PROPOSAL TO INCREASE HEALTHCARE FUNDING

IN

SAN JUAN COUNTY PUBLIC HOSPITAL DISTRICT NO. 1

CONTENTS

PROPOSAL IN BRIEF

INTRODUCTION

We propose investments in the following areas, to be built around the purchase of the Village at the Harbor, and organized in two phases. The use of an existing facility allows us to avoid undermining an existing resource, and also saves substantial time in licensing and construction by using the existing business to expand. It also enables enough funding to ensure adequate staffing and provide an improved and more stable service.

Phase One (Year 1-2)

- Purchase of the Village at the Harbor
- Immediate provision for 4-6 Medicaid beds for assisted living at the Village (lasting only until phase two is complete)
- Investment in worker wages and benefits to promote a reliable and well-trained workforce
- Care coordination to promote aging in place
- Other healthcare needs: LGBTQ and reproductive health

Phase Two (Year 2+)

- Construction of new Medicaid beds (goal is 12 – 24) for assisted living on San Juan Island

Phase Three *(requires private funding in phases one or two)*

- Adult daycare

- Worker Housing (temporary or permanent)
- Memory Care facilities or Memory Care activity support

Phase one and two is possible with only public funding, but phase three relies on having had private funding pay for either the acquisition of the Village at the Harbor or the construction of new Medicaid facilities.

These services will be run out of the same entity, allowing the use of staff and resources in common.

BUDGETING BRIEF

This plan calls for the braiding together of bond funding to finance the acquisition of the Village at the Harbor and the expansion of Medicaid beds through construction. While the bond value and annual payments are not final, we are placing a placeholder for each. This bond funding will be financed, and paid monthly for the duration of the bond (in other words, the cost of these bonds is included in the operating budget). It does not represent an increase over the budget outlined below.

We have not attempted to predict how costs will change over the next four years as a result of consumer price index increases and inflation; the Year 4+ budget is primarily designed to show how it is structured differently from the year 1 – 3 budget.

The remainder of the expenditures represent anticipated net operating cost after subtracting out anticipated revenues, with an appropriate tax rate set to cover these projects.

Ideally, the District would be able to acquire private funding for either the acquisition of the Village at the Harbor or the Medicaid facilities expansion. This would allow investment in more service lines as outlined in phase three (e.g. adult daycare).

ESTIMATED NET ANNUAL EXPENDITURES	
YEAR 1 - 3 (pre completion of Medicaid expansion)	
Project	**Total Annual Cost**
Bond service: acquisition of the Village at the Harbor (est. 5 million)	$310,000
4-6 Medicaid beds (pre-expansion)	$230,400
Wages, Benefits, and Staffing increase	$492,000
Care Coordination	$217,740
Other healthcare needs	$60,000
Medicaid Beds Expansion bond maintenance (est. 3 million)	$185,000
TOTAL:	$1,495,140
YEAR 4+ (Following Completion of Medicaid Expansion)	
Bond service: acquisition of the Village the Harbor (est. 5 million)	$310,000

Wages, Benefits, and Staffing increase	$492,000
Care Coordination	$217,740
Other healthcare needs	$60,000
Medicaid Beds Expansion bond maintenance (est. 3 million)	$185,000
Medicaid Expansion maintenance	$300,000
TOTAL:	$1,564,740
TOTAL BOND MONEY RAISED (serviced annually via above budget)	$8,000,000

The District estimates that a minimum $0.70 levy rate will be needed to fund this, which would raise an additional $1.5 million in revenue. However, setting the rate to meet expected 2022 needs and nothing more will mean needing more revenue within six years. The District would prefer to leave enough room in the levy by setting it at $0.75 to ensure financial sustainability. There is enough uncertainty about building and expansion costs that there is otherwise a meaningful risk of ending up with inadequate capital to adequately accomplish the objectives of this proposal – even a significant increase in interest rates or building costs could have a significant impact.

ANTICIPATED TAX FUNDING			
Tax Rate	**Total Tax**	**Difference**	**Parcel Tax***
$0.34 (current)	$1,391,604.87	0	$168.00
$0.75	$3,106,260.87	$1,714,656.00	$375.00

** = parcel tax for a $500,000 property*

The remainder of the District's funding representing its existing tax levy at $0.34 is currently committed to PeaceHealth Peace Island Medical Center, the operations of the hospital district, and several small subsidies.

PHASE ONE: INVESTING IN HEALTHCARE ON SAN JUAN ISLAND

PURCHASE OF THE VILLAGE AT THE HARBOR (annually est. $310,000 for debt service)

This is expected to cost around $4.9 million, to be funded by a bond, or private money if possible. The annual cost to service that debt is expected to be between $310,000 and $350,000 per year for the maximum of twenty years, to be paid for from property taxes.

If the District is able to secure private funds for this purchase, it will open funding for its Phase 3 stretch goals.

IMMEDIATE PROVISION FOR 4-6 MEDICAID BEDS FOR ASSISTED LIVING AT THE VILLAGE (est. $230,000 / year)

The estimated loss per Medicaid patient per year at the Village at the Harbor is about $35,000. The Village at the Harbor does not generally take Medicaid patients as a result. This cost will go down in phase two, when the District can house Medicaid patients in what will be a high quality and new facility, but with less space than private pay residents and a more efficient design.

In order to fund 4-6 Medicaid beds before the construction of new facilities it will cost an estimated $200,000 per year, but this will be an immediate benefit to people in need. This persistent loss should be narrowed when Medicaid facilities are completed in phase two (estimated 3 years)

COSTING: **4-6 Medicaid Beds in Existing Village at the Harbor Facility**			
Revenue	**Per Patient / month**	**Per Patient / year**	**Total (6 beds for one year)**
Medicaid Reimbursement	$2,100	$25,200	$151,200
Expense			
Room and Board	$4,000	$48,000	$288,000
Care (level 2) *	$1,300	$15,600	$93,600
total:	$5,300	$63,600	$381,600
profit / loss:			-$230,400

** Note that some Medicaid patients only require a level 1 care, which costs $650 / month*

This will also provide key experience in helping us expand our Medicaid services, and we try to figure out what the service will truly cost – what costs can be covered through existing staffing, and what new costs will be incurred.

The District estimates conservatively that the entire loss versus the cost of private pay is true out-of-pocket loss, which isn't necessarily the case (i.e. while the District would receive an estimated $230,400 less for six Medicaid residents vs private pay, that isn't necessarily an overall cash loss). It certainly could become the case if the mix of private pay and Medicaid pay is changed significantly.

If for some reason the cost is lower than expected, that will expand our ability to help patients; if it's higher than expected, the District will conversely be able to do less.

INVESTMENT IN WORKER WAGES AND BENEFITS (est. $500,000 / year)

In theory, there is adequate labor for long-term care – the problem is that facilities like the Village at the Harbor cannot pay enough to keep people from getting the training they need then jumping ship for private care, PeaceHealth, or another entity. Additionally, many employees can make more in the summer working in the tourism industry (cleaning, restaurants, etc.).

A common wage in private care is $35, whereas a facility like the Village pays closer to $17. Neither generally provides benefits.

The number one way to address the workforce issue is to partly to pay a little better, but primarily to offer benefits. Benefits help commit employees to the employer (and vice versa) and is more sustainable through the summer as employees are reluctant to give up those benefits. Most importantly, if we take care of our workforce they will want to stay.

The village currently has about twenty full-time employees and ten part-time employees. An average cost per person for medical/dental benefits on a group plan of working age individuals is about $900 per person per month. Only full-time employees would receive benefits (32 hours or more / week).

There are about thirty employees total, and for a modest wage increase of $2, assuming a forty-hour workweek, it will cost about $110,000.

The expansion of services in multiple ways will require more coordination and back-office work. Additionally, the construction, licensing, and other needs will require legal, accounting, and numerous other professional services. Many new policies will need to be created, programs planned and coordinated, employee benefits managed, equipment and assets acquired, etc., all of which will also mean legal and accounting needs. As a public agency, the organization will be subject to various state laws, such as the Public Records Act.

The District will leverage existing hospital district staff to reduce this increase in cost. The overall cost is hard to estimate but is likely to not exceed $150,000 per year for at least the first several years of the project.

Employee $2/hr. Wage Increase and Benefits for Existing Employees			
Revenue	**Per Employee / month**	**Per Employee / year**	**Total**
N/A			
Expense			
Wage Increase (30 employees)	$350	$4,200	$126,000
Benefits (20 employees)	$900	$10,800	$216,000
New Office Staff, consultants, accounting/legal support	$12,500	$150,000	$150,000
total:	$13,750	$165,000	$492,000
profit / loss:			-$492,000

CARE COORDINATION TO PROMOTE AGING IN PLACE (est. $220,000 / year)

Care Coordination is one of the goals of the HRSA Care Coordination that the District received in the fall of 2020 (see below). However, that program is not sustainable based on reimbursement rates for service (under $100 per visit). It may defray costs, however. There needs to be a place for that program to land after the grant, and we would like to significantly expand that program.

Care Coordination as we envision it is closer to a mobile integrated health or a community paramedicine program as provided by many fire districts, where some level of in-the-home care is provided. These programs were originally meant to reduce demand on emergency resources by reducing the frequent use of EMS services by a small proportion of patients that represent a high volume of 911 calls. However, this program will also include the social worker role of connecting patients with services and a care plan (involving the patients primary care provider), in addition to actually providing a modest level of home-based care.

This program makes sense as part of a long-term care facility that is trying to run lean by enabling the facility to release patients and still provide some care, and to provide some care to help keep people from needing a facility in the first place. This is far more cost efficient than simply providing a substantial expansion of beds, and more achievable.

This program on its own would require at least one higher level provider (Paramedic, nurse, doctor) supervising people with lesser certifications (CNA, EMT, etc.). However, as part of the Village at the Harbor, existing oversight may be adequate, and perhaps even existing staff could contribute some hours to this program (e.g. an employee who provided care while the patient was in the facility could do follow up), but this would increase the need for staffing in core services.

Regardless this means at least three full-time equivalents, as well as supplies, per diem for employee-owned vehicles when visiting patients, wages, and benefits.

The cost of billing does not necessarily vary a great deal – if the company is billing for $90 or $1000, it can take a similar amount of time. Therefore, billing at such a low reimbursement rate is only barely worth it at current rates. These are new programs, though, and if they are successful, we are likely to see more funding for these services.

Care Coordination Program			
Revenue	**Per Employee / month**	**Per Employee /yr**	**Total Annual for 3 employees**
Estimated Charges (5 billable per week, $90/visit) (many visits not billable)	$1,935	$23,220	$69,660
Expense			
Wages	$4,583	$55,000	$165,000
Benefits	$900	$10,800	$32,400
Vehicle Operation per diem	$500	$6,000	$18,000
Supplies	$500	$6,000	$18,000
Billing (rough estimate)	$500	$6,000	$18,000
total:	$6,983	$83,800	$251,400
profit / loss			-$181,740

The "Care Coordination" model is being tested nationwide and is a new service. Many details of this program will need to be worked out. The amount of money set aside for this seems conservative.

OTHER HEALTHCARE NEEDS: LGBTQ AND REPRODUCTIVE HEALTH ($60,000 / year)

The District would like to further subsidize reproductive healthcare, and provide some level of support to the LGBTQ community. This cost is not large, but it can have a meaningful impact. This is not directly related to long-term care, but is part of the District's overall effort to meet underserved healthcare needs.

We estimate $50,000 to Mount Baker Planned Parenthood, and $10,000 for a LGBTQ organization(s) that support the healthcare related needs of that underserved population.

Reproductive Health and LGBTQ Healthcare Support		
Revenue	**Subsidy Per month**	**Subsidy per year**
N/A		
Expense		
Mount Baker Planned Parenthood (or similar)	$4,166	$50,000
LGBTQ Healthcare support groups (will solicit proposals)	$833	$10,000
total:	$4,999	$60,000
Profit / loss:		-$60,000

PHASE TWO: MEDICAID BED EXPANSION

CONSTRUCTION OF NEW MEDICAID BEDS ($500,000 /month)

A final estimate to expand Medicaid beds will depend on a comprehensive study to be undertaken to determine the most cost-efficient way to provide this care, as well as an understanding of how the regulatory system works with respect to Medicaid. Whether that means constructing a second floor at the Village or whether it means acquiring land and building something, the scope of the program will be adapted to meet this need.

The District is essentially setting aside a certain amount of the lid lift amount to fund more Medicaid beds. It is not certain how many beds that will "buy," but we believe we can leverage the Village at the Harbor to do this much more inexpensively than on our own. The simplest method would be building a second story, but it is not yet known if this is feasible. It would simplify licensing and allow for shared use of infrastructure (e.g. kitchen). The District also believes it is possible to negotiate a higher Medicaid reimbursement rate due to the lack of access in our county.

We anticipate a significant bond to fund this construction, and then a maintenance cost that will support the program. Care must be given to ensure the private pay model remains intact, and a reasonable mix of payers that is financially sustainable achieved.

As a placeholder, we estimate at least a $3,000,000 bond, with annual maintenance of $185,000, and additional funding to support the program itself of at least $300,000, for a total of $485,000 – about $500,000.

Once this is done, phase 1 Medicaid support can be retired, saving $200,000 per year.

PHASE THREE: STRECH GOALS (REQUIRES PRIVATE FUNDING IN PHASES ONE OR TWO)

The following programs are stretch goals should the District be able to secure funding to acquire the Village at the Harbor or construct new Medicaid beds.

- Adult daycare
- Worker Housing (most likely temporary housing)
- Memory Care facilities or Memory Care activity support

Depending on the success of the EMS and Fire integration project, the District may be able to repurpose the current EMS building for one of these projects as well.

Adult day care could play a very substantial role in reducing the strain on care providers in the District. Memory care is sorely needed, but is labor intensive. The ability to house new workers on a temporary basis is a model that has helped PeaceHealth Peace Island Medical Center. All of these things would be of value in building a comprehensive model to help take care of the public.

FUNDING SOURCES

The District hopes that it is able to raise private funding for part or all of the construction of facilities or acquisition of the Village at the Harbor. However, the plan is designed to work with or without private support. The amount of private support is unpredictable, but will make an impact on what can be accomplished.

HISTORICAL LID LIFT DETAILS

San Juan County Public Hospital District No. 1 has a permanent levy, which has not been lid lifted in many years. It had a one-time 15-year temporary lid lift to $0.75 in 2001, which lasted from 2001 to 2015. During each year the rate declined due to rising property tax values, such that by 2015 the rate had fallen to $0.60. Once the lid lift expired, the levy rate reset to what it would have been without the one-time lid lift: $0.43. Since then, the levy rate has continued to decline to $0.33 in 2021.

The maximum rate for a hospital district is $0.75, though it may also assess a separate EMS levy (as can counties, cities, etc.).

LID LIFT POSSIBILITIES

Based on 2021 assessed values, the District may assess the following taxes (subject to voter approval), listed by rate:

LID LIFT POSSIBILITIES			
Tax Rate	**Total Tax**	**Difference**	**Parcel Tax***
$0.34 (current)	$1,391,604.87	0	$168.00
$0.50	$2,070,840.58	$679,235.71	$250.00
$0.55	$2,277,924.64	$886,319.77	$275.00
$0.65	$2,692,092.75	$1,300,487.88	$325.00
$0.70	$2,899,176.81	$1,507,571.94	$350.00
$0.75	$3,106,260.87	$1,714,656.00	$375.00

** = cost per $500,000 parcel*

Levy lid lifts can be permanent or temporary. A permanent levy lid lift still falls over time if assessed values go up, but unlike the fifteen-year temporary lid lift described above does not reset to the rate it would have been without the lid lift.

MRSC explains well: “There are two types of levy lid lifts: single-year lifts (sometimes known as “one-year,” “one-bump,” “basic,” or "original" lifts) and multi-year lifts. However, these names can be confusing, since “single-year” levy lid lifts typically last for multiple years too. A good way to think of the difference between "single-year" and "multi-year" lid lifts is: How many years can your total levy increase by more than 1 percent?”

The law states that a temporary lid lift may not be used to service debt for more than nine years (presumably to prevent taking on debt that eventually cannot be serviced). We do expect to take on debt, so we need to plan on a permanent levy lid lift. If we can avoid taking on a bond (debt), then a temporary single year lid lift would likely be easier to get passed.

Therefore, we propose a permanent, single year lid lift to $0.75, to generate an estimated $1,714,656 based on 2021 assessed values. This would represent an increase of $207 for a $500,000 property.

COMPARISON TO LOPEZ / ORCAS

Lopez and Orcas hospital districts suffer a disadvantage due to the fact that they are much closer to their maximum levy rate and have lower overall underlying property values. Lopez began with about $0.75 in 2019, and Orcas began at about $0.65 in 2019 as well.

LOPEZ HOSPITAL DISTRICT		
Tax Rate	**Total Tax**	**Difference**
0.677 (current)	$884,676.66	0
0.75	$980,070.15	$95,393.49

ORCAS HOSPITAL DISTRICT		
Tax Rate	**Total Tax**	**Difference**
0.65 (Current)	$1,798,863.12	0

0.75	$2,075,611.30	$276,748.17

This represents the maximum tax increase that each District could obtain based on current rates and is one of the biggest challenges to developing services countywide.

BONDS

A bond is essentially a loan. It can be approved by a vote of the public, if there is existing capacity within the district's levy that is not required. Nor does delivery of the funding depend on the election cycle – if the district is approved for the bond, it does not need to wait until the following year as with tax levies.

The following steps are necessary:

- Approval from the governing body for the bond
- A Request for Proposal is necessary for some government entities
- Review of credit and acceptance by the bank wishing to buy the bond
- Needs to go through processing generally, and clear the state clearinghouse for bonds (US Bank)
- This process is assisted by bond counsel – an attorney who specializes in this sort of thing

Currently interest rates are in the low 2%, but this may not be the same when the bond is taken. From the bank's perspective, this sits on their books as a commercial loan, although it's classified as a municipal bond. Most bonds under $15 million are private placement bonds, meaning it isn't underwritten by a group of investors. The maximum length of the bond is 20 years. Many bonds are paid twice a year, though they can be paid monthly depending on how it is structured.

Based on this information, we can build the following chart of possibilities:

PROSPECTIVE BOND COSTS		
Amount (at 2.25%)	**Monthly**	**Annual**
$3,000,000	$15,500	$186,000
$5,000,000	$25,890	$310,680
$7,000,000	$36,247	$434,964
$9,000,000	$46,603	$559,236
Amount (at 2.75%)	**Monthly**	**Annual**
$3,000,000	$16,265	$195,180
$5,000,000	$27,108	$325,296
$7,000,000	$37,952	$455,424
$9,000,000	$48,795	$585,540

It is possible to take out a first bond, and later on take out a second. However, the District needs to have the means to pay. It is intended that the District will first acquire the Village at the Harbor, and later get a second bond to do more construction. Better yet, the District will secure private funding for at least part of the expense reducing the overall debt burden.

The entire process can take from six weeks to four months.

APPENDIX: GRAPPLING WITH LONG-TERM CARE

Having introduced the plan, it is worth reviewing how we got here, and the steps that have been taken up to now.

Long-term Care Task Force (2018)

At the end of 2017, The Life Care Center of San Juan Island Closed due to a 1-million-dollar deficit annually. This large facility had 76 beds, and is now considered an outdated and unsustainable model, although, it should be said, tax money could have closed this gap if time had been given the District to do so. Whether that was a good idea or not is debatable. Regardless, it left a gap.

In 2018 a task force was organized to figure out what to do, "The Community Long-Term Care Options Task Force, herein referred to as "task force." They met over eight months, and had twelve healthcare professionals representing key organizations: Evan Perrollaz (Administrator of the Village at the Harbor), Kathryn Clary (RN with Hospice of the Northwest), Janice Fisher (Former Administrator with Life Care of San Juan), Beth Williams Gieger (PIMC- Director of Administrative Services), Julia Thompson (Physical Therapist - Formerly with Life Care of San Juan), Kyle Davies (EMS Paramedic), Beth Helstien (SJI Library Outreach/ Volunteer Coordinator), Deanna Osborn (Senior/ In-home care Provider), Pamela Hutchins (SJCPHD#1 Superintendent), Carrie Unpingco (SJICF Director), Dennis King (Executive Director of Lahari), and Mark Tompkins (Director of San Juan County Health and Community Services).

This group compiled a lengthy report (if never entirely finished) and spent many hundreds of hours working on this project. Their core recommendations were that the large nursing home model be replaced with a suite of options that address care in more cost-effective ways:

- Micro Nursing Homes on each major island
- Technology-based Social Services
- Home Care
- Medicare certified home health
- Affordable Senior Housing

They recommended that a professional feasibility study be performed to figure out how to make this happen.

Feasibility Study (2019)

A feasibility study to evaluate the suggestions of the task force required a nonprofit entity to collect donations and fund the study. The task force was not equipped to do that. They passed things off to the Inter Island Healthcare Foundation (IIHF) for fundraising and added Evan Perrollaz (Village at the Harbor) to the foundation to help spearhead this effort.

The IIHF included the Chair of San Juan County Public Hospital District No. 1 ("hospital district"), Michael J. Edwards, and Vice-chair Rebecca Smith. The hospital district, with consent from the rest of the Board, also contributed funding for the study's estimated cost of $50,000. It was assumed that at some point,

public money would be needed to accomplish at least part of the mission, and that the entity to accomplish at least part of that on San Juan Island would be the hospital district.

Their hope was that the feasibility study would evaluate cost requirements for each of the solutions outlined by the Long-Term care task force and hoped that it would come up with potential governance and organization models to carry out the different solutions.

The survey of need as part of the feasibility study was used to leverage two Health Resources and Services Administration ("HRSA"), one a planning grant to help build a governance model, and another to establish care coordination.

Background: Survey Results (2019)

The survey clearly established the need for long-term care services through its survey of County residents that were over the age of 70 or who serve as a caregiver for an individual over the age of 70. The intention was to use healthcare use patterns and levels of chronic care needs and conditions within the County's 70+ population, as well as program and service needs and gaps.

The survey had 444 surveys, of which about 50 were excluded for not meeting necessary criteria. A total of 393 total surveys were deemed complete and were used for the analysis. Respondents were from across the county and had to be either a caregiver or over the age of 70. Surveys were offered via phone, an online link, or in paper (at the library, fair, etc.). 201 of the surveys considered were from San Juna Island, 109 from Orcas, 62 from Lopez, and 9 from Shaw.

Question	San Juan Respondents with 3+ Health Issues	Other San Juan	Orcas Respondents with 3+ Health Issues	Other Orcas	Lopez Respondents with 3+ Health Issues	Other Lopez	All County 3+ Health Issues	Other County Total
Living Situation (Lives with others)	70%	68%	74%	61%	46%	67%	67%	66%
ER visits 2+	59%	25%	33%	25%	38%	23%	48%	24%
Hospitalized 2+	65%	15%	50%	14%	100%	17%	65%	19%
Ambulance Needed 2+	60%	13%	42%	17%	50%	33%	54%	36%
Rating of 1-2 (poor health and marginal declining health)	47%	5%	42%	9%	31%	6%	43%	7%

Source: Survey

Overall, San Juan County's seniors are healthy and vibrant, with more than two- thirds of survey respondents self-reporting good to excellent health. 29% of all respondents reported no health care conditions/needs.

Nevertheless, nearly three quarters of respondents did report at least one health care condition/need; the vast majority with only 1 or 2 health conditions/needs still reported good overall health. More than one of every four respondents reported three or more health care conditions/needs. This same group

was more likely to report poor health or declining health. This led to high use of Emergency Departments, frequent hospitalizations, and higher use of the ambulance service.

The survey clearly showed that services are lacking across the County: 37% of those respondents that indicated that they had tried to access a community long term care service, across the County, reported either not being able to find the service or not being able to find all services needed. The most frequently identified service needs included: assistance with cleaning, cooking, transportation; medication management and personal care. Home safety checks, blood pressure monitoring and availability of assisted living was also identified frequently.

Survey respondents are long-term residents, and about 75% reside with at least one other person. At least 69% of respondents indicated that they were aware of someone having to relocate from San Juan, Orcas, Lopez or Shaw Island to areas where long-term care was provided. 23% of the respondents with 3 or more conditions will need state funded (Medicaid) Support.

Additionally, 69% of the respondents indicated that they were aware of someone having to move off island due to the lack of services in the last several years. Of this group, 30% knew of 5+ people moving off island. These numbers were somewhat higher for Orcas and Lopez, but a problem across the county.

Fortunately, a very high percentage of respondents have primary care and the overwhelming majority receive that care on the Island on which they reside. In many rural issues this is a major issue.

Although many are healthy, the elderly population in San Juan County is quite high. If need exists for even a modest proportion, it represents a great deal of need. The 2020 census reported 15,768 people in San Juan County, an 11.5% over 2010. Fully 35% of the population was over 65 – almost three times the population under the age of 18.

Background: Solutions (2020 – 2021)

The result of the task force and feasibility study was two HRSA planning grants. These grants move things forward in specific ways, such as countywide advocacy on healthcare issues and the development of care coordination, but do not address other components except in general terms.

a. HRSA Planning Grant

In the fall of 2020, applicant agency San Juan County Public Hospital District No. 1 was awarded a planning grant from HRSA along with three partners: the Inter-Island Healthcare Foundation, PeaceHealth, and San Juan County Public Hospital District No. 2. (Lopez Island Hospital District). This one-year $100,000 grant from the HRSA Network Planning Grant Program began in October of 2020. This grant was ably managed by Anne Presson, the Lopez and Orcas hospital districts superintendent.

The specific purpose of HRSA's Rural Network Planning Grant is to promote the development of integrated health care networks in order to increase efficiency and improve the quality of basic health care services in rural healthcare systems.

The planning grant has proposed an Interlocal Agreement between the hospital districts on each of the three islands, which is intended to help promote advocacy as a county. The countywide focus will allow

the Districts to apply for a planning development grant to be awarded for 2023, that goes for three years. It does not contemplate the collective operation of services as of right now.

b. HRSA Care Coordination Grant

In fall of 2020 the same four entities as the Planning Grant were awarded a Care Coordination grant. This grant goes three years and is about $300,000 per year. This grant is intended to build care coordination services to enable people to age in place.

Aging in place is a crucial component of any long-term care model, as it works to connect patients with resources and services. It helps reduce admissions to care facilities, and once released from a facility allows for follow up.

The main issue with care coordination is that it's not financial sustainable on its own. The service can be billed to insurance, but at less than $100 per visit, it would need subsidized by an entity that would see financial reward for doing so – e.g. a hospital or care facility that is stretched thin for resources and needs to reduce admissions, or a government entity that can afford to lose money.

At the time of writing, an effort to meld together Community Paramedicine and care coordination would be a highly beneficial way to enhance this effort, making care coordination able to provide some basic assistance in the same way the Community Paramedicine does.