Maricopa County Special Health Care District

Bond Advisory Committee Meeting

September 17, 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 3 and 4 ·
· 2601 E. Roosevelt · Phoenix, AZ 85008 · Clerk's Office 602-344-5177 · Fax 602-344-0892 ·

Tuesday, September 17, 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.

9/11/2013 7:24 AM

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

2. Review the Maricopa Integrated Health System Clinical Network Plan 90 min
   Michael Eaton, Navvis & Healthways
   Susan Doria, MIHS, Vice President of Strategic Planning

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

4. **Approve** Bond Advisory Committee Meeting Minutes dated August 12, 2013 5 min
   Committee

Adjourn

Maricopa County Special Health Care District

Bond Advisory Committee Meeting

September 17, 2013

Item 1.

Planning Process Update: Timeline

Over the next two months the planning process transition from the strategic plan to the physical / capital requirements under this approximate timeline:

- August 28th - clinical network development portion of the strategic plan approved
- **September 17th – Strategic Plan presentation to Bond Advisory Committee**
- October 15th – Bond Advisory Committee
  - Continued strategy discussion and presentation of projected activity volumes
- September/October – preparation and Board review
  - Convert clinical volume distribution to facility needs
  - Interpret facility implications (e.g. gaps on the main campus, off-campus new/closed/growth)
  - Draft planning goals (e.g. right size, consolidate behavioral, new campus vs. replacement)
  - Develop baseline financials
- November 12th – Bond Advisory Committee
- October/November– Presentation to the Board including
  - High-level facility options presentation
  - Order-of-magnitude capital implications / projections
  - Overall financial implications of strategies and capital investments
- December – BAC Final Recommendations

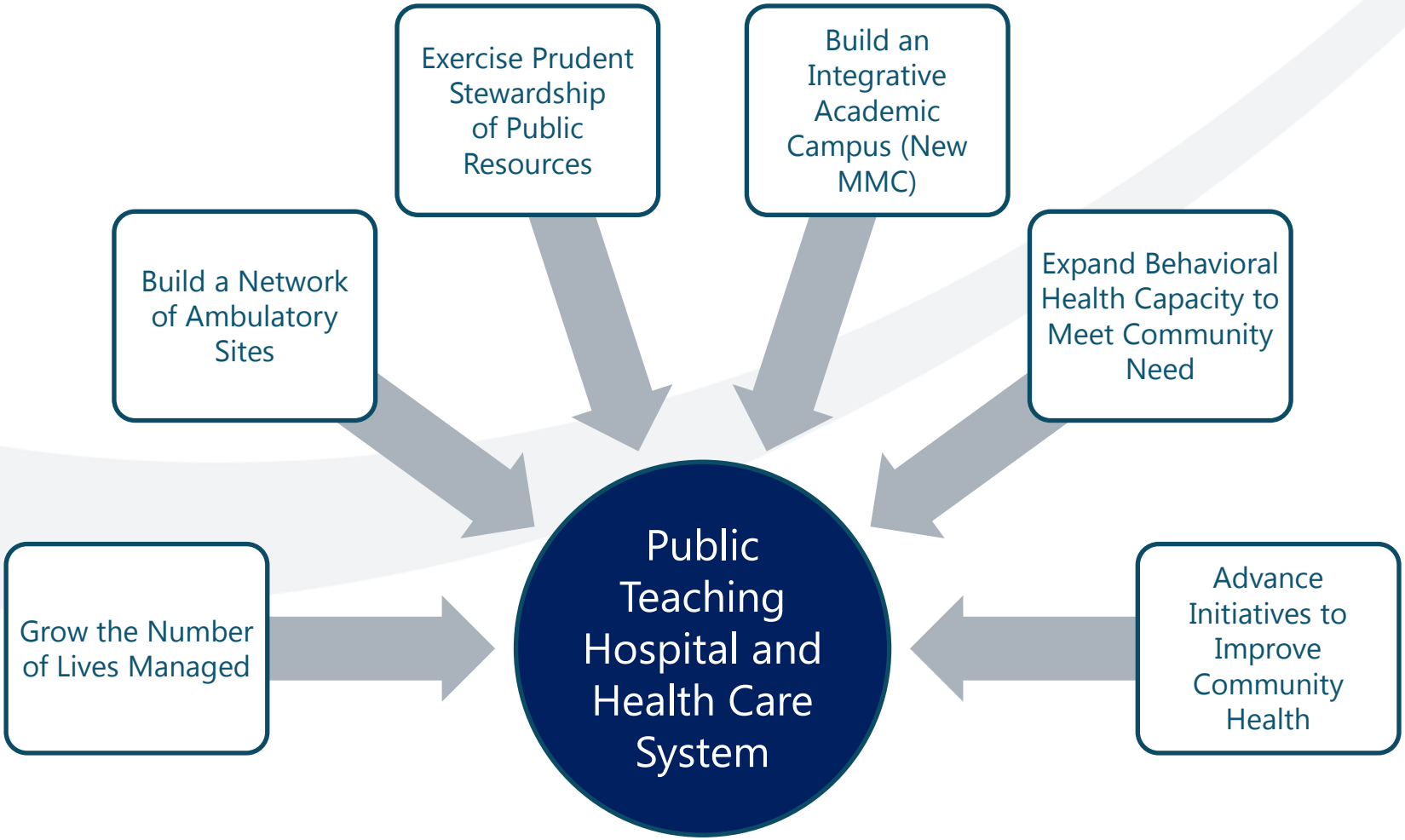
Maricopa County Special Health Care District

Bond Advisory Committee Meeting

September 17, 2013

Item 2.

Strategy Priorities



Mission/Vision

Mission Statement [1]

Maricopa Integrated Health System (MIHS) is Maricopa County's only public teaching hospital and health care system. We are committed to providing safe, comprehensive, high-quality physical and behavioral health care in a patient-centric environment to the communities we serve; and expanding the community's available pool of physicians and other health care professionals by offering excellent academic programs.

Vision Statement [1]

MIHS will be recognized locally and nationally as an effective, efficient, and fiscally responsible organization that maintains an integrated, high quality, patient-centric health care delivery system and an excellent academic medical center.

Aligning Our Network to Our Vision

Our vision is to organize a clinical network to design and deploy systems of care around the needs of patients and evidence-based care standards, with a goal of improving health outcomes, better managing costs, and improving the patient experience.

As we think about designing and deploying that clinical network, our strategies and resource allocations will be informed by the answers to the following:

1. Where is there unmet need or emerging demand in the community?

2. If our goal is to improve health outcomes and to better manage costs, what services must we organize and provide?

3. If the success of our brand and business strategy is to improve the patient care experience, how should we configure and organize our care sit specifically should they be located?

NAVVIS & HEALTHWAYS

Strategic Market Analysis

Context for our Strategy Recommendations

Emerging Market Dynamics

Critical Trends that Will Shape our Strategy

- Demand for care in Maricopa County will continue to increase, especially in the southwest (15.1%) and northeast (9.0%) valley and away from Maricopa Medical Center's primary service area.
- Demand will grow for adult primary and urgent care, pediatrics, orthopedics, cardiac medicine, and behavioral health – and will be in office-based and ambulatory care settings, not hospitals.
- Payors will increasingly reward care models that destroy inpatient demand. Hospitals will struggle to maintain inpatient volume and margin, and compete aggressively for inpatient specialty volumes.\.
- Expanded access to insurance coverage (AHCCCS, insurance exchanges) will mean more people have coverage but not necessarily care, as the primary care shortage worsens.

Inpatient market share will be a less reliable indicator of success, impact and sustainability than total lives managed in risk-arrangements

NAVVIS & HEALTHWAYS

New Competitive Realities

Shift from Inpatient Focus to Ambulatory Brand

- MIHS must pursue strategies to [1] extend its presence into new markets in the southwest and northeast valley, [2] grow its presence in the northwest and southeast valley; and [3] diversify its portfolio of service offerings in all markets.
- MIHS will need to decouple its primary and ambulatory care strategies from a goal of driving demand from the secondary markets into Maricopa Medical Center and/or the Comprehensive Care Center. The cost of acquiring a point of inpatient market share in those distant markets is too great.
- This shift in strategy enables MIHS to rethink MMC as an integrative teaching hospital focused on care delivery, health science research and systems-based training in primary care and population health management.
- MIHS will need to shift its business and brand strategies away from a hospital-centered focus to a network of convenient non-hospital care.

Hospital beds and specialty care are increasingly commoditized; new value will be created by efficient and effective outcomes and cost management

NAVVIS & HEALTHWAYS

Physician Network Analysis

Opportunity and Imperative to Partner with Primary Care Across all Markets

- Employment of physicians by systems in the market has not translated into tight alignment for purposes of referral network management. There is a significant cohort of non-DMG primary care physicians whose patients end up "down-stream" seeing a DMG specialist.

- There are a sizable number of patients who are seen by a physician in the FHC who are shared with specialists from other systems. The data suggests an opportunity to improve continuity of care by having dedicated specialists at ambulatory sites in critical northwest and southeast markets. This strategy does not presume capture of patients for inpatient care at MMC.

- There are a significant number of DMG-aligned specialists who could generate additional patient volume and revenue if they had referral options for follow-up care in the secondary service area and emerging markets. These referral options would be to programs, services, and physicians located in network ambulatory care sites.

MIHS should leverage its clinically integrated network as the platform for aligning with primes in the emerging geographic markets.

NAVVIS & HEALTHWAYS

Growth Outside the MMC PSA

2012 – 2017 Current Year Estimates & Five Year Projections

MIHS Market Area	2017 Population Size	% Growth 2012 - 2017	2017 Medicare % of Total Population	2012 Number of Households	2012 Median Household Income	2012 Median Age
SE Valley	1,226,412	7.0%	11%	428,110	$58,709	33
Phoenix	1,159,132	3.3%	9%	420,143	$48,130	34
NW Valley	787,360	9.0%	20%	272,789	$55,054	40
SW Valley	627,265	15.1%	8%	155,887	$51,588	31
NE Valley	368,375	4.5%	16%	158,447	$76,367	43
Total	**4,168,544**	**7.2%**	**12%**	**1,435,376**	**$56,094**	**36**

Source: Census Bureau; Thompson Reuters

Demographic characteristics by market area indicate that the:

- SE Valley market will have the largest population and number of households
- SW Valley market will grow the fastest, will have the youngest median age and lowest percent of its population in the Medicare aged cohort
- NE Valley market will have the highest median household income and oldest median age
- Phoenix market will experience the slowest growth and the lowest median household income
- NW Valley market will have the highest percent of its population in the Medicare aged cohort

NAVVIS & HEALTHWAYS

Growth in the Ambulatory Market

2012 – 2017 Aggregate Outpatient Size & Growth Projections for Maricopa County

MIHS Market Areas	2012 Hospital Outpatient Department	2017 Hospital Outpatient Department	5 Year Estimated Growth	% Growth	2012 Physician Practice/Ambulatory	2017 Physician Practice/Ambulatory	5 Year Estimated Growth	% Growth
SE Valley	1,308,190	1,426,532	118,342	9.0%	7,422,356	8,194,160	771,804	10.4%
Phoenix	1,118,663	1,205,785	87,122	7.8%	6,507,980	7,090,227	582,247	8.9%
NW Valley	886,283	980,729	94,446	10.7%	4,791,603	5,369,361	577,758	12.1%
SW Valley	487,360	565,438	78,078	16.0%	2,956,479	3,453,079	496,600	16.8%
NE Valley	455,351	488,650	33,299	7.3%	2,443,809	2,649,303	205,494	8.4%
Total	**4,255,847**	**4,667,134**	**411,287**	**9.7%**	**24,122,227**	**26,756,130**	**2,633,903**	**10.9%**

Aggregate service volumes in the table above represent all ambulatory services by market area within either a Hospital based outpatient department or within a physician practice/non hospital based ambulatory center setting.

MIHS Market Areas	2012 ED Volume	2017 ED Volume	5 Year Estimated Growth	% Growth	2012 Urgent Care Volume	2017 Urgent Care Volume	5 Year Estimated Growth	% Growth
SE Valley	536,703	577,520	40,817	7.6%	592,154	645,902	53,748	9.1%
Phoenix	485,943	500,183	14,240	2.9%	518,045	536,123	18,077	3.5%
NW Valley	317,837	346,010	28,173	8.9%	340,619	373,021	32,402	9.5%
SW Valley	247,070	284,690	37,620	15.2%	263,228	303,667	40,438	15.4%
NE Valley	144,604	150,664	6,059	4.2%	155,019	161,771	6,751	4.4%
Total	**1,732,157**	**1,859,066**	**126,909**	**7.3%**	**1,869,066**	**2,020,483**	**151,417**	**8.1%**

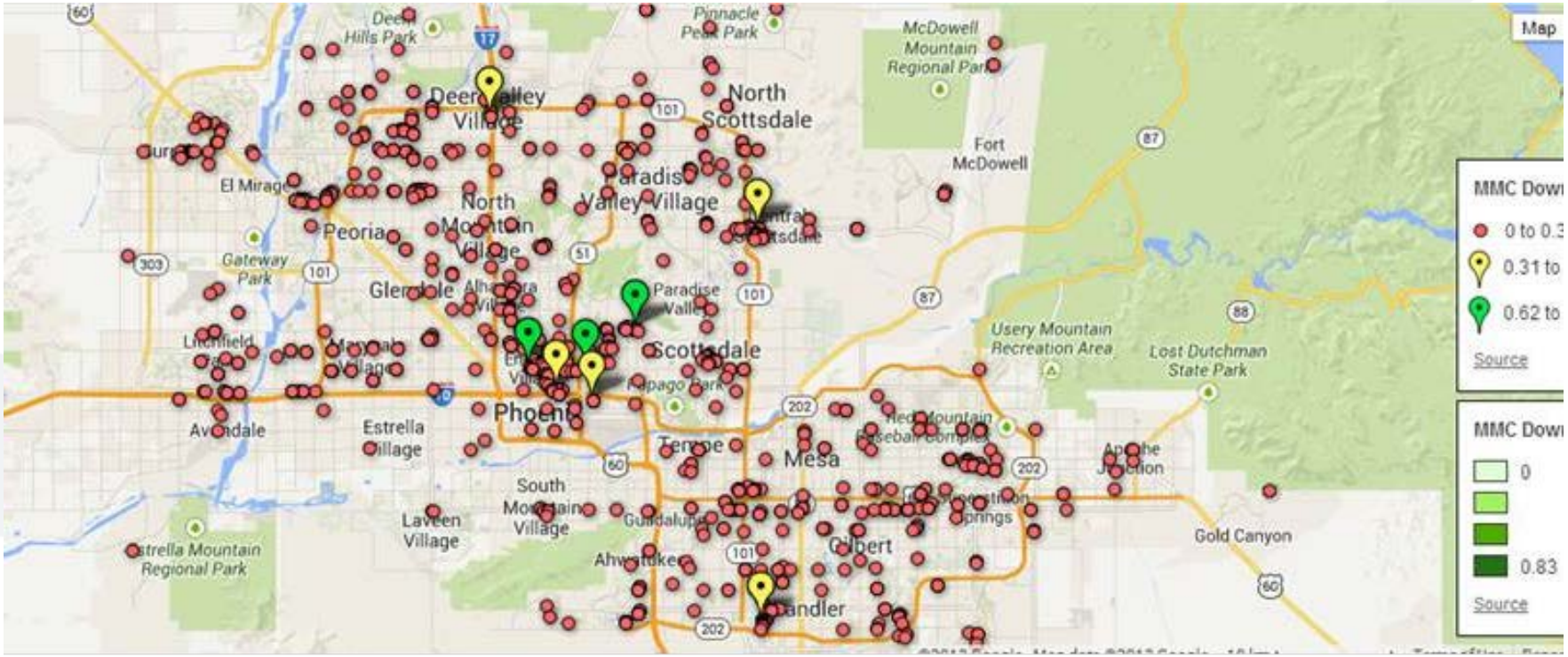
Aggregate service volumes in the table above represent the ambulatory services by market area for only emergency department visits or visits to an urgent care setting.

Source: Advisory Board, Thompson Reuters

NAVVIS & HEALTHWAYS

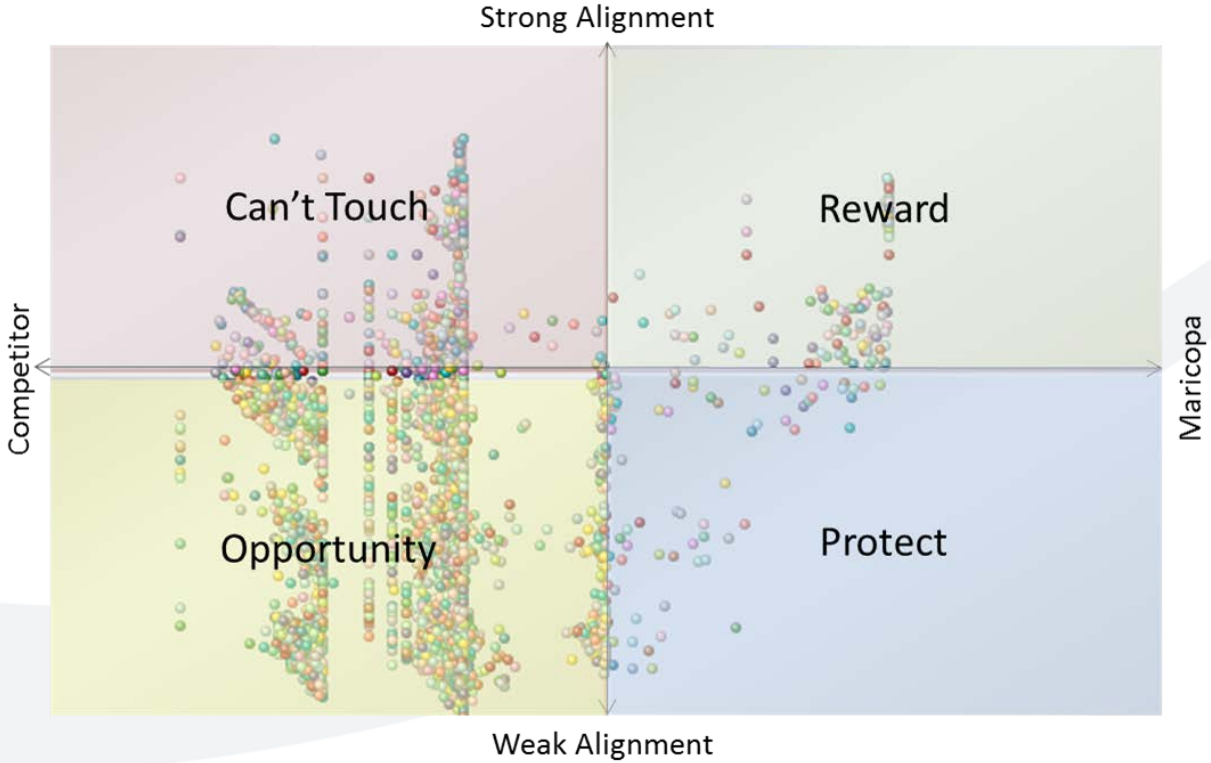
MIHS Source of Business

Rather than focus on moving people to MMC, how does MIHS move care to where people live and work as a means of improving the care experience?



Source: Maricopa County Claims Data 2011 – 2013; (Non-Emergent Referrals)

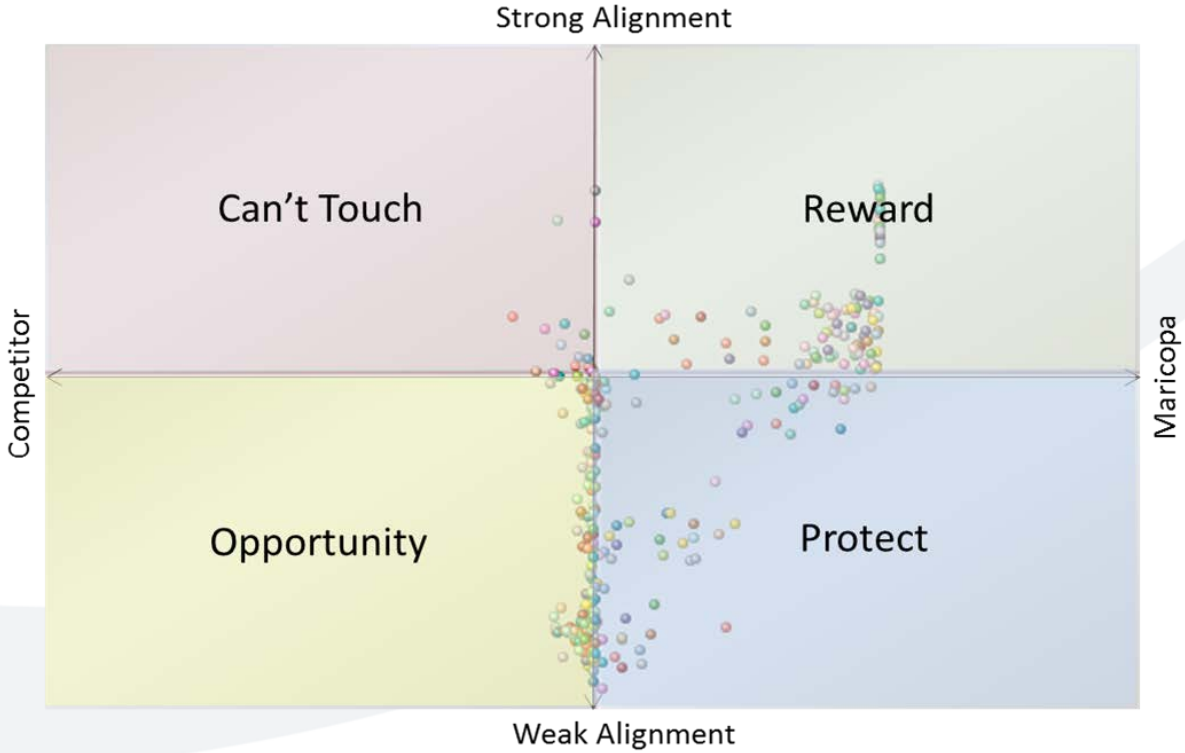
Greater Primary Care Alignment



Opportunity to grow the MIHS primary care / ambulatory footprint

Employment of physicians by systems in the market has not translated into tight referral alignment. There is a significant cohort of non-DMG primary care physicians whose patients end up "down-stream" seeing a DMG specialist. These physicians should be partnership targets in the secondary service area.

Improved Continuity of Patient Care



Opportunity to capture downstream revenue from DMG specialists

There are a significant number of DMG-aligned specialists who could generate additional patient volume and revenue if they had referral options for follow-up care in the secondary service area and emerging markets. These referral options would be to programs, services, and physicians located in network ambulatory care sites.

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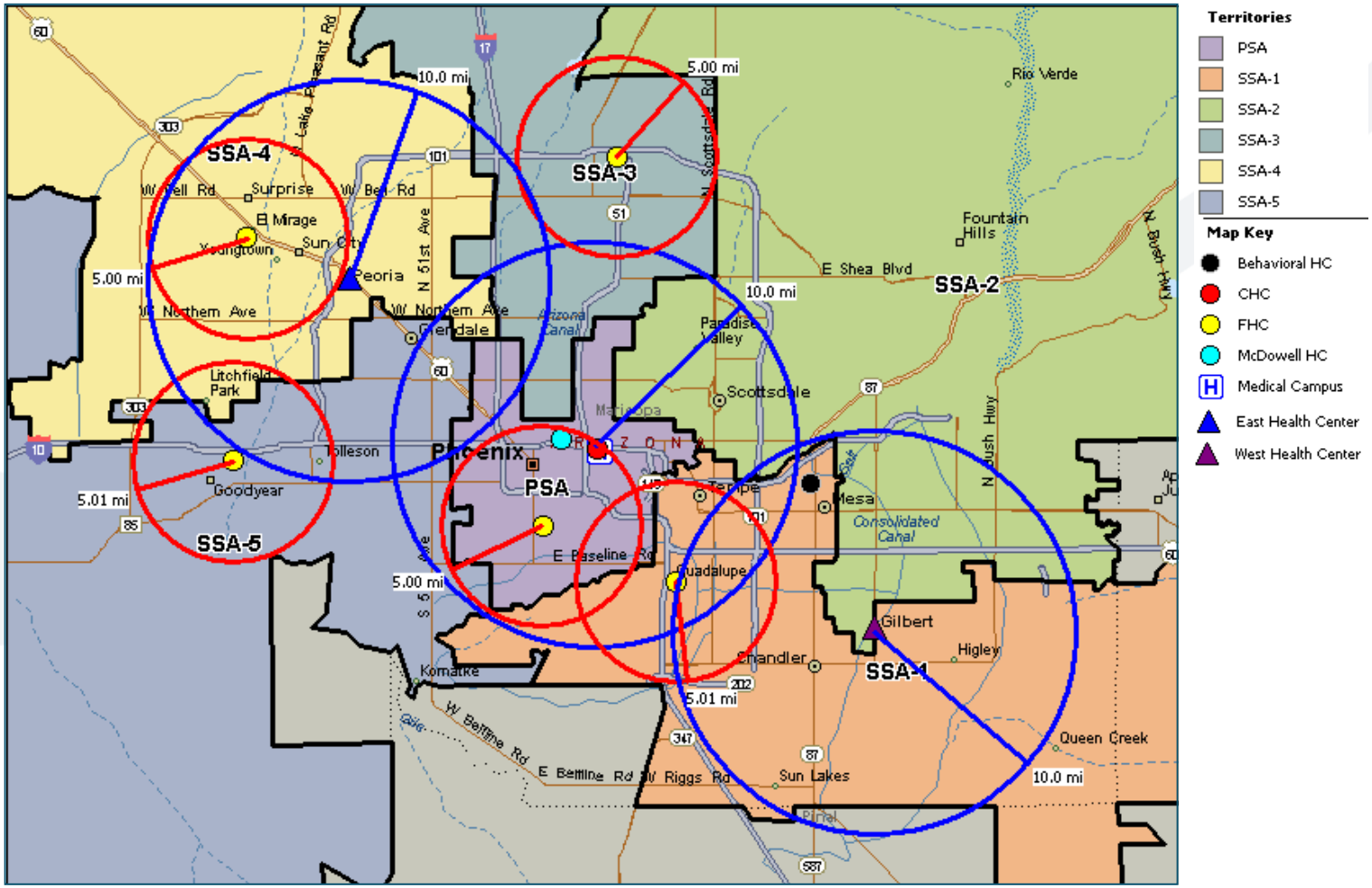
Distributed Ambulatory Services



Ambulatory Service Priorities

Based on Strategic Opportunity and Emerging Demand

Service Categories		Strategic Criteria
Group A: Critical Access Channels		
• Adult office visits • Pediatric office visits • Urgent care visits	• ED visits • Imaging • Lab tests	• Critical access channels for patient populations and related immediate diagnosis and screening modalities • Alignment with ambulatory education/training needs for medical education and the next generation of providers
Group B: Highest Strategic Priority Services (Based on Emerging Demand and Market Opportunity)		
• Behavioral Health • Cardiology Medicine • Dermatology • Gastroenterology • General Surgery	• Gynecology • Obstetrics • Orthopedics • Pediatrics • Pulmonary	• Highest priority clinical services identified for the MIHS ambulatory network development plan • Aligns to service needs of target populations across Maricopa County and with expected higher growth opportunities
Group C: Tier 2 Services (Based on Emerging Demand and Market Opportunity)		
• Cancer • Cardiac Invasive • ENT • Neurosciences • Ophthalmology	• Physical Therapy/Rehab • Podiatry • Urology • Vascular	• Aligned with ambulatory clinical service needs based on Maricopa County population • Not prioritized as high based on market dynamics, competitive positioning; may be opportunity for partnered services.

Prioritization based on strategic positioning, financial performance, community need, and emerging demand forecasts.

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Ambulatory Site Program Features

Neighborhood, Community, and Health Center Configurations

Services/Metric	Neighborhood	Community	Health Center
Primary Care	✓	✓	✓
Specialty Clinics		✓	✓
Specialty Full Time			✓
Lab/Draw	✓	✓	✓
Basic Imaging	✓	✓	✓
Pharmacy	✓	✓	✓
Advanced Imaging			✓
Advanced Diagnostics			✓
ASC			✓
Dedicated Provider Training Space			✓
Community Education/Resource	✓	✓	✓
Service Mix Footprint (GSF est.)	8,000-9,000	20,000-22,000	70,000-125,000

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Recommended Strategies

1. Grow the number of covered lives under MIHS care and management.
   - Organize a physician-led clinically integrated care network that brings physicians, hospitals and others together to redesign care systems and improve outcomes, better manage cost, and enhance the patient care experience by January 2014.
   - Manage at least a total of 100,000 lives through arrangements with payers and employers by December 2015.
   - Increase total system revenue earned from managing lives enrolled in the MIHS health plans and under contract with insurers and employers by December 2015.
2. Build and upgrade a network of ambulatory care facilities, in consultation with the Maricopa Health Centers Governing Council, in key markets outside the Maricopa Medical center primary service area:
   - Design and build an east and a west ambulatory health center to extend the MIHS brand, grow office-based and outpatient volumes, and meet emerging community need by December 2016.
   - Add a new Family Health Center (FHC) in the central portion of northern Maricopa County to meet emerging care needs among AHCCCS patients in an underserved market by July 2016.
   - Reinvest in and reconfigure the existing FHCs to achieve more efficient market coverage and bring more services (including specialists) to targeted markets by July 2016.

Recommended Strategies

2. Exercise prudent stewardship of our resources as a public teaching hospital and health care system.
   - Build a strategic financial plan that the MIHS Board and management can use to assess market strategy and make informed resource allocations by November 2013.
   - Continuously review and refine operational practices so that MIHS can manage lives, deliver care, and teach and train clinicians in the most efficient and effective manner possible (ongoing).
   - Develop an organizational and reporting structure to enhance the ability to evaluate the performance of strategic lines of business (June 2014).
3. Build a coalition of academic programs (medical schools, nursing programs, allied health) to design an integrative academic medical campus that includes a replacement hospital for Maricopa Medical Center.
   - Design a campus to support an inter-professional model of education; deploy and train those teams in evidence-based care models. Complete design work by December 2015.
   - Design a new Maricopa Medical Center as an academic medical center with sufficient beds (220 – 250) to support residency requirements and serve the needs of core service lines including Level 1 burn, adult and pediatric trauma, general surgery, and orthopedics by December 2015.
   - Build an academic brand for MIHS and the clinically integrated network; position MIHS as the program where the finest clinicians chose to train, teach and practice, and as an expert resource for the diagnosis and treatment of complex, comorbid conditions by December 2014.

Recommended Strategies

5. Expand behavioral health capacity to meet community need, specifically:
   - Consolidate the behavioral health programs on a single campus that enables the program to serve rising demand more effectively and efficiently by December 2017.
   - Integrate outpatient behavioral health into the community health clinics to grow convenient access to needed mental health and substance abuse services by December 2014.

6. Advance community initiatives to improve the health of Maricopa County.
   - Develop and deploy population health tools through the clinically integrated network to manage at-risk patient cohorts (dual eligible, uninsured, and populations with disparities) in 2014.
   - Support the Maricopa Health Foundation in its efforts to generate additional funding for community health initiatives.

Maricopa County Special Health Care District

Bond Advisory Committee Meeting

September 17, 2013

Item 3.

Next Steps

1. Complete detailed strategic volume projections (Navvis)
2. Initiate translation of volumes to future space needs and facility implications
3. Next BAC – October 15th, 2013
    1. Present projected volumes by service location (Navvis)

Maricopa County Special Health Care District

Bond Advisory Committee Meeting

September 17, 2013

Item 4.

Maricopa County Special Health Care District
Board of Directors Bond Advisory Committee Meeting
Maricopa Medical Center
Auditoriums 1 and 2
August 12, 2013
2:30 p.m.

DRAFT

Voting Members Present:	Lattie Coor, Ph.D., Vice Chairman Tony Astorga Kote Chundu, M.D. Nita Francis Doug Hirano Diane McCarthy Rick Naimark – *left at 2:59 p.m.* Brian Spicker – *arrived at 2:59 p.m.* Ted Williams
Absent:	Bill Post, Chairman Paul Charlton Frank Fairbanks Merwin Grant Terence McMahon, Ex-officio, Director, District 5 Joey Ridenour
Others/Guest Presenters:	Michael Eaton, Navvis & Healthways – *participated telephonically* Larry Sterle, Kurt Salmon Betsey Bayless, MIHS, President & CEO Bill Vanaskie, MIHS, Chief Operating Officer Susan Doria, MIHS, Vice President of Strategic Planning Warren Whitney, MIHS, Chief External Affairs Officer Louis B. Gorman, MIHS, District Counsel
Recorded by:	Patricia Schultheis, MIHS, Assistant Clerk of the Board Melanie Talbot, MIHS, Executive Director of Board Operations

Call to Order

NOTE: Due to Chairman Post's absence, Vice Chairman Coor chaired the meeting.

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

Roll Call

Ms. Talbot called roll. Following roll call, it was noted that eight of the fourteen voting members of the Maricopa County Special Health Care District Bond Advisory Committee were present, which represents a quorum. Mr. Spicker arrived after roll call.

Ms. Talbot announced that Mr. Michael Eaton was participating telephonically for his benefit, she named the individuals present in the meeting room.

Call to the Public

Vice Chairman Coor called for public comment. Ms. Talbot indicated no speaker slips were submitted.

General Session Presentation, Discussion and Action:

Mr. Naimark stated he would need to leave the meeting by 3:40 p.m. and when he leaves the Board would be without a quorum. He asked if the Board should consider any action items first, prior to his departure.

Vice Chairman Coor asked if there was any reason not to move item # 6 forward which was approval of the minutes.

Ms. Talbot stated it was fine to move the agenda item forward for consideration. She also asked Mr. Gorman for legal advice to clarify if her understanding was correct that the meeting could not continue once they were without a quorum.

Mr. Gorman confirmed that the Committee would not be able to continue meeting once a quorum was lost. He recommended moving action items up on the agenda while a quorum existed.

6. Approve Bond Advisory Committee Meeting Minutes dated July 8, 2013

MOTION: Mr. Naimark moved to approve the June 10, 2013 Bond Advisory Committee meeting minutes. Ms. Francis seconded. **Motion passed by voice vote.**

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

Mr. Sterle stated the process review was on track. The network assessment and future facility needs was a little further out and will be reviewed in September. His staff will work with Ms. Talbot on the timing so it is seamless with the Board's review and strategy and will consider the effects of this on the facility timing process.

2. Facility Condition/Functionality Follow-Up

There were two key questions at the last Committee meeting. The first was regarding areas identified as blue, based on existing volume and deployment of rooms in the hospital along with areas in the hospital that have more space than necessary. Based on this, the question was whether or not there was enough space in the hospital. Second, there was conversation about converting semi-private rooms to private rooms. The example given related to the medical/surgical areas being a bit under their targeted utilization and if they were converted to private rooms, whether there are enough beds and could the spaces be redefined.

Mr. Sterle reviewed what the right-sized space needs would be for curren- day needs versus what actually exists in the Main Tower and the Comprehensive Health Center (CHC). The red areas represent the shortfall of space, by floor. Assuming all of the space issues could be corrected and the floors could be expanded to efficiently and effectively utilize that space, the main tower would still be 25 percent short and the CHC would be 18 percent short of the amount of space needed to serve the present-day needs. This demonstrates that these two buildings are pretty well utilized. Even if the first floor was built from scratch it would be difficult to get the same foot-per-foot utility out of Imaging. In order to correct the shortage of beds per floor and assuming this is the only thing that needs to be corrected, four more floors would have to be added to the Main Tower. The building is not structured to do this and it would not be a good footprint.

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

2. Facility Condition/Functionality Follow-Up

Another comparison of the right-sized space need versus the current-day needs is in the Surgical Intensive Care Unit (SICU). The ICU's are the parts of the building that are lacking the most in space. The existing SICU is about 3,200 department gross square feet (DGSF) and the right-sized space needs are 11,700 DGSF. This means the current space is 25 percent of the amount needed for a good SICU. It would be very difficult to achieve the amount needed in the existing building structure due to the way the building is configured.

Vice Chairman Coor asked how many beds the space would serve if the DGSF was adequate.

Mr. Sterle stated, if he recalled correctly, there are 12 beds and swing space for a thirteenth bed. A contemporary intensive care unit would be somewhere in the neighborhood of 850 to 900 DGSF per bed. Maricopa Medical Center's (MMC's) existing model is more like a post-anesthesia care unit (PACU) with beds side-by-side and curtains in between them.

Mr. Naimark questioned if the driving force behind the right-sized data was the new standards versus new growth.

Mr. Sterle stated the right-sized corrections were based on the same number of beds that exist today at MMC.

The current layout of one end of the seventh floor general acute area is four semi-private rooms, for eight beds total. The rooms are 475 net square feet (NSF), for two patients, with one ADA accessible toilet and no shower. It was originally built for four patients per room so it has improved by converting to two patients per room.

Mr. Sterle reviewed how a conversion to a private room on the sixth floor would look like. One of the limiting factors in the conversion is that the existing columns restrict where the walls can be placed. The patient room is 220 NSF in the interior walking space, inclusive of the toilet and shower room. Since the work is being done in the existing building the State granted a request for a waiver of up to 10 percent of the square feet. It is a private room but the space is very tight. The space includes a requisite sized bathroom and sink. The dimension around the foot of the bed is an issue from a safety standpoint. It is not unsafe, however, it is challenging to move around the bed. Part of the reason for this is that beds continue to get larger. The family area is cozy but workable and it cannot be made any smaller.

Mr. Sterle reviewed what a contemporary room size of 300 square feet would look like. There are some room entry constraints and three rooms could fit in the space however one of the rooms would not be usable. Effectively, 300 square feet would yield two rooms. Toilets are treated a little differently since you can make a building where they are located on the outside. This is not included in the current example since the window placement prohibits it. The bed model is based on a universal size and could be used as a medical/surgical bed or converted to an ICU bed.

The question is whether a conversion would yield enough beds in today's environment to meet the necessary utilization levels. The current bed count is 26 semi-private or 28 total beds. If the entire floor was converted to 300 NSF rooms, with two beds per room, it would yield 15, or possibly 16 rooms in a best-case scenario. Based on current utilization levels of 75 percent at midnight, a reduction in beds of this sort would result in a 100 percent midnight occupancy rate. There would be no room during the day to bring new patients in and turn beds over. It is not a workable model. The highest maximum ratio hospitals operate at is 80-to-90 percent midnight occupancy. For planning purposes you would never plan more than 85 percent midnight occupancy for a general medical/surgical bed and the percentage would be lower for an ICU bed.

Mr. Naimark asked for clarification if the present day standard room size is 300 NSF.

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

2. Facility Condition/Functionality Follow-Up (cont.):

Mr. Sterle replied that the standard currently, with a toilet, is around 300 NSF. This could range anywhere from 295 NSF to 300 NSF. Some places go as high as 350 NSF but this is larger than needed and his firm would not recommend this. A NSF space of 300 would be enough to provide for code requirements the proper circulation and a safe environment that includes space for family members.

Mr. Sterle stated the column placement will also present challenges in conversion of the lower levels such as in the Imaging Department.

Mr. Astorga commented that it seemed to be a two-edged sword and asked if the quality of patient care would improve due staff-to-patient ratios. Meaning if the rooms were to be converted, there would be fewer patients to the same number of staffing members.

Mr. Sterle explained more staff is required, per patient, in a 15-bed model versus a 30-to-35 bed model.

3. Review of Short and Long-Term Capital Projects

Mr. Vanaskie updated the Committee regarding ongoing capital projects.

The current focus is to take full advantage of the space available in order to create usable space consistent with MIHS's purpose that will also permit accessibility to many different kinds of patients in the future.

The Affordable Care Act (ACA) will bring about change in the number of insured individuals; people will have choices and more people may be covered by Medicaid. Above all else, MIHS has a mission which includes patient care and education and there needs to be a certain number of beds in order to be a substantial academic model, as well as a good in-patient provider.

The current capital projects are geared to adjust for the changes with the ACA. Funds have not always been available for projects that have been planned for some time in order to execute them efficiently and quickly. However, one by one, various projects have been accomplished. The funding strategy identified for the remaining projects would be to borrow funds so they do not come out of capital and reserves. It is important for the Committee to be aware of this plan.

The total of the projects is $35.4 million. There are ten principle areas being considered. The first four were approved by the Board and are in some stage of construction or planning.

- MRI Imaging Facility – This includes replacement of the 12-year-old MRI machine with 2 new machines and the construction of an improved facility in a location allowing for increased patient volume and flow. All of the other radiology services are located in the north end of the facility and the current machine is in the extreme south end. Additionally there is no prep and recovery area or separate registration area at the current location. The new spot will be on the north side of the hospital, immediately west of the main entrance. Construction work has begun. MIHS currently has one MRI machine in-house and a second one located in a trailer outside. Approximately 100 procedures are sent out per month to other facilities, even with the two machines currently in place. Some are sent out due to scheduling issues and some are sent out due to the incapability of the current machines. The new unit will have a registration and prep area and two magnets.

- 4 East Remodel and Conversion – This was previously the detention unit which was designed and built to house prisoners in the control of the Maricopa County Sheriff's Office. The rooms are concrete block walls, with metal pan ceilings, toilets hung on the wall, two doors on an entrance, along with metal detectors. It is capable of serving 24 patients. The patient population has decreased due to many changes in the treatment of prisoners and patient needs that are beyond the capabilities of the unit, like intensive care or labor and delivery.

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

3. Review of Short and Long-Term Capital Projects (cont.):

As a result, the unit has been vacant most of the time or only houses one or two patients at a time. Two nurses are required due to the locked doors, regardless of the number of patients and this is very inefficient.

This floor can accommodate the creation of thirteen single-bed rooms for medical/surgical patients that are consistent with the rooms Mr. Sterle spoke about on the sixth floor. The floor to floor height and column spacing prohibits doing more, however, they can be converted to private rooms. Each room will have a shower and provide space for some family members. It will have its own waiting area and nursing station. On average there are 19 to 20 observation patients on any given day and this will be able to house 13 observation patients.

- 5 West Remodel – This unit used to house a critical care cardiac unit, with four or five beds in a semi-circle, with walls between and open on the end. The space is tight with no private bathrooms. There were two semi-private rooms across the hall that could be used for critical care. These beds are currently used for observation and are not suitable for long-term stays.

  The intention is to gut these areas and build six private rooms, consistent with what Mr. Sterle demonstrated for private rooms. They will be a little larger and are geared to handle critical care patients as well. This has received preliminary approval from the Arizona Department of Health Services.

- Wound Clinic – MIHS treats many patients that are victims of trauma and does not have an adequate wound clinic to treat the variety of wounds inherent in these cases. It will include two hyperbaric chambers (HBOT). It will enhance treatment of patients with diabetes, wounds, burns and other traumas. The clinic will provide new volume, revenues and integrated patient care.

- Physician Administrative Building – This will be a three story building southeast of the medical center. It will enable the move of physician administrative offices from patient care areas in the medical center in order to provide space for expansion of the Adult Emergency Department, create a simulation lab for teaching residents and nurses, create office space for the teaching faculty and expand other patient care activities. There is no budget shown for this since other financing options are being reviewed.

- Desert Vista Expansion – MIHS is the largest provider of in-patient psychiatric services in Arizona and is the sole provider of court-ordered evaluations in Maricopa County. MIHS has two locations for psychiatric patients – two units at the main campus and 120 beds at Desert Vista. Desert Vista was built as a behavioral health facility so it is appropriate. There is an unused building at Desert Vista and the thought is to move administrative space to this unused space. After this there will be two choices, either to close the units at the main campus and move them to Desert Vista or expand on services for adolescent psychiatric in-patient care. Some of the support services at Desert Vista such as dietary and kitchen would need to be enlarged as well.

- Urgent Care Clinic in the Comprehensive Health Center (CHC) & Adult Emergency Department (AED) Expansion – The volumes in the AED have steadily increased, with 150 to 170 patients seen on a daily basis. This is in addition to the Burn and Pediatric Emergency Rooms. The AED expansion is necessary and the most expensive of the projects, at around $11 million to $15 million. The expansion would increase the number of bays for treating patients; include a fast-track area; add some observation beds and remedy the issues of undersized trauma bays that MIHS is cited for at every American College of Surgeon inspection.

About $4 million of the total $35.4 million project cost is for infrastructure needs. If the Family Health Centers (FHCs) are relocated then some of this cost may be eliminated but that is further down in the project priority list.

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

3. Review of Short and Long-Term Capital Projects (cont.):

Ms. Francis expressed her belief that the recommended projects are important, critical items that need to be accomplished currently in order to serve the existing population.

Mr. Vanaskie stated the plan for the future is to become a hospital destination versus a hospital of last resort for the uninsured. With insurance reform, people will have insurance and choices as to where to seek services.

Mr. Williams asked if consideration was begin given to moving or elevating the existing helicopter landing space.

Mr. Vanaskie stated some of the reasons helicopter pilots like MIHS' pad is that it is capable of landing Blackhawk helicopters and also its close proximity to the airport. The pad can house four of the current Medevac helicopters at one time and other facilities do not have this capability. If new buildings are constructed at the main campus something else could be done with the helipad but right now it is a very attractive set-up.

Mr. Naimark commented that all of the individual projects made sense to him financially and otherwise. The big picture involves $35 million of important, high-priority projects that need to be accomplished now and cannot wait for the Committee's bigger process. He questioned if any of the projects being implemented might foreclose other big picture options that the Committee may consider.

Mr. Vanaskie stated the projects under consideration are currently needed and have been thought of over time. They would have been implemented along the way had the money been available but dollars went to more immediate needs, such as necessary equipment. He did not believe any of the items included in the $35.4 million figure would forestall the Committee's consideration of new items in a new facility.

Mr. Naimark questioned if it was administration's belief that the issuance of bonds would mitigate some of the financial obligations in the future.

Mr. Vanaskie explained the intention is if bond funds are made available it would cover the cost for the projects.

Mr. Hirano asked if some of the improvements would have lasting value. As an example, would the MRI machines be moved, if necessary, to a new location?

Mr. Vanaskie stated the MRI unit can be moved; the Wound Care Clinic is new revenue; the beds on 5 West that are capable of housing intensive care patients, if needed, would expand on the existing services and there are a few options at Desert Vista. These are to either expand services and add adolescent care, which isn't possible with the current configuration, or consolidate both the number of beds and locations to cut operating costs. There is no cost estimate for the Physician Administrative building since the financing is still being considered.

Ms. Francis asked for clarification as to whether her understanding was correct that the recommended projects were necessary for MIHS to maintain a competitive advantage as it moves forward on the bond issue.

Mr. Vanaskie confirmed that the projects were necessary and that the first four were already in the works. The remaining projects are pending until funding is identified.

Ms. Francis commented that it appeared either the projects are funded or money will be borrowed to fund them.

Mr. Vanaskie answered in the affirmative.

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

3. Review of Short and Long-Term Capital Projects (cont.):

Ms. Bayless stated the objective is to have a hospital that meets the current day standards and handle the needs of the community. Building a new hospital for this purpose does not necessarily mean closing the door on existing facilities. A decent facility will create many possibilities like creating a behavioral health facility or rehabilitation center.

4. Strategic Plan Overview and Update

Vice Chairman Coor stated Ms. Susan Doria would walk through the strategic plan with the help of Mike Eaton, who was on the telephone. He also mentioned that Mr. Spicker joined the meeting and although Mr. Naimark was leaving, there would still be a quorum of members present.

Mr. Naimark reminded Vice Chairman Coor that he included the wrong date in his earlier motion to approve the minutes therefore the July minutes still needed to be approved.

Ms. Doria stated that the Board of Directors has been leading the planning process. The Board would like the Committee's input and involvement along the way. The strategic plan is a work in progress and is in a "draft" state until the Board approves the plan later in the month.

The question posed in terms of building a strategy, is to determine where healthcare is heading in the next 20 years and how MIHS can position itself as good stewards of the resources for Maricopa County moving forward. The next part, which will be presented at the September Committee meeting, is a design for what the services and facilities should look like across the county. The financial aspect of the plan will be presented in September or October.

Since the hospital was built in 1970, the focus has been on maintaining it versus investing for the future. The current opportunity, which was reinforced by the Citizen's Taskforce in 2003 that formed the Special Health Care District, was for Maricopa County to have a vibrant public hospital and healthcare system, to attract future providers, train them so they understand research and patient care, and to retain those providers to care for the population.

The challenge today in the U.S. healthcare system is staggering costs due to the specializations in healthcare. These costs cannot be managed in the fragmented model that exists currently. The opportunity now is to shift to a model that is preventive, wellness-oriented and addresses the whole person. This is what public safety-net hospitals and MIHS has always done. MIHS's role is even more critically viable since its physicians know how to train in the model of whole person care that includes systems of care, levels of care that are appropriate, outpatient, inpatient, after-care, education. The staff at MIHS understands the social, emotional, financial, and cultural well-being of the individual. This new model is the strategic shift that the District Board of Directors is looking at.

Ms. Doria presented an overview of community needs:

- Access to primary care remains an issue in Maricopa County, with both too few and a poor distribution of basic access points throughout the County along with provider-centered rather than patient-centered operating models (hours, sites).

- Access to behavioral health care is a challenge; where access does exist it is often organized apart from basic primary physical health access even though behavioral health issues are a critical determinant of poor physical health.

- Coordination of care and navigation across care venues is a challenge despite the accumulation of physician practices, the consolidation of outpatient services under hospital system brands and deployment of electronic health records.

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

4. Strategic Plan Overview and Update (cont.):

- The expansion of access to insurance (through AHCCCS and insurance exchanges) may be of limited benefit to those who are newly insured unless health systems shift resources into community, work-site, retail, and virtual settings.

- The absence of a dedicated academic medical center (AMC) impedes the community's ability to focus and accelerate change and recruit and retain the best clinical talent. (Phoenix is the largest metropolitan area in the U.S. without an AMC.) MIHS is already the largest training facility in multiple disciplines and multiple professions and the belief is that it can grow this and elevate Phoenix in terms of the scientific and medical advances going on in other parts of the country.

Ms. Doria spoke about market assumptions:

- The population of Maricopa County will continue to grow and it will grow most quickly outside the core of Maricopa Medical Center's primary market. In order to serve this growth MIHS will need to expand its ambulatory footprint.

- Growth in the AHCCCS population will accelerate and there will be increased competition among providers to capture and manage those lives; there will be both opportunity and threat in this trend.

- Consolidation among providers will continue to accelerate as systems look to build economies of scale and leverage with payers; stand-alone systems like MIHS will need to find clinical partners to meet emerging needs.

- Phoenix is prime for an investment in academic medicine; MIHS can generate public support for funding a new academic medical center if it can secure a medical school affiliation.

- The shift in care from the inpatient to outpatient setting will accelerate and broaden to include efforts to manage and improve population health – with a focus on slowing the progression of chronic disease.

- MIHS's public safety net mission will remain critical to the health of the community; it must organize and operate based on an assumption that in ten years it will need to finance that mission without a tax levy. The Board is passionate about being able to do this by designing a system that is sustainable and the right system to serve the needs of the community.

The belief is that MIHS is both relevant and complimentary in the community. MIHS is complimentary since it teaches in a manner to show how medical education, patient care and research can be done. It can provide leadership in this direction that will raise the level of patient care and translational science across the Valley.

MIHS's vision for the last 100 years has been to keep people well. MIHS wants to slow down the progression of chronic disease. Currently, individual's health states peak at an early age and then the rest is spent in decline. The challenge is to move past chronic disease management and understand what healthy living looks like in a community. MIHS is uniquely positioned as Maricopa County's public hospital teaching system to do this for the community.

The Board wants to take a leadership role in creating metropolitan Phoenix as one of the healthiest communities in the country and elevating the health status of its residents. This will be done by teaching in inter-professional teams, with evidence based practices that are centered on the patient and are accountable for outcomes related to quality and cost.

MIHS is where Arizona's best doctors, nurses and other health professionals choose to train, teach and practice medicine.

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

4. Strategic Plan Overview and Update (cont.):

They choose MIHS because: the culture supports the training and deployment of inter-professional teams of clinicians; the health professionals are committed to the mission of education and training; a diverse mix of clinical encounters and a full-continuum of care sites is offered; it provides a system of care that encompasses physical, mental, emotional, and social well-being; and, it is focused on continually improving access, quality, outcomes, experience and costs.

Teaching, research and medical education are not add-ons to patient care for MIHS. These are at the core of what it does and transforming the industry through teaching tomorrow's providers is essential.

The Vision and Value Proposition has the patient and physician at the center with a clinically integrated network teaching tomorrow's practitioners academic medicine. These two pieces are the essence of what MIHS is. The proposition has four quadrants: Value for Academic Partners; Value for the Community; Value for Patients and Value for Payers.

Value for Academic Partners is provided by training students, providing clinicians with the environment they need going forward and through clinical research to advance patient care. Value for the community will be in healthier outcomes and advanced care in Maricopa County. Value for payers will be in better outcomes in health indicators and lower costs. Value for patients will be in lifestyle and stability.

The strategy priorities are broken down into seven very high levels – three in care delivery, three in academics and one that is overarching. The following three strategies are about care delivery:

1. Organize a clinically integrated network to deliver evidence-based care to manage populations. This involves coming together as a larger enterprise in partnership with MIHS's physicians to understand and set a path of common goals, strategies and investments that work together. This will reduce fragmentation and allow for focused efforts. Many organizations in healthcare today are set up competitively or in an adversarial way. Instead, they should be set up with legal and financial structures that bind people together, working towards common goals.

2. Distribute ambulatory services to enhance convenience and access for County residents. More outpatient settings need to be created for increased outpatient monitoring of chronic disease. Care needs to be convenient and people should not have to travel too far to receive it.

3. Develop clinical partnerships as a means to grow total patient encounters and improve efficiency. MIHS cannot provide all services for its patients and will need to partner with other clinicians in other geographic areas. MIHS also needs to be a place others feel comfortable coming to and partnering with and to be known for that brand.

The following three strategies are about academics:

4. Affiliate with a medical school(s) and allied health programs for an inter-professional training program. MIHS is currently affiliated with several medical schools and academic allied health professional programs. The goal is to bring all of these programs together and create team-based training that is grounded in technology. MIHS wants to be known as the place to come for advanced training. No one else in the marketplace is doing this and it is essential in order for the MIHS community to advance.

5. In partnership with a medical school(s) build an academic medical center to support Phoenix's needs. MIHS did build an academic medical center and it should not be thought of as one place. It should be thought of as academic medicine that is provided across an entire network; an entire system of care. It is more of an orientation versus a location.

6. Build an academic medical center brand that grows awareness and preference for MIHS care. MIHS believes its brand has always encompassed this, however, there is a negative halo around the County hospital brand. This creates an opportunity to re-educate the community about MIHS and its relevance in the market.

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

4. Strategic Plan Overview and Update (cont.):

The strategy priority overarches in care delivery and in academics:

7. Refine governance and management to reflect an integrated care delivery model. The District Board recognizes that it needs to look at this and decide how it should share responsibility for outcomes through governance models with other partnering organizations. The Board is open to considering how to work together and identify the structures that allow for this flexibility moving forward.

The MIHS business model will focus resources and strategies around two major lines of business – delivery of health services and academic medicine. In terms of delivery of health services, MIHS wants to be all across the network. This does not mean MIHS will provide every service and may need partners to help with this. The important thing is that MIHS knows how to assemble the pieces to provide a system of care.

Delivery of health services will be coupled with academic medicine, whether it is through patient care in the clinical network sites, residency programs, fellowships, nursing programs, allied health or research. MIHS knows how to manage and integrate all of these components. These two lines of business are synergistic with each other and not separate components. They are like two gears that feed each other. Clinical encounters fuel the training opportunity to be affiliated with medical schools and the workforce is used back in the network of care. It is a closed loop – as MIHS creates the environment for training, it trains more and those individuals stay in the community.

The vision for patient care is centered on the patient's needs versus the needs of the provider, specialist or hospital administrator. Providers would come together collaboratively to determine how to advance the goals of the patient. It could be via the employer site, the pharmacy, behavioral health, vision, insurance providers, wellness classes – all of these pieces would be integrated into a whole person system of care.

The partnership would be through affiliation agreements. The strategy is to create a network bringing like-minded organizations together who support the same goals that MIHS has in terms of improving patient care. The network would not be totally funded by MIHS. Partners can maintain their own independence and the governance model would be very important with respect to the network.

The care delivery strategy is: to organize a clinically integrated network to align physician and system incentives around improved outcomes, cost and growth; to develop and leverage core system-level competencies that will determine what needs to be done strategically. These will begin to guide the Board and senior leadership's work into the steps that need to be taken; and to create products to go to market.

The vision for academic medicine is at the heart of why MIHS exists since it has created an environment where Arizona's future doctors, nurses and allied health professionals come to train. A few things need to be done in order to grow and maintain this position. MIHS will need to strengthen patient encounters and residency programs; invest in training technology to build skills and demonstrate proficiency; partner with others investing in translational research so MIHS has the latest access to advanced patient care modalities; and develop fellowships in critically needed specialties.

The academic medicine strategy will include some critical success factors such as: leadership; infrastructure to support teaching; affiliation with multiple training programs and medical schools; innovation in new training models; and promoting greater awareness of MIHS' academic program and services.

To determine the results of these efforts, performance milestones include: securing additional affiliations; achieving BBB/Baa bond rating; developing a recognizable brand; improving the outcomes of managed lives; and becoming the largest primary care network.

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

4. Strategic Plan Overview and Update (cont.):

Mr. Eaton stated the main piece that flows through the strategic plan is the historical mission that MIHS has fulfilled for over 100 years and continues to fill. The Board believes they have an important stewardship in this respect. The market is large and diverse; no one system can serve all of the needs and everyone will bring something unique to the equation.

The data supports the unique ability that MIHS has to engage, serve and care for a population which has multiple, chronic, complex needs that encompass physical, social, emotional and cultural barriers to accessing care. This need is not going away, is continuing to grow and is spreading out to all corners of the County.

Mr. Astorga asked if the business model with the two major lines of business, delivery of health service and academic medicine, was a single or two-folded issue as it relates to meeting the performance milestones. It appears the delivery of health services would also create performance milestones and consideration of the bond issue also focuses on the delivery of health services, promoting a brand, enhancing MIHS's image, developing leadership and establishing credibility. All of this will require academic medicine to enhance it but could this be done without being simultaneous or is it something that can be transitioned in to?

Ms. Doria replied that the focus is on a simultaneous equation. The academic medicine piece is already present with MIHS's affiliation with the University of Arizona College of Medicine. The plan going forward is to strengthen relationships with medical schools with new geographies.

Ms. Bayless agreed with Ms. Doria stating both of the pieces are critical to MIHS and should be pursued together.

Dr. Chundu believed the processes should be simultaneous. The future of care is not centered on physicians alone but as a team-based approach with interpersonal arrangements. The value is in reducing costs and enhancing outcomes. In order to do this, MIHS will need affiliations with nursing, pharmacy and social work schools and not just with medical schools. This will be necessary to address issues like chronic and preventive illness that many other health systems cannot do. MIHS has been doing this for a long time, it is all inter-related and MIHS has an advantage over other systems.

Mr. Hirano asked what constitutes an institution as an academic medical center. MIHS does residencies and is currently affiliated with the University of Arizona Medical School, therefore, is there something else specific about the number of relationships that make an institution an academic medical center? Maybe the more important question is how it all relates to staffing, facilities, and the implications of this for planning.

Ms. Doria asked Dr. Chundu to address Mr. Hirano's questions.

Dr. Chundu explained the three legs of academic medicine are teaching, research and patient care. When all three of these things are done it enhances patient treatment, provides better outcomes and if it is evidence based, costs will be controlled. If all three of these things are being done then you can call yourself an academic medical center. It doesn't necessarily mean you have to be associated with a particular university. For example, Mayo Clinic does not have a university so they started their own medical school. Cleveland Clinic did the same thing. They were in existence for a long time and about then started a medical school. They both had hospitals to begin with and then a medical school was a secondary venture. The medical school is not as important as the three components and either you do all three yourself or through partners. The basic tenet is if the three components are employed it provides better outcomes for patients.

Ms. Francis commented for as long as she can recall MIHS has had a research and academic teaching component. The labeling is sort of the marketing and branding that gets back to the core of being the place to go for the best care. The best care is now based in clinical research which MIHS has always done but has never taken credit.

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

4. Strategic Plan Overview and Update (cont.):

The doctors who train at MIHS are loyal to MIHS and train other physicians across the Valley, State and Country. MIHS has always been known as the County Hospital and the opportunity is now available to give a name to what it has been doing all along.

Ms. Doria stated the direction that academic medicine is moving towards at the present time is to partner with many medical schools and allied teaching programs. The past model with a relationship of one hospital to one medical school does not work since it cannot serve all of the complex needs of today's patients. The new approach will be to have multiple schools coming together to create a team-based environment so that research and education are integral with patient care in every encounter.

5. Wrap Up, Next Steps and Future Agenda Items

Mr. Sterle explained the next meeting of the Committee is September 9, 2013, at which time everything should start to come together. The current state environment has been reviewed and the shift will be to look at the needs of the future. Things like volumes of activity, growth levels, shifting distributions will be reviewed in order to start to compare and plan for the future. A meeting with the Board is scheduled toward the end of August to start to form this information and this is when facility implications will begin to be compared to what is present today.

6. Approve Bond Advisory Committee Meeting Minutes dated July 8, 2013

MOTION: Mr. Spicker moved to approve the Bond Advisory Committee meeting minutes dated July 8, 2013. Ms. McCarthy seconded the motion. **Motion passed by voice vote.**

Ms. Francis stated she had heard that the Chair and Vice Chair may not be able to attend the meeting on September 9, 2013 and asked if the Committee members should consider an alternative date in order to get the largest turnout since the meeting should be a critical one.

Vice Chairman Coor stated he agreed with this idea.

Ms. Francis suggested that Ms. Talbot poll the committee members as to their availability on another date versus September 9th.

Ms. Talbot agreed to coordinate to find a mutually convenient date in order to secure a better turnout.

Adjourn

MOTION: Ms. Francis moved to adjourn the August 12, 2013 Bond Advisory Committee Meeting. Dr. Chundu seconded. **Motion passed by voice vote.**

Meeting adjourned at 4:15 p.m.

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Bill Post, Chairman
Bond Advisory Committee