ECG MANAGEMENT CONSULTANTS

Sitka Community Hospital/ SouthEast Alaska Regional Health Consortium

Collaboration Planning: Summary Presentation

September 19, 2016

CONFIDENTIAL

Agenda

I. Introduction

I. Introduction

Project Background and Objectives

Sitka Community Hospital (SCH) and SouthEast Alaska Regional Health Consortium (SEARHC) conducted a strategic and programmatic assessment to evaluate options for collaboration that would support Sitka and its surrounding communities.

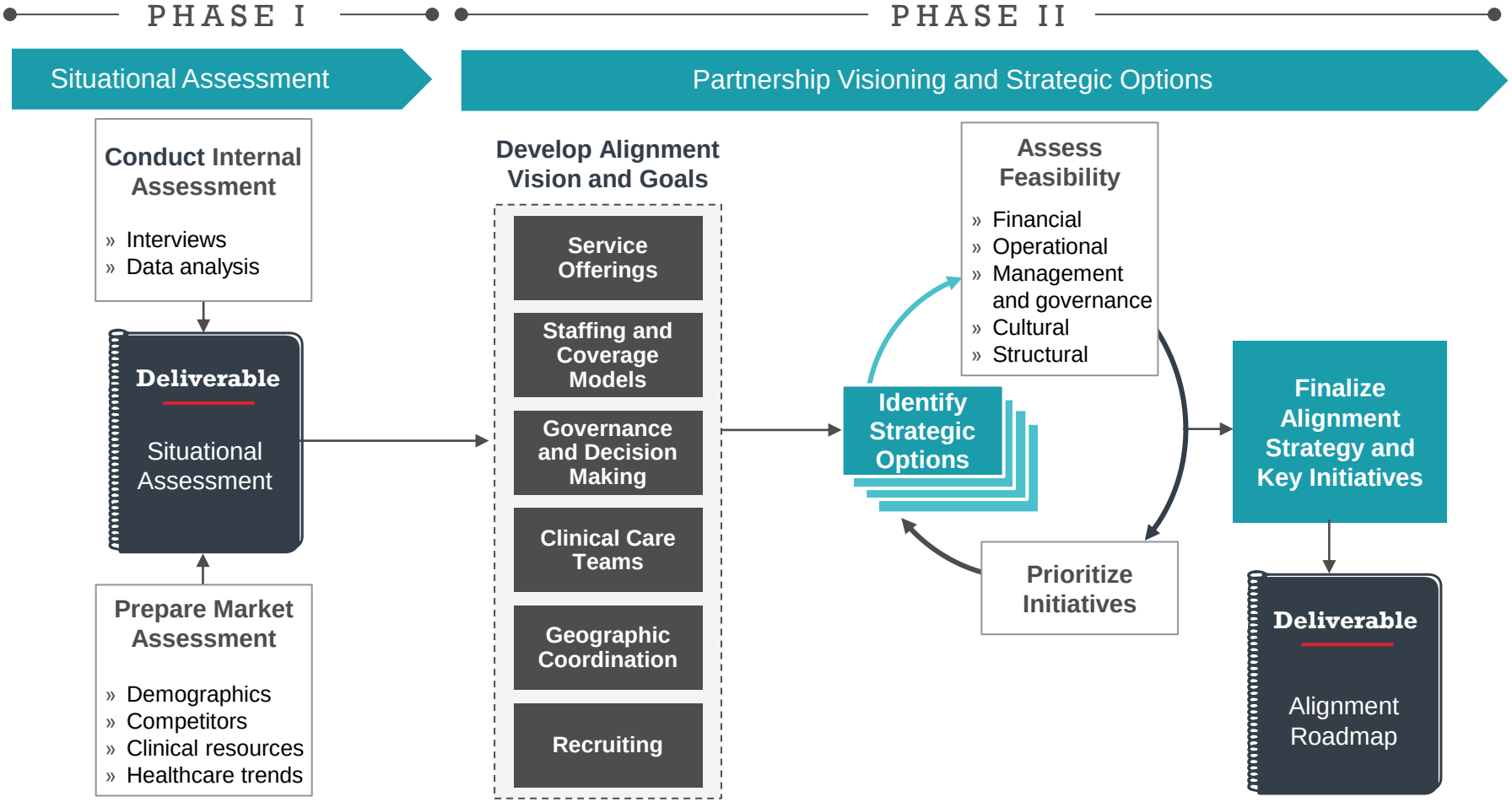
ENGAGEMENT OBJECTIVES

- Complete an internal and external situational assessment detailing organizational strengths, identifying gaps, and summarizing services and infrastructure opportunities.
- Develop a combined future vision for healthcare in Sitka that aligns the goals of each party and better serves the needs of the community.
- Analyze the potential structural options for collaboration and alignment.
- Recommend a preferred strategic direction and framework for the collaboration.

I. Introduction

Planning Approach

The planning process took place in two phases, with intermittent Steering Committee meetings at key milestones.



I. Introduction

Steering Committee Membership and Meeting Summaries

The Steering Committee included leaders from SCH and SEARHC who reviewed and provided feedback on proposed alignment and collaboration options.

SCH	SEARHC
Rob Allen, CEO	Charles Clement, CEO
Steve Hartford, Director of Operations	Dan Neumeister, COO
Kay Turner, Long-Term Care (LTC) Program Administrator	David Vastola, MD, Mt. Edgecumbe Hospital (MEH) Interim Medical Director

Meeting #1 July 6

- Introduced the project structure and approach
- Reviewed internal and external assessments and interview findings
- Provided an overview of contracts, structures, and regulatory considerations

Meeting #2 July 19

- Developed the collaboration shared vision, values, and goals
- Identified a range of potential areas of opportunity for collaboration
- Reviewed a range of scenarios and alignment models to realize the shared goals

Meeting #3 August 25

- Assessed the feasibility, benefits, and implications of three strategic options
- Selected a recommended strategic direction and framework for the collaboration
- Created an action plan for the reviewing process and collaboration next steps

II. Collaboration Rationale

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Organizational Snapshots

SCH and MEH are located approximately two miles apart in Sitka, both providing inpatient services. Organization-wide, SEARHC operates clinics in 18 communities throughout Southeast Alaska and provides other community services such as dental and optometry.

Key Statistics

Statistic	SCH	SEARHC
Organizational and Volume		
Total Revenue	$24,697,578	$124,842,681
Admissions	229	1,001
Outpatient Visits	38,975	168,157
FTEs — Provider	33.1	77.15
FTEs — Non-Provider	123.1	625.85
Average Daily Census		
Acute and Swing	3.5	10.8
Long-Term Care	9.9	N/A
Beds		
Inpatient Acute Care/Swing	12	25
Long-Term Care	15	0
Total	**27**	**25**

NOTE: Data for SCH is for FY 2016 per the June 2016 Financial Report and provider FTE data is furnished by Cynthia Brandt on May 27, 2016. SEARHC data is annualized from October 2015 - August 2016 per emails from Dan Neumeister received on September 12, 2016 and includes detail from all services including dental and optometry.

II. Collaboration Rationale

Environmental Summary Findings and Implications

An environmental analysis indicates it will become more difficult for two healthcare organizations to maintain the current scope and quality of services in Sitka, absent collaboration. However, collaboration presents an opportunity to expand the breadth of care, enabling patients to access more care locally.

Findings		Implications
» Medicare and Medicaid rate freezes, combined with Alaska's state budget crisis, could result in up to a 30% decrease in SCH's Medicaid funding. » Medicare reimbursement reform and other payors will continue to emphasize quality and data tracking. » Cash infusions from the City and Borough of Sitka are unlikely to continue, further challenging SCH's long-term financial sustainability (see APPENDIX A).	**Continued Financial Pressure**	» Other sources of revenue and cost efficiencies should be explored to strengthen financial sustainability and decrease reliance on public funds. » SCH and SEARHC will continue needing to upgrade their information systems for quality reporting and infrastructure for capital upgrades.
» The community is unlikely to see meaningful population growth; rather, the average age will increase as residents move into the 65 and over cohort. » Stakeholder interviews and physician inventory compared with provider demand (see APPENDIX B) indicate the need for more specialty providers in the service area. » On average, Sitka has 60% excess capacity of costly inpatient space.	**Stagnant Care Delivery**	» The community will not experience the growth necessary to sustain two health systems in their current configurations. » Collaborating, instead of competing for the same patient populations and duplicating services, would enable SCH and SEARHC to expand specialty services for the community.

II. Collaboration Rationale

Potential Impact Through Geographic Coordination

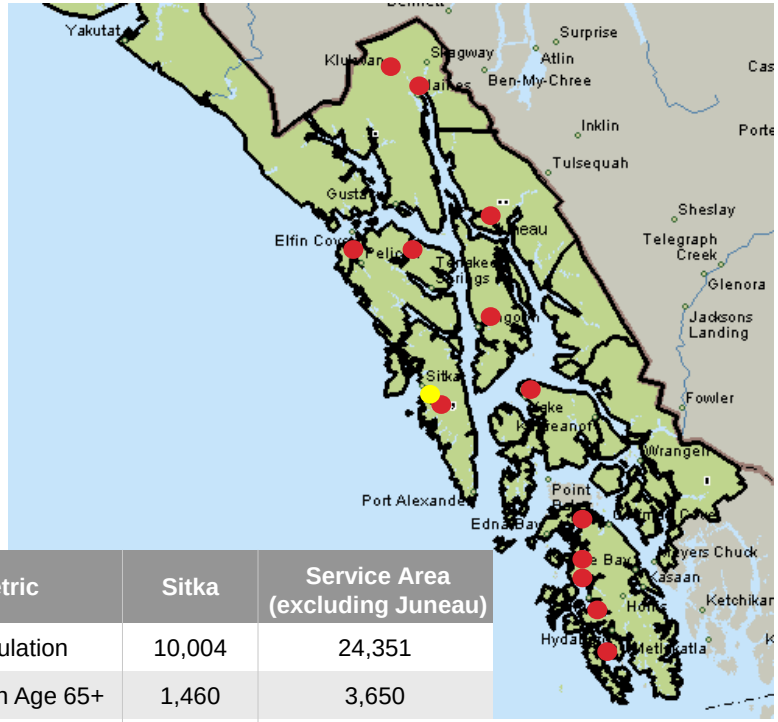
Since SEARHC draws from a larger service area, collaborating will allow the Sitka community to access healthcare services, cost structures, and infrastructure scaled to the much larger population of southeast Alaska. These capabilities would not be available to Sitka's population in isolation.

EXPAND SERVICES

A collaboration will lead to enhanced access to existing services, the development of new programs, and the recruitment of new providers to reduce the need for patients to leave the community for care.

ACCESS CAPITAL

A tight integration could enable capital investments for new and improved buildings and equipment that are currently financially and operationally not possible.



Metric	Sitka	Service Area (excluding Juneau)
Total Population	10,004	24,351
Population Age 65+	1,460	3,650
Population AN/AI	1,703	4,434
Five-Year Population Growth	0.7%	1.2%

SEARHC
SCH

IMPROVE STABILITY

Affiliating could mitigate operating risks arising from competitive threats and the changing reimbursement landscape, as well as difficulties recruiting and retaining providers and staff.

CONTROL EXPENSES

Financial sustainability may be achieved by realizing economies of scale, reducing duplication, and utilizing more favorable purchasing rates for supplies and pharmaceuticals.

III. Shared Vision

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Shared Vision, Values, and Goals

The Steering Committee drafted the following shared vision, values, and goals to help guide alignment efforts:

VISION

To become the premier
healthcare provider in the communities we serve,
improving community health through the sustainable provision
of a broad array of high-quality clinical services

VALUES

- Ensure equal access to care for all patients.
- Provide services tailored to the needs of patients and the community.
- Provide high-quality, culturally appropriate care.
- Ensure equitable employment opportunities.

GOALS

- Improve access to primary and specialty services close to home.
- Attract and retain high-quality providers and staff.
- Create a financially thriving enterprise that enables the expansion of services in our community.
- Enhance patient care, quality, experiences, and clinical outcomes.

III. Shared Vision

Future Impact Through Collaboration

A coordinated healthcare delivery model in Sitka will result in tangible benefits for SCH, SEARHC, and the community.

Present State

- Competition for patients
- Duplicative services and equipment
- Decreasing reimbursement
- Declining city support
- Staffing shortages
- Intermittent specialty care availability

Future Impact

SCH and SEARHC

- **Coordinated workforce,** resulting in more reliable staffing
- Shared patient pool to **expand specialty offerings** to orthopedics and cardiology, **enhance care quality** through higher patient volumes, and **optimize reimbursement** programs
- **Improved access to capital** for new equipment, provider recruitment, data tracking, or facility improvements
- **Less excess capacity** of costly inpatient space

Community Members

- **Increased access and decreased wait times** for primary and specialty care and behavioral health
- **Reliable and secure employment** opportunities in Sitka
- More choice to **receive care at home** in Sitka

IV. Collaboration Options

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Breadth of Tactics Considered

The committee analyzed a range of collaborative tactics designed to achieve the shared vision and goals. The more complex and impactful tactics require closer alignment between SCH and SEARHC.

LOW — LEVEL OF COMPLEXITY/ COMMUNITY BENEFIT — HIGH

- Improve the community's understanding of the services offered and the policies at each facility.
- Collaborate on health promotion initiatives.
- Collaborate on training and cross-coverage opportunities for staff.
- Combine overhead services such as housekeeping, food services, maintenance, and materials management.
- Develop shared behavioral health and substance abuse programs.
- Grow the LTC program at SCH.
- Jointly recruit specialists to Sitka (e.g., cardiology, GI, OB, pediatrics, dermatology).
- Develop a single program for itinerant physicians.
- Improve billing office performance.
- Create shared medical staff policies and management structure.
- Share specialist clinics to increase volumes and patient access for visiting providers.
- Create additional geriatric services, such as a dedicated geriatric clinic.
- Combine primary care practices into a single program.
- Integrate EHRs to create clinical data exchanges for patients visiting both facilities.
- Consolidate OB to one facility.
- Consolidate emergency departments.
- Optimize the use of available reimbursement programs.

IV. Collaboration Options

Strategic Options Reviewed

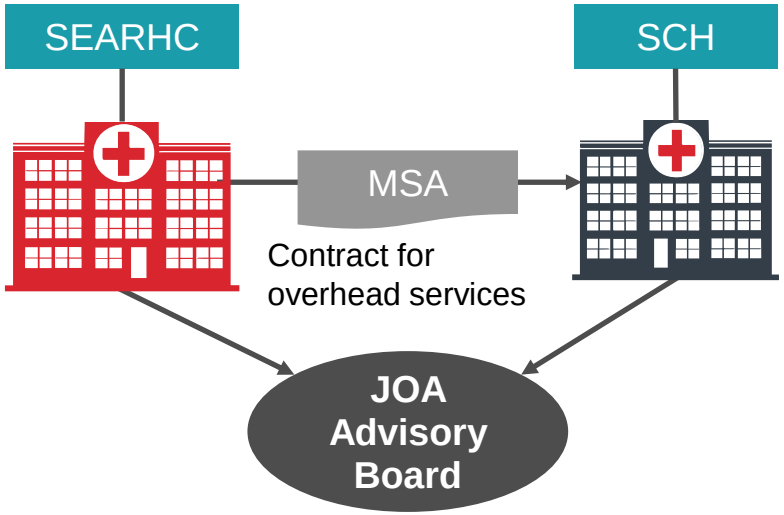
The committee analyzed three options with differing levels of formal integration and structural complexity to illustrate the scope of tactics that may be realized through a collaboration between SCH and SEARHC.

	Status Quo	Selective and Coordinated	Comprehensive and Integrated
Summary	Each organization continues without collaborating.	The organizations create a shared plan for geriatric services, primary care, and centralized OB services.	There would be substantial consolidation and expansion of services.
Top Risks	» Less access to funding » Decreased or interrupted services » Beyond FY 2019, SCH viability likely in question	» Organizations still in competition for services outside JOA » Incremental impact possibly not enough for SCH to reach financial viability » JOA model is complex to develop and manage with fewer organizational benefits	» Community apprehension » Less autonomy » Complex, with longest timeline for implementation
Benefits	» Organizational autonomy » Simplest option to implement	» Expense control through reduction of some duplication and shared overhead » Incremental expansion of clinical services » Opportunity for expansion of partnership in future years	» Access to higher reimbursement, funding, and cost savings » Expansion of clinical programs and elimination of duplication within community
Structure	Unchanged	JOA	New healthcare delivery enterprise

IV. Collaboration Options

Selective and Coordinated Model Overview

A JOA model was considered in which SCH and SEARHC would consolidate select administrative (e.g., overhead) and clinical (e.g., OB, LTC) services to reduce duplication and expand care availability.



- Governs OB and geriatric services
- Jointly recruits specialists to Sitka

Spending Category	Range of Net Community Impact
Duplicative Services and Overhead Savings[1]	$0.50M–$0.75M
Service Expansion[2]	0.25M–0.40M
Total Yearly Impact	**$0.75M–$1.15M**

1 Duplicative services and overhead savings include estimates from consolidated OB programs, consolidated overhead departments, and efficiencies resulting in a reduction in traveler usage. Aggregate volumes are not expected to increase.

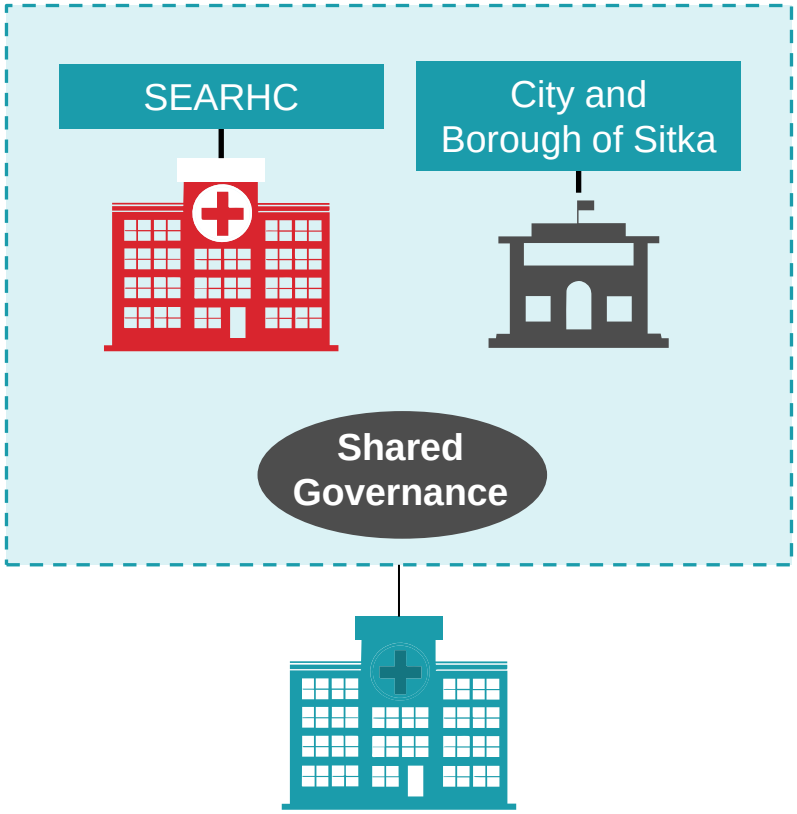
2 Service expansion includes recruiting for a cardiologist and expanding the LTC program.

While this model offers expense savings and reduces duplication, the financial benefits are incremental compared to a more integrated scenario and may not stabilize SCH in the long term.

IV. Collaboration Options

Comprehensive and Integrated Model Overview

Structurally, in a fully integrated model, SEARHC and the City and Borough of Sitka would form a new healthcare delivery enterprise that can optimize reimbursement and expense control, as well as combine efforts for provider recruitment and service expansion.



Integrated Delivery Enterprise

Spending Category	Range of Net Community Impact
Incremental Annual Revenue From SEARHC Reimbursement[1]	$2.00M–$2.50M
Duplicative Services and Overhead Savings[2]	0.50M–0.75M
Service Expansion[3]	0.25M–0.40M
Total Yearly Impact	**$2.75M–$3.65M**

1 SEARHC reimbursement rates were estimated compared to SCH FY 2015 inpatient and outpatient volumes.

2 Duplicative services and overhead savings include estimates from consolidated OB programs, consolidated overhead departments, and efficiencies resulting in a reduction in traveler usage. Aggregate volumes are not expected to increase.

3 Service expansion includes recruiting for a cardiologist and expanding the LTC program.

IV. Collaboration Options

Programmatic Outcomes

The comprehensive and integrated option best aligns with the shared goals and provides access to the most benefits for the organizations and community.

Shared Goals

Access *Finance* *Retention* *Quality*

Sample Collaboration Tactics	Status Quo	Selective and Coordinated	Comprehensive and Integrated
Collaborate on health promotion initiatives.	🟢	🟢	🟢
Grow the LTC program and expand other geriatric services.	🔴	🟡	🟢
Develop viable behavioral health and substance abuse programs.	🔴	🔴	🟢
Combine overhead services such as housekeeping, food services, maintenance, and materials management.	🔴	🟡	🟢
Improve billing office performance.	🔴	🟡	🟢
Optimize the use of available reimbursement programs.	🔴	🔴	🟢
Jointly recruit specialists to Sitka (e.g., cardiology, GI, OB, pediatrics, dermatology).	🔴	🟡	🟢
Collaborate on training and cross-coverage opportunities for staff.	🟡	🟡	🟢
Create shared medical staff policies and management structure.	🔴	🟡	🟢
Integrate EHRs to create clinical data exchanges for patients visiting both facilities.	🔴	🔴	🟢
Consolidate OB to one facility.	🔴	🟢	🟢

IV. Collaboration Options

Organizational Commitments and Participation

To be successful, a tightly integrated affiliation would require commitments from both sides as well as local participation in governance and decision making in order to protect both parties and advance the agreed-upon principles.

ORGANIZATIONAL COMMITMENTS

Fair Employment Practices

Leadership will address the need for fair hiring practices.

Workforce Preservation

Current employees will be offered employment in the new delivery enterprise.

Equal Access to Services

The new delivery enterprise will adopt policies that guarantee all members of the community equal access to clinical services.

Limited Reliance on City Finances

The governing board will prioritize minimizing the need for and use of funding from the City and Borough of Sitka to finance operations.

V. Next Steps

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Approval and Planning Process

If SEARHC and the Sitka Assembly agree to further explore the comprehensive alignment option, the next steps will entail convening a committee for Phase II to develop a more specific operational plan for the affiliation, culminating in a business plan and Letter of Intent.

Approval Process

Present strategic direction options to SCH and SEARHC boards and Sitka Assembly for input on the comprehensive alignment option and Phase II process.

Conduct SEARHC board and Assembly vote on whether to approve or reject the recommendation for SCH.

Phase I: Committee Presentations

Phase II: Due Diligence and Letter of Intent

Phase III: Final Approvals and Implementation Planning

Planning Activities

- Conduct detailed planning to create a business plan and Letter of Intent for the affiliation.
- Provide internal updates as appropriate.

- Obtain board approvals.
- Convene work groups to drive implementation efforts.
- Conduct education sessions for internal and external constituencies.
- Develop definitive agreements.

Appendix A
SCH Financial Analysis

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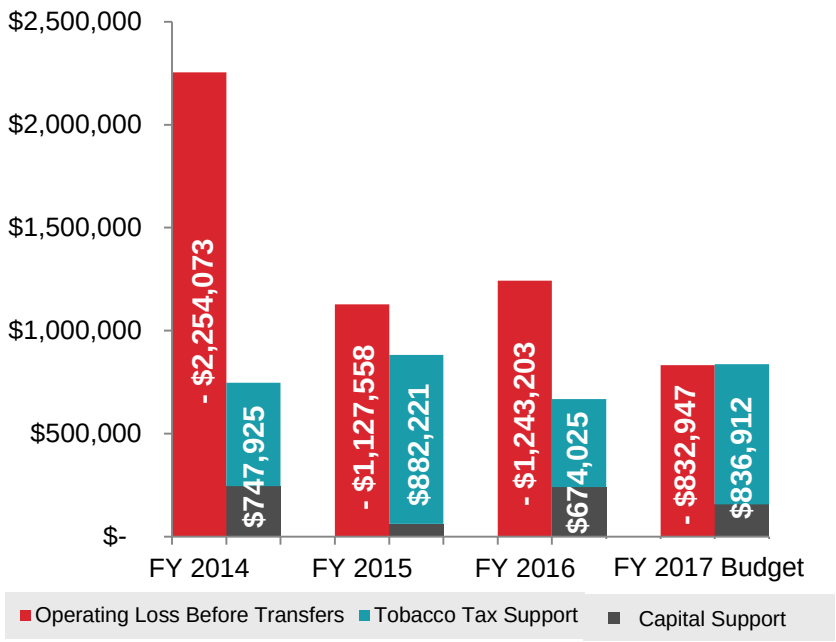
Appendix A

SCH Financial Analysis — Historical City Support

Historically, SCH's financial solvency has been dependent on cash infusions (i.e., line of credit, tobacco tax, and capital support) from the City and Borough of Sitka. While the tobacco tax is a dedicated fund to SCH, city capital support may be discontinued in the future and the line of credit is unlikely to be increased.

SCH Operating Loss Before Transfers Compared to City Support[1]



KEY POINTS

- Capital support averaged $182,753 between FY 2014 and FY 2016, reaching a low in FY 2015 of $61,472.
- Between FY 2014 and FY 2016, city support averaged $768,000, which covered less than half of the average loss before transfers of $1.54 million per year.
- In the October election, the City and Borough of Sitka will vote to increase property taxes to cover budget shortfalls, which will also increase financial strain for the community.[2]

1 Source: SCH FY 2017 budget presentation and June 2016 year-end financials.
2 Source: *http://www.kcaw.org/2016/08/11/property-tax-question-appear-october-ballot/.*

Appendix A

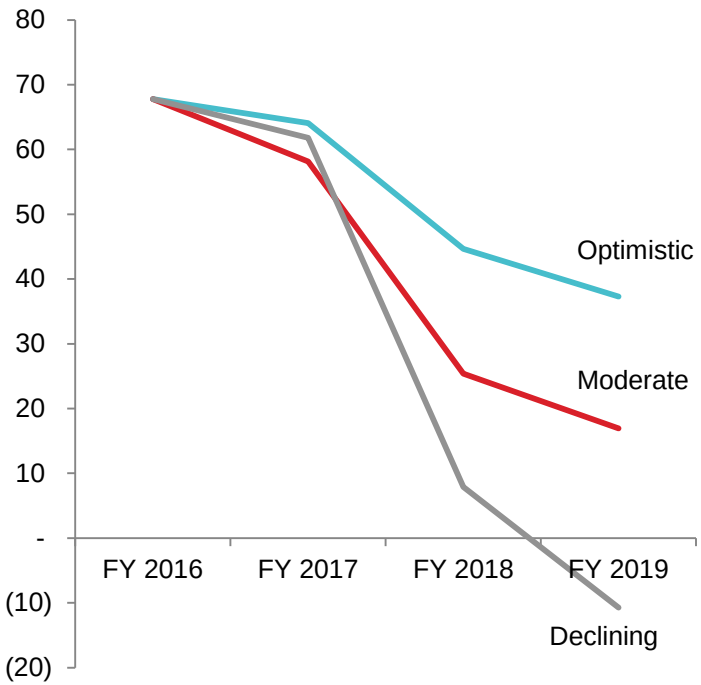
SCH Financial Analysis — Projections

While SCH and SEARHC have overcome financial challenges in the past, financial pressures continue to present a real risk in the coming years. Based on financial assumptions, retaining the status quo of the competing organizations will result in SCH's inability to remain operationally viable for the community.

Financial Projection Assumptions

	Optimistic	Moderate	Declining
Revenue Growth	Increases 5% yearly over the FY 2017 budget	Increases 2% yearly over FY 2016 actuals	» Inpatient and outpatient revenue increases 2% yearly » Long-term care revenue declines 50% between FY 2016 and FY 2019
Expense Projections	» Projections utilize FY 2014 to FY 2016 average expense-to-revenue ratios by line item. » Salaries fluctuate with patient revenue. » Benefits comprise 55% of salaries, which is the average of the benefits-to-compensation ratio between FY 2014 and FY 2017.		
Capital Budget	$816,000 yearly, which matches the FY 2017 budgeted depreciation amount	$419,000 yearly, which is the current FY 2017 capital budget	» $200,000 in FY 2017, which is half the current capital budget » $0 in FY 2018 to FY 2019, reflecting depleted cash reserves to reinvest in the business
City Tobacco and Capital Support	Remains at FY 2017 budgeted support	10% yearly decline, which represents scale-down of city capital support	15% yearly decline, which represents termination of city capital support by FY 2019
City Line of Credit Repayment	$400,000 in FY 2017	$400,000 in FY 2017	$0
Repayments to Payors	» Medicare: $0 » Medicaid: $736,000 in FY 2018	» Medicare: $1,000,000 in FY 2018 » Medicaid: $736,000 in FY 2018	» Medicare: $2,000,000 in FY 2018 » Medicaid: $736,000 in FY 2018

SCH Days Cash on Hand Projections



Appendix B
Physician Inventory and Demand

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Appendix B

Physician Inventory and Demand

Physician inventory compared with provider demand in the service area shows the need for more specialty providers in Sitka. As the population continues to age, the need for internal medicine providers specializing in geriatrics will increase.

SCH and SEARHC Provider Inventory and Demand Estimates

	SCH	SEARHC — Sitka	Total Supply	Estimated Demand (excludes Juneau)	Surplus/ (Shortage)
Primary Care Providers					
Primary Care (FP, IM, pediatrics)	3.38	14.33	17.71	15.31	2.40
Medical Specialists					
Cardiologist	0.05	0.03	0.08	1.70	(1.62)
Dermatologist	-	-	-	0.78	(0.78)
Gastroenterologist	-	-	-	0.90	(0.90)
Hematologist-Oncologist	-	-	-	0.79	(0.79)
Neurologist	-	0.08	0.08	0.87	(0.79)
Ophthalmologist	-	0.07	0.07	1.26	(1.19)
Psychiatrist	-	1.00	1.00	2.91	(1.91)
OB/GYN	0.23	1.05	1.28	2.80	(1.52)
Medical Specialists Total	**0.28**	**2.23**	**2.51**	**12.01**	**(9.50)**
Surgical Specialists					
General Surgeon	1.00	2.00	3.00	1.77	1.23
Orthopedic Surgeon	-	1.30	1.30	1.60	(0.30)
Surgical Specialists Total	**1.00**	**3.30**	**4.30**	**3.37**	**0.93**

NOTE: Provider inventory for SCH is per information furnished by Cynthia Brandt on May 27, 2016, as well as from Patrick Williams, Clinic Manager at Mountainside Family Healthcare, and the SCH website. Provider inventory for SEARHC is per Litia Garrison, with estimates for visiting specialty providers, received on June 21 and 29, 2016. Pediatric estimates are based on the 2016 population under age 15. SEARHC has recently recruited an orthopedic surgeon, which is included in SEARHC's supply estimates.