

**Preliminary Analysis of Sutter's 2008 Revised  
Business Plan  
July 14, 2009**



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and  
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# Table of Contents

	<b>Page</b>
<b>I. Executive Summary</b>	<b>3</b>
<b>II. Introduction, Current Environment</b>	<b>8</b>
<b>III. Delivery System Variables</b>	<b>12</b>
<b>IV. Quality, Cost and Access: Evaluating the Business Plan</b>	<b>16</b>
<b>V. Detailed Hospital Capacity Analysis</b>	<b>19</b>
<b>VI. Services and Program Issues</b>	<b>32</b>
<b>VII. Summary Conclusion</b>	<b>38</b>
<b>VIII. Excerpts From the Health Care Access Agreement (HCAA)</b>	<b>39</b>
<b>IX. Glossary of Terms</b>	<b>41</b>

## **I. EXECUTIVE SUMMARY**

This report presents the Sonoma County Department of Health Services' findings and analysis of Sutter Medical Center of Santa Rosa's revised Business Plan. In accordance with the existing Health Care Access Agreement (HCAA) executed in 1996, Sutter was required to develop a business plan addressing seismic safety. Current law requires that the existing Chanate Hospital facility must be retrofitted or replaced or closed by 2013. Sutter determined that building a new hospital was the preferable option and in 2004 requested that the Board of Supervisors approve a Business Plan providing for construction of a 118 bed hospital at the Wells Fargo Center for the Arts site in Santa Rosa. Although the Board of Supervisors approved the original request, the land use approval process was not completed and this facility was never built. On November 20, 2008 Sutter submitted a revised Business Plan that reflects changes in the local health care environment that have occurred since 2004 and proposes to construct a smaller 70 bed hospital located at the same Wells Fargo site. The construction project is under a tight timeline; under existing law, if construction does not start before December 31, 2010, Sutter could be required to close the existing facility until the new hospital is completed.

The proposed new 70 bed hospital includes 20 medical/surgical beds, 30 obstetrical/perinatal beds, 12 neonatal intensive care unit beds, 8 ICU beds, 12 Emergency Department treatment bays and 16 universal care stations. The new hospital would not provide cardiac surgery or other invasive cardiac treatment. A potential 29-bed expansion is also part of the design, and could be built if needed in the future and financially feasible. The expansion would have 10 medical/surgical beds, 12 obstetrical/perinatal, 3 NICU, and 4 ICU beds, along with 4 ED bays. Although not part of the revised Business Plan, Sutter also plans to build a medical office building and a second small hospital, known as the Physicians Medical Center (or PMC) on the same site. If built, the PMC would be separately owned and would be a joint venture between Sutter and local physicians including the Sutter Medical Foundation. It would focus on cardiac and other surgical services and would not have an emergency department.

The Health Care Access Agreement (HCAA) between Sutter and the County requires the Business Plan to comply with certain requirements. It does not, however, require Sutter to maintain any particular number of beds, or resolve community capacity issues, but only to maintain the specified services and provide access to them for the uninsured and people on government funded programs including Medicare, Medi-Cal, County Medical Services Program (CMSP) and successor programs. In addition to providing the specific hospital services identified in the HCAA, and complying with legal requirements and medical standards, Sutter must ensure that the new site and facilities will:

- *be located in an area and designed in such a manner as to provide equal or better access to County Residents enrolled in government funded programs such as those described in Section 10.4 [Medi-Cal, Medicare, CMSP, CCS, uninsured];*

- *be generally consistent with prevailing community standards governing the provision of health care services;*
- *comply with all licensing and regulatory requirements applicable to such new facilities;*
- *reduce overall costs of health care;*
- *provide an equal or better level of quality of Services than [was] being provided at the Premises(i.e., the Chanate Rd. campus);*
- *allow Sutter to otherwise meet all the terms and conditions of the Agreement....; .*
- *allow Sutter to maintain accreditation from the Joint Commission ....*

This report analyzes Sutter’s proposed revised Business Plan relative to the current HCAA and the specific criteria for a replacement hospital at a new site. The analysis considers the health care environment and health care delivery system that will be the context for and interact with the proposed new facility.

**Current Health Care Environment:** Sutter’s revised Business Plan comes at a time of rapid change and uncertainty in the health care environment. The economic downturn is adding to the number of uninsured and increasing the number of individuals seeking care from community clinics and other safety-net providers. In some communities, hospital emergency departments remain the only “open door” for care to the underinsured. This increasing burden is reducing hospital revenues across the state. Some hospitals have closed; many are posting losses and reconsidering which services they can afford to offer. State seismic safety laws require that many California hospitals be retrofitted or rebuilt, some as early as 2013. While state timelines could change, the 2013 deadline applies to the existing Sutter Medical Center of Santa Rosa, located on Chanate Road in Santa Rosa. Support for health care reform is at an all time high, and could eventually increase demand and revenues for health services. Membership in Kaiser continues to grow, reducing the pool of Medicare and privately insured individuals utilizing private sector physicians and other hospitals in the County. Sonoma County plans the transition of 47,000 Medi-Cal enrollees from the state operated fee-for- service program to a regional Medi-Cal managed care model operated by Partnership HealthPlan of California (PHC)<sup>4</sup> by fall 2009. This change is expected to improve access and the quality of services provided to Medi-Cal beneficiaries and reduce unnecessary hospitalizations and emergency department use for Medi-Cal beneficiaries.

The Sonoma County Department of Health Services has conducted a detailed analysis of the business plan provided by Sutter to build a replacement hospital at a new location. The Department’s analysis looks not only at whether Sutter could comply with the HCAA through this proposal, but also at the possible effects on overall hospital capacity and health needs in

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<sup>4</sup> Partnership is a public authority that currently manages the care for all Medi-Cal beneficiaries in Solano, Napa, and Yolo counties and plans to expand to Sonoma, Marin Lake and Mendocino counties. [www.partnershiphp.org](http://www.partnershiphp.org)

Sonoma County. The Department engaged Elinor Hall (of Health Policy and Management Consulting) to assist with the analysis and Deloitte Financial Advisory Services to develop projections for the future demand for acute hospital services. The Department also solicited comments from the public and key stakeholders through a series of public meetings and incorporated this input into the analysis. The key findings of this process are summarized below:

**Findings:**

1. Access: The proposed Wells Fargo site provides equal or better geographic access to hospital services compared to the current facility located on Chanate Road in a residential section of east Santa Rosa. The Wells Fargo location is adjacent to the freeway providing easier access by car and ambulance and is also close to city bus routes. The proposed new medical complex includes hospital services, a physician office complex, outpatient surgery capacity and diagnostic services.
2. Quality: The new hospital will contain modern technology and equipment. Single occupancy patient rooms will reduce hospital infections, increase operational efficiency and improve patient privacy. The new facility will comply with all licensing and regulatory requirements, and will be ADA compliant, earthquake safe and energy efficient.
3. Cost Reduction: The proposed facility is significantly smaller and more cost-effective than the Chanate structure. The new smaller campus will be more efficient and reflective of modern practice of medicine. The current facility and configuration of services is not financially sustainable.
4. Hospital Capacity: As noted above, the Health Care Access Agreement doesn't require Sutter to have any particular number of beds, but it does require Sutter to provide equal or better access to a full range of services for government insured and uninsured residents. The Department elected to analyze Sutter's proposal from a perspective of community health needs as well as compliance with the HCAA. Projections for future hospital services demand (created in this case by Deloitte Financial Advisory Services) are complex and subject to unpredictable factors and unforeseen changes over time. Deloitte's analysis shows that if Sutter builds a 70-bed hospital, 29-bed expansion and 28-bed PMC, Sutter will likely have adequate capacity to provide services to its current market share (trended forward) including uninsured patients and those in government funded programs.

However, if only the 70-bed hospital were built, Deloitte's analysis of Sutter's proposed 70 bed hospital indicates that the new Hospital will likely operate at full capacity upon opening (estimated for mid-2013) with a growing shortfall of licensed beds, ranging

from 16 beds in 2014 to 29 beds in 2021, indicating that the potential 29-bed expansion may be needed. Deloitte's service specific analysis found that there will likely be more than enough perinatal beds and NICU beds and there will likely be too few medical/surgical and ICU beds. Without the expansion or other methods to reduce preventable hospitalizations, the size of the facility and the division of the beds by services will likely require some of Sutter's existing med-surg and ICU patient share to be redistributed to other area hospitals.

Sutter's planned construction of the PMC and/or possible 29 bed expansion of the 70 bed hospital would likely provide adequate capacity to address the projected shortfalls and the Sutter Hospital would have adequate capacity to accommodate its current market share of patients, trended forward.

Deloitte's projections are based on numerous supply and demand assumptions that are subject to change over time. Changes in the supply of beds could occur if Sutter constructs the 28 bed PMC hospital or the 29 bed expansion to the 70 bed hospital or if other hospitals change their services or add beds. For example, Santa Rosa Memorial could construct its planned 12 bed ICU expansion (which currently is on hold). If Kaiser continues its historic growth pattern, the demand for hospital beds outside the Kaiser system could decrease. Or, demand could increase with the adoption of national health care reform.

Due to the uncertainty of hospital capacity and demand projections, the County will monitor capacity at the new Sutter facility over the term of the HCAA to assure that the requirements of the HCAA continue to be met, particularly the requirement that Sutter provide equal or better access to uninsured and government funded patients in the new facility.

5. Other Criteria Contained in the HCAA: The proposed Business Plan was reviewed for compliance with other HCAA requirements, including the provision of outpatient services, charity care, and academic training of resident physicians among others. Sutter could comply with the HCAA through this Business Plan and the County will continue to monitor the Hospital over the life of the Health Care Assess Agreement. If the PMC is built, Sutter has agreed that it will be subject to Sutter Health's charity care policy, thus enhancing access to care for low-income and uninsured patients.
6. Long-term Commitment: Construction of the new hospital (estimated at \$176 million) represents a long-term investment by Sutter in the local health care delivery system. This investment will help stimulate the local economy at a critical time and on-going operation of the facility will insure availability of important services to local residents. Although not part of the Business Plan, the proposed medical office building and Physicians Medical Center would be additional significant construction projects.

**Conclusions:**

The revised Business Plan for relocation of the hospital and construction of a modern seismically safe hospital provides several important advantages to the community. A comprehensive medical campus offering hospital, diagnostic and outpatient physician services in a single location would offer convenience and efficiencies. The proposed new hospital will employ modern environmentally sound construction and will incorporate new technology that will support improved quality of care. The new proposed facility will be more financially sustainable over the long-term than the current configuration of services.

The Health Care Access Agreement does not require Sutter to maintain any particular number of beds, but it is required to provide access to its services for persons enrolled in government programs and for the uninsured. The Department's detailed analysis of capacity finds that the proposed hospital is sized to meet Sutter's current average daily census (less invasive cardiac patients), however growth projections suggest that Sutter's ability to accommodate its existing market share trended into the future may be difficult, especially for medical/surgical and ICU services if the PMC and/or 29 bed expansion are not completed. In the absence of other factors mitigating demand, some of Sutter's current market share of medical/surgical and ICU days may have to be absorbed by other hospitals or additional beds constructed to meet demand.

The Department concludes that Sutter could continue to comply with the HCAA through this Business Plan as long as Sutter provides equal or better access to government funded and uninsured patients.

Access results from many factors acting together. Providing genuine access at the new hospital may require a variety of efforts including building additional beds (if Deloitte's bed demand projections prove true over time), insuring access to primary and medically necessary specialty care; reducing preventable hospitalizations and supporting other programs that improve quality and access to care. The County will continue to monitor Sutter's performance and hospital capacity throughout the term of the HCAA to assure that all terms and conditions continue to be met.

# Preliminary Analysis of Sutter's Proposed Business Plan

## II. Introduction and Current Environment

Sutter Medical Center of Santa Rosa (Sutter) has requested that the Sonoma County Board of Supervisors approve a revised Business Plan pursuant to the 1996 Health Care Access Agreement (HCAA) between Sutter and the County. Sutter's revised Business Plan, with a 70-bed hospital at the Wells Fargo Center for the Arts site rather than a previously proposed 118 bed facility, has generated a great deal of community interest. While mindful of its obligation to assure care for the medically indigent (pursuant to California Welfare and Institutions Code section 17000), the Board is limited in its legal and practical ability to work serious change in the intensely competitive hospital marketplace through this approval/disapproval process. The Health Care Access Agreement only applies to some aspects of the operations of a single hospital, and if services are relocated from the current Sutter site at Chanate, the HCAA requires that the Business Plan comply with certain additional requirements. It does not require Sutter to resolve the many concerns identified in the health care system. According to the HCAA, in addition to providing certain hospital services and complying with legal and medical standards, Sutter must ensure that the new site and facilities will:

- *be located in an area and designed in such a manner as to provide equal or better access to County Residents enrolled in government funded programs such as those described in Section 10.4 [e.g. Medi-Cal, Medicare, CMSP, CCS, uninsured];*
- *be generally consistent with prevailing community standards governing the provision of health care services;*
- *comply with all licensing and regulatory requirements applicable to such new facilities;*
- *reduce overall costs of health care;*
- *provide an equal or better level of quality of Services than [was] being provided at the Premises(i.e., the Chanate Rd. campus);*
- *allow Sutter to otherwise meet all the terms and conditions of the Agreement.....;*
- *allow Sutter to maintain accreditation from the Joint Commission ....*

The health care delivery system in California is in a period of rapid change; many factors are impacting the demand for health services and the economics of providing care and local health care providers are responding rapidly. Drivers of change include:

**More Uninsured:** There are more uninsured people as businesses reduce coverage and lay off workers. The California Hospital Association (CHA) reports there has been a 73% increase in consumers having difficulty paying out-of-pocket health care costs, and a 33% increase in

uninsured patients visiting the ER.<sup>5</sup> A recent Kaiser Commission Report on Medicaid and the Uninsured reports that for every one percent increase in unemployment, another 1.1 million people nationwide become uninsured. More uninsured patients result in an increased use of ED services, sicker patients and a need for more charity care, which further strains the safety net system.

**Changing Demand:** Hospitals around the state are experiencing decreased utilization of non-emergency services and are receiving less revenue. The California Hospital Association's recent survey showed a 30% decrease in elective procedures which was characterized as "one of the few areas that provide hospitals an opportunity for revenue growth."<sup>6</sup> Sutter's med/surg utilization has gone from an average of 57 patients per day in 2005 to 41 patients per day in 2008.<sup>7</sup> Sutter's decreases may have been accelerated by its 2007 closure plan but economic factors are also affecting its census.

Reduced demand for hospital services will likely be temporary; over time, population growth, the aging of the population and health care reform will eventually lead to increased demand for hospital services. The California HealthCare Foundation study, "Beds for Boomers: Will Hospitals Have Enough?" projects a 76% increase in the need for hospital days in California between 2000 and 2030; most of that increase is due to the increased number of people who will be over age 65.<sup>8</sup> In Sonoma County, the 60 to 79 year old age group is the fastest growing sector of the population and is projected to increase 58% between 2007 and 2021<sup>9</sup>. At the same time, the Hispanic population is projected to grow from 22% of the population in 2007 to 32% in 2021. Both of these demographic changes are expected to impact volume and scope of future hospital services.

**State and local health budget cuts:** State Medi-Cal payments to hospitals and physicians were cut 10% last year resulting in millions of dollars of lost revenue for local hospitals, including \$10 million dollars of revenue for Sutter.<sup>10</sup> The 2009-2010 State budget is anticipated to contain many reductions to publicly funded health programs.

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<sup>5</sup> California Hospital Association, "A Report on California Hospitals and the Economy," January 2009, page 2

<sup>6</sup> California Hospital Association, "A Report on California Hospital s and the Economy" January 2009, p 2.

<sup>7</sup> Data provided to the County by Sutter

<sup>8</sup> Though representing only 18% of the population, adults over age 65 will use 51% of the hospital days in 2030. Although the days per 1000 seniors have been declining, aging of the population will have a dramatic impact on demand. California HealthCare Foundation, "Beds for Boomers: Will Hospitals Have Enough?" 2008 [www.chcf.org/documents/hospitals/SnapshotBedsBoomers.pdf](http://www.chcf.org/documents/hospitals/SnapshotBedsBoomers.pdf)

<sup>9</sup> California Department of Finance, Demographic Projections

<sup>10</sup> [www.suttersantarosa.org/relations/New Hospital Plan Submitted - Press Release 112008.pdf](http://www.suttersantarosa.org/relations/New%20Hospital%20Plan%20Submitted%20-%20Press%20Release%20112008.pdf)

**Kaiser continues to compete:** Kaiser continues to be a strong competitor in Sonoma County experiencing steady growth over the past 29 years. Current estimates indicate that almost half of all privately insured patients are members of Kaiser. Kaiser's dramatic growth has had a significant economic effect on the health care delivery system, reducing the number of privately insured and Medicare patients available for private sector physicians and hospitals. Kaiser's construction project in Santa Rosa remains on track with 56 new beds and 17 additional ED bays scheduled to open in 2010. However, the Kaiser system is also being affected by the rising unemployment rate and the resulting loss of health coverage. Kaiser has suspended several new construction projects in Northern California due to the economic downturn, including a new hospital in Vacaville that was scheduled to open in 2013.<sup>11</sup>

**The importance of primary care is being recognized:** Health plans, employers and health policy experts are recognizing that increased access to outpatient primary care improves health outcomes and controls costs (partly through reductions in preventable hospitalizations and ED use).<sup>12</sup> If and when access to primary care is increased, the volume of hospital services required will decrease while the intensity and acuity will increase.

**Health care reform is coming:** Political and public will to reform health care is growing; increased coverage through public programs, insurance reform, increased funding for outpatient care, restrictions on "unproven" care and new criteria for non-profit status for health system entities may be in the wings. Efforts to expand coverage will likely increase demand for services, at least initially, as demonstrated by the state of Massachusetts and other early reform projects.

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<sup>11</sup> New article from the Vacaville Reporter, November 7, 2008

<sup>12</sup> Mass General Hospital, Stoeckle Center for Primary Care Innovation, "Primary Care: A Miracle of Modern Medicine," [www.massgeneral.org/stoecklecenter/assets/pdf/brochure\\_miracle.pdf](http://www.massgeneral.org/stoecklecenter/assets/pdf/brochure_miracle.pdf)

### **III. Delivery System Variables**

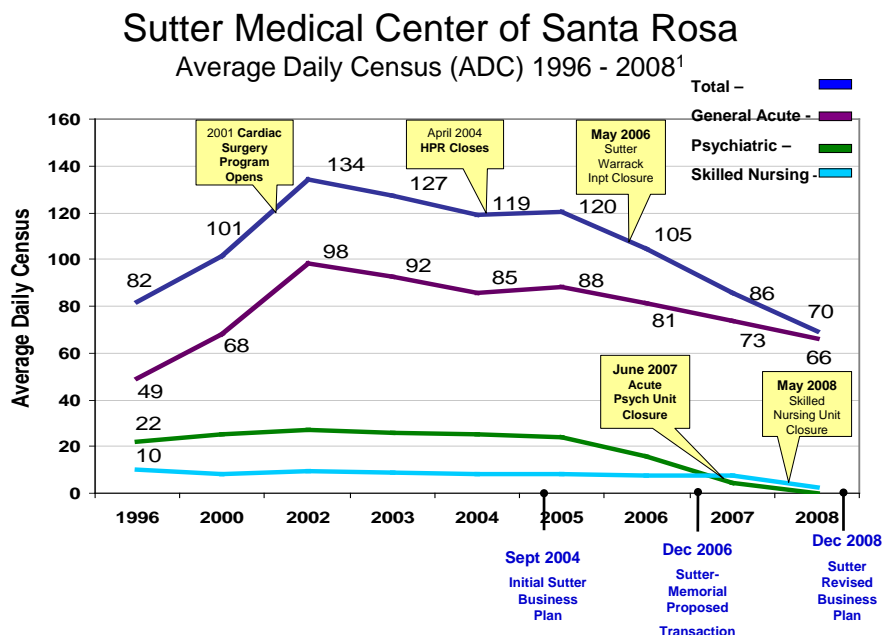
In addition to the dynamic health care environment in general, there are a number of specific variables related to Sonoma County health care delivery systems that influence an analysis of Sutter's revised Business Plan. These variables result in multiple potentially valid, but different assumptions regarding future bed demand and service needs. Some of these unknowns may be resolved in the near future but others will take years to unfold. The many variables in the environment make it difficult to plan far into the future and also make it clear that it would be shortsighted to plan merely by looking at the recent past.

Sutter's bed demand projections and the County's (provided by Deloitte) relied on some assumptions that were different, but reasonable. Sutter assumed an average length of stay that was relatively flat projected into the future; Deloitte assumed a trend toward an increasing length of stay. Both studies considered increased and decreased demand by demographics; the Deloitte analysis also considered future impacts of chronic disease which Sutter did not; Sutter also considered effects of emerging medical technologies, which Deloitte did not.

Specific variables that impact the County's evaluation of Sutter's proposed revised Business Plan include:

- The census at the Sutter Medical Center of Santa Rosa has shown a steep decline in the past three years. At the time the hospital transitioned from County operation to Sutter in 1996, the average acute census (not including acute psychiatric and long term care) was 49 patients. Sutter's acute census grew to a high of 98 in 2002 and by 2008 had fallen 32% to an average of 66 patients a day. Sutter's figures for 2009 (January through May) show an average daily census of 63 patients. It is uncertain if this decline will continue or when the census will stabilize. Deloitte's projected bed demand analysis is based on the 2007 OSHPD (Office of Statewide Health Planning and Development) data, the most recent public data available for all Sonoma County hospitals.

**Chart 1. Sutter Hospital – General Acute Patient Census 1996 - 2008**



<sup>1</sup>. Includes Sutter Warrack Utilization Information  
Source: OSHPD Annual Hospital Report, Utilization Reports (2002- 2007) and Sutter Medical Center of Santa Rosa data for 2008

- Sutter’s proposed private Physicians Medical Center (PMC) may or may not be constructed, but if it is, Sutter has confirmed that it will be subject to the charity care requirements of the HCAA. Additionally, the Sutter Medical Foundation (a Sutter medical group) is a non-profit organization and has its own charity care requirement (which is not the case for all private practitioners). This carries forward the current situation at the Chanate hospital under the HCAA, but it is a positive development toward better access to care that is not driven by the Health Care Access Agreement. A key difference between the PMC and the proposed 70-bed replacement hospital is that the PMC will not have an emergency room, which can be the route to health care services for patients without a regular source of primary or specialty care. Sutter is currently seeking physician investment for the PMC and had hoped to announce its plans in May ’09; however given the difficult economic environment, a final decision on the PMC may be delayed. The PMC, which would include 24 med/ surg beds, 4 ICU beds, 30 universal care stations and 8 operating rooms, would increase capacity in the county.
- Partnership HealthPlan of California (PHC) expects to begin operating a Medi-Cal managed care program in Sonoma County by fall of 2009. PHC will serve approximately 47,000 County residents and is expected to reduce Medi-Cal demand for ED visits and

inpatient days at all hospitals by improving access to primary care services.<sup>13</sup> After managed care is implemented, hospitals and physicians must contract with PHC in order to be reimbursed for serving non-emergency Medi-Cal patients. Sutter Medical Center of Santa Rosa and the Sutter Medical Foundation's willingness to contract to provide care for Medi-Cal patients will be important to PHC's success.

- At some point in the future, Memorial Hospital could revive prior plans to double its ED capacity and to build 12 new ICU beds. Memorial could also make other changes to the services it now provides by adding or eliminating services, programs and beds.
- The District Hospitals could change their beds and services or one or more of these hospitals could even close during the term of the HCAA. In 2007, three of the four District Hospitals lost over \$5 million in total with only Healdsburg Hospital showing a positive net margin. District hospitals are important providers of geographically accessible health care in their respective communities. In 2007, an average of 68 acute patients per day were hospitalized in the District hospitals (18% of total hospital days in the County) compared to 306 acute patients per day hospitalized at Kaiser, Memorial and Sutter Hospitals.<sup>14</sup>
- Sutter's proposed projects must receive local land use approval (including the completion of environmental review under CEQA, through preparation of an EIR) and approval of the detailed architectural plans by the Office of Statewide Health Policy and Development (OSHPD), as well as other land use entitlements. During the EIR process, other alternatives will be identified; feasible alternatives can be evaluated by the Department as directed by the Board of Supervisors. The estimated opening date of the new hospital(s) described in Sutter's application to the County's Permit and Resource Management Department is still more than three years away (mid-2013). During the interval between potential approval of the Business Plan and opening a new Hospital, the health care environment and delivery system will continue to evolve.
- State seismic safety regulations require approximately 120 hospitals in California to be compliant with new regulations by 2013. Sutter Medical Center of Santa Rosa falls into the category of facilities (SPC-1) required to meet seismic requirements by 2013. Many hospitals throughout the state are struggling to plan and finance the renovations needed to meet these regulations. State legislators have extended the deadline for compliance in the past and there is the possibility that the 2013 deadline could also be

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<sup>13</sup> These anticipated reductions in demand are not included in the projected need for beds and ED visits since Medi-Cal managed care has not yet been implemented.

<sup>14</sup> Per OSHPD reports, the District hospitals provided 24,852 acute days in 2007 (or 18% of total acute days). The three Santa Rosa Hospitals provided 111,558 days or 82% of all countywide acute days (acute days include med/surg, ICU and perinatal services but not hospital skilled nursing days).

extended. Sutter is committed to continued coordination with the Sonoma County Permit and Resource Management Department (PRMD) to complete the CEQA review, with a goal of bringing the replacement hospital project and any feasible alternatives, including a “no project” alternative, to the Board of Supervisors in 2010.

- Sutter is under a tight timeline for completion of the planning, environmental review and construction phases of the project. If the timelines for seismic compliance are not extended by Sutter’s compliance with AB 1661, a replacement hospital would have to be finished by the end of 2012.

## **IV. Quality, Cost and Access: Evaluating the Business Plan**

### **OVERVIEW:**

Section 10.11.3 of the HCAA deals specifically with the Business Plan and includes requirements (cited in the Executive Summary and in Section I) that deal with cost, quality and access. This section of the Analysis addresses the key HCAA requirements for the Business Plan and evaluates whether the proposed new facility would meet those requirements.

**Quality of Care:** The proposed new hospital will be a great improvement over the existing facility at Chanate, where the inpatient wing dates from 1972. The new hospital will provide an equal or better quality of services in comparison to the existing, inefficient facility. The proposed new hospital will provide all single occupancy rooms, allowing patients more privacy and reducing risk of infection.<sup>15</sup> The services will be arranged so that care can be delivered more effectively. The hospital will contain the latest new equipment and technology for treating and monitoring patients.

**Cost of Care:** The HCAA requirement that a new hospital reduce the overall cost of healthcare is paradoxical and difficult to measure. New hospital construction is expensive, costing between \$2 and \$3 million per bed.<sup>16</sup> Sutter estimates the proposed 70 bed hospital will cost \$176 million. After several years of 18% increases, Hospital construction costs have recently begun declining due to the economic downturn and reductions in the cost of steel and other raw materials;<sup>17</sup> however, the cost of securing financing is increasing. In 2007, Rand issued a study estimating that the construction costs of complying with California seismic regulations would add between \$250 and \$950 per day to the cost of hospital care and that the added cost of financing could potentially double that amount.<sup>18</sup> As result of high construction costs, hospitals pursuing new construction projects, carefully analyze size and efficiency – looking for the most cost- effective structure and the configuration of services to best meet customer demand. Hospitals often increase the number and scope of services provided in separate lower-cost outpatient structures and minimize the size of the higher cost inpatient facility. Co-locating physician offices, outpatient surgery, pharmacy, lab and other related services on a

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<sup>15</sup> The Center for Health Design, “A Review of the Research Literature on Evidence-Based Healthcare Design, “Reducing Multiroute Transmission by Means of Single-Bed Rooms and Increased Isolation” pg 16  
[www.healthdesign.org/hcleader/HCLLeader\\_5\\_LitReviewWP.pdf](http://www.healthdesign.org/hcleader/HCLLeader_5_LitReviewWP.pdf)

<sup>16</sup> [www.bizjournals.com/sanfrancisco/stories/2009/03/02/story9.html?q=cost%20of%20hospital%20construction%20in%20California](http://www.bizjournals.com/sanfrancisco/stories/2009/03/02/story9.html?q=cost%20of%20hospital%20construction%20in%20California)

<sup>17</sup> [www.bizjournals.com/sanfrancisco/stories/2009/02/09/story6.html?b=1234155600^1774288](http://www.bizjournals.com/sanfrancisco/stories/2009/02/09/story6.html?b=1234155600^1774288)

<sup>18</sup> [www.chcf.org/documents/hospitals/SB1953IssueBrief.pdf](http://www.chcf.org/documents/hospitals/SB1953IssueBrief.pdf)

single campus makes economic sense and is also more efficient and convenient for physicians and patients.

Sutter has been working to complete plans and construction of a replacement hospital in Sonoma County for several years. The initial 2004 Business Plan calling for a 118 bed hospital was not pursued because of the poor financial performance of the hospital and its continued losses. Were it not for the HCAA with the County, Sutter would likely have closed the Chanate hospital some time ago. The hospital has generated losses in the past five years in excess of \$46 million dollars.

The smaller 70 bed hospital, physician office complex, outpatient surgery services and PMC are Sutter's new design to create a more financially sustainable and cost-effective medical campus. The hospital is sized to operate at full capacity immediately with a potential to add 29 beds in the future for a total of 99 beds. All rooms will be single occupancy in contrast to the current facility which has all double occupancy rooms. The facility includes a 16 bed universal care unit, an innovative approach to providing care for patients requiring observation or post-surgical services. The universal care unit will allow more efficient use of the inpatient beds but is not a substitute for licensed beds.

**Access to Care, Geographic:** The HCAA requires that the new hospital "be located in an area and designed in such a manner as to provide equal or better access to County residents enrolled in government funded programs." The HCAA criteria do not call for the hospital to be optimally located for government-sponsored patients, just that the location be equal or better than the current location. The current location at Chanate is far from ideal; low-income patients are not particularly concentrated around the current facility which is located in a residential neighborhood several miles off the freeway. There are numerous stop lights and stop signs between the freeway exit and the hospital. The bus stop at the hospital is located across a busy road with fast moving traffic which makes access for people with disabilities and/or small children more difficult.

Southwest Community Health Center, the largest community clinic in the County, currently provides outpatient services across from Sutter on Chanate Road. However, Southwest is in the process of moving these outpatient services to a new as yet undetermined location in Santa Rosa. Once the outpatient services have been re-located, the existing Chanate facility would be even less convenient for low-income patients.

The proposed Wells Fargo site for the new hospital is near a freeway exit which will provide easier access for ambulances and other traffic approaching from Highway 101. The plans call for construction of an additional exit lane to be used by emergency vehicles only. One of the fastest growing areas of the County is north of Santa Rosa. People living in Windsor, and in communities in Mendocino and Lake Counties, will find the new site easier to reach than the Chanate facility.

A review of the bus schedule for Roseland area, a low income neighborhood of Santa Rosa where the main Southwest Community Health Center clinic is located, shows that a trip to the Sutter Chanate campus takes 45 minutes. From the same location, a bus trip to Old Redwood Highway/Mark West Springs Road near the Wells Fargo Center takes 34 minutes. It is likely that transit lines and stops will be adjusted to improve service to the Wells Fargo site if more bus riders want to go there.

In summary, it appears that the new facility will “be located in an area” that will provide equal or better access (from a geographic standpoint) to county residents enrolled in government funded programs as required in the HCAA.

**Access to Care, Hospital Beds and Services:** While the HCAA does not require a specific number of beds, the criteria requires that it be “*designed in such a manner as to provide equal or better access to County Residents enrolled in government funded programs such as those defined in Section 10.4.*”[e.g. Medi-Cal, Medicare, CMSP, CCS, CHDP, Medi-Cal managed care and uninsured]. A standard approach to projecting demand is to calculate the beds that would be needed to serve the hospital’s existing patient population trended into the future. The “future” could be the day the new Hospital opens, the end date for the HCAA or some time in between. The County selected 2014, shortly after the new Hospital opens, as its measuring point. The HCAA will be in effect until 2021 and over the long term, the market place should respond to the need for beds.

A detailed analysis of hospital capacity issues is presented in the next Section of this document.

## **V. Detailed Hospital Capacity Analysis**

The Health Care Access Agreement does not require Sutter to maintain any particular number of beds, but it is required to provide access to its services for persons enrolled in government programs and the uninsured. Access is the result of a variety of interactive factors, including geographic accessibility, bed capacity in the needed services and physicians on staff to admit and treat patients who need care. The Department conducted a detailed analysis of the proposed replacement hospital to determine its capacity to provide care for Sutter's existing market share of patients, trended forward, including privately insured patients, government funded patients and those with no insurance coverage. The Department also assessed the future need for total hospital beds throughout the County through the end of the HCAA in 2021. The County engaged Deloitte Financial Advisory Services to develop these future bed need projections.

Projections for future bed needs are complex and subject to factors that are not foreseen, or that cannot be fully quantified. Even as this analysis was being undertaken, the County and nation have experienced an unprecedented economic downturn, with rippling effects throughout healthcare. Hospital admissions have recently declined for reasons that are not well understood but which may be related to rising unemployment. Credit has tightened, and many hospitals are unable to obtain financing for planned expansions and other projects. The effects of current and future developments in healthcare technology can't be quantified based on existing data. Some innovations may result in fewer hospitalizations, as procedures that now require hospitalization may be done on an outpatient basis in the future. Laparoscopic surgery is an example of such a technological advance. Other innovations may offer hospital treatment for conditions that are not now treatable through hospitalization. Some innovations may not affect hospitalization rates at all but will improve outcomes. Still others may simply improve a hospital's ability to use its resources more efficiently. Sutter believes its use of universal care stations may prove to be such an innovation, but the impact can't be quantified at this time, because there is as yet no data. The bed need projections developed by Deloitte, with assistance from the Department, are best estimates of future need given the information known today, but are nevertheless subject to change.

### **Sutter Hospital Capacity**

Sutter is currently licensed for 135 general acute care beds and 15 ED bays, but its average daily acute census for 2008 was only 66 patients. The proposed new hospital at the Wells Fargo site will have 70 acute care beds and 12 ED bays as well as 16 universal care stations. Table 1 shows

the number of licensed hospital beds at the Sutter hospital in 1996, current beds and proposed beds in the first Business Plan (2004) and the revised Business Plan (2008).

**Table 1. Past, Current and Proposed Licensed Hospital Beds at Sutter Hospital**

<b>Summary of Sutter Hospital Licensed Beds</b>				
<b>Acute Hospital Services</b>	<b>Community Hospital 1996</b>	<b>Sutter Medical Ctr. (Current)</b>	<b>2004 Business Plan</b>	<b>2008 Business Plan Proposal</b>
<b>Med Surg Beds</b>	85	91	NA	20
<b>ICU</b>	16	16	NA	8
<b>Perinatal</b>	18	18	NA	30
<b>NICU</b>	10	10	NA	12
<b>Psychiatric &amp; SNF Beds</b>	46	0	NA	0
<b>TOTAL BEDS</b>	<b>175</b>	<b>135</b>	<b>118</b>	<b>70</b>
<b>Universal Care Unit</b>	<b>0</b>	<b>0</b>	<b>NA</b>	<b>16</b>
<b>ED Bays</b>	<b>NA</b>	<b>15</b>	<b>22</b>	<b>12</b>

Capacity Assessment of Sutter’s Proposed 70 Bed Hospital

Both Sutter and the County hired expert consultants to develop bed need projections through 2021 for the Sutter replacement hospital. Cattaneo and Stroud developed bed demand projections for Sutter. The County engaged Deloitte Financial Advisory Services to analyze the need for hospital beds now and into the future for both the Sutter hospital and for overall County requirements. Both Sutter and the County started with Sutter’s inpatient census and ED visits in 2007, the latest publicly reported data available.<sup>19</sup> The studies assumed that there would be no market share shifts among the hospitals and made additional assumptions regarding County population growth and changes in the age distribution, ethnic composition and health status of the population. Further assumptions were made regarding changes in length of stay, the impact of technology and the health status of the population in the future.<sup>20</sup> Finally the analysis compared the number of beds needed to serve Sutter’s existing patient

<sup>19</sup> Publicly-reported hospital data for 2008 for all the hospitals is not yet available, however the County was able to review 2008 and 2009 data for Sutter and validate the general continuation of 2007 patterns.

<sup>20</sup> Sutter projected reduced utilization for technology changes whereas the County did not find any published studies quantifying this. The County projected increased future utilization based on other factors including increasing lengths of stay and the prevalence of obesity.

share trended into the future, with the number of beds that Sutter plans to construct. Sutter’s consultants projected bed demand for 2014 and 2021. The Sutter and Deloitte bed demand projections are summarized in Table 2. below.

**Table 2. Bed Demand Projections by Sutter and by Deloitte** (beds shown in the 2008 Business Plan column exclude the 29 bed expansion and PMC hospital beds)

<b>Bed Demand Projections for Sutter Hospital</b>					
<b>Acute Hospital Services</b>	<b>2008 Business Plan Proposal</b>	<b>Sutter Projected Bed Need 2014</b>	<b>Sutter Projected Bed Need 2021</b>	<b>Deloitte Projected Bed Need 2014</b>	<b>Deloitte Projected Bed Need 2021</b>
<b>Med Surg Beds</b>	20	38	44	53	61
<b>ICU</b>	8	7	8	12	14
<b>Perinatal</b>	30	16	20	14	16
<b>NICU</b>	12	8	9	7	8
<b>TOTAL BEDS</b>	<b>70</b>	<b>69</b>	<b>81</b>	<b>86</b>	<b>99</b>
<b>ED Bays</b>	<b>12</b>	<b>12</b>	<b>12</b>	<b>11</b>	<b>13</b>

Source: Cattaneo & Stroud Sept. 2008 & Deloitte FAS July 2009

Bed Demand Projections:

The overall bed demand projections by Sutter and the County’s consultants are similar, but there are some significant differences that result from differing assumptions made by each consultant. Sutter’s projection indicates a need for 69 total beds in 2014 increasing to 81 in 2021 while the County’s consultant (Deloitte FAS) projects a need for 86 beds, increasing to 99 by 2021. Both Sutter and Deloitte’s bed demand projections were reduced based on discontinuation of invasive cardiac services at the new Sutter hospital (approximately 12 beds in 2014 and 13 beds in 2021). The County’s analysis regarding the proposed hospital’s capacity is contingent on this important assumption and should it change, it would materially impact the conclusions. Table 3 summarizes the difference between the number of beds in the proposed Business Plan and required beds from the Sutter and Deloitte studies.

**Table 3: Difference Between Required Beds and Available Beds for Sutter and Deloitte Bed Need Projections, 2014 and 2021** (figures do not include the 29 bed expansion or PMC hospital beds)

<b>Surplus/Shortfall of Licensed Beds - Compared to Business Plan</b>					
<b>Acute Hospital Services</b>	<b>2008 Business Plan Proposal</b>	<b>Sutter Projected Bed Shortfall/Surplus 2014</b>	<b>Sutter Projected Bed Shortfall/Surplus 2021</b>	<b>Deloitte Projected Bed Shortfall/Surplus 2014</b>	<b>Deloitte Projected Bed Shortfall/Surplus 2021</b>
<b>Med Surg Beds</b>	20	-18	-24	-33	-41
<b>ICU</b>	8	+1	0	-4	-6
<b>Perinatal</b>	30	+14	+10	+16	+14
<b>NICU</b>	12	+4	+3	+5	+4
<b>TOTAL BEDS</b>	<b>70</b>	<b>1</b>	<b>-11</b>	<b>-16</b>	<b>-29</b>
<b>ED Bays</b>	<b>12</b>	<b>0</b>	<b>0</b>	<b>+1</b>	<b>-1</b>

Source: Cattaneo & Stroud Sept. 2008 & Deloitte FAS July 2009

Table 3 further illustrates the difference in bed need projections between Sutter and Deloitte relative to the proposed 70 bed hospital (excluding the 29 bed expansion and the PMC hospital beds).

Sutter’s projections indicate an overall 1 bed surplus in 2014 and an 11 bed shortfall in 2021. If only adult beds are considered, there would be no surplus in 2014. Service specific projections by Sutter show a shortfall of 18 med/surg beds in 2014 and 24 beds in 2021. Sutter plans to flex med/surg patients into the excess perinatal beds to address the shortfall in licensed med/surg beds; but assuming this is feasible, it would still not accommodate all of the projected med/surg demand.

Deloitte uses different assumptions to project bed need resulting in an overall 16 bed shortage in 2014, increasing to a 29 bed shortage in 2021. Service specific projections by Deloitte show a shortfall of 33 to 41 med/surg beds and 4 to 6 ICU beds through 2021.

Deloitte’s analysis of emergency department capacity uses the target rate of 2,439 emergency department visits per bay per year (the 90th percentile of Emergency department visits per bay per year for California hospitals in 2007). Applying this target rate, Deloitte projects one surplus ED bay in 2014 and a shortfall of one bay in 2021. Sutter projects the need for fewer ED bays than Deloitte based on its planned use of the 16 bed universal care unit to more efficiently care for patients needing observation or awaiting diagnostic testing, thereby maximizing the use of ED bays.

The implementation of managed Medi-Cal is expected to reduce ED utilization by Medi-Cal patients by linking every member with a primary care provider. Sutter has historically had a larger proportion of ED visits that are low-to-moderate acuity relative to other local hospitals. For this reason, it is likely that ED demand could be reduced if these patients were more appropriately managed in a primary care or urgent care setting where they could receive the right level of medical attention and be linked to an ongoing source of primary care. PHC is projecting a 50% reduction in Medi-Cal emergency department visits, which translates to an approximate 20% reduction or 4,300 fewer ED visits to Sutter, reducing the required number of ED bays by approximately 2.

Applying either Sutter’s or Deloitte’s bed need projections, the 70 bed hospital would likely operate at full capacity upon opening in 2013 and even using excess perinatal beds for med/surg patients, it would have difficulty accommodating Sutter’s current market share of med/surg patients. In that scenario, it is likely that some of Sutter’s patient share would need to be redistributed to other area hospitals. Over time, as the population grows and the percentage of older adults increases, it is likely that the Sutter hospital will not be able to accommodate its existing market share of patients without construction of the PMC or the proposed 29 bed expansion.

If Sutter completes the full build-out of the Wells Fargo Campus, the campus will provide a total of 127 general acute care beds, 16 ED bays and 46 universal care stations. The 127 beds would provide sufficient capacity to address both the Sutter or Deloitte bed need projections through 2021. Table 4. describes the total beds that would be potentially available at the Wells Fargo campus if Sutter follows through with its plans to construct the PMC and expand the 70-bed hospital by an additional 29 beds.

**Table 4. Wells Fargo Campus – Proposed Hospital Beds**

<b>Wells Fargo Campus - Planned Hospital Beds</b>				
<b>Acute Hospital Services</b>	<b>2008 Business Plan Proposal</b>	<b>Expansion - 29 Beds</b>	<b>Physicians Medical Center</b>	<b>Total Campus</b>
<b>Med Surg Beds</b>	20	10	24	54
<b>ICU</b>	8	4	4	16
<b>Perinatal</b>	30	12	0	42
<b>NICU</b>	12	3	0	15
<b>TOTAL BEDS</b>	<b>70</b>	<b>29</b>	<b>28</b>	<b>127</b>
<b>Universal Care Unit</b>	<b>16</b>	<b>0</b>	<b>30</b>	<b>46</b>
<b>ED Bays</b>	<b>12</b>	<b>4</b>	<b>0</b>	<b>16</b>

Source: Sutter Revised Business Plan, 2008

There are several possible options for addressing the projected shortfall of beds at Sutter.

- If Sutter completes its planned construction of the PMC, providing an additional 24 med/surg beds and 4 ICU beds and if Sutter expands the 70 bed facility by another 29 beds then the two hospitals would likely provide adequate capacity.
- The demand for hospital beds could be less than projected due to a number of factors. Implementation of managed Medi-Cal is expected to reduce Medi-Cal hospital days by 15%, resulting in 3 to 5 fewer patients per day at the Sutter hospital. If Kaiser's strong historical growth patterns continue, its market share could increase, reducing the need for capacity in non-Kaiser hospitals including Sutter.
- A portion of Sutter's existing market share of med/surg and ICU patients could be served at other hospitals in the future. Other area hospitals could change their services or add beds especially over the long term.

### County-Wide Bed Need Projections

The Department requested Deloitte to develop bed need projections for the entire County to assess the potential impact of Sutter's proposed hospital on overall hospital capacity.

Table 5 summarizes the current, proposed and projected bed need for the whole County through 2021.

**Table 5. Current, Proposed and Projected Hospital Bed Need for Sonoma County, 2014 and 2021**

	<b>Current beds 2007</b>	<b>Proposed beds 2013</b>	<b>Needed beds 2014</b>	<b>Needed beds 2021</b>
Acute care:				
Medical/Surgical	498	502	424	467
Perinatal	69	88	54	61
Pediatric	13	13	9	10
ICU	76	78	67	74
NICU	33	35	26	29
Total acute care	689	716	580	641
ED Bays	83	97	61	67

Sources: OSHPD (2008b) for 2007 figures;  
 Based on information County received from Memorial for 2008 and 2009 and from Kaiser for 2010 expected bed count;  
 Sutter Medical Center of Santa Rosa Health Care Access Agreement Background and Business Plan dated 10/20/2008, for Sutter's proposed new facility.

Source: Deloitte FAS, Bed Demand Report, July 2009

In 2013, after the new Sutter Hospital is opened, Deloitte assumes there will be a total of 716 acute care licensed beds in the county, including the Kaiser expansion completed in 2010 but not including the potential PMC beds or 29 bed potential expansions. The Deloitte projections indicate a need for 580 acute beds in 2014 increasing to 641 beds in 2021. This suggests that the total licensed hospital capacity in Sonoma County will be adequate to meet community demand in both 2014 and 2021, even with Sutter’s smaller hospital. Although the total licensed beds may appear adequate, merely looking at the total beds does not provide sufficient detail to determine if the distribution of beds by service is adequate, nor does it address the geographic distribution of beds in relation to demand. The discussion below points out the anticipated constraints on beds by service and the inherent difficulties in assessing and projecting hospital capacity for the county as a whole.

Deloitte developed bed need projections by service for each hospital in the County using target occupancy rates of 85% for med/surg, 80% for ICU and perinatal beds and 70% for NICU. The target use rate for emergency services was 2,439 visits per emergency department bay per year based on the 90<sup>th</sup> percentile of California hospitals in 2007.

This analysis indicates that there is adequate overall licensed capacity for perinatal, pediatrics, NICU beds and emergency services through 2021. However, the ability of med/surg beds and ICU beds to meet future demand, particularly in the Santa Rosa area, may be stressed.

**Table 6. Projected Med/Surg Bed Occupancy Rates for Sonoma County, by Hospital and by Year, 2007 – 2021** (excluding the proposed 29 bed expansion and PMC hospital beds)

	Sutter	Memorial	Kaiser	Healds- burg	Petaluma	Sonoma Valley	Palm Drive	Sonoma County
2007	49.4%	72.4%	86.9%	41.0%	44.4%	25.4%	32.1%	58.8%
2008	50.4%	61.6%	88.8%	41.9%	45.3%	26.0%	32.8%	56.1%
2009	51.5%	62.9%	90.8%	42.8%	46.3%	26.6%	33.5%	57.3%
2010	52.7%	64.3%	60.2%	43.7%	47.3%	27.1%	34.3%	54.6%
2011	53.8%	65.7%	61.5%	44.7%	48.4%	27.7%	35.0%	55.8%
2012	55.0%	67.1%	62.8%	45.7%	49.4%	28.3%	35.8%	65.0%
2013	170.5%	68.6%	64.2%	46.7%	50.5%	29.0%	36.6%	66.5%
2014	174.2%	70.1%	65.6%	47.7%	51.6%	29.6%	37.4%	67.9%
2015	178.0%	71.6%	67.0%	48.7%	52.7%	30.2%	38.2%	69.4%
2016	181.9%	73.2%	68.5%	49.8%	53.9%	30.9%	39.0%	70.9%
2017	185.9%	74.8%	70.0%	50.9%	55.1%	31.6%	39.9%	72.5%
2018	189.9%	76.4%	71.5%	52.0%	56.3%	32.3%	40.7%	74.0%
2019	194.1%	78.1%	73.1%	53.1%	57.5%	33.0%	41.6%	75.7%
2020	198.3%	79.8%	74.7%	54.3%	58.8%	33.7%	42.5%	77.3%
2021	202.7%	81.5%	76.3%	55.5%	60.1%	34.4%	43.5%	79.0%

Source: Deloitte FAS, Bed Demand Report, July 2009

Tables 6 (above) and 7 (below) illustrate the effect of building the 70 bed hospital, without additional beds built by Sutter or other hospitals (except those beds already under construction). The percentages shown for each hospital are the percentage of that hospital's licensed medical/surgical beds needed to fill its projected demand, assuming no changes in market share. Percentages that greatly exceed the target occupancy rate (such as are shown for Sutter beginning in 2013) indicate that patients will have to be seen at other hospitals. They also suggest that additional beds could exacerbate community concerns that there may be an excess of beds in Sonoma County.

Table 6. suggests that med/surg capacity exists, and will continue to exist at other hospitals and county wide, through 2021. The overall occupancy rate for licensed medical/surgical beds in Sonoma County will not exceed the industry standard target occupancy rate of 85% through 2021. Kaiser is currently exceeding this target occupancy slightly and will continue to do so until construction of 39 additional med/surg beds is completed in 2010. Sutter's med/surg occupancy is projected to exceed the target occupancy rate upon opening. However, as previously discussed in this section, Sutter proposes to address this by flexing med/surg patients into excess perinatal beds. This will help meet the demand for med/surg services upon opening provided there are vacant perinatal beds as projected. However, the new hospital will not likely have adequate capacity through 2021 to meet med/surg demand without construction of additional beds either through the 10 bed potential med/surg expansion at the 70 bed hospital or through construction of the PMC which would add 24 med/surg beds. Alternatively, patient demand could be met through a shift in some of Sutter's market share to other hospitals. While challenges exist for redistribution of med/surg patients, the challenges are even greater for redistributing ICU patients.

Table 7. found on page 26 provides similar data for projected ICU bed occupancy rates in Sonoma County

**Table 7. Projected ICU Bed Occupancy Rates for Sonoma County, by Hospital and by Year, 2007 - 2021 (excluding Sutter’s proposed 29 bed expansion and PMC hospital beds).**

	Sutter	Memorial	Kaiser	Healds- burg	Petaluma	Sonoma Valley	Palm Drive	Sonoma County
2007	62.9%	76.2%	63.7%	0.0%	45.9%	33.4%	21.6%	57.2%
2008	64.3%	77.9%	65.1%	0.0%	46.9%	34.2%	22.1%	58.4%
2009	65.7%	79.6%	66.5%	0.0%	47.9%	34.9%	22.6%	59.7%
2010	67.1%	81.3%	34.0%	0.0%	48.9%	35.7%	23.1%	53.9%
2011	68.6%	83.1%	34.7%	0.0%	50.0%	36.4%	23.6%	55.1%
2012	70.1%	84.9%	35.5%	0.0%	51.1%	37.2%	24.1%	56.3%
2013	114.6%	86.8%	36.3%	0.0%	52.2%	38.1%	24.6%	61.9%
2014	117.1%	88.7%	37.1%	0.0%	53.4%	38.9%	25.2%	63.2%
2015	119.6%	90.6%	37.9%	0.0%	54.5%	39.7%	25.7%	64.6%
2016	122.2%	92.6%	38.7%	0.0%	55.7%	40.6%	26.3%	66.0%
2017	124.9%	94.6%	39.5%	0.0%	56.9%	41.5%	26.9%	67.5%
2018	127.6%	96.7%	40.4%	0.0%	58.2%	42.4%	27.5%	68.9%
2019	130.4%	98.8%	41.3%	0.0%	59.5%	43.3%	28.1%	70.4%
2020	133.3%	101.0%	42.2%	0.0%	60.8%	44.3%	28.7%	72.0%
2021	136.2%	103.2%	43.1%	0.0%	62.1%	45.2%	29.3%	73.5%

Source: Deloitte FAS, Bed Demand Report, July 2009

The Deloitte study calculated that the overall occupancy rate for licensed ICU beds in Sonoma County will be below the industry standard 80% target occupancy rate through 2021 with a high occupancy rate of 73.5% in 2021. Both Sutter’s and Memorial’s ICU occupancy rates are projected to exceed the target occupancy rate during the study period. Sutter’s ICU occupancy rate is projected to exceed the target rate upon opening of the new facility in 2013. Memorial’s ICU occupancy is projected to exceed the target rate of 80% in 2010. Memorial has a planned 12 bed ICU expansion currently on-hold. Kaiser shows excess ICU capacity but as a membership based system it would be difficult for non-Kaiser members and physicians to use these beds. Local ICUs may vary in their ability to provide critical care services based on the availability of physician specialty services, capacity of support staff and their geography. Theoretically the seven hospitals combined would be able to absorb all ICU patients, however given the obstacles to efficient and continuous allocation of ICU patients<sup>21</sup> to facilities with spare capacity, Deloitte FAS expects that the collective hospitals in Sonoma County will have trouble accommodating ICU patients toward the end of the projection period in the absence of construction of additional beds by Sutter or other hospitals, or in the absence of other factors

<sup>21</sup>: ICU patients are the most seriously ill patients in a hospital, and should not generally be transferred except to a higher level of care.

that reduce ICU bed demand. The Santa Rosa area would be the most stressed due to occupancy rates over the target rate of 85% at Sutter and Memorial hospitals.

Sutter’s planned construction of the PMC would provide four additional ICU beds, and the expansion plan for the 70 bed hospital could also provide for 4 additional ICU beds. Together these additional beds would provide adequate capacity for Sutter’s projected patient volumes but would not provide sufficient capacity for the greater Santa Rosa area. If Memorial moves forward with their planned 12 bed ICU expansion (currently on hold), these additional ICU beds would also provide adequate capacity for the greater Santa Rosa area. Palm Drive and Healdsburg General hospitals have both recently expanded their ICU capacity, demonstrating the rapidly evolving nature of the health care marketplace.

The County asked Deloitte to project occupancy at the 70 bed replacement hospital with the PMC and the 29 bed expansion and showing the potential effect of the use of 10 perinatal beds for med/surg patients as illustrated in Table 8. below.

**Table 8. Projected Sutter Occupancy Rates with Proposed 29 Bed Expansion and 28 Bed Physician’s Medical Center (PMC)**

	Medical/ Surgical	Perinatal	Pediatric	ICU	NICU	ED bays
2007	49.4%	68.2%		62.9%	61.5%	0.62%
2008	50.4%	69.5%		64.3%	62.7%	0.64%
2009	51.5%	70.7%		65.7%	63.8%	0.65%
2010	52.7%	72.1%		67.1%	65.0%	0.66%
2011	53.8%	73.4%		68.6%	66.2%	0.68%
2012	55.0%	74.7%		70.1%	56.2%	0.69%
2013	94.7%	68.5%		81.8%	57.2%	0.88%
2014	96.8%	69.8%		83.6%	58.3%	0.90%
2015	98.9%	71.1%		85.5%	59.4%	0.92%
2016	85.3%	45.2%		76.4%	48.4%	0.70%
2017	87.1%	46.1%		78.1%	49.3%	0.71%
2018	89.0%	46.9%		79.8%	50.2%	0.73%
2019	91.0%	47.8%		81.5%	51.1%	0.74%
2020	93.0%	48.7%		83.3%	52.0%	0.76%
2021	95.0%	49.6%		85.1%	53.0%	0.77%

Source: Deloitte FAS, Bed Demand Report, July 2009

Table 8 above illustrates the projected occupancy rate of the collective Sutter hospitals if the campus is fully built-out as planned on the Wells Fargo campus. This scenario assumes the 28 bed PMC is constructed in 2012 and the 29 bed expansion of the proposed 70 bed hospital is

added in 2016. This scenario provides for 127 licensed beds: 54 med/surg beds; 16 ICU beds; 42 perinatal beds; 15 NICU beds and 16 ED bays. Table 8. assumes current invasive cardiac services provided by Sutter would continue at the PMC, e.g. invasive cardiac census is included in occupancy projections. If constructed, the proposed beds would provide sufficient capacity for either the Sutter or Deloitte bed need projections through 2021.

### **Impact of Sutter on other hospitals countywide**

If redistribution of some of Sutter's market share of med/surg and ICU patients occurs in the future, what will be the financial impact on other hospitals in Sonoma County? In 2007, 37% of all Sutter's acute inpatient days were charity care and low-income government funded program days (including Medi-Cal and CMSP but not Medicare). Medi-Cal and government funded patient days were heavily concentrated in maternity and infant services with 70% of women and infants and NICU days being government funded and charity care. The payer mix in med/surg and ICU (excluding invasive cardiology) was the opposite: 70% of Sutter's days were commercial insurance and Medicare and only 30% of days were charity care or low-income government funded. Since Sutter's new maternity and NICU services will be more than adequate to handle projected demand, the potential for redistribution exists mainly for med/surg and ICU patients.

Sutter's had an average of 11.7 charity and low-income government funded patients per day<sup>22</sup> in its med/surg and ICU beds in 2007. This equates to 4,270 low-income med/surg and ICU days per year representing 14% of the charity and Medi-Cal days provided countywide.<sup>23</sup>

Sutter's proposed new hospital with 28 beds of med/surg and ICU services would have the capacity to serve its current market share of government and charity patients in the future if those patients could be admitted on a priority basis. However, patients are admitted according to medical need, and it is not possible to predict by payer which patients will be hospitalized at Sutter and which will have to be seen at other facilities.

If the redistributed patients had the same payer mix as currently served in Sutter's med-surg and ICU beds, 70% of those patients would be covered by commercial insurance or Medicare. This is similar to the District Hospital's and Memorial's current payer mix which is 77% commercial and Medicare reimbursed.

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<sup>22</sup> Invasive cardiology days are excluded from payer mix calculations.

<sup>23</sup> OSHPD inpatient data for 2007, excludes skilled nursing days

Two-thirds of Sutter's government funded and charity days are Medi-Cal days. A Medi-Cal reimbursed day may be preferable to having an empty bed. The value of Medi-Cal reimbursement could improve under the new PHC managed care program which is coming to Sonoma County. Moreover, Medi-Cal managed care is expected to reduce Medi-Cal inpatient days by a minimum of 15% based on improved access to primary care and a reduction in preventable hospitalizations. Thus Medi-Cal managed care has the potential to decrease Medi-Cal days, increase Medi-Cal revenue and generally lessen the impact of redistribution of Sutter's med/surg and ICU days.

In summary, it appears that any future redistribution from Sutter would not be in the maternal and child services days which are disproportionately government funded and charity care cases, but of med/surg and ICU days which are 70% commercially and Medicare insured and 20% Medi-Cal covered.

**Surge Capacity:** The HCAA does not address surge capacity, and Sutter is not required to provide it. However, the Department of Health Services works with local hospitals, including Sutter, on an ongoing basis to plan for hospital surge capacity to meet community needs in the event of a health emergency or disaster. A sudden surge in demand for care will be more difficult to meet if all local hospitals are already operating close to capacity.

The federal and state governments have recommended that communities have the ability to serve 20% to 25% more patients than the average daily census.<sup>24</sup> This surge capacity does not all need to be in licensed beds; it can include makeshift spaces such as putting beds in hallways or conference rooms. In addition to beds, surge capacity must also include staffing, pharmaceuticals, equipments and supplies. The Deloitte report projects a need for 580 acute care beds in 2014 and 641 in 2021. If Sutter builds the proposed 70 bed Hospital (and not the PMC), Kaiser opens its new beds as anticipated, and District Hospital beds remain as they are now, there will be 716 licensed acute beds in Sonoma County. This capacity would provide 23% emergency surge capacity of licensed beds in 2014 and 12% surge capacity in 2021. Sutter's proposed unlicensed universal care stations could also be useful as surge capacity in an emergency. The 70 bed Hospital will have 16 universal care stations and the PMC (if built), would have 28 beds and 30 universal care stations. If this capacity is available, it would provide 23% emergency surge capacity in 2021 also.

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<sup>24</sup> Schultz, Carl H, Koenig, Kristi, "State Of Research in High Consequence Hospital Surge Capacity", Acad Emerg Med Volume 23, Issue 11, pgs 1153-1156

In addition, there are specific requirements for a Pandemic Influenza event of high severity (index 4 or 5) established by the federal Centers for Disease Control and Prevention (CDC). Using the CDC guidelines, Sonoma County should have 751 beds over and above the existing number of available acute care beds. The County Department of Health Services staff, working with the cooperation of local hospital and skilled nursing facilities, have identified an additional 425 unlicensed beds of the 751 total required to meet CDC guidelines (not considering the 2010 Kaiser expansion). The remaining gap in surge capacity for Sonoma County would need to be made up through government run Alternate Care Sites (ACS). Plans for the development and readying of three such sites are underway with signed MOUs for each site on file. Two of these sites, the Sonoma Developmental Center and the Health Sciences Building at SRJC could supply 160 surge beds. As the third site, the currently shuttered Warrack Hospital facility would provide up to 180 surge beds. This would give a total of 765 surge beds, thereby meeting and surpassing by 14 the CDC projected goal. A loss of 65 acute care beds through the Sutter proposal would increase the number of surge beds needed by a similar amount. The universal care stations would make up for some of this loss, as would the beds and universal care stations in the PMC (if built). Additionally space could be available in the Chanate hospital building when vacated.

#### **FINDINGS ON PROPOSED HOSPITAL CAPACITY:**

1. The Health Care Access Agreement does not require Sutter to maintain any particular number of beds but it is required to provide equal or better access to its services for persons enrolled in government programs and the uninsured.
2. Without additional beds in the community, and without other factors tending to reduce bed demand, the 70 bed hospital would likely operate at full capacity upon opening with a shortfall of med/surg and ICU beds in 2014 that will grow into the future.
3. Sutter's planned construction of the PMC and the possible 29 bed expansion of the 70 bed hospital would likely provide adequate capacity to accommodate Sutter's current market share of patients during the term of the HCAA. If future capacity problems surface, Sutter may need to construct additional beds or participate in programs to reduce preventable hospitalizations to continue to comply with the HCAA.
4. Absent construction of the PMC and expansion of the Sutter hospital to 99 beds, patients who would have gone to Sutter will likely need to seek care from other area hospitals. The need to redistribute patients is estimated to be 16 beds per day, on average, in 2014 growing to approximately 29 beds in 2021.
5. County-wide bed need projections by Deloitte indicate the County's hospitals have adequate licensed med/surg capacity to accommodate all med/surg patients even if Sutter only constructs the 70 bed hospital.

6. Deloitte's Countywide bed need projections for ICU beds indicate that if Sutter only constructs the 70 bed hospital, the County's hospitals, collectively, will likely have adequate capacity of ICU beds, but the Santa Rosa area will be stressed as both Sutter and Memorial are projected to be over the target occupancy standard for ICU services. Kaiser and district hospitals may have excess capacity; however, redistribution of ICU patients, by virtue of their critical condition, is more problematic than for other types of patients. Such patients may not be stable for transport and movement from one facility to another should not be assumed.
7. Assessment of overall capacity of County hospitals for emergency surge by both federal/state government standards for a non-severe influenza event and for a severe influenza event indicates the projected number of licensed beds in 2014 and in 2021 will likely provide the recommended additional bed capacity. Surge capacity planning utilizes licensed and unlicensed beds and three planned Alternate Care Sites.

## **VI. Services and Program Issues**

The proposed revisions to the Business Plan raise issues relating to various health care programs and services currently specified in the HCAA and/or offered by Sutter. The services and programs under consideration include:

- Cardiac Services
- Family Medicine Residency
- Charity Care
- Medi-Cal Patient Access
- Outpatient Clinic Services
- Pediatric Beds

**Cardiac Services:** The HCAA lists those services that must be provided in the Business Plan hospital unless the County approves their elimination; listed services include coronary care and a cardiac catheterization laboratory. In 1996, when Sutter assumed operation of the hospital, Community Hospital did not have a cardiac surgery program, and did not provide invasive cardiac procedures that by law require cardiac surgery back-up. Sutter Medical Center of Santa Rosa (SMCSR) added a cardiac surgery service in 2001, and expanded the variety of cardiology services accordingly. The proposed replacement hospital will not have a cardiac surgery service, but it will have a cardiac cath lab and will provide updated coronary care services similar to those being provided by Community Hospital in 1996, focusing on non-invasive cardiology procedures.<sup>25</sup> Sutter plans to continue providing invasive cardiology and cardiac surgery services at the PMC hospital.

### **Findings:**

1. Continued access to noninvasive cardiology services at the 70 bed hospital is consistent with the terms of the HCAA, though the scope of services will be more limited than currently available. Sutter instituted its cardiac surgery program after assuming operation of Community Hospital in 1996, and is not required to continue it under the HCAA.

**Santa Rosa Family Medicine Residency Program:** The HCAA commits Sutter to operate the Family Medicine Residency which was started by the County hospital in the 1930's. The Family Medicine Residency Program is an important asset to the community; over 50% of local primary

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<sup>25</sup> Sutter and the County concur that the HCAA does not require the provision of cardiac surgery since that service was not provided at Chanate at the time Sutter took over operation of the facility.

care physicians were trained by the program. Resident physicians are also a major provider of health services to the uninsured and underinsured patients. Over the past three years, Sutter has worked with the County and other community providers to redesign the Residency Program as a Community Consortium with governance and responsibility for the program shared by a group of local health providers. In June 2009, Sutter determined that the financial structure of the Consortium would not permit the program to retain essential Medicare reimbursement for Graduate Medical Education. Sutter plans to continue operation of the Residency Program pursuant to the HCAA. The Department will need to evaluate any change in the model and structure of the Residency Program to assess the potential impact of any change on residency training requirements.

**Findings:** The existing HCAA provisions requiring Sutter to support the Residency have not been changed and Sutter has affirmed its long-term obligations in this area. Continued operation of the Residency Program by Sutter will support access to the Sutter Hospital and other medical services for low income patients.

**Charity Care Provisions:**

The HCAA requires Sutter to provide at least 3% of its net patient revenues as charity care. This index was selected in 1996 to help insure that the level of charity care provided by Sutter would not be proportionately less than the actual amount provided by Community Hospital at the time the HCAA was approved. Since initiation of the HCAA, the State has developed formal regulations for administering and reporting charity care provided by California hospitals. Sutter is in compliance with current regulations and routinely reports charity care contributions through the annual OSHPD reporting process.

**Reduced charity care due to smaller hospital:** The revised Business Plan and corresponding charity care pro forma provided by Sutter show the estimated dollar volume of Sutter's charity care contribution declining by 50% when the new Hospital opens. The smaller facility will generate less revenue and therefore have a lower obligation to provide charity care to the community. Other changes also have the potential to reduce the amount of charity care provided. As proposed by Sutter, the PMC, if built, will not be subject to the HCAA. However Sutter has agreed to provide the same percentage of charity care and use the same charity care policy at the PMC, as it does at Sutter Medical Center of Santa Rosa. Providing 3% charity care at the PMC will help to offset the reduction in charity care volume that results from the construction of the smaller 70 bed hospital and will expand access for low-income or uninsured residents to cardiac and surgical care.

**Findings:**

1. The revised Business Plan complies with the terms and conditions in the HCAA related to charity care.
2. Sutter has adopted a more extensive charity care policy than in 1996 with expanded eligibility and income guidelines, while still adhering to the HCAA requirements.
3. Inclusion of the PMC, if constructed, could enhance charity care available to the community for the specialized services that would be provided at the PMC.

**D. Medi-Cal Patient Access:** The HCAA commits Sutter to provide access to care for government sponsored patients and affirms the County's and Sutter's strong commitment to Medi-Cal managed care. After an extensive community planning process involving health care providers and consumer representatives, the Board of Supervisors accepted the Planning Group recommendations to invite Partnership Health Plan of California (PHC) to implement Medi-Cal managed care in Sonoma County. PHC is a governmental authority that provides Medi-Cal Managed care in Solano, Napa and Yolo counties. It was established in the mid-1990s and has an excellent record of improving access and quality along with patient and provider satisfaction. The County and many community advocates believe that implementation of Medi-Cal managed care by PHC in Sonoma County will dramatically improve access to care and quality of care for all Medi-Cal beneficiaries and is a very important step in improving the health care system.

PHC recently finalized its agreement with the State Medi-Cal program and has begun contracting with Sonoma County providers. PHC intends to begin operations in the fall of 2009. PHC would automatically enroll nearly all of the 47,000 Medi-Cal beneficiaries in Sonoma County; children, families, seniors and people with disabilities would all become health plan members.

PHC's essential ingredient for improving access and quality of care is the linkage of every Medi-Cal beneficiary to a primary care provider who is responsible for treating the patient and coordinating care. Medi-Cal patients are guaranteed timely appointments with their primary care providers and specialty physicians and thus do not need to rely on ED services for access to care. Using redirected savings from acute care, PHC is able to pay primary care providers twice what Medi-Cal pays and to pay specialists at rates that are close to Medicare. This increases provider willingness to participate in Medi-Cal and in turn increases patient access and satisfaction.

When PHC began operations in Solano, Napa and Yolo counties, the new system improved access to primary care and resulted in a 50% reduction in ED visits by Medi-Cal beneficiaries. In

2007, 39% of Sutter's ED visits were for Medi-Cal patients. If these visits were reduced by half it would reduce total visits by close to 20% and would reduce the demand for ED bays by approximately 2 bays. Based on their experience in other Counties, PHC estimates that managed Medi-Cal will reduce acute hospital days for Medi-Cal beneficiaries in Sonoma County by 15%. Medi-Cal made up 24% of Sutter's non-perinatal acute days in 2007; if those were reduced by 15%, the reduction in all acute non-perinatal days would be 3.6%. This translates into a reduced med-surg bed demand of approximately 3-5 beds. These projected reductions have not been factored into the County's or Sutter's bed and ED need projections since managed care implementation has not been completed. Sutter's participation in Medi-Cal managed care will likely reduce bed need.

The HCAA requires Sutter to provide access to Medi-Cal patients; once those patients are enrolled in Medi-Cal managed care it will be necessary for the Sutter Hospital and its medical group to contract with PHC in order to continue serving them. Sutter participated in the managed care community planning process and was very supportive of PHC coming to Sonoma County. Sutter has stated its intent to contract with PHC, which will be important for the success of managed care. Sutter's commitment to participating in Medi-Cal managed care would result in more actual access if the physicians who practice at Sutter Hospital also contracted with PHC. Unless Sutter's physicians also contract with PHC and agree to accept and serve Medi-Cal, all planned Medi-Cal hospital admissions (for childbirth for example) would be routed to other physicians who would admit patients where they practice and not at Sutter.

**Findings:**

1. Implementation of Medi-Cal managed care in Sonoma County by PHC is one of the most important and promising options available for improving access and quality of care for government-sponsored patients. Medi-Cal managed care, as delivered by PHC, will increase access to outpatient services, improve delivery of prevention services, improve health status and increase provider and patient satisfaction with Medi-Cal.
2. In order to operate in Sonoma County, PHC will need to build a network of participating hospitals and physicians. Sutter's participation is essential to network success.
3. In order to provide access for Medi-Cal patients as required by the HCAA, Sutter will need to contract with PHC. Without a contract, Sutter will only be able to serve Medi-Cal patients in an emergency. Sutter has stated its willingness to contract with PHC.
4. In order to create genuine access to the Sutter Hospital(s), the Sutter medical staff and Medical Foundation physicians will also need to contract with PHC and accept and serve Medi-Cal patients

5. Participation by Sutter and its physicians will likely reduce bed demand by 3 – 5 beds and demand for ED bays by approximately 2 bays at the Sutter Hospital.

**E. Outpatient Clinic Services:** The Family Practice Center clinics were a part of Community Hospital when Sutter took over their operation in 1996; the HCAA requires continued provision of outpatient services. With the County’s approval, Sutter worked with Southwest Community Health Center (SCHC) to assume responsibility for Clinic operations and finances in 2007. SCHC entered into a sub-lease and affiliation agreement with Sutter through 2013 for the Family Practice Center clinic space at Chanate. As a Federally Qualified Health Center (FQHC) Southwest receives better Medi-Cal reimbursement than Sutter did and has been able to increase the number of patient visits provided. SCHC plans to move to a new location and is currently exploring several options including lease of a site near the Wells Fargo Center. The new facility will permit SCHC to significantly increase the number of patients served.<sup>26</sup>

Like most community clinics, SCHC struggles to secure access to specialty physician care for its patients. Some outpatient physician specialty services that were provided at Community Hospital, (e. g. orthopedics), were discontinued by Sutter due to a lack of physician participation, while other specialty clinics have continued or expanded. It is widely agreed that improving access to outpatient specialty care services for low-income patients is an important goal for improving the health care delivery system, and could reduce preventable hospitalizations thus decreasing bed demand. It would be very desirable if Sutter could work with the County and the community clinics to help improve specialty physician access.

**Findings:**

1. SCHC’s management of the outpatient clinics at Chanate has improved access to care for low-income patients by increasing the number of visits provided. Sutter has also been able to reduce its subsidy of these services.
2. SCHC plans to relocate the outpatient clinic from Chanate which will permit further expansion of primary care, mental health and dental services.
3. The safety net clinic system is hampered by restricted access to certain specialty physician services (including but not limited to orthopedics).
4. Nothing in the Revised Business Plan would alter Sutter’s obligations with regard to outpatient services.

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<sup>26</sup> [www.swhealthcenter.org/SCHC-FutrellPressRelease12162008.pdf](http://www.swhealthcenter.org/SCHC-FutrellPressRelease12162008.pdf), and a communication from SCHC

**F. Pediatric Beds:** Pediatric inpatient services were provided at Community Hospital in 1996 and are listed as a required service by the HCAA. Sutter was licensed for eight pediatric beds but in the last year asked for and received the County's consent to discontinue its dedicated pediatric beds, due to the very low numbers of pediatric patients being served. Some children and older teens have been hospitalized at Sutter in the adult medical/surgical beds, but generally, children's inpatient care has been de facto consolidated at Memorial Hospital. Memorial has 24-hour on-site pediatricians (pediatric hospitalists) and recently opened a new specially designed pediatric unit that is large enough to meet the demand for this service. Kaiser also has an inpatient children's service but it is not generally available to non-Kaiser members.

The pediatric inpatient census is small and local pediatricians believe that a single consolidated unit is preferable to multiple competing units. A unit with a larger census is able to provide better quality care since staff can specialize in children's needs and conditions, the hospital can better afford specialized pediatric equipment and ancillary services are more accustomed to serving children. Additionally, a consolidated unit is more efficient and therefore less costly than multiple units. Memorial Hospital is certified to care for children in government-sponsored programs (namely CCS which manages Medi-Cal and Healthy Families care) so children are not currently being disadvantaged by the move to Memorial. However, there is no guarantee that Memorial will continue to operate pediatric beds over the long term; many hospitals around the state are closing these units and it is also possible that Memorial could cease to be certified to care for CCS sponsored children.

**Findings:**

1. In the interest of quality and cost-containment, Sutter should not be required by the County to have licensed, dedicated pediatric beds, although Sutter will continue to provide pediatric care to appropriate patients in its facility.
2. Memorial currently has a new dedicated pediatric unit that serves all children including government- sponsored patients from the Medi-Cal and California Children's Services (CCS) program.
3. Memorial could choose to close its pediatric unit in the future or could lose CCS certification thus creating limitations on access for children covered by government programs.

## **VII. Summary and Conclusion:**

At an estimated cost of \$176 million, the 70 bed hospital proposed in Sutter's revised Business Plan, if approved after environmental review, will provide a much improved, modern hospital for Sonoma County. The proposed facility will be accessible and efficient and most important will be earthquake safe, complying with California seismic safety laws. The proposed hospital will provide expanded bed capacity for women and infants' services (namely perinatal and NICU beds) but decreased beds for med/surg and ICU patients. The ED will be somewhat smaller than at the Chanate facility. Sutter believes that the proposed hospital is "right-sized" and cites its declining med/surg census over recent years. However, even with minimal projected growth in demand, Sutter's figures show a significant shortfall in med/surg beds shortly after the hospital opens. The County anticipates modest growth in demand and anticipates a larger shortfall in med/surg and ICU capacity.

The Health Care Access Agreement does not require Sutter to maintain any particular number of beds, but it is required to provide access to its services for persons enrolled in government programs and the uninsured. Thus the Revised Business Plan could comply with the HCAA as long as Sutter provides equal or better access to government funded and uninsured patients. This may require a variety of efforts including improving access to primary and medically necessary specialty care; reducing preventable hospitalizations and other programs improving quality and access to care, and possibly additional beds. The County will consider whether to approve Sutter's proposed hospital project when environmental review is completed, and will continue to monitor Sutter's performance under the HCAA.

## VIII. Excerpts from the Health Care Access Agreement

The Health Care Access Agreement (HCAA) is the legal basis of the County and Sutter's relationship. Its provisions provide some guidance regarding the standards the County will use to evaluate the proposed new Business Plan. The full HCAA is posted on the Department of Health Services web site <http://www.sonoma-county.org/health/admin/suttter.htm>.

Certain relevant excerpts from the HCAA are contained in this attachment. The HCAA does not require Sutter to provide a specific number of beds (in total or by service type). Rather it requires Sutter to continue to offer services "*which have been customarily provided Community Hospital to Sonoma County residents.*" [and states] "*Sutter shall not eliminate or limit access to any of the Services listed in Section 10.11.4 without County's prior written consent.*" [Section 10.5(a) and (b)] The HCAA is particularly focused on access for the uninsured and government program patients who include Medi-Cal,<sup>27</sup> Medicare, CMSP,<sup>28</sup> CCS and CHDP. The Hospital is also obligated to provide inpatient and outpatient hospital services for jail inmates and public health required quarantine services (which are a rare occurrence).

Section 10.11.4 defines necessary services as:

- (a) *any service listed on the license of Community Hospital and offered as of the Effective Date of this agreement [1996]:*
- (i) *General Acute care*
  - (ii) *Perinatal*
  - (iii) *Intensive Care*
  - (iv) *Pediatric*
  - (v) *Coronary care*
  - (vi) *Acute Psychiatric [this service discontinued by the County in 2007]*
  - (vii) *Skilled Nursing [Sutter requested and received County permission to discontinue this service in 2008]*
  - (viii) *Basic Emergency*

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<sup>27</sup> Medi-Cal is a State/federal program that provides health care coverage for low-income children and families, seniors and people with disabilities. Approximately 48,000 Sonoma County residents are enrolled in Medi-Cal at anyone time. Many private providers do not serve Medi-Cal patients due to the low reimbursement rates and high "hassle factor" of dealing with program administration. Medi-Cal patient use more hospital services than commercially insured patients.

<sup>28</sup> The County Medical Services Program (or CMSP) pays for medical care provided to low income, legally resident indigents who do not qualify for Medi-Cal. These are often adults who do not have a dependent child. Sonoma County is one of 32 Counties that participate in CMSP and that use this program to discharge their obligations under Section 17000 of the CA Welfare and Institutions Code.

- (ix) Podiatric Services
- (x) Cardiac Cath Lab
- (xi) Respiratory Services
- (xii) Physical Therapy
- (xiii) Outpatient services
- (xiv) Occupational Therapy
- (xv) Nuclear Medicine

Section 10.11.13 of the HCAA Deals specifically with the Business Plan as follows:

*“The Business Plan shall ensure that Sutter provides the Services in a manner that meets or exceeds prevailing standards of quality, access and cost containment and is otherwise consistent with the terms and conditions of this Agreement. In addition, in the event that the Business Plan recommends relocating the Services to a site other than the existing Premises, then the Business Plan must include a financial analysis of the alternative location and specifically ensure that the new site and facilities will:*

- a) be located in an area and designed in such a manner as to provide equal or better access to County Residents enrolled in government funded programs such as those described in Section 10.4 [Medi-Cal, Medicare, CMSP, CCS ]*
- b) be generally consistent with prevailing community standards governing the provision of health care services;*
- c) comply with all licensing and regulatory requirements applicable to such new facilities;*
- d) reduce overall costs of health care*
- e) provide an equal or better level of quality of Services than [was] being provided at the Premise;*
- f) provide for the continued provision of IPS [ Inpatient Psychiatric services]*
- g) allow Sutter to otherwise meet all the terms and conditions of the Agreement.....*
- h) allow Sutter to maintain accreditation from the Joint Commission ....*

## **IX. Glossary of Terms**

**Average Daily Census (ADC)** - The average number of patients who have been admitted to the facility per day. Derived by dividing the number of patient days for the year by the number of days the facility was open during the year. Does not include emergency department visits.

**Average Length of Stay (ALOS)** – The average number of days a patient remains in a facility (e.g., hospital).

**Business Plan** –The Sutter Medical Center of Santa Rosa Health Care Access Business Plan dated September 2004 for the construction of a 118-bed hospital on the Wells Fargo site. It was approved by the Sonoma County Board of Supervisors in October 2004. On November 20, 2008 the County received a request from Sutter to approve a revision to the 2004 Business Plan to construct a 70-bed hospital on the Wells Fargo site, with possible expansion up to an additional 29 beds.

**Cattaneo and Stroud** – A management consulting firm specializing in strategic planning and managed care consulting services exclusively to the healthcare industry.

**California Children’s Services (CCS)** – California Children's Services (CCS) is a state program for low-income children up to 21 years old with certain diseases or health problems.

**CEQA** – The California Environmental Quality Act (California Public Resources Code Sections 21000 et seq.) The purpose of CEQA is to inform governmental decision makers and the public about the potential significant environmental effects, if any, of proposed activities and to provide opportunities for other agencies and the public to review and comment on draft environmental documents.

**Chanate Campus** – The current location of Sutter Medical Center of Santa Rosa and former site of the County’s Community Hospital, on Chanate Road in Santa Rosa.

**Emergency Department (ED)** – The department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care. The emergency department is also called the emergency room or ER.

**Environmental Impact Report (EIR)** – A report required by the California Environmental Quality Act that evaluates a proposed project's impact(s) on the environment and as applicable, recommends steps to avoid or minimize those impacts, called mitigation measures

**Federal Qualified Health Center (FQHC)** – A community-based organization that serves one or more Federally-designated medically underserved populations, providing comprehensive primary care and preventive care, including health, oral and mental health/substance abuse services to persons of all ages, regardless of their ability to pay.

**Health Care Access Agreement (HCAA)** – An agreement between the County of Sonoma and Sutter Medical Center of Santa Rosa (SMCSR) dated March 25, 1996 whereby SMCSR agreed to provide or arrange for certain health care services to Sonoma County residents. In conjunction with the Health Care Access agreement, Sutter also leased the former county hospital, located on Chanate Road in Santa Rosa.

**Intensive Care Unit (ICU)** – A unit of the hospital with specialized equipment and trained personnel that provides close monitoring and constant medical care for patients with life-threatening conditions. Also referred to as a critical care unit.

**Labor / Delivery / Recovery / Postpartum (LDRP)** – A birthing room or suite equipped so a patient can remain in the same room throughout the birthing experience and into the postpartum period.

**Magnetic Resonance Imaging (MRI)** – A noninvasive nuclear procedure for imaging tissues of high fat and water content that cannot be seen with other radiologic techniques.

**Medical/Surgical (Med/Surg)** – Medicine/Surgical (Med/Surg) hospital beds are used to hospitalize individuals with medical conditions (such as congestive heart failure, kidney disease, etc.) and with conditions requiring surgical interventions (i.e. orthopedic surgeries, abdominal surgery, etc.).

**OSHPD** – The California Office of Statewide Health Planning and Development and is the licensing authority for health facilities and the building permit authority for hospitals.

**Neonatal Intensive Care Unit (NICU)** - A unit of a hospital specializing in the care of ill or premature newborn infants. Licensed NICU beds are actually bassinets for newborns

**PRMD** – The Sonoma County Permit, Resource and Management Department.

**PMC** - The Physicians Medical Center proposed by Sutter Medical Center of Santa Rosa in the proposed revision to the 2004 Business Plan submitted to the County of Sonoma in November 2008. The Physicians Medical Center is proposed to be owned jointly with local physicians, Sutter Medical Foundation North Bay and Sutter Health.

**Residency Program** –The Santa Rosa Family Medicine Residency that Sutter Medical Center of Santa Rosa is required to guarantee pursuant to Section 10.10 of the Health Care Access Agreement.

**Southwest Community Health Center (Southwest)** – A nonprofit, federally qualified health center (FQHC) providing comprehensive outpatient health care to uninsured and underinsured people in the greater Santa Rosa area regardless of their ability to pay.

**Sutter Health (Sutter)** – A not-for-profit network of community-based physician organizations, hospitals and other health care service providers delivering health care in more than 100 Northern California communities.

**Sutter Medical Center of Santa Rosa (SMCSR)** – Sutter Medical Center of Santa Rosa is non-profit acute care hospital licensed by the State of California Department of Health Services to operate 244 beds and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). SMCSR is an affiliate of Sutter Health.

**Sutter Medical Foundation of the North Bay** – Sutter Medical Foundation of the North Bay, a Sutter Health affiliate, is a non-profit, multi-specialty outpatient health care organization operating in Marin, Sonoma, and Lake Counties..

**Universal Care Unit** - In addition to the 70 private room hospital beds and a 12-bay emergency department, the new hospital proposed in Sutter Medical Center Santa Rosa's proposed revision to the 2004 Business Plan will include a 16-station Universal Care Unit to expand the Emergency Department and Medical/Surgical operational capacities. The Universal Care Unit is multi-purpose room for patients for anesthesia care, surgical pre-op, recovery, short-term observation, ER care etc.

**Wells Fargo Site** – The proposed location of the new hospital in Sutter Medical Center of Santa Rosa's 2004 Business Plan and SMCSR's proposed revision to the Business Plan located on a 25-acre property at the Wells Fargo Center for the Arts.