HB
365

COMMITTEE REPORT

HOUSE

FURTHER: FINANCE

3/19/81

(5)

Date: _____

Mr. Speaker:

The Committee on HEALTH, EDUCATION & SOCIAL SERVICES has had HB 365

"An Act making a special appropriation to the City of Cordova for a feasibility study for hospital care; and providing for an effective date."

under consideration and reports it back as follows:

[ ] do pas. [ ] do not pass

[ ] do pass with attached amendments(s)

[✓] replace with CS for HB 365 [ ] same title [ ] new title

and recommends do pass

[ ] AND attaches a "Letter of Intent" [ ] New Fiscal Note

[ ] reports it back without recommendation

[ ] referred to the _____ Committee

MEMBERS SIGNING
DO PASS

MEMBERS HAVING
OTHER RECOMMENDATIONS:

Lore Martin do Concurred

CHAIRMAN

H 60 (Rev. 3/81)

alaska
state
hospital
association

319 Seward St., Juneau, Alaska 99801 (907) 586-1790

REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

President
Sister Barbara Hasse
Ketchikan General Hospital
Ketchikan

President Elect
Tom Mingen
Fairbanks Memorial Hospital
Fairbanks

Secretary/Treasurer
Ron Pavelka
Alaska Hospital & Medical Center
Anchorage

Immediate Past President
Al Carnesso
Providence Hospital
Anchorage

Executive Director
Dennis L. DeWitt
Juneau

MAR 12 1981

March 6, 1981

The Honorable Bette Cato
State House of Representatives
Pouch V, State Capitol Building
Juneau, Alaska 99811

Dear Representative Bette Cato:

The Alaska State Hospital Association wishes to inform you of its support of an appropriation of approximatly $600,000 for a feasibility study on the need and design of a new physical plant for Cordova Community Hospital. The Association will be pleased to assist you and Cordova Community Hospital in achieving that goal.

Sincerely,

Dennis L. DeWitt
Executive Director

DLD/b

cc: Ed Zeine

Phone: (907) 424-3237
or 424-3238

CITY OF CORDOVA

Box 1210 602 Railroad Ave.
CORDOVA, ALASKA 99574
"The Friendly City"

Reply to:

FEB 9 1981

February 2, 1981

rec'd 2-9-81

Commissioner Helen D. Beirne
Dept. of Health & Social Services
Pouch H-01, Mail stop 0600
Juneau, AK 99811

Dear Commissioner:

I want to thank you for the opportunity to meet and talk with you about my concerns for increased revenue sharing for small hospitals and a State-funded capital improvement program to upgrade and replace obsolete facilities.

It appears that several bills are in the hopper to increase revenue sharing to hospitals including the bill to be introduced and supported by the Alaska Hospital Association. Talking with Keith Specking and several legislators, it appears that some form of assistance will be authorized.

You indicated that you felt that the administration could be enticed to fund a capital improvement program to upgrade and/or replace obsolete hospitals, but it would constitute a major policy decision. I want to encourage you to move forward with this approach, and I believe I speak for most, if not all of the hospitals, that you can count heavily on our support.

Please keep me advised of the steps you are taking to accomplish this goal, and I will keep you posted of our inter-action with the legislature. Our cooperative goal is to produce the very best medical facilities possible for our citizens

Again, thank you very much for your time and kind words.

Very truly yours,

Perry D. Lovett
City Manager

cc: Senator J. Kerttula
Representative B. Cato
Representative E. Hagen
Dennis L. DeWitt
Ed Zeine

Phone: (907) 424-3237
or 424-3238

CITY OF CORDOVA

Box 1210 602 Railroad Ave.
CORDOVA, ALASKA 99574
"The Friendly City"

Reply to:

February 2, 1981

Received 2-6-81

Dennis DeWitt
Executive Director
Alaska State Hospital Association
319 Seward Street
Juneau, AK 99801

Dear Dennis:

I wish to thank you for the courtesy extended to me on my trip to Juneau. Your activities with the legislature are very impressive. With your on-the-spot timing and our support, I believe that a bill to increase revenue sharing to hospitals is almost assured. Both the legislature and administration appear to be very receptive to the idea. Hopefuily, our work last year softened them up to the idea, and with your steady pressure, it will become a reality.

Commissioner Beirne spoke of consideration and possible support for a capital improvement program to replace or upgrade obsolete hospitals. She spoke of Cordova, Palmer, Petersburg and Wrangell as the four worse facilities in the State and the most need for replacement. She spoke of a loan program, but I advised her that we surely wouldn't be asking for increased revenue sharing to shore-up our operating losses if we could afford to pay back loans. She made note of "grants." With the oil revenues the State now receives, it appears to me that we should take advantage of that money to make capital improvements before the Federal government starts taking a larger cut.

Dennis, you have Cordova's support on both of these items. Please advise if we can be of assistance. Good luck!

Very truly yours,

Perry D. Hovett
City Manager

cc: Ed Zeine
Cordova Community Hospital Advisory Board
Senator J. Kerttula
Representative B. Cato

CORDOVA COMMUNITY HOSPITAL

P. O. Box 160 Phone: (907) 424-7551
CORDOVA, ALASKA 99574

FEB 17 1981

February 6, 1981

The Honorable Bette Cato
State House of Representatives
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Mrs. Cato:

Thank you for your interest in small rural hospitals.

I certainly appreciate your contacting me regarding small hospitals in Alaska. I will try to respond in an objective way and place our dilemma in proper perspective.

OCCUPANCY EQUALS REVENUE

Occupancy or utilization is a problem that is the most difficult for small hospitals to cope with. We must have nursing staff (RN's and aides) on duty 24 hours a day for inpatients as well as emergency room coverage. We must staff cooks, housekeepers, and maintenance personnel as bare necessities of patient care. This is true whether we have 3 patients in the hospital or 10 patients. We must provide diagnostic services so the physicians can order drugs and other services to heal the patient - other services being lab, x-ray and pharmacy.

We must also have equipment, i.e. cardiac monitor, apnea monitors, sterilizers, whirlpool, hospital beds, oxygen, defibrillators, etc.

In addition, of course, we must heat the building, provide food, electricity, water, sewer, and garbage. All of these are fixed costs and regardless of how well or poorly a small hospital is managed there is little one can do effectively regarding these costs. We cannot staff a half of a person, purchase less costly equipment, or heat half of our building when occupancy is down.

I feel confident that you are aware of this information but I thought I should state it anyway.

Inflation in the health care area has placed a heavy financial burden on hospitals. Following are some cost comparisons so you can have specific examples of the problem.

The Cordova Community Hospital

Honorable Bette Cato
State House of Representatives
Pouch V (MS 3100)
Juneau, Alaska 99811

COST COMPARISONS

ITEM	79/80	80/81
MICA	$18,027.14	$25,236.00 (est.)
Salaries	9% over 78/79	10% over 79/80
Retirement	6.13%	6.65%
Health Insurance		
Single	36.78/mo	42.96/mo
Married	79.95/mo	93.38/mo
Family	111.76/mo	130.18/mo
Air Freight -to Anchorage	16.45 Min.	18.10 Min.
Sea Land per 100#	35.79 Min.	43.21 Min.
Sea Land -Fuel surcharge	5%	3%
Air fare to Anchorage round trip	90.00	94.00
X-ray film 11 x 14	440.96/case 100	725.10/case 100
Developer	41.63/case	49.95/case
Fixer	20.84/case	24.50/case
IV solution 5% Dextrose/water	6.67/case	9.56/case
Toilet tissue	34.66/case	71.25/case
Plastic Can Liners	33.95/case	52.75/case
Eggs	36.00/case	45.00/case
Milkman	28.14/case	33.88/case
Coffee	84.50/case	81.75/case
Electricity rate	.085/1,000kw	.088/1,000kw
Fuel Escalation	33%	47%

Electricity - cost	1979	1980	1981
February	1252.89	1657.23	1949.15
Fuel Rates - February	.493	.866	.981

Normally, businesses would attempt to increase sales (for hospitals that's increase occupancy) to offset their costs. Hospitals in rural areas serve a fixed population and are unable to control occupancy.

Hospitals have worked together to reduce costs but rural hospitals must work with high fixed costs to comply with patient safety needs and the various regulatory agencies that control our business. Some examples of cost containment programs are:

1: Shared purchasing - Through the Alaska State Hospital Association we have established a shared purchasing program through the Sisters of Providence Hospitals (Providence Hospital in Anchorage). Because of the many

hospitals under the management of the Sisters of Providence they are able to contract for volume purchase of supplies at reduced costs. Small rural hospitals enjoy the ability to purchase small quantities but at the same volume price contracted to Sisters of Providence, a real savings to the small hospitals.

2: Rural hospitals are able to contract with large metropolitan hospitals in the southcentral area for highly specialized technical maintenance and repair personnel. The cost to the hospital is the actual one time cost for the service, i.e. hourly salary plus benefits and expenses. This is much less expensive to the rural hospital as the only other choice is to fly a technician in from a for-profit corporation in Seattle. They charge hourly from the time the technician leaves his shop in Seattle until he returns, plus expenses.

3: Other shared services have been established by the Alaska State Hospital Association such as audio/visual training films, micro filming, etc. Hospitals are trying to contain costs in these and many other ways.

All hospitals must comply with Medicare/Medicaid and federal regulations. There is no difference in interpretation of the requirements whether the hospital is located in New York City, Seattle, Anchorage, Valdez, or Cordova. Obviously the cost of complying with most regulations is much higher in rural areas where there are fewer people than in more highly populated areas because of the lack of available technical people to carry out the regulatory requirements.

Cordova Community Hospital operating expenses exceed operating revenue by $120,907 according to the audited financial statements for year ending June 30, 1980. Revenue sharing has kept our doors open for operation with no equipment purchases, maintenance or replacements.. Attached is a graph indicating the problem of small hospitals as it relates to occupancy.

I hope this information provides you with the necessary data that may assist you in working with our rural hospitals in Alaska. Please feel free to call on me at any time and if I do not know the answers to your questions I would be happy to pursue to obtain the answers.

Best Regards,

Edward Zeine
Administrator

EZ/ml

enclosure

AVUTE CARE BEDS/ CENSUS

LICENSED BEDS'78

Av. Daily Census '78

CORDOVA COMMUNITY HOSPITAL
MENTAL HEALTH AND ALCOHOL CLINIC

P.O. Box 160 Phone: (907) 424-7131
CORDOVA, ALASKA 99574

April 21, 1981

Bette Cato
Pouch 5
MS 3100
Juneau, Alaska 99811

Dear Bette:

As co-directors of the MHAC in Cordova, we have interfaced extensively with the youth of the community both directly and through the Eyak Youth Center. We feel that prevention programs for youth are a priority for our community for many reasons, including the decreased costs of subsequent state intervention requiring detention/rehabilitation. Therefore we strongly support a direct appropriation of $899,1[illegible]0 to the Division of Family and Youth Services to meet the current requests for youth prevention programs.

Sincerely,

Dianne Bailey Frost K. Bradley Frost

Dianne Bailey Frost, PhD
Co-Director

K. Bradley Frost, PhD
Co-Director

DBF/KBF/pkh

The Cordova Community Hospital

CITY OF CORDOVA

RESOLUTION 81-22

A RESOLUTION OF THE CITY OF CORDOVA ENDORSING THE PASSAGE OF HB 223.

WHEREAS, the City of Cordova is a rural, isolated community that has available Health Care services for all its citizens,

WHEREAS, Pioneers in Cordova have had to leave their community to obtain Health Care Pioneer benefits,

WHEREAS, Cordova Pioneers leaving their family and friends to obtain Health Care Pioneer benefits outside of Cordova has caused great loneliness, mental anguish and undue hardship, and,

WHEREAS, Cordova Community Hospital provides acute care and long term care for the community, and,

WHEREAS, House Bill 223 would enable Pioneers to remain in Cordova when in need of long term health care

NOW THEREFORE, BE IT RESOLVED that the City Council of Cordova strongly endorses the passage of this bill by the Alaska State Legislature.

PASSED AND APPROVED THIS 30 DAY OF April, 1981.

Hollis Honrieder

Mayor

Marie Bishop

City Clerk

Phone: (907) 424-3237
or 424-3238

CITY OF CORDOVA
Box 1210 602 Railroad Ave.
CORDOVA, ALASKA 99574
"The Friendly City"

Reply to:

1981 City of Cordova's Legislative Priorities List

1. Water Development - Phase II - $1,500,000
2. Alternate Energy Funds
3. 100% School Funding
4. Increase financial assistance to hospital from $75,000 to $200,000 and $650,000 funds for a study and design of a new hospital
5. Marine Facilities Financing:
   a. $400,000 final rock cover
   b. $1,000,000 Marine ways and appertenances
6. Property tax relief
7. Funds for street improvements:
   a. Breakwater Avenue - $425,000
   b. Residential streets - $500,000
8. Repair of Ocean Dock ($200,000) to include cathodic protection
9. Harbor electrical and water - $200,000
10. Funds for Whitshed-Copper River Highway-Eccles Creek $1,200,000

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

CORDOVA COMMUNITY HOSPITAL

P. O. Box 160 Phone: (907) 424-7551
CORDOVA, ALASKA 99574

February 24, 1981

To: Mr. Perry D. Lovett
City Manager

From: Cordova Community Hospital Medical Director
Cordova Community Hospital Administrator

Subject: Cordova Community Hospital Building Status

Attached is documentation of the City's Hospital's Structural/Building deficiencies as experienced by the hospital's medical, and nursing staff and Administrator.

Also attached are two additional documents, i.e.

1. Survey of Cordova Hospital by Robert McFarlane, Architect, Division of State Health Planning and Development conducted 15 September, 1980.

2. Report on Hospital and Health Facility Operation and Construction Assistance by Department of Health and Social Services, Helen D. Beirne, Commissioner, dated 1 Feb. 1981.

These reports are submitted to assist you and the City of Cordova in obtaining State funds to conduct a study as to the feasibility of correcting the deficiencies or constructing a new facility.

Arthur D. Tilgner, M. D.
Medcial Director

Edward Zeine
Administrator

ADT-EZ/ml

enclosures

Cordova Community Hospital was constructed in 1955 and has been serving the community and Prince William Sound area for the last 26 years. The structure is wood framed with concrete floor erected on solid rock formation. Original structure was a main floor consisting of an operating room and delivery room, central supply, x-ray, laboratory, Administrative office, 10 patient rooms (designed to house 22 patients) a small dining room and kitchen. The lower section of the hospital consisted of a store room, a laundry, a PHN clinic and boiler room.

In 1976 a PHS grant was obtained to add a physicians' clinic, a Mental Health and Alcohol clinic and State Social Services offices.

The laundry equipment was eliminated in 1972 and the area was eventually modified for a laboratory facility. In 1980, the old laboratory area on the main floor was converted to offices for the Director of Nursing and the Business Office Manager. An area which was the labor room was converted to the Administrator's office.

In 1972 modification was made to the existing structure for a new roof and sprinkler fire system. The roof had rotted from water leakage and ceiling plasterboard sections of the hospital had fallen to the floor.

This 26 year old structure continues to present major problems in meeting Fedeal and State regulations as well as meeting acceptable present day health care standards. Except for two patient rooms which have their own toilet, the patients must cross the hall to avail themselves of a community toilet and bath facility. The roof continues to leak and dry rot is present through out the wood frame structure. The 26 year old diesel fueled boilers have not been modified since installation. Their present use of high cost fuel to perform their design functions is a great financial burden on the hospital, besides a great waste of energy. The hospital is heated by the hot water circulated through the boilers. Attempts have been made to install zone controlls in patient rooms but are ineffective in controlling heat to the areas. Windows must be opened or ventilation. The air circulation system has not been updated in the last 26 years and is non-operable due to malfunction of the power plant system. Cost estimates 2 years ago to repair the air circulation system was $50,000. To meet acceptable standards of temperature control for drug room, medical supplies, operating and delivery room as well as patient rooms would require individual air conditions. Because of the expense involved and the cost of electricity, this is not an acceptable alternative.

Water pipes, elbows, and turn valves are rusted and corroded inside the pipes to the point that little water is allowed to pass through the pipes.

Flooring throughout the hospital is badly worn and is unsightly. Broken tile have been replaced with various mismatched colors through the years.

Adequate storage space for medical supplies and equipment is totally lacking, in fact, it is necessary to allow certain equipment to remain in hallways as there is no place to store the items.

The operating room is outdated for many reasons, i.e. no air flow (ventilation), no humidity control, inadequate lighting system; all of major importance for infection control and safe operating procedures.

The entrance to the hospital emergency room is through the hospital's main doors which is in close proximity to the hospital rooms. During an emergeny situation, usually, in the evening, this is very disturbing to the sick inpatients.

There is no acceptable security of the patients and staff at night as the only access to the hospital is through unlocked main entrance doors. These unlocked doors provide access to the entire hospital and nursing home.

The below data is an excerpt from "Cordova Comprehensive Development Plan" conducted by Alaska Consultants Inc., Anchorage, Alaska.

"...it is predicted that the population of the Cordova planning area will be 3,360 by 1985 and, by 1995, it will range between 2,700 and 7,000 with the "most probable" population estimated to be about 4,500."

The 1980 census for Cordova is 2,800 which is 800 higher than the 1975 census of 2000.

Following is a summary of the major areas of deficiency revealed by the many state and federal inspectors over the past years as well as the practicing physicians, and medical technicians that use the hospital to care for patients.

Patient rooms without toilet or bath facilities.
Hospital building is a wood structure with dry rot throughout.
Scalding hot water flows directly from boilers to patient rooms.
Boiler of 1955 vintage.
No heat or shut off temperature controls in hospital.
No air circulation due to malfunction and obsolete system.
No adequate storage area for equipment.
Leaking roof with support structure rotted.
Water pipe system rusted to the point of restricting water flow.

Attached is a recent survey of the hospital conducted by an Alaskan State employeed architect. His recommendations is that a study and design of a new, replacement structure be implemented.

Because of the financial difficulties of this small rural city owned and managed facility it is necessary to look for state funding to conduct the appropriate study and design and eventual replacement hospital.

MEMORANDUM State of Alaska

TO: Phoebe A. Lindsey
Director
Division of State Health
Planning and Development

DATE:

FILE NO

TELEPHONE NO

SUBJECT

FROM: Robert MacFarlane
Architect

THRU: Dave Williams
Economist

On the week of September 15, 1980 I conducted a survey of the Hospital in Cordova. Cordova is an old hospital built in 1954-55. In 1975 the present elevator was installed and improvements were made to the basement. Later the basement was finished to house a Doctor's office, a community mental health facility and public health nurse. The Hospital laboratory was relocated in the basement. The hospital is clean, brightly painted and is generally a cheerful atmosphere.

It is located on a noisy street that interferes with the operation of the hospital. The property provides limited parking. Access to the building is difficult; either through the main entry or into the basement. There is no emergency entrance except through the main entrance.

The hospital was designed with the following deficiencies:

1. There is no place to store wheel chairs and stretchers out of corridors and normal circulation patterns.

2. The sprinkler system is an exposed pipe sprinkler system. This kind of installation is impossible to keep clean.

3. The exterior of the building was sheathed with corrugated asbestos cement board. The exterior walls were not insulated. On part of the building the asbestos cement board has been replaced with plywood and insulation was added. Extensive dryrot was encountered in the studs.

4. During the 1975 remodeling a metal roof was removed and a built-up roof was installed. The roof leaks.

5. The domestic water is distributed directly from the boiler. The water that is circulated is too hot.

6. The heating system is a steam system. There are no local controls and the system is not well balanced.

7. The ventilation system that was installed is inoperable. When it does operate it is not capable of maintaining proper pressure relationships in the building.

8. Not all closers required by current codes exist. There is no protection between patient rooms and corridors. Many of the closers that do exist are improperly adjusted.

Phoebe A. Lindsey
Director

9. Doors to the main entry are key locked without panic hardware. When they are locked they block exiting from the hospital. There is a smoke door that separates the acute care side of the hospital from the long term care side. When the door is locked the acute care corridor is one long dead end corridor with only one exit, provided of course, that the main doors are not also locked; in which case there are no exits.

10. Medical records is too small.

11. The emergency area has no on grade direct entry. There is no waiting area; no storage area for stretchers and wheel chairs. There is no staff work area or charting area. There is no convenient patient toilet and no clean and soiled workroom.

12. The room designed for a surgical recovery room has been remodeled to the Administrator's office.

13. The delivery room is too small. It is 214 square feet. 300 square feet is required. There is no labor room. All service facilities are shared with the surgery. The lights in the delivery room are concentric ring fixtures which are difficult to clean.

14. The surgery is too small. It is 340 square feet. It is required to be 360 square feet. Missing from the service area is:

    a. a control station
    b. a supervisor's office
    c. drug distribution station
    d. surgical soiled workroom
    e. fluid waste disposal
    f. clean workroom
    g. staff clothing change
    h. stretcher storage
    i. surgical lounge and toilet

15. The portion of the xray that exists is inadequate in size; however, a portion of it is being used as an office for the director of nursing. There is no waiting space either for the ambulatory patients or for a patient in a bed to wait out of the corridor. There are no dressing rooms.

16. An ICU is scheduled to be established in the room which was formerly the laboratory. This can work if proper visual access is provided from the nurses station which is across the hall.

17. All corridors are less that the 8 foot minimum width; 7'11" in acute care and the corridor leading to surgery; 7'5" in front of the nurses station and 7'5" in long term care where chair rails have been installed.

Phoebe A. Lindsey
Director

The corridor in front of the elevator is being used as a lounge for housekeeping personnel.

18. The present ICU is also being used as a cardiac care unit. It is a two bed room which is not permitted for cardiac care. There is no toilet except across the corridor for this room. There is a window from the corridor into the room but the nurses do not have direct visual access from the nurses station.

19. The long term care rooms do not have direct access to the toilets except across the corridor. There are not sufficient toilets to provide toilets at the rate of 1 toilet to 4 beds as required. Some acute care beds lack access to toilets in the same manner.

20. Nursery has 4 cribs and 1 isolet. There is no public viewing directly into the nursery. Babies are wheeled into the work room for public viewing. There is no infant examination and treatment room. There is no gowning area. The space is adequate for 5 cribs if it were arranged properly.

21. The nurses station has the following deficiencies:

    a. The Director of Nurses does not have an office.
    b. The charting facilities are inadequate.
    c. There is no storage area for administrative supplies.
    d. There is no lounge and locker space for the nursing staff.
    e. The staff conference room is remote in the basement.
    f. There is no space for wheel chairs and stretchers.
    g. There is no storage space for emergency gear, crash cart, etc.
    h. The temperature cannot be controlled in the drug room.

22. The Administrator proposes to make 3 small rooms in the basement into a laundry with access from a chute in the acute care corridor. A hall outside the existing linen storage area will be enclosed to become a clean linen folding area and the present clean linen closet will continue to be used. This modification is badly needed. The old laundry was converted to a laboratory. Present laundry service is obtained by filling an old station wagon with dirty laundry, putting the station wagon on a ferry which takes it to Valdez where it is reserted and transhipped to Anchorage. The clean laundry from Anchorage is loaded into the old station wagon in Valdez and ferried to Cordova.

23. According to utilization formulae the lab is large enough. Lab technicians complain they don't have enough work counter space. The laboratory facility is newly completed.

24. The hospital has not incorporated the required barrier free design for the handicapped.

25. Existing heating and ventilating system are obsolete. To incorporate modern energy saving equipment, insulation, openings, etc., will be very difficult and expensive.

Report on

Hospital and Health Facility Operation and Construction Assistance

Prepared for

Alaska Legislature

by

Department of Health & Social Services

Helen D. Beirne, Commissioner

February 1, 1981

CONTENTS

Introduction

The report that follows describes the condition of Alaska's health care facilities based on reports and inventories prepared by the Division of State Health Planning and Development. This report examines existing programs of state aid for hospital and health facility construction and operation in Alaska. Options for changes in the program and the rationale and bases for these options follow.

Current Alaska Facilities

Alaska has 17 public and private hospitals, seven of which include an intermediate and/or skilled nursing component. There are also eight facilities (exclusive of the Pioneer Home System) for intermediate care and/or intermediate care for the mentally retarded which are not associated with a hospital. It should be noted that a certificate of need application is currently being reviewed which requests authorization for a specialized hospital. Should this certificate be granted, there will be a total of 18 hpspitals in the state (exclusive of Public Health Service and U.S. military hospitals).

Another major provider of care in Alaska is its system of public health clinics scattered throughout the state. The 1981 proposed State Health Plan lists unverified data indicating that 127 clinics, either free-standing structures or existing as a part of a community center or multipurpose building, are located throughout the state. The state has made available through the sale of bonds approximately $3.7 million since 1973 to construct and/or equip clinics in some 38 locations.

Other health care facilities defined by the revenue sharing act include maternity homes (of which there is one in the state), community mental health centers (of which there are 23 in the state according to the 1981 proposed State Health Plan), facilities for the mentally or physically handicapped (there are at least 9 facilities which receive revenue sharing funds in this category), nursing home or convalescent center (this capability is noted above, since nursing homes are licensed facilities). In addition, a number of drug abuse and alcoholism facilities receive revenue sharing funds.

Current Status of the Hospital and Health Facility Revenue Sharing Program

The hospital and health facility revenue sharing program was modified during the 1980 Legislative session to provide construction funds to general hospitals only (and not to other health facilities). Currently only three hospitals (Fairbanks Memorial and Providence Hospital and Alaska Hospital and Medical Center in Anchorage) are receiving construction funds. Attachment I, based on data provided by the Department of Community and Regional Affairs, indicates where and in what amounts revenue sharing dollars were distributed in 1980.

Further Changes in the Health Facility Revenue Sharing Program

The health facility revenue sharing program, which was originated to relieve health facilities of financial strains placed on them because of uncollected debts, has undergone changes in support levels and perhaps in its philosophy since it was established in 1971. There have been efforts to increase the minimum amounts available in recent legislative sessions. There is also some interest in tying requirements for specific types of services to the receipt of revenue

sharing funds. It has been suggested, for example, that community hospitals willing to designate psychiatric care beds should receive a revenue sharing incentive for this designation. Such an incentive could relieve the overcrowded situation at the Alaska Psychiatric Institute and perhaps avert the need for constructing other psychiatric hospitals in the state. Yet another interest expressed is in restoring the availability of construction funds to facilities other than hospitals.

DHSS Approach in Developing Report

Recognizing the significant scope of work this report suggests, staff reviewed existing data and accelerated their schedule of inventories for rural hospitals. The revenue sharing program was discussed with staff in the Department of Community and Regional Affairs, the current program administrators. Input was requested as well from recipients of the revenue sharing funds - municipalities, hospitals and other health facilities (see Attachment 2). Several discussions were held with hospital administrators to gain further information regarding the impact of hospital revenue sharing on health care services. Information on current facility status was derived from the 1981 proposed State Health Plan, from reports of deficiencies resulting from annual licensure and certification surveys and from on-site review of the physical plant for architectural condition of hospitals. The inventories focused on the more rural hospitals, and those facilities identified in the proposed State Health Plan as needing immediate attention (Valley Hospital at Palmer, Cordova Community Hospital and Petersburg General Hospital) were inventoried first. Other rural hospitals with the exception of those at Kodiak and Valdez have been inventoried, the larger, more metropolitan hospitals have not yet been inventoried.

A Review of Current Programs of State Aid for Hospital and Health Facility Construction and Operation

There are three major sources of state aid for hospital and health facility construction and operation in Alaska, as follows:

1) revenue sharing -- the current bill provides operation and/or construction support to non-federal, non-state health care facilities. Funds are made available on the basis of facility size (number of beds) and a minimum amount is available per facility.

2) The Alaska Medical Facility Authority -- created by AS 18.26.010 to provide financing through the issuance of tax-exempt bonds for non-profit facilities to finance capital projects. One major project has bee financed to date -- Fairbanks Memorial Hospital in the amount of approximately $12 million. Alaska Hospital and Medical Center in Anchorage is currently working with the Authority to determine the viability of this funding approach to assist them with refinancing their facility and possibly acquiring the adjacent Professional Office Building.

The Medical Facilities Authority is an excellent source of funds for those private non-profit facilities which generate sufficient revenues eventually to repay the loans. However, in communities such as Palmer, and Glenallen where there is little possibility that hospital income

would be sufficient for operational costs as well as loan repayment, the Authority as it is presently structured is not a viable financing option.

3) Direct legislative funding (through the sale of bonds or from general funds to support projects) is the final source of state support for health care facility construction and operation. Since 1973, some $17,882,671 (exclusive of Hill-Burton matching funds) has been made available through the sale of bonds to support 38 clinic construction projects and 12 hospital or other health facility construction projects. This is an important source of funds, especially for rural facilities in more isolated areas. There are several difficulties with this approach. The amount of funds made available is often not adequate to construct an acceptable facility.

In non-hospital facility construction consideration is not always given to the availability of water systems, sewage systems and solid waste disposal systems, all of which are integral to a functional clinic. There is no assessment of the community's need for a clinic, what type and size of clinic should be developed or whether it could be integrated with another community function (part of a multi-purpose facility, for example).

Other sources of funds (a combination of state and federal funds) which have assisted with health facility operation and construction in past years but are no longer available include Hill-Burton funds (Title VI of the Public Health Service

Act), and funds under the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. Hospitals in Kodiak and Homer are receiving final payments under the Hill-Burton Act; no new funds will be available under this Act. Title XVI of the Public Health Service Act authorized federal funds to be used with state funds for health facility construction; to date, no federal funds have been appropriated for this purpose under this title.

Considerations in Determining Appropriate State Support to Health Care Facilities

The State's role in assisting in the construction and operation of health care facilities is an incremental one based, presumably, on its interest in protecting and promoting the health and well being of its citizens. With its vast geographic area, climatic extremes, transportation and communication problems, there is a need for health care facilities in key places to provide at least primary care not only to residents but to seasonal populations and visitors. The need for these facilities is no necessarily related to a community's ability to fully support the facili

Historically, the state has put funds into health facility construction and/or operation, starting with the Hill-Burton program (established in 1947). The State's construction and operation of the Pioneer Home system is further evidence of a policy to provide health care facilities (and indeed health care services) to its citizens.

While no one would suggest that the state had a responsibility for full construction and/or operational support of all health care facilities in the state, it is clear that many needed facilities are deteriorating and their communities are not financially able to correct these steadily worsening situations. It can be argued that the state has a responsibility for ensuring access to quality care for its citizens when other sources of assistance are non-existant.

Health facility need for assistance has been determined in large part by the on-going inventory of existing hospitals and by the certificate of need process. Physical plant adequacy is annually determined, as well, by the on-site survey for operational licensure and certification for Medicare and Medicaid reimbursement (which applies primarily to hospitals skilled nursing and intermediate care facilities). Deficiencies in the facility, particularly those related to patient life and safety, are noted and the facility is required to develop a plan of correction to rectify the situation. The dilemma is that some hospitals are so old and outmoded that it simply is not cost efficient or effective to modernize or renovate them. There currently is no mechanism to assess the need for clinics; resources have never been available to inspect current clinics, site-visit areas requesting or needing clinics, or review with communities their proposed program and design for a clinic.

Other dimensions of need, as outlined in Section 14 of Chapter 155, were reviewed in preparing this report. In the area of acute care in a hospital setting, the number of beds available to a service area can be a factor in determining need, since the operating cost of a facility is related to some degree

to the physical plant area within the facility. There are national formulas and data available indicating that generally a maximum of four (4) beds for each 1,000 people will more than adequately make care available. Alaska has overall an average of 2.7 beds per thousand population and there are additional beds authorized through the certificate of need process for future development.

Formulas to determine long term care and other kinds of service needs are much less precise and are not tied to numbers of beds required to provide acceptable levels of service. Much more study and research on a national as well as a local basis needs to occur in this regard.

The occupancy rate of health care facilities can be used to help determine the need for acute care and long term care facilities. The nationally recommended occupancy level for hospitals is 80 percent, for example. In looking at health facility need in Alaska, however, this figure must be used cautiously. Data from the 1981 proposed State Health Plan indicate that only one hospital - Providence in Anchorage - had an average annual occupancy rate even approaching 80 percent (Providence's average was 75 percent average annual occupancy for 1980). The fact that the Valdez Community Hospital average annual occupancy for 1980 was only 14 percent does not necessarily indicate that that facility is unneeded. Geographic location, seasonal population fluctuations, and transportation are only a few of the variables which must be considered in assessing occupancy. Further, a major accident or a natural disaster could quickly fill all beds in a smaller hospital.

The kinds and levels of services provided to determine facility need requires lengthy review and analysis. This process has been underway since June 11, 1980, under the appropriateness review program being conducted by the State's three Health Systems Agencies and the Department. Two services will be reviewed each six-months; end stage renal disease and cardiac catheterization have already been reviewed by the State's three Health Systems Agencies and other institutional services are scheduled for review through 1983. Although the review process is not yet complete, it is clear that there is a need for short-term psychiatric beds to be designated in Alaska's community hospitals to meet a critical need and to avert, if possible, the construction of additional facilities similar to Alaska Psychiatric Hospital.

Alternatives for Making Revenue Sharing Funds Available

The Department reviewed other alternatives to the number of beds option for making revenue sharing funds available. Some of the other options considered included:

- wealth of the community
- population served (including seasonal fluctuations)
- uncompensated care levels at the facilities
- facility occupancy
- health care services offered

While this assessment was not exhaustive in its exploration of possibilities, each option considered had major deficiencies, including:

- creating incentives for providing unnecessary care (i.e., basing a formula on occupancy rate could induce arbitrary raising and lowering of the occupancy rate)

- penalizing good management and rewarding poor management. By no means is a facility's financial status solely the result of management, but establishing a formula only on the basis of a facility's financial status could have this spin-off effect.

- creating a complex operation to administer the program. The concept of revenue sharing can be interpreted to be the provision of some resources to all members in a similar class. Complex formulas incorporating a number of variables would inevitably require additional staff, an audit capability, an application and a review process. This Department interpreted that revenues for a variety of purposes were to be made readily available to facilities through the municipal structure with a minimum of qualifications and strings attached.

Comprehensive Program for Hospital Care and Health Care Services

This report focuses primarily on the assistance which could be provided for hospital and health facility construction and operation. More intensive focus on the state's role in providing or assisting in the provision of health care services can be found in the 1981 (proposed) State Health Plan. These issues as well as financing issues are being extensively reviewed in the current Health Care and Financing Study funded through the Department. The first phase of this

study is scheduled for completion in December 1981 and could provide additional insight into the state's role in assisting municipalities in the provision of hospital care and health care services.

Options for Hospital and Health Facility Operation and Construction Assistance

Access to quality health care at reasonable cost is the aim of Alaska's health care delivery systems. Access and quality are tied to the existence of appropriate facilities which ensure an environment protective of patient life and safety.

The type of facility most appropriate to a given area is outlined in the State Health Plan. This plan articulates a level of care concept identifying minimum facilities and services which should be available in various sized communities in Alaska. This plan, developed in a public forum, guides the certificate of need process so that needed health care facilities and services are approved; unneeded and unnecessarily duplicative services are therefore disapproved. This process offers a safeguard against the proliferation of hospitals and other health facilities subject to review.

The question of the appropriate state role in assisting in the operation and construction needs of existing facilities is a complex one. This report has noted that the state has previously had a role in establishing and/or assisting in the support of the operation of many of these facilities. With the discontinuation of federal funds which had also previously supported health care facilities, the state's role has become less clear and in need of further exploration

and definition. Regardless of the extent of the state's role, the fact remains that many of Alaska' health care facilities, which are deemed to be needed facilities by virtue of the access to services they provide, are in need of renovation, modernization or replacement in order to continue to make quality health care reasonably accessible to Alaskans as well as to the many visitors to this state.

The options for assistance for hospital and health facility operation and construction will be discussed separately to facilitate review and policy development.

Hospital and Health Facility Operation

All health facilities have basic operational costs which must be supported regardless of the volume of patients available to generate revenues. This fact can perhaps best be seen by looking at the minimum requirements for a hospital.

Each hospital, whether rural or urban, must have the following basic areas in its facili through which to provide health care services:

Pati care including:	gross square feet
intensive care room	
1 coronary care room	
1 isolation room	
1 psychiatric room	
1 two bed pediatric room	
2 two bed acute care rooms	
1 five crib nursery	5,600

Surgical	2,400
Obstetrics	3,400
Emergency	1,100
Radiology	900
Laboratory	400
Physical therapy	500
Dietary	1,700
Administration	1,600
Central services	400
General storage	300
Laundry	700
Waste disposal	600
Morgue	400
Outpatient	2,000
	22,000

There is a basic cost of operation for this minimum hospital which results from staffing costs, building maintenance, and utilities.

The costs for building maintenance and utilities are almost entirely a function of the area of the hospital. The staffing costs are directly related to the services which are offered by the hospital and comprise the greater part of operating costs. A certain level of minimum staffing for the functions of medical records, dietary, maintenance, housekeeping, laundry, nursing, laboratory, x-ray, etc., is unavoidable and must exist in order for a hospital to provide service. Due to the low population served and thus the low levels of revenue generated, the rural hospitals and nursing homes have difficulty in meeting operating expenses. Many of the rural hospitals subsist only as a result of grants from local government.

All facilities continue to experience operational cost increases as a result of inflation reflected in increased fuel costs, increased salaries and increased costs of supplies. Larger facilities may be able to offset some of these costs by increased charges to patients, but this assumes a constant high occupancy

level within a facility. Such a constant is simply not the case in most Alaska health facilities, and yet the basic operational costs continue to rise. Options currently available to assist health facilities meet some of the operating costs include the health facility revenue sharing program and the municipal assistance program.

The health facility revenue sharing program provides operational costs to facilities on a regular annual basis according to the number of patient care beds available in each facility. Funds are made available to privately owned facilities (owned by a religious order, for example) as well as municipal facilities. These funds have been essential in the support of operational expenses in many Alaska facilities. Current revenue sharing fund levels are not sufficient to provide more than a portion of the operating expense of most hospitals, for example, and this is a key factor for some of the smaller, more rural hospitals in particular. There has been an interest in linking the receipt of revenue sharing funds to the provision of specifically needed services such as psychiatric beds. This option could be further explored.

The second option for operational assistance to health facilities is the municipal assistance program. This option would allow municipalities to increase the amount of operational support to health care facilities in accordance with local determination of need. One aspect of this option requiring further exploration is the eligibility of the six private, non-municipal hospitals and other non municipal health facilities for such assistance.

Hospital and Health Facility Construction

The current health facility revenue sharing program provides construction funds (up to 25% of the costs disbursed over a five-year period) to hospitals only. This program could be modified to provide a greater portion of construction funds for renovation, modernization or replacement of hospitals in communities which have an insufficient tax base to undertake 75% or more of the costs. This program could also be modified to provide up-front money where it is needed when the construction begins. Yet a third modification of this program could be to include facilities other than hospitals as eligible for construction assistance. A consideration for modification of this program might be to include funds for planning and design to ensure the most viable construction alternative.

Municipal assistance is a second option for facility construction. Municipalities which place their health facility needs as a high priority could support needed appropriate construction. Again, the eligibility of non-municipal facilities for such assistance needs to be resolved.

Bond issues offer a third possibility for assistance with health facility construction. Possible bond issues include:

(a) bond issue by an individual community

(b) bond issue by the state for facilities in a number of communities.

(c) municipal bond bank

(d) tax exempt bonds sold by the Alaska Medical Facilities Authority to support construction in nonprofit facilities.

Bond issues by the state for health facility construction provide resources to the community that do not necessarily require community obligation or indebtedness. All other bond issues presume a tax base to support repayment and a bonding capability for the community. Communities which may be approaching the upper limit of bonded indebtedness would be unlikely candidates to support a bond issue.

Health facility construction assistance is presently limited to the above listed alternatives. The likelihood of federal assistance for which Alaska facilities would be eligible any time in the near future is remote. Health facility construction need not be bound by current programs if it is determined that the state has a role in assisting with health facility construction. The state could, for example, establish a program of assistance for health facility construction similar to the now defunct Hill-Burton program. Such a program could include the following features:

- an inventory of all existing health facilities to determine precisely their structural status and need for renovation, expansion, modernization or replacement. This process would not preclude a recommendation for closure of facilities which are no longer providing needed appropriate services.

- DHSS has for many years recognized the need for designated hospitals to provide psychiatric care. AS 47.30.010(b)(1) authorizes the Commissioner of DHSS to designate such hospitals. Alaska Psychiatric Institute is currently the only designated facility in Alaska. This facility is now

experiencing an occupancy rate of 114%. An effective method of providing the needed psychiatric beds is to designate hospitals which would dedicate certain beds for the provision of psychiatric care. This method could, if successful, obviate the need for additional construction and would place psychiatric care into more areas of the state.

- the development of a program of state assistance based on the results of the inventory and the current edition of the State Health Plan. This program could incorporate an initial planning and design component, a community match requirement (based, perhaps, on the size of the community) and the establishment of a representative body to review applications and make recommendations for funding.

All the above options, singly or in combination, have the potential for addressing the needs for health facility construction programs in the state. The age and inadequate status of many of our health facilities make it imperative that a rational system for renovating or replacing deficient facilities be established now to stem the problem. Failure to establish a consistent and timely approach can be expected to result in a plethora of requests from individual communities to the Legislature ---and determining which community should get what level of resources in the absence of a total picture of the state's needs could become a most complex and controversial issue.

APPENDIX

Attachment I - Printout on Distribution of Health Facility Revenue Sharing Funds

Attachment II - DHSS Letter of Request for information to recipients of revenue sharing funds

Attachment III - Structural deficiencies reports:

a. Petersburg General Hospital

b. Wrangell General Hospital

c. Valley Hospital, Palmer

d. Cordova Community Hospital

e. Seward General Hospital

f. Wesleyan Nursing Home, Seward

g. Faith Hospital, Glenallen

PLEASE NOTE: THE PRECEDING PAGES WERE TREATED AS A UNIT IN THE ORIGINAL DOCUMENT.

Alaska
state
hospital
association

319 Seward St., Juneau, Alaska 99801 (907) 586-1790

REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

President
Sister Barbara Haase
Providence General Hospital
Anchorage

President Elect
Tom Mingen
Fairbanks Memorial Hospital
Fairbanks

Secretary/Treasurer
Jon Pavelas
Alaska Hospital & Medical
Center
Anchorage

Immediate Past President
A. Camposo
Providence Hospital
Anchorage

Executive Director
Dennis L. DeWitt
Juneau

March 19, 1981

The Honorable Bette Cato
State House of Representatives
Pouch V, State Capitol Building
Juneau, Alaska 99811

Dear Representative Cato:

The Alaska State Hospital Association has reviewed HB 365 and wishes to express its support.

The appropriation will begin the process of determining the best approach at modernizing hospital services in the city of Cordova. While Cordova Hospital is delivering good quality care now, the condition of its physical plant makes delivering quality health care more difficult each year. The feasibility study and design and engineering reports will provide a solid basis for consideration of capital funding of a viable proposal.

We will be happy to assist you as you move HB 365 through the legislative process.

Sincerely,

Dennis L. DeWitt
Executive Director

DLD/b

cc: Ed Zeine

Seward General Hospital

P.O. BOX 365
SEWARD, ALASKA 99664
(907) 224-5205

January 20, 1981

Representative Betty Cato
Pouch Y
Juneau, Alaska 99811

Dear Representative Cato:

Seward General Hospital is a non-profit corportation serving the health needs of the 3,600 full time residents of the eastern portion of the Kenai Peninsula.

The bulk of our equipment has been in use since 1958 and is past or swiftly approaching its useful life. Most of the funds that are available to the Hospital Board must be spent on day to day operations, leaving very few funds for modernization. The Hospital Board has ascertained that a one-time infusion of funds is necessary to adequately re-equip the hospital with current State-of-the-Art items of equipment. Once adequately equipped, a program for maintaining and up-dating, along with a plan for replacement of obsolete items would be meaningful and practical.

The hospital has been operational in the current facilities since 1958. All of the major equipment, with the exception of the X-ray machine, was installed as part of the initial construction effort. Time, usage and technical innovations in the State-of-the-Art have made these equipment items obsolete. In order to maintain quality care, funds have been expended as they became available to upgrade equipment requirements. The advancing age necessitates the contemplation of total replacement of the bulk of the patient care equipment.

The objective of upgrading equipment encompasses all departments of the hospital operation. Needs exist for items directly concerned with patient care such as cardiac monitoring and patient data systems, though ancillary items such as a floor scrubber and a one-half ton van are purely support items. All items considered for acquisition are essential for continued modern hospital care. They can be installed with currently available utilities and are within the scope of the existing employees to install and operate, and with limits, maintain with minimal training.

A perusal of the attached listing, with approximate pricing information, will indicate no unusual items of equipment requested.

Thank you for your consideration.

Sincerely,

C. Keith Campbell, Administrator

CKC:ecb

Enclosure

EQUIPMENT REQUIREMENTS
SEWARD GENERAL HOSPITAL

INDEX

Embossing System	$ 4,200.
Reception Area Furniture	6,000.
Electrocardiograph	2,400.
Bath Lift	3,000.
Executive Pagers	4,500.
Infant Circle Filter Anesthesia Apparatus	570.
Window Mount Air Conditioner	6,000.
Washer-Extractor	14,003.
Laundry Conditioner-Dryers (Two)	10,940.
Air Vent System (Laundry)	3,600.
Dietetic Ice Machine	1,644.
Food Freezer	2,305.
Kitchen Work Table	218.
Deep Fat Fryer	841.
Dishwasher	4,200.
Entry Ramp	5,500.
Nursing Station Call System	70,000.
Coffeemaker	700.
Boiler/Burner	8,714.
Bili-Meter and Bili-Timer	1,231.
Pressure Sensor Valve	255.
Silver Recovery Unit	1,634.
Patient IV Walker(s) Two	299.
Laboratory Furniture	13,725.

Phase Contact Microscope	$ 5,195.
Laboratory Computer/Printer	5,100.
Centrifuge	750.
Waterbath	580.
Blood Gas Machine	6,995.
Calcium Analyzer	2,150.

Equipment Requirements	$339,177.

alaska
state
hospital
association

319 Seward St., Juneau, Alaska 99801 (907) 586-1790

REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

MAR 12 1981

March 6, 1981

The Honorable Bette Cato
State House of Representatives
Pouch V, State Capitol Building
Juneau, Alaska 99811

Dear Representative Cato:

The Alaska State Hospital Association wishes to inform you of its support of an appropriation of approximatly $600,000 for a feasibility study on the need and design of a new physical plant for Cordova Community Hospital. The Association will be pleased to assist you and Cordova Community Hospital in achieving that goal.

Sincerely,

Dennis L. DeWitt
Executive Director

DLD/b

cc: Ed Zeine