Maricopa County Special Health Care District

Bond Advisory Committee Meeting

July 8, 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	Diane McCarthy
Tony Astorga	Terence McMahon, Ex-officio
Paul Charlton	Rick Naimark
Kote Chundu	Joey Ridenour
Frank Fairbanks	Brian Spicker
Nita Francis	Ted Williams
Merwin Grant	

AGENDA – Bond Advisory Committee Meeting

Board of Directors of the
Maricopa County Special Health Care District

· Maricopa Medical Center · Administration Building · Auditoriums 1 and 2 ·
· 2601 E. Roosevelt · Phoenix, AZ 85008 · Clerk's Office 602-344-5177 · Fax 602-344-0892 ·

Monday, July 8, 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. Update on Bond Advisory Committee's Project Process, Deliverables and Timeline 10 min
   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.

7/3/2013 10:32 AM

General Session Presentation, Discussion and Action:

2. Future Healthcare Environment and Special Health Care District Facilities Condition Assessment Report 80 min
   Larry Sterle, Kurt Salmon
   Rob Farr, Kurt Salmon

3. Strategic Plan Overview and Update 20 min
   Michael Eaton, Navvis & Healthways

4. Wrap Up, Next Steps and Future Agenda Items 5 min
   Jared Averbuch, Kurt Salmon

5. **Approve** Bond Advisory Committee Meeting Minutes dated June 10, 2013 5 min
   Committee

Adjourn

Maricopa County Special Health Care District

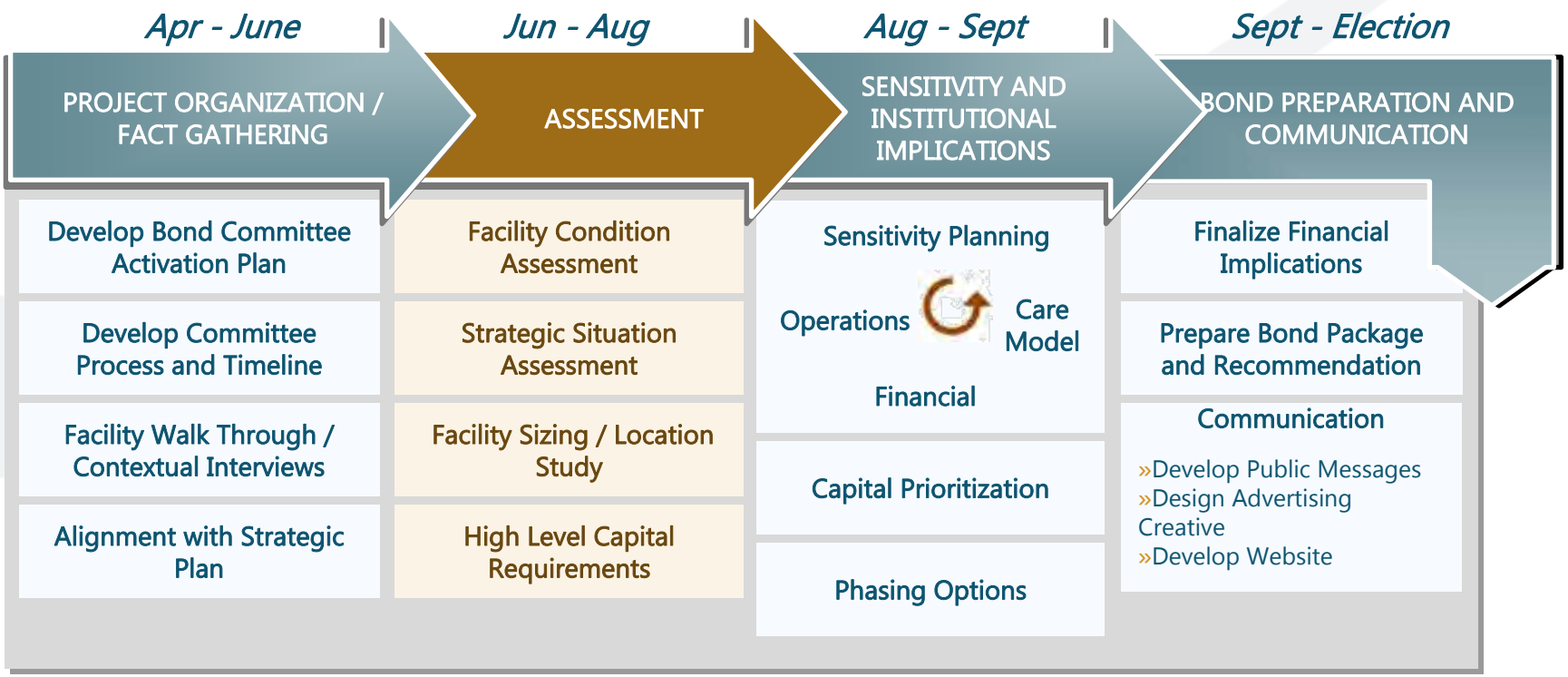
Bond Advisory Committee Meeting

July 8, 2013

Item 1.

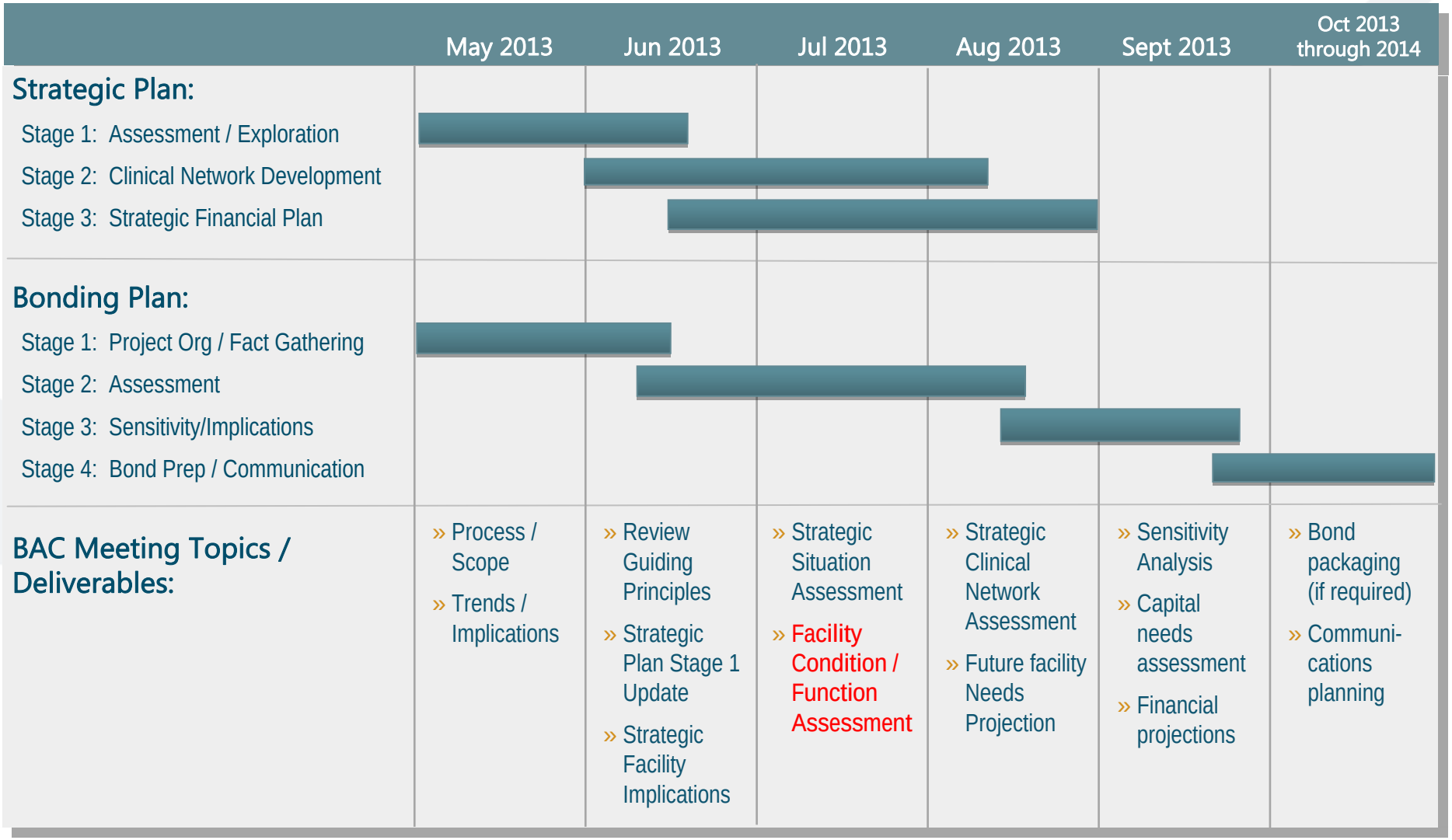
Process Update: Work Steps & Timeline

- This is the first meeting associated with Phase 2: **Assessment**



MARICOPA INTEGRATED HEALTH SYSTEM

Process Update: Today's Meeting Agenda



MARICOPA INTEGRATED HEALTH SYSTEM

Maricopa County Special Health Care District

Bond Advisory Committee Meeting

July 8, 2013

Item 2.

Context for Facility and Functional Assessment

The MIHS Main Tower was built in 1970 – much has changed in 43 years

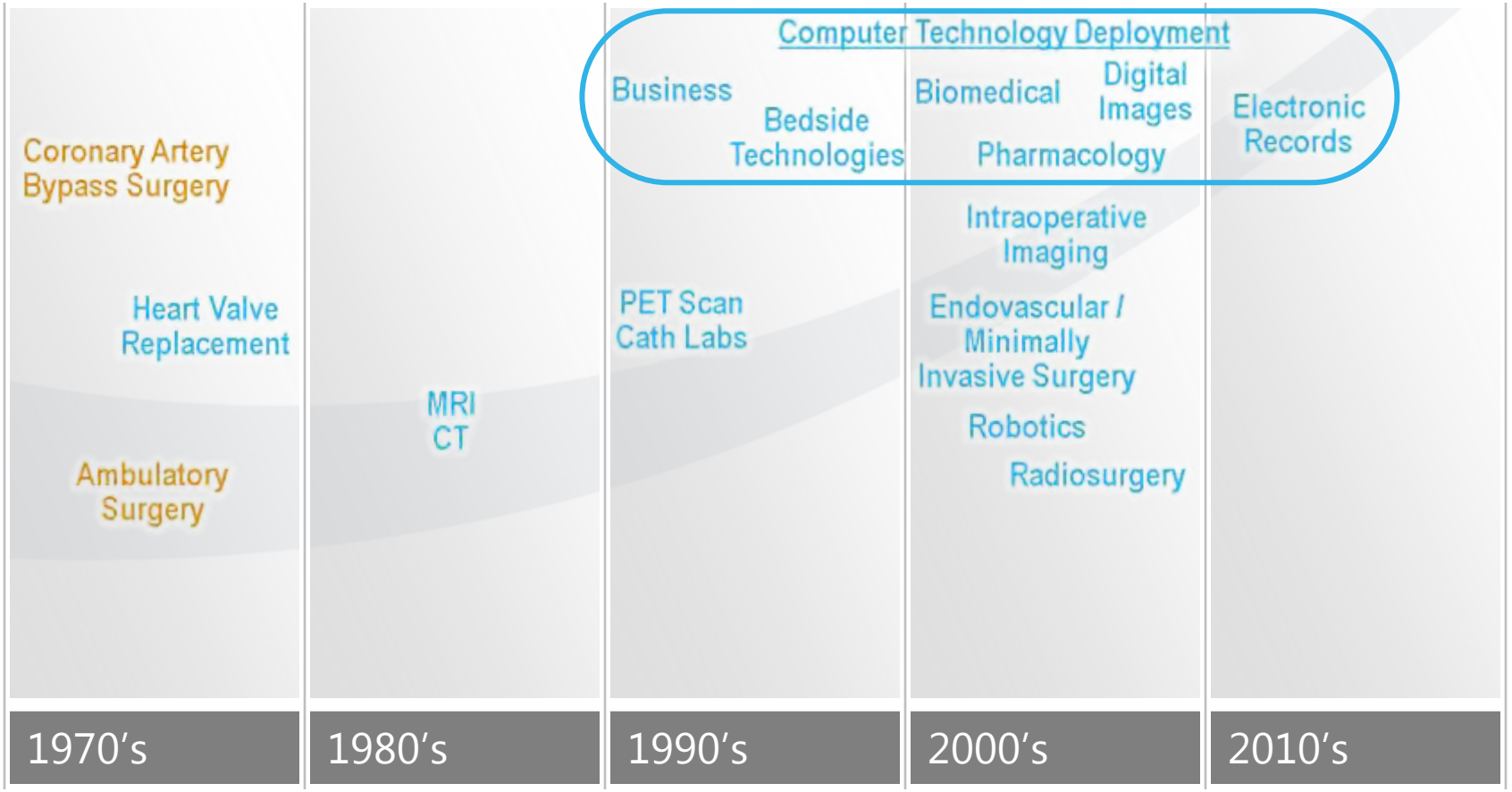
- Medical technologies
- Information / communication technology
- Models of clinical care
- Pharmaceuticals
- Infections and drug-resistant diseases
- Patient and family expectations
- Regulation
- Reimbursement
- Speed of change

Any evaluation of facilities and functionality must account for these changes

MARICOPA INTEGRATED HEALTH SYSTEM

Evolution of Healthcare: Changes Since 1970

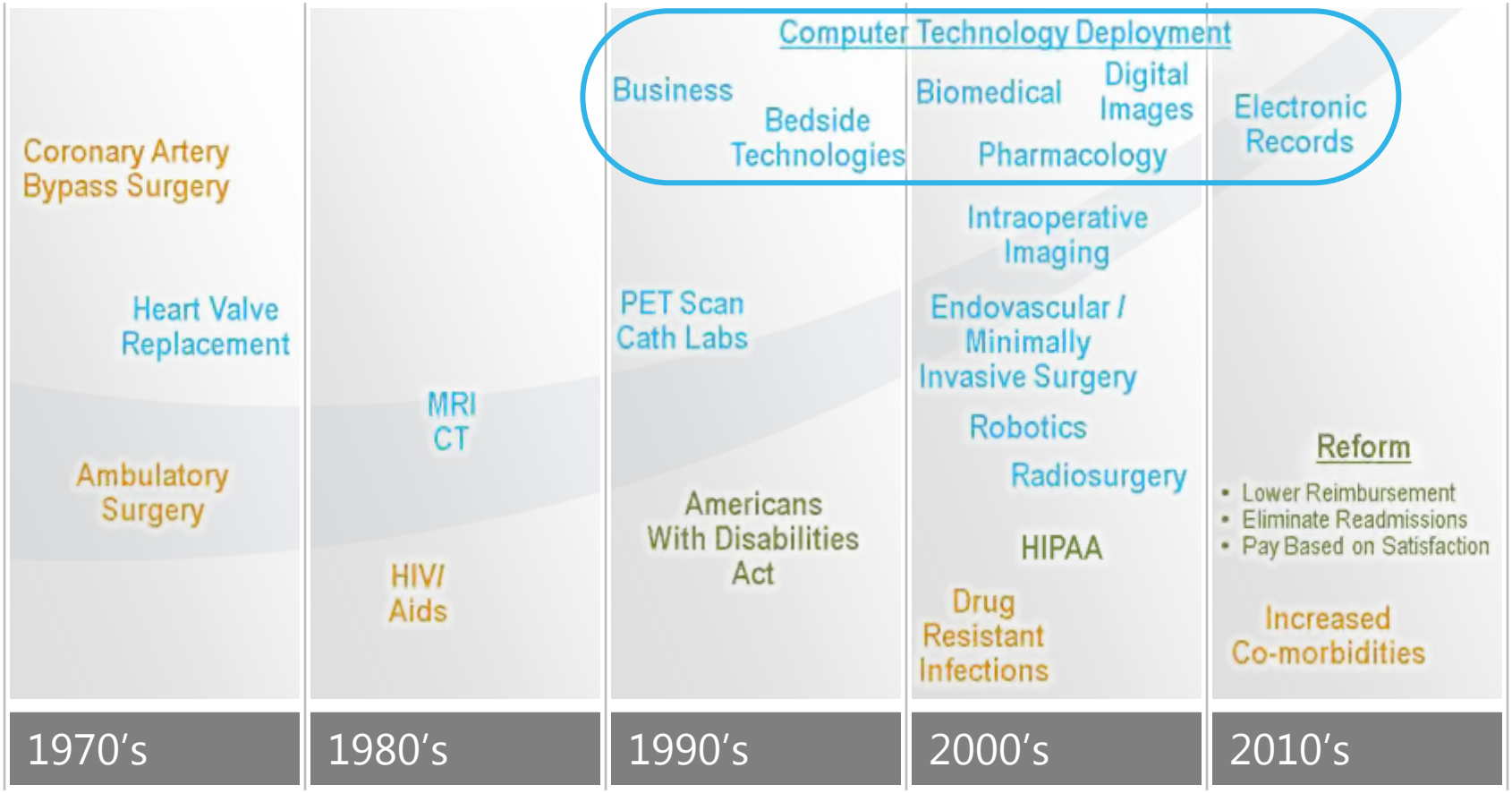
New technology added at an increasing rate



MARICOPA INTEGRATED HEALTH SYSTEM

Evolution of Healthcare: Changes Since 1970

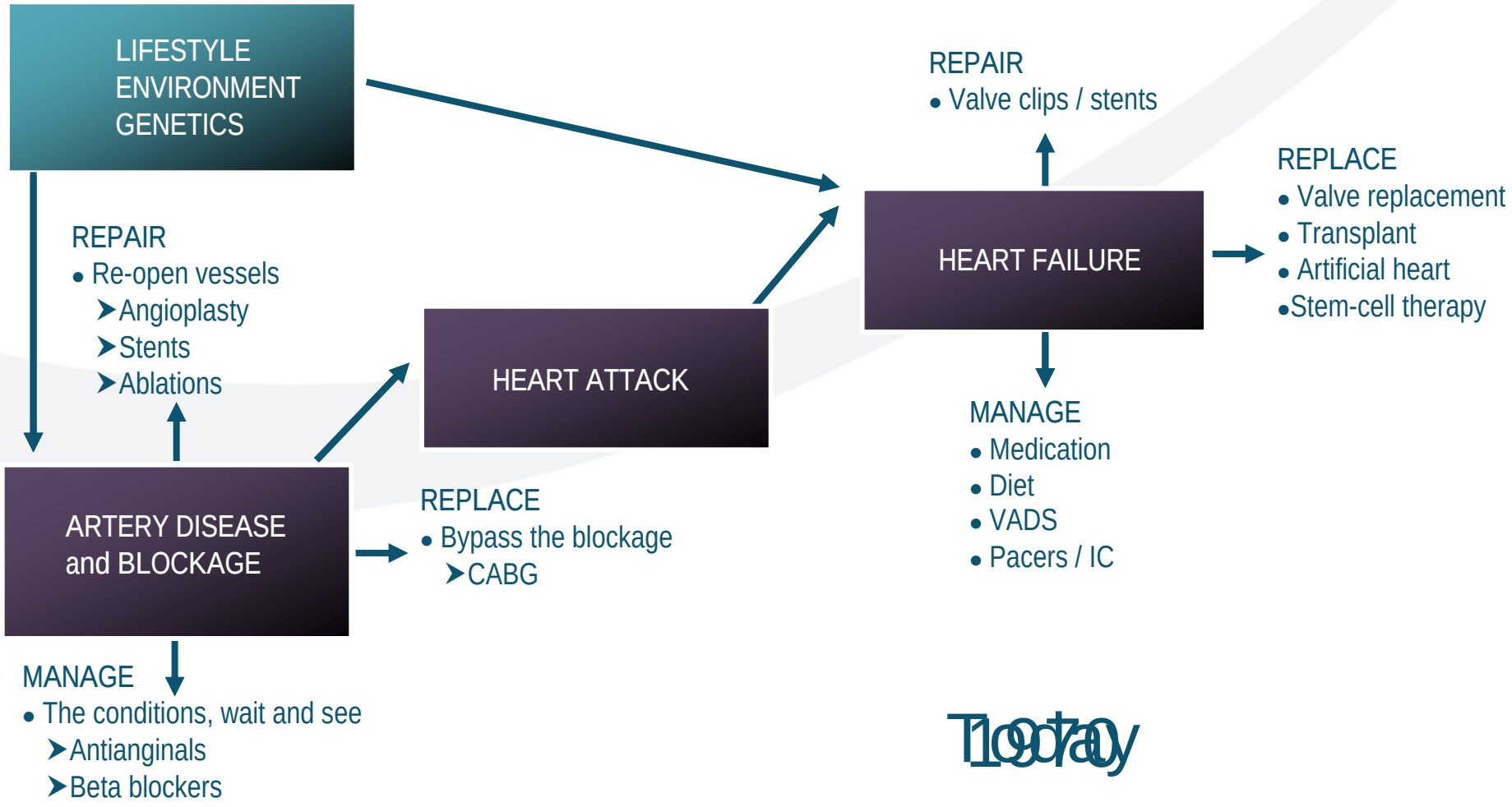
Legislation and new diseases have also come into play



MARICOPA INTEGRATED HEALTH SYSTEM

Evolution of Healthcare: Changes Since 1970

More and improved treatments to extend life

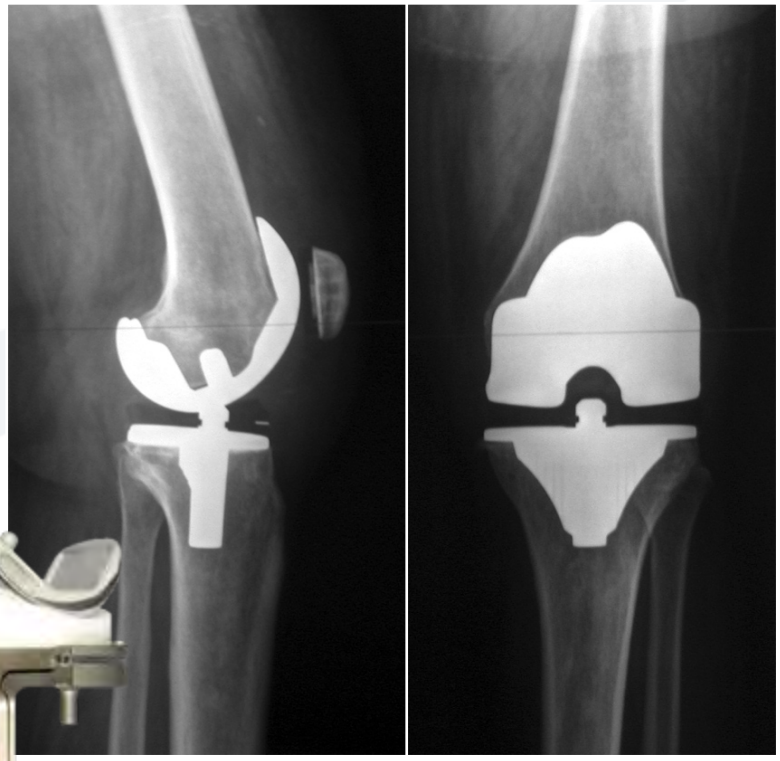


MARICOPA INTEGRATED HEALTH SYSTEM

Evolution of Healthcare: Changes Since 1970

More and improved treatments to improve the quality of life

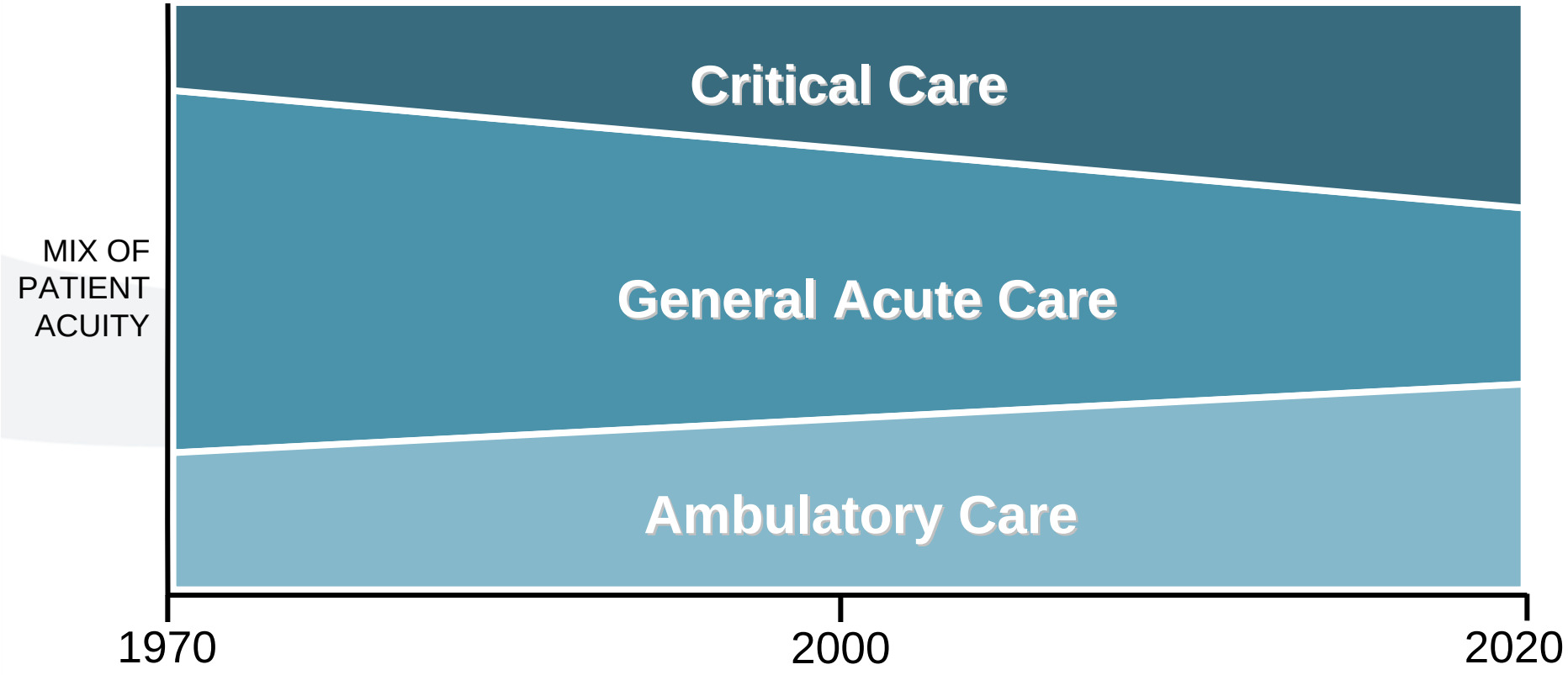
- Implantable Devices
  - Joints
  - Pacemakers
  - Deep brain stimulators
- Cosmetic surgery
- Bariatric Surgery



MARICOPA INTEGRATED HEALTH SYSTEM

Evolution of Healthcare: Acuity Shifting

The mix of patient acuity in healthcare facilities continue to change as the result of the changes outlined above



MARICOPA INTEGRATED HEALTH SYSTEM

Environment Responses: Safety

Inpatient rooms are changing in response:

- All private rooms
- More medical equipment
- Smart and wired
- Accommodations for family

Goals

- Improved clinical care / outcomes
- Enhanced safety
  - Reduce infections
  - Prevent falls
  - Eliminate medication errors
- Efficiency
  - No blocked beds
  - Shorten length of stay
  - Fewer transfers / transport

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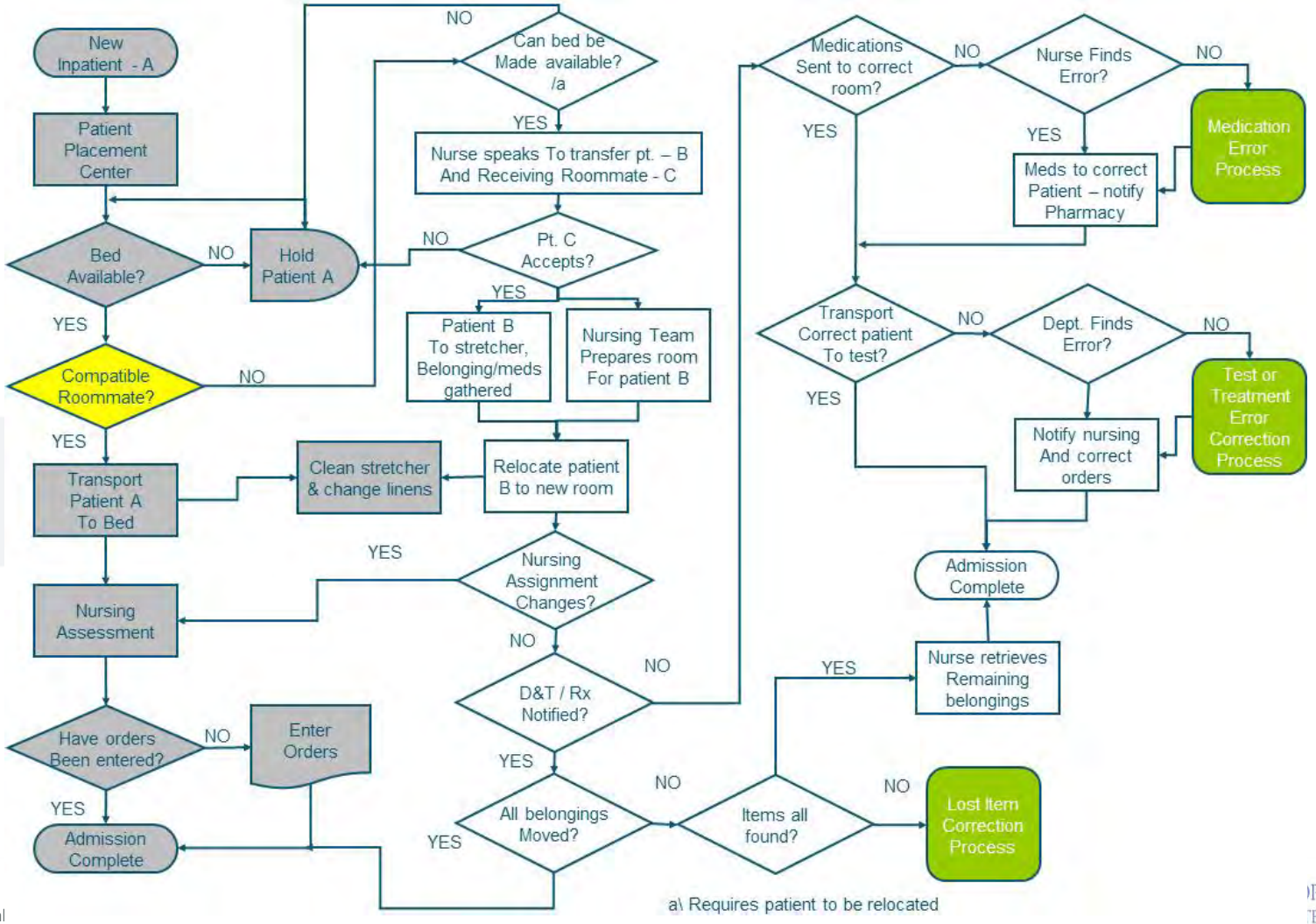
Environment Responses: Efficiency

Bed assignment streamlined with all-private rooms



Environment Responses: Efficiency

Example – interventional platform at UCLA Westwood

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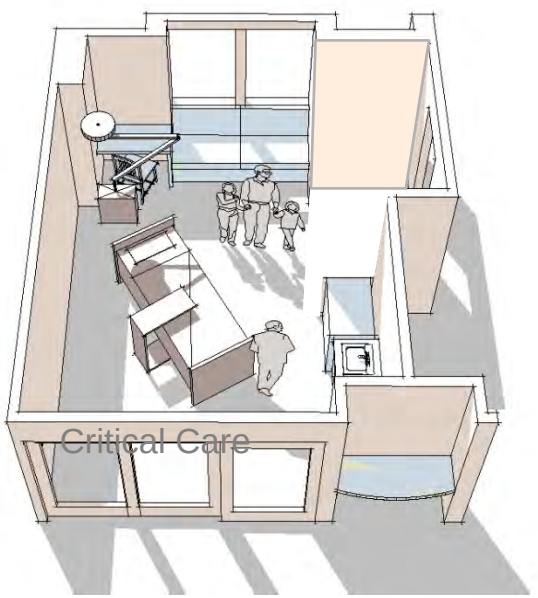
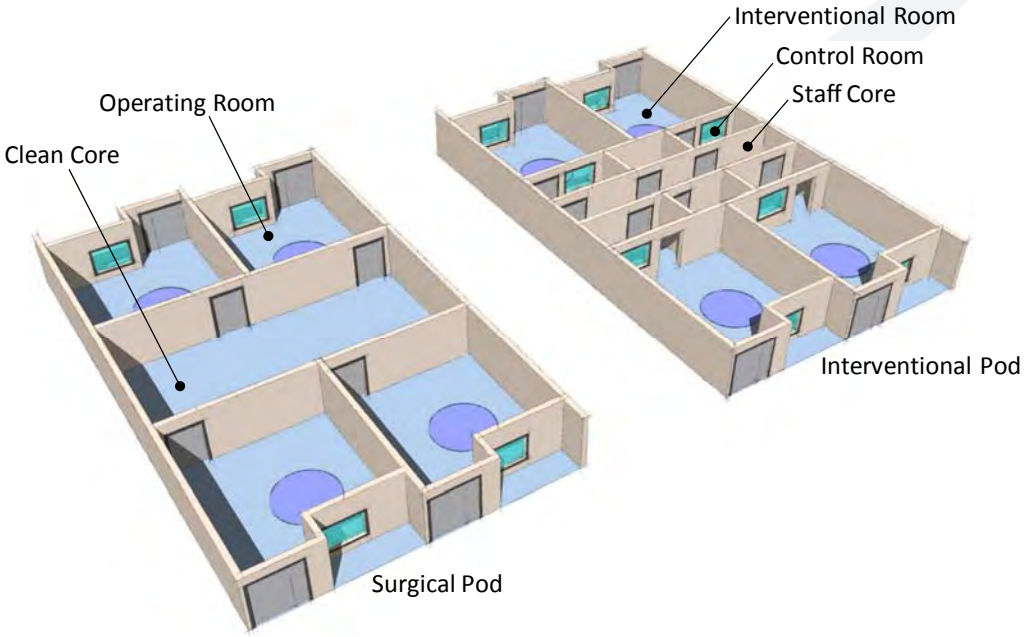
Environment Responses: Adaptability

Modularity and sharing of spaces – standardized outpatient models

Convertible Acuity





Convertible Use

Source: FKP Architects

MARICOPA INTEGRATED HEALTH SYSTEM

Environment Responses: Technical Capacity

Building Infrastructure

- Larger column grids
- Greater floor-to-floor heights
- Greater floor loading
- Higher HVAC capacity
- Wireless friendly
- Pervasive technology cabling
- Greater electrical capacity

Intelligent buildings

- Pervasive computing
- Centrally linked to on / off campus buildings and physician offices
- Master-controlled energy systems – green buildings
- Automated pharmacy, supplies, bio-medical
- Virtual clinicians

Johnson Controls

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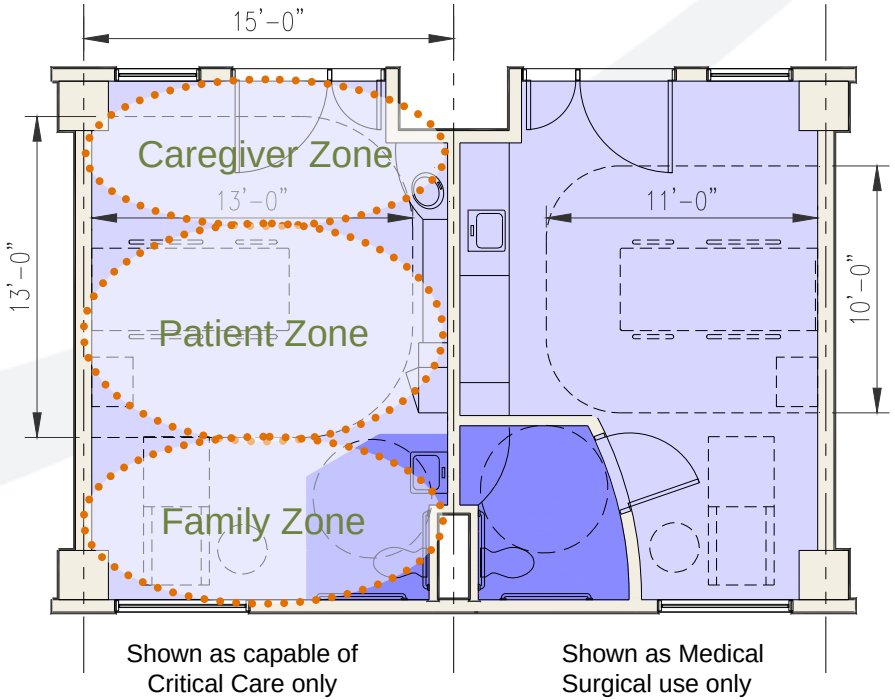
Environment Responses: Amenities

Increasing important for healing, satisfaction, and family involvement

- Controllable environment
- Access to internet
- Room service
- Designed family spaces
- VIP suites
- Light / open / green



MARICOPA INTEGRATED HEALTH SYSTEM

Environment Responses: Planning Standards

Planning standards have increased – comparative MIHS examples:

Surgery

- MIHS today = 2,487 Department Gross Square Feet (DGSF) per operating room
- Today's planning standards = 3,200 to 3,500 dgsf

Intensive Care Units

- MIHS today = 249 to 299 DGSF per bed
- Today's planning standards = 800 to 900 DGSF

Pediatric Clinic

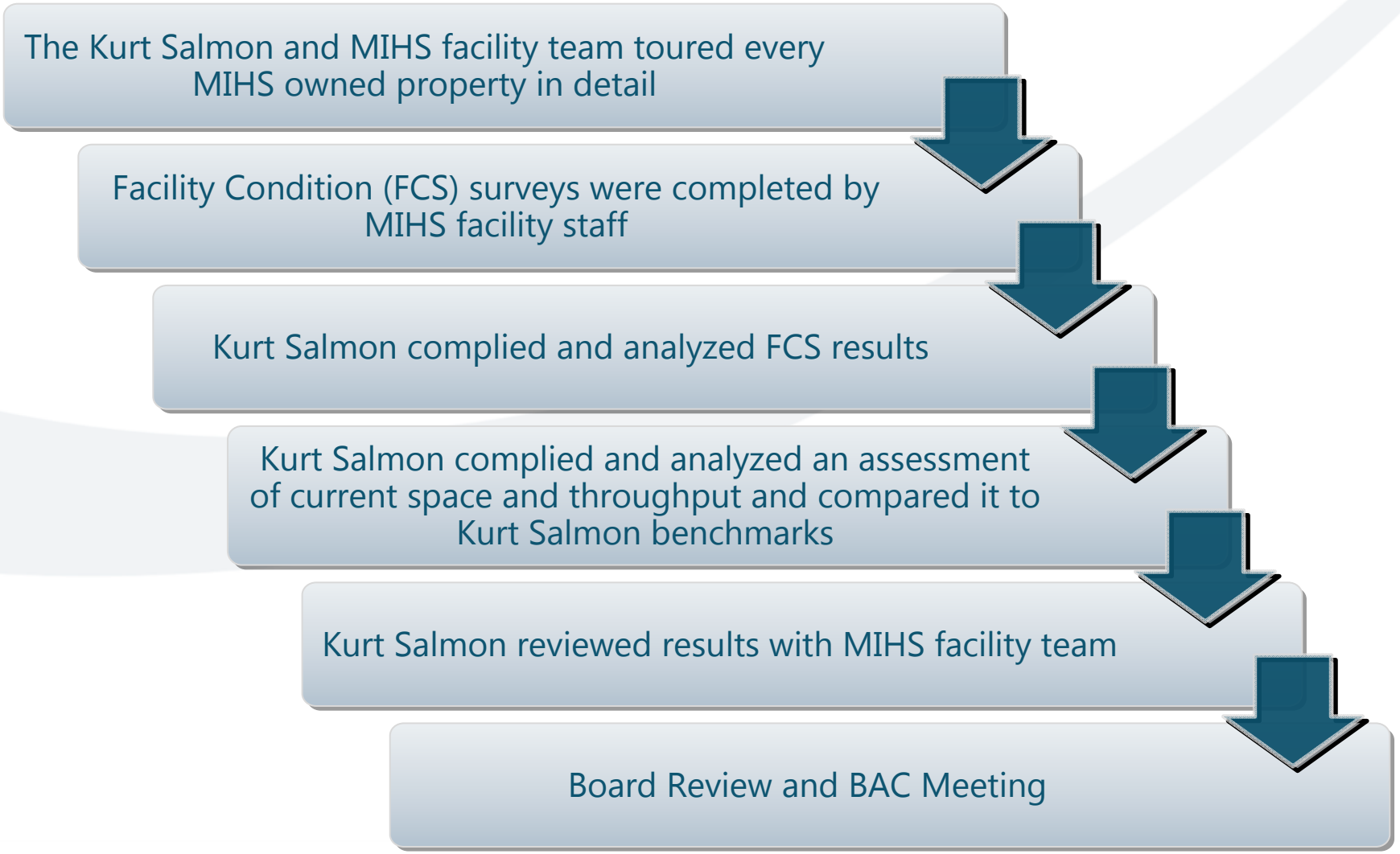
- MIHS today = 415 DGSF per exam room
- Today's planning standards = 600 to 650 DGSF

* Department Gross Square Feet

MARICOPA INTEGRATED HEALTH SYSTEM

Facility Condition Survey

Process Review: FCA Process



MARICOPA INTEGRATED HEALTH SYSTEM

Process Review: MIHS Locations Evaluated

Main Campus	Off Campus Sites
Main Tower	Desert Vista
CHC	FHC:
Administration	» *Avondale*
Hogan Building	» *Chandler*
Power Plant	» *El Mirage*
Laundry/Maintenance	» *Glendale*
2611 Warehouse	» *Guadalupe*
2619 Building	» *Maryvale*
	» *Mesa*
	» *South Central*
	» *SunnySlope*

Note: Kurt Salmon only evaluated MIHS owned facilities. Leased or rented facilities were not part of scope.

MARICOPA INTEGRATED HEALTH SYSTEM

Facility Condition Survey: Overview

The Facility Condition Survey (FCS) provides a leadership-focused report

- High-level understanding of building infrastructure status
- Broad in scope—eight categories/54 subcategories

Proprietary scoring system based on survey of attributes within each category

Master planning tool providing insight on each building's…

- Suitability for current use
- Suitability for continued investment

Inputs represent externally observable attributes and the internal knowledge of MIHS' facility engineering staff

- This survey is not a substitute for a detailed engineering study or as a guide infrastructure investment and maintenance schedules

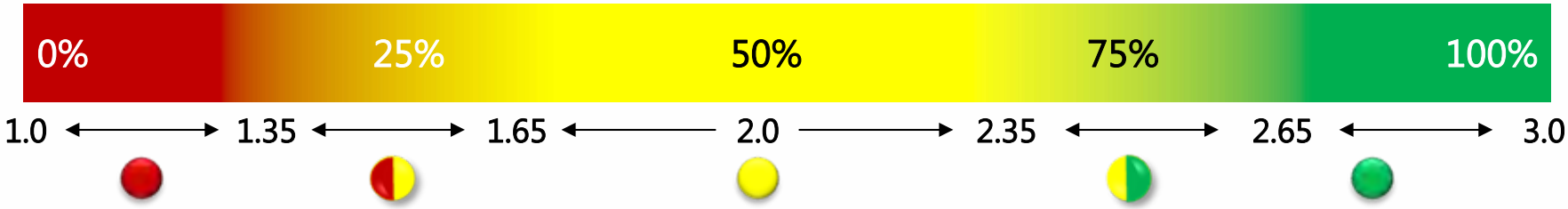
Note: Kurt Salmon's Facility Condition Survey is a proprietary tool

MARICOPA INTEGRATED HEALTH SYSTEM

Facility Condition Survey: Scoring

The rating indicates a building's capability to continue to serve it's current use:

- Not suited for continued current use
- Sufficient for continued investment in current use
- Strong asset for the long-term investment, multiple uses



Elements of Facility Condition Survey:

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

Note: elements that are difficult or impossible to change are weighted more heavily

MARICOPA INTEGRATED HEALTH SYSTEM

Facility Condition Survey: Clinical Buildings

Main Tower

Characteristics:

- Building Year: 1970
- Floors: 10

Primary Function:

- Inpatient Beds
- Diagnostic & Treatment
- Emergency Department
- Pediatric Emergency Department
- Surgery
- Labor and Delivery
- Burn Unit

CHC

Characteristics:

- Building Year: 1994
- Floors: 3

Primary Function:

- Outpatient Clinics
  - Breast Center, Cardiac Rehab, Dentistry, ENT, Orthopedics, Oncology, Primary and Specalty Care (adult and peds), Renal, Surgery, Woman's Clinic

2619 Building

Characteristics:

- Building Year: 1975
- Floors: 2

Primary Function:

- Behavioral Health
  - Inpatient
    - Adult
    - Geriatric
- MIHS Offices
  - IT
  - Human Resources

Desert Vista

Characteristics:

- Building Year: 1998
- Floors: 2

Primary Function:

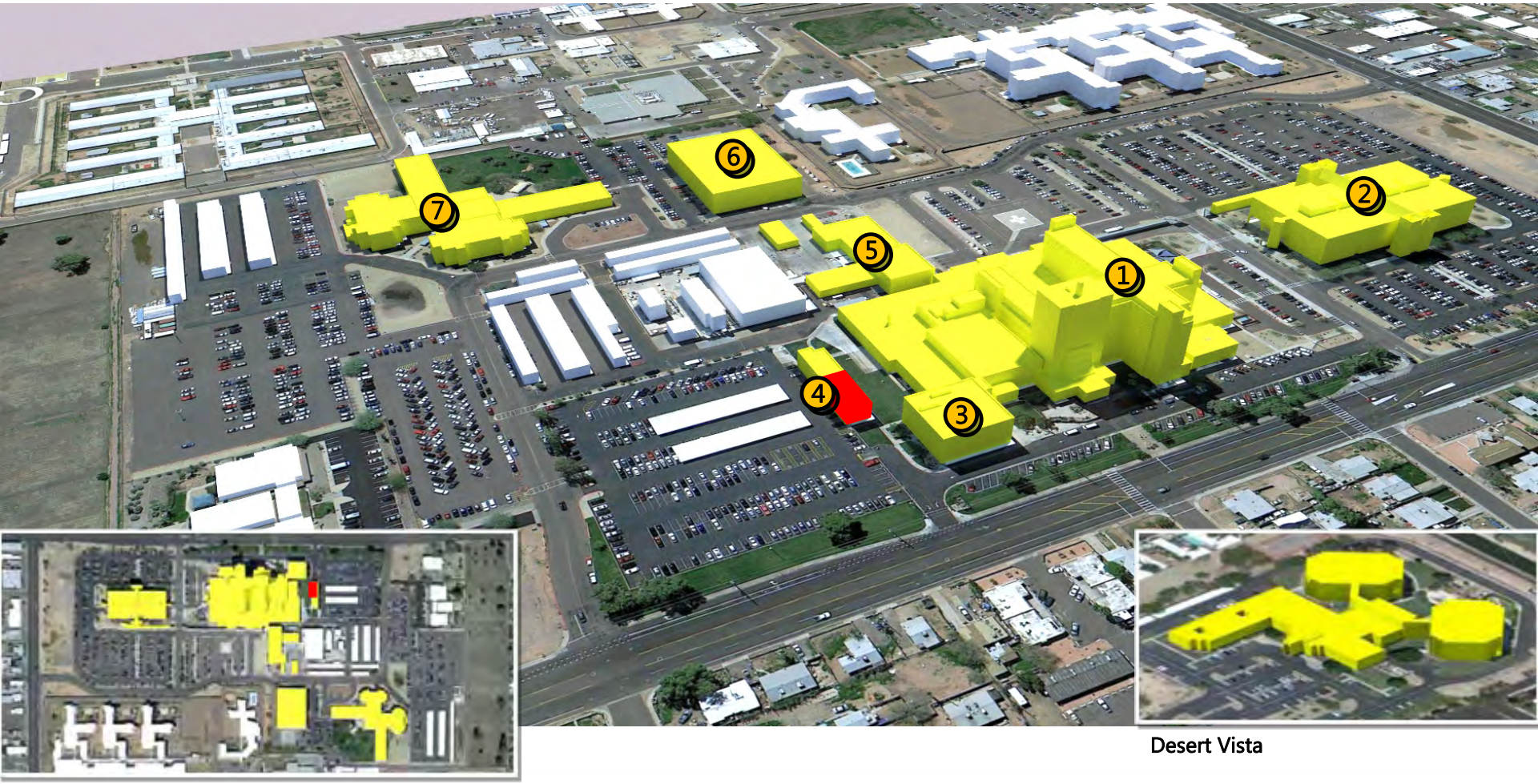
- Behavioral Health
  - Inpatient
    - Voluntarily
    - Court Ordered
  - Outpatient
  - County Court

Source: MIHS Website

MARICOPA INTEGRATED HEALTH SYSTEM

Facility Condition Survey: Current State

1 Main Tower	1970	**3** Administration	1996	**5** Laundry/Maintenance	1970	**7** 2619 Building	1975
2 Comp. Healthcare Center (CHC)	1994	**4** Hogan Building	1989	**6** 2611 Warehouse	1995		



Desert Vista

Notes: Kurt Salmon and MIHS Facility Staff toured each FHC; Data review by MIHS Staff

MARICOPA INTEGRATED HEALTH SYSTEM

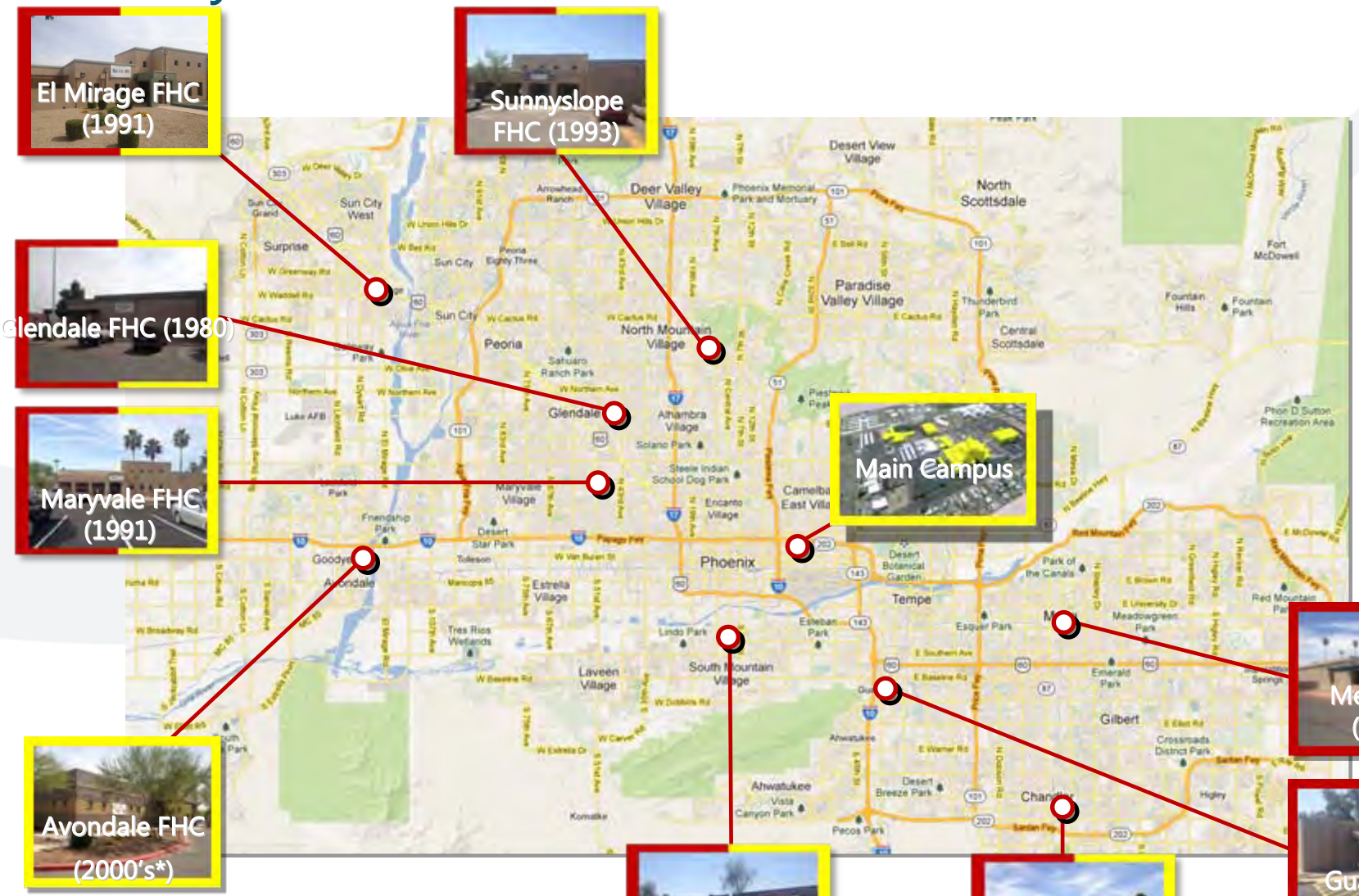
Summary by Category: Main Campus/Desert Vista

	Main Tower	CHC	2611 Warehouse	Admin	2619 Building		Laundry/ Warehouse	Hogan	Desert Vista
					Office	*Inpatient*			
Site Access/Parking									
Functional – Structural									
Exterior Envelope									
Mechanical									
Electrical									
IT Communication									
Life-Safety									
Vertical Circulation									
ADA Accessibility									
Overall Physical Condition									
Score	2.14	2.10	2.07	2.01	1.89	1.71	1.72	1.64	1.73

Notes: Kurt Salmon and MIHS Facility Staff toured each FHC; Data review by MIHS Staff

MARICOPA INTEGRATED HEALTH SYSTEM

Family Health Center: FCS Scores



*: Avondale was constructed in the 2000's but exact year was not know at time of printining
Notes: Only MIHS owned FHC were evaluated.; Kurt Salmon and MIHS Facility Staff toured each FHC; Data review by MIHS Staff

MARICOPA INTEGRATED HEALTH SYSTEM

Summary by Category: FHC

	Avondale	South Central	Chandler	Maryvale	Glendale	El Mirage	Sunny Slope	Guadalupe	Mesa
Site Access/Parking									
Functional – Structural									
Exterior Envelope									
Mechanical									
Electrical									
IT Communication									
Life-Safety									
ADA Accessibility									
Overall Physical Condition									
Score	**1.78**	**1.64**	**1.61**	**1.58**	**1.48**	**1.47**	**1.47**	**1.35**	**1.24**

Notes: Only MIHS owned FHC were analyzed; Kurt Salmon and MIHS Facility Staff toured each FHC; Data review by MIHS Staff

MARICOPA INTEGRATED HEALTH SYSTEM

Other Considerations

Administration has done a good job of making the best use of the Main Tower through productive renovations given the building's design limitations

1. The first level was not originally designed to support the shift to greater outpatient volume in the diagnostic and treatment services
   - » Few recovery beds for day surgery and same-day admission patients
   - » MRI and CT have been retrofitted into the building, but are not closely tied to the main imaging department
2. The bed tower configuration was not designed for the transition to high acuity patients and increased technology
   - » Column layout limits the ability to convert the building to private rooms
   - » Conversion to fewer beds per floor results in undersized, less efficient bed units
3. There is little relationship between parking and building entries on the main campus
   - » There is a sufficient amount of parking on the campus
   - » Much of the parking capacity is far away from the patient entrances
   - » Public transportation is close to the hospital front door

MARICOPA INTEGRATED HEALTH SYSTEM

Space and Throughput Assessment

Space and Throughput Assessment: Definitions

Kurt Salmon has developed a robust set of assessment metrics developed through our 60+ years of facility planning

The space assessment is based on two primary metrics:

1. Department gross square feet (DGSF) per "key room"
   - Key rooms = beds, operating rooms, emergency beds, etc.
   - DGSF includes all rooms, corridors and walls within a given department
2. Net square feet (NSF) measurements of key rooms
   - NSF is the space within the rooms

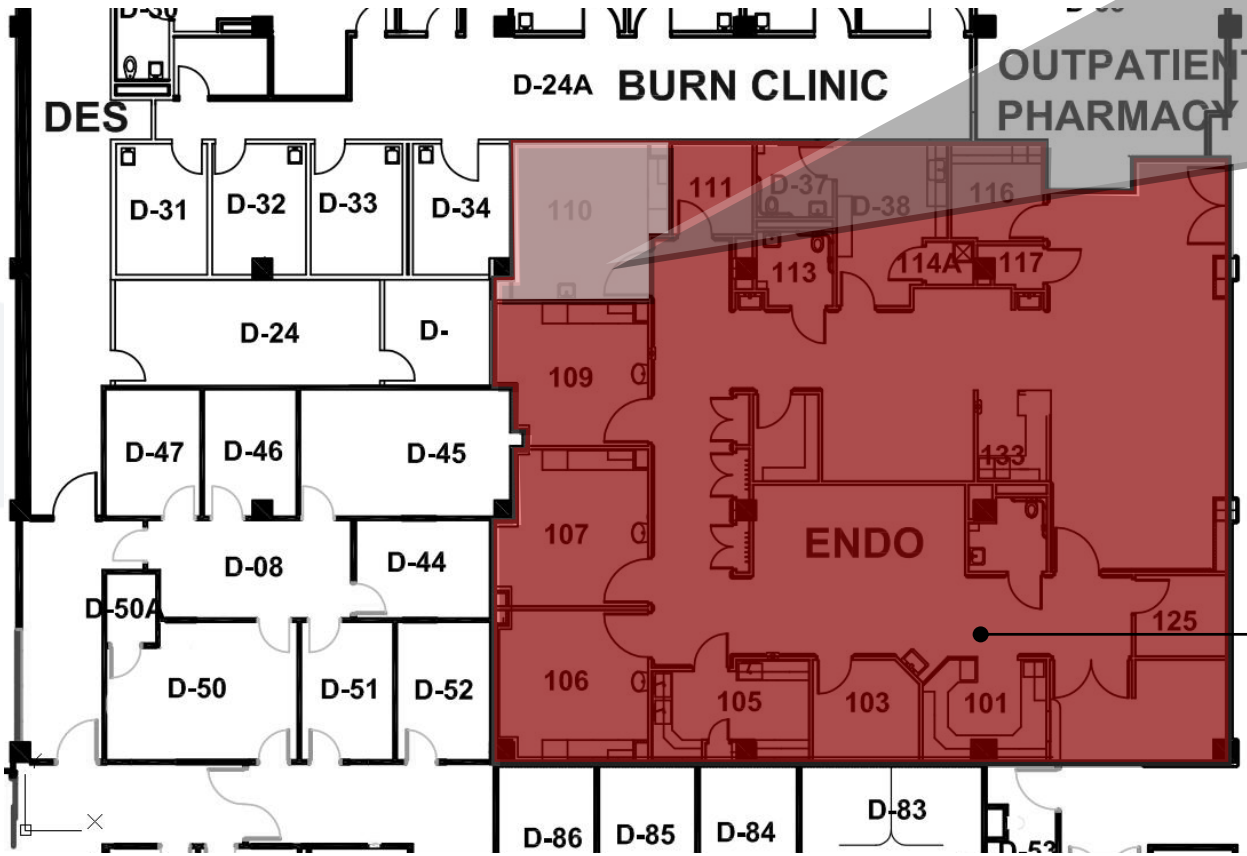
Throughput assessment is likewise based on two measures:

- Use of inpatient units is measured by occupancy rate at midnight census
- Diagnostic, treatment and clinic spaces are based on patients per key room per year
- Each of these measures allows for a certain ratio of "down time" for rooms turnover, seasonal variability and maintenance

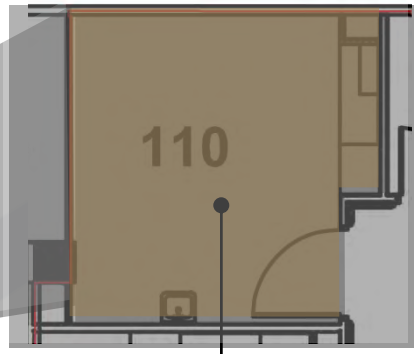
MARICOPA INTEGRATED HEALTH SYSTEM

DGSF/NSF: Graphic Example

Department Gross Square Feet (DGSF)



Net Square Feet (NSF)



Room
222 NSF

4,385 DGSF

MARICOPA INTEGRATED HEALTH SYSTEM

Functional Assessment: Summary – Inpatient Beds

- When compared to contemporary standards

Unit/Room Assessment		Patient Days/Volume Assessment
Green: within target range		**Green**: below target capacity; growth opportunity
Yellow: within 10% of target range		**Yellow**: within target capacity; limited growth opportunity
Red: greater than 10% below target range		**Red**: exceeds target capacity; insufficient capacity available for current activity
Blue: greater than 10% above target range		

MARICOPA INTEGRATED HEALTH SYSTEM

Functional Assessment: Summary – Inpatient Beds

- Contemporary hospitals use an all-private room model
  - Infection control
  - Improved efficiency
  - Better healing environment
  - Family participation
  - Complies with AIA guidelines
- Room sizes and total support space have expanded in the past 40 years
  - Increased patient acuity
  - Larger beds
  - More equipment & technology

Bed Unit	Private Ratio	DGSF/Bed Rating	NSF/Room Rating	Occupancy %
Main Tower				
Adult M/S	🔴	🔴	🔴	🟢
Adult Intermediate	🔴	🔴	🔴	🔴
Adult ICU	🔴	🔴	🔴	🟡
Adult Burn Unit	🟡	🟡	🔴	🟢
Post-Partum	🔴	🔴	🟡	🟢
LDR	🟢	🔴	🟡	🟢
Neonatal ICU	🔴	🔴	🟢	🟢
Pediatric M/S	🔴	🔴	🔴	🟢
Pediatric ICU	🔴	🔴	🔴	🟢
2619 Building				
Adult Behavioral Hlth	🔴	🔴	🔴	🔴
Desert Vista				
Adult Behavioral Hlth	🔴	🔴	🔴	🔴

Notes: Occupancy % is as of end of April 2013 – May 2012; Data review by MIHS Staff
Source: MIHS_Trend_Department Statistics Data Set – April 2013

Functional Assessment: Main Tower

- Most patient rooms are converted from four-bed wards
- Building design limits the ability to reconfigure to private rooms and meet building code
- Both MICU and SICU beds are mostly open bays

					Unit Assessment		Room Assessment				Patient Days		
Flr	Department	Beds	% Prvt	DGSF	DGSF/Bed	Rating	Room Type	NSF	RM Count	Rating	Patient Days	Occ %	Rating
Adult Med Surg													
7	Burn (Peds)	28	7%	16,927	605		Inpatient - Semi Private	470	2		26,730	75%	
							Inpatient - Private	225	1				
7	Burn (Adult)/Med Surg Overflow						Inpatient - Semi Private	470	11				
							Inpatient - Private	225	1				
6	General-Med Surg	38	26%	9,775	257		Inpatient - Semi Private	475	13				
							Inpatient – Private	225	10				
4	Surgery /Trauma	31	6%	12,795	413		Inpatient - Semi Private	460	14				
							Inpatient - Private	220	2				
Adult Intermediate													
5	APCU	23	22%	11,000	478		Inpatient - Semi Private	480	9		9,607	114%	
							Inpatient - Private	220	5				
5	APCU – West	9	100%	2,317	257		Inpatient - Private	143	9			N/A	
Adult ICU													
5	Medical ICU	11	0%	3,285	299		Inpatient (ICU) - Semi Private - Bays	213	11		3,359	84%	
4	Surgical ICU	13	0%	3,240	249		Inpatient (ICU) - Semi Private - Bays	219	13		3,322	70%	
Adult Burn													
1	Burn Unit	19	89%	14,316	753		Inpatient - Semi Private	415	1		5,045	73%	
							Inpatient - Private	222	17				

Notes: APCU West patient days are unable to be broken out, therefore APCU occupancy could be overstated; A Semi Private Room types contain 2 or more beds; Data review by MIHS Staff
Source: MIHS_Trend_Department Statistics Data Set – April 2013 (Full Year April 2013-May 2012)

MARICOPA INTEGRATED HEALTH SYSTEM

Functional Assessment: Main Tower

- Most pediatric intensive care beds are in open bays
- The NICU is not designed to contemporary concepts that support the neonates ability to thrive

					Unit Assessment		Room Assessment				Patient Days		
Flr	Department	Beds/ RMs*	% Prvt	DGSF	DGSF/Bed	Rating	Room Type	NSF	Room/ Count	Rating	Patient Days	Occ %	Rating
Pediatric Med Surg													
3	Pediatrics Med/Surg	34	38%	13,467	396		Inpatient - Semi Private Inpatient - Private	455 215	10 13		5,340	43%	
PICU													
3	PICU	7	0%	3,927	561		Inpatient - Semi Private	180	7		1,714	67%	
NICU													
2	NICU	31	0%	6,801	219		Inpatient (NICU)	219	31		6,168	55%	
Mother/Baby													
2	Post Partum	27	7%	10,180	377		Post Partum - Semi Private Post Partum - Private	490 220	13 2		4,874	49%	
2	Labor Delivery	20	100%	19,648	982		Labor Delivery, Recovery (LDR)	300	20		3,043	42%	

Notes: PICU and NICU contains bays and pods not rooms or beds; A Semi Private Room types contain 2 or more beds; Data review by MIHS Staff
Source: MIHS_Trend_Department Statistics Data Set – April 2013 (Full Year April 2013-May 2012)

MARICOPA INTEGRATED HEALTH SYSTEM

Functional Assessment: 2619 Annex

- Standards of behavioral health care have changed to a private room therapy model, since the building was opened
- Behavioral health patients who have medical needs are admitted to this building. However, the building is not designed to manage those types of patients

					Unit Assessment		Room Assessment		Patient Days		
Flr	Department	Beds/ RMs	% Prvt	DGSF	DGSF/Bed	Rating	NSF	Rating	Patient Days	Occ %	Rating
2619 Annex – Inpatient Behavioral Health											
1	Unit A - Adult	20	10%	9,010	451		205		6,804	93%	
1	Unit B - Geriatric	20	15%	9,010	451		215		7,892	108%	
2	Unit C - Adult	20	20%	9,010	451		205		6,975	96%	

Note: Data review by MIHS Staff
Source: MIHS_Trend_Department Statistics Data Set – April 2013 (Full Year April 2013-May 2012)

MARICOPA INTEGRATED HEALTH SYSTEM

Functional Assessment: Desert Vista

- The entire patient population is comprised of involuntary admissions
- Demand for voluntary admissions is reported to exceed the capacity of this facility
- Standards of behavioral health care have changed to a private room therapy model, since the building was opened

					Unit Assessment		Room Assessment		Patient Days		
Flr	Department	Beds/ RMs	% Prvt	DGSF	DGSF/Bed	Rating	NSF	Rating	Pat Days	Occ %	Rating
Desert Vista											
1	Unit 2 - Adult Women	14	0%	7,500	536		228		4,812	94%	
1	Unit 3 - Adult Men	24	0%	7,500	313		228		7,838	89%	
2	Unit 4 - Adult	24	0%	7,500	313		228		8,067	92%	
2	Unit 5 - Adult	17	0%	7,500	441		228		5,705	92%	
2	Unit 6 - Adult	22	0%	7,500	341		228		7,304	91%	
2	Unit 7 - Adult	22	0%	7,500	341		228		7,267	90%	

Note: Data review by MIHS Staff
Source: MIHS_Trend_Department Statistics Data Set – April 2013 (Full Year April 2013-May 2012)

MARICOPA INTEGRATED HEALTH SYSTEM

Functional Assessment: Summary – Diagnostic and Treatment

- With the shift to more outpatient treatments, contemporary surgery suites include:
  - Robust outpatient recovery beds
  - Prep beds for outpatients and same-day admissions
- Non-invasive diagnostic imaging has expanded to more modalities with larger footprints and technology capabilities
- Emergency departments are doing more treatments and lengths of stays have increased to do more admission preparation than when this hospital was built

Department	DGSF/RM Rating	NSF/RM Rating	Cases/ RM/YR
Surgery			
Cardiac Cath			
Endoscopy			
CT			
Diagnostic Imaging			
MRI			
Ultrasound			
Nuclear Medicine/Vascular			
Angiography Suite			
Emergency Department			

Note: Data review by MIHS Staff
Source: MIHS_Trend_Department Statistics Data Set – April 2013 (Full Year April 2013-May 2012)

MARICOPA INTEGRATED HEALTH SYSTEM

Functional Assessment: Main Tower

- The surgical suite has a minimal amount of prep and outpatient recovery beds – most patients are placed in an inpatient unit to recover
- While there are enough emergency department treatment rooms, staff and support space is undersized
- The main imaging department is unable to accommodate new, major technologies

				Unit Assessment		Room Assessment		Volume (Cases/Room)		
Flr	Department	RMs/ Bays	DGSF	DGSF/ RMs/Bay	Rating	NSF	Rating	Patients	Cases/RM/YR	Rating
Surgery/Invasive										
1	Surgery	11	27,362	2,487		519		7,741	704	
	Cardiac Cath	2	4,645	2,323		525		678	339	
	Endoscopy	4	4,385	1,096		200		3,486	871	
Imaging*										
1	CT	2	22,199	2,220		353		13,682	6,841	
	Diagnostic	3				279		27,791	9,264	
	MRI	1				345		2,695	2,695	
	US	3				165		5,987	1,996	
	Nuclear Medicine	2				378		1,047	523	
	Angio Suite	1				625		665	665	
ED										
1	ED (Adult and Peds)	57	29,140	511		138		71,074	1,247	

Notes: *Imaging volume was calculated using an procedure per patient ratio, ratios are listed in appendix; Peds ED was recently renovated, Adult and Peds ED patients are treated in separate and distinct locations
Data review by MIHS Staff
Source: MIHS_Trend_Department Statistics Data Set – April 2013 (Full Year April 2013-May 2012)

MARICOPA INTEGRATED HEALTH SYSTEM

Functional Assessment: Summary – Ambulatory (Main Tower/CHC)

- Healthcare is facing an increasing shift to the outpatient setting
- Efficient clinic utilization is predicated on sharing space and flexibility of use vs. assigned spaces
  - Some specialization is necessary
- All of the CHC has been built out
  - Some public spaces have been "borrowed" for clinical and ancillary functions

Department	DGSF/RM Rating	NSF/RM Rating	Cases/RM/Year
Main Tower Clinics			
Burn			
Cardiology			N/A
CHC Clinics/Imaging			
Oncology			
Medicine Clinic (Specialty)			
Medicine Clinic (Primary Care)			
Renal Dialysis			
Dermatology			N/A
Antepartum Testing			
Dental			
Pediatric Clinic (Primary & Specialty)			
ENT Clinic			
Woman's Care			
Eye Clinic			
Orthopedic Clinic			
Surgery Clinic			
Woman's Breast Center			
CHC Imaging			

Note: Data review by MIHS Staff
Source: MIHS_Trend_Department Statistics Data Set – April 2013 (Full Year April 2013-May 2012)

Functional Assessment: Main Tower/CHC

				Unit Assessment		Room Assessment		Volume (Cases/RMs)		
Flr	Departments	RMs	DGSF	DGSF/ RMs	Rating	NSF	Rating	Patients	Cases/ RM/YR	Rating
Main Tower Clinics										
1	Burn Clinic	5	2,054	411		120		6,364	1,273	
1	Cardiology Clinic	7	3,740	534		125			N/A	
CHC Clinics										
1	Oncology	13*	5,920	455		100		8,358	643	
1	Medicine Clinic (Specialty)	20	8,200	410		110		19,816	991	
1	Medicine Clinic (Primary Care)	20	9,045	452		120		10,733	537	
1	Renal Dialysis	11	5,700	518		100		9,356	851	
1	Dermatology	5	2,460	492		110			N/A	
2	Antepartum	4	2,795	699		120		9,468	2,367	
2	Dental	12	4,960	413		110		10,148	846	
2	Pediatric Clinic (Primary & Specialty)	22	9,130	415		100		22,910	1,041	
2	ENT Clinic	4	3,915	979		115		5,677	1,419	
2	Woman's Care	15	7,400	493		120		19,554	1,304	
2	Eye Clinic	10	5,680	568		100		11,862	1,186	
3	Orthopedic Clinic	14	2,575	180		80		13,041	932	
3	Surgery Clinic	16	7,130	446		120		14,590	912	
3	Woman's Breast Center	5	4,410	882		120		2,034	407	
CHC Imaging										
3	CHC – Mammo	2	-	-	-	150		2,136	1,068	
3	CHC - Diagnostic	3	2,985	934		273		8,545	2.848	
2	CHC – US	2	-	-	-	160		1,518	759	

Notes: *Includes 7 chemotherapy chairs. Data review by MIHS Staff
Source: MIHS_Trend_Department Statistics Data Set – April 2013 (Full Year April 2013-May 2012)

MARICOPA INTEGRATED HEALTH SYSTEM

Functional Assessment: Summary – Ambulatory (FHC)

- Current clinic trends are focused on providing patient and family friendly amenities (e.g. free coffee, play areas)
- Current FHC's vary in patient friendly amenities with some utilizing window bars while others have large family learning centers

Department	DGSF/RM Rating	NSF/RM Rating	Cases/RM/ Year
Clinic			
South Central			
Avondale			
Maryvale			
Glendale			
El Mirage			
Mesa			
Chandler			
Guadalupe			
Sunny Slope			
Dental			
Chandler			
South Central			
Avondale			
Mesa			
Glendale			
Imaging			
Chandler	-		
Maryvale	-		
Avondale			

Note: Data review by MIHS Staff
Source: MIHS_Trend_Department Statistics Data Set – April 2013 (Full Year April 2013-May 2012)

Functional Assessment: FHC

			Unit Assessment		Room Assessment		Volume (Cases/RMs)		
FHC	RMs	DGSF	DGSF/RMs	Rating	NSF	Rating	Vol.	Cases/ RM/YR	Rating
CHC									
South Central	17	14,076	828		120		16,548	973	
Avondale	13	10,769	828		100		14,495	1,115	
Maryvale	22	14,274	649		118		21,619	983	
Glendale	16	12,990	812		100		19,009	1,188	
El Mirage	9	8,019	891		108		15,046	1,672	
Mesa	18	16,281	905		125		18,331	1,018	
Chandler	19	9,923	522		100		20,815	1,096	
Guadalupe	8	4,791	599		107		11,465	1,433	
Sunny Slope	20	9,550	478		115		17,316	866	
Dental									
Chandler	2	998	499		80		1,966	983	
South Central	3	1,074	358		100		968	323	
Avondale	6	1,695	283		110		3,112	519	
Mesa	3	1,081	360		108		2,371	790	
Glendale	2	894	447		125		2,014	1,007	
Imaging									
Chandler – Diagnostic	1	-	-	-	305		519	519	
Chandler – US	1	-	-	-	248		158	158	
Maryvale – US	1	-	-	-	350		162	162	
Avondale – Mammo	1				158		201	201	
Avondale – Diagnostic	1	934	311		228		277	277	
Avondale – US	1				210		153	153	

Noes: Chandler and Maryvale imaging DGSF is included within clinic DGSF; Data review by MIHS Staff
Source: MIHS_Trend_Department Statistics Data Set – April 2013 (Full Year April 2013-May 2012)

MARICOPA INTEGRATED HEALTH SYSTEM

Maricopa County Special Health Care District

Bond Advisory Committee Meeting

July 8, 2013

Item 3.

MARICOPA INTEGRATED HEALTH SYSTEM

2013 – 2015 STRATEGIC PLAN OVERVIEW

DRAFT DISCUSSION DOCUMENT FOR BOND ADVISORY COMMITTEE

Mission and Vision

Mission

Maricopa Integrated Health System (MIHS) is committed to keeping healthy people well, to slowing the progression of chronic disease, and filling gaps in care for all people living and working in Maricopa County. We achieve those goals by teaching and training inter-professional teams in diverse clinical settings, advocating for investments in the health of our community, and designing care systems that continually improve outcomes, experience and cost.

Vision

MIHS is where Arizona's best doctors, nurses, and allied health professionals come to train, teach and practice medicine. They choose MIHS because:

- Our culture supports the training and deployment of inter-professional teams of clinicians;
- Our health professionals are committed to our mission of education and training;
- We offer a diverse mix of clinical encounters and a full-continuum of care sites;
- We provide a system of care that encompasses physical, mental, emotional, and social well-being; and,
- Our people, technology, and processes are focused on continually improving outcomes, experience and cost.

NAVVIS & HEALTHWAYS

Key Strategies and Goals

To Succeed, We Will Focus our Organizational Resources on Seven Priorities:

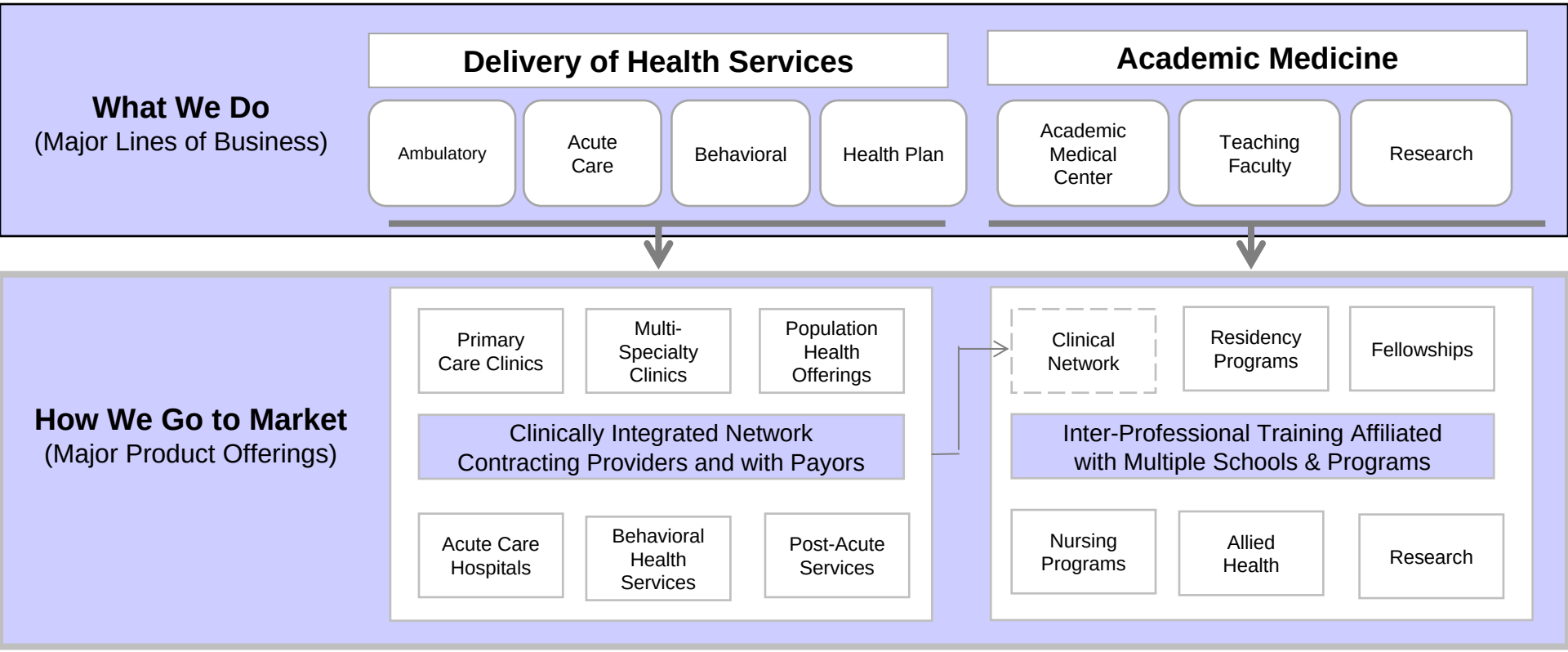
1. Organize a clinically integrated network to deliver evidence-based care and to manage populations	Success	• Clinically Integrated Network • Evidence-Based Care Models • Multi-disciplinary Teams • Accountable for Population Outcomes • National Top Quartile Performance
2. Distribute ambulatory services to enhance convenience and access for County residents		
3. Develop clinical partnerships as a means to grow total patient encounters and improve efficiency		
4. Affiliate with a medical school(s) and allied health programs for an inter-professional training program		• Phoenix's Academic Medical Center • Sufficient Clinical Training Encounters • Fellowships in Critical Specialties • Affiliation with Medical School(s) • Preferred Choice for Clinical Training
5. In partnership with a medical school(s) build an academic medical center to support Phoenix's needs		
6. Build an academic medical center brand that grows awareness and preference for MIHS care		
7. Refine governance and management to reflect an integrated care delivery model		• Alignment Between MIHS and DMG Boards and FHC Governing Council

NAVVIS & HEALTHWAYS

Enterprise Business Model

WORKING DRAFT

MIHS will Focus Resources and Strategies Around Two Major Lines of Business

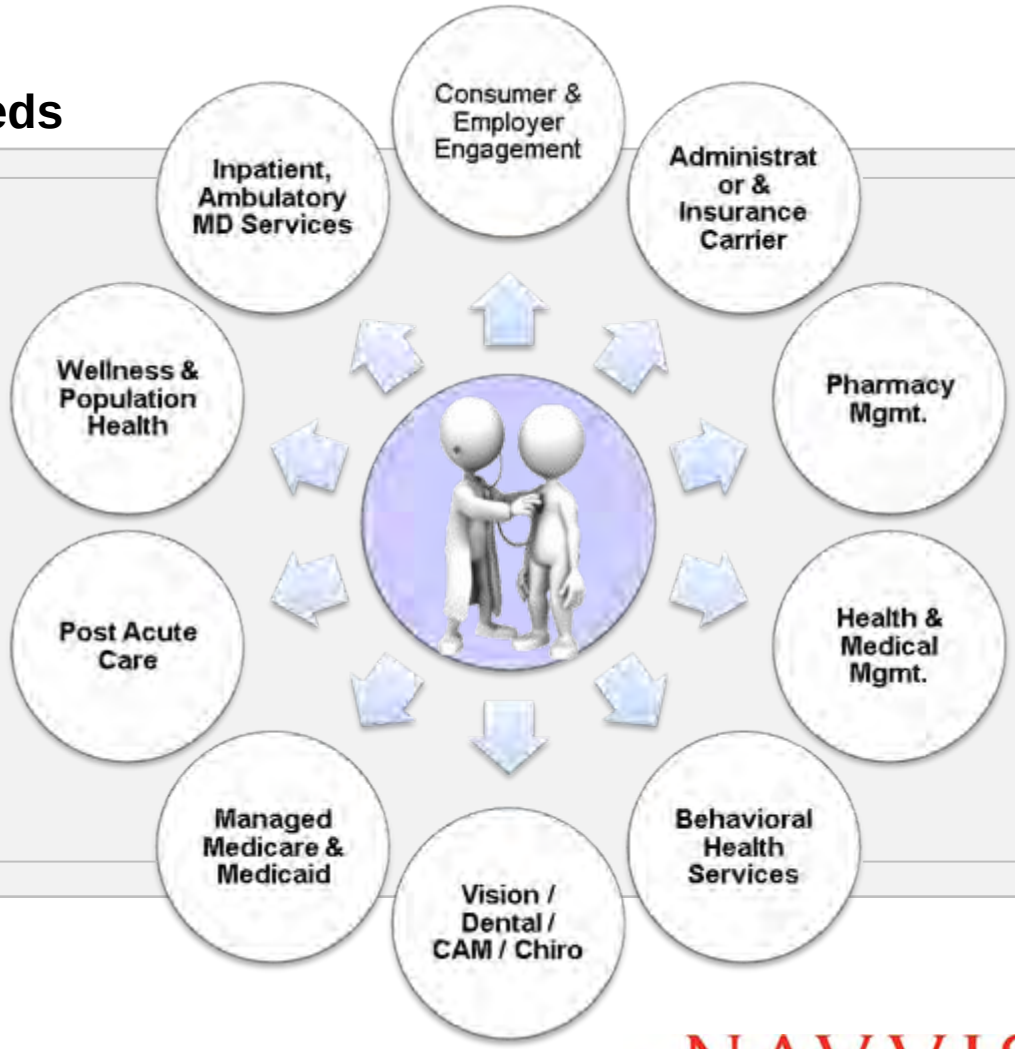


NAVVIS & HEALTHWAYS

Patient Centered Care

Care Organized Around Patient Needs

- ❑One-to-many model of partnership in the context of clinically integrated networks
- ❑Focus on partners who can cost efficiently deliver services in a risk-based accountable care model
- ❑Adopt a common participation agreement for entities in the network; multiple alignment models at the enterprise level
- ❑Maintain independent entity governance model / shared network governance council



NAVVIS & HEALTHWAYS

Academic Medicine Vision

Maricopa Integrated Health System is where Arizona's future doctors, nurses, and allied health professionals come to train. They choose MIHS because:

- Our culture supports the success of inter-professional teams.
- Our health professionals are committed to our mission of education and training.
- We offer a diverse mix of clinical encounters and a full-continuum of care sites.
- We provide a system of care that encompasses physical, mental, emotional, and social well-being.
- We are nationally recognized for innovations in training that anticipate and respond to new models of care.

To maintain our position as the premier training program in Arizona – and a preferred partner for medical schools, nursing programs, and allied health programs -- MIHS will:

- Grow patient encounters to strengthen MIHS clinical training and residency programs.
- Invest in training technology to allow inter-professional teams to build skills and demonstrate proficiency.
- Invest in translational research to enhance care access, population outcomes and patient experience.
- Partner with academic programs to strengthen our health services and clinical research capabilities.
- Develop fellowships in critical y needed specialties.

NAVVIS & HEALTHWAYS

Maricopa County Special Health Care District

Bond Advisory Committee Meeting

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Item 4.

Next Steps

1. Address Bond Advisory Committee questions on facility condition / functionality assessment and future implications
2. Advance the strategy development into forward looking forecasts
3. Integrate outputs of strategic planning effort into facility implications

MARICOPA INTEGRATED HEALTH SYSTEM

Imaging Ratios

Modality	Exams per Patient
CT	2.2
MRI	1.3
Radiology	2.0
US	2.5
Angiography	4.8
Nuclear Medicine	1.3

MARICOPA INTEGRATED HEALTH SYSTEM

Maricopa County Special Health Care District

Bond Advisory Committee Meeting

July 8, 2013

Item 5.

DRAFT

Maricopa County Special Health Care District
Board of Directors Bond Advisory Committee Meeti
Maricopa Medical Center
Auditoriums 1 and 2
June 10, 2013
2:30 p.m.

Voting Members Present:	Bill Post, Chairman Lattie Coor, Ph.D., Vice Chairman Tony Astorga Paul Charlton Kote Chundu, M.D. Merwin Grant Doug Hirano Diane McCarthy Terence McMahon, Ex-officio, Director, District 5 Rick Naimark – *left at 4:19 p.m.* Brian Spicker Ted Williams
Absent:	Frank Fairbanks Nita Francis Joey Ridenour
Others/Guest Presenters:	Michael Eaton, Navvis & Healthways Farzan Bharucha, Kurt Salmon
Recorded by:	Patricia Schultheis, MIHS, Assistant Clerk of the Board Melanie Talbot, MIHS, Executive Director of Board Ops - *arrived at 3:11 p.m.*

Call to Order

Chairman Post called the meeting to order at 2:36 p.m.

Roll Call

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

Call to the Public

Chairman Post called for public comment.

Chairman Post recognized Mr. Bil Bruno from Chandler, Arizona. Mr. Bruno stated he was a lifetime resident of Maricopa County. He has served on similar type committees in the past and realizes how time consuming they can be. He thanked the members for their service on the Committee.

Mr. Bruno stated he was a member of the Maricopa County Special Health Care District Board when it voted last fall to establish the Bond Advisory Committee.

Call to the Public (cont.):

The Committee's purpose is to make a recommendation to the Board on a possible bond election. He was troubled by a few comments made at the last Bond Advisory Committee meeting which seemed to indicate it was the Committee's responsibility to sell the bond proposal to the voters in November. If this is or becomes part of the Committee's duties he is concerned that the citizens will not be able to rely on the Committee's work. He urged the Committee to assist the Board to think through the whole idea so he can rely on their proposals and recommendations when deciding how he will vote.

General Session Presentation, Discussion and Action:

1. Update on Bond Advisory Committee's Project Process, Deliverables and Timeline

Mr. Bharucha stated his focus would be on two things: ensuring the Committee is working in parallel with the Board's Strategic Plan; and what are some of the preliminary facility implications that the Committee will have to consider.

Mr. Bharucha stated they are still at the end of the first phase of the process timeline. The Committee will need to understand what some of the facility and capital implications are and what questions they need to ask themselves in order to make recommendations to the Board. He will provide a list of questions to consider and will give examples of what other institutions have done in similar situations. This is the last meeting involving generic, trend based discussions. Future meetings will be much more specific to Maricopa Integrated Health System (MIHS).

Mr. Bharucha stated the Strategic Plan is scheduled to be defined by September and the Committee's efforts have to be phased so they understand what the Board has approved. Mr. Eaton will walk the Committee through the Guiding Principles, Strategic Plan Stage 1 Update & Strategic Facility Implications. At July's Committee meeting, discussions will begin to focus on the facility condition and functional assessment. Subsequent meetings will involve the clinical network and what the capabilities are in terms of growth or redistribution of the future facility.

Mr. Bharucha pointed out that the Committee will use the Guiding Principles as a checklist to evaluate options. At last months' meeting the Committee discussed how to change them to more accurately represent their views. Mr. Bharucha asked the Committee members to review them and reply with any suggested changes. At the end of the process the options will be evaluated as to how they match up to the Guiding Principles.

2. Discuss and Review Alignment with the Strategic Planning Process

Mr. Eaton stated the health systems that progress most quickly are those that have a sense of clarity about where they are going – a strategic direction. This allows for a greater certainty as to how to allocate resources and deploy in the marketplace. It is critical for the Board to think about what success looks like and how to measure and achieve it in order to be meaningfully different and relevant in the community. It is also very important to understand the external forces shaping the market place, how the organization performs, and what barriers to success have to be overcome. These questions and the answers to them will feed the decisions the Committee has to make.

Mr. Eaton said there are two core foundational pieces to vision and value: delivery of integrated health services (not necessarily all under one roof and one brand); and academic medicine & training.

Within these tow cores are four quadrants representing what MIHS does that delivers value for the community, for patients and providers, for payers and for academic partners:

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

2. Discuss and Review Alignment with the Strategic Planning Process (cont.):

- Organize Effective Systems of Care
  - This is a challenge due to multiple interdependent processes in terms of patient flow from provider to provider and department to department, across an episode of disease.
- Train Clinicians for Emerging Needs – the model is changing
  - The model of academic medicine is less about a physician-centric classroom, didactic process of learning one-on-one and more of an eco-system of doctors, nurses and other clinicians operating to manage, anticipate and respond with care
- Measurably Improve Health and Well-Being
  - MIHS must consider not just the health and well-being at an individual patient level but also the organization as an asset for the community as a whole
- Create New Value through Research and Innovation

Mr. Naimark questioned the weighting given to the Integrated Health Services and Academic Medicine & Training pieces. The slide shows the circles equal in size. He asked if there was a sense as to how they are actually weighted in terms of resource allocation, strategies, etc.

Mr. Eaton stated he did not believe the two could be separated without destroying the DNA – the power is in the synergy between the two.

Vice Chairman Coor asked to what extent the current patient base is being considered in articulating a desired, anticipated or targeted future demographic basis.

Mr. Eaton said this will be covered in the presentation to the Committee in July.

Chairman Post commented that the economic dynamics of each quadrant is different, which may not force the model to be optimum, yet the vision and value proposition seems reasonably optimum. He questioned how the real economic forces would be molded to apply themselves in each of the quadrants.

Mr. Eaton stated there will be fewer dollars flowing in globally. With all other things remaining equal, i.e., the organization staying the same size; downward pressure on reimbursement; increasing pressure on costs and expectations to deliver more; it will be critical to be efficient in order to be an effective system of care. The business model has to include making the organization as streamlined as possible to be able to deliver the best possible care, in the lowest cost care setting, as efficiently as possible.

Mr. Eaton explained the global economics, from a community standpoint, will be to figure out how to train and improve care outcomes for the community. On a population level, how will costs be brought down, outcomes improved, positive impact be created for businesses, employers, families and individuals. There is a macroeconomics and financials and there are organizational levels that have to be balanced throughout the process.

Mr. Eaton reviewed the Strategic Imperatives reviewed by the Board in May:

- Access
  - Enhance/innovate to improve access to services
  - Design innovative programs to fill gaps in care
- Efficiency
  - Leverage partnerships were possible
  - Improve quality to reduce costs
- Effectiveness
  - Build population health competencies
  - Design evidence based systems of care
- Stewardship
  - Perform better to fund the future of our mission
  - Train the workforce to meet emerging health

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

2. Discuss and Review Alignment with the Strategic Planning Process (cont.):

Mr. Astorga questioned how the strategic initiatives are being aligned to the patient, who is looking for access, affordability, choice and quality.

Mr. Eaton stated there are other considerations besides brand. Some of these are convenience, cost, speed, and building confidence that MIHS has experts and expert programs. These considerations are being included in the process and will be translated into the story being told.

Dr. Chundu commented that the current operating model is to be paid for quantity, not quality. He believes this will change in the future. Providers are not currently paid for prevention, however the health system design is moving toward this. The model will be changing and there are not mechanisms in place for this. He believes it will be hard to answer the economic issues without knowing what the future model is.

Mr. Eaton stated the new model is not simply one of how to achieve better outcomes at a lower cost, but what interventions can be put in place to avoid surgery. A model can be built to account for this and it will include learning to operate at the lowest possible cost, with the best possible outcomes and intervening where possible to keep people out of the hospital.

Mr. Hirano commented that the concept of building the public health population sounds like public health, epidemiology and health policy. He wondered if there had been any discussions around trying to embed these skills within MIHS or whether it was something different that was being talked about. He also asked what the incentives are for a health care entity to do this type of work if it is only getting paid for specific services. He suggested that partnerships with county health departments may be useful. This could create funding streams to allow a system as large as MIHS to actually do some of the community health work.

Mr. Eaton stated the old model is kind of a one-to-one partnership and we are shifting to one to many partnerships. There must be many people around the table in partnership, delivering certain expertise. The public health function and community based care function are critical elements of this. The advantage is that it is a mobile, engaged work force. The old public health model is a great model with nurses and workers deployed throughout the community. They went into people's homes and delivered the needed care, when and where it was needed. The challenge for most health systems is they want to own everything. This takes away the "DNA" that made it effective, which is, it was low cost, it was nimble, it was mobile, it was out in the community. MIHS has to be able to go back to that population health piece. MIHS ought to be the organization that convenes people and brings those partnerships together. From an impact standpoint it's not the bed count, or the inpatient market share, or total encounters. It's the ability to create something new, and forging partnerships that are most effective.

Chairman Post asked how outside forces which may not be consistent with the values of the strategic initiatives will be incorporated into the strategic plan. For example, there could be regulatory processes and economic and political influences that may not be consistent with what the internal profession has decided it wants to be.

Mr. Eaton stated if the regulations conflict with the strategic plan the answer is two-fold. MIHS has to be an advocate to change them and in some cases, will have to find a way around the rules, without subverting them, until they change.

Mr. Spicker asked if they had looked at or if health care is looking at the social impact bonds, like those emerging in homelessness. There is a high cost to having someone on the street in terms of emergency police, fire and hospital services. He wondered if there was any thought being given as to how to incentivize fixing some of these health problems.

Mr. Eaton stated they are looking into this and it will be part of what they bring forward. It is real fertile ground and there are great opportunities.

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

2. Discuss and Review Alignment with the Strategic Planning Process (cont.):

People are doing some real innovative things in order to leverage new sources of funds to put programs together that radically change the cost structure of how care is delivered. The key is to focus on those that have the greatest amount of impact, given the limited resources to spend, and how to deploy them in the most cost effective way. It is a process of narrowing items down, quantifying the impact and prioritizing what comes first. Regulatory processes may also dictate what can come first, given the rules.

Mr. Eaton spoke regarding the Vision for Integrated Care. It is a "one-to-many" partnership model with a network of services and systems working together seamlessly, across the partnerships. MIHS, DMG, nurses, clinicians, post-acute care, pharmacy, etc. – all of these pieces are what people define as their care. The key is not to own it but how to partner with entities that efficiently deliver services with a shared vision and set of goals. The Committee has to think about this when they think of facilities. It needs to think about a participation agreement and it has to be defined. Incentives also have to be aligned within the model.

Mr. Eaton spoke next about Academic Medicine. The shift is to a more systems based organization around patient needs. This involves different professions working together.

Mr. Eaton reviewed the potential barriers to success:

- Access to Strategic Capital – where will dollars come from? Can MIHS fund its strategies and operations if/when the Safety Net Care Pool and the Special Health Care District Tax Levy Authority sunset?
- A Strong Brand – When given a choice in 2014 to go elsewhere for care, will MIHS's core patient base abandon the brand for alternatives?
- Greater Scale in the Market/Population Health – Can MIHS aggregate enough lives to deploy a system of care and spread risks and costs over a defined population managed in a risk-based contract? How do you aggregate enough lives to support the residency programs? You must have a certain number of clinical encounters and deploy a system of care to spread risks. How do you make this happen?
- Academic Affiliation – Should MIHS structure an affiliation with a medical school to maintain and enhance its residencies, workforce training, and research programs? The model is changing nationally. It used to be there was an academic medical school affiliated with an academic medical center and increasingly, medical centers have multiple affiliations with hospitals serving as a medical center for multiple programs and supporting residents. What does this look like?

In terms of timing and planning, the Committee should think about understanding the future demand; the geographic markets; what services based on the needs of the population; how to fill the gaps and how to make best use of the resources to do this.

Mr. Naimark asked if the trend across the country is for medical education to shift to inter-professional relationships.

Mr. Eaton stated they are seeing nurses and physicians working together as a team on the same curriculum. They are also seeing outcomes being defined on the basis of the entire team, not just at the individual practitioner level. There are four types of physician leaders - clinical, governance (who sit on boards to help define vision), business and small team leaders. The small team leaders are the ones that really drive service. They are the missing piece in health care and that is what they see being developed.

Mr. Naimark commented that there has been a lot of focus in Arizona with genomic and proteomic research. He asked, overall, where MIHs stands with respect to the rest of the world when it comes to translational research.

Mr. Eaton believes MIHS is not behind with respect to translational research and has the opportunity to be a leader, however, there are others who are further ahead.

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

2. Discuss and Review Alignment with the Strategic Planning Process (cont.):

Chairman Post asked if Kurt Salmon or Navvis will provide a distribution around each of the facilities in terms of their probability of success.

Mr. Eaton stated they will be providing this type of information to the Committee after the Board has had a chance to review it.

Mr. Naimark asked if there was anyone out there doing things well that MIHS could learn from.

Mr. Eaton stated Baylor Health System, Geisinger Health System (Geisinger Medical Center), Penn State and Indiana University are some of the institutions that are doing some very good things. The area most of them are making good progress in is moving from the didactic lecture based teaching to more of a team based virtual training. This puts data into the process and allows people to make decisions based on it.

3. Discuss and Review Preliminary Facility Implications

Mr. Bharucha then reviewed the Preliminary Facility Implications:

- Developing a clinically integrated network implies potential facility investment beyond traditional acute care facilities
- Improving access to the community implies an extension of the existing ambulatory platform, and potentially the development of new/different access points
- Building a "brand" that is more quality and service-oriented could require greater levels of investment in the ambience/feel associated with MIHS facilities
- Shifting to systems-based care, organizing around patient needs, and embracing new models of teaching and clinical research, could all require a major rethink of optimal layouts and adjacencies within future facilities

Ms. McCarthy asked Mr. Bharucha for an example of developing a clinically integrated network implies potential facility investment beyond traditional acute care facilities.

Mr. Bharucha said to think about the continuum of care today and what a patient accesses for health care. It could be work that occurs before they are in an operating room or a hospital. This work may be provided by a specialist, a free standing imaging center or urgent care. Then there are services that are automatically tied to the acute care episode and later, a whole range of post-acute care elements. For instance, MIHS does not have a Long Term Acute Care or Hospice services. If the strategic plan direction is that there is no real good provider for these services in the community but it is critical for the care of MIHS populations, MIHS may choose to build facilities for this purpose. These kinds of decisions come back to what does MIHS's clinically integrated network look like.

Mr. Bharucha pointed out that MIHS's campus is relatively young compared to academics across the country. In thinking about depreciation MIHS is at the tail end of the useful life for some of its facilities but compared to facilities across the country, MIHS facilities are a lot younger. It is also important to think about the functionality and what it can actually support.

If you took all of the facilities from across the country and aerated them across from an age standpoint you get something that looks like a bell curve. Facilities that were built in the 1970's or older cannot put too much more clinical care in the facilities. They are built so they cannot support technologies that are in place. Some of them do not have internet connectivity, HVAC or electrical systems to support some of the equipment that needs to be installed.

At the same time, facilities built in the 1990's are starting to get phased out of inpatient use. Thinking about the intensity that is required to take care of patients, the highest cost is on the inpatient and operating room side and after a while, they are no longer contemporary.

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

3. Discuss and Review Preliminary Facility Implications (cont.):

The facility then moves to an ambulatory function, then to administrative and office and then into some kind of an infrastructure and support function. This is usually the life cycle of some of these buildings.

Mr. Naimark commented that it seems there are a number of local hospitals that are aging and have converted a lot of hospital floor space to outpatient clinical care. He asked if this is generally an effective and efficient thing.

Mr. Bharucha responded that sometimes the cost to gut and renovate is almost as much as the cost of building new but in other cases, it is not.

Mr. Bharucha stated in terms of access points, MIHS will have to decide whether it needs bricks and mortar access points for the entire integrated network and think about what the core competency is in terms of delivering care. For instance, Duke just began providing more primary care. They realized they didn't have access so they decided to partner with Target in creating retail clinics. It was their capital decision to leverage what Target is doing in the community in order to establish access points.

Mr. Bharucha reviewed a survey that American Society for Healthcare Engineering (ASHE) prepares every year showing where various health care systems are spending money. There are four categories that are considered more fee for structure related and sometimes the cost of these infrastructure projects can be huge: parking, data centers, central energy power plant and the physical plant. Sometimes they are a rate limiting step, meaning an inpatient tower can't be built until the central energy plant is taken care of. All of these things have to be thought through and implemented in a phased manner.

Dr. Chundu asked Mr. Bharucha about the distribution of the dollar investment for services that are interdependent like ambulatory and inpatient care.

Mr. Bharucha stated each situation is different and this will be looked at and prioritized. Based on the condition assessment report, which hasn't been released yet, the ambulatory facilities are in better shape than the inpatient facilities. However, this doesn't mean you would invest in the inpatient facilities if the demand and need is more on the ambulatory side.

Mr. Bharucha touched on the capital needs associated with non-facility investments like information technology, telemedicine and ICD-10. In many cases these investments are outpacing facility type investments. They are easily in the tens of millions of dollars and quite frequently in the hundreds of millions of dollars. Expenditures for equipment will also have to be considered along with what the physician model is going to look like. There are dollar implications associated with expanding the physician model too.

Mr. Bharucha pointed out that capital and design costs of building a new facility are a fraction of the lifetime costs of maintaining and operating it over its lifetime. Over the next couple of months the Committee should be thinking about whether they need a smaller or different inpatient platform, like the mix of beds or configuration of beds.

Dr. Chundu asked if they would be addressing the same implications for the outpatient facilities.

Mr. Bharucha stated they would be doing this.

Mr. Farzan spoke about the ambulatory network of the future. The medical office building from 20 years ago is not very different from the medical office today, but it is starting to slowly change. Almost all patients today see their physicians in an ambulatory environment in the same way. Most places have hours from eight to five; they require patients to come in, park and come into the medical office building, sit in the waiting room, and wait for the physician or provider before they have their clinic visit. Some places use extenders, mid-level providers, etc., to optimize the physicians time. The model has been the same whether you are a low complexity patient coming in for a well visit or a very complex patient that has multiple co-morbidities and has to come in once every couple of weeks just to maintain their health.

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

3. Discuss and Review Preliminary Facility Implications (cont.):

The model is changing. For instance if you need a wellness visit or a flu shot why are you coming in from eight to five to a medical office building? It's not a model that will prove efficient in the long run.

The fastest growth in any sector has been in retail health. Retail clinics like CVS and Walgreen's are talking about doubling the number of clinics in their existing pharmacies over the next five years. It's due to convenience and it is a much lower cost point.

Mr. Naimark commented that it seems the electronic medical record issue is critical to that future.

Mr. Bharucha agreed and said one of the biggest issues and the reason you still come into the physician office building is so the provider knows what else has happened with that particular patient, but that is slowly starting to change.

Mr. Williams stated that is exactly why the health information exchange (HIE) needs to be built, along with the ability to use it.

Mr. Bharucha agreed and said there are communities with providers that are now entering into HIEs between themselves.

Dr. Chundu stated planning is crucial in order to deploy the dollars wisely. He questioned the type of data being gathered from MIHS.

Mr. Bharucha stated that Mr. Eaton's team has already started to pull some information and they have an algorithm that they will run to produce a high-level review.

Dr. Chundu stated there is a great opportunity to create some cost effective and convenient options for the community.

Mr. Bharucha commented they have seen reduced no show rates in places that are employing more of the ambulatory diversification.

Mr. Bharucha reviewed Facility Implications and Considerations for MIHS. MIHS is still relatively traditional in terms of the way the facility is organized. You have a hospital in one building and an ambulatory center in another building with most of these things tending to be vertically organized. Some places have gone entirely to a programmatic organization, like the Cleveland Clinic. Their Miller Family Pavilion has all the requirements for all heart care in one building. They do the same for their neurological institute and cancer institute. All the requirements for a specific institute are together but the beds are separate. There are also hybrid models that go in between traditional and programmatic models. If you want a multi-disciplinary layout then maybe you place things close to each other. Or you may want all of the ICUs together and all of the ambulatory clinics together. The things to consider are what the organizing model needs to look like and what the implication is for the facilities that exist today.

Mr. Bharucha stated another important element will be to include flexibility in the facilities so they have better long-term use. The cost to do this up front may not always be cheaper but it will pay off in the long term.

Mr. Bharucha stated there are some things that will be emphasized as they go through the facility planning:

- Eliminate unjustified things like space and the pathways and processes that the space encourages
- Optimize what you have in place
- Focus on high priority elements and determine how to phase them in, over time
- Do not use capital solutions to fix operational problems

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

4. Wrap Up, Next Steps and Future Agenda Items

Mr. Bharucha laid out the next steps to include:

- Incorporating a lot of the discussion that has already occurred into the next document
- Presenting a representation of the facility condition and functionality assessment
- Continuing to bring items back to the Committee that are deliberated and approved by the Board so the Committee and Board are functioning in parallel

Mr. Charlton commented he recently visited the Guadalupe FHC and though it may not be as efficient as having patients coming downtown for care there is something wonderful about having physicians, physician assistants, nurses, etc. in the community. He asked if there was a way to measure this type of thing.

Mr. Bharucha stated that historically, productivity metrics are the ones that hospitals focus on and not always the access and service metrics. Some places have looked at what percentage of their service area population is within 10 minutes of an access point and this is easy to do. In the strategic planning process when tradeoffs are required, it is hard to say what the Board will decide in terms of their direction. It will be a balancing act but is something that can be looked at as facilities discussions continue.

Mr. Grant asked if the consultants would be providing direction as to where the District might partner; what it can do in that respect and what benefits will arise from this.

Mr. Bharucha stated, from his understanding, the whole development of the clinically integrated network, which is one of the principles in the strategic planning process, is focused on that. His assumption is that if the Board agrees that it makes sense to partner in certain areas, they will provide that input to the Committee.

Chairman Post stated this is the last process meeting that the Committee will have before moving forward. He asked the Committee members to provide feedback in those areas of the process that they feel uncomfortable with or that they believe need to be strengthened. The Committee has an obligation to get back to the consultants.

Mr. Bharucha recapped that the past few meetings have been spent talking about trends and to some extent, things that are not directly applicable. That phase is complete and the intent moving forward is to focus specifically on the issues. Input form the Committee will be incorporated into the process. Additionally, things have to be translated from the strategic planning process and coordinated with the Board so the more advance notice there is, the more time there will be to process through the Board.

Chairman Post stated he had two concerns. One was that the feedback loop going back to the strategic plan is very important. In his past dealings with facilities planning this has usually been substandard and it is a very critical piece. The second was that there should be some way to get a sense of how to prioritize between operational and capital solutions and the monies for those.

Mr. Bharucha stated all of the discussions from the facility condition assessment and throughout are being looped back to the Board. From an operational standpoint he was unaware if the strategic planning process is at the point of developing financial proformas. He confirmed that they will gain an understanding of what the implications are of operational changes. Revenue and expense numbers are changing with the way that the environment is moving and they will consider the capital implications to those proformas. They will be looking at the interplay of both.

Mr. Spicker stated he agreed with Mr. Grant's & Mr. Charlton's earlier comments and that it was important to understand how to move forward in a community because place does matter. Further evidence of this was when he and Vice Chairman Coor visited South Mountain. It was very evident that the clinic played an important role in the community.

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

4. Wrap Up, Next Steps and Future Agenda Items

Mr. Bharucha stated he felt it was important that this feedback go back to the Board. The issue of determining where the access points need to be throughout the community will actually come before discussions about the facility implications of those access points.

Mr. Williams said regardless whether it's Guadalupe or South Phoenix they still have to look at the Affordable Care Act and determine how to make money with prevention, how to focus on wellness, determine where the competition is and how do these things affect the overall need for facilities.

5. Approve Bond Advisory Committee Meeting Minutes dated May 13, 2013

MOTION: Mr. Grant moved to approve the May 13, 2013 Bond Advisory Committee meeting Minutes. Ms. McCarthy seconded. **Motion passed by voice vote.**

Vice Chairman Coor asked Chairman Post how he wanted to harvest the Committee's observations.

Mr. Post asked the Committee members to email Ms. Talbot with their thoughts. He stated the next phase of the process will be less listening and more talking on the Committee's part. He will ensure there is enough time on future agendas to accommodate these discussions.

Meeting adjourned at 4:35 p.m.

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Bill Post, Chairman
Bond Advisory Committee