

THE  
CAMDEN  
GROUP

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# Healthcare Options – Discussion Draft

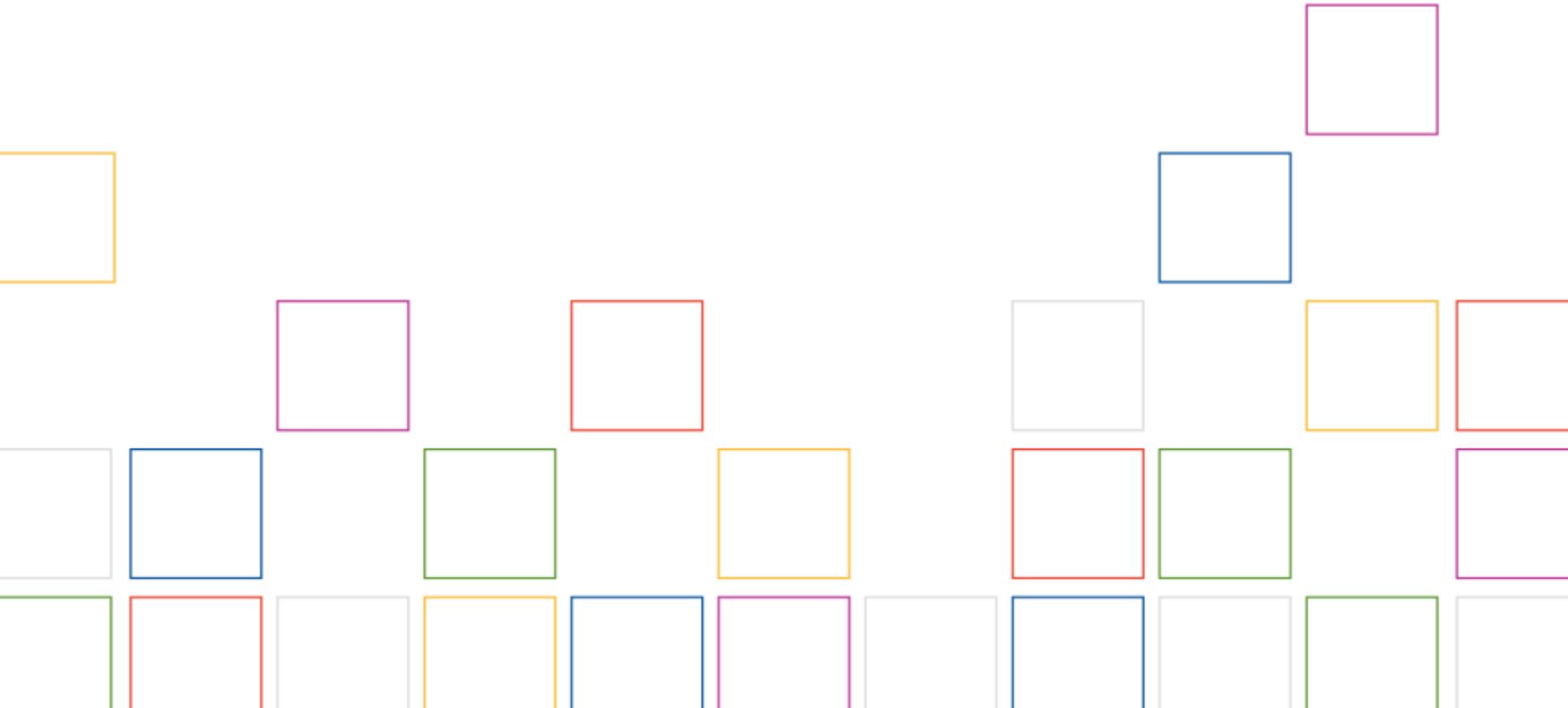
Coast Life Support District  
Gualala, California  
December 17, 2013



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# Engagement Schedule

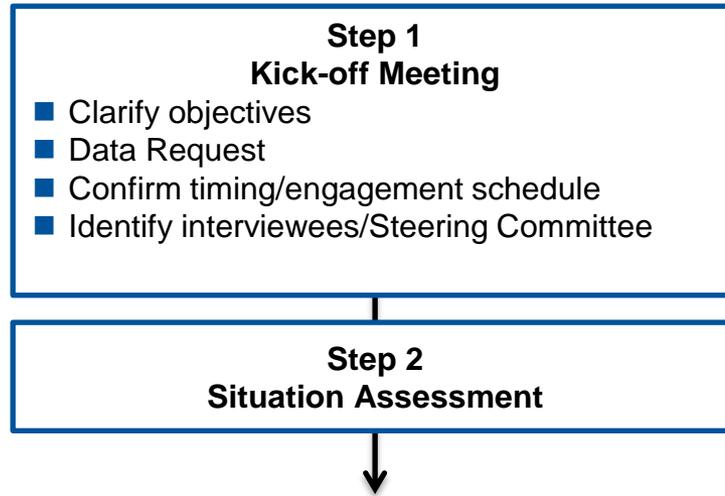


# Engagement Schedule

## Timeframe



Weeks 2-4  
(After Data is Received)



## Meetings/Site Visits

On-site Meeting  
September 10, 2013

# Engagement Schedule

Timeframe

Meetings/  
Site Visits



## Step 2a Review of Current Capabilities/Services

- Ambulance/Emergency medical services data
- Urgent care data including clinic size, visits, financials
- After-hours urgent care clinic data (pre-closure)
- FQHC community needs assessment

## Step 2b Market Analysis

- Market size and services
  - ▶ Service area inpatient data by service line, by payer, and where patients are going for care. (data through Office of Statewide Health and Planning Development ["OSHPD"])
  - ▶ Service area outpatient data by service, by payer, and where patients are going for care. (data through Truven Health Analytics)
- Profile of healthcare districts (similar in size, demographics - age, income, and geographic characteristics to CLSD) in California that do and do not operate hospitals
  - ▶ Identify services offered to meet the healthcare needs of the community (Data through publically available information, phone calls)
  - ▶ Identify how they are able to attract/retain medical professionals
- Need for skilled nursing and/or assisted living services

## Step 2c Physician Needs Assessment

- Current inventory of physicians by specialty
- Physician-to-population ratios to determine service area community need by physician specialty

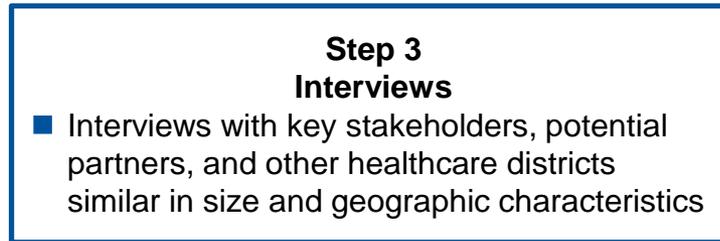
Weeks 2-4  
(After Data is  
Received)



# Engagement Schedule

Timeframe

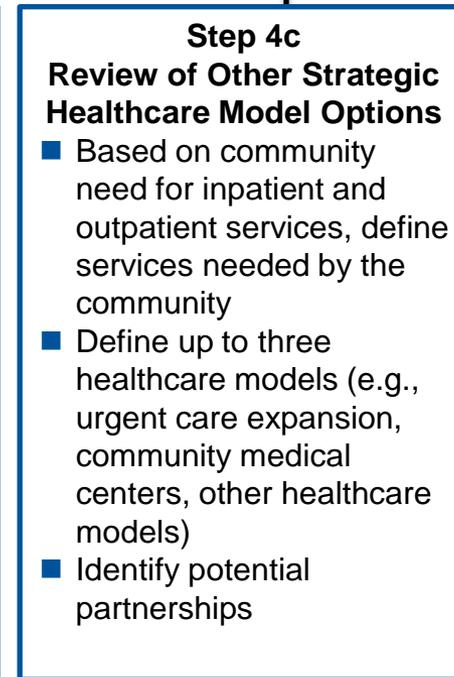
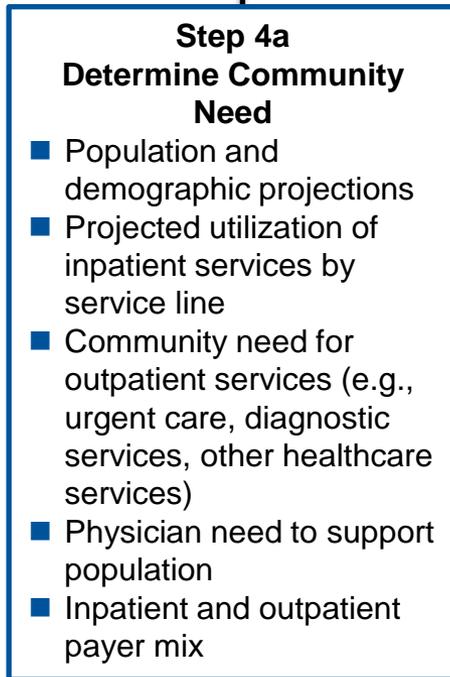
Meetings/Site Visits



On-site October 29, 2013  
and October 30, 2013



Weeks 6-7



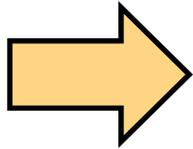
Conference  
Call



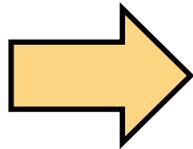
# Engagement Schedule

## Timeframe

## Meetings/Site Visits



Week 8



Weeks 9-10

**Step 5**  
**Present Draft**

- Utilization projections and governance models of three profiled healthcare models
- Refine as necessary

On-site Meeting  
December 17, 2013

**Step 6**  
**Develop Financial Projections**

- Develop financial projections for the three healthcare models defined in Step 5, taking into account:
  - ▶ Reimbursement projections
  - ▶ Staffing and facility costs
  - ▶ Physician availability
  - ▶ Other expenses
  - ▶ Implication of Affordable Care Act and relevant California regulations
- Anticipated tax burden to support operational losses
- Develop benchmarks from The Camden Group databases and compare expected performance to similarly sized community medical centers, urgent care facilities, and other services to be offered to the community

Conference Call



# Engagement Schedule

Timeframe

Weeks 11-12

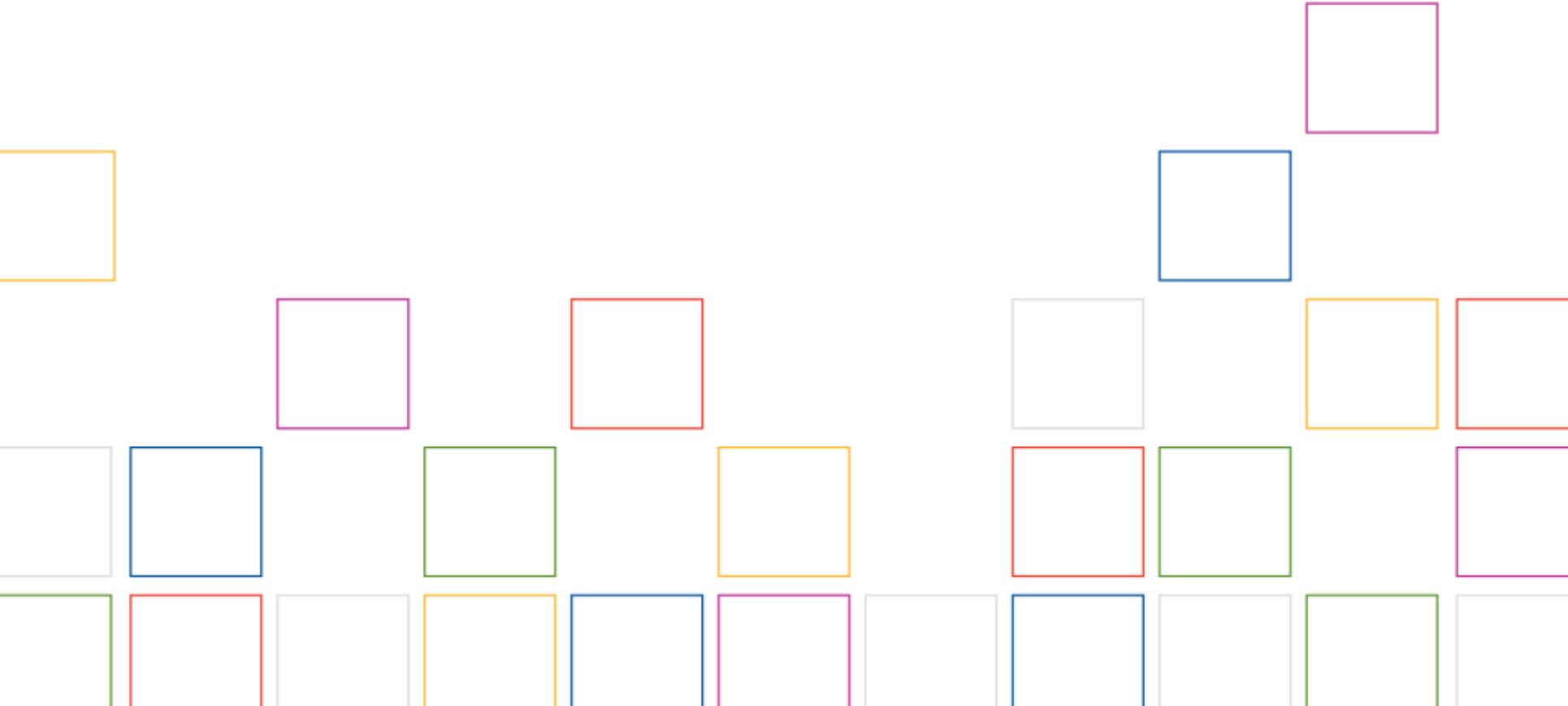
**Step 7**  
**Develop and Refine Final Business Plan for Sustainable Healthcare Model**

- Review draft financials
- Review draft business plan
- Present summary of business plan and discuss findings and recommendations with the Board
- Finalize business plan

Meetings/Site Visits

Board Meeting  
(On-site)

# Executive Summary



## Executive Summary

- The Camden Group was hired by Coast Life Support District (“CLSD” or the “Coast Life”) to identify a financially sustainable healthcare model that will serve as a road-map for local delivery of medical services in conjunction with the Redwood Coast Medical Service (“RCMS”) to the residents of the coastal communities located in southern Mendocino and northern Sonoma counties.
- On October 29 and 30, 2013, The Camden Group met with the Engagement Task Force, which includes members from CLSD, RCMS, and the community, to review the service area’s Situation Assessment, and to identify options for a financially sustainable healthcare model.

## Executive Summary

- The Situation Assessment included a review of current services and capabilities, market analysis, physician needs, and comparison of similar markets. The following conclusions were drawn from the Situation Assessment report:
  - ▶ CLSD and RCMS have been innovative and resourceful in their ability to increase access of healthcare services to the population.
  - ▶ Access to urgent/emergency care continues to be a critical issue due to distance, weather, and road conditions.
  - ▶ The population of CLSD is small (~6,200 people) which affects the level of healthcare services that can be provided in the community without outside funding or support.

# Executive Summary

- ▶ Portions of CLSD's service area are designated either as a Health Professional Shortage Area ("HPSA") or a Medically Underserved Area ("MUA") indicating a state and federally recognized shortage of primary care resources. Benefits of practicing in shortage-designated areas can include: physician recruitment assistance, and physician financial incentive programs/payments.
- ▶ There were approximately 374 inpatient discharges from CLSD's service area in calendar year ("CY") 2011 generating an average census of 4.7 patients per-day in a hospital bed, assuming 100 percent market retention of volume (no outmigration).
- ▶ Expansion of after-hours urgent care is a viable extension of current services given it leverages existing infrastructure and capabilities if a sustained funding source can be secured.

# Executive Summary

- ▶ Given the service area's population size, there is the potential for some increase in specialty rotation on a part-time basis (e.g., one to three days per week) and/or coverage through telehealth:
  - General surgery
  - Hematology and oncology
  - OB/GYN
  - Otolaryngology
  - Pediatrics
  - Psychiatry
  - Urology

# Executive Summary

- ▶ Partnership with other care providers to increase access through telehealth is a potential solution if grant/funding sources can be identified.
- ▶ Other innovative programs are being piloted in California or elsewhere that may eventually provide increased access for rural providers, although they are not currently allowed under California regulation.
- Additionally, The Camden Group completed a review of the scope of services provided by California healthcare districts and counties with comparable populations and geographic characteristics to CLSD's service area. Data collected from the comparison was used to identify solutions and key characteristics that lead to successful healthcare models in other markets.

# Executive Summary

- At the conclusion of the October 29 and 30, 2013 meetings, the following options were identified to explore further:
  - ▶ Option 1: Expand urgent care hours (a preliminary financial analysis for this option was completed prior to the October 29, 2013 meeting)
  - ▶ Option 2: Build a community medical center (less than 25 beds) with a 24/7 emergency room
  - ▶ Option 3: Develop a new ambulatory care center (“ACC”) to house expanded outpatient services
- The Camden Group recommends Option 1, the expansion of the urgent care hours, as the near-term strategy. Expansion of urgent care was consistently stated as the highest need by community members. RCMS’ existing infrastructure is the most financially viable, cost-effective, consistent model to expand healthcare services to the community.

## Executive Summary

- For longer-term solution, The Camden Group recommends CLSD pursue Option 3, develop a new ACC to house expanded outpatient services. The ACC could include space to house technology that will expand access to services through telehealth and remote monitoring. More planning should be conducted to see if the building could be constructed for a cost more in line with medical buildings built throughout California and the reasonableness of rental rates.
- CLSD and RCMS should continued to explore grants to fund innovations in telehealth that will expand access to healthcare locally.

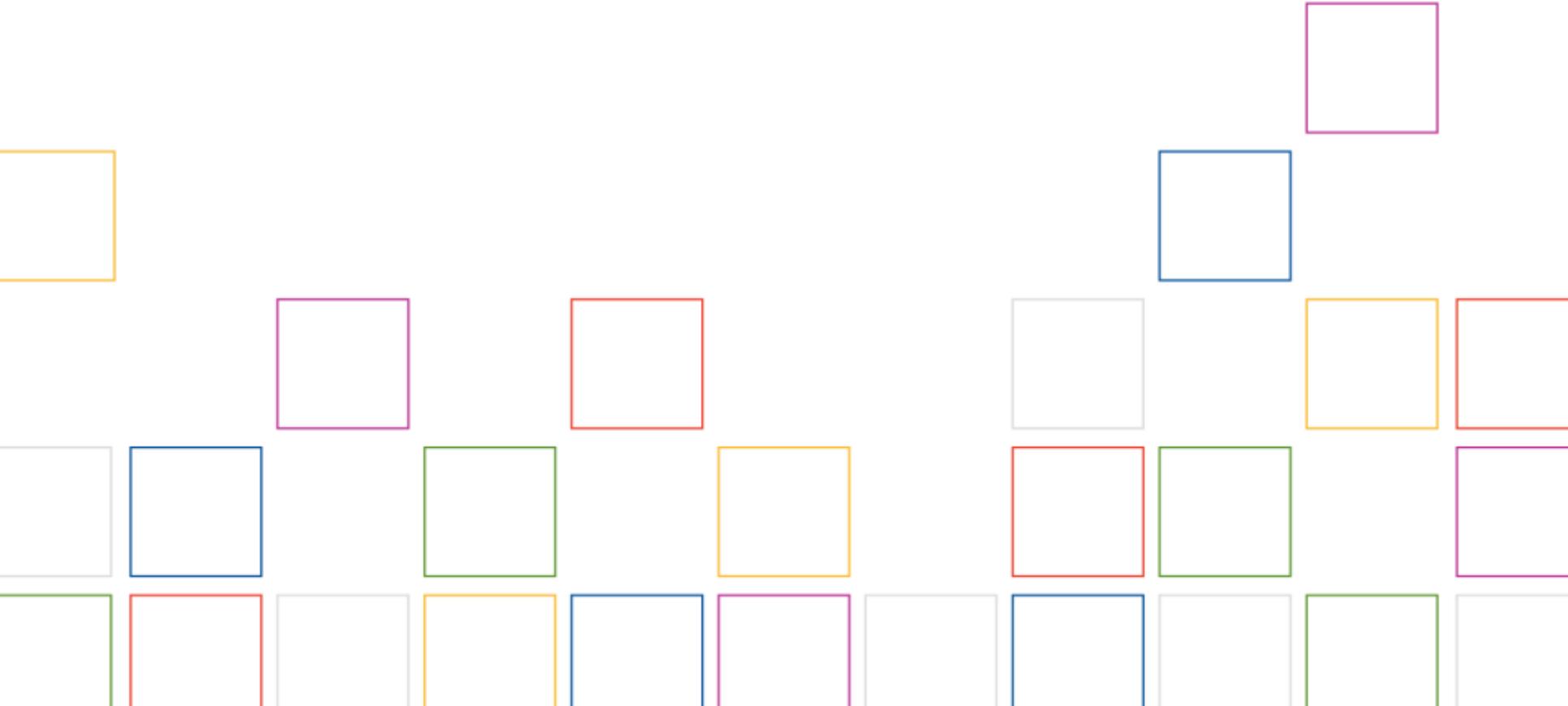
# Executive Summary

- As part of this analysis, The Camden Group considered a series of other potential options, but determined they were not optimal solutions for a financially sustainable healthcare model for the community:
  - ▶ Community Medical Center (Option 2 listed on page 14)
    - The Camden Group recommends CLSD not pursue this option due to an amalgamation of high start-up costs to build the facility, low patient occupancy levels, poor payer mix, anticipated challenges recruiting and retaining clinical providers, and required on-going needed financial support.
  - ▶ Development of Community Paramedicine (“CP”) program
    - Not currently allowed in California, although use of paramedics was modeled into the after-hours urgent care expansion as a staffing option
  - ▶ Free-standing Emergency Department (“ED”)
    - Not currently allowed in California

# Executive Summary

- ▶ Hospital at Home (“HAH”)
  - Distance from acute care hospital, considerable start-up costs and staff requirements
- ▶ Development of a district clinic
  - Duplication of resources and less financially viable model
- ▶ Development of a hospital clinic
  - Outside of distance requirements
- ▶ Addition of other full-time specialists and related services (e.g., surgery, advanced imaging/diagnostics)
  - Not supported by population

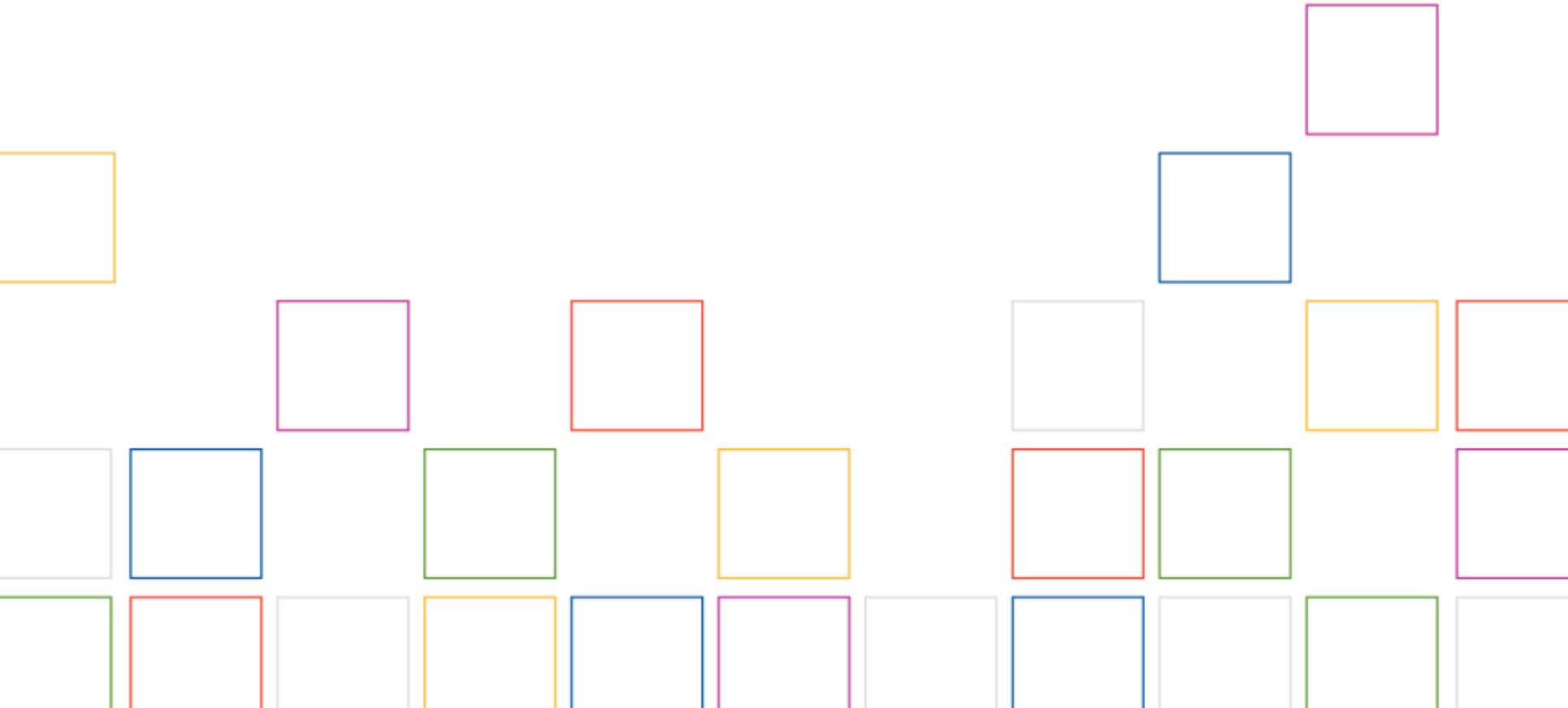
# Engagement Objectives



# Engagement Objectives

- The objectives of the Coast Life business plan are as follows:
  - ▶ Create a financially sustainable healthcare model that will serve as a road-map for local delivery of medical services in conjunction with RCMS to the residents of the coastal communities located in southern Mendocino and northern Sonoma counties.
  - ▶ Evaluate the community benefit of reinstating some level of after-hours urgent care.
  - ▶ Develop a long-term fiscally responsible plan to expand other local medical services and facilities; in order to reduce time wasting, stressful transportation, and road trips, and enable more community members to age-in-place.
  - ▶ Enable a course for the future to anticipate advances in medical services and delivery.

# California Healthcare Trends



## California Healthcare Trends

- **Continued downward pressure on revenue rates: healthcare operating expenses will outpace payment increases.** There will be continued pressure to minimize rate increases from payers, especially governmental payers. Cost per unit will rise unless an organization increases throughput, clinically integrates, and reduces resource consumption. Strategy must focus on attracting/capturing a larger population. This means increasing market share in an environment of no per capita growth in volume. Cost reduction must be at the forefront to assure that these new volumes are profitable.

## California Healthcare Trends

- **Continual movement away from pay-for-procedure payments to pay-for-performance (value) payments:** economic incentives and new payment models (e.g., value-based purchasing, shared savings) are being put into place to reward improved quality, reduced costs, and top patient service satisfaction. There will be greater transparency of quality scores of hospitals and physicians (e.g., HCAHPS surveys). Penalties to occur if quality standards are not met. Consistent high quality is difficult to achieve for low volume services/providers.
- **New care models are here, and still evolving.** The new models will either target managing a population or treating episodes of care (resource consumption per case). Expect greater use of information technology (“IT”), including telemedicine, wireless devices, and population and utilization analytics. New models include those mentioned above, as well as global payments and mini PCMHs targeted to specific major chronic diseases.

## California Healthcare Trends

- **Just as efforts to reduce readmissions and length-of-stay are achieving the desired results for purposes of succeeding in new payment models, there will be a need to replace this “unwanted” volume with “new” volume.** There will be an all-out effort to consolidate markets (hospital-to-hospital, medical group to medical group, medical groups/physicians to hospitals, and health plan to health plan) as hospitals seek to gain scale, reduce costs, and capture a greater portion of the healthcare continuum. Health systems will focus on geographic markets where they can concentrate resources and better utilize assets. Medical groups and IPAs will consolidate as well, given that many physician organizations will not have the capital to invest in the necessary infrastructure (e.g., IT, care models, protocols, human resources to manage the “new” delivery system).

## California Healthcare Trends

- **Keep an eye on the government.** With state budgets still reeling from the recession and a disappointingly slow economic recovery, state governments will need to find solutions to their problems, which include Medi-Cal expansion, Covered California, state employee costs (health and retirement), and infrastructure costs to manage all of the changes underway. This will put continued economic pressure on the programs funded by the state.
- **Covered California** will continue to play a pivotal role in the State's changing healthcare landscape, but the impact on healthcare utilization (ED use increase), physician shortages (increase), and insurance premiums (go up for the same benefits) is still to be determined.

## California Healthcare Trends

- **IT will continue to consume a greater portion of a health system's budget.** Health systems must invest in IT in order to be ready for healthcare reform's new delivery models and payment systems. The necessary investment includes those that should be completed now such as picture archiving and communications system ("PACS"), results reporting, electronic medical records ("EMR") for the inpatient and outpatient setting, and computerized physician order entry ("CPOE"). In 2013 and 2014, the focus has and will continue to be on data warehousing and health information exchanges in which to participate or interface, and finally moving to population analytics and web portals for patients and physicians.

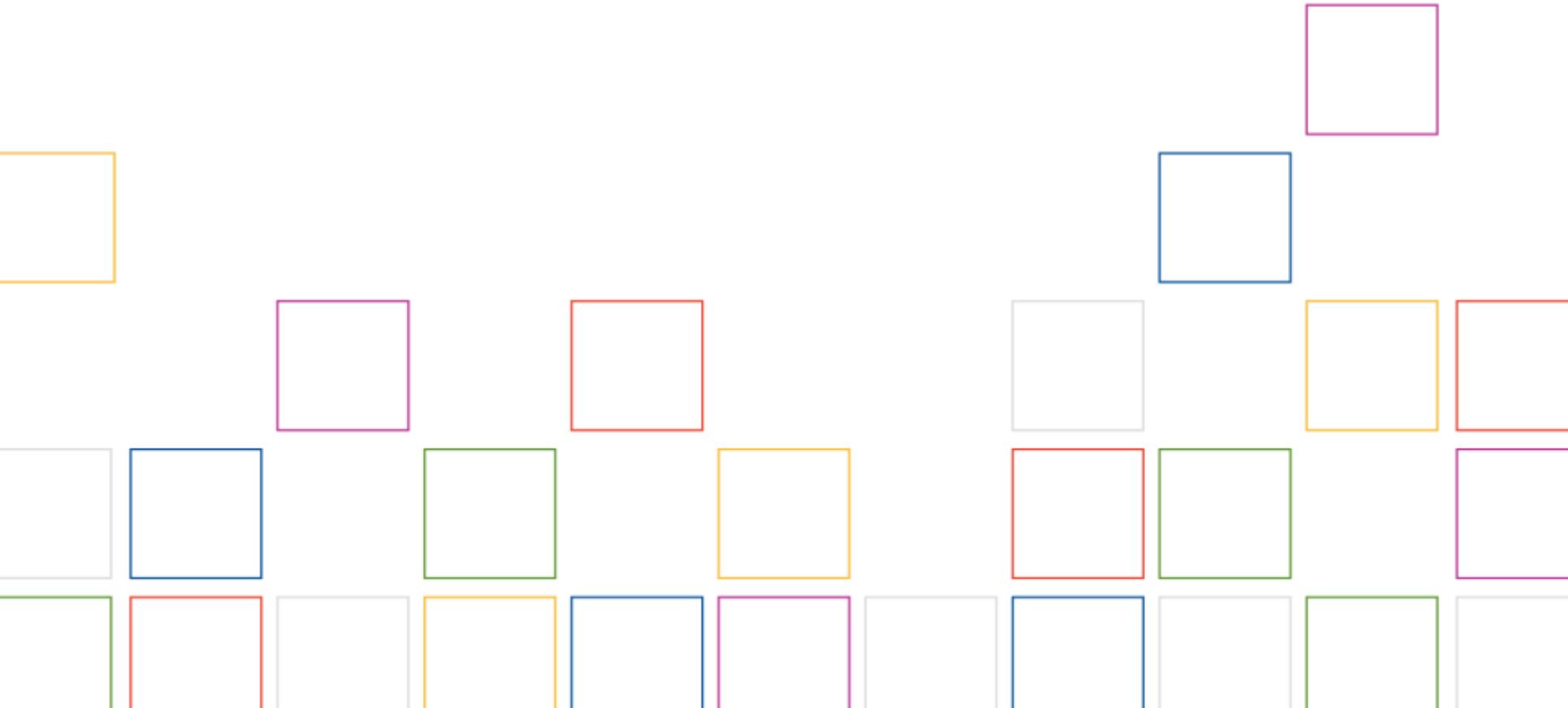
## California Healthcare Trends

- **Continued physician economic alignment.** Hospitals and physicians will pursue a variety of models: patient-centered medical homes (“PCMHs”), bundled payments, ACOs, clinical integration, co-management, and joint ventures. A significant focus of health system resources will be setting economic incentives that reward improved quality, reduced costs, and top patient service satisfaction.
- **Continued development of the continuum of care:** As Medicare and other major payers continue to modify payment methodologies that penalize preventable readmissions, use case rates and focus on population health, providers will focus on outpatient and lower levels of care, decreasing inpatient and emergency use.

## California Healthcare Trends

- **Academic medical centers (“AMCs”)** are aggressively expanding their networks and marketing their “brand” to steer more volume into their System and retain patients. AMCs are continuing to buy up primary care physician practices, expand their urgent care presence, and acquire small community hospitals as a strategy to stay operational and profitable as a tertiary/quaternary care center in the new era of population health.
- **Physician shortages are looming.** The already anticipated physician shortages are likely to be exacerbated as additional Californians gain insurance coverage in January 2014 due to Covered California and Medi-Cal eligibility coverage expansion.

# Discussion of Healthcare Models



# Discussion of Healthcare Models

## Option 1: Expand Urgent Care Hours

- The Camden Group completed the expanded urgent care financial analysis and issued the assessment, findings, and conclusions as a separate document dated November 6, 2013.
- In the urgent care analysis document, The Camden Group assessed the reasonableness of projected costs associated with plans to expand operating hours at the RCMS urgent care clinic.
- The analysis compared RCMS' operating expenses to industry benchmarks and data from similar organizations and found that the projected incremental expenses associated with the expanded hours were reasonable in the 10/7 option, and more costly in the other options than the RCMS prepared projection. We recommended a contingency be added.

# Discussion of Healthcare Models

## Option 1: Expand Urgent Care Hours (Cont'd)

- The Camden Group compared RCMS' model to other organizational models and determined that utilizing RCMS' current structure as the provider of service is the most cost-effective and best reimbursement model given the community's payer mix.
- Recommendation: Expansion of urgent care was consistently stated as the highest need by community members. RCMS' existing infrastructure is the most financially viable, cost-effective, consistent model to expand healthcare services to the community.
  - ▶ The Camden Group recommends CLSD and RCSM continue to work together to expand urgent care services to the community.

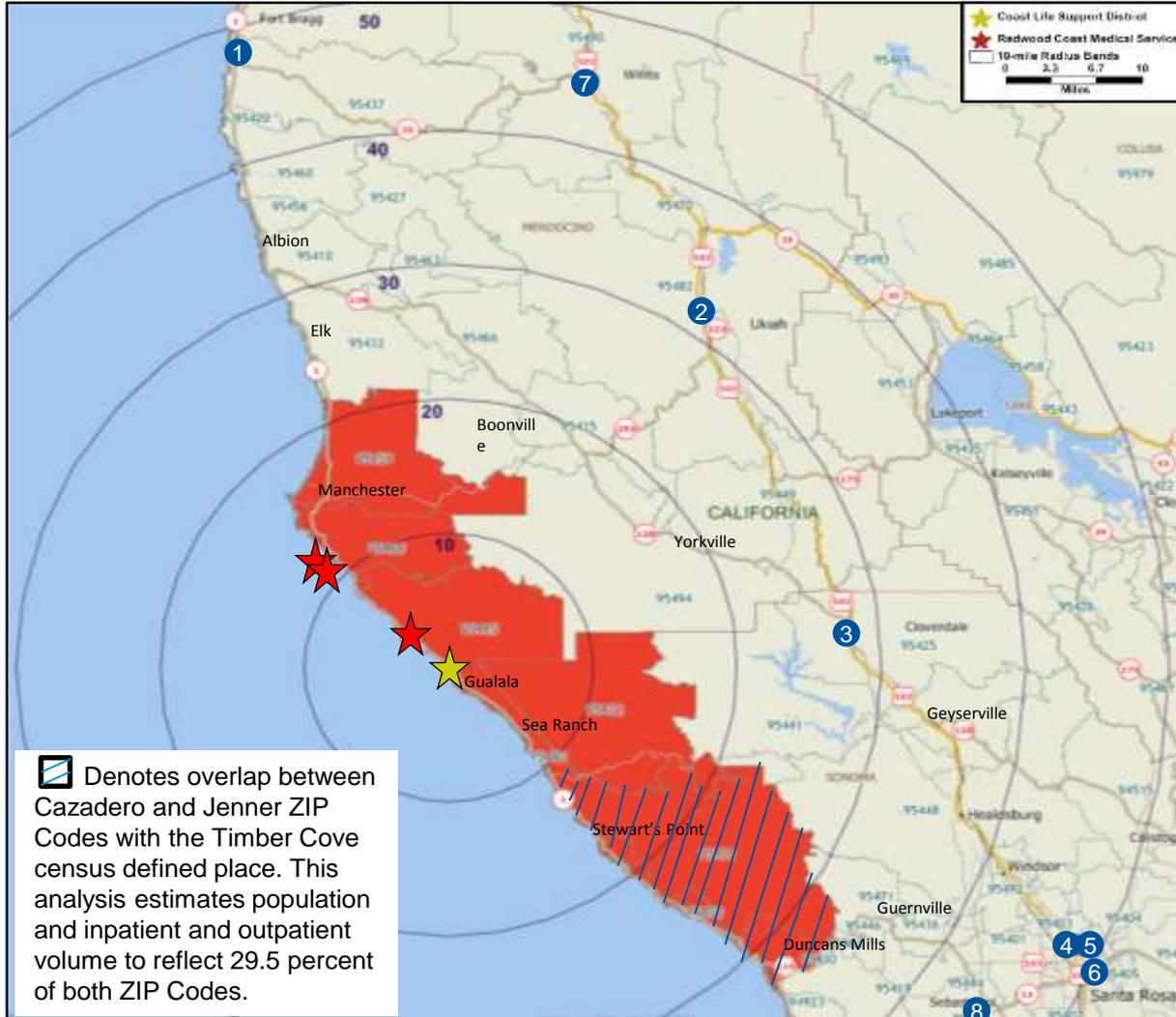
# Discussion of Healthcare Models

## Option 2: Build a Community Medical Center

- The Camden Group completed utilization and financial projections associated with building a community medical center (less than 25 beds: qualifies for critical access designation) with a 24/7 emergency room and issued the assessment, findings, and conclusions as a separate document dated December 17, 2013.
- The service area (shown on the following page) was defined at the engagement kick-off meeting on September 10, 2013. It was used to develop the utilization and financial projections for the community medical center.

# Discussion of Healthcare Models

## Option 2: Build a Community Medical Center (Cont'd)



### Area Hospitals

- 1 Mendocino Coast District Hospital (49 beds)**  
 59.6 miles driving (98 min. drive time)  
 47.6 miles direct
- 2 Ukiah Valley Medical Center (78 beds)**  
 65.9 miles driving (122 min. drive time)  
 31.5 miles direct
- 3 Healdsburg District Hospital (26 beds)**  
 69.9 miles driving (131 min. drive time)  
 27.3 miles direct
- 4 Kaiser Foundation Hospital – Santa Rosa (173 beds)**  
 79.8 miles driving (140 min. drive time)  
 48.1 miles direct
- 5 Sutter Medical Center of Santa Rosa (135 beds)**  
 80.8 miles driving (142 min. drive time)  
 48.3 miles direct
- 6 Santa Rosa Memorial Hospital – Montgomery (278 beds)**  
 82.8 miles driving (144 min. drive time)  
 49.7 miles direct
- 7 Frank R. Howard Memorial Hospital (25 beds)**  
 87.4 miles driving (143 min. drive time)  
 44.4 miles direct
- 8 Palm Drive Hospital (37 beds)**  
 75.5 miles driving (138 min. drive time)  
 46.0 miles direct

Source: The Camden Group

Note: Beds represents licensed acute care beds.

# Discussion of Healthcare Models

## Option 2: Build a Community Medical Center (Cont'd)

The following list includes a series of critical success factors for the community medical center, and the likelihood of accomplishment.

Critical Success Factors	Likelihood
Critical access designation	Probably
Part of System	Potentially
High Medicare payer mix (60+ percent)	Probably not
High occupancy levels and critical mass	No
Adequate physician supply and select specialist coverage	Probably not
Support tax, donations, and other non-operating revenue to support facilities	To Be Determined

## Discussion of Healthcare Models

### Option 2: Build a Community Medical Center (Cont'd)

- Recommendation: The Camden Group does not believe that building a small community medical center (less than 25 licensed beds) in CLSD's service area would serve as a financially sustainable healthcare model for the community due to an amalgamation of high start-up costs to build the facility, low patient occupancy levels, undesirable payer mix, anticipated challenges recruiting and retaining clinical providers, and required on-going needed financial support.
- In addition, anticipated future trends in the healthcare environment (e.g., reimbursement levels, declining inpatient use, physician and clinical shortages) will continue to make it difficult to successfully operate and maintain financially viable hospitals in general, and smaller hospital players in particular.

# Discussion of Healthcare Models

## Option 3: Develop a New Ambulatory Care Center (“ACC”)

- The ACC includes a new building that would house new/expanded outpatient services.
- The site of the ACC would be located adjacent to the current RCMS clinic in Gualala, on land currently owned by RCMS.
- The new/expanded ambulatory services are assumed to include:
  - ▶ Urgent care center with current capability, and dedicated additional space with telehealth capabilities.
  - ▶ Primary care services, to include space for four primary care providers (one geriatric provider).
  - ▶ Specialty care services, to include space for rotating specialists (existing and new), as well as space dedicated for telemedicine visits/consults.

# Discussion of Healthcare Models

## Option 3: Develop a New Ambulatory Care Center (Cont'd)

- A list of which physician specialists the service area could support (part-time or full-time), as well as which specialists are currently rotating through the service area is provided in **Appendix A.**
- ▶ Additional community health services could rent space within the new medical office building, and may include:
  - Acupuncture
  - Chiropractor
  - Cranio-sacral therapy
  - Gym
  - Hearing testing
  - Massage therapy
  - Optometry
  - Physical therapy
  - Yoga, aerobics, balance training
  - Meeting space (e.g., education, coordinated multi-county disaster response team)

# Proposed Sizing of New Ambulatory Care Center

The proposed sizing for the new ACC is shown in the table below.

**Coast Life Support District  
Square Footage Summary of Proposed New Ambulatory Care Center**

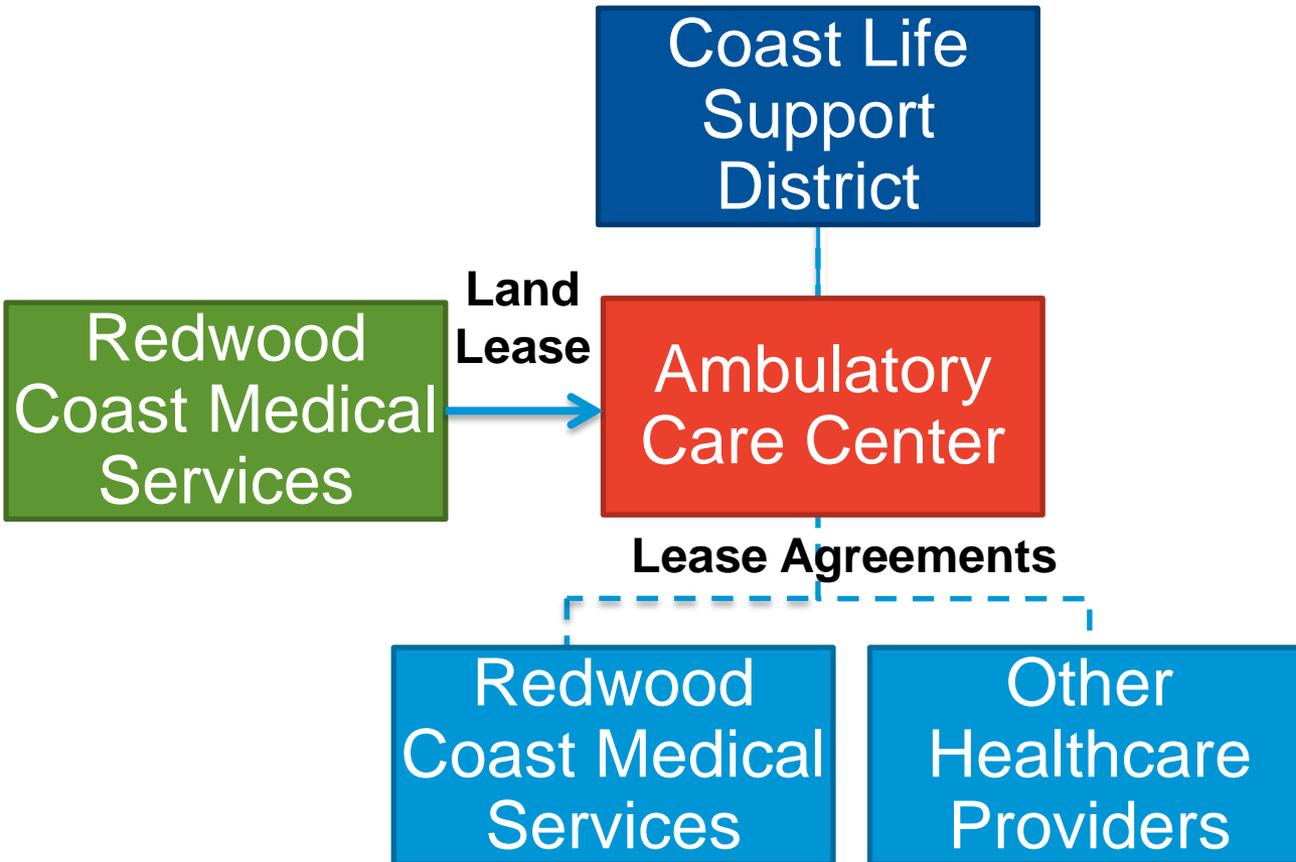
Proposed Service	Square Footage Range per Physician		Square Feet Needed	Comments
	Low	High		
Primary Care	1,500	1,750	7,000	Four physicians; higher square footage per physician for medical home model
Urgent Care	1,000	1,200	1,200	Three Rooms
Specialty Care	1,200	1,500	1,500	
Other Services	8,200	9,700	9,700	Space to be dedicated to community/education room, other community organizations that can rent space
<i>Subtotal</i>			19,400	
<i>Common Space Building Factor</i> <sup>(1)</sup>	20.0%	25.0%		
<b>Total</b>			<b>24,250</b>	

(1) Typically common space factor ranges 16 to 17 percent; larger factor used because this is a smaller healthcare building

[https://sharepoint.thecamden.com/Clients/Coast\\_Life\\_Support\\_District/Business\\_Plan\\_2013/Planning/\[ACC\\_Square\\_Footage.xlsx\]Sizing Table](https://sharepoint.thecamden.com/Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/[ACC_Square_Footage.xlsx]Sizing Table)

# Potential Ambulatory Care Building – Model 1

Owned by Coast Life Support District

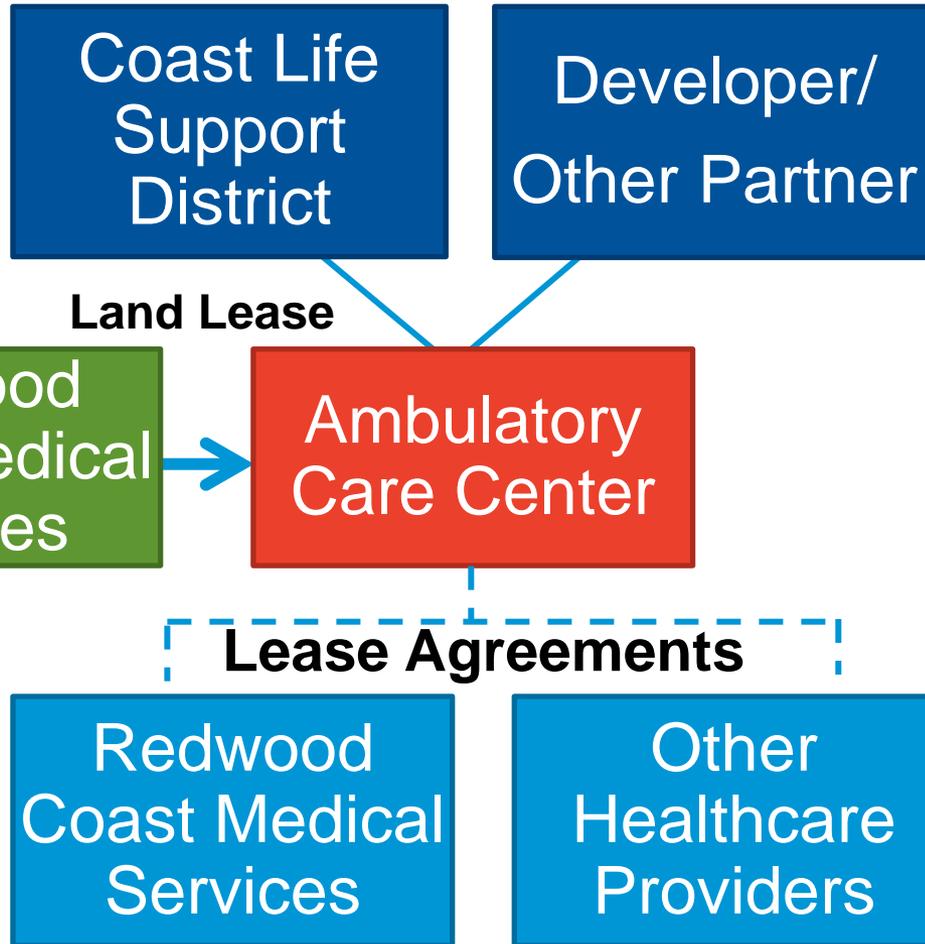


## Description

- CLSD raises funds and/or borrows money to finance the construction of a new ACC.
- CLSD pays a fee for the land (upfront, annual) to RCMS.
- CLSD rents space to local healthcare providers.
- Potential to offer ownership.

# Potential Ambulatory Care Building – Model 2

## Joint Venture Agreement



## Description

CLSD partners with a developer or other partner (“JV”) to build/finance the construction of a new ACC.

- The JV pays a fee for the land (upfront, annual) to RCMS.
- The JV rents space to local healthcare providers.
- Potential to offer ownership.

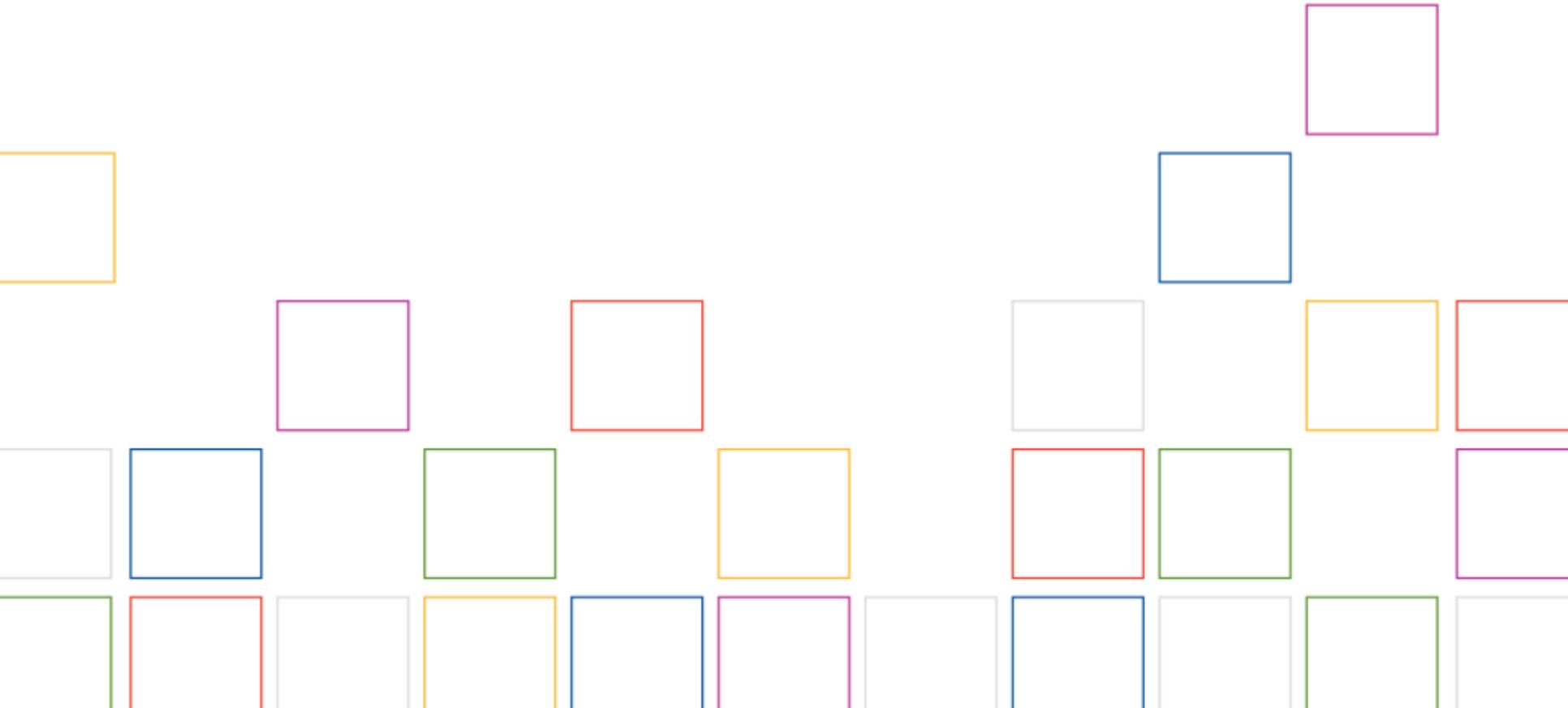
# Partnership with Health Systems and Community Providers

- CLSD and RCMS should consider partnering with hospital/health system to provide expanded access to healthcare services in the community (e.g., specialists, tele-health). These services could be housed or accessed through the new ACC.
- Establish clinical linkages between providers:
  - ▶ Share patient information: hospitals, physicians, labs, other services.
  - ▶ Advice/Consults in real time: emergency rooms, specialty physicians, tele-health
  - ▶ Manage patient care: identify high-risk patients, patient monitoring at home or remote setting

# Partnership with Health Systems and Community Providers

- Partner with other community providers to increase access to services
  - ▶ Lease space in ACC
  - ▶ Coordinate services to improve health
  - ▶ Potential to target age-in-place services (see Appendix B)

# Financial Projections



# Assumptions

- The ACC was assumed to be 25,000 square feet and constructed at a cost of \$800 per square foot for a total cost of \$22.0 million (\$20.0 million in planned capital with an additional \$2.0 million for contingency). This is based on local knowledge of recent non-medical construction. Similar medical buildings are built for significantly less cost in other parts of the State.
- Fifty percent of the project cost was assumed to be funded through an equity contribution by the District.
- The remaining project costs would be funded through a 30-year term loan at a rate of 3.84 percent. The loan included:
  - ▶ Issuance cost at 2.5 percent
  - ▶ Debt service reserve fund
  - ▶ Capitalized interest (two years)
- Working capital was assumed to be approximately \$2.2 million for legal, consulting, and other related project expenses.

# Assumptions

The table below summarizes the sources and uses of funds in the development of the ACC.

**Coast Life Support District  
Ambulatory Care Center: Sources and Uses  
Pre-opening and Years 1 - 5**

Sources	Amount	Uses	Amount
Bond proceeds	\$15,531,780	Capital expenditures <sup>(1)</sup>	\$22,000,000
Equity contribution	11,000,000	Working capital requirement	2,200,000
		Debt service reserve fund	1,211,980
		Cost of issuance	275,000
		Capitalized interest	844,800
<b>Total</b>	<b><u><u>\$26,531,780</u></u></b>	<b>Total</b>	<b><u><u>\$26,531,780</u></u></b>

Clients/Coast\_Life\_Support\_District/Business\_Plan\_2013/Financial/[Coast\_ACC\_Finance\_120913.xlsx]PandL\_1

<sup>(1)</sup> Capital expenditures include building costs, architecture and engineering, and contingency

## Assumptions

- The ACC assumes full tenant occupancy upon opening with a rental rate of \$4.50 per square foot per month (rental income).
- Operating costs were estimated to be \$1.35 per square foot per month.
  - ▶ Excludes potential costs of a land lease.
- Rental income and operating expenses were assumed to inflate at rate of 2.5 percent each year.
- The ACC was assumed to be depreciated over a 35 years.

# Financial Projection: Pre-opening and Five-Years

- The table below summarizes the estimated financial performance of the ACC during the pre-opening period and the first five years of operation.
- Assumes a 50 percent equity capital contribution by the District.

Coast Life Support District  
Ambulatory Care Center: Operating Financial Performance  
Pre-opening and Years 1 - 5

Category	Pre-opening	Projected Year				
		1	2	3	4	5
Revenue (Rental Income)	\$0	\$1,350,000	\$1,383,750	\$1,418,344	\$1,453,802	\$1,490,147
Operating Expense <sup>(1)</sup>	\$2,200,000	\$405,000	\$415,125	\$425,503	\$436,141	\$447,044
<b>Operating Profit</b>	<b>(\$2,200,000)</b>	<b>\$945,000</b>	<b>\$968,625</b>	<b>\$992,841</b>	<b>\$1,017,662</b>	<b>\$1,043,103</b>
Depreciation	\$0	\$628,571	\$628,571	\$628,571	\$628,571	\$628,571
Interest on Debt	0	591,505	580,515	569,095	557,229	545,945
<b>Net Operating Income</b>	<b>(\$2,200,000)</b>	<b>(\$275,077)</b>	<b>(\$240,462)</b>	<b>(\$204,826)</b>	<b>(\$168,139)</b>	<b>(\$131,413)</b>

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(1) Does not include potential land lease expense

# Financial Projection: Cash Flow

The table below highlights the estimated cash flow of the ACC during the pre-opening period and first five years of operation.

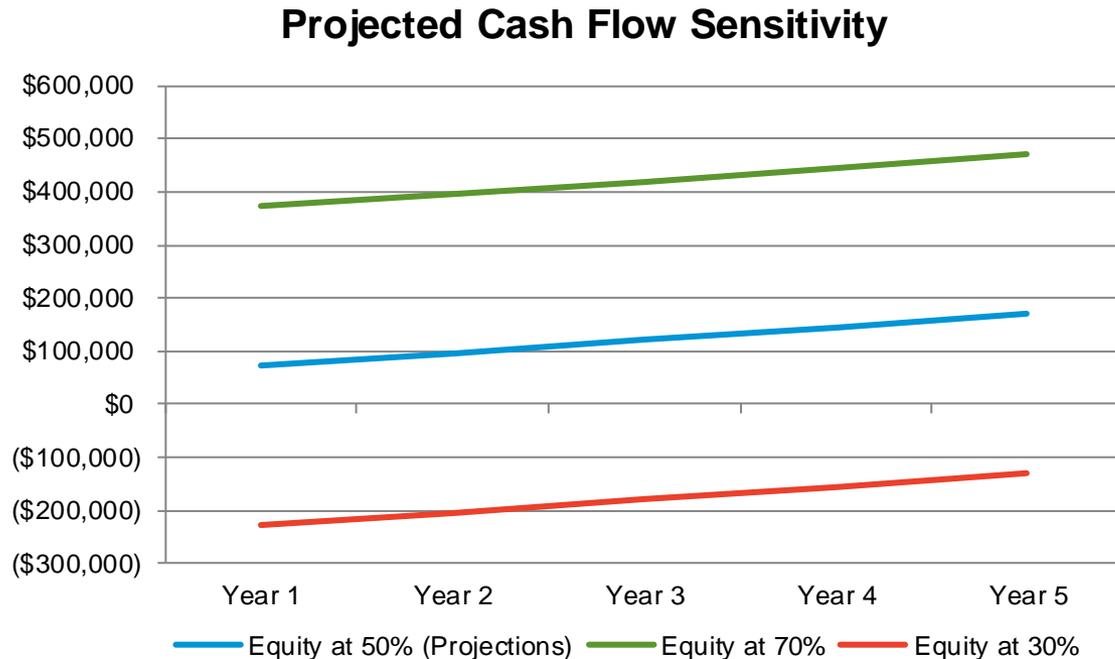
**Coast Life Support District  
Ambulatory Care Center: Cash Flow  
Pre-opening and Years 1 - 5**

Category	Pre-opening	Projected Year				
		1	2	3	4	5
<b>High-level Cash Flow</b>						
<b>Net Operating Income</b>	<b>(\$2,200,000)</b>	<b>(\$275,077)</b>	<b>(\$240,462)</b>	<b>(\$204,826)</b>	<b>(\$168,139)</b>	<b>(\$131,413)</b>
Add: Depreciation	0	628,571	628,571	628,571	628,571	628,571
Less: Capital Additions	(22,000,000)	0	0	0	0	0
Less: Financing Costs	(2,331,780)	0	0	0	0	0
Add: Equity Contribution	11,000,000	0	0	0	0	0
Add: Income from Financing	15,531,780	0	0	0	0	0
Less: Principal Payments	0	(281,202)	(292,192)	(303,612)	(315,478)	(326,762)
<b>Estimated Cash Flow</b>	<b>\$0</b>	<b>\$72,293</b>	<b>\$95,918</b>	<b>\$120,134</b>	<b>\$144,955</b>	<b>\$170,396</b>
<b>Cumulative Cash Flow</b>	<b>\$0</b>	<b>\$72,293</b>	<b>\$168,211</b>	<b>\$288,344</b>	<b>\$433,299</b>	<b>\$603,695</b>

is://sharepoint.thecamden.com/Clients/Coast\_Life\_Support\_District/Business\_Plan\_2013/Financial/[Coast\_ACC\_Finance\_120913.xlsx]PandL\_1

# Financial Projection: Summary of Findings

- Although net operating income is negative, cash flow is positive throughout the projections, if fully occupied at projected lease rates.
- The financial performance of the ACC is sensitive to the initial equity contribution provided by the District:



## Existing RCMS Gualala Building

- The existing RCMS building in Gualala is proposed to be repurposed as an administrative building. The proposed services to be put into the existing RCMS building are:
  - ▶ Billing/Finance
  - ▶ Grants/Resource Development Staff
  - ▶ EMR/IT staff
  - ▶ Management Staff
  - ▶ More storage space
  - ▶ Sleeping quarters for on-call providers/staff
  - ▶ Other miscellaneous non-clinical activities
- Remodeling the existing RCMS building may cost an estimated \$1 million.

## Estimated Telehealth Costs

- Start-up and ongoing costs associated with a higher-quality tele-health unit are approximately \$40,000. This would include good audiovisual equipment and compatible diagnostics, digital stethoscope, and the vital diagnostics.
  - ▶ There are several software programs to choose from ranging in cost from \$1,000 to \$2,000. Training and support will vary.
- Alternatives to tele-health units exist such as a dedicated codec (teleconferencing) or Internet-based programs. Set-up would include a high-quality webcam and computer monitor, internet-based software, and traditional diagnostics. The alternative method to telehealth is assumed to cost an estimated \$5,000.

# Potential Funding Options

- Local donations
- Grants (e.g., Kaiser, rural health, California Healthcare Foundation)
- Partnerships with other adjacent health systems
- Partnership with local Indian Health Services
- New market tax credits – difficult to get
- Tax
- Debt
- Joint Venture with a real estate developer
- Others

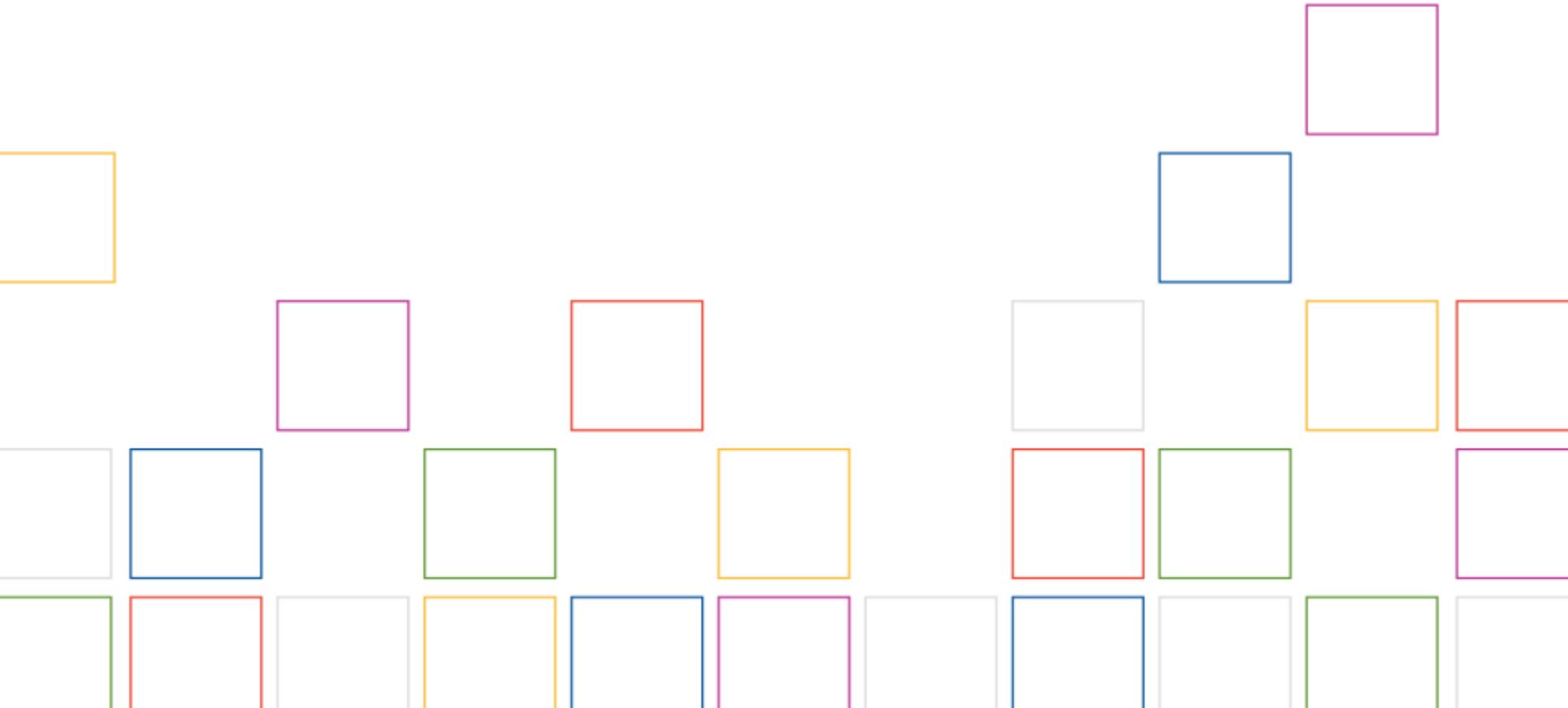
# New Markets Tax Credit Program

- Established by Congress in 2000 to spur new or increased investments into operating businesses and real estate projects located in low-income communities. (See next page for low-income definition)
- Helps economically distressed communities attract private investment capital by providing investors with a federal tax credit.
- Investments are used to finance businesses and real estate projects.
- Communities wishing to receive funds must be a certified Community Development Entity and must proceed with a competitive application process.
- Communities benefit from added jobs as well as greater access to public facilities, goods, and services.

# New Markets Tax Credit Program

- Low-income Communities (“LIC”) are defined as:
  - ▶ High out-migration rural county census tracts:
    - Population census tract which, during the 20-year period ending with the year in which the most recent census was conducted, has a net out-migration of inhabitants from the county of at least ten percent, if the median family income for the census tract does not exceed 85 percent of statewide median family income (at 82 percent)
  - ▶ Low population/empowerment zone census tracts:
    - Population census tract with a population of less than 2,000 if the tract is within an empowerment zone, and is contiguous to one or more LICs (not including other LICs in this category)
  - ▶ Targeted Populations:
    - Certain individuals, or an identifiable group of individuals, including an Indian tribe, who (A) Are low-income persons [median family income at or below 120 percent of the applicable median family income]; or (B) Otherwise lack adequate access to loans or equity investments.

# Recommendations



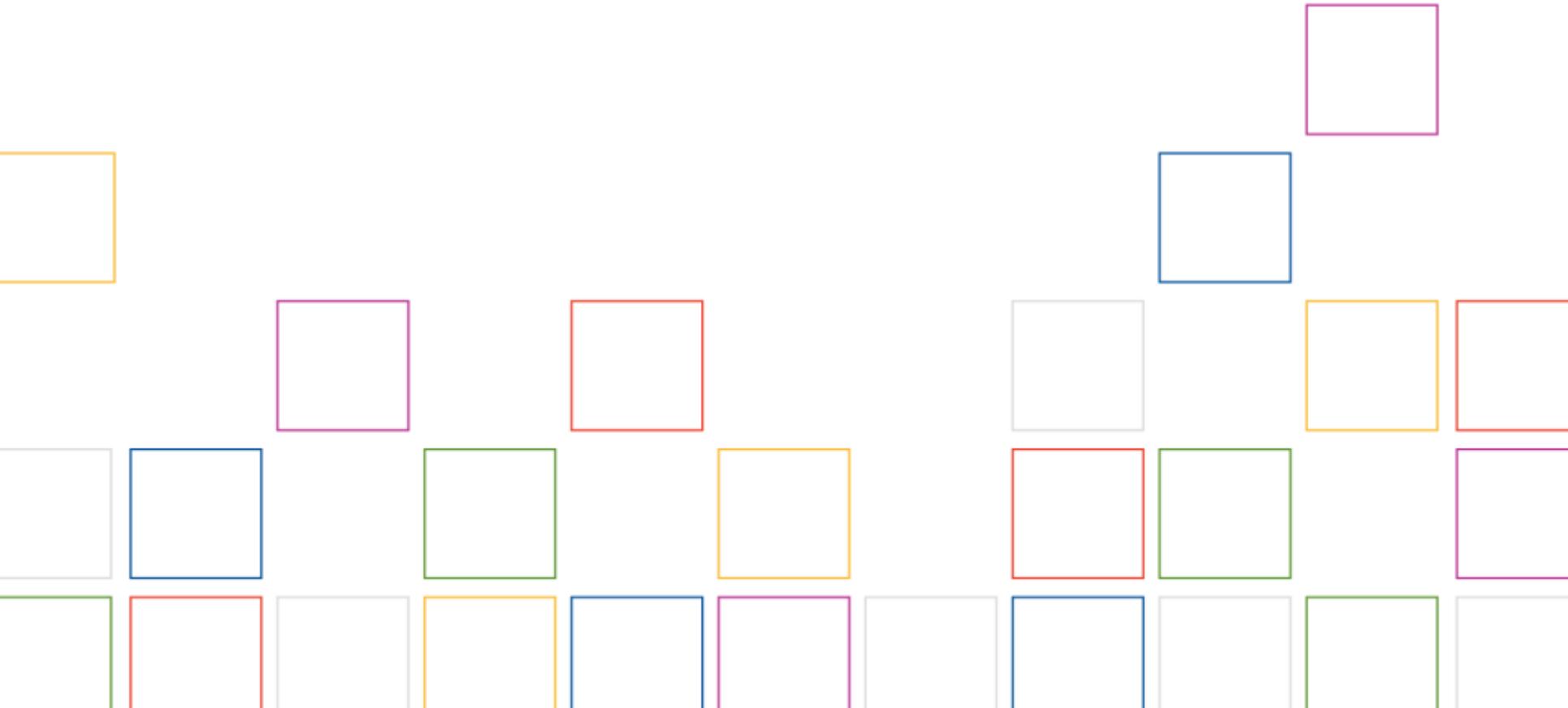
## Recommendations

- The Camden Group recommends Option 1, the expansion of the urgent care hours, as the near-term strategy. Expansion of urgent care was consistently stated as the highest need by community members. RCMS' existing infrastructure is the most financially viable, cost-effective, consistent model to expand healthcare services to the community.
- For longer term solution, The Camden Group recommends CLSD pursue Option 3, develop a new ACC to house expanded outpatient services. The ACC should include space and technology to expand access to services through tele-health and remote monitoring.
  - ▶ More planning should be conducted to see if the building could be constructed for a lower cost, given comparable medical buildings in other parts of the state are much less costly.

## Recommendations

- ▶ Either fundraising or tax support will be needed to make the new building feasible.
- ▶ If occupancy, fundraising and rates can be achieved, the excess cash flow could be used to fund additional healthcare services to the community.
- CLSD and RCMS should continued to explore grants to fund innovations in tele-health/universal access that will expand access to healthcare locally.

# Options Considered and Excluded



## Additional Options Considered and Excluded

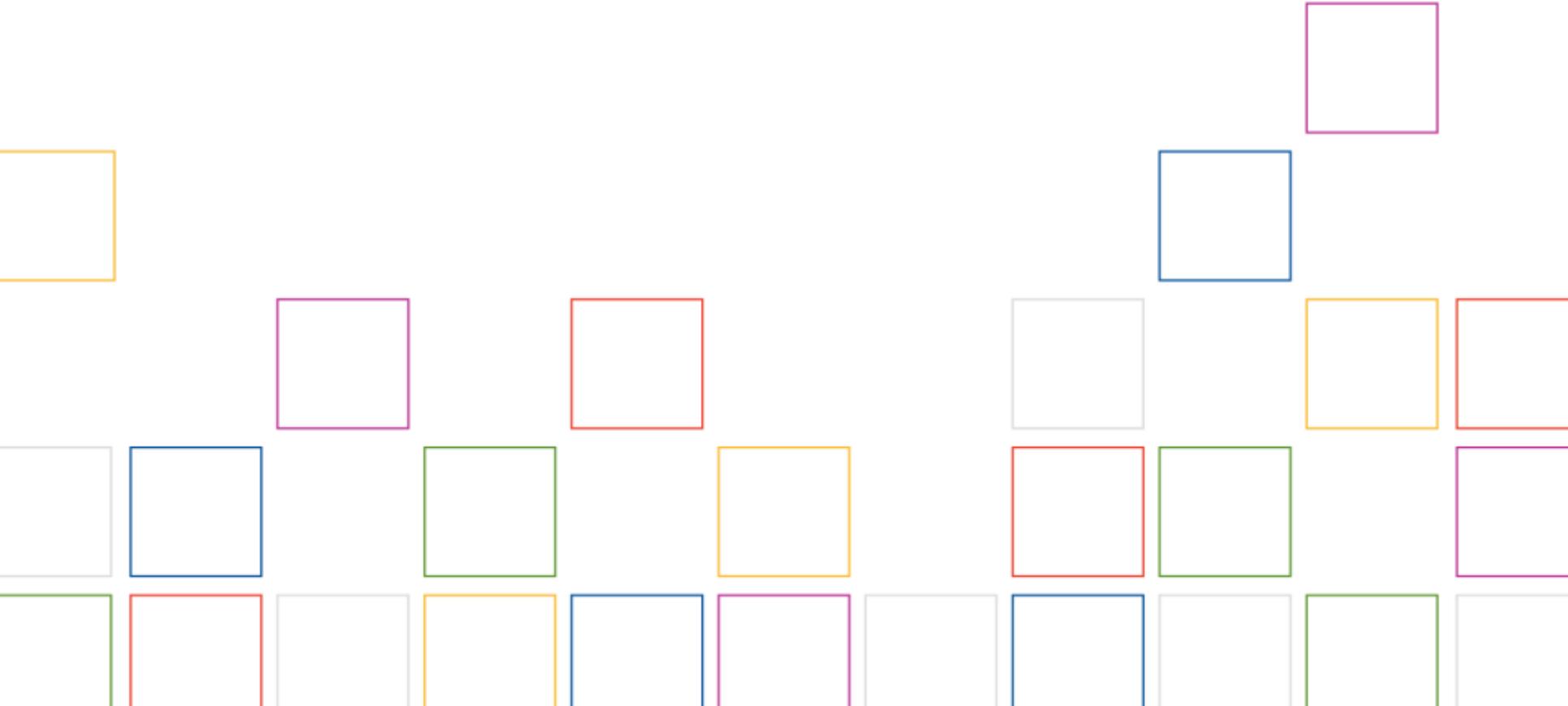
- Development of a community medical center (less than 25 licensed beds)
  - ▶ Low volume
  - ▶ Difficulty recruiting and retaining physician support
  - ▶ Difficulty maintaining consistently high quality and clinical competencies
  - ▶ Significant financial support needed
- Development of Community Paramedicine program
  - ▶ Community Paramedicine is currently not practiced in California due to strict paramedic scope-of-practice specifications, and restrictions placed on where paramedics may treat patients. However, OSHPD and California Emergency Medical Services Authority (“EMSA”) are beginning demonstration CP programs.
  - ▶ Although, use of paramedics to staff after-hours urgent care could be a viable staffing alternative

## Additional Options Considered and Excluded

- Development of a free-standing ED
  - ▶ Not currently allowed in California
- HAH
  - ▶ Distance from acute care hospital, considerable start-up costs, and staff requirements
- Development of a district clinic
  - ▶ Duplication of resources and less financially viable model
- Development of a hospital clinic
  - ▶ Outside of distance requirements
- Addition of other full-time specialists and related services (e.g., surgery, advanced imaging/diagnostics)
  - ▶ Not supported by population

# Appendix A

## Physicians to Support Population



# Physicians to Support Population

- At a 2010 population size of 6,194, the service area could support full-time primary care physicians. Based on discussions with CLSD, population was held flat at 2010 levels.
- The population could support the following nine specialties at least one day per week including:
  - ▶ Cardiology\*
  - ▶ General surgery
  - ▶ Hematology and oncology
  - ▶ OB/GYN
  - ▶ Ophthalmology\*
  - ▶ Orthopedics\*
  - ▶ Otolaryngology
  - ▶ Pediatrics
  - ▶ Urology

\* Indicates specialties with partial physician coverage currently

Coast Life Support District  
Physician Full-Time Equivalents ("FTE") Required to Support Population  
Calendar Year 2013

Specialty	Physician Demand	Physician Supply <sup>(2)</sup>
<b>Primary Care <sup>(1)</sup></b>	<b>3.62</b>	5.75
Allergy & Immunology	0.05	
Cardiology	0.21	0.05
Cardiovascular Surgery	0.05	
Dermatology	0.18	
Endocrinology	0.05	
Gastroenterology	0.17	
General Surgery	0.62	
Hematology & Oncology	0.24	
Infectious Disease	0.06	
Neonatology	0.03	
Nephrology	0.07	
Neurology	0.15	
Neurosurgery	0.06	
Obstetrics & Gynecology	0.65	
Ophthalmology	0.29	0.10
Oral & Maxillofacial Surgery	0.07	
Orthopedics	0.40	0.05
Otolaryngology	0.21	
Pediatrics	0.97	
Physical Medicine & Rehab	0.11	
Plastic Surgery	0.07	
Pulmonary Disease	0.10	
Radiation Oncology	0.07	
Rheumatology	0.04	
Thoracic Surgery	0.05	
Urology	0.22	
<b>Population</b>	<b>6,194</b>	

Clients/Coast\_Life\_Support\_District/Business\_Plan\_2013/Planning/(Physician\_Ratios.xlsx)Sheet1

Sources: Redwood Coast Medical Services, GMENAC 1990; Merritt, Hawkins & Assoc. 2002; Claritas, Inc., and The Camden Group

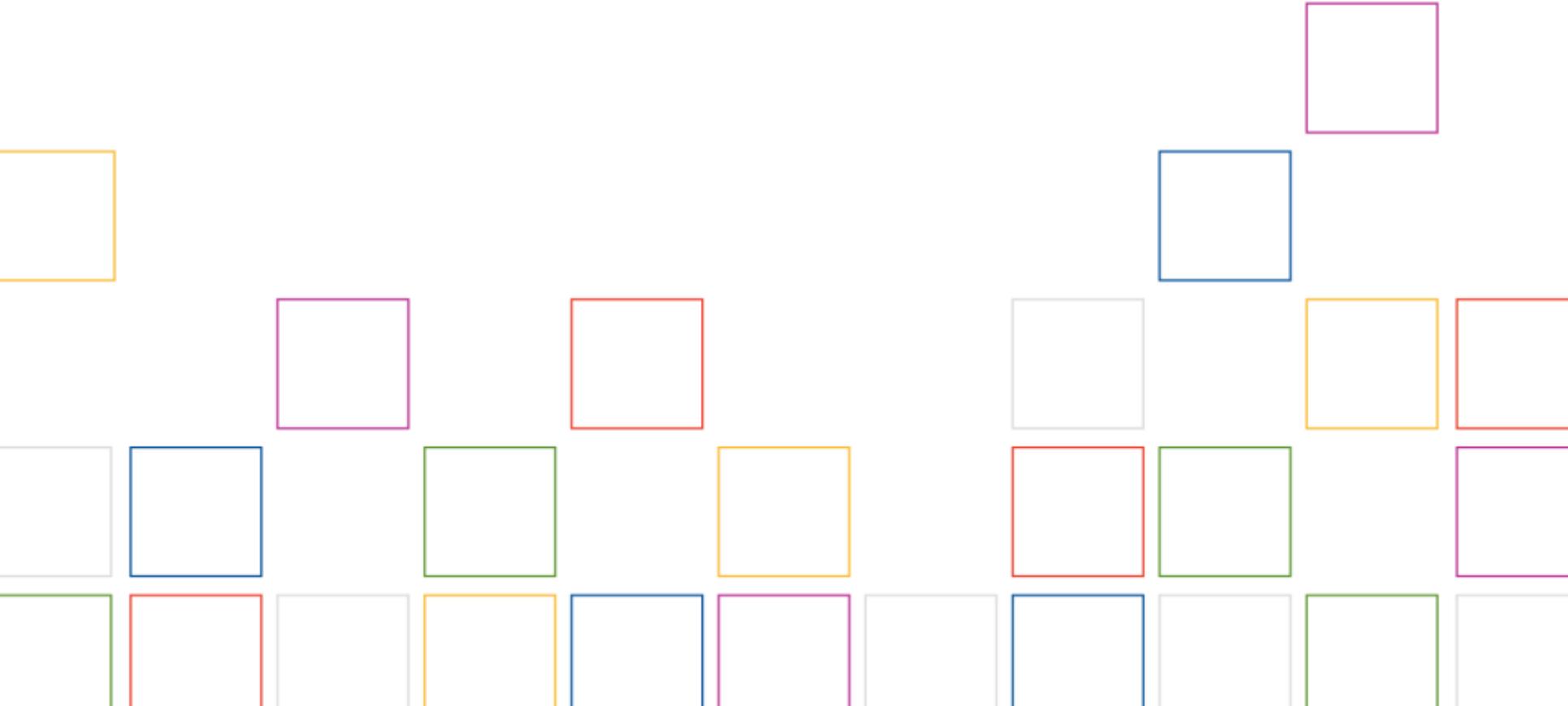
□ Denotes FTE demand greater than or equal to 1.0.

(1) Primary care providers inclusive of family practice, internal medicine, and mid-level providers (e.g., physician assistants, nurse practitioners).

(2) MD/DO providers are considered 1.0 FTE per 40 hours worked per week. Mid-level providers are assigned an FTE of 0.75.

# Appendix B

## Age-in-Place Services



# Hospital at Home

- Developed through Johns Hopkins School of Medicine, Hospital at Home (“HAH”) is an acute, home-based program in which eligible older patients are provided state-of-the-art acute care services at home post-hospital discharge.
- HAH focuses on patients age 65+ who required hospital admission for diseases such as community-acquired pneumonia, congestive heart failure, chronic obstructive pulmonary disease, and cellulitis.
- Patients meeting specific medical eligibility criteria can receive hospital-level care including diagnostic tests and treatment therapies from doctors and nurses in their own home. The patient is treated until stable for discharge from the HAH program.

# Hospital at Home

## Considerations for Replication

- Successful implementations of this model have limited the geography to a 20 to 30 mile radius from a hospital.
- Takes health systems that are fairly large, capitated and integrated with the population to draw patients from.
- Considerable start-up costs, nearly \$500k
- Significant amount of work and staff time to get the program up and running
  - ▶ It took Presbyterian Healthcare Services (Albuquerque, Arizona) 150 people working in 12 teams over nine months to get the program running
- Reimbursement struggles; limiting factor is payer sources

# Hospital at Home

## Considerations for Replication (Cont'd)

- Forge provider relationships to refer patients into program – primary care physicians, hospitalists, emergency physicians, triage nurses, who must determine which patients are a good fit for the HAH program.

## Age-In-Place Services

- Age-in-place services could rent space from, or be based in the ACC.
- Key trends in age-in-place services for future aging generations:
  - ▶ Maintaining resident independence: use of “smart” technology, home health, tele-health in senior living facilities
  - ▶ Expanding senior programs and services outside of senior living communities: home health, adult day care, the Village Model
  - ▶ Wellness and continuing education programs for seniors

# The Village Model

- Community-based membership organization that empowers elderly adults to remain active and engaged in their communities as they age.
- Villages facilitate access to community services and provide connections to ongoing civic engagements by providing three core services to its members:
  - ▶ Concierge or referral to providers/volunteers for anything
    - Transportation is the most common requested service
    - Home maintenance is the second most common requested service
  - ▶ Health and wellness programs and services (i.e., exercise programs, home health care, meals and groceries delivered)
  - ▶ Social and community building programs, including seminars, wellness and prevention activities developed and administered by the members themselves.

# The Village Model

- 22 Villages open in California
- 17 Villages in development in California
  - ▶ Three Villages in development closest to Gualala located in Petaluma, St. Helena, and Napa.
- Village model relies heavily on volunteerism to provide member services.
- Fostering friendships and social connections are a key component of the Villages model.

