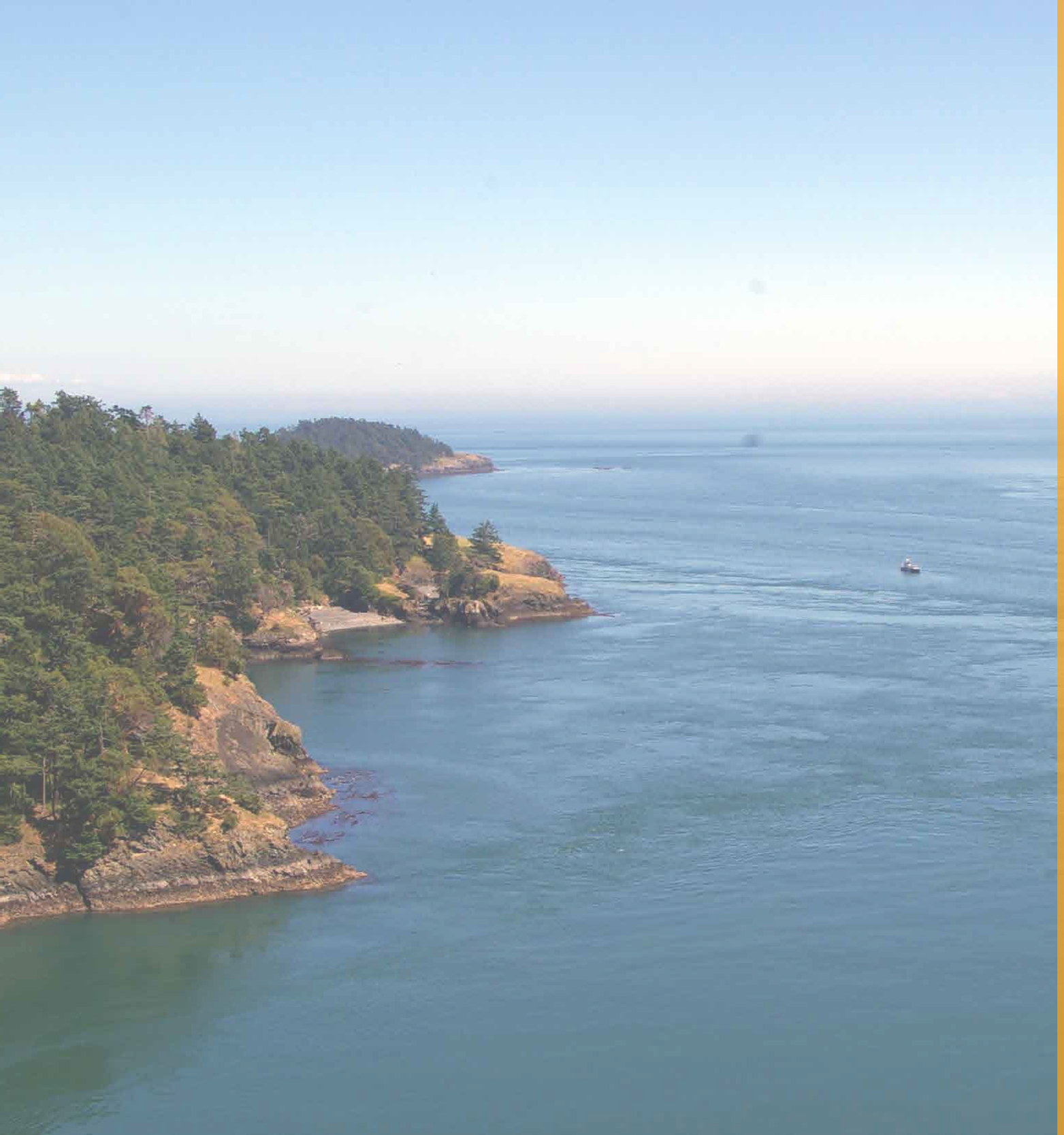


ISLAND HOSPITAL MASTER PLAN

SEPTEMBER 27, 2013

ISLAND HOSPITAL

nbbj

PLANNING

VISIONING

DISCOVERY

EXECUTIVE SUMMARY

Island Hospital asked NBBJ to advance master planning for their medical campus in Anacortes. Our work together with hospital executives and Island Hospital board members commenced in January 2013 and was completed in September 2013. The master planning team, demonstrating deep organizational understanding and community commitment, tasked themselves with optimizing the hospital's campus viability and relevance in a dynamically changing health reform environment.

The macro and micro approach to planning was adopted by the master planning team; near-term service needs and programmatic challenges were explored alongside broader assessments of national and local trends. Master planning goals were solidified and focused on assuring organizational viability and preservation of an efficient, comprehensive medical campus while advancing the health and well-being of the Anacortes community. With this clarity and mindset, the planning team focused on the physical campus and shifts that are likely necessary in the near and long term.

While the focus of the team's work remains squarely on the campus, thinking more broadly about Island Hospital's future success brought forth many other ideas that are catalogued with the master plan documentation for use in later strategic efforts. These ideas, while not acted on in the planning work, suggest that Island Hospital should continue to keep open conversations about servicing the broader Anacortes community along the care continuum in support of reducing costs and improving health outcomes. In brief, ideas included, and that should remain open for conversations, are as follows:

- Development of specific centers of excellence and an increase in in-migration of services
- New business models such as off-campus ambulatory surgery centers
- Growth in employer health service programs
- Advancing development of hospice programs and additional options for long term care.

This study ultimately evolves into a master planning strategy that emphasizes development of a framework that is responsive to immediate needs, while at the same time, flexible in consideration of potential future alliances or other, yet unknown, changes within the market. This plan outlines the phased, ongoing opportunities and investments for Island Hospital. The next steps critical for successful execution of the new master plan include:

1. Zoning the campus into Hospital and Ambulatory zones
2. Prioritizing campus facility development strategies with cost projections
3. Developing a timeline and frame work for the long term campus plan of the hospital

Details of the plan are found in the following document.


0'
20'
40'
24th STREET
24th STREET
M AVENUE
COMMERCIAL AVENUE
25th STREET
25th STREET
26th STREET
26th STREET
PARKING, NEAR TERM
MODERNIZATION OF CLINICAL AND OPERATORY SERVICES
CONTINUED GROWTH OF AMBULATORY SERVICES TO MEET GROWING HEALTHCARE TRENDS
"EMPTY CHAIR" ZONE FOR FUTURE HOSPITAL EXPANSION
NEED TO MOVE ESSENTIAL SERVICES OUT OF THE OLDEST BUILDINGS
REDIRECT 26th STREET TO CLARIFY HOSPITAL ZONE
PARKING, LONG TERM

CAMPUS PLANNING

STRATEGY AND SEQUENCING OF MAJOR COMPONENTS OF THE ISLAND HOSPITAL CAMPUS

CURRENT SITE

24th STREET

M AVENUE

25th STREET

26th STREET

COMMERCIAL AVENUE

24th STREET

25th STREET

26th STREET

0' 20' 40'

PATIENT & VISITOR

EMERGENCY WALK-IN

AMBULANCE

LOADING

SITE
CURRENT

SITE DRIVERS

Key drivers of the current state of the campus that provided the focus of the 2035 Island Hospital Campus Master Plan Study are as follows:

- Desire for distinct Main and Emergency entrances to the hospital to improve way finding and patient experience.

- Strategize future development to enhance and improve the visual presence and recognition of the Island Hospital campus from Commercial Avenue.

- Relocate the helipad to be above grade allowing, for additional parking area and elimination of occasional damage caused to vehicles from rotor wash of large aircraft.

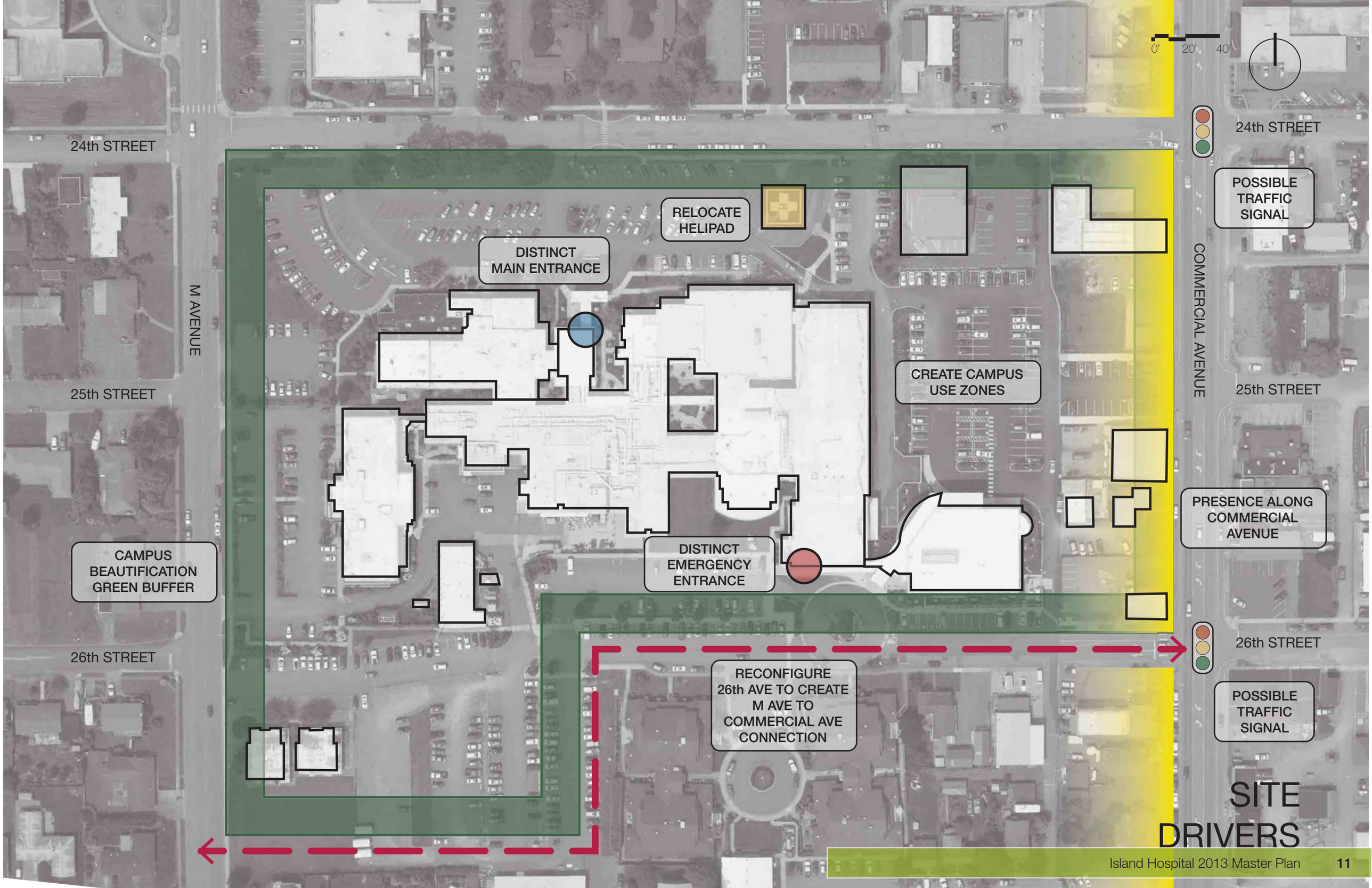
- Identify campus use zones to guide future development and create clarity of campus organization. This will help to focus way finding and understanding of campus services and provide planning that will secure future development land for the long term existence of Island Hospital.

- Acknowledge the potential need for traffic signals at the intersections of 24th and 26th streets and Commercial Avenue. This will provide safe turning for public and emergency vehicles entering and exiting the campus. It will particularly address the challenges of making a left north bound turn from the campus to Commercial Avenue.

- Because Commercial Avenue is a State of Washington highway, further interactions with Washington State Department of Transportation will be required. A traffic study and potentially an EIS may be required as part of the process.

- Develop a through block connection of 26th Street connecting M and Commercial avenue to provide though block vehicular passage outside of the Hospital campus. A traffic study and potentially and EIS may be required as part of the process.

- Concept of a campus green edge for beautification and enhanced campus identity.



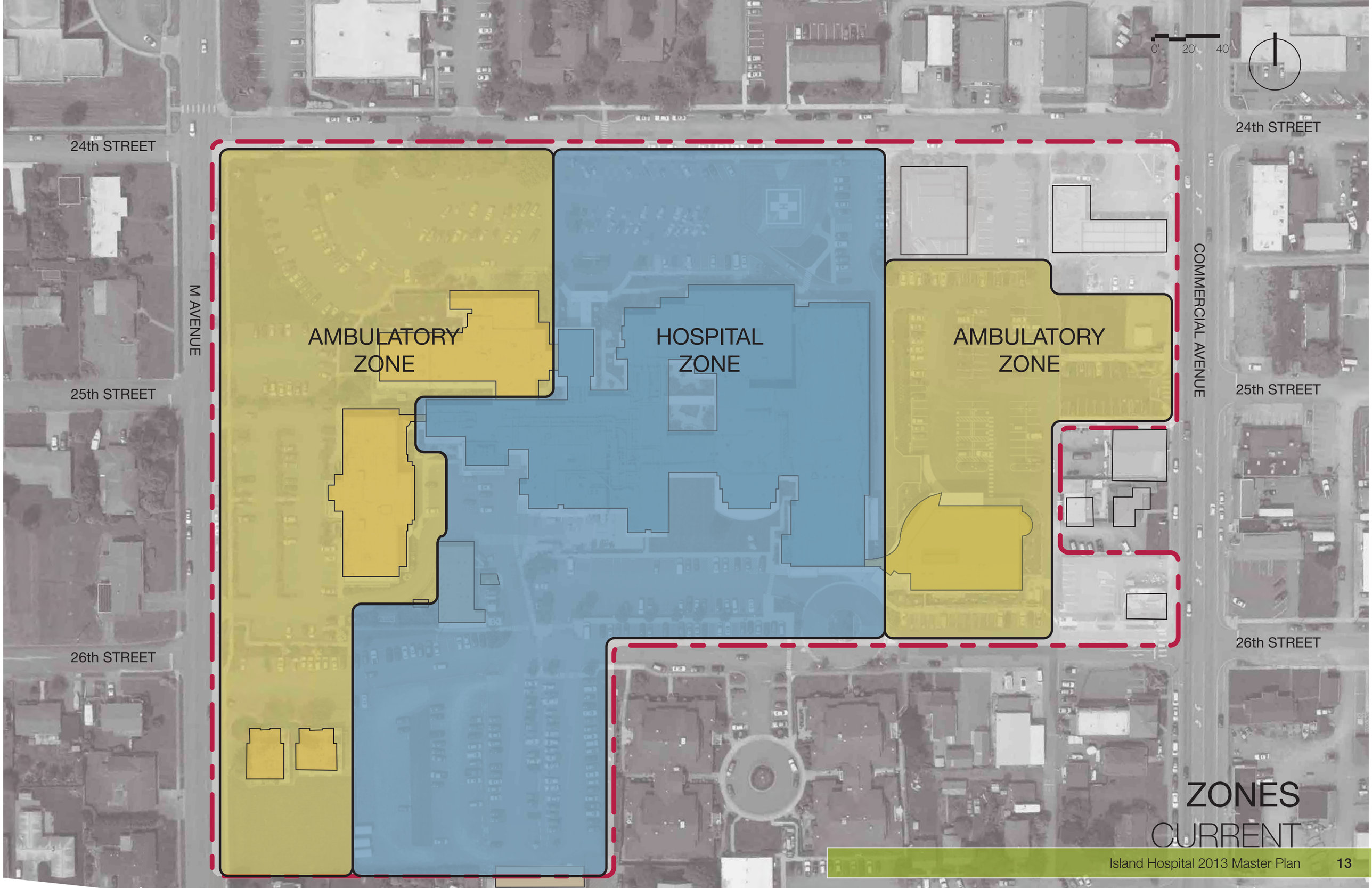
SITE DRIVERS

CURRENT ZONES

The existing campus is partitioned into three areas:

- The western segment is for ambulatory use
- The center zone is for hospital acute care
- The eastern zone is used for ambulatory care

The current zoning is a product of long term growth of the hospital over time. The past growth of the campus appears to have been organic in nature and responsive to the immediate needs the Hospital addressed. Now that the hospital land is largely occupied it is evident that a path for structured yet flexible development needs to be established.



ZONES
CURRENT

FUTURE ZONES

The 2035 master plan proposes a long term strategy that partitions the campus into two zones for clarity of campus organization and patient flow:

Ambulatory Zone - fronting Commercial Avenue to the west.

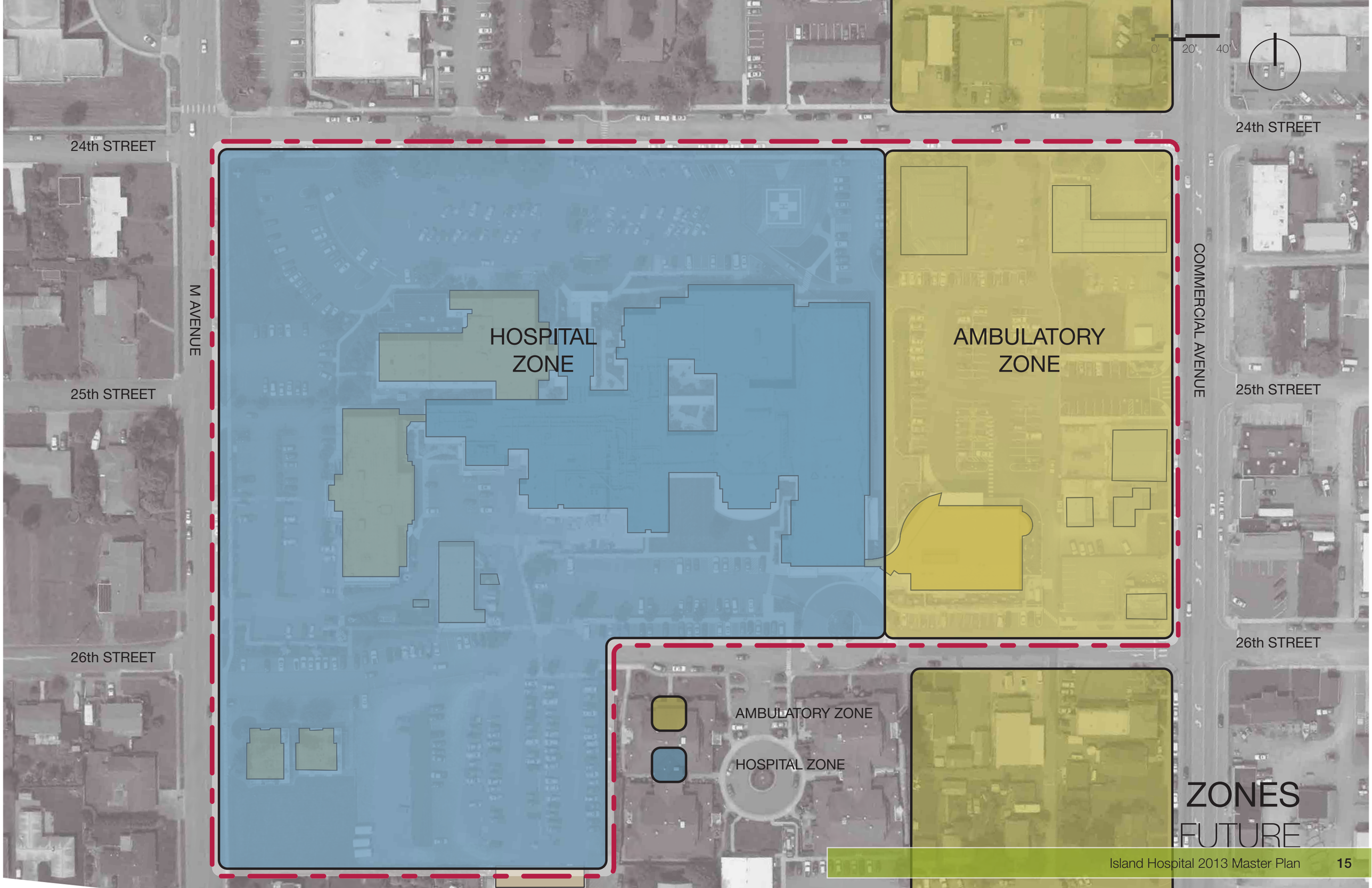
- As ambulatory service needs require additional space, new Medical Office Building (MOB) development is recommended in the Ambulatory zone.

- As the oldest MOBs on the western section of the campus exceed their usable life, replacement and expansion MOB development should occur in the Ambulatory Zone. This will clarify development, provide better circulation, locate patients closest to services, and provide land area for future flexibility.

Hospital Zone - focused to the center and eastern boundary of the campus

- As the existing ambulatory buildings on the west side of campus exceed their useable life, it is recommended that they be demolished to allow for future hospital development and parking. This strategy develops the “Empty Chair”, reserving space for future replacement and expansion of the hospital beyond 2035.

Acquisition of property in the proposed Ambulatory Zone is recommended.



ZONES FUTURE

NEAR TERM | 5 - 10 YEARS

The Near Term strategy, within the next five to ten years, addresses the most pressing current state needs of the hospital: increase surgical volumes, resolve code citations within the current surgical department, increase parking capacity, resolve cross flow issue and modernization needs of ICU, and locate the helipad above ground.

The 2035 study proposes that a hospital addition be constructed directly north as an extension of the 2007 Island Hospital Renovation and Expansion Project (IHREP). This addresses current needs on property presently owned by the hospital. The expansion is proposed as: lower level MOB, level one Obstetrics (OB), level two Intensive Care Unit (ICU), and a prefabricated roof mounted helipad. A vertical transportation core will be required to connect staff and public flow and will need to extend to the roof to serve the helipad. A connection to surgery between OB and ICU will be maintained accordingly.

The study also proposes that a parking structure be developed at the northwest corner of the campus. To maximize gained parking spaces, it is envisioned that the structure would be two non-contiguous decks; one elevated the other at grade. Also proposed, for near term development, is extending 26th Street as a connection between Commercial Avenue and M Avenue, on the south border of the Hospital's property. This formally addresses non-hospital related traffic that uses the hospital parking lots and drives as a through block connection.

It is recommended that the hospital continue to pursue acquisition of property in the proposed ambulatory zone. Until the time that new MOB development is appropriate, the land can be considered for use as surface parking.

Development contingencies:

- The expansion will require coordination to move, bury, or work around the existing pad mounted transformer located on the east property line of the ambulance drive.

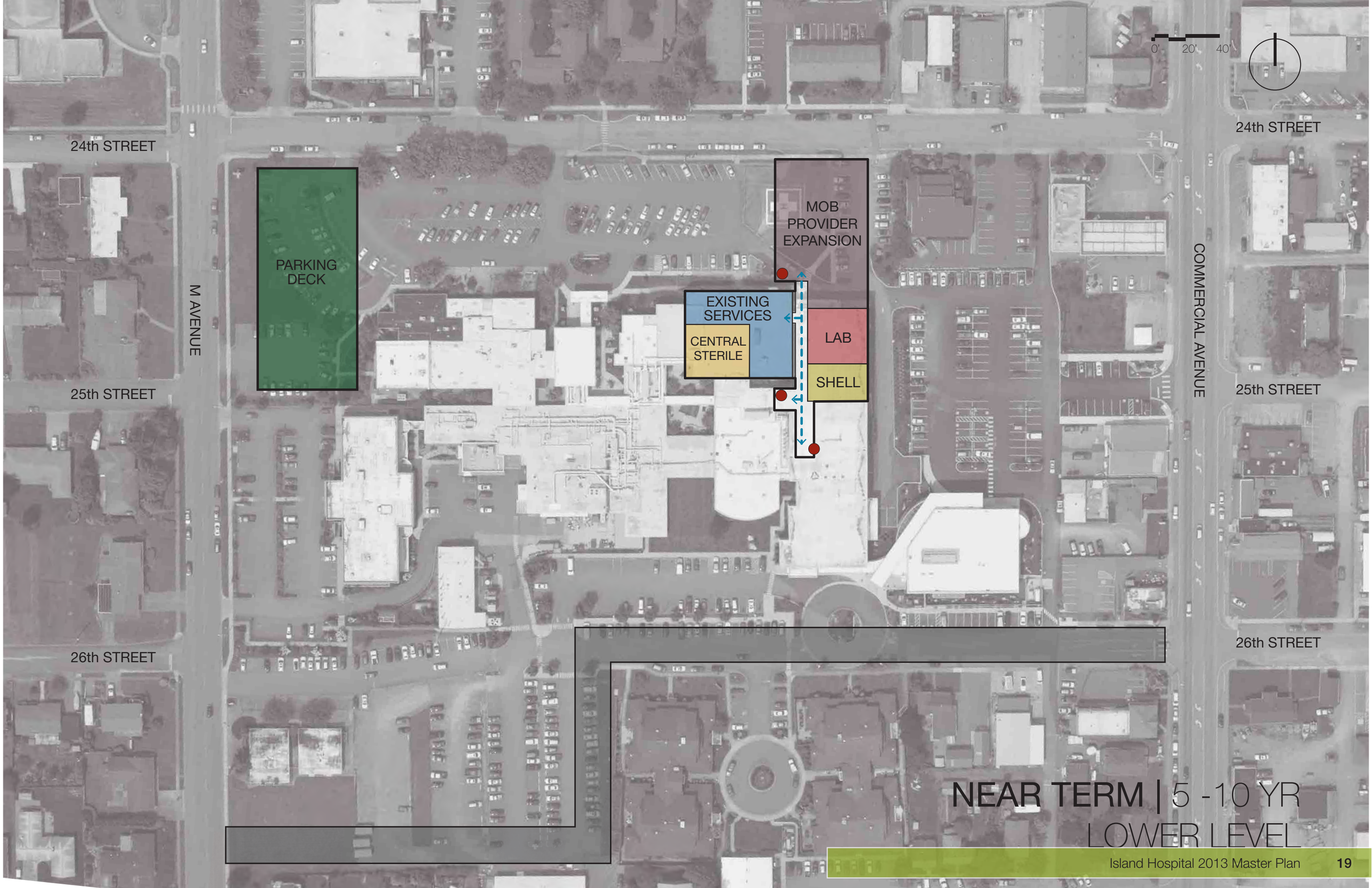
- The roof mounted helipad and the elevator required to serve it will exceed current height limits; provision for additional height will need to be accommodated as part of a medical use overlay (MUO) or variance granted by the City of Anacortes. Fluid dynamics studies should be conducted to inform the project of anticipated air flow so the project can appropriately address and mitigate the risk of exhaust fumes entering the air intakes of the hospital. An aviation consultant will be required.

- The 26th Street connection may require a traffic study and EIS as part of the process.

NEAR TERM LOWER LEVEL

An MOB is proposed to occupy the lower level. This affords additional increased provider space to allow expansion of the surgical program and improved patient experience. This addresses the findings in the analysis that the space within the Island Medical Center, in pre and post recovery areas, is currently operating at maximum capacity and may be limiting the volume of surgical cases that providers can accommodate.

This floor is envisioned to be level with existing buildings and, as a result, has a floor to floor height of twelve feet, which is appropriate for medical office use but not for acute care patient services. The floor will have daylight on the north and east faces.



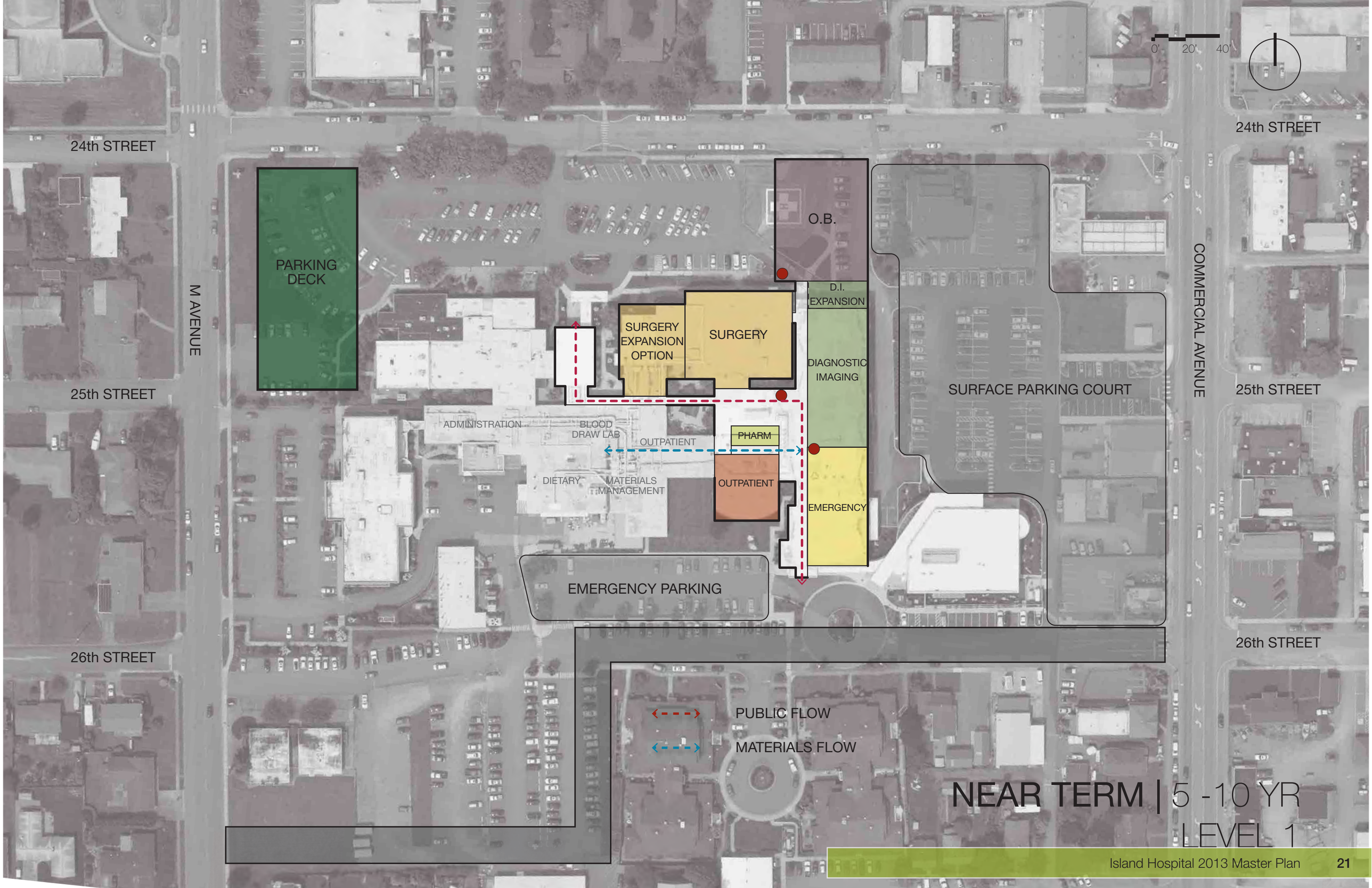
NEAR TERM | 5 -10 YR
LOWER LEVEL

NEAR TERM LEVEL 1

A replacement OB department is suggested to occupy a portion of level one of the addition, along with shell space for future diagnostic imaging expansion needs. The OB department could have a dedicated entrance and discharge area from the parking lot to the west. The OB department will be adjacent and have a direct connection to the surgery department.

Following the move of OB, the surgical department can expand and backfill the vacated area; providing opportunity for a surgery modernization project, resolution of code citations, as well as improved services for patients and family. The expansion can also provide opportunity to increase the endoscopy program as appropriate.

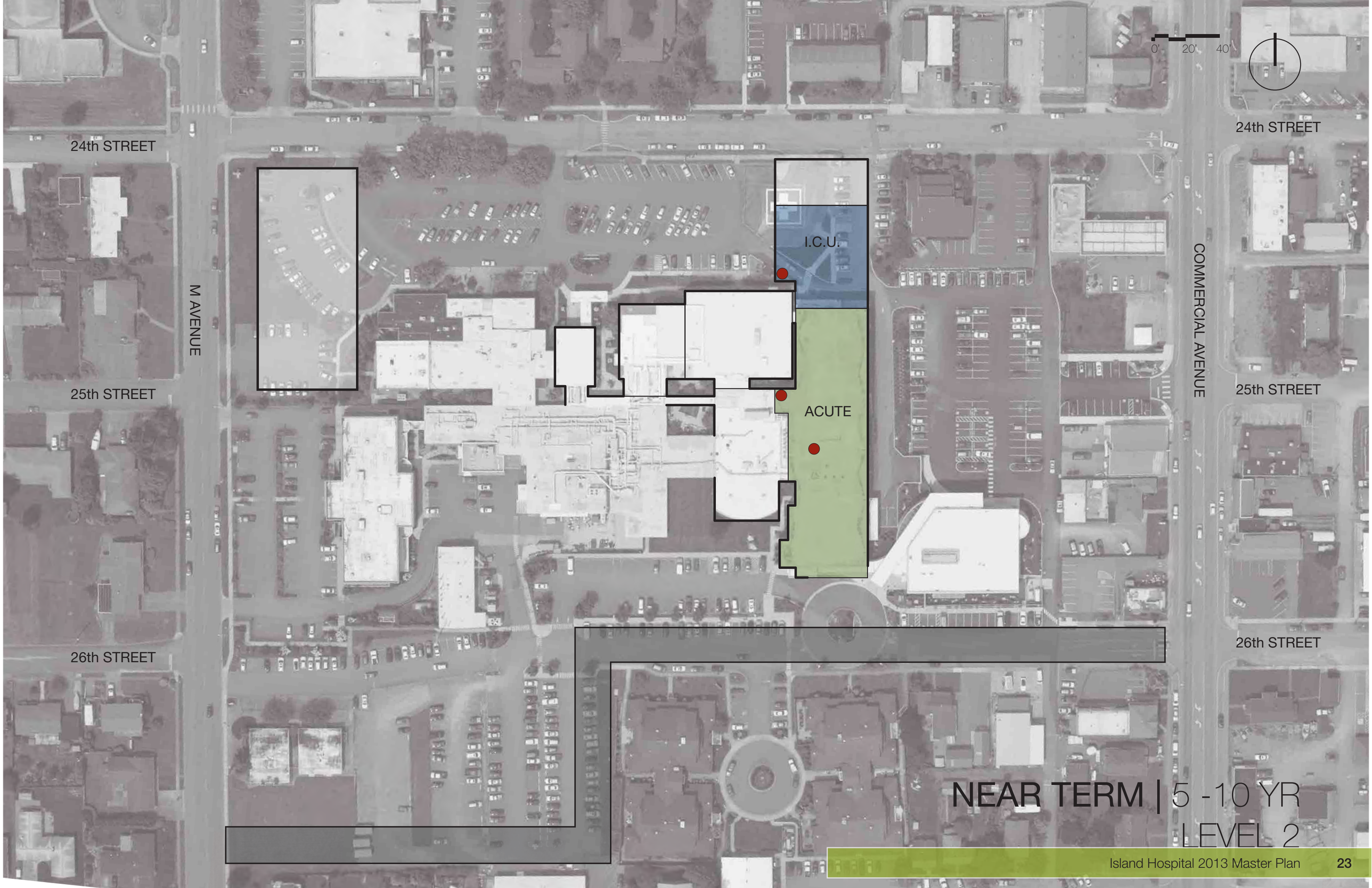
Following the move of the ICU to level two of the addition, the existing ICU can be renovated and backfilled with outpatient services. This helps to advance moving hospital services out of the oldest part of the hospital.



NEAR TERM | 5 -10 YR
LEVEL 1

NEAR TERM LEVEL 2

A replacement ICU is proposed for level two of the addition. A direct connection to the surgical department will be facilitated by an elevator. This location of the ICU creates a direct adjacency to the acute care beds and will provide ease of transport for step down of care. This will provide greater efficiency for staff and patient movement, and co-locate or create better adjacencies for inpatient care.



NEAR TERM | 5 -10 YR
LEVEL 2

LONG TERM | 10 - 20 YEARS

The long term strategy proposes that a new MOB be developed at the southeast corner of the Ambulatory Zone. The need for the MOB will be triggered as a response to increased demand for modern ambulatory services and as replacement for the oldest existing MOBs on campus. The southeast corner provides an excellent opportunity to locate an urgent care clinic on a prominent public corner, as well as, be in close proximity to the emergency department.

A new hospital addition is proposed in the location of the current ICU. The single story existing structure is proposed to be demolished and replaced with a single story with basement addition that should be structured to allow multiple floors to be built above in the future. The addition will house materials management and dietary departments. This moves these essential services out of the 1962 building, allowing it to be demolished. A new loading dock and receiving area is proposed as part of the expansion.

Relocation of the central utility plant (CUP) as a stand-alone project is also proposed. Relocating the CUP moves it to a location that allows the greatest flexibility for the long term development of the campus and places it out of the way of the future development zone.

LONG TERM LOWER LEVEL

The materials management department is proposed to be relocated to the lower level of the expansion. A lower level connection is proposed to be constructed to connect to the 2007 IHREP to allow for materials movement to occur at the lower level and delivered to patient care areas by vertical transport. This solves existing flow issues of material movement crossing public zones.

0' 20' 40'

24th STREET

24th STREET

M AVENUE

COMMERCIAL AVENUE

PARKING DECK

MOB PROVIDER EXPANSION

EXISTING SERVICES

CENTRAL STERILE

LAB

SHELL

SURFACE PARKING COURT

25th STREET

25th STREET

MATERIALS MANAGEMENT

LOADING DOCK / SHIPPING & RECEIVING

M.O.B.

EMERGENCY PARKING

SURFACE PARKING COURT

26th STREET

26th STREET

C.U.P.

LONG TERM | 10-20 YR
LOWER LEVEL

LONG TERM LEVEL 1

The dietary department and cafeteria are proposed to be located in level one of the addition.

The emergency department is proposed to expand and occupy the adjacent public corridor to allow for self-contained waiting and registration. A physical separation between the existing central waiting and emergency department will be constructed to provide a secure barrier for after-hours operation, as well as, allow for a semi public transport zone for dietary material to the elevator serving level 2 patient beds. This modification can be accelerated and made part of near term planning. It is contingent on the addition of the new parking structure at the northeast corner of the campus.

0' 20' 40'

24th STREET

24th STREET

M AVENUE

COMMERCIAL AVENUE

PARKING DECK

O.B.

D.I. EXPANSION

SURGERY EXPANSION OPTION

SURGERY

DIAGNOSTIC IMAGING

SURFACE PARKING COURT

25th STREET

25th STREET

BLOOD DRAW LAB

OUTPATIENT

PHARM

OUTPATIENT

DIETARY

EMERGENCY

LOADING DOCK / SHIPPING & RECEIVING

M.O.B.

EMERGENCY PARKING

SURFACE PARKING COURT

26th STREET

26th STREET

C.U.P.

LONG TERM | 10-20 YR
LEVEL 1

LONG TERM LEVEL 2

No work is proposed for level 2 as part of the Long Term strategy.

As discussed in the summary, a multi-story MOB is proposed for the southeast segment of the ambulatory zone. Parking studies will be required to confirm that the required parking demand can be met.

LONG TERM | 10-20 YR
LEVEL 2

BEYOND 2035

Planning for beyond 2035 exceeds the scope of the study, however, it is important to acknowledge how the 2035 plan positions the hospital campus to flexibly develop a framework for the future. The 2035 Plan strategizes how the hospital can move essential services out of the oldest buildings on campus allowing them to be demolished to provide the land area or “empty chair” for future hospital replacement. The plan also indicates the continued development of the ambulatory zone to add additional MOB capacity as well as parking. As the current MOBs located to the west section of the campus are demolished, it is proposed that they be replaced with surface parking. As new services and replacement facilities are developed, a new free standing parking structure is proposed in the southwest corner of the site to concentrate parking and allow the proposed surface parking areas to act as the “empty chair” for the next generation of hospital expansion and replacement.

The beyond 2035 framework also suggests that the connection to 26th Street for ambulance traffic be re-established. This move will position all emergency services to be accessed from 26th Street. It will allow the current north south ambulance drive to be eliminated and free the drive for flexible development.

LOWER LEVEL BEYOND 2035

0' 20' 40'

24th STREET

24th STREET

M AVENUE

COMMERCIAL AVENUE

PARKING DECK

MOB PROVIDER EXPANSION

M.O.B.

EXISTING SERVICES

CENTRAL STERILE

LAB

SHELL

SURFACE PARKING COURT

BASEMENT

MATERIALS MANAGEMENT

LOADING DOCK / SHIPPING & RECEIVING

M.O.B.

EMERGENCY PARKING

25th STREET

25th STREET

SURFACE PARKING COURT

26th STREET

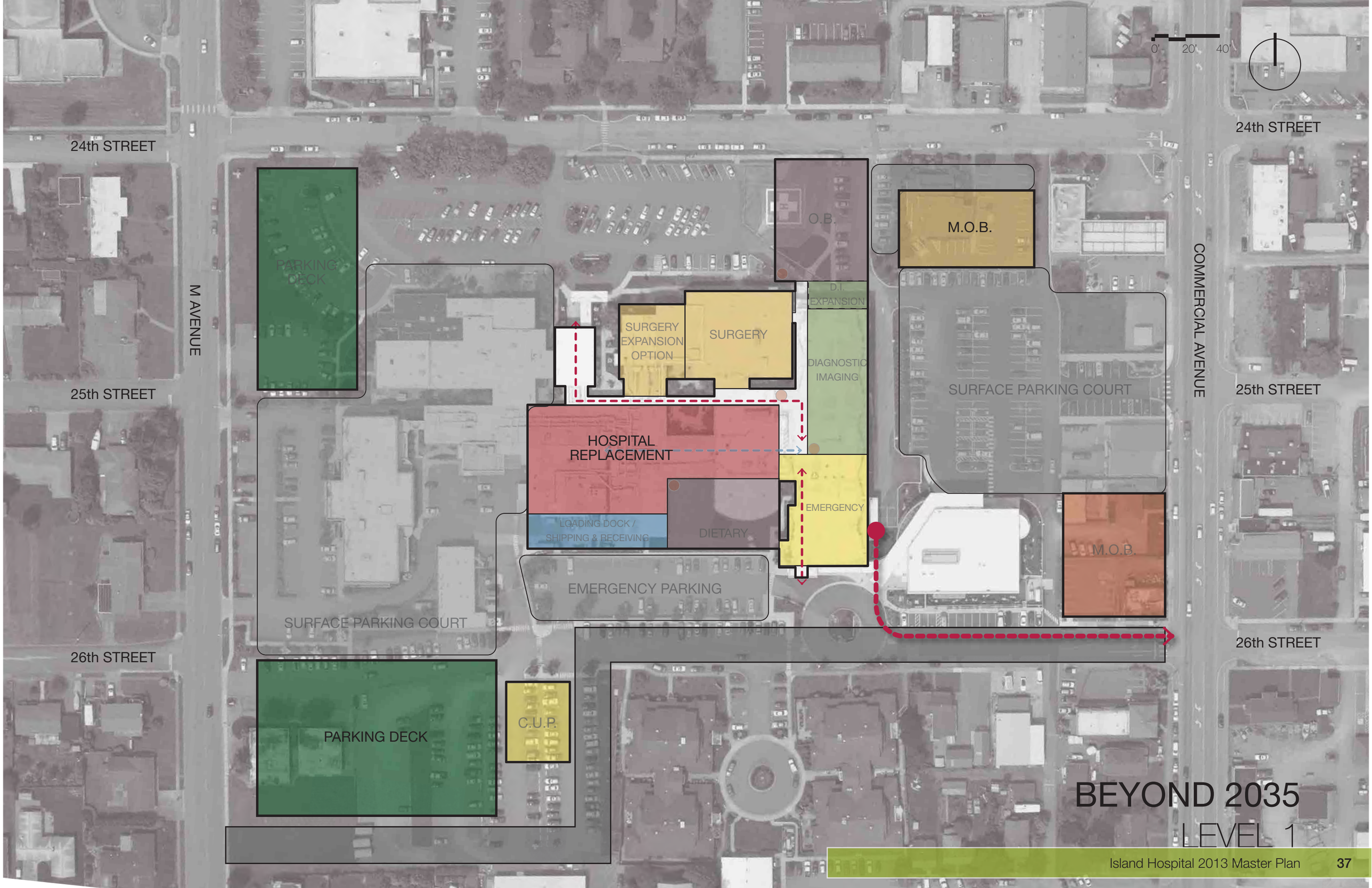
26th STREET

PARKING DECK

C.U.P.

BEYOND 2035
LOWER LEVEL

LEVEL 1 BEYOND 2035



BEYOND 2035
LEVEL 1

LEVEL 2 BEYOND 2035

BEYOND 2035

LEVEL 2

COSTS

NEAR TERM | 5 - 10 YEARS		TODAY'S DOLLARS CONSTRUCTION COST*	TODAY'S DOLLARS PROJECT COST*	ESCALATED TO 2020 DOLLARS CONSTRUCTION COST*	ESCALATED TO 2020 DOLLARS PROJECT COST*
1	HOSPITAL ADDITION	21,585,000	34,639,976	25,686,150	41,221,571
2	SURGERY REMODEL	10,380,000	21,395,800	12,352,200	25,461,002
3	OUTPATIENT REMODEL	1,625,000	2,630,706	1,933,750	3,130,540
4	STRUCTURED PARKING	3,850,000	5,119,000	4,581,500	6,091,610
5	BUILDING DEMOLITION	318,000	365,700	378,420	435,183
6	SURFACE PARKING LOT	368,275	447,902	438,247	533,003
7	26th STREET EXTENSION	INSUFFICIENT INFORMATION			

LONG TERM | 10 - 20 YEARS		CONSTRUCTION COST*	PROJECT COST*	ESCALATED TO 2030 DOLLARS CONSTRUCTION COST*	ESCALATED TO 2030 DOLLARS PROJECT COST*
8	HOSPITAL DEMOLITION	180,000	207,000	268,200	308,430
9	SOUTH HOSPITAL ADDITION	17,155,000	27,530,636	25,560,950	41,020,648
10	MOB (STAND-ALONE)	12,967,500	17,513,624	19,321,575	26,095,299
11	CUP (EXISTING EQUIPMENT)	2,110,000	3,141,000	3,143,900	4,680,090

BEYOND 2035		CONSTRUCTION COST*	PROJECT COST* (NOT ESCALATED)
12	ABOVE GRADE PARKING	3,300,000	4,387,714
13	MOB	12,967,500	17,513,624
14	STRUCTURE PARKING	4,375,000	5,817,045
15	REPLACEMENT HOSPITAL	57,095,000	117,687,206
16	HOSOPITAL DEMOLITION	375,000	431,250

* Construction Cost is the total expense incurred by the Contractor to complete a project; this includes the cost of material, prevailing labor wages, and the Contractor's own overhead and profit. This is often referred to as 'bricks and mortar costs.'
* Project Cost is the total expense associated with the completion of a construction project; this includes the Construction Cost as well as other 'Soft Costs' such as permitting, insurance, sales tax, furniture, commissioning, etc. Items not included in the Project Cost are listed in the 'Exclusions' above.
* Escalation is the increase of construction prices over a certain period of time; this includes periodic increases in labor wages, and increases in the cost of construction materials. The rate of escalation can vary significantly from year-to-year; an escalation rate of 3% per year has been assumed for this estimate.

EXCLUSIONS:

LAND COSTS
RISK INSURANCE
SOILS
HAZARDOUS MATERIALS REMOVAL
LEGAL FEES
LEASING COMISSIONS
MARKET STUDIES
SURVEYS FOR PURCHASE
TENANT INDUCEMENTS
OWNERS ADMINISTRATION
APPRAISAL FEES
PROPERTY TAXES DURING CONST.
SURVEYS
OFF-SITE WORK
MOVING EXPENSES
INTERIM FINANCING
PERMANENT FINANCING PLACEMENT
TDM COSTS


24th STREET
M AVENUE
25th STREET
26th STREET
COMMERCIAL AVENUE
24th STREET
25th STREET
26th STREET
0'
20'
40'
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16

VISIONING

CREATING A COMMON VISION FOR THE ISLAND HOSPITAL CAMPUS

PARTICIPANTS

AS PART OF OUR INTRODUCTION, WE WERE ASKED, "WHAT DO YOU WANT OUT OF THIS MASTER PLAN?"

LAURIE GERE, ISLAND HOSPITAL

The hospital is the true leader in the community. We need to educate the City in our growth. We need to rezone the property and obtain the property we will need for the future.

CARL TULLY, NBBJ

"An opportunity to refresh the 2020 master plan and go more in-depth. We hope to learn your vision of the future."

BUZZ ELY, ISLAND HOSPITAL

Buzz wants us to fine tune what we started (in the 2007 master plan). He would like the Registration study to be activated and move full speed with the hospital re-zones work. He would like the visioning session to look out onto the future.

REESE PARRETT, NBBJ

"An opportunity for forward thinking and new ideas."

ANDREW BUHAYAR, NBBJ

"An opportunity for comprehensive understanding of the goals of the master plan."

VINCE OLIVER, ISLAND HOSPITAL

"This is an opportunity for a more refined vision of the future. The vision is to be shared with the community and with City Hall."

JANE LOURA, NBBJ

"This is a great opportunity to get to know you better." Jane has her second house in the San Juan Islands and considers Anacortes her second home.

MARC ESTVOLD, ISLAND HOSPITAL

"This is an opportunity for more work! Marc is especially interested in rezoning the site to create a Health Care Zone with the City of Anacortes."

CHIP BOGOSIAN, ISLAND HOSPITAL

Chip introduced the idea of Therapeutic Architecture. Chip is interested in the overall image of the hospital and site. Buildings and the campus can make you feel better (patients and staff)

SEAN WALDRON, NBBJ

"Looking forward to being more aware of Island Hospital's vision and aspirations and working with their leadership, staff, and patients to actualize that."

SCOTT HARRISON, ISLAND HOSPITAL

Scott was also interested in the re-zoning of the site. He wants the City to allow us to grow vertically. Presently he feels the campus looks like an industrial park.

LOIS PATE, ISLAND HOSPITAL

We need to maintain the efficiency of the hospital. We have an aging population and the planning should incorporate the changing needs of the community.

BRIAN BERG, NBBJ

"I am very interested in today's visioning session to learn what interests you most and to tailor our master plan about your concerns and interests."

ELISE CUTTER, ISLAND HOSPITAL

"The present hospital is confusing to find your way. We need to stream line the process. The master plan must be flexible for future use."

PAUL MAUGHAN, ISLAND HOSPITAL

He is interested in the statistics for growth in our area. He wants to put in place a facility for growth.

LAY OF THE LAND

A quick overview of national and local trends.
Preliminary data on Island Hospital
What is the competitive landscape

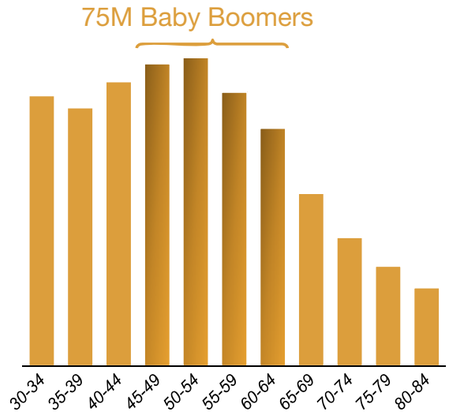
National and Local Trends

- Healthcare is unsustainable; providers will be forced to constantly have to “do more with less.”
- Declining reimbursements and increasing patient demand will create pressure on facilities and operations
- The Island Hospital service area population is older than nearby regions with an increasing percentage of the population becoming elderly, resulting in an older and potentially sicker patient population for the hospital.

Baby Boomer Surge Beginning

Medicare Rolls in Line to Increase Dramatically – Shifting Payer Mix

2011 US Population Distribution By Age



~7,000/day
Newly eligible Medicare beneficiaries

23%
Percentage of population covered by Medicare in 2030

Source: U.S. Census Bureau, available at: http://www.census.gov, accessed on September 13, 2011; Kaiser Family Foundation, available at: http://www.kff.org/medicare/h08_7821.cfm, accessed on September 13, 2011; Health Care Advisory Board interviews and analysis.

Adopted by NBBJ from Health Care Advisory Board slides

ISLAND HOSPITAL MASTER PLAN UPDATE: PRELIMINARY ANALYSIS

Comparison Summary

Key Figures:	2006 Actual	2010 2020 Study Projection	2011 Actual
Licensed Beds	43	37 (needed)	43
Discharges	2,819	3,035	2,995
Patient Days	9,619	10,331	9,586
Occupancy Rate	61%	66%	61%
Average LOS (Days)	3.4	3.4	3.2
ADC	26.4	28.0	26.3
Ambulatory Surgery Visits	3,674	4,358	4,013
Births	365	401	362

Source: Island Hospital

Service Area Population growth rate has declined slightly, but growth is occurring as the population ages

2020 Study projected growth rate: 1.6% per year
Updated growth rate: 1% per year
Population is aging, WA State 65+ projected at 21% in 2030
Source: WA State Office of Financial Management, 2010 Census

IH Market Share is relatively stable in primary service areas

		% of Discharges within hospital		% of Discharges within zip code	
Top 3 Cities		2006	2011	2006	2011
ANACORTES	15,778 pop. (2010)	49%	47% ↓	69%	67% ↓
OAK HARBOR	22,075 pop. (2010)	15%	21% ↑	18%	22% ↑
LA CONNER	891 pop. (2010)	9%	7% ↓	46%	42% ↓

Source: WA DOH CHARS database

Workload Forecasts on Target

1. Inpatient bed forecast matches the 2020 Study "low" forecast, projecting 42 beds needed in 2020
2. Imaging and Emergency Department forecast matches the 2020 Study "baseline" forecast
   Projecting a total 12 imaging units (2 MRI) and 9 ED bays needed in 2020
   ED Bays:
3. OR forecast is higher than 2020 Study "aggressive" forecast, projecting 3.5 OR's and 1 Endo needed in 2020

Overall, the planning forecast from the earlier study are in line with actual utilizaiton over the past 5 years

Preliminary Data about Island Hospital

Current data is in line with expected national and statewide healthcare trends. Preliminary workload forecasts are consistent with the forecasts in the previous 2020 Study.

Workload Forecast

Overall, the planning forecasts from the earlier study are in line with actual utilization over the past five years.

The Competitive Landscape

As a part of study we are reviewing the competitive landscape that IH is in in order to ensure that IH is able to play an intentional role in the market.

Key Figures and Workload Forecasts

Key Figures:	**2006** Actual	**2010** 2020 Study Projection	**2011** Actual
Licensed Beds	43	37 (Needed)	43
Discharges	2,819	3,035	2,995
Patient Days	9,619	10,331	9,586
Occupancy Rate	61%	66%	61%
Average LOS (Days)	3.4	3.4	3.2
ADC	26.4	28.0	26.3
Ambulatory Surgery Visits	3,674	4,358	4,013
Births	365	401	362

Workload Forecasts on Target

1. Inpatient bed forecast matches the 2020 Study "low" forecast, projecting 42 beds needed in 2020
2. Imaging and Emergency Department forecast matches the 2020 Study "baseline" forecast
   Projecting a total 12 imaging units (2 MRI) and 9 ED bays needed in 2020
3. OR forecast is higher than 2020 Study "aggressive" forecast, projecting 3.5 OR's and 1 Endo needed in 2020

Demographic and Market Share Changes

- Population growth is projected to slow
- Island Hospital service areas are more elderly, proportion of elderly expected to increase

County	Population	65+ %	Growth 2000-10 (%)	Projected Growth 2010-20 (%)
Island	78,506	18.4%	9.7%	5.4% ↓
Skagit	116,901	16.1%	13.5%	9.7% ↓
San Juan	15,769	23.2%	12.0%	3.1% ↓
Snohomish	713,335	10.3%	17.7%	12.9% ↓
King	1,931,249	10.9%	11.2%	9.2% ↓

- Market share is relatively stable in primary service areas

Top 3 Cities		Discharges within Hospital (%)		Discharges within zip code (%)	
City	2010 Population	2006	2011	2006	2011
Anacortes	15,778	49%	47% ↓	69%	67% ↓
Oak Harbor	22,075	15%	21% ↑	18%	22% ↑
La Conner	891	9%	7% ↓	46%	42% ↓

LAY OF THE LAND

Comments from Island Hospital Participants

1. Insurance
   - Island Hospital mentioned concern over the way by which employees will be insured in the future and whether they will still be able to provide core services.
   - How to decrease the health costs of their own employees? This is the single largest Island Hospital expense

2. Physician Recruitment
   - Some expressed concern over the aging of providers. There must be a focus on attracting young talent, and in hiring teams rather than hiring individuals.
   - Y Generation doctors want more time off with the same pay
   - There is a new trend to recruit teams versus recruiting doctors
   - Recruit and grow Nurse Practitioners, a change in culture
   - What is the difference between existing, aging doctors and young graduates? How does one “deal with the new generation of physicians?”
   - Change is difficult for aging doctors

3. Design
   - Design should cater to the patient and foster a healing environment
   - Clinics are the front door to the hospital. Currently it is the emergency room
   - We need BIG BOLD signage. Consider the patient and the type of lighting and materials that they need.
   - The landscaping could incorporate an art walk or a healing garden
   - Island Hospital is a positive landmark and destination

4. Providing Excellent Care
   - The interface between staff or patients and technology must be friendly.
   - “How do we get people to drive 50 miles to come see us?”
   - To attract patients we have to be unique
   - We need to maintain a strong connection to kids and schools
   - Island Hospital has the ability to connect with outside resources via technology
   - Island Hospital should consider the transition to wellness care from treatment
   - Patient experience is key, both inside and outside of hospital

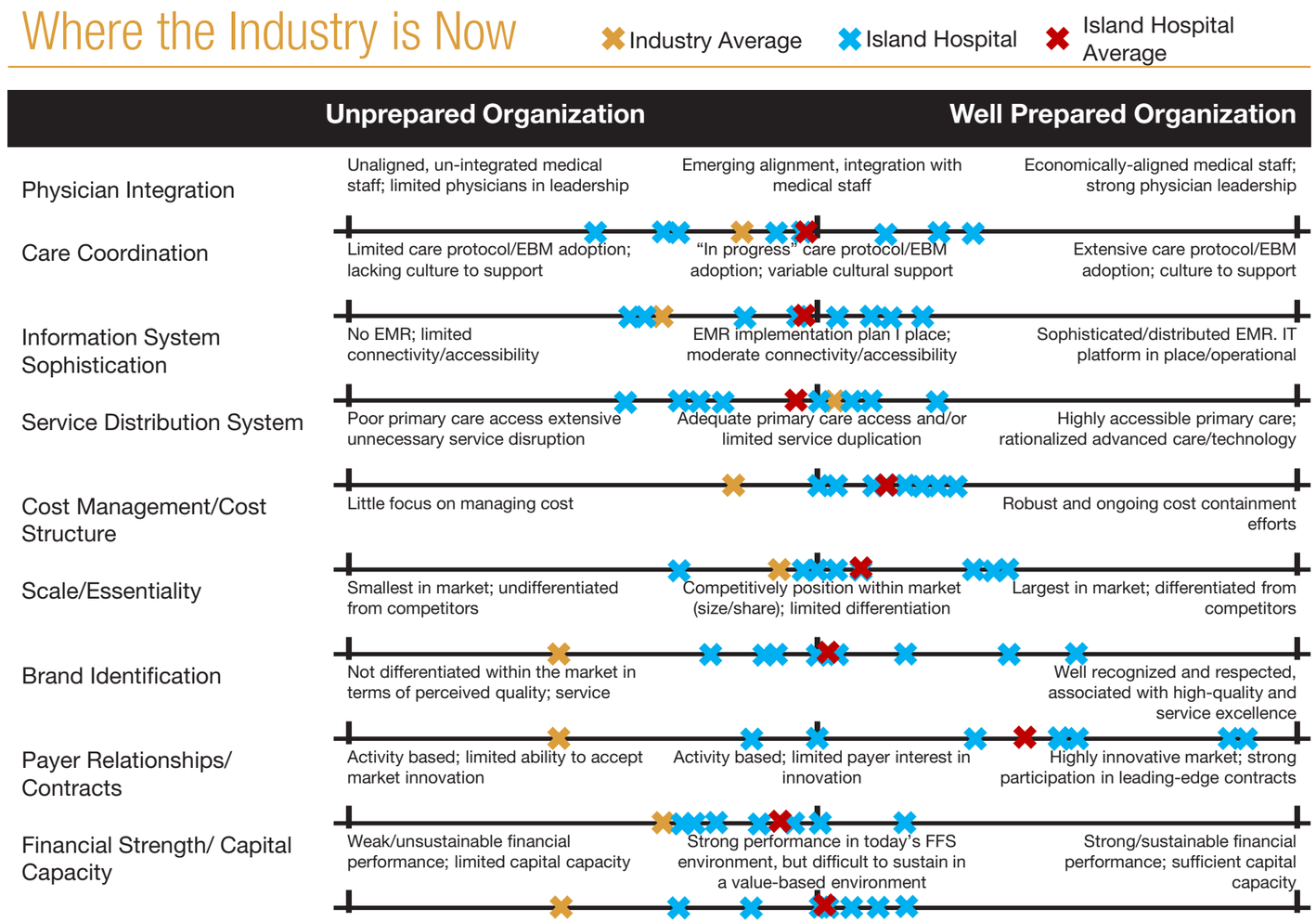
5. Competition
   - How to get patients from 20-50 miles away?
   - North Whidbey is a key market area – need to strengthen and maintain
   - Concern on how to maintain successful future of rural hospitals

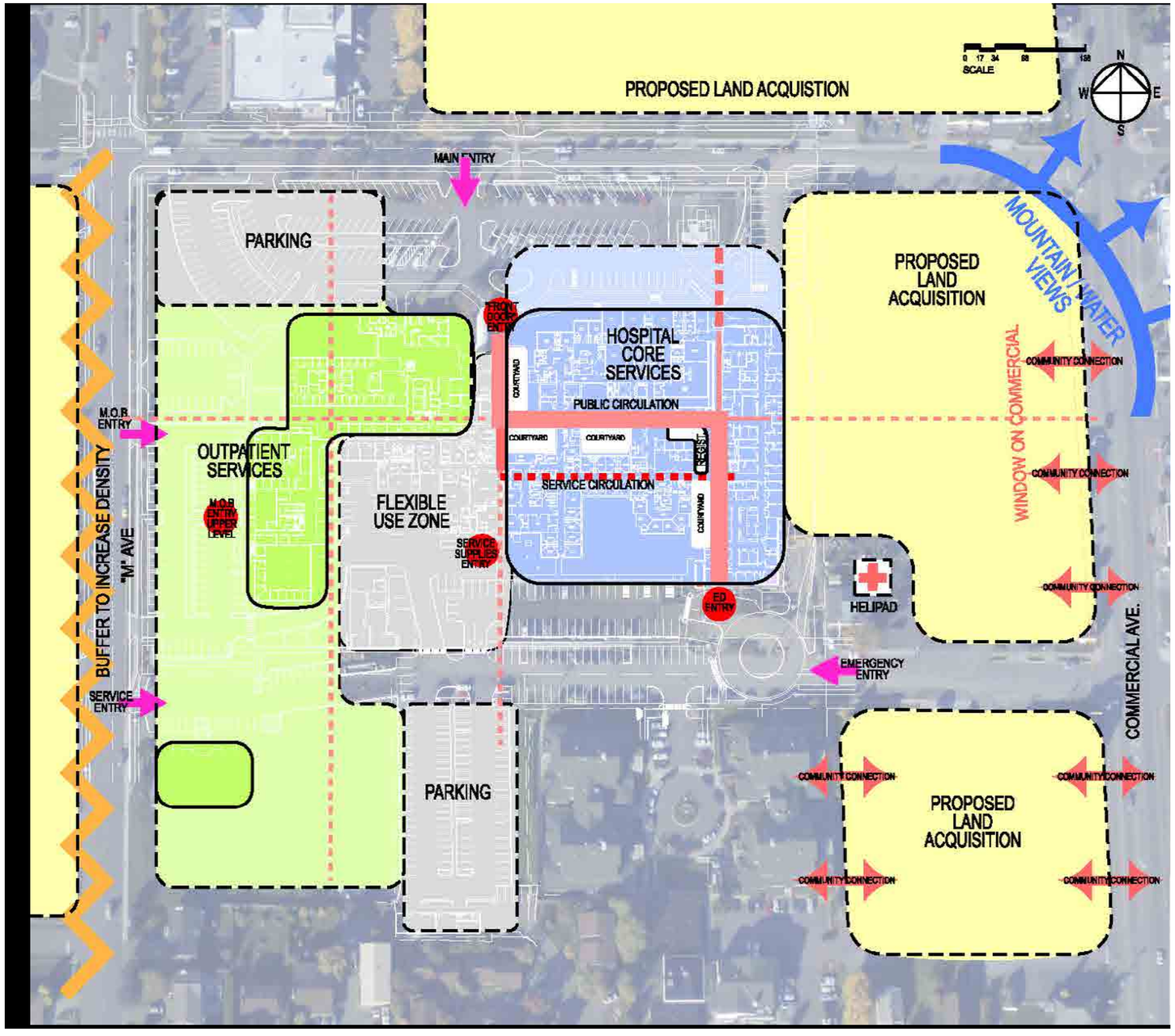
LAY OF THE LAND

Where Island Hospital Sits Within the Broader Industry

A chart showing a number of key issues facing hospitals today was presented including industry average responses - ranging from prepared to unprepared organizations. IH attendees were asked to rate their organization's level of preparedness. The adjacent chart indicates the collected responses.

Where the Industry is Now





Master Plan 2007 Review

The 2020 master plan considered trends in health care and validated that the 43 licensed beds, 6 birthing units and 4 operating rooms, 1 endoscopy room were adequate in number to meet the demands of 2020. The new addition had just been completed at the time of the study. The emergency room and imaging center were properly sized to meet demand as well.

The 2020 master plan recommended constructing a new medical office building to the west of the hospital along “M” avenue. Parking for the medical office building would require additional surface parking or a new parking garage. It recommended the helipad to be relocated to the space now occupied by the Medical Arts Building. The oncology center was to have been constructed in the hospital basement below the surgery (so that it could be close to lab and imaging). Several proposed land acquisitions were identified along Commercial Avenue. At the time of the study there were 523 total onsite parking stalls. Parking for the hospital and medical office buildings were 65 stalls short of projected demand. Additional parking was recommended.

MASTER PLAN 2007 REVIEW

Growth for departments within the hospital were shown to expand outward pushing the perimeter of the hospital and taking over surface parking areas. these assumptions were challenged and will be further reviewed in this master plan.

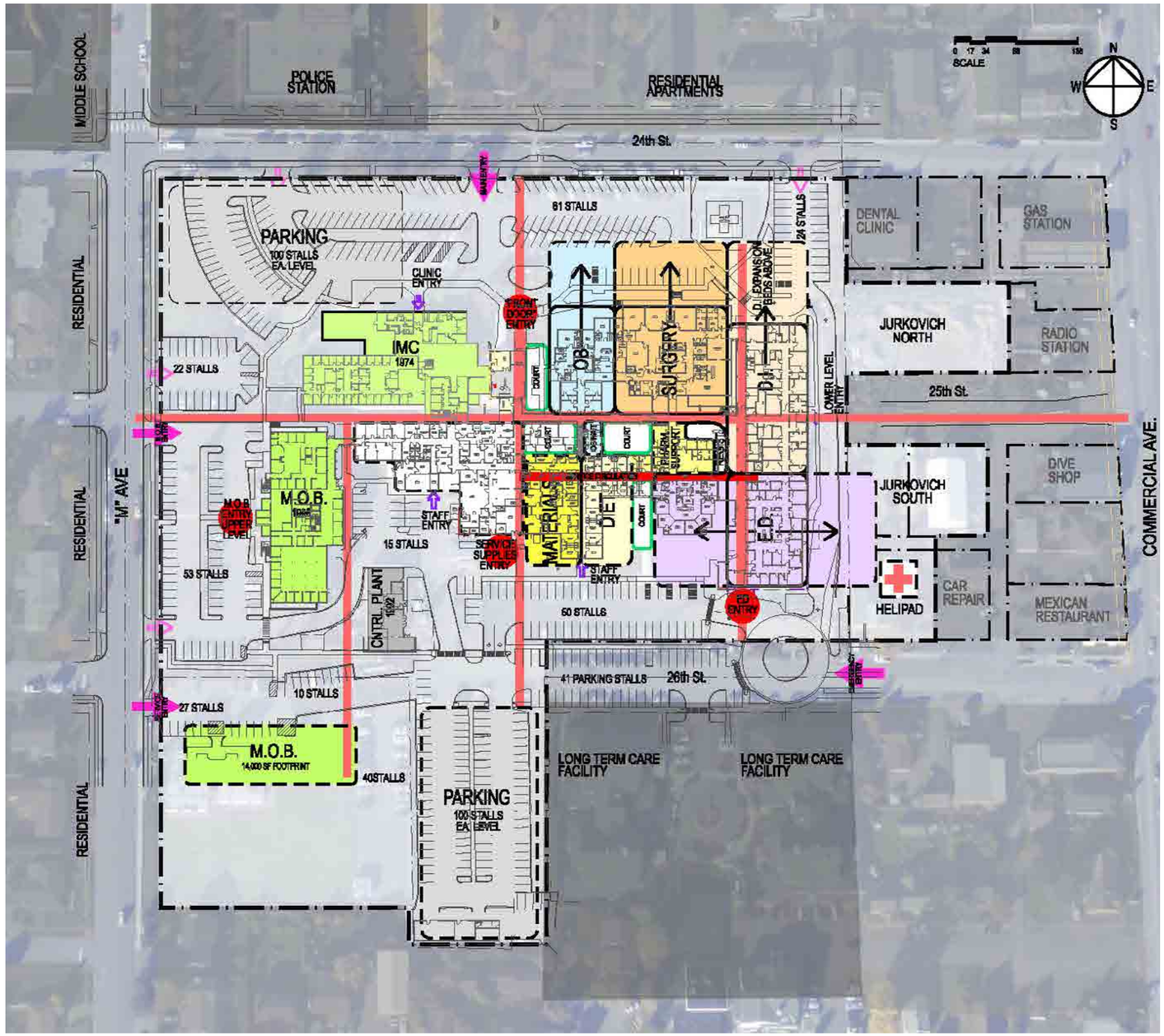
The 2007 master plan has near term and long term growth recommendations. The 24 month recommendation discussed options for a new medical office building, new cancer center, relocated home health and conference rooms, relocation of the helipad to be closer to the emergency department and to provide additional parking. The recommendations were made, but not located as shown on the master plan.

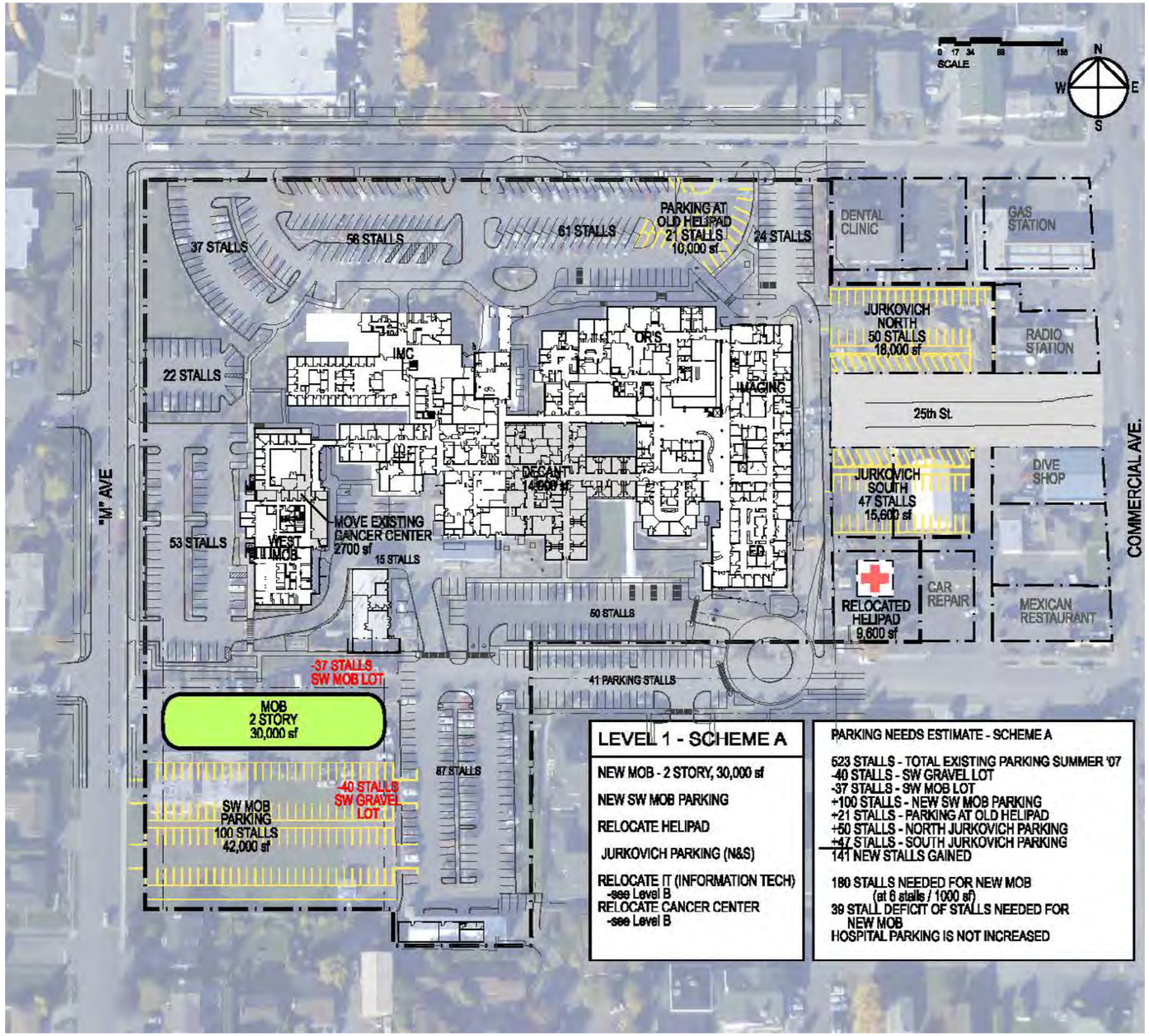
Comments from Island Hospital

- Island Hospital owns the land on Commercial Avenue currently occupied by the radio station.

- Some expressed the desire to provide pre-registration services to patients.

- The goal of this master planning effort should be to “refresh and extend” the 2007 master plan to 2035.





Current Zoning

Island Hospital is located within zone R4A which is a residential zone that allows for hospital and medical use. A portion of the new Medical Arts Pavilion extends into the adjacent commercial zone. The commercial zone allows for medical use, but only through a Conditional Use Permit process. The impacts to the hospital are limited height (35 feet maximum building height for zone R4A, and 40 feet maximum building height for the commercial zone. Purchasing property in the commercial zone is a risk because the City may not approve the Conditional Use Permit, and they could deny a building permit.

The city's perspective is that medical use encroachment on the commercial zone displaces retail uses and, therefore, a loss of tax base to the city.

Re-zone requests are accepted by the city between January 2 and March 31 annually. The direction from the board and the members of the visioning session was to submit a rezone proposal to the city requesting a hospital zone that extends to Commercial Ave. A meeting with the City Planner has been established for Monday January 28. NBBJ stated that we can meet the submittal requirements for a re-zone and meet the March 31 deadline.

Parking

NBBJ updated the parking study using a current aerial photograph to count existing parking stalls. The parking demand table uses the patient forecast numbers used in the workload analysis. The current parking count on the site is 665 stalls. The demand for medical office and hospital use (including the new Medical Arts Building) is 751 stalls. This represents a deficit of 86 stalls. During the presentation, it was noted that parking stalls along 26th Street are public stalls and are not always available to Island Hospital because the Long Term Care Facility uses those stalls as well.

Observations from NBBJ

Growth for the surgery department should be carefully studied. We have learned that additional operating rooms are not needed. However, the patient experience for both inpatient and outpatient needs improvement and additional area. The 2007 master plan diagrams would be expensive to build and do not address the real issues. This master plan should update the surgery needs.

The 2007 master plan circulation plan is now outdated with the addition of the Medical Arts Pavilion. A revised circulation plan identifying the path of travel for patients, providers, materials, equipment, and pharmacy products is needed.

Multiple entrances to the site at 24th, 25th, and 26th Streets may create confusion for patients and visitors. Site circulation and signage will be reviewed in this master plan.

VISION & PROJECT GOALS

SWOT Analysis

Strengths, Weaknesses, Opportunities, and Threats

The aim of the SWOT analysis is to identify the key internal and external factors that are important to the hospital. SWOT analysis groups key pieces of information into two main categories:
Internal factors – The strengths and weaknesses internal to the organization.

External factors – The opportunities and threats presented by the external environment to the organization.

The internal factors may be viewed as strengths or weaknesses depending upon their effect on the organization's objectives. What may represent strengths with respect to one objective may be weaknesses for another objective

Strengths

Community Loyalty
Geographic Location
People – the right people committed
Reputation – quality work environment, good patient scores
Cost Structure / High value
Size: Small and Nimble

Weaknesses

Payer Mix
Recruitment – geography, cost of living
Medical staff age
Electronic Medical Records
Labor and Delivery
Funding future capital needs

Opportunities

Electronic Medical Records Improvements
Relationships – nursing homes
EMS Affiliation
Service Line / Technologies (Cath Labs)
Orthopedics
Labor and Deliver
Donors / Philanthropy
Centers of Excellence

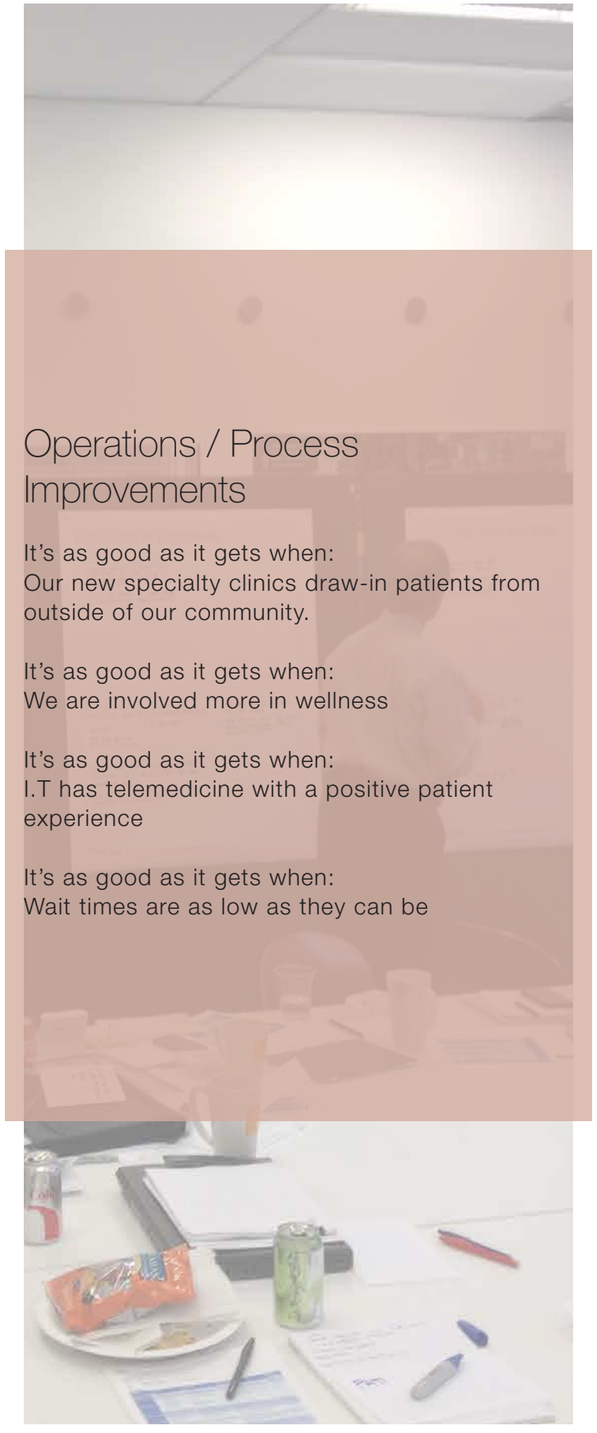
Threats

Peace Health in Friday Harbor
Orthopedics
Reimbursement / Rules and Regulations
Loss of rural status

VISION & PROJECT GOALS

The Vision Statement is sometimes called “a picture of your hospital’s future.” Your Vision Statement is your inspiration.

How would you define your goals when asked, “It’s as good as it gets when…”



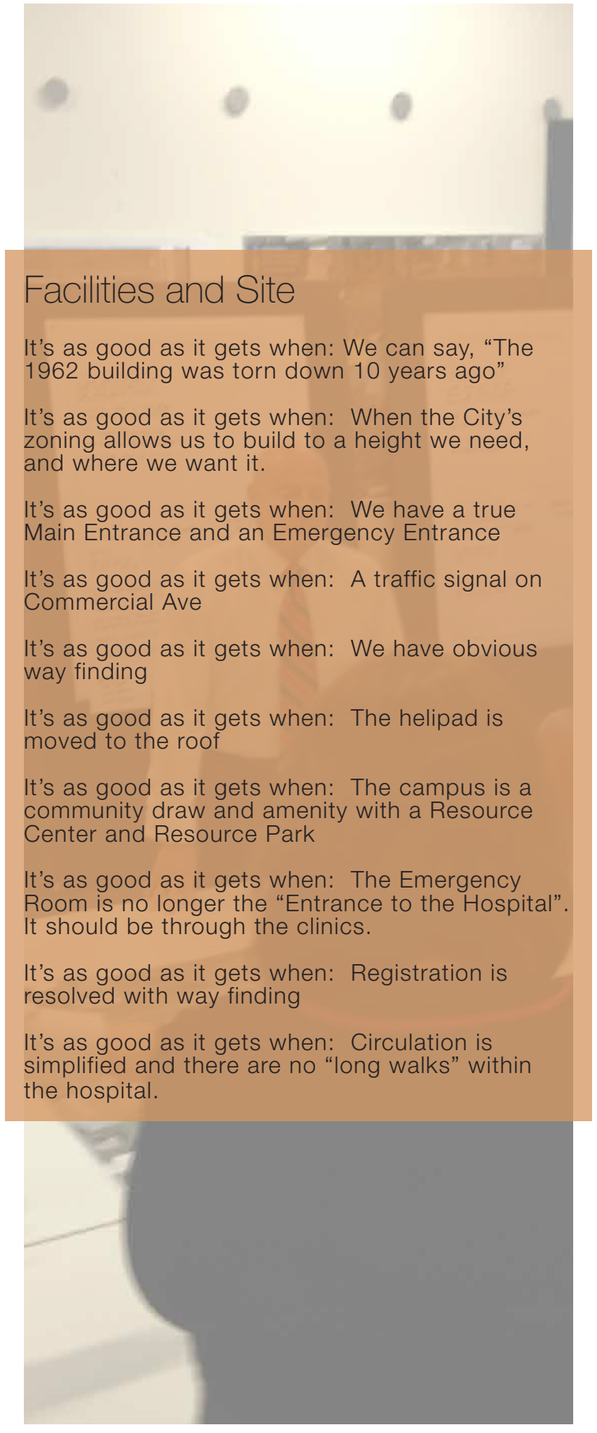
Operations / Process Improvements

It’s as good as it gets when:
Our new specialty clinics draw-in patients from outside of our community.

It’s as good as it gets when:
We are involved more in wellness

It’s as good as it gets when:
I.T has telemedicine with a positive patient experience

It’s as good as it gets when:
Wait times are as low as they can be



Facilities and Site

It’s as good as it gets when: We can say, “The 1962 building was torn down 10 years ago”

It’s as good as it gets when: When the City’s zoning allows us to build to a height we need, and where we want it.

It’s as good as it gets when: We have a true Main Entrance and an Emergency Entrance

It’s as good as it gets when: A traffic signal on Commercial Ave

It’s as good as it gets when: We have obvious way finding

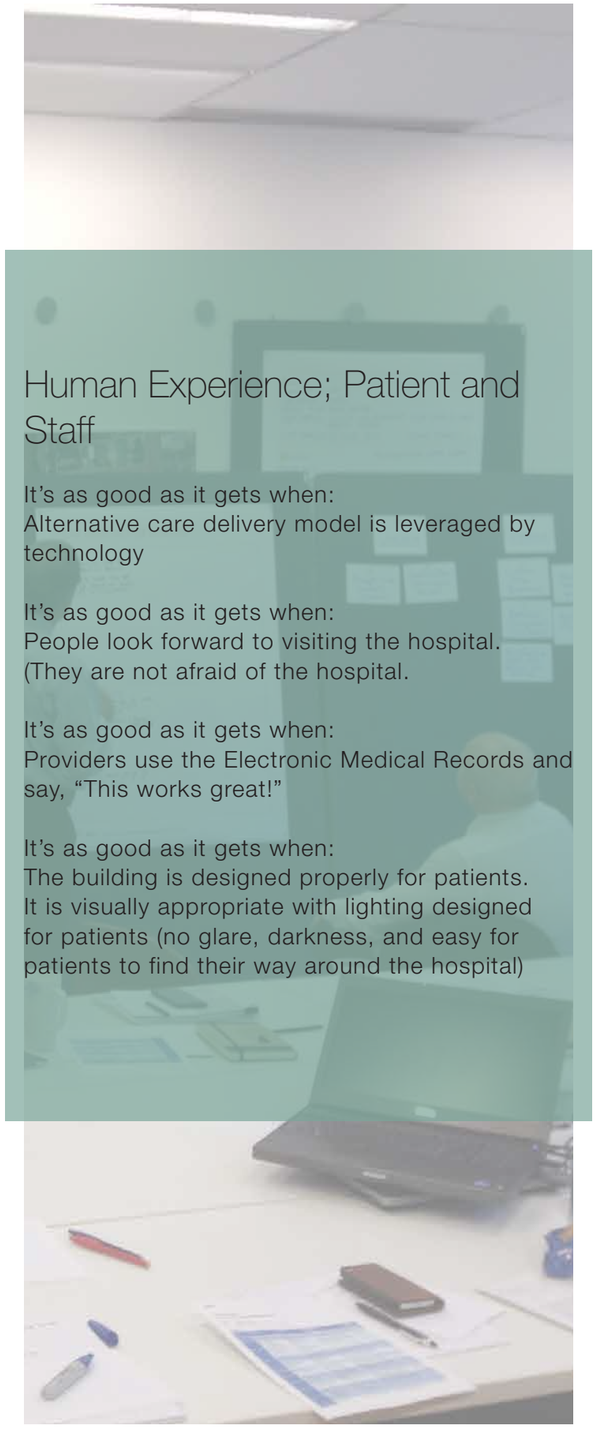
It’s as good as it gets when: The helipad is moved to the roof

It’s as good as it gets when: The campus is a community draw and amenity with a Resource Center and Resource Park

It’s as good as it gets when: The Emergency Room is no longer the “Entrance to the Hospital”. It should be through the clinics.

It’s as good as it gets when: Registration is resolved with way finding

It’s as good as it gets when: Circulation is simplified and there are no “long walks” within the hospital.



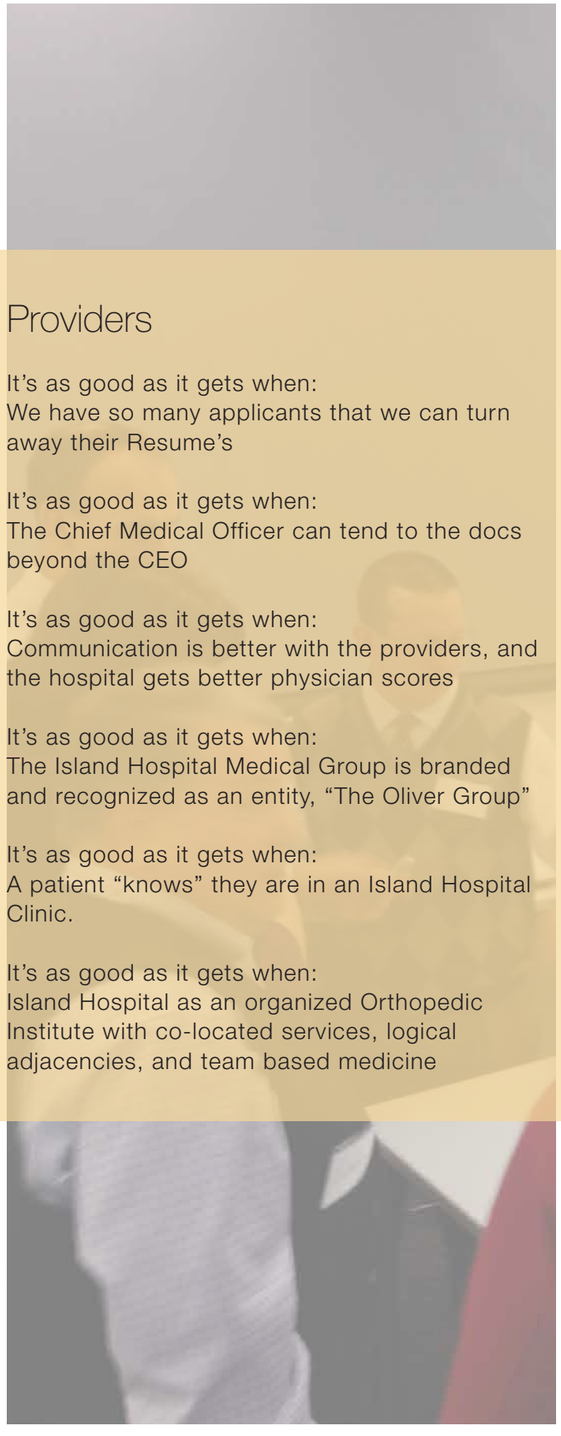
Human Experience; Patient and Staff

It’s as good as it gets when:
Alternative care delivery model is leveraged by technology

It’s as good as it gets when:
People look forward to visiting the hospital. (They are not afraid of the hospital.

It’s as good as it gets when:
Providers use the Electronic Medical Records and say, “This works great!”

It’s as good as it gets when:
The building is designed properly for patients. It is visually appropriate with lighting designed for patients (no glare, darkness, and easy for patients to find their way around the hospital)



Providers

It's as good as it gets when:
We have so many applicants that we can turn away their Resume's

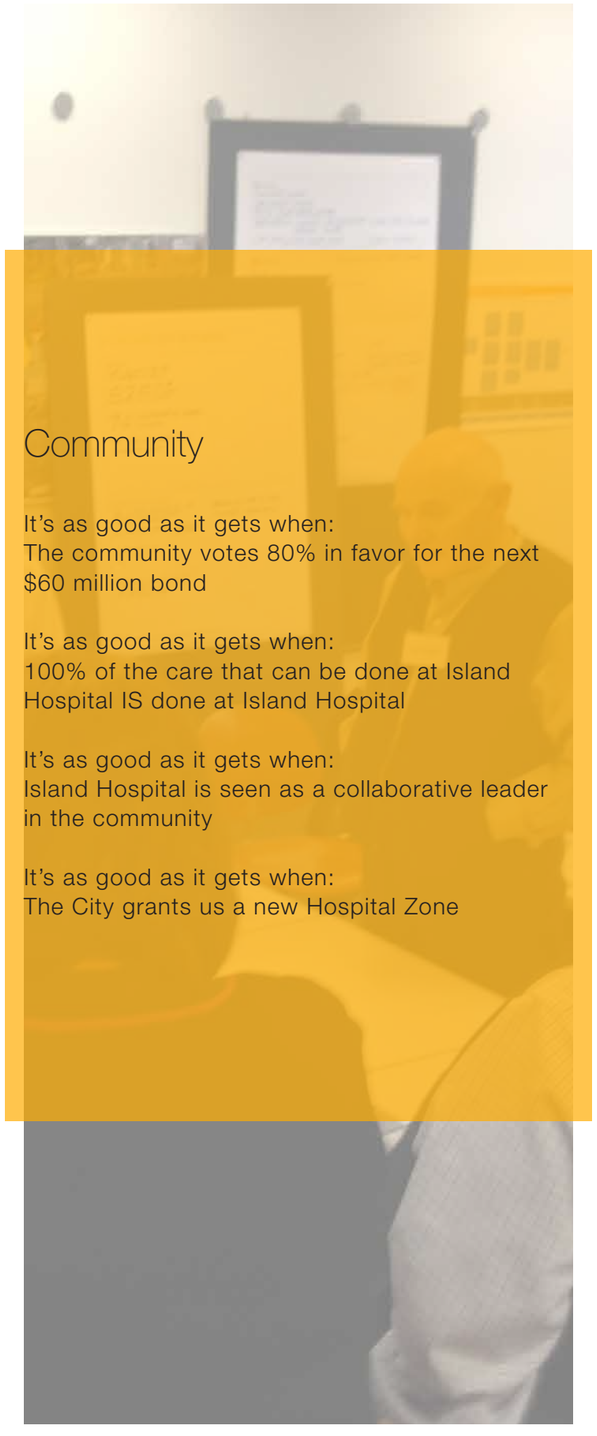
It's as good as it gets when:
The Chief Medical Officer can tend to the docs beyond the CEO

It's as good as it gets when:
Communication is better with the providers, and the hospital gets better physician scores

It's as good as it gets when:
The Island Hospital Medical Group is branded and recognized as an entity, "The Oliver Group"

It's as good as it gets when:
A patient "knows" they are in an Island Hospital Clinic.

It's as good as it gets when:
Island Hospital as an organized Orthopedic Institute with co-located services, logical adjacencies, and team based medicine



Community

It's as good as it gets when:
The community votes 80% in favor for the next $60 million bond

It's as good as it gets when:
100% of the care that can be done at Island Hospital IS done at Island Hospital

It's as good as it gets when:
Island Hospital is seen as a collaborative leader in the community

It's as good as it gets when:
The City grants us a new Hospital Zone

Business Plan / Affiliations

It's as good as it gets when:
The organization is fully adapted to a new payment mechanism

It's as good as it gets when:
Patients can say, "I know what my healthcare will cost me when I leave home"

It's as good as it gets when:
We have marketing excellence and get the message of quality of Island Hospital to the patient base.

It's as good as it gets when:
We reach out more to the younger generation

These comments define the vision and project goals in terms of the hospital's values rather than bottom line measures. These visions are guiding inspirations about the future.

ARRIVAL & REGISTRATION PROJECT REVIEW

NBBJ took us through the Central Registration and Arrival Study high lighting challenges and solutions. Current processes, technology and facility design make it difficult for Island Hospital to deliver the positive arrival and registration experience it strives for. The solution was to reposition a registration area at each entrance along with a relocation of lab draw services as a satellite function near the main entry. This solution will provide Island Hospital with an environment supporting an optimal patient and staff experience as well as one that operates more efficiently. The project may not be fully developed and scaled alternatives were presented for a staged implementation. This is a high priority for Island Hospital.

ISLAND HOSPITAL

Central Registration and Arrival Study

December 26, 2012 DRAFT

2012 DEC 26 DRAFT

43

The Arrival &Registration is regarded as a high priority project.

Phase 1 (Pink)

Consolidate housekeeping - no rennovation reconfigure in existing space.

Phase 2 (Green)

Use current main entry desk at entry as registration function - possibly add a second desk - minimal waiting provided. Assumes relocating desk from existing central registration for second desk. No other rennovation work.

Build New Lab

Remove existing registration desks and consolidate furniture. Assumes limited patch and repair work.

MASTER PLANNING EXERCISE

The Gaming Board

An ariel photograph with a floor plan overlay provided the backdrop for the gaming board. Overlaid onto the photograph were property lines and building set backs. The team explored building and parking development options, circulation paths within the site and within the building. The present zoning restrictions keep the hospital from building above 35 feet. A proposed new zone for the area is underway. The proposed new Medical Use Overlay would be for a four-story building or a 60 foot height.

Outcomes

A new Orthopedic Center of Excellence concept was discussed as a potential new development. An orthopedic center would want to be located near the hospital surgeries, have easy access to parking and become connected to the hospital. One option would be to demolish the old 1962 building and construct a new taller building in it's place.

Another medical office building site along M Street was also discussed. This was the proposed site from the previous master plan.

Development along Commercial Avenue is seen as the entrance to the hospital. With other medical office buildings along Commercial Avenue, it strengthens the image of a medical campus. A new medical office building could provide street frontage and more of a presence for the hospital. The medical campus should consider landscaping as part of the development and make the hospital an inviting place to come.

While these ideas were very informative to the project theam, this exercise took place very early in the master planning process. As the process continues, the project team will analyze and study various opportunities and strategies further.

NEXT STEPS

The Visioning Session is Task 1 in the Master Plan Process and Schedule Diagram

The next three tasks will occur simultaneously and are studies that NBBJ will conduct separately. Findings of these studies will be presented to Island Hospital prior to the development of the master plan.

Task 2

Workload Analysis and Forecasting will continue to collecting the hospital volume projections, and utilization benchmarks.

Task 3

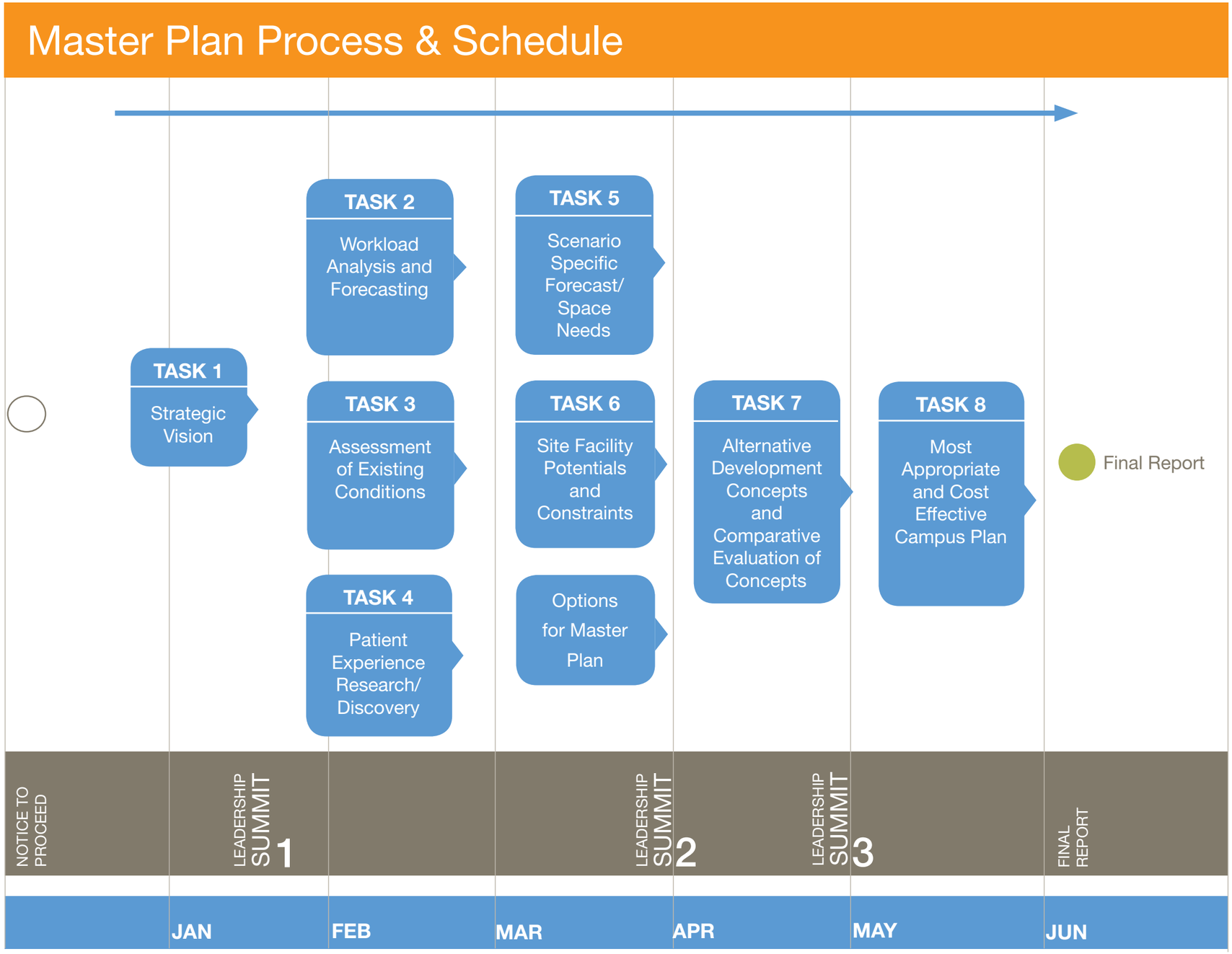
Assessment of Existing Conditions:
This study focuses on the existing hospital and utility building. We learned during the visioning session that there is an option to add a wing to the hospital. This assessment is to determine the impacts to the existing engineering building. This task would also look into the growth or improvements to the surgey, birthing center, and intensive care unit departments. The existing hospital has a central corridor in which patients, public staff, and materials all mingle. We will explore ways of improving the paths of travel.

Task 4

Discovery and Patient Experience
This includes a number of studies that will influence the improvement recommendations to the hospital. We will explore existing challenges and opportunities on these topics

- Surgical Patient Experience
- Outpatient services demand
- Inmigration / Outmigration Analysis
- Labor and Delivery Services
- Impact demographics on payer mix
- Evaluation of nearby competitors
- Orthopedic Center of Excellence
- MOB analysis or Physician Needs Analysis

Master Plan Process & Schedule



DISCOVERY

FRAMING THE DATA AND PROVIDING A FOUNDATION FOR MAKING DECISIONS

PARTICIPANTS

JAN IVERSEN, ISLAND HOSPITAL

CARL TULLY, NBBJ

BUZZ ELY, ISLAND HOSPITAL

REESE PARRETT, NBBJ

ANDREW BUHAYAR, NBBJ

VINCE OLIVER, ISLAND HOSPITAL

CHIP BOGOSIAN, ISLAND HOSPITAL

SEAN WALDRON, NBBJ

LOIS PATE, ISLAND HOSPITAL

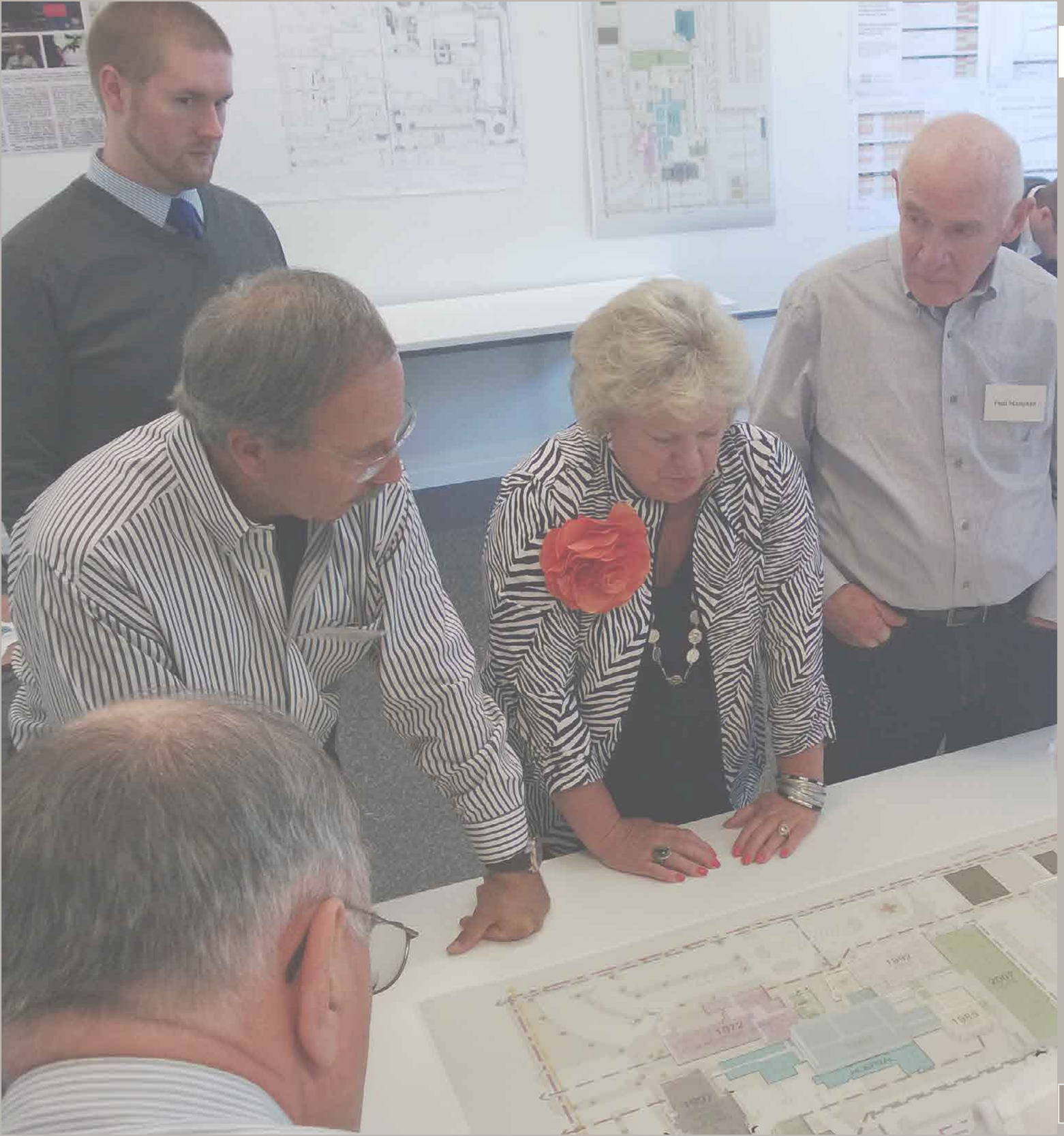
BRIAN BERG, NBBJ

ELISE CUTTER, ISLAND HOSPITAL

PAUL MAUGHAN, ISLAND HOSPITAL

BILL HUCKS, NBBJ

LYNNE LANG, ISLAND HOSPITAL



GOALS

PROVIDE A PERSPECTIVE ON THE DATA

PROVIDE A FOUNDATION FOR THINKING ABOUT:

- Provision of guide posts for scenario development
- Board perspective
- Determine the timeline / horizon

ALIGN AROUND CURRENT EVENTS

WORKLOAD ANALYSIS & FORECAST

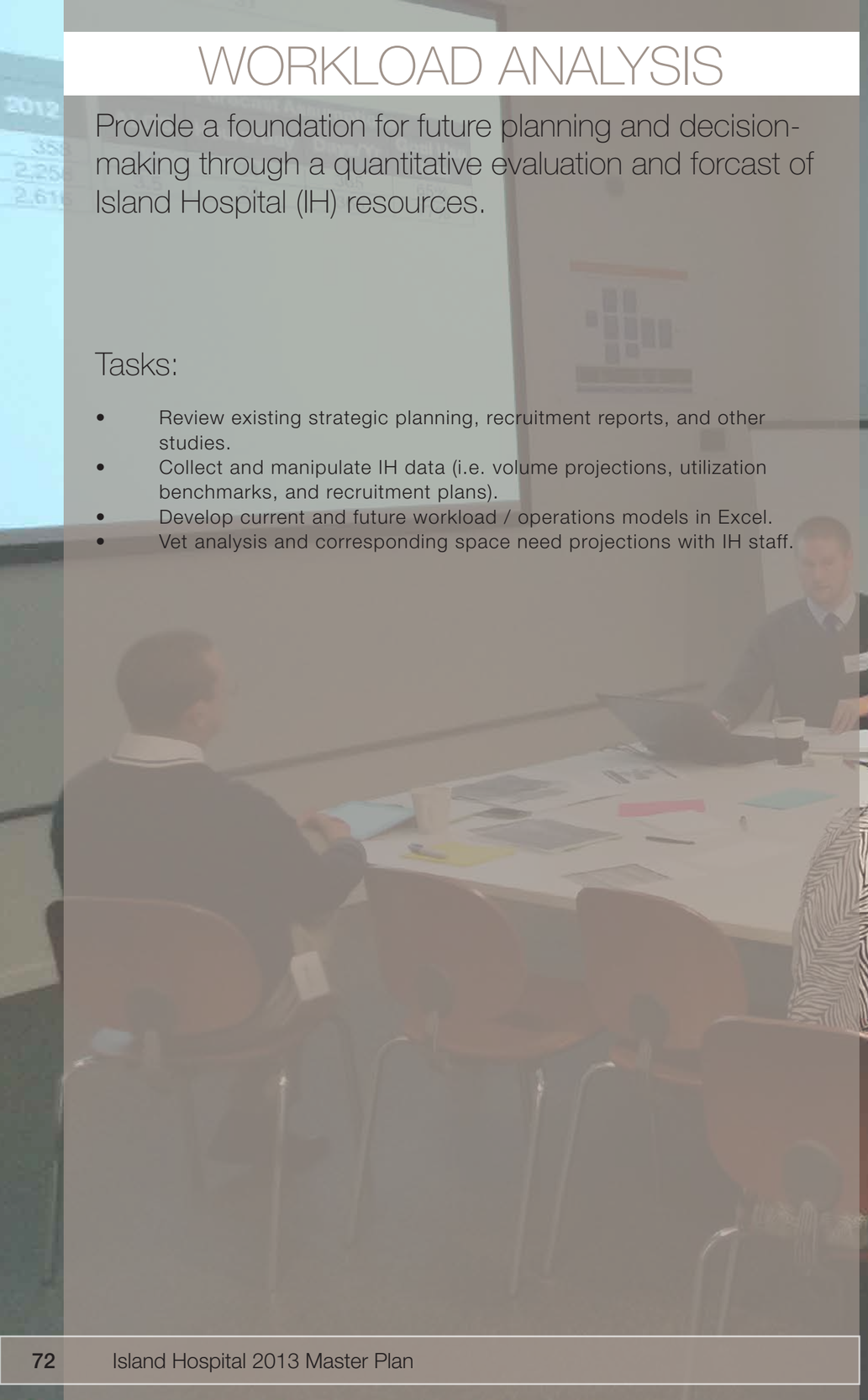
ANALYSIS OF CURRENT WORKLOAD AND CONSIDERATIONS OF POTENTIAL FUTURE SCENARIOS

WORKLOAD ANALYSIS

Provide a foundation for future planning and decision-making through a quantitative evaluation and forcast of Island Hospital (IH) resources.

Tasks:

- Review existing strategic planning, recruitment reports, and other studies.
- Collect and manipulate IH data (i.e. volume projections, utilization benchmarks, and recruitment plans).
- Develop current and future workload / operations models in Excel.
- Vet analysis and corresponding space need projections with IH staff.



ANALYSIS SUMMARY

Overview

Currently right-sized
Continue to invest in / align resources around the needs of Anacortes

Inpatient bed

Total bed capacity meets expected future demand through 2030
Acute care bed need exceeds current capacity by 1.3 beds
Additional bed management is needed to properly utilize and control ALOS
OB bed capacity meets expected future demand past 2035

Imaging

Under current operating conditions; RF / CR, Echo, CT, and MRI needs exceed current capacity

Emergency Department

Adequately sized currently, but by 2025 it will likely be undersized

Surgical Services (OR)

OR and Endoscopy capacity meets current and future needs

WORKLOAD ANALYSIS

SERVICE AREA

Primary service counties will grow by a modest amount, but when compared to the state will be composed of a larger number of elderly

Population forecasted by main service counties: Island, San Juan, and Skagit

Average projected population growth for service counties
~ 0.70% per year

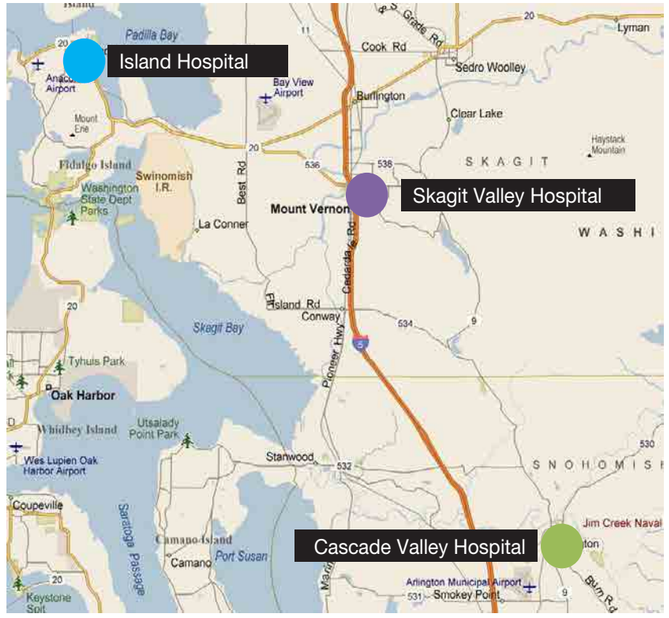
Washington State 65+ = 12.3% in 2010
Island County 18.4%
San Juan County 23.2%
Skagit County 16.1%

Population	2010	2015	2020	2025	2030	2035
Island	78,506	80,337	82,735	85,073	87,621	90,239
San Juan	15,769	15,907	16,256	16,606	16,939	17,216
Skagit	116,901	121,624	128,249	136,410	144,953	153,632

% Change	2010	2015	2020	2025	2030	2035
Island	2.3%	0.6%	0.6%	0.7%	0.7%	0.7%
San Juan	0.9%	0.5%	0.5%	0.5%	0.4%	0.3%
Skagit	4.0%	1.1%	1.4%	1.3%	1.2%	1.2%
Annual Average %	0.5%	0.71%	0.81%	0.81%	0.76%	0.71%

Total Annual Average	**0.70%**

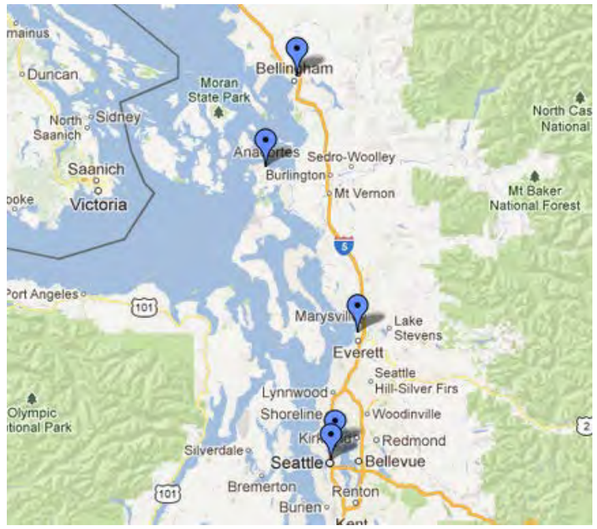
Source: Office of Financial Management - Washington State, 2010 Census



Beds

Skagit Regional Health (Skagit Valley Hospital · Skagit Regional Clinics)	137
Island Hospital	43
Cascade Valley Hospital (Cascade Valley Hospital and Clinics — Close to Home, Close to Heart)	48
	228

	Mileage	Drive Time (minutes)
Peace Health	44	50
PRMCE / Swedish	53	60
UWMC	79	83
VMMC	80	83



COLLECTIVE STRENGTH IN THE REGION

Closest competitors are also strategic partners with significant local strength

DRIVE TIME MAP: POTENTIAL PARTNERS

Drive times represent relative distance to major regional competitors from a patient and staff perspective

PRIMARY SERVICE AREA COMPETITORS

Island Hospital's market share in three primary service zip codes has remained relatively stable over the last 3 years.

Market share is represented as inpatient discharges within a zip code.

Source: CHARS standard reports (Inpatient Discharge Database Reports - Washington State Community Hospitals 2011 – 2006), Washington State Department of Health

Market Share - % of Discharge within Zip Code

Anacortes, 98221	2009	2010	2011
1. Island Hospital	67.1%	66.8%	66.9%
Skagit Valley Hospital	10.0%	11.4%	10.2%
PeaceHealth Saint Joseph Hospital	4.7%	4.0%	3.7%
Providence Regional Medical Center Everett	2.6%	2.7%	3.4%
University Of Washington Medical Center	2.8%	2.0%	2.2%
Harborview Medical Center	1.8%	2.2%	2.1%

Oak Harbor, 98277	2009	2010	2011
Whidbey General Hospital	33.6%	33.4%	31.2%
2. Island Hospital	20.1%	22.0%	22.3%
PeaceHealth Saint Joseph Hospital	7.7%	6.3%	7.2%
Skagit Valley Hospital	7.6%	7.9%	10.7%
Providence Regional Medical Center Everett	7.1%	8.5%	6.4%
Seattle Childrens	5.8%	3.6%	3.2%

La Conner, 98257	2009	2010	2011
1. Island Hospital	45.3%	40.7%	42.1%
Skagit Valley Hospital	30.2%	38.7%	30.7%
Providence Regional Medical Center Everett	4.9%	3.9%	4.3%
PeaceHealth Saint Joseph Hospital	3.5%	3.2%	3.2%
Swedish Medical Center - First Hill	2.9%	0.9%	0.9%
Harborview Medical Center	2.4%	2.7%	3.6%

Increase from Prior Year

Decrease from Prior Year

SENSITIVITY FORECAST METHODOLOGY

For each core service line, a sensitivity analysis was performed to provide a range of estimated projections. Each is represented in the following pages.

Using the three growth data sets allows the project team to look at resource need from multiple points of view. This helps ensure planning remains flexible and the team works within a range instead of a fixed point.

All forecasts are Market and Strategy neutral, and do not incorporate effects due to Health Care Reform.

Advisory Board (AB) (High, 1.3% Annual Growth) – based on Advisory Board Inpatient and Outpatient Market estimators, using WA state averages

Census (Medium, 1.0% Annual Growth) – based on 2010 Census, historic population growth from 2000-2010 for key service counties

Office of Financial Management (OFM) (Low, 0.7% Annual Growth) – based on estimated population growth of service area forecasted by Washington State Office of Financial management for key service counties

WORKLOAD ANALYSIS

INPATIENT BED FORECAST

Current total bed capacity meets expected need until 2030

ICU capacity meets needs through 203 with *population and clinical trending*

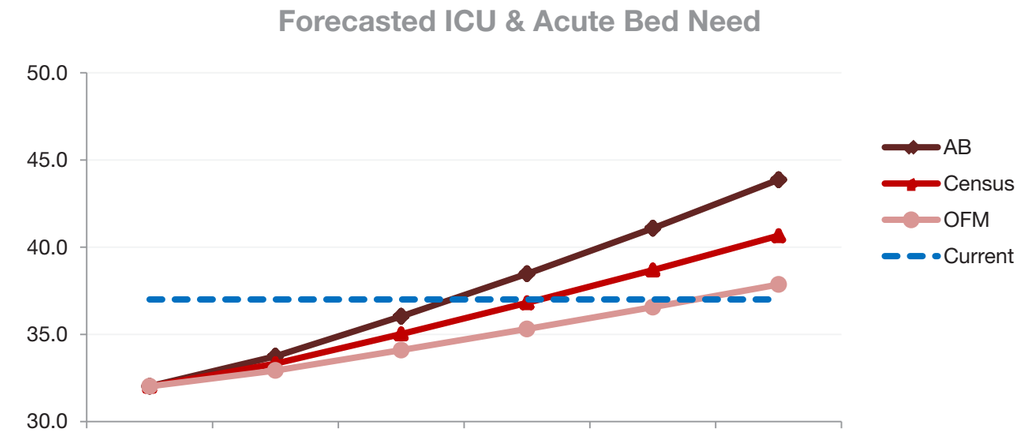
Based on current operations and bed designations, current acute care bed needs exceedcapacity by 1.3 beds

Excess need is currently filled by using ICU beds

Forecast Assumptions:

Current Volume	
BED TYPE	2012
ICU	358
ACUTE	2,258
TOTAL DISCHARGES	2,995

Forecast Assumptions			
ALOS	Hours/Day	Days/Yr	Goal Use Rate
2.5	24	365	65%
3.5	24	365	77%



		FORECASTED IP BED NEEDS					
Advisory Board	**Current**	**2012**	**2015**	**2020**	**2025**	**2030**	**2035**
ICU	10.0	3.7	3.9	4.2	4.5	4.8	5.1
ACUTE	27.0	28.3	29.8	31.8	34.0	36.3	38.7
Total	**37.0**	**32.0**	**34.7**	**36.0**	**38.5**	**41.1**	**43.8**
Current	37	37	37	37	37	37	37

Census	**Current**	**2012**	**2015**	**2020**	**2025**	**2030**	**2035**
ICU	10.0	3.7	3.9	4.1	4.3	4.5	4.8
ACUTE	27.0	28.3	29.4	30.9	32.5	34.2	35.9
Total	**37.0**	**32.0**	**33.3**	**35.0**	**36.8**	**38.7**	**40.7**
Current	37	37	37	37	37	37	37

Office of Financial MGMT	**Current**	**2012**	**2015**	**2020**	**2025**	**2030**	**2035**
ICU	10.0	3.7	3.8	4.0	4.1	4.3	4.4
ACUTE	27.0	28.3	29.1	30.1	31.2	32.3	33.4
Total	**37.0**	**32.0**	**32.9**	**34.1**	**35.3**	**36.6**	**37.9**
Current	37	37	37	37	37	37	37

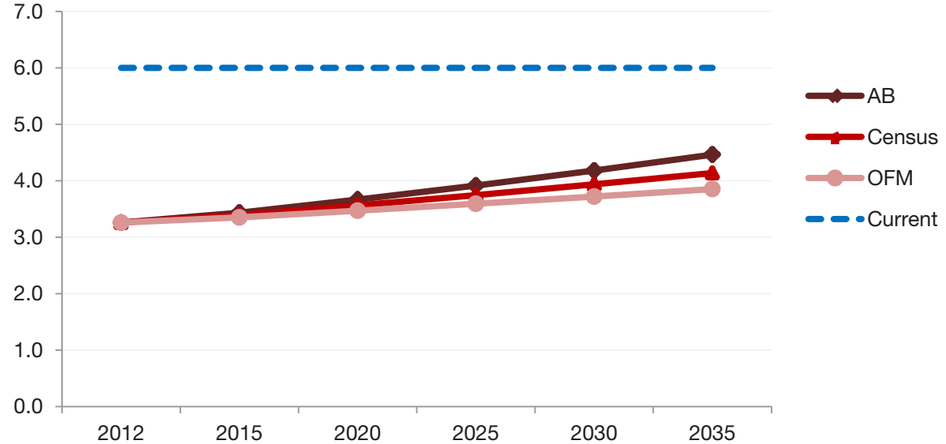
Forecast Assumptions:

Current Volume (Births)	
BED TYPE	2012
OB	379
TOTAL BIRTHS	**379**

Forecast Assumptions			
ALOS	Hours/Day	Days/Yr	Goal Use Rate
2.0	24	365	65%

	FORECASTED BIRTHS						
Sensitivity	2012	Annual Growth Rate	2015	2020	2025	2030	2035
Advisory Board	379	1.3%	399	426	455	486	519
Census	379	1.0%	394	415	436	458	481
Office of Financial MGMT	379	0.7%	390	404	418	433	448

Forecasted OB Bed Need



	FORECASTED OB BED NEEDS						
Sensitivity	Current	2012	2015	2020	2025	2030	2035
Advisory Board	6.0	3.3	3.4	3.7	3.9	4.2	4.5
Census	6.0	3.3	3.4	3.6	3.7	3.9	4.1
Office of Financial MGMT	6.0	3.3	3.4	3.5	3.6	3.7	3.9
Current	6.0	6.0	6.0	6.0	6.0	6.0	6.0

LABOR AND DELIVERY FORECAST

Labor & Delivery operates 8 beds;

4 Labor & Delivery Room beds (LDR)

4 Post Partum beds (PP)

OB Capacity meets needs through 2035 with *population and market trending*

WORKLOAD ANALYSIS

EMERGENCY DEPARTMENT FORECAST

Current Bays;

- 7 Treatment
- 1 Behavioral Health
- 2 Trauma

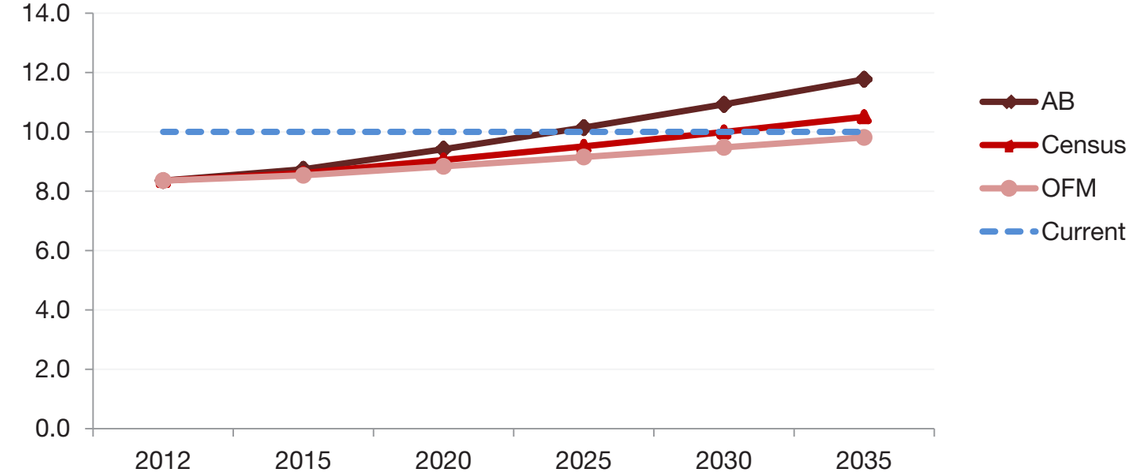
Emergency Department will be at full capacity by 2030

Assumptions:

Level of Service	2012 Visits	2012 Distribution
Level 1	41	0.3%
Level 2	229	2%
Level 3	4,441	36%
Level 4	3,737	30%
Level 5	3,680	30%
Level 6	-	-
Level 7	326	3%
Total	**12,454**	100%

FORECAST ASSUMPTIONS					
Mins/Case	Clean-up Time	Hours/Day	Days/Yr	Goal Use Rate	% During Sch'd Day
73	0	24	365	40%	100%
96	0	24	365	40%	100%
87	0	24	365	40%	100%
141	0	24	365	40%	100%
205	0	24	365	40%	100%
-	0	24	365	40%	100%
198	0	24	365	40%	100%

Forecasted ED Need



	2012	2015	2020	2025	2030	2035
Advisory Board	8.4	8.7	9.4	10.1	10.9	11.8
Census	8.4	8.6	9.1	9.5	10.0	10.5
Office of Financial MGMT	8.4	8.5	8.8	9.2	9.5	9.8
Current	10.0	10.0	10.0	10.0	10.0	10.0

OPERATING ROOM FORECAST

Procedure volume has increased over time

Outpatient procedures make up the majority of all cases and have steadily increased as a proportion of total cases

Operating Room Needs - Current

- 4 ORs ~14 procedures per day in 2012, compared to ~12 procedures per day in 2006
- 1 Endoscopy Room ~7 procedures per day in 2012, compared to ~5 procedures per day in 2006

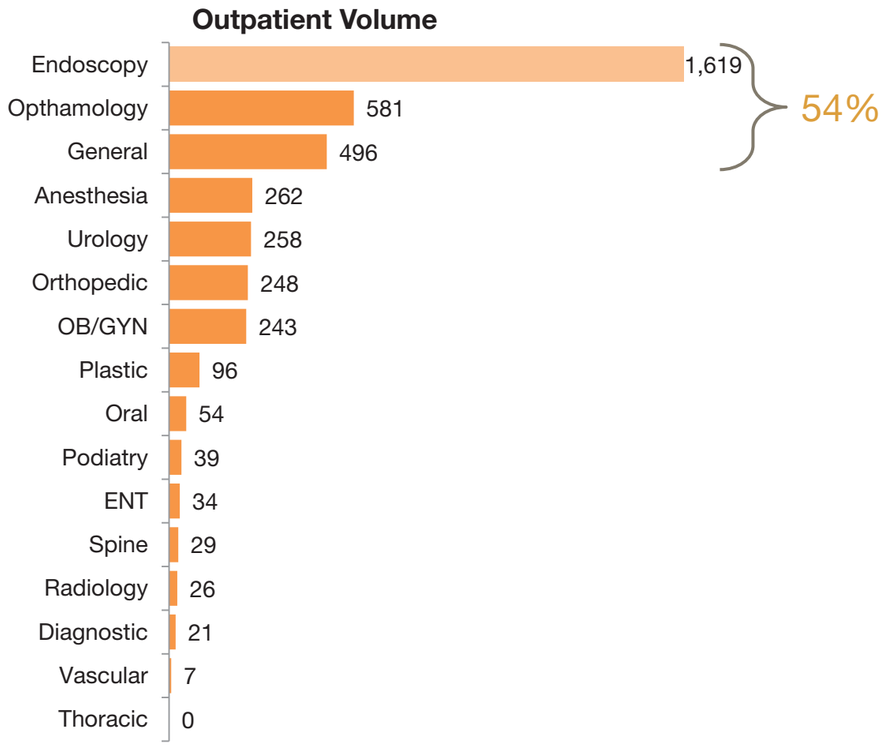
	2006	2012
OP Volume %	73%	77%
IP Volume %	27%	23%
Average OP Case Time	108 mins	95 mins
Average IP Case Time	51 mins	59 mins

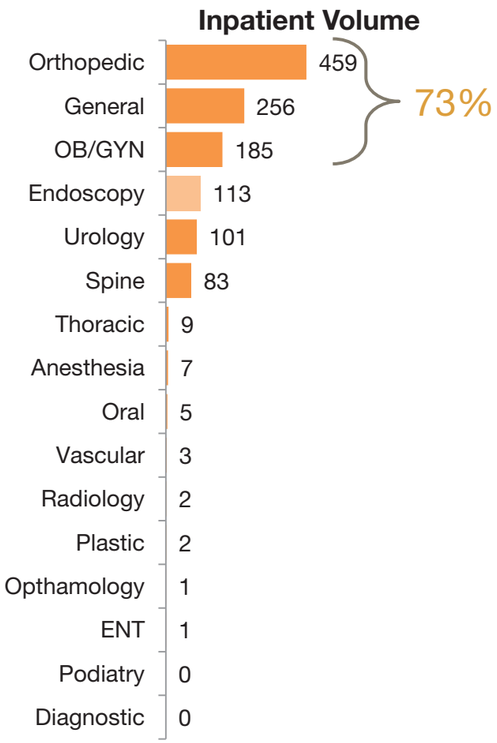
Operating Room Needs - Assumptions

- 2012 Actual min/case by case type
- Turn around time:
    - o 15 minutes for OP cases
    - o 30 minutes for IP cases
- 10 hour days, 250 days per year
- 80% utilization rate
- 90% cases are scheduled

Operating Room Needs – Volume Detail

- Top 3 OP Case Types **~54% of OP Volume**
- Top 3 IP Case Types **~73% of IP Volume**





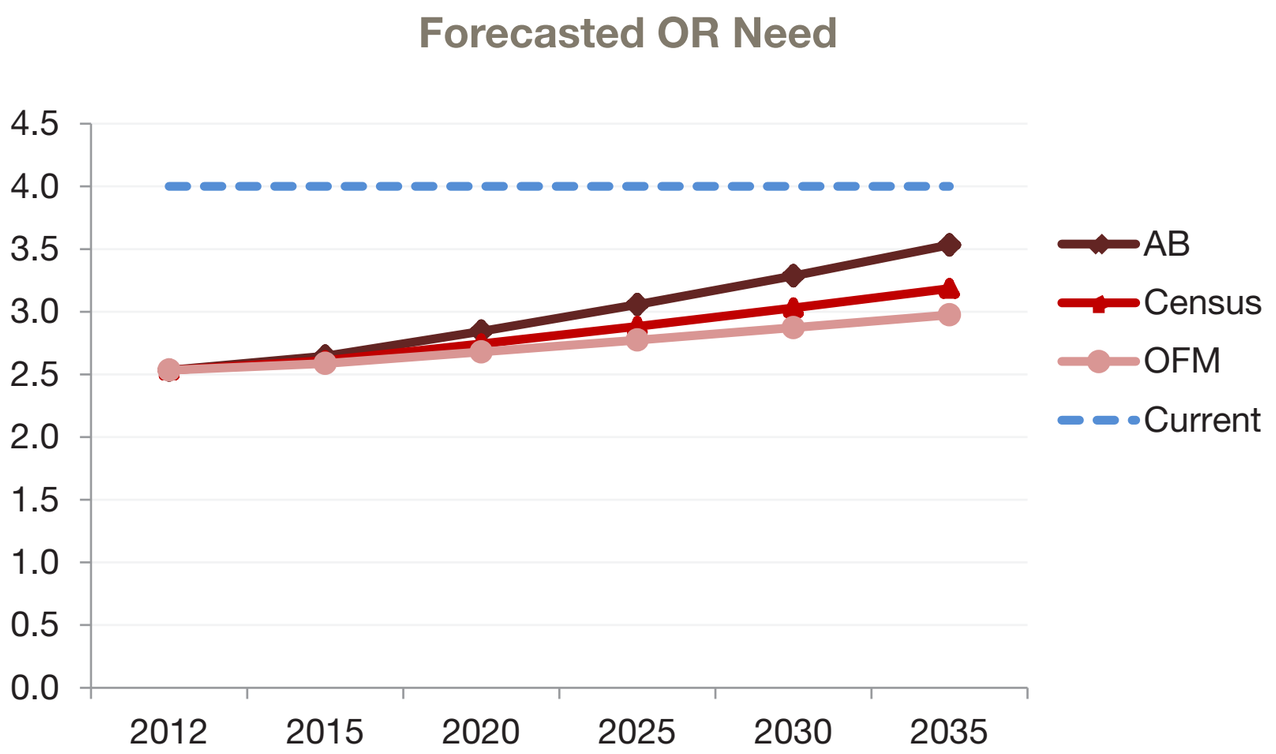
OPERATING ROOM FORECAST

Detailed look at surgery case volumes provides a clearer picture of the case types and specialties

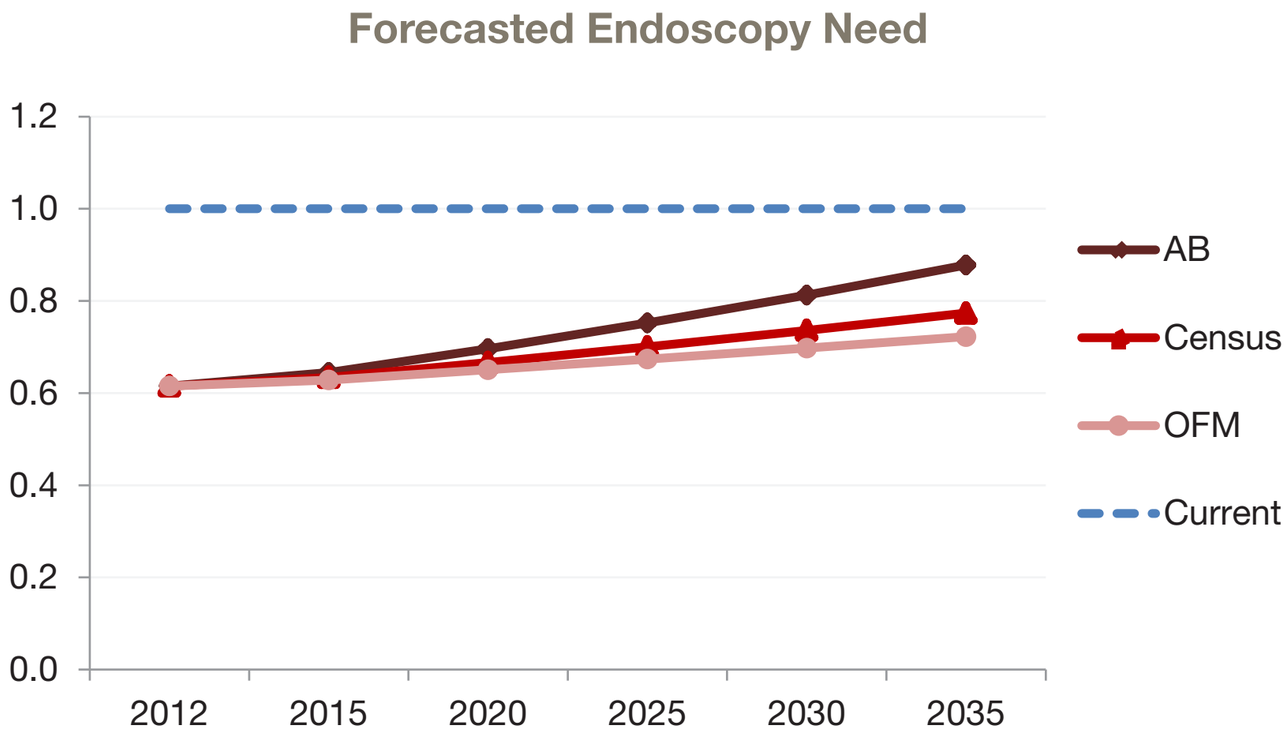
Endoscopy is the largest volume specialty, but operates out of a single Endoscopy room and not the general surgery ORs

OPERATING ROOM FORECAST

OR capacity meets expected need through 2035



OR	2012	2015	2020	2025	2030	2035
Advisory Board	2.5	2.6	2.8	3.1	3.3	3.5
Census	2.5	2.6	2.7	2.9	3.0	3.2
Office of Financial MGMT	2.5	2.6	2.7	2.8	2.9	3.0
Current	4.0	4.0	4.0	4.0	4.0	4.0



ENDOSCOPY	2012	2015	2020	2025	2030	2035
Advisory Board	0.6	0.6	0.7	0.8	0.8	0.9
Census	0.6	0.6	0.7	0.7	0.7	0.8
Office of Financial MGMT	0.6	0.6	0.7	0.7	0.7	0.7
Current	1.0	1.0	1.0	1.0	1.0	1.0

OPERATING ROOM FORECAST

Endoscopy capacity meets expected need through 2035

DIAGNOSTIC IMAGING FORECAST

Operating assumptions vary for each Modality

Diagnostic Imaging Needs - Methodology

Forecast Assumptions:

Modality	Mins/Case	Clean-up Time	Hours/Day	Days/Yr	Goal Use Rate	% Sch'd
RF / CR	20	5	12	250	85%	90%
ECHO	60	5	8	250	90%	95%
DEXA	25	5	8	250	90%	95%
MAMMO	15	5	8	250	90%	100%
CT	30	5	9	365	85%	90%
MRI	45	10	14	250	90%	95%
ULTRASOUND	30	10	9	250	90%	90%
IR	60	15	8	250	80%	80%
NUC MED	60	5	8	250	90%	90%

Need greater than capacity Capacity meets need

Advisory Board	Existing	2012	2015	2020	2025	2030	2035
RF / CR	2	2.7	2.8	3.2	3.5	3.9	4.4
ECHO	1	2.3	2.4	2.7	3.0	3.4	3.8
DEXA	1	0.2	0.2	0.2	0.3	0.3	0.3
MAMMO	1	0.8	0.9	1.0	1.1	1.2	1.3
CT	1	1.4	1.5	1.7	1.8	2.1	2.3
MRI	1	1.1	1.2	1.3	1.5	1.7	1.9
ULTRASOUND	2	1.7	1.9	2.1	2.3	2.6	2.9
IR	1	0.6	0.6	0.7	0.8	0.8	0.9
NUC MED	1	0.6	0.6	0.7	0.8	0.9	1.0

Census	Existing	2012	2015	2020	2025	2030	2035
RF / CR	2	2.7	2.7	2.9	3.0	3.2	3.4
ECHO	1	2.3	2.4	2.5	2.6	2.7	2.9
DEXA	1	0.2	0.2	0.2	0.2	0.2	0.3
MAMMO	1	0.8	0.8	0.9	0.9	1.0	1.0
CT	1	1.4	1.4	1.5	1.6	1.7	1.8
MRI	1	1.1	1.2	1.2	1.3	1.4	1.4
ULTRASOUND	2	1.7	1.8	1.9	2.0	2.1	2.2
IR	1	0.6	0.6	0.6	0.6	0.7	0.7
NUC MED	1	0.6	0.6	0.7	0.7	0.7	0.8

Office of Financial MGMT	Existing	2012	2015	2020	2025	2030	2035
RF / CR	2	2.7	2.7	2.8	2.9	3.0	3.1
ECHO	1	2.3	2.3	2.4	2.5	2.6	2.7
DEXA	1	0.2	0.2	0.2	0.2	0.2	0.2
MAMMO	1	0.8	0.8	0.9	0.9	0.9	1.0
CT	1	1.4	1.4	1.5	1.5	1.6	1.6
MRI	1	1.1	1.2	1.2	1.2	1.3	1.3
ULTRASOUND	2	1.7	1.8	1.8	1.9	2.0	2.0
IR	1	0.6	0.6	0.6	0.6	0.6	0.7
NUC MED	1	0.6	0.6	0.6	0.7	0.7	0.7

DIAGNOSTIC IMAGING FORECAST

RF / CR, Echo, CT, and MRI current needs exceed capacity, these modalties require utilization and operational management to meet needs

WORKLOAD ANALYSIS

OUTPATIENT SERVICES FORECAST

Census		2013 Annualized	Annual Growth Rate*	Visit Volume - FORECAST			Visits per Day - FORECAST				OPERATIONAL ASSUMPTIONS	
Group / Unit	Visit Type			2015	2025	2035	2013	2015	2025	2035	Hours/Day	Days/Yr
RHC	Lopez Visits	6,666	1.0%	6,868	7,587	8,380	27	27	30	34	9	250
RHC	AFM Visits	13,995	1.0%	14,419	15,928	17,594	56	58	64	70	9	250
RHC	Walk-in Clinic Visits	5,568	1.0%	5,737	6,337	7,000	19	19	21	23	12	300
RHC	FMA Visits	35,337	1.0%	36,408	40,217	44,424	141	146	161	178	9	250
RHC	Orcas Visits	4,749	1.0%	4,893	5,405	5,970	19	20	22	24	9	250
Subtotal RHC Visits		**66,315**		**68,324**	**75,473**	**83,369**						
Woundcare	Inpatient Visits/Procedures	195	1.0%	201	222	245	1	1	1	1	8	250
Woundcare	Outpatient Visits	2,223	1.0%	2,290	2,530	2,795	9	9	10	11	8	250
Oncology	Total Provider Visits	3,933	1.0%	4,052	4,476	4,944	16	16	18	20	8	250
Oncology	Total Infusion Clinic Procedures	8,181	1.0%	8,429	9,311	10,285	33	34	37	41	8	250
Sleep Lab	Total Studies	582	1.0%	600	662	732	2	2	3	3	8	250
Clinic	Psychiatry Visits	2,553	1.0%	2,630	2,906	3,210	10	11	12	13	8	250
Clinic	Therapist Visits	1,980	1.0%	2,040	2,253	2,489	8	8	9	10	8	250
Clinic	Island Surgeons Visits	3,150	1.0%	3,245	3,585	3,960	42	43	48	53	8	75
Clinic	Plastic Visits	1,158	1.0%	1,193	1,318	1,456	6	6	7	7	7	200
Subtotal Outpatient Visits		**23,955**		**24,681**	**27,263**	**30,115**						

Medical Office Building Analysis

Preliminary Conclusions:

- **The Anacortes market is competitive with ambulatory and satellite facilities opening in recent years.**

- **Island Hospital maintains a strong local presence and is a preferred health services provider in for the area.**

LOCAL COMPETITORS

Skagit Island Orthopedic Center
Orthopedic Health Care
2720 Commercial Avenue
Anacortes, WA 98221
http://www.skagitislandorthopedics.com/

March 2011, SIO opened a new, state-of-the-art clinic in Anacortes. The 4,000-square-foot facility offers patients digital X-ray services and a physical therapy center complete with new treadmills, exercise bicycles and private treatment rooms.

Proliance Preferred Provider with Premera

Located on Commercial Ave, 0.4 miles from Island Hospital

LOCAL COMPETITORS

Fidalgo Island Walk-In Clinic*
Primary Care
1500 Commercial Avenue
Anacortes, WA 98221
(360) 299-2650
http://www.fidalgowalk-in.com

Island Internal Medicine
Primary Care
912 32nd St # A
Anacortes, WA 98221
(360) 293-4343
islandinternalmedicine.com

Rosario Skin Clinic
Dermatology Clinic
3110 Commercial Avenue
Anacortes, WA 98221
(360) 755-3253

Northwest Orthopaedic Surgeons*
Integrated Musculoskeletal Care
1017 20th Street
Anacortes, WA 98221
(360) 424-7041
http://www.nwosonline.com/home/

North Sound Oral & Facial Surgery Building**
2620 Commercial Avenue
Anacortes, WA 98221

*Affiliated with Island Hospital
**Needs confirmation

WORKLOAD ANALYSIS

Hospital Systems Continue to Restructure and Expand

Providence's Northwest & Southwest divisions and Swedish Medical Center finalized their affiliation agreement in February of 2012.

Providence has opened new 10 story tower and extended capacity of Emergency Department and Inpatient beds.

UW Medicine joined forces with Northwest Hospital & Medical Center to create a new nonprofit and entered into an affiliation with Valley Medical Center.

Swedish Health System opened a new Issaquah medical campus in the summer of 2011, and Stevens Hospital (a public hospital district) is now Swedish/Edmonds.

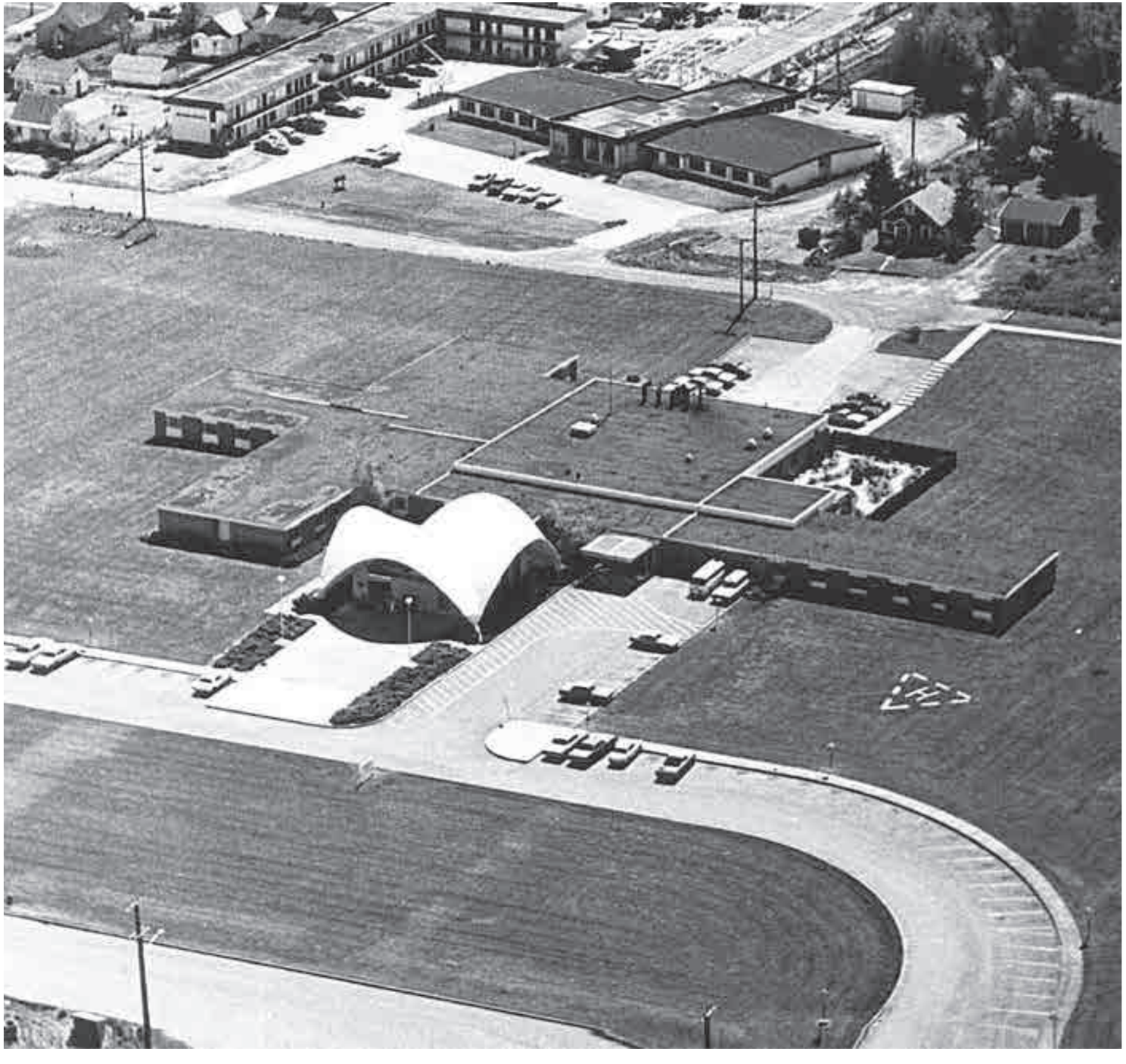
Olympic Medical Center affiliated with Swedish Medical Center in October of 2011.

Peace health has opened Peace Island Medical Center in Friday Harbor, a 10 bed critical access hospital with 5 ED beds, an outpatient OR, full diagnostic, primary care, obstetric, and cancer services.

ASSESSMENT OF EXISTING CONDITIONS

ANALYSIS OF THE CURRENT STATE OF EXISTING ISLAND HOSPITAL OPERATIONS AND FACILITIES

INTRODUCTION



Island Hospital is the center for health and wellness in west Skagit County, also serving north Whidbey Island and the San Juan Islands since 1962. Recognized as one of the most innovative small hospitals is the U.S., and honored in 2006 as one of our nation's "100 Top Hospitals" for performance improvement, Island Hospital is an integral part of the great quality of life on Fidalgo Island. Staffed by more than 190 physicians and healthcare providers, Island Hospital offers a quality and range of services typically found in a much larger facility. With 43 private beds, Island is the smallest hospital in Washington providing Level III trauma care. Island Hospital also operates seven family care clinics and six specialty clinics

History of Island Hospital

1962 Island Hospital opened in 1962 as a rural hospital. The original building still stands at the center of the present campus.

1974 the Island Medical Center was constructed adjacent to the front door of the hospital

1985 a new addition for ICU was constructed on the south end of the hospital

1990 Emergency Department expanded on the south end

1992 the Central Plan was constructed. This addition allowed the central boiler, chillers, emergency generator and medical gas system including oxygen tank to be centrally located to support the medical campus

1996 a new surgery department, birthing center and health resource center was added to the east end of the hospital entrance

1998 the West Medical Office Building was added with an entrance along M Street and a lower entrance connecting to the hospital

2008 Renovations and a new addition to the east was completed adding a new ER, Diagnostic Imaging, New bed tower, new hospital entrance

2012 the Medical Arts Pavilion with cancer care, physical therapy and wound care was constructed to the east of the hospital with a parking entrance and frontage along Commercial Ave

The history of the hospital is important information as it gives us clues as to the where the hidden engineering support services are located and how they work. The facility assessment for this master plan will focus on the hospital structures and not the medical office buildings.

MEDICAL USE OVERLAY

Purpose

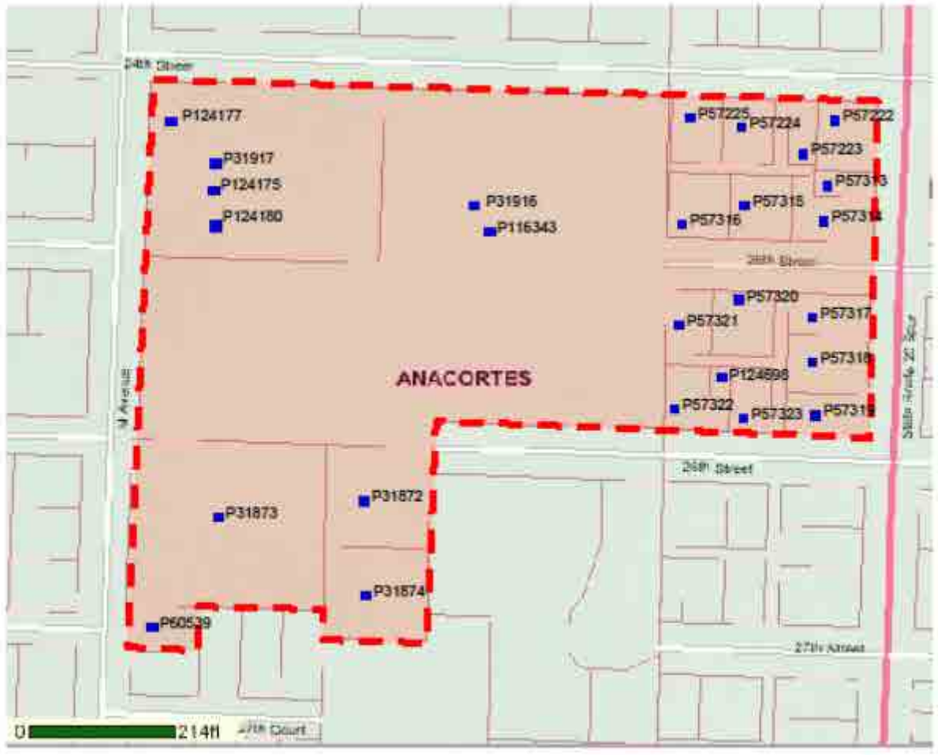
The City of Anacortes Zoning Code allows hospital use in residential zone R4A. Because it is a residential zone, there are limitations on height, setbacks, and maximum land coverage to be consistent with residential use. The land along Commercial Ave is zoned as a Commercial Zone. Healthcare is allowed but only by permission of the City. Because of these restraints, we proposed that a Medical Use Overlay be developed to allow both commercial and healthcare uses without special permission or conditional approval. The City has a process for land use development modifications and we have applied for this change.

Advantages

The Medical Use Overlay will allow Island Hospital to develop property within the Commercial Zone without the City's conditional use requests, or concern that the City could deny healthcare development along Commercial Ave. Once the city approves the Medical Use Overlay, additional modifications can be made to widen the zone, increase height allowances, and reduce setbacks.

Milestones:

March 8, 2013	Application submitted to City Planning
May 8, 2013	City Council Meeting, Public hearing receives 12 applications for changes to zoning
June 3, 2013	City Council Meeting to announce selected applications to be further reviewed by City Staff
TBD	City Council Public Hearing: We are expecting this date to be in September
TBD	Final Approval: We are expecting this date to be February or March 2014



CENTRAL PLANT

The Central plant does not serve all of the buildings on the campus. The Medical Arts Pavilion is a stand-alone building as is the Island Medical Center Building. The Utilities for the Central Plant, with few exceptions, are sized for future growth of the campus.

Oxygen

The oxygen tank holds 900 gallons of liquid oxygen which is sufficient to last 3 weeks. The hyperbaric chamber at the Medical Arts Pavilion has a separate oxygen tank. In addition to the bulk oxygen tank, there is a back-up bank of oxygen tanks that can keep the hospital operational for an additional 48 hours.

Vacuum

There are 3 vacuum pumps of which only 1 is needed to support the hospital. The other two are redundant and needed for emergency purposes only.

NItrous Oxide

There are 4 bottles serving the operating rooms, endoscopy and interventional rooms. This is enough capacity to keep the hospital operational for 2 – 3 months.

Medical Air

Only one medical air pump is required to provide all of the medical air needed on campus. There is a second medical air pump to provide for redundancy or back-up.

CENTRAL PLANT

Emergency Power

There are (2) 66 KVA emergency generators with a 6,000 gallon diesel fuel tank. These generators can supply 40% of the total capacity of the hospital. The Medical Arts Pavilion is not part of the emergency power because there is insufficient space on the Automatic Transfer Switch. Consideration should be given to increase the size of the Automatic Transfer Switch.

Chilled Water

There are (3) cooling towers and (3) chillers supporting the hospital's HVAC system. This is not adequate capacity for the hospital. The Medical Arts Pavilion is not connected to the chilled water system primarily due to the insufficient capacity. A new cooling tower and chiller are needed for the hospital.

Boilers

There are (4) boilers that serve the hospital and Medical Office Building to the west. Only 2 boilers are needed to support the hospital on the coldest day of the year. Boiler redundancy is needed for maintenance and emergency purposes. The facility engineers are proposing that the boilers be located under the new 2007 addition. The piping connections occur in an underground utility trench encased in concrete beneath the new parking stalls leading from the Central Plant to the new 2007 addition. The engineers have determined that there is significant heat loss from the boilers to the hospital and by locating them under the building, a savings in energy costs can be captured.

HELIPAD

The existing helipad, located near the front entrance of the hospital, no longer provides a close entrance to the emergency department and consumes valuable parking spaces. The helipad is fenced off from the parking lot so that cars do not park in the helipad area.

Consideration should be given to relocating the helipad to a rooftop or other site location closer to the emergency department.

Rooftop helipads are more secure, private and usually safer for patient transportation. They are more expensive especially on an existing roof. Ground helipads are simple and less expensive. They take up valuable land.

Helicopter flight patterns should be away from tall buildings, power lines, and away from mechanical roof top units. Approach and departure paths should be such that downwind operations are avoided and crosswind patterns are kept to a minimum. Helicopters should have more than one approach/ departure path and be aligned with predominate prevailing winds. The separation between approach and departure should be at least 135 degrees.

The placement of the new helipad should consider future building additions. New additions close to the helipad will limit the approach and departure pathways.

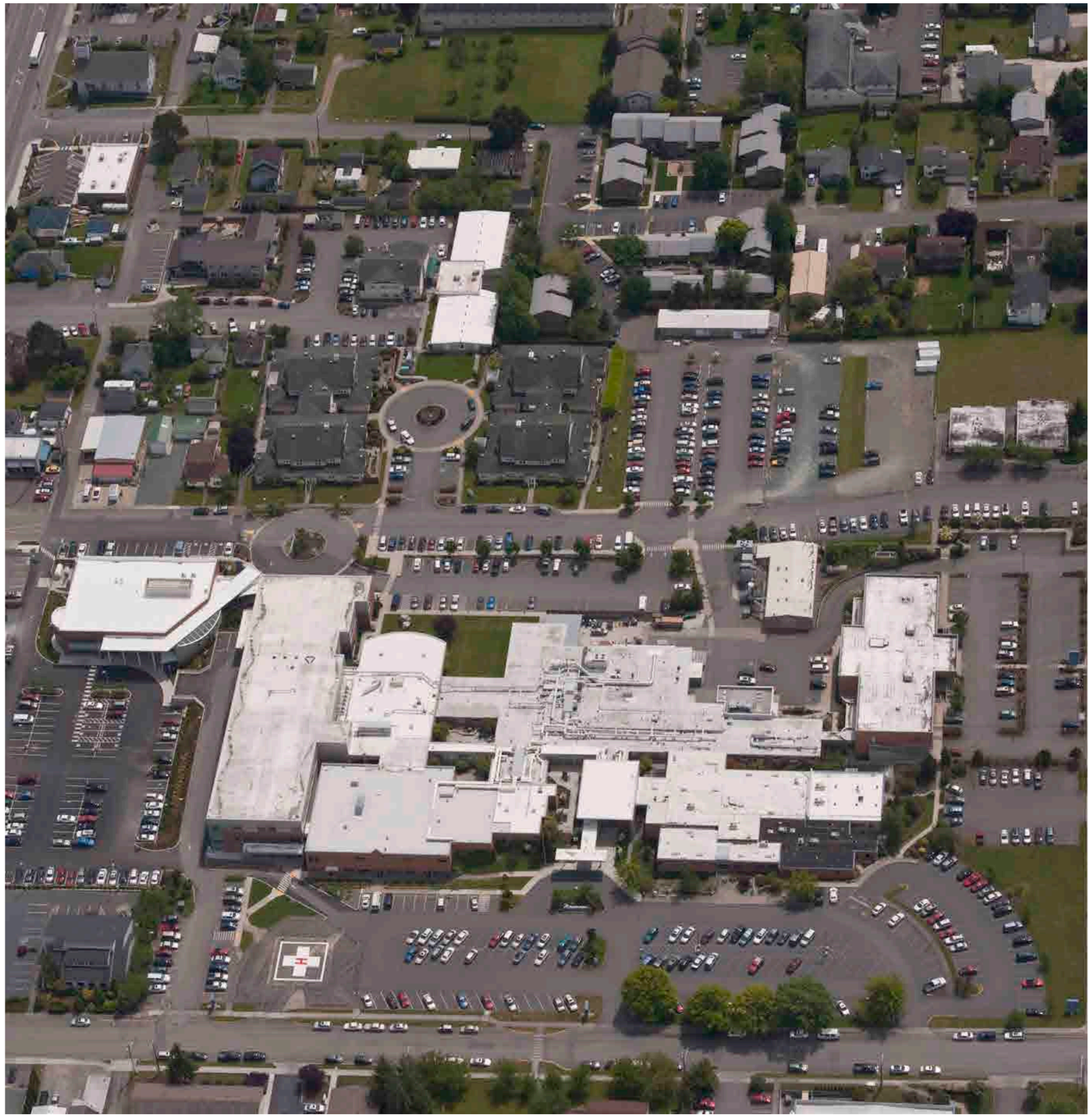
PARKING

Presently there are 625 available parking stalls across the entire campus. According to our calculations based upon the need for hospital and medical office use combined,

there is a need for 750 stalls today during the busiest time of the day, and during the daytime and evening staff shifts.

The trends for development indicate that more parking will be needed as outpatient and medical office building demand increases.

We estimate that by 2020, there will be a need for 870 parking stalls. By 2030 the demand will increase to 1000 parking stalls.



MOB EXPANSION

Fidalgo Medical Associates and Island Surgeons, located in the Island Medical Office Building, are encountering problems of insufficient space to be efficient.

Presently there are 17 providers in both clinics. Even if more staff and providers were added, no additional patients could be seen due to the lack of additional exam rooms and provider space.

Island Hospital leases space from the Island Medical Office Building Owners. New clinical space would solve the inefficiencies, and would allow for growth for new providers. If the average provider had 2.5 exam rooms, the gross space for 17 providers would be 27,625 sf. They have less than half of that area now (11,172 sf). Planning for future growth should double this area. This does not consider space for diagnostic imaging, lab, or an ambulatory surgery center.

PATIENT EXPERIENCE DISCOVERY

ANALYSIS OF PATIENT EXPERIENCE

PATIENT EXPERIENCE

Meeting the mission:

We will deliver quality, compassionate, and personalized health care to the communities we serve

A specific promise:

Our promise to our patients;

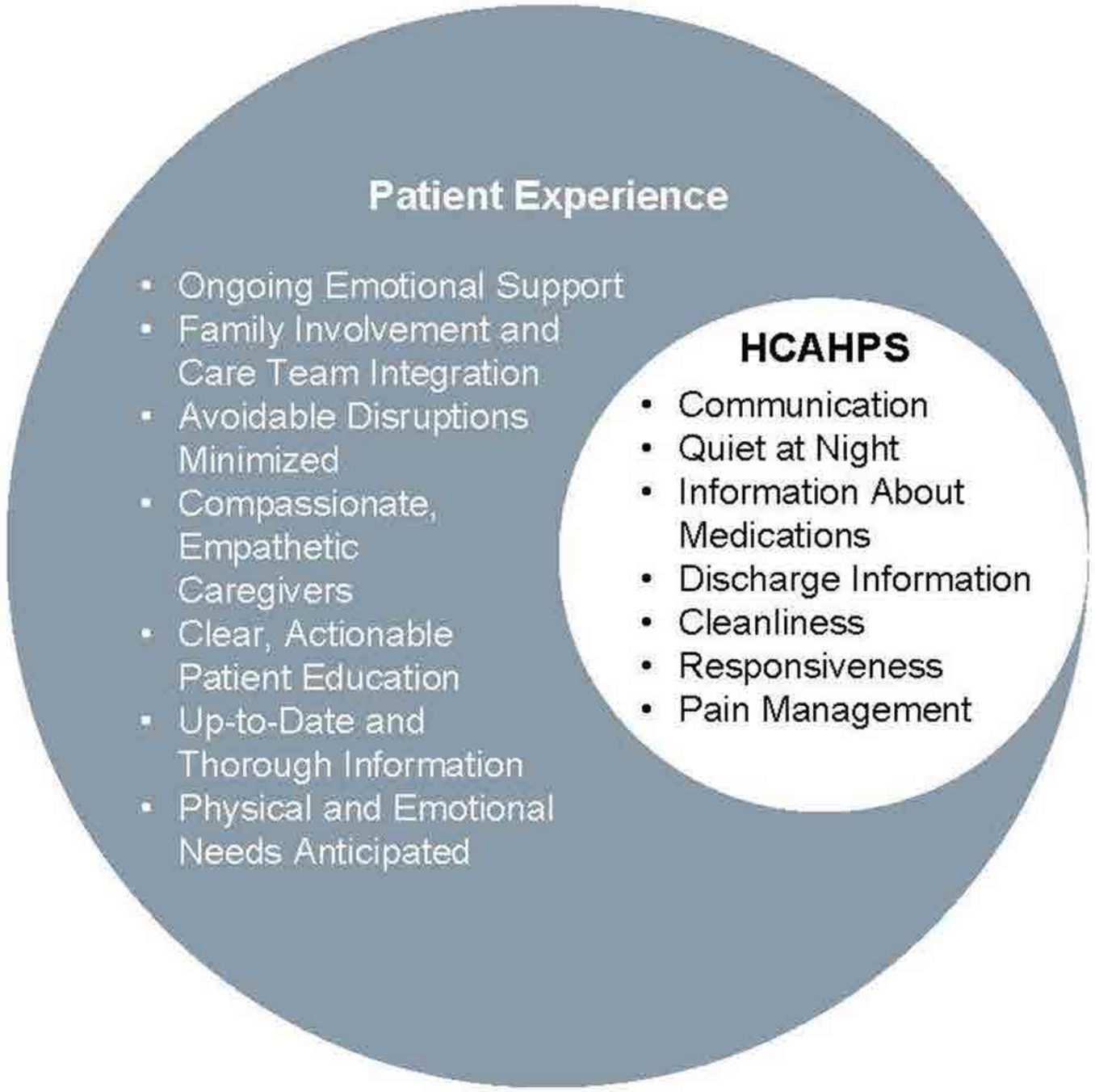
Your best healthcare experience begins at Island Hospital.

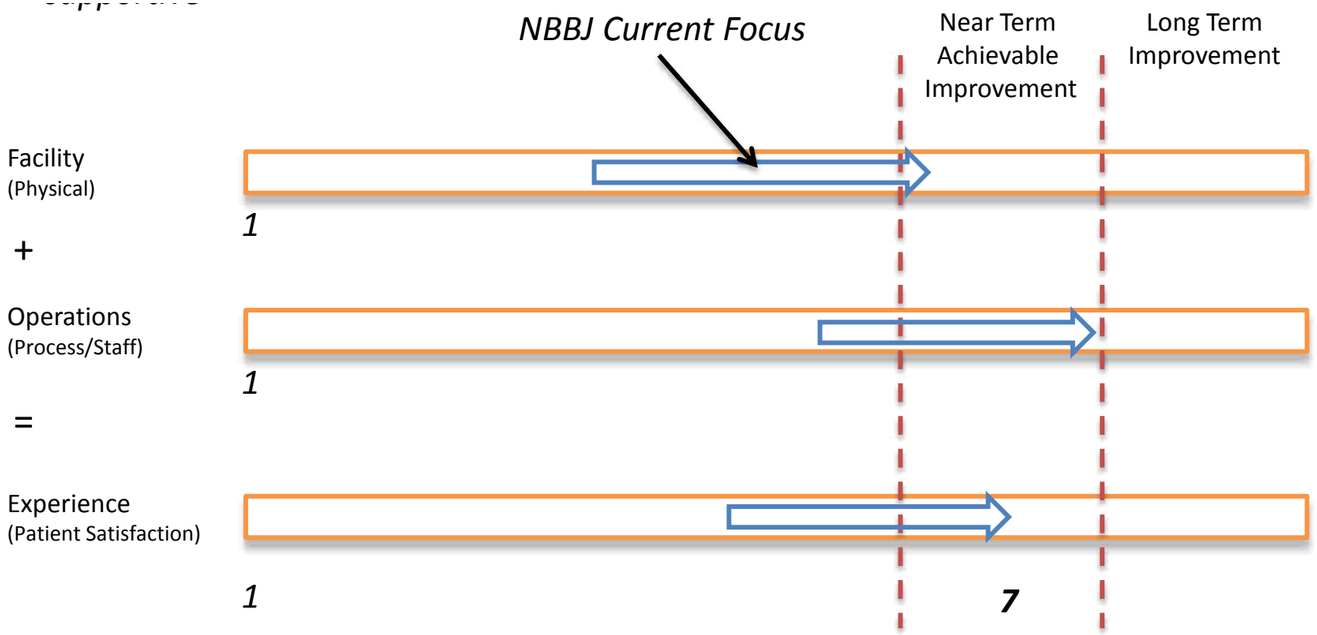
We always place your emotional and medical needs first and foremost.

How we deliver our Promise: Service Hospitality, Promise Behaviors

Creating exceptional healthcare experiences

What is Island Hospital competing on AND potentially being penalized for?





Creating a “Good” Patient Experience

A great experience can be achieved when the Facility and Operations are mutually supportive

How does Island see its experience currently – what’s at the root of experience issues?

Are operational and facility changes feasible? Near-term/long-term?

SURGERY

Highs

Natural light in patient bays and OR

Great connection to staff/proximity during recovery and prep

Multiple exits – more convenient to parking (have to ask where they park)

Volunteers manage communications / take phone number (inconsistent staffing)

Supply carts well organized

Lows

Prep area – no audible privacy for patients (completely open)

2 bathrooms - used for gowning/changing (bottleneck)

Many consults take place in public areas, no privacy

ICU transport rough – too many thresholds/carpet without electric beds

Family goes back out to the general waiting area during procedure – not private

Floor equipment causes congestion (booms are expensive)

One corner entry to Prep/Recovery - congested

Trash/equip/visuals in OR core/hallway not ideal

Little room for family in recovery area

SURGICAL EXPERIENCE

Multiple entries and wayfinding systems do not support an easy navigation

Dual registration / check – in desk and processes are redundant and confusing

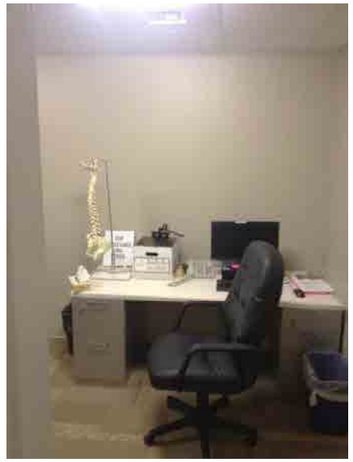
Wait space is open and lively (enjoyable for some, not for all)

Not all adjacent areas are fully utilized

Proximity to staff is great, audible privacy and space for family not prioritized as much as could be

Patient changing often creates bottlenecks in bathrooms

SURGICAL EXPERIENCE



Some consult spaces could be better utilized and oriented for patient/family communications

Patient confidentiality may be compromised with curtain walls

Wait space is open and lively (enjoyable for some, not for all)

Mix of patient and staff flows warrants a more tidy configuration of space and equipment if possible (ex. patients transported next to medical waste)

Support spaces are too small to support current surgeries, supplies can be found in the corridors

During a procedure family have few amenities or options regarding places to work, relax or congregate beyond the general waiting room

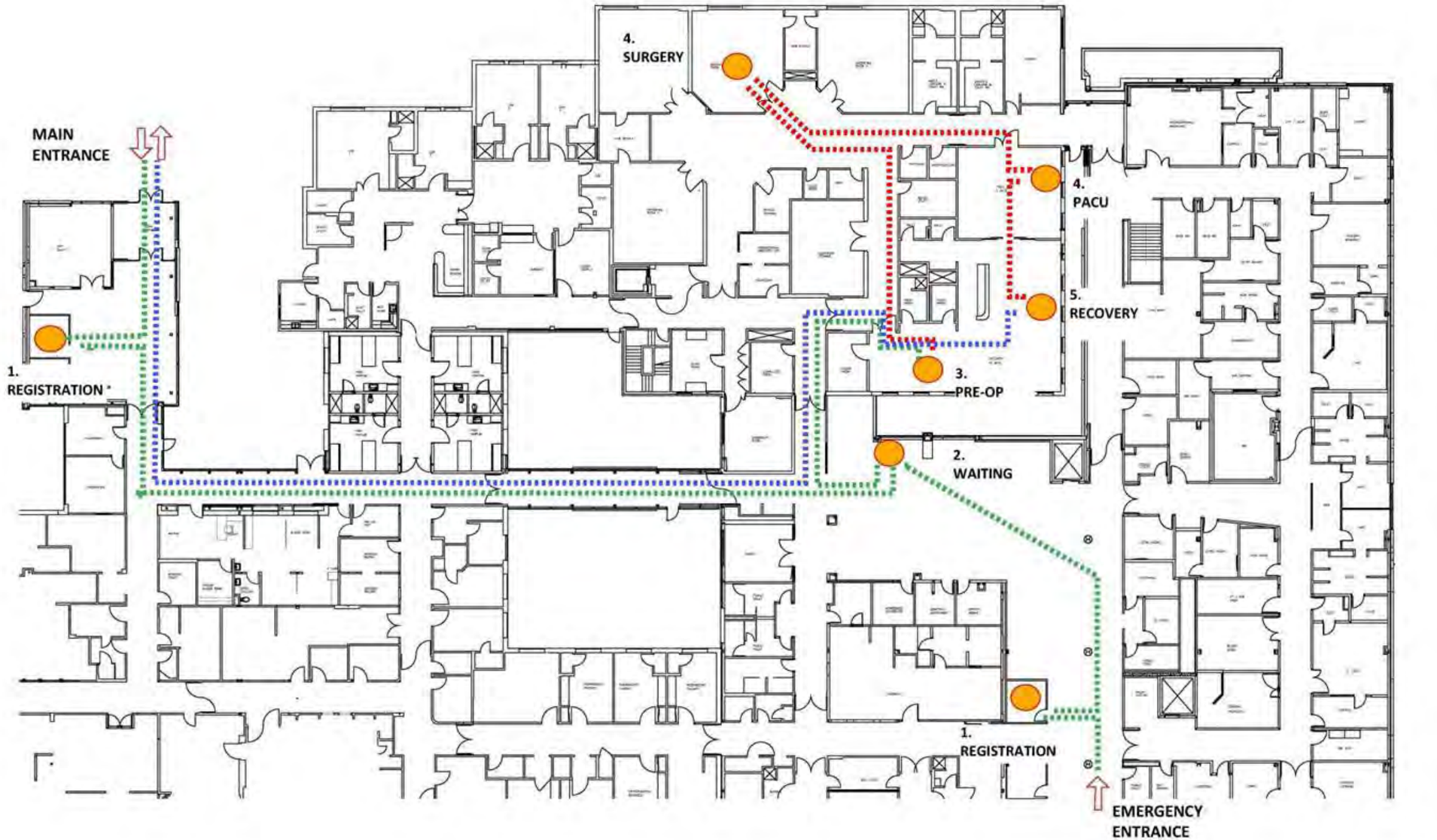
Communication and smart tracking boards may assist in communications

Designed discharge area underutilized despite proximity to parking/pickup space, patient preference is to use either the Main or ED entry – requires additional steps and communication in the discharge process

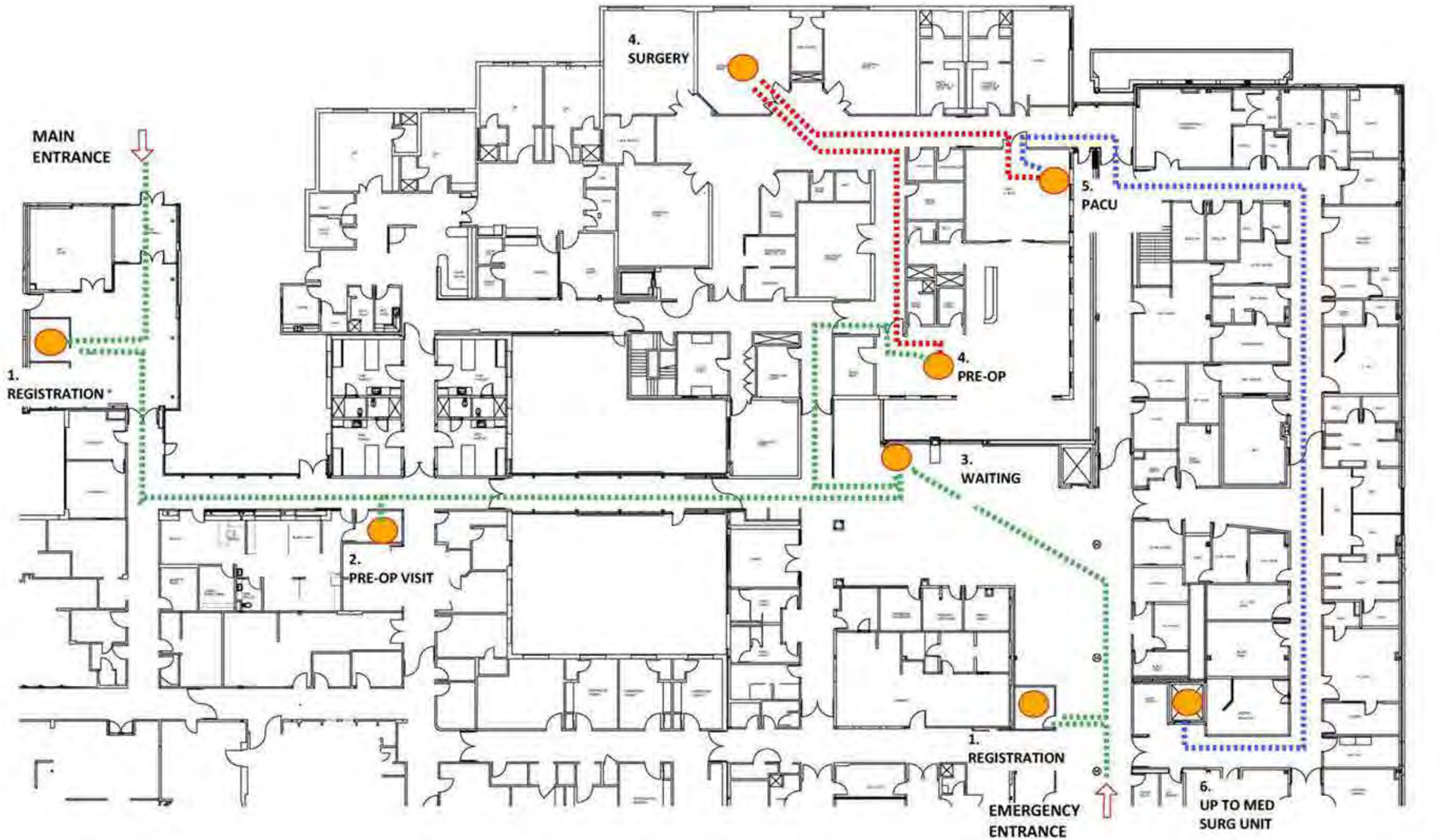
Patient transport was often difficult to ICU due to multiple thresholds and carpeting. Patients going to ICU are moved through one of the most open and public areas of the facility

SURGERY DIAGRAM

OUTPATIENT SURGERY FLOW



INPATIENT SURGERY FLOW



PROVIDER FLOW

EQUIPMENT & MATERIAL FLOW

Virginia Mason Medical Center
Lindeman Pavilion Outpatient Surgery Center

4 new operating rooms

5 pre-operative admitting spaces

11 post-operative recovery areas

Family waiting area

Private consultation room

Lean, highly efficient, and patient safe

LOCAL BEST PRACTICE

Virginia Mason Medical Center
Lindeman Pavilion Outpatient Surgery Center

Safer, better, more patient-centered

Patient stays on stretcher throughout the process

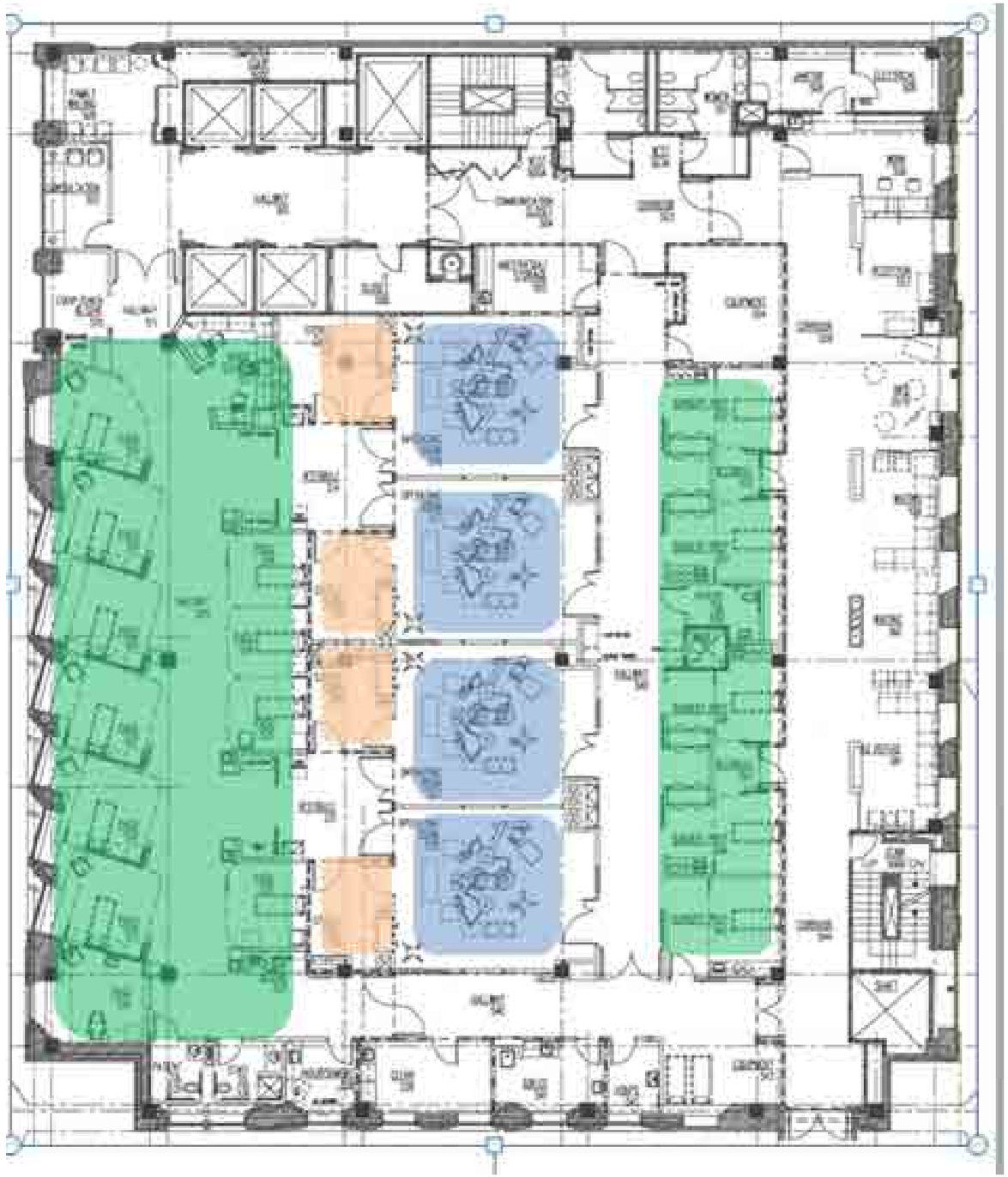
Vitals “brick” remains attached

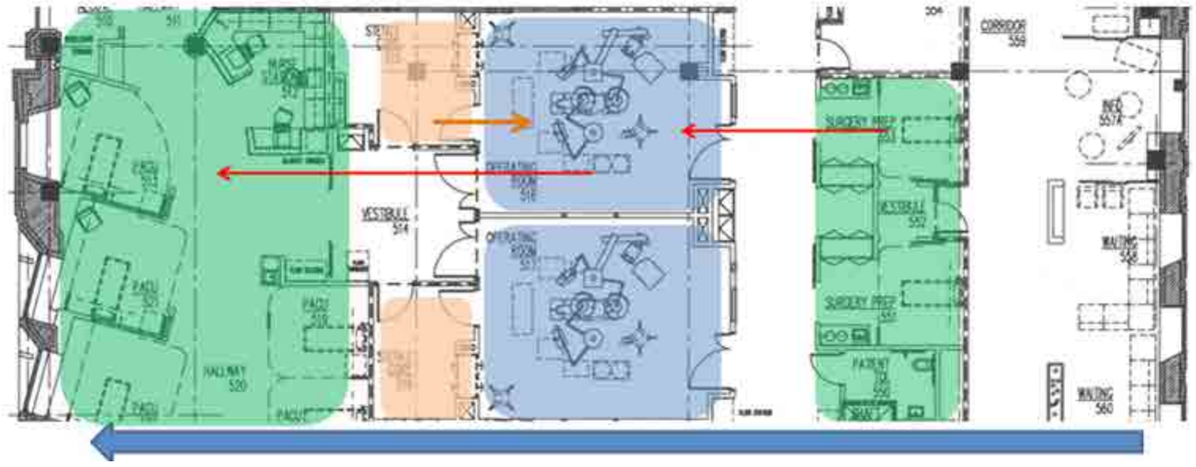
Faster room set-up

Sterile instrument set up in ante room

Better visual tracking

Use of visual cues to show continual progress and plan for surgeries





Family and friends are able to track the progress of patients during the operating process on two large-screen televisions, located in the waiting area.

Directly across from the operating rooms is the surgery pre-operative room. Patients remain on a single patient platform (mobile stretcher/table) throughout the operation process.

Reported Outcomes from Design

40% increase in cases per room
Case turnover time, less than 15 minutes
82% reduction in patient travel
40% less patient time in process (check-in to discharge)

Surgical specialties using the Lindeman Surgery Center include General Surgery, Hand, Otolaryngology (Ear, Nose and Throat), Orthopedics, Sports Medicine (including Podiatry) and Urology

The Surgery Center is equipped with 11 post-operative recovery rooms, designed to provide privacy and efficient post-operative care so that family and friends can spend as much time as possible with patients. The recovery rooms are located a short distance from the waiting area.

RECOMMEDATIONS

Private surgery waiting lounge for patients and family

Patient / family communications system – patient tracking (anonymous)
Ability for family to track patient progress

Designated supply/equipment storage (out of patient sight, accessible to staff)

Semi private surgery pre-op bays (three walls and a curtain) for consultation privacy

Semi private surgery post op (three walls and a curtain) for family to join patient in recovery.

Additional space for a family members to be with patients in pre/post op

BIRTHING

BIRTHING

Observations

Three sizes of Labor Delivery Rooms. One is too large (above), one is too small, and two are just right

Well designed staff nurse station facing LDR Rooms

Staff nurse station facing wall is inefficient


LDR
LABOR DELIVERY
RECOVERY
OPERATING ROOM
C SECTION
PACU
NURSERY
POST
PARTUM
FAMILY WAITING

PATIENT FLOW DIAGRAM

BIRTHING CENTER
PATIENT FLOW

PATIENTS CAN ENTER EITHER FROM THE MAIN ENTRANCE OR AFTER HOURS AT THE EMERGENCY ENTRANCE.

.

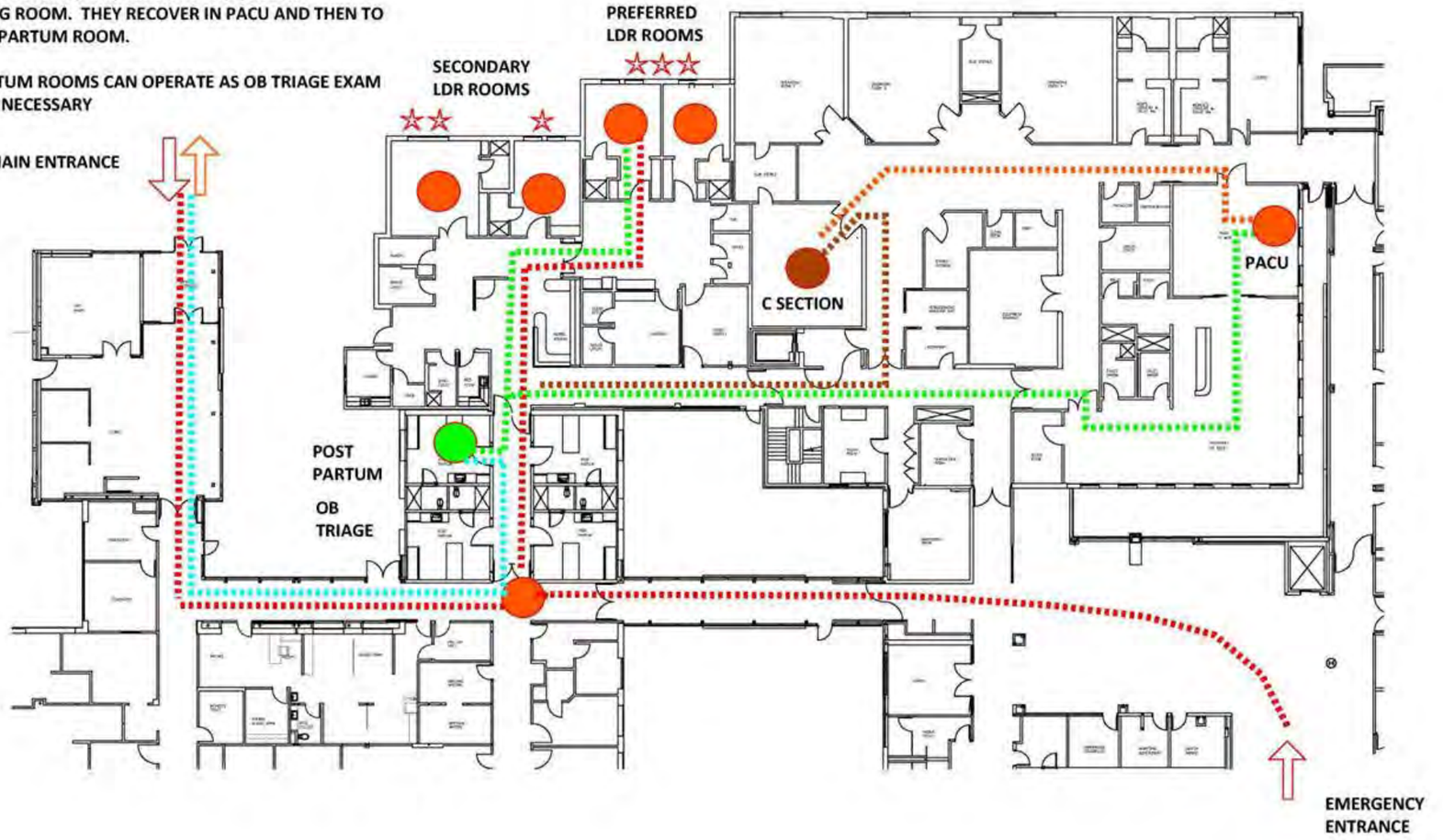
THERE ARE 4 LDR ROOMS. TWO ARE RIGHT-SIZED, ONE IS TOO LARGE, ONE IS TOO SMALL.

.

C-SECTION PATIENTS ARE TAKEN TO AN ADJACENT OPERATING ROOM. THEY RECOVER IN PACU AND THEN TO THE POST PARTUM ROOM.

.

POST PARTUM ROOMS CAN OPERATE AS OB TRIAGE EXAM ROOMS IF NECESSARY



BIRTHING CENTER
PROVIDER FLOW

THERE ARE 4 PROVIDER ZONES WITHIN THE BIRTHING CENTER. EACH ZONE HAS IT'S OWN NURSE STATION

- **PREFERRED LDR ROOMS**
- **SECONDARY LDR ROOMS**
- **POST PARTUM ROOMS**
- **NURSERY**

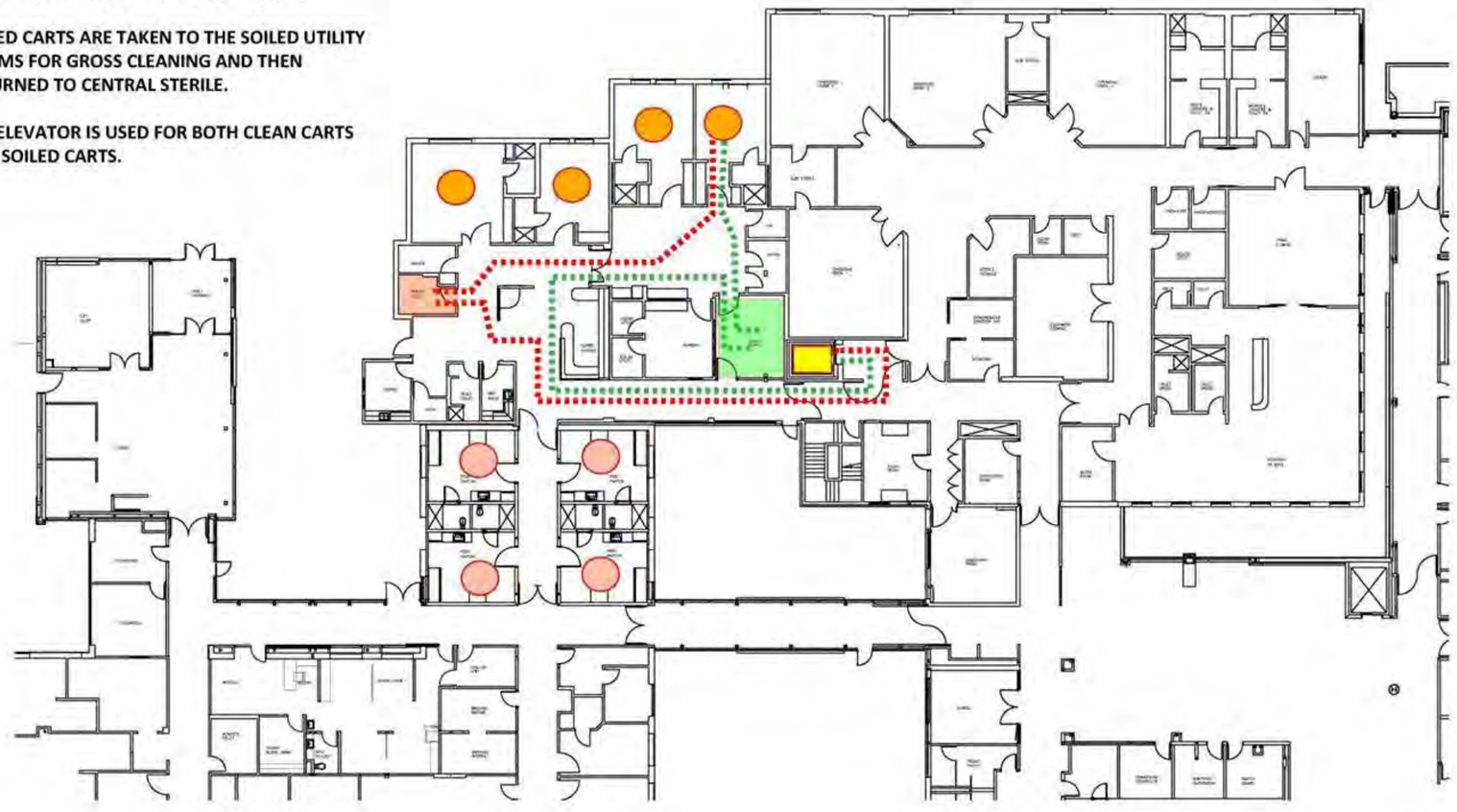
.

SUPPORT SPACES ARE DECENTRALIZED WITHIN THE ZONES CREATING EXTENDED TRAVEL DISTANCES

EQUIPMENT & MATERIAL FLOW

BIRTHING CENTER
EQUIPMENT & MATERIAL FLOW

CASE CARTS ARE BROUGHT UP FROM THE CENTRAL STERILE LOCATED IN THE BASEMENT.
THE CARTS ARE STORED IN THE CLEAN UTILITY ROOM UNTIL NEEDED IN THE LDR ROOMS
.
SOILED CARTS ARE TAKEN TO THE SOILED UTILITY ROOMS FOR GROSS CLEANING AND THEN RETURNED TO CENTRAL STERILE.
.
THE ELEVATOR IS USED FOR BOTH CLEAN CARTS AND SOILED CARTS.



RECOMMENDATIONS

Standardize size of birthing unit

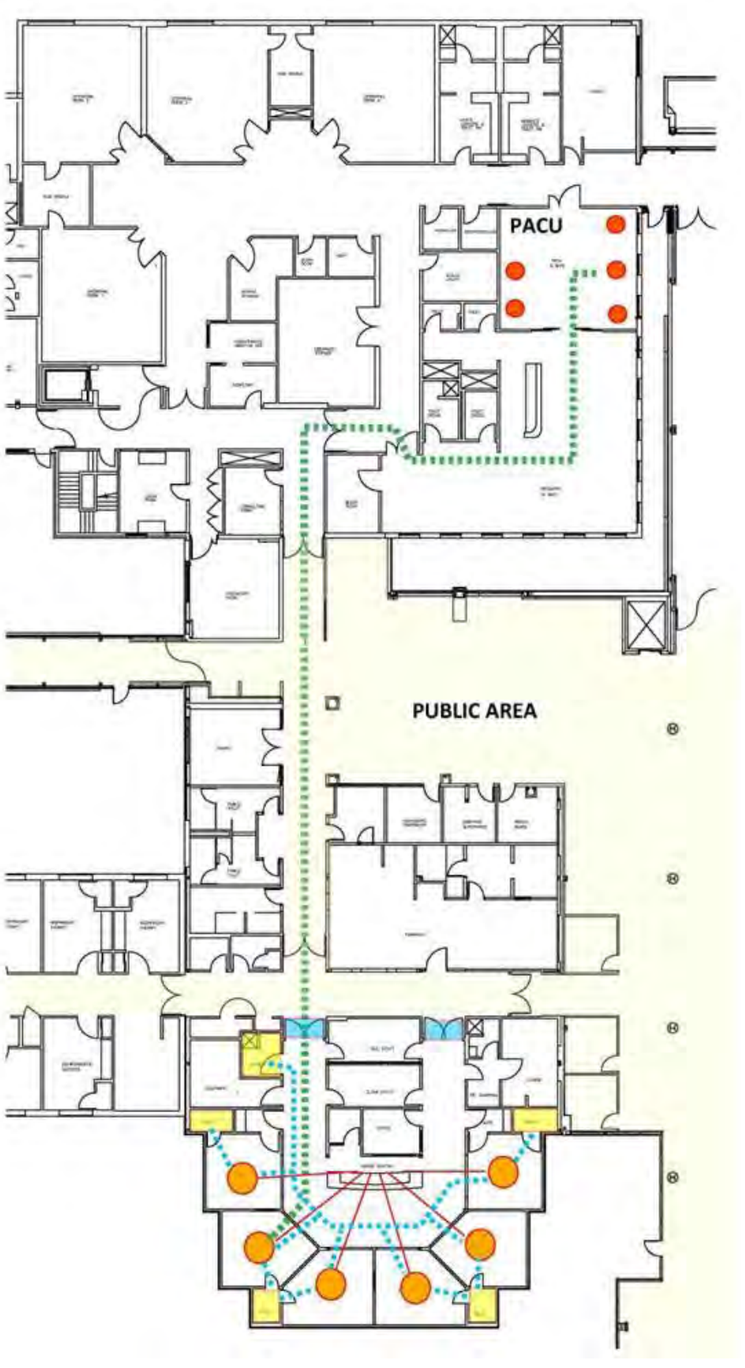
Standardize patient flow because in future, volume will require use of all spaces that are currently flex used

Remodel nurse station supporting rooms 7 & 8

Potentially relocate birthing center to allow surgical expansion, standardize and right size birthing center in new location

ICU / MED SURG

ICU / MED SURG



PRO

Excellent line of sight from nurse station to patient

Secure entrance into ICU suite

CON

Pathway from surgery to ICU is in a public area

Only 1 shower for 6 patients (not all patients in this suite are ICU patients)

4 of the 6 rooms share a common toilet room

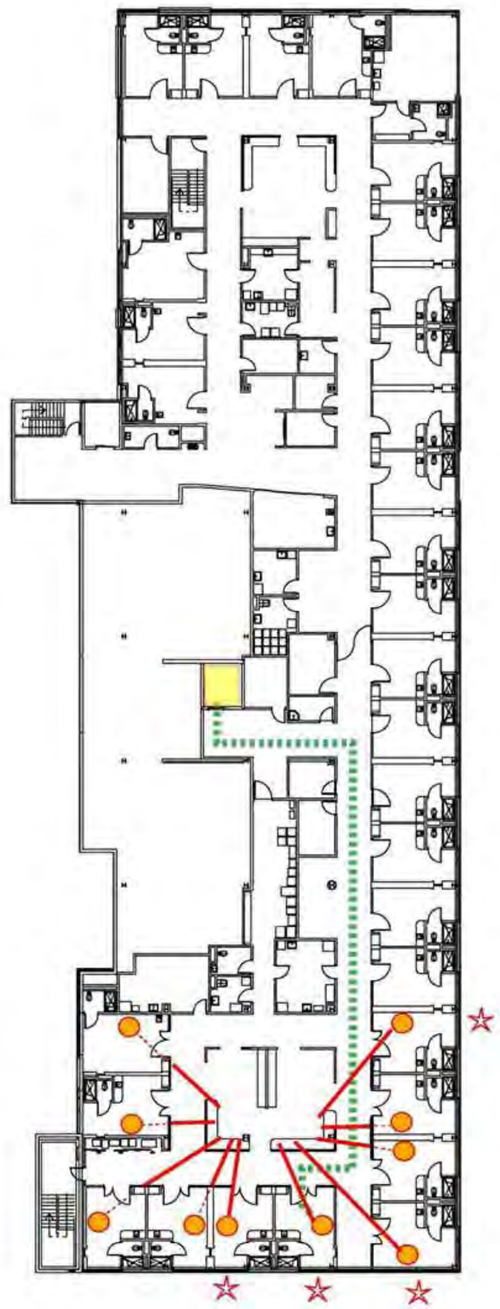
ICU / MED SURG

Ample space for circulation

Line of sight is excellent for all 6 ICU rooms

Space around the bed is compromised with medical head wall design

ICU / MED SURG



PRO

Level 2 rooms are acuity adaptable

More room around the head of the bed

Every patient room has a shower and a toilet

CON

Long distance from PACU to ICU

Line of sight from nurse station to ICU bed is good for only 4 out of 10 rooms

There is no security or sound separation from med surg unit

ICU / MED SURG

Large Nurse Station
Line of sight only good for 4 of 10 acuity adaptable beds

Family Zone

Modern patient lift for patient and staff safety in each
Of the acuity adaptable rooms

Plenty of room around the bed

ICU / MED SURG

ICU / Med Surg Beds

Pre-op tests / paperwork are done day of surgery – not the day before

10 bed admit / discharge area (pre/post)

5 bed pacu (built to 6, one bay taken by workstation)

Family is allowed in second stage recovery

Discharged at bedside – then transported via wheelchair to location of family / transport

Staff try to go to right exit by asking family, not always the case

Outpatient pick up spot is rarely used – all other “discharge” exits are equidistant from stage two, staff do not have preference

2nd Floor ICU travel was too cumbersome with equipment and such – back end route is still used for inpatient transport to floor

1st Floor ICU is more private – locked doors, 2nd Floor ICU is very open and loud

Carpet in main waiting area / hallways create problems for transport of patients in beds between ICU and Surgery – desire to replace carpet

Respiratory Therapy

11 Total staff covering the entire hospital from ER, Delivery, ICU, inpatient beds. Staff are cross trained

Single equipment storage room could be increased for more equipment

Department has a break space with charting computers

Provides outpatient Pulmonary Function Testing and EKG in the hospital.

Provides EKG services for Inpatient Pre-Admit Surgeries

New Accountable Care Act could increase the numbers of diagnostic testing for PFT

OUTPATIENT SERVICES

FIDALGO MEDICAL ASSOCIATES

Located in the Island Medical Center

14 Providers:

- 2 OB/GYN – Still seeing new patients
- 5 FPs
- 1 Internists
- 3 ARNP
- 2 Pediatricians
- 1 Part-time Neurologist

Current space limits productivity, especially when all providers are in clinic – 2 times a week

See peak ~225 patients per day given space constraints (Not provider capacity)

Anticipate that accountable care will increase the number of visits, as well reduce their acuity

Providers are using their offices less frequently

Switch to EMR system is seen as a way to gain back table top workspace

Census		2013 Annualized	Annual Growth Rate*	Visit Volume - FORECAST			Visits per Day - FORECAST			
Group / Unit	Visit Type			2015	2025	2035	2013	2015	2025	2035
RHC	FMA Visits	35,337	1.0%	36,408	40,217	44,424	141	146	161	178

ISLAND SURGEONS

3 General Surgeons, seeing patients 4 days per week.

1.5 Days in Clinic, 2.5 Days in Surgery

Salaried

OR Capacity Exists (shown in earlier analysis)

Potential to perform additional colonoscopy screenings

Recent improvement to patient experience: ex. clarity on patient billing, pre-op requirements and communication

Census		2013 Annualized	Annual Growth Rate*	Visit Volume - FORECAST			Visits per Day - FORECAST			
Group / Unit	Visit Type			2015	2025	2035	2013	2015	2025	2035
Clinic	Island Surgeons Visits	3,150	1.0%	3,245	3,585	3,960	42	43	48	53

SLEEP

Dedicated lab, new building in 2009 near the main campus with 4 sleep rooms

New pediatric program

Try to schedule 2 studies a night (depending on backlog may move to 4 studies a night if needed)

Staffing model efficient at 2 or 4 studies per night (1 or 3 is not ideal)

As volume grows day-time consultation in clinic space may become a bottleneck

Census		2013 Annualized	Annual Growth Rate*	Visit Volume - FORECAST		
Group / Unit	Visit Type			2015	2025	2035
Sleep Lab	Total Studies	582	1.0%	600	662	732

Visits per Day - FORECAST			
2013	2015	2025	2035
2	2	3	3

PT / OT

PT / OT Volume is primarily from Physical Therapy visits

Located in basement of the new Medical Arts Pavilion

- Treatment space is limited
- Current ability to meet demand is capped by staffing

Recently added a new OT provider and decreased the size of PT to accommodate OT growth

Inpatient Physical Therapy is located in the hospital on the bed floors and is approximately 10% of all PT volume

- When necessary OP PT staff can flex to meet IP demand

2013 Annualized Visits	
Total Inpatients (OT & PT)	1,779
Total Outpatients (OT & PT)	13,989
New Outpatients	1,302

CARDIOPULMONARY REHAB

Recently relocated to a new space within the Medical Office Building

Currently operates Monday, Wednesday, Friday

Should they grow, demand can be met by operating on Tuesday and Thursday

2013 Annualized Visits	
Total Visits	4,200

SPEECH THERAPY

Speech Therapy recently relocated to the old library of the Medical Office Building

Speech Therapy is primarily educational, not clinical

2013 Annualized Visits	
Total Inpatients	228
Total Outpatients	2,073

DIABETES

Staffed by a single provider 3 days per week.

Located in a single office in the basement of the Medical Office Building.

New educational program with a goal of seeing 5 patients per day.

2013 Annualized Visits	
Visits	600

PT / OT

New space in the basement of the Medical Office Building opened up May 8, 2013

2 Therapists booked through June

2 Psychiatrists booked through September

This program is the only hospital based behavioral health program in Skagit Valley

Likely adding a new Psychiatrist in September

Need a Group Therapy Room (used for Group Therapy, Family, Addiction Program)

New space already remodeling to accommodate growth.

Census		2013 Annualized	Annual Growth Rate*	Visit Volume - FORECAST			Visits per Day - FORECAST			
Group / Unit	Visit Type			2015	2025	2035	2013	2015	2025	2035
Clinic	Psychiatry Visits	2,553	1.0%	2,630	2,906	3,210	10	11	12	13
Clinic	Therapist Visits	1,980	1.0%	2,040	2,253	2,489	8	8	9	10