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ALASKA HEALTH CARE COMMISSION
2009 REPORT

APPENDIX A: HEALTH CARE IN ALASKA

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APPENDIX A: HEALTH CARE IN ALASKA

I. HOW HEALTH CARE IN ALASKA IS PROVIDED

A. HEALTH CARE DELIVERY SYSTEMS: PRIVATE, TRIBAL, MILITARY AND VETERANS ADMINISTRATION

INTRODUCTION

People in Alaska obtain care for health needs through three different systems: the private sector, the military and Veterans' Administration health system, and the Alaska Tribal Health System. The "private sector" can be defined as any services provided by non-military/VA or non-tribal providers. It includes hospitals, physicians, dentists, mental health and substance abuse professionals, and various kinds of clinics. It also includes a wide array of support services such as pharmacies, imaging centers, renal dialysis centers, medical supplies and equipment sales and service, medical transportation services, nursing homes, rehabilitation centers, residential psychiatric treatment facilities, and home care and hospice.

The tribal and governmental systems represent a larger portion of both facilities and service providers in Alaska than in other states, since one fifth of the population (about 135,000) is eligible for services in the tribal system, and 14% percent (about 90,000) are covered by the military system. (In the U.S. as a whole the proportions are 2% tribal and 4% military.)¹

In Alaska, services that are provided by federal or state governments directly (rather than through reimbursement or an insurance program) are mostly Veterans Administration and military services for active duty and former service people in the Army, Air Force, and the Coast Guard. State and local government services are limited primarily to state psychiatric hospital, Pioneer Homes, public health services,² and some locally owned and operated clinics. Governments also play a major role in reimbursing private and tribal providers for the costs of providing care (rather than providing care directly) through Medicare, Medicaid and other programs. Governments also contract with or provide grants to private, tribal and for-profit organizations to provide services.

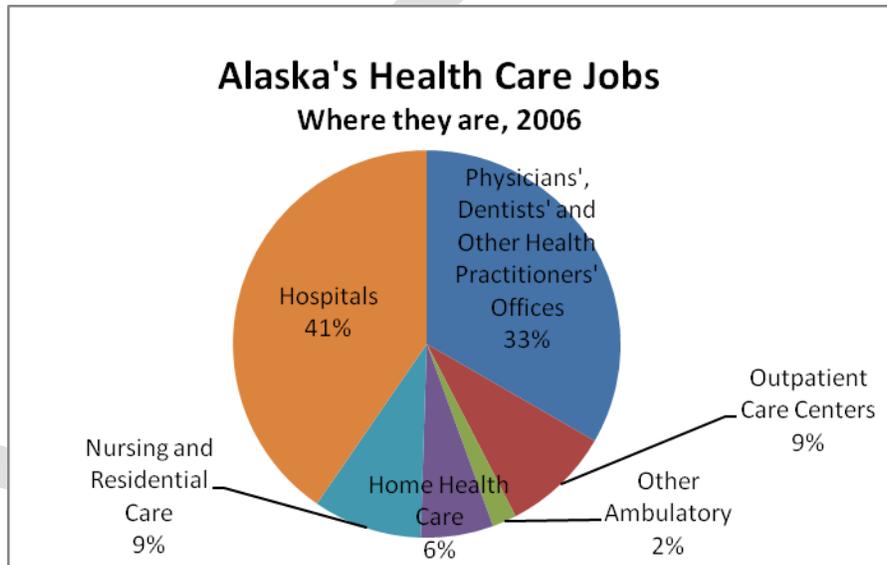
Alaska's health services have evolved in response to many factors including geography, population needs and traditions, and historical events. Many of Alaska's hospitals are former tuberculosis control hospitals built by the U.S. Public Health Service to treat the epidemic of the early 20th century. Then Alaska's location gave it a critical military and communication defense role for the country during World War II and during the Cold War of the 1950s and 1960s. The

¹ U.S. Bureau of the Census, 2000 Census.

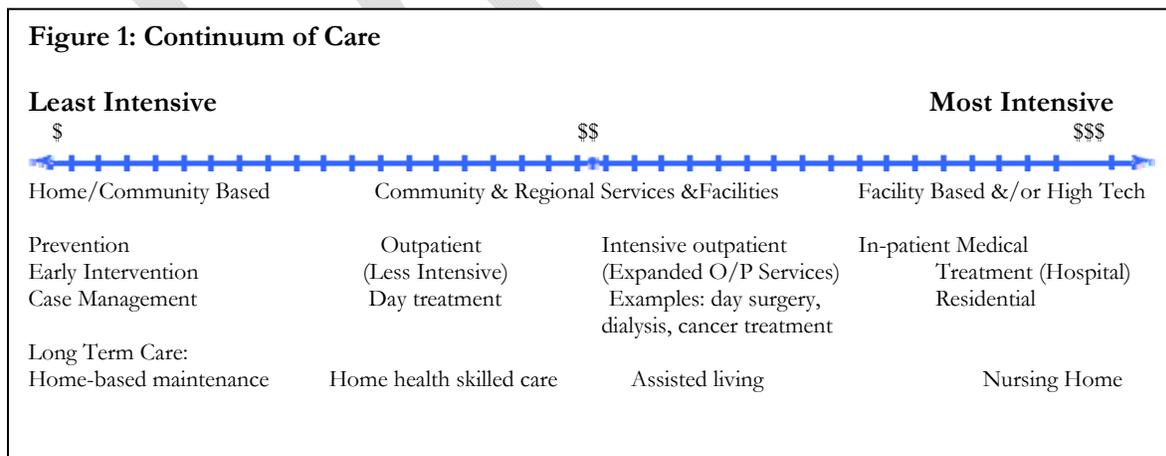
² Services include immunizations, well child care, services related to infectious diseases, sexually transmitted disease screening, treatment and partner management, newborn hearing screening, family planning, and home visits for follow-up on referrals of high risk families with children.

major role of the federally recognized tribes in planning and implementing a coordinated system of care for Alaska Natives, through an agreement with the Indian Health Service called “compacting,” has supported and determined the development of care in rural areas of the state.

Health care is a major contributor to the state’s economy. Health care accounted for eight percent of Alaska’s employment in 2006, with 29,000 workers, and payroll of about \$1.2 billion. Most of the jobs were in the private and tribal sectors – 93%. Fully one third of Alaska’s health care employees worked in physicians’, dentists’ and other health practitioners’ offices, with 40% in hospitals, and 9% in nursing home and other residential care. About 9% worked in outpatient care centers such as ambulatory surgery centers, dialysis centers, imaging facilities, and other diagnostic and treatment facilities, 6% worked in home health care, and 2% in other ambulatory care settings. Seven of the twenty five largest health care employers were tribal organizations – they accounted for 6,000 employees of 16,640 in those twenty five firms. Thus employment in the non-tribal private sector was likely about 23,000 in 2007, or at least 6% of the state’s total employment.³



Thinking of health care services as a “continuum” of care from prevention through treatment, rehabilitation, and maintenance of optimum health can help one comprehend the many different services, facilities and programs. A simplified graphical presentation shows relationships of some of the key components:



³ Fried, N. “Alaska’s Health Care Industry,” Alaska Economic Trends, Anchorage, February 2008.

1. PRIVATE HEALTH CARE SECTOR

The private health care sector includes an array of services from highly specialized diagnosis and treatment to primary care, prevention, and supporting goods and services. Firms range from self-employed professionals, contractors and small businesses to national corporations. Even the not-for-profit health services include very large entities like Providence Alaska Health Systems, the largest employer in Alaska with about 4,000 employees in 2006,⁴ to small community-based community health centers like Bethel Family Health Services with 9 employees. Seattle, Washington is still the nearest source for some highly specialized services such as heart and other organ transplants and severe trauma treatment.

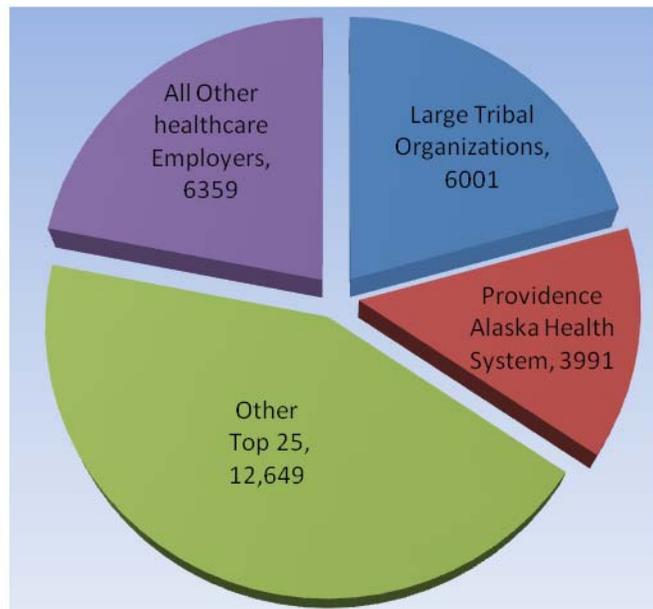


Figure [#] Distribution of Health Care Employment 2006

Only two of Alaska's hospitals are for-profit entities, Alaska Regional Hospital and North Star psychiatric hospital. However many of the free-standing diagnostic, treatment and ambulatory services facilities are for-profit entities. Private sector physicians, dentists, psychologists and other practitioners are either self-employed or have incorporated to pay themselves and staff salaries. Drug stores, medical supply companies, and many other support services are for-profit firms.

Nearly one-third (approximately 10,000) of all health industry jobs in 2007 were in private hospitals. Hospitals are major employers because "they're labor intensive and provide around-the-clock care; three shifts of workers cycle through the hospitals each day."⁵ The Alaska Department of Labor identifies 82 percent of Alaska's non-military employment in hospitals to be in the privately owned and managed facilities rather than local public or tribal facilities.

The private not-for-profit organizations include community-based Community Health Centers and mental health service agencies that receive grants from federal and state government

⁴ Fried, N., "The Trends 100," Alaska Economic Trends, Anchorage, July 2009. P. 6.

⁵ Ibid., p. 9.

programs. Although these organizations must meet guidelines of public programs, most are not government-run organizations – their boards of directors, employment policies, salary rates, goals and programs are governed by their own bylaws and policies.

In Alaska, no “managed care organizations” exist in the private sector, and formal provider networks are lacking. However informal referral patterns, and “panels” of preferred providers associated with a variety of insurance programs, result in some structured relationships, and some facilities and groups are affiliated or jointly managed.

2. ALASKA TRIBAL HEALTH SYSTEM

The Alaska Tribal Health System (ATHS) is a voluntary affiliation of nearly 40 tribes and tribal organizations providing health services to American Indians/Alaska Natives (AI/AN) in Alaska. The ATHS is a diverse and multifaceted health care system that has developed over the last 30 years since passage of the 1975 Indian Self-Determination and Education Assistance Act (ISDEA). Each of the tribal health organizations within the ATHS is owned and operated independently, while remaining interconnected via the system’s sophisticated patterns of referrals and their primary and common mission of improving the health status of Alaska’s American Indian/Alaska Native (AI/AN) population.

Alaska has 228 federally recognized tribes, accounting for about 135,000 people. At present, Alaska Native villages are situated mostly along the coast and rivers of Alaska. The dispersal of the communities across a huge, mostly roadless territory accounts in large part for the creation of the innovative statewide health system.

As part of its trust responsibility to Native people, the federal government is required to provide a basic level of health care services to the AI/AN population. The trust responsibility deems these services “pre-paid” with aboriginal lands and authority that tribes ceded to the U.S. government in treaties. In 1975, Congress created a process for transferring Bureau of Indian Affairs and Indian Health Service health programs to tribal governments through the Indian Self-Determination and Education Assistance Act (ISDEA, Public Law 93-638). In doing so, Congress noted the past inadequacies of Native American health care, and reaffirmed its intention to involve tribes in health care programs through tribal self-governance.⁶

⁶From *Jumping Through Hoops: Traditional Healers And The Indian Health Care Improvement Act*, 4 DePaul Journal of Health Care Law 843-860, 844-847 (Summer 1999) , accessed on <http://academic.udayton.edu/health/02organ/Indian03.htm> August 10, 2009:

“In passing the Act, Congress noted the government’s “unique legal relationship with, and resulting responsibility to” Indians, necessitated the creation of a comprehensive health care system. The IHCA set forth the following goals for the IHS:

- (1) to assure Native Americans access to high-quality comprehensive health services in accordance with need;
- (2) to assist tribes in developing the capacity to staff and manage their own health programs and to provide opportunities for tribes to assume operational authority for IHS programs in their communities; and

(footnote continued)

The Alaska Native Medical Center (ANMC), a 156 bed facility in Anchorage, serves as the referral center for specialty care. The other tribally administered hospitals (former US Public Health Service hospitals) are located in the six rural communities of Sitka, Barrow, Bethel, Dillingham, Kotzebue and Nome. There are 36 tribal health centers and 176 tribal community health aide clinics. In many rural areas of the state tribal health organizations are the only health care providers available, and serve everyone in the area regardless of race or IHS-beneficiary status.

The federal Indian Health Service (transferred from the Bureau of Indian Affairs to the US Public Health Service in 1955) manages an Alaska Area Native Health Service office (one of eleven Area Offices) that works in conjunction with nine tribally operated service units to provide comprehensive health services to about 135,000 Alaska Native people. Services funded in-part by IHS are delivered by tribal health organizations, or under contract with non tribal service providers. The federal government through the IHS holds title to six tribally operated hospitals⁷ and three tribally operated health centers in Alaska (on St Paul Island, Annette Island and Tanana Village) and is responsible for their maintenance.

Together, the tribal organizations that compose the AHS operate an \$800 million (FY2006) health care sector, and employ more than 7,000 full and part-time staff statewide. Beneficiaries are not charged for most services received within the AHS. Financing for the entirety of the AHS's programs is split between a variety of sources, including federal and state grants and contracts for specific services; Medicaid, Medicare, and private insurance revenue; rural sanitation funding; and other smaller sources of funding. While the Indian Health Service represents the largest funding source, it accounts for only 60% of total revenue.

The Alaska Tribal Health Compact, which authorizes tribes and tribal health organizations to operate health and health-related programs, was formed October 1, 1994. The Alaska Native Tribal Health Consortium (ANTHC) was organized as a statewide non-profit health service organization owned by Alaska Natives and managed by all tribes in Alaska. Other "compact" organizations under P.L. 93-638 include the tribal health corporations that serve regions and specific communities. ANTHC manages all statewide health services formerly provided by the Indian Health Service. ANTHC has responsibility for essential statewide services, including the Alaska Native Medical Center, which it manages in conjunction with the Southcentral Foundation (the regional tribal health organization serving Anchorage and the surrounding communities).

(3) to be the primary federal advocate for Native Americans with respect to health care matters and to assist them in accessing programs to which they are entitled. Subsequent amendments in 1992 extended the purpose of the IHCA to raising the health status of Native Americans over a specified period of time to the level of the general United States population. Additionally, the IHCA sought a high level of participation by Indian tribes in the planning and management of IHS programs, services, and demonstration projects under subsequent self-determination amendments.

⁷ The Alaska Native Medical Center in Anchorage, Samuel Simmons in Barrow, Kakanak in Dillingham, Maniilaq Health Center in Kotzebue, Mt. Edgecumbe in Sitka, and Yukon-Kuskowim Delta Hospital in Bethel. Norton Sound Hospital in Nome is the only tribally managed hospital that is not Federally-owned.

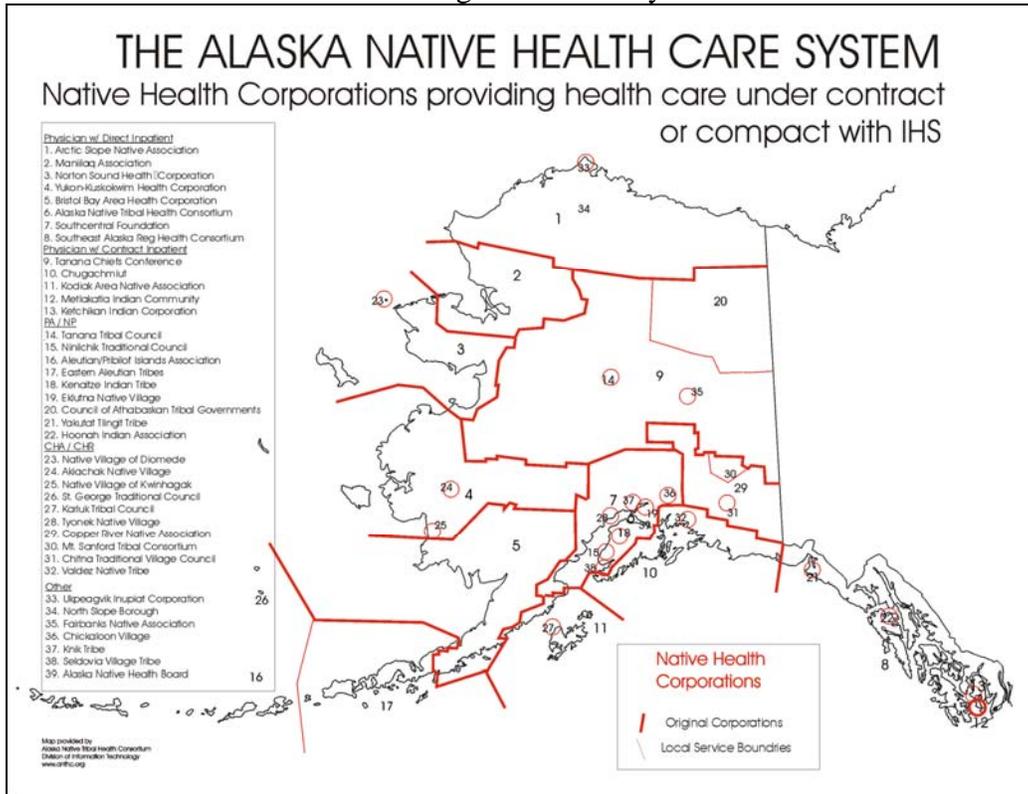
The Compact is the umbrella agreement (also identified as P.L. 93-638, Title-V Self-Governance Compact) that sets forth the terms and conditions of the government-to-government relationship between Alaska Native tribes and/or tribal organizations, and the United States government through the Indian Health Service.⁸ The 23 tribes and tribal organizations that belong to the Compact include:

- Alaska Native Tribal Health Consortium
- Aleutian//Pribilof Islands Association Inc.
- Annette Island and SU--Metlakatla Indian Community
- Arctic Slope Native Association
- Bristol Bay Area Health Corporation
- Chugachmiut
- Copper River Native Association
- Council of Athabascan Tribal Governments
- Eastern Aleutian Tribes Inc.
- Ketchikan Indian Community
- Kenaitze Indian Tribe
- Knik Tribal Council
- Kodiak Area Native Association
- Maniilaq Association
- Mt. Sanford Tribal Consortium
- Native Village of Eklutna
- Norton Sound Health Corporation
- Seldovia Village Tribe
- Southcentral Foundation
- SouthEast Alaska Regional Health Consortium
- Tanana Chiefs Conference Inc.
- Yakutat Tlingit Tribe
- Yukon-Kuskokwim Health Corporation

In addition, there are 17 tribes and tribal organizations that contract with the Indian Health Services to provide health services under P.L. 93-638, Title I.

⁸ <http://www.anhb.org/index.cfm?section=Advocacy>

ANTHC Maps are available on www.anthc.gov in formats that can be printed to large sheets for more legible readability:⁹



3. U.S. MILITARY AND THE VETERANS AFFAIRS SYSTEMS

U.S. Department of Defense

About 50,000 active duty military and dependent Alaskans are eligible for health care services provided by the Department of Defense. Military retirees and veterans (numbering 76,000¹⁰) have access to certain services. The U.S. Air Force has responsibility for all military, dependents' and veterans' health care in the southern part of the state, and the U.S. Army is responsible for serving these populations in the northern part of the state. A major health center serves each of these areas: Elmendorf AFB Hospital serves the Southern Region,¹¹ and Bassett

⁹ Maps of the Tribal system as well as resource materials about its components are available on the website <http://www.anthc.org/ref/maps/>.

¹⁰ US Department of Veterans Affairs, <http://www1.va.gov/opa/fact/statesum/akss.asp> accessed 8/13/2009

¹¹ **Southern Region:** The 3rd Medical Group, Elmendorf AFB, Alaska is responsible for military services including Air Force, Army, Navy, Marine, Coast Guard, Army/Air National Guard and reserve services units and family members of active duty service personnel.. The health care services provided by the 3rd Medical Group include:

a. Primary Care- Pediatrics, Family Practice, Flight Medicine, Internal Medicine and Dental.

(footnote continued)

Army Community Hospital serves the Northern Region.¹² The Veterans' Administration runs an outpatient medical center in Anchorage, and clinics in Fairbanks, Wasilla and Kenai.¹³ When a patient requires highly specialized care, he or she may be referred to a private sector hospital or, more often, to military medical centers out of state. The military has medical centers to serve local military installations in Alaska as well as to provide for surge capacity in times of emergencies. Alaska's military forces have the capability of airlifting complete surgical and hospital facilities to any part of the world or to provide services in times of national emergencies.

The Department of Defense (DOD) TRICARE program (formerly CHAMPUS) is a regionally managed health coverage program for active duty and retired members of the uniformed services, their families and survivors. TRICARE is not an insurance plan, but a health care entitlement program, funded by the U.S. Department of Defense (DoD) for active duty, Guard and Reserve and retired members of the military, and their eligible family members and survivors. TRICARE for Life now provides health care coverage to TRICARE beneficiaries 65 years of age or older. Beneficiaries need to pay the premium for participation in Medicare Part B (physician and other non-inpatient care). TRICARE provides services at military treatment facilities, and supplements that with access to civilian health care networks where necessary (much like the IHS Contract Health Care program).

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- b. Specialty Care- Women's Health Clinic (OB/GYN), Physical and Occupational Therapy, Optometry/Ophthalmology, Ear/Nose/Throat, Surgery, and Nutritional Medicine
 - c. Ancillary- Pharmacy, Radiology, Laboratory
 - d. Inpatient services including Intensive Care Unit and Labor & Delivery
 - e. Emergency Care- Emergency Room (ER)
 - f. Supplementary Services-Family Advocacy Program/Social Work/Mental Health/Health Promotions and Life Skills.

¹² Northern Region: Bassett Army Community Hospital, Fort Wainwright, Alaska is attached to the Alaska Command, and reports to Chief of All Army Medical Services at Walter Reed Army Hospital. It serves Fort Wainwright, Eielson Air Force Base, Fort Greely and its associated units. Remote army sites are provided with health services through Troop Medical Clinics at Fort Richardson, Fort Greely and Eielson Air Force Medical Clinic. The health care services provided by are:

- a. Primary Care
- b. Women's Health Care
- c. Orthopedics
- d. Audiology
- e. Health Promotion
- f. Medical Laboratory and X-Ray
- g. Mental Health Care
- h. Dental Care
- i. Pharmacy

¹³ Sources:

- 3rd Medical Group Elmendorf AFB website: [www.elmendorf.af.mil/units/3rd Medical Group](http://www.elmendorf.af.mil/units/3rd%20Medical%20Group)
- Alaska VA Healthcare System and Regional Office: www.visn20.med.va.gov/Alaska and, www.va.gov/hac/forbeneficiaries/champva.asp
- MEDDAC – Fort Wainwright, Alaska website: www.wainwright.army.mil/sites/local

Alaska Veterans Administration (VA) Healthcare System

The Alaska VA Healthcare System and Regional Office offer primary, specialty, and mental health outpatient care. Services are provided at the Anchorage VA Medical Center, on Elmendorf Air Force Base (through a joint venture with the USAF), and through fee-based arrangements with community hospitals in Fairbanks, Wasilla and Kenai.¹⁴ The VA Medical Center in Anchorage also features a comprehensive Homeless Veteran Service consisting of a Domiciliary Residential Rehabilitation Treatment Program, Veterans Industries, Psychosocial Residential Rehabilitation Treatment Program, VA Supported Housing Program and outreach. These health care services are provided and coordinated through the Anchorage VA Medical Center. In addition to this center of care, the Veterans Administration has established a system of Community Based Outpatient Clinics located at Fort Wainwright, Kenai, and Wasilla.

A pilot project announced in September 2009 is intended to enable veterans to get care through community health centers or other local clinics with Veteran's Administration reimbursement so that less travel for care should be involved.

Coast Guard Clinics

The US Coast Guard history of service in Alaska dates back to the Revenue Cutter Service. Coast Guard personnel and their families are stationed throughout Alaska, including remote sites such as Port Clarence, St. Paul, Attu, Dutch Harbor, and Shoal Cove. Coast Guard clinics in Kodiak, Juneau, Sitka, and Ketchikan support the health care needs of the nearly 5,000 Coast Guard members and their families in Alaska.¹⁵

Alaska Federal Health Care Partnership

Alaska Federal Health Care Partnership (AFHCP) is a voluntary partnership of the organizations serving the federal health care beneficiaries in Alaska. AFHCP combines the healthcare resources of the Alaska Native Medical Center, Alaska Native Tribal Health Consortium, Department of Defense, Department of Homeland Security, Department of Veterans Affairs, U.S. Coast Guard, and the Indian Health Service. The combined beneficiary population of these organizations is over 250,000 with some beneficiaries having dual, or even triple, eligibility within the health and wellness provider systems. The Partnership represents over 250 health care facilities across the state-- from isolated village clinics staffed by health aides in the most remote parts of Alaska, to the Alaska Native Medical Center, the military hospitals in Anchorage and Fairbanks, and the extensive VA clinical services in the Anchorage area.¹⁶

¹⁴ About eighty health care providers are paid for by the Veterans Administration at the Elmendorf AFB Hospital, for providing emergency room care, intensive care and staffing for a medical services unit. The Veterans Administration also provides social workers to this hospital.

¹⁵ <http://www.afhcp.org/coast%20guard.html>

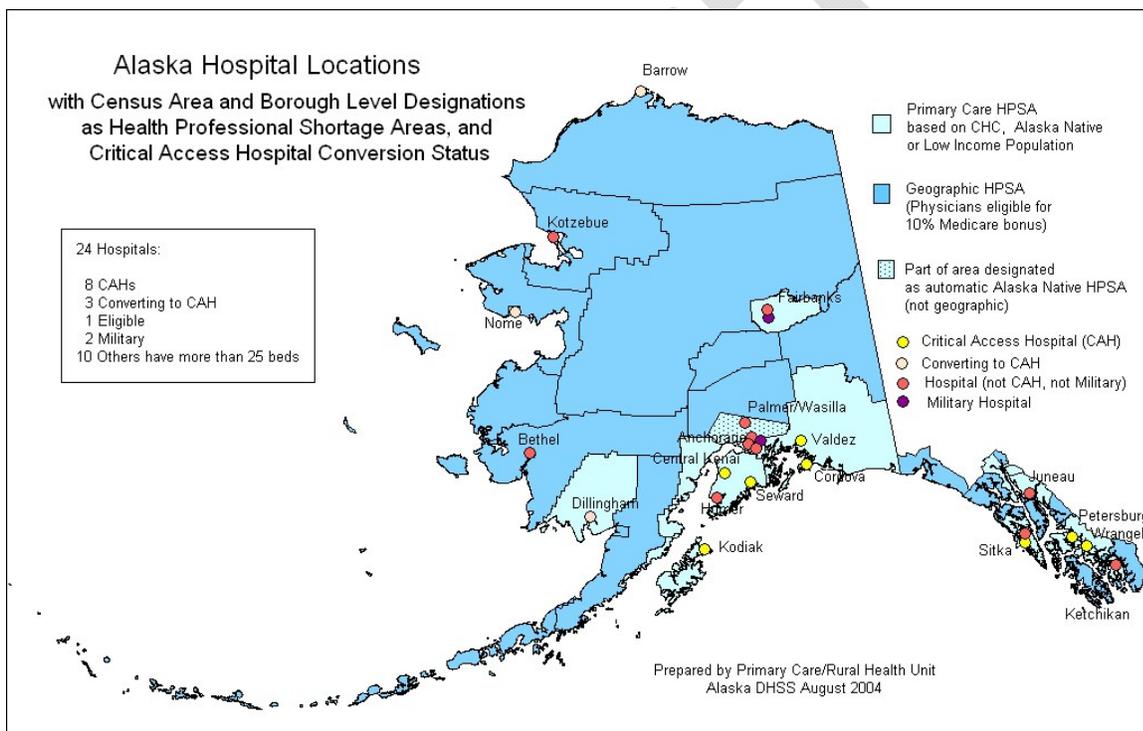
¹⁶ Alaska Federal Health Care Partnership website <http://www.afhcp.org/index.html> accessed 8/13/2009

B. FACILITIES

I. MEDICAL FACILITIES

1. HOSPITALS

There are 27 hospitals in Alaska: 24 that provide general acute care (including two military and seven tribally operated hospitals), and three specialized hospitals (one long term acute care and two psychiatric hospitals).¹⁷ The greatest concentration of hospitals is in the Anchorage/Mat-Su region.¹⁸ The relatively large hospitals in Anchorage and Fairbanks serve as referral facilities for providers from rural areas of the state. Hospitals in Seattle also serve as key referral destinations for residents of Alaska in need of “high tech” and specialty services.



¹⁷ A general acute care hospital must provide surgical, anesthesia, perinatal, medical, nursing, pharmaceutical, dietetic, laundry, medical records, radiological, laboratory, and emergency care services. Such a hospital must also provide speech, occupational, or physical therapy services. A rural primary care hospital or a critical access hospital must provide the services of a general acute care hospital except that the provision of surgical, anesthesia, perinatal, speech, occupational therapy, or physical therapy services is optional. A long-term acute care hospital must provide medical, nursing, pharmaceutical, dietetic, occupational therapy, physical therapy, laundry, medical records, radiological, social work, respiratory, and laboratory services. (7 AAC 12.105)

¹⁸ <http://www.hss.state.ak.us/dph/Healthplanning/publications/healthcare/default.htm> (Alaska Health Care Data Book, figure 4.170)

Statewide, there are 1,562 beds in Alaska hospitals, not including those operated by the military. Of those beds, 154 are psychiatric in the two specialized hospitals, 60 are “long term acute care,” and 1348 are acute care beds (of which 146 are identified as swing beds that can be used for acute or long term care). (Updated map still needed.)

TABLE [#]: ALASKA HOSPITALS, 2008

<i>Region/Hospital</i>	<i>Location</i>	<i>Licensed Beds**</i>	<i>Governance</i>
Anchorage Matanuska-Susitna Region			
Providence Alaska Medical Center	Anchorage	326	Private Non-Profit
Alaska Regional Hospital	Anchorage	250	Private For-Profit
Alaska Native Medical Center	Anchorage	150	Tribal Health Corporation; Federal ownership
Air Force Medical Center – Elmendorf	Anchorage	105	Federal Military
Mat-Su Regional Medical Center	Palmer	74	Private Non-profit
St. Elias Long Term Acute Care Hospital	Anchorage	60	Private Non-Profit
Alaska Psychiatric Institute	Anchorage	80	Public State
North Star Hospital	Anchorage	74	Private For-Profit
Interior Region			
Fairbanks Memorial Hospital	Fairbanks	152	Private Non-Profit
Bassett Community Army Hospital	Ft. Wainwright	55	Federal Military
Southeast Region			
Bartlett Regional Hospital	Juneau	71	Public Municipal
Ketchikan General Hospital*	Ketchikan	25	Public Municipal
Petersburg Medical Center*	Petersburg	12	Public Municipal
Mt Edgecumbe Hospital	Sitka	27	Tribal Health Corporation; Federal ownership
Sitka Community Hospital *	Sitka	12	Public Municipal
Wrangell Medical Center*	Wrangell	8	Public Municipal
Gulf Coast Region			
South Peninsula Hospital*	Homer	22	Public Municipal
Providence Kodiak Island Medical Center*	Kodiak	25	Public Municipal
Providence Seward Medical Center*	Seward	6	Public Municipal
Central Peninsula Community Hospital	Soldotna	49	Public Municipal
Providence Valdez Community Hospital *	Valdez	11	Public Municipal
Cordova Community Medical Center*	Cordova	13	Public Municipal
Southwest Region			
Yukon-Kuskokwim Delta Regional Hospital	Bethel	50	Tribal Health Corporation; Federal ownership
Kanakanak Hospital*	Dillingham	16	Tribal Health Corporation; Federal ownership
Northern Region			
Norton Sound Regional Hospital*	Nome	18	Tribal Health Corporation
Simmonds Memorial Hospital*	Barrow	14	Tribal Health Corporation; Federal ownership
Manillaq Medical Center*	Kotzebue	18	Tribal Health Corporation; Federal ownership

*Critical Access Hospital

** Total beds include licensed and/or certified acute care and swing beds. Many hospitals are operating with fewer beds than the number licensed.

Data Source: Health Facilities List, Licensing and Certification Section, Division of Public Health 2009

The scope of services provided by Alaska's urban hospitals has been changing dramatically. Bed counts have remained quite stable in the last decade, but hospital "campuses" have grown to accommodate an array of emerging technologies and day treatment services that were formerly available only as inpatient services or out-of-state. Examples of services that have been introduced by hospital systems in the last five years include: cardiac catheterization, cardiac electrophysiology ablation, cardiac rehabilitation, chemotherapy and cancer services, renal dialysis, pediatric medicine, birthing centers, outpatient surgery, sleep disorder testing, sports medicine rehabilitation, and expanded hospice and home care. The addition or expansion of these services to Alaska's urban hospitals has provided an incentive to physicians and businesses that support these services to establish residence and to provide care in Alaska, often partnering with the hospital care system. This has allowed Alaskans to receive care in-state.

Alaska's hospitals in communities with populations smaller than 30,000 – that is, outside of Anchorage, Mat-Su, Fairbanks and Juneau – are recognized to be critical "economic engines" of their communities, providing jobs directly, and providing assurance of emergency services and access to care for residents of their service areas, and for employers who want to attract workers. 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. Thirteen Alaska hospitals (see table above) are now certified by Medicare as Critical Access Hospitals (CAH) enabling them to obtain cost-based reimbursement rates from the Federal Medicare program.

Critical Access Hospital Certification

A Critical Access Hospital (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. CAHs generally provide inpatient care for up to 96 hours, unless discharge or transfer is precluded due to inclement weather or other emergency conditions. CAHs 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 operate nursing home beds or provider-based services like home health. CAHs are reimbursed on a "reasonable cost" basis for services provided to Medicare beneficiaries.

Trauma Center Designation

Alaska's highest level Trauma Center (Level II) is the Alaska Native Medical Center (ANMC). Level II Trauma Centers provide comprehensive trauma care, serving as the lead trauma facility for a geographical area. Emergency physicians and nurses are available in-house to provide direct patient care and initiate resuscitation and stabilization. Prompt availability of general surgeons and certain specialty surgeons is required. A Level II Trauma Center also provides educational outreach and prevention programs, and assumes responsibility for trauma system

leadership in the absence of a Level I Trauma Center. Under ACS criteria, Level I centers must conduct trauma research and teach trauma care physicians. Cities in Alaska do not have the patient loads or academic medical centers to support this level of care and the nearest Level I Trauma Center is located in Seattle. There are four Level IV-designated Trauma Centers in Alaska: Norton Sound Regional Hospital (Nome), Yukon-Kuskokwim Delta Regional Hospital (Bethel), Mt. Edgecumbe Hospital (Sitka), and Sitka Community Hospital (Sitka).

2. Outpatient Facilities

Recent changes in technology and medical practice have allowed patients to receive some services as outpatients rather than being hospitalized. Outpatient services can be performed in a hospital setting or in a freestanding facility. Currently the State of Alaska licenses ambulatory surgery centers, and birthing centers, as authorized by Alaska Statute 47.32. (It also licenses hospitals that may offer ambulatory surgery and ESRD services.)¹⁹ In addition, Alaska has Medicare certified end stage renal disease facilities.

An ambulatory surgical facility provides surgery and anesthesia service, in some cases including pain management and diagnostic services, in an outpatient setting. Ambulatory Surgery Centers (ASC) (which may be called outpatient surgery centers or same-day surgery centers when part of a hospital) perform procedures that are more intensive than those done in the average doctor's office, but not so intensive as to require a hospital stay.

In order for a facility to be licensed as an ASC, services must comply with the state's standards for surgical and anesthesia services in general acute care hospitals. There are also requirements, similar to hospital medical staff regulations,²⁰ for physicians working in these licensed facilities. Currently there are nine licensed Ambulatory Surgery Centers in the state.

Freestanding Birthing Centers are facilities which are not a hospital or in a hospital, where births are planned to occur away from the mother's residence following normal, uncomplicated pregnancy. The state has eight licensed Birthing Centers: one each in Juneau, Soldotna and Fairbanks, and three in Anchorage and two Wasilla.

Alaska also has Medicare certified facilities for treatment of end stage renal disease, commonly referred to as dialysis centers. Dialysis is used to provide an artificial replacement for lost kidney function. It may be used for acutely ill patients who have suddenly but temporarily lost their kidney function and require services for only a short time period; but is used mostly for patients who have permanently lost their kidney function and require dialysis for a long,

¹⁹ Per AS 47.32.010

²⁰ Purpose and accountability include that "the provisions of [AS 47.05.300](#) - 47.05.390, regarding criminal history, criminal history checks, criminal history use standards, and a centralized registry, apply to entities listed in (b) of this section, as provided in [AS 47.05.300](#)."

indefinite period of time. The state currently has seven Medicare certified End State Renal Disease facilities.²¹

Other diagnostic and testing services now being established in some instances as freestanding businesses are imaging (including Magnetic Resonance Imaging and CT Scan), sleep studies, and laboratories. Such entities are being called “Independent Diagnostic Testing Facilities” (IDTF) when they are not engaged in patient treatment, but perform diagnostic tests by certified non-physician personnel under physician supervision. These facilities are independent of a hospital or physician’s office. The state does not license IDTFs but does monitor the credentials of staff performing tests and the proper functioning of diagnostic equipment used by the facility.

3. Community Health Centers (CHCs) and Special Clinic Certifications

Community Health Centers (CHCs, sometimes referred to as “330 Clinics”) are non-profit, community-based organizations that provide health care to low income and medically underserved areas and populations. The CHC program was established under section 330 of the Public Health Services Act, and federal grant funding is provided through the US Department of Health and Human Services, Health Resources and Services Administration (HRSA).²²

Similar to many outpatient medical clinics, CHCs are required to provide typical primary care services²³ including:

- Health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology provided by physicians, physician’s assistants, nurse practitioners, nurse midwives, and health aides.
- Diagnostic laboratory and radiological services.
- Preventive services (prenatal services; screening for breast and cervical cancer; well-child services; immunizations; screenings for communicable diseases, environmental contaminants, and chronic health conditions; pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care; family planning services; and preventive dental services.)
- Emergency medical services.
- Pharmaceutical services.

Additionally, community health centers are expected to provide:

²¹ Licensing and Certification Section, Division of Public Health 2009

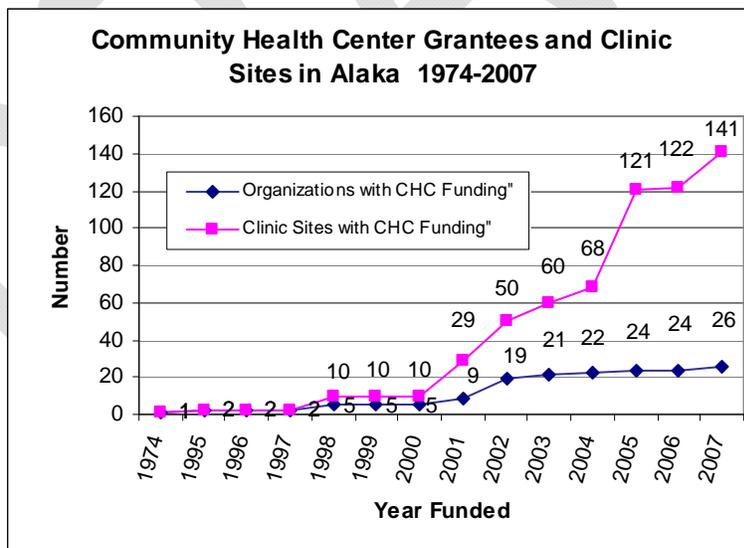
²² For criteria for designation of Medically Underserved Areas/Populations and health professional shortage areas, see <http://bhpr.hrsa.gov/shortage/index.htm>, www.hss.state.ak.us/dhcs/healthplanning or <http://www.hss.state.ak.us/dph/healthplanning/primarycare/MUA.htm>

²³ Primary care is the provision of professional, comprehensive health services that include health education and disease prevention, initial assessment of health problems, treatment of acute and chronic health problems, and the overall management of an individual’s or family’s health care services. It entails first-contact care of persons with undifferentiated illnesses, comprehensive care that is not disease or organ specific, care that is longitudinal in nature and care that includes the coordination of other health services.

- Referrals to providers of health related services including substance abuse and mental health services.
- Patient case management services including counseling, referral, and follow-up services.
- Patient education regarding health conditions and the availability and use of health services.

CHCs differ from privately run physician offices and clinics in several ways. They are required to include a majority of consumer representatives on their Boards of Directors. Their funding is contingent upon demonstration in their funding proposals and utilization reports that they attend to the health status of the entire community in addition to the clinic’s patient population. This often means that CHCs participate in prevention program opportunities to address such conditions as diabetes, hypertension, or chronic obesity. Further, chronic care management, medical homes, and the benchmarking of patient outcomes have been the foci of health center activities.

US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care periodically makes US Public Health Service, Section 330 funds available to CHCs to expand their scope of services. Oral health and mental health services are two of the services that have been the focus of additional funding available to CHCs. Many Alaska CHCs have taken advantage of these funding opportunities, and increasingly CHCs are co-locating or otherwise integrating the provision of general dentistry and behavioral health services into their primary care clinics.



Between 1995 and 2009 the number of Community Health Centers in Alaska that were funded in part through Section 330 of the Public Health Service Act grew from two provider agencies – the

Anchorage Neighborhood Health Center and Interior Neighborhood Health Center (Fairbanks) who were operating four sites in 1995, to 26 agencies operating 145 healthcare delivery sites.²⁴

Community Health Centers are by definition “Federally Qualified Health Centers,” or “FQHCs,” which are further defined by section 1861 of the Social Security Act.²⁵ Tribally managed clinics are also FQHCs.

²⁴ Based on the sites listed as reporting to the Bureau of Primary Health Care’s Uniform Data System.

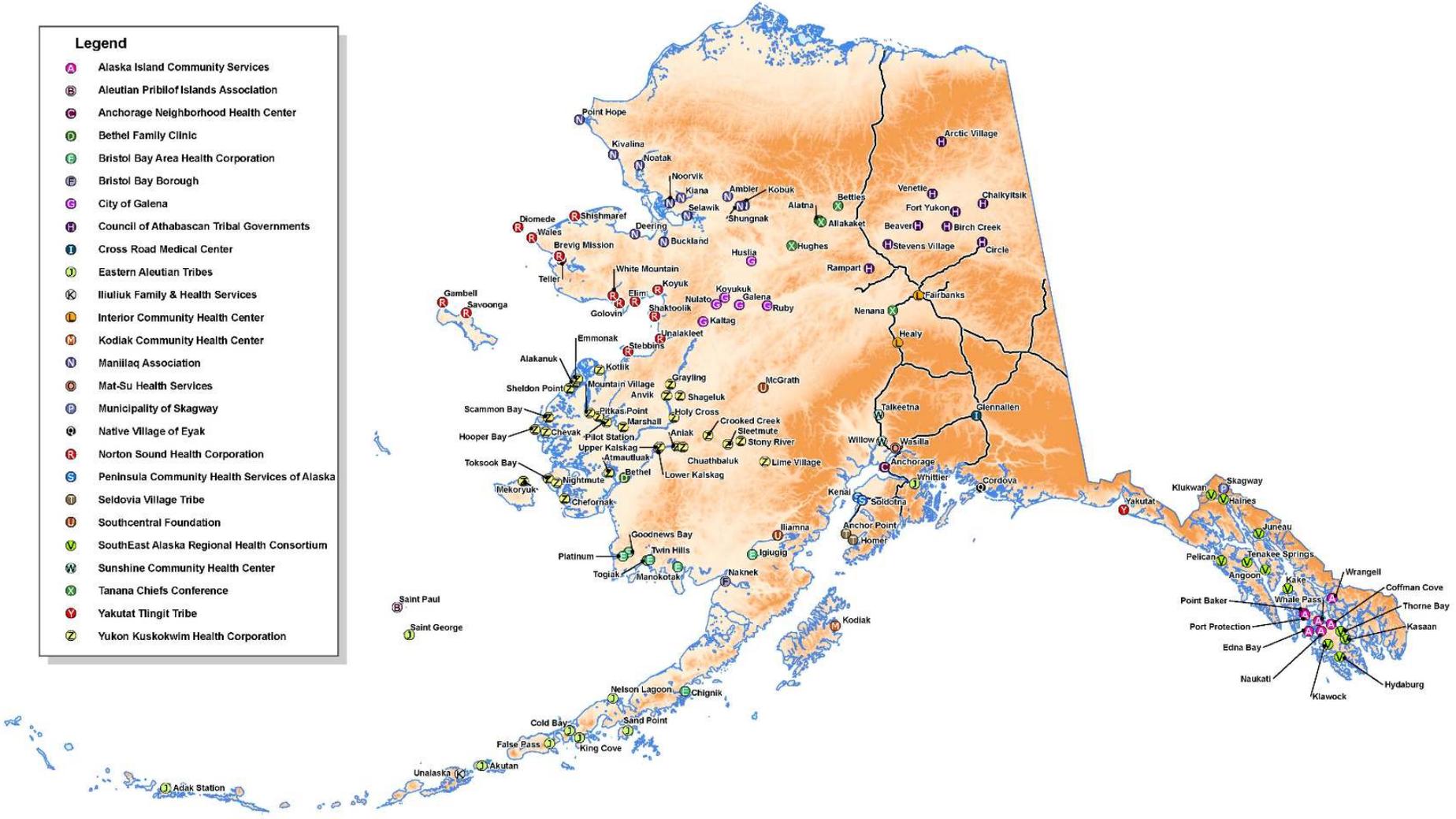
http://ftp.hrsa.gov/bphc/pdf/uds/2007/07Rollup_StateAK_08Jul2008.pdf

²⁵ Section 1861 of the Social Security Act "(4) The term “Federally qualified health center” means an entity which—

- (A)(i) is receiving a grant under section 330 (other than subsection (h)) of the Public Health Service Act, or
- (ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 330 (other than subsection (h)) of such Act;
- (B) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant;
- (C) was treated by the Secretary, for purposes of part B, as a comprehensive Federally funded health center as of January 1, 1990; or
- (D) is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act[423]."

Map of the Alaska Community Health Centers, Prepared by Alaska Primary Care Association (David Wilson), Jan. 2009

- Legend**
- A Alaska Island Community Services
 - B Aleutian Pribilof Islands Association
 - C Anchorage Neighborhood Health Center
 - D Bethel Family Clinic
 - E Bristol Bay Area Health Corporation
 - F Bristol Bay Borough
 - G City of Galena
 - H Council of Athabascan Tribal Governments
 - I Cross Road Medical Center
 - J Eastern Aleutian Tribes
 - K Iliuliuk Family & Health Services
 - L Interior Community Health Center
 - M Kodiak Community Health Center
 - N Manillaq Association
 - O Mat-Su Health Services
 - P Municipality of Skagway
 - Q Native Village of Eyak
 - R Norton Sound Health Corporation
 - S Peninsula Community Health Services of Alaska
 - T Seldovia Village Tribe
 - U Southcentral Foundation
 - V SouthEast Alaska Regional Health Consortium
 - W Sunshine Community Health Center
 - X Tanana Chiefs Conference
 - Y Yakutat Tlingit Tribe
 - Z Yukon Kuskokwim Health Corporation



Frontier Extended Stay Clinics

In remote frontier areas of the country weather and distance can prevent patients who experience severe injury or illness from obtaining immediate transport to an acute care hospital. For residents in some of these communities providers offer observation services traditionally associated with acute care inpatient hospitals until the patient can be transferred or is no longer in need of transport. A Medicare demonstration project is under development in Alaska in which “Frontier Extended Stay Clinics” (FESCs) would be able to be reimbursed more adequately for the extended services provided to Medicare and Medicaid patients, as Medicare certified providers of these services.

Rural Health Clinics

A Rural Health Clinic is a clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is improving access to primary care in underserved rural areas. RHCs must provide outpatient primary care and laboratory services, and are required to use a team approach of physicians and midlevel practitioners such as nurse practitioners, physician assistants, and certified nurse midwives to provide services. The clinic must be staffed at least 50% of the time with a midlevel practitioner.

RHCs can be for-profit or non-profit entities, and can be either publicly or privately owned and operated. Medicare visits are reimbursed based on allowable costs, and Medicaid visits are reimbursed under the cost-based method or an alternative Prospective Payment System (PPS). This may result in an increase in reimbursement over typical Medicare and Medicaid fee-for-service reimbursement rates.²⁶

Rural Health Clinic certification was established under the Rural Health Clinics Act, passed by Congress and signed into law in 1977. The goal of this Act was twofold. First, it encouraged the utilization of physician assistants (PAs) and nurse practitioners (NPs) by providing reimbursement for services to Medicare and Medicaid patients by these health professionals, even in the absence of a full-time physician.²⁷ Second, it created a cost-based reimbursement

²⁶ Downloaded 08-17-09: http://www.raconline.org/info_guides/clinics/rhcfaq.php#whatis

²⁷ A physician assistant (PA) is a licensed health professional who practices medicine under the supervision of a physician. A physician assistant provides a broad range of health care services that were traditionally performed by a doctor. As part of the physician/PA team, a physician assistant exercises considerable autonomy in diagnosing and treating illnesses. What a physician assistant does varies with training, experience, and state laws. In general, PA's can provide approximately 80 percent of the services typically provided by a family physician. They perform physical exams, diagnose illnesses, develop and carry out treatment plans, order and interpret lab tests, suture wounds, assist in surgery, provide preventive health care counseling, and in 39 states, can write prescriptions. A PA can do whatever is delegated to him/her by the supervising physician and allowed by law. The scope of the PA's practice corresponds to the supervising physician's practice. For example, the PA working with a surgeon would be skilled in surgical techniques in the operating room, perform pre- and post-operative care, and be able to perform special tests and procedures.

Nurse Practitioner: The [American Academy of Nurse Practitioners](#) defines Nurse Practitioners as licensed independent practitioners who practice in ambulatory, acute and long term care as primary and/or specialty care providers. They provide nursing and medical services to individuals, families, and groups according to their area of practice/specialty. In addition to diagnosing and managing acute episodic and chronic illness, they also emphasize

(footnote continued)

mechanism for services when provided at clinics located in “underserved” rural areas.²⁸ Because of subsequent changes in the Medicare law authorizing Medicare Part B coverage for PAs and NPs in all practice settings (not just RHCs), the original incentive for utilizing PAs and NPs was diminished. However, because a RHC gets reimbursed the same amount from Medicare and Medicaid regardless of whether the patient is seen by a mid-level provider (MLP) such as a PA, NP, Certified Nurse Midwife (CMN), or physician, the clinic continues to have a strong incentive to utilize these practitioners whenever it is clinically appropriate.

In Alaska where a majority of rural primary health care programs have been run with funding from the Indian Health Services (IHS) and Section 330 Community Health Center grants (USDHHS Health Resources and Services Administration), the RHC program has not provided the same financial advantages that it has in other states. Tribally managed clinics have more favorable reimbursement rates than Rural Health Clinics for their Medicare and Medicaid patients. Also, many of the tribal clinics are already within the Community Health Center program.

There are currently three Medicare-certified Rural Health Clinics in Alaska: the Edgar Nollner Health Center in Galena, the Hoonah Midlevel Practice Clinic, and the Yakutat Community Health Center.

4. Physician, Dentist and Other Professional Offices

Many physicians and dentists in Alaska are practicing in solo practice offices, but many share professional office space with others or form group practice offices. Some are primary care physician offices, others include one or more specialties. Physicians and dentists, as well as other specialty service providers, are concentrated in Alaska’s largest communities, likely due to the amenities available, support staff availability, referral resources, and access to other resources. As noted above, about a third of health care jobs are in health practitioners’ offices, according to the industry survey data of the Alaska Department of Labor.²⁹ Thus in terms of practice settings, professional offices are the most common place of work.

Urgent care centers

Some physicians operate their office as an urgent care center or clinic. They have been established in Anchorage, Fairbanks, Juneau, Kenai, and the Matanuska-Susitna Valley. These can be operated by a single physician or group of practitioners, or the center can be affiliated with a hospital based health care system. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care, on an unscheduled or walk-in basis, but who’s condition is not serious enough to warrant a visit to a hospital emergency department. Often urgent care clinics are not open on a continuous basis, unlike a hospital emergency room,

health promotion and disease prevention, incorporating teaching and counseling of individuals, families, and groups as a major part of their practice.

²⁸ “Underserved” means that an area has too few providers to meet the needs of the population. For official designation as an “underserved” area, the area needs to be found to be a “health professional shortage area,” or HPSA, as defined in Federal regulations. The Alaska Primary Care Office in AKDHSS handles designation applications to the USDHHS health Services and Resources Administration, HRSA.

²⁹ Fried, N. “Alaska’s Health Care Industry,” *Alaska Economic Trends*, February 2008.

but provide extended hours compared to a primary care physicians office. They often provide basic laboratory and imaging services, and referral is made to the appropriate health care provider for follow-up care and treatment. Urgent care centers have the same licensing requirements as that of a primary care physician's office or practice.

5. Mid-Level Provider Clinics

Mid-level providers (MLPs) include Nurse Practitioners, Certified Nurse Midwives, and Physician's Assistants.³⁰ Clinics staffed by MLPs include a handful of private clinics established by these providers. Several community clinics (such as Gustavus and Hoonah) run by communities or tribal organizations have hired mid-level providers as full-time or part-time staff, since the community does not have a population base sufficient to support a physician practice. Another example of mid-level clinic models in use in Alaska is the workplace clinic model used on the North Slope, where oil companies provide contracted physician's assistant services for their employees.

6. Publicly provided clinical medical services

Services provided by state and local health departments include the Municipality of Anchorage and State Public Health Nursing and emergency preparedness immunization programs' services, Early and Periodic Diagnosis and Testing (EPSDT), home visits to high risk newborns and families (upon referral), newborn hearing screening, infectious disease follow-up including follow-up of contacts, Sexually Transmitted Diseases screening and partner management, foodborne outbreak follow-up, and other services.

Alaska Health Fairs and various periodic volunteer programs including the "Northern Edge" training program (sponsored and carried out by the military) bring additional screening, health education, and in some instances treatment services, to selected communities each year. Also, for several years, Anchorage Project Access has organized voluntary donations of services by physicians, especially specialists, and has matched patients with physicians. The Anchorage Neighborhood Health Center (providing primary care services as a Community Health Center) has referred a number of its patients requiring more highly specialized care than the CHC can provide.

7. Comment on Health Care Safety Net

"Health Care Safety Net" is a term used to refer to health care providers who are required by law to see patients regardless of ability to pay. The "health care safety net" includes a wide variety of providers delivering care to low-income and other vulnerable populations, including the uninsured and those covered by Medicaid. Major safety net providers include public hospitals and community health centers as well as teaching and community hospitals, private physicians, and other providers who deliver a substantial amount of care to these populations.

³⁰ Definition of NPs and PAs in previous footnote.

8. Health Facilities and the “Certificate of Need” Requirement

The Certificate of Need (CON) program as established in statute AS 18.07 is intended to promote the rational planning of health care facilities and health care services, improve citizen access to and choice of health care facility services, review the availability of qualified human resources available to staff facilities and provide services, contain the costs to the state for health care facility services paid for by public funds, and avoid the proliferation of unneeded health care facilities and services in the state through the application of approved standards, review of the needs and activities of an area, and considering input from residents.³¹

The certificate of need requirements of AS 18.07 apply to the following health care facilities licensed under AS 47.32:³²

- an acute care hospital;
- a critical access hospital;
- an ambulatory surgical center;
- an intermediate care facility for the mentally retarded;
- a nursing facility;
- a psychiatric hospital;
- a residential psychiatric treatment center.

The CON requirements also apply to certain health care facilities that are not licensed under AS 47.32: independent diagnostic testing facilities and kidney dialysis centers. For facilities other than nursing homes and residential psychiatric treatment centers, the process is required if costs will exceed \$1.3 million (as of 2009, threshold raised \$50,000 each fiscal year).

II. LONG TERM CARE SERVICES AND FACILITIES

Long term care is distinct from acute care, which focuses on curing an illness or restoring an individual to a previous state of better health. Long term care encompasses a broad range of assistance, services, and supports to meet health and personal care needs over an extended period of time, from nursing home care to home based assistance.

The primary goal of long term care services is to enable senior citizens and disabled individuals to remain in their homes or communities and includes not only health care but services necessary to maintain quality of life including such things as housing and transportation.

Long term care is provided in a range of settings known as a “continuum of care” depending on an individual’s needs and preference.³³ Most long term care is non-skilled personal care assistance, commonly referred to as custodial care, such as help performing everyday Activities of Daily Living (ADL) such as bathing and dressing, in the individual’s home. Another level of care in the patient’s home is home health care provided by skilled and licensed medical

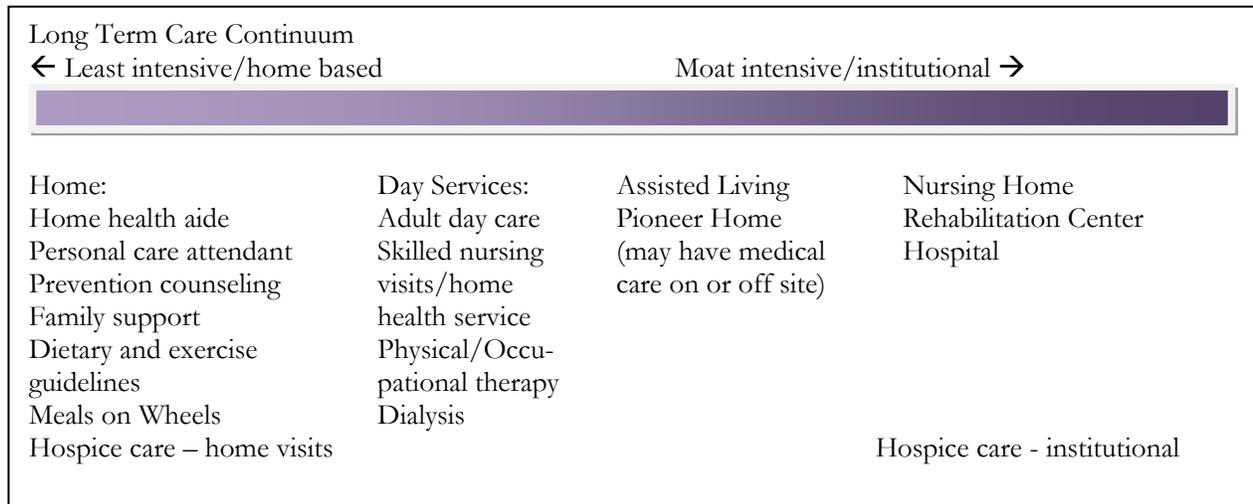
³¹ As articulated in public notice for regulations 8/12/2009

³² Certificate of Need Program website http://www.hss.state.ak.us/dph/healthplanning/cert_of_need/

³³ Definitions for *Continuum of Care Matrix*, <http://www.hss.state.ak.us/dph/healthplanning/movingforward/matrices/RDdefs.htm>

professionals. Alaska currently has 16 licensed Home Health Care agencies which provide skilled medical care to patients in their homes. Of these 16 agencies, nine are hospital based.

When a patient is terminally ill, regardless of age, hospice care can be a choice for the patient and their family. Hospice care provides support by both medical professionals and trained volunteers focusing on the palliation, or relief of symptoms, of a terminally ill patient. This support can be physical, emotional, spiritual, or social. The State currently has 12 licensed Hospice agencies.



Senior housing provides living arrangements designed for handicapped accessibility and convenient access to services. When a senior citizen or disabled individual is no longer able to remain in his or her own home, or with supportive family members, other types of residential care may be available to allow the person to remain in the community. Group homes with assistive services are called “assisted living” facilities. Alaska Pioneer Homes are state-run assisted living homes. Assisted living beds (other than Pioneer Homes) average 2200 annually according to State Certification and Licensing, in about 260 homes.³⁴ The six Pioneer Homes have 508 beds. Skilled Nursing Facilities (SNFs) or nursing homes provide intensive services for those needing a higher level of care. They offer both short and long-term placements for senior who require significant nursing interventions each day. Alaska has 15 nursing homes with 716 beds.³⁵

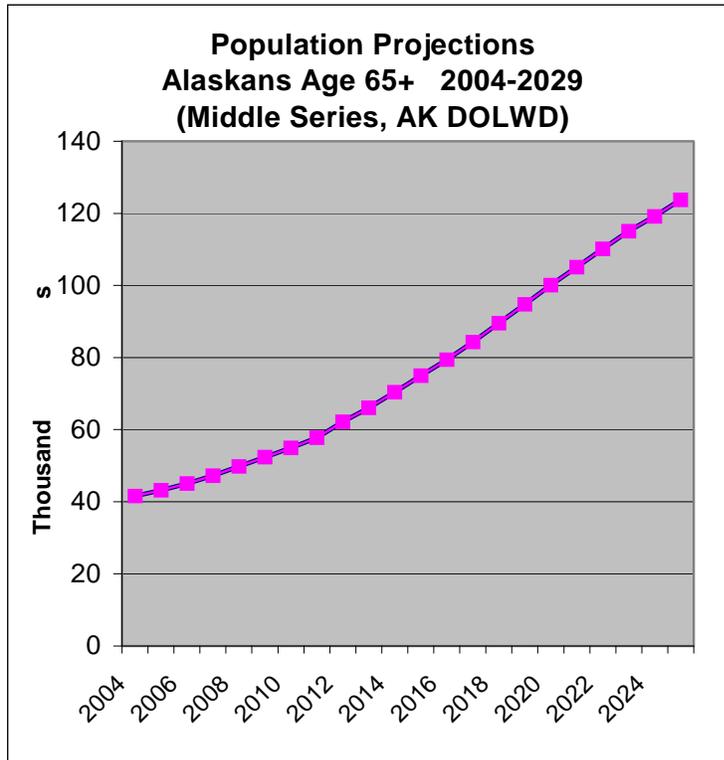
Assuming that age-specific migration and mortality patterns will remain similar to the current (2000-2005) patterns, it is projected that the population aged 65 and older will nearly triple by 2025, from about 43,000 people in 2005 to about 124,000 in 2025.³⁶ Those who are 85 and over have the highest rates of use of long term care.

³⁴ 2009 count is 269 licensed senior assisted living facilities with 2,346 beds.

³⁵ Current Facilities List, by email from Certification and Licensing, July 31, 2009

³⁶ Alaska Population Projections, Alaska Department of Labor, 2007

The Commission on Aging along with the Department of Health and Social Services, through their 2008-2011 Plan identifies the goal of Alaska seniors staying in their communities, and having access to an integrated array of health and social supports along the continuum of care.³⁷ These goals identify the concern for individuals to be able to maintain quality life through the least invasive and expensive services required in the continuum of care.



The goal of keeping people in their homes and communities is also expressed through planning for services for individuals with developmental disabilities, to provide home and community based services where possible, for housing and support for employment.

Selected Agencies Providing Long Term Care Services	Number	Types of Employees	Beds (if applicable)
Home Health	16	PCA, Home Health Aide, RN	n.a.
Hospice	12	RN, LPN, Volunteers, LSW, others	n.a.
Senior Center	45*		n.a.
Pioneer Home	6		550
Assisted Living	269		2,346
Nursing Homes	15	RN, LPN, aides, physician supervision	716

*45 senior centers receive state or tribal funding; several others are known to exist with community funding.

³⁷ <http://www.hss.state.ak.us/acoa/StatePlan.htm>

III. BEHAVIORAL HEALTH FACILITIES

Facilities that offer care to people with mental illness and substance abuse problems range from community clinics (least intensive services) to hospitals for acute psychiatric care (North Star with 74 beds and Alaska Psychiatric Institute with 80 beds). Additional hospitals in Juneau, Fairbanks and regional hubs provide evaluation, stabilization, and short-term treatment and referral. Thirteen (13) non-profit organizations receive grants to provide residential substance abuse treatment.³⁸ Detoxification beds are available in Anchorage, Juneau, and Fairbanks.

Alaska has six Residential Psychiatric Treatment Centers in Anchorage for youth (total 183 beds), and a total of 438 residential psychiatric beds for youth (2009), distributed as follows:

- Northwest: 14
- Southwest: 13
- Anchorage/Mat-Su: 165
- Southeast: 114
- Interior: 117
- Kenai/Kodiak: 15

In addition, there are approximately 320 beds in “Treatment Resource Homes” with behavioral health services for youth. Most are located in the Anchorage Municipality and Matanuska-Susitna Borough.

Agencies across the state receive grant funds from the Department of Health and Social Services and the [Alaska Mental Health Trust Authority](#)³⁹ to assist residents with behavioral health needs and help to prevent suicide, substance abuse, and other problems. Approximately 65 organizations are receiving grants from the Department of Health and Social Services Division of Behavioral Health in FY 2010 to provide behavioral health treatment and recovery services. (See [Behavioral Health Grantees List](#)).

³⁸ These are:

Sitka Counseling and Prevention
Rainforest Recovery
Southeast Alaska Regional Health Corporation
Salvation Army Clitheroe
Southcentral Foundation
Akeela, Inc.
Volunteers of America - ARCH
Alaska Rehabilitation Services - Nugen's Ranch
Bristol Bay Area Health Corporation
Central Peninsula Hospital - Serenity House
Tanana Chiefs Conference
Fairbanks Native Association
Yukon Kuskokwim Health Corporation

³⁹ The Alaska Mental Health Trust Authority is a state corporation that administers the Alaska Mental Health Trust, a perpetual trust managed on behalf of [Trust beneficiaries](#). The Trust operates much like a private foundation, using its resources to ensure that Alaska has a [comprehensive integrated mental health program](#) to serve Trust beneficiaries. Detailed elements of the program are included in the Alaska Statutes. (AS 47.30)

By default, the Department of Corrections (DOC) has become the single largest provider of mental health care in Alaska. A 2006 study found that approximately 42 percent (1,524 of 3,628 as of June 30, 2006) of the people incarcerated in Alaska correctional facilities were Trust beneficiaries, with mental illness, substance-related disorders and/or mental disabilities.⁴⁰ Also many youth within the Division of Juvenile Justice system have a co-occurring disorder (substance related disorder accompanied by a mental health disorder). A current alternative to incarceration for adults with severe mental illness is diversion into Anchorage or Palmer Coordinated Resources Projects (therapeutic courts). Therapeutic court programs are also operating in Bethel and Fairbanks.

The DHSS Behavioral Health Integration Project, supported by the Co-occurring State Incentive Grant (COSIG) from SAMHSA, has developed the state's capacity to serve clients with co-occurring disorders. Integration of behavioral health and primary care has been advanced by some Section 330 Community Health Centers that have received special funding from HRSA to include services for mental health and substance abuse.

The Department of Health and Social Services coordinates with the Alaska Mental Health Trust Authority and associated boards to develop the [Comprehensive Integrated Mental Health Plan](#) to address the needs of Alaskans with mental and emotional illness, alcoholism and substance use disorders, brain injury, developmental disabilities, and Alzheimer's disease and related dementia. The Department and the Trust convene the interested parties to review and plan for population needs, facilities, workforce, and multiple program initiatives.

IV. EMERGENCY MEDICAL SERVICES

Seven Regional EMS Programs (three non-profit EMS councils, three programs based in regional health corporations, and one program residing in a borough-wide fire department) work with the community-based emergency medical services to be sure that emergency medical services personnel (EMTs) are available to respond to the emergency medical needs of Alaska's citizens and visitors, and to be sure that the personnel and their ambulances and air transport are properly equipped. The State Division of Public Health and Alaska Council on EMS have duties to certify EMTs and work with the EMS programs on their training, reporting and assurance of adequate equipment. "Medevacs" (air rescues) play a major role in Alaska.

⁴⁰ Hornby Zeller Associates, Inc. (December, 2007). *A Study of Trust Beneficiaries in the Alaska Department of Corrections*, p. ii. This does not include individuals in custody in community residential centers or in the contracted facility in Arizona.

C. Health Care Providers

Health care professionals include a variety of specialists and primary care providers in medicine, dentistry, mental health and substance abuse services, and support services. In recent years, concerns about current and potential shortages of health care professionals have led to several studies of supply and demand, recruitment, and retention of physicians and other health care providers in Alaska.⁴¹

Primary Care and Specialty Medical Providers

Primary care services in Alaska are provided by a spectrum of providers, including over 800 primary care physicians, many of about 700 licensed mid-level providers (physician assistants and nurse practitioners), and about 550 Community Health Aides and Community Health Practitioners (see description below). The state licensing database (relying on address listed by the license applicant) shows that most physicians are located in larger communities, those with at least 1,000 people. Some of the physicians and mid-level practitioners practice in Community Health Centers and Rural Health Clinics (RHCs).

Several of the smallest hospitals have hired physicians directly to ensure staffing, and most larger hospitals as well as the tribally managed facilities have hired physician staff members, to serve as emergency room physicians, “hospitalists,” or generalists who work in outpatient, inpatient and itinerant services.

Three quarters of primary care physicians (including family practice doctors, internists, pediatricians and obstetrician-gynecologists) are in the Anchorage-Wasilla, Fairbanks and Juneau areas. Recruitment and retention are difficult in remote areas. Turnover of health personnel is an ongoing problem.

The National Health Service Corps “scholars” program (with six placements in Alaska in 2009) and loan repayment program (with ten placements in Alaska in 2009), and the Indian Health Service loan repayment program, provide financial support in exchange for service for physicians and mid-level providers committed to work in health professional shortage areas.⁴² A federal grant approved in September 2009 for a state-federal loan repayment program will expand the loan repayment opportunities for at least two years.

⁴¹ Securing an Adequate Number of Physicians for Alaska’s Needs, [Alaska Physician Supply Task Force Report, August 2006](http://www.hss.state.ak.us/commissioner/Healthplanning/publications/assets/PSTF-06.pdf) <http://www.hss.state.ak.us/commissioner/Healthplanning/publications/assets/PSTF-06.pdf>;

SORRAS I: Status of Recruitment Resources and Strategies (2004), <http://www.hss.state.ak.us/dph/healthplanning/publications/assets/SORRASreport.pdf>;

SORRAS II: Status of Recruitment Resources and Strategies 2005–2006, http://nursing.uaa.alaska.edu/acrh/projects/sorras_report05-06.htm ; and Alaska Center for Rural Health, 2007 Alaska Health Workforce Vacancy Study, http://nursing.uaa.alaska.edu/acrh/index_downloads/workforce_7-24-07_body-final.pdf

⁴² For explanation and criteria for shortage designations, see Alaska Primary Care Office webpage http://www.hss.state.ak.us/dph/healthplanning/primarycare/PC_home.htm and USDHHS Health Resources and Services Administration, Shortage Designation Branch, <http://bhpr.hrsa.gov/shortage/>

Specialists are more likely to be in the largest urban areas where they can rely on access for their patients to the tertiary care hospitals (those with more advanced services), the support staff and other support services that can support their practices. Ninety one percent of psychiatrists practice in the Anchorage-Wasilla, Fairbanks and Juneau areas, and 89% of other specialists are located in these urban areas.

Figure [#] Licensed Physician, Mid-level and Dental Workforce, by Type, by Region. 2009

Region/Census Area	Medical Doctor	Osteo-path	Physician Assistant	Nurse Practitioner	Dentist	Hygienist
Statewide	1461	122	320	490	486	444
Anchorage/Mat-Su	967	76	179	315	279	287
Gulf Coast	112	15	29	48	53	50
Interior	163	17	55	52	70	50
Northern	19	5	14	9	10	5
Southeast	162	6	22	47	55	48
Southwest	38	3	21	19	19	4
Statewide	100%	100%	100%	100%	100%	100%
Anchorage/Mat-Su	66%	62%	56%	64%	57%	65%
Gulf Coast	8%	12%	9%	10%	11%	11%
Interior	11%	14%	17%	11%	14%	11%
Northern	1%	4%	4%	2%	2%	1%
Southeast	11%	5%	7%	10%	11%	11%
Southwest	3%	2%	7%	4%	4%	1%

*Generalists and Specialists (34 are licensed as specialists, without a “generalist” license)

Source: Alaska Division of Corporations, Business and Professional Licensing, Department of Commerce, Community, and Economic Development (2009).

Figure [#]. Alaska Physicians with Active Licenses, by Region and by Specialty, 2009

Specialty Group:	Anchorage -Mat-Su	Gulf Coast	Interior	North	South- east	South- west	Grand Total
FAMILY PRACTICE	207	57	41	21	67	27	420
INTERNAL MEDICINE	142	12	32	1	19	2	208
PEDIATRICS	91	2	13		13	5	124
OBSTETRICS AND GYNECOLOGY	59	3	9		2		73
GENERAL PRACTICE			1				1
PRIMARY CARE Total:	499	74	96	22	101	34	826
SURGERY	117	17	21		17		172
EMERGENCY MEDICINE	63	9	15		13	2	102
ANESTHESIOLOGY	68	4	12		6		90
PSYCHIATRY	64	5	8		11		88
RADIOLOGY	37	7	8	1	7		60
PATHOLOGY	24	2	3		1		30
OPHTHALMOLOGY	21	2	4		2		29
OTOLARYNGOLOGY	22	1	4		2		29
NEUROLOGY	14	2	2		1		19
UROLOGY	15	1	1		1		18
PHYSICAL MEDICINE/REHABILITATION	13				1		14
CARDIOVASCULAR DISEASE	13						13
DERMATOLOGY	8	1	2				11
MEDICAL ONCOLOGY	5						5
PREVENTIVE MEDICINE	4				1		5
RADIATION ONCOLOGY	4		1				5
AEROSPACE MEDICINE	1	1	1			1	4
ALLERGY AND IMMUNOLOGY	3				1		4
GASTROENTEROLOGY	4						4
NEONATAL-PERINATAL MEDICINE	3						3
OCCUPATIONAL MEDICINE	3						3
RHEUMATOLOGY	3						3
ANATOMIC AND CLINICAL PATHOLOGY	1				1		2
ENDOCRINOLOGY, DIABETES, AND METABOLISM	2						2
INFECTIOUS DISEASE	2						2
NEPHROLOGY	2						2
PEDIATRIC CARDIOLOGY	2						2
INTERVENTIONAL CARDIOLOGY	1						1
PEDIATRIC HEMATOLOGY-ONCOLOGY	1						1
PSYCHIATRY AND NEUROLOGY			1				1
PULMONARY DISEASE			1				1
SPORTS MEDICINE	1						1
Grand Total	1020	126	180	23	166	37	1552
Population (2008 Population Estimates)	367509	75876	104421	23612	69202	39100	679720
Physicians per 1000 population	2.78	1.66	1.72	0.97	2.40	0.95	2.28

Source: July 2009 Occupational Licensing Database. Active (AA status) resident physicians.

Nurses: RNs and LPNs are licensed; Certified Nurse Aides and Personal Care Attendants are not licensed. It should be noted that many nurses cycle into and out of Alaska from out-of-state employment services that help to fill needs for either specialist or generalist nurses, when local supply is insufficient to meet local needs. Data on numbers of such seasonal and/or temporary nurses is not available.

Region/Census Area	RN (Registered Nurse)	Practical Nurse
Statewide	6334	735
Anchorage/Mat-Su	4089	412
Gulf Coast	629	67
Interior	731	150
Northern	90	24
Southeast	660	70
Southwest	135	12
Statewide	100%	100%
Anchorage/Mat-Su	65%	56%
Gulf Coast	10%	9%
Interior	12%	20%
Northern	1%	3%
Southeast	10%	10%
Southwest	2%	2%

Physical and Occupational Therapists, active and resident in Alaska, August 2009:

Region/Census Area	Physical Therapists	Occupational Therapists
Statewide	421	186
Anchorage/Mat-Su	269	123
Gulf Coast	49	24
Interior	51	18
Northern	1	1
Southeast	43	20
Southwest	8	0
Statewide	100%	100%
Anchorage/Mat-Su	64%	66%
Gulf Coast	12%	13%
Interior	12%	10%
Northern	0%	1%
Southeast	10%	11%
Southwest	2%	0%

Pharmacists: 471 pharmacists and 1246 pharmacy technicians are licensed in 2009 in Alaska. The vacancy study by Alaska Center for Rural Health suggests that there is a serious shortage of these professionals.

Region/Census Area	Pharmacist	Pharmacy Tech
Statewide	471	1,246
Anchorage/Mat-Su	294	778
Gulf Coast	51	125
Interior	59	160
Northern	3	35
Southeast	55	130
Southwest	9	18
Statewide	100%	100%
Anchorage/Mat-Su	62%	62%
Gulf Coast	11%	10%
Interior	13%	13%
Northern	1%	3%
Southeast	12%	10%
Southwest	2%	1%

Behavioral Health Providers

Many rural Alaska communities have either only part-time workers helping with behavioral health needs or no mental health services other than the occasional itinerant provider. The *2009 Alaska Health Workforce Vacancy Study*⁴³ showed that the vacancy rates for all behavioral health occupations were about 10%, with psychiatrist and clinical psychologist vacancy rates about 16% statewide.

To help bridge the gaps in services, the Alaska Native Tribal Health Consortium has been developing a training certification program for behavioral health aides (BHAs). Currently there are 117 village-based behavioral health aide positions throughout the state, being funded by multiple sources. (Not all of these positions use the title BHA but they all operate within the BHA scope of practice). Where possible, BHA services are integrated into primary care settings.

Behavioral health professionals with current active licenses in Alaska (in August 2009) include 88 psychiatrists; 132 clinical psychologists (PhD); 417 licensed professional counselors; 77 marriage and family therapists; 488 social workers (bachelor's and master's level); and 40 psychological associates. Approximately 480 certified chemical dependency counselors, counselor technicians, and traditional counselors provide services throughout the state; many also have state behavioral health professional licenses. The levels and requirements for certification for the many categories of provider are summarized on the website of the Alaska Commission for Behavioral Health Certification.⁴⁴

⁴³ <http://nursing.uaa.alaska.edu/acrh/>

⁴⁴ [Alaska Commission for Behavioral Health Certification](http://www.nattc.org/getCertified/certification.asp?oldID=sakacbhc)
<http://www.nattc.org/getCertified/certification.asp?oldID=sakacbhc>

Sixty four of the State's 88 active licensed psychiatrists (73%) are located in Anchorage-Mat-Su area. Seventy percent of psychologists are in this area. Many are in private practice, others work partially or wholly as contractors or employees within the tribal system, the military or not-for-profit service agencies. Several Alaska-based and out of state psychiatrists itinerate to regional medical centers to provide psychiatric assessments and to oversee treatment for residents. Telemedicine has become a tool for increasing access to psychiatric services with links to remote sites across the state, through the tele-behavioral health program based at the Alaska Psychiatric Institute, the telebehavioral health network based at the Alaska Native Health Consortium, and through the Department of Corrections' links to prisons from Anchorage.

Active Alaska Resident Licensed Providers in Behavioral Health (August 2009)

Region	Psychiatrist	Clinical Psychologist	Licensed Professional Counselor	Marriage & Family Counselor	Clinical Social Worker (BA, MSW, LCSW)	Psych Associate
Statewide	88	132	417	77	488	40
Anchorage -Mat-Su	64	92	230	51	259	30
Gulf Coast	5	10	30	6	41	3
Interior	9	16	64	9	71	6
North	0	1	10	0	13	0
Southeast	10	12	65	6	68	1
Southwest	0	1	18	5	36	0
Statewide	100%	100%	100%	100%	100%	100%
Anchorage -Mat-Su	73%	70%	55%	66%	53%	73%
Gulf Coast	6%	8%	7%	8%	8%	8%
Interior	10%	12%	15%	12%	15%	16%
North	0%	1%	2%	0%	3%	0%
Southeast	11%	9%	16%	8%	14%	3%
Southwest	0%	1%	4%	6%	7%	0%

ALLIED HEALTH PROVIDERS

Allied health professions are clinical health care professions distinct from medicine, dentistry, and nursing, but generally supporting those services in helping to meet patients' needs. Although they are an integral part of the overall delivery of care and assist in making the health care system function, there is relatively little information tracking these workers, except for the categories of workers for whom licensure is required by state law. Their salaries and other costs are generally rolled into administrative or program costs. The Alaska Center for Rural Health at University of Alaska Anchorage conducted a study called the Alaska Health Care Workforce

Vacancy Study which identified allied health providers employed, positions available and vacancies.⁴⁵ Also, the Occupational Database files posted by the Alaska Department of Labor provide regular reports of employment by quarter, and total workers employed in each occupation each year, by standardized occupational code. Selected allied health occupations are listed in the following table, showing the average quarterly employment in Alaska for 2007 calendar year.

Figure [#] Allied Health Employment (Average per Quarter, 2007)

Occupation	Average quarterly employment
Dental Assistant	1079
Dental Hygienist	584
Dental Lab Tech	59
EMT/ETT & Paramedic (308 licensed paramedics '09)	356
Medical & Clinical Lab Technician	297
Medical & Clinical Lab Technologist	238
Medical Records Technician	433
“Other” health technician (SOC code 292099)	401
Optician (74 licensed as dispensing opticians '09)	140
Optometrist (98 licensed, '09)	30
Pharmacy Technician (1126 licensed '09)	544
Psychiatric Technician	253
Physical Therapy Assistant	52
Radiologic Technician	428
Respiratory Therapist	165
Sonographer	39
Surgical Tech	94

Source : Alaska Department of Labor and Workforce Development, Occupational Database, <http://laborstats.alaska.gov/?PAGEID=67&SUBID=212>, accessed 8/10/2009

IV. PARAPROFESSIONALS (CHA/P, DHA, BHA)

The Community Health Aide (CHA) Program was developed in the 1950s in response to a number of health concerns including the tuberculosis epidemic, high infant mortality, and high rate of injuries in rural Alaska. In 1968, the CHA Program received formal recognition and congressional funding. The long history of cooperation and coordination between the federal and state governments and the tribal health organizations has facilitated improved health status in rural Alaska.

⁴⁵ http://nursing.uaa.alaska.edu/ACRH/projects/archives/ahw_vacancy.htm

The CHA Program now consists of a network of approximately 550 Community Health Aides/Practitioners (CHA/Ps) in over 170 rural Alaska villages. CHA/Ps work within the guidelines of the 2006 *Alaska Community Health Aide/Practitioner Manual*, which outlines assessment and treatment protocols. There is an established referral relationship, which includes mid-level providers, physicians, regional hospitals, and the Alaska Native Medical Center. In addition, providers such as public health nurses, physicians, and dentists make visits to villages to see clients in collaboration with the CHA/Ps.

The Alaska Area Native Health Service has the responsibility for provision of medical and health related services to Indian Health Service beneficiaries residing in Alaska. These services are provided by tribal organizations within the Alaska Tribal Health System. The village based CHA/Ps are a vital link in the delivery system.

Community Health Aides are selected by their communities to receive training. Training centers are located in Anchorage, Bethel, Nome, and Sitka. There are four sessions of CHA training; each lasts three to four weeks. Between sessions, the CHAs work in their clinics completing a skills list and practicum. Completion of the four session training curriculum and successful completion of a clinical skills preceptorship and examination, qualify the CHA as a Community Health Practitioner (CHP). CHA/Ps at any level of training may obtain certification by the Community Health Aide Program Certification Board.

The Community Health Aide Program model is currently being used as a template to develop programs in the areas of dental care, behavioral health, and elder care.⁴⁶

VI. COMPLEMENTARY AND ALTERNATIVE HEALTH PRACTITIONERS

The National Library of Medicine (Medical Subject Headings (MeSH) Section, 2002) classifies alternative medicine under the term complementary therapies. This is defined as therapeutic practices which are not currently considered an integral part of conventional allopathic medical practice. Therapies are termed as *Complementary* when used in addition to conventional treatments and as *Alternative* when used instead of conventional treatment.

The Office of Alternative Medicine, National Institutes of Health (Bethesda, Maryland, April 1995) defined “complementary and alternative medicine (CAM) as a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well being. Alternative therapies include, but are not limited to folk medicine, herbal medicine, diet fads, homeopathy, faith healing, new age healing, chiropractic, acupuncture, naturopathy,

⁴⁶ <http://www.akchap.org/GeneralInfo.cfm>

massage, and music therapy. In Alaska, licensed alternative or complementary providers are chiropractors, acupuncturists and naturopaths.⁴⁷

Region/Census Area	Licenced Complementary/Alternative Providers		
	Chiropractors	Acupuncturists	Naturopaths
Statewide	220	74	37
Anchorage/Mat-Su	141	48	22
Gulf Coast	25	10	3
Interior	23	7	8
Northern	3	0	0
Southeast	24	9	4
Southwest	4	0	0
Statewide	100%	100%	100%
Anchorage/Mat-Su	64%	65%	59%
Gulf Coast	11%	14%	8%
Interior	10%	9%	22%
Northern	1%	0%	0%
Southeast	11%	12%	11%
Southwest	2%	0%	0%
Source: Alaska Division of Corporations, Business and Professional Licensing, Department of Commerce, Community, and Economic Development (2009).			

⁴⁷ <http://www.pitt.edu/~cbw/altm.html>

Figure [#] Summary of Major Health Occupational Groups' Employment Levels, 2007

Occupational Database: Alaska Health Care Employment	Calendar Year 2007 Employment	
	Total People Employed in the Jobs during 2007	Average Quarterly Employment 2007
("Covered employment" -- does not include self-employed or military)		
Allied Health	13,952	9,422
Nursing	10,088	7,581
Home Health Aides	3,497	2,191
Behavioral Health Professionals	3,480	2,394
Dental	2,805	1,806
Other professionals	2,737	1,941
Administration	1,719	1,304
Physicians	1,070	804
Lab techs	819	552
Pharmacists, Podiatrists & Speech/Language Pathologists	723	533
Mid-Levels (Physician Assistants, Nurse Practitioners)	595	382
EMTs (emergency medical technicians)	553	356
Radiologic Techs	547	428
Chiropractors	62	45
<i>Grand Total</i>	<i>42,647</i>	<i>29,737</i>

Source: Alaska Department of Labor and Workforce Development, Research and Analysis Section

The worksheet contains the count of workers by occupation for the calendar year. These files are continuously updated and posted to the Web periodically. Six months must pass before data for a particular quarter is considered complete.

The Occupational Database (ODB) contains occupation and place of work information for each wage and salary worker covered by unemployment insurance employed in Alaska. This data series differs from others published by Research and Analysis in that it provides information on each unique worker/employer combination rather than an average monthly employment count or a count of the number of jobs at a particular point in time.

Worker Count Data Limitation: The count of workers is comprised of each unique worker/employer combination. Workers holding jobs with multiple employers are counted more than once.

The worker count is presented for each calendar quarter and summarized for the calendar year. The calendar year totals represent the unique worker/employer count. An employee working all four quarters for the same employer is counted only once.

Occupation codes are based on the Standard Occupational Classification (SOC) system as published by the Office of Management and Budget in October 2000.

Self-employed are NOT included in the figures above. Note that 45 chiropractors were employed on average each quarter in "covered" employment – however there are 218 licensed chiropractors in Alaska with active licenses, so it is likely many are self-employed, not in employment covered by unemployment insurance.

D. HEALTH INFORMATION TECHNOLOGY

HEALTH INFORMATION TECHNOLOGIES IN ALASKA

Health Information Technology (HIT) is expected to be a means to achieve more affordable, safe, and accessible health care. Digital applications available for use by health-care providers and organizations include personal health records (PHRs), electronic health records (EHRs), electronic medical records (EMRs), computerized physician order entry (CPOE) systems, and health information exchange (HIE) systems. All are governed by privacy and confidentiality regulations. Each of these refers to a different set of services:

- Personal health records are records the patient can have in his/her possession, to share with any health care provider seen, and have updated with each visit. Digital PHRs may be kept on a digital memory stick for the patient to carry. They may be self-contained or a copy of a record maintained by a provider.
- Electronic health records and electronic medical records are the mechanisms for replacing paper records with digital ones, that can be easier for doctors or other providers to “search” for medical history, prescriptions and lab results, and that can be stored locally or in a remote location for electronic retrieval or for “exchange” with another provider. Although they are often used interchangeably, there is a difference between EHR and EMR. The EHR is a comprehensive, longitudinal, record of the patient’s medical history or complete medical record. EMR refers to the individual pieces of the EHR such as laboratory results, electrocardiograms, prescriptions, history and physical exams, post operative reports, radiology reports, etc.
- Computerized physician order entry (CPOE) is a process of electronic entry of medical practitioner instructions for the treatment of patients (particularly hospitalized patients) under his or her care. These orders are communicated over a computer network to the medical/nursing staff or clinical departments (pharmacy, laboratory or radiology) responsible for fulfilling the order. CPOE has the potential to decrease delays in order completion, reduce errors related to handwriting or transcription, allows order entry at the point-of-care or off-site, provides an opportunity to double check for duplicate or incorrect doses or tests, and simplifies inventory and posting of charges
- Health information exchange systems provide for electronic transfer of patient record information for various possible purposes: to store records in a central place for programs that have multiple service sites; for sending referrals or requested, approved reports between providers. Such information can be limited or comprehensive according to the permissions granted to a potential recipient based on need to know and the patient’s requests and approvals.

Digital telehealth systems, such as teleradiology, laboratory reports, telebehavioral health, telepharmacy, and distance learning systems utilizing videoconferencing equipment are also emerging as ways intended to be cost-effective means to improve health care quality and outcomes.

ELECTRONIC HEALTH RECORD USE IN ALASKA

The Alaska EHR Alliance completed a state-wide survey of physicians (378 respondents) and clinic managers (62 respondents) to assess the status of EHR use in Alaska. 29 communities were represented in the survey.⁴⁸ This survey found that there are currently at least 55 different EHR systems currently being used in healthcare practices across the state. Of those 55 different EHR systems, no single entity holds a significant portion of the EHR market in Alaska with the two leading products being Centricity (11%) and eClinicalWorks (8%). Most (74%) of EHRs in use include a practice management system. Half of the EHRs are connected to labs and one third are connected to one or more pharmacy. One third of the EHRs in the survey did not connect to any other entity.

E-PRESCRIBING

Adoption of e-prescribing has been identified as being critically important to the advancement of e-Health. E-prescribing is recognized as a gateway technology that could speed the development of EHRs and widespread use of other HIT initiatives. Beginning January 1, 2009, CMS will provide an incentive to “successful e-prescribers.” The Medicare e-Prescribing incentive is a new program authorized under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008. The program begins January 1, 2009, and provides incentives for eligible professionals who are “successful e-prescribers.” Efforts to maximize implementation of e-prescribing systems statewide could result in increase systemic use of other e-health components such as personal health records and electronic health records in both the private and public sectors of health care.

Additionally, there is a disincentive for health-care providers who do not become “successful e-prescribers” by 2012. Under rules adopted by the USDHHS Center for Medicare and Medicaid Services (CMS), eligible professionals who are not “successful e-prescribers” by 2012 will be subject to a differential payment (penalty) for Medicare services beginning in 2012. The differential payment would result in the physician getting 99 percent of the total allowed charges of the eligible professional’s physician fee schedule payments in 2012, 98.5 percent in 2013, and 98 percent in 2014.

HEALTH INFORMATION EXCHANGE SYSTEM DEVELOPMENT

The current “system” of health information exchange for Alaskan healthcare providers is a conglomeration of disparate systems with a variety of capabilities and structural platforms that may or may not be interoperable with each other. An integrated Health Information Exchange HIE system is needed to bring the disparate systems together into one functional product that will improve access to critical health information by healthcare providers and the citizens of Alaska in an interoperable, secure, safe, and efficient manner.

Senate Bill 133 (SB 133), passed in the 2009 legislative session, is intended to modernize Alaska’s health-care IT infrastructure by providing for development of a secure electronic Health Information Exchange (HIE) system that will bridge connections between disparate EHR

⁴⁸ Status of EHR Use In Alaska, 05/11/ 2009:
http://www.aehra.org/images/downloads/summary_of_ehr_survey_findings_52009.pdf retrieved 08/11/2009

systems. A standards-based HIE will allow individual Alaskans to manage their own personal health records and to authorize their personal health-care providers to exchange electronic medical records in a timely, secure manner. The intended outcome of a fully implemented Alaska Health Information Exchange Network is to improve the patients' access to care, reduce unnecessary testing and procedures, improve patient safety, reduce health agency administrative costs, and enhance rapid response to public health emergencies.

The Alaska Department of Health & Social Services is in the process of soliciting proposals for the statewide HIE Entity as authorized by SB 133.

TELEHEALTH

The Alaska Federal Health Care Access Network (AFHCAN) is a telehealth system composed of 248 sites across the state. A total of 44 federal beneficiary organizations participate in the network, including Native and tribal groups, veteran and military providers, and the state of Alaska. AFHCAN initially focused on developing store-and-forward telehealth solution, but has recently expanded into broadband video conferencing telehealth solutions. Store-and-forward solutions were initially developed in response to the limited availability of broadband connectivity in Alaska. Now, however, broadband connectivity supports the larger data payloads and image sets that are often part of an electronic consultation. It has become clear that store-and-forward telehealth offers significant advantages in a distributed multi-organizational health-care environment due to the flexibility it affords providers to respond to cases at their convenience.

Every year, the Alaska Native Medical Center (ANMC) responds to approximately 3,000 telehealth cases and handles 66 percent of these consultations in the same day. Perhaps more impressive is that 50 percent of these cases are responded to within 60 minutes. While store-and-forward was specifically designed to enhance primary care access, approximately 25 percent of all cases today are specialty consultation requests. Video conferencing capacity is also increasing at a rate of three to four times every 12–18 months, with a large deployment of endpoints (funded through the Alaska Federal Health Care Partnership) planned at ANMC in 2009–10 consistent with the growth of video teleconferencing capability at most of the regional health corporations throughout Alaska.

Department of Corrections psychiatric services unit has used video conferencing since [2000], for Anchorage-based psychiatrist and psychologist to provide follow-up and counseling to prisoners in facilities around the state.

The Alaska Psychiatric Institute (API) Tele-Behavioral Health care Services (TBHS) program was originally envisioned under the auspices of the Alaska Telehealth Advisory Council to serve rural communities in south-central and northern Alaska. The API TBHS multidisciplinary team of mental health clinicians provides behavioral health-care services to rural communities throughout Alaska by way of advanced video-teleconferencing technology. The program has continued to grow in the specific number of sites that may access psychiatry because of continuing integration with other information technology, video teleconferencing, and health-care provider networks across Alaska, including the Alaska Native Tribal Health Consortium,

Alaska Federal Health Care Access Network (AFHCAN), the Alaska Rural Telehealth Network (ARTN), and GCI Connect M.D., a medical network that is comprised of over 200 facilities including clinics, hospitals, and medical corporations in the Pacific Northwest and Alaska.⁴⁹

The Alaska Rural Telehealth Network (ARTN) is operational in 11 communities across Alaska, including Soldotna, Cordova, Petersburg, Wrangell, Valdez, Kodiak, Seward, Sitka, Glennallen, Unalaska, and Homer. All sites have digital X-ray capability and most have digital mammography. A Picture Archive and Communications System (PACS) has been implemented system-wide. The PACS is a computer network dedicated to the storage, retrieval, distribution, and presentation of various types of images including ultrasound, mammography, X-ray, computerized tomography (CT), and positron emission tomography (PET). It allows facilities to have their images read from an off-site location (i.e. a Radiologist not located in their facility), which is commonly referred to as teleradiology. The PACS also replaces the need for facilities to maintain hardcopy images on-site by digitally archiving the diagnostic images on the central storage facility – a server located at the Wide Area Network (WAN) core in Anchorage.

DRAFT

⁴⁹ GCI ConnectM.D., Medical Network Overview: <http://www.connectmd.com/mednet.htm> retrieved 04/05/2009.

II. HOW HEALTH CARE IN ALASKA IS FUNDED

A. Introduction

Health care in Alaska is funded by individuals, businesses, and local, state and federal government sources. Individuals pay out-of-pocket costs and contributions to insurance premiums amounting to one fifth of total expenditures. Businesses contribute almost another fifth of the total through purchase of insurance premiums, support for self-insurance programs, and worker’s compensation medical benefits. Together the individual and business contributions, “private” sources, account for 38 percent of the total – just under \$2 billion of the \$5.3 billion total expenditures for health care in Alaska in 2005.

The most comprehensive recent Alaska-focused analysis of funding of health care (not including public health activities or facility construction) by ISER (UAA Institute of Social and Economic Research), identified Federal Government programs as the largest purchaser of these services, accounting for another 38 percent of the total -- \$2 billion of the total of \$5.3 billion. Local and state government expenditures for covering employee health benefits, for Medicaid and for other programs, make up the remaining 24 percent of the total.

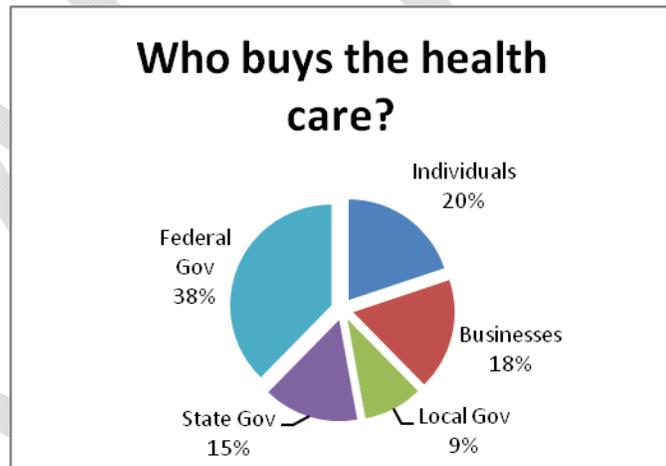


Table 1. Health-Care Spending in Alaska, FY 2005

Who provides the coverage?	Who Buys the Health Care? (Millions of dollars)					
	Individuals	Businesses	Local Government	State Government	Federal Government	Total*
Individuals	\$1,028					\$1,028
Employers		\$922	\$454	\$252	\$411	\$2,039
Government Health Programs			\$38	\$535	\$1,654	\$2,227
Total Spending	\$1,028	\$922	\$492	\$787	\$1,950	\$5,294

Source: *Alaska’s \$5 Billion Health Care Bill – Who Pays?* March 2006 UA Research Summary No. 6. Institute of Social and Economic Research, University of Alaska, Anchorage

Nearly a quarter of the Federal share is accounted for by military health services (\$221,000), insurance premiums and self-insured costs. Half of the Federal share is attributable to Medicare and Medicaid claims paid, and another quarter covers Indian Health Service, veteran's benefits, community health centers and payments for services in elementary and secondary schools. ISER's previous study (1991) provides a base for comparison of rate of increase. In the fifteen year period, employer costs quadrupled, while government program expenditures tripled, and individual's contributions almost tripled.

B. Funding Sources: Expenditures, Services and Facilities Supported, and Covered Populations

A summary of "health care coverage" based on responses to the US Census Bureau's annual Current Population Survey (CPS) shows the following types of reported coverage by insurance programs and public programs:

Health Insurance Coverage Type Average for data years 2006-2008	Alaska		United States
	Count	Percent of Total	Percent of Total
Covered by Any Source	547,203	81.8%	84.5%
Employer	388,381	58.0 %	59.0%
Individual (self-purchased)	42,891	6.4 %	9.0%
Medicaid & Denali KidCare	78,636	11.8 %	13.4%
Medicare	57,384	8.6 %	13.9%
Military/VA	88,944	13.2 %	3.7%
Uninsured all year	121,713	18.2%	15.5%
Total	668,917	(percentages add up to more than 100% because of overlapping coverage types)	

Source: Current Population Survey (CPS), 2007-2009 surveys, 2009 data released September 2009

It is important to note that if otherwise-uninsured American Indians and Alaska Natives are redefined as "covered," then the estimate becomes 14% "uninsured" in Alaska (15% in the US) By CPS definition, "uninsured" includes people of Alaska Native and American Indian Race who may have access to IHS-funded services. In Alaska this is 19% of the uninsured. 63% of

Alaska Natives are covered by private insurance (36%) or public programs (27%), 36% have no health insurance.⁵⁰

Being “underinsured” (lacking insurance coverage or personal resources to pay for specific services, or being required to pay deductibles or co-payments that exceed personal resources) is a major problem to many individuals even though they have some coverage. It is also an issue for their health care providers. How many people are “underinsured” is not known. Data are available from surveys asking people about their perceptions, for example, did you decide not to see a doctor or other health care provider because of cost? Data from hospitals about levels of charity care, “self-pay” patients, and “left against medical advice” may be informative.

- a. **Private Insurance** – including all employment-based except military, and individually purchased policies -- \$2.281 billion (43% of total)
 - Private insurance is generally interpreted to mean both the insurance products sold to employers and employees, and to individuals, whether the employment is for a private for profit or not-for-profit firm. Individuals who pay for private insurance are likely to pay for a policy premium, and then also to pay co-payments, deductibles, and out-of-pocket costs of any services not covered by the insurance policy. The ISER estimates⁵¹ found that about 42 percent of individuals’ costs were for such out-of-pocket expenses .
 - Expenditures for “self-insured” programs include employers’ contributions to such programs. In Alaska, about two thirds of all employers’ (non-military) contributions are to such self-insured plans, while only one third is for “insurance premiums” in the private sector, for the insurance products regulated by the State’s Division of Insurance.
 - Covered lives: the most recent Alaska Division of Insurance survey of health insurers reported 86,645 individuals were covered under comprehensive health insurance plans at year-end 2008. These numbers are reported by the insurers. The estimate suggests that as many as 340,00 individuals are covered through employer-based “self-insured” plans. (See table of Coverage Type above.)
 - Rolling up the expenditures managed by private insurance and “self insured” (private and public) entities, and the premium payments by individuals, the ISER report estimates \$1.685 billion in expenditures for what we generally consider “employment based health insurance.” This accounts for about 32% of health care expenditures in FY2005.

⁵⁰ Tribal contract health care facilities are legally required to serve their tribal members. Other qualified American Indians/Alaska Natives may be eligible to receive care as determined by the organization. This policy makes it difficult or impossible for an American Indian or Alaska Native who leaves his tribal home for education or employment to receive the health care services to which he is legally entitled. This lack of “portability” as well as limitations in some of the services that can be provided is the basis for the Census Bureau determination not to count IHS beneficiary status as “health insurance coverage.”

⁵¹ *Alaska’s \$5 Billion Health Care Bill – Who Pays?* March 2006 UA Research Summary No. 6. Institute of Social and Economic Research, University of Alaska, Anchorage

b. Public insurance and coverage

i. Medicare -- \$0.419 billion (Federal)

Medicare provides coverage for health care for about 54,000 individuals in Alaska including 44,000 senior citizens (age 65 and over) and about 10,000 disabled individuals and people with end stage renal disease. Allowable costs include “Part A” (primarily inpatient) services, “Part B” (primarily outpatient/physician/clinic services) for those participating and paying a monthly enrollment fee, and certain prescription drugs under “Part D” for those who have selected that option. With the aging of the baby boomers, a cohort of about 5,000 new “seniors” will join the ranks of the senior population over the next five years, while about 1,800 deaths per year will deplete the population 65 years and over, so the net increase may be over 3,000 Medicare-eligible people per year.

For the individuals with end stage renal disease, benefits include inpatient, outpatient, and home dialysis (including training, equipment and supplies, and drugs) – not paid for are blood, transportation, or dialysis aides or technicians coming to house. Although dialysis facilities reimbursed must be certified by Medicare (CMS), a patient can obtain services at any approved site in the country, so travel is not restricted for individuals who need service usually two or three times a week. Kidney transplant costs are also allowable – organ registration fees, laboratory tests for the patient and potential donors, full cost of care for donor, and immunosuppressant drugs.

Physician participation/availability: Concern about availability of physicians who will accept Medicare patients has emerged in Alaska in the last five years. The issue arose when a two-year special reimbursement rate for Alaska physicians (effective in 2004 and 2005, providing a differential for Alaska physicians 67% above the US average) sunset in January 2006. For the three years 2006-2008, the Medicare differential for Alaska was about 5% above the US average. A new geographic differential for Alaska (29% above the US average) for “physician work” was effective January 1, 2009, but the reports of physician non-participation continue.

First in Fairbanks, then Anchorage, participants at health care forums and articles in newspapers across the state reported that physicians – especially primary care providers - - were refusing to accept new Medicare patients, and in some cases were telling established patients they would no longer see them. This selective refusal to see Medicare patients appears generally not to have been followed up by notification to CMS that the provider was “opting out” of the Medicare program, so the officially reported “participation rate” for Alaska providers is still high (11% opt-out rate reported in March 2009 by ISER).⁵²

⁵² Frazier, Rosyland and Foster, Mark, “How hard is it for Alaska’s Medicare Patients to Find Family Doctors?” March 2009, UA Research Summary No. 14. Institute of Social and Economic Research, University of Alaska Anchorage.

Provider non-participation has major consequences for patients who may have Medicare as “primary” payer and state retirement benefits or state employment or other insurance as secondary payer, since refusal of the primary payer to pay results in denial of all payers. As a result, individuals who thought they were very well insured found themselves paying out of pocket for all their health care costs or having to seek care from new providers. Medicare patients able to reach a federally funded community health center (CHC) can obtain at least primary care services at such clinics.

The CHCs have experienced very large increases in the number of Medicare patients seen each year since 2000 – from about 3,000 in 2002 to 7,000 in 2007. Some of the increase is attributable to the addition of community health center sites, but most of the increase is believed to have occurred in the urban clinics. In 2007 about 15 percent of all Medicare enrollees were using CHCs as at least one source of care. Anchorage Neighborhood Health Center Executive Director has reported dramatically increased numbers of Medicare patients using the Center, and also increased referrals to the Anchorage Project Access, which matches patients to specialists who have volunteered to see a certain number of charity care cases.

- ii. Medicaid - \$0.303 billion State of Alaska, \$0.667 billion Federal (FY 2005)

Medicaid is an “entitlement program” created by the federal government, but administered by the state, to provide payment for medical services for low-income citizens. People qualify for Medicaid by meeting income and asset standards and by fitting into a specified eligibility category. Under federal rules, DHSS has authority to limit services as long as the services provided are adequate in “amount, duration, and scope” to satisfy the recipient’s medical needs.

Medicaid began as a program to pay for health care for poor people who were unable to work. It covered the aged, the blind, the disabled, and single parent families. Over the years, Medicaid has expanded to cover more people. For instance, children and pregnant women may qualify under higher income limits and without asset limits. Alaska’s Medicaid expansion for these children and pregnant women is called Denali KidCare. Families with unemployed parents may qualify, and families who lose regular Family Medicaid because a parent returns to work may continue to be covered for up to one year.

There have also been changes in the eligibility rules for people who need the level of care provided in an institution, such as a nursing home. Now, most Alaskans who need — but cannot afford — this expensive care may qualify for Medicaid. In addition, provisions within the Alaska Medicaid program give some people who need an institutional level of care the opportunity to stay at home to receive that care.

- iii. Dual Eligibility (for Medicare and Medicaid) – annual expenditure amounts for either program included in above totals

Low income seniors and disabled people may have “dual eligibility” for Medicare and Medicaid coverage, in which case Medicare pays first for what it covers, and Medicaid only pays for services (including beneficiary cost sharing) that are not paid by Medicare. In Alaska, Medicaid generally covers the cost of the Part B (currently \$96.40/month) for all recipients. Part B is the part of Medicare that covers physician, outpatient, some pharmaceutical, and other treatment and rehabilitation services. Part A covers hospital services; few people have to pay premiums for Part A, but Alaska Medicaid will pay those for dual eligibles if necessary.

Also Medicaid recipients do not have to pay a Part D (Pharmacy Benefit) (\$37/month) premium for basic plans, and have greatly reduced cost-sharing.

- iv. Indian Health Service Funds for Alaska Natives and American Indians - \$0.401 billion Federal (FY 2005)

Alaska Natives and American Indians in Alaska from Federally recognized tribes are entitled to health care provided by Indian Health Service, in Alaska primarily through tribal contracts to provide health care services. A portion of these funds are used for “contract health services,” purchase of specialty or out of area care from non-tribal providers for beneficiaries when the services are not available through the tribal system.

- c. Other

- i. COBRA: The *Consolidated Omnibus Budget Reconciliation Act (COBRA)* provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available when coverage is lost due to certain specific events. Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since usually the employer pays a part of the premium for active employees while COBRA participants generally pay the entire premium themselves. It is ordinarily less expensive, though, than individual health coverage. Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. The law amends the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise might be terminated.⁵³
- ii. ACHIA: The Alaska Comprehensive Health Insurance Association (ACHIA) was created by the Alaska State Legislature in 1992 to provide access to health insurance

⁵³ http://www.dol.gov/ebsa/faqs/faq_consumer_cobra.html downloaded 08-17-09

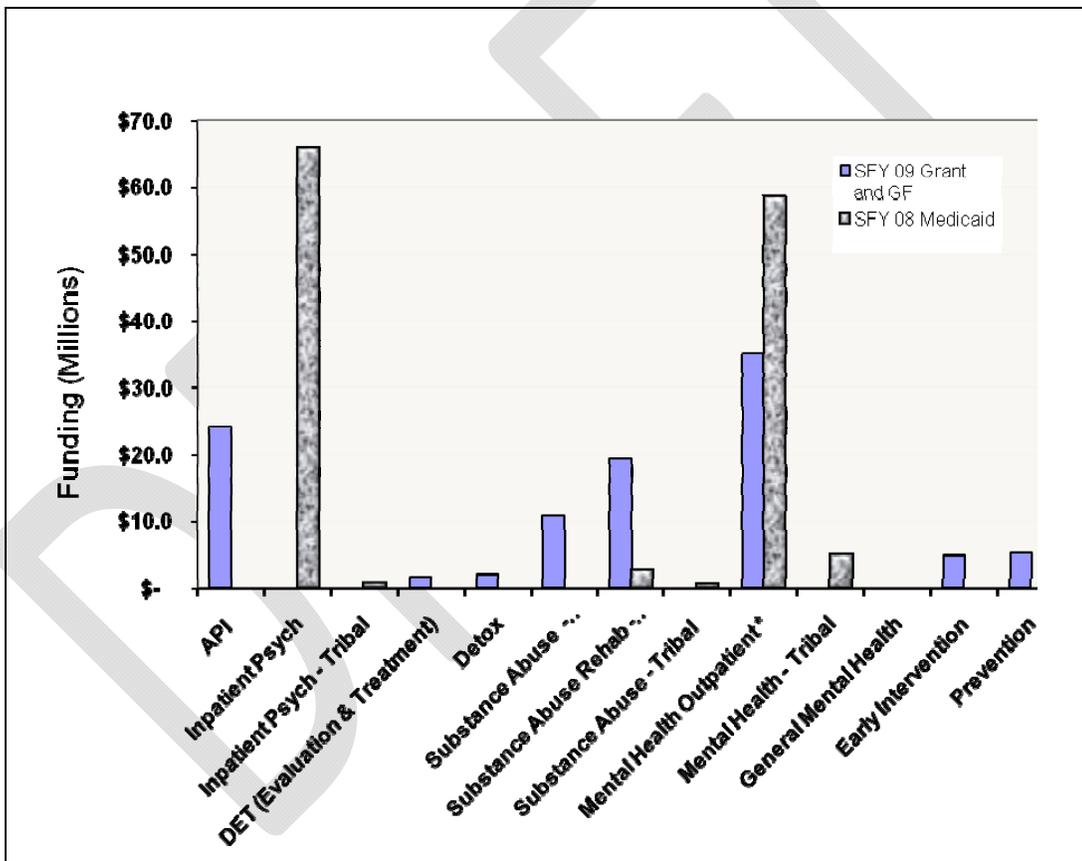
coverage to all residents of the state who are unable to obtain individual health insurance due to a preexisting medical condition and who meet certain eligibility requirements.⁵⁴

- iii. Federal Programs providing care (includes some of the SAMHSA funds)
 - Military care provision (direct)
 - Veterans services
 - Tri-care – insurance-like coverage for dependents
 - Federal employee benefits
- iv. Federal Grants: support operating costs (fixed grant amounts each year) for Community Health Centers, and support Frontier Extended Stay Clinic demonstration project development – also limited direct services provided by several small demonstration projects – but little actually go to patient care which is covered through the claims-based programs.
- v. Denali Commission: Federal funding of village clinics, regional clinics and hospital clinics, also some behavioral health facilities.
- vi. Anchorage Muni: Maternal Child Health, immunizations (public health activities that relate to provision of health care – there are also many monitoring, assessment, prevention, health education – health promotion, protection and disease prevention activities not addressed here; see <http://www.muni.org/departments/health/pages/default.aspx>.)
- vii. Volunteer activities:
 - Anchorage Project Access (APA) uses a volunteer network of providers to increase access to health care for low-income uninsured members of the Anchorage area. Currently, 333 physicians, 98 mid-level providers, and other support services participate in APA’s provider network. Patients are carefully screened for income eligibility, and cannot be eligible for other programs. Since December 2005, APA has processed over 2,035 applications for eligibility, with over 1,110 applicants meeting program eligibility guidelines and receiving medical treatment. See www.anchorageprojectaccess.org.
- viii. State general funds:
 - Public health services that provide direct care – Early and Periodic Screening, Diagnosis and Testing (EPSDT), newborn hearing screening, immunization clinics, other.
 - Division of Juvenile Justice, Department of Corrections, Office of Children’s Services, Department of Education each pay for health services for clients to some degree.

⁵⁴ www.achia.com

- Fishermen’s Fund: Established in 1951, the Fishermen's Fund provides for the treatment and care of Alaska licensed commercial fishermen who have been injured while fishing on shore or off shore in Alaska. Benefits from the Fund are financed from revenue received from each resident and nonresident commercial fisherman's license and permit fee.
- Division of Behavioral Health funds for provision of behavioral health services (i.e., not services billable to insurance). Note in the figure below, showing the funding of the continuum of care, that the majority of state funding (both Medicaid and operating API) go to the most intensive mental health and substance abuse treatment services.

Behavioral Health Funding, SFY09:



Source: Alaska Division of Behavioral Health, Policy and Planning Unit, March 2009