Minnesota College of Osteopathic Medicine — Bold Solution to the Physician Shortage?

Presenter: Philip Keithahn
Thursday, March 10, 2016
2:50 – 3:20 p.m.
Philip A. Keithahn, MBA

Phil Keithahn is a founding investor and chief financial officer for the proposed Minnesota College of Osteopathic Medicine. Phil is chairman of ProGrowth Bank, which is located in Gaylord, Minnesota with branches in Mankato and Nicollet. A third-generation banker, Phil joined ProGrowth Bank in 1990 after spending 7 years with Norwest Bank and Norwest Corporate Finance. During the last 35 years, he has worked on a broad range of corporate and investment banking transactions, and has financed several integrated senior health care facilities.

As CEO for Sterling Capital Advisors, Phil provides advisory services to entrepreneurs and business owners. Starting in 2013, he assembled the financing for RS Fiber Cooperative, which is building a gigabit fiber-optic broadband network in South Central Minnesota. During this assignment, Phil established a business relationship with Dr. Jay Sexter and Tony Danza as they were developing the educational strategy and feasibility analysis for MNCOM.

Phil’s knowledge of the Upper Midwest has helped MNCOM build a strategic plan that focuses on educating the next generation of physicians for service in rural America. Phil’s family has lived and worked in rural communities in Minnesota, South Dakota, Montana, Colorado, Missouri, and southern India. Phil’s family DNA includes five generations of physicians, teachers, ministers, doctors, and business owners.

Phil has an MBA with second-year honors from Harvard Business School with concentrations in business strategy and finance. His education includes a BA in Economics from Carleton College after finishing high school in Benson, Minnesota. In his spare time, Phil has led Scouts to four World Scout Jamborees, volunteered as a wrestling coach, led a Rotary mentoring program, and chaired multiple school, church, and community development committees.
Bold Solution to the Physician Shortage?

Is MNCOM a solution for the looming physician shortage?

Is MNCOM a problem for existing residency spots?

Value + Competition = Disruptive Innovation

Presented by Philip A. Keithahn, Chief Financial Officer, March 10, 2016
“Managers tend to pick a strategy that is least likely to fail rather than pick a strategy that is most efficient,” said Palmer.

‘The pain of looking bad is worse than the gain of making the best move.’

Michael M. Lewis
Moneyball: The Art of Winning an Unfair Game

Leaders AND Managers

Leadership is doing the right things; management is doing things right. — Peter Drucker
“Win-Win” Agenda

• Background & Vision – A CEO’s View
• Minnesota Healthcare Outlook
• Rural Minnesota Healthcare Crisis
• Osteopathic Medical School Solution
• Rural Minnesota Healthcare Strategy

Background

Why Would a Medical School Come to Gaylord, MN?
From Banker to Medical Educator
MNCOM and Other DO Schools

<table>
<thead>
<tr>
<th>Data as of 2013: 26 private and 11 public campuses</th>
<th>All Osteopathic Medical Schools</th>
<th>Touro COMs</th>
<th>MNCOM (2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median Class Size</td>
<td>162</td>
<td>135</td>
<td>150</td>
</tr>
<tr>
<td>Median Graduates</td>
<td>156</td>
<td>130</td>
<td>TBD</td>
</tr>
<tr>
<td>Median Attrition</td>
<td>4.00%</td>
<td>3.85%</td>
<td>&lt;4%</td>
</tr>
<tr>
<td>Median Tuition (2013)</td>
<td>44,140</td>
<td>48,270</td>
<td>46,100</td>
</tr>
<tr>
<td>Total School Costs (Non-Res.)</td>
<td>74,093</td>
<td>86,043</td>
<td>73,196</td>
</tr>
<tr>
<td>Average Debt, 2013 Graduates</td>
<td>218,227</td>
<td>235,326</td>
<td>215,576</td>
</tr>
<tr>
<td>Median Revenues per Student</td>
<td>55,679</td>
<td>67,393</td>
<td>47,145</td>
</tr>
<tr>
<td>Median Expenses per Student</td>
<td>43,957</td>
<td>44,142</td>
<td>28,783</td>
</tr>
<tr>
<td>Pretax Profit before Interest, Debt Service, and Taxes</td>
<td>11,673</td>
<td>23,251</td>
<td>18,362</td>
</tr>
</tbody>
</table>

Gaylord < 75 miles from:
- 60% of MN hospital beds,
- 26% of rural hospital beds
- 13 private colleges
- 3 state universities
- University of Minnesota

Rural/Urban “Win-Win” Collaboration

Within 2 Hours of Gaylord
- 85% of MN physicians
- 80% of MN primary care physicians.
Minnesota Private College Network

60%+ of medical students live in the state where they receive their degree.

Each year, almost 250 Minnesota students enroll in medical schools outside of Minnesota.

- 95 students enroll in osteopathic schools of medicine.
- ~150 Minnesota students enroll in allopathic medical schools.

Minnesota State Colleges & Universities – (Articulation, Collaboration and Affiliation Agreements)

Minnesota graduates of private and public state colleges and universities will have a clearly defined path to gain acceptance at MNCOM.

- Early Application / Decision
- 28/29+ MCAT
- 3.50+ GPA
- 4,000 Applications
- 1,000 Interviews
- Qualified MN Students guaranteed an interview
MNCOM Vision, Focus, & Goals

- 4-year Graduate School for Osteopathic Medicine in Rural Minnesota.
- Educate 150 doctors annually with 50%+ serving Rural America.
- By year five, MNCOM will have 600 medical school students and 80+ students in the Master’s program.
- Faculty will include full-time DO and MD Professors and part-time Adjunct Professors, so classroom education is integrated with clinical experiences.

**Goals:**
- Recruit Upper Midwest students to attend a medical school in rural MN.
- Mix of clinic and hospital rotations & residencies in MN & adjacent states.
- At least 50% of graduates pursue medical careers in Greater Minnesota.
- At least 50% of graduates pursue medical careers in primary care.
- Quality medical education: integrated, team-based curriculum.
- At least 50% of residencies in MN – blend of rural and urban educators.

Feasibility Study

stop looking at the problem and start looking at the solution

Dear Optimist, Pessimist, and Realist,

While you guys were busy arguing about the glass of water, I drank it!

Sincerely,
The Opportunist

WANTED!
A Problem for my Solution
REWARD!
If satisfied with existing status...

- Why is MN ranked #38 in healthcare disparities?
- Why do rural MN citizens face a 31% higher likelihood of premature death?
- Why are rural hospitals hurting?
- Why do 250+ medical students leave MN annually?
- Why do less than 50% of those students return?
- Why are health care costs increasing at 3x income growth?

Phil is “Passionate” About MNCOM

Dividing the Pie “Fairly”  Baking a “Larger” Pie

Your eyes are bigger than your stomach
Minnesota Projections for Population Demographics, Income, and Healthcare Costs

Population Demographics Matter

### 2015-2035 Population Growth

<table>
<thead>
<tr>
<th>Region</th>
<th>Growth Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan (23)</td>
<td>0.38%</td>
</tr>
<tr>
<td>MN State Avg (87)</td>
<td>0.34%</td>
</tr>
<tr>
<td>Micropolitan (18)</td>
<td>0.26%</td>
</tr>
<tr>
<td>Rural (46)</td>
<td>0.19%</td>
</tr>
</tbody>
</table>

### 2015-2035 Age 65+ Population Growth

<table>
<thead>
<tr>
<th>Region</th>
<th>Growth Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan (23)</td>
<td>2.57%</td>
</tr>
<tr>
<td>MN State Avg (87)</td>
<td>2.22%</td>
</tr>
<tr>
<td>Micropolitan (18)</td>
<td>1.47%</td>
</tr>
<tr>
<td>Rural (46)</td>
<td>1.29%</td>
</tr>
</tbody>
</table>

Source: March 2014, MN State Demographer
Per Capita Matters

**Per Capita Income**

- Metropolitan (23): $32,706
- MN State Avg (87): $30,913
- Micropolitan (18): $25,905
- Rural (46): $24,920

Source: 2013 America’s Community Survey

**Per Capita Health Care Cost**

- Metropolitan (23): $8,004
- MN State Avg (87): $7,788
- Micropolitan (18): $7,449
- Rural (46): $7,682

Source: 2013 County Health Rankings

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Total Estimated Health Care Spending (Public and Private)

- MDH = 6% CAGR, 2025, 92,379,362,866
- 3% Growth, 2025, 64,101,123,911
- MDH = 6% CAGR, 2045, 313,105,714,740
- 3% Growth, 2045, 115,773,760,037

**2014 Forecast, Minnesota Department of Health**

After 10 years – by the year 2025 at current growth rates, the difference between 3% and 6% growth is $28 billion in total health care spending PER YEAR
At $150,000 per resident per year, for 150 students and a 3-year residency, the annual expenses are $67.5 million, but BEFORE revenues and impact on health care outcomes.

Do the Math. What would you spend each year for 10 years in order to reduce the rate of increase in total health care costs from 6% to 3%?

MN State totals of $45 billion today. The 3% difference is $1.35 billion PER YEAR.

What “success probability” is needed to win?

Source: 2015 County Health Rankings. Total MN Population of 5,420,380
Disparate Impact of Healthcare Outcomes for Rural Minnesota

Metropolitan (23 Counties)

% Veterans, 75.68%
% Native American, 54.26%
% Elderly, 67.06%
% Population, 75.48%
% Physicians, 87.20%
% Primary Care Physicians, 80.76%
% Residencies, 91.96%
% Students, 49.57%
% Property Taxes, 71.86%

Micropolitan (18 Counties)

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.44%</td>
<td>Veterans</td>
</tr>
<tr>
<td>8.43%</td>
<td>Physicians</td>
</tr>
<tr>
<td>11.29%</td>
<td>Primary Care Physicians</td>
</tr>
<tr>
<td>8.04%</td>
<td>Residencies</td>
</tr>
<tr>
<td>23.42%</td>
<td>Native American</td>
</tr>
<tr>
<td>16.00%</td>
<td>Elderly</td>
</tr>
<tr>
<td>12.52%</td>
<td>Population</td>
</tr>
<tr>
<td>13.00%</td>
<td>Property Taxes</td>
</tr>
</tbody>
</table>


Rural (46 Counties)

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.88%</td>
<td>Veterans</td>
</tr>
<tr>
<td>4.37%</td>
<td>Physicians</td>
</tr>
<tr>
<td>7.94%</td>
<td>Primary Care Physicians</td>
</tr>
<tr>
<td>0.00%</td>
<td>Residencies</td>
</tr>
<tr>
<td>22.32%</td>
<td>Native American</td>
</tr>
<tr>
<td>16.94%</td>
<td>Elderly</td>
</tr>
<tr>
<td>11.99%</td>
<td>Population</td>
</tr>
<tr>
<td>15.14%</td>
<td>Property Taxes</td>
</tr>
</tbody>
</table>

Rural & Micropolitan (64 Counties)

- % Physicians: 12.80%
- % Primary Care Physicians: 19.23%
- % Residencies: 8.04%
- % Students: 50.43%
- % Property Taxes: 28.14%
- % Veterans: 24.32%
- % Native American: 45.74%
- % Elderly: 32.94%
- % Population: 24.51%


Wellness Factors 64 Counties

- % Uninsured: 26.52%
- % Severe Housing: 23.63%
- % Single Parent: 24.18%
- % Labor Force: 24.27%
- % Unemployed: 26.95%
- % Diabetic: 29.25%
- % Under Age 18: 23.67%
- % Total Household Income: 20.43%
- % Total Health Care Costs: 23.49%

Osteopathic Medical Schools and Rural Primary Care Physicians

Minnesota Primary Care Physicians

58 New Primary Care Physicians Annually

Source: Robert Graham Center, September 2013
Physician Workforce Conclusions

**Mayo + U of MN**

- **No expansion plans**
- 482 doctors/year turn 65.
- **284 = 100% retention**
- 198 = Shortfall
- +58 = New primary care
- **256 = Combined Need**

- **250 students go to med schools in other states**

**...AND...MNCOM**

- 150 MNCOM students
- Recruit from rural
- Educate in rural
- Rotations / Residencies
  - MIX of rural and metro
  - MIX of clinics and hospitals
- **Rural FOCUS =**
  - Higher Placement
  - Higher Retention
The “**AND**” Strategy

- **Primary Care Physician Workforce**
  - Invest in Telemedicine
  - Educate Allied Health Professional TEAMS
  - Develop Pathway for Immigrant Physicians
  - Expand U of M Medical School
  - Rebalance Resources – Twin Cities & Duluth

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Residencies and Rotations

150 students x 3 years x $150,000 per student = $67,500,000 ongoing funding needs

**Existing GME**
- Reliant on State & Federal Funding and old GME Limits
- “At Capacity”
- $150,000 Cost/Resident
- No “Time” to Train
- Competition for U-of-M
- Large Hospital & Metro
- No Priority for Rural MN
- “We have our own problems”
- **Change Requires Work**

**MNCOM New GME**
- COCA approval requires:
  - Create NEW rotations
  - Creating NEW residencies
- **Rural Clinics & C.A.Hospitals**
  - Teaching Health Clinics
  - FQHC & Rural Training Track
  - VA System has programs
- Urgent Need for Rural MN
- “We need a new solution”
- **We Die If We Do Nothing**
Public “AND” Private Medical Schools

UofMN Med School

- **Taxpayer** Funding
- 230 students/year
- 960 TOTAL Students
- Metro location
- NIH Research Focus
- \((125,000,000+)\) Facilities and Start-Up
- \((35-40 Million)\) Annual Operating Losses

**MNCOM**

- **Private** Funding
- 150 NEW students/year
- 600 NEW Students
- Rural location
- Rural Primary Care Focus
- \(100,000,000\) Start-up
- **No** Taxpayer Funding
- \(2-3 Million\) ANNUAL New State Tax Revenue

The MNCOM Advantage

**Features**

- Privately Funded
- Rural Focus and Location
- Successful Prior Track Record
- Access to Rural Funding Sources
- Collaborative Partner Network

**Advantages**

- No Risk to Taxpayers
- Access to Federal HRSA Programs
- Tax Revenues Offset GME Expenses
- Lower Funding Cost
- More Rural Physicians

**Benefits**

- \$100 million private investment
- \$35-40 Million Annual Costs AVOIDED
- \$500 Million = 10 Year SAVINGS
- Improved Population Healthcare Outcomes
Collaborative and Integrated Strategy to Improve Rural Healthcare Outcomes by Assembling a Community Wellness Network

Rural Barriers to Overcome

- Education
- Employment
- GME Funding
- Recruiters
- Community Amenities & Facilities
- Gigabit Fiber Internet Access
- Clinic, Hospital, &/or Wellness Centers
- Housing

PRIVATE FUNDING
- CAH Recruiting Cost
- Insurance Companies
- Health Care
- Life, LTC
- Employers
- Communities
- Debt Forgiveness...
Improved Population Health Outcomes

Win-Win, Public/Private Collaborations

Rural Housing & Amenities

Community Infrastructure (FTTH)

Incentives & Rewards

Primary Care Physicians – GME + Earnings

Wellness Centers – Place to go & Things to do

Health Care Facilities – THC, LTC, & Hospitals

Improved Population Health Outcomes

Hub and Spokes Wellness Strategy

- 30+ Wellness Centers
- 15-mile radius
- Locations serve 6,000+ People
  - “Actively Aging Adults” Age 50+
- $4-5 million per center
- $750 per person to build
- Total Investment = $150 million
- 1/3 Local, 1/6 State, ½ USDA
- RDC “Community Facility Loan”
- Establish a “Wellness Network”
- Rural Investment/Quality of Life
- 150-200+ jobs, 150+ Volunteers
- Standard Facility: 5-10% lower costs
### Leadership Team & Strategic Partners

<table>
<thead>
<tr>
<th>2014-2018 Pre-Application</th>
<th>2016-2020 Provisional Accreditation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Chairman</td>
<td>• Expand Leadership Team</td>
</tr>
<tr>
<td>• Board / Trustees</td>
<td>• Faculty / Staff (Yrs 1 + 2)</td>
</tr>
<tr>
<td>• CEO – CAO – CFO</td>
<td>• Preceptors</td>
</tr>
<tr>
<td>• COCA Advisor</td>
<td>• Clinical Sites &amp; Schedule</td>
</tr>
<tr>
<td>• Advisors / Consultants</td>
<td>– Rotations</td>
</tr>
<tr>
<td>• Strategic Partners</td>
<td>– Residencies</td>
</tr>
<tr>
<td>• Investors</td>
<td>• Facilities &amp; Curriculum</td>
</tr>
<tr>
<td></td>
<td>• <strong>All COCA Standards</strong></td>
</tr>
</tbody>
</table>

### Diagnosis ➔ **Outlook** ➔ **Prescription** ➔ **Cure**

“Never doubt that a small group of thoughtful, committed citizens could change the world. Indeed, it’s the only thing that ever has.”

— Margaret Mead

**Rural Lives Matter. Rural Health Matters.**
Thank You!

• Questions?

• How Can I Help?

• Who Do I Contact?

Contact Information

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MNCOM.edu
Two years ago, I was a small-town community banker; a third-generation bank owner working with my wife and colleagues to serve our personal, small business, and farm customers in Gaylord, Nicollet, and Mankato and the surrounding areas.

I grew up in Benson, Minnesota and graduated from Carleton College and Harvard Business School. I then left rural Minnesota and worked in commercial banking and investment banking for Wells Fargo in the Twin Cities. 25 years ago I returned to my rural Minnesota roots, assuming control of our family bank.

I did not realize that a series of events would lead me to move from banking to medicine. I should not have been surprised. My grandmother was the first female graduate of Rush Medical School in Chicago. My great-uncle was a family physician who spent his entire career in Sleepy Eye. My dad’s two sisters were doctors who served in rural Minnesota and New Mexico. My brother and sister-in-law are physicians in Columbia, MO where my brother is an Assistant Professor of Clinical Medicine and Pediatrics with the University of Missouri Medical School. One of my best friends is a family physician whose clinic was named one of two Hypertension Control Champions in the nation by the CDC and Million Hearts Program. And my good friend and college classmate introduced me to the CEO of an innovative health care organization.

The Connection with RS Fiber Cooperative

Two years ago, I resigned from the Board of RS Fiber Cooperative, so I could provide independent advisory services to the Coop. RS Fiber needed my help to develop a business strategy and to secure financing for a proposed high-speed fiber-optic broadband network to connect every business, homeowner, and farmer in 17 townships and 10 cities spread among portions of four counties in South Central Minnesota.

During my November 12, 2013 meeting with other investment bankers in the Twin Cities, a New York investment banker stated, “If you can get this fiber network built, we need to discuss phase two.”

“Phase 2?” I responded. He replied, “I represent a group of medical educators, physicians, and investors who believe there is a need for a new osteopathic medical school in Minnesota to train primary care physicians for service in the North Central US. We need access to high speed internet service. If you build the network, we want to work with you on developing the new medical school.”

At that time I did not know the difference between allopathic and osteopathic medicine...even though my “MD” personal physician had recently retired and my new personal physician was a “DO”!

Since 2013, I have had a steep learning curve and am co-leading the “sprint-a-thon” to receive provisional accreditation from COCA, which is an acronym for the Commission on Osteopathic College Accreditation.

For 6 months in 2014 I sent information to the New York development team about Minnesota, Gaylord, our medical communities, health care in the state, and various other research to convince them to build a new school in Minnesota. They were completing due diligence on us. In a similar manner, I was completing my due diligence on the development team, led by Dr. Jay Sexter and Dr. Martin Diamond who were retiring from Tuoro University. They had successfully worked together to found all four Touro Medical Schools in California, Nevada, Harlem, New York, and upstate Middletown, New York.

In mid-2014 my communications with Dr. Sexter and his development team stopped.

As I told my wife, “If this medical school is meant to happen, they will come back to me.”
On November 4, 2014 the Sibley East School District successfully passed a $43 bond referendum to build a new elementary school in Gaylord and renovate and expand another campus in Arlington. I unsuccessfully opposed this bonding issue, but I told the school superintendent that I would focus on economic development, so we could pay for the new school.

This referendum meant that a 125,000 square foot campus in Gaylord would be vacated in mid-2017 and the 6 acre site would be available for redevelopment. If nothing was done, the taxpayer cost to maintain those buildings would exceed $100,000 annually.

That same week I received a phone call from Dr. Sexter and his development team. They said, "OK. We're ready to come to Minnesota. We want to open a medical school in Gaylord! When can we start?"

The table was set. We had an experienced group of leaders in medical education. We had the potential for redeveloping an existing school building. We were going to have access to high-speed internet. We would have broad community support. And the entire $100 million investment would be made through a combination of private investor dollars and loans that are available to rural Minnesota organizations.

No taxpayer funding was needed for the school.

My role originally focused on co-leading the financing strategy necessary to acquire, construct, and operate the medical school. In early 2015, Dr. Sexter asked me to become a founding investor, to serve as the Chief Financial Officer. "Make this a Minnesota school. Develop an integrated win-win collaborative strategy with the medical community."

A rural banker was becoming a medical educator.

2015 – The First Stage of the “Sprint-a-Thon”

In this first year of our 3-year accreditation process, we have made great strides. In March 2015, I spent 3 days at the Middletown, NY Campus of Touro Medical School, meeting with students, faculty, administration, and local healthcare executives. The trip provided me with firsthand knowledge of how a medical school could be integrated successfully with an existing medical community in a small rural town.

Several years ago, one of my trusted advisors said, "Phil, if you had to start your bank again, would you set it up the same way for the future needs of your customers?" When I responded, "No", he quickly replied, "Then what is preventing you from making those changes today?"

What prevents many people from leading change is a mindset that is anchored on the legacy of past investments, instead of focusing on future needs.

My advisor challenged me to “think forward and leave a legacy forward.” Move outside my comfort zone. Use resource limitations as an opportunity to become laser-focused on the urgent and important strategies that MUST be implemented well.

That is what I observed on the Touro Middletown Campus in March 2015. The medical school was focused on educating future physicians. Leaders built a school that actively integrated the lives of the professor and the student, so they worked together. They effectively used technology. They integrated campus housing with educational facilities to reduce the pressure and stress of living and/or commuting to school. They encouraged conversations and collaborations with the medical system of hospitals, clinics, physicians, and healthcare professionals, AND ALSO with the community that doctors serve.

It became hard for me to see where the school boundaries ended and the hospital gateway opened. Minnesota can also pursue this strategy of building quality healthcare connections.

Dr. Sexter’s development team made multiple visits to Minnesota in 2015, where we met with a cross-section of representatives from our medical community. The City of Gaylord endorsed the preliminary concept of the medical school in April 2015. An option was signed in June 2015 to acquire the school buildings when they are vacated in 2017. We are assembling the materials required by COCA in order to continue the process of applying for formal accreditation. We are reaching out to Minnesota’s medical community, business and community leaders, and elected officials to build a strong relationship focused on improving healthcare outcomes. We have made great strides in the last year, but we still have much work to do over the next 30 months, so that we can enroll our first class of 150 students in August 2018.