SB

326

# HOUSE COMMITTEE REPORT

(7)
Date Referred: April 28, 1990 FURTHER REFERRALS: FINANCE

Date of Committee Action: 4/30/90

The HESS Committee considered: CSSB 326(FINANCE)

CS SB NO. 326 (Fin) GRANTS FOR COMMUNITY HEALTH PLANNING

"An Act relating to grants for health planning; and providing for an effective date."

RECOMMENDATIONS:
[ ] be replaced with _____ [ ] the same title [ ] a new title
[ ] have attached amendment(s)
[X] do pass
[ ] do not pass
[ ] no recommendation
[ ] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept)
[ ] fiscal impact _____
[ ] zero fiscal note _____
[ ] zero with analysis _____

APPROVES PREVIOUS: (Date/Dept)
[X] fiscal note(s) 4/26/90 / DHSS
[ ] zero fiscal note(s) _____
[ ] zero fn/analysis _____

SIGNING DO PASS:
J Ellis
W Furnace
M Luna
Chris Dallis
Mark Boyer

SIGNING: (Check approp. column)

| | Do Not Pass | No Rec | Amend |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
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| | | | |
| | | | |

J Ellis
Chairman's Signature

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSSB 326 (Fin)
PUBLISH DATE: 4/26/90

# FISCAL NOTE

Corrected Note

REQUEST:

Revision Date: April 26, 1990
Title: Grants for community health planning
Sponsor: Senator Jones
Requestor: Senate Finance

Agency Affected: Health & Social Services
BRU: Administrative Services
Components: Planning

EXPENDITURES/REVENUES: (Thousands of Dollars)

| OPERATING | FY 91 | FY 92 | FY 93 | FY 94 | FY 95 | FY 96 |
|---|---|---|---|---|---|---|
| PERSONAL SERVICES | 0 | 0 | 0 | 0 | 0 | 0 |
| TRAVEL | 0 | 0 | 0 | 0 | 0 | 0 |
| CONTRACTUAL | 37.1 | 26.0 | 0 | 0 | 0 | 0 |
| SUPPLIES | 0 | 0 | 0 | 0 | 0 | 0 |
| EQUIPMENT | 0 | 0 | 0 | 0 | 0 | 0 |
| LAND & STRUCTURES | 0 | 0 | 0 | 0 | 0 | 0 |
| GRANTS, CLAIMS | 150.0 | 150.0 | 0 | 0 | 0 | 0 |
| MISCELLANEOUS | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL OPERATING | 187.1 | 176.0 | 0 | 0 | 0 | 0 |
| CAPITAL | 0 | 0 | 0 | 0 | 0 | 0 |
| REVENUE | 0 | 0 | 0 | 0 | 0 | 0 |

FUNDING: (Thousands of Dollars)

| | | | | | | |
|---|---|---|---|---|---|---|
| GENERAL FUND | 187.1 | 176.0 | 0 | 0 | 0 | 0 |
| FEDERAL FUNDS | 0 | 0 | 0 | 0 | 0 | 0 |
| OTHER | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL | 187.1 | 176.0 | 0 | 0 | 0 | 0 |

POSITIONS:

| | | | | | | |
|---|---|---|---|---|---|---|
| FULL-TIME | 0 | 0 | 0 | 0 | 0 | 0 |
| PART-TIME | 0 | 0 | 0 | 0 | 0 | 0 |
| TEMPORARY | 0 | 0 | 0 | 0 | 0 | 0 |

ANALYSIS: (Attach a separate page if necessary)

Prepared by: Senator Rick Uehling, Co-chairman
Division: Senate Finance Committee
Phone: 465-4821
Date: April 26, 1990

Approved by Commissioner: _____ Date: _____
Agency: _____

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

HEALTH ASSOCIATION OF ALASKA

STATEMENT OF SUPPORT
April 28, 1990
CSSB 326 -- Grants for Community Health Planning

Community hospitals and nursing homes across the state support CSSB 326 as it provides an opportunity for communities and/or regions within the state to measure the cost and the effectiveness of their local health system.

CSSB 326 provides:

1. That the Department of Health & Social Services establish a grant program under which up to 12 municipalities, Native service areas or rural government entities may receive a grant of up to $50,000.00 to:

   A. Conduct a comprehensive analysis of the local health care delivery system;

   B. Review coordination and cooperation of community, regional, state and federal health care services and programs;

   C. Review adequacy of health care facilities;

   D. Identify the uninsured and the under insured;

   E. Recommend to local, state, regional and federal agencies ways to coordinate and maximize the delivery of health care services.

2. Communities or regional areas applying for grants must:

   A. Have broad community or regional participation;

   B. Provide cash and in-kind contributions totaling in value of up to 1/3 of the grant applied for.

3. The fiscal note is:

   1991 -- $150,000 grants; $37,100 administration = $187,100.00.

   1992 -- $150,000 grants; $26,000 administration = $176,000.00.

   The program is repealed July 1, 1992.

FOR MORE INFORMATION CONTACT:

Harlan Knudson - 586-1790
Health Association of Alaska
319 Seward Street, #11
Juneau, AK 99801

# # #

140-SC-117-M

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSSB 326 (Fin)
PUBLISH DATE: _____

# FISCAL NOTE

Corrected Note

REQUEST: _____

Revision Date: April 26, 1990
Title: Grants for community health planning
Sponsor: Senator Jones
Requestor: Senate Finance

Agency Affected: Health & Social Service:
BRU: Administrative Services

Components: Planning

**EXPENDITURES/REVENUES:** (Thousands of Dollars)

| OPERATING | FY 91 | FY 92 | FY 93 | FY 94 | FY 95 | FY 96 |
|---|---|---|---|---|---|---|
| PERSONAL SERVICES | 0 | 0 | 0 | 0 | 0 | 0 |
| TRAVEL | 0 | 0 | 0 | 0 | 0 | 0 |
| CONTRACTUAL | 37.1 | 26.0 | 0 | 0 | 0 | 0 |
| SUPPLIES | 0 | 0 | 0 | 0 | 0 | 0 |
| EQUIPMENT | 0 | 0 | 0 | 0 | 0 | 0 |
| LAND & STRUCTURES | 0 | 0 | 0 | 0 | 0 | 0 |
| GRANTS, CLAIMS | 150.0 | 150.0 | 0 | 0 | 0 | 0 |
| MISCELLANEOUS | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL OPERATING | 187.1 | 176.0 | 0 | 0 | 0 | 0 |
| CAPITAL | 0 | 0 | 0 | 0 | 0 | 0 |
| REVENUE | 0 | 0 | 0 | 0 | 0 | 0 |

**FUNDING:** (Thousands of Dollars)

| | | | | | | |
|---|---|---|---|---|---|---|
| GENERAL FUND | 187.1 | 176.0 | 0 | 0 | 0 | 0 |
| FEDERAL FUNDS | 0 | 0 | 0 | 0 | 0 | 0 |
| OTHER | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTAL | 187.1 | 176.0 | 0 | 0 | 0 | 0 |

**POSITIONS:**

| | | | | | | |
|---|---|---|---|---|---|---|
| FULL-TIME | 0 | 0 | 0 | 0 | 0 | 0 |
| PART-TIME | 0 | 0 | 0 | 0 | 0 | 0 |
| TEMPORARY | 0 | 0 | 0 | 0 | 0 | 0 |

**ANALYSIS:** (Attach a separate page if necessary)

Prepared by: Senator Rick Uehling, Co-chairman
Division: Senate Finance Committee
Phone: 465-4821
Date: April 26, 1990

Approved by Commissioner: _____
Agency: _____
Date: _____

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)



[redacted]

- Fiscal Note and Fiscal Note Analysis -

FISCAL NOTE ANALYSIS (continued)

CSSB 326 (FIN) BY JONES
5/6/89

"An Act relating to grants for community health planning; and providing for an effective date."

Contractual funding is based upon the following assumptions:

| PURPOSE | FY 1991 | FY 1992 |
|---|---|---|
| Grant administrator | $21,000 | $21,000 |
| Advertising of RFP | 600 | |
| Printing | 500 | |
| Technical assistance work sessions | 15,000 | 5,000 |
| | 37,100 | 26,000 |

It is estimated that a half-time grant administrator will be needed to organize and administer the grant program. Funding for this purpose is shown in the contractual line to facilitate a reimbursable services agreement for use of an existing position if such an arrangement proves feasible and efficient. Two year funding of the half-time position reflects the spread of grants over two fiscal years.

Advertizing cost is for notices in major newspapers and by mail.

Printing costs are estimated for publishing a Request for Proposal and for application forms.

Technical assistance work sessions would be held in 5 regional locations to assist with initial application completion. Additional on-site assistance, grant administration, monitoring and evaluation would occur as funding allows.

Grant funding assumes a maximum grant amount of $50,000 for each grantee in FY 91 and a maximum grant amount of $50,000 for each grantee in FY 92. The sum of all grant funding would be limited to $150,000 each fiscal year. The total number of grants would be limited to up to twelve.

## SB 326 - Grants for Community Health Planning

### Introduction

Through the work of the Governor's Interim Commission on Health Care, certain principles were developed and commended to the Governor and legislature to guide the development of health policy. One principal focused on ensuring access to basic health care services for all Alaskans. Another principal emphasized community responsibility for health care and health promotion. This bill allows for several communities, regions, or combination of municipalities, non-profit agencies, etc., to apply for a grant.

Senate bill 326 focuses directly on local responsibility to ensure health care access for Alaskans. The bill makes it possible for local health leaders to identify health care priorities and to coordinate future efforts in reaching those goals.

### Background

Changes in the cost of health services, in reimbursement policies for public and private purchasers, in the economic and demographic conditions in rural areas, in the availability of health care providers, and other trends, threaten the availability of health care services in many Alaskan communities.

In addition, many factors inhibit necessary changes in the delivery of health services to Alaska, including:

- inappropriate and outdated regulatory laws
- aging and inefficient health care facilities
- the absence of local planning and coordination of rural health services
- the lack of community understanding of the costs and benefits of supporting hospitals and other health service providers
- the lack of state or regional assistance to assure access to care that cannot be provided in every community, and
- the lack of clarity of state health policy objectives.

### The Program

This program is designed to utilize a method for strengthening health services in Alaska by working directly with communities. The model program, developed by the University of Washington School of Medicine Rural Health Office, includes four phases:

- **Community selection:** Any community desiring to participate in this program may initiate a request to the administrator of the program, designated by the State.

- **Community analysis**: A thorough and intensive study will be made of the health services system in each participating community. This will include a management and financial study of the community hospital and/or nursing home; a market survey; a needs assessment; and other community analysis that may be deemed important.

- **Strategic planning**: A strategic plan will be developed for the community, involving all elements of the health services delivery system.

- **Implementation of the plan**: Problems indentified in the planning process and changes in service configuration will be implemented.

Each grantee will develop a long-range plan covering the local spectrum of health services. It will be the grantees' responsibility to involve all major health care providers, business leaders, public officials and other community leaders, to develop the project design and to oversee and implement the program. Grantees will also participate in the financial support of the program with a one-third match in cash or in-kind contributions.

**Appropriation**

In this act, the state of Alaska will appropriate $187.1 in FY91 to support the program, $176.0 in FY92. Grantees will receive up to $50,000 each. The bill allows for one-half of the grants awarded by the Department of Health and Social Services to go to rural areas with special needs, as defined by the department.

Other costs include funding a half-time grant administrator, advertising of the RFP, printing and technical assistance work sessions. Communities will be expected to contribute 33-percent of the total grant appropriation in cash or in-kind contributions (see attached fiscal note analysis).

**Administration**

The Department of Health and Social Services shall establish the Alaska Rural Health Systems Project. The Department may contract with a third party to carry out the implementation of the legislation where this makes most effective use of available expertise, avoids duplication of efforts and promotes economy of resources. The Department will develop a list of appropriate resources and consultants to assist the grantees.

December 1989
Bruce Amundson, M.D.
Associate Director
Community Health Systems

The Community Health Services Development (CHSD) strategy for assisting rural communities is a product of the University of Washington Rural Hospital Project (PHP). This four-year demonstration project was designed to develop approaches to stabilize and improve health services in a sample of six rural communities in the states of Washington, Alaska, Montana and Idaho (WAMI). The RHP emerged out of a recognition that the stability of rural health systems in the WAMI states was being threatened and one symptom was the increasingly tenuous status of rural hospitals that exist in the majority of rural communities in the four-state region. The basic premise of the RHP was that the hospital could be used as a point of entry into the community, a way to engage community leadership in a fundamental attack on the issues threatening health services in that rural community.

Although the community hospital is often the focal point for community agreement ("contract") to work with University of Washington/AHEC staff, the CHSD strategy includes strengthening all elements of the community health care system. The Community Health Services Development cycle has been completed in all six initial communities, and a formal evaluation of outcomes is currently underway. The CHSD

approach has been used in an additional 14 communities in the WAMI region.

Seward, Alaska was one of the original six RHP communities. A discussion of why Seward applied to participate, the issues the community was facing and a review of its accomplishments can serve to demonstrate the potential for this community-oriented approach.

Why Seward applied as a Rural Hospital Project Demonstration Community:

All participating communities were rural with hospitals under 50 beds. The hospital had to be experiencing financial distress in order to be selected.

In 1984, at the time communities were polled for their interest in partnering with the University of Washington School of Medicine, Seward faced the following problems:

- The small population base in Seward created severe limits on the range of health services and financial resources available to support those services; in addition, there was substantial out-migration by the service area population for hospital, physician, dental and other health services.

- The hospitals long-term financial viability was a major concern. The loss from operations for FY's 1982 and 1983 totalled $650,000.

- The hospital facility had significant structural deficiencies in building, equipment and safety, with no capital reserve to modernize.

- Physician recruitment and retention had been a problem for many years. The number of physicians the small population could support was so small that physician stress and burnout was a recurring problem.

- The hospital board of trustees had not conducted a strategic planning process and was generally feeling overwhelmed by the responsibilities for stabilizing hospital and health services for the community.

- Public satisfaction surveys of health care in the community revealed major problems with confidence and quality. This clearly contributed to patient out-flow to other communities for services.

- A lack of cooperation and coordination among the

major health care providers in the community was noted.

- Various hospital financial practices and policies and practices are inadequate, including a very high accounts receivable.

- There was a high level of dissatisfaction with pharmacy services in the community.

- There was substantial dissatisfaction with alcoholism and mental health services, with massive out-migration to Anchorage for these services.

- The scope of medical services provided at the hospital was smaller than many hospitals of similar size. No surgery was being performed at that time, and a large portion of obstetrical patients were leaving the community for care.

In summary, approximately 40 significant problems, including those listed above, were documented by the Rural Hospital Project team when health services in Seward were analyzed carefully. Not surprisingly, the small cadre of health care leaders in the community was experiencing immense

frustration and was feeling overwhelmed by the problems they faced as they attempted to sustain health services for community residents.

The University of Washington team recognized that the number and range of problems facing a typical community such as Seward, in today's threatening environment, could only be addressed successfully if a more comprehensive strategy was developed. The underlying tenet of the Community Health Services Development strategy is that substantial change in failing rural health services can only be accomplished by mobilizing broad community health leadership and public support for these changes.

Four objectives of the Community Health Services Development strategy are:

1. To design a community health system to meet the individual community's needs.

   A major proposition of the CHSD strategy is that the community rural health system should be constructed to meet the needs of the population it serves, including the large segments of rural communities that lack access to basic health care services because of financial, cultural and geographic barriers. In order

to accomplish this objective, we work with the community to determine the health needs of the local population and to develop a mix of services to meet those needs. This often means expanding the range of services available, since they have often atrophied for unnecessary and idiosyncratic reasons.

2. To improve the financial stability of local health institutions.

A major intervention is to provide thorough financial and managerial review of rural hospitals, nursing homes and clinics, and make specific recommendations on how to improve financial management and general administrative leadership.

3. To increase community utilization of and satisfaction with local health services.

A common problem in many rural communities is that the population is ambivalent about the quality of services provided locally. Local services are often perceived as unavailable or inferior, and a substantial portion of the population seeks health care outside the local area. This has the perverse effect of becoming a self-fulfilling prophecy when a shrinking market share and

falling utilization undermine the ability of health care personnel and institutions to sustain services that are in place.

4. To enhance local community leadership and effectiveness.

A common denominator in many rural communities is inadequate or dysfunctional community leadership. Too often communities have no mechanism for identifying, energizing and engaging local health and community leaders an effort to improve local health care capacity and quality. Rural hospital boards are often weak, and unaware of their need to serve as a conduit for community participation in shaping local health care systems. Many important components of rural communities are uninvolved or disaffected, and communication and teamwork among community leaders, hospital leadership, local physicians and other health providers is often more fractious than functional.

The Community Health Services Development Process:

Once a community agrees to participate in the CHSD process, there are three major phases:

1. Community Analysis:

The issues discussed above regarding Seward were identified through an extensive and careful analysis of the community health services. This analysis includes: a community market survey, mailed to each household in the service area to document satisfaction and utilization by local citizens; an exhaustive analysis of the financial, management, and organizational systems of institutions (hospital, nursing home, etc.); a needs assessment documenting health care strengths and weaknesses from interviewing 30 to 40 leaders in each community; and a demographic profile of each community.

From this thorough and objective study, the primary strengths and problems in the community health care system are clearly identified. This includes not only financial, personnel, and market share problems but also quality, performance, teamwork and leadership issues. In most communities, this is the first time these issues have been both comprehensively and honestly documented and described.

2. Hospital and community-wide health services planning: The above information becomes the raw material for a strategic planning process which usually involves both the

hospital (first) and the entire spectrum of community health services. This planning process necessitates broad community participation. The plan should reflect the optimal menu of health services that the community needs, and the steps to address the problems that have been identified.

It is instructive here to illustrate some of the major goals that were part of Seward's initial strategic plan. They included:

- To achieve a financial position for the community hospital that will insure long-term stability and enable the hospital to meet the challenges of a dynamic health care environment.

- To maintain and improve the market position of Seward General Hospital throughout the east Kenai peninsula.

- To demonstrate leadership, through the hospital trustees and administration, to provide, integrate, and coordinate human services in the east Kenai peninsula.

- To maintain an environment in which individual

employees and others associated with Seward General Hospital can achieve maximum equality.

- To develop maximum integration and collaboration among the major health care providers in the community including the physicians, hospital, nursing home and mental health services.

- To develop a community health insurance plan to retain maximum health care dollars and patient services within the community.

- To improve the quality of pharmacy and mental health services.

These goals included many sub-tasks to effectively address the problems outlined earlier in this document.

3. Implementation:

Every effort is made by health care and community leaders, in collaboration with University of Washington/AHEC staff, to aggressively implement the changes reflected in the strategic plan. This requires clear delineation of responsibilities, diffusion of responsibility to a wider range of community participants and leaders, clearly

delineated timelines, and commitment to an ongoing planning cycle each year for both the hospital and other community health services.

Major outcomes of the CHSD strategy:

A rigorous two-year evaluation of the six initial communities, including Seward, is currently underway. This evaluation involves repeating most parts of the community analysis. Quantitative information regarding changes in market share, public satisfaction levels, etc. is not yet available.

However, in hospital financial status, a number of changes have already been documented as a result of the CHSD model. The more important outcomes include:

1. A commitment by hospital board and administration, as well as all community providers, to a rigorous, goal-oriented, problem-solving strategic planning process, to be re-examined annually. This is a major accomplishment for hospitals and communities that have never before accepted the need to plan in order to insure efficient use of scare resources and to direct aggressive attention to threats and problems.

2. An improvement in the financial "bottom line" for Seward General Hospital.

3. The development of a community problem-solving organization, the "expanded core group", which includes representation from every element of health and human services in Seward. This group has developed more effective problem-solving approaches by providers in the community, improved teamwork, and is insuring better cooperation among the health care providers.

4. Hospital governance (by board and administration) is markedly improved. Changes have included a commitment by the board to a planning process, dramatically increased board confidence and competence, a board recruitment and development program, streamlined decision making and meetings, annual planning retreats, and the enlistment of new community members for specific expertise. As in other communities, this has been one of the most dramatic outcomes of enhanced community health leadership.

5. A hospital marketing plan has been developed to aggressively address the reasons many residents were leaving the community for health services. Prenatal and obstetrical services have been expanded, anesthesia

coverage has been improved and limited surgical services are now provided at the hospital. The image of the community hospital has improved through attention to the buildings, equipment, and their appearance. Programs to improve the interpersonal skills, personal appearance, sensitivity, and nurturing attitudes of personnel have been carried out. The importance of these efforts cannot be overemphasized when the reasons for citizen out-migration are understood.

6. New community technology including ultrasound and fetal monitoring equipment has been purchased.

7. A new hospital management information system has been instituted, and numerous management and financial systems changes have been implemented.

8. A more coordinated and functional physician recruitment strategy has been developed by the community, with excellent cooperation between the medical staff and the hospital.

9. An expanded range of physician specialists is now coming to the community to provide services locally.

10. Improved cooperation between the hospital and nursing home has been achieved, and an effective nursing home administrator recruited.

11. The community is exploring the development of a community health insurance plan to maximize the use of local dollars and develop incentives for local utilization of health services.

The above accomplishments are impressive. They represent constructive changes across the entire spectrum of community health services, and they also reflect a rate of change that certainly exceeds that which existed before the CHSD strategy was implemented.

In summary, general outcomes from the CHSD strategy in all participating communities include the following:

a. A systematic, comprehensive approach to strengthening health care which includes system-wide planning, change on multiple fronts, more openness to outside facilitation and assistance, and greater peer group accountability.

b. Improved system performance including enhanced community and health care leadership, improved teamwork, improved morale and optimism, and an

expansion of the scope of health services available locally.

c. A structure for the future which insures continuing planning and problem-solving, a future-oriented attitude, and a willingness to continue to use outside resources to augment community skills and leadership.

In summary, Seward's experience has mirrored our experience in approximately 20 communities to date. Although some health care problems in rural communities will continue to be vexing due to the small population size and limited resources, the overall perspective of the CHSD strategy is that only with a community-driven approach involving broad health care and community leadership can many communities hope to sustain, let alone expand, the health services available to their residents. We believe at this time, even without the data from the Rural Hospital Project evaluation, that this process is far more effective than the crisis oriented, fragmented responsess that many rural communities have historically utilized.

The partnering of community leaders with outside facilitators and consultants has proved to be a powerful team to address the complex issues facing rural communities. At a very modest cost per community (considering the overall

expenditure of health care dollars annually in a community), we believe that our experience with the CHSD strategy has shown that rural communities themselves are the most effective resources to stablilize their health services, rather than rely primarily on external saviors and solutions.

1219ch.doc

# ALASKA STATE LEGISLATURE

*While in Ketchikan*
352 Front Street
Ketchikan, AK 99901
907-225-9675

*While in Juneau*
P.O. Box V
Juneau, AK 99811
907-465-3743

## Senator Lloyd Jones

April 29, 1990

**MEMORANDUM**

To: Representative Johnny Ellis, Chair
House Health, Education and Social Services Committee

From: Senator Lloyd Jones LJ

Subj: SB 326 - Health Planning Grants

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Thank you for hearing Senate Bill 326.

SB 326 establishes a health planning grant program in the Department of Health and Social Services for community health care planning. The bill is based on a model grant program established by Dr. Bruce Amundson of the University of Washington. Dr. Amundson was also instrumental in establishing a health planning grant for the City of Seward. Attached is a position paper written by Dr. Amundson, which gives background on the model program. Also included for backup are:

- Revised fiscal note and analysis
- Summary of the bill
- Written testimony and letter of support
- Case study

As you know from our work with the Governor's Interim Commission on Health Care, one of the Commission's serious concerns was the state's inability to put together either a long or short term health care policy. As state revenues dwindle, so will state support for much needed health care facilities and programs. This bill allows local decision making regarding the future of health care programs and facilities at the community level.

I hope you will support this bill and join me in cross-sponsorship. If you have any questions regarding this bill, please feel free to call me or Glenda Carino of my staff.

SCHOOL OF MEDICINE

February 16, 1990

TO: Alaska State Senate Finance Committee

FROM: Peter J. House PH
Associate Director (Acting)
Office of Rural Health
University of Washington

RE: Senate Bill 326

I am writing this memo to you as follow-up to my testimony before the Senate Finance Committee on February 1, 1990. As you know from my remarks of a few weeks ago, the purpose of the Office of Rural Health at the University of Washington is to help rural communities stabilize their health care systems. We believe that Senate Bill 326 is consistent with our purpose, and for that reason we would like to reiterate our support for this legislation.

First let me answer the question concerning the need for community-based planning. One of the central findings of our work (starting in 1984 with the Rural Hospital Project and continuing today with the Community Health Services Development Program), is that the fundamental factor destabilizing rural health care systems is the fact that significant portions of local populations seek health care services outside their community when those services are available in the local community. This out-migration damages the financial viability (and ultimately the availability) of local health care services. A corollary finding is that the communities themselves hold the key to stemming this outflow of patients.

Senate Bill 326, we believe, adopts (and sets aside funds for) a process that will empower communities to develop strategies to stabilize their rural health care systems. Our experience, working with communities utilizing an approach like that supported by Senate Bill 326, shows a history of communities progressing from desperate circumstances to well ordered strategies leading to amazing improvements of the health care resources in their communities.



SCHOOL OF MEDICINE, OFFICE OF

98195 (206) 543-6020 (206) 545-2491

Another aspect of the need for planning concerns the necessity of state financing of the work. Most rural communities lack the resources to get a project like this started. In communities with hospitals, nursing homes, or other health and social services organizations, chances are that the administrators or the boards simply don't have the time to undertake the comprehensive approach as outlined in Senate Bill 326. In communities without such organizations, there is a near certainty that there is no one in town with the skills and the time to lead such an effort. We have found well organized projects (led by the state and utilizing consultants), as envisioned in Senate Bill 326, to be an effective and efficient approach to the problem.

Assigning resources to community-based planning can avoid the expenditure of funds on more expensive strategies. Hasty, underfunded planning projects are the kind that produce simplistic yet, all to often, expensive solutions to health care problems. In our experience with applying this approach to over 20 communities since 1984, only rarely have community groups come up with initiatives that bore large capital price tags. The more elegant and effective strategies have often been inexpensive. So, for that reason, spending money on some solid planning now can save wasted capital dollars later.

I understand that certain portions of my testimony on February 1 were difficult to hear and I accept that as a hazard of testifying by telephone. My hope is that by placing my comments in this written format I will be able to strengthen the testimony I have already made to you. We at the University of Washington, are "true believers" in the community-based approach to stabilizing local health care systems and we urge you to move forward with the enactment of this important legislation.

Thank you, and please call me or my associates if we can be of further assistance in providing testimony or documentation to support Senate Bill 326.

PJH:sb
2-16ala.mem

TONASKET, WASHINGTON
A CASE STUDY

## Demographic Profile

| | |
|---|---|
| Population - Community | 1,000 |
| Population - Service Area | 9,000 |
| Hospital Size | 22 Beds |
| Providers | 4 M.D.s<br>2 Mid-Levels |
| Distance to Nearest Hospital | 23 Miles |
| Economic Base | Agriculture<br>Timber |

# CASE STUDY OF A RURAL WAMI COMMUNITY

| HEALTH CARE PROBLEMS | INTERVENTIONS AND RESULTS |
|---|---|
| Persistent primary care physician shortage. | Successful recruitment of two additional family physicians |
| Fragile hospital financial status (including $650,000 in warrants). | Dramatic change in hospital financial status. |
| | Establishment of hospital district and tax levy. |
| | Construction of new 70-bed nursing home. |
| Weak hospital board. | Restructured, educated, effective board. |
| Substantial outmigration for most health services | Increased utilization data (i.e., hospital occupancy). |
| | Additional medical specialty consultants coming to community. |
| | Addition of new technology (US and shared CT). |
| | Marketing program targeted at weakest utilizers. |
| Substantial weaknesses in hospital management & financial systems (i.e., massive AR, no management information system). | New computer-based MIS. |
| | Contract for financial expertise. |
| | Revamped billing and collection policies. |
| Lack of community awareness of fragility of hospital and health system. | Creation of a community health care foundation. |
| | Weekly series of article on health issues in local newspaper. |
| Lack of teamwork among major providers. | Explicit help with conflict resolution and development of consensual goals. |
| Highest percentages of uncompensated care of any state hospital. | |
| Timber-dependent, economically depressed environment. | |

NORTH VALLEY HOSPITAL

Financial Status Before and After
Rural Hospital Project

| | 1983 | 1986 | 1987 | 1988 |
|---|---|---|---|---|
| Income From Operations[1] | (210,004) | 6,711 | 414,165 | 35,743 |
| Net Gain/Loss[2] | (169,774) (plus 650,000 in short-term debt) | 238,538 | 555,253 | 113,995 |

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[1] Income (loss) from operations

[2] Operating Margin plus non-operating revenue

# THE TWO COMPONENTS TO DEVELOP A DURABLE COMMUNITY-BASED HEALTH PLAN:

| COMMUNITY PREPARATION & ORGANIZATION | + | HEALTH PLAN DEVELOPMENT |
|---|---|---|

## STAGE I: COMMUNITY PREPARATION

FACILITATOR: COMMUNITY CONSULTANT (UNIV. OF WA/ALASKA)

- o IDENTIFY AND CONVENE HEALTH AND COMMUNITY STAKEHOLDERS
- o DISCUSS CONCEPT, BENEFITS TO COMMUNITY AND ORGANIZATION
- o PERFORM SURVEY OF EMPLOYERS (# EMPLOYEES, INSURANCE COVERAGE, LEVEL OF INTEREST)
- o CONDUCT ANALYSIS OF HEALTH SERVICES IF DATA NEEDED (I.E., MARKET SURVEY; NEEDS ASSESSMENT)

STAGE II: COMMUNITY BODY - COMMUNITY CONSULTANT/ LEGAL COUNSEL

- o ESTABLISH A COMMUNITY CORPORATION AND BOARD (EMPLOYERS, HOSPITAL, PHYSICIANS, OTHER PROVIDER GROUPS, ETC.)

STAGE III: HEALTH PLAN DEVELOPMENT

FACILITATOR: COMMUNITY CONSULTANT/ BOARD/HEALTH CARRIER

- o ESTABLISH AND CLARIFY CONTRACTING AUTHORITY OF CORPORATION TO:
  - MANAGE PLAN
  - CONTRACT WITH PRIVATE AND PUBLIC EMPLOYERS
  - BEAR RISK
- o OBTAIN LEGAL AND REGULATORY APPROVAL
- o DEVELOP BENEFIT PLAN(S)

## STAGE IV: MANAGE THE HEALTH PLAN OVER TIME

FACILITATOR: BOARD/CONSULTANT/ HEALTH CARRIER

- MARKET THE PLAN
- CLAIMS TRANSACTIONS
- MANAGEMENT INFORMATION TO BOARD FOR UR AND QA
- MANAGEMENT DECISION
  - BENEFITS
  - UTILIZATION

The Department of Health and Social Services is authorized to contract with an appropriate agency, educational institution or organization to carry out the purpose of this legislation. An appropriate contracting entity would be one with experience and demonstrated success in community health services development, in rural Alaska. [This entity would have responsibility for community selection and allocating monies to carry out the work program.]

University of Washington Correspondence

# INTERDEPARTMENTAL

SCHOOL OF MEDICINE
OFFICE OF THE DEAN
REGIONAL AFFAIRS, XF-01

April 18, 1989

TO: Attendees, House Health, Education and Social Services Committee Conference on Financing Health Care for Alaska's Uninsured and Underinsured

FROM: Bruce Amundson, M.D.
AHEC Associate Director for Community Health Systems

SUBJECT: A PROGRAM TO MAINTAIN RURAL HEALTH CARE DOLLARS IN COMMUNITIES THROUGH THE DEVELOPMENT OF COMMUNITY-BASED HEALTH PLANS

A large proportion of rural communities in the United States are experiencing threatened or actual deterioration of their health services. The rural hospital, traditionally the core of the rural health care system, is currently the weakest link in the elements that comprise that system in many communities. However, a broad and vexing array of other problems are simultaneously confronting communities. These issues have been carefully documented by recent studies and community-based intervention efforts at the School of Medicine at the University of Washington.

The belief is widely held among state and national policy makers and some rural leaders that many or most rural communities cannot afford to sustain any but the most rudimentary health services. Our research, however, does not support this pessimistic assumption. Through studying a sample of communities we have demonstrated for the first time that more money is already being spent for health services in each community than is required to support the entire existing health care system. The following 1985 data illustrates this finding:

| | Community A | Community B | Community C |
|---|---|---|---|
| Money expended for health care by or on behalf of all service area residents (i.e. private insurance, Medicare, Medicaid, etc.) | $18,715,268 | $8,906,050 | $8,130,605 |
| Revenue needed to support basic health services (i.e. hospital, home health, mental health budgets, gross M.D. revenue) | $ 9,791,327 | $4,635,539 | $5,268,737 |
| Available "surplus" | $ 8,923,941 | $4,270,511 | $2,861,868 |

The conclusion is obvious: rural communities appear to have more than enough money to sustain their services if that money can be kept in the communities. Community insurance plans (i.e., PPOs) can provide incentives and organizational frameworks to keep care local and manage patients that leave to obtain services not provided in the community.

The Situation in Alaska

Current developments in Alaska regarding health care costs have created special concern. While health care costs are spiraling across the country, the increase in insurance rates in Alaska has been particularly high, forcing insurers to increase premiums as much as 40% or decrease benefits. It appears that unless we are able to control health care costs, health insurance and health care will become unaffordable for many more people in the state.

Experience with Community PPOs i our Region

Substantial interest has developed in the northwest region in the idea of community-based insurance plans. First, they are a way to keep insurance premium expenditures and out-of-pocket payments in the community, supporting the very important primary care system. Second, the development of community boards with broad representation including hospitals, physicians, community leaders, and major employers, provides a structure wherein the predominant goal of maintaining and strengthening community health services can be supported by all interested parties. Third, this community non-profit corporate structure provides an unprecedented vehicle for communities to regain control and ownership of their health system, including the dollars. Fourth, there is preliminary, but fascinating, evidence that utilization

may be more effectively controlled from within the community (because people know each other and this network can be effectively utilized for utilization, monitoring and review), than any other utilization process to date.

At least four community-based health plans are operational in the WAMI region. With the assistance of the Rural Hospital Project at the University of Washington and Blue Cross of Washington and Alaska, the Seward community is currently developing such a plan.

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