ALASKA LEGISLATURE COMMITTEE FILES 2001-2002 8672

10529 SENATE HEALTH EDUCATION & SOCIAL SERVICES

10/25/01

Senator Lyda Green;

As a nurse who has worked home health care for a number of years I would like to take this opportunity to express to you the positive impact to our community the Medicaid Waiver program for private duty nursing has provided. Many times a citizen is in need of ongoing nursing help to remain safely in their home + to avoid repeat hospitalization + emergency services. This waiver program allows a nurse, under physician orders, to monitor a clients medication use + side effects, conduct ongoing clinical assessment to catch deteriating health before they become severe + to assist citizens to access community resources. Medicare + regular Medicaid will not cover these chronic care maintenance type cases. With our aging population + lack of chronic care resources in our community this has helped a number of clients remain in their home environment + continue as productive citizens in our community. I would deeply appreciate any support you may lend to continue with this valuable service.

Sincerely,

Karen Losinski RN,C
3474 Sharon Rd
North Pole, AK 99705

cc: John Coghill

October 25, 2001

Dear Senator Lyda Green,

I am writing to express my concern regarding the issue of state medicaid funding. I understand that you and the legislature are considering reducing medicaid services for the residents of our state. I am particularly concerned with the idea being put forth to reduce funding and services for Denali Kid Care and Breast Cancer.

Denali Kid Care provides insurance coverage for children and teens, our most vulnerable residents. Providing good health care up front, prevention of disease, early discovery and treatment can save us all money in the long run. Children who grow up healthy can then become productive members of our society. This would seem to me to be a good thing.

I cannot believe I live in a state where our elected officials can be so shortsighted not to see how providing mammograms and funding for the early treatment of breast cancer can benefit us all. Spending $100.00 for early detection is a small amount to pay when compared with the costs of treating breast cancer after it has spread. Plus, the social and emotional costs can be just as high or higher.

As a woman and a mother these two issues greatly concern me. As adults it is our responsibility to protect the children. They will be the ones to make decisions about issues in the future. As a woman I cannot stand by and do nothing about issues at the state level that concern women's health. Trying to save a little money now on Denali Kid Care and Breast Cancer can and will cost us big money in the future.

Sincerely,

Corlis Taylor

Corlis Taylor

Corlis Taylor
1335 Viewpoint
Fairbanks AK 99709

Cc: John Coghill

John Cannon
3101 Whispering Woods Dr.
Wasilla, AK 99654
(907) 376-6063

November 7, 2001

Senator Lyda Green
600 East Railroad Avenue
Wasilla, AK 99654

Re: HESS Subcommittee on Health Care and Welfare

Dear Senator Green:

I am writing you regarding the Subcommittee meeting that will be held at the Mat-Su Legislative Information Office on November 8-9. Unfortunately, due to a schedule conflict I will not be able to attend the meeting in person. Please accept this correspondence as public testimony. Over the last twenty years it has been my privilege to work with Alaskans with developmental disabilities. During this time period our great State has demonstrated exemplary commitment to citizens with developmental disabilities. This commitment has truly made a difference in the successful community living of thousands of Alaskans. On November 15, 1997 Harborview Developmental Center in Valdez closed after 36 years of operation as Alaska's institution for people with developmental disabilities. Gone are the days when Alaskans with developmental disabilities have no choice but to live in institutions. Gone are the days when Alaskans with developmental disabilities have to move away from their community, their friends and families to obtain needed support. Gone are the days when young Alaskan children experiencing complex medical conditions have to grow up in hospitals or nursing homes.

Much of the success experienced by Alaskans with developmental disabilities and children with complex medical conditions is a direct result of funding available through Medicaid, Home and Community Based Waivers. Presently in Alaska Medicaid Waivers are providing the funding needed to make community living possible for 143 children with complex medical needs and 779 individuals with developmental disabilities. Yes, costs to the State of Alaska for these services have increased in recent years. However, each member of Senate HESS must remember that the service costs for these Alaskan citizens would be much higher if institutional care still existed.

Another important issue for the committee to consider is the fact that Medicaid is almost always the only means by which Alaskans with disabilities can access health care. The ability to live successfully in the community, even survival often depends on needed health care services. Regrettably, for Alaskans with disabilities full coverage for many needed health care services (e.g. durable medical, assistive technology and personal assistance services) is seldom available.

On behalf of Alaskans with developmental disabilities I urge you to "stay the course" in terms of your commitment to Alaskans with developmental disabilities. Please continue to be mindful of the critically important role Medicaid funding plays in successful community living for these citizens.

Should you or any committee members have any questions or require further information do not hesitate to contact me. Thank you for considering my testimony.

Sincerely,

John Cannon

John Cannon

November 7, 2001

Senator Lyda Green
600 East Railroad Avenue
Wasilla, Alaska 99654

Re: CHOICE Services

Dear Senator Green:

My name is Anthony Ward. I am a 65 year old retired and disabled professional, who has experienced 9 surgeries during the last 24 months most of which were performed by the excellent staff and associates at Providence Hospital here in Anchorage.

Living in Alaska for the past 19 years, I have been a patient at Providence for several extended stays including a bilateral amputation, diabetes Type II, congestive heart failure and radial palsy.

Post surgically, I required an extensive period of rehabilitation before being able to return home and required a number of services in the community to prevent a nursing home admission. Before being allowed to be released, I was visited by a Circle of Care Care Coordinator, Joy Blankinship who introduced me to the "CHOICE waiver program." This program provided me all the services needed so that I could stay in my home and remain safe and somewhat independent with CHOICE community based services.

My outstanding Care Coordinator, Joy, calls and visits frequently checking on me and coordinating the many services the CHOICE program has set-up. Services include in-home nursing, housekeeping, hospital and medical care/appointments medical equipment and supplies.

These often critical CHOICE services have greatly reduced my need for emergency admittance to Providence due to stressful cardiac incidents.

I cannot commend the CHOICE program and the services the program provides enough. I am most grateful and feel truly blessed to enjoy and continuously benefit from CHOICE services via coordination of Circle of Care which has allowed me to live in my home of 19 years safely and independently.

Please support the continuation of these services for the growing population of seniors and adults with physical disabilities.

Sincerely,

Anthony Ward

November 7, 2001

To: The Senate Health, Education and Social Services Committee

Reference: Subcommittee on Health Care and Welfare

My name is Lila Berry, and I am a social worker and the manager of Circle of Care at Providence. Circle of Care began 12 years ago in response to a terrible tragedy to a senior. An elderly woman living alone in Anchorage with many health problems was utilizing several health care providers, but no provider realized how isolated the senior was. She died alone in her home, and was not found for several days. Several providers in Anchorage and statewide came together to problem solve how to better care for our frail seniors, and that was the birth Circle of Care and care coordination in the state of Alaska. Geriatric care coordinators can be found in all parts of the United States and in many parts of the world. Care coordinators assist seniors and adults with physical disabilities and their family members in a variety of ways. We provide consultation, screenings, and assessments to help clients find their way through the maze of eligibility criteria, and become eligible for programs such as the Choice Waiver program. We help them problem solve and obtain services to have the best possible health and safety. We assist seniors and those with physical disabilities access services, and monitor to ensure that their needs are being met. We work with frail seniors, some who are close to death, some who have dementia, some who have given up hope, and assist them to meet their physical, emotional, social and spiritual needs, when their world and their options may be decreasing. We help them transition so that their care and safety needs are met. This may mean assisting the senior who cannot afford their current housing, food, medication and other expenses, due to the loss of a spouse. Or assisting a senior whom is being financially exploited. The care coordinator may assist the senior or adult with physical disabilities find housing, such as an assisted living facility. It may mean going to the doctor's office with the senior to help them understand their medical plan and to help facilitate communication so that the physician understands the day to day concerns the senior is facing. Care coordinators might need to explain the meaning of a new diagnosis to the senior, and help them set up a living will and comfort one. The role of the care coordinator is quite complex.

Waiver services include care coordination, assisted living, environmental modifications, (such as a ramp, so that the disabled person enter and leave their home), assistance with food and eating, bathing, chore services and respite. There is an array of services available and the senior, disabled adult or family member may only need some of the above services, or all of them. Hundreds of seniors and disabled adults really benefit from the Choice Waiver program. Our population of seniors is rapidly growing and is predicted to continue to grow. We need to enhance and improve our menu of services for the senior population and those adults with physical disabilities.

There are many gaps in services for those with chronic illnesses. Our state safety net for the chronically ill is not adequate to meet the needs of the residents. Circle of Care provides assistance to hundreds of clients with chronic illnesses who are not eligible for Medicaid. They might be $10 dollars over income for Medicaid, or have a chronic illness that is not covered by CAMA, (respiratory illnesses, heart disease without high blood pressure) or have not worked long enough in a given period to be eligible for disability. Other states,(Oregon being just one example), have developed innovative plans to care for those with chronic illnesses that are not covered by traditional Medicaid. I am requesting that the subcommittee consider the health care and social service needs for those whom are not currently eligible for Medicaid, and consider expanding CAMA coverage to include those who are chronically ill. I would like to focus first on those with respiratory illnesses that are not currently eligible for CAMA Medicaid.

Sincerely, Lila Berry 261-4849

Testimony of Patricia Hong, RN
Chair, Medical Care Advisory Committee
November 8, 2001

Senate Health, Education and Social Services Subcommittee on Health Care and Welfare
November 8-9, 2001

Senators Green, Davis, Taylor, and Ward; Reps Dyson, Cissna and Coghill – good morning.

Thank you for the opportunity to speak on behalf of the Medical Care Advisory Committee (MCAC). As you know, the MCAC was established in 1974, and its members are well informed about the Medicaid Program. We meet four times per year, and receive detailed briefings on the Medicaid program and related issues. We work closely with the Director of the Division of Medical Assistance and staff, and are privileged to meet with the Commissioner of Health and Social Services on an annual basis.

The MCAC is currently composed of 15 members who bring expertise as providers and consumers of care associated with the Medicaid Program. The MCAC works hard to obtain public input during each of the four meetings. We have heard from both consumers of services covered by the program as well as providers of those services. We have also heard from a variety of interested parties who have concerns about the Medicaid Program. Overall, the MCAC has heard over and over again how valuable the Medicaid Program is in enabling needy Alaskans to access necessary health care.

This past summer, the MCAC drafted budget recommendations. More than 600 individuals were contacted by postal or electronic mail and their comments were solicited. The draft budget recommendations were available on the DMA website, and were downloaded 118 times during the comment period. The following Budget Recommendations for the Medicaid Program were adopted and transmitted to the Commissioner, Health and Social Services.

#1 Priority
The existing Medicaid Program and the FY 2002 budget should be the base for the FY 2003 Medicaid program budget. This should be interpreted to mean that there should be no reductions in covered services or eligible groups, and that the Administration should not be forced to finance new services, new eligible groups, cost increases, or program changes by reducing the existing program.

We know that, in some states, those who do not have insurance coverage are twice as likely to be hospitalized for avoidable disease complications as those who have insurance. Maintaining a strong Medicaid program that covers treatment for chronic disorders, such as diabetes and hypertension, will actually decrease the cost of health care.

Testimony of Patricia Hong, RN
Chair, Medical Care Advisory Committee
November 8, 2001

#2 Priority
The Department of Health and Social Services improve geographic parity of reimbursement by developing a regional reimbursement adjustment factor or a payment adjuster for remote areas and include the cost of implementing the regional reimbursement adjustment factor in their FY 2003 budget. The MCAC believes that consideration of local cost variables will improve access to care for Medicaid recipients who live in remote areas.

The MCAC has heard testimony from providers in remote areas who are genuinely concerned about residents in those communities, but cannot afford to care for a high percentage of Medicaid recipients when reimbursement isn't enough to meet their costs. The MCAC believes that adopting a regional reimbursement adjustment factor would encourage providers to continue to give care to Medicaid recipients.

#3 Priority
The Department of Health and Social Services consider ways to simplify the authorization and billing systems for medical transportation and include the cost of implementing the changes in the medical transportation system in their FY 2003 budget. The MCAC recognizes that a simplified payment and authorization for transportation process would improve access to care for Medicaid eligibles.

The MCAC has heard testimony from providers who experience frustration when patients miss appointments, often because of unreliable transportation. Simplifying the authorization and payment process would reduce this barrier to care.

#4 Priority
The Department of Health and Social Services update dental coverage for adults to include preventive and treatment services commonly included in mainstream dental insurance. The MCAC believes that these services would improve the employability of Medicaid beneficiaries and reduce the need for oral health related emergency medical care.

The MCAC has heard testimony from dental providers who are frustrated with the current allowable treatment options because they know that tooth extraction is not the best way to improve oral health. The dental providers want to establish an appropriate treatment plan for Medicaid recipients, but are unable to do so because of current constraints. Dentists know that prevention is the key to good oral health, and the MCAC believes including preventive dental services will result in improved health for needy Alaskans.

Thank you once again for the opportunity to address the members of the subcommittee.

Robert and Bambi Gilpin
1001 Elsinore Way
Apt 3-C
Wasilla, Alaska 99654
(907) 357-9880 home/fax
alexmacks@gci.net

November 07, 2001

To Whom It May Concern:

This letter is in regards to the continuation of Denali Kid Care and the importance of it in our lives.

In May of 2000, our daughter Alexandra was diagnosed with Leukemia. When we arrived back in the state after the initial treatment in Utah, we signed up for Denali Kid Care. Because our income was not over the limit, all three of our children qualified. If we did not have Denali Kid Care, we would be in serious financial debt, even though we have another insurance. Cancer can be very expensive and we appreciate and look forward to the added security of Denali Kid Care for the portions of expenses that are not covered.

I am asking that you keep Denali Kid Care around for as long as possible. Thank You for your time.

Sincerely,

Robert Gilpin
Bambi Gilpin

ALASKA PRIMARY CARE ASSOCIATION INC

ALASKA PRIMARY CARE ASSOCIATION INC.

903 West Northern Lights Blvd., Suite 202 Anchorage, AK 99503 Ph (907) 272-6131 Fx (907) 274-6131
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Testimony

Alaska Senate Health, Education and Social Services Committee
Subcommittee on Health Care and Welfare
November 8 - 9, 2001

Introduction:

Thanks for the opportunity to speak with you today as you meet to discuss issues of relevance to the Committee. I understand that your focus during these meetings is to gather information to prepare you for the coming Legislative session.

My name is John Riley- I am the Board President of the Alaska Primary Care Association. I am also a practicing primary care clinician, and the Medical Director of Alaska's oldest community health center. *What I want to educate you about today is the importance of the federally funded community health center- or CHC- program to Alaska.* This program is growing here. In 1995, Alaska had a single CHC in Anchorage. In the last six years, CHC's have blossomed into a network of eight non-tribal and tribal organizations with 28 sites statewide. All see people who would not otherwise have access to basic primary health care.

President Bush recognizes the importance of health centers in providing access to health care for those in need. He has shown his commitment to the program with a plan to double the number of health centers in America, and to double the number of people they serve. Senators Stevens and Murkowski have also recognized the importance of health centers, and have worked with those of us here to strengthen the program in our state.

CHC's are and will continue to be a major safety net provider here. It is extremely important that the Legislature be aware and supportive of Alaska's CHC's, and that the Legislature reduce barriers to the ability of Alaska's CHC's to provide those in need with necessary basic primary health care.

Brief statistics about CHC's in Alaska:

The most recent year for which we have statistics is 1999. In that year, Alaska had five CHC organizations with clinics located in 13 communities. Those centers:

- served nearly 20,000 patients
- provided nearly 61,000 medical patients visits
- provided a signif[illegible]ant amount of dental and [illegible]ental health services as well.

In those centers, on average:

- 37% of these patients were uninsured. (Some had a level exceeding 50%)
- 34% were insured by Medicaid, Denali KidCare or Medicare
- 29% had private insurance

Since 1999, the CHC program has doubled in size in our state. CHC's sites now provide care in 28 communities. It is too early to know numbers of patients served, number of visits provided, etc., but *it is clear that Alaska's CHC's have become a major source of quality primary care to medically underserved Alaskans.*

This is very important in a state such as ours, where the most expensive cost-of-living category is medical service (which costs 60% more then it does nationally) and where the cost of medical care has risen nearly 200% in the last 20 years. The financial barriers to obtaining health care are considerable- even if one has insurance, but especially if one doesn't.

Alaska's Health Centers save the system money:

Health centers result in cost savings. The impacts health centers have on the health of their patients include:

- lower hospital admission rates
- shorter lengths of stay
- less inappropriate use of emergency room services
- significantly lower infant mortality rates
- reduced incidence of low birth weight
- higher immunization rates, and
- better use of preventive health services that result in lower rates of preventable illness.

Studies over the last decade have found that nationally, Medicaid patients who regularly use health centers receive care of equal or greater quality and cost significantly less than those who use private primary care providers, such as hospital outpatient units or private physicians. *These findings are consistent with those from dozens of previous studies on the cost-effectiveness and quality of care provided through the health center model, and in particular documenting their substantial savings to state Medicaid programs.* The record is clear that health centers save the system money.

Even as they are providing important services and saving resources, Alaska's CHC's are under threat:

- the numbers of uninsured, while temporarily dented by Denali KidCare, are again escalating. This places additional burden on health center resources.
- the costs of providing health care are escalating rapidly.
- the reasonable reimbursement system for Medicaid patients previously used is changing to a system that actually cost health centers to see these patients.

Over the coming year, this Committee will be hearing more about the good health centers do, and the problems they face. Requests will be made for support for this system that provides so much good to Alaskans and assists the state in providing a health care home for Medicaid and uninsured patients. We look to the Committee, and to the Legislature to respond appropriately.

Thank you.

John Riley, PA-C
Alaska PCA Board Chair

Additional Background Information on Community Health Centers:

Health centers have:

- been around nationally for 35 years and represent federal, state, and local community investment in primary care infrastructure for medically underserved people and communities.
- Been present in Alaska since 1974.

Statutorily, health centers must:

- Be located in, and serve, a community that is designated as "medically underserved," thus ensuring the proper targeting of federal resources on areas of greatest need;
- Make services available to all residents of the community, without regard to ability to pay, and make those services affordable by offering a sliding scale fee;
- Provide comprehensive primary health care services, including preventive care (such as regular check-ups and pap smears) and care for illness and injury, as well as services which improve the accessibility of care (such as transportation and translation services) and the effectiveness of care (such as health / nutrition education);
- Be governed by a Board of Directors a majority of whose members are active, registered patients of the health center, thus ensuring that the center is responsive to the needs of the community it serves. Boards also include local community leaders and others who are committed to provide access to primary health care that meets the needs of their community

Health centers:

- Provide access to quality preventive and primary health care for the medically underserved – including those without health insurance, low-income working families and rural residents.
- Serve as a prototype for effective public-private partnerships, demonstrating their ability to meet pressing local health needs while being held accountable for meeting national performance standards.
- Are community owned and operated businesses- professional health care organizations providing a comprehensive range of high quality preventive and primary health care services under one roof, in a "one-stop caring" system. Health centers offer 24 hour care, both for prevention and for treatment of illness or injury, and in addition provide diagnostic laboratory and x-ray services as well as prescribed medications in many cases.
- Are individual and unique, reflecting local decision-making on how best to meet the health care needs of that health center's patient load.
- Are subject to ongoing federal monitoring of their cost – effectiveness, quality of care, and management at a level that is more stringent then that applied to any other provider.

- Are one of the best health care and taxpayer bargains anywhere. Comprehensive services are provided at a national average of less then a dollar per day for each person served. Considering the fact that health center patients are generally poor and suffer greater health disparities, this is an astonishingly low cost.

Additional Background Information on the Uninsured In Alaska:

Did you know these facts?

Alaskans without health insurance ...

- People we all know- 16% of all people in Alaska, or nearly two in ten of your friends and family are uninsured.
- Young- between 18-44 years old.
- Employed: 71% are employed, often in small, family-owned businesses. Most small employers can't afford to cover the high costs of insurance premiums.
- Male: 57%
- Low – income: 66% (in Anchorage) make less then $35,000 annually.
- High – income: Even high-income people are often not able to afford health insurance. Insurance premiums for a standard 80/20 medical and dental plan with a $500 deductible cost between $450 / month for a single person and $1300 / month for a family. Most of us, even those of us who are highly paid, would have trouble affording the $15, 600 per year it costs to insure a family.
- Sick- Among the uninsured in Anchorage, 40% have the silent killer of high blood pressure, and 22% have elevated cholesterol levels.

Do you know that lack of access to health insurance, and thus lack of access to health care, costs society a lot of money?

- 43% of people without health insurance have not seen a doctor in the past year, when they needed to, due to cost. Less preventive care means people wait until they have a crisis on their hands before presenting for care. A problem easily resolved early on festers into a crisis situation that is much more costly to handle in the later stages. This cost is passed along to the hospitals that end up providing this emergency care, and ultimately gets passed along to those who pay the premiums.
- 23% of uninsured people have not had a routine checkup in the last five years. Again, a problem easily resolved in the early stages festers and then escalates, resulting in higher costs for resolution. This means more costs passed along to the payors and consumers.
- 30% of the uninsured cannot fill prescriptions due to cost. A treatment plan that is not carried out because the person couldn't get the drugs they needed to heal is substandard, and again, results in escalation of a problem and more costly resolution.
- 25% of bankruptcies are caused by costs of illness or injury.

ALASKA PRIMARY CARE ASSOCIATION INC.

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Alaska's Federally Funded Community Health Center Family

Anchorage Neighborhood Health Center, Funded 1974
- Fairview
- Mt. View

Interior Neighborhood Health Center, Funded 1995
- Fairbanks
- Healy

Eastern Aleutian Tribes, Funded 1998
- Adak
- Akutan
- Cold Bay
- False Pass
- King Cove
- Nelson Lagoon
- Sand Point

Sunshine Community Health Center, Funded 1999
- Talkeetna
- Trapper Creek
- Willow

Southeast Alaskan Regional Health Consortium, Funded 1999
- Angoon
- Haines
- Kake
- Klukwan
- Pelican
- Prince of Wales Island- Hydaburg, Kasaan, Klawock, Thorne Bay
- Tenakee Springs

Yukon Kuskokwim Health Corporation, Funded 2001
- Emmonak
- St. Mary's

Bethel Family Clinic, Funded 2001
- Bethel

Central Peninsula Health Center, Funded 2001
- Kenai

Nov. 8 2001

Committee members,

My name is Kris Moore. I have four children ages 4, 7, 9, and 11, two of which we adopted two years ago. The adoption was not planned for or expected. They were my husband's niece and nephew and if we did not receive them into our home, they would have been adopted outside of the home. With an issue such as this we couldn't factor in being able to afford health coverage into the decision. We had to do it because it was the right thing to do.

Like many other families, we would like to be in a position where my spouse or myself held a job that offered affordable, comprehensive health coverage for our family. However, at our current time that is not a reality. My husband's job, that he has been at for 10 years, does not offer health coverage, and I am going through a transition due to an unexpected lay off. Unfortunately we do not see our resources changing in the real near future. Many families experience unexpected transitions such as we are facing, and if a medical emergency, or even a necessary basic care came during these times, we could be financially set back for years. Programs like Denali KidCare provide us the assurance that health care will be met and not compromised, which can lead to additional cost. I am open to evaluation of the programs offered in our state in order to insure effectiveness. We must however keep in mind that families need to be able to access health services when needed without risking neglected care for fear of financial downfall.

Last night I had to rush my four-year-old daughter to the Urgent Care Clinic because she split her head open while playing. I was able to meet her needs without a second thought. Without having our Denali KidCare coverage I would have been more willing to compromise her health by debating the seriousness of the injury and worrying about how we were going to pay for it—instead of putting my focus and attention where it should be—on comforting my child.

Please consider the needs of families and their children while evaluating and shaping their health insurance needs. Not all families want or plan to be dependent on these services, but the value of their lives would be tramadic if they couldn't access it when in need.

Kris Moore

My name is Ruth Titler I am a 61-year-old female. I have been an insulin dependent for 52 years. I also have the other major complications, which relate to diabetes. I wish to tell you what the Choice Waiver and Circle of Care program do for me. In January of 1999, before I was released from the hospital my doctor requested that Circle of Care evaluate me at home. It was determined that I needed help with everyday chores and transportation. In mid-June, 1999 upon approval by the Choice Waiver my life drastically improved. I now receive Meals-on-Wheels, weekly help with chores and shopping. I also have Lifeline and that is a blessing. I also receive door-to-door transportation and if I had to use People Mover, I would have a real problem.

As for Circle of Care, they are a blessing in disguised and a great support system. Besides helping with the yearly Choice Wavier Program my Care Coordinator and I have contact a minimum of twice a month and this includes one face-to-face visit. She monitors the service I receive and acts as a advocate for my needs. If she has concerns about how I am feeling she contact my physician immediately. When I was in the hospital last year Circle of Care was there for me and very supportive. This is very important to me since my children lives in the State of Washington and South Dakota's Air Force Base.

About 22 years ago, I was a State employee. During that time the State Union opted out of Social Security. Therefore, I received SSI and APA only. I do not qualify for Medicare and receive Medicaid. When I have a doctors visit it would cost me between $100 to $ 150 dollars for the visit and lab work. I have been told that if I had to pay for all my medical supplies, it would run $852.00 to 1,000.00. My total monthly income is less than $900.00. If I had to pay for my medical bills, pay rent, buy food, telephone bill, and transportation I believe I would be in bankruptcy court in fewer than two months. Without the help of Medicaid and Choice Waiver paying for my basic and necessary needs, I could not afford them and I would die in less than two weeks.

If it were not for the Choice Waiver, Circle of Care, and the Medicaid Programs I believe I would not be able to live independently. It would be necessary for me to reside in a skilled care facility and this I do not want, plus it would cost you more money! I pray to God that you would never have to walk in my shoes, but if you had to, consider what your life would be like. Life with dignity is a precious thing. Because of your support of health care programs in prior years, this is possible. Please, please continue to show your support by ensuring that Medicaid monies is available to those in need. Thank You!

Ruth Titler

Dawn M. Harris
Po Box 45
Talkeetna, AK 99676

Message to Lyda Green
Wasilla, AK 11/8/01
Subject: Denali Kid Care Income Guideline

My name is Dawn Harris. I am married and have 3 children ages 4, 18 months and 3 months. My husband works seasonal construction jobs and makes a modest income.

I am not employed; I work at home taking care of my family. Because of my husbands type of employment he has never been covered under a health insurance plan through his employers. We have been married 10 years and have never had health insurance. I checked into buying a policy several times over the years and found all of them to be very expensive and for us unaffordable. The bare minimum average was around $500 before we even had children a month and that only included emergency care. Not for checkups, immunizations, dental care, pregnancy coverage, prescriptions or in cases where my child has an ear infection and needs to see a doctor and get antibiotics. After rent, food, bills and household expenses we don't have that much left over. Two of my children have respiratory disorders (asthma and spasmodic croup) and my newest child was born premature and needed. Hospitalization. Since the advent of the Denali Kid Care System, my pregnancies have been covered and I have been able to sleep at night, knowing if my children need medical attention I can take them in without debating whether or not we can afford it.

[redacted] My husband and I provide a safe, healthy home for our children. It's just that we simply cannot afford health insurance. It is expensive to live in Alaska, but we love it here and it is our home. We are not asking for large handouts, only to feel secure that our children can go to the doctor when they need to.

Bartlett Regional Hospital

3260 Hospital Drive • Juneau • Alaska 99801 • 907-586-2611

November 2, 2001

Senator Lyda Green
State Capitol, Room 125
Juneau AK 99801-1182

Dear Senator Green:

I understand you are chairing a committee to pursue reducing Medicaid expenditures in our State. While I agree with the concept of looking for efficiencies in the administration of the Medicaid program, I do not support the reduction of services covered under Medicaid.

I know of numerous low-income families and individuals in my community who would not otherwise have access to healthcare services if it were not for Medicaid. Healthcare is not a luxury; it is not an option; it is a necessity that all members of our communities should have access to.

Expansion of Medicaid coverage in recent years to include Breast Cancer Detection and Children's health care to families who otherwise wouldn't qualify for Medicaid will reduce Medicaid costs in the long run. I applaud the State for these efforts. Furthermore, the current Medicaid reimbursement system is modeled to ensure that the State always pays less for health care services than insurance companies or individuals who pay privately. I believe the State already pays the least amount for the most healthcare that it possibly can.

Please consider, very carefully, the long-term effects of any actions you may take in your efforts to reduce Medicaid expenditures.

Sincerely yours,

Michael K. Garland

JANE WALSH

October 30, 2001

Senator Lyda Green,

By cutting funding to Medicaid programs, such as Denali Kid Care, you will be negatively affecting many, many people. Many of these people, through the voting process, have put you in the office you currently hold.

Not a good career move.

Please reevaluate your position on this issue. Thank you for your time.

Jane Walsh

Cc: John Coghill
119 N. Cushman #211
Fairbanks, AK 99701

1097 VICKI LANE, NORTH POLE, AK 99705

7209 Richardson Hwy.
Salcha, AK 99714

October 30, 2001

Senator Lyda Green
State Capitol
Juneau, AK 99801-1182

Dear Ms. Green,

I am writing to you to ask your support toward strengthening Medicaid funding.

My personal experience regarding the need to maintain a strong base of assistance to our states residents involves my 85-year-old mother. She has worked hard all of her life, supporting her family, sometimes working two or more minimum wage jobs. Her social security benefits are now based on those 60 years of minimum wage jobs. Without the benefit of Medicaid, she would not be able to afford her needed medications, let alone maintain a reasonably comfortable standard of living.

Sincerely,

JAN - OWEN-DENTON

Janet Owen-Denton

cc: John Coghill

ROBERT GOULD
4820 Drake St.
Fairbanks, AK 99709

October 29, 2001

Senator Lyda Green
State Capitol
Juneau, AK 99801-1182

Dear Senator Green:

It has come to my attention that you are seriously looking to reduce Medicaid spending. I could not disagree more! You should be looking at ways to increase spending and ways to make the current system more efficient.

At this point, Medicaid fails to pay their share of the cost of care. As a result, providers are forced to shift the cost to individuals who have insurance. Talk to any provider, physician or insurance company and they will tell you that the insured population has to cover for the shortcomings of the Medicaid program.

Let me offer the following suggestions. Please look for ways to increase spending on preventative care (breast cancer detection, low birth weight, mental health, programs that help people reduce their drinking or help them to stop smoking.)

Please take the time to listen to the stories of the people who have been helped by Denali Kid Care. The vast majority is trying to become self-reliant, but life has gotten in the way.

Visit with a family who has a loved one in a long-term care facility. There is no way the family could provide the level of care that is required. There is also no possible way that a family could pay for the care of someone who lives in a facility for a long period of time.

Please pick up any article that focuses on the shortage of nurses and read about what is going to occur in healthcare in the years ahead. Make every effort to find a way to increase the programs for educating nurses.

Please look at all of the money being spent pushing paper. Look for ways to computerize and automate.

We don't need you to cut spending; we need you to look at where we need more funding.

Sincerely,

Robert Gould

cc: Rep. John Coghill

JANA WALTERS
P.O. BOX 81293
FAIRBANKS, ALASKA 99708

October 31, 2001

Senator Lyda Green
State Capitol
Juneau, AK 99801-1182

Dear Senator Green,

Having worked for over 30 years in the healthcare industry I have witnessed the impact of providing Medicaid funds to people in need.

The most profound effect, I believe, is in providing these funds to women and children. As an example, a young teen finds herself giving birth to her own child without the resources, emotionally or financially, to adequately care for herself or her unborn child. Without Medicaid funding she most likely will forego pre-natal care, putting herself and her child at risk for costly medical complications.

These complications often result in life-long medical expenses which ultimately are reimbursed by State funds. Adequate pre-natal care can and does decrease this risk. To eliminate the Medicaid funds at this level results in more costly expenditures throughout the lives of mother and child.

Maintaining the funds to provide care to this population is essential in allowing these individuals to lead productive and health lives.

Sincerely,

Jana Walters

Jana Walters

cc: Representative John Coghill
119 N. Cushman St. Suite 211
Fairbanks, AK 99701

Jennifer House
1951 Gilmore Trail
Fairbanks, AK 99712

October 30, 2001

Senator Lyda Green
State Capitol
Juneau, AK 99802-1182

Dear Senator Green,

I understand you are chairing a committee to pursue reducing Medicaid expenditures in our State. While I agree with the concept of looking for efficiencies in the administration of the Medicaid program, I do not support the reduction of services covered under Medicaid.

I know of numerous low-income families and individuals in my community who would not otherwise have access to healthcare services if it were not for Medicaid. Healthcare is not a luxury; it is not an option; it is a necessity that all members of our communities should have access to.

Expansion of Medicaid coverage in recent years to include Breast Cancer Detection and Children's health care to families who otherwise wouldn't qualify for Medicaid will reduce Medicaid costs in the long run. I applaud the State for these efforts. Furthermore, the current Medicaid reimbursement system is modeled to ensure that the State always pays less for health care services than insurance companies or individuals who pay privately. I believe the State already pays the least amount for the most healthcare that it possibly can.

Please consider, very carefully, the long-term effects of any actions you may take in your efforts to reduce Medicaid expenditures.

Sincerely yours,

Jennifer House

Jennifer House

cc: John Coghill

Bartlett Regional Hospital

3260 Hospital Drive • Juneau • Alaska 99801 • 907-586-2611

November 2, 2001

Senator Lyda Green
State Capitol, Room 125
Juneau, AK 99801-1182

Dear Senator Green,

It has come to my attention that you are seriously looking to reduce Medicaid spending. I could not disagree more! You should be looking at ways to increase spending and ways to make the current system more efficient.

At this point, Medicaid fails to pay their share of the cost of care. As a result, providers are forced to shift the cost to individuals who have insurance. Talk to any provider, physician or insurance company and they will tell you that the insured population has to cover for the shortcomings of the Medicaid program.

Let me offer the following suggestions. Please look for ways to increase spending on preventative care (breast cancer detection, low birth weight, mental health, programs that help people reduce their drinking or help them to stop smoking.)

Please take the time to listen to the stories of the people who have been helped by Denali Kid Care. The vast majority is trying to become self-reliant, but life has gotten in the way.

Visit with a family who has a loved one in a long-term care facility. There is no way the family could provide the level of care that is required. There is also no possible way that a family could pay for the care of someone who lives in a facility for a long period of time.

Please pick up any article that focuses on the shortage of nurses and read about what is going to occur in healthcare in the years ahead. Make every effort to find a way to increase the programs for educating nurses.

Please look at all of the money being spent pushing paper. Look for ways to computerize and automate.

We don't need you to cut spending; we need you to look at where we need more funding.

Sincerely,

Michael R. Gorham

Post-it® Fax Note	7671	Date 11-8-01	# of pages ▶ 1
To Senator Lyda Green		From C.I.T.C.	
Co./Dept		Co.	
Phone #		Phone #	
Fax # 376-3157		Fax #	

COOK INLET
TRIBAL
COUNCIL, INC.

Date: November 7, 2001

Senator Lyda Green
600 Ease Railroad Avenue
Wasilla, AK 99654

Dear Senator Green:

Consider the working poor. Medicaid, Food Stamps, and Denali Kid Care are going to be essential pieces of the safety net for working families who reach the end of ATAP eligibility.

In order to help these struggling families maintain pride in being members of the work force, a solid safety net needs to be in place. Welfare reform and a healthy economy have combined to allow for a 50% reduction in cash benefit caseloads.

Currently we are facing the first wave of families who are at the end of their five years of eligibility and we are in a recession.

Now seems to be the appropriate time to assure Medicaid and Denali Kid Care continue to be available at the current level of services. This will go a long way in helping families break the dependency cycle and give their children the best chance to grow healthy and independent. This decision will be pivotal to the continued success of welfare reform.

Sincerely,

Gloria O'Neill, President and CEO

TRANSITIONAL SERVICES DEPARTMENT
670 W. FIREWEED LANE, ANCHORAGE, ALASKA 99503-2578
FAX: (907) 265-7942
PHONE: (907) 265-5900

Dear Honorable Committee Members, 11-5-2001

My name is Randal Esslinger. I have numerous urgent medical needs that I am unable to meet. I have contacted DHSS and I have been seen by several doctors and I qualify in all respects. I am however being denied Medicaid. I am being told that unless I am getting either SSI or SSD I can't have Medicaid benefits. This is contradictory to Alaska Statue 7.08.010&47.07.020. Some of the injuries that I am seeking care for and corrective surgery happened while I was incarcerated for DUI. The state violated facility safety regulations by allowing an inmate to flood his cell repeatedly and I fell in the water seriously injuring myself This was 3-17-2000 so I have been suffering since that time. I am at home now yet unable to work due in part to this injury. It is my belief that medicaid is illegally being withheld as retaliation for filing lawsuits against the state for damages. I request that this committee look into this matter for me.

Thank you

R Es

Randal L. Esslinger
PO19551
Thorne Bay,Alaska 99919
(907) 828-8880
DHSS Case No.05383414

IONE WRIGHT

October 25, 2001

Senator Lyda Green
State Capitol
Juneau, AK 99801-1182

Dear Senator Lyda Green:

It has come to my attention that certain funding reductions are being considered for Medicaid patients. I have been in nursing for 20 years, and have witnessed the significant impact of persons / patients who fall through the cracks when it comes to medical care.

We have ongoing Fetal Alcohol Syndrome and drug addicted infants that require extensive and ongoing medical care, placement, and support throughout their lives.

We have many psychiatric patients and substance abuse patients that require many repeated hospitalizations with the result of no employment or income to support their families and children. This is especially critical in single parent homes – the children suffer the most.

I would emphasize also the many elders in the community who, following an admission for a fractured hip or severe pneumonia, cannot return home to live alone again. They often have no one from their family in our state that they can turn to. Taking them from familiar surroundings into assisted living and / or long-term care is traumatic enough without forcing them to relocate to another state. The high cost of medications is another issue that causes severe strain to our senior citizens.

I realize these are very tough issues to address for the state of Alaska and would like to encourage you to not cut funding, but rather seek ways of increasing support for these hurting areas of our communities. I believe the "return to work" programs are very good and would like to see that continued.

I feel children are our most important assets in this state and should be afforded every opportunity for health wellness, education, and support, as they will someday become Alaska's leaders.

I believe strongly in wellness programs for all in the community because this helps to keep medical costs/hospitalization down for the entire state and keep our population healthy. I would ask that you please make every attempt to be supportive of the medicaid system and funding required maintaining these programs. Thank you.

Sincerely,

I. Wright

Ione Wright

Cc: John Coghill

P.O. BOX 82929, FAIRBANKS AK 99708

October 31, 2001

Senator Lyda Green
Alaska State Legislature
State Capitol
Juneau, Alaska 99801

Dear Senator Green,

I am writing as a concerned citizen to urge your not to pursue a decrease in the Medicaid budget. Funding for these services is crucial in the Fairbanks community. As a health care provider, I see numerous instances in which this funding has prevented disastrous consequences.

I recall a young mother of two suffering from breast cancer, which became well advanced. Their Christmas two years ago consisted of concern over heating their one bedroom apartment, having enough food for her small children and adequate clothing to endure a Fairbanks winter. This is exactly the type of instance which I would desire my tax dollars, state dollars and general concern be focused towards.

Granted, there are times that I am frustrated with people who abuse the system intended to do good; however, I do not believe the approach of cutting dollars is the best. I would suggest instead a focus towards efficiency, accountability of dollars spent, and demonstrated value of programs be the priority.

Thank you for your consideration.

Sincerely,

Karl H. Sanford

Karl Sanford
384 Snowy Owl Ln.
Fairbanks, Alaska 99712

cc: Rep. John Coghill

October 25, 2001

Senator Lyda Green
State Capitol
Juneau, AK 99801-1182

Dear Senator Lyda Green,

I have recently been advised of your position on Medicaid funding, and to be quite honest I am disappointed in our state government and in your decision making process. I have been a registered nurse for 16 years. For the past 13 years, I have been working with the Mentally Ill and Substance Abuse populations.

These populations are becoming more and more recognized and require greater types of services. Unfortunately these populations are affecting many children and adolescents.

I have had to serve as a nurse to many teenagers whose parents either had/have major Mental Health Illness and/or Alcohol or Substance abuse issues. These children are victims. Dysfunctional parents who are unable to be good role models or educate their children are raising these children.

Many of these children become severely depressed and turn to substance abuse themselves. Many develop major mental illness themselves. On the Mental Health unit we have used the Denali Kid Care services to help get some of these children into early treatment. Out of the many children we have sent to treatment, I have had the pleasure of seeing two return to our community and they are able to contribute to other teenagers in need. These adolescents could not have been so productive if they had not gone to treatment. They could not have had treatment without the aide of Denali Kid Care.

Another request I have in supporting the continued funding of Alaska's Medicaid Program is the importance of the pharmaceuticals to individuals who cannot afford it. Many of our Mental Health patients are not on Medicaid as they choose to be employed, yet their income could never cover the cost of the medications required to keep them productive, functioning individuals. Without the help of Medicaid funding these patients could not afford medications, and soon would not be able to be productive, and surely would cost the public more in the long run.

Senator Green, I implore you to reconsider your stand and continue supporting these inpatient programs. Thank you for understanding the general public's position.

Sincerely,

Lauri Ellis

Lauri Ellis
cc: John Coghill

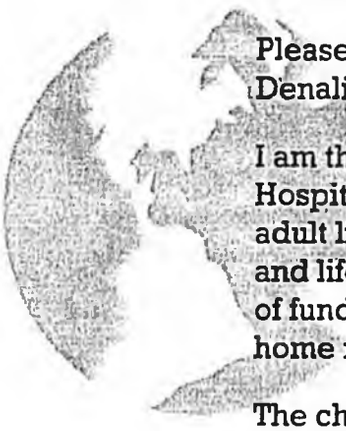
P.O. BOX 55521
NORTH POLE, AK 99705

Pat Connelly
4525 Woodriver Drive
Fairbanks, AK 99709

October 25, 2001

Senator Lyda Green
State Capitol
Juneau, AK 99801-1182

Dear Senator Green:



Please reconsider your position on Medicaid funding, especially for Denali Kid Care and Breast Cancer detection.

I am the manager of the surgical orthopedic unit at Fairbanks Memorial Hospital. We frequently see patients who have been healthy for their adult life and then they fall and break a hip. This can be a very expensive and life threatening injury in an elderly patient. They frequently run out of funds and need Medicaid funds for long-term care, home care, and home medical equipment.

The children, elderly, and poor people of Alaska need this program. Please reconsider your position.

Sincerely,

Pat Connelly

cc: John Coghill

Carol Barnett
1696 Dredgeview Dr.
Fairbanks, AK 99712

October 26, 2001

Alaska State Senator Lyda Green
State Capitol
Juneau, Alaska 99801-1182

Dear Senator Green:

I am writing this letter today to implore that you not cut Alaska Medicaid funding. In my personal opinion, I am most concerned about what budget reductions will do to existing programs that support our children. Particularly programs such as Denali Kid Care and TEFRA benefit so many children who otherwise wouldn't get the care they need. As a mother of three children, it is one of my strongest desires that each and every child receive the medical attention and preventative care they need.

Furthermore, special needs babies relinquished by parents are helpless victims who deserve a safe and nurturing home. Without this financial assistance, finding adoptive homes will become much more difficult; leaving these children to grow up in a less than optimal environment as Wards of the State. Children who are not raised in a safe and nurturing environment eventually end up costing tne public system more dollars in the end, i.e. illness, accidents, crime, alcoholism, drug abuse.

Please continue supporting and funding these very important programs that protect our children and future adult population. It is a wise investment into Alaska's future.

Sincerely,

Carol Barnett

Carol Barnett

cc: Rep. John Coghill
119 N. Cushman
Suite 211
Fairbanks, AK 99701

CAROL MEYER

SENATOR LYDA GREEN
STATE CAPITOL
JUNEAU, AK 99801-1182

DEAR SENATOR,

AS A CONCERNED CITIZEN OF ALASKA, AND A NURSE IN THE EMERGENCY DEPARTMENT, I FEEL COMPELLED TO WRITE TO YOU REGARDING YOUR PROPOSED CUTS TO THE MEDICAID PROGRAM IN ALASKA.

MANY OF THE PATIENTS I HAVE SEEN IN THE EMERGENCY DEPARTMENT ARE MEDICAID BENEFICIARIES. WHILE CERTAINLY THERE ARE SOME THAT ARE ABUSIVE OF THIS PROGRAM, MANY MORE WOULD BE DESTITUTE WITHOUT IT, PRIMARILY THOSE WITH CHILDREN. HOW YOU COULD EVEN FATHOM CUTTING THE MEDICAID BUDGET TO THE DETRIMENT OF ALASKA'S CHILDREN AND THEIR HEALTH CARE NEEDS IS BEYOND ME. I FEEL THAT THE REPERCUSSIONS OF THIS ACTION WOULD HAVE VERY NEGATIVE CONSEQUENCES TO THE HEALTH AND WELFARE OF KIDS ACROSS THE STATE, PERHAPS WHICH WOULD EVENTUALLY COST THE STATE MORE THAN WHAT YOUR PROPOSED CUTS WOULD SAVE.

I URGE YOU TO RECONSIDER THIS PROPOSED ACTION AS I FEEL IT WOULD HAVE A MONUMENTAL NEGATIVE IMPACT STATEWIDE.

SINCERELY,

Carol Meyer

CAROL MEYER

CC: JOHN COGHILL
119 N. CUSHMAN #211
FAIRBANKS, AK 99701

4250 ASPENWOOD DRIVE
FAIRBANKS, AK 99709

715 John Cole Road
Fairbanks, AK 99712

October 25, 2001

Senator Lyda Green
State Capitol
Juneau, AK 99801-1182

Dear Senator Lyda Green:

As an administrator in early childhood programs in Fairbanks for the past 17 years, I am imploring you to strengthen Medicaid funding. I have personally seen the impact of Alaska's Medicaid program on Fairbanks families.

An employee of mine, who is a single parent, adopted three FAS/FAE children (siblings). She has provided them a loving, stable home and they have made tremendous progress over the past few years. She could never have done this without the continuation of the children's Medicaid after the adoption process was completed.

I have seen many families utilize Denali Kid care insurance for their children. What a wonderful program, and what a great way to invest in our future – by ensuring a health population by providing preventative care and early treatment for our children and teens.

Again, I encourage you to support continued funding of Alaska's Medicaid program.

Sincerely,

Patty Rich

Patty Rich
cc: John Coghill

ALASKA STATE LEGISLATURE

Interim:
600 East Railroad Avenue
Wasilla, Alaska 99654
(907) 376-3370
(907) 376-3157 Fax

Session:
State Capitol
Juneau, Alaska 99801-1182
(907) 465-6600
(907) 465-3805 Fax

SENATOR LYDA GREEN
SENATE DISTRICT N

PRESS RELEASE FOR THE HEALTH CARE AND WELFARE SUBCOMMITTEE

September 19, 2001

For Immediate Release —Lyda Green (R-Mat-Su), Chair of the Senate Health, Education and Social Services Committee announced the formation of a legislative subcommittee to explore the future of health care costs and welfare reform in Alaska.

After education, health care is Alaska's most expensive service, and it is continuing to grow every year. At the current rate of growth, approximately 10% annually, Medicaid costs could overtake education costs within five years and the state's total budget for Medicaid services will double in seven years. Alaska's Medicaid expenditures increased by approximately $75 million in the last budget cycle and are anticipated to exceed that in the next cycle unless cost containment measures are implemented. In addition to the rising costs of the total program, reductions by the new leaders in Congress of Alaska's Federal Match Percentage (FMAP), which go into effect October 1, 2001, will create an immediate shortfall of $10 million in the coming year. Cost containment measures must begin now to address that shortfall.

State provided welfare is another program that will be revisited during the coming legislative session, since the mandatory 60-month limit occurs for some recipients in 2002. Additionally, the federal government is reducing their funding of the state's welfare program by $7 million in the upcoming year. Consequently, it will be necessary for the Legislature to address the continuation of and changes to the welfare program.

In response to these issues, Senator Green has formed a legislative subcommittee to progressively address these important social and policy issues. "It has been years since the legislature has taken a comprehensive look at our state's growing health care costs. It is important that, as these costs increase, the legislature consider these programs and their costs and whether they are appropriate and reasonable," said Senator Green. "Furthermore, access to quality health care is a major concern to residents of both rural and urban areas of Alaska. I want to be sure that Alaskans who really need health care coverage are receiving it, and we need to explore how greater access to health care insurance can be provided for the people of Alaska," continued Green.

Senator Green will be joined by Senators Bettye Davis, Robin Taylor and Jerry Ward, as well as Representatives Fred Dyson (Chair of the House Health, Education and Social Services Committee), Sharon Cissna and John Coghill.

The subcommittee will hold a series of public meetings at the Mat-Su Legislative Information Office this fall. The meetings will focus on:

- Access to health insurance for Alaskans;
- Welfare reform and reauthorization and its effects on health care costs and access;
- The Certificate of Need Program for expanding health care facilities or building new health care facilities and its effects on health care costs;
- Review of Medicaid programs, including the Child Health Insurance Program (CHIP), costs associated with Medicaid, cost containment and proposed solutions; and
- Rural Health Care and the role of the state, the federal government, the Denali Commission and native non-profit health corporations.

The subcommittee will be inviting expert testimony from state and federal agencies and interested groups as well as public testimony. At the conclusion of the hearings, the subcommittee will submit a written report to the Legislature and may propose legislation to be introduced by the Senate or House Health Education and Social Services Committees.

The public is encouraged to contact Senator Green to provide the subcommittee with questions to explore with experts and written testimony concerning health care costs and access. Questions or comments can be submitted to Senator Green in writing at 600 East Railroad Avenue, Wasilla, AK 99654, by email at Senator_Lyda_Green@legis.state.ak.us, or by telephone at (907)376-3370 or (888)465-6601.

Denali Commission Update
November 2001

Note to Legislators and Staff: Please contact Krag Johnsen, Alaska State Legislature's Staff Representative at the Denali Commission for further information. (907) 271-1413, Kjohnsen@denali.gov.

Energy

Energy projects comprise nearly $65 million of Denali Commission funding. This is leveraging an additional $22 million from other funding sources. The two primary agents used to complete projects are **Alaska Industrial Development and Export Authority/Alaska Energy Authority (AIDEA/AEA)** with **$43.8 million, and Alaska Village Electric Cooperative (AVEC)** with $21.3 million presently funded.

All Federal FY01 financial awards incorporated sustainability criteria for their projects. This requires that a business plan be developed demonstrating how the community will operate and maintain the utility in a business-like manner, attain the full expected economic life of the utility, and build some equity for future replacement. Construction funds are not authorized for these projects until the business plan has been approved, and a potential backup operator is named for the event that a community is unable to adhere to the business plan. Funding for business plan development is currently available for 54 communities. Most Denali Commission Energy projects need a two-year cycle to complete planning design and construction. As the cycle has developed, questions continue to arise on how to fund projects equitably, and how to plan for future work. In September, the Denali Commission issued three draft policies regarding capacity, fuel pipelines and dispensers, and energy project prioritization.

BULK FUEL UPGRADES

Bulk Fuel Upgrades are the largest part of the Energy program at $39.3 million. By the end of 2001, new bulk fuel projects will be substantially complete and operational in nine communities: **Kotlik, Chignik Lagoon, Old Harbor, Noorvik, Port Graham, Manokotak, Kiana, Allakaket, and Napaskiak.** Three projects were put into operation last year.

RURAL POWER SYSTEMS UPGRADES

Rural Power Systems Upgrades represent $16.9 million of the Energy program. Twelve other energy projects (including power plant upgrades, electrical distribution upgrades, and fuel-line replacements) should be complete in **Kasigluk. Kiana, Huslia, Kivalina, Ambler, Quinhagak, Pilot Station, Shishmaref, Savoonga, Toksook Bay, Tuntutuliak and Kotlik.**

ENERGY COST REDUCTION RFP

Energy Cost Reduction RFP, with $4 million in Denali Commission funds, was issued by AEA on May 18, 2001. Preference in evaluation will be given to economically distressed rural communities, or those with extremely high-energy costs. It is anticipated this money will be allocated to projects in the January 2002 Quarterly meeting.

Contact Information:
AIDEA/AEA Contact Mike Harper, (907) 269-3000
AVEC Contact Meera Kohler, (907)561-1818
Denali Commission Program Manager Kathy Prentki, (907) 271-1414

Health

To date the Commission has obligated $22 Million for health care facilities leveraging an additional $20 Million in contributor funding. A total of 24 clinic construction projects have been funded and an additional 28 planning/design projects have been funded.

There is no one State or Federal agency tasked with provision of health care facilities throughout all of Alaska. Many agencies and health care organizations have overlapping interests, but there is no one agency to turn to. Accordingly, the Commission established a Health Care Steering Committee of agencies and organizations with interests in health care. The Steering Committee is chaired by the **Director, State of Alaska Division of Public Health** and has members from the following organizations: **Indian Health Service, Alaska Native Tribal Health Consortium (ANTHC), University of Alaska, Alaska Primary Care Association, Alaska Native Health Board, and the Alaska Mental Health Trust Authority.**

For carrying out its Health Care Program for the "Small Clinic" program (typically a clinic that serves one community with a year-round population less than 750) and the "Clinic Repair/Renovation" program, the Commission has turned to the State of Alaska as our "pre-award" partner and ANTHC as our "post-award" partner. The State manages the Commission's request for proposals process in conjunction with the Commission. Once projects have been identified, then ANTHC will manage the projects on our behalf. Communities have a choice of 6 management options through ANTHC:

- Community-managed force account
- Community-managed competitive contract with strong local hire component
- Regional Health Corporation - managed force account
- Regional Health Corporation - managed contracts with strong local hire requirement
- ANTHC-managed competitive contract with strong local hire requirement
- ANTHC Department of Environmental Health and Engineering - managed force account

For our "Large Clinic" program (typically a clinic that serves multiple communities or a community with a year-round population greater than 750) the State of Alaska is our "pre-award" partner. To date, all project applicants are our "post-award" partners and provide project management. However, in time the Commission may have to revisit this approach as the volume of "Large" clinic grantees grows beyond Commission staffing ability to respond to our Large Clinic partners needs.

Contact Information:
Denali Commission
Joel Neimeyer, Health Care Program Manager: (907) 271-1459
Al Ewing, Chief of Staff: (907) 271-1426

ANTHC
Rick Boyce, Facilities Program Manager: (907) 729-3601
Seth Yerrington, Clinic Construction Program Manager: (907) 729-3747, (907) 729-3600

State of Alaska
Karen Pearson, Director, Division of Public Health & Chair of the Steering Committee: (907) 465-3090
Pat Carr, Program Manager, Primary Care and Health Promotions: (907) 465-8618

Training

DENALI TRAINING FUND

The Denali Training Fund was established by the Denali Commission specifically to ensure that local residents have the skills to become employed on the construction, operation, and maintenance of Denali Commission and other state and federally funded public infrastructure projects. To date over three hundred people from rural Alaska communities have been trained for numerous construction, operations, and maintenance careers.

The **Department of Labor and Workforce Development** operates, selects, oversees, and administers the Denali Training Fund. On a quarterly basis applications of up to $25,000 for training are solicited from non-profit and for-profit organizations and governments.
Contact Information: Gerry McDonagh, (907) 269-4551

ALASKA NATIVE COALITION ON EMPLOYMENT AND TRAINING (ANCET)

ANCET consists of the **twelve regional Native Nonprofit Corporations** and **Metlakatla** as a unified organization to further employment and training issues statewide and nationally. The focus of ANCET for the Denali Commission has been to implement a **Regional Coordination Initiative** that handles much of the recruitment for various training courses that are funded by the Denali Training Fund.
Contact Information: Bonnie Jo Savland, (907) 644-8312

ASSOCIATED GENERAL CONTRACTORS OF ALASKA

With Denali Commission funds the **Associated General Contractors** administer the **Construction Career Pathways Initiative**, placing construction curriculum in rural schools through **Build Up!** for elementary grades. To date **Build Up!** has been introduced to 27 different schools in 13 rural school districts. AGC is looking for more for more rural schools to offer the curriculum.
Contact Information: Vicki Schneibel, (907) 561-5334

ALASKA WORKS PARTNERSHIP

Alaska Works Partnership (AWP) and the Denali Commission have partnered to deliver apprenticeship outreach services in rural Alaska. **AWP** provides information to students and adults about jobs in the construction industry and opportunities to learn construction skills through registered apprenticeship. To date thirty rural residents successfully entered specific craft apprenticeship programs, and over sixty are registered as **Building Maintenance Repair (BMR)** apprentices with **Alaska Works**.
Contact Information: Tom Brice, (907) 457-2597

ALASKA VOCATIONAL TECHNICAL CENTER

AVTEC has implemented two programs that provide advanced skills certification. The first is the **Building Maintenance Repairer Apprenticeship (BMR)**, which includes comprehensive training in the basics of carpentry, plumbing, heating, and electric. The second initiative developed the curriculum for the **Bulk Fuel Tank Farm Operator course**, which trains the individual in the statutes, regulations, and requirements of the operation and maintenance of bulk fuel storage facilities in Alaska.
Contact: Dick Harrell, (907) 224-4162

Contact Information:
Denali Commission
Krag Johnsen, Program Manager, (907) 271-1414

Other Infrastructure

MINI-GRANT PROGRAM
The Division of Community and Business Development (DCBD) administers the program, under the **Alaska Department of Community and Economic Development**. The program has one grant cycle, which began August 8, and will conclude with final awards on January 15. The Denali Commission contributed $500,000 and the **USDA Forest Service** contributed $144,755, for a total Mini-grant program of $644,755. *Contact Information: Nelda Warkentin, (907) 269-4568*

COMMUNITY PRIORITIES PROGRAM
The Denali Commission invested $4,500,000 in this program, which is administered by the **Division of Community and Business Development (DCBD)**, under the **Alaska Department of Community and Economic Development**. The program has quarterly grant cycles. The second grant cycle is under way. Pre-applications for the third and fourth grant cycles are due November 2, 2001, and February 18, 2002 respectively. *Contact Information: Nelda Warkentin, (907) 269-4568*

ALASKA GROWTH CAPITAL PROGRAM
The Denali Commission has invested $2,340,000 with **Alaska Growth Capital** to support viable businesses in rural Alaska, with emphasis on Alaska-owned businesses in economically distressed communities. The program does not have a funding cycle, but responds to requests for assistance on a year round basis. **Alaska Growth Capital** (AGC) has made $1,625,000 in loans this year to Alaska-owned businesses in economically distressed communities. An additional $600,000 in loans is in the closing process. The businesses that received loans have an annual payroll of $350,000. In addition, AGC has made 15 consulting engagements with clients or potential clients. *Contact Information: David Hoffman at (907) 349-4904*

Contact Information:
Denali Commission
Paul McIntosh, Program Manager, (907) 271-1640

First Alaskans Foundation

In late 2000, the Commission granted $1.2 million to the First Alaskans Foundation. The foundation, a non-profit organization affiliated with the Alaska Federation of Natives, is working to develop capacities of Alaska Native people and communities "to meet social, educational and economic challenges of the future." This capacity building program will be phased over a two-year period and will work on the development of local decision-making, and enhancement of management and governance skills necessary to plan and implement sustainable community development efforts. Funding has been made available through five separate RFP processes: community development, community economic development, statewide visioning, regional/sub-regional infrastructure planning, and community infrastructure construction.

Contact: Jason Metrokin, Director of Programs, (907) 263-9890

Denali Commission brings GrantStation.com to Rural Alaska

The Denali Commission, Alaska State Libraries, USDA Rural Development, and GrantStation.com Inc. recently announced a jointly funded project to bring state of the art grant seeking services to organizations and residents in rural Alaska.

GrantStation.com is an Alaskan owned and operated company provides an on-line comprehensive, fully interactive and searchable database of funding sources for organizations at www.grantstation.com. Members of GrantStation have access to worldwide funding sources (soon to include all state and federal sources) with the most up-to-date contact information, an accurate understanding of a funder's philosophies and rules, and valuable information on the most effective way to work with a particular funder.

Under the terms of the contract GrantStation.com membership will be provided to the following organizations for two years:

- All State Libraries (approximately 75 Rural Locations will have grantstation.com access for the public)
- All Tribal offices
- All City offices
- All Health Corporations
- All Regional Native Non-Profits
- All Rural School Districts
- All Rural Borough offices

Jeff Staser, Federal Co-Chair of the Denali Commission said, "The Denali Commission has already been successful in securing private foundation dollars with previous projects, we believe that GrantStation.com services will help expand on this success and bring more funding to rural Alaska and ultimately stretch the federal and state's investment into rural communities

Alaska
Rural Primary Care Facility Needs Assessment

Volume I • Overview

Final Report

ALASKA RURAL PRIMARY CARE FACILITY NEEDS ASSESSMENT

October 20, 2000

Dear Commissioners:

The Steering Committee for the Alaska Rural Primary Care Facility Needs Assessment Project has published the enclosed Final Report summarizing its work to:

- Build a statewide database of detailed information on rural primary care facilities and program services.
- Develop a set of goals and guidelines that can be used as a benchmark for estimating the statewide-unmet need related to primary care facilities.
- Establish a resource distribution methodology for rural primary care facility projects funded through the Commission.

This Final Report is the culmination of ten months of collaborative effort incorporating information from a community questionnaire, testimony received during statewide public meetings, and written comments submitted to the Steering Committee.

We appreciate the significant contribution made by the 218 communities that completed the questionnaire and the over 200 individuals who attended meetings and/or submitted written comments. While this project has launched a process that will improve Alaska's rural clinic infrastructure, the work has just begun. We encourage the on-going, active participation of those who are committed to strengthening and continually improving the recommendations and procedures outlined in this report. Our intent and hope is that this first effort will evolve into an on-going process that meets the primary care infrastructure needs of all Alaskans.

Sincerely,

Steering Committee Members

Joel Neimeyer, PE
Project Manager
Denali Comr ission

Rick Boyce, PE
Director, Division of Health Facilities
Alaska Native Tribal Health Consortium

Torie Heart, MS, RN
Director, CHAP/Rural Health
Indian Health Service

Patricia A. Carr, MPH
Unit Manager, Primary Care and Health
Promotion Unit
Division of Public Health, State of Alaska

3925 Tudor Centre Drive, Anchorage, Alaska 99508
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ALASKA RURAL PRIMARY CARE FACILITY NEEDS ASSESSMENT PROJECT

FINAL REPORT

VOLUME I

OVERVIEW

Prepared for:

DENALI COMMISSION

510 "L" Street
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Prepared by:

Alaska Native Tribal Health Consortium
Department of Health and Social Services
Indian Health Service

October 2000

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LIST OF ACRONYMS

ACRH ..... Alaska Center for Rural Health
ADA ..... Americans with Disabilities Act
ANHB ..... Alaska Native Health Board
ANMC ..... Alaska Native Medical Center
ANTHC ..... Alaska Native Tribal Health Consortium
APCA ..... Alaska Primary Care Association
APCD ..... Alaska Primary Care Database
APCDS ..... Alaska Primary Care Data System
ARC ..... Appalachian Regional Commission
ARPCFNA ..... Alaska Rural Primary Care Facility Needs Assessment
BTU ..... British Thermal Unit
CDBG ..... Community Development Block Grant
CHA ..... Community Health Aide
CHAP ..... Community Health Aide Program
CHA/P ..... Community Health Aide/Practitioner
CHC ..... Community Health Centers
CLIA ..... Clinical Laboratory Improvement Act
C/MHC ..... Community/Migrant Health Center
DCED ..... Alaska Department of Community and Economic Development
DHHS ..... U.S. Department of Health and Human Services
DHSS ..... Alaska Department of Health and Social Services
HUD ..... U.S. Department of Housing and Urban Development
EMS ..... Emergency Medical Service
EMT ..... Emergency Medical Technician
FNAQ ..... Facility Needs Assessment Questionnaire
FQHC ..... Federally Qualified Health Centers
FTE ..... Full Time Equivalent
GIS ..... Geographic Information System
GSF ..... Gross Square Feet
HRSA ..... Health Resources and Services Administration
HTML ..... Hyper Text Markup Language
HVAC ..... Heating, Ventilation, and Air Conditioning
ICDBG ..... Indian Community Development Block Grant
IHS ..... Indian Health Service
M&I ..... Maintenance and Improvement
MLP ..... Mid Level Provider
MRP ..... Multi-disciplinary Review Panel
NFPA ..... National Fire Protection Association
O&M ..... Operation and Maintenance
PITS ..... Project Information Tracking System
RDM ..... Resource Distribution Methodology
RFP ..... Request for Proposal
RHC ..... Rural Health Clinic
SOW ..... Scope of Work
UBC ..... Uniform Building Code

UFC ..... Uniform Fire Code
USDA ..... U.S. Department of Agriculture
WIC ..... Women, Infants, and Children
YKHC ..... Yukon-Kuskokwim Health Corporation

PREFACE

The Denali Commission Act of 1998 (Division C, Title III, P.L. 105-277) created the Denali Commission (Commission). The Commission is an innovative federal-state partnership established by Congress to provide critical utilities, infrastructure, and economic support throughout Alaska. Its mission is to lower the cost of living --- and raise the standard of living --- throughout rural Alaska in the most cost effective manner possible. The Commission receives an annual appropriation from Congress and then, through its Commissioners, allocates these funds for specific projects. Criteria for funding and an annual work plan are developed with public participation. Priority is given to comprehensive, community based and regionally supported, sustainable projects. The original enabling legislation identified three areas of focus for the Commission including job training, economic development, and infrastructure development.

The Commission has seven members who are listed below.

- Fran Ulmer — Lt. Governor, State of Alaska and State Co-Chair
- Jeffrey Staser — Federal Co-Chair
- Mark Hamilton — President, University of Alaska
- Julie Kitka — President, Alaska Federation of Natives
- Mano Frey — Executive President, Alaska State AFL-CIO
- Kevin Ritchie — Executive Director, Alaska Municipal League
- Henry Springer — Executive Director (Retired), Associated General Contractors of Alaska

In general, the Commission is based upon a format similar to the Appalachian Regional Commission (ARC), which was created in 1965 to fulfill a similar mission for 13 eastern seaboard states. Of interest to the Denali Commission and Alaskans is that one of ARC's primary goals was to insure that: "Appalachian residents will have access to affordable, quality health care." As further evidence that Congress intended for the Denali Commission to address health care issues, amendments to P.L. 105-277 were enacted at the end of 1999 authorizing demonstration projects between the Commission and the U.S. Department of Health and Human Services (DHHS) --- that can extend beyond primary care facilities, e.g., into hospitals, mental health facilities, elder care and child care facilities (see Appendix I for

full text of referenced amendment). Accordingly, the Denali Commissioners adopted Resolution 00-01 on January 28, 2000 identifying rural health care facilities and services as the second area of focus or theme for infrastructure related projects funded and supported by the Commission. Their first infrastructure focus was rural energy projects.

The following report provides background on the goals and objectives of the Alaska Rural Primary Care Facility Needs Assessment (ARPCFNA) Project --- one of the first health care related initiatives undertaken by the Commission. It includes an initial estimate of the unmet need with respect to primary care facilities in rural Alaska, and describes the Alaska Primary Care Data System (APCDS) and Resource Distribution Methodology (RDM) developed as part of the project.

The following websites contain more specific information about the Denali Commission itself and the Rural Primary Care Facility Needs Assessment Project.

- *www.denali.gov*
- *www.apcds.org*

EXECUTIVE SUMMARY

A. EXECUTIVE SUMMARY

In October 1999, the Denali Commission approved funding for a project with the Alaska Native Tribal Health Consortium (ANTHC) to develop an assessment of rural primary care facilities related needs throughout Alaska. The Commission and ANTHC subsequently formed a partnership with the State of Alaska Department of Health and Social Services (DHSS) and the Indian Health Service (IHS) to:

1. Build a statewide database of detailed information on rural primary care facilities and program services.

2. Develop a set of goals and guidelines that can be used as a benchmark for estimating the statewide unmet need related to primary care facilities.

3. Establish a resource distribution methodology for rural primary care facility projects funded through the Commission.

The purpose of this final report is to document the results of the Alaska Rural Primary Care Facility Needs Assessment (ARPCFNA) Project. The report includes an initial estimate of the unmet facility related needs.

A relational database has been developed that includes detailed information on primary care facilities and program services for 288 communities throughout rural Alaska (all locations with year-round populations greater than 20 and no existing in-patient facility). The final database and associated applications are being referred to as the Alaska Primary Care Data System (APCDS) which has the following capabilities.

- Web Enabled
- Ad Hoc Queries
- Graphical Analysis via a Geographic Information System (GIS) Component

A set of primary care program goals and space guidelines have been established for rural Alaska. These goals and guidelines (reference Tables 8 and 9 on pages 24 and 25) were used as a benchmark for establishing unmet, rural primary care needs for the state. Table 1

summarizes the new statewide space requirements derived from these goals and guidelines. Also included in the table is an allowance for 12 - 14 new multi-community clinics around the state where it may be more appropriate to construct a single but somewhat larger facility to serve several small communities within a common service area. This multi-community or "sub-regional" concept is a proven model and is being successfully implemented by entities such as the Yukon-Kuskokwim Health Corporation (YKHC). The last entry in the table is an estimate of the funding required to correct the backlog of needed renovations and repairs at existing rural primary care clinics.

Table 1: Unmet Need Data

Unmet Need Category	Basis (GSF)	Amount (millions)[1]
New Space at Individual Locations	305,000	$99
New Multi-Community Clinics	130,000	$52
Backlog of Repairs	330,000	$102
Total		**$253**

1. In terms of May 2000 dollars

The dollar estimates summarized above include design, construction, and equipment. They do not include unmet program needs (staffing and other operational costs).

A resource distribution methodology has been developed for prioritizing funds made available through the Denali Commission for primary care design and construction projects. Significant public and stakeholder input was solicited during the development of this management tool. The three-part process is outlined below.

Part I: Community Prioritization

Comparison of all eligible communities based on data in the APCD and a prioritization formula that includes seven factors.

1. Facility Related Deficiencies
2. Overall Regional Health Status
3. Isolation
4. Dependency Ratio (Ratio of Young and Old to Working Age Residents)

5. Economic Status
6. Local Incidence Rates of Trauma Related Hospitalizations
7. Seasonal Population Increases

Part II: Proposal Review and Capability Measurement

Based on available funding, a short-list of communities from the top of the Part I prioritization list will be invited to submit detailed project proposals. Proposals will be evaluated by a multi-disciplinary review panel (MRP) with respect to the following criteria.

1. Local Support for Project
2. Site Availability and Control
3. Utility Extension Plan
4. Cost Sharing
5. Service Delivery Plan
6. Business Plan
7. Facility Related Deficiencies
8. Consistency With Overall Community Development Plan
9. Multi-use Components of Project
10. Project Management Plan

If proposals are determined to be inadequate with respect to any of these factors and/or specific data needs to be verified, the proposal will be referred back to the community for amendment. In these instances, recommendations may be provided on where to secure technical assistance to develop the appropriate amendments. Based on the Part II results, an annual approved project list will be published.

Part III: Funding

Funding agreements and transfers will be initiated once the Denali Commission's Program Manager has determined that all appropriate planning, design, permit and construction related documents are in place.

The recommended methodology is intended to be an equitable system for the distribution of federal funding to those communities with the greatest need, recognizing that the successful delivery of health services includes the ability of a community to operate and maintain the facility over the long term. More detail on the distribution methodology can be found beginning on page 31. Appendix XII contains the FY01, Part I Community Prioritization.

In September 2000, the Denali Commission selected ANTHC as the Program Manager for the APCDS and most of the rural primary care facilities related projects funded through the Commission. ANTHC is providing a database administrator who will maintain the APCDS. The four primary partners in the project will have full access to all data in the system. For data confidentiality reasons, other organizations and/or the general public will only have access to aggregate data summarized on a regional or service area basis.

B. BACKGROUND

In most parts of the country, the highest cost of delivering health care service is found in urban areas. This does not hold true in Alaska where rural residents generally face higher costs than those found in the state's major population centers. Rural residents are isolated from the regional hospitals and health centers by immense distances, climatic extremes, and geographic barriers.

Initial access to either the native or private health care system for most rural residents in Alaska is through a small, village-built clinic facility. Most are locally staffed with a Community Health Aide / Practitioner, funded in part by IHS. Services are generally limited to basic primary care and emergency medical treatment. Most clinics do not provide behavioral or dental health services. The IHS provides minimal lease funds (typically $20,000 annually to a community) for some 168 such facilities to cover basic utility and janitorial costs. IHS has no recurring capital improvement program for these facilities. A large number of these facilities are in need of repair, renovation or replacement. Many are not even connected to a water and wastewater system. Small, non-native communities scattered around the state have similar facility and program issues. In 1994, DHSS compiled basic information on most village health clinics in the state (reference *DHSS Village Health Clinic Survey*). Of the 174 facilities that were subjectively "rated" with respect to physical condition, approximately 33 percent were categorized as needing replacement or major renovation. Seventy-nine facilities (40 percent) were still using a honey bucket and/or pit privy system for sewage disposal. Currently no one federal or state agency is tasked with oversight or prioritization of improvements for these facilities. There are unmet needs both with respect to program and facility funding.

There has never been a comprehensive one time or recurring funding source to build or renovate primary care clinics for rural Alaska. Nor can small rural communities participate in the normal (and backlogged) IHS health facilities priority system, which is solely for building and replacing regional and referral facilities. The limited capital funding made available for rural clinic projects to date has come largely from the U.S. Department of Housing and Urban Development (HUD) - Community Development Block Grant (CDBG)

Program, Department of Agriculture (USDA) - Rural Development Loan Program, special state appropriations, and/or commercial loans. At best, communities are usually forced to patch a project together from several sources. More often, projects are either put on hold due to a lack of funding or significant compromises made with respect to space and/or construction standards.

C. NEEDS ASSESSMENT PROJECT

C.1.0 Authorization and Funding

In October 1999, the Commissioners approved funding for a project with ANTHC to produce an assessment of rural primary care facility related needs throughout the state. ANTHC offered to provide project management and a portion of their own funds for the effort. In light of its mission to provide federal services for all of Alaska, the Commission and ANTHC sought the participation of the Alaska DHSS. After DHSS agreed to collaborate on the project, the three parties then sought the participation of the IHS based upon their long history and in-depth knowledge of rural primary care programs and facilities. On February 24, 2000, the four partners finalized an agreement for carrying out the ARPCFNA Project.

C.2.0 Objectives and Schedule

The needs assessment project had three main goals.

1. Build a statewide database of detailed information on rural primary care facilities and program services.

2. Develop a set of goals and guidelines that can be used as a benchmark for estimating the statewide unmet need related to primary care facilities.

3. Establish a resource distribution methodology for rural primary care facility projects.

An overall schedule for the project appears below.

Table 2: Project Milestones
(Calendar Year 2000)

Task	Start	Finish
Scoping and Project Start-Up	January	February
Establish Criteria	January	May
Data Collection	March	August
Design and Develop Database	April	July
Interim Report	July	
Develop Methodologies	May	September
Design and Develop Computer Applications	March	September
Final Report	October	

Information from the needs assessment project will be used by the partners to seek funding for both improvements and/or new facilities and primary care service enhancements. In the event Congress looks favorably on the results of the assessment, the distribution methodology should guide federal, state, municipal, and tribal managers on which projects to fund and in what order.

C.3.0 Project Team

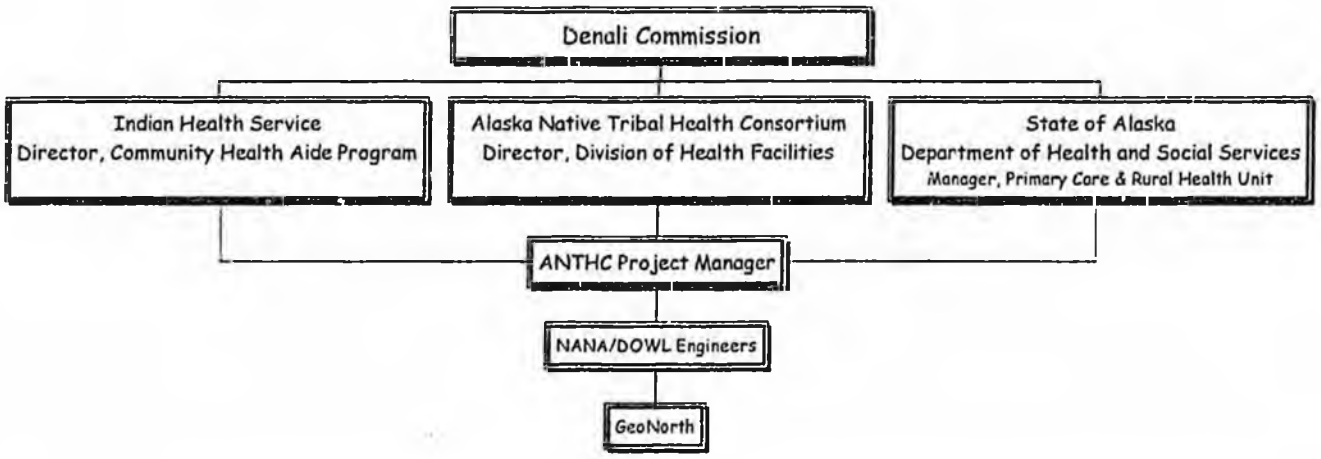
A project Steering Committee was formed that included representatives from the Denali Commission, ANTHC, IHS, and DHSS. A project organizational chart and primary contact list appears below.

Table 3: Primary Contacts

Name	Organization	Position	Phone	e-mail
Joel Neimeyer, PE	Denali Commission	SC	(907) 271-1414	jneimeyer@denali.gov
Pat Carr, MPH	DHSS	SC	(907) 465-8618	pat_carr@health.state.ak.us
Torie Heart, MS, RN	IHS	SC	(907) 729-3642	vheart@anmc.org
Rick Boyce, PE	ANTHC	SC	(907) 729-3601	rboyce@anthc.org
Gary Kuhn, PE	ANTHC	Project Manager	(907) 729-3604	gkuhn@anthc.org

SC = Steering Committee Member

Figure 1. Alaska Rural Primary Care Facility Needs Assessment Project Organizational Chart



ANTHC was tasked with the overall responsibility for developing a work plan and schedule to meet project goals. ANTHC and the Steering Committee received assistance from two primary consultants during the project: NANA/DOWL JV (health facility expertise) and GEONORTH, LLC (database design). These services were obtained through an existing indefinite delivery contract between ANTHC and NANA/DOWL. The Commission and ANTHC agreed to use this contract in order to expedite the project and meet the key milestone dates.

C.4.0 Basic Criteria

The project addressed needs in all native and non-native communities in the state that met the following basic criteria:

- Year-round community population of at least 20 individuals.
- No local in-patient health care facility.

In order to provide some practical limits to the assessment, the parties agreed to study only those communities without a local in-patient facility, i.e. a hospital. The assumption is that, in general, primary care services are available in these communities at a significantly higher level than most rural, "non-hospital" communities. A population threshold of 20 was used since the IHS has a program to lease clinic space from villages with 20 year-round residents or more. The parties accepted this existing federal program criterion as a reasonable lower community population limit for the needs assessment.

A list of the 288 communities meeting the above criteria appears in Appendix II. Both an alphabetical and ascending population sort are presented. The population figures are 1999 values as reported by the State Department of Community and Economic Development (DCED).

C.5.0 Website

A website was developed to facilitate communications during both the Needs Assessment Project and follow-on program implementation. The website has two levels; one for the general public and a more detailed one for use by the project / program management team. The current address is: *http://www.apcds.org*

C.6.0 Public and Stakeholder Input

The Steering Committee determined early on that developing public support through outreach to stakeholders and other interested parties would be essential to the success of the Needs Assessment Project. Accordingly, committee meetings were open to the public. The project team also conducted five regional workgroups during May. The primary purpose of these workgroups was to collect input and ideas on the factors used to develop a statewide resource distribution methodology for facilities related projects. Open workgroup meetings were held in Anchorage, Juneau, Fairbanks, Kotzebue, and Bethel. As well, there was a special statewide public meeting conducted on July 11 via both a teleconference with the twenty-two Legislative Information Office sites and a facilitated meeting at the Loussac Library in Anchorage. The partners also had on-going communications with interested organizations and individuals throughout the project by way of special mailings and presentations at related meetings (e.g., State MEGA meetings, Alaska Native Health Board [ANHB], Primary Care Partnership, and Community Health Aide Program [CHAP] Certification).

C.7.0 Phase II - Primary Care Program Development and Support

In September 2000, the Steering Committee presented a proposal to the Denali Commission for a Phase II Primary Care Program Development and Support project to build on the program data collected as part of the initial needs assessment described in this report ("Phase

1"). The Phase II scope of work focuses on working with communities to develop and support primary care programs. Public testimony received during Phase 1 emphasized the necessity for developing and supporting primary care programs as a complimentary component to the construction, renovation, and repair of primary care facilities.

C.8.0 Beyond Primary Care Facilities

It is anticipated that the work of the Denali Commission and their health care partners will be expanded to investigate other health related service delivery and infrastructure gaps in rural Alaska. There are unmet needs beyond those identified in this report and/or additional communities that should be evaluated. Undertaking this additional work would be consistent with the intent of federal legislation passed at the close of the 1999 Congressional calendar authorizing demonstration projects between the Commission and U.S. DHHS --- that can extend beyond primary care facilities (e.g. hospitals, mental health facilities, elder care, and child care facilities).

D. QUESTIONNAIRE

D.1.0 Overview

A Facility Needs Assessment Questionnaire (FNAQ) was developed and mailed to all 288 communities meeting the basic project criteria during the last week of March 2000. Copies of the questionnaire were also made available to Regional Health Corporations and Boroughs. All data received by September 1 was entered into the database and used to develop both the unmet need estimate and the FY 2001 community priority list. The Steering Committee encourages all 288 communities to submit responses; questionnaires are still being accepted. Communities submitting after the deadline will be eligible for subsequent fiscal year funding. Three mechanisms are available for submitting data: (1) Internet, (2) hard copy via mail, and (3) hard copy via FAX.

The FNAQ has an introductory section that requests information on the number of organizations/programs providing primary care services in the community and the total number of facilities being used to support these services. The body of the questionnaire is divided into two main sections that address current status and additional needs with respect to

facilities and services / programs. The Steering Committee agreed that a review of program needs must be a part of any facility condition and/or additional space needs evaluation A summary of the Sections and Subsections in the main questionnaire appears below. A full copy of the questionnaire appears in Appendix III.

***Facilities*:**

- Basic Data
- Ownership / Lease Data
- Physical Deficiencies
- Space Related Deficiencies
- Medical Equipment Deficiencies
- Utility and Maintenance Data

Data from these sections were used to calculate the unmet need compared to the space guidelines developed as part of this project. Data were also used to estimate the backlog of repairs for existing space. The methodology to prioritize communities and distribute resources utilized some of this data.

Program:

- Services Provided and/or Needed
- Patient Transportation Data
- Program Administration Data
- Support Services Delivery Location and Mechanism
- Staffing Provided and/or Needed
- Clinical Caseload (Workload) Data
- Extended Patient Stay Data
- Living Quarters Information
- Telehealth Information

As discussed in Section C7.0, the program data collected via the FNAQ will become the basis for additional research and analysis under a Phase II assessment project. It is envisioned that this data will be instrumental in the development of program advocacy and

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION

facilities and services / programs. The Steering Committee agreed that a review of program needs must be a part of any facility condition and/or additional space needs evaluation. A summary of the Sections and Subsections in the main questionnaire appears below. A full copy of the questionnaire appears in Appendix III.

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- Telehealth Information

As discussed in Section C7.0, the program data collected via the FNAQ will become the basis for additional research and analysis under a Phase II assessment project. It is envisioned that this data will be instrumental in the development of program advocacy and

support strategies for numerous organizations and entities around the state involved with primary care issues.

D.2.0 Response Rate

The following is a summary of the responses received and entered into the database as of September 1, 2000.

Table 4: FNAQ Response Summary as of September 1, 2000[1]

Communities Responding To General Section	218
Total Program Section Responses	194
Total Facilities Section Responses	183

This represents a total response rate on the order of 76 percent. Numerous efforts were made (via phone, fax, and mail) to contact all locations that did not initially respond to the questionnaire. Documentation on the results of these efforts is on file at ANTHC. It should also be noted that some communities had multiple organizations, programs, and/or facilities.

E. ALASKA PRIMARY CARE DATA SYSTEM

The database and applications developed as part of the project are collectively referred to as the *Alaska Primary Care Data System* (APCDS). This is a web-enabled system comprised of the following core components.

- The Alaska Primary Care Database (APCD), containing all questionnaire responses and other relevant data from multiple external resources.
- An ad hoc query tool that facilitates data analysis and allows Primary End Users to create a variety of reports.
- A Geographic Information System (GIS) that provides for the graphical presentation of data.
- Applications for calculating unmet need and prioritizing communities.

The primary software used to develop the APCDS tools and applications are summarized in Table 5.

[1] As of October 20, the number of responses were 220, 196, and 185, respectively.

Table 5: APCDS Software

Name of Software	Purpose
SQL Server	Database platform
Cold Fusion	Web development language
QueryMill™	Ad hoc query tool
MapObjects Internet Mapping Server	Enables development of custom GIS applications
MapOptix™	Web-enables graphical and tabular information

E.1.0 Alaska Primary Care Database

Obtaining data from existing database resources was a key requirement for the development of the APCD. Various state and federal sources were reviewed and selected to provide additional data content for a variety of research and reporting needs. The following table summarizes the major data resources utilized for the APCD.

Table 6: APCD Data Resources

DATA CATEGORY	PRIMARY SOURCE	SECONDARY SOURCES	% of APCD
General Community Information	State DCED		85
Access	State EMS System	State DCED	
Existing Clinic Facility Information	FNAQ	IHS and 1994 State Survey	
Existing Health Program Information	FNAQ	State Public Health Nursing Survey	
Demographics	State DCED		15
Health Status Indicators	State DHSS		

The data content extracted from all external data resources is static, i.e. a one-time data download from each resource. The technology to create dynamic links to a variety of resources is available; however, this capability was not necessary since APCD updates will only be accomplished on an annual or semiannual basis.

A web-enabled application was developed for the APCD since the end users are geographically dispersed throughout the state. SQL Server was the underlying technology used to build the APCD. SQL Server is highly compatible with Access, Excel, GIS software and web applications, as well as many SQL compliant query tools. SQL Server was selected because it is a robust system and many of the external data resources and systems currently in place are already in SQL Server or Access. Also, the APCD had to be built in a manner that would support easy to learn solutions and require minimal help from support personnel at project turnover. Currently the APCD has 106 data tables and contains 1,447 data columns. In addition, it contains 32 views for querying with 747 data columns, and 12 QueryMill-specific tables with 88 data columns. The current size of the database is approximately 21.5 MB.

E.2.0 Queries and Reports

The APCDS provides both standard and ad hoc query and reporting capabilities. The various standard reports, such as the Unmet Need Report, are static reports in read-only format with limited access depending on the user's security level. Raw Data Reports are another example of standard reports. They contain all of the supporting data used to generate one of the summary reports, such as the Unmet Need or Part I Community Prioritization.

Ad hoc queries enable the Primary End Users to create a wide variety of unique reports depending on their specific area of interest. The query tool allows individual analyses to be saved and recalled at a later date. It also allows Primary End Users to share query results electronically. The primary categories for initiating queries are listed below.

- Census Area
- Borough
- Regional Health Organization
- Community
- State Election Districts, both House and Senate
- Data Dictionary

Each major category is further subdivided to refine the query. Ultimately, any query report can be produced in either MS Word, MS Excel or Hyper Text Markup Language (HTML)

format as specified by the Primary End User. Since this was a statewide project, Census Areas (see Appendix IV) have been designated as the primary method for organizing and summarizing data.

While analysis of the information collected during this Needs Assessment was beyond the scope of the project (except for unmet need estimates and an initial community prioritization). Appendix V contains a sample ad hoc query report. It is a summary by House Election District of all Emergency Medical Service (EMS) Level I and II communities with clinics that are not equipped to accommodate over night patients or have no existing clinic facility at all.

E.3.0 Geographic Information System

The APCDS includes a GIS component that provides for the graphical presentation of data using the following geographic boundaries:

- Census Areas
- State Election Districts, both House and Senate
- Boroughs

It can also display the following information for individual locations:

- Regional Health Organization Affiliation
- Unmet Need
- Communities With Hospitals
- Communities Without Any Primary Care Facilities

These layers are in addition to routine map elements such as major rivers and highways. The GIS application can be easily enhanced to meet future, additional requirements.

E.4.0 Access to Data

In September 2000, the Denali Commission selected ANTHC as the Program Manager for the APCDS and most of the rural primary care facilities related projects funded through the Commission. Accordingly, the APCDS was recently installed on a server at ANTHC. ANTHC is providing a database administrator who will maintain the system. The four

primary partners in the project will have full access to all data in the APCDS. For data confidentiality reasons, other organizations and/or the general public will only have access to aggregate data summarized on a regional or service area basis.

F. PUBLISHED PROGRAM GUIDELINES AND REGULATIONS

As with many issues related to the delivery of health care services, Alaska is unique. National recommendations, where they exist, do not adequately provide for the variables encountered in Alaska with respect to remoteness, weather, and lifestyle. Therefore, most national standards and guidelines that do exist must be adapted for use in Alaska or not used at all. The recommended program goals in this report were developed after a review of the following.

(1) Federal Section 330 Community Health Center Program

(2) DHSS "Community Levels-of-Care" system

(3) IHS Community Health Aide Program

(4) Alaska Assistance for Community Health Facilities Program

(5) Federal Rural Health Clinic Program

F.1.0 Federal Community Health Center Program

Community health centers (CHCs) are publicly funded organizations that provide primary health and related services to residents of a defined geographic area that is medically under served. Community health centers are authorized under Section 330 of the Public Health Service Act (42 USC, 254b.). Section 330 was revised in 1996 by the Consolidated Health Centers Act, which combined community health centers with migrant health centers, health care for the homeless, and public housing health care programs. The CHC program is administered by the U.S. DHHS, Health Resources and Services Administration (HRSA), Bureau of Primary Health Care.

Community health centers are required by law to provide primary health services and additional health services as necessary to the residents of the area served by the center. Primary health services are defined as 1) health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology, 2) diagnostic laboratory and radiology services, 3) preventive health services, 4) EMS, and 5) pharmaceutical services. Additionally, primary health services include patient case management services, enabling services such as transportation and language translation, patient education, and referrals to providers of substance abuse and mental health services

The guidelines for health center structure, population served, service area, services provided, personnel, financial characteristics, organizational arrangements, governance, community participation, and referral systems are specified by the Bureau of Primary Health Care.

CHCs are recognized as federally qualified health centers (FQHCs). FQHCs meet statutory requirements for receiving federal community or migrant health center grant or health care for the homeless program funds. Certification as a FQHC reserves a health center's right to cost-based reimbursement for Medicaid services in states which have not received special waiver provisions. Health centers receiving federal Community/Migrant Health Center (C/MHC) funding are automatically eligible for certification as Medicaid and Medicare FQHCs.

The information included in the Consolidated Health Center Act of 1996 and the guidelines issued by HRSA, Bureau of Primary Health Care, were instrumental in defining the program related questions and establishing the program goals for this Rural Primary Care Needs Assessment Project.

F.2.0 State Emergency Medical Service Program

Alaska EMS Goals (February 1996) describes Community Levels-of-Care and makes recommendations for EMS services. It is based on a regional approach / organization as described in the 1984 *Alaska State Health Plan*. This approach identifies appropriate health resources and services for five community levels. These are:

Table 7: Community Levels

LEVEL	DESCRIPTION	POPULATION IN IMMEDIATE COMMUNITY
I	Village	50 – 1,000
II	Sub-Regional Center	500 – 3,000 +
III	Regional Center	2,000 – 10,000 +
IV	Urban Center	10,000 – 100,000
V	Metropolis	100,000 +

There is no counterpart to the EMS goals document, which makes a recommendation on the level of primary care services that should be provided in Alaska communities. A key discriminator in establishing EMS levels of service is how people get to and from a community, i.e. access. The *EMS Goals* document identifies communities as either "Isolated" or "Highway". Highway refers to those major roadways in the state, including:

- Alaska
- Copper River
- Dalton
- Denali
- Edgerton/McCarthy Road
- Elliott
- George Parks
- Glenn
- Haines
- Klondike
- Richardson
- Seward
- Steese
- Sterling
- Taylor/Klondike Loop
- Marine

The Marine Highway is Alaska's marine transportation system, which provides year-round ferry service to Alaska's coastal communities and to Washington and British Columbia. A map showing the major roadways in relation to organized boroughs within the State appears in Appendix VII.

F.3.0 IHS Community Health Aide Program

The IHS has the responsibility for providing health care services to Alaska Native and American Indian beneficiaries in Alaska. The total beneficiary population is 17 percent of

the state's population. Historically, the Alaska Native population lived mainly in the more isolated village communities.

The Community Health Aide Program (CHAP) was developed in the 1950s in response to a number of health concerns including the tuberculosis epidemic, high infant mortality, and the high rate of injuries in rural Alaska. In 1968, the CHAP received formal recognition and congressional funding. The program was established under the authority of 25 U.S.C. §16161. The long history of cooperation and coordination between federal and state governments and the Native regional health corporations has facilitated improved health status in rural Alaska. The CHAP is considered a model for delivering primary health care services in a remote area. In addition to strong training and supervision components, there is an established referral relationship that includes mid-level providers, physicians, regional hospitals, and the Alaska Native Medical Center (ANMC). One hundred forty (140) villages with less than 500 population have a clinic facility staffed by Community Health Aides / Practitioners (CHA/P) providing primary care and emergency medical services. Another 38 communities with a population greater than 500 have a Community Health Aide (CHA) clinic. In the non-Native health care delivery system, there is no model. Communities vary in their level of organization, resource base, and ability to partner with other agencies to provide primary care and emergency services at the local level.

F.4.0 Alaska Assistance for Community Health Facilities Program

The Assistance for Community Health Facilities Program is outlined in Alaska Statute (AS 18.23.100 and 18.25.010 – 18.25.120) and Alaska Administrative Code (7 AAC 13.010 – 13.140 and 13.845 – 13.900).

The scope of authority is subject to legislative appropriation and the provisions of AS 18.25.070-18.25.110. The Alaska DHSS awards grants to assist in the operation of community health facilities when there are operational deficits. Statutes outline the requirements of facilities that are receiving monies such as the application procedure, an overview of service areas to be considered, government and advisory boards, collection of fees for services, self-sufficiency issues, coordination and non-duplication issues, capital expenditures, other monetary issues, and personnel.

The Assistance for Community Health Facilities Program through the Alaska DHSS currently supports grants to 12-15 communities to partially support primary clinics. Most of the funds are used to help cover salaries of mid-level practitioners. Primary care clinics follow state statutes, regulations, and program guidelines in the areas of administration and program reporting.

F.5.0 Federal Rural Health Clinic Program

In 1977, Public Law 95-210 was enacted by Congress and authorized Medicare and Medicaid reimbursement to non-physician primary care practitioners in rural health clinics. This program was created because many isolated rural communities are not able to attract or retain physicians. Congress recognized that many clinics were staffed by non-physician providers who were not covered by Medicare unless they were under the immediate supervision of a physician. There was concern was that these clinics would never become self-sufficient; they would continue to have financial difficulties and may be forced to close.

The Rural Health Clinic (RHC) Program is one of the few federal programs that is able to address under-service in small communities that do not have a traditional health care system in place. The RHC program is administered nationally by the Health Care Financing Administration.

In Alaska, the RHC certification process is administered by the DHSS, Division of Medical Assistance, Health Facilities Licensing and Certification.

Guidelines for the RHC Program and the Rural Health Clinic Survey Reports were considered in the development of the ARPCFNA program goals described in this needs assessment final report.

G. PUBLISHED SPACE STANDARDS AND GUIDELINES

Specific space planning information was collected from recent projects and existing institutional / organizational standards (e.g. prototype designs produced by the Yukon-Kuskokwim Health Corporation (YKHC), Maniilaq Association, North Slope Borough, DHSS Public Health Nursing Center Design Standards, etc.). That data is summarized in

Appendix VIII. It includes summary information for a full range of clinic sizes, from small up to and including multi-community (sub-regional) facilities.

H. ALASKA RURAL PRIMARY CARE GOALS

Based on a review of the existing program and space guidelines, standards, and regulations summarized above, the Steering Committee developed the general Rural Primary Care Program Goals and Space Guidelines outlined in Tables 8 and 9. These criteria are presented as a minimum benchmark. The detail provided should not be interpreted as a prescriptive design standard. These are general guidelines only. They were used for estimating unmet needs and establishing criteria for the funding of projects through the Denali Commission.

It should be noted that permanent staff quarters are not included in the recommendations based on the assumption that these facilities are more appropriately provided by private individuals and/or businesses in the community.

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Table 8: Minimum Program Goals

EMS CATEGORY			POPULATION		
			20 - 100	101 - 500	> 500[1]
Access		Community Level	Space Guideline Small = 1,535 GSF Medium = 1,990 GSF Large = 2,460 GSF		
Designation	Description				
Isolated	Limited air / water access and / or Road access > 60 miles; Daily air/water access	I & II	Small	Medium	Large
Highway	Considered a subregional center and < 60 minutes travel time to next care level	II		Medium	Large
Highway	< 60 minutes travel time to next care level	I	*EMS Only*	Designated Itinerant Space[2]	Medium

1. Some communities in this population range may be candidates for multi-community or sub-regional centers. While services, staffing & square footage will be unique for each individual subregional center, a general guideline of 10,000 GSF is recommended.
2. 500 GSF of designated space in community building, school, etc.

STAFFING	Dedicated Itinerant Space	Small Clinic	Medium Clinic	Large Clinic
Resident Providers	EMT	EMT CHA/P	EMT CHA/P	EMT CHA/P MLP
PHN	Itinerant	Itinerant	Itinerant	Itinerant
Dental	Itinerant	Itinerant	Itinerant	Itinerant

PROGRAMS AND SERVICES[3]	Dedicated Itinerant Space	Small Clinic	Medium Clinic	Large Clinic
Basic EMS	X	X	X	X
Preventive Health Screenings	X	X	X	X
Other Preventive Health Services		X	X	X
Basic Primary Care		X	X	X
Limited Laboratory & Pharmacy		X	X	X
Patient Case Management			X	X
Outreach, Transportation & Interpreter			X	X
Community Health			X	X
Advanced EMS			X	X
Limited Radiological				X
On-site Administration & Support				X

[3] *See Pages 14-17 and 20 of FNAQ (Appendix III) for more detail*

Table 9: Space Guidelines

	Designated Itinerant Space			Small Clinic			Medium Clinic			Large Clinic		
Purpose / Activity	Size	#	Net Area (SF)	Size	#	Net Area (SF)	Size	#	Net Area (SF)	Size	#	Net Area (SF)
Arctic Entries			0	50	1	50	50	2	100	50	2	100
Waiting / Reception / Closet	150	1	150	100	1	100	150	1	150	170	1	170
Trauma / Telemedicine / Exam	200	1	200	200	1	200	200	1	200	200	1	200
Office / Exam			0	150	1	150	150	1	150	150	2	300
Admin./Records			0			0	110	1	110	110	1	110
Pharmacy / Lab			0	80	1	80	80	1	80	80	1	80
Portable X-ray			0			0			0	40	1	40
Specialty Clinic / Health Education / Conference			0	150	1	150	150	1	150	150	1	150
Patient Holding / Itinerant Sleeping Room			0	80	1	80	80	1	80	150	1	150
Storage	150	1	150	80	1	80	100	1	100	120	1	120
HC Toilet	Access To			60	1	60	60	2	120	60	2	120
Janitor's Closet	Access To			30	1	30	30	1	30	30	1	30
Subtotal			500			980			1,270			1,570
Circulation & Net to Gross Conv. Factor @ 45%			n/a			441			572			707
Subtotal (GSF)						1,421			1,842			2,277
Mechanical Space @ 8%						114			147			182
Total Heated Space			500			1,535			1,989			2,459
Morgue (unheated enclosed space)			0	30	1	30	30	1	30	30	1	30
Exterior Ramps, Stairs, Loading Area	HC Accessible			As Required			As Required			As Required		

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I. UNMET NEED

I.1.0 Additional Space for Individual Locations

The unmet space need for individual locations was derived by subtracting the existing square footage at that location from the appropriate space standard in Table 9. The cost of this new space was calculated using the following algorithm.

$$C = S \times B \times Z \times LI$$

Where:

C = **Cost of Additional Space**

S = **Additional Space Need = Space Standard - E**

E = **Existing Square Footage**

B = **Unit Construction Cost** of new clinic space in Anchorage (construction only)
= $183.20 per gross square foot (May 2000 dollars)

Z = **Other Project Cost Factor** (accounts for design, movable equipment and furniture, construction inspection and contingencies), expressed as a decimal percentage of B
= 1.45

LI = **Location Index** (adjusts Anchorage base costs to specific locations)

The unit construction cost and location factors were developed by Estimations, Inc., a professional cost estimating firm with extensive rural Alaska experience. As a check on the base unit cost and the location indices, an algorithm estimate was compared to the actual bid costs for the new 2,430 gross square feet (GSF) clinic in Noorvik. This project is now complete and occupied. The May 1999 bid price reduces to $320.93 per GSF when adjusted to the spring of 2000 at an annual inflation rate of 2.5 percent. This compares very well with the algorithm estimate of $320.60 per GSF (construction only).

The total, statewide unmet need based on the algorithm is 305,000 GSF, which extends to $99M. These costs include and/or assume the following:

- Site Work
- Design Fees
- Permits
- Construction Inspection

- Construction Contingency
- Communications System
- Movable Medical Equipment and Furnishings
- Competitive Pricing on Construction
- Prevailing State Construction Wage Rates

They do not account for:

- Land Acquisition
- Off site Utility or Road Extensions
- Special Purpose Equipment (e.g. radiography, dental)
- Special Local Taxes

I.2.0 Multi - Community and/or Larger Facilities

A preliminary analysis indicates that there are probably 12 – 14 locations around the state where it may be more appropriate to construct a single but somewhat larger clinic, which in most cases would serve several small communities within the same service area (above and beyond these types of facilities that are already in place or currently under construction). This multi-community or "sub-regional" concept is a proven model and is being successfully implemented by entities such as the YKHC. Assuming a 10,000 GSF new facility and applying an average location factor of 1.5 yields a total multi-community facility unmet need of $52M.

I.3.0 Backlog of Repairs

The total cost to correct deficiencies (other than new space) at existing facilities was estimated based on the deficiency data for each facility in the APCD. The FNAQ had requested data on each of the following eight categories and an overall condition rating.

- Structural
- Mechanical
- Electrical
- Energy Management
- Handicap Access
- Site / Environmental
- Fire / Life Safety
- Floor Plan

The *1994 State Clinic Survey* also contained an overall "status" rating for most rural clinics in the state. Each facility was evaluated against the following three algorithms in the process of assigning an estimated backlog repair cost to it. If a facility did not fall into one of these categories or if insufficient data was available to run the algorithm, then it was assigned a backlog cost of zero.

1. If data in the APCD indicated that a facility needed "replacement" or was in "poor" condition, then the new space algorithm was applied to the existing space, i.e.

$$BRC = E \times B \times Z \times LI$$

2. If data in the APCD indicated that a facility had "deficiencies needing correction", needed "major renovation" or was in "fair condition", then the following algorithm was applied to the existing space.

$$BRC = E \times K \times Z \times LI$$

3. If actual cost estimate data was submitted in response to the FNAQ, and it exceeded either of the above, then BRC was set equal to that self reported value.

In these algorithms:

BRC = Backlog Repair Cost

K = Base Renovation Cost = $119.08 per gross square foot

The base renovation cost of $119.08 is 65 percent of the Anchorage based unit cost for new construction, i.e., 0.65 x (B). The IHS Health Facility Budget Estimating System uses this factor for renovations that involve the replacement of interior walls and finishes. This is the "middle" factor in the IHS system; they use 25 percent for projects that only involve the upgrade of finishes, but 85 percent where facilities are completely gutted on the interior and then rebuilt.

The total estimated cost to correct existing deficiencies based on this methodology is $102M for 330,000 square feet of evaluated space. This figure includes design, construction, equipment and contingencies.

As more accurate and site specific code and condition data is collected by ANTHC in support of the Denali Commission's primary care facilities program, it will be entered into the APCD. Through this process, the statewide unmet need estimate will be continuously refined and updated.

I.4.0 Routine Maintenance and Improvement

The IHS methodology for identifying the annual maintenance and improvement (M&I) funding requirement for health care facilities is based on the "Oklahoma Formula". This is a methodology developed at the University of Oklahoma specifically for health care facilities. It estimates the recurring annual cost for benchstock supplies and materials, service contracts, in-house repairs and minor renovations, routine replacement of fixed equipment, and maintenance training. It does not include wages for maintenance staff or the cost of utilities. The methodology is summarized below.

$$M\&I = S \times B_I \times CC \times UI \times LI$$

Where:

M&I = **Annual Maintenance & Improvement Funding**

S = **Additional Space Need = Space Standard - E**

E = **Square Footage of Facility**

B_I = **Unit Cost** of new clinic space in Anchorage (design and construction)
= $262.32 per gross square foot (March 2000 dollars)

CC = **Construction Classification**

UI = **Use Intensity**

LI = **Location Index** (adjusts Anchorage base costs to specific locations)

Applying this methodology to the total existing and total new space requirements using a construction classification factor of 0.0175 (wood frame), a use intensity of 1.00 (moderate), and an average location index of 1.5 results in a total annual M&I requirement of approximately $5M.

Apart from the work of the Denali Commission, there should be an evaluation of the IHS Village Built Clinic appropriation currently being used to lease clinics in support of the CHA

Program and its relationship to the M&I unmet needs reported here. There is some question about whether or not the lease funds being provided are sufficient to warrant these arrangements being classified as true full service leases. In communities without an IHS leased clinic, there is in all likelihood, even less chance that an adequate routine M&I funding stream is available. In the long term, this issue could represent a significant unmet need for all program providers and/or communities in rural Alaska.

I.5.0 Summary

Appendix IX contains an unmet need summary by census area. A statewide summary appears below.

Table 10: Unmet Need Data

Unmet Need Category	Basis (GSF)	Amount (millions)	Type
New Space at Individual Locations	305,000	S99	Capital
New Multi-Community Clinics	130,000	S52	Capital
Backlog of Repairs	330,000	S102	Capital
Subtotal		S253	Capital
Routine Maintenance and Improvement	765,000	S5	Recurring

J. RESOURCE DISTRIBUTION METHODOLOGY

The Steering Committee has developed a three part process for funding "small", individual community primary care facilities projects through the Denali Commission[1]. Figure 2 is a simplified flowchart of the process. A preliminary multiple year schedule appears in Appendix X. Facilities constructed using Denali Commission funds must be operated by not-for-profit entities, and everyone in the service area must have access to the primary care services provided in the facility. Projects funded through this methodology may include the following, but are limited to a total of one million dollars.

- Planning and Pre-Design
- Design
- Repair of Existing Structures
- Renovation and/or Expansion of Existing Structures
- Construction of New Facilities
- Non-expendable Medical Equipment

This methodology will be reviewed annually by the Steering Committee and amended as appropriate.

[1] The Steering Committee has recommended that an additional funding methodology be developed for communities with populations greater than 800 (needing larger facilities) and/or those locations that may be logical candidates for a subregional or multi-community type facility. The committee will continue to work on an RFP type process for such communities. It is anticipated that this second methodology will follow a format similar to the resource distribution methodology described in this report for small individual communities. In addition, it is noted here that on 14 September 2000, the Commission approved design funding for two replacement health centers in St. Paul and Metlakatla. Extensive project justification documents have already been prepared for both projects and they have been on the IHS National Priority List since 1995. These are the only two outpatient facilities in Alaska currently on the national IHS list. Denali Commission funding for St. Paul and Metlakatla is for design only; it is assumed that IHS will construct and staff the facilities once the designs are complete. Accordingly, these two locations were excluded from the final FY 2001 Part I Prioritization analysis described in this report.