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Proposition 480 Implementation Planning

Findings and Recommendations

September 2016

September 2016

Mr. Stephen A. Purves, FACHE
President and CEO
Maricopa Integrated Health System
2601 E. Roosevelt Street
Phoenix, AZ 85008

Dear Mr. Purves:

We have completed our engagement to assist Maricopa Integrated Health System (MIHS) with the implementation planning for Proposition 480 ("Prop 480") and are pleased to present a summary of key findings and recommendations. The attached document outlines how MIHS can effectively and successfully implement Prop 480 as a means to address the future healthcare needs of Maricopa County.

The Proposition 480 implementation planning was a highly inclusive process with active participation by the Maricopa County Special Health Care District Board of Directors, MIHS' executive leadership team, and physicians from the District Medical Group. We would like to thank all the individuals who contributed their time, insights, and ideas to the implementation planning process. Their dedication to the people MIHS serves is truly remarkable and the Proposition 480 implementation planning process benefited greatly from their contributions.

We appreciate the opportunity to be of service to MIHS and we look forward to working with MIHS to implement Proposition 480.

Regards,

Kevin C. "Casey" Nolan
Managing Director

Fred D. Campobasso
Managing Director

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I. Executive Summary

Executive Summary

INTRODUCTION

Following the approval of Proposition 480 by the voters of Maricopa County in November 2014, MIHS embarked on a planning initiative designed to effectively and efficiently implement Proposition 480. In the fall of 2015, MIHS engaged Navigant Consulting, Inc. ("Navigant") to assist with the implementation planning process. This document presents the key findings and major recommendations regarding how MIHS can effectively and successfully implement Prop 480 as a means to address the future healthcare needs of Maricopa County and fulfill its mission as the County's safety net provider. The Prop 480 implementation planning process was a comprehensive, highly inclusive, very interactive process with active participation by the Maricopa County Special Health Care District Board of Directors, MIHS' executive leadership team and physicians from the District Medical Group.

Executive Summary (Continued)

STRATEGIC CONTEXT

To fully understand the recommendations presented in this document, it is important to recognize that the healthcare industry in the United States is undergoing a profound, permanent, and unprecedented transformation. This transformation, which has been underway for more than 30 years and is gaining momentum, is fundamentally changing how healthcare in this country is organized, financed, and delivered. A core element of this transformation is the shift from the traditional fee-for-service (FFS), volume-based reimbursement system to a fee-for-health, value-based reimbursement environment. To survive and thrive in this transformed environment, healthcare organizations must ensure their plans take this shift into account and address new incentives and implications.

In addition, healthcare organizations must recognize that their core business is changing: they are increasingly in the "care coordination" business more so than the "hospital" business. Leadership teams and boards must understand and confront the new realities of this transformed environment, which in addition to the movement of payments to value-based instead of volume based, also includes continued declines in inpatient utilization on a per capita basis and in total as a natural evolution of improved clinical care processes and the economics of population health management. The recommendations in this document are designed to position MIHS to succeed in this transformed, value-based reimbursement, population health focused marketplace.

Executive Summary (Continued)

ACUTE CARE AND BEHAVIORAL HEALTH BED NEED

One of the first components of the Prop 480 implementation planning process was to update MIHS' bed requirements for acute care and behavioral health to reflect the significant changes that have taken place in the local, regional, and national healthcare environment since the Bond Advisory Committee (BAC) issued its report in early 2014. Chief among these changes were the shift away from fee-for-service reimbursement to value-based reimbursement, a focus on reducing readmissions, the continued transition of care from inpatient to outpatient settings, and improvements in care delivery.

In estimating MIHS' future acute care bed requirements, the following factors were considered:

- **Demographic changes** – overall population increases / decreases by age cohort and overall aging of the population.
- **Technology advancements** – continued shift of cases from the inpatient to the outpatient setting; some of this will be accelerated due to reform as systems seek low cost alternatives to traditional inpatient cases (e.g., heart failure); additionally, the increased adoption of IT / EMR technologies should allow providers to manage patients more effectively across the continuum, and telehealth / virtual care will play an increasingly important role.

Executive Summary (Continued)

ACUTE CARE AND BEHAVIORAL HEALTH BED NEED (CONTINUED)

- **Health reform impact** – the renewed focus on quality will limit inpatient growth and will most likely lead to utilization declines as health systems focus on reducing readmissions, eliminating "never" events, decreasing hospital-acquired conditions, and implementation of ACOs and medical homes.
- **New payment models –** which are rewarding providers for reducing inpatient utilization.
- **Average length of stay** – continued pressure from payers to reduce average length of stay (ALOS), as well as internal initiatives driving efficiency and cost reduction.
- **Observation stays –** the increase in patients occupying a bed but not registered as an inpatient must also be taken into consideration.

Inpatient utilization in Maricopa County has declined over the last several years. Since 2012, the number of people living in Maricopa County hospitalized for inpatient care decreased by almost 13,000 (or roughly 6%), in spite of steady steady increases in population and the aging of the population. These declines are the result of the changes discussed earlier, all of which will continue to impact utilization levels into the foreseeable future.

Executive Summary (Continued)

ACUTE CARE AND BEHAVIORAL HEALTH BED NEED (CONTINUED)

Based on updated volume projections, the recommended bed complement that MIHS should plan for is 200-240 acute care beds (including observation beds) and 225-240 behavioral beds. In addition, it is recommended that MIHS plan for 8 short stay beds at the new, to-be-developed East Specialty Center and 8 short stay beds at the new, to-be-developed West Specialty Center to augment the main campus acute care capacity.

Executive Summary (Continued)

AMBULATORY CARE

The healthcare environment is shifting dramatically in terms of sites of care and where care is being delivered. The shift from inpatient settings to outpatient and ambulatory settings has been underway for decades and is accelerating, driven by healthcare reform, technology advancements, and changing payment mechanisms. In fact, the new indicator of meeting community need is less focused on the number of inpatient beds an organization operates or its inpatient market share and more on the location and number of primary care assets within a market.

Based on extensive discussions with the MIHS management team and physician leaders from DMG, a set of strategic ambulatory facility development parameters and access goals were developed for MIHS. These parameters include the following:

- Widely distributed access to primary care medical homes supported by care management that features:
  - Culturally-aligned care coordination
  - Targeted case management
  - Promotion of self-management
  - Patient navigators

Executive Summary (Continued)

AMBULATORY CARE

- Community health educators
- Disease specific care managers

- Distributed physical access points supported by extensive use of telemedicine and virtual medicine.
- Partnerships to address service gaps.
- Integrated behavioral health.

The ambulatory access goals reflect input from the MIHS leadership team and DMG as well as federal guidelines and include the following two goals:

- An MIHS operated (or partnered) primary care location within 15 minute drive time of targeted population centers (neighborhood or community access point)
  - Phoenix – South of Salt River
  - Phoenix-North of Salt River
  - Avondale
  - Chandler
  - El Mirage
  - Gilbert
  - Maryvale
  - Glendale
  - Guadalupe
  - Mesa
  - Peoria
  - Others such as Buckeye, Goodyear

Executive Summary (Continued)

AMBULATORY CARE (CONTINUED)

- A specialty center with advanced imaging, ambulatory surgery, and specialty consultations within a 30-minute drive time of 70% of the County residents.

Given these access goals, and in light of the fact that an evaluation of the locations and physical plants of the Family Health Centers indicated that they should all be relocated and replaced with new facilities (with the exception of the McDowell and Pendergast sites), the recommended ambulatory network configuration for MIHS is summarized on the following chart.

Executive Summary (Continued)

Recommended MIHS Ambulatory Network Configuration

Access Point Description	Scope of Services	Providers	Estimated Number
Community Access	• Culturally-aligned care coordination • Targeted case management • Promotion of self-management • Telehealth • Virtual health	• Patient navigators • Community health educators • Disease specific care managers	TBD
Neighborhood Center	• Focus on preventive and primary care • May be freestanding or school/community center/retail based	• 2 – 4 Primary Care Providers (PCPs) per site per day	10-12
Community Center (Primary Care Plus)	• Integrated behavioral health and medical care • Basic imaging and lab onsite	• 4 to 6 PCPs and 2 to 4 specialists per site per day (e.g., Cardiology, Orthopedics, etc.)	4-5
Specialty Center	• Integrated behavioral health and medical care, accessible primary care co-located with specialty services • Urgent care or freestanding ED with observation beds • Ambulatory surgery • Advanced imaging and lab onsite	• 4 to 6 PCPs and 12 to 16 specialists per day per site (e.g., Cardiology, Orthopedics, etc.)	3

Executive Summary (Continued)

PHYSICIAN RESOURCES

Based on a goal of 175,000 covered lives and a panel size of between 4,000 to 5,000 patients per primary care team (with acceptable levels of productivity), MIHS will need somewhere between 35 and 44 physician-led primary care teams to staff the proposed ambulatory care network and manage the covered lives goal.

Similarly, based on projected physician specialty encounters at the new East and West Valley specialty centers, MIHS will need somewhere between 38 and 56 incremental specialty providers to staff the new specialty centers.

In addition, it is important to note that a stronger, more collaborative partnership with DMG will be a critical success factor in positioning MIHS for success. A stronger alignment will be required for MIHS to address its financial challenges through enhanced efficiencies and reduced variations in care as well as to develop the level of clinical integration required to effectively manage the health of a defined population. Key components of the greater alignment between MIHS and DMG will include, but not be limited to, factors such as:

- Successfully executing the revised agreement between MIHS and DMG that is mutually beneficial and that appropriately aligns the incentives of both parties,

Executive Summary (Continued)

PHYSICIAN RESOURCES (CONTINUED)

- Establishing an effective clinically integrated network (CIN) that will facilitate quality improvements and joint contracting,
- Leveraging the clinical service line management physician / administrative dyad structure in place for select service lines, and
- Collaborating on preparing and successfully implementing a medical staff development plan that addresses the needs of patients in the community.

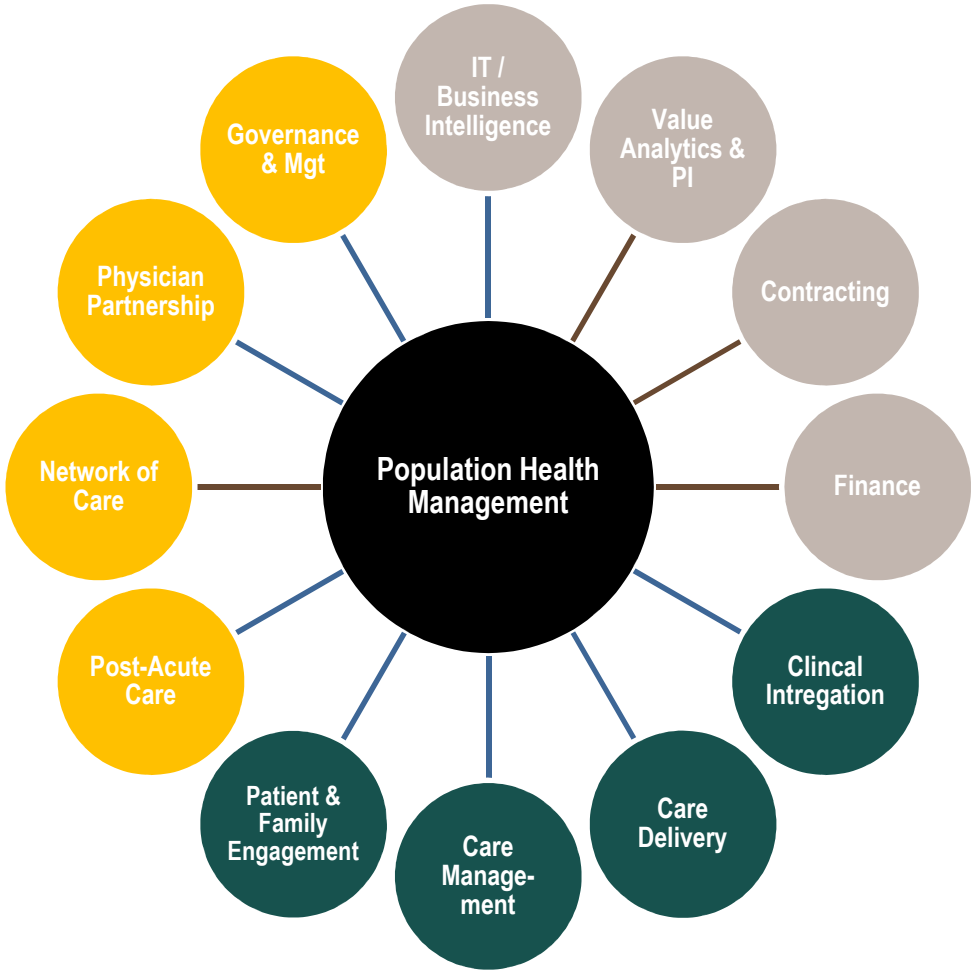
Executive Summary (Continued)

CARE MODEL

The transformation of the healthcare system in the United States will require healthcare organizations to develop fundamentally different skills and competencies. And at the core of these new skills and competencies is a care model focused on population health management. The essential population health management capabilities can be grouped into three basic types of competencies, as shown in the exhibit on the following page.

Executive Summary (Continued)

POPULATION HEALTH MANAGEMENT REQUIREMENTS



- **Essential Infrastructure** to support the integration of care, reporting and analytics, and financial management.
- **Advanced Clinical Model** focused on clinical integration, enhanced care delivery, care coordination, and patient and family engagement.
- **Foundational Elements** to drive clinical and financial performance in a network of care across the continuum and the supporting governance model.

Executive Summary (Continued)

CARE MODEL (CONTINUED)

While MIHS has made progress in developing and implementing advanced clinical care models, both MIHS management and DMG physicians readily acknowledge that there is much work to be done in building their clinical care capabilities and that MIHS' capabilities in essential infrastructure and foundational elements are in the early stages of development and need further development. It is therefore recommended that MIHS move quickly to build the essential infrastructure and foundational elements of population health management while concurrently pursuing further development of advanced clinical care models, including telehealth / virtual care, and integrate those models into the planning for and operation of the new facilities (both inpatient and ambulatory). Furthermore, a key element of MIHS' future care model should be the integration of behavioral health with general acute care. MIHS' future care delivery model should include the following features:

- **Information continuity —** Patients' clinically relevant information should be available to all providers at the point of care and to patients through E.H.R. systems,
- **Care coordination and transitions —** Patient care for both routine and complex patients is coordinated among multiple providers and transitions across care settings are actively managed,
- **System accountability —** There is clear accountability for the total care of patients,

Executive Summary (Continued)

CArE MODEL (CONTINUED)

- **Peer review and teamwork for high value care —** Providers (including nurses and other members of the care team) both within and across settings have accountability to each other, review each other's work, and collaborate to deliver high quality, high value care,
- **Continuous innovation —** The system is continuously innovating and learning in order to improve the quality, value, and patient experiences of health care delivery,
- **Easy access to appropriate care —** Patients have easy access to appropriate care and information at all hours, there are multiple points of entry to the system, and providers are culturally competent and responsible to patients' needs,
- **Team model of care —** To sustainably meet the acute care, preventative, and chronic care needs of the safety net population an expanded primary care team needs to be established (which includes culturally competent community members),
- **Health literacy —** There is a significant need to reinforce basic health literacy amongst the diverse safety net population served by MIHS, and
- **Integrated behavioral health —** given the incredibly high prevalence of mental health and social health issues as well as physical health issues, it is essential that MIHS address the mental, physical, and social issues together in an integrated manner.

Executive Summary (Continued)

TELEHEALTH/VIRTUAL CARE

A key element in MIHS' future care delivery model is telehealth / virtual care. Telehealth / virtual care describes the ability of a healthcare provider to serve and interact with a patient who is in a different location using two-way video, email, smartphones, wireless devices and other forms of technology. Most importantly, telemedicine provides more efficient ways for virtual clinicians and caregivers to work together to improve patient care. Given the direction of healthcare, having a major telehealth / virtual care capability as part of the MIHS future care delivery model with be a requirement and not an option. Therefore, appropriate considerations for telehealth / virtual care should be incorporated into the planning for the acute care, behavioral health, and ambulatory facilities. Furthermore, since there are a number of healthcare providers and systems that have already developed telehealth / virtual care capabilities, it would be in MIHS' best interests to partner with one of those organizations rather than trying to "get up the learning curve" on its own. MIHS could benefit from the experience and scale of these organizations as well as reduce its "speed to market" and the financial commitment required.

Executive Summary (Continued)

PARTNERSHIP ASSESSMENT AND OPPORTUNITIES

As a single hospital in a market in which virtually every other acute care facility is part of a multi-hospital system, Maricopa Integrated Health System occupies an increasingly unique position. MIHS must compete with healthcare systems that can—and do—effectively use their size and scale to achieve efficiencies in a number of functions. A key question in the Prop 480 implementation planning process was whether MIHS can (or should) continue to operate as a standalone provider.

An objective assessment of MIHS' situation identified several strategic needs that could be addressed by a partnership. MIHS should, therefore, explore potential partnerships designed to address its most pressing strategic issues. These partnerships include the following:

- ***A "scale collaborative"*** to achieve economies of scale and reduce overhead expenses (this could be through an outsourcing arrangement with a company (or companies) that specialize in performing certain functions (i.e., revenue cycle management) or through a provider system (or group of systems) that has the ability / capacity to service MIHS on a contractual basis).
- ***Service / program specific alignment opportunities*** in which MIHS partners with an other organization (or organizations) to provide certain clinical services that the other providers have distinctive / recognized capabilities in and which MIHS is challenged to provide in an

Executive Summary (Continued)

PARTNERSHIP ASSESSMENT AND OPPORTUNITIES (CONTINUED)

economically viable and / or clinically appropriate manner. The services most frequently cited by internal stakeholder groups at MIHS that fall into this category are pediatrics and obstetrics, as there is a nationally recognized children's hospital located a few miles away that MIHS already collaborates with on education and teaching initiatives, and there are a number of large obstetrics programs within a relatively short distance from MIHS.

- A partnership focused on ***advancing MIHS' clinical integration efforts and capabilities***. As an independent, standalone facility, MIHS faces significant challenges in developing its clinical integration capabilities in a timely and cost effective manner. Because these capabilities will become increasingly essential in the value-based environment (as discussed previously) MIHS should seek a partnership that enables it to accelerate its clinical integration initiatives.
- ***Public / private community partnerships*** to leverage / further develop "future state" ambulatory network. There is a clear and strong interest among communities in the greater Phoenix area to have MIHS develop healthcare facilities in their markets as well as numerous potential public-private partnership opportunities. MIHS should aggressively pursue these economic development and public-private partnership opportunities.

Executive Summary (Continued)

PARTNERSHIP ASSESSMENT AND OPPORTUNITIES (CONTINUED)

While there is a strong preference among MIHS leadership (management and board) for MIHS to remain an independent entity at this time due to successful cost management strategies over the past two years, the environment locally and nationally is likely to become increasingly challenging for all health systems. Therefore, MIHS should continue to assess the environment, its opportunities and vulnerabilities, its viability as a freestanding provider, and potential enterprise-level partnership opportunities as part of its ongoing strategy planning.

Executive Summary (Continued)

FACILITY REQUIREMENTS

Detailed facility assessments were conducted of the family health centers, Desert Vista, and the Roosevelt Street campus, and a program of requirements and planning and design considerations were developed for the implementation of Proposition 480 With respect to the family health centers, the assessment included review of the site, building, and infrastructure conditions at each location. Findings were consistent with BAC findings that the existing family health centers, except for the Pendergast and McDowell sites, do not meet adequate facility standards and should be replaced.

In terms of Desert Vista, the existing Desert Vista facility is antiquated and operationally inefficient in layout. Consolidation of MIHS' two behavioral health facilities would be optimal.

All of the facilities on the Roosevelt campus were toured and evaluated, resulting in the following conclusions:

- **Acute Care Hospital –** The existing hospital is antiquated and operationally inefficient. Replacement is indicated. Much of the equipment in the existing Central Plant is new and in view of costs, it is recommended that the existing Central Plant be upgraded and expanded to serve new and existing facilities.

Executive Summary (Continued)

FACILITY REQUIREMENTS (CONTINUED)

- **Comprehensive Care Center -** The existing facility can continue to be used although substantial renovation is recommended.
- **2619 Building -** The building, which is currently used for inpatient Behavioral Health services and administrative services, should be renovated to accommodate expanded administrative services.
- **Warehouse** - The existing warehouse building is in good condition and can continue to be used.

A "fit test" was conducted to determine if the Roosevelt campus could feasibly be developed to accommodate the program of requirements or functions contemplated for the site. The results of this "fit test" were that the existing campus could accommodate the facilities and functions of MIHS' future state.

Executive Summary (Continued)

HEALTHCARE VILLAGE

One of the concepts identified in the Proposition 480 Implementation Planning was the potential to develop a "healthcare village" as part of the ambulatory care network development. A healthcare village is a mixed-use setting anchored by a healthcare provider. Healthcare villages are scalable and may be developed in both urban and suburban neighborhoods. A healthcare village is a destination for the community; a branded environment which appropriately integrates healthcare with retail, commercial, education, residential and wellness services scaled by size of land and market driven needs. Demonstrating a commitment to community, development can interest both public and private entities participating in a healthcare village project since the successful outcome can have significant direct and indirect benefits to the communities it serves.

A healthcare presence in a mixed-use / healthcare village setting will be an essential strategy in meeting expectations inherent in a restructured health system where success is measured by keeping patients healthy, rather than continuing to try and maximize the changing fee-for-service paradigm.

Executive Summary (Continued)

FINANCIAL IMPLICATIONS

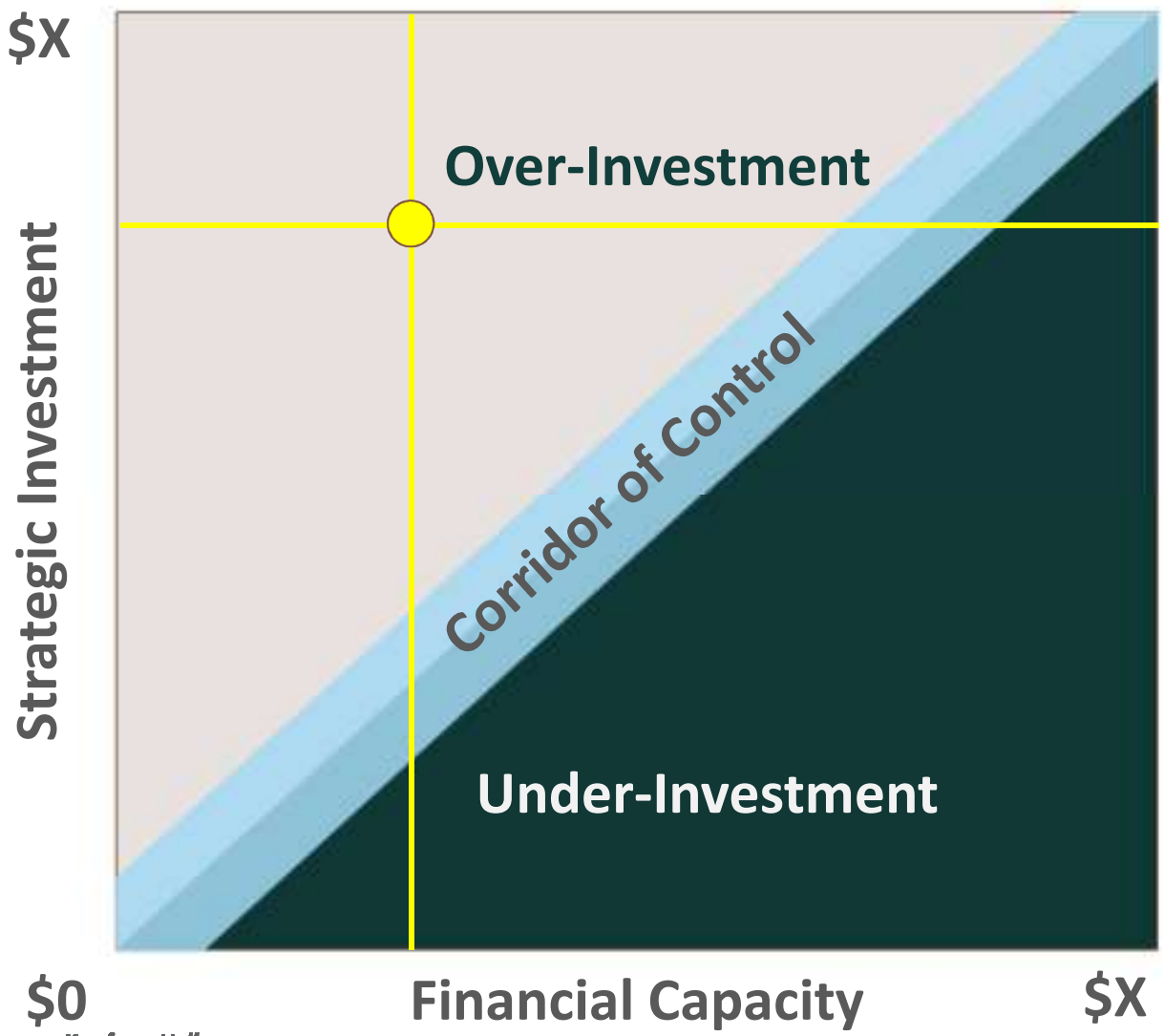
A key component of the implementation planning for Prop 480 was assessing the affordability of the project. To assess the project's affordability, MIHS engaged Kaufman Hall to provide financial modeling capabilities. Navigant worked closely with MIHS and Kaufman Hall to develop the key assumptions used in the financial model and the following pages reflect the output of their work.

Executive Summary (Continued)

- A long-range financial plan provides a view of the expected financial health of an organization over a specified period of time (typically 5-10 years)
  - Integrated view of operating, balance sheet and cash flow performance
  - Quantifies the impact of expected future initiatives, allowing management to link strategic and operational decision making with financial performance
  - Directional in nature and not intended to be prepared at budget level detail
- A strategic financial projection has two primary building blocks:
  - A "Current State" projection based on current operations with no new initiatives in order to provide a clean starting point from which to assess the impact of any such initiatives
  - Incremental future impacts from strategic and operating initiatives which are layered over the "Current State" projection
- For many organizations, a "Current State" financial projection scenario demonstrates the need for future performance improvement in order to maintain financial strength and stewardship of resources
  - Industry-wide operating pressures have resulted in eroding margins, increased competition and a rapid evolution to new business and care delivery models

Source: KaufmanHall

Executive Summary (Continued)



Source: KaufmanHall

The corridor of control is the balancing point between two opposing goals:

1. Compete as effectively as you can, which requires aggressive investment of capital and commitment of operating dollars, BUT
2. Respect the fiduciary role of management and the Board to maintain the long-term financial integrity of a community asset.

Executive Summary (Continued)

- The purpose of the analysis is to assess the affordability of the proposed strategic capital projects
  - Critical Question: What is the right scope and portfolio of projects that will allow MIHS to continue to serve its mission without compromising long-term financial viability?
- Management and the Board have performed thorough and thoughtful due diligence on the impact of the proposed projects on the long-term financial health of the organization
- Management and the Board have identified a mix of projects with a total cost of $829 million that will meet the objective to expand access to high-quality healthcare in Maricopa County while also allowing MIHS to maintain an appropriable amount of available cash reserves throughout and beyond all phases of project implementation
- Although a ten-year financial projection requires assumptions about future performance, a conservative approach demonstrates that the projects will support stewardship of essential community assets by leaving MIHS in a stronger strategic and financial position at the end of the construction period
- The recommended project scope therefore fits conservatively within the bounds of the corridor of control, allowing the system to serve as a model safety net provider while maintaining sufficient financial flexibility

Source: KaufmanHall

Executive Summary (Continued)

- A Total project cost of $829 million has been considered

» The analysis includes all capital investment required for the projects along with the associated Bond Tax Levies, debt service payments and depreciation expense

» **In order to evaluate the projection scenario results, the primary metrics to focus on are Cash Flow, Total Unrestricted Cash and Days Cash on Hand**

» Volume growth from new sites has been modeled based on current levels, with normal future growth and inflation assumptions applied system-wide

  › Reasonable assumptions have been made to model incremental strategic growth from the initiatives. However, the analysis is not an attempt to measure operational or payer mix improvements or other benefits that may result from these or future new strategies other than those already included in the analysis

» **All scenarios assume successful implementation of planned performance improvement initiatives by FY 2020**

Source: KaufmanHall

Executive Summary (Continued)

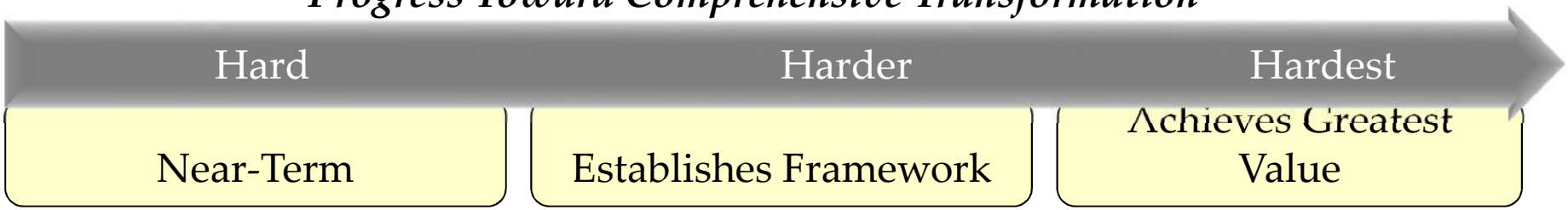
- The financial projections have been developed with appropriate rigor and at a level of detail sufficient for evaluating the proposed projects
  - Projection models built using a healthcare specific long-range planning software tool
  - Underlying detail includes breakouts of major acute and non-acute service lines to allow for scenario and sensitivity analysis
  - Construction costs and timing of capital expenditures tied directly to the work prepared by Navigant Healthcare
  - Capital and operating impact of each individual project development and layered in independently
  - Operating impact of new sites based on historical information from existing clinics
- The projections assess the future financial health of MIHS inclusive of the Prop 480 projects
  - Results have allowed management and the Board to evaluate expected annual operating, balance sheet and cash flow performance over a ten-year period
- The financial projections incorporate the objective of financial stewardship by incorporating assumptions demonstrating a commitment to continued operational improvement and the responsible use of resources

Source: KaufmanHall

Executive Summary (Continued)

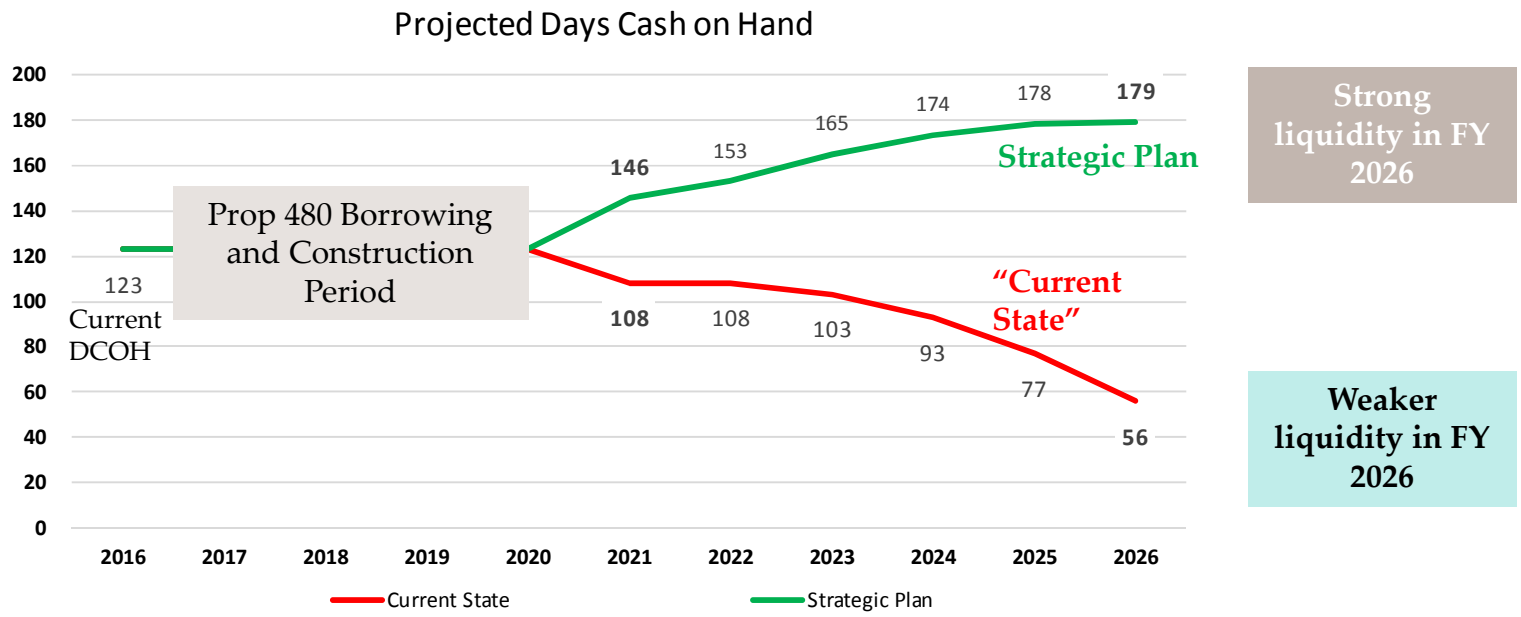
Cost Restructuring/ Margin Improvement	*Business Restructuring*	*Clinical Transformation/Value Creation*
☐ Productivity	☐ Business Line Portfolio Review	☐ Clinical Integration Programs
☐ Service Delivery Costs (e.g., staffing)	☐ Optimization of Product Offerings	☐ Value Creation (e.g., paid for value, and at risk if not achieved)
☐ Overhead Costs (e.g., duplicate mgmt. positions)	☐ Service Distribution Planning	☐ Clinical Variation
☐ Revenue Cycle	☐ Enhanced Capital Allocation	☐ Care Processes
☐ Supply Chain/Purchased Services	☐ Enhanced Non-Operating Performance	

Progress Toward Comprehensive Transformation



Source: KaufmanHall

Executive Summary (Continued)



- Market headwinds are too strong to overcome without a strategic plan that addresses a dynamic industry and changing forms of delivery
- Liquidity in the "Current State" will be a serious concern if no strategic investment in the system is made
- Implementing the strategic capital plan will improve the organization's future financial position and enhance its ability to meet community need

Source: KaufmanHall

Executive Summary (Continued)

$ in millions	FY 2017 - FY 2026			
	Total Uses of Funds	Total Sources of Funds	Total Cash Flow Surplus/(Shortfall)	Avg. Annual Surplus/(Shortfall)
Strategic Plan	$1,360,254	$1,570,355	$210,101	$21,010

- **Total Uses of Funds include:** capital expenditures (Prop 480 funded, additional strategic and routine), principal payments on debt, working capital and target FY 2026 cash balance
- **Total Sources of Funds include:** Prop 480 debt, bond tax levies, general tax levies, operating cash flow and current cash balance

The Average Annual Cash Surplus of $21.0 million demonstrates that MIHS will have sufficient resources to fund all identified uses of cash while also building cash reserves during the ten-year period from 2017 to 2026.

Source: KaufmanHall

Executive Summary (Continued)

IMPLEMENTATION

A preliminary overall timeline was developed for implementation of the Prop 480 projects which involves additional business, operational, and facility planning continuing through 2016 and construction of the Neighborhood, Community, and Specialty centers commencing in 2017 along with work on the Roosevelt campus. While the implementation timeline is somewhat aggressive, it is achievable and may even be shortened based on the assumption "fast track" design and construction methodology and approach will be implemented as well as Prototypical and Standardized program, design and construction techniques will be implemented on Community, Neighborhood and Specialty Centers. It is important to note that the faster the project can be implemented, the lower the escalation premiums will be, freeing funding for additional development. Escalation has been estimated at 3.425% annually. This is equivalent to $2+ million monthly decrease in the value of funding; therefore, an expedited implementation plan is very important.

Executive Summary (Continued)

CONCLUSION

Public health and safety net healthcare services are just as essential to the quality of life in Maricopa County as police, fire fighters, clean water ,and good schools and must be valued the same and supported accordingly. Over the last three years, MIHS has worked diligently to enhance its operational performance. Successful implementation of the Prop 480 plan will help MIHS sustain its improvements and secure its financial future. Successful implementation of Prop 480 will require MIHS to effectively implement a number of key initiatives, including (but not limited to) the following:

- Preparing detailed business plans for each project,
- Conducting operational planning processes to change care delivery models for ambulatory, inpatient, and behavioral health services,
- Using “lean” techniques to improve labor and non-labor operations,
- Recruiting (and/or partnering) to provide the needed physician and physician extender complement,
- Developing population health and care management capabilities, and
- Making and implementing decisions in a timely manner.

Executive Summary (Continued))

CONCLUSION (CONTINUED)

MIHS has employed a deliberate, disciplined approach to planning for the implementation of Proposition 480. Concurrently with this planning process, MIHS has worked diligently to significantly enhance its financial and operational performance, and these improvements have built a solid foundation for the execution of the Proposition 480 projects. The implementation plan MIHS has developed provides a clear roadmap for the effective, efficient implementation of Proposition 480 in a fiscally responsible manner and will help MIHS fulfill its mission and vision of improving the health of the people it serves.

II. Background, Scope, and Approach

Background and Scope

Following the approval of Proposition 480 by the voters of Maricopa County in November 2014, Maricopa Integrated Health System ("MIHS") embarked on a planning initiative designed to enable MIHS to effectively and efficiently implement Proposition 480; position MIHS to fulfill its mission in an environment which is increasingly challenging for safety net providers; and prepare MIHS to succeed in a value-based reimbursement, population health focused marketplace. In the fall of 2015, MIHS engaged Navigant Consulting, Inc. ("Navigant") to assist with the implementation planning process. The scope of Navigant's work included:

- Updating volume projections and determining future bed need and program and service complement,
- Outlining MIHS' ambulatory care "footprint" in terms of locations and services,
- Defining MIHS' future state clinical care delivery model, including population health management capabilities and physician resource requirements,
- Identifying potential economic development incentives and partnership opportunities,
- Assessing the financial implications of implementing Proposition 480, and
- Developing a master project budget and schedule.

Approach

Navigant used a highly interactive, phased approach for the Proposition 480 implementation planning. This approach included the following phases:

- **Mobilization and Strategic Validation**—This initial phase established the foundation for the efficient and effective execution of the engagement by ensuring the scope and approach were clearly understood and agreed to, key milestones were identified, and the key issues / strategic questions that need to be addressed were delineated. In addition, this phase involved reviewing and validating MIHS' strategic direction and key imperatives in order to better understand the overall context within which the Prop 480 activities were being developed.
- **Program and Service Configuration, Facilities Programming and Planning, and Partnership Planning**—The focus of this phase entailed development of updated volume projections and bed requirements for acute care and behavioral health, exploration of economic / community development partnership opportunities, preparation of high-level space program, and validation of capital cost estimates.
- **Ambulatory Care Network Plan Development**—In this phase, Navigant conducted an assessment of MIHS' ambulatory care sites and collaborated with MIHS on an ambulatory care network plan that identified what ambulatory services MIHS should offer in what locations.

Approach (Continued)

- **Clinical Care Delivery Model Development**—This component included an assessment of MIHS' current delivery model and identified the desired future state delivery model, including MIHS' approach to population health management and the associated physician resource requirements.
- **Financial Impact Assessment**—In this phase, Navigant and Kaufman Hall assisted MIHS assess the impact of implementation of Proposition 480 on MIHS' ability to meet operating expenses, working capital needs, and other financial implications to validate the investment and use of taxpayer dollars.
- **Implementation Framework Development**—The final phase of the implementation planning process entailed preparation of an implementation schedule and project budget that outlines the steps in the implementation process, key milestones, and financing implications (e.g., use and timing of the bond proceeds).

To facilitate completion of the implementation planning process, Navigant conducted monthly meetings with the Maricopa County Special Health Care District Board of Directors, weekly calls and regular meetings with MIHS' senior leadership team, and periodic update sessions with representative from District Medical Group ("DMG") /and the Governing Council.

III. Clinical Delivery Requirements

Clinical Delivery Requirements—Background

To fully understand and appreciate the recommendations presented in this document it is important to recognize that the healthcare industry in the United States is experiencing a period of profound and unprecedented change. These changes are fundamentally reshaping the industry and reflect a growing consensus among providers, payers, purchasers, physicians, policy makers, and particularly patients—that the current healthcare system is not sustainable and requires not just modest reform but true transformation. As noted by Susan Dentzer, Senior Policy Advisor at the Robert Wood Johnson Foundation, who spoke at the American College of Healthcare Executives' 57th Congress on Healthcare Leadership in Chicago in March of 2014, the U.S. healthcare industry is a $2.8 trillion industry (the size of the gross domestic product of France), an amount far higher in total and per capita than any other country in the world. Yet life expectancy in the United States is below that of the world's 28 richest countries and 80% of adults are expected to be overweight (if not obese) in six years. Further, when people get sick, much of the care they receive (up to one half by some estimates) has no evidence to suggest it works, while one of the top three causes of death results from adverse events when patients receive care.

The current transformation of the healthcare system is arguably the most significant in this country since the publication of the Flexner Report more than 100 years ago. The Flexner Report was commissioned by the American Medical Association Council on Medical Education and conducted under the aegis of the Carnegie Foundation to address unacceptably high levels of variability in

Clinical Delivery Requirements—Background (Continued)

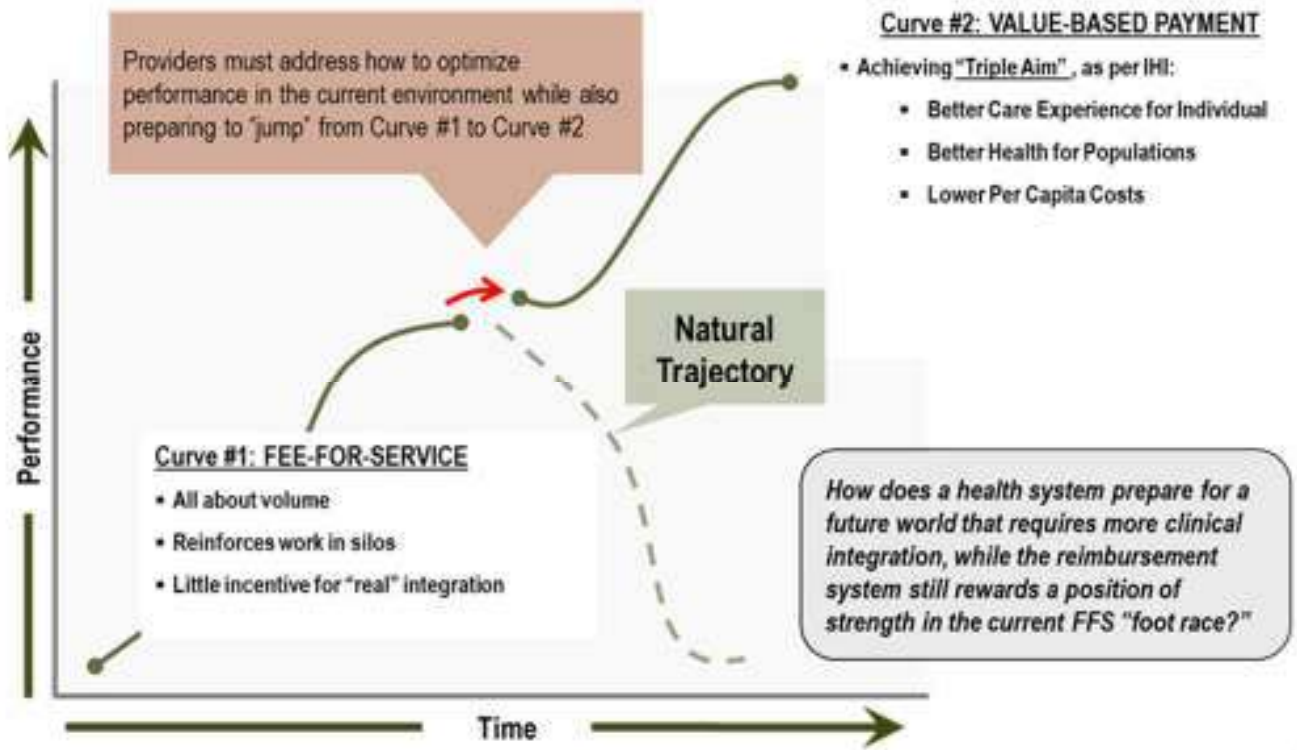
the quality of medical school education in the United States. Publication of the report in 1910 and the subsequent adoption of its recommendations to enact higher admission and graduation standards and adhere to the protocols of mainstream science in teaching and research transformed the medical education system (and ultimately the entire healthcare system) by creating a single model of medical education that has largely survived to the present day. Subsequent efforts to reform the healthcare industry in the United States date back to the Truman administration and include every administration since then. However, since the Flexner Report, virtually all of the major reform efforts and changes in healthcare (e.g., the Hill-Burton Act, Medicare, Medicaid, Diagnostic Related Groups ("DRGs"), the Balanced Budget Amendment, and the Medicare Prescription Drug Act) have dealt with how healthcare is financed. The factors driving the current transformation have been building steadily for the last half century and are changing not just how healthcare is financed, but how it is organized and delivered.

In dealing with this transformation of the industry, healthcare organizations must strategically plan to move from the traditional fee-for-service (FFS), volume-based reimbursement world to the future fee-for-health, value-based reimbursement environment. This shift, which has become known as the shift from Curve One – Volume-Based Reimbursement to Curve Two – Value-Based Payment, found its way into healthcare in Ian Morrison's 1996 bestseller ***The Second Curve:***

Clinical Delivery Requirements—Background (Continued)

Radical Strategies for Managing Change, which posited a theory that after a period of success, organizations hit a plateau as their environment changes. Some organizations are paralyzed by the changes; others chart a new course—their "second curve." The concept of the Curve One to Curve Two shift in healthcare is illustrated in the graphic below.

The Shift From Curve #1 to Curve #2



NAVIGANT HEALTHCARE

Clinical Delivery Requirements—Background (Continued)

This shift from Curve One to Curve Two is gaining traction, as evidenced by the Department of Health and Human Services' (HHS) announcement on January 26, 2015 regarding performance goals and timelines for the transition of Medicare payments from volume to value and a public-private partnership to encourage employers, health insurers, physicians and hospitals to adopt similar goals. The primary focus of HHS is expansion of programs that enable Medicare payments to shift from FFS to value via accountable care organizations (ACOs; Medicare Shared Savings Program), bundled payments (Bundled Payment for Care Improvement Initiative), primary care medical homes (PCMHs), and the value-based purchasing programs included in the Affordable Care Act. In its announcement, HHS noted that 20% of Medicare's payments to providers in 2014 were made through alternative payment models like these. Medicare's new goal is to increase value-based payment models to 30% by 2016 and 50% by 2018. In addition, it also proposed that by 2016, 85% (vs. 80% today) of all Medicare FFS payments have a component based upon quality or efficiency of care, increasing to 95% by 2018. In a ***New England Journal of Medicine*** editorial, HHS Secretary, Sylvia Burwell wrote: "We are dedicated to using incentives for higher-value care, fostering greater integration and coordination of care and attention to population health, and providing access to information that can enable clinicians and patients to make better-informed choices. We believe that, by working in partnership across the public and private sectors, we can accelerate these improvements and integrate them into the fabric of the U.S. health system."

Clinical Delivery Requirements—Background (Continued)

It is also important to note that the transformation of the healthcare system in the United States, which has been underway for more than thirty years and is taking place at an increasing pace and on an unprecedented scale, has achieved "critical mass." There is virtually no realistic chance of returning to the previous, unsustainable system. It is clear, therefore, that in order to be successful in the transformed healthcare landscape of the future, healthcare organizations must recognize that their core business is changing: they are increasingly in the "care coordination" business more so than the "hospital" business. Leadership teams and boards must also understand that success in a "care coordination" paradigm will require fundamentally different skills and competencies, as well as new key performance criteria and measures of success. Furthermore, leadership teams and boards must confront the new realities of this transformed environment, including the movement of payments to value-based and continued declines in inpatient utilization on a per capita basis and in total as a natural evolution of improved clinical care processes and the economics of population health management.

It is with this transformation and its accompanying realities in mind that the recommendations regarding MIHS' acute and behavioral bed need, its ambulatory network, physician resource requirements, and clinical care model were developed. These recommendations are presented on the subsequent pages, beginning with the acute care bed need.

Clinical Delivery Requirements—Acute Care Bed Need

The Bond Advisory Committee (BAC) report in early 2014 recommended replacing the acute care facility with fewer beds and consolidating the behavioral facilities. Since the issuance of the BAC report 2 ½ years ago, significant changes have taken place in the local, regional, and national healthcare environment, chief among them the acceleration of the shift away from fee-for-service reimbursement to value-based reimbursement. This shift (along with other factors such as a focus on reducing readmissions, the continued transition of care from inpatient to outpatient settings, and improvements in care delivery) resulted in steady declines in the number of people needing inpatient acute care. Therefore, one of the first components of the implementation planning process was to update volume projections and subsequently MIHS' bed requirements for acute care and behavioral health.

Inpatient utilization in Maricopa County (and indeed, across the United States) has steadily declined over the last several years. This decline has occurred in spite of steady increases in population and overall aging of the population in both Maricopa County and the nation as a whole. In fact, since 2012, the number of Maricopa County residents needing inpatient care decreased by almost 13,000 (or roughly 6%). These declines are the result of several factors, all of which will continue to impact utilization levels into the foreseeable future and include:

Clinical Delivery Requirements—Acute Care Bed Need (Continued)

- Ongoing shift of activity from inpatient to outpatient settings,
- Increased focus on reducing readmissions, particularly among Medicare recipients,
- Focus on increased classification of patients as observation patients versus admitting them as inpatients, and
- Improvements in care management and subsequent reductions in inappropriate or unnecessary admissions.

In estimating MIHS' future acute care bed requirements, the following factors were considered:

- **Demographic changes** – overall population increases / decreases by age cohort and overall aging of the population.
- **Technology advancements** – continued shift of cases from the inpatient to the outpatient setting; some of this will be accelerated due to reform as systems seek low cost alternatives to traditional inpatient cases (e.g., heart failure); additionally, the increased adoption of IT / EMR technologies should allow providers to manage patients more effectively across the continuum.

Clinical Delivery Requirements—Acute Care Bed Need (Continued)

- **Health reform impact** – the renewed focus on quality will limit inpatient growth and will most likely lead to utilization declines as health systems focus on reducing readmissions, eliminating "never" events, decreasing hospital-acquired conditions, and implementation of ACOs and medical homes.
- **New payment models –** which are rewarding providers for reducing inpatient utilization.
- **Average length of stay** – continued pressure from payers to reduce average length of stay (ALOS), as well as internal initiatives driving efficiency and cost reduction.
- **Observation stays –** the increase in patients occupying a bed but not registered as an inpatient must also be taken into consideration.

With respect to the demographic changes, Table III-1 on the following page shows the current and projected population by age cohort for Maricopa County and the Phoenix Metropolitan Statistical Area (MSA).

Clinical Delivery Requirements—Acute Care Bed Need (Continued)

Table III-1 Population by Age Cohort

Region/MSA	Age Group	2015 Population	2020 Population	% Change	% of 2015 Population	% of 2020 Population	CAGR (2015-2020)	US CAGR (2014-2020)
Maricopa County	Under 18	1,045,183	1,090,012	4.3%	25.4%	24.7%	0.8%	0.1%
	18 to 44	1,524,851	1,597,931	4.8%	37.0%	36.2%	0.9%	0.3%
	45 to 64	990,880	1,066,211	7.6%	24.0%	24.2%	1.5%	0.2%
	65+	561,264	660,654	17.7%	13.6%	14.9%	3.0%	3.8%
Phoenix-Mesa-Scottsdale, AZ Metro	**Under 18**	**1,140,472**	**1,189,250**	**4.3%**	**25.3%**	**24%**	**0.8%**	**0.1%**
	18 to 44	**1,658,217**	**1,736,544**	**4.7%**	**36.8%**	**35.2%**	**0.9%**	**0.3%**
	45 to 64	**1,078,336**	**1,153,156**	**6.9%**	**23.9%**	**24%**	**1.4%**	**0.2%**
	65+	**629,391**	**738,252**	**17.3%**	**13.9%**	**15.3%**	**3.0%**	**3.8%**

Source: Claritas (2015), Census.gov

Table III-1 shows similar projected growth rates by age cohort for Maricopa County and the Phoenix MSA (Maricopa and Pinal Counties), with the most significant growth rates occurring in the 65+ population group.

Table III-2 on the following page compares the 65+ population in Maricopa County, the State of Arizona, and the United States, and indicates that Maricopa County's 65+ population is projected to grow at a slightly faster rate than the State and the nation, although the percentage of the population 65+ is somewhat lower in the County than in the State and the U.S.

Clinical Delivery Requirements—Acute Care Bed Need (Continued)

Table III-2
65+ Population

Location	2015 65+ Population	Percent of Population 65+	% Change of Population
Maricopa County	561,264	14%	18%
Arizona	**6,738,461**	**16%**	**16%**
United States	**319,459,991**	**15%**	**18%**

Source: Claritas (2015), Census.gov

With respect to inpatient utilization in Maricopa County, the number of people living in Maricopa County discharged from an acute care inpatient hospital during the period 2012 through 2014 by major service declined by almost 5% during this period, as shown in Table III-3.

Clinical Delivery Requirements—Acute Care Bed Need (Continued)

Table III-3
Maricopa County Inpatient Discharges by Service 2012-2014

Service	Market			
	2012	2013	2014	% change 2012-2014
Med/Surg	278,130	265,248	261,851	-5.9%
OB / Gyn	57,967	56,996	58,233	0.5%
Pediatric	44,123	40,517	40,786	-7.6%
Trauma	4,166	3,882	3,812	-8.5%
Unidentifiable	804	879	1,212	50.7%
Behavioral	23,610	23,970	23,321	-1.2%
Grand Total	**408,800**	**391,492**	**389,215**	**-4.8%**
Acute Total	*341,067*	*327,005*	*325,108*	*-4.7%*
Pediatric	*44,123*	*40,517*	*40,786*	*-7.6%*
Behavioral	*23,610*	*23,970*	*23,321*	*-1.2%*

Source: ADHS State Discharge Data; Navigant analysis

Clinical Delivery Requirements—Acute Care Bed Need (Continued)

Data for the first six months of calendar year 2015 (the most current data available), indicate the trend in declining inpatient utilization is continuing, as shown in Table III-4.

Table III-4
Maricopa County Inpatient Discharges 2012-2015

First 6 Months of Calendar Year	Total Discharges from Maricopa County Hospitals	Percent Change from Prior Year
2012	207,746	
2013	201,269	-3%
2014	196,448	-2%
2015	194,889	-1%

Excludes normal newborns; includes behavioral

Source: ADHS State Discharge Analysis; Navigant analysis

Clinical Delivery Requirements—Acute Care Bed Need (Continued)

Maricopa County inpatient utilization trends were converted into discharge use-rates (discharges / 1,000 population), which, as shown in Table III-5 below, have declined steadily over the last several years and are expected to continue to decline in the future.

Table III-5
Maricopa County Inpatient Use-Rates 2012-2014

Service	Market Use Rate			
	2012	2013	2014	% Change 2012-2014
Med/Surg	95	89	85	-10%
OB / Gyn	20	19	19	-4%
Pediatric	41	39	39	-5%
Trauma	1	1	1	-13%
Behavioral	8	8	8	-6%
Other	1	1	1	4%
Grand Total	**103**	**98**	**95**	**-7%**
Acute Total	*125*	*118*	*113*	*-9%*
Pediatric	*41*	*39*	*39*	*-5%*
Behavioral	*1.1*	*1.0*	*1.1*	*4%*

Source: ADHS State Discharge Analysis; Navigant analysis

Note: Observation patients are not included in these numbers and need to be added to determine total bedded utilization

Clinical Delivery Requirements—Acute Care Bed Need (Continued)

Another key variable in estimating bed need for MIHS is MIHS' market share by service. As shown in Table III-6 below, MIHS' share of the Maricopa County inpatient market has increased modestly in the last few years from 4.0% to 4.2%.

Table III-6
MIHS Market Share by Service 2012-2014

MIHS Discharges SA only				MIHS Share of Maricopa County Discharges		
	2012	2013	2014	2012	2013	2014
Med / Surg.	6,726	7,078	7,030	2.4%	2.7%	2.7%
OB / GYN	2,629	2,733	2,993	4.5%	4.8%	5.1%
Pediatric	3,102	2,693	2,902	7.0%	6.6%	7.1%
Trauma	229	208	187	5.5%	5.4%	4.9%
Behavioral	3,504	3,354	2,982	14.8%	14.0%	12.8%
Not Identified	72	98	80	2.4%	3.3%	2.4%
Total	**16,262**	**16,164**	**16,174**	**4.0%**	**4.1%**	**4.2%**
Acute Care Total	**12,758**	**12,810**	**13,192**	**3.3%**	**3.5%**	**3.6%**

Source: ADHS State Discharge Analysis; Navigant analysis

Clinical Delivery Requirements—Acute Care Bed Need (Continued)

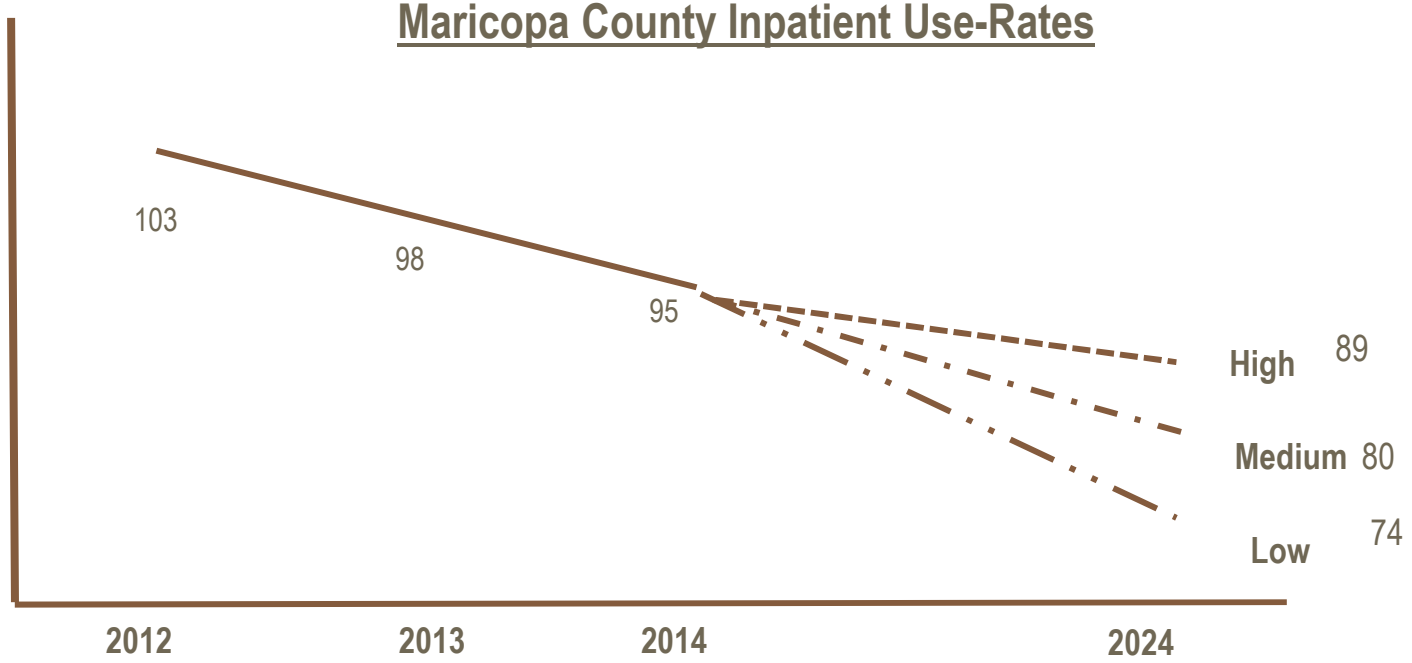
To update MIHS' bed need, three scenarios were developed that reflected potential trends in the key variables of use-rates, market share, length of stay, in-migration (the number of people from outside Maricopa County using MIHS' inpatient services), and readmissions. The key assumptions for these scenarios are outlined below.

Variable	Low	Medium	High
Use rates	Decline accelerates slightly	Current decline continues	Decline moderates
Market share	Decreases by 0.1% per year	Constant	Increases by 0.1% per year
Length of stay	Reduction to geometric mean max 15%	Reduction to geometric mean max 5%	Constant at 2014 level
In-migration / Out-migration	Constant	Constant	Constant
Readmissions	Slight decline	Slight decline	No impact

Clinical Delivery Requirements—Acute Care Bed Need (Continued)

In terms of use-rates, the medium bed need scenario projects continuation of the downward utilization trends for the next ten years while the low bed need scenario accelerates the trend by 50 percent and the high bed need scenario assumes the downward trend moderates by 50 percent. Table III-7 below shows the resulting use-rates under the three scenarios.

Table III-7
Maricopa County Inpatient Use-Rates

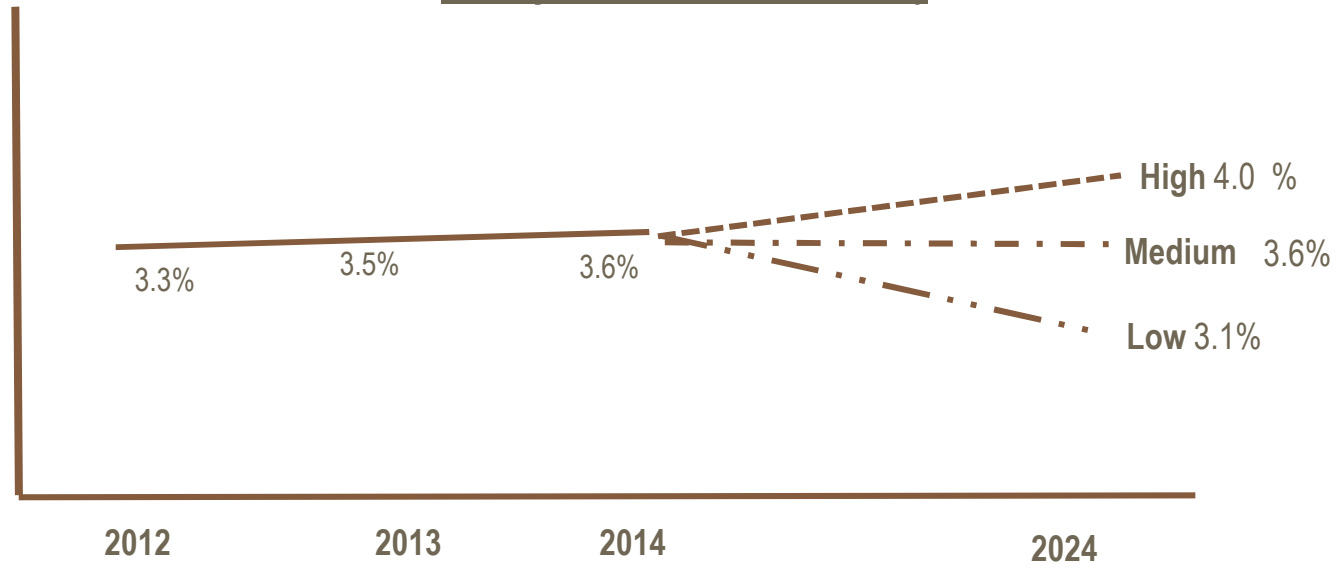


Source: ADHS State Discharge Data; Navigant analysis

Clinical Delivery Requirements—Acute Care Bed Need (Continued)

With respect to MIHS' overall market share (all services except Behavioral Health), MIHS' market share was projected to remain flat under the medium bed need scenario, decrease by 0.1% annually under the low bed need scenario, and increase by 0.1% annually under the high bed need scenario. Behavioral Health market share was projected to remain constant at 12.8% in all three scenarios.

Table III-8
MIHS Inpatient Market Share (All Services Except Behavioral Health)



Source: ADHS State Discharge Data; Navigant analysis

Clinical Delivery Requirements—Acute Care Bed Need (Continued)

Another key variable in estimating MIHS' bed need is average length of stay. ALOS is simply the arithmetic mean (average) time people spend in the hospital measure in days and is calculated by adding up the number of days a group of patients have stayed in the hospital and dividing by the number of patients in question. The Medicare Geometric mean length of stay (GMLOS) is a bit more complicated. This is calculated by multiplying all of the lengths of stay and then taking the nth root of that number (where n=number of patients). The advantage of the GMLOS is that it will minimize the impact of outliers. Hospitals generally track ALOS and compare that to the GMLOS.

For purposes of estimating MIHS' bed need, the following projection assumptions were developed:

- Low bed need scenario = reduction to geometric mean ALOS by 2017 with a maximum reduction of 15%.
- Medium bed need scenario = reduction to geometric mean ALOS by 2017 with a maximum reduction of 5%.
- High bed need scenario = LOS remains at 2014 level.

Clinical Delivery Requirements—Acute Care Bed Need (Continued)

Because hospitals are penalized for each Medicare patient readmitted to the hospital within 30 days of discharge, reduction in the number of readmissions is also expected to have an impact on bed need. For purposes of estimating MIHS' bed need, it was assumed that readmission rates will decline in the low and medium bed need scenarios and remain constant in the high bed need scenario. The 2014 readmission rate for the State of Arizona and assumptions regarding the MIHS readmission rates under the three bed need scenarios are shown in Table III-9 below.

Table III-9
Readmission Rates

2014 Arizona State Average	19%
Scenario	**Assumption**
Low Bed Need	17%
Medium Bed Need	18%
High Bed Need	19%

Source: ADHS State Discharge Data; Navigant analysis

Clinical Delivery Requirements—Acute Care Bed Need (Continued)

In-migration rates track the number of people discharged from MIHS who do not live in Maricopa County (i.e., they migrate into MIHS to receive their inpatient care). While the in-migration rate to MIHS has trended down slightly over the last few years, the proportion of patients who reside outside of Maricopa County that are admitted to MIHS was projected to remain constant in all scenarios as shown in Table III-10.

Table III-10
In-Migration Rate to MIHS

Year	In-migration
2012	8.6%
2013	8.5%
2014	8.0%
2024 (Projected)	8.0%

Source: ADHS State Discharge Data; Navigant analysis

Clinical Delivery Requirements—Acute Care Bed Need (Continued)

An addition key consideration in estimating MIHS' bed need is the occupancy rate of the beds, or the proportion of the beds occupied on average across an entire year. For this analysis occupancy targets were based upon industry standards for new hospitals with private acute care rooms and semi-private behavioral rooms. Table III-11 shows the target occupancy rates for MIHS by service.

Table III-11
Target Occupancy Rates by Service

Service	Occupancy Target
Medical/Surgical	85%
Ob/Gyn	65%
Pediatric	65%
Trauma	85%
Behavioral	90%
Other	85%

Source: Navigant analysis

Clinical Delivery Requirements—Acute Care Bed Need (Continued)

Applying the assumptions outlined on the previous pages to the bed need projection methodology shown in the Appendix generated the following acute care bed need for MIHS.

Table III-12
Projected MIHS Acute Care Bed Need

	Low Bed Need Scenario			Medium Bed Need Scenario			High Bed Need Scenario		
	2014	2019	2024	2014	2019	2024	2014	2019	2024
Discharges	14,204	11,922	10,618	14,204	13,450	13,296	14,204	15,326	16,794
Average Daily Census	182	147	136	182	173	175	182	198	219
Projected Bed Need	237	190	175	237	223	225	237	257	281

Source: Navigant analysis

The future bed complement must also accommodate observation patients, which are patients occupying a bed but not registered as an inpatient. The absolute number and the trend in observation days on a monthly basis at MIHS over 12 months were reviewed and based upon an 80% occupancy target and a compound annual growth rate of 1.2% in observation days, there is a need for 17-20 observation beds in 2024.

Clinical Delivery Requirements—Acute Care Bed Need (Continued)

Based on the above bed need estimates that indicate MIHS will need somewhere between 175 to 225 general acute care beds and up to 20 observation beds, the recommended future acute care bed complement that MIHS should plan for is 200-240 beds on the main campus, including observation beds. In addition, preliminary plans include 8 short stay beds at the East Specialty Center and 8 short stay beds at the West Specialty Center to augment the main campus acute care capacity.

Clinical Delivery Requirements—Behavioral Bed Need

As previously noted in Table III-3, behavioral health discharges in Maricopa County declined 1.2% between 2012 and 2014. This resulted in a modest decline in behavioral health use-rates, as shown in Table III-13.

Table III-13
Maricopa County Behavioral Health Utilization 2012-2014

	2012	2013	2014	% Change
MIHS Discharges/Maricopa County Residents	3,504	3,354	2,982	-15%
MIHS Total Discharges	3,904	3,797	3,369	-14%
Discharges of County Residents from Hospitals in Maricopa County	23,610	23,970	23,321	-1%
Total Discharges from Hospitals in Maricopa County	26,291	26,880	26,392	0%
Maricopa County utilization rate per 1,000 adults 18+	8.1	8.1	7.6	-6%

Source: ADHS State Discharge Data; Navigant analysis

Clinical Delivery Requirements—Behavioral Bed Need (Continued)

MIHS' share of Maricopa County behavioral health discharges (see Table III-6) declined steadily from 14.8% in 2012 to 12.8% in 2014, in part because of capacity and placement issues at MIHS and expanded competition in the market. Bed need projections assumed MIHS' behavioral health market share would continue to decline in the low bed need scenario, remain constant at the 2014 level in the medium scenario, and recover slightly to 13.8% in the high bed need scenario.

With respect to in-migration, the proportion of behavioral health patients who reside outside of Maricopa County that were admitted to MIHS fluctuated slightly between 2012 and 2014 and were assumed to remain constant at the 2014 level of 11.5% in all three scenarios.

Readmissions were assumed to be 17% in the low bed need scenario, 18% in the medium scenario, and 19% in the high bed need scenario, while length of stay was projected to decline slightly in the low bed need scenario to 16.8 days and remain constant at 18.73 days in the medium and high bed need scenarios. The occupancy target for behavioral health was set at 90% in all three scenarios.

Based on the assumptions described above, the MIHS behavioral bed need will be as shown in Table III-14.

Clinical Delivery Requirements—Behavioral Bed Need (Continued)

Table III-14
MIHS Behavioral Health Bed Need

	Low Bed Need Scenario			Medium Bed Need Scenario		High Bed Need Scenario	
	2014	2019	2024	2019	2024	2019	2024
Key MIHS Volume Indicators							
Discharges	3,369	3,463	3,597	3,558	3,784	3,717	4,101
ADC	173	153	159	183	194	191	210
Bed Need/Supply Comparison							
Projected Bed Need	192	170	176	203	216	212	234

Based on these projections, the recommended behavioral bed complement for MIHS is 225-240 beds.

These projections are based on the assumption that MIHS' behavioral health program and service complement remains focused on the involuntary, court ordered evaluation patients. The considerable (and growing) capacity targeted at voluntary patients would make it very challenging for MIHS to compete successfully for that business. MIHS would be better served focusing its efforts and resources on bringing its new facility on line versus trying to do that and build a new line of business that would represent a significant departure from MIHS' core competency. In addition, these projections assume MIHS will focus on reducing behavioral length of stay through improving access to services at the most appropriate level of care, e.g. step-down or intermediate care capacity.

Clinical Delivery Requirements—Ambulatory Care

As noted in the BAC report and discussed extensively with the Maricopa County Special Health Care District Board of Directors, the healthcare environment is shifting dramatically on a number of fronts, most specifically in terms of sites of care and where care is being delivered. The shift from inpatient settings to outpatient and ambulatory settings has been underway for decades and is accelerating in light of healthcare reform, technology advancements, and changing payment mechanisms. In fact, the new indicator of meeting community need is less focused on the number of inpatient beds an organization operates and more on the location and number of primary care assets within a market.

The BAC concluded in its report that:

- "The network of Family Health Centers…are a collection of buildings inherited by the District from the County. Most are undersized, outdated relative to changing care models, and not in locations that correspond to emerging community needs."
- "The Comprehensive Health Center (CHC)…on the Roosevelt campus requires updating and expansion, and additional CHC sites are needed across the County to accommodate emerging community need for geographically dispersed specialty services."

Clinical Delivery Requirements—Ambulatory Care (Continued)

In light of these conclusions, each existing ambulatory ***location*** was evaluated to assess its appropriateness as a site of care and each ***facility*** was evaluated on its site, building condition, and quality of its infrastructure. The site evaluations included five key factors and ranked on a scale of 1 to 5, with 1 being the lowest rating and 5 being optimal. The evaluation criteria used to evaluate each existing location are described in Table III-15 below. Section V presents a more detailed assessment.

Table III-15
Ambulatory Location Evaluation Criteria

Factor	Description	Methodology
Demographics	Population density, population growth, AHCCCS population, and average household income	Each factor was scored on a scale of 1 to 5 and then averaged for a combined score.
Accessibility	Overall ease of pedestrian and transit access; "approachability".	Factor compiled through a combination of site observation, condition of sidewalks, current and future transit availability and options, approximate frequency, walk score, transit score and professional judgement.
Location	Located in a neighborhood context to serve the target population; proximity to residential, retail, commercial, hospitality development, infrastructure investments, schools.	Factor compiled through a combination of site observation, assessment of uses in area, walk score and professional judgement.
Other care options in area	Proposed or existing similar type medical facilities.	Web based search of other FQHCs and ambulatory centers of other Maricopa County providers.
Propensity for Partnership Opportunities	Location that presents/creates synergistic partner opportunities.	Meetings with economic and community development representatives/groups

Clinical Delivery Requirements—Ambulatory Care (Continued)

Based on the criteria in Table III-15, MIHS' existing ambulatory locations were all judged to be less than appropriate, with no location scoring more than 18 points (out of a total of 25 possible points) and all but three locations scoring less than 16 points (as shown in Table III-16 below).

Table III-16
Ambulatory Location Evaluation Scores

Site	Total Score**
Chandler	18/25=72%
Mesa	18/25=72%
El Mirage	18/25=72%
S. Central	16/25=64%
Sunnyslope	15/25=60%
Pendergast	15/25=60%
7th Avenue	14/25=56%
Glendale	14/25=56%
Avondale	13/25=52%
Maryvale	12/25=48%
Guadalupe	12/25=48%

** Maximum score = 25

Source: Navigant analysis

Clinical Delivery Requirements—Ambulatory Care (Continued)

As noted previously, each existing ambulatory facility was evaluated on its site, building condition, and quality of its infrastructure. The specific considerations assessed with respect to site, building condition, and infrastructure included the following:

- **Site:** Site Access, Pavement Condition, Site Infrastructure Condition, Landscape, Entry / Sense of Presence, Exterior Appearance, Exterior Signage.
- **Building Condition**: Exterior Envelope, Windows, Roofs, Functionality, Adjacencies, ADA Conformance, Life Safety Conformance, Interior Finishes.
- **Infrastructure:** Fire Protection, Plumbing Systems, Mechanical Systems, Information Technology / Communication Systems, Lighting, Electrical Systems.

Facilities were toured and rated 1 to 5 for each of the three considerations listed above, with 1 being poor and 5 representing optimal. Site managers were interviewed during the tours of each site. The site and building sizes were evaluated to determine current capacity and to identify if sites and facilities were right-sized, oversized, or undersized for current use. Objective assessments of each facility were summarized along with data collected from several past studies. Cost and timeline evaluations were performed for each site to determine impact of renovation rather than new construction.

Clinical Delivery Requirements—Ambulatory Care (Continued)

The results of the assessment of MIHS' ambulatory facilities indicated that except for the McDowell and Pendergast facilities, all Family Health Center buildings were found to be in marginal, less-than-adequate condition. It was also determined that renovation of any of the facilities would take at least 6 to 12 months and represent a significant disruption to ongoing operations and likely result in an erosion of volumes and market share. ***The recommendation, therefore, is that all of the Family Health Center should be replaced (with the exception of the McDowell and Pendergast facilities). Furthermore, the assessment of the facilities indicated there is no MIHS brand identification at any of the Family Health Centers and the recommendation is that the rebuilt and relocated facilities should reflect a MIHS brand***, especially in the following areas:

- Exterior Signage
- Building Entry
- Public Areas

The results of the facility assessments are shown in Section V.

Clinical Delivery Requirements—Ambulatory Care (Continued)

Based on extensive discussions with MIHS management team and physician leaders from DMG, a set of strategic ambulatory facility development parameters and access goals were developed for MIHS' ambulatory network. The strategic ambulatory facility development parameters included the following:

- Widely distributed access to primary care medical homes supported by care management that features:
  - Culturally-aligned care coordination
  - Targeted case management
  - Promotion of self-management
  - Patient navigators
  - Community health educators
  - Disease specific care managers
- Distributed physical access points supported by extensive use of telemedicine and virtual medicine.
- Partnerships to address service gaps.
- Integrated behavioral health.

Clinical Delivery Requirements—Ambulatory Care (Continued)

The ambulatory access goals reflect input from the MIHS leadership team and DMG as well as federal guidelines and include the following two goals:

- A MIHS operated (or partnered) primary care location within 15 minute drive time of targeted population centers (neighborhood or community access point)
  - Phoenix – South of Salt River
  - Phoenix-North of Salt River
  - Avondale
  - Chandler
  - El Mirage
  - Gilbert
  - Maryvale
  - Glendale
  - Guadalupe
  - Mesa
  - Peoria
  - Others such as Buckeye, Goodyear
- A specialty center with advanced imaging, ambulatory surgery, and specialty consultations within a 30-minute drive time of 70% of the County residents.

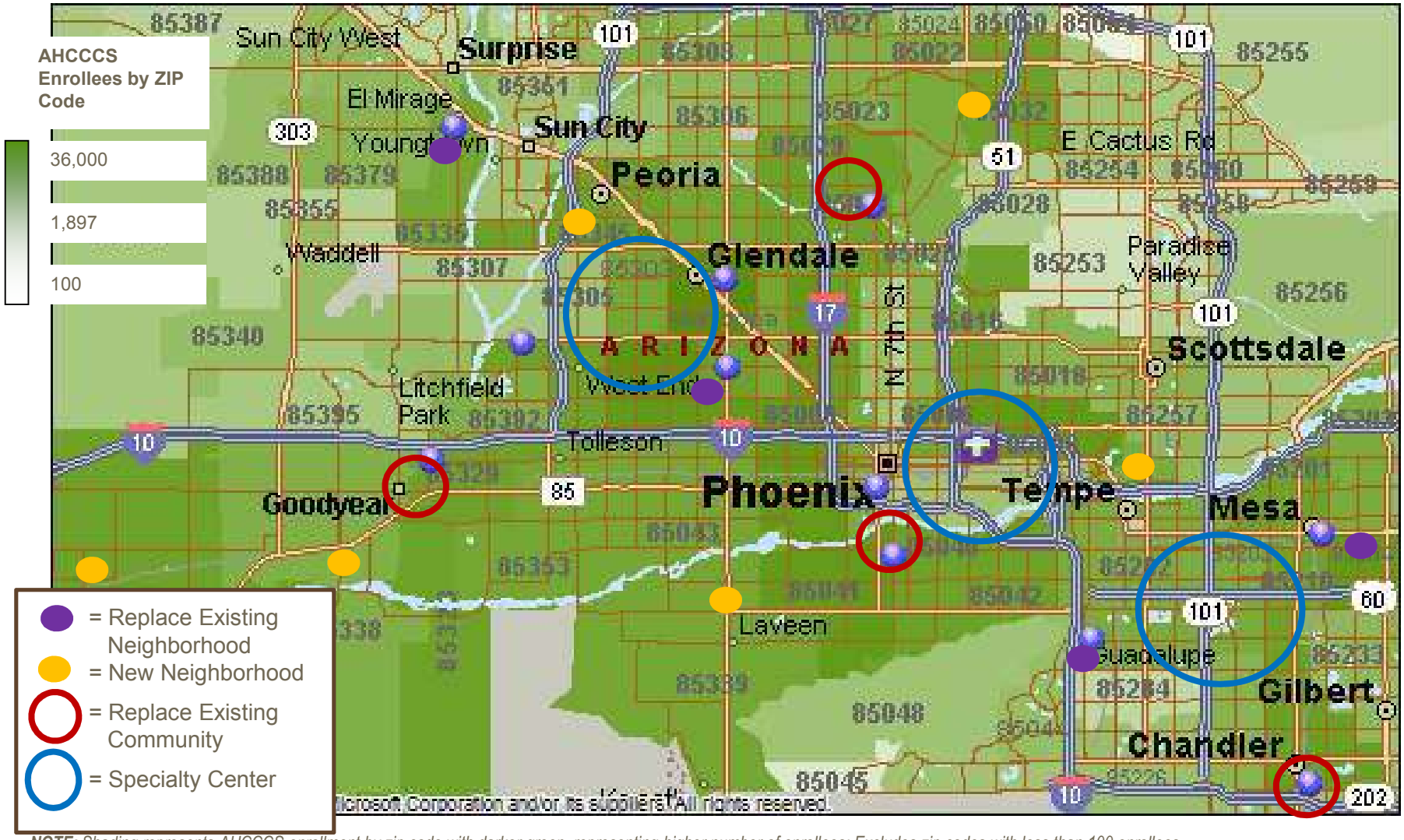
Given these access goals, the recommended ambulatory network configuration for MIHS is summarized in the chart and the map on the following pages (with the caveat that the specific locations of the ambulatory sites will be determined in the next phase of work).

Clinical Delivery Requirements—Ambulatory Care (Continued)

Recommended MIHS Ambulatory Network Configuration

Access Point Description	Scope of Services	Providers	Estimated Number
Community Access	• Culturally-aligned care coordination • Targeted case management • Promotion of self-management • Telehealth • Virtual health	• Patient navigators • Community health educators • Disease specific care managers	TBD
Neighborhood Center	• Focus on preventive and primary care • May be freestanding or school/community center/retail based	• 2 – 4 Primary Care Providers (PCPs) per site per day	10-12
Community Center (Primary Care Plus)	• Integrated behavioral health and medical care • Basic imaging and lab onsite	• 4 to 6 PCPs and 2 to 4 specialists per site per day (e.g., Cardiology, Orthopedics, etc.)	4-5
Specialty Center	• Integrated behavioral health and medical care, accessible primary care co-located with specialty services • Urgent care or freestanding ED with observation beds • Ambulatory surgery • Advanced imaging and lab onsite	• 4 to 6 PCPs and 12 to 16 specialists per day per site (e.g., Cardiology, Orthopedics, etc.)	3

Clinical Delivery Requirements—Ambulatory Care (Continued)

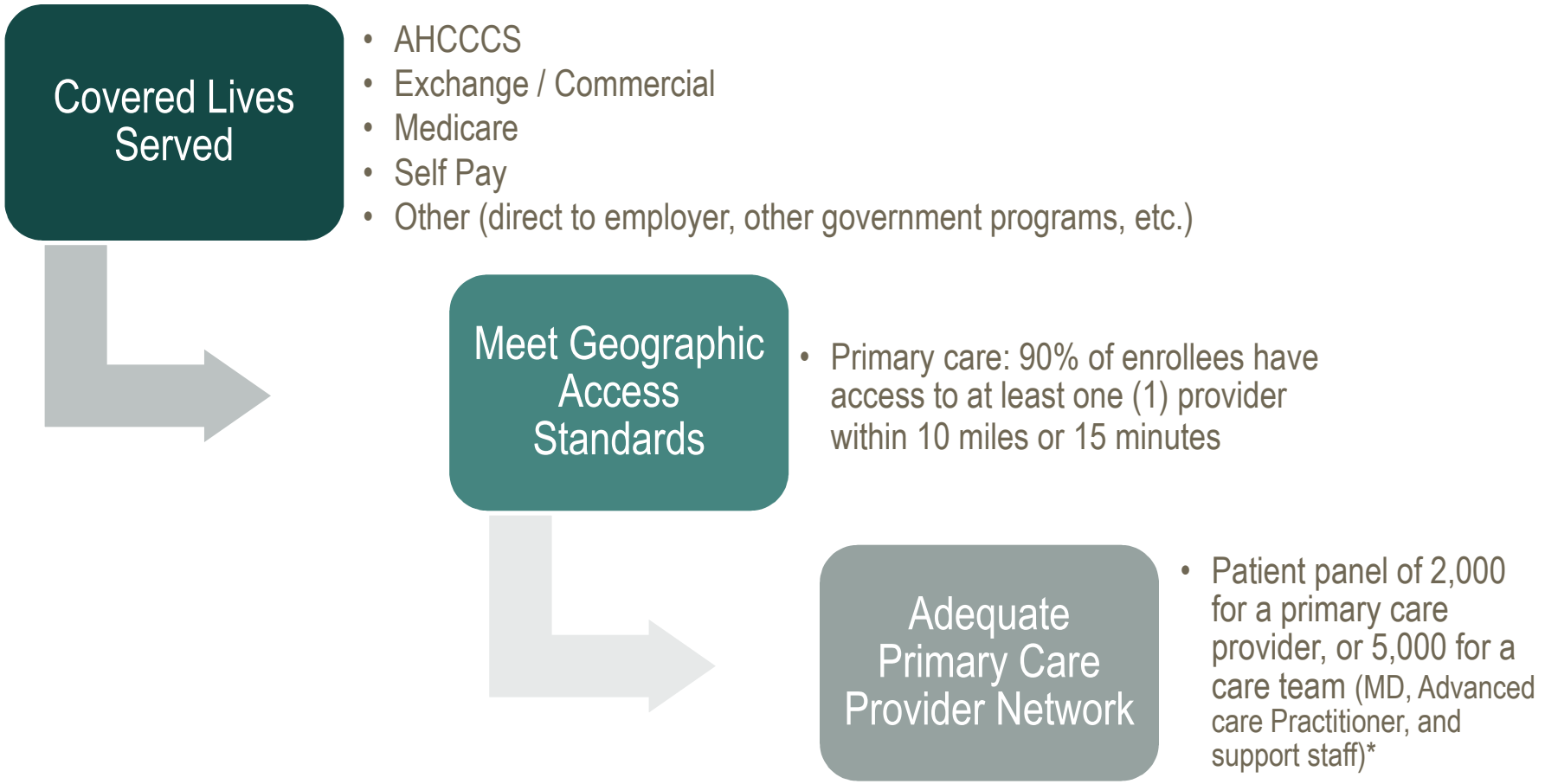


NOTE: *Shading represents AHCCCS enrollment by zip code with darker green representing higher number of enrollees; Excludes zip codes with less than 100 enrollees*

Clinical Delivery Requirements—Physician Resources

With respect to physician resource requirements, two essential aspects were evaluated: the need for primary care providers given MIHS' recommended ambulatory care footprint, and the number of net new specialty physicians needed to staff the additional specialty centers recommended as part of the ambulatory care network strategy. In estimating physician resource requirements, and in keeping with the discussion regarding the ongoing transformation of the healthcare system in the United States, a population health management approach was utilized to estimate future physician resource requirements as delineated in the graphic on the following page.

Clinical Delivery Requirements—Physician Resources (Continued)



* *Assumes integrated Care Management and Coordination teams (including RN, SW, and pharmacy resources) critical for vulnerable populations*

Clinical Delivery Requirements—Physician Resources (Continued)

The number of current lives touched by MIHS was estimated through analysis of Fiscal Year 2015 ambulatory encounters. Unique patients were identified by major payer category. Five-year covered lives goals are preliminary estimates based upon MIHS' current situation and its strategic plans and goals along with market realities. In addition ambulatory network primary care geographic distribution goals were established based upon proposed Federal Exchange requirements (which are slated to be implemented in FY 2017). As shown in Table III-17, the goal established for MIHS is to expand its current number of covered lives from approximately 135,000 to approximately 175,000 within five years, an increase of almost 30%. This represents about 4% of the projected Maricopa County population, which is in line with MIHS' historical inpatient market share.

Table III-17
MIHS Covered Lives Goal

Payer Class	Approximate MIHS Current Lives Touched	Five-Year Goal Covered Lives
AHCCCS	60,000	90,000
Commercial	12,000	15,000
Medicare	11,000	20,000
Other	5,000	5,000
Self Pay	47,000	45,000
Total	135,000	175,000

Source: Navigant analysis

Clinical Delivery Requirements—Physician Resources (Continued)

Based on the goal of 175,000 lives touched and a panel size of between 4,000 to 5,000 patients per primary care team (with acceptable levels of productivity), ***MIHS will need somewhere between 35 and 44 physician-led primary care teams to staff the proposed ambulatory care network and manage the covered lives goal.***

Clinical Delivery Requirements—Physician Resources (Continued)

In terms of the incremental specialty staff required to service the proposed two additional specialty care centers and meet the population health needs, projected year three visit volumes were utilized to determine the number of incremental providers required to staff the centers (Table III-18)

Table III-18
Specialty Center Year 3 Projected Specialty Encounters

Specialty	Clinic Encounters		
	East	West	Total
Pediatric Specialties	2,500	5,000	7,500
Heart Center	0	9,300	9,300
Women's Center	7,000	7,000	14,000
Behavioral Health	7,500	7,500	15,000
Hematology/Oncology	7,000	0	7,000
Dermatology	7,000	6,000	13,000
Pulmonary Medicine	2,500	2,500	5,000
Sleep Medicine	1,500	1,500	3,000
Neurology	2,300	2,000	4,300
Surgical / Procedural Specialties			
General Surgery	900	900	1,800
Orthopedics	11,500	9,000	20,500
Ophthalmology / Optometry	6,500	5,000	11,500
Otolaryngology	5,000	5,000	10,000
Gastroenterology	1,200	1,200	2,500
Pain	8,000	8,000	16,000

Source: Navigant analysis.

Clinical Delivery Requirements—Physician Resources (Continued)

Based upon the encounter projections, a range of estimated specialty physicians was developed utilizing median productivity for low end of the range and top quartile productivity for the high end of the range. ***MIHS will need somewhere between 38 and 56 specialty providers to staff the new specialty centers.***

Table III-19
Specialty Center Specialty Provider Requirements

Specialty	Providers Required (Median Productivity)			Providers Required (Top Quartile Productivity)		
	East	West	Total	East	West	Total
Pediatric Specialties	1.4	2.8	4.2	1.0	2.0	3.0
Heart Center	0.0	3.7	3.7	0.0	1.7	1.7
Women's Center	3.0	3.0	6.1	2.0	2.0	4.0
Hematology/Oncology	2.8	0.0	2.8	1.9	0.0	1.9
Behavioral Health	5.4	5.4	10.7	4.4	4.4	8.8
Dermatology	1.3	1.1	2.4	0.9	0.8	1.7
Pulmonary Medicine	1.2	1.2	2.4	0.8	0.8	1.6
Sleep Medicine	0.6	0.6	1.1	0.5	0.5	1.0
Neurology	1.2	1.1	2.3	0.9	0.7	1.6
Surgical Specialties (Operting in ASC also)						
General Surgery	0.5	0.5	1.1	0.4	0.4	0.7
Orthopedics	4.4	3.5	7.9	2.6	2.0	4.6
Ophthalmology/Optometry	1.8	1.4	3.2	1.3	1.0	2.3
Otolaryngology	1.4	1.4	2.8	1.1	1.1	2.2
Gastroenterology	1.0	1.0	2.0	0.3	0.3	0.6
Pain	1.8	1.8	3.6	1.1	1.1	2.3
Total Specialists	28	28	56	19	19	38

Source: Navigant analysis.

Clinical Delivery Requirements—Physician Resources (Continued)

It is important to note that in positioning MIHS for success in the future value-based reimbursement environment, a stronger, more collaborative partnership with DMG will be a critical success factor. While the relationship with DMG has improved in the last three years, the need for tighter alignment has never been greater (even as competitive and market dynamics are straining the relationship). This alignment will be essential for MIHS to address its financial challenges through enhanced efficiencies and reduced variations in care as well as to develop the level of clinical integration required to effectively manage the health of a defined population. Key components of the greater alignment between MIHS and DMG will include, but not be limited to, factors such as:

- Successfully executing the revised agreement between MIHS and DMG that is mutually beneficial and that appropriately aligns the incentives of both parties,
- Establishing an effective clinically integrated network (CIN) that will facilitate quality improvements and joint contracting,
- Leveraging the clinical service line management physician / administrative dyad structure in place for select service lines, and
- Collaborating on preparing and successfully implementing a medical staff development plan that addresses the needs of patients in the community.

Clinical Delivery Requirements—Care Model

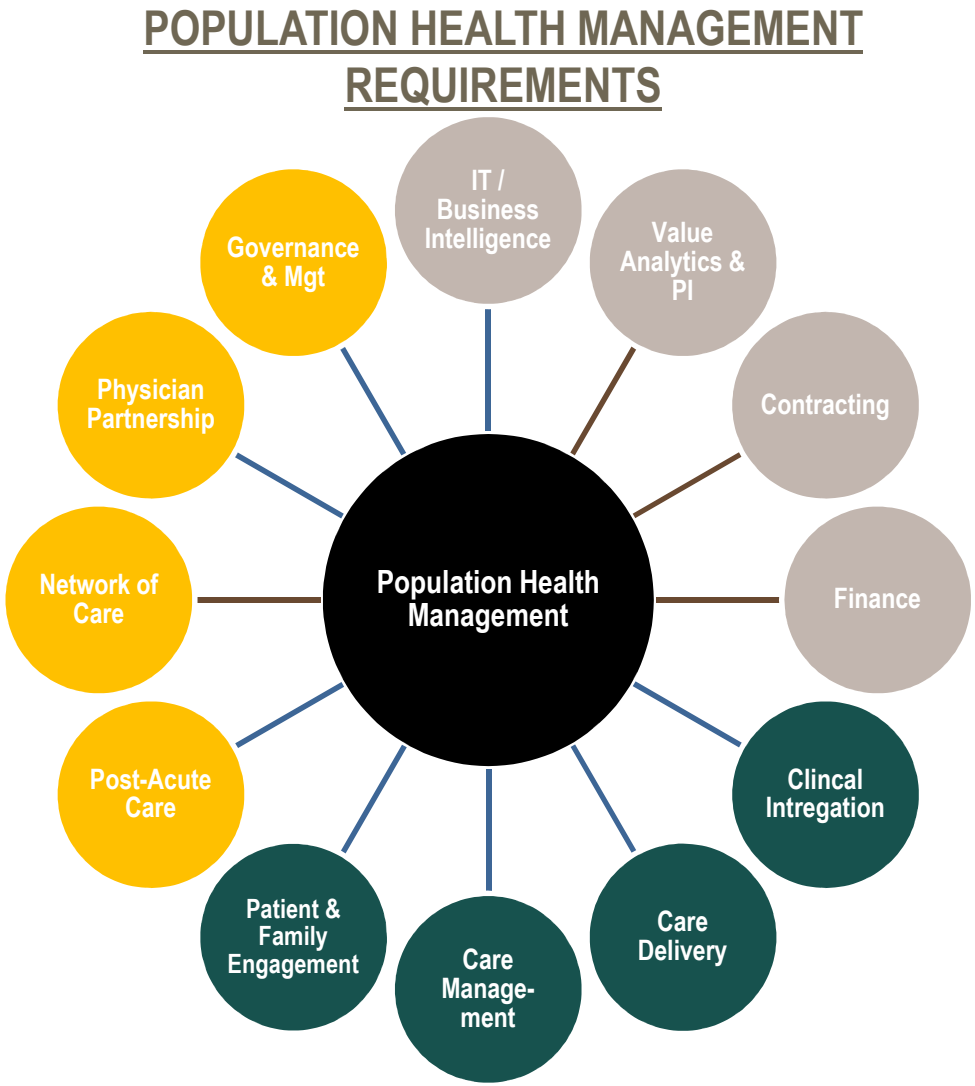
As noted earlier in this section, the transformation of the healthcare system in the United States will require fundamentally different skills and competencies, as well as new key performance criteria and measures of success. And the core of these new skills and competencies is a care model focused on population health management.

With respect to population health management capabilities, there are three core types of competencies:

- **Essential Infrastructure** to support the integration of care, reporting and analytics, and financial management,
- **Advanced Clinical Model** focused on clinical integration, enhanced care delivery, care coordination, and patient and family engagement, and
- **Foundational Elements** to drive clinical and financial performance in a network of care across the continuum and the supporting governance model.

The following pages provide more detail on the competencies included in each of these three areas along with an assessment of MIHS' capabilities in there three areas.

Clinical Delivery Requirements—Care Model (Continued)



Essential core population health management capabilities can be grouped into three (3) competencies:

- **Essential Infrastructure** to support the integration of care, reporting and analytics, and financial management.
- **Advanced Clinical Model** focused on clinical integration, enhanced care delivery, care coordination, and patient and family engagement.
- **Foundational Elements** to drive clinical and financial performance in a network of care across the continuum and the supporting governance model.

Clinical Delivery Requirements—Care Model (Continued)

POPULATION HEALTH MANAGEMENT REQUIREMENTS

Capabilities	Essential Components
Information Technology & Business Intelligence	• **Infrastructure**: Enables a variety of capabilities and functions to manage the health of populations. • **Care management platform**: Includes workflow, ADT feeds of patient data, alerts, messaging and outreach. • **Claims analytics**: Claims integrated with other data to mine, develop reports and predictive insights. • **Registry functionality**: Quickly identify patients with specific conditions based upon clinical data. • **Risk stratification and predictive modeling**: Assign specific levels of risk to patients that can then be used to direct care and provide input in predictive modeling used to mitigate patient risk. • **Provider referral system**: Standardizes screening and decision-making steps of patient referral, improve tracking and communication and strengthen data collection. • **Support mechanisms**: Supports are in place to ensure a collaborative and timely response to data capture and reporting capabilities that consider clinical, operational and financial data.
Value Analytics and Performance Improvement	• **Coordinated information and workflow**: Supports information-sharing and enables coordination. • **Clinical value analytics and predictive modeling:** Identify individual patients and / or patient populations likely to benefit from specialized care management programs and interventions (e.g., disease management programs, social support programs, etc.). • **Measurement and reporting**: Clinical and business performance and development of new metrics. • **Continuous performance improvement**: Measure, manage and continuously lead / enable improvement.
Contracting	• **Monetizing of new models**: Contract models that reward improvement in quality and efficiency and pay for value • **Market penetration**: Measure existing market share and performance to determine market opportunities.
Finance	• **Risk and revenue management**: Evaluate, plan for and optimize the impact of value-based payment models.

Clinical Delivery Requirements—Care Model (Continued)

POPULATION HEALTH MANAGEMENT REQUIREMENTS

Capabilities	Essential Components
Clinical Integration	• **Collaborative guideline development**: Develop, deploy, and improve common clinical protocols, leading practices and clinical programs. • **Evidence based care**: Create, disseminate and adhere to evidence-based care guidelines.
Care Delivery	• **Accessible care**: Provide patients with ready access (e.g., same day visits) to healthcare services in convenient time and settings. • **Efficient care**: Provide care at a resource intensity that matches the needs of the patient. • **Team based care**: Deliver care through a team-based approach that allows clear delineation and delegation of activities.
Care Management	• **Care Coordination**: Organize health care activities and facilitate smooth transitions across care settings. • **Targeted interventions**: Design and implement evidence-based specialized care programs and interventions that cost-effectively support the health and positive outcomes of targeted patient populations. • **Community Partnerships**: Work with community agencies and resources to extend the reach of the organization's own care management capabilities.
Patient and Family Engagement	• **Patient provider communication**: Patients and their families securely and conveniently communicate with their care teams, providers and the ACO as a whole through a variety of channels. • **Convenience and self-service**: Patients and their families conveniently track their healthcare activities, arrange for care and manage financial transactions related to their care and coverage.

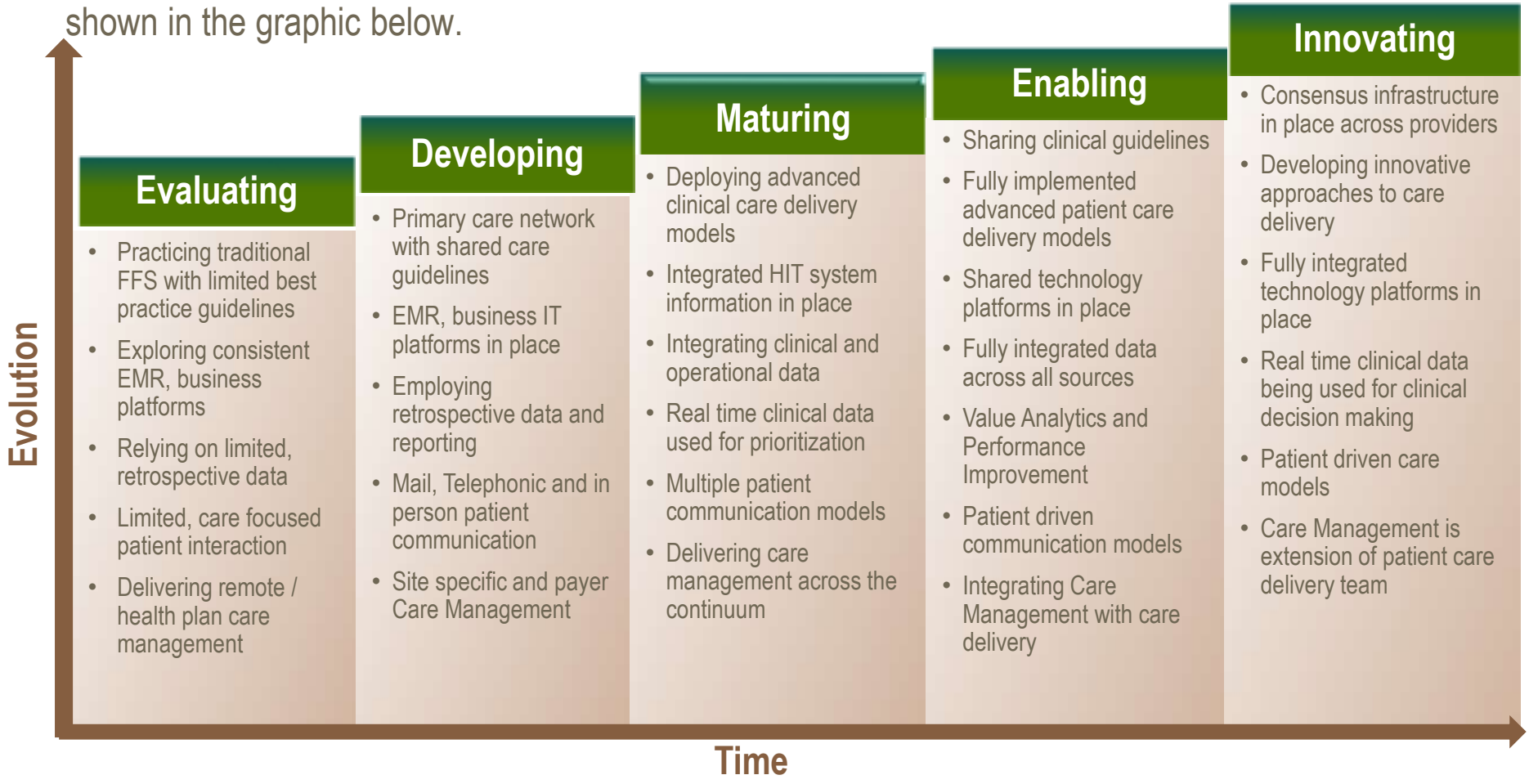
Clinical Delivery Requirements—Care Model (Continued)

POPULATION HEALTH MANAGEMENT REQUIREMENTS

Capabilities	Essential Components
Governance and Management	• Engaged leaders: Actively and effectively lead the enterprise to realize goals and objectives that differentiate and achieve the triple aim. • Governance: Define responsibilities and authority and hold levels of leadership accountable for organizational objectives and their associated definitions and metrics of success.
Network of Care	• Network and market alignment: evaluate and measure the current market and align network strategies for appropriate operations and growth. • Network adequacy: Grow, develop, and integrate a network of desired providers that meets all care needs of the organization's population and delivers care in a timely and convenient fashion.
Physician Partnerships	• Aligned incentives: Align incentive across diverse constituencies to achieve common goals and closely align provider with measurable population health goals in quality, cost and patient satisfaction. • Physician Leadership: The active involvement of physicians in leadership and governance roles for the clinically integrated network and health system. • Engagement: Frontline physicians are engaged via organizational support, incentive compensation models and operational processes, which underpins a collective movement to population health.
Post-Acute Care	• Preferred partnerships: Effectively evaluate post-acute providers and establish partnerships in alignment with enterprise goals and culture. • Collaborative structure: Clearly identify a structure for collaboration that is responsible to ensure communication, data sharing and reporting requirements are effective.

Clinical Delivery Requirements—Care Model (Continued)

In addition to the capabilities and requirements delineated on the previous pages, it is important to note that healthcare providers' processes and infrastructure evolve and develop in a phased manner, as shown in the graphic below.



Clinical Delivery Requirements—Care Model (Continued)

In evaluating MIHS' capabilities in these core elements, it appears that MIHS has, partly out of necessity given its role as a safety net provider and partly as a result of progressive leadership on the part of physicians and management, made progress in developing and implementing advanced clinical care models. However, both MIHS management and DMG physicians readily acknowledge that there is much work to be done in building their clinical care capabilities and that MIHS' capabilities in essential infrastructure and foundational elements are in the early stages. With respect to the overall stage of development of MIHS' population health management capabilities, it appears that MIHS' capabilities fall primarily in the "Developing" stage (see Table III-20). This is, it should be noted, the case with most healthcare systems. While MIHS has made some important strides, it has a substantial amount of work to do in developing essential infrastructure, furthering advanced care models, and establishing key foundational elements needed to achieve full functionality in terms of being able to effectively manage population health.

In light of these findings, it is recommended that MIHS move quickly to build the essential infrastructure and foundational elements identified on the previous pages while concurrently pursuing further development of advanced clinical care models, including telehealth / virtual care, and integrate those models into the planning for and operation of the new facilities (both inpatient and ambulatory). Furthermore, a key element of MIHS' future care model should be the integration of behavioral health with general acute care.

Clinical Delivery Requirements—Care Model (Continued)

Furthermore, ***MIHS' future care delivery model should include the following features*** (based on research conducted by Kaiser Permanente and Cambridge Health Alliance):

- **Information continuity —** Patients' clinically relevant information should be available to all providers at the point of care and to patients through E.H.R. systems,
- **Care coordination and transitions —** Patient care for both routine and complex patients is coordinated among multiple providers and transitions across care settings are actively managed,
- **System accountability —** There is clear accountability for the total care of patients,
- **Peer review and teamwork for high value care —** Providers (including nurses and other members of the care team) both within and across settings have accountability to each other, review each other's work, and collaborate to deliver high quality, high value care,
- **Continuous innovation —** The system is continuously innovating and learning in order to improve the quality, value, and patient experiences of health care delivery,
- **Easy access to appropriate care —** Patients have easy access to appropriate care and information at all hours, there are multiple points of entry to the system, and providers are culturally competent and responsible to patients' needs,

Clinical Delivery Requirements—Care Model (Continued)

- **Team model of care —** To sustainably meet the acute care, preventative, and chronic care needs of the safety net population an expanded primary care team needs to be established (which includes culturally competent community members),
- **Health literacy —** There is a significant need to reinforce basic health literacy amongst the diverse safety net population served by MIHS, and
- **Integrated behavioral health —** given the incredibly high prevalence of mental health and social health issues as well as physical health issues, it is essential that MIHS address the mental, physical, and social issues together in an integrated manner.

Clinical Delivery Requirements—Care Model (Continued)

Table III-20 Assessment of MIHS' Population Health Management Capabilities

	Population Health Management Capabilities	Developing	Maturing	Enabling
Essential Infrastructure	IT Infrastructure & Business Intelligence	◆		
	Value Analytics & Performance Improvement	◆		
	Contracting	◆		
	Finance	◆		
Advanced Clinical Model	Clinical Integration	◆		
	Care Delivery		◆	
	Care Management	◆		
	Patient & Family Engagement	◆		
Foundational Capabilities	Governance & Management	◆		
	Physician Partnership	◆		
	Network of Care	◆		
	Post-Acute Care	◆		

Source: Navigant analysis

Clinical Delivery Requirements—Telehealth / Virtual Care

In addition to the above mentioned features, another key element in MIHS' future care delivery model is telehealth / virtual care. Telehealth / virtual care describes the ability of a healthcare provider to serve and interact with a patient who is in a different location using two-way video, email, smartphones, wireless devices and other forms of technology. Virtual care integrates telemedicine technology with real-time electronic health record data. Advanced algorithms detect patients needing intervention immediately. Most importantly, telemedicine provides more efficient ways for virtual clinicians and caregivers to work together to improve patient care.

While telehealth / virtual care has been around for 40 years, recent advances have integrated it into the daily operations of hospitals, ambulatory care setting, home health agencies and private physician offices, as well as homes and workplaces. According to a report from *Tractica*, there were almost 20 million telehealth video consultations in 2014 and that number is projected to increase to more than 160 million by 2020, an increase of 700%. The flexibility and efficiency of telehealth / virtual care can help healthcare providers achieve tangible value in terms of patient outcomes, cost savings, and patient satisfaction. Telehealth / virtual care can significantly augment traditional bedside care in a variety of ways, as listed on the following page.

Clinical Delivery Requirements—Telehealth / Virtual Care (Continued)

Potential Telehealth / Virtual Care Opportunities

- Centralized 24/7 “eyes” on the acute care patient floors, PAC, ICU and at home
  - Telehealth paradigm
  - Allow for care givers to be at the bedside → less documentation
  - Virtual scribes for physicians in the office
  - Decrease unnecessary utilization
- Increase access to specialty and primary care
  - Primary care on demand models – 24/7
    - Support primary care within communities
  - Specialty care in the communities – tele stroke
- Home monitoring thru virtual units and wearable technology
- Use of smart devices and mobile technology
  - Secure texting
  - Asynchronous e-visits
- Utilize analytics to add prescriptive and predictive interventions

Clinical Delivery Requirements—Telehealth / Virtual Care (Continued)

Given the direction of healthcare, having a major telehealth / virtual care capability as part of the MIHS future care delivery model with be a requirement and not an option.

Therefore, the recommendation for MIHS is that telehealth / virtual care should be a key component of its future care delivery model and appropriate considerations for telehealth / virtual care should be incorporated into the planning for the acute care, behavioral health, and ambulatory facilities. Furthermore, there are a number of healthcare providers and systems that have already developed telehealth / virtual care capabilities and it would be in MIHS' best interests to partner with one of those organizations rather than trying to "get up the learning curve" on its own. MIHS could benefit from the experience and scale of these organizations as well as reduce its "speed to market" and the financial commitment required.

IV. Partnership Assessment and Opportunities

Partnership Assessment and Opportunities

Maricopa Integrated Health System occupies an increasingly unique position in the healthcare system in Maricopa County and the nation: it operates as a single hospital system in a local market in which virtually every other acute care facility is part of a multi-hospital system. Nationally, more than 75% of hospitals are part of a multi-hospital system (up from less than 40% in 1990). As a result of this position, MIHS finds itself competing with healthcare systems that can—and do—effectively use their size and scale to achieve efficiencies in purchasing and supply chain management; revenue cycle management; managed care contracting; physician recruiting; talent acquisition, development, and retention; information technology; and a multitude of other functions. In addition to its unique position as the lone independent hospital in Maricopa County, MIHS' role as the safety net facility further sets it apart from other providers in the market who serve a broader (and generally more affluent) patient base.

Given its unique position, and the ongoing (and accelerating) consolidation among providers around the region and across the country, the question of what types of partnerships MIHS should have or develop to support its safety net role and its mission were addressed as part of the implementation planning process. In addition, some of the numerous public-partnership opportunities available to MIHS to assist with the implementation of Proposition 480 were identified during the implementation planning process.

Partnership Assessment and Opportunities (Continued)

Partnerships are not, in and of themselves, a strategy. Rather, they are a means to an end. As a result, it is essential to have a clear understanding of what the organization needs a partnership to do or address. ***Based on an objective assessment of MIHS' position and strategic needs, it is recommended that MIHS explore development of four potential types of partnership designed to address its most pressing strategic issues.*** These partnerships include the following

- ***A "scale collaborative"*** to achieve economies of scale and reduce overhead expenses (this could be through an outsourcing arrangement with a company (or companies) that specialize in performing certain functions (i.e., revenue cycle management) or through a provider system (or group of systems) that has the ability / capacity to service MIHS on a contractual basis).
- ***Service / program specific alignment opportunities*** in which MIHS partners with an other organization (or organizations) to provide certain clinical services that the other providers have distinctive / recognized capabilities in and which MIHS is challenged to provide in an economically viable and / or clinically appropriate manner. The services most frequently cited by internal stakeholder groups at MIHS that fall into this category are pediatrics and obstetrics, as there is a nationally recognized children's hospital located a few miles away that MIHS already collaborates with on education and teaching initiatives, and there are a number of large obstetrics programs within a relatively short distance from MIHS.

Provider Partnership(s) Assessment

- A partnership focused on ***advancing MIHS' clinical integration efforts and capabilities***. As an independent, standalone facility, MIHS faces significant challenges in developing its clinical integration capabilities in a timely and cost effective manner. Because these capabilities will become increasingly essential in the value-based environment (as discussed in the Clinical Delivery Requirements section of this report), MIHS should seek a partnership that enables it to accelerate its clinical integration initiatives.
- ***Public / private community partnerships*** to leverage / further develop "future state" ambulatory network. There is a clear and strong interest among communities in the greater Phoenix area to have MIHS develop healthcare facilities in their markets as well as numerous potential public-private partnership opportunities. MIHS should aggressively pursue these economic development and public-private partnership opportunities.

While there is a strong preference among MIHS leadership (management and board) for MIHS to remain as an independent entity at this time due to successful cost management strategies over the past two years, the environment locally and nationally is likely to become increasingly challenging for all health systems. Therefore, ***MIHS should continue to assess the environment, its opportunities and vulnerabilities, its viability as a freestanding provider, and potential enterprise-level partnership opportunities as part of its ongoing strategy planning.***

Provider Partnership(s) Assessment (Continued)

In addition to the types of partnerships identified on the previous pages, it appears MIHS has a number of opportunities to develop a wide variety of public / private community partnership opportunities that could help with respect to site of care location, community development, transit and pedestrian accessibility, and leveraging local government and community partner resources.

V. Facility Requirements

Facility Requirements—Overall Approach

This section provides a detailed facility assessment of the family health centers, Desert Vista, and the Roosevelt Street campus, along with a program of requirements and planning and design considerations for the Proposition 480 implementation.

- **Facility Assessment** Each site and building was toured and objectively evaluated in terms of site condition, building envelope, interior conditions and infrastructure to identify facilities that should be reused and those requiring replacement.
- **Program of Requirements** Preliminary functional and space requirements were identified for each facility. Access points for services were identified throughout the service area. Ambulatory facilities were categorized as "Neighborhood", "Community" and "Specialty" Centers. Based on initial preliminary projections of service demand, physician complements and clinical programs and services using Navigant benchmarks, preliminary space needs were identified for all ambulatory and inpatient facilities.
- **Planning and Design Considerations** Upon identification of specific sites and finalized program requirements, each facility will require detailed design. As part of this study, Navigant evaluated the potential development of "Healthcare Villages" at the site of the two proposed new Specialty Centers. In addition, a "Fit Diagram" was developed for the Roosevelt campus to confirm its ability to accommodate future planned facility needs.

Facility Assessment—Approach

- **Facility Tours -** Facilities were toured to evaluate existing condition. Site managers were interviewed during the tours of each site.
- **Assessment Criteria -** Objective assessments of each site and facility were summarized along with data collected from several past studies. Each site and building was evaluated using a 1 to 5 rating for each of the following criteria:
  - **Site** Site Access, Pavement Condition, Site Infrastructure Condition, Landscape, Entry / Sense of Presence, Exterior Appearance, Exterior Signage
  - **Building** Exterior Envelope, Windows, Roofs, Functionality, Adjacencies, ADA Conformance, Life Safety Conformance, Interior Finishes
  - **Infrastructure** Fire Protection, Plumbing Systems, Mechanical Systems, Information Technology / Communication Systems, Lighting, Electrical Systems
- **Capacity Analysis -** The site and existing building sizes were evaluated to determine current capacity and to evaluate if sites were properly sized for current use.
- **Potential for Renovation -** Cost and timeline evaluations were performed for each site to determine impact of renovation rather than new construction (no facilities were identified as candidates for renovation).

Facility Assessment—Summary of Family Health Center Assessments

- The assessment included review of the site, building and Infrastructure conditions at each location, ranked on a 1-5 scale with 5 being optimal and 3 being adequate. Overall ratings are summarized at right.

Poor:	**1.0**
Marginal:	**2.0**
Adequate:	**3.0**
Very Good:	**4.0**
Optimal:	**5.0**

- Findings were consistent with BAC findings that the existing Family Health Centers, except for the Pendergast and McDowell sites, do not meet adequate facility standards and should be replaced. A more detailed assessment of each facility is outlined on the following pages.

No.	FHC Site	Navigant		
		Rating	Percentile	Rank
1	Avondale	2.91	48%	1
2	Guadalupe	2.71	43%	2
3	Chandler	2.68	42%	3
4	El Mirage	2.59	40%	4
5	Glendale	2.53	38%	5
6	Sunnyslope	2.50	38%	6
7	Mesa	2.41	35%	7
8	South Central	2.38	35%	8
9	Maryvale	2.29	32%	9
10	Pendergast	3.59	65%	NA
11	McDowell	3.47	62%	NA
12	7th Avenue	Not rated	NA	NA

Facility Assessment—Avondale Family Health Center

No.	Description	Rating (1 to 5)
1.0	Site	2.5
2.0	Building	2.9
3.0	Infrastructure	3.3
4.0	Overall	2.91

1.0	2.0	3.0	4.0	5.0
Poor	Marginal	Adequate	Very Good	Optimal

- Building Area: 18,730 sq. ft. (owned).
- Site size: 2.6 acres; site area needed: 1.6 acres.
- Comparison to theoretical area: Right-sized.
- Treatment: 13 exam rooms; 2 procedure rooms.
- Dental Treatment: 5 treatment bays.
- Family Medicine, Cardiology, Optometry, Audiology, Radiography, Mammography, Ultrasound, Lab, Pharmacy, WIC Program, Family Learning Center.

Facility Assessment—Guadalupe Family Health Center

No.	Description	Rating (1 to 5)
1.0	Site	2.5
2.0	Building	2.6
3.0	Infrastructure	3.0
4.0	Overall	2.71

1.0	2.0	3.0	4.0	5.0
Poor	Marginal	Adequate	Very Good	Optimal

- Building Area: 5,112 sq. ft. (owned).
- Site size: 1.2 acres; site area needed: 0.7 acres.
- Comparison to theoretical area: Undersized.
- Treatment: 8 exam rooms; 1 procedure room.
- Dental Treatment: No treatment bays.
- Family Medicine, OB / GYN, Laboratory.

Facility Assessment—Chandler Family Health Center

No.	Description	Rating (1 to 5)
1.0	Site	2.7
2.0	Building	2.5
3.0	Infrastructure	2.8
4.0	Overall	2.68

1.0	2.0	3.0	4.0	5.0
Poor	Marginal	Adequate	Very Good	Optimal

- Building Area: 11,795 sq. ft. (owned).
- Site size: 1.8 acres; site area needed: 1.7 acres.
- Comparison to theoretical area: Right-sized.
- Treatment: 18 exam rooms; 1 procedure room.
- Dental Treatment: 5 treatment bays.
- Family Medicine, Internal Medicine, Pediatrics, OB / GYN, Laboratory, Pharmacy, Radiography, Ultrasound, Family Learning Center.

Facility Assessment—El Mirage Family Health Center

No.	Description	Rating (1 to 5)
1.0	Site	2.7
2.0	Building	2.2
3.0	Infrastructure	2.8
4.0	Overall	2.59

1.0	2.0	3.0	4.0	5.0
Poor	Marginal	Adequate	Very Good	Optimal

- Building Area: 8,683 sq. ft. (owned).
- Site size: 1.3 acres; site area needed: 0.5 acres.
- Comparison to theoretical area: Oversized.
- Treatment: 9 exam rooms; 1 procedure room.
- Dental Treatment: No treatment bays.
- Family Medicine, Laboratory.

Facility Assessment—Glendale Family Health Center

No.	Description	Rating (1 to 5)
1.0	Site	2.4
2.0	Building	2.6
3.0	Infrastructure	2.6
4.0	Overall	2.53

1.0	2.0	3.0	4.0	5.0
Poor	Marginal	Adequate	Very Good	Optimal

- Building Area: 18,000 sq. ft. (owned).
- Site size: 3.1 acres; site area needed: 1.5 acres.
- Comparison to theoretical area: Right-sized.
- Treatment: 20 exam rooms; 1 treatment room.
- Dental Treatment: No treatment bays.
- Family Medicine, Internal Medicine, laboratory, Pharmacy, Outpatient Dialysis.

Facility Assessment—Sunnyslope Family Health Center

No.	Description	Rating (1 to 5)
1.0	Site	2.8
2.0	Building	2.3
3.0	Infrastructure	2.3
4.0	Overall	2.50

1.0	2.0	3.0	4.0	5.0
Poor	Marginal	Adequate	Very Good	Optimal

- Building Area: 9,376 sq. ft. (owned).
- Site size: 1.1 acres; site area needed: 1.2 acres.
- Comparison to theoretical area: Undersized.
- Treatment: 12 exam rooms.
- Dental Treatment: No treatment bays.
- Family Medicine, Internal Medicine, OB / GYN, Laboratory, Pharmacy.

Facility Assessment—Mesa Family Health Center

No.	Description	Rating (1 to 5)
1.0	Site	2.0
2.0	Building	2.6
3.0	Infrastructure	2.7
4.0	Overall	2.41

1.0	2.0	3.0	4.0	5.0
Poor	Marginal	Adequate	Very Good	Optimal

- Building Area: 19,839 sq. ft. (owned).
- Site size: 1.8 acres; site area needed: 1.2 acres.
- Comparison to theoretical area: Oversized.
- Treatment: 17 exam rooms.
- Dental Treatment: 3 treatment bays.
- Family Medicine, Internal Medicine, OB / GYN, Laboratory, Pharmacy.

Facility Assessment—South Central Family Health Center

No.	Description	Rating (1 to 5)
1.0	Site	2.0
2.0	Building	2.4
3.0	Infrastructure	2.8
4.0	Overall	2.38

1.0	2.0	3.0	4.0	5.0
Poor	Marginal	Adequate	Very Good	Optimal

- Building Area: 15,524 sq. ft. (owned).
- Site size: 1.3 acres; site area needed: 1.1 acres.
- Comparison to theoretical area: Oversized.
- Treatment: 20 exam rooms; 1 treatment room.
- Dental Treatment: 3 treatment bays; Panorex.
- Family Medicine, Internal Medicine, Pediatrics, OB / GYN, Laboratory, Pharmacy, Family Learning Center.

Facility Assessment—Maryvale Family Health Center

No.	Description	Rating (1 to 5)
1.0	Site	2.3
2.0	Building	2.2
3.0	Infrastructure	2.3
4.0	Overall	2.29

1.0	2.0	3.0	4.0	5.0
Poor	Marginal	Adequate	Very Good	Optimal

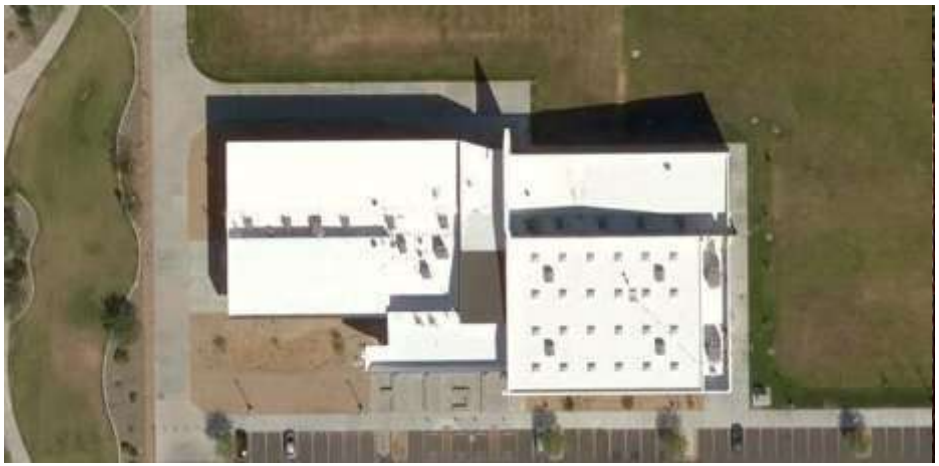
- Building Area: 15,750 sq. ft. (owned).
- Site size: 2.4 acres; site area needed: 1.1 acres.
- Comparison to theoretical area: Oversized.
- Treatment: 20 exam rooms; 1 treatment room.
- Dental Treatment: No treatment bays.
- Maternal / Child Health, Pediatrics, OB / GYN, Laboratory, Ultrasound, Family Learning Center.

Facility Assessment—Pendergast Family Health Center

No.	Description	Rating (1 to 5)
1.0	Site	3.0
2.0	Building	3.8
3.0	Infrastructure	4.0
4.0	Overall	3.59

1.0	2.0	3.0	4.0	5.0
Poor	Marginal	Adequate	Very Good	Optimal

- Building Area: Unknown (leased area).
- Site size: Unknown (leased area).
- Comparison to theoretical area: Unknown.
- Treatment: 3 exam rooms; 1 procedure room.
- Dental Treatment: 3 treatment bays; Panorex.
- Family Medicine, Laboratory.



Facility Assessment—McDowell Family Health Center

No.	Description	Rating (1 to 5)
1.0	Site	3.0
2.0	Building	3.6
3.0	Infrastructure	3.8
4.0	Overall	3.47

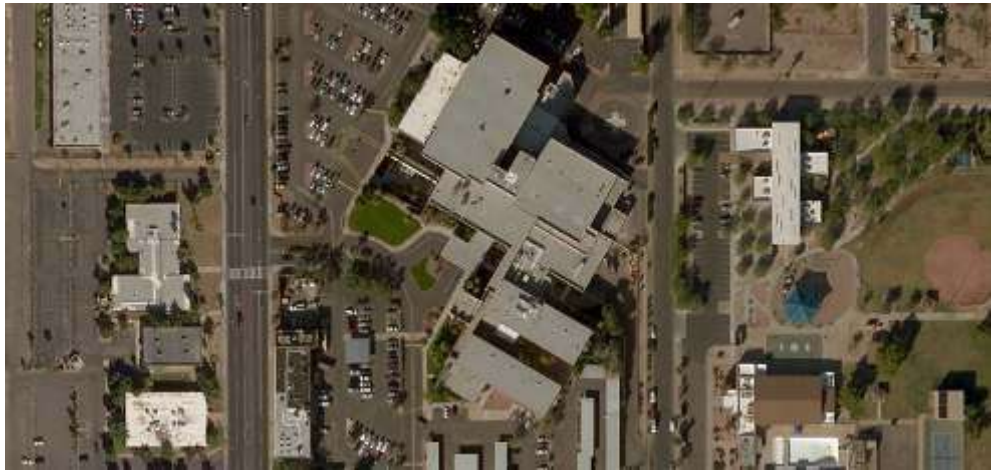
1.0	2.0	3.0	4.0	5.0
Poor	Marginal	Adequate	Very Good	Optimal

- Building Area: Unknown (leased area).
- Site size: Unknown (leased area).
- Comparison to theoretical area: Unknown.
- Treatment: 13 exam rooms; 2 procedure rooms.
- Dental Treatment: 3 treatment bays; Panorex.
- Family Medicine – HIV, Internal Medicine – HIV, Psychiatry, Laboratory.

Facility Assessment—Seventh Avenue Family Health Center

Facility not Assessed

- Building Area: 17,141 sq. ft.
- Site size: Unknown.
- Comparison to theoretical area: Right-sized.
- Treatment: 12 exam rooms; 1 procedure rooms, 8 exam rooms in Walk-in Clinic.
- Family Medicine.



Facility Assessment—Desert Vista Behavioral Health Center

No.	Description	Rating (1 to 5)
1.0	Site	2.7
2.0	Building	2.4
3.0	Infrastructure	2.8
4.0	Overall	2.65

1.0	2.0	3.0	4.0	5.0
Poor	Marginal	Adequate	Very Good	Optimal

- Building Area: approx. 140,000 sq. ft. (owned).
- Site size: Unknown .
- Comparison to theoretical area: Undersized by approximately 45%.
- Beds: 124 (mostly semiprivate).
- Other: Includes outpatient and court space.

Facility Assessment—Desert Vista and Roosevelt Campus

- **Desert Vista Behavioral Health Hospital -** Navigant concurred with the Bond Advisory Committee study, which concluded that the existing Desert Vista facility is antiquated and operationally inefficient in layout. Consolidation of MIHS's two Behavioral Health facilities was recommended.
- **Roosevelt Campus -** All of the facilities on the Roosevelt campus were toured and evaluated. The following was noted:
  - **Acute Care Hospital -** Navigant concurred with the Bond Advisory Committee study, which concluded that the existing hospital is antiquated and operationally inefficient. Replacement is indicated. Much of the equipment in the existing Central Plant is new and in view of costs, it is recommended that the existing Central Plant be upgraded and expanded to serve new and existing facilities.
  - **Comprehensive Care Center -** The existing facility will continue to be used although substantial renovation will be eventually be required.
  - **2619 Building -** The building is currently used for inpatient Behavioral Health services and administrative services. It was recommended that Behavioral Health services be consolidated with the new Behavioral Health hospital and that the building be renovated to accommodate expanded administrative services.
  - **Warehouse** - The existing warehouse building is in good condition and can continue to be used.

Facility Assessment—Key Findings and Conclusions

- **MIHS Brand -** Currently there is no MIHS brand identification at the various Family Health Centers. Future facilities should reflect an MIHS brand, especially in the following areas:
  - Exterior Signage
  - Building Entry
  - Public Areas
- **Overall Assessment -** Except for the McDowell and Pendergast sites, all Family Health Center buildings were found to be in marginal, less than adequate condition.
- **Potential for Renovation -** Each facility would require substantial renovation in order to be retained. Phased disruption of each facility would last for 6 to 12 months, likely causing erosion of market share. (On the other hand, new facilities should have a positive effect on market share.) Therefore all Family Health Centers except McDowell and Pendergast should be replaced.
- **Competitor Facilities -** A comparison of the MIHS Mesa facility to a similar facility owned by Adelante Healthcare is illustrated on the following pages to demonstrate the marginal condition of current MIHS ambulatory facilities.

Facility Assessment—Key Findings and Conclusions

Main Entry to Adelante Healthcare Facility in Mesa

Main Entry to MIHS Facility in Mesa

Facility Assessment—Key Findings and Conclusions

Nursing Stations at Adelante Healthcare Facility in Mesa

Nursing Stations at MIHS Facility in Mesa

Facility Assessment—Key Findings and Conclusions

Waiting Area at Adelante Healthcare Facility in Mesa

Adelante Cafe

Waiting Area at MIHS facility in Mesa

Program of Requirements—Approach

Program of Requirements - Initial models were developed for "small" and "large" versions of Neighborhood, Community and Specialty Centers. Table V-1 on the following two pages outlines approximate space needs for these facilities. The three pages following the space needs tables illustrate the scope and development of similar facilities.

Program of Requirements—Initial Model

TABLE V-1

No.	Driver Description	Bench-mark per Driver (sq. ft.)	Neighborhood Health Center				Community Health Center				Specialty Health Center			
			Small		Large		Small		Large		Small		Large	
			Quan-tity	Area (sq. ft.)	Quan-tity	Area (sq. ft.)	Quan-tity	Area (sq. ft.)	Quan-tity	Area (sq. ft.)	Quan-tity	Area (sq. ft.)	Quan-tity	Area (sq. ft.)
	1.0 Treatment Areas													
1.1	Exam/Procedure Rooms (Note 1)	450	6	2,700	6	2,700	18	8,100	30	13,500	44	19,800	62	27,900
1.2	Behavioral Health Consult	350	2	700	2	700	2	700	2	700	4	1,400	4	1,400
1.3	Dental Treatment Bays	500			4	2,000	4	2,000	6	3,000	6	3,000	6	3,000
1.4	Outpatient Dialysis Stations	650									8	5,200	8	5,200
1.5	Urgent Care Center/Walk-in Clinic	550							4	2,200				
1.6	Rehabilitation	8,000									1	8,000	1	8,000
1.0	**Subtotal Treatment Areas**			**3,400**		**5,400**		**10,800**		**19,400**		**37,400**		**45,500**
	2.0 Diagnostic Areas													
2.1	Laboratory (Note 2)	500			1	500	1	500	1	500	1	500	1	500
2.2	Women's Center (Note 3)	550									6	3,300	6	3,300
2.3	Cardiology Center (Note 4)	650									6	3,900	6	3,900
2.4	Radiology	1,400							1	1,400	1	1,400	2	2,800
2.5	CT Scan	1,800									1	1,800	1	1,800
2.6	Ultrasound	800									1	800	1	800
2.7	Ambulatory Surgery	3,400											4	13,600
2.8	Short Stay Beds	650											8	5,200
2.9	Freestanding Emergency (Note 5)	650									10	6,500	10	6,500
2.10	Endoscopy Center	1,400									2	2,800	2	2,800
2.11	Sleep Center	650											4	2,600
2.0	**Subtotal Diagnostic Areas**					**500**		**500**		**1,900**		**21,000**		**43,800**
	3.0 Education / Administrative Areas													
3.1	Medical Home Wellness (Note 6)	250					2	500	6	1,500	6	1,500	8	2,000
3.2	Health Education Conference	Varies			1	200	1	200	1	200	1	600	1	600
3.3	Family Learning Center	400			1	400	1	400	1	400	1	400	1	400
3.4	Eligibility Offices (Note 7)	200	1	200	2	400	4	800	4	800	4	800	4	800
3.5	WIC Program Offices	200			2	400	2	400	2	400	4	800	4	800
3.0	**Subtotal Education/Admin Areas**		**1**	**200**		**1,400**		**2,300**		**3,300**		**4,100**		**4,600**
	4.0 Retail Areas													
4.1	Pharmacy	Varies			1	400	1	400	1	400	1	1,200	1	1,200
4.2	Café	500									1	500	1	500
4.3	Other Retail (Note 8)	500									1	500	1	500
4.0	**Subtotal Retail Areas**					**400**		**400**		**400**		**2,200**		**2,200**
Subtotal Area				**3,600**		**7,700**		**14,000**		**25,000**		**64,700**		**96,100**
5.0	General Circulation		0.0%	0	3.0%	231	5.0%	700	5.0%	1,250	12.0%	7,764	12.0%	11,532
6.0	Mechanical / Electrical / Data		3.0%	108	3.0%	238	5.0%	735	5.0%	1,313	8.0%	5,797	8.0%	8,611
7.0	Building Envelope		3.5%	130	3.5%	286	3.5%	540	3.5%	965	3.5%	2,739	3.5%	4,068
Total Area (Rounded)				**4,000**		**8,000**		**16,000**		**30,000**		**80,000**		**120,000**
Site Area w/50% Expandability (acres) (Note 9)				0.4		0.7		1.5		2.7		5.4		8.2

Program of Requirements—Model for Preliminary Space Requirements

TABLE V-1 (CONTINUED)

N O T E S

Note 1 Program assumes 3 Exam/Procedure Rooms per physician; 2 Exam/Procedure Rooms per NP. Number of physicians practicing concurrently assumed to be as follows ~

- Neighborhood Health Center - Small: 2 PCPs
- Neighborhood Health Center - Large: 2 PCPs
- Community Health Center - Small: 4 PCPs, 2 Specialists
- Community Health Center - Large: 6 PCPs, 4 Specialists
- Specialty Health Center - Small: 4 PCPs, 8 Specialists, 4 Nurse Practitioners
- Specialty Health Center - Small: 6 PCPs, 12 Specialists, 4 Nurse Practitioners

Note 2 Laboratory area assumes 100 sq. ft. draw, 50 sq. ft. restroom, 120 sq. ft. work area, 180 sq. ft. processing and testing and 50 sq. ft. storage.

Note 3 Women's Center includes Exam Rooms, Ultrasound, Mammography, Bone Density

Note 4 Cardiology Center includes Exam Rooms, Nuclear Medicine, Echocardiography, Stress Testing

Note 5 Alternately, consideration was discussed regarding provision of space for a Birthing Center rather than a Freestanding Emergency Department in the Specialty Center. This will require further market evaluation. Navigant concluded that approximately 600 to 800 annual births could be accommodated within a 6,500 sq. ft. facility.

Note 6 Medical Home Wellness Center includes consult rooms/offices for wellness, nutrition, social, lifestyle, administration

Note 7 Eligibility offices may be provided in a central location rather than in each ambulatory center as currently configured.

Note 8 Retail component could include DME, optical shop or other retail services

Note 9 Site analysis assumes 4.5 parking spaces/1,000 sq. ft; 365 sq. ft. paved area/parking space; 80% lot coverage; 50% future expansion

Program of Requirements—Initial Model – Neighborhood Care Centers

Small – 4,000 sq. ft. (0.4 Acres)

- 2 PCPs; 6 exam rooms.
- 9,000 annual patient encounters.
- Behavioral Health Consult.

Large – 8,000 sq. ft. (0.7 Acres)

- 2 PCPs; 6 exam rooms.
- 9,000 annual patient encounters.
- Behavioral Health Consult.
- 4 Dental Treatment Bays.
- Satellite Laboratory; Pharmacy.
- Health Education Conference Room; Family Learning Center; WIC Program.

Program of Requirements—Initial Model – Community Care Centers

Small – 16,000 sq. ft. (1.5 Acres)

- 4 PCPs; 2 specialists; 18 exam rooms.
- 26,000 annual patient encounters.
- Behavioral Health Consult.
- 4 Dental Treatment Bays.
- Satellite Laboratory; Pharmacy.
- Health Education Conference Room; Family Learning Center; WIC Program.

Large – 30,000 sq. ft. (2.7 Acres)

- 6 PCPs; 4 specialists; 30 exam rooms.
- 43,000 annual patient encounters.
- Behavioral Health Consult.
- 6 Dental Treatment Bays.
- Urgent Care.
- Satellite Laboratory; Pharmacy; Radiology.
- Health Education Conference Room; Family Learning Center; WIC Program.

Program of Requirements—Initial Model – Specialty Care Centers

Large – 120,000 sq. ft. (8.2 Acres)

- 6 PCPs; 12 specialists; 4 NPs', and 62 exam rooms.
- 87,000 annual patient encounters.
- Behavioral Health Consult.
- Women's Center; 2 physicians; 6 exam rooms; 7,000 annual patient encounters.
- Heart Center; 2 physicians; 6 exam rooms; 10,000 annual patient encounters.
- 6 Dental Treatment Bays.
- Satellite Laboratory; Pharmacy.
- Health Education Conference Room; Family Learning Center; WIC Program.
- Outpatient Dialysis; PT / OT: Imaging (Radiology, CT, Ultrasound); Sleep Center; Freestanding Emergency; Endoscopy.
- ASC; 8 Short Stay Beds.
- Café; Retail.

Program of Requirements

- **Specialty Center -** The "large" version of the Specialty Center described in Table V-1 was used as a basis for preliminary planning for the proposed new East and West Specialty Centers.
- **Neighborhood and Community Centers -** The size of these ambulatory centers are primarily driven by the number of physicians practicing concurrently as well as by the projected need for ancillary programs and services such as Laboratory, Pharmacy and Imaging. The approach to preliminarily sizing these facilities was as follows:
  - **Number of Providers -** Based on current physician demand and projected growth a preliminary projection of physicians and nurse practitioners was prepared. See Table V-2 on the following page.
  - **Facility Drivers -** Based on the number of projected providers, programs and services, the number of space drivers, such as exam rooms, procedure rooms and other clinical and administrative facilities was projected. See Table V-3.
  - **Facility Space Needs -** Based on Navigant benchmarks for space needs per driver, overall space needs for each Neighborhood and Community Center was preliminarily projected. See Table V-4.

Program of Requirements—Model for Number of Providers

TABLE V-2

Site	Current							Calculated							Planned						
	FY15 Volumes	Physician FTEs	NP/PA FTEs	Total FTEs	Encounters per Provider	Exam/ Procedure Rooms	Dental Bays	Percent Volume Increase FY16 to FY23	FY23 Volumes	Physician FTEs Calculated with Increase	NP/PA FTEs Calculated with Increase	Total FTEs Calculated with Increase	Exam/ Procedure Rooms Calculated with Increase	Variance	Projected Physician FTEs Planned with Increase	Projected NP/PA FTEs Planned with Increase	Maximum Physician FTEs Planned with Increase	Maximum NP/PA FTEs Planned with Increase	Total Maximum FTEs Practicing Con-currently	Exam/ Procedure Rooms Calculated with Increase	Variance
Formula	A	B	C	D = B+C	E = A/D	E	F	G	H = Ax(1+G)	I = Bx(1+G)	J = Cx(1+G)	K = I+J	L = Ix3 + Jx2	M = L-E	N	O	Q	R = J/Q	P = N+O	S = Nx3 + Ox2	T = S-E
Note	1	1	1			2	2	3					4		5 and 6	5 and 6	7				
Avondale	28,620	2.35	2.80	5.15	5,557	15	5	24%	35,500	2.91	3.47	6.39	16	1	2.8	2.8	3	3	6	15	0
Guadalupe	12,124	1.25	1.65	2.90	4,181	9	0	11%	13,400	1.38	1.82	3.21	8	(1)	1.1	1.1	2	1	3	8	(1)
Chandler	30,524	4.10	2.35	6.45	4,732	19	5	28%	39,000	5.24	3.00	8.24	22	3	3.1	3.1	3	3	6	15	(4)
El Mirage	17,039	1.00	2.00	3.00	5,680	11	0	10%	18,800	1.10	2.21	3.31	8	(3)	1.5	1.5	2	2	4	10	(1)
Sunnyslope	24,212	3.40	3.40	6.80	3,561	12	0	24%	30,100	4.23	4.23	8.45	22	10	2.4	2.4	3	2	5	13	1
Mesa	24,557	4.00	1.00	5.00	4,911	17	3	-39%	15,000	2.44	0.61	3.05	9	(8)	1.2	1.2	2	1	3	8	(9)
S Central/7th Ave	40,936	7.50	4.80	12.30	3,328	34	3	28%	52,300	9.58	6.13	15.71	42	8	4.2	4.2	5	4	9	23	(11)
Maryvale	24,077	3.33	1.70	5.03	4,787	21	0	10%	26,600	3.68	1.88	5.56	15	(6)	2.1	2.1	2	2	4	10	(11)
Pendergast	Unknown	0.40	2.00	2.40	Unknown	4	3	0%	Unknown	0.40	2.00	2.40	4	0			No Change				
McDowell	Unknown	3.60	2.00	5.60	Unknown	15	3	0%	Unknown	3.60	2.00	5.60	15	0			No Change				

Note 1 Based on MIHS data.
Note 2 Based on Field Survey.
Note 3 Based on Navigant projections.
Note 4 Assumes 3 exam/procedures rooms per physician; 2 exam/procedure rooms per NP
Note 5 Approximates 3,700 annual patient encounters per primary care physician and 2,600 annual patient encounters per NP, which is approximately 50th percentile per 2014 MGMA data
Note 6 New Medical Home Model preliminary contemplates care teams consisting of 1 physician, 1 nurse practitioner and 1 care manager
Note 7 Future staffing plan to be developed in concert with MIHS in subsequent phase of planning

Program of Requirements—Model for Ambulatory Programs and Services

TABLE V-3

No.	Description	Replacement Neighborhood Centers					New Neighborhood Centers						Replacement Community Centers (Note 2)					Remarks
		El Mirage	Guadalupe	Maryvale	Mesa	Pendergast	Buckeye/ Southwest	Goodyear/ Southwest	Levine/Phoenix	North Phoenix	Peoria/ Northwest Valley	Tempe/ Scottsdale/ Phoenix	Avondale	Chandler	McDowell	South Central/ 7th Avenue (Note 1)	Sunnyslope	
1.0	**Providers**																	
1.1	FY15 Patient Visits (includes all services regardless of revenue assignment)	17,039	12,124	24,077	24,557	Unknown	0	0	0	0	0	0	28,620	30,524	Unknown	40,936	24,212	
1.2	FY16 Projected Patient Visits (FHC billed only)	14,830	10,425	21,579	18,889	5,146							24,391	26,425	18,927	39,212	20,268	
1.3	FY17 Projected Patient Visits (FHC billed only)	15,743	10,634	23,061	18,910	4,920							24,064	26,121	17,897	37,196	21,259	
1	Projected FY23 Visits (all visits)	18800	13400	26600	15000	No change	9000	9000	9000	9000	9000	9000	35500	39000	No change	52300	30100	
2	Maximum Concurrent Physicians	2	2	2	2	No change	1	1	1	1	1	1	3	3	No change	5	3	Verify with final MIHS staffing plan
2	Maximum Concurrent NP/APs	2	1	2	1	No change	1	1	1	1	1	1	3	3	No change	4	2	Verify with final MIHS staffing plan
2	Number of Residents	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	Verify requirements
2	Number of Exam/Procedure Rooms	**10**	**8**	**10**	**8**	**4**	**5**	**5**	**5**	**5**	**5**	**5**	**15**	**15**	**15**	**23**	**13**	3 exam per phys; 2 exam per NP
2.0	**Behavioral Health Consult Rooms**	**1**	**1**	**1**	**1**	0	**1**	**1**	**1**	**1**	**1**	**1**	**2**	**2**	No change	**2**	**2**	
3.0	**Dental Patient Stations**	0	0	0	0	**3**	0	0	0	0	0	0	**6**	0	**3**	**6**	0	Verify requirements
4.0	**Imaging**																	
4.1	Radiology	0	0	0	0	0	0	0	0	0	0	0	**1**	**1**	0	0	0	
4.2	Ultrasound	0	0	0	0	0	0	0	0	0	0	0	**1**	**1**	0	0	0	
4.3	Mammography	0	0	0	0	0	0	0	0	0	0	0	**1**	0	0	0	0	
5.0	**Other Clinical Services**																	
5.1	Audiology	0	0	0	0	0	0	0	0	0	0	0	**1**	0	0	0	0	
5.2	Laboratory	1	0	0	0	0	0	0	0	0	0	0	**1**	**1**	**1**	**1**	**1**	
5.3	Pharmacy	0	0	0	0	0	0	0	0	0	0	0	**1**	**1**	0	**1**	**1**	
5.4	Urgent Care Center Exam Rooms	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Verify requirements
5.5	Vision Services	0	0	0	0	0	0	0	0	0	0	0	**1**	0	0	0	0	
6.0	**Offices/Workstations Required**																	
6.1	Medical Home Care Managers	**2**	**1**	**2**	**1**	No change	**1**	**1**	**1**	**1**	**1**	**1**	**3**	**3**	No change	**4**	**2**	
6.2	Eligibility determination	2	1	2	1	No change	**1**	**1**	**1**	**1**	**1**	**1**	4	4	No change	4	3	Verify requirements
6.3	WIC Program	0	0	0	0	0	0	0	0	0	0	0	4	4	No change	4	3	Verify requirements
6.4	Other Administrative	2	1	2	1	No change	1	1	1	1	1	1	3	3	No change	4	2	Verify requirements
7.0	**Health Education Conference Room**	**1**	**1**	**1**	**1**	**No change**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**No change**	**1**	**1**	
8.0	**Family Learning Center**	0	0	0	0	0	0	0	0	0	0	0	1	1	0	1	0	Verify requirements

Note 1 Assumes existing South Central and 7th Avenue FHCs are consolidated at new Raza Development.
Note 2 Assumes existing Glendale FHC is consolidated with new Specialty Center.

Program of Requirements—Model for Preliminary Space Requirements

TABLE V-4

Bench-Mark (See Note 1)	Description	Replacement Neighborhood Centers					New Neighborhood Centers						Replacement Community Centers (Note 2)				
		El Mirage	Guadalupe	Maryvale	Mesa	Pendergast	Buckeye/ Southwest	Goodyear/Southwest	Levine/Phoenix	North Phoenix	Peoria/Northwest Valley	Tempe/Scottsdale/Phoenix	Avondale	Chandler	McDowell	SouthCentral/ 7th Avenue (Note 1)	Sunnyslope
550	Exam Rooms	5,500	4,400	5,500	4,400		2,750	2,750	2,750	2,750	2,750	2,750	**8,250**	8,250		12,650	7,150
220	Behavioral Health Consult	220	220	220	220		220	220	220	220	220	220	**440**	440		440	440
500	Dental Bays	0	0	0	0		0	0	0	0	0	0	**3,000**	0		3,000	0
1,400	Radiology	0	0	0	0		0	0	0	0	0	0	**1,400**	1,400		0	0
850	Ultrasound/Mammography	0	0	0	0		0	0	0	0	0	0	**1,700**	850		0	0
650	Audiology	0	0	0	0		0	0	0	0	0	0	**650**	0		0	0
500	Laboratory	500	0	0	0		0	0	0	0	0	0	**500**	500		500	500
500	Pharmacy	0	0	0	0		0	0	0	0	0	0	**500**	500		500	500
550	Urgent Care Exam Rooms	0	0	0	0		0	0	0	0	0	0	**0**	0		0	0
1,500	Vision Services	0	0	0	0		0	0	0	0	0	0	**1,500**	0		0	0
220	Offices	1,320	660	1,320	660		660	660	660	660	660	660	**3,080**	3,080		3,520	2,200
400	Health Education Conference	400	400	400	400		400	400	400	400	400	400	**400**	400		400	400
400	Family Learning Center	0	0	0	0		0	0	0	0	0	0	**400**	400		400	0
3-5%	General Circulation	200	200	200	200		100	100	100	100	100	100	**1,100**	800		1,100	600
5.0%	Mech/Elec/Data	400	300	400	300		200	200	200	200	200	200	**1,100**	800		1,100	600
3.5%	Building Envelope	300	200	300	200		200	200	200	200	200	200	**800**	600		800	400
	Totals	**8,800**	**6,400**	**8,300**	**6,400**		**4,500**	**4,500**	**4,500**	**4,500**	**4,500**	**4,500**	**24,800**	**18,000**		**24,400**	**12,800**

Note 1 Benchmarks represent departmental gross square feet per driver (e.g., 550 DGSF per Exam Room, etc.)

Planning and Design Considerations

- **Neighborhood and Community Centers -** Access points, sizes and approximate land requirements have been identified. Design concepts are contemplated to be developed in subsequent phases of implementation and depend on whether facilities are developed in new construction or leased facilities.
- **Specialty Centers -** Consideration is recommended for possibly incorporating the East and West Specialty Centers within a multi-use setting that considers other compatible developments and transportation access. See the following Section VI. Healthcare Village for details.
- **Roosevelt Campus -** Planning occurred to assure that the Program of Requirements would fit on the existing Roosevelt campus. The following was noted:
  - **Parking Analysis -** Preliminary parking requirements for the future Roosevelt campus were projected. See Table V-5.
  - **Fit Diagram -** A diagram follows below that illustrates that the campus could feasibly be developed to accommodate the Program of Requirements. Note that this diagram is intended to illustrate "fit" of program requirements and is not a proposed design. Considerable additional site design studies will be needed to finalize the site plan. -- **Navigant recommends site/facility designs allow for flexible future expansion of Acute and Behavioral Facilities.**

Planning and Design Considerations—Roosevelt Campus – Parking

TABLE V-5

Description	Drivers	Type	Area per Driver (sq. ft.)	Total Area (sq. ft.)	Parking Spaces Required	Total Needed	Total Provided
Acute Care Hospital	225	Beds	2,400	540,000	2.2/1000 sf	1,188	
Behavioral Health Hospital	240	Beds	1,500	360,000	2.2/1000 sf	792	
Physicians/Education Building		KSA Program		45,000	3.5/1000 sf	158	
Subtotal						**2,138**	
Warehouse Office Area		Existing Area of Offices		12,000	3.5/1000 sf	42	
2619 Building		Existing Area		74,600	3.5/1000 sf	261	
Subtotal						**303**	
CHC		Existing Area		150,000	5/1000 sf	**750**	
Ambulatory Surgery Center		4 ORs @3,400 sf + support		16,000	5/1000 sf	80	
Subtotal						**3,271**	**2,944**
New Parking Garage (net increase)							400
Total Parking Required						**3,271**	**3,344**

Note 1 100 spaces deducted from totals to accommodate handicap parking
Note 2 Assumes 600-car parking garage (i.e., 400 car variance plus 200 cars displaced by parking structure footprint)

Planning and Design Considerations—Roosevelt Campus – Site Fit Plan

VI. Healthcare Village

Healthcare Village

One of the concepts identified in the Proposition 480 Implementation Planning was the potential to develop a “healthcare village” as part of the ambulatory care network development. A healthcare village is a mixed-use setting anchored by a healthcare provider. Healthcare villages are scalable and may be developed in both urban and suburban neighborhoods. A healthcare village is a destination for the community; a branded environment which appropriately integrates healthcare with retail, commercial, education, residential and wellness services scaled by size of land and market driven needs. Demonstrating a commitment to community, development can interest both public and private entities participating in a healthcare village project since the successful outcome can have significant direct and indirect benefits to the communities it serves.

A healthcare presence in a mixed-use / healthcare village setting will be an essential strategy in meeting expectations inherent in a restructured health system where success is measured by keeping patients healthy, rather than continuing to try and maximize the changing fee-for-service paradigm.

VII. Financial Implications

Financial Implications

The scope of the financial implications portion of the Proposition 480 implementation planning involved working with MIHS to assess the impact of the implementation of Proposition 480 on MIHS' financial situation.

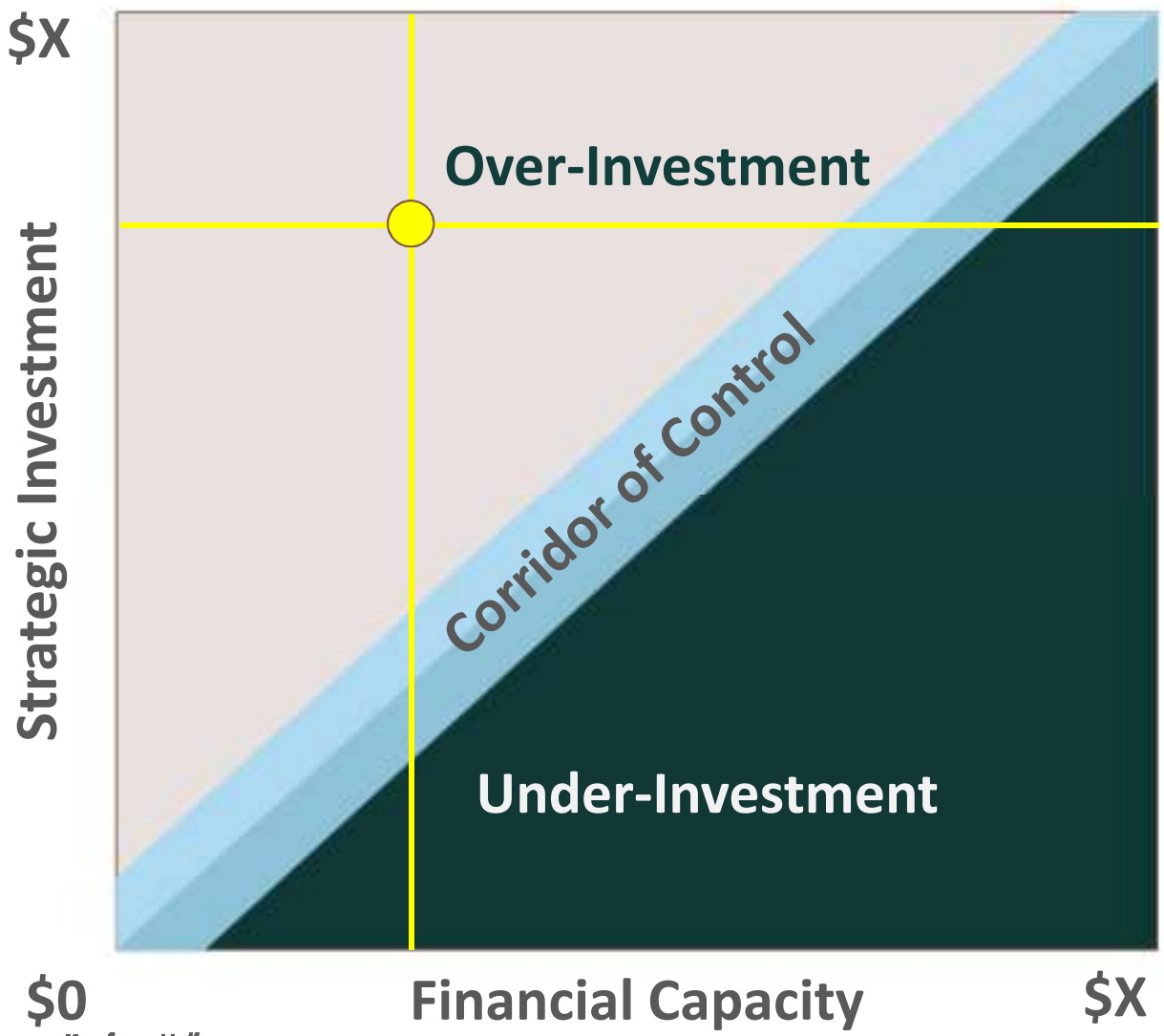
MIHS engaged Kaufman Hall to provide a financial model capable of running the financial analyses. Navigant worked closely with MIHS and Kaufman Hall on developing the key assumptions used in the financial model (the results of which are summarized in this section of the report), along with estimates of capital expenses and an analysis of probably costs.

Executive Summary (Continued)

- A long-range financial plan provides a view of the expected financial health of an organization over a specified period of time (typically 5-10 years)
  - Integrated view of operating, balance sheet and cash flow performance
  - Quantifies the impact of expected future initiatives, allowing management to link strategic and operational decision making with financial performance
  - Directional in nature and not intended to be prepared at budget level detail
- A strategic financial projection has two primary building blocks:
  - A "Current State" projection based on current operations with no new initiatives in order to provide a clean starting point from which to assess the impact of any such initiatives
  - Incremental future impacts from strategic and operating initiatives which are layered over the "Current State" projection
- For many organizations, a "Current State" financial projection scenario demonstrates the need for future performance improvement in order to maintain financial strength and stewardship of resources
  - Industry-wide operating pressures have resulted in eroding margins, increased competition and a rapid evolution to new business and care delivery models

Source: KaufmanHall

Executive Summary (Continued)



Source: KaufmanHall

The corridor of control is the balancing point between two opposing goals:

1. Compete as effectively as you can, which requires aggressive investment of capital and commitment of operating dollars, BUT
2. Respect the fiduciary role of management and the Board to maintain the long-term financial integrity of a community asset.

Executive Summary (Continued)

- The purpose of the analysis is to assess the affordability of the proposed strategic capital projects
  - Critical Question: What is the right scope and portfolio of projects that will allow MIHS to continue to serve its mission without compromising long-term financial viability?
- Management and the Board have performed thorough and thoughtful due diligence on the impact of the proposed projects on the long-term financial health of the organization
- Management and the Board have identified a mix of projects with a total cost of $829 million that will meet the objective to expand access to high-quality healthcare in Maricopa County while also allowing MIHS to maintain an appropriable amount of available cash reserves throughout and beyond all phases of project implementation
- Although a ten-year financial projection requires assumptions about future performance, a conservative approach demonstrates that the projects will support stewardship of essential community assets by leaving MIHS in a stronger strategic and financial position at the end of the construction period
- The recommended project scope therefore fits conservatively within the bounds of the corridor of control, allowing the system to serve as a model safety net provider while maintaining sufficient financial flexibility

Source: KaufmanHall

Executive Summary (Continued)

- A Total project cost of $829 million has been considered

» The analysis includes all capital investment required for the projects along with the associated Bond Tax Levies, debt service payments and depreciation expense

» **In order to evaluate the projection scenario results, the primary metrics to focus on are Cash Flow, Total Unrestricted Cash and Days Cash on Hand**

» Volume growth from new sites has been modeled based on current levels, with normal future growth and inflation assumptions applied system-wide

  › Reasonable assumptions have been made to model incremental strategic growth from the initiatives. However, the analysis is not an attempt to measure operational or payer mix improvements or other benefits that may result from these or future new strategies other than those already included in the analysis

» **All scenarios assume successful implementation of planned performance improvement initiatives by FY 2020**

Source: KaufmanHall

Executive Summary (Continued)

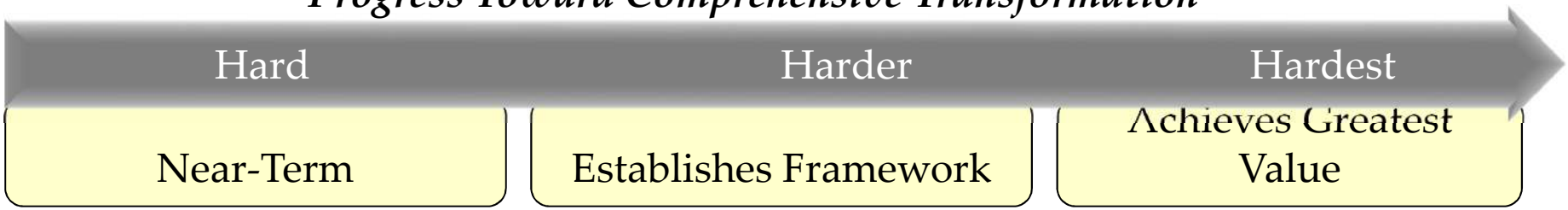
- The financial projections have been developed with appropriate rigor and at a level of detail sufficient for evaluating the proposed projects
  - Projection models built using a healthcare specific long-range planning software tool
  - Underlying detail includes breakouts of major acute and non-acute service lines to allow for scenario and sensitivity analysis
  - Construction costs and timing of capital expenditures tied directly to the work prepared by Navigant Healthcare
  - Capital and operating impact of each individual project development and layered in independently
  - Operating impact of new sites based on historical information from existing clinics
- The projections assess the future financial health of MIHS inclusive of the Prop 480 projects
  - Results have allowed management and the Board to evaluate expected annual operating, balance sheet and cash flow performance over a ten-year period
- The financial projections incorporate the objective of financial stewardship by incorporating assumptions demonstrating a commitment to continued operational improvement and the responsible use of resources

Source: KaufmanHall

Executive Summary (Continued)

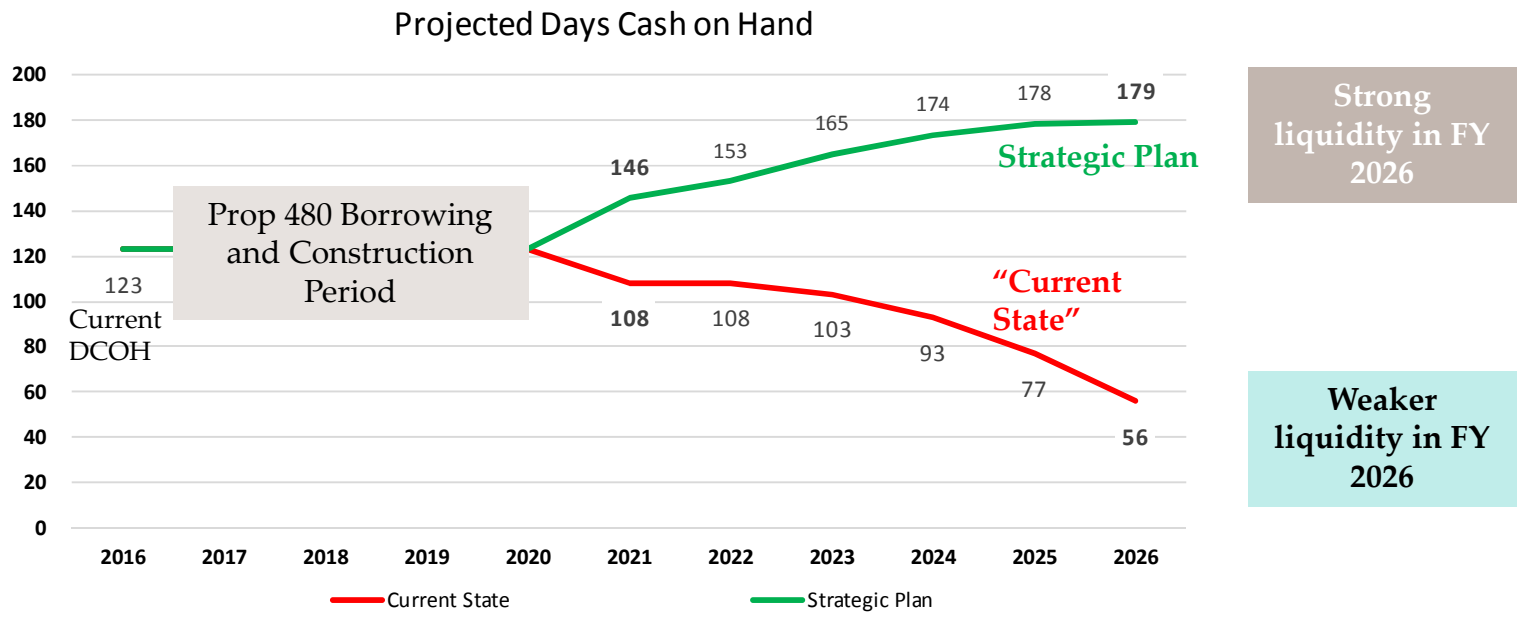
Cost Restructuring/ Margin Improvement	*Business Restructuring*	*Clinical Transformation/Value Creation*
☐ Productivity	☐ Business Line Portfolio Review	☐ Clinical Integration Programs
☐ Service Delivery Costs (e.g., staffing)	☐ Optimization of Product Offerings	☐ Value Creation (e.g., paid for value, and at risk if not achieved)
☐ Overhead Costs (e.g., duplicate mgmt. positions)	☐ Service Distribution Planning	☐ Clinical Variation
☐ Revenue Cycle	☐ Enhanced Capital Allocation	☐ Care Processes
☐ Supply Chain/Purchased Services	☐ Enhanced Non-Operating Performance	

Progress Toward Comprehensive Transformation



Source: KaufmanHall

Executive Summary (Continued)



Strong liquidity in FY 2026

Weaker liquidity in FY 2026

- Market headwinds are too strong to overcome without a strategic plan that addresses a dynamic industry and changing forms of delivery
- Liquidity in the "Current State" will be a serious concern if no strategic investment in the system is made
- Implementing the strategic capital plan will improve the organization's future financial position and enhance its ability to meet community need

Source: KaufmanHall

Executive Summary (Continued)

$ in millions	FY 2017 - FY 2026			
	Total Uses of Funds	Total Sources of Funds	Total Cash Flow Surplus/(Shortfall)	Avg. Annual Surplus/(Shortfall)
Strategic Plan	$1,360,254	$1,570,355	$210,101	$21,010

Comfortable Surplus

- **Total Uses of Funds include:** capital expenditures (Prop 480 funded, additional strategic and routine), principal payments on debt, working capital and target FY 2026 cash balance
- **Total Sources of Funds include:** Prop 480 debt, bond tax levies, general tax levies, operating cash flow and current cash balance

The Average Annual Cash Surplus of $21.0 million demonstrates that MIHS will have sufficient resources to fund all identified uses of cash while also building cash reserves during the ten-year period from 2017 to 2026.

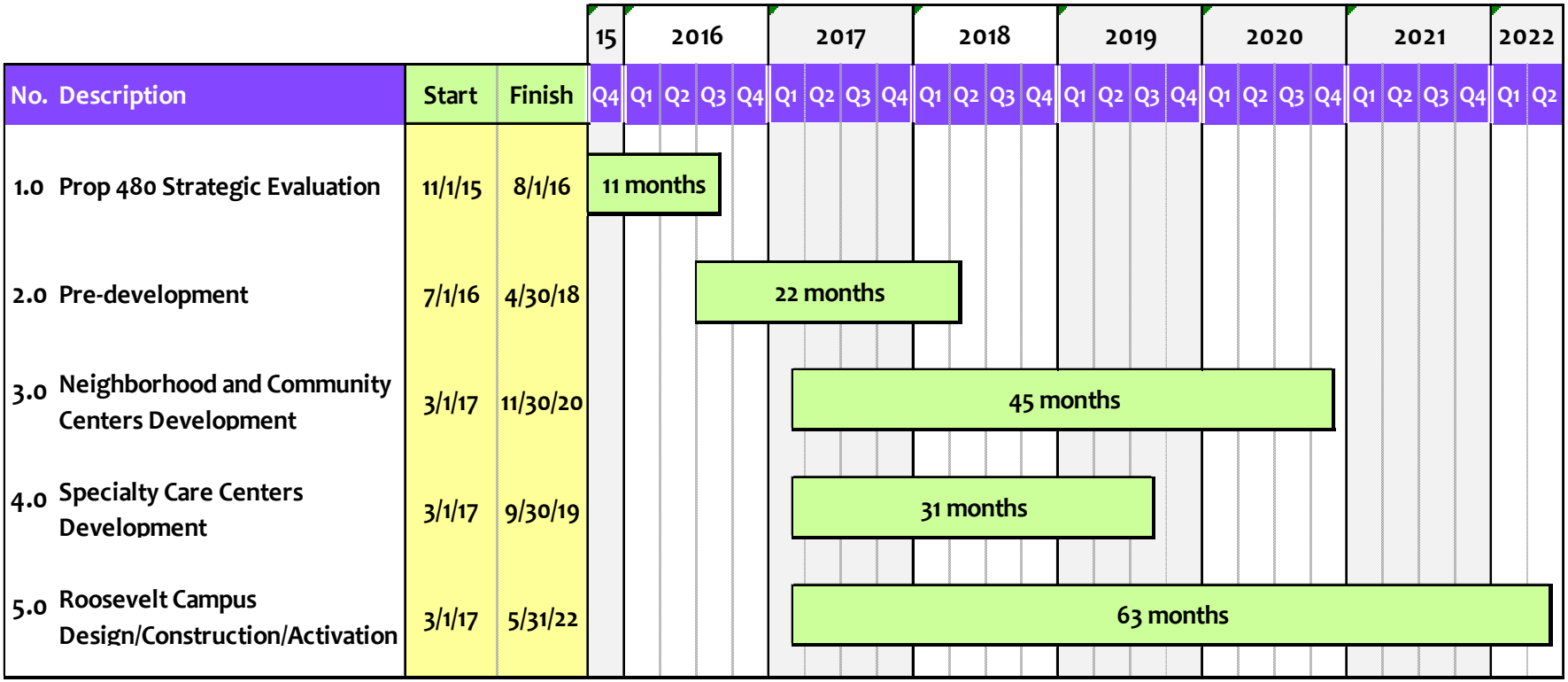
Source: KaufmanHall

VIII. Implementation

Implementation Plan—Preliminary Overall Timeline

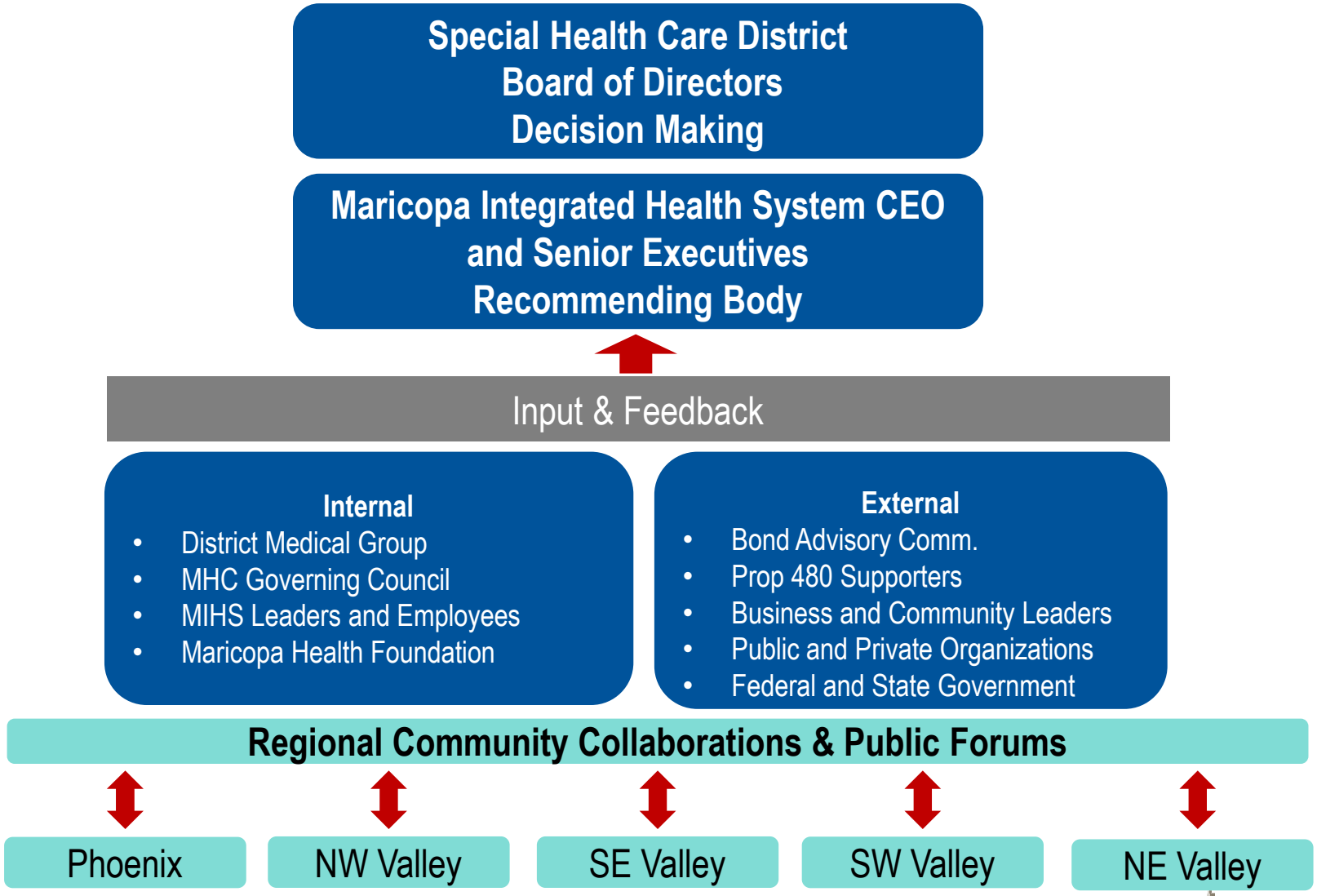
A preliminary overall timeline was developed and is illustrated on the following page. While the following timeline is somewhat aggressive, it is achievable and may even be shortened based on the assumption "fast track" design and construction methodology and approach will be implemented as well as Prototypical and Standardized program, design and construction techniques will be implemented on Community, Neighborhood and Specialty Centers . It is important to note that the faster the project can be implemented, the lower the escalation premiums will be, freeing funding for additional development. Escalation has been estimated at 3.425% annually. This is equivalent to $2+ million monthly decrease in the value of funding; therefore, an expedited implementation plan is very important.

Project Implementation Schedule

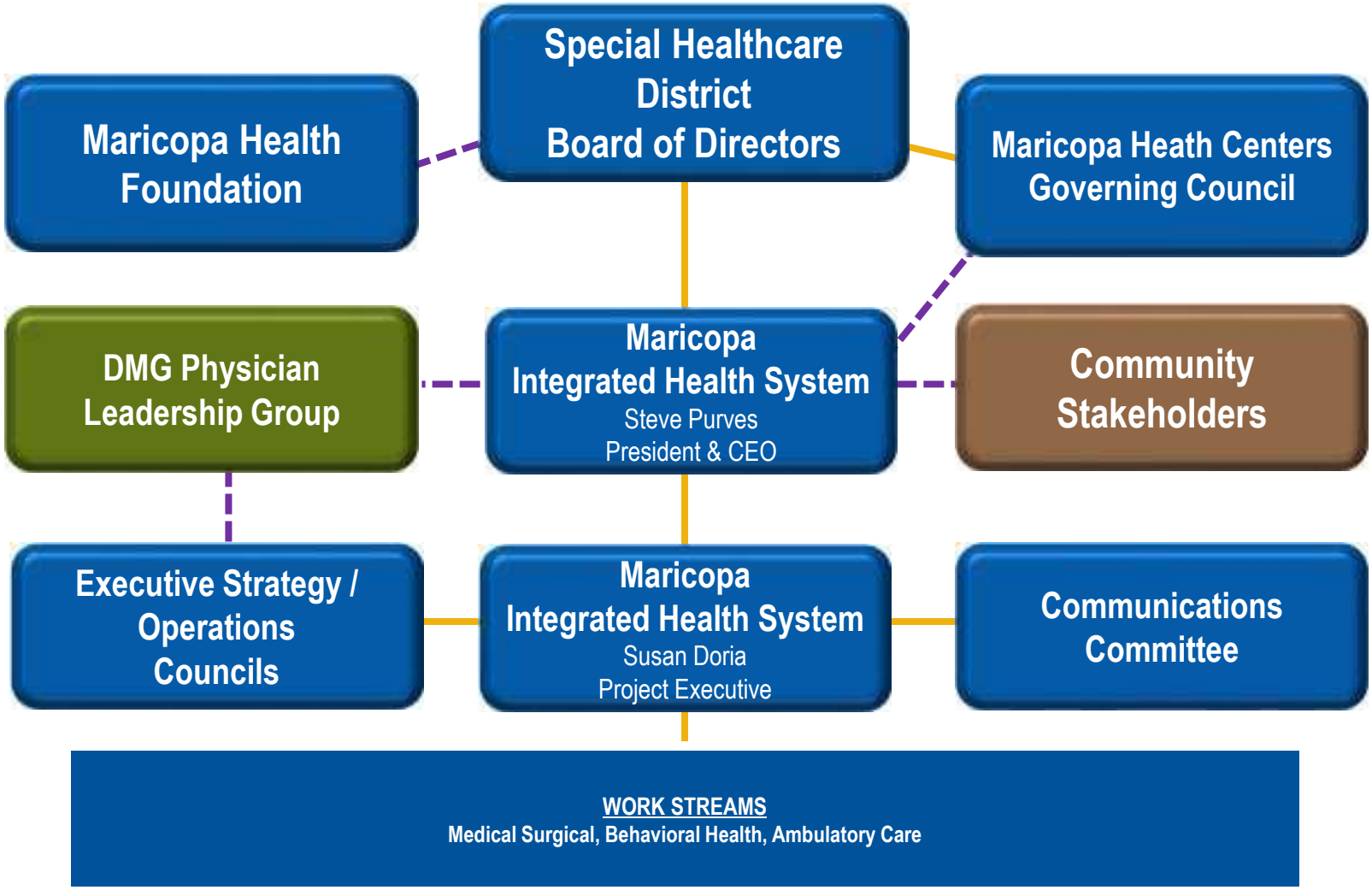


IX. Appendix

Prop 480 Community Engagement and Communication



Prop 480 Project Organization & Governance Structure



DRAFT

Community Engagement Plan

Strategy 1

Internal & External On-going Communication

- **Audience**
  - Internal Stakeholders – DMG, MIHS Governing Council, MIHS leaders & employees, MIHS Foundation.
  - External Stakeholders – Bond Advisory Committee, Prop 480 Supporters, Key influencers, Potential partners.
- **Communication Approach**
  - Monthly talking points
  - Prop 480 implementation planning meetings
  - CEO newsletters
  - Leadership meetings and employee forums
  - Electronic messages
  - Outreach phone calls
  - One-on-one meetings

Strategy 2 (to be executed)

Regional Public Forum with Stakeholders, Key Influencers, Potential Partners

- **Audience**
  - Internal Stakeholders – DMG, MIHS Governing Council, MIHS leaders & employees, MIHS Foundation.
  - External Stakeholders - Bond Advisory Committee, Prop 480 Supporters, Key influencers, Potential partners.
  - Individuals and organizations identified as co-host, sponsors, or speakers.
- **Communication Approach**
  - Essential Health Summit
    - Day 1: Evening dinner with a key note national inspirational speaker.
    - Day 2: Full day session of panel discussions and group break-outs.

Strategy 3

Market-Level Community Planning & Collaboration

- **Audience**
  - Market Level Internal Stakeholders – DMG, MIHS Governing Council, MIHS leaders & employees, MIHS Foundation.
  - Market Level External Stakeholders - Bond Advisory Committee, Prop 480 Supporters, Key influencers, Potential partners.
  - Potential partners defined more broadly to those who address clinical as well as economical issues / opportunities.
- **Communication Approach**
  - Planning meetings with the following markets: Central Valley, Northwest Valley, Southwest Valley, Southeast Valley.

The "Triple Aim" is the New Touchstone

How will emphasis on quality vs. quantity
influence future strategies such as
payment models, physician networks, and technology?

"The Best Care, for the Whole Population, at the Lowest Cost"

Metrics:
- QUEST outcomes
- Select HEDIS metrics
- Health status
- Mortality rates

Population Health

INSTITUTE FOR HEALTHCARE IMPROVEMENT

Metrics:
- Total medical PMPM
- Total Medical Trend
- Total Rx PMPM
- Admissions / 1000
- Readmission rate

Metrics:
- Patient satisfaction
- Patient Activation Measure scores

Experience of Care

Per Capita Costs

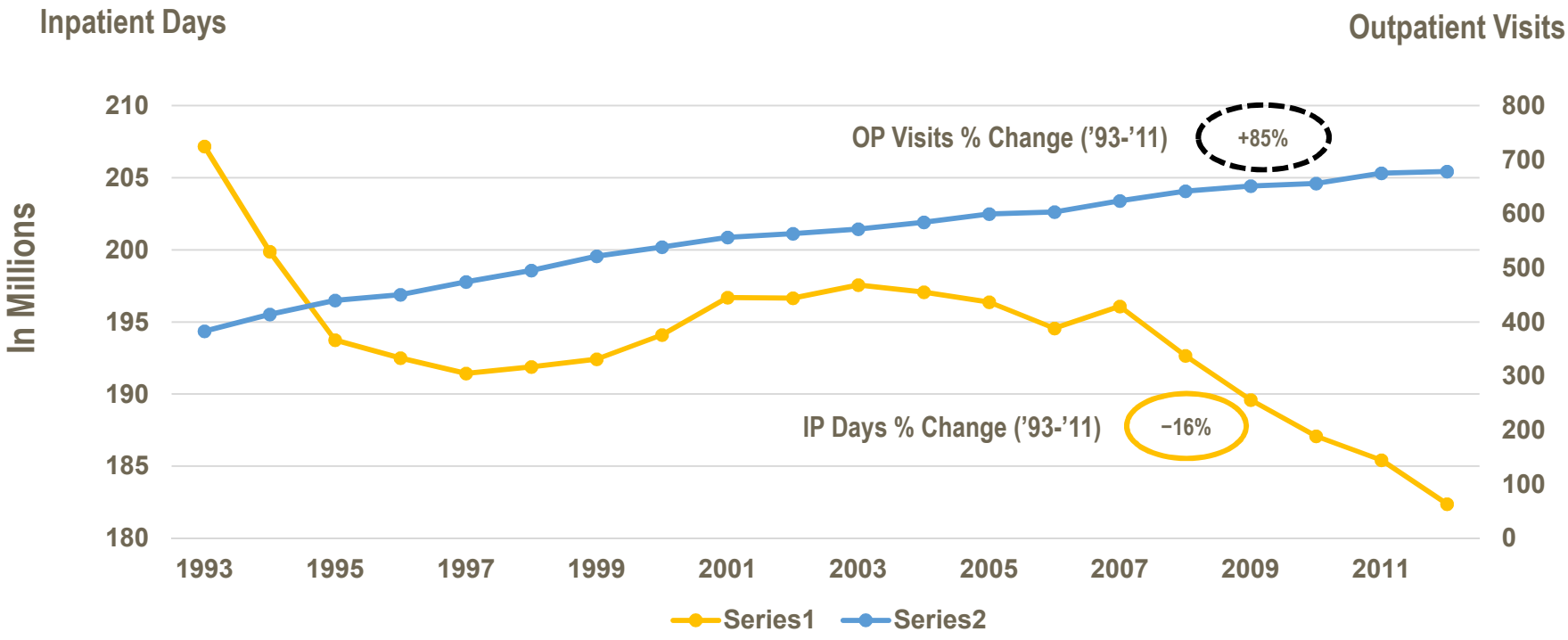
The term "Triple Aim" is a trademark of the Institute for Healthcare Improvement

NAVIGANT HEALTHCARE

Foundational Shift in the Sites Of Care…

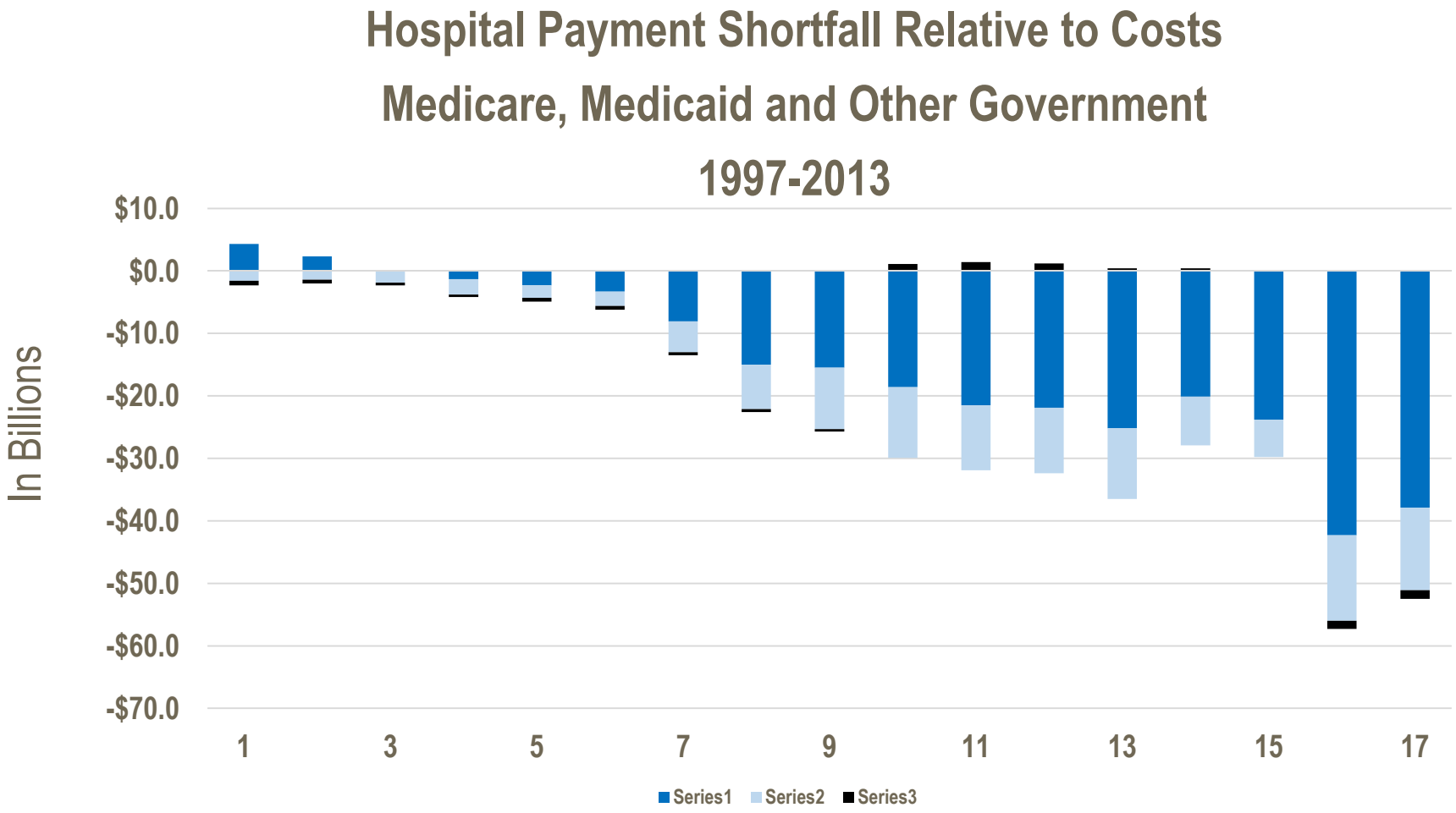
How will national and regional utilization trends influence service line growth strategies?

National Inpatient Days and Outpatient Visits, 1993-2011



Source: AHA Trendwatch Chartbook, 2013.

…Combined With Declines in Reimbursement…



Source: AHA Trendwatch Chartbook, 2013.

…And Met With The Impact of The Affordable Care Act…

Decrease Costs → **Increase Access** → **Improve Quality**

Population Health

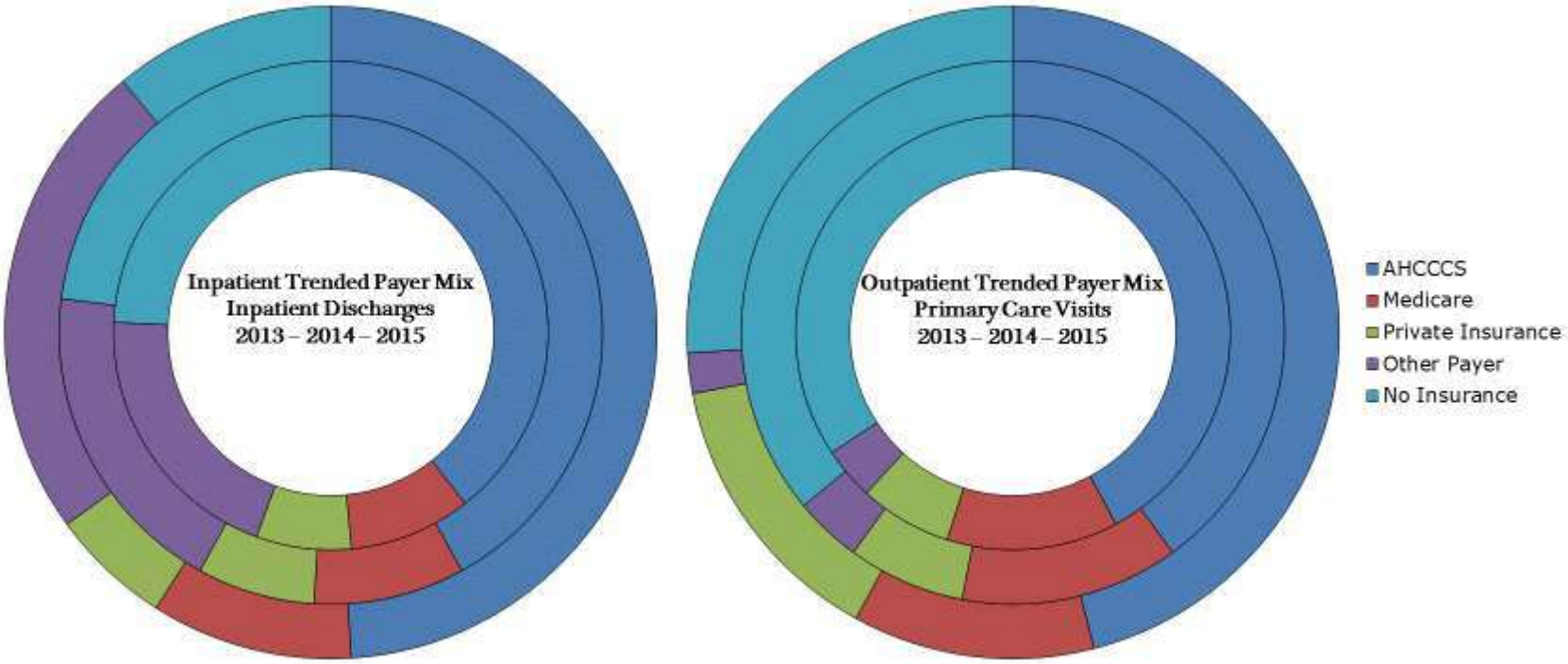
- Delivery system reform
- Public health, prevention and wellness investments
- Payment constraints
  - Hospital market basket reductions
  - Hospital productivity adjustments
  - DSH payment reductions

- Coverage and benefit requirements
  - Elimination of restrictions
  - Mandates
  - Essential benefits
  - Dependent coverage
- Premium subsidies
- Medicaid Expansion
- Exchanges expand competition of choice

- Care delivery provisions
- Evidence-based guidelines
- Expanding use of IT
- Transparency provisions
- Quality provisions

…Have Created Increased Access…

With the ACA reducing the number of uninsured lives, what strategies will MIHS use to be a provider of choice?

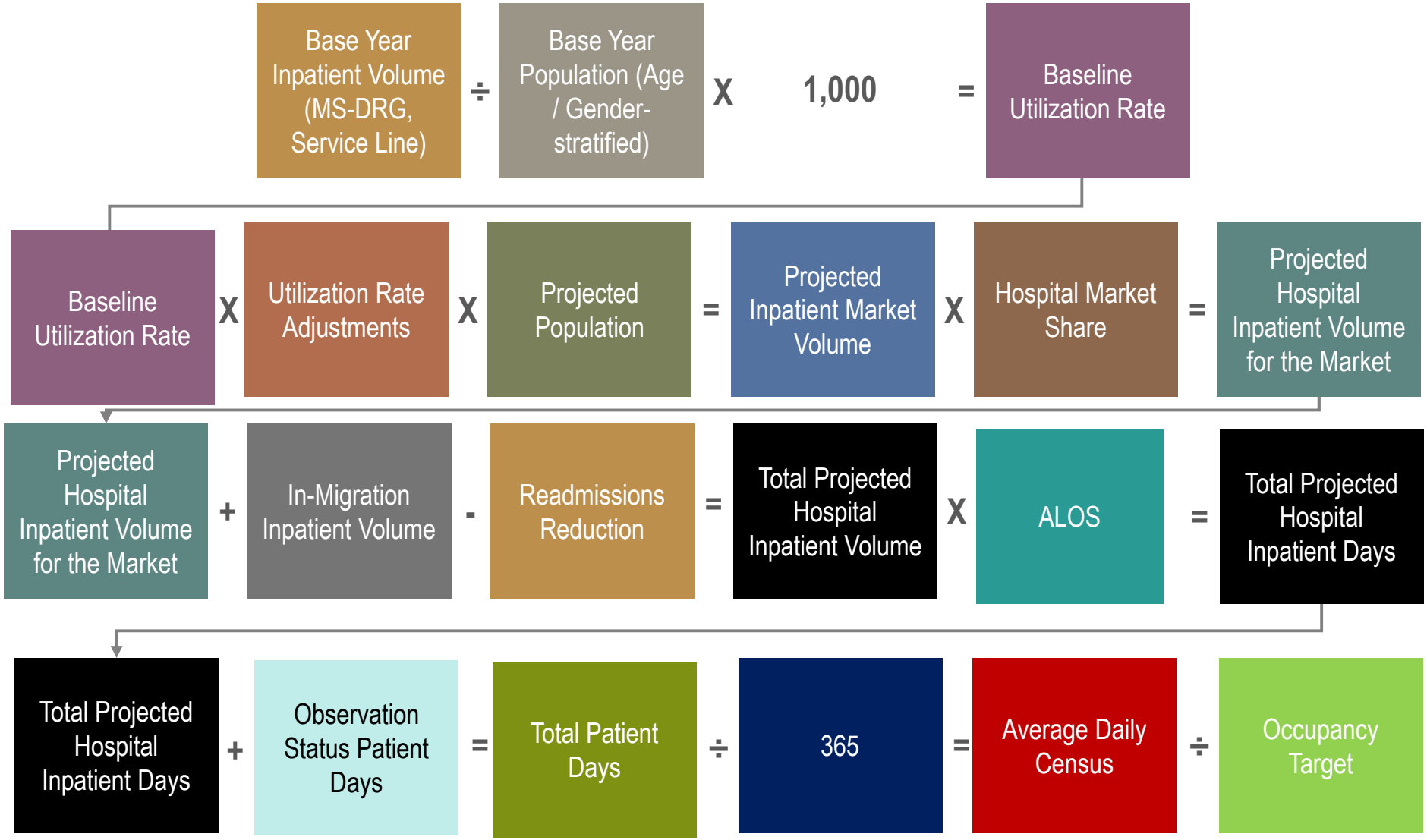


Source: MIHS website (http://grants.mihs.org/uploads/sites/41/Compendium2014_2015.pdf

And New Paradigms in the Arizona Market…

The Arizona healthcare industry is a vital one, with changing regulations affecting both the provider and payer landscape.

Bedded Patient Days Were Projected Based on Market Trends and Current Observation Stay Experience



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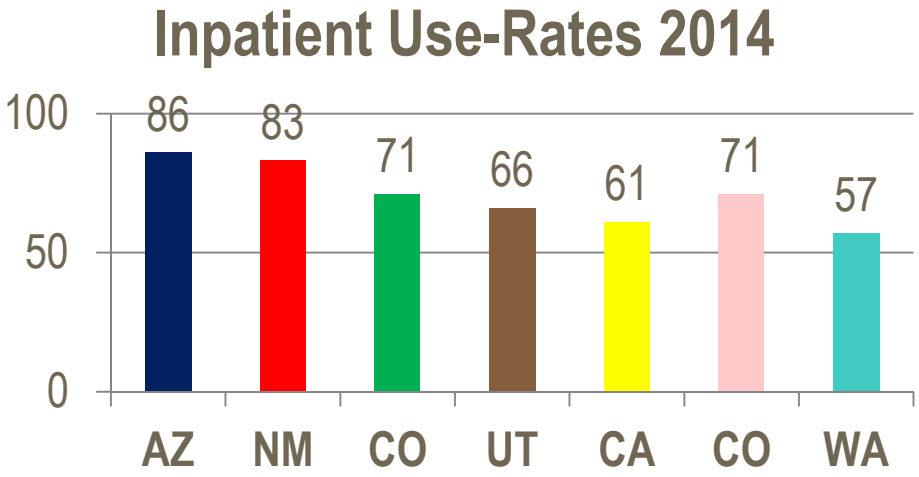
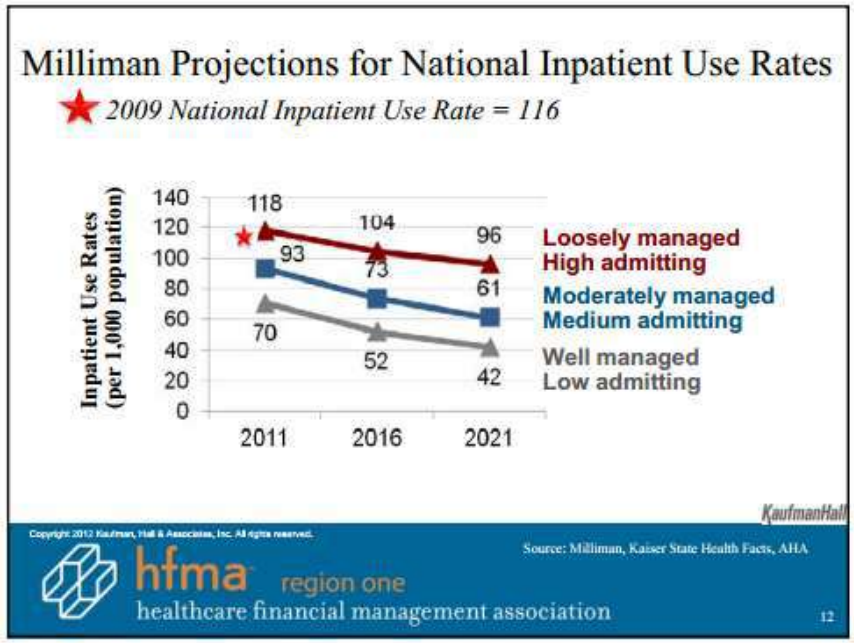
We Expect That While AZ Use-rates are Less Than National Rates, They Still are Likely to Decrease Further

"Hospital systems are setting their strategic plans with the assumption that inpatient care will continue to decline."

Modern Healthcare, February 24, 2014



Source: AHA



NAVIGANT HEALTHCARE

Pediatric Inpatient Behavioral Health Discharges for Maricopa County Residents By Hospital

Hospital	< 18 yr. old	
	2014 Discharges	2014 Patient Days
St. Luke's Behavioral Health Center	811	8,577
Maricopa Integrated Health System	8	51
Banner Behavioral Health Hospital - Scottsdale	820	7,615
Aurora Phoenix Hospital	1,280	8,784
Aurora Tempe Hospital	778	6,698
Oasis Behavioral Health Hospital	738	5,900
Phoenix Children's Hospital	569	4,372
All Others	1,357	13,265
Total	**6,361**	**55,262**

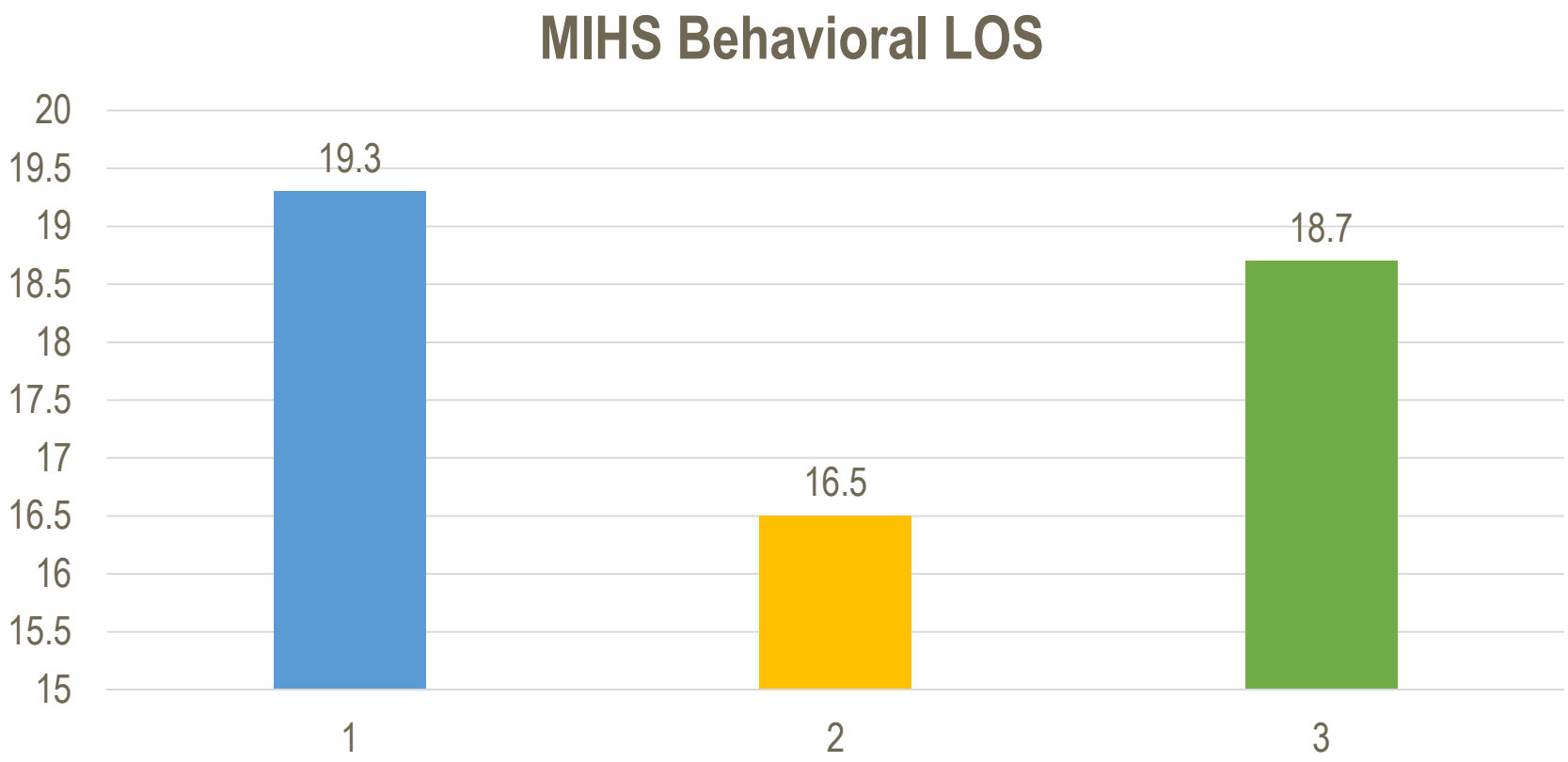
Source: ADHS State Discharge Data; Navigant analysis

Combined (Adult and Pediatric) Occupancy Rates for Largest Maricopa County Providers Varies

Top Behavioral Facilities in Maricopa County	2014 ADC	Beds	2014 Occupancy
St. Luke's Behavioral Health Center	115	124	93%
Maricopa Integrated Health System	154	190	81%
Banner Behavioral Health Hospital - Scottsdale	75	95	79%
Valley Hospital Phoenix	87	122	71%
Aurora Phoenix Hospital	82	90	91%
Aurora Tempe Hospital	63	75	83%
Banner Thunderbird Medical Center	38	62	61%
Banner University Medical Center Phoenix Campus	18	22	84%
Banner Del E. Webb Medical Center	19	34	55%
Haven Senior Horizons	21	30	70%
St. Luke's Medical Center	25	36	69%
Oasis Behavioral Health Hospital	28	64	44%

Source: ADHS State Discharge Data; Navigant analysis

There Was Not a Clear Trend in MIHS Behavioral Length of Stay From 2012-2014



Source: ADHS State Discharge Data; Navigant analysis

Maricopa County Behavioral Health Bed Need In-Migration

In-migration

» The proportion of patients who reside outside of Maricopa County that are admitted to MIHS is projected to remain constant in all scenarios.

In-migration Assumptions

Year	In-migration
2012	10.2%
2013	11.7%
2014	11.5%
2024 (Projected)	11.5%

Source: ADHS State Discharge Data; Navigant analysis

The proportion of behavioral health patients from outside of Maricopa County increased from 2012 to 2014
What are the implications and opportunities of this trend?

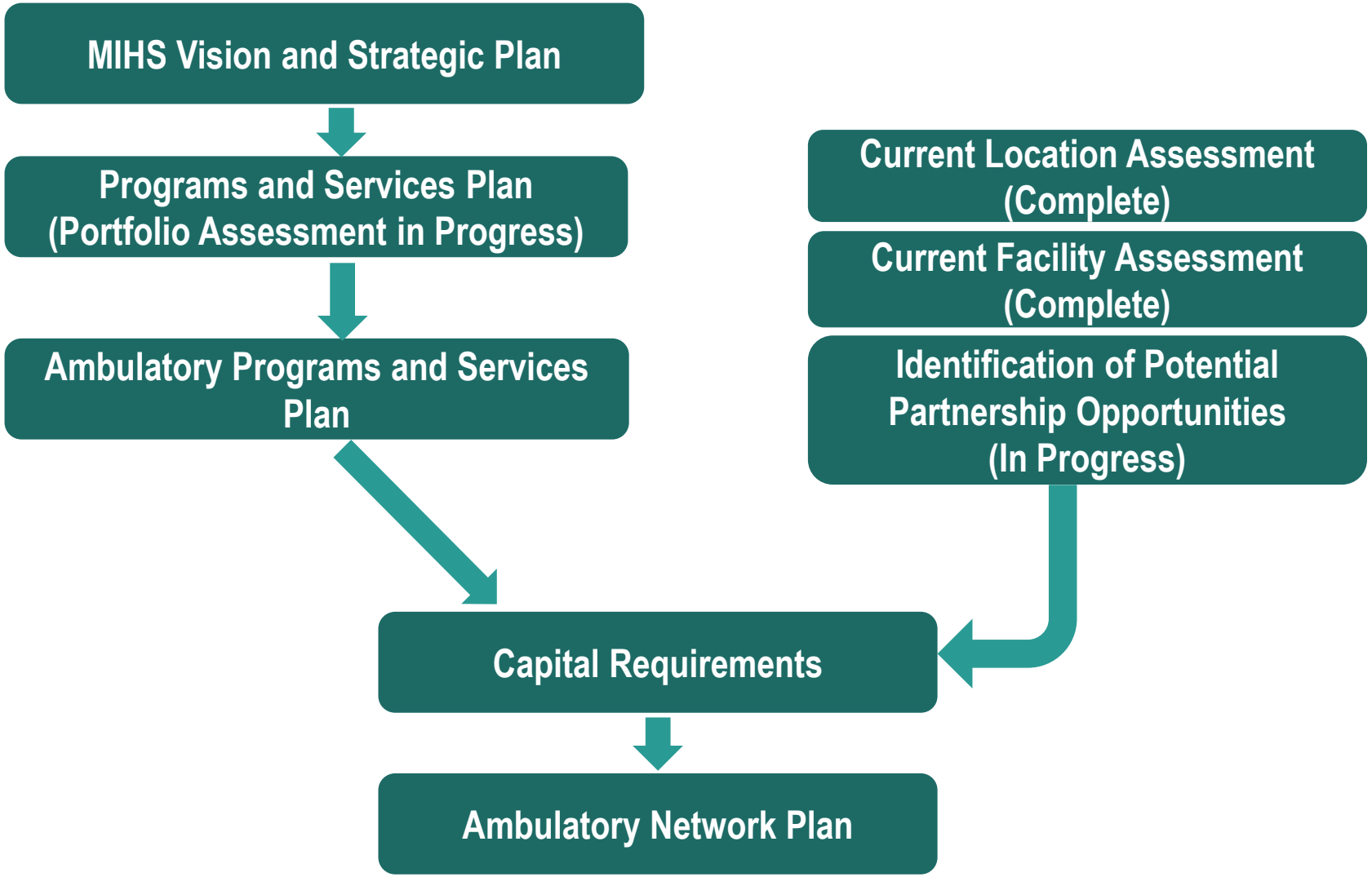
MIHS' Ambulatory Network Will Provide a Foundational Building Block to its Transformation to Population Health

1. The new indicator of meeting community need is **not the number of beds**, but the **location and number of primary care assets**, including retail clinics, within a market.

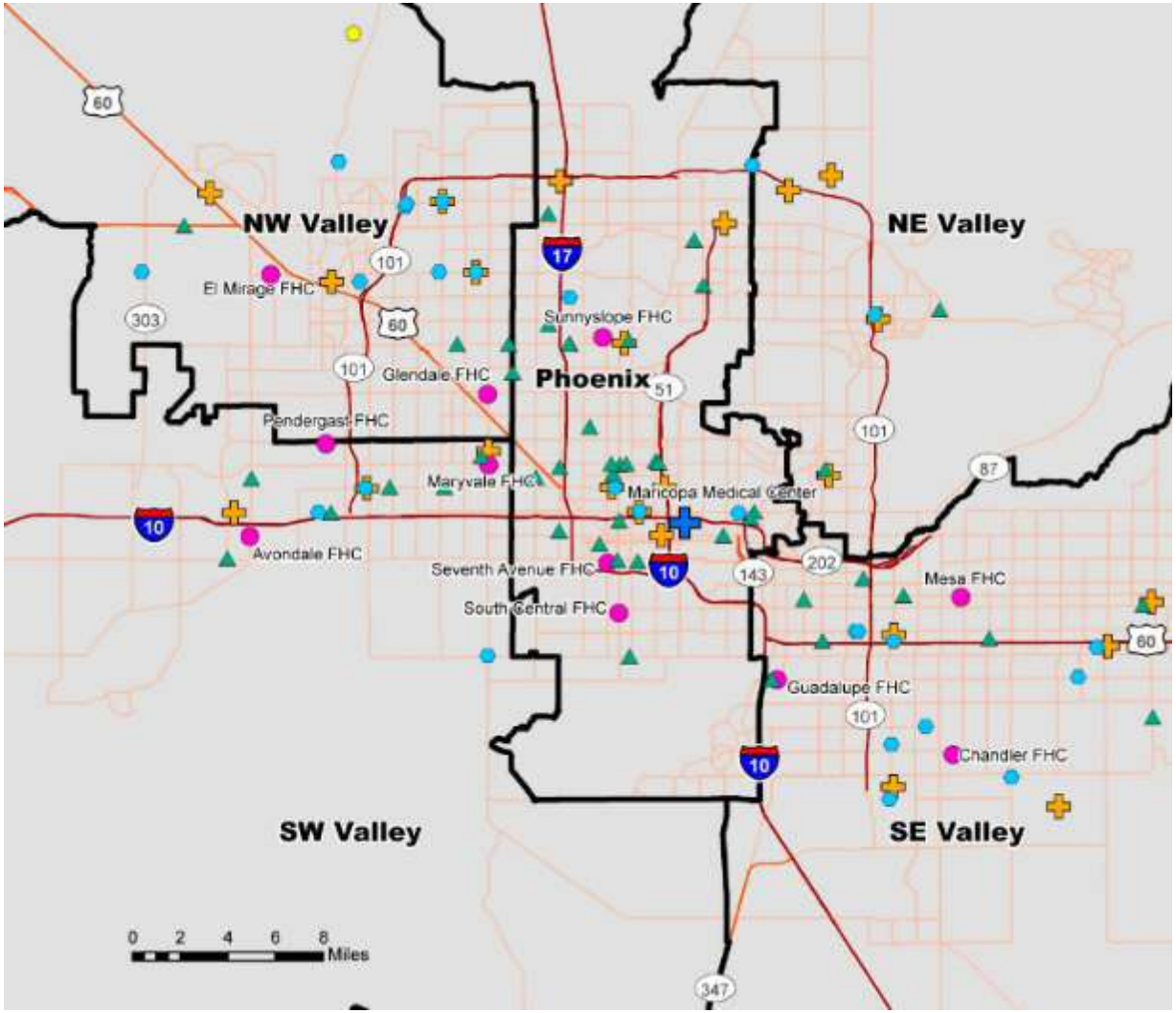
2. Market definitions should no longer be based on hospital service areas, but instead be **correlated with covered-live distributions** within defined products.

3. Historical fee-for-service (FFS) competitors represent potential partners in a value-based world. A **network must cover the entire continuum of care**, though expansion can be achieved via many tactics, including participation or full ownership.

Ambulatory Network Strategy Development



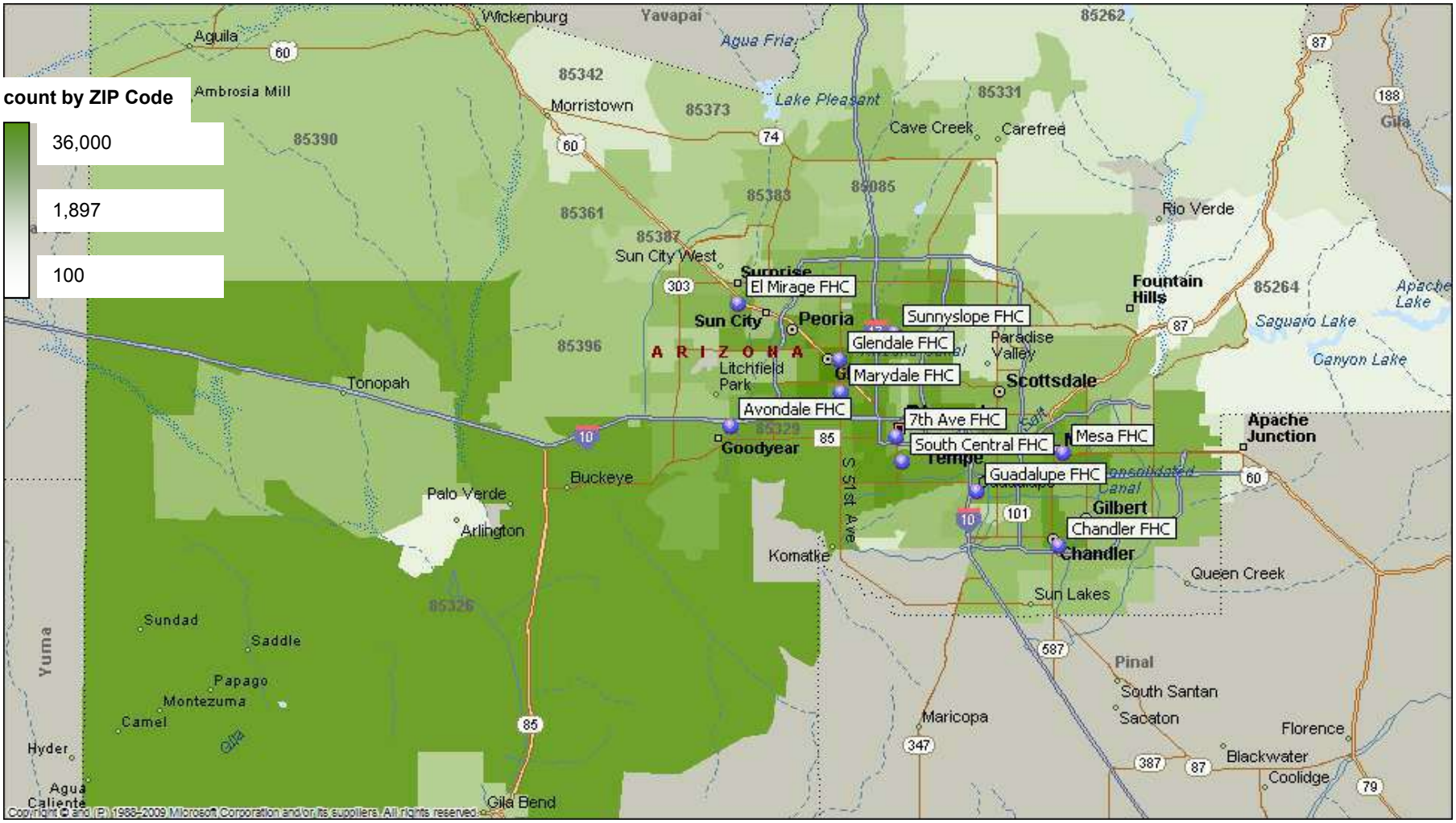
MIHS' Family Health Centers are Distributed Across Maricopa County



- Maricopa Medical Center
- Other Hospitals
- ASC
- Free standing ED
- FHC Clinics
- Market FQHCs
- Valley Region Subdivisions

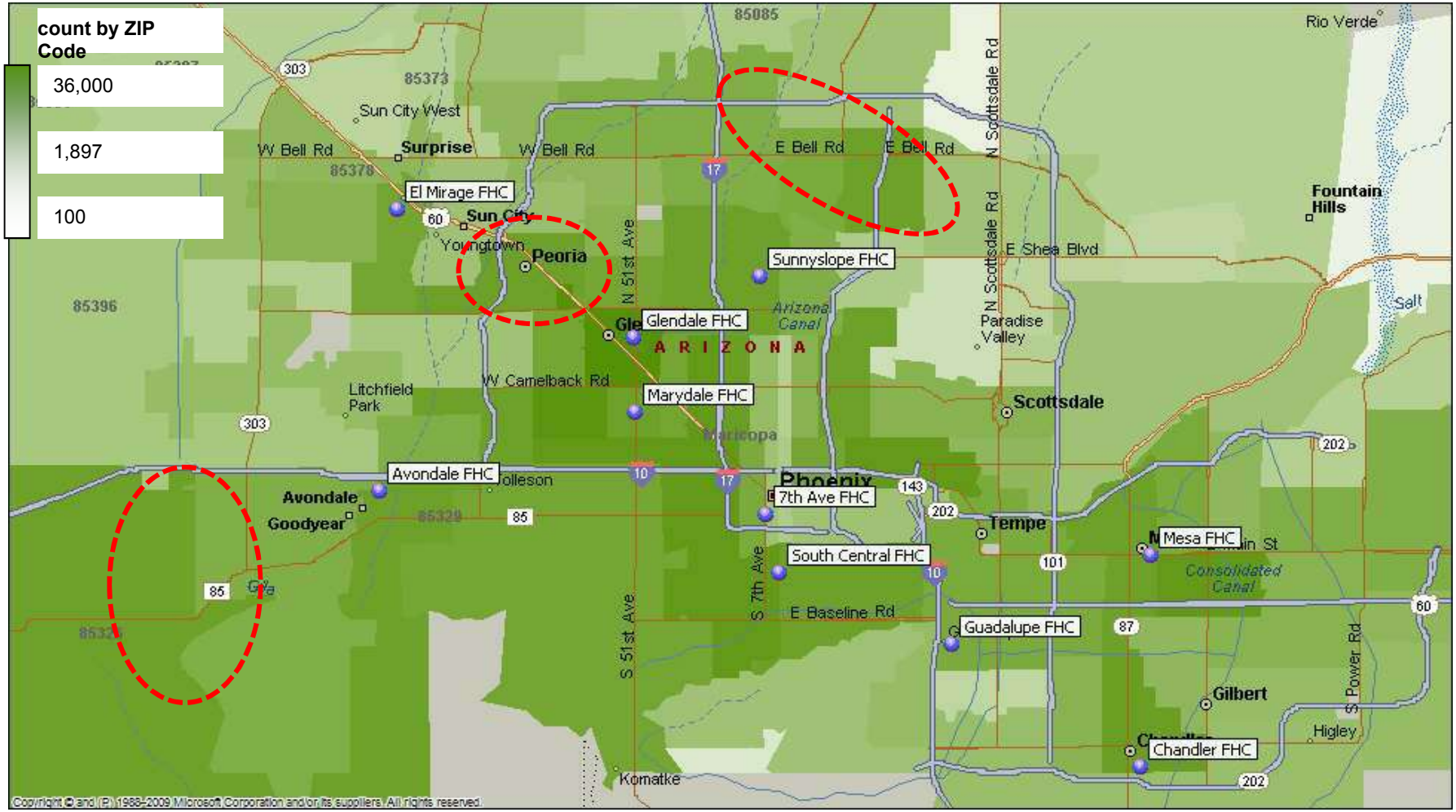
While primary care services are fairly well distributed, most specialty care is only available on the main CHC / Hospital campus

AHCCCS Enrollment in Maricopa County



NOTE: *Excludes zip codes with less than 100 enrollees*

AHCCCS Enrollment by Zip Code Suggests Several Potential Areas for Targeted Ambulatory Expansion



NOTE: *Excludes zip codes with less than 100 enrollees*

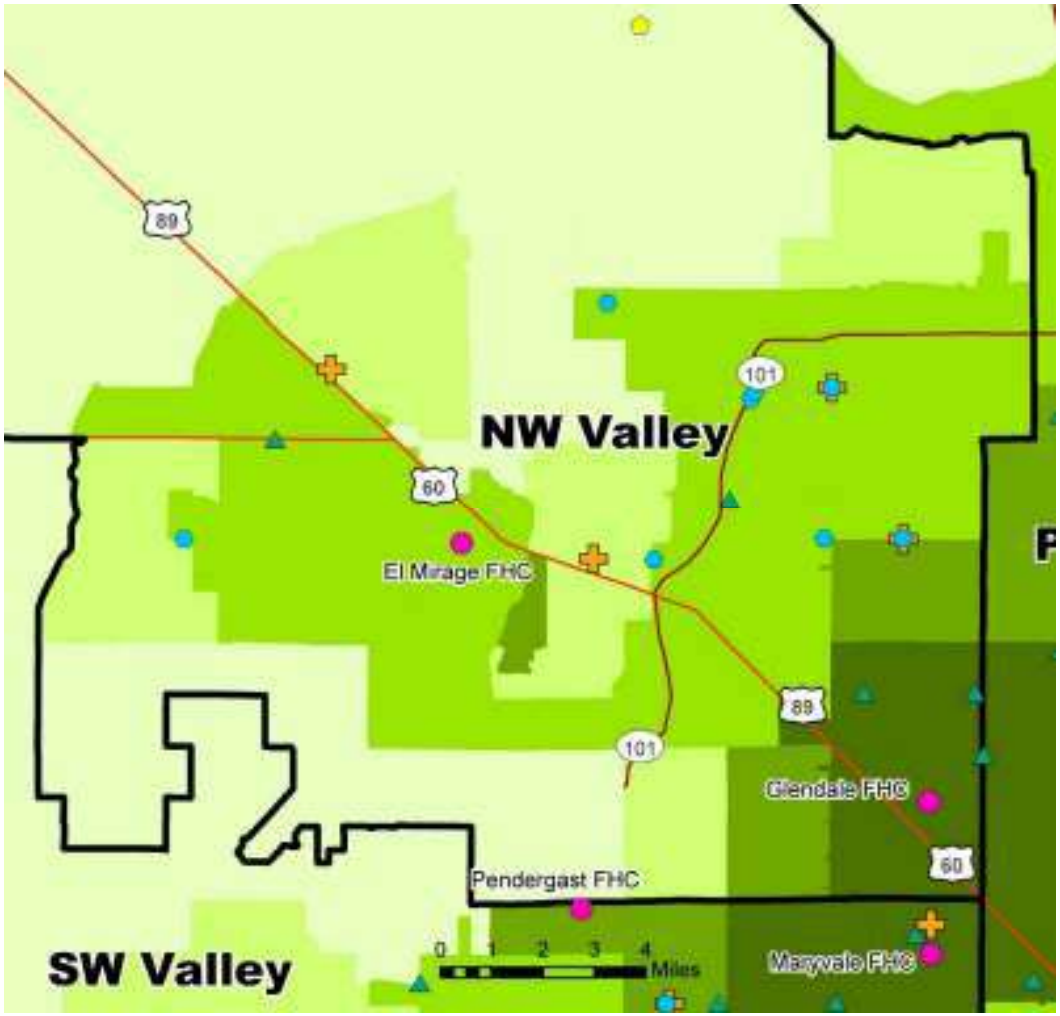
Proposed but Not Yet Implemented Federal Exchange Requirements Specify Targeted Time and Distance Standards for Network Adequacy

Specialty Area	Maximum Time and Distance Standards (Minutes/Miles)				
	Large	Metro	Micro	Rural	CEAC
Primary Care	10/5	15/10	30/20	40/30	70/60
Dental	30/15	45/30	80/60		
Endocrinology	30/15	60/40	100/75	110/90	145/
Gynecology (OB/GYN)	30/15	45/30	80/60	90/75	125/110
Infectious Diseases	30/15	60/40	100/75	110/90	145/130
Oncology - Medical/Surgical	20/10	45/30	60/45	75/60	110/100
Oncology - Radiation/Radiology	30/15	60/40	100/75	110/90	145/130
Mental Health	20/10	45/30	60/45	75/60	110/100
Pediatrics	30/15	45/30	80/60	90/75	125/110
Cardiology	20/10	30/20	50/35	75/60	95/85
Rheumatology	30/15	60/40	100/75	110/90	145/130
Hospitals	20/10	45/30	80/60	75/60	110/100
Outpatient Dialysis	30/15	45/30	80/60	90/75	125/110
Inpatient Psychiatric Facility Services	30/15	70/45	100/75	90/75	155/140

For each specialty, the issuer would need to provide access to at least 1 provider for 90% of enrollees. For example, for a metro area, 90% of enrollees should have access to at least 1 primary care provider within 15 minutes or 10 miles

Northwest Valley

In the Northwest Valley, the Population Is Most Concentrated In Areas Currently Served by the Glendale and Maryvale FHCs



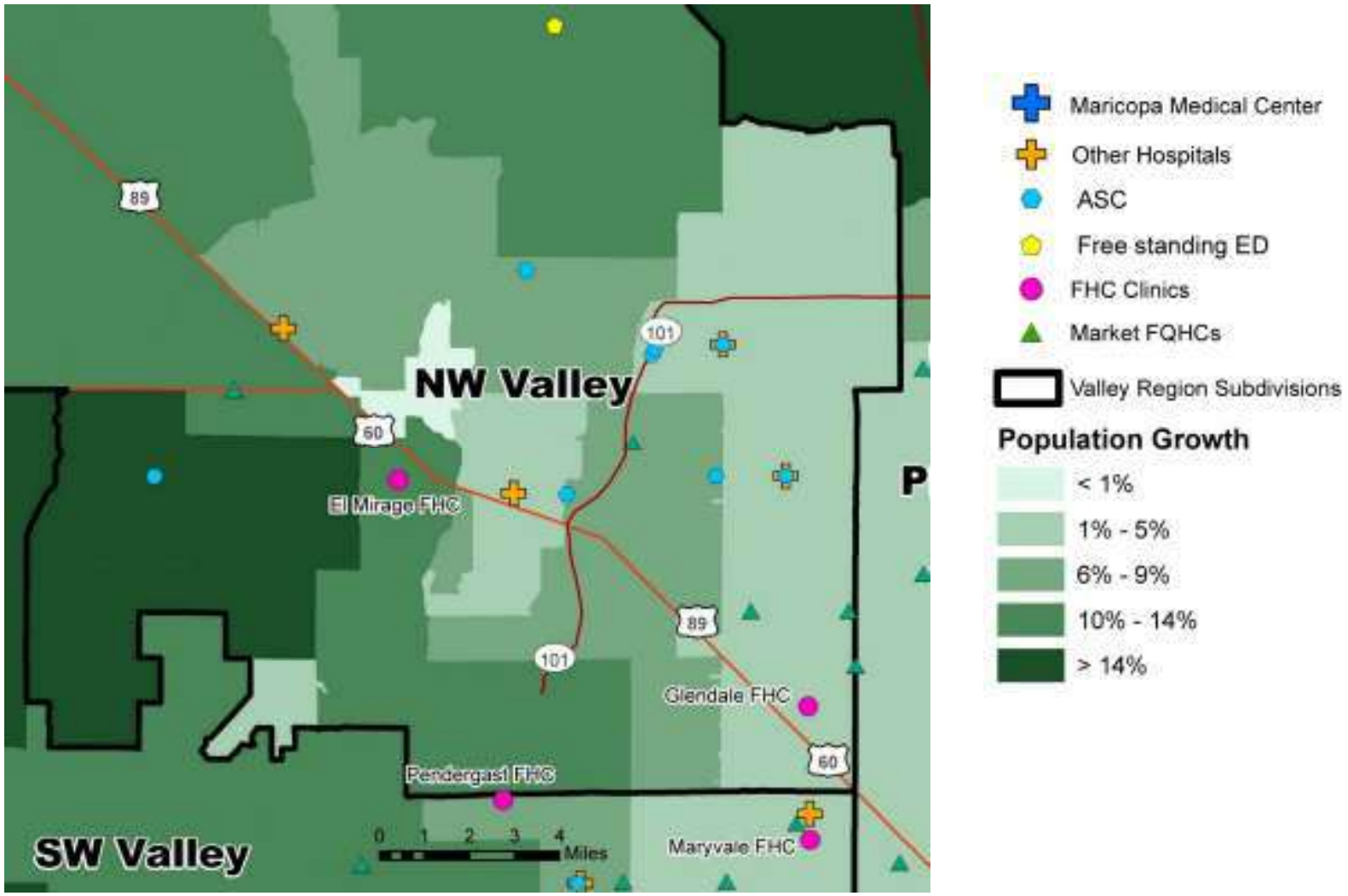
Maricopa Medical Center
Other Hospitals
ASC
Free standing ED
FHC Clinics
Market FQHCs
Valley Region Subdivisions

Population Density

< 1,200
1,200 - 2,700
2,700 - 4,400
4,400 - 6,000
> 6,000

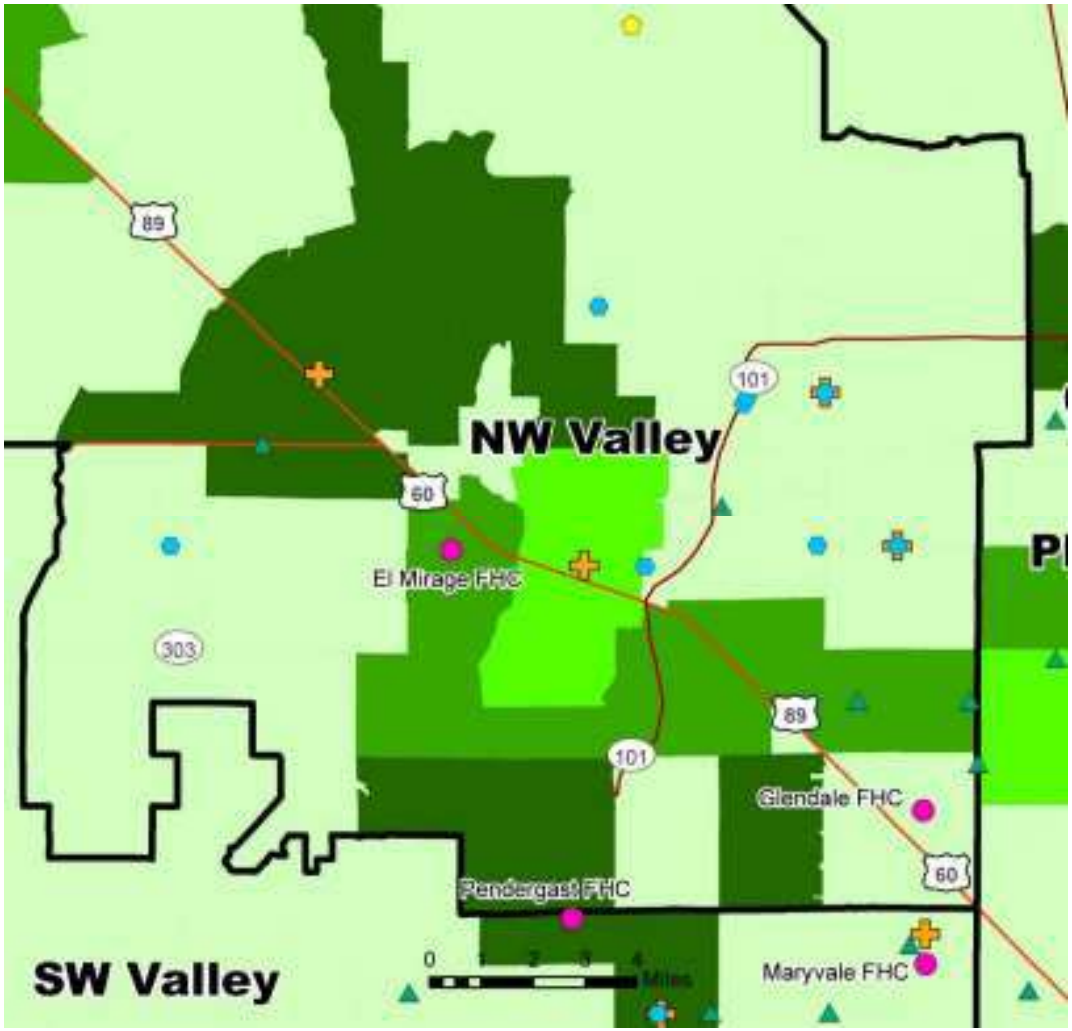
Source: 2014 Claritas Demographic database; Navigant analysis

In the Northwest Valley, the Highest Rate of Population Growth Is In the West



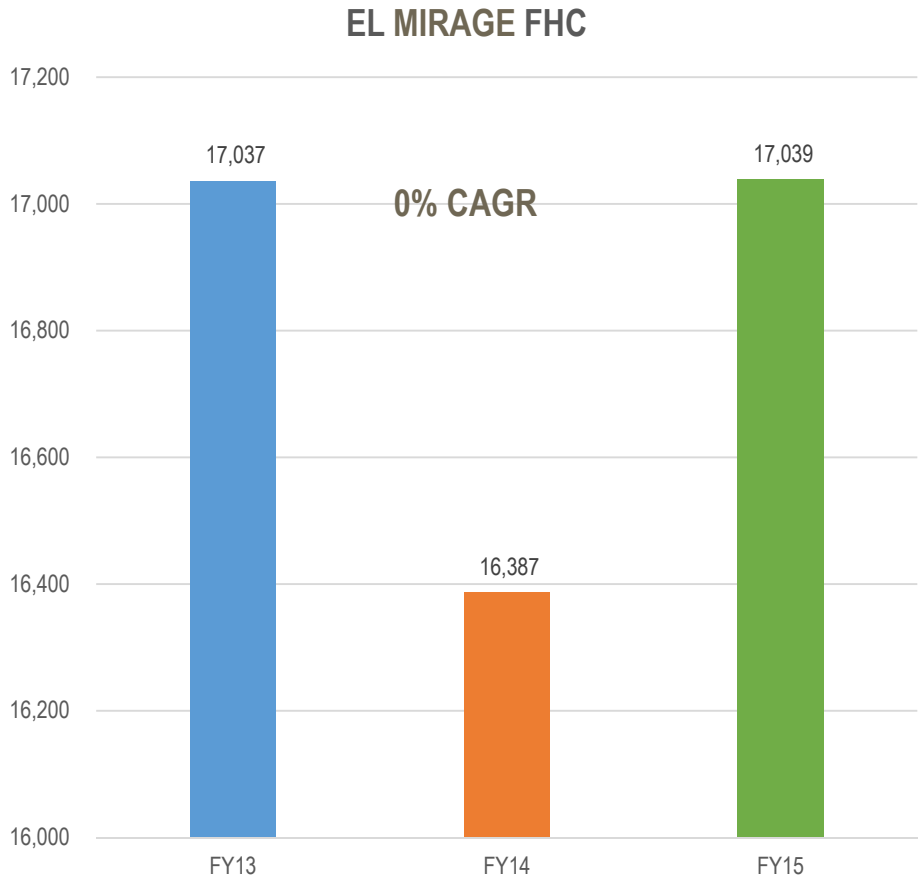
Source: 2014 Claritas Demographic database; Navigant analysis

Within the Northwest Valley, All Zip Codes Have a Relatively Low Average Household Income



Source: 2014 Claritas Demographic database; Navigant analysis

El Mirage Clinic Utilization Has Fluctuated Over the Last Three Years and Growth Has Been Limited Due to Capacity Constraints

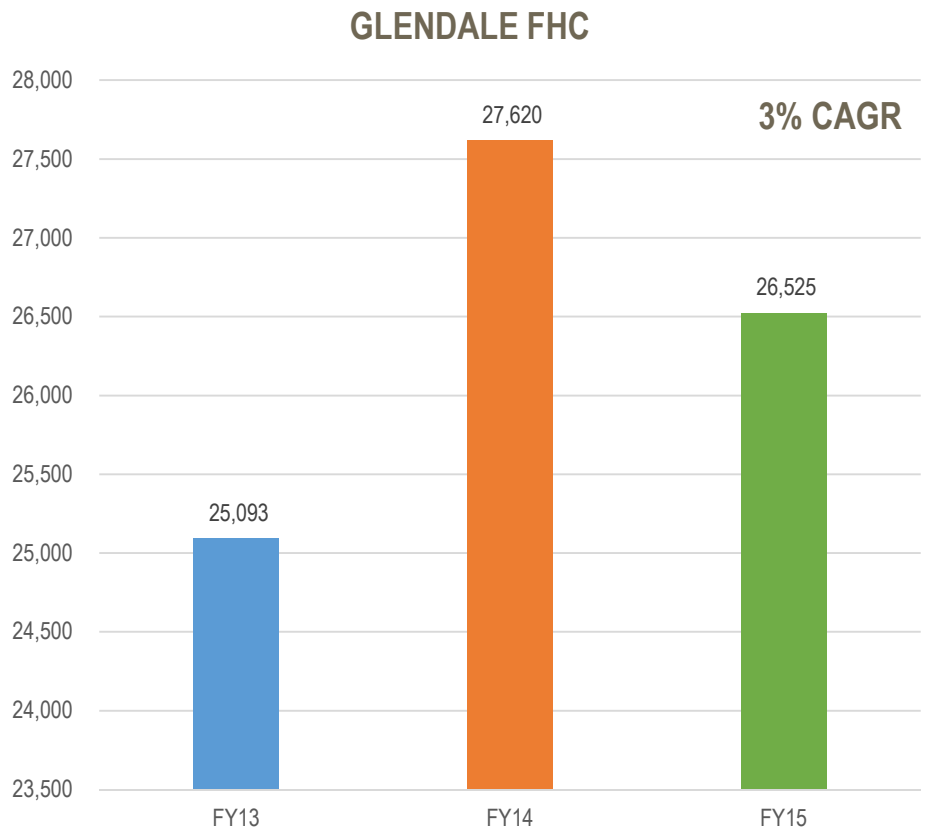


Source: Internal MOAD claims data

Services:

- Cardiology
- Diabetes Education
- Family Practice
- Lab

Glendale Clinic Volumes Have Fluctuated Over the Past Three Years

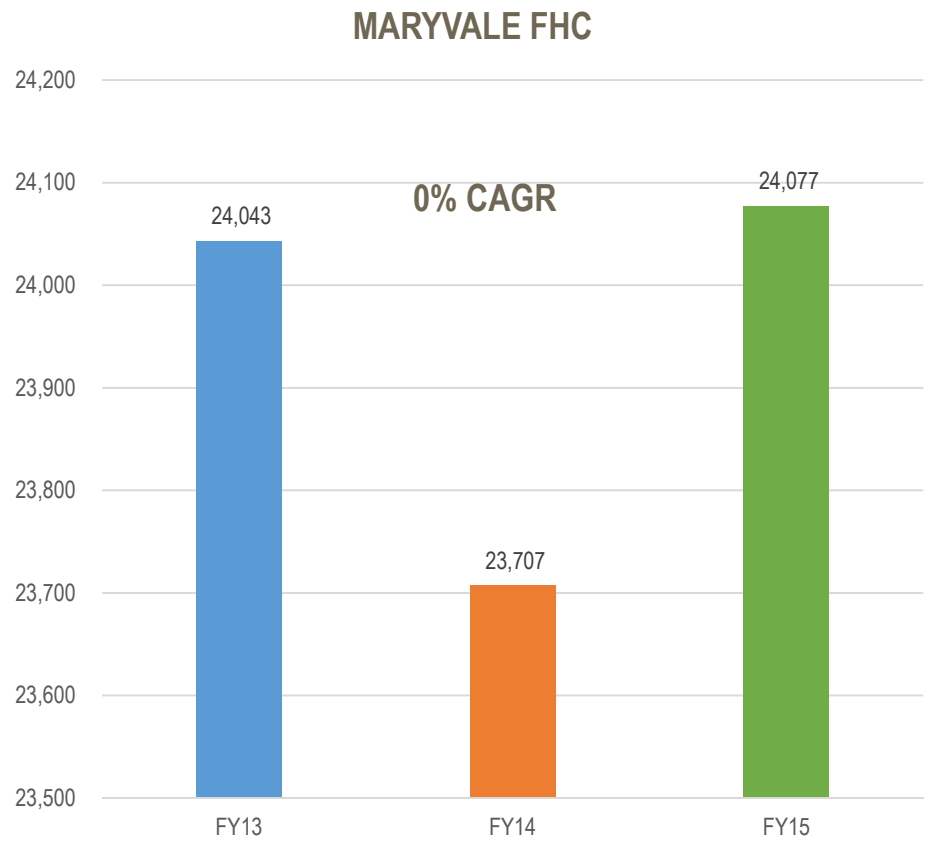


Source: Internal MOAD claims data

Services:

- Cardiology
- Dental
- Diabetes Education
- Dialysis
- Eye Screening
- Family Practice
- Internal Medicine
- Lab
- Neurology
- Nutrition
- Ophthalmology
- Social Services

Maryvale Clinic Volumes Have Fluctuated Over the Past Three Years



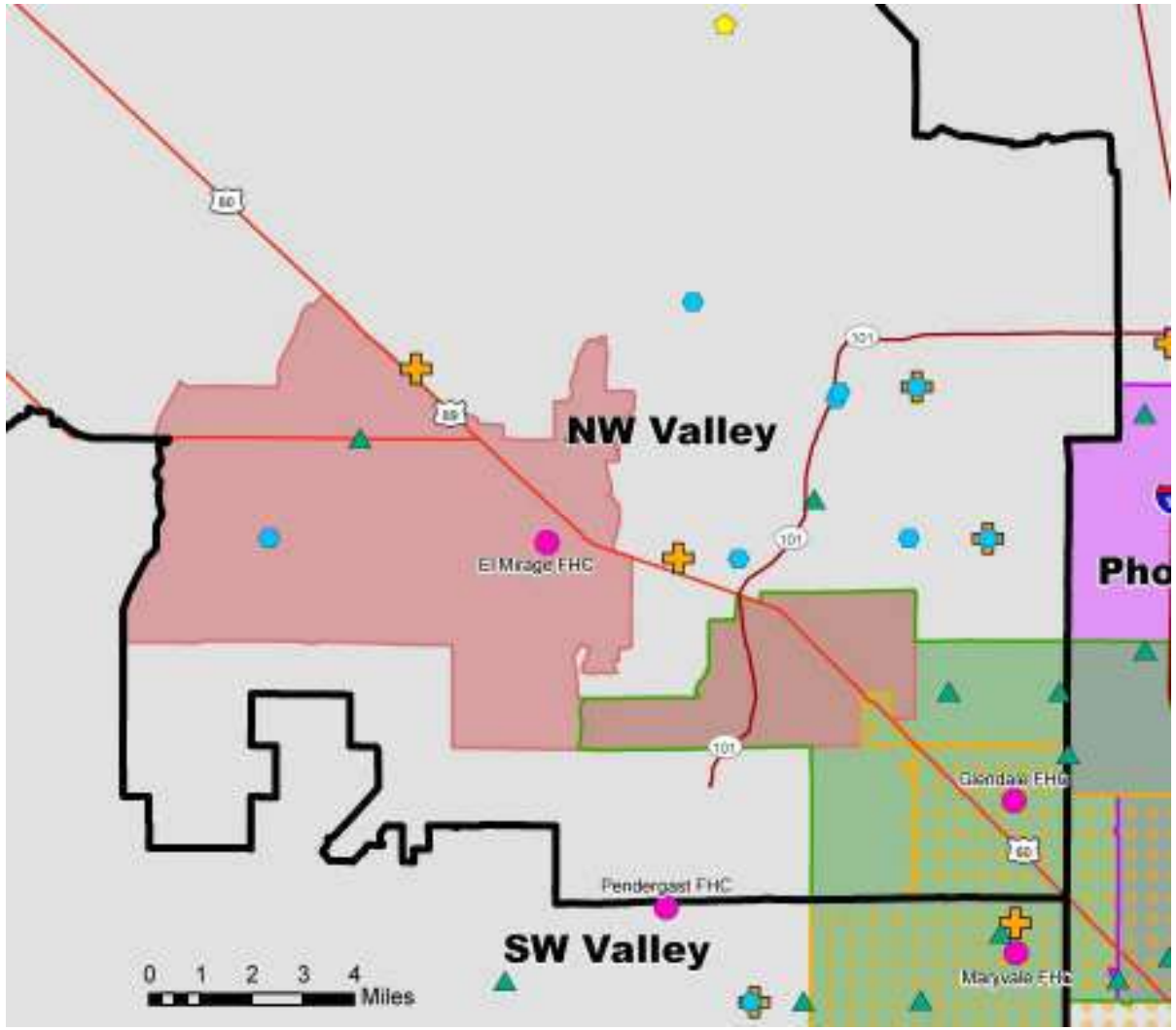
Source: Internal MOAD claims data

Services:

- Audiology
- Diabetes Education
- Ear / Nose / Throat
- Endocrine
- Lab
- Neurology
- Ob / Gyn
- Ortho Sports Med
- Peds
- Pulmonary
- Rad Ultrasound

FHC Primary Service Areas—Northwest Valley

An analysis of FHC primary service areas indicates that several serve the NW Valley



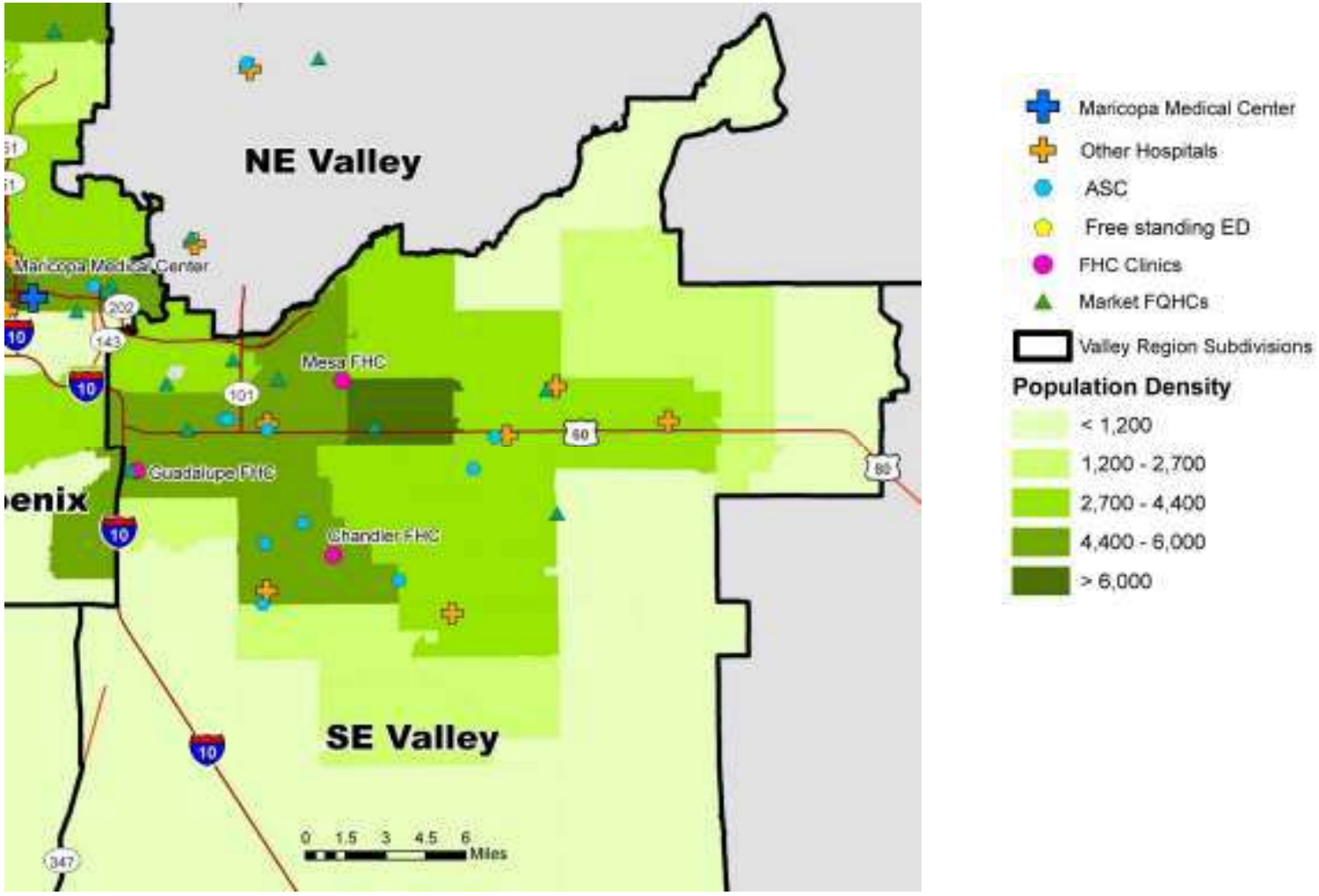
Maricopa Medical Center
Other Hospitals
ASC
Free standing ED
FHC Clinics
Market FQHCs
Valley Region Subdivisions
El Mirage
Glendale
Maryvale
Sunnyslope

An FHC primary service area is defined as the zip codes from which the FHC generates 70% of its visits

Source: Internal MOAD claims data; Navigant analysis

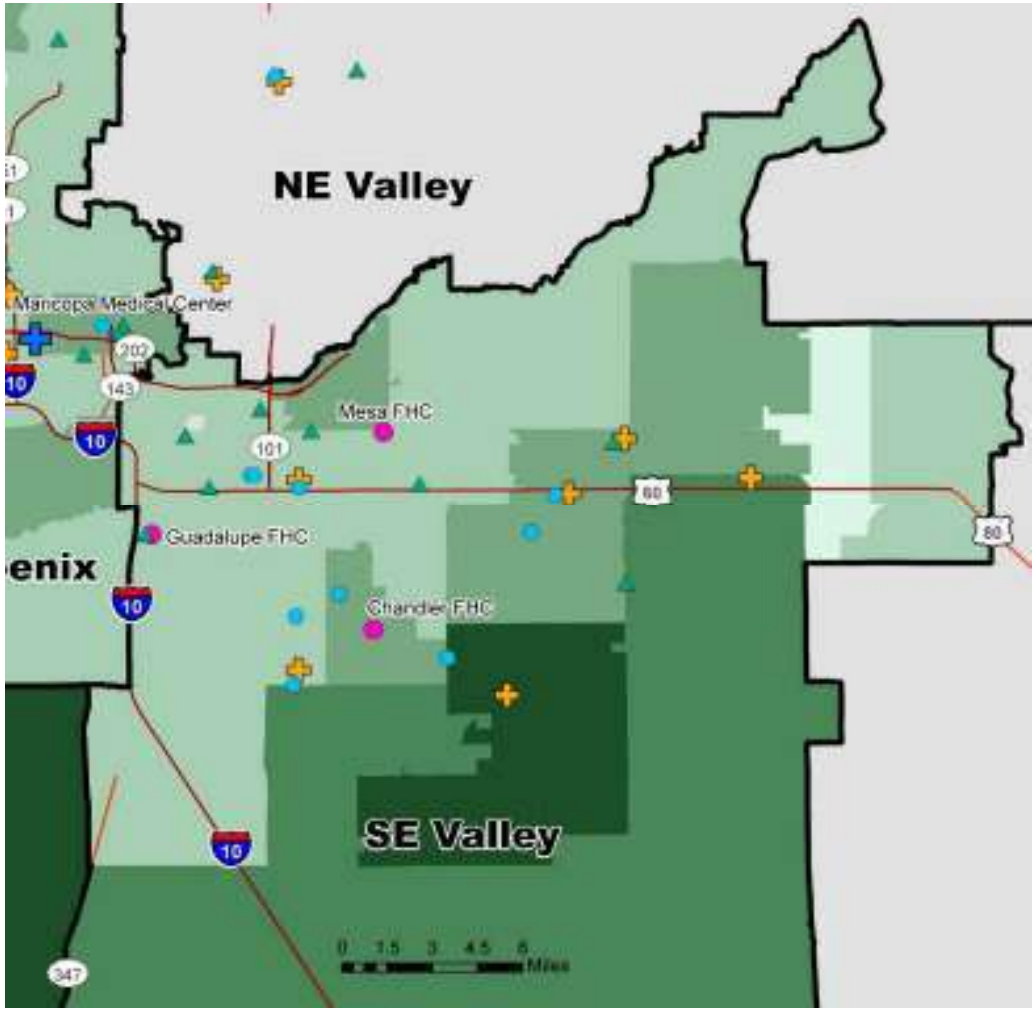
Southeast Valley

In the Southeast Valley, the Population Is Most Concentrated In Areas Currently Served by MIHS Family Health Centers



Source: 2014 Claritas Demographic database; Navigant analysis

The Largest Population Growth In the Southeast Valley Is Expected to Be In to the South And East



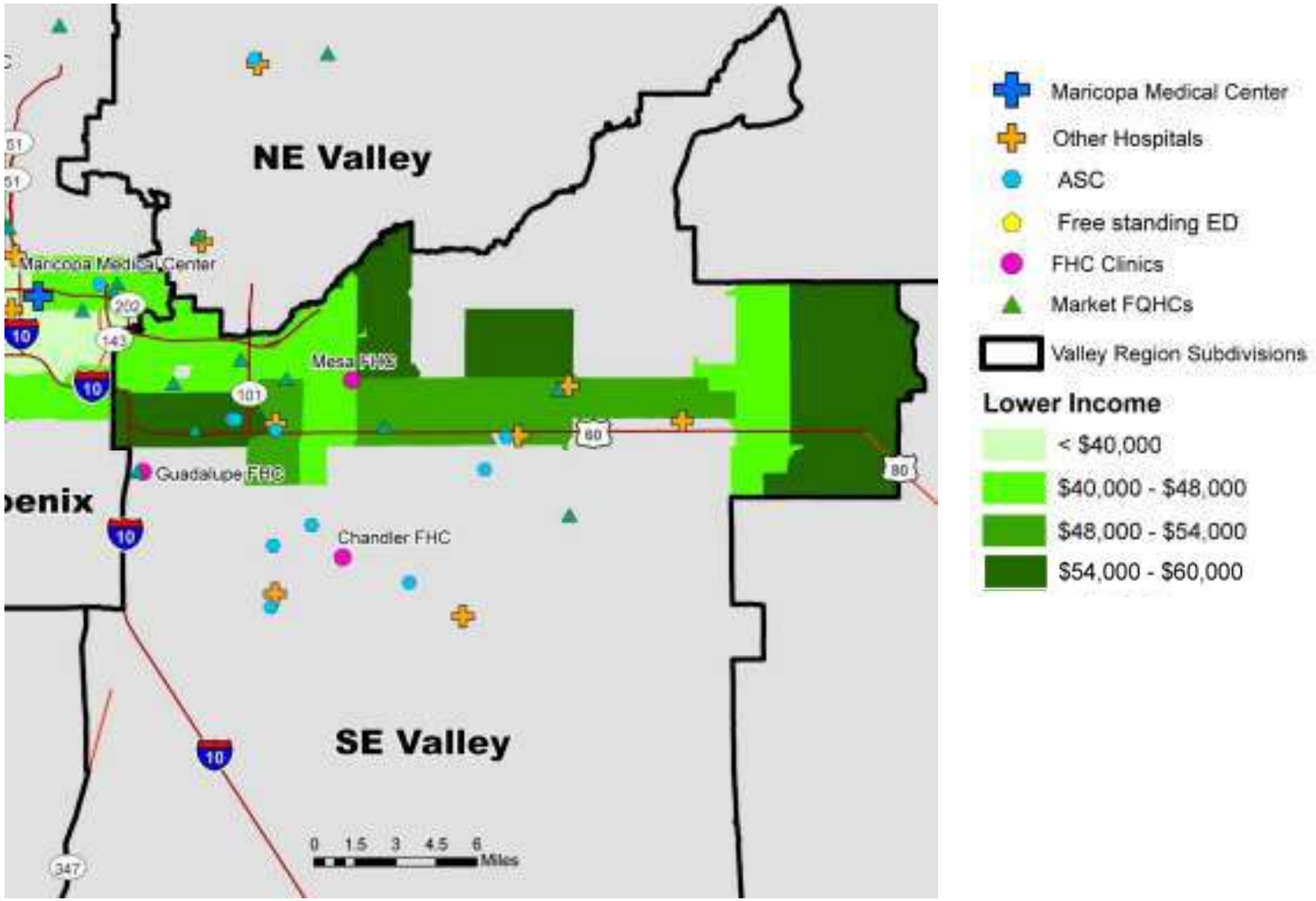
Maricopa Medical Center
Other Hospitals
ASC
Free standing ED
FHC Clinics
Market FQHCs
Valley Region Subdivisions

Population Growth

< 1%
1% - 5%
6% - 9%
10% - 14%
> 14%

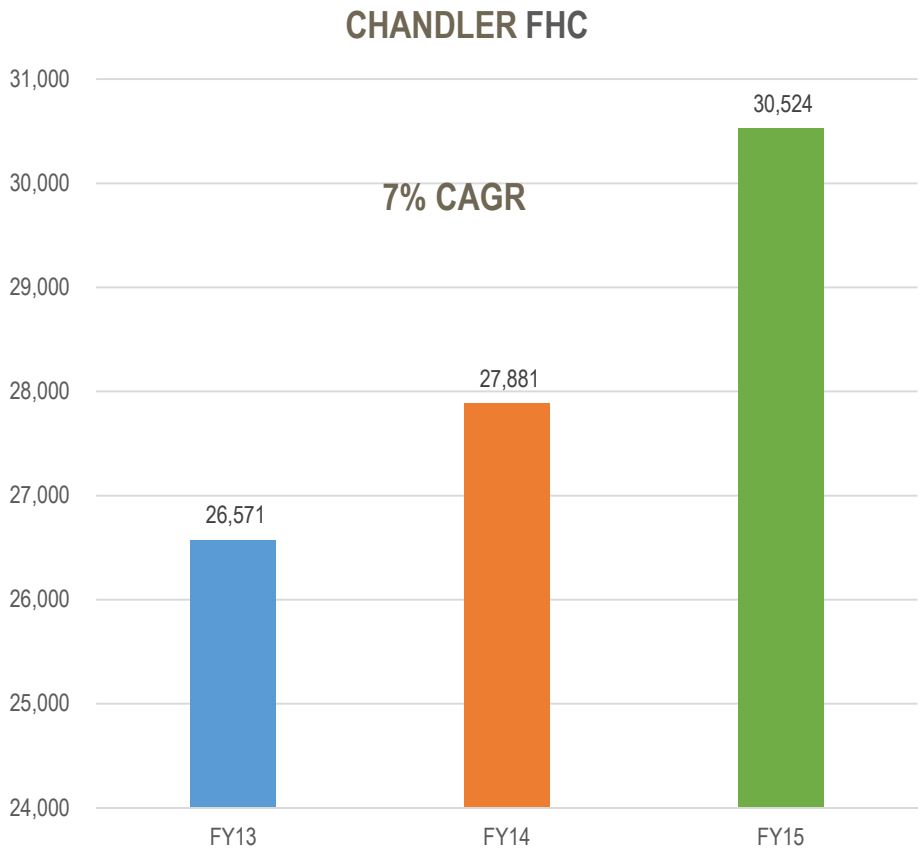
Source: 2014 Claritas Demographic database; Navigant analysis

The Areas With the Lowest Average Income In the Southeast Valley Are Along the Highway 60 Corridor



Source: 2014 Claritas Demographic database; Navigant analysis

The Chandler Clinic Has Experienced Consistent Volume Growth Over the Past Three Years

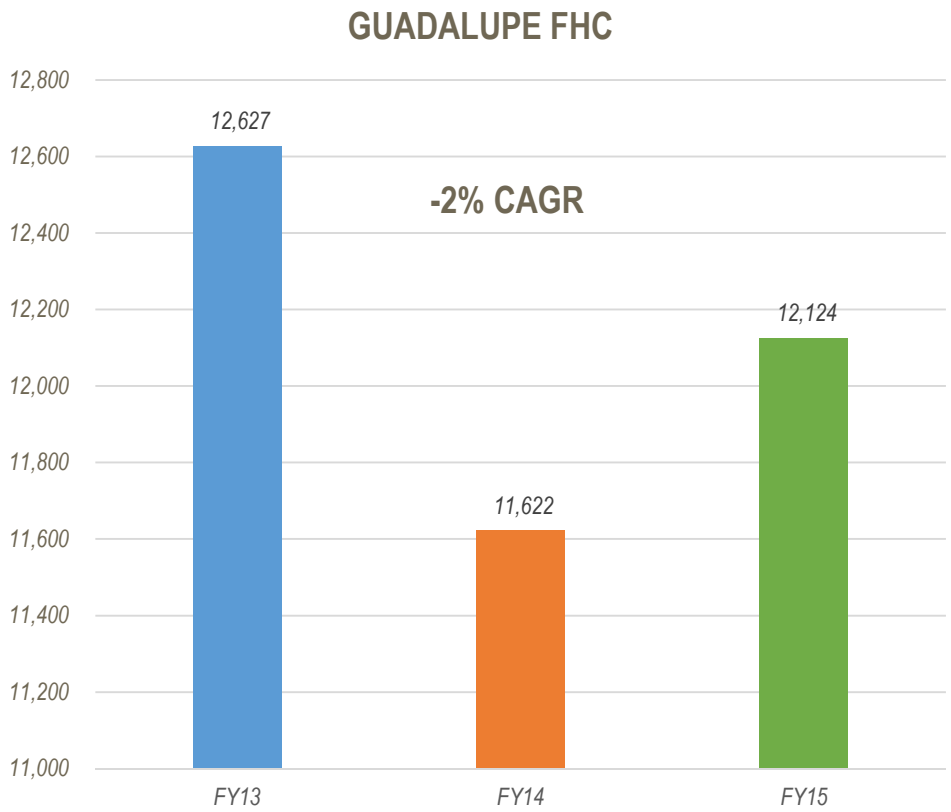


Source: Internal MOAD claims data

Services:

- Cardiology
- Dental
- Diabetes Education
- Eye Screening
- Family Practice
- Internal Medicine
- Lab
- Ob/Gyn
- Radiology Ultrasound
- Radiology

The Guadalupe Clinic Experienced a Slight Decline In Visit Volume from FY13 To FY 15

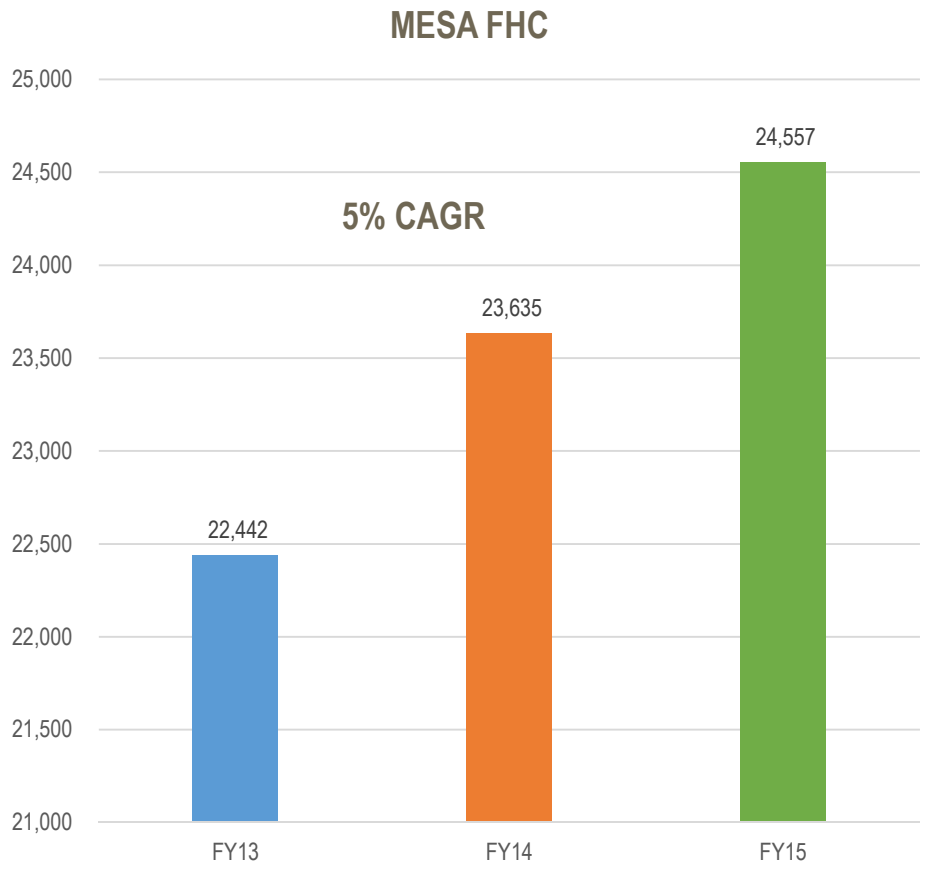


Source: Internal MOAD claims data

Services:

- Diabetes Education
- Family Practice
- Lab
- OB / GYN

The Mesa Clinic Has Experienced Consistent Volume Growth Since FY13



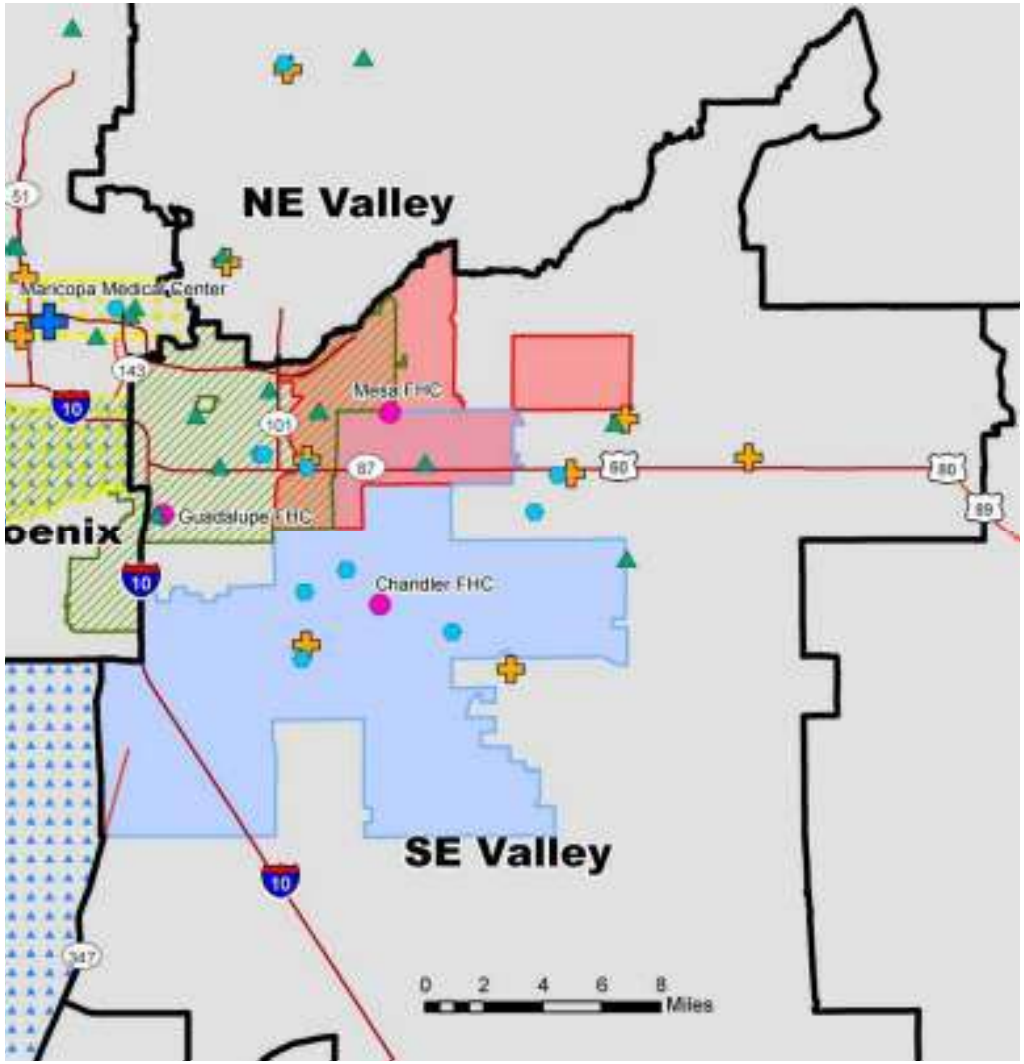
Source: Internal MOAD claims data

Services:

- Cardiology
- Dental
- Diabetes Ed
- Echo Lab
- Endocrine
- Eye Screening
- Internal Medicine
- Lab
- Neurology
- Ob/Gyn
- Ortho Sports Med
- Peds

FHC Primary Service Areas—Southeast Valley

An analysis of FHC primary service areas indicates that several serve the SE Valley



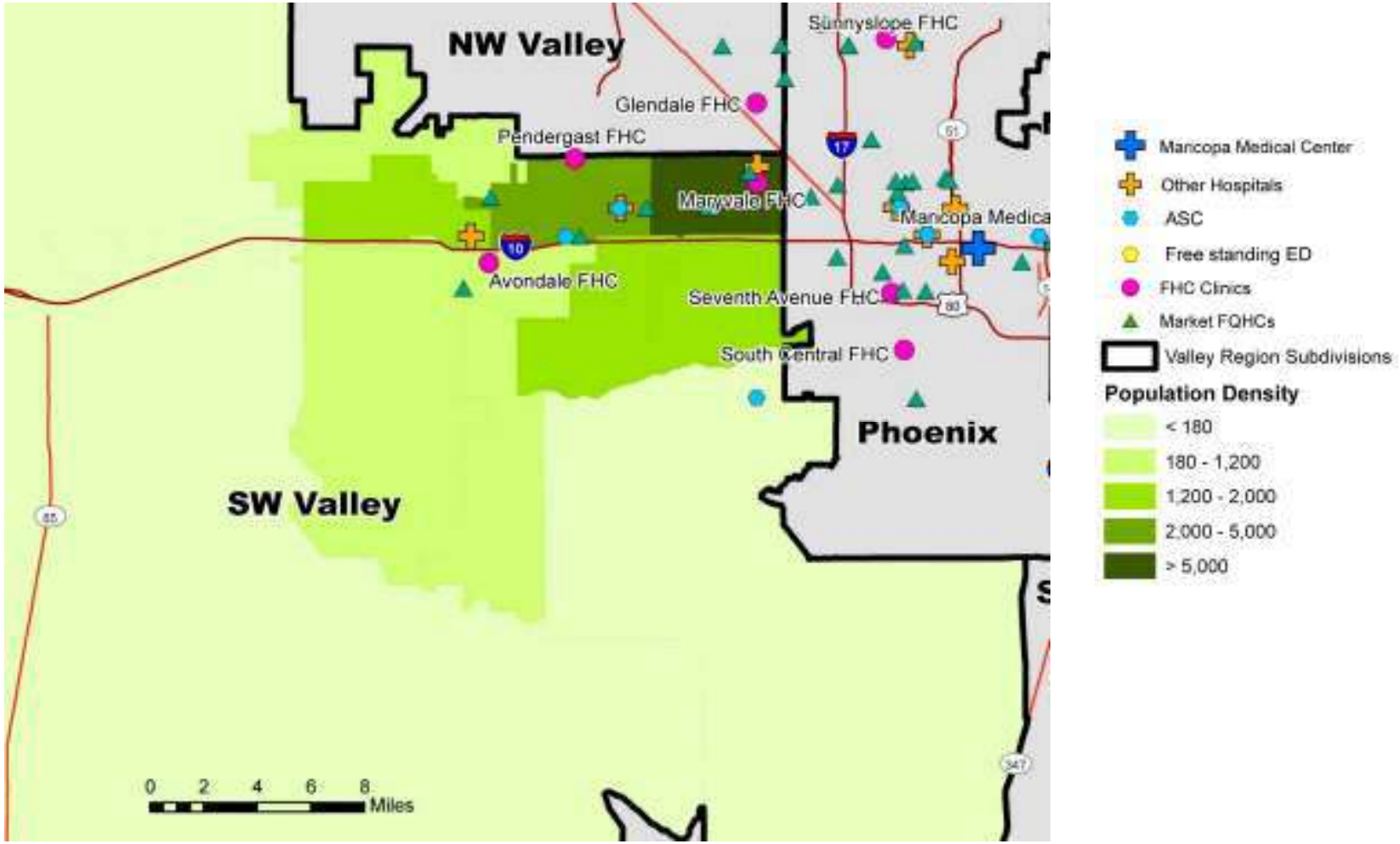
- Maricopa Medical Center
- Other Hospitals
- ASC
- Free standing ED
- FHC Clinics
- Market FQHCs
- Valley Region Subdivisions
- 7th Avenue
- Chandler
- Guadalupe
- Mesa
- South Central

An FHC primary service area is defined as the zip codes from which the FHC generates 70% of its visits

Source: Internal MOAD claims data; Navigant analysis

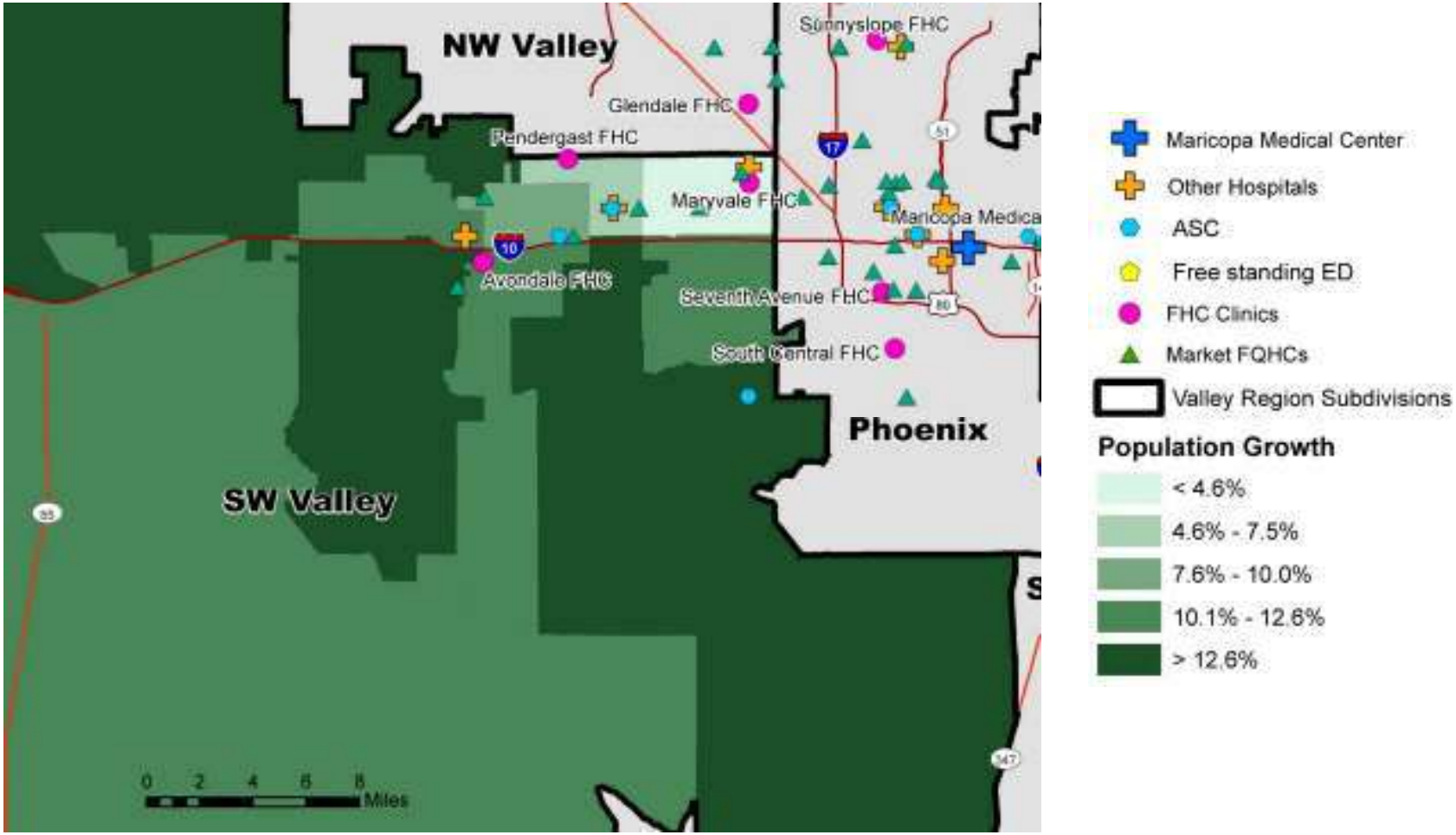
Southwest Valley

In The Southwest Market Area, the Population Is Most Concentrated In Areas Currently Served By MIHS Family Health Centers (FHCS)



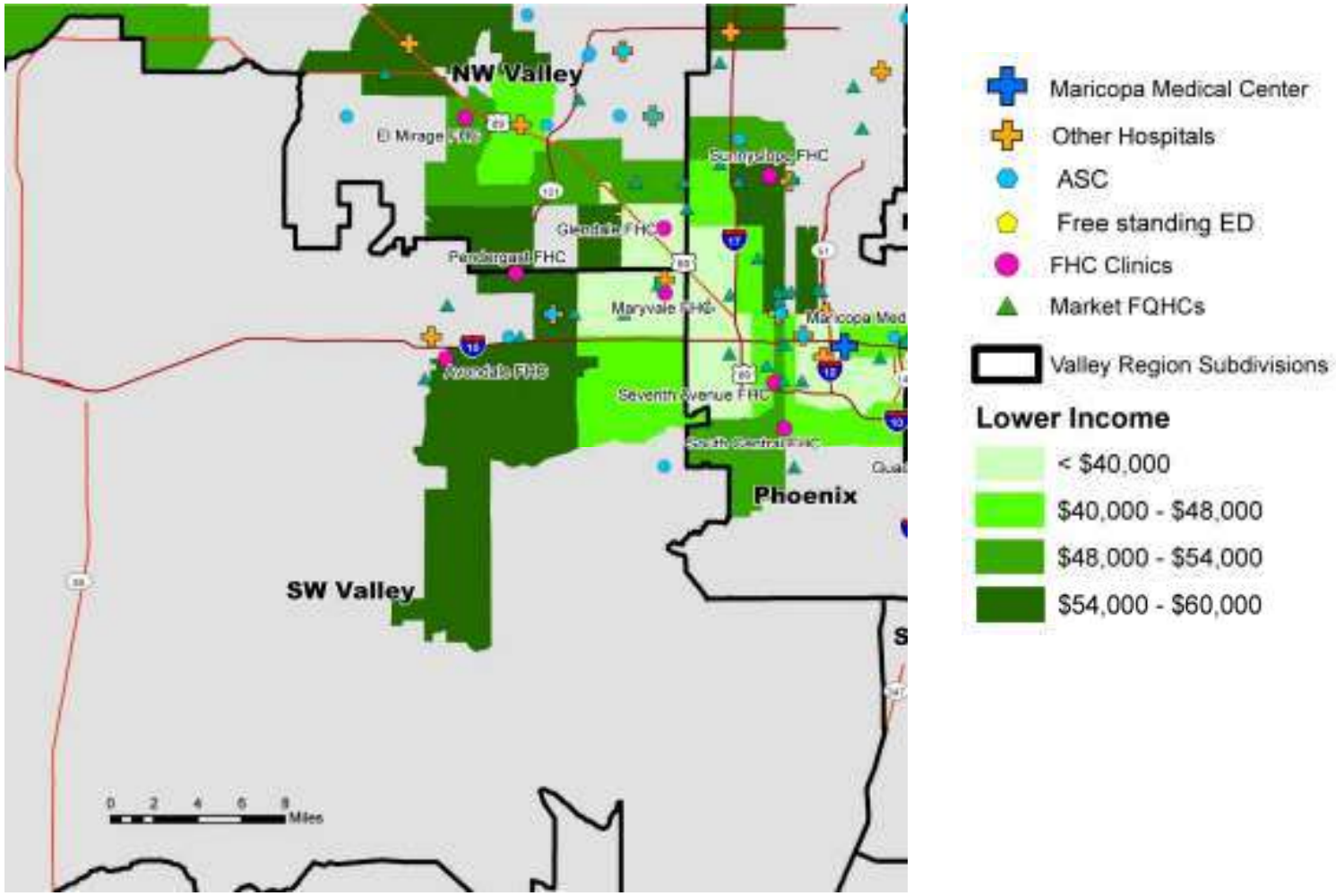
Source: 2014 Claritas Demographic database; Navigant analysis

Significant Population Growth Is Expected Throughout the Southwest Valley



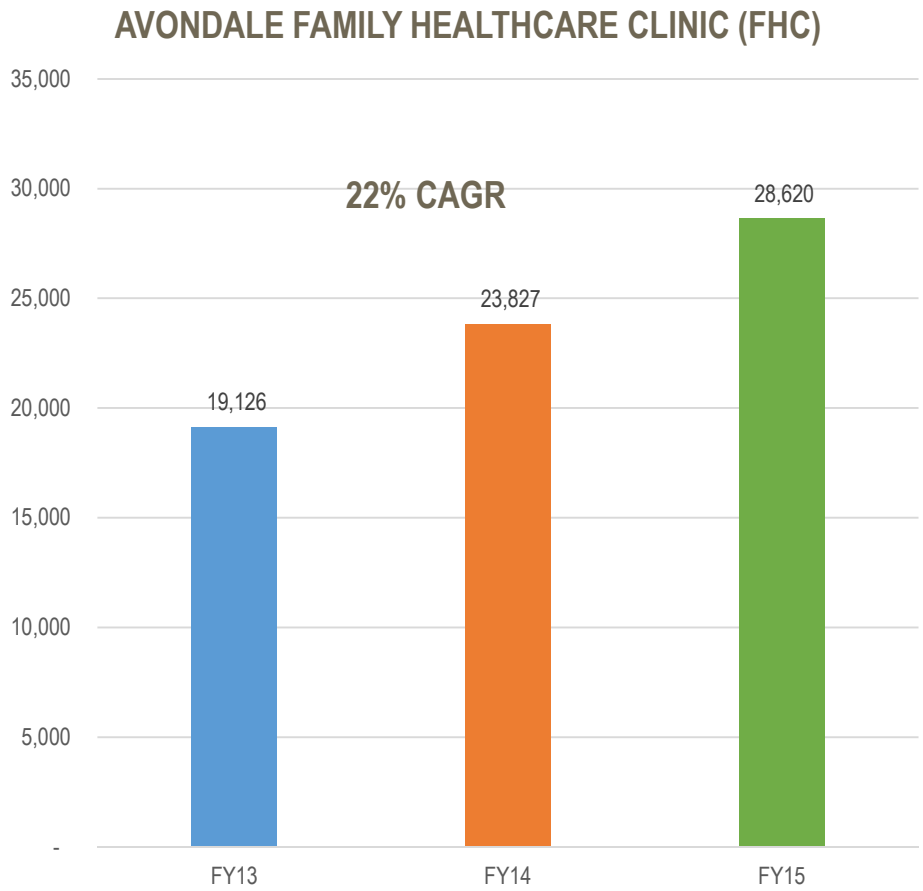
Source: 2014 Claritas Demographic database; Navigant analysis

In the Southwest Area, Both the Avondale and the Pendergast FHCS are Located In Areas With Moderately Low Average Income



Source: 2014 Claritas Demographic database; Navigant analysis

Avondale Has Experienced the Largest and Most Consistent Utilization Growth Compared To All Other FHC

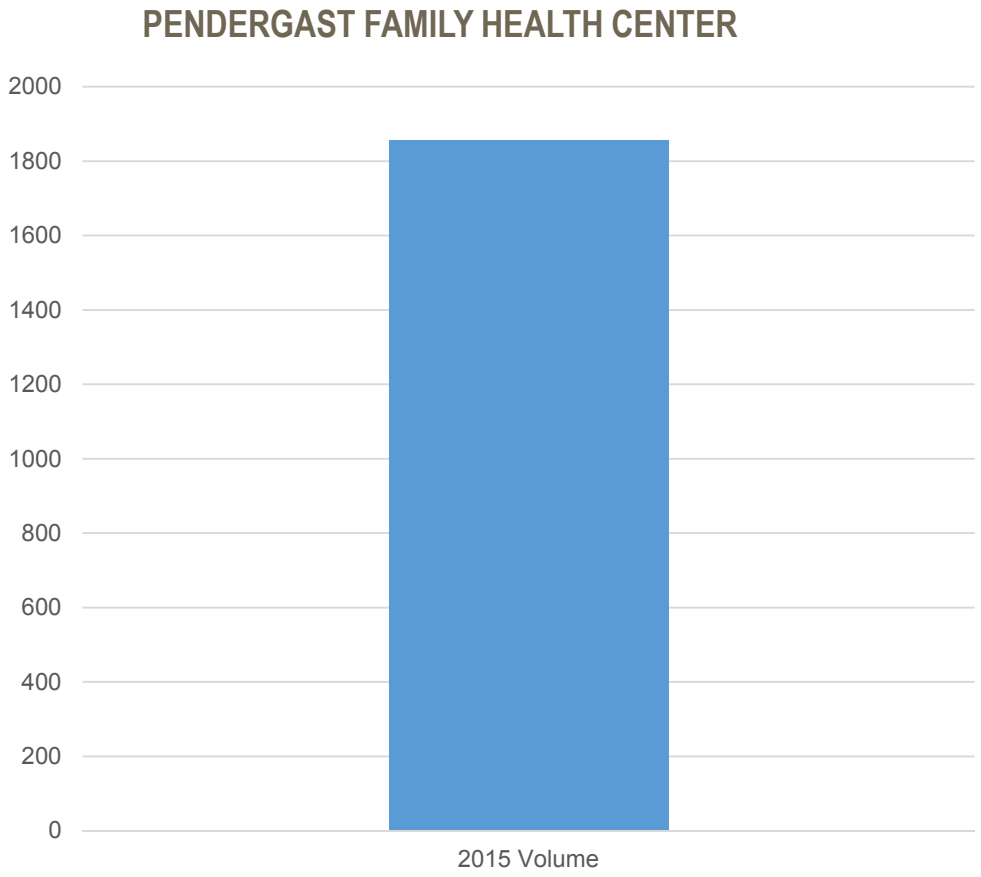


Source: Internal MOAD claims data

Services:

- Cardiology
- Dental
- Diabetes Education
- Echo Lab
- Eye Screening
- Family Practice
- Lab
- Mammography
- Ophthalmology
- Radiology Ultrasound
- Radiology

Pendergast FHC Opened During FY15 and Serves As A Neighborhood Clinic



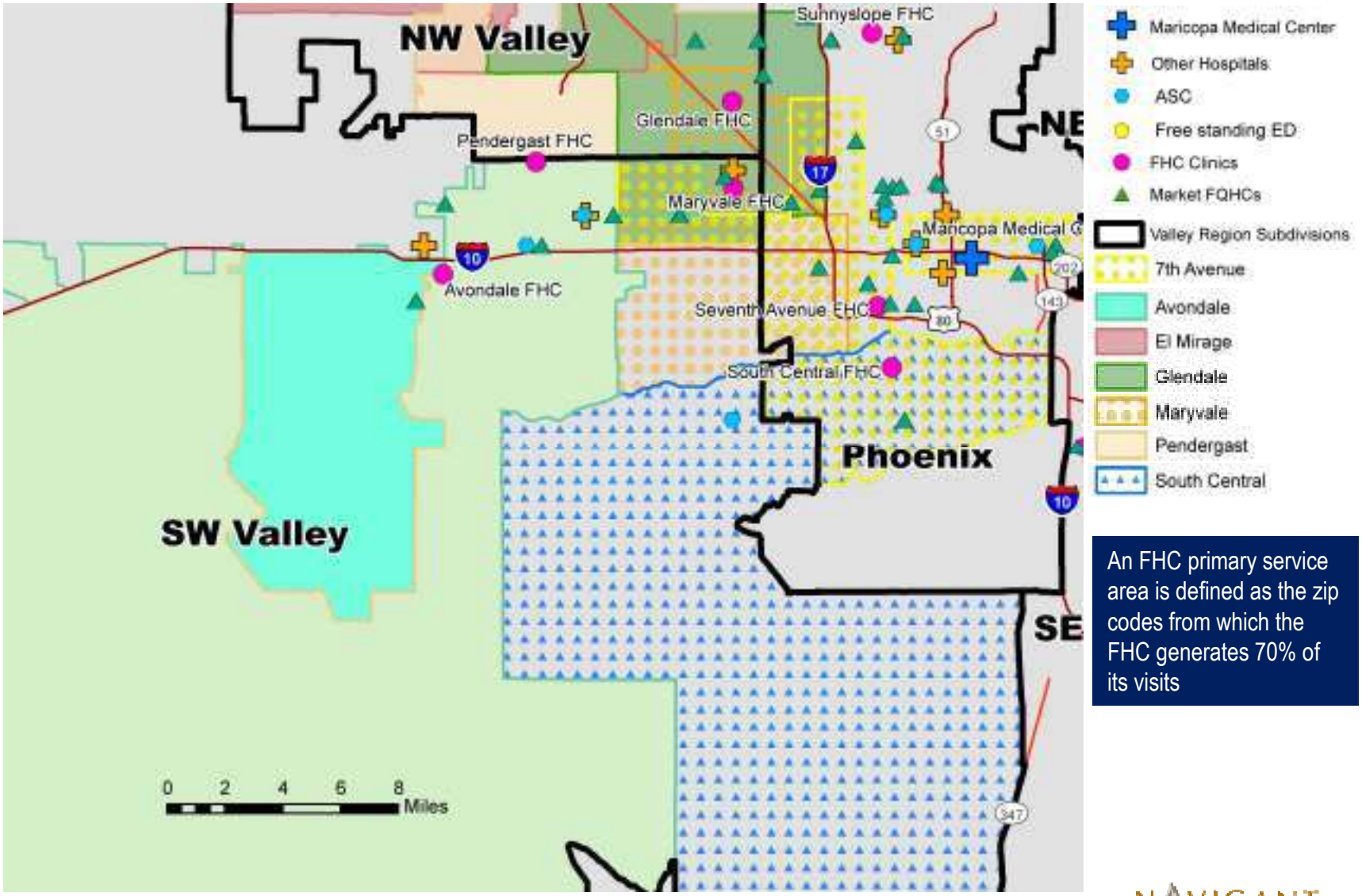
Source: Internal MOAD claims data

Services:

- Dental
- Family Practice
- Lab

FHC Primary Service Areas—Southwest Valley

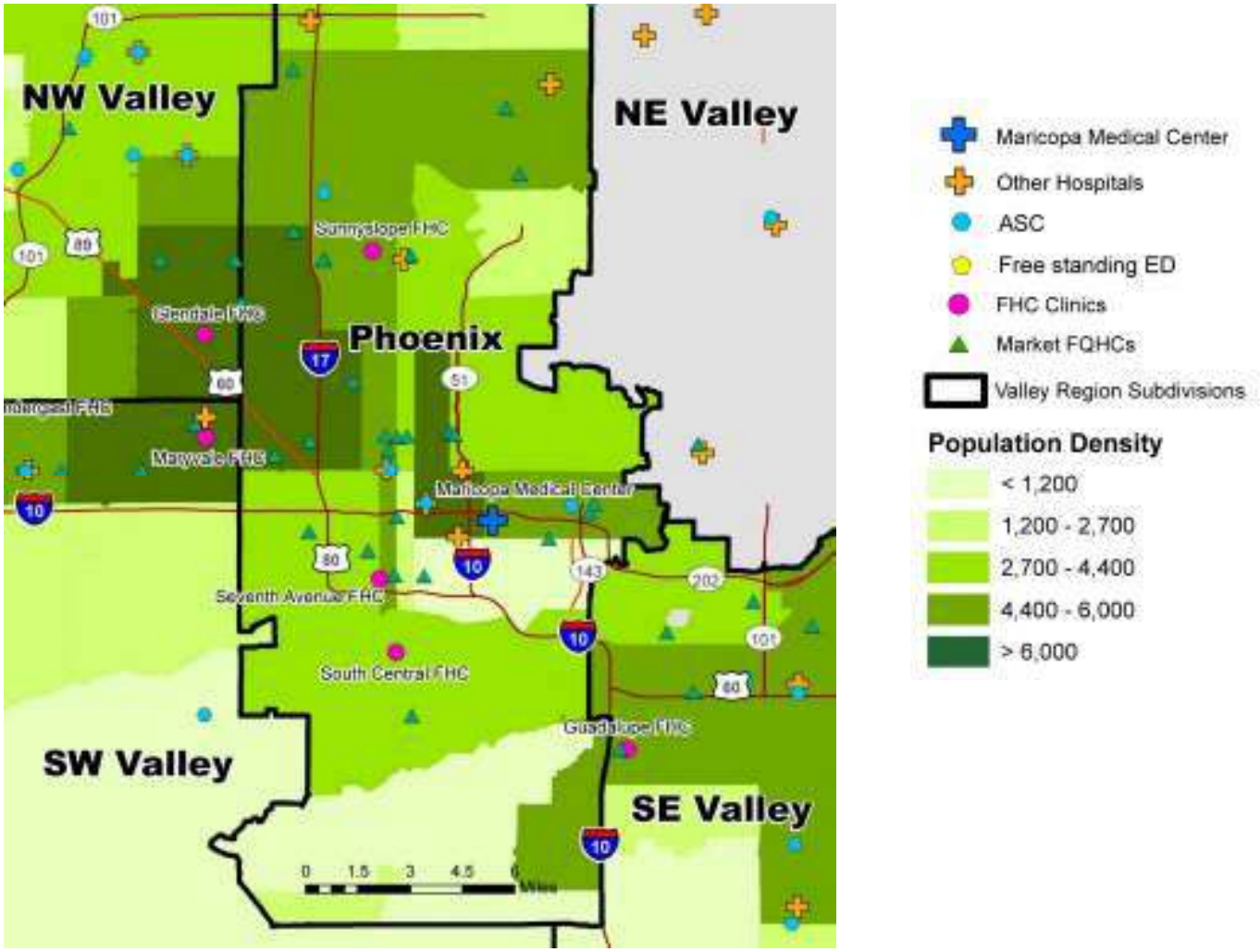
An analysis of FHC primary service areas indicates that several serve the SW Valley



An FHC primary service area is defined as the zip codes from which the FHC generates 70% of its visits

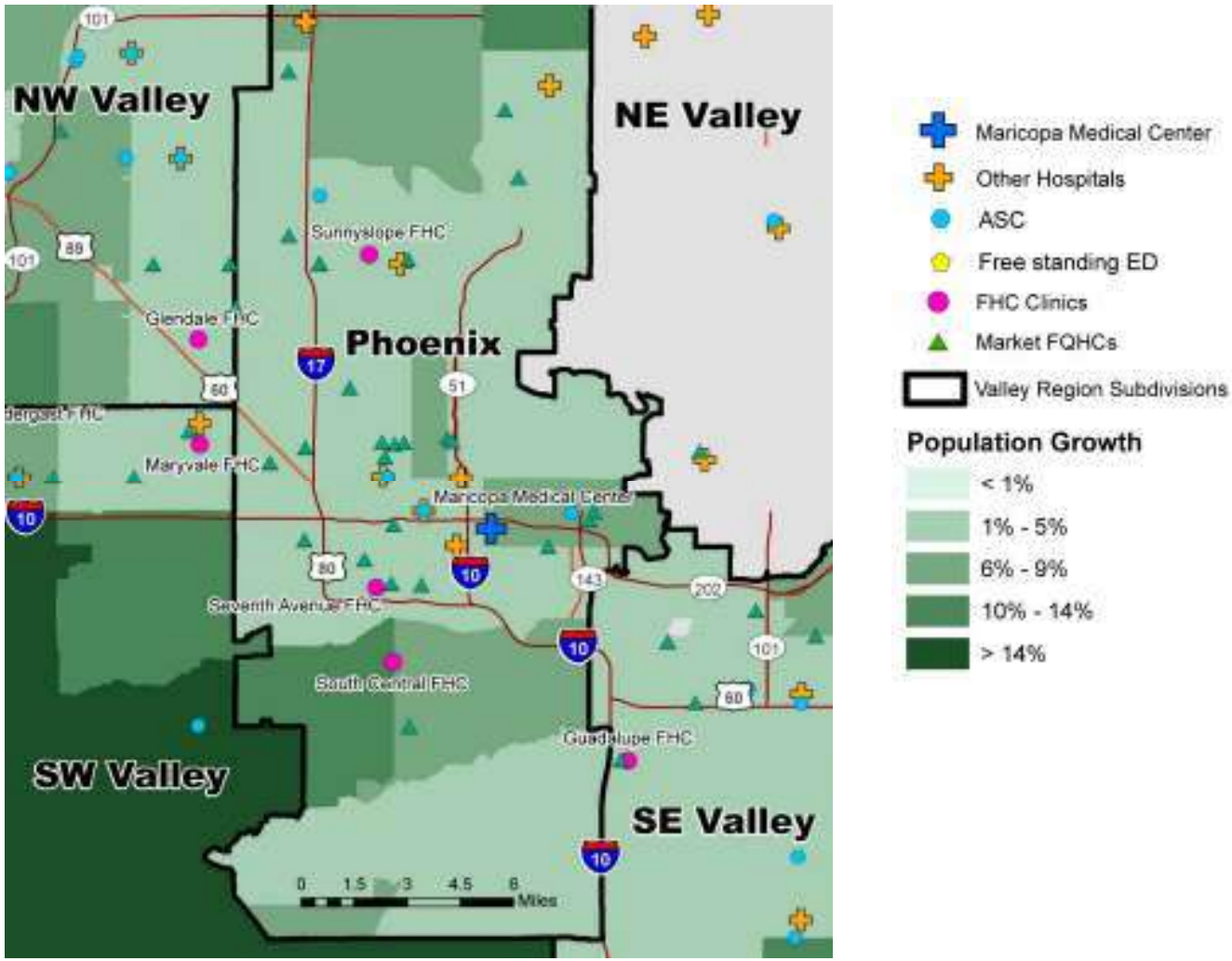
Phoenix Area

The Core Phoenix Area Is Densely Populated



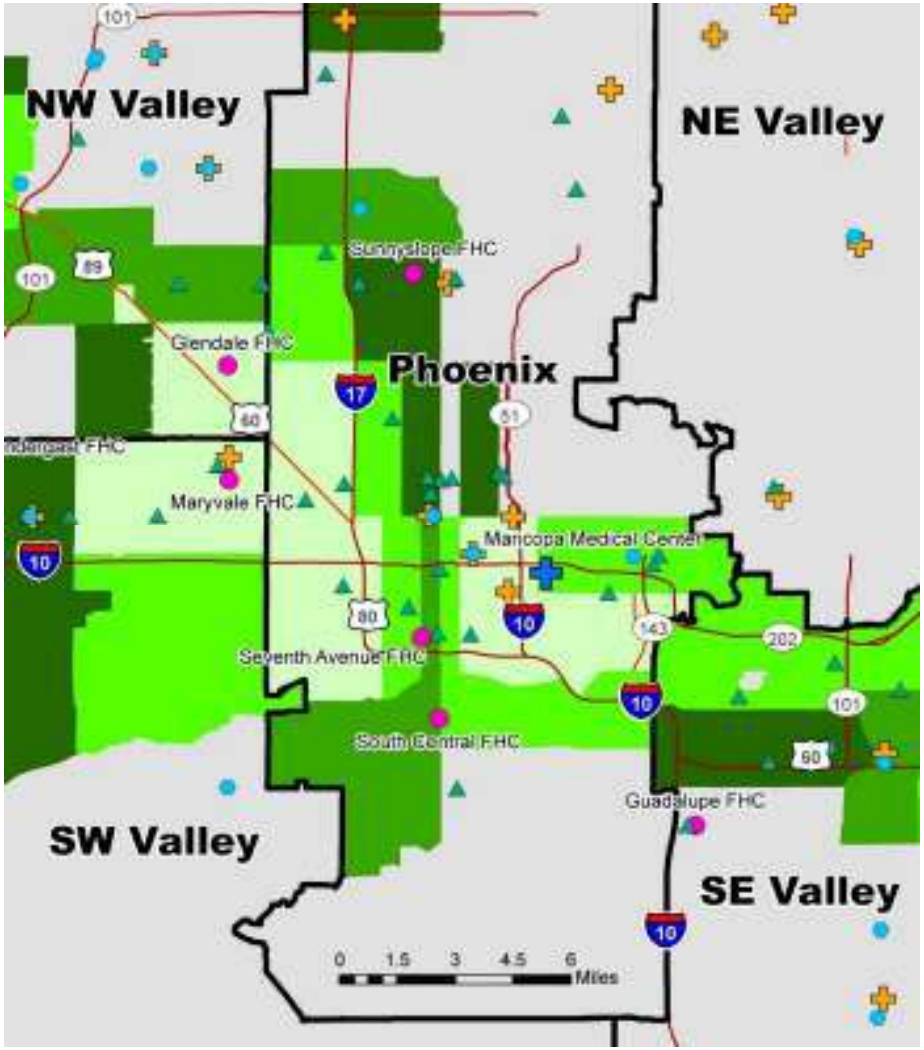
Source: 2014 Claritas Demographic database; Navigant analysis

The Phoenix Core Is Projected to Growth More Slowly That the Other Regions



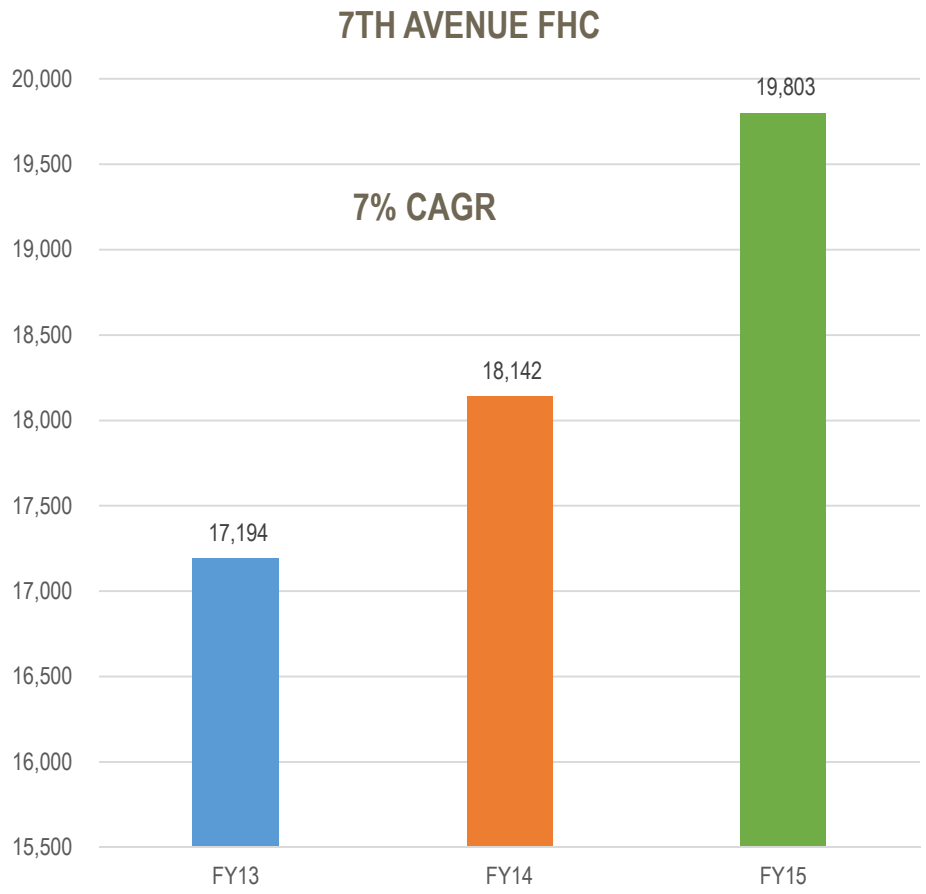
Source: 2014 Claritas Demographic database; Navigant analysis

The Phoenix Area Has a Number of Areas With a Low Average Household Income



Source: 2014 Claritas Demographic database; Navigant analysis

7th Avenue Clinic Has Experienced Steady Volume Growth

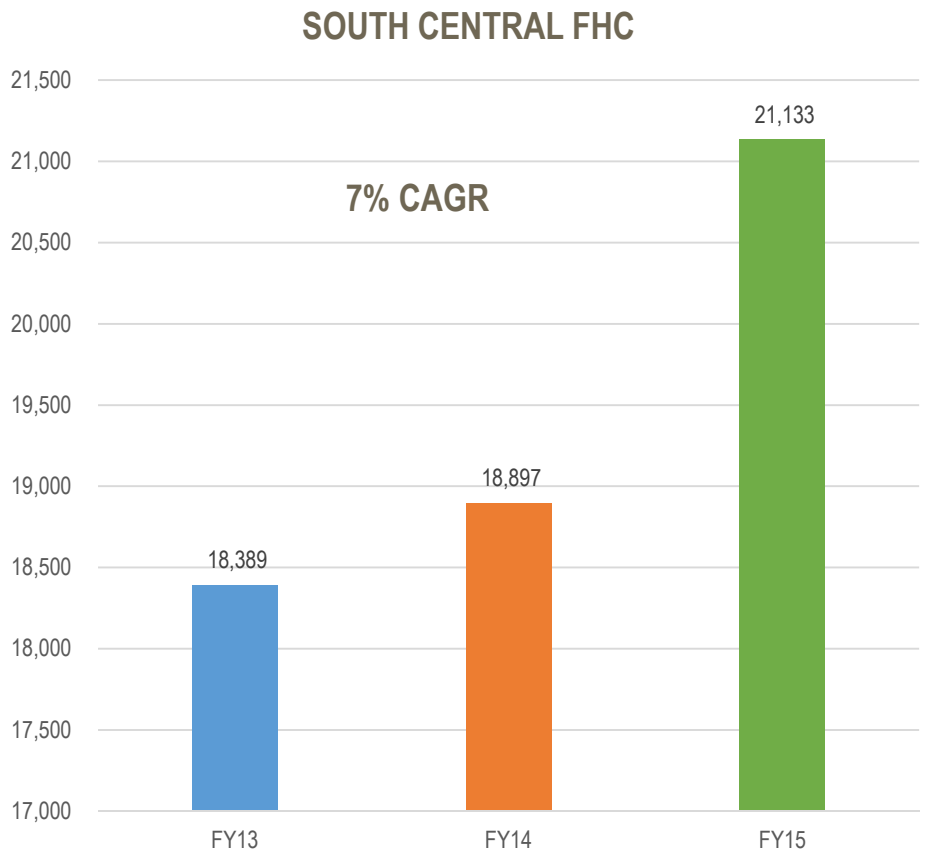


Source: Internal MOAD claims data

Services:

- Diabetes Education
- Family Practice
- Lab
- OB / GYN

South Central Clinic Has Experienced Volume Growth, With a Large Increase Between FY14 – FY15

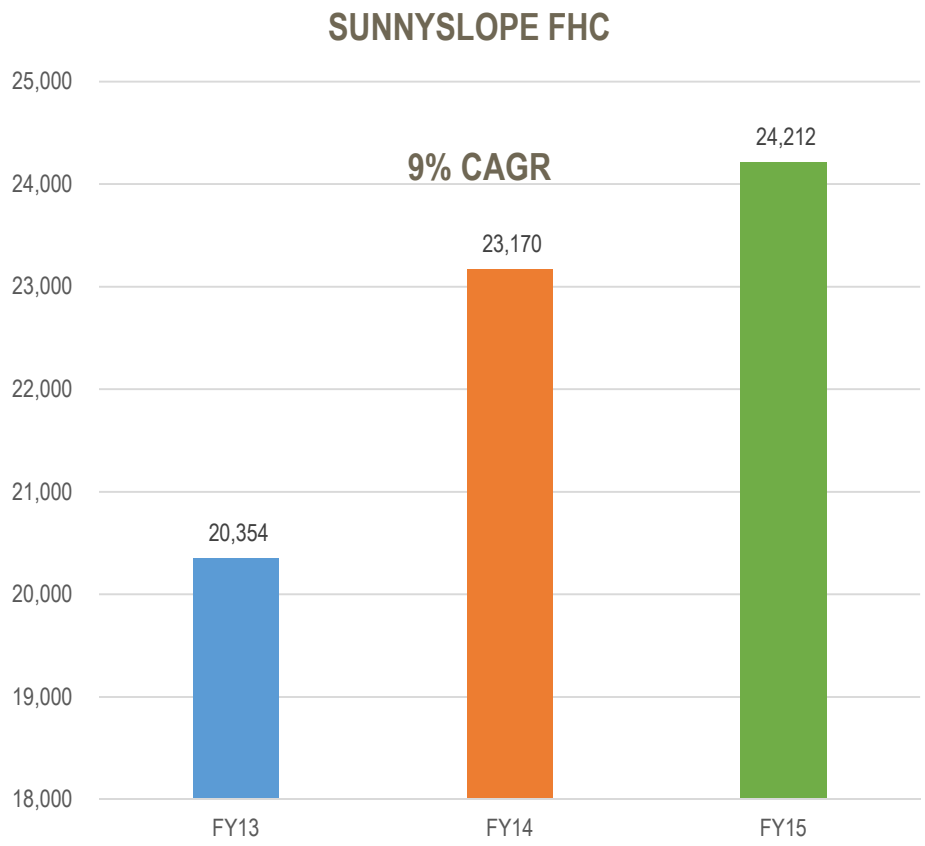


Source: Internal MOAD claims data

Services:

Dental
Diabetes Education
Eye Screening
Family Practice
Internal Medicine
Lab
OB / GYN
Peds

Sunnyslope Clinic Has Experienced Consistent Utilization Growth

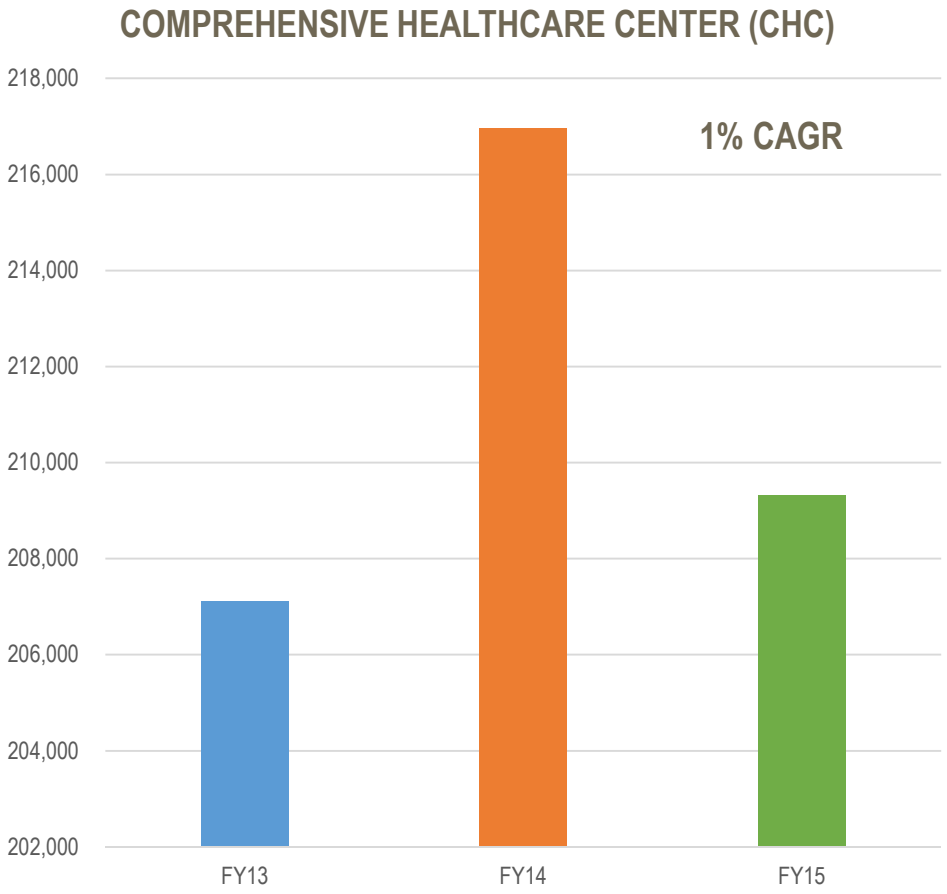


Source: Internal MOAD claims data

Services:

- Diabetes Education
- Eye Screening
- Family Practice
- Internal Medicine
- Lab
- OB / GYN

Overall the CHC Has Had Fluctuating Volumes Over the Last Three Years



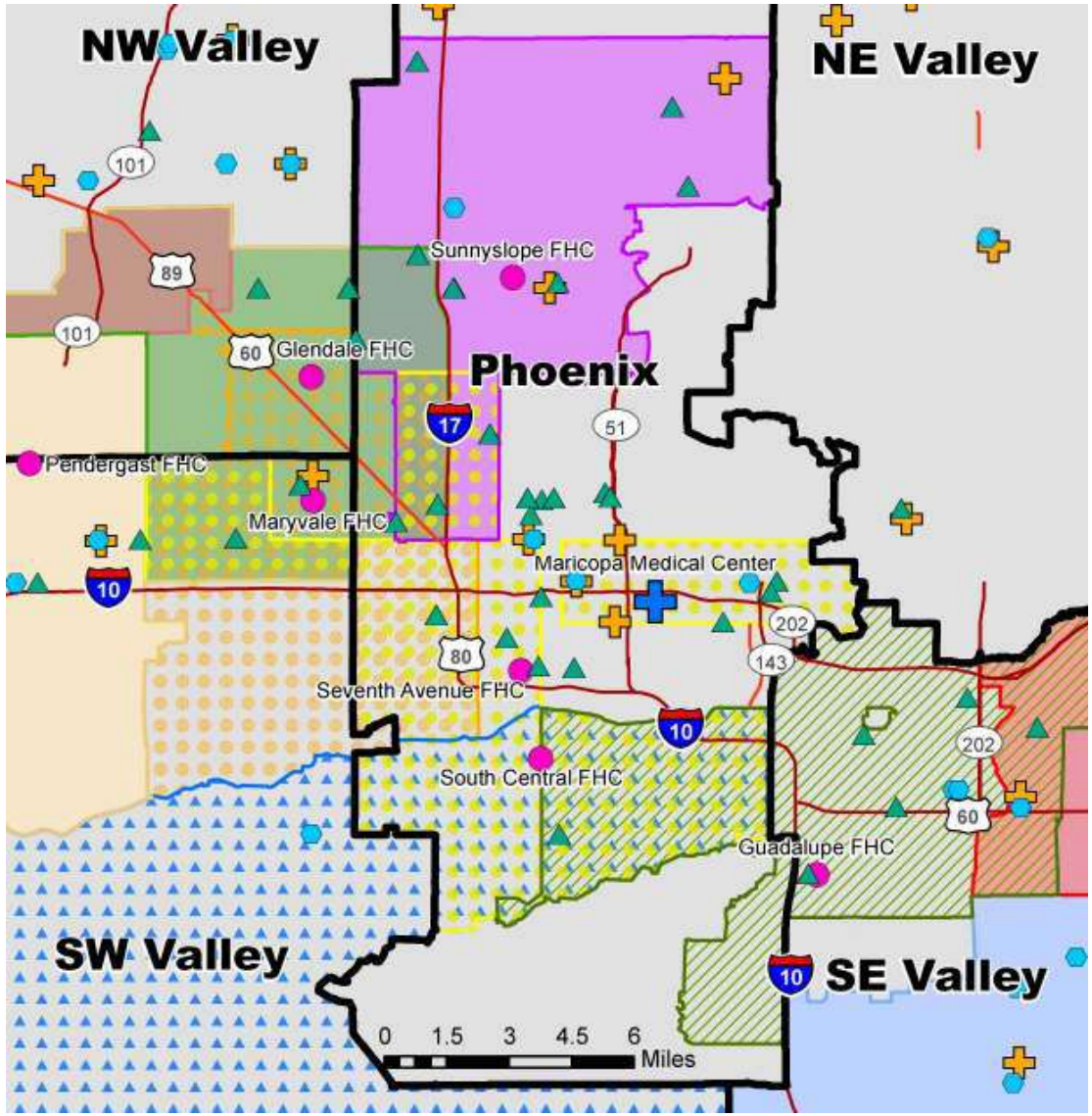
Source: Internal MOAD claims data

Services:

- Breast Center
- Cardio-pulmonary
- Dental
- Dialysis
- Ear-Nose-Throat
- Internal Medicine
- Medical Subspecialty
- Oncology
- Orthopedics
- Ophthalmology
- Pediatrics
- Radiology
- Surgical Vascular
- Women's Care

FHC Primary Service Areas—Phoenix

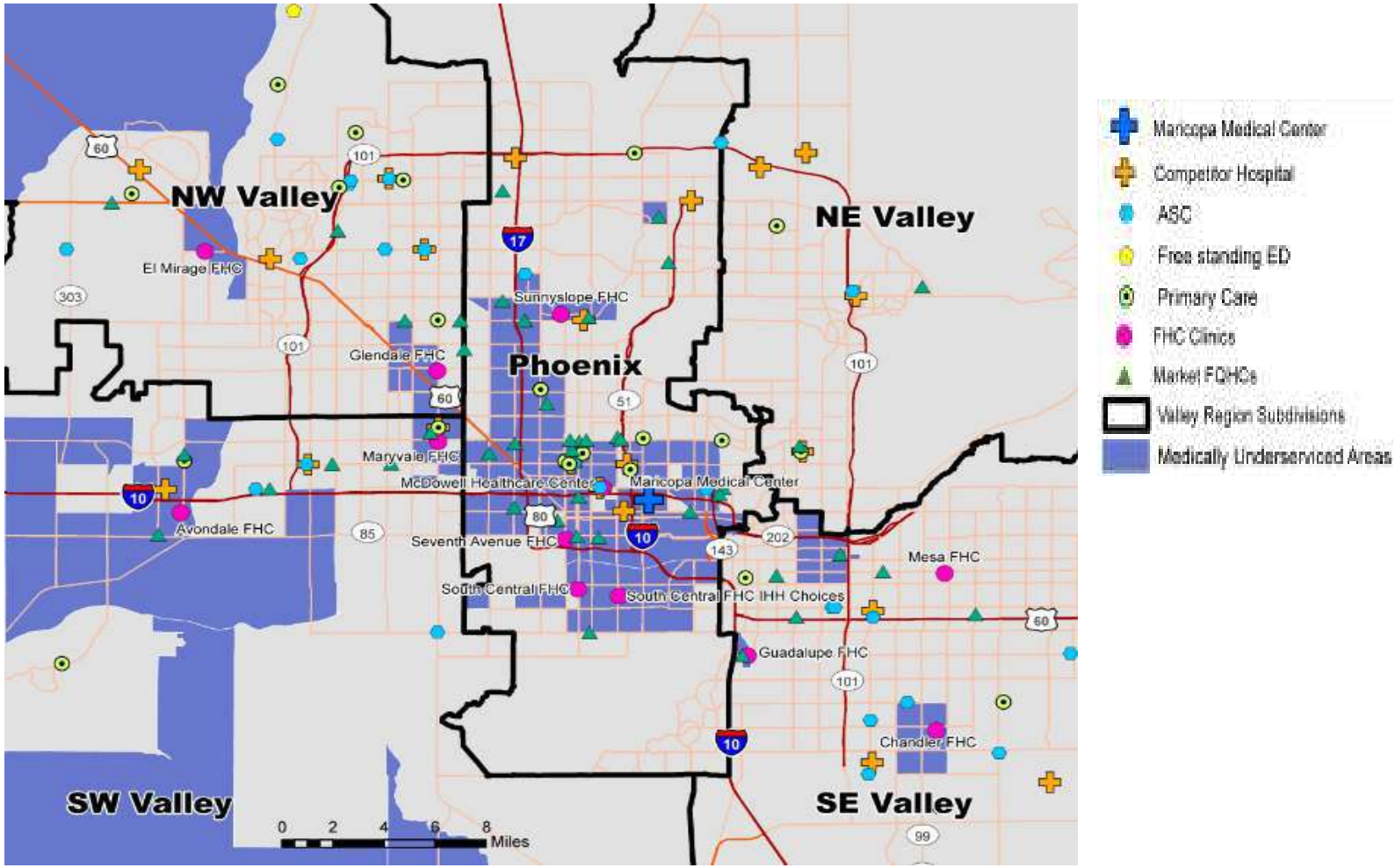
An analysis of FHC primary service areas indicates that several serve the Phoenix Valley



An FHC primary service area is defined as the zip codes from which the FHC generates 70% of its visits

Medically Underserved Areas

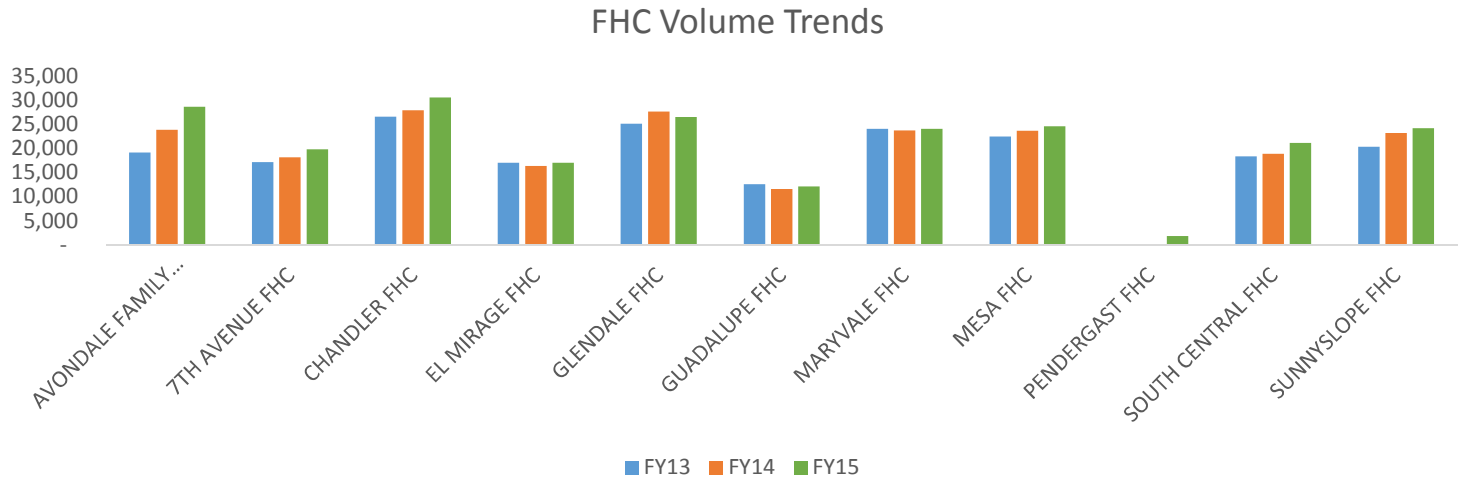
Phoenix Medically Underserved Population



Source: http://datawarehouse.hrsa.gov/tools/analyzers/muafind.aspx

Summary of FHC Volume Trends

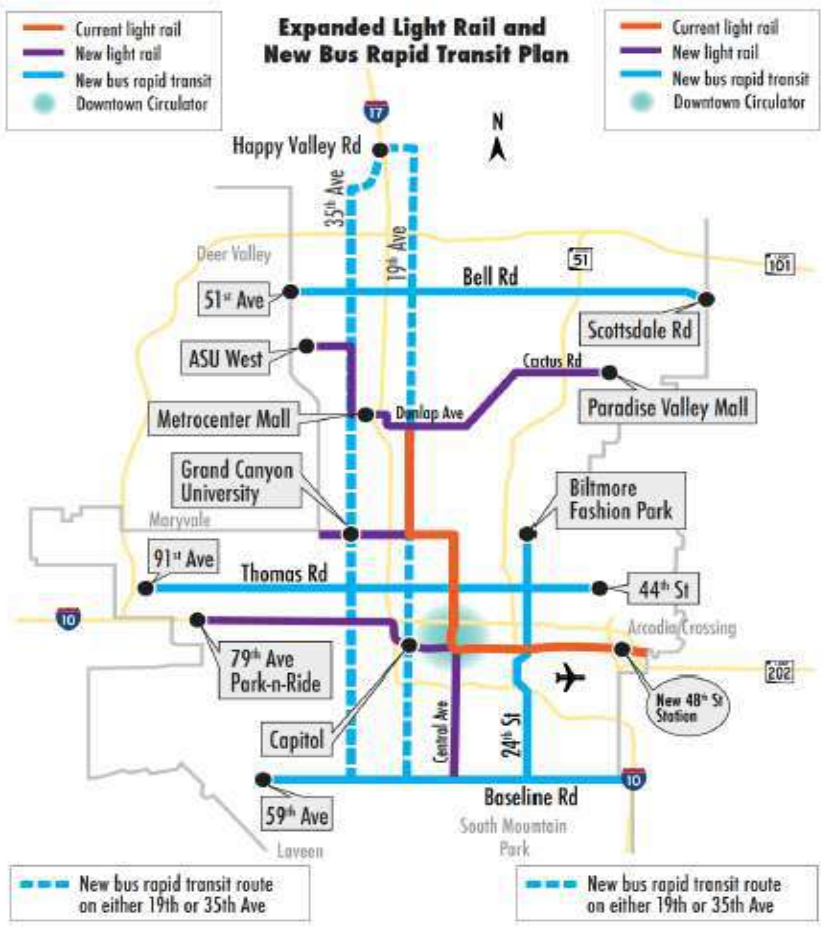
Overall, FHC Volumes Have Shown Steady Growth Over the Past Three Years



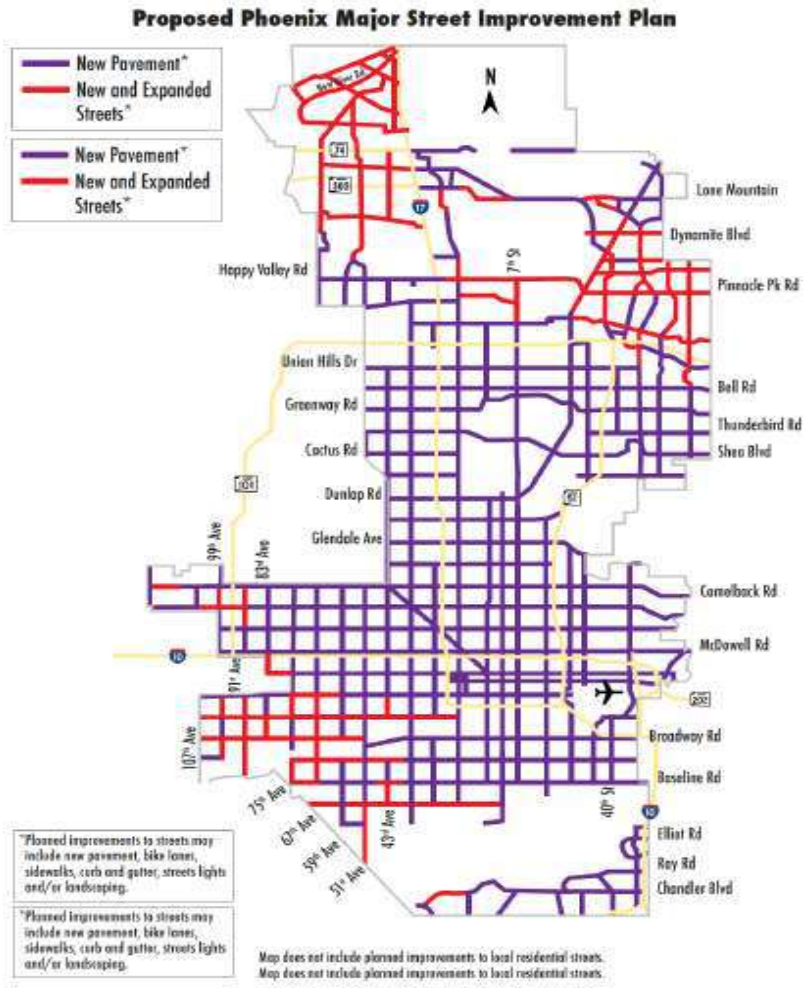
	FY13	FY14	FY15	FY13 - 'FY14	'FY14 - 'FY15
AVONDALE FAMILY FHC	19,126	23,827	28,620	25%	20%
7TH AVENUE FHC	17,194	18,142	19,803	6%	9%
CHANDLER FHC	26,571	27,881	30,524	5%	9%
EL MIRAGE FHC	17,037	16,387	17,039	-4%	4%
GLENDALE FHC	25,093	27,620	26,525	10%	-4%
GUADALUPE FHC	12,627	11,622	12,124	-8%	4%
MARYVALE FHC	24,043	23,707	24,077	-1%	2%
MESA FHC	22,442	23,635	24,557	5%	4%
PENDERGAST FHC	-	-	1,857	-	-
SOUTH CENTRAL FHC	18,389	18,897	21,133	3%	12%
SUNNYSLOPE FHC	20,354	23,170	24,212	14%	4%
Grand Total	**202,876**	**214,888**	**230,471**	**6%**	**6%**

Source: Internal MOAD claims data

Expanded Light Rail and New Bus Rapid Transit



Proposed Phoenix Street Improvement Plan



Current Location: Scoring Methodology

- We created a scoring tool to rate the FHC sites to provide a metric that would be used to guide discussion on the condition of the facilities. Five factors were considered to measure the facility in relation to the context. These factors are; Demographics, Location, Accessibility, Proximity of Other Care Options, and Partnership Opportunities. These factors are measured on a scale of 1 to 5 with 1 being the least desirable and 5 being most desirable. Primarily they are weighted to an industry best practice for Family Health Clinics that are respectable facilities, integrated into the community and accessible by the target population. These four factors were chosen to measure the desirability of a site due to the inherent value of the factor and the ideal scenario for a clinic accessible to the community.
- **Demographics**
  - The population density, population growth, and AHCCCS population at current locations were scored on a 1-5 scale with “1” being least attractive and “5” being most attractive. The three scores were then averaged to determine overall score for demographics.

Current Location: Scoring Methodology (Continued)

- **Location**
  - A macro scale analysis, used to measure the extent that the FHC in located in a desirable area to serve the target population, e.g. the FHC is proximate to residential, retail, commercial, civic and hospitality uses. A site that is well located near a mix of uses is important because it ensures that the clinic is near not only the user's homes and employment but also the everyday commercial and civic needs. This factor is compiled through an assessment of uses in the area as determined by Walk Score (walkscore.com), site visits, and interviews.
- **Accessibility**
  - The overall ease of getting to the site either in a vehicle, transit, bike or as a pedestrian. Priority is given to transit frequency, reliability (i.e. rail vs bus) and quality of sidewalks and pedestrian environment vs simple availability of sidewalks. Degree to which current site provides transportation options other than just a single occupancy vehicle. This factor is compiled through an assessment of transit in the area as determined by Transit Score (transitscore.com) and backed up by site visits of the quality of streets, transit and pedestrian facilities.

Current Location: Scoring Methodology (Continued)

- **Proximity of Other Care Options**
  - Measurement of the proposed or existing similar type of medical facilities in the area. In an effort to provide efficient service it is important to know the proximity of similar types of care options. This factor was determined through a Web based search of other FQHCs and ambulatory centers of other Maricopa County providers.
- **Partnership Opportunities**
  - "3" was defined as a neutral score – to denote the site does not have a propensity toward partnership opportunities, but also does not discourage them. A "2" denotes challenges to attracting and securing partnership opportunities and a "4" denotes a higher likelihood of creating synergy between potential partners.

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Current Location: Scoring Methodology (Continued)

- **Walk Score**
  - Walk Score measures the walkability of any address using a patented system. For each address, Walk Score analyzes hundreds of walking routes to nearby amenities. Points are awarded based on the distance to amenities in each category. Amenities within a 5 minute walk (.25 miles) are given maximum points. A decay function is used to give points to more distant amenities, with no points given after a 30 minute walk.
  - Walk Score also measures pedestrian friendliness by analyzing population density and road metrics such as block length and intersection density. Data sources include Google, Education.com, Open Street Map, the U.S. Census, Localeze, and places added by the Walk Score user community.
- **Transit Score**
  - Transit Score is a patented measure of how well a location is served by public transit. Transit Score is based on data released in a standard format by public transit agencies.
  - To calculate a Transit Score, we assign a "usefulness" value to nearby transit routes based on the frequency, type of route (rail, bus, etc.), and distance to the nearest stop on the route. The "usefulness" of all nearby routes is summed and normalized to a score between 0 - 100.

Current Location: Scoring Methodology (Continued)

- **Bike Score**
  - Bike Score measures whether an area is good for biking. For a given location, a Bike Score is calculated by measuring bike infrastructure (lanes, trails, etc.), hills, destinations and road connectivity, and the number of bike commuters.
  - These component scores are based on data from city governments, the USGS, OpenStreetMap, and the U.S. Census.

Health Center Clinics Included in the Analysis

FQHC Clinics		
Valle del Sol Red Mountain Service Center	Mountain Park Health Center: Tempe	Desert Mission Community Health
Southwest Center for HIV/AIDS	Mountain Park Health Center: Maryvale	Terros: Stapley Counseling
Terros: Safe Haven	Adelante Healthcare: Phoenix	Mountain Park Health Center
Velle del Sol	Terros: Phoenix Interfaith - Dunlap	Neighborhood Outreach
Native Health	NHW Community Health	Mountain Park Health Center: Sunrise
Wesley Health Center	Pascua Yaqui Tribal Health	Adelante Healthcare: Surprise
Terros: HIV/STI Services	Terros: Olive Counseling	Terros: East Valley LADDER
Circle the City: Parsons Family Health Center	Neighborhood Outreach: Heuser Family Practice	Valle del Sol
Circle the City	Terros: Phoenix Interfaith - Tempe	Adelante Healthcare: Peoria
Terros: 27th Ave Counseling	Valle del Sol	Terros: Phoenix Interfaith
Terros: Phoenix Interfaith - 16th Street	Valle del Sol	Adelante Healthcare: Mesa
Mountain Park Health Center: Gateway	Terros: Glendale Counseling	Neighborhood Outreach
Terros: Community Prevention	Valle del Sol	Adelante Healthcare: Avondale
Valle del Sol	Terros: Metro LADDER	Mountain Park Health Center: Baseline
Terros: McDowell Counseling	Mountain Park Health Center: Marc T. Atkinson	Mountain Park Health Center: Christown, YMCA

Ambulatory Surgery Centers in Maricopa County

ASCs	
Banner Estrella Surgery Center	Medpost UCC - Surprise
Banner Del E. Webb Surgery Center	Metro Surgery Center, LLC
Surgicenter	Mt. View Surgery Center at Glendale
Banner Gateway Surgery Center	Mt. View Surgery Center at Gilbert
Banner Thunderbird Outpatient Surgery Department	Mt. View Surgery Center at Phoenix
Camp Lowell Surgery Center	Phoenix Regional Office
Arrowhead Endoscopy and Pain Management Center	St. Joseph's Outpatient Surgery Center
Banner Desert Surgery Center	Physicians Surgery Center of Tempe
Chandler Endoscopy Center	Surgery Center of Peoria
Desert Ridge Outpatient Surgery Center	Surgical Elite of Avondale
MedPost UCC - Peoria	Tempe New Day Surgery Center
Arizona Orthopedic Surgical Hospital	Surgery Center of Scottsdale
MedPost UCC - Gilbert Fiesta	Warner Outpatient Surgery Center
MedPost UCC - Laveen	MedPost UCC - Scottsdale
Abrazo Peoria Emergency Center	OASIS Hospital
Abrazo Buckeye Emergency Center	

Maricopa County Hospitals

Other Hospitals	
Banner Baywood Medical Center	Chandler Regional Medical Center
Abrazo Maryvale Campus	HonorHealth Deer Valley Medical Center
Banner Del E. Webb Medical Center	Mayo Clinic Hospital
Banner Boswell Medical Center	HonorHealth Scottsdale Osborn Medical Center
Arrowhead Hospital	HonorHealth Scottsdale Shea Medical Center
Banner Estrella Medical Center	Mountain Vista Medical Center
Abrazo Scottsdale Campus	Phoenix Children's Hospital
Banner Gateway Medical Center	St. Joseph's Hospital and Medical Center
Banner Good Samaritan Medical Center	St. Luke's Medical Center
Banner Desert Medical Center	HonorHealth Scottsdale Thompson Peak Medical Center
HonorHealth John C. Lincoln Medical Center	West Valley Hospital
Banner Thunderbird Medical Center	Mercy Gilbert Medical Center

Bond Advisory Committee
Ambulatory Care Recommendations

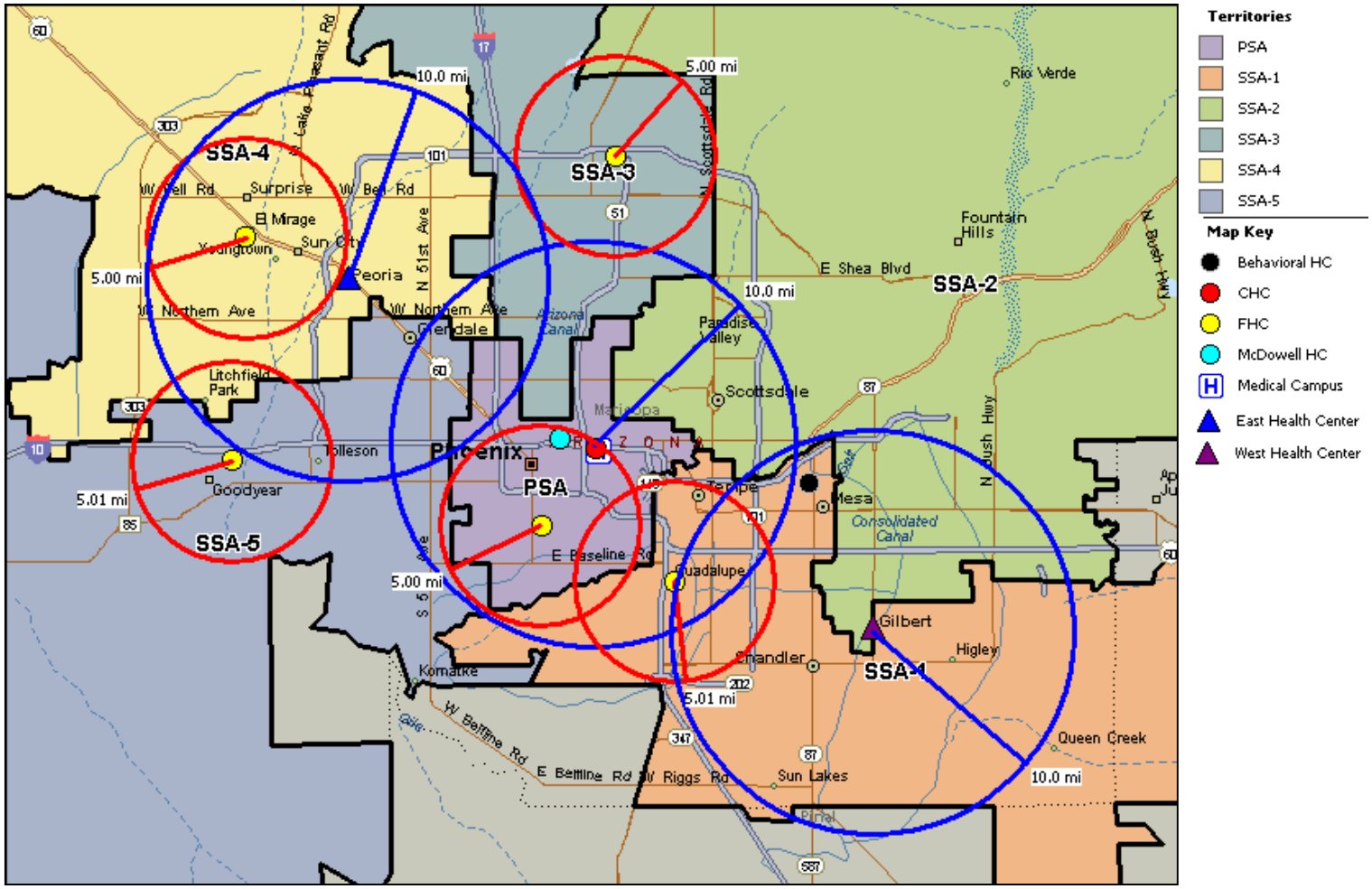
Key Assumptions & Basis for Projections

FHC Ambulatory Network Development

Current FHC Site	Strategic Growth Scenario Strategy	Service Footprint	Growth Level
Avondale	Develop into community model	Community	Above Market
Chandler	Merge with Mesa to form base for Eastern Health Center, SE Valley	SE Health Center	Above Market
El Mirage	Evaluate new site potential for expansion to community model	Community	Above Market
Glendale	Merge with Maryvale to form base for Western Health Center	NW Health Center	Above Market
Guadalupe	Maintain as neighborhood model	Neighborhood	Market Rate
Maryvale	Merge with Glendale to form base for Western Health Center	NW Health Center	Above Market
Mesa	Merge with Chandler to form base for Eastern Health Center	SE Health Center	Above Market
South Central	Maintain as neighborhood model, possible merge with activity from 7th Avenue	Neighborhood	Market Rate
Sunnyslope	Relocation to NE and development of new community model	Community	Above Market
7th Avenue	(1)Maintain as neighborhood model (2)Close, merge activity with South Central	Neighborhood	Market Rate

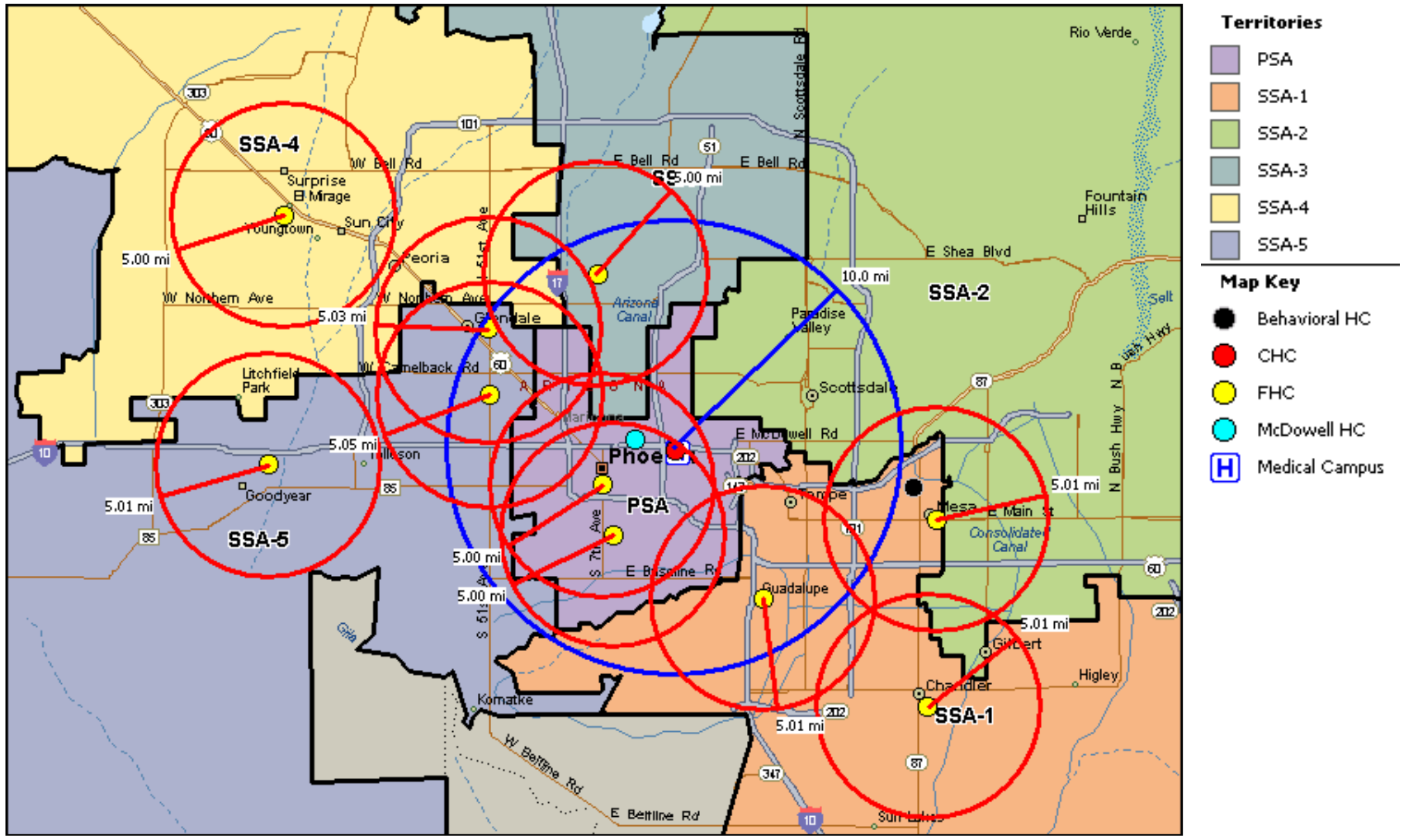
MIHS FHC Consolidation / Addition of Two Health Centers

Goal is to Achieve Better Geographic Coverage and More Efficient Distribution



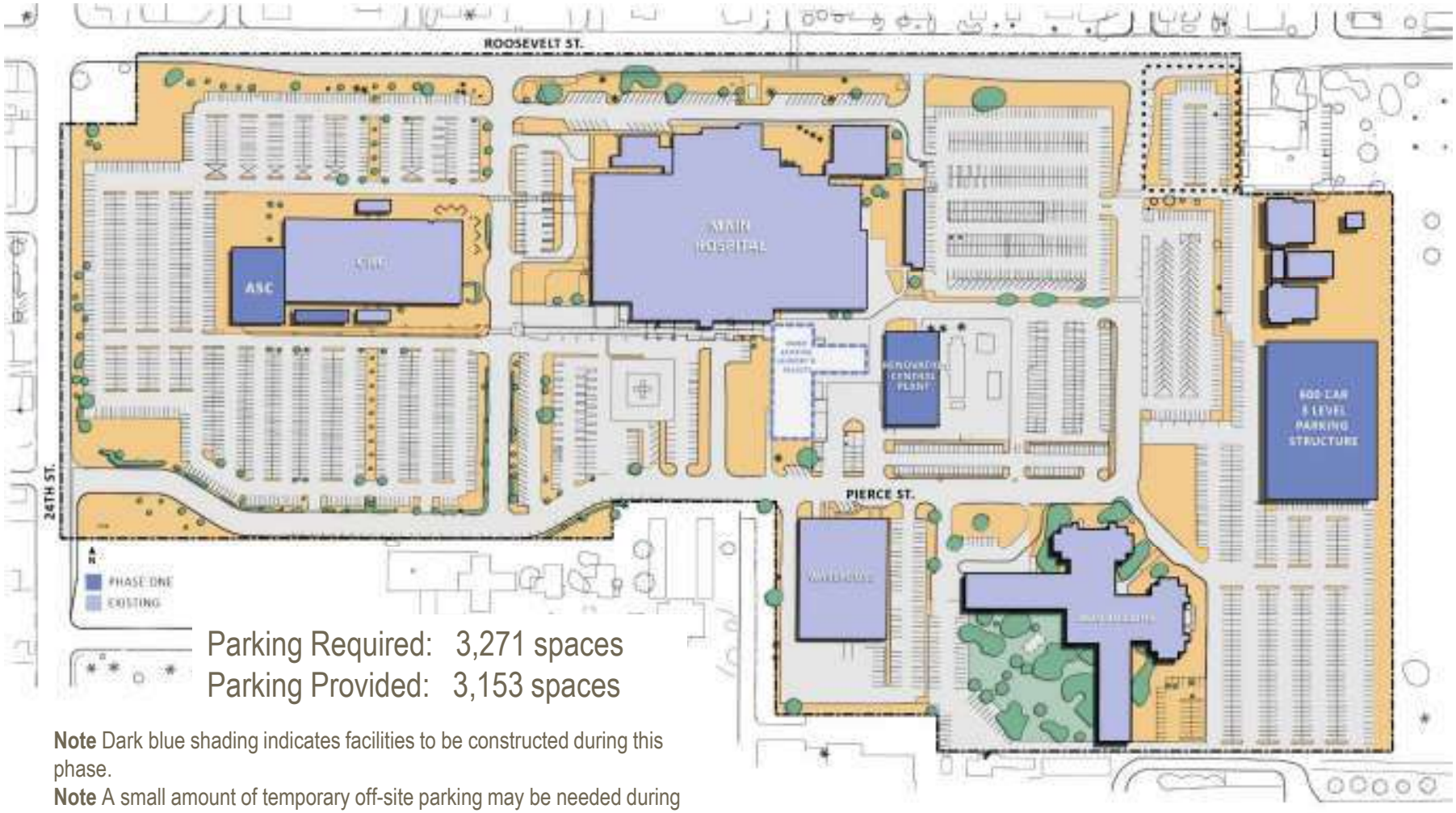
Current State Deployment of Ambulatory Sites

Significant Market Overlap; Need for More Intensive Resources East and West



NAVIGANT HEALTHCARE

Roosevelt Campus—Implementation – Phase 1

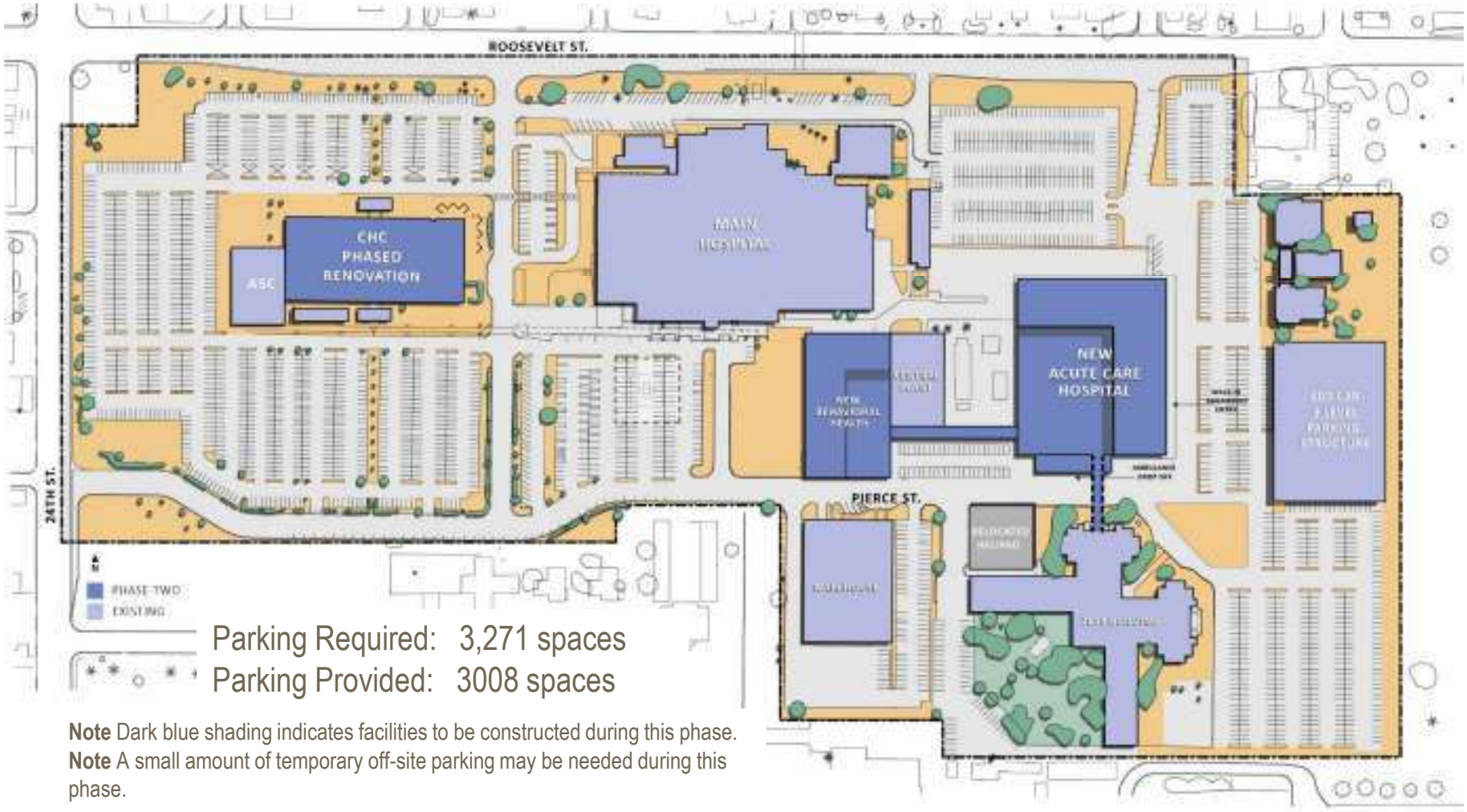


Parking Required: 3,271 spaces
Parking Provided: 3,153 spaces

Note Dark blue shading indicates facilities to be constructed during this phase.

Note A small amount of temporary off-site parking may be needed during this phase.

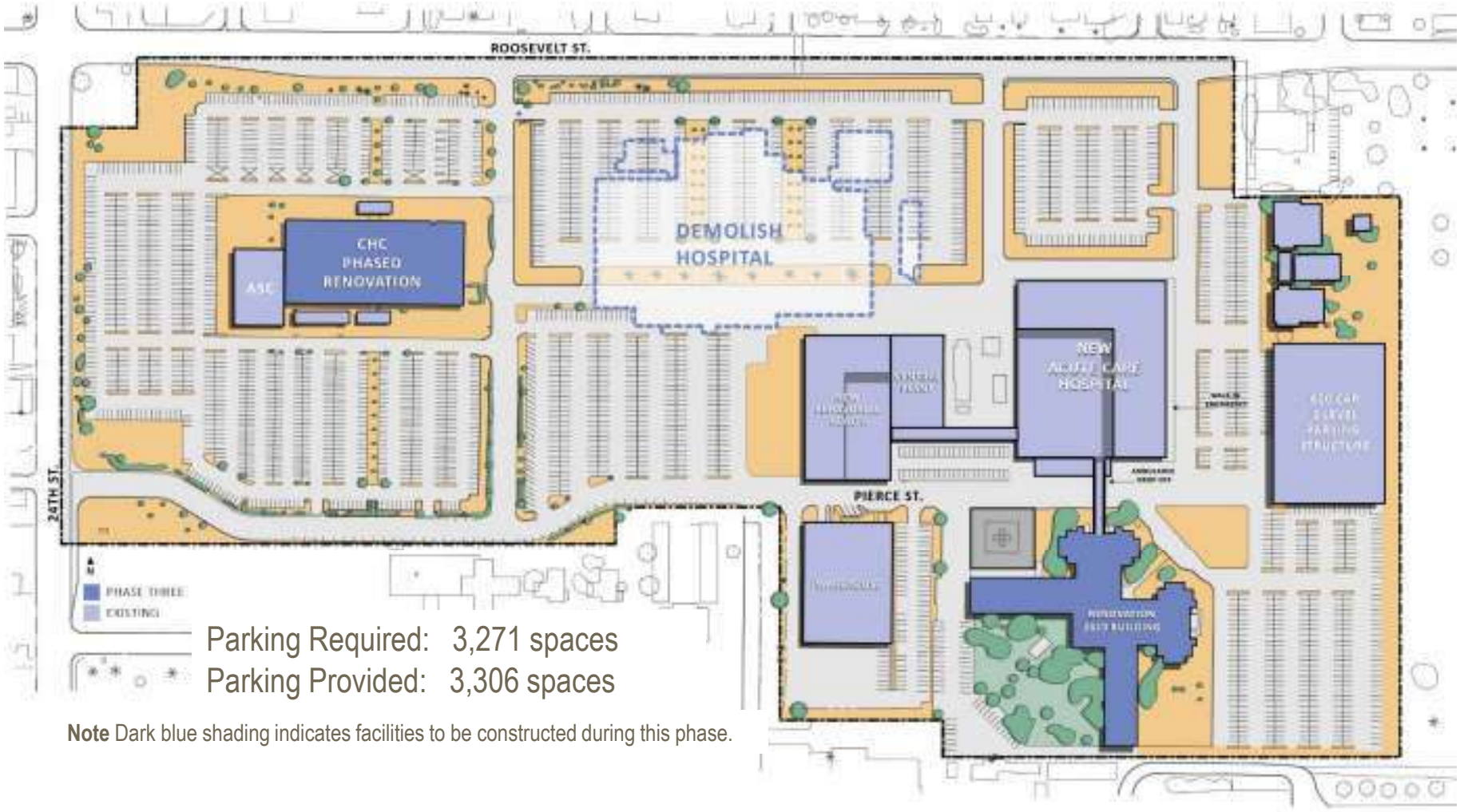
Roosevelt Campus—Implementation – Phase 2



Parking Required: 3,271 spaces
Parking Provided: 3008 spaces

Note Dark blue shading indicates facilities to be constructed during this phase.
Note A small amount of temporary off-site parking may be needed during this phase.

Roosevelt Campus—Implementation – Phase 3



Parking Required: 3,271 spaces
Parking Provided: 3,306 spaces

Note Dark blue shading indicates facilities to be constructed during this phase.

Roosevelt Campus—Implementation – Phase 4

Parking Required: 3,271 spaces
Parking Provided: 3,306 spaces

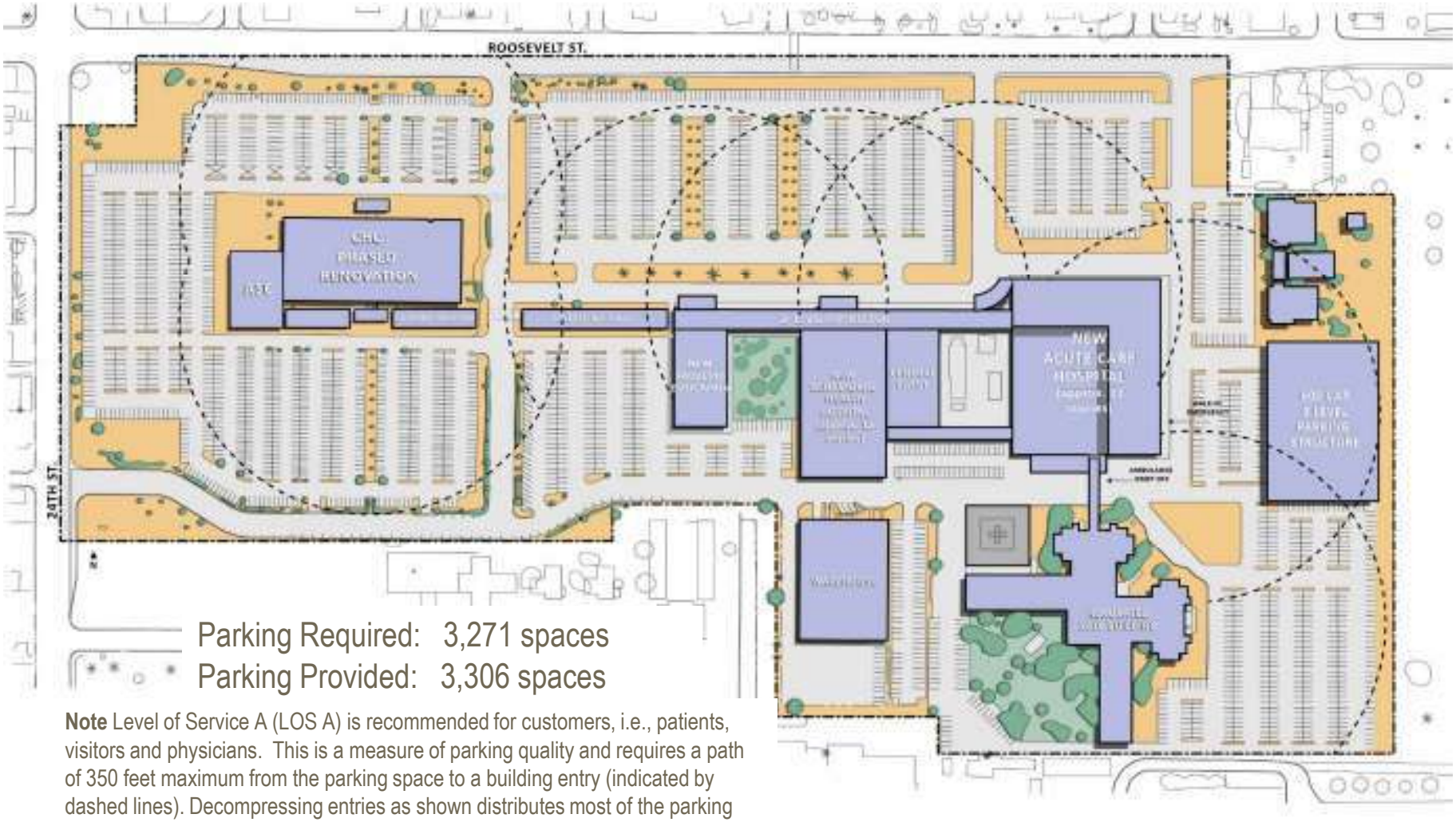
Note Dark blue shading indicates facilities to be constructed during this phase.

Roosevelt Campus—Implementation – Phase 5 (Final Configuration)

Parking Required: 3,271 spaces
Parking Provided: 3,306 spaces

Note MIHS is considering a potential public-private partnership opportunity being solicited by the State of Arizona Department of Health Services for the adjacent Arizona State Hospital. This partnership could possibly affect site configuration, bed need, parking need and other site layout considerations.

Roosevelt Campus—Parking Level of Service



Note Level of Service A (LOS A) is recommended for customers, i.e., patients, visitors and physicians. This is a measure of parking quality and requires a path of 350 feet maximum from the parking space to a building entry (indicated by dashed lines). Decompressing entries as shown distributes most of the parking within 350 feet of an entry.

There is Tremendous Experimentation in Health Care on Innovative Care Delivery and Reimbursement Models

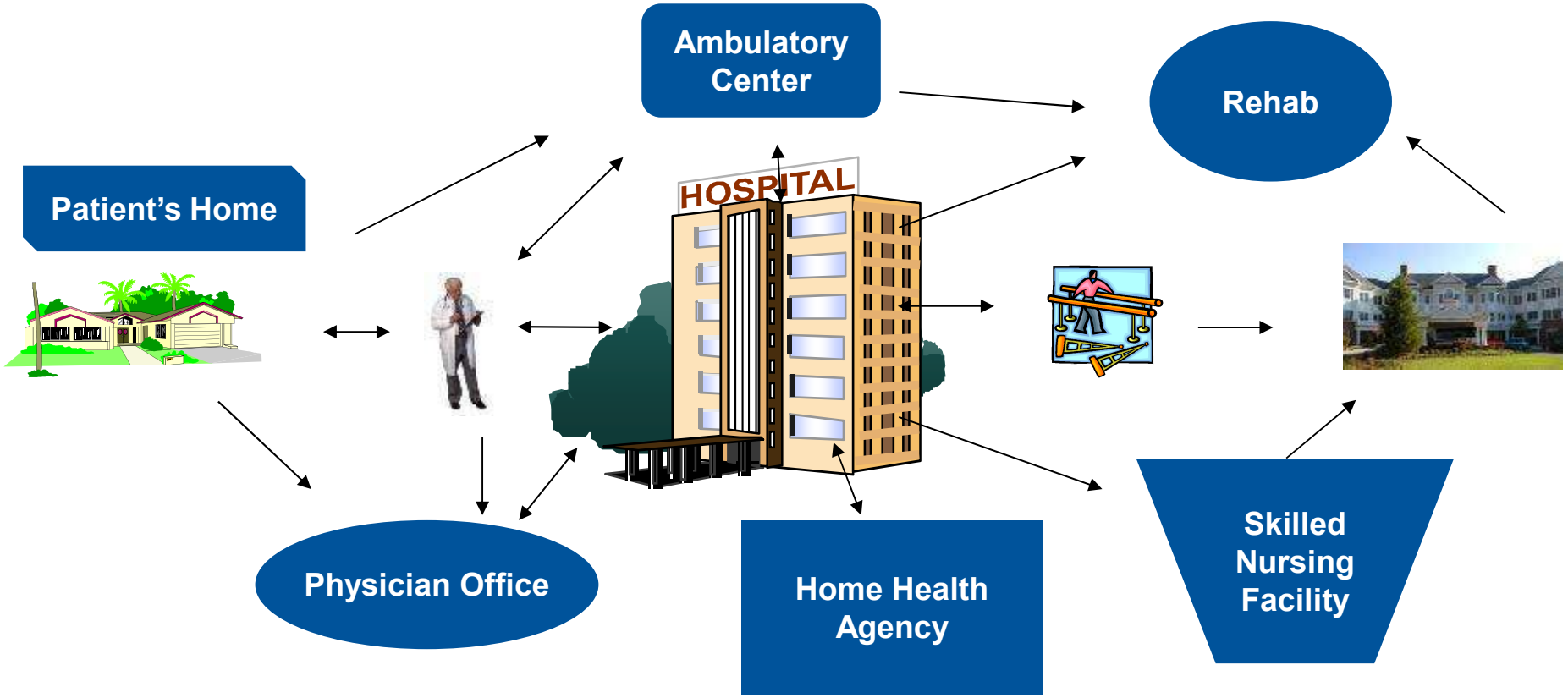
Payor CEOs are focusing on health care value and payment innovation

Payors and providers are piloting innovative new models (ACOs, bundled payments)

"I know we need to move away from volume-based to more outcome-linked reimbursement– *Blues CEO*

Healthcare Delivery Models are Changing

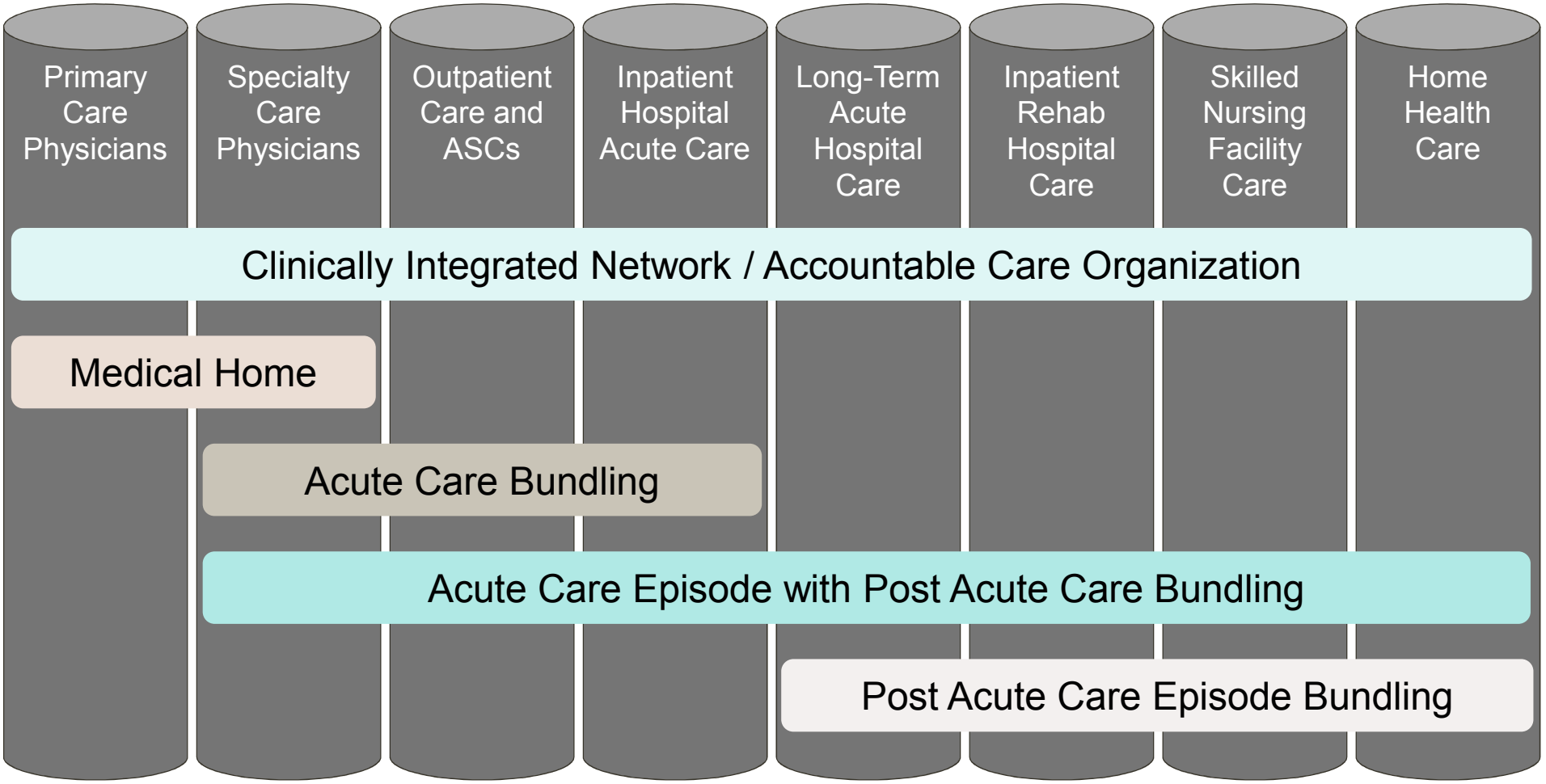
Systems are transitioning from being a hospital business to being a care coordinator



Health Systems are Redefining their Core Business

To Being in the Care Coordination Business

Transforming Fragmented Silos into Coordinated Care



Maricopa Current Mission, Vision, and Values

Source: MIHS website

Mission Statement 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 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.

Values

Respect, Compassion, Collaboration, Excellence, Stewardship, Leadership, Integrity, Education, Innovation, Accountability.

Defining The Key Building Blocks: *Core Purpose / Mission Statement*

- The mission statement articulates the organization's ***reason for being*.**
- It can / should provide ***motivation to people*** for doing the company's work.
- Mission statements are ***lasting*** – they are not changed every few years and serve as a kind of touchstone for everyone in the company.
- They should be ***short*** and very ***easy to understand***.
- ***It is not merely a description of the organization's output or target customers***.

Examples of "Why We Exist"

3M: To solve the unsolved problems innovatively

Cargill: To improve the standard of living around the world

Merck: To preserve and improve human life

Hewlett-Packard: To make technical contributions for the advancement and welfare of humanity

Navigant Consulting: To help our clients be more successful

Nike: To experience the emotion of competition, winning, and crushing the competition

Sony: To experience the joy of advancing and applying technology for the benefit of the public

Google: To organize the world's information and make it universally accessible and useful

Fannie Mae: To strengthen the social fabric by continually democratizing home ownership

Walt Disney: To make people happy

Defining The Key Building Blocks: *Vision*

- Consists of two parts:
  - A multi-year Big Hairy Audacious Goal ("**BHAG**").
  - A vivid description of what it will be like to accomplish that goal (**Envisioned Future**).
- Clear and compelling statement(s) of what the company wants to become / do / accomplish.
- Serves as a **unifying focal point** of effort; clear finish line; engages people—they "get it" right away.
- Require a **multi-year effort** to accomplish. Unlike missions, they can be achieved and you should plan on revising them once they have been achieved or the environment changes.
- These statements can be quantitative or qualitative; focus on a common-enemy; identify a role model; or call for internal transformation.
- These statements are not "slam dunks;" good ones only have a 50%-70% probability of success.
- They inspire and cause those hearing to have a "gulp" factor.

Examples of Multi-Year "BHAGs"

- Become the Harvard of the West (Stanford, 1940s)
- Democratize the automobile (Ford, early 1900s)
- Bring the world into the jet age (Boeing, 1950)
- Crush Adidas (Nike, 1960s)
- Yamaha wo tsubusu! (Honda, 1970s)
- Become number 1 or 2 in every market we serve (GE, 1980s)
- Become a $125B company by 2000 (Wal-Mart, 1990)
- Become the company most known for changing the poor quality image of Japanese products

Examples of Envisioned Future

"I will build a motor car for the great multitude—It will be so low in price that no man making a good salary will be unable to own one and enjoy with his family the blessing of hours of pleasure in God's great open spaces…When I am through, everybody will be able to afford one, and everyone will have one. The horse will have disappeared from our highways, the automobile will be taken for granted…(and we will) give a large number of men employment at good wages." Henry Ford

"We will create products that become pervasive around the world…We will be the first Japanese company to go into the U.S. market and distribute directly…We will succeed with innovations that U.S. companies have failed at—such as the transistor radio…Fifty years from now, our brand name will be as well known as any in the world…and will signify innovation and quality that rival the most innovative companies anywhere…"made in Japan" will mean something fine, not something shoddy." Sony, 1950

Defining The Key Building Blocks: *Core Values*

- Core values are ***essential and enduring tenets*** that are at the foundation of the organization. They describe what the organization believes in.
- They have ***intrinsic versus extrinsic value***. They are important to the people in the organization and do not have to be accepted or endorsed by outsiders.
- They are ***limited number*** (e.g., no more than 5). If you have more than 5, they probably are not core values.

Examples of Core Values

Nordstrom

- Service to the customer above all else
- Hard work and individual productivity
- Never being satisfied
- Excellence in reputation; being part of something special

Disney

- No cynicism
- Nurturing and promulgation of "wholesome American Values"
- Creativity, dreams, and imagination
- Fanatical attention to consistency and detail
- Preservation and control of the Disney magic

Merck

- Corporate social responsibility
- Unequivocal excellence
- Science-based innovation
- Honesty and integrity
- Profit from works that benefit humanity

Maricopa Vision—Significant Work Has Been Done - Current Focus on Affirming and Streamlining Language

RECENT VISION DISCUSSION "TO REINVENT THE COMMUNITY SAFETY NET"

- Given the need for change, the Special Health Care District Board of Directors has set a bold vision for Maricopa Integrated Health System. The vision creates a better model for patient care and medical education that improves access, quality, cost and outcomes for patients and increases the supply of future health professionals.
- First, the vision allocates a greater share of system resources to grow primary and specialty care in underserved parts of the County and to deliver that care more cost-effectively.
- Second, the vision calls for the expansion of behavioral health capacity to meet the glaring need in the community for more mental health and substance abuse services.
- Third, the vision calls for training the next generation of physicians, nurses and allied health professionals in response to an ongoing critical shortage of clinicians in Arizona.
- Overall, the goal is to deliver more care outside the walls of the hospital and in the community, and deploy new methods of clinical training that align accountability for that care with improved outcomes and reduced costs.

Source: MIHS Leadership

Mission, Vision, and Values Refresh

Navigant's Perspective:

- While the mission statement accurately reflects what MIHS is and does, it does not meet the test of being a compelling mission.
- Similarly, the vision statement needs to be refined to reflect the characteristics of a compelling vision and incorporate recent discussions / work.
- There are too many values.

Proposed Values

- Conduct a survey of employees and providers asking them to list top five (5) values of MIHS.
- Create “Word Cloud” like sample below to identify highest frequency responses.

“Straw Model” Mission, Vision, Values

Mission:
To improve the health of Maricopa County

Vision:
To reinvent the community safety net

Values:
***A*ccountability**
***C*ompassion**
***E*xcellence**

MIHS's Envisioned Future

MIHS in Phoenix, Arizona was named the winner of the prestigious "Re-Inventing Healthcare" prize, which is awarded to the healthcare organization that leads the nation in "delivering healthcare the way it should be." The panel of judges unanimously selected MIHS from more than 1,000 other healthcare organizations, and in doing so, noted that MIHS has been a leader in reinventing the community safety net. MIHS is seen as leading the way locally and nationally in managing population health with a new patient-centered delivery model that focuses on prevention and wellness to reduce unnecessary hospitalizations and readmissions. The judges commented that MIHS is a model for the country on how a safety net provider can serve as a catalyst in transforming healthcare for vulnerable populations, improving the health of the community, and in fact, in transforming the community itself.

MIHS's journey to excellence accelerated in November 2014, when the citizens of Maricopa County overwhelmingly approved Proposition 480, which granted the special healthcare district authority to issue and sell general obligation bonds to meet community's need for healthcare facilities throughout Maricopa County. While the bonds stated purpose was to enable MIHS to develop updated and expanded facilities for outpatient care and behavioral health and replace the district's teaching hospital, MIHS's Board and executive leadership recognized that Prop 480 represented a unique, once-in-a-century opportunity to reinvent the community safety net and transform MIHS from the "county hospital" into a model for achieving improved health by addressing health disparities, reducing the impact of the social determinants of health attainment, and improving the economic health of underserved areas.

MIHS's Envisioned Future (Continued)

As part of its transformation, MIHS conducted a comprehensive review of its mission, vision, and values and developed a bolder, clearer, and more compelling mission and vision which served to focus MIHS's efforts and created a powerful motivational touchstone for MIHS's staff and physicians. The mission shifted from a general description of what MIHS is and does to one that reflects the essence of why it exists ("To improve the health of the community"). And the vision became both simpler and more challenging: "To reinvent the community safety net." Underpinning this ambitious vision were several strategic imperatives, including delivering more—and better—care more cost efficiently in the community, expanding and integrating behavioral health capabilities and programs to better meet pressing community needs, developing and deploying new methods of training the next generation of health professionals, collaborating with others to create healthier communities, and improving performance excellence in operations, patient experience, and quality.

Delivering More—And Better—Care

The judges noted that one of the keys to MIHS's selection was the development of care models aimed at population health management for vulnerable populations rather than merely taking care of people when they got sick. MIHS's innovative approach to providing increased access to care, expanded behavioral health capacity, and integrated programs to better prevent and treat mental illness have significantly moved the needle on health disparities to the point that minorities in Maricopa County, who historically had increased rates of chronic illness and poor health outcomes, now are as healthy as the

MIHS's Envisioned Future (Continued)

average American. MIHS's patient centered medical home evolved into community centered health homes and MIHS reoriented its practices, programs, and quality initiatives to work effectively with the new capitated payment system and was rewarded for the improved health outcomes of its patients.

Prop 480 also enabled MIHS to expand and diversify its ambulatory care network, providing funds for the construction of three new multi-specialty Comprehensive Health Centers and several new Family Health Centers and FQHCs in strategic locations throughout the County. These facilities offer a range of services 7 days a week, 8 am to 8 pm, and through partnerships with other community-based organizations, address factors that affect the community's health, including employment, education, access to care, communication, and transportation. In addition, the availability of these facilities provides greater access to care locally and helps alleviate unnecessary ED visits and moves these patients to a more appropriate, lower cost place of service.

MIHS also recognized that part of its new vision was to provide ***more*** care ***in*** the community and it therefore initiated an aggressive program to diversify and expand its offerings through ambulatory surgery centers and urgent care centers (in addition to its expanded network of Comprehensive Health Centers and Family Health Centers).

MIHS's Envisioned Future (Continued)

Integrating Behavioral Health

One of the core components of Prop 480 was funding for expanded behavioral health capacity to meet pressing community needs. MIHS took this mandate on and has become a model for the nation on how to integrate medical and behavioral health services. Behavioral health was integrated into the community centered health home concept with innovative payment models that encouraged the use of peer support, health coaches, social workers, community health workers, and primary care providers working in concert with behavioral health providers. Gone are the days in which behavioral health and physical health were provided completely independently. Now, patients admitted to MIHS see a team of providers working together to meet all of the patients needs, regardless of their primary presenting issue. Through a partnership with the State of Arizona, MIHS was able to develop prevention and early identification initiatives which were rolled out to schools, community groups, and medical providers throughout Maricopa County. In addition, MIHS helped organize a Community Advisory Council composed of community leaders and organizations involved in behavioral health that facilitated the coordination of identification, prevention, and treatment programs throughout the County. MIHS has been so successful in its efforts to better integrate behavioral healthcare into the mainstream of acute and ambulatory healthcare that the State of Arizona has recognized MIHS for its accomplishments in this area.

MIHS's Envisioned Future (Continued)

New Methods of Training the Next Generation of Health Professionals

MIHS is Arizona's public teaching hospital and had historically been the largest clinical teaching program in Maricopa County. In its heyday, MIHS trained more than 400 physicians every year in highly sought-after graduate medical education programs, ranging from emergency medicine to psychiatry, and provided more than 3,000 clinical rotations a year to train medical students, nurses and allied health professionals. However, as the healthcare marketplace evolved in the late 2010s and early 2020s and inpatient volumes contracted, MIHS was forced to reexamine its role in medical education. What emerged from that assessment was a decision to continue MIHS's role in medical education but to do so in a more innovative, more focused manner. In addition, MIHS's focus on burn and critical care allowed it to become "the" place for emergency medicine and intensive care residency programs. And MIHS's participation in the Phoenix Area Research Collaborative helped increase the number of research grants. MIHS's new model of medical education, combined with its patient-centered, transparent, collaborative, accountable, and value-driven approach to care (supported by new facilities) has made MIHS one of the more desired locations for training in the country.

MIHS's Envisioned Future (Continued)

Collaborating to Create Healthier Communities

Perhaps one of the more notable hallmarks of MIHS's transformation was the development of innovative partnerships, not just with other healthcare providers, but with a wide array of community organizations and groups throughout the greater Phoenix area. Today, MIHS has strong clinical, academic, and business partners, all of whom are working together to better deliver care, especially to vulnerable populations. MIHS works collaboratively with community partners to address factors that affect a community's health, including employment, education, access to care, communication, and transportation. As with its program complement, MIHS recognized that one of the keys to its survival and success was to identify and focus on what it does best and partner with others for what they do best. These partnerships engaged the entire community with a focus on leveraging public and private resources to achieve what is known as the "triple aim:" improving the health of the population, enhancing the care experience, and reducing cost. As a result of this emphasis on collaboration and partnership, the local neighborhood has changed dramatically for the better, with improved transportation infrastructure (including light rail), modern and affordable housing, community parks, and a burgeoning small business community. The local citizens community committee noted that thanks to MIHS and like-minded community partners taking a long, hard look at how they could work together to transform not just the MIHS campus but the entire community, the impact of Prop 480 has been far greater and longer lasting than anyone could have imagined.

MIHS's Envisioned Future (Continued)

Collaborating to Create Healthier Communities

The judges also noted that the selection of MIHS was influenced by the partnership MIHS has with its physicians and the remarkable degree of alignment, engagement, and integration with the District Medical Group (DMG). This alignment can be traced back to the redrafted contract between DMG and MIHS that called for greater shared risk between the organizations and a greater focus on collaborating on ambulatory care and population health management. The partnership built off of the deep commitment to MIHS's mission and vision that MIHS and the physicians shared. As one judge noted, "There is no "us versus them." MIHS and DMG are one multi-disciplinary team of care givers working together to create health for the community by providing the right care at the right place at the right time at the right price."

MIHS's Envisioned Future (Continued)

Improving Performance Excellence

A key element of MIHS's transformation has been its relentless focus on improving performance excellence in everything it does. This focus began even before the passage of Prop 480, when MIHS's leadership team launched a major program designed to significantly reduce MIHS's operating expenses and enhance its efficiency. In addition to identifying significant efficiency and cost reduction opportunities, this effort led MIHS to review virtually every department and function in the organization and outsource those that could be done better, faster, and/or cheaper by other organizations.

MIHS's focus on performance excellence focus also included dramatically improving its quality metrics. An objective assessment of MIHS's quality metrics in 2016 galvanized the organization and created a shared purpose to standardize its use of best practices to ensure patients consistently received the best care possible. MIHS's E.H.R. served as the "glue" to this effort, enabling effective coordination of care across care sites and easy access to necessary data and information. The E.H.R. allows MIHS to seamlessly transition patients from one level of care to another which led to expedited treatment decisions, which in turn led to reduced admissions and ED visits. Furthermore, MIHS has been a leader in technology enablement and telehealth. Its telehealth and real-time patient-provider interaction was well-received by patients and providers and resulted in a sharp increase in medication adherence, timely appointment availability and provider access, which contributed to reduced readmissions and enhanced revenue due to simultaneous coding and billing connections. Primary care is now accessible to all Maricopa citizens, regardless of distance, through the use of mobile and biomonitoring devices.

MIHS's Envisioned Future (Continued)

Improving Performance Excellence

Healthcare professionals (doctors, physician assistants, nurse practitioners and health coaches) collaborate as an extended care team to provide health, wellness and disease management options to patients and families across Arizona. Professional health monitoring devices and video solutions have reduced hospital admissions and treatment costs at MIHS and across the state, while simultaneously allowing patients treatment options virtually in the comfort and privacy of their home. Health kiosks at local malls and pharmacies handle patients' needs for medical tests, cancer screening, diagnosis, and referrals for specialty care. Smart consumers take advantage of these technologies, to stay healthy and purchase services on the basis of high quality and low price. As a result, MIHS has achieved "best in class" quality metrics.

An exciting example of MIHS's technological innovation was the "My Integrated Health Service" app, which provides easy access to information for patients, their families, and providers and ensures seamless navigation of health services and information. Through the "MIHS" app, which includes alerts and scheduling capabilities, patient needs are well-anticipated and patients are actively engaged in managing their health. In short, patients describe MIHS as their "go to resource for health" and marvel at MIHS's ability to anticipate their health needs. These improvements have led to some local wags to comment that MIHS stands for "Most Improved Health System," while others counter that it stands for "Most Impressive Health System."

MIHS's Envisioned Future (Continued)

Improving Performance Excellence

Another component of MIHS's emphasis on performance excellence was the transformation of MIHS's culture to one characterized by a sense of ownership, collaboration, communication / transparency, decisiveness, and improving every day. The judges commented that on their anonymous site visit, every time they looked lost or confused, an MIHS team member would ask if they needed help and answer their question or get them to where they needed to go. And the MIHS team members always thanked them for choosing MIHS for their care. So it is no surprise that MIHS is top decile in patient satisfaction.

Physicians, nurses, and staff were particularly excited about being involved in leading the way in population health management, an effort that started shortly after passage of Prop 480 when MIHS piloted a series of innovative population health programs for its own employees and their dependents and was then rolled out to local businesses, starting with its nearby neighbor Sky Harbor International Airport. MIHS is now considered one of the best places to work in the state of Arizona with turnover rates among the lowest in the state. As one judge noted, "MIHS recruits to its culture. The only waiting list MIHS has is the list of people from around the country who want to work there. They don't hire—they select."

MIHS's Envisioned Future (Continued)

The Next Century of Service

Having been an integral part of Arizona's healthcare delivery system since before Arizona was a state, MIHS has endured numerous trials and tribulations and evolved greatly since the Maricopa County Board of Supervisors first approved funding for indigent healthcare in 1872. With the passage of Prop 480, MIHS shifted its focus from survival to sustainability to success. MIHS has gone from almost an afterthought in the Phoenix healthcare market to a provider that is highly regarded locally and nationally for its outstanding outcomes, innovative partnerships, creative education program, world class integrated behavioral health service, and sustained performance excellence. Today, the quality of life in Arizona is better because of MIHS's work and its collaboration with other community organizations. The State Medicaid program has saved hundreds of millions of dollars over the past ten years because of MIHS's success in reducing duplication of services in the community, its effective management of patient care, and its ability to reduce avoidable (and expensive) visits and readmissions to hospitals.

In summary, the judges concluded that MIHS's ability to articulate a clear and compelling vision and its ability to execute on that vision made the selection decision an incredibly easy one. As the judges noted, "MIHS put a stake in the ground and said they wanted to reinvent the community safety net and lead the transformation of healthcare delivery in Maricopa County, the state of Arizona, and the nation and they backed up that vision with action and made it happen."