Minutes

Maricopa County Special Health Care District
Board of Directors Bond Advisory Committee Meeting
Maricopa Medical Center
Auditoriums 1 and 2
April 8, 2013
2:30 p.m.

Voting Members Present:	Lattie Coor, Ph.D., Vice Chairman Paul Charlton Kote Chundu, M.D. Frank Fairbanks Nita Francis Doug Hirano Diane McCarthy Terence McMahon, Ex-officio, Director, District 5 Rick Naimark Joey Ridenour Brian Spicker Ted Williams
Absent:	Bill Post, Chairman Tony Astorga Merwin Grant Len Kirschner, M.D.
Others/Guest Presenters:	Betsey Bayless, MIHS, President & Chief Executive Officer Warren Whitney, MIHS, Chief External Affairs Officer Farzan Bharucha, Kurt Salmon
Recorded by:	Melanie Talbot, MIHS, Executive Director of Board Operations

Call to Order

Vice Chairman Coor called the meeting to order at 2:37 p.m.

Roll Call

Ms. Talbot called roll. Following roll call, it was noted that eleven of the fifteen voting members of the Maricopa County Special Health Care District Bond Advisory Committee were present, which represents a quorum. .

Call to the Public

Vice Chairman Coor called for public comment. There were no comments.

General Session Presentation, Discussion and Action:

1. Introduction of Bond Advisory Committee Facilitator/Consulting Team, Kurt Salmon and First Southwest

Mr. Whitney stated that the consulting firm of Kurt Salmon has been engaged to assist and facilitate the Bond Advisory Committee activities. They will also work with the staff and give guidance on the Committee's behalf as it moves forward.

2. Overview of Future Healthcare Trends

Mr. Bharucha stated he would spend time going through a very high-level, national trends discussion on the national stage and the state stage, which will impact to the discussions and ultimately the recommendation that comes from the Committee.

The first fact is that US spending patterns on healthcare are not sustainable, because what the US has developed over the last 50 or 60 years is the world's best sick care system but not the world's best healthcare system.

Hospitals and physicians, the cost of hospitals and physicians, is what has really been driving healthcare expenditures over the last decade. Over the last five years the average individual spent $1,259 more in healthcare than they did five years ago.

If you were to look at the US as a whole, 26% of all healthcare spending is on 1% of the population. Five percent of the population drives 50% of all healthcare spend, so that $2.6 trillion number - $1.3 trillion of it is coming from 5% of the population.

The US cannot afford all of the healthcare that's being delivered today. The fact of the matter is the US is spending more than it is taking in.

There will be more growth in your total population and it will get older. Patients are becoming more chronic. Diseases that twenty years ago were terminal have now been converted to chronic status.

The health status of the population in general has deteriorated. There are more people that are morbidly obese, there are more people with asthma. There are far more underlying health-related conditions being tracked today than there were twenty years ago. Arizona is squarely smacked up in the middle in the US.

Science and technology – there will always be some science that means you don't need to go back to the hospital. It's shifted to the outpatient or it's improved the way the care is delivered, but there's also the new MRI or the new CT that tends to drive more healthcare demand.

There will be more demand for healthcare services over the next ten years. This is important when you're facility planning because one of the things that the ACA is founded on, one of the "Better Op" principles is that by changing the way we utilize healthcare we can reduce the total amount of healthcare that is utilized. Our belief is you can bend the cost curve down but you can't make it negative.

I you look at all of the remainder of the clinical workforce that you will need – nurses, social workers – across the board there are gaps. What it suggests in a typical supply/demand market is if there's more demand than there is supply it's really hard then to cut salaries. That suggests that it's not really going to be coming out of the labor dollars.

The NAPH is the National Association of Public Hospitals and if you look at the dollars that flow into the average NAPH hospital, a large percentage of it comes from Medicaid or supplemental Medicaid payments. Some percentage of it comes from state support, but the reality is hospitals that are NAPH hospitals like MIHS is, hospitals that tend to have a relatively high percentage of Medicaid or self-pay patients are hospitals that serve a very distinct and critical role in the care delivery of their populations.

General Session Presentation, Discussion and Action (cont.):

2. Overview of Future Healthcare Trends (cont.):

If you think about a hospital in itself, if you decide to close a hospital you can't then convert it into an apartment complex. The facilities and the development of these facilities is super sub-specialized in things aimed at making patients better. Because of that and because of the super specialty nature of them, the return on assets of teaching hospitals tends to be very, very low.

It is hard without having discussions like this in a public setting for teaching hospitals to make the case to generate their own facilities on their own because when you start looking at the capital requirements for these facilities and then you start looking at the return on these facilities there's a disconnect.

At the same time, you can't provide the care without the specialized assets. You can't provide the care in a general partner complex or in a general office building – the sub-specialty requirements are too great. As we start to talk about what are the capital requirements as part of this Committee, keep this in mind with regard to the return on assets. One of the things that we will talk a lot to you about, one of the reasons why we're here as your advisors, is can you defer certain components of capital? Can you invest in certain pieces which tend to have a better return in terms of the way that care is delivered across your community?

The average age of planned hospitals is going up. Hospitals have been deferring capital expenditures probably since the 2008 financial crash.

The ability of institutions to regenerate their capital planned was diminished when access to capital diminished, but that doesn't change the fact that as you start talking about patient care moving forward a lot of the facilities that you're in are not set up to care for patients in a 21st century model.

The mechanicals, electrical, HVAC and all of those kinds of things that are critical to running the hospital are still in '60s or '70s era buildings. At some point they're not capable of supporting the needs of contemporary care.

That's one of the things that we'll be talking to you about as we go through the facility condition assessment – what is the condition of your infrastructure itself? Not just what the patient sees but also what the patient ultimately will experience because the guts of the building are what tends to get neglected.

The high complexity bucket - these are patients that can only be taken care of in places and hospitals that have specialty resources. They've got equipment, they've got technology, they've got facilities that are specifically set up for that particular component – so burn is a perfect example. As you would expect the percentage of patients that are in the high complexity is relatively small. It's usually in the 5% to 10% range. Because their lengths of stay are so high, though, because they're highly complex they're a lot of your census, they're a lot of your heads in beds. They represent 37.5% of the census in this kind of illustrative hospital.

One of the questions that you will have to ask yourselves as you go forward is "As a hospital, if we do look like this and let's say that 50% of our admissions are basic admissions, 30% of the census is basic census, should we be taking care of those kinds of patients in this kind of high-complexity environment?"

Are there alternative environments that we could be taking care of those patients, maybe in an outpatient setting, maybe in a lower-complexity type of hospital setting? What are the implications for facility development? What are the implications for capital allocation? What's the program, what are the types of patients that are going to be cared for in whatever this facility potentially looks like if it were to go forward?

General Session Presentation, Discussion and Action (cont.):

2. Overview of Future Healthcare Trends (cont.):

As we start to think about the system, MIHS as a system – as we start to think about this system of care where are our capital dollars going to be allocated? Are we going to try to develop the full continuum of care? What is the appropriate allocation of dollars across all of the various system entities, not just across the hospital beds?

One of the things that MIHS will have to think about is how is it going to position itself moving forward?

There are multiple nuances and many shades of grey, but as you start to think about the development, as you start to think about capital allocation there are two general paths that major teaching hospitals are going down today. The first path is we're going to be an integrated system. We're going to take care of the health of populations. We're not just trying to take care of patients when they're sick; we're trying to take care of them from beginning to end of that episode of care. We're trying to prevent them from needing the hospital because we have the full continuum of ambulatory care, post-acute care, physician offices that are necessary to keep them out of the hospital.

That's a very different path than the second one, which is our core competency is in highly specialized care. We do burn care better than anyone. We do high-complexity pediatrics care better than anyone. That's where we are the best. We're not going to try to take care of patients before they get to the hospital or after they leave the hospital. We're going to partner for those pieces. We're going to be the best provider of tertiary and quaternary care we can be and if we really are the best then everybody else's system should want us.

Obviously there are pros and cons to both of these and there are big teaching hospitals that have chosen to do path one and path two, but it has a very different impact on what you're actually going to invest in. We'll have these discussions as we go through the facility condition assessment, as we start to talk about future capital priorities.

3. Discuss Process and Timeline for Development of Recommendation for District Board of Directors

Mr. Bharucha reviewed the process, work steps and timeline. There is a strategic planning effort that's going on right now and a lot of what senior administration is doing right now is looking at your market, looking at your demographics, looking at your current access points, looking to see what the competition or the other providers in the market are doing. A lot of that will directly interface with this process.

Ultimately the recommendations that come out of the Committee needs to support whatever the strategic vision is and vice-versa – the vision needs to match with what we're talking about in terms of capital allocation. As we go through this we're hoping to see a lot of that dual track. May and June is really the timeframe in which our firm will be doing a lot of the baseline assessment. We will be going through every facility – the hospital, CHC, all the various Family Health Center and starting to benchmark them with regards to their condition, their functionality.

4. Discussion and Possible Action on Sub-Committees of the Bond Advisory Committee

Vice Chairman Coor questioned if in addition to the work groups, whether subcommittees ought to be formed.

Mr. Bharucha commented that typically subcommittees are not created up front.

General Session Presentation, Discussion and Action (cont.):

5. Approve Bond Advisory Committee meeting minutes dated March 11, 2013

MOTION Ms. McCarthy moved to approve the Bond Advisory Committee meeting minutes dated March 11, 2013. Mr. Spicker seconded. **Motion passed by voice vote.**

6. Future Agenda Items

None.

Adjourn

MOTION: Ms. Francis moved to adjourn the April 8, 2013 Bond Advisory Committee Meeting. Dr. Chundu seconded. **Motion passed by voice vote.**

Meeting adjourned at 4:00 p.m.

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Bill Post, Chair
Bond Advisory Committee