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INSPECTOR GENERAL

October 2008

To: George Cannelos, Federal Co-Chair

FINAL REPORT

From: Mike Marsh, CPA, MPA, CFE, Esq., Inspector General

FOR PUBLIC RELEASE

Subject: Inspection of Chitina clinic (grant nos. 100-DC-2003-I13 and 146-DC-2004-I29)

In July 2008, my office conducted an inspection of the clinic that was constructed at tiny, unincorporated Chitina, Alaska (est. pop.  $\approx$  100) using \$1 million of funding from the Denali Commission. Denali presumed a 30-year lifespan for the clinic when the grant was awarded. However, the owner-tribe<sup>1</sup> temporarily closed the clinic last spring after less than three years of use.

During our inspection, we found that the clinic is open again. Services are very reduced, though, and unlikely to increase given the lack of capacity that the small tribe ( $\approx$  250 members nationwide) has to operate a public clinic on its own.

The purpose of this inspection was to evaluate (1) how this clinic's closure was ultimately resolved for the community and (2) what "lessons learned" exist for Denali's funding of future clinics around Alaska.

#### WHY THIS PROJECT MATTERS

The Denali Commission serves as a national "experimental field station" that explores different possibilities for providing basic facilities in remote settlements (clinics, power plants, fuel tanks, places to wash clothes and take a shower). In this search, the commission has tried grants to every form of recipient entity: municipal, nonprofit,<sup>2</sup> tribal, cooperative, educational, state, and corporate. And the size of its grantees has ranged from a schoolhouse with 11 pupils<sup>3</sup> to a large, multinational, publicly-traded corporation.<sup>4</sup>

<sup>1</sup> The clinic's owner is the Chitina Traditional Indian Village Council.

<sup>2</sup> Both secular and faith-based.

<sup>3</sup> See our report for Red Devil, Alaska at the inspector general home page at [www.denali.gov](http://www.denali.gov).

<sup>4</sup> See our report for the Agrium corporation's project (Nikiski, Alaska) at the inspector general home page at [www.denali.gov](http://www.denali.gov).

In the inspected project, Denali explored the outer limits of the envelope as to what a small tribe could do on its own in an isolated place where winters can reach  $-50^{\circ}$  F. The tribe hired a grant writer, and Denali responded by building them a \$1 million clinic.

Often these experiments work; sometimes they don't. In this case, the clinic failed less than three years after completion. The key in such instances is to candidly advance the public understanding of what went wrong.

#### WHY THIS PROJECT FAILED

Earlier this year, the Chitina tribe announced that it could no longer afford to keep the clinic open. However, during our inspection, we found the clinic to be open again with very limited services — a sole, unsupervised health-aide who, while caring and well-meaning, can't write prescriptions.

Like Chitina, around half of Alaska's rural settlements have less than 350 people. Several parameters seem to control the ability of clinics in such small places to provide the types of medical treatment that the Lower 48 would consider "normal:"

- Staffing by a certified "physician assistant" (PA) who is authorized to act under the general supervision of a distant physician.
- Periodic visits by physicians and dentists ("itinerant" services).
- Consultations with distant physicians via "telehealth" diagnostic equipment.
- Staffing by a financial manager who can supplement the basic Indian Health Service operating grant with other funding, such as Medicaid and Medicare reimbursement, federal grants for low-income clinics, and the traditional billing of private insurance companies.
- Economies of scale by sharing overhead, such as billing services or office space.

Problems in all five of these areas contributed to the failure of Chitina's clinic. To put it another way, the small tribe lacks the capacity to operate a public clinic on its own.

As in many of these tiny settlements, the sustainability of a publicly-funded facility is often linked to the sustainability of one or two key residents. The founder of the Chitina clinic was the physician assistant who provided its treatment as a part-time contractor. He ironically died from a continuing illness on the day after he spoke in detail to Denali's program manager about the downfall of his institution. This clinic was his passion, and he was willing to live under conditions that make recruitment of any replacement difficult (a one-room cabin without running water).

The owner-tribe has terminated the common arrangement for consultations with physicians from the statewide Alaska Native Tribal Health Consortium (ANTHC). Sophisticated "telehealth"

equipment for remote diagnosis lies unused, despite an annual federal payment of around \$200,000 for this clinic to access the network.

Termination of the clinic's billing staff has eliminated the cash flow from Medicaid and private insurance. (An estimated 60% of Chitina's users were billable under these options.) And the potential federal subsidy for a low-income clinic has not been pursued by the tribe.

As requested by the tribe in its application to Denali, the clinic was implemented as a stand-alone structure five miles away from Chitina itself. Despite the small size of the settlement, we found considerable uncertainty among the locals as to what services are still available, and for whom.

In fact, this appears to be somewhat of an "absentee owner" situation. Three of the five tribal board members told us that they live in Anchorage (300 miles from Chitina). And at least two of these three have never personally used the Chitina clinic.

#### HOW WE REVIEWED THIS PROJECT

Our review was conducted in accordance with section 2 of the commission's standard grant assurances, sections 4(a) and 6(a) of the Inspector General Act, and the *Quality Standards for Inspections* issued by the federal Executive Council on Integrity and Efficiency.

A project "inspection," such as this one, is narrower in scope and procedures than the classic financial "audit." One prominent originator of this type of inspector general review described it as follows:

*The idea is to prevent problems before they occur and to avoid vulnerabilities from becoming permanent features of programs. We usually initiate these reviews ourselves, but sometimes senior program managers request that we find out what is happening as grantees or government agencies struggle with the complex tasks of starting a new program — what seems to be working, what is not, what barriers grantees are facing, what, if anything, any of them have been able to do about problems which arise, what innovative practices grantees are experimenting with, and whether and how they are measuring progress, etc. . . .*<sup>5</sup>

In conducting this inspection, our main procedures included (1) an on-site field visit to the clinic and surrounding community, (2) interviews of the clinic's owner, staff, and users, (3) interviews of state and federal officials, (4) interviews of Denali Commission personnel, and (5) qualitative analysis of records and reports.<sup>6</sup>

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<sup>5</sup> George F. Grob, "Inspections and Evaluations: Looking Back, and Forward Too," *Journal of Public Inquiry* (spring/summer 2004), page 11.

<sup>6</sup> Michael Ketover (JD) of my staff was the primary field reviewer and contributed substantially to this report. I much appreciate the assistance of the inspector general for the U.S. Department of Commerce in providing my office with a temporary interagency detail of this senior program analyst under Denali Commission Act §§ 306(d), 305(a).

Our detailed interview of Denali's program manager and director of programs was memorialized in a 105-page transcript. At the exit conference, the agency's COO and director of programs offered us their input on a preliminary inspection report. The agency head was provided an opportunity to comment either formally or informally at his discretion on our final report.

### ***LESSON LEARNED NO. 1***

#### **THE FEDERAL CO-CHAIR SHOULD ADD A "RURAL OMBUDSMAN" TO DENALI'S STAFF**

Denali funds the construction of facilities, not their operation. Nevertheless, the public seems to expect that they can return to the Denali Commission for intervention if a project disappoints in the years after they get the keys. And, instead of retreating to bureaucratic silos, Denali has accepted its implicit mantle as the "great convener," or Alaska's de facto federal ombudsman.

The Chitina clinic was completed years ago, but we observed during our inspection that all parties seem to respect Denali's management as the legitimate mediator (and meetings of the commissioners as the legitimate forum). We have previously recommended that the agency head formalize this honor by adding the position of "rural ombudsman" to Denali's staff.<sup>7</sup>

Denali's management envisions a more active role by the state government in the agency's work. The state's commerce commissioner has now stationed an experienced "bush" specialist at the commission, and that individual — fluent in both Yupik and English — could potentially be detailed to serve as Denali's first "rural ombudsman" under the Intergovernmental Personnel Act.

Given Denali's role as an experimental station that tests the untested, some projects will be initially unsuccessful and require course corrections. A recent study of Denali-funded facilities recommended retention of talented contractors to shepherd derailed projects.<sup>8</sup> The rural ombudsman would seem the appropriate position to coordinate such intervention.

### ***LESSON LEARNED NO. 2***

#### **DENALI SHOULD EXPLORE SCHOOL DISTRICT OPERATION OF NON-REGIONALIZED CLINICS**

Clinics in tiny, unincorporated settlements like this frequently operate as part of a regional health corporation. The Chitina tribe, however, wanted its own clinic — and Denali allowed it. Given the tribe's current inability to implement the underlying assumptions of the grant, Denali needs to salvage the project with some form of creative, mediated solution.

We note that the public school is usually the dominant public facility in remote Alaskan communities. Unlike the Lower 48, many rural schools are directly funded by the state

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<sup>7</sup> See our report for Red Devil, Alaska at the inspector general home page at [www.denali.gov](http://www.denali.gov).

<sup>8</sup> See Brian Saylor, *Multi-Use Facility Program Evaluation* (NANA Pacific, April 30, 2008), page 56.

government due to the lack of a local tax base. And the state by law funds a school, complete with running water and electricity, for every place with at least 10 students.

However, Chitina does not even have its own school — a signal in itself that this isolated spot may not be a good home for a \$1 million clinic. The nearest school (130 students, 10 teachers) is 25 miles down the road at Kenny Lake, where its more-centralized location allows it to serve various unincorporated settlements.

We recommend that Denali's state co-chair (the state's former deputy commissioner of education) attempt to negotiate a transfer — both physical and organizational — of this failed clinic to the Kenny Lake School. And, if successful, we recommend that Denali's federal co-chair (the former general in command of the Alaska National Guard) attempt to arrange military assistance in moving the structure down the road. (The military has quite the reputation for community service here in moving everything from dinosaur fossils,<sup>9</sup> to a historic biplane,<sup>10</sup> to an Italian statue,<sup>11</sup> to a local elephant at the zoo that recently needed to retire in a warmer climate.<sup>12</sup>)

Direct operation of clinics by local schools presents quite symbiotic opportunities for all parties. The school district's business office can profit from additional federal funding and the processing of insurance billings. The school is the one place in the community with the most reliable utilities (including electricity, Internet, and running water). The same housing used to recruit rural teachers can entice the skilled physician assistant and itinerant doctors that are critical to clinic success. No target population is more important for health care than the next generation (and the parents raising it). Both the popular educational video-conferencing network and the underused telehealth diagnostic system are funded through the same national excise tax on phone bills. And, last but not least, physical inclusion within a local school is the best insurance of some well-maintained, continuing public use if Denali's hope for three decades of use as a clinic turns out to be overly optimistic.

This type of solution will definitely require agencies at all levels to dismantle their "silos." And that dismantling would seem squarely within the Denali Commission's inherited coordination role as the "great convener."

### *LESSON LEARNED NO. 3*

#### DENALI'S EVALUATION MANAGER SHOULD NEGOTIATE A DATA-SHARING AGREEMENT TO ASSESS SMALL CLINIC USE OF TELEHEALTH SERVICES

Consumers pay a national excise tax on their phone bills to support the Universal Service Fund. Rural "telehealth" networks are one service subsidized out of these nationwide collections.

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<sup>9</sup> North Slope to Fairbanks.

<sup>10</sup> Montana to Anchorage.

<sup>11</sup> Seattle to Fairbanks.

<sup>12</sup> Anchorage to California.

And no state gets subsidized more than Alaska for rural telehealth. The FCC's monitoring report shows that 58% of the entire nation's \$34.4 million subsidy went to Alaskan providers, with Alaska's average subsidy of \$54 per rural person dwarfing the next-highest of less than \$2 per person in North Dakota.<sup>13</sup>

However, Alaska's appetite for telehealth is not surprising given both the lack of rural doctors and the lack of rural roads compared to most of America. The basic theory is that a local paraprofessional will examine a patient using a kiosk of sensors and imaging devices that enable diagnosis by a distant physician. This equipment is found in over 200 of Alaska's bush clinics, and it's a key component in Denali's basic paradigm for their construction. A study by the University of Alaska shows, overall, lots of provider use and lots of provider satisfaction with the telehealth system.<sup>14</sup>

However, we continue to encounter anecdotes of small clinics that simply don't use the provided equipment. Chitina's telehealth equipment lies unused, despite an annual federal payment of around \$200,000 for this clinic to access the network. Our prior report on tiny, unincorporated Takotna (pop.  $\approx$  50) noted the same lack of use.<sup>15</sup> And the agency head himself recently noted the lack of use at Huslia (pop.  $\approx$  250).

Denali aspires to provide a clinic in each Alaskan settlement of at least 50 people. These anecdotes initially suggest a need for Denali to revisit its paradigm that presumes a telehealth capability in every clinic. For instance, the \$200,000 federal payment for unused service at Chitina hypothetically could have instead sent 20 residents to the Mayo Clinic — or brought several Mayo Clinic doctors to Chitina for a summer of treatment (and fishing).

But telehealth remains a promising technological answer for remote health care. We thus recommend that Denali's evaluation manager execute a data sharing agreement with the agency that tracks the exact use of the network by every clinic in Alaska. While that detail was obscured within aggregated regional statistics in the university study, the underlying data is kept by the Alaska Federal Health Care Access Network (AFCHAN) office at ANTHC in Anchorage.

Denali's evaluation manager should analyze the telehealth usage patterns for every clinic funded in settlements of less than 150 people. Any pattern of nonuse at tiny clinics may be symptomatic of the recurring need to emphasize the sustainability of local skills as much as the sustainability of local buildings.

#### ***LESSON LEARNED NO. 4***

##### **DENALI SHOULD TRY A PILOT PROJECT THAT TRAINS LOCALS IN THE FINANCIAL MANAGEMENT OF SMALL CLINICS**

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<sup>13</sup> Federal Communications Commission, *Universal Service Monitoring Report*, docket no. 98-202 (2007), page 5-14, Table 5.4.

<sup>14</sup> University of Alaska, *Evolution & Summative Evaluation of the Alaska Federal Health Care Access Network Telemedicine Project* (November 2004). We note that one member of the study's evaluation team was a university official who is now appointed as the university's commissioner on the Denali Commission.

<sup>15</sup> See our report for Takotna, Alaska at the inspector general home page at [www.denali.gov](http://www.denali.gov).

The above challenges underscore the Faustian bargain that small clinics make if they sacrifice the support of a financial management staff. To use an aviation analogy, service will suffer if the aces in the cockpit aren't backed by the mechanics in the hangar.

While Chitina lies at the very end of Alaska's paved road system, this didn't need to be the little clinic that got left behind. Given the larger context, the clinic's inabilities to bill private insurance and pursue diversified federal funding reflect wasted opportunities for lucrative self-support.

Chitina is the gateway to one of the most spectacular national parks (Wrangell-St. Elias), a favorite recreational destination for the fearless and affluent. Visitors make the 300-mile drive from Anchorage for everything from first-ascent climbing, to extreme skiing, to world-famous fishing, to bungee jumping,<sup>16</sup> to exploring the state's best-preserved ghost town.<sup>17</sup> These hoards of adventurous visitors get sick, get hurt, fill prescriptions, and never leave home without the plastic evidence of their credit and their health insurance.

But Chitina is just one of several settlements in the area that seek Denali funding for clinics. We thus recommend that Denali attempt a pilot project that would train a dozen or so residents in the financial management of small, publicly-funded clinics. For instance, Denali could conceivably implement this by convening an inspiring coalition of faculty from these organizations that have various degrees of past connection with the agency:

- Association of Government Accountants (AGA), which offers its Certified Government Finance Manager (CGFM) course throughout the nation.
- Foraker Group, which develops grant management skills within Alaskan nonprofits.
- Alaska Department of Health & Social Services, which supports small clinic efforts to bill for Medicaid.
- Anchorage's Career Academy, a local vocational school which offers training to be an "insurance coding and billing specialist."
- Alaska Native Tribal Health Consortium, which offers billing services of its own and trains in billing for telehealth through its AFHCAN affiliate.

Such a pilot project in local capacity would emphasize that Denali projects are as much about the sustainability of people as the sustainability of buildings. In fact, the outgrowth of this project might be a consolidated billing entity similar to that which Denali has supported for rural utilities.

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<sup>16</sup> The old McCarthy railroad trestle.

<sup>17</sup> McCarthy and its historic Kennecott mine.

***LESSON LEARNED No. 5*****DENALI SHOULD TRY A PILOT PROJECT THAT TESTS ITS OPEN DOOR POLICY WITH “MYSTERY SHOPPERS”**

The tribe at Chitina obtained Indian Health Service funding to provide clinic services to its members. However, Denali approved the tribe’s construction grant based on its representations that the \$1 million clinic would serve the public at large. In fact, Denali’s grants are conditioned on the agency’s “open door policy:”

*The Denali Commission requires that all health care facilities that it funds be open to all who seek service and can pay for this service. We recognize that some organizations are not set up to handle third-party billing (i.e., Medicaid/Medicare, and other insurance forms). At a minimum, however, we expect the clinic to provide health care services to anyone who can pay for those services. All applicants must have appropriate and necessary resolutions and support letters to acknowledge their responsibility for compliance with this policy.*

Nevertheless, local debate continues — as it has since the original opening in 2005 — as to whether Chitina’s only clinic is equally available to non-tribal users. Denali’s staff has fielded periodic complaints, with the tribe always promising Denali that all paying customers will be served.

Our inspection interviews provided anecdotes that were, overall, ambiguous on the issue. And, regardless of who is now getting treated, it’s operating as a clinic that doesn’t bill its users.

The classic method to test for disparities in customer service is a “mystery shopper” program, such as that used by large retailers and the U.S. Postal Service. If Denali’s management is concerned about equal access in its clinics, we recommend that it try a pilot project of this nature. The pool of unknown, visiting “customers” could potentially be drawn from the university’s nursing or public health students, or from the Career Academy’s medical assistant program. And this experience may even inspire some students to work in rural Alaska as part of the larger solution.

***LESSON LEARNED No. 6*****DENALI SHOULD REVISIT ITS OPEN DOOR POLICY**

At first glance, Denali’s “open door policy” seems an unquestionable tenet of a pluralistic society that aspires to eliminate discrimination — including the specter of reverse discrimination. However, the sensitive, Alaskan version of this issue is more complex in practice, and Denali should revisit its policy in light of several years of experience with the nuances.

For some small clinics like the one at Chitina, the grantee may have committed to serve the general public as an argument in support of its proposal’s “sustainability.” An estimated 60% of Chitina’s patients were not members of the tribe.



However, small clinics in some other locations may see few non-tribal members. If such a clinic relies solely on an annual Indian Health Service operating grant, the economies of scale could potentially not warrant establishment of a billing system for the occasional non-tribal visitor. And the absence of any rural clinic might mean that tribal patients would travel at greater public expense to urban Alaska for treatment. Or that communicable disease would go untreated until the patient eventually arrived at a population center.

Federally-funded health facilities vary in the degree to which they are open to the general public rather than restricted to a target population. Military clinics serve military personnel and their dependents. The Capitol's clinic serves senators and representatives elected to Congress. Veterans Administration facilities obviously have their limited user group.

Such familiar examples, of course, involve boundaries that are not defined by ethnicity. But Denali's clinics in western Alaska form the backdrop for a recent landmark court decision based squarely upon the federal mission to serve tribal patients. Tribal entities trained "dental therapists" to perform procedures (fillings, extractions) that have traditionally been conducted only by dentists. The Alaska Superior Court found that the federal responsibility for tribal health trumped any objections based on state licensing laws.<sup>18</sup> To the extent that Denali's open door policy might require a dental therapist to extract a non-tribal tooth at a tribal clinic, the policy seems on a collision course with the uncharted edges of the landmark case.

Similarly, tribal leaders sometimes argue that continuing health care is an expected part of last century's compensation for transfer of the areas historically occupied before the U.S. purchase of Alaska. For instance, a recent publication of tribal viewpoints states that "[i]n essence, health care for indigenous peoples in the United States has been 'prepaid' through trades of land and resources owned by indigenous nations for basic services from the United States government."<sup>19</sup>

And one well-known corporate president has asserted that "[t]he health, housing and other benefits that are conferred on the Alaska Natives as partial payment for the past takings of land are of importance, not only to the Native community but to the economy of the state itself."<sup>20</sup>

Other Alaskan leaders counter that the Alaska Native Claims Settlement Act transferred land and cash in full, complete, and final satisfaction of everyone's historical claims. We note this very polarized, longstanding issue only because Denali may be unintentionally enmeshing itself in a larger political controversy beyond its control.

Once Denali gives an owner the keys to its clinic, Denali has little practical ability to police what happens there. The most potent motivator may just be what Professor Axelrod theoretically calls

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<sup>18</sup> *Alaska Dental Society v. State of Alaska*, case no. 3AN-06-4797 Civil (Alaska Superior Court, June 27, 2007). See Erik Bruce Smith, "Dental Therapists in Alaska: Addressing Unmet Needs and Reviving Competition in Dental Care," 24 *Alaska Law Review* 105-143 (2007).

<sup>19</sup> University of Alaska and Alaska Pacific University, *Do Alaska Native People Get Free Medical Care?* (2008), page 78.

<sup>20</sup> Roy M. Huhndorf, *Reflections on the Alaska Native Experience* (CIRI Foundation, Anchorage, Alaska, 1991), page 36.

“the shadow of the future,”<sup>21</sup> that is, the perceived risk that Denali will have a long memory the next time the same community wants a grant.

On the other hand, civil rights statutes already exist to protect against discrimination in any facility that serves the public. Regardless of whether Denali has an open door policy, any victims of reverse discrimination have recourse to civil rights regulators at the Justice Department and the Alaska Human Rights Commission (who would then have to reconcile the tension between the federal objectives of nondiscrimination and service to a target population).

In short, Denali’s well-meaning policy may be unenforceable, redundant, or trumped by other federal interests.

In view of all these complicating nuances, Denali’s management should revisit its assumption that every clinic, no matter where located or how funded, should set up a billing system that enables it to serve every potential visitor. An intended bar on reverse discrimination may be having unintended effects in practice.

Tribal lands in the Lower 48 are far more accessible from the national highway system, and Denali may wish to compare how the tribes there have agreed to care for the health issues of their many non-tribal visitors. This comparison may become especially pertinent if a viable, transcontinental shipping channel continues to open up in the arctic over the next decade. If that long-sought “Northwest Passage” materializes as projected, health facilities along Alaska’s northern and western coasts will be part of the action.

#### *LESSON LEARNED NO. 7*

##### DENALI SHOULD REQUIRE AN IN-KIND CONTRIBUTION OF STAFF HOUSING FROM COMMUNITIES WANTING A CLINIC

Chitina lost its physician assistant who was willing to live in a one-room cabin with no running water. The difficulties in recruiting a replacement are the same as those faced by rural schools in retaining their teachers. This is the reason that Denali has been a significant player in the construction of teacher housing around the state.

Where a Denali-funded clinic does not include its own housing, the community needs to offer it as part of its 20% contribution to the project. Since students and their parents will be major users of any clinic, the community may be able to negotiate the joint use of teacher housing. State government representatives to the Denali Commission may be able to assist with such agreements in the case of rural school districts that are directly funded by the state as REAAs.

We have previously recommended that Denali give priority to communities that emphasize grant leveraging rather than grant harvesting. Long-run national support for the agency’s programs may be encouraged to the extent that projects are perceived more as innovative partnerships and community “barn raisings” — and less as short-term cash injections and entitlements. In this era,

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<sup>21</sup> See, generally, Robert Axelrod, *The Evolution of Cooperation* (Basic Books, 1984), pages 126-132.

we would expect public patience to be worn pretty thin by any Denali clinics that can't be staffed, plumbed, or heated.

### *LESSON LEARNED No. 8*

#### DENALI'S DIRECTOR OF PROGRAMS SHOULD EXPLORE THE CLINIC'S POTENTIAL USE AS A MEDICAL SCHOOL FIELD STATION

The Denali Commission serves as a national experiment that explores diverse possibilities for providing basic facilities in remote settlements. And, at Chitina, Denali explored the outer limits of the envelope as to what a small tribe could do on its own in an isolated place.

Over the past several years, Denali has increased the technical sophistication with which it screens grant requests for small clinics. Under this improved process, failures like Chitina should be rare. Operation under the supportive umbrella of a regional health corporation will probably be the norm.

One "salvage" possibility for this clinic might be its use as a medical school field station. We recommend that Denali's director of programs (an MPH herself) contact the deans of medical schools that focus on public health (such as Johns Hopkins) and explore the potential assignment of students serving rotations, residencies, and fellowships. Any doctors-in-training who appreciate mountain climbing, fishing, skiing, and flying may find this a more than tolerable way to serve their professional rites of passage.

### *LESSON LEARNED No. 9*

#### DENALI'S GRANT AGREEMENTS SHOULD ADDRESS THE CONTINGENCY OF FAILED PROJECTS

Idealistic Denali Commission insists that grantees commit to operate the funded facilities for a period of 30 years (an entire generation). Denali requires grant writers to submit a "business plan" that demonstrates this capacity but, in reality, the "business" is largely a projection of the continued willingness of other federal agencies to fund operations in the decades after Denali provides the keys.

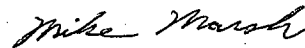
Failure is indeed an option when the bar is set this high, and the Chitina experience underscores the need for Denali to write its grant agreements with terms that anticipate the contingency in a constructive manner.

For example, Denali requires the constructing entity (usually ANTHC) and the ultimate owner to sign the "cooperative project agreement" that implements the grant (gets the building built). However, unless the clinic is under the umbrella of a regional health corporation, there is no advance arrangement for any agency to intervene if the clinic derails after opening. Denali should remedy this ambiguity by insisting that either ANTHC or the state health department sign the cooperative project agreement with a commitment of continuing technical assistance over the optimistic 30-year lifespan of any clinic going it alone.

On the other hand, should Denali find in screening projects that ANTHC, the state health department, and the regional health corporation are all hesitant to make such a commitment, that would in itself be a troubling signal as to a clinic's prospects for long-term success.

More specifically, Denali should explore with its lawyer how recorded real estate documents could structure an automatic transfer of a closed facility to a government entity who can give it a good home for a public use. The local school district would seem an ideal candidate for such a reversion if a clinic fails. When ANTHC or the state agrees to provide long-term technical assistance, the cooperative project agreement should indicate that entity's responsibility to negotiate a voluntary transfer or pursue the legal action to quiet title.

Expecting Denali to personally police a facility's fate over 30 years is unrealistic for obvious reasons. The handwriting is on the wall that the future of the Denali Commission lies in an increasing financial partnership with the State of Alaska. The state's written commitment to shepherd lonely clinics would be an important advancement.



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