

# **ALASKA RURAL HEALTH PLAN**

## **Alaska's Plan for Participating in the Medicare Rural Hospital Flexibility Program**

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# **Alaska's Plan for Participating in the Medicare Rural Hospital Flexibility Program**

## **INTRODUCTION**

### **Purpose of the Plan**

The Balanced Budget Act of 1997 (Public Law 105-33) established the Medicare Rural Hospital Flexibility Program, a national program designed to assist states and rural communities in improving access to essential health care services through the establishment of limited service hospitals and rural health networks. The program creates the Critical Access Hospital (CAH) as a limited service hospital eligible for Medicare certification and reimbursement and supports the development of rural health networks consisting of CAHs, acute care hospitals, and other health care providers.

In response to the requirements of the program statute and regulations, the State of Alaska has developed this Rural Health Plan to guide implementation of the Medicare Rural Hospital Flexibility Program. This Plan provides for the creation of rural health networks, promotes the regionalization of rural health services, improves access to hospital and other services for rural residents, and establishes the process for designating rural not-for-profit and public hospitals as CAHs. Submission of the Plan follows a comprehensive review of the health care system in Alaska, including analysis of existing State and Federal law, regulation, policy, and programs. The Plan was created with the input and participation of a large number of organizations and individuals, including the Alaska State Hospital and Nursing Home Association, rural hospitals located in the State, and the Alaska Center for Rural Health, the State's designated Office of Rural Health (a complete list of organizations that were consulted in development of the plan is provided in Appendix B).

### **State Profile**

#### **Geography**

Descriptions of Alaska's geography invariably begin by declaring that Alaska is the largest state in the nation. This simple declaration, however, is inadequate to effectively depict the vastness of the State's geography and the extremes of its terrain and climate. All states are unique to some extent, but Alaska is indeed distinct in many aspects, from its size to its climate to the differences in lifestyle and living conditions between its metropolitan areas and its smallest most remote villages. As a result, the citizens of Alaska face special and uncommon circumstances in building, maintaining, and accessing a health care system that must serve such an expansive and varying territory.

Alaska *is*, by far, the largest state in the nation, accounting for 20 percent of the land mass of the continental United States and encompassing an area larger than the states of Texas, Montana, and California combined. At its widest points, it stretches 2,400 miles from east to west and over

1,400 miles from north to south. As shown below, if a map of Alaska is overlaid on a map of the continental United States, Alaska would stretch across the country, extending from south of California to South Carolina and from North Dakota to Texas.



Alaska is home to some of the most varied and formidable terrain in the world, ranging from one of North America's only rainforests in the southeast to treeless tundra in the Arctic. The State has more miles of coastline than the lower 48 states combined and thousands of residents inhabit islands that can be reached only by water or air. Even Juneau, the State's capital and third largest city, is not connected to the mainland by roads and is reachable only by boat or aircraft.

Glaciers, icefields, and mountains (Alaska is home to six major mountain ranges) blanket much of the State, hindering road and infrastructure development and rendering even inland areas accessible only by aircraft or by snowmachine, if the distances to be traveled are not too vast. Despite its size, Alaska ranks 47th among the 50 states in road miles and approximately 75 percent of Alaska communities are not connected by road to a community with a hospital. In addition, extreme weather, including snow, ice, and temperatures that can reach 70 degrees below zero, makes travel very difficult in much of the State during parts of the year.

## **Demographics**

### Population

The U.S. Census Bureau reports that Alaska is home to about 610,000 people, ranking 48<sup>th</sup> out of

the 50 states in population. Coupled with its vast geography, Alaska's relatively small number of residents yields a population density of approximately one person per square mile, about 70 times smaller than the national average. Indeed, the many definitions of "rural" and even the federal definition of "frontier" -- an area of less than six people per square mile -- are inappropriately dense classifications to describe most of Alaska. Although close to half of Alaska's population is concentrated in the Anchorage region, the State's largest metropolitan area, 25 percent of all Alaskans, and 46 percent of Native Alaskans, live in communities of less than 1,000 people. Nearly one-quarter of the State's population lives in towns and villages that are reachable only by boat or aircraft.

Despite small population figures, the State has grown rapidly during the past fifteen years, experiencing a population growth rate of greater than 40 percent over this period, more than four times the national average. This growth is another factor that has distinguished Alaska from other, more "typical" rural states, which have grown at a much slower rate, or in some cases, have lost population. The population growth rate has slowed in recent years, however, as net migration has declined due to military base closings and realignments, low national unemployment rates, and declines in some of the State's key industries, such as oil and timber.

#### Age

Alaska's population is younger than the nation's as a whole, and far younger than the population of most rural areas of the country. The median age of the State's population is slightly less than 30 years of age, and close to 80 percent of the people living in Alaska are 44 years of age or younger. Only about five percent of Alaska's population is age 65 and over, compared to almost 13 percent nationwide. The State's relatively young population produces a different set of health system development issues and service requirements than those encountered in most rural regions of the country, creating greater needs for such services as maternal and child health and accentuating the relative dominance of Medicaid, as opposed to Medicare, as a major payer of health care services.

#### Ethnicity

Another of Alaska's unique demographic features is the high proportion of indigenous peoples in the population. Native Americans make up less than one percent of the population of the U.S., but comprise more than 16 percent of Alaska's population. The Alaskan Native population is dominant in the Northern region of the State, where more than three of every four residents are Alaskan Native, and in the Southwest region, where Alaskan Natives comprise over 60 percent of the population. This high proportion of Alaskan Natives, many of whom live in small remote villages, and the complexity of federal laws addressing this population, are fundamental considerations in developing sustainable health care delivery and financing systems in Alaska.

After Alaskan Natives, African American and Alaskan/Pacific Islanders are the most predominant ethnic minority groups, although they each make up less than five percent of the population. Whites comprise close to 75 percent of the population of the State.

#### Economy and Income

Alaska's economy is dominated by a few industries and is subject to periods of boom and bust. More than 90 percent of the State's revenue is generated by the oil and natural gas industry and the State is therefore exposed to ups and downs in the market for these products. Local economies also depend on fishing, timber, mining, and tourism, all industries that are highly dependent on world markets and environmental status. Fishing and tourism, in particular, tend to be seasonal and dependent on transient workers, creating heavy demands on local health systems during parts of the year. A delivery system which may be adequate for the year-round resident population can be heavily stressed by the influx of large numbers of workers and travelers during fishing or tourist season.

Due to the seasonal nature of much of Alaska's industry, the rate of unemployment fluctuates drastically during the year. In 1997, the unemployment rate varied from a high of 10.4 percent in February to a low of six percent in August. Similar fluctuations occur every year. The yearly average unemployment rate in Alaska has ranged between seven and eight percent over the last four years, compared to the national average of about five percent.

Despite high unemployment rates, Alaska appears relatively affluent when compared to the rest of the United States, with higher household median income and per capita income than the nation as a whole. Alaska ranks second in the nation, behind Connecticut, in these categories. These figures are driven by the predominance of the petroleum and fishing industries in parts of the State. Bristol Bay, the State's most productive fishing area, and the North Slope Borough, the home of North America's largest oil field at Prudhoe Bay, each have median household incomes of more than \$50,000 per year. Median income figures in some of the outlying rural and "bush" regions are less than half as much. In addition, the cost of living in Alaska is extremely high, diluting the buying power of these relatively high incomes.

Despite favorable overall income statistics, much of Alaska is relatively poor. Some small outlying villages lack sewage and water systems and housing is often barely adequate, particularly in Alaska's extreme climate. These factors have obvious and profound implications for public health. Coupled with the scarcity of health care providers and facilities in many of these regions, provision of even the most basic public health and primary care services is often difficult or impossible.

### Health Status

Alaska ranks fairly low in many health status measures, standing near the bottom of state rankings in rates of infectious disease, occupational fatalities, and prevalence of smoking. The rate of premature deaths is also very high, resulting in part from high death rates due to accidents, suicide, and chronic liver disease and cirrhosis, which rank respectively as the State's

third, fourth, and eighth leading causes of death. The State's suicide rate is more than twice the national average. All of these causes of death may be reflective of a young, predominately male population and culture, limited access to health care services in many parts of the State, and a lack of well financed and organized mental health and substance abuse services. Interestingly, Alaska's age-adjusted rate for heart disease is much lower than the U.S. rate, perhaps reflective of residents' active lifestyles.

A significant reason for the State's low ranking in health status measures is the relatively poor health status of the Alaskan Native population. The HIV infection rate for Alaska Natives is the highest in the State and death rates for suicide and homicide are three to four times the national average. Rates of substance abuse and resulting health problems (e.g., fetal alcohol syndrome, liver disease) are high and rising. Alaska Natives have one of the highest age-adjusted mortality rates for cancer in the U.S. and the prevalence of diabetes is also very high and continues to increase. In addition, as noted above, basic public health measures, such as adequate water and sanitation services, are not available in many small native and non-Native villages.

### **Profile of the Alaska Health Care System**

Like almost everything in Alaska, the health care system is shaped by the unique geography, climate, and demographics of the State. The remoteness of some villages and extreme weather conditions play important roles in determining access and availability of care. Alaskan Natives and a substantial military presence often result in two, or even three, "systems" of care in some communities, each providing similar services to different populations.

Services are financed by a variety of payers, including the U.S. Indian Health Service (IHS), the U.S. Departments of Defense (DoD) and Veterans' Affairs (VA), Medicare, Medicaid, and individuals, businesses, and private insurers (primarily Blue Cross of Washington and Alaska). The impact of the federal government is substantial, as over 70 percent of the population receives some federally funded health care. Through IHS, DoD, VA, Medicare, Medicaid, and other programs, the federal government is the largest single payer for services, accounting for over a third of all dollars spent on health care in Alaska. Public expenditures, from Federal, State, and local government sources, account for more than 60 percent of Alaska's health care spending. Over 70,000 people, more than 11 percent of the population, are uninsured.

### **Levels of Care**

The Alaska health care system uses a regional approach to service organization, with communities categorized based on the types of services and levels of care available. The community levels-of-care approach identifies appropriate health resources and services for five community levels, considering factors such as continuity, coordination, and continuum of services and referral patterns. Service linkage from lower to higher levels of care are a central element of the system. Descriptions of each level of care and the services available are discussed below.

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#### **Level I -- Village**

Level I communities offer basic primary care services that encompass many of the daily personal health care needs of residents. Services include health education, preventive care (e.g., surveillance, immunizations, health promotion), and evaluation and management of episodes of general discomfort and chronic conditions. Directing patients to more specialized services is also a major function of primary care providers in Level I communities. Level I communities meet at least one of the following criteria:

1. Continuing services can be conveniently provided in the area.
2. The system is designed primarily for ambulatory care.
3. Emergency measures can be provided in a timely manner.

Villages that support Level I services typically have populations between 25 and 750 residents. Non-dedicated clinic space (i.e., the space may not be used exclusively for health care services) is often utilized for the provision of care. Staffing of Level I services may be comprised of a Community Health Aide, a resident trained as a Level I Emergency Medical Technician (EMT-I), or an itinerant Public Health Nurse. Level I communities are isolated and may be accessible only by limited air or marine travel services.

#### Level II -- Sub-Regional Centers

Level II communities also focus on the delivery of primary care and preventive services, but offer a broader range of these services than are provided in Level I communities. They typically contain a Health Center that may be staffed by a Physician Assistant or Nurse Practitioner, a Public Health Nurse, and EMT-II's or EMT-III's. Level II communities typically have service area populations of at least 1,000 residents and have access to higher level centers by sea or daily air service.

#### Level III -- Regional Centers

Level III communities provide an expanded set of services that encompass secondary levels of care. Services may include basic hospital services in a facility that is capable of providing diagnostic and routine laboratory services, uncomplicated obstetrical services, and hospital inpatient care. Level III communities usually have more than 3,000 people in the primary service area and up to 60,000 in the surrounding community within 60 minutes travel time. Staff available include primary care physicians, itinerant specialist physicians, hospital support staff, EMT-III's or paramedics, and other health care professionals (e.g., dentists, pharmacists, and optometrists).

#### Level IV -- Urban Centers

Services in Level IV communities are typically institutional and specialized. Secondary and tertiary care services, such as high risk neonatal care, open heart surgery, and head and spinal cord injury services are examples of Level IV services. Provision of these services requires a significant population base (typically at least 40,000 residents) to support the necessary staffing

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and equipment. As a result, Level IV communities are regional centers for the provision of specialty care.

#### Level V -- Metropolis

Level V communities contain highly specialized and technologically intensive services that are economically out of reach of all but the largest communities. They contain medical and dental teaching facilities and may provide services such as organ transplants and burn care. A population of at least 450,000 is required to support Level V services; as a result, they are not

currently available in Alaska. Seattle is the closest and most frequently utilized Level V community for Alaska residents.

## **Federal Government-Owned or Funded Services**

### Services for Alaskan Natives/ Native Americans

As part of its trust responsibility, the federal government is required to provide health care services to the Native Alaskan population, which numbers about 90,000. Services are delivered through the Alaska Area Native Health Service (AANHS), an administrative unit of IHS, and a combination of other organizations, including Regional Health Corporations, Village Corporations, State and local government. Most of the facilities and services provided through AANHS are managed directly by Regional and Village Corporations through compacts and contracts negotiated under Public Law 93-638, the Indian Self-Determination and Education Assistance Act of 1975. This law authorized tribes (or, in Alaska's case, Native Corporations) to assume the operation and administration of certain programs previously administered by the federal government (i.e., rather than providing services directly, the federal government provides funding to Tribes/Native Corporations and these entities provide services to the Alaskan Native population).

Services available in the Alaska Native Health System range from sophisticated high-tech inpatient and trauma care at the Alaska Native Medical Center in Anchorage to basic personal care services provided by Community Health Aides (CHAs) in remote villages. CHAs work under remote physician supervision in small villages throughout the State to provide primary care, prevention, and health promotion services. These providers are unique to the Native Health System and have no direct counterparts in the non-Native system. A full range of other services, including Community Health Clinics (CHCs), community mental health services, and hospitals are available under the Alaska Native Health System (some of these services are supported by State and private funding in addition to federal funding). Despite this breadth of services, it is widely accepted that funding for the Native system is inadequate and, as discussed above, the health status of the Native population lags behind that of the rest of the State.

### Services for Military Personnel and Veterans

Almost a quarter of the Alaska population is eligible for health care services through the Department of Defense and the Department of Veterans' Affairs. Through these two agencies, military personnel, dependents, and retirees are provided a range of services through ten federal health facilities, including two hospitals. The military also contracts with a network of private and other providers to deliver services to eligible beneficiaries.

### **Primary Care and Physician Services**

Primary care services in Alaska are provided by a spectrum of providers, ranging from Community Health Aides in remote Native villages, to mid-level practitioners in CHCs and Rural Health Clinics (RHCs), to physicians in urban multi-specialty group practices. A variety of government agencies and organizations supports the development of primary care services, including the Department of Health and Social Services, the Alaska Primary Care Office, the Alaska Primary Care Association, the Alaska Center for Rural Health, and the Alaska Family Practice Residency Program.

As in many rural areas of the country, Alaska has an inadequate supply of primary care practitioners and those that are available are disproportionately located in urban communities, especially Anchorage. The State has 20 federally designated Health Professional Shortage Areas (HPSAs) and 10 Medically Underserved Areas (MUAs), covering nearly a third of the population and two-thirds of the land area. Recruitment and retention is especially difficult, primarily in remote areas, and there is extensive turnover of health personnel. Many communities rely on the National Health Service Corps for placement of physicians and other primary care providers and itinerant Public Health Nurses play an important primary and preventive care role, particularly in the most isolated villages.

In some cases, RHCs and other primary care clinics must retain patients overnight due to severe weather or other conditions that prevent travel and transfer. These facilities and attending practitioners cannot be reimbursed for providing this care, as third party payers have no mechanism for paying for "inpatient" services in these outpatient facilities (e.g., federal law precludes Medicare and Medicaid payment for overnight stays in RHCs and clinics). For this reason, there is some interest in expanding eligibility for CAH conversion to isolated clinics where adequate personnel and other resources are available. Senator Murkowski of Alaska has proposed legislation to authorize such conversions and the State believes that it may be appropriate in some cases. The State is also examining other alternatives and will stay in contact with HCFA to discuss these plans.

Physician specialty services tend to be concentrated in larger communities with hospitals. The majority of physician specialists and services are located in Anchorage.

## Hospitals

There are 24 acute care hospitals in Alaska, including two military hospitals and six hospitals operated by Native Corporations.<sup>1</sup> A full inventory of Alaska hospitals, by census region, is provided below. A map showing the location of Alaska's hospitals is located in Appendix A.

The relatively large hospitals in Anchorage, Fairbanks, and Juneau serve as regional referral facilities for providers from rural areas of the State. As described in the description of levels-of-care, above, hospitals in Seattle also serve as key referral destinations for residents of Alaska in need of high tech and specialty services.

Like hospitals in the rest of the country, Alaska's hospitals face continuing trends of declining inpatient utilization and tight finances. Occupancy is generally low, with several hospitals experiencing occupancy rates below 10 percent. Population growth in some areas of the State may help to alleviate these declines, but growth is typically in young age groups that are not heavy users of health care services, particularly inpatient services. Overall trends are likely to continue, therefore, and may accelerate as managed care makes inroads in the State, particularly in urban areas.

### ALASKA HOSPITALS

Regional and Hospital	Locations	Total Beds	Governance
<i>Anchorage Matanuska Region</i>			
Providence Hospital	Anchorage	303	Private Non-Profit
Alaska Regional Hospital	Anchorage	238	Private For-Profit
Alaska Native Medical Center	Anchorage	143	Federal - AANHS
Air Force Medical Center--Elmendorf AFB	Anchorage	105	Federal - Military
Valley Hospital	Palmer	36	Private Non-Profit

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<sup>1</sup>It is not clear that military hospitals or hospitals operated by Native Corporations are eligible to participate in the Medicare Rural Hospital Flexibility Program. As a result, in the sections of the Plan describing development and implementation of the program, only non-Native and non-federal hospitals are addressed. State authority over Native and Federal facilities is limited, and it is not clear that the State would be able to survey and license such facilities. If these issues are adequately addressed and Native and/or federal facilities express interest in the program, the State will work with HCFA and other appropriate organizations to develop and file an amendment to the Plan incorporating these providers.

<i>Interior Region</i>			
Fairbanks Memorial Hospital	Fairbanks	166	Private Non-Profit
<i>Southeast Region</i>			
Bartlett Memorial Hospital	Juneau	51	Public/Municipal
Ketchikan General Hospital	Ketchikan	92	Public/Municipal
Peterburg General Hospital	Petersburg	25	Public/Municipal
Mt. Edgecumbe Hospital	Sitka	78	Federal - AANHS
Sitka Community Hospital	Sitka	22	Public/Municipal
Wrangell General Hospital	Wrangell	22	Public/Municipal
<i>Gulf Coast Region</i>			
South Peninsula Hospital	Homer	40	Public/Municipal
Kodiak Island Hospital	Kodiak	44	Public/Municipal
Seward General Hospital	Seward	20	Public/Municipal
Central Peninsula General Hospital	Soldotna	46	Public/Municipal
Valdez Community Hospital	Valdez	15	Public/Municipal
<i>Southwest Region</i>			
Cordova Community Hospital	Cordova	23	Public/Municipal
Yukon-Kuskowim Delta Regional Hosp	Bethel	50	Federal - AANHS
Kanakanak Hospital	Dillingham	15	Federal - AANHS
<i>Northern Region</i>			
Norton Sound Regional Hospital	Nome	34	Private Non-Profit
Basset Army Hospital	Ft. Wainwright		Federal - Military
Alaska Native - Barrow General Hosp	Barrow	12	Federal - AANHS
Manilaq Medical Center	Kotzebue	22	Federal - AANHS

\*Total number of beds includes acute care, long term care, and other inpatient beds operated by the hospital.

## **Emergency Medical Services (EMS) System**

As noted above, injuries are the third leading cause of death in Alaska. Coupled with the State's geography and climate and the vast distances between communities, a coordinated EMS system that links emergency personnel and other providers at all levels of the health care system is essential. Alaska's EMS system has been built over the last 30 years and has evolved from a few communities with poorly equipped and inadequately trained personnel to a system that includes both volunteer and paid first responders, trained and certified EMTs and paramedics, ground and air ambulance services, and 24-hour hospital emergency departments staffed by physicians, nurses, and other personnel trained in emergency and trauma care.

Over 4,000 EMTs, EMS Instructors, and Defibrillator Technicians are certified by the Department of Health and Social Services and another 150 Mobile Intensive Care Paramedics are licensed through the Department of Commerce and Economic Development, Alaska State Medical Board. Many of these personnel are members of the approximately 100 EMS agencies and 18 air medical services. Ground and air medical services providing advanced life support must be certified by the Department of Health and Social Services. Services range in size from small rural agencies providing basic life support to state of the art, paramedic-based agencies in the more populous areas of the State.

The State is divided into seven EMS regions, which encompass the community levels-of-care approach to service organization. System goals for State, regional, and community EMS programs are set around 15 core components, including training, communications, patient transport/transfer, equipment and supplies, accessibility to care, prevention, education, and safety, and disaster response.

The lead agency in the State for the development of EMS and trauma care services is the Community Health and Emergency Medical Services (CHEMS) Section of the Department of Health and Social Services, Division of Public Health. Responsibilities of this agency include overall system coordination, injury prevention education, training and certification, and Medevac and trauma system planning. CHEMS is advised by the Alaska Council on Emergency Medical Services and has facilitated the development of the *Alaska EMS Goals*, which is used by State, regional, and local agencies for EMS planning and evaluation. The State also maintains a Trauma Registry to track the causes and severity of injuries and the quality of the trauma care provided.

### **Public Health Services**

As in other states, the mission of the Public Health system in Alaska focuses on health protection and promotion, disease prevention, and assuring access to quality services. To achieve this mission, Public Health services are population-based and address clinical prevention, health education, chronic and communicable diseases, maternal and child health, food and drug safety,

developmentally disabled, and other key health issues.

The Public Health system in Alaska is unique in several respects. First, Public Health in Alaska is almost entirely a State responsibility. Except for the city of Anchorage and the North Slope Borough, there are no local or Borough Public Health Departments. As a result, the Division of Public Health in the Alaska Department of Health and Social Services is responsible for both the financing and the provision of Public Health services throughout much of the State (in addition, Native Regional Health Corporations serve as de facto local/regional health departments for Native communities).

Second, due to the isolation of many villages and the lack of health care providers and infrastructure, the Public Health system represents the only point of access to health care or social services for much of the population. As a result, Public Health Nurses (PHNs), including itinerant PHNs that travel to remote villages, are often the only providers available to many residents of these villages. The multiple needs of the population require each PHN to carry out a variety of roles that are usually carried out by multiple people representing multiple professions in urban-based systems. It is not unusual, for example, for a PHN in a small village to provide well child care, EPSDT screening, immunizations, infectious disease prevention, education, and treatment, family planning services, coordination of care for children with special needs, home visits for at-risk families, community advocacy and organization, and other services related to health care, social, and community needs.

With the assistance of a Turning Point grant from the Robert Wood Johnson and W.K. Kellogg Foundations, the Division of Public Health is currently engaged in a process to assess and redesign the State's Public Health system to better meet future needs. This effort is expected to be completed in 2000.

### **Other Services and Programs**

A variety of other health care services and programs are available to residents of Alaska, including mental health, substance abuse, and long-term care services. In addition, services for special populations, such as the developmentally disabled and victims of domestic violence and sexual assault, are important components of the health care and social services system. More information on these services is available from a number of sources and documents, including the *Overview of Alaska's Health Care Delivery Systems, February 20, 1996*.

### **Economic Impact of the Health System on Rural Communities in Alaska**

As in the rest of the United States, the health care system in Alaska is a key component of the State's economy, generating jobs and income, encouraging new business formation and expansion, and attracting new residents. Over 20,000 people work in the health care industry in Alaska, making it one of the State's largest employers, and accounting for more workers than the

oil, restaurant, or timber industries, or the finance sector. More than 40 percent of all private health sector workers are employed in hospitals, accounting for as many jobs as the next four

largest health care sectors combined. Because of Alaska's rural nature, the importance of the health care sector is heightened, as rural economies are rarely as diverse as urban economies and are thus very dependent on the fitness of existing industries.

In 1991, health care services in Alaska accounted for nearly \$1.6 billion in spending. This total was expected to double by 1998. The federal government accounts for more than one-third of this spending, through the Indian Health Service, Medicaid, Medicare, veterans' and military health services, and other programs. Through the Medicaid program, revenue sharing for small rural hospitals, grants, direct services funding, etc., the State is the second largest payer of health care services in Alaska.

## ALASKA RURAL HOSPITAL FLEXIBILITY PROGRAM

### Program Background and Description

The Balanced Budget Act of 1997 (Public Law 105-33) established the Medicare Rural Hospital Flexibility Program, a national program designed to assist states and rural communities in improving access to health care services in rural areas through the development of limited service hospitals and rural health networks. The program creates the Critical Access Hospital (CAH), a new type of provider eligible for Medicare reimbursement. A CAH is an acute care facility that provides emergency, outpatient, and limited inpatient services and may be linked to full service hospitals and other types of providers in a rural health network.

The Medicare Rural Hospital Flexibility Program combines features of the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) program and the Montana Medical Assistance Facility (MAF) Demonstration, two limited service rural hospital programs which have been operating in eight states over the past several years. The Medicare Rural Hospital Flexibility Program replaces these two programs and all states are eligible to participate. The program is administered at the federal level by the Health Care Financing Administration (HCFA), which published regulations implementing the program effective October 1, 1997.<sup>2</sup>

Rural not-for-profit or public hospitals are eligible to convert to CAHs, which may contain up to 15 acute care beds and provide inpatient care for up to 96 hours, unless discharge or transfer is precluded due to inclement weather or other emergency conditions or the Peer Review Organization, upon request, authorizes a longer stay.<sup>3</sup> CAHs are permitted to participate in the swing bed program and may maintain up to 25 beds to furnish both acute and skilled nursing-level care, provided that no more than 15 of these beds are used for acute care at any one time. A CAH may also operate distinct part units (e.g., distinct part Skilled Nursing Facility) and other provider-based services (e.g., home health agency) and be co-located with other providers (e.g., a co-located nursing home).

CAHs are subject to certain distance requirements (i.e., a CAH must be more than a 35-mile drive, or 15 miles in mountainous terrain or areas with only secondary roads, from a hospital) or must be designated by the State as “necessary providers” of health care services to residents of the area. A CAH must make available 24-hour emergency care but need not meet all the staffing and service requirements that apply to full service hospitals (e.g., some ancillary and support services may be provided on a part-time off-site basis). Inpatient care in a CAH may be provided

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<sup>2</sup> The regulations were published as “interim final.” Although they are effective as of October 1, 1997, a public comment period was held and HCFA may revise the regulations based on the comments received. As of April 1998, revised rules had not been published.

<sup>3</sup> Only existing, Medicare-certified hospitals are eligible to participate in the Medicare Rural Hospital Flexibility Program (i.e., hospitals that are closed or other types of providers are not eligible for conversion). Legislation that would allow Rural Health Clinics to “upgrade” to CAHs is currently being considered in the U.S. Congress.

by a mid-level practitioner (Physician Assistant or Nurse Practitioner) under the remote supervision of a physician. CAHs are reimbursed on a reasonable cost basis for services provided to Medicare beneficiaries.

CAHs, full service hospitals, and other health care providers may be organized into “rural health networks,” and maintain agreements for the referral and transfer of patients, the development and use of communications systems, and the provision of emergency and non-emergency transportation services. A CAH that is a member of a rural health network must also have an agreement for credentialing and quality assurance with a hospital that is a member of the network or a Peer Review Organization (PRO) or other appropriate entity.<sup>4</sup>

### **Process of Developing the Alaska Rural Health Plan and the Alaska Rural Hospital Flexibility Program**

The process of developing the Medicare Rural Hospital Flexibility Program in Alaska and creating the Rural Health Plan was spearheaded by two agencies within the Alaska Department of Health and Social Services -- the Division of Medical Assistance, Health Facilities Licensing and Certification Section, the state agency responsible for administering the program, and the Division of Public Health, Section of Community Health and Emergency Medical Services. A number of other agencies, organizations, and individuals were consulted during development of the Plan. A complete list of participants is provided in Appendix B of the Plan.

With the assistance of a consultant, officials from Health Facilities Licensing and Certification and Community Health and Emergency Medical Services held frequent meetings with representatives of various groups, either in person or by telephone, to discuss issues such as plan and program requirements, regulatory concerns, the process of CAH designation and licensure, reimbursement, and other program and policy matters. These meetings were instrumental in keeping interested parties involved in the process, identifying questions and concerns, and crafting solutions to problems. In addition to these formal communications, participants and interested parties were frequently in contact informally, as well. Several of these groups also reviewed drafts of the Rural Health Plan and program policies and procedures and provided comments and feedback on these documents. Letters indicating participation in the Plan development process and support of the program from many of these organizations are included in Appendix C.

To ensure ongoing program monitoring and evaluation, a Program Advisory Committee will be formed to provide program guidance and advice to Health Facilities Licensing and Certification

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<sup>4</sup> The program statute defines a “rural health network” as an organization consisting of at least one facility that the State has designated or plans to designate as a CAH and at least one hospital that furnishes acute care services. While required to maintain certain agreements, therefore, these networks do not necessarily operate under common governance, provide integrated services, or meet other criteria that are often associated with “health networks.”

as the program is implemented. This Advisory Committee will consist of representatives of the Alaska Department of Health and Social Services, the Alaska State Hospital and Nursing Home Association, the Alaska Center for Rural Health, individual hospitals, and others. The group will meet quarterly, or more frequently if necessary, to assure an ongoing collaborative effort and to address issues and problems that may arise.

### **Purpose and Goals of the Program**

The Rural Hospital Flexibility Program will be instrumental in fulfilling a number of health care policy goals in the State of Alaska, including those required by the federal legislation and those that are more specific to the needs of the State. Purposes for development of the program in Alaska include:

- **Improve Access to Hospital and Other Health Care Services**

Like similar hospitals across the country, some of Alaska's small rural hospitals face financial difficulties and will be forced to cut back services or close their doors if present utilization and reimbursement trends continue. Some of these hospitals also face ongoing difficulties in recruitment and retention of physicians and other personnel, further threatening their ability to meet hospital licensure and certification requirements. As these facilities are often remotely located and are important providers of health care services to broad regions of the State, their survival is critical to maintaining access to health care services for some of Alaska's most vulnerable communities.

The Rural Hospital Flexibility Program provides these hospitals with additional options in meeting the needs of their communities. Through possible reductions in the cost of meeting regulatory requirements, enhanced Medicare reimbursement, and the flexibility to staff the facility with mid-level practitioners on a long-term basis, the program may allow some hospitals that otherwise may have closed to survive. In addition, cost reductions and enhanced payments may bolster the bottom line at some facilities, bringing stability to their operations and permitting service expansion and outreach to previously underserved populations. Likewise, regular staffing by mid-level practitioners can stabilize the provider supply, enhancing access to ambulatory and inpatient care and reducing the need for hospitals and communities to expend limited resources in an ongoing cycle of physician recruitment.

- **Enhance Rural Health Network Development and Regional Delivery Systems**

Because of the great distances between communities and the small number of specialty providers and secondary and tertiary level hospitals in the State, health care providers in Alaska have traditionally maintained regional networks of care, particularly for transfer,

referral, and transportation of patients. In an environment where referral of a patient to another provider may entail a transfer of 1,000 miles or more in less than ideal travel

conditions, effective network relationships are a necessity. In addition, mirroring health care market trends taking place in the rest of the country, large systems, including those operated by Native Corporations, have begun to seek out relationships with smaller providers in more isolated parts of the State.

The Rural Hospital Flexibility Program will build on these existing and developing affiliations by formalizing network relationships, particularly between hospitals that convert to CAHs and larger, more specialized providers. As discussed further below, the State of Alaska strongly supports network development and the regionalization of health care and encourages all CAHs to join networks and maintain formal relationships with hospitals and other providers for patient referral and transfer, development and use of communications systems, provision of emergency and non-emergency transportation, and quality assurance and credentialing services. In addition, the Plan goes beyond the federal criteria and requires that CAHs that are staffed by mid-level practitioners maintain a formal network affiliation with at least one hospital.

- Establish and Maintain Consultative Relationships

As described above, the Alaska Department of Health and Social Services has sought the input of a large number of organizations and individuals in the development of this Plan. In addition to required collaboration with the Alaska Hospital and Nursing Home Association, rural hospitals, and the Alaska Center for Rural Health (the State's designated Office of Rural Health), provider groups, regulators, communities, quality assurance advocates, and federal representatives have been consulted. Through the formal establishment of a Program Advisory Committee, which will have ongoing responsibility for program monitoring and guidance, and continuing communication with interested parties, the Program provides a foundation upon which to maintain the positive relationships which have been created through the Plan development process and continue to address the health care issues faced by Alaska's rural communities and providers.

- Designate Rural Not-for-Profit and Public Hospitals as CAHs

As part of the process of developing the Rural Hospital Flexibility Program, the State must play an active role in examining the characteristics of small rural hospitals and designating as CAHs those that can meet the requirements of the program and that are located in communities that may benefit from conversion. As detailed later in the Plan, the State will conduct a "formal" designation process, which requires interested hospitals to submit sufficient information to allow Health Facilities Licensing and Certification to make an informed decision on the suitability of the hospital for the program and the facility's readiness for a licensure/certification survey. The State expects to provide information and technical assistance to interested hospitals and that the Alaska Hospital and Nursing Home

Association and rural hospitals themselves will have substantial input and involvement in the designation process.

- Establish Criteria for Certification of “Necessary Providers of Health Care Services”

To be eligible for conversion to a CAH, the federal legislation authorizing the Rural Hospital Flexibility Program requires that a rural not-for-profit or public hospital is more than a 35-mile drive (or in the case of mountainous terrain, or in areas with only secondary roads, a 15-mile drive) from a hospital or is certified by the State as being a “necessary provider of health care services” to residents of the area. Unlike hospitals in many other states, every non-federal, non-Native rural hospital in Alaska is at least 35 miles from another non-federal hospital. In only a single instance are two rural hospitals closer than 35 miles -- Sitka General Hospital in Sitka is about two miles from Mt. Edgecumbe Hospital, a facility owned and operated by the Southeast Alaska Regional Health Consortium (SEARHC). SEARHC is a Native Corporation formed to provide hospital and other health care services to Alaska Natives in the southeastern part of the State. Like other Native Health Corporations in the State, SEARHC receives federal (e.g., Indian Health Service) and other funding to carry out its mission. Provision of services at SEARHC Mt. Edgecumbe Hospital is generally limited to Alaska Natives and other Alaskan Natives.

As a result, the State believes it is not essential to develop alternative criteria to define “necessary providers.” However, because it is not clear that hospitals operated by Native Corporations will be considered in determining compliance with the 35-mile criterion, and to ensure that all rural hospitals that are essential points of access for portions of the population are clearly eligible for participation in the program, the State has developed “necessary provider” criteria that considers factors other than driving distance to another hospital to define eligibility. These criteria are described in the section of the Plan on “Certification as a Necessary Provider of Health Care Services” on pages 24-25.

- Other Considerations

The State of Alaska believes that development of the Rural Hospital Flexibility Program will result in other positive impacts on the provision of health care services in the State. These effects may result either directly from the participation in the program by small rural hospitals or indirectly through factors such as linkages established between providers or problems that are identified and solved as a result of the collaborative process of program development and monitoring. These impacts may include:

- \* Improved integration of health care services between network partners and within regions.
- \* Enhanced emergency medical services through planning and network development.

- \* Ongoing monitoring and evaluation of the Rural Hospital Flexibility Program and the health care system.

- \* Enhanced ability to identify issues and address policy and legislation related to rural health.

### **Critical Access Hospital Designation Process**

Conversion to a CAH under the Medicare Rural Hospital Flexibility Program requires that a hospital first be designated and then licensed by the State and certified by the federal government. The licensure and certification process for CAHs is essentially the same as the process for licensure and certification of other types of providers -- upon request from the provider, an on-site survey is conducted by Health Facilities Licensing and Certification staff to determine whether the facility meets applicable State and Federal law and regulations. If these requirements are met, the facility is licensed and certified to provide health care services (the State licenses health care facilities under its own authority and is delegated responsibility by the federal government to determine consistency with federal rules). The Rural Hospital Flexibility Program requires an additional step in this regulatory process -- "designation" by the State that the hospital is eligible to participate in the program and convert to a CAH.

This section of the Rural Health Plan describes the designation process and sets out criteria that a hospital must meet to be designated. Health Facilities Licensing and Certification, a component of the Department of Health and Social Services, Division of Medical Assistance, is the state agency responsible for administering the program and designating CAHs. Following designation, a hospital will be eligible to formally request and undergo a survey for licensure/certification as a CAH. This survey also will be carried out by Health Facilities Licensing and Certification, with consultation from the Section of Community Health and EMS and other appropriate agencies.

### **Identification of Interested Hospitals**

Hospitals that are likely to be most interested in conversion to a CAH are those that have a reason to consider a change in operations -- e.g., they are experiencing financial problems or difficulty in physician recruitment and retention -- and can most easily meet the CAH requirements regarding bed size and length of stay. In addition, hospitals that may be currently too large to qualify for CAH status, but are critical access points for their communities and are experiencing financial or recruitment problems, may also wish to examine participation in the program.

Because of its small population and lack of concentrated population centers, the State of Alaska has relatively few acute care hospitals, most of which are small and already provide limited services. Twenty-four hospitals are located in the State, including six hospitals operated by

Native Corporations and two military hospitals. Of the 16 non-Native, non-federal acute care general hospitals in the State, only three have more than 62 acute care beds. Eleven of the remaining 13 hospitals have less than 50 acute care beds, nine of these have 25 beds or fewer,

and five of these are already at or below the CAH maximum of 15 acute care beds.

Like rural hospitals across the country, many of Alaska’s rural hospitals are experiencing low inpatient volume (even in relation to their bed sizes) that is likely to continue to decline. It is reasonable, therefore, to consider all non-Native, non-federal hospitals with 25 or fewer acute care beds as potential CAHs. All such hospitals will not, of course, convert to CAH status and only those that are currently in serious financial difficulty or are already close to meeting the CAH requirements will likely consider conversion in the near term. As a result, the following list of hospitals does not represent a “target” list, but instead is intended to provide HCFA and the State with a comprehensive inventory of hospitals that may be in a position to convert to CAH status over the next several years. None of these hospitals has yet expressed a formal intent to convert to a CAH. Health Facilities Licensing and Certification staff will stay in close contact with these facilities and will be prepared to offer program information and technical assistance as needed. Through the ongoing process of monitoring and evaluation of the program, this list may be updated in the future. All updates will be filed with the HCFA Regional Office in Seattle.

The following hospitals have 25 or fewer acute beds and are considered potential candidates for CAH conversion:

**Hospitals Eligible for CAH Designation**

Hospital	Location	Number of Acute Beds	Number of Swing Beds
Cordova Community Medical Center	Cordova	13	4
Norton Sound Regional Hospital	Nome	19	0
Petersburg Medical Center	Petersburg	11	4
Providence Kodiak Island Medical Center	Kodiak	25	4
Providence Seward Medical Center	Seward	6	2
Sitka Community Hospital	Sitka	17	4
South Peninsula Hospital	Homer	20	4
Valdez Community Hospital	Valdez	15	6
Wrangell General Hospital	Wrangell	8	4

## Application for CAH Designation

A hospital that wishes to be designated as a CAH is required to submit an application to Health Facilities Licensing and Certification. Application forms will be provided to hospitals that have expressed interest in CAH conversion, either formally (e.g., submission of a letter of intent) or informally (e.g., a telephone call). The application for designation must include the following information (a draft of the application form is included in Appendix D):

- Basic information about the facility (governance, bed size, services, staff, etc.).
- Documentation that the hospital meets (or will meet at the time of certification survey) the following federal requirements:
  - Is a non-profit or public hospital that is located in a rural area and --
    - is located more than a 35-mile drive from a hospital or another CAH, or
    - is certified by the State as being a necessary provider of health care services to residents in the area (Alaska's criteria for certifying necessary providers are described below).
  - Makes available 24-hour emergency medical care services that the State determines are necessary for ensuring access to emergency care services in each area served by a CAH.<sup>5</sup>
  - Provides not more than 15 acute care inpatient beds.
  - Provides inpatient care for a period not to exceed 96 hours, unless a longer period is required because --
    - transfer to a hospital is precluded because of inclement weather or other emergency conditions, or
    - a peer review organization or equivalent entity, upon request, waives the 96-hour restriction on a case-by-case basis.<sup>6</sup>

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<sup>5</sup> In most circumstances, a CAH must provide Level III emergency medical services, as defined in the fourth edition of *Alaska EMS Goals: A Guide for Developing Alaska's Emergency Medical Services System*, February 1996. Level III services require that the emergency department be staffed on a 24-hour basis by a physician, mid-level practitioner, or Registered Nurse with appropriate medical training, equipment, and supplies and that physicians with specialized emergency care training are available on-call. This standard, which is stricter than that mandated in federal law, is intended to address the unique circumstances of Alaska's rural communities and support the State's existing EMS structure. Further discussion is included in the Plan section on "State Program Requirements," below.

<sup>6</sup> Due to the State's extreme climate and the distances and expense associated with travel, it is expected that CAHs in Alaska will need to keep inpatients in the facility for longer than 96 hours more frequently than CAHs in other States.

- Meets such staffing requirements as would apply to a hospital located in a rural area, except that --
  - The facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which it must be open and fully staffed, except as required to make available emergency medical care services as described above and must have nursing services available on a 24-hour basis, but need not otherwise staff the facility except when an inpatient is present;
  - the facility may provide the services of a dietitian, pharmacist, laboratory technician, medical technologist, and/or radiological technologist on a part-time, off site basis; and
  - the inpatient care described may be provided by a Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist subject to the oversight of a physician who need not be present in the facility.
  
- If the facility is a member of a Rural Health Network (as defined by the federal law), the following information must be provided:
  - A description of the network, including network partners, the network's service area, documentation of past working relationships, and an explanation of historical referral patterns;
  - Documentation of agreements for the following services with at least one hospital that is a member of the network --
    - Patient referral and transfer;
    - Development and use of communications systems including (where feasible) telemetry systems and systems for electronic sharing of patient data;<sup>7</sup>
    - Provision of emergency and non-emergency transportation.
  - Documentation of an agreement with respect to credentialing and quality assurance with at least one hospital that is a member of the network or a peer review organization or equivalent entity.
  - Documentation that the network's full service hospital partner is capable of fulfilling its role in the proposed network.

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<sup>7</sup> Due to the size of the State and extreme weather conditions, telemedicine represents a promising method to link providers in Alaska. With Medicare payment for some telemedicine services expected in January 1999, as required by the Balanced Budget Act, network members are encouraged to utilize telemedicine for communications and clinical applications.

- Demonstration that the facility meets State program requirements:
  - If inpatient care in a CAH is provided by a Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist under off-site physician supervision, the CAH must be a member of a Rural Health Network and submit network documentation and agreements, as described above.
  - The hospital must submit the following documents:
    - Community Needs Assessment -- An analysis of the availability and utilization of health care services in the community and a discussion of how conversion to a CAH will better meet community needs.
    - Community Education Plan -- A description of the steps that have been or will be taken to educate and involve the community in the decision to convert to a CAH.
    - Financial Feasibility Analysis -- A study that analyzes the financial impact on the hospital of conversion to a CAH, accounting for factors such as changes in utilization, services, staffing, and Medicare reimbursement.
    - EMS Plan -- A plan that coordinates the provision of emergency medical services in the community with the regional emergency services plan. In addition, this plan must certify that the facility will continue to provide Level III emergency services as defined in the fourth edition of *Alaska EMS Goals: A Guide for Developing Alaska's Emergency Medical Services System*, February 1996. Level III services require that the emergency department be staffed on a 24-hour basis by a physician, mid-level practitioner, or Registered Nurse with appropriate medical training, equipment, and supplies. In addition, there must be 24-hour on-call coverage by physicians with specialized emergency care training.

If the CAH will be unable to maintain a Level III emergency department, it must request a waiver of this requirement, which will be reviewed and approved/disapproved by the State. The waiver request must --

- ◇ Demonstrate that it will not be financially feasible to continue to provide a Level III emergency department; and
- ◇ Document that the community was involved in the decision to discontinue Level III emergency medical services and is aware that the emergency department of the CAH may close on occasion, with arrangements in place

reasonable period of time, as approved by the State.

### **Certification as a Necessary Provider of Health Care Services**

The federal legislation authorizing the Rural Hospital Flexibility Program requires that a CAH be more than a 35-mile drive (or in the case of mountainous terrain, or in areas with only secondary roads, a 15-mile drive) from a hospital or be certified by the State as a “necessary provider of health care services” to residents of the area. This provision of the law is intended to limit participation in the program to hospitals that are essential points of access to a community or to parts of a community that are unable to readily access services at other facilities. The State of Alaska agrees that the focus of the program should be on hospitals that meet health care needs that cannot be easily met by other facilities due to distance and/or other factors. The State will certify a hospital as a “Necessary Provider of Health Care Services” if it meets the following criterion:

- The hospital is less than a 35-mile drive (or in the case of mountainous terrain, or in areas with only secondary roads, a 15-mile drive) from another hospital that provides services only to a certain population group or subgroup and does not routinely provide services to all members of the community. Examples of such hospitals may include facilities owned and operated by Native Health Corporations, the Indian Health Service, the U.S. military, or the U.S. Department of Veterans’ Affairs.

As discussed above, every non-federal, non-Native rural hospital in Alaska is at least 35 miles from another non-federal, non-Native hospital. However, Sitka General Hospital, a public facility located in Sitka, is only about two miles from Mt. Edgecumbe Hospital, a facility owned and operated by the SEARHC, a corporation formed to provide hospital and other health care services to Alaskan Natives in the southeastern part of the State. Provision of services at SEARHC Mt. Edgecumbe Hospital is limited to Alaska Natives and other Native Americans and are not routinely available to all members of the community. As a result, Sitka General Hospital meets the criterion for certification as a Necessary Provider of Health Care Services.

### **Network Development**

The State of Alaska strongly supports the intent of the Program to foster network development. While all rural hospitals in Alaska participate in networks at least informally, the State believes that formal membership in a network will be critical for some CAHs -- i.e., those that are staffed by a mid-level practitioner under the remote supervision of a physician. As a result, network membership is mandated for these CAHs, as detailed above. Because of the difficulty in physician recruitment and retention in many areas of the State, it is expected that this model of CAH will be utilized in the State and formal network relationships will be formed.

In addition, Providence Seward Medical Center, one of the hospitals eligible for CAH designation, as identified in the chart on page 21, is a formal network partner of Providence

Alaska Medical Center-Anchorage. These facilities share common system governance and meet the Rural Health Network requirements identified in the federal statute.

## **SOURCES**

## SOURCES

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# **APPENDICES**

**Appendix B**  
**Participants in the Rural Health Plan Development Process**

- Alaska State Hospital and Nursing Home Association
- Hospitals
  - Alaska Native Medical Center, Anchorage
  - Bartlett Regional Hospital, Juneau
  - Cordova Community Medical Center, Cordova
  - Ketchikan General Hospital, Ketchikan
  - Norton Sound Regional Hospital, Nome
  - Petersburg Medical Center, Petersburg
  - Providence Alaska Medical Center, Anchorage
  - Providence Kodiak Island Medical Center, Kodiak
  - Providence Seward Medical Center, Seward
  - Sitka Community Hospital, Sitka
  - Valdez Community Hospital, Valdez
  - Wrangell General Hospital, Wrangell
- Alaska Center for Rural Health (the State’s designated Office of Rural Health)
- Alaska Department of Health and Social Services
  - Commissioner’s Office
  - Division of Public Health
    - Director’s Office
    - Section of Community Health and Emergency Medical Services
    - Section of Public Health Nursing
    - Medicaid Services Unit
  - Division of Medical Assistance
    - Director’s Office
    - Section of Health Facilities Licensing and Certification
    - Medicaid Rate Advisory Commission
- Alaska State Medical Association
- Alaska State Medical Board
- PRO-West (the State’s Peer Review Organization)
- Alaska Nurse Practitioner Association
- Alaska Family Practice Residency Program
- Alaska Primary Care Association
- Anchorage Neighborhood Health Center, Anchorage
- Executive Director, Eastern Aleutians Tribe
- Health Care Financing Administration (Central Office and Region X)

# **Appendix C**

## **Letters of Support**

**Appendix D**  
**Draft CAH Application**