Maricopa County Special Health Care District

Bond Advisory Committee Meeting

May 13, 2013
2:30 p.m.

Agenda

MARICOPA SPECIAL HEALTH CARE DISTRICT
Count on us to care.

Committee Members	
Bill Post, Chair	Doug Hirano
Lattie Coor, Vice Chair	Len Kirschner
Tony Astorga	Diane McCarthy
Paul Charlton	Terence McMahon, Ex-officio
Kote Chundu	Rick Naimark
Frank Fairbanks	Joey Ridenour
Nita Francis	Brian Spicker
Merwin Grant	Ted Williams

AGENDA – Bond Advisory Committee Meeting

Board of Directors of the
Maricopa County Special Health Care District

· Maricopa Medical Center · Administration Building · Auditoriums 3 and 4 ·
· 2601 E. Roosevelt · Phoenix, AZ 85008 · Clerk's Office 602-344-5177 · Fax 602-344-0892 ·

Monday, May 13, 2013
2:30 p.m.

If you wish to address the Committee, please complete a speaker's slip and deliver it to the Executive Director of Board Operations. If you have anything you wish distributed to the Committee and included in the official record, please hand it to the Executive Director who will distribute the information to the Committee Members. Speakers are limited to (3) three minutes.

ITEMS MAY BE DISCUSSED IN A DIFFERENT SEQUENCE

Call to Order

Roll Call

Call to the Public

This is the time for the public to comment. The Bond Advisory Committee may not discuss items that are not specifically identified on the agenda. Therefore, pursuant to A.R.S. § 38-431.01(H), action taken as a result of public comment will be limited to directing staff to study the matter, responding to any criticism or scheduling a matter for further consideration and decision at a later date.

General Session Presentation, Discussion and Action:

1. Discuss Bond Advisory Committee's Project Process, Deliverables and Timeline for Development of Recommendation for District Board of Directors 40 min
   Farzan Bharucha, Kurt Salmon
   Jared Averbuch, Kurt Salmon

Agendas are available within 24 hours of each meeting in the Board of Directors Office, Maricopa Medical Center, Administration Bldg, 2nd Floor 2601 E. Roosevelt, Phoenix, AZ 85008, Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m. Accommodations for individuals with disabilities, alternative format materials, sign language interpretation, and assistive listening devices are available upon 72 hours advance notice through the Clerk of the Board's Office, Maricopa Medical Center, Administration Bldg, 2nd Floor 2601 E. Roosevelt, Phoenix, Arizona 85008, (602) 344-5177. To the extent possible, additional reasonable accommodations will be made available within the time constraints of the request.

5/9/2013 5:43 PM

General Session Presentation, Discussion and Action:

2. Discuss and Review System Responses to Macro Market Changes 60 min
   Michael Eaton, Navvis & Healthways
   Jon Cunningham, Navvis & Healthways

3. Wrap Up, Next Steps and Future Agenda Items 15 min
   Farzan Bharucha, Kurt Salmon
   Jared Averbuch, Kurt Salmon

4. **Approve** Bond Advisory Committee Meeting Minutes dated April 8, 2013 5 min
   Committee

Adjourn

Maricopa County Special Health Care District

Bond Advisory Committee Meeting

May 13, 2013

Item 1.

Bond Advisory Committee Process

BAC Process: Final Deliverable

At the end of the process, at a minimum, the following elements will be included in a deliverable to go to the Board of Directors:

1. An assessment of all current MIHS facilities, encompassing a detailed **Facility Condition and Functionality Assessment**

2. Understanding of the facility implications as they relate to the high-level **strategic direction** laid out in the ongoing strategic planning process

3. **Projections of future space needs** that support the long-term needs of the institution's strategic direction

4. A comprehensive **facility recommendation**, and associated **estimated capital costs**

5. **Outline of next steps**, including communication and financing options

MARICOPA INTEGRATED HEALTH SYSTEM

Facility Condition Evaluation: Scoring

Each building is rated on a red-yellow-green scale indicating its capability to continue to serve it's current use.

- **Not suited for continued current use**:
  Consider repurposing or decommissioning
- **Sufficient for it's current use**:
  Investment for current or lesser use is justified
- **Strong asset for the long-term**:
  Capable of being an "anchor building" that requires little investment for its current use and can be flexible to support current or more intense functions

Elements of Facility Condition Evaluation:

- Functional-Structural
- Exterior
- Vertical Circulation
- Mechanical
- Electrical
- IT
- Life Safety
- ADA

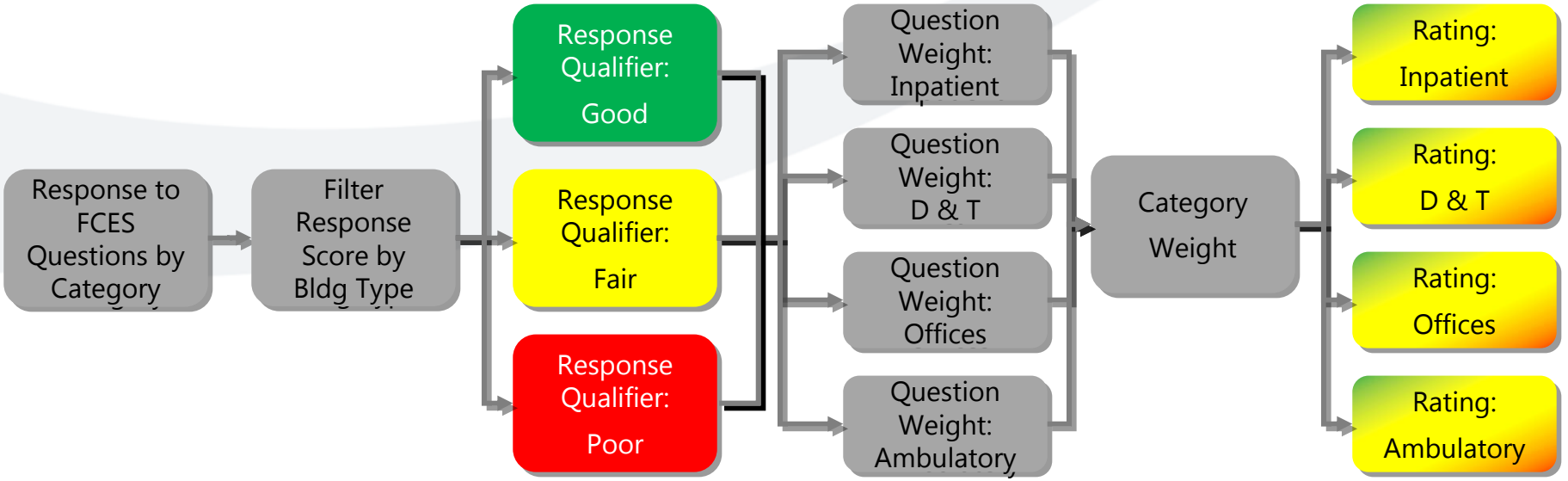
MARICOPA INTEGRATED HEALTH SYSTEM

Facility Condition Evaluation: Adaptation

The response to specific FCES input answers will change, depending upon the building type. For example, a 13' floor-to-floor height will drive different ratings, as shown below:

Inpatient Offic Ambulatory ces

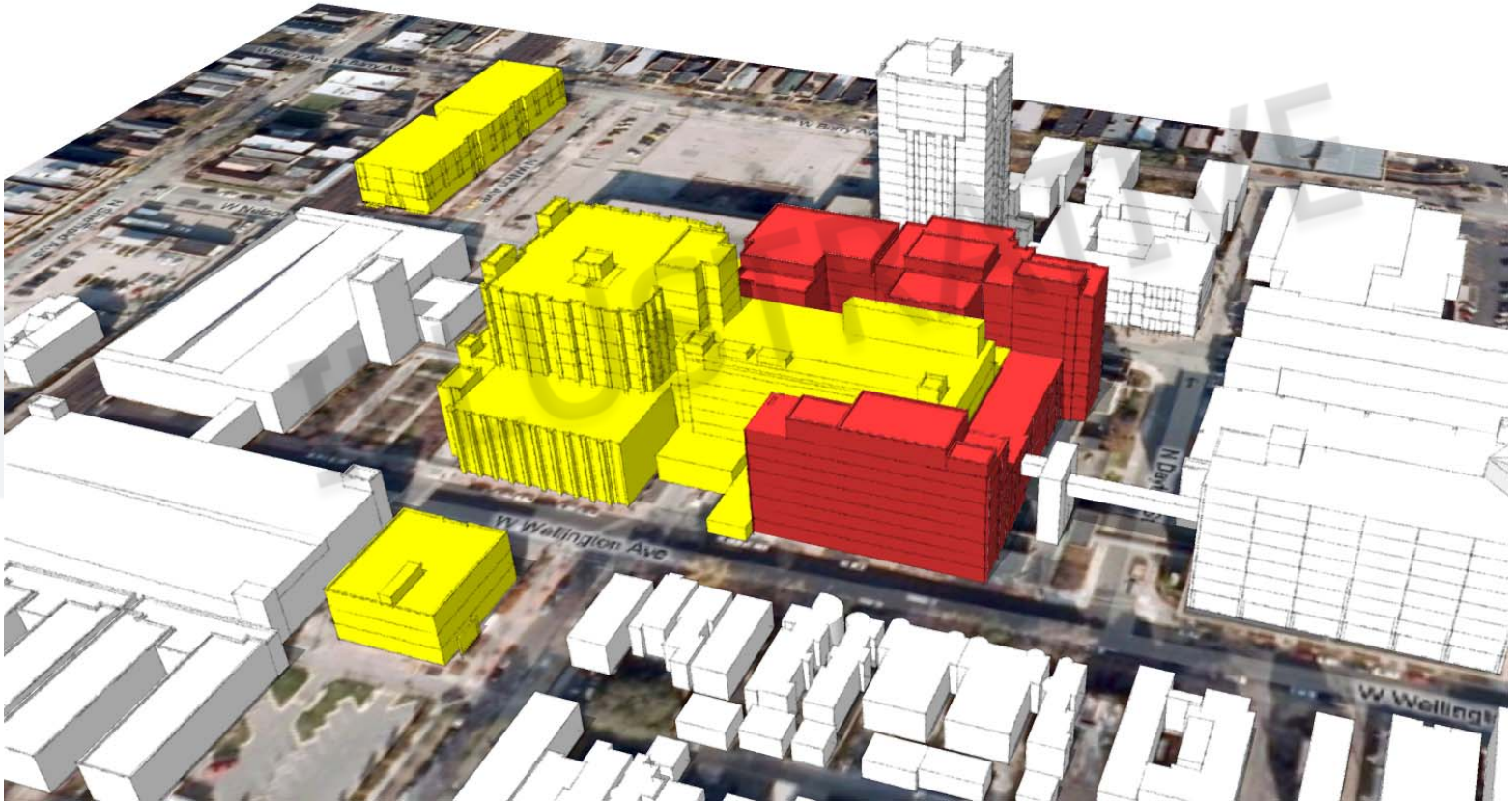
How the same responses are scored differently:



MARICOPA INTEGRATED HEALTH SYSTEM

BAC Process: Illustrative Deliverables

3D Campus Map Example



MARICOPA INTEGRATED HEALTH SYSTEM

BAC Process: Illustrative Deliverables

	Building A	Building B	Building C	Building D	Building E	Building F
Site Access/Parking						
Functional Design						
Structural Systems						
Exterior Envelope						
Mechanical/HVAC						
Elect/Communication Systems						
Life Safety Condition/ Code Compliance						
Vertical Circulation						
ADA Compliance						
Hazardous Materials						
Overall Physical Condition	**70%**	**65%**	**70%**	**64%**	**69%**	**59%**

MARICOPA INTEGRATED HEALTH SYSTEM

BAC Process: Illustrative Deliverables

Department	2009 Procs.	Exam to Patient Ratio*	2009 Volume Adj*	Rooms	2009 Actual Cases/Rm /Yr	Benchmark Low	Benchmark High	Capacity Rating
Surgery	8,379	1.0	8,379	12	698	600	700	2
Emergency Services	41,661	1.0	41,661	24	1,736	1,400	1,600	1
Imaging								
CT	31,973	2.2	14,533	2	7,267	8,000	10,000	3
Interventional Radiography	5,854	4.8	1,220	1	1,220	700	1,000	1
MRI	7,642	1.3	5,878	1	5,878	3,000	4,000	1
Radiography	65,749	2.0	32,875	5	6,575	6,000	12,000	2
Ultrasound	17,537	2.5	7,015	5	1,403	2,000	4,000	3
Mammography	15,760	2.2	7,164	3	2,388	3,000	4,800	3
Nuclear Medicine/Vascular								
Nuclear Medicine	5,849	1.3	4,499	3	1,500	3,000	4,000	3
Vascular	4,003	2.4	1,668	2	834	1,000	1,600	3
Cath/Electrophysiology	5,414	2.5	2,166	3	722	700	800	2
Gastroenterology	5,202	1.0	5,202	3**	1,734	1,400	1,700	1

MARICOPA INTEGRATED HEALTH SYSTEM

BAC Process: Illustrative Deliverables

Adult Units				Unit Assessment					Room Assessment			
Bed Unit	Beds	Private Beds	% Private	GSH DGSF	DGSF/ Bed	Low	High	Rating	GSH NSF	Low	High	Rating
Adult Acute	**99**	**40**	**40%**	**40,598**	**410**	**650**	**750**	**1**				
2N Cardiac Care	25	25	100%	13,248	530	650	750	1	200	300	330	1
4C Oncology Med/Surg	24	8	33%	8,594	358	650	750	1	270	360	390	1
4E Telemetry Med/Surg	26	2	8%	8,813	339	650	750	1	270	360	390	1
4W Orthopedics Med/Surg	24	5	21%	9,943	414	650	750	1	270	360	390	1
Adult ICU	**30**	**26**	**87%**	**19,727**	**658**	**850**	**950**	**1**				
CVICU	18	18	100%	11,346	630	850	950	1	245	300	330	1
MICU	12	8	67%	8,381	698	850	950	1	230	360	390	1

Pediatric Units				Unit Assessment					Room Assessment			
Pediatric Acute	**14**	**2**	**14%**	**5,799**	**414**	**750**	**850**	**1**				
3W Pediatrics	14	2	14%	5,799	414	750	850	1	270	360	390	1
Neonatal ICU	**18**		**0%**	**2,471**	**137**	**550**	**650**	**1**				
Special Care Nursery	18		0%	2,471	137	550	650	1	Bays	N/A	N/A	1

OB/GYN Units			Unit Assessment					Room Assessment			
Post-Partum	**24**	**100%**	**12,830**	**535**	**650**	**750**	**1**	**270**	**300**	**330**	**1**
Labor & Delivery	**9**	**100%**	**9,868**	**1,096**	**1,000**	**1,200**	**3**				
LDRs[1]	9							365	340	380	2
C-Section Rooms	2							420	450	550	2

MARICOPA INTEGRATED HEALTH SYSTEM

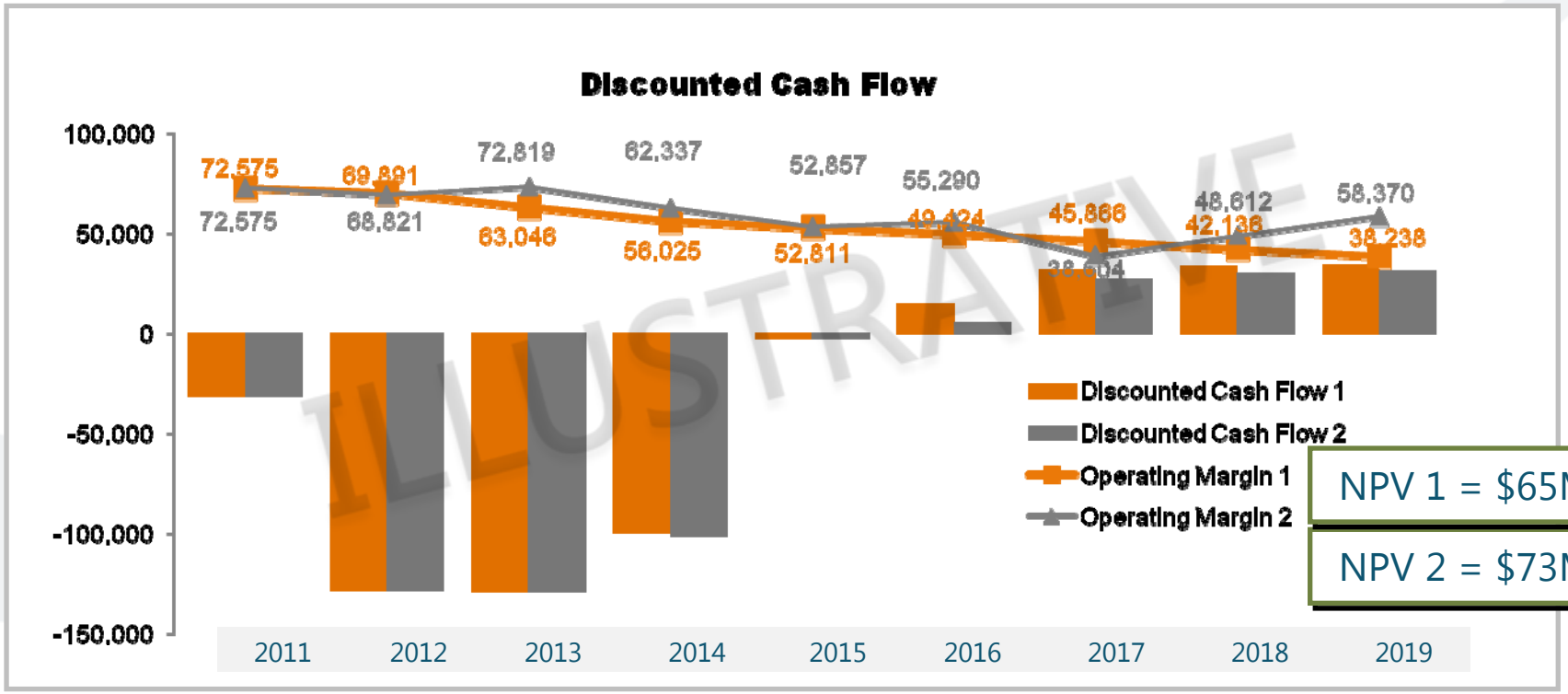
BAC Process: Illustrative Deliverables

Project	Description	Est. Cost	Source of Funds
Roads, Entrances, & Utility Loop	On campus infrastructure projects (Phase One & Phase Two)	$16,000,000 ($11M & $5M)	• Bonding capacity • 2010 Bonds ($5.6M)
Physical Facilities Building	New Facilities building in northeast corner of campus	$8,000,000	• Bonding capacity
Critical Care Hospital Additional Floor	Build out shelled space for ICU beds (up to 20 additional ICU beds)	$8,000,000	• Bonding capacity • Hospital operations
University Hospital Additional Floors (6th & 7th)	Build out shelled space for rehab, med/surg and other services (up to 128 additional beds)	$16,000,000	• Bonding Capacity • Hospital operations
Children's Hospital Expansion	New construction to increase capacity and right-size to national standards (Site, Shell, and Partial Build Out)	$119,000,000 ($59 Shell, $60 BO)	• Bonding Capacity • Hospital operations • Philanthropy
Ambulatory Clinics (Pavilion) Replacement Facility	New expanded location per the Transitional Facility Master Plan	$135,000,000	• Bonding capacity • Design-Build lease arrangement with a 3rd party
Parking Garage D	New garage near Clinic site; potentially shared with VA	$25,000,000	• Bonding capacity • Parking fees • 3rd party developer

Note: Cost are reflective of 2010 figures, non escalated.

MARICOPA INTEGRATED HEALTH SYSTEM

BAC Process: Illustrative Deliverables



NPV 1 = $65MM

NPV 2 = $73MM

Financial assumptions include:

- 12% discount rate
- 9% terminal cap rate
- 90% debt financing at 5.25% and 30 year tenor

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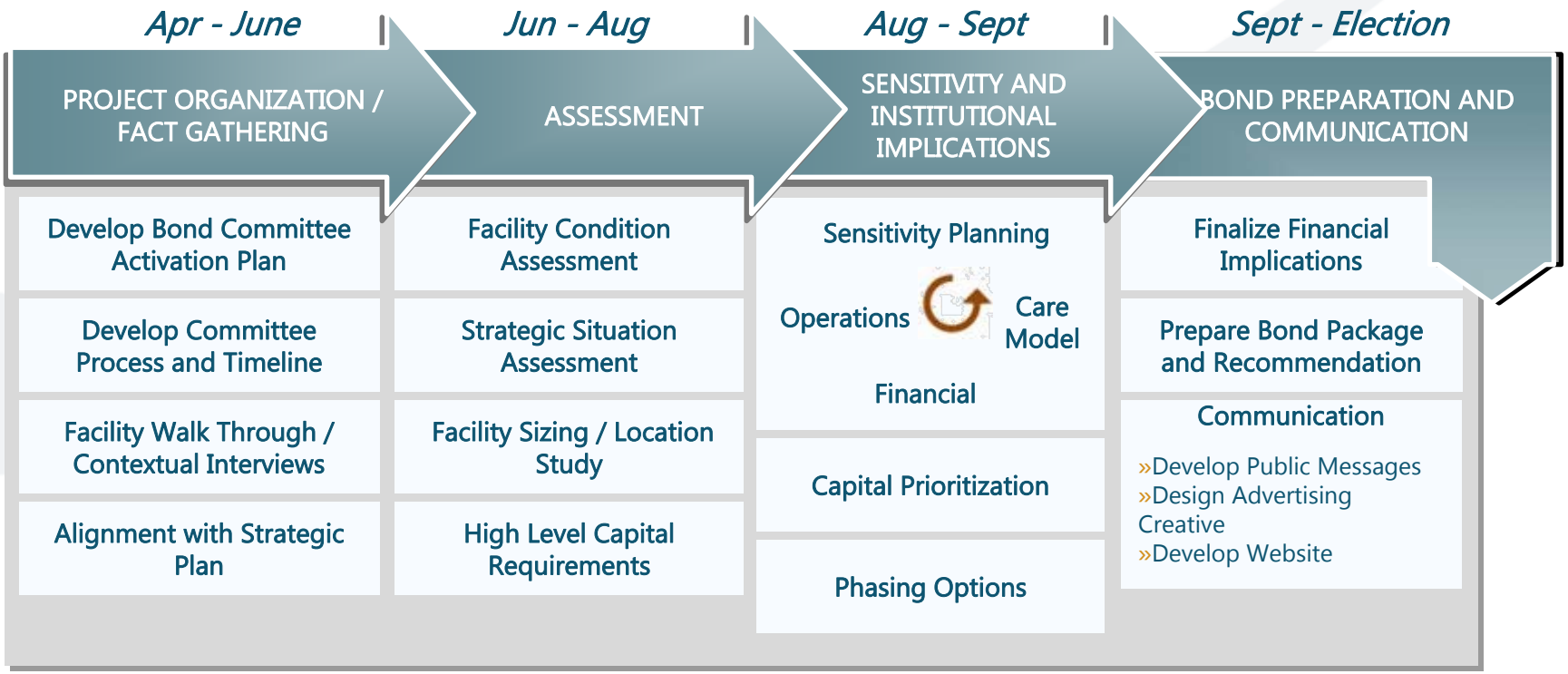
BAC Process: Work Steps & Timeline (Updated)

- The following high level schedule has been updated to better align with the timing of the ongoing strategic planning initiative



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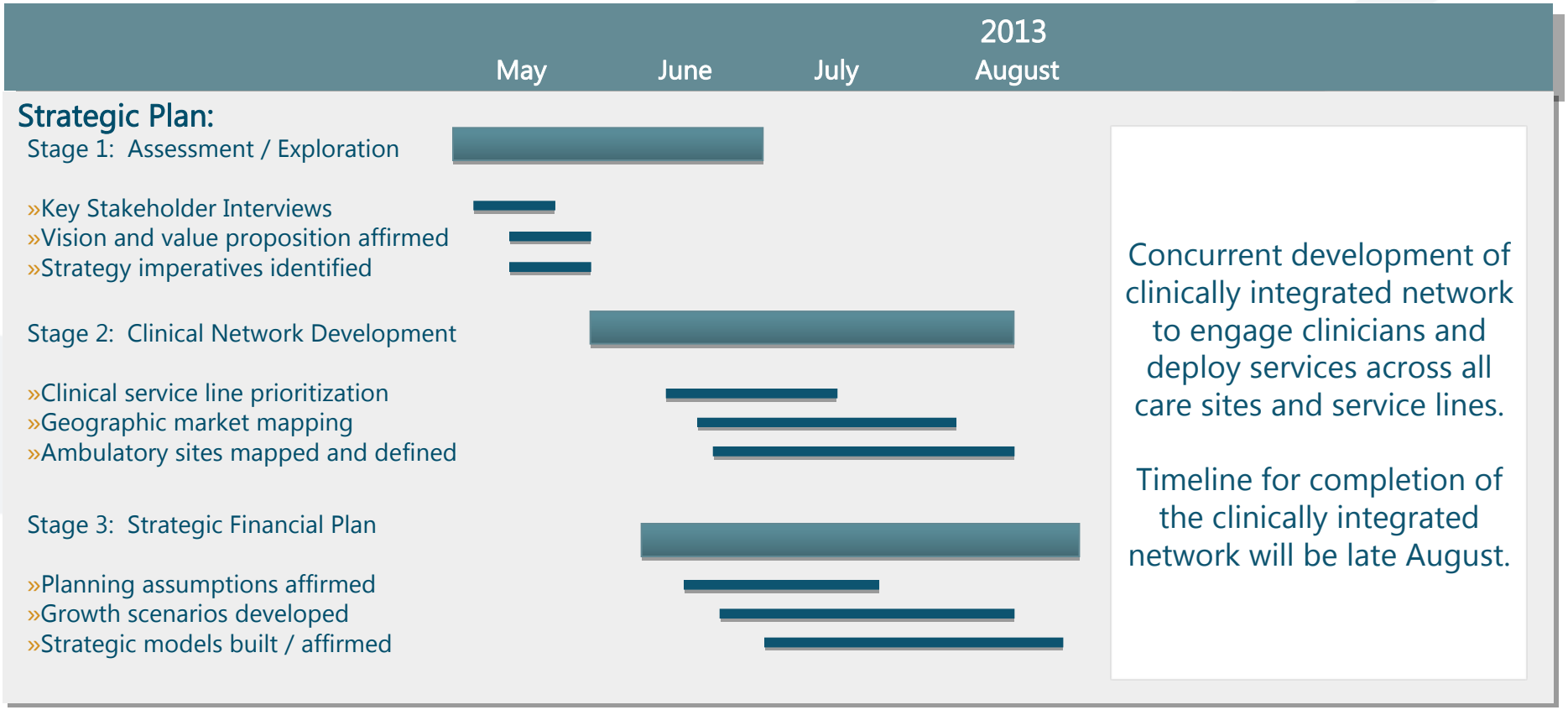
BAC Process: Integration with the Strategic Plan



Concurrent development of clinically integrated network to engage clinicians and deploy services across all care sites and service lines.

Timeline for completion of the clinically integrated network will be late August.

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BAC Process: Participants

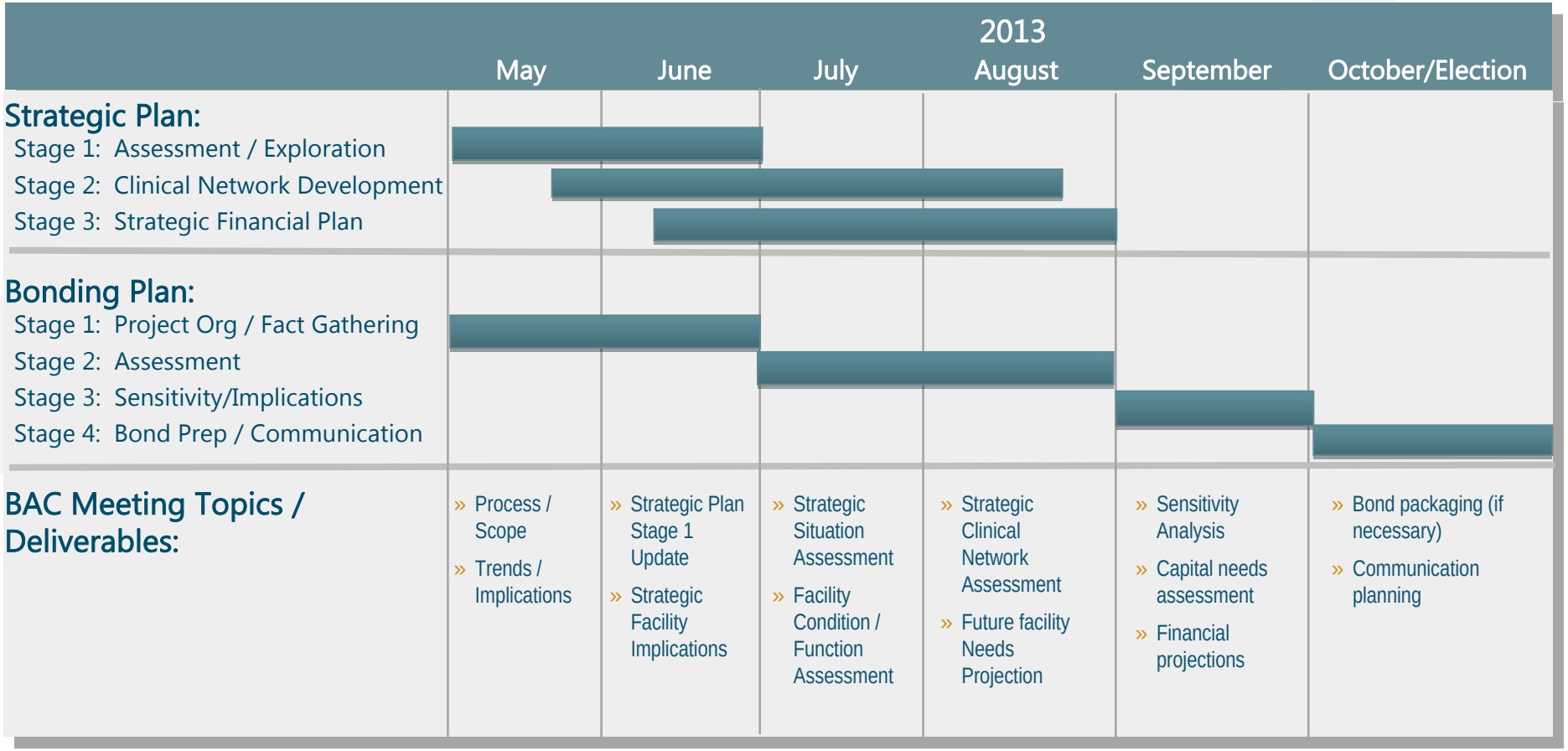
Initial participants/forums include:

1. **Bond Advisory Committee**
   - Task: To review all documented material, provide feedback / recommendations, and ultimately sign-off on the final bond package to go out for election
   - Meetings: Scheduled for the second Monday of every month
2. **Core Team**
   - Task: To work with the consultants to develop and review material to go before the Bond Advisory Committee for approval
   - Meetings: Scheduled as needed to ensure proper process is being followed and appropriate materials are being developed
3. **Ad Hoc Workgroups**
   - Task: Subject matter experts to focus on particular areas for further analysis or review (e.g. finance, facilities, volume projections)
   - Meetings: Workgroups will be developed as needed throughout the process to properly review material and ensure accuracy

MARICOPA INTEGRATED HEALTH SYSTEM

BAC Process: Proposed Meeting Agendas

- The timing for the Bond Advisory Committee scope and recommendations must align with the strategic planning process



MARICOPA INTEGRATED HEALTH SYSTEM

BAC Process: Guiding Principles

The Bond Advisory Committee will have a set of guidelines to reference throughout this engagement, to help direct its ultimate recommendations to the Board of Directors

An illustrative set of Guiding Principles could include the following:

The Bond Advisory Committee will…

1. Ensure any and all capital asset recommendations will be **fiscally responsible,** and represent the best interests of the residents of Maricopa County
2. Advise facility and capital solutions that **enable the strategic direction** as laid out by leadership, and approved by the Board of Directors
3. Deliver facility recommendations that enable **high quality, patient-centered care**
4. Consider all potential **benefits and risks** associated with any recommendation
5. Consider solutions which position the institution to be successful in a new paradigm based on the **tenets of healthcare reform**

MARICOPA INTEGRATED HEALTH SYSTEM

Maricopa County Special Health Care District

Bond Advisory Committee Meeting

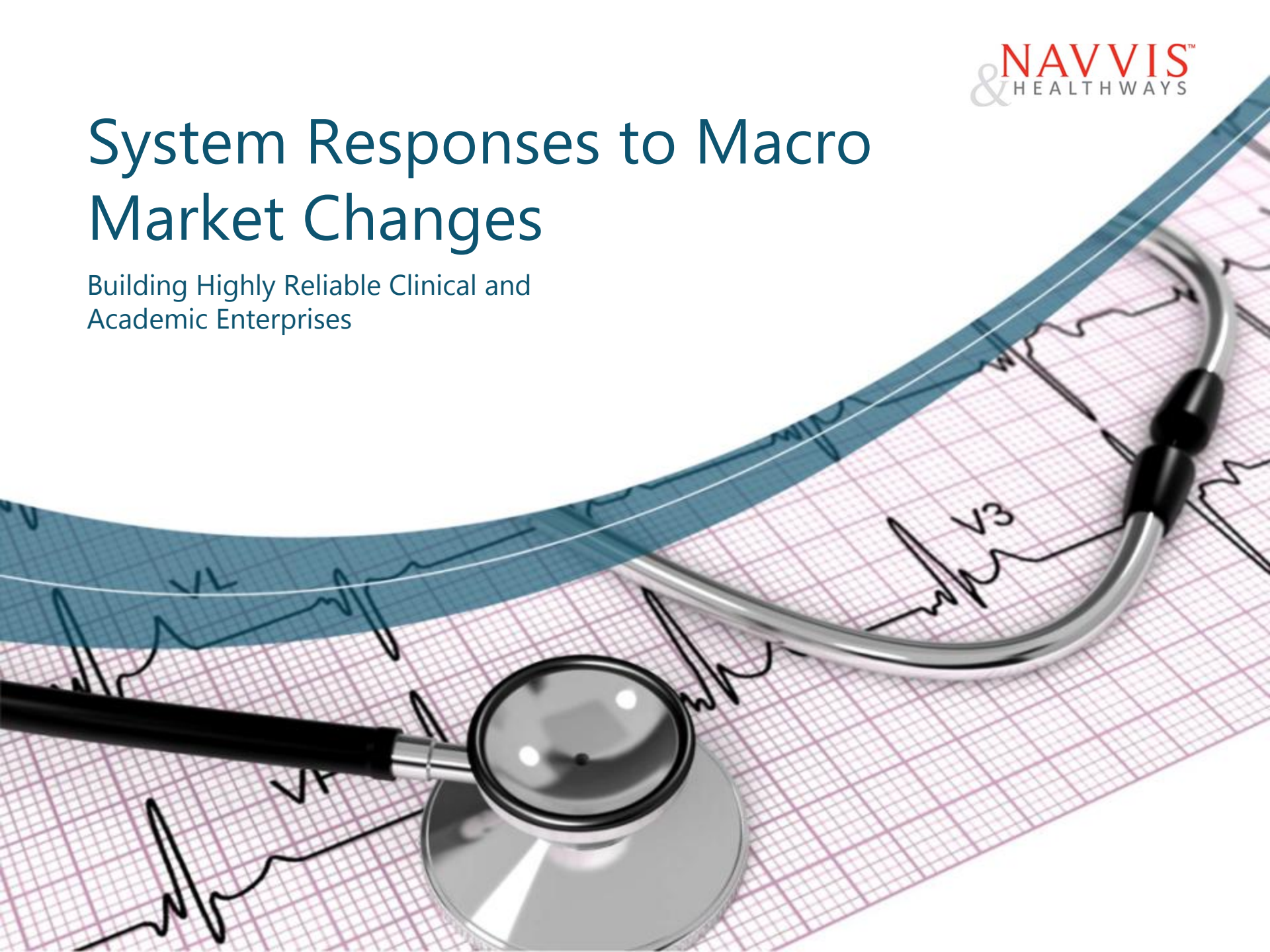
May 13, 2013

Item 2.

NAVVIS & HEALTHWAYS

System Responses to Macro Market Changes

Building Highly Reliable Clinical and Academic Enterprises



Discussion Agenda

The Shift From Health Care to Health:
Rethinking the Business We Are In

The Network Model of Care:
Future-Ready Clinical Enterprise

Building Value Beyond the AMC:
Emerging Model for Academic Medicine

» Our purpose is to help the Committee understand how health system strategy, organizational and operational models, and market approaches are evolving in response to rapidly changing macro economic dynamics.

MARICOPA INTEGRATED HEALTH SYSTEM

The Shift from Health Care to Health: *Rethinking the Business We Are In*

Fragmentation and Chaos

The flood of progress and knowledge imposed on fragmented delivery system leads to individual clinicians feeling less knowledgeable; and super-specialization among physicians that results in:

- More physicians involved in patient care;
- No one person with total accountability for care;
- Diminishing returns on quality; and,
- Unsustainable rise in cost (in spite of ACA).

"Today, 21st century medical technology is delivered with 19th century organization structures, management practices, and pricing models."

Michael Porter

Source: Thomas H. Lee, MD, MSc. Network President, Partners HealthCare System; Professor of Medicine, Harvard Medical School

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Century Old Roots

1910 Abraham Flexner Report

Flexner emphasized lab-based scientific research that focused on acute infectious diseases in a young population. Yet, today's aging population is at greater risk from chronic diseases than infectious conditions.

Given the science based focus of Flexner's model, training generally ignored subclinical disease unless risk factors were "medicalized" so asymptomatic persons can be redefined as "diseased" to facilitate drug treatment.

From Sick Care to Health Care Reengineering Prevention into the U.S. System
Farshad Fani Marvasti, M.D., M.P.H.,

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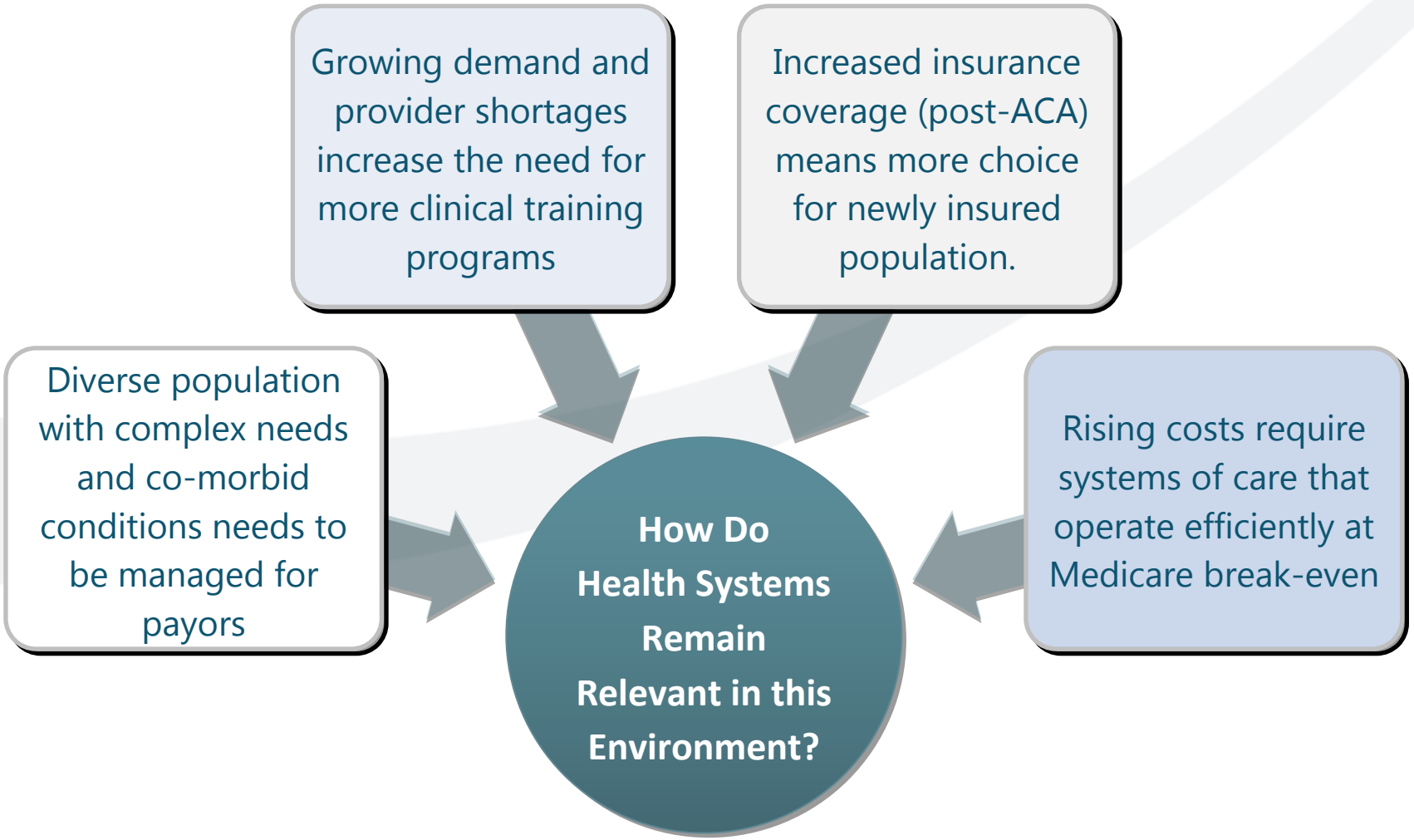
Rapidly Changing Market Dynamics



MARICOPA INTEGRATED HEALTH SYSTEM

The Emergence of Health as Our Core Business

"While much of recent U.S. medical practice proceeds as if health and disease were entirely biologic, our understanding of health's social determinants has become deeper and more convincing.

An enormous body of literature supports the view that differences in health are determined as much by the social circumstances that underlie them as by the biologic processes that mediate them."

What Business Are We In? The Emergence of Health as the Business of Health Care

David A. Asch, M.D., M.B.A., and Kevin G. Volpp, M.D., Ph.D.

New England Journal of Medicine; September 6, 2012

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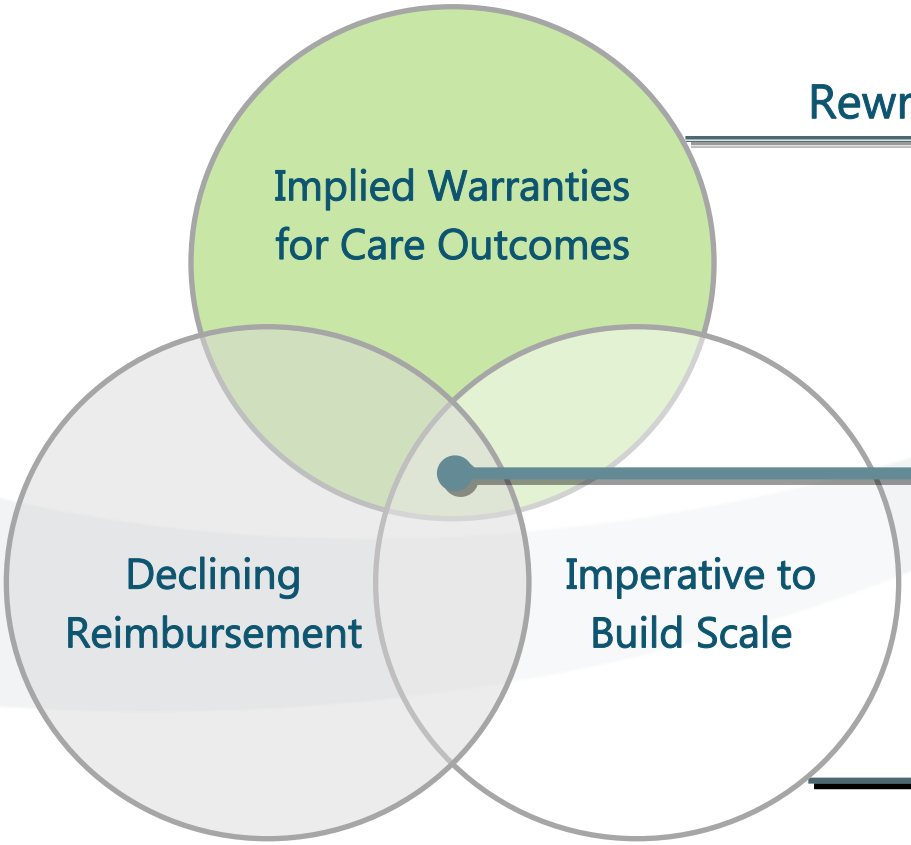
The Burning Platform



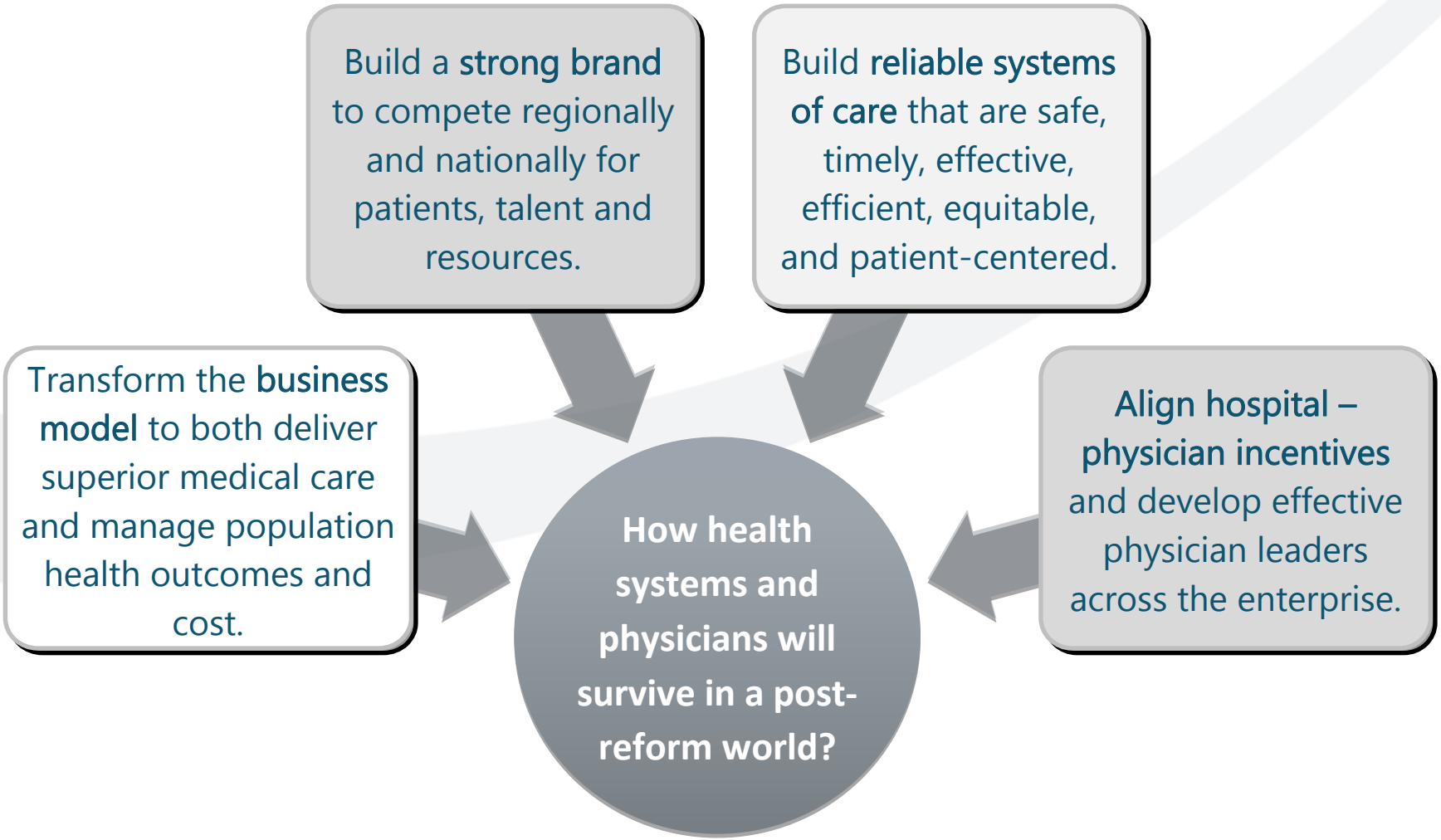
Rewriting the Rules of Health Care Financing

- Shared Savings Programs
- Bundled Payments to Providers
- Accountable Care Organizations
- Readmissions Penalties
- Health Insurance Exchanges
- Risk-Based Payor Contracts
- Direct to Employer Strategies
- Declining Reimbursement

MARICOPA INTEGRATED HEALTH SYSTEM

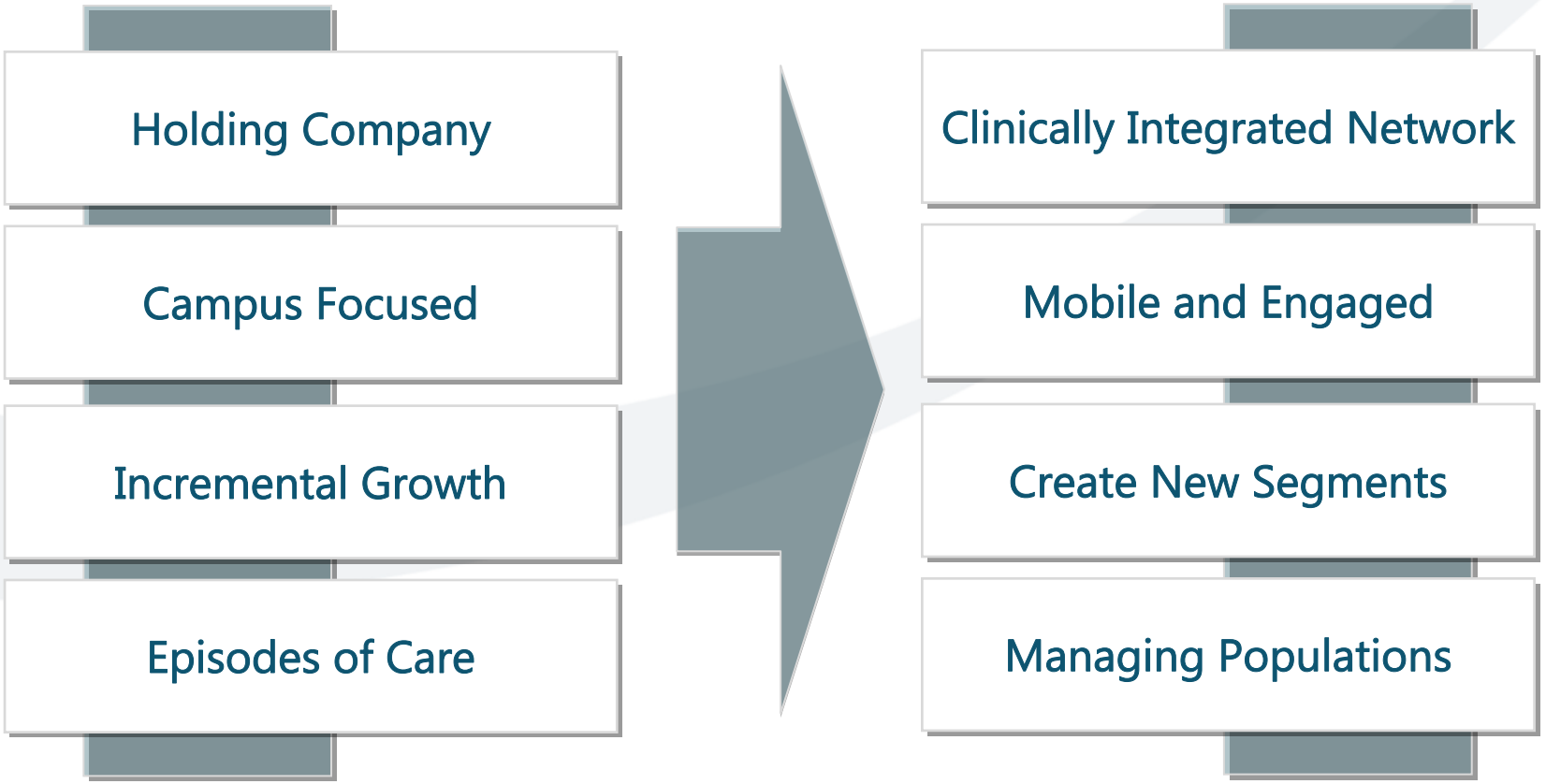
Future Ready Clinical Enterprise: *The Network Model of Care*

Four Strategy Imperatives



MARICOPA INTEGRATED HEALTH SYSTEM

The Desired Destination



MARICOPA INTEGRATED HEALTH SYSTEM

Rethinking How We Engage People

100%

- Well-Being Assessment
- Health Advisor Outreach Call
- Well-Being Plan
- Online Tools

50-60%

- Sustained Health Coaching and Behavior Change Programs for those with Lifestyle Risk Factors

15-20%

- Clinical Support for those with Gaps in Care and Hospitalization Risk

MARICOPA INTEGRATED HEALTH SYSTEM

New Competitive Requirements

Six Attributes of a Market Competitive Care Delivery System

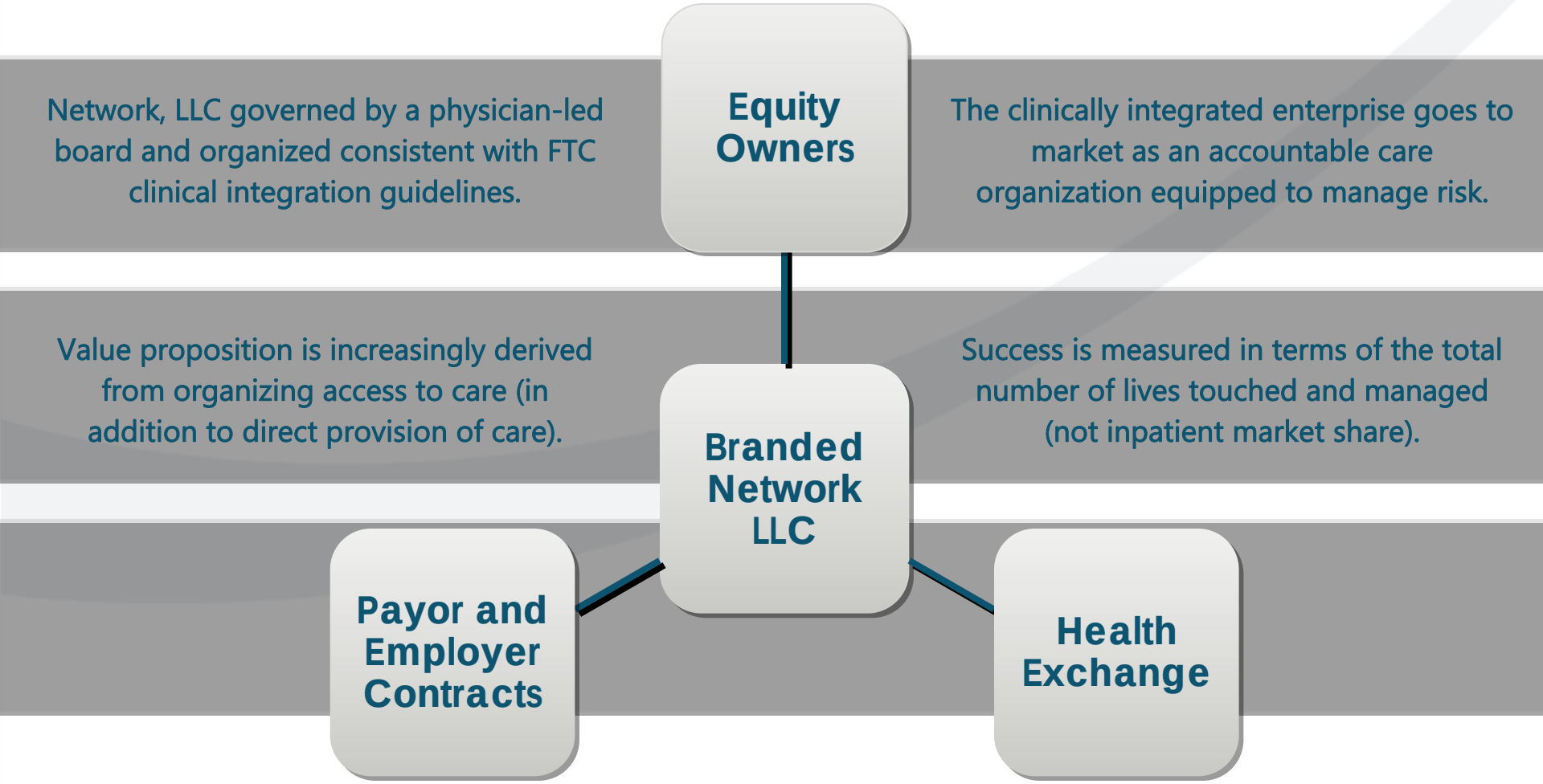
1. Commitment to providing patient-centered care;
2. Health home that provides primary and preventive care;
3. Population health and data management capabilities;
4. Provider network to delivers top outcomes at a reduced cost;
5. Established accountable care governance structure;
6. Payer partnership arrangements.

The goal is to balance cost control with improving care outcomes and patient experience

Source: Commonwealth Fund ; Accountable Care Strategies:
Lessons from the Premier Health Care Alliance's Accountable Care Collaborative; 2012

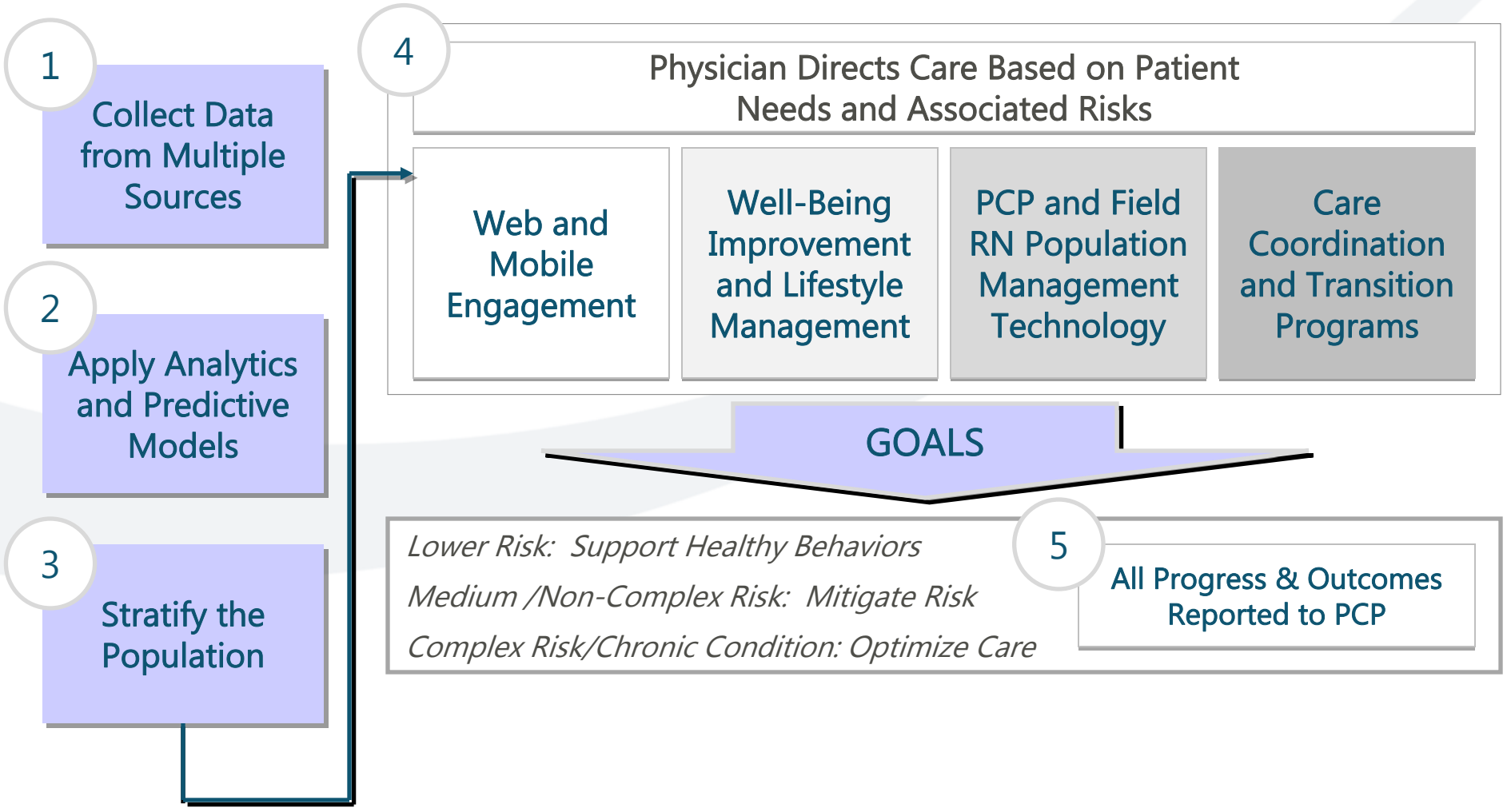
MARICOPA INTEGRATED HEALTH SYSTEM

Emerging Business Model



MARICOPA INTEGRATED HEALTH SYSTEM

Evolving Primary Care Model



MARICOPA INTEGRATED HEALTH SYSTEM

Challenges to Overcome

Rapid Clinical Knowledge Growth	No longer expect health professionals to recall all the biomedical information they may need during patient encounters; but practice models are still based on that expectation even as the pace of knowledge growth accelerates.
Emerging, Broader Definition of Health	Despite advances in knowledge about the multidisciplinary determinants of health, the dominant focus of care remains on the biomedical sciences.
Outdated Clinical Work Rules	Successful performance will depend on effective responses to unpredictable factors that emerge from workplace dynamics; this environment demands a new set of skills, including the ability to work in inter-professional teams.
Resistance to Continual Learning	The current system does not adequately nurture the skills needed for lifelong learning, nor does it develop in learners the ability to analyze practice performance and make changes that improve patient outcomes.

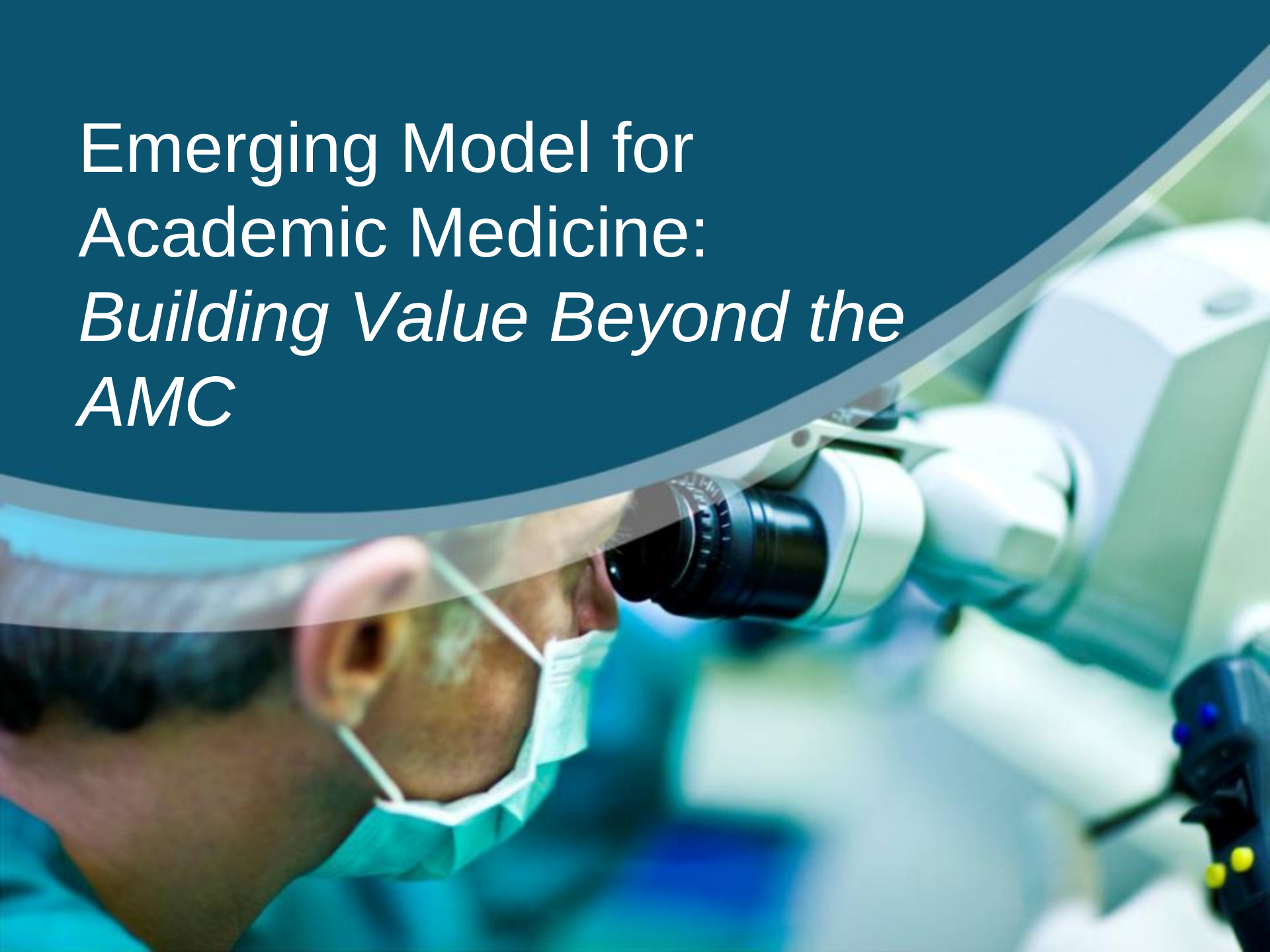
MARICOPA INTEGRATED HEALTH SYSTEM

The Strategist's Dilemma

....How will systems know when and how fast to change in response to external regulatory and market forces...

MARICOPA INTEGRATED HEALTH SYSTEM

Emerging Model for Academic Medicine: *Building Value Beyond the AMC*



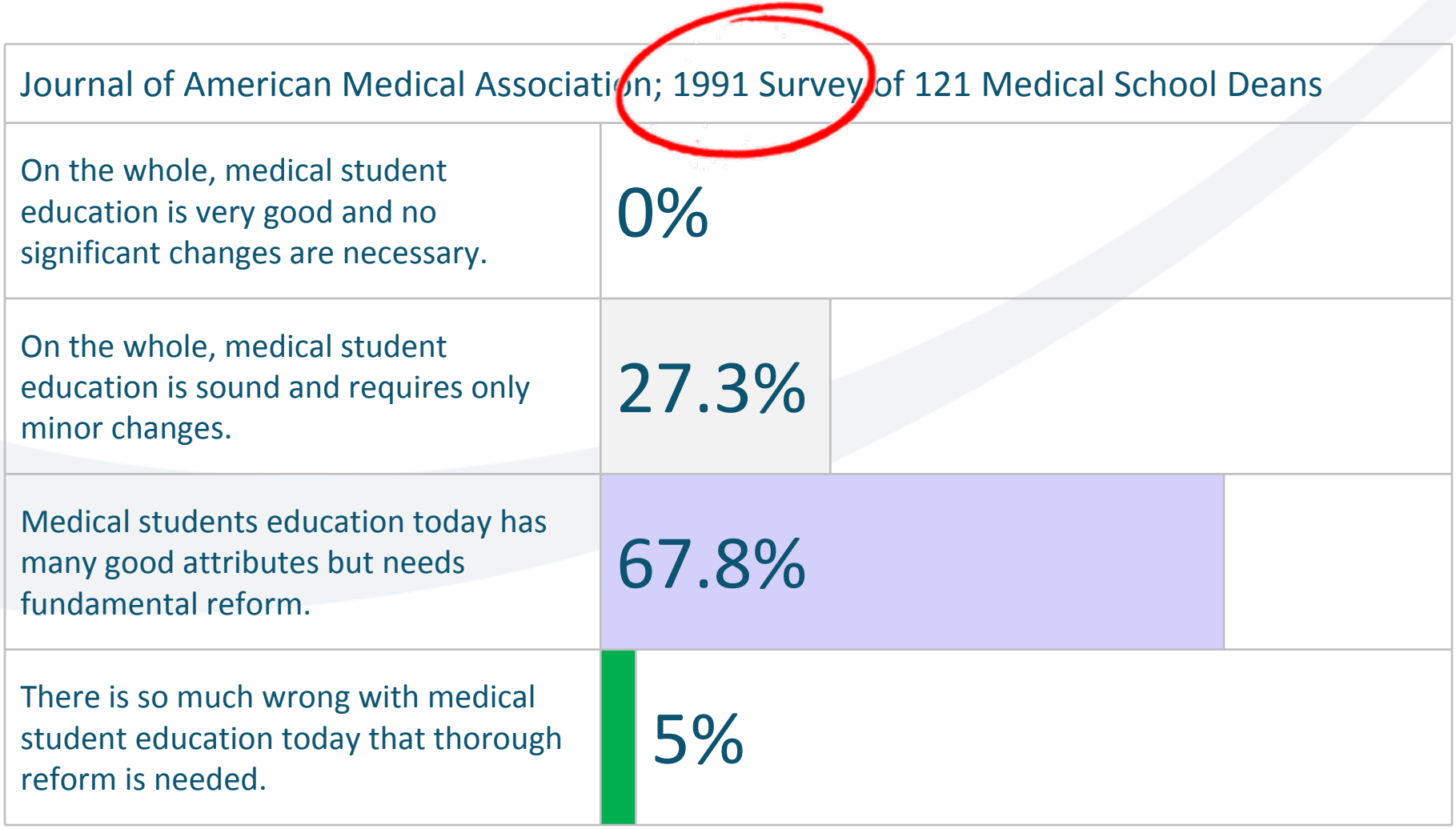
The Big Idea

Phoenix is the largest metropolitan area in the United States without an academic medical center (AMC).

Can that gap be filled with an innovative approach to health workforce development that trains clinicians in systems-based care as the foundation for a new AMC model.

MARICOPA INTEGRATED HEALTH SYSTEM

Unresolved Concerns



Source: JAMA 1991

MARICOPA INTEGRATED HEALTH SYSTEM

Guiding Principles

Principles of the New Model for Health Workforce Development

1. Learning is competency based and embedded in the workplace.
2. All workers learn; all learners work.
3. Learning linked to patient needs is undertaken by individuals, teams, and institutions.
4. Learning activities are modular with multiple entry and exit points.
5. Learning is inter-professional, with shared facilities, common schedules and shared foundational coursework.
6. A rich information technology infrastructure supports the learning system.
7. Health outcomes and educational outcomes are directly linked.

Source: Vanderbilt University School of Medicine proposal for medical education reform 2008

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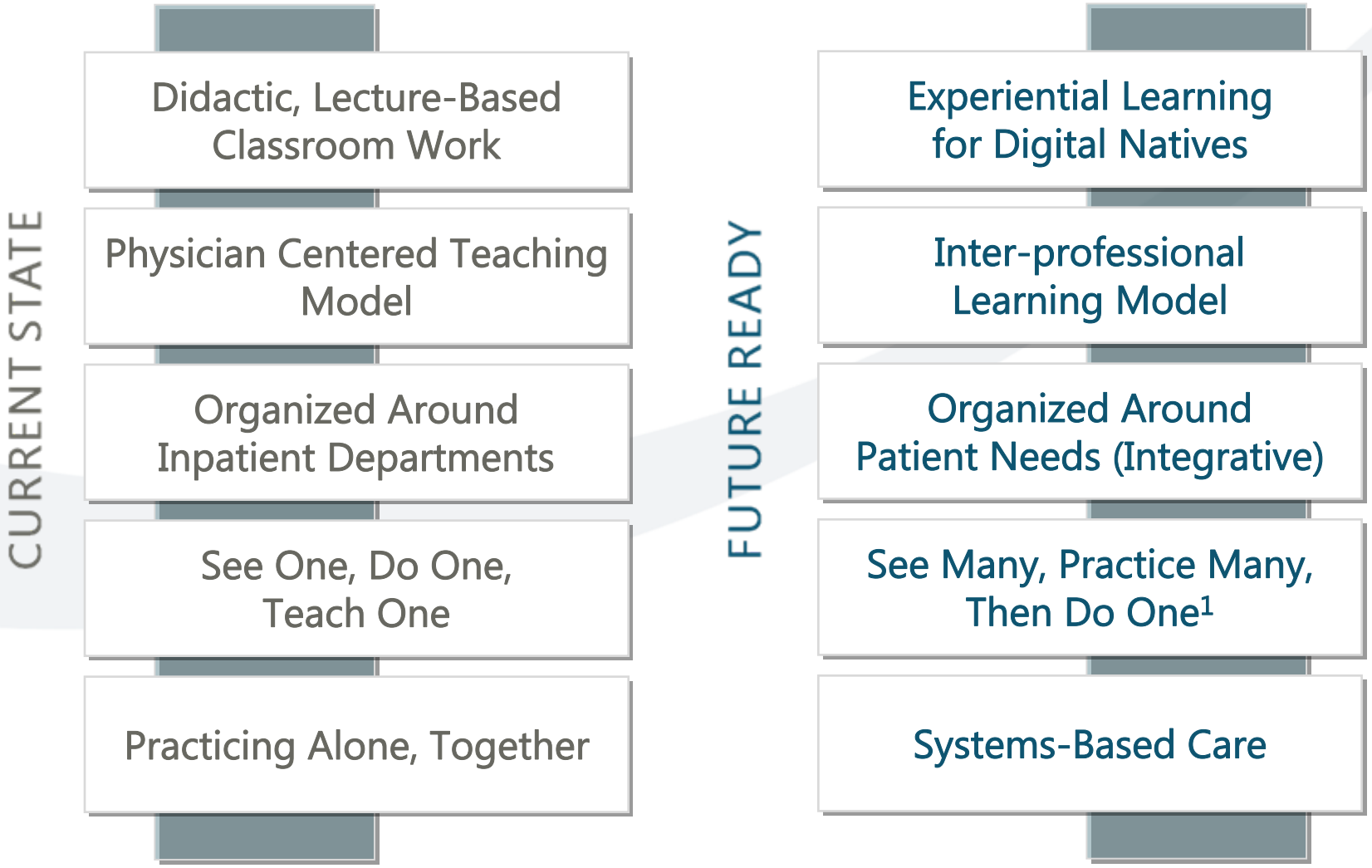
Functional Implications



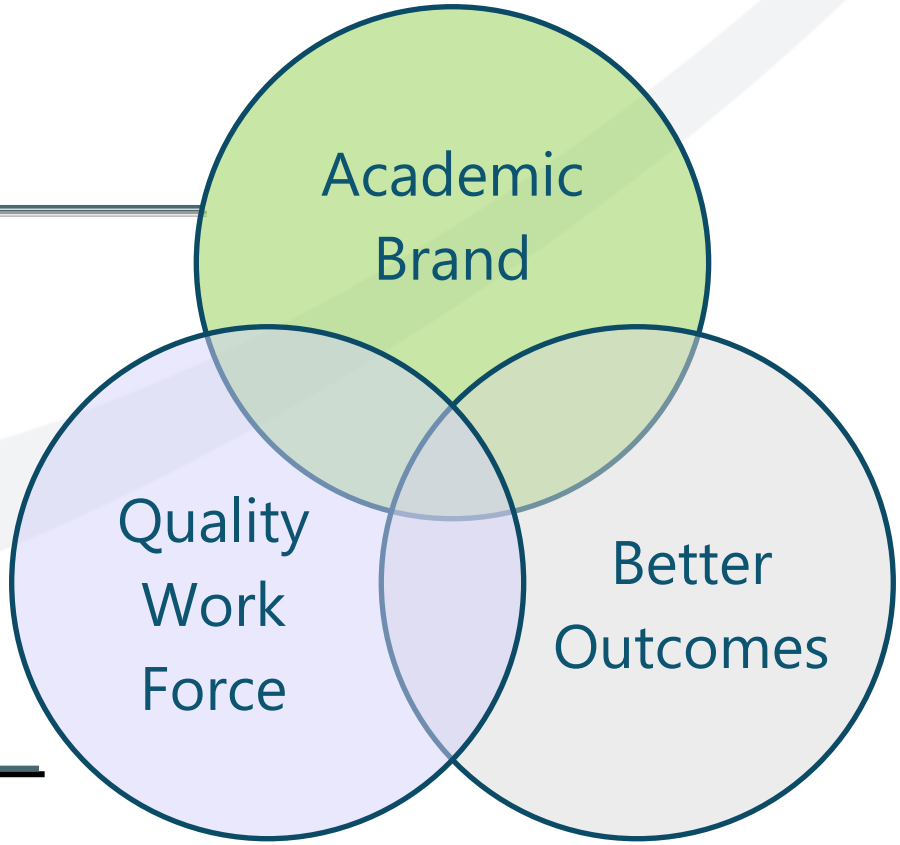
1. After meeting benchmarked proficiency standards

MARICOPA INTEGRATED HEALTH SYSTEM

Definition of Success

Success Metrics

- Regional perceptions of the System brand and attributes of leadership, advocacy, innovation, and value
- Increasing percentage of graduates stay in the community to practice
- Measurable improvements in the health of the population, better access to care



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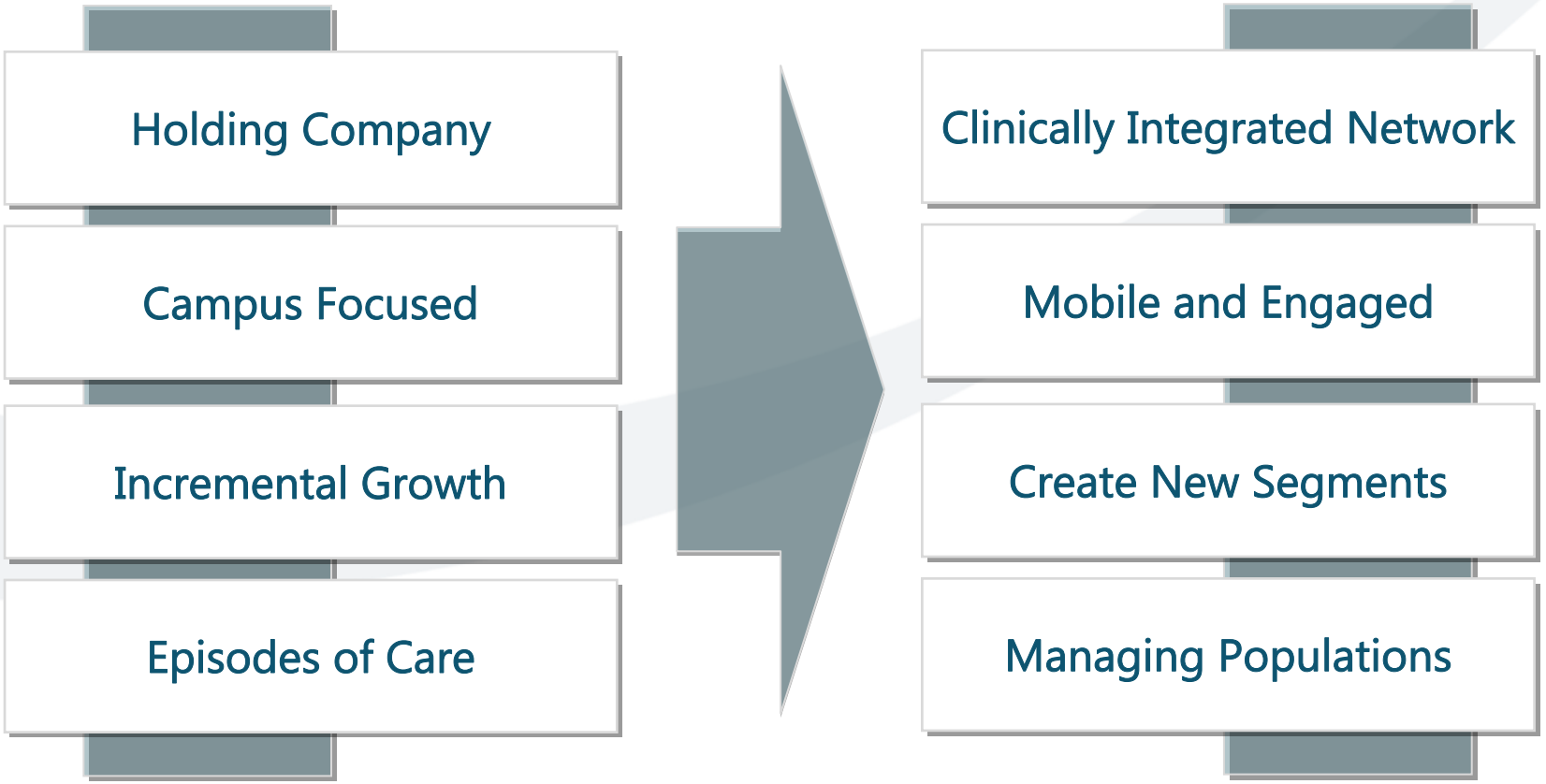
The Desired Destination



MARICOPA INTEGRATED HEALTH SYSTEM

Maricopa County Special Health Care District

Bond Advisory Committee Meeting

May 13, 2013

Item 3.

Next Steps

Next Steps

1. Apply BAC feedback to timeline, work steps, and guiding principles
2. Continue working to complete Facility Condition and Function Assessment
3. Continue to align with the progress of the strategic planning engagement

MARICOPA INTEGRATED HEALTH SYSTEM

Maricopa County Special Health Care District

Bond Advisory Committee Meeting

May 13, 2013

Item 4.

Minutes

DRAFT

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