**Demonstration Overview**

The three years of the FCHIP Demonstration ended July 31st, 2019. Disparities based on varying populations, community services, state and county economics and geographic location continued to impact waiver associated intervention and utilization. The approach to successful waiver implementation was based on each CAH’s ability to focus on their individual strengths and weaknesses, the positive as well as the vulnerable aspects of daily functioning and viability.

MHREF ongoing evaluation of facility activity and functionality continued throughout the final months of the Demonstration. Collaborative efforts included communication with the various FCHIP team members from HRSA, CMS, the CMS Implementation Contractor Team (John Gale/SSS/ARC) and the CMS Evaluation Contractor (RTI). These efforts kept all team members apprised of waiver implementation and development providing input and feedback based on continued work and intervention with the ten FCHIP critical access hospitals.

Multiple site visits were conducted and various educational opportunities were offered in an effort to facilitate and enhance waiver implementation. Contracts to educate staff and providers were offered, including the development of Chronic Care Management programs and offering IT assistance with various software products.

MHREF was able to offer an extensive marketing and outreach campaign to educate and improve the knowledge base at the community level regarding their local telehealth services and long term care and rehabilitative bed services. Marketing efforts included local bill board placement, development of appointment cards with reminders to ask providers about telehealth as an option for connecting with specialty providers virtually, canvas and retractable banners and razor flags, assistance with the design and development of facility websites and/or facebook home page was also facilitated.

At Demonstration end, telehealth implementation by Mount Grant General Hospital in Hawthorne, NV, and McKenzie County Healthcare in Watford City, N.D., reflected significant success. Both facilities were able to add specialty services and expand contract opportunities where available by focusing on their community and population health needs. Mount Grant reported 30 encounters for Q1/2019, and McKenzie 50 for just the months of Jan/Feb 2019. Having a much smaller population to draw from, Roosevelt Medical Center in Culbertson, MT, was able to expand their telehealth program adding specialty service as needed. Q1/2019 activity reflected 10 patient encounters and multiple utilization of their virtual equipment for educational purposes including provider and nursing grand rounds, case conferencing and educational webinars.

With the implementation of cost based reimbursement for Medicare transfers, Southwest Healthcare Services in Bowman, N.D., was able to hire additional para-medical staff and initiate future plans toward the development of a Community Para-Medical Program.

Jacobson Memorial Hospital Care Center in Elgin, N.D. experienced consistent utilization of their bed expansion beds allowing local residents to remain at home, close to family and friends during their convalescence.

Though the demonstration saw significant success, frontier facilities continue to experience barriers when attempting to implement and enhance their services. In the telehealth arena, one challenge is the difficulty accessing distant site provider contracts and the reluctance of some providers to engage with telehealth services. CAHs are often able to contract with large provider groups or healthcare systems, but frequently physicians within the system or group will not offer themselves as telehealth providers.

The reluctance of these providers appears to be two fold. On some occasions, there is an unwillingness to engage with telehealth services and adapt to the changing ‘virtual care’ environment, some preferring to continue to practice the traditional ‘face to face’ mode of healthcare delivery. Secondly, credentialing, which can be a burdensome process for the distant site provider and the CAH, has been verbalized by both as a barrier. Several provider networks do offer credentialing by proxy, or ‘delegated’ credentialing within the language of their contracts. This option allows the CAH to accept the screening and review process of the provider’s certifications, letters of recommendation, and state licensure, previously completed by the contracting entity, as satisfactorily meeting the required credentialing elements. Though this simplifies the credentialing burden, the CAH nevertheless, is bound by their medical services bylaws as well as the conditions of participation mandated by CMS pertaining to telehealth.

As telehealth/virtual care continues to expand and is accepted as a standard and an effective means of patient/physician interaction rather than the exception, public perception and acceptance of this form of healthcare will play a significant role altering physician attitude. The COVID-19 pandemic has, unfortunately, demonstrated this drastic change of attitude exponentially.

Several participating facilities experienced multiple administrative turnover, which had a significant impact on facility functionality and waiver implementation. The assimilation of tasks and the undertaking of becoming a proficient administrator at frontier CAH sites is a considerably time intensive process.

Fluctuation of other key staff members associated with demonstration activity affected waiver outcome as well. Frontier staff often find themselves functioning at several levels, their duties being multi-focused due to the shallow hiring pool in remote rural areas. Provider and staff recruitment is a constant concern and process, as are the issues of aging infrastructure and the constant shifting of regulatory obligation.

The waiver opportunities within the demonstration provided the financial support mechanism required for participating frontier CAHs to implement and expand needed services. When asked as to continuing services without the enhanced reimbursement, they agreed it will be difficult, but they have no intention of scaling back on what has been accomplished. Regardless of the lack of reimbursement, and the various barriers and challenges faced by the frontier hospital, they are dedicated to their communities and committed to maintaining quality focused healthcare for their residents.