Urgent Care Clinic Development- Wagner, SD

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 four counties in southeastern South Dakota. All four counties have designated primary medical care Health Care Shortage Areas, and are Medically Underserved Areas by the Health and Resource Services Administration.

HPSA	ID#	Type	Score
Charles Mix County	146023	Single County	7
Bon Homme County	146009	Single County	6
Douglas County: Corsica/Armour	1469994634	Geographic Area	10
Gregory County: Fairfax SA	1469994638	Geographic Area	17
MUA/MUP	**ID#**	**Type**	
Charles Mix County	07031	MUA	
Bon Homme County	07027	MUA	
Douglas County	03126	MUA	
Gregory County	03131	MUA	

Partnership with Local Community Hospital
Delivery System Description
Avera is a regional healthcare system based in South Dakota. 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. 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.

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. Wagner Community Memorial Hospital Avera is a 20-bed Critical Access Hospital, and part of the Avera network. The local community hospital has committed to the project goals and activities, as well as to providing in-kind support for grant project management. Please see attached letter of commitment. All project staff will be employed by the hospital and urgent care space will built on to the existing hospital infrastructure.

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 current emergency services system is understaffed and overburdened. With anticipated closure of the local Indian Health Service ER in December, the condition of the emergency system is expected to further deteriorate due to an influx of patients and reduction in the number of local providers. The proposed project will positively impact the current emergency system by providing alternative non-emergency care in the form of an urgent care clinic. It is estimated that 1800 visits, representing several hundred people, will be made to the urgent care clinic. Hours of available non-emergency health care will increase by 83%.

Urgent Care Clinic Development- Wagner, SD
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. Wagner, South Dakota is located in Charles Mix County. Charles Mix County and surrounding counties have Health Professional Shortage areas and are considered Medically Underserved per the federal Health and Resources Services Administration. Charles Mix County per capita income ranks it as 80th poorest county in the nation, and the county has a large per capita American Indian and Medicaid enrolled populations. Furthermore, Medicaid recipients in Charles Mix County have numbers of emergency room visits and claim rates far higher than the state average.

American Indians in this part of the state are currently served by an Indian Health Service (IHS) emergency room but this service will be discontinued in December 2007. The anticipated pressure on other existing health care resources is great, and there is a critical need to prepare for this change. Providing urgent care services outside the existing clinic's business hours will help treat the health care needs of American Indians and others in this rural area of the state.

This project proposes to open an urgent care clinic, to provide services from 5pm to 10pm Monday through Friday and Saturday 10am to 5pm, thus almost doubling the current available hours of non-emergency health care services in this community. Currently there is no available building capacity for offering urgent care. The clinic rooms are small, and not able to be renovated to house urgent care equipment. This project will allow for three clinic rooms to be contracted and outfitted for urgent care needs. Additionally, a provider will be hired to cover the extended shifts. It is estimated that 1800 visits, representing several hundred people, will be made to the urgent care clinic.

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. South Dakota American Indians had the highest death rate of any race/ethnic group in the nation. 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. 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%), and lower respiratory illnesses (4%).

This project will provide greater access to non-emergency care through the creation of an urgent care clinic in Wagner, SD. The result will be greater heath outcomes for the population of Charles Mix and surrounding counties, which include a large American Indian population. The project will also result in Medicaid cost avoidance from expensive emergency room visits to urgent and primary care costs.

URGENT CARE CLINIC DEVELOPMENT- WAGNER, SD

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.

The geographical focus of this grant application includes the Yankton Sioux Indian reservation and surrounding rural counties. 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%
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%

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
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%).

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 Charles Mix and surrounding counties. American Indians in this part of the state are currently served by an IHS emergency room but this service will be discontinued in December 2007. The anticipated pressure on other existing health care resources is great, and there is a critical need to prepare for this change. Providing urgent care services outside the existing clinic’s business hours will help triage and treat the health care needs of American Indians and others in this rural area of the state. The project will almost double the current available hours of non-emergency health care services in this community.

Project Justification

Wagner Community Memorial Hospital/Avera is one of two hospitals located in Wagner, South Dakota. Along with Wagner Indian Health Services Unit, Wagner Community Memorial

currently serves a population of 6,844 people in the surrounding area. The community of Wagner is located on the Yankton Sioux Indian Reservation.

Currently, two full-time physicians serve Wagner Community Memorial Hospital and its associated clinic. The clinic operates from 9am to 5 pm Monday through Friday, in a cramped space in an aging facility. The nearest after-hours care is available in Yankton, SD (57 miles) or Mitchell, SD (59 miles). Presently, Wagner Community Memorial Hospital sees 4-6 non-emergent cases in their emergency room each night. With the anticipated closure of the Indian Health Services (IHS) emergency room in December of 2007, this number is expected to increase substantially, thus increasing the need for after-hours primary care services. This project proposes to open an urgent care clinic, to provide services from 5pm to 10pm Monday through Friday and Saturday 10am to 5pm.

Plans for construction of an addition to the clinic facility are currently being considered. As a part of this process, the needed clinic space will be added. Currently there is no available capacity for offering urgent care. The clinic rooms are small, and not able to be renovated to house urgent care equipment. When building the addition, three clinic rooms will be outfitted for urgent care needs. Additionally, a provider needs to be hired to cover the extended shifts. By providing urgent care in a setting that is familiar to area residents, the program hopes to increase utilization of this resource, and reduce utilization of the emergency room in non-emergent cases by five visits each night or approximately 1,800 visits a year (estimate of 5 visits per night multiplied by 365 days per year).

The service area for the Wagner urgent care clinic includes Charles Mix, Douglas, Bon Homme, and Gregory counties in South Dakota, and Boyd, Holt, and Knox counties in Nebraska. All of these counties are federally designated Medically Underserved Areas (MUAs),

and federally designated health professional shortage areas (HPSAs) for primary care, mental health, and dental services. This project will help to alleviate existing health care access needs. 31.8% of the population of Charles Mix County is estimated to be uninsured. One fourth of people in Charles Mix County have Medicaid coverage, and 69% of these eligibles had an emergency room claim in the last 12 months. Statistics are similarly disheartening in surrounding counties.

Project Goals and Outcomes

Goal #1: Provide additional access to primary care by offering extended clinic hours in the community of Wagner, SD by October 31, 2008.

Outcome: Residents from the surrounding seven county area, in excess of the current 6,844 residents served, will have access to urgent care with 30 miles of their homes.

Outcome: 1800 visits will be made to the urgent care clinic per year

Outcome: 1800 fewer non-emergent visits to the emergency room

Estimate of Impact to Beneficiaries

The service area for the Wagner urgent care clinic includes Charles Mix, Douglas, Bon Homme, and Gregory counties in South Dakota, and Boyd, Holt, and Knox Counties in Nebraska. It is estimated that 1800 visits, representing several hundred people, will be made to the urgent care clinic. Hours of available non-emergency health care will increase by 83%.

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. 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.

Total Medicaid emergency room expenditures for the last 12 months in Charles Mix County, which is where the community hospital is located, were $1.08 million. The average per visit cost for each Medicaid recipient who utilized emergency room services was $841. The financial impact of reducing emergency room use by 1800 visits per year is substantial.

Furthermore, 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.

Description of Sustainability of Project

Long-term sustainability is critical if this proposal is to succeed. This proposal will enable providers of enhanced primary care services to build a foundation and infrastructure, and then rely on third party and Medicaid funding for covered services to cover the costs of ongoing operations. In most cases, Medicaid funding covers the provider's costs of delivering a particular service. However, strategies such as additional and enhanced Medicaid funding such as differential payments to providers offering services after normal business hours will be considered to incentivize the delivery of regular, non-emergency care.

Future discussions with the 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

The project evaluation will be both qualitative and quantitative, formative and summative. Quarterly and annual measures will include:

- Completion of project milestones.
- Decrease number of non-emergent cases seen in the emergency room, including repeat users for non-emergent reasons
- Increase number of Medicaid patients receiving care in the urgent care clinic
- Measure high use hours in the urgent care clinic

Description of Project Implementation Readiness

Task	Completion Date	Milestones	Status
Purchase equipment and supplies	April 31, 2008	Clinic supplies and equipment purchased	Begin equipment purchases March 1, 2008
Recruit physician, RN and receptionist	October 31, 2008	Staff recruited	Initiate recruitment process November 1, 2007
Construct additional space for urgent care	October 31, 2008	Urgent Care Clinic space constructed	Initiate construction activities November 1, 2008
Prepare policies and procedures	October 31, 2008	Policies and procedures	Initiate development by December 1, 2007

		prepared	
Conduct public relations & marketing campaign	October 31, 2008	Public relations & marketing plan implemented	Initiate activities January 1, 2008
Begin service delivery	October 31, 2008	Urgent care clinic services provided to community	Initiate activities October 31, 2007

BUDGET

	Year 1	Year 2	Total
Federal Grant	$556,859	$605,750	$1,162,609
In-Kind	$16,010	$16,489	$32,499
Total	$572,869	$622,239	$1,195,108

Budget			**Year 1**	**Year 1**	**Year 1**
			Federal Grant $	**In-Kind $**	**Total $**
Personnel	*Salary*	*Time*			
Administrator	$ 97,650	0.10 FTE		$ 9,765	$ 9,765
Clinic Manager	$ 51,000	0.05 FTE		$ 2,550	$ 2,550
Personnel sub-total			**$ -**	**$ 12,315**	**$ 12,315**
Fringe Benefits					
Administrator				$ 2,930	$ 2,930
Clinic Manager				$ 765	$ 765
Fringe sub-total			**$ -**	**$ 3,695**	**$ 3,695**
Contractual					
Marketing			$ 25,000		$ 25,000
Utilities			$ 10,500		$ 10,500
Contractual sub-total			**$ 35,500**	**$ -**	**$ 35,500**
Supplies					
Medical/Admin. Supplies			$ 12,480	$ -	$ 12,480
Supplies sub-total			**$ 12,480**	**$ -**	**$ 12,480**
Equipment					
EMR & hardware			$ 66,000		$ 66,000
Medical equipment			$ 95,000		$ 95,000
Equipment Sub-total			**$ 161,000**	**$ -**	**$ 161,000**

Construction			
Building Construction	$ 255,000	$ -	$ 255,000
Construction Sub-total	**$ 255,000**	**$ -**	**$ 255,000**
Other			
Recruitment Costs	$ 90,000	$ -	$ 90,000
Other Sub-total	**$ 90,000**	**$ -**	**$ 90,000**
Total Direct Charges	**$ 553,980**	**$ 16,010**	**$ 569,990**
Indirect			
Indirect Costs	$ 2,879	$ -	$ 2,879
Indirect Sub-total	**$ 2,879**	**$ -**	**$ 2,879**
TOTALS	**$ 556,859**	**$ 16,010**	**$ 572,869**

Year 1 Budget Narrative

Personnel – The Hospital Administrator will spend 10% of their time on project administration, as well as policy and procedure development. The Clinic Manager will contribute 5% of their time to the project. This position will have a pivotal role in project development and implementation, and assist in development of policies and procedures. **Fringe Benefits -** Fringe benefits include a standard benefits package, including health insurance, retirement support, unemployment insurance, etc. Fringe benefits are estimated at 30% of salaries.

Contractual - Costs are budgeted for marketing including radio and print advertising. Utilities are budgeted for 3 months, as utilities will be necessary during the last 3 months of construction. Utilities include gas, electricity, water/sewer, and telecommunications. **Supplies -**1 month of supplies in Year 1 are budgeted to enable the urgent care clinic to open in Year 2. 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 - $66,000 is budgeted for an electronic medical record for the clinic. The electronic medical record includes the LSS electronic medical record, as is the standard throughout the Avera Health System, and is the most widely used EMR in South Dakota. $95,000 is budgeted for medical equipment. This includes lamps, exam tables, thermometers, scales, supply carts, file cabinets, etc.

Construction - $255,000 is budgeted for construction costs related to the development of the Urgent Care Clinic. This is based on costs estimates of $637,500 to build a clinic with 6 exam rooms, as well as a waiting room, bathroom, facilities, reception areas, and a procedure room. A 4,250 square foot clinic is estimated to cost $637,500. Approximately 40% of the clinic and costs are deemed necessary for the Urgent Care Clinic costs. This includes the costs of upgrading what would have been a standard primary care exam room to an urgent care exam room. It also covers some necessary additions, such as oxygen, not need for rooms only used for primary care. $255,000 is 40% of $637,500.

Other - $90,000 is budgeted for costs associated with recruitment for clinical staff. Approximately $70,000 is budgeted for the physician recruitment and $20,000 for an RN. Costs include use of professional recruitment firm, travel reimbursement for candidates, and advertising.

Budget			**Year 2**	**Year 2**	**Year 2**
			Federal Grant $	**In-Kind $**	**Total $**
Personnel	*Salary*	*Time*			
Administrator	$ 100,580	0.10 FTE		$ 10,058	$ 10,058
Clinic Manager	$ 52,530	0.05 FTE		$ 2,626	$ 2,626
Physician Provider	$ 170,000	1.00 FTE	$ 170,000		$ 170,000
RN	$ 53,000	1.00 FTE	$ 53,000		$ 53,000
Receptionist	$ 32,000	1.00 FTE	$ 32,000		$ 32,000
Personnel sub-total			**$ 255,000**	**$ 12,684**	**$ 267,684**
Fringe Benefits					
Administrator				$ 3,017	$ 3,017
Clinic Manager				$ 788	$ 788
Physician Provider			$ 51,000		$ 51,000
RN			$ 15,900		$ 15,900
Receptionist			$ 9,600		$ 9,600
Fringe sub-total			**$ 76,500**	**$ 3,805**	**$ 80,305**
Contractual					
Marketing			$ 20,000		$ 20,000
Utilities			$ 42,000		$ 42,000
Contractual sub-total			**$ 62,000**	**$ -**	**$ 62,000**
Supplies					
Medical/Admin. Supplies			$ 144,000	$ -	$ 144,000
Supplies sub-total			**$ 144,000**	**$ -**	**$ 144,000**
Equipment					
EMR & hardware			$ 12,000		$ 12,000
Medical equipment			$ 24,000		$ 24,000
Equipment Sub-total			**$ 36,000**	**$ -**	**$ 36,000**
Total Direct Charges			**$ 573,500**	**$ 16,489**	**$ 589,989**
Indirect					
Indirect Costs			$ 32,250	$ -	$ 32,250
Indirect Sub-total			**$ 32,250**	**$ -**	**$ 32,250**
TOTALS			**$ 605,750**	**$ 16,489**	**$ 622,239**

Year 2 Budget Narrative

Personnel - Salaries for the Hospital Administrator and the Clinic Manager are budgeted at a 3% increase from Year 1. **Fringe Benefits -** Fringe costs are budgeted at 30% of salary dollars. Fringe benefits include a standard benefits package, including health insurance, retirement support, unemployment insurance, etc.

Contractual - Marketing costs are budgeted at $20,000. Utilities include gas, electricity, water/sewer, and telecommunications are budgeted at $42,000.

Supplies - $144,000 is budgeted for supplies. 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 - $12,000 is budgeted for costs associated with the electronic medical record. $24,000 is budgeted for medical equipment.