

Alaska's SHARP Program

SLRP Grantee Profile

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Contact Information:

State – Alaska

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Program Description:

The purpose of Alaska's SHARP Program is to address the worsening shortage of certain health professionals in Alaska. SHARP does this by increasing the number and improving the distribution of healthcare professionals who provide direct patient care. SHARP has two program components, SHARP-I, which is our traditional HRSA SLRP grant option, and SHARP-II, which is a wholly non-federal option established through Alaska State Statute AS 18.29. The purpose of the SHARP-I program component is to recruit and retain selected primary health care professionals to serve in federally designated Health Professional Shortage Areas (HPSA) in exchange for the repayment of qualifying educational loans, pursuant to a signed SHARP MOA with the State of Alaska. SHARP-I is operated by the State of Alaska, Department of Health and Social Services, and is jointly supported by funds from several sources including the U.S. Department of Health & Human Services, Health Resources & Services Administration (HRSA), the Alaska Mental Health Trust Authority, and required partial employer match.

Program Overview:

Eligible Occupations

The healthcare disciplines supported by SHARP-I include:

Tier-1:¹

- Doctor of Allopathic Medicine (M.D.)
- Doctor of Osteopathic Medicine (D.O.)
- General Practice Dentist (D.D.S. or D.M.D)
- Pharmacist
- Pediatric Dentist (D.D.S. or D.M.D)

¹ The "Tier" designations relate to the Maximum Annual Benefit available for payment for the Practitioner's occupation, as stated in our service contract (Memorandum of Agreement).

Tier-2:

- Primary Care Certified Nurse Practitioner
- Primary Care Physician Assistant
- Registered Clinical Dental Hygienist
- Registered Nurse (RN)
- Clinical or Counseling Psychologist (Ph.D. or equivalent)
- Licensed Clinical Social Worker (LCSW)
- Psychiatric Nurse Specialist
- Licensed Professional Counselor (LPC)
- Licensed Marriage & Family Therapist
- Certified Nurse Midwife

For physicians, the primary care specialties approvable are family medicine (and osteopathic general practice), internal medicine, pediatrics, obstetrics/gynecology, geriatrics and psychiatry.

Contract Length:

Alaska's SHARP-I option requires a minimum two-year service contract, called a Memorandum of Agreement (MOA). In addition, Clinicians can potentially receive a Continuation Award as well, but that opportunity occurs only through competitive application.

Full-Time & Half-Time:

SHARP provides for both full-time and half-time service contracts. Definitions of full-time and half-time service are in keeping with federal HRSA regulation. The half-time option is particularly appealing for those clinicians who have other expectations in their lives, such as family or also partially working in a program administrative role.

Contract Payment:

Subject to the Clinician's service contract, the maximum annual benefit (annual cap) amounts are up to the following levels:

- Full-Time Clinical Practice: for Tier-1 up to: Regular-Fill positions \$35,000, and Very Hard-To-Fill positions \$47,000, and, for Tier-2 up to: Regular-Fill positions \$20,000, and Very Hard-To-Fill positions \$27,000. Tier-1 includes physicians, dentists & pharmacists.
- Half-Time Clinical Practice: for Tier-1 up to: Regular-Fill positions \$17,500, and Very Hard-To-Fill positions \$23,750, and, for Tier-2 up to: Regular-Fill positions \$10,000, and Very Hard-To-Fill positions \$13,500. Tier-2 includes all other eligible occupations that are not classified as Tier-1 (e.g. nurse practitioners, psychologists, dental hygienists, etc.).

State Legislative Impact:

In addition to SHARP-I (SLRP), Alaska's support-for-service program has another component, which is SHARP-II. SHARP-II is wholly non-federally funded, and was established through passage of HB-78 in Alaska's 27th Legislature, stated there as the "Health Care Professions Loan

Repayment and Incentive Program” (AS Chapter 18.29). It is exclusively supported by non-federal sources, including the State General Fund and required partial employer-match. The loan repayments and direct incentive payments (aka “support-for-service”) provided by this statute are intended to ensure that residents throughout the state, including recipients of medical assistance and Medicare, have access to healthcare and that residents of rural areas of the state, in particular, experience improved access to healthcare services. The impact of legislative passage of the SHARP-II statute has been substantial. SHARP-II significantly broadened the range of eligible occupations, work locations and practice settings. In addition, AS 18.29 established a full-time program administrator position, provided significant support-for-service funding, and provided considerable codification and clarity of SHARP rules and regulations. It also established in statute the requirement and role of an empowered Advisory Council. Further, it provided two support-for-service options: traditional loan repayment, and, direct incentive.

Matching Funds:

Federal HRSA’s SLRP grant (aka SHARP-I) requires that at least 50% of award value is supported by *non-federal* sources. Alaska has now received its 3rd HRSA grant, SLRP-3, which has non-federal matching funds from three sources, in the following descending size: (a) required partial Employer Match (25%, or \$1,100,000), and (b) two state sources (25%, or \$1,100,000) which are: (1) the Alaska Mental Health Trust Authority (\$700,000), and (2) Alaska State General Fund (via DHSS) (\$400,000).

State Fiscal Year:

As is typical, Alaska’s State Fiscal Year begins July 1st, and ends June 30th.

Advisory Council:

Over the last eight years, SHARP developed through work with a large set of prominent interagency partners to consider and plan for our support-for-service program. This interagency planning group advanced the concept of a state-sponsored Health Care Professions Loan Repayment & Incentive Program (AS 18.29, eventually, SHARP-II). Council is now established in state statute (AS 18.29) and attendant regulation. It is a multi-disciplinary effort, composed of highly varied institutional members. It is the Council that makes all clinician-participant selections via public voting in publicly noticed quarterly meetings, from panels of otherwise eligible Clinician-applicants, presented via blind case-code.

Voting Members:

- United Way of Anchorage (Chair)
- Alaska Academy of Physician Assistants (Vice Chair)
- Alaska Commission on Post-Secondary Education
- Alaska State Hospital and Nursing Home Association
- Alaska Behavioral Health Association
- National Association of Social Workers Alaska
- Alaska Nurses Association
- Alaska Pharmacists Association
- Alaska Primary Care Association
- Alaska Family Practice Residency Program

- University of Alaska, Health Programs
- Alaska Department of Labor, Research & Analysis Section
- Alaska Dental Society
- Alaska Mental Health Trust Authority
- Alaska Native Tribal Health Consortium, 729-2601, 2-year term

Ex-officio Members:

- Alaska Native Health Board
- Alaska Division of Public Health

Eligible Site Types:

An eligible Site is a public or nonprofit private entity located in and providing health services in a current DHSS-designated Healthcare Shortage Service Area (HSSA). HSSA designation includes, but is not limited to, federal HPSA designations. SHARP-I requires that participating Sites have federal HPSA designation, whereas SHARP-II does not.

For Non-Tribal Healthcare Sites: The Site must provide health services to any individual seeking care, accept Medicare and Medicaid assignment rates, and treat patients regardless of their ability to pay (i.e., discounted sliding fee schedule). The Site cannot discriminate on the basis of the patient’s ability to pay for such care or on the basis that payment for such care will be made pursuant to Medicare (established in Title XVIII of the Social Security Act), or Medicaid (Title XIX of such Act).

For Tribal Healthcare Sites: Site must provide health services to any individual seeking care who is also eligible for services under 25 U.S.C. 1680c, accept Medicare and Medicaid assignment rates, and apply Site’s charity care policy to all qualifying individuals. The Site cannot discriminate on basis that payment for such care will be made pursuant to Medicare (established in Title XVIII of the Social Security Act), or Medicaid (Title XIX of such Act).

For SHARP-I, the most common examples include: Community Health Centers (Sec. 330), Community Behavioral Health Centers, Critical Access Hospitals, and Tribal Health Organizations.

Program Administration:

Contract Default:

Our SHARP-I, SLRP-3 grant project does not have any Clinicians who are in contractual default at this time, nor were there any instances in our prior SLRP-2 grant cycle (Dec. 2013-Nov 2014)

Monitoring:

Alaska’s SHARP Program conducts rigorous program monitoring. The main approach relies on a required, clinician-specific “Quarterly Work Report” (QWR). This report is submitted jointly by the Clinician and the official Site Representative. The quarterly cycle is as follows: (a)

calendar quarter of service, (b) then report-month, (c) then clinician payment-month, and then (d) employer-match invoicing-month (e.g. Jan-Mar, then Apr, then May, then June).

The Quarterly Work Report is submitted electronically and indicates all of the following: (a) Clinician attributes (e.g. name, occupation, email, licensure & number); (b) Site attributes (e.g. name, location); (c) productivity data, which includes required reporting of unduplicated counts of patients seen and client-visits served via direct patient care during the quarter, and reporting on those for at both the clinician and the site levels, according to “payer-type” (e.g. Medicaid, Medicare, the uninsured, private insurance, federal health beneficiaries, etc.); and (d) clinician’s work attendance, gauged by “days-away-from-clinic” for any reason except weekends. In this way, SHARP is assured on a quarterly basis as to who is working, where they are working at, and with whom, and how much. Essentially, answering the question: is the clinician working, and is he or she working with the priority populations?

Compliance in submitting reports is 100%, and is assured because no support-for-service payments are made unless and until each quarterly report is received. SHARP makes any payment in advance, but rather, all payments occur only after receipt of acceptable reports.

Any Pending Actions:

Staffing is stable, and increasingly mature. Robert Sewell manages the SHARP Program, and has been the main progenitor and architect throughout. Dr. Sewell remains firmly committed to building Alaska’s support-for-service program to the level of clear institutionalization and sustainability. Overall, the program has steadily grown: SHARP-I is now in its 3rd SLRP iteration, and as mentioned, SHARP-II is now established by Alaska state statute. In addition, the SHARP Council has continued to demonstrate solid ownership, and full participation. Overall, SHARP’s clinician census now stands at 199 practitioners to-date. We anticipate that during the next two months there will be another 5-8 clinicians admitted to program. Finally, SHARP is developing a standing Program Guidelines & Processes Manual.

Application Cycle:

Between SHARP-I and SHARP-II options, Alaska has been able to offer at least one clinician application solicitation window per year, and sometimes two openings. Overall, seven cohorts have been admitted to-date. When a publicly announced clinician solicitation begins is strictly determined by available funds. As mentioned, SHARP-I has two-year service contracts, whereas SHARP-II has three-year service contracts. The solicitations are of set, pre-announced durations, typically 2-3 months of opening. On the other hand, Sites can apply for basic eligibility at any time (i.e. rolling admission).

Application Review Process:

In brief, clinicians submit their applications during publically announced solicitation windows (usually open for 2-3 months). Thereafter, the SHARP Program Manager reviews all applications for basic eligibility, compliance and timeliness. The panel of all clinician-applicants that meet basic eligibility (e.g. citizenship, licensure, proposed HPSA location, acceptable occupation designation, etc.) is then presented via blind case-code to the standing Advisory Council. Council meetings in announced Quarterly Business Meeting via videoconference in two urban locations, with teleconference connection also available to anyone.

In the most recent clinician-application cycle, SHARP received 99 applications, and of those the Council reviewed 85 highly eligible practitioner-applicants, but also found that there were resources for loan repayment (LRP) to support only about 45 applicants. In the end, there were 42 clinicians selected.

Council based its recommendations on varied aspects of both Clinician & Site applications. Numerous considerations are usually examined, but especially those regarding balance across the following factors:

Locality of practice-site

- Geographic distribution of sites across the state
- Frontier, rural and urban considerations
- Level of social need in catchment area
- Tribal vs. non-tribal sites
- Support of newly eligible site-types
- Total number of SHARP clinicians at site
- Other Site characteristics

Occupation-mix

- Eligible occupation
- Occupation category-mix (medical, dental & BH)
- Support of newly eligible occupation-types

Other considerations

- Aspects & level of education loan debt
- Number of program Clinicians (current & expected) at Site
- Priority provided by Sites for Clinician applications
- Level of social & medical need in catchment area

Council publicly votes on all its official actions, including both overall policy, and clinician-specific admittance to program. Once Council issues its recommendations, then clinician applicants (and their Sites) are notified, and service-contracts are issued. Contracts become fully executed (and a specified service start-date set) when all of the following are true: Clinician has received employment, has graduated from training, has a license to practice the occupation, and the MOA is signed & endorsed throughout by the Clinician (in presence of Notary Public), the Site Representative, the SHARP Program Manager, and specified Alaska DHSS official.

Number of Awards:

The current SHARP-I (SLRP-3) grant is a four-year HRSA award. Our submitted and accepted plan is to loft two cohorts, each of about 45 clinicians (e.g. 90 overall), serving two-year contracts. The two cohorts are staged in a staggered fashion, with the start of the first of the two sets (n=42) now selected and provided contracts. Thus far, total committed budget for the 42 clinicians thus far admitted is: (a) \$1,963,518 total expense, and of that (b) \$490,880 in employer match. In Spring 2017, we plan to start the second solicited group of 45 clinicians (ca.).

We plan to expend all available loan repayment funds. It is important to note two factors: (a) HRSA NGA date was 9/1/14, and start-up of our Cohort-A has taken six months; and (b) in addition, as is known, the state, federal and project fiscal years are not synchronized, and this means that each year there will be an unavoidable carry-forward request submitted to both HRSA and our main non-federal funder, the Alaska Mental Health Trust Authority.

We remain on-track as to our initially proposed and awarded SHARP-I, SLRP-3 budget. We anticipate total budget for loan repayment expense at \$4,396,000, composed of \$2,198,000 Federal, and \$2,198,000 Non-Federal. Totals are broke-out below, by year, for HRSA, & Non-Federal portions. State of Alaska (SOA) portion is composed of DHSS (\$400K) & AMHTA (\$700K) across the 4 years. Employer match (EM) (25% of awards) required from Sites.

	<u>Totals</u>	<u>HRSA-50%</u>	<u>SOA-25%</u>	<u>EM-25%</u>
Year-1	\$ 719,333	\$ 359,667	\$ 179,833	\$ 179,833
Year-2	\$ 1,079,000	\$ 539,500	\$ 269,750	\$ 269,750
Year-3	\$ 1,478,667	\$ 739,333	\$ 369,667	\$ 369,667
Year-4	\$ 1,119,000	\$ 559,500	\$ 279,750	\$ 279,750
Totals	\$ 4,396,000	\$ 2,198,000	\$ 1,099,000	\$ 1,099,000

Any Changes from Initial HRSA Application?

No, there are no changes anticipated from initial proposal; things are progressing as plan. The biggest single impediment to progress remains that which has been discussed, and it is a real problem: We do not have a “Multi-Year Operations Fund.” This means that we confront, yearly, the same problem of losing unexpended funds to having been “swept” at end of state fiscal year. We cannot “encumber” across state fiscal years, but this could be rectified.

Other/Additional Details:

One main finding: SHARP is working, and we are making progress.

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