Interim Report:
Doctors Medical Center
Stakeholder Group

Sept. 24, 2014
OVERVIEW

The failure of the Measure C parcel tax measure this spring put Doctors Medical Center (DMC) on life support. Although recent cutbacks in non-essential services and a series of staff reductions have cut operating expenses, hospital management estimates that under the best-case scenario, DMC has only enough cash available to keep its doors open through the first quarter of 2015.

No one wants to see Doctors Medical Center close, as evidenced by the effort made over the past 20 years – by the community, the West Contra Costa Healthcare District, the county and other area hospitals – to fund the operation of a full-service institution. But the failure of the parcel tax in May compelled the Hospital Council of Northern and Central California to request the organization of a Stakeholder Group – led by Dr. William Walker, Director, Contra Costa Health Services -- to find a sustainable alternative. Member hospitals of the Hospital Council agreed to fund a technical advisory group to support the effort.

The Stakeholder Group has based its analysis on a number of assumptions, chief among them that the loss of DMC emergency services would be catastrophic for residents of West County. More than 40,000 people a year visit the DMC emergency room, and the 25 ED treatment stations represent 62 percent of emergency room capacity in West County. A recent study by county Emergency Medical Services concluded that losing the DMC emergency room would overwhelm the emergency care resources of neighboring hospitals and significantly increase wait times during peak hours.

Over the past two months a number of health-care models have been analyzed and discarded as financially unsustainable by the Stakeholder Group, among them a full-service hospital under the existing or county hospital license. The economic realities do not make it possible for DMC to continue to operate under its current full-service model. By Stakeholder estimates, such a hospital would continue to lose $18 million to $20 million a year. A state-mandated seismic retrofit of the main hospital building – due to begin in 2015 and estimated to cost more than $100 million – also makes maintaining a full-service hospital at the current site cost prohibitive.
An evaluation of a streamlined hospital – one with fewer acute care beds that retained diagnostic and emergency care, which is how DMC is now configured – found that it too would carry unsustainable operating losses of $18 million.

Meanwhile, the county supervisors, saddled with rising pension and employee costs and facing budget difficulties in law enforcement and other departments, have stated emphatically that the county is not in a position to take over operation of DMC.

Clearly, options are limited. Nonetheless, the Stakeholder Group and its team of technical and clinical experts remain optimistic that a self-sustaining, clinically appropriate health-care model can be found for West County. A final report is expected to be made to the Healthcare District board this fall.

The Stakeholder effort is now focused on a financial and clinical analysis of two health-care models. One, an enhanced urgent care center with diagnostic capabilities, shows great clinical promise and would not require regulatory approval in California. The second, a 24-hour standby emergency department, likely on the license of the county medical center, has the advantage of retaining higher emergency care reimbursement rates but faces licensing and regulatory hurdles in the state.

**SATELLITE EMERGENCY DEPARTMENT**

As envisioned, the satellite ED would have no inpatient beds but would retain the existing 25 emergency beds at DMC, some of which could be used for observation and patient stabilization.

- The satellite ED would initially be located at the site of current emergency room then relocated to a new location to be built nearby.
- The ED would be staffed by board-certified emergency room physicians around the clock and include standard diagnostic services.
- The satellite ED would not accept emergency ambulance delivery, although an on-site ambulance could be available to immediately transport patients in need of hospital admission.
In general, a satellite ED would be capable of delivering a higher level of care than traditional urgent care or primary care facilities.

- Tying the satellite ED to the county medical license increases reimbursement rates from Medi-Cal.
- Similar EDs operate successfully in other states, providing traditional emergency care in coordination with regional hospitals. As of 2013, there were 284 freestanding or satellite EDs operating in 45 states, according to the American Medical Association.
- The American College of Emergency Physicians recognizes freestanding and satellite emergency care as clinically viable health-care options and has provided recommendations on staffing and related issues.
- Only 11 percent of the patients seen at the DMC emergency room require inpatient care – a percentage that continues to decrease as heart attack and other critical care patients are diverted to other hospitals.
  - It is expected that a satellite ED would receive 25 percent fewer patients overall than the full-service ED.
  - While limited, jumps in inpatient admissions are expected to significantly impact some of the smaller hospitals in the region.
  - The recent diversion of 20-25 daily ambulances has put pressure on nearby emergency departments, reinforcing the need to maintain limited emergency or urgent care services at DMC.
  - County health services would work with regional physicians to have more specialists on call to support a satellite ED. Telemedicine services would also be considered to enhance specialty care.
- Although DMC still retains 30 inpatient beds, its emergency room is effectively functioning as a satellite ED today following the elimination of ambulance delivery Aug. 8 and the recent move to standby status.
  - The changes at the DMC emergency department represent an opportunity to determine the long-term feasibility of a satellite ED in West County.
  - Issues to be analyzed in this transition period include the impact of patient transfers on other facilities, the timely treatment of critical
care patients and whether such a system of care would be embraced by the community.

- Issues surrounding the state authorization of a satellite ED are unsettled. The Stakeholder legal team believes a satellite ED could operate under current California regulations and is actively working with state agencies on finding common ground, although significant regulatory hurdles remain.
  - It is critical that the state work with the local communities to find a way to meet changing health care needs. California hospital license laws date from the 1970s and are in dire need of revision.

URGENT CARE

The advanced 24-hour urgent care center would use board-certified emergency room physicians and be modeled after successful clinics in other states, including those used by Kaiser Permanente.

- The advanced urgent care center would provide similar basic services as a satellite ED but would not require special state licensing.
- The advanced urgent care center would likely include:
  - Diagnostic and radiology capabilities, including CT observation beds.
  - An on-site ambulance to immediately transport patients in need of hospital admission.
  - On-site lab and pharmacy
  - On-call specialty physicians

FINANCES

- Financial losses for a satellite ED are estimated to be $8.7 million a year -- $7 million of which is tied to debt payments.
- Operational costs have yet to be modeled for the advanced urgent care center. Funds from the 2011 tax measures put in place to support DMC are limited to a hospital or emergency room.
• In either case, a multiparty financial solution involving the county, the healthcare district, regional hospitals and other interested stakeholders will be explored to reduce or retire the DMC debt service, with the goal of getting a satellite ED or an urgent care facility as close to breaking even as possible.
• No decisions have been made on debt reduction and serious obstacles remain, but the initiatives being discussed include:
  o Sale of the existing Healthcare District properties
  o Forgiveness of county portion of debt service
  o Direct, one-time contributions from outside sources
• The Healthcare District is also looking to identify other non-hospital sources willing to provide support for operational expenses.

OTHER CONSIDERATIONS

The Alameda-Contra Costa Medical Association has agreed to participate in a clinical and financial analysis of a satellite ED and urgent care center while it continues to advocate for a full-service option.

LifeLong Medical Care and West County Clinic, the local Federally Qualified Health Centers, will consider expanding their primary care facilities.

• This option will allow services to continue for the patients who currently use the DMC emergency department but do not require hospitalization or full emergency care.
• Connecting patients to more appropriate primary care services and providing assistance to manage their health will reduce the demand on regional emergency rooms.
• Federally Qualified Health Centers enjoy favorable payments from Medicare and Medi-Cal as well as special grant funding, since they are located in designated medically underserved areas.

ATTACHMENTS:
DOCTORS MEDICAL CENTER TIMELINE

- Despite a 2004 parcel tax and bond financing, DMC struggled financially in 2005 and 2006, losing in excess of $3 million monthly by the summer of 2006. In October of that year, the district filed for bankruptcy and borrowed $20 million from the county.

- In an effort to develop a financially sustainable plan, in 2007 and 2008 the hospital reduced expenses by $17 million, and secured a $51 million commitment of support from the state, Kaiser Permanente and John Muir Health (a combined $17 million per year for 3 years: 2008, 2009 and 2010). Based upon these commitments and the cost reduction, DMC exited bankruptcy in the summer of 2008. The state later reported its inability to fund the entire portion of its commitment, and in 2010 DMC received a total of $11 million rather than the anticipated $17 million. All of the funding ended in 2011.

- In 2011, with the discontinuation of the outside funding stream, DMC again found itself in extreme financial distress and unable to make payroll without immediate action. In January of that year the CEO was terminated, and interim management was retained. A $10 million tax advance was provided by the county and Kaiser Permanente provided an additional $4.1 million in support. Management also put in place a line-of-credit with a healthcare finance lender – the first such financing in a public hospital.

- That summer, management initiated a regional planning initiative including Kaiser, county Health Services, John Muir Health and other local agencies. That group evaluated options for continued support of DMC as a full-service hospital, and also evaluated options for the development of a “legacy plan” in the event of closure, including a freestanding E.D., a smaller hospital, and urgent care services. Keeping the hospital open as a full-service hospital was the priority and management pursued strategies to secure the funding to achieve this goal.

- In the summer and fall of 2011, with mounting accounts payable obligations, management negotiated with all vendors on past due amounts. Through this process we were able to get a reduction of more than $1.2 million in amounts past due.
In November of 2011 the second parcel tax measure was passed (Measure J), and in December an additional bond financing was arranged. This bond financing provided the cash necessary to support the operating gap going forward.

In February 2012 the Camden Group was retained to develop a strategic plan. Camden reported that DMC was not sustainable as a freestanding hospital, and recommended that a partner be found. Activities started immediately to find such a partner, and more than two dozen organizations at the local, state and national level were contacted, including UCSF and Stanford. None of the organizations were interested in moving forward with partnership discussions. To this day management and the Board continue to pursue potential partners in an effort to find an interested party.

In 2012, 2013 and 2014, as reimbursement from Medicare and Medi-Cal continued to decline, the organization continued to pursue expense reduction measures just to “stay open,” including:

- Renegotiated better rates with insurance companies
- Improved billing and collection practices
- Streamlined staffing, making DMC one of the most efficient hospitals in the Bay Area
- Reduced management staffing, saving approximately $600,000 a year
- Renegotiated physician contracts to reduce costs
- Renegotiated vendor supply costs
- Made significant changes in the health benefits structure all employees
- Eliminated our self-insured employee benefit program, thereby reducing costs and eliminating the financial risk

Repeatedly throughout 2011 – 2014 met with federal and state elected officials and Medi-Cal officials in Sacramento seeking additional support and funding, and seeking Medi-Cal contract rate increases.

In 2013 and 2014 two additional tax advances were provided by the county totaling $15 million.

In 2013 DMC distributed an RFP to post-acute care operators (skilled nursing, long-term acute care, rehab services). The goal was to lease excess capacity within the hospital to a provider of post-acute services to both meet community need and to provide an additional revenue stream to the hospital. There were no interested parties.
In early 2014, after attempts to receive a charitable contribution from the Lytton Tribe, DMC entered into a lease arrangement with the Lytton Casino for the casino to rent approximately 180 parking spaces from the hospital for $4.6 million.

In May 2014, a parcel tax was placed on the ballot (Measure C). If passed, this tax would have generated $20 million and would have closed the operating gap that has existed for many years. While a majority of the voters did support the tax, it failed to receive the needed two-thirds approval.

With the failure of the new parcel tax measure, the board and management again began working with a regional planning group to revisit the scenarios evaluated in 2011 as a potential legacy plan: smaller hospital, freestanding E.D., urgent care.

Since the failure of the parcel tax we have also:

- Worked with state elected officials in an attempt to be designated as a public hospital for reimbursement purposes – the measure failed to pass the Senate.
- Worked with state elected officials to get a $3 million appropriation from the legislature. Pending the governor’s signature.
- Worked with Rep. Miller’s office to approach the Veterans Administration system – their need for inpatient beds is not significant enough to require additional beds for their system. In addition, this region does not qualify for VA reimbursement to be paid to non-VA hospital providers.
- Worked with Touro University to explore options for their support – they are not in a position to invest in DMC.
- Met with the California Endowment, the San Francisco Foundation, and filed proposals with the Gates Foundation Global Health Initiative for potential funding – the CA Endowment and the SF Foundation will not provide funding. The Gates proposal is pending but no likely to produce results as they don’t generally fund healthcare services in this county.
- Continued to reach out to potential investors and hospital operating firms in search of a potential partner – none have been willing to pursue discussions beyond an introductory meeting.
DMC Stakeholder Group
Technical Advisory Group roster

- Patrick Godley – COO/CFO Contra Costa Health Services
- Dr. William Walker – Chair, Director and Health Officer, Contra Costa Health Services
- Dawn Gideon – Interim CEO, Doctors Medical Center
- John Pfeiffer – CEO, HFS Consultants
- Steven Rousso -- Principal, Chairman of Board, HFS Consultants
- Steve Lipton – Attorney, Hooper, Lundy & Bookman
- Felicia Sze – Attorney, Hooper, Lundy & Bookman
- Art Sponseller – President/CEO, Hospital Council of Northern and Central California
- Rebecca Rozen – Regional VP, Hospital Council of Northern and Central California
- Kevin Keane – Senior Consultant, Singer Associates
### DOCTORS MEDICAL CENTER - SAN PABLO

#### ACTUAL AND PROJECTED FINANCIAL SCENARIOS

<table>
<thead>
<tr>
<th>Projected FYE 12/31/16</th>
<th>Scenario 1a - Streamlined Hospital</th>
<th>Standby ED under CCRMC license</th>
<th>Scenario 1b - Satellite ED under CCRMC’s license</th>
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<tr>
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<td>Actual 2013</td>
<td>Basic Model</td>
<td>Standby ED</td>
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<td>Key Utilization Statistics:</td>
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<td>Patient Days</td>
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<td>Discharges</td>
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<td>Average Daily Census</td>
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<td>ER Visits</td>
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<td>Net operating revenue</td>
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<td>Wages &amp; benefits</td>
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<td>Supplies, utilities, insurance &amp; other</td>
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<td>Interest, depreciation &amp; rent</td>
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<td>Total operating expenses</td>
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<td>District tax revenue</td>
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<td>Other non-operating income</td>
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<td>Net Income/(Loss)</td>
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<td>Net cash flow for period</td>
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BUDGET CONCERNS 2014-15

1. While Assessed Valuations (AV) have risen this year in Contra Costa County, the increase does not solve the County’s long term financial issues.

2. Over half of the Assessed Valuations increase was already built into the 2014/2015 Departments Operating Budgets to cover increased costs (salary and benefits) to maintain an existing level of county services.

3. The County’s unfunded liability for Other Post-Employment Benefits (retiree health care) exceeds $900 Million and the unfunded liability for Pensions exceeds $1.9 Billion. Both of which will require significantly more contributions from the County General Fund over the next several years.

4. The Contra Costa Regional Medical Center in Martinez requires an annual subsidy from the General Fund of over $30 Million each year. This hospital serves primarily lower income residents from throughout the County.

5. The County continues to negotiate with some of its Unions to arrive at an agreement over wages and benefits and no funds have been set aside for any such increases.

6. The County has a Health Insurance Re-opener with its Unions in April 2015, which is likely to result in a different cost sharing agreement and will require greater financial commitment from the County which could increase the County’s cost by $4 million/year.

7. Infrastructure needs of $270 million will require that funds be committed to reducing this massive backlog.

8. We are already aware of a number of Department Shortfalls expected in the current 2014/15 fiscal year:
   a. Sheriff – COPS Grant requires $1 M match
   b. Probation (Title IV-E cuts - $2.4 to $4 M)
   c. Employment & Human Services $1 M
   d. Mental health (Laura’s Law costs - $45K per case @ 45 cases = $2 M)
   e. Health Services Department as much as $20 M shortfall

9. None of us wish to return to the difficult period of the Great Recession when we were cutting wages, cutting programs, facing layoffs and furloughs.