COACHELLA VALLEY ECONOMIC PARTNERSHIP (CVEP) DESERT HEALTHCARE DISTRICT (DHCD) STUDY:

The Regional Economic Impacts of DHCD's Community and Clinical Social Needs Goals and Recommendations Implementation

COACHELLA VALLEY ECONOMIC PARTNERSHIP
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INTRODUCTION

In 2023, the Desert Healthcare District engaged the Huron Consulting Group to produce a Community Clinical and Social Needs Assessment. The Final Report, presented to the District's Board of Directors in March 2023, outlined the district population's current healthcare challenges. The report found gaps between community healthcare demand and currently available health assets. And most importantly, it presented goals and recommendations to address these gaps.

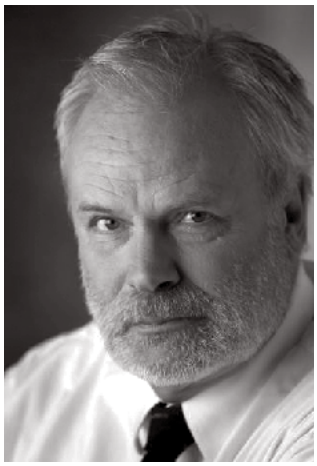
This study focuses on a key statement found in the report. The report's first stated goal in the recommendations section was to "craft (a) business case to provide targeted (services)." One step in crafting a business case for healthcare expansion in the Coachella Valley is estimating and quantifying the economic benefits of implementing the report's recommendations for recruiting new healthcare professionals to meet existing and future healthcare demands. This study provides such quantification, as well as recommendations and best practices for healthcare professional recruitment collected from an academic literature review as well as documented examples of such practices.

Attracting considerably more healthcare professionals to the Valley, as the study urges, bolsters the local economy. The study recommends adding a minimum of 40 new health professionals to address resident healthcare needs. These highly paid professionals and associated staff bring increased consumer spending and demand for goods in the local economy. It increases local tax revenue to enhance the public good. The report concentrates on increasing local access to high-value care in pediatrics, internal/family medicine, cardiology, and general surgery. This proposal will estimate the benefits to our economy of both building the new capacity and the increased local spending on healthcare that the new capacity brings. Moreover, increased healthcare spending is year-round, helping to tamp the seasonality of our local economy.

David Robinson

Director of Analytic Services, Coachella Valley Economic Partnership (CVEP)

- David is a Geographic Information Systems specialist. He studies and analyzes the local socioeconomic landscape of the Coachella Valley through mapping and geographic analysis. As the Director of Analytic Services at CVEP, he uses GIS to find the local specifics of our complex economy, using geographic analysis to aggregate important economic and demographic data that is often found at the county or MSA level. For ten years at CVEP, he has authored many reports on the local economy and presents a blog, David's Data Digest, on focused economic and geosocial topics about the Valley.



Dr. Manfred Keil

Professor of Economics, Claremont McKenna College

- Dr. Keil is CVEP's chief economist and leads the team for our annual Summit Economic report. Professor Keil received his Ph. D. in Economics from the London School of Economics and has been working at Claremont McKenna College since 1995. He specializes in Macroeconomics, Statistics, and Econometrics. Prof. Keil is also the Associate Director of the Lowe Institute for Political Economy and leads a relatively large research staff of student RAs to provide forecasting analysis for the Inland Empire.

Dr. Darren Filson

Director of the Randall Lewis Center for Innovation and Entrepreneurship, the Academic Director of the Silicon Valley Program, and the James G. Boswell Professor of Economics and George R. Roberts Fellow at Claremont McKenna College

- Professor Filson received his Ph.D. in Economics from the University of Rochester in 1996, and he has taught at the Claremont Colleges since 1997. Most of his research and teaching focuses on the intersections of industrial organization, finance and strategy with an emphasis on industry evolution and innovation.

Recommendations from the Huron Report

The 2023 Community Clinical and Social Needs Assessment assessed three primary themes:

1. Provide the Desert Healthcare District with a clear understanding of the district's healthcare needs.
2. Analyze the currently available health assets to district residents to find gaps between community demand for services and healthcare district supply.
3. Combine recommended short - and long-term initiatives, measures of success, and timelines into actionable recommendations to spur district development.

Addressing these themes, the report recommended two specific goals:

1. Proactively expand community access to primary and specialty care services.
2. Proactively expand community access to behavioral/mental health services.

These goals were quantified by identifying significant gaps in physician shortages in 3 specialties:

Specialty	Gap to Target (full time equivalents)
Primary Care	181.0
Psychiatry	36.5
Surgery Specialties	46.3
Total	**263.8**

Building on the insights from the Huron Recommendations, it's clear that addressing physician shortages requires more than just recruitment efforts. To create a sustainable solution, we need the infrastructure capable of supporting an increase in physician supply. Physicians do not work alone. They require a trained staff to assist and run a successful practice.

The methodology used in this study estimates economic impacts by modeling offices or practices of physicians and psychiatrists. They are modeled as units, not the sum of individual occupations. In this way, the economic effects of running a practice (i.e., supplies, facility rent, etc.) are also included in the methodological models.

Establishing office configurations to supply recommended additions

Two model configurations were created to estimate office staffing for adding the 264 physicians needed. One is a traditional private practice office, and one is a community health clinic providing comprehensive services (including dental), often set up as a Federally Qualified Health Center (FQHC), to provide primary care to underserved communities.

These configurations were set up from an amalgam of research on typical physician office staffing, as well as input from interviews of local healthcare leaders.

Offices of Physicians

Employee	Quantity
Physicians	2
Registered Nurse (RN)	1 minimum
Licensed Practical Nurse (LPN) or Medical Assistant (MA)	1-2
Administrative Staff	2-3
Clinic Manager	1
Billing and Coding Specialist	1
Total	**8 - 10**

2 PHYSICIANS + 8 STAFF = OFFICE WITH 10 EMPLOYEES

This model will be used for all three recommended specialties: Primary care, Psychiatry, and Surgical Specialties

Community Health Clinics

Employee	Quantity
Physicians	8
Administrative Staff – Front Desk	16
Benefits Coordinators	4
Dentists	8
Dental Assistants	4
Behavioral Health Staff (e.g., Social Workers)	4
Case Managers	4
Total	**48**

8 PHYSICIANS + 40 STAFF = COMMUNITY HEALTH CLINIC WITH 48 EMPLOYEES (ROUNDED TO 50 EMPLOYEES)

This model will not be used for Psychiatric and Surgical Specialty offices as those specialties are not traditionally offered in Community Health Clinics.

Regional Economic Impact Models

This report provides estimates of the economic impacts of expanding the healthcare workforce in the Coachella Valley. Findings were developed using IMPLAN Economic Impact Analysis methodology and software.

As said above, this report models two expansion types: ***Offices of physicians and Community Health Clinics***. In each case, the analysis considers the impact of adding a 50-person facility. The analysis results can also be interpreted as adding combinations of facilities that employ 50 people, such as two 25-person facilities, five 10-person facilities, or a combination of one 17-person facility and one 33-person facility.

The Huron report focused on three principal needs: Primary Care, Psychiatry, and Surgery Specialists. For Psychiatry and Surgery Specialists, the Offices of Physicians expansion model type is used. For primary care, we assigned a part of the estimate need of 181 physicians to the Offices of Physicians model and a part to the Community Health Clinics model. These proportions can be adjusted based on later estimates on how many full-service community health clinics are needed versus providing care in traditional private general practitioner offices.

The analysis focuses on the total annual economic impact associated with the expansion, including the impact on output (revenues), economic activity (value added), employment, and employee earnings in the Coachella Valley. Implications for expanded tax revenues and revenue gains for local industries most impacted by these expansions are also discussed.

Results scale in a linear way: if one wanted to consider adding a 100-person facility (or the equivalent in terms of employed people, such as two 50-person facilities), one would simply double the magnitudes reported here. Similarly, if one wanted to consider adding a single 10-person facility, one would divide the magnitudes reported here by 5.

Some expansions may require constructing new healthcare facilities or renovating existing buildings or spaces. This analysis does not include the economic impact associated with the construction of new healthcare facilities. Rather, it focuses on the annual impact associated with operations once the facilities are running.

Healthcare workers moving to the Coachella Valley may bring with them partners, family members, etc. Some partners or family members might start new businesses or contribute in other ways to economic activity in the Coachella Valley. This analysis does not include such potential impacts. The analysis focuses on the operations of the healthcare facility, local suppliers to the facility, local suppliers to those suppliers, and so on, along with local spending by employees and other recipients of value added (including owners of firms and local governments) by the healthcare facility and all impacted suppliers.

Methodology

Offices and clinics are assumed to have the typical employee composition for the Coachella Valley as revealed in interviews. For example, if a typical 50-person clinic has eight physicians, four benefits coordinators, eight dentists, four social workers, etc., then the 50-person expansion considered in this report has the same composition. The analysis relies on economic data from the area that includes the typical revenues, number of employees, and employee earnings of the types of facilities we are examining.

The accuracy of the estimates of employee earnings were checked using Occupational Reports along with the typical office employee compositions. One can combine the typical earnings of each type of employee in a typical office, and the results will closely approximate what the IMPLAN methodology used will estimate.

Terminology

Impact	Employment[1]	Labor Income[2]	Value Added[3]	Output[4]
Direct[5]	50	$4,939,603	$4,769,911	$7,586,661
Indirect[6]	11.26	$538,218	$843,066	$1,623,895
Induced[7]	18.45	$863,983	$1,705,553	$2,814,141
Total[8]	79.71	$6,341,805	$7,318,530	$12,024,696

Above is a typical table used throughout this report to present the estimated findings. The following are definitions of terminology used in these tables:

[1] **Employment** includes full and part-time jobs, the self-employed and sole proprietors.

[2] **Labor Income** = employee compensation + proprietor income

Includes wages and benefits and the earnings of the self-employed and sole proprietors (physicians running a physician's office, for example).

In the case of a physician's office owned by the physician, the physician's income would likely be recorded as "proprietor income" rather than "employee compensation." This analysis does not distinguish between the two. It focuses on the entire category of "labor income."

[3] **Value added** = output – the cost of intermediate inputs

The counterpart to gross regional product (GRP) or gross domestic product (GDP), the standard measures of macroeconomic activity. For example, suppose a restaurant sells a steak for $40. The output (revenues) associated with the steak is $40. Now suppose the restaurant bought the steak for $15. For simplicity, assume there are no other inputs required. The value added is **$40 - $15 = $25**.

[4] **Output** = revenues

"Double counts" value added. It includes the revenue from the medical office as well as the revenue from which the office buys supplies, etc.

Value added avoids the double-counting of revenue.

[5] **Direct** impacts pertain to the healthcare facility's own activities: employment, labor income, revenue, and value added (revenue – costs).

[6] **Indirect** impacts are associated with the healthcare facility purchasing inputs (supplies, etc.) from local suppliers, those suppliers purchasing from other local suppliers, and so on.], creating a ripple effect of economic activity.

[7] **Induced** impacts are the effects that occur when employees and other recipients of value added (including owners of firms and local governments) of the healthcare facility and all impacted suppliers spend their earnings within the local economy. This includes spending on goods, services, and other local products.

[8] **Total** impacts include all the effects of the healthcare facility's operations—combining the direct, indirect, and induced impacts to show the full economic contribution of the facility to the local economy.

Adjustments to IMPLAN's default assumptions:

For this study, IMPLAN's default settings were customized in two principal ways. First, IMPLAN's assumptions based on within-county (Riverside County) trade were found to be implausible. They improperly assume that for some goods and services Coachella Valley (CV) firms and households engage in a considerable number of purchases outside of the CV, as do many in the western portion of the county. Also, it assumes that many firms export too much of their output domestically (outside the CV but within the US). For this report, we propose purchases for utilities, wholesale goods, retail goods, construction, maintenance, and most other services are local to the CV. Basically, when these goods are produced locally, they are consumed locally to the extent possible. Thus, this report minimizes the import and export of most services and goods outside of the Coachella Valley.

Second, IMPLAN defaults assume I level of commuting in or out of the Coachella Valley based on the typical patterns of the whole of Riverside County, putting too much weight on the commuting patterns in the Western section of the county to LA County and Orange County. For this report, we assume that nearly all employees live (and hence consume most of their goods and services) within the CV. An estimate of 0% in-commuting is based in part on the geographical isolation of the Coachella Valley, but it is also informed by experts leveraging direct knowledge of commuting patterns and residential patterns of employees (for example, the Occupation Reports on Healthcare Practitioners and Support Occupations).

Offices of Physicians

Applicable to Primary Care, Psychiatry and Surgical Specialties needs

Suppose employment in offices of physicians in the Coachella Valley expands by 50 people (with the composition of typical such offices). The estimated impacts are in Table 1.

Table 1. The Economic Impacts of a 50-person expansion of physicians' offices in the Coachella Valley

Impact	Employment	Labor Income	Value Added	Output
Direct	50	$4,939,603	$4,769,911	$7,586,661
Indirect	11.26	$538,218	$843,066	$1,623,895
Induced	18.45	$863,983	$1,705,553	$2,814,141
Total	**79.71**	**$6,341,805**	**$7,318,530**	**$12,024,696**

- Each 50-person physician office is expected to create approximately
  - 80 jobs in the Coachella Valley (50 in the office (direct) and 30 (indirect and induced) others)
  - $6.3M in Employee Earnings ($4.9M direct from the office and the remainder from indirect and induced income in the CV)
  - $7.3M in value added (revenues – costs)
  - $12.0M in output in the Coachella Valley ($7.6M from the office and the remainder from indirect and induced outcomes in the CV).

Table 2. Tax Implications of a 50-person expansion of physicians' offices in the Coachella Valley

Impact	Sub County General	Sub County Special Districts	County	State	Federal	Total
Direct	$19,130	$23,776	$15,999	$104,420	$798,158	$961,482
Indirect	$9,821	$12,124	$8,151	$40,500	$103,126	$173,722
Induced	$31,704	$39,071	$26,259	$112,239	$179,351	$388,624
Total	**$60,655**	**$74,971**	**$50,409**	**$257,158**	**$1,080,635**	**$1,523,828**

Sub-County General: Cities and Townships
Sub-County Special Districts: For services such as Fire, School, Sewer, Water (this includes the Desert Healthcare District)
County: Riverside County

Generally, over some long-time horizon, on average within the U.S. each tax dollar comes back to the taxpayer as funds get redistributed within the county, state, or country, but there is clearly variation due to factors like military bases, prisons, government-funded research facilities, welfare-related transfers, and so on.

If we abandon the typical case (where every tax dollar comes back to the region providing the dollar), we do not have a good way to estimate how much of the county, state, and federal tax revenue gets returned to the Coachella Valley as transfers to residents, infrastructure investments, services, etc. Local officials might have insight into whether the Coachella Valley receives more or less than it contributes to the county, state, or country, but we expect that, in many cases, it would be hard for local officials to know (they might not be aware of the costs associated with a particular federally funded effort, for example).

And here are two additionally critical issues. First, if bringing a physician's office to the Coachella Valley involves removing it from somewhere else in the U.S. (so the office moves), federal tax revenues are not expected to be impacted. Similarly, if an office moves from within California, state tax revenues are not expected to be impacted.

And if an office moves from within Riverside County, county tax revenues are not expected to be impacted. Second, many government programs are funded through borrowing rather than through tax revenues. This is another reason local government spending might not have a strong relationship with local tax revenues.

Table 3. Annual Industry Outputs Impacted $50k or more by a 50-person expansion of physicians' offices in the Coachella Valley

Industry	Impact on Output	Percentage of Total Industry Output
Other real estate	$440,691	0.01%
Owner-occupied housing	$426,795	0.02%
Full-service restaurants	$189,841	0.01%
Medical and diagnostic laboratories	$177,701	0.11%
Wholesale - Professional and commercial equipment and supplies	$164,711	0.08%
Hospitals	$151,689	0.01%
Other local government enterprises	$133,408	0.01%
Limited-service restaurants	$127,819	0.01%
Employment services	$109,354	0.04%
Other financial investment activities	$104,356	0.02%
Hotels and motels, including casino hotels	$103,094	0.01%
All other food and drinking places	$99,698	0.03%
Retail - Motor vehicle and parts dealers	$78,552	0.01%
Retail - Food and beverage stores	$61,010	0.01%
Securities and commodity contracts intermediation and brokerage	$60,447	0.02%
Management consulting services	$53,417	0.04%
Monetary authorities and depository credit intermediation	$52,371	0.01%
Outpatient care centers	$50,003	0.01%
Total	**$2,584,957**	

This table (as well as the following Table 9 and Table 12) outlines how much Valley business sectors are positively impacted by the proposed office expansion. The actions of a new medical office – labor income, revenue, etc. – positively impact other local businesses disproportionately as noted in the table. The relatively high incomes of office staff, their behaviors in the local economy, as well as the purchasing of goods locally for this specialized business, are reflected in these estimates. Only industry sectors with an estimated $50,000 or more economic impact were considered.

Community Health Clinics

Applicable to Primary Care

Suppose employment in community health clinics in the Coachella Valley expands by 50 people (with the composition of typical such centers). The estimated impacts are in Table 4.

Table 4. The Economic Impacts of a 50-person expansion of community health clinics in the Coachella Valley

Type of Impact	Employment	Labor Income	Value Added	Output
Direct	50	$4,514,878	$5,452,295	$8,321,364
Indirect	15.29	$678,358	$1,030,214	$1,890,601
Induced	17.42	$815,598	$1,610,063	$2,656,641
Total	**82.71**	**$6,008,834**	**$8,092,572**	**$12,868,606**

Table 5. Tax Implications of a 50-person expansion of community health clinics in the Coachella Valley

Impact	Sub County General	Sub County Special Districts	County	State	Federal	Total
Direct	$13,820	$17,222	$11,593	$113,484	$774,081	$930,200
Indirect	$10,477	$12,939	$8,699	$44,931	$127,881	$204,926
Induced	$29,929	$36,883	$24,789	$105,954	$169,308	$366,863
Total	**$54,226**	**$67,044**	**$45,080**	**$264,369**	**$1,071,270**	**$1,501,989**

Table 6. Annual Industry Outputs Impacted $50k or more by a 50-person expansion of community health clinics in the Coachella Valley

Industry	Impact on Output	Percentage of Total Industry Output
Other real estate	$473,660	0.01%
All other food and drinking places	$472,725	0.13%
Owner-occupied housing	$402,952	0.01%
Medical and diagnostic laboratories	$189,605	0.12%
Hospitals	$143,186	0.01%
Employment services	$140,463	0.05%
Full-service restaurants	$137,064	0.01%
Other local government enterprises	$131,579	0.01%
Limited-service restaurants	$109,866	0.01%
Other financial investment activities	$100,809	0.02%
Wholesale - Professional and commercial equipment and supplies	$84,654	0.04%
Offices of physicians	$80,211	0.01%
Hotels and motels, including casino hotels	$78,607	0.01%
Securities and commodity contracts intermediation and brokerage	$75,655	0.02%
Retail - Motor vehicle and parts dealers	$74,418	0.01%
Monetary authorities and depository credit intermediation	$58,543	0.02%
Retail - Food and beverage stores	$57,629	0.01%
Total	**$2,811,626**	

The Huron Report calculated these estimated gaps between the Valley's current supply of Primary Care, Psychiatry, and Surgery Specialists physicians and the targets necessary to adequately service its regions' needs.

Specialty	Gap to Target
Primary Care	181.0
Psychiatry	36.5
Surgery Specialties	46.3
Total	**263.8**

The economic modeling methodology in this report generates estimates based on physician offices. When comparing the relative labor and supply costs of running an office of Psychiatrists or Surgery Specialists, the differences were reasonably negligible at the level of this study. As such, despite the wide range of specialists of Psychiatric and Surgery physicians, this study recognizes such offices as comparable enough to combine the gaps of both.

Due to the use of 50-person offices as a base for estimating economic impacts, we have rounded the gaps to target accordingly for ease of calculation and clarity.

Specialty	Gap to Target
Primary Care	180
Psychiatry & Surgery Specialties	80
Total	**260**

Adding Primary Care Physicians

Scenario:

- Add 100 physicians in a traditional office of physicians
- Add 80 physicians in a Community Health Clinic Model - Federally Qualified Health Center (FQHC)

Traditional Physician Office – 100 physicians

a. 2 physicians + 8 staff = 10 employee office
b. Table 1 quantifies a 50-employee office = 10 physicians
c. Need for 100 physicians = 10 additional 50-employee offices
d. Multiply quantities in Tables 1 - 3 by 10

Table 7. The Economic Impacts of adding 10 – 50 employee physicians offices (100 additional physicians)

Impact	Employment	Labor Income	Value Added	Output
Direct	500	$49,396,030	$47,699,110	$75,866,610
Indirect	112.6	$5,382,180	$8,430,660	$16,238,950
Induced	184.5	$8,639,830	$17,055,530	$28,141,410
Total	**797.1**	**$63,418,040**	**$73,185,300**	**$120,246,970**

Table 8. Tax Implications of adding 10 – 50 employee physicians offices (100 additional physicians)

Impact	Sub County General	Sub County Special Districts	County	State	Federal	Total
Direct	$191,300	$237,760	$159,990	$1,044,200	$7,981,580	$9,614,820
Indirect	$98,210	$121,240	$81,510	$405,000	$1,031,260	$1,737,220
Induced	$317,040	$390,710	$262,590	$1,122,390	$1,793,510	$3,886,240
Total	**$606,550**	**$749,710**	**$504,090**	**$2,571,590**	**$10,806,350**	**$15,238,280**

Table 9. Annual Industry Outputs Impacted $50k or more by adding 10 – 50 employee physicians offices (100 additional physicians)

Industry	Impact on Output	Percentage of Total Industry Output
Other real estate	$4,406,910	0.10%
Owner-occupied housing	$4,267,950	0.20%
Full-service restaurants	$1,898,410	0.10%
Medical and diagnostic laboratories	$1,777,010	1.10%
Wholesale - Professional and commercial equipment and supplies	$1,647,110	0.80%
Hospitals	$1,516,890	0.10%
Other local government enterprises	$1,334,080	0.10%
Limited-service restaurants	$1,278,190	0.10%
Employment services	$1,093,540	0.40%
Other financial investment activities	$1,043,560	0.20%
Hotels and motels, including casino hotels	$1,030,940	0.10%
All other food and drinking places	$996,980	0.30%
Retail - Motor vehicle and parts dealers	$785,520	0.10%
Retail - Food and beverage stores	$610,100	0.10%
Securities and commodity contracts intermediation and brokerage	$604,470	0.20%
Management consulting services	$534,170	0.40%
Monetary authorities and depository credit intermediation	$523,710	0.10%
Outpatient care centers	$500,030	0.10%
Total	**$25,849,570**	**4.60%**

Community Health Clinic Model – 80 physicians

a. Estimated 8 physicians per 50 employee clinic = 10 clinics

b. Multiply Tables 4-6 quantities by 10

Table 10. The Economic Impacts of adding 10 – 50 employee clinics (80 additional physicians)

Type of Impact	Employment	Labor Income	Value Added	Output
Direct	500	$45,148,780	$54,522,950	$83,213,640
Indirect	152.9	$6,783,580	$10,302,140	$18,906,010
Induced	174.2	$8,155,980	$16,100,630	$26,566,410
Total	**827.1**	**$60,088,340**	**$80,925,720**	**$128,686,060**

Table 11. Tax Implications of adding 10 – 50 employee clinics (80 additional physicians)

Impact	Sub County General	Sub County Special Districts	County	State	Federal	Total
Direct	$138,200	$172,220	$115,930	$1,134,840	$7,740,810	$9,302,000
Indirect	$104,770	$129,390	$86,990	$449,310	$1,278,810	$2,049,260
Induced	$299,290	$368,830	$247,890	$1,059,540	$1,693,080	$3,668,630
Total	**$542,260**	**$670,440**	**$450,810**	**$2,643,690**	**$10,712,700**	**$15,019,890**

Table 12. Annual Industry Outputs Impacted $50k or more by adding 10 – 50 employee clinics (80 additional physicians)

Industry	Impact on Output	Percentage of Total Industry Output
Other real estate	$4,736,600	0.08%
All other food and drinking places	$4,727,250	1.04%
Owner-occupied housing	$4,029,520	0.08%
Medical and diagnostic laboratories	$1,896,050	0.96%
Hospitals	$1,431,860	0.08%
Employment services	$1,404,630	0.40%
Full-service restaurants	$1,370,640	0.08%
Other local government enterprises	$1,315,790	0.08%
Limited-service restaurants	$1,098,660	0.08%
Other financial investment activities	$1,008,090	0.16%
Wholesale - Professional and commercial equipment and supplies	$846,540	0.32%
Offices of physicians	$802,110	0.08%
Hotels and motels, including casino hotels	$786,070	0.08%
Securities and commodity contracts intermediation and brokerage	$756,550	0.16%
Retail - Motor vehicle and parts dealers	$744,180	0.08%
Monetary authorities and depository credit intermediation	$585,430	0.16%
Retail - Food and beverage stores	$576,290	0.08%
Total	**$28,116,260**	**4.00%**

Total Impacts of adding 180 Primary Care Physicians

Table 13. The Economic Impacts of adding 180 physicians

Impact	Employment	Labor Income	Value Added	Output
Direct	1000	$94,544,810	$102,222,060	$159,080,250
Indirect	265.5	$12,165,760	$18,732,800	$35,144,960
Induced	358.7	$16,795,810	$33,156,160	$54,707,820
Total	**1624.2**	**$123,506,380**	**$154,111,020**	**$248,933,030**

Table 14. Tax Implications of adding 180 physicians

Impact	Sub County General	Sub County Special Districts	County	State	Federal	Total
Direct	$329,500	$409,980	$275,920	$2,179,040	$15,722,390	$18,916,820
Indirect	$202,980	$250,630	$168,500	$854,310	$2,310,070	$3,786,480
Induced	$616,330	$759,540	$510,480	$2,181,930	$3,486,590	$7,554,870
Total	**$1,148,810**	**$1,420,150**	**$954,900**	**$5,215,280**	**$21,519,050**	**$30,258,170**

Table 15. Annual Industry Outputs Impacted $50k or more by adding 180 physicians

Industry	Impact on Output	Percentage of Total Industry Output
Offices of physicians	$160,402,030	3.31%
All other food and drinking places	$5,724,230	1.34%
Employment services	$2,498,170	0.80%
Full-service restaurants	$3,269,050	0.18%
Hospitals	$2,948,750	0.18%
Hotels and motels, including casino hotels	$1,817,010	0.18%
Limited-service restaurants	$2,376,850	0.18%
Management consulting services	$534,170	0.40%
Medical and diagnostic laboratories	$3,673,060	2.06%
Monetary authorities and depository credit intermediation	$1,109,140	0.26%
Offices of physicians	$802,110	0.08%
Other financial investment activities	$2,051,650	0.36%
Other local government enterprises	$2,649,870	0.18%
Other real estate	$9,143,510	0.18%
Outpatient care centers	$500,030	0.10%
Owner-occupied housing	$8,297,470	0.28%
Retail - Food and beverage stores	$1,186,390	0.18%
Retail - Motor vehicle and parts dealers	$1,529,700	0.18%
Securities and commodity contracts intermediation and brokerage	$1,361,020	0.36%
Wholesale - Professional and commercial equipment and supplies	$2,493,650	1.12%
Total	**$53,965,830**	**8.60%**

Adding Psychiatrists and Surgery Specialists

Scenario:

- Add 37 Psychiatrists
- Add 46 surgery specialists

Add 80 new physicians

a. 2 physicians + 8 staff = 10 employee office

b. Table 1 quantifies a 50-employee office > 5 - 10 employee offices = 10 physicians

c. Need for 83 new physicians = 8 new 50-employee offices (round down to 80)

d. Multiply quantities in Tables 1-3 by 8

Table 16. The Economic Impacts of adding 8 new 50-employee offices

Impact	Employment	Labor Income	Value Added	Output
Direct	400	$39,516,824	$38,159,288	$60,693,288
Indirect	90.08	$4,305,744	$6,744,528	$12,991,160
Induced	147.6	$6,911,864	$13,644,424	$22,513,128
Total	**637.68**	**$50,734,432**	**$58,548,240**	**$96,197,576**

Table 17. Tax Implications of adding 8 new 50-employee offices

Impact	Sub County General	Sub County Special Districts	County	State	Federal	Total
Direct	$153,040	$190,208	$127,992	$835,360	$6,385,264	$7,691,856
Indirect	$78,568	$96,992	$65,208	$324,000	$825,008	$1,389,776
Induced	$253,632	$312,568	$210,072	$897,912	$1,434,808	$3,108,992
Total	**$485,240**	**$599,768**	**$403,272**	**$2,057,272**	**$8,645,080**	**$12,190,624**

Table 18. Annual Industry Outputs Impacted $50k or more by adding 8 new 50-employee offices

Industry	Impact on Output	Percentage of Total Industry Output
Other real estate	$3,525,528	0.08%
Owner-occupied housing	$3,414,360	0.16%
Full-service restaurants	$1,518,728	0.08%
Medical and diagnostic laboratories	$1,421,608	0.88%
Wholesale - Professional and commercial equipment and supplies	$1,317,688	0.64%
Hospitals	$1,213,512	0.08%
Other local government enterprises	$1,067,264	0.08%
Limited-service restaurants	$1,022,552	0.08%
Employment services	$874,832	0.32%
Other financial investment activities	$834,848	0.16%
Hotels and motels, including casino hotels	$824,752	0.08%
All other food and drinking places	$797,584	0.24%
Retail - Motor vehicle and parts dealers	$628,416	0.08%
Retail - Food and beverage stores	$488,080	0.08%
Securities and commodity contracts intermediation and brokerage	$483,576	0.16%
Management consulting services	$427,336	0.32%
Monetary authorities and depository credit intermediation	$418,968	0.08%
Outpatient care centers	$400,024	0.08%
Total	**$20,679,656**	**3.68%**

Total Impacts of Implementing the Huron Recommendations

Specialty	Gap to Target
Primary Care	180
Psychiatry & Surgery Specialties	80
Total	**260**

Table 19. The Economic Impacts of adding 260 new physicians

Impact	Employment	Labor Income	Value Added	Output
Direct	1400	$134,061,634	$140,381,348	$219,773,538
Indirect	355.58	$16,471,504	$25,477,328	$48,136,120
Induced	506.3	$23,707,674	$46,800,584	$77,220,948
Total	**2261.88**	**$174,240,812**	**$212,659,260**	**$345,130,606**

Table 20. Tax Implications of adding 8 new 50-employee offices

Impact	Sub County General	Sub County Special Districts	County	State	Federal	Total
Direct	$482,540	$600,188	$403,912	$3,014,400	$22,107,654	$26,608,676
Indirect	$281,548	$347,622	$233,708	$1,178,310	$3,135,078	$5,176,256
Induced	$869,962	$1,072,108	$720,552	$3,079,842	$4,921,398	$10,663,862
Total	**$1,634,050**	**$2,019,918**	**$1,358,172**	**$7,272,552**	**$30,164,130**	**$42,448,794**

Table 21. Annual Industry Outputs Impacted $50k or more by adding 8 new 50-employee offices

Industry	Impact on Output	Percentage of Total Industry Output
Offices of physicians	$221,775,118	4.52%
All other food and drinking places	$6,521,814	1.58%
Employment services	$3,373,002	1.12%
Full-service restaurants	$4,787,778	0.26%
Hospitals	$4,162,262	0.26%
Hotels and motels, including casino hotels	$2,641,762	0.26%
Limited-service restaurants	$3,399,402	0.26%
Management consulting services	$961,506	0.72%
Medical and diagnostic laboratories	$5,094,668	2.94%
Monetary authorities and depository credit intermediation	$1,528,108	0.34%
Offices of physicians	$802,110	0.08%
Other financial investment activities	$2,886,498	0.52%
Other local government enterprises	$3,717,134	0.26%
Other real estate	$12,669,038	0.26%
Outpatient care centers	$900,054	0.18%
Owner-occupied housing	$11,711,830	0.44%
Retail - Food and beverage stores	$1,674,470	0.26%
Retail - Motor vehicle and parts dealers	$2,158,116	0.26%
Securities and commodity contracts intermediation and brokerage	$1,844,596	0.52%
Wholesale - Professional and commercial equipment and supplies	$3,811,338	1.76%
Total	**$74,645,486**	**12.28%**

Additional Demand Estimates

The Huron Report recommendations are to fill current gaps. The report estimates that by 2032 these additional physicians will be needed to address population growth and need:

Primary Care	14
Psychiatry	2
Surgical Specialties	5

Beyond adding or attracting new physicians to the Valley, one must account for current physicians leaving the workforce through retirement, relocation, or position/career changes. Data from JobsEQ, a workforce data service, provides 5-year estimates of replacement needs for occupations. Based on Quarter 2 2024 data:

- Physicians – Additional 32 demand
  - 16 will leave the workforce, 4 will relocate or take other positions, and an additional 12 will be needed based on population growth estimates. These numbers do account for the unmet need that the Huron Report recommends.
- Surgeons – Additional 3 demand
  - Estimates state that 1 surgeon will leave the workforce, 1 will relocate or take other positions, and 1 additional will be needed based on population growth estimates. These numbers do account for the unmet need that the Huron Report recommends.
- Psychiatrists – Additional 8 demand
  - Estimates state that 4 psychiatrists will leave the workforce, 1 will relocate or take other positions, and 4 additional will be needed based on population growth estimates. These numbers do account for the unmet need that the Huron Report recommends.

PRELIMINARY WORK ON HEALTH-RELATED IMPACTS

Expanding physician's offices and/or outpatient clinics in the Coachella Valley has the potential to have a positive impact on the health of the residents. Thus, there is interest in evaluating the potential impacts on:

1. Worker absenteeism
2. Productivity
3. Emergency room visits
4. Other advantages of a healthier workforce
5. Health impacts of visiting a physicians (getting regular checkups). For example, if a clinic is only open during the week, and opening it during evenings and/or weekends would lead to more physicians' visits, could we measure the health impact?

These preliminary findings summarize preliminary results from a review of textbooks and peer-reviewed literature. These findings should only be used internally for research purposes and inspiration. Some quotes and findings may not have been adequately cited or sub noted.

Preliminary Findings

1. There are many determinants of health, but isolating the impact of access to medical care is challenging, and available evidence suggests that marginal changes in non-care factors have more important impacts than do marginal changes in access to care.

Over long time periods, advances in medical care and access to such care have clearly driven improvements in important health outcomes. For example, Cutler (2004, page 63) reports that improvements in treatments for low birth-weight infants and cardiovascular disease patients extended life spans by approximately 3.5 years from 1950 to 2004. The entire improvement in life spans during the period was 9 years, so treatments for these two conditions alone clearly had substantial effects. More generally, the contributors to Murphy and Topel (2003) demonstrate that medical research has enormous benefits. Thus, we know that medical care is an important contributor to health outcomes.

Despite the obvious importance of medical care, there are substantial challenges associated with isolating and measuring the impact of marginal changes in access to care on health at a given point in time. The level of technology (including available prescription drugs) is fixed at a point in time, and essentially all Americans have access to emergency services. Thus, marginal changes, such as having an additional physician's visit every year, might have little-to-no detectable effect on measurable outcomes.

One complication is that medical care is just one of the factors that produce good health. Other contributing factors include income, wealth, education, genetics, behavior (including smoking, drinking, recreational drug use, frequency of exercise, and sitting), and other socio-economic and environmental factors (including exposure to pollutants, allergens, low-quality food, and harmful chemicals). Existing studies tend to suggest that (within modern America) other factors have larger marginal effects than marginal changes in access to care do (for example, available evidence suggests that adjustments along dimensions such as smoking vs not, being obese vs not, being sedentary vs not, being uneducated vs educated, and so on are more important than adjusting the frequency of physicians' visits).

If ethics were not a concern, an ideal study to isolate the impact of medical care on health would randomly assign a large sample of people into two categories: one would have access to care and the other would not. Of course, one cannot run such studies; they would be inhumane. Most of the limited findings come from studies of interventions that indirectly led to changes in accessing care. One famous study is the RAND Health Insurance study (1971-82): The RAND study randomly placed 7,000 individuals into 1 of 14 insurance plans and 1 health maintenance organization that varied along two dimensions: maximum out-of-pocket expenses and various coinsurance rates (coinsurance is the percentage of an expense a patient pays once they exceed their deductible: if a procedure costs $10,000 and a patient has a deductible of $100 and coinsurance of 5%, the patient pays $100 + 5% of $9,900 = $595). Some plans had deductibles and others did not. Coinsurance ranged from 0 to 95%. The maximum out-of-pocket outlay was set

at 5-15% of income up to a maximum of $1,000 per participant. After reaching the max, care was free.

The results of the experiment suggested that copays, etc., influence decisions to access care. Phelps (2003) reports that the low-coverage group used about two-thirds of the care used by the full-coverage group. Thus, the experiment allows us to examine the impact of changes in accessing care (although it clearly falls short of randomly assigning people to care vs. no care). For most participants, the plan had no measurable effect on health (the sole detectable differences were that the low-income full-coverage group had better corrected vision than their counterparts, and they also had slightly reduced blood pressure). Thus, evidence from the RAND study tends to support the view that non-care factors (smoking, alcohol abuse, overeating, under-exercising, genetics, food quality, and so on) are likely more important for explaining health differences than marginal differences in medical care are.

More recent work by Chetty et al. (2016) is also informative. Chetty et al. (2016) used data from 1999-2014 to examine the relationship between income and life expectancy while controlling for other factors; the sample consisted of 1.4B person-year observations of individuals between the ages of 40 and 76 (the main outcome of interest was life expectancy at age 40). The authors attempted to control for access to medical care by measuring the percent of the population uninsured, risk-adjusted per capita Medicare spending, quality of inpatient care (measured by 30-day hospital mortality rates), and the quality of primary and preventive care (measured by the percentage of the population with a routine primary care visit).

Although access to care was not a primary focus, one of the findings of Chetty et al. (2016) is that variation in life expectancies for individuals in the lowest income quartile across geographic areas did not correlate well with their measures of access to care. The factors that mattered included smoking, obesity, and exercise.

Life expectancy is an important measure of health outcomes, but it is far from the only measure; the next subsection discusses different measures. A useful study that incorporates outcomes other than life expectancy is described by Henderson (2023): In 2008, Oregon initiated a limited expansion of Medicaid by choosing 30k people from 90k by lottery. The experiment presented an opportunity to study the effects of Medicaid coverage on medical care use and outcomes.

After two years, the experiment showed that Medicaid coverage led to higher prescription drug use, more preventive screening, better access to primary care, and higher healthcare spending. However, the study did not detect a significant improvement in the quality of life related to health (measured blood pressure, cholesterol levels, or glycated hemoglobin levels) or in self-reported levels of happiness. Thus, the study reinforces the view that marginal changes in access to care and/or receiving care have small or nondetectable effects on health.

Henderson (2023) cites some studies that find positive impacts of access and/or receiving care on health outcomes in specific domains. For example, Currie and Gruber (1996a) found that Medicaid eligibility expansions among pregnant women improved prenatal care utilization and birth outcomes, and Currie and Gruber (1996b) found that expanding eligibility for children decreased child mortality.

2. Measuring the impact of care at a point in time is challenging

One reason marginal impacts might be hard to detect is that there are many possible measures and indicators of health. For example, one could measure life spans, the incidence of heart attacks by a certain age, days spent in a hospital by a certain age, blood pressure, cholesterol levels, need for home care, mobility, happiness, anxiety, pain, and more. Determining which measure(s) on which to focus is challenging.

Further, some measures are clearly more objective and/or easier to measure in large populations than others. Lifespans (mortality) are often used in cross-country or other regional comparisons of

health outcomes because they are less subject to interpretation and relatively easy to measure. Quality of life is often more salient to someone who is suffering, but quality of life is much more difficult to measure, particularly in large populations.

Another complicating factor is that some measures of health tend to offset each other. For example, longer life spans associated with reductions in heart attacks and strokes might be associated with higher observed rates of cancer and other late-in-life illnesses. Eventually, everyone dies from something. Longer life spans might also be associated with higher rates of in-home care, reduced mobility, more pain and isolation, and so on.

A further complication is likely minor: sometimes care harms patients. Surgeries can go wrong, medicines can cause harm, and so on.

3. Comparing geographical areas likely requires restricting attention to studies within the U.S.

It is well known that the U.S. spends far more on healthcare as a percentage of GDP than other countries and that many metrics (particularly lifespans) do not show a positive relationship between spending and health outcomes when evaluated across countries. Further, the U.S. experiences the highest rate of amenable mortality among leading economies (premature death that could have been avoided with timely access to high quality healthcare; comparisons include Canada, European countries, and Japan; see Henderson (2023, page 221). Thus, relying on data from other countries to conduct comparisons across geographies (that in some cases might make it easier to compare care vs. no-care settings) is likely inappropriate: the U.S. is sufficiently different from other countries that comparisons should be within the U.S.

4. Quality of care potentially varies across geographical regions holding access to care constant (as measured by number of clinics or physicians, for example)

This is a substantial measurement issue: Phelps (2003) discusses how the use of specific practices and procedures varies by region; such variation could have implications for health outcomes holding the number of clinics or physician's constant. This creates a measurement problem for measuring impacts of access on health, because an increase in access will typically be measured using physicians per person without considering whether knowledge and practices are state-of-the-art.

Skinner (2012) also focuses on this issue: "... what is most striking is how much variability there is in outcomes across providers or regions, and how poorly such variability is associated with factor inputs." (page 48). Thus, efforts to determine how marginal differences in access across regions impact health outcomes might fail to detect effects partly because of unmeasured differences in the adoption of specific practices and procedures.

Further, the variation in health observed across regions is only incidentally correlated with variation in healthcare utilization. As mentioned previously, most variation in health at a point in time is associated with factors other than measurable differences in care received. An additional measurement issue: the more contact one has with the healthcare system, the more likely a diagnosis is. Thus, in the short run, bringing physicians to an area or expanding clinic hours could appear to have a detrimental impact on health in the region as more problems get documented.

Physicians respond to incentives when making location decisions, and policies and programs could potentially encourage them to locate in the Coachella Valley

Phelps (2003) discusses how physicians tend to locate where the population/physician ratio is high: they look for gaps in the market and attempt to fill the gap. It is reasonable to expect that income, amenities, etc. are all considered. Thus, the main recommendation for attracting physicians to a region is to pay them enough that they're willing to come and stay.

Another device has been successful, at least for a period of time: The National Health Service Corps (NHSC) helped (Phelps (2003) physicians cover the cost of medical school in exchange for accepting an assignment to an underserved area for a fixed amount of

time. However, studies generally showed low retention rates after the contracted period had passed.

A version of the NHSC program could focus on students with pre-existing ties to the Coachella Valley: students who grow up in the area and/or have family ties to the area and want to go to medical school could be favored for support from stakeholders in the Coachella Valley in exchange for agreeing to practice in the Coachella Valley for a period after graduating. Rabinowitz (1997) explains that a rural background is a primary determinant of physicians practicing in a rural area; it seems likely that having a background in the Coachella Valley would also influence the decision to locate there.

Rabinowitz (1997) notes that having a spouse with a rural background also matters for explaining the decision to locate in a rural area. Thus, another program could potentially target people from the Coachella Valley whose partners are physicians or in medical school. Of the 204 other factors evaluated, only one matters: first-year intent to pursue family practice. Thus, Rabinowitz (1997) strongly suggests policies and programs should focus on attracting those with pre-existing ties to the area. Subsequent studies reinforce this view and suggest nuances that could be considered (Hancock et al. (2009), Verma et al. (2016)).

References

Chetty et al. (2016) JAMA
Currie and Gruber (1996a) JPE
Currie and Gruber (1996b) QJE
Cutler (2004) Your Money or Your Life
Hancock et al. (2009) Social Science & Medicine
Henderson, James W. (2023) Health Economics and Policy 8e (Cengage).
Murphy and Topel (2003) Measuring the Gains from Medical Research
Phelps (2003) Health Economics 3e
Rabinowitz (1997) Health Policy Newsletter
Skinner (2012) Handbook Chapter
Verma et al. (2016) BMC Health Services Research

Background Facts on Aggregate Activity in the Coachella Valley

IMPLAN provides the following estimates of overall economic activity in the Coachella Valley for the year 2023 (in Y2024$):

Gross Regional Product (the counterpart to GDP): $24.6B

Total Employment: 268.5k
Population: 453.4k

The impact results are reported in year 2024$.

Offices of Physicians have the following characteristics:

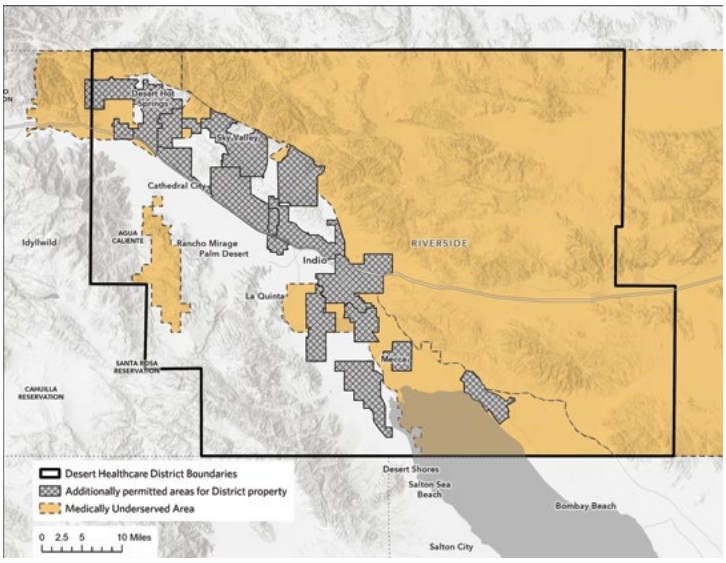
Output (Revenue): $633.6M
Wage and Employment Salary: 3,135
Employee Compensation: $378.6M
Proprietor Employment: 1,074
Proprietor Income: $34.0M

Outpatient Care Centers:

Output: $399.3M
Wage and Employment Salary: 1,831
Employee Compensation: $197.6M
Proprietor Employment: 618
Proprietor Income: $19.1M

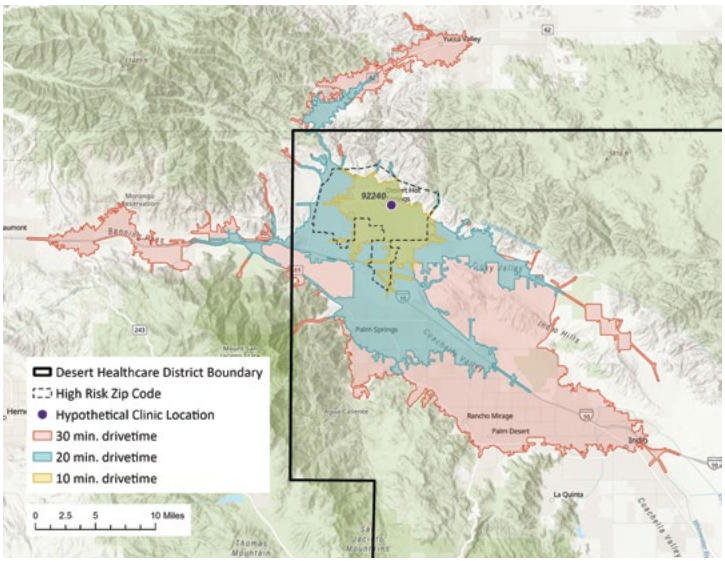
Zip Codes Included for Analysis

92201	Indio
92202	Indio
92203	Indio
92210	Indian Wells/Palm Desert
92211	Palm Desert
92234	Cathedral City
92235	Cathedral City
92236	Coachella
92240	Desert Hot Springs
92241	Desert Hot Springs
92247	La Quinta
92248	La Quinta
92253	La Quinta
92254	Mecca
92255	Palm Desert
92258	North Palm Springs
92260	Palm Desert
92261	Palm Desert
92262	Palm Springs
92263	Palm Springs
92264	Palm Springs
92270	Rancho Mirage
92274	Thermal
92276	Thousand Palms



The DHCD's Tenet Desert Lease Purchase agreement designated agreed upon areas where the District is permitted to develop, symbolized on this map with a hatch pattern.

In addition, the orange shaded areas represent Medically Underserved areas. The District is allowed to develop in these areas as well.

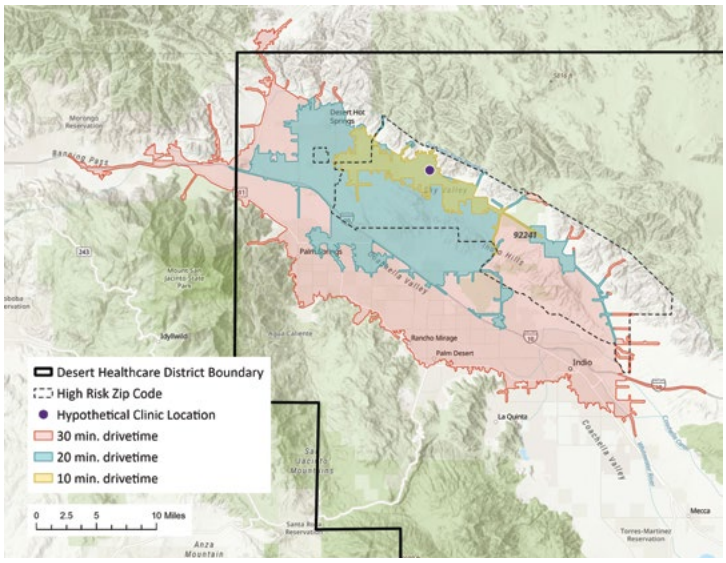


The Huron Report designated "High –Risk" communities by zip code. The Valley's Hispanic population primarily live in High-Risk Communities. High-risk communities also consist of households making less than $50,000 per year. They are expected to have annual growth higher than the Valley average of 0.41%. And high-risk communities have a population with a median age 20 years younger than low-risk communities.

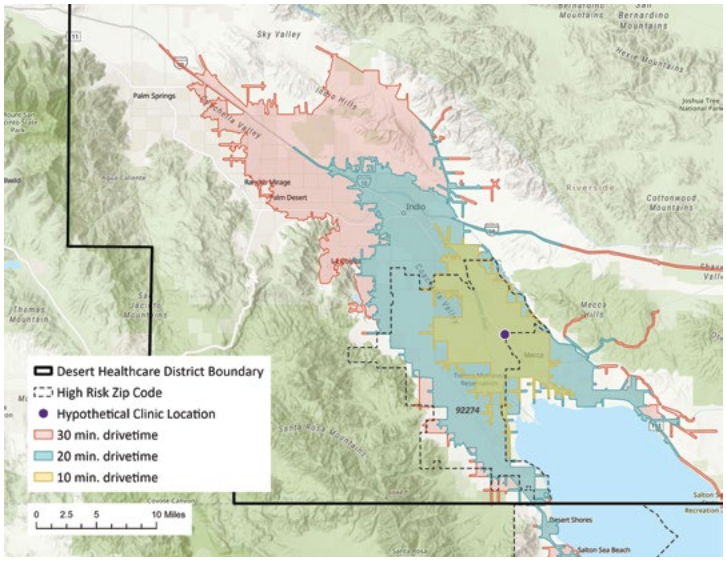
The following three maps present three hypothetical locations for future health clinics serving these high-risk communities. For each proposed location, drive-time boundaries were created for a typical 10-, 20-, and 30-minute drive. The high-risk demographics were aggregated within each of these drive-time boundaries. Note that the 30- and -20-minute drive time demographics include their respective smaller drive times.

Demographics	Drive Times		
	30 min	20 min	10 min
2024 Total Population	315,343	123,013	43,511
2024-2029 Annual Growth Rate	0.49	0.56	0.69
2024 Median Age	48.1	43.1	35.3
2024 Hispanic Population (%)	46.7	55.25	65.59
2024 Household Income (%)			
<$15,000	10.38	11.44	15.74
$15,000 - $24,999	7.48	8.37	9.98
$25,000 - $34,999	7.7	8.35	9.59
$35,000 - $49,999	11.24	12.2	13.52

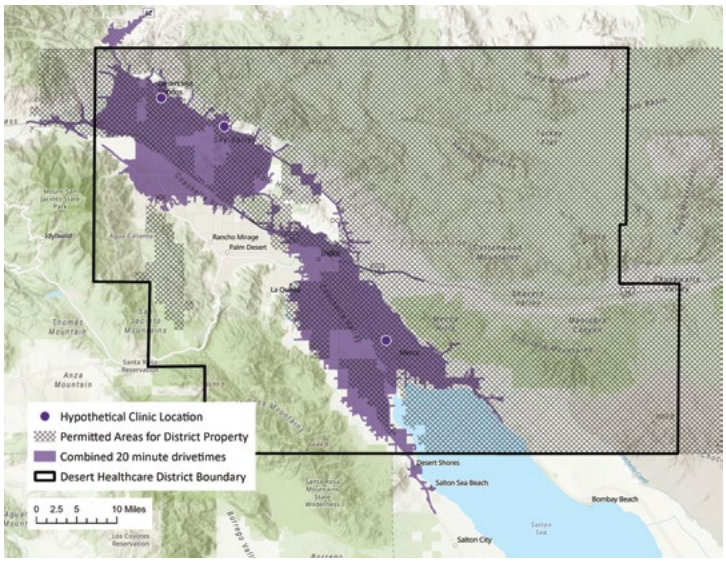
Demographics	Drive Times		
	30 min	20 min	10 min
2024 Total Population	336,252	84,760	14,075
2024-2029 Annual Growth Rate	0.52	0.53	0.31
2024 Median Age	46.2	40.6	42.8
2024 Hispanic Population (%)	52.18	59.82	56.33
2024 Household Income (%)			
<$15,000	10.18	11.41	13.62
$15,000 - $24,999	7.49	8.28	11.64
$25,000 - $34,999	7.64	8.32	11.6
$35,000 - $49,999	11.07	11.89	17.5



Demographics	Drive Times		
	30 min	20 min	10 min
2024 Total Population	283,993	152,079	16,662
2024-2029 Annual Growth Rate	0.6	0.64	0.27
2024 Median Age	42	35.2	28.9
2024 Hispanic Population (%)	61.89	80.73	97.38
2024 Household Income (%)			
<$15,000	9.72	12.22	23.87
$15,000 - $24,999	7.48	9.59	18.17
$25,000 - $34,999	7.84	8.42	9.93
$35,000 - $49,999	10.92	12.81	19.66



Demographics	20 min Drive Time
2024 Total Population	282,316
2024-2029 Annual Growth Rate	0.59
2024 Median Age	38.9
2024 Hispanic Population (%)	68.92
2024 Household Income (%)	
<$15,000	11.66
$15,000 - $24,999	8.9
$25,000 - $34,999	8.3
$35,000 - $49,999	12.36



These overall demographics are derived by combining all three 20-minute drive times into one boundary. Within a 20-minute drive, these three proposed locations would reach over 62% of the total valley population. The annual growth rate would be 18 points above the Valley estimate. 69% of the population would be Hispanic. And 41.3% of households would make less than $50,000 annually.

CONCLUSIONS

A critical component of the Huron Report's recommendations was filling the shortage of physicians in the District's boundaries. The report identified a gap of 181 primary care physicians, 37 psychiatrists, and 46 surgery specialists. This report set out to quantify the economic impacts of attracting these highly paid professionals to the Valley along with the respective support staff. Two office models were utilized to build the estimates - A 10-employee Physicians office (consisting of 2 Physicians and 8 staff) and a 50-person Community Health Clinic (consisting of 8 physicians and 40 staff).

Providing 181 primary care physicians (rounded to 180) was modeled on a distribution of 100 physicians in 10, 50-employee Physicians Offices, and 80 physicians in 10, 50-employee Community Health Clinics.

ADD 180 PRIMARY CARE PHYSICIANS

Direct Employment **= 1000**
Employee Earnings **= $94.5 million**
Revenue **= $159.1 million**

Indirect/Induced Employment **= 624**
Indirect/Induced Earnings **= $29.1 million**
Indirect/Induced Revenue **= $89.9 million**

Providing 35 Psychiatrists and 45 Surgery Specialists (in order to round to 80 was modeled on adding 8 50-person Offices of Physicians

ADD 35 PSYCHIATRISTS AND 45 SURGERY SPECIALISTS

Direct Employment **= 400**
Employee Earnings **= $39.5 million**
Revenue **= $60.7 million**

Indirect/Induced Employment **= 238**
Indirect/Induced Earnings **= $11.2 million**
Indirect/Induced Revenue **= $35.5 million**

FULFILL THE ENTIRE PHYSICIAN GAP OF 260

Direct Employment = 1,400
Employee Earnings = $134.1 Million
Revenue = $219.8 Million

Indirect/Induced Employment = 862
Indirect/Induced Income = $40.2 Million
Indirect/Induced Revenue = $125.4 Million

Total Employment = 2,262
Income = $174.3 Million
Revenue = $345.2 Million

ADDENDUM

INTERVIEW HIGHLIGHTS

Interview highlights

To familiarize the study team with the real-world impacts of the Huron Report's recommendations, the team interviewed local healthcare leaders. Nine individuals, representing seven local healthcare organizations, were interviewed. These interviews were invaluable in uncovering the specific needs of the local healthcare community in the context of the Huron report findings. Most importantly, these interviews helped solidify a local perspective on the configuration of successful and Valley specific Community Health Centers. The team also gained greater perspective on the needs and goals of a variety of Health delivery modalities, from hospitals to Primary Care facilities.

Jim Mangia – President and CEO of St John's Community Health
Claudia Galvez - Chief Office of Government and Community Relations, Innercare
Gemma Kim, MD (Family Medicine/ Primary Care) and Tae Kyu Kim, MD (Family Medicine/Primary Care, DPMG Health
Brandy Orr, MBA - Chief Strategy Officer, DAP Health
Ken Wheat - Executive Vice President, Chief Operating Officer, Eisenhower Health
Michele Finney, CEO and **Linda Evans**, Chief Strategy Officer for Community Advocacy, Desert Care Network
Les Zendle, MD – Former Director of Desert Healthcare District & Foundation

General Challenges

- Impending retirement of many healthcare professionals
- High turnover of staffing
- Importance of establishing a local 4-year college here
  - graduates often stay in area
  - "My dream – open a medical school here"
- Salton Sea health effects

Attracting Medical Personnel

- Cost of living (especially housing) high for people relocating to the area from outside of California
- Expand localized training
  - People will stay if trained here
  - Training for staff is critical – exceedingly difficult to find non-medical support staff – perhaps more COD programs
  - "Grow our own physicians"
  - Customer service training
- Help pay student loans
- Pay local students for medical school
- Create a centralized "medical recruitment" agency
- Support workforce development programs at clinics
  - More partnerships with PaCE – COD Program
- Investigate Trailing Spouse programs
- Create a "trusted" cost-of-living calculator for professionals considering relocating here
- Attracting Physicians
  - Physicians are willing to earn less to live closer to the coast
  - Expand local residency opportunities
    - Make Desert Regional a true academic hospital
    - Expand program that brings physicians from Mexico, even temporarily – VISA and housing assistance
- Invest in retention programs

Healthcare Access Needs

- Provide more extended hours - evenings and weekends - for primary care appointments. Many in the Valley cannot access care during regular office hours
- Provide full-service clinics – "integrated experience"
  - Medical, dental, behavioral health, pharmacy, optometry
  - X-rays for simple fractures, etc.
- "Within 2 years, our clinics are full"
  - Funding for expansion
- Transportation challenges – especially in the East Valley
- Medication deliveries
- Better communications and outreach about new and expanding healthcare offerings in the Valley
- More bilingual and bicultural physicians and staff
- Emphasize prevention
  - Expand access to routine screenings
- Make Urgent Care more accessible
  - Encourage residents access Urgent Care, not the ER
- Create clinics at public schools
- Community Resilience Centers
- Telehealth for Behavioral Services

Opportunities

- The new generation of healthcare professionals have different work standards and expectations – work/life balance
  - Personal earnings are not as important as cultural and equity impacts
    - For example, community-based residencies that include things like a street medicine program are really appealing to young physicians
- Aging population and their specific needs

ADDITIONAL RECOMMENDATIONS

In addition to quantitative recommendations, the Huron Report offered these qualitative recommendations for attracting new physicians:

- Grow residency programs across DHCD, with particular focus on FQHCS
- Focus development of future brick and mortar ambulatory clinic spaces in these communities:
  - Desert Hot Springs
  - Coachella
  - Thermal
  - Mecca
- Parallel efforts to recruit physicians and/or advanced practice providers (NPS/PAS) to work in high-need areas, with focus on patient- provider concordance
- Integration of community health workers/promatoras to connect community members to resources and reduce stigma for accessing healthcare resources (e.g., care coordination, case management, etc.).

CVEP conducted seven interviews with nine leaders in healthcare in the Coachella Valley. The following are the most repeated recommendations:

- Establish a local 4-year college
- Address the health challenges posed by the Salton Sea
- Expand training for locals for health support positions
  - Provide customer service training
- Support local students to attend medical school
- Pay student loans for physicians willing to relocate to the Valley
- Create a centralized recruitment center
- Provide extended hours for health clinics – evenings and weekends
- More bilingual and bicultural physicians and staff

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