Bartlett Regional Hospital

AGENDA
PLANNING COMMITTEE MEETING
Monday, June 13, 2022 – 12:00 p.m.
Zoom Video Conference

This virtual meeting may be accessed via the following link:
https://bartletthospital.zoom.us/j/94747501805

or call 1-888-788-0099 and enter webinar ID 947 4750 1805

I. CALL TO ORDER

II. APPROVAL OF AGENDA

III. PUBLIC COMMENT

IV. APPROVAL OF THE MINUTES

- May 5, 2022 Draft Planning Committee Meeting Minutes (Pg.2)

V. OLD BUSINESS

1. Family Practice Building Update – Marc Walker
2. Master Facility Plan and Timeline – Marc Walker (Pg.4)
3. Current Projects Update - Marc Walker (Pg.7)
4. BOPS/Crisis Stabilization Project Update – Marc Walker (Pg.8)
5. ED Expansion Project Update – Marc Walker
6. Strategic Goal Initiatives – Jerel Humphrey (Pg.12)
   - Strategic Initiatives Update – Kim McDowell (Pg.14)
   - ECG Report Review– Brenda Knapp (Pg.15)

VI. COMMENTS

VII. NEXT MEETING – 12:00pm, Friday, July 1, 2022

VIII. ADJOURN

Bartlett Regional Hospital

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

Planning Committee Meeting Minutes
May 5, 2022 – 12:00 p.m. Zoom Videoconference

Called to order at 12:01 p.m., by Planning Committee Chair, Brenda Knapp.

PLANNING COMMITTEE* AND BOARD MEMBERS PRESENT: Brenda Knapp***,** Lance Stevens*, Mark Johnson*, Deb Johnston, Hal Geiger, Iola Young and Kenny Solomon-Gross

ALSO PRESENT: Jerel Humphrey, Robert Tyk, Kim McDowell, Dallas Hargrave, Marc Walker, Jeanne Rynne, Claire Stremple and Anita Moffitt

APPROVAL OF AGENDA – ***Mr. Stevens made a MOTION to approve the agenda as written. Mr. Johnson seconded. There being no objections, agenda approved.***

PUBLIC PARTICIPATION – None

APPROVAL OF THE MINUTES – ***Mr. Johnson made a MOTION to approve the minutes from the April 1, 2022 Planning Committee meeting. Mr. Stevens seconded. There being no objections, minutes approved as presented.***

MASTER FACILITY PLAN AND TIMELINE – Mr. Walker reported the facility plan and timeline, included in the packet, is up to date. Color coding clarified at Ms. Knapp's request: Green represents small projects less than $500,000, yellow are projects between $500 Thousand and $2 Million, orange are projects $2 Million to $10 Million and red are major projects greater than $10 Million. We are still in design for power conditioning and surge suppression.

CURRENT PROJECTS UPDATE – Mr. Walker provided an overview of the project update list included in the packet. He reported the water main and site improvement project is well underway and moving along quicker than anticipated. Parking is very limited. The ASU-11 Endoscopy fan project is ongoing. RRC siding and window replacement should be finished by the end of this month. Doors are due to be here mid to late July for the door replacement project and will be installed in phases. Surge suppression project is close to going out to bid. CT/MRI 100% bid documents due May 9th. ED addition and renovation meetings ongoing. Underground fuel line project will soon go out to bid with caveats that work cannot start until after the site work is complete. The windows and siding replacement of the administration building is an ongoing project that will drag out over the next year. The hospitalist sleep room renovation is on hold until the fall.

BOPS / CRISIS STABILIZATION PROJECT UPDATE – Ms. Rynne reported construction is moving along very well. Steel erection completed this week, interior framing going in, main roof dried in yesterday. The only roofing left to do is the entry canopy. Some utilities are being relocated.

ED EXPANSION PROJECT UPDATE - Ms. Rynne reported we are moving along through design, concept drawing submittals due to be received today. Cost estimate with concept drawing expected next week. She presented a procurement methodology for the project and requests consideration of approval by the committee. CBJ procurement code allows alternative public works upon approval by the Assembly. It might be beneficial to use this methodology for this project. A recommendation to use the GC/CM (General Contractor/Construction Manager) approach was made. This allows a general contractor to come on board early to give input on phasing and provide pricing as we work our way through design. Renovation of the ED is a complex job and will need to be done in phases to cause as little disruption in operations as possible. GC/CM methodology allows for a qualifications based selection of the contractor versus taking the lowest bidder. It allows prices to be locked in on scopes of work for trades earlier in the project and spreads the risk of

construction escalation over time. Senior Leadership has reviewed this methodology and recommends committee approval. Because using this option requires an ordinance to be passed by the assembly, it also needs to go to Public Works and Facility Committee and the Assembly for approval. She noted the best time to bring this procurement method on board is between schematic design (July 11th) and design development (September). Architect is working on the components of the Certificate of Need (CON) application related to the design. Nathan Overson is in conversations with the State about the CON. Ms. Knapp obtained confirmation that use of this alternate procurement methodology is determined on a case by case basis. At Mr. Solomon-Gross' request, Ms. Rynne explained the differences between the options presented in the packet. It was agreed that it would be prudent to go through Bartlett's process first, as outlined in option 2. There is an RFP (Request for Proposal) specifically for receiving GC/CM pre-construction services. Ms. Johnston noted she has successfully used this methodology in the past and expressed her support. Mr. Geiger also expressed support of this methodology and enquired why this is a board issue and not a management issue. Requests to go before the Assembly on behalf of BRH need board approval. Mr. Stevens expressed support of the methodology.

MOTION by Mr. Stevens to accept option number 2 and the timeline it represents for this project. Mr. Johnson seconded. There being no objection, MOTION approved. This will now be presented to the board for approval.

Bartlett Surgery and Specialty Clinic (BSSC) Relocation – Mr. Humphrey reported SEARHC has agreed to extend the BSSC lease for 3 months. BSSC will have a semi-permanent home in the Juneau Medical Center building when behavioral health services move into their new space.

Prioritization of Strategic Goal Initiatives – Ms. Knapp reported she and Mr. Humphrey met to discuss the strategic initiatives assigned to Planning. Some initiatives can be worked on simultaneously but staff input and recommendations are needed. Mr. Humphrey noted we are already working on expanding workforce development programs and he has had discussions with Mr. Tyk about exploring the feasibility of a hospital run clinic. A return on investment evaluation will be done on any new services brought on. Expansion or affiliation will be Board directed with an expectation that the facility would have telemedicine capabilities to help build BRH's telemedicine capabilities. A Business Development Analyst is coming on board in a couple of months and will be expected to run with this project when an affiliate is identified. Ms. Knapp agreed that it makes sense that expanding workforce development programs rests with HR and the clinical staff; they can advise the board on progress. Mr. Tyk is to provide input about the feasibility and practicality of hospital run clinics and employed physicians. Ms. Knapp suggests committee members review the recommendations of the affiliation study conducted by ECG in 2020. Mr. Stevens said it's important to evaluate what we're already doing. The evaluation of clinics is a great step and we should use Mr. Tyk's expertise while we have it. We are 2-3 months away from hiring a CEO. The CEO and the Business Development Analyst are going to drive the affiliations and buildouts process so it would be wise to pause for now to get their input in the early process. Mr. Tyk cautions that small independent hospitals need to be careful when it affiliates with a large organization. Historically, small facilities become gobbled up and become a feeder to the bigger hospital. It is important for the board to take time and effort to make sure both parties benefit. Ms. Knapp and Mr. Johnson agree with Mr. Tyk. Mr. Johnson also agrees that it would be good to pause until a new CEO is in place. He also noted it wouldn't hurt to explore the federally funded qualified health center issue but it isn't easy to justify the need for one. Brief discussion held about whether Front Street Clinic qualified as one or not.

Comments – Mr. Geiger requested a COVID update. Ms. McDowell reported 2 positive patients in house and 15 positive employees. BRH has taken over CCFR COVID testing and it is now being done on campus. Supplies are good. COVID case numbers keep increasing in the community. The current strains are more transmissible but have less impact, partly due to high vaccination rates. BRH has had no critically ill COVID patients in a while. COVID updates will continue to be provided at monthly board meetings as a standing agenda item but not at committee meetings.

Next Meeting – To be determined. Ms. Knapp will be out of town June 3rd. Mr. Stevens will no longer be on the board. Ms. Knapp will work with Ms. Moffitt to identify a date and will speak with Mr. Solomon-Gross about replacing Mr. Stevens on the committee.

Adjourned – 12:54 pm.

Bartlett Regional Hospital
Facilities Master Plan - Project Priorities List
June 13, 2021

Originally Prepared by Jensen Yorba Wall, Inc.
586-1070 corey@jensenyorbawall.com

		Project	Type	Estimated Cost	Primary Cat.	Priority	Notes	Funding	Status
A. Bidding / Under Construction									
	A1	Ventilation Improvements to Surgery (Endoscopy) SF11 Replacement	Reno	$400k	Surgery			BRH	Construction Winter 20/21
	A4	BOPS Replacement Building	New	$18M	Behavioral Health		May impact ED Addition	BRH	Under Construction
	A5	Rainforest Recovery Center Exterior Upgrade	Reno	$460k	Infrastructure			Def Maint Fund	Under Construction
	B5	Fuel Oil Tank Supply Line Upgrade	Site	$609k	Infrastructure			Def Maint Fund	Ready to Bid
	B3	Phase 1 Sidewalk Replacement	Site	$1.8M	Infrastructure			Def Maint Fund	Under Construction
	B4	Southwest Asphalt Replacement (Combined with B3)	Site		Infrastructure			Def Maint Fund	Under Construction
	NEW	Campus Door Upgrades	Reno	$1.1M	Infrastructure			Def Maint Fund	Awarded In Submittal Phase
	NEW	Chiller 2 Replacement	Reno	$465K	Infrastructure			Def Maint Fund	Awarded In Submittal Phase
	C9	Power Conditioning	Site	$1.8M			Comprehensive surge protection & power cond.	Def Maint Fund	Phase 2 Surge Suppression Ready To Bid
B. In Design									
	C1	Emergency Dept. Addition & Ventilation Upgrade	Reno	$18M	Covid			Bonding / BRH	In Conceptual Design
		ED - Expanded ED. incl. new Exam, Triage, & Pysch Rms (3,675 sf)			ED				
		ED - New 24-hour Pharmacy (1,215 sf)			ED				
		ED - Reconfigured, relocated and possibly expanded ED Waiting Room			ED		Enlarge for patient separation. Relocate to Entrance.		
		2005 Bldg - OB/Nursery/Special Care. Convert 1 room to +/- pressure			Covid		Requires ventilation system modification		
		2005 Bldg - CCU. All patient rooms with negative/positive pressure			Covid		Requires ventilation system modification		
		2005 Bldg - MHU. Convert 2 rooms for negative/positive pressure			Covid		Requires new ventilation system		
		Pre-2005 Bldg - Med/Surg. Entire back wing negative/positive pressure			Covid		Requires new ventilation system		
		Pre-2005 Bldg - Med/Surg. Add bariatric isolation room with +/- pressure			Covid		Requires new ventilation system		
	NEW	Phsician Sleep Rooms (Redesign and rebid in August 2022)	Reno	$500K	Physician			Def Maint Fund	Redesign/Rebid August 2022
	NEW	CT/MRI Replacement	Reno	$6M	DI			BRH	In Design
C. Future Projects									
	B6	New South Site Access	Site	$1.5M	Access		CBJ primary project permitting	BRH/CBJ	
	NEW	OR Lights/Booms and required infrastructure upgrades	Reno	$3M	Surgery			BRH	Working with vendor on ROM
	C2	North Addition - Phase 1 (34,600 sf 2-story or 51,900 sf 3-story)	New/Reno	$30-50M			Where majority of dominos could go	Bonding	
		Physician Services rental to replace Juneau Medical Center (8,200 sf)			N. Addition				
		Facilities Offices to replace Juneau Medical Center (950 sf)			N. Addition				
		Expanded Phys. / Occ. / Speech Therapy to replace 1988 Add. (6,880 sf)			N. Addition				
		Expanded Cardiac Gym to replace 1988 Add. (980 sf)			N. Addition				
		Expanded Infusion to replace 1988 Add. (760 sf)			N. Addition				
		Expanded Cafeteria / Kitchen, incl. dedicated Loading Dock (8,625 sf)			N. Addition		Kitchen must move before 1st Floor Reno	BRH	
	C2B	Proper Changing Rooms and Areas to deal with PAPR's etc.	Reno	Small	Covid		Requires new ventilation system	BRH	
	C2C	Permanent IT Room	Reno	Medium					
	C3	1st Floor Renovation	Reno	$12M			Requires moved Kitchen (North Addition)	Bonding	
		Abatement / Replacement of ductwork and mechanical in Main Shaft					All individual 1st Floor projects could be phased		
		Expanded Materials Management w/ dedicated Loading Dock (4,250 sf)			1st Floor				
		Expanded Facilities, including Shop space (4,040 sf)			1st Floor				
		Expanded Facilities-Biomedical Shop (300 sf)			1st Floor				
		Expanded Facilities – Laundry (2,470 sf)			1st Floor				
		Reconfigured Shared Staff Space (300 sf)			1st Floor				
		New Diagnostic Imaging Women's Clinic (2,580 sf)			1st Floor				
	C4	South Addition over Cafeteria (2,800 sf, 5,000 sf, or 10,000 sf)	New	$3-10M	S. Addition		New Lab space would allow reno of extg. Lab	Bonding	
		Relocate Lab or partially relocate and renovate (2,800 sf or 5,000 sf add.)							
		Create new direct cooridor from ED elevator to Surgical Services							
		Relocate Med Surge patient rooms to exterior, add core (10,000 sf add.)							
	C4B	Lab Renovation, including Ventilation Upgrade	Reno	Medium	Lab		Not clear how to renovate without domino space	BRH	
	C4C	Ventilation Upgrade - Boiler Room	Reno	Small	Infrastructure		May not totally solve heat problem in Lab	BRH	

Bartlett Regional Hospital
Facilities Master Plan - Project Priorities List
June 13, 2021

Originally Prepared by Jensen Yorba Wall, Inc.
586-1070 corey@jensenyorbawall.com

		Project	Type	Estimated Cost	Primary Cat.	Priority	Notes	Funding	Status
	C5	Surgical Service Expansion. Options: 2016 plan, North, or South Add.	New	Large	Surgery		Some or all could be in North Addition	Bonding	
	C6	Remove Medical Arts Building, Improve Central Site	Site	Medium	Med. Arts Bldg		Requires Admin. room elsewhere (North Addition)	BRH	
	C7	New Parking Garage	Site	Large	Parking		Requires temporary parking loss	Bonding	
	C7B	New Parking Garage with Rental / Physician Space above	Site	Large	Parking		Requires temporary parking loss	Bonding	
	C8	South Parking / Entrance / Garage		Medium	Parking		Required by ED expansion, South Site Access		
	C8B	Site Assessment		$150K	Assessment			Transfer from Deferred Maint to CIP	
		List 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 Size: Small < $500k, Medium $500k - $2M, Large $2M - $10M, Major > $10M							

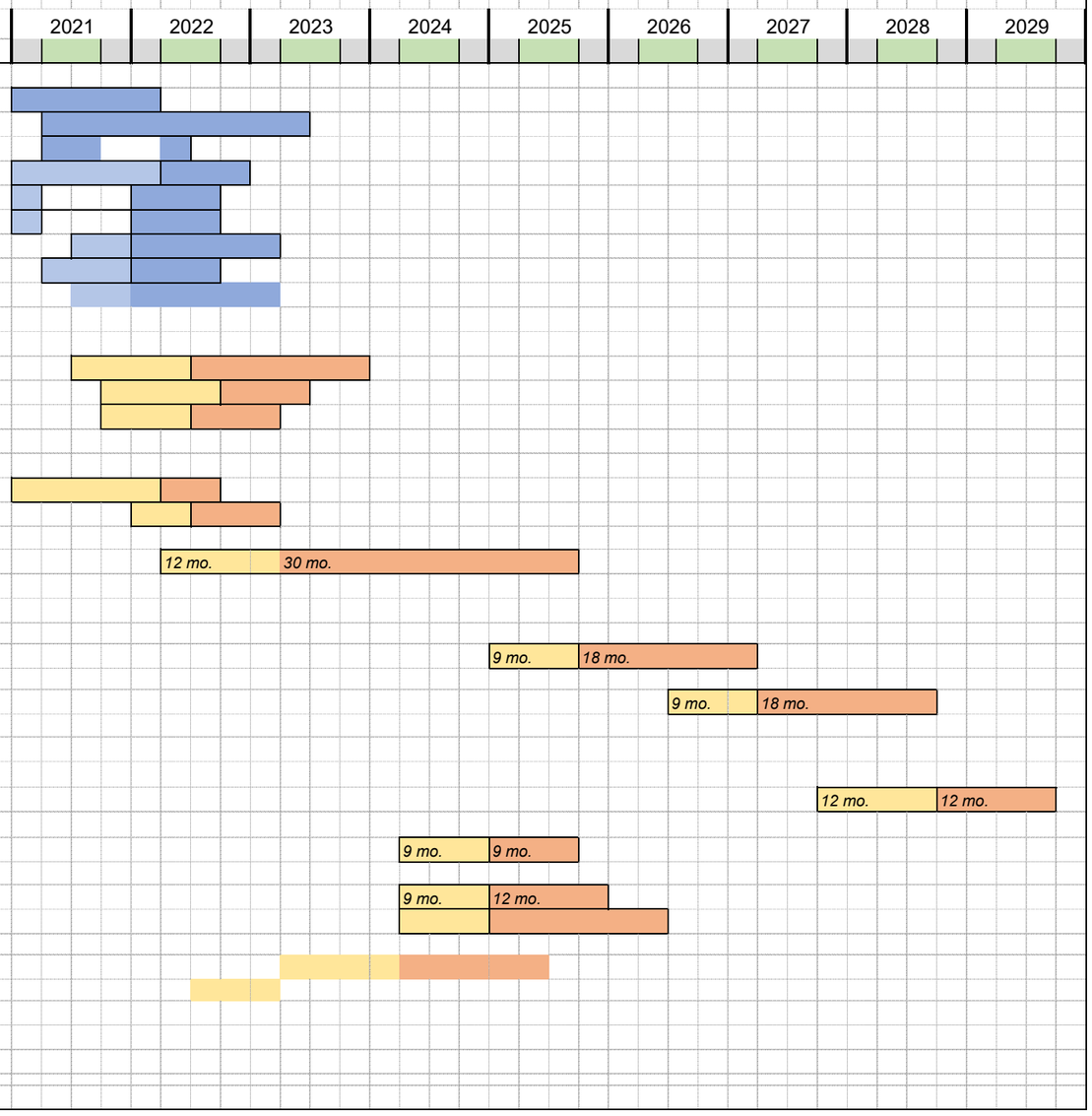
Bartlett Regional Hospital

Facilities Master Plan - Project Priorities Project Timeline

June 8, 2022

Originally Prepared by Jensen Yorba Wall, Inc
586-1070 corey@jensenyorbawall.com

		Project
A. Bidding / Under Construction		
	A1	Ventilation Improvements to Surgery (Endoscopy) SF11 Replacement
	A4	BOPS Replacement Building
	A5	Rainforest Recovery Center Exterior Upgrade
	B5	Fuel Oil Tank Supply Line Upgrade
	B3	Phase 1 Sidewalk Replacement (+Road Work)
	B4	Southwest Asphalt Replacement (Combined with B3)
	NEW	Campus Door Upgrades
	C9	Power Conditioning
	NEW	Chiller 2 Replacement
B. In Design		
	C1	Emergency Dept. Addition & Ventilation Upgrade
	NEW	Phsician Sleep Rooms (Redesign and rebid in August 2022)
	NEW	CT/MRI Replacement
C. Future Projects		
	B6	New South Site Access (Intrim CEO Request to await arival of permenant CEO)
	NEW	OR Lights/Booms and required infrastructure upgrades
	C2	North Addition - Phase 1 (34,600 sf 2-story or 51,900 sf 3-story)
		C2B - Proper Changing Rooms and Areas to deal with PAPR's etc.
		C2C - Permanent IT Room
	C3	1st Floor Renovation
	C4	South Addition over Cafeteria (2,800 sf, 5,000 sf, or 10,000 sf)
		C4B - Lab Renovation, including Ventilation Upgrade
		C4C - Ventilation Upgrade - Boiler Room
	C5	Surgical Service Expansion. Options: 2016 plan, North, or South Add.
	C6	Remove Medical Arts Building, Improve Central Site
	C7	New Parking Garage
	C7B	New Parking Garage with Rental / Physician Space above
	C8	South Parking / Entrance / Garage - See also C7 and C7B
	C8A	Site Assessment



- Project Planning & Design

- Project Construction

BRH Project Updates

May 26, 2022

Close-out Phase

- **CSR Equipment Upgrades:** Final pay request has been approved.

Under Construction

- **ASU-11/Endo Fan**: RFP 13 for additional ductwork and final system re-balance has been approved. Ductwork scheduled for Friday 6/3 through Saturday 6/4. System rebalance scheduled for week of 6/27-7/1.
- **RRC Siding and Window Replacement:** Substantial completion date for project is 5/31/2021. All interior work is completed, remaining work is gutter installation, re-seeding and punch list items.
- **Behavioral Health Facility:** Application of spray-on fire-proofing is nearly complete. All roofs are dried in. Interior wall framing is underway, beginning at the basement level. Exterior wall framing continues. New water line has been installed through the site along the temporary access road. The final completion date is anticipated to be early March of 2023.
- **BRH New Water Main and RRC Waste Line Repairs:** Admiralty Construction has finished work on the waterline up the temporary access road on the Behavioral Health Facility site; currently tying into the existing system near the Emergency Entrance. Work should be completed in this area next week. Work will continue with replacement of the sewer system. Estimated duration of the sewer work is two weeks. Substantial Completion for the project is 8/15/22.
- **BRH Site Improvements:** Phase I, II and III are almost complete. Pouring the remaining curb and gutter this week in preparation for paving before the end of the month, weather permitting. Soon after, Phase IV work will begin on the access road to Salmon Creek Lane. Substantial Completion for the project is 9/30/22.
- **Campus Door Upgrades:** Currently in submittal phase of project. Lead time for hollow metal doors is approximately 20 weeks; submittal for doors and frames was approved on 2/23/2022, which puts arrival of doors approximately mid-July.
- **Chiller #2 Replacement:** Currently in submittal phase of project. Chiller lead time is approximately 27 weeks and the chiller submittal was approved on 3/25/2022, which puts arrival of chiller around 9/30/2022.

In Design

- **BRH Surge Protection Campus TVSS (Transient Voltage Surge Suppression) Upgrades**: The project is currently advertised with bids opening on June 2. The engineer's estimate range is $250,000-$350,000. Phase 2 to address UPS (Uninterruptable Power Source) is in design; CBJ and BRH are reviewing the fee proposal. Design for Phase 2 is estimated to be complete in April 2023.
- **CT Scanners/MRI Infrastructure Upgrades:** 100% bid documents are due June 17th. Project will advertise for bid mid-July. Architect's construction estimate range is $1.1M-$1.3M. Construction planned to begin September 2022 with completion in November 2023.
- **ED Addition and Renovation:** Architects Alaska (AA) completed concept drawings and is moving into the Schematic Design phase. The project team is evaluating the merits of a hammerhead turn-a-round verse a roundabout at edge of Wildflower Court as the ambulance path. Selection is pending concept cost estimate and a practice drive by CCFR. LEED exemption request approved by JCOS (Juneau Commission on Sustainability) May 4, 2022 and by PWFC on 6/6; moves to Assembly on 6/13. AA is working with HPD per BRH's direction, supporting the concurrent path of submitting a Request for Determination and preparing application materials for a Certificate of Need.
- **Underground Fuel Line Replacement:** 100% documents received by Taku Engineering February 22, 2022. Construction estimate is $ 415,000. Total project cost is $609,000. Currently advertising for bidders. Bids will be opened on June 7, 2022
- **Valiant Administration Building Window Replacement**: Scoping meeting for Phase 1 investigative repairs was held on May 6. JYW and Carver Construction are preparing fee proposals for their associated scopes of work under their respective term contracts. Work to be completed this summer.
- **Hospitalist Sleeping Quarters Renovation (AKA Physician Call Room):** Currently revising scope and value engineering the project in order to reduce construction cost. Planning to rebid the project in August 2022.

Planning

- **Parking Study:** BRH Board of Directors has approved $150,000 to be used for a Parking Study. This project has been assigned to CBJ Engineering.

On hold/Cancelled

- N/A

CITY & BOROUGH OF JUNEAU
ALASKA'S CAPITAL CITY

Daily Observation Report

ENGINEERING DEPARTMENT
CIP Engineering, Third Floor
230 So. Franklin Street, Marine View Center

Project: BRH Behavioral Health Facility, CBJ Contract # BE21-149

Contractor: Dawson Construction

Date/Time Friday, June 3, 2022 08:45 a.m.

Weather: Sunny, calm wind, 63 degrees (ground surface – dry.)

Report by:
Rod Wilson, Project Manager, (907) 789-4867 (landline)
Jeanne Rynne, CBJ City Architect, 586-0800, x4186
X Steven Garger, Project Manager, 586-0800x4206

Onsite Workforce/Equipment:

Trades	# of Persons	Major Equipment / Notes
General – Dawson Construction (DC)	6	Site supervisor (Jason) & 5 laborers
Mechanical/Plumbing – Inside Passage (IP)	2	Plumber & 1 laborer
Civil – Southeast Earth Movers (SEEM)	0	Not on site at time of field visit

On Site Equipment	# of Pieces	Major Equipment Listing
Equipment, active (DC)	1	-Telescoping forklift (GEHL RS10-55 GEN 3)
Equipment, idle (DC)	1	- Genie S60 Man Lift (Tyler Rental)
Equipment, idle (SEEM)	1 1 1	-10 yard dump truck - Large Excavator (Link-Belt 290-LX) - Large drum compactor
Equipment, idle (SEEM)	1 1	- BOMAG 70/70 Compactor - Front-end loader (Volvo CR6U36 L110G)

Purpose of site visit: Routine, daily site visit.

Description of Work:

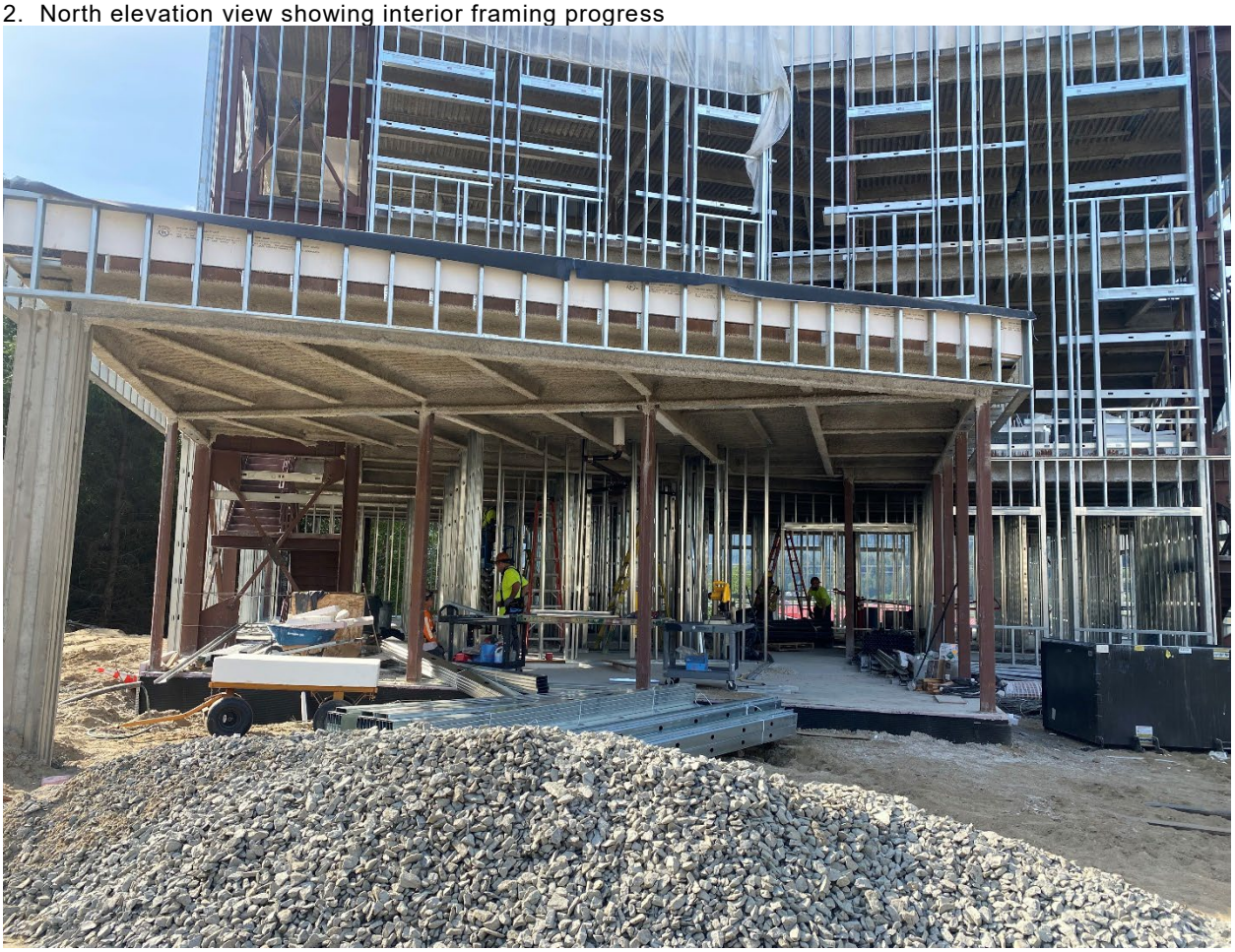
Dawson Construction: DC workers: Continuing work on interior framing on level one and balcony framing on level two.

Inside Passage: IP workers transporting plumbings materials to the upper floor levels

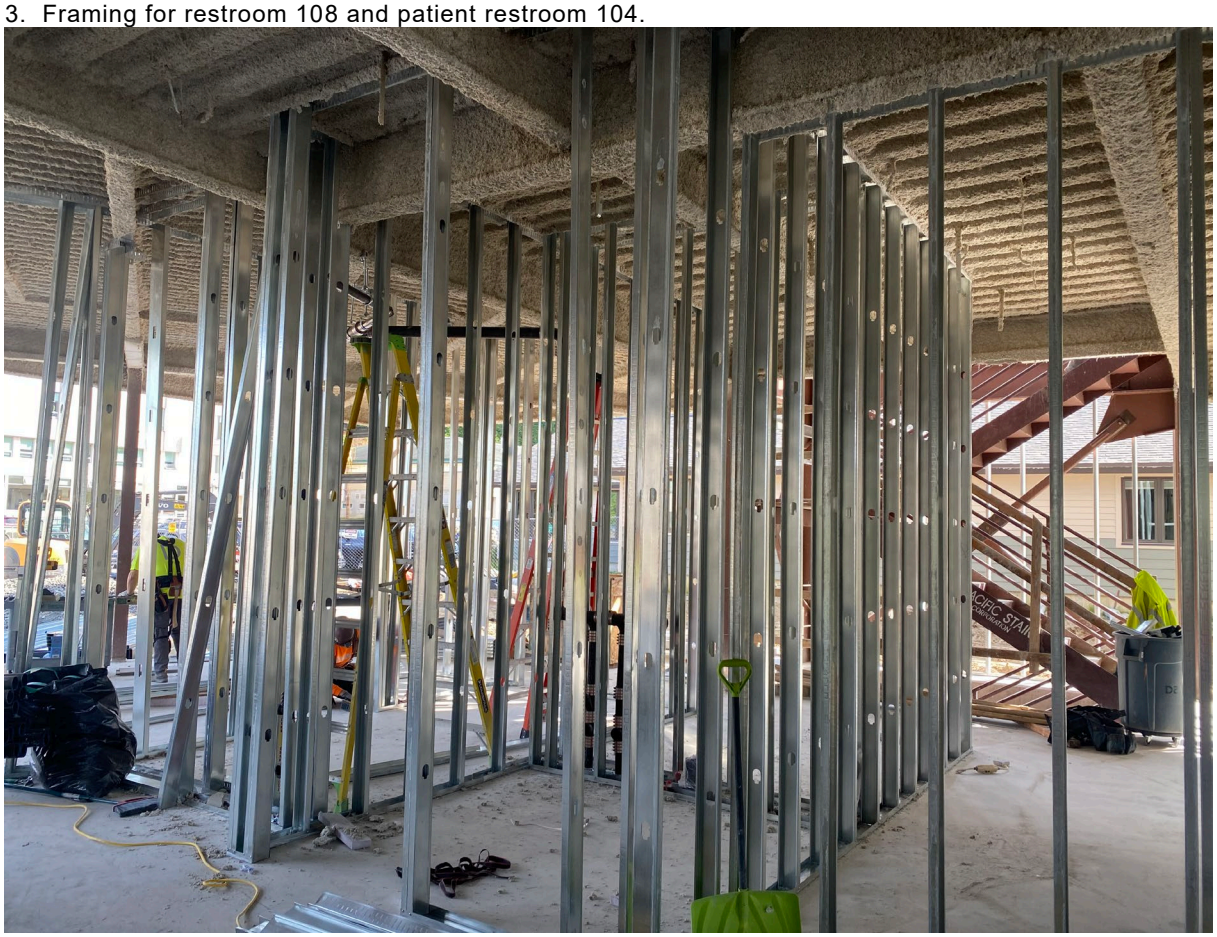
Southeast Earth Movers: Workforce not on site at time of field visit.

1. IP workers moving pipe to new location. DC workers cutting studs for interior framing.

2. North elevation view showing interior framing progress



3. Framing for restroom 108 and patient restroom 104.



4. Roof access hatch installed.

5. Gasket on roof access hatch was coming off. Jason said they would apply additional sealant to get it to adhere.

1. Services: Develop, maintain, and grow a sustainable service portfolio that is responsive to community needs.		
	Initiative	**Owner**
1.1	Evaluate and expand affiliations and partnerships with other healthcare organizations.	Planning Committee
1.2	Develop a comprehensive telehealth department at Bartlett Regional Hospital to help develop new service lines.	Planning Committee
1.3	Recruit needed medical specialists.	Physician Recruitment Committee

2. Facility: Maintain a comprehensive campus. Address major replacement needs and options for future service lines and revenue growth.		
	Initiative	**Owner**
2.1	Develop a facility plan that provides for the efficient delivery of clinical services.	Planning Committee
2.2	Develop proformas for additional service lines, change of use, and acquisitions to properly evaluate return on investment so the board can move decisively.	1. Planning Committee 2. Governance Committee
2.3	Evaluate current Bartlett Regional Hospital technology and industry best practices to prioritize replacement and identify new equipment needs.	Governance Committee

3. People: Create an atmosphere that enhances employee, physician, and stakeholder satisfaction to improve our ability to recruit and retain. Improve strategic alliances and communication to maintain a community continuum of care.		
	Initiative	**Owner**
3.1	Resolve electronic medical record system concerns.	1. Finance Committee 2. Quality Committee
3.2	Expand workforce development programs.	1. Planning Committee 2. Quality Committee
3.3	Explore feasibility of hospital run clinics and hospital employed providers.	1. Planning Committee 2. Finance Committee

4. Financial: Develop a revenue and net income stream that maintains cash reserves while facilitating above goals and objectives.		
	Initiative	**Owner**
4.1	Evaluate current guidelines to identify the number of days of unrestricted cash on hand that are required.	Finance Committee
4.2	Ensure Bartlett Regional Hospital has the proper executive team to manage finances and assure adequate financial controls.	Finance Committee
4.3	Monitor inflation, provider shortages, and labor shortages impact on budget.	Finance Committee
4.4	Evaluate service line impact on revenues.	Finance Committee

5. Quality and Safety: Provide excellent community centered care that improves outcomes, maximizes safety, improves access and affordability and is in compliance with national and state regulations.		
	Initiative	**Owner**
5.1	Stay current on technology and resources to facilitate risk management, data security, and employee safety.	Quality Committee
5.2	Develop quality initiatives that exceed accreditation and regulation requirements.	Quality Committee

6. Compliance: Continuously improve a robust, proactive compliance program at all levels while maintaining our strategic goals.		
	Initiative	**Owner**
6.1	Maintain a robust education and training program at all levels to assure compliance goals are achieved.	Compliance Committee

06/08/2022 Strategic Goal Updates by Kim McDowell, CCO

Initiative 1.1 Evaluate and expand affiliations and partnerships with other healthcare organizations.

- CCO asked to co-chair the Rural Chair on the Alaska Hospital & Healthcare Association. This will aid in building relationships with other healthcare organizations and possibly make partnerships/affiliations easier to obtain.

Initiative 3.1 Resolve EMR system concerns.

- Currently working with IT & Meditech to do a site visit for ED Director, CCO and Dr. Jones to see how ED Expanse works in an ED in Mississippi.

- Had IT amend Expanse contract to reflect a six-week training for nurses upon conversion, instead of the original four weeks.

Initiative 3.2 Expand workforce development programs

- Hospital based CNA program- Active

- OR Tech Program- Active

- Pharmacy Tech Training Program- Active

- Partnering with UAA/APU nursing program for nursing student co-horts to do clinicals at BRH- Active

- Food Services Aides (FSA)- Providing opportunity pathway to have FSA l, ll, and lll- in process

Bartlett Regional Hospital

Provider Network Development Analysis

Final Report

June 23, 2020

1111 Third Avenue, Suite 2500
Seattle, WA 98101
P **(206) 689-2200**
F (206) 689-2209

ECG MANAGEMENT CONSULTANTS
A Siemens Healthineers Company

800.720.7635 ecgmc.com

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Table of Contents

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 sunsetting 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 precense 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.[1] 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.[2]

» *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.[3] 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.[4] "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

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

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

3 "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.

4 "Ambulatory Surgical Center Payment System," CMS, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AmbSurgCtrFeepymtfctsht508-09.pdf.

points. Recent proposals have indicated future reductions to provider-based departments that were previously exempt from reimbursement cuts.[5]

» *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.[6]

» *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.[7]

» *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[8] and Mt. Edgecumbe Hospital in 2019.[9] SEARHC also purchased 17 acres of undeveloped land in Juneau in 2018[10] 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.[11]

» *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

5 "2019 Rural Report," American Hospital Association, https://www.aha.org/system/files/2019-02/rural-report-2019.pdf.

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

7 "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.

8 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.

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

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

11 "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).[12]

» *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.

[12] "2016 Alaska Health Care Workforce Profile," https://www.uaa.alaska.edu/academics/college-of-health/departments/acrhhw/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[13]

Type	Measure		
Qualitative Measures	» Revenue structure » Revenue-raising ability and tolerance » Political dynamics	» Quality of financial management (budgetary, capital, and strategic planning) » Timely implementation of strategies in response to changing internal and external dynamics » Public policy frameworks	» Track record of social and political stability » Assessment of political commitments (fiscal adjustment, oil price stability) » Environmental issues
Quantitative Measures	» Structure of the economy » Investment rate, saving rate » Inflation record » 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)	» Financial operations (e.g., expense structure, including fixed cost trends, trend of budget surplus or deficit, size and liquidity of financial reserves) » Factors that help assess the sustainability of public debt » Off-balance sheet liabilities	» Future liabilities such as pension and healthcare costs » Composition of the debt in terms of maturity, interest-rate sensitivity, and the size of assets that can be liquidated

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.

13 "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 Aa2 Aa3	High quality, subject to very low credit risk
	A	A1 A2 A3	Upper-medium grade, subject to low credit risk
	Baa	Baa1 Baa2 Baa3	Medium-grade, subject to moderate credit risk and may possess certain speculative characteristics
Speculative Grade	Ba	Ba1 Ba2 Ba3	Judged to be speculative, subject to substantial credit risk
	B	B1 B2 B3	Considered speculative, subject to high credit risk
	Caa	Caa1 Caa2 Caa3	Speculative and likely in, or very near, default, with some prospect of recovery of principal and interest
	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

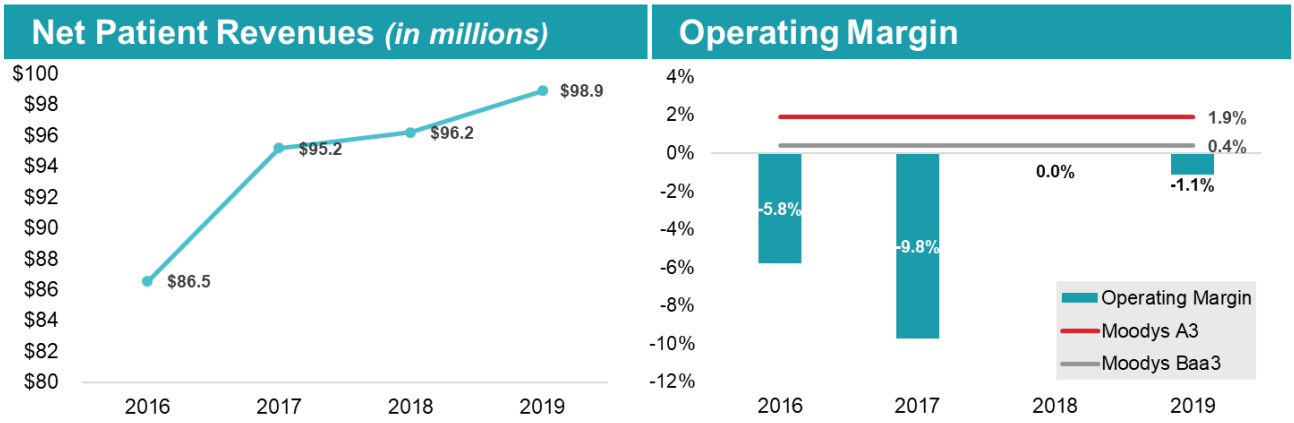
C. BRH Internal Assessment

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.[14]

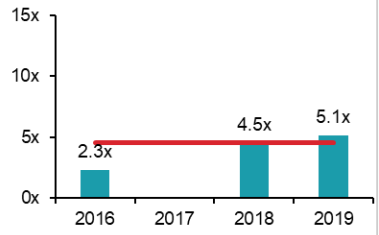
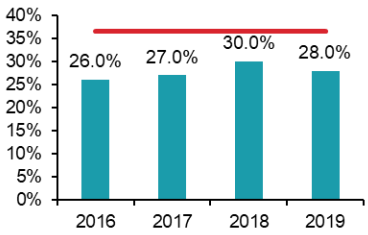
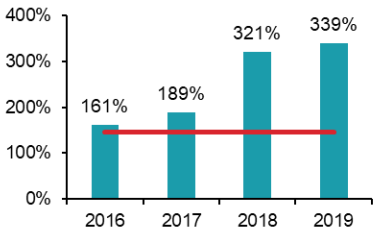
[14] FY 2016 to FY 2019 data from audited financial statements. FY 2020 sourced from internal 1/17/20 Finance Committee Packet. FY 2021 to FY 2025 capital plan provided by BRH leadership.

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.[15]

Figure 2: Debt Capacity Analysis

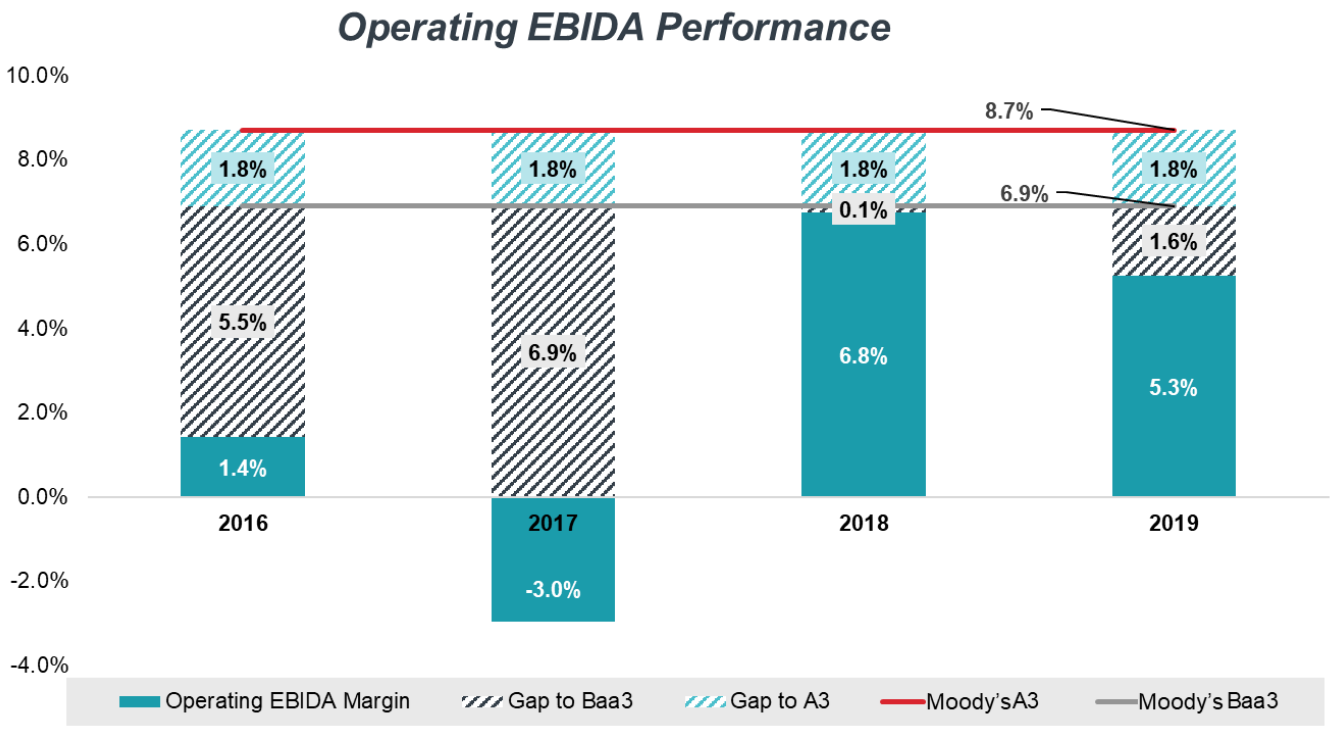
Item	Approach One: Cash Flow	Approach Two: Debt to Capitalization	Approach Three: Cash to Debt
Historical Position			
Debt Capacity	Moody's A3 Median: 4.5x	Moody's A3 Median: 36.6%	Moody's A3 Median: 145.1%
Commentary	The ability to service debt is the ultimate determinate of capacity.	While debt to capitalization is the least important factor, it is still relevant from a capital structure perspective.	This approach is dependent on relationship of unrestricted cash to long-term debt.

» *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

[15] Ibid.

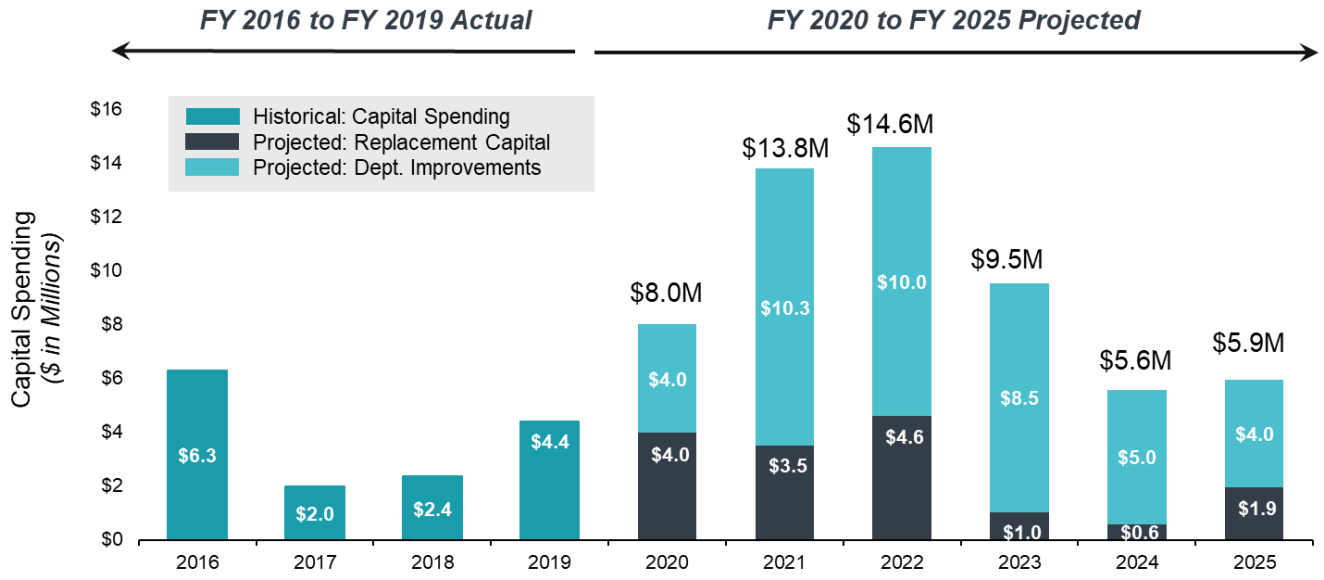
approximately 82% of that amount planned for department improvements (figure 4). Additionally, BRH has an old infrastructure that will require many repairs and a high level of maintenance going forward.[16]

Figure 3: BRH Operating EBIDA Performance



[16] Ibid.

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.[17] 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.[18]

» *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

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

18 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.

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.[19]

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

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[1]	$3.12	$(1.38)	$7.84	$8.72
Cash Flow (Net Income + D&A)[2]	$3.90	$(0.59)	$7.19	$8.08
Unrestricted Cash[3]	$37.64	$42.26	$68.68	$69.01
Capital Expenditures	$23.38	$22.40	$21.40	$20.39
Profitability				
Operating Margin	(5.8%)	(9.8%)	0.0%	(1.1%)
Operating EBIDA Margin	1.4%	(3.0%)	6.8%	5.3%
Debt Position				
Coverage	2.3x	(0.9x)	4.5x	5.1x
Total Debt to Capitalization	63.6%	68.7%	63.1%	64.2%
Liquidity				
Cash to Total Debt	54.5%	44.6%	86.7%	81.6%
Days Cash on Hand[4]	188	198	262	266
Other				
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.

[1] FY 2018 adjusted net revenue available for debt service and adjusted DSCR normalized for investment loss.
[2] Includes inflows from local government.
[3] Unrestricted cash defined as cash + cash equivalents + long-term investments.
[4] 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

[19] "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.

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.[20]

» *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 further declines in general fund reserves and declines in the tax base.[21] 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.[22] 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.[23]

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.[24] The impact on BRH's revenue stream is estimated at 10% to 15% of total revenue (approximately $11.3 million).[25]

20 "Spring 2020 Revenue Forecast," Alaska Department of Revenue.

21 "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.

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

23 Ibid.

24 Government and Community Relations, Holland America Group—Princess Cruises, Holland America Line, and Seabourn.

25 "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.

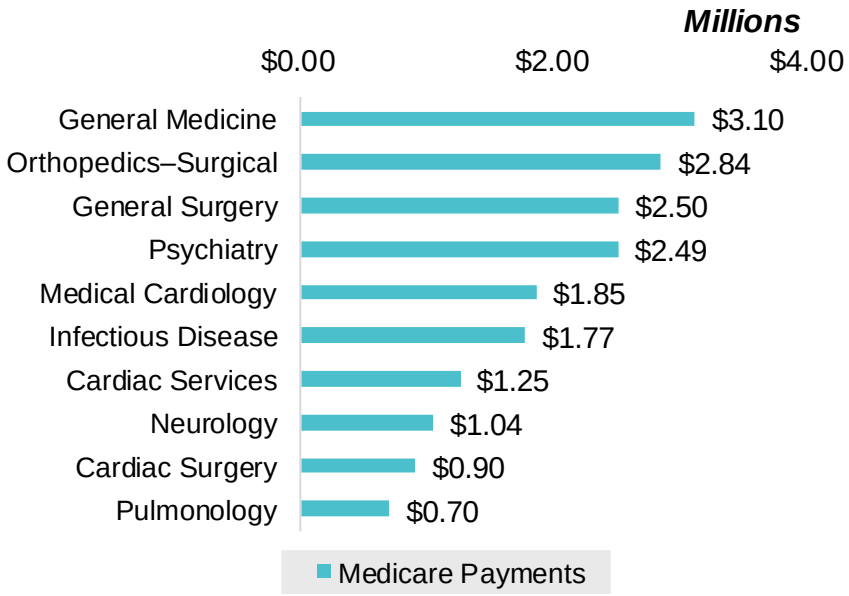
Figure 5: Juneau Competitive Landscape

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.[26] 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.

Figure 6: Inpatient Leakage by Specialty (Medicare only)[27]



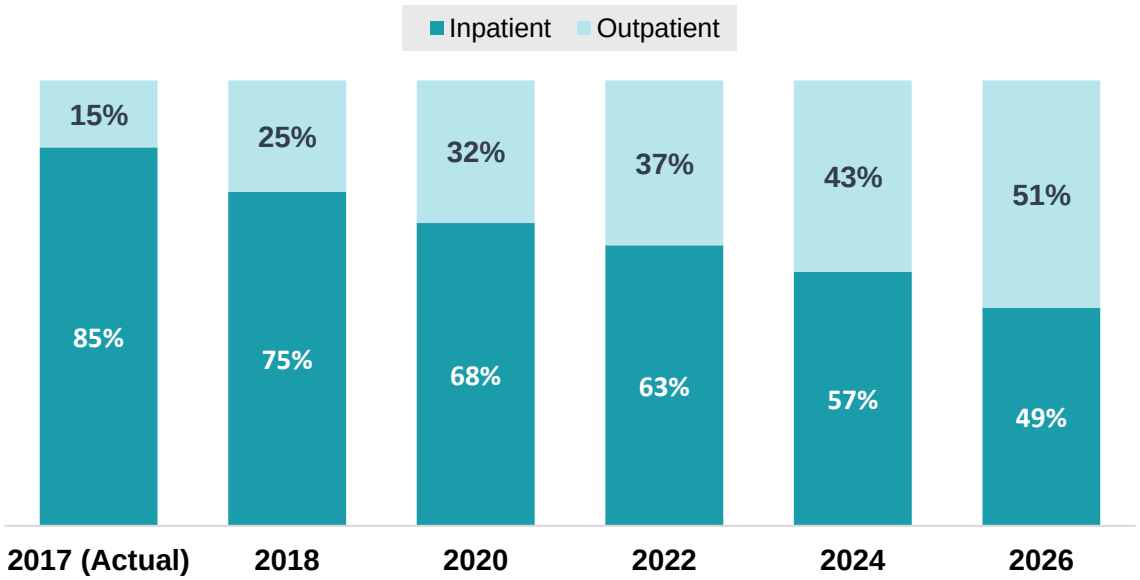
Health systems and hospitals are feeling pressure from payers and their communities to reduce costs. In addition, changes in government regulations and among commercial payers reward providers for migrating high-acuity surgery to the ASC setting, which poses a financial threat to health systems due to the significance of surgical revenue. Improved surgical techniques are allowing more surgeries to move

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

[27] Definitive Healthcare, annual Medicare data is from CMS Medicare SAFs. The most recent annual Medicare data is from calendar year 2018.

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.

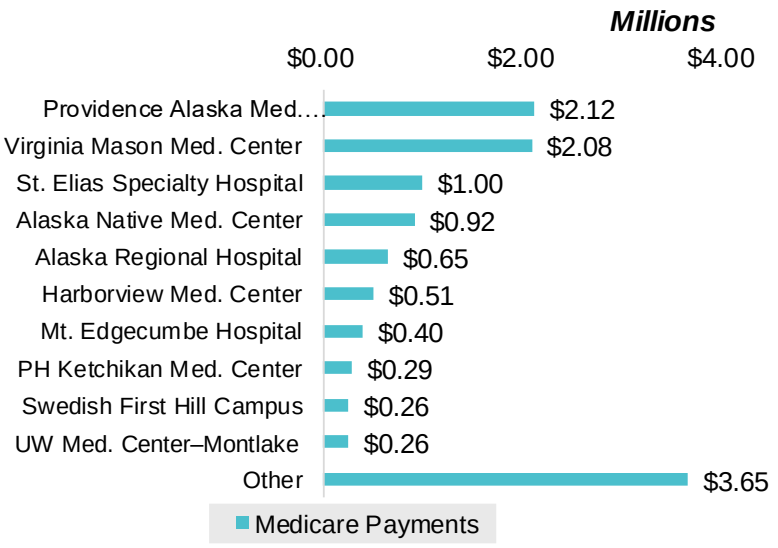
Figure 7: Projected Percentage of Joint Replacements by Care Setting



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)[28]



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.[29] 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."[30] 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.

[28] 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).

[29] "2019 Rural Report," American Hospital Association, https://www.aha.org/system/files/2019-02/rural-report-2019.pdf.

[30] "2019 Survey: Final-Year Medical Residents," Merritt Hawkins, https://www.merritthawkins.com/uploadedFiles/MerrittHawkins_Final_Year_Medical_Residents_Survey_2019.pdf.

VI. Summary Findings

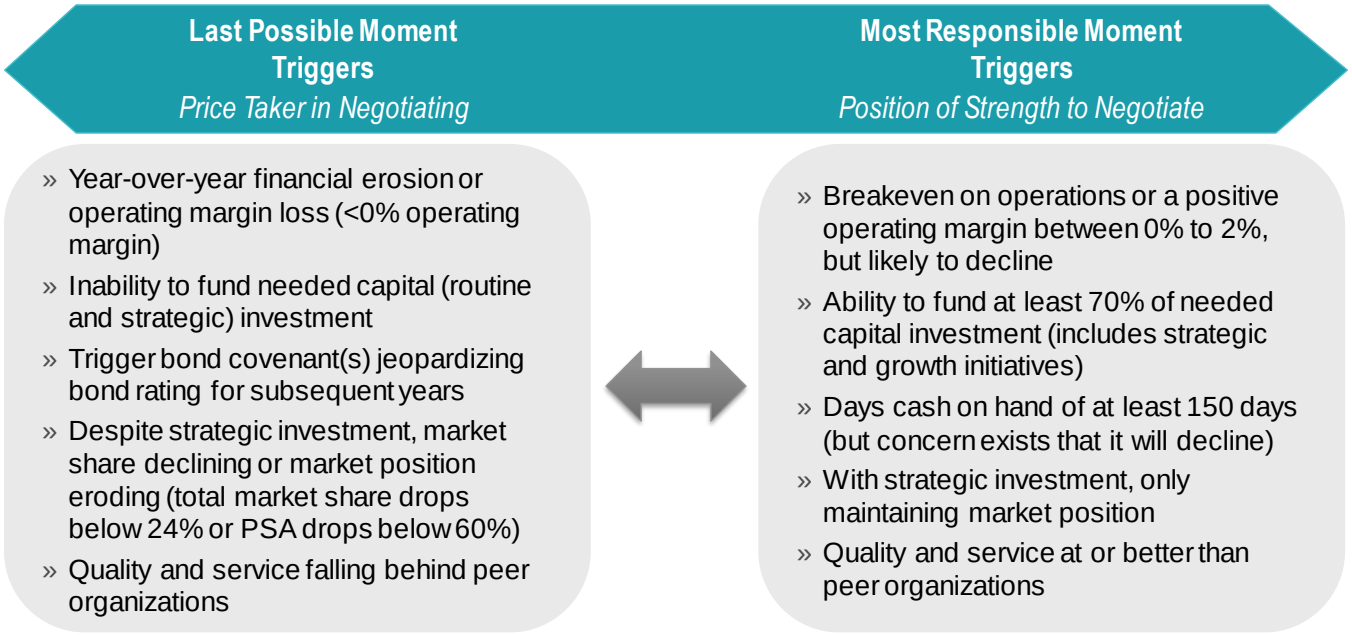
VI. Summary Of Findings

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.[31] 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.[32] 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

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

32 "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

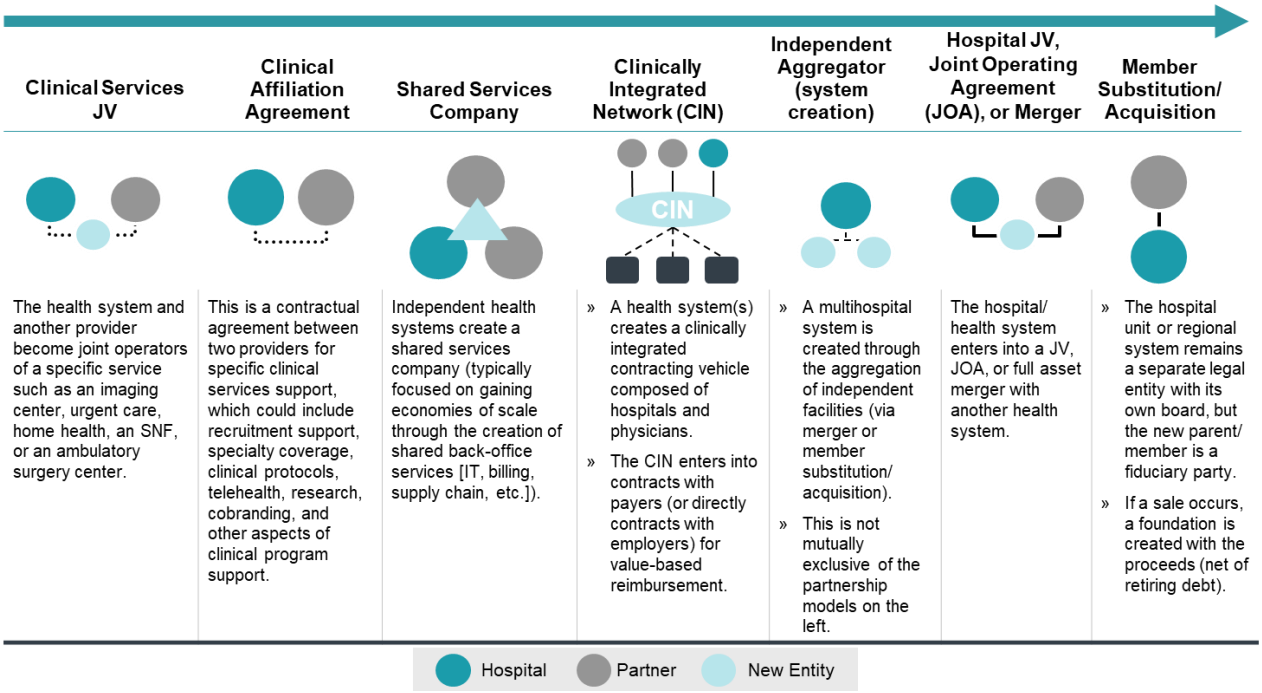
» *Professional Services Agreement (PSA):* Financial relationship between a physician practice and a hospital in which the physician practice remains an autonomous entity, but the physicians are compensated by the hospital at fair market value for their professional services

» *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.