.

There is no cure for Type 1 diabetes but it can be effectively managed through changes in diet, physical activity and managing a healthy weight. In some cases, if these interventions are not enough, drugs can be used to manage the blood sugars.

The management of this disease will be addressed through a diabetes specialty clinic at or near the Pine Ridge Indian Reservation. The clinic will be held twice a month staffed by Board Certified Endocrinologist, Registered Nurse and a Diabetes Educator. Between clinics a Physician Assistant will accomplish follow-ups through the aid of telemedicine functionality. On-site wellness classes will be available to all patients.

Warfarin Management is vital to the health of the patient. Warfarin is used when there is a risk of blood clotting due to an illness, artificial heart valves, certain abnormal heart rhythms and defibrillators, pacemakers and diseases of the veins. Warfarin is the most widely used oral anticoagulant drug in North America. Patients taking warfarin must be closely monitored to ensure the level of anticoagulation is properly maintained. This is done through periodic usually monthly blood tests. Areas of additional concerns include the patient's diet, use of other medications and other medical concerns of the patient. Periodic monitoring of the drug side effects is also critical to the patients will being. Patient compliance is critical for the success of the drug as well as to alleviate any significant side effects.

The management of this disease will be addressed through a Warfarin specialty clinic at or near the Pine Ridge Indian Reservation. The clinic will be held twice a month staffed by Board Certified Internal Medicine physician, Registered Nurse and a lab technician. Between clinics a Physician Assistant will accomplish follow-ups through the aid of telemedicine functionality. On-site wellness classes will be available to all patients.

Project Goals and Outcomes

The overall project goal is to increase the health of those patients who have been diagnosed with CHF, COPD, and Type 2 Diabetes as well as those patients who take warfarin in the Pine Ridge Reservation in southwestern South Dakota. The outcome is a reduction of emergency room visits for non-emergent issues related to these diseases and warfarin drug effect. More importantly, the patients involved in this project will live healthier and longer lives.

Estimate of Impact to Beneficiaries

The target area for the clinics is the Pine Ridge Indian Reservation located in southwestern South Dakota. Each of the disease clinics (CHF, COPD, Diabetes) will be able to see approximately 20-25 patients per clinic with each patient being seen at least once per month. The warfarin clinic should be able to see 25-30 patients per day and again the patients to be seen at least once a month. Each of the disease clinics should be able to manage 50 patients per month for a total of 150 patients. The warfarin clinic should be able to manage approximately 60 patients. The grant will impact approximately 210 individuals.

Description of Magnitude of the Impact to Medicaid

The impact upon Medicaid of decreasing emergency room visits through improved primary care and preventive services in rural and underserved areas is substantial, in both financial terms and health outcomes. The geographical focus of this grant application does target Indian reservations, the rural areas in close proximity to them, and larger population centers that serve American Indians off the reservations. While nearly nine percent of the population in South Dakota is American Indian, thirty-six percent of the Medicaid enrolled individuals are American Indian. Increasing the capacity and access to primary care health services in these

counties or in communities where the residents of these counties travel to for care will directly impact the local community hospital emergency room expenditures.

The current data for emergency room utilization and costs for Shannon County is believed to be skewed due to claims coding irregularities. The data indicates the average number of recipients utilizing emergency room services to be 38% - equal to the statewide average. The average emergency room cost per recipient, $521, is also lower than the statewide average of $545.

Geographically, Shannon County is very similar to Todd County and the access to primary health care services is identical since there is no community hospital and only Indian Health Service to provide care. Todd County is part of the nearby Rosebud Indian Reservation. It is likely the true emergency room utilization and costs are closer to those in Todd County. These factors will be analyzed as part of the project and an accurate baseline of emergency room visit data and diagnostic information will be established for the target population. It is anticipated there will be a 50% reduction in emergency room visits for emergent and non-emergent care for symptoms of diabetes, COPD, and CHF by people served by the specialty clinics.

Description of Sustainability of Project

Long-term sustainability is critical if this proposal is to succeed. This proposal will enable a provider of enhanced primary care services to build a foundation and infrastructure, and then rely on Medicaid funding for covered services to cover the costs of ongoing operations.

Implementation of disease management programs that will allow for consultation with specialty staff onsite and via telemedicine will be sustained through Medicaid reimbursement of state plan covered services. In most cases, Medicaid funding covers the provider's costs of

delivering a particular service. Current Medicaid reimbursement policies for telemedicine dictate reimbursement for one site only – the site where the Medicaid client is present. In order to encourage the provision of more telemedicine and cover the cost of providing health care professionals at two sites, these policies will also be reconsidered to determine if reimbursing for staff at both sites is feasible.

Future discussions with provider associations regarding where to direct available inflation for reimbursement will include an emphasis on primary care services, urgent care services, and after-hours clinic care. This can be accomplished in a budget-neutral manner by applying savings attributable to reduced emergency room utilization to future increases to promote primary health care services. The true long-term savings to the Medicaid program will be in the improved health outcomes as a result of better primary healthcare services.

Evaluation Plan

To measure the effectiveness of these clinics, we would implement two measurement tools. The first is a survey that each patient will take at the beginning of the clinic whereby the patient indicates based on their perception their current health status and their current daily functionality. At the end of six and twelve months of treatment, the patient will be asked to re-take the survey to determine any changes in their perception of their health. The second measurement tool will be an examination of each patient's emergency room and hospitalization history for the past two years, which will become the baseline. Emergency room use and hospitalizations will be tracked during the grant time period to measure the cost impact from the clinic visits.

Description of Project Implementation Readiness

Regional Health is ready and able to implement this grant. Regional Health is an integrated community based health care system of more than 40 health care facilities serving South Dakota, Wyoming and Nebraska. We are dedicated to ensuring communities' access to an array of comprehensive health care services featuring advanced technologies and highly skilled professionals.

Regional Health offers a variety of specialized service through five community hospitals, eight senior care facilities, twenty-two clinics and 87 physicians, 64 mid-level providers, 4,200 employees and three centers of excellence including cancer treatment, rehabilitation, and behavioral services along with a multitude of other service. Our 87 employed physicians and 64 employed mid-level providers representing 15 different specialties including Audiology, Cardiac Surgery, Cardiology, Endocrinology, ENT, Family Medicine, General Surgery, Gynecology/Obstetrics, Internal Medicine, Nephrology, Neurosurgery, Pediatrics, Podiatry, Pulmonology, and Urology. The 22 clinics are in 15 separate locations located in the towns of Belle Fourche, Custer, Edgemont, Hill City, Lead-Deadwood, Newell, Rapid City, Spearfish, Sturgis, and Summerset in western South Dakota. Regional Health is well equipped to implement this grant.

Regional Health through its Regional Health Physician subsidiary currently employs all of the physicians, mid-levels and nurses for these clinics. The positions that will need to be filled include the technicians and administrative staff. Additionally dedicated equipment must be purchased and delivered. T-1 data lines will need to be installed to provide connectivity with Regional Health's information systems. Finally, the clinic will need to be advertised to the

population. The proposed opening date of the clinics would be the week of December 17, 2007. The following is a chart of tasks and projected completion dates.

	November				December			
Task List	5	12	19	26	3	10	17	Status
Order teleradiology equipment								Pending
Install teleradiology equipment								Pending
Install T1data lines								Pending
Order medical equipment								Pending
Install medical equipment								Pending
Purchase vehicle								Pending
Advertise required staff								Pending
Interview required staff								Pending
Hire required staff								Pending
Develop advertising campaign								Pending
Implement advertising campaign								Pending
Open Clinic Doors								Pending
Milestones								

Each of the tasks listed can be accomplished within the current Regional Health infrastructure and can be quickly implemented. Funding of this proposal will allow these critical services to be developed and implemented.

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BUDGET

	Year 1	Year 2	Total
Federal Grant	$823,881	$662,358	$1,486,239

In-Kind			
Total	$823,881	$662,358	$1,486,239

Budget - Pine Ridge Chronic Care Clinic Access

Budget			**Year 1**	**Year 2**
			Federal Grant $	**Federal Grant $**
Personnel	*Salary*	*Time*		
Physician (Specialist)	$ 369,231	0.52 FTE	$ 192,000	$ 199,680
Mid-Level Practioner	$ 75,363	0.31 FTE	$ 23,362	$ 24,297
RN	$ 48,500	0.52 FTE	$ 25,220	$ 26,229
Diabetes Educator	$ 30,000	0.31 FTE	$ 9,300	$ 9,672
PFT Tech	$ 30,000	0.13 FTE	$ 3,900	$ 4,056
Wellness Coordinator	$ 35,000	1.00 FTE	$ 35,000	$ 36,400
PC Tech	$ 30,000	0.13 FTE	$ 3,900	$ 4,056
Receptionist	$ 25,000	0.52 FTE	$ 13,000	$ 13,520
Lab Tech	$ 30,000	0.13 FTE	$ 3,900	$ 4,056
Personnel sub-total			**$ 309,582**	**$ 321,966**
Fringe Benefits				
Calculated @ 25%			$ 77,396	$ 80,492
Fringe sub-total			**$ 77,396**	**$ 80,492**
Travel				
Travel			$ 7,000	$ 7,280
Travel sub-total			**$ 7,000**	**$ 7,280**
Contractual				
Lab Fees			$ 38,280	$ 39,811
Transcriptions			$ 8,820	$ 9,173
Professional Liability			$ 11,693	$ 12,161
Other Insurance			$ 1,000	$ 1,040
Advertising			$ 4,000	$ 4,160
Telephone			$ 7,800	$ 8,112
Data Lines			$ 7,500	$ 7,800
Data & Information			$ 20,000	$ 20,800

System		
Equipment Rent	$ 4,500	$ 4,680
Office Rent	$ 14,400	$ 14,976
Misc.	$ 12,000	$ 12,480
Disease Mgmt Classes	$ 63,000	$ 65,520
Contractual sub-total	**$ 192,993**	**$ 200,713**
Supplies		
Office Supplies	$ 2,520	$ 2,621
Medical Supplies	$ 6,300	$ 6,552
Pharmaceutical Supplies	$ 5,040	$ 5,242
Supplies sub-total	**$ 13,860**	**$ 14,415**
Equipment		
Transportation Van	$ 32,000	$ -
Teleradiology Equipment	$ 100,000	$ -
A1C Analyzer	$ 15,000	$ -
Portable Ultrasound	$ 40,000	$ -
Equipment Sub-total	**$ 187,000**	**$ -**
Total Direct Charges	**$ 787,831**	**$ 624,866**
Indirect		
Indirect Costs	$ 36,050	$ 37,492
Indirect Sub-total	**$ 36,050**	**$ 37,492**
TOTALS	**$ 823,881**	**$ 662,358**

Budget Narrative

Personnel – The number of Full Time Equivalents (FTE's) for physicians are based on two-7 hour clinics per month plus travel time from Rapid City, SD to Pine Ridge, SD. Salary rtes are based upon current physician contracted compensation. The rate varies based on the type of physician; Endocrinologist, Internal Medicine, Cardiologist, Pulmonologist as examples. A Mid-Level Practioner is based on approximately 24 hours of patient follow up calls two weeks per month (non-clinic weeks). A Wellness Coordinator role will be to coordinate and schedule

patients into required nutritional, disease management/prevention and wellness classes. All other positions are based upon the requirements of the clinics and clinic hours. **Fringe Benefits –** Benefits are budgeted at 25% salaries and wages. **Travel –** Travel includes fuel and maintenance for the transportation van that will be used for travel to and from Pine Ridge Indian Reservation. **Contractual –** Lab Fees are based on expected Warfarin blood tests performed locally. Transcription fees are for the transcriptions of medical records and physician dictation. Professional liability is for current cost of malpractice insurance. Other insurance is primarily automobile insurance for the transportation van. Advertising is for the costs of mailing information to perspective clinic patients. Telephone, long distance and data lines are for connectivity back to Regional Health as well as the long distance costs for contacting patients between appointments. Data and information systems are costs for access for scheduling, billing, and medical records. Equipment rent is for the rent of an EKG machine. Office rent is for rental of clinic space in the Pine Ridge area. Disease management costs are for classes that include smoking cessation, exercise and physical activity, weight management, diabetes management, lipid management, blood pressure management, stress management and personal relationship classes. **Supplies –** This includes standard disposable clinic supplies including bandages, syringes, sutures, and a variety of medications. It also includes office supplies (folders, paper, receipts, etc.). **Equipment –** This includes a transportation van for $32,000, Teleradiology Equipment for $100,000, A1C Analyzer for $15,000 and a portable ultrasound for $40,000 under year 1 of the proposal.

Year Two – Overall inflation for the clinic expenses are expected to be 4%.