# ANTHC
# Scorecard Report

September 2024

Empower the Workforce
Enhance the System of Care
Achieve Performance Excellence

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

# Working Together

## Strategic Plan

### View 2025:

As part of a unified health care system, ANTHC leads, manages and facilitates enhanced healthcare coordination among Tribal partners, and delivers quality services at the right place in an efficient way that promotes a healthy mind, body, and spirit.

## Empower the Workforce

- Employees choose ANTHC because we offer a fulfilling and rewarding career
- Employees have the tools and resources to be effective

## Enhance the System of Care

- Patient care is coordinated across regions, episodes of care, and Tribal partners
- Invest purposefully in infrastructure to improve public health

## Achieve Performance Excellence

- Establish core metrics to measure and monitor ANTHC's progress toward performance excellence
- Deliver excellent services that improve the health and wellness of the community
- Achieve sustainable financial health allowing for critical investments to be made

**Vision:**
Alaska Native people are the healthiest people in the world.

**Mission:**
Optimizing health and well-being through collaborative partnerships and services.

**Values:**
Self-determination, Quality, Integrity, Teamwork

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

# ANTHC Board of Directors Strategic Plan - FY24 Organizational Scorecard

September 2024

Working Together Strategic Plan

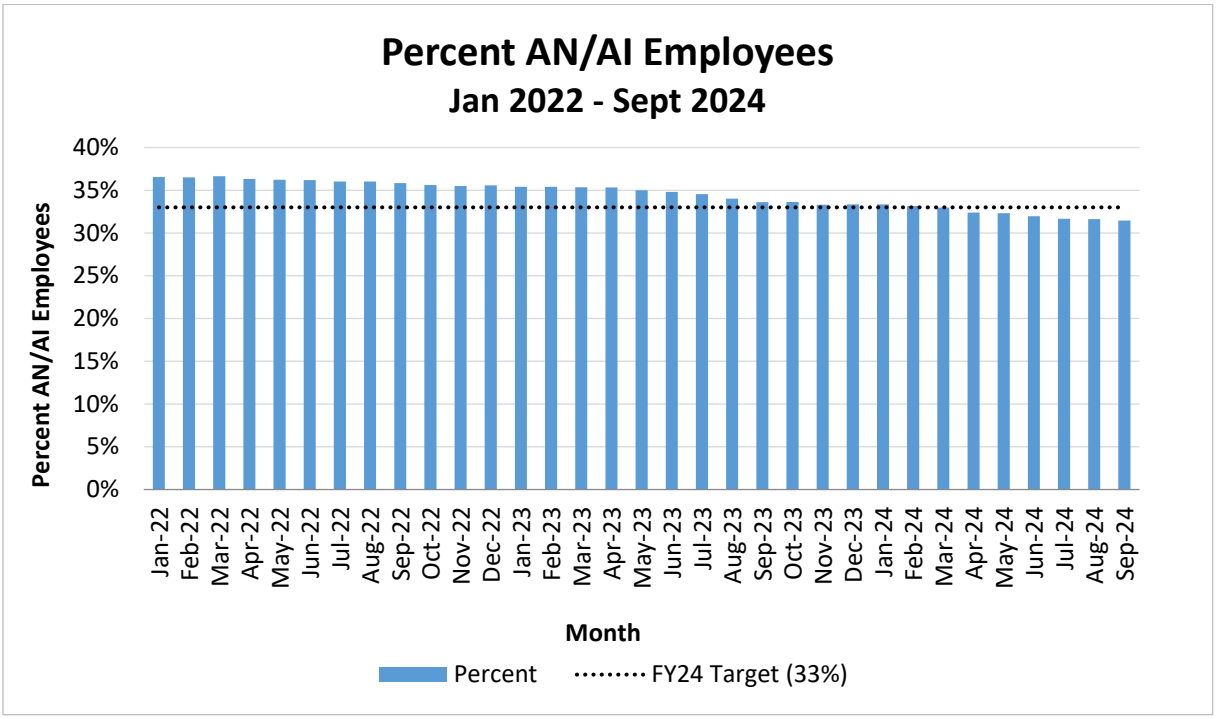
| Strategic Theme | Goal | Objective | Measure | Definition | Baseline and Targets | | | | Current Results |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | Baseline | 80% | 100% | 120% | |
| Empower the Workforce | Employees choose ANTHC because it offers a fulfilling and rewarding career | Evolve culture to empower colleagues | **1) Percent Alaska Native/American Indian (AN/AI) Employees** | Percent of full-time and part-time ANTHC employees who are Alaska Native or American Indian (AN/AI) people during the reporting period. | 35% (Aug2023 FYTD) | 30% | 33% | 35% | **31%** |
| | | | **2) Employee Engagement Survey** | Press Ganey's Engagement Indicator is a composite metric of six (6) items that measure employees' degree of pride in the organization, intent to stay, willingness to recommend, and overall workplace satisfaction. Average rating by employees on a scale of 1 to 5. | 3.93 (FY23 Survey Results) | 3.83 | 3.88 | 3.93 | **3.99** |
| | | Consistently and visibly invest in workforce development, reward high performance, and support strong succession planning | **3) Percent AN/AI Employees in Leadership Positions** | Percent of full-time and part-time ANTHC employees in leadership roles who are Alaska Native or American Indian (AN/AI) people during the reporting period. | 36% (Aug2023 FYTD) | 32% | 34% | 36% | **33%** |
| | | | **4) Workforce Development and Succession Planning** | Focus and improve the effectiveness of workforce development initiatives ensuring alignment with strategic goals and growth across all levels of the organization. | Implementation Measure | 80% | 100% | 120% | **120%** |
| | Employees have the tools and resources to be effective | Invest in strategies that systematically address deficiencies felt by ANTHC employees | **5) Employee Communications and Resources** | Strengthen and align internal communication strategy to empower employees at all levels and support strategic plan implementation. | Implementation Measure | 80% | 100% | 120% | **120%** |
| | | | **6) Clinical and Professional Workstations** | Ensure staff have access to clinical and professional workstations that meet industry standards. Replace up to 50% of aging employee desktops/laptops (1,400) and 100 clinical Workstations on Wheels (WOWs) at ANMC. | New Measure | 1,000 | 1,250 | 1,500 | **1,396** |
| Enhance the System of Care | Patient care is coordinated across regions, episodes of care, and Tribal partners | Optimize the Electronic Health Record (currently Cerner) to enhance the quadruple aim and to serve as a bridge to participating Tribes and THOs | **7) Electronic Health Record Strategy** | Successfully implement accelerated FY24 EHR roadmap and advance overall EHR strategy. | Implementation Measure | 80% | 100% | 120% | **80%** |
| | | Enhance referral management, scheduling/patient access, and care management | **8) Patient Travel and Housing** | Advance Statewide and ANTHC Patient Travel and Housing objectives. | Implementation Measure | 80% | 100% | 120% | **120%** |
| | | | **9) Urgent Referrals Seen** | Percentage of patients with urgent referrals who receive care in ANMC Specialty clinics within 14 days of referral being sent. | 46% (91-day rate as Sept2023) | 50% | 55% | 60% | **63%** |
| | | Develop program / service line plans for key specialties (in person and telehealth), incorporating the diverse needs of each region and THO | **10) Strategic Business Assessments** | Develop framework that reviews volume, quality, safety, workforce, financial performance, and other inputs to identify opportunities for enhanced strategic, operational, and financial alignment. Initial assessments to include one DEHE program, one Business Support department, and at least two ANMC service lines. | New Measure | 4 | 5 | 6 | **4** |
| | Invest purposefully in infrastructure to improve public health | Advance Department of Environmental Health and Engineering (DEHE) projects and investment milestones based on community needs | **11) First Service Community Projects** | Number of First Service Community projects (27 total) where DEHE has met planning phase milestones, including community project kick-off, selection of preferred alternative, and Preliminary Engineering Report (PER) submission to IHS. Completion is required for communities to be eligible to apply for Infrastructure Investment and Jobs Act (IIJA) funding. | New Measure | 20 | 22 | 24 | **22** |
| | | Align health education, food security, and training initiatives with the strategic direction | **12) Statewide Tribal Public Health Assessment** | The Statewide Tribal Public Health Assessment is an assessment of the Alaska Tribal Health System's capacity to deliver foundational public health services that will help inform ANTHC's efforts to align public health initiatives with the strategic direction. | Implementation Measure | 80% | 100% | 120% | **100%** |
| Achieve Performance Excellence | Establish core metrics to measure and monitor ANTHC's progress towards performance excellence | Establish baseline performance and define metrics to track performance against quadruple aim (quality, access, cost, service) and strategic direction ("View 2025" and beyond) | **13) Establish Revenue Cycle Scorecard** | Develop, roll out, and adopt a Revenue Cycle scorecard to help monitor and manage performance. | Implementation Measure | 80% | 100% | 120% | **120%** |
| | | | **14) Establish Operational Scorecard** | Develop, roll out, and adopt Operational scorecards for two divisions, ANMC and DEHE, to help monitor and manage performance. | Implementation Measure | 80% | 100% | 120% | **120%** |
| | | | **15) Establish Medicaid Redetermination Scorecard** | Develop, roll out, and adopt a Medicaid Redetermination scorecard to help monitor and manage performance. | Implementation Measure | 80% | 100% | 120% | **120%** |
| | | | **16) Establish Margin Management Scorecard** | Develop, roll out, and adopt a Margin Management scorecard to help monitor and manage performance. | Implementation Measure | 80% | 100% | 120% | **120%** |
| | Deliver excellent services that improve the health and wellness of the community | Campus modernization: finalize short term facility plans and develop long-term plans aligned with strategic direction and capital availability | **17) Emergency Services Expansion** | Complete Board-directed FY24 Emergency Services Expansion funding, design and construction milestones. | Implementation Measure | 80% | 100% | 120% | **100%** |
| | | | **18) Short-Term Skilled Nursing Facility** | Initiate Board-directed Short-Term Skilled Nursing Facility (SNF) plan. | Implementation Measure | 80% | 100% | 120% | **80%** |
| | | | **19) Master Site Facilities Plan** | Initiate stakeholder-driven assessment and planning process to update Master Site Facilities Plan. | Implementation Measure | 80% | 100% | 120% | **120%** |
| | | Accelerate efforts to improve patient access, quality, and experience, including behavioral health services | **20) HCAHPS Recommend the Hospital** | Percent of patients who reported "Yes, they would definitely recommend the hospital" (Would you recommend this hospital to your friends and family?) on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. | 64% (7/1/22-6/30/23) | 60% | 62% | 64% | **64%** |
| | | | **21) HCAHPS Communication with Nurses** | Percent of patients who reported that their nurses "Always" communicated well (Nurses treat you with courtesy/respect, Nurses listen carefully to you and Nurses explain in way you understand) on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. | 73% (7/1/22-6/30/23) | 69% | 71% | 73% | **77%** |
| | | | **22) Specialty Clinic Visits** | Number of in-person and telemedicine specialty clinic visits. | 112,386 (7/1/22-6/30/23) | 112,386 | 118,005 | 123,625 | **126,877** |
| | | | **23) Surgical Cases** | Number of inpatient and outpatient surgical cases. | 18,256 (7/1/22-6/30/23) | 18,256 | 19,169 | 20,082 | **20,111** |
| | Achieve sustainable financial health allowing for critical investments to be made | Meet key financial performance indicators critical to ensuring overall financial health | **24) Operating Margin** | (Total operating revenue – total operating expenses) / Total operating revenue | -3.2% (FY23 Projected, Aug2023) | -3.2% | -2.6% | -2.0% | **0.5%** |
| | | | **25) Net AR Days** | (Net patient accounts receivable x 365) / Net patient service revenue | 63.3 Days (Aug2023 FYTD) | 61.3 | 59.3 | 57.3 | **50.6** |
| | | | **26) Discharged Not Final Billed (DNFB)** | Dollar amount in patient accounts discharged not final billed / Average daily revenue | 21.5 Days (Aug2023 FYTD) | 19.5 | 17.5 | 16.5 | **10.7** |
| | | | **27) Margin Management** | Cumulative dollar value of margin improvement initiatives | $12.6M (FY23 Projected, Aug2023) | $34M | $40M | $46M | **$51.7M** |

Board Approved October 2023

# Empower the Workforce

## 1) Percent Alaska Native/American Indian (AN/AI) Employees FY2024

**Measure Definition –** Percent of full-time and part-time ANTHC employees who are Alaska Native or American Indian (AN/AI) people during the reporting period.




**FY24 Results:** 31% (September 2024) – 80% target met

**FY24 Targets:**

| | |
|---|---|
| **80%** | 30% |
| **100%** | 33% |
| **120%** | 35% |

**Year End Summary:**

Despite a decrease in overall representation, ANTHC added +71 Alaska Native and American Indian people to our workforce in FY24, excluding recruitment and attrition factors. We remain committed to increasing representation and ensuring our workforce reflects the communities we serve.

Q4 Programs and Initiatives:

- **Hiring Priority:** We prioritize Alaska Native and American Indian people for every position at ANTHC.
- **HR KPI Dashboard:** This tool allows management and HR to track progress toward representation measures for Alaska Native and American Indian employees.
- **Talent Bank Program:** This initiative established a pool of Alaska Native and American Indian people for temporary assignments. This year, the program exceeded its goal by 45%, hiring 29 individuals, with a 48% conversion rate to full-time permanent positions.
- **CLIMB Program:** CLIMB, ANTHC's newest training initiative for early-career talent, focuses on five key themes in healthcare and career development. In FY24, the program had 116 participants, 70% of whom were Alaska Native or American Indian employees.

# *Empower the Workforce*

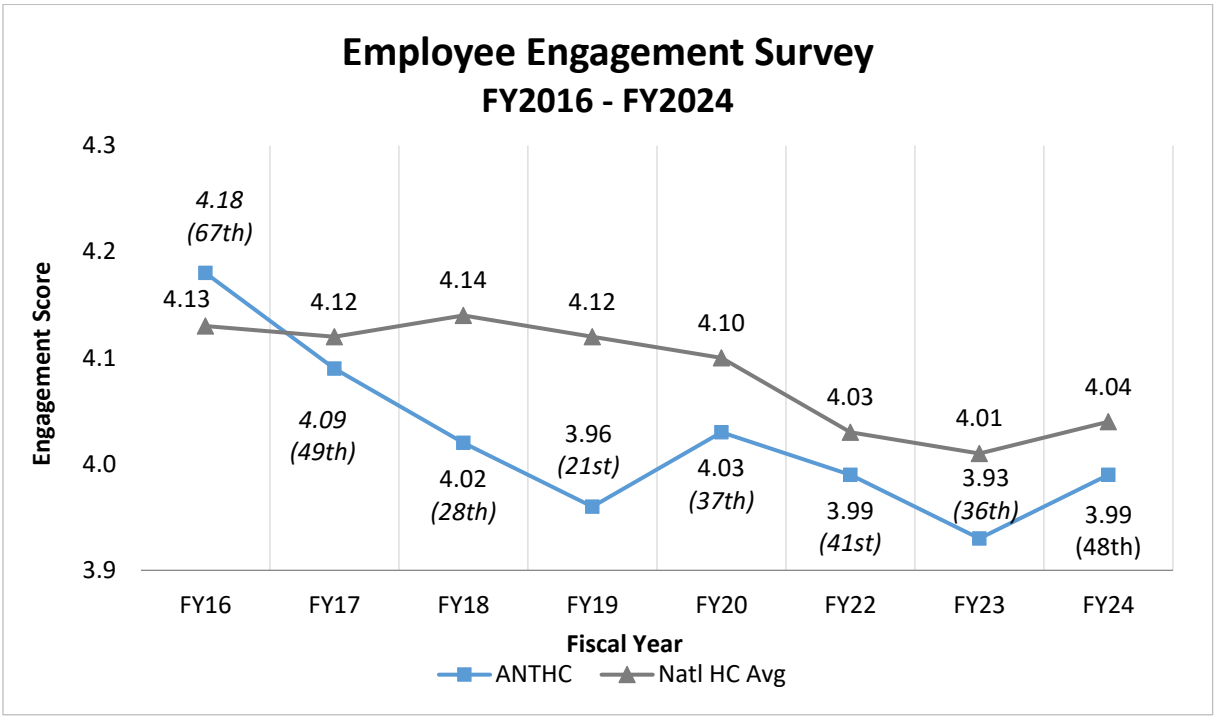
## 1) Percent Alaska Native/American Indian (AN/AI) Employees FY2024

- **Expanding Educational Partnerships:** To broaden our talent pool, the Workforce Development team is enhancing partnerships locally and nationally to support not only talent acquisition but also community programs and initiatives.
- **Employee Referral Program:** Expanded in FY24, this program continues to yield results, with 1 out of 5 employees referred for critical skill sets at ANMC, DEHE, and CBSS being Alaska Native or American Indian people.
- **Tuition Assistance Program:** Enhancements implemented in FY24 have resulted in 49% of funding requests being made by Alaska Native or American Indian employees.
- **Leadership Development Programs:** Launched in September for the FY25 cohort, these programs include 47 participants across Pathways, LEAD, and ANELP – 100% are Alaska Native or American Indian employees.
- **Provider Recruitment:** Proactive recruitment efforts, including engagement at specialty conferences and educational outreach, successfully led to the hiring of two Alaska Native/American Indian Providers.

# Empower the Workforce

## 2) Employee Engagement Survey FY2024

**Measure Definition –** Press Ganey's Engagement Indicator is a composite metric of six (6) items that measure employees' degree of pride in the organization, intent to stay, willingness to recommend, and overall workplace satisfaction. Average rating by employees on a scale of 1 to 5.




**FY24 Results:** 3.99 (FY2024) – 120% target met

**FY24 Targets:**

**80%** 3.83

**100%** 3.88

**120%** 3.93

**Year End Summary:**

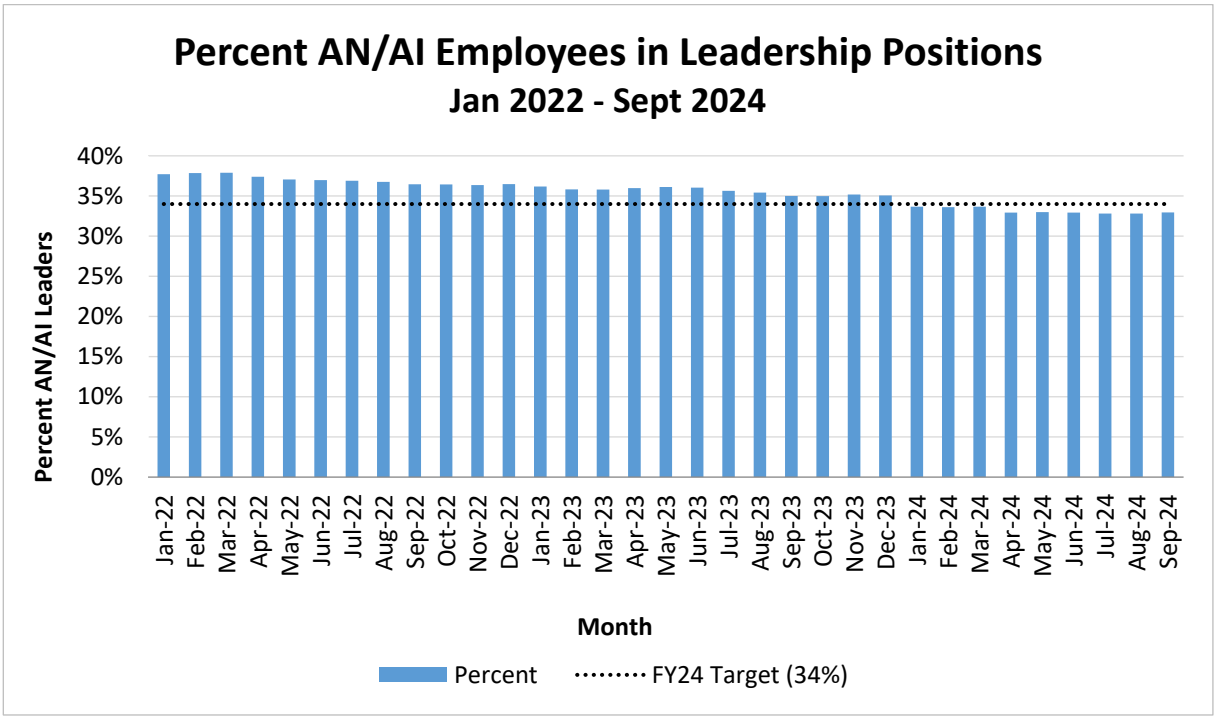
This year, we are pleased to see an increase in our engagement score from 3.93 to 3.99 and a significant improvement in survey participation, with a 20% increase in overall response rate compared to last year. Increased participation was driven by a stronger collaboration with managers and the development of a comprehensive communications strategy.

HR is in the process of finalizing a strategic plan for continuing to improve employee engagement scores in FY25.

# Empower the Workforce

## 3) Percent AN/AI Employees in Leadership Positions FY2024

**Measure Definition –** Percent of full-time and part-time ANTHC employees in leadership roles who are Alaska Native or American Indian (AN/AI) people during the reporting period.




**FY24 Results:** 33% (September 2024) – 80% target met

**FY24 Targets:**

| | |
|---|---|
| **80%** | 32% |
| **100%** | 34% |
| **120%** | 36% |

**Year End Summary:**

Despite an overall decrease in representation, the actual number of AN/AI leaders increased slightly over the year (from 167 in October 2023 to 170 in September 2024). We remain committed to increasing the percent of AN/AI employees in leadership positions and ensuring that our workforce continues to reflect the communities we serve. In addition to the core recruitment, retention, and development strategies outlined in Measure 1 for Alaska Native/American Indian Employees, the following represent important FY24 efforts to support growing and retaining AN/AI employees in leadership positions:

- **Leadership Training and Coaching:** The HR Business Partner Open Hour initiative continued to expand to provide structured and systematic training and coaching sessions tailored for supervisors and leaders at all levels. Year to date, our leaders accessed 750 training hours of education and discussion. This resource has become invaluable to both AN/AI leaders and non-AN/AI leaders bringing consistency and standards to leadership roles.
- **Leadership Development and Engagement:** In addition to the 47 individuals who participated in the Pathways, LEAD, and ANELP programs, ANTHC hosted Dare to Lead Workshops: In Q2, ANTHC sent 38 managers and leaders to a Dare to Lead Workshop. In Q3, a pilot group of 14 ANMC leaders, 36% of those were Alaska Native or American Indian, participated in an additional workshop focused on integrating ANTHC's values into our daily work.
- **Administrative Fellow Program:** This two-year rotational program currently includes two Alaska Native fellows and provides hands-on experience and mentorship opportunities alongside senior leadership across the consortium, enabling them to gain a holistic understanding of healthcare administration.

# *Empower the Workforce*

## 4) Workforce Development and Succession Planning FY2024

**Measure Definition –** Focus and improve the effectiveness of workforce development initiatives ensuring alignment with strategic goals and growth across all levels of the organization.

| Action Items | Status |
|---|---|
| 1. Identify high-potential leaders at the Senior Director and above levels using 9-box succession planning mapping and create individualized development plans to cultivate growth. | Complete |
| 2. Implement an administrative fellow program for Alaska Native/American Indian (AN/AI) masters-prepared talent. | Complete |
| 3. Enhance director-level professional development offerings, focusing on skills for effective management in change management processes, 90-day planning, and driving organizational alignment. | Complete |
| 4. Implement CLIMB program to create space for lower level employees to gain skills to move to high level roles. (CLIMB is a workforce development program to create space for employees to grow their potential to move to higher level roles within ANTHC.) | Complete |

**FY24 Results:** 120% target met (September 2024)

**FY24 Targets:**

**80%** 3 of 4 action items completed by end of year

**100%** 4 of 4 action items completed by end of year

**120%** Completion of significant accomplishment beyond these 4 action items that materially improves workforce development programming

**Year End Summary:**

1. **Succession Planning:** HR has successfully completed the high-potential leadership identification and development initiative. Through rigorous evaluation using 9-box succession planning mapping, promising leaders at the Senior Director level and above have been identified. Subsequently, individualized development plans have been created to address growth, stretch opportunities, and enhance their leadership skills. These plans are tailored to address specific developmental needs and align with organizational goals.
2. **Administrative Fellow Program:** ANMC successfully recruited and hired two Alaska Native candidates who started in Q3 for the Administrative Fellow Program, aimed at cultivating emerging leaders in healthcare administration. This two-year rotational program provides fellows with hands-on experience and mentorship opportunities alongside senior leadership across the consortium, enabling them to gain a holistic understanding of healthcare administration.
3. **Director-Level Professional Development:** The Training and Development team is enhancing onboarding and leadership programs to align with the ANTHC Strategic Plan. Initiatives include a revamped Leadership Foundations program for new managers, Change Management training through Prosci, and the development of new curriculum for employee professional development.
4. **CLIMB:** The CLIMB initiative is a new professional development program designed for early-in career employees. Through micro learning modules emphasizing essential skills, CLIMB focuses on real-world practice and continuous learning across 5 themes and 14 micro learning sessions. Cohort A, from March to April, had 33 participants from HR-Talent Bank and Patient Housing, with 70% identifying as Alaska Native or American Indian people. Cohort B, from May to June, included 66 participants from Security (day shift), Medicaid Travel Office, and Patient Experience, with 77% identifying as Alaska Native or American Indian. Cohort C consisted of 21 participants from Security (night shift), Internal Medical Outpatient, and Hospital Administration. The CLIMB program is designed to have a significant impact on growing AN/AI leaders who are early in their careers, fostering essential skills and providing real-world practice to support their professional development.

# Empower the Workforce

## 5) Employee Communications and Resources FY2024

**Measure Definition –** Strengthen and align internal communication strategy to empower employees at all levels and support strategic plan implementation.

| Action Items | Status |
|---|---|
| 1. Facilitate development of a cross-divisional strategic internal communications plan for FY24, with priority actions and roles and responsibilities clearly defined. | Complete |
| 2. Provide technical assistance and resources to departments to support strategic internal communications plan implementation. | Complete |
| 3. Monitor implementation and establish baseline metrics. | Complete |
| 4. Establish an internal communications calendar to accompany plan and support execution. | Complete |
| 5. Coordinate quarterly senior leadership updates to staff. | Complete |

**FY24 Results:** 120% target met (September 2024)

**FY24 Targets:**

**80%** 4 of 5 action items completed by end of year

**100%** All action items completed by end of year; cross-divisional strategic internal communications plan developed by end of Q1

**120%** All action items completed by end of year; cross-divisional strategic internal communications plan and internal communications calendar developed by end of Q1

**Year End Summary:**

The end of the fiscal year closed out the FY24 cross-division strategic internal communications plan—including the one-time projects, recurring initiatives, and weekly meetings that served as the plan's framework. The final quarter of activities benefited from the collaborative foundation, tools, and processes Marketing & Communications established with departments and leaders across the Consortium throughout the year.

Key initiatives in the final quarter included:

- Continued engagement with Human Resources to increase the number of employees who completed the Employee Engagement Survey. This year, a record number of employees took that opportunity and ANTHC's overall score saw a statistically significant improvement.
- Near completion of a new and improved career website. Initiated by Marketing and Communications, this months-long process has involved multiple department leaders, a communications plan centered on an employee value proposition, and a complete overhaul of the website that currently houses all open positions for the organization. With the completion of this improved website, anticipated in Q1 of FY25, ANTHC will have a career landing page that matches the caliber of employees we hope to attract.
- The digital signage pilot project was a success, resulting in an investment of over $80,000 in a comprehensive digital signage program that will provide coverage throughout campus and at the Ted Stevens International Airport for incoming patients. With the introduction of digital signs, Marketing and Communications is seeing increased requests to display information—a clear sign that medical staff at ANMC are seeing the benefit of this technology.

Marketing's service line managers have continued to update the internal communications plan established in earlier quarters, supporting the development of an FY25 plan. The department has also established baseline engagement metrics through the communications tools used to reach employees, including The Hub employee information page, SharePoint intranet, and employee emails. A Marketing and Communications scorecard monitors web traffic, most visited pages, open rates of employee emails, and SnapComms messages to advise on the effectiveness of messaging strategies. We now have enough data to inform decisions on methodologies to communicate more effectively.

# *Empower the Workforce*

## 6) Clinical and Professional Workstations FY2024

**Measure Definition –** Ensure staff have access to clinical and professional workstations that meet industry standards. Replace up to 50% of aging employee desktops/laptops (1,400) and 100 clinical Workstations on Wheels (WOWs) at ANMC.

**FY24 Results:** 1,396 (September 2024) – 100% target met

**FY24 Targets:**

**80%** 1,000

**100%** 1,250

**120%** 1,500

**Year End Summary:**

Through September HIT has deployed 1,304 employee desktops/laptops and 92 clinical Workstations on Wheels (WOWs). The rollout of WOWs is particularly complex and requires HIT to work in close partnership with the Chief Nursing Officer, Chief Medical Officer, and Chief Medical Informatics Officer. The result has reduced the turnaround time for booting up WOWs from 8 minutes to 90 seconds and improved both provider experience and efficiency. This project will continue in FY2025 and held to the same targets as an operational measure (instead of a Board-level measure). At the end of FY2025, we will pivot to following refresh/replacement schedule: 3 year laptop replacements, 5 year desktop replacements, and 5 year WOW replacements.

# Enhance the System of Care

## 7) Electronic Health Record Strategy FY2024

**Measure Definition –** Successfully implement accelerated FY24 EHR roadmap and advance overall EHR strategy.

| Action Items | Status |
|---|---|
| 1. Complete Cerner Upgrade | Complete |
| 2. Implement Cerner Revenue Cycle kit for Health Plan Master | Complete |
| 3. Implement Cerner Revenue Cycle kit for DNFB Reduction | Complete |
| 4. Engage key stakeholders to assess EHR alternatives | Ongoing in FY25 |
| 5. Engage key stakeholders to develop FY25 priorities, roadmap and strategy | Complete |

**FY24 Results:** 80% target met (September 2024)

**FY24 Targets:**

**80%** 4 of 5 action items completed by end of year

**100%** 5 of 5 action items completed by end of year

**120%** Completion of significant accomplishment beyond these 5 action items such as Nursing Documentation that materially improves functionality/use of the EHR

**Year End Summary:**

1. Complete Annual Cerner Code Upgrade
   - Complete
2. Implement Cerner Revenue Cycle kit for Health Plan Master
   - Complete
3. Implement Cerner Revenue Cycle kit for DNFB Reduction
   - Complete
4. Engage key stakeholders to assess EHR alternatives
   - Released and selected RFP for external vendor assessment. Stakeholder engagement to continue to FY25.
5. Engage key stakeholders to develop FY25 priorities, roadmap and strategy
   - The bridge plan documented and agreed to. We continue to flex in projects as necessary to fulfill internal and state-wide partner needs.
6. Completion of significant accomplishment beyond these 5 action items such as Nursing Documentation that materially improves functionality/use of the EHR
   - Significant ESD Expansion work was completed for new beds. In addition, RapidAI was deployed for diagnostic enhancements. The ilocal pharmacy lockers were deployed at SCF for patients to pick up prescriptions at their convenience. Several other small THO deliverables were deployed as the team flexed around Cerner contract delays.

# Enhance the System of Care

## 8) Patient Travel and Housing FY2024

**Measure Definition –** Advance Statewide and ANTHC Patient Travel and Housing objectives.

| Action Items | Status |
|---|---|
| 1. Provide facilitation support to FY24 Travel summit(s) and workgroups | Complete |
| 2. Formal Alaska Tribal Health System Travel Initiative with IHS | Complete |
| 3. Update and share ANTHC Travel and PRC policies | Complete |
| 4. Continue to advance improvements to achieve average Patient Housing check-in within 30 minutes or less | Complete |
| 5. Establish Patient Housing check-out time | Complete |
| 6. Establish processes to ensure patient escorts understand responsibilities and THO's informed on breaches | Complete |
| 7. Increase patient communication through process and technology advances | Complete |
| 8. Complete ANMC Patient Housing Assessment and present findings to Board | Complete |

**FY24 Results:** 120% target met (September 2024)

**FY24 Targets:**

**80%** 6 of 8 action items completed by end of year

**100%** 7 of 8 action items completed by end of year

**120%** 8 of 8 action items completed by end of year

**Year End Summary:**

1. Provide facilitation support to FY24 Travel summit(s) and workgroups
   - Successfully hosted November 2023 Travel Summit (and prepared update for October 2024 Tribal Health Forum).
   - Continued to support workgroups in FY24 and made significant progress toward closing FY24 Travel Summit workgroup action plans (workgroups have now evolved into advisory committees).
2. Formal Alaska Tribal Health System Travel Initiative with IHS
   - In FY24, Intergovernmental Affairs (IGA) submitted two formal initiatives to IHS: 1) In May, ANTHC submitted a $5 million request from the IHS Director's Emergency Fund to address immediate funding gaps related to the high cost of patient travel in Alaska. 2) In August, ANTHC submitted a proposal to establish an intermediate risk pool demonstration project for high cost travel in order to create a financing mechanism to assist T/THOs that must pay for extremely high cost ground ambulance and medivac flights. Payment for these costs is likely through the Catastrophic Health Emergency Fund (CHEF); however, it can take 12 to 24 months meaning that some T/THOs must tap limited PRC funds restricting availability for other needs.
3. Update and share ANTHC Travel and PRC policies
   - In FY24, PRC policies were updated and shared through email, online training, and in the October Alaska Tribal Health Forum packet materials.
   - Travel policies are up-to-date and were shared with THOs through a variety of means in FY24. ANTHC is actively working on resolution of Statewide air ambulance cost concern through the Board-recommended Medevac Taskforce, which could lead to future updates to ANTHC's Travel policies.
   - The ANTHC Housing policy was also updated in FY24 and is currently pending final review.
4. Continue to advance improvements to achieve average Patient Housing check-in within 30 minutes or less
   - Implemented new tracking and several strategies to reduce check in time.
   - In September 2024, 97% of patients received their room key within 30 minutes.
5. Establish Patient Housing check-out time
   - Check-out time at 12:00pm began November 1 with a check-in time of 4:00pm.

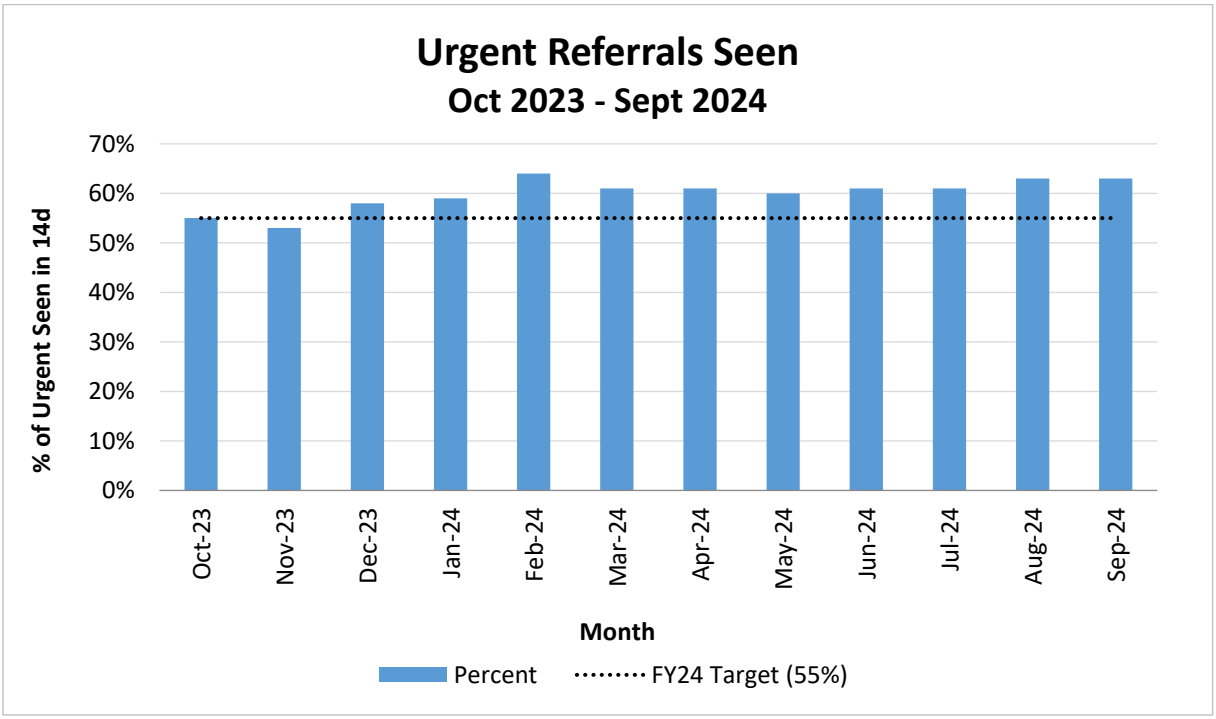
## 8) Patient Travel and Housing FY2024

6. Establish processes to ensure patient escorts understand responsibilities and THO's informed on breaches
   - Updated Patient Housing rules to cover patient escorts; rules are available in the Patient Housing packets that are mailed, available online, and provided upon check in.
   - Patient Housing established a reporting process through box.com to notify THOs of Patient and Patient Escort breaches; continued improvements are planned to automate future notifications and include all evictions as well as photo documentation where available.
7. Increase patient communication through process and technology advances
   - Integrated Patient Experience staff desk in Patient Housing lobby.
   - Implemented virtual queues to streamline Patient check in and help facilitate meal cards, taxi cards, etc.
   - Established Patient Housing Hotline 844-729-8430 and PEC 360 for appointment reminders.
   - Implemented patient and THO Advisory meetings to provide regular forum for direct feedback.
   - Added shuttle campus maps inside the shuttles.
   - Launched new patient travel packet in September 2024.
8. Complete ANMC Patient Housing Assessment and present findings to Board
   - The Patient Housing Assessment was completed and presented at the June 2024 Directors meeting.

# Enhance the System of Care

## 9) Urgent Referrals Seen FY2024

**Measure Definition –** Percentage of patients with urgent referrals who receive care in ANMC Specialty clinics within 14 days of referral being sent.




**FY24 Results:** 63% (September 2024) – 120% target met

**FY24 Targets:**

**80%** 50%

**100%** 55%

**120%** 60%

**Year End Summary:**

Overall, Specialty Clinics have increased the percentage of patient seen with urgent referrals within 14 days from 54% (baseline) to 63% by end of fiscal year. Thirteen (13) or 60% of the specialty clinics have met or exceeded the annual target. All specialty clinics receive weekly reports to prioritize urgent referral scheduling and are in the process of building and utilizing schedule templates to standardize operations to create more availability for patient appointments. For clinics with a high volume of incoming urgent referrals, they added urgent slots on their provider schedule templates. In August, the specialty clinics updated the urgent referral guidelines for case managers and providers.

The specialty clinics that made the most improvement are Ear, Nose, and Throat from 71% to 100%; Neurosurgery from 22% to 92%; and Rheumatology from 22% to 58% patients seen within 14 days.

The specialty clinics will partner with clinical leadership to establish action plans for FY25 for clinics that still have areas for improvement.

## 10) Strategic Business Assessments FY2024

**Measure Definition –** Develop framework that reviews volume, quality, safety, workforce, financial performance, and other inputs to identify opportunities for enhanced strategic, operational, and financial alignment. Initial assessments to include one DEHE program, one Business Support department, and at least two ANMC service lines.

**FY24 Results:** 4 (September 2024) – 80% target met
**FY24 Targets:**
**80%** 4
**100%** 5
**120%** 6

**Year End Summary:**
In FY24, the Strategy Office successfully completed four Strategic Business Assessments (SBAs):

1. **Department of Environmental Health and Engineering (DEHE)** – Presented at the February Board Meeting
2. **Patient Housing** – Presented at the June Board Meeting
3. **Purchased/Referred Care** – Presented at the June Board Meeting
4. **Surgical Services** – Presented at the August Board Meeting

As we look ahead to FY25, this measure will no longer be tracked in the scorecard. However, the Strategy Office will continue to support the organization through ongoing strategic business assessments and analyses, as directed by executive leadership.

# Enhance the System of Care

## 11) First Service Community Projects FY2024

**Measure Definition –** Number of First Service Community projects (27 total) where DEHE has met planning phase milestones, including community project kick-off, selection of preferred alternative, and Preliminary Engineering Report (PER) submission to IHS. Completion is required for communities to be eligible to apply for Infrastructure Investment and Jobs Act (IIJA) funding.

**FY24 Results:** 22 (September 2024) – 100% target met
**FY24 Targets:**
**80%** 20
**100%** 22
**120%** 24

**Year End Summary:**
Twenty-two first service communities have met all three planning milestones, which will help set them up to seek funding for their first service project. The three planning milestones are: community planning project kick-off, community selection of preferred first service project, and submission of the planning report ("preliminary engineering report" or "PER") to Indian Health Service. Eight of the 22 communities received Fiscal Year 2024 Indian Health Service (IHS) funding for their first service project through the Infrastructure Investment and Jobs Act ("IIJA" aka Bipartisan Infrastructure Law, "BIL"). The remaining 14 communities that met all three milestones will seek FY2025 IHS funding for their first service project. Completing the planning milestones is not a guarantee of funding. IHS approval of the Tier 1 ("ready to fund") status is required for a project to be considered for funding. Projects will be funded in priority order based on their scores in the IHS Sanitation Deficiency System (SDS). Tribal Health Organizations (THOs) can impact the project scores by applying tribal points to a set number of SDS projects each year. THOs assigned tribal points assignments to their top SDS projects in July before IHS initiated its project reviews for the FY2025 funding cycle. Once IHS completes its review and approval of the Tier 1 status, THOs will have an opportunity to reassign their points to projects that received IHS Tier 1 approval. IHS will lock SDS in November for the FY2025 funding cycle and the funded projects will be announced in spring 2025.

Fiscal year 2025 is the second to last year of the IIJA. Not all 14 communities will receive FY2025 IHS IIJA funding because the total project costs exceed the amount of FY2025 IHS IIJA funding nationwide. The projects that don't receive FY2025 funding will seek FY2026 IIJA funding. The work to request FY2026 funding (final year of the infrastructure funding) will take place in summer 2025. IHS indicated in June 2024 that there may not be sufficient IIJA funding for all the first service projects. More will be learned about the remaining IIJA funding during the FY2025 IHS IIJA Tribal consultation, which is expected to take place in early 2025.

Completing the three planning milestones over the past year was an immense effort for the communities as well as the consultants and ANTHC and VSW staff. The first service communities face the most constraints and challenges in providing running water and piped sewer, which is the main reason that the IIJA is their best opportunity to make piped water and sewer a reality. It is also the reason that there is not one clear-cut obvious project for each community to pursue and the reason that so much effort was required to achieve the three planning milestones. Community engagement and close collaboration among the involved parties were critical to identifying the selected alternatives for first service, gathering the data that IHS demands, responding to myriad comments from reviewers and funding agencies, and adjusting to moving goalposts, requirements, and deadlines set by the funding agencies. These tasks include, but are not limited to, site visits, data gathering, evaluating capacity of the local water sources and electrical generation facilities to support improved level of water and sewer service, consideration of environmental impacts such as flooding, erosion, and permafrost degradation, report writing, technical review and comment, rewrites based on the reviews, local and regional engagement with schools and commercial entities that are important customers for water and sewer utilities, and community-wide meetings to narrow down the possible projects to one selected project. Community and THO participation is critical for the process and scheduling the meetings to maximize participation is challenging.

# Enhance the System of Care

## 12) Statewide Tribal Public Health Assessment FY2024

**Measure Definition –** The Statewide Tribal Public Health Assessment is an assessment of the Alaska Tribal Health System's capacity to deliver foundational public health services that will help inform ANTHC's efforts to align public health initiatives with the strategic direction.

| Action Items | Status |
|---|---|
| 1. Complete all required staff trainings for Public Health Accreditation Board (PHAB) readiness assessment. | Complete |
| 2. Complete project charter for statewide assessment. | Complete |
| 3. Complete key informant interviews with regional THOs. | Complete |
| 4. Complete PHAB readiness assessment. | Complete |
| 5. Complete executive summary report for the Statewide Tribal Public Health Assessment. | Not Started |

**FY24 Results:** 100% target met (September 2024)
**FY24 Targets:**
**80%** 3 of 5 action items completed by end of year
**100%** 4 of 5 action items completed by end of year
**120%** 5 of 5 action items completed by end of year

**Year End Summary:**
As of the end FY24, the 100% target was achieved. A first draft of the final report is estimated to be completed by early November, and an executive summary will be completed by the end of FY25 Q1.

1. **Key Informant Interviews (KII) Update:** KIIs for this project are now considered to be fully complete, and no additional KIIs with regional THO staff are anticipated. In total, staff completed interviews with 44 key informants. Of these 44 key informants, 38 were with staff of regional Alaska Tribal Health Organizations (THOs) and 20 regional THOs were represented by a KII. An additional 6 interviews were completed with key informants not working at a regional Alaska THO; two (2) with staff from the State of Alaska Division of Public Health, two (2) with ANTHC staff, one (1) with staff from the Alaska Area Native Health Services, and one (1) former THO staff.
2. **PHAB Readiness Assessment Update:** The PHAB Readiness Assessment was completed and the assessment was submitted to PHAB in March. In April, ANTHC received results and a response from PHAB, which is being reviewed for possible relevant action items.
3. **Executive Summary and Final Tribal Public Health Assessment (TPHA) Report Update:** Qualitative analysis for the project is complete, and gaps and opportunities have been identified and catalogued. The initial draft of the final report is underway. Staff anticipate the first draft to by early November. Work on the executive summary will begin as soon as the draft of the final report has been completed.

**Next steps:** Complete the in-progress first draft of the final report and begin work on the executive summary. Staff also anticipate responding to additional requests for analysis of results as needed. After the full report and executive summary have been finalized, staff will share results to the appropriate audiences.

# *Achieve Performance Excellence*

## 13) Establish Revenue Cycle Scorecard FY2024

**Measure Definition –** Develop, roll out, and adopt a Revenue Cycle scorecard to help monitor and manage performance.

| Action Items | Status |
|---|---|
| 1. Develop and roll out version 1 of scorecard | Complete |
| 2. Provide training and documentation to end users | Complete |
| 3. Develop and roll out priority enhancements to scorecard | Complete |
| 4. Adopt scorecard to help monitor and manage performance | Complete |

**FY24 Results:** 120% target met (September 2024)

**FY24 Targets:**

**80%** All action items completed by end of year

**100%** Version 1 Scorecard rolled out by end of Q2 and all other action items completed by the end of the year

**120%** Version 1 Scorecard rolled out by end of Q1 and all other action items completed by the end of the year

**Year End Summary:**

During October, Revenue Cycle department successfully completed version 1.0 of a Revenue Cycle scorecard. The scorecard was rolled out internally to help manage department performance, as well as included in the month end consolidated financial statements. The Revenue Cycle team continues to enhance and leverage the scorecard to manage performance and report to the Board on progress.

# *Achieve Performance Excellence*

## 14) Establish Operational Scorecard FY2024

**Measure Definition –** Develop, roll out, and adopt Operational scorecards for two divisions, ANMC and DEHE, to help monitor and manage performance.

| Action Items | Status |
|---|---|
| 1. Develop and roll out version 1 of operational scorecards for two divisions | Complete |
| 2. Provide training and documentation to end users | Complete |
| 3. Develop and roll out priority enhancements to scorecard | Complete |
| 4. Adopt scorecard to help monitor and manage performance | Complete |

**FY24 Results:** 120% target met (September 2024)

**FY24 Targets:**

**80%** All action items completed for one division completed by end of year

**100%** All action items completed for two divisions completed by end of year

**120%** Version 1 ANMC Operational Scorecard rolled out by end of Q1; all other action items completed for two divisions by end of year

**Year End Summary:**

During Q1, ANMC leadership and the Data & Analytics team partnered to develop and rollout Version 1.0 of ANMC Operational Scorecard developed using PowerBI. This comprehensive scorecard encompasses key aspects of ANMC's Emergency Services Department, inpatient length of stay, readmissions, and surgical services. Additional enhancements were made in subsequent quarters to enable self-service analytics and refine the methodology supporting key measures like readmissions. The operational scorecard is currently accessible in Power BI and is distributed daily alongside other executive reporting notifications, including the CFO Daily Indicators.

During Q2, DEHE developed a first draft of its Operational Scorecard, establishing a set of initial KPIs to help the leadership team monitor operational and strategic objectives. This scorecard was first presented to the Executive Council during DEHE's Monthly Operating Review for March and is now updated and reviewed monthly.

# *Achieve Performance Excellence*

## 15) Establish Medicaid Redetermination Scorecard FY2024

**Measure Definition –** Develop, roll out, and adopt a Medicaid Redetermination scorecard to help monitor and manage performance.

| Action Items | Status |
|---|---|
| 1. Develop and roll out version 1 of scorecard | Complete |
| 2. Provide training and documentation to end users | Complete |
| 3. Develop and roll out priority enhancements to scorecard | Complete |
| 4. Adopt scorecard to help monitor and manage performance | Complete |

**FY24 Results:** 120% target met (September 2024)
**FY24 Targets:**
**80%** All action items completed by end of year
**100%** Version 1 Scorecard rolled out by end of Q2 and all other action items completed by the end of the year
**120%** Version 1 Scorecard rolled out by end of Q1 and all other action items completed by the end of the year

**Year End Summary:**
The Medicaid Redeterminations scorecard was first developed in December 2024 and successfully went live with our partnering Tribes & Tribal Health Organizations (T/TTHOs) in February 2024. The Medicaid Redeterminations scorecard serves as a valuable resource, offering both data and insights for ANTHC and T/THOs that use the shared Cerner domain. Feedback received during our Shared Tribal Analytics & Reporting (STAR) meetings highlighted the tool's effectiveness in prioritizing screening for patients with upcoming appointments.

# *Achieve Performance Excellence*

## 16) Establish Margin Management Scorecard FY2024

**Measure Definition –** Develop, roll out, and adopt a Margin Management scorecard to help monitor and manage performance.

| Action Items | Status |
|---|---|
| 1. Develop and roll out version 1 of scorecard | Complete |
| 2. Provide training and documentation to end users | Complete |
| 3. Develop and roll out priority enhancements to scorecard | Complete |
| 4. Adopt scorecard to help monitor and manage performance | Complete |

**FY24 Results:** 120% target met (September 2024)
**FY24 Targets:**
**80%** All action items completed by end of year
**100%** Version 1 Scorecard rolled out by end of Q2 and all other action items completed by the end of the year
**120%** Version 1 Scorecard rolled out by end of Q1 and all other action items completed by the end of the year

**Year End Summary:**
During Q1, leaders from across multiple departments partnered with Finance to develop and rollout Version 1.0 of a Margin Management Scorecard. The scorecard was designed to track net margin improvement by area in alignment with the Financial Plan and anticipated timelines for benefit realization monthly to enable leadership to monitor the success of identified margin improvement efforts. The scorecard was presented to the leadership team in December with fiscal year results through November and management has continued to leverage the scorecard to drive positive results and monitor progress towards margin improvement goals. Enhancements throughout the year focused on clarifying the process of identifying new margin management initiatives as they move from ideas to approved initiatives, projecting impact, and collating the necessary information monthly.

# *Achieve Performance Excellence*

## 17) Emergency Services Expansion FY2024

**Measure Definition –** Complete Board-directed FY24 Emergency Services Expansion funding, design and construction milestones.

| Action Items | Status |
|---|---|
| 1. Complete funding analysis to support Board decision (May 2024) | Complete |
| 2. Submit necessary materials to IHS for approval (May 2024) | Complete |
| 3. Complete 100% design for initial ESD renovation (March 2024) | Complete |
| 4. Complete 100% design for tower core and shell (September 2024) | Complete |
| 5. Award initial construction work package (March 2024) | Complete |
| 6. Complete Orthopedic Clinic Move to ULMC (May 2024) | Complete |
| 7. Complete renovation of vacated Ortho space in hospital (March 2025) | In Progress |
| 8. Establish ESD and ambulance temporary entrances (August 2024) | Complete |

**FY24 Results:** 100% target met (September 2024)
**FY24 Targets:**
**80%** 6 of 8 action items completed by end of year
**100%** 7 of 8 action items completed by end of year
**120%** 8 of 8 action items completed by end of year

**Year End Summary:**

- ANMC Temporary Emergency Services Department (ESD) opened on September 7. Patients now present for emergency care to the Temporary ESD, located on the southeast side of the ANMC hospital.
- New Fast Track (existing Ortho) targeting completion in March 2025.
- Demolition of the entry to the old Emergency Department is tentatively scheduled early October.
- Construction crews continue demolition of the exterior brick on the east side of the ANMC hospital in the north corner, and of existing footings and retaining walls. Demolition of the old ambulance bay also remains under way.
- In early October, Phase 1B work also began: Interior framing, gypsum wall board, and insulation are all going up, and the overall phase includes waste piping and ventilation installation, concrete pouring, trenching, and ductwork through the second-floor courtyard.

# Achieve Performance Excellence

## 18) Short-Term Skilled Nursing Facility FY2024

**Measure Definition –** Initiate Board-directed construction of a Short-Term Skilled Nursing Facility (SNF) on campus.

| Action Items | Status |
|---|---|
| 1. Enter into development and management agreements with SNF partner | Ongoing |
| 2. Secure project funding | Complete |
| 3. Finalize SNF design with Alaska Native interior design elements | Complete |
| 4. Issue notice to proceed construction | Complete |

**FY24 Results:** 80% target met (4 out of 5 action items; September 2024)

**FY24 Targets:**

**80%** Enter into development and management agreements with SNF partner (action item # 1)

**100%** Enter into development and management agreements with SNF partner (action item # 1), secure project funding (action item # 2)

**120%** Finalize design and issue notice to proceed construction (action items 1-4)

**Year End Summary:**

ANTHC has made significant progress on this important project, including entering into four agreements (for construction consulting services, architecture and design services, general contracting services and construction management services), securing project funding, finalizing the design, issuing the notice to proceed, preparing the site for construction, completing the utility tie-ins and installing deep utilities. Construction of footers, foundation and stem walls is currently underway. Steel is expected to begin going up in Q1 of FY25.

The work associated with action item #1 shifted during FY24 and remains ongoing. As management gained a more nuanced understanding of project contracting needs, we discovered that four key contracts (described above) instead of a single development contract with Maple Springs would be needed to support a successful design and construction phase. This updated information was brought to the Board of Directors for review and modified approval in February 2024. Subsequent to the February board meeting, we executed all agreements necessary to support proceeding with FY24 design and construction activities. The management agreement was roughly 85% negotiated but final issue resolution and execution of the management agreement was intentionally shifted to FY25. The management agreement is not slated to begin until approximately six months before opening so executing the agreement in FY25 does not place the overall timeline at risk. Additionally, management believes pushing final negotiations and execution of the management agreement benefits ANTHC as we will have more confidence in the project, more clarity in the final design of the facility, which impacts the clinical and other services that can be provided, and more time for discovery to ensure the contract is as comprehensive as possible.

# Achieve Performance Excellence

## 19) Master Site Facilities Plan FY2024

**Measure Definition –** Initiate stakeholder-driven assessment and planning process to update Master Site Facilities Plan.

| Action Items | Status |
|---|---|
| 1. Complete initial assessment of services and sites, including ANMC and APU lands | Complete |
| 2. Data collection and analysis | Complete |
| 3. Conduct stakeholder interviews | Complete |
| 4. Develop summary of findings, needs and initial recommendations | Complete |
| 5. Develop potential phasing and future expansion options | Complete |
| 6. Engage stakeholders to refine recommendations and phasing | Complete |

**FY24 Results:** 120% target met (September 2024)
**FY24 Targets:**
**80%** 4 out of 6 action items completed by end of year
**100%** 5 out of 6 action items completed by end of year
**120%** 6 out of 6 action items completed by end of year

**Year End Summary:**
During Q1 and Q2, the team progressed through Phases 1 & 2 of the project, nearly completing the Information-Gathering Process by collecting inputs from over 50 stakeholders, completing structural analysis as needed of all in-scope buildings across the ANTHC site, and developing a Gap List for use in future planning.

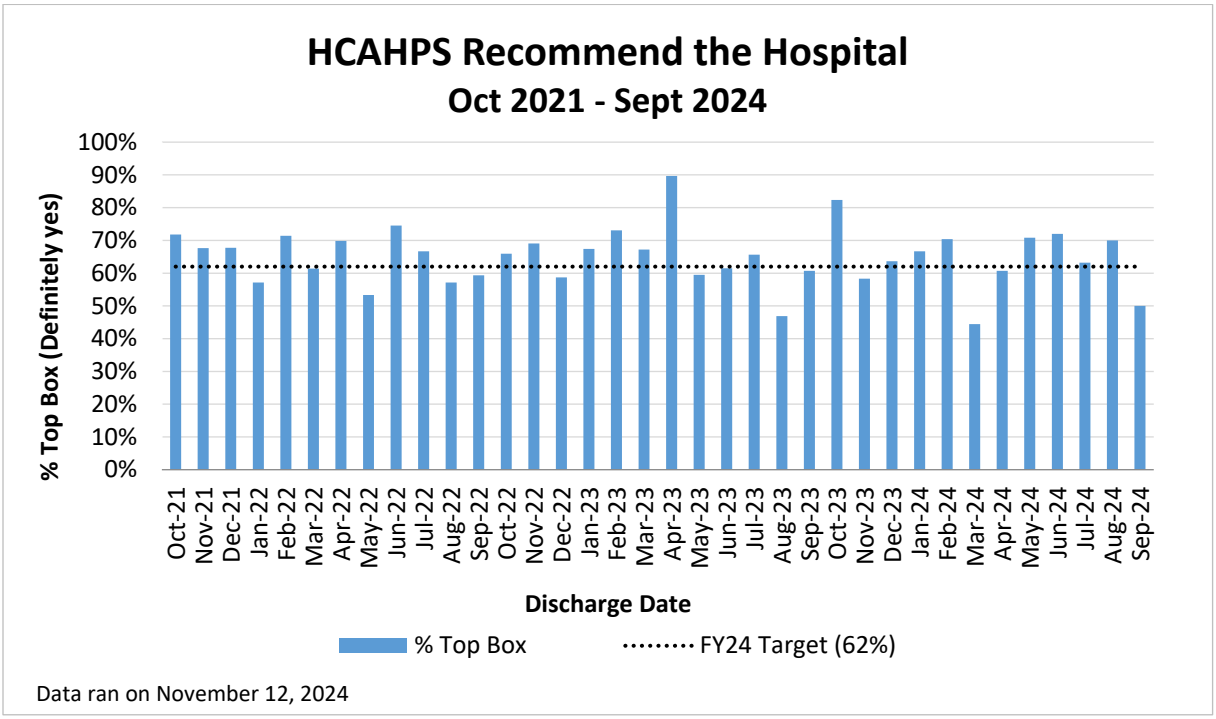
During Q3, the team completed a Gap List, prioritized the identified opportunities with the ANTHC Executive Steering Committee, and began to develop options for the site in the near term (3-5 years), mid-term (5-8 yrs.) and long term (8-12 yrs.). The ANTHC Board of Directors was engaged through individual interviews to gauge each member's priorities and vision for the campus, with their inputs being rolled into the development of the initial options.

During Q4, the MSFP team developed and refined the options for the MSFP based on Steering Committee feedback, as well as developed a preliminary phasing plan with cost estimates for each component/phase. The team is working to refine the recommendations and estimates and will present the MSFP to the Board in early FY2025 (likely Q2).

# Achieve Performance Excellence

## 20) HCAHPS Recommend the Hospital FY2024

**Measure Definition –** Percent of patients who reported "Yes, they would definitely recommend the hospital" ("Would you recommend this hospital to your friends and family?") on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.




Data ran on November 12, 2024

**FY24 Results:** 64% (October 2023 – September 2024) – 120% target met

**FY24 Targets:**

| | |
|---|---|
| **80%** | 60% |
| **100%** | 62% |
| **120%** | 64% |

**Year End Summary:**

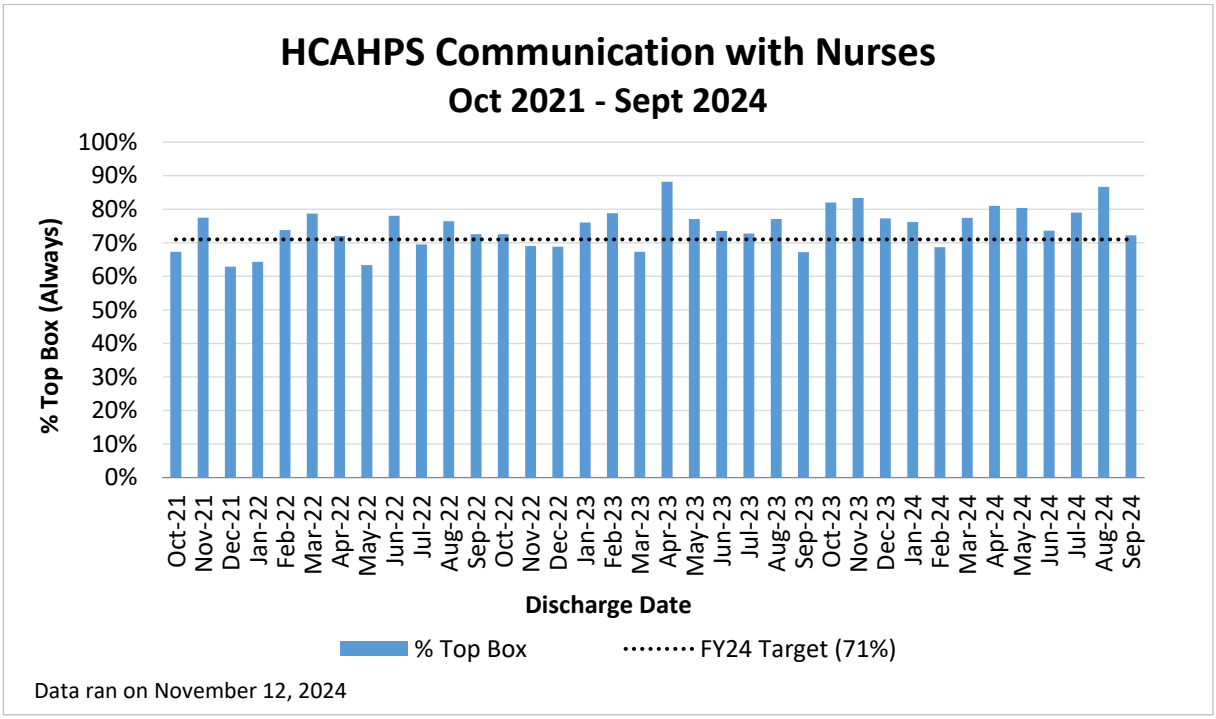
ANMC is currently meeting the FY24 120% target of 64% for Recommend the Hospital. The ANMC Top Box Score of 64.68% means ANMC is performing better than 30 percent of the All Press Ganey database of 2,380 reporting hospitals. Leader Rounding continues in all inpatient areas to complement other Patient Experience (PX) and patient safety initiatives: Hourly Rounding, Bedside Shift Report, Nurse Manager Rounding, 72 Hour Post-Discharge Calls, and Discharge Folders. These initiatives also provide opportunity to role model service standards-Acknowledge, Introduce, Duration, Explanation and Thank (AIDET), and service recovery while patients are admitted. Leadership continues collaboration with Press Ganey for best practices, provider engagement, optimization of current survey process and developing ways to increase survey response rates. Nurse leaders continue to submit myHero recognition appreciation for nurses positively recognized with weekly patient feedback. Patient Experience staff continue to submit myHero recognition appreciation for providers positively recognized with patient feedback.

N=269 surveys received for Oct 2023-Sept 2024

# Achieve Performance Excellence

## 21) HCAHPS Communication with Nurses FY2024

**Measure Definition –** Percent of patients who reported that their nurses "Always" communicated well (Nurses treat you with courtesy/respect, Nurses listen carefully to you and Nurses explain in way you understand) on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.




Data ran on November 12, 2024

**FY24 Results:** 77% (October 2023 – September 2024) – 120% target met

**FY24 Targets:**

**80%** 69%

**100%** 71%

**120%** 73%

**Year End Summary:**

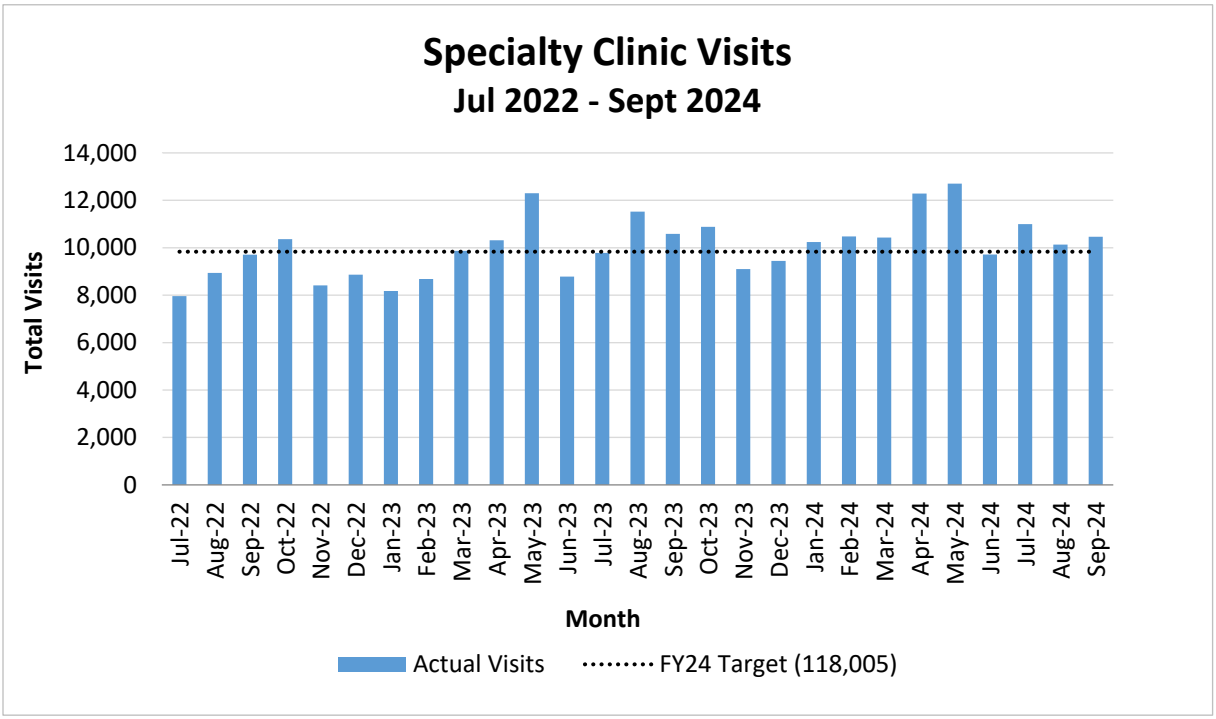
ANMC is currently exceeding the FY24 target of 71% for Communication with Nurses. The ANMC Top Box Score of 77.88% means ANMC is performing better than 35 percent (up from 31st percentile in August) of the All Press Ganey database of 2,389 reporting hospitals. Leader Rounding continues in all inpatient areas to complement other Patient Experience (PX) and patient safety initiatives: Hourly Rounding, Bedside Shift Report, Nurse Manager Rounding, 72 Hour Post-Discharge Calls, and Discharge Folders. These initiatives also provide opportunity to role model service standards-Acknowledge, Introduce, Duration, Explanation and Thank (AIDET), and service recovery while patients are admitted. Leadership continues collaboration with Press Ganey for best practices, provider engagement, optimization of current survey process and developing ways to increase survey response rates. Nurse leaders continue to submit myHero recognition appreciation for nurses positively recognized with weekly patient feedback. Patient Experience staff continue to submit myHero recognition appreciation for providers positively recognized with patient feedback.

N=275 surveys received for Oct 2023-Sept 2024

# Achieve Performance Excellence

## 22) Specialty Clinic Visits FY2024

**Measure Definition –** Number of in-person and telemedicine specialty clinic visits.




**FY24 Results:** 126,877 (September 2024) – 120% target met

**FY24 Targets:**

**80%** 112,386
**100%** 118,005
**120%** 123,625

**Year End Summary:**

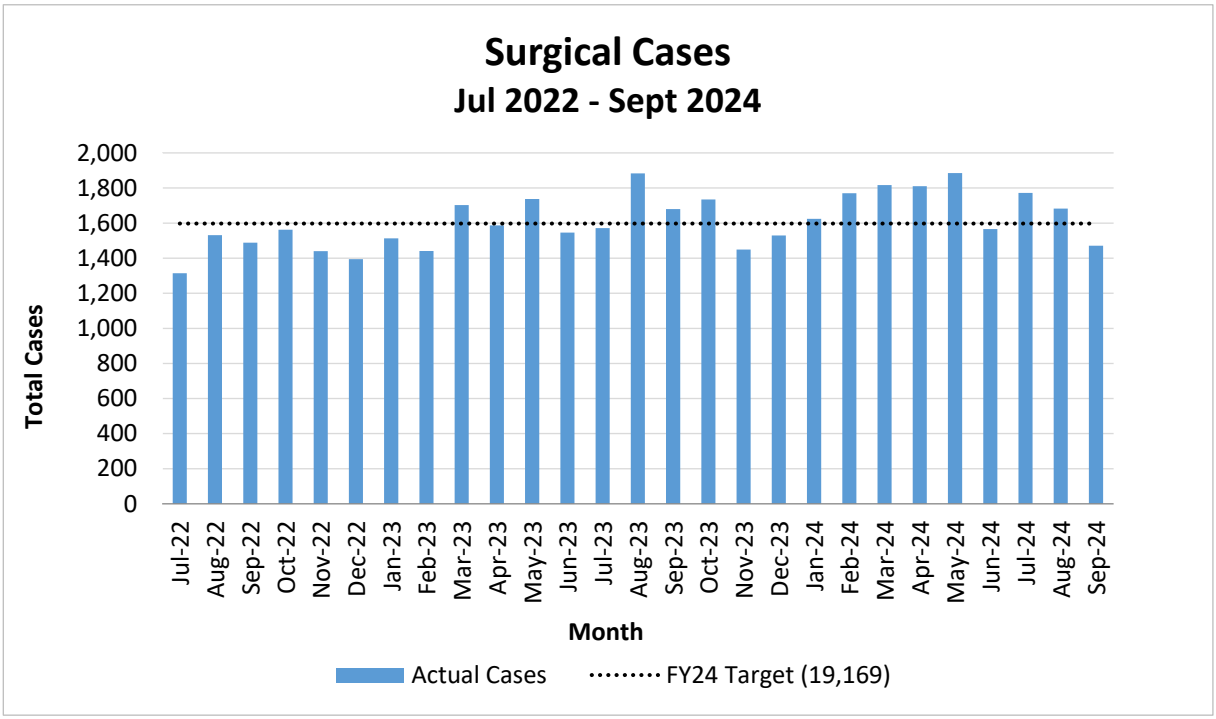
Specialty Clinics had a total of 10,467 visits in FY24-September. The most significant positive variances compared to FY23-September occurred in Ophthalmology with 283 more visits, ANMC Walk-in with 209 more visits, and Cardiology with 135 more visits. Cardiology increased the number of mid-level providers from 3 to 5. The most significant negative variances compared to FY23-Sept occurred in Orthopedics with 726 less visits, Oncology with 87 less visits, and Pain Management with 79 less visits.

In FY24, ANMC surpassed both the annual and stretch targets with a total of 126,877 in-person and telemedicine specialty clinic visits. There were 9,819 more visits compared to FY23 which represents a positive 8% variance. The most common causes of variation in performance were schedule management, provider time off, field clinic visits, providers dropping their own charges and continuing medical education. The special causes of variation were provider vacancies, lack of anesthesia support, and unfilled provider schedules. Specialty clinics have been working to recruit specialty providers, implement provider schedule templates and scheduling management guidelines to standardize scheduling practices within a specialty service. In Internal Medicine, this included time studies, assessments of clinical patient flow, appointment slot and duration, and implementation of co-locating Assistant Case managers from Internal Medicine clinics creating a centralized scheduling office. The Specialty Clinics will continue to expand standardized scheduling practices to outpatient surgical services departments in FY25.

# Achieve Performance Excellence

## 23) Surgical Cases FY2024

**Measure Definition –** Number of inpatient and outpatient surgical cases.




**FY24 Results:** 20,111 (September 2024) – 120% target met

**FY24 Targets:**

**80%** 18,256

**100%** 19,169

**120%** 20,082

**Year End Summary:**

Surgical cases year-to-date count came to 20,111, marking a 5.5% growth over the prior year. With the fiscal year now complete, ANMC exceeded its annual target. Quality initiatives this year focused on First Case on Time Starts (FCOTS), block time utilization, room turnover time, supply management, and improvements in high-level disinfection—all showing positive trends toward ensuring high-quality patient care.

Despite this growth, surgical demand still exceeds capacity, with anesthesia as the main roadblock. We currently have 11 locum anesthesia providers, and while we've successfully recruited anesthesiologists (MD/DO), CRNA recruitment remains challenging due to competition from surgery centers offering roles with no holidays, weekends, nights, or call shifts. In response, we're targeting CRNA schools and regularly reviewing our compensation to remain competitive.

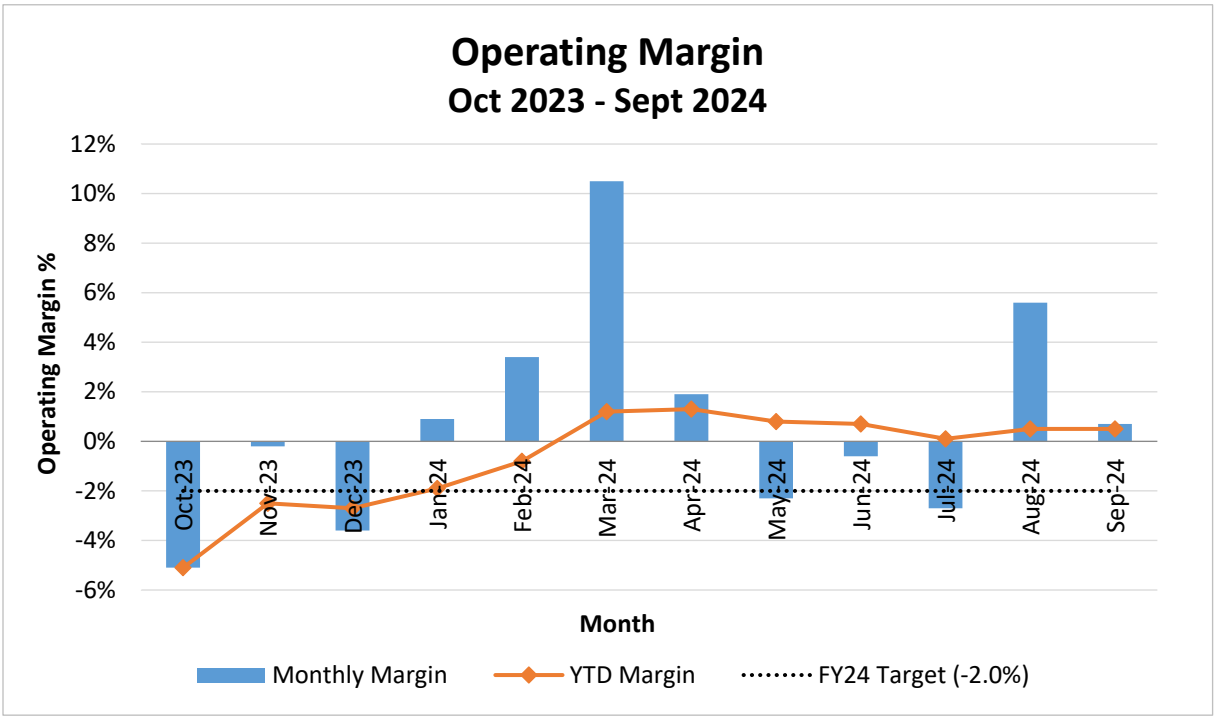
We're also planning to expand surgical services to Yukon-Kuskokwim for basic ENT procedures and strengthen our partnership with Tanana Chiefs Conference by adding general surgery, enabling more patients to receive care close to home.

New OR leadership has brought greater stability, which is already proving beneficial. However, the renovation of the Sterile Processing department is paused until spring to create a better environment.

# Achieve Performance Excellence

## 24) Operating Margin FY2024

**Measure Definition –** (Total operating revenue – Total operating expenses) / Total operating revenue




**FY24 Results:** 0.5% (September 2024) – 120% target met

**FY24 Targets:**

**80%** -3.2%

**100%** -2.6%

**120%** -2.0%

**Year End Summary (based on the draft/unaudited September 2024 Consolidated Financial Statement):**
ANTHC's FY24 operating margin was 0.5% compared to a target of -2.0%, which is favorable. Operating income was positive $5.2M compared to a projected loss of -$18.4M. When looking at the normalized financial returns excluding non-recurring impacts, operating income for the year would have been -$6.4M. These amounts are in-line with our financial projections and allow us to reaffirm our FY25 financial plan as presented to the Board in August.

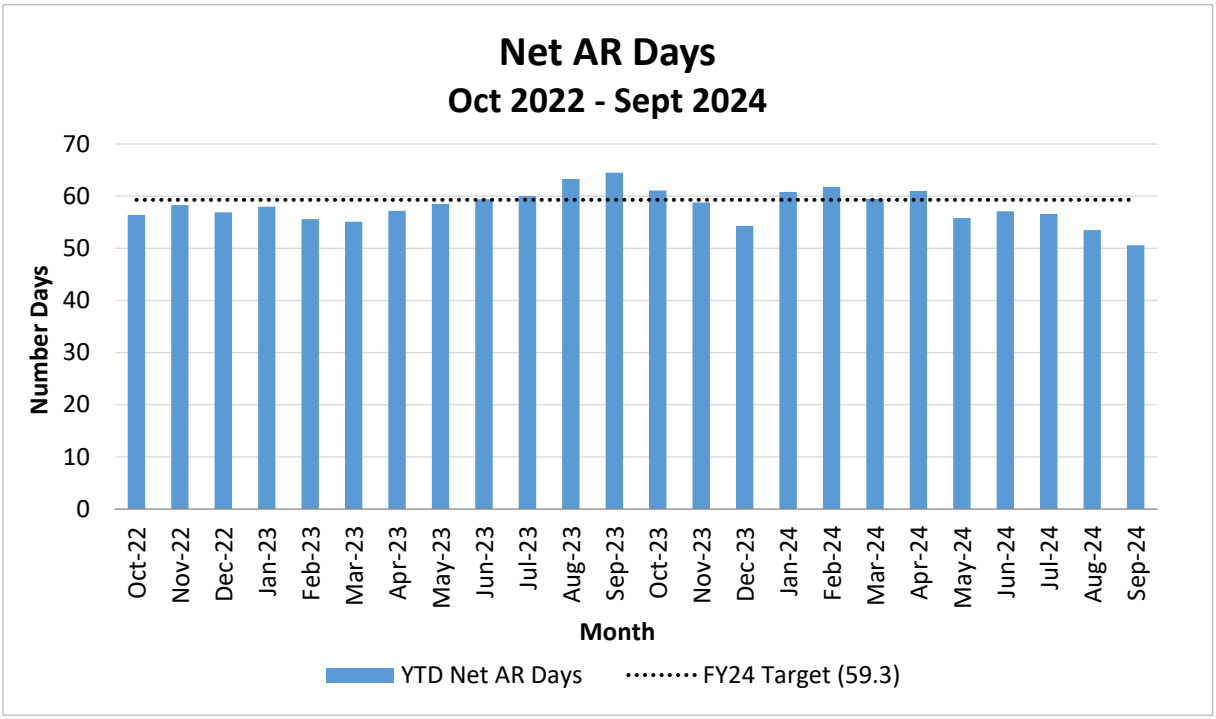
Numerous areas exceeded targets with ANMC leading the way. Strong volumes, more efficient cost measures put in place for nursing, significant revenue cycle improvement, and many other areas at ANMC exceeded targets. DEHE, CHS, APU, Springhill Suites – Marriot all exceeded their targets for the year. Strong margin management work from nursing, revenue cycle, supply chain, legal, intergovernmental affairs, and finance (as well as many others) all contributed to $50M+ in net margin management improvements during FY24.

The FY24 results are overwhelmingly positive. We generated a profit from operations, strengthened our overall financial health, improved processes, enhanced access to services, and improved staff and patient satisfaction.

# Achieve Performance Excellence

## 25) Net AR Days FY2024

**Measure Definition –** (Net patient accounts receivable x 365) / Net patient service revenue




**FY24 Results:** 50.6 days (September 2024) – 120% target met

**FY24 Targets:**

**80%** 61.3
**100%** 59.3
**120%** 57.3

**Year End Summary:**

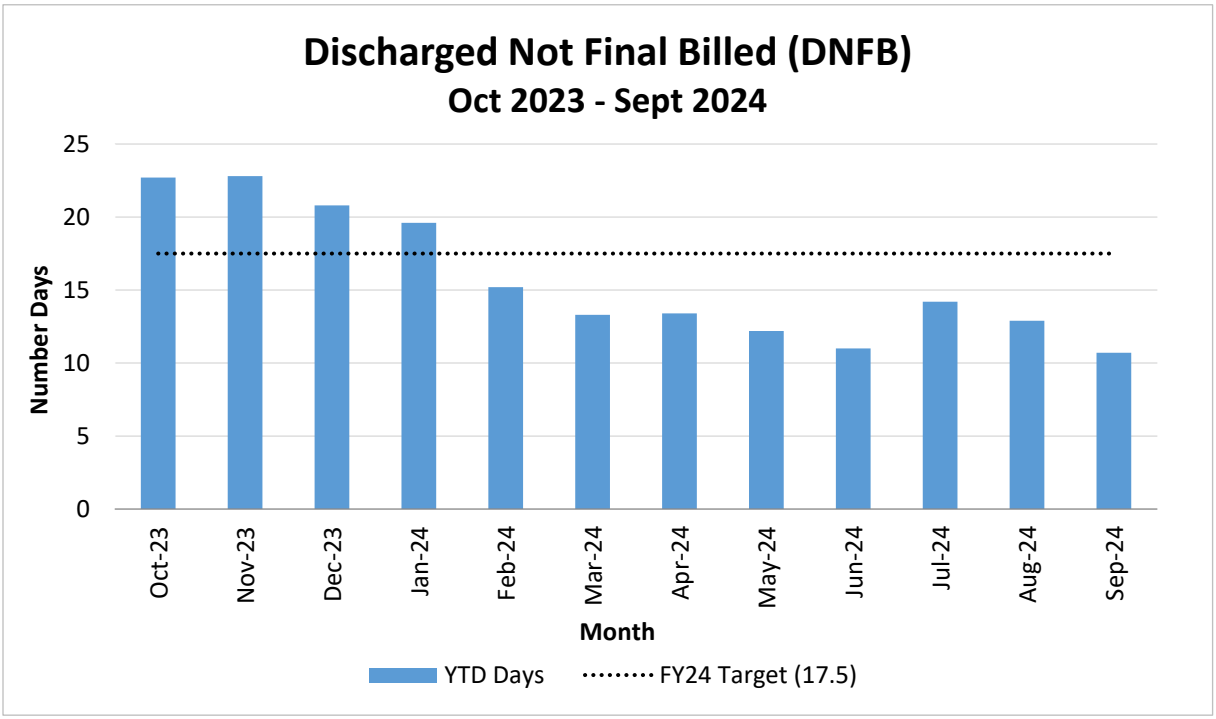
September 2024 net AR days were at 50.6 days. Our reduction initiatives and work plan included the following:

- Ongoing onboarding of additional coders to expand internal coding coverage.
- Ongoing onboarding of Patient Financial Services to improve billing and collections coverage.
- Targeted areas for staff to focus on to strategically reduce AR.
- Clean up of accounts receivable by resubmitting claims for Medicaid claims on hold.
- Contracted with third party to assist with automation opportunities in Cerner to assist with Accounts Receivable reduction.
- Weekly initiative meetings for coding, Patient Financial Services and overall revenue cycle to discuss strategies and remain focused on appropriate initiatives.

# Achieve Performance Excellence

## 26) Discharged Not Final Billed (DNFB) FY2024

**Measure Definition –** Dollar amount in patient accounts discharged not final billed / Average daily revenue




**FY24 Results:** 10.7 days (September 2024) – 120% target met

**FY24 Targets:**

**80%** 19.5

**100%** 17.5

**120%** 16.5

**Year End Summary:**

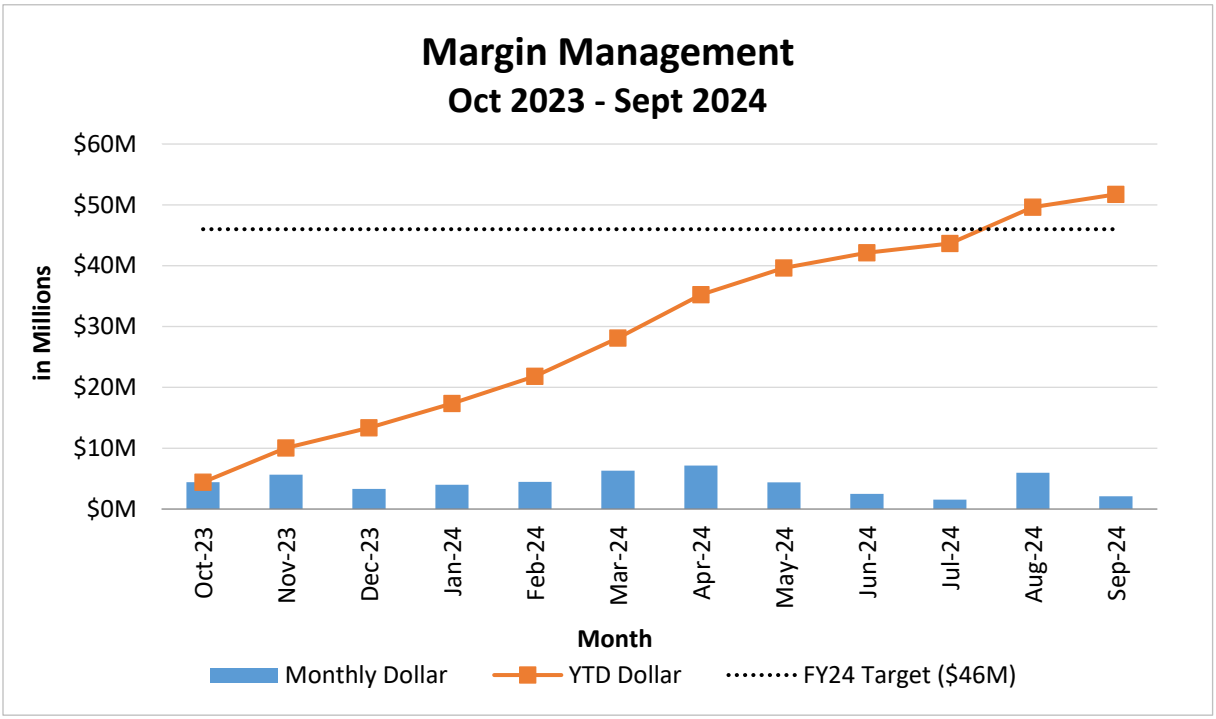
DNFB days at 9/30/24 was 10.7. Our reduction initiatives and work plan included the following:

- Ongoing onboarding of additional coders to expand internal coding coverage to reduce DNFB waiting for coding (DNFC).
- Ongoing onboarding of Patient Financial Services to improve billing and collections coverage to target DNFB areas.
- Targeted areas for staff to focus on to strategically reduce DNFB as well as focus on cash collections payers and aging.
- Weekly DNFB focused meetings for coding and Patient Financial Services focused on targeted DNFB reduction initiatives.
- Contracted with third party to assist with automation opportunities in Cerner to assist with DNFB reduction.
- Completion of multiple specialty clinic provider charge entry/initiation. This will lead to reduction on workload for coding as well as late charges.
- Clean up of accounts receivable by resubmitting claims for Medicaid claims on hold.

# Achieve Performance Excellence

## 27) Margin Management FY2024

**Measure Definition –** Cumulative dollar value of margin improvement initiatives.




**FY24 Results:** $51.7M (September 2024) – 120% target met

**FY24 Targets:**

**80%** $34M
**100%** $40M
**120%** $46M

**Year End Summary:**

In FY24, the organization prioritized margin management as a key strategy for meeting our financial targets. The $50M+ in net margin improvement achieved during FY24 exceeded our expectations and is attributable to several initiatives, including positive margin trends related to found insurance backlog, reductions in contract labor utilization and critical staffing pay, increases in surgical and specialty clinic volumes, and expansion of 105(l) lease payments. Strong margin management work from nursing, revenue cycle, supply chain, legal, intergovernmental affairs, and finance (as well as many others) all contributed to $50M in net margin management improvements during FY24.