15. Access to Quality Health Care

Goal:

Improve access to comprehensive, high quality health care services.

Health Goal for the Year 2010: Improve access to comprehensive, high-quality health care services.

	Indicator	Alaska Data Source	U.S. Baseline	Alaska Baseline	Alaska Target Year 2010
	Clinical Preventive & Primary Care Services				
1	Decrease the percent of Alaskans without health insurance coverage throughout the year.	Census Bureau, Current Population Survey	14.0% (2000)	19.3% (2000)	5%
2	Decrease the percent of Alaska children (under 18) without health insurance.	Census Bureau, Current Population Survey	12% (2000)	7.4% (2000)	0%
3	Increase the proportion of Alaskan adults appropriately counseled about health behaviors within the last year.				
3a	Increase the proportion of Alaskans counseled about diet or eating habits.	BRFSS		25% (1997)	100%
3b	Increase the proportion of Alaskans counseled about physical activity or exercise.	BRFSS		31% (1997)	80%
3c	Increase the proportion of Alaskans who drank alcohol in the past month that are counseled about alcohol use.	BRFSS		15% (1997)	80%
3d	Increase the proportion of Alaskans who currently smoke that are counseled about quitting smoking.	BRFSS		54% (1997)	80%
3e	Increase the proportion of Alaskans counseled about injury prevention, such as safety belt use, helmet, or smoke detectors.	BRFSS		16% (1997)	80%
4	Increase the proportion of adults that report that their general health is excellent or very good.	BRFSS	56% (2000)	59% (2000)	75%
5	Increase the proportion of adults aged 18 or older with a usual place to go for care if sick or needing advice about health.	BRFSS	84% (1997) NHIS	79% (1997)	100%
	Alaska Native	BRFSS		87% (1999)	100%
6a	Reduce the proportion of adults aged 18 or older reporting that the distance or time to travel to their health care provider was either fair or poor.	BRFSS	12% of families report delays or difficulties in obtaining health care for one or more family member MEPS (1996)	10% (1997)	5%
6b	Reduce the proportion of adults aged 18 or over reporting that they could not afford to see a doctor in the last 12 months.	BRFSS	10% (2000)	12% (2000)	5%
7	Increase the proportion of children eligible for Denali KidCare and Medicaid who have health insurance through Denali KidCare and Medicaid.	DHSS/DMA		18,000 children at or below 200% of the federal poverty level uninsured (1997-1999)	100% insured

	Health Goal for the Year 2010: Improve access to comprehensive, high-quality health care services.				
	Indicator	**Alaska Data Source**	**U.S. Baseline**	**Alaska Baseline**	**Alaska Target Year 2010**
8	Ensure that the in-state school of nursing and other health professional training schools include the core competencies in health promotion and disease prevention that are currently being developed by HRSA and the Association of Teachers of Preventive Medicine.	Special Survey of Schools	Developmental	Developmental	100%
9	Increase the proportion of degrees in nursing awarded to members of underrepresented racial and ethnic groups.	University of Alaska		Developmental	
9a	Alaska Native		0.7 (1995-96)		18%
9b	Asian or Pacific Islander		3.2 (1995-96)		5%
9c	African American		6.9 (1995-96)		5%
9d	Hispanic or Latino (all races)		3.4 (1995-96)		5%
10	Reduce hospitalization rates for three ambulatory-care-sensitive conditions— pediatric asthma, uncontrolled diabetes, and immunization-preventable pneumonia and influenza in older adults.	Hospital Discharge Survey (potential)	1996 HCUP	Developmental	
	Emergency Medical Services (EMS)				
11a	Extend emergency radio communication systems to all rural highways.	Statewide EMS Communications Plan, Information Technology Group, Land Mobile Radio (LMR) System (Digital Trunking) Plan		Statewide EMS Communications Plan (9-97)	Provide at least 90% coverage for all rural highways
11b	Ensure that all residents and visitors have access to telephones to call for emergency assistance along all rural highways in Alaska.	Statewide EMS Communications Plan, Information Technology Group		Statewide EMS Communications Plan (9-97); State Highway Call Box Report (1-97)	Increase coverage by telephone or emergency call box to every ten miles of highway in accordance with the Highway Call Box Report
11c	Ensure that a statewide communications system exists that allows easy access to emergency dispatch centers; coordination of public safety agencies; on-line medical direction; and flexibility to handle emergencies of any magnitude.	Statewide EMS Communications Plan, Information Technology Group		Statewide EMS Communications Plan (9-97), LMR (Digital Trunking) Plan	Implementayion of the Statewide Emergency Medical Services Communications Plan and LMR recommendations[2]

	Health Goal for the Year 2010: Improve access to comprehensive, high-quality health care services.				
	Indicator	**Alaska Data Source**	**U.S. Baseline**	**Alaska Baseline**	**Alaska Target Year 2010**
12a	Increase the proportion of persons who have access to rapidly responding prehospital emergency medical services.	State Emergency Medical Personnel and Ground Ambulance Certification Databases	Developmental	Baseline varies[2]	10% increase in number of certified and licensed EMS personnel and state-certified prehospital emergency medical services
12b	Increase the proportion of persons who have access to certified air medical services.	DHSS, DPH, CHEMS Air Medical Services Database	N/A	Air Medical Services: Medevac: 9; Critical Care: 10; Specialty Air Service: 1	10% increase in number of certified air medical services
13	Increase to 100% the number of EMS dispatchers trained as Emergency Medical Dispatchers.	State Certification Database		25 Certified Dispatchers (2000)	100 additional certified Emergency Medical Dispatchers
14	Increase to 100% the number of hospitals certified as level II, III or IV trauma centers.	CHEMS Trauma Center Certification Database		One State-certified Trauma Center (Level II) in 2000	Certify 100% of hospitals in the State as level II, II or IV Trauma Centers
15a	Increase the number of communities that have implemented statewide pediatric protocols for online medical direction.	EMS for Children Annual Grantees Survey; HRSA		Developmental	
15b	Increase the number of communities that have adopted and disseminated pediatric guidelines that categorize acute care facilities with the equipment, drugs, trained personnel, and other resources necessary to provide varying levels of pediatric emergency and critical care.	EMS for Children Annual Grantees Survey; HRSA		Developmental	
	Long-Term Care and Rehabilitative Services				
16	Increase access to continuum of Long-term Care (LTC) services including assisted living, respite, personal care, adult day services, care coordination, nursing home beds.	LTC Survey, ACoA grantee information and SNF licensing data	Developmental	Overview of services by communities is described in narrative.	Ongoing development of the continuum of care when it is supportable by each community
17	Increase the number of eligible people receiving services from a home and community based waiver.	Medicaid		2800 (2000)	2% Increase per year
18	Maintain Alaska's low ratio of nursing home beds per 1000 population 65 and older.	SNF licensing information, Department of Labor population statistics		21.1 per 1,000 (2001)	21.1 per 1,000

	Health Goal for the Year 2010: Improve access to comprehensive, high-quality health care services.				
	Indicator	**Alaska Data Source**	**U.S. Baseline**	**Alaska Baseline**	**Alaska Target Year 2010**
19	Lower average cost per day of total Medicaid long-term care costs by increasing the number of clients on Home and Community Based Waivers and maintaining or reducing nursing home bed days.	Medicaid		Nursing home bed days 190,008 HCB Waiver days 654,653 (2000)	Nursing home bed days 190,000 HCB Waiver days 798,000

[1] Implement 100% of the Statewide EMS Communications Plan recommendations and the land mobile radio digital trunking communications system in communities of at least 10,000 in population and along major highway systema

[2] Certified & Licensed Personnel: EMT-I: 2,148; EMT-II: 569; EMT-III: 519; Paramedics: 358.
Certified Ground Ambulance Services: Basic Life Support: 6; Advanced Life Support: 82

BRFSS - *Alaska Behavioral Risk Factor Surveillance System. All US BRFSS data are age-adjusted to the 2000 population; the Alaska BRFSS data have not been age adjusted, so direct comparisons are not advised. See Technical Notes.*
NHIS - *National Health Interview Survey*
MEPS - *Medical Expenditure Panel Survey*
DHSS - *Alaska Department of Health and Social Services*
DPH - *Alaska Division of Public Health*
DMA - *Division of Medical Assistance*
HCUP -*Healthcare Cost Utilization Project*
CHEMS - *Community Health and Emergency Medical Services*
EMT - *Emergency Medical Technician*
ABVS - *Alaska Bureau of Vital Statistics*
EMS - *Emergency Medical Services*
HRSA - *Health Resources and Services Administration*
LTC - *Long Term Care*
ACoA - *Alaska Commission on Aging*
SNF - *Skilled Nursing Facility*

Overview

Access to quality health care reduces health disparities and increases the years of healthy life for all Alaskans. Six components of the health care system are discussed in this chapter, after a review of cross-cutting issues of organization and facilities, workforce and funding:

- clinical preventive care
- primary care
- emergency services
- telehealth
- long-term and rehabilitative care
- hospitals.

Tertiary services, such as hospital and specialty care, are not included in the national Healthy People 2010 objectives. In Alaska, however, small rural hospitals are essential providers of preventive services and primary care, as well as links to emergency care and transport. A brief overview of Alaska hospitals, therefore, is included in this chapter.

Clinical preventive services impact many of the leading causes of disease and death. People must have access to clinical preventive services that are effective in preventing disease (primary prevention) or in detecting disease early when treatment is an option. Improving access to appropriate preventive care requires addressing barriers that involve the patient, provider, and system of care.[1] Barriers that limit access to preventive care include lack of knowledge, skepticism about the effectiveness of prevention, lack of a usual source of primary care, and lack of money to pay for preventive health care. Access to health care often depends on whether a person has health insurance.[2] Having health insurance, a higher relative income, and a usual primary care provider are strong predictors that a person will receive appropriate preventive care

Issues and Trends in Alaska

Alaska has over 300 communities. Approximately 25 percent of all Alaskans and 46 percent of Native Alaskans live in communities of less than 1,000 people. Despite its large land mass, Alaska ranks 47th among the 50 states in road miles. Nearly one-quarter of the state's population lives in towns and villages that are reachable only by boat or aircraft. Approximately 75 percent of Alaskan communities are not connected by road to another community with a hospital. Air travel within Alaska is expensive, and many rural residents have little cash income. Severe weather often limits air travel, causing delays in obtaining care. The geography and climate of the state limits access to care, as well as increasing the costs of health care.[3]

The organization of health care services in Alaska depends on a variety of factors including a community's access to the road system and distance to the nearest hospital, population size, local resources for health care and the reimbursement systems covering care for residents in the area. If the community is on the road system, is access limited by weather or seasonal changes? Is there access by water or by snowmobile trail? What kind of aircraft can land at the nearest landing strip? Are there large seasonal changes in population due to tourism, fishing, or industry? Are there different reimbursement systems for various community residents?

Several state government health care related agencies in Alaska uses a "levels of care" framework detailed by Emergency Medical Services for planning health services and resources allocations. Each community is assigned a level based on size, location, and access hospitals (Table 15-1).

Health Care Organizations and Facilities

Alaska experiences many health and health care delivery challenges that are different from those of the rest of the United States. With 226 federally recognized tribes, 162 local governments, numerous federal and state supported health associations, nine community health centers as of January 2002, and many privately run clinics, Alaska is unique.

Almost a quarter of the Alaska population is eligible for health care services through the Department of Defense and the Department of Veteran's Affairs. Military personnel, dependents, and retirees receive services through ten federal health facilities, including two hospitals. Alaska's 200,000 federal beneficiaries (Indian Health Service, military and dependants, and veterans) face confusing options for services in some areas and absent or limited services in others.

As part of its trust responsibility, the federal government is required to provide health care services to the Alaska Native population. The Alaska Area Native Health Service works in conjunction with nine tribally operated service units to provide comprehensive health services to 120,000 Alaska Native people. Federally recognized Alaska tribes administer 99 percent

Figure 15-1

Levels of Community for Health Planning in Alaska

Community Type	Population	Health Services	General Access
LEVEL I			
Isolated Village	50 to 1,000	Community clinic, CHA or EMT	Limited air or marine highway access or road access that exceeds 60 miles
Highway Village	50 to 1,000	Community clinic, CHA or EMT	Limited air or marine highway access; year-round, 60 minute or less road access
LEVEL II			
Isolated Sub-Regional Center	500 to 3000+	Community clinic PA, NP, MD or DO	Marine highway or daily air access; air service to Level I communities in area
Highway Sub-Regional Center	500 to 3000+	Community clinic PA, NP, MD or DO	Marine highway or daily air access; year-round 60 minute or less road access
LEVEL III			
Regional Center	2,000 to 10,000+	Community hospital MD or DO Public and private providers	Daily airline service; road or marine highway access all year
LEVEL IV			
Small City	10,000 to 100,000	Hospital with a 24 hour ED and full continuum of care; Multiple providers of health care Public and private programs	Daily airline service; road or marine access all year
LEVEL V			
Urban Center	100,000+ statewide sevices	Specialized medical and rehabilitation services	Daily airline service to Level II to V communities; road or marine access all year

of the Indian Health Service funds earmarked for Alaska through the provision of 20 Title I contracts, 26 grants, and one compact with 20 Title V annual funding agreements.

Health Care Workforce

In 1998, Alaska ranked 48th among the states in the ratio of doctors to residents. Only Idaho and Oklahoma had fewer doctors per 100,000 population.[4] Access to care is also limited by shortages of other health care providers and allied health workers. The Alaska Center for Rural Health, in a November 2000 survey, identified shortages of nurses, social workers, dentists, dental assistants, pharmacists, opticians, speech pathologists, school psychologists, physical therapists, emergency medical technicians, mental health counselors, medical transcriptionists, radiologists, respiratory therapists, community health aides, and certified nursing assistants.[5] Alaska wages are no longer high enough to attract qualified workers from other states, and educational programs within the state are not adequate to meet Alaska's needs. The aging of health professionals in Alaska, where 25 percent of registered nurses and 43 percent of physicians responding to a survey were over 50, is another concern.[6,7] Many census areas and boroughs in Alaska are federally designated as health professional shortage areas (Table 15-2).

Alaska relies on community health aides, public health nurses, nurse practitioners, and physician assistants to deliver health care outside communities with hospitals. Community health aides (CHAs) are unique to Alaska. Most CHAs are Alaska Natives serving in their own rural communities. They learn primary, preventive, and emergency care in regional training programs and practice with telephone or radio consultation from a physician. Public health nurses employed by the state, the Municipality of Anchorage, and several tribal health associations provide a wide variety of services throughout the state. Alaska also has the highest ratios of nurse practitioners and physician assistants per capita in the nation. [8]

Figure 15-2

Alaska Health Professional Shortage Area (HPSA) and Medically Underserved Area (MUA/MUP) Designation Status

Geographic Location:	Primary Care	Mental Health	Dental Health	MUA/MUP
Aleutians East Borough	Yes	Yes	Yes	Yes
Aleutians West Census Area	Yes	Yes	Yes	Yes
Anchorage (North Census Tracts)	Yes		Yes	Yes
Anchorage AK Native Population				
Bethel Census Area	Yes	Yes	Yes	Aniak/Lower Kuskokwim
Bristol Bay Borough	Yes	Yes	Yes	Yes
Denali Borough	Yes	Yes	Yes	
Dillingham Census Area		Yes	Yes	
Fairbanks NSB (Low Income Pop)	Yes	Yes	Applied	
Haines Borough		Yes		Yes-Gov
Juneau Borough				
Kenai Peninsula Borough				Yes-Gov
Ketchikan Gateway Borough		Yes		
Kodiak Island Borough				
Lake and Peninsula Borough	Yes	Yes	Yes	
Matanuska-Susitna Borough		Yes		Yes-Gov
Talketna/Trapper Creek	Yes		Yes	
Nome Census Area		Yes		Yes
Norton Sound	Yes			
North Slope Borough	Yes	Yes	Yes	Prudhoe/Kaktovik
Northwest Arctic Borough	Yes	Yes	Yes	Yes
Palmer Correctional Cntr				
Prince of Wales-Outer Ketchikan	Yes	Yes		Outer Ketch/Prince of Wales
Sitka Borough				
Skagway-Hoonah-Angoon CA	Yes	Yes	Yes	Skagway/Angoon
Southeast Fairbanks Census Area	Yes	Yes	Yes	
Valdez-Cordova Census Area		Yes		
City of Whittier				Applied
Wade Hampton Census Area	Yes	Yes	Yes	Yes
Wrangell-Petersburg Census Area		Yes		
Wrangell Sub-Census				
Yakutat Borough	Yes	Yes	Yes	Yakutat
Yukon-Koyukuk Census Area	Yes	Yes	Yes	Koyukuk/Yukon/McGrath

Revised - Jan 28, 2002
APPL - Application at Division of Shortage Designation, pending review
MUA/MUP - Designated Census Subareas are listed, if the entire Borough/Census Area is not designated.

Turnover in remote areas affects the quality of health care, as professionals who have learned the cultural and epidemiological characteristics of a community are replaced by less knowledgeable newcomers. Community leaders in the Yukon-Kuskokwim Delta described the problem poignantly when they listed "physician turnover ratio" as one of their health care priorities for 2001-2002: "When physicians learn, they move away from our region and we have to start all over with new physicians."[9]

Increasing the number and proportion of members of under-represented racial and ethnic groups who are primary care providers is important because they are more likely to provide services in a culturally appropriate manner, to practice in areas where health services are in short supply and are more likely to practice in areas with high percentages of under-represented racial and ethnic populations.

Health Insurance and Payment Sources

Adequate health insurance is crucial in determining access to primary care. In 1999, 17 percent of Alaskan adults reported that they did not have health care coverage.[10] The percentage of those who lacked health insurance coverage was higher for non-Native Alaskans than for Native Alaskans who were covered by the Indian Health Service. Lower income adults and those who were out of work or self-employed also were more likely to lack health insurance coverage.

Access to care depends, in part, on access to an ongoing source of care. People with a usual source of health care and a usual primary care provider are more likely than those without to receive a variety of preventive health care services.[11] Nationally, about 16 percent of adults lack a usual source of care.[12] Eighty-one percent of Alaskan adults reported they had a usual place to go for primary care services when they were sick or when they needed health care advice, and 80 percent of Alaskan adults reported they had a routine checkup within the last two years.[13] This indicates that about 19 percent of adults lack a usual source of care. Children and the elderly are most likely to have a usual source of care.

The State Children's Health Insurance Program, Denali KidCare in Alaska, implemented in 1999, provides a mechanism for increasing the proportion of children who have an ongoing source of health care. Over 16,000 children have become eligible for insurance as eligibility was expanded to the 200 percent poverty level.

Current Strategies and Resources

The essential interface of preventive and primary care services with acute care and specialties is improved by planning, networking and coordinating among all sectors of the health care system.

Hospitals and nursing homes are involved individually and through the Alaska State Hospital and Nursing Home Association. Professional medical, nursing and dental associations participate in statewide planning efforts. These relationships cannot be taken for granted – identifying common interests is often a challenge.

Public health partners in Alaska, including federal, state, non-profit, and private partners, are working to address health care access disparities. The partners include the Bureau of Primary Health Care (BPHC) and the National Health Service Corps (NHSC) of the United States Department of Health and Human Services, the State of Alaska Department of Health & Social Services (DHSS), regional Alaska Native health corporations, municipal health agencies, and non-profit organizations such as the Alaska Primary Care Association. Current programs support the availability of health care through direct funding with limited federal funds for clinics, technical support to clinic administrators and providers, and recruitment and retention activities.

Statewide planning efforts that involve state, regional, and local health care partners and periodic meetings between health care access partners are underway to help resolve or eliminate specific political and/or regulatory barriers or problems related to access to health care. One example of the successful coordination of health care partners to address specific access concerns is the Denali Commission. One of Denali Commission goals is to improve health care access in rural Alaskan communities. Denali Commission projects include the design and construction of rural health clinics in communities with the highest need. Statewide, regional, and local partners work together to prioritize and support Denali Commission resolutions, proposals, and projects.

Clinical Preventive Care

Clinical preventive services are effective in primary prevention, including prevention of many of the diseases that are leading causes of death, and in early detection of disease where treatment is an option. Improving ac-

cess to appropriate preventive care requires addressing barriers that involve the patient, provider, and system of care.[14] Barriers that limit access to preventive care include lack of knowledge, skepticism about the effectiveness of prevention, lack of a usual source of primary care, and lack of money to pay for preventive health care. Although some prevention efforts are widely recognized, a small but significant number of patients remain skeptical of even widely accepted preventive measures, such as immunizations. Having health insurance, a higher relative income, and a usual primary care provider are strong predictors that a person will receive appropriate preventive care.

Primary Care

Primary care services in Alaska are provided by a spectrum of practitioners, ranging from Community Health Aides and Practitioners in remote villages served by the Alaska Native tribal health organizations to mid-level practitioners in Community Health Centers, tribal health centers and rural health clinics (both public and private settings), to physicians in urban multi-specialty group practices. Itinerant Public Health Nurses provide primary and preventive care in even the most isolated villages. A variety of agencies support the development of primary care services, including the Department of Health and Social Services, the Alaska Primary Care Office, the Alaska Native Tribal Health Consortium (ANTHC) and regional tribal organizations, the Denali Commission, the Alaska Primary Care Association, the Alaska Center for Rural Health, and the Alaska Family Practice Residency program. In some areas, access to primary care for people covered by Medicare or eligible for Medicaid is limited because of physicians' unwillingness to accept Medicaid patients or to bill Medicare.

Emergency Services

In the current health care delivery system, emergency departments are the only institutional providers required by federal law to evaluate anyone seeking care.[15] They are expected at least to stabilize the most severely ill and injured patients, and they provide walk-in care for persons who face financial or other barriers to receiving care elsewhere.

The outcome of many medical emergencies depends on the prompt availability of appropriately trained and properly equipped pre-hospital emergency medical care providers. Under national guidelines, in urban areas this capability is defined by an interval of less than 5 minutes from the time an emergency call is placed to arrival on the scene for at least 90 percent of first-responder emergency medical services and less than 8 minutes for at least 90 percent of transporting emergency medical services (EMS). In rural areas, this capability is defined as an interval of less than 10 minutes from the time an emergency call is placed to arrival on the scene for at least 80 percent of EMS responses. In many parts of Alaska, it is simply not possible to meet this standard by virtue of the geographic distribution of the population. Further, the availability of emergency medical personnel varies widely throughout the state; rural, isolated volunteer providers have difficulty recruiting and retaining personnel.

A reliable communications system is an essential component of an overall EMS system. Over 90 percent of Alaska's population is covered by the 911 system, yet some villages have only satellite telephones or even more limited communications. There are 120 microwave wireless radio links comprising the backbone of the communications system along Alaska's major highways, but the system is incomplete. There are only 12 emergency call boxes along the major highways. There is no common mutual aid frequency and some rural areas have no radios at all or have access only to Citizens' Band (CB) radios.

Alaska has been one of the nation's leaders in the field of early defibrillation and has, since 1987, allowed first responders to use automated external defibrillators (AEDs). Recent changes in guidelines from the American Heart Association, state legislation in 1998, and the potential for national funding for rural AED implementation has refocused interest on this important subject.

The State of Alaska has an active and efficient Emergency Medical Services for Children (EMSC) program which has, as a high priority, the development and promulgation of emergency medical protocols which deal specifically with children. The State's medevac guidelines and model pre-hospital standing orders were both revised to include the model pediatric guidelines developed through the national EMSC Project. The State of Alaska's EMS for Children Program has been active in the development and distribution of pediatric guidelines and equipment and has supported pediatric emergency medical training for all levels of emergency personnel.

Additional information on the state's EMS system can be found on the CHEMS website at www.chems.alaska.gov.

Telehealth

Advancements in telecommunications infrastructure and telehealth technologies within Alaska are beginning to have a profound impact on access to primary, preventive, and emergency care. Telehealth is being applied in a variety of rural settings within Alaska. Telehealth involves the use of telecommunications to facilitate health care in situations where the patient and the provider or where the general practitioner and the specialist are separated by distance. Telehealth applications include clinical consultations, tele-radiology, tele-dermatology, tele-home health care, tele-psychiatry, and an array of other technologies.

The combined efforts and cooperation of telecommunication carriers, health care providers, health organizations, and health care consumers, as well as government agencies at the federal, tribal, state, and local levels, are needed to maintain and improve primary, preventive, and emergency care throughout Alaska. The Alaska Telehealth Advisory Commission, the Alaska Federal Health Care Access Network (AFHCAN), and other regional telemedicine planning processes and projects are helping to bring telecommunications and health care to rural Alaska.

In addition to providing real-time services in some settings, and "store and forward" modes of transmitting information in others, telehealth is expected to help communities retain qualified providers by helping to reduce isolation. Telehealth provides a stimulating and supportive environment for health care workers and enhances communication and professional relationships between providers. Efforts are underway to extend the AFHCAN tools and systems to private partners interested in promoting telehealth throughout the state. Privacy and security are being taken into consideration and will continue to be discussed.

Beginning in 1999 the Alaska Telehealth Advisory Council (ATAC) provided a framework for organizations interested in telehealth to work on common issues and problems. The ATAC published draft technical standards, draft telepsychiatry guidelines for the State of Alaska, completed a statewide survey of telehealth interests and capacity in the rural non-federal sectors of the state, awarded two telepsychiatry pilot contracts, awarded a telemedicine efficacy pilot contract and made recommendations for regulatory changes for the Medicaid program to allow payment for telemedicine services.

Hospitals

There are 24 acute care hospitals in Alaska, including two military hospitals and seven hospitals operated by tribal health corporations (Table 15-3). The relatively large hospitals in Anchorage and Fairbanks serve as regional 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.

With 202 hospital beds per 100,000 population in 1998, Alaska fell far below the national average of 311. Community hospital beds per capita declined 11 percent from 1980 to 1997, less than the national decline of 29 percent.[1]

Like hospitals in the rest of the country, Alaska's hospitals face rising costs, increases in outpatient visits, and declining inpatient utilization. Occupancy rates fluctuate, but often average 30 percent or less of the licensed beds. Some hospitals struggle with the problem of seasonal fluctuations [in census]. Shortages of health care workers, especially nurses, make it difficult to provide care for times of higher census or acuity.

Alaska's small rural hospitals face both unique problems created by Alaska's geography and problems common to small rural hospitals throughout the country. Paramount among these problems are difficulty in recruiting and retaining physicians, financial problems related to declining inpatient use while continuing to provide emergency care and necessary transfer to more sophisticated levels of medical care in larger communities. A federal program, the Rural Hospital Flexibility Program, allows Alaska's small rural hospitals to make some changes to address these issues by reducing the cost of meeting regulatory requirements, enhancing opportunities for Medicaid and Medicare reimbursement, and increasing flexibility to meet staffing needs. The program requires hospitals seeking designation as "necessary providers of health care services" or Critical Access Hospitals (CAH) to establish and maintain formal networks to assure continuity of care for patients and consultative relationships that enhance quality of care.

To be eligible for the Rural Hospital Flexibility Program, public and non-profit hospitals must meet certain criteria, including being more than 35 miles from another hospital or being needed to assure access to care for individuals within the community. By 2002, four Alaskan hospitals (Petersburg Medical Center, Sitka Community Hospital, Providence Seward Med-

Table15-3

Alaska Hospitals 2001

Region/Hospital	Location	Total Licensed Beds	Governance
Anchorage Matanuska Region			
Providence Alaska Medical Center	Anchorage	303	Private Non-Profit
Alaska Regional Hospital	Anchorage	238	Private For-Profit
Alaska Native Medical Center	Anchorage	156	Tribal Health Corporation
Air Force Medical Center, Elmendorg AFB	Anchorage	105	Federal Military
Valley Hospital	Palmer	36	Private Non-Profit
Interior Region			
Fairbanks Memorial Hospital	Fairbanks	162	Private Non-Profit
Basset Community Army Hospital	Ft. Wainwright	55	Federal Military
Southeast Region			
Bartlett Regional Hospital	Juneau	55	Public Municipal
Ketchikan General Hospital	Ketchikan	92	Public Municipal
Petersburg Medical Center	Petersburg	27	Public Municipal
Mt Edgecumbe Hospital	Sitka	60	Tribal Health Corporation
Sitka Community Hospital	Sitka	25	Public Municipal
Wrangell Medical Center	Wrangell	22	Public Municipal
Gulf Coast Region			
South Peninsula Hospital	Homer	47	Public Municipal
Providence Kodiak Island Medical Center	Kodiak	44	Public Municipal
Providence Seward Medical Center	Seward	6	Public Municipal
Central Peninsula Community Hospital	Soldotna	62	Public Municipal
Valdez Community Hospital	Valdez	15	Public Municipal
Southwest Region			
Cordova Community Medical Center	Cordova	22	Public Municipal
Yukon-Kuskokwim Delta Regional Hospital	Bethel	50	Tribal Health Corporation
Kanakanak Hospital	Dillingham	15	Tribal Health Corporation
Northern Region			
Norton Sound Regional Hospital	Nome	34	Tribal Health Corporation
Simmonds Memorial Hospital	Barrow	14	Tribal Health Corporation
Maniilaq Medical Center	Kotzebue	17	Tribal Health Corporation

** Total beds includes licensed and/or certified acute care and swing beds. Many hospitals are operating with fewer beds than those licensed.*
Source: Alaska Division of Medical Assistance, Health Facilities Licensing and Certification, August 1, 2001

ical Center and Valdez Community Hospital) were designated as Critical Access Hospitals. Other hospitals are exploring the value of such designation.

Some of Alaska's larger and more fully equipped rural health clinics are monitoring the criteria for the Critical Access Hospital program and the implications for their primary care clinics. Many of these clinics are already staffed with mid-level providers, offer emergency services around the clock, and receive regular visits from a supervising physician. They keep patients overnight or longer when transfer to another facility is not possible. Clinics in Metlakatla, Unalaska, St. Paul, Unalakeet, St. Mary's, Emmonak, Talkeetna, Aniak, McGrath, Galena, Klawock, Craig, and Haines are examples of clinics that currently meet some of these criteria. The requirement for previous certification as a hospital is currently a barrier for a primary care clinic becoming a Critical Access Hospital.

Long-Term Care and Rehabilitation

People with conditions that limit their capacity for self-care need long-term care and rehabilitative services. The long-term care population includes individuals who need help or supervision to perform activities of daily living. The goals of long-term care services are to improve functioning, maintain existing functioning, or slow deterioration in functioning while delivering care in the least restrictive environment. Rehabilitative services, a critical component of long-term care, strive to return individuals to their optimal level of functioning. Many clients will leave long-term care facilities to return to more independent living situations when their health or functional level improves or when home and community services can provide adequate support.

Access to long-term and rehabilitative care is a significant problem for people who lack health insurance, who are under-insured, who live in remote areas, and who are unable to pay for the type and quality of health care they need. Others, such as Alaskans with traumatic brain injury, must leave the state for the specialized rehabilitative and support services they need. People in the long-term care population need access to a range of services, including nursing home care, home health care, adult day services, assisted living, and hospice care.

Alaska is first in the nation in the proportional growth of our senior population – with a 50 percent increase in people aged 65 years and older between 1990-1999.16 An increase in the number of elderly and adults with disabilities in Alaska means a dramatic increase in the number of people needing long-term care services.[17] Table 15-4 outlines the long-term care services available for seniors in Alaska by census area.

In the past ten years Alaska has made progress in moving toward a balanced long-term care system that is accessible to people throughout the state. The Medicaid Waiver program established in 1995 revolutionized the long-term care industry in Alaska. Since its inception, the program has grown tremendously (360% from FY96 to FY99). In Alaska Medicaid pays for the cost for 80 percent (as of 1997) of all nursing home residents and the state pays for 40 percent of all Medicaid costs. Private insurance policies and Medicare do not usually pay for long-term care. Employees of the State of Alaska can purchase long term care insurance when they retire. Private organizations like the American Association of Retired Persons educate people about the benefits of long-term care insurance and offer such plans for purchase.

Five years ago the state started phasing out Intermediate Care/Mental Retardation facilities and transitioning those residents into home and community based care settings. Alaska has also seen a significant growth in the assisted living industry in the past five years. Grants from the state have increased the availability of respite care, care coordination (case management), and adult day services in both urban and rural areas.

It is a priority in Alaska to provide a continuum of long-term care services for elderly and disabled Alaskans statewide. The Long-Term Care Implementation Team was organized in 1996 for policy makers in the Departments of Administration and Health and Social Services to identify a comprehensive, multi-year strategy to guide long-term care development in the state. The Long-Term Care Implementation Plan was completed in 2001. Plan goals are to create a balance in the long-term care system between institutions and integrated community-based care and to make long-term care services more accessible by making them more affordable and efficient. In addition, the plan focuses on assuring safe, high quality care that will prevent or correct unjustified institutionalization. Targeting financial resources and state reimbursement policies are methods to achieve the plan's goals. Planned activities include seeking national accreditation for Pioneers' Homes, making Licensing & Certification reports public, enhancing and expanding care coordination and counseling, and streamlining and simplifying the administration and payment of and eligibility for long-term care services. Additional action

Table 15-4

Senior Services Long-Term Care Services by Census Area

Service Area	Adult Day Services	Respite Care	Personal Care Attendant	Care Coordination	Numbers of Seniors (1998)	Independent Living Facility	Assisted Living Beds	Nursing Home Beds
Anchorage/ Mat-Su Borough	115	Yes	Yes	Yes	15,692	955	779	330
Bethel/Wade Hampton Census areas	16	No	Yes	Yes	1,190	39	0	0
Cordova, Census Subarea	0	No	No	No	152	22	0	10
Dillingham/Bristol Bay/ Lake & Pen Boro	0	Yes	Yes	Yes	600	55	10	0
Fairbanks N. Star/ Denali/SE Fairbanks	20	Yes	Yes	Yes	4,400	262	197	90
Juneau/Haines/ SKAG/HNH/ ANG/YAK	16	Yes	Yes	Yes	2,349	267	60	44
Kenai Peninsula except for Seward	37	Yes	Yes	Yes	2,913	163	80	70
KTN Gateway Br/POW Is/Metlakatla	20	Yes	Yes	Yes	1,488	107	54	46
Kodiak Island Borough	12	Yes	Yes	Yes	609	70	0	19
North Slope Borough (Barrow)	0	No	No	No	299	37	11	0
Northwest Arctic Borough (Kotzebue)	0	Yes	Yes	Yes	368	16	20	0
Nome Census area	20	No	Yes	Yes	544	46	0	15
Prince William Sound/ Copper River	0	No	No	Yes	457	35	0	0
Seward census subarea	0	Yes	Yes	Yes	316	30	11	66
Sitka Borough	0	Yes	Yes	Yes	700	44	102	10
Wrangell-Petersburg census area	0	Yes	Yes	Yes	652	48	5	29
Totals	256	5 no	3 no	2 no	32,729	2196	1329	729

steps call for exploration of options for Medicaid and other public funding for community based long-term care services for people on waiting lists who cannot afford such care. The plan also details activities for workforce development, training and retention.

Data Issues and Needs

Information on preventive services and primary care use among public health and tribal health clients is available through the Resources Patient Management System. There is no comparable data source for the majority of the population of Alaska. Unlike many states, Alaska does not have managed care associations collecting health data for their members.

The federal uniform data system for federally supported Community Health Centers will provide a new source of information about primary care patients and services in 29 communities and service areas now served.

Hospital discharge data would be useful in evaluating primary and preventive services. Admissions for asthma, complications of diabetes, and other conditions that could be managed by primary care providers could be compared to national hospital discharge data. Estimates of people who need rehabilitative or long-term care could be enhanced by examining discharge diagnosis codes for stroke, hip fracture, and other conditions that are likely to require further care.

Related Focus Areas

The *Ceeguu"vq"Swcnkv{"Jgcnvj"Ectg"Ugtxkegu* chapter is interconnected to all the other chapters of *Jgcnvj{"Cncumcpu"4232*.

Endnotes

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Denali Commission	www.denali.gov/
Denali Kidcare	www.hss.state.ak.us/dma/DenaliKidCare/
Alaska Federal Health Care Access Network (AFHCAN)	www.afhcan.org
Alaska Center for Rural Health	www.uaa.alaska.edu/ichs/acrh/
Alaska Telemedicine Project	www.telemedicine.alaska.edu/
Alaska Primary Care Association	www.alaskapca.org/
Alaskan Association of Hospitals and Nursing Homes	www.ashnha.com/
Alaska Information Technology Group	www.state.ak.us/itg
Alaska Poison Control Center	www.chems.alaska.gov/ems_poison_control.htm
Alaska Human Resource Investment Council (AHRIC)	www.labor.state.ak.us/commish/ahric/home.htm
Alaska Telehealth Advisory Council	www.telemedicine.alaska.edu/

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Agency for Healthcare Research and Quality	www.ahrq.gov/consumer/index.html#plans
Office of Minority Health Recommended Standards for Culturally and Linguistically Appropriate Health Care Services	www.omhrc.gov/clas/ds.htm