Cordova Health Services
Strategic Planning
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Strategic Assessment Final Report

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I. Executive Summary

The Community of Cordova has reached a significant milestone in shaping its future and specifically, the future for its health services. After decades of challenges including financial losses and lack of stable leadership or providers, the four governing councils unanimously approved a joint strategic planning effort in 2010. The Cordova Health Services Task Force was established with representatives from each council.

Cordova Health Services Task Force

Angela Arnold	Native Village of Eyak
Sandra Aspen	Cordova Health Services Board
Keren Kelley	Ilanka Community Health Center & Cordova Community Medical Center
Mark Hoover	Native Village of Eyak Tribal Council
Mark Lynch	City of Cordova
Noel Pallas	Ilanka Community Wellness Advisory Committee (ICWAC)
Dave Reggiani	Cordova City Council

The Task Force completed a Strategic Assessment which is detailed in this report and includes several elements that begin the journey towards their newly defined vision of:

A financially sustainable and stable health care system that provides quality care for the health & wellness of all Cordovans

The Strategic Assessment activities and deliverables included:

- Analysis of Strengths, Weaknesses, Opportunities and Threats
- Research of Cordova's community needs and perceptions via survey and focus group
- Community engagement, education, and dialogue via five public forums or work sessions, regular newspaper coverage, and radio interviews
- Employee engagement to develop and review several aspects of the project
- Identification of three major strategic alternatives
- Research / interviews with comparable communities and their health care providers
- Assess each of the three options to define potential scenarios, strengths and weaknesses, estimated financial impact, risks, and potential next steps
- Joint Council development of a shared action plan to advance the selected strategies

The three general options identified early in the project were:

A. Improve within Existing Structure
B. Restructure Existing Entities
C. Bring in New / Third Party

Research confirmed that other communities have been successful with each of these models and the Task Force became clear that each could bring significant benefits and improvements

to Cordova. Each also has risks that will require attention by leadership to anticipate, manage and mitigate. Overall, a core finding was the importance of building on the collaboration which led to the joint planning. Best practice throughout the United States points to close collaboration between rural Community Access Hospitals and local Community Health Centers. By working together, these two can eliminate duplication and competition, allowing a shared focus on the implementation of a joint strategic plan to achieve the vision. Such a partnership will reduce costs and increase the resources available to Cordova's health system.

The action plan developed and agreed by the Joint Councils on November 24 incorporates steps to implement Option A: Improve within Existing Entities. The potential advantages of this model are significant, and could be adopted relatively soon without removing the potential to go further in the future with either Option B or C. Elements of Option A include transition to an elected Health Services Board, joint meetings of HSB and the Ilanka Community Wellness Advisory Committee (ICWAC), a permanent Shared Administrator, consolidation of clinics, and the implementation of shared systems and services such as billing, patient registration and Electronic Medical Records. Together these actions may result in savings or revenue improvements of up to $532,000, although some of these savings would be passed through to Medicare / Medicaid. An additional recommendation to work with the State of Alaska and request a rate increase for long term care reimbursement could improve revenues by another $400,000.

While taking steps to implement improvements within the existing structure, i.e. Option A, there was not enough information for the Joint Councils to take the other options off the table. The councils agreed to steps that would help them to know if either of these options brought even more benefits to Cordova. To better understand Option B: Restructure Existing Entities – the Native Village of Eyak (NVE) will develop a business plan, pro forma, and complete description of how the health services would operate and be governed as a consolidated system under NVE. To further understand Option C: Bring in New / Third Party – the City of Cordova will issue a Request for Information to determine if there are interested parties that would warrant the development of a full Request for Proposals.

Throughout the Strategic Assessment, it became clear that the collaborative, thoughtful and inclusive approach provided a distinct opportunity to transform the health services in Cordova, and ultimately the health of the community. The willingness of all parties to come together and work on a joint plan was crucial. The high level of public input and engagement ensured that leaders could genuinely hear and address the community needs. The willingness to focus on the future, move beyond the difficult history, learn from many diverse perspectives both in the community and beyond it, and the significant commitment of time to understand health care complexities as well as 'possibilities' were all vital to success of the Strategic Assessment. These same characteristics will assure success in completing detailed strategic plans, business plans, and assuring effective implementation.

II. Strategic Vision

A. Project Scope & Approach

The community of Cordova, Alaska is a remote, rural community located near the Copper River Delta on the eastern shore of Prince William Sound. Cordova has a population of approximately 2,300 and is served by two main health care providers. Cordova Community Medical Center (CCMC) is owned by the City of Cordova and governed by the Health Services Board. The Ilanka Community Health Center (ICHC) is a Federally Qualified Health Clinic operated and governed by the Native Village of Eyak and has the Ilanka Community Wellness Advisory Council (ICWAC).

The four councils / boards responsible for these health care services have mutually agreed upon the need to develop a unified strategic vision for health care in the community. The project was driven by community needs and designed to ensure Cordova residents have access to quality, affordable health services. Cordova sought experienced contractors to gather the necessary data, work with community stakeholders, develop strategic direction, identify, explore and recommend alternatives for ensuring effective, efficient, and sustainable approaches to meet the health needs of the community.

CCMC and ICHC operate in a co-located facility and currently share leadership on an interim basis. Historically, the two organizations have worked side by side to meet community needs; however the project undertaken was to examine more deeply the potential options for closer alignment including structural and operational alternatives. The results of the strategic assessment, more detailed strategic planning, and subsequent implementation efforts will ultimately include:

- A shared community vision and achievable goals for health services in Cordova;
- Integrated and potentially enhanced health services;
- Improved health outcomes for community residents;
- Sharing of key resources; and
- Improved financial performance to address current subsidies.

The Strategic Assessment involved setting a strategic direction, research, identification of organizational and operational alternatives, and a feasibility assessment of alternatives. A financial assessment of each option was made and is provided in Appendix A. Upon completion of these activities, detailed business and strategic planning should be conducted, and a system of performance management established to ensure successful execution and monitoring of progress.

The figure below illustrates how a Strategic Assessment or the process of defining and selecting a strategy is approached using a staged model and increasingly detailed assessment.

Strategy Making – Cordova Health Services

Environmental Assessment	Market Assessment	Options ID & Analysis	Option Selection
Understand the General Environment	Understand the Industry & Organization / Unit	Identify and Explore Options / Opportunities	Select Implementation Strategy
• Government • Demographics • Technology • Social Structure • Economics • Environmental	• Community Perception and engagement • Competitor / Partner Analysis • SWOT Analysis • Current Financial Situation / Summary	• Best practice research • Explore innovative new options • Assess each option – Valuable, quality and range of services – Cost effectiveness – Governance and community support – Leverage available resources and talents • Future State Scenario • Financial Feasibility Assessment • Compare to vision and end goals	• Develop Implementation Strategy • Define ultimate indicators of success for strategic initiative • Incorporate in detailed strategic plan • Incorporate in budgets • Incorporate in capital planning • Initiate detailed Business Plan

Catalyst Consulting Services, LLC (Kitty Farnham) with partners – Craciun Research Group, Inc. (Jean Craciun) and Wipfli, LLP (Michael Bell) – were contracted to perform the first three of the following four phases.

I. **Strategic Direction**: Data gathering, work sessions, and community engagement to define the strategic vision for health services in Cordova.
II. **Alternatives Assessment**: Identification of structural and service alternatives; assessment of the feasibility of options, and selection of preferred alternatives for further analysis.
III. **Research:** Conduct a community needs assessment and in-depth research in the method of Focus Groups with select community members.
IV. **Business Planning & Analysis**: Detailed analysis of preferred alternatives and development of a business plan for recommended option.

The Strategic Assessment project and this report focus on the first three components. Further due diligence and detailed business planning will be needed to guide implementation. The project approach and high level deliverables for each phase of the project completed are summarized below.

I. Strategic Direction

- Engage local planning team to confirm project goals and approach.
- Review current financial and operational information for both CCMC/ICHC.
- Conduct a SWOT Analysis (Strengths, Weaknesses, Opportunities, and Threats).
- Develop a strategic vision and mission for health services in Cordova.
- Document long term strategic direction for health services in Cordova.

II. Alternatives Assessment

- Review current and potential health services funding sources.
- Review current and potential operational and reimbursement models.
- Review current and potential health services organizational structures.
- Identify alternatives for future health care services and evaluation criteria that ensure selected alternatives align with the strategic direction.
- Determine the financial and operational feasibility of the alternatives.
- Assess alternatives according to the findings of research efforts in the community.
- Select preferred alternative(s) for further business planning.

III. Research

- Conduct a community needs assessment survey of health services in Cordova.
- Conduct Focus Group Research with select community members and stakeholders to capture in-depth understanding of desire for services, current service gaps, and to inform the alternatives assessment.

IV. Business & Strategic Planning & Analysis – NOT IN SCOPE of STRATEGIC ASSESSMENT

- Conduct financial and operational analysis of selected alternative.
- Determine results criteria for final recommendation.
- Compare and select recommendation for future health services.
- Strategic planning in the context of the recommended alternative.
- Complete a business plan and financial pro forma for health services in Cordova.
- Define high level implementation plan including change management, performance management, and communication / engagement with the community.

It is recommended that Phase IV, the detailed Planning and Analysis be scoped and executed after the completion of the first three phases of the project. It is vital that there is clear direction from the Task Force, and the four governing councils, backed by community support as to where further due diligence is needed (ideally no more than three strategies). Ultimately, these groups must define their preferred and best option around which a business plan and long term strategic plan will be completed.

B. Vision

The Task Force developed initial ideas for an overarching vision at the first work session on August 5th. This was subsequently revised and then reviewed and revised with input from staff at ICHC, CCMC, and members of the Health Services Board and Ilanka Community Wellness Advisory Council. The resulting vision for the long term is:

A financially sustainable and stable health care system that provides quality care for the health & wellness of all Cordovans

C. Strengths, Weaknesses, Opportunities & Threats Analysis

An assessment of internal and external factors was conducted in three parts. Staff from ICHC and CCMC each developed a summary of their respective Strengths, Weakness, Opportunities and Threats (SWOT) using the definitions below. The Task Force then used these and created a SWOT for the overall "Health System" in Cordova.

The following table illustrates the items included in the three SWOT analyses provided on the following pages.

Internal Assessment	**Strengths** Where can we outperform others	**Weaknesses** Where can others outperform us
External Assessment	**Opportunities** How we might enhance our successes	**Threats** What/who might threaten our success

Cordova Community Medical Center SWOT Analysis:

Strengths	**Weaknesses**
• We have fantastic staff at the hospital! • Many staff with longevity • Wonderful residents in long term care • Have an adequate facility, great large space and offices • Have increased communication between departments • Sound Alternatives is operating very well; successfully using AKAIMS • Recent grant increase for Sound Alternatives • At full capacity in LTC since March • Using 1-3 Swing Beds regularly • Work well with Bartlett Hospital in Juneau who will transfer patients to Cordova • Dietary program is excellent • Good reputation for bariatric rehab • Provide good patient care • New recruits: QA, CFO, nursing, • Down to two travelling nurses • Small town atmosphere where everyone comes together to help one another • Very good Medical Records staff	• Facility concerns ; unfunded depreciation and maintenance: - Could use better ventilation - Building structure/integrity concerns - Need to replace roof - Basement leaks in high water - Rooms too small for the patients in long term care; more hospital than home-like • Lack of long term staff, including LTC staff, understaffed in billing • Staff have not had a raise in 4 years • Tenuous work environment undermines day to day care – always in the background • Outdated equipment: - Portable x-ray is broken - Need CT scan & qualified staff to run it - Need new cardiac monitor and call system • Community support is not strong • Financials for hospital not good – subsidized • Not much data for quality/patient satisfaction • Have programs we've not been able to use: lack the staff to administer HealthStream) • Information Technology issues: bad server; no EMR; Practice Mgmt. System due for upgrade • Malpractice Insurance is very high
Opportunities	**Threats**
• Could become part of Providence or IHS as operator/owner • Expand Physical Therapy • Need more providers who will come and *stay* in Cordova; seeking a female physician • Strategic Planning will help us eliminate a divided community, settle the organization with good management and clear direction • Bring more specialists to Cordova • Potential to increase funds through collaboration with ICHC • Increase education for nursing staff • Increase staff who stay for long term • Create Assisted Living, Adult Day Care (grant potential for startup) • Outreach about LTC to community/state • Need new equipment, cross-training, career development • Boards work together for a better outcome – Because "WE ARE READY!" • Providers and insurance for local births • New Cordova Center may make community a 'gathering place' – economic growth	• Fear due to uncertain future • Fear loss of jobs if any department closes • Loss of PERS pension if not stay with City • Fear of hours cut, reduced wages, and/or layoffs • Concerns for trust with new management • Lack of funds to support hospital • Closure of hospital is a real possibility • Retirements! Dietary and Lab (both long term) • Boards have been divided (HSB & City Council); too many politics; micro-manages • Community/economy is based on fishing, seasonality • High cost of transportation in/out of town • Residents get health care in Anchorage (while shopping) • Lack of housing

Ilanka Community Health Center SWOT Analysis:

Strengths	**Weaknesses**
• Funding is strong • Committed staff; like working together as a team • Small, manageable team ~ 12 ; talk to one another • Perseverance; a number of long term staff • Recently added WIC program • Purchasing power (ANTHC/IHS relationship) allows us to get services / supplies at a lower cost (equipment, supplies, training & travel free) • Can provide unique services, e.g. immunizations at the cannery; medical services on the dock, home visits & education • Willing to collaborate with other agencies; cross referrals between CHC and hospital, e.g. treadmill • Co-located with hospital – able to use x-ray, lab, educ., auto-claiming (at no charge), laundry, etc. • Tribe is very supportive of the program; one of their major services • Serve the entire community; • ICWAC is representative of the entire community • Very good equipment • Awesome billing company • Some staff work in both CHC and hospitals – assist with covering during absences • Collaborating with other villages on diabetes & WIC program • CHC able to work across tribal programs to share resources, interrelated programs, e.g. sobriety • Doggone FUN place to work!	• Need more people • Need to fully staff with providers • Providers can become involved with politics • Building space is limited / cramped; need more storage space • Lack of continuity of care • Still a new entity • High cost for services from hospital, e.g. lab & x-ray, high rent • Public education and perception about the CHC; misconception that we only serve Natives • Not a lot of men ☺ • Still learning the many programs and services CHC can offer
Opportunities	**Threats**
• Additional Funding Opportunities – Federal, state, private foundation grants – Two grants in the works • Opportunity to join forces • Find staff that want to do things • Can bring in specialists with new change in IHS funding • Continuing education – free from ANTHC • Creative staff who can develop programs • Increase cross training, e.g. cover for one another in the case of absences • Extend diabetes education program to benefit the elders in long term care - ☺ • We can work with other villages to improve their health care, e.g. MOA with Yakutat	• Tribal Council has ultimate authority • Other agencies see us as a competitor • Lack of community understanding of CHC grant and structure • Heat issues due to poor air exchange • Lack of housing

Cordova Health System SWOT Analysis:

Strengths	**Weaknesses**
• Joint strategic planning endorsed across four boards and councils – a *breakthrough!* • Community greatly appreciates seeing familiar faces, people they know • Diverse array of services in the community: ER, LTC, Health Center, Lab, PT, Behavioral Health • City Council has been very supportive of hospital • Hospital/LTC at high capacity for past 12-18 months • Stability, independence, and funding for Ilanka CHC • Ilanka serves all people regardless of ability to pay	• Difficult to retain staff with diversity of LTC, ER and clinic needs • High turnover - providers, nurses, administration • Hospital equipment and facility is out-dated • Perception that politics are impacting health care • Misunderstanding of who Ilanka serves • Ilanka CHC space is crowded Lack of funds to support hospital
Opportunities	**Threats**
• Joint strategic planning – shared vision; a unique time to do something we've not done before – a new and better way • Willing to revisit new ways of working within organizations and in the community – everyone is ready for a change • Revisit the structure of the HSB; consider advisory council representative of community (like ICWAC) • Increasing collaboration across the existing entities • Reduce inefficiencies and duplication of services • Revenue increases, e.g. grant funding, IHS, new programs/services • Focus resources on what they do best and enjoy the most (improve job satisfaction & retention)	• Community concern that Native health system would exclude others if operator of hospital • How restructuring of hospital could affect employee retirement

D. Options Overview

The Task Force identified three basic alternatives as part of the strategic assessment, and within these, several variations. In reality, each major option brings with it a wide range of specific possibilities. For the purposes of the Feasibility Assessment, the following descriptions were developed. See definitions for acronyms in Appendix D.

A. Improve within Existing Structure

(Can implement both; *not mutually exclusive)*

A1. Operational Improvement

- Improve financial performance of current operations
  - "Leaving $ on the table" per review of cost reports, Medicare/Medicaid reimbursements
  - Growth in revenue generating areas: LTC, Swing Bed conversion, etc.

A2. Shared Services

- Determine what each entity does best
- Examine what is the most financially viable
- Achieve efficiencies through sharing, e.g.: support services, practitioners, ancillaries, processes, staff
- Achieve through contractual agreements

B. Restructure Existing Entities

B1. Reorganization: Consolidation

- Consolidate administration and services under one 'parent' organization
  - Single/shared governance
  - Only one approach is allowable* under current regulations:
    - NVE as 'parent' to both ICHC and CCMC **is** allowable per Vermont model
    - City as 'parent' to both ICHC and CCMC currently **not** allowable

* Based on CHC governance requirements & IHS contract health funding

B2. New Designation/Billing Structure for CCMC

- Conversion of licensed designation for hospital only
  - FROM: Critical Access Hospital (CAH)
  - TO: Frontier Extended Stay Clinic (FESC)
- No change to ICHC

C. Bring in New / Third Party

C1. Third party / new health care entity to operate all health care services

- ICHC, CCMC, Long Term Care, Sound Alternatives
- Must meet standards for CHC governance
- Must be able to retain CHC and IHS funding
- City continue to support, with goal to drive subsidy down

C2. Third party / new health care entity to operate some or all of the City owned health services

- CCMC, Long Term Care and Sound Alternatives

- No change to ICHC
- Bundled contract with one operator or separate contracts

Some of the considerations and variations on Third Party options are noted below.

- Requires a RFI / RFP / bid process to select
- May include both for-profit and non-profit entities
- Some current operators in Alaska: Banner Health, Community Health Systems, Health Corporation of America, Peace Health, Providence, SEARHC.
- Third parties may own, lease, or operate under mgmt. agreement

III. Research

Research Objectives

- Conduct a community needs assessment survey of health services in Cordova.
- Conduct focus group research with select community members and stakeholders to capture in-depth understanding of desire for services, current service gaps, and to inform the alternatives assessment.

Phase One of the research, the baseline survey, was conducted with professional interviewers over the period from August 23 - through September 4th, 2010. The full report is provided as Appendix B.

Phase Two the qualitative research phase, consisted of two focus groups that were conducted September 15, 2010. The full qualitative research report is provided as Appendix CB.

A. Community Survey Summary

Overall View of Cordova's Health System

Nearly everybody wants good health care available in Cordova; only five people out of three hundred did not report that it was important.

- Overall, satisfaction with the availability of health care in Cordova is <u>not high</u>; 19% of the respondents who have some knowledge about it are very satisfied, and 36% are somewhat satisfied, for a total of 54%.
- Satisfaction with the availability of doctors is <u>even lower</u> (18% very satisfied and 22% somewhat satisfied) with a total satisfaction at forty percent (40%).
- The availability of emergency services is rated much higher by Cordova residents, with 29% very satisfied and 39% somewhat satisfied, for a total of 68%.
- Only thirty percent of the households in Cordova have a Primary Care Physician in Cordova.
- People who have a doctor in Cordova are overall, better satisfied with the availability of health care than are those who do not currently have a Primary Care Provider in Cordova

Suggestions for Improving Healthcare in Cordova

Hire More Doctors (41 answers)
Management Related Issues (31 answers)
Stop Firing Doctors (22 answers)
Bring in an Outside Organization (17 answers)

Better Cooperation (10 answers)
Deliver Babies (7 answers)

Healthcare Funding & Structure

Six in ten residents are aware of the City subsidy for the hospital. Regardless of the advance knowledge, just half (51%) completely approves of that subsidy. Another 19% somewhat approves of it, and 16% are unsure what they currently think. Only 13% actually offered disapproval.

Among the 300 people in the study, 5% feel the city should be paying more, 9% that it should be paying less and 12% that the city should be paying nothing. Nearly a quarter (24%) of the survey respondents has no opinion

Roughly half of the community are favorable to new structures for healthcare services, such the City/Village working together, or bringing in a Outside health organization.

Ratings of Current Health Care Services

- 45% of the respondents (or a family member living in their households) had been to the Hospital or ER in the last five years.
- 62% had visited the Hospital Clinic.
- 66% had sought care at the Ilanka Community Health Center.
- 90% had visited one clinic or the other in the last five years.

- 72% of the residents who had been patients (or had a family member who lived in their household who was a patient) at the ER or Hospital rated it overall, good or very good.
- 69% of the people who had been treated at the Hospital Clinic (or had a family member who lived in their household who was treated) rated it overall, good or very good.
- 57% of the people who had been patients (or had a family member who lived in their household as a patient) rated the Ilanka Community Health Center overall, good or very good.

Travel Outside for Care

Just under two-thirds (61%) of the respondents had traveled Outside of Cordova for medical care for themselves (or a household member) in the last five years. However, it is important to note that many were actually following the doctor's orders to leave. Thirty-four percent of Cordova Community Members went elsewhere for healthcare based upon their own volition.

Among those who had left town for medical care, most reported making more than one trip.

People who have a Primary Care Physician in Cordova are less likely to have left Cordova for treatment of their own volition (28%), and more likely to have been referred Outside of Cordova (36%) than those who do not have a Primary Care Physician (22%).

Half of the respondents who had left Cordova for medical treatment went to see a Specialist.

In this open-ended question Cordova Community Members offered many other reasons related to doctors, or lack thereof.

Reasons for Seeking Medical Care Elsewhere

I see a specialist …… 49.0%

No one knew how to treat what was wrong……	29.4%
I have a doctor elsewhere & always go to that one……..	27.5%
Don't trust any of the local doctors.....	22.5%
I don't trust either of the clinics.....	8.8%
I wanted a second opinion.....	7.8%
Doctor turnover.....	4.9%

B. Focus Group Executive Summary

There is Good Healthcare in Cordova
Participants in both groups believe Alaska in general is doing fine when it comes to quality healthcare. Further, most agree that Cordova itself has good basic medical care and great facilities.

Cordova needs more
There are several areas needing improvement. Key issues that come up include lack of stability in providers, inconsistent care across facilities, and need for more specialized care in the area. Many attribute most of the issues with local healthcare here in Cordova to lack of solid and sound organization of resources.

People want quality over quantity
Quality of medical care available will always take precedence over quantity. If their medical needs are taken care of in a high quality, appropriate manner, residents of Cordova are satisfied with local healthcare.

Consistency in Physicians is Paramount to Cordovans
Numerous participants emphasize they want more stability in providers, more consistency in doctors they go to for care. They want to develop long-term relationships with providers who become well-versed in their medical history and can be trusted. They want to feel secure that their doctors will be there for them.

It is challenging to keep good physicians here
There is chronic turnover in doctors and medical staff in Cordova. It happens at both clinics so residents feel they cannot get the consistency they need anywhere here.

Why the excessive turnover of doctors?
While most are painfully aware that Cordova has an excessive turnover of doctors, quite a few participants are unsure 'why' this is the case. Turnover in local doctors is sending patients and their money out of Cordova and into Anchorage, and most of the people do not really even understand why.

Politics prominently come into play

Participants see hints of political reasons for physician turnover in Cordova. Whether it is City council or facility administration, a lot of residents believe physicians are leaving because of politics. Politics can include someone complaining about services or personalities not getting along.

Traveling Physicians Cost Cordova

Both groups actually do see the negative monetary effects of having physicians come and go from the area, rather than make Cordova home.

Money is going out of Cordova

Traveling doctors are not adding economic value to Cordova by buying homes in the area and spending money in the community. A few participants worry about the cost of constant coming and going of medical providers—whether it is costs to the community or costs to the doctors and nurses themselves. Constant turnover in medical providers essentially prohibits physicians from becoming part of the community kinship, whereby citizens wish to band together for common goals.

Cordovan money is going to Anchorage

Residents of Cordova are spending their money elsewhere, instead of keeping it local, and it costs a lot to travel to get quality healthcare. The subsidy required for the hospital could go down if more residents stayed local for medical care and kept their dollars in the community.

There are missed opportunities in Cordova

Many realize that it is not feasible to have specialists in Cordova full time. The community is simply not large enough to support that type of healthcare. However, many believe that having rotating specialists who visit on a regular basis, like monthly or quarterly is an acceptable idea that would be met with huge success. It's a compromise to keep healthcare dollars in Cordova, and it's been proven to work effectively in the past.

Conflict among Two Healthcare Entities

It is common knowledge that there are two major players in healthcare in Cordova: Cordova Community Medical Center (CCMC) through the City and Ilanka Community Health Center (ICHC) through the Native Village of Eyak. Many participants agree that simply having two major players in such a small geographic area leads to conflict.

The entities lack a common structure

Because each facility is operated by a separate entity, there is no consistent organizational structure. There is no common responsible administrator over both of them, and the policies, procedures, and goals of each entity remain uniquely different. With the two medical entities separate, politics always come into play and there are chronic issues with competition between them.

There are different types of funding

Because CCMC and ICHC are funded in very different ways and the parameters associated with each vary greatly, it is no wonder that there is conflict of interest between the two entities.

Locals are confused about which clinic to go to
Many participants did not realize that they could go to Ilanka for medical care. Based on feedback from both groups, there is widespread confusion among natives and City residents as to which clinic they are allowed to visit and which clinic will accept Alaskan Natives vs. Non-Native residents living in Cordova.

They Must Work Together
Both groups agree that is it imperative that the Native Village of Eyak and the City take what the two clinics have and work together toward one common goal. However, past experience shows that cooperation is not possible under the current structures and managements.

It is Important to Keep Healthcare in Cordova
Participants realize that healthcare could go away if subsidies do not continue. Those who did not realize this are a bit shocked that it is a possibility. Regardless, all residents realize that there needs to be healthcare in Cordova – it would not be good if it just went away. Whatever the ramifications are, they must be dealt with to keep healthcare local.

Cordova does not want to lose the Coast Guard
Participants realize that if the hospital goes away, the Coast Guard will have to leave, and this represents a significant impact on population and commerce. Once participants realize that the City might ultimately be devastated with loss of the Coast Guard, the thought of losing the City hospital becomes horrifying. It becomes even more paramount and urgent to find a way to make things work better than they currently are.

STRATEGIC ALTERNATIVES – FUNDING / STRUCTURAL OPTIONS

It is Critical to Educate the People of Cordova
From the blue summary chart of the three main structural alternatives for Cordova Health Services, a key theme in discussions of really implementing one of the strategic alternatives was that the people of Cordova need to be educated in depth on both the current status and the proposed changes to local healthcare entities.

Option A: Improve within Existing Structure
Both groups agree that Option A is not viable for all the reasons discussed prior to this point. Option A1, which is operational improvements to achieve cost savings an increased reimbursement is considered a non-option and was not discussed much further.

Option A2 – Shared Services. Option A2, which is shared services to reduce duplication, got a lot more commentary, but is still not considered a viable option.

Option B: Restructure Existing Entities
Not very many participants understand how the federal funding works. However, because of that, they realize that it is a complicated situation that would not be solved by maintaining existing entities. The key issue with regard to Option B is the lack of clear definition as to who is ultimately in charge. Without someone accountable for both facilities, the numerous issues with the current situation in Cordova will not be fixed.

Option B1 – Consolidate ICHC and CCMC. Most did not realize consolidation can only go one way because of federal stipulations. When they find out that consolidation is only allowable if the Native Village of Eyak is ultimately the parent of both entities, most strongly believe Option B1 is not worthy of consideration.

Option B2 – Frontier Extended Stay Clinic. Both groups got into discussions about the possibility of establishing a new designation for the hospital as a Frontier Extended Stay Clinic. However, as soon as the cat was out of the bag that Cordova would lose the Coast Guard under this scenario, option B2 was no longer viable. [NOTE – this assumption has not been confirmed]

Option C: Bring in a New Entity / Third Party

The fact that both groups came to the conclusion that neither Option A nor Option B could work creates an automatic openness to Option C. Option C is the only option that seems new, different, and actually logical. One of the key attractions to Option C is that the third party might be better equipped to come in, analyze the situation, use their expertise, and actually get both entities to work together.

Pertinent third-party experience is key

Based on what they have seen in the past, participants emphasize the importance of bringing in a third party that has expertise in this field. Some even bring up Providence specifically when discussing the caliber of third party healthcare organization necessary to successfully implement Option C.

There are key aspects to consider

Bringing in a third party to run the healthcare entities open up the issues of what happens to current subsidies. The ultimate goal of the third party must be to stay profitable and provide the patients with the absolute best possible medical care. Fortunately, a new third party will have a fresh look from outside would take out long-standing political issues and personality conflicts.

People know about the success stories in Valdez and Kodiak

Several participants know about Valdez and Kodiak examples with Providence stepping in and successfully managing the local healthcare.

Option C1 – New Provider to Manage ICHC and CCMC

Both groups spontaneously suggested an organization like Providence would be a good fit as the new provider to manage both healthcare centers. Some raised concerns about how the Native Village of Eyak not agreeing to the third party option, based on the legalities of their federal funding stipulations.

Option C2 – New Provider to Manage CCMC Only

Option C2 brings up good questions from participants, reiterating the importance of educating Cordova and then thoroughly researching actual implementation prior to initiating change.

Good Things About Living In Cordova

Cordova is a good place to raise a family
Because of high quality schooling, recreational options, and the secluded nature of Cordova, many participants were proud to say that this is a great place to settle down and raise a family. Participants from both groups rave about the quality of people in Cordova, who tend to be more laid back and easygoing. Even though most residents have above average education, intelligence, and cultural value, there is not a sense of pretentiousness around. The secluded nature and small-town feel of Cordova creates a strong sense of community.

The outdoor life is indescribable
Even besides the fact that commercial fishing is the engine of the community, the beautiful scenery and plentiful outdoor life opportunities make Cordova an aesthetically amazing place. For outdoors-oriented people, this community is a dream come true.

There is pride in the long-term care facility
People in the first group like to brag about the success of the long-term care facility, saying It is thriving with all the beds full and nearing four-star status.

IV. Community Engagement

A. Community Forums – September 27-28, 2010

More than 100 people participated in Community Forums held September 27 and 28 at the Cordova High School gymnasium. The first night focused on reviewing the research results, developing a vision for health services in Cordova, and a review of Strengths, Opportunities, Aspirations and Results (SOAR) the community sees and wants from their health care system.

Following the overview of research results, participants discussed what supported their own views as well as what surprised them. One key fact emerged and surprised few – the community wants change.

Of note among the 'surprises' was the support for the City subsidy for health care services. A full 70% of residents approved of the subsidy, with that dropping to only 61% after being reminded that the subsidy is funded by taxes. This demonstrates a positive level of ownership in the community for their health services.

Other surprises included the level of support for third party solutions, as well as pursuing a solution with NVE and the City working together – both being only and also the number of residents with a local primary care provider. While there is room for improvement, these are positive foundations on which the community can work to achieve a sustainable health care system.

The Forum participants used the research results and input from the Task Force to build a vision of their future health care system. The table below defines SOAR, which is designed to help build a future based on assets.

Strategic Inquiry	**Strengths** What are our greatest assets	**Opportunities** What are the best possible opportunities
Appreciative Intent	**Aspirations** Who do we want to be and what is our preferred future	**Results** What are the measureable results we want to achieve

Community Forum participants were provided the draft Vision and the following draft SOAR summary and asked to contribute additional comments based on personal experience and their reflections from the Research results.

Strengths – *greatest assets*	**Opportunities – *best possible opportunities***
• The Community Cares! Almost all Cordovan's say having good Health Care is important. • Commitment by four councils/boards with oversight for health to joint strategic planning – a Unique Opportunity! • A wide array of services are available: - Hospital / Emergency Department - Primary Care - Long Term Care - Laboratory, Physical Therapy - Behavioral Health	• Operational Improvement • Increasing Collaboration / Reduce Duplication • Integrated Operations under a single organization - Native Village of Eyak or City of Cordova • Bring in a Third Party to operate health services in Cordova • Explore new options – e.g. - Frontier Extended Stay Clinic (FESC) - Separate Long Term Care - Increase visiting specialists • Restructure governance to remove political aspects
Aspirations – *who we want to be; preferred future*	**Results – *measureable results we want to achieve***
• Physicians and health care staff who stay and love Cordova like we do • Improve the financial performance of the hospital • Become a model for excellence in rural health care • Each provider / part of the system does what they do best, and what they most enjoy	• Improved health for all residents – ***Healthy Cordovans!*** • Financially sustainable systems of care • A living, working Strategic Plan that we *monitor* and ACHIEVE! • Health Providers who know us – long tenure

Community Forum SOAR Contributions:

Strengths	**Opportunities**
• Public Health Nurses (not mentioned) • Concerned group working on the problem • EMS / EMTs • Employees / local talent • Permanent doctors, nurses, medicine • Rescue when something happens bad; be ready at any time; have ready communication to get help from others • Life is important • A great building that just needs good maintenance • Concerned group working on the problem • Community pharmacy • EMS, Fire Department, Police • Health education • Sliding Scale at Ilanka • People who care already working here • 1 male doctor; 1 female doctor available at all times (on S sheet, but do we have this now?)	• Improve management • Need to engage youth - not engaged yet! • To take the discussion of what might be offered to a new level – what Sue Kesti suggested, cutting edge, holistic wellness • Outside help – better management • Emphasize again and again – Leadership and politics out of health care! • More efficient billing and collections • Administration to provide support to providers • Training and local education • Home health care • Assisted Living Home • Sell Cordova [sic] to outdoor-loving health care providers • Elect health services board instead of being appointed • Improvement management so doctors / PA's stay. • Specialty Clinics

Aspirations	Aspirations Continued:
• Community focused on wellness for everyone • Knowledge, articles, newsletter, etc. informing the public of what is happening and why • Quality vs. just availability • Staff that cares • Provide a more home like environment for the nursing home residents • Politics out!! Good health care for all! • Expansion of rural health care for veterans and women's health care • Alternative care (acupuncture, massage, etc.) nutrition, naturopath • What can we do now [good question for Tues) • Healthy, supportive stress free work environment • All we want is health care for all and no politics • Consistency • With good leadership composed of health professionals and professional medical infrastructure, problems can be solved • Make the health care in Cordova a driving force that makes Cordova prosper • Why can't NVE and City work together?? • Healthy work environment • Something happen the important is doctors stay; anytime in the hospital mom and son; the important thing is life • Complete instrumentation here in Cordova; spent doctors and more how to future all kids and everybody they more they save life • Goal … to encourage Dr's to stay in Cordova • Health care not an issue anymore • Better sound system for the hearing impaired • Short and long internships for local student • No more politics; No drama!	• NOT a 'model' health care – we just want it to work • An Ombudsman – someone to go to • Better communication between health care entities and the public • Financially solvent • Use the best technologies for example audio-video conferencing • More than one type of health care provider … such as medical, holistic, Rx, etc. to satisfy everyone's needs • Higher level of expertise needed then what exists within the council, tribal council,HSB, Ilanka Wellness Committee • Separate Senior Services from Acute • Please explain the different funding streams • City and NVE splitting services so both can do several things well (and no duplication) – for example: - City: LTC/PT/labs/Radiology/mental health - NVE: Clinic/ER/Swing Beds **Results** • Healthy people • Less people going to Anchorage • Keep services or add • NOT improved health, but improved access to quality care • NEED consistent leadership processes (problem lies with management structures, not individual people) • Affordable health care • Consistent local health care • Get council and tribal council out of management Stable medical care I can trust

To prepare for more in-depth conversations on the second night of Community Forums, participants responded to the question, "What is possible? What can transform our community and inspire you," and "What aspect of the future are you interested in contributing to?" The responses were reviewed by the consulting team to bring focus to the deliberations at the second Community Forum on Tuesday, September 28. A total of eleven topics or themes were identified which appeared to have strong interest by community members. These were shared with participants on Tuesday, with an explanation of how a "Open Space" forum would take place based on the topics of greatest interest to the participants. Eight of the original 11 topics were selected are noted in the following table in **bold/blue**, i.e. items 5, 9 and 11 were not discussed.

PRIORITY TOPICS / GOALS

Structure & Management	Health & Services
1. NVE and City working together	**6. New approaches, holistic care, wellness**
2. Third Party operator	**7. Specialty Clinics / visiting physicians**
3. "Depoliticize" the governance of health services	**8. Women's & children's services**
4. Doctors – attract and keep them	9. Technology / telemedicine
5. Understand the funding	**10. Developing a local workforce**
	11. Alternative / complimentary medicine

Blue/bold items discussed by Forum participants

The table conversations addressed a number of questions for each of the priority topics/goals. These started with, "What does this (topic/theme/goal) mean to you?" The groups then explored action at three levels by discussing: what the "systems" can do, what citizens can do, and what citizens and systems can do together. Participants were asked to share their doubts and reservations as well.

A summary of each topic's discussion was captured on table top notes and reported out by one member. A summary of the comments reported out at the Forum are provided below.

1: City and NVE working together – There have been failures on both sides and a lot of misinformation, again on both sides. We need to be responsible, respect one another, and work towards competence, continuity and confidence in our health systems. Be responsible to learn the facts, continue the dialogue and invest in education about what we have and what we can do together.

2: Third Party – It's fairly confusing and we listed a lot of questions we're anxious for someone to answer, although we *know we need to change*. We know third parties work in other communities, e.g. examples like Kodiak. They can help retain workers and increase the stability. Need to learn more about what works in other communities.

3: Depoliticize Governance – First, we acknowledged that the topic might be an oxymoron but we do believe much can be done. Need to engage us as citizens of Cordova. Need checks and balances, perhaps some outside professional group can assist. Need to go back and revisit the system we have.

4: Attract and Retain Good Doctors – We discussed what is a *good* doctor. For attracting them, need to emphasize the value of life in Cordova, the lifestyle. Citizens need to support their local care providers – *use them!* Private practices might be something to look into; can the community incentivize a private practice? Would it be easier if the system changed? Is it even possible if the system doesn't change?

6: New, Holistic, Wellness Care: Empower and push the system to our limits. Need a citizen Board. Ensure all parts of the system complement one another and offer balanced care. Citizens and system are both knowledgeable about affordable, consistent, spiritual and mental health care. Need care that is integrated / circular to achieve our Vision.

7: Specialty Care / Visiting Physicians: Specialist physicians should be peer consultants with our local physicians. Listed a number of specialists we'd like to see, but Incentives might be needed for them to come to Cordova. Let's look back to how it used to work.

8: Women's & Children's Services: Need an obstetrician (OB) in Cordova, as well as an anesthesiologist to have babies here. A pediatrician and a female doctor too. Know this is probably asking for much and recognize these come with a cost. Need to invest in care beyond just health care, several community partners and services can help. We need to speak out, be informed and aware.

10: Developing a Local Workforce – Recognize numerous ways it works and many more ways we can better build a local workforce who want to stay. Need to research how it works in other communities.

Questions raised by Forum Participants – Areas of Confusion

In the course of the Forums, and in recognition of the early stage of the strategic assessment process, it became clear that many community members had questions regarding the current and potential health services and potential future solutions. These questions were just some of the indications that there was confusion and sometimes misinformation in the community. The Task Force recognizes the need to provide further information, continue their research and analysis, and provide answers to the community. Some of the questions gathered at the Forums are listed below.

- Why do we have two clinics?
- Why is it OK for the City Council and Tribal Council to run a medical facility when they have little or no medical management expertise?
- Why when HSB makes a decision, Council can override/nullify decision?
- Would 3rd party management stop inner power struggles?
- Would a board of locals still run the hospital if there was a 3rd party managing?
- Decentralization or centralization or multiple entities? Are there insurance pools for independent/3rd party providers?
- Why don't we spend more time talking about cooperative efforts?
- How will a 3rd party bring in consistency in doctors?
- Want a clean understanding of financial structures, limitations, and implications.
- What are the options for a 3rd party---nuts and bolts of mechanics and monies?
- Still confused by what does what; what services are available where?
- How can we consolidate Governing boards?
- How do we assure the competence of our providers and managers? Who checks?
- Clarify what board would prevail in a NVE/CCMC blend & who has hiring priority--NVE has Native hire priority, CCMC does not.
- Would it be helpful to survey the doctors who have been let go, to get their perspective?
- Is it a City department what about "PERS"?
- Does the state want a particular Model? Would employees lose jobs?

B. Joint Council Work Session – October 13, 2010

The Cordova Health Services joint strategic planning effort was unanimously endorsed by four councils: the City of Cordova, the Native Village of Eyak Tribal Council, the Health Services Board, and the Ilanka Community Wellness Advisory Committee. It is also understood that these same councils would ultimately make decisions regarding the future of health services in Cordova. The Task Force published the Draft Strategic Assessment report on October 11; it was posted to the City and NVE websites and presented to the four Councils and members of the public at a Joint Work Session on October 13th. Members of the Task Force and the consulting team shared findings to date relating to the approach, history, strategic vision, community survey research results, and Community Forums. The three major options were outlined and a discussion of each was facilitated to understand:

- What might the option really look like if implemented?
- What would be required for it to be successful?
- Who has done this successfully?
- What are the advantages and distinct benefits of the option?
- What are the challenges, concerns and barriers to success in Cordova?

Council members and the public were invited to contribute to the dialogue at which everyone present gained a deeper appreciation for the distinct strengths and weaknesses of each model. Frank conversations about the potential challenges were met with creative offers to mitigate concerns and information sharing to counter misinformation. Council members were asked to indicate their relative preference of the three models, which resulted in the largest interest in Model B, due in part to a greater understanding of distinct benefits it offers. Model C was also well supported with continued, but lesser interest in Model A. The Task Force realized that this was not conclusive other than to reinforce the need to continue the Strategic Assessment of all three models and to further expand its outreach to comparable communities. Notes from the deliberation are provided as Appendix E.

C. Community Forum – November 22, 2010

The Final Draft of the Cordova Health Services Strategic Assessment Report was published on November 19 and posted to the City website. The Community was encouraged to participate and receive an overview of the assessment by Task Force members with a focus on a description, strengths and weaknesses of various elements in Options A, B and C. Forum participants shared information on each option, listing what they liked, what concerns they still had, and what aspects of the scenario would the potentially change, add or remove. Forum participants concluded by indicating which major option they believe should be pursued, and by providing their personal perspective for the leaders responsible for the Joint Council meeting on November 23, which was in the form of "Requests" and "Offers." Index cards were used by each participant to capture what they request of the Joint Councils or the "system" – as well as what they offer as individuals, as "citizens." These results are captured below.

Option A: Improve Existing Services	
Like: + Familiar + Quickest and easiest to implement + Not set in stone – 'mold-able' + See immediate savings of ~ $932K	+ Most likely to keep PERS + No "show stopper" concerns + Most able to control capital investments and pace + Eliminates duplication + Shared EMR
Concerns: - Politics – still not clear who sets the direction - Not enough change - Needs to be accountable AND NOT stall; still go for B or C - Fear: could get too comfortable - City still on the hook "alone"@ higher level	- Infrastructure / capital needs - Still difficult to attract and retain staff - Need to encourage MDs to peep patients here - Can't keep people here without equipment - Almost 'too much' local control
Change/Improve the Scenario: + Check points to re-evaluate progress + Benchmarks to target and track results	+ Future work on B & C also on the table + Regular performance reporting using benchmarks; publicize results

Option B : Restructure Existing Services	
Like: + All the financial benefits + Lowest potential subsidy + More funds to improve the facility + Improves the Cost Report bottom line + Able to optimize facility /equipment locations + Good depth of resources for all Codovans	+ Some history of collaborating + Eliminates any source of competition + More attractive for recruiting + Full malpractice coverage + Access to Southcentral Foundation expertise, including Patient Centered Medical Home "Nuka" model

Concerns: - We're need to be more clear about transparency of finances - Do we have enough experience working together? Do we need more experience first?	- Politics – still elected / combined Board - High $'s needed to invest in infrastructure - Almost "too much' local control
Change/Improve the Scenario: + Make finances very transparent and put this in the contract between NVE and City	+ Regular performance reporting using benchmarks; publicize results + Public review of annual audit

Option C : Bring in Third Party	
Like: + Absence of politics + Access to expertise and specialty network	+ Strong, focused management + Positive for recruitment + Contract elements always negotiable
Concerns: - No shared EMR and other Admin/IT systems - Not as good at working with the VA - Two systems for health care and potential to lead to competition - "New" expense i.e. management fee - May take more time	- City needs to provide up-front cash? E.g. Days Cash On Hand / capital investments - Time by City personnel to provide oversight of the third party budget - Perception that it's perfect and we can 'walk away'; it removes all concerns - Loss of local control
Change/Improve the Scenario: + Contract to specify NO competition with ICHC + Include NVE in the agreements	+ Include an "Opt Out" clause to be able to end contract if not meeting needs + Regular performance reporting using benchmarks; publicize results

Requests of Community Leaders	Offers and Contributions of Citizens
Work it out with Ilanka	1 – Property tax 2 – Volunteer time as an elected official
Bring in third party interim management for management improvements as a near-term step forward before deciding on a 3rd party management on a permanent basis	Help with RFP process for third party management assistance
Work together – no "backroom" politics and decisions. Communicate	My continued expertise in a lifetime working in health care: critical thinking, hard work, fairness, vision, team-player
The A option requires reviving Cordova as much as it requires reviving the medical system. If you are not up to that dual task, then just pass of the option of a stronger participatory democracy and let some outsiders take control.	What I can offer depends on which of the two options on the reverse side you chose. Vince Patrick

To keep full time doctors and full time nurses	To be on a governing board with full support
Please resolve this issue by: • Keeping governance local; local control • Transparent financials • Reducing redundancy i.e. billing, administration, etc. • Let's work together with City & NVE • Disband HSB and elect officers	• I will continue to promote Cordova • I would pay additional taxes or support bonds or special tax district to improve our health care • I will volunteer time • I would/will use local services and encourage others
Autonomy of health care administration from City. Do the easy stuff from "A" now … Go for proposals to see possibility for "C"	Will stay out of the way if my way is not chosen … (until it fails, then I'll be back!). Will provide any knowledge and support I have.
Make a decision	Continue to work for better health care in Cordova
Promoting health care to our leaders and not giving up. Getting the people involved in the health care	I'm going to keep speaking out about the improvement of health care for our community
I can insure the transparency of finances and the status of operation	
Make a decision to keep PERS	I will continue as an administrator and provider
1 – Doctor retention – female is important 2 – Blending of clinics 3 – Transparency of finances	Initiate changes – Streamline !!!
Keep focused on health care	Offer input
Make a decision to stick to it so it works. Dysfunction is a never ending cycle.	• A positive vote to change the City Charter as needed to make this work. • A promise to keep my health care $ local if you provide a system that works.
Drop your baggage; leave the past in the past	Stay engaged in the process
City – NVE get out of the hospital business	How to keep health services in Cordova
I want the leadership to choose the option that will provide the most benefit for our community without bias	I as a citizen will offer to continue my support of the process to find a solution to the health care problem
If we should go to option "B" – PLEASE do not allow health care to be run by an all Native Board. The Board must consist of members from the entire community - must be elected by the community.	To help when I can – and if I can. Please choose Providence.
Make a decision quickly! The employees have waited long enough.	I will continue to work hard to provide excellent health care for all Cordovans as I always have. But I will have a better attitude when this process is complete ☺

Make a decision quick. Leave your own agenda out and look at the facts and the community wants	I will support your decision
Get your personal bias out of the way	I'll stay if you do
Request to everyone - work together	Time
Take the time needed for a strong system that meets the needs of all citizens. Transparent finance and supports	Time to participate in process and support change – Kris S. Johnston
Don't give up -- Don't' go easy route. Change is always an opportunity	I will keep being involved

D. Joint Council Work Session - November 23, 2010

A second Joint Council Work Session was held on November 23 to review the Final Draft report and the feedback from the Community Forum. Task Force members summarized the work accomplished to date as well as their individual and collective views on how to move ahead. They acknowledged the benefits of all three options, and encouraged implementation of Option A in the near term as a means of strengthening health services in Cordova. Improving the existing services would not preclude either Options B or C at a later point. It was also noted that there was insufficient information to take either of those options off the table at this point.

The work session then focused on action planning using the proposed next steps listed in Section VI – Option Assessment as a starting point. Each of the four councils deliberated the proposed next steps and put forward a set of action items that were jointly supported for implementation. The result was a shared commitment to the following action plan.

#	What	Who	When
	Option A: Improve Existing Services		
1	Initiate efforts with State of Alaska to improve Long Term Care reimbursement and achieve ~ $400k improvement.	Keren Kelly	Initiate by Dec. 1
2	Resume monthly financial reporting to Health Services Board (HSB) using new format.	Keren Kelly & CCMC CFO	Dec. HSB meeting
3	Develop proposal for permanent Shared Administrator between CCMC and ICHC.	Keren Kelley Mark Lynch Angela Arnold Sandra Aspen	Dec. 15 with update Dec. 1
4	Begin joint meetings of the HSB and ICWAC.	Keren Kelley	January 2011

#	What	Who	When
5	Research City Charter changes that would establish an elected HSB; pursue inclusion on March 2011 election.	Mark Lynch	Include in Dec. 1 management report to City Council
6	Document needs and specifications for an EMR system at CCMC; compare to ICHC system; determine relative fit of ICHC EMR for CCMC needs.	Keren Kelley	Bring plan and timing to Dec. 17 HSB meeting
	Option B: Restructure Existing Services		
7	NVE to produce a detailed business plan including assumptions, pro-forma, specific examples of potential grant opportunities, impact to employees, etc.	Angela Arnold Keren Kelley	March 30, 2011
	Option C: Bring in New/Third Party		
8	Issue a Request for Information (RFI) to include minimum expectations for response, e.g. governance, management fee, facility needs, employee impact, etc.	Mark Lynch Assistance from Mike Bell & Kitty Farnham	Dec. 7 for 12/15 City Council Meeting
	Other Actions to Sustain Momentum		
9	Document and circulate list of actions to Boards/Councils and the community; maintain as progress is achieved; report monthly to Boards/Councils & community	CHS Task Force	Dec. 1 initially; Monthly updates
10	Joint Strategic Quality Plan for CCMC and ICHC	Keren Kelley & Mgmt. Team	March 30, 2011
11	Joint Council Work Session to review results from Strategic Planning Actions	CHS Task Force	April 2011

V. Comparable Community Research

In order to learn from other, comparable communities, the Cordova Health Services Task Force identified five communities based on similarities in size, services offered, operational successes, and interest in their organizational structure. High level 'fact finding' for each community's health services was conducted via email based on a number of factors. A teleconference with Task Force members was also held to inquire as to the community's approach and experience as illustrative examples Cordova could consider as they defined the future of their own health services. The five communities included: Wrangell, Kodiak, Seward and Valdez Alaska, as well as Springfield, Vermont. These were selected as they each demonstrate a well-functioning health care system following one of the models being considered in Cordova.

A. Model A - Wrangell, Alaska

Community Overview: City & Borough of Wrangell

Current Population:	2,058 (2009 DCCED Certified Population)
Incorporation Type:	Unified Home Rule Borough
Borough Located In:	City & Borough of Wrangell
Taxes:	Sales: 7%, Property: 12.75 mills, Special: 6% Bed Tax

Health Services Overview:

- Hospital (8 hospital/acute/swing beds) and Long-Term Care facility (14 beds)
- Community Health Center co-located
- Community owned and operated hospital
- Non-profit operating Community Health Clinic; was originally a mental health provider which expanded function for FQHC designation and hired physicians
- Hospital and FQHC/CHC collaborate on services
- Currently preparing for major capital expansion at hospital with Revenue Bond; will include co-located CHC; New hospital will have 20 beds, adding 6 LTC.
- Community Health Center: Primary Care and ER cover/WMC Medical Staff provided by Alaska Island Community Services (AKICS)
- Clinic employs the physicians; contract between hospital & clinic for ER coverage by MDs. Hospital provides ancillaries (lab, imaging, etc.).
- Several other health and social services also provided by AKICS, e.g. Behavioral Health, wellness, home health, physical therapy, etc.
- Three physicians at CHC and a fourth who does PT/Locums work; private NP in town

Task Force Observations:

- Most similar structure, size and geography
- Community owned hospital & long-term care center
  - Elected Board of Directors; has helped to keep politics out; less volatile
- Community Health Center – non-profit

  - Self-Appointed Board of Directors
- Work to remain collaborative – optimize balance of services and revenue
  - Occasional tensions but they work at having good relationships
  - Working on transparency across operations
  - All physicians at the CHC, contracted by the CAH for ER
  - All ancillaries from the hospital
- Only 40-50 evacuations a year; good to keep patients and services in the community
- Working to keep all staff working at 'top of license' and strengthen quality
- Both remain financially viable; although the mix of payers in Wrangell is fairly good with more commercial payers and fewer government or self-pay than Cordova
- Hospital has not had a City subsidy in the past 3+ years; also attracting grants and private funds (e.g. Denali Commission, legislative appropriations, Murdock, USDA).
- Currently separate EMR systems due to the high cost to integrate; not ideal

Contacts: Noel Rea, CEO, Wrangell Medical Center
Mark Walker, ED, Alaska Island Community Services

B. Model B – Springfield, Vermont

Community Overview:

Current Population: Approximately 35, 000

Located In: Vermont and New Hampshire; 14 towns in four counties

Health Services Overview:

- Springfield Medical Care System (SMCS) – parent organization for hospital and clinics http://www.springfieldmed.org/
- Springfield Hospital
  Critical Access Hospital, average daily census of 19 (excluding swing beds)
  Designated 10 bed psychiatric unit located off-campus
  http://www.springfieldhospital.org/
- Community Health Center Network
  http://www.springfieldmed.org/CommunityHealthCenterNetwork.aspx
  Consists of eight FQHCs in five communities in Windsor and Windham Counties in south eastern Vermont

Task Force Observations:

- Began looking at structural opportunities in 2003 that would optimize the reimbursement and improve services to the ~25,000 patients served.
- Considered several structural alternatives, many 'shot down' by regulators.
- Ultimately, hospital was approved as a New Access Point FQHC, paving the way to integrate the hospital and the existing system of CHCs.

- System is a 501(c)(3) non-profit FQHC governed by a board compliant with HRSA regulations
- Springfield Hospital is a wholly owned subsidiary corporation of the System, SMCS.
- Operate with two boards which meet separately and a single executive team.
- Greatest challenges was arriving at an operating configuration that satisfied the IRS, HRSA, providers, administrative team and most importantly – the various Boards.
- Required extensive research, education, consensus building and some legal fees
- Concern about lack of prominence of hospital in new configuration was overcome through well-crafted by-laws and emphasis on symbiotic nature of a combined system and leadership.
- Importance of board and medical staff in overcoming obstacles was critical
- Once aligned, able to capitalize on the variety fo financial benefits: 340B, FTCA deeming, grant funding, enhanced reimbursement, etc.
- Expanded quality initiatives across acute and primary care settings

Contacts:

Glenn Cordner, CEO, Springfield Medical Care System
Andrew J. Majka, CFO, Springfield Medical Care System

C. Model C

Kodiak, Alaska

Community Overview: Kodiak Island Borough

Current Population: 13,889 (2009 DCCED Certified Population)
Incorporation Type: 2nd Class Borough
Borough Located In: Kodiak Island Borough
Taxes: Sales: None, Property: 11.27 mills, Special: 5% Bed Tax; 1.05% Severance Tax

Health Services Overview:

- Providence Kodiak Island Medical Center, owned by Kodiak Island Borough
  25 acute/19 long term/25 swing beds; co-located nursing home wing
  4 birthing suites, 2 psychiatric care beds and 2 ICU beds
  http://www.providence.org/alaska/kodiak/
- Kodiak Community Health Center is a separate building adjacent to the hospital
  http://www.kodiakchc.org/
- Behavioral Health Services operated by Providence.
- Primary care services from KCHC and local / private practices.
- KCHC collaborates with the local Native Association on a shared call arrangement every other weekend.

- Clinic and hospital both employ physicians
  - KCHC with four full-time physicians vs. using NPs or PAs
  - Providence employs specialists: orthopedics, surgery, psychiatry
  - Long-term relationship with private practice physicians who provide emergency call services for the hospital

Task Force Observations:

- Community isolated, 4x larger population than Cordova
- Community owned hospital & long-term care center
  - Lease and management agreement to Providence Health & Services
  - Local Advisory Council selected locally to guide hospital and other services
  - Providence Region Board includes two representatives from Kodiak
- Kodiak Community Health Center is a relatively new 501(c))(3) non-profit
  - Self-Appointed Board of Directors
- Hospital and CHC work collaboratively; occasional tensions but good working relations
- Both remain financially viable – hospital has been able to eliminate losses and CHC continuously works to address the relatively higher cost of salaries with revenue. Noted above: have MDs with OB experience, vs. PAs or NPs as is common in CHCs)
- Providence leases the facility for a cost that meets the bond indebtedness, and has a management agreement to operate the hospital & LTC
- Profit or Loss of PKIMC falls to Providence per current management agreement; they have been profitable for the last few years, even after paying for Providence management fee and System and Region allocations for services like Finance, IT and HR
- Net revenues stay in Kodiak; are reinvested in facility, equipment needs or new services
- Major capital and small minor capital for hospital from Borough; KCHC funding from a variety of private and grant sources
- Providence hires Hospital Administrator; hospital administrator hires physicians
- KCHC Board hires its Executive Director, who in turn hires their physicians
- Being part of a larger system is attractive for recruiting talent to small, rural communities. Also more challenging, inspires and holds administrator accountable for tangible targets and achieving excellence
- Providence and CHC work collaborative with KANA; seeking to improve, e.g. behavioral health alignment. Specialty needs and procedures often sent to ANMC
- Providence offers specialty clinics: arrangements with 13 specialists to come through; benefits for onsite staff, training, etc.
- Providence conducted a Community Needs Assessment in 2008 and provided $100k grant for community led "Healthy Tomorrows" wellness initiative resulting from CNA
- Coast Guard has own primary care clinic, but are significant users of the facility; USGC supports efforts to serve people 'on island' as much as possible
- Currently do not have locums, and only 5% of nursing are travellers

Contacts: Brenda Friend, ED, Kodiak Community Health Center
Don Rush, Administrator, Providence Kodiak Island Medical Center
Colleen Bridge, Providence Health & Services, Area Operations

Seward, Alaska

Community Overview: City of Seward

Current Population:	2,609 (2009 DCCED Certified Population)
Incorporation Type:	Home Rule City
Borough Located In:	Kenai Peninsula Borough
Taxes:	Sales: 4% (city); 3% (borough), Property: 8.12 mills, Special: 4% Bed Tax

Health Services Overview:

- Providence Seward Medical and Care Center; 6 acute / 6 swing bets
  - http://www.providence.org/alaska/seward/
- Providence Seward Mountain Haven; 40 rooms in Greenhouse ™ Model
  - http://www.providence.org/alaska/psmh/default.htm
  - City of Seward, http://www.cityofseward.us/
- Primary Care:
  - Clinic within PSMCC
  - City of Seward submitting application for Community Health Center to be collocated / replace PSMCC clinic – working in partnership with Providence
  - Glacier Family Medicine – private practice PA
  - North Star Clinic, Chugachmiut; primary care for Native beneficiaries http://www.chugachmiut.org/Services/Health/Northstar.html
- Seaview Behavioral Health Services
- Private dentist

Task Force Observations:

- City owned hospital and LTC facility; management agreement with Providence for operations
- City retains the financial responsibility, i.e. subsidy funded by designated 1% sales tax Capital is the responsibility of the City; again use 1% tax to pay bond for hospital construction; recent revenue bond approved for construction of LTC facility
- A total of 5 physicians in Seward: 4 at PSMCC and one at Chugachmiut
- Small grants support facility and capital needs, including Denali Commission
- Providence conducted Community Needs Assessment in 2008 and subsequently awarded a grant of $100k to support the community led "Wellness for All" initiative
- Local Advisory Council for PSMCC – self appointed
- Representative from City of Seward on the Providence Region Board
- City does not 'approve' Providence's budget but retains close oversight to ensure costs stay at a reasonable level for very small community
- Providence hires Administrator who in turn hires PSMCC physicians and staff
- History in Seward similar to Cordova, with politics affecting the operations and staffing issues – unable to recruit or retain the health care professionals they needed
- Engaged Providence to assist with the management which has stabilized operations

- Success in Seward remains highly dependent on a local Administrator with the right vision and skills to ensure quality and cost effective services
- Losses have been significant which have required focus in recent years on ensuring a good census and swing beds program is effectively managed
- Current losses primarily in the clinic, leading to the City led and Providence supported effort to establish a FQHC/CHC in Seward
- New FQHC will have own 501(c)(3) board initially appointed by the City, then self-appointed; will be 'owned' by City; will replace the current physician clinic
- City and Providence strongly reinforced the importance of creating a collaborative, aligned structure with clear goals and vision, maximum collaboration, and elimination of duplication will help to reduce losses and improve access to care for all residents

Contacts: Chris Bolton, PSMCC Administrator
Susan Humphrey-Barnett, Area Operations Administrator
Phillip Oates, City Manager
Kris Erchinger, City Finance Director

Valdez, Alaska

Community Overview: City of Valdez

Current Population: 4,498 (2009 DCCED Certified Population)
Incorporation Type: Home Rule City
Borough Located In: Unorganized
Taxes: Sales: 0%, Property: 20.0 mills, Special: 6% Bed Tax

Health Services Overview:

- Providence Valdez Medical Center
  11 acute beds; 10 long term care beds
  http://www.providence.org/alaska/valdez/
- Valdez Medical Clinic – Primary Care / Family Medicine
  valdezmed@cvalaska.net
- Behavioral Health – Providence Behavioral Health Clinic
- All services are co-located
- Four full time physicians employed by private practice; contracted by PVMC for ER coverage; no PAs or NPs to ensure higher skills needed in rural community and for ER
- Providence recently hired Anesthesiologist; still too early to tell, but anticipate potential increase in revenues due to ability to have more procedures done locally

Task Force Observations:

- City owned facility, leaded and operated by Providence via a management agreement
- City retains financial responsibility – both capital investments, e.g. City bond to construct new facility, and operational subsidies

- Prior to Providence, City had a separate appointed board which provided oversight to the hospital; situation resulted in extensive politics which detracted from effective health services
- Physician clinic owners initiated outreach to third party to operate hospital; Providence was the only entity interested
- Providence worked with the City and the previous Board to manage effective transition; changed the working environment for providers "180 degrees"
- Difficult at first to shift from local authority to an 'advisory' capacity, but have worked with Administrators, City and Providence to ensure a proactive role
- City has limited involvement in operations – approve budget, but rely on Providence to manage operations and LAC to ensure local alignment and priorities are met, to vet budget, etc.
- Local Advisory Council for PVMC – recently restructured to consolidate hospital and behavioral health councils; Council has designated seats as defined by the City
- Two representatives Valdez on the Providence Region Board
- Subsidy by City of Valdez has steadily gone down since Providence began managing to where there has been no subsidy in the past year and even the ability to not charge the City for the Management Fee
- Management agreement recently extended and revised: added transparency to financial aspects of relationship including management fee, overhead allocations, how revenues are defined and reported, agreed levels of Days Cash on Hand, and how excess revenues over expenses would be retained in the community and reinvested in capital and/or service improvements
- All operations - hospital, LTC and clinic financially sound at this time; improvements gained by retaining more services and procedures locally; made more attractive by modern facility and long term employees and staff
- Currently engaged in strategic planning to consider future capital / facility needs: MRI, Assisted Living, expanded LTC unit (continuous waiting list, always 100% full)
- Providence hires PVMC Administrator with input / participation by City Manager
- Private clinic hires physicians with collaboration from Providence including some financial supports for recent hires
- Physicians noted studies the document typical pattern of trust, respect and patience needed to retain rural providers; following a 'honeymoon' period, practioners need 4-7 years of being able to stay in place and develop the lasting relationships and trust
- In a rural community – a base level of 3 and ideally four physicians is essential to avoid burning out physicians who have 24 hour call every 2nd or 3rd day
- In Valdez, the privately operated clinic is viewed as a strength in that it is separate from City politics and hospital operations; but acknowledge that there are few new physicians interested in opening up their own practices – especially in very small, rural and historically political communities
- Very positive relation between City, Providence and the Clinic due to continuous improvement and focus on shared vision for the good of the residents of Valdez

- All parties cited the criticality of having the depth and knowledge of a larger health system to manage their health services effectively, maximize resources and minimize subsidies, while also reducing local politics which had plagued Valdez for years
- While appreciating the benefits of a larger system, there are also challenges – Providence is not always aware of what it takes to create a quality and affordable health system in very small communities. What is clear is that their intent and values are aligned to serve the community and they are willing to learn and change.

Contacts: Sean McCallister, PVMC Administrator
Susan Humphrey-Barnett: Area Operations Administrator
Dr. Kathy Todd, Dr. John Cullen, Dr. Spencer Dr. Alfaro
John Hozey, City Manager, City of Valdez

VI. Option Assessment

Following Community and Joint Council meetings, each of the three options was considered as feasible for further assessment by the Task Force. With additional research and understanding of the options, an optimal or 'best case' scenario is described below for each option. The scenarios are informed by the interviews with comparable communities, work with the existing organizations, and development of new recommendations. In selecting a single scenario for each option, others have necessarily been excluded, such as consolidation under the City and inclusion of ICHC in a third party arrangement. Neither of these offers the greatest benefits to the Community and are thus excluded. The three options are described below and assumptions declared as it relates to seven key priorities defined by the Task Force: access to services, community support, employee impact, financial improvement, governance, and stability / retention. A summary of relative strengths and weakness of each option are offered to assist decision makes in distinguishing the differences between the models. It should be noted that in all cases, there are significant benefits for the community of Cordova and each model has the potential of being successful in helping to achieve the vision.

A. Improve Existing Services

General Description and Assumptions:

The best scenario under Option A includes elements of both A1 – Operational Improvement, and A2 – Shared Services, including:

- Grow in revenue generating areas: LTC, Swing Bed conversion, etc.
- Eliminate Duplication of services by consolidation and sharing
- Determine what each entity does best; examine which is the most financially viable
- Achieve efficiencies through sharing, e.g.: support services, practitioners, ancillaries, processes, staff
- Achieve through contractual agreements

Option A incorporates numerous strategic and financial improvement opportunities which have been identified, and which can be accomplished with the existing structure. In Option A, no ownership changes would occur. The Cordova Community Medical Center would be owned and operated by the City of Cordova, while the Ilanka Community Health Center would be owned and operated by the Native Village of Eyak. Model A is a viable model as evidenced by the success currently seen at Wrangell, Alaska which has a similar structure, optimizes shared services, and has not had a City subsidy for health services for several years – although they do have a more favorable mix of payers (commercial insurance versus Medicare/Medicaid and self-pay).

In Option A, and in fact in each option, a significant reduction in operating losses would be expected, however it is recommended that the City continue to subsidize the hospital with funds to address outstanding deferred maintenance and equipment replacement needs. The City would continue to pay a subsidy for health services, although over time as the infrastructure was reinforced and operations stabilize, the level of subsidy would very likely decrease. Given the payer mix and small volumes in Cordova, it is unlikely that the City will see the elimination of a subsidy altogether.

It is important to understand that Option A does not reflect the "status quo." Many program changes would be made to reduce duplication and provide services from the entity best able to provide it at a reasonable cost and optimal reimbursement. The assumptions made for the assessment of Option A include consolidating the physician clinic at ICHC; moving Sound Alternatives and the associated grant from the State Division of Behavioral Health to ICHC for improved reimbursement. Billing, accounting, patient registration and other services can also be consolidated to reduce cost, improve efficiency, and promote alignment.

Success under Model A would be enhanced by continuing to use a shared Administrator between the two entities which has proven successful since May, 2010. This has led to significant financial gains and intra-team collaboration by removing competition between the existing organizations and operating the overall health system with community goals at the fore.

Option A – Improve Existing Services

Criteria / Description	*Strengths*	*Weaknesses*
1. Access to Services • Increase Mental Health services with increased revenue from CHC operator • Potential addition of dental services in CCMC clinic space • Access to specialty clinics from Southcentral Foundation	• Financial improvements allow for reinvestment in programs, services and equipment	• No new access to services resulting from being part of a larger health system
2. Community Support • 53% of Cordovans favor the City and NVE working together	• Minimizes structural change	• Perceived as the "status quo"

3. Employee Impact • Employees largely unaffected • Intra-organizational alignment continues with shared leader • Some employees affected by the consolidation of services, e.g. physicians move to ICHC; Sound Alternatives move to ICHC.	• Retains PERS benefits for hospital employees • Consolidates similar services in one organization or the other • Current informal arrangements would be clarified by contracts	•
4. Financial Improvement CCMC losses of $897,478 (2009) may be offset by $730,000: • $400,000 - approach State to request nursing home rate that equals actual cost of care • $291,000 - Combine clinics • $19,000 – Raise CHC rental (already completed in 2010) Other potential savings of $202,000*: • Shared Administrator savings: – Medical Center $108,000* – ICHC $32,000 • $27,000* – Consolidate other administrative functions • $35,000* – Consolidate IT services and infrastructure, including the elimination of Arctic IT * Some of these savings would be passed on to Medicare/Medicaid due to cost-based reimbursement model	• Significant reductions in operating losses at hospital • Opportunity to reinvest subsidy to address facility and equipment needs that have been deferred • No third party management fee or overhead expenses • Access to SCF specialists will increase revenues for local ancillaries	• Hospital cannot access resources from Indian Health Services, e.g. grants and technology available to IHS operated facilities • Transition time and training to consolidate functions and IT systems

5. Governance • Health Services Board retains oversight of CCMC • ICWAC retains oversight of ICHC • Amend City Charter and by-laws create a community elected Health Services Board • Regular joint meetings of HSB and ICWAC	• Shared Administrator for two entities stabilizes leadership • Joint governance meetings of ICWAC and HSB increases transparency and promotes alignment across councils • Retains local authority vs. Advisory role that third party would introduce • Community directly elects Health Services Board; less volatile	• Four distinct governing bodies continue to have a role in Cordova's health care • Amendments to HSB structure may not be enough to get politics out of health care • Requires discipline and patience to allow trust to be strengthened • Shared Administrator needs authority and autonomy to instill the collaborative approach and reap the associated benefits
6. Service Integration/EMR/Health Outcomes • Integrated billing, patient registration, and accounting services • ICHC retains EMR from IHS • CCMC could adopt ICHC EMR assuming the physician and Administrator work for NVE • ANTHC training / telemedicine	• Shared EMR systems allow for seamless data sharing • Patients experience a single registration process; integrated/ seamless experience for care • Eliminates confusion relating to dual physician clinics	
7. Stability / Retention • Permanent contract for shared Administrator stabilizes current leadership • No disruption or change to current recruiting which has proven successful	• Timing: relatively few changes allow immediate implementation • Reduce uncertainty: physicians and staff can be assured of future structure and known leadership/Administrator • Anticipate continued recruiting success from current Administrator to fill vacancies	• Four governing bodies and their respective members may continue to assert influence in operational and staffing issues • ICWAC and NVE have authority over physician hiring

Risk Management:

Risk	Mitigation
Failure to separate health care operations from community politics	• Permanent contract for shared Administrative leadership • Elected Health Services Board provides for less volatility • Health Services Board and ICWAC meet jointly • Physician and major operational decisions made jointly • Increased education and transparency of health care services
Failure to agree to shared / NVE Administrator & Providers	• Document and community the significant benefits relative to alignment, collaboration, EMR and other benefits
Lack of community support – perceived as the status quo	• Education and awareness regarding success in past year and planned changes to align / improve the health system
Physician dissatisfaction with consolidation of clinics at ICHC	• Negotiate acceptable contracts which promote collaboration and teamwork across all health services

Next Steps:

- Approve Joint Resolution to pursue strategic goal of optimizing services with existing entities
- Complete permanent contract for shared Administrator
- Begin joint ICWAC and HSB meetings to engage and monitor implementation of the strategic plan
- Engage employees in transition and change management plans
- Negotiate physician contracts to consolidate clinics at ICHC
- Migration of Sound Alternatives to ICHC
- Amend City Charter to achieve greater autonomy for health care Administrator
- Integrate administrative services including: billing, accounting, patient registration
- Implement EMR from ICHC at CCMC
- Engage State of Alaska to define and address all regulatory approvals, e.g. grants and licensure status, etc.
- Complete associated strategic plan for quality and operations as well as longer term master site and facility plan

B. Restructure Existing Entities

General Description and Assumptions:

Option B would reflect a consolidation of the Cordova Community Medical Center (including long term care and Sound Alternatives) with the Ilanka Community Health Clinic under either City or NVE governance. Consolidation under the City is not considered viable for a variety of reasons including:

- Regulations do not allow a City to operate Federally Qualified Health Clinics (FQHCs), requiring a separate non-profit to be established.
- Loss of Indian Health Service support that are currently available based on NVE ownership of ICHC. This includes grant funds, enhanced reimbursement, EMR system, training, and numerous other operational and service benefits.

Converting the existing services to a Frontier Extended Stay Clinic was not appealing to members of the Task Force nor was it encouraged by the State of Alaska.

Therefore the best scenario for Option B is to consolidate health services under the Native Village of Eyak, which would entail transferring the Cordova Community Medical Center, long term care services, and Sound Alternatives to NVE where it would become fully integrated the ICWAC. The CCMC facility would likely remain under City ownership, and leased to the operator of the health services for a nominal fee. This model has proven successful as evidenced by the Springfield Medical care Centers in Vermont which consolidated a Critical Access Hospital and a system of Community Health Centers under a shared governance structure.

The ICWAC and NVE governance structure as they currently exist may technically be allowable for oversight of the CHC, the hospital and related services. However the community would prefer to see a health care governance structure established that provides for greater community accountability and autonomy from the NVE Tribal Council. This would involve a transition from ICWAC and the HSB to a new governing council. Details for such a council have not been defined; although it would need to have balanced representation and appointments would likely be made by designated entities, including the City – not just the Native Village of Eyak as is the case for ICWAC at this time.

Unifying health care services under a single entity within a tribal structure offers a variety of advantages not available under the current structure or with a third party. Under this structure, CCMC would have access to IHS provided technology (EMR), training, expertise, systems, access to specialists, and more favorable reimbursement. The integration of health care would be optimized in this scenario leading to better health outcomes for the residents of Cordova, as evidenced by the success of Southcentral Foundation's Nuka model, or Patient Centered Medical Home service delivery model which has improved health outcomes while also reducing the costs of health care for patients and the health care system.

Option B retains all of the financial benefits in Option A while offering several new advantages, however it should be noted that these may not be sufficient to eliminate all losses at CCMC. Similarly, the facility would continue to require investments in deferred maintenance and equipment replacement. The City would likely need to provide a sustained financial commitment in the early years, and perhaps on an ongoing basis. Detailed assessment and estimates would be required from a full business planning.

Option B: Restructure Existing Entities

Criteria / Description / Assumptions	*Strengths*	*Weaknesses*
1. Access to Services • Include all in Option A • Access to specialists from Southcentral Foundation may be greater and better able to support CCMC patients • Referrals to any Anchorage hospital as needed • Rotation of physicians with ANTHC gain more experience in higher volume ER • New services via ANTHC: pathologist, pharmacist, radiologist	• Repayment of Student loans promotes recruiting • Enhanced ability to learn from and implement Patient Centered Medical Home / Nuka model with support from Southcentral Foundation • Specialists able consult non-native patients both in Cordova and if transferred to Anchorage • Access to peers to promote better collaboration with pharmacist, radiologist and pathologist • Faster response rate for radiology reads, medications, etc.	

2. Community Support • 53% of Cordovans favor the City and NVE working together	• The Native Village of Eyak has a track record of providing quality services to all Cordovans at ICHC • NVE willingness and practice of working on behalf of broad community needs	• Concern about 'turning over' health services to the tribal organization; lack of trust •
3. Employee Impact • CCMC employees transition to employment and associated benefits by the Native Village of Eyak • NVE benefits are typically better than PERS Tier 3 & 4 employees • Larger support system for technical assistance and employee backfill from ANTHC	• Equity across all employees in relative to common employer and terms • Common leadership, vision and direction from unified organization and shared leadership • Opportunity for employee bonuses • Increase in employee holidays, leave; jury duty, etc. • Technical assistance and backfill deepens the employee bench	• Transition issues and change management during implementation • Employees would lose PERS benefits unless a negotiated agreement could be reached with the State/City
4. Financial Improvement CCMC losses of $897,478 (2009) may be offset by up to $932,000*by: • All savings in Option A • Additional improvements through improved hospital reimbursement, access to tribal (IHS) and ANTHC grants • Access to maintenance and inspection funds and services • Potential savings in employee benefits *Some of these savings will be passed on to Medicare / Medicaid	• As tribal owned facility, hospital reimbursement would increase by small amount • No management fee paid to third party • Access to SCF specialists will increase revenues for local ancillaries	• City would continue subsidy at some level, particularly to address deferred capital where grants are not possible

5. Governance • New governance structure replaces ICWAC and HSB • Complies with FQHC standards • Representative of the community & patients served • Designed with accountability to entire community, not just the Native Village of Eyak • Potentially able to be elected or appointed with designated representative seats, e.g. City • City Charter amendment to eliminate HSB and establish relationship with new council • City would need staff to provide oversight and input on health care finances	• Unified, representative voice to guide all aspects of the health system • More efficient than two councils • Single organization reduces competition and increases trust	• May not achieve sufficient autonomy from the Native Village of Eyak Tribal Council • Unclear how to ensure accountability to the larger community • Legal questions not fully vetted
6. Service Integration/EMR/Health Outcomes • CCMC implements the EMR currently in use at ICHC • Integrate other administrative systems and services • ANTHC training / telemedicine	• Little cost and much faster implementation for a fully integrated EMR solution • Effective telemedicine system • Other information systems at ICHC could be shared at very little cost • Nuka / PCMH model noted above	
7. Stability / Retention • Permanent consolidation would offer clarity and unified vision for current and potential employees	• Future recruiting may be enhanced by alignment with a larger health system • Single Administrator and Council promotes clear and stable vision, strategies, and ability to execute	• Transition of employees to NVE may result in dissatisfaction and turnover

Risk Management:

Risk	Mitigation
Unwillingness of community or City to consolidate under NVE	• Develop transition plans with defined deliverables to address specific concerns, e.g. transparency • Education community on history and benefits of tribal health services to all residents •
HRSA regulatory approval of the new FQHC board and ownership structure	• Engage legal counsel is engaged and structure designed to continue HRSA designation as FQHC
Failure to separate health care operations from community and tribal politics	• Design new organization and council with autonomy for operations separate from both City and Tribal Councils • Empower and trust Administrator with physician and major operational decisions
CCMC employee dissatisfaction	• Explore transition plan with State of Alaska for PERS benefits • Employee engagement in transition planning

Next Steps:

- Approve Joint Resolution agreeing to pursue strategic goal of integrating health services under the Native Village of Eyak
- Proactive education and awareness in the community to share benefits and assure community support
- Begin joint ICWAC and HSB meetings to engage and monitor implementation of the strategic plan
- Engage employees in transition and change management plans
- Engage State of Alaska to define and address all regulatory approvals, e.g. Certificate of Need if necessary, grants and licensure status, etc.
- Complete a detailed Business Plan, including negotiated agreements, assumptions, and pro forma
- Complete associated strategic plan for quality and operations as well as longer term master site and facility plan
- Amend City Charter to eliminate the Health Services Board and establish relationship with NVE and new council
- Consolidate entities per the business plan, including new council, employee transitions, and lease of facility

- Integrate administrative services including: billing, accounting, patient registration
- Implement EMR at CCMC and build interface with ICHC EMR
- Pursue additional programs and services through expanded relationship with ANTHC and Southcentral Foundation

C. Bring in New/Third Party

General Description and Assumptions:

The most likely scenario under Option C would entail the identification and selection of a third party health care system to operate Cordova Community Medical Center and associated long term care. It would not make sense to include ICHC in a third party arrangement given the favorable reimbursement structure ICHC receives as a result of being owned by the Native Village of Eyak with access to additional Indian Health Service resources that benefit all Cordovans. Sound Alternatives would benefit from increased revenues as part of the CHC and thus would also likely be excluded from a management agreement for the hospital, although this requires further assessment to determine the best option for improving behavioral health services in Cordova.

There are several examples of communities who own Critical Access Hospitals that are successfully managed by an outside health system. The Task Force contacted three in Alaska: the City of Seward, the Kodiak Island Borough, and the City of Valdez – all of which are managed by Providence Health and Services, and each with distinct management agreements. There are also examples where management agreements are not beneficial to the local community due to costs associated with management fees, overhead allocations, and loss of local control. The critical factors in establishing a successful relationship would have to emerge from a careful selection process and negotiation of a financially sustainable arrangement.

The process would likely require a Request for Information from prospective operators to identify interested parties. This process would surface a variety of models and their relative costs, benefits, constraints, and expectations from potential management firms. Following an RFI, the City would refine and detail local expectations and issue a Request for Proposals. Due diligence and careful assessment of the potential parties in terms of mission, vision, values and culture in addition to traditional business planning is highly recommended.

While a range of management models exist, for the purposes of Cordova's Strategic Assessment, the model described and assessed here assumes the following:

- City leases the facility to the hospital operator for a nominal fee ($1); they in turn lease space to ICHC
- Capital expenditures for facility and equipment upgrade and replacement are the City's responsibility
- A negotiated management fee and acceptable overhead fees are paid by the City to the management firm
- Operational losses are expected to be reduced over time with a goal of achieving neutral or positive net revenues
- The City retains responsibility to subsidize hospital losses
- Any potential positive revenues would remain in the community to enhance services and/or fund capital needs

Collaboration between a third party operator of CCMC and ICHC may be negotiated to achieve many if not all of the advantages listed in Option A. However it should be understood that third parties typically bring in their own administrator, systems, processes, etc. Given alignment of mission, vision and values with a third party *and* a carefully developed management agreement, CCMC and ICHC would likely be able to continue collaborative efforts and avoid the costly impact of competition in the community. The City can also require the operator to hire / transfer all employees to assure stability and retention of staff.

Option C: Bring in New / Third Party

Criteria / Description / Assumptions	*Strengths*	*Weaknesses*
1. Access to Services • Health System may increase access to additional services through referral or tele-health	• Larger health systems have depth in a wide range of health services, processes and systems	• Large system services may not be suitable or cost effective for a community as small as Cordova
2. Community Support • 53% of Cordovans favor bringing in a third party •	• Positive perception of Providence both in Anchorage and as operator in Kodiak, Valdez & Seward	• Perceived and potentially real loss of local influence
3. Employee Impact • Employees transferred to new operator	• Large health systems typically have robust employee benefits and policies	• Transition issues and change management during implementation • Employees would lose PERS benefits unless a negotiated agreement could be reached with the State/City

4. Financial Improvement CCMC losses of $897,478 (2009) may be offset by up to $932,000* by: • Including some, but not all savings in Option A • Expect improved operations and associated savings • Additional expenses: management fee + overheads • Potential savings in employee benefits • City staff to provide oversight of health care finances * Some of these savings would pass through to Medicare/Medicaid	• Experienced operator would identify and implement operational improvements to reduce costs and improve quality	• City retains responsibility for financial losses, which are likely to continue • Must develop means to maintain control and influence over the level of fees and overheads paid to management firm must be • No access to IHS grants for hospital • Shared administrative systems may not be viable if operator brings own systems
5. Governance • Health Services Board would transition to a Local Advisory Council • Formal governance likely with health system	• Clearly separates health care operations from City and Tribal Councils and potential community politics	• Role of City or local advisory board in developing and approving budgets unclear • Implementation cannot be immediate
6. Service Integration/EMR/Health Outcomes • Separate EMR would be installed at CCMC • System expertise in service integration	• Larger health systems likely to deploy their EMR systems • May implement evidence based 'bundles of care' to promote service integration and higher health outcomes	• Integration of services with ICHC may require additional effort, e.g. EMR interface
7. Stability / Retention • Larger health systems would promote leadership and employee longevity	• Larger health systems may be more effective at recruiting new physicians and staff offering wider career opportunities	• Introduction of a new hospital Administrator would potentially detract from alignment and collaboration with ICHC

Risk Management:

Risk	Mitigation
Less local control of health care and associated costs	• Negotiate firm management and overhead fees, as well as expectations of financial improvements over time
Few or no parties interested in operating CCMC	• Widely advertise the opportunity to organizations with aligned mission, vision and value
Ineffective collaboration leading to a sense of competition between CCMC and ICHC	• Contract for shared Administrator • Develop joint, detailed strategic and operating plan • Joint meetings of the ICWAC and the new Advisory Council
Transition risk – time to select and implement new operator	• Strong communication and change management plan • Continue current service structure, i.e. shared Administrator; collaboration before and during transition

Next Steps:

- Approve Joint Resolution agreeing to pursue strategic goal of third party operator for CCMC
- Issue Request for Information and market widely to maximize responses
- Based on RFI findings, define local goals and approach; issue Request for Proposals to relevant parties
- Due diligence with preferred operator to ensure alignment on mission, vision, goals and management agreement terms
- Begin joint ICWAC and HSB meetings to engage and monitor implementation of the strategic plan
- Complete a detailed Business Plan, including negotiated agreements, assumptions, and pro forma
- Complete associated strategic plan for quality and operations as well as longer term master site and facility plan
- Engage employees in transition and change management plans
- Engage State of Alaska to define and address all regulatory approvals, e.g. Certificate of Need if necessary, grants and licensure status, etc.
- Amend City Charter to eliminate the Health Services Board
- Implement business plan in concert with third party, including advisory council, employee transitions, lease of facility, etc.
- Pursue additional programs and services through expanded relationship with third party operator

VII. Additional Strategic Recommendations

A. Facility and Capital Planning

A major component of health care strategic planning must be an assessment of the current facility and equipment, with strategic plans to assure the routine replacement and maintenance of equipment and facilities. These are essential elements in a modern health care system, and while such expenses can be deferred in lean years, CCMC has experienced far too many financial shortfalls and associated deferrals of capital investment. Savings expected from the implementation of any of the strategic options should be reinvested in the capital needs that have been neglected rather than immediate conversion to reduce the City subsidy.

An equipment list with replacement needs is provided as Appendix E. Note this is not a complete inventory, but it does document the need for $3,138,500 for capital improvements and equipment over the next several years to bring the facility up to date. Additional investments may need to be considered to address some of the facility constraints. The Ilanka CHC would like to expand its space in order to more effectively serve patients. Also, the lack of separation between the Emergency Room and the long term care residents is not desirable. A long term Master Site and Facility Plan to address capital needs should be completed as part of the detailed strategic planning.

It should be noted that the responsibility for facility and capital investments remains with the City in each option. The governing and operating entities would need to determine when and how to sustain the facility and make capital investments, but the major investments would be funded by the City as the owner of the facility.

There is some concern that a third party might expect and potentially require upgrades to address facility deficiencies as condition of their engagement as an operator. In specific inquiries with Providence, they indicated that this has not been a condition for them to work with a community. It was acknowledged that City ownership and operatorship, Option A, retains the greatest degree of local control over the timing of capital improvements.

B. Quality and Operational Planning

By completing the Strategic Assessment phase, Cordova's health services are well positioned to develop a detailed strategic plan inclusive of operational and quality goals, strategies, tactics and targets. Completing such a plan jointly with CCMC and ICHC will ensure alignment of the entire plan with the shared vision and the direction set by the Strategic Assessment. Engaging employees as well as the boards/councils will generate the depth and specificity that leadership and employees can use to define, implement and monitor the contributions each

part contributes to the whole. The State of Alaska has provided technical assistance to complete and implement such a plan; this work will begin in January, 2011.

VIII. Conclusion

The Cordova Health Services Task Force has completed the first three phases of the Health Services Strategic Planning effort, referred to as the Strategic Assessment. This effort has engaged the public, employees and community leaders in a comprehensive and collaborative process to define a compelling vision, document the current reality, and develop three very viable options for the future. This has enabled the community to set a new direction for the health care system in Cordova.

The Task Force took a proactive role throughout to ensure the process was transparent, fact based, and future focused. Every participant brought diverse knowledge, skills and experience to the table, while remaining open to new information and creative in developing distinct strategies based on best practices and what can best serve the residents of Cordova. The time and talents of many people across the community and around the State were very helpful and greatly appreciated.

As the report documents, each of the three options assessed brought distinct strengths and weaknesses, risks and implementation requirements. However what is common across all of the options, and what emerged from the research and analysis, is the criticality of collaboration. This was noted as the single greatest factor to achieving successful health services in small rural communities where resources are invariably limited. By empowering leadership and removing competition, Cordova can look forward to financial, quality and service improvements.

The Joint Councils concluded the Strategic Assessment by developing a shared action plan to implement several elements in Option A – Improve within Existing Entities. In parallel, they also agreed to gather more information about the additional potential value that might come from Option B – Restructure Existing Entities, or Option C – Bring in a New / Third Party.

With the completion of the Strategic Assessment, implementation will need to proceed smoothly to sustain the momentum, to build clarity and stability for staff and providers, and to bring the benefits forward as quickly and effectively as possible. The plan of action developed by the Joint Councils offers the direction needed; the Task Force needs to provide ongoing oversight to track and assure progress. The detailed strategic plan should also include a Master Site and Facility Plan so the community can anticipate and properly fund their health care facilities for the future. Equally, a comprehensive quality and operational plan will be needed to complement the direction set by this Strategic Assessment. These, together with collaborative leadership, transparent operations, positive community and employee engagement can deliver Cordova's vision:

A financially sustainable and stable health care system that provides quality care for the health & wellness of all Cordovans

APPENDIX A
Financial Analysis

December 2, 2010

Members of the Joint Health Services Task Force and
Cordova City Council
Native Village of Eyak Traditional Tribal Council
Community Health Services Board
Ilanka Community Wellness Advisory Committee
Cordova, Alaska 99574

WIPFLi LLP
CPAs and Consultants

Dear Members:

We have completed our financial assessments of the Cordova healthcare community as requested by the Joint Health Services Task Force. The Joint Health Services Task Force is made up of representatives from Cordova City Council (City), Native Village of Eyak Traditional Tribal Council (NVE), Community Health Services Board (CHSB), and Ilanka Community Wellness Advisory Committee (ICWAC). The purpose of the financial assessments is to explore various alternatives that may improve the financial wellbeing of the Cordova healthcare community. As part of our assessment process, we collected financial information from the Cordova Community Medical Center (Medical Center) for the fiscal year ended June 30, 2009 (more current information was not available as of the date of this report), the City, Ilanka Community Health Center (Community Health Center) for the year ended September 30, 2009, NVE, and other organizations.

Organizational Options Being Considered

The Cordova Health Services Board (HSB) is considering three options. Option A involves the continuation of the current organizational structures; Option B involves the consolidation of healthcare services under the ownership of one entity; and Option C involves management of the Medical Center by an outside organization. This financial assessment will explore each of these options.

Option A – Continuation of the Current Organizational Structures

Our initial step in exploring this option was to determine the financial results of the current healthcare organizations. We determined the following:

> Based on the Medical Center's audited financial statements for the year ended June 30, 2009, the Medical Center's loss was $897,478 before operating transfers (see Appendix B page 74). The City of Cordova provided financial support totaling $1,004,847 (see Appendix B page 74).

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Based on the Native Village of Eyak's audited financial statements for the year ended September 30, 2009, the Community Health Center Fund and the Indian Health Service Fund experienced an excess of revenues over expenses of $104,420 before operating transfers. Based on this report NVE provided no financial support to the Community Health Center.

Based on this information, it appears that the financial wellbeing of the Cordova healthcare community would be improved if we can identify the reasons for the Medical Center losses.

As documented in our report dated September 7, 2010, we identified the following activities that appeared to account for the losses at the Medical Center:

Nursing home	$(400,000)
Medical Center's physician clinic including overhead costs of $129,000 (see letter dated September 7, 2010) (see a)	(211,000)
Medical Center physician emergency room coverage	(206,000)
Community Health Center rental agreement	(19,000)
Senior Meal Program	(43,000)
Identified Medical Center Losses	$(879,000)
Additional income and (losses):	
Rural Health Care Program – Universal Service Fund assistance	$ 305,326
Administrative Adjustments – unexplained – possibly accounts receivable write-off of old and disputed accounts	$ (438,061)

Based on further review, as also documented in our report dated September 7, 2010, we suggested several opportunities to reduce the Medical Center losses as follows:

Approach the State of Alaska and request a Medicaid nursing home rate that equals the actual cost of care	$ 400,000
Combine the Medical Center's physician clinic with the Community Health Center's clinic that has sufficient practitioners to meet the needs of both clinics and negotiate a contract with the Community Health Center to provide emergency room practitioner coverage (see b) (see a)	291,000
Raise the Community Health Center rental rate (already completed in fiscal year 2010)	19,000
Potential change in Medical Center Loss	$ 730,000

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a - Discussion with management identified the reason for some of the clinic related losses and the potential for savings. The Hospital incurs annual cost of $30,140 associated with the current physician coverage of the clinic as follows: automobile $8,000, lodging and utilities $9,840, telephone and internet access $1,800, meals $4,500, and airfare $6,000. In addition Hospital management estimates the current physician compensation for the part-time physician position (2/3rd position) is estimated to cost $61,600 more than fair market value. This total savings of $91,740 is included in the clinic related opportunity noted below.

b - Because the Community Health Center is paid two to three times the amount currently being received by the Medical Center for Medicare and Medicaid primary care services and the Community Health Center's costs are expected to increase very little as a result of the additional patient visits; we anticipate Community Health Center's profitability may increase as a result of the consolidation of the two clinics. Some of this increased profitability may be passed by the Community Health Center onto the Medical Center in the form of lower emergency room physician coverage cost.

As part of our previous preliminary assessment, we also determined that the amount paid by the Community Health Center for ancillary services provided by the Medical Center were approximately equal to the cost of providing those services and that other activities between the Community Health Center and the Medical Center appeared to be based on an equitable arrangement. The current arrangements should be based on a formal written agreement.

In our opinion, small rural communities are best served when all elements of the healthcare community work together to collectively meet the needs of the community. This effort requires complete cooperation and coordination of all services in an effort to promote operating efficiency, eliminate duplication of services, eliminate competition for patients, provide access to the maximum amount of resources available to the community from outside sources (primarily federal and state resources), and work together to clinically enhance the healthcare delivery system.

In addition, each rural healthcare community must understand that services can be provided in a number of ways and each of those alternative methods influence the ultimate payment for those services and the community's access to outside financial resources to deliver those services. Essentially, the community can provide services using one method and receive a set amount of resources or the community can provide the services using an alternative method and receive an enhanced amount of resources. The community has already explored two of these situations and changed its method of delivery in an effort to obtain additional resources for the delivery of healthcare in the community:

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The Medical Center elected to become a critical access hospital (CAH) under federal and state regulations. Although this election did not directly change the clinical delivery of inpatient and outpatient services it did enhance the amount that the state and federal government agencies (Medicare, Medicaid, TriCare, and Indian Health) pay for those services provided. This election improved the Medical Center's ability to meet the needs of the community by obtaining additional state and federal resources.

The Community Health Center elected to become a federally qualified health center (FQHC) under federal and state regulations. Although this election did not directly change the clinical delivery of primary care services it did enhance the amount that the state and federal government agencies (Medicare and Medicaid) pay for those services provided and it allowed the Community Health Center to apply for significant federal grants from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). This election improved the Community Health Center's ability to meet the needs of the community by obtaining additional state and federal resources.

With that said, we continued to explore other opportunities to improve the Cordova healthcare system and have the following recommendations:

Until recently the Medical Center and the Community Health Center had separate administrators. It has been our experience that small rural communities have difficulty attracting one qualified healthcare administrator to the community. Finding two qualified healthcare administrators is almost impossible. We believe a critical part of the cooperation and coordination of services in the community is the employment of one qualified person to fill both positions. We also believe that the community has such an individual. The following is a brief discussion of the issues that may be faced by the community as it seeks to find a second qualified healthcare administrator:

Each time a new healthcare administrator is hired, the facility's strategic direction changes. This can cause the community to expend scarce resources in pursuit of those new goals. In some instances the new direction is needed and the achievement of the related goals enhances the healthcare delivery system. In other instances, the new direction may not be beneficial and the community may find itself using up scarce resources without obtaining any meaningful return. Currently we find that the new direction charted by the joint administrator appears to be beneficial for Cordova.

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Each time a new administrator is hired; time is needed for the new administrator to understand the community's healthcare system, providers, challenges, and other issues that are unique to the community. Each healthcare system has its own unique strengths and weaknesses, which have to be identified before optimum results can be achieved. I have worked with a number of healthcare systems and have yet to find two that are alike. During this period that is needed to understand the Cordova healthcare community very little may be accomplished. We believe the community does not have the resources to delay the pursuit of positive changes.

Each time a new administrator is hired, the community runs the risk that the newcomer may not stay. Adjustments to a new community are a high source of stress for any new administrator and his/her family. We have seen all too often the small rural communities' healthcare administrator position is like a revolving door. Turnover is significant and it is very difficult to know if a new administrator will remain in the community for a long-term basis. In addition, there is a high demand for highly qualified and effective healthcare administrators and competition for those individuals is high. High administrator turnover is also high due to this competition between healthcare communities.

Two healthcare administrators may inhibit cooperation between the two entities and promote competition for limited patients and limited resources. This situation may be counter productive. We currently find the joint administrator appears to be making every effort to balance the interests of each of the healthcare organizations while promoting an efficient and effective healthcare delivery system.

The use of one healthcare administrator for both entities would potentially reduce the Medical Center related cost by fifty percent per year. Management estimates this savings for the Medical Center would be approximately $108,000 per year. Some of that savings would be passed onto Medicare and Medicaid due to the cost-based reimbursement method currently being used for hospital inpatient and outpatient services. In addition, the Community Health Center would save approximately $32,000 per year.

Currently the Medical Center and Community Health Center have separate billing and patient registration functions and other support services that are duplicated within each organization. In our opinion, the healthcare delivery system in Cordova is small enough to warrant separate billing and patient registration systems. Based on information provided by management, the elimination of duplicate billing and patient registration systems would each save the Medical Center and the Community Health Center $27,000 per year. Some of that savings would again be passed onto Medicare and Medicaid.

Currently the Medical Center and Community Health Center have separate information systems. Management believes that portions the two systems could be shared under common management. Management believes that this sharing of the same system will save the Medical Center approximately $35,000 per year. Some of that savings would again be passed onto Medicare and Medicaid.

Currently the Medical Center provides mental health services, and those services are provided without subsidy from the City. As an option to increase revenue, these same services could be provided through the Community Health Center. As an FQHC the Community Health Center can obtain higher payments from the federal and state government agencies for those services and additional grant funds may be obtained from HRSA. The additional resources could be used to expand the current mental health services to meet more of the community needs, for example enhancing the existing services for substance abuse counseling and school counseling.

Currently the Medical Center and Community Health Center do not provide dental services due to lack of space and other reasons. However the space currently being utilized by the Medical Center for a physicians' clinic could be used to expand Community Health Center services to include dental services. As an FQHC the Community Health Center can obtain higher payments from the federal and state government agencies for those services and additional grant funds may be available from HRSA. The additional resources could be used to expand the community's access to dental services.

As a final note, the Medical Center has been able to keep the City subsidies to a minimum by deferring building maintenance, infrastructure improvements, equipment replacement, purchase of new equipment, and other costs. Although it is common to defer these costs in lean years, the deferral of these costs over longer periods of time may cause the healthcare system's investment in capital assets to fall below an acceptable level. Based on information provided by management and results of recent state surveys, the Medical Center building and equipment are in need of significant capital investment.

Based on information provided by management, the following building and equipment items need to be replaced in the near future: the roof, the boilers, the emergency generator system, the portable radiology equipment, laboratory equipment, the ventilation system, cardiac monitoring system, call system, and other components of the healthcare infrastructure. Management estimates the cost of these capital improvements is $3,138,500 as identified in the Attached E. The financial improvements noted above are not expected to be available to reduce the City's annual subsidy of the Medical Center in the next few years. Instead, the additional resources made available from these improvements will be needed to make capital investments in building and equipment located at the Medical Center.

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Option B – Consolidation of Healthcare Services Under the Ownership of One Entity

The initial purpose of examining consolidation of healthcare services under one entity is for the same reasons that we have noted above.

> Small rural communities are best served when all elements of the healthcare community work together to collectively meet the needs of the community. This effort requires complete cooperation and coordination of all services in an effort to promote operating efficiency, eliminate duplication of services, eliminate competition for patients, provide access to the maximum amount of resources available to the community from outside sources (primarily federal and state resources), and work together to clinically enhancement the healthcare delivery system.
>
> In addition, each rural healthcare community must understand that services can be provided in a number of ways and each of those alternative methods influence the ultimate payment for those services and the community's access to financial resources to deliver those services. Essentially, the community can provide services using one method and receive a set amount of resources or the community can provide the services using at alternative method and receive an enhanced amount of resources.

We believe the consolidation of services under the ownership of one entity may enhance the healthcare community's ability to pursue those opportunities identified in our discussion of Option A. In fact there are no opportunities noted in Option A that cannot be pursued under Option B.

Our initial step in exploring this Option is to determine if ownership by either the Medical Center or the Community Health Center would cause the community to gain or lose healthcare resources.

If the Cordova healthcare system were consolidated under the City owned Medical Center, the following issues would exist:

- HRSA grants funds currently being provided to the Community Health Center to pay for indigent primary care would be eliminated. These funds are provided to the Community Health Center because of its FQHC status. HRSA has indicated that a city owned and operated organization may not receive FQHC status unless the city has established a separate non-profit organization that is not controlled by the City. The formation of a separate non-profit organization would defeat the purpose of the Option B consolidation exercise.

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- Indian Health Services grant funding currently provided to the Community Health Center because it is owned and operated by NVE would be eliminated.
- Payments for primary care services provided by the Community Health Center owned and operated by the NVE would be significantly reduced. Tribal owned clinics are paid two to three times the amount that is paid to clinics owned by other entities for Medicare and Medicaid primary care.
- Electronic health record and other information systems would have to be replaced since they are provided as a result of the NVE ownership and tribal connection.

Based on the issues noted above, it appears that consolidated under the City owned Medical Center is not a viable Option.

If the Cordova healthcare system were consolidated under NVE, the following issues would exist:

- HRSA grants funds currently being provided to the Community Health Center would continue.
- Indian Health Services grant funding currently provided to the Community Health Center would continue.
- Payments for primary care services provided by the Community Health Center would continue to be paid at the higher rate.
- The Medical Center's CAH status could continue.
- As a tribal owned CAH, Medicare and Medicaid payments for hospital services would be increased by a small amount.
- As a tribal owned nursing home, Medicaid payments would be based on the same method current being used to pay the Medical Center.
- Electronic health record system used by the Community Health Center could be provided to the Medical Center at very little cost. Although most of the electronic health record cost incurred by a City owned Medical Center would be paid by Medicare and Medicaid, it would be years before the Medical Center could arrange to have such a system installed due to the high demand at larger hospitals. The current Community Health Center system is not available to organizations outside of the tribal system.
- The other information systems currently being used by the Community Health Center could be provided to the Medical Center at very little cost.
- Tribal owned organizations have access to grant funds for hospital equipment and operations that are not available to other hospitals. These funds could be used to meet the current equipment needs noted earlier. The exact amount of those funds is not easily identifiable since funding varies considerably from year to year and, like any other form of grant funding, the organization has to compete for grant funds along with other tribal owned organizations.

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> We believe the ability of the community to access grant funds through a tribal owned organization will be enhanced considerably.

Based on the issues noted above, it appears that consolidating under NVE would allow the Community Health Center and the Medical Center to maintain its current funding and/or enhance its access to additional funding from outside sources.

Under an NVE ownership arrangement, the City would continue to own the building and lease it to NVE for a nominal amount. We would also assume that a large part of the City's current financial assistance to support the Medical Center's operations would be redirected toward updating the building currently occupied by the hospital, nursing home and Community Health Center. This redirection of funds toward those deferred building costs noted above would improve the community's healthcare facilities. The operation of the hospital, nursing home and Community Health Center with the additional outside funding from Medicare, Medicaid, Indian Health, and other sources also with the enhanced cooperation and coordination of services may provide an outcome that is better than the outcome expected under Option A.

Before Option B can be implemented, the form of governance of the consolidated healthcare system would have to be discussed. It is logical to expect that the entities who sponsored the Task Force would have to work together to form an acceptable governing body arrangement that allows NVE to own and operate the Medical Center but allows all interested parties to participate in the overall governance of the new healthcare organization. This may be in the form of an advisory board. Any governance issues would also have to be reviewed and approved from a regulatory and legal standpoint.

As the current owner of the hospital and nursing home, the City would have to transfer ownership of the hospital and nursing home operations to NVE. This transfer would have to be approved by the state and federal government agencies. That process may take months to accomplish. This transfer would also have to be considered a permanent change of ownership. We are not aware of a method that would transfer ownership to NVE on a conditional basis and permit the return of ownership if certain City or community expectations are not met.

Also the City would have to negotiate a lease agreement with NVE that allows the City to provide the new organization with unimpeded long-term use of the hospital building with the understanding that this arrangement would be revisited at specified intervals for the purpose of evaluating the new organization's ability to meet the healthcare needs of the community. The lease would also require the City to maintain the physical building at a level that meets all of the local, state, and federal construction codes and other healthcare requirements.

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Option C - Management of the Medical Center by Outside organization

The City recognizes that it does not have the healthcare expertise to manage a hospital at the same level that an outside organization would be able to provide. There are numerous hospital management firms that may be interested in entering into a contract to manage the hospital and nursing home. Because of
the number of management firms and the various types of contracts that can be negotiated, this option will have to go though an RFP (request for proposal) process before the various options can be properly compared and evaluated. The following is a list of our general observations and expectations concerning management contracts:

- Outside management firms have healthcare industry knowledge and experience that does not exist in most small rural communities.
- Some management firms' healthcare industry knowledge is based on experiences in large urban communities and healthcare systems while their knowledge and expertise involving small rural healthcare communities may not exist. In our opinion, small rural healthcare systems can not be managed as small versions of larger healthcare systems.
- Larger organizations have the resources to develop and maintain clinical policies and procedures that can enhance the quality of care that is available in Cordova.
- Larger organizations may have access to electronic healthcare and information technology systems that are far superior to those that may be available to small rural healthcare systems.
- The ability of a management company to operate a hospital and nursing home efficiently and effectively is no better than the administrator that they have on-site to manage the day-to-day operations. The selection of an on-site administrator must involve approval by both the City and the management firm.
- Management firms are generally not interested in assuming the full financial risk of operating a hospital and nursing home. This is especially true in a small rural healthcare community with limited patient volumes. Generally the financial risk remains with the owner. This suggests that if the hospital and nursing home incur financial losses, the City will provide a subsidy that is equal to the financial loss.
- With the higher quality and increase in resources available, communities can expect to continue to provide financial subsidies at a level that is close to the amounts provided before the management firm was employed. This may be summarized as the same financial support with a higher level and quality of healthcare.
- Management firm contracts may include but are not limited to any of the other following arrangements:
    - Employ all staff, operate the facility under its name, and expect that the City will pay an amount equal to any annual financial losses incurred.

- The City will maintain the building that meets all construction code standards (local, federal and state standards) and make all repairs and improvements that are required to maintain compliance with those standards.
- The City will maintain the building at a specified standard and lease the building to the management firm for a nominal amount ($1 per year). The management firm will receive an annual negotiated financial subsidy from the City. The management firm will assume any additional financial risk. Any profits or losses remaining at the end of the year will belong to the management firm.
- The management firm will provide an administrator for a fixed amount each month without any guarantees. The City assumes all financial risks. Additional support services are provided from the management firm's home office at a specified hourly rate plus expenses.
- The management firm will provide an administrator, chief financial officer, and director of nursing for a fixed amount each month without any guarantees. The City assumes all financial risks. Additional support services are provided from the management firm's home office at a specified hourly rate plus expenses.
- The management firm will enter into a long-term contract (three year for example) requiring a fixed monthly fee that is not contingent on performance or any other measure.

In general we find that a good management contract will significantly improve the quality of healthcare in the community and maintain the City's financial subsidy at the current level. At the other end of the spectrum, we find a poor management contract will require the City to increase its financial subsidy due to escalating financial losses and the quality of care in the community may decline. We have seen both extremes in small rural communities. We would strongly encourage the City to carefully evaluate each management contract opportunity by discussing the management company with hospitals, cities, and other entities that are current clients of the management firm. We would also strongly suggest that the City carefully review the management firm contract to ensure that it is aware of its obligations under that contract.

The management contract option was not considered a viable option for NVE. Currently NVE through various tribal healthcare associations has access to outside expertise that can provide many of the same support services that are being considered by the City. Also the Community Health Center was not being subsidized in fiscal year 2009 by NVE.

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If you have any questions or require additional information, please call Michael Bell at 509-489-4524.

Sincerely,

Wipfli LLP

Wipfli LLP

APPENDIX B

Cordova Community Medical Center 2009 Audited Financial Statement

CORDOVA
COMMUNITY
MEDICAL
CENTER

P.O. Box 160 • 602 Chase Ave. • Cordova, Alaska 99574-0160
Phone: (907) 424-8000 • Fax: (907) 424-8116

MANAGEMENT'S DISCUSSION AND ANALYSIS

Cordova Community Medical Center (the "Medical Center") functions as a Rural Critical Access Hospital, with a 24/7 Emergency Room, Out-Patient Physicians Clinic, Long-Term Care Facility and a dual diagnosis treatment capable Behavioral Health Program. The following is a discussion and analysis of the Medical Center's financial performance, providing an overview of the activities for the fiscal year ended June 30, 2009. This discussion and analysis contains other supplementary information in addition to the basic financial statements for the year ended June 30, 2009. Please read it in conjunction with the Medical Center's financial statements, which follows this section.

Financial Highlights

- The Medical Center's total net assets at June 30, 2009 were $3,226,721 which is an increase of $379,831 or 13.3% from fiscal year 2008.
- The Medical Center's operating revenues for FY09 were approximately $5.7 million.
- The Medical Center's operating expenses for FY09 were approximately $6.7 million.

Overview of the Financial Statements

The Medical Center is a component unit of the City of Cordova. Per City of Cordova ordinances, the Community Health Services Board (CHSB) administers the Medical Center's programs, except that a subcommittee of the CHSB oversees the behavioral health program, Sound Alternatives. The Medical Center's financial statements are prepared in conformity with accounting principles generally accepted in the United States (GAAP) as applied on an accrual basis. Under the accrual method of accounting, the same method used by private sector businesses, revenues are recognized in the period in which they are earned and expenses are recognized in the period in which they are incurred. The three basic financial statements of the Medical Center are as follows:

Balance Sheet - This statement presents information regarding the Medical Center's assets, liabilities and net assets. Net assets represent the total amount of assets less the total of liabilities. The balance sheet classifies assets, liabilities and net assets as current, non-current and restricted.

Statement of Revenues, Expenses and Changes in Net Assets – This statement presents the Medical Center's income, operating expenses and changes in net assets for the fiscal year.

Statement of Cash Flows – This statement presents cash flows from operations, non-capital financing, capital and investing activities. The Medical Center presents its cash flows statement using the direct method of reporting operating cash flows.

CORDOVA COMMUNITY MEDICAL CENTER

MANAGEMENT'S DISCUSSION AND ANALYSIS

Financial Analysis

The following condensed financial information was derived from the Medical Center's financial statements and reflects the Medical Center's changes during the fiscal year:

Net Assets

	2009	2008	Percentage Change
Current Assets	$1,593,536	$1,579,668	+0.9%
Property and Equipment, net	2,681,096	2,734,286	-1.9%
Total Assets	$4,274,632	$4,313,954	-0.9%
Current Liabilities	$1,001,402	$1,130,018	-11.4%
Non-current Liabilities	46,509	337,046	-86.2%
Total Liabilities	1,047,911	1,467,064	-28.6%
Net Assets invested in capital assets, net of related debt	2,616,512	2,653,552	-1.4%
Net Assets unrestricted	610,209	193,338	+215.6%
Total Net Assets	3,226,721	2,846,890	+13.3%
Total Liabilities and Net Assets	$4,274,632	$4,313,954	-0.9%

Changes in Net Assets

	2009	2008	Percentage Change
Operating revenues	$5,653,178	$5,451,796	+3.7%
Operating expenses	(6,749,509)	(5,710,932)	+18.2%
Non operating revenues and grant program activity, net	198,853	22,396	+787.9%
Loss before transfers	(897,478)	(236,740)	+279.1%
Transfers	1,004,847	349,819	+187.2%
Special Item – Net Pension assumed by SOA	272,462	-	
Increase in net assets	379,831	113,079	+235.9%
Net assets at beginning of year	2,846,890	2,733,811	
Net assets at end of year	$3,226,721	$2,846,890	+13.3%

CORDOVA COMMUNITY MEDICAL CENTER

MANAGEMENT'S DISCUSSION AND ANALYSIS

The Medical Center's operating revenues increased by $201K in FY09. The State of Alaska provided Employer relief in-kind revenue of $354K. Patient Revenue was substantially lower than anticipated with decreased census in long-term care, swing bed, and acute care. The City of Cordova supported the hospital by forgiving $421K in debt from prior years, transferring $559K for general support/matching funds and $24K of in-kind utilities and services. Cordova Community Medical Center's FY10 budget includes continued support from the City of $400K in general support, $150K for matching funds for capital improvements and $24K for in-kind support.

Overall expenses increased by $1M. Wages increased with additional medical provider and staffing costs. A medical provider was included in the payroll for the entire fiscal year. Staff turnover in critical roles created higher wages and increased overtime to fill open positions. No raises were implemented in FY09. Benefit costs increased by $558K - ($378K for State of Alaska funded PERS and $179K for medical insurance). Repairs and Maintenance costs were up by $77K and are projected to continue as the hospital building and equipment ages.

Medical Center Activities and Conditions Affecting Financial Position

The purpose of the Cordova Community Medical Center (dually certified as a Critical Access Hospital and long-term care (LTC) facility) is to provide 24/7 emergency room services, outpatient physicians' clinical services, observation and acute inpatient medical services, as well as rehabilitative swing bed services and long-term care services for the residents of the City of Cordova and the surrounding geographic area. Swing bed patients often come from outside of the community.

Historically, the Medical Center had been the sole provider of these services, however, in mid FY01, the Ilanka Health Center opened in Cordova as a federally funded 580 clinic for tribal members; operation of that facility had a moderate adverse effect on the utilization of the Medical Center by community members. However, during FY06 the City of Cordova negotiated an agreement with the Native Village of Eyak in which the Medical center closed its clinic operation and the Ilanka Health Center moved into the space previously occupied by the Medical Center's clinic. The Ilanka Community Health Center was funded largely by a HRSA 330 grant; it was to provide physician services for the hospital. Unfortunately, by the fall of 2007, the Ilanka Health Center had become unable to meet its contractual obligations regarding provision of medical providers to the Medical Center, thus necessitating the Medical Center's return to employing medical providers directly. Communication with the Ilanka Health Center has continued since that time in an effort to find common ground for future efforts of collaboration in providing health care to the community.

FY09 was a very challenging year for the Medical Center, a year which saw the hospital employing a number of medical providers (physician and mid-level practioners) to maintain services in the emergency room, the long-term care facility and continue the operation of the outpatient physician's clinic which been started in FY08 in order to assure consistent access to quality medical care by the community. FY09 saw a decrease in LTC bed occupancy, as well as fewer observation, acute, and swing bed admissions than anticipated, placing financial strain on the hospital. Much of that downturn in admissions now appears attributable to individual provider's medical practice philosophies, as well as the practice of locum tenen emergency room physicians sending patients to Anchorage for additional treatment rather than admitting and managing the patient locally. Additional marketing of LTC beds was undertaken, with development of brochures and with travel by administration to potential referring hospitals throughout the state.

CORDOVA COMMUNITY MEDICAL CENTER

MANAGEMENT'S DISCUSSION AND ANALYSIS

A search for a full time family practice physician was enjoined, with the goals of decreasing reliance on locum tenen providers while at the same time, providing more consistent services to area consumers. The community has not regularly had consistent, well liked physicians present since at least 2004; without such a physician presence, it is anticipated that consumers will continue to either seek medical services elsewhere or avoid having their health needs dealt with on a regular basis. It is vital that the Medical Center provide such physician services in order to maintain and grow its market share over the future.

The Medical Center management, the Community Health Service Board, and Cordova's City Council remain committed to continuing to work together to guarantee provision of quality medical services in Cordova and the surrounding Prince William Sound area.

Capital Assets

	2009	2008	Percentage Change
Land and improvements	$ 122,010	$ 122,010	0.0%
Buildings	5,546,776	5,588,205	-0.7%
Building improvements	3,595,412	3,581,716	+0.4%
Equipment	1,260,942	1,614,468	-21.9%
Construction in Progress	22,750	-	
Total property and equipment	10,547,890	10,906,399	-3.3%
Less accumulated depreciation	(7,866,794)	(8,172,113)	-3.7%
Net property and equipment	$ 2,681,096	$ 2,734,286	-1.9%

Obligations Under Capital Leases

	2009	2008	Percentage Change
Capital Leases	$ 64,584	$ 80,734	-20.0%

Leased equipment includes a heart monitor.

Other Facts, Decisions or Conditions

As previously stated the Medical Center Administration, with assistance from the City of Cordova, has implemented marketing plans and cost reductions to increase utilization and address shortfalls in revenues, as well as reducing liabilities for the future.

Contacting the Medical Center's Financial Management

This financial report is designed to provide our customers, investors and creditors with a general overview of the Medical Center's finances and to demonstrate the Medical Center's accountability for its assets. If you have any questions about this report or need additional financial information, contact the Finance Officer of the Medical Center at (907) 424-8000.

INDEPENDENT AUDITORS' REPORT

Honorable Mayor, City Council and
Cordova Community Health Services Board
Cordova Community Medical Center
Cordova, Alaska

We have audited the accompanying balance sheets of Cordova Community Medical Center, a component unit of the City of Cordova, as of June 30, 2009 and 2008 and the related statements of revenues, expenses, and changes in net assets, and cash flows for the years then ended. These financial statements are the responsibility of Cordova Community Medical Center's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Cordova Community Medical Center as of June 30, 2009 and 2008, and the results of its operations and cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

In accordance with *Government Auditing Standards,* we have also issued our report dated November 10, 2009 on our consideration of Cordova Community Medical Center's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements and other matters. The purpose of that report is to describe the scope of our testing over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audits.

The Management's Discussion and Analysis on pages 1 through 4 is not a required part of the basic financial statements but is supplementary information required by accounting principles generally accepted in the United States of America. We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the required supplementary information. However, we did not audit the information and express no opinion on it.

ERM

November 10, 2009

CORDOVA COMMUNITY MEDICAL CENTER

BALANCE SHEETS

June 30, 2009 and 2008

	2009	2008
ASSETS:		
CURRENT ASSETS:		
Cash	$ 263,346	$ 574,674
Receivables		
Patient accounts receivable, less allowance for uncollectible accounts of $322,530 and $510,307	1,012,767	738,560
Other	105,850	60,895
Grant programs	80,911	66,459
Supplies inventory	110,914	121,781
Prepaid expenses	19,748	17,299
Total current assets	1,593,536	1,579,668
PROPERTY and EQUIPMENT, net	2,681,096	2,734,286
Total assets	$ 4,274,632	$ 4,313,954
LIABILITIES AND NET ASSETS:		
CURRENT LIABILITIES:		
Accounts payable	$ 505,705	$ 139,433
Due to City of Cordova	-	421,334
Accrued payroll and related liabilities	477,622	553,101
Current portion of obligations under capital leases	18,075	16,150
Total current liabilities	1,001,402	1,130,018
NET PENSION OBLIGATION	-	272,462
OBLIGATIONS UNDER CAPITAL LEASES, net of current portion	46,509	64,584
Total liabilities	1,047,911	1,467,064
NET ASSETS:		
Invested in capital assets, net of related debt	2,616,512	2,653,552
Unrestricted	610,209	193,338
Total net assets	3,226,721	2,846,890
Total liabilities and net assets	$ 4,274,632	$ 4,313,954

CORDOVA COMMUNITY MEDICAL CENTER

STATEMENTS OF REVENUES, EXPENSES, AND CHANGES IN NET ASSETS

For the Years Ended June 30, 2009 and 2008

	2009	2008
OPERATING REVENUES:		
Net patient service revenue	$ 4,926,561	$ 5,081,241
Rent	63,604	55,090
PERS on-behalf contribution	353,558	82,572
Rural Health Care Program - Universal Service Fund assistance	305,326	224,395
Other	4,129	8,498
Total operating revenues	5,653,178	5,451,796
OPERATING EXPENSES:		
Salaries and related benefits	4,127,046	3,445,271
Professional services	574,667	545,828
Facility	563,776	520,168
Bad debt expense, net of recovery	447,920	143,360
Depreciation	270,417	246,216
Medical supplies	222,668	298,689
Other supplies	203,060	207,860
Repairs and maintenance	126,380	47,713
Insurance	110,301	120,973
Other expenses	60,946	84,793
Training and travel	40,119	43,114
Small equipment	2,209	6,947
Total operating expenses	6,749,509	5,710,932
Operating loss	(1,096,331)	(259,136)
NONOPERATING AND GRANT REVENUES AND EXPENSES:		
Sound Alternatives revenue	899,953	784,166
Sound Alternatives program expenses	(651,783)	(723,007)
Investment income	271	366
Interest expense	(7,458)	(11,497)
Contributions	-	10,081
Grant revenues and other	104,034	103,771
Other grant program expenses	(146,164)	(141,484)
Net nonoperating and grant revenues and expenses	198,853	22,396
Loss before operating transfers and special item	(897,478)	(236,740)
TRANSFERS IN:		
City of Cordova:		
Support for debt forgiveness	421,334	-
Transfers	559,031	329,563
Utility costs waived by the City	24,482	20,256
Total transfers in	1,004,847	349,819
SPECIAL ITEM:		
Net pension obligation assumed by State of Alaska	272,462	-
Increase in net assets	379,831	113,079
NET ASSETS AT BEGINNING OF YEAR	2,846,890	2,733,811
NET ASSETS AT END OF YEAR	$ 3,226,721	$ 2,846,890

The accompanying notes to financial statements are an integral part of these statements.

CORDOVA COMMUNITY MEDICAL CENTER

STATEMENTS OF CASH FLOWS

For the Years Ended June 30, 2009 and 2008

	2009	2008
CASH FLOWS FROM OPERATING ACTIVITIES:		
Cash received from patient services	$ 4,204,434	$ 5,105,849
Cash from other sources	22,778	44,514
Net cash from Sound Alternatives and grant programs	191,589	14,988
Cash paid to suppliers	(1,199,629)	(1,818,448)
Cash paid to employees	(3,848,967)	(3,375,048)
Net cash used for operating activities	(629,795)	(28,145)
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES:		
Net proceeds from contributions	-	10,081
Transfer in - City of Cordova	559,031	329,563
Net cash provided by noncapital financing activities	559,031	339,644
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Proceeds from obligations under capital leases	-	91,278
Cash payments on obligations under capital leases	(16,150)	(39,105)
Interest payments on obligations under capital leases	(7,458)	(11,497)
Purchase of property and equipment	(217,227)	(264,667)
Net cash used for capital and related financing activities	(240,835)	(223,991)
CASH FLOWS FROM INVESTING ACTIVITIES:		
Interest and dividends on investments	271	366
Net cash provided by investing activities	271	366
Net increase (decrease) in cash and cash equivalents	(311,328)	87,874
Cash, beginning of year	574,674	486,800
Cash, end of year	$ 263,346	$ 574,674

(Continued)

The accompanying notes to financial statements are an integral part of these statements.

CORDOVA COMMUNITY MEDICAL CENTER

STATEMENTS OF CASH FLOWS

For the Years Ended June 30, 2009 and 2008
(Continued)

RECONCILIATION OF OPERATING LOSS TO NET CASH PROVIDED BY OPERATING ACTIVITIES

	2009	2008
Operating loss	$ (1,096,331)	$ (259,136)
Items considered operating activity for cash flow:		
Sound Alternatives revenue	899,953	784,166
Sound Alternatives program expenses	(651,783)	(723,007)
Grant revenues and other	104,034	103,771
Other grant program expenses	(146,164)	(141,484)
Adjustments to reconcile net loss to net cash used for operating activities:		
Depreciation	270,417	246,216
Bad debt expense, net of recovery	447,920	143,360
Utility costs waived by the City of Cordova	24,482	20,256
Changes in assets and liabilities:		
Patient accounts receivable	(722,127)	24,608
Other receivables	(44,955)	(19,074)
Grant program receivables	(14,452)	(8,458)
Supplies inventory	10,867	(20,542)
Prepaid expenses	(2,449)	20,511
Patients' deposits	-	(6,450)
Accounts payable	366,272	(177,723)
Accrued payroll and related liabilities	(75,479)	55,360
Net pension obligation	-	(67,709)
Unearned revenue	-	(2,810)
Net cash used for operating activities	$ (629,795)	$ (28,145)
SUPPLEMENTAL DISCLOSURE:		
Schedule of non-cash non-capital activity that affects recognized liabilities		
Net pension obligation assumed by State of Alaska	$ 272,462	$ -
Debt forgiveness by City of Cordova	$ 421,334	$ -

The accompanying notes to financial statements are an integral part of these statements.

CORDOVA COMMUNITY MEDICAL CENTER

NOTES TO THE FINANCIAL STATEMENTS

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity

Cordova Community Medical Center (the "Medical Center") is a 23-bed Medical Center owned by the City of Cordova, Alaska, (the "Authority") and operated by the Health Services Board, whose members are appointed by the City Council. For this reason, the Medical Center is considered to be a component unit of the City of Cordova and is included in its annual financial statements. The Medical Center provides acute inpatient and outpatient, long-term care, and other community health care services.

Proprietary Fund Accounting

The Medical Center utilizes the proprietary fund method of accounting whereby revenue and expenses are recognized on the accrual basis. Substantially all revenues and expenses are subject to accrual.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Accounting Standards

Pursuant to Governmental Accounting Standards Board (GASB) Statement No. 20, *Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting*, the Authority has elected to apply the provisions of all relevant pronouncements of the Financial Accounting Standards Board (FASB), including those issued after November 30, 1989, that do not conflict with or contradict GASB pronouncements.

Property and Equipment

Property and equipment are carried at original acquisition cost or estimated fair market value at the time of donation. Depreciation is computed using the straight-line method at rates calculated to depreciate the cost of the assets over the following useful lives:

Description	Useful Life
Equipment	5-20 years
Building improvements	5-40 years
Buildings	5-40 years

Inventories

Inventories are stated at replacement cost, which approximates cost on a first-in, first-out method.

Interfund Services Provided and Used

Interfund transfers are transfers between funds or the component unit that are required when revenue is generated in one fund and expenditures are paid from another fund.

CORDOVA COMMUNITY MEDICAL CENTER

NOTES TO THE FINANCIAL STATEMENTS

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Operating Revenues and Expenses and Nonoperating Items

The Medical Center distinguishes operating from non-operating revenues and expenses. Operating revenues and expenses generally result from delivering services in connection with the Medical Center's principal ongoing operations. The principal operating revenues of the Medical Center are charges to patients for hospital and long-term care services provided. All revenues and expenses not meeting this definition, including mental health service revenue and expenses (Sound Alternatives), are reported as nonoperating revenues and expenses.

Net Patient Service Revenue

The Medical Center has agreements with third-party payors that provide for payments to the Medical Center at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments. Net patient service revenue is reported at the estimated net realizable amount from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, as final settlements are determined.

Charity Care

The Medical Center provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Charity care charges are estimated to be $252 in 2009 and $141,898 in 2008.

Because it received federal funding to build an incinerator, the Medical Center was obligated to provide free medical care to patients qualifying under the eligibility requirements established in the Hill Burton Act until February 3, 2006. The Medical Center fulfilled this obligation during the year ending June 30, 2008.

NOTE 2 – NET PATIENT SERVICE REVENUE

The Medical Center has contractual agreements with several third-party payors that provide for prospective payment and cost reimbursement at specified rates. For the years ended June 30, 2009 and 2008, revenue and the related accounts receivable for such care are recorded at established rates and unreimbursed charges are accounted for as a contractual allowance, which is an adjustment to patient service revenue.

A summary of the basis of reimbursement with major third-party payors follows:

- Medicare
  Inpatient acute care and outpatient hospital services rendered to Medicare program beneficiaries are paid based upon cost reimbursement methods. These cost reimbursements occur on an interim basis and these tentative rates are settled with final amounts determined after annual cost reports are submitted and audited by the Medicare Fiscal Intermediary. Long-term care services are paid based upon the RUGS payment system, a prospectively determined amount with rates that vary according to a classification system that is based upon clinical factors, with no final settlements.

CORDOVA COMMUNITY MEDICAL CENTER

NOTES TO THE FINANCIAL STATEMENTS

NOTE 2 – NET PATIENT SERVICE REVENUE (Continued)

- Medicaid
  Inpatient and outpatient services rendered to Medicaid program beneficiaries are reimbursed based upon a prospective reimbursement methodology. The Medical Center is reimbursed at a prospective rate from an adjusted four-year prior rate, plus a four-year inflation add on rate with final settlement determined after submission of annual cost reports by the Medical Center and audits by the Medicaid fiscal intermediary. In management's opinion, the final contractual allowances for the years ended June 30, 2009 and 2008 will not be significantly different from the estimates reflected in the accompanying financial statements.

NOTE 3 – STATE OF ALASKA RELIEF FUNDING

On-behalf payments for fringe benefits
The State of Alaska provided financial relief to entities participating in the State of Alaska Public Employees' Retirement System by making direct contribution to PERS plans and reducing annual contribution rates paid by employers. PERS on-behalf amounts recognized by the Medical Center as revenue and expenses were $353,558 and $82,572 for the year ended June 30, 2009 and 2008, respectively. As discussed in Note 9, Senate Bill 125 fixed PERS employer contribution rates beginning in fiscal year 2009.

NOTE 4 – DEPOSITS WITH FINANCIAL INSTITUTIONS

The Medical Center has concentrated its credit risk for cash by maintaining deposits in one financial institution, which may at times exceed amounts covered by insurance provided by the U.S. Federal Deposit Insurance Corporation (FDIC). The Medical Center has not experienced any losses in such accounts and believes it is not exposed to any significant credit risk to cash.

The Medical Center does not have a formally adopted deposit policy.

NOTE 5 – CAPITAL ASSETS

The Medical center owns land, buildings, equipment and construction work in progress as follows:

	Balance at June 30, 2007	Additions	Retirements	Balance at June 30, 2008	Additions	Retirements	Balance at June 30, 2009
Land	$ 122,010	$ -	$ -	$ 122,010	$ -	$ -	$ 122,010
Buildings	5,588,205	-	-	5,588,205	-	(41,429)	5,546,776
Building Improvements	3,461,908	119,808	-	3,581,716	59,242	(45,547)	3,595,411
Equipment	1,469,609	144,859	-	1,614,468	135,235	(488,760)	1,260,943
Construction in Progress	-	-	-	-	22,750	-	22,750
Total Property and Equipment	10,641,732	264,667	-	10,906,399	217,227	(575,736)	10,547,890
Accumulated Depreciation	(7,925,897)	(246,216)	-	(8,172,113)	(270,417)	575,736	(7,866,794)
Net Property and Equipment	$ 2,715,835	$ 18,451	$ -	$ 2,734,286	$ (53,190)	$ -	$ 2,681,096

Depreciation expense was $270,417 and $246,216 for the years ending June 30, 2009 and 2008, respectively.

CORDOVA COMMUNITY MEDICAL CENTER

NOTES TO THE FINANCIAL STATEMENTS

NOTE 6 – OBLIGATIONS UNDER CAPITAL LEASES

A summary of capital lease obligations at June 30 follows:

	2009	2008
Capital lease obligation, at 9.6% interest, collateralized by leased equipment.	$ 64,584	$ 80,734
	64,584	80,734
Less current portion	18,075	16,150
	$ 46,509	$ 64,584

Amortization expense associated with above leasing agreements is included in depreciation expense.

Scheduled payments on capital lease obligations for future fiscal years ending June 30 are as follows:

2010	$ 23,221
2011	23,221
2012	23,221
2013	5,805
	75,468
Less amounts representing interest on capital lease obligations	(10,884)
	$ 64,584

NOTE 7 – CHANGES IN LONG-TERM LIABILITIES

The changes in net pension and Other Post-employment Benefits (OPEB) obligation for the fiscal year ended June 30, 2009 are as follows:

	Balance at July 1, 2008	Increases	Decreases	Balance at June 30, 2009
Net pension/ OPEB obligation	$ 272,642	$ -	$ (272,642)	$ -

As discussed in Note 9, effective July 1, 2008, the State of Alaska converted its Public Employees Retirement System agent-multiple employer plan to a cost-sharing plan. The net pension and OPEB obligation was written off on July 1, 2008 and reported as a special item in the Statement of Activities.

NOTE 8 – RURAL HEALTH CARE PROGRAM

The Medical Center participates in the Rural Health Care Program (RHC) of the Universal Service Fund (USF), which is administered by the Universal Service Administrative Company. RHC is a support program authorized by Congress and designed by the Federal Communications Commission (FCC) to provide reduced rates to rural health care providers for telecommunications services and internet access charges related to the use of telemedicine and tele-health. RHC is intended to ensure that rural health care providers pay no more for telecommunication in the provision of health care services than their urban counterparts.

CORDOVA COMMUNITY MEDICAL CENTER

NOTES TO THE FINANCIAL STATEMENTS

NOTE 8 – RURAL HEALTH CARE PROGRAM (Continued)

Payments under RHC are made directly by USF to the Medical Center's telecommunications provider upon submission by the Medical Center of the required FCC forms. The Medical Center's contribution benefit under the program, which meets the definition of contributed services under generally accepted accounting principles, was $305,326 and $224,395 the years ended June 30, 2009 and 2008, respectively, and is included in other income in the accompanying statements of revenues, expenses and changes in net assets.

NOTE 9 – RETIREMENT PLANS

Public Employees' Retirement System Tier I - III Defined Benefit Pension Plan

Plan Description

The Medical Center participates in the Alaska Public Employees Retirement System (PERS) which was originally established as an agent multiple-employer defined benefit plan. On July 1, 2008, the State Legislation (Senate Bill 125) converted the plan to a cost-sharing multiple-employer plan. Under the cost-sharing plan arrangement, the State of Alaska Division of Retirement and Benefits will no longer track individual employer assets and liabilities. Rather, all plan costs and past service liabilities will be shared among all participating employers.

The Plan was established and administered by the State of Alaska to provide pension and post-employment healthcare, death and disability benefits, and cost of living adjustments for eligible State and local government employees. Benefit and contribution provisions are established by State law and may be amended only by the State Legislature. PERS issues a publicly available stand-alone financial report, the PERS Comprehensive Annual Financial Report, which includes financial statements and required supplementary information for PERS. That report may be obtained by writing to the Department of Administration, Division of Retirement and Benefits, P.O. Box 110203, Juneau, Alaska 99811-0203 or by calling (907) 465-4460.

Funding Policy

The Medical Center's contribution requirements are established and may be amended by the Legislation. Defined benefit PERS plan members are required by statute to contribute 6.75% (2.01% for pension and 4.74% for healthcare) of their annual covered salary.

AS 39.35.255 established a statutory employer contribution rate of 22%. Out of the 22%, 6.56% funded pension benefits and 15.44% funded other postemployment benefits (OPEB).

AS 39.35.280 required additional State contribution to make up the difference between 22.00% and the actuarially determined fiscal year 2009 contribution rate of 35.22%. In accordance with the provisions of GASB Statement Number 24, the Medical Center has recorded the State contribution in the amount of $353,558 as a PERS on-behalf payment. However, because the Medical Center is legally responsible only for the payments of up to 22% of covered payroll, this amount has been excluded from pension and OPEB cost as shown below. The Medical Center's annual pension and OPEB costs for the year ending June 30, 2009 and the amounts actually contributed are listed below.

Period Ending	Annual Pension Cost	Annual OPEB Cost	Total Benefit Cost	Percentage of Required Contribution Contributed
June 30, 2009*	$ 123,775	$ 291,577	$ 415,352	100%

*Due to PERS conversion to a cost-sharing plan in fiscal year 2009, information for prior two fiscal years is not available.

CORDOVA COMMUNITY MEDICAL CENTER

NOTES TO THE FINANCIAL STATEMENTS

NOTE 9 – RETIREMENT PLANS (Continued)

Public Employees' Retirement System Tier IV Defined Contribution Plan

Plan Description

All new employees who first become participants on or after July 1, 2006, will be enrolled in the Public Employees' Retirement System (PERS), Tier IV defined contribution plan. The plan was established and is administered by the State of Alaska to provide pension, occupational death and disability benefits. Also included in the Plan is a separate health reimbursement arrangement account. Benefit and contribution provisions are established by State law and may be amended only by the State Legislature.

Benefits depend solely on amount contributed to the plan and investment earnings. Annual contributions by the Medical Center amounted to 22% of annual covered payroll. This rate consists of 5% pension, .58% occupational death and disability, .99% retiree medical, and 3% Health Reimbursement Arrangement with the rest of the rate funding PERS defined benefit unfunded liability.

Qualified employees contribute 8% of covered employee wages. Employees are eligible to participate from the date of employment. Contributions made by employees and any investment earning on the account are vested to the employee immediately.

The Medical Center made pension contributions of $38,520 and other postemployment benefits contribution of $35,207 for the year ending June 30, 2009. Medical Center employees contributed $61,631 during fiscal year 2009.

NOTE 10 – CONCENTRATIONS OF CREDIT RISK AND OFF BALANCE SHEET RISK

Patient Receivables

The Medical Center grants credit without collateral to its patients, most of who are local residents and are insured under third-party payor agreements. The mix of receivables from patients and third-party payors at June 30, 2009 and 2008, are as follows:

	2009	2008
Patients/other	49%	50%
Medicare	43	33
Medicaid	8	17
	100%	100%

NOTE 11 – CONTINGENT LIABILITIES

Amounts received or receivable under grant programs from the State of Alaska are subject to audit and adjustment. The amount, if any, of expenditures which may be disallowed by the granting agencies cannot be determined at this time, although the Medical Center expects such amounts, if any, to be immaterial.

Payments made under the Medicaid program are subject to audit by the State of Alaska. Paid claims could be disallowed upon audit if there is inadequate documentation to substantiate the services provided to Medicaid beneficiaries. The amount, if any, of claims which may be disallowed by the State of Alaska cannot be determined at this time, although the Medical Center expects such amounts, if any, to be immaterial.

CORDOVA COMMUNITY MEDICAL CENTER

NOTES TO THE FINANCIAL STATEMENTS

NOTE 12 – RISK MANAGEMENT

The Medical Center is exposed to various risks of loss related to torts, theft of, damage to, and destruction of assets; errors and omissions; injuries to employees; and natural disasters. The Medical Center carries commercial insurance for all risks of loss. Settled claims resulting from these risks have not exceeded commercial insurance coverage in any of the past three fiscal years.

REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

Honorable Mayor, City Council and
Cordova Community Health Services Board
Cordova Community Medical Center
Cordova, Alaska

We have audited the financial statements of Cordova Community Medical Center, a component unit of the City of Cordova, as of and for the year ended June 30, 2009, and have issued our report thereon dated November 10, 2009. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States.

Internal Control Over Financial Reporting

In planning and performing our audit, we considered the Cordova Community Medical Center's internal control over financial as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Cordova Community Medical Center's internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Cordova Community Medical Center's internal control over financial reporting.

A control deficiency exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements on a timely basis. A significant deficiency is a control deficiency, or combination of control deficiencies, that adversely affects the Cordova Community Medical Center's ability to initiate, authorize, record, process or report financial data reliably in accordance with generally accepted accounting principles such that there is more than a remote likelihood that a misstatement of the Cordova Community Medical Center's financial statements that is more than inconsequential will not be prevented or detected by the Cordova Community Medical Center's internal control.

A material weakness is a significant deficiency, or combination of significant deficiencies, that results in more than a remote likelihood that a material misstatement of the financial statements will not be prevented or detected by the Cordova Community Medical Center's internal control.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph of this section and would not necessarily identify all deficiencies in internal control that might be significant deficiencies or material weaknesses. We did not identify any deficiencies in internal control over financial reporting that we consider to be material weaknesses, as defined above.

Compliance

As part of obtaining reasonable assurance about whether Cordova Community Medical Center's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards.*

We noted certain other matters that we reported to management of Cordova Community Medical Center in a separate letter dated November 10, 2009.

This report is intended for the information of the City Council, the Health Services Board, management, and others within the organization, and is not intended to be and should not be used by anyone other than these specified parties.

ERM

November 10, 2009

APPENDIX C
Community Survey Report

Cordova Health Services - A Needs Assessment

CRACIUN RESEARCH

September 20, 2010

Jean Craciun
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RESEARCH METHODS

Keren Kelley, Administrator, issued an RFP and Jean Craciun, CEO/President; Craciun Research contacted Kitty Farnham, Catalyst Consulting to partner and take the lead with this important Strategic Assessment for Cordova Health System.

BACKGROUND

The community of Cordova is a remote, rural community located near the Copper River Delta on the eastern shore of Prince William Sound. Cordova has a population of approximately 2,300 and is served by two main health care providers. Cordova Community Medical Center (CCMC) is owned by the City of Cordova and governed by the Health Services Board. The Ilanka Community Health Center (ICHC) is a Federally Qualified Health Clinic operated by the Native Village of Eyak which is governed by the Tribal Council and has a Community Advisory Board.

The leadership entities responsible for these health care providers have mutually agreed upon the need to develop a unified and strategic vision for health care in the community. The project will be driven by A Strategic Assessment with a strong research component. This report is the first research document and is the "Cordova Health System Community Needs Assessment." This product was developed with a thorough understanding that our clients are seeking to gather the necessary data through high quality research with a community of stakeholders and; to develop strategic direction, identify, explore and recommend alternatives for ensuring effective, efficient, and sustainable approaches to meet the health needs of the community of Cordova now and into the future.

Craciun Research was hired to lead the research elements for this important endeavor. We have conducted the first-ever comprehensive multi-phase research project for CCMC/ICHC. After completing the survey we met with team representatives to review the findings and to determine which individuals we would like to further study in Focus Group Research. It is very helpful in these type of assessments to first gain knowledge in a generalize able way through survey research but to then look for greater understanding by meeting with representative groups of the community. The connection between survey research and focus groups is to learn why residents answered survey questions in a specific direction and to understand opinions and attitudes more in-depth through these small group discussions

This first report focuses on the survey research component, which provides direction and required input from the community of Cordova. The second report is the result of Focus Group Research and will be under separate cover. Craciun Research tasks include the following:

- Conduct a community needs assessment survey of health services in Cordova.
- Conduct Focus Group Research with select community members and stakeholders to capture in-depth understanding of desire for services, current service gaps, and to inform the alternatives assessment.

THE SURVEY SAMPLE

The random sample of three hundred (n=300) was drawn from telephone numbers in Cordova, Alaska. The respondents were screened to ensure they were all adults, and the ratios of men to women and of age-group levels were kept in proportion to State population figures.

The probability is 19 out of 20, for the overall sample size, that if researchers had sought to interview every household from the sample frame above by using the same questionnaire, the findings would differ from these overall survey results by no more than 5.7 percentage points in either direction. Thus, the margin of error is +/- 5.7%; for sub-groups the sampling error is larger.

The sampling error is not the only way in which survey findings may vary from the findings that would result from talking to every super-voter in the population studied. Survey research is susceptible to human and mechanical errors such as interviewer recording and data handling errors. However, the standardized procedures used by Craciun Research eliminate such errors associated with paper and pencil methods; thus keeping the human error potential to a minimum.

DATA ANALYSIS & REPORTING

Members of the Craciun Research team, employing SPSS[1], analyzed the sample. The primary procedures reported are frequencies and cross-tabulations.

Notes to Readers

Included in the presentation of each response is a summary or example of any significant findings, followed by relevant tables. All percentages in the narrative are rounded to the nearest whole percentage point. Often times a few respondents fail to answer a question. Unless the percentage that failed to answer is significant, these people are not included in the totals upon which the percentages are based. Percentages in the tables occasionally do not add to exactly 100% because of rounding.

Cross tabulations describe data that may be related in some way. In many crosstabulations, categories are combined or omitted because the numbers are too small to be statistically significant. This manipulation may change the totals on which percentages are based, but does not affect the relationships between percentages. Cross tabulations may be used to indicate differences (or lack of differences) between subgroups of people. When a lack of difference is being shown, a footnote is appended to the table indicating that the differences are not "statistically significant".[2]

[1] Trademark registered.

[2] Statistical significance is determined by using a chi-square test with a significance factor of less than .05. The chi square test is used by researchers to determine whether a result may be due to random variation, and is sensitive to sample size, since large random variation may occur in small samples.

RESEARCH FINDINGS

A. Overall View of Cordova's Health System

Question: In general, how satisfied are you with the availability of health care in Cordova - very satisfied, somewhat satisfied, somewhat unsatisfied, or very unsatisfied? If you have no experience with health care in Cordova, just tell me.

Question: How satisfied are you with the availability of DOCTORS in Cordova?

Question: And with the availability of EMERGENCY care?

Question: And with the availability of LONG TERM CARE?

Question: And with the availability of additional services for the aging population?

Overall, satisfaction with the availability of health care in Cordova is not high; 19% of the respondents who have some knowledge about it are very satisfied, and 36% are somewhat satisfied, for a total of 54%.

Satisfaction with the availability of doctors is even lower (18% very satisfied and 22% somewhat satisfied) with a total satisfaction at forty percent (40%).

The availability of emergency services is rated much higher by Cordova residents, with 29% very satisfied and 39% somewhat satisfied, for a total of 68%.

Note: This table presents only the respondents who had some experience with each question. For population totals, regardless of experience, please see the Appendix.

Table A1.1: Satisfaction with Availability of Medical Care in Cordova

	Very satis-fied	Somewhat satis-fied	Neutral, no opinion	Somewhat unsatis-fied	Very unsatis-fied	Number
Availability of:						
Emergency care:.....	29.0%	38.5%	8.4%	8.8%	15.3%	262
Long term care:.....	27.4%	30.7%	16.8%	6.7%	18.4%	179
Added services for the aging.	20.2%	32.7%	17.9%	11.3%	17.9%	168
Health care in Cordova.....	18.6%	35.6%	7.5%	21.0%	17.3%	295
Doctors in Cordova.....	17.8%	21.9%	6.5%	24.0%	29.8%	292

Percentages are of each row.

Question: Do you have a doctor in Cordova who meets most of the health needs for you and your family/household?

Only thirty percent of the households in Cordova have a Primary Care Physician.

TABLE A2.1: PRIMARY CARE PHYSICIAN

Family has:		
A doctor in Cordova	91	30.3%
Does not	198	66.0%
Don't know	11	3.7%
Total	300	100%

People who have a doctor in Cordova are overall, better satisfied with the availability of health care than are those who do not currently have a PCP in Cordova.

TABLE A2.2: RATING OF THE AVAILABILITY OF CARE BY HAVING A PRIMARY CARE PHYSICIAN

	Family has:		Total
	A doctor in Cordova	Does not	
Availability of health care			
Very satisfied	25.9%	16.4%	19.3%
Somewhat satisfied	46.9%	36.1%	39.4%
Somewhat unsatisfied	18.5%	25.7%	23.5%
Very unsatisfied	8.6%	21.9%	17.8%
Number	81	183	264
Availability of doctors in Cordova			
Very satisfied	25.9%	15.2%	18.6%
Somewhat satisfied	28.2%	20.8%	23.2%
Somewhat unsatisfied	28.2%	25.3%	26.2%
Very unsatisfied	17.6%	38.8%	31.9%
Number	85	178	263

Column percentages

Question: How important to you is having good healthcare available in the community – very important, somewhat important, somewhat unimportant, somewhat unimportant or very unimportant?

Nearly everybody wants good health care available in Cordova; only five people out of three hundred did not report that it was important.

TABLE A3.1: IMPORTANCE OF THE AVAILABILITY OF GOOD HEALTHCARE

Having good healthcare available is:		
Very important	285	95.0%
Somewhat important	10	3.3%
Makes no difference	3	1.0%
Somewhat unimportant	1	.3%
Very unimportant	1	.3%
Total	300	100%

Question: Do you have any ideas about what the community could do to improve healthcare?

Question: [IF YES] What one thing would you most like to see happen?

Below is a summary of findings from our open-ended question that allowed residents of Cordova to offer suggestions during the Community Needs Assessment.

Note: Please see the Appendix for the detailed verbatim comments offered.

TABLE A4.1: SUGGESTIONS FOR IMPROVING HEALTHCARE IN CORDOVA

Management Related Issues (31 answers)
Better Cooperation (10 answers)
Bring in an Outside Organization (17 answers)
Stop Firing Doctors (22 answers)
Hire More Doctors (41 answers)
Deliver Babies (7 answers)
Good Job, Considering (4 answers)
Lower Health Costs (5 answers)
Suggestions (22 answers)
Other (8 answers)

B. Funding Healthcare Discussion

Question: Are you aware that the City of Cordova helps to keep local medical care available by subsidizing the hospital with funds– depending on need, between half a million and a million dollars a year?

Question: Do you approve of that?

Question: [IF DOES NOT APPROVE COMPLETELY] Do you think the City of Cordova should be paying more or less or nothing at all?

Six in ten residents are aware of the City subsidy for the hospital. Regardless of the advance knowledge, just half (51%) completely approves of that subsidy. Another 19% somewhat approves of it, and 16% are unsure what they currently think. Only 13% actually offered disapproval.

Among the 300 people in the study, 5% feel the city should be paying more, 9% that it should be paying less and 12% that the city should be paying nothing. Nearly a quarter (24%) of the survey respondents has no opinion.

Table B1.1: Funding by the City of Cordova

Respondent is aware that:		
The City subsidizes the hospital	186	62.0%
Is not aware	114	38.0%
Total	300	100%
Respondent:		
Completely approves of the subsidy	153	51.0%
Somewhat approves	58	19.3%
Does not	40	13.3%
Unsure	49	16.3%
Total	300	100%
The City should be:		
Paying more	14	4.7%
Paying Less	27	9.0%
Paying nothing	35	11.7%
Don't know	71	23.7%
Completely approves the subsidy	153	51.0%
Total	300	100%

Community members who are very satisfied with the availability of health care in Cordova are least likely to know about the City subsidy and most likely to approve of it.

Generally, the better satisfied with health care, the more likely the support for the subsidy.

TABLE B1.2: CITY FUNDING BY RATINGS OF HEALTHCARE AVAILABILITY

	Cordova health care				Total
	Very satis-fied	Somewhat satis-fied	Somewhat unsatis-fied	Very unsatis-fied	
Respondent is aware that:					
The City subsidizes the hospital	40.0%	65.7%	67.7%	72.5%	62.3%
Is not	60.0%	34.3%	32.3%	27.5%	37.7%
Number	55	105	62	51	273
Respondent:					
Completely approves of the subsidy	70.9%	53.3%	46.8%	33.3%	51.6%
Somewhat approves	7.3%	20.0%	25.8%	27.5%	20.1%
Does not	3.6%	10.5%	12.9%	25.5%	12.5%
Unsure	18.2%	16.2%	14.5%	13.7%	15.8%
Number	55	105	62	51	273

Column percentages
* Difference is not statistically significant

People who have a doctor in Cordova are much more likely to be aware of the City subsidy and also to approve of it.

TABLE B1.3: CITY FUNDING BY HAVE A PHYSICIAN IN CORDOVA

	Family has:		Total
	A doctor in Cordova	Does not	
Respondent is aware that:			
The City subsidizes the hospital	70.3%	58.6%	62.3%
Is not	29.7%	41.4%	37.7%
Number	91	198	289
Respondent:			
Completely approves of the subsidy	62.6%	46.0%	51.2%
Somewhat approves	14.3%	20.7%	18.7%
Does not	14.3%	13.6%	13.8%
Unsure	8.8%	19.7%	16.3%
Number	91	198	289

Column percentages

Question: [IF DOES APPROVE OF THE SUBSIDY] Of course, the money comes from taxes. Does that make you more or less in favor of the subsidy?

When reminded that the City subsidy comes from taxes, the percentage of respondents who disapprove of the subsidy rises from 13% to 20%.

TABLE B2.1: FUNDING BY THE CITY OF CORDOVA

Knowing the money comes from taxes:		
Approves to a degree		
Completely approves	145	48.3%
Somewhat approves	38	12.7%
Subtotal, Approves to a degree	183	61.0%
In doubt		
Approved, now in doubt	8	2.7%
Disapproves		
Approved, now disapproves	20	6.7%
Disapproves	40	13.3%
Subtotal, Disapproves	60	20.0%
Has no opinion	49	16.3%
Total:	300	100%

Question: Some people are suggesting that the City of Cordova and the Native Village of Eyak work together to handle healthcare services? Would you strongly favor that, somewhat favor it, somewhat oppose it or strongly oppose it or do you have no opinion?

Question: Some people are suggesting that the City bring in an Outside health organization for hospital operations. Would you strongly favor that, somewhat favor it, somewhat oppose it or strongly oppose it or do you have no opinion?

Exactly the same percentage (53% of respondents) favors both of the options presented in this question – for the City/Village to work together to handle healthcare services and to bring in an Outside health organization. However, as shown on the cross tabulation on the next page, the percentage is a coincidence.

TABLE B3.1: IDEAS FOR ASSISTANCE WITH FUNDING

City and the Native Village of Eyak should cooperate:		
Favor		
Strongly favor	103	34.3%
Somewhat favor	56	18.7%
Subtotal favor	159	53.0%
Neutral, no opinion	76	25.3%
Oppose		
Somewhat oppose	25	8.3%
Strongly oppose	40	13.3%
Subtotal oppose	65	21.7%
Total	300	100%
City should bring in an Outside health organization:		
Favor		
Strongly favor	105	35.0%
Somewhat favor	54	18.0%
Subtotal favor	159	53.0%
Neutral, no opinion	94	31.3%
Oppose		
Somewhat oppose	23	7.7%
Strongly oppose	24	8.0%
Subtotal oppose	47	15.7%
Total	300	100%

As you can see below, while some Community Members favor both the City/Village and Outside options, there are many people who <u>favor</u> one and <u>oppose</u> the other.

TABLE B3.2: IDEAS FOR ASSISTANCE WITH FUNDING

	City and the Native Village should cooperate:			Total
	Favor	No opinion	Oppose	
City should bring in an outside health org:				
Favor	50.9%	42.1%	70.8%	53.0%
No opinion	25.2%	52.6%	21.5%	31.3%
Oppose	23.9%	5.3%	7.7%	15.7%
Number	159	76	65	300

Column percentages

C. Ratings of the Three Healthcare Organizations in Cordova

Question: In the last five years about how often have you or a family member living in your household been an in-patient at the Cordova Hospital or ER, not in the clinic?

Question: How often have you gone to the Hospital Clinic, located in the downstairs of the Hospital to get care for yourself or a family member living in your household?

Question: And also in the last five years have you gone to the Ilanka Community Health Center to get care for yourself or a family member living in your household?

Forty-five percent of the respondents (or a family member living in their households) had been to the Hospital or ER in the last five years.

Sixty-two percent had visited the Hospital Clinic.

Sixty-six percent had sought care at the Ilanka Community Health Center.

Ninety percent had visited one clinic or the other in the last five years.

Note: The detailed table may be found on the next page.

TABLE C1.1: USE OF THE THREE HEALTHCARE PROVIDERS

In-patient in hospital or ER:		
5 times or more	33	11.0%
3 or 4 times	13	4.3%
1 or 2 times	79	26.3%
Some, unsure how many	10	3.3%
Never	165	55.0%
Total	300	100%
Hospital Clinic:		
20 times or more	24	8.0%
10 to 19 times	36	12.0%
5 to 9 times	32	10.7%
3 to 4 times	22	7.3%
1 to 2 times	63	21.0%
Some, unsure how many	10	3.3%
Never	113	37.7%
Total	300	100%
Ilanka Community Health Center:		
20 times or more	27	9.0%
10 to 19 times	33	11.0%
5 to 9 times	43	14.3%
3 to 4 times	31	10.3%
1 to 2 times	57	19.0%
Some, unsure how many	6	2.0%
Never	103	34.3%
Total	300	100%
Treated at one clinic or the other:		
10 or more times	103	34.3%
5 to 9 times	61	20.3%
1 to 4 times	100	33.3%
Some	7	2.3%
Never	29	9.7%
Total	300	100%

Question: Thinking of the last time that you or a family member living in your household was in the Hospital or the ER itself, not the clinic, how would you rate that visit overall – very good, good, average, poor or very poor?

Question: How would you rate:
*the medical care from the doctor or physician assistant?
*the care from the nurses?
*from the other people who helped you?
*how about the waiting time when you rang for help? AND
*the billing process?

Question: Compared to ERs or Hospitals you have been to in other places, was the care you received from the ER or Hospital about as good as you could get in a larger city, better or worse?

Seven in ten (72%) of the residents who had been patients (or had a family member who lived in their household who was a patient) at the ER or Hospital rated it overall, good or very good.

All of the individual features of care tested were rated as high as or higher than the overall with one exception. As is the case with many ERs or Hospitals, the billing process only received a 36% rating for good or very good.

Note: This table measures the ratings of those who have experienced the hospital within the last five years. A table reflecting the total population may be found in the Appendix.

TABLE C2.1: RATING OF THE FEATURES OF THE ER OR HOSPITAL

	Very good	Good	Average	Poor	Very Poor	Number
Overall ER or Hospital.....	34.6%	36.9%	21.5%	3.1%	3.8%	130
Care from nurses.....	53.2%	32.5%	11.9%	1.6%	.8%	126
Waiting time after ringing for help.....	51.2%	20.8%	19.2%	7.2%	1.6%	125
Other people who helped you..	48.0%	29.3%	19.5%	.8%	2.4%	123
Medical care from MD or P)...	41.1%	33.3%	17.1%	5.4%	3.1%	129
The billing process.....	23.3%	12.9%	33.6%	13.8%	16.4%	116

Percentages are of each row.
Statements have been somewhat abbreviated. See question for exact wording.

Half of the Community Members in our study with recent experiences at the Cordova hospital or ER rated it the same or better than hospitals or ERs they had experienced elsewhere. Since it is probable that those who gave no answer had never experienced another hospital; we provide a second column in the table below which gives the percentages based upon those with opinions and experiences Outside of Cordova.

TABLE C2.2: COMPARISON OF THE HOSPITAL OR ER TO ELSEWHERE

Cordova hospital or ER is:			
Better than a larger city.....	27	20.0%	23.1%
About the same.....	41	30.4%	35.0%
Worse.....	49	36.3%	41.9%
Don't know.....	18	13.3%	
Total.....	135	100%	118

Question: Thinking of the last time you were at the Hospital Clinic, located in the downstairs of the Hospital, for yourself or a family member living in your household, how would you rate that visit overall – very good, good, average, poor or very poor?

Question: How would you rate:
*the medical care from the doctor or physician assistant?
*the care from the nurses?
*from the other people who helped you?
*how about the waiting time until you were seen? AND
*the billing process?

Question: Compared to clinics you have been to in other places, was the care you received from the Hospital Clinic about as good as you could get in a larger city, better or worse?

Sixty-nine percent of the people who had been treated at the Hospital Clinic (or had a family member who lived in their household who was treated) rated it overall, good or very good.

All of the individual features of care tested were rated higher than the overall with two exceptions. First of all, the waiting time which was rated equally well (within the margin of error) by 66% and, secondly, the billing process again the lowest ranked with 43% good or very good.

Note: This table measures the ratings of those who have experienced the clinic within the last five years. A table showing the responses of the entire population may be found in the Appendix.

TABLE C3.1: RATING OF THE FEATURES OF HOSPITAL CLINIC

	Very good	Good	Average	Poor	Very Poor	Number
Overall Hospital Clinic.....	32.6%	36.0%	25.8%	4.5%	1.1%	178
Care from the nurses.....	51.1%	38.5%	8.6%	1.1%	.6%	174
Other people who helped you..	43.1%	39.4%	15.0%	1.3%	1.3%	160
Medical care from MD or PA...	38.8%	39.3%	17.4%	3.9%	.6%	178
Waiting time until you were seen.....	36.3%	30.2%	24.6%	7.8%	1.1%	179
The billing process.....	16.7%	26.5%	33.3%	11.7%	11.7%	162

Percentages are of each row.
Statements have been somewhat abbreviated. See question for exact wording.

Twenty-eight percent of all those who had visited the Hospital Clinic within the last five years (and 31% of those with experience Outside of Cordova) rated it worse than clinics they had visited elsewhere.

TABLE C3.2: COMPARISON OF THE HOSPITAL CLINIC TO ELSEWHERE

The Hospital Clinic is:			
Better than a larger city.....	32	17.1%	18.8%
About the same.....	86	46.0%	50.6%
Worse.....	52	27.8%	30.6%
Don't know.....	17	9.1%	
Total.....	187	100%	170

Question: Thinking of the last time you were at the Ilanka Community Health Center for yourself or a family member living in your household, how would you rate that visit overall, – very good, good, average, poor or very poor?

Question: How would you rate:
*the medical care from the doctor or physician assistant?
*and the care from the nurses?
*and from the other people who helped you?
*how about the waiting time until you were seen? AND
*the billing process?

Question: Compared to clinics you have been to in other places, was the care you received from the Ilanka Community Health Center about as good as you could get in a larger city, better or worse?

Fifty-seven percent of the people who had been patients (or had a family member who lived in their household as a patient) rated the Ilanka Community Health Center overall, good or very good.

All of the individual features of care tested were rated higher than the overall with one exception. As is the case with the other organizations in our study, the billing process received a 50% rating for good or very good.

Note: This table measures the ratings of those who have experienced the clinic within the last five years. A table reflecting the total population may be found in the Appendix.

TABLE C4.1: RATING OF THE FEATURES OF THE ILANKA COMMUNITY HEALTH CENTER

	Very good	Good	Average	Poor	Very Poor	Number
Overall Ilanka Center.....	24.2%	33.0%	30.4%	9.3%	3.1%	194
Care from the nurses.....	40.4%	37.2%	18.6%	2.1%	1.6%	188
Other people who helped you..	39.5%	37.3%	17.8%	4.9%	.5%	185
Waiting time until you were seen.....	35.4%	28.1%	25.5%	9.4%	1.6%	192
Medical care from MD or PA...	30.4%	29.4%	29.9%	7.7%	2.6%	194
The billing process.....	22.9%	27.4%	22.9%	15.4%	11.4%	175

Percentages are of each row.
Statements have been somewhat abbreviated. See question for exact wording.

Twenty-six percent of those who had visited the Ilanka Community Health Center found it worse than others they had visited Outside of Cordova.

The table below offers a second column that gives the percentage (29%) based upon those with opinions and experiences Outside of Cordova.

TABLE C4.2: COMPARISON OF THE ILANKA COMMUNITY HEALTH CENTER TO ELSEWHERE

The Ilanka Clinic is:			
Better than a larger city.....	30	15.2%	16.9%
About the same.....	96	48.7%	54.2%
Worse.....	51	25.9%	28.9%
Don't know.....	20	10.2%	
Total.....	197	100%	177

D. Reasons for Traveling from Cordova to Outside Healthcare

Question: In the last five years have you gone away from Cordova for medical treatment for yourself or a household member?

Question: [IF YES] About how many times a year have you been leaving Cordova for medical treatment?

Question: Was it because a doctor referred you to another doctor or clinic?

Just under two-thirds (61%) of the respondents had traveled Outside of Cordova for medical care for themselves (or a household member) in the last five years. However, it is important to note that many were actually following the doctor's orders to leave. Thirty-four percent of Cordova Community Members went elsewhere for healthcare based upon their own volition.

Among those who had left town for medical care, most reported making more than one trip.

Table D1.1: Frequency of Going Elsewhere for Healthcare

Leaving Cordova for medical treatment:		
Left of own volition	102	34.0%
Referred by MD or PA	82	27.3%
Has not left	116	38.7%
Total	300	100%
Has left Cordova for treatment Approximate times a year:		
Six or more times	24	13.0%
Four or five times	26	14.1%
Two or three times	67	36.4%
Once	58	31.5%
None	4	2.2%
No answer	5	2.7%
Total	184	100%

The less satisfied with the availability of healthcare or doctors in Cordova, the more likely the respondent was to have gone elsewhere for medical care.

TABLE D1.2: FREQUENCY OF GOING ELSEWHERE BY SATISFACTION WITH THE AVAILABILITY OF HEALTHCARE

	Very satis-fied	Somewhat satis-fied	Somewhat unsatis-fied	Very unsatis-fied	Total
	Cordova healthcare				
Leaving Cordova for medical treatment:					
Left of own volition	10.9%	35.2%	43.5%	45.1%	34.1%
Referred by MD or PA	21.8%	21.9%	35.5%	37.3%	27.8%
Has not left	67.3%	42.9%	21.0%	17.6%	38.1%
Number	55	105	62	51	273
	Availability of doctors in Cordova				Total
Leaving Cordova for medical treatment:					
Left of own volition	21.2%	31.3%	31.4%	54.0%	36.6%
Referred by MD or PA	13.5%	23.4%	45.7%	28.7%	28.9%
Has not left	65.4%	45.3%	22.9%	17.2%	34.4%
Number	52	64	70	87	273

Column percentages

People who had been (or had a close family member) treated at the hospital were more likely than other respondents to have gone elsewhere for care.

TABLE D1.3: FREQUENCY OF GOING ELSEWHERE BY HOSPITAL/ER VISITS

	Inpatient or ER:				Total
	5 times or more	3 or 4 times	1 or 2 times	Never	
Leaving Cordova for medical treatment:					
Left of own volition	48.5%	61.5%	32.9%	29.1%	33.8%
Referred by MD or PA	42.4%	7.7%	25.3%	27.3%	27.6%
Has not left	9.1%	30.8%	41.8%	43.6%	38.6%
Number	33	13	79	165	290

Column percentages

People who have a Primary Care Physician in Cordova are less likely to have left Cordova for treatment of their own volition (28%), and more likely to have been referred Outside of Cordova (36%) than those who do not have a Primary Care Physician (22%).

TABLE D1.4: FREQUENCY OF GOING ELSEWHERE BY HAVING AN MD

	Family has:		Total
	Has PCP in Cordova	Does not have PCP	
Leaving Cordova for medical treatment:			
Left of own volition	27.5%	37.9%	34.6%
Referred by MD or PA	36.3%	22.2%	26.6%
Has not left	36.3%	39.9%	38.8%
Number	91	198	289

Column percentages
* Difference is not statistically significant

People who have left Cordova for healthcare are more aware of the City subsidy and slightly more likely to disapprove of it.

TABLE D1.5: CITY FUNDING BY GOING ELSEWHERE FOR HEALTHCARE

	Leaving Cordova for medical treatment:			Total
	Left on own volition	Referred by MD or PA	Has not left	
Respondent is aware that:				
The City subsidizes the hospital.....	81.4%	65.9%	42.2%	62.0%
Is not.....	18.6%	34.1%	57.8%	38.0%
Number.....	102	82	116	300
Respondent:				
Completely approves of the subsidy....	47.1%	48.8%	56.0%	51.0%
Somewhat approves.....	25.5%	17.1%	15.5%	19.3%
Does not.....	18.6%	15.9%	6.9%	13.3%
Unsure.....	8.8%	18.3%	21.6%	16.3%
Number.....	102	82	116	300

Column percentages

Question: Did you leave Cordova just to get medical treatment elsewhere, or were you going to be gone anyway, and decided to do medical things while you were gone?

Question: Was the medical care you went for a routine check-up or for something special?

Looking only at those who had gone of their own volition, more than half (57%) made the trip exclusively to receive medical care.

Half (51%) of the healthcare sought was for something special, not reported as a routine check-up.

TABLE D2.1: DETAILS OF VOLUNTARILY SEEKING HEALTHCARE ELSEWHERE

Left Cordova because		
Went to get medical treatment	58	56.9%
Was going to be gone anyway	11	10.8%
Some of both	31	30.4%
Don't recall	2	2.0%
Total	102	100%
Type of medical care:		
Routine	44	43.1%
Special	52	51.0%
No answer	6	5.9%
Total	102	100%

Question: Why did you leave Cordova for medical care?

Half of the respondents who had left Cordova for medical treatment went to see a Specialist.

In this open-ended question Cordova Community Members offered many other reasons related to doctors, or lack thereof.

TABLE D3.1: REASONS FOR SEEKING MEDICAL CARE ELSEWHERE

Reasons for leaving:		
I see a specialist	50	49.0%
No one knew how to treat what was wrong	30	29.4%
I have a doctor elsewhere & always go to that one	28	27.5%
Don't trust any of the local doctors	23	22.5%
I don't trust either of the clinics	9	8.8%
I wanted a second opinion	8	7.8%
Doctor turnover	5	4.9%
Couldn't get an appointment here	4	3.9%
I was traveling already	4	3.9%
Cordova lacks capability for certain disorders	2	2.0%
Hospital care is poor	1	1.0%
To deliver a baby	1	1.0%
Care lacks quality, consistency and confidentiality	1	1.0%
No answer	4	3.9%
Total Respondents	102	

Percentages add to more than 100% because many respondents gave more than one response.

E. Demographics

The gender and age of the participants was deliberately controlled to match the population statistics for Cordova, Alaska.

Seventy percent of the sample are Caucasian. A third had lived in Cordova fewer than five years.

Table E1.1: Demographics

Gender:		
Male	147	49.0%
Female	153	51.0%
Total	300	100%
Age group:		
18-34	56	18.9%
35-44	82	27.6%
45-54	75	25.3%
55-64	50	16.8%
65 and Up	34	11.4%
Total *	297	100%
Ethnicity:		
Caucasian	206	70.3%
Alaska Native	39	13.1%
American Indian	9	3.1%
African American	5	1.7%
Hispanic	11	3.8%
Asian, Pacific Islander	15	5.1%
Other	8	2.7%
Total *	293	100%
Lived in Cordova:		
Less than 5 years	101	33.7%
5 to 10 years	39	13.0%
10 to 20 years	60	20.0%
Longer	100	33.3%
Total	300	100%

* Respondents who refused to answer have been omitted from the percentage base.

On the following pages key questions are cross tabulated by gender, age, ethnicity and length of residence.[3] Included here are some examples of the more interesting findings.

Men are more likely to be satisfied with the availability of healthcare in Cordova than are women, but also less likely to have been treated at either of the clinics. [Table E2.1]

Although there are some differences, age is not a reliable predictor of satisfaction with healthcare and availability of Physicians in Cordova. [Table E2.2]

The longer they had lived in Cordova, the less satisfied with the availability of healthcare people had become. [Table E2.4]

Thirty-nine percent of women and twenty-nine percent of men have sought healthcare Outside of Cordova of their own volition. [Table E3.1]

Cordova Community Members 45 and older are more likely to be aware of the City subsidy to the Hospital when compared to the younger residents. People 55 and up are more likely than younger people to strongly favor the subsidy. [Table E3.2]

Respondents who identify themselves as Caucasian are more likely than other races to have decided to travel Outside of Cordova for medical treatment. [Table E3.3]

None of the variables – gender, age, ethnicity or length of residence – show any statistically significant difference in how they view the two options (City/Village work together & Outside Health Organization coming to Cordova) for ways to curtail the subsidy to the hospital.
[Tables E3.1 to E3.4].

[3] Using a 95% confidence level for analyses.

TABLE E2.1: SATISFACTION AND ATTENDANCE BY GENDER

	Gender:		Total
	Male	Female	
Availability of health care			
Very satisfied	27.3%	13.8%	20.1%
Somewhat satisfied	44.5%	33.1%	38.5%
Somewhat unsatisfied	15.6%	29.0%	22.7%
Very unsatisfied	12.5%	24.1%	18.7%
Number	128	145	273
Availability of doctors in Cordova			
Very satisfied	30.4%	9.5%	19.0%
Somewhat satisfied	25.6%	21.6%	23.4%
Somewhat unsatisfied	27.2%	24.3%	25.6%
Very unsatisfied	16.8%	44.6%	31.9%
Number	125	148	273
Inpatient or ER: *			
5 times or more	12.1%	10.7%	11.4%
3 or 4 times	2.9%	6.0%	4.5%
1 or 2 times	25.7%	28.7%	27.2%
Never	59.3%	54.7%	56.9%
Number	140	150	290
Treated at Hospital Clinic:			
10 or more times	15.7%	25.3%	20.7%
5 to 9 times	7.9%	14.0%	11.0%
1 to 4 times	33.6%	25.3%	29.3%
Never	42.9%	35.3%	39.0%
Number	140	150	290
Treated at Ilanka Clinic:			
10 or more times	15.3%	25.3%	20.4%
5 to 9 times	6.9%	22.0%	14.6%
1 to 4 times	29.2%	30.7%	29.9%
Never	48.6%	22.0%	35.0%
Number	144	150	294

Column percentages
* Difference is not statistically significant

TABLE E2.2: SATISFACTION AND ATTENDANCE BY AGE

	Age group:					Total
	18-34	35-44	45-54	55-64	65 and Up	
Availability of health care						
Very satisfied	27.5%	19.2%	16.7%	17.4%	23.3%	20.3%
Somewhat satisfied	39.2%	51.3%	30.3%	30.4%	36.7%	38.7%
Somewhat unsatisfied	23.5%	17.9%	19.7%	34.8%	16.7%	22.1%
Very unsatisfied	9.8%	11.5%	33.3%	17.4%	23.3%	18.8%
Number	51	78	66	46	30	271
Availability of doctors in Cordova *						
Very satisfied	31.4%	20.8%	10.1%	16.3%	20.7%	19.3%
Somewhat satisfied	21.6%	29.2%	20.3%	22.4%	20.7%	23.3%
Somewhat unsatisfied	29.4%	18.1%	27.5%	32.7%	20.7%	25.6%
Very unsatisfied	17.6%	31.9%	42.0%	28.6%	37.9%	31.9%
Number	51	72	69	49	29	270
Inpatient or ER: *						
5 times or more	10.9%	7.9%	12.2%	10.0%	18.8%	11.1%
3 or 4 times	3.6%	2.6%	5.4%	8.0%	3.1%	4.5%
1 or 2 times	23.6%	28.9%	25.7%	36.0%	18.8%	27.2%
Never	61.8%	60.5%	56.8%	46.0%	59.4%	57.1%
Number	55	76	74	50	32	287
Treated at Hospital Clinic:						
10 or more times	12.7%	15.8%	28.4%	18.4%	30.3%	20.6%
5 to 9 times	12.7%	7.9%	13.5%	14.3%	6.1%	11.1%
1 to 4 times	30.9%	35.5%	18.9%	20.4%	45.5%	28.9%
Never	43.6%	40.8%	39.2%	46.9%	18.2%	39.4%
Number	55	76	74	49	33	287
Treated at Ilanka Clinic:						
10 or more times	27.3%	20.0%	18.9%	18.0%	12.5%	19.9%
5 to 9 times	18.2%	10.0%	14.9%	22.0%	9.4%	14.8%
1 to 4 times	36.4%	16.3%	35.1%	34.0%	34.4%	29.9%
Never	18.2%	53.8%	31.1%	26.0%	43.8%	35.4%
Number	55	80	74	50	32	291

Column percentages
* Difference is not statistically significant

TABLE E2.3: SATISFACTION AND ATTENDANCE BY ETHNICITY

	Ethnicity:			Total
	White	AK. Native, Indian	Other	
Availability of health care *				
Very satisfied	20.3%	26.7%	11.1%	20.1%
Somewhat satisfied	34.2%	44.4%	52.8%	38.4%
Somewhat unsatisfied	24.1%	13.3%	27.8%	22.8%
Very unsatisfied	21.4%	15.6%	8.3%	18.7%
Number	187	45	36	268
Availability of doctors in Cordova				
Very satisfied	21.2%	17.9%	8.8%	19.2%
Somewhat satisfied	19.2%	33.3%	38.2%	23.7%
Somewhat unsatisfied	25.4%	17.9%	35.3%	25.6%
Very unsatisfied	34.2%	30.8%	17.6%	31.6%
Number	193	39	34	266
Inpatient or ER: *				
5 times or more	10.4%	15.6%	13.9%	11.7%
3 or 4 times	4.5%	4.4%	2.8%	4.2%
1 or 2 times	28.2%	22.2%	22.2%	26.5%
Never	56.9%	57.8%	61.1%	57.6%
Number	202	45	36	283
Treated at Hospital Clinic: *				
10 or more times	20.2%	23.9%	20.6%	20.8%
5 to 9 times	11.8%	4.3%	14.7%	11.0%
1 to 4 times	28.1%	21.7%	44.1%	29.0%
Never	39.9%	50.0%	20.6%	39.2%
Number	203	46	34	283
Treated at Ilanka Clinic:				
10 or more times	19.4%	31.9%	15.4%	20.9%
5 to 9 times	17.9%	12.8%	2.6%	15.0%
1 to 4 times	32.3%	21.3%	17.9%	28.6%
Never	30.3%	34.0%	64.1%	35.5%
Number	201	47	39	287

Column percentages
* Difference is not statistically significant

TABLE E2.4: SATISFACTION AND ATTENDANCE BY RESIDENCE

	Lived in Cordova:				Total
	Less than 5 years	5 to 10 years	10 to 20 years	Longer	
Availability of health care					
Very satisfied	34.8%	16.2%	14.3%	11.0%	20.1%
Somewhat satisfied	44.9%	40.5%	37.5%	31.9%	38.5%
Somewhat unsatisfied	15.7%	24.3%	25.0%	27.5%	22.7%
Very unsatisfied	4.5%	18.9%	23.2%	29.7%	18.7%
Number	89	37	56	91	273
Availability of doctors in Cordova					
Very satisfied	38.8%	11.1%	10.7%	9.4%	19.0%
Somewhat satisfied	34.1%	16.7%	23.2%	16.7%	23.4%
Somewhat unsatisfied	15.3%	41.7%	21.4%	31.3%	25.6%
Very unsatisfied	11.8%	30.6%	44.6%	42.7%	31.9%
Number	85	36	56	96	273
Inpatient or ER:					
5 times or more	3.2%	10.3%	18.3%	15.6%	11.4%
3 or 4 times	2.1%	5.1%	8.3%	4.2%	4.5%
1 or 2 times	30.5%	20.5%	23.3%	29.2%	27.2%
Never	64.2%	64.1%	50.0%	51.0%	56.9%
Number	95	39	60	96	290
Treated at Hospital Clinic:					
10 or more times	7.3%	13.5%	23.7%	34.7%	20.7%
5 to 9 times	6.3%	5.4%	23.7%	10.2%	11.0%
1 to 4 times	41.7%	29.7%	15.3%	25.5%	29.3%
Never	44.8%	51.4%	37.3%	29.6%	39.0%
Number	96	37	59	98	290
Treated at Ilanka Clinic:					
10 or more times	16.2%	17.9%	30.5%	19.6%	20.4%
5 to 9 times	7.1%	15.4%	22.0%	17.5%	14.6%
1 to 4 times	24.2%	38.5%	22.0%	37.1%	29.9%
Never	52.5%	28.2%	25.4%	25.8%	35.0%
Number	99	39	59	97	294

Column percentages

TABLE E3.1: LEAVING AND CITY SUBSIDY BY GENDER

	Gender:		Total
	Male	Female	
Leaving Cordova for medical treatment:			
Left of own volition	29.3%	38.6%	34.0%
Referred by MD or PA	18.4%	35.9%	27.3%
Has not left	52.4%	25.5%	38.7%
Number	147	153	300
Respondent is aware that:			
The City subsidizes the hospital	55.8%	68.0%	62.0%
Is not	44.2%	32.0%	38.0%
Number	147	153	300
Respondent: *			
Completely approves of the subsidy	51.7%	50.3%	51.0%
Somewhat approves	14.3%	24.2%	19.3%
Does not	15.0%	11.8%	13.3%
Unsure	19.0%	13.7%	16.3%
Number	147	153	300
City and the Native Village should cooperate: *			
Strongly favor	34.0%	34.6%	34.3%
Somewhat favor	20.4%	17.0%	18.7%
No opinion	27.9%	22.9%	25.3%
Oppose	17.7%	25.5%	21.7%
Number	147	153	300
City should bring in an outside health org: *			
Strongly favor	28.6%	41.2%	35.0%
Somewhat favor	19.0%	17.0%	18.0%
No opinion	34.0%	28.8%	31.3%
Oppose	18.4%	13.1%	15.7%
Number	147	153	300

Column percentages
* Difference is not statistically significant

TABLE E3.2: LEAVING AND CITY SUBSIDY BY AGE

	Age group:					Total
	18-34	35-44	45-54	55-64	65 and Up	
Leaving Cordova for medical treatment:						
Left of own volition	23.2%	26.8%	46.7%	38.0%	35.3%	34.0%
Referred by MD or PA	28.6%	20.7%	24.0%	38.0%	32.4%	27.3%
Has not left	48.2%	52.4%	29.3%	24.0%	32.4%	38.7%
Number	56	82	75	50	34	297
Respondent is aware that:						
The City subsidizes the hospital	39.3%	56.1%	69.3%	82.0%	67.6%	62.0%
Is not	60.7%	43.9%	30.7%	18.0%	32.4%	38.0%
Number	56	82	75	50	34	297
Respondent:						
Completely approves of the subsidy	48.2%	45.1%	45.3%	62.0%	64.7%	50.8%
Somewhat approves	17.9%	19.5%	25.3%	18.0%	8.8%	19.2%
Does not	7.1%	13.4%	16.0%	20.0%	8.8%	13.5%
Unsure	26.8%	22.0%	13.3%		17.6%	16.5%
Number	56	82	75	50	34	297
City and the Native Village should cooperate: *						
Strongly favor	33.9%	31.7%	30.7%	40.0%	35.3%	33.7%
Somewhat favor	17.9%	22.0%	21.3%	12.0%	17.6%	18.9%
No opinion	35.7%	26.8%	21.3%	14.0%	32.4%	25.6%
Oppose	12.5%	19.5%	26.7%	34.0%	14.7%	21.9%
Number	56	82	75	50	34	297
City should bring in an outside health org: *						
Strongly favor	26.8%	39.0%	37.3%	36.0%	29.4%	34.7%
Somewhat favor	14.3%	15.9%	26.7%	14.0%	17.6%	18.2%
No opinion	44.6%	29.3%	24.0%	28.0%	38.2%	31.6%
Oppose	14.3%	15.9%	12.0%	22.0%	14.7%	15.5%
Number	56	82	75	50	34	297

Column percentages
* Difference is not statistically significant

TABLE E3.3: LEAVING AND CITY SUBSIDY BY ETHNICITY

	Ethnicity:			Total
	White	AK. Native, Indian	Other	
Leaving Cordova for medical treatment:				
Left of own volition	39.3%	18.8%	20.5%	33.4%
Referred by MD or PA	27.7%	35.4%	17.9%	27.6%
Has not left	33.0%	45.8%	61.5%	38.9%
Number	206	48	39	293
Respondent is aware that: *				
The City subsidizes the hospital	66.0%	50.0%	53.8%	61.8%
Is not	34.0%	50.0%	46.2%	38.2%
Number	206	48	39	293
Respondent:				
Completely approves of the subsidy	53.4%	52.1%	41.0%	51.5%
Somewhat approves	20.9%	16.7%	15.4%	19.5%
Does not	14.1%	8.3%	10.3%	12.6%
Unsure	11.7%	22.9%	33.3%	16.4%
Number	206	48	39	293
City and the Native Village should cooperate: *				
Strongly favor	34.5%	47.9%	17.9%	34.5%
Somewhat favor	19.9%	12.5%	23.1%	19.1%
No opinion	22.8%	22.9%	41.0%	25.3%
Oppose	22.8%	16.7%	17.9%	21.2%
Number	206	48	39	293
City should bring in an outside health org: *				
Strongly favor	38.3%	31.3%	23.1%	35.2%
Somewhat favor	17.5%	12.5%	30.8%	18.4%
No opinion	29.6%	37.5%	33.3%	31.4%
Oppose	14.6%	18.8%	12.8%	15.0%
Number	206	48	39	293

Column percentages
* Difference is not statistically significant

TABLE E3.4: LEAVING AND CITY SUBSIDY BY RESIDENCE

	Lived in Cordova:				Total
	Less than 5 years	5 to 10 years	10 to 20 years	Longer	
Leaving Cordova for medical treatment: *					
Left of own volition	15.8%	41.0%	46.7%	42.0%	34.0%
Referred by MD or PA	15.8%	23.1%	28.3%	40.0%	27.3%
Has not left	68.3%	35.9%	25.0%	18.0%	38.7%
Number	101	39	60	100	300
Respondent is aware that:					
The City subsidizes the hospital	38.6%	66.7%	66.7%	81.0%	62.0%
Is not	61.4%	33.3%	33.3%	19.0%	38.0%
Number	101	39	60	100	300
Respondent:					
Completely approves of the subsidy	56.4%	41.0%	50.0%	50.0%	51.0%
Somewhat approves	8.9%	25.6%	25.0%	24.0%	19.3%
Does not	10.9%	23.1%	5.0%	17.0%	13.3%
Unsure	23.8%	10.3%	20.0%	9.0%	16.3%
Number	101	39	60	100	300
City and the Native Village should cooperate: *					
Strongly favor	33.7%	35.9%	36.7%	33.0%	34.3%
Somewhat favor	18.8%	23.1%	21.7%	15.0%	18.7%
No opinion	34.7%	17.9%	16.7%	24.0%	25.3%
Oppose	12.9%	23.1%	25.0%	28.0%	21.7%
Number	101	39	60	100	300
City should bring in an outside health org: *					
Strongly favor	22.8%	43.6%	45.0%	38.0%	35.0%
Somewhat favor	16.8%	20.5%	18.3%	18.0%	18.0%
No opinion	41.6%	28.2%	21.7%	28.0%	31.3%
Oppose	18.8%	7.7%	15.0%	16.0%	15.7%
Number	101	39	60	100	300

Column percentages
* Difference is not statistically significant

APPENDIX A:

City of Cordova Health Care Study
FINAL approved by Jean Craciun 8/25/2010

INTRODUCTION: Hello my name is _____ and I'm with Craciun Research, an Alaskan company. We are conducting a study on what you think of the health care available in Cordova. Your phone number was randomly selected; this interview should take about 10 minutes of your time. All of your answers will be strictly confidential and I can answer any questions you may have at the end of the survey.

A. First, which of the following age groups do you belong in?

1, 18 to 34 years
2, 35 to 44
3, 45 to 54
4, 55 to 64
5, 65 and up
6, No answer
0, Under 18 [ASK TO SPEAK TO SOMEONE 18 OR OLDER]

B. [RECORD GENDER] 1, Male 2, Female

[GENERAL SATISFACTION WITH HEALTH CARE]

2. In general, how satisfied are you with the availability of health care in Cordova – very satisfied, somewhat satisfied, somewhat unsatisfied or very unsatisfied? If you have no experience with health care in Cordova, just tell me.

   [ANSWERS FOR THE NEXT FEW QUESTIONS]
   1, Very satisfied
   2, Somewhat satisfied
   3, Neutral, no opinion
   4, Somewhat unsatisfied
   5, Very unsatisfied
   6, No experience

3. How satisfied are you with the availability of doctors in Cordova?

4. And with the availability of emergency care?

5. And with the availability of long term care?

6. And with the availability of additional services for the aging population?

7. Do you have a doctor in Cordova who meets most of the health needs for you and your family/household?
   1, Yes
   2, No
   3, Don't know

[IDENTIFICATION OF WHERE TREATMENT HAD BEEN RECEIVED]

8. How long have you lived in Cordova?
   1, Less than five years
   2, Five to ten years
   3, Ten to twenty years
   4, Longer

9. There are three places to get health care in Cordova. All are in the same building. One is the Ilanka Community Health Center with an entrance next to the grassy field. Another is the Hospital Clinic, located downstairs in the Hospital, and the third place is the Hospital itself, which includes the ER, long term care facility and hospital beds.

10. In the [LAST FIVE YEARS/SINCE YOU MOVED HERE] about how often have you or ***a family member living in the household*** been an inpatient at the Cordova Hospital or ER, not in the clinic?
    1, Five times or more
    2, Three or four times
    3, Once or twice
    4, Some, don't recall how many
    5, Never [GO TO BEGINNING OF HOSPITAL CLINIC Q'S]

11. How often have you gone to the Hospital Clinic, located in the downstairs of the Hospital to get care ***for yourself or a family member living in the household***?
    1, Twenty times or more
    2, Ten to nineteen times
    3, Five to nine times
    4, Three or four times
    5, Once or twice
    6, Some, don't recall how many
    7, Never [GO TO BEGINNING OF ILANKA Q'S]

12. And also in the [LAST FIVE YEARS/SINCE YOU MOVED HERE] how often have you gone to the Ilanka Community Health Center to get care ***for yourself or a family member living in the household***?

1, Twenty times or more
2, Ten to nineteen times
3, Five to nine times
4, Three or four times
5, Once or twice
6, Some, don't recall how many
7, Never [GO TO BEGINNING OF ILANKA Q'S]

[QUESTIONS ABOUT TREATMENT AT THE HOSPITAL – ASK THIS SECTION IF HAS BEEN IN HOSPITAL OR ER IN LAST FIVE YEARS]

13. Thinking of the last time that you or a family member living in the household was in the ER or the Hospital itself, not the clinic, how would you rate that visit overall – very good, good, average poor or very poor?

    [ANSWERS FOR NEXT FEW QUESTIONS]
    1, Very good
    2, Good
    3, Average
    4, Poor
    5, Very poor
    6, Don't recall, no experience with that

14. How would you rate the medical care from the doctor or physician assistant?
15. And the care from the nurses?
16. And from the other people who helped you?
17. How about the waiting time when you rang for help?
18. And the billing process?

19. Compared to hospitals or ERs you have been to in other places, was the care you received from the Hospital about as good as you could get in a larger city, better or worse?
    1, Better than a larger city
    2, About the same
    3, Worse
    4, Don't know

[QUESTIONS ABOUT TREATMENT AT THE HOSPITAL CLINIC – ASK THIS SECTION IF HAS BEEN IN HOSPITAL CLINIC IN LAST FIVE YEARS]

20. Thinking of the last time you were at the Hospital Clinic, located in the downstairs of the Hospital, for yourself or a family member living in the household, how would you rate that visit overall – very good, good, average, poor or very poor?

[ANSWERS FOR NEXT FEW QUESTIONS]
1, Very good
2, Good
3, Average
4, Poor
5, Very poor
6, Do not recall, no experience with that

21. How would you rate the medical care from the doctor or physician assistant?
22. And the care from the nurses?
23. And from the other people who helped you?
24. How about the waiting time until you were seen?
25. And the billing process?

26. Compared to clinics you have been to in other places, was the care you received from the Hospital Clinic about as good as you could get in a larger city, better or worse?
1, Better than a larger city
2, About the same
3, Worse
4, Don't know

[QUESTIONS ABOUT TREATMENT AT THE ILANKA COMMUNITY HEALTH CENTER – ASK THIS SECTION IF HAS BEEN IN THE ILANKA COMMUNITY HEALTH CENTER IN LAST FIVE YEARS]

27. Thinking of the last time you were at the Ilanka Community Health Center for yourself or a family member living in the household, how would you rate that visit overall, – very good, good, average, poor or very poor?

[ANSWERS FOR NEXT FEW QUESTIONS]
1, Very good
2, Good
3, Average
4, Poor
5, Very poor
6, Don't recall, no experience with that

28. How would you rate the medical care from the doctor or physician assistant?
29. And the care from the nurses?
30. And from the other people who helped you?
31. How about the waiting time until you were seen?
32. And the billing process?

33. Compared to clinics you have been to in other places, was the care you received from the Ilanka Community Health Center about as good as you could get in a larger city, better or worse?
1, Better than a larger city
2, About the same
3, Worse
4, Don't know

[QUESTIONS ABOUT TREATMENT AWAY FROM CORDOVA]

34. In the last five years have you gone away from Cordova for medical treatment for yourself or a family member living in the household?
1, Yes
2, No, Don't recall [SKIP TO NEXT SECTION]

35. [IF YES] About how many times a year have you been leaving Cordova for medical treatment? [READ LIST OF NECESSARY]
1, Six or more times
2, Four or five times
3, Two or three times
4, Once
5. None [SKIP TO NEXT SECTION]
6, No answer

36. [IF YES] Was it because a doctor referred you to another doctor or clinic?
1, Yes, Always [GO TO CITY SUBSIDIES SECTION BELOW]
2, Sometimes
3, No

37. Did you leave Cordova just to get medical treatment elsewhere, or were you going to be gone anyway, and decided to do medical things while you were gone?
1, Went to get medical treatment
2, Was going to be gone anyway
3, Some of both
4, Don't recall

38. Was the medical care you went for a routine check-up or for something special?
1, Routine
2, Special
3, No answer

39. Why did you leave Cordova for medical care?
[READ LIST. ACCEPT MULTIPLE ANSWERS]
1, I couldn't get an appointment here
2, There wasn't a doctor who knows how to treat what was wrong

3, I see a specialist
4, I wanted a second opinion
5, I don't trust any of the local doctors
6, I don't trust either of the clinics
7, I have a doctor elsewhere and I always go to that one
8, Other [SPECIFY]
9, No answer

[CITY SUBSIDIES DISCUSSION]

40. How important to you is having good health care available in the community – very important, somewhat important, somewhat unimportant, somewhat unimportant or very unimportant?
1, Very important
2, Somewhat important
3, Makes no difference, no opinion, Don't know
4, Somewhat unimportant
5, Very unimportant

41. Are you aware that the City of Cordova helps to keep local medical care available by subsidizing the hospital with funds – depending on need, between half a million and a million dollars a year?
1, Yes
2, No

42. Do you approve of that?
1, Yes, completely
2, Yes and no, approve somewhat, etc.
3, No
4, Unsure

43. [IF DOES NOT APPROVE COMPLETELY – ANSWERS 2 OR 3] Do you think the City of Cordova should be paying more or less or nothing at all?
1, More
2, Less
3, Nothing at all

44. [IF DOES APPROVE AT ALL – ANSWERS 1 OR 2] Of course, the money comes from taxes. Does that make you more or less in favor of the subsidy?
1, More
2, Makes no difference
3, Less
4, No answer

45. Some people are suggesting that the City of Cordova and the Native Village of Eyak **work together** to handle healthcare services? Would you strongly favor that, somewhat favor it, somewhat oppose it or strongly oppose it or do you have no opinion?
    1, Strongly favor
    2, Somewhat favor
    3, Neutral, no opinion
    4, Somewhat oppose
    5, Strongly oppose

46. Some people are suggesting that the City bring in an outside health organization for hospital operations. Would you strongly favor that, somewhat favor it, somewhat oppose it or strongly oppose it or do you have no opinion?
    1, Strongly favor
    2, Somewhat favor
    3, Neutral, no opinion
    4, Somewhat oppose
    5, Strongly oppose

47. Do you have any ideas about what the community could do to <u>improve health care?</u>
    1, Yes
    2, No

48. [IF YES] What <u>one</u> thing would you most like to see happen? [OPEN END]

Finally, I have just a few more questions for statistical purposes and an invitation.

49. Would you describe yourself as
    1, Caucasian, White
    2, Alaskan Native
    3, Black, African American
    4, American Indian
    5, Hispanic
    6, Asian, Pacific Islander
    7, Other, mixed
    8, No answer

50. Another way that research can be done is through the use of focus groups. Focus groups are small group discussions of 8-10 people discussing a particular topic. We offer cash incentives and a meal at the groups. Do you think you would be interested in participating in a focus group about this topic?
    1, Yes
    2, No
    3, Don't know/ No answer

51. [IF YES] Great, can I get your name and phone number?

    Name _____
    Phone _____

That is all of my questions for today; thank you for your time and consideration.

APPENDIX B:

TABLE B.1: SATISFACTION WITH AVAILABILITY OF MEDICAL CARE IN CORDOVA

Availability of Emergency care		
Very satisfied	76	25.3%
Somewhat satisfied	101	33.7%
Neutral, no opinion	22	7.3%
Somewhat unsatisfied	23	7.7%
Very unsatisfied	40	13.3%
No experience	38	12.7%
Number	300	100%
Availability of long term care		
Very satisfied	49	16.3%
Somewhat satisfied	55	18.3%
Neutral, no opinion	30	10.0%
Somewhat unsatisfied	12	4.0%
Very unsatisfied	33	11.0%
No experience	121	40.3%
Number	300	100%
Availability of added services for the aging		
Very satisfied	34	11.3%
Somewhat satisfied	55	18.3%
Neutral, no opinion	30	10.0%
Somewhat unsatisfied	19	6.3%
Very unsatisfied	30	10.0%
No experience	132	44.0%
Number	300	100%
Availability of doctors in Cordova		
Very satisfied	52	17.3%
Somewhat satisfied	64	21.3%
Neutral, no opinion	19	6.3%
Somewhat unsatisfied	70	23.3%
Very unsatisfied	87	29.0%
No experience	8	2.7%
Number	300	100%
Availability of health care:		
Very satisfied	55	18.3%
Somewhat satisfied	105	35.0%
Neutral, no opinion	22	7.3%
Somewhat unsatisfied	62	20.7%
Very unsatisfied	51	17.0%
No experience	5	1.7%
Number	300	100%

Statements have been somewhat abbreviated. See question for exact wording.

TABLE B.2: RATING OF THE FEATURES OF THE ER AND HOSPITAL

Overall		
Very good	45	33.3%
Good	48	35.6%
Average	28	20.7%
Poor	4	3.0%
Very Poor	5	3.7%
Don't recall, no experience	5	3.7%
Number	135	100%
Care from nurses		
Very good	67	49.6%
Good	41	30.4%
Average	15	11.1%
Poor	2	1.5%
Very Poor	1	.7%
Don't recall, no experience	9	6.7%
Number	135	100%
Waiting time after ringing for help		
Very good	64	47.4%
Good	26	19.3%
Average	24	17.8%
Poor	9	6.7%
Very Poor	2	1.5%
Don't recall, no experience	10	7.4%
Number	135	100%
Other people who helped you		
Very good	59	43.7%
Good	36	26.7%
Average	24	17.8%
Poor	1	.7%
Very Poor	3	2.2%
Don't recall, no experience	12	8.9%
Number	135	100%
Medical care from MD or PA		
Very good	53	39.3%
Good	43	31.9%
Average	22	16.3%
Poor	7	5.2%
Very Poor	4	3.0%
Don't recall, no experience	6	4.4%
Number	135	100%
The billing process		
Very good	27	20.0%
Good	15	11.1%
Average	39	28.9%
Poor	16	11.9%
Very Poor	19	14.1%
Don't recall, no experience	19	14.1%
Number	135	100%

TABLE B.3: RATING OF THE FEATURES OF THE HOSPITAL CLINIC

Overall		
Very good	58	31.0%
Good	64	34.2%
Average	46	24.6%
Poor	8	4.3%
Very Poor	2	1.1%
Don't recall, no experience	9	4.8%
Number	187	100%
Care from the nurses		
Very good	89	47.6%
Good	67	35.8%
Average	15	8.0%
Poor	2	1.1%
Very Poor	1	.5%
Don't recall, no experience	13	7.0%
Number	187	100%
Other people who helped you		
Very good	69	36.9%
Good	63	33.7%
Average	24	12.8%
Poor	2	1.1%
Very Poor	2	1.1%
Don't recall, no experience	27	14.4%
Number	187	100%
Medical care from MD or PA		
Very good	69	36.9%
Good	70	37.4%
Average	31	16.6%
Poor	7	3.7%
Very Poor	1	.5%
Don't recall, no experience	9	4.8%
Number	187	100%
Waiting time until you were seen		
Very good	65	34.8%
Good	54	28.9%
Average	44	23.5%
Poor	14	7.5%
Very Poor	2	1.1%
Don't recall, no experience	8	4.3%
Number	187	100%
The billing process		
Very good	27	14.4%
Good	43	23.0%
Average	54	28.9%
Poor	19	10.2%
Very Poor	19	10.2%
Don't recall, no experience	25	13.4%
Number	187	100%

TABLE B.4: RATING OF THE FEATURES OF THE ILANKA CENTER

Overall		
Very good	47	23.9%
Good	64	32.5%
Average	59	29.9%
Poor	18	9.1%
Very Poor	6	3.0%
Don't recall, no experience	3	1.5%
Number	197	100%
Care from the nurses		
Very good	76	38.6%
Good	70	35.5%
Average	35	17.8%
Poor	4	2.0%
Very Poor	3	1.5%
Don't recall, no experience	9	4.6%
Number	197	100%
Other people who helped you		
Very good	73	37.1%
Good	69	35.0%
Average	33	16.8%
Poor	9	4.6%
Very Poor	1	.5%
Don't recall, no experience	12	6.1%
Number	197	100%
Waiting time until you were seen		
Very good	68	34.5%
Good	54	27.4%
Average	49	24.9%
Poor	18	9.1%
Very Poor	3	1.5%
Don't recall, no experience	5	2.5%
Number	197	100%
Medical care from MD or PA		
Very good	59	29.9%
Good	57	28.9%
Average	58	29.4%
Poor	15	7.6%
Very Poor	5	2.5%
Don't recall, no experience	3	1.5%
Number	197	100%
The billing process		
Very good	40	20.3%
Good	48	24.4%
Average	40	20.3%
Poor	27	13.7%
Very Poor	20	10.2%
Don't recall, no experience	22	11.2%
Number	197	100%

APPENDIX C:

TABLE C.1: RESPONDENTS' SUGGESTIONS

Management Issues

Change management
Get a new administrator.
Get rid of all the people on the board of trustees and start anew.
Get rid of the board members and the admin staff then maybe it would be run better.
Get someone in to run the hospital that knows what they're doing.
I think we need to see some changes in leadership in the both boards. City Council is fine I would like to see some changes on the health board/boards.
If someone else controlled our finances and operations, I would feel better about having a hospital there.
Start from scratch for a new board and clean house!!!
They should get rid of the hospital board.
Vote off the mayor.
We need someone besides the Ilanka president running the place.
More public involvement
Consistency (2 answers)
Don't make it so political.
I would like to see better management and funding and better adherence to procedures.
I would like to see the health care under one person in charge and not everybody in town.
I'm pretty familiar with the politics; just make sure the community has knowledgeable people on the hospital board.
People in charge LISTEN to the community's concerns and input!
Replace the board members. Health care for the people. Remove the political aspect to how the hospitals run now. More health care, less politics. Permanent doctors.
Stop having secret meetings; tell people what's going on. Bring in real doctors not physician assistants. Remove the political aspect to how the hospitals run now. More health care, less politics. Permanent doctors.
Their attorney should represent board as whole. Investigate what's really going on in there instead of just firing everyone. Combine into one place. Be more open with the community about why people are being fired. Hospital employees need to be watched better. They're letting them all slide. Remove the political aspect to how the hospitals run now. More health care, less politics. Permanent doctors.

Run more professionally.
They need someone to run the hospital efficiently.
Support the clinics and the health care that is provided.
Get the politics out of the actual health care.

All the information needs to get to the board rather than one person making the decision, because not all people are aware of certain situations when a vote occurs.

I want to have the city control the hospital not the board directors

I think Eyak should take over health care.
They should let the tribe take it over; they're doing a good job. Remove the political aspect to how the hospitals run now. More health care, less politics. Permanent doctors.
If the city gets out of it that would improve the health care for a beginning point. Let the board take care of the medical issues, it will stop all of the drama! **CONTINUED**

TABLE C.1: RESPONDENTS' SUGGESTIONS, CONTINUED

Better Cooperation

Better cooperation between NVE and the City of Cordova that reduces the amount of turnover among the health care providers and keeps staff members such as financial officers and medical coding personal staffed. Continuity of all staff!

Everyone be united, division is what is causing the problems now.

Improve the communications from Ilanka and the hospital itself.

Everyone needs to work together better and be a team, drop the politics out of our health care building.

I would like everyone work together more.

Just maybe the clinics could work together. Maybe that would help.

Try and find a compromise.

We need to get together and have a vote; we need to have a hospital board open up a meeting so we can all voice our opinions.

Working together with the communities and the city and native village of Eyak, and listening to them.

People should just be good people and keep their opinions and their mouths to themselves.

Bring in an outside organization

Bring in an outside health organization, like Providence!

Bring in some outside expertise.

Bring in that outside health organization, get rid of the city in control, it's a conflict of interest.

Bringing in another organization would help.

City needs to get out of the health care business and let someone who knows what they're doing operate it.

For it to be taken over by a bigger hospital, expert management.

Have Providence get involved instead of NVE.

Having an organization come in and help out.

I was under the impression that when the Cordova hospital was in money problems that an Anchorage larger hospital would buy it out. I think that would have be a good idea.

I would like to see a scoping session, and get input on the community to see what people would be willing to support because they're all population. There have been many changes within the hospital, I would like to see a real good spirit come in and support the healthcare system we have going. Providence should could in and help out Cordova, I've been to Providence and they're on the job! They're awesome, I take my hat off to those people.

I'd like to see Providence buy our health care system and bring in more services, equipment and doctors.

I'm feeling like an outside entity needs to come in and help us out, when we bring someone in from around here, they get too involved and cause drama.

Make hospital into a private sector.

Providence

They ought to give it to Providence to run. I'm envious of Valdez, Kodiak, etc that have them running it.

Use outside source to watch over our healthcare, like Providence.

We should bring in an unbiased health care organization to oversee the operations and manage it.

continued

TABLE C.1: RESPONDENTS' SUGGESTIONS, CONTINUED

Stop firing doctors

Figure out how to keep doctors here. I think from what I've heard it's a lot more political more than they are qualified.

Get rid of the hospital board, we had a really good doctor here for 3/4 years who wanted to stay but someone on the board didn't like him so they terminated him. The issue was the hospital administrator didn't like someone because of personal reasons due to politics. I know a dozen people right now who travel to Wasilla to go to one of the doctors who used to be here because they liked her so much. They board makes really bad decisions. I thought she was a great doctor, so now we're back to point 1.

Remove the political aspect to how the hospitals run now. More health care, less politics. Permanent doctors.

I would to like to see one functional clinic or hospital where the hospital and clinic boards can't fire doctors without reason.

If we could keep the good doctors that would like to stay instead they get run out of town.

Ilanka could try to keep a doctor, they just fired a really good one and now we're all missing out on good health care.

Listen to the citizens! Because of personality conflicts providers are being fired. There are incompetent people running. And not enough people, not enough administrators.

Maintain the same doctors without switching them out.

Need more stable doctors!!!! They always come and go, or get fired. They get run out of town and it's stressful for the people of Cordova.

Quit firing the good doctors over political nonsense.

Quit running doctors out of town! Small town politics run them all away!

Quit running off the doctors.

The board may not be the most efficient way to run the health care services. There has to be something that would keep the doctors here. And it must be beyond the politics.

The boards should not be allowed to fire the doctors without public knowledge.

The Native Health Board has driven a lot of good doctors and health providers.

They get doctors and they don't stay because the boards fire them for unknown reasons.

We need more doctors and not let politics ride them out!

We need to get a permanent doctor in Cordova. There are too much politics going on that they get ran out of the city.

We need to get someone who is experienced with rural healthcare. Find and retain good doctors by providing with a healthy work environment. Ease up on politics so the doctors will stay and do the work..Don't run them off!!!Quit running them off!!!.

We need to have a health care environment that would encourage professional medical staff to stay here.

We need to provide better health care; the clinic is really causing us to lose good doctors. The city needs to keep the upper hand on our healthcare service because the board at the hospital will run it down the drain.

Hire good doctors and treat them nicely and forget the politics.

continued

TABLE C.1: RESPONDENTS' SUGGESTIONS, CONTINUED

Hire More Physicians

Doctors available more.

I think that my issues most always come from the political things that are going on; we need doctors who know what they're doing. When they're hiring doctors they need to be good candidates for all of the issues which are presented at the clinics.

Probably have more doctors in the clinics and hospital.

The doctors that have been here are wonderful; the problem is we can't keep doctors. Either their terminated or they just leave because it's too difficult. It's not fair to say it's not available, the staff who is here are always so kind. It's just hard to keep them around; they are great doctors/staff/nurses regardless!

They could get more doctors.

They should bring in more doctors.

We need qualifying people to work for that hospital.

Would like encourage long term doctors that live in the community.

A doctor and staff that doesn't leave.

Consistency in doctors.

Consistency of doctors staff.

Doctors keep changing and I would like to see a more stable consistent doctor personnel.

Find a doctor that stays here.

Get some doctors that would stay. We need long term doctors that we can rely on being there.

Have and keep long term, permanent doctors. [Speaking for the Ilanka CHC].

I think it would be nice that they would find permanent health care staff, such as doctors, nurses, assistants

I would like the doctors to stay longer.

I would like to see more provider consistency.

If we can just keep a doctor here when we get one would be really good.

Keep doctors and nurses to stay, continuity of care for patients!

Locums need to go. Consistent doctors!

Need to stabilize a doctor, JUST ONE would be nice. We need to work together to make this happen.

Reliable healthy doctors that stay in town, and are physically active in Cordova.

Steady doctor, no turn over!

That we would get more quality doctors who stay longer.

The turnover rate of the doctor makes us feel unconfident because people aren't following up with care, they don't know our history, we get comfortable with them and then they leave. Every doctor makes mistakes but when they're always running back and forth it's hard to keep going to the health clinics here.

They could get some doctors that want to live and stay here.

They have to be able to keep good PA's & doctors in the hospital.

We could take that half million dollars and get some stable year round doctors.

We need more stable doctors.

continued

TABLE C.1: RESPONDENTS' SUGGESTIONS, CONTINUED

Hire doctors, continued

We need permanent doctors, because ours come and go.
We need permanent physicians in the hospitals.
We should go back to the old when we had a qualified long term doctor.
Get a good specialist on board for the hospital.
If they put their OR back together so they could do more emergency procedures now.
Make sure that there is a doctor in town for trauma and small operations.
More different doctors.
More diversified medical staff, wide background of medical experience.
Offer minor surgeries.
They can have regular doctors in town.
We need continuity of providers, specialty clinics, and female doctors.

Deliver babies

Deliver babies! Cordova does have the capabilities; just don't want to pay for the higher insurance. It is good business to deliver babies.
expand health care. ex: pregnancy births.
Get more available services, when I had my twins I had to go to anchorage for two months waiting to have my babies. We need an OBGYN.
If we had expanding level of services such as OBGYN care, a lot of people wouldn't have to leave Cordova. We need more visiting specialist to analyze us, more thoroughness for physicals. More permanent doctors, specialists PLEASE!
More options, better equipment, be able to treat people in Cordova! Need a GYN, OB, and Pediatrician. More Specialists.
Start delivering babies again!
We need an OBGYN, having to go to anchorage to have a baby.. is ridiculous

Suggestions

Better technology (2 answers)
City of Cordova and the Native Village of Eyak teaming up for healthcare.
Community to take an interest in health care for the town.
Continue to have surveys!
Focus group, come up with agreements and abide by them! There's no trust, things happen behind the scenes. It's a matter of having good communication and trust.
Have professional ethics training
Having a specialist to come to town to treat people in all areas, endocrinologist that handle diabetes, eyes, and ears specialists.
It would help if they could fly in some specialists for those who need it.
Higher taxes for better hospital funding! We need something to be done, if this is what it's going to take then I'm all for the idea of higher taxes going towards healthcare. Everyone has the right to good health care service, no matter the people, and no matter the size of the city/town. From what I've been dealing with, we don't have the right equipment or the right staff appropriate for the healthcare issues that need to be taken care of.
It would be nice if they could expand the services year round.
Keep records in the hospital and clinic together. It would make it so much easier for patients to get care between places.

continued

TABLE C.1: RESPONDENTS' SUGGESTIONS, CONTINUED

Suggestions, continued

Let the doctor's work for themselves and not under the City of Cordova or anyone else such as NVE because NVE doesn't represent the entire community but only the natives (even though NVE has done a great job at providing health care compared to the city of Cordova). The physicians need to offer more services to the community!

Make the health fair better to help members of the community become more preventative and aware of better health.

It really only needs one clinic.

Merge all hospitals/clinics together.

More medical equipment

There is a good balance between the Public Health Nurse and the Ilanka Health Center, like to see that strengthened and continued! Would like to see that the PHN and CCMC hospital have that connection as well, and just have all three work well together more so.

Open a VA clinic, better ER services.

They have to give a much bigger voice to the doctors.

We need to return to a private practice model. The clinic was a private practice and the physicians staffed the clinic and the hospital. It worked 15 years ago. We had continuity of care.

Home care for seniors.

There is no home health for anyone in Cordova; Assistants outside the clinics and hospital.

Good job, considering

Given the current resources, I'd say their doing a good job with what they have. More equipment and more staff isn't a fault on their part, it's their only economically acceptable option.

Keep supporting it

My mom works at the hospital, everyone's problem is drama.

Lower health care costs

Use state money

Lower health care costs

More available monetary wise. More affordable to the young.

The price should be way lower than what we are being charged.

They could lower the cost of the health care.

Other

The simplest thing is to make sure the kids are educated so in the future they can help the medical community.

They could hire me as a consultant

Universal health care, single payer

Drink less

Quit smoking and drinking.

Regular group walk to promote health.

The community needs to promote healthy choices more.

Try to be healthy and improve themselves.

Appendix D

Focus Group Research Report

By

CRACIUN RESEARCH

October 1, 2010

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BACKGROUND & METHODS

Keren Kelley, Administrator, issued an RFP and Jean Craciun, CEO/President; Craciun Research contacted Kitty Farnham, Catalyst Consulting to partner and take the lead with this important Strategic Assessment for Cordova Health System. The research study included both quantitative and qualitative methods implemented in two consecutive Phases: 1. Baseline survey; and 2. Focus group Research.

This product was developed with a thorough understanding that our clients are seeking to gather the necessary data through high quality research with a community of stakeholders and; to develop strategic direction, identify, explore and recommend alternatives for ensuring effective, efficient, and sustainable approaches to meet the health needs of the community of Cordova now and into the future.

Research Objectives

- Conduct a community needs assessment survey of health services in Cordova.
- Conduct focus group research with select community members and stakeholders to capture in-depth understanding of desire for services, current service gaps, and to inform the alternatives assessment.

Phase One of the research, the baseline survey, was conducted with professional interviewers over the period from August 23 - through September 4th, 2010, and is reported under separate cover.

Phase Two the qualitative research phase, consisted of two focus groups that were conducted September 15, 2010. The qualitative research report follows and is broken down into three chapters.

Focus Group Participant Profile

- Group one with residents with middle range opinions regarding Structural Options for healthcare in Cordova leaning toward the **City and Village working together**.
- Group two with residents with middle range opinions regarding Structural Options leaning toward bringing in a **third party Outside health organization**.

Focus Group Research Background

Focus group research, by design, provides quality controls on data collection in that participants tend to provide checks and balances on each other, which weed out false or extreme views. The group dynamics typically contribute to focusing on the most important topics and issues being discussed. Trained qualitative analysts can assess the extent to which there is a relatively consistent, shared view of the discussion topics among the participants[4].

[4] Patton, Michael Quinn, How to Use Qualitative Methods in Evaluation, Sage Publications, November 1987.

The focus group interview is an information gathering process that seeks to discover the perceptions, feelings, and experiences of the selected participants about a particular topic. Focus groups help to determine the ways that participants structure their world around the particular topic. Focus group participants respond to the questions in their own words and trained observers can learn much from the group interview. The unit of analysis for this type of research is "the group" and not the individual. From the focus group interview we learn how people view the particular topic or experience, hear their terminology and capture the complexities of the individual experiences in a group interview environment[5].

A focus group study is a carefully planned series of discussions designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment. A trained professional moderator conducts each group with six to eight people. The discussions are relaxed, and often participants enjoy sharing their ideas and perceptions. Ideally, you don't do just one focus group—the group discussion is conducted several times with carefully selected participants so the researcher can identify trends and patterns.[6]

Notes to Readers

The participants' verbatim comments are indented rather than set off in quotation marks. Brackets set off the analyst's explanations of some of the participants' comments. Themes are analyzed and developed to facilitate in-depth understanding of the participants' perspectives on the issues being studied.

Jean Craciun, Research Director, collaborated with the client's representatives on development of the screener and the focus group discussion guides to ensure a successful project.

Professional Craciun Research interviewers recruited the participants for two groups; the focus group sessions were held September, 15 at the Cordova City Library in downtown Cordova.

Ms. Craciun moderated these focus groups; she holds a Bachelor of Arts undergraduate degree from the University of Cincinnati in Sociology with an emphasis on research methodology; a Master's Degree in Sociology from Cleveland State University; and is ABD on a doctoral degree in Human Resources Education from Boston University. She currently serves on the national board for Qualitative Research Consultants Association (QRCA).

Tracy Dudley was an assistant analyst to Jean Craciun serving as the Assistant Moderator for this qualitative study. She holds an MBA and has more than twenty years experience in marketing, qualitative analysis and quantitative research.

[5] Gredler, Margaret E., Program Evaluation, Prentice Hall, September 1995.

[6] Krueger, Richard A., Casey, Mary Anne, Focus Groups 3rd Edition - A Practical Guide for Applied Research, Sage Publication, Inc. 2000.

EXECUTIVE SUMMARY

HEALTHCARE NEEDS ASSESSMENT IN CORDOVA

There is Good Healthcare in Cordova
Participants in both groups believe Alaska in general is doing fine when it comes to quality healthcare. Further, most agree that Cordova itself has good basic medical care and great facilities.

Cordova needs more
There are several areas needing improvement. Key issues that come up include lack of stability in providers, inconsistent care across facilities, and need for more specialized care in the area. Many attribute most of the issues with local healthcare here in Cordova to lack of solid and sound organization of resources.

People want quality over quantity
Quality of medical care available will always take precedence over quantity. If their medical needs are taken care of in a high quality, appropriate manner, residents of Cordova are satisfied with local healthcare.

Consistency in Physicians is Paramount to Cordovans
Numerous participants emphasize they want more stability in providers, more consistency in doctors they go to for care. They want to develop long-term relationships with providers who become well-versed in their medical history and can be trusted. They want to feel secure that their doctors will be there for them.

It is challenging to keep good physicians here
There is chronic turnover in doctors and medical staff in Cordova. It happens at both clinics so residents feel they cannot get the consistency they need anywhere here.

Why the excessive turnover of doctors?
While most are painfully aware that Cordova has an excessive turnover of doctors, quite a few participants are unsure 'why' this is the case. Turnover in local doctors is sending patients and their money out of Cordova and into Anchorage, and most of the people do not really even understand why.

Politics prominently come into play
Participants see hints of political reasons for physician turnover in Cordova. Whether it is City council or facility administration, a lot of residents believe physicians are leaving because of politics. Politics can include someone complaining about services or personalities not getting along.

Traveling Physicians Cost Cordova
Both groups actually do see the negative monetary effects of having physicians come and go from the area, rather than make Cordova home.

Money is going out of Cordova
Traveling doctors are not adding economic value to Cordova by buying homes in the area and spending money in the community. A few participants worry about the cost of constant coming and going of medical providers—whether it is costs to the community or costs to the doctors and nurses themselves. Constant turnover in medical providers essentially prohibits physicians from becoming part of the community kinship, whereby citizens wish to band together for common goals.

Cordovan money is going to Anchorage
Residents of Cordova are spending their money elsewhere, instead of keeping it local, and it costs a lot to travel to get quality healthcare. The subsidy required for the hospital could go down if more residents stayed local for medical care and kept their dollars in the community.

There are missed opportunities in Cordova
Many realize that it is not feasible to have specialists in Cordova full time. The community is simply not large enough to support that type of healthcare. However, many believe that having rotating specialists who visit on a regular basis, like monthly or quarterly is an acceptable idea that would be met with huge success. It's a compromise to keep healthcare dollars in Cordova, and it's been proven to work effectively in the past.

Conflict among Two Healthcare Entities
It is common knowledge that there are two major players in healthcare in Cordova: Cordova Community Medical Center (CCMC) through the City and Ilanka Community Health Center (ICHC) through the Native Village of Eyak. Many participants agree that simply having two major players in such a small geographic area leads to conflict.

The entities lack a common structure
Because each facility is operated by a separate entity, there is no consistent organizational structure. There is no common responsible administrator over both of them, and the policies, procedures, and goals of each entity remain uniquely different. With the two medical entities separate, politics always come into play and there are chronic issues with competition between them.

There are different types of funding
Because CCMC and ICHC are funded in very different ways and the parameters associated with each vary greatly, it is no wonder that there is conflict of interest between the two entities.

Locals are confused about which clinic to go to
Many participants did not realize that they could go to Ilanka for medical care. Based on feedback from both groups, there is widespread confusion among natives and City residents as to which clinic they are allowed to visit and which clinic will accept Alaskan Natives vs. Non-Native residents living in Cordova.

They Must Work Together
Both groups agree that is it imperative that the Native Village of Eyak and the City take what the two clinics have and work together toward one common goal. However, past experience shows that cooperation is not possible under the current structures and managements.

It is Important to Keep Healthcare in Cordova
Participants realize that healthcare could go away if subsidies do not continue. Those who did not realize this are a bit shocked that it is a possibility. Regardless, all residents realize that there needs to be healthcare in Cordova – it would not be good if it just went away. Whatever the ramifications are, they must be dealt with to keep healthcare local.

Cordova does not want to lose the Coast Guard
Participants realize that if the hospital goes away, the Coast Guard will have to leave, and this represents a significant impact on population and commerce. Once participants realize that the City might ultimately be devastated with loss of the Coast Guard, the thought of losing the City hospital becomes horrifying. It becomes even more paramount and urgent to find a way to make things work better than they currently are.

STRATEGIC ALTERNATIVES – FUNDING / STRUCTURAL OPTIONS

It is Critical to Educate the People of Cordova
From the blue summary chart of the three main structural alternatives for Cordova Health Services, a key theme in discussions of really implementing one of the strategic alternatives was that the people of Cordova need to be educated in depth on both the current status and the proposed changes to local healthcare entities.

Option A: Improve within Existing Structure
Both groups agree that Option A is not viable for all the reasons discussed prior to this point. Option A1, which is operational improvements to achieve cost savings an increased reimbursement is considered a non-option and was not discussed much further.

Option A2 – Shared Services. Option A2, which is shared services to reduce duplication, got a lot more commentary, but is still not considered a viable option.

Option B: Restructure Existing Entities
Not very many participants understand how the federal funding works. However, because of that, they realize that it is a complicated situation that would not be solved by maintaining existing entities. The key issue with regard to Option B is the lack of clear definition as to who is ultimately in charge. Without someone accountable for both facilities, the numerous issues with the current situation in Cordova will not be fixed.

Option B1 – Consolidate ICHC and CCMC. Most did not realize consolidation can only go one way because of federal stipulations. When they find out that consolidation is only allowable if the Native Village of Eyak is ultimately the parent of both entities, most strongly believe Option B1 is not worthy of consideration.

Option B2 – Frontier Extended Stay Clinic. Both groups got into discussions about the possibility of establishing a new designation for the hospital as a Frontier Extended Stay Clinic. However, as soon as the cat was out of the bag that Cordova would lose the Coast Guard under this scenario, option B2 was no longer viable. [NOTE – this assumption has not been confirmed]

Option C: Bring in a New Entity / Third Party

The fact that both groups came to the conclusion that neither Option A nor Option B could work creates an automatic openness to Option C. Option C is the only option that seems new, different, and actually logical. One of the key attractions to Option C is that the third party might be better equipped to come in, analyze the situation, use their expertise, and actually get both entities to work together.

Pertinent third-party experience is key

Based on what they have seen in the past, participants emphasize the importance of bringing in a third party that has expertise in this field. Some even bring up Providence specifically when discussing the caliber of third party healthcare organization necessary to successfully implement Option C.

There are key aspects to consider

Bringing in a third party to run the healthcare entities open up the issues of what happens to current subsidies. The ultimate goal of the third party must be to stay profitable and provide the patients with the absolute best possible medical care. Fortunately, a new third party will have a fresh look from outside would take out long-standing political issues and personality conflicts.

People know about the success stories in Valdez and Kodiak

Several participants know about Valdez and Kodiak examples with Providence stepping in and successfully managing the local healthcare.

Option C1 – New Provider to Manage ICHC and CCMC

Both groups spontaneously suggested an organization like Providence would be a good fit as the new provider to manage both healthcare centers. Some raised concerns about how the Native Village of Eyak not agreeing to the third party option, based on the legalities of their federal funding stipulations.

Option C2 – New Provider to Manage CCMC Only

Option C2 brings up good questions from participants, reiterating the importance of educating Cordova and then thoroughly researching actual implementation prior to initiating change.

GOOD THINGS ABOUT LIVING IN CORDOVA

Cordova is a good place to raise a family

Because of high quality schooling, recreational options, and the secluded nature of Cordova, many participants were proud to say that this is a great place to settle down and raise a family. Participants from both groups rave about the quality of people in Cordova, who tend to be more laid back and easygoing. Even though most residents have above average education, intelligence, and cultural value, there is not a sense of pretentiousness around. The secluded nature and small-town feel of Cordova creates a strong sense of community.

The outdoor life is indescribable

Even besides the fact that commercial fishing is the engine of the community, the beautiful scenery and plentiful outdoor life opportunities make Cordova an aesthetically amazing place. For outdoors-oriented people, this community is a dream come true.

There is pride in the long-term care facility

People in the first group like to brag about the success of the long-term care facility, reporting that it is thriving with all the beds full and nearing four-star status.

RESEARCH FINDINGS

HEALTHCARE IN CORDOVA

A. Good Healthcare in Cordova

Participants in both groups believe Alaska in general is doing fine when it comes to quality healthcare. Further, most agree that Cordova itself has good basic medical care and great facilities.

> Within the hospital, we have long-term care. It provides for our senior citizens. We've got physical therapy, we've got an outpatient clinic, we've got emergency room, and we have people who come in as outpatients as well.
>
> I think we've had excellent healthcare here in Cordova, and we have an excellent facility. We have doctors, nurses. We have emergency facilities.
>
> The facility is great. We also have the lab that can do a lot of testing here on site—we don't have to send everything away. We have x-ray and some new equipment for body scans and things like that.

But Cordova Needs More

The point of contention for both groups is there are several areas needing improvement. Key issues that come up time and again include lack of stability in providers, inconsistent care across facilities, and need for more specialized care in the area.

> I think it's good, but it needs improvement. I think it needs improvement, I think it needs stability. We need consistency, we don't have that. We have rotation after rotation.
>
> I've gone to the Ilanka clinic a couple of times, and I've gotten better service from them than I ever got at the hospital. It was in quick, I got right to a point. When I brought my daughter there, everything was good.
>
> It's like a specialized thing. The doctors need to refer because they're just general practitioners. They can't do my son's specialized care, but they can do any kind of general medical care.

Many attribute most of the issues with local healthcare here in Cordova to lack of solid and sound organization of resources.

> I think in major City Alaska there are good options for healthcare, but I think the healthcare in town here is lacking. Just too many players, too many people. Every time the council changes, every time the village changes, why it's somebody else running the show. I've been here like 41 years.
>
> I think the crux of the issue is a business problem. We have a good facility; we have that, but the way they approach it… My impression in 10 years is that they manage all the risk out of it. They do the minimum they can do to get by, but they just don't want to accept risk. For example, I think we should deliver babies here. If we did, that's a service they'd provide that pays very well. But, they are not willing to make it work. It's a business problem, and the problem is what we *can* offer. As a community, we spend enough individually here and in Anchorage or Seattle to support anything here.

Quality over Quantity

Participants in both groups feel that quality of medical care available will always take precedence over quantity. As long as their medical needs are taken care of in a high quality, appropriate manner, residents of Cordova will be satisfied with local healthcare.

> I don't care so much about quantity of healthcare as quality because I want to know that if I go here for something it's quality.
>
> As far as cost, I'm more concerned about value. I'd rather the City put $1,000,000 in the hospital and feel like we're getting value for that quality care – rather than spending $500,000 and not getting the quality.
>
> It's quality, you know. Things happen here; you get hurt. You need to be able to know you have somebody here that can treat you.

B. Consistency is Paramount

Numerous participants in both groups emphasize that they want more stability in providers. They want consistency in doctors they go to for care. They want to develop long-term relationships with providers who become well-versed in their medical history and can be trusted. They want to feel secure that their doctors will be there for them.

> I have a growing family, young kids. I just want to know there's consistency and stability. I don't care which clinic I go to or whatever, as long as I know there's going to be quality and options. Consistency is important to build relationships with providers.
>
> That is my main thing. I want a doctor that I can rely on that knows my case, so if I'm having problems, I don't have to explain everything or they don't have to sit there and read all the notes again to find out what's wrong. It's consistency – so we have someone that is consistent with our case.

> I know see the same person when I go to Anchorage. I do have a consistent doctor and that's a big part of healthcare…feeling comfortable with your care, having consistency.

Cordova Does Not Have Consistency

To all of the participants in both groups, there is chronic turnover in doctors and medical staff in Cordova. Further, it happens at both clinics so residents feel they cannot get the consistency they need anywhere here.

> We need physicians that you can rely on, here in town. Lately what's happened is you get a doctor, you get used to them being there, and all of a sudden they're gone. Then you have to start building your trust in another doctor or else you totally go out of town.
>
> It's not just the doctors. It's the hospital, the nursing…you get used to the nursing staff… You get a really good lab tech, now they're leaving. Our lab people are leaving, and we're getting new people that are travelers.
>
> The problem with all the turnover now is… Some of the nurses that I trusted, I could call them and say, 'What about this doctor – are they any good or not?' Now, even those nurses are leaving, so there's no reliable inside information.
>
> People start feeling like doctors are ripped away, and then they don't want to count on them being there anymore. For a while, there was talk about… Wouldn't it be great if we had maternity care here in town? I don't hear that talk anymore; because people feel like after losing so many doctors we don't want to count on that.

C. Challenging to Keep Good Physicians Here

While most are painfully aware that Cordova has an excessive turnover of doctors, quite a few participants are unsure why this is chronically the case.

> It's always been a question mark – why people are leaving that actually don't want to leave. That's probably one of my biggest questions…especially people that are really happy here.
>
> I've only been here for seven years. But I've still seen some really great doctors come and go many times already.
>
> My wife had a good relationship, when we first moved here, with a doctor that left kind of unexpectedly. She was upset about that, and then had to make quite a few trips to Anchorage.

> Find out where the problem lies to eliminate what seems to be the problem, because the doctors keep leaving. Is it personality wise? They need someone to come in and figure out why this keeps happening because it's becoming a regular thing. You say okay, we're bringing in a new doctor, and all of a sudden you hear that he's gone because somebody said something over here about his services or whatever.

Time and again, turnover in local doctors is sending patients and money out of Cordova and into Anchorage. And, most of the people do not really even understand why – they just know that it is happening on a regular basis.

> We need someone who wants to be here. You don't mind being deferred to specialists, I understand that…but to go to Anchorage to get your physical? I just had a baby and had to stay there a month. It was a big hit in the middle of summer and paying to stay there.
>
> I see a doctor in Anchorage currently. When I went to go see him in, he said, 'Oh I used to go to Cordova, I used to make regular stops down in Cordova.' I said, 'Please come back.' I think we are getting a bad reputation.

Politics Prominently Come into Play

However, participants from both groups do see the hints of political reasons for physician turnover in Cordova. Whether it is City council or facility administration, a lot of residents believe physicians are leaving because of politics!

> It's something not really having anything to do with healthcare per say. It's politics, different agendas.
>
> I'm a long timer…and I have seen them come and go. We've had some fabulous doctors here, and through some futility of the personalities of City council, aggravating them among themselves…
>
> You can stay if you want to—tell them that. But, they have to be protected from the politics.

Politics can be things as simple as someone complaining about services or as ludicrous as personalities not getting along and someone is forced out.

> Well, we had stable doctors here and families that wanted to live here. Then politics come into play, and someone says who knows what, and then they leave.
>
> The trouble is, we have had specialists come and reside and then they leave over some small little personality disorder that isn't of their own making usually.

> I haven't ever heard of a doctor wanting to leave and go somewhere else, except for a very specific reason. I've only ever heard of doctors feeling like they had to leave.

D. Traveling Physicians Cost Cordova

Both groups actually do see the negative monetary effects of having physicians come and go from the area, rather than make Cordova home. These doctors are not adding economic value to Cordova by buying homes in the area and spending money in the community.

> They're pretty much all travelers. That means you don't have people living here and spending their money here.

> Are we paying for the doctors that are coming and going, paying for their housing, travel and all that? If we had a doctor who stayed here and was paying taxes on their property and their home…they'd be spending money within the community.

Further, a few participants worry about the cost of constant coming and going of medical providers—whether it be costs to the community or costs to the doctors and nurses themselves.

> With the dysfunction of the system now, it's going to be like that until this gets settled down. The last couple years have been outrageously expensive because everybody is coming for two weeks and leaving for two weeks. It costs a tremendous amount of money to do that.

> We need to maximize local hire before we start bringing people from outside… We are renting like 12 apartments for the traveling nurses right know, that's got to be a tremendous amount of money.

To make things worse, a small secluded community like Cordova tends to be very close knit. Constant turnover in medical providers essentially prohibits physicians from becoming part of the community kinship, whereby citizens wish to band together for common goals.

> There are spending problems, and the options could be different if we had quality, consistent care. With them staying here, you could get the relationship part. And, they're part of the community, which is a small community. There's your doctor, your banker, lawyer…

> I think if we could advocate for anything for here, it is to have stable providers. We can always get these traveling people, but they don't have a buy-in into the community.

Cordovan Money Going to Anchorage

Some participants are aware that when patients go to Anchorage for healthcare, instead of staying in Cordova, the local economy suffers for it. Residents of Cordova are spending their money elsewhere, instead of keeping it local. And, it is costing Cordovans more money to have to travel to get quality healthcare.

> Everybody says, 'I go to Anchorage for my healthcare.' It costs me 500 bucks every time I go up there. I stay overnight and my appointments aren't scheduled well. I've got hotel fees; I have to rent a car…
>
> I've lived here 16 and half years this time, raised two daughters that are now grown, and I go elsewhere for my mammogram and other things.
>
> I know a lot of gals that would love to stay in town and have their kids...instead of paying the expense to go to Anchorage. They're usually sent about a month before their due date. So, they're having to find someplace to stay.
>
> It's gonna help the market. Again, it's back to quality. I get my annual physical in Anchorage because I have confidence there. But I've had the same dentist at Cordova for 12 years. I've had everything from fillings, to checkups, to crowns. I didn't even think about going to Anchorage for that. But there's good service, and I know what the quality is.

One participant in the second group feels like the subsidy required for the hospital could go down if more residents stayed local for medical care and kept their dollars in the community.

> I guess this is kind of a throwback to the finance issue, but I think that we used to have a healthcare system in Cordova that didn't require so many subsidies. I think that if people felt better about the care that they were getting and it was more consistent, you would see more of that money staying here. Then you would see less subsidy required.

E. Missed Opportunities

Many participants from both groups realize that it is not feasible to have specialists in Cordova full time. The community is simply not large enough to support that type of healthcare. However, many believe that having rotating specialists who visit on a regular basis, like monthly or quarterly is an acceptable idea that would be met with huge success. It's a compromise to keep healthcare dollars in Cordova, and it's been proven to work effectively in the past.

> What about a specialist – if you knew they were coming on a regular basis that would be the main thing. Just to have them on a regular basis, so you knew them…you could rely on them being there.
>
> We have an ortho guy who comes in once every three months. We have an OBGYN that comes in every three months.

> Like a cardiologist or a podiatrist… I don't think there are enough people in this community to support a cardiologist or an OBGYN or podiatrist or any specialists. In and out, that would be great.
>
> It seems like having a specialist come in works pretty well. Like the orthodontist comes, and I take my son there because he comes here to town and it is so much more convenient. And, I think that if other specialists were to come to the hospital – the same specialist on a regular basis – people could count on that, and we would have more care here.
>
> We have a reliable eye doctor, and he's only here every three months.

However, it will be a tricky task to decide which specialties could be supported full time locally and which ones should be brought in on a rotating schedule instead.

> It just depends; we can't do everything in a tiny community that has lost 500 people in population in the last couple years.
>
> The basis of getting any kind of handle on this thing is you have to have a survey, like what we are doing, as to the needs and the volume that those needs would generate. Then, you can see if you are going to have enough revenue to pay the specialist or whoever to come here and reside here or not.
>
> I'm going to say no; we probably don't want to go into maternity or baby delivery because I think you would have to have so many people that are specialized. It wouldn't be just like one general person, you would have to have an OBGYN. Then, if you have a crisis, you are going to have to get people quickly to Anchorage anyway…so I really think that would be risky in this day and age.
>
> You wouldn't be paying a neurologist to come here to live here full time, but you would bring people in, like in the past…an orthopedic surgeon or a bone specialist or a pediatrician. Different people would come through at certain times and everybody would line up their needs and we'd know what everybody needed. We really need to be thinking that we are a small community, so we can't have everything. We have to be realistic; we can't have everything all the time here. Sometimes we will have to go to the large areas for specialized treatments and different things. We just kind of need to wake up some people in the community a little bit to that.

F. Conflict among Two Healthcare Entities

Throughout both groups, it is common knowledge that there are two major players in healthcare in Cordova: Cordova Community Medical Center (CCMC) through the City and Ilanka Community Health Center (ICHC) through the Native Village of Eyak. And, many participants agree that the simple fact that there are two major players in such a small geographic area leads to much conflict.

> For me, combining the two is purely financial. This community's just too small to have to compete. We just don't have the economy of scale to support that, especially if you end up with two entities providing one service, yet neither is providing the needed service.
>
> My impression is that when Ilanka got established, it took a bunch of the paying patients from the City facility. Our contribution had to go up to maintain that because we are getting less through put. Why would that be when you have two entities that are supposedly driving towards the same goal, a healthier community? Why can't they merge their resources? I'm sure it can be done, it's just politics.

Lack of Common Structure

Because each facility is operated by a separate entity, there is no consistent organizational structure. In addition, there is no common administrator over both of them, and the policies, procedures, and goals of each entity remain uniquely different.

> I think it is organizational structure too. It's a two-headed chicken, where you have two different bidders that don't have a real set organizational structure with one responsible party and the accountability. Between the Native Village of Eyak and the City of Cordova, I don't think there's a real defined organizational structure that works.
>
> It's that you really have two separate entities – the Native Village and the City, regardless that they both share a common goal in terms of trying to provide quality healthcare. There can be congruent goals at times, but it seems like in other areas there may be competition between the village and the City.
>
> The other thing is that the Native Village has certain amnesty against torts and illegal actions that provide benefits. So if those are thoroughly looked at, at the end of the day it's a lack of organizational structure and the cooperation is broken down.

Several participants believe that because the two medical entities are separate, politics always come into play and there are chronic issues with competition between them.

> I think there was also a sense of competition with Ilanka on the part of that former administrator. They weren't always cooperating the best that they could, and I think that's an ongoing challenge.

> For the medical hospital clinics to function properly, they've got to come together on some level to make it work. You can't have the bickering between the two, trying to outdo each other.
>
> I think politics is a huge problem. I think that's what we have been dealing with in our healthcare.

Different Types of Funding

Some participants are aware that CCMC and ICHC are funded in very different ways. Because of the different sources of funding and the parameters associated with each, it is no wonder that there is conflict of interest between the two entities.

> I'd like to ask a question that would maybe inform the whole group, because I have been here all these years and I don't know the answer to this. You have Ilanka – they are getting native subsidies for community health services and that sort of thing. And then you've got the City-owned facility and they started out one down…in a different area of town. Then they finally brought Ilanka up into the facility. I don't know if they are sharing their funding or not. I doubt it. I think they should just pool the money and rid of the double…
>
> Well, it's illegal, I think, when Ilanka is federally funded. Nonprofit can offer a sliding scale to people. The hospital part is for profit. As a critical access hospital that has long-term care added to it, the clinic cannot offer that. It does not get federal funds. So it's profit/nonprofit, federal money/ non-federal money, and the people's money. Can that really gel? Can they get married together?
>
> But the reality is… The situation right now is they're not paying their full cost of things, they have been heavily subsidized and they have gotten the benefit. For example, they've got half of that facility, but they're not paying adequately for it. It's kind of unrealistic.

Confusion about Which Clinic to Go to

In the first group, many of the participants did not realize that they could go to Ilanka for medical care. Further, based on feedback from both groups, there is widespread confusion among Alaska Native vs. Non-Native residents as to which clinic they are allowed to visit. There are stereotypes leading to confusion as to which clinic will accept which type of citizen.

> People don't know… Which door do I walk through here? They really don't know.
>
> I think a lot of it is… When the Native Village took over the existing clinic part, a lot of people did not realize that VanWinkle was downstairs and was taking patients on a regular basis.

> I didn't even know I could be seen at the hospital. I thought it was just an emergency situation or when they brought in the specialty doctors. I didn't know that I could just go.
>
> But based on past experience, I have no trust the native clinic. So, I fly to Anchorage because I strictly don't trust the care that I received there. I didn't know the hospital clinic, as I said earlier, was available.
>
> It's an identification problem, they need to make a merger here.

They Must Work Together

Both groups agree that is it imperative that the Native Village of Eyak and the City take what the two clinics have and work together toward one common goal.

> Yeah, I think the clinics should try to blend or meld together somehow.
>
> That's my concern. In a perfect situation, the City and the Native Village could come together. It would be nice to have the village funding and the City funding going hand in hand.
>
> CCMC is like an alternative to the native clinic, but that's what we don't want anymore. We want to meld them together.

However, past experience has lead residents to believe that cooperation is not possible under the current structure of the clinics and management thereof. For example, based on feedback from a few participants, there was at one time a deal between the two facilities regarding lab work procedures. Since this agreement was made, so the statement goes, the Ilanka Clinic apparently has not lived up to its end of the bargain and some believe that it is costing the City. Variations of this presumed fact were mentioned.

> You have to work together in a cooperative way so there is a trust that's verifiable. Some of the people in the hospital feel like Ilanka is not always utilizing the services of the lab. At times, they're providing for nursing home patients in the village, but are there more things they can do to help the hospital?
>
> The Native Village of Eyak or the Ilanka clinic will not use our lab. They have their own set up, and things go out every day. That's a lot of revenue the community's losing.
>
> When the agreement was initially ratified between the City council and the Native Village of Eyak, the agreement specified they would utilize that lab to the maximum extent possible.

G. Cordova Community Medical Center

While most participants understand that the hospital is under City control and governed by the Health Services Board, not that many know exactly how that arrangement came to be. Further, not everyone fully understands how the subsidy works, nontheless some can talk about it in detail.

> CCMC is really an administrative department. The City charter sets forth that there is a hospital that is City-operated that's under the supervisor control of a hospital board appointed by the council. Now as an administrative department of the City, it's just the department of their creation, like the hardware department, or the library, or the police department. It's reasonable to subsidize those services as a function of the City.
>
> The attraction of the community health center grant that was being presented, at that time, was $650,000 would be coming into the community for healthcare services. The village was already getting $500,000 a year for meeting the healthcare needs of tribal members. That was the money coming in for healthcare services. It's my understanding now that the community health grant is at $800,000 a year. So, you can't turn your back on those federal dollars.

H. Important to Keep Healthcare in Cordova

A lot of participants in both groups realize that healthcare could go away if subsidies do not continue. Those who did not realize this are a bit shocked that it is a possibility. Regardless, all residents realize that there needs to be healthcare in Cordova – it would not be good if it just went away. Because of this, most realize that whatever the ramifications are, they must be dealt with to keep healthcare local.

> The question is, is it affordable? What's the level that you're willing to subsidize and what do you suffer if you don't? What's the cost and what's the loss if you don't have those services available?
>
> Well ultimately, it would be nice if the City wouldn't have to put as much in, but right now they have to.

About Losing the Coast Guard

A very heated part of the discussions surrounding the prospect of losing healthcare in Cordova circles around the Coast Guard issue. A few participants realize that if the hospital goes away, the Coast Guard will have to leave—and this represents a significant impact on population and commerce. And, once participants realize that the City might ultimately be devastated with loss of the Coast Guard, the thought of losing the City hospital becomes horrifying to some.

> I think people don't think they should have to pay it. But, I think given the circumstances, once brought to their attention… If we don't pay it and the Coast Guard has to leave, everyone understands that...but we should be able to figure out a way not to need to.

> What is the importance of the Coast Guard? You're saying that anything we choose is still dependent on the Coast Guard protocol?
>
> If you don't keep the hospital, the Coast Guard goes away. And, that is more important than a million dollars. I'm serious.
>
> I think it's worth the City paying the money, if we are going to lose a quarter of our population.
>
> If you go to the emergency frontier, they will not house the Coast Guard. And, that starts a spiral effect. [Note: this assumption has not been confirmed]
>
> There are probably other elements that would probably leave as well.

Ultimately, people realize that they need to keep healthcare in Cordova. As such, it becomes even more paramount and urgent to find a way to make things work better than they currently do.

> I think you really need to clarify the level of healthcare that you want to provide for the people of Cordova and see how you're going to pay for it, who's going to deliver it, and how you are going to find the professional people to do it. With the turnover and the shortages that exist in that area right now, I think you need to find the minimum that you're accepting and try to meet certain goals—and get some feedback on meeting those goals. It seems like we continually keep going through the problems of a hospital and putting our money in. Are we getting feedback that things are working or not working? If they're not working, why aren't they working and what can we do about it?

STRATEGIC ALTERNATIVES – FUNDING / STRUCTURAL OPTIONS

A. Educate the Residents of Cordova

Participants in each group studied and discussed the blue summary chart of the three main structural alternatives for Cordova Health Services. One key theme in discussions surrounding implementation of one of the strategic alternatives was that the people of Cordova need to be educated in depth on both the current status and the proposed changes to local healthcare entities.

> I think people need to know what they have right now. Without knowing that first, you won't really know what's going on. I just think that people do need to be educated on what they do have available to them right now, before we really make a big jump. But uh, this has all been educational to me. I feel good about getting some of this information.
>
> So, more communication among the people at Cordova… If you didn't know there was a CCMC clinic that's been in existence for 3 years…
>
> I don't think we have explored all the options because it never gets beyond the decision making that people have to do. They never get all the facts. They never get a full insight on the economic issues. Until you get down into the weeds and find out what's going on truly, you can't make an intelligent decision.

B. OPTION A: Improve Existing Structure

Both groups agree that Option A is not viable for all the reasons discussed prior to this point. Option A1, which is operational improvements to achieve cost savings an increased reimbursement is considered a non-option and was not discussed any further.

> I think that needs to fade into the past.
>
> I think on this 'improve the existing structure'… Maybe the basics are that we have two different health entities, and they have tried to come together, and we are suffering from that. I don't think this is going to get any better.

Option A2 – Shared Services

Option A2, which is shared services to reduce duplication, got a lot more commentary, but is still not considered a viable option. Participants from both groups cite many thoughts and examples as to why shared services will not work in Cordova.

> They've got funding for Medicare, for their citizens, for the Native Village of Eyak, for their people. They don't represent me they don't represent most of us in this community. The funding doesn't represent us, so anything that includes them is adding a burden to the system. My feeling is the Native Village ought to be treated…if you want to be more efficient under this first section, they ought to be treated as a customer to the hospital. A customer to the City. And they pay their share of things and they do their thing.
>
> They are independent operators; they can't be coerced. They were down at Fisherman's Row…they had their own offices there, they had their own building. All I'm saying is that they are independent. If they don't like the deal the City offers them, they can go back and open their own place, and we can't do a thing about it.
>
> Right now it's a conflict of interest, truthfully, because we have the Ilanka clinic administrator running our hospital. She knows everything about the hospital, and she works for NVE. We are contracting and paying her to run the hospital.
>
> Not A2, reducing duplication of services. I think the hospital has their own clinic. We have a stable doctor who has been here for many years, and he's got a lot of patients. The other clinic has their doctors too. Their approach is more of a wellness approach, more holistic. I'm just saying that people should have a choice.
>
> My problem with the shared services is… I take my son in to the clinic, and they tell me you have to go over to the hospital for that service. So, I have to physically walk outside, I can't go through the door that connects these two facilities, these two offices. So, the shared services is not working either.

C. OPTION B: Restructure Existing Entities

While a few people are clear on it, not very many participants understand how the federal funding works. However, because of that, they realize that it is a complicated situation that would not be solved by maintaining existing entities.

> My question is – because I'm not a healthcare specialist – I don't understand the legality, you know, the natives with the federal funding. I don't understand how that is. I sat in these meetings years ago, and they talked about how we are going to merge...and oh yeah, there aren't going to be all these problems and everything.
>
> The concept of improving operations, I'm wholeheartedly for it. The idea of doing that in conjunction with the clinic is fundamentally flawed, and it will never succeed.

The key issue participants bring up with regard to Option B is the lack of clear definition as to who is ultimately in charge. Without someone ultimately accountable for both facilities, the numerous issues with the current situation in Cordova will not be fixed.

So the politics part of merging… The question I have is, in the end who is responsible for hiring and firing doctors? Is it healthcare professionals or a healthcare administrator in the hospital/City setting. If it's native board members for the Native Village, that's a big difference in the way it runs. Ultimately, who has the power? I don't know what's true in that situation, but that is one of the things that has come up in discussions I've had with people around town.

When you talk about merging them, I guess in the very beginning I don't understand who ultimately… Is it a citizen board that ultimately controls the administration and how it runs? Does the native tribal council ultimately control who runs our healthcare? If you merge them, will it just be like citizens and tribal council?

Option B1 – Consolidate ICHC and CCMC

Most participants did not realize that consolidation can only go one way because of federal stipulations. When they find out that consolidation is only allowable if the Native Village of Eyak is ultimately the parent of both entities, most strongly believe Option B1 is not worthy of consideration.

This is likely only allowable under the Native Village of Eyak, not allowable by City?

If the Native Village takes over healthcare, then there won't be doctors here. They're federal funding.

This is the crux of the whole thing we are evaluating here today, the Native Village in town. We have our healthcare, we have our system. The Native Village set up theirs to take care of the Indian affairs. So now what you're saying is… Since they are already here, if they want to, we could let them just take it over. I'm saying that's really not an option for this community. That is a huge step backwards. What that means is the hospital is dead, and five years from now, we are a much smaller town.

Option B2 – Frontier Extended Stay Clinic

Both groups got into discussions about the possibility of establishing a new designation for the hospital as a Frontier Extended Stay Clinic. However, as soon as the cat was out of the bag that Cordova would lose the Coast Guard under this scenario, option B2 was no longer viable.

I think that was looked at four years ago – it would be just an emergency center, no overnights. People would have to be medevac'd out almost immediately… It would just be an emergency center, a lab, an x-ray – no long-term care, nothing.

That's kind of what I think of us now. No offense, but it's just an emergency, ship-em-out. Everybody gets medevac'd out of here.

> No, we have a nursing home, a lab, physical therapy… You have other services that would not be available if we did a frontier clinic. Three or four years ago they were looking at those Frontier clinics—that was one of the options the state was presenting when they came in and bailed the hospital out.

D. OPTION C: Bring in a New Entity / Third Party

The fact that both groups came to the conclusion that neither Option A nor Option B could work creates an automatic openness to Option C. To most participants in both groups, Option C is the only option that seems new, different, and actually logical.

> I think we've been doing A and B. I mean, we've been trying to. Every City council, every committee, every tribal council has tried to improve this situation, and seven years later, we're still trying to plow the same sand. You know, consolidate the two? That was the whole point. We're trying to consolidate, but it hasn't been working. So, if we keep doing what we've been doing, we're gonna keep getting what we've gotten.

> It's all, 'Oh yes, we can work together' and then when it gets down to it, some things work and most don't.

One of the key attractions to Option C is that the third party might be better equipped to come in, analyze the situation, use their expertise, and actually get both entities to work together.

> Option C looks like the only one that involves both organizations.

> Well, it may take a third party to get it to work again.

> Really, the only option for the two to get together is like a mediator to lay the ground rules.

> If it takes a third party to get it to work, then that's what we need to do.

> An impartial third party, to take some of the personalities out.

> We need someone to find out where the problem is that's causing all of this to keep happening. Maybe we can make it work together, eliminate where the friction is.

Pertinent Experience is Key

Based on what they have seen in the past, participants from both groups emphasize the importance of bringing in a third party that has expertise in this field. Some even bring up Providence specifically when discussing the caliber of third party healthcare organization necessary to successfully implement Option C.

> My big thing is experience. Do you want more non-experienced people running your healthcare?

> The people running the hospital need to know what they are doing. And, they have to be healthcare management professionals in order to keep consistent high quality healthcare professionals here, for us. It seems to me that we might know what our needs are, but someone else should know how to best meet them. For example, make it run a business—I have no idea how to run healthcare.
>
> Expertise, someone who has been there, done that. Could be third party, someone who knows.
>
> I just want to have professional expertise people in the healthcare field running our hospital and creating an atmosphere of consistent and professional healthcare that's available, so that we can recruit more people to our community and recruit more people to use our health services. And, I think it will be paying for itself.
>
> We need some experience, some leading experience for the hospital, for the facility. Right now we don't have anyone.
>
> We've tried everything else why not try it? I just want somebody running the hospital that knows how to run a hospital. That's all I want. I'm not willing to give it to the City and not the NVE. I want someone that knows what a hospital is supposed to be and runs it that way.

In fact, in discussions of how important experience is in the third party, some participants even suggested having doctors themselves in charge of the situation, running the healthcare entities as profitable businesses.

> How about an option of the City contracting with a small group of doctors and leasing the facility and let them make a business out of it?
>
> I think the City doesn't need to be in the healthcare business… Let the doctors run their own business then they will know what their patients need. They know what's best as needs come in. The problem is they are not really in charge, the City is in charge.
>
> Here's an opportunity for a small group of doctors…two or three doctors.

Key Aspects to Consider

Some participants are aware that bringing in a third party to run the healthcare entities opens up the issues of what happens to current subsidies. The ultimate goal of the third party would be to stay profitable so as to be able to provide the patients with the absolute best possible medical care. Group members agree that this goal must be first and foremost at all times.

> I think that's the core of the issue; the City has no business in the healthcare business. If the City got out of the business there would be no subsidy. If the people in the healthcare business came in and ran the clinic...they ran the emergency room and doctors set up practice here, they could make a living out of it, a good living out of it. And it would be up to them to decide what resources are where. But what happens is these subsidies are coming in and there are certain things they say that they will do and they make their plan. Then, that's the way it is regardless of what the patient's needs are. So you have a structure and a cost that's nothing to do with your business case. It just has to do with what City council and City management have dictated it shall be, and that's ineffective.
>
> I think Option C is about organizational structure and accountability. What that's doing is really making one party responsible. Accountability should be to the patients ultimately, but it has to start with where the money comes from. Whether it's federal funding that provides $1,300,000 total through the Ilanka center or $500,000 that comes through the City. That money has to be followed all the way through to the patients to make sure it's doing its job. There needs to be an organizational structure between the hands that get that money and the patients that get that service.
>
> If you bring in another provider, like... If Providence comes in like they did in Valdez or in Kodiak, you're still going to have the City submitting money to subsidize that facility. It's still a City building.
>
> I think the problem with the building is gonna be who owns it.

Another key attraction to the new third party is that a fresh look from an Outsider would take out long-standing political issues and personality conflicts.

> For me, it could improve if it was run as a business, taking the personnel and politics out of it. It has to be run as a profitable business.
>
> Option C takes the politics and the personalities out! And, if it's a bigger entity, it can provide some cost saving by providing specialists and by getting all the pharmaceuticals that every hospital has to buy. With the bigger entity…you have purchasing power.

Success Stories in Valdez and Kodiak
A few people in the first group, and several in the second group, knew about Valdez and Kodiak examples with Providence stepping in and successfully managing the local healthcare.

> They are available, and I would like to point out Valdez. I don't know when, but Providence provides the health service for Valdez.
>
> Kodiak too, I don't know much about that, but I know it's out there. And, from what I've heard about it – I haven't used the service myself – but I've heard great things about the service in Valdez.

Ironically, participants in the second group were more likely than those in the first group to raise questions about Option C. It was the second group that tended to lean toward bringing in a third party in their quantitative surveys, yet they are the first to voice concerns regarding this option.

> I guess my question is, would that really be that different than what we have now? I guess the biggest difference would be that the entity could still run… The native healthcare, they could still have that. So that part would still be there. But the difference would be that instead of the City running it, it would be a different organization like Providence or some other organization who would run it for us instead of the City.
>
> Can a business manager be also responsible for the CEO of both the hospital and Ilanka?

Option C1 – New Provider to Manage ICHC and CCMC
Both groups spontaneously suggest an organization like Providence would be a good fit as the new provider to manage both healthcare centers.

> I think putting Providence on there will do a lot to bring the right people to Cordova.
>
> We need consistency, we need Providence to put things aside and hopefully that will calm things down to where nurses and doctors will like to come here. And stay here.
>
> 10 years ago when we were having City meetings and talking about this, I was totally against the idea of Providence because we had an awesome system going—everybody loved what was happening with healthcare in Cordova. But, I'm very open to it now.

Further, someone from each group raised concerns about how the Native Village of Eyak might not agree to the third party option, based mainly on the legalities of their federal funding stipulations.

First of all I don't like the Native Village of Eyak under it. Its self determination policies would not be willing to surrender their control over that money to provide services for their people. They're not going to give up that money.

Now would they (a third-party provider) be able to integrate the native funding into their system that we can't here as a community?

Option C2 – New Provider to Manage CCMC Only

Option C2 brings up some good questions from participants, which reiterates the importance of educating the people of Cordova and then thoroughly researching actual implementation prior to initiating change.

So my question is then, we would still have NVE operating a clinic? And, then we would have a clinic and a hospital and an extended care facility operated by some other entity?

My (preference) is…C2; focus on the needs of the hospital and the community separate from the Native Village.

I don't think it will work. If they are taking half the business away, the hospital is never going to survive. They've got to work together.

I'm hesitant about going to the third party without looking at the positive and negative effects of that. I think you're rushing into a solution that you don't know the positive and negative consequences of yet. You're hopeful that this will solve your problem, but I'm not that optimistic about a third party coming in and solving our problems.

I tend to go a little bit with that until the specifics are actually ironed out and looked at and quantified. A and B haven't worked, so moving toward C would be an idea, but…

GOOD THINGS ABOUT LIVING IN CORDOVA

Participants from both groups echo that many people living in Cordova are here by choice and have intentionally made this small community their home forever.

> I live here because I want to live here. There are very specific reasons for living here, and that's what you have to advertise.
>
> I'm one of the few people who moved here by my own choice and not related to fishing. This is where I was going to carve out my life.

A. Great Place to Raise a Family

Because of the high quality schooling system, the recreational options available, and the secluded nature of Cordova, many participants were proud to say that this is a great place to settle down and raise a family.

> For families, this is a great place to raise your kids. School-wise, it's got a great system. There's lots for the kids to do. You need to really get out and look around.
>
> We have a great swimming pool, rec center.
>
> Great schools, it's an incredible place to raise a family.
>
> We live in a gated community. We are gated by our environment, and we live in this beautiful place that is protected from a lot of outside influence, like roads and what not. We have a wonderful, safe place to bring up our kids and to enjoy the outdoors.
>
> It's a safe community. It's pretty protected.

Participants from both groups rave about the quality of people in Cordova, who tend to be more laid back and easygoing. Even though most residents have above average education and intelligence, and there is deep cultural value within the community, there is no pretentiousness around.

> I do it because it's not pretentious, people don't care how you dress, what kind of car you drive, that kind of stuff. It's what's real. And there are very intelligent people in this community. It's creative… Life's good.
>
> When my brother told me you could wear blue jeans to church on Sunday morning, no ties… And they do, and nobody says anything.
>
> We have a very musical community—that is also an excellent layer of Cordova's community.

> And scientific…it's a very scientific area that's very interested in the environment and maintaining that fishing.
>
> The educational levels…there are more PhD's per capita.

Because of the secluded nature and the small-town feel of Cordova, there is a very strong sense of community among all of its residents.

> Our community bonding is really incredible.
>
> The support that people have.
>
> Around here it's really important to be able to say, 'Oh my kid's in school with your kid.'

B. Outdoor Life is Indescribable

Even besides the fact that commercial fishing is the engine of the community, the beautiful scenery and plentiful outdoor life opportunities make Cordova an aesthetically amazing place. For outdoors-oriented people, this community is a dream come true.

> There's an economic engine that drives the community, which is commercial fishing. That keeps the core in the community. You've got this basic core.
>
> 'Right out the door' access to fishing and hunting and outdoor recreation.
>
> You just look out the window and that's says it all really, especially on a day like today. The recreational opportunities are optimal…indoor and outdoor.
>
> We have all kinds of outdoor opportunities.

C. Long-Term Care Facility nearing 4 Stars

People in the first group like to brag about the success of the long-term care facility, saying it is thriving with all the beds full and nearing four-star status.

> One thing that hasn't been mentioned is the long term care facility, which has gone from a struggling two star almost on the edge teetering off the edge to four star plus. The residents really like it.
> And, all the money stays in the community. It's paid for.
> Our long-term care is full; there's a waiting list.
> You lose three patients and you're underwater again.

However, a few naysayers in the second group think the long-term care facility is too small to make a difference, and the fact that it is full and thriving is vulnerable to change.

APPENDIX

Cordova Focus Group Discussion Guide
September 15, 2010

[TARGET SEGMENT: These sessions are made up of respondents who participated in the recent survey. A screener was established that questioned satisfaction with availability of health care in Cordova, importance of having health care available in the community, and views on structures including City/Village working together, suggestion that City bring an outside organization to Cordova and selected demographics (age and ethnicity to attempt a mix in the Two Focus Groups. The group compositions were determined through market segmentation analysis where researchers profiled survey/screener participants' answers to the above questions. The breakdown follows:

September 15 – Both groups somewhat satisfied/unsatisfied with Cordova Health Care.

5:30pm – Middle range opinions (no extreme views) or leaning toward the City/Village "working together".
7:00pm – Middle range opinions (no extreme views) or leaning toward a Third Party Outside Health Organization]

I. INTRODUCTION

Today we are here to gain a better understanding regarding your awareness of health care issues facing Cordova, what you want for your future, and how we can ever meet our need for quality, available health care right here in the community of Cordova. We would appreciate learning from a group of community members ---who participated in a recent survey and I thank you for that -- and now you are here for our small group discussion we appreciate **and thank all of you** for your comments today--individually and collectively.

II. WARM-UP: Health Care in Alaska/Cordova

Let's begin with the big picture. We really do not need any detail at this time, but rather top-of-mind thoughts. I would like to start off with something I have studied off and on in my 20 years as a researcher in Alaska.

1. Do we have good health care close to home? What are your options? [UNAIDED]

2. What are people in Cordova looking for typically when they leave? Is it their doctors referring them out or is it by choice to get something they can't find?

3. Why is it so hard to get and keep good health care providers? Is there a doctor or type of practice that you believe could do well here…that is now a missed opportunity for this community. [Watch for visiting Specialty clinics]

[PROBE: How important is it to keep healthcare in Cordova? How optimistic are they that something can be worked out to everyone's satisfaction…and keep something local]
[SHOW RESEARCH: Table A3.1 Importance of the availability of good healthcare. Page 8 detail from Table B1.1 Funding by the City.]

4. In this recent study you participated in…we all want health care 95% and the City has been paying for it in a subsidy…half a million! Then when I asked should the City pay less or nothing…63% agreed? Can you help explain this to me?

5. [PROBE] Then what is going to happen? Who should pay? What are you comfortable with relative to health care funding?

[PROBE: Is closure of the hospital a real possibility? Assess the degree to which they are aware that something has to change? And if change must happen are they open to it and do they have ideas that will make them happy?]

III. IN-DEPTH: Funding Ideas and Structural Options Explored

Let's talk about some more of those details from the survey you took….can you help me gain a better understanding about what some of these sentences mean to you?

1. [SHOW REPORT] page 11, Table B1.2: "Ideas for Assistance with Funding"

[5:30 takes middle or leans working together City/Village; 7:00 takes middle or leans toward the suggestion that the "City Bring in an outside health organization to run the hospital."]

2. [UNAIDED] What are your thoughts looking at this page? What makes group members like or favor one idea over another? What don't you like about these suggestions? [JC: USE ACRONYMNS sheet and expanded STRUCTURAL OPTIONS detail to help with clarity and examples.]

3. [REVIEW OPTIONS FROM PowerPoint handout; short version only 1 pager]
4. OPTIONS 1, 2, 3, pro/con for each; why do they like one idea over another etc.

IV. WRAP – UP:

After this discussion today what is your single most important piece of advice for the people trying to make the best health care options available here in Cordova?

Finally, what should they be saying to physicians and other health care professionals to have them see the best parts of Cordova and want to live and work here. What are the positive quality of life reasons you and your neighbors prefer life in this community?

Come on lets brag a little…it is quite beautiful!!!!!

Appendix E

Cordova Health Services – Strategic Assessment
Joint Council Work Session Notes
Oct. 13, 2010

A. Improve Existing Structure, e.g. Wrangell

What does it look like? What does it take? Challenges? Tactics? Boundaries?

- No change – still two entities (City & NVE) with two separate governance systems (City Council/HSB & Tribal Council/ICWAC) and two different leaders (hospital Administrator and Ilanka Director)
- Can be successful – e.g. Wrangell does it without a City subsidy
- Can change the Health Services Board, e.g. could make them elected versus appointed
    - City Council is open to making changes to HSB as a result of this work
- Likely continue a City Subsidy (even though Wrangell Medical Center is able to operate "in the black," need to recognize the differences in community 'payer mix'
- There ARE financial improvements to be made per Mike Bell's report
- Can increase the value of 'shared services' i.e. identify what each does best (and who gets the best reimbursement) by service. Do it there, and contract / share the other; establish clear contracts for, e.g.
    - Combine/integrate ER coverage
    - Lab/x-ray – hospital only (with ER)
- Motivated to stabilize and lower City subsidy to hospital
    - Would continue to contribute, but ideally like to see it go to zero
- Need to stabilize leadership – hire good people and let them lead
    - ICMC & Hospital leadership, who hire …
        - Physicians
        - All staff
- P & L liability (and sources of capital)
    - ICHC: Stays with NVE; possible grants & gifts for capital
    - CCMC: Stays with City; possible grants & gifts for capital
- Electronic Medical Records
    - ICHC: retains theirs
    - CCMC: doesn't have one, would have to license separately (some grant funds may be available to help with those costs
    - If not same system, additional cost to create an interface would be required to streamline patient care and health records for locals and providers.

QUESTIONS:

- What can we do to reduce the politics in this scenario?
- Can NVE acquire equipment that is located in hospital and used by all/both staffs?
    - Be careful of Stark Laws

B. Restructure with Existing Entities – e.g. Vermont

What does it look like? What does it take? Challenges? Tactics? Boundaries?

- NVE with oversight for both hospital and Community Health Clinic
- Could be designed as a single board over all (e.g. West Virginia) or the Tribal Council as parent and some kind of health council under that.
- NVE has recently negotiated a separate, tribal "Compact" to receive IHS funding directly as a Regional Health Organization; no longer through Chugachmuit.
    - Result has been an increase in funds going directly to NVE
- Can negotiate for increased IHC funding
- Tribal run CHC gets 3 times higher Medicaid reimbursement than non-tribal CHC does for ALL Medicaid patients (not just Native beneficiaries)
    - State 'likes" as IHS funding is 100% federal, vs. Medicaid which is 50% State $.
- Private payers (e.g. Tri-Care, Premera, any payer besides Medicare, Medicaid and IHS beneficiaries are not billed at the '3 x' rate. They pay what they do now.
- Can access specialists from South Central Foundation
    - Large network of providers can be scheduled for specialty clinics in Cordova
        - Increase consistency in specialists seen
        - No cost to clinic, in fact the revenues flow to ICHC
        - Increase access for all, especially for 65+ residents who have trouble getting to see a specialist now
    - Opportunity for local physicians to call their peers/specialist in Native system
    - Immediate access to specialists as needed via telemedicine
        - Helps to keep more patients (and the funds for their care) in Cordova
    - Referrals to Alaska Native Medical Center in Anchorage
        - Q: does this work for Native and non-native both?
    - Non-Native referrals to Anchorage for hospital care would go to one of the other providers (Alaska Regional or Providence) – SCF physicians can consult
- Would continue to see ALL patients
- Equipment – access to some at no cost, free inspection and maintenance, and access to a greater number of grant opportunities, i.e. very likely more funds
- Free training to all staff – physicians, nursing, administrative
- Electronic Medical Records that NVE has could be shared
    - Integrated patient care opportunity is 'built in'
- Sliding scale at the CHC is open to everyone (as it is now)

Questions?

- If not enough new / federal revenue to eliminate losses, how does the city help?
- Remaining challenges? Political issues still exist. How to remove the political concerns?
    - Could create a health services board "under" the Tribal Council (e.g. VT)
        - Can it be publically elected?
        - Can it have representational appointment by City?
    - Need full financial disclosure and transparency for all sources and uses of funds.

C. Bring in Third Party – e.g. Valdez

What does it look like? What does it take? Challenges? Tactics? Boundaries?

- Example in Valdez
  - City owns facility and pays subsidy for management fee + to cover losses
  - Providence operates the hospital
  - Private clinic with 2 long term doctors and two 'new' doctors
- Similar in Seward, although the physicians are employed by the hospital (no CHC)
  - Chugachmiut operates the North Star clinic in Seward with 1 MD serving natives
  - Comment – tribal members are not happy with Chugachmiut Services
- Third party greatly reduces political challenge
- Have access to "system" depth, e.g. technology, specialists, staff, quality, etc.
  - Depth and remote partner helps keep patients in Cordova (telemedicine, etc.)
- Enhance ability to recruit & retaining people, e.g. staff, administration and physicians.
  - Many of those feel 'more secure' in a larger system than one that is city owned.
- Revenues STAY in the community; are reinvested to enhance services (e.g. Kodiak MRI)
- Would require a Request for Information (RFI) to find out who is interested followed later (if path selected) a full Request for Proposals (RFQ) that is designed to meet the requirements of Cordovans.
- Likely to reduce the subsidy over time (e.g. Valdez)
- Would like include the Critical Access Hospital and Long-Term Care
- Would run health services with a business model, focus on quality over quantity
  - Not like School District which is 100% cost; health care has to manage for optimal revenues too.
- Could design to retain a local board
- Builds in a partner/referral system (if selected third party operates in Anchorage)

D. What Makes Most Sense? What's Worth Doing?

Council/Board and Task Force members were given time to discuss and then asked to indicate their current inclinations for future direction using three 'dots' which they could place all on one path, or spread equally on the three if they feel we need to do work on all of them.

The direction or what was called "prevailing winds" at this time indicated continued interest in all three still, but roughly half interested in what can be done with existing entities.

A. Improve Existing Structure – least interest
B. Restructure with Existing Entities – greatest interest
C. Bring in Third Party – medium interest

It was acknowledged that this is not a formal or binding vote, but something which provides direction to the Task Force members. There remained some confusion and many unanswered questions.

E. Alignment and Clarity

- **What do you / your organization bring to the table?**
- **How / what can you contribute?**
- **What would it take for us to work together in support of the vision?**

- This reflects the interests of those here tonight, these council members. But it is not necessarily what the Community wants and we need to recognize that challenge.
- Need more detail on all of these, e.g.
  - Financial analysis
  - Employee impact
    - Benefits, continuation of PERS, transition/job security, etc.
      - Note – a lot of experience to draw upon to research, design what is wanted, and manage change
- While B is compelling, we NEED to know how NVE and Ilanka Community Health Center would overcome the challenges of politics and the turnovers seen, particularly with physicians
  - Need to SEE how that might work in practice
- If B – how to ensure BOTH entities stay committed to the long-term success
  - Cannot 'walk away' from responsibility to advance the shared vision
  - In ANY solution – need assurance that it cannot fail
  - Not sure how to write that into agreements or contracts
- If RFI / RFP – NVE Council would confer, and yes, would expect to submit a proposal

F. Commitment

- **What doubts or reservations do you have?**
- **What would it take for you to participate in the next steps?**

- NEED education and awareness for the community, e.g.
  - History of native health services in Cordova and NVE
  - Clarity on who does what
  - Financial facts / background
  - Alternatives, with greater clarity
  - What works in other places
- Shared goal – quality health services for all of Cordova
  - Overcome the politics and history of native / non-native
  - Still several questions about structures (elected vs. appointed) but what *really* "depoliticizes" the way we interact and trust?

Staff and potential recruits still have huge reservations and fear with all of this uncertainty – How soon can this be solved?

Appendix F

Cordova Community Medical Center
Equipment List – Nov. 19, 2010

Laboratory & Radiology

Current equiptment	Age	Status		Replacement Cost
ACE chemistry	installed 2002	needs rplacement now		50000
CellDyne	installed 2005		2012	25000
Comp Pro Med	installed 2002	needs rplacement now		10000
blood bank fridge	ukn	replace as needed		2500
med fridge	ukn	replace as needed		1500
fridge/freezer	ukn	replace as needed		1000
DCA 2000	refurbished 2010	current but older model		1000
BFT II	refurbished 2010	current		600
Urine strip reader	installed 2010	current		1000
triage meter	installed 2006	current		1000
centrifuge	loaner from Reference lab	current		1000
computers x3	ukn at least 5 years old	needs rplacement now		10000
hood	ukn	current		1000
microscopes x3	ukn at least 20 years old			5000
Portable Xray				62000
Ultrasound	Refurbished			125000
Cat Scan				450000
				747600

Sound Alternatives	Estimated Price
Large flat screen TV for Therapy Groups and Educational Groups.	$500
DVD player for Therapy Groups and Educational Groups.	$150
Laptop Computer for Off-Site Assessments, Therapy Groups, Educational Groups, and PowerPoint Presentations.	$750
	$1,400

Nursing

Cardiac Monitoring System		2007	Leased	$100,000
EKG Machine		1999		5,000
Bladder Scanner				10,000
IV Pumps	10-15 years old each			25,000
Stretchers				12,000
Pyxis System				120,000

Computers	10 years old each		only has 3 -- needs 6	25,000
Printers				5,000
Beds x10		1989		15,000
Call Bell System		1990		150,000
Towel Warmers				500
TVs for Patient Rooms	1989-90			5,000
Furniture for Rooms				10,000
Commercial Microwave in Nutrition Center				5,000
Linens				10,000
				$497,500

Building & Maintenance

Roof			1,000,000
Vehicles		3	100,000
LTC Van			150,000
Heating system	25 years old		200,000
Generator			100,000
Booster heater of Laundry			50,000
Water Filter System			50,000
New Flooring			30,000
Painting			8,000
Carpet and Upholstry Cleaning System			5,000
Soundproofing			80,000
			1,773,000

Mortuary

Flight Casket	**1000**

Administration

Server and Program Upgrade for Healthland -- Not the same as last server just bought	78,000
Computers	15,000
New Phone System	25,000
	118,000

$3,138,500

Appendix G

Acronyms and Definitions

Acronym	Name	Description
CAH	Critical Access Hospital	Federal designation for small, rural hospitals; CCMC is currently a CAH. Designation drives reimbursement for services to Medicare and Medicaid beneficiaries.
CCMC	Cordova Community Medical Center	Owned and operated by the City of Cordova; includes Emergency Room, Long Term Care, Sound Alternatives, Labs, Physical Therapy, physician clinic and Senior Meals program.
CHC	Community Health Center	Federal designation for community health clinics with distinct reimbursement structure; only one per community; NVE currently operates Ilanka CHC serving *all* Cordovans.
FESC	Frontier Extended Stay Center	State designation for small, rural health facilities; differs from CAH by not offering surgical care and full time physician.
ICHC	Ilanka Community Health Center	Owned and operated by the Native Village of Eyak; funded through a federal grant with strict requirements; provides primary care to *all* residents of Cordova. Benefits from CHC grant funding and also Indian Health Service contract funds for Native beneficiaries.
IHS	Indian Health Services	Federal entity responsible for health services to all Native Americans. With distinct funding/reimbursement rates. The Native Village of Eyak is the sovereign entity receiving IHS funds in Cordova.
LTC	Long Term Care	Nursing home services for frail and elderly patients needing full time nursing level of care. LTC in Cordova is provided within the CCMC facility and organizational structure.
P&L	Profit & Loss	Profit & Loss accountability lies with the owner of the entity; they are responsible for losses /subsidies and the beneficiary of profit or surplus. Contracted operators may not have P&L responsibility, but continue to receive City /community subsidy if they experience losses.