

STRENGTHENING COMMUNITY CARE

TALKEETNA'S SUNSHINE CLINIC

"Alaska residents face some of the most extreme barriers to obtaining health care services in America, the greatest of these barriers being isolation."

*-USDHHS Secretary Tommy G. Thompson
August 4, 2002*

Many Alaskans who live far from urban centers struggle to get their basic health care needs met. Providers are scarce. Transportation is difficult and expensive. Some communities have addressed this need by participating in a federal grant program for Community Health Centers (CHCs). CHCs are private, not-for-profit, consumer-directed health care corporations. Community health centers provide high quality, cost-effective primary and preventive care to medically underserved and uninsured people.

Growth of community health centers in Alaska has been rapid and mostly recent—from one center in Anchorage in 1974 to 19 in 2002. For these centers, federal funding offers financial stability to keep clinic doors open, to expand available services to include dental and mental health, and to increase the number of people served. Becoming a community health center also connects a clinic to statewide and national networks of health care management resources.

Following is the story of how a small community, Talkeetna, started and expanded a community health center.

THE LITTLE CLINIC THAT COULD

By Jessica Stevens, Physician's Assistant-C, Medical Director

As of this writing in 2002, Sunshine Clinic has over thirty employees and manages nine separate programs spanning the gamut from primary care to family advocacy, home health care and, its most recent venture, a mobile clinic. But it wasn't always like that.

Act 1

Our tale begins in 1987 in the Upper Susitna Valley, in South Central Alaska. For the folks who lived in the Upper Susitna Valley there was no local health care for an area the size of Delaware and Maryland. People had to drive between 70 and 80 miles to the nearest hospital, if there weren't too many moose or too much snow or ice on the roads and if they could get out of their remote cabins by dog sled, snow machine or plane to get to that road. A group of committed folk from the communities of Talkeetna and Trapper Creek decided that enough was enough. Spearheaded by a local emergency medical technician, Gail Saxowski, who wrote her thesis on how to start a small rural clinic, the group approached the State of Alaska and got a small Alaska Community Health Facilities grant to start a "mid-level" clinic. They formed an impromptu board, bought a trailer, and hired a part time nurse practitioner.

The clinic went through a series of part time health staff. Underpaid, no employment benefits, working in isolation and with only one clerical support person, each solo midlevel practitioner burned out. The clinic was open sporadically and struggled continuously to make ends meet. Without stable staffing, the clinic could not become a reliable community resource, and clinic revenues stagnated at levels that could not support operations. The idea was a grand one, but the vision was hard to realize.

In 1992 a nurse practitioner left, state funding was suspended, and with \$80 in its bank account, Sunshine Clinic closed. Concerned citizens pooled resources and with \$10,000 raised locally and the state grant resumed, the Sunshine Community Health Center advertised for a physician's assistant in early 1993.

Act 2 (The longest act!)

Act 2 begins in 1993. The thought of a quiet little clinic with only a few patients per day sounded mighty attractive to me. As I sat in a second interview with about 16 community members, I felt the power of commitment and will from the people in the room. As I accepted the position, I had little idea of what the bank account held or the uphill struggle that stretched ahead of us.

The board ran the clinic and oversaw my position. We hired a front office person and opened the clinic full time. Supplies were limited and outdated. My first clinic patient had a huge gash from a chain saw. Donned in a black garbage bag with plastic sacks on my feet, I used expired anesthetic and a miscellaneous assortment of cleaning solutions and sutures to clean and repair his wound. That was only the beginning.

We needed to rebuild the clinic and give people confidence in its ability to meet their varied needs. The clinic began taking calls 24 hours a day. As the only clinician, being on-call sometimes involved three or four round trip visits to the clinic on a weekend day, driving as much as 120 miles per day. People knocked at my door at all hours. I maintained a small inventory of medicines at my home to meet the needs of people who would drop by. We held specialty wellness clinics for women, children and men, using the goodwill and volunteer efforts of many Wasilla, Palmer and Anchorage physicians. We begged everyone we met for equipment, supplies and help. A gentleman driving up the Parks Highway stopped by to ask what we needed. He turned out to be a retired physician from Nebraska who later mailed us an antique electrocardiogram machine and a lung capacity measurement machine. We sought mentors and advisors wherever we could. The

two of us did cleaning, billing, saw patients, developed budgets, fought with insurance companies, and provided veterinary care all in a day's work.

I gave birth to my son at one in the morning in late September 1993, having been at the clinic for a little over five months. The day of his birth, we had an influenza clinic for about 40 local elders, a patient who went into anaphylactic shock, a full day of patients, and an extended board meeting to discuss our financial crisis. The meeting ended at 9:20 in the evening. My son was born at home four hours later. The board meeting planned a spaghetti feed which later raised \$10,000 which allowed the clinic to keep its doors open.

During those first three years, we were designated as a Rural Health Clinic by the federal government, which allowed us to receive Medicaid and Medicare reimbursement. We moved into a tiny family duplex. I saw so many different problems which I felt ill-equipped to deal with. Wasilla health care providers got tired of hearing about our needs, and continuously reminded us that there were no resources available to help those "north of Wasilla." In 1996, after a brainwave in the shower, we applied for and received a Rural Health Outreach grant that gave us funds to provide badly needed additional services, namely, substance abuse treatment, in-home parent support, mental health, and domestic violence counseling.

And so begins Act 3

In 1996, the Sunshine Clinic hired seven additional people and the board began partnerships with several "lower valley" organizations. For the first time, we offered behavioral health services and outpatient drug and alcohol treatment. A second primary care clinician was added, as were a family advocate to work with families experiencing violence in their lives, and a family support worker to offer support to new parents and their babies. We worked hard to consolidate these services which are still in existence today, six years later.

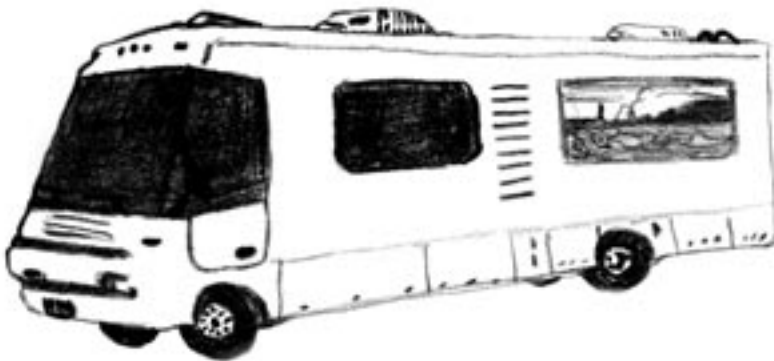
In 1999 Sunshine Clinic received two large federal grants which at last, after 12 years, allowed us to reach the original dream of that first visionary board. We became a federally funded Community Health Center. Finally, we had operating funds to be what we had always been, a community health center. But before, we did not have the funding! We also had funds to work with hospitals and other health care providers in a group called Susitna Rural Health Services. Through this partnership, we were finally able to hire a director, more clinicians, and a care coordinator for a home health care program.

We are always out in the community, teaching at the schools, working with civic groups, hosting a bi-weekly radio program, *Here's to Your Health*, holding health fairs, participating in Talkeetna's famous Moose Dropping Festival, and attending community council meetings. Our participation in these ways keeps us in touch with what people are saying about their health concerns and health care needs.

Act 4: where do we go from here?

Now, in 2002, and reflecting on the past of the "little clinic that could," we have just put our new mobile clinic "on the road." We bought a used Winnebago from the State and will soon be providing services to Trapper Creek and Willow. With funds from the Denali Commission, we will soon have a new, custom designed facility. The new building will increase our capacity for integrating mental health and substance abuse services into our other services. Also, we hope to start a dental program and develop a satellite dental clinic in Willow.

The journey has been a long one, made possible by the help of many incredibly committed individuals. Without them, there never would have been a dream. We struggle to be a model rural clinic, offering an approach to health care that recognizes and integrates physical, emotional, and spiritual health to work towards a healthier community. We think we have made a good few steps in that direction.



"Sunshine Clinic gets an A grade—the phenomenal amount of work people give to make it happen, and staff keep moving the bar higher, striving for excellence. The community has gotten on board, as we've provided a proven level of care. The providers are such good people and so trusted by the community. They are known to be able to do the job and to do it regardless of pay. They've made it clear they will care for people; hopefully people will pay, but care is provided anyway. People know the Sunshine Clinic is there. It's a real blessing to the community."

*David Sutton
Vice-President
Sunshine Clinic
Board of Directors*

"Our communities historically have been marginalized in the eyes of service providers located in more urban environs, and their programs rarely reach our communities."

"Health care problems most frequently diagnosed are diabetes, cardiovascular disease and hypertension."

*Sunshine Clinic, Community
Health Center New Start
Proposal 1999*

About Talkeetna

“Since 1987 Sunshine Community Health Center has brought health care to approximately 5,400 rural residents, without regard to patients’ ability to pay. The Upper Susitna Valley is the northern half of the Matanuska-Susitna Borough, about 12,250 square miles, an area larger than Maryland and Delaware combined. The Clinic’s service area stretches nearly 160 miles along the Parks Highway from Willow to Cantwell, on the edge of Denali National Park, and into Petersville and Skwentna. Population density is about 0.44 people per square mile.

“Public officials often compare people who live in the Upper Susitna Valley to stereotypes of Appalachia—predominately white and poor. The population is among the fastest growing in the country. Adjusting for cost of living, fully 80% of all families in the area live in poverty. Most jobs are seasonal and a large part of the population lives a subsistence lifestyle. Over 40% of the area’s population have no health insurance, a number which has increased since welfare reform. A study conducted by Sunshine Clinic in 1993 indicated that 43% of Upper Susitna households failed to seek health care during the previous five years due to inability to pay.”

Sunshine Clinic, Community Health Center New Start Proposal 1999

A Kodiak Demonstration Project

The Kodiak Island Health Access Project Clinic was opened in October 2001 and closed in March 2002. During those six months of the pilot project, medical care for people without health insurance was available once a month. For years, a group of Kodiak residents had applied for grants and tried other strategies to fund a clinic to provide services to Kodiak’s seasonal cannery workers and their families, as well as to the many fishing families who were also without health insurance. The seafood industry provides one-third of the total employment in the Kodiak Island Borough. Forty-four percent of Kodiak’s population are minorities. Many immigrant minorities are not eligible for federal health programs, such as Medicaid.

The Saturday clinic was supported by a \$60,000 grant from the Kodiak hospital and by in-kind donations of goods and services and volunteer staffing. Interpreters were available for each visit. The Kodiak Health Access Project clinic was open on the first Saturday of each month from 9AM to 4PM. Twenty-five appointments were arranged for each Saturday on first come first served basis. The clinic was promoted in the community through newspaper, radio, and word of mouth. Each Saturday, many more people tried for an appointment and were not able to get one. Many people with greater medical care needs than had been anticipated also tried to receive care. Care was less efficient than anticipated because they could not access previous health care records.

The pilot project showed a great need for drugs for the chronically ill, for example, people with diabetes or hypertension. Other lessons learned were that the clinic needed to be held during the week, and that coordination with other providers was important. Clinic supporters hope for an interpreter with special health interpreter training.

The clinic ceased operations when funding was exhausted. While this volunteer effort was not a long-term solution, some residents got needed medical services, and data were collected that can be used in future grant requests. Importantly, the clinic educated the community about the needs of the medically underserved population in the community and fostered a vision for a future clinic in Kodiak.

Rae Jean Blaschka, one of the staff volunteers, says, “It was a worthwhile experiment.”

Mountain View Health Center

In November of 1999, the dreams of a dedicated group of Anchorage residents were realized when the Mountain View Health Center opened its doors. Today the Mountain View Health Center is operated by the Anchorage Neighborhood Health Center in a collaborative effort with Southcentral Foundation providing medical services to persons living in the neighborhood, including Alaska Natives.

The neighborhood's first clinic opened in 1997 when a grassroots organization, the Concerned Citizens of Mountain View, partnered with the Anchorage Latino Lions Club and Providence Health System in Alaska to improve health care access for the neighborhood. When it was clear that additional space and staff were needed, the clinic moved to new space located in the Mountain View Plaza.

Basic dental services have been started at Mountain View Health Center. Services are provided to adults and children age 1 year and older with or without insurance. Dental services include check-ups, fillings, and preventive care. Walk-ins are also welcome. Services for uninsured patients are provided based on ability to pay.

Interior Neighborhood Health Clinic

The Interior Neighborhood Health Clinic is a community health center that offers basic preventive and primary health care services to families in interior Alaska on a sliding fee scale. The Interior Neighborhood Health Clinic works in cooperation with other health care providers to increase the health and medical care services available to communities. The clinic is managed by a local non-profit group, the Interior Neighborhood Health Corporation.

The clinic seeks to fill the large gap for those who need primary medical care but have financial or other barriers. Services are provided on a sliding fee scale, for those who do not have adequate insurance or do not have Medicaid. During calendar year 2001, the Interior Neighborhood Health Clinic served 4,762 patients. Nearly 50% (2,306) were uninsured; 52% (2,479) live at or below 200% of poverty.

Grant revives closed clinic

WHITTIER: Money from tribal organization will turn facility into community health center.

*By Ann Potempa, Anchorage Daily News
(Published: August 8, 2002)*

After struggling without a doctor for more than a month, Whittier will reopen its medical clinic with the help of a tribal health organization. The Eastern Aleutian Tribes received federal grant money to turn the town's clinic into a community health center.

Whittier has been without a physician since July, when Dr. William Cooper resigned his position. Cooper, from Soldotna, had been making regular medical visits to the town. His departure left residents relying on emergency medical services or traveling to Anchorage for care.

To meet the town's need, city leaders joined the Eastern Aleutian Tribes in its grant application to the U.S. Department of Health and Human Services. Chris Devlin, executive director of Eastern Aleutian Tribes, said he learned this week that the grant was approved. Details still need to be worked out, but Devlin didn't expect delays in reopening the clinic. ...

Devlin said there's precedent for his nonprofit health organization helping communities outside the Eastern Aleutian region. "We have a track record of being able to help communities that are hurting with their health care system," Devlin said.

The organization operates clinics that serve all communities in the Aleutians East Borough. But it also runs a clinic in Adak, which is located on the western part of the chain and is not a traditional Native community. Adak's health care system needed help last year, and the Eastern Aleutian Tribes took control, Devlin said.

When Whittier's clinic closed and the community needed help this year, the tribal health organization applied for an annual grant that will set aside \$300,000 of federal money to operate the facility. Devlin said the new clinic will be run by a community health aide and a mid-level practitioner, which is either a nurse practitioner or a physician assistant.

Denali Commission

The Denali Commission is an innovative federal-state partnership established by Congress in 1998 to provide critical infrastructure and economic support in Alaska. Early on, the Commission designated rural health as a top priority. The Commission funds health care facilities that have completed a comprehensive plan that fully addresses both the community's health care needs and its capacity to maintain facilities in the future.

Design work is being done for new clinics in dozens of communities. The Commission is funding construction of new clinics around the state, for example, in Talkeetna, Stebbins, Scammon Bay, and Angoon and funding repairs to existing clinics in Craig, Ft. Yukon, Eyak and Pilot Point. The total investment of Commission funds for rural clinics for FY 99–FY 02 is approximately \$50 million.

WHAT NUMBERS CAN TELL US

Community health centers are funded by a federal grant program under Section 330 of the Public Health Service Act and administered by the federal Health Resources and Services Administration. The federal health center program consists of four types of health centers: Migrant, Homeless, School based, and Community. So far, most centers in Alaska are Community Health Centers. One center serves homeless people in Juneau.

Growth of community health centers in Alaska has been rapid and recent. In the year 2000, 59,355 Alaskans received quality medical care from a community health center. Anchorage Neighborhood Health Center, funded in 1974, was the pioneering community health center in Alaska. In 1995, Interior Neighborhood Health Center in Fairbanks became the second community health center in the state. Nineteen community health centers are currently funded.

In looking at your community to assess the need for a community health center, look at access to primary and secondary care. Are medical resources available in the community? Can people see someone when they feel ill? Are

there dentists? Mental health professionals and specialists in addictions? Are long, inconvenient or expensive trips needed to see these health providers?

Look at your community's population data and income data. (The applications for CHC funding require a considerable amount of data about the population to be served, and the services already available.) Sometimes health care services exist in a community, but the care is too expensive for the majority of the population. Sometimes available care is restricted to only a portion of the population, for example, Alaska Natives. When communities have populations of both Native Alaskans and Caucasians or other minority groups, community health centers may be valuable to everyone. The Native Health Corporation may be able to open a community health center that would serve the entire population, establish a sliding scale fee system for non-members, and provide needed primary care and support dental and behavioral health care.

Applicants for federal community health center grant funding are required to show that they are serving or will serve a designated Medically Underserved Area or Population (MUA/P). Staff at the Division of Public Health assist by collecting available data, completing applications and sending them to the federal Bureau of Primary Health Care on behalf of communities. As of August 2002, twenty service areas were designated as underserved for primary health care.

THINGS TO CONSIDER

What are the possible benefits of having a community health center?

Community health centers differ from traditional health care clinics in a number of ways. Community health centers focus on improving the health status of the entire community as well as the health of individual patients. Health care services are accessible to everyone, are comprehensive—including dental and mental health services, and are coordinated with other social services. In addition, community health

centers are accountable to the community by involving community members and health center users in program planning and in governing the center through a board of directors. The board is responsible for identifying community health needs, planning how to meet health needs, and evaluating the health center's efforts.

Community health centers provide high quality primary and preventive health care to everyone, regardless of their ability to pay. Health center services are not free, but patients who have no health insurance can pay on a sliding fee scale.

What does it take to establish a community health center?

Establishing a community health center is a long and complicated process. First, the clinic must be located in an area designated as "medically underserved" by the federal Health Resources Services Administration. Federal funding is competitive and you must show that services are needed. Need is related to how many people will have access to health care. Additionally, a community must be able to support its own community health center, including governance and administrative capacity. The center must be able to provide access to comprehensive health care including primary, mental, and dental health. If these services are not provided onsite, they must at least be accessible through referral networks or contract services. Community health centers must be staffed by at least one Nurse Practitioner or Physician's Assistant. The staffing level is determined by the community health center's board of directors, based on patient visits.

Is there a special way of setting up a community health center?

There is no single model of health center development in Alaska. Currently, there are 19 community health centers in Alaska serving more than 54 communities. The organizations operating the community health centers are private non-profits, Regional Native Health Corporations, and local government. Health care delivery varies from itinerant and mobile services to permanent on-site programs. Some

smaller centers are staffed by Community Health Aides and a mid-level provider, while those in urban areas are staffed by full-time physicians and dentists. Centers with patients in dispersed communities extend their reach through mobile or itinerant services.

Federally funded programs have a policy of not competing with private enterprise. The federal program strongly encourages collaboration with all the health providers in the area. Some existing clinics have converted to community health centers and retained the same providers they had before (Talkeetna, Haines, Bethel). In most areas, private providers continue to serve their same patients, while the community health center serves others who weren't able to receive care before.

Will the federal government continue to support community health centers?

The federal Health Center program has grown considerably over several decades. The program enjoys broad, bipartisan, Congressional support. Communities with federal grants can count on CHC funds as a stable, continuing source of revenue. However, if a center fails to fulfill the intent of the program, or is negligent in management, funding may be discontinued. Before funding is withdrawn, every attempt is made to bring the center into compliance.

Federal CHC funding is not flexible and must be used for the intended purpose. Good management of this funding is essential to ensure accountability to health center clients and to taxpayers. The federal government monitors management closely. Reporting requirements include quarterly financial status reports, yearly Uniform Data System (UDS) reports (program performance data), and yearly project reports.

TO FIND OUT MORE

U.S. DHHS Bureau of Primary Health Care
Community Health Centers home page
www.bphc.hrsa.gov/CHC/

For the official guidance and Requests for Proposals, HRSA Policy and Information Notice (PIN) 2001-18:
<ftp://ftp.hrsa.gov/bphc/docs/2001pins/2001-18.pdf>

Health Center program expectations:
<ftp://ftp.hrsa.gov/bphc/docs/1998PINS/PIN98-23.PDF>
Other documents may be found at www.bphc.hrsa.gov/pinspals/

Creating Health Centers
Interactive website with tools to determine eligibility and improve readiness
www.bphc.hrsa.gov/dpspnewcenters

State profile: Alaska
www.stateprofiles.hrsa.gov/1999/AK199901SP.htm

Alaska Primary Care Association
www.alaskapca.org

Alaska Primary Care Office
(907) 465-3091
www.chems.alaska.gov/primary_care.htm

Federal HRSA Field Office (Seattle)
(206) 615-2264
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REFERENCE CHAPTERS IN HEALTHY ALASKANS 2010, VOLUME I

Chapter 5. Mental Health
Chapter 6. Educational and Community-Based Programs
Chapter 13. Oral Health
Chapter 15. Access to Quality Health Care
Chapter 26. Public Health Infrastructure