

# Bartlett Regional Hospital

## AGENDA

### STRATEGIC PLANNING MEETING

Saturday, September 19, 2020; 9:15 a.m.

Bartlett Regional Hospital Zoom Video Conference

Public may follow the meeting via the following link <https://bartletthospital.zoom.us/j/98281544697>  
or call

1-253-215-8782 and enter webinar ID 982 8154 4697

<b>I.</b>	<b>CALL TO ORDER</b>	<b>9:15</b>
<b>II.</b>	<b>PUBLIC PARTICIPATION</b>	<b>9:20</b>
<b>III.</b>	<b>REVIEW MISSION, VISION, VALUES</b> <ul style="list-style-type: none"><li>• Mission, Vision and Values statement (Pg.2)</li></ul>	<b>9:25</b>
<b>IV.</b>	<b>HOW MUCH OF A CASH RESERVE SHOULD WE MAINTAIN</b> <ul style="list-style-type: none"><li>1) Implications of not enough</li><li>2) How much we can spend on projects (Pg.3)</li><li>3) What are each of our ideas/vision for 6,12,18 and 24 months from now</li></ul>	<b>9:30</b>
<b>V.</b>	<b>REVIEW PRIOR PLAN</b> <ul style="list-style-type: none"><li>1) Board Objectives for 2019 (Pg.8)</li><li>2) Focus and Execute</li><li>3) Robotics (Pg.9)</li></ul>	<b>9:40</b>
<b>VI.</b>	<b>JENSEN YORBA WALL CAMPUS PLAN REVIEW</b> <ul style="list-style-type: none"><li>1) Departments project list incorporated in JYW list (Pg.14)</li><li>2) Hospital COVID-19 Modifications Memo from Dr. Jones (Pg.21)</li><li>3) COVID-19 Facility Changes/Modifications (Pg.29)</li><li>4) Review of Re-Prioritized list</li></ul>	<b>10:00</b>
<b>VII.</b>	<b>ECG DISCUSSION IN THE CONTEXT OF THE “NEW NORMAL”</b> <ul style="list-style-type: none"><li>1) SE Health Care SWOT and Initiatives Analysis (Pg.43)</li><li>2) Provider Network Development Plan (Pg.64)</li></ul>	<b>11:00</b>
<b>VIII.</b>	<b>EMPLOYEE SURVEYS</b> <ul style="list-style-type: none"><li>1) COVID-19 Incident Command Survey (Pg.164)</li><li>2) Employee Health and Well Being survey (Pg.176)</li><li>3) Follow-up Employee Health and Well Being survey (Pg.182)</li></ul>	<b>12:30</b>
<b>IX.</b>	<b>COMMENTS AND QUESTIONS</b>	<b>12:55</b>
<b>X.</b>	<b>ADJOURNMENT</b>	<b>1:30</b>

# Bartlett Regional Hospital

## Mission

Bartlett Regional Hospital provides its community with quality, patient centered care in a sustainable manner.

## Vision

Bartlett Regional Hospital will be the best community hospital in Alaska.

## Values

At Bartlett Regional Hospital **WE...C.A.R.E.**

### Courtesy.

We act in a positive, professional and considerate manner, recognizing the impact of our actions on the care of our patients and the creation of a supportive work environment.

### Accountability.

We take responsibility for our actions and their collective outcomes; working as an effective, committed and cooperative team.

### Respect.

We treat everyone with fairness and dignity by honoring diversity and promoting an atmosphere of trust and cooperation. We listen to others, valuing their skills, ideas and opinions.

### Excellence.

We choose to do our best and work with a commitment to continuous improvement. We provide high quality, professional healthcare to meet the changing needs of our community and region.

# BARTLETT REGIONAL HOSPITAL STRATEGIC PLANNING SESSION

SEPTEMBER 19, 2020

## **Financing Capital Projects**

# INTERNAL FUNDING (RESERVES)

## PROS:

- ▶ Future funds are not tied up in servicing debt payments
- ▶ Interest savings can be put toward other projects
- ▶ Avoid risk of default

## CONS:

- ▶ Long wait time for new infrastructure
- ▶ Large projects may exhaust the entire reserve for capital projects
- ▶ Inflation risk



# DEBT FINANCING

## PROS:

- ▶ Project is delivered when it's needed
- ▶ Spreads cost over the useful life of the asset
- ▶ Increases capacity to invest reserves
- ▶ Capital investment's beneficiaries pay for projects
- ▶ Presently the interest rate of borrowing funds is very low

## CONS:

- ▶ Debt payments limit future budget flexibility
- ▶ Diminishes the choices of future projects
- ▶ Future generations forced to service debt requirements

Cash Balances:	2018	2019	2020
Equite in Central Treasury	69,007,166	68,679,495	68,162,973
Restricted for Capital Projects	4,678,117	1,178,300	5,740,967
Total	73,685,283	69,857,795	73,903,940
Operating Expenses	99,874,264	103,665,322	112,297,884
Less: Depreciation Expense	7,422,119	7,196,120	7,185,318
Net Cash Requirement	92,452,145	96,469,202	105,112,566
Days Cash on Hand	291	264	257
Cash to Debt	388%	385%	428%
Debt to Capitalization	37%	34%	29%
Operating Margin	2.14%	2.06%	2.46%
<b>S&amp;P BBB Rating*</b>			
Days Cash on Hand	172	158	N/A
Cash to Debt	131%	131%	N/A
Debt to Capitalization	37%	36%	N/A
Operating Margin	0.70%	0.00%	N/A

\* US Not-For-Profit  
Health Care  
Stand-Alone  
Hospital Median  
Financial Ratios  
2019 vs. 2018

## OTHER CONSIDERATIONS:

- Return on Reserves is about the same as interest on debt would cost (virtually even-money)
- What is the right amount of reserves?
- When is debt appropriate for a project?

## **Board Objectives for 2019**

**Quality and Safety** – Provide safe, quality patient care as evidenced by maintaining Joint Commission and other certifications and benchmarking against Alaskan and National quality and safety measures.

**People** – Create an atmosphere that enhances employee and physician satisfaction and improves our ability to recruit and retain.

**Services** – Develop and maintain a service portfolio that meets community needs and is sustainable. This includes collaborations with National, State and local agencies to maximize community benefits.

**Financial** – Enhance efficiencies of current services and develop new profitable service lines and funding sources that allow us to perform at break even or better without the Rural Demonstrations Project funding (\$3.7 Million) by the end of FY2020.

**Facility** – Update the existing campus plan to identify major replacement needs and options for future revenue growth.

**Compliance** – Maintain compliance at all levels while accomplishing above goals

## **Bartlett Regional Hospital Robotic Surgery Proposal**

Bartlett Regional Hospital has been presented with the opportunity to advance its surgery program with the utilization of robotic instrumentation. This technology was introduced in the healthcare industry in the early 2000s and has advanced over the years. While there are many benefits to having robotic surgery capability, the main driving force behind its development is improved quality of patient care.

Robotic surgery achieves improvement in patient care and outcomes through precise and minimally invasive surgery. This results in a lower rate of complications, fewer readmissions and a shorter length of stay. Patients recover quicker which results in increased patient satisfaction. While use of robotic surgery is increasing as the technology improves, the most common types of robotic surgery performed are urological, gynecological and some general surgery.

Due to the benefits of the quality of care, surgeons in residency are being trained for robotic surgery. This means a facility without robotic surgery capability will experience difficulty in recruiting surgeons that have robotic training.

Patients are currently referred out of town for robotic procedures that cannot be performed here in Juneau. To date, there are four facilities in the state of Alaska that have robotic surgery capability. Central Peninsula will have it within the year.

The advancement into robotic surgery presents an opportunity to market a new advanced form of surgery. It can also enhance the image of the organization as having state of the art equipment and services meaning patients don't need to travel to receive this level of service.

The financial commitment for moving into robotic surgery is significant. The equipment investment is \$2,211,181. The annual maintenance cost is \$154,000 per year beginning in year 2 (first year is under warranty). Physician and staff training are included in the purchase price of the equipment. The third Operating Room has been reviewed and would be ideal to house the robotic service.

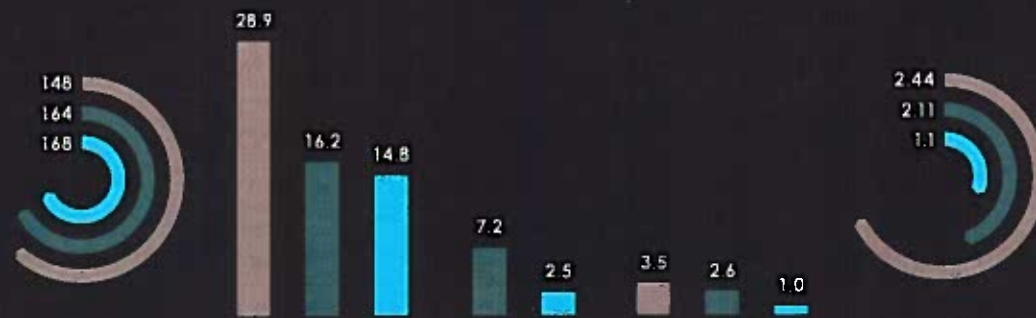
To improve patient quality and to develop competency on the robotic equipment, it is expected that appropriate surgeries currently performed either laparoscopically or open would convert to robotic surgery. Bartlett receives cost based reimbursements for inpatient services therefore, a shorter length of stay would reduce reimbursement.

The proforma shows a 3.3 year Return on Investment. There is the opportunity for increased revenue by capturing procedures that are being referred out of town. Only these revenues for the incremental volumes were included in the proforma. The volumes included on the proforma were identified by Bartlett surgeons looking at their past year's practices. Revenues on existing procedures that would convert to robotic were not included.



## Clinical Outcomes – Benign Hysterectomy And Potential Cost Offsets<sup>1</sup>

• TV  
• LAP  
• OPEN



	Cost	OR Time* (min)	Complications* (percentage)	Conversions* (percentage)	Readmissions* (percentage)	Length of Stay* (days)	Total
	\$11 <sup>1</sup>		\$3,632 <sup>2</sup>	\$3,162 <sup>3</sup>	\$11.08 <sup>4</sup>	\$1,553 <sup>5</sup> (avg. LOS)	
Potential Savings vs Open	-		\$51	-	\$27	\$2.08	\$2.65
vs Laparoscopy	\$228		\$51 <sup>2</sup>	\$14 <sup>9</sup>	\$7 <sup>7</sup>	\$1.56 <sup>9</sup>	\$1.98 <sup>1</sup>

\* Data for surgical site infections not reported.

<sup>1</sup> This data comparison is not case-matched for patient complexity and/or disease status and may not be comparable across these surgical modalities.

<sup>2</sup> As such, this data presentation should be considered as informational only and is not conclusive.

<sup>3</sup> Complications based on patient rate for benign hysterectomy only. DRG: 17.263 (2016 QMS inpatient Facility Reimbursement) Overall complications

calculation based on 0.5 x DRG.

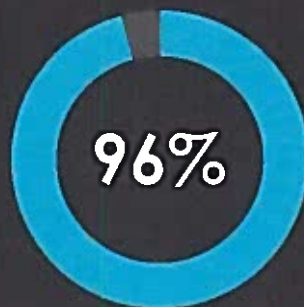
<sup>4</sup> Surgery time decreased with progressive experience, falling below three hours after 100 cases (2.8 hours for the last 25 cases).



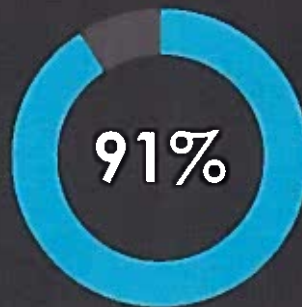
# Attracting the Next Generation of Surgeons

Proliferation of *da Vinci*® Surgery in Residency and Fellowship Programs<sup>20-23</sup>

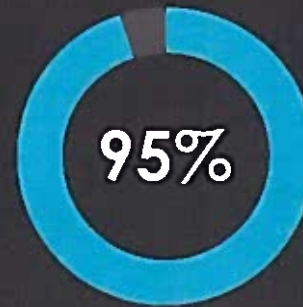
Urology Residency Programs with *da Vinci* Surgery<sup>20</sup>



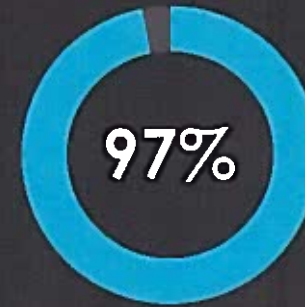
GYN Residents Reporting Staff Surgeons Performing *da Vinci* Surgery for GYN<sup>21</sup>



GYN-Oncology Fellowships with *da Vinci* Training<sup>22</sup>



U.S. Colorectal Fellowship with *da Vinci* Basic Training<sup>23</sup>

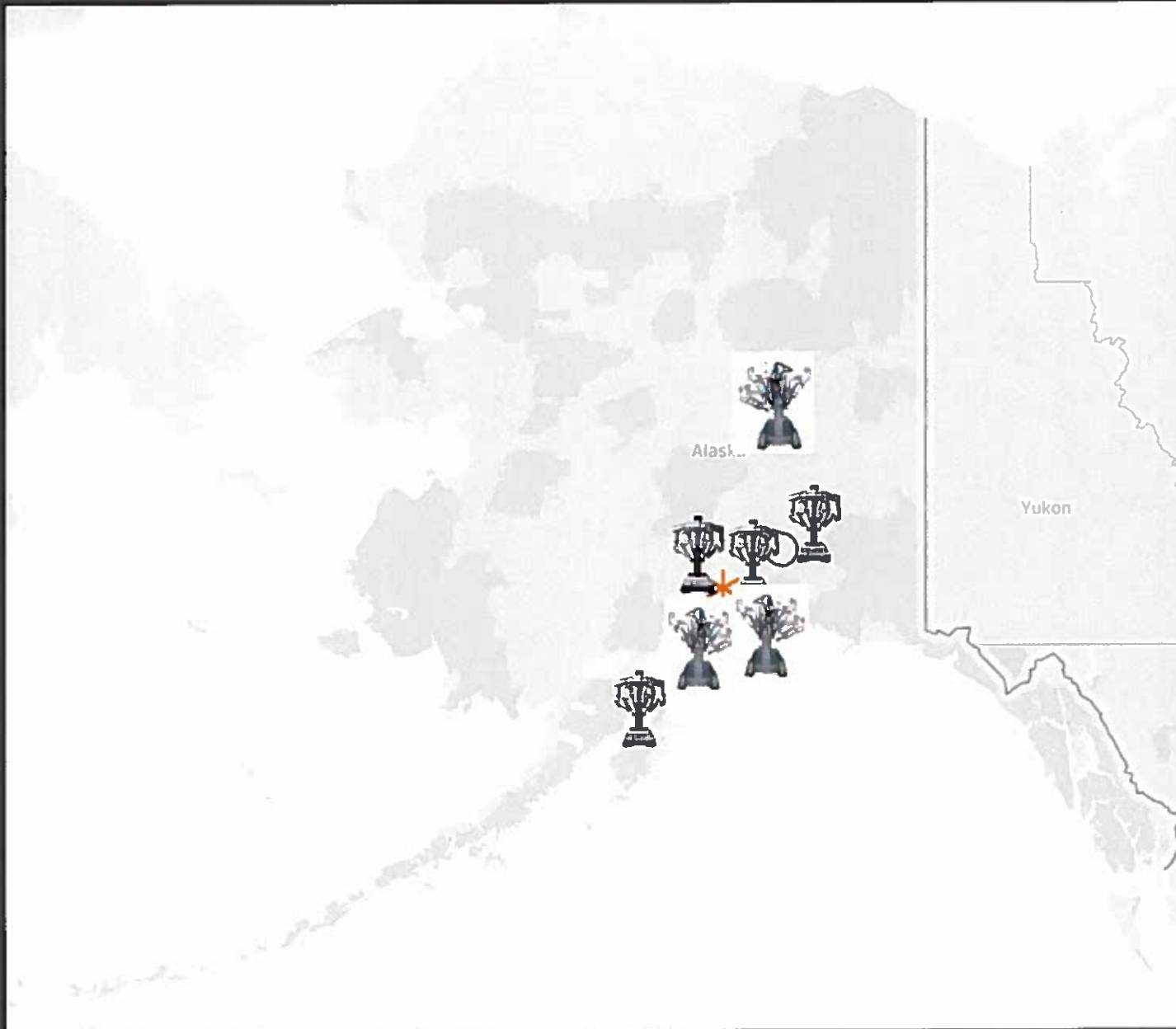


\*Source: ISI Internal analysis based on 2014 Premier data. The data have not been peer-reviewed and have not been published.



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# Da Vinci Install Map—Alaska



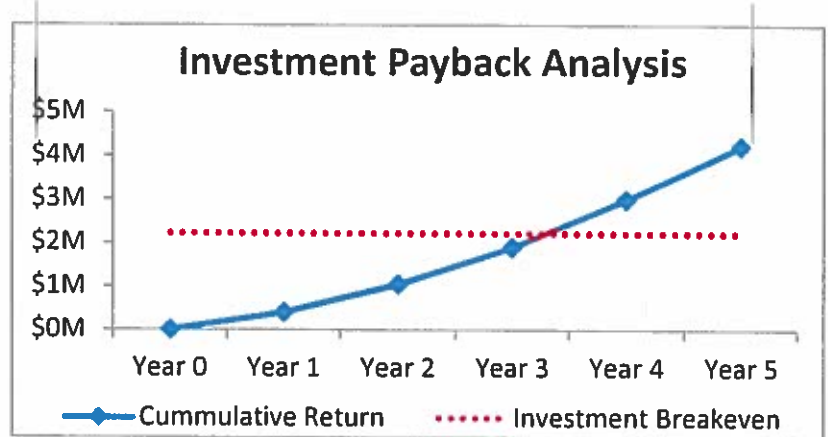


## Bartlett Regional Hospital

### Robotic Reinvestment 5-Year Proforma

System Type	Estimated Cost		Est. Expense	Est Return	Net Return
da Vinci Xi Single	\$2,211,181	Year 1	\$2,211,181	\$392,055	(\$1,819,126)
Service Years 2-5	\$154,000	Year 2	\$154,000	\$652,366	\$498,366
5-Year Capital Exp.	\$2,827,181	Year 3	\$154,000	\$842,890	\$688,890
		Year 4	\$154,000	\$1,103,201	\$949,201
		Year 5	\$154,000	\$1,233,289	\$1,079,289
<b>Investment Summary</b>		<b>Totals</b>	<b>\$2,827,181</b>	<b>\$4,223,802</b>	<b>\$1,396,621</b>

Project IRR	15.6%
Estimated Payback	3.3 Years
Incremental Admissions	430
Open-to-MIS Conversions	350
Bed-Days Preserved	1,480
Total Cost Avoidance	\$1,986,274
Incremental Revenue	\$7,298,817



\*Based on a 35% commercial payer mix and a 60% commercial payer premium to Medicare

### BUSINESS PLAN DETAIL

Procedure Type	Patient Source	Est. Reimburse.	Year 1	Year 2	Year 3	Year 4	Year 5	Totals
Colon Resection	Existing	\$34,579	11	13	15	17	19	75
Ventral Hernia	Existing	\$18,220	35	35	40	40	45	195
Inguinal Hernia	Existing	\$6,149	25	30	35	40	45	175
MP Chole	Existing	\$5,723	25	30	35	40	45	175
Hysterectomy - Benign	Existing	\$10,202	35	40	45	50	50	220
Prostatectomy	Existing	\$12,467	1	2	3	4	5	15
Sacralcolpopexy	Incremental	\$8,131	8	8	8	8	8	40
Colon Resection	Incremental	\$34,579	5	10	15	20	25	75
Rectal Resection	Incremental	\$26,772	5	10	10	15	15	55
Ventral Hernia	Incremental	\$18,220	10	15	20	25	25	95
Inguinal Hernia	Incremental	\$6,149	15	20	25	30	35	125
Hysterectomy - Benign	Incremental	\$10,202	8	8	8	8	8	40
<b>Totals</b>		<b>\$13,972</b>	<b>183</b>	<b>221</b>	<b>259</b>	<b>297</b>	<b>325</b>	<b>1,285</b>

Bartlett Regional Hospital - Facilities Master Plan

Jensen Yorba Wall      December 9, 2019

Space Program	Net Areas	Gross Area	Additional Needed	
ALL BUILDINGS				
CEO - Administration	1,771	<div></div>		General reconfiguration to address privacy concerns / adjacency issues
CEO - Community Relations	164			
CEO - Compliance	260			
CEO - Quality	726			
CEO - Hospitalist	489	<div></div> 25%	122	
CEO - Medical Staff Services	2,193			
CEO - Physician Services	16,461	<div></div> 15%	2,469	Could consolidate Medical Office spaces and increase housing
CEO - Education and Staff Development	2,595	<div></div>		Reconfiguration for increased storage
CEO - Gift Shop	378			
HR - Human Resources	937			
CFO - Case Management	1,027			
CFO - Finance	818			
CFO - Health Information Services	5,064			
CFO - Information Services	2,637			
CFO - Patient Access Services	1,724			
CFO - Patient Financial Services	2,174			
COO - Diagnostic Imaging	10,323	<div></div> 25%	2,581	Remote Women's Clinic to allow for expansion of CT and other needs.
COO - Food and Nutrition	5,390	<div></div> 60%	3,234	Double Serving and Seating, 50% increase to Storage and Kitchen
COO - Laboratory and Histology	4,894	<div></div> 25%	1,224	Space needs to be renovated. Additional area would be beneficial, but not required.
COO - Materials Management	2,835	<div></div> 50%	1,418	Additional Storage, Loading Dock, and Unboxing areas
COO - Pharmacy	1,832	<div></div> 25%	458	24-hour retail space near ED, additional equipment space
COO - Physical, Speech, Occ. Therapy	5,441	<div></div> 50%	2,721	Additional gym, therapy space. Could be outside main facility.
COO - Respiratory, Cardiac, Sleep Study	2,522	<div></div> 25%	631	Additional gym space, more storage
COO - Facilities	6,138	<div></div> 25%	1,535	Move Facilities areas out of mechanical spaces and improve access
COO - Facilities - Biomedical	218	<div></div> 100%	218	Additional main Shop space, additional Shop in Surgical Services
COO - Facilities - Environmental Services	1,427			
COO - Facilities - Laundry	1,644	<div></div> 50%	822	Additional Storage, Laundry space in addition to mechanical renovation
COO - Facilities - Security	798	<div></div>		Needs more central and visible location
COO - Facilities - Mechanical	16,641			
CBHO - B. Outpatient Psychiatric Services	2,320			
CBHO - Grants	108			
CBHO - Mental Health Unit	8,305			
CBHO - Rainforest Recovery Center	10,739			
CNO - Critical Care Unit	6,124			
CNO - Emergency Department	7,349	<div></div> 50%	3,675	Additional Exam, Triange, Psych rooms needed
CNO - Infusion and Chemotherapy	1,391	<div></div> 50%	696	New spa-like facility could be located outside main facility
CNO - Medical Surgical Unit	17,020	<div></div>		Continue renovations to decrease Med/Surg rooms, increase Swing Beds, etc.
CNO - Nurse Admin	136			
CNO - Obstetrics	8,177	<div></div>		Reconfiguration for larger Triage room.
CNO - Surgical Services	13,019	<div></div> 10%	1,302	Comprehensive reno and some additional clean/dirty circulation. 2016 project had 7,500 sf addition
Shared Space - Public	2,491			Additional Conference Rooms, General Break Room
Shared Space - Staff	2,021	<div></div> 50%	1,011	
Elevators	1,640			
	180,361	209,425	28,936	

## **Bartlett Regional Hospital Facilities Master Plan**

### **Possible Projects List - DRAFT**

December 9, 2019

#### **1. First Floor Renovation / Reconfiguration**

The original portions of the Main Building first floor have not been fundamentally reconfigured or renovated since the first portion of the building was constructed in 1968. The spaces contain the majority of the unabated asbestos as well as many departments that are undersized or badly configured. By moving the Kitchen and Cafeteria to a new location, space would be freed up to allow the rest of the existing departments to shuffle as the entire area is holistically abated and reconfigured.

- **16,700 sf of Renovated Space** (including current pedestrian ramp)
  - 2,580 sf new Diagnostic Imaging Women's Clinic
  - 4,250 sf expanded Materials Management, including dedicated Loading Dock
  - 4,040 sf expanded Facilities, including shop space
  - 300 sf expanded Facilities-Biomedical Shop
  - 2,470 sf expanded Facilities – Laundry
  - 300 sf reconfigured Shared Staff Space (Toilet Rooms)
  - *13,940 sf Subtotal (x 1.2 circulation, walls, etc) = 16,728 sf Total Area*
- **Pros:**
  - Building will be fully abated
  - Many of the most pressing facility needs can be addressed, allowing for smoother operations of all departments
  - Will eliminate public traffic down to east side of Floor 1
- **Cons:**
  - Significant project costs devoted to back-of-the-house departments may limit fund-raising
  - Will require relocation of the Cafeteria

#### **2. Emergency Department Addition**

The Emergency Department has shown significant increases in use since construction a decade ago. Department use is expected to continue to increase with the projected growth in summer visitors. Because of Diagnostic Imaging to the north and the Boiler Rooms to the east, the only area for expansion is to the south. A single-story, 28' wide addition along the entire of the existing department could provide needed space without blocking the view out of the Critical Care Unit patient rooms above. Relocating the Waiting Room to the front could also be studied as part of the addition.

- **4,890 sf of Added Space**
  - 3,675 sf expanded Emergency Department including new Exam, Triage, Pysch, rooms
  - 1,215 sf new 24-hour Pharmacy

- **Pros:**
  - Addition could be constructed without impacting the current ED
  - Pharmacy and Security station could be added to new Emergency Entrance at the south side
- **Cons:**
  - Addition would require moving the Ambulance Bay to the south and will impact parking / drive lanes.
  - Addition will impact siting of new Crisis Intervention Center

### 3. North Addition

The north side of the Main Building is a single-story, metal-framed addition constructed in 1988 adjacent to the original 2-story portion of the 1960 building. Roughly 1/3 of this addition sits north of a lateral structural bay and could be removed without impacting the rest of the structure to the south. Removal of this portion of the 1988 addition, along with the adjacent wood-framed Juneau Medical Center, would allow for construction of a new, multi-story building of significant size. A 92' wide (the depth of the 2009 addition) x 260' long (extending almost to the east wall of the current Juneau Medical Center) would be possible without extending past current building limits. An addition of this size could provide 23,920 sf per floor. A 3-story addition would provide 71,760 sf of space—almost twice what is envisioned as being required by currently-projected BRH needs.

A 92' x 188' addition would provide 17,300 sf per floor. A 2-story addition would provide 34,600 sf.

- **34,600 sf of Added Space**
  - 8,200 sf replaced Physician Services rental spaces to replace Juneau Medical Center
  - 950 sf replaced Facilities offices to replace Juneau Medical Center
  - 4,160 sf + 2,720 sf replaced/expanded Physical / Occupational / Speech Therapy to replace 1988 addition
  - 350 sf + 630 sf replaced/expanded Cardiac Gym to replace 1988 addition
  - 260 sf + 700 sf replaced/expanded Infusion to replace 1988 addition
  - 8,625 sf expanded Cafeteria, including dedicated Loading Dock
  - *26,600 sf Subtotal (x 1.3 circulation, walls, mech. etc) = 34,600 sf Total Area*
- **Pros:**
  - Addition could be more than adequate to meet projected space needs.
  - Addition could contain non-medical spaces to reduce construction costs.
  - Addition could replace lower-quality spaces (Juneau Medical Center).
  - Locating the Cafeteria in the north additional would allow for new Loading Dock, easing traffic on south portion of site.
- **Cons:**
  - Addition may not be properly located for Surgical Services renovation / replacement project.
  - Addition may not be properly located for Laboratory renovation / replacement project.
  - Addition will require new elevators to access floors above main level.

### 4. Surgical Services Renovation / Replacement

The Surgical Services suite was constructed in 1988 and needs comprehensive renovation. The space is centrally located and staff has not wanted to move farther out of the building core. A 2016 conceptual plan showed a new 7,500 sf addition constructed adjacent to the east which would allow for phased renovation and replacement. Although some improvements to the layout (particularly separated paths for clean and dirty materials) is needed, staff has not identified a need for significant additional space.

- Option 1: Add space to west as per 2016 plan. Renovate existing area.
- Option 2: Utilize space in North Addition (see 3 above) for temporary or permanent Surgical Services.
- Option 3: Other ideas?

## 5. South Addition

The south side of the Main Building has two single-story, metal-framed additions constructed in the mid-2000s which are designed for additional floor loads above. The Boiler Room addition has a 2,200 sf footprint and the Cafeteria addition has a 2,800 sf footprint. The Boiler Room is currently under-ventilated, making the spaces above over-heated, but assuming the issue could be addressed, a 5,000 sf per floor addition is possible without new foundation work. Adjacent Floor 2 spaces are mostly Laboratory-related, while Floor 3 has patient rooms which require exterior windows.

- Option 1: Move Laboratory into a new 5,000 sf Floor 2 addition over both Boiler and Cafeteria.
- Option 2: Move a portion of Laboratory into new 2,800 sf addition over just Cafeteria.
- Option 3: Add 5,000 sf at both floors. Move patient rooms on Med Surg to new exterior wall, use expanded core for Case Managers, Storage, and Therapy spaces.

## 6. Medical Arts Replacement

The Medical Arts is a single-story 5,400 sf building located between the Main and the Valliant Admin buildings. Although the building is in good shape, it is taking up valuable real estate in the middle of the campus.

- Option 1: Replace the building with a 3-story building, connected to the Valliant Admin Building. This new, expanded Admin center could take the majority of Admin offices out of the Main Building, providing additional space for medical services there.
- Option 2: relocate Admin offices to the new North Addition (see 3 above) and demolish the Medical Arts building to provide additional parking and landscaping in the middle of campus.

## 7. North Parking Garage

The campus has 480 parking stalls, located in lots of various size and quality around the entire site. The 2011 Master Plan identified 442 stalls, so it is clear that staff has been reconfiguring the site to maximize parking wherever possible. Although the existing parking count more than meets CBJ requirements, it is clear that more is needed, particularly near the Emergency Department entry to the south, the Main Entry to the north, and for public classroom use at the Valliant Building. Exact needs are difficult to quantify, but an additional 25% (120 stalls) would likely solve current deficits with more needed for future growth.

- Option 1: Construct a 3-story, 125' x 250' parking garage on the north-east surface parking lot. The garage would have 285 stalls and replace about 100 existing stalls for a net addition of 185 stalls.
- Option 2: Construct a 4-story, 125' x 250' parking garage on the north-east surface parking lot. The garage would have 380 stalls and replace about 100 existing stalls for a net addition of 280 stalls.

## 8. South Parking Garage

There is a triangular property between the south campus and Egan Drive which has previously been listed for sale. Although the lot is small, it could be used as the base of a new parking garage which would extend into the hillside and connect the south portion of the campus to Egan Drive 30' +/- below.

- **Pros:**
  - Significant new parking near the Emergency Room entrance.

- Garage would connect campus to Egan drive below.
- **Cons:**
  - Would require demolition of the Bartlett House.
  - Would probably take up a significant portion of the anticipated Crisis Intervention Center.
  - Constructing the garage into the hillside would be more expensive than on a flat site.

## 9. South Campus Entry

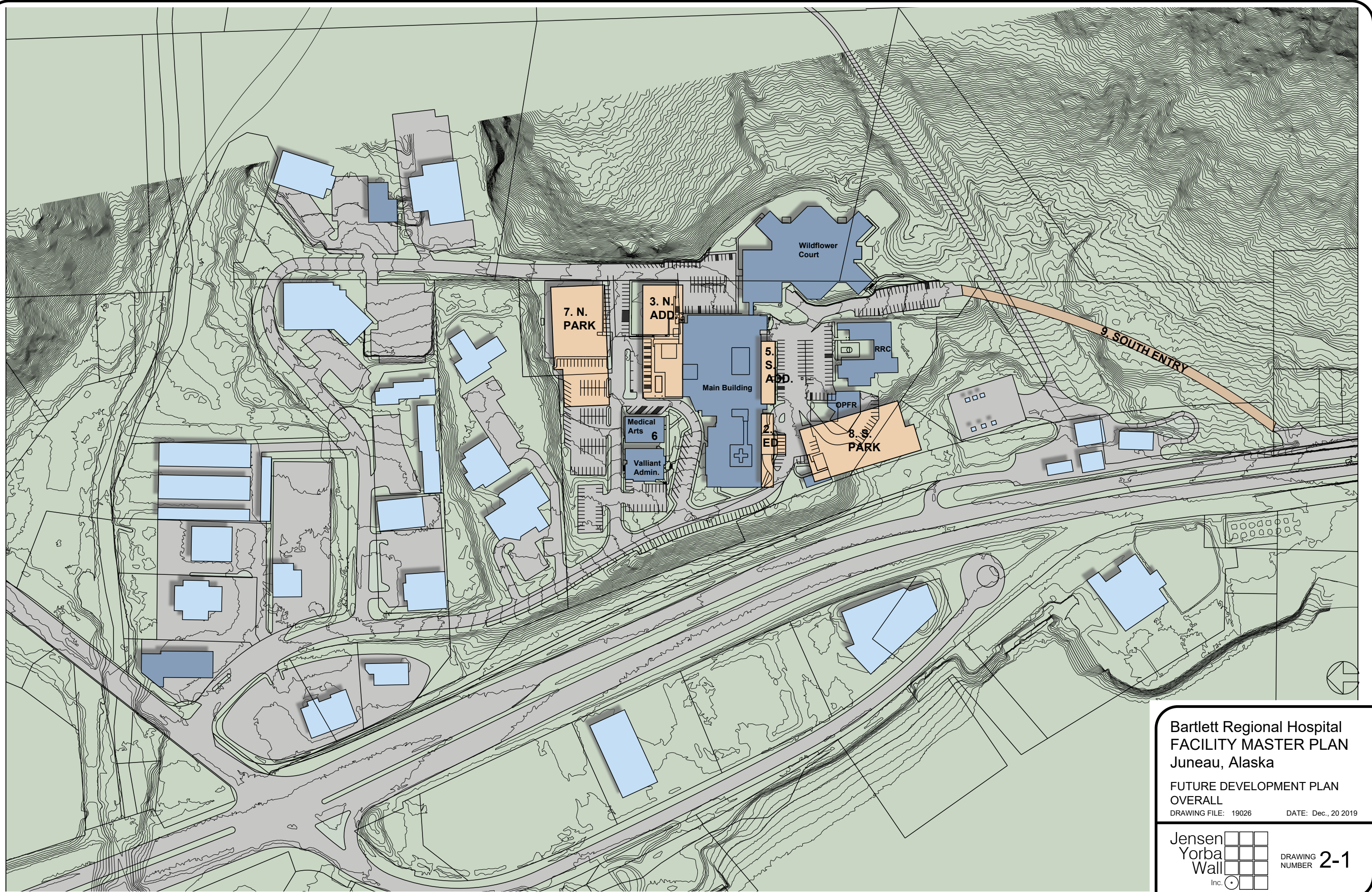
Currently the only vehicular entrance to the campus is through the signaled intersection at Egan Drive / Glacier Highway and then up Hospital Drive to the north of campus. Any accident blocking Hospital Drive essentially cuts off BRH. Additionally, projected outflow from Salmon Creek dam runs down east of BRH property and then down through Hospital Drive, meaning BRH would be cut off in the case of a dam breach. CBJ has contingency plans to access BRH from the end of Glacier Hwy to the south through the woods above the AEL&P substation, but this would require rapid emergency tree removal and grading.

- Option 1: Create a permanent limited-use road from the end of Glacier Hwy up to the south end of the Wildflower Court parking lot.
- Option 1B: create a permanent second access road from end of Glacier Hwy up to the south end of the Wildflower Court parking lot.
- Option 2: Create a permanent limited-use road up from Egan Drive, though the AEL&P site, to the south end of the Wildflower Court parking lot. The road would be right-turn only exit and entry.
- Option 2B: create a permanent second access road up from Egan Drive, though the AEL&P site, to the south end of the Wildflower Court parking lot. The road would be right-turn only exit and entry.

## 10. North Parking Lot Access Reconfiguration

Currently an access road leading from Hospital Drive to the west cuts between the north parking lots and the north side of the Main, Valliant Admin, Medical Arts and Juneau Medical Center Building. Reconfiguring the access road to run on the north side of the parking lots would allow for safer pedestrian access between the parking and the buildings. The north side of BRH property could also be regraded with added retaining walls to possibly add additional parking.





Bartlett Regional Hospital  
FACILITY MASTER PLAN  
Juneau, Alaska

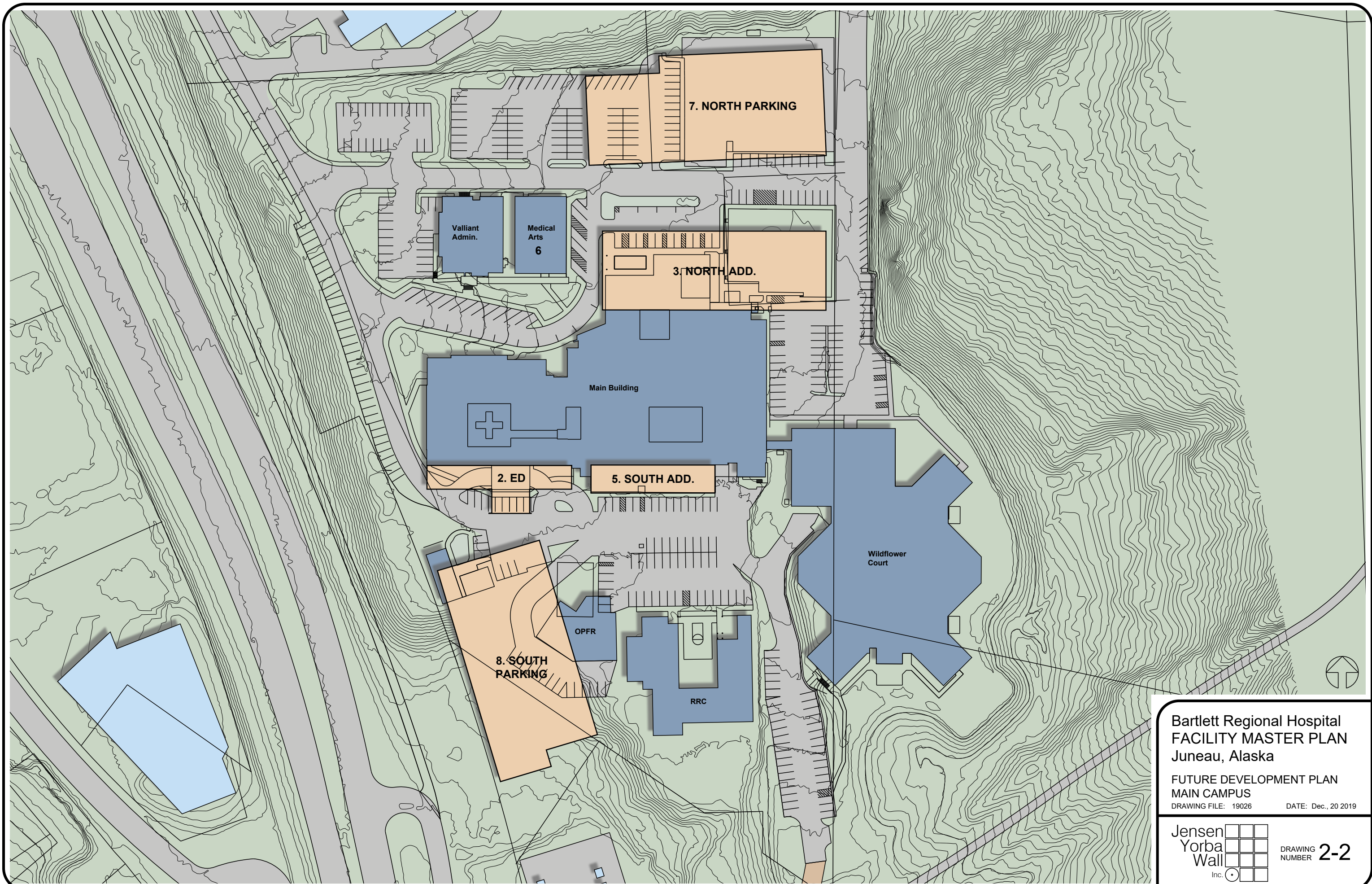
FUTURE DEVELOPMENT PLAN  
OVERALL

DRAWING FILE: 19026 DATE: Dec., 20 2019

Jensen  
Yorba  
Wall  
Inc.

DRAWING  
NUMBER 2-1





**Bartlett Regional Hospital  
FACILITY MASTER PLAN  
Juneau, Alaska**

**FUTURE DEVELOPMENT PLAN  
MAIN CAMPUS**

DRAWING FILE: 19026 DATE: Dec., 20 2019

Jensen  
Yorba  
Wall  
Inc.

DRAWING  
NUMBER **2-2**



To: Bartlett Regional Hospital Board Planning Committee

From: Dr. Lindy Jones

Cc: Chuck Bill, CEO; Billy Gardner, COO

Date: August 9, 2020

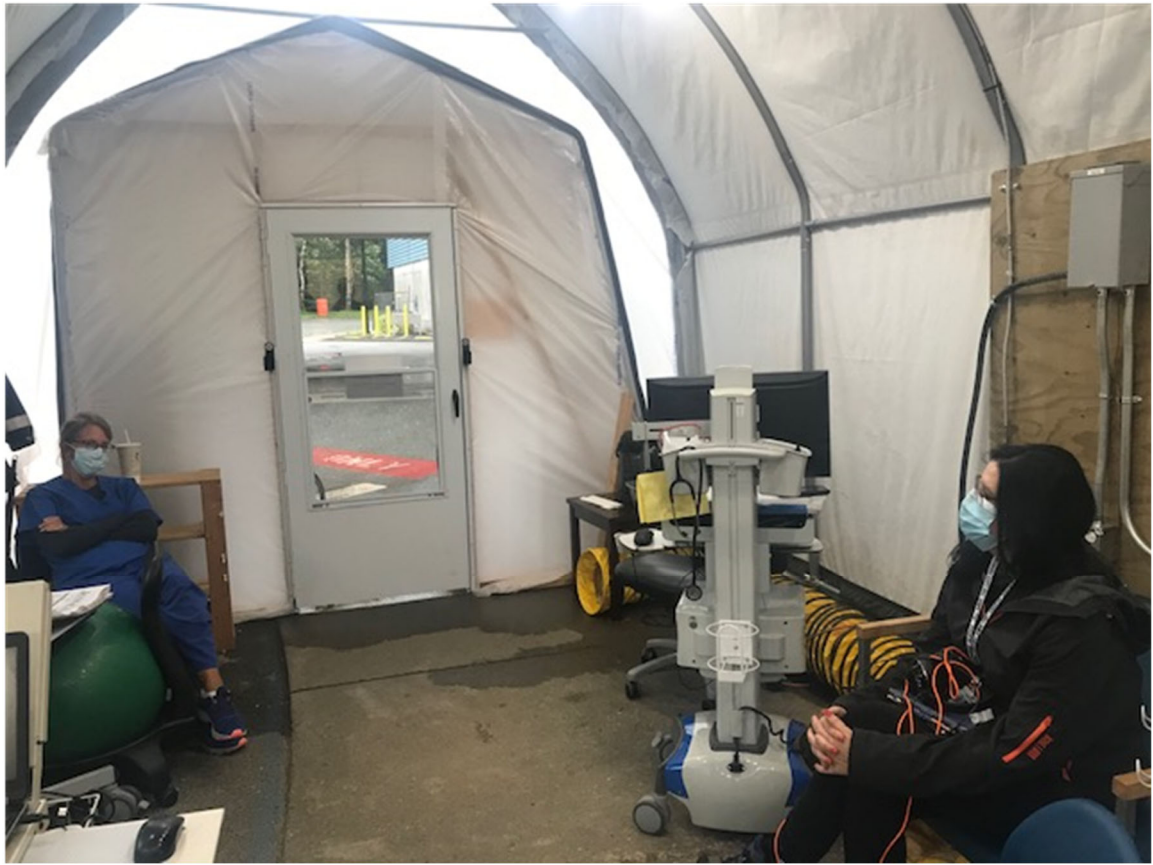
Re: Hospital COVID-19 modifications

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Before the upcoming planning committee meeting, I wanted to provide information and raise some concerns about our ability to function efficiently and safely, given our new normal with COVID-19. This list provides insight into some of these challenges, but is not comprehensive, as I do not understand the workings of all hospital departments. I do believe that 6 months ago we did a good job of putting together makeshift changes that quickly made our hospital a safer place to work; however, many of the modifications are temporary and need to be redesigned in a more permanent and deliberate manner to ensure long term safety of Bartlett's care teams and patients.

- 1) Hospital entrance and prescreening—we have erected a temporary tent in front of the ER, which is staffed 24/7 for COVID prescreening. Although the tent offers a level of protection, it has temporary heat, electricity and the floor leaks in heavy rain. We also staff a screening station at the main entrance during weekdays. These areas should be reviewed from a safety, efficiency, and aesthetic perspective so that we can improve our hospital prescreening. We may need to redesign one or both of our entrances to facilitate this process.







- 2) ER waiting room issues—currently the waiting room has temporary pieces of tape on half the chairs and is underutilized as there is no way to have social distancing. Long term strategies need to be identified, potentially with assistance from expert consultation, to provide a safer environment for patients, families, and our staff members who work in this area.



- 3) ER negative pressure issues—we created one critical care negative pressure room by using a portable HEPA filter to push air into the existing duct system. Problems still exist with this room. It is too small to run a full trauma code and is frequently occupied with patients experiencing respiratory issues and needing negative airflow space. Our current trauma bays are all open and not negative pressure, so if our single negative pressure room is occupied, or we have multiple trauma patients, we are forced to care for these individuals in rooms with less than optimal ventilation. We often do not know patients' true risk for COVID-19 on arrival and caring for critical patients often requires aerosolizing procedures. We need a better, long-term solution for managing critically ill patients in an environment that is safe for the care team.







- 4) ER exam room HEPA filter issues—most of our rooms can accommodate a mobile HEPA filter which is turned on if one has concerns about the patient having COVID. These filters create issues with care delivery. They are loud, making it difficult to interview patients, and impossible to hear anything through a stethoscope. Also, due to their size, it is difficult, if not almost impossible, for patients to transfer between bed and wheelchair, or to perform bedside tasks such as portable ultrasound.



- 5) Microbiology/virology issues—the current space is very small, only includes one small viral hood, limiting our ability to process specimens for send out. It also limits the type of high-volume polymerase chain reaction (PCR) analyzer we can purchase. If we were called upon to perform high volume testing such as at a school or on a small cruise ship, currently we would be unable to not only run the samples but process them in an efficient and timely manner.







- 6) Med/Surg surge capacity—currently we have a negative pressure wing set up on Med Surg for admissions that exceed the capacity of our 2 CCU and 4 Med Surg negative pressure rooms. This wing relies on a temporary plastic dividing wall, and a makeshift ventilation system to create the negative pressure environment.



I am sure there are other issues that need to be identified and addressed in our facility to improve our ability to safely care for our patients in our new state of normal. I recommend that we develop a master plan to address these issues. There may be an opportunity to access additional CARES Act funding to make the modifications in a more permanent manner.

Please call me if you have questions or would like to take a look at things yourself. I am having some problems with CBJ email

Lindy  
907-723-1460  
Lindy@jema.email



# Covid 19/Pandemic Facilities Response

CHANGES BY DEPARTMENT

WILLIAM GARDNER, COO/MARC WALKER, FACILITIES DIRECTOR

**Request sent to SLT/Clinical Directors:**

Good Morning,

The Board of Director's Planning Committee has requested the following information:

Summary of changes that have been made in your department to address our Covid Crisis (Facilities modifications including: walls, ventilation, any other temporary structures or equipment/supplies; social spacing, barriers, etc.)

Which of these changes need to be made permanent, or reinforced for several years? What other changes will we need to be making as this crisis unfolds and assuming it will be with us for several years?

I will be working with Marc to put together charts and plans and while the request came in this morning, it is due by Tuesday's board meeting.

Thank you for assisting with this request.

Senior Leaders please send out this or a similar information request to your departments so that Marc and I can add them in.

Billy

Quality, Patient-Centered, Sustainable Care  
William C. Gardner MBA, HCM, MSN-RN  
Chief Operating Officer

[wgardner@bartletthospital.org](mailto:wgardner@bartletthospital.org)

Phone: 907-796-8678

Fax: 907-463-4919

Department/Area	Summary of Covid Changes/Modifications	Future and Permanent Modifications
OB/Nursery/Special Care	Convert 1 room to capable of being positive or negative pressure including pressure monitoring and alarms.	Permanent <ul style="list-style-type: none"> <li>• Design Team – Yes</li> <li>• Architectural – Yes</li> <li>• Mechanical – Yes</li> <li>• Electrical – Yes</li> </ul>
Medical-Surgical Director: Liz Bishop,RN	Long term: <ul style="list-style-type: none"> <li>• (Aggressive option) Make back wing and include back nurses station to be all negative pressure without use of hepa machines. This would close off conference room for hospitalists office. And remove sleep room from covet wing. Consider conversion of conference room to two patient rooms. Conference room could be used as a ward room if we have access to gasses and plumbing . ( Just thinking outside the box.) If I remember the plumbing was already in place in the wall for this conversion.</li> <li>• Close off the area of back wing to just after MS room 18 allows for one bariatric room in isolation- leaving open room 19, solarium and right side hallway to be open to regular patients. Would be potential for 18 + 2 in conference room = 20 isolation rooms plus the 4 that we already have . That leaves 17 regular patient rooms.</li> <li>• <b><u>Negatives to this:</u></b> hospitalist need a new home and sleep room. Loss of dictation room and large storage area.</li> </ul>	Permanent <ul style="list-style-type: none"> <li>• Hospital License change to add two new beds.</li> <li>• Design Team – Yes</li> <li>• Architectural – Yes               <ul style="list-style-type: none"> <li>• Potential new rooftop mechanical room.</li> </ul> </li> <li>• New patient rooms.</li> <li>• New doors to create isolation wing.</li> <li>• Mechanical – Yes               <ul style="list-style-type: none"> <li>• New fan systems.</li> <li>• New ducting.</li> <li>• Sprinkler modifications.</li> <li>• New mechanical controls.</li> <li>• Plumbing.</li> <li>• Medical gases.</li> </ul> </li> <li>• Electrical – Yes               <ul style="list-style-type: none"> <li>• New feeds to support mechanical.</li> <li>• Nurse call.</li> <li>• Fire alarm.</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>• (Not so Aggressive) Place a permanent wall and door where temporary plastic one is currently. Create whole area to be negative pressure without the need to set up hepa filters. This would give us 7 isolation rooms that are negative pressure. + current 4 on floor for a total of 11 isolation rooms. This would leave 16 regular patient rooms.</li> <li>• <b><u>Negatives to this:</u></b> Hospitalist will need new sleep room, hospitalist sleep room is currently in patient room, loss of large storage room and physician dictation room. Large store room is our doffing area and also would become our charting and staging area. Need large room divided between doffing area and staging area to include a omnicell or a place to store medications. Dictation room is donning room.</li> <li>• Keep solarium open for staff and patients. Need as expanded lunch , rest area for staff to spread out and for patient and visitor use. Used by pharmacy also.</li> <li>• Need crash cart and Defibrillator for area.</li> <li>• Need additional capnography machines for each room.</li> <li>• Staff request a lock to the MS unit (Badging system) with a communication phone to slow visitor traffic on the unit.</li> </ul>	<p>Permanent</p> <ul style="list-style-type: none"> <li>• Design Team – Yes</li> <li>• Architectural – Yes <ul style="list-style-type: none"> <li>• Potential new rooftop mechanical room.</li> <li>• New patient rooms.</li> <li>• New doors to create isolation wing.</li> </ul> </li> <li>• Mechanical – Yes <ul style="list-style-type: none"> <li>• New fan systems.</li> <li>• New ducting.</li> <li>• New mechanical controls.</li> </ul> </li> <li>• Electrical – Yes <ul style="list-style-type: none"> <li>• New feeds to support mechanical.</li> </ul> </li> </ul>
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<p>CCU Director: Audrey Rasmussen, RN</p>	<p>Attached are the pictures representing the changes in CCU since COVID -19.</p> <p><b>Make all CCU Patient Rooms capable of being positive or negative pressure including pressure monitoring and alarms.</b></p> <ul style="list-style-type: none"> <li>• We turned CCU 08 into a negative airflow room with a new fan in the ceiling. This is a permanent solution.</li> <li>• We recently converted windows in CCU 07, CCU06, and CCU 05. This will allow us to connect a HEPA filter to the vent in the window and make the rooms a negative airflow room.</li> <li>• CCU 08- CCU 06 have plastic curtains for more of a barrier to doffing gown and gloves. There is also markings on the floor which differentiate 6 feet from the bed. Maintenance has already reinforced the top to make them longer lasting. We have requested that all curtains in CCU-0-09 be plastic so they are easier to clean.</li> <li>• We have a barrier between OB and CCU near room 8, so traffic cannot easily flow from CCU into OB and to prevent airflow into OB.</li> <li>• We also have a cart near 08/09 for mask storage.</li> </ul>	<p>Permanent</p> <ul style="list-style-type: none"> <li>• Design Team – Yes</li> <li>• Architectural – Yes <ul style="list-style-type: none"> <li>• Potential new rooftop mechanical room.</li> </ul> </li> <li>• Mechanical – Yes <ul style="list-style-type: none"> <li>• New fan systems.</li> <li>• New ducting.</li> <li>• New mechanical controls.</li> </ul> </li> <li>• Electrical – Yes <ul style="list-style-type: none"> <li>• New feeds to support mechanical.</li> </ul> </li> </ul>
<p>Emergency Department</p> <p>Director: Kim Mcdowell, RN</p>	<p>ED response to COVID -19 required the yellow triage disaster tent be deployed outside the emergency department entrance to be used as a COVID-19 screening tent. This tent was later replaced with a screening tent that is more durable and sturdy to sustain all weather. The new screening tent includes a</p>	<p>Waiting Room/Triage is a full project including all Professional Services.</p>

	<p>heater, lighting, Wi-Fi and an electrical panel to provide power. The new screening tent is also anchored to the pavement. The entrance and exit areas of the screening tent has storm doors, the entrance has an overhang to be able to screen people without entering the tent, and the exit has the same size overhang to accommodate a donning and doffing area for staff and providers, when COVID possible, stable patients are seen in the car. This is to decrease risks of COVID-19 entering the hospital. Although the screening tent is more durable, it is still a temporary screening area and the need for a permanent screening area needs to be created. This needs to be separate from the current triage room in the ED.</p> <p>The exterior of tent requires exterior lighting as well as jersey barriers to protect staff, patient's and equipment. A port-a-potty was also placed for patients to use that are being seen in their car. With the need to potentially see patient's in their cars, the ED nurse staffing needs to be changed from three day shifts RN's, a mid- shift RN and three night shift RN's(3-1-3) to four day shift RN's, a mid-shift RN and four night shift RN's. This staffing grid needs to be maintained, as COVID screening will need to continue. ED waiting room was arranged to accommodate social distancing. Current capacity is six people. Plans need to be made to accommodate overflow when needed.</p> <p>Fully enclose trauma rooms, make all exam and trauma rooms capable of being negative or positive pressure with monitoring and alarms.</p>	<p>Permanent</p> <ul style="list-style-type: none"> <li>• Design Team – Yes</li> <li>• Architectural – Yes</li> </ul>
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	<p>Multiple hepa filters are being used in emergency department E rooms as a temporary fix to make needed negative pressure rooms for possible or positive COVID patients. ED Rooms, minor suture and ortho have been reconstructed to be negative pressure rooms. This required a temporary wall to be constructed, a door added and requiring the fire doors to remain closed and sealed with painters tape on one side as well as tape to seal seams at temporary wall. This creates an ante room for donning and doffing, as well as storing PPE for each room. This required all supplies in each of the rooms to be relocated to director's office and alcove outside P-1. While these two rooms are used for highly presumptive or positive COVID-19 patients, there is a need for negative pressure rooms to run a trauma in. The two negative pressure rooms are unable to accommodate running a trauma due to size and location. A trauma room needs to be created that has negative pressure to ensure staff and patients are not exposed to COVID-19 during traumas, as most times, the trauma patient is unable to answer screening questions.</p> <p>Supplies in the clean utility room moved to hallways in ED to accommodate an area for clean and dirty PAPR's and N-95s. This along with the storage in the alcove by P-1 violates Joint Commission and OSHA standards for hallway clearance etc. Wire racks purchased to place outside of the E rooms to hold dirty masks storage for nurses and providers shifts.</p> <p>Windows in patient rooms at RRC were change to accommodate a negative pressure in case RRC needed to be converted to an alternate care site in case of a surge of COVID-19.</p>	<ul style="list-style-type: none"> <li>• Potential new rooftop mechanical room.</li> <li>• Mechanical – Yes <ul style="list-style-type: none"> <li>• New fan systems.</li> <li>• New ducting.</li> <li>• New mechanical controls.</li> </ul> </li> <li>• Electrical – Yes <ul style="list-style-type: none"> <li>• New feeds to support mechanical.</li> </ul> </li> </ul>
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Infusion/Oncology		None

Surgical Services	We have not made any temporary or permanent modifications to the facility because of the Covid Crisis	None
PT/OT/ST Rehab Director: Rusty Reed, PT	<p>COVID changes made to Physical Rehab department:</p> <ol style="list-style-type: none"> <li>1. Patient and therapist schedules spaced/staggered in order to avoid overcrowding and lack of social distancing</li> <li>2. 15 minutes between appointments to allow for properly sanitizing of the treatment rooms</li> <li>3. Screening and proper protocols for sanitizing patient rooms and the Peds gym using Oxivir wipes and spray bottles of alcohol</li> <li>4. Ordered (2) entire room UV lamps to disinfect primarily the Peds gym but can be utilized in other areas of our department</li> <li>5. Utilization of Teletherapy where appropriate.</li> <li>6. Waiting on plexiglass/barrriers for Administrative desk area and patient sign in</li> <li>7. Waiting on laptops to exchange out the older ones and the desk top computers in order to allow therapists to document more remotely as work stations do not allow for 6' distancing</li> <li>8. 2 treatment tables have been replaced that were deemed infection control risk</li> <li>9. We need to change out chairs in our treatment rooms that are in poor quality and considered infection control issues</li> </ol>	



	<p>10. We need to change out therapists and administrative assistance work chairs that are cloth and cannot be adequately cleaned</p> <p>11. We need remodeling of our reception desk area to allow for better patient work flow and proper distancing for our administrative assistance team.</p> <p>12. We need remodeling of our therapist work stations to allow for more spacing</p> <p>13. Consider offsite location for all pediatrics for improved spacing and prevent frequent hospital exposure</p> <p>**all would be considered permanent except #1 as our expectation is to get our service lines back at 100% capacity</p>	<p>11. Term contract under \$50,000</p> <p>12. Term contract under \$50,000</p>
<p>Respiratory Director: Rob Follett, RT</p>	<p>RT: Plexiglas barriers planned for but not yet installed. Permanent in nature. Additional Oxygen , O2 concentrators , Ventilators and supportive supplies, we need space to store them.</p> <p>Cardiac and Pulmonary Rehab: HEPA filter and social spacing in place. Permanent in nature.</p> <p>Sleep Lab: HEPA filters in place. Permanent in nature.</p>	<p>Bulk Oxygen System Permanent</p> <ul style="list-style-type: none"> <li>• Design Team – Yes</li> <li>• Architectural – Yes</li> <li>• Mechanical – Yes</li> <li>• Electrical – Yes</li> </ul>
Cardiac Rehab		
Sleep Studies		
<p>Diagnostic Imaging Director: Paul Hawkins,</p>	<p>Diagnostic Imaging COVID-19 implemented plan.</p> <ul style="list-style-type: none"> <li>• Patients are pre-registered so they just check in with PAS next to diagnostic imaging to get their bracelet and sign consent for treatment papers.</li> </ul>	None

	<ul style="list-style-type: none"> <li>• Schedule is staggered so only a few patients are checking in at a time.</li> <li>• Checked in patients go directly to the exam area without waiting most of the time.</li> <li>• Mammography patients go directly to the mammography suite.</li> <li>• Patients are screened over the phone when scheduled, have you traveled out of state? Do you have a fever or subjective fever? Do you have any symptoms?</li> <li>• Clean pen / Dirty pen area at reception. Clipboards are cleaned between patients. Counters are cleaned.</li> <li>• Chairs were taken out of DI and arranged remaining chairs so any patient waiting would be 6 feet apart.</li> <li>• Patients with COVID-19 like symptoms that needed urgent outpatient X-Ray are registered over the phone, one technologist meets them at car in full PPD, checks name and DOB puts on the bracelet and brings them in the back door while another technologist make sure hallway to temporary COVID 19 x-ray area is cleared and escorts them back outside in the same manner.</li> <li>• Plexiglas barrier was requested to be placed on DI Reception counters, shortage of glass, still waiting.</li> <li>• Now that the UV light has been repaired we will continue with our plan to use it at night to treat exam rooms.</li> <li>• ER patients with suspected COVID -19 are imaged in the ER when possible and brought to DI after rapid test is resulted provided they are medically stable.</li> <li>• Extra equipment has been removed from imaging area to minimize areas need to be cleaned.</li> </ul>	
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	<ul style="list-style-type: none"> <li>• Terminal cleaning is done in any area that a suspected patient is treated in.</li> <li>• Planning to implement Jelly Fish software if purchased so patients can register online and wait in their car until it is their turn and can text or call patients when we want them to come into the hospital. This would be something all BRH departments could use, Kevin Benson has more information on this project.</li> <li>• Universal masking, frequent hand washing, screening employees daily, personal protective equipment and cleaning surfaces between patients.</li> <li>• Following the hospitals current visitor policy.</li> </ul> <p>Here is what we have changed in DI. We are prepared to do this as long as needed.</p>	
Pharmacy		
Laboratory Services	<p>Laboratory COVID-19 implemented plan.</p> <ul style="list-style-type: none"> <li>• Patients are screened at the entrances to get their bracelet. Travel, temperature and questionnaire are completed.</li> <li>• No Patients with COVID-19 like symptoms are allowed to enter hospital as outpatients.</li> <li>• Patients do register in PAS for drop off or collections. No need for appointments, Outpatient loads have been light, so no furniture has been removed.</li> <li>• Staff in outpatient area follow masking and distancing. Once checked in patients go directly to the exam area</li> </ul>	

	<p>without waiting. Patients are required to have a mask and hand sanitizer is available.</p> <ul style="list-style-type: none"> <li>• Exam area is wiped down after each patient, using provided cleaning equipment.</li> <li>• Plexiglas barrier was requested to be placed on reception counters, shortage of glass, still waiting.</li> <li>• ER patients with suspected COVID -19 samples are placed in stainless receptacle and wiped down for each time samples are removed.</li> <li>• All phlebotomy staff have been assigned 10 N-95's and instructions provided for reprocessing. All phlebotomy staff trained to follow signage posted on patient rooms.</li> <li>• Universal masking, frequent hand washing, screening employees daily, personal protective equipment and cleaning surfaces between shift or any time expected need.</li> <li>• Following the hospitals current visitor policy.</li> </ul>	
Cafeteria		
Materials Management		
Hospitalist Services		
Main Building		
PAS		
MHU Director: Ariel Thorsteinson, RN	<p>Convert 2 rooms to be capable of being negative or positive pressure with monitoring and alarms.</p> <p>MHU has removed a significant amount of furniture and supplies from our dayroom. Limited each table to 1 chair and measured the space from each table to make sure its six feet. We</p>	<p>Permanent</p> <ul style="list-style-type: none"> <li>• Design Team – Yes</li> <li>• Architectural – Yes <ul style="list-style-type: none"> <li>• Potential new rooftop mechanical room.</li> </ul> </li> </ul>

	<p>don't allow more than six people including staff into our dayroom. We don't do any activities that involve sitting two person to a table or sharing any objects. We also aren't doing any activities that involves increased droplet production. Only things like yoga, tai chi, walking etc. We are using a patient room for overflow from all these objects.</p> <p>We run a HEPA filter after talk therapy and low risk physical activity. We wipe after each activity in case patients change tables or positions.</p> <p>We close down our unit in half when a high risk for violence patient comes into the unit and do not allow them in the dayroom. Generally these patients are psychotic, with low masking compliance and altered mental status. We wear more protective gear and restrict their access until the patient mental status, masking compliance and medication compliance improves to lower the safety threat.</p> <p>We are not allowing visitors unless approved by the treatment team.</p> <p>The hospital does not have a very good answer if we have a COVID positive or symptomatic psychotic patient (suspicious of covid) but I don't have a great answer for that.</p>	<ul style="list-style-type: none"> <li>• Mechanical – Yes <ul style="list-style-type: none"> <li>• New fan systems.</li> <li>• New ducting.</li> <li>• New mechanical controls.</li> </ul> </li> <li>• Electrical – Yes <ul style="list-style-type: none"> <li>• New feeds to support mechanical.</li> </ul> </li> </ul>
Behavioral Health Clinical Services Director: Janell Meade, RN	I think we may want to make our larger rooms into 2 rooms, that would mean putting up partitions in room 10 and room 12. This would allow us to serve 8 instead of 6 inpatients.	
RRC		

IS		
Outpatient Clinics		





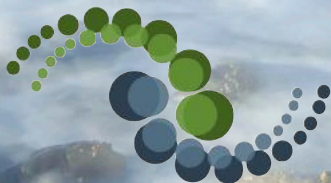
**SOUTHEAST  
CONFERENCE**

2025

# **Southeast Alaska Economic Plan**

Meilani Schijvens  
Rain Coast Data

## **SWOT Analysis Health Care**





# Timeline: Where are we in process?





# Southeast Alaska Health Care Workforce Analysis

December 2019

Health care  
planning -  
building off of  
the work  
developed in  
the Southeast  
Alaska Health  
Care Workforce  
Analysis



Prepared by  
Rain Coast Data



ALASKA STATE HOSPITAL &  
NURSING HOME ASSOCIATION

**Bartlett**  
Regional Hospital



SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM

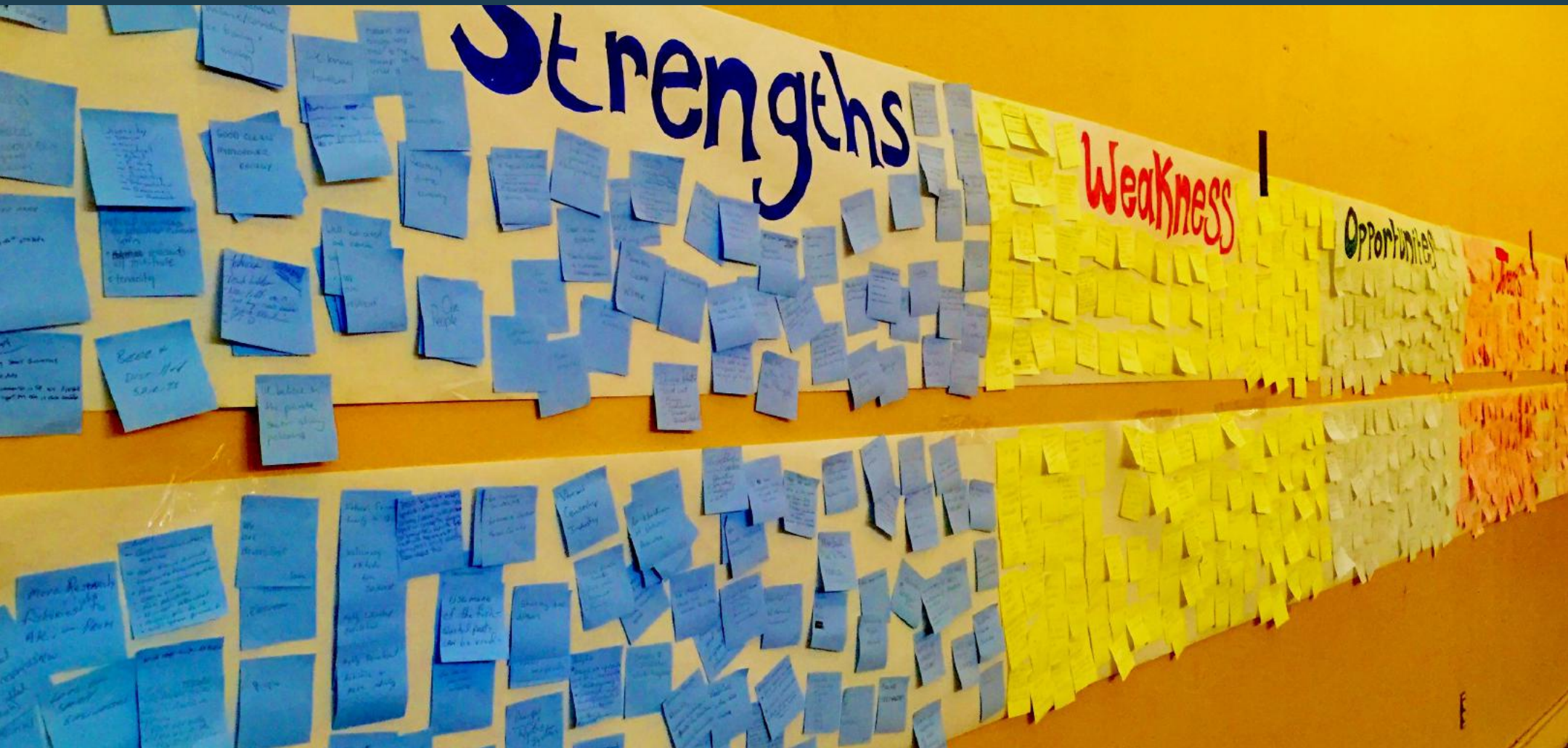


UAA College of Health  
UNIVERSITY of ALASKA ANCHORAGE

UNIVERSITY  
of ALASKA  
SOUTHEAST



# Health Care SWOT Analysis



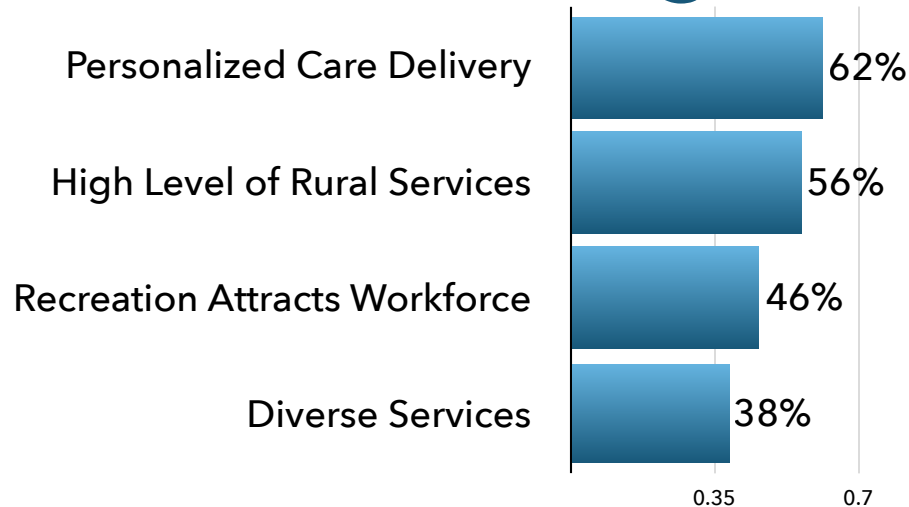
October 9, 2019 SWOT analyses

The Southeast Alaska Health Care SWOT analysis was conducted by the Southeast Conference Health Care Committee on October 9th, 2019. Once the SWOT lists were completed by the group, committee members were asked in July 2020 to prioritize by choosing the top three items that they felt were most representative of regional health care strengths, weaknesses, opportunities, and threats.

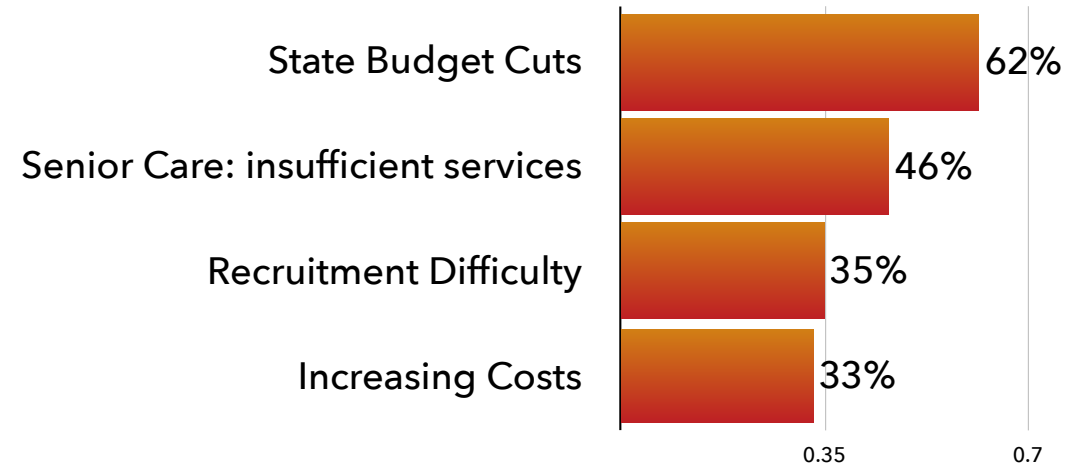
# Summary of Southeast Alaska Health Care SWOT: Top responses

Overall: COVID-19 and post COVID-19 uncertainty impacts all health care related analysis

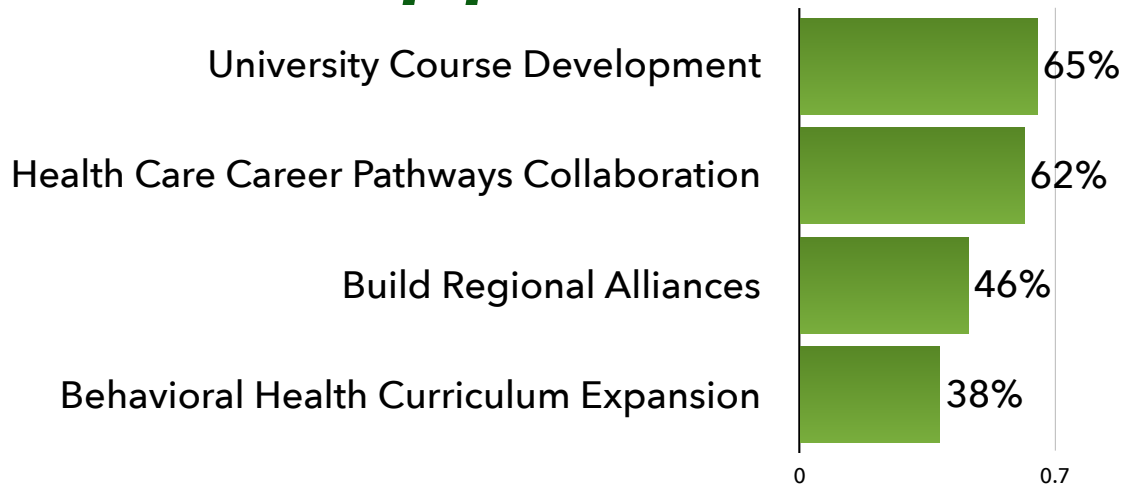
## *Strengths*



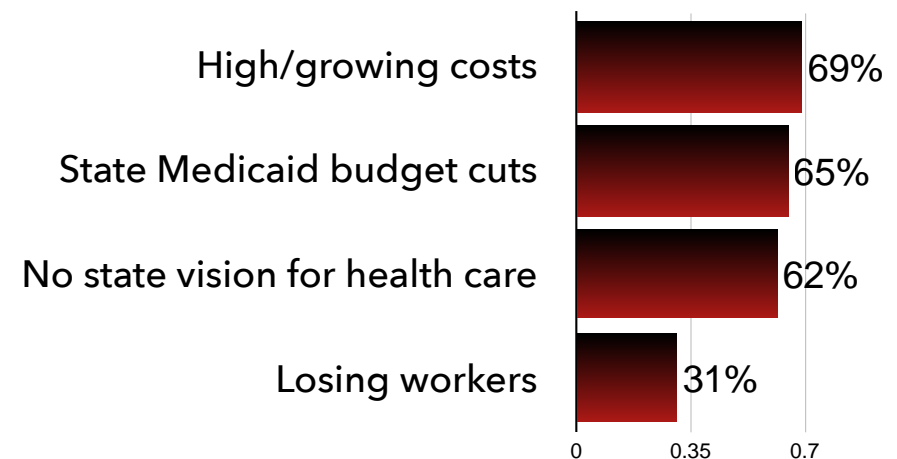
## *Weaknesses*



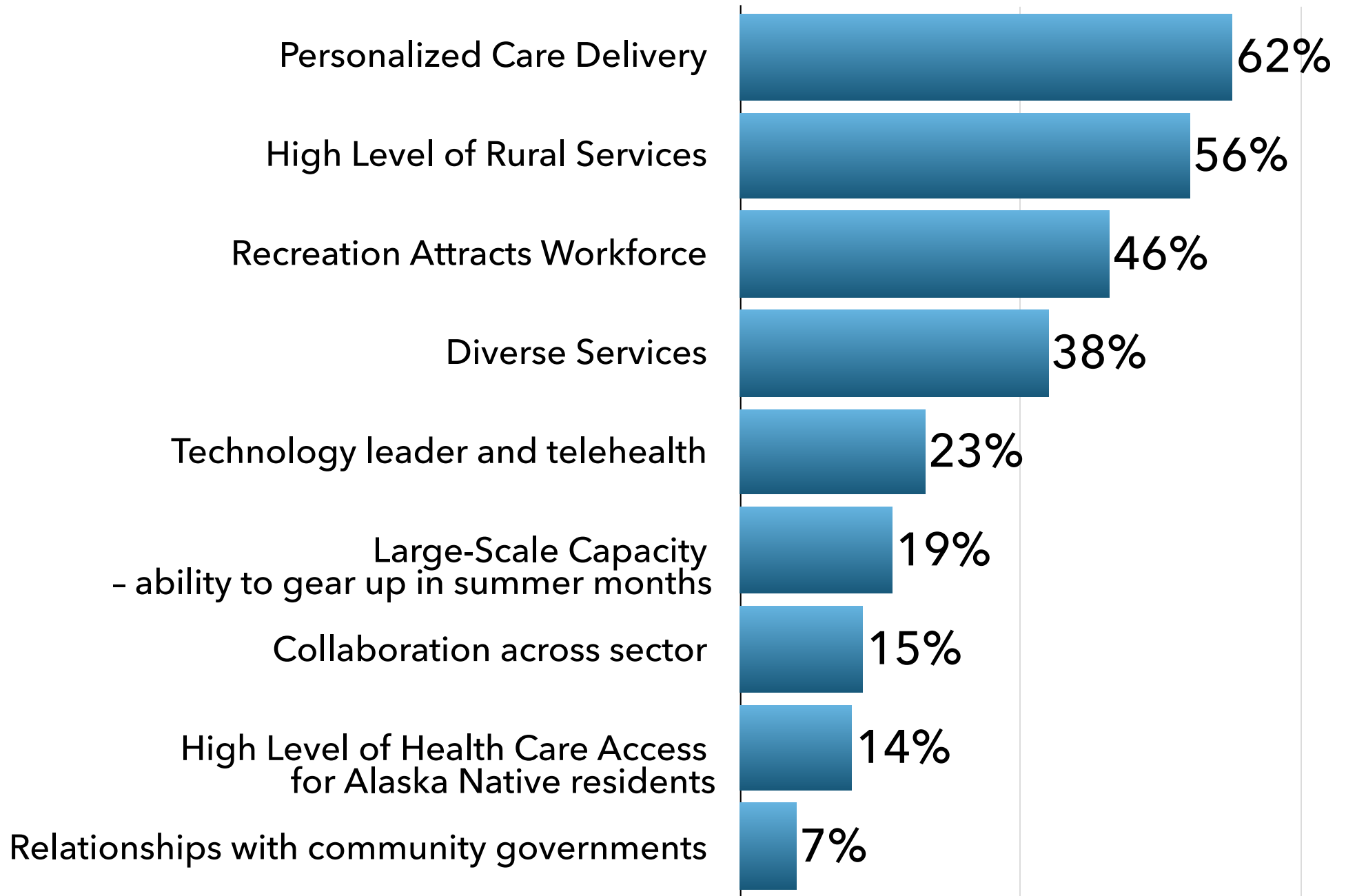
## *Opportunities*



## *Threats*



# *Southeast Health Care Strengths*

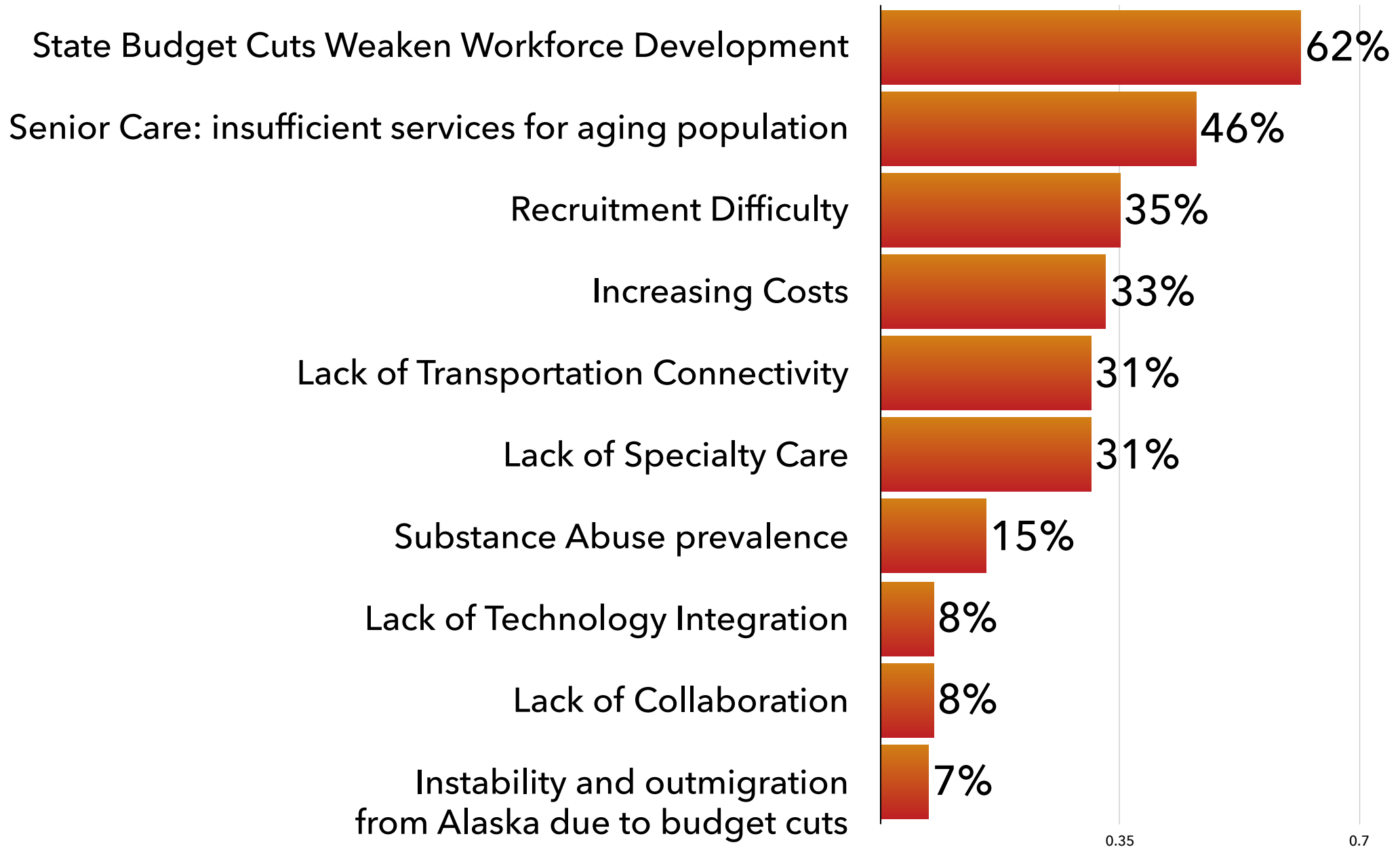


0.35

0.7

# ***Southeast Health Care Weaknesses***

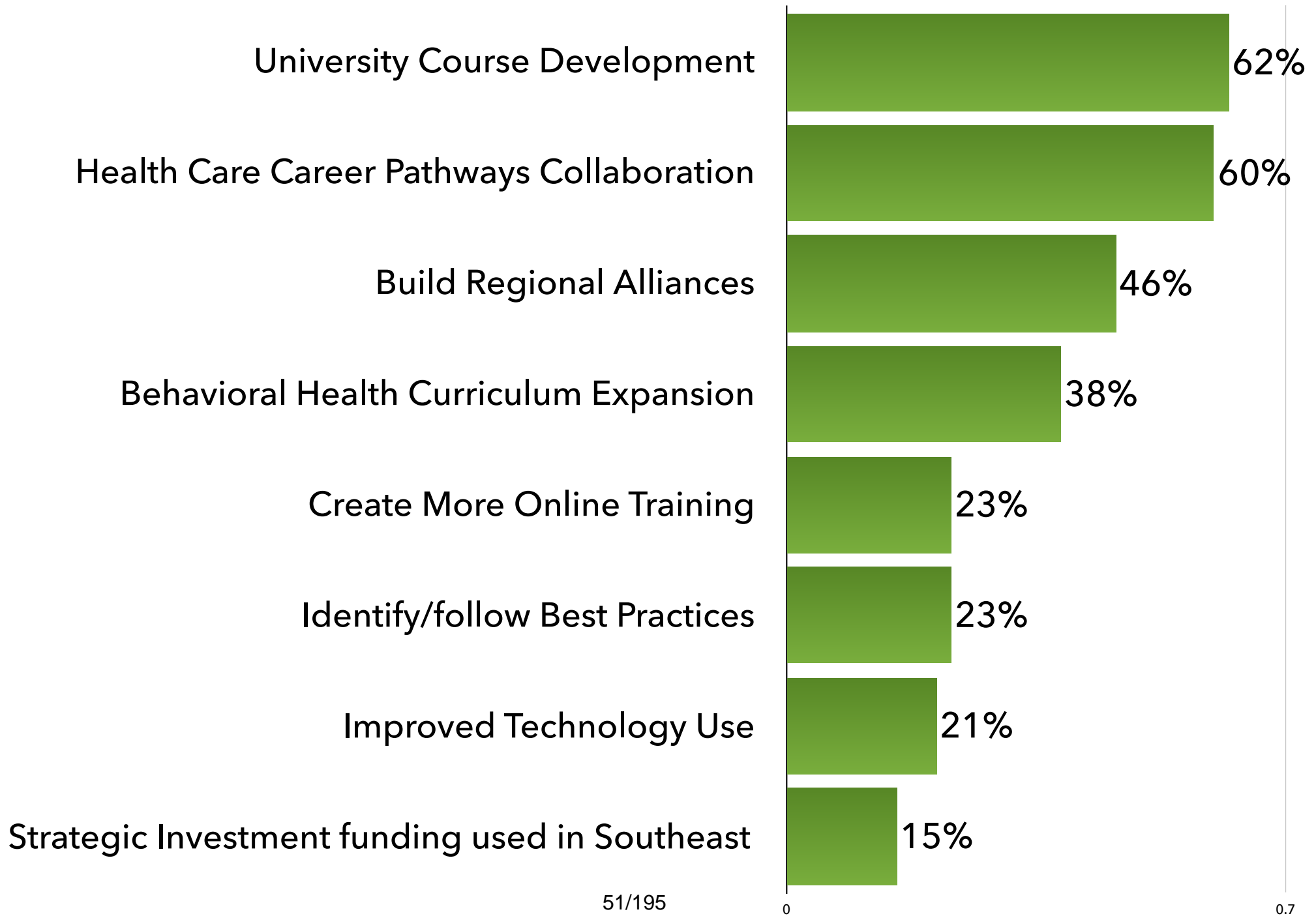
COVID-19 and post COVID-19 uncertainty impacts impacts throughout



0.35

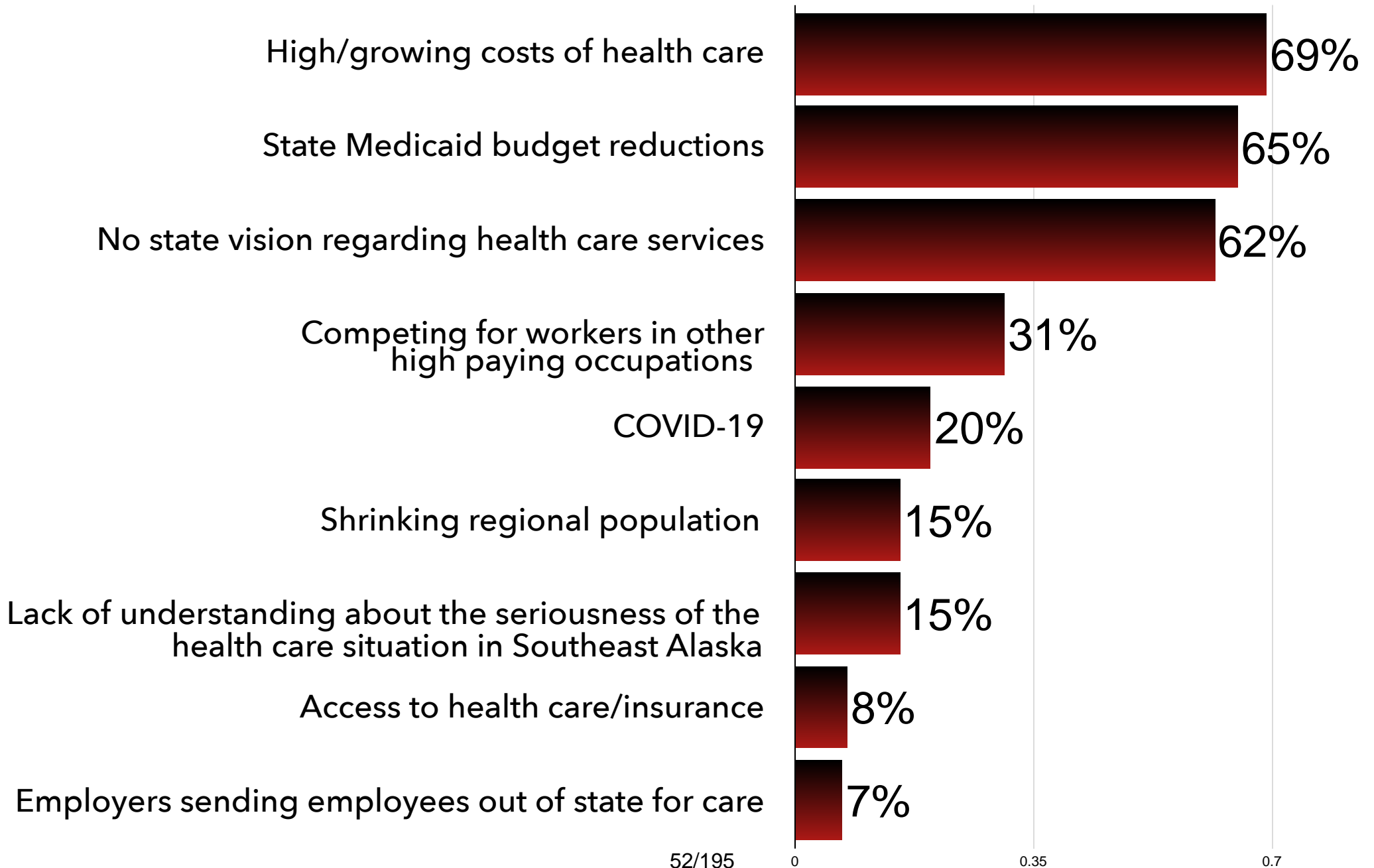
0.7

# *Southeast Health Care Opportunities*



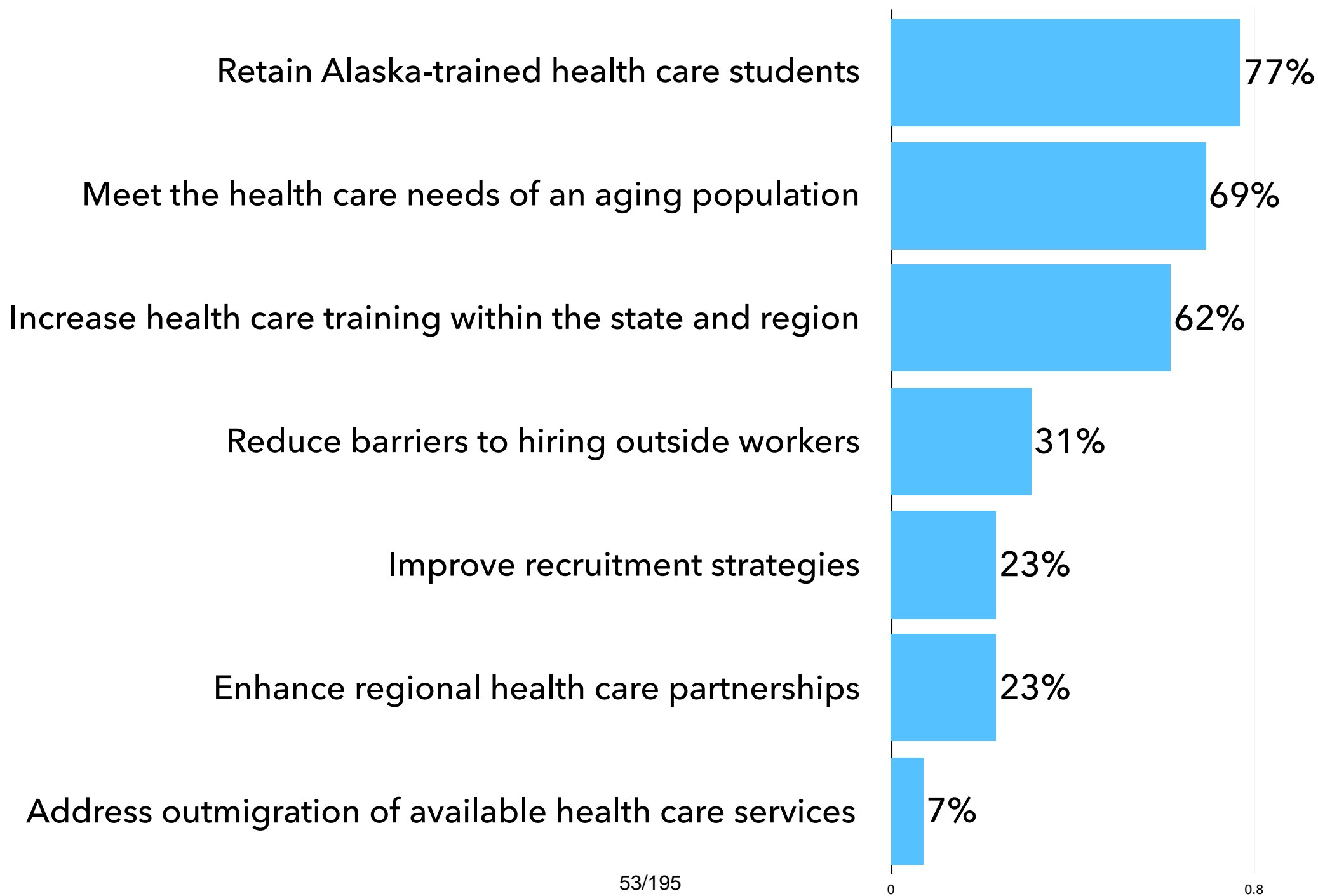
# ***Southeast Health Care Threats***

COVID-19 and post COVID-19 uncertainty impacts impacts throughout



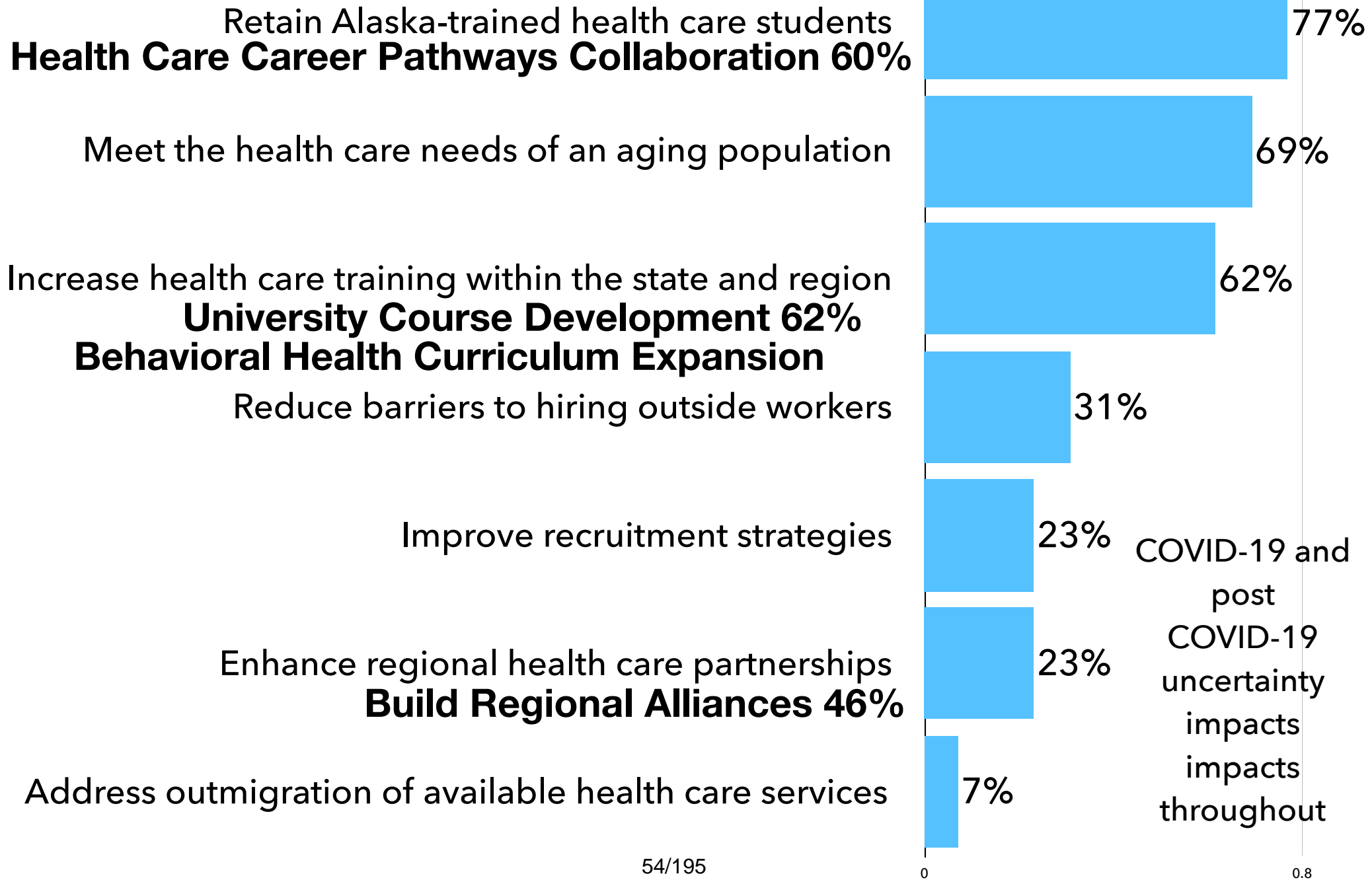


# Health Care Initiatives



# Health Care Initiatives

How do opportunities fit it?



# *Health Care Initiatives*

New initiative discussion, what do we need to add:  
The Southeast Alaska 2025 economic plan needs to  
include planning now for a post-COVID-19 world,  
especially when it comes to the state budget.

## **Plan for a post COVID-19 Southeast Alaska economy and health care system:**

Identify funding capabilities of state going forward. What does the Southeast Alaska economy look like one year from now? How do we continue operations, both from a health care perspective and for our larger economy? Advocate for the development of a state fiscal plan so that we have a plan to fund state services.

There are vulnerabilities within the health care system that are likely to be exacerbated following the COVID-19 crisis, including Medicaid cuts, reduced access to health care insurance. etc. Primary goal: We need to ensure that our populace is healthy, has access to care, access to insurance, and has community support to make healthy choices.

# Priority Objective Submission Template for 2025 Southeast Alaska Economic Plan

**Priority Objective Project Title:**

**Project Description**

**Outline of steps required for project to be completed. (Include realistic timeframe & benchmarks.)**

**People/Organizations responsible for completing these steps**

**Cost Estimates (Include a list of the integrated funding sources — public, private, nonprofit—to support the costs).**

**Evaluation Measures**

**Key Project Contact**

The Southeast Alaska Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis was developed by more than 200 Southeast Conference members, including business, municipal, and tribal leaders from across the region in February 2020.

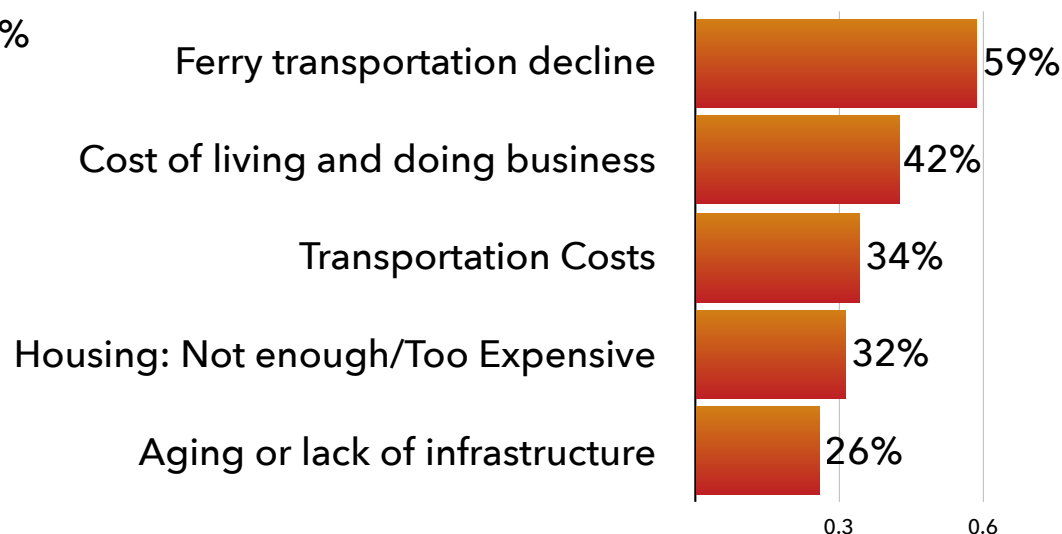
# Summary of Southeast Alaska SWOT:

## Top responses

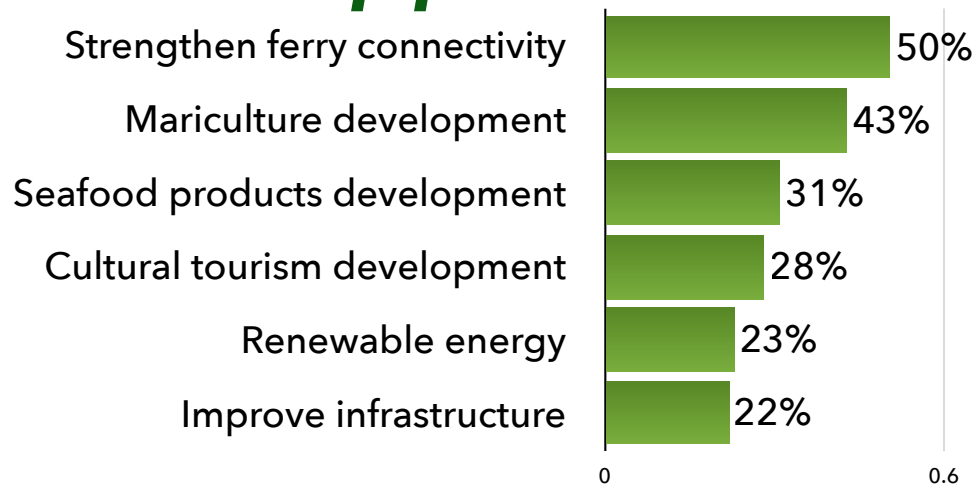
### *Strengths*



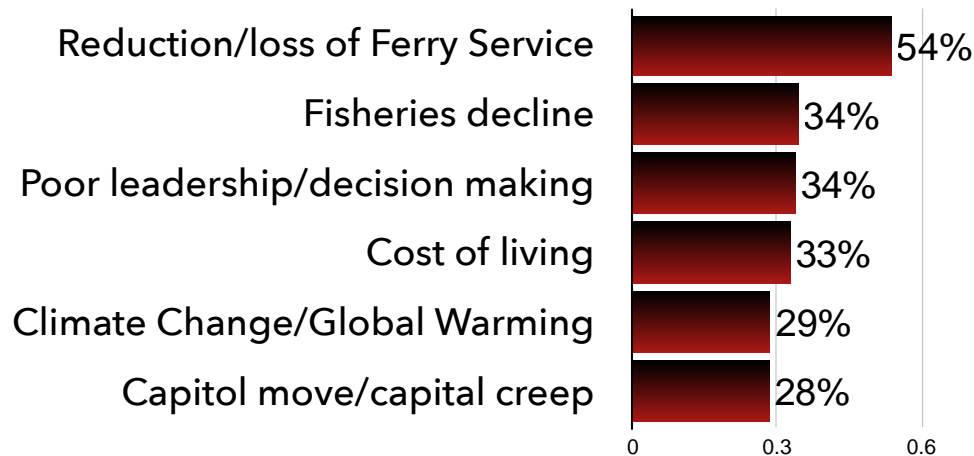
### *Weaknesses*



### *Opportunities*

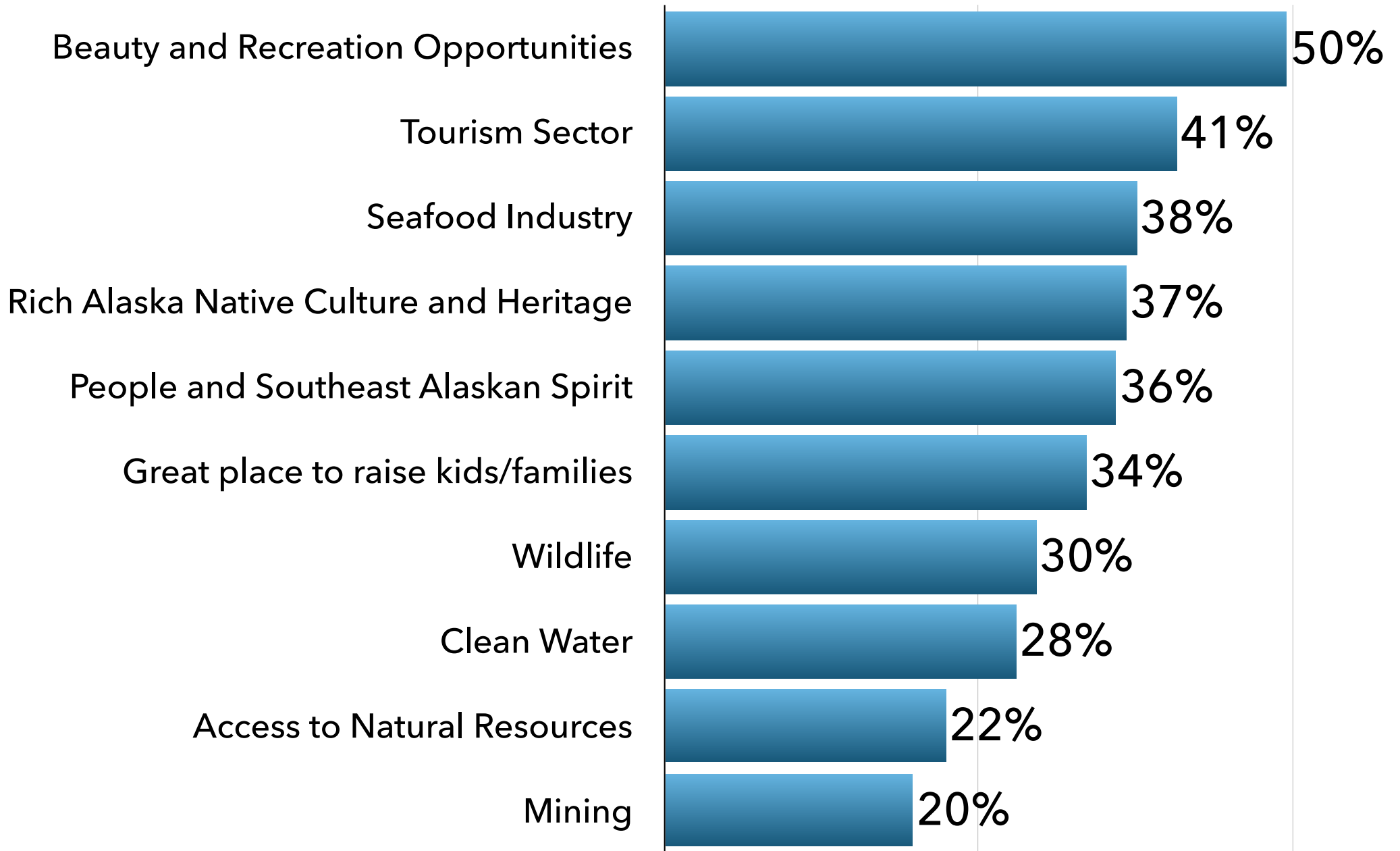


### *Threats*

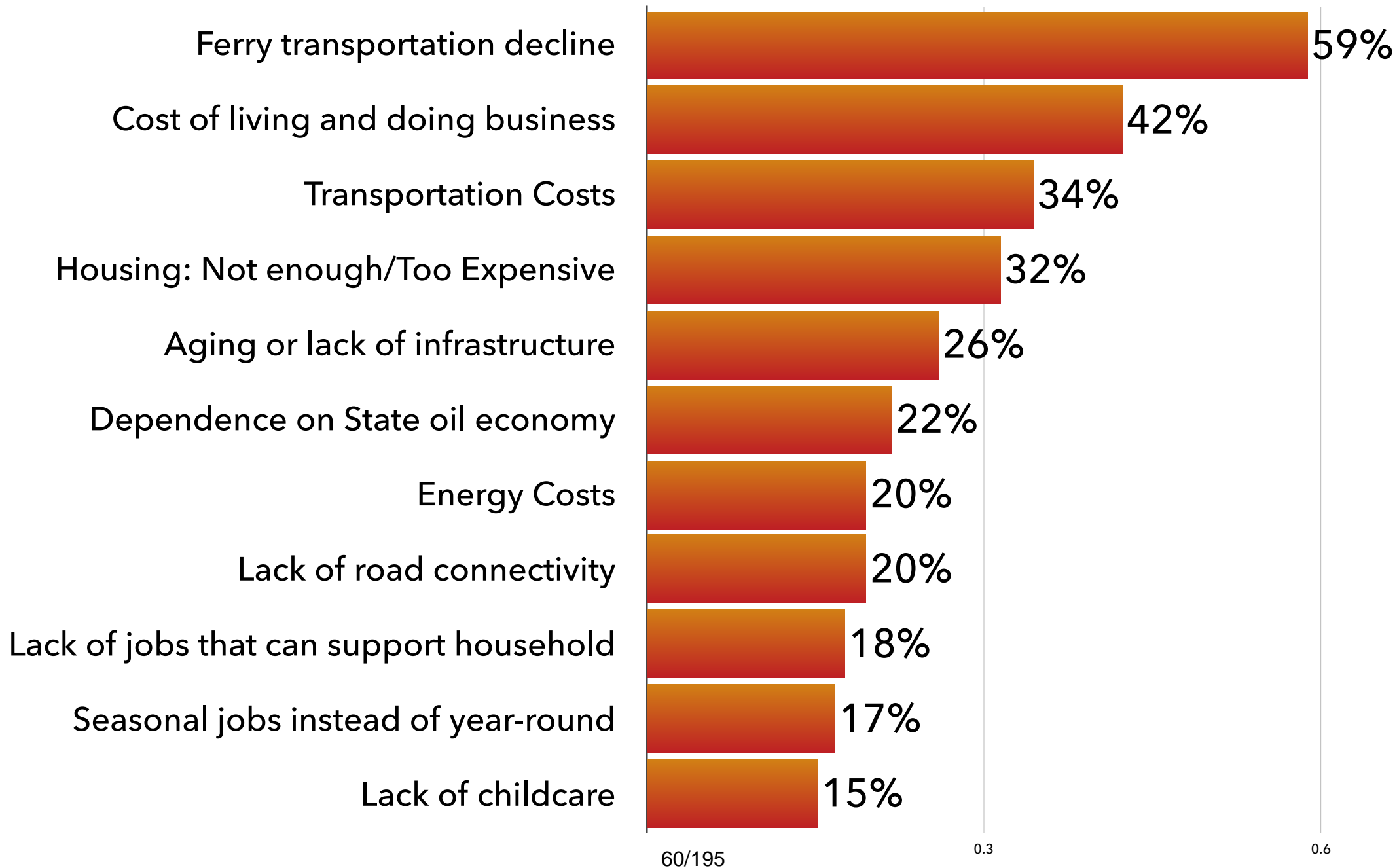




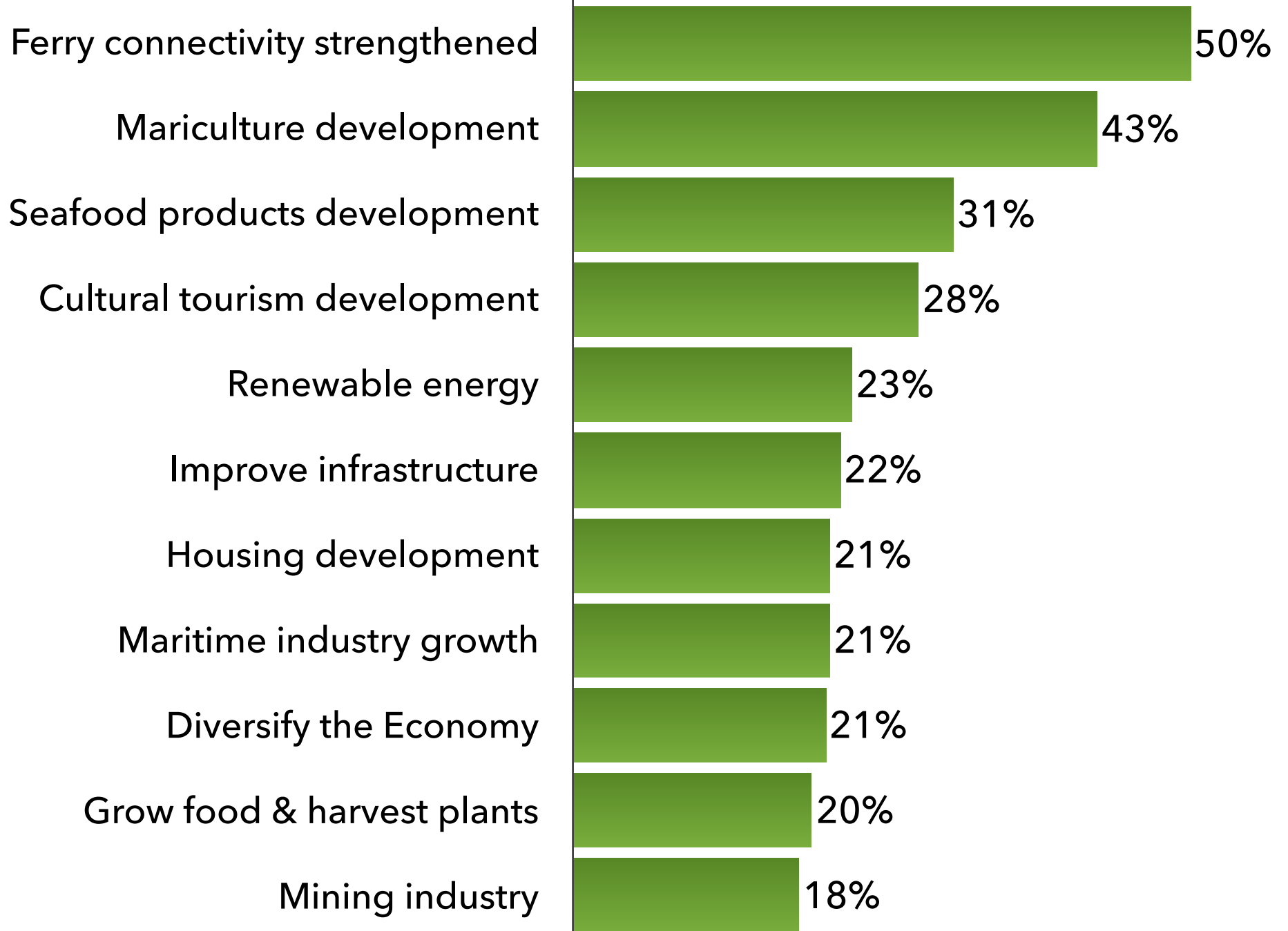
# Strengths



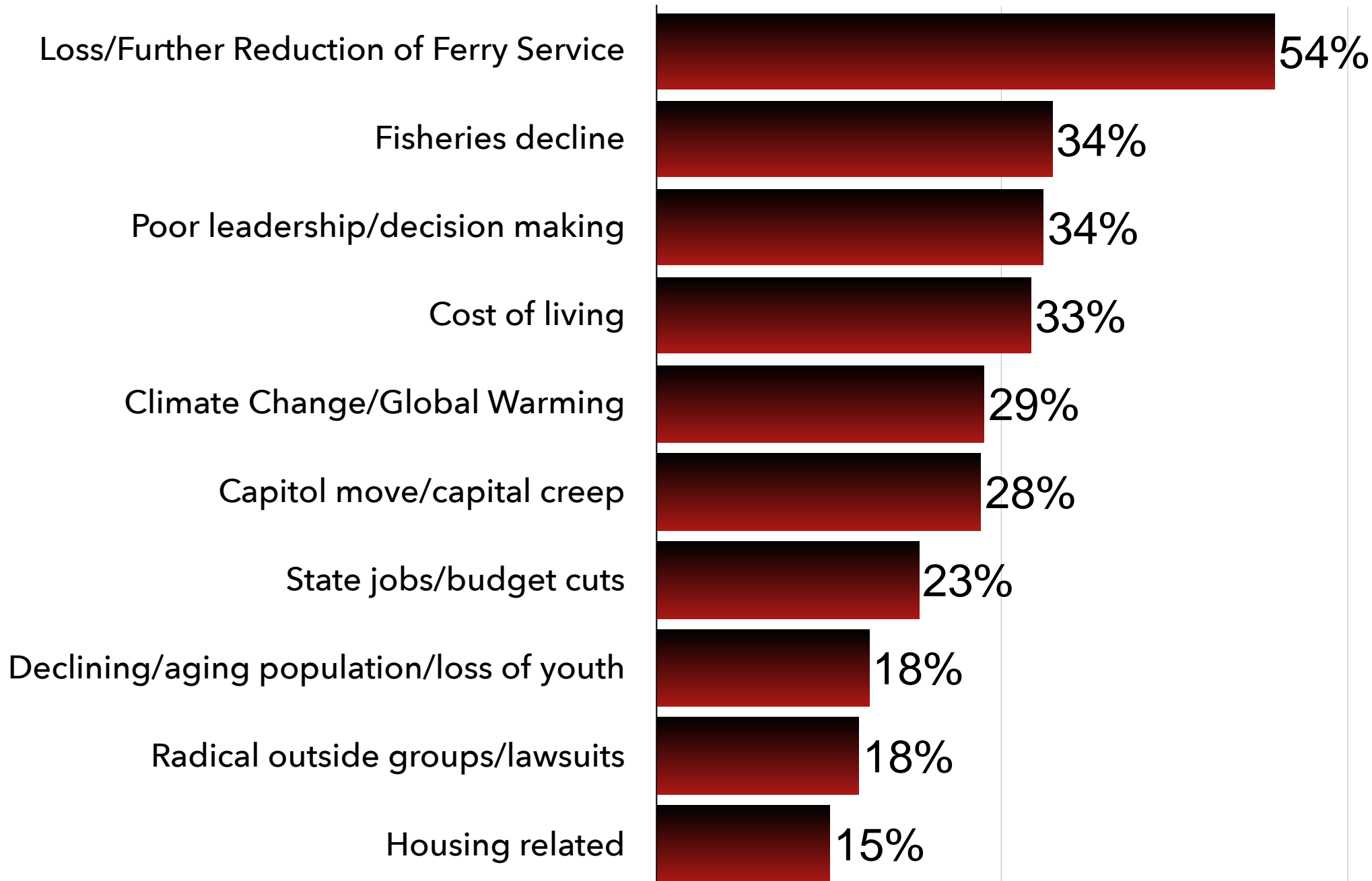
# Weaknesses



# Opportunities



# Threats





Questions?

Meilani Schijvens  
Rain Coast Data



# Health Care Southeast Alaska **Economic Plan**







# Bartlett Regional Hospital

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Provider Network Development Analysis  
BRH Board Meeting

September 19, 2020

**CONFIDENTIAL**

# ECG Facilitators



**Jeff Hoffman**  
Partner,  
Strategy and  
Business Advisory



**John Budd**  
Associate Principal,  
Acute Services

# Agenda

I.	Engagement Overview
II.	Situational Assessment
III.	Key Findings
IV.	Strategic Options and Recommendation
	Appendix A

# I. Engagement Overview

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# I. Engagement Overview

## Approach

### Engagement Objectives

- » Objectively assess Bartlett Regional Hospital's (BRH's) strategic, market, and financial situations, and determine its ability to remain viable in the foreseeable future.
- » Evaluate potential strategic initiatives and alternatives the organization can undertake to enhance its future-state vision.
- » Assess and evaluate the strategic alternatives related to BRH's future-state goals and objectives.

#### Component A

##### Assessment of the Current Position

- » National and regional community hospital trends
- » Stakeholder interviews and analysis
- » Market and strategic position assessment
- » Financial position assessment

**Meeting One:  
Complete**

#### Component B

##### Assessment of the Future-State Position

- » Articulation of point of view
- » Implications of strategic options

**Meeting Two:  
Complete**



# II. Situational Assessment

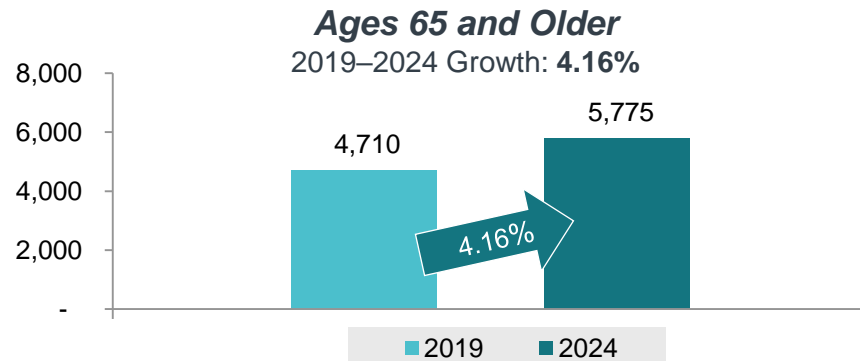
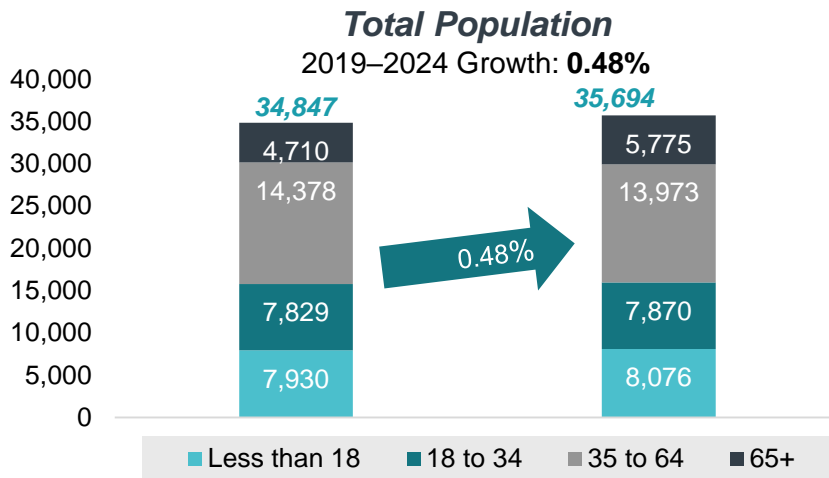
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# II. Situational Assessment

## Market Overview

**Organic population growth will result in a compound annual growth rate of 0.48% in the Juneau area over the next five years, largely driven by the population ages 65 and older.**


### Juneau, Alaska Area<sup>1</sup>: Population Growth



Organic population growth will result in only an **average annual growth rate of 0.48%** in the Juneau area over the next 5 years.

**Other Demographic Characteristics**

### Where Juneau Works (top five industries)<sup>2</sup>



**Median Age**  
**39**



**Median Household Income**  
**\$84,781**

<sup>1</sup> Based on ESRI population data for the Juneau, Alaska micropolitan statistical area (zip codes 99801, 99820, and 99824).

<sup>2</sup> Alaska Department of Labor and Workforce Development, 2018 Quarterly Census of Employment and Wages; US Census.

# II. Situational Assessment

## National Trends: Key Considerations in Community Hospital Strategy

**Based on the prevailing industry trends, a successful community hospital strategy must take the below into consideration.**



### Reimbursement Adequacy

As Medicare grows to be a larger portion of an organization's revenue base, and reimbursement rates remain flat, successful organizations are seeking higher-yielding revenue sources, such as value-based care.



### Staff and Provider Shortages

The United States is projected to see a shortage of physicians (nearly 122,000 by 2032) and nurses as demand intensifies due to the growing and aging population.



### Recruitment and Succession Planning

Recruiting challenges specific to community hospitals (geographic isolation, small local candidate pool, etc.) means organizations must have a longer runway for physician recruitment and an increased focus on succession plan development.



### Ambulatory Migration of Key Services

As CMS expands cases that can be done in the outpatient environment and payers drive toward site neutrality, leaders need to evaluate sites of care.



### Patient Leakage

Patients leave the community for services that could otherwise be performed at the local community hospital.



### Behavioral Health and Substance Use Disorder Treatment Scarcity

As demand for behavioral health and substance use disorder treatments increases, workforce shortages, unsustainable service models, and insufficient funding limit organizations' ability to meet community demand.



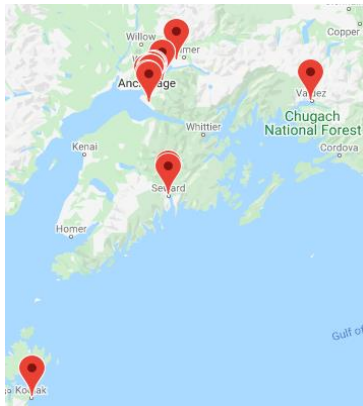
### Overhead Scale

Without partnership support, the localized structure of the community hospital limits the ability to realize regional economies of scale through overhead allocation.

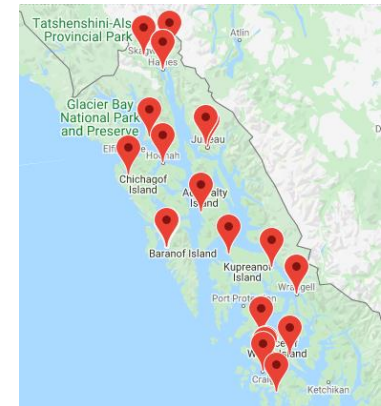
# II. Situational Assessment

## Regional Trends: Hospital Market

**Multistate health systems have consolidated much of the Alaska market, including Providence in Anchorage and PeaceHealth in Ketchikan. In addition, SEARHC has been active in expanding its geographic reach.**



- » Providence St. Joseph Health operates as a system in seven states, with 51 hospitals and over 800 physician clinics.
- » Recent activity includes the opening of a primary care clinic in South Anchorage in February 2020.



- » SEARHC acquired Wrangell Medical Center in 2018.
- » The City of Sitka approved the sale of Sitka Community Hospital to SEARHC in April 2019.

# II. Situational Assessment

## Regional Trends: CMS Rural Community Hospital Demonstration

**BRH participates in CMS's Rural Community Hospital Demonstration, which reimburses inpatient services on a cost basis for participating hospitals.**

### Background

The goal of the program is to test the feasibility and advisability of cost-based reimbursement for small rural hospitals that are too large to be Critical Access Hospitals. CMS is conducting an intensive evaluation of the demonstration, assessing the financial impact on participating hospitals as well as the effect on healthcare for the populations served.

### BRH Impact

- » In FY 2019, BRH received **\$2.7M** in additional reimbursement due to CMS's Rural Community Hospital Demonstration. This represents **45%** of operating EBIDA.
- » The demonstration is scheduled to end **June 30, 2020**, at which point BRH will no longer receive the additional funding for inpatient Medicare services.
- » The demonstration may be extended after the scheduled end date, but CMS has not released specific information regarding the future of the demonstration.



# II. Situational Assessment

## Regional Trends: COVID-19

### CORONAVIRUS



*Of BRH's overall revenue, 6.5% is attributed to tourism* (approximately \$5.9 million), but this does not include the revenue derived from locals who are in the service and tourism industry. As of June, *the likely impact on the revenue stream is estimated at 10%–15%* (approximately \$11.3 million).

- » Hospitals that reduced elective services and have a low volume of COVID-19 cases will be disproportionately impacted financially.
- » The impact may not be fully offset by provisions in the Families First and CARES acts.

- » Based on current COVID-19 admission projections, midsize and rural markets will be disproportionately hurt.
- » *The economic downturn will directly impact the City and Borough of Juneau (CBJ), limiting its ability to aid BRH.*

# II. Situational Assessment

Regional Trends: COVID-19 *(continued)*

## CORONAVIRUS



### *Impact as of June 2020*

- » BRH has an **estimated loss of \$150,000 per day** since the crisis began and can expect to lose approximately **\$4 million each month** during the pandemic.
- » Outpatient cases have been deferred to reduce the usage of personal protective equipment.
- » April **revenues are down approximately 50%** from March.
- » BRH has received over \$1 million in federal funds from the CARES Act.
- » COVID-19 preparation cost BRH \$600,000.

# II. Situational Assessment

Open Discussion



1

Have any significant changes in the market occurred in the last four months that would impact the findings in the situational assessment?

2

Has there been any new analysis within the last four months that indicates an improved outlook for the cruise industry?

# III. Key Findings

---

# III. Key Findings

## Major Strategic Issues

### Unstable Financials

- » COVID-19 has materially impacted BRH's financial outlook.
- » Seasonal revenue growth derived from tourism will decline and lead to higher regional unemployment.
- » The PERS obligation may limit options.

### Change in Competitive Providers

- » Competitor incursion into the Juneau market has begun, and expansion is inevitable.
- » The single largest factor of BRH's success is its sole community provider status in the market.

### Key Issues

### Leakage of Services

- » Key specialty gaps at BRH create natural outmigration into other communities.
- » A lack of local health plan incentives to stay in the community creates opportunities for outmigration.

### Challenges in Recruitment

- » The challenges in recruiting will not change.
- » Multiple barriers to recruitment exist that limit the available talent in the recruitment pool.



# III. Key Findings

Open Discussion



1

How has BRH recovered since the onset of COVID-19?

2

Have there been any notable improvements impacting the key strategic issues identified in this section?

# IV. Strategic Options and Recommendation

---

# IV. Strategic Options and Recommendation

## Path Forward

**Two options are available to BRH; maintain status quo or pursue a partnership.**

### *Maintain Status Quo*

#### Assumption

BRH's future position is in flux. They will continue to operate according to the current strategic plan with some strategic and operational adjustments.

#### Considerations

- » Will BRH be able to stabilize its declining operating performance and remain a financially viable independent healthcare provider?
- » Will a deteriorating financial position and the continued encroachment of competitors make it harder for BRH to pursue a partnership down the road, at least from a position of strength?
- » Will BRH be able to make operational adjustments to counter competitive changes?

### *Pursue a Partnership*

#### Assumption

The status quo is unsustainable. BRH will explore an array of partnership structures to improve its strategic position.

#### Considerations

- » Can a partner help address BRH's current strategic position?
- » Can a partner assist BRH to enhance community benefit and retain local/community governance?
- » Is a partnership available to improve specialty physician rotations or a partnership to JV competitor expansions?

# IV. Strategic Options and Recommendation

Assessing the “Most Responsible Moment”

**If an independent organization cannot fully execute across its strategic imperatives, an affiliation or partnership may be necessary.**

## Last Possible Moment Triggers

*Price taker in negotiating*

- » Year-over-year financial erosion or operating margin loss (<0% operating margin)
- » Unable to fund needed capital (routine and strategic) investment
- » Trigger bond covenant(s) jeopardizing bond rating for subsequent years
- » Despite strategic investment, market share declining or market position eroding (total market share drops below 24% or PSA drops below 60%)
- » Quality and service falling behind peer organizations



## Most Responsible Moment Triggers

*Position of strength to negotiate*

- » Breakeven on operations or a positive operating margin between 0%–2%, but likely to decline
- » Able to fund at least 70% of needed capital investment (includes strategic and growth initiatives)
- » Days cash on hand of at least 150 days, but concern exists that it will decline
- » With strategic investment, only maintaining market position
- » Quality and service at or better than peer organizations

**ECG believes BRH is at its most responsible moment. ECG recommends pursuing a partnership while in a position of strength.**

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# IV. Strategic Options and Recommendation

## Alignment Options

**While we do not envision significant alignment with local providers, a broader alignment may blend elements from both options.**



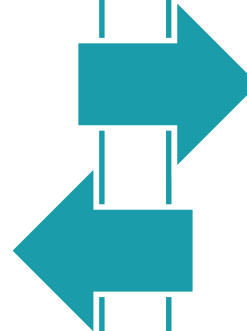
### *Physician Alignment Options*

- » Medical Directorship
- » Call Coverage
- » Practice Management MSO
- » Bundled Payments
- » Co-management Arrangement
- » Joint Venture
- » PSA
- » Full Employment



### *Health System Alignment Options*

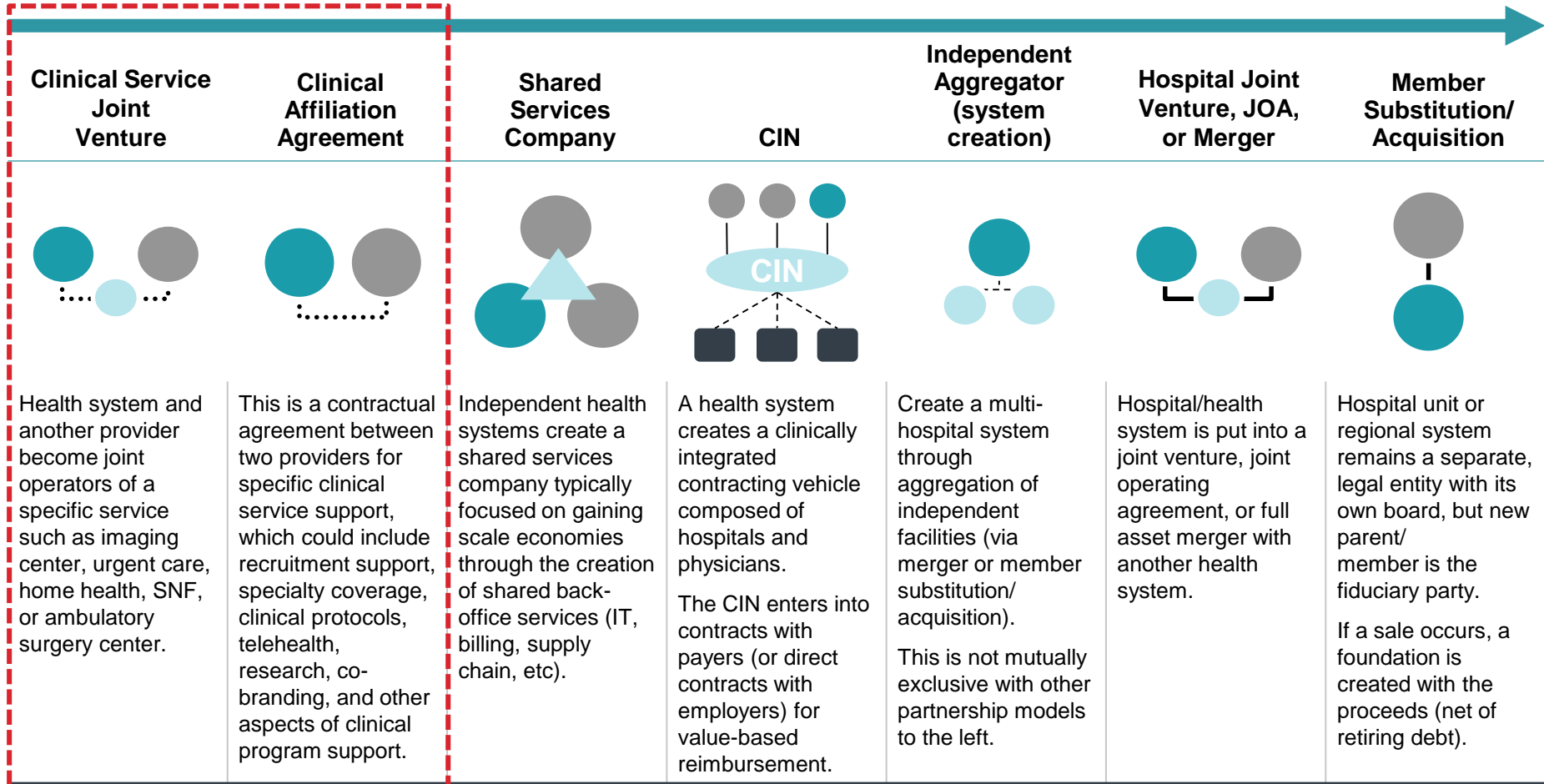
- » Clinical Service Joint Venture
- » Clinical Affiliation Agreement
- » Shared Services Company
- » Clinically Integrated Network (CIN)
- » Independent Aggregator (system creation)
- » Hospital Joint Venture, JOA, or Merger
- » Member Substitution/Acquisition



# IV. Strategic Options and Recommendation

## Health System Alignment Options

**ECG recommends BRH pursue a clinical service joint venture or clinical affiliation agreement with a provider that can bring a wider range of specialties and new services to the region.**





# IV. Strategic Options and Recommendation

## BRH's Guiding Principles

**We heard resounding themes regarding the parameters and key tenets that any partnership will need to achieve for BRH and the CBJ to consider affiliation a viable option. Below outlines the key guiding principles stressed.**

### Independence

The CBJ will not consider selling the hospital.



### Span of Control

BRH wants to remain an independent organization capable of providing care locally, meeting ongoing capital investment needs.



### Commitment to SE Alaska

Any partner must be able to understand the unique aspects of providing care in Alaska and provide services that are suited to the region.



### Commitment to BRH and CBJ

BRH and the CBJ do not want to get lost inside a larger health system. The expectation is that they will continue to influence how health care is delivered in Juneau.



What realistic partnership options exist within these parameters?

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# IV. Strategic Options and Recommendation

## Partnership Profiles: “Local” Affiliation

**Joint ventures, management agreements, and clinical affiliations are less-than-fully-integrated models that may provide a competitive advantage to BRH while it remains an independent health system.**

### Service

Exact agreements are defined through negotiation and terms sheets. However, goals and priorities are defined up-front to establish a framework that adds value to both organizations. Partnership options include branding and, potentially, clinical management services.

### Advantages

- » One partner to negotiate with and define service agreements
- » Flexible structure to meet BRH’s specific needs



### Drawbacks

No “off the shelf” partnerships exist; all future partnerships require significant administrative and legal effort to establish and operate.

### Cost

There are administrative and legal overhead costs. Partnerships with excess costs will be avoided.



# IV. Strategic Options and Recommendation

## Partnership Profiles: Network Affiliation

**The Mayo Clinic and Cleveland Clinic provide opportunities to enhance the BRH brand and clinical patient care without sacrificing governance powers and operational control.**

### Service

- » Paid partnership model where independent health systems join the network and, in return, receive clinical protocols and **“Part of the Clinic Care Network”** advertising
- » eConsults, eBoards, IP Telephone Consults, Health Care Consulting, and Patient Education Library

### Advantages

- » **Recruiting:** Providers get access to specialists and infrastructure, which can assist in recruiting.
- » **Second Opinion on Cases:** Patients and physicians can electronically confer with staff as opposed to the patient going away for these opinions. Once comfortable with the second opinion, patients can stay local for treatment.
- » **Quality of Care:** Access to professionals for clinic operations consulting exists.

### Drawbacks

- » Securing a Mayo Clinic or Cleveland Clinic partnership requires significant, onetime project management and application expenses and has an ongoing expense.
- » Potential community misconceptions regarding the arrangement will need to be addressed.

### Cost

The exact cost is variable dependent on the level of services utilized.



# IV. Strategic Options and Recommendation

## Process Overview

**Identifying a partner that shares BRH's objectives and complements its existing service offerings involves a five-step process.**



# IV. Strategic Options and Recommendation

Evaluate Services for Focus

1

## Evaluate Services for Focus



### *Key Elements*

- » Evaluate the spectrum of clinical services BRH currently offers.
- » Discuss the long-term track record for success associated with the services.
- » Assess the impact on BRH's ability to address the need for increased specialists in the community and expanded access for patients.



# IV. Strategic Options and Recommendation

## Compile Potential Partner Profiles

2

### Compile Potential Partner Profiles



#### *Key Elements*

Assemble profiles of potential partners, including those organizations in the market and/or region that could potentially advance BRH's achievement of critical success factors and guiding principles. Potential partnership profiles typically consider the following:

- » Corporate form and infrastructure
- » Ownership or sponsorship
- » Scope and scale of principal service delivery sites
- » Physician platform
- » Utilization trends
- » Market share trends
- » Key services and points of competitive differentiation
- » Financial analysis and credit profile
- » Consolidated financial analysis

# IV. Strategic Options and Recommendation

Contact Potential Partners and Develop RFP

3

## Contact Potential Partners and Develop RFP



### *Key Elements*

- » Contact the partners identified in task 2.
- » Develop an RFP for pursuing partnership.
  - › Identify RFP parameters and evaluation criteria.
  - › Interview potential partners to discuss partnership options.
  - › Manage the overall RFP process (schedule of key dates, response submission, etc.).

# IV. Strategic Options and Recommendation

Evaluate Partnership Opportunity

4

## Evaluate Partnership Opportunity



### *Key Elements*

- » Develop a set of guiding principles.
- » Determine the desired partnership elements (e.g., core offerings, funds flow structure).
- » Establish a partnership framework that clearly identifies BRH success criteria to facilitate partnership selection.
- » Develop a detailed evaluation matrix and accompanying analyses that summarize the qualitative and quantitative factors to assess each potential partner.
- » Delineate the strategic alternatives available and the potential risks and rewards associated with each partner.

# IV. Strategic Options and Recommendation

Conduct Deliberations

5

## Conduct Deliberations



### *Key Elements*

- » Facilitate a series of discussions with BRH and the CBJ leadership to review and discuss the partnership opportunities.
- » Interpret the implications and reach consensus on the strategic direction for BRH.

# IV. Strategic Options and Recommendation

Open Discussion



1

What is the initial reaction to the potential partners presented? Are there any missing?

2

Are there any questions regarding the partnership process?

# Appendix A

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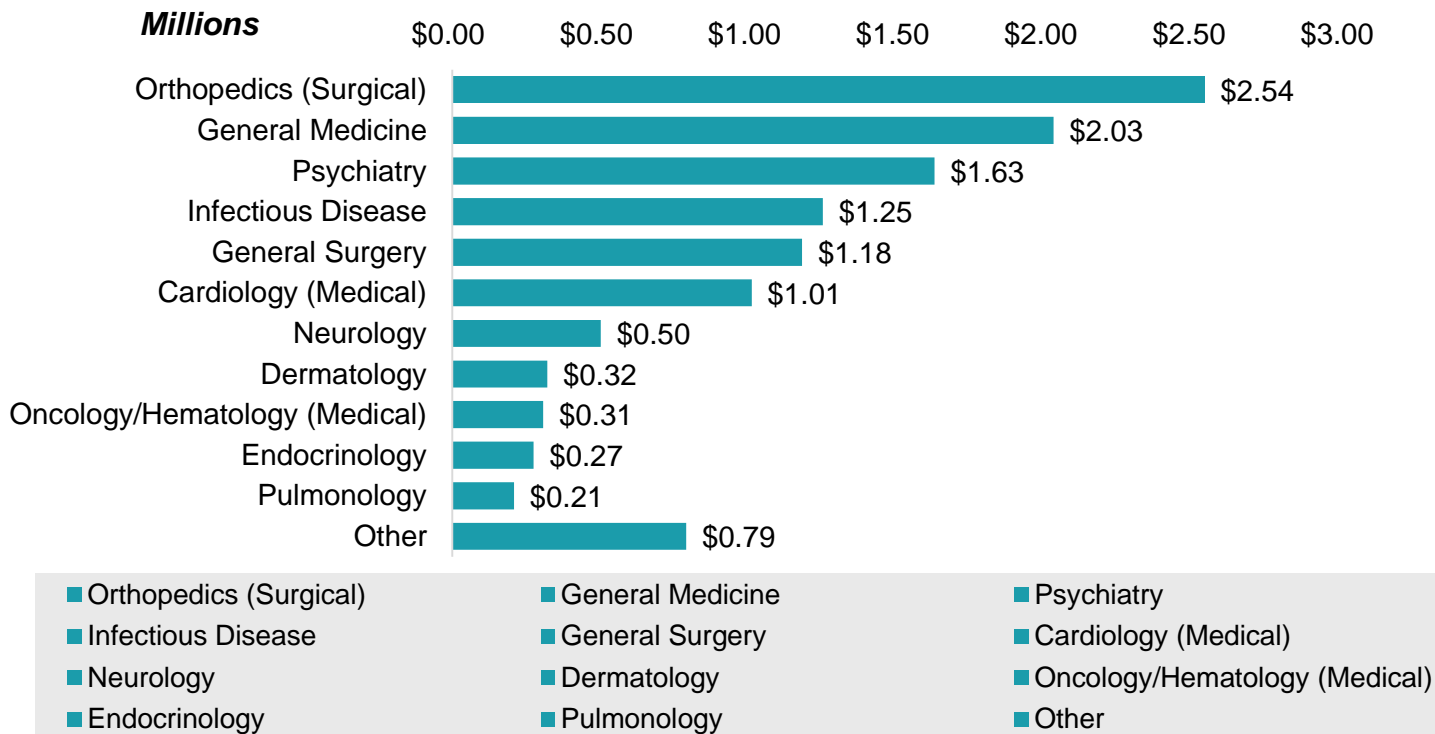


# Appendix A

## Service Offerings

**Growth in the cohort ages 65 and older will drive utilization for orthopedic and cardiology services. With approximately 17% of inpatient Medicare payments attributed to orthopedic surgery, we expect orthopedics to remain the highest contributing service for BRH.**

### *Inpatient Discharge Payments by Specialty (Medicare only)*



### Key Interview Themes

Isolation, lack of volume, and difficulty recruiting impede BRH from offering a broader array of specialty services (e.g., cardiology).

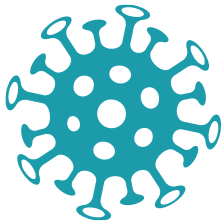
Source: Definitive Healthcare—annual Medicare data is from the Centers for Medicare and Medicaid Services (CMS) Medicare Standard Analytical Files (SAF). The most recent annual Medicare data is from calendar year 2018.

# Appendix A

## Unstable Financials

**The instability of BRH's financial position heightens the urgency to take action.**

### COVID-19 Impact



### PERS Obligation



### CMS Demonstration



### Cash Reserve Reduction



The impact on the revenue stream is an estimated 10% to 15% reduction, and the lack of tourism will drive increased unemployment throughout the region.

BRH's FY 2019 net pension liability of \$60.3 million decreases liquidity for the organization and limits available partnership opportunities given the cash required to resolve it in a transaction.

Of BRH's operating EBIDA, 45% is derived from the CMS demonstration. The demonstration is scheduled to end on June 30, at which time BRH will no longer receive the additional funding.

BRH will not be able to fund capital plans with operating cash flows. Additionally, BRH will be further impacted if CBJ siphons reserves.

# Appendix A

## Change in Competitive Providers

**Increased competitor activity has resulted in regional consolidation and expanding footprints. BRH must be realistic about the impact of a changing market landscape.**



- » SEARHC acquired Wrangell Medical Center in 2018.
- » The City of Sitka approved the sale of Sitka Community Hospital to SEARHC in April 2019.
- » According to city data, SEARHC purchased approximately 17 acres of undeveloped land in 2018 (left, highlighted in red).

### Other Competitors



### Considerations

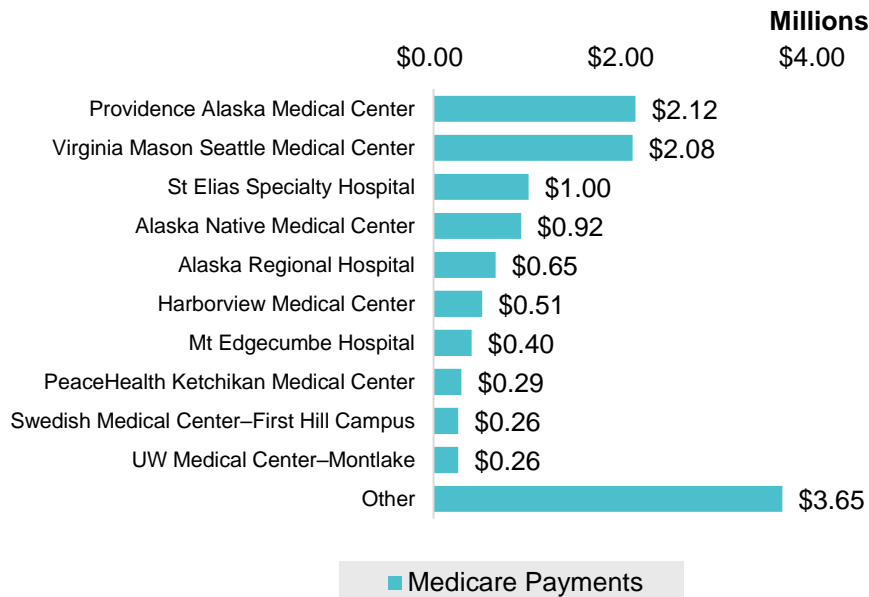
- » New entrants or competitor partnerships will increase patient leakage, negatively impacting BRH's financials and eroding market capture.
- » Changes in the current competitor footprint will quickly influence patient choice.
- » Independent specialty care and imaging entering Juneau will quickly undercut high-value BRH services, ultimately destabilizing BRH's financial position.

# Appendix A

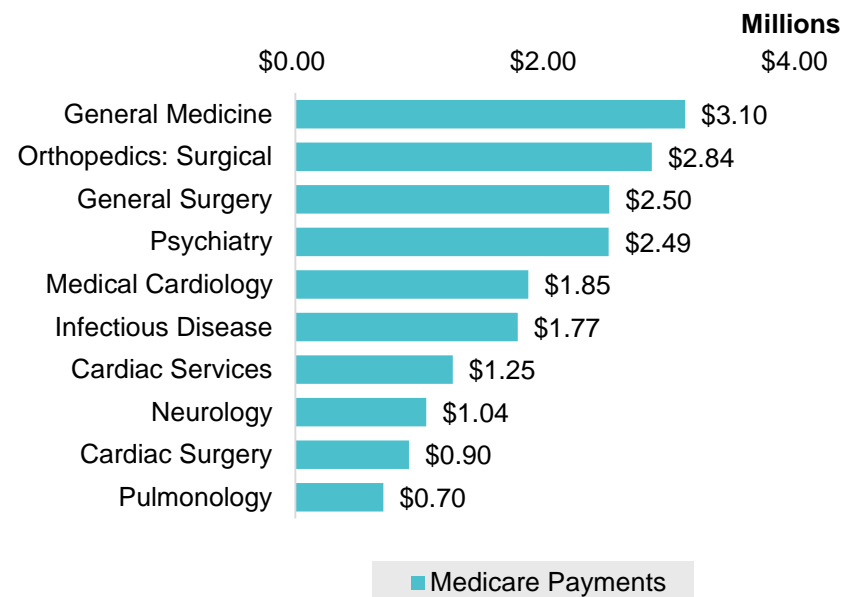
## Leakage of Services

**More than \$12 million in patient services is leaving the Juneau market due to a lack of specialty care and the public employee insurance plan that incentivizes members to seek care in Seattle or Anchorage.**

*Inpatient Leakage by Facility  
(Medicare only)*



*Inpatient Leakage by Specialty  
(Medicare only)*



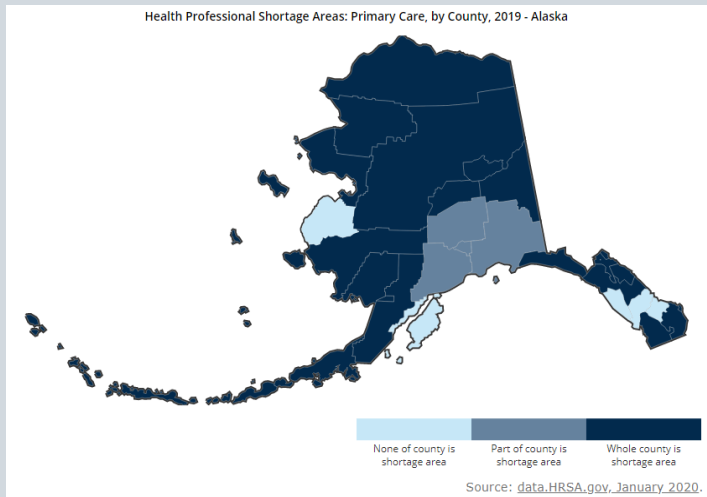
### Implications

- » Total patient leakage is in excess of \$12 million, driven by orthopedics and general medicine.
- » Shifting the local health plan incentives to keep patients in Juneau will have a large financial impact due to the number of residents employed by the state and local government.

# Appendix A

## Challenges in Recruitment

**Physician recruitment is a national issue exacerbated in Alaska due to the fragmented landscape. The stark reality is that recruitment will only get more difficult going forward.**



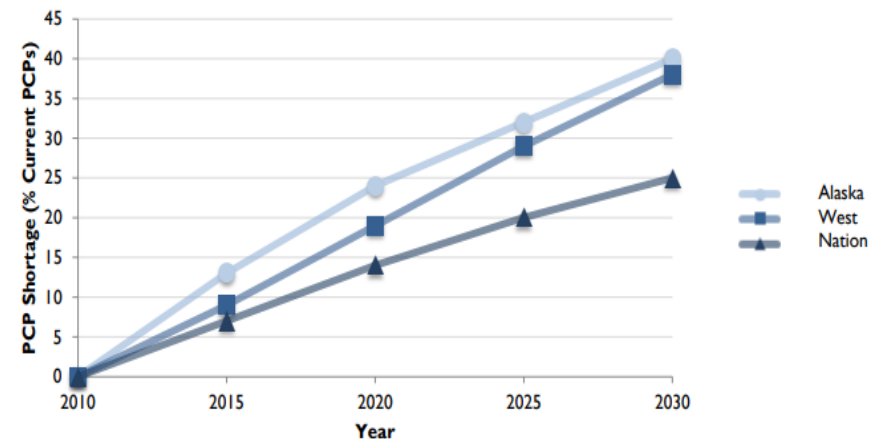
### Barriers to Recruitment<sup>1</sup>

- » Lack of qualified candidates (physicians often required to work without direct supervision, colleagues for support, or specialists to refer cases)
- » Geographic isolation
- » Personal and professional isolation
- » Spousal compatibility
- » Lack of urban amenities

<sup>1</sup> "Status of Recruitment Resources and Strategies," Alaska Department of Health and Social Services.

<sup>2</sup> <https://data.hrsa.gov>, Alaska FY 2018.

Physician Demand Comparison – State, Region, Nation



Source: "Projecting Primary Care Physician Workforce," Robert Graham Center.

### Health Professional Shortages<sup>2</sup>

HPSA Discipline	Count (FY 2018)
Primary Care	84
Dental Health	69
Mental Health	75
<b>Total</b>	<b>228</b>

A 2019 Merritt Hawkins survey found only 1% of final-year medical residents would prefer to practice in a community of 10,000 people or fewer, and only 2% would prefer to practice in a community of 25,000 people or fewer.

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# **Bartlett Regional Hospital**

## Provider Network Development Analysis

### Final Report

June 23, 2020



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## **I. Executive Summary**

# **I. Executive Summary**

## **A. Engagement Overview**

ECG was engaged to assist Bartlett Regional Hospital (BRH) and the City and Borough of Juneau (CBJ) in developing a comprehensive situational assessment and provide leadership with a detailed analysis of available strategic options. The purpose of this document is to:

- » Objectively assess BRH's strategic, market, and financial situation and determine its ability to remain viable into the foreseeable future.
- » Evaluate potential strategic initiatives and alternatives the organization can undertake to enhance its future-state vision.
- » Assess and evaluate the strategic alternatives related to BRH's future-state goals and objectives.

## **B. The “Most Responsible Moment”**

When an independent organization cannot fully execute its strategic imperatives, an affiliation or partnership may be necessary. ECG believes BRH is at its most responsible moment; meaning, BRH has reached the point where not committing to an affiliation or partnership strategy is a greater cost than that of committing. BRH's historical strategic, market, and financial position indicates they can negotiate from a position of strength, but if the decision to develop a strategic relationship is delayed, the negotiating platform will deteriorate due to several key challenges that the organization will likely face in the next one to three years. The remainder of this document aims to outline the key drivers and assumptions that drive ECG's belief.

## **C. Key Findings**

Our analysis indicates that BRH is currently financially sustainable. However, while ECG believes BRH's status as a going concern remains intact, this belief is tenuous due to the high likelihood of BRH being materially impacted by one or multiple significant regional and industry trends that will challenge its ability to operate independently over the coming years. These factors include the following:

- » Historically, BRH's greatest strategic advantage was the remoteness of Juneau and the lack of significant competitor presence in the market. Over the past decade, SouthEast Alaska Regional Healthcare Consortium (SEARHC) has continued to expand its presence in the CBJ and is able to fund continued regional expansion through favorable government and tribal reimbursement that is not available to BRH. SEARHC has demonstrated its desire to grow as a southeast Alaska integrated health system with its acquisitions of Mt. Edgecumbe Medical Center in Sitka and Wrangell Medical Center in Wrangell. More recently and perhaps most concerning to BRH, SEARHC acquired 17 acres of undeveloped land on which to build facilities and expand offerings, which may include specialty care and imaging, presenting a significant threat to BRH's financial viability as

these services represent high-margin activities to BRH and competitive pressure may materially draw volume outside of BRH.

- » The impact of COVID-19, coupled with the current market volatility of oil prices, has created a state budget crisis resulting in the possibility of the constitutional budget reserve being empty by FY 2022. Though BRH has significant cash reserves and will likely be able to weather this form of economic downturn, the overall state financial outlook could impact BRH's margin through changes to payer mix, requests to use BRH's cash reserves by local government, and declines in volume as residents may leave the community for employment.
- » While BRH has demonstrated above expected liquidity, the current capital plan cannot be solely supported by operating cash flows. Further, CMS's Rural Community Hospital Demonstration (RCHD) is set to expire in June with the net impact effectively reducing BRH's operating EBIDA margin to 2.8%, leading to further dependence on cash reserves. While ECG and BRH leadership believe that the sunseting of the RCHD at this time is unlikely, the reliance on a federal program outside of BRH's core competencies for financial sustainability does present future risk.
- » Declines in the regional tourism industry over the next one to three years will temporarily change the volume at BRH and will likely reduce cash reserves further. Seasonal revenue derived from tourism will decline and lead to higher regional unemployment and an estimated BRH revenue stream reduction of 10% to 15%.
- » Pressure on health systems and hospitals to reduce costs has resulted in the ambulatory migration of key services. By 2026, over 50% of orthopedic joint replacement cases are projected to be performed in the outpatient setting, putting over \$3 million in BRH orthopedic surgical revenue at risk and ultimately leading to patient leakage.
- » As the sole community provider, BRH is especially susceptible to changes in the current competitor footprint. Key specialty gaps exist within BRH that will continue to create natural out-migration into other communities, and SEARHC's increasing market presence exacerbates the risk of patient leakage. Stagnant organic population growth in the CBJ will limit BRH's prospects for improving market capture, and a lack of local health plan incentives for government employees further highlights BRH's challenge of stemming patient leakage. Physician recruitment will continue to be an ongoing issue due to the geographic isolation of Juneau and Alaska's fragmented physician landscape. Only 1% of final-year medical residents have expressed the desire to pursue employment in a rural setting, indicative of ongoing recruitment difficulties into the future.

## D. Strategic Options and Recommendation

ECG recommends BRH pursue a clinical service JV or clinical affiliation agreement with a provider that can bring a wider range of specialties and new services to the region while allowing the broader system to remain independent. These models will allow BRH to stabilize and expand access for patients to key service lines and physician specialties while also maintaining autonomy. A clinical service JV and clinical affiliation agreement do not fully insulate BRH from the threat of competitors entering the market, but they will provide BRH with a platform to address the need for specialists in the community and a potential expansion of services that patients currently must travel for.

## **II. Engagement Overview**



## II. Engagement Overview

### A. Engagement Background

BRH is the sole community provider of hospital services within the CBJ. With primary competitors located at least 400 miles away, BRH is uniquely positioned to provide care across approximately 3,250 miles of the southeastern Alaska Panhandle. The nature of the geography, as well as the distinctive competitive landscape in the state, has allowed the organization to secure a stable market and financial outlook; however, the traditional market boundaries that once made Juneau a largely self-contained healthcare service area may be redefined by efforts to reduce the cost of care through innovative methods of access and evolving care pathways.

While BRH has demonstrated its commitment to providing high-quality care through top-quartile performance in readmissions, HCAHPS, and Medicare's Value-Based Purchasing Program performance scores, the operating cost structure that is required to sustain this performance in Alaska is high. In fact, BRH's current operating expenses per adjusted patient day are among the highest in the country. This degree of investment makes the organization particularly vulnerable to reimbursement changes and the potential out-migration resulting from payers directing patients to out-of-state providers. In fact, BRH's second largest competitor in terms of leakage is Virginia Mason Medical Center in Seattle.

While many health systems in the state have been able to mitigate this impact through a partnership or alternative reimbursement models (e.g., tribal affiliation), as an independent health system, BRH has managed to remain viable through more traditional management. To date, this approach has been successful, as BRH's Board of Directors and management believe that the organization is currently in a strong financial and market position. However, in light of the changing healthcare landscape and factors like those discussed above, the board feels the need to proactively evaluate how to best maintain and expand upon BRH's existing strengths. It also wants to evaluate strategic alternatives in order to better define and identify the most effective options for the organization's long-term success.

### B. Engagement Objectives

To achieve these goals, BRH and the CBJ engaged ECG to conduct a comprehensive situational assessment and provide leadership with a detailed analysis of available strategic options. Specifically, BRH and the CBJ requested:

- » A thorough situational assessment outlining the most relevant commercial, organizational, and statewide factors that will be pertinent to planning for the future positioning of the organization
- » A thoughtful evaluation of BRH's current-state trajectory that is accompanied by available strategic options, including short- and long-term analyses, tradeoffs, and the implications of any changes on the medical staff

## C. Methodology

Based on ECG's experience with other community hospitals that were exploring their strategic options, the process that BRH and the CBJ employ can be as important as the outcome; constituents and regulators will ask whether the BRH Board of Directors honored its fiduciary responsibility to objectively evaluate its options. Ultimately, the fundamental determination of whether BRH should consider a strategic partnership of any type should be based on that partner's ability to successfully meet the needs of its community and independently achieve its strategic goals. Accordingly, our method was designed to help BRH objectively make a decision and ensure its board could confidently represent to the community that all potential courses of action were thoroughly examined in the best interest of the organization and the population it serves.

As part of this approach, ECG engaged BRH board members and executive leadership and members of the medical staff to provide guidance and support in evaluating BRH's future direction.

### **III. Situational Assessment**

### III. Situational Assessment

In order to evaluate the strategic positioning and outlook of BRH, a thorough analysis begins with understanding the national and regional trends that impact independent community hospitals. These trends provide relevant context that ultimately will help BRH develop their strategy. The healthcare landscape has created unique challenges for healthcare organizations. In responding to a world in which the framework and basis of competition are always changing, a community hospital strategy must consider more than traditional performance measures. Such a strategy must account for external forces and regional trends and be implemented before the full impact manifests at the local level.

#### A. National Community Hospital Trends

- » *Reimbursement Adequacy:* As Medicare grows to be a larger portion of an organization's revenue base, and reimbursement rates remain flat, successful organizations are seeking higher-yielding revenue sources, such as value-based care.<sup>1</sup> Pursuing value-based care is especially difficult for rural hospitals as they grapple with the challenge of operating with high fixed costs and continual reductions in reimbursement. For example, in efforts to reduce the federal budget, Congress passed Medicare sequestration in 2011, which cut all payments to hospitals by 2%—these cuts have been extended several times.<sup>2</sup>
- » *Staff and Provider Shortages:* The United States is projected to see a shortage of physicians (nearly 122,000 by 2032) and nurses as demand intensifies due to the growing and aging population.<sup>3</sup> The trend is intensified in rural communities due to challenges in recruitment and succession planning.
- » *Recruitment and Succession Planning:* Recruiting challenges specific to community hospitals (geographic isolation, small local candidate pool, etc.) means organizations must have a longer lead time for physician recruitment and an increased focus on succession plan development.
- » *Ambulatory Migration of Key Services:* As the Centers for Medicare & Medicaid (CMS) expands cases that can be seen in the outpatient environment and payers drive toward site neutrality, leaders need to evaluate sites of care.<sup>4</sup> "Site-neutral" policies that seek to reduce reimbursement for nonemergency services delivered in hospitals' off-campus, provider-based departments have disproportionately impacted rural providers by reducing reimbursement for primary patient access

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<sup>1</sup> "NHE Fact Sheet," CMS, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet>.

<sup>2</sup> "2019 Rural Report," American Hospital Association, <https://www.aha.org/system/files/2019-02/rural-report-2019.pdf>.

<sup>3</sup> "New Findings Confirm Predictions on Physician Shortage," AAMC, April 23, 2019, <https://www.aamc.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage>.

<sup>4</sup> "Ambulatory Surgical Center Payment System," CMS, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AmbSurgCtrFeepymtfctsh508-09.pdf>.

points. Recent proposals have indicated future reductions to provider-based departments that were previously exempt from reimbursement cuts.<sup>5</sup>

- » *Patient Leakage:* Patients leave the community for services that could otherwise be performed at the local community hospital, largely driven by changing demographics and high-acuity episodes of care.<sup>6</sup>
- » *Behavioral Health and Substance Use Disorder Treatment Scarcity:* As demand for these kinds of treatments increases, workforce shortages, unsustainable service models, and insufficient funding limit the ability of organizations to meet community demand.<sup>7</sup>
- » *Overhead Scale:* Without partnership support, the localized structure of the community hospital limits the ability to realize regional economies of scale through overhead allocation.

## B. Regional Community Hospital Trends

- » *Hospital Market:* Multistate health systems have consolidated much of the Alaska market, including Providence Health & Services in Anchorage and PeaceHealth in Ketchikan. Providence operates as a system in seven states, with 51 hospitals and over 800 physician clinics, and PeaceHealth has approximately 16,000 caregivers, a medical group practice with more than 1,100 providers, and 10 medical centers that serve both urban and rural communities throughout the Northwest. In addition, SEARHC has been active in expanding its geographic reach with the acquisition of Wrangell Medical Center in 2018<sup>8</sup> and Mt. Edgecumbe Hospital in 2019.<sup>9</sup> SEARHC also purchased 17 acres of undeveloped land in Juneau in 2018<sup>10</sup> and the same year signed a Letter of Intent with Swedish Medical Center in Seattle, which is affiliated with Providence, for the purpose of expanding specialty services and clinics in Southeast Alaska.<sup>11</sup>
- » *Physician Landscape:* A fragmented physician landscape and difficulties with physician recruitment will continue to be ongoing challenges faced by Alaska health systems. Recruiting is challenging

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<sup>5</sup> “2019 Rural Report,” American Hospital Association, <https://www.aha.org/system/files/2019-02/rural-report-2019.pdf>.

<sup>6</sup> Definitive Healthcare; annual Medicare data from CMS Medicare Standard Analytical Files (SAFs). The most recent annual Medicare data from calendar year 2018.

<sup>7</sup> “National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013–2025,” <https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/behavioral-health2013-2025.pdf>.

<sup>8</sup> June Leffler, “After Months of Negotiations, SEARHC Takes over Wrangell Medical Center,” Alaska Public Media, November 1, 2018, [www.alaskapublic.org/2018/11/01/after-months-of-negotiations-searhc-takes-over-wrangell-medical-center](http://www.alaskapublic.org/2018/11/01/after-months-of-negotiations-searhc-takes-over-wrangell-medical-center).

<sup>9</sup> “Mt. Edgecumbe Medical Center (S'ÁXT' HÍT),” SEARHC, June 7, 2020, <https://searhc.org/location/mt-edgecumbe-hospital>.

<sup>10</sup> “Finance Homepage,” City and Borough of Juneau Assessor's Database, <https://property.juneau.org/parcel-7B0901100000>.

<sup>11</sup> “SEARHC Signs Letter of Intent with Swedish to Expand Specialty Services,” SEARHC, September 12, 2018, <https://searhc.org/searhc-signs-letter-intent-swedish-expand-specialty-services>.

due to geographic isolation, personal and professional isolation, and a lack of qualified candidates (physicians are often required to work without direct supervision or colleagues for support).<sup>12</sup>

- » *COVID-19*: BRH's workforce, community, and organizational performance are negatively impacted by the effects of COVID-19 on the cruise season, as nearly 500 cruises have been canceled for 2020. Further, the negative impact of COVID-19 on state and local budgets has pushed Alaska dangerously close to a fiscal cliff, which will have a trickle-down effect on BRH and the CBJ due to state support weakening and the PERS obligation becoming a higher-risk liability.

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<sup>12</sup> "2016 Alaska Health Care Workforce Profile," [https://www.uaa.alaska.edu/academics/college-of-health/departments/acrhww/dataandreportspages/\\_documents/2016-AK-Health-Care-Workforce-Profile.pdf](https://www.uaa.alaska.edu/academics/college-of-health/departments/acrhww/dataandreportspages/_documents/2016-AK-Health-Care-Workforce-Profile.pdf).

## **IV. Financial Position Assessment**



## IV. Financial Position Assessment

ECG assesses the financial position of an organization according to the methodology used by Moody's and other credit agencies for determining financial sustainability and credit worthiness. The ratings are from before COVID-19 and consider a range of qualitative and quantitative measures, including but not limited to the variables depicted in table 1.

**Table 1: Moody's Financial Sustainability and Credit Worthiness Measures<sup>13</sup>**

Type	Measure		
Qualitative Measures	<ul style="list-style-type: none"> <li>» Revenue structure</li> <li>» Revenue-raising ability and tolerance</li> <li>» Political dynamics</li> </ul>	<ul style="list-style-type: none"> <li>» Quality of financial management (budgetary, capital, and strategic planning)</li> <li>» Timely implementation of strategies in response to changing internal and external dynamics</li> <li>» Public policy frameworks</li> </ul>	<ul style="list-style-type: none"> <li>» Track record of social and political stability</li> <li>» Assessment of political commitments (fiscal adjustment, oil price stability)</li> <li>» Environmental issues</li> </ul>
Quantitative Measures	<ul style="list-style-type: none"> <li>» Structure of the economy</li> <li>» Investment rate, saving rate</li> <li>» Inflation record</li> <li>» Demographic trends (e.g., trends of personal income and wealth, tax base growth trends, employment growth, unemployment rate, population growth, age distribution, and geographic concentration)</li> </ul>	<ul style="list-style-type: none"> <li>» Financial operations (e.g., expense structure, including fixed cost trends, trend of budget surplus or deficit, size and liquidity of financial reserves)</li> <li>» Factors that help assess the sustainability of public debt</li> <li>» Off-balance sheet liabilities</li> </ul>	<ul style="list-style-type: none"> <li>» Future liabilities such as pension and healthcare costs</li> <li>» Composition of the debt in terms of maturity, interest-rate sensitivity, and the size of assets that can be liquidated</li> </ul>

Compared to similarly sized organizations, BRH performs near the level of a Baa3-rated organization (table 2), which places BRH on the lower end of investment grade performance. While this position is considered sustainable, there are nuances that provide additional levels of concern. Baa3-rated organizations are especially susceptible to adverse economic conditions or changing circumstances; with regards to BRH, the vulnerability created by COVID-19 has materially weakened BRH's capacity to meet its financial commitments.

<sup>13</sup> "Procedures and Methodologies Used to Determine Credit Ratings," Moody's Investors Service.

**Table 2: Moody's Rating Scale**

Grade	Rating Symbols	Rating Notches	Comments
Investment Grade	Aaa		Highest quality, subject to the lowest level of credit risk
	Aa	Aa1	High quality, subject to very low credit risk
		Aa2	
		Aa3	
	A	A1	Upper-medium grade, subject to low credit risk
		A2	
		A3	
Speculative Grade	Baa	Baa1	Medium-grade, subject to moderate credit risk and may possess certain speculative characteristics
		Baa2	
		Baa3	
	Ba	Ba1	Judged to be speculative, subject to substantial credit risk
		Ba2	
		Ba3	
	B	B1	Considered speculative, subject to high credit risk
		B2	
		B3	
	Caa	Caa1	Speculative and likely in, or very near, default, with some prospect of recovery of principal and interest
		Caa2	
		Caa3	
	Ca		Speculative of poor standing and subject to very high credit risk
	C		Speculative and likely in, or very near, default, with some prospect of recovery of principal and interest

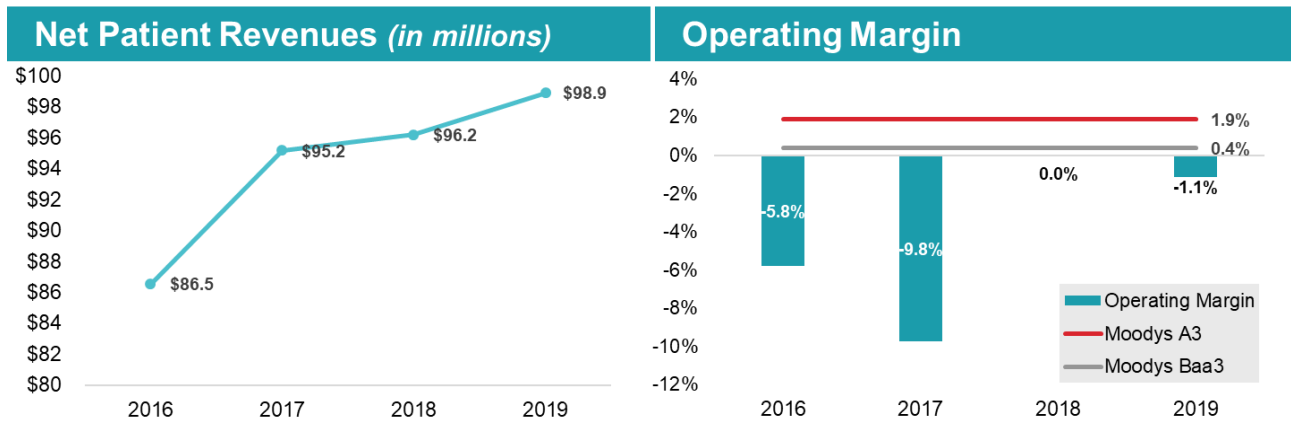
## C. BRH Internal Assessment

Organizational financial positioning is best understood by considering how well positioned a system is to answer key strategic questions, ultimately determining credit-worthiness.

*Profitability:* Net patient service revenue increased 2.8% from FY 2018 to FY 2019; meanwhile, operating margin decreased from 0.0% to -1.1% (figure 1). The current operating margin indicates a credit worthiness equal to an organization rated as Baa3, indicating adequate performance but increased susceptibility when exposed to adverse market conditions. Comparing expenses to similarly sized

organizations in the Alaska market, BRH has historically performed favorably, with an expense per discharge that is 9% lower than that of PeaceHealth Ketchikan Medical Center in FY 2019.<sup>14</sup>

**Figure 1: BRH Net Patient Revenue and Operating Margin**

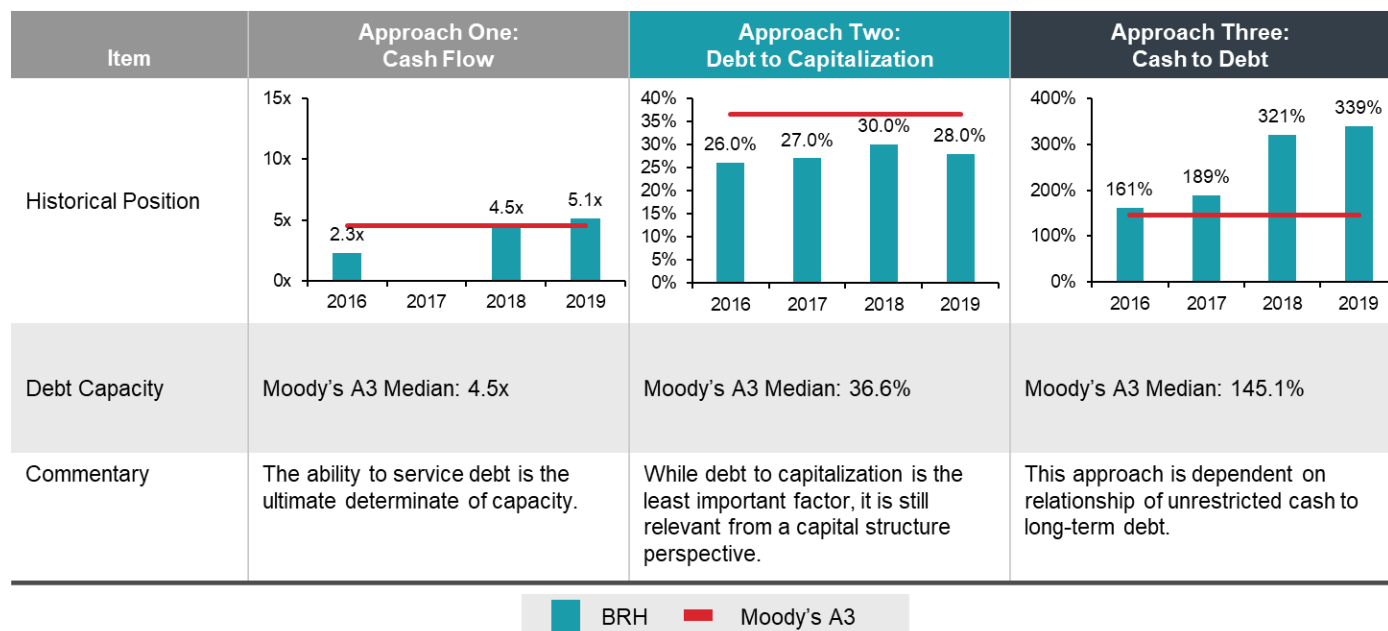


- » *Debt Position:* Based on FY 2019, BRH was performing above Moody's A3 median of 4.5x, indicating a strong ability to service its debt (figure 2). Additionally, BRH has the capacity to borrow incremental debt if needed; however, the decreases in state and CBJ general funds may limit borrowing options.<sup>15</sup>

<sup>14</sup> FY 2016 to FY 2019 data from audited financial statements. FY 2020 sourced from internal 1/17/20 Finance Committee Packet. FY 2021 to FY 2025 capital plan provided by BRH leadership.

<sup>15</sup> Ibid.

Figure 2: Debt Capacity Analysis



- » *Liquidity:* Historically, BRH has high levels of balance sheet liquidity, but its low EBIDA margin indicates cash flows from operations (figure 3) will not be able to support future capital needs through operations alone. Capital expenditures total \$57 million over the next five years, with approximately 82% of that amount planned for department improvements (figure 4). Additionally, BRH has an old infrastructure that will require many repairs and a high level of maintenance going forward.<sup>16</sup>

<sup>16</sup> Ibid.

Figure 3: BRH Operating EBIDA Performance

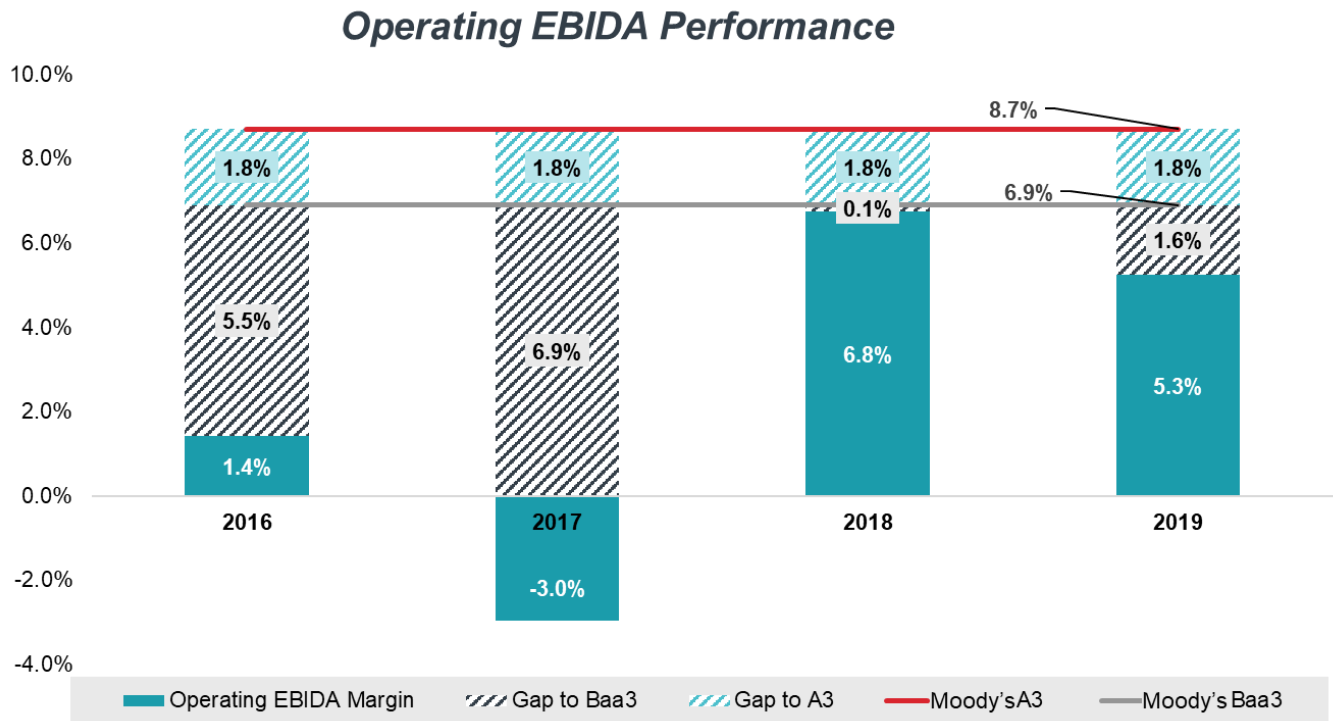
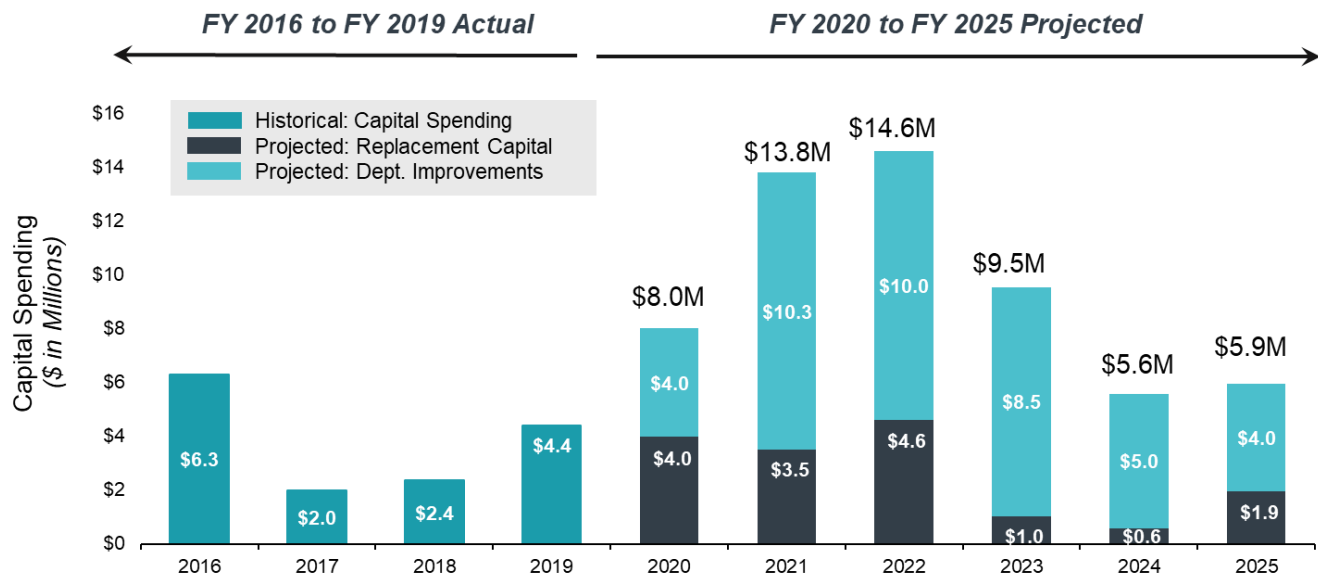


Figure 4: BRH Capital Plan



Notes: FY 2016 – FY 2019 data from audited financial statements. FY 2020 sourced from internal January 17, 2020 Finance Committee Packet. FY 2021 to FY 2025 capital plan provided by BRH leadership.

- » **CMS Rural Community Hospital Demonstration:** The goal of this program is to test the feasibility and advisability of cost-based reimbursement for small rural hospitals that are too large to be

designated as Critical Access Hospitals. CMS is conducting an intensive evaluation of the demonstration to assess the financial impact on participating hospitals, as well as the effect on the healthcare of the populations served. For FY 2019, the benefit of this program increased BRH's Medicare reimbursement by \$4.8 million, indicating a significant impact on reimbursement if this project is not renewed. BRH comes to the end of its five-year cycle on June 30, meaning there will be a \$3.2 million reduction in its Medicare reimbursement, factoring in the \$1.5 million in additional reimbursement BRH would receive from applying to CMS for a Low-Volume Hospital Payment Adjustment to its DRG rates.<sup>17</sup> CMS has not released a statement regarding the termination or continuation of the demonstration.

- » *Public Employees' Retirement System (PERS) Obligation:* PERS is a cost-sharing, multiple employer-defined benefit pension plan administered by the State of Alaska that provides retirement, health insurance premium supplement, long-term disability, occupational death and disability, and survivor benefits. BRH's net pension liability for FY 2019 was \$60.3 million. BRH's obligation decreases operating margin for the organization and may limit available partnership opportunities given the cash required to resolve the balance in an acquisition-style transaction.<sup>18</sup>
- » *COVID-19:* COVID-19 first affected operations at BRH in March. Revenues and volumes were strong through the first half of the month, but in response to COVID-19, outpatient services were discontinued, and services were only provided to inpatients and emergency patients. The result was a 50% reduction in daily revenue, 24% reduction in inpatient revenue, and 8% reduction in outpatient revenue.<sup>19</sup>

Table 3 summarizes the analysis of BRH's profitability, debt position, and liquidity.

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<sup>17</sup> "Budget Packet— FY 2021," Bartlett Regional Hospital, <https://www.bartletthospital.org/media/38527/fy21-budget-packet.pdf>.

<sup>18</sup> FY 2016 to FY 2019 data from audited financial statements. FY 2020 sourced from internal 1/17/20 Finance Committee Packet. FY 2021 to FY 2025 capital plan provided by BRH leadership.

<sup>19</sup> "5-26-2020 Board of Directors Packet," Bartlett Regional Hospital, <https://www.bartletthospital.org/media/38724/05-26-2020-board-of-directors-packet-public-revised-v2.pdf>.

**Table 3: Historical Credit Profile**

Ratio/Statistic	Fiscal Year-End June 30			
	2016	2017	2018	2019
Total Operating Revenue	\$90.6	\$98.5	\$99.8	\$102.5
Net Patient Service Revenue	\$86.54	\$95.19	\$96.20	\$98.91
Operating Income	\$(5.25)	\$(9.60)	\$(0.02)	\$(1.17)
Operating EBIDA	\$1.96	\$(2.24)	\$7.40	\$6.02
Adjusted Net Income	\$(4.77)	\$(9.41)	\$(0.24)	\$0.89
Adjusted Net Revenue Available for Debt Service <sup>1</sup>	\$3.12	\$(1.38)	\$7.84	\$8.72
Cash Flow (Net Income + D&A) <sup>2</sup>	\$3.90	\$(0.59)	\$7.19	\$8.08
Unrestricted Cash <sup>3</sup>	\$37.64	\$42.26	\$68.68	\$69.01
Capital Expenditures	\$23.38	\$22.40	\$21.40	\$20.39
<b>Profitability</b>				
Operating Margin	(5.8%)	(9.8%)	0.0%	(1.1%)
Operating EBIDA Margin	1.4%	(3.0%)	6.8%	5.3%
<b>Debt Position</b>				
Coverage	2.3x	(0.9x)	4.5x	5.1x
Total Debt to Capitalization	63.6%	68.7%	63.1%	64.2%
<b>Liquidity</b>				
Cash to Total Debt	54.5%	44.6%	86.7%	81.6%
Days Cash on Hand <sup>4</sup>	188	198	262	266
<b>Other</b>				
Capital Spending Ratio	87.3%	26.8%	31.7%	61.1%

Notes: Credit ratings sourced from BRH Moody's Credit Opinion published 08/29/2019. BRH data is based on audited financial statements, continuing bond disclosures, and internal management reports. All dollar amounts are in millions.

<sup>1</sup> FY 2018 adjusted net revenue available for debt service and adjusted DSCR normalized for investment loss.

<sup>2</sup> Includes inflows from local government.

<sup>3</sup> Unrestricted cash defined as cash + cash equivalents + long-term investments.

<sup>4</sup> Days cash on hand defined as unrestricted cash ÷ [(operating expenses – noncash expenses) ÷ 365].

## A. Regional Impact Assessment

- » *Alaska State Budget:* Alaska relies on two main sources of revenue: (1) oil taxes/royalties and (2) federal funding for all state services to build and maintain the necessary infrastructure and increase cash reserves. The Alaska spring 2020 budget forecasts a \$527 million reduction in projected Unrestricted General Fund revenue and a projected FY 2021 reduction of \$815 million. Over 85% of the reductions are due to declines in projected petroleum revenue, which is largely a function of a lower oil price. Alaska North Slope revenue forecasts oil prices to remain below \$30.00 per barrel for the remainder of FY 2020, resulting in an annual average price of \$51.65 per barrel. The oil price forecast is based on oil futures and reflects the current extreme supply and demand imbalance gradually relaxing over the next several years. Ultimately, if oil prices and production remain below the annual spring forecast, the constitutional budget reserve will be empty after FY 2021.<sup>20</sup>
- » *CBJ Budget:* In 2012, Moody's downgraded the CBJ from Aa2 to Aa3 as a reflection of weakened financial flexibility that resulted from consecutive years of draws upon reserves in the General Fund and other general operating funds. Cited as reasons that the rating would further decrease include

<sup>20</sup> "Spring 2020 Revenue Forecast," Alaska Department of Revenue.



further declines in general fund reserves and declines in the tax base.<sup>21</sup> According to the CBJ FY 2020 Biennial Budget, by the end of FY 2022, the general fund balance will be down to a level that can no longer accommodate further draws.<sup>22</sup> The result will increase the cost of capital and require increased dependence on tax revenue.

April ended with an approximate loss in revenue of 50%, but BRH received two payments from the CARES Act that totaled approximately \$2.0 million. BRH leadership estimates that net revenue for April will likely result in a total loss of \$2.5 million. As of May, elective radiology and other procedures have reopened, resulting in revenue and patient day volumes increasing.<sup>23</sup>

Of BRH's yearly revenue, 6.5% is attributed to tourism (approximately \$5.9 million), not including the revenue derived from local residents who are in the service and tourism industry. Therefore, COVID-19 will have an additional impact on BRH's revenue stream through the remainder of the year and potentially longer. As of May 2020, 479 Alaskan voyages with an estimated 955,784 passengers have been canceled, representing an 80% loss of expected voyages and 73% loss of expected passengers.<sup>24</sup> The impact on BRH's revenue stream is estimated at 10% to 15% of total revenue (approximately \$11.3 million).<sup>25</sup>

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<sup>21</sup> "Moody's Investors Final Report," Moody's, [https://www.juneau.org/beta\\_transfer/assemblyftp/agendas/2012/2012-05-21\\_Special/documents/Moodys\\_Investors\\_Final\\_Report.pdf](https://www.juneau.org/beta_transfer/assemblyftp/agendas/2012/2012-05-21_Special/documents/Moodys_Investors_Final_Report.pdf).

<sup>22</sup> "Biennial Budget FY 2020," City and Borough of Juneau, <https://3tb2gc2mxpvu3uwt0l20tbhq-wpen-gine.netdna-ssl.com/wp-content/uploads/2019/07/FY20-ADOPTED-Budget-Book-FINAL-for-INTERNET.pdf>.

<sup>23</sup> Ibid.

<sup>24</sup> Government and Community Relations, Holland America Group—Princess Cruises, Holland America Line, and Seabourn.

<sup>25</sup> "Budget Packet—FY 2021," Bartlett Regional Hospital, <https://www.bartletthospital.org/media/38527/fy21-budget-packet.pdf>.

## **V. Market and Strategic Position Overview**

## **V. Market and Strategic Position Overview**

### **A. Market Size and Competition**

New population growth in the region is projected to be flat, with a compound annual growth rate (CAGR) of 0.48% from 2019 to 2024, largely driven by CAGR of 4.16% of the age 65 and over population. Low population growth in the under 65 age cohort indicates that in order to increase the patient base BRH will need to capture incremental market share from competitors or provide new or expand existing services. To grow BRH through developing new services, the hospital's leadership would likely need to offer services targeting the age 65 and over population or capture market share from established competitors by significantly differentiating BRH's service offerings, such as offering telehealth services for behavioral health and primary care and expanding clinic days for rotating specialties.

The primary competition in the Southeast Alaska market includes SEARHC and PeaceHealth in Ketchikan. SEARHC operates the Ethel Lund Medical Center in Juneau, which offers medical and dental clinics with physical therapy, radiology, laboratory, and pharmacy services, as well as scheduled specialty clinics that include ear, nose, and throat; pediatric; orthopedic; and other services (figure 5). SEARHC also owns 17 acres of undeveloped land less than one mile from BRH. BRH has limited competition for hospital-based services in the CBJ, but experiences significant patient leakage due to limited service offerings and acuity threshold.

**Figure 5: Juneau Competitive Landscape**



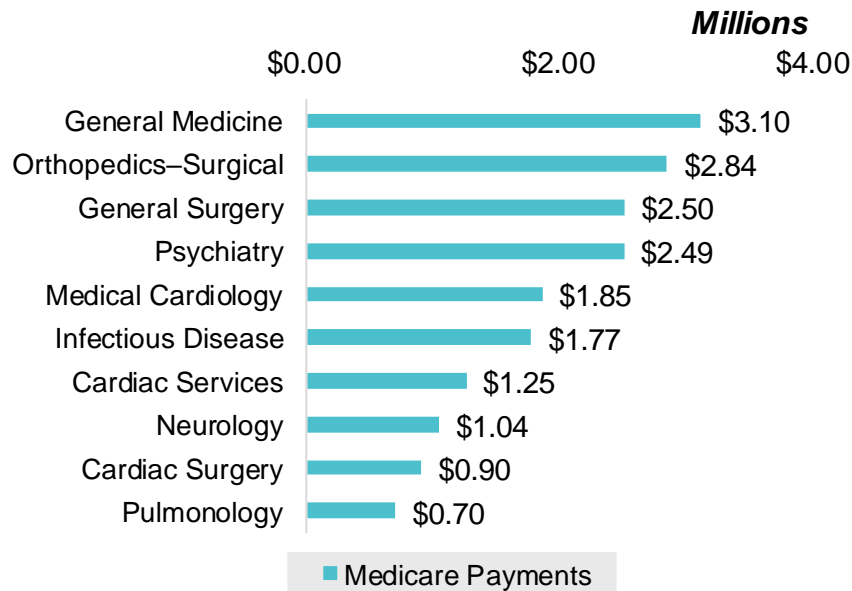
## B. Leakage of Services

Physician shortages and geographic isolation contribute to low availability of services, including primary care and behavioral health. While the average rate of primary care physicians across the US is approximately 80 per 100,000 people, rural areas exhibit a much lower rate of 68 per 100,000 people.<sup>26</sup> The difficulty for rural residents to access services leads to the increased likelihood of costly, higher-acuity episodes of care. This increased likelihood, combined with prominent population growth in the age 65 and older cohort and current out-migration of Juneau patients to higher-acuity centers, indicates that the incremental capture of regional patients without new facilities or additional specialties will be difficult. BRH volume usually increases 12% to 15% over the summer due to tourism, but given the impact of COVID-19 and general state of the cruise industry, 2020 seasonal volumes will not reach historical levels.

Growth in the age 65 and older cohort will drive utilization for orthopedic and cardiology services. With approximately 17% of inpatient Medicare payments attributed to orthopedic surgery, orthopedics is expected to remain the highest-contributing service for BRH behind general medicine, as shown in figure 6.

<sup>26</sup> "2019 Rural Report," American Hospital Association, <https://www.aha.org/system/files/2019-02/rural-report-2019.pdf>.

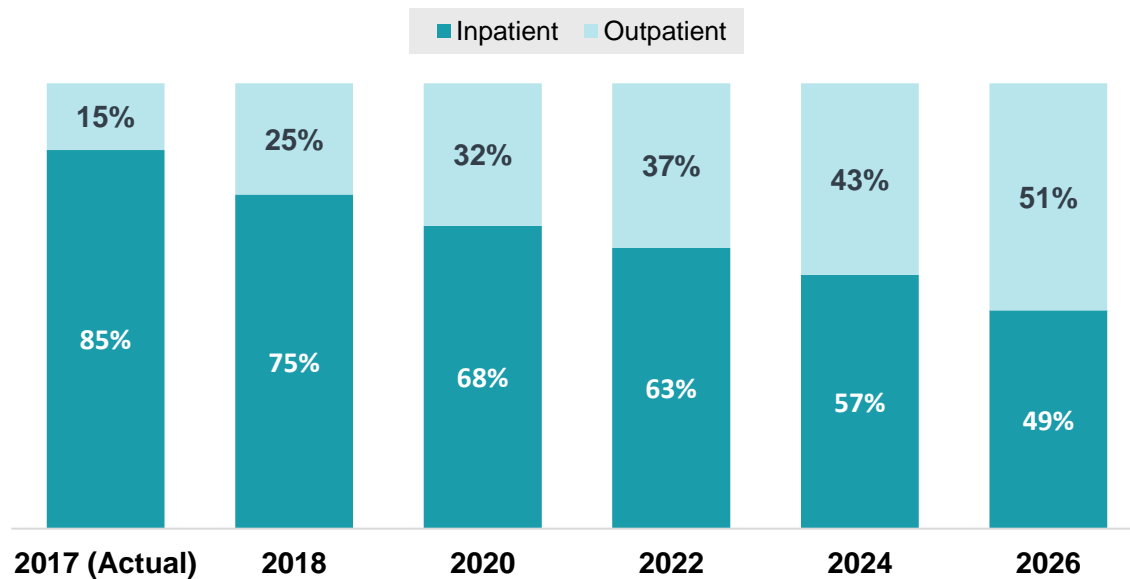
**Figure 6: Inpatient Leakage by Specialty (Medicare only)<sup>27</sup>**



Health systems and hospitals are feeling pressure from payers and their communities to reduce costs. In addition, changes in government regulations and among commercial payers reward providers for migrating high-acuity surgery to the ASC setting, which poses a financial threat to health systems due to the significance of surgical revenue. Improved surgical techniques are allowing more surgeries to move out of hospital inpatient settings and into ambulatory surgery facilities. In 2020, 32% of orthopedic joint replacements are projected to be performed in the inpatient setting, contrasted with 51% by 2026 (figure 7), representing a considerable financial risk to BRH.

<sup>27</sup> Definitive Healthcare, annual Medicare data is from CMS Medicare SAFs. The most recent annual Medicare data is from calendar year 2018.

**Figure 7: Projected Percentage of Joint Replacements by Care Setting**

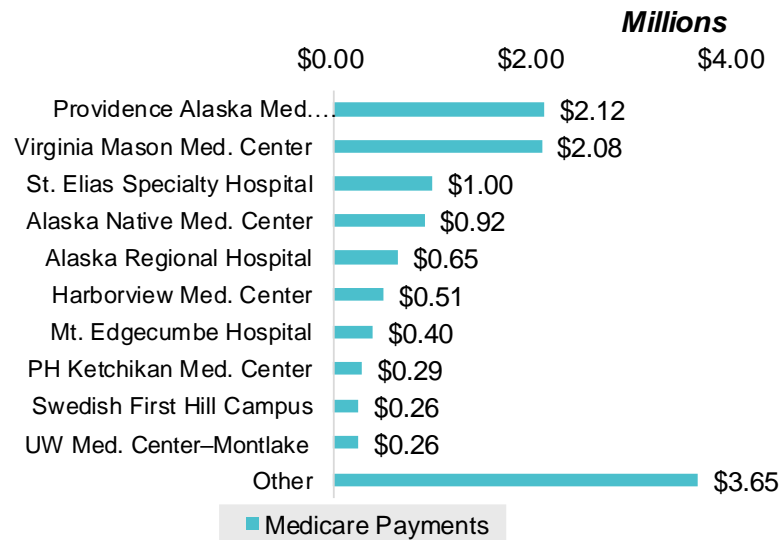


Based on estimates provided by SG2 (Vizient).

Source: <https://www.bcbs.com/the-health-of-america/reports/planned-knee-and-hip-replacement-surgeries-are-the-rise-the-us>.

Providence Alaska Medical Center in Anchorage and Virginia Mason Medical Center in Seattle split 35% of patient leakage, with total patient leakage in excess of \$12 million, as shown in figure 8.

**Figure 8: Inpatient Leakage by Facility (Medicare only)<sup>28</sup>**



## C. Physician Recruitment

Recruitment and retention of healthcare professionals in the rural setting has been and will continue to be a persistent challenge and costly endeavor for rural hospitals. While almost 20% of the US population lives in rural areas, fewer than 10% of US physicians practice in these communities.<sup>29</sup> Physician shortages and difficulty to recruit will be an ongoing issue, as a 2019 Merritt Hawkins survey of medical residents in their final year found, “only 1% of final-year medical residents surveyed would prefer to practice in a community of 10,000 people or fewer, and only 2% would prefer to practice in a community of 25,000 people or fewer.”<sup>30</sup> The aging population of the CBJ exacerbates the issue. As the current physician workforce nears retirement, proactive efforts will need to be made to not only replace retiring physicians but recruit for growing specialties and service areas.

<sup>28</sup> Definitive Healthcare data based on the population of Medicare patients who had at least one claim at BRH (3,052 patients). The analysis evaluated those patients to determine where they go for care across all providers and across the entire continuum of care (hospitals, physicians, post-acute care).

<sup>29</sup> “2019 Rural Report,” American Hospital Association, <https://www.aha.org/system/files/2019-02/rural-report-2019.pdf>.

<sup>30</sup> “2019 Survey: Final-Year Medical Residents,” Merritt Hawkins, [https://www.merritthawkins.com/uploaded-Files/MerrittHawkins\\_Final\\_Year\\_Medical\\_Residents\\_Survey\\_2019.pdf](https://www.merritthawkins.com/uploaded-Files/MerrittHawkins_Final_Year_Medical_Residents_Survey_2019.pdf).



## **VI. Summary Findings**

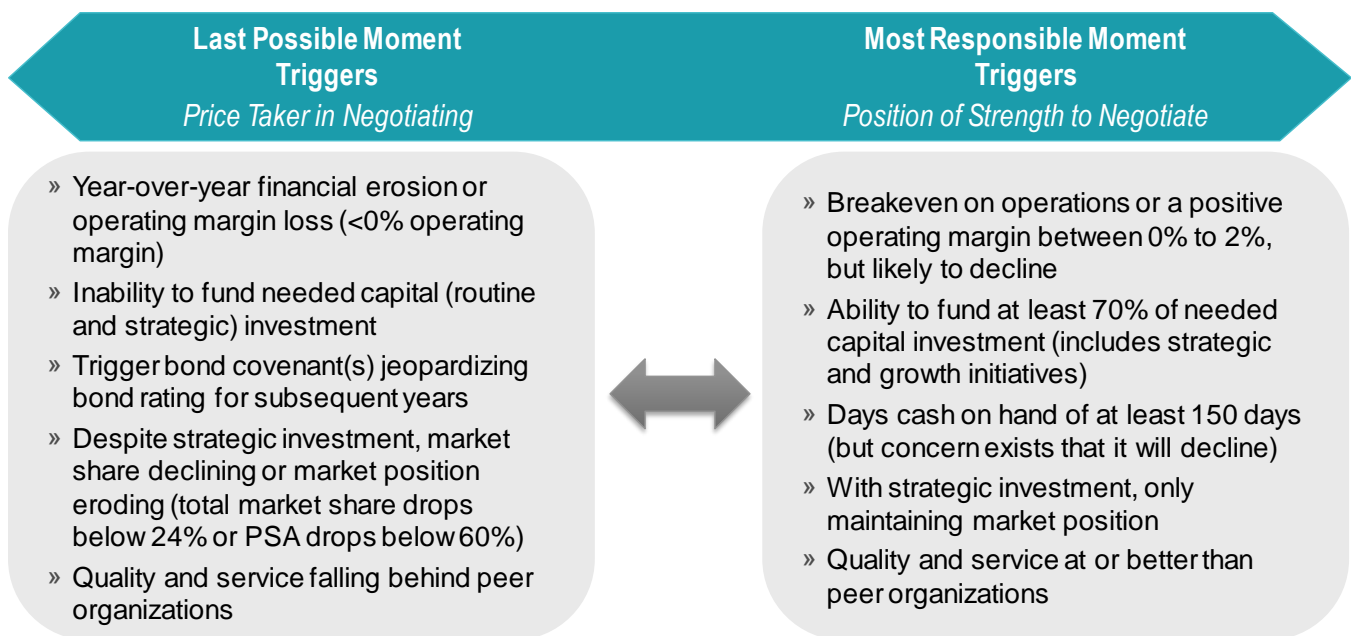
## VI. Summary Of Findings

ECG's findings are based on BRH's current financial, market, and strategic performance and accounts for variables and trends predicted to impact the one- to three-year outlook of the organization.

### A. The Most Responsible Moment

If an independent organization cannot fully execute its strategic imperatives, an affiliation or partnership may be necessary. ECG believes BRH is at its most responsible moment, as detailed in figure 9.

**Figure 9: Assessing the Most Responsible Moment**



### B. Unstable Financials

BRH performs near the level of a Baa3-rated organization and has adequate capacity to meet its financial commitments. However, adverse economic conditions or changing circumstances are more likely to lead to a weakened capacity on BRH's part to meet its financial commitments. The oil industry accounts for one-quarter of Alaska jobs and about one-half of the overall economy when considering state spending.<sup>31</sup> Nearly 70% of Alaska's unrestricted general fund (UGF) is derived from petroleum revenues, which is budgeted to decrease by approximately \$600 million in FY 2021.<sup>32</sup> As state funds continue to decline, the PERS obligation becomes a higher-risk liability. Additionally, financial support provided to the CBJ by the state will reduce future capital spending. Though BRH has significant cash

<sup>31</sup> Kati Capozzi, "Oil and Gas," Home Page, [www.akrdc.org/oil-and-gas#:~:text=Oil%20production%20has%20been%20the,in%20total%20revenue%20since%20statehood](http://www.akrdc.org/oil-and-gas#:~:text=Oil%20production%20has%20been%20the,in%20total%20revenue%20since%20statehood).

<sup>32</sup> "Spring 2020 Revenue Forecast," Alaska Department of Revenue.

reserves, the current capital plan cannot be solely supported by operating cash flows, emphasizing the significance that the reduction in UGF (for the state and city) may have on BRH. Further, CMS's Rural Community Hospital Demonstration accounted for \$4.8 million in revenue for BRH and is set to expire in June without a definitive decision in place regarding the future of the program. The net impact would effectively reduce BRH's operating EBIDA margin to 2.8%, leading to further dependence on cash reserves. Seasonal revenue growth derived from tourism will also continue to decline and lead to higher regional unemployment, as tourism is estimated to reduce BRH's revenue stream by 10% to 15%. Lastly, independent specialty care and imaging services entering the Juneau market will quickly undercut high-value BRH services, ultimately destabilizing BRH's financial position.

### **C. Change in Competitive Providers**

Competitor incursion into the Juneau market has begun, with SEARHC having an established presence in the CBJ. SEARHC benefits from favorable government and tribal reimbursement, making narrow- or no-margin service lines sustainable and difficult for BRH to compete with. The most important factor of BRH's success is its status as the sole community provider in the market. Over the last three years, SEARHC has acquired medical centers, including Mt. Edgecumbe Medical Center in Sitka, proving its structural and operational capability to compete at the hospital level. Though BRH is not threatened by another hospital entering the market, SEARHC has 17 acres of undeveloped land on which to build facilities and expand offerings. The introduction of specialty care and imaging services would greatly diminish BRH's margin, as SEARHC would capture high-value cases.

### **D. Leakage of Services**

New entrants or competitor partnerships will increase patient leakage, negatively impacting BRH's financials and eroding market capture. Changes in the current competitor footprint will quickly influence patient choice, and key specialty gaps at BRH will continue to create natural out-migration into other communities. A lack of local health plan incentives to stay in the community creates further out-migration as patients seek care outside the region. Stagnant population growth will continue to inhibit BRH's ability to backfill leakage with new patients.

### **E. Challenges to Recruiting**

Physician recruitment is a national issue that is exacerbated in Alaska due to the fragmented landscape. The stark reality is that recruitment will only become more difficult going forward. Multiple barriers exist that limit the available talent in the recruitment pool, including geographic isolation, personal and professional isolation, and a lack of qualified candidates.

## **VII. Strategic Options and Recommendation**

## VII. Strategic Options and Recommendation

### A. BRH Guiding Principles

Interviews with BRH stakeholders uncovered themes regarding the parameters and key tenets that any partnership will need to achieve in order for BRH and the CBJ to consider it a viable option.

- » *Independence:* The CBJ will not consider selling the hospital.
- » *Span of Control:* BRH wants to remain an independent organization capable of providing care locally and meeting ongoing capital investment needs.
- » *Commitment to Southeast Alaska:* Any partner must be able to understand the unique aspects of providing care in Alaska and provide services that are suited to the region.
- » *Commitment to BRH and the CBJ:* BRH and the CBJ do not want to become “lost” within a larger health system. The expectation is that these two entities will continue to influence how healthcare is delivered in Juneau.

### B. Alignment Options

ECG does not envision significant alignment with local providers, but a broader alignment may blend elements from both physician and health system options.

#### Physician Alignment Options

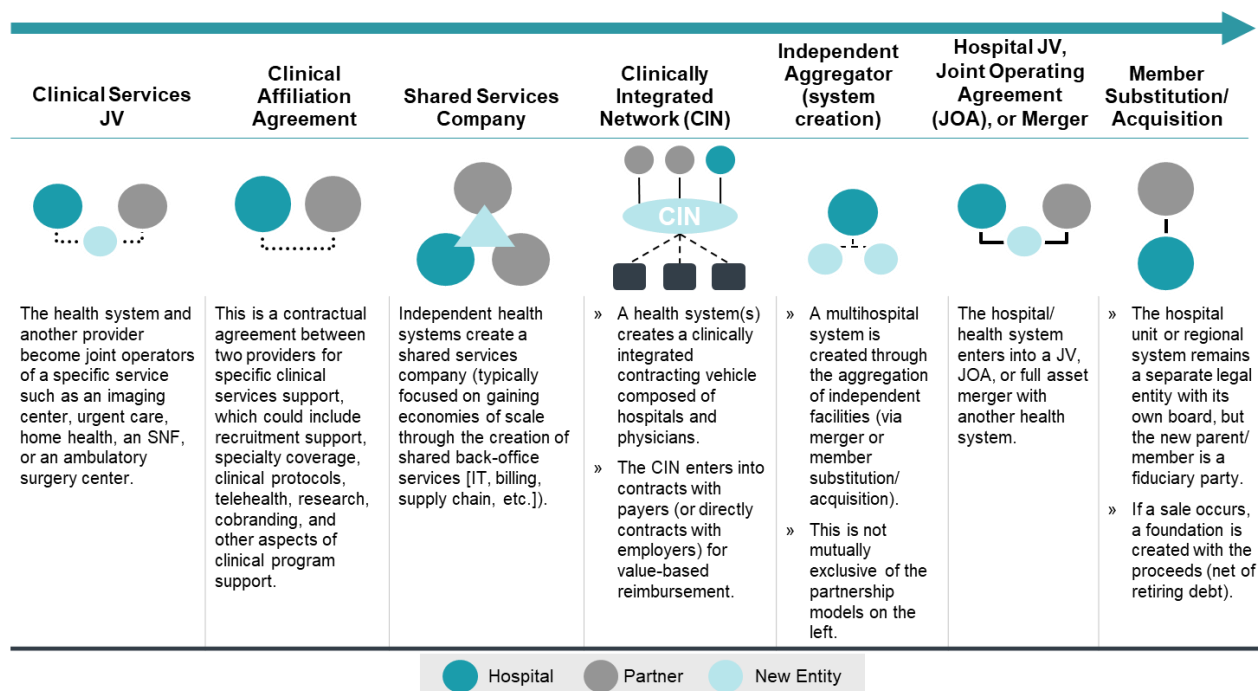
- » *Medical Directorship:* Financial agreement between a physician and healthcare organization in which the physicians provides service line leadership and participates in broader organizational strategy
- » *Call Coverage:* Financial agreement between a physician and healthcare organization in which the physician provides on-call medical services for patients
- » *Practice Management Services Organization (MSO):* Contractual relationship between a physician practice and an MSO to host administrative and management functions
- » *Bundled Payments:* Reimbursement of healthcare providers on the basis of expected costs for clinically defined episodes of care
- » *Comanagement Arrangement:* Contractual relationship between physicians and a hospital that results in a shared-responsibility management structure for a specific service line
- » *Joint Venture (JV):* A commercial enterprise undertaken jointly by two or more healthcare organizations that otherwise retain their distinct identities

- » *Professional Services Agreement (PSA)*: Financial relationship between a physician practice and a hospital in which the physician practice remains an autonomous entity, but the physicians are compensated by the hospital at fair market value for their professional services
- » *Full Employment*: Financial relationship between a physician practice and a hospital in which the physician practice is owned by the hospital entity, and the physicians are compensated by the hospital at fair market value for their professional services

## Health System Alignment Options

Figure 10 depicts these types of options for BRH's and the CBJ's consideration.

Figure 10: Health System Alignment Options



## C. Recommendation

Given the strategic positioning of the organization and in the context of BRH's guiding principles, ECG believes that the organization needs to select a model that allows it to stabilize and expand access to key services and physician specialties in the market while also retaining much of the autonomy that BRH has enjoyed since its opening. While there is no single option short of full integration on the spectrum outlined above that will fully insulate BRH from the competitive risks of incursion from a competitor such as SEARHC, selecting a model that addresses the following challenges will be key:

- » Recruitment of physicians
- » Leakage of services
- » Access to expanded care options

To that end, ECG recommends BRH pursue a clinical service JV or clinical affiliation agreement with a provider that can bring a wider range of specialties and new services to the region while allowing the broader system to remain independent. This type of structure will provide BRH with a platform to address the need for specialists in the community as that need arises and potentially expand some services that patients currently have to travel for. The tasks outlined in table 4 will need to be undertaken in order to implement the recommendation.

**Table 4: Implementation Tasks**

---

**Task 1 Evaluate Services for Focus**

Evaluate the spectrum of clinical services BRH currently offers, and discuss the long-term track record for success associated with the services. For each clinical service, assess the impact on BRH's ability to address the need for increased specialists in the community and expanded access for patients, relative to the current state.

**Task 2 Compile Profiles of Potential Partners**

Assemble profiles of potential partners, including those organizations in the market and/or region that could potentially advance BRH's achievement of critical success factors and guiding principles. Potential partnership profiles typically include the following:

- » Corporate form
- » Ownership/sponsorship
- » Scope and scale of principal service delivery sites
- » Corporate infrastructure
- » Physician platform
- » Utilization trends
- » Market share trends
- » Key services and points of competitive differentiation
- » Financial analysis and credit profile
- » Consolidated financial analysis

**Task 3 Contact Potential Partners, and Develop RFP**

Contact the partners identified in task 2, and develop an RFP for pursuing a clinical joint venture.

**Task 4 Evaluate Partnership Opportunities**

Develop a detailed evaluation matrix and accompanying analyses that summarize the qualitative and quantitative factors to assess each potential partner. The framework would delineate the strategic alternatives available and the potential risk/rewards associated with each partner.

**Task 5 Conduct Deliberations**

Facilitate a series of discussions with BRH and the CBJ leadership to review and discuss the partnership opportunities, interpret the implications, and reach consensus on the strategic direction for BRH.

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# COMMUNITY HEALTH NEEDS ASSESSMENT

## BARTLETT REGIONAL HOSPITAL

### 2019-2020



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## **PART A: CHNA**

# **HISTORY OF BARTLETT REGIONAL MEDICAL CENTER COMMUNITY HEALTH NEEDS ASSESSMENTS**

The Community Health Needs Assessment became a requirement for 501c3 hospitals with the implementation of the Affordable Care Act beginning in 2012. Under the ACA. It was designed to ensure that tax exempt status was going to hospitals that were actually trying to serve their communities in the best way. Government hospitals like Bartlett Regional Hospital (BRH) were exempt from this requirement, as it was only reserved for 501c3 Hospitals.

Many hospitals that are either for profit or are not a 501(c)(3) organization, have seen the benefits of a CHNA and have chosen to conduct a CHNA in order to better understand and serve their community. Bartlett Regional Hospital (BRH) engaged Cycle of Business to:

- ◆ Complete a Community Health Needs Assessment (CHNA) report
- ◆ Provide Bartlett Regional Hospital with a better understanding of the community they serve
- ◆ Provide information needed for BRH to better understand specific health needs and plan for services that will improve the health of the people they serve
- ◆ Integrate results into the BRH strategic plan ensuring completion of the plan.

## **THE BRH COMMUNITY HEALTH NEEDS ASSESSMENT:**

Bartlett Regional Hospital has always tried to stay abreast of the services needed in their community. They have had a belief that understanding the community and making sure you are staffed to meet the needs of that community will always ensure patient loyalty and the best quality healthcare in the community. As a result, over the years, BRH has looked into



what services people are needing that BRH was not providing. They have analyzed leakage reports and conducted a physician staffing analysis in order to better meet the needs of the community. This year BRH decided to conduct a Community Health Needs Assessment as a final piece to the puzzle. The information derived from all these efforts will be utilized to verify their services meet the needs of the community and they are staffing appropriately so fewer people have to leave the community for their healthcare needs.

## SERVICE AREA:

The Primary Service Area for Bartlett Regional Hospital pulls mainly from the residents of the City and Borough of Juneau Alaska. However the Secondary Service Area expands to areas as far north as Skagway and as far south as Wrangle. Because of the remoteness of the cities in Alaska and the difficulty of travel to neighboring cities and hospitals, the people in BRH's Total Service Area have limited access to the hospital.

Community	Zip Code	Population-2015
Douglas, AK	99824	2,111
Angoon, AK	99820	479
Juneau, AK	99801	29,164
Gustavus, AK	99826	442
Haines, AK	99827	2,602
Hoonah, AK	99829	777
Petersburg, AK	99833	3,202
Skagway, AK	99840	986
Wrangell, AK	99929	2,338
Estimated Potential For Total Service Area Population		42,101

The population of the City and Borough of Juneau is 31,754. This population is made up of just 3 zip codes covering the Cities of Juneau, Angoon and Douglas. There are also surrounding areas between these areas that are included in that Primary Service Area. This secondary service area adds an additional 10,347 to the population served to bring the total to 42,101.



Bartlett Regional Hospital Total Service Area

## PROCESSES AND METHODOLOGY

Completion of the BRH Community Health Needs Assessment (CHNA) followed an outline designed by the Center for Rural Health at the University of North Dakota for the North Dakota Critical Access Hospitals. The sections of this CHNA generally follow their suggested methodology but were slightly modified to meet the needs of BRH and requirements of their RFP.

Two meetings were held to complete the CHNA. An initial meeting to discuss the survey as well as a follow-up meeting to discuss the results. The survey was conducted in between meetings to gather appropriate data to make final decisions on which health needs were appropriate to address in this fiscal year.

The first meeting was a general review of health information on a Borough level. After that meeting, Bartlett Regional Hospital reviewed and refined an electronic survey that would be distributed throughout the service area and in local businesses. The survey was further revised in conjunction with Cycle of Business and Bartlett Regional Hospital to ensure the questions asked would help Senior Leadership and the Board decide on the best course of action for the Hospital. Before the survey was distributed to the community special care was taken to ensure the verbiage was inclusive.

A second meeting was held with Senior Leadership to review the information from the survey and prioritize the most important health issues that could and should be addressed given the resources of Bartlett Regional Hospital. Key findings from the survey were looked at to see what needed to be addressed by the hospital and what needed to be given priority.

As the survey was reviewed by the Senior Leadership team, areas of focus and clarification were outlined. The Senior Leadership Team wanted to ensure the CHNA was not only dealing with the opinions of the community, they wanted to make sure they had the data to make appropriate decisions. Finally a revised CHNA was prepared and taken to the Board of Directors for their input and approval.

## **RESOURCES AND SECONDARY INFORMATION:**

The CHNA for Bartlett Regional Hospital Utilized Data From:

**County Health Rankings.** Since it began in 2010, County Health Rankings ranks the health of nearly every county in the nation and is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The program awards grants to local coalitions and partnerships working to improve the health of people in their communities. The information received from this website appears to be from 2016.



**Current Census Data.** The United States Government conducts a census every few years to gather data on certain demographics in the country. The last census data for Juneau, AK was conducted in 2015.

**Survey Conducted Through the Hospital and Community.** A survey was designed in conjunction with Cycle of Business and Bartlett Regional Hospital to gather information from the community on the immediate needs of the population.

**Broad Interests of the Community Were Considered:**

Special care was used to find individuals in the community who could help define the health care needs of the community representing the youth, the elderly, and varied cultures.

The individuals involved in the initial meeting were asked to review the survey and give their input on the needs of the hospital. Additional efforts were made to reach out to the community in general to give input on the survey. A link to the survey was sent out to the major employers in the community. Employers and community members were contacted personally.



Bartlett Regional Hospital has some of the best imaging equipment in the state.

## **PARAMETERS FOR DATA COLLECTION**



COB and BRH used the most recent population and demographic information available to ensure the community needs were being met. This included gathering national statistics of the services area as well as the demographics of the service area. The federal government also tracks certain health statistics across the U.S. by county. This information was compiled to give a good baseline of where certain health needs were being met and areas that needed improvement.

## DEMOGRAPHICS:

The demographics for the area were collected through the use of census data and other reports. Unfortunately the latest data was only as recent as the 2015 census. Although exact population and demographic information may vary slightly from that articulated in the CHNA, the outcomes of the CHNA will not be affected by any minor discrepancies.

The population of the Borough of Juneau, AK is estimated for 2015 at approximately 31,754. Due to the fact the additional zip codes from the secondary service area we incorporated into this analysis only make up a small portion of the population served, we will use the demographic data from Juneau to represent the secondary service areas. Therefore, based on what we know from Juneau:

- 67% of the population are between the ages of 18 and 64
- 18% are 60 or older

### Age

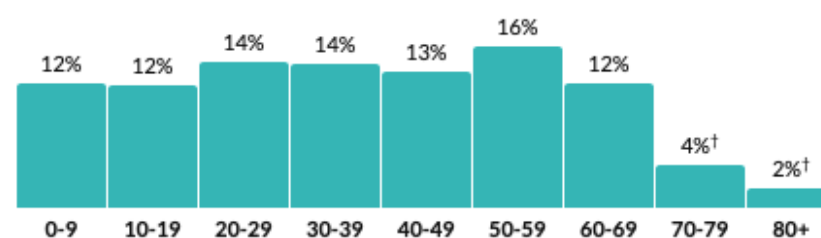
**38**

#### Median age

about the same as the figure in the Juneau, AK Micro Area: 38

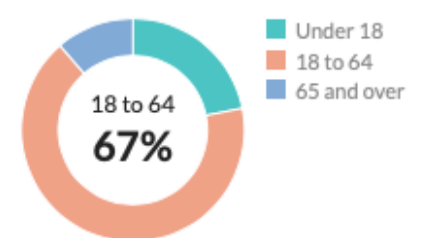
about 10 percent higher than the figure in Alaska: 33.9

Population by age range



[Show data / Embed](#)

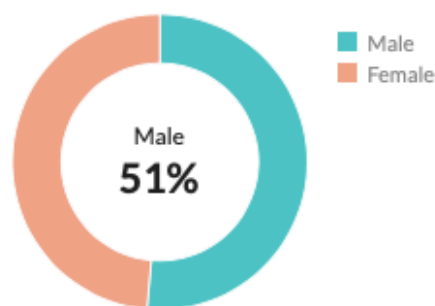
Population by age category



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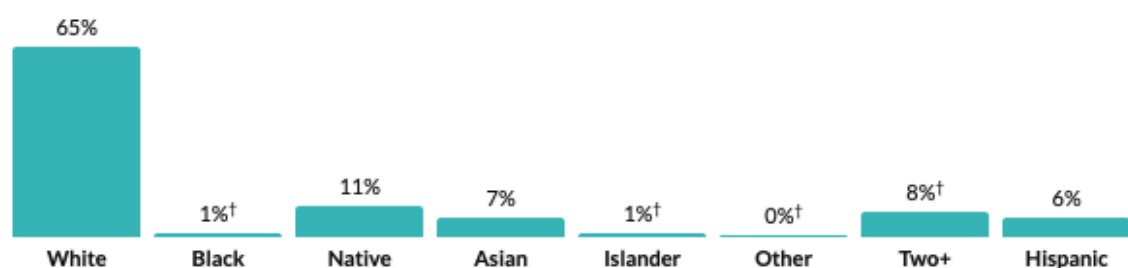
- 49% of the population identify as women
- 65% are white and 11% are Native Alaskan, 7% are Asian, while 6% regard themselves as Hispanic

## Sex



[Show data / Embed](#)

## Race & Ethnicity



\* Hispanic includes respondents of any race. Other categories are non-Hispanic.

[Show data / Embed](#)

- 96% of Juneau residents have graduated from high school compared to the Alaska average of 92.4%.
- 40.3% of Juneau residents have a Bachelor's degree or higher.
- This is 1.4 times the rate of the rest of Alaska which is only about 29%.

## Educational attainment

**96%**

High school grad or higher

about the same as the rate in the Juneau, AK Micro Area: 96%

a little higher than the rate in Alaska: 92.4%

**40.3%**

±2.1%

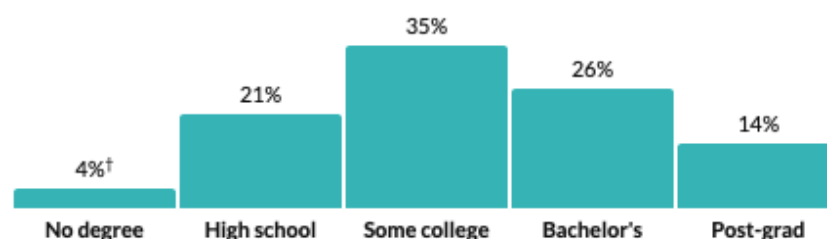
(8,998 ±476)

Bachelor's degree or higher

about the same as the rate in the Juneau, AK Micro Area: 40.3% 8,998 (±2.1% / ±476)

about 1.4 times the rate in Alaska: 29% 137,821 (±0.5% / ±2,424)

## Population by minimum level of education

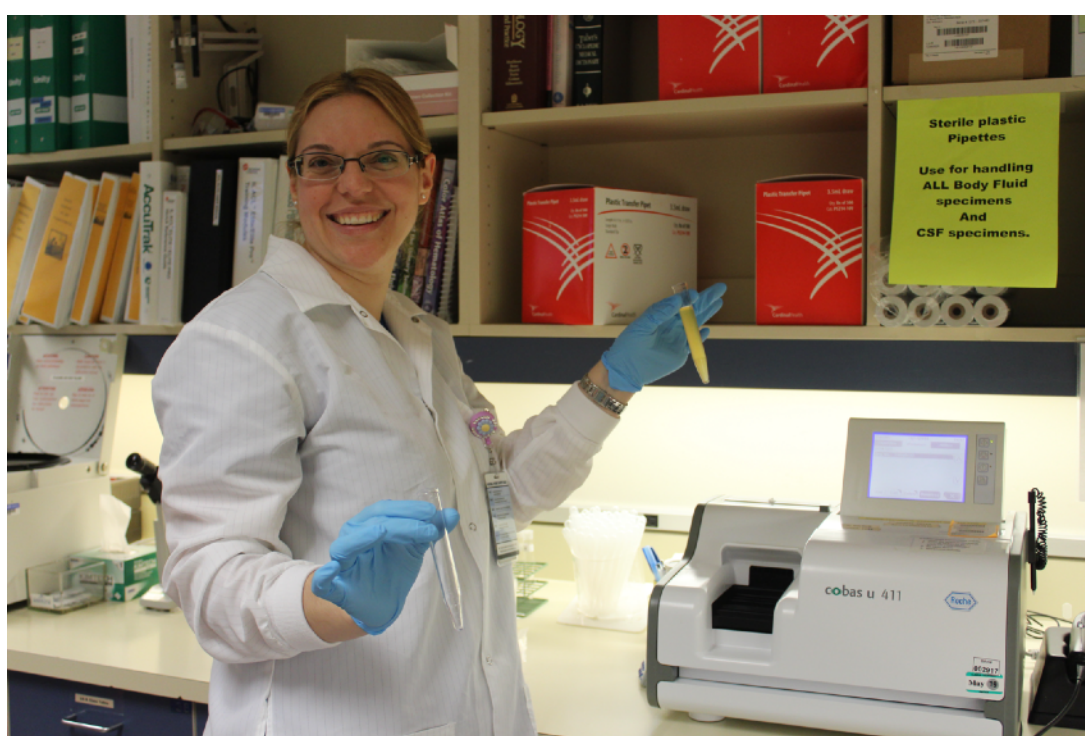


\* Universe: Population 25 years and over

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"BRH DOES AN OUTSTANDING JOB PROVIDING ESSENTIAL SERVICES TO THE COMMUNITY OF JUNEAU WITH A LIMITED AMOUNT OF FUNDING"

Survey Participant



Bartlett Regional Hospital offers a full range of laboratory services to the community

- The median household income in the Borough of Juneau is \$90,749 with a per capita income of \$41,904.
- 7.4% of the population live in poverty
- 13% of the population of Juneau Borough live without health insurance. This 13% of uninsured people is 3% less than the state of Alaska which is 16%.

#### Income

**\$41,904**

Per capita income

about the same as the amount in the Juneau, AK Micro Area: \$41,904

about 20 percent higher than the amount in Alaska: \$35,065

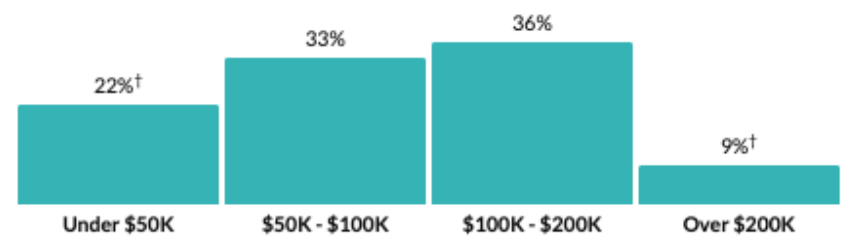
**\$90,749**

Median household income

about the same as the amount in the Juneau, AK Micro Area: \$90,749

about 20 percent higher than the amount in Alaska: \$76,114

#### Household income



[Show data / Embed](#)

#### Poverty

**7.4%**

Persons below poverty line

about the same as the rate in the Juneau, AK Micro Area: 7.4%†

about three-quarters of the rate in Alaska: 10.2%

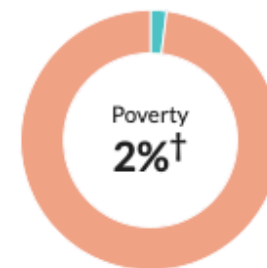
#### Children (Under 18)



■ Poverty  
■ Non-poverty

[Show data / Embed](#)

#### Seniors (65 and over)



■ Poverty  
■ Non-poverty

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The Borough of Juneau has some areas that are advantageous to the people who live there. 100% of the people report having access to exercise. The 13% of people without insurance is relatively low and they have extremely good ratios of patient to provider for Primary Care, Mental Health, and Dental.

On the other hand Juneau has a fairly high ratio in the following health risk factors:

- Excessive drinking is above top performing counties
- Alcohol impaired driving deaths (Half of all automobile deaths)

According to the County Health Rankings website, in half of all driving accidents where there is at least one fatality, alcohol was a contributing factor.

	Juneau County	Top Performers	Alaska
Adult Smoking	18%	14%	19%
Adult Obesity	29%	26%	30%
Excessive Drinking	22%	13%	19%
Alcohol Impaired Driving Deaths	50%	13%	37%

- STDs including HIV are much higher than we would like to see

	Juneau County	Top Performers	Alaska
HIV per 100,000	69	49	109
Sexually Transmitted Infections per 100,000	494.6	152.8	771.6
Teen Births per 1000	17	14	30

- Drug overdose almost 3 times what we would like to see
- Mammogram Screenings should be higher
- Flu Vaccinations 35% lower than top performers

	Juneau County	Top Performers	Alaska
Life Expectancy	79.5	81	78.5
Premature Death	7,900	5,400	8,200
Mammography Screenings	33%	49%	33%
Flu Vaccinations	34%	52%	32%
Drug Overdose	29	10	18

Premature death is another area of concern. This number is calculated by taking the cumulative number of years people die in the community before reaching their 75th birthday and extrapolating that number for a population of 100,000 residents. For Juneau the equivalent of 7900 years would be lost between the time people die and their 75th birthday if Juneau had a population of 100,000. In the state of Alaska 8,200 years are lost per 100,000, However the CDC would like to see those rates closer to 5,400 per 100,000.

One other point of concern is that drug overdoses in Juneau are almost 3 times the national average and almost 66% more than the State of Alaska. This concerning health factor was supported later with the results of the CHNA survey. Mental and Behavioral Health issues were the most common concern of the respondents in open ended questions.

# THE PROCESS

## MEETINGS WITH COMMUNITY MEMBERS AND FOCUS GROUPS



## Initial meeting:

On October 4 and 5 of 2019 a meeting was held with members of the community who demographically, represented the people of the community. Special care was taken to ensure all people would be represented in the results of the survey. This meant reaching out to large employers as well as special interest groups who would help ensure all demographics were well represented. Discussions took place to review a template of the survey to be distributed, and suggestions were made to ensure the survey would be acceptable to all potential respondents.

The focus group recognized that health care needs may differ between genders, ethnicity, sexual preference and age. The focus group also pointed out that Juneau has a growing LGBTQ+ population and each subset of that group would have unique needs. As a result, the survey was written to be inclusive and ensure that everyone would feel comfortable in responding to the question.

The survey was also written to go beyond the current national data that is readily available. BRH wanted to be able to specifically look at the results needed to meet the service needs of the community. They also wanted to staff the hospital with the appropriate physician mix.



Bartlett Regional Hospital has state of the art 3D Mammogram services

## DISTRIBUTION OF SURVEY

After reviewing and revising the CHNA survey, BRH sent a link to the survey out to community members who represented the population at large and specific demographics within the community. The representatives then forwarded that link to their respective communities in order to ensure the population was appropriately represented in the answers of the survey. Additional links to the survey were also placed on the hospital's website and radio interviews were given to make sure the community would

know how to access the survey.

After giving the community 3 weeks to respond to the survey, the responses were gathered and analyzed to be presented to the Senior. Leadership staff.

## **COMMUNITY ENGAGEMENT**

The community was well represented in the initial meeting where the process and a description of their assistance was discussed. Bartlett staff wanted to ensure the broad interests of the community were taken into consideration. The participants gave important insight into what needed to be included in the survey and how to make sure certain specialties were brought to the public to insure what services were most needed.

253 members of the community responded to the survey. Respondents appeared to cover all the demographics of the community. Their feedback covered health needs of the community but also social challenges and suggestions for improving access to care. They were candid in their responses and gave the hospital information that will assist them as they improve on their service to the community. The feedback from this survey will be utilized to develop a strategic plan for the year 2020 and beyond.

## **THE RESULTS**

### **SURVEY RESULTS**

Results of the survey centered around a few key areas.

**Utilization:** The hospital is currently not being utilized by the community as one would expect. 57% of the respondents said they do not use BRH for their main healthcare. 56% of the respondents had received some of their healthcare from hospitals outside of Juneau in the last 3 years. The reasons for this varied, but dealt mainly with specialties the patient needed. Due to the nature of specialties and what BRH offers, it is possible that some of the respondents could be using BRH for primary care only to be referred outside for specialties that are not available in Juneau.



There were also concerns about insurance coverage as well as the cost to the patient. Alaska has a higher cost of healthcare than other areas in the lower States. This concern showed itself throughout the survey.

**Specialties:** Recruitment is always difficult in rural hospitals. Due to the remoteness of the area and the limited number of people in the area, it has been difficult to hire and retain specialists. This has made it more important than ever to ensure the specialties provided by a hospital such as Bartlett Regional Hospital are specialties that are supported by the community and ensure the physician is able to have enough business to make it viable.

The Community Health Needs Assessment mentioned several specialties that will need to be explored. Those specialties included, Cardiology, Endocrinology, Nephrology, Neurology, Orthopedics, Oncology among others. Developing a responsible plan for growth in the specialties will take more research beyond the CHNA, however, the information in the CHNA will assist in focusing our attention in the correct areas. BRH will review the results of the survey, comparing them to current hospital data to see how those requested specialties line up with existing physicians as well as needed specialists. Based on the need, the expressed desire to have someone local, and the financial feasibility, BRH will decide on which specialties need to be filled, methods for filling them, and the timeline for doing so.

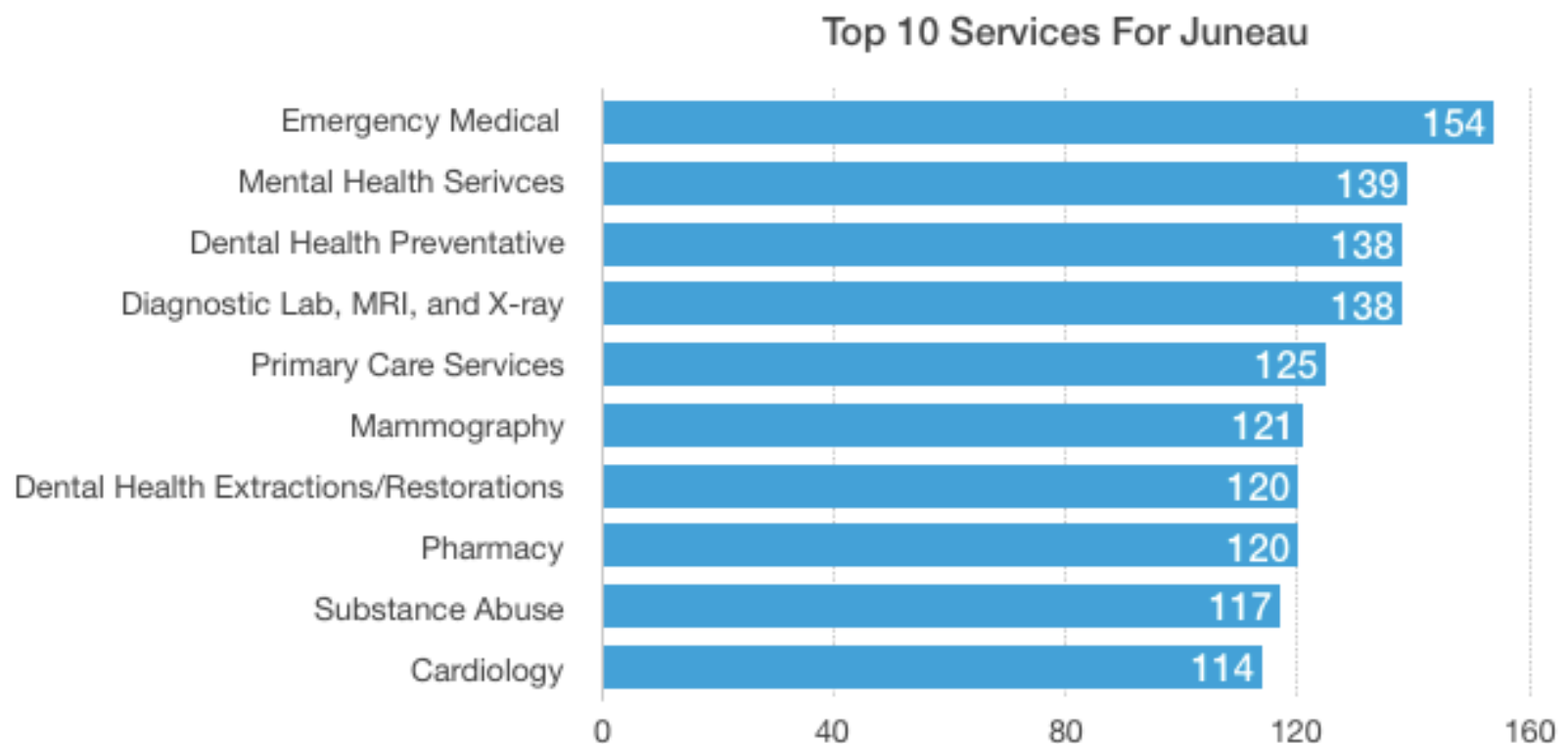
**Mental Health:** Mental health was referred to more than any other topic in the open ended questions. It appears that Mental and Behavioral health is a concern that affects almost every member of the community. Areas specifically mentioned were mental health among the homeless population, grief counseling, and drug and alcohol addiction. As mentioned above, Juneau faces nearly four times the level of alcohol related driving deaths, nearly three times the level of drug overdoses, and nearly twice the level of excessive drinking as the top performing counties in the nation.

Bartlett already has a robust Mental health program which includes:

1. 16 bed residential substance abuse recovery program
2. Large behavioral outpatient service
3. 12 bed locked adult mental health unit
4. 8 bed crisis intervention center under development with separate beds for Adults and Youth

Additional insights from the survey:

When asked what services the respondent, a member of their family, or a person they know from the community utilized, respondents prioritized the following at the top 10 services. Many of these are already provided by BRH.



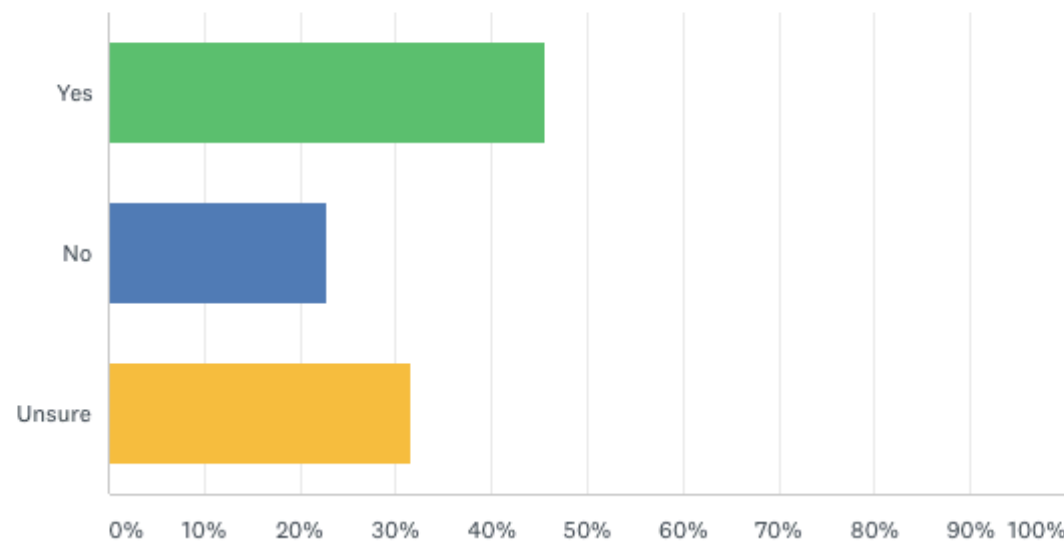
### Robotic Surgery:

Robotic surgery is becoming more prevalent in the industry and many newer physicians are being trained to use them for specialty procedures during medical school and their internships. Some rural hospitals are finding they are unable to recruit specialists who are trained and rely on these machines. There are concerns about how patients, as well as physicians, would feel about bringing these services to Juneau.

When asked, “Would you be open to having a robot used for a surgery performed on you or a loved one?” 45% of the respondents said yes, 32% were unsure, and 23% said no.

Would you be open to having a robot used for a surgery performed on you or a loved one?

Answered: 250 Skipped: 3



### Supportive Services:

When asked about how people felt about the supportive services BRH provides to their patients, the top five services where BRH was doing well were as follows.

1. Follow-up /Discharge Planning
2. Referral to Other Locations
3. Health Education
4. Help Understanding Recommended Medical Care
5. Care Management

However, there were areas where BRH could improve. These areas include:

1. Bariatric Services
2. Translation
3. Help With Enrollment Services for Medicaid
4. Medical Supplies For In Home Use
5. Transportation

Transportation issues were multifaceted with difficulties coming to Bartlett from surrounding areas because the Governor of Alaska has cut funding for the Ferry. This has made transportation difficult for some people.

The second area of transportation concerns dealt with Air Transport from Juneau to outside hospitals that can better serve certain healthcare needs. Juneau has three separate transportation companies each requiring an annual fee. These companies take shifts to fly people out when needed. Juneau residents are concerned the transporter they have chosen may not be the on duty service when they need it.

### **Demographic Services:**

When looking at areas BRH does well in servicing the health needs of the community, positive results were seen in the following categories:

1. Adults
2. Children
3. Women Of Child Bearing Age
4. People Eligible for Medicare / Seniors
5. Schools

However, there are a few groups where the community felt needs were not being met. Those groups included:

1. Transgender Community
2. People with no insurance
3. The Homeless
4. People with Behavioral Health Needs and Substance Abuse Issues
5. People with minimal insurance

When asked what aspects of healthcare are most important to the community, it was interesting to see the perspective of the people of Juneau. The top five most important areas to the residents revolved mostly around taking charge of their own health. They were:

1. Access to healthy foods
2. Scheduled Appointments
3. Urgent Care
4. Convenient Pharmacy
5. More active care management by your primary care practitioners

### Barriers to Using BRH:

When asked if there were barriers to using BRH only 29% of the respondents said there were. The top two reasons they gave were Cost and the availability of Specialist. However, when asked where people had actually received care in the last 24 months, the main reasons for getting care outside of BRH or its clinics were because of lack of specialties at BRH. Cost was the least common answer.

When asked in what areas the people of Juneau would like additional information and learning to help them stay healthy, Addiction Recovery and Substance Abuse took the top two position. They were followed by Depression and Anxiety, Diet and Nutrition, with Smoking/vaping rounding out the top 5.

	HIGHLY APPLICABLE	APPLICABLE	NOT APPLICABLE	TOTAL
▼ Addiction Recovery	56.31% 125	18.02% 40	25.68% 57	222
▼ Substance Abuse	57.34% 125	19.72% 43	22.94% 50	218
▼ Depression or Anxiety	55.36% 124	28.57% 64	16.07% 36	224
▼ Diet/Nutrition	44.59% 99	41.89% 93	13.51% 30	222
▼ Smoking/Vaping	45.41% 99	28.44% 62	26.15% 57	218



**Bartlett Medical  
Oncology  
Center: Bringing  
the best cancer  
treatment to  
Southeast Alaska.**

# **IMPLEMENTATION PLAN**

Senior Leadership reviewed the results of the survey in order to create a structured Implementation plan. During this meeting several areas of concern were identified as areas BRH would like to explore as they prepare for an upcoming strategic planning session. These areas, as well as the physician analysis will be discussed in the upcoming strategic planning session this spring.

## **Enhance Patient Navigation:**

Residents mentioned they would like more help in navigating their healthcare. This included educating the population around what to do when they have a condition and how to work with the BRH, their Insurance Company and what to do once they are released.

## **Getting the right Physician/Specialist mix:**

BRH will be working with the local physician group to review the physician assessment and how those numbers align with the current staffing levels.

## **Develop a faster way for people to move through the ER:**

BRH would like to reduce the time in the ER and become more efficient in dealing with wait times and service there.

## **Dealing with the 5% cut on medicaid payments:**

The State of Alaska has cut 5% in reimbursements from medicaid. This loss can negatively affect the organization's ability to support programs that don't cover their cost.

## **What to do about state employee cutbacks/less insured people**

With cutbacks in government employees, fewer people have insurance. This has had a negative effect on the hospital. BRH is looking into what if anything can be done to prepare for such cutbacks and loss of covered people.

## **Ferry and Air Evacuation transportation issues.**

Transportation can be an issue in remote areas. The government has cut back on the number and frequency of Ferry Transportation to Juneau. In the CHNA survey people from BRH's Secondary Service Area expressed concern they were not able to



get to BRH for services. In addition, survey participants mentioned they would like to see a better solution for Air Evacuation issues. Maybe with a program that covers all carriers.

### **Partner with state on health plans for employees and retirees**

BRH would like to explore with the State what can be done to help employees and retirees keep their health insurance.

### **Mental Health/Behavioral Health**

Even though BRH has a fairly robust Mental Health Program and is building a new facility to assist both adults and teens. They would like to ensure the needs of the community are covered and that the community is aware of what is offered.

## **REVISIONS TO PHYSICIAN RECOMMENDATIONS**

In 2015 BRH hired MJ Philps and Associates to conduct a Hospital Development Plan for Medical Staff and Hospitalists. This report was designed to give a better understanding of the staffing needs at Bartlett Regional Hospital based on population and a number of widely accepted physician to population ratios. This report identified a number of areas where BRH could modify their existing staffing models and better meet the population models.

Cycle of Business took the MJ Philps Study and compared the identified staffing needs to the feedback on the Community Health Needs Assessment Survey. This was done to ensure the recruiting efforts were focused on staffing that met population needs as well as the specific health needs of BRH's primary and secondary service areas.

Recommended physician to population ratios were reviewed based on the same studies used for the Michael Philps Study of 2015. Declining populations also impacted the number of physicians needed at BRH.

These numbers were then matched to survey information as well as data from BRH databases to calculate the correct physician mix. BRH and Cycle of Business also addressed the prioritization of specialty need in an effort to bring in the right services first.

Other options such as Telehealth and Traveling Physicians were also discussed as strategies to meet the current and upcoming needs of the population.

## **FINAL PRESENTATION TO BOARD**

Senior Leadership met to review the information from the CHNA survey. This information outlines the wants and desires of the community. It gave insight into areas the respondents considered were important to the health of the community. However, there were areas of concern that weighed heavily on the community that may not have been as wide spread of a concern as the CHNA survey made them out to be. These false positives were a result of recent government cutbacks coming directly from the Governor's office. Before taking information that may have been disproportionately influenced by recent news stories, the results of the survey were matched against data from the hospital. This allowed BRH to take the most important topics directly to the board for consideration and allowed BRH to focus their energies on the right areas.

The Final presentation to the board will be given after the Senior Leadership team has had a chance to review and create a recommended implementation plan. Additional steps will be taken to convert the more general action plan to more specific actions during the Strategic Planning session planned for Spring of 2020.

## **PART B: UPDATED PHYSICIAN ANALYSIS**

### **BACKGROUND:**

In 2015 Bartlett Regional Hospital contracted with Michael J Philps & Associates to analyze the number of physicians currently working with BRH. The purpose of this study was to ensure the correct level of staffing to handle the healthcare needs of the community. Recommended levels of physicians by specialty were based on ratios of physician per 100,000 residents and then adjusted based on the population of the BRH primary service area.

Cycle of Business has revisited those numbers and that methodology and revised the numbers accordingly. Some specialties BRH is currently offering were not included in the original analysis. COB has added those specialties to the current analysis and included

recommended staffing based on current nationally accepted staffing levels. Adjustments were made in the formulas to scale appropriately. Finally the specialists were given a staffing relevance ranking based on the level of concern stated in the Community Health Needs Assessment. This allows BRH to prioritize the recruiting efforts of staff based, not only on the shortage of physicians but also on the wants of the community.

## **CONSIDERATIONS:**

The levels stated in this survey are based on current levels. In 2015 the projected staffing, numbers were based on expected population for the year 2020. During the last 4 years the population of Juneau Borough has not grown according to expected growth rates. In fact, the population has decreased slightly. As a result COB has recommended staffing to current population and not for growth.

When calculating staffing levels this year, several organizations that project physician numbers have adjusted their 2015 calculations for what the appropriate staffing levels should be as of 2019. Those numbers have been modified for 2019 when calculating blended averages. Even though the same companies were used where possible, the recommended numbers of those companies varied slightly. COB also found in some cases there were no updated numbers for certain specialties.

A few points to mention are around Oncology and Geriatrics. These specialties are focused mainly on the elderly. Therefore, the blended averages were also multiplied by the percent of the population most effected to get a better idea of how many physicians to consider. In the case of Juneau, 28% of the population are 60 or older. Once the blended averages were reached, 28% of those numbers were used as the recommended number of physicians needed based on appropriate demographics.

## **CALCULATING PHYSICIAN STAFFING AVERAGES:**

Exhibit 1 is designed to give a blended average of physicians required given the population size of BRHs primary service area. The numbers used were based on the 4 sources used in 2015. For some specialties recommended numbers were not available from the original sources, and therefore COB utilized the numbers available to them from other sources. In those cases the recommended ratio was placed in the Solucient column in Exhibit 1.

An area that needed special consideration was the right staffing levels based on current mix of Family Medicine physicians vs OB/GYN. All national numbers were based on OB/GYN levels. BRH has several Family Medicine physicians that also do OB work. They have only

one physician who specializes in Obstetrics and Gynecology. Current physician levels confirm that BRH has more than enough physicians to fill Family Medicine positions. For the size of the Primary Service Area , between 10.0 and 13.5 Family Medicine physicians are recommended. BRH currently has a total of 19 FTEs in this category. On the other hand, for the population size, 3.5 to 4.7 OB/GYN physicians are recommended. BRH currently has 1 physician who specializes in OB/Gynecological work. Therefore it might make sense to replace retiring Family Medicine physicians with OB/GYNs in order to balance the mix. (See Exhibit 2)

In the case of certain specialties, the numbers of specialists were difficult to find. Also in the case of specialties like Geriatrics and Oncology, the specialty is either exclusively or primarily used by the elderly. The rationale for the numbers presented in these specialties are explained in the appendix.

## **PHYSICIAN DEFICITS AND OVERAGES:**

Bartlett Regional Hospital wanted to see where the community had appropriate resources and where they had deficits. Recommended staff levels were calculated and compared to current FTEs in order to decide where to focus efforts. Information from the CHNA was also reviewed in order to help prioritize areas where the community might have needs waiting to be filled.

A unique characteristic is the population adjustments needed for the tourist months. Juneau is a port on many Alaskan Cruise lines. This leads to the population increasing dramatically over those months. For 6 months out of the year an addition 11,111 people per day are coming to the area. This brings its own set of problems, one of which is staffing for potential illnesses that may occur.

### **Exhibit 1: Physician Calculations**

COB calculated the physician staffing levels based on non-tourist season populations as well as tourist season populations in order to get a better idea of what the levels of staffing should be. They are also reflected in Exhibit 2 above.

## **NEXT STEPS:**

BRH will discuss the staffing levels with the physician groups covering the area, to decide on correct staffing. They will discuss the areas that showed up in the CHNA as levels of

### Calculation Of Physical Ratios Blended Averages For Seasonal Changes

	Academy Physicians	GMENAC	AMA	Solucient	Blended Average	By Population of Juneau in off Season	By Population of Juneau in Tourist Season	Off Season Staffing	Tourist Season Staffing
<b>Anesthesiology</b>	7.0	9.1	13.4		9.8	31.754%	42.865%	3.1	4.2
<b>Cardiology</b>	1.0	3.2	7.3	4.2	3.9	31.754%	42.865%	1.2	1.7
<b>Dermatology</b>	2.0	2.9	3.7	3.1	2.9	31.754%	42.865%	0.9	1.3
<b>Emergency Medicine</b>	2.7	5.5	9.3	12.3	7.5	31.754%	42.865%	2.4	3.2
<b>Family Medicine</b>	40	25.2	38.3	22.5	31.5	31.754%	42.865%	10.0	13.5
<b>Family Practice / OB</b>	9.1	9.9	14.7	10.2	11.0	31.754%	42.865%	3.5	4.7
Gastroenterology	2.0	2.7		3.5	2.7	31.754%	42.865%	0.9	1.2
<b>General Surgery</b>	10	9.7	13.9	6	9.9	31.754%	42.865%	3.1	4.2
Geriatrics	Numbers unavailable See Appendix for calculations							3.8	5.1
Gynecology	9.1	9.9	14.7	10.2	11.0	31.754%	42.865%	3.5	4.7
Hospitalist			10	4.0	7.0	31.754%	42.865%	2.2	3.0
<b>Internal Medicine</b>	12.8	28.8		19	20.2	31.754%	42.865%	6.4	8.7
<b>Nephrology</b>		1.1	2.6	0.7	1.5	31.754%	42.865%	0.5	0.6
Neuro Surgery	1	1.1	1.9		1.3	31.754%	42.865%	0.4	0.6
<b>Neurology</b>	1.3	3.4	5.0	1.8	2.9	31.754%	42.865%	0.9	1.2
Oncology	2.5	3.7		1.08	2.4	31.754%	42.865%	0.8	1.0
<b>Opthamology</b>	5.0	4.8	6.5	4.7	5.3	31.754%	42.865%	1.7	2.3
<b>Orthopedic Surgery</b>	3.3	6.2	8.6	6.1	6.1	31.754%	42.865%	1.9	2.6
<b>Otolaryngology</b>	2.0	3.3	3.5	2.8	2.9	31.754%	42.865%	0.9	1.2
<b>Pathology</b>	4.1	6.5	6.1		5.6	31.754%	42.865%	1.8	2.4
<b>Pediatrics</b>	7.3	15	18.4	13.9	13.7	31.754%	42.865%	4.3	5.9
<b>Plastic Surgery</b>	2.0	1.1		2.2	1.8	31.754%	42.865%	0.6	0.8
Podiatry				4.9	4.9	31.754%	42.865%	1.6	2.1
Psychiatry	10	23.2	13.6	6.3	13.3	31.754%	42.865%	4.2	5.7
<b>Pulmonologist</b>	1.0	1.5	3.5	1.3	1.8	31.754%	42.865%	0.6	0.8
Radiation Oncology*			1.28		1.3	31.754%	42.865%	0.4	0.5
<b>Radiology</b>	8.0	8.9	11		9.3	31.754%	42.865%	3.0	4.0
<b>Urology</b>	3.3	3.2	3.7	2.9	3.3	31.754%	42.865%	1.0	1.4

concern with the population. They will also look at what specialties they are seeing that are currently being referred outside of the area for services. In deciding on the proper specialty — patient — population ratio, BRH will be able to better meet the demands of the community.

Once the staffing levels are decided, BRH will need to look deeper into the feasibility of certain roles and staffing levels. This will be part of the Strategic Planning sessions planned for spring of 2020.

BRH Medical Staff With Work Adjustments, Consulting And Retirement									
Physician Priority from CHNA	Specialty	BRH Medical Staff FTEs	FTEs with Work Adjustment & Consulting	Physicians Over Age 61	FTEs With Work Adjustment, Consulting & Retirement	Recommended Staffing levels Non Tourist Season	Recommended Staffing levels Tourist Season	Physicians Needed (Non Tourist Season)	Physicians Needed (Tourist Season)
	Anesthesiology	4	3	1	2	3.1	4.2	1.1	2.2
2	Cardiology	0	0.4	0	0.4	1.2	1.7	0.8	1.3
6	Dermatology	0	0.1	0	0.1	0.9	1.3	0.8	1.2
1	Emergency Medicine	11	8.3	2	6.3	2.4	3.2	-3.9	-3.1
	Family Medicine	3	0	0	3	10	13.5	7	10.5
4	Family Medicine / OB	18	17	1	16	3.5	4.7	-12.5	-11.3
	Gastroenterology					0.9	1.2	0.9	1.2
	General Surgery	5	2.3	2	2.3	3.1	4.2	0.8	1.9
	Geriatrics	0	0	0	0	3.8	5.1	3.8	5.1
	Gynecology	1	1		1	3.5	4.7	2.5	3.7
	Hospitalist	8	6.5	0	6.5	2.2	3.0	-4.3	-3.5
	Internal Medicine	4	3	0	3	6.4	8.7	3.4	5.7
	Nephrology	0	0.1	0	0.1	0.5	0.6	0.4	0.5
	Neuro Surgery					0.4	0.6	0.4	0.6
7	Neurology	0	0	0	0	0.9	1.2	0.9	1.2
	Oncology	3	1	2	-1	0.8	1.0	1.8	2.0
	Ophthalmology	0.5	0	0	0.5	1.7	2.3	1.2	1.8
3	Orthopedic Surgery	5	5	0	5	1.9	2.6	-3.1	-2.4
	Otolaryngology	0.2	0.2	0	0.2	0.9	1.2	0.7	1.0
	Pathology	2	1.4	1	0.4	1.8	2.4	1.4	2.0
5	Pediatrics	3	3	0	3	4.3	5.9	1.3	2.9
	Plastic Surgery	0	0	0	0	0.6	0.8	0.6	0.8
	Podiatry	1	0.5	0	0.5	1.6	2.1	1.1	1.6
	Psychiatry	3	3	0	3	4.2	5.7	1.2	2.7
	Pulmonologist	0	0	0	0	0.6	0.8	0.6	0.8
	Radiation Oncology*	1	1	0	1	0.4	0.5	-0.6	-0.5
	Radiology	3	2.4	0	2.4	3.0	4	0.6	1.6
8	Urology	1	0.5	0	0.5	1.0	1.4	0.5	0.9

Exhibit 2: Physician Staffing Report



## APPENDIX

Rationale for numbers.

**Geriatrics:** This was a difficult number to find. None of the reference studies had calculated for geriatrics. COB was able to find a US News and World Report article in which the American Society of Gerontology gave some statistics. These were that about 30 percent of the 65 and older patient population will need a geriatrician and that one geriatrician can care for 700 patients. Given the population of Juneau during tourist season and the off season, COB calculated the needed geriatrician numbers as follows.

Calculation for Gerentologists				
Population of Juneau / Season	Percent of population considered Elderly	Percent of population likely to use a Geriatrician	Number of patients a Geriatrician can handle in a year	Geriatrician FTE
31,754	28%	30%	700	3.8
42,865	28%	30%	700	5.1
Reference	<a href="https://health.usnews.com/health-news/patient-advice/articles/2015/04/21/doctor-shortage-who-will-take-care-of-the-elderly">https://health.usnews.com/health-news/patient-advice/articles/2015/04/21/doctor-shortage-who-will-take-care-of-the-elderly</a>			

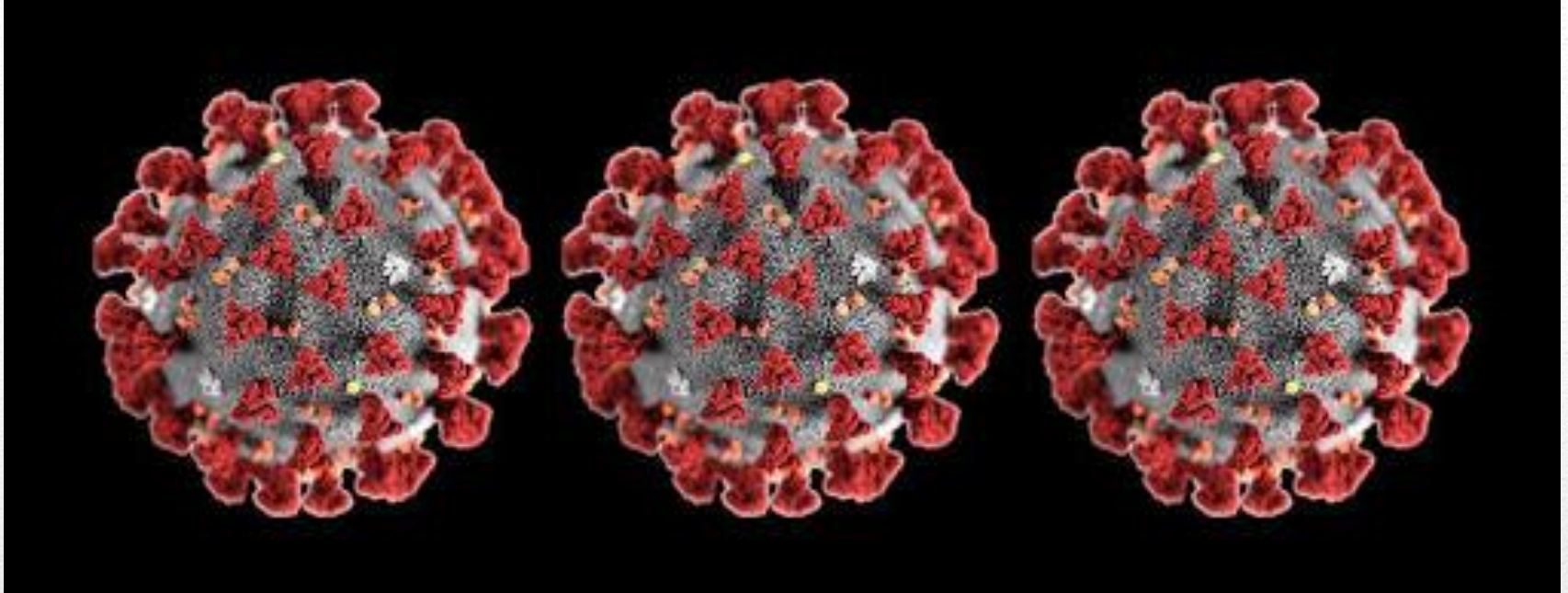
**Radiation Oncology:** COB was unable to find credible numbers for Radiation Oncologists as well. Most of the tables had numbers for a category called Hematology/Oncology. This number was used to for the calculation of Medical Oncologists in our study. However, the only numbers available for Radiation Oncologists were based on the Supply of Radiation Oncologists Rather than the Demand for them. COB then calculated what the supply would dictate based on the the percentage of population likely to get cancer and the percentage of cancer patients likely to use radiation for treatments. In just new patients based on 2020 estimates, Juneau would need a .2 FTE increase to the existing demand. This validated an estimate for Radiation Oncologists as a percentage of the supply side as a starting point and then consulting with the existing oncology practice in Juneau to decide on what would be most appropriate.

Radiation Oncology Calculations					
2020 Expected New Cancer Cases in U.S.	Expected 2020 U.S. population	Percentage of population likely to get cancer	Juneau Population	Number of Juneau residents likely to get cancer	Population likely to Use Radiation Oncologist
1,956,916	333,546,000	0.59%	31,754	186.3	54.0
Patients per Radiation Oncologist per year	FTE for Radiation Oncologist for new patients in 2020				
250	0.2				



**CONDUCTED BY  
CYCLE OF BUSINESS  
2019-2020**

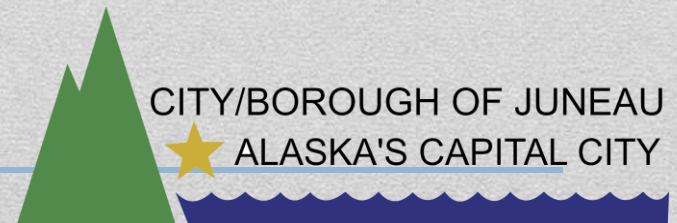




# Bartlett

## Regional Hospital

QUALITY in Community Healthcare™



# COVID-19 Incident Command System (ICS) Debrief and Discussion

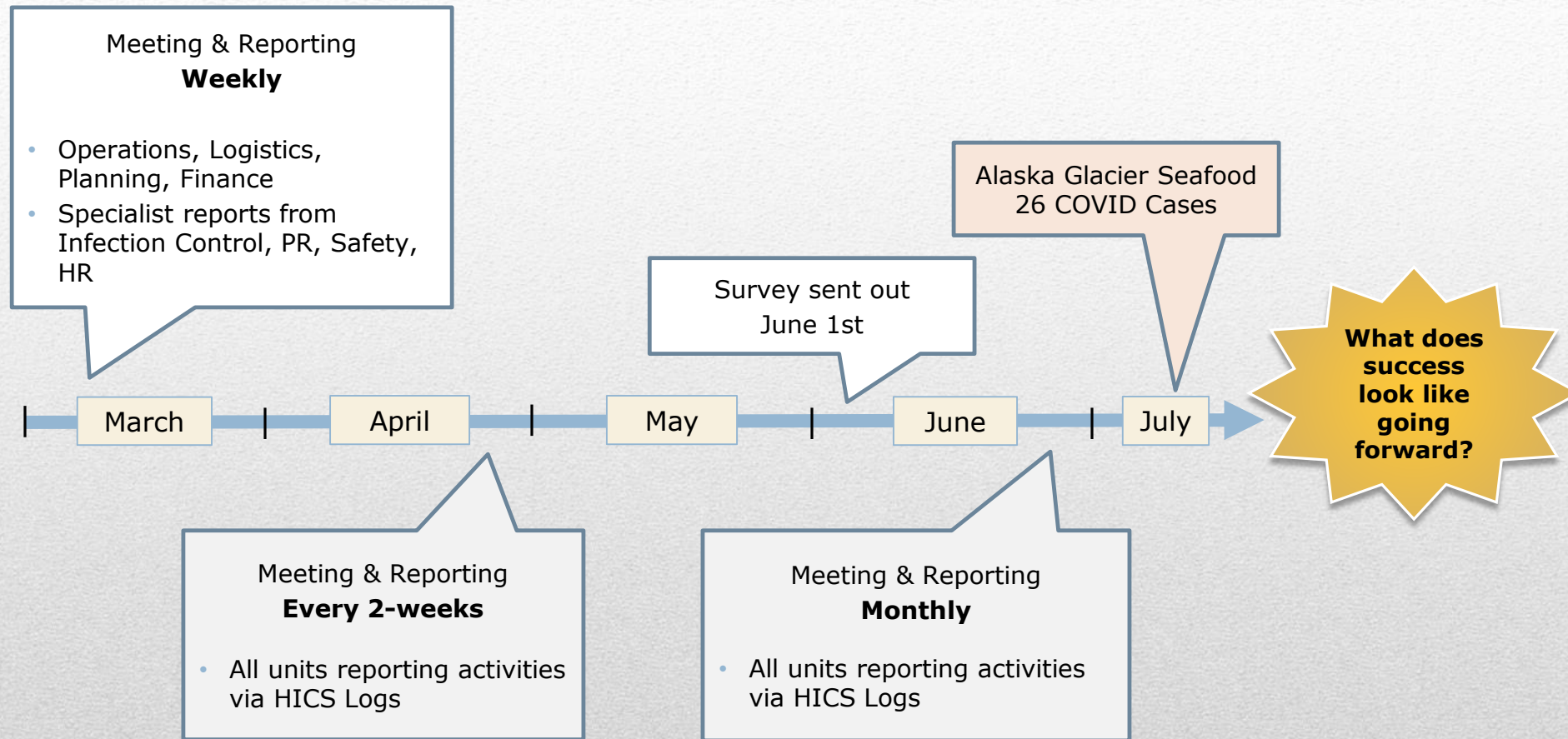
July 22, 2020



- |                                    |         |
|------------------------------------|---------|
| • Timeline of ICS Activities       | 5 mins  |
| • A Collaborative Look at the Data | 65 mins |
| • Comments/Feedback                | 15 mins |

# Agenda

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- Emailed to all Bartlett staff – 15% response rate
  - 100 responses of ~650 active employees
- Response Scale

No not at all	Somewhat disagree	Did not apply to me	Somewhat agree	Agree strongly
---------------	-------------------	---------------------	----------------	----------------

- Main Themes

Communication

Education

Operations

Environment

■ No not at all ■ Somewhat disagree ■ Did not apply to me ■ Somewhat agree ■ Agree strongly

The **frequency** of communication was appropriate to the level of crisis.



**Incident directives** were communicated timely and effectively.



I opened the shared drive and used the **COVID-19 file**.



I feel like my **leader was involved** in my unit based decision making and direction setting.



I found my unit **leader's communication** to be useful and timely.



It felt like many people did talk to each other during the event, avoiding **mixed messages**.



I found the **regular zoom updates** offered by many individuals helpful and informative.



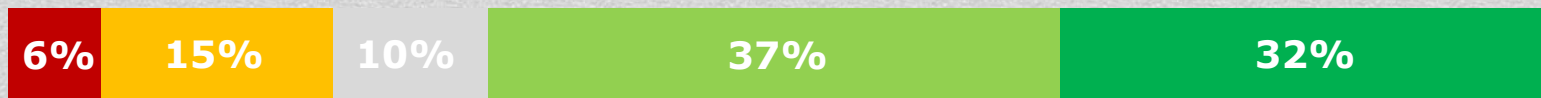
The **labor pool/staffing office** communicated clearly & was easy to interact w/ as a staff member.



The **infection prevention** updates during the crisis were informative, and well put together.



0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%



*Yriel has done a wonderful job communicating to the MHU staff.*

*Jandi and Meghan are rock stars.*

*Audrey did an amazing job keeping us updated.*

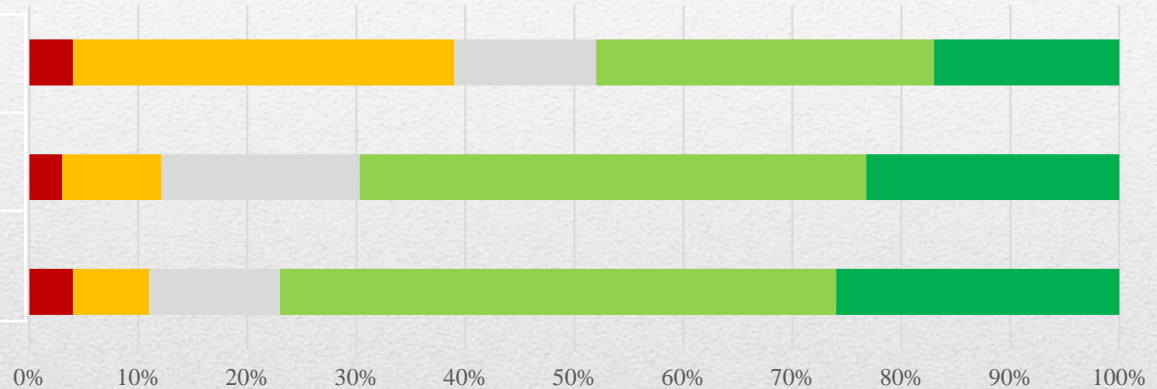


■ No not at all ■ Somewhat disagree ■ Did not apply to me ■ Somewhat agree ■ Agree strongly

The **education was usually on time** or instituted before process change happened on my unit.

The **just in time** education was helpful and informative.

The **types of education materials** suited my learner style.



■ No not at all ■ Somewhat disagree ■ Did not apply to me ■ Somewhat agree ■ Agree strongly

When I voiced a concern, I felt heard and my **needs were addressed**.

I am convinced that **we are prepared** to handle a surge of patients if we were to receive one.

The **efforts to save PPE** were safe and effective.

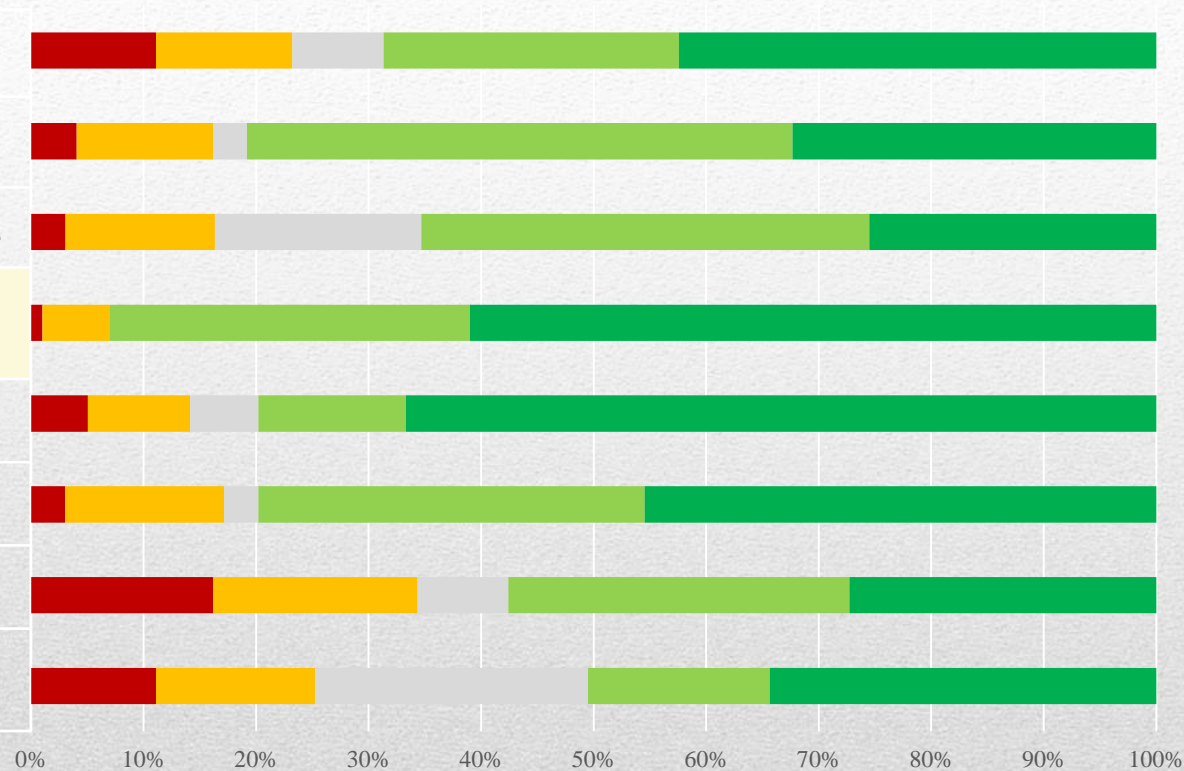
I was impressed by my hospital's **ability to respond** to this event.

I feel the **visitor restrictions** were adequately restrictive.

I had what I needed to **safely do my work**.

I felt like I was **included on decisions** that impacted me or my unit.

I **routinely saw my leader** during this time rounding on my unit.



*Our department director is very collaborative and shows great interest in learning from staff / respect for staff ideas.*

171/195

*I felt visitor restrictions were appropriate!*



■ No not at all ■ Somewhat disagree ■ Did not apply to me ■ Somewhat agree ■ Agree strongly

I was **treated fairly** during this event.

I am **more proud**, now than ever before, to work at Bartlett Regional Hospital.

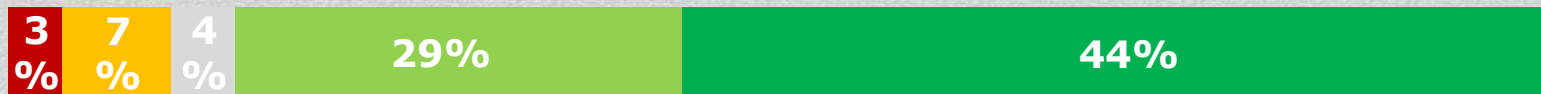
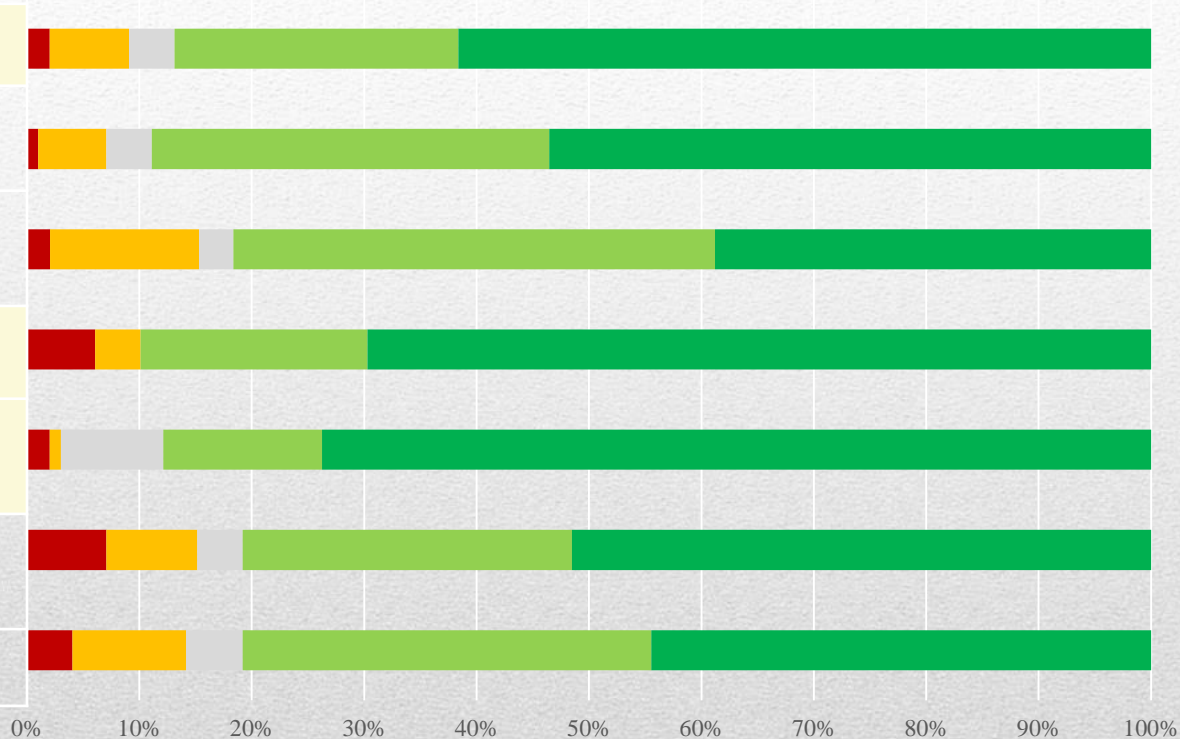
As situation changed, changes were made to the environment that **made sense** to me, kept me **safe**.

The **universal masking policy** made sense to me, and I felt like it was done for my protection.

There were enough **hand washing stations** and **hand gel dispensers** to allow me to wash my hands as needed.

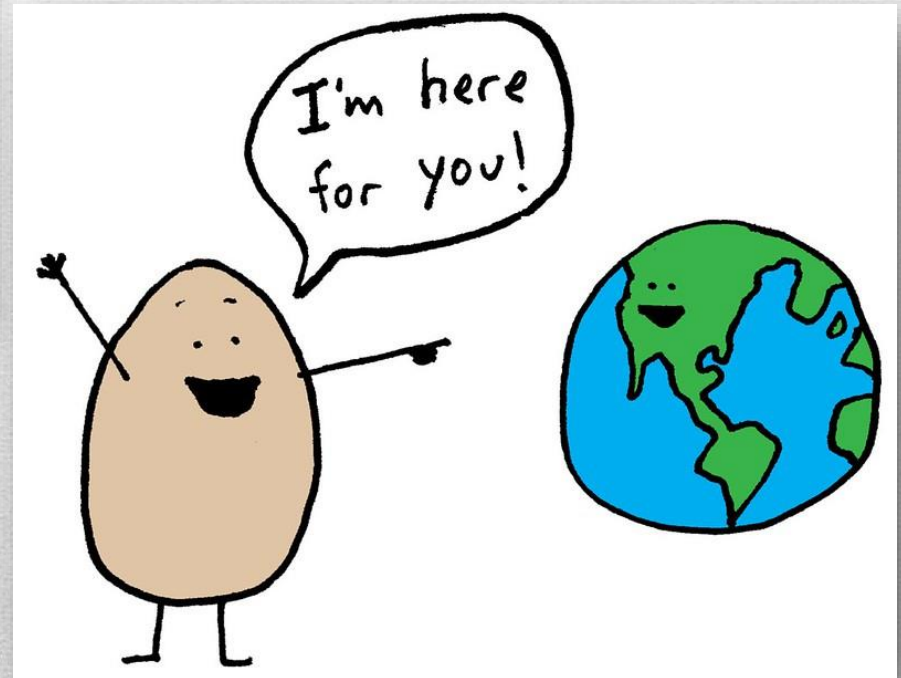
I **felt safe to speak up** about any concern I had regarding patient safety or my personal safety during this event.

Appropriate changes were made in my **physical environment** to keep me as safe as possible.



*I feel so fortunate to work for the BRH family.*

172/195





# Thank YOU!

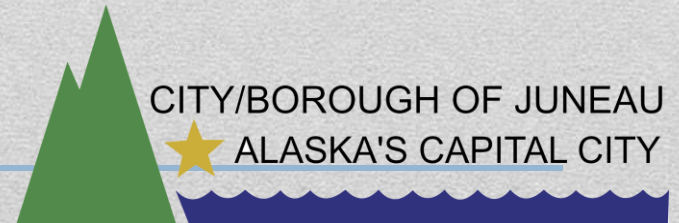
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**Quality in Community Healthcare**

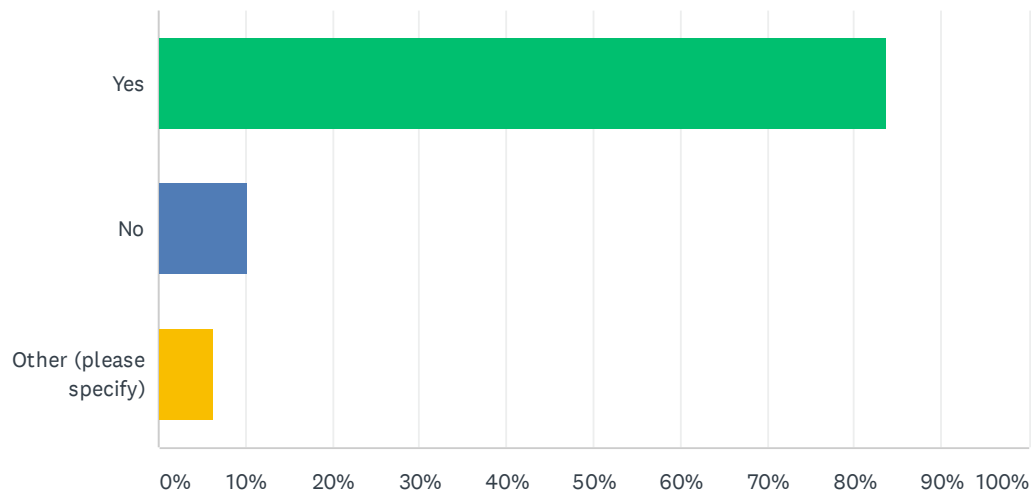
**Right Here in Your Hometown**

**Bartlett**  
**Regional Hospital**



## Q1 In the past 2 weeks, do you feel that Bartlett Regional Hospital has met your needs as an employee?

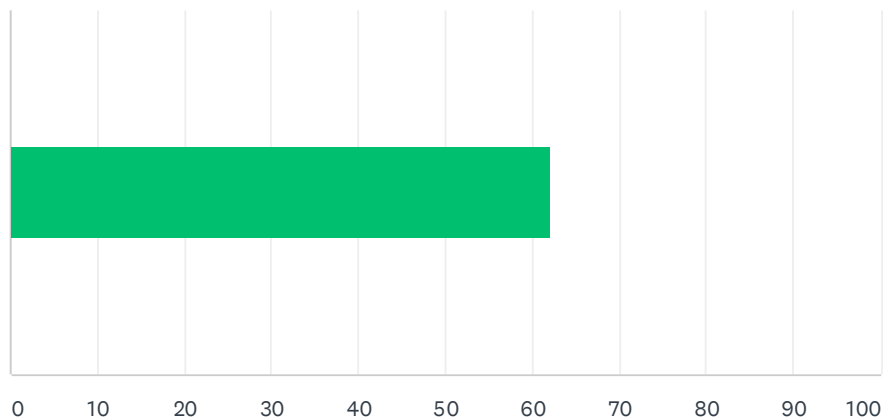
Answered: 226 Skipped: 1



ANSWER CHOICES		RESPONSES	
Yes		83.63%	189
No		10.18%	23
Other (please specify)		6.19%	14
TOTAL			226

## Q2 On a scale of 1-5 (5 being high optimism, 1 being low optimism), rate your level of optimism regarding Bartlett Regional Hospital's ability to handle the expected COVID surge?

Answered: 225 Skipped: 2

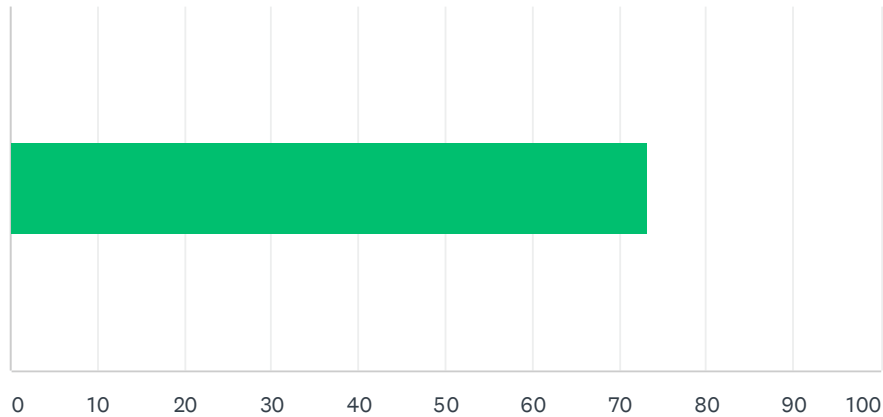


## Employee Health and Well-being Survey

ANSWER CHOICES	AVERAGE NUMBER	TOTAL NUMBER	RESPONSES
	62	13,984	225
Total Respondents: 225			

**Q3 On a scale of 1-5 (5 being most confident, 1 being least confident), how confident do you feel with your employment at Bartlett Regional Hospital?**

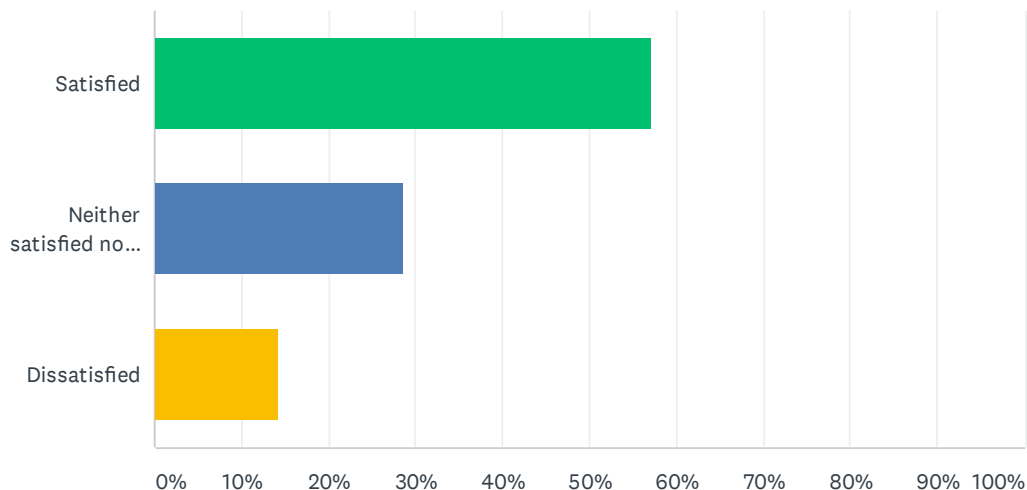
Answered: 226 Skipped: 1



ANSWER CHOICES	AVERAGE NUMBER	TOTAL NUMBER	RESPONSES
	73	16,546	226
Total Respondents: 226			

**Q4 How satisfied are you with communication/the flow of communication from management to frontline staff on COVID-19 information, policies, and resources?**

Answered: 226 Skipped: 1



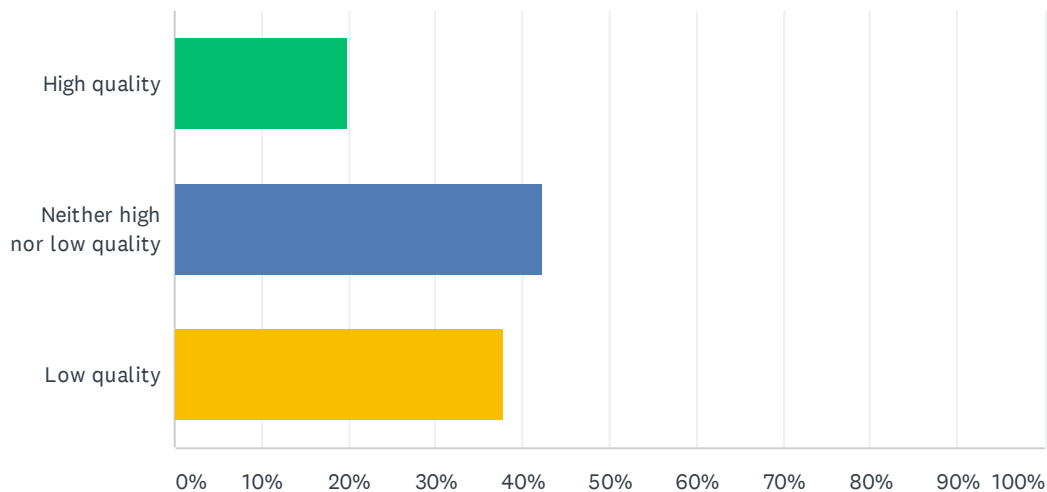


## Employee Health and Well-being Survey

ANSWER CHOICES	RESPONSES	
Satisfied	57.08%	129
Neither satisfied nor dissatisfied	28.76%	65
Dissatisfied	14.16%	32
TOTAL		226

**Q5 In the past 2 weeks, how would you rate your quality of sleep (based on average hours of sleep per night, feeling well-rested, etc.)?**

Answered: 227 Skipped: 0

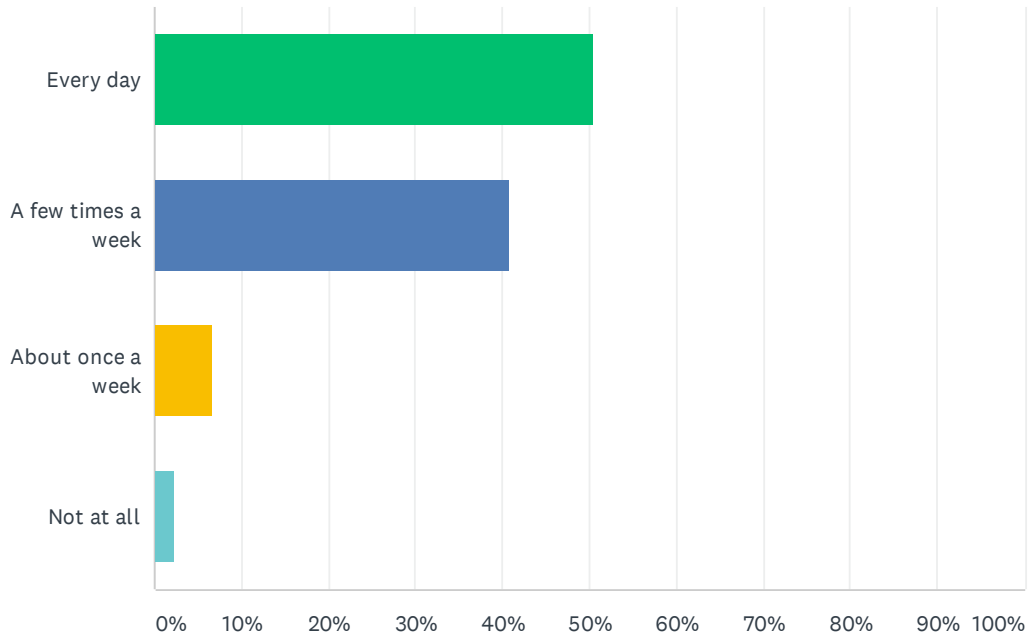


ANSWER CHOICES	RESPONSES	
High quality	19.82%	45
Neither high nor low quality	42.29%	96
Low quality	37.89%	86
TOTAL		227

**Q6 In the past 2 weeks, how often have you been able to eat healthy meals/meet your nutritional needs?**

Answered: 226 Skipped: 1

## Employee Health and Well-being Survey



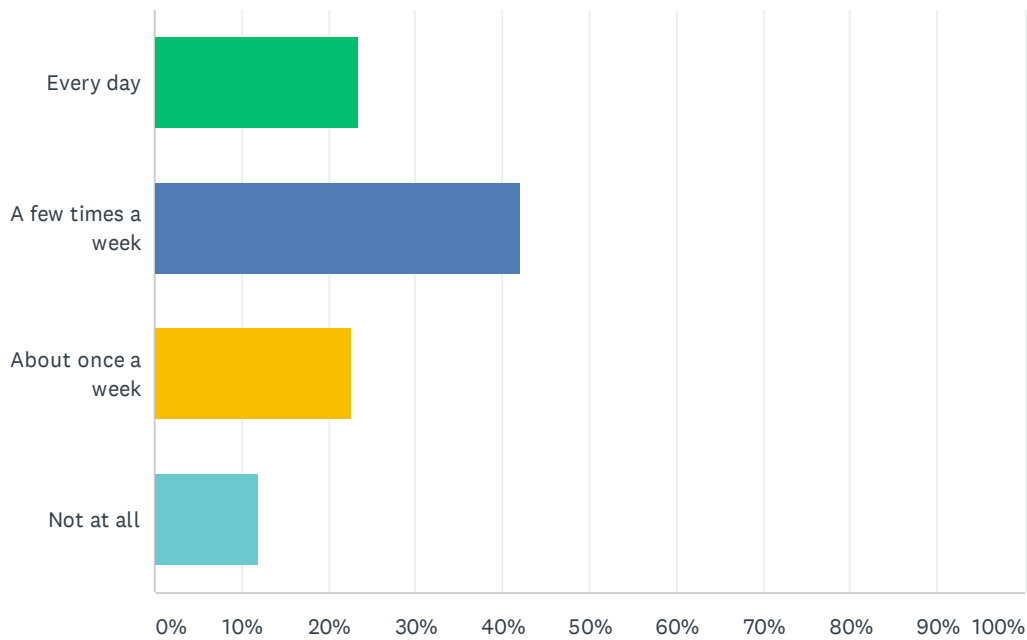
ANSWER CHOICES	RESPONSES	
Every day	50.44%	114
A few times a week	40.71%	92
About once a week	6.64%	15
Not at all	2.21%	5
TOTAL		226

Q7 In the past 2 weeks, how often have you been physically active (through exercise, walking, hiking, etc.)?

Answered: 226   Skipped: 1



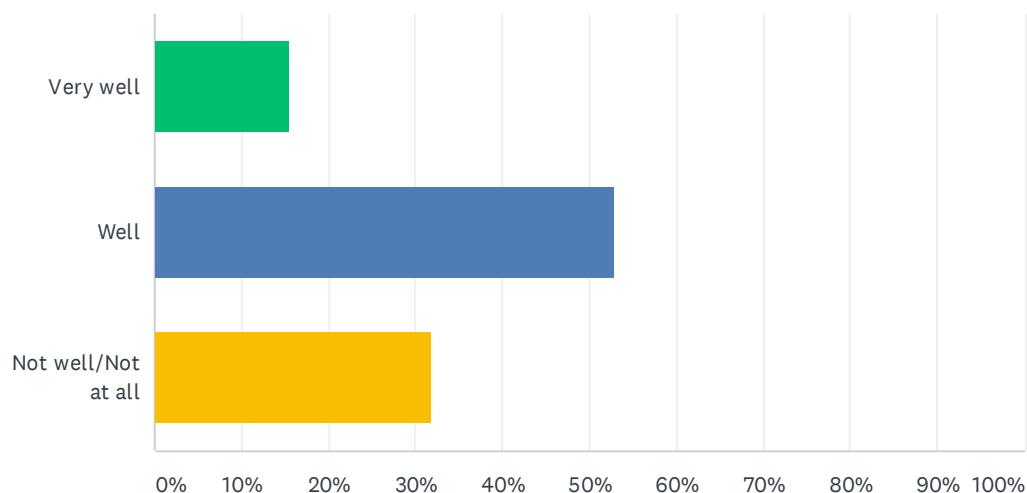
## Employee Health and Well-being Survey



ANSWER CHOICES	RESPONSES	
Every day	23.45%	53
A few times a week	42.04%	95
About once a week	22.57%	51
Not at all	11.95%	27
TOTAL		226

## Q8 How well have you been able to cope/manage your mental health and well-being (such as practicing meditation, guided imagery, other anxiety reduction techniques, etc.)?

Answered: 227 Skipped: 0

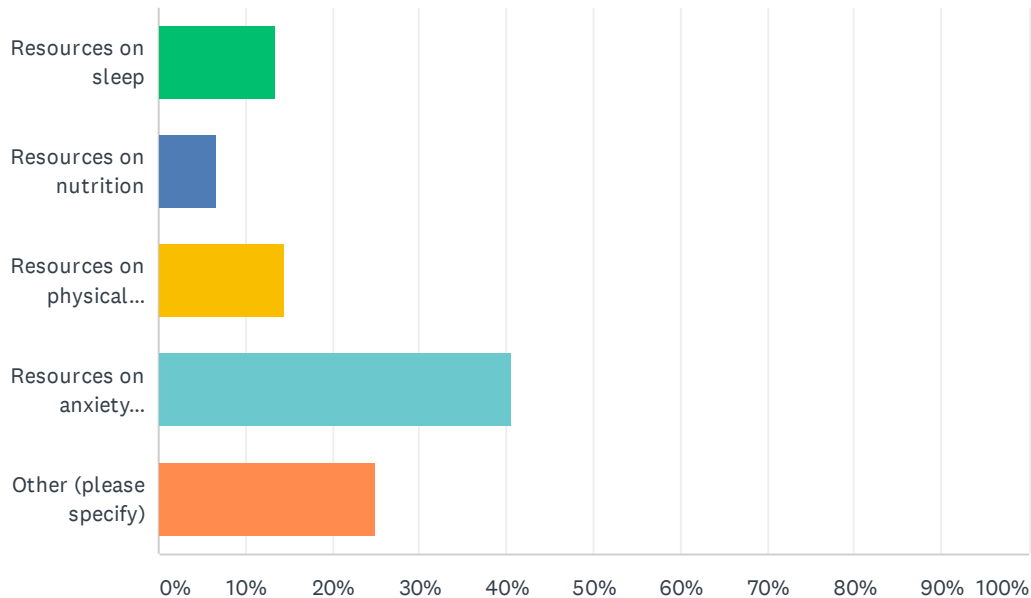


## Employee Health and Well-being Survey

ANSWER CHOICES	RESPONSES	
Very well	15.42%	35
Well	52.86%	120
Not well/Not at all	31.72%	72
TOTAL		227

### Q9 What kinds of resources would be helpful to you during this time?

Answered: 180 Skipped: 47



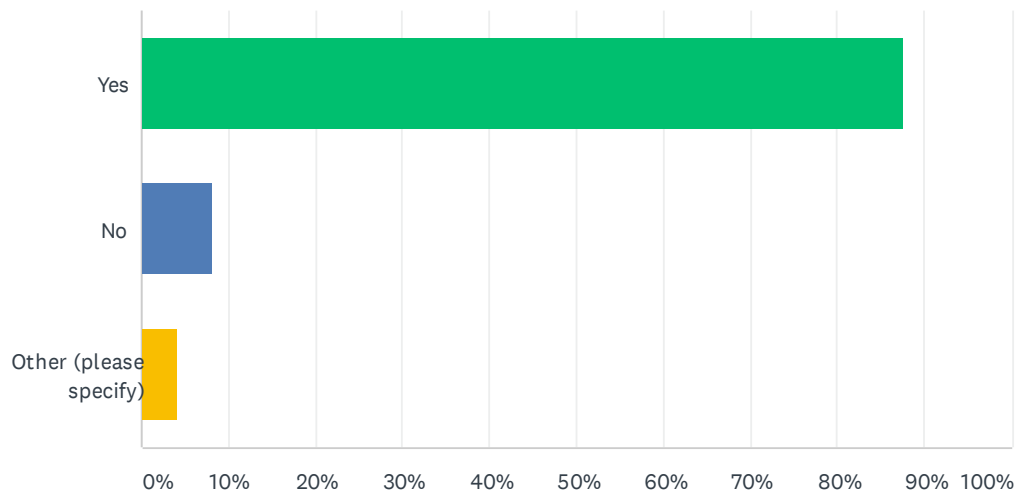
ANSWER CHOICES	RESPONSES	
Resources on sleep	13.33%	24
Resources on nutrition	6.67%	12
Resources on physical activity/exercise	14.44%	26
Resources on anxiety reduction/mental health and wellness	40.56%	73
Other (please specify)	25.00%	45
TOTAL		180

### Q10 If you have thoughts or ideas on employee health and well-being needs and things we could offer, please let us know!

Answered: 61 Skipped: 166

## Q1 Since the initial survey, do you feel that Bartlett Regional Hospital has met your needs as an employee?

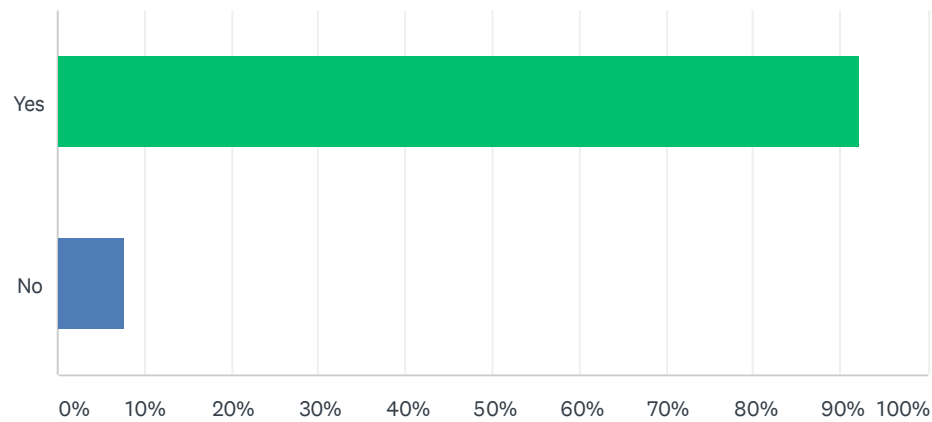
Answered: 147 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	87.76%	129
No	8.16%	12
Other (please specify)	4.08%	6
TOTAL		147

## Q2 Do you feel that Bartlett Regional Hospital will continue to be able to manage the expected COVID surge?

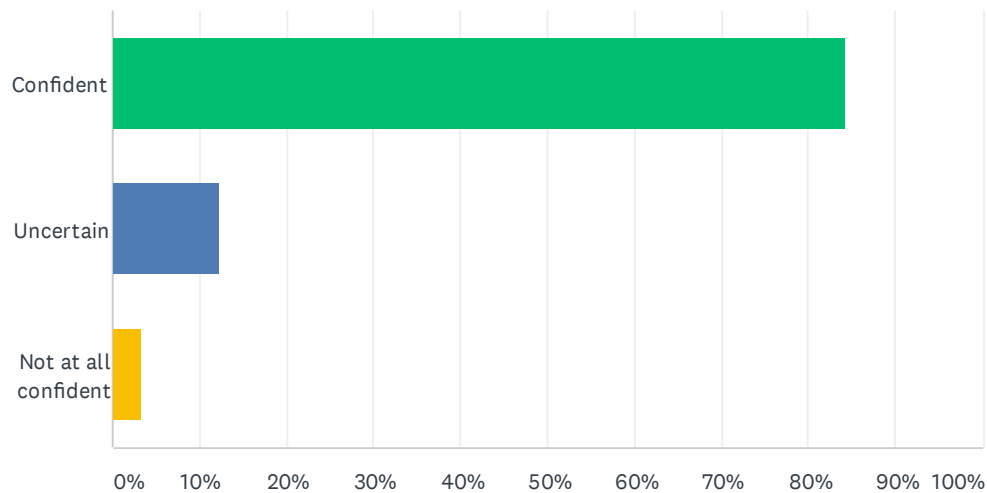
Answered: 144 Skipped: 3



ANSWER CHOICES	RESPONSES	
Yes	92.36%	133
No	7.64%	11
TOTAL		144

### Q3 Since the initial survey, how confident do you feel with your employment at Bartlett Regional Hospital?

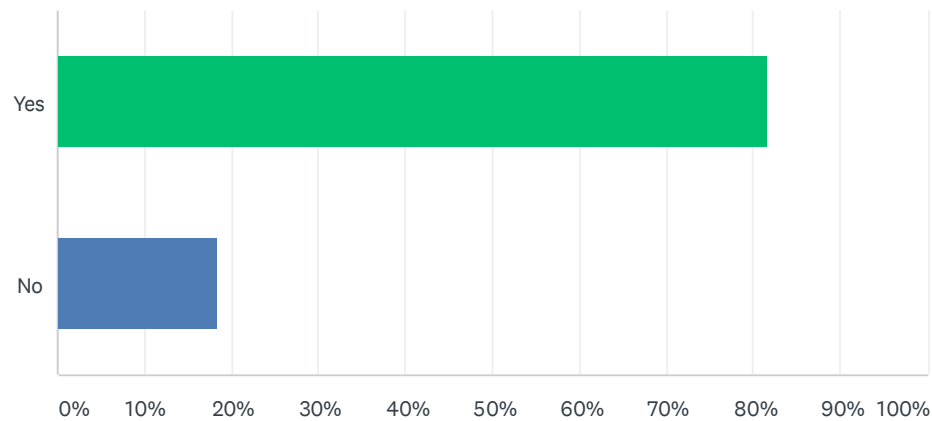
Answered: 146 Skipped: 1



ANSWER CHOICES		RESPONSES	
Confident		84.25%	123
Uncertain		12.33%	18
Not at all confident		3.42%	5
TOTAL			146

# Q4 Since the initial survey, do you feel that communication/the flow of communication from management to frontline staff on COVID-19 information, policies, and resources has improved?

Answered: 147 Skipped: 0

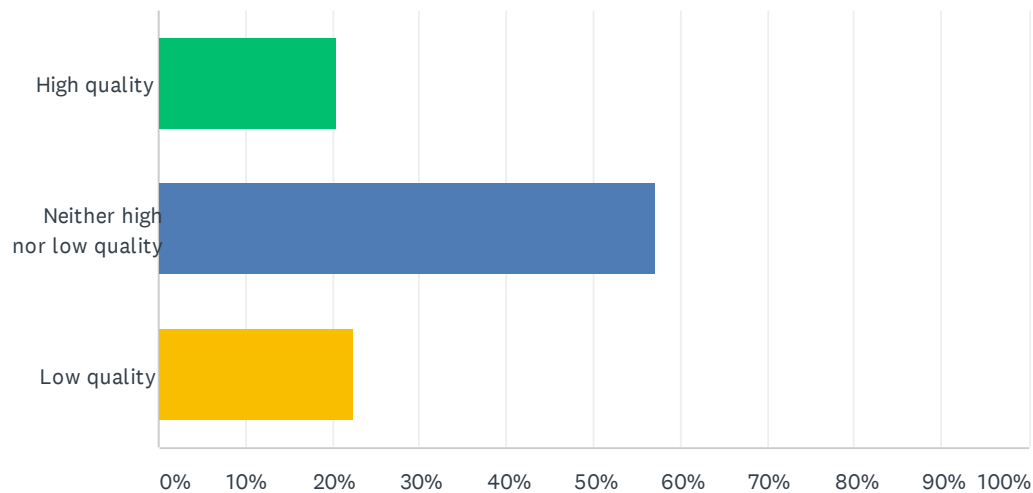


ANSWER CHOICES	RESPONSES	
Yes	81.63%	120
No	18.37%	27
TOTAL		147



## Q5 Since the initial survey, how would you rate your quality of sleep (based on average hours of sleep per night, feeling well-rested, etc.)?

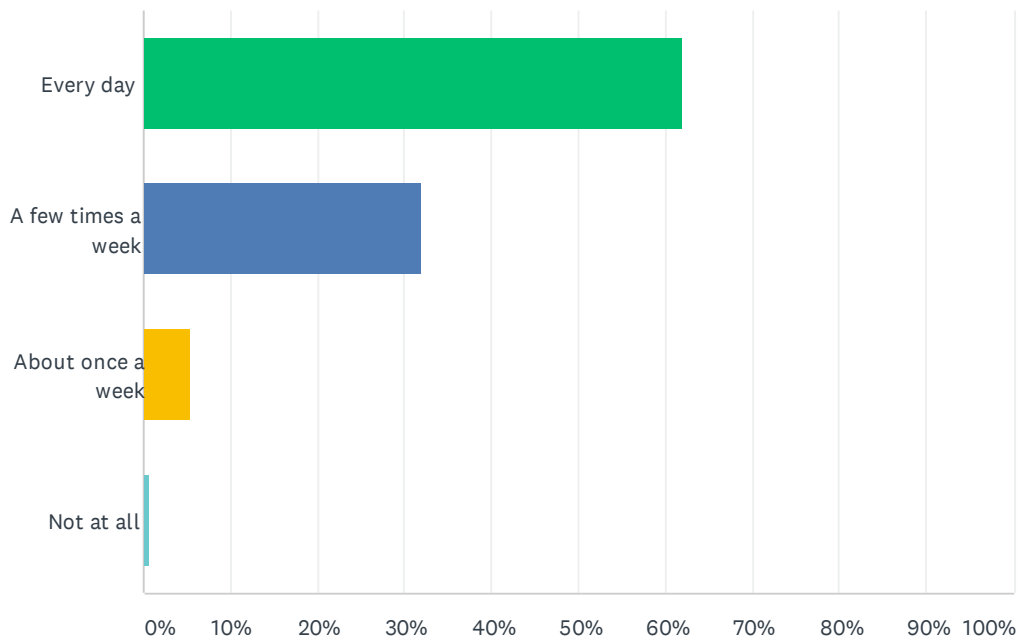
Answered: 147 Skipped: 0



ANSWER CHOICES		RESPONSES	
High quality		20.41%	30
Neither high nor low quality		57.14%	84
Low quality		22.45%	33
TOTAL			147

## Q6 Since the initial survey, how often have you been able to eat healthy meals/meet your nutritional needs?

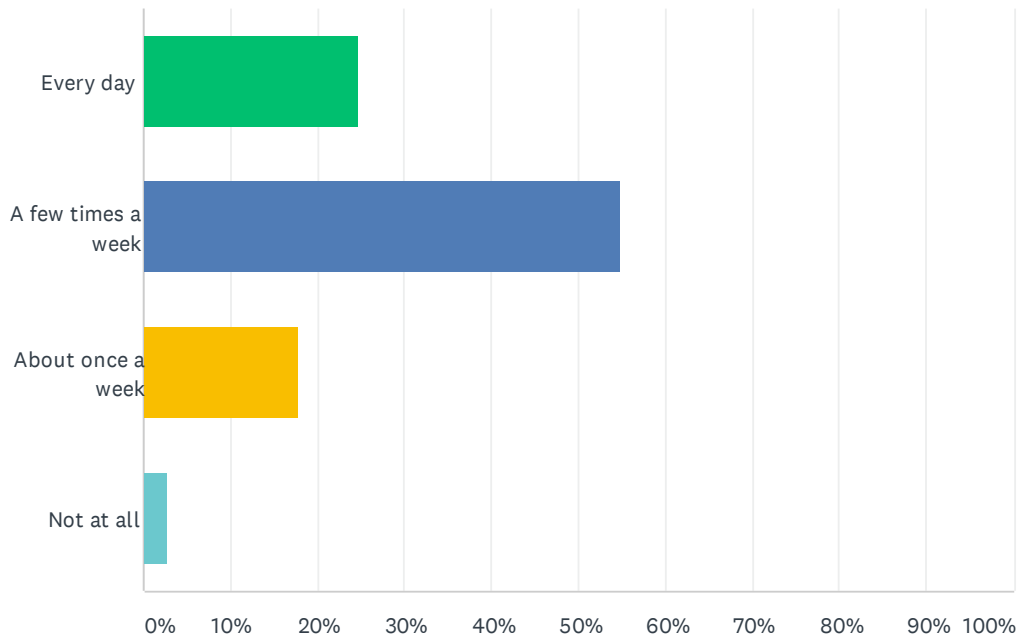
Answered: 147 Skipped: 0



ANSWER CHOICES	RESPONSES	
Every day	61.90%	91
A few times a week	31.97%	47
About once a week	5.44%	8
Not at all	0.68%	1
TOTAL		147

## Q7 Since the initial survey, how often have you been physically active (through exercise, walking, hiking, etc.)?

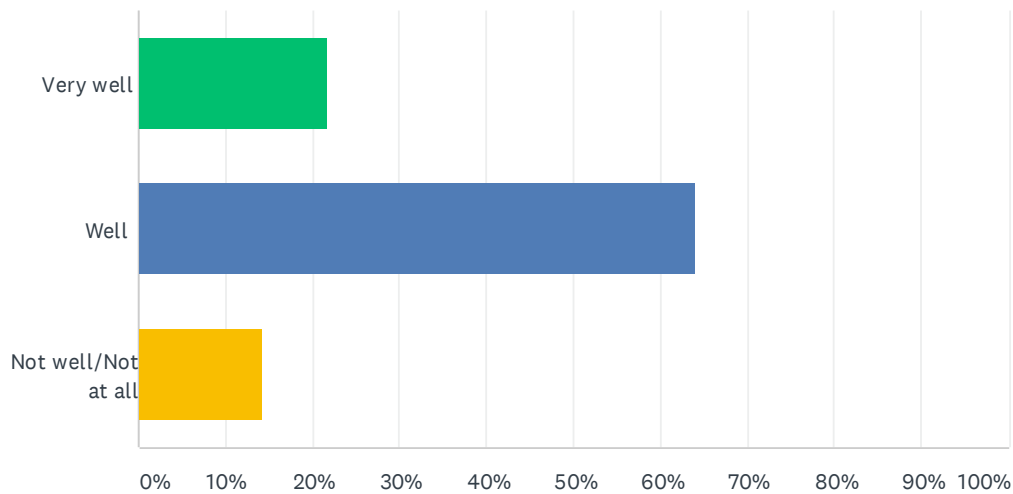
Answered: 146 Skipped: 1



ANSWER CHOICES	RESPONSES	
Every day	24.66%	36
A few times a week	54.79%	80
About once a week	17.81%	26
Not at all	2.74%	4
TOTAL		146

Q8 Since the initial survey, how well have you been able to cope/manage your mental health and well-being (such as practicing meditation, guided imagery, other anxiety reduction techniques, etc.)?

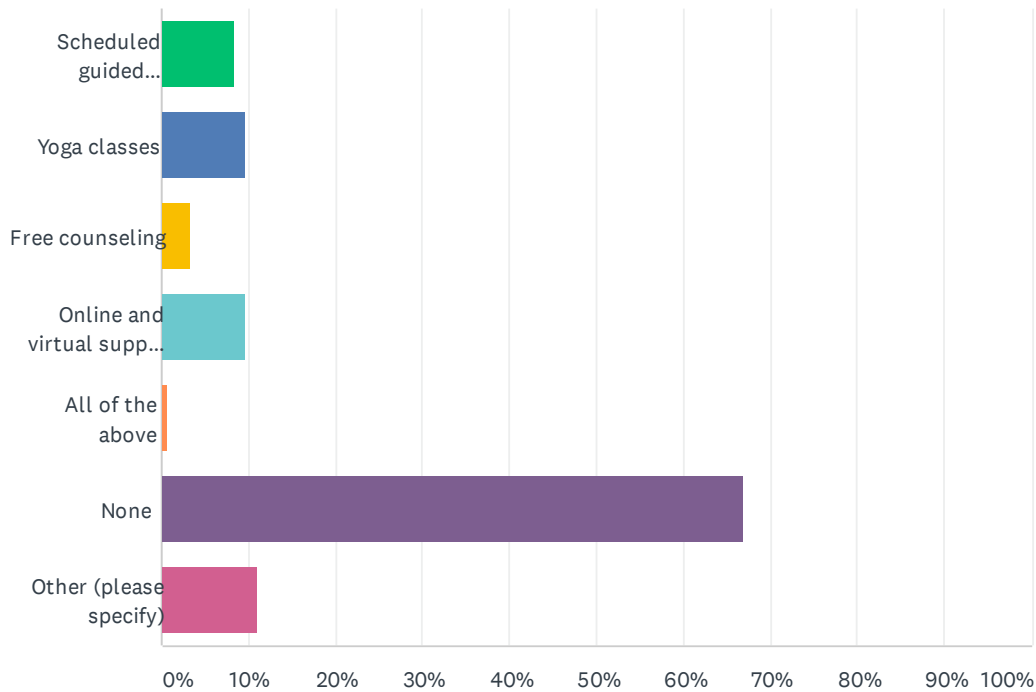
Answered: 147 Skipped: 0



ANSWER CHOICES		RESPONSES	
Very well		21.77%	32
Well		63.95%	94
Not well/Not at all		14.29%	21
TOTAL			147

## Q9 Since the initial survey, which support resources offered have you been using? Check all that apply.

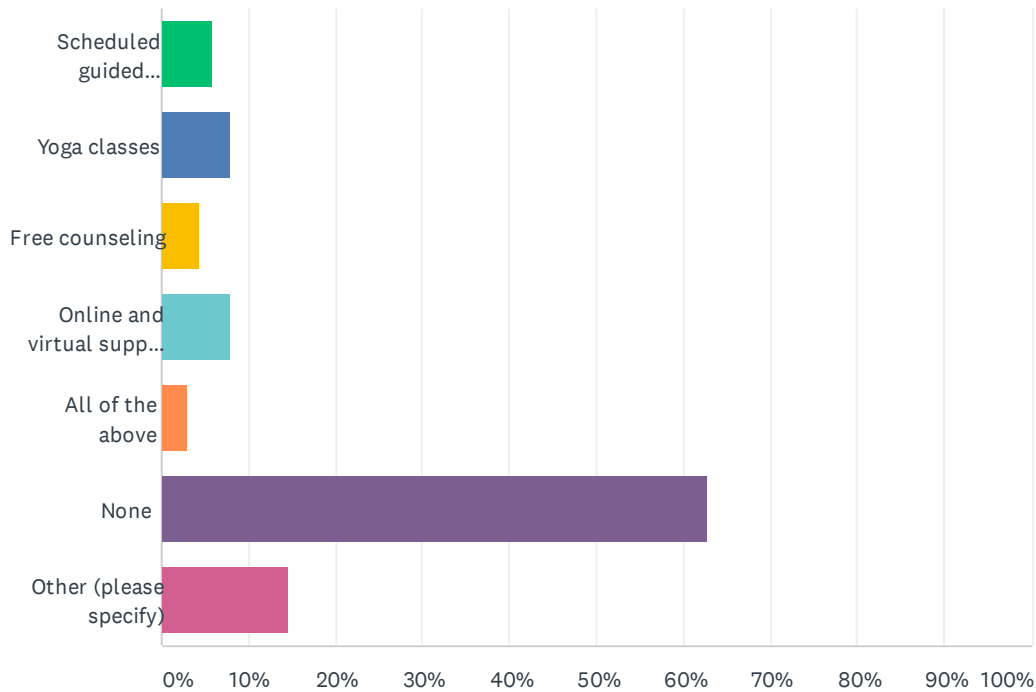
Answered: 145 Skipped: 2



ANSWER CHOICES	RESPONSES	
Scheduled guided meditation	8.28%	12
Yoga classes	9.66%	14
Free counseling	3.45%	5
Online and virtual support resources	9.66%	14
All of the above	0.69%	1
None	66.90%	97
Other (please specify)	11.03%	16
Total Respondents: 145		

## Q10 Since the initial survey, which support resources offered have you have found most helpful? Check all that apply.

Answered: 137 Skipped: 10

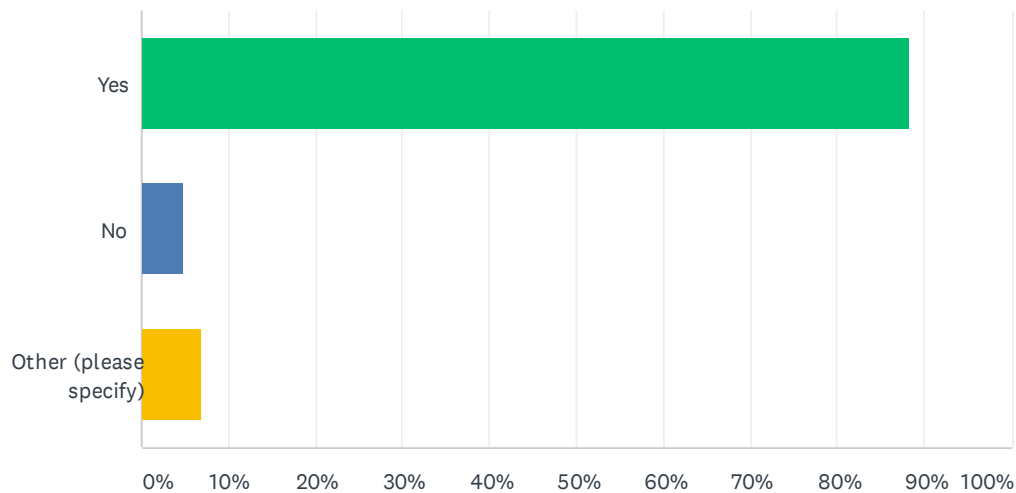


ANSWER CHOICES	RESPONSES	
Scheduled guided meditation	5.84%	8
Yoga classes	8.03%	11
Free counseling	4.38%	6
Online and virtual support resources	8.03%	11
All of the above	2.92%	4
None	62.77%	86
Other (please specify)	14.60%	20
Total Respondents: 137		



## Q11 Do you feel support resources are readily available to you and you know where to find these support resources?

Answered: 146 Skipped: 1



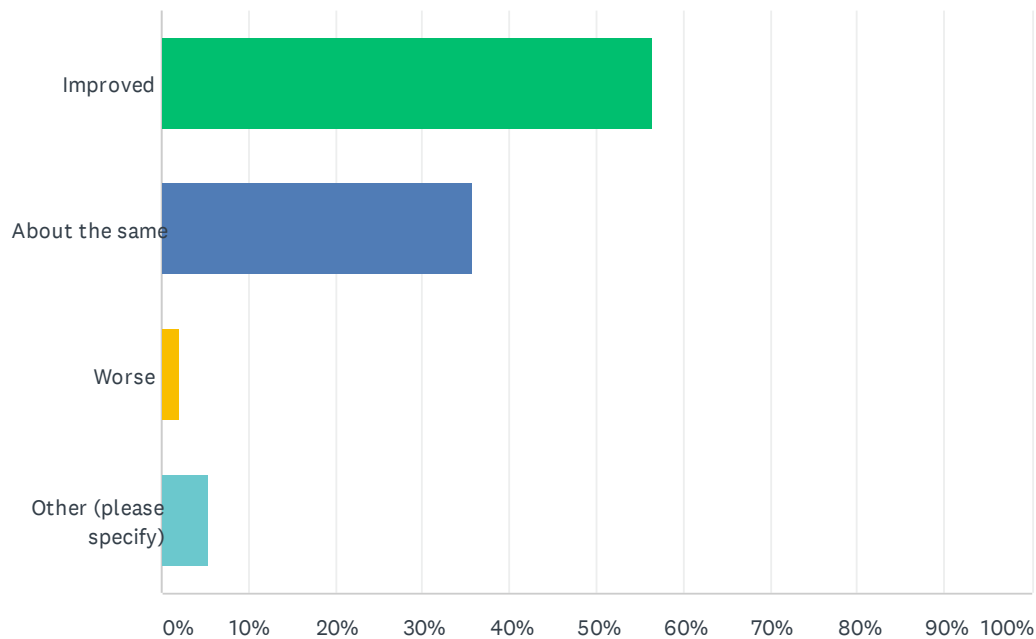
ANSWER CHOICES		RESPONSES	
Yes		88.36%	129
No		4.79%	7
Other (please specify)		6.85%	10
TOTAL			146

**Q12 What ideas do you have regarding supporting employee health and well-being? We want to know what you would like to see offered.**

Answered: 51   Skipped: 96

### Q13 In relation to COVID-19, overall, how do you think things are going at Bartlett since the initial survey?

Answered: 145 Skipped: 2



ANSWER CHOICES	RESPONSES	
Improved	56.55%	82
About the same	35.86%	52
Worse	2.07%	3
Other (please specify)	5.52%	8
TOTAL		145

Q14 If you would like someone from the Employee Health and Well-being Unit reach out to you, you may leave your name and best contact information. Or you may email [employeeewellbeing@bartletthospital.org](mailto:employeeewellbeing@bartletthospital.org) at anytime. If you are in crisis, you may call the Alaska Careline at 877-266-4357. If you need immediate help, please call 9-1-1.

Answered: 4   Skipped: 143