

Bartlett Regional Hospital

AGENDA

PLANNING COMMITTEE MEETING

Thursday October 15, 2020 – 7:00 a.m.

Bartlett Regional Hospital Zoom Video Conference

Public may follow the meeting via the following link <https://bartletthospital.zoom.us/j/98026853653>
or call
1-253-215-8782 and enter webinar ID 980 2685 3653

I. CALL TO ORDER

II. PUBLIC COMMENT

III. APPROVAL OF THE MINUTES

1. [August 18, 2020 Draft Planning Committee Meeting Minutes](#) (Pg.2)
2. [September 19, 2020 Draft Strategic Planning Meeting Minutes](#) (Pg.5)

IV. OLD BUSINESS

1. COVID status
2. Rainforest Recovery and Crisis Stabilization Center updates

V. NEW BUSINESS

1. Strategic Planning Meeting recommendations
 - A. Facilities
 - a) [Temporary Triage Facility](#) (Pg.12)
 - b) [Combining adopted list with Departmental COVID related items](#) (Pg.19)
 - c) [Re-prioritizing the entire list](#) (Pg.40)
 - d) How to determine the order of projects based on the combination of priority and practicality?
 - B. Partnering
 - a) Are there facilities changes that would foster partnering?
 - b) [How can the Board help staff move on the task list in ECG Table 4?](#) (Pg.41)
 - c) Governance Institute Webinar – Partnering in Pandemic Times
2. How do these recommendations work into our existing planning document

VI. FUTURE AGENDA ITEMS

VII. COMMENTS

VIII. NEXT MEETING

IX. ADJOURN

Bartlett Regional Hospital

3260 Hospital Drive, Juneau, Alaska 99801 907.796.8900 www.bartletthospital.org

Planning Committee Meeting Minutes

August 18, 2020 – 7:00 a.m.

Bartlett Regional Hospital Boardroom / Zoom Videoconference

Called to order at 7:00 a.m., by Planning Committee Chair, Marshal Kendziorek

Planning Committee and Board Members: Marshal Kendziorek, Kenny Solomon-Gross, Iola Young, Rosemary Hagevig, Mark Johnson, Deb Johnston, and Lindy Jones, MD.

Also Present: Chuck Bill, CEO, Billy Gardner, COO, Bradley Grigg, CBHO, Dallas Hargrave, HR Director, Kevin Benson, CFO, Rose Lawhorne, CNO, Marc Walker, Director of Facilities and Anita Moffitt, Executive Assistant

APPROVAL OF THE MINUTES – Mr. Solomon-Gross made a MOTION to approve the minutes from June 18, 2020 Planning Committee. Ms. Young seconded. Minutes approved.

PUBLIC PARTICIPATION – One public participant listening with no comments

COVID STATUS – Mr. Bill reported that even though Juneau has had a couple of COVID outbreaks recently, we have not been overrun here at the hospital. We currently have one COVID positive patient in house. We are seeing more potential COVID cases in the ED which reinforces the use of our appropriate protocols and PPE. BRH, working in conjunction with CBJ Incident Command, performed rapid COVID testing on the people of the Matanuska ferry last weekend. All tests came back negative. This event highlights challenges we continue to see as it relates to rapid testing and turnaround times. There was an Incident Command Task Force meeting yesterday to look at standing up PCR testing here in Juneau. Currently there are 4 machines on order, Cepheid, Roche, Abbott and Panther. The one we can get up and running the fastest is the one we will end up buying when they become available in several months. We are working with CBJ Engineering to identify a space that will accommodate the most complex unit (Roche) should that be the one to become available. The space must have a solid base with no vibration. If there is no adequate space identified at BRH, an offsite location must be found. After space is identified, we will begin work on whatever mechanical, drainage and other necessary specs needed to have the space ready when the equipment arrives. Mr. Solomon-Gross requests a timeline for identifying a location and preparing for this equipment. Mr. Bill stated that a timeline cannot be provided before the engineers have helped identify an appropriate location and noted that Mr. Watt has made this a high priority for CBJ engineering. Engineering will meet with Billy Gardner and Marc Walker today to get this process going. We may be able to avoid the RFP process due to the emergent situation and the fact that CBJ is funding it. Mr. Bill clarified that the community and the task force has asked BRH to manage the process but it does not have to be on the BRH campus. Bartlett's Clinical Laboratory Improvement Amendments (CLIA) license would be used to certify the equipment to get it up and running. We are looking at what would be needed to repurpose space for the equipment, this would include hoods and outside ventilation, etc. One option to be explored is to move Dr. Vanderbilt's office which is adjacent to the micro lab. This space would be readily available for retrofitting, etc. Mr. Gardner reported that hoods and equipment have already been ordered in anticipation of getting a Roche machine. If CBJ engineering does identify an appropriate space at BRH, hopefully by the end of this week, we will start preparing that

space immediately. It was noted that the Cepheid machine would be the easiest to set up but we are constrained by getting an adequate supply of test kits. The other machines are less dependent on kits because they can use normal saline as the medium to work up the samples. The medium that is needed for Roche testing is readily available and can be made here in Juneau. We have communicated directly to the companies and through our federal delegation and the state through Incident Command, how remote we are to try to make us a priority to obtain equipment. Because everyone is considered to be a priority, allocations of equipment will be made based on when we got in the queue. Ms. Young initiated a discussion about personnel needs. We are conducting a national search to fill four certified lab technologist positions. If unable to recruit, we will have to reallocate staff and limit times of testing. In response to Mr. Solomon-Gross' query, Mr. Bill stated that there is no lab tech training program in Alaska that he is aware of. The current turnaround time for send out tests is up to 72 hours unless there are flight delays. Mr. Bill reported there are no delays in reporting once results are in at this point in time. There is consideration of sending airport testing kits to a lab in California that is guaranteeing a 24 hour turnaround time on results once they receive the specimens. Flight delays will still cause slow turnaround times. The lab in California would take the responsibility of contacting the patient. Dr. Jones noted that the challenge is variable, if there's an outbreak elsewhere, it effects our turnaround time and we are not in control of our destiny.

RAINFOREST RECOVERY CENTER UPDATES – Mr. Grigg reported COVID is effecting Behavioral Health as well. We have been on the path of reopening RRC at 50% capacity on September 8th. We have recently learned of COVID positive patients in two facilities in AK that provide similar services to RRC. This has caused us to look at all of our up front strategies and precautions again to ensure that we can open safely. The new construction on the building is complete and we are finalizing and installing all of the fixtures and furnishings. Mr. Grigg expressed his thanks to Ms. Lawhorne and the directors of the Critical Care Unit and Medical for their assistance in getting some of the essential equipment that will be needed to provide the detox/withdrawal management services in this new unit. He also reported that the renovation of the existing facility that has been taking place as part of phase two is to be completed this week. We are at the point of opening with extreme caution, both residential and detox simultaneously for locals while looking at ways to keep our staff safe with this communal program. Part of keeping our staff safe while continuing to provide services includes virtual programs. We currently have 26 patients in virtual treatment. Dr. Jones stated that Mr. Grigg and his staff have done an excellent job implementing telemedicine services for behavioral health. He asked if anyone is working to make a more robust telemedicine program at the hospital. Mr. Bill reported that Mr. Gardner is working closely with Virginia Mason to expand our telemedicine relationship with neurology being at the top of the list of where we are going. This will be discussed at the Strategic Planning retreat.

STRATEGIC PLANNING RETREAT and the “NEW NORMAL” – The Strategic Planning retreat is scheduled to take place on September 19th. It will be held via Zoom from the BRH boardroom. We can accommodate a few people in the room but request the majority of participants participate remotely, including the facilitators. We expect to have packets out about two weeks prior to the retreat. We will use the facility plan as a base but will modify it to match the new normal for COVID. Mr. Kendziorek requests a gantt chart plan for the major categories including negative pressure rooms, waiting room space, triage space, etc. be available for review. Mr. Bill will have it available prior to the Strategic Planning Retreat. Ms. Young thanked Dr. Jones for his report. Mr. Solomon-Gross expressed his thanks to Dr. Jones and Ms. Lawhorne for the tour they provided of the areas noted in Dr. Jones' report and stressed the importance of providing a better triage space as soon as possible. Dr. Jones highlighted the

difficulties in the working environment for the staff and providing quality patient care in tough conditions. Mr. Johnson proposed setting up a trailer to replace the triage tent. The logistics of setting one up in that location is very challenging. We need to be able to make the necessary changes while remaining operational. Mr. Solomon-Gross requests options be presented to the BOD to address the triage tent issue and requests updates on the progress prior to the Strategic Planning retreat. Ms. Hagevig requests bare bones options be presented at next week's Board of Directors meeting. In addition to Dr. Jones' report, Ms. Young requests a report of issues that need to be addressed in other areas throughout the hospital be provided.

Future Agenda Items:

1. Strategic Planning Retreat recommendations review
2. How do these recommendation work into our existing planning document

Comments: Dr. Jones noted that his document covers areas he's familiar with only and said we need insight into challenges we face from other areas of the hospital. Ms. Hagevig asked whether CARES funding would cover any of the improvements we are looking at. We have a \$2.7 million place holder in CARES funding to cover the purchase of the testing equipment only. There is no funding identified for remodeling. Mr. Johnson said this topic is one the agenda for Friday's Finance Committee meeting. The money we have already received from the CARES ACT can only be applied to lost revenues and if we can't show lost revenue, we have to pay it back. The only option we would have to use CARES funding for renovations would be from the money allocated by the state to the CBJ. We need to make our needs known to the Assembly before that money is allocated for other purposes. Mr. Solomon-Gross stated that he is proud of our organization for setting things up so quickly and efficiently as a result of this pandemic.

Next meeting: To be held in October, date to be determined. (Mr. Bill will be out of town October 5th through 23rd. Meeting will be held without him.)

Adjourned – 8:15 a.m.

Bartlett Regional Hospital

Minutes

STRATEGIC PLANNING MEETING

September 19, 2020 – 9:30 a.m.

BRH Boardroom / Zoom videoconference

CALL TO ORDER – The Board of Director’s meeting was called to order at 9:34 a.m. by Lance Stevens, Board President

BOARD MEMBERS PRESENT

Lance Stevens, President	Rosemary Hagevig, Vice President	Brenda Knapp
Kenny Solomon-Gross – Secretary	Mark Johnson	Marshal Kendziorek
Deb Johnston	Iola Young	Lindy Jones, MD

ALSO PRESENT

Chuck Bill, CEO	Kevin Benson, CFO	Billy Gardner, COO
Bradley Grigg, CBHO	Dallas Hargrave, HR Director	Rose Lawhorne, CNO
Megan Costello, CLO	Michelle Hale, CBJ Liaison	Joy Neyhart, DO, COS
Anita Moffitt, Executive Assistant	Katie Bausler, Public Relations	Noble Anderson, MD
Keegan Jackson, MD	Mimi Benjamin, MD	Corey Wall, JYW
David Sandberg, Cycle of Business	John Budd, ECG	Jeff Hoffman, ECG
Rashah McChesney (KTOO)	Roseman GenPublic (Public)	Martin Stepetin (Public)

PUBLIC PARTICIPATION – None

REVIEW MISSION, VISION AND VALUES – Mr. Bill provided an overview of Bartlett’s Mission, Vision and Values to make sure they are still pertinent.

Mission – BRH provides its community with quality patient centered care in a sustainable manner.

Vision – BRH will be the best community hospital in Alaska

Values – At BRH 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.

It was expressed that this still speaks to what we want to be and how we want to deliver our services. No changes recommended.

HOW MUCH OF A CASH RESERVE SHOULD WE MAINTAIN - Mr. Benson provided an overview of different means of financing capital projects: debt vs. using internal reserves. Pros and cons of both options were provided. Cash balances and cash to debt ratio for the past three years were presented and it

was noted that our return on reserves is about the same as what the interest on debt would cost. He then provided different scenarios that might impact the days' cash on hand. Mr. Kendziorek suggested we take a backwards approach to this plan and settle on a number for days' cash on hand to tell us how much is reasonable to be financing. We then need to look at the list of projects we have, prioritize them and get them going. He feels that this is the most important high level thing we need to do as a result of this meeting. Ms. Hale expressed appreciation of Mr. Benson bringing in the public perception of budget reserves as well as Mr. Kendziorek's idea of a backwards approach. She noted that the Assembly is keenly aware that BRH has a robust balance. Discussions were held about debt to capitalization ratio, the need to maintain the ability to respond to disasters and other unforeseen events and the need for making some of the changes as a result of COVID happen very quickly. Mr. Bill made a recommendation that we look at establishing a 180 operating day reserve and fund deferred maintenance and COVID projects out of Capital while anticipating that we may need to go to the bonding market for anything more substantial than that. Mr. Kendziorek agreed with this process and the need to get moving on high prioritized projects. He suggests we begin the process of developing a bond package for about \$8 Million and see how far that gets us on the projects that we can finish in the next 12 – 18 months. These steps would allow us to know how much money we have available both in terms of our equity contributions and our finance bonds. He then stressed the importance of explaining, in detail so the Assembly and the public understands, what is really contained in the spreadsheet showing the days' cash on hand and why we would need six months' worth of money in case something goes wrong. Ms. Hagevig expressed a debt of gratitude to previous Board members for the financial decisions they had made to put us in the financial situation we are in.

REVIEW PRIOR PLAN – David Sandberg of Focus and Execute, provided a high level overview of the goals established for 2019. Overall, 79% of the action plans have been completed. Some items not yet completed are tied to today's presentations by Jensen Yorba Wall (JYW) and ECG. Telehealth services in psychiatry are functional at this time and are being explored for other specialties. Mr. Johnson requests a list of services and specialties that we are considering for telehealth services. This topic will be further explored during the ECG presentation about partnering.

Robotics – Mr. Bill reported that the discussion about robotics is being brought up again for a couple of reasons; 1) Dr. Newbury is bringing in a new partner, freshly out of school that is very interested in robotics. 2) With Dr. Saltzman leaving the community, at least temporarily, we are trying to recruit a urologist. Robotics could be a useful recruitment tool. Discussion was held about how well robotics are working for other facilities in Alaska. Mr. Solomon-Gross and Ms. Knapp expressed support in bringing this topic back to the table. Mr. Kendziorek, very supportive of this project, feels that it should be a moderately high priority but higher priority projects need to be taken care of first. Dr. Jones expressed concerns that the volume of cases at BRH would not be sufficient for providers to remain competent in this area, a specialized OR staff would be required, robotic surgery does not improve surgical outcomes, they take more OR time and are considerably more expensive. He also noted that we are not currently recruiting for another OB/GYN and the Urologist we are looking at is not interested in using robotics. Dr. Benjamin noted that the 4 surgeons we currently have are not trained in robotics and not particularly interested in training. Further discussion held about the volume of cases needed for providers to maintain competency, specialized staffing, aging populations and patients traveling out of town for services. Ms. Hagevig and Dr. Neyhart agreed that a robotics program should not be implemented now but needs to stay on future plans. Mr. Bill will continue to work with the surgeons to try to predict what the demand and usage would be. If

it's determined that we would have the volumes to maintain competency, he will bring it back to the Finance Committee for acquisition.

JENSEN YORBA WALL CAMPUS PLAN REVIEW – Corey Wall provided an overview of the campus plan that had been presented in January. Due to COVID, the list of projects and priorities associated with that plan have changed considerably as have health care designs everywhere. He reported that nationally, changes include, ventilation improvements, creating negative pressure spaces and increased filtration, larger waiting rooms with more isolated spacing and drive through spaces where initial evaluations, inoculations and testing can be conducted while the patient is still in their car. Shell spaces are being thought about as patient areas from the beginning of the design phase and are to be used for surge capacity in the event of a big outbreak of disease. Non-critical areas are being prepped with med gas and emergency power so are ready to be converted to patient rooms if needed. Parking garages could be used for triage spaces or enclosed emergency centers. Space designed for equipment storage such as extra beds, screens and other equipment are to be put into use in the event of an emergency. Materials Management departments to have increased storage space to stock enough supplies in case supply chains break down. Technology upgrades include touchless check-in, telehealth services space and equipment and video conferencing abilities in patient rooms. Smaller locker rooms and break rooms for staff to be distributed throughout facilities. While the ventilation issues were not something that had been anticipated, Bartlett had identified and prioritized several of these other things in its master plan prior to the pandemic. Discussion was held about proposed OR and Lab renovations and the flow of moving patients through the hospital. Mr. Gardner provided an overview of the priorities identified in the COVID-19 Facility Changes/Modifications document included in the packet. Staff will work with JYW to combine and prioritize the lists of projects, identify timelines, figure out how much money we have and how far down that list we can get. The Planning Committee will review this revised plan and make a recommendation to the Board. Mr. Bill reported that we should have the fair market value appraisal of the Bartlett Surgery and Specialty Clinic building in about three weeks. Purchasing this building would provide some additional flexibility in moving things around while renovations are going on in the hospital and can then be configured to accommodate services in the future. Dr. Benjamin expressed the importance of providing safe spaces for staff to take their breaks and suggests this be a high priority to help combat staff and physician burnout. Mr. Stevens said other things to consider are what projects can be done simultaneously and how to work with tenants of the Juneau Medical building if we displace them to tear down the building.

BREAK – Mr. Stevens called for a recess at 11:24am. Session resumed at 11:35am

ECG DISCUSSION IN THE CONTEXT OF THE “NEW NORMAL” – Mr. Bill noted the SE Health Care SWOT and initiative analysis were included in the packet as a resource for ECG. John Budd and Jeff Hoffman of ECG provided an overview of the Provider Network Development Plan included in the packet. ECG's analysis included discussions with the medical staff and leaders across the organization to shape a strategic fact base. BRH's liquidity is stronger than a lot of organizations. Juneau's population growth rate is anticipated to be pretty flat over the next 5 years while the population aged 65 years and older grows. This is important because it will shift utilization patterns and payor mix. Reimbursements from federal programs, staff and provider shortages, outmigration of key services to competitors, patient leakage, behavioral health and substance use disorders and overhead scale are key considerations in community hospital strategies. BRH is heavily reliant on governmental programs for reimbursements that may not be

available in the future. Mr. Benson noted that in FY2020, BRH would have a \$1.5 Million reduction in reimbursements without the Rural Demonstration Project. Operational expenses continue to be greater than what was anticipated due to COVID. Mr. Stevens suggested that travel restrictions and the capacities of out of town hospitals, may change the behaviors of Juneau residents seeking healthcare. After receiving quality care at BRH, hopefully, they will continue to get their health care here. Discussion held about a marketing plan to promote BRH services and increase patient volumes.

There were four issues at the core of ECG findings: 1) the notion of unstable financials 2) changes in competitive providers across the region 3) leakage of services 4) challenges in recruitment. ECG recommends thinking long term. Our cash position will continue to be a struggle to improve. The big issue is services leaving the community. We need to market and continue to build our services. Recruitment is going to become more difficult across the country, not just in Juneau. ECG recommends looking at a partnership with an organization where we could find a mutually beneficial agreement where we could support a broader rotation of specialists in the community and potentially find some joint venture opportunities. There are two types of strategic partners when thinking big strategy. One is best of breed, find an organization that offers what we want and need to partner with. The downside of that is that we don't get a long term partner. The second type is a more strategic partnership where we start aligning with a partner and look for opportunities to work together to provide more service options. This tends to be a longer more beneficial partnership than best of breed partnerships. While BRH is in good position today, it makes sense, strategically, to start thinking about these things before it gets to a point where we don't have options. While we look at different alignment options, we need to understand that each potential partner is going to approach it differently with their own strategic needs.

ECG wants to be very clear that they are not talking about a merger or any type of joint operating agreement where another organization takes over. They aren't talking about a shared service company. What they are recommending is clinical affiliations where we rotate different specialties to get better access to expertise not available in Juneau and to look at joint venture opportunities. They are not recommending an option where another organization will take over BRH and do not think BRH is in a position where it needs to be considering this as an option at this time. Guiding principles – 1) Independence, CBJ will not consider merging or selling the hospital. 2) The span of control: BRH wants to remain an independent organization capable of providing care locally, meeting the ongoing capital investment needs. 3) Commitment to southeast Alaska – Any partner must be able to understand the unique aspects of providing care in AK and provide services that are suited to the region. 4) Commitment to BRH and CBJ – BRH and the CBJ do not want to get lost inside a larger health system and expect to continue to influence how health care is delivered in Juneau. It is suggested that as we look for a potential partner in services, initial discussions should begin with Swedish, Providence, St. Joseph Health, SEARHC, Virginia Mason and Peach Health. Other opportunities include the Mayo Clinic and Cleveland Clinics. If BRH wants to successfully move forward with looking at different options to build this, it has to have a slightly different approach than has been done traditionally. Identifying a partner that shares BRH's objectives and complements its existing service offerings involves a five-step process. 1) Evaluate services for focus 2) Compile potential partner profiles 3) Contact potential partners and develop RFP 4) Evaluate partnership opportunities 5) Conduct deliberations. Dr. Jones stated that once these partnerships are aligned, it would be a great time to talk about robotics again. He also suggested talking to the University of Washington as a potential partner and speaking to medivac providers about the extra costs of sending someone to Seattle as opposed to

Anchorage. Mr. Kendziorek noted that the Board had already approved the implementation tasks that had been outlined on page 135 of today's packet and said we need to stop talking and get moving on them. Mr. Hoffman clarified that a comprehensive alignment is a partnership with an organization that can provide a broad list of specialty services and does not impede the ability for local physicians to continue their existing referral relationships. In order for this to work really well, physician buy in is needed. Mr. Johnson would like the Board to have a more robust conversation about the pros and cons of pursuing each type of strategic partner before deciding how to move forward. Dr. Benjamin suggested looking at the use of an organizations community version of their EMR as part of the partnership as a way to save money and improve the EMR we already have. Ms. Knapp expressed her support of moving ahead with caution. Mr. Johnson noted that COVID is putting a strain on a lot of facilities across the country and expressed concern that BRH would become less of a priority for an affiliate under a financial strain. Mr. Bill agreed that this could be a concern. He also noted that it is really important that we get the medical staff's input and assure them that we are not trying to change anyone's referral patterns. Providers and their patients will still be able to choose where to obtain services.

Mr. Bill reported that the Physician Recruitment Committee and some local physicians have met to discuss the Community Health Needs Assessment results and specialties were identified as being important to recruit for. He also reported that he has already made contact with some potential partners. We will be looking at a combination of telemedicine and intermittent clinic rotations for in person visits. A brief discussion was held about the challenges BRH would face as a part of CBJ if we pursued joint venturing, specifically public financial records. Dr. Jones expressed that an easily accessible partnership with sub specialists would probably be welcomed by the medical staff and referral patterns would probably change. Since it will impact our master facility plan, it is important that identifying potential partners and defining what it is we think the community needs the most needs to happen at the same time. Ms. Hale suggested that Mr. Bill speak to Rorie Watt about the best way to communicate with the assembly about what BRH and the Board is thinking. She will provide a high level report at the September 20th Assembly meeting. Dr. Benjamin reported that some telehealth restrictions are being lifted and Virginia Mason is talking about being able to do inpatient consults which will help reduce the number of medivacs. She also feels that the physicians in this community would be interested in this type of relationship.

A discussion was held about the need for help in compiling the profiles of potential partners and defining the RFP so we get the results that we want out of a partnership and not designed to a particular organization. Mr. Stevens expressed concerns that CBJ controls our RFP process and doesn't have the required expertise to make sure we get what we need. Mr. Bill stated that the key is to have BRH define expectations on the front end. If structured correctly, the boiler plate for an RFP is not that difficult to work with. Mr. Hoffman agreed with Mr. Bill that the big part of this process is the upfront discussions to be held with each organization. We would like for the physician rotation or access to have some infrastructure so we know who the point person is and what the process is when our physician wants access. Explain what it is that Juneau and BRH needs over the next 5 years so that potential partners understand what we are thinking and can decide if they would be able to work with us. We can then ask for help in developing an RFP. Mr. Johnson would welcome some input from local providers on this topic. Ms. Costello expressed her appreciation for the discussion about the RFP process and suggested that we may want to hire an outside attorney to help us develop one. Dr. Jones suggested an ad-hoc committee be created with stake holders and physicians to be able to identify our needs and help move the project forward. Mr. Johnson suggests

including one or two community members on the committee to provide input as well. Mr. Bill and Mr. Stevens will discuss this further to identify what the committee looks like and what the role and responsibility is. Mr. Bill thanked Mr. Hoffman and Mr. Budd for their presentation and hard work on this project.

EMPLOYEE SURVEYS – Mr. Bill noted we have done a really good job in assessing needs of employees from a behavioral and personal wellness standpoint during this pandemic. Survey results are in the packet.

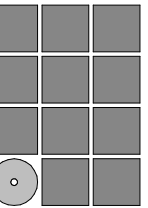
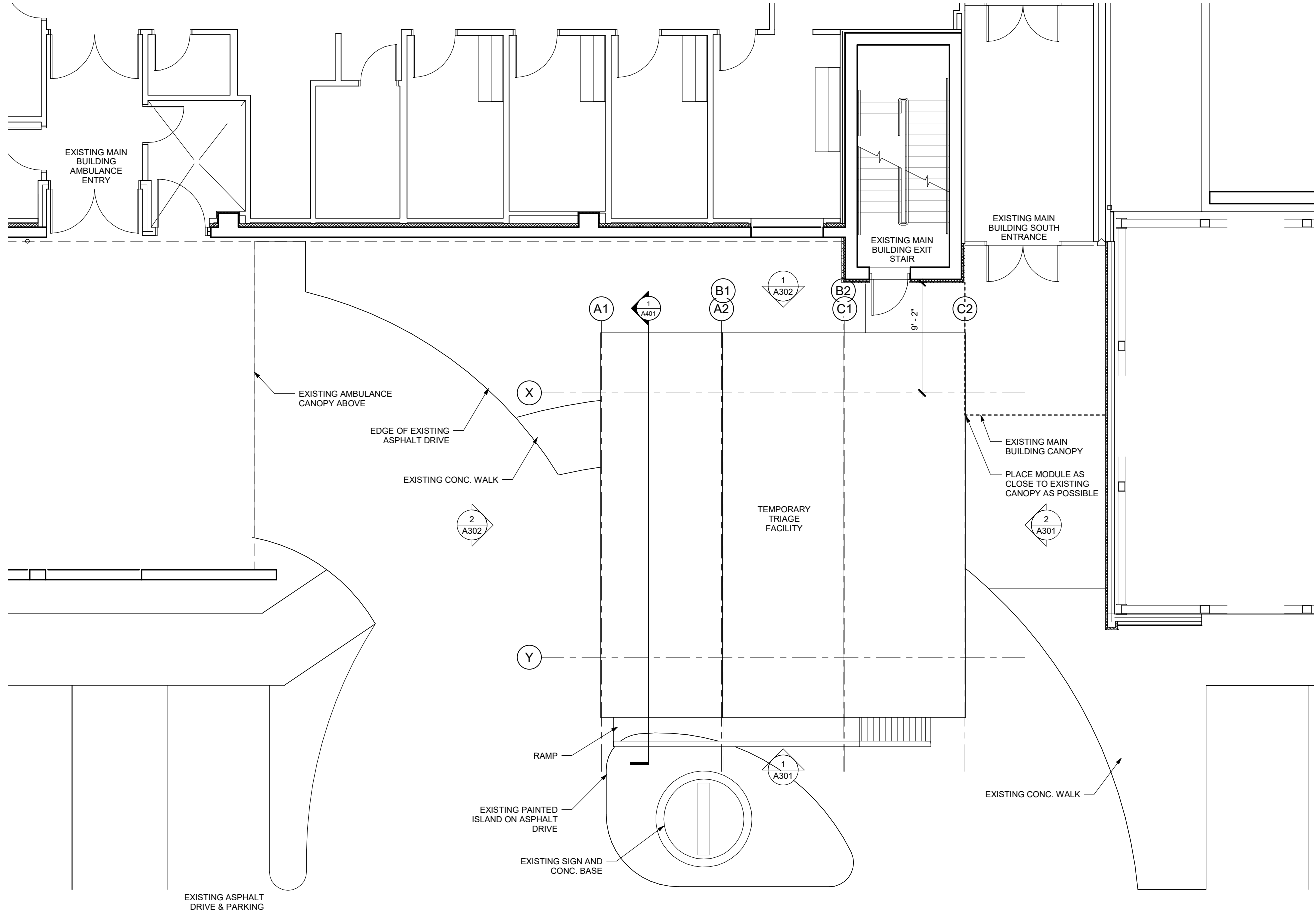
MARKETING PLAN – Mr. Bill reported that he and Katie Bausler have discussed looking at a professional marketing firm to give us some marketing ideas. He sees the marketing plan as a two phase plan; a shorter phase to take advantage of the added loyalty from Juneau patients that came to BRH as a result of COVID. How do we grow that relationship and trust? Second, how do we market for the future with new services? A discussion was held about price competitiveness and insurance companies encouraging patients to receive services out of town. BRH is very competitive with other hospitals but not freestanding specialty centers that don't have a lot of overhead. Mr. Bill reported that the anesthesiologists that provide services at BRH are not currently in any network plan. He is working with them to form a group and enter into a professional services agreement with BRH. It is expected that they will join in the same payor plans as BRH. He also noted that BRH's insurance policy through CBJ pays the same no matter where care is provided. It might be worth looking at giving discounts for receiving care locally or adding penalties for going out of Juneau for care. Conversation returned to marketing. Talk about the services and quality of care BRH provides needs to happen sooner rather than later and the message delivered in different avenues than we've been using. Dr. Anderson suggested that we should consider SEARHC as a partner and not competition. He also reported that SEARHC has recently partnered with Swedish and wonders if it would be mutually beneficial to look at Swedish as well. It was noted that marketing the community successfully by giving all of the positives Juneau has to offer and developing better partnerships with key industries in the community to help cross promote each other's strategic employment needs would help our recruitment efforts.

COMMENTS AND QUESTIONS – Ms. Young said this has been a great meeting for the newest board member. Dr. Jones said that 3 or 4 of the medical students and residents that have come up here through the WAMI program are interested in moving to Juneau. This program is also a great recruiting tool. Mr. Johnson appreciates the good discussions. Mr. Kendziork noted the meeting went pretty well. He encourages as many board members as possible attend the 7:00am Planning meeting scheduled to take place on October 15th to continue these discussions and work through the details. Mr. Solomon-Gross expressed appreciation for everyone's comments today. Ms. Hagevig concurred that this was a very useful conversation and thanked everyone for their participation. She also noted that the Southeast Conference is taking place next week and encourages as many board members as possible to attend. Ms. Knapp reported that this is her 6th Strategic Planning work session and found this one to be the most productive. Ms. Lawhorne expressed appreciation for everyone's time and energy discussing the future of our hospital. She said she is here to participate and support this process however she can. Mr. Grigg echoed Ms. Lawhorne's comments and expressed appreciation for the commitment of the Board. Mr. Gardner stated that we have one of the strongest leadership teams under Mr. Bill and certainly a very strong Board. He is happy that we have this time to get us through this COVID pandemic. Mr. Benson agreed with everything Mr. Gardner said. He then reported that we have been working with our audit firm to complete the GASBY 68 and 75, recording the liability for unfunded pension expense. This particular

entry has been messing with BRH financial statements for the last several years. This year it is in our favor in that the PERS fund had excellent investment performance during 2020. As a result, we are going to see a significant decrease in our pension expense and liability. Mr. Stevens thanked everyone for the reports, good direction and concepts provided and stated that the work is just beginning. We need to start narrowing these down into actionable plans for both the facilities plan and in conjunction with our next steps in providing services within the community, making sure that one doesn't get too far ahead of the other. It's going to take some coordinated efforts and a lot more work to get us to the finish line. He thanked everyone for their commitment to making this happen and said he's glad to be a part of it himself. Ms. Hale expressed her appreciation to the Board for really good thinking and wanting to move things to the next steps with a clear understanding what those steps might be.

ADJOURNMENT – 1:22 p.m.

DRAFT



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Bartlett Regional Hospital

Temporary Triage Facility

Juneau, Alaska

Schematic

REVISIONS



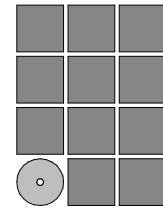
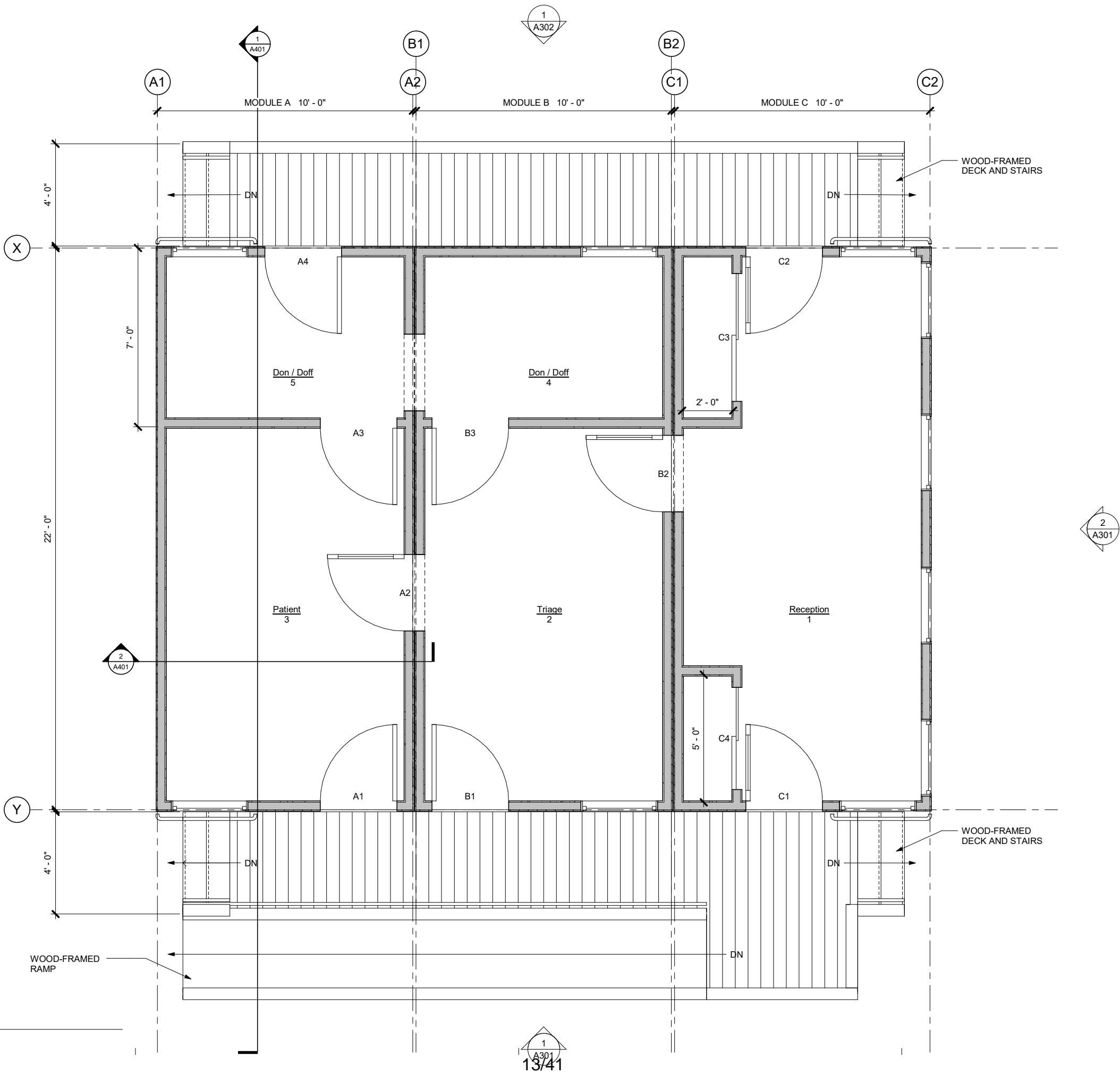
SHEET TITLE

Site Plan

DATE: Sept. 29, 2020
FILE: 20045

A101

1 Floor Plan



Jensen
Yorba
Wall Inc.

522 West 10th Street
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Bartlett Regional Hospital
Temporary Triage Facility
Juneau, Alaska

Schematic

REVISIONS



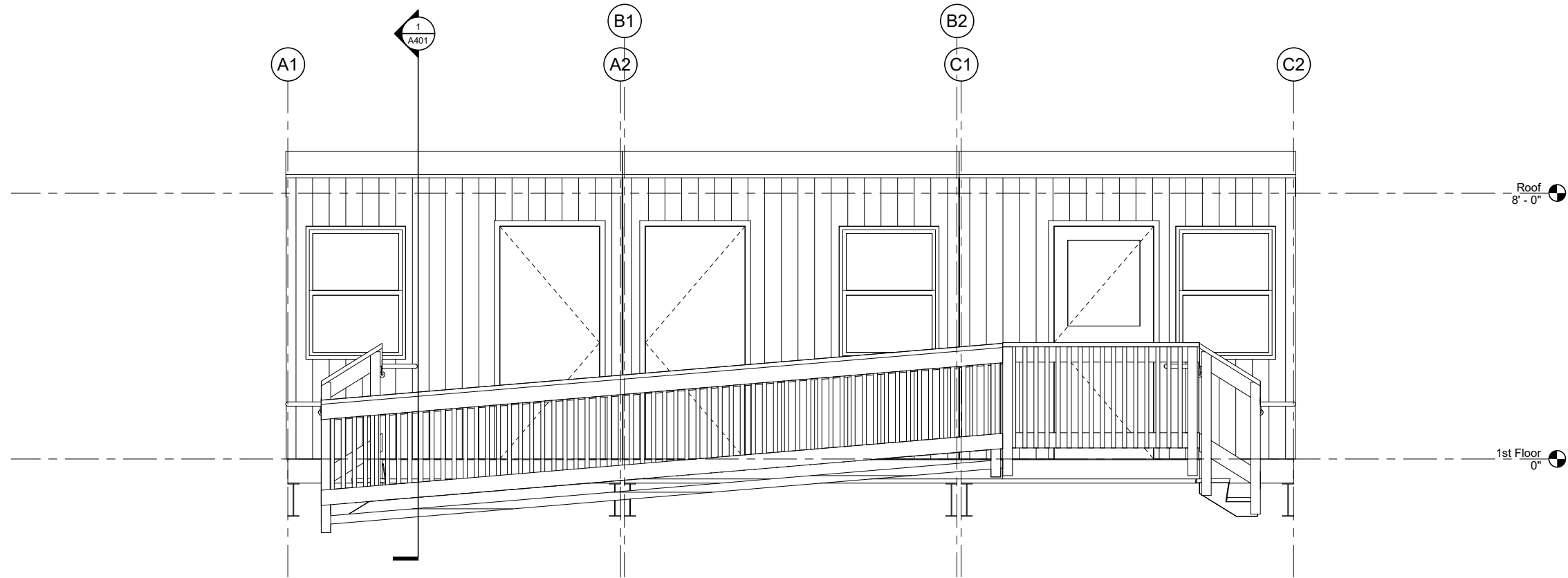
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Floor Plan

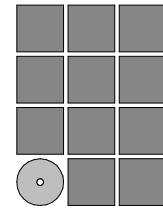
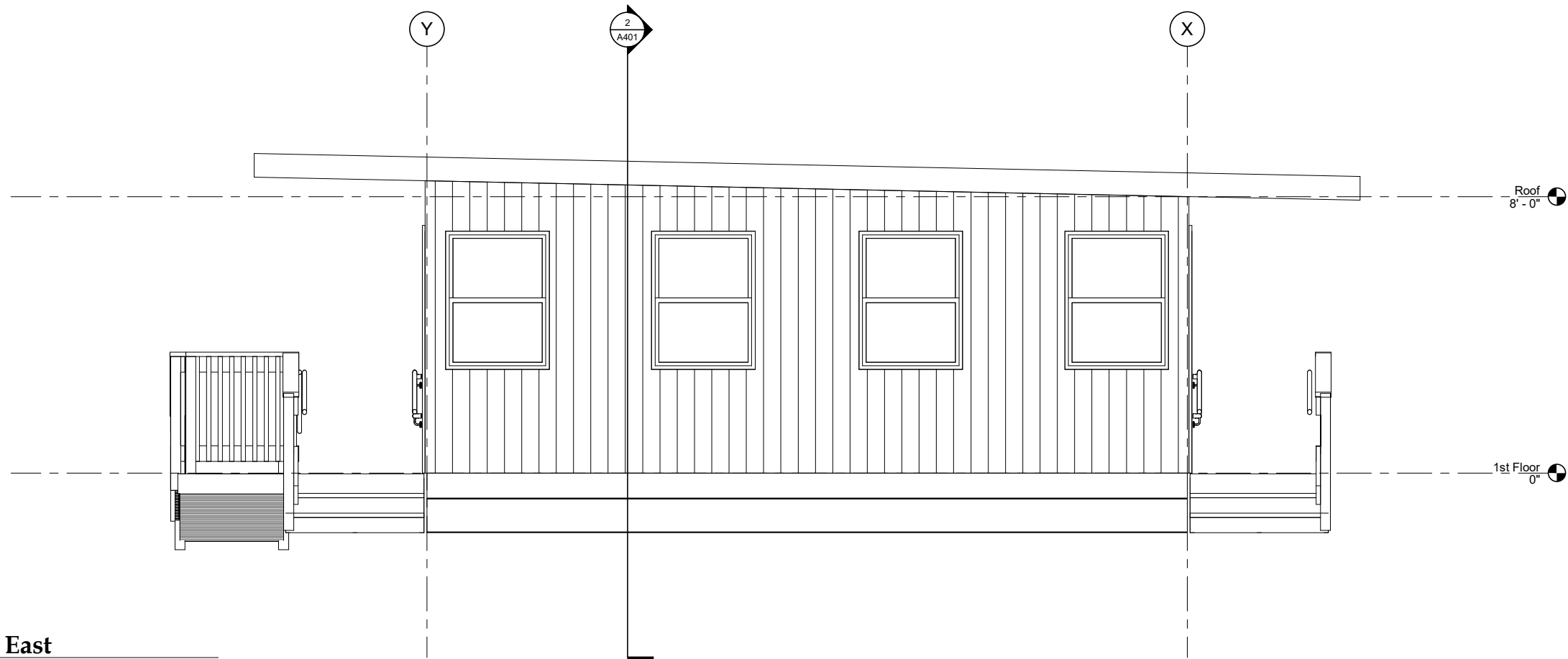
DATE: Sept. 29, 2020
FILE: 20045

A201

1 Exterior Elevation - South



2 Exterior Elevation - East



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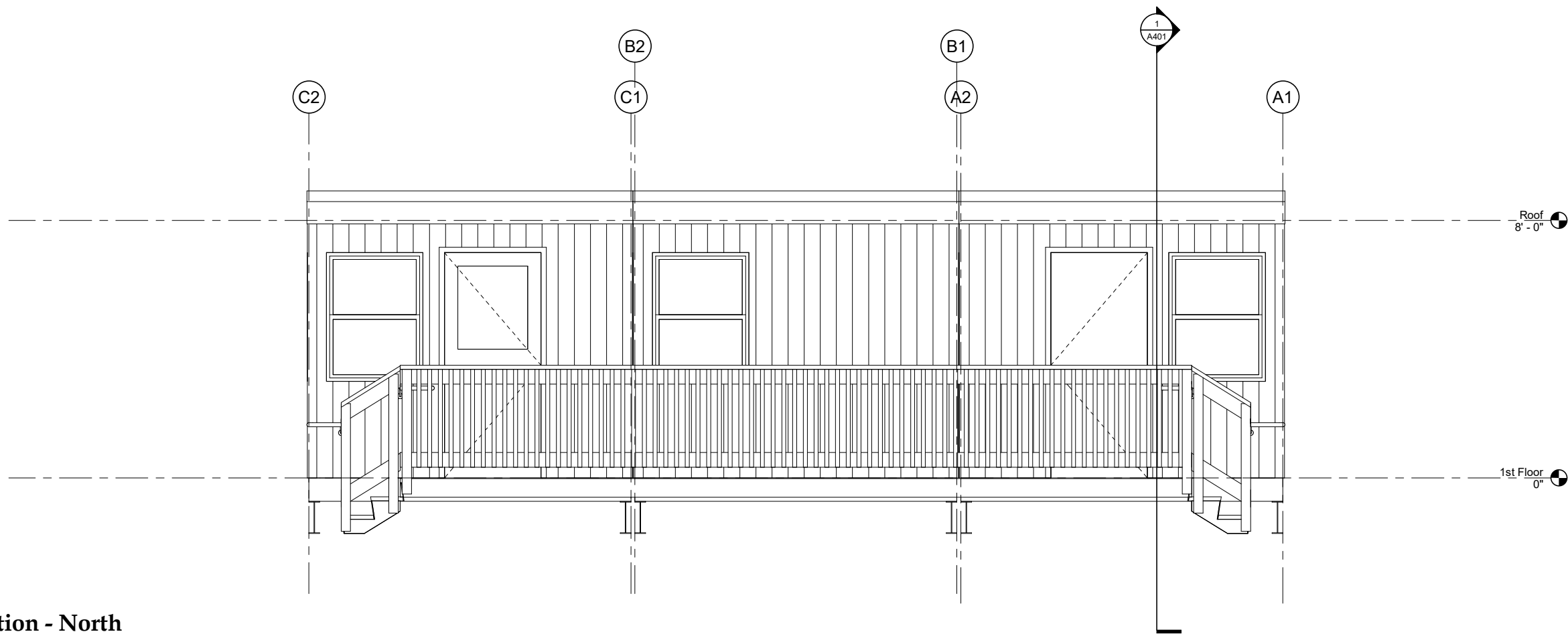
Bartlett Regional Hospital
Temporary Triage Facility
Juneau, Alaska

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Exterior Elevations

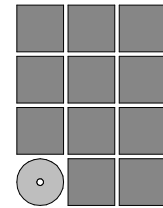
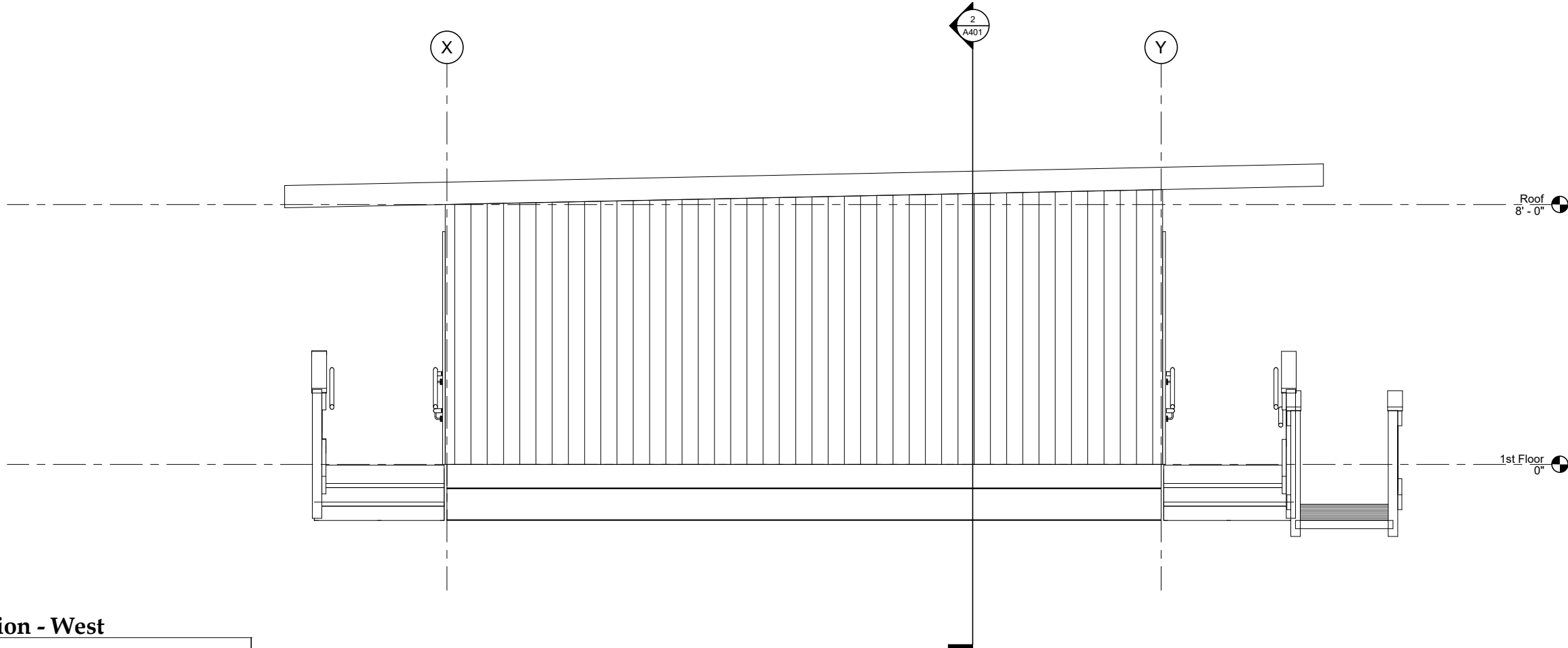
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A301

1 Exterior Elevation - North



2 Exterior Elevation - West



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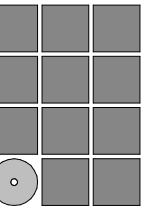
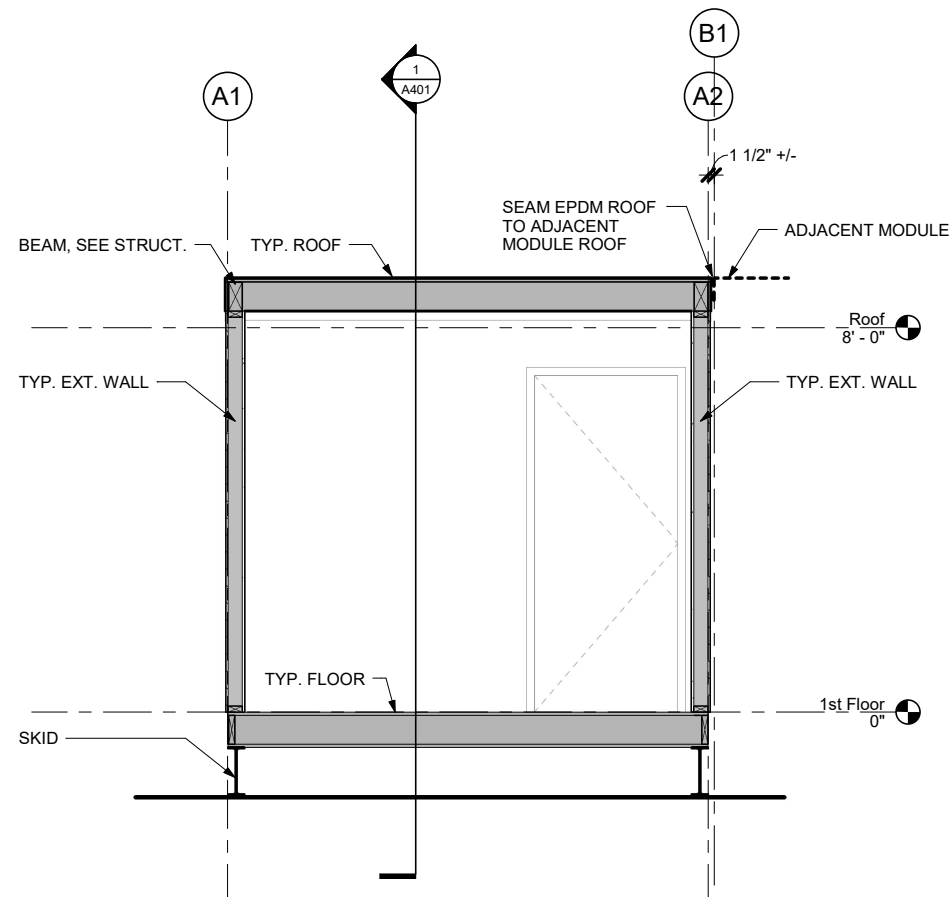
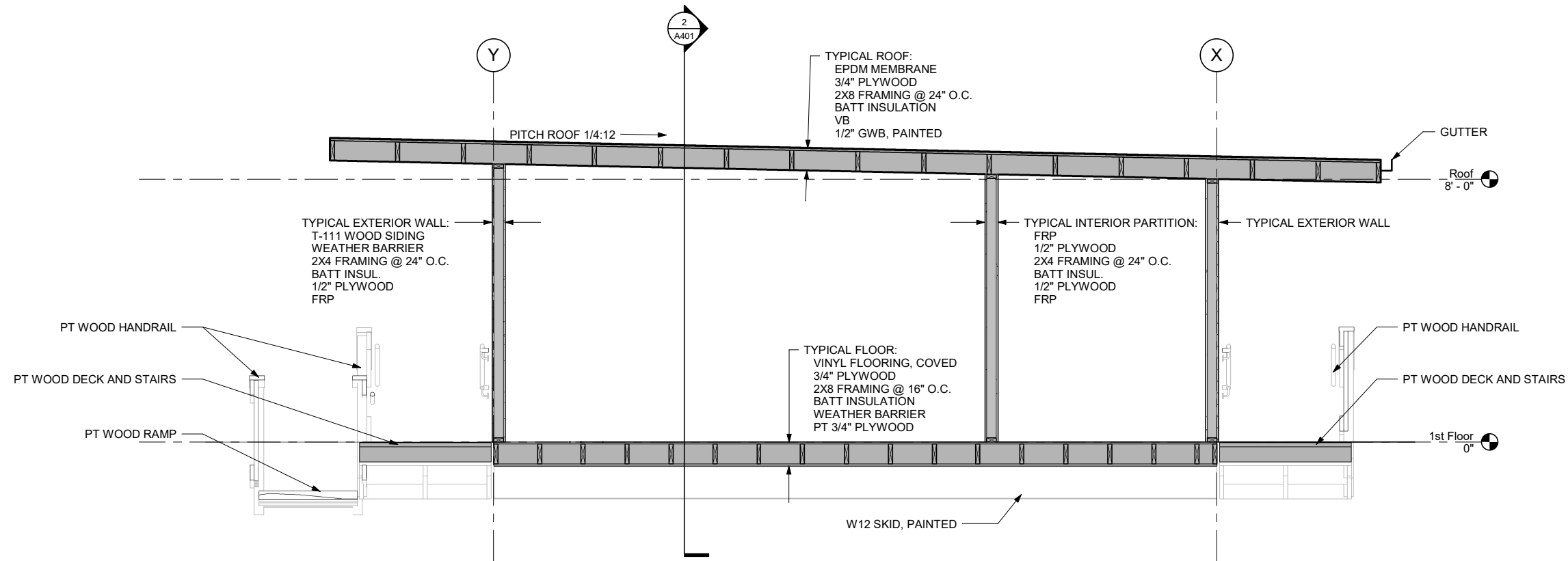
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A302



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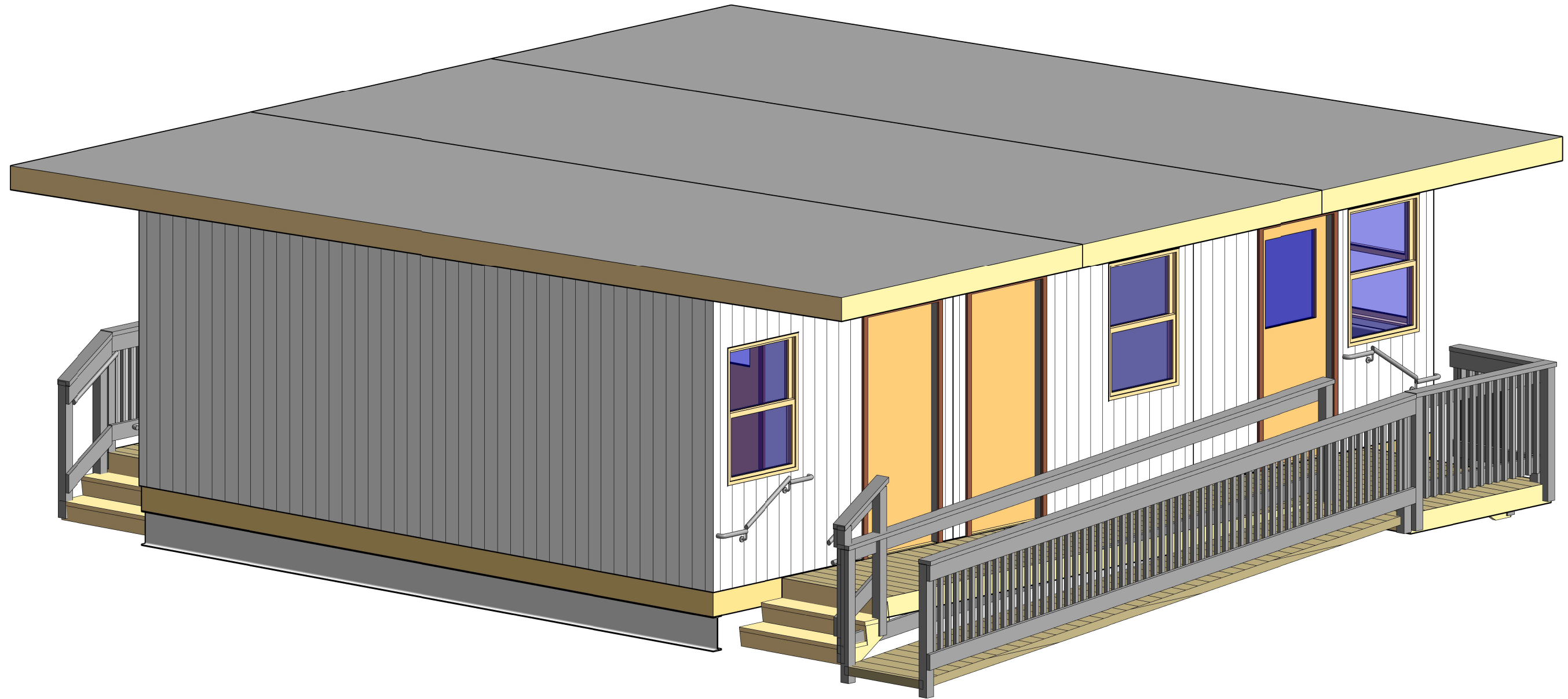
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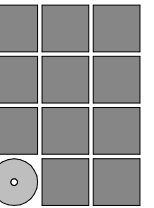
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Building Section

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A401



1 Axo View - Exterior from SW



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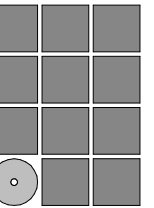
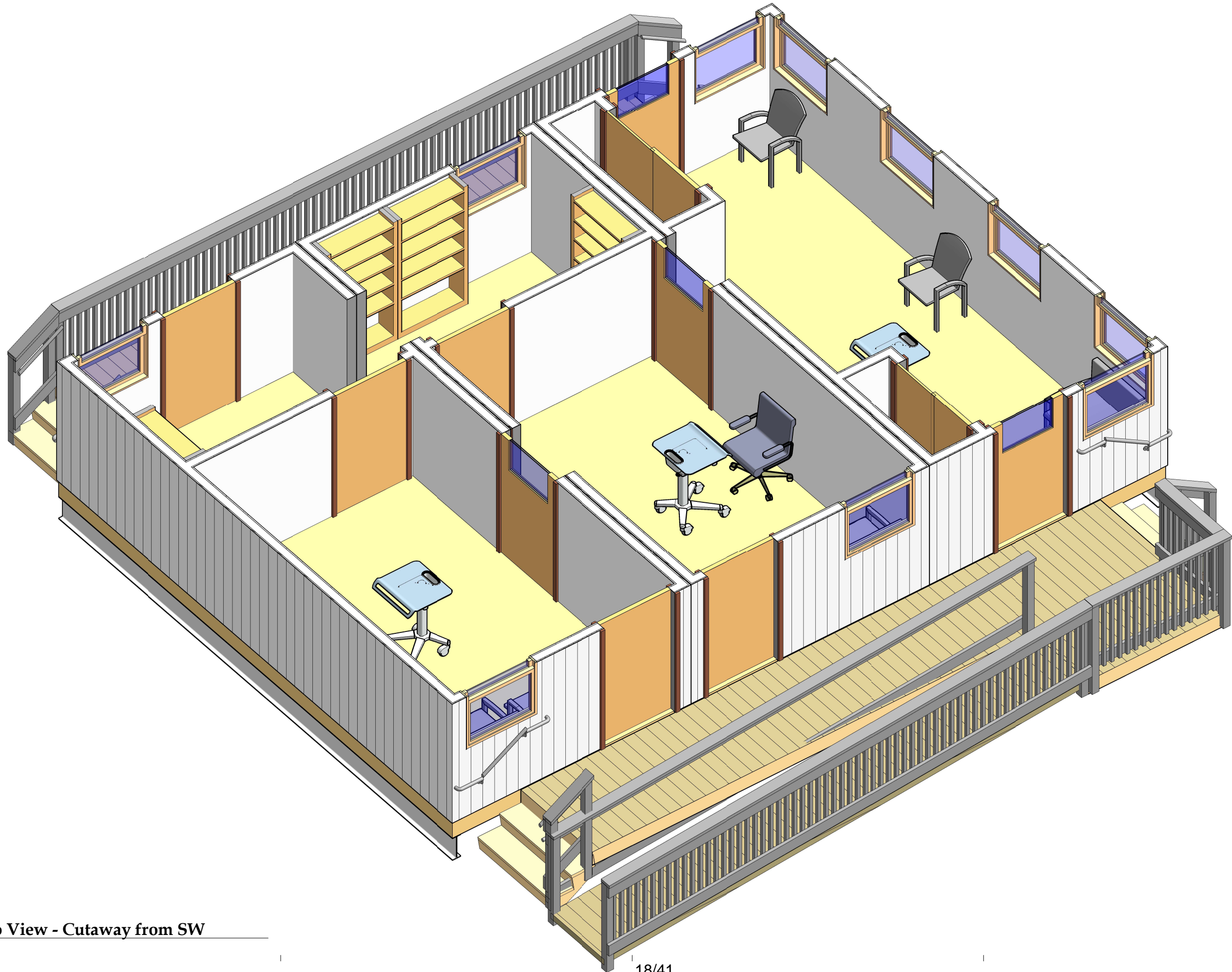
Axo View

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FILE: 20045

A501

1

Axo View - Cutaway from SW



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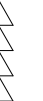
Bartlett Regional Hospital

Temporary Triage Facility

Juneau, Alaska

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Axo View

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A502

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.

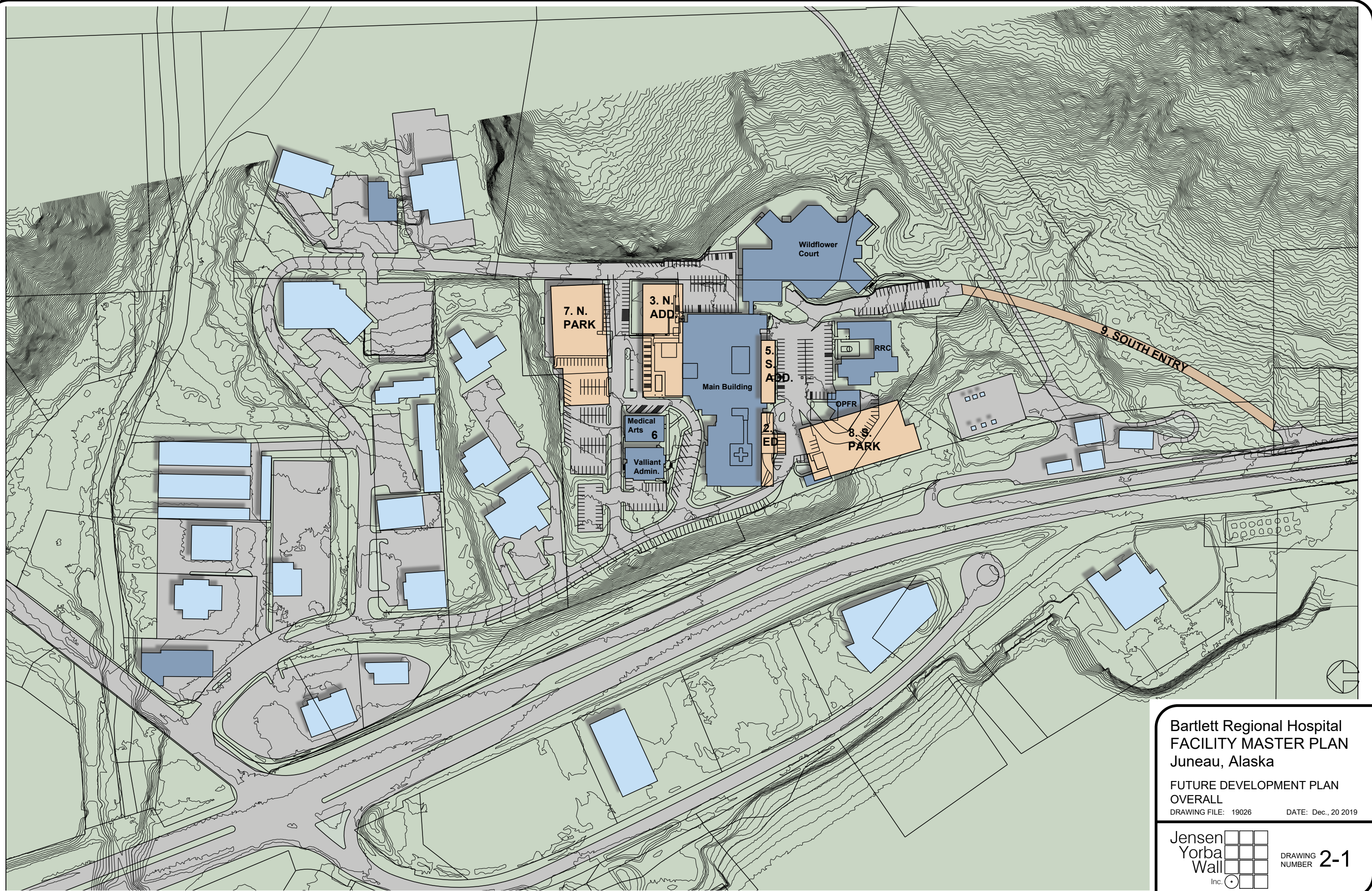
9. South Campus Entry

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.



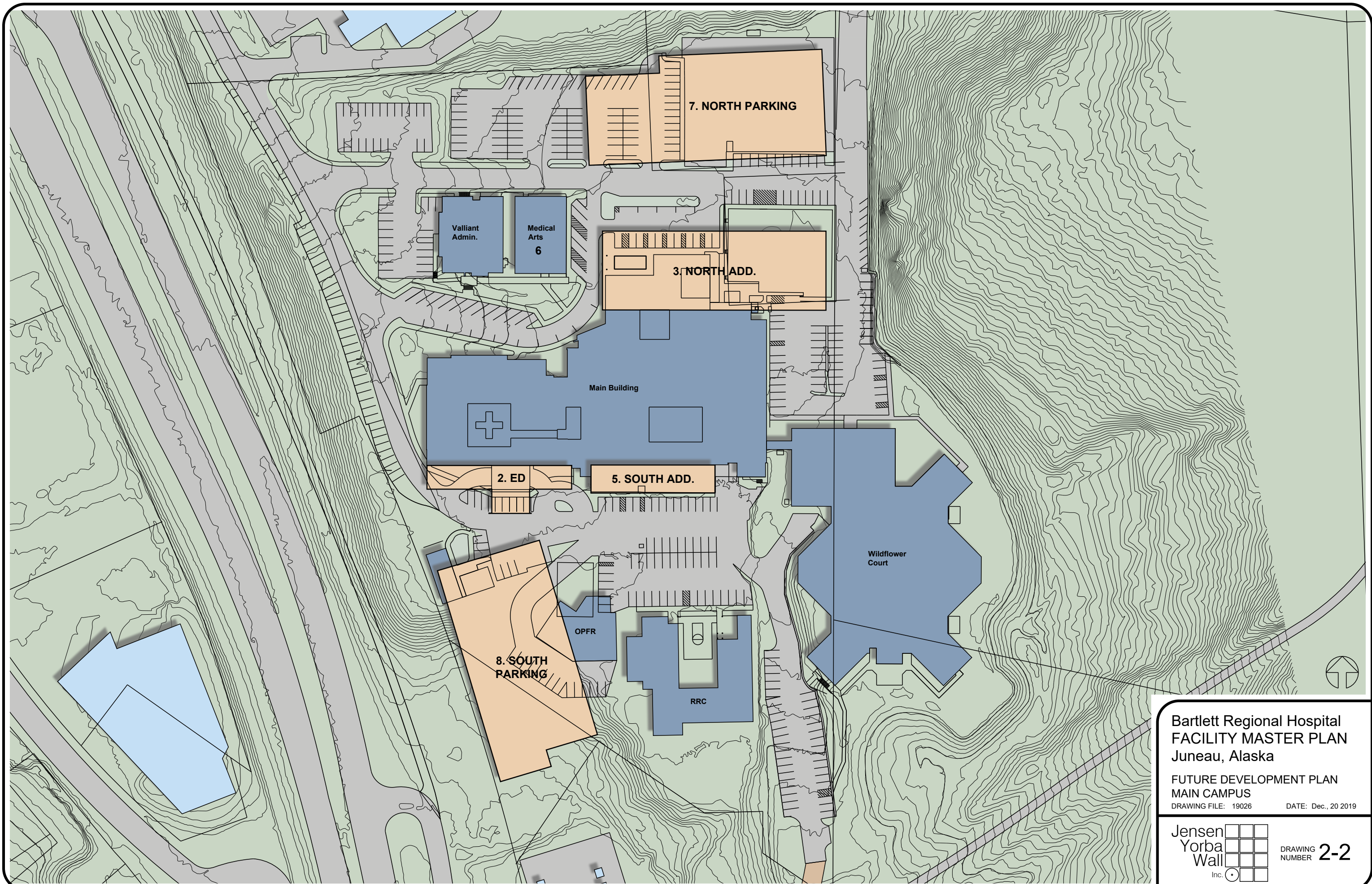
Bartlett Regional Hospital
FACILITY MASTER PLAN
Juneau, Alaska

FUTURE DEVELOPMENT PLAN
OVERALL

DRAWING FILE: 19026 DATE: Dec., 20 2019

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DRAWING
NUMBER 2-1



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

**FUTURE DEVELOPMENT PLAN
MAIN CAMPUS**

DRAWING FILE: 19026 DATE: Dec., 20 2019

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DRAWING
NUMBER **2-2**

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

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"> • Design Team – Yes • Architectural – Yes • Mechanical – Yes • Electrical – Yes
Medical-Surgical Director: Liz Bishop,RN	Long term: <ul style="list-style-type: none"> • (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. • 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. • <u>Negatives to this:</u> hospitalist need a new home and sleep room. Loss of dictation room and large storage area. 	Permanent <ul style="list-style-type: none"> • Hospital License change to add two new beds. • Design Team – Yes • Architectural – Yes <ul style="list-style-type: none"> • Potential new rooftop mechanical room. • New patient rooms. • New doors to create isolation wing. • Mechanical – Yes <ul style="list-style-type: none"> • New fan systems. • New ducting. • Sprinkler modifications. • New mechanical controls. • Plumbing. • Medical gases. • Electrical – Yes <ul style="list-style-type: none"> • New feeds to support mechanical. • Nurse call. • Fire alarm.

	<ul style="list-style-type: none"> • (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. • <u>Negatives to this:</u> 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. • 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. • Need crash cart and Defibrillator for area. • Need additional capnography machines for each room. • Staff request a lock to the MS unit (Badging system) with a communication phone to slow visitor traffic on the unit. 	<p>Permanent</p> <ul style="list-style-type: none"> • Design Team – Yes • Architectural – Yes <ul style="list-style-type: none"> • Potential new rooftop mechanical room. • New patient rooms. • New doors to create isolation wing. • Mechanical – Yes <ul style="list-style-type: none"> • New fan systems. • New ducting. • New mechanical controls. • Electrical – Yes <ul style="list-style-type: none"> • New feeds to support mechanical.
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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>Make all CCU Patient Rooms capable of being positive or negative pressure including pressure monitoring and alarms.</p> <ul style="list-style-type: none"> • We turned CCU 08 into a negative airflow room with a new fan in the ceiling. This is a permanent solution. • 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. • 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. • 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. • We also have a cart near 08/09 for mask storage. 	<p>Permanent</p> <ul style="list-style-type: none"> • Design Team – Yes • Architectural – Yes <ul style="list-style-type: none"> • Potential new rooftop mechanical room. • Mechanical – Yes <ul style="list-style-type: none"> • New fan systems. • New ducting. • New mechanical controls. • Electrical – Yes <ul style="list-style-type: none"> • New feeds to support mechanical.
<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"> • Design Team – Yes • Architectural – Yes
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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"> • Potential new rooftop mechanical room. • Mechanical – Yes <ul style="list-style-type: none"> • New fan systems. • New ducting. • New mechanical controls. • Electrical – Yes <ul style="list-style-type: none"> • New feeds to support mechanical.
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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"> 1. Patient and therapist schedules spaced/staggered in order to avoid overcrowding and lack of social distancing 2. 15 minutes between appointments to allow for properly sanitizing of the treatment rooms 3. Screening and proper protocols for sanitizing patient rooms and the Peds gym using Oxivir wipes and spray bottles of alcohol 4. Ordered (2) entire room UV lamps to disinfect primarily the Peds gym but can be utilized in other areas of our department 5. Utilization of Teletherapy where appropriate. 6. Waiting on plexiglass/barrriers for Administrative desk area and patient sign in 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 8. 2 treatment tables have been replaced that were deemed infection control risk 9. We need to change out chairs in our treatment rooms that are in poor quality and considered infection control issues 	

	<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"> • Design Team – Yes • Architectural – Yes • Mechanical – Yes • Electrical – Yes
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"> • 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. 	None

	<ul style="list-style-type: none"> • Schedule is staggered so only a few patients are checking in at a time. • Checked in patients go directly to the exam area without waiting most of the time. • Mammography patients go directly to the mammography suite. • 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? • Clean pen / Dirty pen area at reception. Clipboards are cleaned between patients. Counters are cleaned. • Chairs were taken out of DI and arranged remaining chairs so any patient waiting would be 6 feet apart. • 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. • Plexiglas barrier was requested to be placed on DI Reception counters, shortage of glass, still waiting. • Now that the UV light has been repaired we will continue with our plan to use it at night to treat exam rooms. • 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. • Extra equipment has been removed from imaging area to minimize areas need to be cleaned. 	
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	<ul style="list-style-type: none"> • Terminal cleaning is done in any area that a suspected patient is treated in. • 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. • Universal masking, frequent hand washing, screening employees daily, personal protective equipment and cleaning surfaces between patients. • Following the hospitals current visitor policy. <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"> • Patients are screened at the entrances to get their bracelet. Travel, temperature and questionnaire are completed. • No Patients with COVID-19 like symptoms are allowed to enter hospital as outpatients. • 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. • Staff in outpatient area follow masking and distancing. Once checked in patients go directly to the exam area 	

	<p>without waiting. Patients are required to have a mask and hand sanitizer is available.</p> <ul style="list-style-type: none"> • Exam area is wiped down after each patient, using provided cleaning equipment. • Plexiglas barrier was requested to be placed on reception counters, shortage of glass, still waiting. • ER patients with suspected COVID -19 samples are placed in stainless receptacle and wiped down for each time samples are removed. • 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. • Universal masking, frequent hand washing, screening employees daily, personal protective equipment and cleaning surfaces between shift or any time expected need. • Following the hospitals current visitor policy. 	
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"> • Design Team – Yes • Architectural – Yes <ul style="list-style-type: none"> • Potential new rooftop mechanical room.

	<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"> • Mechanical – Yes <ul style="list-style-type: none"> • New fan systems. • New ducting. • New mechanical controls. • Electrical – Yes <ul style="list-style-type: none"> • New feeds to support mechanical.
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		

Below does not include basic equipment and small changes like crash carts and lunch room/sleep room needs, small changes to allow better social distancing in PT/OT/ST etc						
Project	Primary Cat.	Secondary Cat.	Priority	Notes	Funding	Notes
ED Triage entry	Covid	ED	1A	no dominos	cares	In process
Main Entry screening	Covid		1B	no dominos	cares	
New Lab for viral and other screening	Covid	other	1C		cares/BRH	
Ventilation capacity	Covid		2		cares/BRH	
Ventilation Ducting to rooms	Covid				cares/BRH	
Ventilation Ducting to surgery	surgery				BRH	
Ventilation Ducting to lab and hoods	lab				cares/BRH	
Ventilation Ducting to boiler room	infrastructure				cares/BRH	
Ventilation Ducting to ED	ED				cares/BRH	
Fully enclose trauma rooms and provide for negative/positive pressure capability	Covid	ED		requires new ventilation system	cares/BRH	
3,675 sf expanded Emergency Department including new Exam, Triage, Pysch, rooms	ED				cares/BRH	
1,215 sf new 24-hour Pharmacy	ED				cares/BRH	
2,580 sf new Diagnostic Imaging Women's Clinic	1 st Floor				cares/BRH	
4,250 sf expanded Materials Management w/ dedicated Loading Dock	1 st Floor				cares/BRH	
4,040 sf expanded Facilities, including shop space	1 st Floor				cares/BRH	
300 sf expanded Facilities-Biomedical Shop	1 st Floor				cares/BRH	
2,470 sf expanded Facilities – Laundry	1 st Floor				cares/BRH	
300 sf reconfigured Shared Staff Space	1 st Floor				cares/BRH	
8,200 sf replaced Physician Services rental spaces to replace Juneau Medical Center	N. Addition				cares/BRH	
950 sf replaced Facilities offices to replace Juneau Medical Center	N. Addition				cares/BRH	
4,160 sf + 2,720 sf replaced/expanded Physical / Occupational / Speech Therapy to replace 1988 addition	N. Addition				cares/BRH	
350 sf + 630 sf replaced/expanded Cardiac Gym to replace 1988 addition	N. Addition				cares/BRH	
260 sf + 700 sf replaced/expanded Infusion to replace 1988 addition	N. Addition				cares/BRH	
8,625 sf expanded Cafeteria, including dedicated Loading Doc	N. Addition				cares/BRH	
Surgical Service expansion. Options include 2016 plan or North addition or South addition	Surgery				cares/BRH	
2 5000sf floors could be added to existing footprint	S. Addition			where the dominos could go	cares/BRH	
Purchase Bartlett Surgery Speciality Clinic building	expansion		2	dominos or alternative expansion	cares/BRH	
Replaces Medical Arts Building and relocated to staff to new north addition	Med. Arts Bldg				cares/BRH	
New parking	Parking				cares/BRH	
New access	access			CBJ primary project permitting	BRH/CBJ	
OB/Nursery/Special Care. Convert 1 room to positive/negative pressure capability	Covid	OB/Nursery/SC		requires new ventilation system	cares/BRH	
Med/Surg Give back wing negative/positive pressure capability	Covid	Med/Surg		requires new ventilation system	cares/BRH	Less impact/expense is a permanent wall where temp is now along with positive/negative pressure capability
Med/Surg add bariatric isolation room with negative/positive pressure capability	Covid	Med/Surg		requires new ventilation system	cares/BRH	
CCU All Patient Rooms with negative/positive pressure capability	Covid	CCU		requires new ventilation system	cares/BRH	
ED waiting area	Covid/General	ED	2		cares/BRH	
Proper changing rooms and areas to deal with PAPR's etc.	Covid	multiple		??requires new ventilation system	cares/BRH	
MHU convert 2 rooms for negative/positive pressure capability	Covid	MHU		Separate vent system from main	cares/BRH	

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.
