

**Agency: Commerce, Community and Economic Development****Grants to Named Recipients (AS 37.05.316)****Grant Recipient: Interior Alaska Hospital Foundation****Federal Tax ID: 91-1820378****Project Title:****Project Type: Planning and Research**

# Interior Alaska Hospital Foundation - Rural Health Care Facility

**State Funding Requested: \$50,000****House District: 12 / F**

Future Funding May Be Requested

**Brief Project Description:**

Research, study, evaluate, design, and construct a health care facility to serve Interior Alaska to be located in the Delta Junction area.

**Funding Plan:**

Total Project Cost: \$50,000

Funding Already Secured: (\$0)

FY2013 State Funding Request: (\$50,000)

Project Deficit: \$0

*Funding Details:**Awaiting***Detailed Project Description and Justification:**

Research, study, evaluate, and construct a health care facility to serve Interior Alaska to be located in the Delta Junction area.

See attached PDF

**Project Timeline:**

FY 2013 Conduct feasibility study.

**Entity Responsible for the Ongoing Operation and Maintenance of this Project:**

Interior Alaska Hospital Foundation

**Grant Recipient Contact Information:**

Name: Mary K. Baker-Kaspari

Title: President

Address: PO Box 177  
Delta Junction, Alaska 99737

Phone Number: (907)895-3232

Email: marykaspari@hotmail.com

Has this project been through a public review process at the local level and is it a community priority? ☒ Yes ☐ No**\$50,000  
Approved**

# INTERIOR ALASKA HOSPITAL FOUNDATION

## PRELIMINARY REPORT

PREPARED BY  
MCCLURE AND ASSOCIATES, INC.  
21308 LINCOLN BLVD. GRETNA, NE 68028



*McClure and Associates, Inc.*

**LEO A DALY**  
PLANNING ARCHITECTURE ENGINEERING INTERIORS



LANCASTER  
POLLARD 

- Health Care in rural and frontier America has been a concern for several decades. For many areas health services have been nonexistent to declining, with rural communities not able to cover the cost of providing services to Medicare and Medicaid.
- For years rural facilities had been punished with low reimbursement rates for Medicare and Medicaid basically receiving 33% of the actual cost of doing business.
- Larger hospitals were able to provide more services and to larger non Medicare markets and thus be successful.
- Rural health care facilities were limited in services they provided because they had to fund the losses of Medicare.
- Rural hospitals were not able to purchase needed new equipment or modernize their facilities due to having to pick up the losses of Medicare.



- A number of things have completely turned the rural market into a positive direction, not only for health care, but also wellness and preventive medicine.
- Numerous rural states have started incentive programs for physicians, mid-level practitioners, registered nurses and technical health care support staff to practice in rural and frontier settings.
- Demographics have improved in many states, with surges in agricultural and energy production. Multiple rural states are seeing meaningful sustainable growth for the first time in the last 20 years.
- The advent of Critical Access Hospitals is the largest incentive to hit the rural areas since the beginning of Hill Burton funds after World War II to handle the impact of rural growth. The Critical Access program provides for cost based reimbursement for certain rural and frontier hospitals. (will explain latter)
- Frontier Extended Care Clinics have also entered into the new expanded market providing service.
- Regional Networks of larger hospitals providing support services for specialty services to rural hospitals.
- Tele Medicine, making it possible, for urgent at the moment assistance in emergency departments and ICU in rural markets, by electronically bringing in specialist, ability to digitally transmit CT Scans, X-ray, laboratory testing and many more implications.
- Full Tele-med diagnostic services are on the horizon, robotic surgery perform by surgeons from anywhere, the technology is already in use, and like the technology of CT Scans and MRI have improved and the cost factor lowered to allow most CAH to have a CT Scanner and now MRI's the robotic surgery is on the horizon.



**What does all this mean to Delta Junction and the Interior Alaska Hospital Foundation?**







- Market designation is approximately 70,000 square miles with 72% of the market within a 30 mile radius of Delta Junction.
- The 2000 census indicated a population base of 5,228, 2011 population estimate based on 2010 census is 5,820 and 2016 projections are 6,036.
- Growth was 11% from 2000 to 2011 and projected growth from 2011 to 2016 of 4.5%. The area has one of the higher growth rates in Alaska.





**Current Clinic Utilization** (Current clinic serves as 24 hour emergency department for the area, stabilization must occur at the clinic before transferring for advanced treatment)

- Clinic patient visits 16,891 for the last year. Benchmark potential for the market is 16,469.
- Current clinic visits include 18% of the total visits from individuals from outside the market, for example those working in the area not being full time residents and tourist of whom Delta Junction had 30,000 visitors go through the area last year.
- Emergency visits provided 24/7 were 1,810 in the clinic the benchmark comparison of potential ED visits for the market was 2,408.
- Laboratory procedures performed at the clinic were 16,478.
- Radiology procedures performed at the clinic were 2,017.
- 355 surgical procedures were performed in the clinic.
- 345 surgical procedures were performed in the emergency room.



# EMS DELTA JUNCTION FIRE RESCUE



The Delta Rescue Squad has run on 236 calls this year

**Types of Calls (most serious)**

- Multiple Severe Burns
- Multiple MVA's on Tenderfoot
- OD's/Attempted Suicides
- Plane Crash
- Helicopter Crash
- Auto Accidents
- Cardiac
- Multiple ATV Accidents
- Assault's
- Snow-machine Accidents
- Babies delivered at Clinic



## Potential Acute Inpatient Admissions

- Benchmark utilization for the market indicates that 652 admissions for the market accounting for an average daily census of 5.6.

## Diagnostic Potential Based on Benchmarks

- CT Scans ED and clinic diagnostic 812 per year, 15.6 per week. Plus potential contracting with Native Health.
- MRI procedures ED and clinic 325 per year 6.25 per week. Plus potential contracting with Native Health.



## Advantages

- Dedicated private clinic
- Health Care Professionals that are established.
- Current programs currently providing more services than many critical access hospitals in the country are providing in larger facilities.

## Concerns

- Current facilities cannot function properly.
- No inpatient care is available.
- Diagnostic services CT, MRI, not existent must be transported.
- Physical Therapy and Occupational Therapy not available.
- Other specialty clinics not provided due to lack of facilities to meet the local need.

## What is a Critical Access Hospital?

- Is located in a rural or frontier area, must be no closer than 35 miles or 15 miles in a mountainous area to another hospital.
- Average length of stay for all admissions must not exceed 96 hours.
- Medicare is reimbursed at 101% of actual cost of service, including capital funding and depreciation.
- By paying the actual cost, the facilities can now create positive margins with additions of services that not only serve the older population but also the younger population.
- Insurance programs negotiate fees for service by region, that fee for service has a built in profit margin.
- Properly operated there is no reason that a CAH should not be sustainable within market perimeters.
- Services are provided by physicians and mid-levels and backed up by specialist from the regional networks, all states have regional network, and every CAH must have an agreement with a network hospital.





## What does a CAH mean to the community?

- Quality local health care.
- Stabilization for critical cases that need to be transported and in some cases in rural America that can be a challenge with extreme weather conditions and may take hours to several days in some circumstances.
- Chronic disease management
- Nutritional education.
- Wellness education.
- Local physical therapy
- Workman's comp testing
- Emergency services
- Diagnostic services
- Specialty services
- Timely accessibility reducing travel cost to patients, less down time for employers.

## What is a Frontier Extended Stay Clinic?

Remote, frontier areas face:

- Severe inclement weather
- Lack of transportation services
- Long distances to travel to nearest acute care hospital

## Eligibility

- Must be at least 75 miles from the nearest hospital or inaccessible by public road.
- Serve seriously or critically ill patients awaiting transport.
- Patients who need monitoring and observation for limited time.
- Staffing available
- Lab
- Radiology
- Transfer Agreements
- Record Keeping
- Physical Space for ambulatory Health Care

## Frontier Clinic Scope of Service

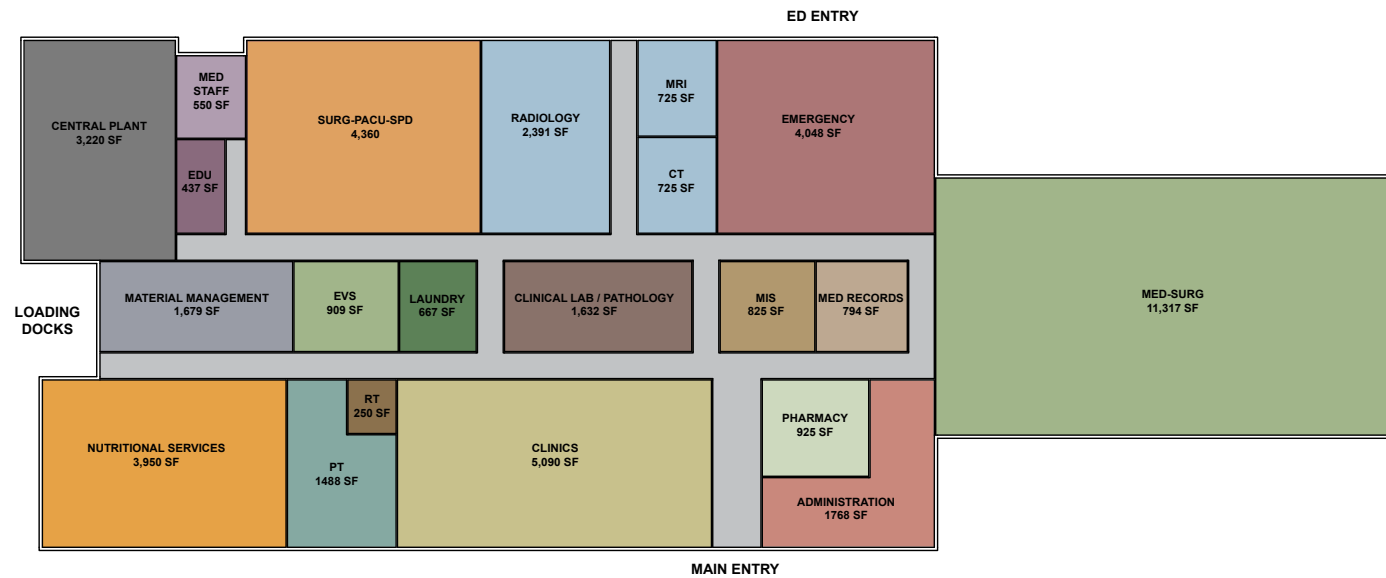
- RN immediately available.
- Patients cannot stay longer than 48 hours
- Monitoring and observation patients cannot meet CMS inpatient hospital admission criteria.
- Reasonable expectation for significant improvement in 24 hours.
- Reasonable expectation care will be completed within 48 hours.
- Manage common complications.
- Medical consultation available.
- Contingency plan in place for transport.



## What does a Frontier Extended Care Clinic mean to the community?

- Quality local non acute or swing bed health care.
- Stabilization for critical cases that need to be transported and in some cases in rural America that can be a challenge with extreme weather conditions and may take hours to several days in some circumstances.
- Chronic disease management
- Nutritional education.
- Wellness education.
- Emergency services
- Diagnostic services
- Timely accessibility reducing travel cost to patients, less down time for employers.



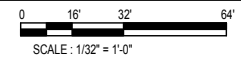


## CONCEPT BLOCK PLAN

DELTA JUNCTION ALASKA CRITICAL CARE HOSPITAL AND CLINIC

001-10083-000

11/23/11



LEO A DAILY



LEO A DAILY  
PLANNING ARCHITECTURE ENGINEERING INTERIORS



LANCASTER  
POLLARD



EXTERIOR



INTERIOR



## DIAGNOSTICS



## EMERGENCY





## OPERATING ROOM



## NURSE STATION





## PATIENT ROOM





### How will the CAH or ECC be organized?

- The foundation is a not-for-profit corporation.
- Will be controlled by a local board of directors.
- Will oversee total operations of the hospital including a clinic.
- Will only happen if found to be financially viable to operate successfully.



## What are the next steps?

- Complete the written feasibility study.
- Develop next step strategy.



- There are approximately 1,400 Critical Access Hospitals in the United States.
- Medicare reimbursement is less than 2 ½ % of Medicare cost and covers a geographic area approximately 70% of the land mass of the United States.
- Is the most efficient program in Medicare!
- Lynch Nebraska is the smallest community in the United States with a critical access hospital population 296.
- One CAH in North Dakota has over 20 practitioners, operate several clinics in communities in North Dakota, South Dakota and Montana, with the closest network hospital 95 miles away. The local community before extending their market is smaller than Delta Junction.
- One CAH in Kansas that operates successfully, in a market of 5,000 people has three physicians, three mid-levels and has half the clinic visits of Delta Junction. The hospital supports and average census of 14 per day, which would peak admissions at times of 22 per day. The facility has an extremely busy physical therapy and cardiac rehab. The emergency department does about half the volume of ED at the Delta Junction clinic.
- CAH are not limited on the services they can provide.



## What can you do?

- Immediate needs include fund raising to complete the feasibility study.
- Volunteering to serve on a variety of committees that will need to be developed as the project progress.
- This is a local grass roots effort will only happen if the community wants it, is planned as a non-government entity locally controlled.



## What else do we know?

- A market exists to support a Critical Access Hospital or Frontier Extended Stay Clinic.
- Project could be phased
- The market is as large as or larger than several existing CAH in Alaska.
- Will most likely have the distinction of the most remote hospital in the United States.
- Quality health care has been provided locally for years in a very restricted environment.
- Will not happen without community support.





Questions??





*McClure and Associates, Inc.*

## **James S. McClure**

President / Project Manager



**James S. McClure**, President and Chief Executive Officer, McClure and Associates, Inc. has over thirty-nine years of experience providing a wide range of consulting services to a variety of business ventures including: country clubs, retail establishments, housing, retirement housing, long-term care, hospitals and medical clinics.

Over the past seventeen years, he has completed market studies and development plans in multiple states with a focus on Critical Access Hospitals in the past 7 years. He has a unique perspective in reviewing potential projects for market feasibility. He believes that the demographics must be accurate to determine numbers of units. He has the experience operationally to determine the financial side and also all aspects of the day-by-day operations.

Jim has developed senior living facilities, hospitals, medical clinics and completed market studies on a variety of projects with total value over \$500,000,000. His company performs a wide array of services such as developer, business plans, market studies, strategic planning, marketing plans, marketing, operational reorganization, and financial and operational work-out plans. McClure and Associates participated in completing the 2008 and 2009 **Rural Hospital Renovation & Expansion Study** and presented at the National Rural Health Association Critical Access Conference. Jim is one of only a few in the mid-west that understands the fifty-five plus market and how to tap this lucrative market for any type of business.

Jim was one of the first nationally to develop the assisted living concept, creating the first prototype facility in Nebraska in 1975 as a federal demonstration project for the commission of aging; in addition he developed one of the first dementia diagnostic centers in western Nebraska.



*McClure and Associates, Inc.*

**LEO A DALY**  
PLANNING ARCHITECTURE ENGINEERING INTERIORS

**Kiewit**  
Building Group

**LANCASTER  
POLLARD**



*McClure and Associates, Inc.*

## **Terry J. Hill**

Executive Director, National Rural Health Resource Center



**Terry J. Hill** has more than twenty-eight years of professional experience in rural hospital performance management, education, health network and community development, strategic planning, grant writing, research, health information technology, program development and administration. He has directed national, state and regional programs on hospital performance improvement, aging, developmental disabilities, emergency medical services and rural health care.

Terry currently participates in seven federally-funded rural health projects including the Technical Assistance and Services Center of the Medicare Rural Hospital Flexibility program, the Mississippi Delta Rural Hospital Improvement program, the Frontier Extended Stay Demonstration Project, the Flex Rural Hospital Monitoring program, the Small Hospital Improvement program, the Minnesota Rural Hospital Performance Improvement project, and the Rural Health Network Technical Assistance Center program.

Terry grew up and spent more than a dozen years in Tok, Alaska, which is approximately 100 miles south of Delta Junction. He was the lead field person, working for HRSA and CMS, on the development of the Frontier Extended Stay Clinic, which is currently the newest Medicare model, and which is now in three locations in Alaska.

Terry is an expert on Critical Access Hospital certification, and the principle advisor to the 45 state Medicare Flex programs that certify and license CAHs, as well as to HRSA. He has been a part of seven CAH feasibility studies, several of those in Alaska and is currently working as a consultant to the Prince of Wales Network, the Alaska eHealth Program, and has also worked for the Alaska Hospital Association. Terry also participates with the Alaska Native Tribal Health Consortium.



*McClure and Associates, Inc.*

**LEO A DALY**  
PLANNING ARCHITECTURE ENGINEERING INTERIORS

**Kiewit**  
Building Group

**LANCASTER  
POLLARD**