

S B

R L O

# SENATE FINANCE COMMITTEE REPORT

DATE: 1/24/90

FURTHER:

DATE TURNED INTO OFFICE: 4/24/90

The Finance Committee considered

SB 326

grants for community health planning; edf.

and recommended:

replace with \_\_\_\_\_ CS SB 326(Fix)  
 or adopt \_\_\_\_\_ CS \_\_\_\_\_  
 attached amendment(s)  
 \_\_\_\_\_ letter of intent adopted

same title  
 new title  
 technical  
title change  
(HB only)

do pass

do not pass

no recommendation

individual recommendations

further referral to \_\_\_\_\_

ATTACHES NEW FISCAL NOTE(S):

fiscal note(s) \_\_\_\_\_ Dept/Date:  
SFC/DHASS #187.1 4/24/90

zero fiscal note(s) \_\_\_\_\_

appropriation-no fiscal note

SIGNING DO PASS:

John Duncan  
Peace  
D. Grife

APPROVES PREVIOUS:

fiscal note(s) \_\_\_\_\_ Dept/Date:

zero fiscal note(s) \_\_\_\_\_

OTHER RECOMMENDATIONS:

1. John Duncan DO PASS

2. Peace (DO PASS)

Co-Chairs: Signatures and Recommendations

1410 JFC- 11-9-90

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 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
<b>TOTAL OPERATING</b>	<b>187.1</b>	<b>176.0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

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
<b>TOTAL</b>	<b>187.1</b>	<b>176.0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

**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)

6-1376D ✓  
Lauterbach  
4/24/99

*Adopted  
as amended*

Original sponsor(s): SEN. JONES

1 IN THE SENATE

BY THE FINANCE COMMITTEE

2 CS FOR SENATE BILL NO. 326 (Finance)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 SIXTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to grants for health planning; and  
7 providing for an effective date."

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 \* Section 1. LEGISLATIVE INTENT. (a) The purpose of the grant program  
10 established under this Act is to encourage community and regional planning  
11 for health services and to promote coordinated planning in those instances  
12 where communities or regions may share resources. Grant funding will be  
13 available to purchase professional expertise in completing needs assess-  
14 ments, market surveys, management and financial studies, and other communi-  
15 ty and regional analyses that will assist community and regional health  
16 leaders to develop planning strategies for improved health services.

17 (b) ~~Although there will be only one grant for each community and~~  
18 ~~region,~~ the department is encouraged to assist communities and regions to  
19 engage in cooperative planning. Cooperative planning among communities and  
20 regions will allow efficient use of consultant services purchased with  
21 grant funds, avoid unnecessary duplication of health services that could be  
22 shared by communities and regions, and provide increased accessibility and  
23 affordability of health care services.

24 (c) To the extent that it is reasonable, the format for community or  
25 regional health planning supported by the grants made under this Act should  
26 be consistent among grantees so that the community and regional health  
27 service data and other information will be useful for statewide health  
28 planning purposes.

29 \* Sec. 2. GRANT PROGRAM FOR HEALTH PLANNING. (a) The Department of

1 Health and Social Services shall establish a grant program under which up  
2 to 12 municipalities, nonprofit entities serving Native service areas, or  
3 rural government entities providing health care services in a health ser-  
4 vice area may be awarded one grant each of up to \$50,000 and provided  
5 technical assistance to help the municipality, nonprofit entity, or rural  
6 governmental entity to

7 (1) establish or designate a community or rural health service  
8 area health care review board;

9 (2) conduct a comprehensive analysis of the local health care  
10 delivery system, which may include health care delivery in areas not within  
11 the boundaries of a municipality;

12 (3) develop an areawide or municipal health services planning  
13 process; and

14 (4) define a strategy for implementation of the health services  
15 plan developed by the municipality, nonprofit entity, or rural governmental  
16 entity;

17 (5) review coordination and cooperation of community, regional,  
18 state, and federal health care services and programs;

19 (6) evaluate effectiveness of public health, mental health,  
20 suicide prevention, drug and alcohol, and preventive health care programs;

21 (7) review cooperation, efficiency, and adequacy of public and  
22 private health care providers;

23 (8) review adequacy of health care facilities;

24 (9) make an accurate estimate, for the grantee's area, of the  
25 number of persons who are unable to receive necessary health care services,  
26 the number of patients who are generating unpaid medical bills, the number  
27 of residents who are uninsured or lack adequate health care insurance,  
28 which health care providers are providing uncompensated care, who is paying  
29 for the cost of uncompensated care, and the total cost of uncompensated

02059

1 care;

2 (10) participate and coordinate information gathered with appro-  
3 priate federal and state committees or agencies;

4 (11) recommend to the community or regional health care board,  
5 the Department of Health and Social Services, appropriate committees of the  
6 Alaska State Legislature, and appropriate federal agencies ways to coordi-  
7 nate and maximize the delivery and health care services.

8 (b) The department, in consultation with the Health Association of  
9 Alaska, the Alaska State Medical Association, the Alaska Native Health  
10 Board, the Department of Community and Regional Affairs, and the University  
11 of Alaska, shall develop guidelines for implementing the grant program,  
12 including application procedures and the terms and conditions under which  
13 grants will be awarded. The department may not award a grant to a munici-  
14 pality or rural governmental entity that does not have a

15 (1) method of ensuring broad community participation in the  
16 development and implementation of the health service plan; and

17 (2) demonstrated commitment to the development and implemen-  
18 tation of the health services plan through an agreement to provide cash and  
19 in-kind contributions to the planning process during the term of the grant  
20 totaling in value an amount that equals or exceeds 33 percent of total  
21 grant funds received during the term of the grant.

22 (c) The department shall, upon submission of appropriate applica-  
23 tions, award ~~six~~ grants under this section in state fiscal year 1991 and  
24 ~~six~~ in state fiscal year 1992. *One half of the* ~~Three of the six~~ grants in each year shall  
25 be awarded to grantees who serve rural areas with special needs, as defined  
26 by the department.

27 ~~(d) A community or rural government entity within a Native service~~  
28 ~~area is not eligible for a grant under this section if a grant under this~~  
29 ~~section has been awarded to a nonprofit entity serving the Native health~~

~~service area. A nonprofit entity serving a Native health service area is not eligible for a grant under this section if a grant under this section has been awarded to a community or rural government entity within the Native service area.~~

(e) The department may contract for technical services necessary for implementing this grant program.

(f) The department shall make available to grantees a list of resources available to provide consultation services on health planning.

(g) In this section

(1) "department" means the Department of Health and Social Services;

(2) "nonprofit entity serving a Native service area" means a nonprofit entity established by a Native regional corporation organized under 43 U.S.C. 1601 - 1628 to conduct health care programs under contracts with the federal government under P.L. 93-638 (Indian Self-determination and Education Assistance Act).

\* Sec. 3. This Act is repealed July 1, 1992.

\* Sec. 4. This Act takes effect July 1, 1990.

# health association of alaska

319 Seward St., Juneau, Alaska 99801 • (907) 586-1790  
FAX (907) 463-3573

REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

Chairman of the Board  
C. Keith Campbell  
Seward General Hospital

Chairman-Elect  
Ed Malowski  
Sitka Community Hospital

Immediate Past Chairman  
Jim Gingerich  
Fairbanks Memorial  
Hospital

Secretary/Treasurer  
Slater Dona Taylor  
Providenc Hospital  
Anchorage

Delegate to the American  
Hospital Association  
Charles Stokes  
Humana Hospital-Alaska  
Anchorage

Alternate Delegate to the  
American Hospital Assoc.  
Ed Zelne  
Cordova Community  
Hospital

Delegate to the American  
Health Care Association  
Tom Boling  
Our Lady of Compassion  
Care Center  
Anchorage

Alternate Delegate to the  
American Health Care  
Mark Bertirud  
Denali Center  
Fairbanks

Delegate to the Healthcare  
Forum  
John Vowell  
Wrangell General Hospital

Delegate to Congress of  
Hospital Trustees  
Jan Trettner  
Seward General Hospital

Government Institutions  
Representative  
Frank Sutton  
Mt. Edgecumbe Hospital  
Sitka

Outpatient Facilities  
Representative  
John J. Conway  
Veterans Administration  
Anchorage

President/CEO  
Harlan R. Knudson

## SB 326

### GRANTS - COMMUNITY HEALTH PLANNING

Purpose of SB 326 is to provide the opportunity for communities throughout Alaska to measure the effectiveness of their health care system. Five \$60,000 planning grants are authorized for 1990 and five for 1991.

The overall goal for this legislation is for communities or regions within Alaska to design a health care system that best meets the needs of the individuals within that community or region.

Questions to be answered by the studies funded by the grants authorized by the bill include:

- health care dollars currently generated by the community and where those health care dollars are being spent
- adequacy of current health care facilities
- need for additional health personnel
- evaluation of current hospital and community strategic plan and/or mission
- review of cooperation and coordination between health care programs and providers
- effectiveness of health facility fiscal management
- evaluate community health programs such as drug and alcohol abuse, mental health, public health and others
- public satisfaction with access, quality and cost of current community health programs and services
- study of health care needs

For more information contact:

Harlan Knudson  
Health Association of Alaska  
586-1790

\* \* \*

SFC 2/1/90

# 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**

January 23, 1990

## MEMORANDUM

To: Senator Rick Uehling, Co-Chair  
Senate Finance Committee

Senator John Binkley, Co-Chair  
Senate Finance Committee

From: Senator Lloyd Jones

Subj: CSSB 326 HESS - Community Health Planning Grants

RECEIVED JAN 25 1990

I am requesting a hearing on CSSB 326 (HESS) by the Senate Finance Committee as soon as your calendar allows. The bill sets up one time only grants in the amount of \$60,000 each for ten communities. Five grants are to be distributed in FY91 and FY92. Each community or government entity can apply for only one grant in either year. The fiscal note also shows the cost of hiring a grants administrator with half-time salary and benefits.

Attached for your perusal are:

- a copy of CSSB 326 HESS
- a fiscal note from DHSS
- a sample budget which outlines the projected grant cost
- a position paper entitled "SB 326 - Grants for Community Health Planning" which explains the bill and the proposed program
- a report written by Dr. Bruce Amundson which outlines the Seward project, the model upon which this program is based

The attached information should give you a good overview of the bill. If you have any questions regarding the bill, please call Glenda Carino of my staff at 465-3743.

LJ:gmc  
Attachments

**ALASKA COMMUNITY HEALTH SERVICES DEVELOPMENT  
PROGRAM COSTS**

**1) Community Analysis Phase**

a) Market Survey	\$ 9,000
b) Needs Assessment	1,500
c) Hospital Financial Analysis	4,000
d) Hospital Management Analysis	4,000

**2) Planning Phase**

a) Strategic Planning Consultant	8,000
b) Other Consultants (i.e. conflict resolution, physician groups of individuals)	3,000

**3) Implementation Phase**

a) Technical Assistance (management, governance, marketing, recruitment, etc.)	6,000
b) Development of Community Insurance Plan (PPO)	12,000

**4) Travel**

<u>Activity</u>	<u># Trips</u>	<u>Avg. Cost Per Trip</u>	<u>Total</u>
Market Survey	2	\$ 350	\$ 700
Needs Assessment	1	350	350
Financial Analysis	1	350	350
Management Analysis	1	350	350
Presentations to Community Members	2	350	700
Strategic Planning	6	350	2,100
Other Consultants	3	350	1,050
Implementation (General)	9	350	3,150
PPO Development	5	350	<u>1,750</u>
			<b>\$10,500</b>

## 5) Other Costs

a)	Per Diem (40 days)	4,000
b)	Car Rental/Mileage	2,000
c)	Core (Central Staff):	
	Project Director	\$ 55,000
	Field Coordinator	40,000
	Secretary	<u>30,000</u>
		\$ 125,000 - 11 = \$11,360
d)	Phone, Insurance, Supplies, Misc.	3,500

[Alaska -- \$ 58,860  
Community -- 20,000]

Total Cost of Project (11 Communities)	867,460
Community Contribution (\$20,000 Each)	220,000
Alaska Appropriation	<del>547,460</del> 647,460

Revised  
4-11-89

## **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.

Senate bill 326 focuses directly on both community responsibility and ensured access for rural Alaskans. The bill makes it possible for communities to set up a community health services plan.

### **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 rural communities.

In addition, many factors inhibit necessary changes in the delivery of health services to rural areas, 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 rural hospitals and providers, the lack of state or regional assistance to assure access to care that cannot be provided in every community, and 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 identified in the planning process and changes in service configuration will be implemented.

Each community will develop its own spectrum of health services. In addition, the administrator of the program will develop a list of appropriate resources and consultants to assist each community. It will be the community's responsibility to involve all major health care providers, business leaders, public officials and other community leaders, to develop the project design, oversee and implement the program. Communities will also participate in the financial support of the program.

### **Appropriation**

In this act, the state of Alaska will appropriate \$337,100 in FY91 to support the program in 5 communities, \$326,000 in FY92 to support 5 more communities. Participating communities will be granted up to \$60,000 each. 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.

### **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.

60h  
302

7/16/63

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 (RHP). 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 scarce 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 responses 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 stabilize their health services, rather than rely primarily on external saviors and solutions.

1219ch.doc

**FISCAL NOTE**

**REQUEST:**

Revision Date: \_\_\_\_\_  
Title: "An Act Relating to Grants for  
Community Health Planning."  
Sponsor: Senator Jones  
Requestor: \_\_\_\_\_

Agency Affected: University of Alaska  
BRU: All  
Components: \_\_\_\_\_

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

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
<b>TOTAL OPERATING</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

CAPITAL						
---------	--	--	--	--	--	--

REVENUE						
---------	--	--	--	--	--	--

**FUNDING:** (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

**POSITIONS:**

FULL-TIME						
PART-TIME						
TEMPORARY						

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

This bill is not expected to significantly impact the fiscal operation of the university.

Prepared by: Marsha Hubbard Phone: 474-7593  
Division: Statewide Budget Date: 3/22/90

Approved by Commissioner: Brian Rogers Date: 3/22/90  
Agency: University of Alaska

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

# FISCAL NOTE

**REQUEST:**

Revision Date: May 6, 1989 Agency Affected: Health & Soc. Svcs.  
 Title: An Act relating to grants for BRU: Administrative Services  
community health planning  
 Sponsor: Senator Jones Components: Planning  
 Requestor: \_\_\_\_\_

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

OPERATING	FY90	FY91	FY92	FY93	FY94	FY95
PERSONAL SERVICES	-0-	-0-	-0-	-0-	-0-	-0-
TRAVEL	-0-	-0-	-0-	-0-	-0-	-0-
CONTRACTUAL	-0-	37.1	26.0	-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	-0-	<del>100.0</del>	<del>100.0</del>	-0-	-0-	-0-
MISCELLANEOUS	-0-	-0-	-0-	-0-	-0-	-0-
TOTAL OPERATING	-0-	337.1	326.0	-0-	-0-	-0-
		<u>150.0</u>	<u>150.0</u>			
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

**FUNDING:** (Thousands of Dollars)

GENERAL FUND	-0-	337.1	326.0	-0-	-0-	-0-
FEDERAL FUNDS	-0-	-0-	-0-	-0-	-0-	-0-
OTHER	-0-	-0-	-0-	-0-	-0-	-0-
TOTAL	-0-	337.1	326.0	-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)

See attached analysis.

*4-24-90*

*Cuts grants and claims in half.*

Prepared by: Dave W. Williams  
 Division: Administrative Services, DHSS

Phone: 465-3015  
 Date: 1-4-90

Approved by Commissioner: *Mike M. Thurman*  
 Agency: Dept. of Health & Social Services

Date: 1-9-90

Distribution (by preparer):

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

*102*

FISCAL NOTE Analysis (continued)

Senate Bill No. 326a  
5/6/89

BY JONES

"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
	<u>37,100</u>	<u>26,000</u>

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 five communities funded in FY 91 at \$60,000 per community and five communities funded in FY 92 at \$60,000 per community.

282