

# HELPING COMMUNITY HOSPITALS

*In Alaska "rural" takes on a new definition. I'm not sure even "frontier" captures it either. Alaska is a case apart, its uniqueness obvious to all.*

*-Elizabeth M. Duke*

*Health Resources and Services Administration  
U.S. Department of Health and Human Services  
Anchorage, April 25, 2002*

Alaska has 24 acute care hospitals, including two military hospitals and seven hospitals operated by tribal health corporations. Hospitals in Anchorage and Fairbanks serve as statewide referral facilities for providers from rural areas of the state. Alaskans often travel to hospitals in Seattle and other Lower 48 hospitals for specialty care that is not available in state.

Like hospitals in the rest of the country, the 18 small, non-profit hospitals in Alaska face rising costs, increases in outpatient visits, and decreases in the number of inpatients. Occupancy rates fluctuate, but generally average 30 percent or less of the licensed beds. Shortages of health care workers, especially nurses, make it difficult to provide care. But in addition to providing in-patient care, the small hospitals are generally a central point for health services in their communities, often including primary care, nursing home care, management of assisted living programs, and classes or programs for community residents. They are often among the largest employers in their communities. They are key components of the economy in their regions, buying services and supplies. Lastly, they provide part of the emergency response capability in rural Alaska, in coordination with emergency medical services and others.

Unlike small hospitals in much of the rest of the country, Alaska's small community hospitals face challenges that are unique to the state. These challenges are related to the local economies, geography and weather. Most of these hospitals face big seasonal fluctuations in demand for services, because of tourists, fish processors, fishing crews and other more or less transient populations who may need primary care, emergency treatment, or hospitalization. The spikes in demand are one reason these hospitals are needed, but they challenge the hospitals to budget and arrange for staffing to deal with both peak and slow times. Fixed costs are high for hospitals, for the physical plant and staffing, regardless of the number of patients seeking care at any particular time.

Weather, distance and geographic barriers like tundra, mountains and seas are always considerations affecting care decisions in Alaska. Due to the scarcity of roads connecting communities, transporting patients is primarily by air and it is expensive and time-consuming. At times weather may make transfers impossible. Small hospitals must often provide care for critically ill patients whose transport has been delayed by weather. Cost of travel also adds to the expense of recruitment, retention, and training of health care workers, and to the cost of supplies and equipment.

## The Rural Hospital Flexibility Program

The federal Rural Hospital Flexibility Program (Flex Program) supports Alaska's smallest rural hospitals (and potentially some large rural clinics) to address these problems by becoming Critical Access Hospitals (CAH). Twelve Alaska hospitals are eligible for CAH designation due to their small number of beds (15 or fewer acute care beds) and their isolated locations. Hospitals with the Critical Access designation receive cost-based federal reimbursements for care for Medicare patients instead of rates set under the "prospective payment" rate system that applies to most hospitals. CAH designation may thus give a financial benefit to many Alaska hospitals.

Critical Access Hospitals are also eligible for other federal funds for new construction. Federal grant funds can be used for management consultation, training, and special projects. Critical Access Hospitals also establish relationships with larger "mentor or referral hospitals" to improve patient transfers, continuity of care, and consultations with specialists. Overall, the Rural Hospital Flexibility Program helps to stabilize small hospitals financially and assists them in improving the quality of patient care.

Hospitals participating in the Rural Hospital Flexibility Program work with the Alaska Department of Health and Social Services Office of Primary Care and Rural Health to identify needs and to decide on a planning process for system improvements. In addition to a CAH financial feasibility analysis and assessment of their financial operations, the hospitals are

expected to do community health care needs assessments and to work with their local emergency medical services (EMS) on planning for better coordination and systems improvement. The emergency medical services are also eligible for funding under the program grants for systems planning and improvement including training. The focus of this program at both the federal and state levels is increasingly on developing and implementing hospital rural health networks, improving quality of care, and improving and integrating emergency medical services into the continuum of health care services for rural residents.

A new federal grant program, the Small Hospital Performance Improvement Program, provides an additional small amount of funding to further assist the seventeen eligible Alaska rural hospitals (49 or fewer beds) to comply with federal requirements for the Health Insurance Portability and Accountability Act (HIPAA), and to improve quality of care. Activities funded under this grant program complement two of the goals of the Flex grant program (network development and quality improvement).

Through funding provided under both of these grant programs the Office of Primary and Rural Health Care and the Alaska State Hospital and Nursing Home Association are assisting several of the small, rural hospitals to create a Hospital Performance Improvement Network. Creating a healthcare database and selecting meaningful quality indicators for comparing and tracking performance will be a major focus of this network.



## **Valdez**

*"When we first looked at Critical Access Hospital (CAH) designation, it didn't look as though it would have a significant impact on us, especially since only 10 percent of our patients were Medicare eligible. As it turned out, because of the high cost of staff and high shipping costs, conversion to CAH status did make a significant difference.*

*"Conversion to a Critical Access Hospital achieved three things. First, it helped our cash flow. Late payments had been straining our relationship with vendors. This problem was solved by increased and guaranteed revenues. Secondly, we were able to take those increased revenues and use them to expand revenue-generating services. For example, we added physical therapy and, within 6 months, had enough new revenue to hire a physical therapy staff.*

*"Third, because of our CAH designation, we are eligible for special federal funds which we will use to build a new hospital, something we never could have afforded otherwise."*  
*-Jim Culley, Hospital Administrator*

## **Sitka**

*"Sitka Community Hospital was the third Alaskan hospital to convert to Critical Access Hospital (CAH) status. Financial estimates predicted revenue increases of one-half million dollars or more. Actual designation happened just when the hospital experienced the lowest volume summer in 10 years! Revamping our billing process allowed us to minimize the impact of low volume and gave us a chance to improve our billing process.*

*SCH has benefited from the network that was established as part of the CAH process. Sitka partnered with Providence Health Systems of Alaska in Anchorage. They give us oversight, support services, and direct support for Medical Staff Peer Review.*

*"Conversion to CAH status makes Sitka eligible for special federal funds that we may use to build a 15-20 bed assisted living facility."*

*-William Patten, Hospital Administrator*

## **Petersburg**

*"One of the major differences the additional reimbursement from CAH designation has made for Petersburg Medical Center is our ability to begin to pay competitive wages to our staff.*

*"For the past several years, our salaries for nurses and other health professionals has been significantly lower than the Alaska average—in fact, lower than the average for hospitals in the Pacific Northwest ... CAH designation increased our revenues, and we have put these funds almost entirely into improving our wage situation. Consequently, we are now finding it easier to fill vacant positions with well-trained and qualified staff. This will improve the delivery of quality health care."*

*-John Bringhurst, Hospital Administrator*

## WHAT NUMBERS CAN TELL US

With 202 hospital beds per 100,000 population, Alaska fell far below the national average of 311 beds in 1998. As the number of elderly Alaskans increases, more hospital beds may be needed in the future.

Information on the use of health care services among public health and tribal health clients is available through the Resources Patient Management System (RPMS). There is no comparable data source for the state as a whole, since there is a mix of public and private health care providers who are not required to report activity to a single point. Unlike many states, Alaska does not have managed care organizations (health maintenance organizations, or HMOs, are a common type elsewhere) collecting utilization data on their members.

Most Alaska hospitals have recently begun reporting their discharge data. This will be useful for comparing Alaska's utilization patterns with other states, and will allow for tracking trends in hospitalizations, reasons for admission, charges, and characteristics of patients served. Hospitalizations for asthma, diabetes, and other conditions that reflect changes in health status, or which suggest need for better primary care, could then be compared to national data. Estimates of the need for rehabilitation or nursing home care could be improved by examining diagnosis codes for stroke, hip fracture, and other conditions likely to require further care.

## THINGS TO CONSIDER

**Are the health care institutions in your community or neighborhood working well together to serve the community? Is their strong community involvement and support?**

As the hospital administrators stated, a program like the Rural Hospital Flexibility Program can help provide resources for management studies to improve efficiency, and to do community needs assessments and various other planning activities to strengthen the health care system in a region.

The Flex program requires them to ask residents their views on how services being provided are meeting community needs.

Non-profit organizations providing health services in a community or neighborhood have boards of directors or overseers who can be asked about priorities, planning efforts, or specific needs in the community.

Citizens can encourage and support their emergency medical services (EMS) organizations and their hospitals and other health programs in many ways—including working as volunteers, or being willing to serve on boards or committees. Citizens can be valuable advocates for their local health service agencies and health care providers including assisted living, home care, primary care, and health education classes when local or state policies are under consideration. They can also influence what services will be added, by sharing their opinions and needs. Being informed is the first step to being able to support the services you think your community or neighborhood needs.

**Is there a clinic or hospital in your rural community that could convert to a Critical Access Hospital, or benefit from a self-assessment and community needs assessment process?**

Some clinics already have 24-hour coverage for emergencies and regular visits from a doctor. If the clinic is caring for people who need more than routine outpatient treatment, such as overnight observation, or frequently has to care for people who cannot be transferred out because of bad weather, the clinic or community may want to do some local planning work to explore alternatives for providing good care. Communities can check on availability of planning assistance. In 2002, outpatient clinics are not eligible to make a direct transition to critical access hospital status, but the state's Primary Care Office is exploring the potential for such an option, or for other mechanisms for such clinics to be better reimbursed for extended care.

## **Is there a community health improvement process you can join?**

This chapter and others give examples of community discussions and planning to improve health and well-being. These are just a few of many across Alaska. In the Matanuska-Susitna Borough, Valley Hospital has taken a leadership role in doing periodic community surveys of health status, behavior, and perceived needs and priorities. Partnerships of many kinds work on important problems like access to health care (e.g. the Kenai Healthy Communities/Healthy People Partnership, and the Anchorage Access to Care Coalition), teen suicide (Mat-Su Partnership), respite services and health education programs (e.g. the family drop-in rest area and educational stop-over at the state fair in the Mat-Su). See the topical chapters of Healthy Alaskans Volume I for links to various state resources and programs that could provide references to nearby community health improvement, health education, and planning activities.

## **TO FIND OUT MORE**

Rural Hospital Flexibility Program  
Alaska Division of Public Health  
Community Health and Emergency Medical Services  
(907) 465-8618 (Juneau)  
(907) 269-3456 (Anchorage)  
[www.chems.alaska.gov/rhfp.htm](http://www.chems.alaska.gov/rhfp.htm)

Health Facilities Licensing and Certification  
Critical Access Hospital Description and Application Link  
Alaska Division of Medical Assistance  
[www.hss.state.ak.us/dma/hflc\\_cah.htm](http://www.hss.state.ak.us/dma/hflc_cah.htm)

Technical Assistance and Service Center (TASC)  
for the Rural Hospital Flexibility Program  
[www.rupri.org/rhfp-track/](http://www.rupri.org/rhfp-track/)

Rural Information Center Health Services  
[www.nal.usda.gov/ric/richs](http://www.nal.usda.gov/ric/richs)

## **REFERENCES CHAPTERS IN HEALTHY ALASKANS 2010, VOLUME I**

Chapter 15. Access to Quality Health Care  
Chapter 26. Public Health Infrastructure

## NOTES