

# Acknowledgements

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Additional maps and text were prepared and provided in this document.

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## *Updates*

In 2011, the City of College Station partnered with the College Station Medical Center (The Med) and other stakeholders in the creation of a Medical District to act as a focused healthcare and wellness district within the City. The Medical District focuses on the general area around State highway 6 and Rock Prairie Road, and includes The Med and the future Scott & White Hospital, both along Rock Prairie Road.

The City's consulting team, led by Schrickel, Rollins and Associates, Inc. worked with a City Council appointed Advisory Committee consisting of various stakeholders from throughout the community. The Advisory Committee, consultant team, and staff completed their work on the draft plan for the Medical District in late 2011 and the results were presented to a joint meeting of the City Council and the Advisory Committee. Since that time, staff has worked to refine the land use and transportation components of the Master Plan, including expanding the Medical District to include properties further to the south. City staff alterations to the Master Plan document are indicated with red text and strikeouts, where appropriate. Additional maps have been created by City staff and are indicated as such.

The Medical District Master Plan is an amendment to the City's Comprehensive Plan, altering the Future Land Use and Character map, the City's Thoroughfare Plan, and Thoroughfare Context map. In response to changed thoroughfare alignments, the City's Water Master Plan, Proposed Pedestrian Facilities, and Proposed Bicycle Facilities maps will also be amended in conjunction with the new thoroughfares. Additional trails have also been added to the Proposed Pedestrian Facilities map in the Bicycle, Pedestrian, and Greenways Master Plan to create the walkable community envisioned by the Master Plan.

Finally, an Implementation Report has been developed by City staff to accompany the Master Plan. This Report provides details regarding potential development regulations and standards, management structure, funding mechanisms, and capital expenditures needed for the success of the Medical District.

# Executive Summary



The City of College Station, Texas is poised to capitalize on one of the most significant economic development opportunities in its history—the creation of a medical district that will become a regional destination as well as an economic catalyst for the City. This effort is supported by that fact that, nationally, healthcare is among the most promising industries for job growth and real estate development in the coming decades. Demand for healthcare services, jobs and development is driven by a number of factors, particularly the tremendous growth of Americans over the age of 65 who require the most medical services. The number of Americans aged 65 and over is expected to double between 2010 and 2040. The demographic conditions driving healthcare growth in the rest of the country exist in College Station as well. The private market in College Station is already showing that medical uses are feasible, so the questions for the future of College Station revolve around not *if* the medical district will happen, but *how* and at *what scale* and *quality*.

Recognizing these healthcare industry trends and their potential for significant economic impact to College Station, City leaders established a goal of creating a special district focusing on medical care, and a health and wellness lifestyle. The College Station Medical District Master Plan supports the City's goal by establishing a master plan for a high quality, mixed-use, pedestrian-friendly district that will complement and enhance the emerging concentration of medical and health care uses in the vicinity of State Highway 6 (SH 6) and Rock Prairie Road.

With a vision of community-wide health and wellness, the master plan integrates health-consciousness and lifestyle into all aspects of development. It focuses on creating a distinct “place” rather than a random collection of businesses and neighborhoods by providing a mixed-use collaboration of medical, commercial and residential uses; an emphasis on walkability; an extensive greenway and trail system; and high-quality, sustainable site development that will provide an

uplifting experience for employees, patrons, visitors and residents. Such “places” are suitable and desirable for people of all ages—young professionals, families with children, empty nesters and seniors.

The mixture of uses, facilities and activities offered in the district will provide a health-centered “lifestyle” environment with activity during the days, evenings and weekends that help energize, populate and animate the district. The two mixed-use village centers are essential to such a thriving urban environment in the medical district. Located adjacent to the two major hospitals, and in close proximity to residential neighborhoods, the village centers will be filled with shops; restaurants; and “third places” such as coffee shops, internet cafes and bookstores, that provide interactive community meeting places and a pedestrian-engaging environment. The village centers will also include a mixture of offices, hotels and a dense, urban-style residential component.

A key component of the master plan is the wide array of medical and supporting services and activities concentrated in the medical district. The density of services and adjacency to the village centers, residential neighborhoods and the network of trails and open spaces will encourage walkability. Medical-related uses include hospitals, medical offices, laboratories, pharmacies, rehabilitation assisted living centers, hotels and education.

Siting of the buildings within the medical district will frame the streetscape, capitalize on the amenities of trails and open space, encourage pedestrianization, make efficient use of the land and create a density that can support local transit service. Housing options will offer variety for people of different age

groups with varying needs, including lofts, live-work units, townhouses and single-family homes. All new projects within the district will reflect best practices for “green” design strategies and techniques that reduce energy consumption and improve air quality.

Visibility of the medical district from SH 6 is limited, emphasizing the need for a unified “branding” concept of landmarks, wayfinding and enhancements that “announce” the district. This branding concept includes enhancements for the new Rock Prairie Road bridge, imagery on the proposed water tower, vertical towers as key architectural landmarks, gateways, signage and distinctive planting design, all working in concert to heighten visibility of the district and convey an image of quality. Used in whole or in part, the branding concept creates an overall identity framework that other medical facilities across the community can plug into if they choose.

Branding a high profile destination like the medical district must also include an internet strategy to differentiate it from other medical developments in the region. Establishing a secured wireless network for the medical district will engage and inform residents, patrons and visitors by providing internet access both indoors and outdoors. Users of the network will have access to medical district information such as district websites, directions, medical appointments, shuttle services, education and special events and activities.

The design for streets within the medical district will reflect the overarching concept of a healthy community focused on wellness. Street are planned to comfortably accommodate and balance the needs of multiple users—transit, cars, bicycles and

pedestrians—and are designed to function as both vehicular ways and civic spaces. The district’s streetscapes incorporate wide, tree-lined sidewalks; landscaped medians; safe crosswalks; pedestrian lighting; benches; shade structures; signage; and other site furnishings that provide safety and comfort to pedestrians and create a visually appealing and walkable environment.

Preservation and enhancement of the district’s parks, open spaces and natural areas is key in creating the extensive network of trails that promote the vision of the health and wellness lifestyle envisioned in the master plan. These amenities will attract residents and businesses to the district and improve the overall visual quality of the area.

This master plan for the medical district defines a design philosophy and implementation strategy for attracting high quality healthcare, housing and services into a setting and lifestyle concept unique to College Station. If successfully implemented, the medical district will stimulate new development opportunities, create jobs, expand the City’s tax base and create inviting, engaging, connective experiences for residents, visitors and patrons. Implementation of such a master plan will have many components—physical, financial, regulatory, operational and organizational—and will necessitate flexibility as market conditions change over time. It will require strong, committed leadership who will run the medical district like a business by providing quality “products and services” over the coming decades that will transform the district into a distinct, sustainable community.

# 1 - Introduction



## **Project Purpose and Description**

Healthcare is identified in the City's Comprehensive Plan as an emerging sector anticipated to play an increasingly significant role in the future economic growth and success of the City of College Station. Recognizing the developing concentration of medical uses in the vicinity of SH 6 and Rock Prairie Road, the City identified the area as a primary gateway with a special focus on linking current and future medical facilities into a cohesive, mixed-use, walkable district. The purpose of the College Station Medical District Master Plan (master plan) is to support the City's goal of designating a special district that will establish identity, promote continuity, and invite significant new investment to fulfill the demand for medical and health care related uses in the emerging medical district and in the City of College Station.

The study area for the master plan encompasses approximately 1,700 acres of land generally located around the intersection of SH 6 and Rock Prairie Road. See **Figure 1B– Final Location Map and Figure 2B – Final Project Area Map**. The master plan will evaluate the market feasibility of such a district, establish a framework and guidelines for the development of improvements, and recommend implementation strategies for the district. Implementation of the master plan should stimulate new development opportunities and create experiences for citizens and visitors beyond what is now possible.

The master plan reflects input from the citizens of College Station, the Medical Corridor Advisory Committee (MCAC), City staff and City Council members. It will be used to aid City staff, decision-makers, district business owners and district leadership in the creation of a mixed-use district that focuses on medical care, health and wellness by creating a distinct "place" rather than a random collection of businesses and neighborhoods. (continued on page 8)

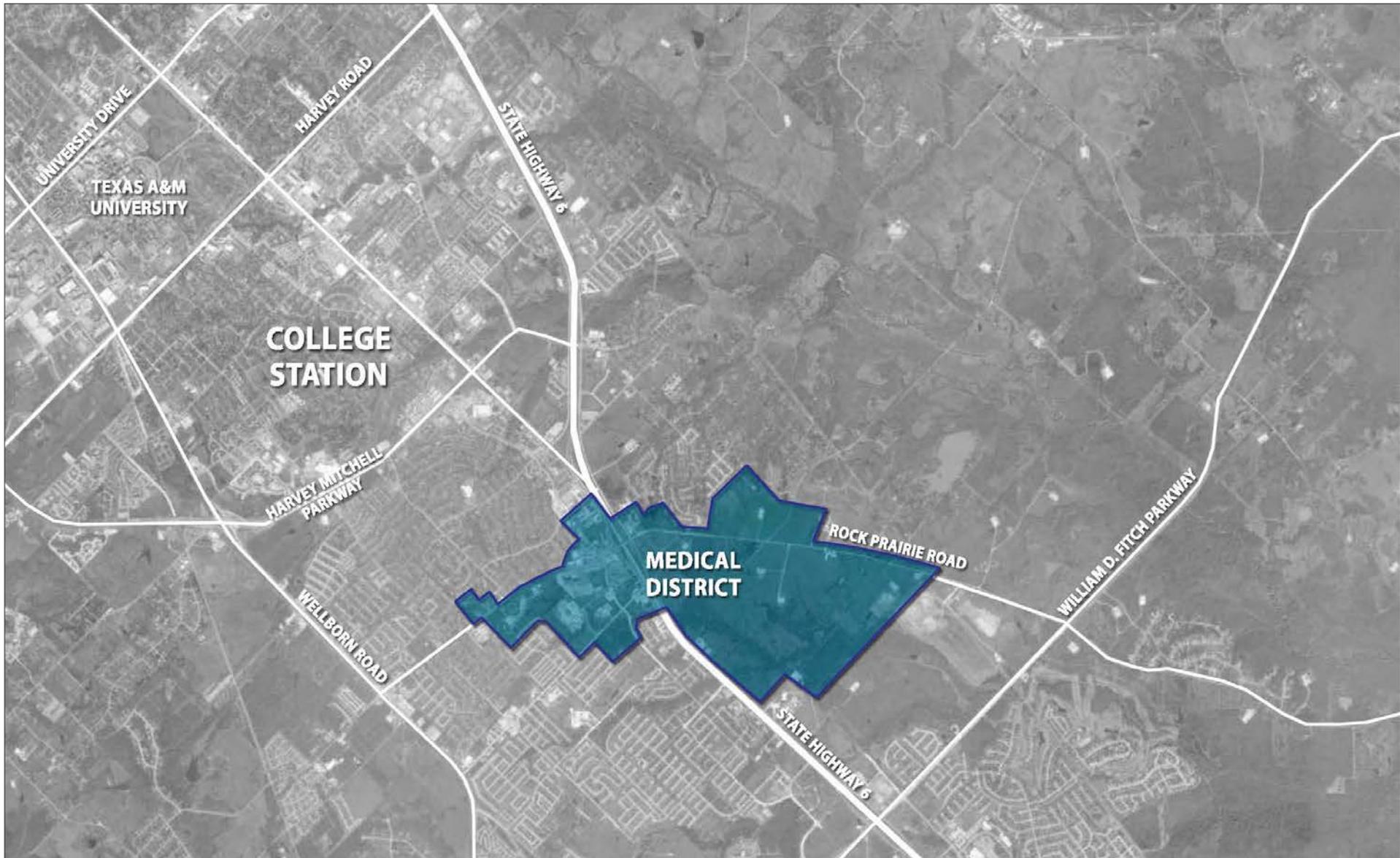


Figure 1A - Initial Location Map



Figure 1B - Final Location Map

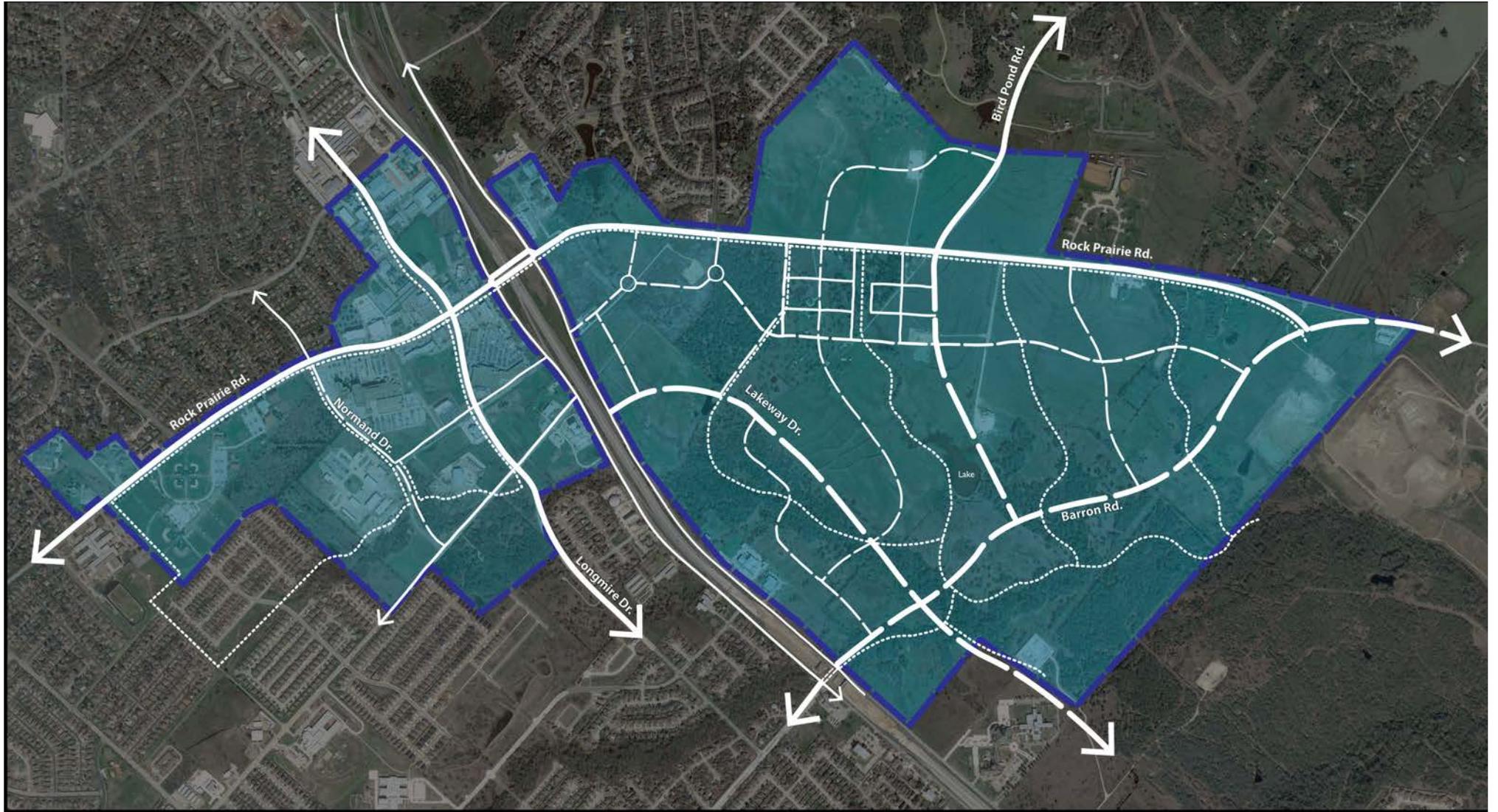


Figure 2A - Initial Project Area Map

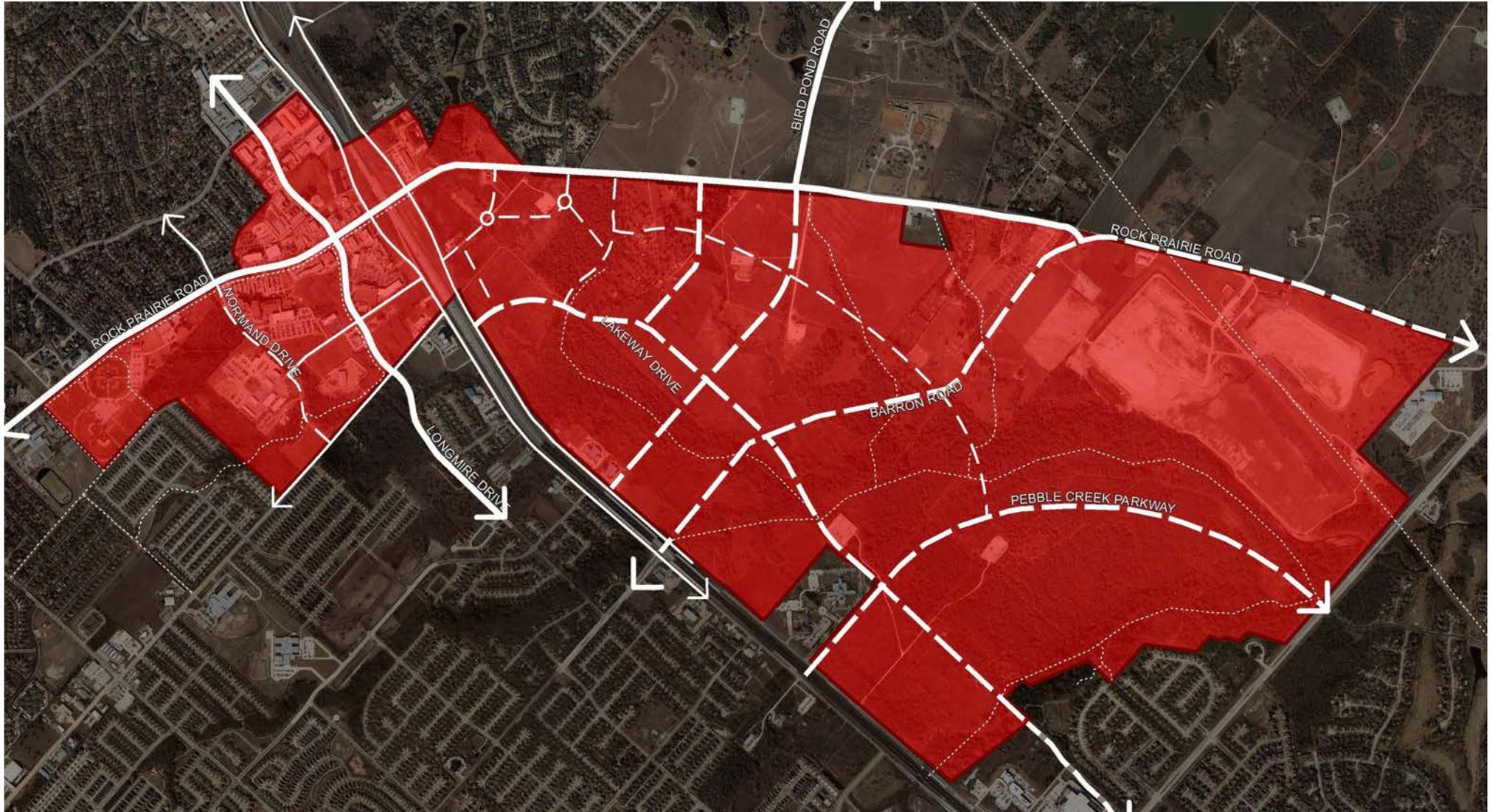


Figure 2B - Final Project Area Map

This master plan cannot anticipate or detail every feature that will ultimately make up the medical district; however, it does define the design philosophy underlying the district enhancements, and illustrates sufficient examples of its application to help facilitate and translate the different components of a medical district into a distinct identity. To be successful, the master plan must focus on defining a distinct image for the medical district, populating the district with pedestrians, providing green spaces for exercise and relaxation through the preservation of valuable environmental features, and stimulating economic growth by providing an atmosphere for attracting businesses.

### **The Planning Process**

In 2010, the City of College Station engaged a multidisciplinary consultant team to prepare the master plan, consisting of Schrickel, Rollins and Associates, Inc. (SRA); Townscape, Inc.; and Leland Consulting Group (LGC). A kickoff meeting between City of College Station staff and the consultant team established the project needs, project schedule and data required for development of the plan.

It was determined during the kickoff meeting that a critical component of the master plan process would be the involvement of stakeholders, made up of representatives from the community who would provide guidance and feedback throughout the planning process. As a result, the City Council appointed 38 committee members to the newly formed Medical Corridor Advisory Committee (MCAC). It was also determined that the public input process should include confidential stakeholder interviews comprised of small groups of three to seven people to obtain additional input about

the future development of the medical district. Stakeholder input is described in more detail in the following section.

During the inventory and analysis phase of the process, an extensive site reconnaissance was conducted by the consultant team, documenting the existing conditions and key observations in and around the study area. In addition, existing planning and engineering reports related to land use, parks and trails, transportation and infrastructure were reviewed during the development of the master plan. The site analysis is discussed in more detail in **Chapter 2** of this report.

Another critical component of the planning process was the preparation of market research and a market analysis to determine the economic feasibility of developing a medical district in College Station. The market research, analysis and resulting development program are discussed in more detail in **Chapter 3** and **Chapter 4** of this report.

After analyzing the various forms of data collected, preliminary concepts were prepared and presented to the MCAC for review and discussion. Based on input from stakeholders and City staff, a refined concept was presented to the MCAC, which ultimately led to the development of the master plan.

### **Stakeholder Input**

As already mentioned, stakeholder input was a critical component of the development of the master plan. The consultant team conducted four meetings with the MCAC at critical milestones during the development of the master plan, as well as interviews of groups of stakeholders.

### **MCAC Meetings**

At the kickoff meeting with the MCAC, held on February 17, 2011, the consultant team introduced the project, the planning process and the results of the initial site reconnaissance. At the second MCAC meeting, held on May 10, 2011, the findings of the analysis process were summarized, including the site analysis, market analysis and stakeholder interviews. In addition, preliminary concepts were presented to the group for feedback. The third meeting with the MCAC was held on July 12, 2011. The consultant team presented concepts and strategies for land use, identity and branding, design guidelines and implementation of the plan. The final master plan was presented to the MCAC on October 25, 2011. The MCAC meeting minutes were prepared by City staff and are located in the **Appendix** of this report.

### **Stakeholder Interviews**

The stakeholder interviews were another important part of the planning process. The small group format and confidential nature of the stakeholder interviews often provides critical information to the project team that may not be revealed in a public meeting or large group setting. Comments made during the interviews are not attributed to individuals in order to respect participant privacy and encourage candor.

The stakeholder interviews allow the project team to make sure that stakeholder aspirations, concerns and knowledge of the project area are heard by the consultant team and integrated into the master plan. While the project team reviewed extensive information and documents about the medical district and the City of College Station, these documents can never be a substitute for small group conversations or local knowledge about the area and its history.

Further, stakeholders often continue to be involved in the master planning process throughout its duration and later in implementing the plan. Therefore, it is critical that their perspectives be documented and considered early and addressed in the final plan.

On March 29, 2011, LGC facilitated the stakeholder interviews. The stakeholder interview process was a full-day event during which selected individuals were interviewed for 50 minutes in small groups of three to seven participants. Stakeholders included leaders of local institutions, district residents, elected leaders, public agency staff, property owners, developers and other members of the development community, advocacy group representatives and others who have knowledge of the project or an interest in its success.

The general themes and trends that were revealed during these interviews include:

- Confusion about the medical district – what it is, the purpose, the location, etc.
- Support for the creation and development of the medical district.
- Need for senior housing and senior care facilities.
- Need for improvements to the pedestrian environment.
- Need for improvements to the transportation system.
- Funding the development of the medical district.

A memo summarizing LGC's findings in more detail is located in the **Appendix** of this report.

#### **Property Owner Meetings**

Two area property owner meetings were held to discuss opportunities. These meetings were on October 18, 2011 and August 27, 2012.



## 2 - Site Analysis



The site analysis is a process of data collection and study that enables the consultant team to experience the study area through the eyes of the users and stakeholders, assess opportunities and constraints, and develop a master plan with recommendations for implementation. As a part of the site analysis process, the consultant team conducted an extensive site reconnaissance, documenting the existing conditions, opportunities and constraints in and around the study area. The study area was analyzed from the viewpoint of the vehicle and the pedestrian as each viewpoint is critical to the development of a successful master plan. In addition, existing planning and engineering reports related to land use, parks and trails, transportation and infrastructure were reviewed during the development of the master plan.

### Project Area

The study area for the master plan encompasses approximately 1,700 acres of land generally located around the intersection of SH 6 and Rock Prairie Road and extending to the south, as indicated in **Figure 2B - Final Project Area Map**. The northern boundary of the medical district is generally defined by Rock Prairie Road, as well as some of the parcels on the north side of Rock Prairie. On the west side of SH 6, the district's southern boundary is generally defined by Graham Road. To the east of SH 6, the southern and eastern boundaries are generally defined by William D. Fitch Parkway and Lick Creek. The western edge of the study area is Southwood Park.

### Existing Land Use

According to the City's 2009 Comprehensive Plan, the existing land uses in the medical district generally include agricultural, large lot residential, office, retail, commercial, industrial, public and semi-public uses. Approximately 675 acres are currently unimproved/vacant within the medical district, and potentially available for future development. See **Figure 3** on page 17. A list of existing businesses, multi-tenant shopping centers and multi-tenant office buildings compiled during the site reconnaissance is documented on **Figure 4** on page 19. **Figures 3 and 4** are based on the initial study area.

On the west side of SH 6, existing development includes a mixture of office, retail, commercial, industrial, public and semi public facilities. Most of the medically oriented developments that currently exist in the medical district are located west of SH 6, including College Station Medical Center (The Med). One of the largest parcels west of SH 6 is Southwood Park, a 45-acre community park. There are a few scattered vacant parcels west of SH 6, all of which are less than 25 acres, and potentially available for “infill” development.

The east side of SH 6 is mostly undeveloped, with large, contiguous unimproved/vacant parcels, potentially available for significant development within the medical district. Existing development east of SH 6 includes a small amount of retail, commercial and large lot residential. The Scott & White Hospital is currently under construction near the intersection of SH 6 and Rock Prairie Road, which should stimulate additional growth and development of the east side. The old landfill, and Southeast Park, and extensive city-owned greenway create a vast open area and natural buffer between the medical district and the properties to the south.

#### **Parks, Open Space and Natural Areas**

Within the study area, there are parks, open space and natural areas that are valuable for their beauty and vulnerable to development impacts, including Lick Creek and its tributaries and drainageways, floodplain land and City parkland. The City’s old landfill provides approximately 150 acres of additional open space within the district. When completed, the proposed Lick Creek Hike and Bike Trail will connect the medical district to Lick Creek Park, the largest park in the City’s park system with

more than 500 acres of open space. Preservation, enhancement and/or restoration of these areas will promote the vision of wellness within the district by facilitating walking, jogging and cycling on the trails and paths that link and connect the district, while improving the overall beauty and visual quality of the district, as well.

#### **Thoroughfares**

\*Further information related to Medical District Thoroughfare Plans can be found in the Implementation Report.

#### **State Highway 6**

The medical district is bisected by SH 6, a major north-south transportation route in the region. One-way frontage roads parallel SH 6 on both sides. Sidewalks are located along the west side of the southbound frontage roads between Ponderosa Drive and Rock Prairie Road. There are no sidewalks on the northbound frontage roads. Several on and off ramps between Harvey Mitchell Parkway and William D. Fitch Parkway provide easy and direct access to and from the medical district.

#### **Arterials**

Rock Prairie Road is the significant east-west thoroughfare within the district, providing direct access to and from SH 6. The City’s Comprehensive Plan delineates Rock Prairie Road as a secondary image corridor to reflect its importance within the City’s transportation system, and provide opportunities to strengthen the image of the City through special identity and beautification elements placed along the corridor. Rock Prairie Road is currently classified in the City’s Thoroughfare Plan as a minor arterial west of SH 6, as well as a

combination of major arterial, minor arterial and major collector east of SH 6.

West of SH 6, Rock Prairie Road is a heavily traveled thoroughfare with four travel lanes, a continuous turn lane in the center and narrow sidewalks on both sides of the road. Without a landscaped center median, this vast expanse of pavement along Rock Prairie Road not only lacks character and identity for the district, it makes crossing the road dangerous for pedestrians and cyclists. This is especially true at the mid-block crosswalk between the north side of Rock Prairie Road and The Med where pedestrians are required to cross five lanes of traffic assisted only by pavement markings and a crosswalk sign.

The Rock Prairie Road bridge crosses over SH 6, connecting the west side of the medical district to the east side. Currently, the bridge has four travel lanes, a continuous turn lane in the center and no sidewalks. Without sidewalks, there is no safe way for pedestrians to cross the overpass.

East of SH 6, Rock Prairie Road is a rural two-lane asphalt road with narrow shoulders and bar ditches on both sides. At the intersection with the SH 6 frontage roads, the road widens to accommodate three lanes. There are center medians with turn lanes between the SH 6 frontage roads and Stonebrook Drive.

Other arterials planned within the medical district include the future extension of Barron Road east of SH 6 and the future extension of Bird Pond south of Rock Prairie Road. Both extensions are planned as

4-lane minor arterials with bike lanes and sidewalks on both sides.

### **Collectors**

Existing major collectors within the medical district include Longmire Drive and Graham Road. Both are 2-lane thoroughfares with bike lanes and sidewalks on both sides. Some sections of these thoroughfares also accommodate turn lanes.

Existing minor collectors within the district include Ponderosa Drive, Birmingham Road and Woodcreek Drive. Ponderosa Drive is a 2-lane thoroughfare with sidewalks along the north side of the road. There appears to be ample room for either bike lanes or parking on both sides of Ponderosa. Birmingham Road is a 2-lane thoroughfare with sidewalks on both sides. However, where Birmingham turns south to connect to Graham, it takes on a rural character with bar ditches on both sides. In this section of Birmingham, there are no sidewalks or curbs. Woodcreek Drive is a 2-lane thoroughfare with sidewalks on both sides.

Other collectors planned within the medical district include the future extension of Normand Drive south of Rock Prairie Road, future Lakeway Drive, and future extension of Pebble Creek Parkway. Normand Drive is planned as a 2-lane minor collector with sidewalks on both sides. Minor collectors also typically have space available for either bike lanes or parking adjacent to the curb. Lakeway Drive and Pebble Creek Parkway is planned as a 4-lane major collector with bike lanes and sidewalks on both sides.

### **Transit**

The City's Comprehensive Plan indicates a variety of

organizations that provide transit service in College Station, including Texas A&M University, Brazos Area Agency on Aging and The District (formerly the Brazos Transit System). Of the three transit organizations, The District currently provides fixed route transit service within the medical district, as well as limited door-to-door services for the elderly and disabled residents. The District's "yellow route" creates a transit loop within the medical district along Longmire Drive, Graham Road, Victoria Avenue and Rock Prairie Road. The route maps for Texas A&M and The District are located in the **Appendix** of this report.

### **Pedestrian Comfort and Safety**

The district currently lacks a comfortable, safe pedestrian environment. In vibrant urban areas, pedestrian environments typically consists of wide, tree-lined sidewalks; landscaped medians; safe crosswalks; pedestrian lighting; benches; shade structures; signage; and other site furnishings that provide safety and comfort to pedestrians and create a visually appealing and walkable environment. During the site reconnaissance, conditions were observed that may impact the comfort and safety of pedestrians within the district, including a lack of street trees and shade structures; lack of sidewalks in some locations; the location or condition of some sidewalks; and an unsafe mid-block crosswalk near The Med. The existing overhead utility lines give the district a cluttered appearance and may conflict with the addition of street trees. The photos on pages 16 reflect these observations.

### **Public Utility Infrastructure**

\*Further information related to Public Utility



*Overhead utility lines can give the district a cluttered appearance and may conflict with the addition of street trees.*



*Some sidewalks within the district are very narrow, with little or no buffer between the sidewalk and the street. This condition is uncomfortable and unsafe for pedestrians due to the close proximity to vehicular traffic.*



*The mid-block crosswalk between the north side of Rock Prairie Road and The Med is unsafe, requiring pedestrians to cross five lanes of traffic assisted only by pavement markings and a crosswalk sign.*



*Few street trees exist along pedestrian corridors within the district. Planting street trees will not only promote the City's strategy of "Greening the City" but they also provide shade and safety buffers for pedestrians when placed between the street and the sidewalk.*



*Some sidewalks within the district are damaged and/or have potential accessibility issues, creating an unsafe environment for the disabled.*



*No sidewalks currently exist on Rock Prairie Road bridge, providing no safe way for pedestrians to cross.*



*One small shade structure is located within the district.*

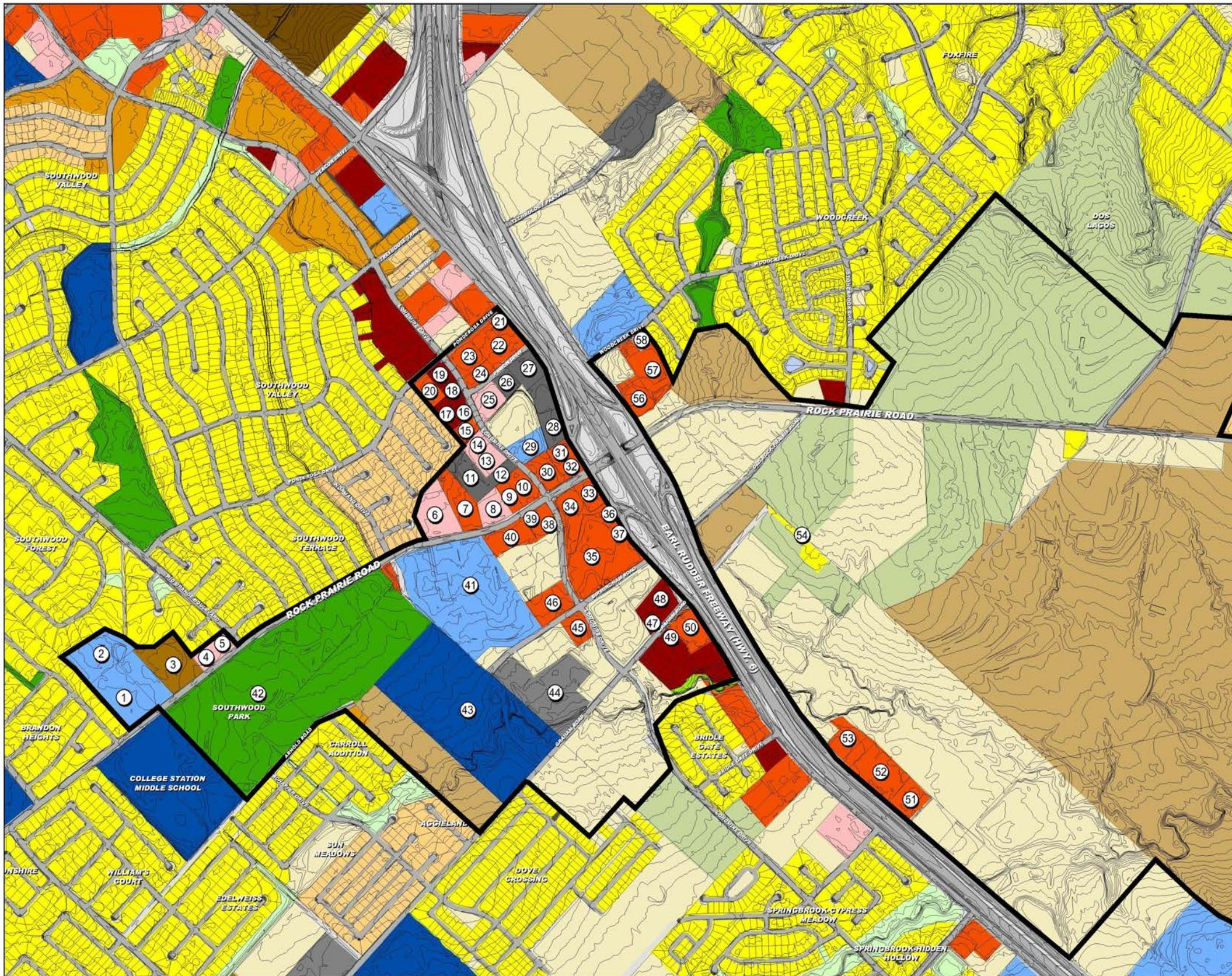


Figure 3 - Existing Land Uses from the City's Comprehensive Plan

## Legend

	Single-Family Residential (townhouse)		
	Duplex Residential		
	Multi-Family		
	Group Quarters (Nursing home, dorm, etc.)		
	Mobile/Manufactured Home		
	Commercial Retail (Banks, hotels)		
	Commercial Office		
	Commercial Other		
	Commercial - Industrial (Warehousing/Distribution)		
	Light Industrial		
	Public Facilities (COCS, CSISD, Library)		
	Semi-Public (Religious, hospitals)		
	TAMU (Easterwood)		
	Transportation, Utilities & Communication		
	Park		
	Greenway		
	Drainage		
	Agricultural		
	Rural (Large lot, >= 5 acres)		
	Unimproved		
1.	St. Francis Episcopal Church	12.	Self Storage
2.	Esperanza Assisted Living	13.	Brazos Dental Associates
3.	Fortress Health & Rehab	14.	Liberty Dialysis and Car Wash
4.	Brazos Valley Pediatric Dentistry	15.	Allergy Associates of Brazos
5.	Watson Orthodontic Specialists	16.	Marketing Office
6.	Office	17.	Bovine Elite
7.	Office	18.	Southern Care - French Door Salon and Spa
8.	Office	19.	Husfeld Homes and College Station Fitness
9.	Whataburger	20.	Brazos Valley Automotive
10.	Walgreens		
11.	Gary Badger, DDS Pediatric Dentistry		
		21.	DD Moving and Storage
		22.	Howard Johnson's Express Inn and Mi Familia Coco Loco Restaurant
		23.	Office/Warehouse - Party Time Rentals, Brazos Ballroom Dance Studio, Ponderosa Fitness Studio, Brazos Valley Gymnastics
		24.	Federal Express World Service Center
		25.	Office/Warehouse - Automotive Research Corporation
		26.	Office/Warehouse - TDI Brooks International
		27.	Retail (multi-tenant) - The Emporium
		28.	Retail (multi-tenant) - Brazos Valley Home Health Services, OSPBS Medical Equipment Saves and Services
		29.	Masonic Library and Museum
		30.	Wells Fargo Bank
		31.	Oil Change
		32.	Exxon Gas Station
		33.	Prosperity Bank and Traditions Health Care
		34.	CVS
		35.	Retail (multi-tenant) - Kroger Shopping Center
		36.	Jack in the Box
		37.	Retail (multi-tenant) - TJIH China Diner
		38.	McDonald's
		39.	Blockbuster
		40.	Retail (multi-tenant) - Open MRI, AT&T
		41.	College Station Medical Center
		42.	Southwood Park
		43.	College Station Public Utilities
		44.	Industrial
		45.	Texas Allergy
		46.	Medical Arts
		47.	Warehouse
		48.	Jack Winslow Body Shop
		49.	Popeye's Chicken
		50.	Brazos Valley Bank
		51.	Independence Harley Davidson
		52.	Retail (multi-tenant) - Wellpoint Physical Therapy
		53.	Club
		54.	Scott & White Hospital
		55.	Southeast Park
		56.	Retail (multi-tenant) - Precision Eye Care, Elements Therapeutic Massage, Windy Sport and Fitness
		57.	Marriott Courtyard
		58.	The Engineering Center

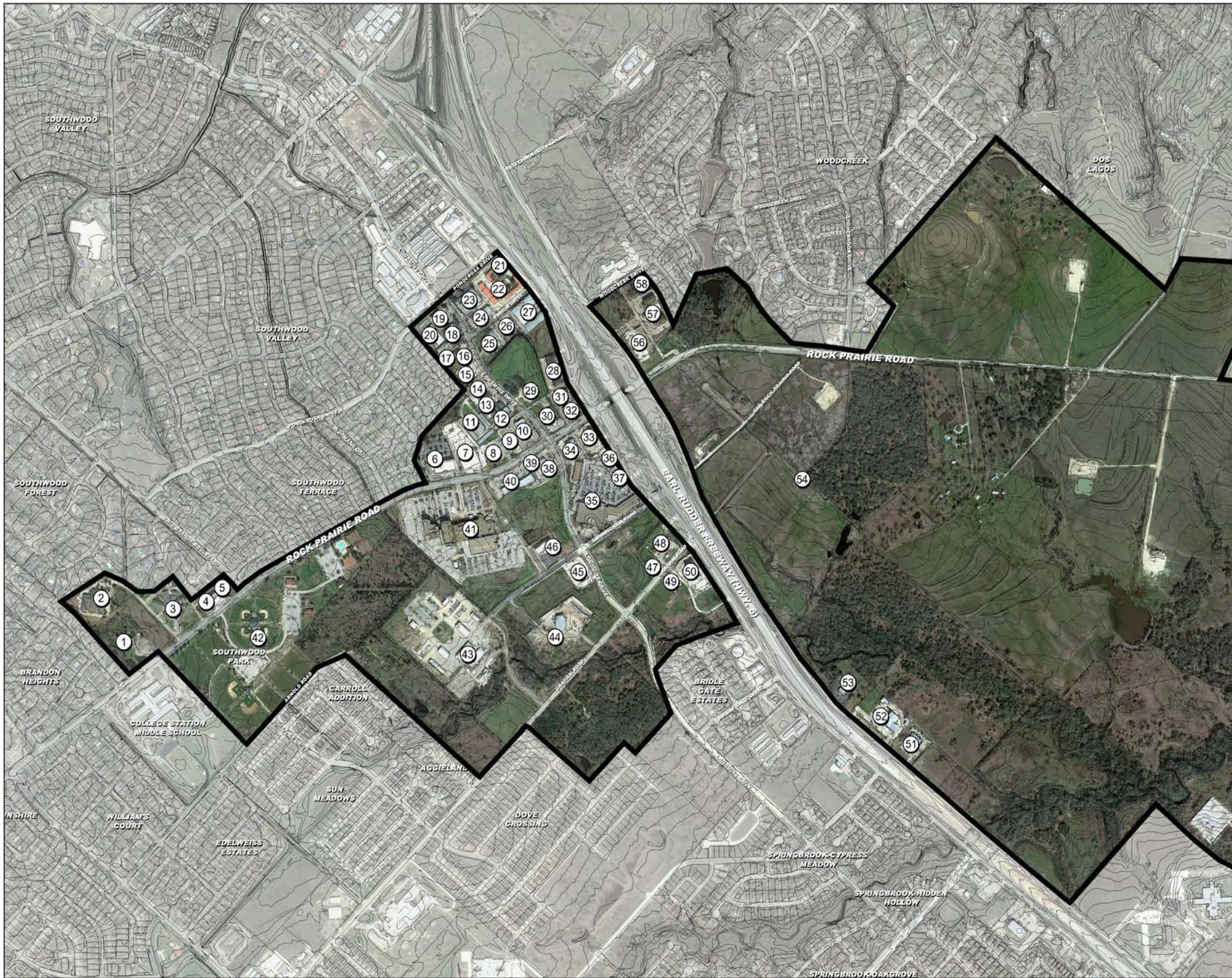


Figure 4 - A list of existing businesses, multi-tenant shopping centers and multi-tenant office buildings compiled during the site reconnaissance

## Legend

1. St. Francis Episcopal Church
2. Esperanza Assisted Living
3. Fortress Health & Rehab
4. Brazos Valley Pediatric Dentistry
5. Watson Orthodontic Specialists
6. Office
7. Office
8. Office
9. Whataburger
10. Walgreens
11. Gary Badger, DDS Pediatric Dentistry
12. Self Storage
13. Brazos Dental Associates
14. Liberty Dialysis and Car Wash
15. Allergy Associates of Brazos
16. Marketing Office
17. Bovine Elite
18. Southern Care - French Door Salon and Spa
19. Husfeld Homes and College Station Fitness
20. Brazos Valley Automotive
21. DD Moving and Storage
22. Howard Johnson's Express Inn and Mi Familia  
Coco Loco Restaurant
23. Office/Warehouse - Party Time Rentals, Brazos  
Ballroom Dance Studio, Ponderosa Fitness  
Studio, Brazos Valley Gymnastics
24. Federal Express World Service Center
25. Office/Warehouse - Automotive Research  
Corporation
26. Office/Warehouse - TDI Brooks International
27. Retail (multi-tenant) - The Emporium
28. Retail (multi-tenant) - Brazos Valley Home Health  
Services, OSPBS Medical Equipment Saves and  
Services
29. Masonic Library and Museum
30. Wells Fargo Bank
31. Oil Change
32. Exxon Gas Station
33. Prosperity Bank and Traditions Health Care
34. CVS
35. Retail (multi-tenant) - Kroger Shopping Center
36. Jack in the Box
37. Retail (multi-tenant) - TJIH China Diner
38. McDonald's
39. Blockbuster
40. Retail (multi-tenant) - Open MRI, AT&T
41. College Station Medical Center
42. Southwood Park
43. College Station Public Utilities
44. Industrial
45. Texas Allergy
46. Medical Arts
47. Warehouse
48. Jack Winslow Body Shop
49. Popeye's Chicken
50. Brazos Valley Bank
51. Independence Harley Davidson
52. Retail (multi-tenant) - Wellpoint Physical Therapy
53. Club
54. Scott & White Hospital
55. Southeast Park
56. Retail (multi-tenant) - Precision Eye Care,  
Elements Therapeutic Massage, Windy Sport and  
Fitness
57. Marriott Courtyard
58. The Engineering Center

Infrastructure can be found in the Medical District Implementation Plan.

### **Water Service**

Water service for the medical district is provided by the City of College Station. Existing water distribution mains along the south side of Rock Prairie Road and along both northbound and southbound frontage roads of SH 6 are currently available for servicing the district.

#### *Future Needs*

Future water lines installed to serve the medical district will follow the street layout. Water mains will consist primarily of PVC pipe and range in size from 8-inch to 12-inch diameters. All areas within the district will have a typical level of water service needed for domestic and fire protection requirements of the land uses. The water mains will be supplemented by additional 6-inch and 8-inch lines, as needed, to support individual developments within the district. To meet the demands of the new Scott & White Hospital and the remainder of the district, the City of College Station is planning for the construction of a new three million gallon elevated storage tank near the Scott & White development.

### **Sanitary Sewer Service**

Sanitary sewer service for the medical district is provided by the City of College Station. The only sewer service available east of SH 6 is a lift station currently under construction and sized to serve the Scott & White Hospital development.

#### *Future Needs*

Future development east of SH 6 will require the construction of an extension to the existing Lick Creek Sewer Line. The trunk sewer main will

generally follow the existing drainage ways within the district and will connect to the existing 18-inch Lick Creek Sewer Line. As development occurs, the Lick Creek line will need to be up-sized to handle the additional flows. The City's 2011 Wastewater Master Plan indicates a 30-inch line. However, due to the changes in land use proposed for the medical district, the future size should be reevaluated. The lines connecting to the trunk main will typically follow the street layout. This gravity system will also replace two other lift stations located along SH 6. It is anticipated that the proposed trunk main will have a 24-inch diameter with the contributing lines typically being 6-inch to 8-inch diameters.

### **Storm Drainage**

Lick Creek runs through the medical district on the east side of SH 6, and will generally be the outfall location for any internal storm drain systems for the district.

#### *Future Needs*

Drainage improvements typically consist of curb inlets and reinforced concrete pipe that follows the street pattern. However, there is an opportunity to guide growth of the district with "low impact development" principles. These principles control storm water runoff at the lot level, using a series of integrated strategies that keep rainwater on site, slowly releasing it and allowing for natural physical, chemical and biological process to do their job.

### **Electric Service**

College Station's Electric Utility provides the construction of new facilities needed to extend electrical service to new consumers, performs repairs and maintenance as needed to maintain the electric system, and installs and maintains streetlights.

#### *Future Needs*

Future electric service should be placed underground wherever possible, especially in locations where street trees are planned.

### **Natural Gas Service**

Natural gas distribution within the medical district is provided by Atmos Energy. Currently, there is a 6-inch gas main along SH 6, and 4-inch and 6-inch lines around the Scott & White site.

#### *Future Needs*

It is anticipated that 4-inch and 6-inch lines will be extended throughout the street system of the medical district. The lines will be polyethylene with a typical working pressure of 25-30 psi and a maximum pressure of 60 psi.

### **Telecommunications**

Comcast Cable and AT&T provide telecommunication facilities for the City of College Station.

#### *Future Needs*

It is anticipated that underground duct banks will be installed to follow the district street layout to provide capacity for telecommunication lines.

### **Planned Public Infrastructure Improvements**

Several infrastructure projects within the medical district and surrounding area have been identified for funding in order to meet the increased demands of development. The projects are identified in the City of College Station's multi-year Capital Improvements Program and the Bryan-College Station Metropolitan Planning Organization's Metropolitan Transportation Plan, including the expansion of Rock Prairie Road bridge and numerous capital improvement projects



including those listed below.

#### **Rock Prairie Road Bridge**

The Bryan-College Station Metropolitan Planning Organization identified improvements to the Rock Prairie Road bridge as the No. 1 priority on the Metropolitan Transportation Plan, and recently recommended funding of approximately \$4.4 million under the Proposition 12 Program through the Texas Department of Transportation. Improvements recommended for funding include expanding the existing bridge from five travel lanes to six, and adding bike lanes and sidewalks on both sides of the bridge. In addition, new structures will be added on either side of the bridge to accommodate U-turn lanes. Pending final funding approval by the Texas Transportation Commission, construction of these improvements is anticipated to begin in summer 2013.

#### **Capital Improvements Program**

The City's Capital Improvements Program (CIP) is a

multi-year plan that identifies and budgets for major capital improvements, balancing rehabilitation projects and expansions projects to enable growth. The six projects in and around the medical district identified in the current CIP are generally described below.

#### **Rock Prairie Road West**

The Rock Prairie Road West project funding includes the engineering analysis needed to determine the optimum right-of-way, and the purchase of land between SH 6 and Normand Drive to provide for the future widening of Rock Prairie Road.

#### **Rock Prairie Road East**

The Rock Prairie Road East project funding includes engineering design services and the purchase of land between SH 6 and William D. Fitch Parkway to provide for the future widening of Rock Prairie Road.

#### **Bird Pond Road**

The Bird Pond Road project funding includes engineering design services and construction for the rehabilitation of the existing street, north of Rock Prairie Road. Construction of this project is anticipated to be complete in 2012.

#### **Barron Road East/Lakeway Drive**

The Barron Road East/Lakeway Drive project funding includes engineering design services and construction of the extension of Barron Road between SH 6 and the future intersection with Lakeway Drive. This project also includes the design and construction of a segment of Lakeway Drive from the intersection with Barron Road southward where it will connect to a segment of Lakeway built by private development. Construction of this project is anticipated to be

complete in 2014.

#### **Lick Creek Hike and Bike Trail**

The Lick Creek Hike and Bike Trail project funding includes engineering design services and construction of approximately three miles of trails along Lick Creek between Lick Creek Park and Victoria Avenue. Construction of this project is anticipated to be complete in 2014.

#### **Scott & White Lift Station**

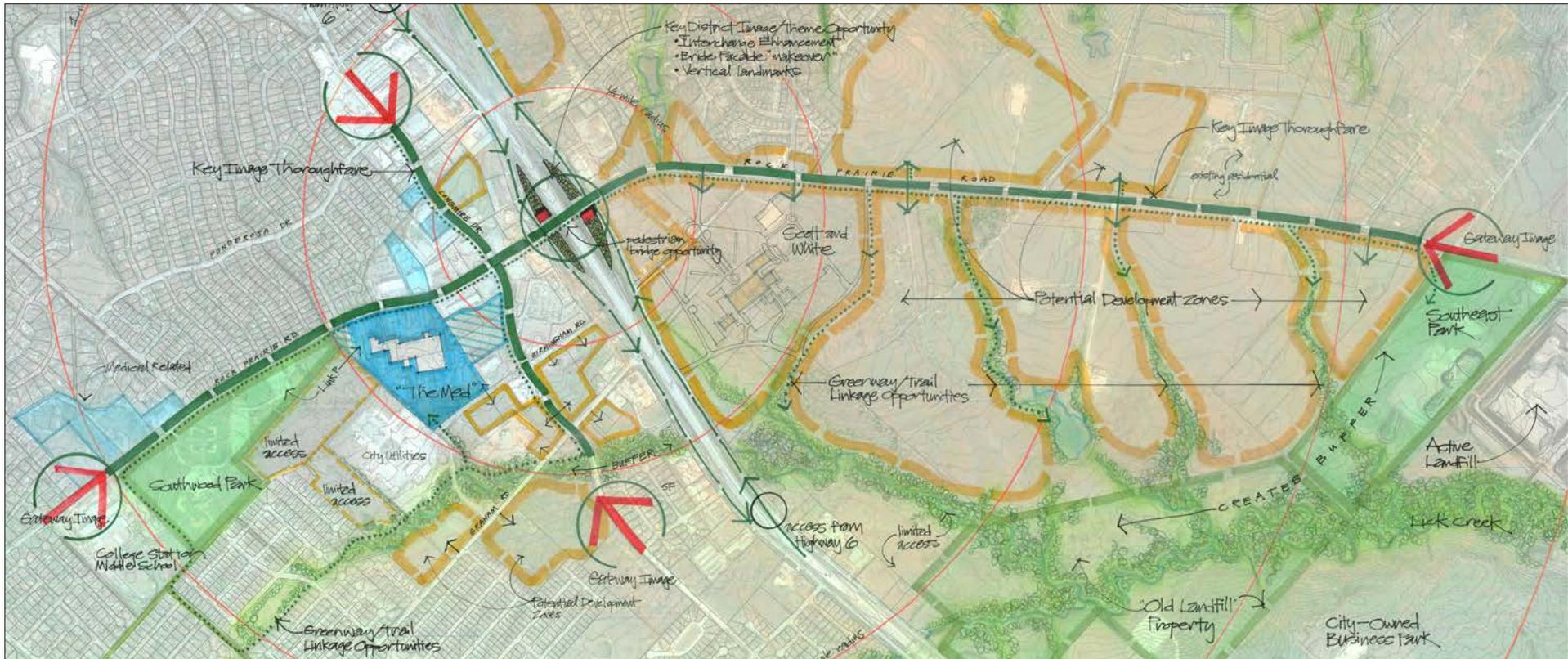
The Scott & White Lift Station project funding includes engineering design services, land acquisition and construction of a lift station and force main along SH 6 that will provide sewer service to the Scott & White Hospital. Construction of this project is anticipated to be complete in 2012.

#### **Planned Private Infrastructure Improvements**

In addition to the public infrastructure improvements discussed above, there are planned thoroughfare improvements within the medical district funded through private development. As a part of the Scott & White development, four collectors will be constructed, including a segment of Lakeway Drive connecting to the SH 6 northbound frontage road. Scott & White will also construct a collector connecting to the SH 6 northbound frontage road north of Lakeway Drive and two collectors connecting to Rock Prairie Road. These collectors will include bike lanes and sidewalks, and will expand the connectivity of the network in that area.

#### **Summary Site Observations**

The areas most conducive to the evolution of a



compact, cohesive medical district near The Med and the Scott & White Hospital have developed over time into today's complex mix of public and private land uses, undeveloped properties, creek corridors, parks and open spaces, and roadways both existing and planned. However, these same land use and infrastructure patterns, considered comprehensively and in the context of the site's underlying physiography, give strong cues and direction for guiding future growth and development in ways that further the goal of a compact, walkable and highly imageable medical community.

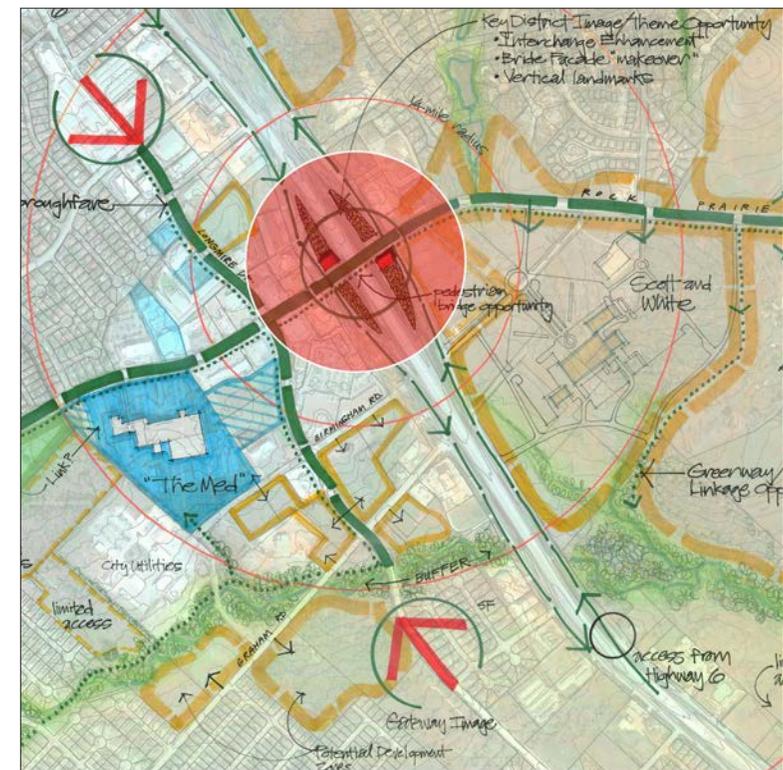
### SH 6 and Rock Prairie Road Interchange

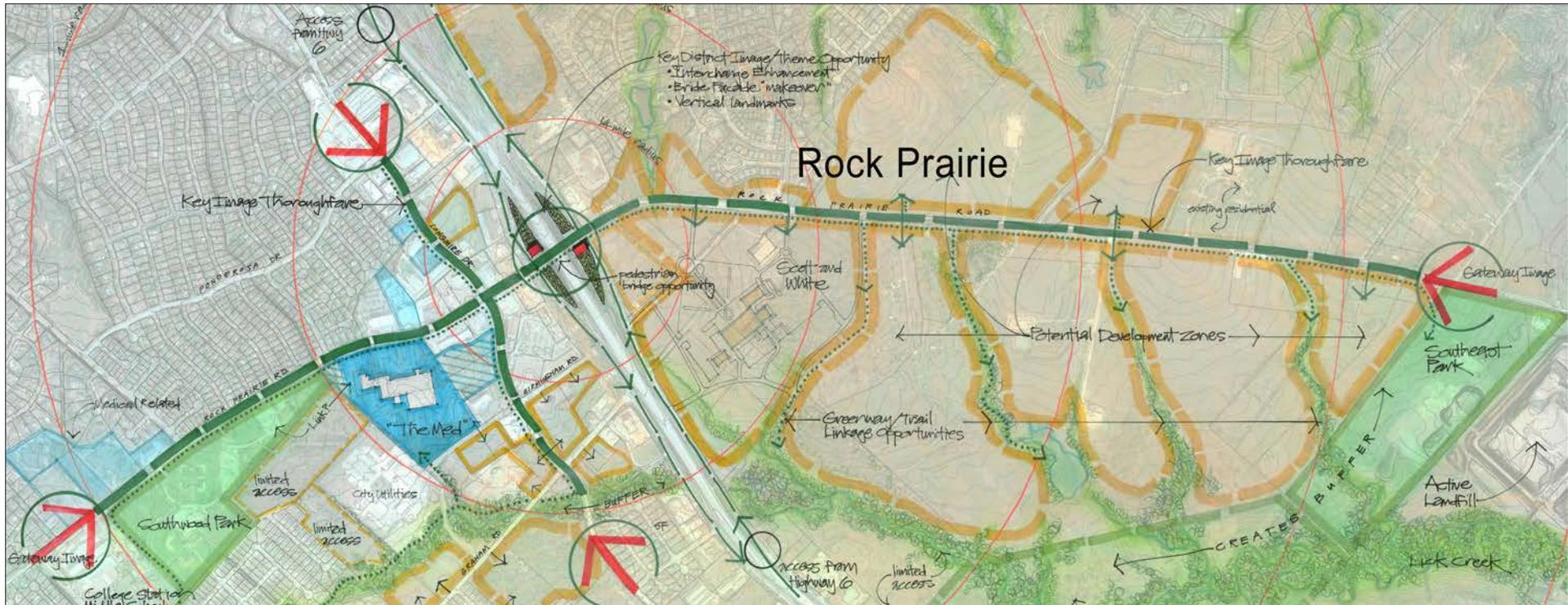
The SH 6 and Rock Prairie Road interchange provides access for the entire area, and is the central cohesive element of any development concept for a district. When reconstructed, the bridge has potential to knit together the east and west sides of SH 6 through the use of efficient

vehicle travel lanes, covered pedestrian walkways, bicycle lanes and enhancements that create a gateway and statement of quality for the medical district.

### Rock Prairie Road

This major thoroughfare is the single most important link that joins together the east and west sides of the district. It also acts as the spine along which the major medical related uses will front and have access. Because it is the first and dominant impression for both employees and visitors of the district, it has potential to set a tone of quality for the entire development. Care should be given to ensure that its cross-sectional design, landscape concept and signage create favorable impression of a grand boulevard that welcomes and is easily navigable, while balancing the mobility needs of vehicles, cyclists and pedestrians.



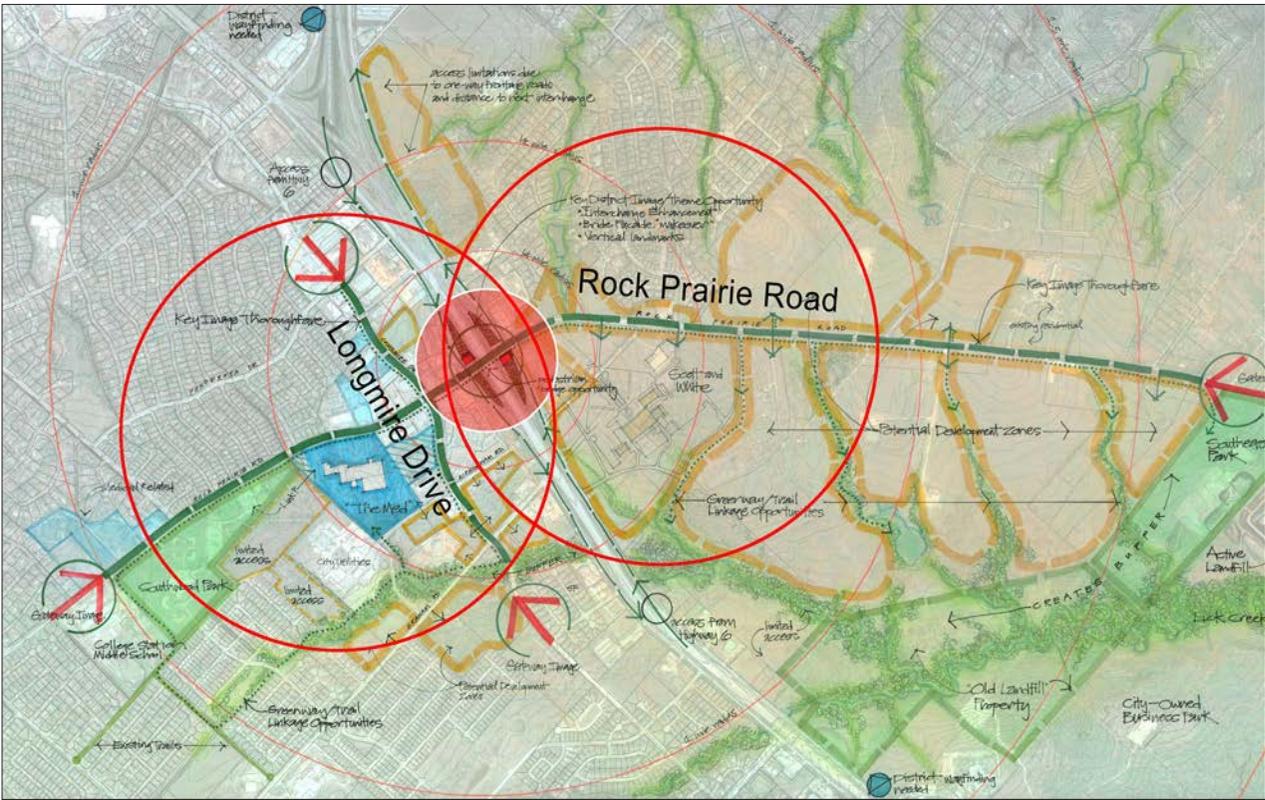


**Secondary Thoroughfares**

The area is well served by secondary thoroughfares both existing (Longmile Drive) and proposed (Bird Pond Road, Barron Road, Lakeway Drive and Pebble Creek Parkway). While none will have the traffic volume and, therefore, the visual impact of Rock Prairie Road, they should likewise be considered opportunities for enhancement with street trees, enrichment plantings, sidewalks, crosswalks, signage and wayfinding to help unify the district while balancing the mobility needs of vehicles, bicycles and pedestrians.

**Walking Radius Drives Development Concept**

A compact, walkable urban development should fit within a one-quarter to one-half-mile radius, placing most destinations within a five to 10-minute walk. A one-half-mile radius that could help define a walkable district fits comfortably on both the east and west sides of the SH 6. This observation implies a development concept that concentrates growth in two



walkable “village” areas, both on the east side of SH 6, redesigned and reconstructed as proposed by the master plan.

### West Side of SH 6

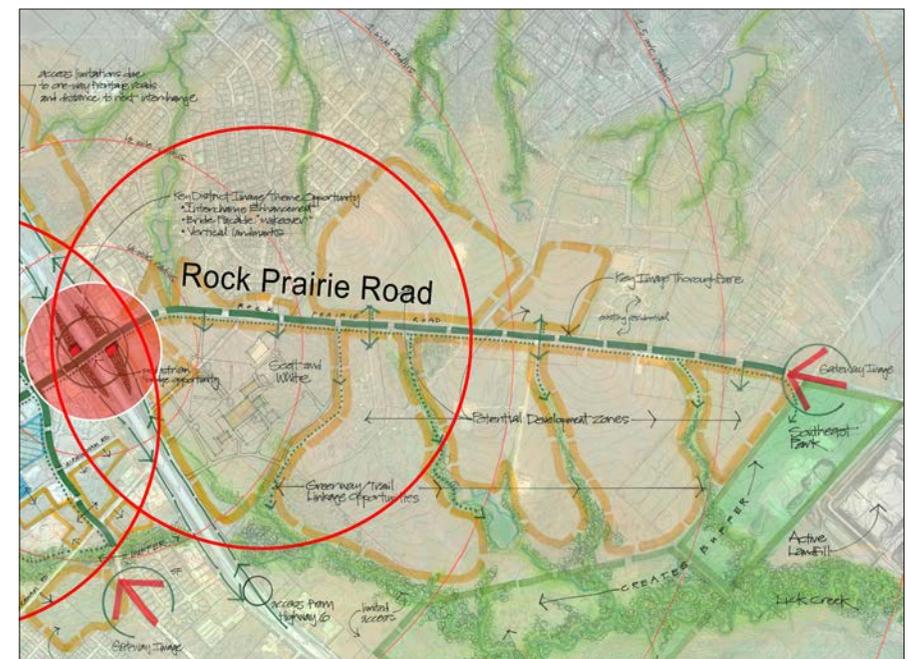
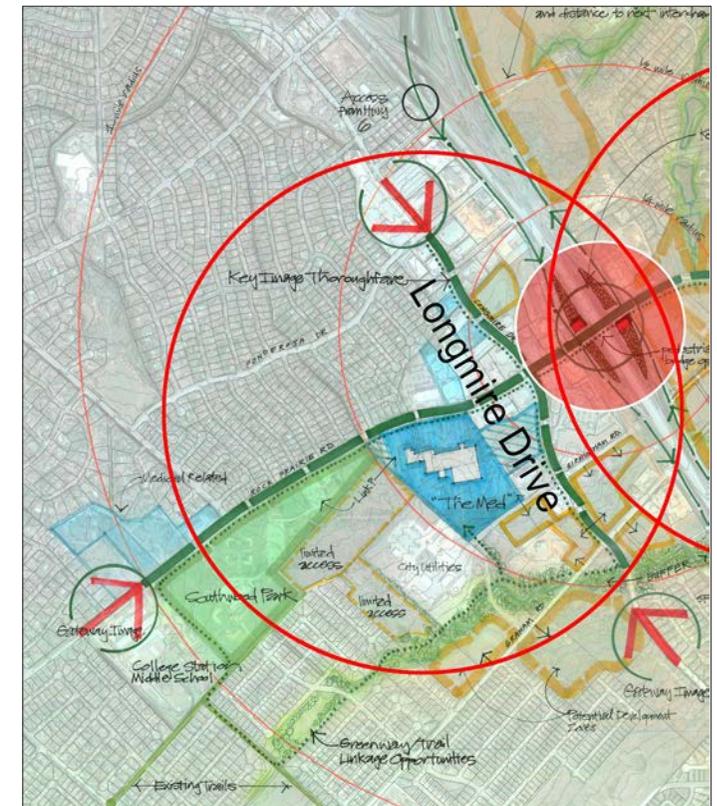
- The Med acts as the anchor and development catalyst.
- Several medical-related businesses have been attracted to the west side of SH 6 to take advantage of proximity to The Med. A growing medical “district” has already formed, to some extent.
- The undeveloped areas are scattered infill opportunities, ranging from 3.5 to 15 acres.
- The existing Southwood Park, trails, and wooded creek corridor have the potential to be linked with street-side paths to create a more extensive trail system that could be a district-wide amenity.
- Enhancements and amenities for the public realm will need to be creatively and sensitively retrofitted into existing development and infrastructure.

### East Side of SH 6

- The new Scott & White Hospital will act as an anchor and development catalyst.
- Undeveloped areas east of SH 6 are contiguous; they range from approximately 4 acres to 100 acres.
- The single family residential area north of Rock Prairie Road will benefit from the medical district with proximity to expanded medical services, shopping and entertainment.
- Lick Creek and its wooded tributaries provide an opportunity to create an extensive network of greenway linkages, which could connect all parts of the east side development to each other and to future greenway development along the creek. These vegetated greenways could also serve to enhance the quality of runoff and serve as wooded buffers between land uses.
- The landfill, Southeast Park, Lick Creek and William D. Fitch Parkway provide a logical eastern boundary for development of the compact, walkable medical district.

### Limited District Visibility

With the exception of the new Scott & White Hospital, limited visibility of medical uses from SH 6 underscores the need for visible landmarks, wayfinding and enhancements to “announce” the district. These efforts should be part of a unified “branding” concept that could include enhancements for a future new Rock Prairie Road bridge, imagery on the proposed water tower, vertical towers as key architectural landmarks, gateways, signage and distinctive planting design, all working in concert to convey an image of quality.



## 3 - Healthcare Trends & Demographics



### Healthcare Drivers

Both in the College Station area and nationwide, healthcare is a large, strong and growing industry—in sharp contrast to most other sectors of the nation’s economy over the past three years. The fundamental drivers of this growth are:

- The growing number of Americans who are over 65 years of age.
- General population growth.
- Affluent demographic groups around the globe that will travel if necessary to seek out the best healthcare and wellness facilities available.
- National policy that has expanded the number of citizens covered by insurance.
- Strong continued growth potential for the biosciences, pharmaceutical, medical devices, and related industries.
- The growing awareness of the need and benefits for health and wellness programs.

### The Graying of America

Throughout their lives—as America’s largest generation—baby boomers (born between 1946 and 1964) have made headlines. This continues today, as economists, demographers and forecasters attempt to discern the impacts that aging baby boomers will have on America in the 21st century. The impact will be broad and will include impacts to the workplace, public policy, retail and other facets of life. **Figure 5** shows the dramatically changing shape of America’s population over the past half-century. Between 2010 and 2040, the US Census projects that the number of Americans over the age of 65 will double—from approximately 40 million today, to 80 million in 2040. Beginning in January 2011, and over the next 19 years, at least 10,000 baby boomers per day will turn 65.

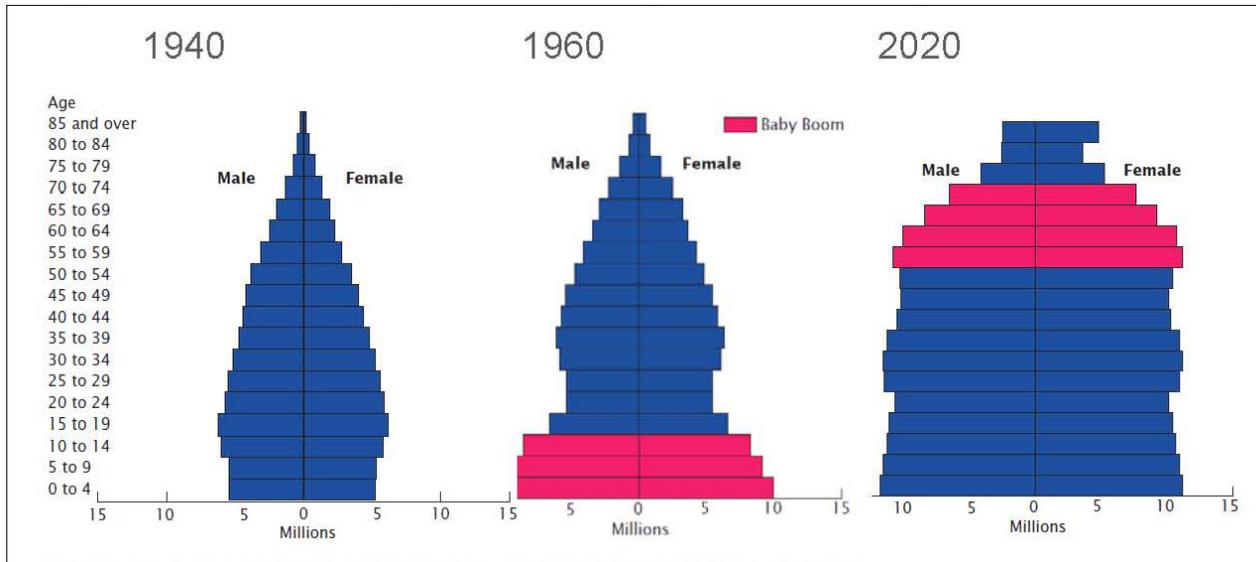


Figure 5. America's Population: From Pyramid to Rectangle  
 Source: US Bureau of Census, Leland Consulting Group

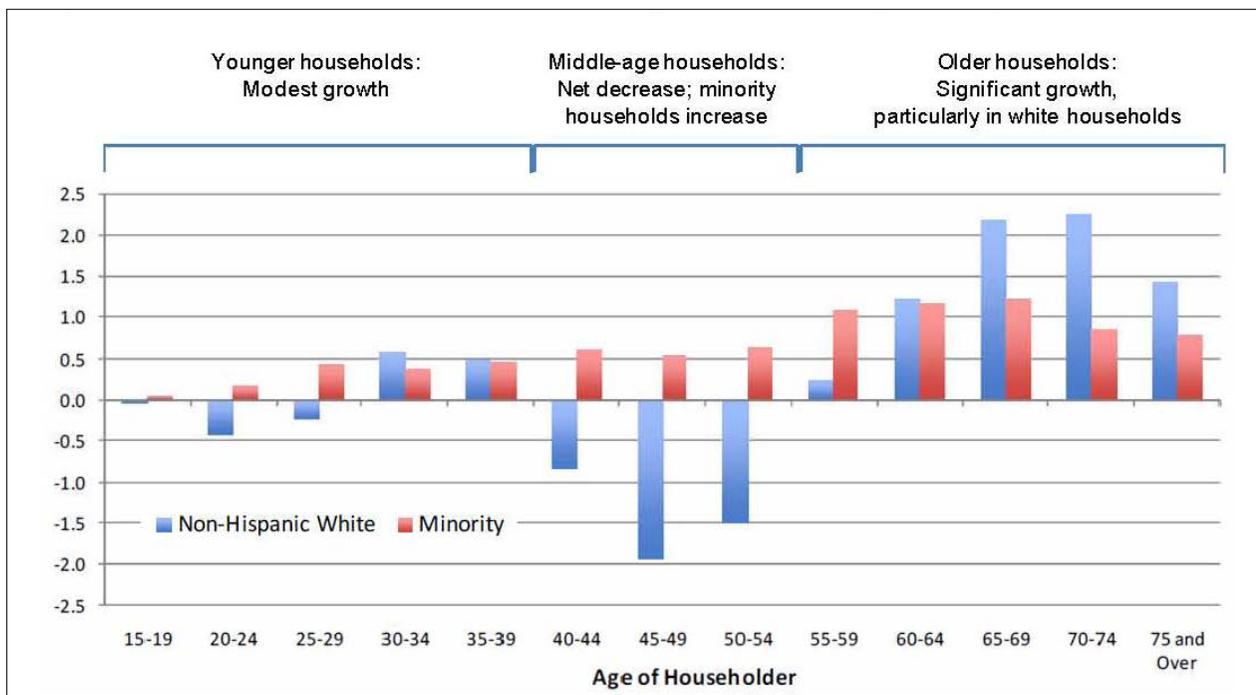


Figure 6. Nationwide Household Growth, 2010 – 2020 (Millions)  
 Source: Joint Center for Housing Studies at Harvard University, Leland Consulting Group

**Figure 6** underscores the scale of the growth in older households nationwide, while also illustrating some additional elements of the nation's changing demographics. This data also portends a growing need for smaller dwelling units with a richer variety. As referenced above, the greatest amount of overall household growth during the coming decade will come from the baby boomer generation. Younger households, with heads-of-households younger than 40 years of age, will also grow—though at a lesser pace. In particular, households aged 25 to 34—a key demographic that drives apartment demand and development—will experience strong growth. The number of middle-age households, however, will decrease, because of the relatively small number of “Generation X” (born between the early to mid 1960s and the early 1980s) households compared to baby boomers. The decrease in this age group—which has the largest percentage of families and children—suggests that the single-family housing market will continue to stagnate for some time. However, there will be a growth in the number of minority-headed middle-age households.

**Seniors Drive Healthcare Demand**

America's aging population will require more medical and healthcare services. Healthcare industry experts estimate that as much as 60 percent of all physician demand is driven by the 65-plus population. (Source: *Medical Office Development Continues to Rise, Real Estate Finance, April 2008.*) As **Figure 7** shows, senior citizens require approximately three times more physicians, in all categories of medicine, compared with younger age groups. The demand for services in turn stimulates strong demand for healthcare and healthcare related real estate including hospitals, clinics, physician offices, outpatient centers, senior housing and related facilities. The specific need for these facilities is outlined in **Chapter 4 – Development Program**.

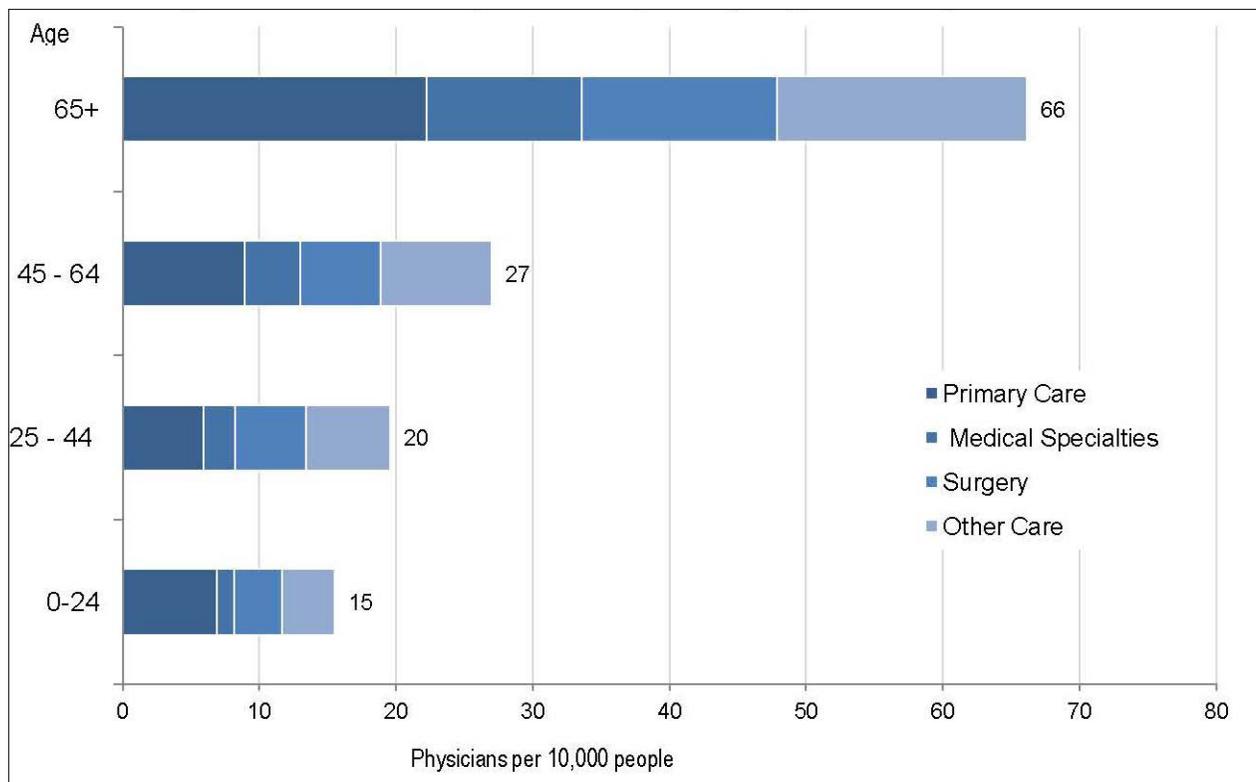


Figure 7. Physicians Required per 100,000 Population by Age Group  
 Source: Department of Health and Human Services, Leland Consulting Group

### More than Healthcare—Lifestyle

As the generation that came of age with rock and roll, increasing mobility and personal freedom, and amidst a seemingly limitless American economic expansion, baby boomers are unlikely to want to register at a retirement community and live out the rest of their days apart from the outside world. They will be seeking more from their communities than simply reliable healthcare. According to a 2007 survey, the following are some of the key features that baby boomers will look for in their future housing choices and communities (Source: “Who are you calling a senior?” *Urban Land Magazine*, January 2011):

- Working will continue to be an important part of the boomer lifestyle. Fifty-five percent of boomers plan to continue to work at least part-time, making urban areas close to job opportunities and transportation more desirable. Urban workforces are better plugged into the new economy, a trend that only stands to strengthen as the U.S. information economy expands.
- Arts and culture. Boomers overwhelmingly seek locations that offer travel, arts, hobbies, fitness, entertainment, dining, culture, shopping and gardening—raising the question, what are boomers not interested in? Surprisingly, they agree on their lack of interest in golf, tennis or a move to a warmer climate.
- Of the boomers who are anticipating a move, only 20 percent are very interested in golf and/or warm locales, and plan to include those factors as part of their moving decision.
- Eighty-six percent of baby boomers want to live in a typical community setting where people of all ages live; diversity of age and experience is critical to boomers.

Information suggests that our definition of “senior housing” will change. Rather than seclusion and exclusivity, many boomers will want activity and connection—with their children, grandchildren, friends and communities. Along with outdoor pursuits, seniors will be looking for arts, culture, food, continuing education and lifelong learning and other pastimes. Further, while high quality healthcare is very important to senior citizens, they are looking for communities in which it is part of an overall puzzle, not the entire picture.

**Increase in Healthcare-Related Jobs**

Job growth in the United States has stagnated over the past several years. In the coming decades, job growth is expected to come from several well-defined industry segments, led overwhelmingly by healthcare and professional services. The Bureau of Labor Services (BLS) predicts that the healthcare industry will generate 3.2 million new jobs between 2008 and 2018. Therefore, the opportunity to accelerate the development of a medical district or cluster of institutions is a major economic development opportunity, since this industry sector is expected to be among the fastest growing in the country.

Figures 9 and 10 show both the types and locations (by development type) of jobs expected to be created in the healthcare fields. This information is relevant because it is indicative of the types of development likely to take place in College Station, and because it shows the breadth of jobs that could be created within the City and region. The greatest demand, as shown in Figure 9, will be for those trained as nurses, physicians and surgeons, followed by many other professionals including social workers, lab technicians and physician assistants. These job types

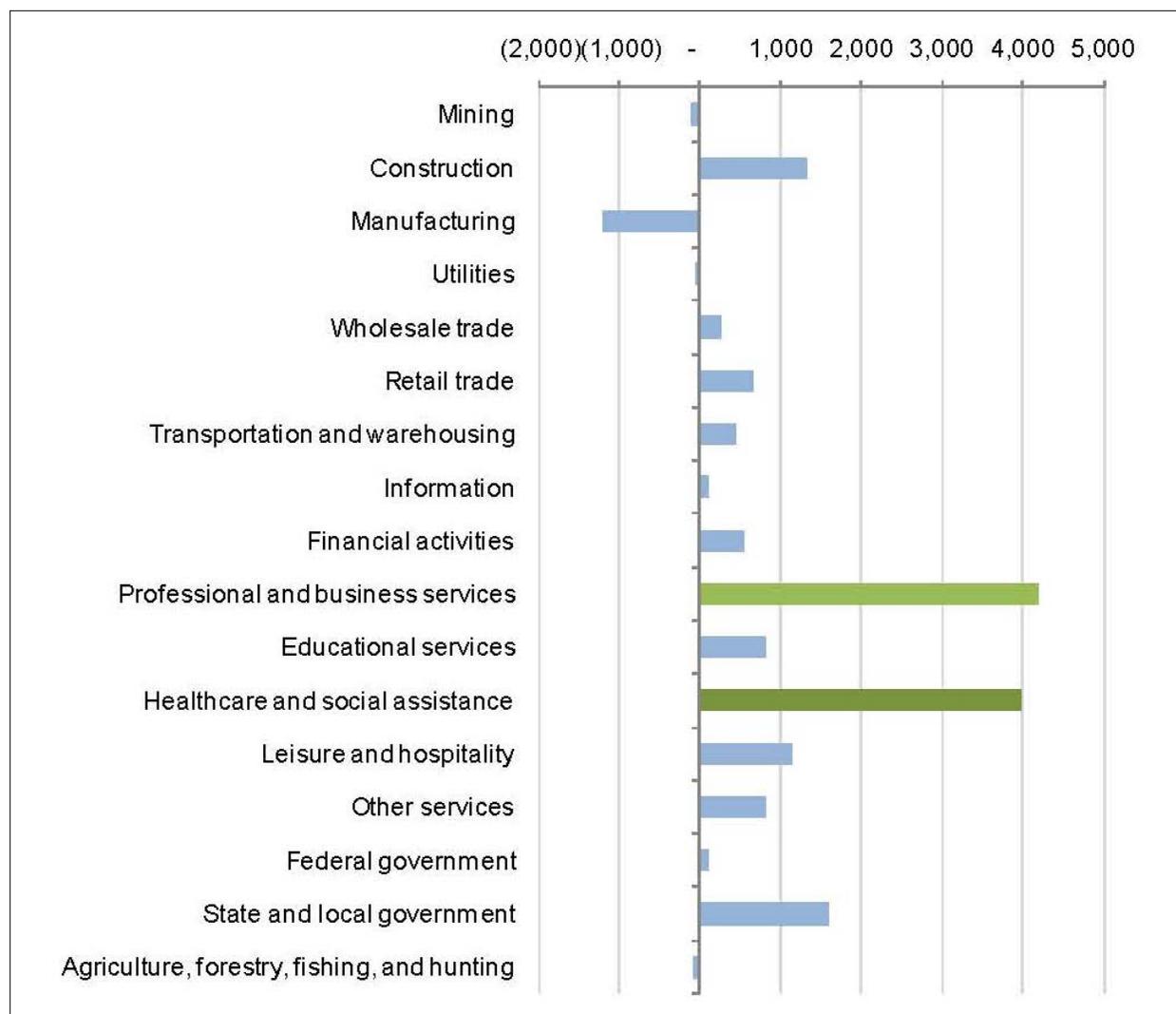


Figure 8. National Employment Growth by Industry Sector, 2008 – 2018 (thousands of jobs)  
 Source: Bureau of Labor Services, Leland Consulting Group

in general offer relatively high wages and security compared with national averages.

College Station’s educational institutions, led by Texas A&M’s Health Sciences Center, have already begun preparing to meet the need for a highly-educated healthcare workforce. **Figure 10** shows that the locations where healthcare professionals will work is diverse and extends well beyond the traditional hospital, to physicians offices, senior housing communities, patient’s homes and clinics. Thus, a diverse range of real estate types will be needed within the medical district.

### Real Estate Development Outlook

Real estate development was a major source of the national recession, and an industry that continues to suffer in its aftermath. Nationwide, most types of real estate development continue to be out-of-favor with investors due to dramatic overbuilding in the early part of the last decade, increased unemployment and stagnating wages, more caution on the part of consumers, increased scrutiny by lending managers, ratings agencies, and regulators and other related factors. These conditions are reflected in **Figure 11**, which shows some of the key findings from the Urban Land Institute’s (ULI) 2011 Emerging Trends in Real Estate, a leading annual real estate industry publication.

While industry leaders are extremely pessimistic about most types of development—most development types are seen as nearly “abysmal”—development within several land uses is “fair”, that is, financeable and profitable under the right conditions. These include apartments, medical offices, senior housing and other types of affordable and infill housing—all

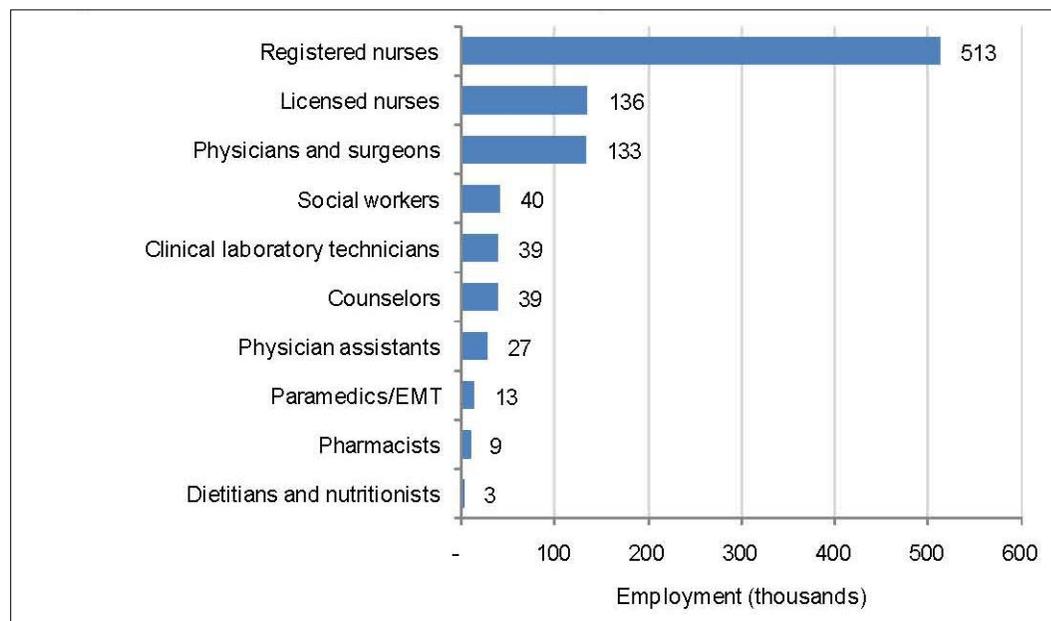


Figure 9. Net New Healthcare Jobs by Title, 2008 – 2018

Source: BLS Guide to Healthcare Industry, 2010-11 Edition, Leland Consulting Group

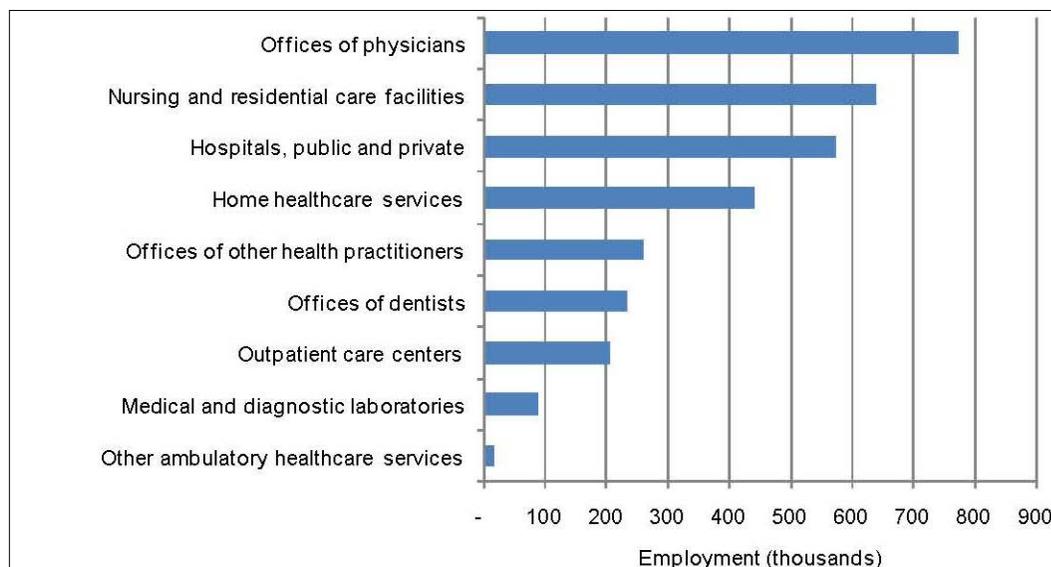


Figure 10. Net New Employment by Facility Type, 2008-2018

Source: BLS Guide to Healthcare Industry, 2010-11 Edition, Leland Consulting Group

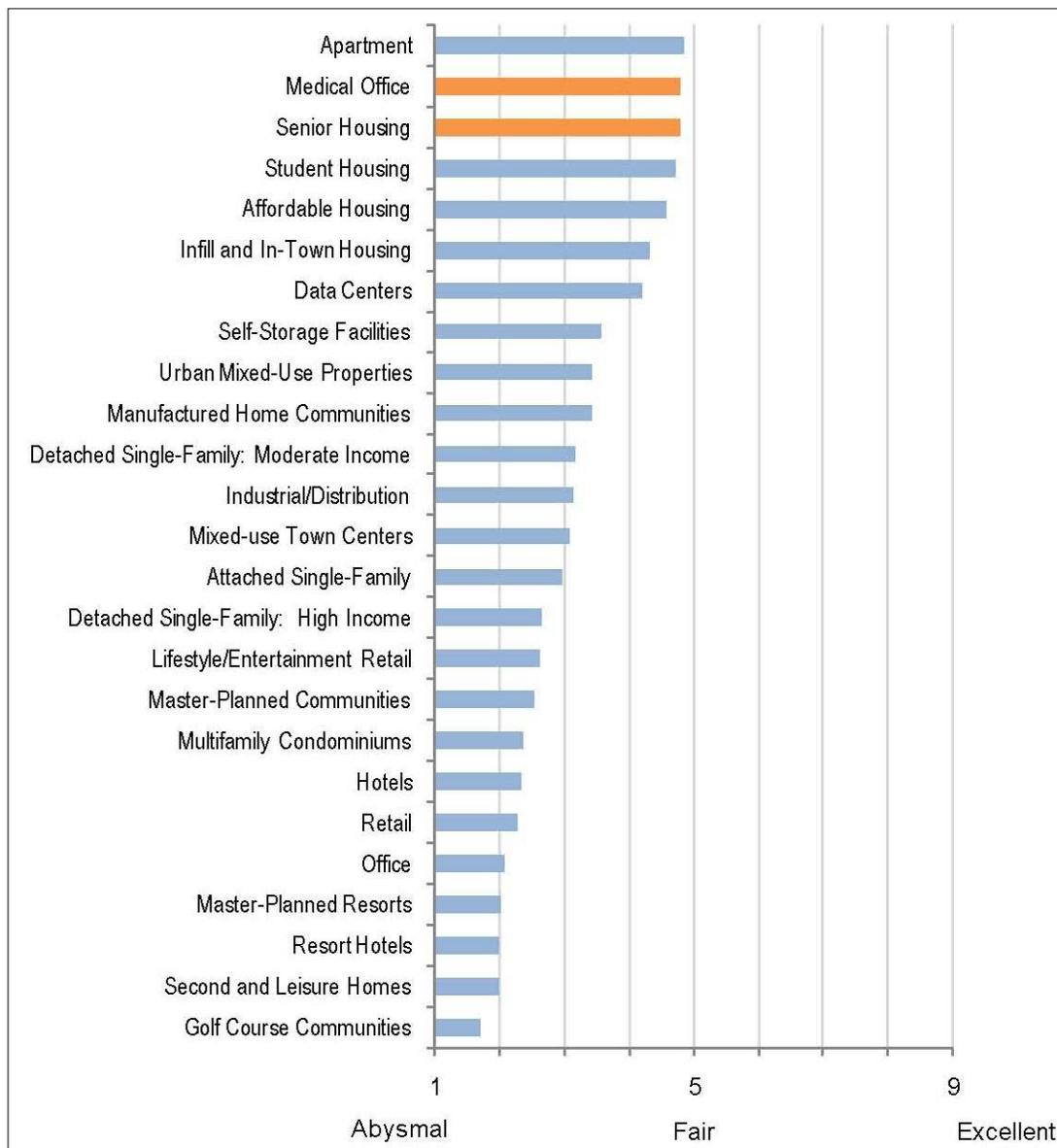


Figure 11. 2011 Real Estate Development Prospects  
 Source: Urban Land Institute, Leland Consulting Group

development types with strong long-term demand drivers that did not suffer from the same scale of dramatic overbuilding as single-family housing and other types did in the early 2000s.

While these trends are important for the medical district, there are a number of qualifications to this information that should be recognized. The Emerging Trends analysis is nationwide and intended for the short term (multi-year outlook focusing on 2011). In fact, we know that every real estate market is highly localized, with its own demand drivers (economy, demographics, etc.) and players (existing development, developers, property owners, etc.). Many Texas cities and metropolitan areas have continued to create jobs and enjoy strong real estate markets through much of the last several years, thus avoiding the worst of the national real estate downturn. In addition, the medical district is intended to be a long-term vision with a long-term build out, and thus, the trends in effect in 2020 and beyond will be nearly as important as those for next year.

However, with these caveats in mind, the land uses anticipated to be strong opportunities in 2011 should continue to maintain their top positions for much of the coming decade. Nationally, the medical office sector has outperformed most other commercial property types through the recession. Texas was expected to add 1.7 million square feet of medical office space in 2010, an increase of 2.5 percent. Asking rents are strong, averaging nearly \$23 per square foot. (Source: Medical Office Research Report, Marcus & Millichap, Q3 and 4 2010) The City and its medical district development partners should take these uses into account when planning and implementing the master plan.

**Previously Uninsured Entering the Healthcare System**

In addition to the growth of the over-65 population and other demand drivers discussed above, the expansion of healthcare to a broader segment of the population, particularly through greater access to insurance, is expected to increase the need for hospitals and other medical real estate.

Healthcare and health insurance has, of course, been much in the news during the past two years. As of 2010, approximately 46 million Americans were estimated to be uninsured. The federal healthcare reform bill, signed into law in March 2010, is expected to lead to coverage for approximately 32 million, and thus an increase of approximately 64 million square feet of healthcare related real estate nationwide. (Source: "Can Healthcare Rescue Real Estate?" Meyer, Kenneth and Rob Grossman, Deloitte Consulting)

**Figure 12** shows the demographic groups that are currently least likely to carry insurance today, but would be covered in the future. Some of these groups—particularly Hispanics, households aged 18 – 29, and southern and western households—are also groups expected to grow quickly in the coming decades, and thus, their impact on healthcare demand will be amplified. Expanded coverage is generally expected to be neutral to positive for the financial health of medical service providers (although its impact on the health insurance industry may be negative). More patients will be able to pay fair-market rates for care through insurance, but insurers may be forced to reduce their co-payments across the board.

However, fierce disagreements about the proper direction of federal and state policy continue. While it is likely that at least some of the insurance expansion put in place in 2010 will continue, it is also possible that the insurance expansions could be diminished or eliminated. This report assumes that at least some of the insurance expansion will stay in place, and that this in turn, will contribute to demand for healthcare related real estate.

#### Additional Trends Affecting Healthcare Real Estate

The following are additional trends affecting the development and operation of healthcare-related real estate within the state and across the nation.

- **Healthcare reform.** New legislation will change healthcare delivery over the next several years, as uninsured people are brought into the system. Insurance companies will be challenged because those who can afford healthcare already have it. Those who have to be added typically cannot pay for services and will have to be supplemented in some way, which will probably mean lower reimbursements for providers. Therefore insurance companies and medical providers will have to look for ways to streamline costs. Many of the uninsured are young and healthy, 20 to 30 year olds. Others are extreme poverty situations,

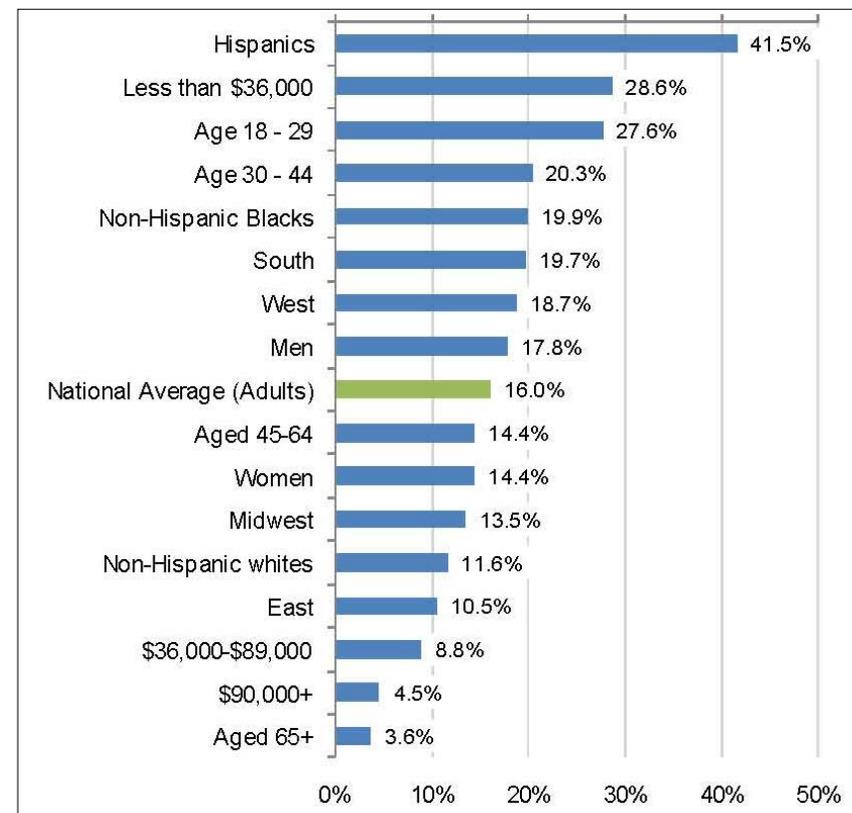


Figure 12. Demographic Characteristics of the Uninsured, 2009  
Source: Gallup Well-Being Index, June 2009, Leland Consulting Group

and will likely need assistance to pay for healthcare. Dental care will be especially critical to this group.

- **Insurance.** The first step in the process will be primarily focused on insurance, getting the uninsured into an insurance group.
- **Delivery:** The second step in the process will be delivery focused, streamlining costs in the system and providing care for an increased number of people.
- **Access and Affordability.** Many HMOs will do well in the future because they control costs with an integrated approach. They are financially stable and will continue to grow.
- **Consolidation.** Physicians will have to be part of a group, as most will not be able to stand alone because the costs of running a private office continues to increase significantly.
- **Streamline Costs.** There will be even greater emphasis placed on reducing redundancies and streamlining the “flow” of patients (as measured by through-put metrics). For example, electronic healthcare records give access to a patient’s medical history, lab tests, etc., to all providers and specialists, thereby reducing repetitive tests and consolidating office visits.
- **Reimbursement.** New members will be paying less than others will. Payments through Medicare/Medicaid barely cover the costs of administration; however, providers will at least get some (albeit low) reimbursement for patients that previously had to be covered for free in the ER.
- **Robotic surgery.** Larger operating rooms will be required.
- **Insurers.** Regional providers will be supporting their communities and will step up to provide

care to the currently uninsured. National for-profit providers are looking for self-funded members where they can get higher profit margins.

- **Collaborative effort.** Healthcare will be less of a hierarchical system. There will be more groups that deliver care through nurse practitioners and other support staff when possible, and fewer stand-alone physicians, mostly out of a necessity to reduce costs.
- **In-home monitoring.** The advent and improvement of electrical monitoring technology allows more patients to be at home, and yet have distant professionals monitoring vital signs and looking for signs that they may need critical attention.
- **Military technology.** The military has long been a leader in technological advances. Equipment and technology developed for use by the military will change the medical community.
- **Electronic ICU (EICU) critical care monitor.** One facility can monitor multiple hospitals, similar to flight control at an airport monitoring multiple airlines. This could help lower costs for regional facilities in areas with several critical care or ICU units.
- **Streamline real estate holdings.** Healthcare institutions will look for ways to cut costs including real estate holdings. Some hospital groups are currently looking to downsize administrative space. They are experimenting with alternate workspaces, such as shared stations, and allowing employees to work at home or otherwise off site.
- **Dental and Medical Synergy.** Providers are recognizing the importance of dental health

in a person’s overall health. More dental care providers will be needed in the future.

- **Information Systems.** Information systems and electronic records streamline costs and improve care by being accessible to multiple providers.
- **eVisits.** Physicians have started responding to patients through email, and can sometimes avoid an office visit. Industry experts expect to see a reduction in office visits, but this has not been the case yet.
- **Rural innovations.** Providers are looking for ways to provide cost effective care to rural areas, where it has traditionally been difficult to attract physicians and other providers. At least one hospital group is testing a small 2,500 square foot clinic for rural areas. Another experiment is a mobile mammogram van, which, while it requires a low level of capital investment, is still costly to operate and requires “partner sites” for water, power and other services.

#### **Medical Districts and Urban Development**

Major healthcare institutions and related uses have clustered together in medical districts across the country. These districts are a result of deliberate and assertive action by healthcare providers, the public sector, and other stakeholders, who seek to provide their patients with more complete offerings for care; proximity to other experts, suppliers and complementary uses; and increased economic outcomes such as growth in jobs and tax bases. The following case studies summarize some of the key characteristics of medical corridors and districts nationwide.

Research of medical districts across the nation indicates successful medical districts tend to be

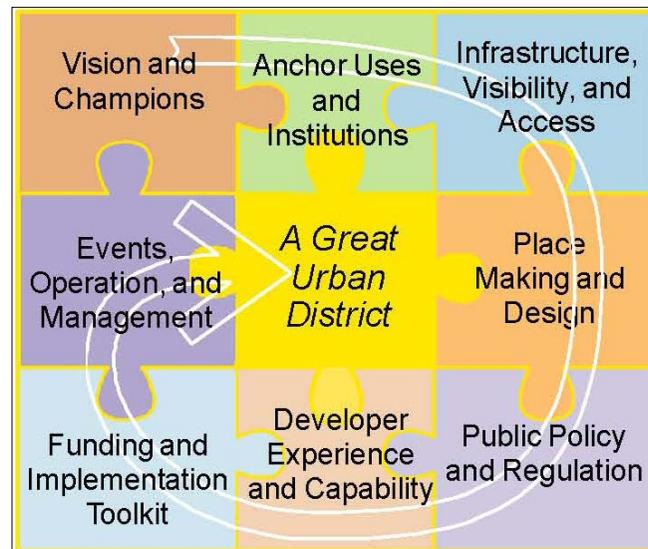
located in larger communities with populations in excess of 500,000. However, one well established and notable example is Winston-Salem, NC. With a population of nearly 230,000, Winston-Salem is comparable to the combined population of College Station and Bryan. Tyler, Texas is also in the process of evaluating and planning a medical corridor with a population similar to College Station and Bryan, but it is too early to identify useful lessons. Communities of less than 50,000 are known to have established medical districts, with East St. Louis, IL being a good example. Attempts to identify a distinct set of success factors for medical districts is problematic given the variation in the size of host cities and the history of medical district development.

### Common Traits of Highly Successful Downtowns and Vibrant Urban Districts

(Source: “Common Traits of Highly Successful Downtowns,” Gary Ferguson, *Ithaca Downtown Partnership*, 2005)

1. **No single organizational model exists.** While College Station can and should learn from other medical district models in similar locations, the approach adopted in College Station will be distinctive to College Station.
2. **Multiple traffic generators are within short walking distances.** The medical district cannot be a single-purpose district. Visitors to and residents of the district will demand a variety of accessible activities including health, wellness, and recreational services, as well as dining, retail and jobs.
3. **Great urban districts are beloved by their citizenry.** Pride in the medical district must be promoted and instilled internally to city residents. The district could be useful in establishing a distinct gathering place for meetings focused on medical issues and for patients and their friends and families in the course of access to comprehensive health care solutions.
4. **Great downtowns and urban districts are able to overcome obstacles.** This requires partnerships, shared resources, vision and patience. The premise of the medical district itself is the product of a shared vision and shared resources. This lesson needs to be extended throughout the district and the community. In the context of current and predicted economic reality, there is no viable alternative to a robust public-private partnership to get things done.
5. **Great districts are walkable and have pedestrian scale.** There must be interesting features that capture the attention of pedestrians while assuring personal safety. The variety of patrons and residents of medical district institutions will help to attract a variety of businesses, public art, aesthetically pleasing streetscapes and visual diversity.
6. **Great urban districts have a commitment to mixed-use development.** Developers and investors are urged to build for and attract a range of occupants, business types and institutional services. Virtually by definition, the medical district will itself be a form of a mixed-use development, so this theme can be applied more broadly, too.
7. **There is broad public/private investment in the future of downtowns and urban districts.** Partnerships are essential for the private, public and non-profit realms. The medical district can and must demonstrate that public/private investments can achieve significant results, and should include a variety of private interests (developers, etc.), public leadership and non-profits such as a district steering committee or business association.
8. **Entertainment is the driving market segment.** Revitalized downtowns increasingly serve as places for dining and recreation rather than simply centers for retail merchandise. The medical district can be a leader in attracting and sponsoring public events (fairs, concerts, art walks, “healthy foods” farmers market, etc.) that instill interest in the medical district, eventually leading to a wide range of investments.
9. **There is a prevalence of strong, adjacent residential neighborhoods that are within walking distance of an urban district.** Respecting the existing area neighborhoods while establishing new residential neighborhoods is essential for the success of the medical district. Access to and from housing in the neighborhoods must be redesigned to encourage pedestrians into the medical district.
10. **Housing is either prevalent or underway.** The medical district must add a substantial amount of housing in addition to improvements in transportation and pedestrian routes. Such housing should appeal to the workforce in the medical district as well as seniors, include affordable options, and be walkable neighborhoods.
11. **Colleges and Universities help, but are not the sole answer.** Many of the medical districts studied are university towns, but the research found that universities are not automatic keys

to district vitality. However, research indicates that a strategic partnership with institutions of higher education is vital to medical districts, is an attraction for regional visitors and a source of well-trained labor for the entire area. Certainly this is true for all major medical providers in the College Station-Bryan market today. Texas A&M University is foundational to the development of a regionally competitive medical district. Additionally, the excellence of the College Station Independent School District is a major asset in the successful establishment of a medical district and is a key element in attracting medical professionals and organizations into the medical district.



*Approaches to urban revitalization success must be multifaceted, multidisciplinary, and holistic. Keep the puzzle pieces together!*

*Source: Leland Consulting Group*

With these metrics in mind, a strategic model for establishment of a medical district in College Station and the broader community that leverages the characteristics of its existing strengths can be designed. Such a model, however, must be unique to College Station and must be supported by those who use or would use the medical district more actively.

**National Medical Corridors and Districts: Key Characteristics and Tenants**

Successful medical corridors and districts have been established in a wide spectrum of urban areas.

**Table 1** provides a sample of some of these districts.

Community	University Affiliation	Population, 2010
Dallas, TX	University of Texas at Dallas	6,500,000
Houston, TX	At least 15 Health related University Organizations	6,100,000
Philadelphia, PA	University of Pennsylvania	6,100,000
Miami, FL	University of Miami	5,547,000
Boston, MA	Harvard Medical School	4,500,000
San Antonio, TX	University of Texas at San Antonio	2,140,000
Oklahoma City, OK	University of Oklahoma	1,253,000
New Orleans, LA	Tulane University	1,236,000
Memphis, TN	University of Tennessee	647,000
Aurora, CO	University of Colorado Denver Anschutz Campus, VA	325,000
Birmingham, AL	University of Alabama	212,000
Tyler, TX	University of Texas at Tyler, Texas College	210,000
Englewood, CO	University of Colorado Denver	32,532
East St. Louis, IL	University of Illinois	27,000
Bryn Mawr, PA	Bryn Mawr College (Pre-Med)	21,000

*Table 1. Successful Medical Districts, University Affiliation and Population Size  
Source: Leland Consulting Group, US Census*



Source: Texas Medical District

**Texas Medical Center  
Houston, Texas**

- World's largest medical center.
- 93,500 employees.
- 1000 acres.
- 14 hospitals and two specialized patient facilities.
- 160,000 daily visitors.
- 69,000 students, 5,000 of whom are international students.
- 5.6 million annual patient visits.
- 50-year Master Plan completed in 2006.
- \$7.1 billion in building and infrastructure investments approved between 2010-2014.
- Annual Economic Impact – \$14 billion.
- Annual Research Expenditures \$1.2 billion.



Source: City of Dallas

**Stemmons Corridor  
Southwest Medical District Study Area  
Dallas, Texas**

- Plan adopted 2010 (to be implemented through 2013).
- TIF district.
- 100,000 employees.
- 5,000 businesses.
- Biotechnology and medical services – key targeted industries.
- Key healthcare providers and tenants:
  - UT Southwestern Medical Center.
  - Parkland Health & Hospital System.
  - Children's Medical Center.
  - Texas Woman's University School of Nursing.
  - 40 Hotels (Stemmons Corridor).
  - Planned expansion of clinical care and new research buildings.
  - Planned 350,000 SF biotech and life science research park.



Source: Urban Land Institute Special Report: Office/ Medical Development, 2008

**Texas Research Park - San Antonio, Texas**

- UT - Institute for Biotechnology.
- UT - Institute for Longevity and Aging.
- Biomanufacturing firms.
- TEKSA Innovations Corporation.



Source: 10th Street Medical Business District Development Strategy, 2006

**10th Street Medical Business District  
Oklahoma City, Oklahoma**

- Recommended Development Program, 2006 to 2020:
  - Office: 450,000 to 800,000 SF.
  - Retail: 130,000 to 175,000 SF, groceries, restaurants, bars, drug stores, household goods, gas stations, apparel, day care, bars.
  - Mid-size hotel: 200-250 rooms.
  - Residential: 1,500 to 2,000 units (average of 1,200 SF per unit).



Source: health.usnews.com

**Five Points Medical District  
Birmingham, Alabama**

- Key healthcare providers:
- University of Alabama Hospital – 908 beds.
  - HealthSouth Medical Center – 73 beds.
  - HealthSouth Lakeshore – 100 beds.
  - Callahan Eye Foundation Hospital – 20 beds.
  - Children’s Hospital Of Alabama – 310 beds.
  - Cooper Green Mercy Hosp – 141 beds.
  - Veterans Affairs Medical Center – 122 beds.
  - St. Vincent’s Hospital – 372 beds.
  - Brookwood Medical Center – 602 beds.
  - Princeton Baptist Medical Center – 368.
  - Birmingham Baptist Medical Center – 375 beds.
  - Select Specialty Hospital – 38 beds.
  - Hill Crest Behavioral – 80 beds.



Source: health.usnews.com

**Sugarland, Texas  
Key healthcare providers**

- Key healthcare providers:
- Memorial Herman Sugar Land Hospital – 77 beds.
  - Triumph Hospital Southwest – 170 beds.
  - Sugar Land Surgical Hospital – 6 beds.
  - Methodist Sugar Land Hospital – 127 beds.

## College Station: Local Demographics and Healthcare Context

The population and demographic trends at work in the City of College Station and its surrounding areas reflect the conditions under which a concentrated medical district would be expected to thrive.

College Station is part of the College Station-Bryan Metropolitan Statistical Area (MSA, a US Census designation), and at a larger geographic scale, Texas' "golden triangle," the super-region framed by three large metropolitan areas: Dallas-Fort Worth, Houston, and San Antonio. The Golden Triangle contains most of the economic engines that are powering the state's economy and population growth. Because of its location within the triangle and its own unique attributes, College Station is also experiencing rapid growth. As **Figure 15** shows, the College Station MSA grew nearly 24 percent between 2000 and 2010, the sixth fastest rate in a fast-growing state. The City itself has grown dramatically, from a population of just over 52,000 in 1990, to an estimated 113,000 by the year 2020. All five of the major metropolitan areas in the Golden Triangle grew faster than the state average in the last decade. This population growth will surely drive demand for medical and healthcare services.

The market area for the medical district, however, extends beyond the City's boundaries and even the officially designated metropolitan area. A market area is the area from which most patients and customers will come from and within which most of the medical district's competition will be found. The estimated market area for the medical district is approximately a 50-mile radius from the City (also shown in **Figure 13**). Those who live fewer than 50 miles from College Station will tend to come here for medical services, assuming that the medical district is competitive in terms of quality of care; those who live further away will tend to go to the city center that they are closest to. Obviously a number of intangible factors—quality of care, availability of specialists, insurance coverage, patients' familiarity with providers—have a large impact on people's choice of providers, so this market area is an approximate rather than exact area.

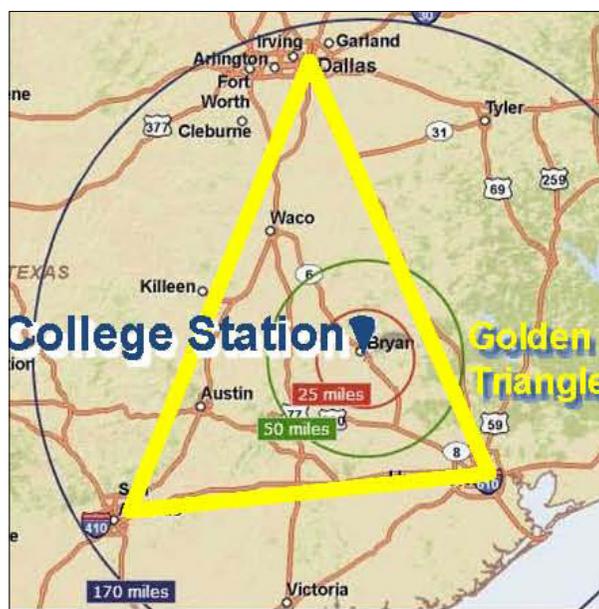


Figure 13. College Station and the Golden Triangle  
Source: ESRI, Leland Consulting Group

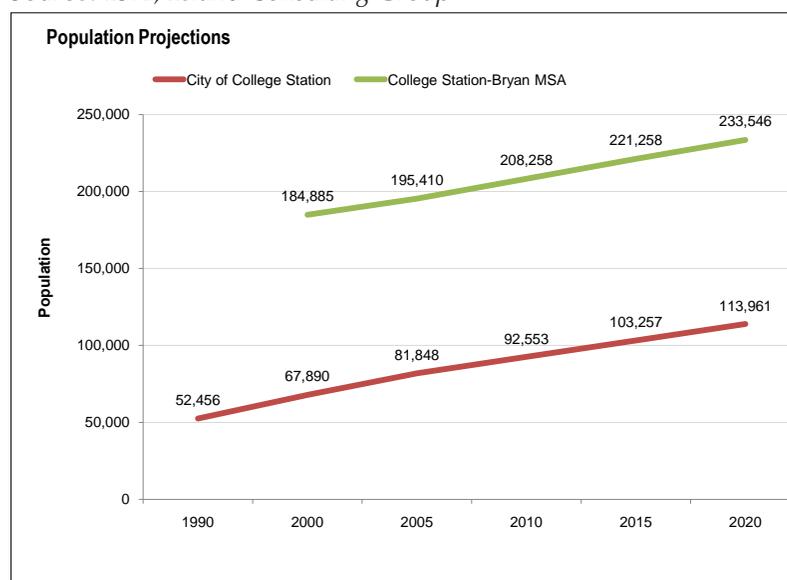


Figure 14. Population Forecasts for College Station and Metropolitan Area  
Source: City of College Station (linear growth projection), Texas State Research Center, Leland Consulting Group

### Senior Population and “Old Aggies”

As discussed above, the other primary driver of healthcare demand beyond raw population growth is the rate of growth amongst the senior population. Here, as well, demographic trends point towards increasing demand for medical services.

**Table 2** shows that, while there are 4,000 residents of the City of College Station who were 65 or older in 2010, 62,000 residents (or 12 percent) of the 50-mile market area are seniors. This is a far larger group, in terms of share and total numbers, than the City’s population alone, and indicates a large population of aging seniors. This group is also growing, and will represent 28 percent (nearly 12,000 new seniors) of the total population growth in the market area in the next five years.

The consultant team’s research and interviews support the story told by the Census data. Those interviewed consistently stated that “lots of ‘Old Ags’ are moving back to town” to reconnect with their old friends and community. Old Ags are certainly potential patrons for the medical services in the medical district, as well as the residential and retail components. A story from 2007 in *The Eagle* stated that, “Many senior citizens consider Brazos County a retirement haven because of Texas A&M, the region’s medical facilities and its friendliness. And Texas overall—partly because of inexpensive housing relative to many other states and partly because it has no state income tax—is popular with retirees, ranking No.2 among the 50 states as a retirement destination. The Kovars, both 63, had a long history with Texas and Brazos County. They met at A&M, where Gary Kovar was a guard on the football team. They married while still in school, and when he retired after 35 years with Amoco Chemical Co., they moved back to Aggieland.” Retirees like Bryan-College Station due to A&M, healthcare, social life.”

*The Eagle*, December 16, 2007.

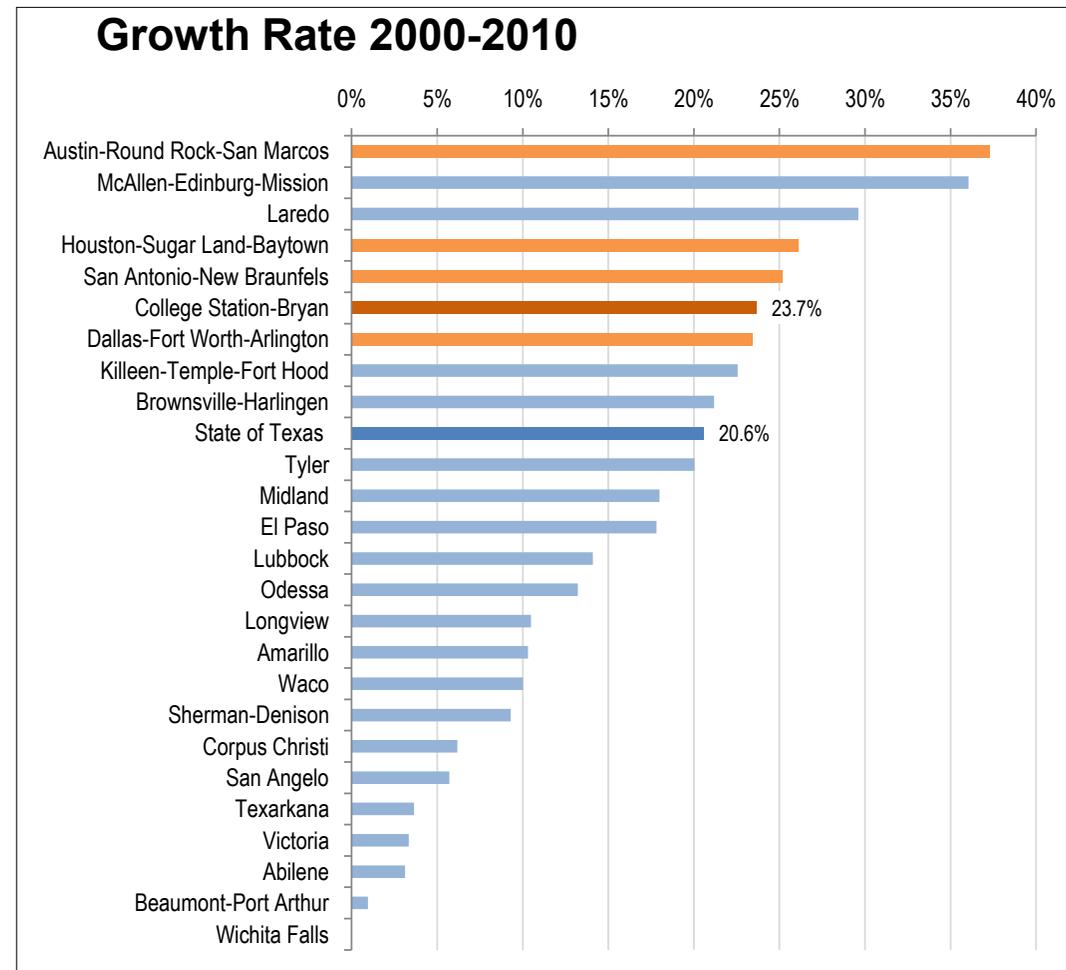


Figure 15. Growth Rate of Texas Metropolitan Areas, 2000 - 2010

Source: Texas State Data Center, Leland Consulting Group

Another important demographic feature of the College Station area is the tremendous number of young, college age residents. As **Table 2** shows, approximately 48 percent of the City’s population is between the ages of 0 and 24, while this percentage is only 40 percent of the 50-mile market area. The percentage of college age residents in College Station is said to be among the highest in the nation, and is certainly one of the highest in Texas. Historically, this high percentage of younger residents has been one of the reasons that the number of hospitals and healthcare-related uses has been lower than average on a per-capita basis—younger people need less care than older people. However, the percentage of the population that is over 65 is expected to grow over time, reaching 13 percent in the City by 2030, as opposed to the eight percent of the population that was over 65 in 2010. The 50 mile market area is expected to have even more seniors, reaching 17 percent by 2030. As is happening nationally, this regional shift to an older population will create more demand for healthcare.

### Housing Demand

Based on existing and projected demographic trends, there is expected to be demand for approximately 10,100 new housing units of all types within the College Station-Bryan MSA. This amount of demand will help to gauge the potential demand for housing in the medical district, outlined in the Development Program. This is based on population growth of over 25,000 in the MSA, and the City’s expected average housing size of 2.5. This is a rough projection of demand, since housing can be provided in many forms, ranging from student housing, to single-family housing to a variety of senior housing. These housing types are explored in greater depth in **Chapter 4 – Development Program**.

As shown in **Figure 16**, College Station grew at a faster rate than Bryan over the past decade and is expected to continue this trend. Therefore, it is reasonable to assume that College Station will capture a greater share of the projected housing demand for the College-Station-Bryan MSA than will the City of Bryan.

### College Station Healthcare Environment

College Station and Bryan already serve as the focal point for healthcare services within the market area. There are two large-scale, established general medical

Population	College Station-Bryan MSA		50 mile Radius	
	%	Pop.	%	Pop.
<b>2010</b>				
Age 0 - 24	48%	99,964	40%	205,385
Age 25 - 44	25%	52,273	25%	128,818
Age 45 - 64	19%	38,736	24%	121,575
Age 65+	8%	17,494	12%	62,081
<b>Total</b>	<b>100%</b>	<b>208,258</b>	<b>100%</b>	<b>517,342</b>
<b>2015</b>				
Age 0 - 24	47%	104,434	39%	217,425
Age 25 - 44	25%	56,200	25%	139,175
Age 45 - 64	18%	40,269	23%	128,555
Age 65+	9%	20,134	13%	73,779
<b>Total</b>	<b>100%</b>	<b>221,258</b>	<b>100%</b>	<b>558,934</b>
<b>2020</b>				
Age 0 - 24	48%	112,102	40%	241,803
Age 25 - 44	24%	56,051	24%	145,082
Age 45 - 64	18%	42,038	23%	139,037
Age 65+	10%	23,355	14%	84,631
<b>Total</b>	<b>100%</b>	<b>233,546</b>	<b>100%</b>	<b>604,507</b>
<b>2030</b>				
Age 0 - 24	45%	133,225	37%	261,629
Age 25 - 44	24%	71,053	24%	169,705
Age 45 - 64	18%	53,290	23%	162,634
Age 65+	13%	38,487	17%	120,208
<b>Total</b>	<b>100%</b>	<b>296,055</b>	<b>100%</b>	<b>707,105</b>

Table 2. Population of College Station and 50-Mile Market Area by Age Group  
Source: US Census, ESRI, Leland Consulting Group

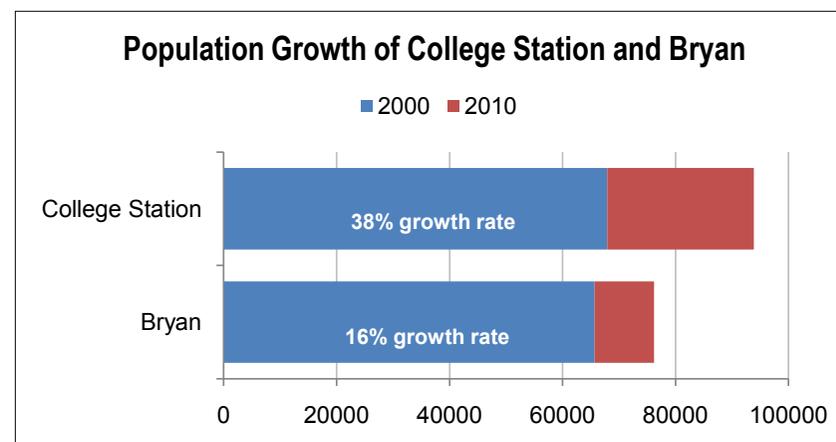


Figure 16. Growth Rate and Population of College Station and Bryan 2000-2010 - Source: Census Bureau, Leland Consulting Group

hospitals, College Station Medical Center (The Med) and St. Joseph Regional Health Center (Bryan). The new Scott & White Hospital is currently under construction at the intersection of SH 6 and Rock Prairie Road in College Station. In addition, two new healthcare-related institutions are expected to grow rapidly in the College Station-Bryan area: Texas A&M University's Health Science Center (HSC) and Research Park. Supplementing these major facilities and institutions are an array of physician's offices, pharmacies and small local clinics that serve nearby neighborhoods.

A medical district has already begun to take shape in the vicinity of SH 6 and Rock Prairie Road. This has long been the site of The Med (approximately 150 beds), which will be joined by the new Scott & White Hospital (projected capacity of 143 beds upon completion). The Med, with 217 active physicians, was founded in 1931 as an acute care hospital and moved from Bryan to College Station in 1997. Through construction of additional floors on the existing building, The Med could accommodate as many as 250 total beds.

The two hospitals form the nucleus of a medical cluster, or medical district, and are complemented by a range of other "supporting uses" such as medical office buildings, pharmacies and physician's offices. In their own way, the existing retail, housing and parks are also supporting uses.

St. Joseph Regional Health Center's main campus in Bryan has 310 beds. Their outpatient facility in College Station is located on 27 acres at William D. Fitch Parkway and SH 6. The St. Joseph outpatient

facility is outside the study area, however, St. Joseph is an important institution and part of the College Station medical community. In 2010, approximately, 24,000 College Station residents chose St. Joseph for their outpatient care while 2,951 residents used St. Joseph for inpatient care. The Physicians Centre Hospital is also located in Bryan, but has only 16 beds and is not considered a full service hospital.

The medical facilities that are currently on the ground or under construction show that the private market is already confident that a medical district is feasible. Thus, the questions for the future really revolve around not if the medical district will happen, but how and at what scale. In other words, what are the scales of medical and related non-medical uses, the time frame for development, qualities of the physical environment and how can new facilities be introduced without creating excessive competition for existing providers?

In planning for future medical facility expansions and additions, the College Station medical community and the City should carefully review the area's competitive position vis-à-vis other areas—particularly larger metro areas such as Houston and Austin. The City's healthcare institutions can and should be able to offer general hospital/medical and acute care facilities that are every bit as good as those in larger metro areas. However, in some specialty care areas—for example, oncology, cardiology and gastroenterology—local institutions will have trouble competing directly and should offer these services through strategic relationships with larger, regional specialty healthcare providers. This dynamic is explained in greater detail in **Chapter 4 -Development Program.**



## 4 - Development Program



A development program is a narrative description of how a property or area should be developed. The program serves as a guide to the physical planners (land planners, landscape architects, architects and engineers) who are responsible for translating the narrative program into a physical land use, transportation and utility plan. The development program describes an overall identity for the project including theme, image and attributes to be merchandised; the overall objective is to capture target markets, maintain economically viable conditions, and create a positive, long-term identity for the project.

Product and amenity opportunities are based on the research and analysis of markets for the project—all of which should be simultaneously pursued for the purpose of accelerating project sales and mitigating absorption risk.

Programming includes identifying and formulating alternative concepts for the master plan, including:

- Development theme and character.
- Timing and phasing. This development program is intended for an approximately 10- to 20-year period. However, some uses will develop before others.
- Land uses by type, including a wide range of medical and non-medical components.
- Land use mix.
- Number, type and land (acreage) needs of the various land uses.
- Likely amounts of medical and commercial uses (measured in square feet) and housing (measured in dwelling units).
- Recommended amenities.

### **Forecasting in the Fog: The Past and the “New Normal”**

Making accurate long-term development projections has never been easy. But it is arguably more difficult now than ever before, given the dramatic changes to the nation’s economy and real estate markets that have taken place over the past four years, and the ripple effect this has had on consumer preferences and demand for housing, retail space and other components of the built landscape.

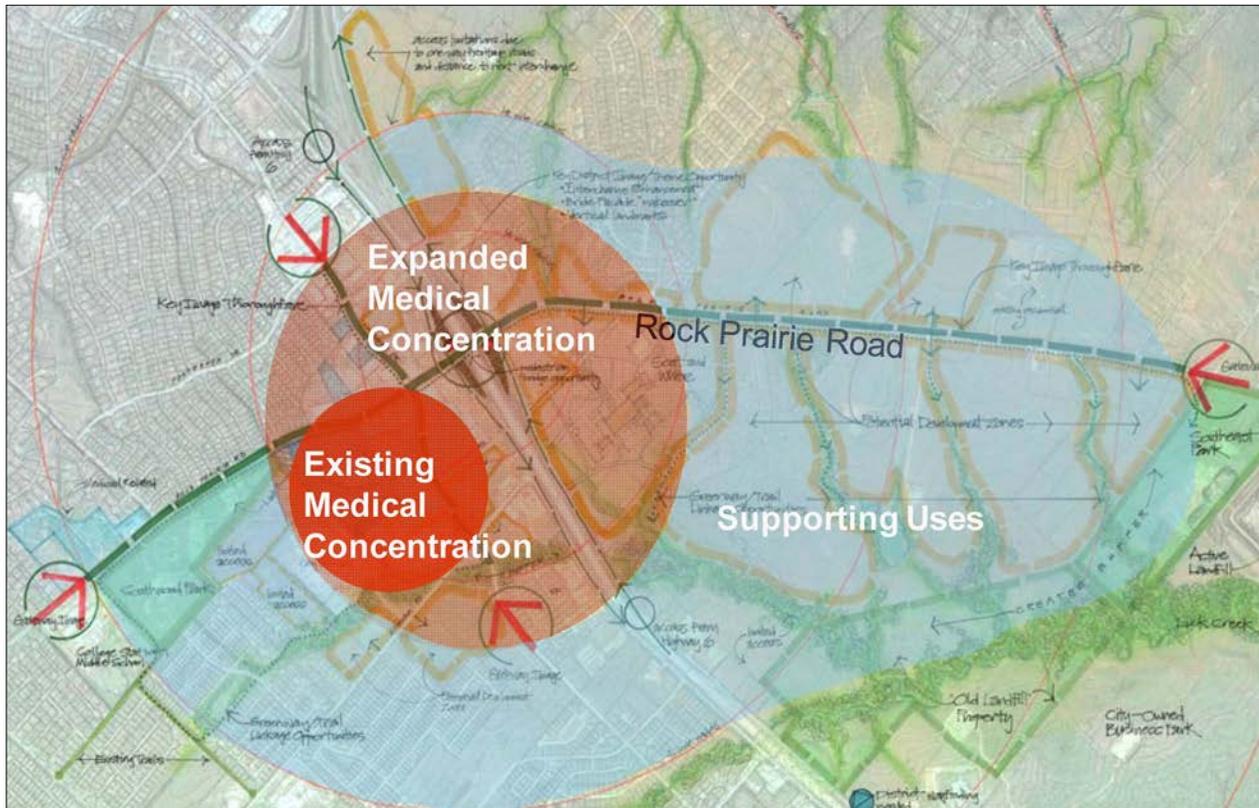


Figure 17. Medical District with Land Use Concentrations  
Source: Leland Consulting Group, SRA, Townscape

**Figure 18** illustrates the difficulty of “forecasting in the fog:” pre-crash data shows a red-hot market in which all real estate products—ranging from single-family homes to commercial real estate—were funded and leased quickly, while post-crash data shows just the opposite. Neither can be relied upon to accurately predict long-term trends, and thus, determining the precise pace or timing of redevelopment in College Station and most other markets is very difficult.

The future market realities are almost certainly somewhere between the 2007 peak and the current trough. This principle is likely to be true with respect to measurements such as annual housing starts,

commercial real estate absorption, rent and lease rates and other metrics throughout the College Station market area.

However, the downturn and eventual upturn—expected in 2011, 2012 or potentially later—will be “lumpy”. Traditional lending institutions are hesitant to make loans to developers, and when they do, the parameters of the loan are often prohibitive. Many households have seen serious wealth depletion, as much of the household worth depends on the value of single-family homes, access to home equity loans, retirement accounts and other funds related to the value of financial markets. No one knows when these forces will return to a state of normalcy

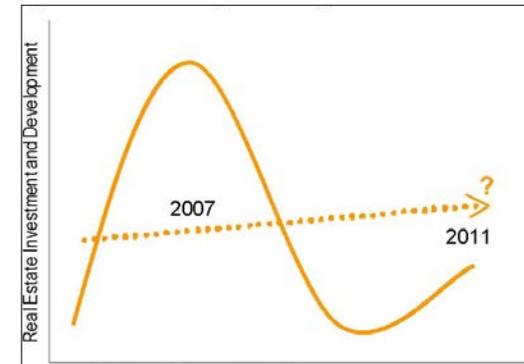


Figure 18. Forecasting in the Fog  
Source: Leland Consulting Group

and exactly what the “new normal” will be. Some markets—defined geographically or by real estate product type—will fare much better than others. For example, the apartment market is in most cases seen as a more desirable area for investment at the moment than single-family homes—which are in most areas overbuilt.

Similarly, in retail, some stores will fare better than others or even be more profitable than before. Sales among fast casual restaurants are up. Movie theaters are generally doing well as consumers redefine leisure as dinner and a movie rather than a week long vacation abroad.

In summary, College Station should take a long view of real estate redevelopment, hope for the best but also plan to be patient with the still-struggling economy.

#### Successful Programs are Market-Driven

The master plan, which can expect successful implementation, must address, to the extent possible, the goals of the City. The additional and equally rigorous layer of considerations that impact the program consists of:

- Market willingness to seek out medical services, housing, shopping or leisure activities, or other products and experiences in the physical environment to be developed.
- Market capacity to pay either through equity, debt service, rents, home ownership or commercial rents.
- Lending and loan underwriting policy and criteria.
- Achieving reasonable levels of profitability commensurate with risk to attract private development capital to the study area.
- Establishing an arrangement of land uses which can be successfully introduced in the marketplace with sufficient velocity (rate of sales) to generate revenues adequate to cover or partially cover the cost of infrastructure both on-site and off-site.

Hence, all development strategies must thoughtfully consider the needs of the potential employers, residents, and shoppers who will come to the district. These considerations include price, size, quality levels, image, quality of life and other factors.

### Development Identity and Character

Preparing a development program for the medical district begins with establishing a statement of the recommended overall identity and character for the project. This statement of the project should be adopted by the medical district leadership and organization. It is analogous to the mission statement in a business plan. It is the guiding statement against which later program details can be “tested” for compliance in support of the overall theme. The recommended program is for a medical district and mixed-use community, as illustrated in the following graphic.



### Exceptional Medical Care

This is the key differentiating feature of the district and the set of uses that will drive its success. Exceptional medical care currently brings substantial numbers of patients and employees to the district every year, and will continue to do so in greater numbers in the future. These visitors then make up the market for the other uses and activities in the medical district, including the “village center” retail, office space, housing and parks. It is absolutely critical to the long-term success of the district that residents of the College Station market area believe in the quality of care and receive the best care possible.

The land use components of medical care include hospitals, specialty and subspecialty clinics (such as children’s medicine, oncology, mental health, etc.), medical office buildings, pharmacies and medical suppliers, research and development, and education and university related uses. Not all of these uses must be on site at all times. For example, The Med currently has relationships with certain specialty doctors who are only in College Station on a part-time basis, since the market is not big enough to sustain those who focus on specific and relatively rare procedures. Thus, some services can be offered through outsourcing or even off-site relationships.

### A Special Place and Destination

The Texas A&M campus is one example of a special place: A place that people return to time and again to enjoy experiences with friends and family, that evokes memories, emotion and attachment. On the Texas A&M campus, experiences include sporting events, reunions, military services, etc. The medical district will of course have a different look, feel, and identity than the A&M campus, but it should establish a sense of place and, in doing so, create a means by which it can differentiate itself from its competition. This will help it to attract patients, doctors and residents because of a natural desire to spend time in high-quality environments.



A pathway on the A&M campus.

Research completed by Texas A&M and the Center for Health Design shows that quality of place matters. According to one in a series of articles and presentations authored by professor Leonard L. Berry of Texas A&M and his colleagues: “The buildings in which customers receive services are inherently part of the service experience...The evidence indicates that the one-time incremental costs of designing and building optimal facilities can be quickly repaid through operational savings and increased revenue and result in substantial, measureable, and sustainable financial benefits.” (“The Business Center Case for Better Buildings,” Leonard L. Berry et. al., *Healthcare Financial Management*, November 2004.)

This analysis is consistent with real estate research completed on the relationship between the quality of the built environment and the price that customers or residents will pay to be there. (Source: “The Business Case for Better Buildings,” Leonard L. Berry et. al., *Healthcare Financial Management*, November 2004. See *Valuing the New Urbanism: The Impact of the New Urbanism on Prices of Single-Family Homes*, Eppli, Mark J. et al, Urban Land Institute, 1999, and *Back to the Future: The Need for Patient Equity in Real Estate Development Finance*, Brookings Institution, 2007. The capital costs of high-quality development are also usually higher, but as these analyses show, this is offset by higher revenues when implemented properly) “Place making” can be achieved through a “village center” or active central place for commerce and social functions, design of signage, gateways and entrances, streets and sidewalks, street lighting, common architectural themes, consistent imagery, graphic design and other features.

**Holistic Wellness**

The medical district has the opportunity to incorporate aspects of health and healthcare that extend beyond the walls of its hospitals and clinics—through health and fitness clubs, walking and biking paths, restaurants that emphasize healthy eating, ball fields, yoga studios, plazas, open spaces and many other features. An example is The Med’s current partnership with Aerofit Health and Fitness that will result in a new fitness center just south of Rock Prairie Road. The American public is, today, broadly interested in a definition of health and well-being that is much broader than medicine alone. By incorporating and integrating health and wellness broadly into the medical district, and by demonstrating this approach through the area’s physical design, the City and its partners can enhance the district’s brand, improve people’s connection

to the place, and increase revenues and economic viability.

**Great Neighborhoods: Housing Options for Seniors, Medical Professionals and Families**

Two key groups—senior citizens and medical professionals—will have a distinct interest in living close to the medical district. Seniors have a demonstrated propensity for living in close proximity to quality medical care, and people tend to seek housing that is within easy access to their jobs. This suggests strong demand within the medical district for both senior housing—which includes a “continuum of care” that ranges from independent living, to assisted living, to skilled nursing facilities—and a wide range of housing for medical professionals. The types of housing sought by medical professionals will also be very broad, and may range from large-lot, single-family homes, to urban-style condominiums within walking distance of the hospitals.

Making these housing options available will enhance the value proposition of the medical district and its potential for long-term success. The medical facilities

will benefit from a consistent base of patients, and find it easier to attract the best doctors, nurses and technicians if great neighborhoods are located nearby. Finally, this population will also help the village center retail component to thrive.

**Medical and Supporting Uses**

As shown in **Figure 19**, the medical district can be generally divided into major use areas: an existing and expanded medical core and a large area of supporting uses. However, both areas—core and periphery—will include a mix of medical and non-medical uses. The types and locations of these uses are summarized in **Figure 19**.

**Land Available for Development**

The study area for the master plan is several hundred acres in size. This total area includes some areas that will remain as-is for many decades, areas that are vacant and are expected to develop and some smaller areas that are already developed but are expected to redevelop within this development program’s time frame.

Medical and Healthcare Uses	Supporting Uses Located in the Medical District Core	Supporting Uses Located in Surrounding Areas
<ul style="list-style-type: none"> <li>Existing Hospitals and expansions</li> <li>Medical Office Buildings</li> <li>Specialty Clinics</li> <li>Research and Development</li> <li>University/Educational Facilities</li> </ul>	<ul style="list-style-type: none"> <li>Retail / Village Center</li> <li>General Office</li> <li>Hotel and conference space</li> <li>Plazas, pathways, parks, and other public spaces</li> </ul>	<ul style="list-style-type: none"> <li>Senior Housing               <ul style="list-style-type: none"> <li>Independent Living</li> <li>Assisted Living</li> <li>Skilled Nursing Facility</li> </ul> </li> <li>Single-Family Detached and Attached Housing</li> <li>Neighborhood retail</li> </ul>

Figure 19. Medical and Supporting Uses

Source: Leland Consulting Group

Land Use	Gross Area	ROW/ Open Space	Not Available for Development	Net Available for Development
<b>Vacant/Buildable</b>				
West Side	87	10%	9	78
East Side	580	35%	203	377
Subtotal	667			455
<b>Medical Uses: Existing and Planned</b>				
The Med	26	NA	21	5
Scott & White	99	NA	50	49
Subtotal	125			54
<b>Constrained/Public Uses</b>	243	NA	NA	-
<b>Redevelopment</b>	25			25
<b>Total</b>	<b>1,035</b>			<b>534</b>

Table 3. Gross and Net Developable Areas (based on initial study area)

Source: Leland Consulting Group

As **Table 3** shows, there are approximately 534 net developable acres within the initial study area that can be reasonably expected to develop within the next decade or beyond. Because of the inherent uncertainty associated with large scale, long-term development (see the “Forecasting in the Fog” section) this area could build out in more or less time.

A number of considerations and inputs influence this land development analysis:

**East and West sides.** A considerable amount of land is currently vacant—most of it on the east side of SH 6. The east side of SH 6 is best suited for large-scale development, especially for residential communities; however, significant amounts of medical and supporting commercial uses will be clustered along Rock Prairie Road, particularly close to SH 6. The west side of SH 6 will also accommodate a mix of

uses; however, these are more likely to be “infill” opportunities. Because of their close proximity to The Med and other established uses, there is a more immediate opportunity to create an urban core or village center for the medical district on the west side.

**Right of Way.** The amount of land needed for right-of-way (ROW), open space and other public areas varies considerably, particularly in contrasting “developable pads” that are already surrounded by urban streets (west side) versus large parcels that still require a network of local streets to be built through them (east side). Thus, on the east side, a greater percentage of the total area must be deducted for ROW and public space.

**Expansion on The Med and Scott & White properties.** The Med and Scott & White hospitals have additional capacity to expand their services on their existing

properties—particularly Scott & White, whose primary property is approximately 99 acres. Some new development (to be planned and completed by the hospitals themselves) can take place here.

**Constrained/Public Uses.** Some properties are considered undevelopable (parkland) or are considered undevelopable pending further site-specific analysis (landfills).

**Redevelopment.** Some properties—particularly those that are not highly improved or that experience large increases in visibility or traffic due to the expansion of the medical district—are likely to redevelop.

### Development Program

**Table 4** shows the development program for the medical district at full build out, including land uses by area, density and development quantity. The time frame for this build out is generally 10 to 20 years, with the speed of absorption to be determined by a number of factors including the national and local economies, demographic patterns such as the immigration rate of seniors to College Station, timing of regulatory approvals, lending environment and other conditions.

### Medical and Healthcare Uses

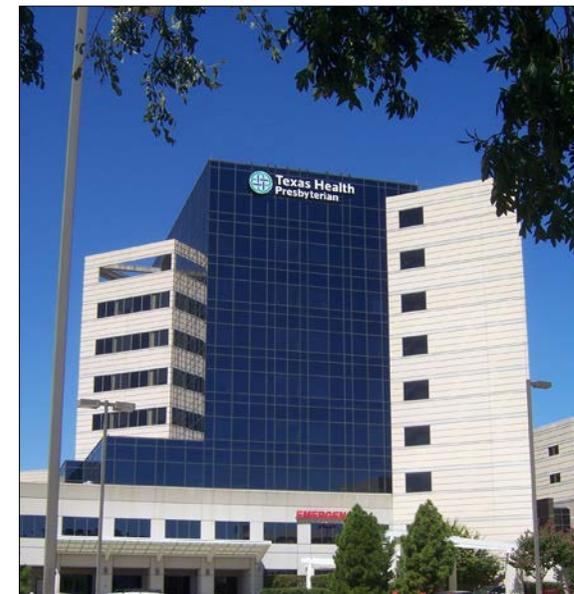
#### Hospitals

As shown in **Table 5** and **Figure 20** there is a significant undersupply of hospital facilities (measured in hospital beds and physicians) in the College Station MSA in the longer term.

While this undersupply is only modest from the perspectives of the short term of the College Station-Bryan MSA alone, it becomes quite significant when viewed from the perspective of the entire 50-mile market area and over the long term. (For the purposes

Land Use	Area (Net acres)	Density FAR or DU/acre	Development Quantity		Value Per SF	Total Development Value
			Building Area (SF )	Dwelling Units		
<b>Medical land uses</b>	<b>75</b>					
Hospital Expansions	10	0.35	150,000	-	\$500	\$75,000,000
New Hospitals	-	-	-	-	\$500	\$0
Medical Office Buildings	25	0.30	330,000	-	\$375	\$123,750,000
Specialty Clinics	25	0.30	330,000	-	\$375	\$123,750,000
Research and Development	10	0.30	130,000	-	\$300	\$39,000,000
Pharmacies, Medical Supplies	5	0.30	70,000	-	\$300	\$21,000,000
<b>Subtotal</b>	<b>75</b>		<b>940,000</b>	<b>-</b>		
<b>Commercial Development</b>	<b>67</b>					
Retail	25	0.30	330,000	-	\$145	\$47,850,000
Hotel	12	0.50	260,000	-	\$275	\$71,500,000
General Office	25	0.35	380,000	-	\$250	\$95,000,000
Mixed Use Village Center	5	1.00	220,000	-	\$250	\$55,000,000
Other	-	0.35	-	-		
<b>Subtotal</b>	<b>67</b>		<b>1,190,000</b>	<b>-</b>		
<b>Housing</b>	<b>260</b>					
Senior Housing						
Independent Living	95	10	950,000	950	\$150	\$142,500,000
Assisted Living	20	20	390,000	390	\$175	\$68,250,000
Skilled Nursing Facility	5	25	130,000	130	\$225	\$29,250,000
Senior Housing Subtotal	120	-	1,470,000	1,470		
General Housing						
Single Family Housing	110	6.5	715,000	715	\$135	\$96,525,000
Attached Housing	30	12	360,000	360	\$145	\$52,200,000
General Housing Subtotal	140	-	1,075,000	1,075		
<b>Housing Subtotal</b>	<b>260</b>		<b>2,545,000</b>	<b>2,545</b>		
<b>All Uses</b>	<b>402</b>					
<b>To Be Developed in Later Phases</b>	<b>133</b>		<b>TBD</b>	<b>TBD</b>		
<b>Total</b>	<b>534</b>		<b>4,675,000</b>	<b>2,545</b>		<b>\$1,040,575,000</b>

Table 4.  
Medical District  
Development  
Program  
Source: Leland  
Consulting  
Group. Some  
figures may not  
sum correctly due  
to rounding  
(based on initial  
study area)



standard measures of services needed, age of the population and presence of other medical demand-drivers, and other market characteristics.

Two frequently used metrics for forecasting hospital and medical facility demand are hospital beds and physicians per 10,000 residents of a given area. The current national average is 31 hospital beds and 27 physicians for each 10,000 residents. (Source: Kaiser Family Foundation, [www.globalhealthfacts.org/data/topic/map.aspx?ind=78](http://www.globalhealthfacts.org/data/topic/map.aspx?ind=78).) On average, the Texas healthcare industry has built somewhat fewer beds per 10,000 residents, but the standard varies significantly between healthcare-intensive cities and rural areas where healthcare services are less accessible. The Houston and San Antonio regions have approximately 45 beds per 10,000 residents and are known nationally and internationally for the reputation of their respective medical districts. Given the evolving characteristics of the College Station MSA and market area, an increase in medical services and concomitant bed-count can be viewed as both reasonable and responsible public policy.

of this report, the short term is considered to be the next five years, medium term from five to 10 years, and long term from 10 to 20 years.) This is both an important community issue for the area and a significant market opportunity.

As of 2013, there will be approximately 636 operating hospital beds within College Station and Bryan, including the Scott & White Hospital now under construction and an expansion underway at the Med. (Source: *The number of hospital beds projected is as follows: College Station Medical Center, 167; Scott & White, 143; St. Joseph, 310;*

*Physician Centre Hospital, 16.*) Presently, the existing hospital bed supply is operating at or near full capacity even as some residents look elsewhere for their medical needs, especially in specialty care. As the population continues to grow and age, this supply will become more obviously inadequate just as the supply of quality senior housing is becoming more obviously inadequate.

The need for future medical facilities can be assessed in several ways and should take into account several factors. The primary factors influencing a projection of medical services include population size, industry

As explained in **Chapter 3**, age is a major factor that has a very significant impact on the demand for medical care and hospital facilities. Senior citizens over the age of 65 require more than three times the number of physicians as those in the 25 to 44 age group. The percentage of senior citizens within the market area is anticipated to nearly double from 62,000 today to 120,000 in 2030. As the market area’s population ages in keeping with national trends, and there is no rational basis for supposing College Station can or will avoid these trends, demand for hospitals and healthcare services will grow significantly. College Station’s ratio of hospital beds has clearly been low historically and comparatively due to the large percentage of college-age residents. And while this will, of course, continue to be an important part of the region’s demographic character, hospital demand should move back into line with state and national averages in the coming decades.

The projections in **Table 5 and Figure 20** were developed based on the factors outlined above: the market area’s growing and aging population, and industry standards for required hospital facilities. The need for hospital facilities has been adjusted to account for the ages of populations served. This analysis shows a gap of almost 700 beds in 2015, and more than 1,000 beds by 2030. While significant new facilities will be needed throughout College Station and Bryan, and in the medical district specifically, much of the growth within the medical district should be able to take place on property already controlled by the Med and Scott & White.

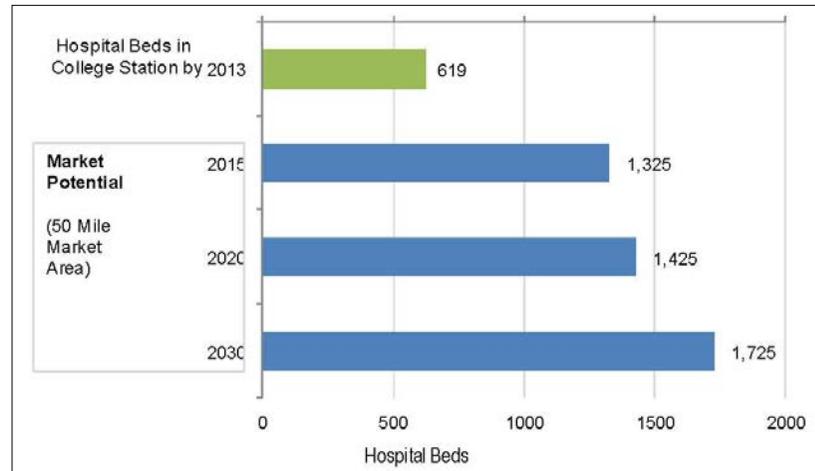


Figure 20. Elderly Living in the Community, by Type of Care

Source: Long Term Care in America, National Commission for Long Term Care, 1999; Leland Consulting Group

Pop by Age	Physicians needed per 10,000	College Station Bryan				50 Mile Market			
		% of Pop by Age	Total Population	Physicians Needed	Beds Needed	% of Pop by Age	Total Population	Physicians Needed	Beds Needed
<b>2010</b>			<b>208,258</b>	<b>562</b>	<b>650</b>		<b>517,342</b>	<b>1,050</b>	<b>1,200</b>
0-24	15	48%	99,964	154		40%	205,385	316	
25-44	20	25%	52,273	102		25%	128,818	252	
45-64	27	19%	38,736	105		24%	121,575	328	
65+	66	8%	17,494	47		12%	62,081	168	
<b>2015</b>			<b>221,258</b>	<b>597</b>	<b>675</b>		<b>558,934</b>	<b>1,150</b>	<b>1,325</b>
0-24	15	47%	104,434	161		39%	217,425	335	
25-44	20	25%	56,200	110		25%	139,175	273	
45-64	27	18%	40,269	109		23%	128,555	347	
65+	66	9%	20,134	54		13%	73,779	199	
<b>2020</b>			<b>233,546</b>	<b>631</b>	<b>725</b>		<b>604,507</b>	<b>1,250</b>	<b>1,425</b>
0-24	15	48%	112,102	173		40%	241,803	372	
25-44	20	24%	56,051	110		24%	145,082	284	
45-64	27	18%	42,038	114		23%	139,037	375	
65+	66	10%	23,355	63		14%	84,631	229	
<b>2030</b>			<b>296,055</b>	<b>799</b>	<b>925</b>		<b>707,105</b>	<b>1,500</b>	<b>1,725</b>
0-24	15	45%	133,225	205		37%	261,629	403	
25-44	20	24%	71,053	139		24%	169,705	333	
45-64	27	18%	53,290	144		23%	162,634	439	
65+	66	13%	38,487	104		17%	120,208	325	

Table 5. Senior Housing Demand in the Market Area and Medical District

Source: Department of Health and Human Services, US Census, Leland Consulting Group



### **Medical Office Building**

Medical office buildings (MOBs) typically include routine and preventative care facilities such as physician’s offices, dentists, ophthalmologists and various other providers. MOBs have many of the same locational requirements as typical office buildings such as easy access for clients; proximity to support services such as food, hotels, labs and medical suppliers; ample parking; and access to intra- and inter-regional transportation connections such as freeways, high capacity transit and airports. However, MOBs usually require a higher degree of technology and services, such as advanced computer systems, greater number of plumbing fixtures, and a higher standard of air quality and purification than typical office buildings.

### **Specialty Healthcare**

Specialty healthcare includes specialists in cardiology, oncology, OBGYN, mental health and other fields that cannot be completely addressed within a single general-care hospital. These specialty services can be offered in multi-tenant or single-tenant clinics, or on a contract basis within the existing hospitals. In addition, medical hardware suppliers and other support facilities are likely to locate in the medical district in the future.

### **Research and Development**

Research and Development (R&D) facilities can be comparable to office buildings, flexible warehouses, or industrial properties depending upon the type of research being conducted. Often they need both types of facilities: an office in which to develop and market concepts and a lab or production room to conduct experiments and fabricate prototypes. Like MOBs they require a greater level of technology and often have higher energy and water consumption. They also require a greater level of security, as products may be in a highly secretive phase of development. R&D facilities benefit from proximity to universities and large research hospitals for prospective employees as ideas spin off from research conducted at these institutions.



### Retail / Village Center

A village center with a strong retail component could thrive within the medical district. Retail provides activity and amenities to the residents, employees and visitors of the medical district. Retail is the “theater” that will entertain visitors and create a sense of place, making the medical district more desirable for residents, visitors and employees of the area.

#### Requirements for Success:

- Visibility. Thousands of customers must pass and see the site on a daily basis. Daily traffic volumes of approximately 20,000 are desirable for most national retailers. SH 6 running through the medical district has daily traffic counts of 60,000 at the intersection of Rock Prairie Road.
- Accessibility. Must be very easy to get to; daily-shopping or convenience retail should be on the “way home” (right) side of the street.
- Central location vis-a-vis target markets. For example, grocery anchored centers should be within approximately one mile of 10,000 residents.

- Manageable competitive environment. Most retailers will avoid an area if competitors are already located there.
- Demographic match. Retailers choose sites located near their “target market” customers.
- Anchor tenants. Retail developments are often “anchored” by one tenant (for example, a high-profile department store) who then attracts other tenants.
- Sense of place, safety, cleanliness.
- Contiguity. Urban retail must be continuous, or many shoppers will stop and turn back.
- Parking capacity.



### Hotel

Experience from other medical corridors shows that additional hotels and conference space will be needed in this medical district to accommodate visiting families, patients, and doctors.

#### Requirements for Success:

- Visitor amenities and attractions.
- Easy access to major thoroughfares.
- Co-location with other hotels.
- Visibility.
- Parking capacity.



### Office

Office uses would be an excellent addition to the medical district as they would provide daytime activity to the area and are compatible with the other uses being proposed for the area.

#### Requirements for Success:

- Easy access to and from clients.
- Accessibility to workforce and executive residences; offices tend to be sited near the center of metro regions or at major transportation hubs.
- “Address status.”
- Proximity to suppliers and collaborator firms.
- Parking capacity.
- Proximity to support services: banking, food, hotels and other services.
- Access to intra- and inter-regional transportation connections such as freeways, high capacity transit and airports.

### Supporting Uses: Senior Housing

Stakeholder interviews and research indicate strong recognition of the need for more senior housing and Long Term Care (LTC) facilities in College Station. Given the significant increases in the College Station over-65 age group over the next 20 years, and the likelihood of significant influx of retirees, the consultant team has estimated the level of senior housing demand. In the decade between 2010 and 2020, the number of residents of the City of College Station who are over the age of 65 is expected to increase by approximately 5,000, from 17,500 to 23,400. In the 50-mile market area, this demographic group is expected to increase by approximately 22,000, from 62,000 to 84,600. See **Table 2 in Chapter 3 – Healthcare Trends and Regional Demographics** for details.

The facilities listed below show the typical range of senior housing, all of which are appropriate in

varying quantities for the medical district. In addition to the categories shown below, continuing care facilities offer the full range of these senior housing types within a single large development. This allows residents to “age in place” and move easily from one housing type to another as their medical needs or preferences change. Continuing care facilities typically require a long-term contract from residents with an initial down payment, whereas the stand-alone facilities are often contracted on a monthly basis. Senior housing differs from other housing types in that it is not only a real estate investment, but also involves a hospitality and health care component that must be considered when operating the facility.

The following sections evaluate the amount of senior housing likely to be in demand within the medical district. Demand for senior housing will come from two primary sources: latent demand and the net new senior population moving to the area.

### Latent Demand

Interviews with College Station residents and those in the healthcare industry strongly indicate that while there are thousands of senior residents of the city and surrounding areas, there is very little senior housing within the City itself. Many seniors reported having to move out of the City in order to find a senior community that met their expectations. Thus, there is expected to be latent demand for senior housing in the market. Up to 420 units of senior housing could be quickly absorbed within the medical district if facilities were provided for a mere five percent of the over-65 population found in College Station-Bryan MSA in 2010, as shown in **Table 3**. This is a conservative estimate that does not take into account any seniors currently living outside of the area who would like to relocate, but have been unable to find a suitable location. With an aggressive marketing campaign the initial absorption could be even higher.



#### Independent Living

*Multi-unit complex marketed to seniors. Rent premium of approximately 10 percent (above other equivalent multifamily units) for communal dining, housekeeping and transportation services.*

*Source: [www.asla.org\\_2010awards\\_564.html](http://www.asla.org_2010awards_564.html) photo by Susan Rudiek  
Loopnet real estate brokerage service, Leland Consulting Group*



#### Assisted Living

*Support services include laundry, food service, arranged activities, limited medical oversight and assistance to those with physical impediments such as blindness or decreased mobility.*

*Source: [www.lakewayjoseyranch.com](http://www.lakewayjoseyranch.com)  
Loopnet real estate brokerage service, Leland Consulting Group*



#### Skilled Nursing

*Facilities designed to provide 24-hour care and intensive medical attention. Staff assists residents with daily tasks such as bathing, dressing and other needs.*

*Source: [www.mirabellaassistedliving.com](http://www.mirabellaassistedliving.com)  
Loopnet real estate brokerage service, Leland Consulting Group*

Demand Factor	Total or Capture Rate	Senior Housing by Type			
		Unaffiliated Private Residence	Independent Living	Assisted Living	Skilled Nursing Facility
Percent of total senior hsg. demand	100%	28%	47%	19%	6%
<b>Latent Demand</b>					
65+ households, 2010	11,214	3,100	5,300	2,100	700
Medical district capture rate	5%				
Latent demand (households)	420	160	270	110	40
<b>Demand from Net New Senior Population</b>					
Net new 65+ households, 50 Mile Radius, 2010-2020	14,495	4,100	6,800	2,800	900
Medical District Capture Rate	10%				
Subtotal	1,050	410	680	280	90
<b>Total</b>	<b>1,470</b>	<b>570</b>	<b>950</b>	<b>390</b>	<b>130</b>

Table 6: Senior Housing Demand in the Market Area and Medical District  
Source: Department of Health and Human Services, US Census, Leland Consulting Group

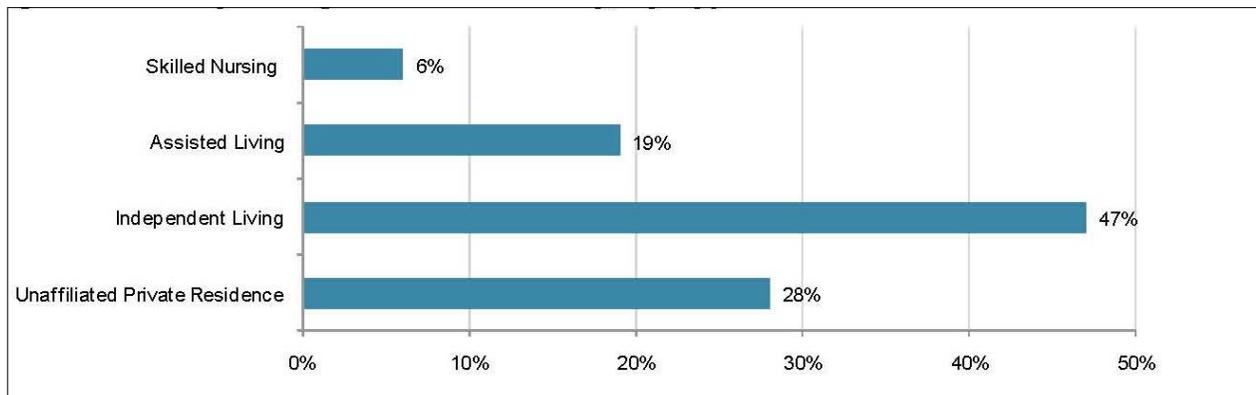


Figure 21: Elderly Living in the Community, by Type of Care  
Source: Long Term Care in America, National Commission for Long Term Care, 1999; Leland Consulting Group

### Net New Senior Housing Growth

Besides the latent demand to meet the need of seniors already living in the community, there will be a continued need to supply senior housing facilities to those who will be turning 65 over the coming decade. The primary market area, or the 50-mile radius, is projected to increase from 62,000 people over age 65 in 2010 to a little over 84,000 by 2020. This is an increase of 22,000 people who will need varying levels of specialized care. As shown in **Figure 21**, nearly 47 percent of seniors live in some type of independent living facility. If the medical district were to capture 10 percent of these new households, there would be a need for 680 independent living units by 2020, as shown in **Table 6**. This can be further broken down by number of units projected for the medical district by other facility types. Given the medical district's unique position in the region, this significant capture rate is reasonable.

While it is true that LTC facilities and assisted living facilities may be located anywhere in the primary market area, those facilities located closer to the community hospitals are more attractive to the senior population for obvious reasons. Planning for the medical district should take into account adequate land reservation for senior housing proximate to or in the medical district. According to the National Commission for Long Term Care, 28 percent of seniors prefer to remain in their homes or to live with family members rather than move to a senior housing facility. Seniors with a preference for living in unaffiliated private residences will most likely not be captured in the medical district and are not included in the senior housing demand projection.

**Supporting Uses: Single-Family and Multifamily Housing**

As previously stated, the housing market in College Station and other locales in the state has changed significantly over the past several years. In contrast to the middle of the last decade, the best selling houses in College Station are smaller (1,500 to 1,800 square feet) and considerably less expensive (\$150,000 to \$300,000 maximum). Some houses priced in the \$400,000 range have been sitting on the market for more than two years. The core of the short-term housing market is seen as those seeking affordable homes and downsizing retirees who have moved out of large homes and are now looking for comparatively smaller and lower-maintenance homes, including “cluster” or “cottage” communities. Both trends are well suited for the medical district.

**Requirements for Success**

- Critical mass: adjacent residential neighborhoods and urban amenities (schools, parks, retail, and services).
- Safety.
- Large share of one and two person households within market area.
- Easy access to employment centers.



*Single-Family Housing  
5 to 10 du/acre, 1 to 2 stories  
Surface parking  
Source: Istockphoto.com*



*Mixed Use Mid-Rise  
40 to 60 du/acre, 4 to 6 stories  
Structured parking  
Source:Leland Consulting Group*



*Wood Frame Condos or Apartments  
20 to 35 du/acre, 2 to 3 stories  
Surface, garage or tuck under parking  
Source:Leland Consulting Group*

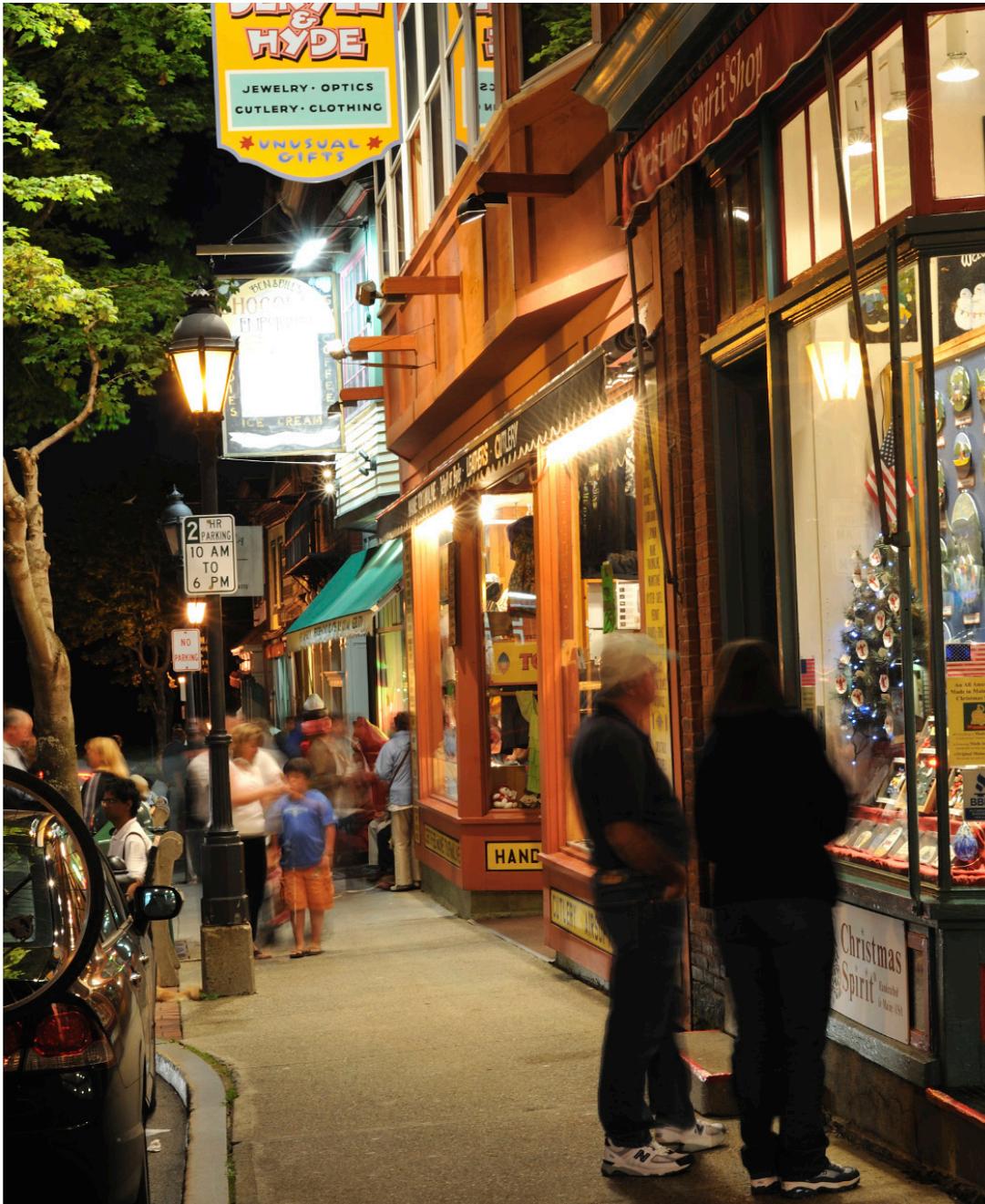


*Town Houses or Row Houses  
15 to 25 du/acre, 2 to 3 stories  
Surface parking or parking within each unit  
Source:Leland Consulting Group*



*Cluster or Cottage Housing  
10 to 25 du/acres, 1 to 2 stories  
Surface parking  
Source:Leland Consulting Group*

## 5 - Guiding Principles for Development



### **Guiding Principles**

The plan for the medical district is based on a series of critical guiding principles. These principles shape the plan, and provide a solid foundation on which to base planning decisions. They act as a compass to guide new projects and policies, as well as a measure against which to evaluate the appropriateness of future development proposals and designs. They are intended to provide decision-makers with common direction; facilitate understanding of the plan and inspire and nurture basic planning attitudes that will enable future community leaders, staff, developers and consultants to bring the vision of the medical district plan to fruition.

### **Create a Distinctive Destination**

The City benefits from distinct districts and neighborhoods that provide citizens and visitors with diversity, variety and choice. The medical district provides an opportunity to establish a special and unique community within the City, the region and the state. It can become an identifiable magnet for medical facilities, distinguished professionals, health and wellness services and activities. These activities will be heightened by a living, working, shopping, dining and recreational environment.

### **Create a Mixed-Use District**

The medical district should include a mixture of medical, wellness, and recreational activities and facilities, as well as retail, personal service, residential and office land uses. This will provide a “life-style” environment with activity during days, evenings and weekends that help energize and animate the district.

Retail space should be focused on the village centers and include windows and entries directly from the sidewalk. These spaces can be populated with stores, restaurants and “third places” such as coffee shops, Internet cafes and bookstores that will provide an engaging community meeting place and pedestrian environment.

A diversity of housing types should also be encouraged in order to fill a variety of needs and markets:

- Lofts.
- Live-work units.
- Townhomes.
- Single-family lot homes.

### **Integrate “Health–Consciousness” into all Development**

Provide many ways to access and circulate within the medical district, with an emphasis on shaded and convenient pedestrian and bike connections, which encourage exercise and a healthy life style.

- Trails should connect to parks, open space and other areas of the district. Certain areas should include exercise stations.
- Provide shade for walking, parking and other hard surfaces in order to lower ambient temperature and make outdoor activity more comfortable.
- Employ LEED and “green building” techniques to reduce energy consumption and improve air quality.
- Utilize storm-water management techniques that create amenities and assist in recharging ground water.
- Provide transit, such as a local trolley or shuttle that would connect medical facilities with professional offices and retail/restaurant areas to minimize the need for driving and to facilitate handicapped access.

### **Design Complete Streets**

Complete streets are those that comfortably accommodate multiple users, such as transit, cars, pedestrians and bicycles, and are designed to function as both vehicular ways and civic space.

When local streets are designed for traffic to move between 20 and 25 mph, all users can share the street. Drivers move slowly enough to watch for pedestrians and see signs and signals. Pedestrians feel safe crossing the roadway; and cyclists can blend in with vehicular movement. Medical district patrons could happily “park once” and enjoy walking to multiple destinations. Other street improvements that help achieve this goal include:

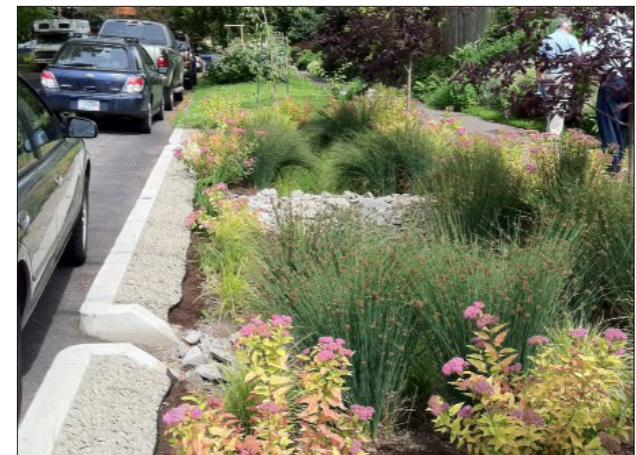
- Bulb-outs at pedestrian crossings.
- Minimal turn radii at corners.
- Special paving at pedestrian crosswalks.
- On-street parking and street trees.
- Street furniture, such as pedestrian level lighting, seating and trash bins.
- Pedestrian-oriented signage.



*UT Arlington - Campus Green Park*



*Portland Rain Garden, Photo by Hayden Consultants*



### Design Engaging Street Walls

New and redeveloped buildings in the medical district should generally be placed at the sidewalk to give streets and blocks a comfortable “outdoor room” feeling. Continuity of windows and doors should create a permeable relationship between the buildings and the sidewalk, creating a flow between inside and outside. A consistent “visual texture” for the street wall, created by complementary arrangements of floor lines, window and doors openings, and other features, is more important to a cohesive image than a consistent architectural period or style.

### Design Parking to Support Urban Design Goals

Parking should be maximized on non-arterial streets to provide easy customer access to businesses and to aid in traffic calming. Additional parking should be placed in the center of blocks and lined with buildings.

### Build Upon Authenticity

Respect and build upon historic and cultural precedents and traditions in site design and architecture. Solid, enduring materials should be used. Buildings should be articulated in a way that establishes a rhythm of bays, and windows should be “punched” and have shadow lines rather than be flush with the building wall surface. Recruit locally owned businesses when possible.

### Design for Visual Richness

Great streets have “a thousand points of detail,” including diverse and detailed architectural facades, engaging signage, attractive furnishings, colorful plantings, sidewalk commerce and public art. The City’s regulatory framework should be flexible enough to allow the unfolding of a diverse and stimulus-rich environment over time.



### Design for Sustainability

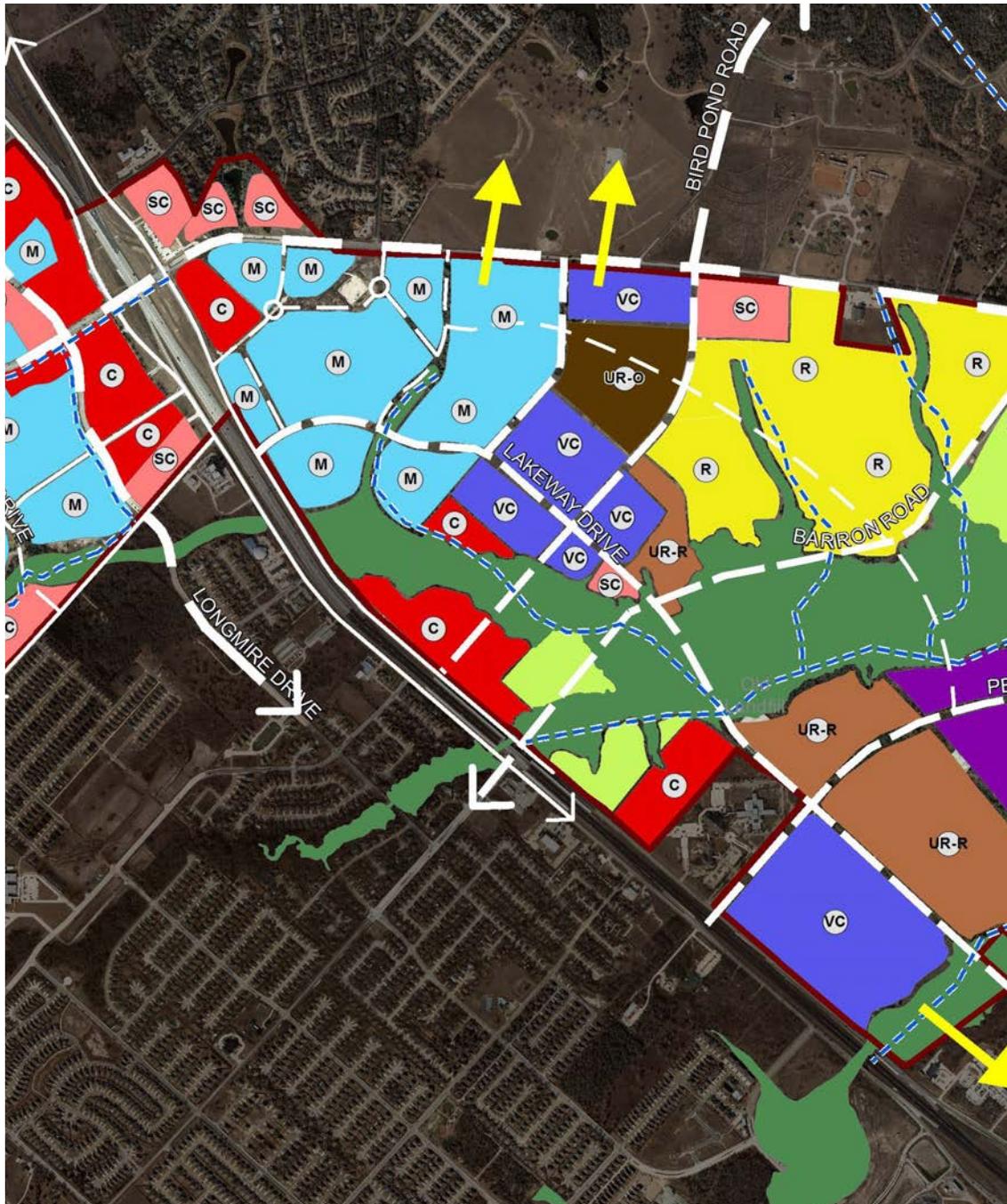
New projects should reflect best practices for “green” urban design strategies and building techniques, “light imprint” site design and cleaner transportation. Design for new buildings and the public realm must respond to local climate extremes, especially in the provision of shade to enhance walkability and reduce ambient temperature.

### Capitalize on Value Creation

There are proven techniques to capture value in developments. These should be utilized throughout in order to ensure ongoing reinvestment in the district.

- Proximity and access to public open space, including buildings that directly face the public amenity.
- Easy and convenient access (walking, biking, transit and auto) to retail, restaurant and recreational uses.

## 6 - Transportation Network & Land Use Plan



### Good Bones for Development

The layout of roadways, open space and trails is a direct outgrowth of the development framework concept suggested by the Site Analysis. It builds on the existing street network and planned thoroughfares, while taking advantage of the site's physiography with sensitive road layout and an interconnected greenway network that respects natural drainage patterns while yielding generous upland development zones. Creating "good bones" for development through the establishment of this infrastructure is the single most important way to facilitate orderly growth for the future. It provides an armature for development to occur, and ensures the continuity of circulation and access to all properties and the district as a whole. Such a layout also, by virtue of accessibility and location, helps determine the most effective and appropriate land uses.

The street network includes realigned City Thoroughfare Plan streets, with additional local and collector streets, and a tighter urban grid of streets for the core of a pedestrian oriented village center east of SH 6.

This particular road and trail network will accommodate three or more medical facility centers, walkable village centers, medical offices and a variety of residential unit types. It also places all development within about a quarter mile of parks, open space and trails. This has a demonstrated impact on creating a sense of "neighborhood" and positive property value.

### Highway Access

Access from SH 6 to all areas of the district can be achieved either by exiting at Rock Prairie Road, Barron Road, or William D. Fitch Parkway. Each has a separate exit from the highway. Rock Prairie would be the most direct route to the major

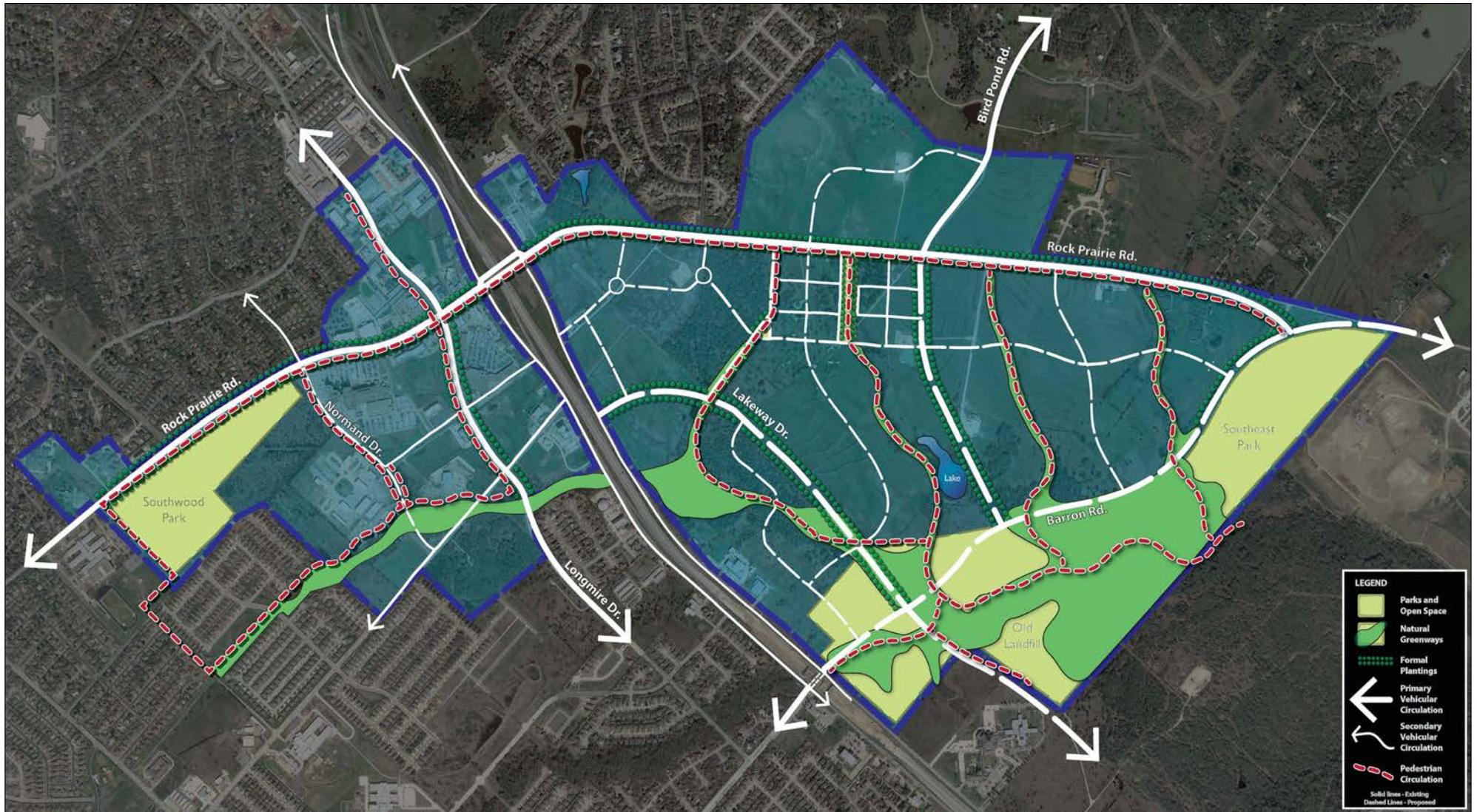


Figure 22A - Initial Primary Transportation Network

medical facilities and retail both west and east of SH 6. Barron Road provides a lower-keyed alternative access to these services, as well as a primary access to new residential areas and major parks. William D. Fitch Parkway provides access to Pebble Creek Parkway and Rock Prairie Road. Well-placed wayfinding signage will be necessary to alert drivers of the district well in advance of the exits.

### Streets and Their Design

Design for streets within the medical district should reflect the overarching concept of a healthy community focused on wellness. This is done primarily by designing streets to accommodate and balance the mobility needs of vehicles (including transit), cyclists and pedestrians concurrently, thereby offering real choices for mobility by the employees, patrons and residents of the district.

The health-conscious design of the street cross-sections, as well as a robust landscape design of canopy street trees planted no more than 25 feet on center, colorful plantings in medians, special paving for key sidewalks, and signage that reflects a district-wide “brand,” will provide an overall design structure to help unify the entire district.

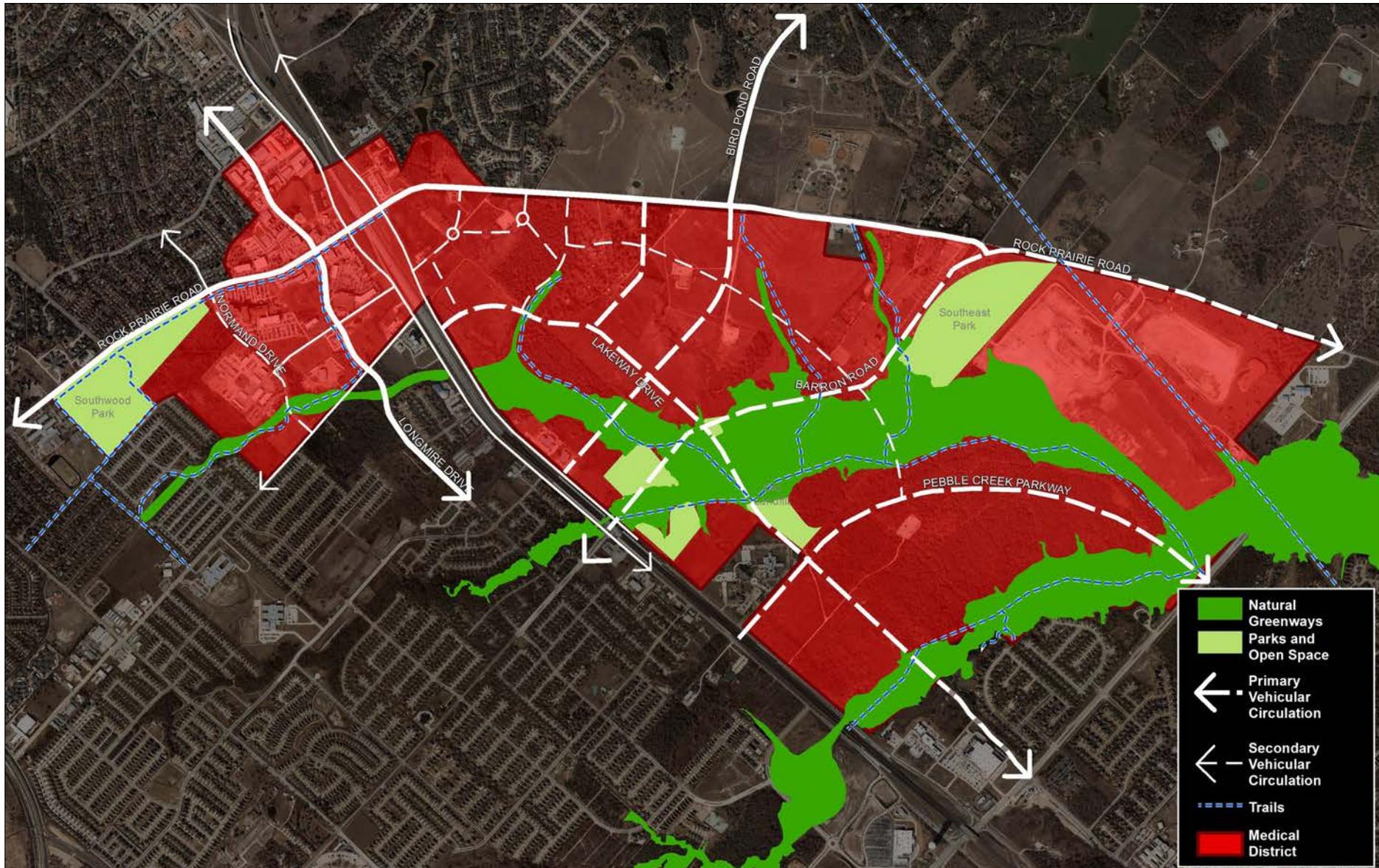


Figure 22B - Final Primary Transportation Network

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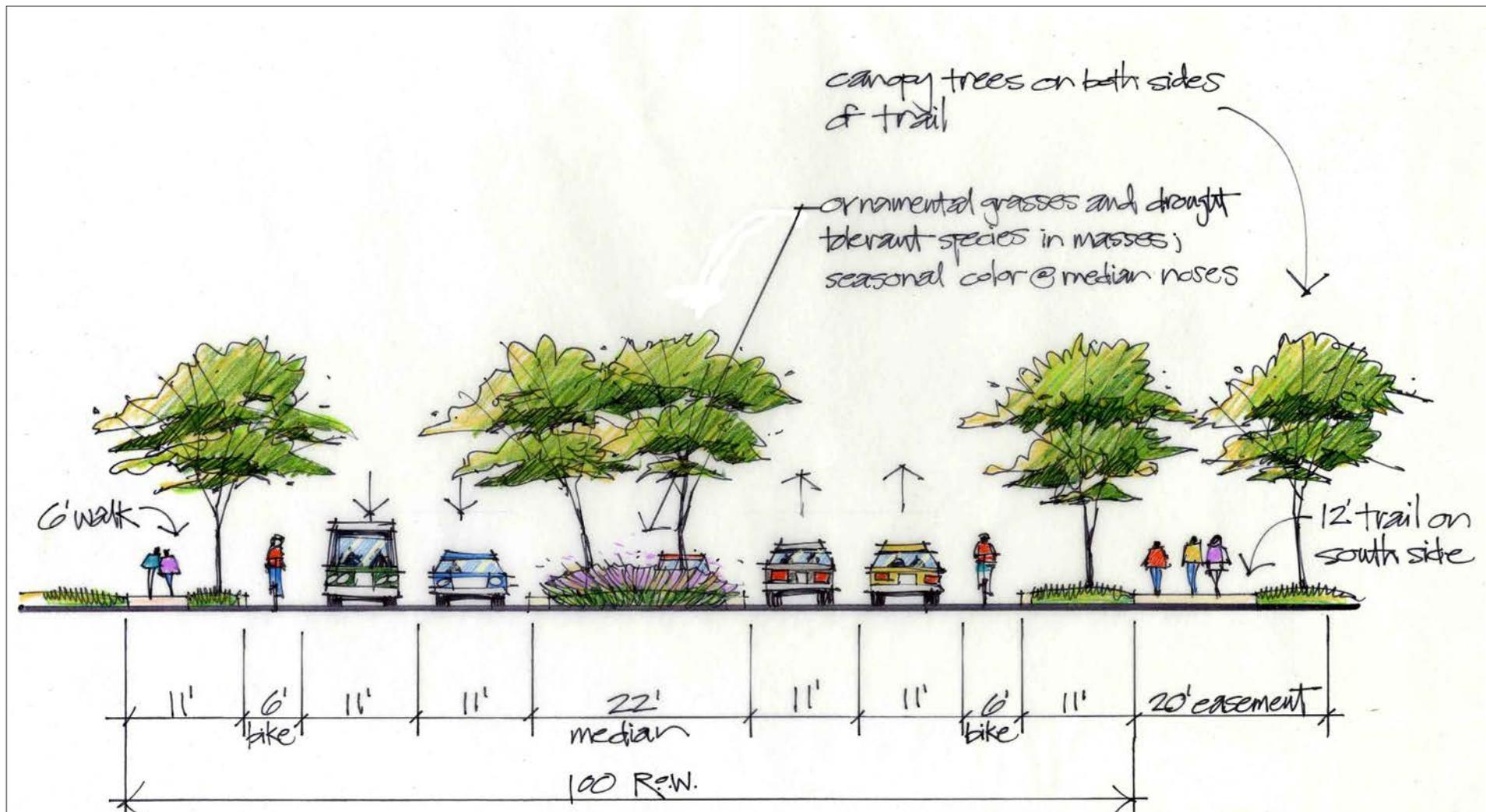


Figure 23 - Rock Prairie Road Schematic

### Rock Prairie Road

Rock Prairie Road is the central corridor connecting the major medical facilities, retail, restaurants, recreation and neighborhoods within the district. It is envisioned as the district's "grand boulevard," linking the entire district from west to east with canopy street trees that will create much-needed shade and a stately ambience. It is recommended that vehicle travel lanes be no more than 10'-6" to 11-feet wide. This efficient lane width, in concert with the planted median and street trees planted in the parkway between the curb and sidewalk, will increase roadway capacity and help calm traffic speeds, contributing to the perception of the district as a high quality, pedestrian-friendly district. A major trail in a 20 foot-wide easement is proposed along the south edge of the right-of-way, running the entire length of the district. It will provide safe and efficient pedestrian access to the range of uses and services along Rock Prairie Road, and will be the central spine of the district-wide network of sidewalks and greenway trails.

Rock Prairie Road is also a prime candidate to accommodate a local transit system that would be of great benefit to visitors and residents, especially seniors. In fact,

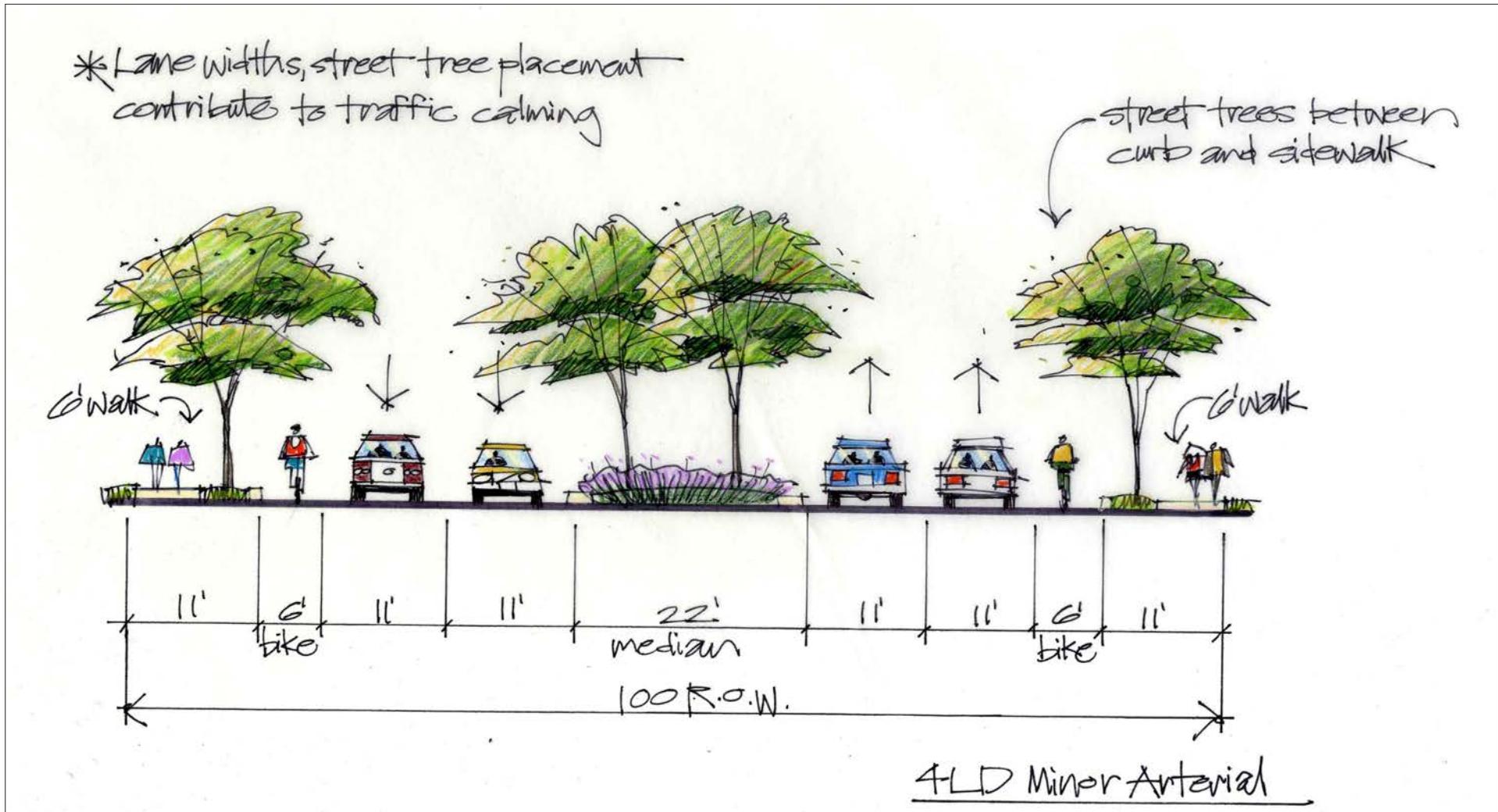


Figure 24 - Four Lane Minor Arterial Schematic

### Secondary Thoroughfares

Key secondary thoroughfares, including Bird Pond Road, Lakeway Drive, Barron Road, Pebble Creek Parkway and Longmire Drive, will help distribute traffic evenly throughout the district. Their cross-sectional design is recommended to be identical to that proposed for Rock Prairie Road, but with 6-foot wide sidewalks on both sides of the street rather than the wide trail on one side. As with Rock Prairie Road, the parkways and wide median will allow for a landscape design of canopy street trees and drought-tolerant median plantings that will be a key element in visually unifying the entire district, while providing critical shade and cooler ambient temperatures for the roadways and sidewalks.

this district could be the first neighborhood in College Station where owning a car would be optional.

### Minor Collectors

Minor collectors will serve to distribute vehicles, cyclists and pedestrians to developed areas off the arterials. In keeping with the “healthy community” concept, they are envisioned as multi-modal streets with one-vehicle travel lane in each direction, supplemented with bicycle lanes and 6-foot-wide sidewalks. Canopy street trees planted between curb and sidewalk provide critical shade, help calm traffic speeds and contribute to the district’s design unity.

### Residential Streets

The cross-sectional design for interior residential streets is taken directly from City standards; it is a superior design that encourages slow traffic speeds appropriate in residential neighborhood settings. It accommodates parallel parking on both sides of the street, and requires that traffic slow down and allow oncoming vehicles to pass in a maneuver called “queuing.” As with the other street designs, canopy street trees are recommended to be planted between the curb and sidewalk.

### Village Center Streets

The street network for the village center east of SH 6 is comprised of short, walkable blocks. The recommended street cross-section accommodates two-way vehicular traffic, angled parking (preferred by seniors over parallel parking), and sidewalks wide enough for strolling pedestrians, sidewalk displays and alfresco dining. Street and parking concepts for the village center west of

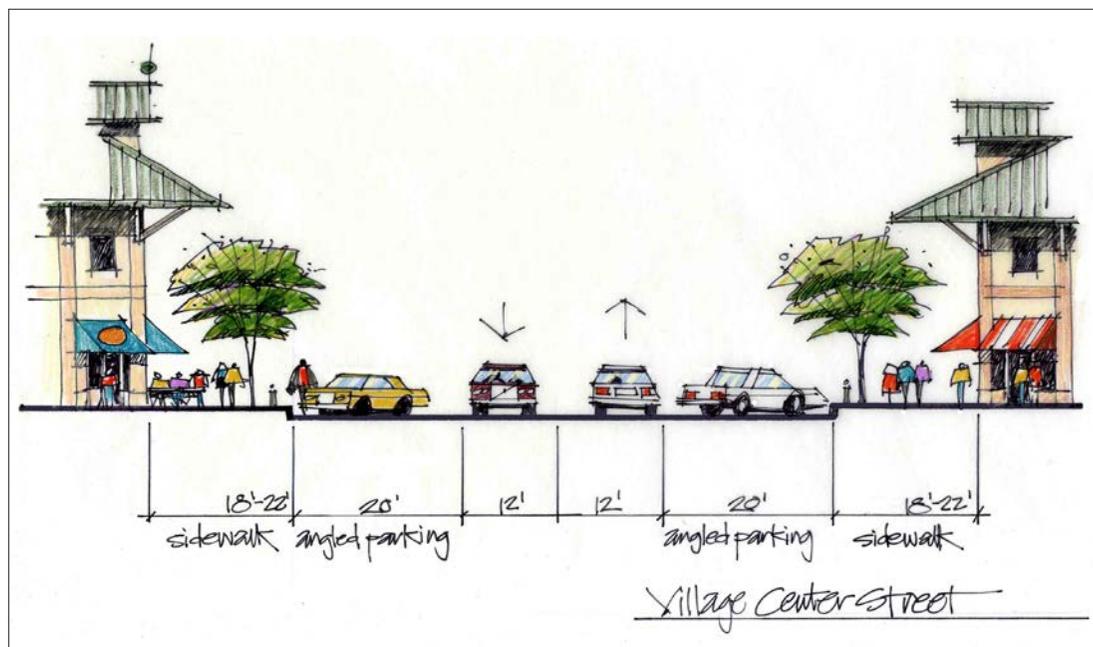


Figure 25 - Village Center Street Schematic

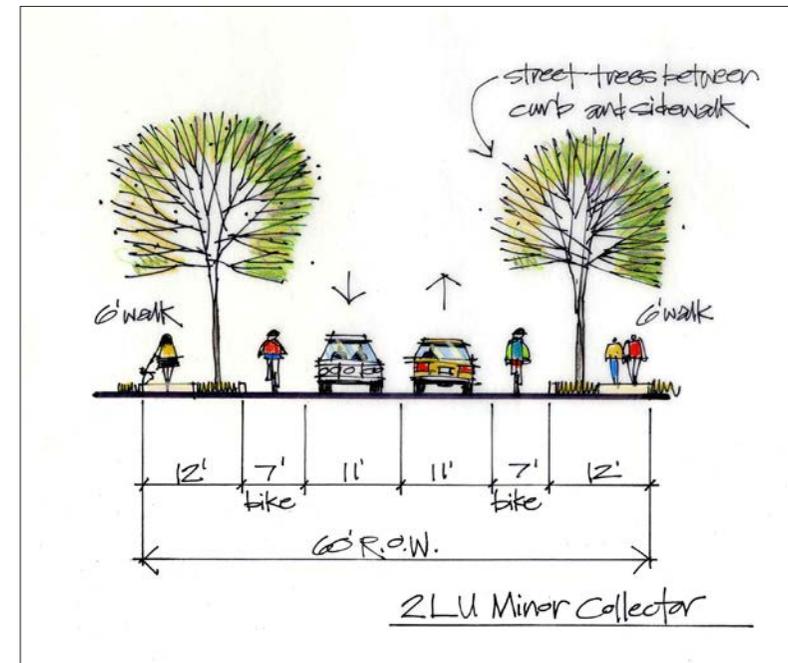


Figure 26 - Two-Lane Minor Collector Schematic

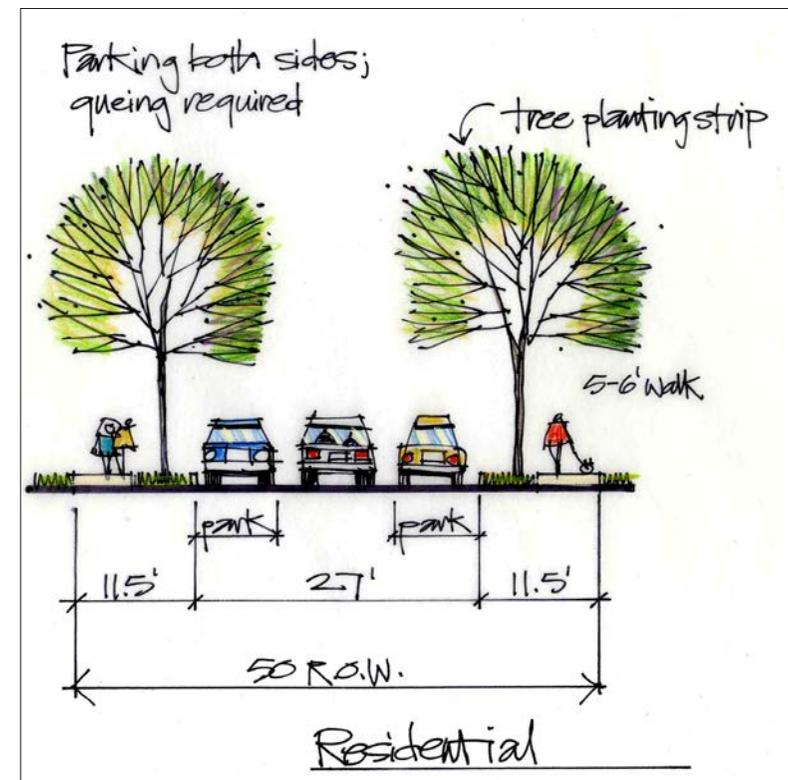


Figure 27 - Residential Street Schematic



Figure 28 - Potential Bridge Improvements

SH 6 shall be designed when the site is redeveloped.

### Bridge at Rock Prairie Road

The Rock Prairie Road bridge is currently being studied to determine appropriate improvements for the area's future traffic needs. Future planning for bridge improvements must recognize that this bridge will serve as the lynchpin that connects the west side and the east side of the growing medical district. As such, it must accommodate vehicular traffic volumes and movements efficiently while safely carrying pedestrians and bicycle traffic. Strategies for rethinking the bridge as a key landmark and unifying element for the district include incorporating wide (10 to 12 feet), shaded paths to accommodate pedestrians and bicycles; the use of vertical design elements and bold side-slope plantings to heighten its visibility as a district gateway; and the use of a unified color and materials scheme to tie the varied

design elements throughout the district together. Additionally, the name of the street and that of the district should be linked, so that the name appearing on the bridge (see illustration) highlights the district.

### Street Improvement Projects

Several street improvement projects are currently underway within the medical district that will create the framework for future quality development as mentioned above, and improve mobility within the district. These street improvement projects are discussed in more detail in **Chapter 2 – Site Analysis**.

### Trails and Open Space

The extensive linked network of trails and open spaces touching every quadrant of the district plan is another critical element in furthering the desirable and highly marketable concept of a healthy and green community, and provides a level of amenity vital to

attracting residents and top-level talent to the area.

The central spine of the network is the 12-foot-wide trail proposed for the south side of Rock Prairie Road, running the length of the district. The character of this path might vary throughout the district depending on context. In less developed areas, such as Southwest Park or the far eastern reaches of the district, the trail might be crushed granite aggregate. In higher traffic areas, a concrete path may be more desirable, while special paving featuring a bold striped pattern for human scale would add a higher level of design refinement in the mixed-use village centers and at transit stop plazas.

On the west side of SH 6, the existing sidewalk and trail system would be augmented to provide good pedestrian access and looped routes for exercise. On the east side of SH 6, 10-foot-wide trails joining

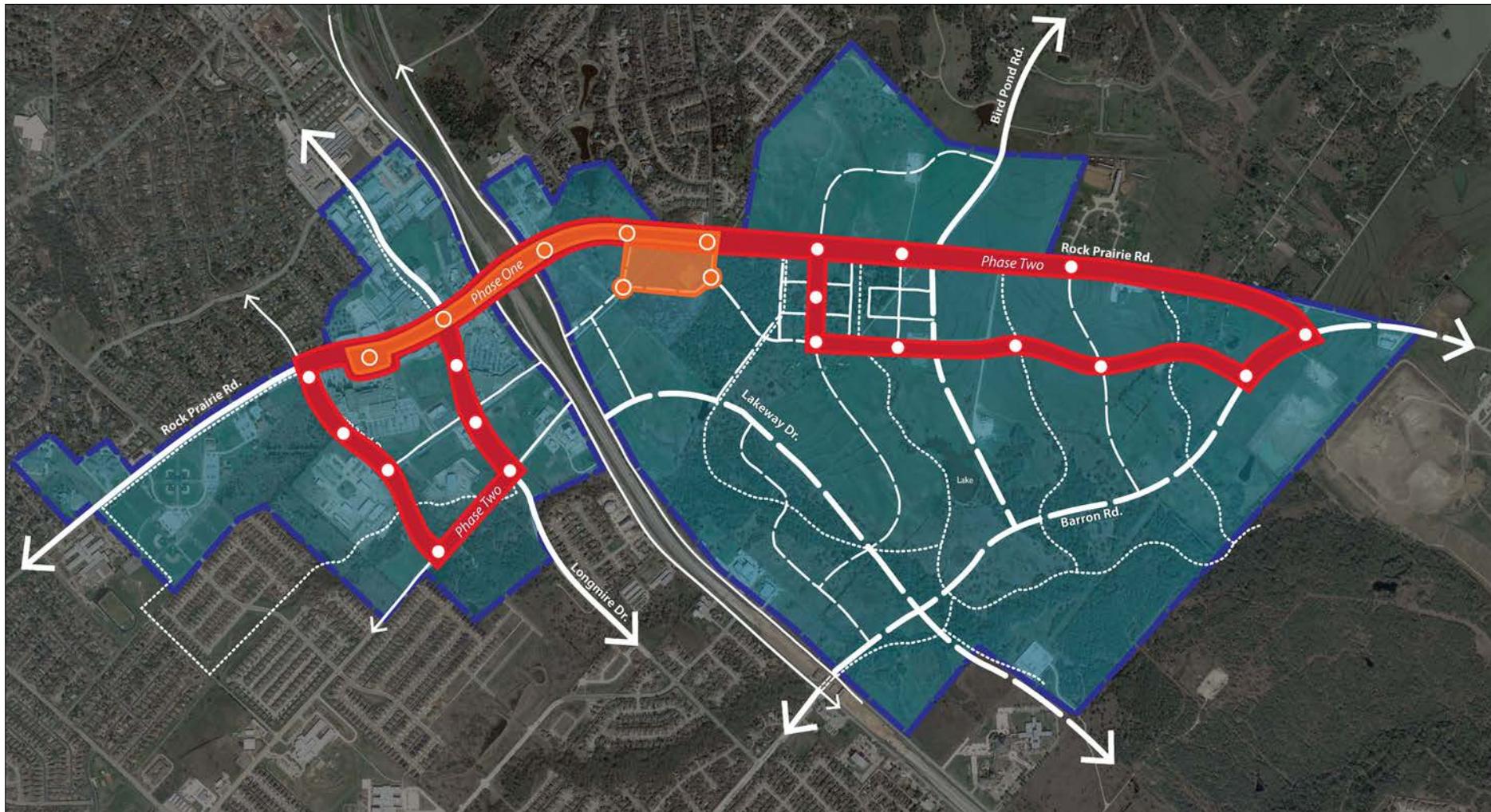


Figure 29 - Transit Loop

the path on Rock Prairie Road would follow natural drainageways and tributaries southward to Lick Creek, where they would tie into a proposed community-wide greenway system. Sidewalk networks from the village center, commercial areas, medical areas and residential neighborhoods would also tie into the greenway trails.

#### Transit

A looped transit system, such as a rubber-tired trolley in the short term, is proposed to add another level of

convenience and mobility to the district. A “Phase One” routing might link The Med, the Scott & White Hospital and important destinations in between. As the district grows, a “Phase Two” routing could expand the original service to create loops on the west and east sides that served the village center areas, all key medical facilities, commercial and residential areas.

## Land Use Plan

### Mixed-Use District and Neighborhood

The medical district will be a fully functioning mixed-use district and neighborhood with its emphasis on pedestrians, bicycles and cars. It will encourage a healthy lifestyle and place amenities within a short walk or bicycle ride, as well as within an easy transit trip. It will also be a place that will be suitable, and in fact very desirable, for people of all ages – young professionals, families with children, empty nesters and seniors. This type of neighborhood meets the demands of the highest growth demographic market over the next 40 years. It also happens to embody timeless principles of successful neighborhoods and could be joined to the ranks of North America’s “greatest places” to live, work and recreate.

A key feature of the land use plan is the establishment of two mixed-use village centers – both on the east side of SH 6. These village centers are in close proximity to major medical facilities and existing and future residential neighborhoods.

On the west side of SH 6, there is an existing retail shopping center that currently serves a similar purpose but is not very pedestrian-oriented. Over the long term – 20 to 30 years or so - this could redevelop into a more pedestrian-friendly form.

The village centers on the east side would be brand new with about 12 walkable blocks that could contain retail, restaurant and service use at street level with residential or office uses above. This would be a classic village center type of development. Higher density residential would be located adjacent and connected by streets and trails.

Both The Med and Scott & White Hospital will have room to expand over time, and benefit from the adjacency of parks, open space and trail connections.

Existing neighborhoods that are adjacent to the district will be buffered. West of SH 6, existing neighborhoods are separated by creek open spaces and a transition to commercial with urban-style residential use. East of SH 6 and north of Rock Prairie, low-density residential will buffer existing neighborhoods from higher density

development across Rock Prairie Road.

It is important to allow for all reasonable mixtures of uses in all areas except the core residential areas to encourage active use at all times and to minimize automobile trips.

### District Expansion

It is anticipated that the Medical District may grow over time as properties within and surrounding the District develop. Arrows on the Land Use Plan map indicates surrounding areas that are natural extensions of the District. Appropriate land uses for these areas will need to be determined at the time of inclusion into the District and should be based on the guiding principles in the Medical District Master Plan, existing surrounding uses, availability of infrastructure, and the marketability of the proposed land uses.

### Flexible Growth

The key to achieving the goal of flexibility in development is to establish the framework of roadways, trails and open space; and to establish “core” land use areas, such as:

- College Station Medical Center (The Med).
- Two Village Centers east of SH 6.
- Scott & White Hospital.
- Residential Areas.
- Possible Additional Specialized Medical Facility.

(Continued on page 68)

Growth can easily be phased outward from SH 6. This cluster is already established, and improvements are committed. **Phase 1** is well under way.

**Phase 2** could entail the creation of additional medical-related uses on the west

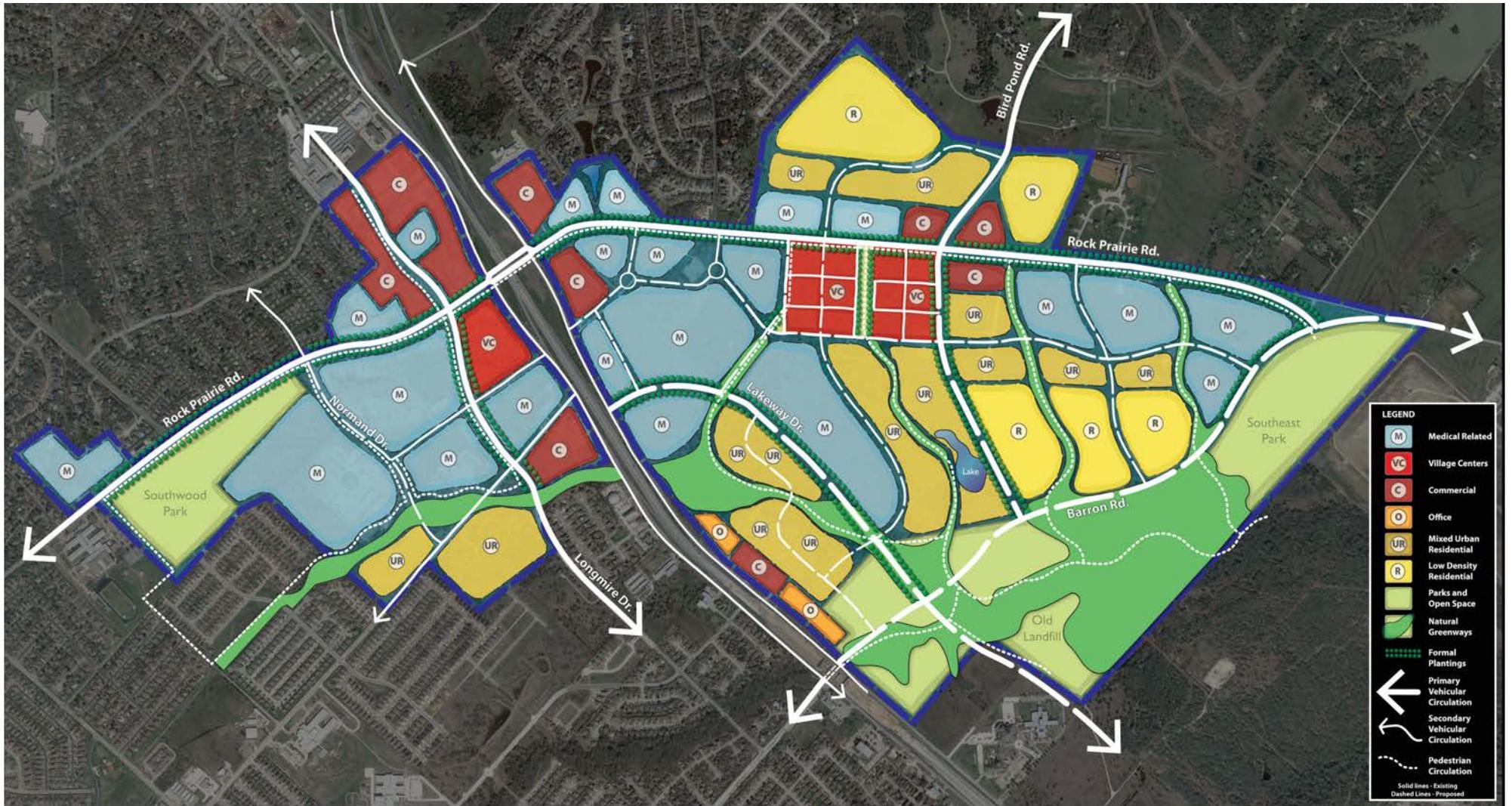


Figure 30A - Initial District Land Use Plan

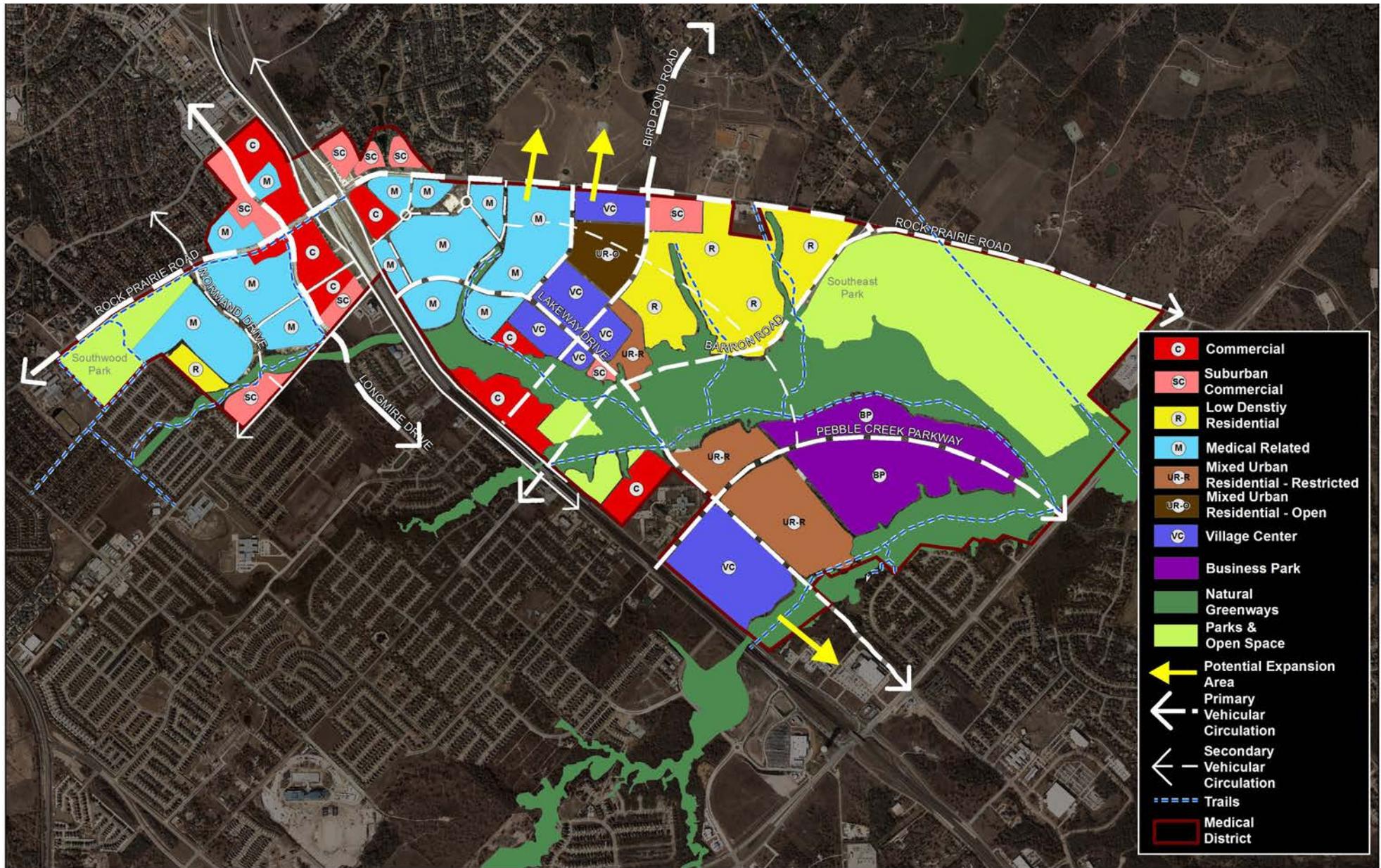
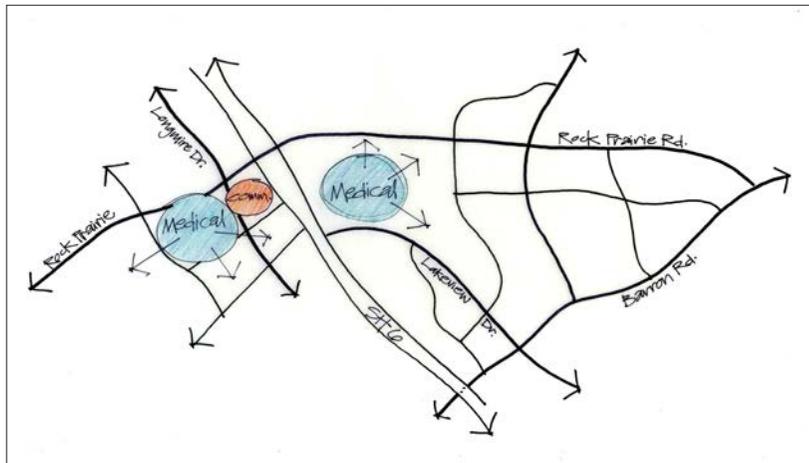
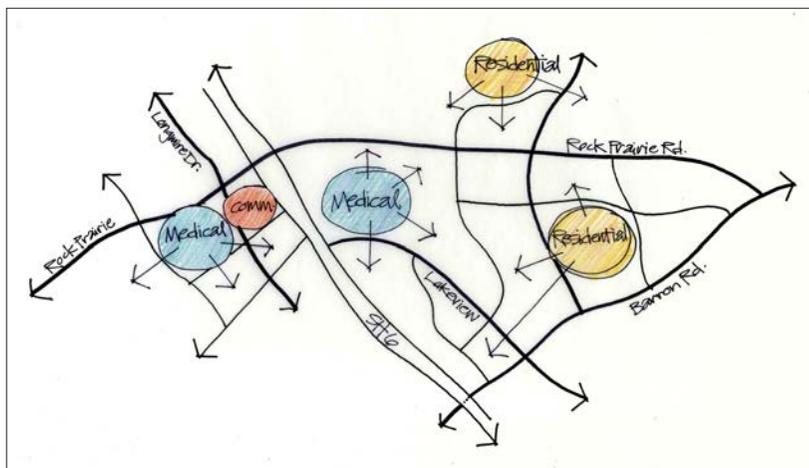


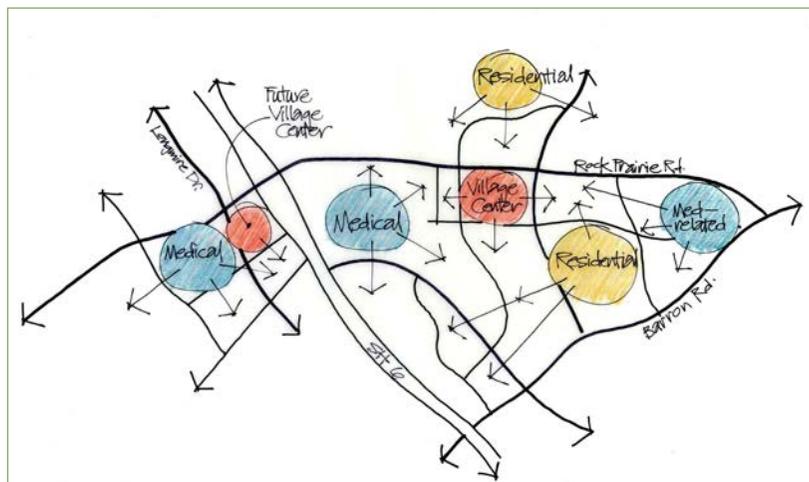
Figure 30B - Final District Land Use Plan



Phase 1



Phase 2



Phase 3

side of SH 6 along with a hotel. On the east side of SH 6 would be additional medical support uses and fairly low-density residential communities which, will begin to establish additional rooftops for future retail. These new neighborhoods will build upon College Station precedents, being linked by trails, open space and well-treed streets. They will serve as a new address and identity for the City, and will be attractive to medical professionals, retirees and families with children.

**Phase 3** would entail the construction of a new village center with retail, restaurants and higher density residential within easy walking distance. This will focus on attracting young professionals, as well as senior and assisted housing on both sides of SH 6. More medical-related uses can be accommodated. Eventually, an additional specialized medical facility could be added and the village center west of SH 6 could become more pedestrian and bike friendly.

It is very important to ensure a mixture of residential unit types and sizes throughout the medical district to provide housing for a person's full life cycle – families with children, young adults, young married couples, empty nesters, seniors, and those who are physically challenged. This will also serve as an important amenity in recruiting key medical staff.

Some of the residential areas should be age-restricted to avoid dominance of university students.

## Land Use Categories

The Land Use diagram indicates several land uses, some of them unique to this plan:



**Medical-Related:** A pedestrian-friendly area intended to provide a concentration of medical-related uses, including labs, professional offices, pharmacies and others that will provide a full range of support uses for medical activities.

Uses include: All Medical Services, Rehabilitation, Sports Medicine, Psychiatric, Laboratories, Pharmacies, Senior Housing, Assisted Living, Hotels and Education.



**Village Centers:** Intended to provide a mixture of retail and residential uses, possibly with supporting offices in a pedestrian and bicycle-friendly environment.

Uses include: Retail, Office, Urban Residential, Restaurants, Medical-Related (no major facilities) and Hotels.



**Commercial:** Intended to provide more professional office space and services, primarily targeted for sites along Rock Prairie Road and Longmire Drive.

Uses include: Professional Office, Retail, Personal Service, Medical Related, Hotels and other similar uses.

**Suburban Commercial:** Intended to provide low intensity professional office space and services, primarily targeted for sites along Rock Prairie Road and Longmire Drive.

Uses include: Professional Office, Retail, Personal Service, Medical Related and other similar uses.



**Urban Residential:** This is a neighborhood adjacent to medical-related facilities and the village center which is fairly high density and very pedestrian and bicycle-friendly. It should contain a variety of residential types and sizes.

Uses include: Townhome, Live-Work, Loft, Apartment, Independent Living, Assisted Living.



**Low-Density Residential:** This is an area of low-density single-family lots that will provide a buffer and transition to existing single-family neighborhoods north of Rock Prairie Road east of SH 6. It may also be used to provide a limited amount of low-density residential south of Rock Prairie adjacent to Barron Road in order to ensure a mixture of residential unit types.

Uses include: Minimum 5,000 square foot single-family lot (adjacent R-1 is also 5,000 square foot minimum), Cottages, Patio Homes (South of Rock Prairie only.)

# 7 - Identity Concepts



The medical district envisioned and planned in the previous pages has the potential to occupy a unique position among similar districts in the region and state. Identity design should underscore the unique qualities of the medical district that will differentiate it from other medical developments—most notably its community-wide focus on health and wellness—and how that focus is expressed in the range of services offered, the convenient and complementary mix of medical, commercial and residential uses, the emphasis on walkability, the extensive greenway and trail system, the high quality of site development, and the uplifting experience envisioned for employees, patrons, visitors and residents. College Station, which has a world-class research university and related employment base, loyal alumni, excellent school system, and proud citizens, makes this location for a medical district unique in the competitive marketplace for medical services, talent and residents.

This study is not charged with designing a comprehensive identity program for the new medical district. Rather, it offers examples and recommendations of how to differentiate the medical district and to enhance its visibility through strong identity design for key site elements, such as gateways, roadways and signage.

## **District name: Impressions and Applications**

A district name should evoke a mental picture or idea that recalls positive impressions or crystallizes key desirable attributes envisioned for the medical district. These might include ideas like:

Health	Natural
Wellness	Greenways
Fitness	Trails
Active	Village
Youthful	College Station
Vibrant	Traditions
Green	Live Oaks

These attributes and impressions can generate many ideas for district names that build on positive associations of the district concept, site and city. A short list for the sake of example might include:

- College Station Medical District.
- Live Oak Medical District.
- Greenway Medical District.
- Rock Prairie Medical District.

A versatile concept such as the alternatives above could be used in multiple ways to suggest the wide range of services, opportunities and experiences available in the district. Examples of ideas that could be tied to Rock Prairie Medical District, for example, would include:

- The Village at Rock Prairie.
- The Spa at Rock Prairie.
- The Shops at Rock Prairie.
- The Trails at Rock Prairie.
- The Rock Prairie Hilton.
- The Rock Prairie Trolley.

### Design Vocabulary

These ideas and attributes also begin to suggest a “design vocabulary,” a term used to describe a palette of shapes or forms, textures, colors, materials and details that work together to create a cohesive image or theme for the medical district. This design vocabulary for the medical district should include simple pure geometries, native stone and metal, water, native plants, earth tones, dark greens, tans and “Aggie” maroon. The following design vocabulary features are important to creating a cohesive and distinct identity for the medical district:

- The rhythmic repetition of site elements such as light poles, street trees, enhanced paving, etc. is used to instill a sense of order and unity throughout the medical district.
- Simple geometric forms with high contrast should be used in the intersection design. Overly ornate or complex patterns distract the pedestrian and vehicular traffic.
- Construction materials and street furnishings should be proven materials and elements that are timeless in their urban setting. These materials should be durable to withstand heavy traffic and use, such as brick, steel and enhanced concrete.
- Other key features to the identity of the medical district include:
  - Lighting – streetlights with a pedestrian scale.
  - Site Furnishings – benches, trash receptacles, bollards, tree grates, bike racks, traffic signals and signs.
  - Architectural elements – gateway monuments, landmarks and bridge enhancements.
  - Paving – enhanced intersections, crosswalks and curb extensions.
  - Landscaping – street trees, median trees, green spaces and ornamental plantings such as shrubs and ground covers.

This “toolbox” of design elements will help with branding and identification of the district, and could help to link other medical-related stakeholders and assets together. Used in whole or in part, this toolbox could help to create an overall identity framework that other medical facilities across the community can plug into if they choose, including Texas A&M Health Science Center, the Physician’s Center, St. Josephs, satellite clinics such as the two Scott & White clinics in College Station and others.

## Design Elements

### Lighting

The quality of light can greatly affect the character of the streetscape within the medical district and the perceived sense of whether the area is safe or unsafe. Lighting for pedestrians should be designed to avoid glare and give the pedestrians the ability to see their immediate area as well as their surroundings outside the lighted area. A well-lighted medical district with pedestrian lighting, attention to human scale and appropriate light levels will invite more pedestrian traffic, and help avoid potential nighttime conflicts. Pedestrian lights and streetlights should complement each other and the other site furnishings.



### Site Furnishings

Site furnishings are a major contributor to a pedestrian-friendly environment within the medical district and include items such as benches, shade structures, trash receptacles, bike racks, signs, traffic signals, tree grates and bollards. A pedestrian-friendly environment is greatly influenced by one's perceived level of comfort. A comfortable place to sit and relax enhances the level of comfort for the pedestrian. Street furnishings can also provide a strong unifying element within the medical district, setting it apart with a distinct identity. The color of the site furnishings should match or compliment the other elements in the design vocabulary.



### Monuments

It is critical for the success of the medical district to have a strong entry statement as it sets the standard and identity for the district as a visual icon. Gateways and landmarks properly located will serve as a visual announcement to let people know they are entering a special district.

### Paving

Enhanced paving treatments are one of the key features in a design vocabulary to introduce color and texture into the streetscape environment. It is also an important component in traffic calming that leads to a safer pedestrian realm. Paving materials should be durable due to the volume of traffic anticipated with the build out of the medical district, especially along Rock Prairie Road. Specialty pavement materials can be used to establish a pedestrian priority. A change in pavement texture or color signals drivers that the crosswalks are a pedestrian priority area. The use of curb extensions, or "bulb-outs," at intersections and crosswalks will function as traffic calming devices, as well. Bulb-outs give the illusion of narrowing the lane of travel, alerting the driver to slow down. The rough texture of enhanced paving and contrasting color will be a second indicator for drivers to reduce their speed.



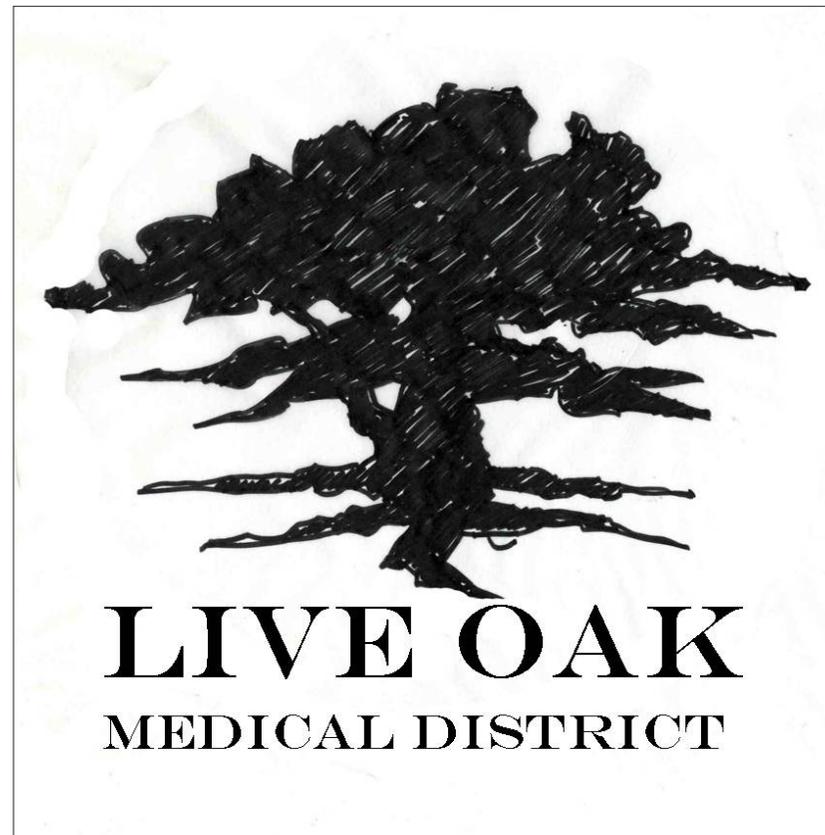
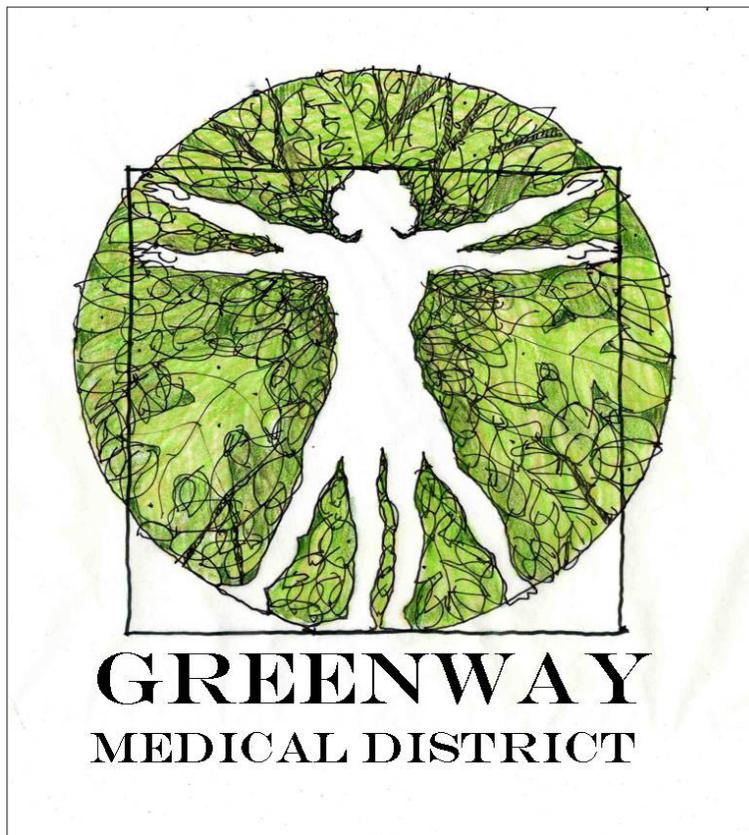
### Landscaping

Street trees are key components to creating a successful streetscape and traffic calming. A tree-lined street not only helps define the vehicular corridor, it also defines the pedestrian spaces while introducing rhythmic groupings of color and texture. Street trees are also one of the vertical elements in a streetscape that provide comfort and shade for pedestrians in the heat of the summer and can also produce "visual friction." Visual friction uses vertical and/or horizontal elements within the streetscape, such as street trees, enhanced pavement or bulb-outs, to make drivers more aware of their surroundings. Drivers perceive they are driving within a pedestrian zone, contributing to a greater awareness and slower speeds.



### Logo Concepts

Logo concepts that evoke the impressions mentioned above have been developed for two of the names above in order to demonstrate potential applications of a name and logo to a range of elements and site design opportunities. The logo concepts are followed by examples of a unified family of site elements that demonstrate how a design vocabulary can reinforce a brand for the medical district.



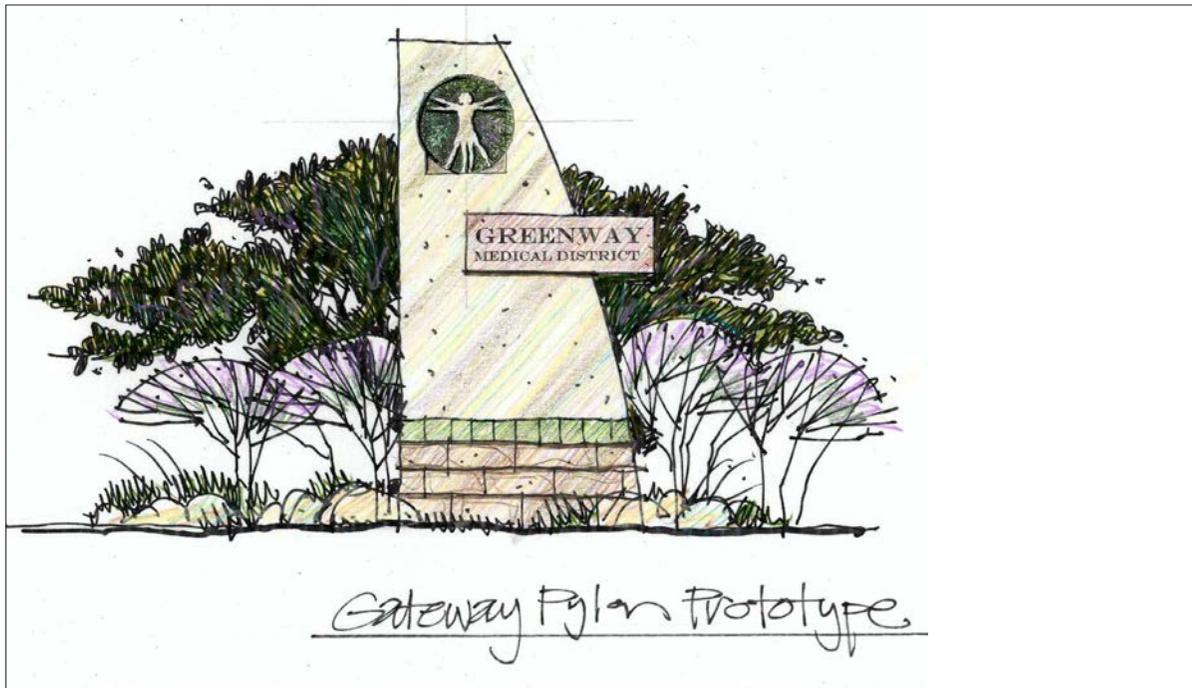
*Logo prototypes for two district name concepts have been developed to demonstrate the potential use of a versatile image in a range of environmental design applications.*

### A Family of Site Design Elements

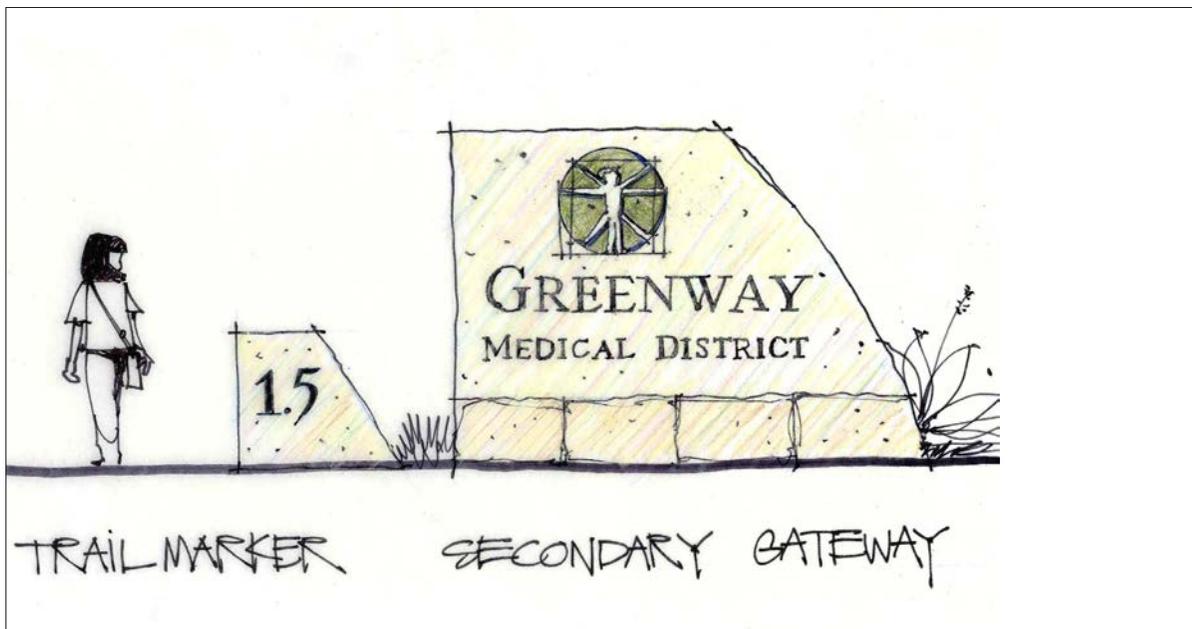
A number of applications of the name and logo concepts, along with the suggested vocabulary of forms, materials and colors, are illustrated here. Although the master plan cannot anticipate or detail every feature that will ultimately make up the visual environment of the medical district, it illustrates sufficient examples of a unified design vocabulary to facilitate translation into other components.



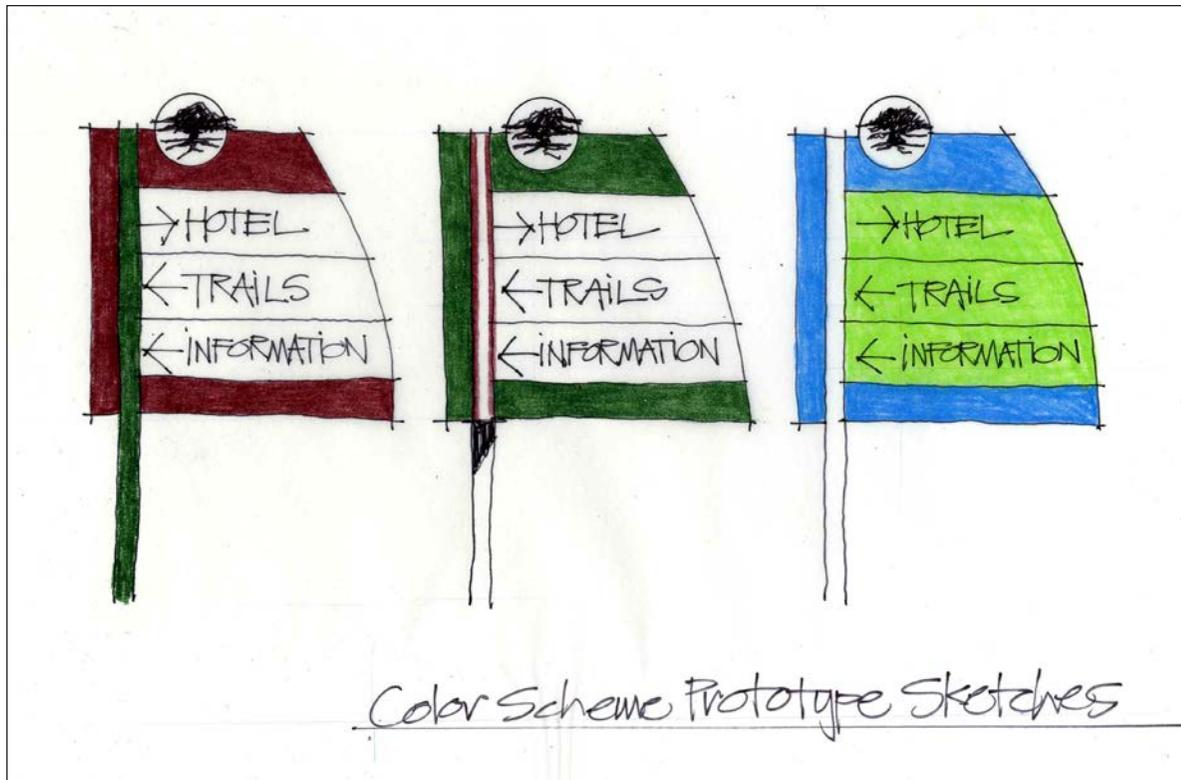
*Water Tower as Visual Landmark. A water tower proposed by the City near the Scott & White Hospital could incorporate a name and logo, creating a landmark for the medical district visible for miles.*



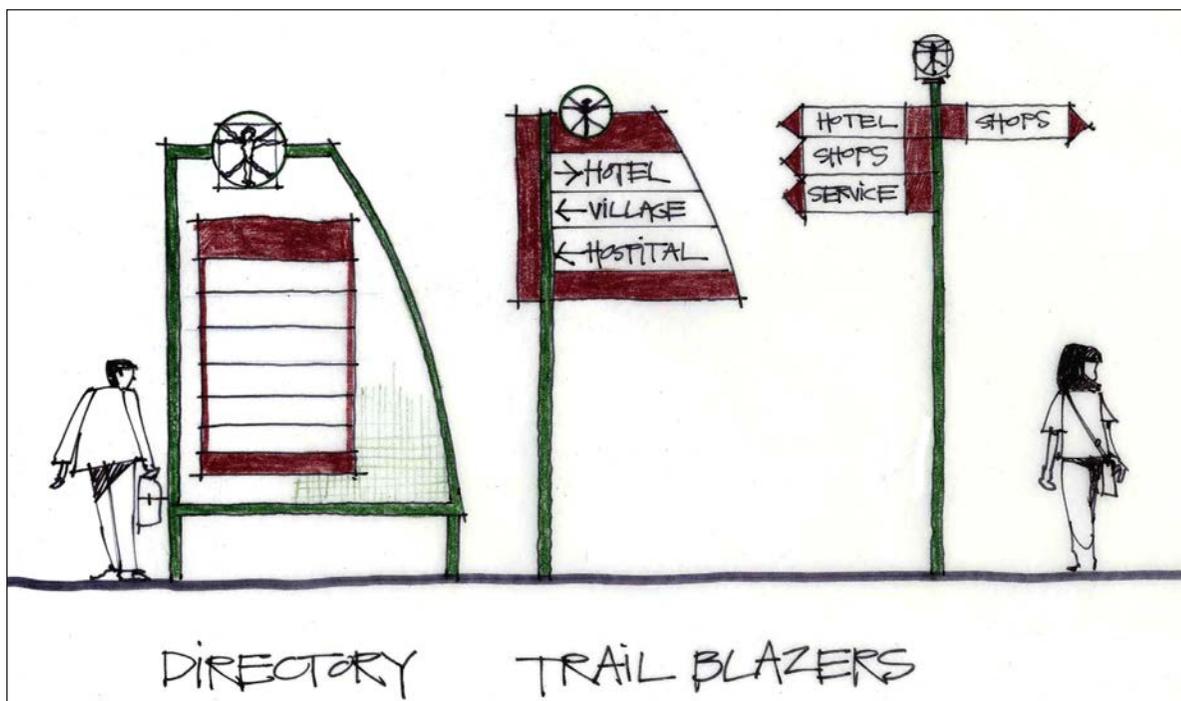
*Gateway Pylon Concept. This vertical pylon design incorporates a sweeping arc, recalling the circle logo motif, and utilizes a variety of native stone materials and earth tone colors. It could be sited at primary roadway entrances to the medical district.*



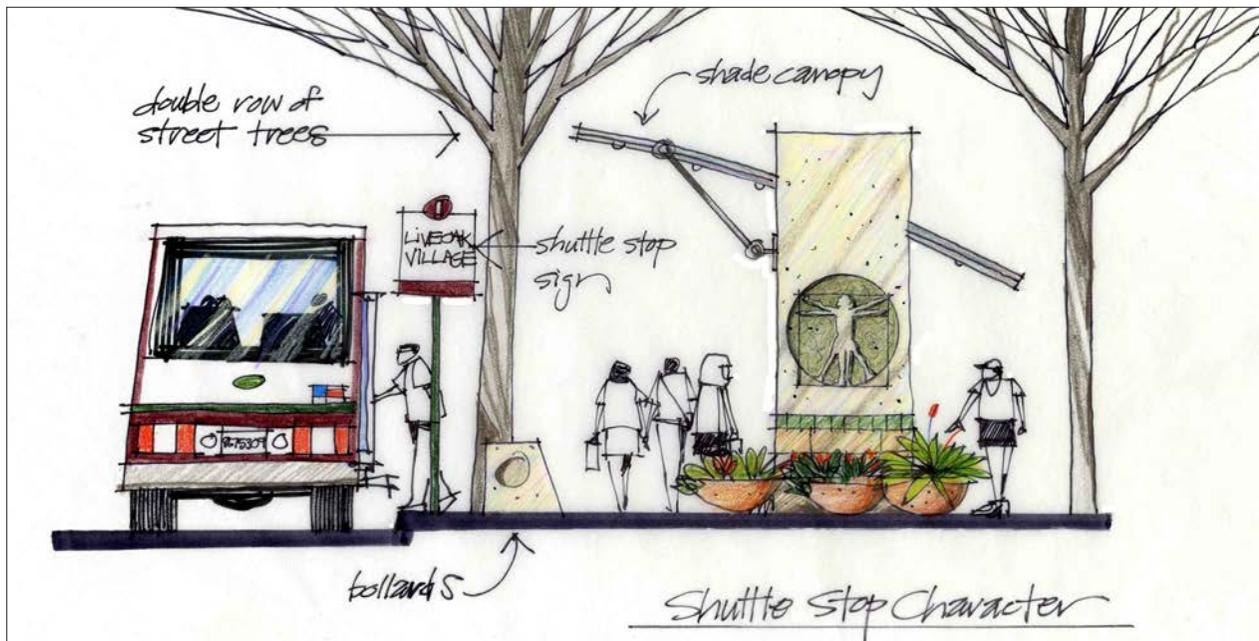
*Secondary Monuments. A family of smaller gateway monuments, trail markers and bollards could enhance secondary entrances, drives, parks and greenway trails. These designs mimic the forms and materials of the large gateway pylons.*



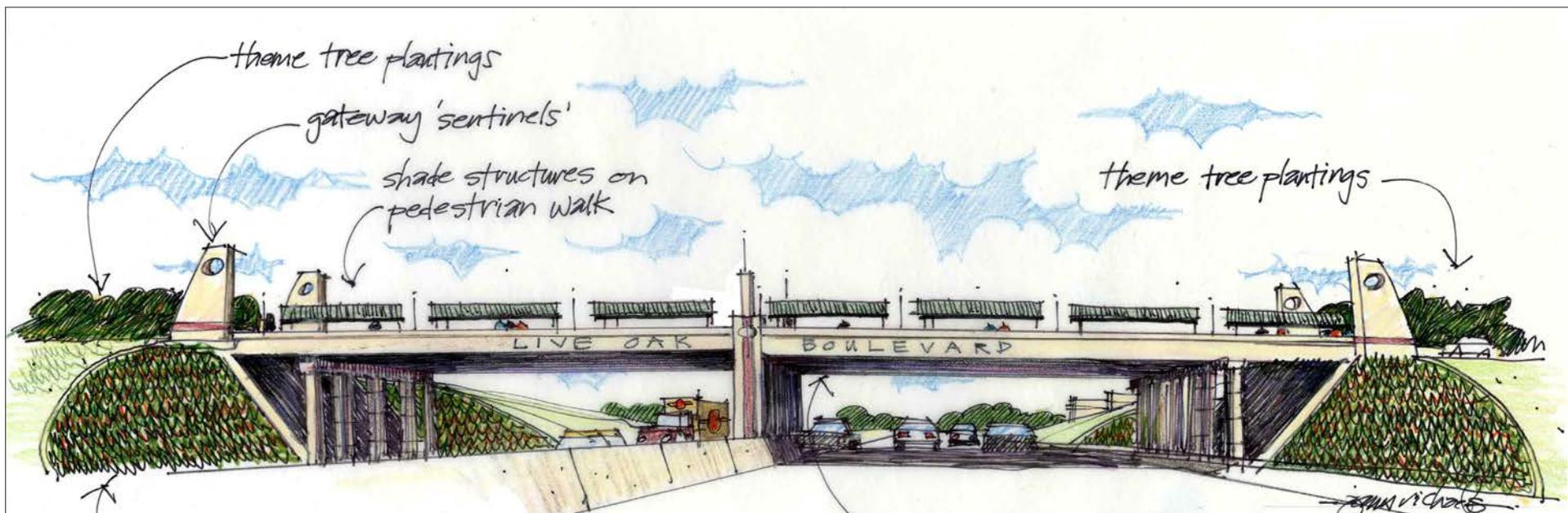
Wayfinding and Color schemes. A number of color schemes inspired by natural materials and the “healthy community concept” would be appropriate in the medical district; the scheme chosen should be fresh, uplifting and visible at a distance. In this example, the metal wayfinding signs utilize the arc motif and logo.



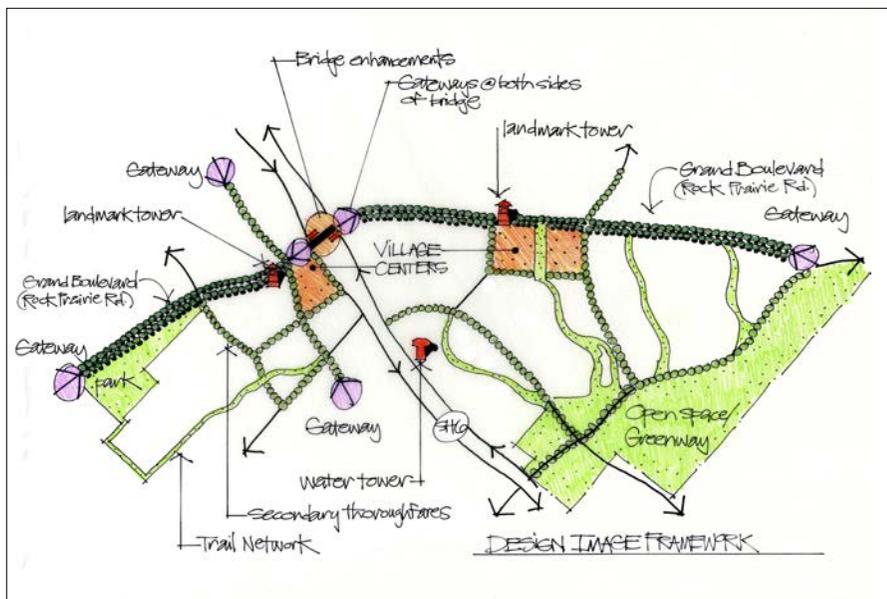
Wayfinding Motif Applications. A strong design motif can produce a family of wayfinding signage to serve a variety of needs throughout the district. Their repeated use works in tandem with the streetscape design to visually unify disparate parts of the district.



*A Sense of Place. In this concept sketch, a logo and use of a unified design vocabulary is utilized to create a transit stop area with a character that is unique to this district.*



*Bridge as District Landmark. The redesign of Rock Prairie Bridge has great opportunities to incorporate design forms and colors that visually tie it to the district's design vocabulary. There is also an opportunity for the street name to echo the district name. With these design strategies the bridge becomes a highly visible and memorable landmark feature for the medical district.*



*Key Design Elements. This diagram illustrates a concept for a framework of key design elements that will heighten the visibility of the medical district and create a distinctive development character that will knit the various aspects of the district together into a unified whole.*

## Development Guidelines

In order to ensure the best outcome for creating a district with a strong identity, sustainability and livability, as well as a district that people will want to return to, it is important to establish basic development standards. These standards should create street corridors and developments that are comfortable and attractive to pedestrians, bicycles and automobiles. This means that the public realm (streets, medians, sidewalks and adjacent building fronts) must be inviting as a place to be.

**Form-Based Code.** Form-based codes are a method of zoning special multi-use districts, such as the medical district, to achieve a more positive outcome of development and to enhance quality-of-life, which is ultimately reflected in enhanced property value. Instead of establishing minimum standards to be met and the separation and buffering of land uses, it establishes desired standards for such things as site layout, basic building form and streetscaping. It also provides for flexibility in compatible uses to respond to changing market demands, and the provision of parking in ways that increase its efficient use and minimize disruption of the public realm.

These standards reflect the timeless principles upon which great districts have been based—making them a comfortable and attractive place for people to meet, socialize, live, conduct business and find entertainment.

Another important element of a form-based code is the procedure for approval of development. It should provide for administrative approvals and waivers of certain standards in order to expedite development and achieve a better development than would be the case without such flexibility.



*Landmark Tower. This concept sketch illustrates the “grand boulevard” character of thoroughfares the Village Centers. The landmark tower contributes to a strong sense of place, and helps heighten the visibility of the district from SH 6.*

**Buildings.** Buildings in the medical district should meet the following standards:

**Materials:** All buildings should be constructed of solid, enduring materials that require a minimum of maintenance.

- **Height:** Buildings within the medical district should be 3 to 5 stories in height in order to properly frame the streetscape, capitalize on the amenities of trails and open space, encourage pedestrianization, make efficient use of the land and create a density that can support local transit service. Major medical facilities may be up to 7 stories in height, or taller with special approval.
- **Building Character:** The character of buildings should reflect central Texas traditions in terms of materials and articulation, and in responding to local climatic conditions.
- **Energy Efficiency:** Buildings should be constructed and sited to minimize the impact on utilities and drainage. They should be constructed to LEED Silver standards to support the theme of a “healthy” and efficient community. (LEED ND standards are largely embodied in the medical district plan.)

**Site Layout.** How buildings and parking are laid out greatly affects the visual and functional character of an area.

- **Building Orientation:** Buildings should be oriented to a shaded sidewalk for ease of access for pedestrians, to be easy to find services, and to enclose the public realm. This may occur in stages in a multi-phased project.
- **Buildings adjacent to trails and open space** should front on to those amenities to take advantage of the value creation opportunities and to provide “eyes on the sidewalk” security. Buildings separated by a small access road would be deemed to meet this standard.
- **Parking:** On-street parking should be maximized on non-arterial streets. Off-street parking should be located toward the center of a block and largely screened from streets and pathways. It should be easily accessible but should not dominate the development or the medical district.

**Public Open Space and Trails.** The public open space and trails identified in the master plan should be incorporated into development. They are an important source of transportation (or conveyance), recreation, exercise, amenity and value creation for the district, which is central to the theme of “Healthfulness.”

**Shade.** There are measures that can significantly reduce energy cost and increase the level of comfort for people who are walking, jogging and exercising outside. According to Lawrence-Livermore Laboratory research, shading of paved areas lowers the surface temperature by 40 degrees and the ambient temperature by 7 to 11 degrees. This has an enormous impact on local air-conditioning bills and the comfort of pedestrians and cyclists. In addition, trees have a greater cooling affect than providing a shade structure.

All sidewalks and trails should be well planted with shade trees, and surface parking areas should also be planted with canopy trees that shade and cool those asphalt and concrete surfaces.



## 8 - Implementation Strategies



### Introduction

\* For further information related to Medical District Implementation strategies, please see the Medical District Implementation Report.

This chapter recommends a series of principles and tools intended to help the City of College Station and its partners to implement the master plan.

Just like the planning process, the implementation of the master plan will have many components, including physical, financial, regulatory, operational and organizational. A wide range of actions is required to transform a paper plan into a vibrant built place. This chapter primarily focuses on financial or funding tools, while also making recommendations regarding other elements of implementation.

In order to recommend the proper set of tools for the master plan, it is important to recognize the content of the plan—what it is that will be implemented. The master plan contains the following critical elements that will require funding and implementation:

- **Public Infrastructure:** Public infrastructure includes streets, roads, and highways, as well as a wide variety of streetscape improvements that are located outside of travel lanes: sidewalk improvements, street furniture and street trees, improved crosswalks, etc. In addition, the plan calls for improvements to the system of trails and gateways and the Rock Prairie Road bridge over SH 6. Finally, improvements will likely be needed for other types of infrastructure, such as water, storm water, sanitary sewer, and electrical utilities. The cost of these improvements is likely to be shared between the public and private sectors.

- **Development and Redevelopment:** The master plan calls for the development and redevelopment of key opportunity sites that are owned by private institutions and landowners. Examples include the village centers to be located on both sides of SH 6. The City does not have control over these properties, however, it can influence and encourage certain types of uses and design treatments on these properties through a range of incentives and approaches covered later in this chapter. These include changes to land use codes and entitlement, land acquisition and write downs, and tax deferral and abatement, among others. The most successful medical districts and other types of urban redevelopment result from robust public-private partnerships, in which the public sector offers effective incentives and rewards to private parties for implementing desired development types.
- **Ongoing management and staffing:** The medical district will require ongoing marketing, planning, management and other types of oversight that requires dedicated staffing.

### Principles of Implementation

In addition to specific implementation tools, there are fundamental approaches or principles that are consistently found in the most successful urban districts. The principles summarized below separate the plans that get implemented from those that flounder.

#### Committed, Ongoing Leadership

- Leadership that desires success for the entire community.
- Leadership that is respected by the community; has strong leadership skills.
- Leadership that is able to motivate and organize

#### How Things Get Done

- Cities cannot do it alone.
- Public-Private Partnerships build great places.
- Private investment follows public commitment.
- Cities grow incrementally through a series of projects that are modest on their own but meaningful as a whole.
- The public realm establishes the opportunity for development excellence.

stakeholders.

- Leadership that moves forward and communicates the vision of the plan.

#### A Good Organization

- Provides ongoing support for the implementation through communication and coordination.
- Provides long-term continuity and unifies divergent interests.
- Provides support for local government, and support to project development.
- Communicates success and opportunities.

#### Many Projects

- The implementation of the plan moves many projects forward at once.
- The term “projects” should be defined broadly and include streetscape and façade improvements, programs, events, marketing, signage and design improvements and real estate development projects.
- A medical district organization catalogs and communicates all public and private projects through a web site and printed materials. The City and its partners should celebrate successes, small and large.

#### Many Stakeholders

Many projects bring many stakeholders; people who are invested in one or more projects must pull together to make and implement the plan.

- Broad base of involvement and promotes project implementation.
- Stakeholders – representative cross-section government, non-profits, businesses, and individuals.
- Stakeholders form the basis of political support for implementation of the plan.

The key to successful implementation of the plan is mechanisms for marrying the identified stakeholders, current and potential with projects, existing and proposed. Implementation requires collaboration with stakeholders for positive results.

#### Development Standards

- Clear and consistent guidelines that communicate the vision of the plan.
- Encourage that which is desired and strongly prohibit that which is not wanted.
- Tools should be dynamic and flexible – pragmatic standards for change.

#### Communications and Marketing

- Both the organization and the leadership must communicate successful implementation.
- Marketing the plan means making news out of the continual projects.
- Communication means acting as a liaison between stakeholders, projects, and the wider community.

### **Internet Strategy**

Create an internet strategy to establish a secured wireless network with enough bandwidth to provide medical district patrons with internet access both indoors and outdoors. The wireless network should allow for expansion as the medical district expands, and include access to district information such as:

- Medical district management organization’s website.
- District business websites.
- Directions.
- Transit/shuttle service information.
- Medical appointments.
- Education/classes/seminars.
- Special events and activities.
- Special ‘subscriber only’ features, such as notifications to patrons, employees and residents of the medical district.

### **Supportive Government**

- Provide support for achieving standards – consultation, code enforcement, and assistance.
- Able to review its practices, identify and change policies.
- Set clear goals.

### **Ongoing Review**

- Dynamic plans require ongoing review that responds to changing conditions.
- Evaluation of the plan, projects, and communications – make periodic adjustments to the plan.

### **Approach Implementation of the Medical District as a Business**

In the coming months and years, College Station’s leadership should approach the implementation of the medical district as a business that is built to last, not a one-time “project.” Great businesses are built to provide a quality product or service for years, while a project calls for a burst of effort for weeks or months.

The medical district is like a major business enterprise, and that means that it must be staffed, funded, marketed, planned, improved, maintained and monitored at a scale commensurate with its importance.

The following is a list of the roles and services that can be offered in the interest of running the medical district like a business. The City along with a public-private district management organization and other partners should do the following:

- District maintenance.
- Security.
- Marketing and outreach.
- Event programming.
- Business recruitment and retention.
- Regulatory advocacy and enforcement.
- Parking and transportation management.
- Urban design advocacy and enforcement.
- Storefront improvement.
- Planning and visioning.
- Targeted capital improvements.
- Facilitating public-private partnerships.
- Securing local, state, federal, and nonprofit grants.
- Surveying and market research—understanding what citizens, customers and employers want.

Private investment follows public commitment. In other words, most developers and business owners want to put their money and life’s work where it will be reinforced and amplified by established public goals and investments. It is usually the public sector’s goal to set the stage and standards and demonstrate that the medical district is a safe, attractive, exciting—and ultimately profitable—place to invest.

### **Funding Tools: Overview and Key Recommendations**

**Table 7** shows an extensive list of the funding tools that can be used to implement the master plan, with tools that are especially important and should be implemented highlighted in yellow. Each of these tools is then explained in detail in the following pages.

- **Capital Improvement Plan (CIP):** The City’s CIP (and potentially the CIPs developed by the County and other agencies) is the first and best place for supporters of the medical district to focus their efforts to fund a variety of needed infrastructure improvements, particularly transportation improvements. CIPs usually list, prioritize, and specify funding strategies for the City’s roadway and other infrastructure projects. Medical district leadership should make sure that the needed improvements to Rock Prairie Road and other roads receive very strong consideration and ultimately inclusion in the CIP. Like other tools on this list, a high priority from the CIP can help a given project to attract matching funds from other sources.

## Funding Tool Descriptions

This section summarizes the most important funding tools listed in **Table 7**.

Key funding tools are shown in yellow.

Tool	Applicable For:	
	Public Infrastructure and Operations	Private Real Estate Development
<b>District Tools</b>		
Tax Increment Financing (TIF)	✓	✓
Public Improvement District (PID)	✓	
Business Improvement District (BID)	✓	
<b>Infrastructure Funding Tools</b>		
Capital Improvement Program/Public Works Funds	✓	
Municipal Debt/Bonds: General Obligation or Revenue	✓	
Impact Fees / Systemn Developmetn Charges	✓	
Special Purpose Tax (e.g., lodging tax)	✓	
<b>Additional Funding Tools</b>		
Regional, State and Federal Grants	✓	✓
Regional Transportation Allocations	✓	
Legislative Appropriations	✓	
<b>Development and Redevelopment Incentives</b>		
Economic Development Staff Assistance		✓
Expedited Entitlement / Permitting		✓
Soft Costs / Professional Fees	✓	✓
Land Acquisition, Assembly, or Write Down		✓
Public Infrastructure Improvements/Place Making	✓	✓
Fee or Tax Deferral or Abatement		✓
Storefront Improvement Grants/Loans	✓	✓
Brownfields Assessment and Cleanup Funds		✓

Table 7. Medical District Funding Toolkit

- Tax Increment Financing (TIF):** TIF is usually the most powerful public financing tool available that can help to spur development and fund public infrastructure projects within a defined district such as the medical district. TIF has been used throughout the country for large scale, mixed-use, urban development projects. TIF essentially captures the net new tax revenues that are generated within a defined district as a result of development and directs them towards projects within the district that will accelerate private sector development and investment. TIF is therefore geared to direct public investments where they have the greatest potential to incentivize private investment and to create a virtuous cycle of investment. Additional TIF information is covered under the Funding Tool Description section below.
- District Organization and Funding Tools: Business Improvement District (BID):** As described above, it is critical that the medical district have the funding and staff capacity to move this vision forward. BIDs are critical tools for the urban districts, such as a medical district, and are used extensively nationwide to fund ongoing operations: marketing, management, safety and security, event planning, and other programs. As the names suggest, these district based tools direct locally collected dollars to activities within a defined district. They are largely funded by the private sector, but this funding is often complemented or augmented by the public sector.
- Creative use of incentives and public private partnerships:** Plan implementation is never smooth sailing. There are always headwinds, whether in the form of funding challenges,

incompatible regulation, external competition or other currents. Therefore, professionals—whether at City, BID or outside consultants—who understand how to build public-private partnerships and work with the private sector and major institutions are essential. The approaches and tools needed to work with private partners vary over time. Sometimes, the key to a major deal may simply be ensuring that the right permit is obtained on time. At other times, a major funding gap may require creative public sector assistance in the form of specific infrastructure improvements, low interest loans or fee deferrals. In order to sustain strong partnerships, experienced staff and elected leaders need to understand the tools at their disposal and keep the focus on the district’s long-term benefits to the community: jobs, investment, economic development and quality of life.

- **Grants and loans from regional, state, and federal government agencies:** Various regional, state, and federal government agencies offer a range of grants and loans for deserving projects. For the medical district, grants could come from agencies focused on economic development, public health, transportation, housing or other issue areas. Examples include the Proposition 12 infrastructure funding awarded by the Texas Department of Transportation (TxDOT), New Market Tax Credits and the Sustainable Communities initiative, a partnership between the federal DOT, Housing and Urban Development (HUD) and Environmental Protection Agency (EPA). Medical district leadership and staff should be proactive about pursuing public grants and loans.
- **Creative development of private and philanthropic funding:** Private and philanthropic

**“Miracles happen in the movies, but they rarely happen in real life. In many communities, market conditions that caused neighborhood commercial streets to decline are still in place, and it takes an aggressive commitment by the public sector in partnership with private stakeholders to address negative influences before sustainable... revitalization will occur.**

**Communities have powerful financial and regulatory tools to attract desired private investment capital if used judiciously. Some of these tools are “carrots” that create a positive investment climate, improve infrastructure, or reward investors who further community goals. Others are sticks, which may need to be used if carrots are not sufficiently convincing. Communities should be willing to use both to convince landowners, developers, and retailers that the revitalization efforts are in their interests.” — Urban Land Institute**

funding have the potential to lift the profile and effectiveness of the medical district, and should be pursued by medical district leadership once the bedrock funding provided by TIF, BID or other sources listed above are established. Private and philanthropic funding can help the district to increase the quality of infrastructure investments, and assist with marketing and event planning. While some funding in this category can be motivated by altruism, it is also often generated by pragmatism. Corporate partners will be interested in contributing through sponsorships, advertising, and promotions if they are able to connect their brand to an iconic place that enhances the health and wellbeing of area residents.

## District Funding Tools

### Tax Increment Financing

Tax increment financing (TIF) is a mechanism whereby public projects are financed by debt borrowed against the future growth of property taxes in a district. The assessed value of all properties within the district is set at the time the district is first established (the frozen base). As public and private projects enhance property values within the district, the increase in property taxes over the frozen base (the increment) is set aside. Debt is issued, up to a set maximum amount, to carry out the urban renewal plan and is repaid through the incremental taxes generated within the district. Districts are usually in effect for 15 to 20 years. When a district is retired, the frozen base is removed and all property taxes in the district return to normal distribution.

### Public Improvement District (PID)

A public improvement district (PID) is a special district within which properties are voluntarily assessed in order to pay for specific infrastructure improvements that benefit the district. These districts are called PIDs in Texas, but Local Improvement Districts (LIDs) in most other states and in most municipal finance literature. Revenues can be collected up front or paid over a fixed period of time in annual assessments. The formula for assessing property can be very flexible. Although not an appropriate tool of acquisition financing, a PID may be used to pay for infrastructure improvements that would benefit the surrounding property owners (connectivity in the street grid, for example) and could be used as a negotiating tool with a private development partner.

### *Advantages*

Powerful revenue generator. Enables property owners and cities to amortize the cost of needed improvements over 20 years or another time frame rather than paying up front. Strong relationship between benefits received by adjacent property owners and costs paid, with a long history of implementation.

### *Disadvantages*

A mixed reception is likely from affected property owners—some will appreciate the cost-benefit connection and others will resist the additional costs, particularly if they do not directly benefit from PID-funded improvements.

**“Planning should be defined as ‘public action that generates a sustained and widespread private market reaction,’ which improves the quality of life of the affected community.” — Alexander Garvin, *The American City: What Works, What Doesn’t*.**

### **Business Improvement District (BID)**

A Business Improvement District (BID) is an independent special assessment district formed to improve the business climate within a designated commercial or industrial area. Independent special districts have characteristics of assessment districts but also have autonomy from local control and authority to issue bonds, enter into contracts for service, and impose user charges. Property owners in the district pay the assessment to support services and/or capital facilities intended to augment—not replace—services and facilities already provided by the local government.

Typically, BIDs are formed by an ordinance or resolution of the local government, but only following explicit statements of support from the affected area. Decisions affecting BID revenues are usually made by a board consisting of private property and business owners. Most BID revenues are used to fund operating expenses in commercial business areas, for services such as sanitation and maintenance, police or marketing and promotion activities. A BID may also pay for capital expenditures supporting the same goals, such as the purchase of a new sanitation vehicle.

### *Advantages.*

When a local jurisdiction has limited resources, a BID can address local problems in a focused, efficient manner. A BID can help create social and economic changes that benefit the real estate market and the community as a whole. They can increase the participation of businesses in coordinated community development and can help a downtown area compete with malls by making possible the same type of coordinated property management and promotional services.

### *Disadvantages.*

Absentee owners and corporations may be hard to reach for support.

## **Infrastructure Funding Tools**

### **Capital Improvement Plan**

Capital Improvement Plans (CIP) are one of the most reliable sources of local funds. Generally, a CIP identifies capital projects (and some major equipment purchases) during a five-year period, providing a planning schedule and identifying opportunities for

financing the projects in the plan. CIPs coordinate community planning, financial capacity and physical development. A CIP typically includes:

- A list of capital improvements (projects or major equipment);
- Projects ranked by priority;
- Project cost estimates and funding sources to demonstrate a balanced funding and expenditure program; and
- A schedule for construction or completion of the projects.

CIPs are typically updated annually. Each update is created with input from the public, advice from the planning commission and direction from the city council. The adopted CIP then becomes the basis for a city’s annual capital budget.

### *Advantages.*

There are a number of benefits that may be realized from the capital improvement plan process including:

- Systematic evaluation of all potential projects at the same time;
- Coordination between capital needs and operating budgets;
- Enhancement of the community’s credit rating, control of its tax rate and stability in debt service obligations;
- Identification of the most economical means of financing capital projects; and,
- Coordination of public capital investments with other public and private development initiatives.

Getting a project into the CIP is an effective strategy for helping ensure the project will receive local funding.

*Disadvantages.*

Much of the funding for CIP projects comes from the City's general fund and other limited local funding sources. The cost of needed infrastructure improvements typically exceeds the availability of CIP funds to pay for them, therefore, only select projects, including projects of the highest short-term priority, may be included in the CIP.

**Municipal Debt/Bonds – General Obligation and Revenue**

A bond is a financing tool that transforms a long-term stream of public-sector income (for example, property taxes) into a near-term source of capital for major capital improvements. In its basic structure, it is not unlike a mortgage: a large asset in the short term is exchanged for a long term debt obligation.

Bonds, therefore, are not truly sources of funding, but financing tools; there must also be a funding source (property or sales taxes, general fund moneys, utility fees, etc.) that secure the bond. While bonds are not funding sources, they are an important resource in the public funding and implementation toolkit. Capital improvement plans are often financed through bond issuances.

One distinction within the category of bonds is between general obligation and revenue bonds. General obligation bonds are often serviced by already existing funding sources and/or the general fund and therefore, must compete with all of a jurisdiction's other funding priorities. Jurisdictions are usually limited in the amount of general obligation bonds they can issue. Revenue bonds are tied to a specific, dedicated and often new source of revenue. For example, a bond that will be used to construct a

new reservoir might be serviced by a surcharge on water rate payers' bills.

*Advantages.*

Tax exempt, low-interest rate.

*Disadvantages.*

Difficult to get voter approval unless well supported by general public. Can be limited by general fund resources. Dependent on city council priorities.

**Impact Fees**

Impact fees, also referred to as "development impact fees" and "transportation impact fees," are assessments made by local governments on new real estate development. Impact fees provide a mechanism for local governments to pay for infrastructure needs associated with growth without raising taxes or fees for services. Government entities levy impact fees against developers at the time of development to cover the additional costs to serve the new development. Impact fees typically cannot be used to correct existing deficiencies in public facilities. Impact fees can be structured in order to encourage development types that will create fewer impacts on various public systems. For example, some municipalities have fee structures that encourage development in areas that are already served by transportation, water, sewer and other infrastructure, and thus where the cost to add new infrastructure may be less.

**Additional Funding Tools**

**Regional, State and Federal Grants and Loans**

Three different federal grant/loan sources, Community Development Block Grants, New Market Tax Credits

and Sustainable Communities Initiative Grants and Loans are summarized in the following paragraphs. This is, of course, a representative rather than comprehensive list. Many other regional, state and federal grant and loan programs exist and should be sought on an ongoing basis. Agencies whose mission is to address economic development, healthcare, housing, and "smart growth" communities may all be able to help to implement the master plan.

**New Market Tax Credit Program (NMTC)**

New Market Tax Credits are tax credits against federal income taxes sold to investors. Investors make qualified equity investments in community development entities (CDEs). (CDEs are certified by the U.S. Treasury through a competitive process.) CDEs apply for a tax credit allocation, an amount not to exceed \$125 million in one year for qualifying census tracts. The NMTC provides investors with a tax credit equal to 39 percent of their investment over seven years: five percent each year for the first three years and six percent each year for the next four years. The actual amount of equity available from the credit will amount to 20 to 25 percent of the allocation amount. For example, a \$10 million allocation will equate to about \$2 to \$2.5 million in equity for a project. Any single project is unlikely to receive more than \$50 million in a tax credit allocation.

*Advantages.*

NMTCs are a relatively flexible equity source that can provide equity for long-term financing and may also provide gap financing for projects that cannot be financed by conventional financing methods. An NMTC allocation originally intended for another project can be applied to a different project of a

similar nature if the original project falls through.

#### *Disadvantages.*

Taxpayers claiming a NMTC are required to recapture a pro rata portion of the credit if they dispose of their interest in the property within five years of the rehabilitated project being placed in service. NMTCs are more appropriate for development rather than acquisition. The tax credit application is a complex and time intensive process that requires a very detailed description of the project purpose and intended end use of the project, along with financial projections and proof of “reasonable expectations” that the project will go forward.

#### **Sustainable Communities Initiative Grants and Loans**

The goal of these grants is to build economically competitive, healthy, opportunity-rich communities. In the 2010 Budget, Congress provided a total of \$150 million to HUD for a Sustainable Communities Initiative to improve regional planning efforts that integrate housing and transportation decisions, and increase the capacity to improve land use and zoning. Of that total, approximately \$100 million will be available for regional integrated planning initiatives through HUD’s Sustainable Communities Planning Grant Program.

#### **Legislative Appropriations**

State and federal appropriations (also known as earmarks) are funds set aside for a specific purpose during the legislative process and often included within a larger spending bill. Appropriations can be used to finance a variety of special projects, including planning or construction projects and transportation projects. Like many other sources of state and federal money, decision-makers will want to see significant

local commitment to a project before pledging state money.

#### *Advantages.*

Appropriations can provide a moderate level of funding for special projects, including projects that are not eligible for funding under other state and federal funding programs. Because they are approved directly by the U.S. Congress and/or Senate, the projects they fund are less likely to be required to pass through the stringent standards set by other federal agencies.

#### *Disadvantages.*

Appropriations are unpredictable. The process of being selected for an appropriation is a very political one, in which senior committee members, favored districts and projects, and hard-lobbying constituents are the most likely to be rewarded with funds, but still suffer from a lack of certainty until final votes are tallied.

#### **Development and Redevelopment Incentives**

##### **Economic Development Staff Assistance / Public-Private Partnerships**

The most basic and often most important way to incentive desirable development is by assigning economic development (or other) public staff to help assist with specific sites, projects, initiatives or developers that have been selected based on specific qualifications. One important way that public agency staff can assist is by helping developers to understand and navigate the local, state or federal approval/entitlement processes. Conditional use permits, zone changes, building permits, and other land use approvals require time and money, and thus public assistance for key projects is valuable.

#### **Expedited Entitlement/Permitting**

In real estate development, time is money. Time spent understanding regulations, completing due diligence, and acquiring permits means expenses accrued through professional fees and debt service on any outstanding loans; this is also time during which revenues from development cannot be realized. Therefore, jurisdictions should make desirable development easy. Development that meets the goals of the community and its design and building standards should be expedited or fast-tracked. Such fast-tracked development processes create a very strong incentive for the development community to build the desired type of development.

#### **Soft Costs/Professional Fees**

Some jurisdictions assist specific development sites or initiatives by hiring architects, real estate analysts, engineers or other professionals to conduct due diligence on specific sites. This makes otherwise marginal projects less risky to developers by reducing upfront fees. This should be undertaken only in the case of specific development sites or initiatives that have been identified as priorities by the community.

#### **Public Infrastructure Improvements/Place Making**

Real estate development responds to transportation infrastructure, the qualities of the adjacent public realm and other inputs. By adjusting the types of infrastructure and place making elements it provides, the City can encourage certain types of development. For example, a great neighborhood park will encourage adjacent residential development; a high-quality urban plaza will help to encourage adjacent employment, lodging, retail or other urban development, though other conditions must also be in place to realize this development.

### **Land Acquisition, Assembly or Write Down**

Public agencies have the ability to acquire, assemble and “write down” land and then transfer it to developers selected through transparent public processes, which enables public sector agencies to incentivize the redevelopment of specific sites. Land assemblage simply refers to the aggregation of multiple properties into a single ownership. A land write down is the sale of land at less than its purchase value (but not necessarily its market value) often to reflect high development requirements, site constraints or challenging site conditions such as contamination. For example, the City of San Diego, California sold off a multi-block parcel to a selected developer at less than its purchase price as part a deal that required the developer to build a major new urban shopping center. The resulting Horton Plaza is now at the heart of San Diego’s revitalized downtown.

#### *Advantages.*

Land write downs are an effective tool for cities to leverage their capital assets to attract desired types of development that might not otherwise be feasible in the marketplace. Land write downs, particularly when used in conjunction with the more long-term actions of land assembly and land banking, are a powerful tool for cities to facilitate private development that is consistent with the community vision.

#### *Disadvantages.*

Redevelopment agencies have limited land assets to leverage. Therefore, it is important to ensure that these assets are only allocated towards deals that will not benefit the community over the long run. To ensure that assets will generate the maximum public

benefit, land write downs should occur in the context of a public-private partnership or other form of legal partnership agreement that provides the agency (and the developer) assurances that its assets will be used to create public benefits.

### **Fee or Tax Deferral or Abatement**

Local governments can use fee or tax deferral or abatement programs to facilitate a private investment that benefits the public and is consistent with the community vision. Abatement means that a property owner is not responsible for paying a particular tax or fee for a given amount of time (one, five or 10 years, for example).

Deferral allows a developer to postpone the payment of a tax or fee, also for a predetermined length of time. Deferral and abatement programs provide developers with an incentive to build projects, including residential developments with an affordable housing component, transit-oriented development and other types of projects that might not otherwise be financially feasible.

### **Building or Façade Improvement Loans or Grants**

Many cities and redevelopment agencies operate programs in which they offer low interest loans and/or grants to assist property owners in key districts with improvements to building facades, other cosmetic improvements or the analysis of major capital improvements. This tool enables cities and property owners to work together to create urban districts that are consistently attractive; for example, it is used extensively in historic downtowns where dilapidated buildings can be returned to their former glory through modest improvements. In the medical district, low interest grants or loans could be used

to incentive specific improvements for properties at important district entryways or other locations.

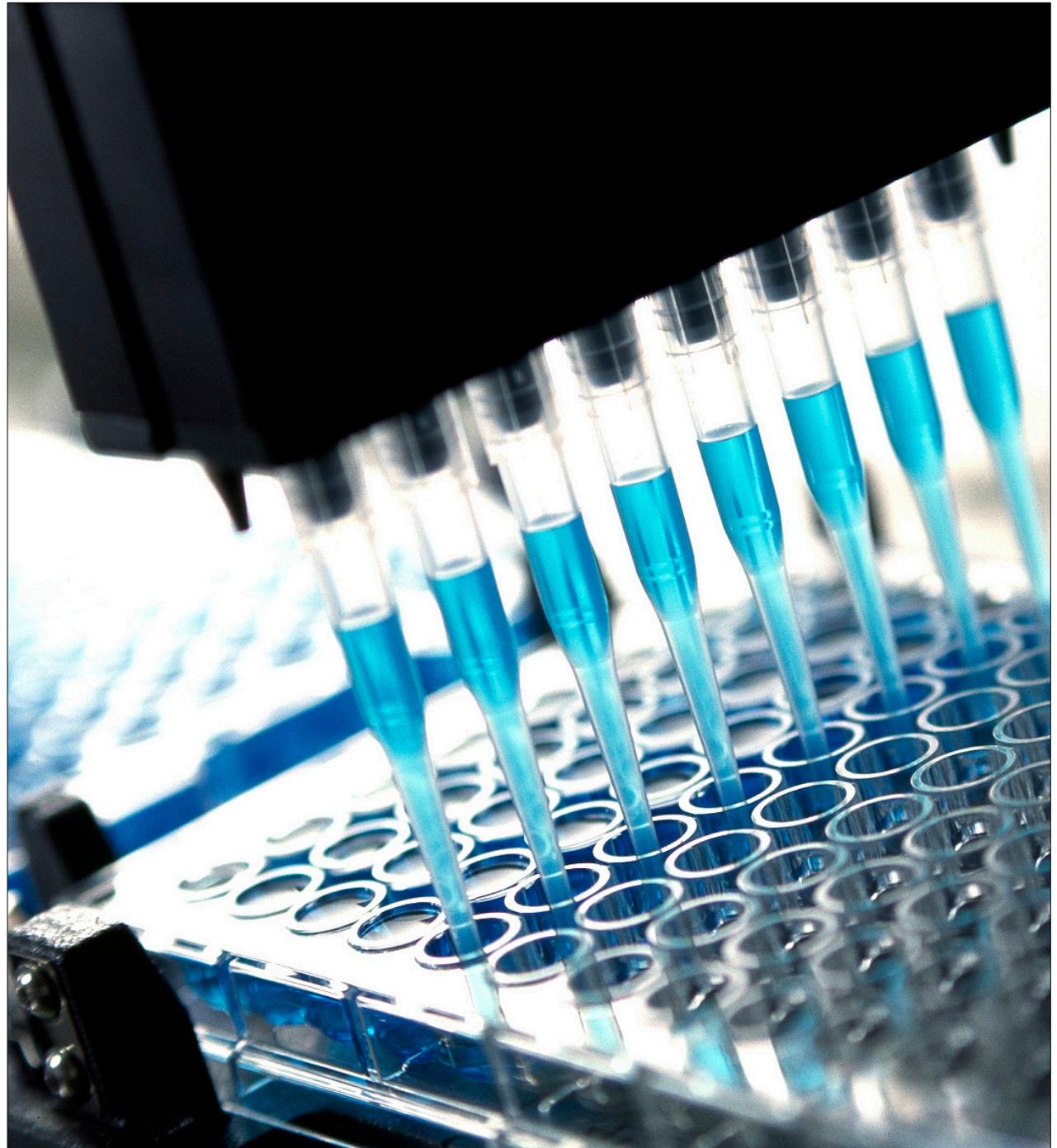
### **Brownfields Assessment and Cleanup Funds**

In some urban locations, the real or perceived contamination caused by previous site users can prevent development of sites for decades. This can take place when redevelopment is attempted at the site of former gas stations, dry cleaners or other types of commercial or industrial operations. In many cases a perception that a “brownfield” site is contaminated may be just as great a deterrent as actual contamination. In order to overcome these barriers and make efficient use of land and infill sites, there are numerous federal, state and private grant and loan sources to help evaluate and address brownfield conditions. The EPA’s Brownfields program is a good starting point for funding investigation.

### **Private Funding/Financing**

While public investment are critical to most urban redevelopment projects, it is important to recognize that private debt and equity sources are still likely to provide the majority of funds for most real estate development. In almost all cases, public funding sources should be used to close a funding gap or achieve additional outcomes that would not otherwise be possible, not fund an entire project alone. If the private sector is entirely unwilling to invest in a development project, that is a strong indication of a fundamental problem with its economics or another key component.

Debt and equity sources vary from project to project but include banks, developer equity, wealthy individuals, investment funds, pension funds and Real Estate Investment Trusts (REITs). Debt and equity investors usually work directly with developers—the recipient of funds—rather than with public agencies. Over the past decade, numerous funds and investment groups have been established specifically with the goal of investing in urban or smart-growth communities. Naturally, these are the groups most predisposed to invest in urban districts such as medical districts.



# *Appendix*

**Medical Corridor Advisory Committee  
Meeting Minutes (2/17/11)  
10:30 AM – 12:00 PM**

Committee Members Present:

Rodney Bailey  
James Batenhorst  
Carol Bode  
Sharon Bond  
Joe Brown  
Patricia Cleere  
Ruth Cohen  
Alicia Dorsey  
Eleanor Ebanks  
Chuck Ellison  
Ed Hard  
Frank Hartman  
Anne Hazen  
Tom Jackson  
Shane Lechler  
James Mason  
Nick McGuire  
Jan McMurrey  
Tim Ottinger  
Sheila Rinard  
Marsha Sanford  
Julie Schultz  
Jon Turton  
Kirsten Walker  
Gentry Woodard

Committee Members Absent:

Dennis Anderholm  
John Anderson  
Bobbyn Barnes  
Denise Barnett  
Angela Clendenin  
Rajesh Harrykissoon  
Jim Morgan  
Doug Phillips

Bill Rayburn  
Chuck Sanders  
Garland Watson  
Randy Yates

City Staff:

David Gwin  
Debbie Eller  
Eric Stein  
Randall Heye  
Jennifer Prochazka

Guests:

Mayor Nancy Berry  
Councilwoman Jana McMillan  
Councilman Dave Ruesink

David Gwin welcomed everyone in attendance and thanked the members for their service on the committee. He then recognized Mayor Nancy Berry for her welcome and opening remarks. Mayor Berry thanked the members for their participation and suggested that they view the medical corridor project as an engine for community growth. She emphasized that the City Council was looking forward to seeing the result of the fruits of the committee's labor. Mr. Gwin then asked that each member briefly introduce themselves and provide their affiliation within the community. After introductions were made, Mr. Gwin began his introductory remarks and mentioned that there would be a section of the City's website dedicated to the Medical Corridor project. He then provided a brief PowerPoint presentation to frame up the corridor study project and how the committee is expected to contribute. Mr. Gwin then recognized Victor Baxter to introduce the project team. Victor Baxter, SRA, introduced the project consulting team of SRA, Townscape, and Leland Consulting. Members on hand included Linda Jordan, SRA, Clint Wofford, SRA, Victor Baxter, SRA, Dennis Wilson, Townscape,

Jim Richards, Townscape, and Lee Bodenhamer, Leland Consulting. Mr. Baxter delivered remarks to frame up the study project from SRA's standpoint. He then introduced the consultant team members and gave their brief background and experience in the industry. He then introduced Linda Jordan.

Linda Jordan, SRA, laid out the initial work plan including the analytical steps, preliminary conceptual design and ultimate development of a master plan for the corridor. She emphasized the need for wayfinding, streetscape enhancements, pedestrian safety, and visual quality associated with medically-oriented development. Ms. Jordan discussed the general timeline and mentioned that the corridor Master Plan would be in draft form prior to the 2011 Christmas holidays. She then introduced Lee Bodenhamer.

Lee Bodenhamer, Leland Consulting delivered the overall corridor viewpoint. He emphasized the need for detailed market analysis, focusing on the idea of increasing strategic premise and adequately analyzing the region. He explained that the corridor study and future study area expansion should benefit both existing and entering providers.

Mr. Bodenhamer also explained some of the economic benefits of a medical corridor, specifically in regards to job creation, branding and identity, generating public revenues, and meeting current and future community need. He drew comparisons to existing medical corridors in Texas and surrounding states in terms of how those developed areas benefitted their respective communities. After discussing the basic medical district elements and what types of public-private partnerships enhance corridor feasibility, Mr. Bodenhamer introduced Dennis Wilson.

Dennis Wilson, Townscape, discussed the numerous opportunities to develop a competitive medical district that has the flexibility to grow and change over time, acting as a major economic driver for the community. Most similar projects and infrastructure for such corridors, he stated, is redevelopment rather than simply new construction. Mr. Wilson introduced Jim Richards.

Jim Richards, Townscape, discussed the project team's initial observations, specifically from a large scale urban landscape and architectural standpoint. Mr. Richards discussed the general study area and how it interacts and revolves around existing structures and facilities. He explained their initial observations for gateways and approaches that would tie into opportunities for recreational amenities, community image and corridor branding.

The floor was then opened for comments and feedback from the committee members.

CM Jana McMillan inquired about the interchange at Highway 6 and Rock Prairie Road, specifically asking if this intersection has been addressed. Mr. Wilson acknowledged her question, stating that highway intersections and other improvements would be addressed through the corridor master plan.

Kirsten Walker applauded the team's presentation. She expressed her excitement for the project and for the potential improvements it would provide for an aging population.

Anne Hazen expressed her desire for the City of College Station to act quickly in developing a catalyst to bring in additional medically-oriented development to prevent resources from leaving the community for other destinations closer to existing medical corridors.

Chuck Ellison spoke in favor of protecting existing providers and expressed his concern that the presentation did not clearly identify what providers the team's presentation provided for. Mr. Wilson addressed his question, explaining that the corridor would create an identifiable market, meeting the market demand for medical and support services inside and outside the initial identified district focus.

Marsha Sanford emphasized the need for additional housing and support services, and stressed that any development should be sensitive to the local climate and environment. This would include all ranges of residential housing to attract a wide variety of retirees and working professionals.

Alicia Dorsey expressed her concern that the current corridor vision would cost a significant amount of money, and was unclear as to where the investment would originate from. Mr. Wilson reminded Ms. Dorsey that the study is only designed to see what elements of a corridor are desirable, and that this work must be done prior to discussing funding mechanisms for potential development. Mr. Ellison inquired again as to why the team's presentation focused on larger metropolitan areas rather than other cities that are commonly used as benchmark cities. He is concerned that College Station does not have a significant enough draw. The project team reminded him that planning for the expanding population is paramount to any corridor success and that only those services that are demanded would be included in the eventual master plan.

Shane Lechler mentioned that the study should take a "hard look" at the serviceable population, including residents from surrounding towns, cities and adjacent counties, before making recommendations, which the team agreed was their intention. Mr. Bodenhamer interjected and stated that, with the College Station

Medical Center and the new Scott & White hospital, the College Station market has already created a functioning medical corridor. He explained that any master plan that emerges from the corridor study would only serve to make the area a better, more readily identifiable district. Ms. Sanford reiterated that she would like to see an increased draw for specialty physicians into College Station. Mr. Bodenhamer and Mr. Baxter assured her that this would be addressed. Jennifer Prochazka suggested that, although the student and senior population will likely remain constant, there currently is no draw for the middle segment of the population. She explained that this middle segment includes those physicians that we are interested in drawing into the community. Therefore, she would like to see any new services within the medical corridor include those that would be attractive to this middle population segment.

CM Dave Ruesink inquired as to where the hard corridor boundary exists. Mr. Wilson and Mr. Richards reminded the committee that there is no hard boundary, but rather only a general boundary exists until feedback is received from the committee and detailed analysis generated by the consultants. Mr. Wilson stated that right now, the City is at a crossroads with the amount of developable property currently available within the proposed corridor, and that the City must take steps to oversee the managed growth of this area to prevent disjointed future development.

James Mason suggested that this project is a great idea to develop a master planned area that continues the natural southward expansion of College Station towards the Navasota River. He explained that he thinks this sort of expansion is natural and inevitable, and that the City should be proactive in developing this area. Mr. Gwin and Mr. Baxtor wrapped up the question and answer segment and adjourned the meeting.

**Medical Corridor Advisory Committee  
Meeting Minutes (5/10/11)  
3:30 PM – 5:00 PM**

Members Present (18):

Rodney Bailey  
Carol Bode  
Sharon Bond  
Patricia Cleere  
Ruth Cohen  
Chuck Ellison  
Frank Hartman  
Anne Hazen  
Tom Jackson  
Nick McGuire  
Jan McMurrey  
Doug Phillips  
Bill Rayburn  
Sheila Rinard  
Marsha Sanford  
Julie Schultz  
Kirsten Walker  
Gentry Woodard

Staff Present (4):

David Gwin  
Debbie Eller  
Eric Stein  
Jennifer Prochazka

Members Absent (19):

Dennis Anderholm  
John Anderson  
Bobby Bains  
Denise Barnett  
James Batenhorst  
Joe Brown  
Angela Clendenin  
Alicia Dorsey  
Eleanor Ebanks

Ed Hard  
Rajesh Harrykissoon  
Shane Lechler  
James Mason  
Jim Morgan  
Tim Ottinger  
Chuck Sanders  
Jon Turton  
Garland Watson  
Randy Yates  
Councilman Dave Ruesink

Guests (3):

Jason Jennings, Chief Executive, Scott & White  
Councilwoman Jana McMillan  
Councilman Dave Ruesink

A. Call to Order. Linda Jordan, SRA, welcomed committee members and guests and introduced the SRA team. Linda reminded the group of topics covered during the February Committee Meeting, as well as those covered during the March Stakeholder Interviews and the April Transportation Coordination meeting with representatives from the Department of Public Works and TxDOT.

B. Presentation and discussion of MCAC Work Plan and results from the Stakeholder Interview Panel. Ms. Jordan summarized the major takeaways from the Stakeholder Interview process and pointed out the key issues that citizens want the corridor study to address.

C. Presentation and discussion of the Medical Corridor Market Analysis. Lee Bodenhamer, Leland Consulting, discussed nationwide trends in healthcare real estate, how medical corridors fit in other urban areas, and how local demographics support the idea and realization of a Medical Corridor in College Station.

D. Presentation and discussion of the Medical Corridor Site Analysis. Jim Richards, Townscape, delivered remarks discussing the analysis that went into the preliminary and current graphics for the corridor study area, including their coordination with existing City Comprehensive and Thoroughfare Plans.

E. Presentation and discussion of Preliminary Medical Corridor Land Use and Concept Development. Dennis Wilson, Townscape, stated that the market and area demographics necessitate the creation of a special district that follows a healthy community theme. Concept analysis suggested increasing utilization of the Barron Road interchange in an effort to alleviate or prevent significant traffic congestion at the Rock Prairie Road interchange.

F. Input from Medical Corridor Advisory Committee members. The floor was opened for questions, comments and feedback from the committee members.

Jana McMillan stated her approval of this type of specialized development and expressed concerns over the number of developers necessary to achieve its implementation. She expressed desire to have corridor development spur local development opportunities.

Gentry Woodard asked for and received clarification on whether this was a district or corridor and added that the Rock Prairie interchange and other points of access must be improved before any corridor development begins.

Chuck Ellison requested more information as to whether or not the concepts, as presented, represent the entire study area, and if the presented concepts were aligned with elements from the City's Comprehensive Plan.

Julie Schultz inquired as to the City's monetary contribution toward corridor development, and expressed her concerns over past, specialized developments that fell through due to low return on investment. Mr. Wilson responded that costs were unknown at this time due to the preliminary nature of the concepts.

David Gwin, ECD Director, reiterated how existing investment by the College Station Medical Center and development by Scott & White created the ideal situation for framing up this type of focused development opportunity.

Marsha Sanford stated that the City must capture this opportunity and develop synergism with similar plans at the Health Science Center, Texas A&M and Bryan in order to prepare for extended-term corridor development.

Kirsten Walker stated that the City must capture investment from senior citizens who are looking to downsize and/or relocate to College Station. She was supportive of the presented concepts.

Jana McMillan inquired about incremental infrastructure development and the expected expense to the City. Mr. Wilson stated that there is already significant infrastructure in place within the corridor study area to accommodate initial sections of this phased development. Additional development would require some additional investment in order to grow as a dynamic medical corridor.

Patricia Cleere requested and received clarification on Mr. Wilson's comments related to the Barron Road interchange. TxDOT is not currently considering additional modifications to this intersection.

G. ADJOURNMENT. Hearing no further questions or comments, Mr. Wilson adjourned the meeting.

**Medical Corridor Advisory Committee  
Meeting Minutes (7/12/11)  
3:30 PM – 5:00 PM**

Members Present (17):

Rodney Bailey  
James Batenhorst  
Carol Bode  
Joe Brown  
Patricia Cleere  
Ruth Cohen  
Chuck Ellison  
Frank Hartman  
Anne Hazen  
Tom Jackson  
James Mason  
Nick McGuire  
Tim Ottinger  
Sheila Rinard  
Marsha Sanford  
Kirsten Walker  
Gentry Woodard

Staff Present (4):

David Gwin  
Debbie Eller  
Eric Stein  
Jennifer Prochazka

Members Absent (20):

Dennis Anderholm  
John Anderson  
Bobby Bains  
Denise Barnett  
Sharon Bond  
Angela Clendenin  
Alicia Dorsey  
Eleanor Ebanks  
Ed Hard  
Rajesh Harrykissoon

Shane Lechler  
Jan McMurrey  
Jim Morgan  
Doug Phillips  
Bill Rayburn  
Chuck Sanders  
Julie Schultz  
Jon Turton  
Garland Watson  
Randy Yates

Guests (2):

Doug Bramwell – Jones & Carter, Inc.  
Lindsey Joy – Scott & White

A. Call to Order

B. Introduction – David Gwin welcomed committee members and guests and introduced the SRA project team. Linda Jordan (SRA) welcomed committee members and guests to the third committee meeting and briefly reviewed the remaining work plan. Her comments included a brief project history, a summary of previously presented concepts, and an update on upcoming opportunities for public comment and engagement.

C. Briefing on CIP Projects in Medical Corridor – Ms. Jordan summarized the major capital improvement projects that are either currently underway, currently in the design phase or currently planned for but not yet funded. These projects include improvements to Rock Prairie Road West and East, Bird Pond Road, Barron Road, Lakeway Drive, the new Scott & White Lift Station, and the Lick Creek Hike and Bike Trail.

D. Presentation and discussion of Land Use Strategies and Design Guidelines – Dennis Wilson (Townscape) updated the committee on the background and guiding principles used to develop the land use

concepts and strategies initially presented to the committee. Mr. Wilson explained that the corridor should be a distinct medical district with integrated parks and open spaces, pedestrian-oriented centers on both sides of Highway 6, and provide for a variety of mixed-use developments. Themes chosen by the City would be carried throughout corridor development and could also be utilized by external stakeholders who want to identify with the health and wellness theme. Mr. Wilson also presented the team's current corridor framework and land use concepts, which were defined very broadly yet established core land use areas near the two major medical providers.

D. Presentation and discussion of Corridor Concepts, Identity, Branding and Streetscapes – Jim Richards (Townscape) delivered remarks on corridor infrastructure and identity concepts and offered several graphic examples of how those concepts might be physically represented in specific elements of corridor development. Additionally, Mr. Richards also offered examples of potential funding sources for establishing and meeting these new development standards and designs.

E. Presentation and discussion of Preliminary Implementation Strategies – Lee Bodenhamer (Leland Consulting) delivered remarks on barriers to corridor implementation, implementation philosophies and principles and the tools and policies necessary for successful corridor implementation. Mr. Bodenhamer emphasized the need for a strong plan, the need for numerous broadly defined public and private development projects, widespread stakeholder involvement and committed ongoing leadership from the City. Mr. Bodenhamer also provided several references to successful corridor projects where these implementation strategies were successfully executed.

F. Input from Medical Corridor Advisory Committee members – The floor was opened for questions, comments and feedback from the committee members.

Kirsten Walker expressed her approval of the corridor plan. She remains concerned about developer support of the corridor.

Anne Hazen expressed her concerns about whether or not current and future City Councils can agree on methods of implementation. She questioned the ability of the community to remain committed to the corridor project based on her experience with past TIF projects.

Chuck Ellison voiced concerns about the project based on his knowledge of the Wolf Pen Creek TIF implementation process. His concerns arise predominantly from the assumption that there is a strong desire for the medical corridor to be developed as a walkable mixed-use district similar to the original intent of the Wolf Pen Creek area.

Marsha Sanford stated that she believes the College Station community has matured significantly since the Wolf Pen Creek project's implementation and is ready to support this project. Additionally, she feels this project already has existing traffic counts and ongoing development to spur the success of the corridor which sets it apart from past corridor projects.

Tom Jackson mentioned that approximately \$400 million dollars in private investment already exists in the proposed corridor area without any City intervention. He feels the existing private investment is extremely significant and that public investment would be a very wise, long-term choice by the City. Nick McGuire asked what the City Council expected to get from the study and subsequent citizen comments.

David Gwin responded that the City Council has tasked City staff with finding ways to diversify development efforts, and medically-oriented development meets this strategic goal. Mr. McGuire commented further that the project is very “do-able” since the anchors (College Station Medical Center and Scott & White) are already in place. He is interested in hearing the City's plan for promoting the project to the general public.

Gentry Woodard voiced his support of the project, but stated his concerns about its success if redevelopment of the Rock Prairie Road intersection with Highway 6 is not completed in a timely manner.

G. ADJOURNMENT. Hearing no further questions or comments, the meeting was adjourned.

**Medical Corridor Advisory Committee  
Meeting Minutes (10/25/11)  
3:00 PM – 5:00 PM**

City Council (5):  
Mayor Nancy Berry  
Julie Schultz  
Dave Ruesink  
Blanche Brick  
Karl Mooney

Staff Present (5):  
Jennifer Prochazka  
Bob Cowell  
Joe Guerra  
Chuck Gillman  
Frank Simpson

Consulting Team:  
Linda Jordan, SRA  
Victor Baxter, SRA  
Dennis Wilson, Townscape  
Jim Richards, Townscape  
Clint Wofford, SRA  
Lee Bodenhamer, Leland

1. Introduction and Project Update
2. City Commitment to the Medical District
3. Update / Public Input on Proposed Rock Prairie Road Bridge Improvements  
Joe Guerra, City of College Station Transportation Planning Coordinator provided information regarding the Rock Prairie Road bridge upgrade.
4. Land Use Concept  
The Consulting Team (listed above) provided a summary of the proposed Medical District Plan and the contents of the document.

5. Identity and Branding  
The Consulting Team (listed above) provided a summary of the proposed Medical District Plan and the contents of the document.
6. Implementation  
The Consulting Team (listed above) provided a summary of the proposed Medical District Plan and the contents of the document.
7. Committee Questions and Input  
The floor was opened for questions, comments and feedback from the committee members.

The terms “Corridor” and “District” have been used interchangeably, what will this area be called? The name is the Medical District. It is a district, encompassing several corridors that a place that people remember and identify as healthy and energetic.

Ben White: There has been past talk of incorporating the medical facilities south toward W.D. Fitch in to the Medical District. How do we do that? - Create a place to create value...which can be then be exported to Fitch or other places further removed. If we start to create a non-cohesive district, it won't stick in peoples mind. Need to focus energy in a specific place.

Anne Hazen : We've had great plans in the past, but never had a consulting team to recruit and market for us. How big of a city do we have to be to have someone do this for us? Are other Cities our size doing this? Lee: we had a list of 15 from millions to 50k population.

Anne Hazen: what do you do with changing councils and lost vision? What do we have to do so that the vision will stay? It's hard to get people behind something because it is a transient community. Lee: Must create a board or committee to oversee it and champion the plan.

Anne Hazen: Do we have the resources here to do this? Recruiting, marketing? Where is the financial backing? Lee: The board will need to raise the funds. Main part comes from private sector (developers, etc.). There is a need for, a market for, housing that is different, something that is not already here. Developers have a certain amount of money for marketing – pool it together with other developers and other land owners. This group will get together; decide on a budget and what to spend it on. Can be Public/private partnership. Purpose of consultant is to help the group get from idea to launch – then you don't need them anymore.

Anne Hazen: How will the City ensure the Plan is followed – keep it and not be changed (if a developer comes in and wants to put all houses here, the Council needs to support the Plan and say “no”). Dennis: need to change the Comprehensive Plan so that it becomes the guide, and then get the municipal management district in place for marketing, identifying priority improvements in the area. Get a TIF established to fund it. There is a lot of value to be captured here (do it in the next year to get some of what may develop around Scott & White). Then property owners and stakeholders in the area will know that the City is serious about the District by their investments. Interest will dwindle if district is not created. Lee: this hasn't happened here before... we believe that it can here...the market and potential are here. A lot of it is dependent on getting the right

kind of housing in place. Talk to developers doing that type of housing – cross generation product. As a society, we are downsizing...people don't want to spend an hour in traffic anymore. Seniors, especially A&M grads, want to stay here for senior housing -don't want to have to move out. After housing is in, services will follow! Dennis: hospitals recruiting won't get best of professionals here without a place like this (College Station doesn't have anything like this now). This many homes to build out will take years! Need the other uses.

Anne Hazen: We need an elementary school in this area!

Lee : the demand for nurses nationwide is huge! Even more than doctors. Technicians also needed to service the medical community.

Anne Hazen: The plan is great, just what do we do to make sure it happens? Lee – need to adopt as part of the Comprehensive Plan. Then create an organization with the right people leading and empower them.

James Murr: Future CIP and financing is critical for us to be able to buy into this Plan. The rooftops needed are in the middle of the Plan area – with no roads and sewer. There is not enough density for this infrastructure to go in without City Help - are these (the list of 9 "What's Next" items in the presentation) all happening simultaneously? Lee: this is a priority list. Have to work together to get the money to get this done (not just public money, either). Dennis: Hospitals will place an emphasis and importance on creating an organization to look out for the district.

Kirsten: This is a wonderful plan if it will happen. It can give a needed identity to this area and to the City.

#### 8. Next Steps

Bob Cowell: We will be working with the Consulting Team in the coming months to develop the planning document. We will still be working with the land owners. The final document will go to City Council for final options (either Comprehensive Plan approval or just endorsement we don't know yet). Over that time, we will also be working through financing options and formation of the district. We don't want to miss out on opportunities that are out there. We will email you and would like you to come to the Council when it moves forward so that the Council and public will know that this is something that this group believes in after working on it.

#### 9. Adjourn

Hearing no further questions or comments, the meeting was adjourned.

## LELAND CONSULTING GROUP



### College Station Stakeholder Interview Notes

Date: 4 April 2011

To: City of College Station

CC: Dave Leland, Leland Consulting Group  
Linda Jordan and Cliff Wofford, SRA

From: H. Lee Bodenhamer, Leland Consulting Group  
Brian Vanneman, Leland Consulting Group

LCG Project: 4836

#### What We Heard - Primary Takeaways

The following are the themes that we heard most consistently throughout the stakeholder interviews:

- **Support for the medical district concept.** Although there were some detractors, many participants recognized that, due to College Station's growing and aging population, more medical services will be needed. Many had visited medical corridors in Houston, Dallas, or elsewhere, and recognized that there is a value to the medical providers and patients when providers are clustered together. Many, though not all, were supportive of the vision for a high-quality physical environment, with attractive gateways, signage, landscaping, etc. Numerous participants stated there is a need for density and the transportation infrastructure needs to be able to move people efficiently. Others expressed concern about limiting the corridor/district to the current scope. Not including the recent St. Josephs College Station campus in the proposed project area is of concern to some, including St. Josephs representatives.
- **An unmet opportunity for senior housing.** In virtually every session, participants expressed a community need for more mid- to high-end senior housing with continuing care in College Station. A number of participants had recently searched for senior housing themselves or for a family member, and because they could not find the right facility in College Station, reluctantly chose facilities in communities elsewhere—in Bryan, Austin, or other cities. Several participants expressed their desire to retire in College Station, and their families want them to be close by. People are looking for communities with a "continuum of care"—that would include a range of housing and service offerings for recent retirees who still want to lead very independent lifestyles to those who need high levels of medical care. Typically, such communities include the following kinds of housing: independent living, assisted living, and skilled nursing. There are probably opportunities for both infill senior housing (on smaller sites, within close proximity to the hospitals) and for larger communities on some of the large vacant properties within the study area. The following communities were mentioned as models: Crestview, Bryan; Watercrest at Bryan (<http://www.watercrestbryan.com>); Brookdale, with numerous locations throughout the state ([www.brookdaleliving.com](http://www.brookdaleliving.com)); Sun City in Georgetown; and

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## LELAND CONSULTING GROUP



Stonebridge. It was suggested there be a sub-committee formed to monitor College Station elderly housing and potentially recruit a quality Continuous Care Retirement company to locate in College Station.

- **Old Aged are moving back!** Stakeholders consistently emphasized that there is a big migration of "old Aged" back to College Station. These retirees are motivated to be back in College Station and are interested in reconnecting with the university, the community, and old friends. This is also the type of demographic that will be very interested in the medical district, and any way that the medical district can be linked together with the university—through signage, branding, events programming, shuttles, Aggie facilities, etc.—will be a positive draw for the district. College Station/Bryan is rated in the top 4 communities in the nation for military retirees by USAA and Military.com
- **"Our phones are ringing every day"—More private sector medical and non-medical organizations want to be in the corridor.** Representatives of the major medical institutions strongly agreed with the premise that additional healthcare providers and developers of secondary uses such as housing are actively interested in locating in the area, and that interest has increased since the announcement of the medical corridor plan—"our phones are ringing every day" with calls from interested parties. Specific potential uses for the near- and medium-term are senior housing, medical office; new specialty and subspecialty clinics such as mental health, oncology, trauma, traumatology, and long-term acute care (LTAC); additional pediatrics, a hotel, NICU (Neonatal intensive-care unit), medical equipment providers, compounding pharmacy, and other uses. One healthcare executive stated that data is available which can identify how many College Station residents are leaving the community to obtain specialized care in the medical districts of Houston, San Antonio, Dallas, etc.
- Healthcare executives stated that, if the public sector could create a solid "framework" through this plan, that the private sector would respond with major investments. They expressed confidence about the medical district vision, and that if the right physical (roads, sidewalks, gateways, etc) and regulatory environment was in place—"if the outside of the puzzle was in place"—then the private sector would fill in the rest of the puzzle. (This is consistent with one definition of successful urban planning: "Public action that generates a sustained and widespread private market reaction." (*The American City: What Works, What Doesn't*, by Alexander Garvin.))
- **Concern about public investment.** Many participants wondered why the City was investing in the medical corridor plan and/or future infrastructure improvements, since they assumed the private sector would build the hospitals and other medical facilities that were needed regardless of public actions. If public investments will be made as part of the this plan, the City and the project team should be prepared to clearly and accurately document the expected economic and fiscal impacts (in jobs created, new property and sales taxes, and other metrics). This will help frame public improvements as investments that generate positive returns rather than optional expenditures. Generally, that minority of participants skeptical of the medical corridor/district concept also raised questions about the funding of the public contribution.
- **Confusion about what a "medical district" is.** Some participants were concerned that a medical district would be a new taxing district, with higher taxes for those living nearby. Some were confused initially about the medical district concept but felt that the consultant team's first presentation did a good job of clarifying the vision.

## LELAND CONSULTING GROUP



- **Confusion about the roles of the Medical District, TAMU Health Science Center, and Research Park.** “Are each of these projects doing the same things in different places?” Participants were confused and worried that each of these areas would be competitive and that thus the public sector return on investment was not being maximized. When it was pointed out that each could have a truly unique role and character—with the Medical District serving as a hub for healthcare delivery, HSC focusing on education for doctors and nurses, and the Research Park focusing on university related research and biosciences—people could immediately appreciate the potential differences and recommended that the City make sure to communicate these differences much more clearly. The close relationship of TAMU HSC to the major community hospitals seems underappreciated.
- **Desire to improve the transportation infrastructure**—to fix current problems and to make sure the roads can handle the future demand introduced by new medical and non-medical development. Current roads were seen as barely adequate or inadequate today, and likely to become much more strained in the future.
- **Rock Prairie Road intersection with Longmire, and Highway 6 Overpass.** This intersection and the overpass were cited consistently as the pieces of the transportation system that were most in need of improvement. Many pointed out that the overpass will need to be rebuilt with sidewalks in order for the east and west sides of the corridor to truly become one district. (It is also possible that some of the improvements discussed below—which are spread over a wider area and are mostly outside of the district—could have a big impact on relieving congestion at this intersection and the overpass.)
- **Limit cut through traffic in Wood Creek and other residential neighborhoods.** Nearby residents were not opposed to new medical uses, but are concerned about significant increases in traffic volumes and speeds through their now-quiet neighborhoods. It is perceived by some that Stonebrook Drive in particular could become a shortcut route, so the City could implement some traffic calming or diversion measures there.
- **More north-south connectivity** on both the east and west sides of Highway 6 is needed. The improvements to Longmire are a good start; another road paralleling Longmire and extending to the south is perceived as needed. Participants wished that Longmire could be extended further south. The City’s East Side Transportation Plan, completed recently, apparently calls for a number of specific transportation improvements within the study area, including widening and improving Rock Prairie Road east of Highway 6 and creating a north-south connector road.
- **Barron Road extension.** Participants felt that a Barron Road extension to the east of Highway 6 was desirable.
- **An extension of Normand Road, along the west side of the Med, is planned.** This could improve connectivity in the district, although it would remove a small amount of land and parking from The Med’s property.
- **Many good plans have been made, but too few have been funded.** (This could be said for most cities.)

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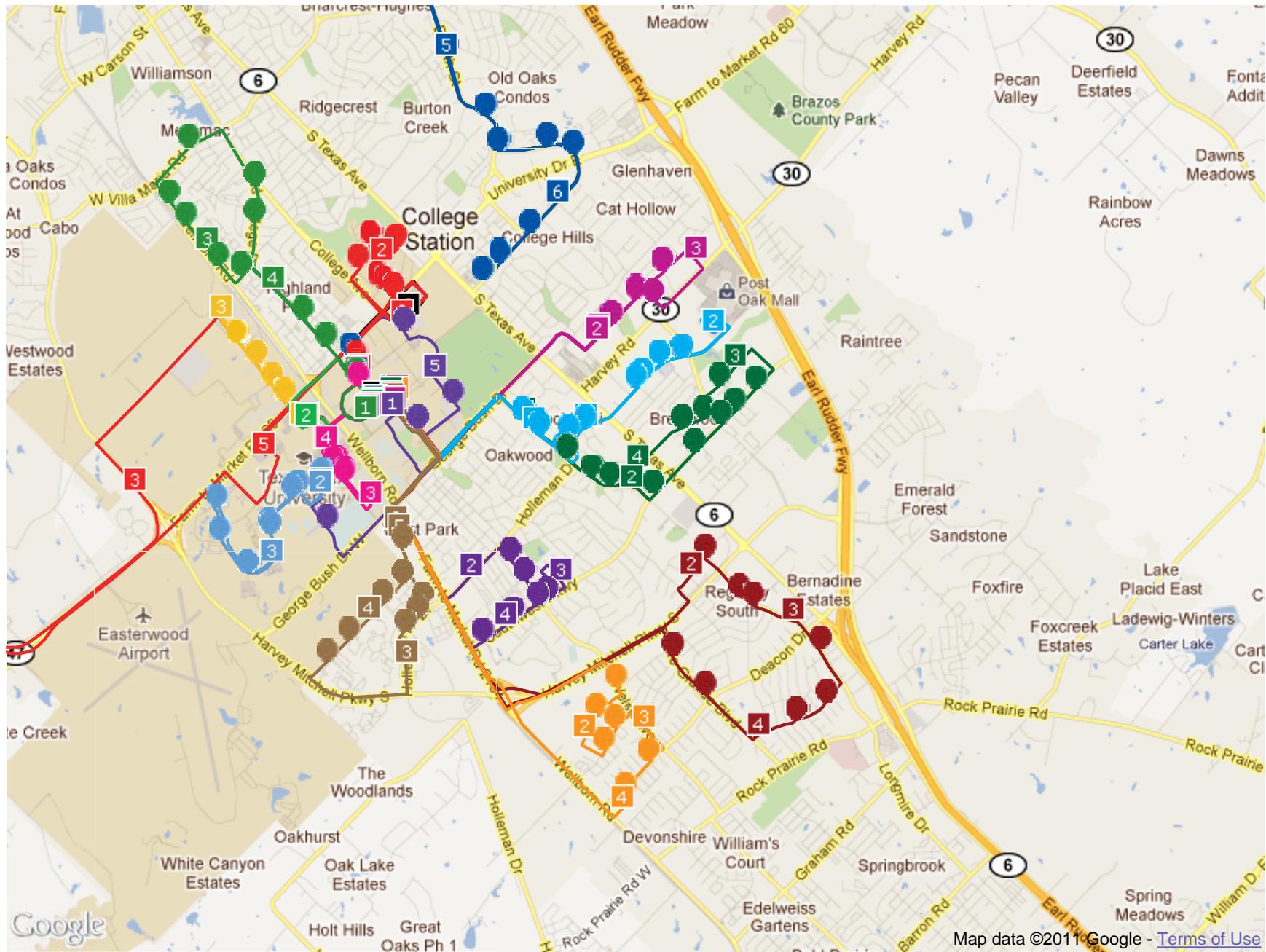


- **Walking and transit—support and skepticism.** Many stakeholders were enthusiastic about opening up more opportunities for walking and transit (and to some degree, biking) in College Station, yet some were very skeptical about large numbers of people use of sidewalks in the medical district.
  - Skepticism about walking was based on two points: first, the heat and humidity, and second, the fact that sick or injured patients and families were not going to walk from one doctor’s office to the next. If extensive sidewalks are to be provided, people emphasized the need for shading and resting points. Despite this, most people were enthusiastic about the City’s program to create green pathways through neighborhoods, and a number of nearby residents really liked the idea of being able to walk to healthcare services, green areas, retail, and restaurants. Crossing Rock Prairie Road on foot between The Med and the medical office buildings to the north was seen as the most dangerous area for pedestrians today, with some pedestrians already attempting to cross there. There was fairly unanimous desire for improvement to the Rock Prairie bridge/overpass.
  - People were divided about the value of a district transit or shuttle system, with some saying that it would make a lot of sense to tie the district together, and others again doubtful about whether people would wait 15 or 30 minutes for a shuttle rather than drive, especially if they were seeing doctors. It was mentioned that St Joseph’s Hospital in Bryan has a golf cart service to pick up patients from their parking lot.

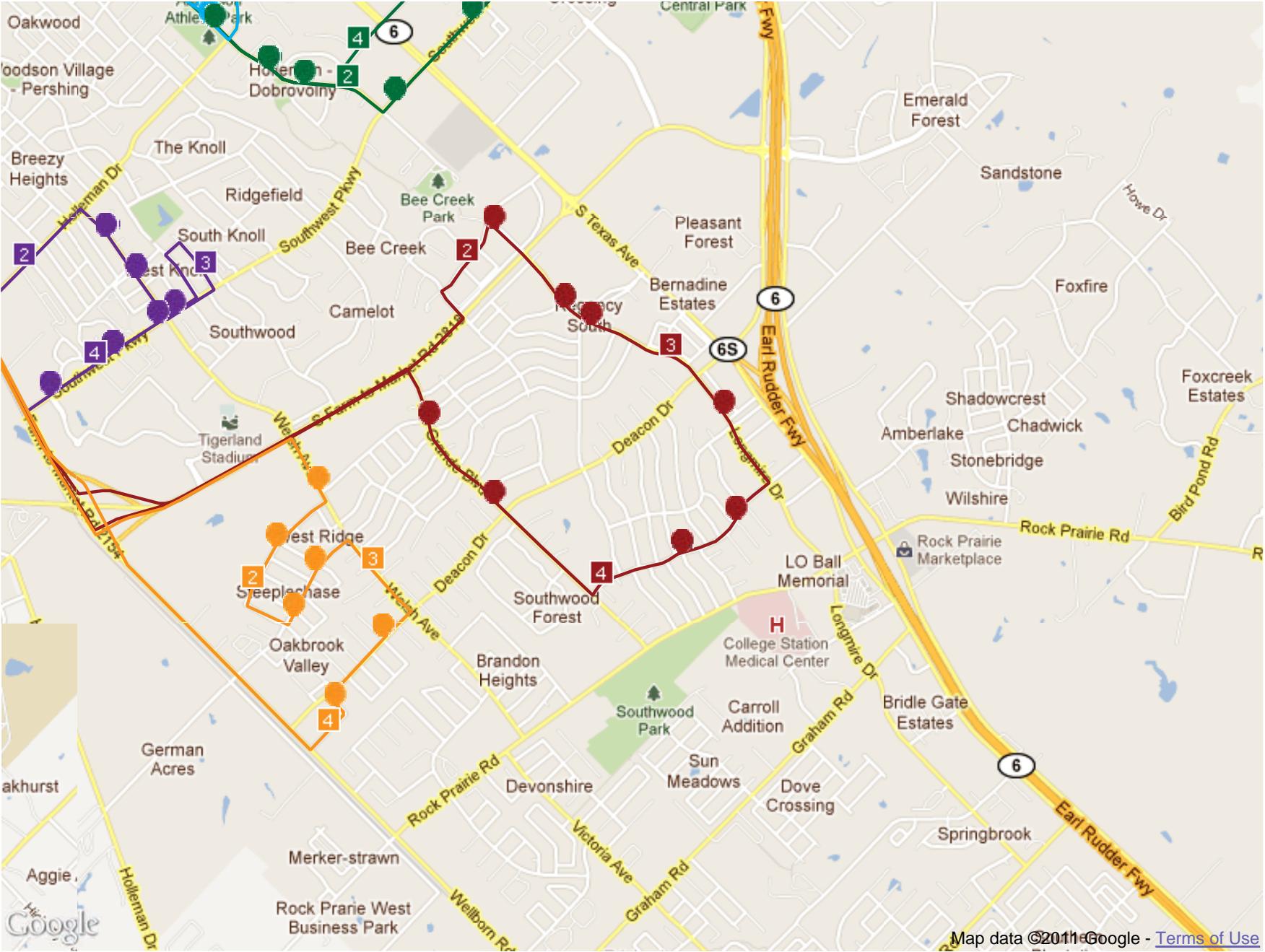
There were a total of eight written comments left by participants and none requested personal follow-up. All written comments have been included in the preceding summary.

In summation, the strongest concerns expressed have to do with the citizen concern with the cost to the city being justified by the value, the immediate need for continuous care senior housing, the necessity to improve mobility in the vicinity of Rock Prairie and Longmire and not further aggravate transportation difficulties in the area, better understanding of the synergy between TAMU HSC and the medical community, and a better understanding of the vision and reality of a dense but planned urban medical corridor/district. And last but not least, the concern on the part of both St Joseph’s hospital and supporters of that medical system that they are recognized and supported for their contribution to the College Station community.

## Texas A&M Transit Route

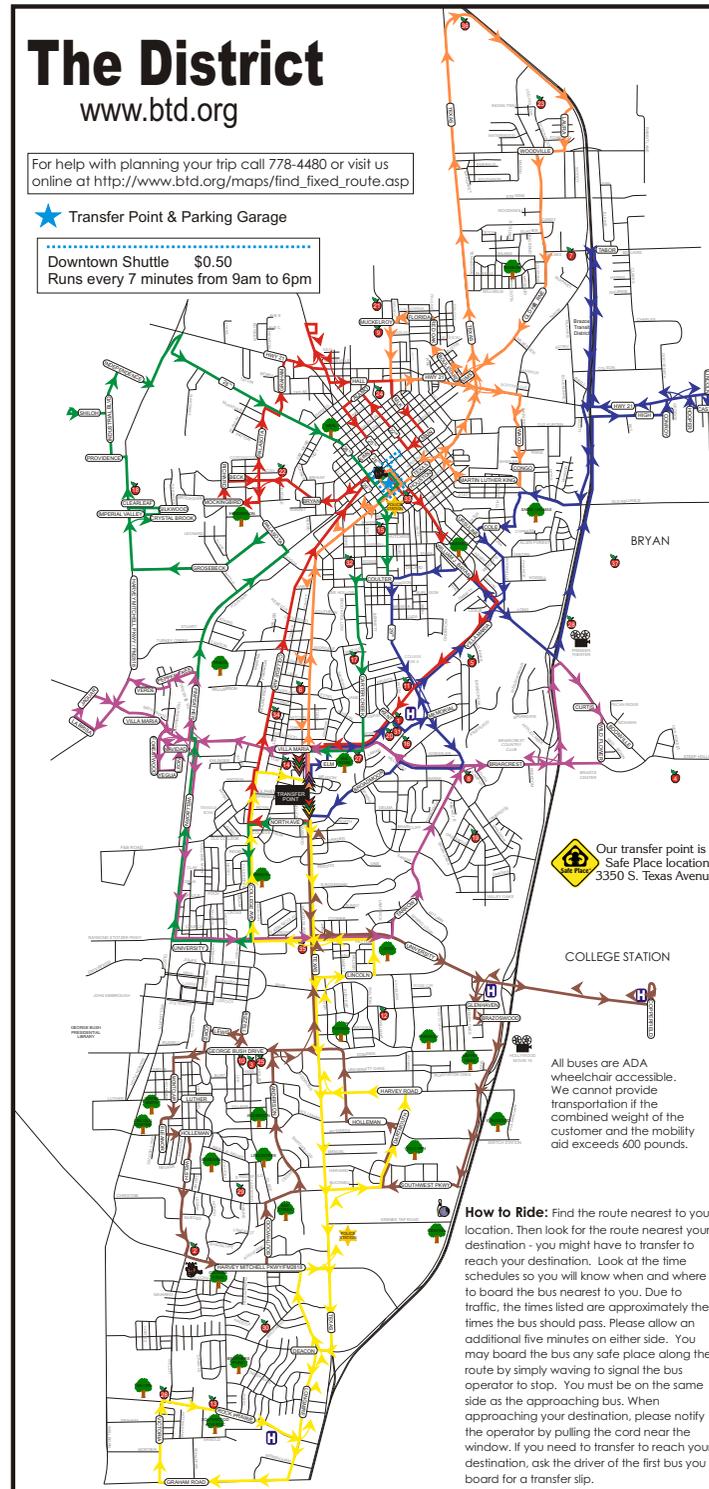


Texas A&M Transit Route Enlargement

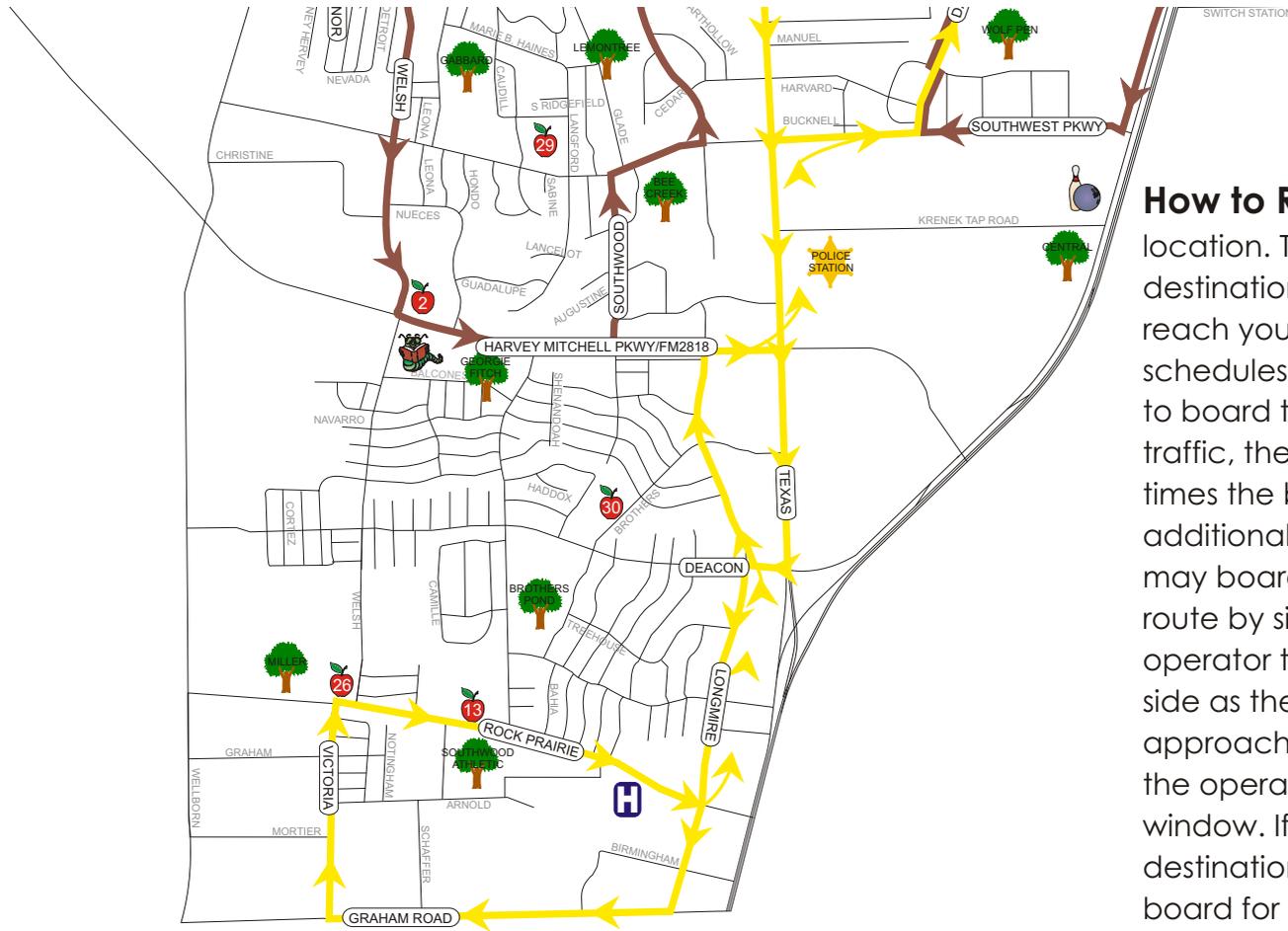


Map data ©2011 Google - [Terms of Use](#)

## The District Transit Route Map



## The District Yellow Route Enlargement



aid exceeds 600 pounds.

**How to Ride:** Find the route nearest to your location. Then look for the route nearest your destination - you might have to transfer to reach your destination. Look at the time schedules so you will know when and where to board the bus nearest to you. Due to traffic, the times listed are approximately the times the bus should pass. Please allow an additional five minutes on either side. You may board the bus any safe place along the route by simply waving to signal the bus operator to stop. You must be on the same side as the approaching bus. When approaching your destination, please notify the operator by pulling the cord near the window. If you need to transfer to reach your destination, ask the driver of the first bus you board for a transfer slip.