Maricopa County Special Health Care District

Bond Advisory Committee Meeting

November 12, 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

Bond Advisory Committee 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 ·

Tuesday, November 12, 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
   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.

11/7/2013 11:06 AM

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

2. Discuss the Basis for Planning; the Purpose of Facility Development
   Larry Sterle, Kurt Salmon

3. Discuss and Review Options Development:
   - Options Overview Process
   - Acute Care Hospital Options
   - Behavioral Health Options
   - Order-of-Magnitude Capital Costs

   Jared Averbuch, Kurt Salmon
   Larry Sterle, Kurt Salmon

4. **Approve** Bond Advisory Committee Meeting Minutes dated September 17, 2013
   Committee

Motion to Recess General Session and Convene in Executive Session

Executive Session:

E-1 Legal Advice; Contracts Subject to Negotiations; Records Exempt by Law from Public Inspection; A.R.S. § 38-431.03(A)(3); § 38-431.03(A)(4) and § 38-431.03(A)(2)[1]: Maricopa County Special Health Care District strategic planning regarding financial, educational and clinical services, health initiatives, facilities, product service line strategies, budget, and operational strategies.

[1] *Exemptions based upon A.R.S. § 48-5541.01(M)(4) (b), (c) and (d) proprietary information provided by a non-governmental entity, information, records or other matters, the disclosure of which would cause demonstrable and material harm and would place the district at a competitive disadvantage in the marketplace; or violate any exception, privilege or confidentiality granted or imposed by statute or common law.*

Recess Executive Session and Reconvene in General Session

General Session Presentation, Discussion and Action:

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

Adjourn

Maricopa County Special Health Care District

Bond Advisory Committee Meeting

November 12, 2013

Item 1.

Planning Process Update: Timeline

November and December are focused on framing, discussing and finalizing the options based on the MIHS Strategic Plan

- **November 12th – Bond Advisory Committee**
  - High-level facility options presentation
  - Order-of-magnitude capital implications / projections
  - Overall financial implications of strategies and capital investments

- December – BAC Final Recommendations
  - Incorporate input / refinements from November meetings
  - Review and approve the final report

MARICOPA INTEGRATED HEALTH SYSTEM

Maricopa County Special Health Care District

Bond Advisory Committee Meeting

November 12, 2013

Item 2.

Facility Development Serves the MIHS Strategy

Training the Next Generation of Healthcare Providers	Acute Care 	Outpatient Capacity 	Team Based Environment 
High Quality Care	Respect & Dignity 	Support Excellent Care 	Space for Technology and Equipment 
Healthcare Reform & Serving Community Need	Acute Care Beds 	Access to Lower Cost Services 	Behavioral Health Beds 
Cost Effectiveness	Utilization of Physical Resources 	Efficient Workspace and Organization 	Behavioral Health Locations / Transfers 

Source: Navvis, MIHS Strategic Plan

MARICOPA INTEGRATED HEALTH SYSTEM

Maricopa County Special Health Care District

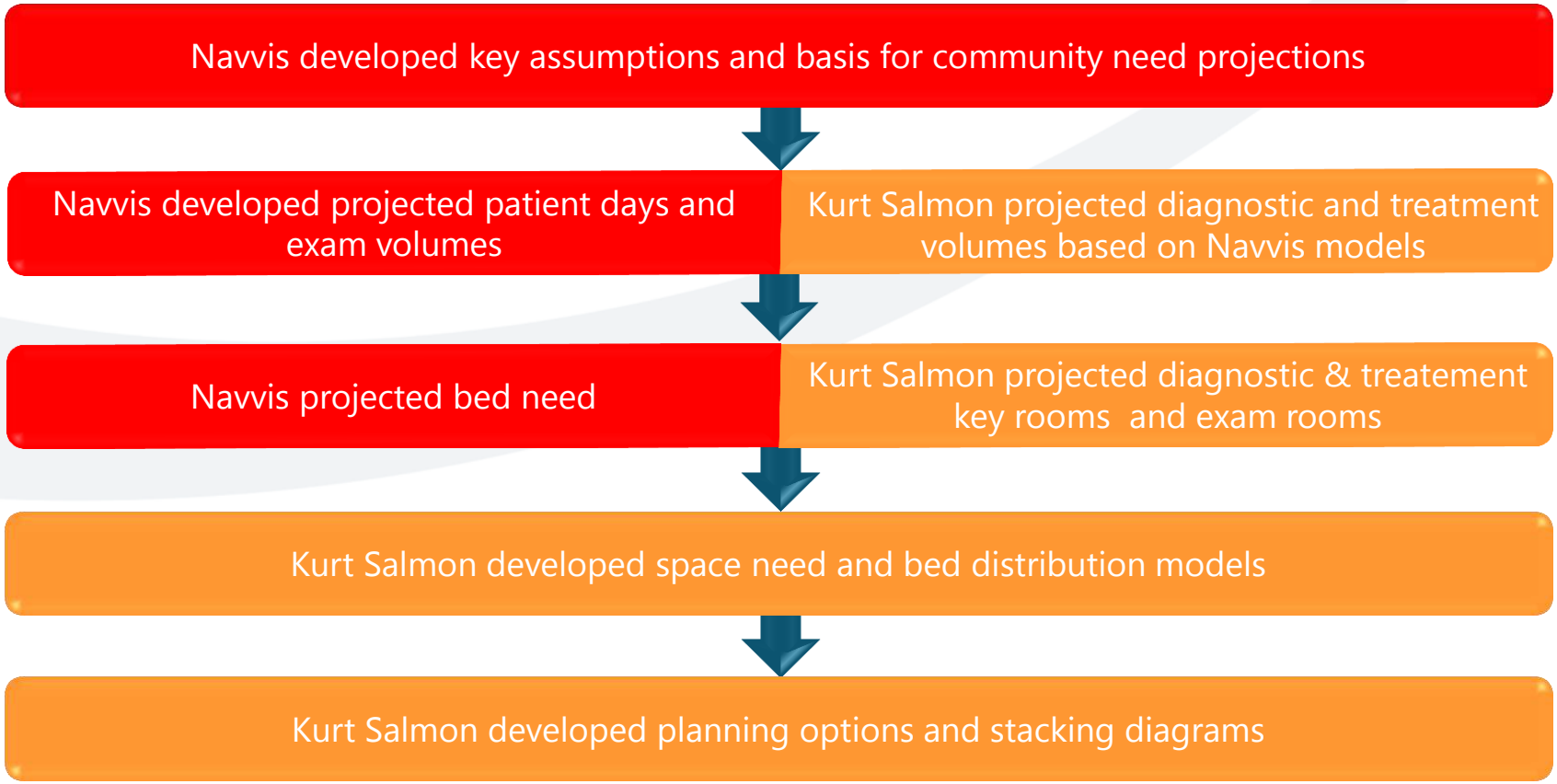
Bond Advisory Committee Meeting

November 12, 2013

Item 3.

Options Development Process

The development options are the outcome of fusing community need volume projections from Navvis with the facility planning guidelines of Kurt Salmon



MARICOPA INTEGRATED HEALTH SYSTEM

Projected Patient Days by Volume Scenario

Projected patient days between the low and high scenarios vary by eight percent

	FY 2013	FY 2023		
Patient Days	Historic	Low	Mid	High
Burn	**4,421**	**4,603**	**4,406**	**4,603**
Medical Surgical				
Adult	35,460	39,968	40,637	42,940
Pediatrics	8,244	10,567	9,588	10,567
Neonates (NICU)	**7,931**	**8,685**	**8,948**	**9,151**
Obstetrics	**7,021**	**6,887**	**7,750**	**7,901**
Behavioral Health	**63,211**	**68,851**	**72,893**	**76,177**

Source: Navvis, MIHS Strategic Plan

MARICOPA INTEGRATED HEALTH SYSTEM

Bed Demand by Volume Scenario

- Projected volume only materially affects bed projections for behavioral health
  - Currently MIHS has 280 acute care hospital beds which are projected to decline to 264
  - MIHS has 183 behavioral health beds today increasing to the low end of the projected range

Type	2023 Average Daily Census (at midnight)				2023 Bed Need (rounded)			
	Low	Mid	High	Planning Occupancy	Low	Mid	High	Recommended \a
Burn ICU	12.6	12.1	12.6	75%	17	16	17	16
Medical/Surgical	138.5	137.6	146.6	80%	173	172	183	176
Adult	109.5	111.3	117.6					
Pediatrics	29.0	26.3	29.0					
Neonates (NICU)	23.8	24.5	25.1	80%	30	31	31	30
Obstetrics	18.9	21.2	21.6	50%	38	42	43	42
Post Partum								32
LDRP								10
Licensed Acute Beds								**264**
Behavioral Health	**188.6**	**199.7**	**208.7**	**80%**	**236**	**250**	**261**	**240**

Source: Navvis, Kurt Salmon planning standards
a\ Based on potential bed unit sizing by bed type

MARICOPA INTEGRATED HEALTH SYSTEM

Diagnostic and Treatment (D&T) – Volume Projections

- D&T projections mirror the change rate of the acute care bed projections
- Emergency volume change is slightly greater than the other services

	FY 2013	Projected FY 2023				
	Historic	Low		Mid		High	
	Volume	Rate	Volume	Rate	Volume	Rate	Volume
Surgery/Invasive							
Operating Room	7,928	1.4%	9,111	1.5%	9,156	2.0%	9,689
Cardiac Catheterization	645	1.4%	741	1.5%	745	2.0%	788
Angiography	665	1.1%	738	1.6%	776	2.1%	817
Endoscopy	3,485	1.4%	4,005	1.5%	4,025	2.0%	4,259
Imaging							
CT	13,682	1.1%	15,189	1.6%	15,957	2.1%	16,816
Diagnostic	27,791	1.1%	30,850	1.6%	32,411	2.1%	34,155
MRI	2,695	1.1%	2,992	1.6%	3,143	2.1%	3,312
US	5,987	1.1%	6,646	1.6%	6,982	2.1%	7,358
Nuclear Medicine	1,047	1.1%	1,162	1.6%	1,221	2.1%	1,287
Mammography	2,136	1.1%	3,338	1.6%	3,338	2.1%	3,338
Emergency Department	71,074	1.4%	74,177	2.4%	79,509	2.4%	79,965

Source: Navvis Scenarios Model; Kurt Salmon analysis

MARICOPA INTEGRATED HEALTH SYSTEM

D & T Room Demand by Scenario

- Like the bed model, projected D&T volumes do not result in a material difference for major hospital-based diagnostic and treatment rooms

	Volume			Visits / Room /Year	Room Need (Rounded)		
	Low	Mid	High		Low	Mid	High
Surgery / Invasive							
Surgery	9,111	9,156	9,689	900	10	10	11
Cardiac Catheterization	741	745	788	1,200	1	1	1
Angiography	738	776	817	1,200	1	1	1
Endoscopy	4,005	4,025	4,259	1,750	2	2	2
Imaging							
CT	15,189	15,957	16,816	3,000	5	5	6
Diagnostic	30,850	32,411	34,155	4,500	7	7	8
MRI	2,992	3,143	3,312	1,500	2	2	2
US	6,646	6,982	7,358	3,000	2	2	2
Nuclear Medicine	1,162	1,221	1,287	1,500	1	1	1
Mammography	3,338	3,338	3,338	3,000	1	1	1
Emergency Department	74,177	79,509	79,965	1,600	46	50	50

Source: Navvis Scenarios Model; Kurt Salmon planning standards

MARICOPA INTEGRATED HEALTH SYSTEM

FHC and CHC Volume Projections

- Scenarios based on community need assumptions with a greater shift to care in the outpatient environment

Location	Historic Volume		FY 2023 Volume					
			Low		Mid		High	
	Clinic	Dental	Clinic	Dental	Clinic	Dental	Clinic	Dental
Avondale	13,936	3,041	17,839	3,333	19,623	3,649	19,623	3,993
El Mirage	15,237	-	18,035	-	19,838		19,838	
Sunnyslope	18,135	-	20,292	-	22,321	-	24,350	-
Guadalupe	11,538	-	13,272	-	13,272	-	13,272	-
7th Avenue	15,986	-	17,887	-	17,887	-	17,887	-
South Central	16,188	1,041	18,113	1,141	18,113	1,249	18,113	1,367
McDowell	11,959	2,802	13,381	3,071	13,381	3,362	13,381	3,679
West CHC	-	-	-	-	52,203	2,413	59,321	2,640
Glendale	18,556	2,011	21,963	2,204	*Consolidated into West CHC*			
Maryvale	21,539	-	27,572	-				
East CHC	-	-	-	-	54,014	5,318	58,516	5,819
Chandler	20,669	2,001	23,775	2,193	*Consolidated into East CHC*			
Mesa	18,462	2,431	21,237	2,664				
Main CHC	153,509	10,119	176,757	11,089	193,637	12,143	205,376	13,286

Source: Navvis Scenarios Model

MARICOPA INTEGRATED HEALTH SYSTEM

FHC and CHC Key Room Need

- Once distributed to the individual locations, the scenarios do not result in a material difference by site

Location	Historic Volume		FY 2023 Volume					
			Low		Mid		High	
	Clinic	Dental	Clinic	Dental	Clinic	Dental	Clinic	Dental
Avondale	13	6	15	3	16	3	16	3
El Mirage	9	-	15	-	17	-	17	-
Sunnyslope	20	-	17	-	19	-	20	-
Guadalupe	8	-	11	-	11	-	11	-
7th Avenue	-	-	15	-	15	-	15	-
South Central	17	3	15	1	15	1	15	1
McDowell	-	-	11	3	11	3	11	3
West CHC	-	-	-	-	44	2	49	2
Glendale	16	2	18	2	*Consolidated into West CHC*			
Maryvale	22	-	23	-				
East CHC	-	-	-	-	45	4	49	5
Chandler	19	2	20	2	*Consolidated into East CHC*			
Mesa	18	3	18	3				
Main CHC	161	12	147	9	161	10	171	11

Source: Navvis Scenarios Model; Kurt Salmon planning standards

MARICOPA INTEGRATED HEALTH SYSTEM

Overall Planning Goals

Inpatient services

1. Replace the Main Hospital per the facility assessment outcomes and strategic plan
2. Consolidate all three behavioral health service sites for improved efficiency
3. Right-size clinical care services to achieve contemporary care and training environment

Outpatient services

1. Right-size and/or relocate the existing FHC's to achieve strategic patient service goals and efficient operating models
2. Expand the CHC capacity on the existing campus to enable continued shifting to outpatient services
3. Develop new CHC's to include exam/diagnostic, treatment and therapy services appropriate to a free-standing ambulatory setting

Training programs

1. Enhance academic and education capabilities and support spaces

Source: Navvis, MIHS Strategic Plan

MARICOPA INTEGRATED HEALTH SYSTEM

Option Development Guidelines

1. Each option must be buildable, phase-able and functional when complete
2. Minimize the number of "make-ready" projects required to achieve the end result
3. Retain and/or repurpose as many existing buildings as possible
4. Each building should have adequate parking that is close to a highly visible front entrance
5. Various types of vehicular traffic circulation should be separated (e.g., public, emergency, physicians/employee, service)

Source: Kurt Salmon

MARICOPA INTEGRATED HEALTH SYSTEM

Rule-out example: Desert Vista Expansion Option

- Although this option does was considered for consolidating inpatient behavioral health, it was ruled out as not buildable / phase-able

Attributes

- Uses an asset where the majority of behavioral health patients are currently seen
- Building structured for vertical expansion without extraordinary investment needed
- Development not dependent on make-ready projects

Deficiencies

- **It will be difficult to renovate while the building is occupied**
- **Property size is limited and sufficient parking will require a parking deck**
- Does not consolidate behavioral health services on a single campus
  - Medical behavioral health on the acute care campus, urgent psych center at a third campus
- Does not achieve a private bed model
  - 138 patients in semi-private rooms; 54 patients in private rooms
- Locates Behavioral Health in a neighborhood that is not highly accessible

Source: Kurt Salmon

MARICOPA INTEGRATED HEALTH SYSTEM

Acute Care and Behavioral Health Hospital Options

Options Overview

From a larger set of alternatives, three options for acute care services and three options for behavioral health services fit the planning criteria

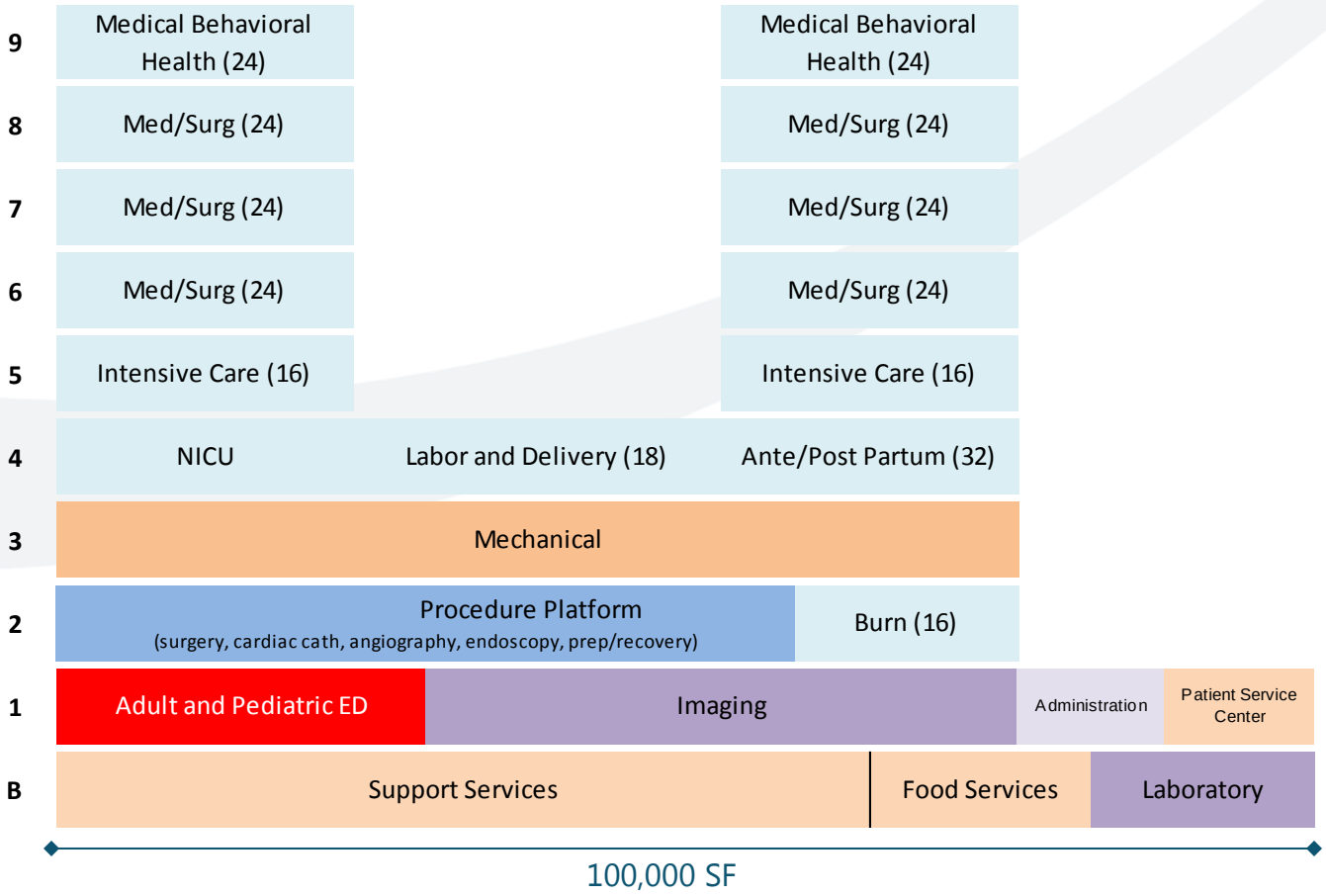
	Acute Care Options		
Behavioral Health Options	Option 1: East 	Option 2: West 	Option 3: New 
Option 1: Renovated Main Hospital	Replace Power Plant and Add Parking Garage	Add Parking Garage	√ (√ = compatible without modification)
Option 2: New Hospital on Main Campus	N/A	√	√
Options 3: Greenfield Site	√	√	√ (assume combined site)

MARICOPA INTEGRATED HEALTH SYSTEM

Acute Care Options

Potential Acute Care Hospital Stacking Diagram

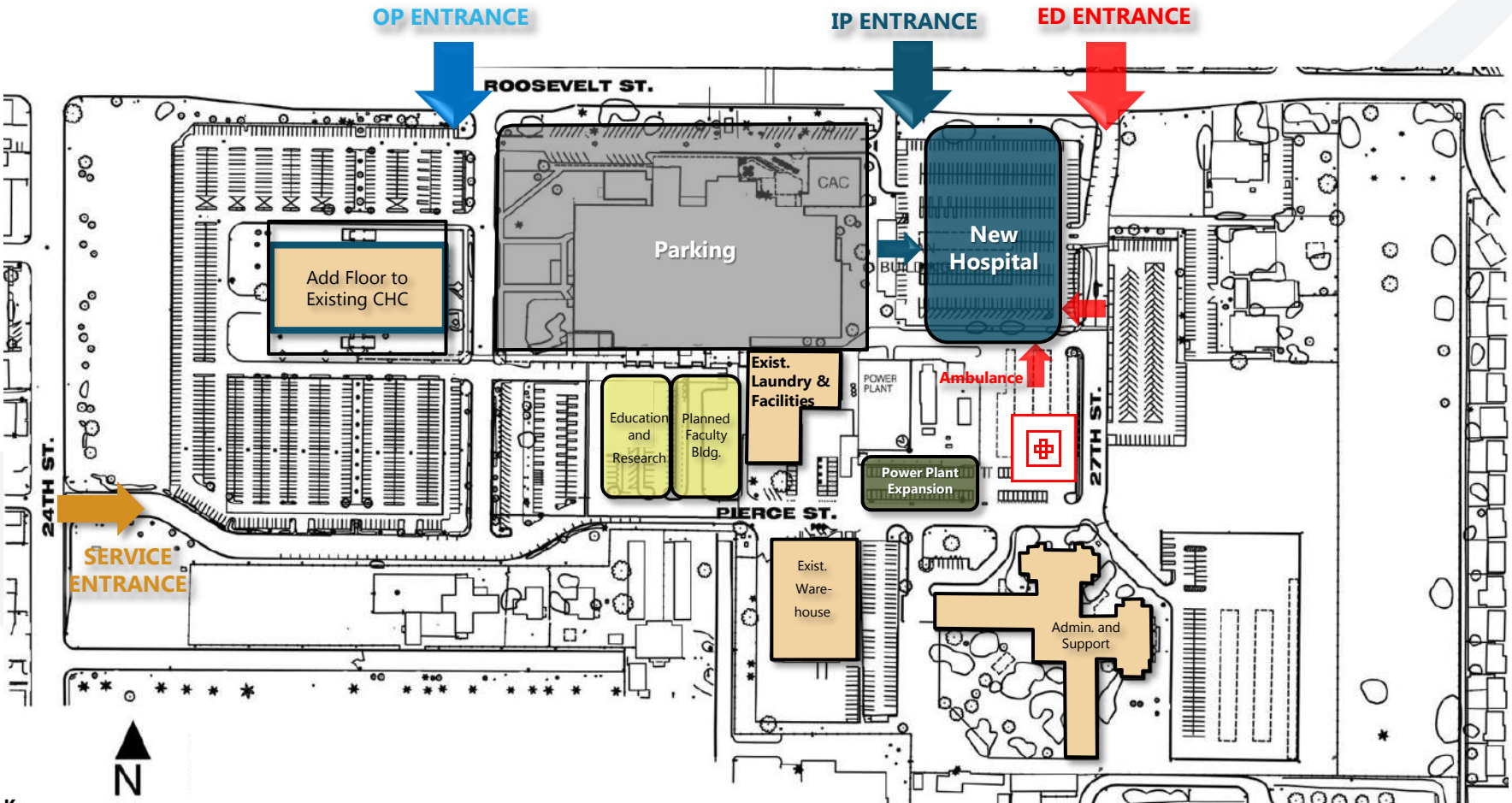
- This potential approach to organizing a new acute care hospital helps establish the approximate footprint of the building



Source: Kurt Salmon analysis

MARICOPA INTEGRATED HEALTH SYSTEM

Acute Hospital Option 1: East Option



Key

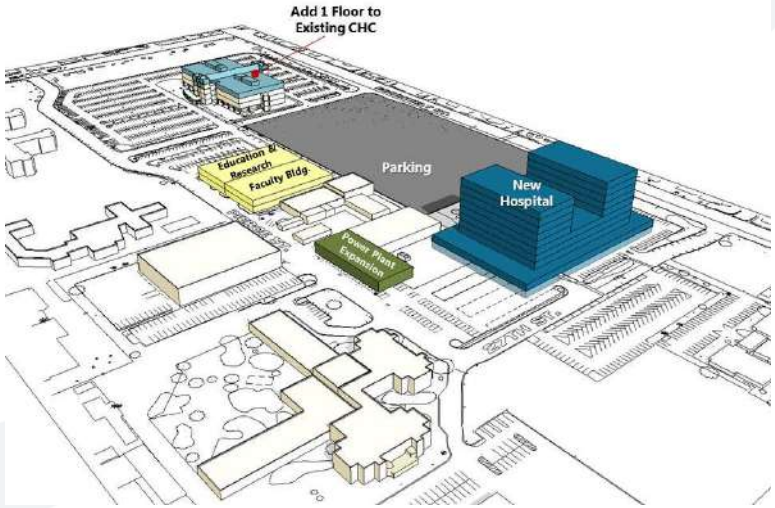
- New Clinical Construction
- New Support Construction
- Renovated Clinical Construction
- New Power Plant
- New Parking
- Existing MIHS Buildings
- Public Entrance
- Ambulance/Walk-in Entrance
- Service Entrance

MARICOPA INTEGRATED HEALTH SYSTEM

Acute Hospital Option 1: East Option

Attributes

- Readily buildable site with minimal impact on patient parking
- Main hospital, CHC and support services right-sized
- Incorporates the current plans for the faculty office building
- Good separation of vehicular traffic
- Continued use of the warehouse, 2619 buildings and existing power plant



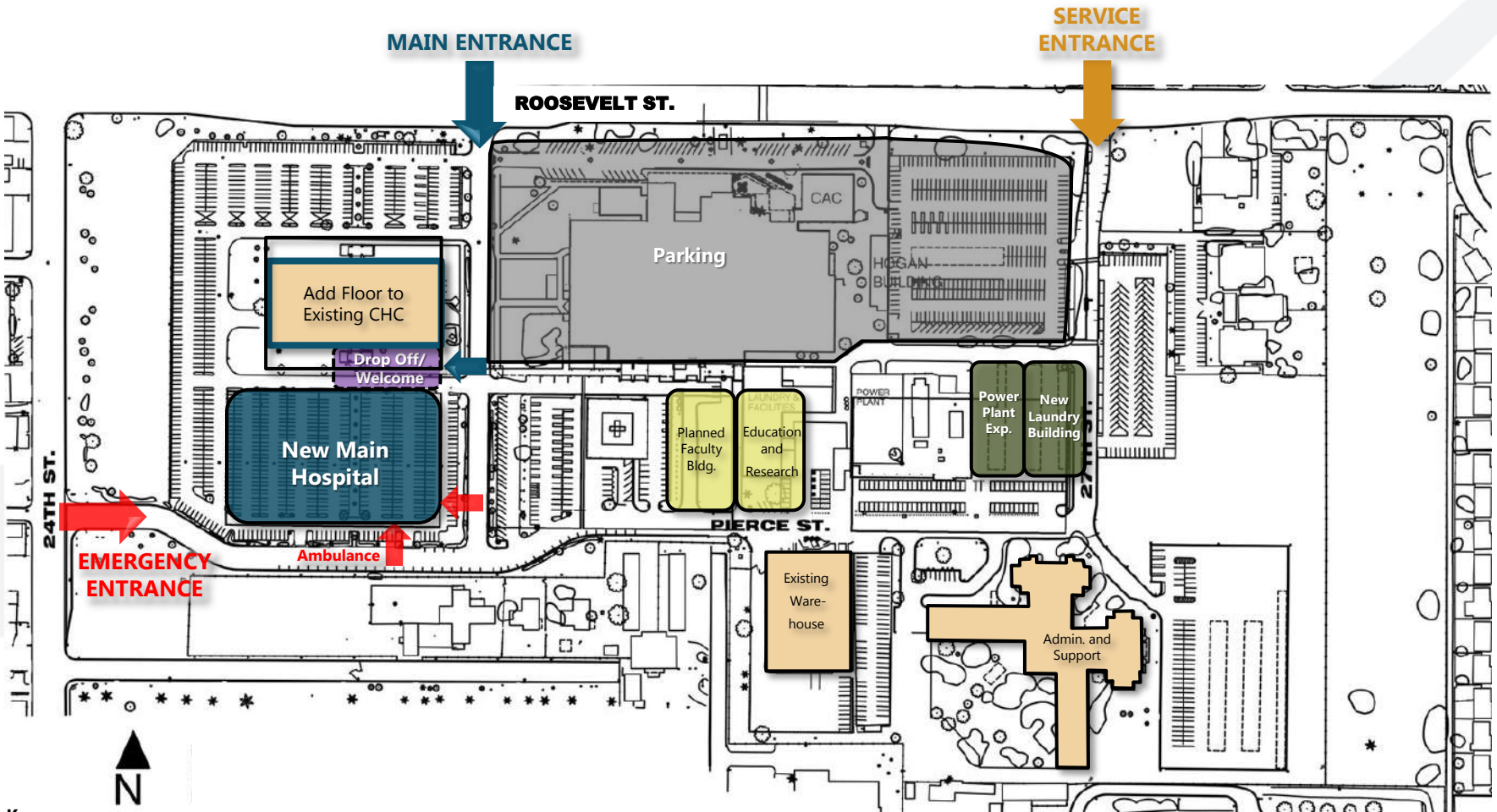
Deficiencies

- Hospital and CHC are disconnected -- on opposite ends of the campus
- Helipad must be relocated
- Expansion of the power plant is required as a "make-ready" project
- An interim parking solution (e.g., shuttle service, parking garage) is also a "make ready" requirement

Source: Kurt Salmon analysis

MARICOPA INTEGRATED HEALTH SYSTEM

Acute Hospital Option 2: West Option

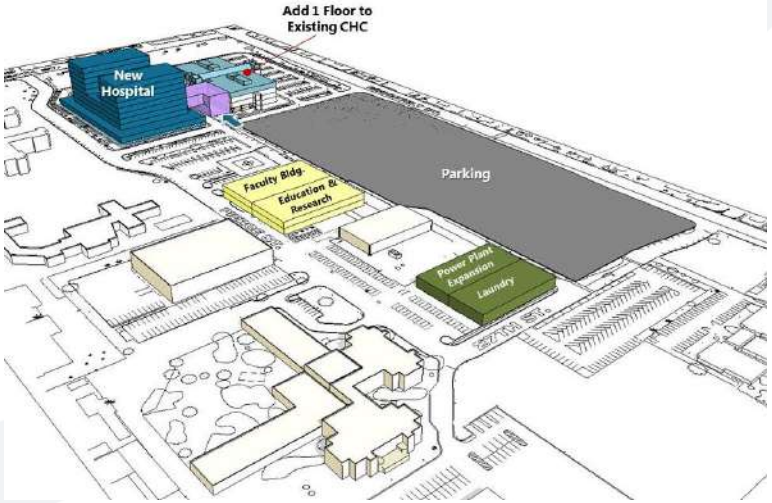


MARICOPA INTEGRATED HEALTH SYSTEM

Acute Hospital Option 2: West Option

Attributes

- Main hospital, CHC and support services right-sized
- Hospital and CHC connected for staff efficiency and patient convenience
- Incorporates the current plans for the faculty office building
- Good separation of vehicular traffic
- Clear separation of service zones from clinical zones
- Continued use of the warehouse, 2619 buildings and existing power plant



Deficiencies

- An interim patient parking solution (e.g., shuttle service) is a "make ready" requirement
- Expansion of the power plant is required as also a "make-ready" project
- Some patient parking is far from the building entrances

Source: Kurt Salmon analysis

MARICOPA INTEGRATED HEALTH SYSTEM

Acute Hospital Option 3: Greenfield Site

New Campus

- Acute care hospital
- Faculty offices
- Education building

Existing Main Campus

- Expanded CHC
- Warehouse
- Laundry
- Administrative and IT support

Location TBD

MARICOPA INTEGRATED HEALTH SYSTEM

Acute Hospital Option 3: Greenfield Site

Attributes

- Can organize site without existing constraints
- Main hospital, CHC and support services right-sized
- Continued use of the warehouse and 2619 buildings to support operations

Deficiencies

- Requires the acquisition of an additional property
- Separate the CHC and major support components from the hospital
- Walks-away from the current plans for the faculty office building
- Cannot leverage existing power plant, must be all new
- Requires more / longer transport of supplies and linen

Source: Kurt Salmon analysis

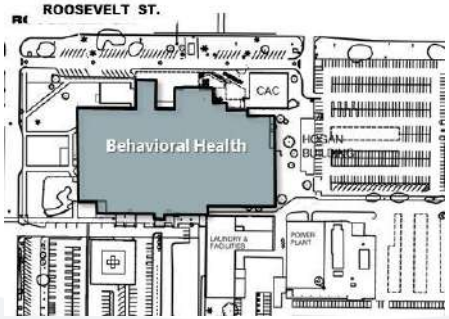
MARICOPA INTEGRATED HEALTH SYSTEM

Behavioral Health Options

Behavioral Health Options

Option 1

Renovate Main Hospital



- Renovate to meet AIA guidelines for behavioral health facilities
- Remove all asbestos
- Replace all interior walls, ceilings, doors, plumbing, electrical, mechanical systems and windows

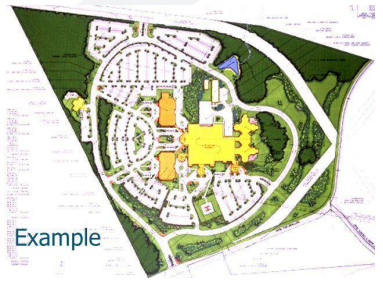
Option 2

New Hospital on Main Campus

- Build a new behavioral health hospital to the east of the existing Main Hospital

Option 3

Greenfield Site



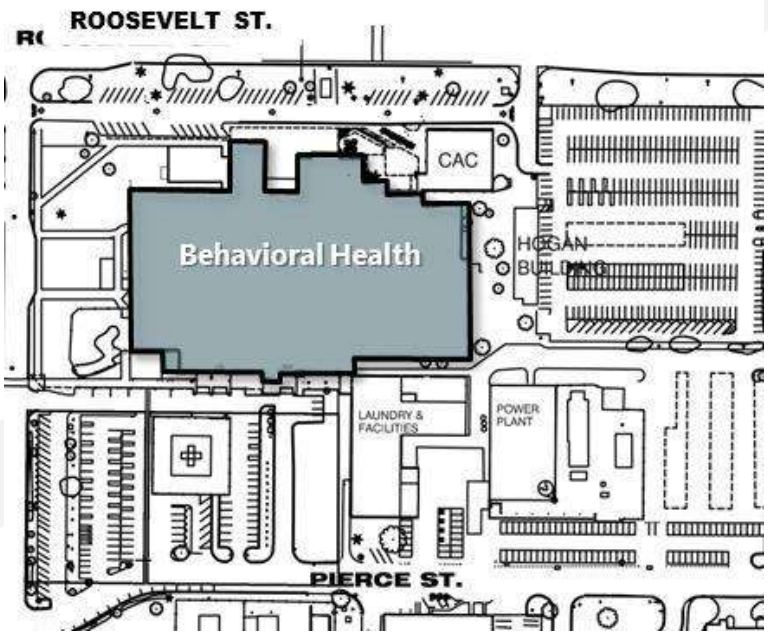
- Develop new inpatient, day hospital and urgent care intake on a new site
- Co-locate with acute care hospital, if acute care option 3 is chosen

MARICOPA INTEGRATED HEALTH SYSTEM

BH Option 1: Renovate Main Hospital

- Existing building can achieve 192 beds to include non-medical behavioral health beds.

7	General (24)	
6	General (24)	
5	General (24)	
4	General (24)	
3	General (24)	
2	Prisoner (48)	
1	Courts, Administrative, Outpatient, Recreation	Geriatric (24)
B	Support (food service, materials, EVS, CSS)	

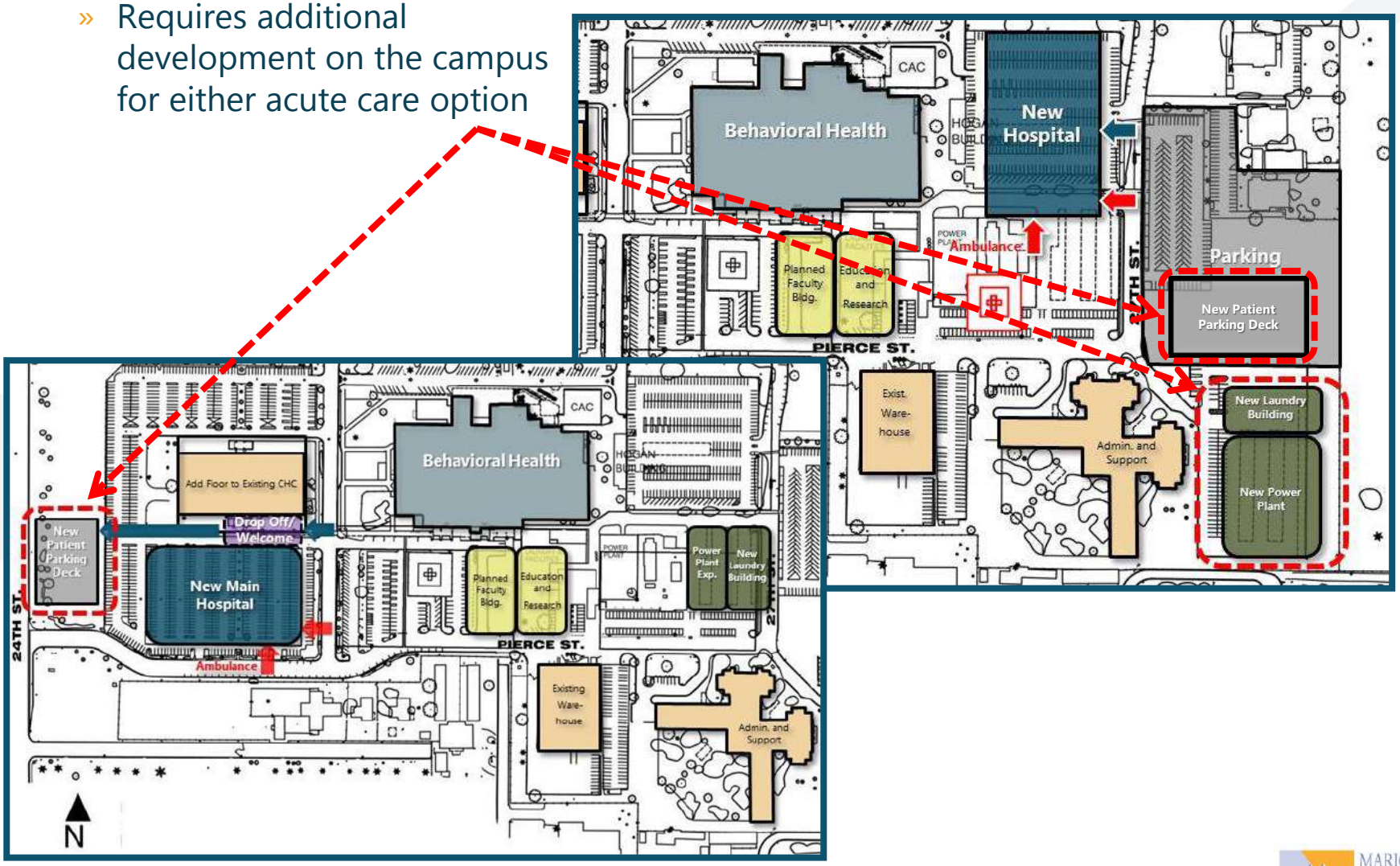


Source: Kurt Salmon analysis

MARICOPA INTEGRATED HEALTH SYSTEM

BH Option 1: Renovate Main Hospital

- Requires additional development on the campus for either acute care option

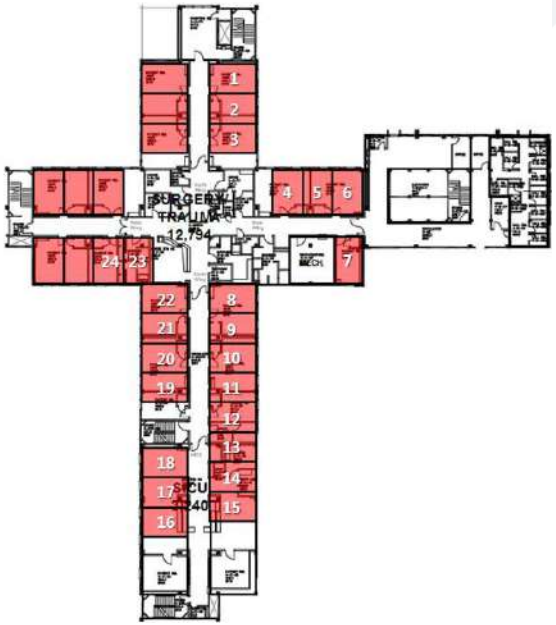


MARICOPA INTEGRATED HEALTH SYSTEM

BH Option 1: Renovate Main Hospital

Attributes

- Utilizes an existing asset
- Consolidates all medical and non-medical behavioral health patients on the same campus
  - Minimizes the number of transfers from intake through discharge
- Sufficient space to include urgent and outpatient programs
- Sale of Desert Vista property can provide some of the funding



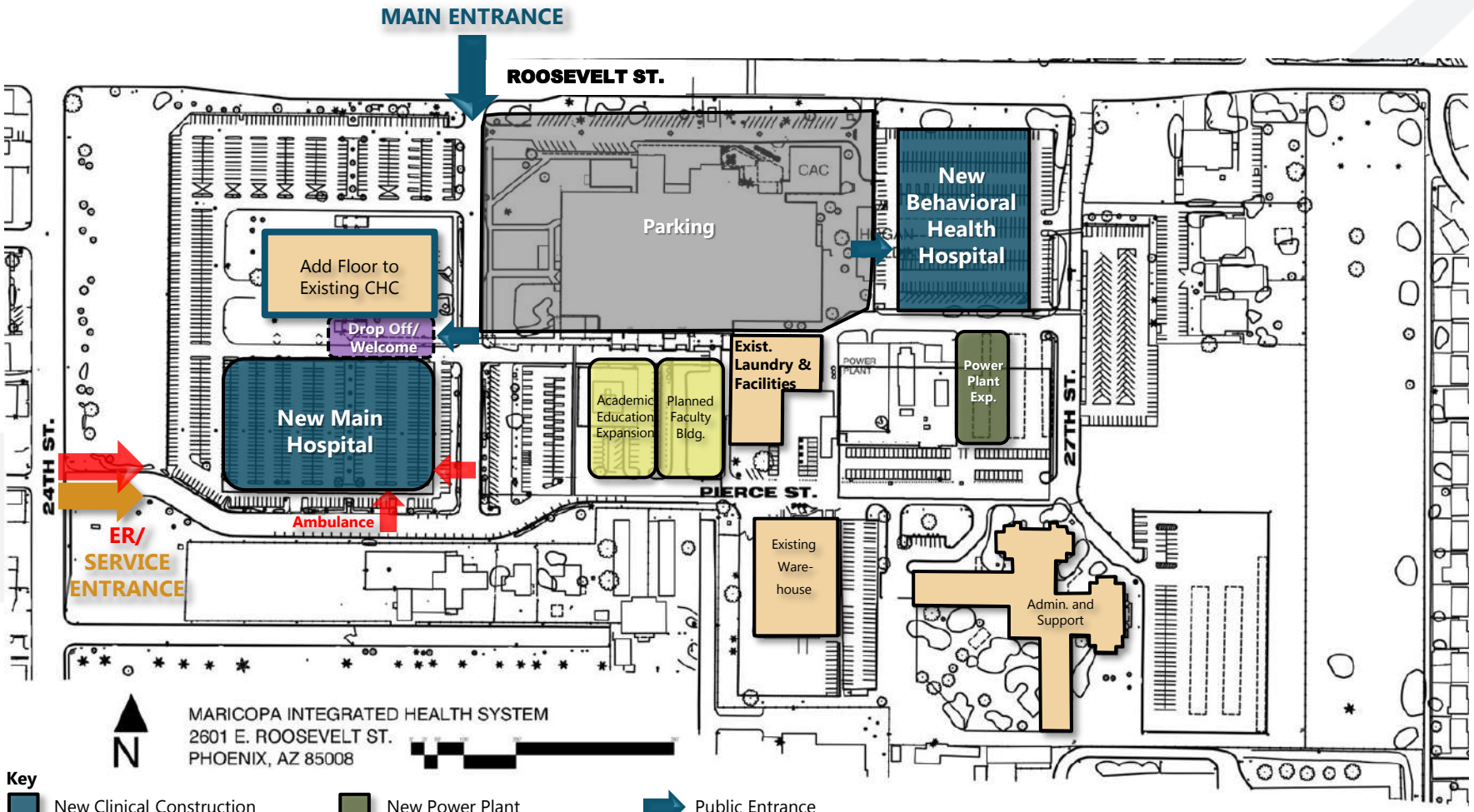
Deficiencies

- Care configuration model will be deficient, despite heavy investment
  - Some of the units will fall short of planning standards
- Adds cost to each on-campus acute care option
- Requires a major investment in a 40+ year old building
- Development cannot start until the new acute hospital is built and occupied
- Abandons existing behavioral health assets

Source: Kurt Salmon analysis

MARICOPA INTEGRATED HEALTH SYSTEM

BH Option 2: New Hospital on Main Campus



Key

- New Clinical Construction
- New Support Construction
- Renovated Clinical Construction
- New Power Plant
- New Parking
- Existing MIHS Buildings
- Public Entrance
- Ambulance/Walk-in Entrance
- Service Entrance

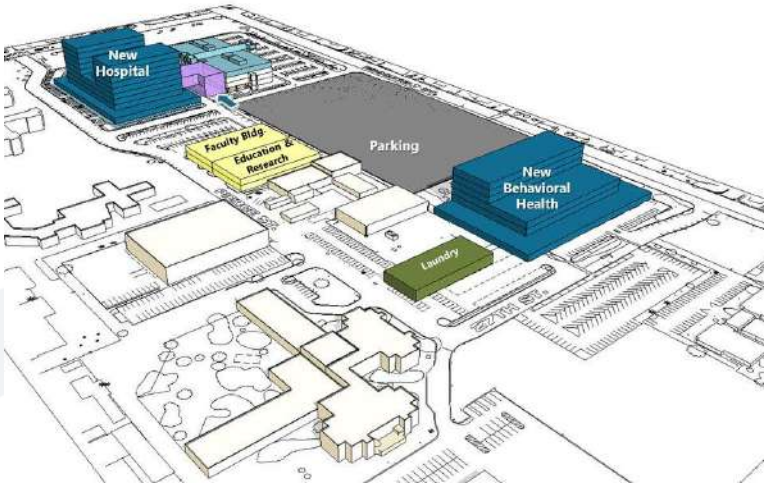
MARICOPA INTEGRATED HEALTH SYSTEM

BH Option 2: New Hospital on Main Campus

The following are additive to the attributes and deficiencies of Acute Care Option #2

Attributes

- Readily buildable site
- Consolidates all medical and non-medical behavioral health patients on the same campus
  - Minimizes the number of transfers from intake through discharge
- Sufficient space to enable development of outpatient programs
- Sale of Desert Vista property can provide some of the funding



Deficiencies

- Abandons existing behavioral health assets
- May require a parking garage to achieve sufficient parking capacity

Source: Kurt Salmon analysis

MARICOPA INTEGRATED HEALTH SYSTEM

BH Option 3: Greenfield Site

Attributes

- Can organize site without existing constraints
- Consolidates all medical and non-medical behavioral health patients on the same campus
  - Assumes combination of greenfield acute care option
  - Minimizes the number of transfers from intake through discharge
- Development not dependent on make-ready projects
- Sale of Desert Vista property can provide some of the funding

Deficiencies

- Requires the acquisition of a new property
- Abandons existing behavioral health assets

Source: Kurt Salmon analysis

MARICOPA INTEGRATED HEALTH SYSTEM

Order-of-Magnitude Cost

Project Cost Overview

Capital project costs for each acute care facility option is nearly the same

- Includes construction, fees, furniture, equipment and contingency
- Escalation of 3% per year through 2020

	Acute Care Hospital	BH Hospital	CHC's	FHC's	Total
	$541M to $548M	$247M	$102M	$26M	**$916M to $923M**
Facility Costs	New Hospital Education / Research Laundry Power Plant Demolition 2619 Renovation Relocate Helipad Demolition of existing hospital	New Hospital Renovate Main Hospital $231M	East CHC West CHC Expand Central CHC	Replace: Avondale El Mirage Sunnyslope South Central Guadalupe 7th Avenue No change to McDowell	
Greenfield Land Cost	+$5.5M		+$2M each for East and West		+$4M to $9.5M

Kurt Salmon capital projection cost model based on projected building sizes and anticipated local construction costs

MARICOPA INTEGRATED HEALTH SYSTEM

Maricopa County Special Health Care District

Bond Advisory Committee Meeting

November 12, 2013

Item 4.

DRAFT

Maricopa County Special Health Care District
Board of Directors Bond Advisory Committee Meeting
Maricopa Medical Center
Auditoriums 3 and 4
September 17, 2013
2:30 p.m.

Voting Members Present:	Bill Post, Chairman Lattie Coor, Ph.D., Vice Chairman Tony Astorga Paul Charlton Frank Fairbanks Nita Francis Merwin Grant Doug Hirano Terence McMahon, Ex-officio, Director, District 5 Brian Spicker - *participated telephonically beginning at 3:01 p.m.*
Absent:	Kote Chundu, M.D. Diane McCarthy Rick Naimark Joey Ridenour Ted Williams
Others/Guest Presenters:	Michael Eaton, Navvis & Healthways Jared Averbuch, Kurt Salmon Betsey Bayless, MIHS, President & CEO
Recorded by:	Melanie Talbot, MIHS, Executive Director of Board Operations

Call to Order

Chairman Post called the meeting to order at 2:34 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.

Ms. Talbot stated that Mr. Spicker would be able to join the meeting, telephonically, at approximately 3:00 p.m.

Call to the Public

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

General Session Presentation, Discussion and Action:

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

Mr. Averbuch stated the current meeting would focus on the strategy, the discussions are very important and will drive what the facility and capital needs of the future will be. He encouraged Committee members to ask questions while Mr. Eaton walks through the strategy that has been developed with the leadership team and the Board to ensure they understand it because everything that comes out, as far as facilities and capital goes, is a direct result of what the strategies are for the organization.

Mr. Averbuch stated that the District Board of Directors approved a five-year strategic plan at its August 28, 2013 meeting. The Kurt Salmon team will be working with the Navvis team to start to materialize the strategies into hard data and volumes that will then drive the facility projections.

2. Review the Maricopa Integrated Health System Clinical Network Plan

Mr. Eaton said there are many moving pieces and parts in healthcare and sometimes the focus is on urgent but unimportant things. The District Board has been able to focus on things that are not necessarily urgent but are vitally important in terms of the health of the community. When thinking about the community of Maricopa County and the individuals and businesses who reside within the County it is important to think about the things that are critical to happen over the next three, to five, to ten-year period. The Bond Advisory Committee's role in the process is to help provide counsel, input and direction as to how to move the strategies forward. Things to consider are where there is unmet need; where is there emerging demand; what are the markets, the services, and the opportunities for the organization to meet the needs but also do it in a way that is meaningfully different and relevant in the community.

At the core of everything is the vision of a public teaching hospital and healthcare system. When you look across the country in many communities the best care is delivered by the public teaching hospital in the healthcare system. The leadership role that the public systems play is vital to the success of the community and critical in educating and delivering care, setting standards for quality of care and having an impact. This impact is not defined by public teaching hospitals inpatient volumes since they are not always the largest of inpatient services, however, they have an outsized impact on how care is organized, delivered and how it is shaped in terms of the community. The key factor for these institutions is their increasing ability to move beyond the hospital walls and start to reshape how care is delivered in the community.

Maricopa Integrated Health System (MIHS) has a unique and critical role in the community and the challenge that all public teaching hospitals and healthcare systems have now is how to fund the mission that they have; how to grow the ability to impact care when the hospital piece of healthcare is shrinking in many cases. There are fewer people being hospitalized so how do you move beyond a hospital, and teach and deliver care beyond the four walls.

The Board identified six strategy priorities as being critical.

1. Grow the Number of Lives Managed. The classic thought of a customer in healthcare are people who show up in the emergency department or show up in a hospital bed. These individuals initiated an action that brought them to MIHS. Looking at the way care is increasingly being financed currently, MIHS is asked to take care of these individuals plus manage the care for people who may not have an immediate need. The question is how to keep healthy people well, slow the progression of chronic disease, and fill the gaps in care and needs that may not manifest into a requirement of use of the emergency department.

This is measured by the number of lives managed under contract. They may be Medicaid lives through the AHCCCS program; they may be commercial in partnership with a managed care plan or an employer; they may be Medicare lives. This is a critical measure that does not equal the number of lives in beds in a hospital but rather to number of lives managed.

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

2. Review the Maricopa Integrated Health System Clinical Network Plan (cont.)

*2. Build a Network of Ambulatory Sites***.** This is key to growing the number of people managed since the number of individuals going into hospital beds continues to decline. This does not mean there will not be growth in demand since there will be sick people who need hospitals but care is increasingly being delivered in an outpatient setting.

3. Exercise Prudent Stewardship of Public Resources. The Board felt strongly about this since it speaks not only to being frugal with resources but more importantly to being smart. The task is how to take limited resources since you are a public steward and make the best choices in terms of how to deploy the dollars so you have the greatest impact on the most number of people in the community. In the past MIHS was paid based on what the costs were and as this shifts to getting paid for value, MIHS will have to focus more on how to be smarter in deploying resources.

4. Build an Integrated Academic Campus (Maricopa Medical Center). This relates to building a new hospital but not simply a replacement for the current hospital. The business model is different since we have to think about working in teams today. Nurses, doctors, pharmacists, dieticians and allied health professionals are working together in teams to manage care, produce better outcomes and lower costs. This has to be thought of from a teaching and training standpoint. The thought needs to be towards figuring out how to bring everyone together on the campus and train them in a setting.

5. Expand Behavioral Health Capacity to Meet Community Need. MIHS is the leader in the community and the demand continues to grow. By 2030 about 50% of people who are coming to Maricopa Medical Center will have an underlying diagnosis of mental health or substance abuse which will drive higher costs, longer lengths of stay and poorer outcomes. The need has to be met beyond what is met today and in many cases it is about commitments in an inpatient setting. The question is how to move this to the community need and deploy it.

6. Advance Initiatives to Improve Community Health. Much of the health of a community is defined not by what happens in a physician's office or hospital bed; it is about risk factors and behaviors, and how you can begin to influence them. For instance, through diet, exercise, social networks have an ability to help people manage their health on their own.

Chairman Post asked Mr. Eaton what he meant by "strategy priorities." Are these things that are established before a plan is developed; did they come out of the plan; are these results of the strategy or are they inputs?

Mr. Eaton stated the strategy priorities are outputs of the process that occurred over a four-month period during the strategic planning process. During this time interviews were conducted, data was reviewed regarding the market and how the organization currently performs. Questions were asked as to where there is unmet need, emerging demands, critical roles that MIHS can uniquely play, and what would have to be done to seize the space and fill the role. Out of this came fifteen or twenty things that were identified as important to do. Six of these rose to the level of highest priority and being critical to fulfilling MIHS's entire mission and vision.

Mr. Eaton stated there is a sequence as to which step comes first and a pace in terms of how quickly they are executed. It is also important to have clearly defined dates for accountability purposes.

Director McMahon pointed out one of the guiding points that the Board used in establishing the strategic plan was the legislation that established the Special Health Care District, which specified it was a safety net health system as well as an academic medical center.

Mr. Fairbanks commented the strategic plan makes sense and comes together well. He agreed with Mr. Eaton's comments about training new medical staff and it is crucial and important for the future. In addition, one of the reasons an academic campus is so important is it guarantees excellent care since you do not want to leave the impression people that enter the campus are guinea pigs.

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

2. Review the Maricopa Integrated Health System Clinical Network Plan (cont.)

These individuals are going to get outstanding care at the same time that MIHS is developing the medical staff it needs for the future.

Mr. Eaton stated the things Mr. Fairbanks described are thought of in terms of what MIHS does and how it does it. MIHS wants to build an integrated medical campus and the task is how people should experience it. The branding of it should be that it is superior, cutting-edge care. MIHS may provide unique services as a public system that other systems may not provide. It does not always mean they are the most advanced, however, there may be some things in a public system that MIHS provides since there is not much volume for and therefore not provided in other systems.

The concepts of safe, comprehensive high-quality care, patient-centered relates directly to MIHS's charge and charter that was given to the organization, not simply when it was founded in 2004 by the taxpayers but really going back to 1871. If you look back to the farthest roots when the County and community was initially created one of the first things they did was to create a provision to create a system, a hospital, to provide care for those in need. This was very progressive at the time and the fact MIHS has held this commitment over all of these years is a real gift to the community and one that the Board is continuing to uphold.

Mr. Eaton explained as MIHS looks to the future and the concept of excellence in terms of an academic medical center it is about teaching, training, clinical care and a patient-centered care delivery system. A patient-centered care delivery system is not just about the experience that people have when they come to MIHS but how MIHS organizes around the needs of its patients.

The community is the fifth largest metropolitan area in the nation. It has a population that is greater than 27 other states with a geographic footprint that is as large as many states, particularly on the East Coast. In many ways, MIHS is the public health system for what in many other parts of the country would be an entire state. This is a unique privilege, charge and mission and is a significant challenge to manage.

Three questions speak to the alignment of what MIHS does and what it says it wants to be.

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. This does not say that MIHS goal is to grow market share, have more buildings, or be the largest or most expansive of organizations. It is really more about health outcomes and costs.

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 sites and where specifically should they be located?

NOTE: Mr. Spicker joined the meeting, via telephone, at this time.

Ms. Talbot advised Mr. Spicker that he was the only individual participating telephonically. She announced to him the others that were present in the room.

Mr. Eaton addressed the topic of the emerging market dynamics. Demand is going to continue to increase and it is not uniform across the County. The growth is going to happen in the southwest and northeast valleys, away from Maricopa Medical Center's primary service area. It is not reasonable to expect someone from the northwest or southeast valley to seek medical care at MMC.

In terms of specific services, demand is going to grow for adult primary and urgent care, pediatrics, orthopedics, cardiac medicine, and behavioral health. It will be office-based and ambulatory, not in hospitals and there are two drivers of this. One is preference – people do not like to go to the hospital and the second is payers – the preference is not to pay for hospitals visits/stays since it is more costly.

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

2. Review the Maricopa Integrated Health System Clinical Network Plan (cont.)

Payers are looking for people to partner with to take care of patients outside of the hospital setting. This is termed "restoring patient demand." Some people say this is about delivering better care but the bottom line is it means there will be increasing incentives to keep people out of hospitals in the future.

There is the issue of expanded access to insurance coverage with more individuals who will have insurance coverage. These individuals will find that they cannot get service right away and it may be a three, four, or five-week wait.

There will be people looking for coverage and care differently than they have in the past and it is an opportunity to make an impression upon them that MIHS is not the place of last resort. This will be especially true if there are ambulatory sites near enough to where people live. The strategy is not "build it and they will come." The data work that has been done is to identify the markets and services, where there is unmet need, emerging demand and where the organization's current strategic advantage is that could be leveraged.

MIHS will need to decouple its primary and ambulatory care strategies from a goal of driving business into MMC or the Comprehensive Health Center to how to provide care to people outside of these settings. If people do need hospital care the question will be whether MIHS has a relationship with someone who can provide that in a cost-effective and efficient manner. This is the shift in strategy.

Mr. Eaton stated his firm did an analysis of three years of claims data from all the physicians in MIHS's market. There were a couple of things that were striking about the market. In MIHS's market there were 181 distinct clusters and the reason for this is the geographical distances are so wide. This creates a challenge for those who are in the business of employing physicians and creates an opportunity for those who are looking to network and get those physicians together at a local level to deliver care.

Data also showed a significant cohort of non-DMG primary care physicians whose patients end up seeing a DMG specialist. This may be for different reasons. Maybe they came through the emergency, trauma or burn departments or it may also be that there are some specialists who have unique positions in the market, which is a strength and should be recognized.

There is a significant number of DMG specialists who can 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. An example would be someone comes to MIHS by ambulance with an orthopedic trauma; they are seen by an MIHS orthopedist; the surgery is done at MMC; later they go back to where they live, which is in Glendale. The likelihood of this patient driving back and forth to MMC for care diminishes with each mile away that the patient lives. Unless MIHS has a presence in the market in Glendale, not just an FHC, but an orthopedic specialty clinic, the likelihood of getting that downstream business or keeping the continuity of care is relatively small.

Mr. Astorga asked how telemedicine was being integrated into the business model since it will be a part of the future in terms of controlling some of the healthcare costs and handling some of the geographic challenges.

Mr. Eaton said telemedicine is a significant opportunity for the organization because of the teaching role that it plays. This will be significant since buildings cannot be built fast enough to meet the need that is going to grow as the population ages. Telemedicine is a great way to get ahead and is an area where MIHS can play a leadership role.

Another way to think of the idea of clinically integrated networks is to think of MIHS as a general contractor with many independent contractors in the community who provide good service. MIHS sets a standard for quality, cost and patient experience and the independent contractors (physicians) want to be aligned with it. This creates an opportunity to build a network without having to make the investment of owning the practices or necessarily constructing new buildings.

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

2. Review the Maricopa Integrated Health System Clinical Network Plan (cont.)

Mr. Eaton presented growth numbers, specifically a five-year projection from 2012 to 2017. The growth that is seen is in the southeast, northwest, and northeast valleys and is outside of the Phoenix market, which is MMC's primary market. If MIHS stays focused on organizing services on its MMC campus it will be serving the slowest growth market. This is not to say it is unimportant to service the needs of the community but rather to think about allocation of resources across the community into other markets with faster growth.

Mr. Hirano asked about the data and what it means to MIHS.

Mr. Eaton said when they look at the Medicare population and age categories they are looking at the mix of services. They look at groups in age 54 plus, 65 plus, frail elderly, healthy, vital elderly and this tells something about the types of services that MIHS would want to tailor to deliver in those sites to match the needs.

Mr. Eaton reviewed growth projections for Maricopa County which included physician and ambulatory growth as well as Emergency Department and Urgent Care Center volumes. Care will move from a hospital to an outpatient setting. Business opportunities outside of MMC are very strong and there is emerging demand. These opportunities can be drilled down to a zip code level and will assist in determining the sequence and pacing of where to put services.

The Emergency Department (ED) and Urgent Care Center (UCC) volumes represent that many people got to the ED because they cannot get in to see a physician, they have chosen not to have a primary care doctor, they know the ED is always open and they will get care. These situations have to be considered when it comes to what type of facility is going to be built and what types of services will be offered.

Mr. Fairbanks was surprised that the numbers do not reflect a significant increase in the 2017 physician practice/ambulatory care numbers given the implementation of the ACA. He believes there will be many more people who may go to the doctor when they are insured. It appears the rate of increase is only about ten percent between 2012 and 2017.

Mr. Eaton replied one issue is that there are not enough primary care physicians to provide services.

Mr. Fairbanks asked if a shift was predicted toward the utilization of more physician assistants.

Mr. Eaton believed this shift would take place and that many people utilize physician assistants more than they do their primary care doctors. MIHS will have a unique opportunity since it is a public teaching hospital.

Director McMahon was surprised at the low urgent care growth since urgent care facilities seem to be popping up all over and you can walk in anytime and get care.

Mr. Eaton said while urgent care centers increase the capacity for care they are limited in the amount of patients they can see. Many of them mirror the hours of the physician offices that are nearby, or may be open a little bit longer but they are not creating significantly more volume than what an ED expansion would provide.

Mr. McMahon asked how the geographic dissemination of services may affect the quality of teaching, if at all.

Mr. Eaton said the geographic dissemination of services can improve the quality of teaching since people are increasingly being taught in an office-based model. Teaching is largely organized around inpatient hospital departments and is focused on what happens in the hospital. MIHS typically sees four times more patients in an outpatient setting than it does in hospital beds.

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

2. Review the Maricopa Integrated Health System Clinical Network Plan (cont.)

MIHS will want to teach where the patients are being seen. The problem with this is that the acuity level is lower in an outpatient setting and you still have to maintain a hospital-based setting to teach complex, co-morbid, high-end conditions. There is a minimum threshold of a 225 to 250-bed hospital to maintain the numbers of cases necessary to train all of the residencies, on all of the pieces that MIHS wants to cover in that training. It is not an either/or situation – it is a matter of training in both inpatient and outpatient settings.

Mr. Post asked how the numbers compare between 2007 and 2012 and if any of them were extraordinary.

Mr. Eaton stated they tested their results to see how accurate they were and they were within about three percentage points so it is an accurate methodology.

A few things that have changed significantly are the cardiovascular inpatient market with every market line going straight down with the use of statins, greater attention to diet, and medications. Being in the inpatient cardiovascular business is not a time-intensive or growth place to be today. The question is how to deliver medical cardiology and manage patients.

Ms. Francis commented she believes it will be important for the facilities and especially the ambulatory centers, to be tele-networked and have accessible hours of operation and accessibility. It is not just about building the buildings but about how they are going to be used. People are not sick only from 9:00 to 5:00.

Mr. Grant commented it seems things are changing much more markedly than in the past ten years and he was wondering how to predict the future when there is so much change.

Mr. Eaton stated it is very challenging when you try to predict ten years in the future. The confidence level is pretty high when you are predicting three years out. Navvis uses an Advisory Board database and MIHS's specific market database for the work they are currently doing for MIHS. It is harder to predict once you go beyond five years since there are so many things that can change.

Mr. Eaton reviewed data regarding MIHS's source of business which was compiled using claims data from 2011 to 2013 for non-emergent referrals. The data is a map showing where physicians are located who are referring business to MIHS. Each dot reflects a physician or clinic that is sending business to MMC or the CHC.

Mr. Hirano commented he was having a hard time discerning what the map was showing since the quantity of referrals was not listed.

Mr. Eaton stated the initial assumption was that there would be a tight cluster in Maricopa Medical Center's primary service area and there would not be a broad distribution. However, the map shows providers are willing to send business to MMC. The map also shows clusters of areas with more business where it might make sense to put a facility since there are physicians there who are already comfortable referring to MIHS.

Mr. Hirano asked if the dots that were clustered further away from the main MMC campus represented possible locations to put a FHC.

Mr. Eaton stated they would not recommend putting FHCs in these locations and would be more of a matter of locating an ambulatory care center with a defined model for specialty services. Specialists would rotate through like ambulatory surgery itself and other types of specialty clinics.

Mr. Hirano commented it would be something like a mini CHC.

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

2. Review the Maricopa Integrated Health System Clinical Network Plan (cont.)

Mr. Eaton stated this was a great way to think about it. The idea would be that providers would send more business to MIHS at these locations due to the proximity.

Mr. Eaton reviewed further data regarding primary care alignment. In many cases, physicians are aligned or employed by the competitor but are sending business to MIHS. This indicates if MIHS delivers a value proposition to them they will send business to MIHS. DMG specialists send a lot of business outside of MIHS because MIHS does not have specialty clinics in the market.

MIHS might want to align distributed ambulatory services in the future. The model includes some new CHCs. Mr. Eaton explained that MIHS inherited a network of clinics so there is significant overlap in some areas. The network was not built by design and the facilities are of all sizes, shapes and capacities that provide all kinds of services. The facilities are not optimized to meet demand or the distribution of care. The idea is whether MIHS can consolidate to get greater coverage. The recommendation is to look at a site in the core Phoenix market, the northern end of the core Phoenix market and the central Phoenix market since there is unmet need in these areas.

Mr. Post asked if Mr. Eaton had another overlay that represented areas of public transportation.

Mr. Eaton explained he did not have the data with him but it does exist and was considered in their recommendation. With regard to ambulatory service priorities, public transportation is essential.

There are services that every ambulatory site should provide access to care: adult office visits, pediatric office visits and urgent care visits. Data is showing that these services will be in high demand and they align with MIHS' training and education needs. With all the new people getting coverage, the question will be how to get them in and accommodate their needs.

The second group of ambulatory service priorities is the highest strategic priority of services, based on emerging demand and market opportunity. This group includes Behavioral Health, Cardiology, Gastroenterology, General Surgery, Gynecology, Obstetrics, and Orthopedics.

The third group of priorities is tier 2 services that are more market specific and each individual market has to be reviewed. These markets are Cancer, Cardiac Invasive, ENT, Neurosciences, Ophthalmology, Physical Therapy/Rehab, Podiatry, Urology, and Vascular. They are not considered high priorities since other providers are already providing services pretty well but there may be opportunities to rotate specialists through sites to deliver some of the care.

Mr. Eaton explained when they were establishing the prioritization of ambulatory service priorities they looked at strategic position, financial performance, need and emerging demand. Care was taken to ensure that MIHS would not simply be duplicating what someone else has already done but rather how to deliver something that is unique and different. It is not about what MIHS does but how it can do something to fill an unmet need in the marketplace.

Chairman Post asked if supply is incorporated in the process of unmet need.

Mr. Eaton replied that supply is incorporated in the process. For instance, if you have a population of 1,000 individuals the expectation would be to see a certain number of cases and the question is what the supply is to meet those needs.

Mr. Post asked if that includes underserved as much as it does the unmet need.

Mr. Eaton stated a lot of the equation is underserved which translates into long wait times or longer drives to get care. The longer patients wait and drive for care the sicker they are when they show up which results in higher costs.

There are three different models of ambulatory sites called Neighborhood, Community and Health Center.

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

2. Review the Maricopa Integrated Health System Clinical Network Plan (cont.)

The neighborhood level is a core level of services. This is a basic clinic, about 8,000 to 9,000 square feet. It has a primary care, lab, basic imaging and pharmacy. When people seek core level care at a primary care they are looking for a prescription. They may have five children and if one has pink eye they all end up getting pink eye. If they have to go to one place to be seen and another for the prescription this is unworkable in many cases. So there are certain groups of services that are about convenience for the patients and this is the thought behind the neighborhood level point of access.

The Community level is a step up and offers specialty clinics. They are not fulltime specialty clinics. Cardiologists may rotate through two days a week to help people with chronic and congestive heart failure; there may be folks that need orthopedic follow-up and there may be an orthopedic clinic.

The Health Centers are the two CHCs (northwest and southeast) that were mentioned earlier. These facilities have key pieces like ambulatory surgical services, advanced diagnostics, and full time specialty clinics. This is the area where there is opportunity to meet need, capture patients and change people's perceptions of a public teaching hospital and system of care from one that is hospital focused to a system of care, in partnership, that meets the needs of the people close to where they live and work.

Mr. Charlton commented that MIHS still has a place within its system where people can learn medicine in an environment that has enough variety for them to learn what they need to in order to become good physicians in the community.

Mr. Eaton stated it is not an either/or proposition but an "and" proposition. MIHS is a public teaching hospital and has to provide both patient care and education and do them well. Employers are looking for partners to do this with and MIHS has a significant opportunity since it has a teaching mission and track record of doing this already.

Mr. Eaton reviewed some of the recommended strategies.

1. *Grow the scale to manage 100,000 lives by December of 2015. MIHS will have to have more access points in order to do this.*
2. *Design and build an east and west CHC or ambulatory health center. The plan is to have this in place by 2017.*
3. *In consultation with the MHCGC, add a new FHC in the central portion of northern Maricopa County to meet emerging needs in that market.*
4. *In consultation with the MHCGC, reinvest and reconfigure the existing FHCs in the central portion of northern Maricopa County to bring more services and specialists to targeted markets.*

Chairman Post asked how far MIHS could go down the path of creating an HMO, particularly given its market, in terms of incomes. Is MIHS prohibited from engaging in that? How far could MIHS go through the process to have a MIHS HMO?

Mr. Eaton stated he did not believe MIHS was prohibited from creating an HMO and deferred to Mr. Gorman to answer the question.

Mr. Gorman replied that MIHS does not currently have a HMO but the District's enabling legislation permits it broad authority, although the leadership is geographically Maricopa County.

Chairman Post asked if MIHS could become a county HMO.

Mr. Gorman stated MIHS could create a health delivery system.

Mr. Eaton commented that MIHS could create an HMO.

Mr. Post questioned whether the proposition of an HMO was considered in the planning process.

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

2. Review the Maricopa Integrated Health System Clinical Network Plan (cont.)

Mr. Eaton stated if MIHS is going to consider establishing an HMO or ACO it has to first have pieces in place to redesign systems of care and improve outcomes. Since the model for 2015-16 is not known, the emphasis is to build the infrastructure first. This piece is moving ahead fairly quickly.

Mr. Grant stated ten years ago, before the vote took place to establish the District, one of the restrictions that would be placed on MIHS if it became a District, was that it would not be able to build another hospital outside of a 3-mile radius of MMC's current location. There were also restrictions on care and the centers. That ten-year restriction is due to expire in four months.

Mr. Eaton stated if MIHS was restricted to a three-mile radius then they would be approaching the planning process much differently. MIHS has a full county to serve and the county has a full set of needs, which is critical.

Mr. Grant stated that the District's enabling legislation also allows the District to have partnerships. He was curious how much MIHS has been able to partner since becoming a District and how much it will be able to partner in the future.

Mr. Eaton believes that MIHS should begin to formalize the partnerships to be more intentional in terms of managing and taking accountability for the total care of the patient. It should not be left to chance as to whether patients get to the right place for the right type of care.

Ms. Francis stated if the primary home happens to be in the Scottsdale network then MIHS would be working closely in partnership with Scottsdale physicians since it provides unique services for a general population. MIHS would not be competing with the major specialty like Scottsdale Healthcare or Thompson Peak Hospital but would be providing unmet services. This would also hold true with other facility locations like Banner Health System and John C. Lincoln.

Mr. Eaton stated MIHS has a unique track record of providing services for unmet needs and that role can transcend all of the competitive dynamics of the community.

Ms. Francis stated this is the only way that MIHS can "pitch this" seriously among its competitors, service providers and patients.

Mr. Eaton stated accountability is key from a strategy standpoint. Plans can be made but if there is no accountability as to when, who and whether things are being accomplished the plan is not of much value. Thought has to be given to how to operate more efficiently in order to build coalitions and design an academic medical center.

There is a value proposition to a dedicated academic medical center that transcends the competitive dynamic and delivers specialized care to MIHS. This is possible since in some cases MIHS is the only one that has this capability or can invest the resources to deliver the care in small volumes. These programs have to be supported and the brand has to be thought about in terms of how people's experiences with MIHS will be. For instance, thinking about 24/7/365 access to test results – this is a fundamentally different thing and no one is doing this yet in MIHS's market.

Mr. Eaton reviewed one last recommended strategy:

5. Expand behavioral health capacity to meet community need.

Data shows that a high percentage of patients who show up in primary care clinics are there because they have emotional ailments, behavioral or mental health issues, or substance abuse. MIHS has an opportunity to integrate outpatient behavioral health into the community health clinics to grow convenient access to these services.

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

2. Review the Maricopa Integrated Health System Clinical Network Plan (cont.)

Chairman Post commented that some of the strategies listed metric while others did not list any. He asked if metric would be developed for all of the strategies. Will Navvis develop both historical and projected goals in terms of metrics for every strategy?

Mr. Eaton commented that two dimensions had to be built; sequence and pacing. The MIHS Chief Financial Officer and his team are working with Navvis and Kurt Salmon to put dollars to the strategies to see how to best allocate funds. Some of the dates are going to be a function of funding. MIHS must prioritize to get the best return in the near term, and those will be built into annual operating plans.

Chairman Post asked if when the Bond Advisory Committee completes it works and comes to a conclusion, whatever that is in terms of the amount of capital needed, the Committee will be able to run that through an operating model and determine a return on that capital for each of these sub-items.

Mr. Eaton said senior administration is now working through the growth scenarios and growth with the market. That will start to give the Committee a sense of magnitude for opportunity, return on the investment and how – if you have only so many dollars, how do you allocate them.

3. Wrap Up, Next Steps and Future Agenda Items

Mr. Averbuch said it was important to have clarity. The next steps is to continue to work together to start to get through those numbers and make sure it is being translated into space and capital to bring back to the Committee over the next two to three months.

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

MOTION: Vice Chairman Coor moved to approve the Bond Advisory Committee meeting minutes dates August 12, 2013. Mr. Fairbanks seconded. **Motion passed by voice vote.**

Adjourn

MOTION: Ms. Francis moved to adjourn the September 17, 2013 Bond Advisory Committee Meeting. Mr. Grant seconded. **Motion passed by voice vote.**

Meeting adjourned at 4:14 p.m.

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Bill Post, Chairman
Bond Advisory Committee

Maricopa County Special Health Care District

Bond Advisory Committee Meeting

November 12, 2013

Item 5.

Next Steps

1. Address Bond Advisory Committee questions on options
2. Prepare final report for review

MARICOPA INTEGRATED HEALTH SYSTEM