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Executive Summary

Critical Access Hospitals (CAHs), as allowed under the Rural Hospital Flexibility Act, are “devolved” small, rural hospitals, who would likely have difficulty surviving under the stipulated change to prospective Medicare reimbursement required by the Balanced Budget Act of 1997. They are different from other hospitals because, unlike their larger, more urban cousins, they will continue to receive reasonable cost-based Medicare reimbursement for their services. Some Alaskan hospitals may convert if they foresee the conversion improving their sustainability without negatively affecting access or quality of care.

In Alaska, up to 12 hospitals (Cordova, Kanakanak, Maniilaq, Norton Sound, Petersburg, Kodiak, Seward, Samuel Simmonds, Sitka, South Peninsula, Valdez and Wrangell) are potentially eligible to participate in the Medicare Critical Access Hospital Program (CAH) and convert to a “CAH”. Examining the process for deciding whether or not to convert, and the impact of that decision, will provide useful insights to future policy decisions in Alaska. Thus, the evaluation of this program and its implementation are important tools for planning the next steps in rural health systems’ development and support when the Rural Hospital Flexibility Program grant ends. In short, the evaluation of “CAH” could be nearly as valuable as the program itself in the maintenance and improvement of Alaska’s health care delivery system.

Key questions that the Rural Hospital Flexibility Program evaluation should answer are:

- Did the program help stabilize Alaska’s small rural hospitals towards the maintenance or improvement of access to health care?
- What are the lessons learned from this program, especially as they relate to future policy decisions in this state?

This proposed evaluation plan, like the program itself, is community-focused. Participants in the evaluation are individuals and agencies who are affected by the program, or should be involved in designing and implementing the Flex program for Alaska. To effectively conduct a community-focused evaluation, the evaluation team must have demonstrated experience in or with rural Alaska health care delivery systems. The emphasis on experience with rural Alaska cannot be understated, as the evaluation team must be able to develop relationships and work with the rural population being served.

The evaluation methodology is participatory, qualitative, and results-oriented. The evaluation process should be easy to understand, the results should be easy to articulate in diverse forums, and the policy implications should be easy to translate into recommendations for future programs or decisions.
Core deliverables for this evaluation include:

- Assessment of effectiveness
- Characterization of the CAH planning process as it was and continues to be articulated by the Alaska CAH Steering Committee
- Comparison of characteristics of hospitals that do and do not elect to convert to a Critical Access Hospital
- Description of the importance of the financial feasibility assessment and community needs assessment if a decision to convert is made
- Description of the success or lack of it if there was a conversion
- Level of community engagement in community needs assessment and corresponding decision-making process
- Description of the development and strengthening of rural health networks and how they stabilized local hospitals and ensured local access
- Characterization of the strengthening and integrating of EMS towards the stabilization of hospitals and ensuring of local access
- Description of health systems changes and impact

I. Introduction

A. Legislation

The Medicare Critical Access Hospital Program is a component of the Rural Hospital Flexibility Act (Flex) passed as part of the Balanced Budget Act of 1997. Critical Access Hospitals are part of a nationwide service hospital program that was built on the Essential Access Community Hospital/Rural Primary Care Hospital and Medical Assistance Facility demonstration programs. CAHs can provide outpatient, emergency and inpatient services and receive reasonable cost-based reimbursement for their services.

The goals of the Medicare Rural Hospital Flexibility Program include:

- Development of a State Rural Health Plan
- Designation of Critical Access Hospitals in Alaska
- Development of Rural Health Networks
- Improvement and Integration of Emergency Medical Services
- Assurance of Quality of Care
- Evaluation of Alaska’s Rural Hospital Flexibility Program

B. Purpose and Use of the Evaluation

In Alaska, up to 12 hospitals are eligible to convert to a Critical Access Hospital. Which hospitals decide to convert, which do not, how they make that decision, and the impact of that decision on their long-term stability – all of this will provide useful insights to future policy decisions and how Alaska handles future endeavors of this nature. The evaluation will serve as an important tool to assist policy makers to plan
for the next steps in rural health systems’ development and support when the RHFP grant ends. In short, the evaluation of “CAH” could eventually equal the program itself in the stabilization and improvement of Alaska’s health care delivery system.

C. Expected Participants

Participants in the evaluation are defined as individuals and agencies who are affected by the program, or should be involved in designing and implementing the Flex program for Alaska. These participants may be clustered into two groups:

1. **Hospitals**: service providers - including and especially EMS - and the community members served by that health care delivery system
2. **CAH Steering Committee Members**, and the agencies they represent

II. Evaluation Questions

A. Key Questions

Given its purpose, key questions the Rural Hospital Flexibility Program evaluation should answer are:

- Did the program help stabilize Alaska’s small rural hospitals, towards the maintenance and improvement of access to health care?
- What are the lessons learned from this program, especially as they relate to future policy decisions in this state?

B. Specific Questions

Breaking the key evaluation questions/goals into a series of agreed upon sub-questions facilitates the process. These “sub-questions” are the result of conversations with the Federal Office of Rural Health Policy (FORHP), hospital administrators (former and current), and members of the CAH Steering Committee - to ensure they are sufficiently broad and in-depth. FORHP is particularly interested in community empowerment as the key mechanism for improving and sustaining local health care delivery systems. The sub-questions, and the proposed methodologies for answering them, therefore, are as follows:

1. How did the Steering Committee’s vision, policies and process (State and CAH Steering Committee) assist local communities to:
   - Develop or strengthen a network;
   - Make a decision regarding conversion to CAH;
   - Strengthen and integrate EMS; and
   - Improve quality

2. How effective was the State and the CAH Steering Committee in promoting community engagement?
3. According to the requirements of the program statute and regulations, a State Rural Health Plan was created. In Alaska, this “plan” has become a planning process. What was the process each year? What was the outcome and what was learned?

4. Implementation of the Rural Hospital Flexibility Program is the responsibility of the CAH Steering Committee. Do the committee members believe the process was sufficiently inclusive and participatory in the program’s development, review and approval of budgets and work plans, staffing and implementation? Why or why not?

5. What were the determining factors in each health care system’s decision to convert, or not convert, to a critical access hospital?

6. What role did the communities play in shaping their health care system under this program? Issues which must be included in this question are:
   - Inclusion in process: being informed, making decisions, involved in implementation
   - Adaptation of services/programs to meet community interests
   - Community participation in network priority setting and governance

7. What was the financial impact of the conversions?
   a. What assistance was provided for the conversion?
   b. Did the hospitals make or save money relative to conversion?
   c. What did they change?

8. Regarding accountability, How were the federal funds spent?
   a. What money went to the hospital, how was it used, what was accomplished?
   b. How was the money spent by the agency (State of AK)?
   c. What assistance did they provide with those dollars?
   d. What role did the Steering Committee play in these decisions?

9. What role did local hospital management, or management changes, play in the success of a conversion to a CAH?

10. What was the role of EMS in the program, and how was it affected by the program?

11. How did the rural hospital flexibility program help strengthen and integrate the emergency medical services system and what were the effects of the program on pre-hospital patient care, transport, and satisfaction?

12. How did rural health network development efforts affect the continuum of care for patients of rural hospitals? What were the networking relationships before conversion and how did they evolve as a result of conversion?
III. Methodological Considerations

An appropriate methodology for this project must be participatory, qualitative, and results-oriented. The process should be easy to understand, the results should be easy to articulate in diverse forums, and the policy implications should be easy to translate into recommendations for future programs or decisions.

As with the national evaluation, qualitative research methods will yield more suitable information than quantitative alternatives. The exception, of course, is financial implications. Otherwise, the program’s impact on hospitals that do and do not decide to participate in conversion to a CAH will be best assessed with qualitative tools collecting participant perceptions regarding engagement, usefulness, improvements, and sustainability.

IV. Qualifications of Evaluators and Process

Qualified evaluators will have demonstrated experience in or with:

- Rural Alaska health care delivery systems
- Rural Alaska hospital management
- Access to program implementation information from other states

The emphasis on experience with rural Alaska cannot be understated, as the evaluation team must be able to develop relationships and work with the rural population being served. Regarding the evaluation process, it is absolutely critical that the process be weighted to solicit and receive substantial information from the hospital, health care providers and community perspectives.

V. Timelines / Periodicity

Communications will occur with each hospital after the initial site visit from the state, after the financial and community assessments, before conversion, and one and two years after conversion - or over an equal time period if they elect not to convert.

VI. Deliverables

A. Assessment of State effectiveness

- Quality of vision, guidance, and policies – in state rural health plan, proposals, etc.
- Promotion of community engagement
- Accountability for use of grant funds - including timely dissemination

B. Comparison of characteristics of hospitals that do and do not elect to convert to a Critical Access Hospital
C. Characterization of the planning process which evolved from the Rural Health Plan

D. Characterization of the role played by the CAH Steering Committee in the program’s development and implementation

E. Level of community engagement in community needs assessment and corresponding decision-making process

F. Characterization of Rural Health Networks (their development or strengthening) and impact on the stabilization of hospitals and ensuring of access to care

G. Description of systems changes and impact on hospital stabilization and access to care
   • Internal facility / systems operations
   • EMS strengthening and integration
   • Financial impact
   • Perception of changes to continuum of care and patient outcomes

H. Presentation of results and recommendations to the CAH Steering Committee