South Dakota Telehealth Urgent Care Clinic Project

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 three communities to be determined located in counties that are designated Health Professional Shortage Areas and Medically Underserved Areas. Primary care Health Professional Shortage Areas exist in 55 of South Dakota's 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.

Partnership with Local Community Hospital

Delivery System Description

Avera is a regional healthcare system based in South Dakota. Avera is a faith-based health system whose mission is to make a positive impact in the lives and health of persons and communities by providing quality services. Avera's focus is to increase access to health services and to promote health and safety for rural residents.

Avera Health is affiliated with health care facilities in South Dakota, Iowa, Minnesota, Nebraska, and North Dakota. Through support services, Avera provides assistance to 227 affiliated hospitals, clinics, long-term care facilities, and mental health centers in 90 communities. Twenty-eight hospitals, including 24 Critical Access Hospitals (CAHs), over 100 clinics, and 40 long term care centers make up the majority of Avera Health's providers. The facilities are staffed by over 12,000 employees throughout the five-state region.

Avera has long been identified as a leader in telehealth activities in the five-state region. To date, Avera Health has videoconferencing units located in approximately 90 points and in 42 different communities, hospitals, clinics, classrooms and boardrooms around the system. The availability of videoconferencing and other telehealth technologies [i.e. teleradiology, and electronic intensive care units (EICU)] has become an expectation as a function of the business of healthcare in this region.

Recently, Avera Health and partner organizations were awarded a prestigious Office for the Advancement of Telehealth, Telehealth Resource Center grants. Avera Health was also the first healthcare system to provide access to critical care services to rural sites using fixed eICU® technology (ICU telehealth), and is the first to Beta test mobile eCare® Mobile.

Length of Operation

Avera's dedication to rural health care stretches back to the mission of its founders. The Benedictine and Presentation Sisters opened a number of frontier hospitals in Dakota Territory in the 19th century. The merger of these two groups came in the founding of Avera Health in 1998, with the creation of the corporate entity of the largest healthcare system in South Dakota.

Impact to the Current Emergency Services Delivery System

The South Dakota Telehealth Urgent Care Clinic Pilot Project will operate through the use of contracted physicians employed by Avera McKennan Hospital & University Health Center in Sioux Falls, South Dakota, Avera Health's largest tertiary care facility. This is indicated in the attached letter of support. The program will positively impact the current emergency care delivery system by reducing the number of inappropriate visits made to South Dakota emergency rooms. Through use of telehealth, 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 in selected counties. In order for the project to be sustainable, the clinic must see at least one patient per hour during extend hours. The clinics will be open for 3 additional hours each week night. This equates to at least 2,800 patients per year over the three clinic sites. It estimated that 2,800 patient visits will be impacted in three rural South Dakota communities, resulting in 2,800 fewer ER visits.

South Dakota Telehealth Urgent Care Clinic Project
Abstract

Geography, lack of health care providers, 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.

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 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.

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 8.8 % of the population and 36% of total Medicaid eligibles. 40% of all emergency room claims billed to Medicaid in the last year were for non-emergency care. This represents $5,713,666 in dollar value of claims. 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.

American Indians in South Dakota 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, cancer, accidents, diabetes, lower respiratory illnesses and suicide.

The South Dakota Telehealth Urgent Care Clinic Pilot Project provides a unique solution to these needs and challenges. It allows patients to receive local primary care, after hours, in their home clinic. Three pilot sites will be selected and will each have a nurse facilitate needed urgent care through advanced telehealth technology linked to an urgent care physician located in an urban community in the state. By providing telehealth consults, one provider is able to assist many remote sites with smaller volumes. Additional staffing is only needed for the RN to facilitate the visits. This not only stretches staffing dollars, but makes better use of the physician's time, and allows the patient convenient access to after hours care, thus reducing the number of unnecessary emergency room visits. This service will offer the additional benefit of providing local access to specialty consults, making it easier for individuals to seek timely care for management of serious chronic conditions, such as diabetes and chronic heart failure. This in turn, has been shown to improve disease management and reduce ER visits.

The provision of this service will decrease inappropriate emergency room use, increase access to urgent care, and result in better health outcomes for South Dakotans in rural counties.

South Dakota Telehealth Urgent Care Clinic Project

Statement of Project Need

Geography, lack of health care providers, 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.

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). Additional counties with high poverty rates are Corson Co. (7); Dewey Co. (11); Jackson Co. (23); Bennett Co. (25); Mellette Co. (32); and Charles Mix Co. (80). 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%
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%

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.

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.

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.

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
Ziebach	81%	274.1	$678,994
Dewey*	80%	283.1	$1,482,182
Charles Mix*	69%	219.2	$1,087,043
Todd	58%	134.8	$1,523,052
Bennett	40%	64.9	$314,193
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 may be 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 Telehealth Urgent Care Clinic Pilot Project provides a unique solution to these needs and challenges. It allows patients to receive local primary care, after hours, in their home clinic. Three pilot sites will be selected and will each have a nurse facilitate needed urgent care through telehealth technology linked to an urgent care physician located in an urban community in the state. The provision of this service will decrease inappropriate emergency room use, increase access to urgent care, and result in better health outcomes for South Dakotans in rural counties.

Project Justification

Local data has shown that urban emergency departments see fewer non-emergent patients per total visits than rural ERs. For the most part, this is a case of access. While urban areas are able to support various forms of after-hours primary care, rural locations do not have the patient volume to make such extended hours available. In many rural counties, the emergency room is the only option for patients seeking non-emergent care after five o’clock.

Because of small volumes, limited resources, and provider recruitment and retention issues, a traditional urgent care scenario is not possible. There are not enough prospective patients in certain areas of the state to financially support hiring additional providers. In the proposed project, a physician consult is provided through telehealth and videoconferencing equipment by an urgent care physician on-duty in an urban center. This physician interacts with the patient just as if they were present, through the aid of two-way audio video, examination camera, stethoscope and otoscope. A registered nurse facilitates the visit and coordinates the local care.

By providing telehealth consults, one provider is able to assist many remote sites with smaller volumes. Additional staffing is only needed for the RN to facilitate the visits. This not only stretches staffing dollars, but makes better use of the physician's time and allows the patient convenient access to after hours care, thus reducing the number of unnecessary emergency room visits. This service will offer the additional benefit of providing local access to specialty consults, making it easier for individuals to seek timely care for management of serious chronic conditions, such as diabetes and chronic heart failure. This in turn, has been shown to improve disease management and reduce ER visits.

Three communities will be selected to pilot the delivery of telehealth services after normal clinic hours. Communities will be selected on the basis of current Medicaid funded emergency room use per population, Medicaid funded emergency room claim rates compared to the state average, percentage of Medicaid eligibles compared to the state average, official Health Professional Shortage Area and Medically Underserved designations, local buy-in and availability of local clinic space to control initial costs. The selection of communities will be completed by a public-private team that includes representatives of the South Dakota Medicaid

agency, the South Dakota Department of Health, Avera Health Care System, and potential local community stakeholders.

Project Goals and Outcomes

Goal #1: Select three rural communities by January, 2008.

Goal #2: Provide alternative urgent care option for three rural communities by May, 2008.

Outcome: Increase number of preventive care visits

Outcome: Increase perceived health status of participants

Goal #3: Reduce non-emergent ER visits in selected rural areas by October 30, 2009.

Outcome: Save physician resources that are scarce in rural communities

Outcome: Save hospital costs by lessening ER visits

Goal #4: Provide a wider array of specialized services through the use of telehealth technology by October 30, 2009.

Outcome: Reduce unnecessary travel/transportation of patients

Outcome: Reduce ER visits because broader scope of services offered at the clinic

Estimate of Impact to Beneficiaries

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 in selected counties. In order for the project to be sustainable, the clinic must see at least one patient per hour. The clinics will be open for 3 additional hours each week night. This equates to 2,800 patients per year over the three clinic sites. While the clinics will be open for 18 months under the grant period, it is expected to take time to "grow the program" and inform community members of its availability. Therefore it estimated that 2,800 patient visits will be impacted in three rural South Dakota communities, resulting in 2,800 fewer ER visits.

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, not only in financial terms but also in health outcomes. Transportation issues, particularly for areas with no community hospital or Indian Health Services facility either in the area or one that has an operational emergency room, result in serious hurdles in accessing timely and appropriate care. Location and availability of primary care services will reduce transportation expenditures and relieve some of the pressures involved in finding transportation in rural and tribal areas.

The three top primary diagnosis for emergency room claims in the state are acute upper respiratory infection; otitis media (middle ear infection); and acute pharyngitis (sore throat). Available data suggests that many who visit the emergency room in a given year are repeat users of emergency room services. The implementation of this project will result in a reduction of emergency room visits and associated costs for non-emergent needs in the target communities.

Description of Sustainability of Project

Long-term sustainability is critical if this proposal is to succeed. Third party payment for services will be sought aggressively. The South Dakota Department of Health has committed to investigating possible sources of funding to sustain this project after the grant funding ends, which is consistent with the Department's focus on rural health care development. The Department of Social Services, which houses the Medicaid agency, has also committed to assist with sustaining the project. In most cases, Medicaid funding should cover the provider's costs of delivering a particular service to Medicaid eligibles. Current Medicaid reimbursement policies for telehealth services dictate reimbursement for one site only – the site where the Medicaid provider is present. In order to encourage the provision of more telemedicine and cover the cost

of providing health care professionals at two sites (RN at end-user site, provider at hub site), these policies will be analyzed to determine how they can be modified to provide support for the full costs of providing telehealth services. Any changes may be accomplished in a budget-neutral manner by applying savings attributable to reduced emergency room utilization. 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

Effectiveness of the South Dakota Telehealth Urgent Care Clinic Pilot Project will be determined by measuring various factors to determine if the following occurs: an increase in the number of local health care visits outside of existing clinic hours, reduction in number of emergency room visits for non-emergency care, reduced travel for emergency room care, increased use of specialty services via telehealth to manage chronic conditions, reduced costs associated with emergency room visits for target population, and increased patient perception of health status. These elements will be measured and reported quarterly by South Dakota Medicaid representatives and Avera Health Systems. Baselines of all measures will be developed during the first quarter of service delivery.

Description of Project Implementation Readiness

Task	**Completion Date**	**Milestones**	**Status**
Grant awarded/project initiated	October 31, 2007	Grant awarded	October 31, 2007
Site selection	January 1, 2008	Three communities selected	October 31, 2007-January 1, 2008
Network planning & implementation	January 1, 2008	Network planning completed & implementation initiated.	October 31, 2007-January 1, 2008
Policies and procedures developed & established	January 15, 2008	Policies and procedures are developed and in place.	November 26, 2007-January 15, 2008

Order equipment	January 15, 2008	Equipment ordered	November 28, 2007- January 15, 2008
Equipment Installation – McGreevy Clinic	January 17, 2008	McGreevy Clinic equipment installed	January 5, 2008- January 17, 2008
Partner project planning meetings held	March 1, 2008	Monthly partner planning meetings held	October 31, 2007- March 1, 2008
Additional Staff Hired	March 1, 2008	Network Director and additional staff hired	January 1, 2008- March 1, 2008
Marketing plan developed	March 1, 2008	Marketing plan developed & implemented	December 1, 2007- March 1, 2008
Testing	March 11, 2008	System tests completed	January 9, 2008- March 11, 2008
Training & implementation	March 11, 2008	Staffs trained & systems implemented	January 11, 2008- March 11, 2008
Install equipment @ Site #1	February 15, 2008	Site #1 equipment installed.	February 1, 2008- February 15, 2008
Go Live Site #1	February 28, 2008	Site #1 is live	February 28, 2008
Install equipment @ Site #2	March 15, 2008	Site #2 equipment installed.	March 1, 2008- March 15, 2008
Go Live Site #2	March 30, 2008	Site #2 is live	March 30, 2008
Install equipment @ Site #3	April 15, 2008	Site #3 equipment installed.	April 1, 2008- April 15, 2008
Go live Site #3	April 30, 2008	Site #3 is live	April 30, 2008
Baseline development and report	July 30, 2008	Initial evaluation activities completed	February 28, 2008- July 30, 2008
Quarterly reporting	1. Feb.28, 2008 2. May 30, 2008 3. Aug. 31, 2008 4. Nov. 30, 2008 5. Feb. 28, 2009 6. May 30, 2009 7. Aug. 31, 2009 8. Nov. 30, 2009	Quarterly evaluation activities completed & report completed.	1. Nov. 1, 2007-Jan. 31, 2008 2. Feb. 1, 2008-April 30, 2008 3. May 1, 2008-July 31, 2008 4. Aug. 1, 2008-Oct. 31, 2008 5. Nov. 1, 2008-Jan. 31, 2009 6. Feb. 1, 2009-April 30, 2009 7. May 1, 2009-July 31, 2009 8. Aug. 1, 2009-Oct. 31, 2009

BUDGET

	Year 1	Year 2	Total
Federal Grant	$301,146	$191,809	$492,955
In-Kind	$16,063	$16,705	$32,768
Total	$317,209	$208,514	$525,723

Budget – Telehealth Urgent Care Clinic Project

			Year 1 Federal Grant $	Year 1 In-Kind $	Year 1 Total $
Personnel	*Salary*	*Time*			
RN Site 1	$ 50,500	0.50 FTE	$ 25,250		$ 25,250
RN Site 2	$ 50,500	0.50 FTE	$ 25,250		$ 25,250
RN Site 3	$ 50,500	0.50 FTE	$ 25,250		$ 25,250
Administrative Hub 1	$ 28,280	0.22 FTE	$ 6,222		$ 6,222
Administrative Hub 2	$ 28,280	0.22 FTE	$ 6,222		$ 6,222
Administrative Hub 3	$ 28,280	0.22 FTE	$ 6,222		$ 6,222
Network Director	$ 50,000	0.50 FTE	$ 12,500	$ 12,500	$ 25,000
Personnel sub-total			**$ 106,916**	**$ 12,500**	**$ 119,416**
Fringe Benefits					
RN Site 1			$ 7,196		$ 7,196
RN Site 2			$ 7,196		$ 7,196
RN Site 3			$ 7,196		$ 7,196
Administrative Hub 1			$ 1,773		$ 1,773
Administrative Hub 2			$ 1,773		$ 1,773
Administrative Hub 3			$ 1,773		$ 1,773
Network Director			$ 3,563	$ 3,563	$ 7,126
Fringe sub-total			**$ 30,470**	**$ 3,563**	**$ 34,033**
Contractual					
Site Fee			$ 3,000	$ -	$ 3,000
Contractual sub-total			**$ 3,000**	**$ -**	**$ 3,000**
Supplies					
Medical Supplies			$ 6,000	$ -	$ 6,000
Supplies sub-total			**$ 6,000**	**$ -**	**$ 6,000**

Equipment			
Video Unit (6)	$ 76,032		$ 76,032
Stethoscope (3)	$ 4,950		$ 4,950
Stethoscope Receiving Station (3)	$ 3,525		$ 3,525
Otoscope (3)	$ 45,000		$ 45,000
Examination Camera (3)	$ 16,470		$ 16,470
Equipment Sub-total	**$ 145,977**	**$ -**	**$ 145,977**
Total Direct Charges	**$ 292,363**	**$ 16,063**	**$ 308,426**
Indirect			
Indirect Costs	$ 8,783	$ -	$ 8,783
Indirect Sub-total	**$ 8,783**	**$ -**	**$ 8,783**
TOTALS	**$ 301,146**	**$ 16,063**	**$ 317,209**

Year 1 Budget Narrative

Personnel - Three RNs will be hired and each will staff an end user site, facilitating patient visits and coordinating local care. Three administrative positions will be hired and each will provide assistance at a hub site, setting up teleconferencing visits and coordinating physician visits. One Network Director will be hired to facilitate purchase of equipment, development of protocols, implementation of equipment, and testing and training. The Network Director will also be responsible for financial management, evaluation activities, sustainability planning, and identifying opportunities for strategic growth.

Fringe Benefits - Fringe benefits include a standard benefits package, including health insurance, retirement support, unemployment insurance, etc. Fringe benefits are estimated at 28.5% of salaries.

Contractual - $3,000 is budgeted for site fees ($1,000 per site). This fee is meant to pay for costs associated with additional clinic hours including utilities, billing, and administrative hours.

Supplies - $6,000 is budgeted for standard medical and office supplies ($2,000 per site). This includes standard disposable clinic supplies including bandages, syringes, sutures, and a variety of medications. It also includes administrative supplies (folders, paper, receipts, etc.).

Equipment - $145,977 is budgeted for telehealth equipment.

Video Unit ($12,672 X 6 units = $76,032)

Stethoscope ($1,650 X 3 units = $4,950)

Stethoscope Receiving Station ($1,175 X 3 units = $3,525)

Otoscope ($15,000 X 3 units = $45,000)

Examination Camera ($5,490 X 3 units = $16,470)

Equipment	**Location**	**Purpose**
Video Unit	End User & Hub Sites	Videoconferencing
Telephony Stethoscope	End User Sites	Transfers audio via data lines
Stethoscope Receiving Station	Hub Sites	Receiver for Telephony Stethoscope
Otoscope	End User Sites	Otoscope, transfers visual feeds
Examination Camera	End User Sites	Allows for live video feeds

Budget			**Year 2**	**Year 2**	**Year 2**
			Federal Grant $	**In-Kind $**	**Total $**
Personnel	*Salary*	*Time*			
RN Site 1	$ 52,520	0.625 FTE	$ 32,825		$ 32,825
RN Site 2	$ 52,520	0.625 FTE	$ 32,825		$ 32,825
RN Site 3	$ 52,520	0.625 FTE	$ 32,825		$ 32,825
Administrative Hub 1	$ 29,411	0.25 FTE	$ 7,353		$ 7,353
Administrative Hub 2	$ 29,411	0.25 FTE	$ 7,353		$ 7,353
Administrative Hub 3	$ 29,411	0.25 FTE	$ 7,353		$ 7,353
Network Director	$ 52,000	0.50 FTE	$ 13,000	$ 13,000	$ 26,000
Personnel sub-total			**$ 133,534**	**$ 13,000**	**$ 146,534**
Fringe Benefits					
RN Site 1			$ 9,355		$ 9,355
RN Site 2			$ 9,355		$ 9,355
RN Site 3			$ 9,355		$ 9,355
Administrative Hub 1			$ 2,096		$ 2,096
Administrative Hub 2			$ 2,096		$ 2,096
Administrative Hub 3			$ 2,096		$ 2,096
Network Director			$ 3,705	$ 3,705	$ 7,410
Fringe sub-total			**$ 38,058**	**$ 3,705**	**$ 41,763**
Contractual					
Site Fee			$ 3,120	$ -	$ 3,120
Contractual sub-total			**$ 3,120**	**$ -**	**$ 3,120**
Supplies					
Medical Supplies			$ 6,240	$ -	$ 6,240
Supplies sub-total			**$ 6,240**	**$ -**	**$ 6,240**
Total Direct Charges			**$ 180,952**	**$ 16,705**	**$ 197,657**

Indirect			
Indirect Costs	$ 10,857	$ -	$ 10,857
Indirect Sub-total	**$ 10,857**	**$ -**	**$ 10,857**
TOTALS	**$ 191,809**	**$ 16,705**	**$ 208,514**

Year 2 Budget Narrative

Personnel -A 4% cost of living adjustment is included for all salaries. Three RNs will staff an end user site, facilitating patient visits and coordinating local care. Three administrative positions will provide assistance at a hub site, setting up teleconferencing visits and coordinating physician visits. One Network Director will facilitate purchase of equipment, development of protocols, implementation of equipment, and testing and training. The Network Director will also be responsible for financial management, evaluation activities, sustainability planning, and identifying opportunities for strategic growth.

Fringe Benefits - Fringe benefits include a standard benefits package, including health insurance, retirement support, unemployment insurance, etc. Fringe benefits are estimated at 28.5% of salaries.

Contractual - $3,120 is budgeted for site fees ($1,040 per site). This fee is meant to pay for costs associated with additional clinic hours including utilities, billing, and administrative hours.

Supplies -$6,240 is budgeted for standard medical and office supplies ($2,080 per site). This includes standard disposable clinic supplies including bandages, syringes, sutures, and a variety of medications. It also includes administrative supplies (folders, paper, receipts, etc.).

Equipment - None