Understanding Health Care Districts 
and the Role of LAFCo

A Course for LAFCo Commissioners, 
Staff, and Consultants

3 February 2012
San Jose

COURSE MANUAL 
and MATERIALS
CALAFCO U:

Understanding Health Care Districts
and the Role of LAFCo

3 February 2012

San Jose
Understanding Health Care Districts and the Role of LAFCo

Friday, February 3, 2012
San Jose

COURSE AGENDA

9:30  Check In and Refreshments

10:00  Welcome / Introductions / Overview of Course

   Kate McKenna, AICP, Executive Officer, Monterey LAFCo and Deputy Executive Officer, CALAFCO

   Martha Poyatos, Executive Officer, San Mateo LAFCo

10:10  Overview of Health Care Districts in California: History, Today’s Challenges, Future Directions

   David McGhee, Chief Executive Officer, Association of California Healthcare Districts

   Tom Petersen, Executive Director, Association of California Healthcare Districts

10:40  Break

10:50  The Local Health Care District Law: Regulations, Issues and Trends

   Colin J. Coffey, Partner, Archer Norris, PLC


   Michael G. Colantuono, Attorney, Colantuono & Levin, 3C

12:10  Lunch

12:40  Framework for Evaluating Health Care District Services in the Municipal Service Review Process

   Oxana Kolomitsyna, Managing Partner, Policy Consulting Associates

   Jennifer Stephenson, Principal, Policy Consulting Associates

1:15   Case Study 1: Health Care Diagnosis, Options for Treating an Ailing Agency – Highlights from the Recently Completed Contra Costa LAFCO Special Study: Mt. Diablo Health Care District Governance Options

   Richard L. Berkson, Principal, Economic & Planning Systems (EPS)

1:55  Break
2:00  Case Study 2:  Rural Health Care in California: Soledad Community Health Care District
    Steven Pritt, Chief Executive Officer, Soledad Community Health Care District

2:40  Case Study 3: Building Partnerships and Generating Growth: City of Alameda Health Care District
    Deborah A. Stebbins, Chief Executive Officer, City of Alameda Health Care District

3:20  Open Questions, Summary & Evaluation

3:30  Adjourn
Understanding Health Care Districts and LAFCo's Role

Panel Members
3 February 2012

Moderator

Martha Poyatos, Executive Officer, San Mateo County LAFCo

Panel Members

Richard L. Berkson, Principal, Economic & Planning Systems (EPS)
Colin J. Coffey, Partner, Archer Norris, PLC
Michael G. Colantuono, Attorney, Colantuono & Levin, PC
Oxana Kolomitsyna, Managing Partner, Policy Consulting Associates
David McGhee, Chief Executive Officer, Association of California Healthcare Districts
Tom Petersen, Executive Director, Association of California Healthcare Districts
Steven Pritt, Chief Executive Officer, Soledad Community Health Care District
Deborah E. Stebbins, Chief Executive Officer, City of Alameda Health Care District
Jennifer Stephenson, Principal, Policy Consulting Associates

Curriculum Coordinator

Kate McKenna, AICP, Executive Officer, Monterey LAFCo and Deputy Executive Officer, CALAFCO
**Course Presenter Biographical Information**

Richard L. Berkson  
**Principal, Economic & Planning Systems (EPS)**

Richard L. Berkson is a Principal and founding partner of Economic and Planning Systems (EPS). EPS provides services related to special district formation and consolidation, municipal service reviews, annexation studies, and intergovernmental agreements. Mr. Berkson has collaborated with numerous LAFCOs over the course of his professional career, worked on dozens of governance studies, and has participated in CALAFCO presentations on the incorporation process. He has primary responsibility for many of EPS’s local government fiscal analyses. Mr. Berkson earned a Masters of Public Policy from the Goldman School at UC Berkeley.

Colin J. Coffey  
**Partner, Archer Norris, PLC**

Colin Coffey’s central practice is healthcare law and regulation, representing providers generally, and medical centers, community clinics, skilled nursing facilities, physician groups, and individual physicians. He has served as General Counsel to large and complex medical entities and Corporate Counsel to their boards of directors. Mr. Coffey also practices public entity and political law, emphasizing government regulation, public contracting, and approval.

**Education**
- University of California, Hastings College of Law, J.D., 1983
- University of California, Berkeley, B.A., with great distinction, 1980

**Admission**
- State Bar of California, 1983

**Memberships**
- American Bar Association, Health Law Section
- American Health Lawyers Association
- California Society of Healthcare Attorneys
- Contra Costa Council’s Healthcare Taskforce
- Contra Costa County Bar Association

**Recognition**
- *Martindale Hubbell* AV Preeminent Rating
- President, Contra Costa Bar Association, 2005

**Practices**
- Business
  - Healthcare
- Real Estate, Land Use and Construction
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Michael G. Colantuono
Attorney, Colantuono & Levin, PC

Mr. Colantuono is a shareholder in Colantuono & Levin ("LEV – in"), a municipal law firm with offices in Los Angeles and Nevada County. Chief Justice Ronald M. George presented him with the 2010 Public Lawyer of the Year award on behalf of the California State Bar Association. The Los Angeles Daily Journal named him one of "California’s Top 25 Municipal Lawyers" in December 2011.

Mr. Colantuono is an expert on municipal revenues and argued three recent public finance cases in the California Supreme Court’s: Richmond v. Shasta Community Services District (2004). Bonander v. Town of Tiburon (2009) and Greene v. Marin County Flood Control and Water Conservation District (2010). He will soon argue a fourth case in that court: Alhambra & 46 other Cities v. County of Los Angeles. Michael served on the committee that drafted the League of California Cities’ Proposition 218 Implementation Guide and chaired the subcommittee that drafted what became the "Proposition 218 Omnibus Implementation Act of 1997." He also chaired the League Committee which drafted the Proposition 26 Implementation Guide (April 2011) and is now defending the first major challenge to an electric utility fee under that measure.

Mr. Colantuono is City Attorney of Auburn, Calabasas and Grass Valley and General Counsel of Calaveras and Yuba County LAFCOs and of a number of special districts. He previously served as City Attorney of Barstow, Cudahy, La Habra Heights, Monrovia and Sierra Madre. He serves as special counsel to counties, cities and special districts around California.

Mr. Colantuono served as President of the City Attorneys Department of the League of California Cities in 2003-2004 and appointed the Department’s first Ethics Committee.

Mr. Colantuono served on the Commission on Local Governance in the 21st Century, the recommendations of which led to substantial revisions of the Cortese-Knox-Hertzberg Local Government Reorganization Act. Michael is General Counsel of the Calaveras and Yuba LAFCOs and serves as outside counsel to the Nevada, San Diego and Yolo County LAFCOs.

Mr. Colantuono graduated magna cum laude from Harvard College with a degree in Government and received his law degree from the Boalt Hall School of Law of the University of California at Berkeley.

Mr. Colantuono frequently posts comments on local government and municipal finance topics to Twitter ( @MColantuono ) and LinkedIn ( Michael Colantuono ).
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Oxana Kolomitsyna, MPP
Managing Partner, Policy Consulting Associates

Ms. Kolomitsyna is a co-founder and the lead policy analyst of PCA, where she specializes in service benchmarking studies, economic and growth analysis, and data collection coordination. She has technical expertise in data discovery, regulatory agency research, and review of agency documents, including general plans, financial reports, bond statements and master plans. As a research analyst at Burr Consulting, Ms. Kolomitsyna reviewed fire protection, solid waste, park and cemetery service levels for MSRs. Ms. Kolomitsyna earned her Master’s degree in Public Policy from Pepperdine University where she was a Forstmann Scholar. She received her B.A. summa cum laude from University of Nebraska. Related experience includes:

- Major contributor to the Countywide Water MSR for Santa Clara LAFCo.
- Serving as co-author and coordinator of data collection for Lake Almanor Area of Plumas County MSR.
- Major contributor to the Countywide Second Tier MSR for Alameda LAFCo.
- Co-author of Susanville Sanitary District MSR for Lassen LAFCo.
- Serving as co-author and coordinator of data collection for Plumas County MSRs, which includes healthcare services.
- Co-authored the Yuba countywide MSR on park and cemetery services, coordinated data collection for all services, including water services, and conducted data analysis.
- Co-authored a service evaluation and infrastructure needs assessment project on emergency services for the Southern California Association of Governments.
- Coordinated databases for the regional infrastructure needs assessment project covering 187 cities and a multitude of special districts.
- Conducted analysis of the financial impact of defined benefit pension plans on municipalities.
- Served as an executive director to a Los Angeles-based nonprofit organization.
- Assisted with HIV/AIDS Finance and Cost Effectiveness Study at the Results for Development Institute in Washington, DC.
- Consulted for the Civil Society team at the World Bank on policy sessions at the 2008 Annual Meetings.
- Participated in campaign strategizing and voter response evaluation in California election campaigns.

David McGhee
Chief Executive Officer, Association of California Healthcare Districts

Mr. McGhee was appointed to the position of Chief Executive Officer of the Association of California Healthcare Districts in June 2011. Prior to that appointment, he served nine years as the Chief Operating Officer for the Association with the primary responsibility of managing the ALPHA Fund Joint Powers Agency, a Workers’ Compensation self-insurance pool for the benefit of Health Care Districts and not for profit health care corporations.
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Mr. McGhee earned his Bachelor of Science Degree in Business Administration from Colorado State University.

Tom Petersen  
Executive Director, Association of California Healthcare Districts

Mr. Petersen joined the Association in 2006 as the Director of Business Development for the Association's insurance subsidiary, the ALPHA Fund. In 2009 his duties were expanded to include Government Relations for the Association and in June of 2011, he was appointed to the position of Executive Director.

Mr. Petersen's professional career includes 20+ years as a Hospital/Corporate Executive with Catholic Healthcare West, the largest not-for-profit hospital system in California and the 8th largest in the nation.

Mr. Petersen earned a Masters of Public Administration degree from Golden Gate University, San Francisco and a Bachelor's degree in Business Administration from the University of San Francisco.

Martha Poyatos  
Executive Officer, San Mateo LAFCo

Ms. Poyatos is the San Mateo LAFCo Executive Officer and has been on LAFCo staff since 1993. In her tenure at San Mateo LAFCo she has processed several complex proposals including a fire district consolidation, water district dissolutions, expansion of the Midpeninsula Open Space District and the Mosquito Abatement District and with one exception has prepared all municipal service reviews and sphere updates in-house. She holds Bachelor of Arts Degrees in History and Spanish from S.F. State, a Masters of Public Administration from Cal State Hayward and a certificate from U.C. Berkeley Goldman School of Public Policy Executive Seminar Series.

Steven Pritt  
Chief Executive Officer, Soledad Community Health Care District

Steven Pritt has served as CEO of the Soledad Community Health Care District (SCHCD) since 1998. SCHCD operates the Soledad Medical Clinic, a busy Rural Health Family Practice Clinic, and the Eden Valley Care Center, a 59 bed skilled nursing facility. Steve is also the Executive Director of the SCHCD Foundation, a 501(c)(3) organization.

Steve holds a BS in Business Administration and a Juris Doctorate. He has a total of 34 years of work experience in health care. Steve is also an active member of the community. As a community leader, he is active in the Soledad Chamber of Commerce, a Board member of the Rotary Club, and a past member of the Board at the Salvation Army.
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Deborah E. Stebbins
Chief Executive Officer, City of Alameda Health Care District

Deborah Stebbins was hired as the Chief Executive Officer of the City of Alameda Health Care District d/b/a Alameda Hospital effective November 1, 2007. As CEO, Stebbins provides strategic direction and operational management to the 161 bed general acute care facility serving Alameda and the surrounding area since 1894.

Stebbins has served in a variety of leadership roles in healthcare management for over thirty years. After earning her AB in Political Science from Stanford and her Master of Public Health at the University of California, Berkeley, she began her career as Vice President of Corporate Development with Alta Bates Corporation (ABC). She rapidly moved up administrative ranks within the ABC holding company finally serving as President and Chief Executive Officer of Alta Bates Ambulatory Health Services, Inc.

In 1987 Stebbins was recruited to Seton Medical Center where she served as President and Chief Executive Officer when it was acquired by Catholic Healthcare West (CHW). She then took on responsibility as Senior Vice President and Chief Operating Officer of CHW Bay Area Region, the third largest division of CHW at the time, with seven hospitals which represented over $600 million in annual revenue.

Following her tenure at CHW, Stebbins became Chief Executive of Masonic Homes, a 109 year old non-profit organization providing senior living, health care, residential group homes for children and community outreach to the membership of the Grand Lodge of Free and Accepted Masons of California. During her seven year tenure Stebbins oversaw completion of $70 million in construction, grew the client base by 35%, and established its first strategic plan.

In November 2007, Stebbins took the position of Chief Executive Officer at the City of Alameda Health Care District / Alameda Hospital, a 161 bed general acute care hospital in Alameda, CA. During her tenure she has expanded the hospital distinct part skilled nursing beds with the addition of a free-standing SNF. During FY 2009 she oversaw a financial turnaround from a loss of 2.4 million to a profit of $419,000. She continues to make great strides for Alameda Hospital in developing new programs, implementing cutting edge technology and developing partnerships with other organizations to ensure the long-term viability of Alameda Hospital.

Stebbins is a Certified Administrator, California Residential Care Facilities for the Elderly (RCFE) and holds a California Real Estate Salesperson License. She is a Fellow of the American College of Healthcare Executives and is a member of the Board of Directors of the Hospital Council of Northern and Central California.

Deborah Stebbins resides in Piedmont with her husband, Don. They have two adult children, Charlie and Ashley. She serves in numerous other leadership roles in her church, community and school organizations.
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Jennifer Stephenson, MPP
Principal, Policy Consulting Associates

Ms. Stephenson is a co-founder and principal of PCA, where she is responsible for the overall direction of the projects, regional and municipal research analysis, and financial analysis. She has technical expertise in benchmarking, performance evaluation, municipal budgeting, survey design, statistics, and economic modeling. As research associate at Burr Consulting she conducted performance evaluation studies of water providers in Amador, Calaveras, Butte, and Yuba counties. She has co-authored incorporation studies, annexation studies, and infrastructure needs assessments. She earned her Master’s degree in Public Policy from Pepperdine University, where she was a Forstmann Scholar. Related experience includes:

#
- Project manager for the Countywide Water MSR for Santa Clara LAFCo.
- Major contributor to the Countywide Second Tier MSR for Alameda LAFCo.
- Co-author and project manager of Susanville Sanitary District MSR for Lassen LAFCo.
- Serving as project manager for Plumas County MSRs, including healthcare services.
- Served as project manager for the Amador Countywide MSR, was lead author for review of water services there, and presented findings to the Commission.
- As performance evaluator, reviewed water providers in high-growth Yuba County for the Yuba Countywide MSR, and drafted policy recommendations for the water districts.
- Reviewed water service for the City of Gridley MSR and SOI update, among other municipal services.
- For a regional infrastructure needs assessment for the Southern California Association of Governments, analyzed transportation, air quality, water quality, open space, and parks in the 187-city SCAG region.
- Assisted with fiscal analysis and budget projections for economic and fiscal studies for the City of Beverly Hills.
- Assisted with fiscal analysis and analysis of service levels for governance studies of annexation and cityhood in north Los Angeles County and in East Los Angeles.
- Served as education analyst to the City of Los Angeles Mayor’s Office and prepared school district performance evaluation study for the City of Los Angeles Mayor’s Office.
- Served as an economic development assistant to the Prime Minister at the United Nations Development Program in Georgia (former USSR).
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Welcome
Introductions
Overview of Course

Kate McKenna, AICP, Executive Officer, Monterey LAFCo and Deputy Executive Officer, CALAFCO

Martha Poyatos, Executive Officer, San Mateo County LAFCo

Overview of Health Care Districts in California:
History, Today's Challenges, Future Directions
California Healthcare Districts

History
- Established in 1946
- First Healthcare District - Sequoia
- First District Hospital - Lompoc VMC
- Current # active districts - 76
- ACHD formed in 1951
- Some, but not all, receive property tax $s

District Locations
- Urban
- Rural
- Present in 37 of the 58 counties
Services

- Hospital
- Clinic
- Skilled Nursing/Long Term Care
- Ambulance
- Adult Day Care
- Community Education
- Community Grants

Challenges

- Varies by economic profile of community served
- Physician shortages, primary and specialty
- Technical and professional staff shortages
- Capital formation
- Unfunded state mandates
- Managed care
- Mother Nature on occasion
Future

- Collaborative relationships likely to increase:
  - Marin/Sonoma/Palm Drive Northern California Healthcare Authority
- New Healthcare Districts may form
- Benefit of ACA ???
Break

The Local Health Care District Law: Regulations, Issues and Trends

California Healthcare District Powers and Authority

(Excerpts from the Local Healthcare District Law, Health & Safety Code Sections 32000 et seq., 32121)
Health Facilities, Programs and Services

To establish, maintain, and operate, or provide assistance in the operation of, one or more health facilities or health services, including, but not limited to, outpatient programs, services, and facilities, retirement programs, services, and facilities, chemical dependency programs, services, and facilities, or other health care programs, services, and facilities and activities at any location within or without the district for the benefit of the district and the people served by the district.

Anything That Promotes Good Health

To establish, maintain, and operate, or provide assistance in the operation of, free clinics, diagnostic and testing centers, health education programs, wellness and prevention programs, rehabilitation, aftercare, and any other health care services provider, groups, and organizations that are necessary for the maintenance of good physical and mental health in the communities served by the district.

Any Business Vehicle

To establish, maintain, and carry on its activities through one or more corporations, joint ventures, or partnerships for the benefit of the health care district.
Health Insurance / Plans

- To establish, maintain, operate, participate in, or manage capitated health care plans, health maintenance organizations, preferred provider organizations, and other managed health care systems and programs properly licensed by the Department of Insurance or the Department of Corporations, at any location within or without the district for the benefit of residents of communities served by the district.

Subsidize Physicians for Recruitment

- Guarantee of minimum income and necessary equipment purchases; Reduced rental rates for office space; Other incentives.

Subsidize Physicians for Recruitment

- (a) Notwithstanding any other provision of law, a hospital district, or any affiliated nonprofit corporation upon a finding by the board of directors of the district that it will be in the best interests of the public health of the communities served by the district and in order to obtain a licensed physician and surgeon to practice in the communities served by the district, may do any of the following:
Provide Services by Contract or Grants

(a) The board of directors of a hospital district or any affiliated nonprofit corporation may do any of the following when it determines that the action is necessary for the provision of adequate health services to communities served by the district.

Provide Services by Contract or Grants

• (1) Enter into contracts with health provider groups, community service groups, independent physicians and surgeons, and independent podiatrists, for the provision of health services.

• (2) Provide assistance or make grants to nonprofit provider groups and clinics already functioning in the community.

• (3) Finance experiments with new methods of providing adequate health care.

To Hold Assets / Property Anywhere

• To purchase, receive, have, take, hold, lease, use, and enjoy property of every kind and description within and without the limits of the district, and to control, dispose of, convey, and encumber the same and create a leasehold interest in the same for the benefit of the district.
Operate Ambulances

To acquire, maintain, and operate ambulances or ambulance services within and without the district.

Support Activities for Health Facilities, Nursing Schools, Child Care

To do any and all things that an individual might do that are necessary for, and to the advantage of, a health care facility and a nurses’ training school, or a child care facility for the benefit of employees of the health care facility or residents of the district.

Anything Advancing Any Of These Activities

To do any and all other acts and things necessary to carry out this division.
Questions?

ARCHERNORRIS
A PROFESSIONAL LAW CORPORATION

Contact Information

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The Cortese-Knox-Hertzberg
Local Government
Reorganization Act and Public
Finance and Taxation Law:
Applicability to Health Care
Districts
Extra-Territorial Service

- Express power to act outside District (HSC 32121):
  - Operate a health plan (r)
  - Provide health care facilities & services (j)
  - Own or lease property (c)
  - Ambulance service (l)
- Other powers impliedly limited to District territory, but how significant are these?
- This is a contested issue.

District Territory

- Need not be contiguous (HSC 32001)
- Must exclude territory not benefited (i.e., uninhabited)
- Annexing territory excluded during formation process due to lack of benefit requires findings (GC 58106)
- May be multi-county (HSC 32001)
- No overlapping districts without consent of the first district unless principal act says otherwise (GC 56119)

Relationship to Other Govts

- Subject to zoning power of city or county
  - 55 Ops. CA AG 375 (1972)
- Medical operations subject to regulation by a variety of state health care agencies, such as OSHPOD, Department of Insurance, etc.
Power to Change their Name

- HSC 32137 allows a Health Care District to change its name by a resolution filed with the County Clerk
- Other laws require all government agencies to register with the Secretary of State

Financial Powers

- Property taxes (HSC 32200 ff.)
- Special taxes: 2/3-voter approval (HSC 32240; GC 53730.5 ff)
- Bonded debt
  - Capital facilities & coinsurance plans (HSC 32300)
  - Revenue bonds (HSC 32315)
  - State bonds (HSC 32350)
- Appear to lack assessment authority
- Substantial revenues from fees for service, health plans, third-party payments, etc.

Formation, Reorganization

- Governed by principal act (HSC 32200)
  - In re Valley Health System, 429 B.R. 692 (Bkcy CD Cal. 2010)
- But CKH can fill gaps in the principal act (id.)
Formation, Reorganization

- If LAFCo receives application to form or reorganize a HCD, it must give notice to state health agencies, one of which no longer exists (GC 56131.5)

- Dissolution requires voter approval (GC 57103) as does transfer of > ½ an HCD's assets (HSC 32121(p))

More on Formation, Reorganization

- Principal Act refers to the District Organization Law
  - HSC 32002 & GC 58030 ff.

- Formation process
  - Petition (GC 58030)
  - Board of Supervisors of largest county (by territory of district) serves as "supervising authority"

More on Formation, Reorganization

- Election (GC 58130 ff.)
- Uniform District Election Law applies (HSC 32002)
- LAFCo provides impartial analysis (HSC 32002.31)
Contested Questions

- Is a HCD subject to LAFCo's power to approve out-of-district service under GC 56133?
  - Broad express powers to act outside district may make this a rare question
  - Where principal act impliedly limits power to within district, the power may be entirely lacking, with or without LAFCo's approval

Contested Questions

- SD LAFCo took the position that it does have this power and affected HCD acquiesced.
- This is a hotly contested issue. Clearly HCDs were intended to compete with private actors, but with each other?

Dissolution

- 2011's AB 912 amended GC 57077(b) to allow dissolution of most special districts without an election.
- There is debate as to whether this applies to HCDs given GC 57103.
How Much Power Does LAFCo Have?

- Certainly has power and duty to approve MSR, SOI & reorganizations.
- Does not control formation, but may be able to do so in the context of a reorganization.
- Dissolution or sale of most assets requires voter approval.
- Difficult role in refereeing disputes between HCDs as to their extra-territorial activity.

LAFCo Power Continued

- LAFCo has a bully pulpit via MSR & SOIs
- Some HCDs are attracting attention due to competition for scare property tax dollars and are therefore vulnerable to criticism if LAFCo, grand jury or others conclude they are not serving the public interest.
- Like all CA governments, HCDs have a need to engage the public they serve and LAFCo can help them do so.

Questions?

Colantuono & Levin, PC
Contact Information

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Lunch Break

Framework for Evaluating Health Care District Services in the Municipal Service Review Process
Framework for Evaluating Health Care Districts

To Be Covered:

- LAFCO's Role Among Other Regulating Agencies
- Challenges of Reviewing Healthcare Districts
- Service Review Requirements
- Criteria to Make the Necessary Determinations
- Issues for LAFCOs to Address

Regulating Agencies of Health Care Providers

- Drug Enforcement Agency
- U.S. Department of Health and Human Services/Health Insurance Portability and Accountability Act (HIPPA)
- Office of Statewide Health Planning and Development (OSHPD)

Regulating Agencies of Health Care Providers (cont.)

- California Department of Public Health
- U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services
- Accreditation Agencies
- LAFCO
The Challenges of Reviewing Health Care Districts

- Varying type and extent of services provided
- Lack of knowledge about LAFCOs and service requirements
- Outdated or unavailable medical indicators from OSHPD
- Size of each agency, which are often run like a business or corporation
- Multitude of competitor providers

Legally Required MSR Determinations

- Growth and Population Projections for the Affected Area;
- Present and planned capacity of public facilities and adequacy of public services, including infrastructure needs or deficiencies;
- Financial ability of agencies to provide services;

Legally Required MSR Determinations (cont.)

- Status of, and opportunities for shared facilities;
- Accountability for community service needs, including governmental structure and operational efficiencies; and
- Any other matter related to effective or efficient service delivery, as required by commission policy.
Data Sources

- The District
- OSHPD
- Accreditation Resources
- Center for Medicare and Medicaid Studies

Present and Planned Capacity

- Capacity Defined As: Beds, Facilities, Physicians, Equipment and Vehicles, Staff, Available Grant Funds
- Demand Defined As: Total Patient Days, Clinician Visits, Type and Number of Procedures Performed, Physician Hours Billed, Grant Funds Applied For
- Remaining Capacity: Analysis or Self-Reported, Emergency Room Wait Times (could be applied to other procedures as well)

Infrastructure Needs and Deficiencies

- Facilities and Their Condition
- Up-to-date Equipment and Its Importance
- Preventative Maintenance and Replacement Planning
  - Reserves and Budgets
  - Capital Improvement Plans
Financial Ability

- Revenue Constraints
- Portion of Revenue Going Towards Health Care Programs
- Reserves
- Long-Term Debt Ratio

Financial Ability (cont.)

- History of Bankruptcy
- Financing Challenges for Healthcare Districts
- How to Determine if a District is in Fiscal Distress - It's All About Marqin, Baby!
- http://www.oshpd.ca.gov/HID/Products/Hospitals/AnnFinanData/PivotProfiles/default.asp

Financial Ability (cont.)
Financial Ability (cont.)

Accountability

- Constituent interest in the agency's activities as indicated by the rate of contested elections
- Agency efforts to engage and educate constituents through outreach activities in addition to open meeting and public record laws

Accountability (cont.)

- Cooperation with the MSR process and information disclosure
- Established process to address complaints
- Website where the District makes information available to the public
Service Adequacy

- Extent of Services Offered
- Challenges to Providing Services as Identified by the Agency
- Achievement of Goals as Established by the District

Service Adequacy (cont.)

- Planning and Management
  - Evaluate employees annually
  - Periodically review agency performance
  - Prepare a budget before the beginning of the fiscal year
  - Conduct periodic financial audits to safeguard the public trust
  - Maintain relatively current financial records
  - Conduct advanced planning for future service needs
  - Plan and budget for capital needs

Service Adequacy (cont.)

Evaluating Service Adequacy Greatly Depends on the Services Provided by the District

- Hospitals
- Primary Care/Specialty Clinics
- Long-term Care Facilities
- Home Health and Hospice
- Grant-giving
- Facilities Managed Through a Contract
- Other Health Support Services (i.e., paratransit, and ambulance services)
Hospitals

- Treatment Response Rates to Heart Attacks and Pneumonia
- Prevention Quality Indicators
- Hospital Occupancy Rates
- Mortality Rates Related to Other Conditions
- EMS Ambulance Diversion Rates
- Operating Room Use
- The Extent To Which Residents Go To Other Hospitals for Service
- Accreditation Information

Primary Care/Specialty Clinics, Long-term Care Facilities, and Home Health and Hospice

- Patient Satisfaction/The Extent to Which Residents Go To Other Clinics for Service
- Accreditation Information

Primary Care/Specialty Clinics, Long-term Care Facilities, and Home Health and Hospice

- Prevention Quality Measures
  - Asthma patients receiving optimal care
  - Patients (ages 51-75) receiving appropriate cancer screening tests
  - Patients with diabetes receiving optimal care
  - Patients with high blood pressure receiving optimal care
  - Children (age 2 and under) receiving recommended immunizations
  - Patients with vascular disease receiving optimal care
Grants

- Rate of Project Delivery (percentage of funded projects fully delivered)
- What percentage of funds available goes toward overhead?
- Effective Grant Management
  - Internal control systems
  - Pre-grant review
  - Pre-award process
  - Managing performance
  - Assessing and using results

Operated Through Contract

- Evaluate the services as though they were provided by the District directly
- What percentage of funds is used for administration of the District?
- What are the Contract Terms?
  - How are public funds being used?

Using the MSR in Helping Healthcare Districts to Improve Their Services

- Reviews need not be punitive, but should make clear concise recommendations for improvement
- Information is invaluable for empowering the Districts
- Require Districts to make reports back to LAFCO on actions taken pursuant to MSR recommendations
- Provisional SOI
Issues That May Need To Be Addressed in the MSR

- Defining a District’s Service Area
- Defining Population Served When There Are Other Providers in the Area
- Evaluating and Determining a Need for Districts That Are Not Providing Services
- Determining an Appropriate SOI
- Gauging Endorsement of District’s Role in the Community

Questions?

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Health Care Diagnosis, Options for Treating An Ailing Agency –
Highlights from the Recently Completed Contra Costa LAFCo Special Study: Mt. Diablo Health Care District Governance

Purpose of the Study

- Addresses past and ongoing community concerns about whether MDHCD should continue as a district, including three Grand Jury reports.
- A "Special Study" (or MSR) is required before dissolution or consolidation of a district.

Purpose of the Study

- LAFCO determinations per GC §56881(b):
  - Public service costs after change are less than or similar to alternatives.
  - Dissolution or change of organization would promote public access and accountability.
Mt. Diablo Health Care District (MDHCD)

- Formed in 1948 as the Concord Hospital District.
- In 1994 renamed "Health Care District".
- Annexed Martinez in the 1950's.
- Boundaries: Martinez, Lafayette (portions), Concord, Pleasant Hill (portions), and unincorporated Clyde and Pacheco.

Mt. Diablo Health Care District (MDHCD)

- Two prior proposals to dissolve MDHCD in 1972, 1976.
- Receives $245,000 in property taxes, and $25,000 from John Muir Health annually.
- In 1996 entered into Community Benefits Agreement (CBA) and transferred assets to John Muir Health.

MDHCD Boundaries
Summary of Findings


- In 2011, 50% of expenditures spent on Community Action.

- After fund balance depleted, $160,000 or 58% of $276,000 operating revenue available for Community Action (before election costs or FT Executive Director).

Summary of Findings

- Newly-hired Executive Director could help address past operational, access and accountability problems.

- After Executive Director costs, elections, and legal costs, minimal operating revenue available for Community Action.

Summary of MDHCD Revenues and Expenditures

[Graph showing revenues and expenditures over time]
Summary of Findings

- Assets (cash and short-term investments) were $830,000 at end of 2010.

- Estimated balance of $787,000 at end of 2011.

- Long-term liabilities for lifetime health insurance benefits in excess of $800,000 at end of 2010.

Summary of Findings

- Insurance costs reduced because of recent changes, but liability remains.

- Additional Executive Director costs ($120,000 annually) plus current $120,000 overhead would consume nearly all recurring $265,000 operating revenue.

Possible Changes of Organization

- Maintenance of status quo.

- Consolidation with another "unlike" or "like" district.
  * e.g., Los Medanos Community Healthcare District.

- Dissolution and appointment of a successor for winding up purposes only.
  * e.g., City of Concord or CSA EM-1.
Possible Changes of Organization

- Dissolution and appointment of a successor to continue health care services within the district.
  - e.g., CSA EM-1.

- City of Concord considered, but cannot form a subsidiary district for healthcare purposes (City less than 70% of current MDHCD boundary).

Status Quo

Advantages

- MDHCD continues to pursue improvements in the provision of local health care.

- MDHCD provides oversight of CBA & participates in HCF.

- Hiring of Executive Director likely to improve operations.

Status Quo

Disadvantages

- High expenditures for overhead (80–90% of operating revenue) assuming ongoing Executive Director costs.

- MDHCD at risk of continuing past practices, including lack of Community Action programs.
Consolidation - MDHCD/LMCHD

- Advantages
  - Existing territory served by MDHCD would continue to be served by successor district.
  - Revenues of the two districts could be used to enhance services of the combined district.
  - Economies of scale result in reduced administrative costs.

- Disadvantages
  - Property tax expended by new, larger district, potentially reducing benefits to MDHCD taxpayers.
  - Reduced local representation.
  - Likely political opposition to consolidation.

Dissolution - Winding Up MDHCD Affairs

- City of Concord (greatest a.v.) or CSA EM-1 (by LAFCO transfer of assets).

- Advantages
  - Elimination of MDHCD admin. Expenses.
  - Existing MDHCD property tax revenues revert to other agencies (after payment of MDHCD obligations).
Dissolution – Winding Up MDHCD Affairs

- Disadvantages
  - No further provision of current MDHCD health-related services.
  - MDHCD property tax no longer available for health care.
  - Loss of CBA provisions, including oversight of facilities and licenses, and participation in CHF grant process.

Dissolution – Successor Continues Services

- CSA EM-1 designated as successor.
- Advantages
  - Existing territory served by MDHCD would continue to be served by a new EM-1 zone.
  - Elimination of MDHCD admin. expenses, elections, funds become available for health care.
  - Continue to use property taxes for health care in area, and provide for an advisory board representing area.

Dissolution – Successor Continues Services

- Professional staff to implement policies and programs.
- Continuation of CBA provisions, including oversight of facilities and licenses, and participation in CHF grant process.
Dissolution – Successor Continues Services

- Disadvantages
  - Primary function of EM1 is ambulance service, with some related training services (CPR, defibrillators).
  - One or more cities could opt out of "zone", potentially reducing property tax increment in the future.
  - Reduced local representation.
  - Some additional staff costs to facilitate public process, i.e. 0.5 to 0.8 FTE, offset savings.

About CSA EM-1

- CSA EM-1 administered by the Contra Costa Health Services Department.
- 1989. CSA EM-1 was established Countywide to:
  - Provide funding for enhancement of emergency medical services.
  - Expand paramedic services.
  - Upgrade the EMS communications system.
  - Provide additional medical training and equipment for fire first responders.

About CSA EM-1

- EM-1 is authorized to provide emergency medical services and "miscellaneous extended services".
- CSA EM-1 was approved by all cities within the County.
Dissolution Process

- At a noticed public hearing, LAFCO:
  - Accepts the special study.
  - Considers adopting a zero SOI.
  - Considers making findings in accordance w/Special Study.
  - Considers adopting a resolution initiating dissolution.

Dissolution Process

- LAFCO notifies State agencies and allows a 60-day comment period.
- At a noticed public hearing, LAFCO considers approving dissolution.
- Following 30-day reconsideration period, LAFCO staff holds protest hearing.
Dissolution Process

- Absent requisite protest, Commission orders dissolution after determining whether an election is required.

- If there is no election or the dissolution is approved by the voters, LAFCO staff:
  - records dissolution paperwork.
  - files with the State Board of Equalization making dissolution effective.

Dissolution Process

- Allocation of property taxes, pursuant to LAFCO Terms and Conditions, would be contingent on County formation of EM-1 zone and creation of advisory board.

Recommendations

- Justification exists for dissolution of MDHCD based on the low portion of revenue available for health care.

- Options exist that could better utilize existing MDHCD resources.

- City as successor to continue MDHCD services rejected because of inability to create subsidiary district, and because of limited service area.
Recommendations

- Consolidation with LMCHD considered, but it would likely encounter high degree of political opposition.
- Dissolution/appointment of CSA EM-1 as successor represents best option for continuing services with substantial reduction in current overhead costs.

LAFCO Hearing 1/11/12

- Public testimony
  - City of Concord expressed strong desire to be the successor and provide ongoing services via a subsidiary district (after boundaries of MDHCD were reduced).
  - CSA EM-1 representative indicated lack of interest and recommended City of Concord.
  - Speakers from other cities expressed interest in ongoing discussions.

LAFCO Hearing 1/11/12

- Commission:
  - Accepted Special Study.
  - Adopted zero sphere.
  - Requested staff to return to next meeting (2 months) with further options for dissolution with successor to provide ongoing services.
Questions?

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Break
Rural Health Care in California: Soledad Community Health Care District

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Building Partnerships and Generating Growth: City of Alameda Health Care District

Outline

- Organizational History
- District Formation
- City of Alameda
- Financial Overview / Key Challenges
- Strategic Vision & Strategies for Success

Organizational Overview

- Hospital and District essentially one in the same
- 161 bed facility: 100 Acute Care Beds, 35 Subacute Beds, 26 Skilled Nursing Beds
- 90% board certified active medical staff
- 575+ employees, one of the largest employers in Alameda
- Nearly 36% of its employees live in Alameda
Organizational Overview

- 5 unions: CNA, ILWU, OPEIU, Operating Engineers, SEIU UHW West
- 560 million annual expense budget
- Emergency Room Visits – 13,500
- Surgeries – 4,400
- Outpatient Visits – 23,000

Formation of the District & Parcel Tax Revenue

- Highly, competitive urban environment dominated by two systems
- Geographically "isolated" community
- District status sought as alternative to joining system
- Intensive six month campaign from LAFCo application to election
- Reorganization / Parcel Tax passed by 2/3 vote
- Strong community support for emergency room and local acute care beds.

District Board Composition

- Five (5) Publicly Elected Board Members
- November 2010 General Election – two new Directors elected
- Board Meetings are open to the Public
- Meeting information can be found on our website at alamedahospital.org
Alameda Hospital: An Abbreviated History

1894 Founded as 6 bed Alameda Sanatorium
1925 110 bed hospital built on Clinton Avenue
1939 Reorganized as not-for-profit hospital
1955, 1968, 1983 expansion to current footprint
2002 By 2/3 vote of electorate, approved establishment of City of Alameda Health Care District supported by $298 annual parcel tax
2008 Alameda Hospital acquires South Shore Convalescent Hospital (SNF)
2009 Hospital open 1206 (b) Community Clinic
2010 Hospital moves forward with expansion of Long-Term Care and other specialty programs

Core Service Area

Total Population: 72,000
Main island: 58,600
Bay Farm Island: 13,400

Secondary Service Area
Attributes of Service Area

- Solid middle class community - good schools, recreational opportunities, shopping, restaurants
- Many residents established ties as result of time of Alameda Naval Air Station (largest on the West Coast at the time)
- Influx of well-educated, affluent professionals
- Very little reason people come to Alameda from off the island

Attributes of Service Area

- Island residents don't want to leave the island
- Historical inclination toward slow to no growth
- Many 4th & 5th generation families
- Increasing ethnic diversity; Asians = largest non-Caucasian subset
- Only population growth forecasted is in > 65 population
- Potential development of Alameda Point - 4,000 new residential units

Market Share – Main Island

<table>
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<th>Hospital</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
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</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
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</tbody>
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Physician Composition

- 70 active staff - 90% boarded or double-boarded
- Affinity IPA is predominant physician contracting vehicle
- One core primary care group on island
- Outstanding 24/7 hospitalist coverage
- Addition of 1206(b) Clinic in 2009
- Specialists with on island offices
  - Dermatology, Vascular, GI, Cardiology, OB-GYN, Ortho, Ophthalmology, General Surgery, Pulmonary, Neurology

Seismic Status

Alameda Hospital has a total of eight building structures, three of which do not comply with the January 2015 seismic standards. The three buildings that do not comply are: the "East" building (Bldg. 1 & original hospital), the Erasmus Wing (Bldg. 2), built in 1950 and the West Wing (Bldg. 3), built in 1947.

Overall, and compared to many other hospitals in the Bay Area, the extent of seismic work that needs to be performed in order to comply with the 2013 seismic standards is relatively small (approximately $10 million).

The hospital has engaged RS&H Architects who are developing the construction documents for OSHPD review. The hospital has also engaged a construction management firm, JRC CM, to coordinate and manage the entire project. Our largest challenge at this juncture is the hospital's ability to obtain capital financing.

Financial Picture
Revenue and Expenses

Challenges
- Basic Hospital surrounded by “full service” medical centers
- Not perceived as a “real” hospital
- Challenge to secure key specialists
- Primary market acute care demand alone is too small to support necessary infrastructure
- Need to generate sufficient earnings to meet capital needs (e.g. seismic and EHR development)
- Need for creative partnerships with other providers

Strategic Vision
- To serve as the primary resource for high quality healthcare services for Alameda and surrounding communities
  - Serving as a direct provider
  - Acting through partnership, and
  - Working as a facilitator to ensure community access to a full spectrum of health care resources
Strategies for Growth/Partnering

- Develop more Specialty Programs
- Continuum of Partnerships:
- Lease out space for "niche" service
  - (e.g. Geriatric Center of Excellence; Pediatric Subacute; Adult Eating Disorders, Bariatric or Plastic Surgery)

Strategies for Growth/Partnering

- Contract out for distinct program (e.g. with Kaiser, ACMC)
- Joint Powers Agreement (with other government entity/ies)
- Merger or complete assimilation with another entity or system

Waters Edge, Alameda, CA
New Program Development and Expansion

- Subacute Care / Center for Excellence for Senior Care
  - Niche services available to Bay Area wide referrals
  - Home centered care for residents and families with chronic neurological impairment
  - Patients alternatively cared for in critical care

New Program Development and Expansion

- Water Edge Skilled Nursing Facility
  - Supports Strategic Vision to broaden revenue and scope of services to support infrastructure needs of acute hospital
  - Extends the continuum of services on island for seniors and long term care residents/patients
  - Allows for expansion of our revenue base in distinct-part skilled nursing business line.
  - High level of Return on Investment due to minimal up-front costs and favorable reimbursement

New Program Development and Expansion

- Wound Care Program
  - Outpatient focused care for patients with chronic non-healing wounds
  - Senior and diabetic patients are specific targets
  - Significant procedural spin-off: hyperbaric oxygen chamber, surgical procedures

- Stroke Center
  - Joint Commission Primary Stroke Center
Community Outreach

- Stroke Education and Outreach Program & Community Stroke Risk Assessments
  - Blood Pressure, Blood Glucose, Total Cholesterol, BMI, EKG, Stroke video, and individual risk counseling /signs and symptoms education.
- Disaster Preparedness
- AUSD Walk and Roll to School
- Annual Community Health Fair
- Bike Helmet Program for AUSD Elementary Children

Community Outreach

- "Let's Move Alameda" Childhood Obesity Program
- City of Alameda Vial of Life
- Flu Vaccination Program
- Interface with public safety and education within the City of Alameda
- 3 B's Assessment (Blood Pressure, Blood Glucose, Body Mass Index)

Questions?

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David McGhee, Chief Executive Officer, Association of California Healthcare Districts

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- Marin/Sonoma/Palm Drive Northern California Healthcare Authority,
  Marin Independent Journal Article, December 2011

Colin J. Coffey, Partner, Archer Norris, PLC

The Local Health Care District Law: Regulations, Issues and Trends

- California Health & Safety Code Sections 32000 – 32492 (Table of Contents)
- California’s Health Care Districts, Prepared by Margaret Taylor, April 2006

Jennifer Stephenson, Principal, Policy Consulting Associates
Oxana Kolomitsyna, Managing Partner, Policy Consulting Associates

Framework for Evaluating Health Care District Services in the Municipal Service Review Process


Richard L. Berkson, Principal, Economic & Planning Systems (EPS)

Case Study #1 - Health Care Diagnosis, Options for Treating An Ailing Agency –
Highlights from the Recently Completed Contra Costa LAFCO Special Study: Mt. Diablo Health Care District Governance Options

- Special Study: Mt. Diablo Health Care District Governance Options, Prepared by Economic & Planning Systems, Inc. and E. Mulberg & Associates, January 2012 (Excerpts)
- Contra Costa LAFCO Executive Officer’s Report, January 2012

Steven Pritt, Chief Executive Officer, Soledad Community Health Care District

Case Study #2 - Rural Health Care in California: Soledad Community Health Care District

- District Map
- Rural Health: Nurturing a Culture of Caring, Prepared by Steven Pritt, CEO, Soledad Community Health Care District, January 2012
Deborah A. Stebbins, Chief Executive Officer, City of Alameda Health Care District

Case Study #3  Building Partnerships and Generating Growth: City of Alameda Health Care District

- *Alameda Hospital: A Snapshot*
Tom Petersen, Executive Director, Association of California Healthcare Districts
David McGhee, Chief Executive Officer, Association of California Healthcare Districts

Overview of Health Care Districts in California: History, Today's Challenges, Future Directions

- Marin/Sonoma/Palm Drive Northern California Healthcare Authority,
  Marin Independent Journal Article, December 20, 2011
Marin General forges alliance with Sebastopol hospital, second affiliation agreement this year

By Richard Halstead
Marin Independent Journal

Posted: 12/20/2011 06:10:19 PM PST

Marin General Hospital has forged its second strategic alliance with another publicly operated Northern California hospital.

The Palm Drive Healthcare District board voted unanimously Monday night to approve an affiliation agreement with Marin General Hospital. The Palm Drive Healthcare District board oversees the operation of the 37-bed Palm Drive Hospital in Sebastopol, just as the publicly elected Marin Healthcare District board oversees the 235-bed Marin General.

In May, Marin General finalized a similar management and affiliation agreement with the Sonoma Valley Health Care District, which operates the 83-bed Sonoma Valley Hospital in Sonoma.

"It's almost identical," said David Cox, Marin General's chief financial officer. "We're in a position to share systems and resources so all three hospitals will achieve some economies of scale and cost savings."

Under the agreement, the Palm Drive district will pay Marin General an annual management fee of $180,000. In return, Marin General will help Palm Drive with physician recruitment, management support, financial planning, centralized support functions, and joint marketing.

Palm Drive board President Nancy Dobbs said, "It's the next step of development for Palm Drive — finding strength by standing with a group rather than standing alone."

The Palm Drive district sought affiliation proposals from a number of hospitals and hospital systems last summer. In addition to Marin General, Catholic Healthcare West, Adventist Health, and Santa Rosa Memorial Hospital, which is part of the St. Joseph Health System, all expressed interest initially.

Dobbs said the Palm Drive board selected Marin General because it offered to do the most to help recruit doctors to western Sonoma County. She said the Palm Drive Hospital has an average census of just 13 patients.
"We need a little more heft and little more stability," Dobbs said, "and that is what Marin General's clinical connection with the physicians brings to the table."

Palm Drive Palm Drive became an independent health-care district in 2001 after voters approved $5.9 million in general obligation bonds to buy the hospital from Columbia Health Care and pay for seismic retrofitting and emergency room improvements. It declared Chapter 9 bankruptcy in 2007 to reorganize and emerged from bankruptcy in 2010.

The new agreement calls for Marin General to help fund the entry of the Prima Medical Foundation into the Sebastopol market but allows Marin General to decide how much it will spend on the effort. The foundation is the mechanism by which Marin General is allowed to help fund the Prima Medical Group, which recruits new doctors to the area and provides member doctors with office space, nursing staff, billing services, technology and other services.

Cox said, "We're also going to try to consolidate some of our support services which is going to save each of the three hospitals some money."

Listed as possible priority projects in the affiliation agreement are: consolidation of information technology services, outsourcing Palm Drive's pharmacy to Marin General, and exploiting "synergies between the clinical laboratories of Palm Drive and Marin General. Also mentioned as "other projects" are the combining of financial functions, patient accounting, medical record keeping and general services.

Cox said the affiliation between the three hospitals will not allow them to improve their leverage when negotiating rates with insurance companies by bargaining jointly.

"We don't have a close enough affiliation to do joint contracting," Cox said.

But "payor contracting" is another of the priority projects identified in the agreement. It calls for evaluating the potential for a "joint powers authority or other such organizational structure" that would "facilitate managed care financial process, including analysis and contract negotiations, on a combined basis."

Dobbs said that while the three aligned hospitals are prohibited from disclosing their contract prices to each other, they could hire a person to bargain on their behalf.

"They would be like a black box," Dobbs said. "We wouldn't know all of the information inside it. We would only know our part. But the person who was negotiating would know and could use that information to negotiate the best rates."
Course Materials

Colin J. Coffey, Partner, Archer Norris, PLC

The Local Health Care District Law: Regulations, Issues and Trends

- *California Health & Safety Code Sections 32000 – 32492 (Table of Contents)*
- *California's Health Care Districts, Prepared by Margaret Taylor, April 2006*
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California's Health Care Districts

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by
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About the Author
Margaret Taylor is the former director of the San Mateo County Health Services Department. She retired in 2004.

About the Foundation
The California HealthCare Foundation, based in Oakland, is an independent philanthropy committed to improving California’s health care delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care. For more information about CHCF, visit us online at www.chcf.org.

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I. Introduction

The purpose of this paper on California's health care districts (originally known as hospital districts) is to provide a basic understanding of their origin, development, and function. Since the goal of such districts is to support the health needs of their communities, there is value in reviewing the role they may play in the California health care environment.

First established in 1946, health care and hospital districts are a form of local government known as a "special district," described under California state law. Special districts are designed to provide a particular function in a specific geographic area and are governed by an elected board of directors. Special districts are independent from city or county governments, which traditionally provide a variety of services in a larger geographic area. The districts provide such unique services as police, fire, sanitation, health care, water, waste disposal, lighting or landscaping services. They are created at the will of local residents to fulfill a particular need not being met by other governmental or private agencies.

This paper presents background on the formation and development of health care and hospital districts. Of particular interest is the extent to which the 85 districts have evolved from their original purpose of building and operating community hospitals to such current activities as managing real estate holdings, leases, and health care contracts, as well as forming grant-making organizations to support a wide range of community-based health and wellness facilities and activities.
II. Origin of Local Hospital Districts

Shortly after the end of World War II, California faced a severe shortage of hospital beds. In fact, many of the more rural and undeveloped areas of the state had almost no access to basic hospital and health care services. County public hospitals, many of which started as almshouses in the late nineteenth century, and large teaching and private hospitals were generally located in the urban centers of California. Historically, the public's attitude toward hospitals had been based on the view that hospitals were like welfare institutions where poor, sick people were housed and often left to die. Middle class patients with financial means were usually cared for at home by their personal physicians. By the turn of the century, the need for local health care facilities was increasing, as the practice of caring for family members at home had become less practical. At the same time, as advancements were made in medical science and hygiene, and as the quality of medical procedures and facilities improved, physicians and middle class patients began to feel more comfortable using hospitals.

In the western part of the United States, access to hospital care presented a challenge to the less populated, lower income areas. The situation was more serious in California where rapid industrialization was creating more employment opportunities and more attractive job markets, with many family members moving to employment outside the home and consequently not so readily available to care for the sick. Yet the number of hospital beds was not growing at the same rate as the population. This shortage of facilities in rural areas was further exacerbated by the return of thousands of U.S. soldiers in need of regular medical treatment and hospitalization. To respond to the inadequacy of acute care services in the non-urban areas of the state, the California legislature enacted the Local Hospital District Law (section 32000 et seq. of the Health and Safety Code) in 1945. The intent was to give rural, low income areas without ready access to hospital facilities a source of tax dollars that could be used to construct and operate community hospitals and health care institutions, and, in medically underserved areas, to recruit physicians and support their practices (e.g., subsidies, office space, equipment).

The Local Hospital District Law allowed communities to create a new governmental entity— independent of local and county
jurisdictions—that had the power to impose property taxes, enter into contracts, purchase property, exercise the power of eminent domain, issue debt, hire staff, and so forth. Typically, the process of creating a hospital district began with a group of citizens in a community or cluster of communities identifying the need for improved access to medical care. Boundaries for a proposed hospital district were usually based on the distance between the communities and the closest available acute care hospital services. Community leaders organized grassroots campaigns to gather support from the majority of residents in a designated area. That designated area could be within a county, near another underserved area in the county (districts do not need to encompass contiguous areas), or could overlap two counties. In fact, a few of the current health care districts do cross county boundaries. (More detail on the formation and dissolution of districts and annexation of geographic areas is contained in the section Rules Governing Health Care Districts at the Local Level.)

The first hospital districts were formed in 1946, starting with Sequoia Hospital District in Redwood City (northern California), which was founded in 1946 and opened its community hospital in 1950. Several more districts were formed in the late 1940s, with hospitals beginning to open in the early 1950s. In 1951, in a response to the needs of these new districts, a new trade organization, the Association of California Healthcare Districts (ACHD), was formed. ACHD's objective was to educate new hospital board members and provide a statewide forum for legislative advocacy. Today that group represents 66 of the 85 health care and hospital districts, both large and small, throughout the state. A survey of the current districts—including location, hospital or health care system, and special services—is contained in Appendix A.

In the 1940s and early 1950s, the formation of a new district was subject to a variety of local and state regulations and codes. The plethora of laws made it even more crucial for the citizens' group to make a strong case for the need for, and feasibility of, establishing a new hospital or health care facility when the group presented petitions for district formation to the county board of supervisors. The board's task was to weigh the facts and determine if the new district was feasible. If it so determined, the board approved a resolution placing the formation of a new district on the ballot. If the residents of the proposed district voted in favor of the measure, the county board of supervisors appointed an interim board (five members) until another election could be held to fill these seats. This process of district development, which in the 1940s and 1950s depended on various city and county regulations, was eventually clarified. In 1963, the Knox Nisbet Act was passed, which created Local Agency Formation Commissions and clarified and formalized the process for establishing a district.
III. Changing Nature of Health Care and Hospital Districts

A total of 85 districts have been formed since the mid-1940s when the local hospital district law was passed. Two of the newest districts, formed in 2002 and 2003, were both in Alameda County in northern California: one district was formed to save Alameda Hospital in the city of Alameda, where two-thirds of the voters approved a new tax of nearly $300 per parcel. The other district was formed to assume operation of the financially strapped county hospital, Highland Hospital, and other county inpatient and outpatient facilities in Oakland, California. In 2000, a third new district was formed farther north in Petaluma in order to maintain acute care services under contract with a local hospital system. These recent district formations, however, are an exception. In general, most of the districts were formed between 35 and 50 years ago, mainly to build and operate hospitals (see Appendix A). Since then, close to a third of these districts have closed, leased, or sold their hospitals; some have declared bankruptcy; and many have changed or expanded their historic mission as providers of acute care to become funders of community health services. To a large extent, these changes in district functions have occurred in reaction to the evolving California health care environment, which has forced all hospitals, especially the smaller facilities, to re-examine their reasons for continued existence. The boards of these locally owned, locally controlled community hospitals were some of the first to recognize that their continued existence as stand-alone entities was threatened by the many factors described below.

By the late 1970s and early 1980s, all hospitals were feeling the impact of major changes in the manner in which they were being reimbursed for services rendered. No longer was a high percentage of acute hospital care funded by tax proceeds and collection of fees, as had been the case up to the early 1960s. Instead hospitals were being paid by insurance companies through carefully controlled contractual relationships, while the public programs, Medicare and MediCal (Medicaid), were beginning to implement their own cost-savings strategies. The rapid growth of managed care and advent of capitation payments, particularly in California, added to the budget deficits hospitals were experiencing. Lower insurance payments and more intense scrutiny of the level of medical care led to earlier discharges of patients, often leaving hospitals with too many empty beds. Added to those changes was the impact of more
advanced technology, improved pharmaceuticals, and new medical procedures that spawned an increase in outpatient services provided in community settings. All these changes, as beneficial as they were for patients, further hurt the bottom line of acute care hospitals. Finally, the emphasis on health promotion and wellness programs, which encouraged people to take better control of their physical well-being, began to have an impact on the way health-insuring organizations spent their resources.

Increasingly, the smaller, independent hospitals were finding it difficult to compete with larger hospitals that were part of hospital systems or chains. As public bodies, district health care boards had to follow the provisions of the open meeting act (Ralph M. Brown Act) and discuss all district hospital board policy and strategy in public, sometimes hindering a board’s ability to develop a competitive advantage. To keep pace with these health care changes and give local health care and hospital districts greater latitude, the legislature began amending the original state law, Section 32000 of the Health and Safety Code.

It should be noted that districts actually had and still have the power “to do any and all things that are necessary for, and to the advantage of,” any type of health promoting service or health care facility (section 32121). Specifically, districts can support the following: health care facilities, including substance abuse and mental health programs; outpatient services and free clinics; programs for seniors, including transportation; nurse training; physician recruitment; ambulance services; health education programs; and a variety of wellness and rehabilitation activities. District boards can build buildings for themselves and for others who serve community health care needs, even to the point of constructing fitness centers. In short, the law generally allowed for anything that is “necessary for the maintenance of good physical and mental health in the communities served by the districts.” However, the changing health care environment required that many of the points in the original law be clarified, and from the late 1940s through the mid-1990s, a number of amendments were made to the original legislation.

Some of the more significant changes in the law included the following:

- The size of communities that could create hospital districts due to threats to public health was expanded;
- The ability to overlap districts was granted;
- The number of district board members allowed was addressed; and
- In 1953, the authority to annex or exclude areas from districts and to consolidate them or dissolve them was spelled out.

However, by 1965, Government Code 56000 was enacted changing the authority for district formation and dissolution. That act further consolidated the authority of the Local Agency Formation Commissions (LAFCo), originally granted in 1963, to oversee district formation and dissolution. In 1994, as a result of SB 1169, the most significant changes in the law were enacted, mainly spelling out regulations governing transfers of property, conflict of interest, health care trade secrets and the public meeting act, lease agreements, and sales of property and assets. At this point, the designation, “hospital district” was changed to “health care district.” Obviously, these changes were in direct response to the changes being sought by the local hospital district boards in their efforts to stay competitive and maintain a strong health care presence in their communities.

As a result of the many changes in the law over the past 60 years, the range of service provided by districts is now vast. The 85 districts in existence now operate 52 public hospitals or health facilities (16 former district hospitals are now operated under contract with for profit or nonprofit hospital chains). Thirty-one of these hospitals are considered “rural” by the state of California, according to ACHD (see Appendix B). These institutions provide a significant portion of the medical care to minority populations and the uninsured in medically underserved regions of the state and are mainly funded by Medicare,
Medi-Cal, and district tax dollars. In fact, ACHD leadership believes that these district hospitals may provide more care to these higher risk, uninsured populations than do the county and university-operated public hospitals in the state, because of their rural locations.

Of the districts still supporting hospitals, a variety of arrangements have been made to keep these hospitals solvent and competitive. Some districts continue to operate independent institutions, governed by the local elected board, while many have chosen to enter into agreements with both for-profit and not-for-profit hospital management organizations. The relationship between the elected district board members and the new health system boards of directors varies from one hospital agreement to another. Some elected members sit on the new boards, while others maintain an oversight role only—for example, controlling lease agreements for facilities. A few boards have no connection with the new hospital management and strictly focus on providing community-based services.

Examples of some of the new relationships include those listed below.

- **Desert Hospital** (Desert Healthcare District) is operated by for-profit Tenet Health System Hospitals under a 30-year lease agreement.

- **Eden Medical Center** (Eden Township Medical District), **Marin General Hospital** (Marin Healthcare District), and **Mills-Peninsula Hospitals** (Peninsula Health Care District) are operated under various long-term arrangements with non-profit Sutter Health.

- **Sequoia Hospital** (Sequoia Healthcare District) is operated under a long term lease to non-profit Catholic Healthcare West (CHW).

- **Petaluma Valley Hospital**, owned by the Petaluma Health Care District, is operated under contract with St. Joseph Health System and is part of a network of Sonoma County health care providers, including Santa Rosa Memorial Hospital, St. Joseph Home Care Network, and Hospice Care of Sonoma.

- **Redbud Hospital** (Redbud Healthcare District) and **Selma Hospital** (Selma Healthcare District) were both sold to non-profit Adventist Health in the 1990s and have no connection to the districts.

According to ACHD, there are now 33 districts (though an actual count of districts and hospitals shows 38) that no longer directly operate hospitals; of that number, 16 have closed or sold their facilities to for-profit or nonprofit systems but still provide health-related services to district residents. The remaining districts provide health-related services to the residents in their areas. These districts may operate in a manner similar to community foundations, providing grants to a variety of health care organizations that serve the specific needs of the community. Determination of a "community need" is largely the purview of the elected boards of directors and varies greatly from district to district. Listed below are a cross-section of examples of the types of services and activities financed by health care districts, with the counties noted in parentheses.

- **Bloss Memorial Healthcare District** (Merced): rural health clinics, dental care, occupational health, services to the developmentally disabled.

- **Camarillo Healthcare District** (Ventura): Adult day support, in-home support, paratransit services, health screenings and education, support groups for patients suffering from catastrophic illnesses.

- **Del Puerto Healthcare District** (Stanislaus): ambulance service.

- **Cambria Healthcare District** (San Luis Obispo): ambulance service, Alzheimer's day care center, public education.

- **Beach Cities Health District** (Manhattan Beach, Redondo Beach, Hermosa Beach—Los Angeles): health and fitness center, senior housing development, family crisis center, free clinics, community service building leases.
Peninsula Health Care District (San Mateo): children’s health insurance, counseling and substance abuse programs, senior services, free clinic.

Clearly the majority of these health care district programs place great emphasis on community health and wellness programs and services designed to prevent or postpone acute hospital care. In many cases, the districts have filled gaps in local health services, resulting from the funding constraints faced by local public health departments, public safety organizations, and transportation agencies. They also play a vital role in physician recruitment and nurse training, in light of the shortages of medical professionals in most regions of California.

One of the challenges facing health care districts without hospitals is the public perception that the districts were formed to operate hospitals, and, once they cease to operate the hospital, they should be dissolved. Local grand juries, city council members, boards of supervisors, newspaper editors, and concerned residents in many of the districts have publicly questioned the continued existence of these tax collecting entities and have suggested that they should disappear and the taxes be returned to the residents. To counter these claims, district administrators have been forced to defend their current activities and to explain the arcane changes of local tax law, as a result of the passage of Proposition 13.

Under this tax reform act passed in the late 1970s, the districts are allocated a portion of the 1 percent real property tax collected by the counties. If districts are dissolved, those taxes are reallocated to the other government entities in the geographic area served by the district (e.g., county, cities, and school districts). They do not cease to be collected, nor are they returned to the taxpayers. However, there are continuing questions about why these districts persist, particularly as community grant-makers. The question of whether there is a better, more efficient way to offer local health care services is soon to be the subject of study by LAFCo throughout the state.
IV. Rules Governing Health Care Districts at the Local Level

**Local Agency Formation Commissions (LAFCos)**

were formed in 1963, as a result of passage of the Knox Nisbet Act, in an effort to make sense out of a variety of local and state codes and laws that had resulted in scattered and illogical boundaries at the local level. Between 1963 and 1985, clarifying legislation was passed that provided more detail on the process for formation, annexation, detachment, and consolidation. By 1985, the Cortese Knox Act consolidated these laws into a comprehensive set of regulations and policies. Today LAFCos exist in each county and have clear jurisdiction over the boundaries of cities and special districts. Any change in an existing district or formation or dissolution of a district is subject to LAFCo review and approval. In the event that a proposed district overlaps another county, the LAFCo of the county containing the greater assessed valuation of property in the district becomes the principal agency in charge. LAFCOs are governed by a Commission, whose members are appointed by county boards of supervisors and include local elected officials and appointed public members. The Commission oversees the work of a small staff who handle all requests for review and change, either directly or through the use of consultants.

In 2000, the Cortese Knox Hertzig Act rewrote the 1985 act and gave LAFCo new powers (Government Code Section 56430) to conduct "municipal service reviews" of all the special districts in a county, including health care districts. That review consists of making determinations about the following:

- Infrastructure needs or deficiencies
- Growth and population projections
- Financing and rate structuring
- Shared resources and cost avoidance constraints and opportunities
- Local accountability and governance
- Management efficiencies
- Government structure options, including advantages and disadvantages of consolidation or reorganization of service providers.
A question for county attorneys is to determine the scope of a LAFCo municipal services review as it pertains to those districts that have divested themselves of hospitals. It is not clear whether the review would consider the hospital once operated by the district or leased to another management group, whether it would look at all hospitals in the area to determine level of acute care services available, or whether it would limit review to the grant-making, leasing, ambulance, and other services provided by the districts that do not operate hospitals.

If, through the LAFCo review, it is determined that a reorganization of health care districts or any special districts should be pursued, then the LAFCo process for consolidating, dissolving, or annexing additional territory would be initiated. That process can be started by a resolution from the district residents, the county board of supervisors, a city council, and so on. It is then up to LAFCo to make findings about the provision of services and hold public meetings to present recommendations regarding the continued provision of similar services by another entity in a cost-effective manner. For example, if a health care district is proposed for dissolution, LAFCo would determine what other organizations could provide similar services and whether they should receive the tax dollars currently going to the district. If the dissolution proposal is not approved by LAFCo, any proposal for change is dropped for a year. If it is approved, LAFCo holds more public meetings and determines if a significant number of protests are received. If over 50 percent of the districts residents protest, the matter is dropped. If there is no opposition, LAFCo would then put the proposal for change to a vote of the district’s electorate.

There is concern among the current leadership of ACHD about the pending LAFCo review process and its impact on the future viability of health care and hospital districts. However, since the municipal service reviews are just beginning to be discussed, it is not possible to predict what, if any, effect LAFCo might have on their continued operations, nor what the public reaction would be.
Appendix A: Survey List of California Hospital Districts

Alameda County Medical Center: Oakland, Alameda County; district formed to assume operation of county facilities; Highland Hospital (399 beds with trauma center), Fairmont Hospital (420 beds), and 7 community health centers.

Alta Hospital District: Dinuba, Tulare County; 50-bed hospital operated by district.

Antelope Valley Hospital: Lancaster, Los Angeles County; full service hospital operated by the district; number of beds varies by source of data (from 309 to 336, 350, and 379).

Avenal Health Care District: Avenal, Kings County; hospital closed in 1996; records not available through OSHPD; district supports ambulance service.

Beach Cities Health District: Manhattan Beach, Redondo Beach, Hermosa Beach, Los Angeles County; South Bay Hospital closed in 1998 (had been operated by Tenet Health Systems); community grants support services to children, seniors (in-home care and housing), health and fitness center, free clinic, recreation facilities for schools, building leases to community groups, and other community-based services.

Bear Valley Community Healthcare District: Big Bear Lake, San Bernardino County; district operates Bear Valley Hospital, 9 acute beds; skilled nursing, 21 beds; district supports family health center, counseling, and paramedic/ambulance service.

Bloss Memorial Healthcare District: Atwater, Merced County; hospital closed by 2000; grants program supports three rural health clinics, dental services and dental surgery for developmentally disabled, urgent care/occupational medicine.

Camarillo Healthcare District: Camarillo, Somis, and Santa Rosa and Las Posas Valleys, some programs available to residents of Ventura County; no hospital; grants support adult day care, in-home support services, community education services, support groups, family services (mainly counseling and education), transportation for seniors.

Cambria Community Healthcare District: Cambria, San Luis Obispo County; founded to support physicians and dentists in the community by building clinics; took over ambulance services in 1951, which is main focus; works with community groups on Alzheimer's day care; provides emergency services training and education.

Chowchilla District Memorial Hospital: Chowchilla, Madera County; district operates rural hospital with 5 acute beds and 19 subacute beds; no grants program.

City of Alameda Healthcare District: Alameda, Alameda County; district formed to save Alameda Hospital (originally Alameda Sanatorium, 1894), 135 acute beds, full service facility; no grants program.

Cloverdale Healthcare District: Cloverdale, Sonoma County; no hospital; supports ambulance services.

Coalinga Hospital District: Coalinga, Fresno County; district operates Coalinga Regional Medical Center, a rural hospital with 24 acute beds, 78 total beds; funds emergency services outreach.

Corcoran Hospital District: Corcoran, Kings County; district operates Corcoran District Hospital, a rural hospital with 24 acute beds, 32 total beds.

Corning Healthcare District: Corning, Tehama County; no hospital; supports senior health services.

Del Norte Healthcare District: Crescent City, Humboldt County; no hospital; partnerships with community groups to support senior programs, First 5 children's services, community wellness center.

Del Puerto Healthcare District: Patterson, Grayson, Crows Landing, and Westley, and western Stanislaus County; closed 40-bed hospital in 1998; provides ambulance services and community wellness services.

Delano District Skilled Nursing Facility: Delano, Kern County; either 141 or 156 (depending on reporting source) skilled nursing beds operated by district.

Desert Healthcare District: Desert Hot Springs, Thousand Palms, Palm Springs, Cathedral City, Rancho Mirage, Palm Desert, and unincorporated Riverside County; Desert Regional Medical Center, 398 beds, operated by Tenet Health Systems since 1997; district oversees lease and operates a community grants program supporting AIDS assistance, breast cancer screening, programs for children with special needs, and various community-based wellness programs.

Doctor's Medical Center: San Pablo and Pinole, Contra Costa County; see West Contra Costa Healthcare District, below.
East Kern Health Care District: California City, Kern County; developing joint powers agreement with Tehachapi Valley Healthcare District for hospital expansion; see below.

Eastern Plumas Health Care: Portola, eastern Plumas County, and Loyalton, Sierra County; Eastern Plumas Hospital, rural hospital with 9 acute beds, total 40 beds; Loyalton campus, 1 acute bed, total 36 beds; Portola Medical and Dental Clinic, Graeagle Medical Clinic, skilled nursing and home health.

Eden Township Hospital District: Castro Valley, Hayward, San Leandro, San Lorenzo, parts of Union City and Oakland, Alameda County; Eden Medical Center (214 beds) and San Leandro Hospital (122 beds), full service facilities with trauma services located at Eden; both operated by Sutter Health.

El Camino Hospital District: Mountain View, Sunnyvale, Los Altos, Santa Clara County; district operates El Camino Hospital, data show 286, 300, 395, or 411 beds, full service hospital.

Fallbrook Healthcare District: Fallbrook, San Diego County; Fallbrook District Hospital, 47 acute beds, total 140; small urban hospital, operated by Community Health Systems of Nashville; forming alliance with fire department to coordinate faster response to medical emergencies, and assessing unmet community health needs; community grants program supports health promotion activities, in-home support services, mental health services, and family health center.

Grossmont Healthcare District: La Mesa and eastern San Diego County; 450-bed, full service hospital, operated by Sharp HealthCare since 1991; grants program supports health education, promotion, and maintenance, and health care services; district is building a multipurpose community building on city-owned property.

Hazel Hawkins Memorial Hospital: Hollister, San Benito County; see San Benito Healthcare District, below.

Healdsburg District Hospital: Healdsburg, Windsor, Geyserville, Cloverdale, Sonoma County; see North Sonoma County Hospital District below.

Heffernan Memorial Hospital District: Calexico, Imperial County; partner with Pioneers Memorial Hospital District to build facility; see below.

Hi-Desert Memorial Health Care District: Joshua Tree, San Bernardino County; district operates Hi-Desert Medical Center, a full service hospital with 59 beds and skilled nursing facility with 120 beds; supports home health and hospice.

Indian Valley Hospital District: Greenville, Plumas County; district operates Indian Valley Hospital with 26 acute beds. Community leader want to make this difference.

John C. Fremont Healthcare District: Mariposa, Mariposa County; district operates rural hospital with 18 acute beds, 34 total; supports long term care, hospice, and medical clinic.

Kaweah Delta Health Care District: Exeter, Visalia, San Joaquin Valley, Tulare County; district operates 490-bed Kaweah Delta Hospital, including small urban hospital with 14 beds, Rehabilitation Hospital (61 beds), Mental Health Hospital (63 beds), Community Health Center (32-bed transitional care beds), Lifestyle Center, San Juan Health Center; grants program supports community outreach to reduce violence, strengthen families, reduce teen pregnancy.

Kern Valley Healthcare District: Lake Isabella, Kern County; Kern Valley Hospital, with 27 acute beds, 101 total.

Kingsburg District Hospital: Kingsburg, Fresno County; Kingsburg Medical Center, rural hospital with 15 acute beds, 35 total.

Lindsay Local Hospital District: Lindsay, Tulare County; no information available.

Lompoc Healthcare District: Lompoc, Santa Barbara County; district operates Lompoc District Hospital, 60 acute beds, 170 total.

Los Medanos Community Healthcare District: Pittsburg, Contra Costa County; faced bankruptcy in the 1990s but has recovered; leased hospital facility to Contra Costa County, which now operates facility.

Marin Healthcare District: Greenbrae and most of Marin County; Marin General Hospital, full service facility, 235 beds, operated by Sutter Health.

Mark Twain Hospital District: San Andreas and Calaveras County; 48 acute beds at Mark Twain St. Joseph's Hospital operated by St. Joseph's Regional Health System; no grant program.

Mayers Memorial Hospital District: Fall River Mills, Shasta County; 121 beds operated by district.
Mendocino Coast District Hospital: Fort Bragg, Mendocino County; district operates rural hospital with 39 acute beds, 49 total.

Menifee Valley Medical Center: Sun City, Riverside County; district operates 84-bed hospital.

Moreno Valley Community Hospital District: Moreno Valley, Riverside County; district operates 101-bed hospital.

Mount Diablo Healthcare District: Concord, Contra Costa County; originally operated Mount Diablo Medical Center; in 1996, a community benefit agreement was approved that merged the hospital with John Muir Medical Center (259 beds); district oversees lease and supports a community grants program.

Mountains Community Hospital: Lake Arrowhead, Riverside County; district operates a rural hospital with 18 acute beds.

Muroc Healthcare District: Boron, Kern County; supports ambulance service, clinics.

North Kern-South Tulare Hospital District: no information available.

North Sonoma County Hospital District: Healdsburg, Windsor, Geyserville, Cloverdale, Sonoma County; district operates Healdsburg District Hospital, 43 beds.

Northern Inyo County Local Hospital District: Inyo County; district operates rural hospital with 32 beds.

Oak Valley Hospital District: Oakdale, Stanislaus County; Oak Valley Hospital, 35 acute beds, 11-bed transitional care unit, and 115 skilled nursing beds, operated by Catholic Healthcare West.

Palm Drive Health Care District: Petaluma and western Sonoma County; Palm Drive Hospital, full service with 49 acute beds, was originally opened in 1941, threatened with closure in 1998, and saved by district formation in 2000.

Palomar Pomerado Hospital District: Escondido, San Diego County; district operates two full service hospitals in Escondido (420 beds) and Poway (provides trauma care and 236 beds).

Palo Verde Healthcare District: Blythe, Palo Verde Valley, Riverside County; landlord for company leasing Palo Verde Hospital, 51 beds.

Peninsula Health Care District: Burlingame and northern San Mateo County; Peninsula Hospital merged with Mills Hospital in 1985 to form Mills-Peninsula Health Services; 288 acute beds on two campuses in San Mateo and Burlingame, 403 total beds; operated by Sutter Health since 1956; grants program supports children's health insurance, free clinic, senior services, and youth counseling program.

Petaluma Health Care District: Petaluma, serving Penngrove, Cotati, Rohnert Park in southern Sonoma County and northwest Marin County; 80 or 99-bed, full service Petaluma Valley Hospital, leased to Santa Rosa Memorial Hospital, St. Joseph's Health System; grants program supports free clinic, health center, and various community health services.

Pioneers Memorial Hospital District: Brawley, Imperial County; district operates 95 or 107-bed full service hospital, Phyllis Dillard Family Medical Center (small/rural designation), Calexico urgent care, two health centers (see Heffernan district, above).

Plumas Hospital District: Quincy, Plumas County; district operates 25-bed hospital.

Redbud Healthcare District: Clearlake, Lake County; sold 40-acute bed hospital to Adventist Health System, 1997.

Redwood Healthcare District: no hospital; funds programs that support a healthier community.

Salinas Valley Memorial Hospital District: Salinas, Monterey County; Salinas Valley Memorial Healthcare System supports a 266-bed full service hospital, 72 assisted living beds; no grant program.

San Benito Health Care District: Hollister, San Benito County; district operates Hazel Hawkins Memorial Hospital, 49 acute beds, 70 skilled nursing, total 176; districts support home health services, clinics, senior mental health services and rehabilitation.

San Bernardino Mountains Community Hospital District: Lake Arrowhead, Riverside County; district operates full service Mountain Community Hospital, 17 acute beds, 35 total, and rural health clinic.

San Gorgonio Memorial Healthcare District: Banning, Riverside County; district operates 52-bed (total 70) small urban hospital.

Selma Healthcare District: Selma, Fresno County; district operates 57-bed Selma Community Hospital; also supports teen pregnancy, diabetes, and health education services.
Seneca Healthcare District: Chester, Plumas County; district operates a 10-bed hospital, 26 total beds.

Sequoia Healthcare District: Redwood City and southern San Mateo County (except East Palo Alto); Sequoia Hospital, a 421-bed hospital, sold in 1996 to Sequoia Health Services (a public benefit corporation) and operated by Catholic Healthcare West; grants program supports nursing education, children's health insurance, free clinic, school nurses, and rebuilding of Sequoia Hospital.

Sierra Kings Hospital District: Reedley, Fresno; district operates 27-bed (44 total) rural hospital

Sierra Valley Hospital District: Loyalton, Sierra County; district operates 40-bed hospital.

Sierra View Hospital District: Porterville, Tulare County; district operates 163-bed hospital.

Soledad Community Health Care District: listed in state special district report as a hospital district and as a health district with two separate budgets; district does some community grant-making.

Sonoma Valley Health Care District: Sonoma, Sonoma County; 72-bed (83 total) full service hospital, operated by Sutter Health since 2000; also supports a medical office building.

Southern Humboldt Community Hospital District: Garberville, Humboldt County; district operates Jerold Phelps Community Hospital, 17 beds; in bankruptcy, 1999–2001.

Southern Inyo Healthcare District: Lone Pine, Inyo County; district operates 4 acute beds, 37 total

Southern Marin Emergency Medical-Paramedic System: listed as a hospital district; provides ambulance services.

Southern Mono Health Care District: Mammoth Lakes, Mono County; district operates 15-bed Mammoth Lakes Hospital.

Southwest Healthcare District: Frazier Mountain, Kern County; listed in state special district report as health district; one reference to district available (complaint about collection of tax dollars).

Surprise Valley Hospital District: Cedarville, Modoc County; district operates Surprise Valley Community Hospital with 4 acute beds, 26 or 37 total.

Tahoe Forest Hospital District: Truckee, Nevada County; district operates 35 acute beds, 72 total, and health center.

Tehachapi Valley Healthcare District: Tehachapi, Kern County; district operates 24-bed full service rural hospital, 19 bed long term care facility, rural health clinics, and community health education services.

Tri-City Hospital District: Oceanside, San Diego County; district operates 397-bed Tri-City Medical Center.

Tulare District Healthcare System: Tulare District Hospital.

Valley Health System: Hemet, Riverside County; district operates 340 beds in Hemet Valley Medical Center, Menifee Valley Medical Center, Sun City, and Moreno Valley Community Hospital, Moreno Valley; and 113-bed skilled nursing facility.

Washington Township Health Care District: Fremont and Newark, Union City, and part of South Hayward and Alameda County; full service hospital with 337 beds; Washington Hospital provides mobile health clinic, outpatient rehabilitation, student health center, health library, child care, and various services for women, seniors, and teens.

Westwood Hospital District: listed in state special district report under hospital districts; no information available.

West Contra Costa Healthcare District: San Pablo and western Contra Costa County; district operated Brookside Hospital until affiliated with Tenet Health Systems; now operated by the district and called Doctors Medical Center, a full service facility with 232 beds; supports Brookside Community Health Center and other health-related activities in the community.

West Side Community Healthcare District: Newman, Stanislaus County; operates ambulance services

West Side Health Care District: Taft, Kern County; district operated West Side Hospital until 1998, when hospital sold to Catholic Healthcare West; acute services closed in 2003, leaving only skilled nursing care; district planning to support community services.
Appendix B: About the Health Care District Survey

Several points must be made regarding the information presented in this survey of hospital and health care districts. First, developing the information for the survey required reviewing a number of reports, websites, and interviews, because there is no one source of information on the districts. The Association of California Healthcare Districts (ACHD) represents 66 hospital and health care districts, but provides only very limited public information (i.e., a roster) about its membership. ACHD website states there are 77 health care districts, with 44 operating 47 hospitals, but does not list the 11 districts not on its membership roster. To find the remaining districts, the California State Controller’s Special Districts Annual Report, 2002–03, was reviewed. The section on Hospital Activity Revenues and Expenses lists 65 hospital and health care districts; the section on Non-Enterprise—General and Special Revenue Funds lists 24 special districts whose business is health care or hospitals. Of these latter districts, four were eliminated as not relevant to this survey. It is interesting to note, however, that several of the special districts designated as “health” are districts that still operate hospitals and are similar to the hospital districts listed in the hospital tables. Included in the “non-enterprise” category are large hospital and health care districts (e.g., Grossmont, Eden, Los Medanos Peninsula, Sequoia, West Contra Costa Healthcare Districts), as well as very small districts such as Redbud Healthcare District (listed as an ACHD member, without a hospital and for which is no recent information) and Southwest Healthcare District (not an ACHD member and for which almost no information exists). In total, the author found references to 85 special districts in California that are designated as providing health care or hospital services.

The next area that requires explanation is the data on number of beds. The information was generally derived from OSHPD reports; however, that information did not always agree with numbers on district Web sites, the Small and Rural Hospital Report, the California Hospital Association reports, and the U.S. News and World Report (www.usnews.com). To the extent possible, licensed acute medical surgical beds are listed separately as “acute beds”; “total beds” includes all beds (e.g., transitional care, skilled nursing, and intermediate care beds). The number of hospital beds in these district hospitals ranges from one bed to several hundred in multiple sites; in general, most of these hospitals state they are “full service” facilities, as noted in the survey. Regions served are designated by city and county. Community grant making activities are listed for all districts for which the information was available.
Appendix C: References

Association of California Healthcare Districts
  interview with Ralph Ferguson, president and CEO,
  and Arthur Faro, board of directors member
  www.achd.org/

California Association of Public Hospitals
  interview with Denise Martin, president and CEO

California Hospital Association
  various materials

California State Controller's Special Districts
  Annual Report, 2002–03

California Statutes regarding hospital and health care
districts

"Final Report on Hospital Closures," Petris Center on
Health Care Markets and Consumer Welfare

Health Care Districts attorneys
  Brenda Carlson (county counsel) and
  Penny Greenberg (private counsel)

Little Hoover Commission report on hospital districts

Newspaper: various articles from throughout California

OSHPD data

Rural and Small Hospital Reports

"Rural Health Care at Risk: California Small and Rural
Hospitals," California Healthcare Association

San Mateo County LAFCo
  interview with Martha Poyntos, executive director

San Mateo County Grand Jury
  report on health care districts

San Mateo County Legislative Director, Mary McMillan

"The Social Transformation of American Medicine"
  Paul Starr, 1982

Web sites for Hospital and Health Care Districts
Course Materials

Jennifer Stephenson, Principal, Policy Consulting Associates
Oxana Kolomitsyna, Managing Partner, Policy Consulting Associates

Framework for Evaluating Health Care District Services in the Municipal Service Review Process

10. EASTERN PLUMAS HEALTHCARE DISTRICT

Eastern Plumas Healthcare District (EPHD) is a small, non-profit, critical access hospital district, providing comprehensive medical services in eastern Plumas County through a hospital and five clinics. This is the first Municipal Service Review for the District.

AGENCY OVERVIEW

Background

EPHD was formed in 1964 as an independent special district.\textsuperscript{164} The District was formed to provide local health care and emergency medical services to residents in eastern Plumas County.

The principal act that governs the District is the Local Health Care District Law.\textsuperscript{165} The principal act empowers healthcare districts to provide medical services, emergency medical, ambulance, and any other services relating to the protection of residents' health and lives.\textsuperscript{166} Districts must apply and obtain LAFCo approval to exercise services authorized by the principal act but not already provided (i.e., latent powers) by the district at the end of 2000.

Boundaries

EPHD is located in the eastern part of Plumas County, in the high Sierra Mountains. The EPHD boundary is entirely within Plumas County, and includes the City of Portola and the communities of Graeagle, Beckwourth, Vinton, and Chilcoot, among others. The District’s boundaries extend to the Lassen County line in the northeast and east, and to the Sierra County line in the south. The District’s boundaries encompass approximately 545,443 acres or 852 square miles.\textsuperscript{167}

There have been no annexations to or detachments from EPHD since its formation.

\textsuperscript{164} Plumas Board of Supervisors, Resolution No. 1499.

\textsuperscript{165} Health and Safety Code §32000-32492.

\textsuperscript{166} Health and Safety Code §32121(j).

\textsuperscript{167} Total agency area calculated in GIS software based on agency boundaries as of July 1, 2011. The data is not considered survey quality.
**Sphere of Influence**

The District’s SOI is coterminous with its boundaries. The SOI was originally adopted in 1976,\(^{168}\) with no updates or amendments since that time.

**Extra-territorial Services**

The District provides services outside of its boundaries at a clinic in Loyalton through an "out-of-area service agreement" (OASA) with Sierra Valley Healthcare District (SVHD). Also, the District is running Indian Valley Health Clinic for Indian Valley Healthcare District (IVHD) through an OASA. Both SVHD and IVHD are currently in financial distress. SVHD filed for Chapter 9 bankruptcy on June 28, 2002, and EPHD began services to SVHD in November 2003.\(^{169}\) IVHD also filed for Chapter 9 bankruptcy in November 2004, and had severe challenges with cash flows prior to closing the clinic in 2006. EPHD began providing services to Indian Valley Medical Clinic began in November 2007.\(^{170}^{171}\)

The District reported that there is a potential to consolidate with Sierra Valley Healthcare District [in Sierra County]. SVHD desires to consolidate with EPHD due to its recent bankruptcy. EPHD plans to convene a study group to assess pros and cons of consolidating with SVHD. EPHD reported that it is not considering consolidation with Indian Valley Healthcare District, as EPHD would like to return all services to IVHD in the future.

The District provides services to residents and non-residents alike. The District does not have separate fees based on residency. No proof of residency is required for hospitals and clinics within EPHD.

**Areas of Interest**

With the exception of the potential for consolidation with Sierra Valley Healthcare District mentioned above, the District did not identify any other areas of interest.

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\(^{168}\) Plumas LAFCo Resolution No. 76-08.


Accountability and Governance

The principal act orders that the governing body of a healthcare district must have five members. Directors may be appointed or elected, pending circumstances.\textsuperscript{172} EPHD is governed by a five-member Board of Directors who are elected to staggered four-year terms. The board members were elected at large, and there are currently no vacancies. There has never been a contested election. Current board member names, positions, and term expiration dates are shown in Figure 10-2.

The Board meets once a month on the fourth Thursday (except November and December) at the Portola Education Center. Board meeting agendas are posted at the post office, at the District's clinics and on the website. Minutes of board meetings are passed out at subsequent meetings after approval by the administrative office. The District has upcoming and past agendas and board meeting minutes available on its website.

**Figure 10-2: Eastern Plumas Healthcare District Governing Body**

<table>
<thead>
<tr>
<th>Eastern Plumas Healthcare District</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contact:</strong> Jeri Nelson, Chief Financial Officer</td>
</tr>
<tr>
<td><strong>Address:</strong> 500 First Ave., Portola, CA 96122</td>
</tr>
<tr>
<td><strong>Telephone:</strong> (530) 832-6500</td>
</tr>
<tr>
<td><strong>Email/website:</strong> <a href="http://www.ephc.org">www.ephc.org</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Board of Directors</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Name</strong></td>
</tr>
<tr>
<td>Gail McGrath</td>
</tr>
<tr>
<td>Larry Fites</td>
</tr>
<tr>
<td>Lucy Kreth</td>
</tr>
<tr>
<td>Janie McBride</td>
</tr>
<tr>
<td>Jay Skutt</td>
</tr>
</tbody>
</table>

**Meetings**

**Date:** Fourth Thursday of every month, except November - December

**Location:** Portola Education Center

**Agenda Distribution:** Posted at the post office, clinics, and on the website.

**Minutes Distribution:** Distributed at meetings after approval, and posted on website.

In addition to the required agendas and minutes, EPHD does public outreach through presence at fairs, charity events, and through advisory groups. The EPHD also maintains a website and newspaper space, as well as social networking site accounts such as Facebook and Twitter.

\textsuperscript{172} Health and Safety Code §32100.
If a customer is dissatisfied with the District's services, complaints may be submitted to the District or reported directly to the State. Complaints are also submitted on patient satisfaction forms. There is one staff member who is responsible for financial inquiries. EPHD's complaints are mostly related to bills and timing. Patient complaints are reviewed every Wednesday. If the complaints have merit, then the Utilization Committee will review them with other healthcare providers through a "peer review" process.

EPHD demonstrated accountability and transparency in its disclosure of information and cooperation with Plumas LAFCo. The District participated in an interview and cooperated with the document requests.

Planning and Management Practices

The District is one of the largest employers in the County with 235 employees or approximately 195 full-time equivalents. The District contracts for services with physicians, speech therapists, occupational therapists, physical therapists, and for snow removal, among others. There are six main departments: Financial Services, Human Resources, Hospital Operations, IT Management, Plant Operations, and Outpatient Clinics. The heads of these departments report to the CEO, who in turn reports to the Board of Directors.

The agency performs staff evaluations annually. Each department head conducts the evaluations for employees within the relevant department, and the Human Resources Department reviews the evaluations after a 525-hour probation period. The agency is implementing a biometric system that uses fingerprints to track employee log-in and log-out times. Timesheets are broken down by department.

The District evaluates its own performance during monthly management and staff meetings, and assesses preparedness during emergency drills. EPHD performance is also gauged by benchmarking with other providers on the Office of Statewide Health Planning and Development (OSHPD) website.

With regard to financial planning, the District adopts an annual budget; financial statements are audited by an independent auditor annually. A monthly financial report is submitted to the Board and department heads. Capital improvements are planned for on an annual basis during each budget process.

The District's planning efforts include an operations plan. In the 2010-2011 Operations Plan, EPHD planned for facility needs and set goals related to financing, quality, community outreach, operations, and all clinics. The 2010-2011 Operations Plan indicates that a strategic plan will be developed for EPHD.

Existing Demand and Growth Projections

Designated land uses within the District are primarily agricultural and wildland, with some residential, suburban and recreational uses around the City of Portola and the
communities of Chilcoot, Beckwourth, Lake Davis, Delleker, Iron Horse, Whitehawk Ranch, Valley Ranch, Clio, Mohawk Vista, C-Road, Blairsden, Graeagle, Johnsville and Plumas Eureka. The total boundary area of EPHD is approximately 852 square miles.

Population

There are approximately 6,239 residents within the District, based on census tract population in the 2000 census. Population information at the census tract level was not yet available for the 2010 census, as of the drafting of this report; however, based on the lack of growth experienced throughout the County over the last decade, and in some cases population decline, it can be assumed that the approximate population has not changed much since 2000.

Existing Demand

The District reported that from 2005 to 2008 service demand was on the rise, but in 2009 and 2010, service demand in basic healthcare and preventative treatment slightly declined. It was reported at the end of 2010 demand was starting to pick up again.

The District's number of total patient days was 20,694 in 2010, which equates to an estimated population served of about 673 patients. The estimated population served by EPHD in 2010 was approximately 40 percent more than the estimated population served by EPHD in 2009, meaning that more individual patients were served 2010. While there were only four less total patient days in 2009 than in 2010, the average length of stay was longer in 2009 than it was in 2010. There were less patient days in 2009 than in 2010 for all types of care except for skilled nursing.

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173 Plumas County Parcel Application.

174 Census Tracts 3 and 2.01 in Plumas County and Table DP-1 for Portola city, California.


176 Author's estimate based on average lengths of stay in days per type of care.
Projected Growth and Development

No formal population projections have been made by the District.

The State Department of Finance (DOF) projects that the population of Plumas County will grow by five percent in the next 10 years. Thus, the average annual population growth in the County is anticipated to be approximately 0.5 percent. Based on these projections, the District’s population would increase from 6,239 in 2010 to approximately 6,551 in 2020. It is anticipated that demand for service within the District will increase minimally based on the DOF population growth projections through 2020.

There are several potential developments throughout the District that may lead to significant population growth in the future. Based on reports from the County, there is one development that has been approved but is currently on hold due to financial constraints. The development consists of 99 lots and is located in Graeagle. According to other districts there are a number of other potential developments: one small 21-home development within Sierra Valley FPD, three areas in Whitehawk Ranch that will add over 40 dwellings, Village of Plumas Pines in Plumas-Eureka, empty lots throughout the Gold Mountain subdivision, and Willow Creek development located three and a half miles west of Delleker that would consist of 210 residential units. Due to the unpredictable nature of the existing economy and housing market, these areas will likely not be developed within the short-term; however, they may be indicative of the long-term potential for growth. Additionally, there are three planned developments within the Portola city limits, which have the potential to add an additional 1,220 dwelling units, or approximately 2,440 additional residents to the District.

The District appears to have the capacity to serve existing and near-term growth areas, but will need to address the challenge of hiring appropriate physicians and maintaining sufficient physician staffing levels.

Growth Strategies

The District is not a land use authority, and does not hold primary responsibility for implementing growth strategies. The land use authority for unincorporated areas is the County. The District does not take part in reviewing plans for proposed developments.

With regard to future growth opportunities, EPHD identified the potential to consolidate with Sierra Valley Healthcare District as previously mentioned in the Background Section of this chapter.

Financing

While the District has historically had financial challenges resulting in bankruptcy in the late 90’s, the District has been able to resurrect itself by coming out of bankruptcy in 2004, and presently reports that current financing levels are adequate to deliver services. While financing levels appear to be adequate, the District faces the challenge of meeting mounting requirements and standards with decreased revenue. Declining revenues are the
result of 1) a reduction in property tax income, 2) a decline in clients during the recent recession, and 3) an increase in unpaid medical bills, which have increased from four to six percent of billings. As a result of these revenue reductions, the District has been forced to downsize and discontinue obstetrician services to stay within its means.

Rates charged to patients for services the District’s primary income. The District’s rates are determined based on competitive rates and need. The District also has “charity care,” or a sliding scale for fees based on income. The District’s total revenues for FY 09-10 were approximately $24.7 million.177 Revenue sources include patient service revenue (95 percent), property taxes (two percent), other operating and non-operating revenue (two percent), and grants and contributions (one percent).

Figure 10-4: EPHD Revenues and Expenditures (FYs 10 & 11)

<table>
<thead>
<tr>
<th>Income/Expenses</th>
<th>FY 09-10 Actual</th>
<th>FY 10-11 Budgeted</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property Taxes</td>
<td>$590,094</td>
<td>$590,000</td>
</tr>
<tr>
<td>Other Operating Revenue</td>
<td>$135,958</td>
<td>$136,000</td>
</tr>
<tr>
<td>Other Non-operating Revenue</td>
<td>$28,957</td>
<td>$29,000</td>
</tr>
<tr>
<td>Charges for Services</td>
<td>$236,923</td>
<td>$237,000</td>
</tr>
<tr>
<td>Contributions and Grants</td>
<td>$211,296</td>
<td>$210,000</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>$927,661</td>
<td>$926,000</td>
</tr>
<tr>
<td><strong>Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries &amp; Benefits</td>
<td>$12,397,754</td>
<td>$12,944,050</td>
</tr>
<tr>
<td>Services &amp; Supplies</td>
<td>$7,625,857</td>
<td>$7,743,000</td>
</tr>
<tr>
<td>Other Charges</td>
<td>$2,651,932</td>
<td>$2,977,717</td>
</tr>
<tr>
<td>Depreciation</td>
<td>$185,961</td>
<td>$200,830</td>
</tr>
<tr>
<td>Interest</td>
<td>$431,342</td>
<td>$396,000</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>$24,004,084</td>
<td>$24,075,439</td>
</tr>
<tr>
<td><strong>Net Income</strong></td>
<td>$7,576,423</td>
<td>$7,049,439</td>
</tr>
</tbody>
</table>

The District’s operating expenses in FY 09-10 were about $24 million.178 Expenditures were composed of employee compensation (52 percent), and services and supplies (32 percent). Debt repayments were approximately 10 percent of the total expenditures. The District’s capital expenses (rental and leases) in FY 09-10 were $89,299.

The District’s operating expenses amounted to $1,160 per patient day, or $35,669 per patient.

With regard to capital financing, the District strives to finance its capital improvements through USDA loans, auxiliary donations, grants, and operating capital, as well as other unidentified sources. The District adequately covers depreciation of capital assets as part of


its budgeted capital expenditures. The District conducts capital improvement planning in the annual budget.

The District had long-term debt of $6.6 million as of the end of FY 09-10. The debt consisted of notes payable and capital lease obligations, the details for which are shown in Figure 10-5.

**Figure 10-5: EPHD Loans and Leases**

<table>
<thead>
<tr>
<th>Payee</th>
<th>Purpose</th>
<th>Balance June 30, 2010</th>
<th>Monthly Payment</th>
<th>Maturity Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plumas Bank</td>
<td>SVDH Purchases</td>
<td>$326,263.59</td>
<td>$3,708.45</td>
<td>11/15/2033</td>
</tr>
<tr>
<td>CHLA/California Facilities</td>
<td>SHR &amp; Bed Equipment</td>
<td>$290,190.29</td>
<td>$3,528.10</td>
<td>12/21/2024</td>
</tr>
<tr>
<td>Western Tile Company</td>
<td>Evergreen Note Services</td>
<td>$387,740.25</td>
<td>$5,211.66</td>
<td>11/29/2013</td>
</tr>
<tr>
<td>USDA #1</td>
<td>Unknown</td>
<td>$345,090.35</td>
<td>$4,712.00</td>
<td>12/21/2013</td>
</tr>
<tr>
<td>USDA #2</td>
<td>Unknown</td>
<td>$421,192.51</td>
<td>$5,353.00</td>
<td>12/21/2021</td>
</tr>
<tr>
<td>USDA #3</td>
<td>Unknown</td>
<td>$407,726.87</td>
<td>$5,011.00</td>
<td>12/25/2013</td>
</tr>
<tr>
<td>USDA #5</td>
<td>Loyalton/Portola Equipment</td>
<td>$369,396.47</td>
<td>$4,824.00</td>
<td>7/14/2014</td>
</tr>
<tr>
<td>USDA #7</td>
<td>Improvements/Debt Service</td>
<td>$360,630.00</td>
<td>$3,847.50</td>
<td>7/14/2014</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$6,397,484.43</strong></td>
<td><strong>$67,216.21</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Debts**

<table>
<thead>
<tr>
<th>Payee</th>
<th>Purpose</th>
<th>Balance June 30, 2010</th>
<th>Monthly Payment</th>
<th>Maturity Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philips Medical Capital</td>
<td>PCR Compano Basic Unit</td>
<td>$8,965.75</td>
<td>$1,515.87</td>
<td>12/1/2010</td>
</tr>
<tr>
<td>Philips Medical Capital</td>
<td>Pre-Op Equipment</td>
<td>$10,299.24</td>
<td>$1,476.42</td>
<td>12/1/2010</td>
</tr>
<tr>
<td>Philips Medical Capital</td>
<td>GE Ultrasound</td>
<td>$14,799.73</td>
<td>$1,514.10</td>
<td>12/1/2010</td>
</tr>
<tr>
<td>Philips Medical Capital</td>
<td>CT Scanner</td>
<td>$27,898.91</td>
<td>$3,183.63</td>
<td>11/15/2011</td>
</tr>
<tr>
<td>Philips Medical Capital</td>
<td>CT Modular Suite</td>
<td>$60,809.45</td>
<td>$4,192.32</td>
<td>9/15/2011</td>
</tr>
<tr>
<td>Philips Medical Capital</td>
<td>CT Scanner</td>
<td>$59,938.12</td>
<td>$3,952.01</td>
<td>9/15/2011</td>
</tr>
<tr>
<td>Philips Medical Capital</td>
<td>CT Foundation</td>
<td>$17,973.49</td>
<td>$1,854.13</td>
<td>4/1/2011</td>
</tr>
<tr>
<td>Philips Medical Capital</td>
<td>Dry-Vue Laser Images</td>
<td>$42,890.33</td>
<td>$3,363.55</td>
<td>1/1/2010</td>
</tr>
<tr>
<td>Beckman Coulter</td>
<td>ACL 7000</td>
<td>$2,659.51</td>
<td>$273.88</td>
<td>4/29/2011</td>
</tr>
<tr>
<td>West America Bank</td>
<td>Canon Copiers</td>
<td>$385,046.29</td>
<td>$3,171.02</td>
<td>4/23/2011</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$238,543.37</strong></td>
<td><strong>$22,172.05</strong></td>
<td></td>
</tr>
</tbody>
</table>

The District currently does not have a reserve policy, but has a goal to maintain 180 days of operating revenue. At the end of FY 09-10, the District had an unrestricted net asset balance of $1.9 million, or approximately one month in operating expenditures.

The District participates in several joint power authorities (JPAs), including a JPA for worker's compensation, the Association of California Healthcare Districts (ACHD), and CHR Optima for insurance.

**HEALTHCARE SERVICES**

**Service Overview**

EPHD runs a hospital with two campuses, and five clinics. Hospital services provided include emergency and ambulance services, full service laboratories, diagnostic imaging (with the exception of MRIs), respiratory therapy, inpatient and outpatient surgery, and outpatient therapy such as endoscopies. Clinic services provided include dental, medical, nutrition, gastroenterology, pediatrics, chiropractics, orthopedics, podiatry, cardiology,
gynecology, internal medicine, family practice, occupational testing, and occupational medicine. The District also provides durable medical equipment (DME) and home oxygen services.

**Staffing**

EPHD has four family nurse practitioners and 21 doctors that provide services directly to patients. There are 16 general practice physicians, and five physicians with specialties—one in dentistry, two in chiropractics, one in obstetrics, and two in podiatry.

All doctors, nurses, and practitioners are expected to have appropriate certifications; and licenses as mandated by law in order to practice in EPHD, or oversee hospitals and clinics. EPHD partners with Feather River College (FRC) to provide clinical education training in FRC’s Vocational Nursing Program.

**Facilities and Capacity**

The District operates the following health care facilities: Eastern Plumas Hospital, Portola Dental Clinic, Portola Medical Clinic, Graeagle Medical Clinic, Loyalton Medical Clinic, and Indian Valley Medical Clinic. EPHD owns Eastern Plumas Hospital, Portola Dental Clinic and Portola Medical Clinic; Sierra Valley Healthcare District owns Loyalton Medical Clinic; and Indian Valley Healthcare District owns Indian Valley Medical.

The Eastern Plumas Hospital has two campuses, one in Portola and one in Loyalton. Each campus provides basic inpatient services. The Loyalton campus has 39 long-term beds available, while the Portola campus has 27 long-term beds and nine acute beds available. There is always an on-call doctor available for emergencies. Hospital services available at the Portola campus include regional ambulance services, a 24-hour emergency room, a full service laboratory, diagnostic imaging (x-ray, ultrasound, CT, and mammogram), respiratory therapy, scheduled inpatient and outpatient surgery, outpatient procedures, skilled nursing, surgical ward, and keeping of medical records. Hospital services available at the Loyalton campus include skilled nursing and keeping of medical records.

Loyalton Medical Clinic provides family practice, pediatrics, nutrition counseling, and podiatry. This clinic is operated by EPHD through an OASA with Sierra Valley Healthcare District.

Portola Medical Clinic provides family practice, gastroenterology, general surgery, nutrition, orthopedic surgery, podiatric surgery, internal medicine, gynecology, pediatrics, OB/GYN, pediatrics, and podiatry.

Portola Dental Clinic provides dental services.
Graeagle Medical Clinic provides family practice, cardiology, chiropractics, gynecology, nutrition counseling, occupational medicine, orthopedic medicine, and podiatry. The Graeagle clinic facility is leased from Graeagle Land and Water.

Indian Valley Medical Clinic provides family practice, chiropractic, general surgery, orthopedics, and podiatry. This building is rented from IVHD. This facility is outside of EPHD bounds (as part of the Indian Valley Healthcare District), but is currently under EPHD management as of 2007.

All facilities were reported to be in good condition, but require work and need to be updated. District’s facilities appear to have sufficient capacity to meet needs; however, capacity to serve demand is constrained by the District’s ability to hire and retain adequate physician staffing levels.

Infrastructure Needs

The District’s facilities are in need of remodeling. The building which houses the boilers and the boilers themselves are planned to be replaced, if grant funds become available, by 2013. The District has made plans for this capital improvement in its capital budget.

Challenges

The District reported the following challenges to providing adequate services:

- There are mounting requirements and standards to meet with decreased revenues;
- Reduced revenues have forced the District to cutback service levels, such as discontinuing OB services; and
- Hiring and retaining sufficient physician staffing levels.

At the end of 2010, the District started formulating a strategic plan. As part of the plan, the District is reviewing opportunities to introduce traveling physicians for specialties, such as endoscopy and plastic surgery. EPHD is also currently undertaking a large electronic records project to digitize records and reduce duplication of efforts.

Service Adequacy

There are several benchmarks that may define the level of healthcare service provided by an agency, such as complaints, patient outcomes, occupancy rates, staffing levels, costs, emergency room closures and workload, operating room use and the extent to which residents go to other hospitals for service. Complaints, costs and staffing levels were discussed in the previous sections of this chapter. Indicators of service adequacy discussed here include 1) treatment response rates to heart attacks and pneumonia, 2) hospital occupancy rate, 3) pneumonia mortality rates, 4) mortality rates related to other
conditions, 5) EMS ambulance diversion rates, 6) operating room use, 7) the extent to which residents go to other hospitals for service, and 8) accreditation information. These indicators for measuring service adequacy are established by the Center for Medicare and Medicaid Studies (CMS)\textsuperscript{179} and Office of Statewide Health Planning and Development (OSHPD).

Although this data is not available specifically for EPHD or even for Plumas County, it is important to discuss Prevention Quality Indicators (PQIs).\textsuperscript{180} Due to small population sizes, twenty-four counties were reported using seven groupings of two to five counties each. Groups were used because the count of selected hospitalizations in some counties was too small for meaningful analysis. Plumas County was grouped together with Lassen, Modoc, Sierra, and Nevada into the Northeastern Group. This group had California's best (lowest) rates for PQIs, suggesting that residents there have the best access to outpatient care. When a person receives early and proper treatment for specific medical conditions, disease complications may be reduced or eliminated, disease progression may be slowed, and hospitalization may be prevented.

Community-acquired pneumonia is one of the leading causes of death both nationwide and in California. For this reason, OSHPD chose it to be one of the conditions studied in the California Hospital Outcomes Program (CHOP), an initiative mandated by the State of California. The latest reports available are for 2002-2004. In 2004, EPHD had similar community-acquired pneumonia mortality rates to the State average. Rates for Plumas Healthcare District and Seneca Healthcare District in Plumas County were lower than the State average.

Inpatient Mortality Indicators (IMIs) for EPHD are available for acute myocardial infarction, congestive heart failure, gastro-intestinal hemorrhage and pneumonia for 2009.\textsuperscript{181} Evidence suggests that high mortality may be associated with deficiencies in the quality of hospital care provided. The IMIs are part of a suite of measures called Inpatient Quality Indicators (IQIs), developed by the Federal Agency for Healthcare Research and Quality (AHRQ), that provide a perspective on hospital quality of care. IMIs are calculated using patient data reported to OSHPD by all California-licensed hospitals. All IMIs include risk-adjustment, a process that takes into account patients' pre-existing health problems to "level the playing field" and allow fair comparisons among hospitals. The District's mortality rates in 2009 for myocardial infarction were 30 percent compared to seven percent statewide; 16 percent for congestive heart failure compared to three percent.

\textsuperscript{179} EPHD website, "Quality Measures" document

\textsuperscript{180} The Prevention Quality Indicators (PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions" in adult populations. These are conditions for which good outpatient care can potentially prevent the need for hospitalisation or for which early intervention can prevent complications or more severe disease. The Prevention Quality Indicators represent hospital admission rates for the following 14 ambulatory care sensitive conditions.

\textsuperscript{181} OSHPD did not report mortality rates for other conditions (esophageal resection, pancreatic resection, abdominal aortic aneurism repair, craniectomy, percutaneous transluminal coronary angioplasty, carotid endarterectomy, acute stroke, and hip fracture) for the District because fewer than three procedures were performed or conditions were treated.
statewide, zero for gastro-intestinal hemorrhage compared to two percent statewide, and five percent for pneumonia compared to 4.6 percent statewide. The District’s mortality rate for congestive heart failure is significantly higher than statewide. EPHD is considered not significantly different from the statewide average for the other Inpatient Mortality Indicators.

In cases of heart attacks, the District’s goal is to have 100 percent of heart pain or heart attack patients receive aspirin on arrival. During the calendar year beginning in July 2010, EPHD has met its goal every month.

In cases of pneumonia, the goal is to have 100 percent of patients receive antibiotics within six hours of arrival. During the calendar year beginning in July 2010, EPHD has met its goal every month.

The District’s hospitals had an occupancy rate of 77.5 percent in 2010, compared to a statewide average of 71 percent.\(^\text{123}\) This occupancy rate suggests that service adequacy is satisfactory, and there are enough hospital beds in the area to serve patients as needed.

Emergency room closure data was not available for the recent years. The last year when this information was reported was 2007. The EPHD was closed for a total of zero hours during that year. For 2010, in lieu of emergency closure rates, EMS ambulance diversion rates were used as an indicator for emergency room use. In 2010, ambulances were not diverted to other hospitals from EPHD.

The operating room at the EPHD hospital in Portola was used for surgeries approximately one percent of the available time in 2010.\(^\text{133}\) The operating room was used about equally for inpatient and outpatient surgery. The operating room has abundant capacity to accommodate existing demand and possible future growth.

The adequacy of hospital facilities and services in meeting the needs of Eastern Plumas County residents can be gauged by the extent to which residents travel outside their region to receive hospital services. The rates were calculated based on patient discharge data from OSHPD. Residential location was approximated by zip code. About 73 percent of Eastern Plumas County residents patronize the hospital in Portola.

There are several major healthcare-related accreditation organizations in the United States: Healthcare Facilities Accreditation Program (HFAP), Joint Commission (JC), Community Health Accreditation Program (CHAP), Accreditation Commission for Health Care (ACHC), The Compliance Team – Exemplary provider programs, Healthcare Quality Association on Accreditation (HQAA), and DNV Healthcare, Inc. (DNVHC). For the State of

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\(^{133}\) Operating room use rates are calculated as the number of surgery-minutes divided by the annual capacity of the operating rooms (number of minutes in a year is based on 24-hour use).
California the primary accreditation organization is the Joint Commission. The Joint Commission is a not-for-profit organization that accredits and certifies more than 19,000 health organizations and programs in the country. Accreditation can be earned by an entire healthcare organization, for example, hospitals, nursing homes, office-based surgery practices, home care providers, and laboratories. In California, the Joint Commission is part of the joint survey process with State authorities. Hospitals are not required to be accredited in order to operate. Accreditation generally recognizes outstanding performance by a healthcare provider. EPHD does not maintain any accreditations.

**Figure 10-6: Eastern Plumas Healthcare District Service Profile**

<table>
<thead>
<tr>
<th>Facilities</th>
<th>Location</th>
<th>Condition</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loyalton Medical Clinic</td>
<td>725 Third Street, Loyalton, CA</td>
<td>Good</td>
<td>EPHD</td>
</tr>
<tr>
<td>Portola Medical Clinic</td>
<td>480 First Avenue, Portola, CA</td>
<td>Good</td>
<td>EPHD</td>
</tr>
<tr>
<td>Portola Dental Clinic</td>
<td>480 First Avenue, Portola, CA</td>
<td>Good</td>
<td>EPHD</td>
</tr>
<tr>
<td>Graeagle Medical Clinic</td>
<td>7597 Hwy 89, Suite 1, Graeagle, CA</td>
<td>Good</td>
<td>Rented</td>
</tr>
<tr>
<td>Indian Valley Medical Clinic</td>
<td>176 Hot Springs Road, Greenville, CA</td>
<td>Good</td>
<td>Rented</td>
</tr>
<tr>
<td>Eastern Plumas Hospital—Loyalton</td>
<td>700 Third Street, Loyalton, CA</td>
<td>Good</td>
<td>EPHD</td>
</tr>
<tr>
<td>Eastern Plumas Hospital—Portola</td>
<td>500 First Avenue, Portola, CA</td>
<td>Good</td>
<td>EPHD</td>
</tr>
</tbody>
</table>

**Service Challenges:**
The District's challenges include getting physicians, and meeting requirements with reduced revenue. The District had to discontinue OB services to stay within means.

**Facility Needs/Deficiencies:**
The boilers are planned to be replaced in 2013 and the facilities need remodeling.

**Facility Sharing:**
Current Practices:
The District practices facility sharing by managing clinics for IVHD and SVHD. The District works collaboratively with five other providers for training and referrals, especially as it pertains to psychiatric cases and drug abuse.

**Future Opportunities:**
The District did not identify future opportunities for facility sharing.

**Service Adequacy:**
- Occupancy rate, 2010: 77.5% (versus statewide average of 71%)
- Heart attack: 100% (actual) out of 100% (goal) of patients given aspirin on arrival
- Pneumonia: 100% (actual) out of 100% (goal) of patients given antibiotics within first six hours
EASTERN PLUMAS HEALTHCARE DISTRICT DETERMINATIONS

Growth and Population Projections

- There are approximately 6,239 residents within the District.
- Over the past few years, the District has not experienced a significant increase in population and service demand.
- There are several potential developments throughout the District that may lead to significant population growth in the long term.
- Due to the recent recession, most of the planned developments are on hold and therefore minimal growth is expected within the District in the next few years.

Present and Planned Capacity of Public Facilities and Adequacy of Public Services, Including Infrastructure Needs and Deficiencies

- The District’s facilities appear to have sufficient capacity to meet needs; however, capacity to serve demand is constrained by the District’s ability to hire and retain adequate physician staffing levels and by the elimination of some services due to declining revenues.
- The District’s facilities in Portola are in need of remodeling and the boilers need to be replaced.
- Capital improvements are planned for on an annual basis during each budget process.
- The District should consider adopting a capital improvement plan to identify financing needs, potential revenue sources for these needs and timing of the improvements.

Financial Ability of Agencies to Provide Services

- The District reports that current financing levels are adequate to deliver services; although, the District has been compelled to eliminate some services, due to reduced revenues as a result of the recent recession.
- While financing levels appear to be adequate, the District faces the challenge of meeting mounting requirements and standards with decreased revenue.
Reduced revenues have forced the District to cutback service levels, such as discontinuing OB services.

EPHD seeks donations and applies for various loans and grants to increase its level of funding and fund capital improvements.

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**Status of, and Opportunities for, Shared Facilities**

- The District practices facility sharing by managing clinics for IVHD and SVHD.
- EPHD works collaboratively with five other providers for training and referrals.
- Consolidation with another healthcare district would offer opportunities for shared resources and finances.

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**Accountability for Community Service Needs, Including Governmental Structure and Operational Efficiencies**

- EPHD demonstrated accountability and transparency by disclosing financial and service related information in response to LAFCo requests.
- The District conducts extensive outreach in the community.
- A governmental structure option is consolidation with SVHD.
Richard L. Berkson, Principal, Economic & Planning Systems (EPS)

Case Study #1 - Health Care Diagnosis, Options for Treating An Ailing Agency — Highlights from the Recently Completed Contra Costa LAFCO Special Study: Mt. Diablo Health Care District Governance Options

- Special Study: Mt. Diablo Health Care District Governance Options, Prepared by Economic & Planning Systems, Inc. and E. Mulberg & Associates, January 2012 (Excerpts)
- Contra Costa LAFCO Executive Officer’s Report, January 2012
Final Report

Special Study:
Mt. Diablo Health Care District Governance Options

Accepted by LAFCO 1/11/12

Prepared for:
Contra Costa LAFCO

Prepared by:
Economic & Planning Systems, Inc.
E Mulberg & Associates

January 11, 2012

EPS #21082
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1. **INTRODUCTION**

**Mt. Diablo Health Care District**

**Formation and Statutory Authority**

The Mt. Diablo Health Care District (MDHCD) was formed pursuant to Health and Safety Code Sec. 32000 in 1948 as the Concord Hospital District by the registered voters of the District. Following the formation of the Concord Hospital District in 1948, the District built and operated the Mt. Diablo Community hospital with funding provided by property taxes.

In 1994 (SB 1169) the State Legislature amended the enabling legislation renaming hospital districts to health care districts. The definition of health care facilities was expanded to reflect the increased use and scope of outpatient services. The legislation enacted a number of other substantial regulations governing the transfer of property, conflicts of interest, health care secrets and the public meeting act, lease agreements, the sale of property and assets.

**Boundaries**

The MDHCD boundaries include the cities of Martinez, Lafayette (portions), Concord, and Pleasant Hill (portions), along with the unincorporated communities of Clyde and Pacheco. **Figure 1** shows the current boundaries of the MDHCD. The MDHCD has evolved over the years both in terms of its physical boundaries and its organizational structure. The City of Martinez was annexed in 1956, before the existence of Local Agency Formation Commissions (LAFCOs). Between 1967 and 1991, there were a number of boundary changes relating to the MDHCD (i.e., annexations, detachments), as well as two proposals to dissolve the District in 1972 and 1976, both of which were denied by LAFCO. The City of Pleasant Hill attempted unsuccessfully on two occasions to detach from the District.

**Financing**

The MDHCD continues to receive property taxes to fund its operations. It currently receives approximately $245,000 annually from its property tax apportionment.

**Other Relevant History**

In 1996, the MDHCD faced bankruptcy and entered into a Community Benefit Agreement (CBA) which transferred the assets of the District to John Muir Health (JMH) in exchange for certain assurances regarding health care services to be provided within the District.

The principal act for health care districts, Health and Safety (HSC) Code 32000, allows for transfer of district assets to either a private corporation or a nonprofit agency under certain conditions. HSC section 32121 (p) requires approval by the registered voters for the transfer of 50 percent or more of the district's assets. Measure MM was submitted to the voters on November 5, 1996. The measure requested approval of the merger of Mt. Diablo Medical Center and John Muir Medical Center. The transfer became effective when the voters approved Measure MM.
The MDHCD has been involved in lawsuits with JMH regarding the provision of various services and facilities. During 2001 and 2002, the MDHCD spent approximately $739,000 on legal fees. The actions ultimately were settled.

In addition to the transfer of assets, the CBA also created the Community Health Fund (CHF); the CBA requires JMH to provide funding for CHF administrative expenses and to contribute $1 million per year to fund CHF programs, grants and events that address health issues and promote a healthy community. The MDHCD Directors serve on the CHF Board, ex officio (and/or appoint CHF Board representatives), along with the JMH appointees. The CHF Board makes annual allocations of the CHF to meet health care needs within the District.

**Purpose of the Study**

LAFCO initiated this Special Study in response to past and ongoing community concerns about whether the MDHCD should continue as a special district, and in response to recommendations of the Healthcare MSR adopted by Contra Costa LAFCO in 2007. The MDHCD was the subject of Grand Jury Reports in 2001, 2003, 2008 and 2011. The Grand Jury has been concerned that the District is no longer fulfilling a useful mission and should be dissolved. Other members of the community have called on LAFCO to begin the process of dissolving the District.

Under Government Code (GC) §56375(a)(3), a commission may initiate the dissolution or consolidation of a district only if that change of organization or reorganization is consistent with a recommendation or conclusion of a study prepared pursuant to GC §56378 (special study), §57425, (SOI update), or §56430 (MSR). This is a Special Study undertaken pursuant to Government Code §56378. That statute requires that this study include an inventory of the agency and determine the maximum service area and service capacity.

This Final Draft Report includes revisions to the Draft Report (12/2/11) based on comments received. A summary of comments and responses is included as Appendix C. A Final Report will be prepared following the LAFCO hearing January 11, 2012.

**Determinations Required to Dissolve or Consolidate Districts**

Under §56881(b), if LAFCO initiates action to dissolve or consolidate a district the resolution making the determination must include both of the following determinations:

a. That the public service costs resulting from a dissolution or change of organization would be less than or substantially similar to the costs of alternative means of providing the service.

b. That a dissolution or change of organization would promote public access and accountability for the community services needs and financial resources.

This purpose of this study is to assist the Commission in evaluating whether it can make the required determinations.
Evaluation of Possible Changes of Organization

This Study evaluates the relative merits of the following potential actions by the Commission:

a. Maintaining the status quo.

b. Consolidation with another "like" or "unlike" district (i.e., formed under the same or different principal acts).

c. Dissolution and appointment of a successor for winding up purposes only.

d. Dissolution and appointment of a successor to continue health care services within the district.

The options are evaluated based on relative costs of providing service, public access and accountability, and other factors related to community acceptability and provision of comparable functions and services.

Process

The process for a change in organization includes several basic steps summarized below, pursuant to GC §57077. There may be some variations depending on what action, if any, LAFCO decides to take regarding future service in the dissolved district boundaries.

a. At a noticed public hearing, the Commission accepts the special study, considers adopting a zero SOI to signal proposed dissolution and for consistency with SOI (GC §56375.5), considers making findings in accordance with the conclusion/recommendation of the special study and considers adopting a resolution initiating dissolution.

b. LAFCO notifies State agencies per GC §56131.5 and allows a 50-day comment period.

c. At a noticed public hearing, LAFCO considers approving dissolution.

d. Following 30-day reconsideration period (GC §56895), LAFCO staff holds protest hearing in the affected territory (GC §57008). The protest hearing is a ministerial action. While the Commission is the conducting authority, it often designates the Executive Officer to conduct the hearing.

e. Absent requisite protest, Commission orders dissolution after determining whether an election is required.

f. If there is no election or the dissolution is approved by the voters, LAFCO staff records dissolution paperwork and files with the State Board of Equalization making dissolution effective.

Additional LAFCO actions are noted in subsequent chapters for each option evaluated.
2. SUMMARY OF FINDINGS AND RECOMMENDATIONS

In accordance with the requirements of GC §56378, this section summarizes those items to be included as part of a special study. These items are discussed in additional detail in subsequent chapters. This chapter also includes recommendations regarding change of organization.

Findings

1. Inventory of the District Assets and Liabilities

   Assets - The MDHCD has no physical assets, other than office equipment. The MDHCD had approximately $833,946 in fund balances at the end of 2010; the projected fund balance at the end of 2011 is $787,707.¹ This balance could change depending on actual expenditures and a final accounting for the year.

   Liabilities - The MDHCD will be liable for contract termination costs for the newly hired interim Executive Director.² The MDHCD’s long-term liability consists of health insurance benefits provided to two directors (one current director, one former director). As described in more detail below, the present value of the health insurance liabilities, including all potential future payments, are estimated at more than $800,000.³ These benefits and their cost to the MDHCD have been reduced by agreement with the two directors, beginning January 1, 2012. According to the MDHCD, there are no other long-term obligations or liabilities.⁴

2. Maximum Service Area and Service Capacity

   The MDHCD current service area corresponds to its SOI, which is coterieshous. The MDHCD service capacity is limited primarily by its financial resources, which currently total approximately $277,000 annually including property tax and John Muir contributions, in addition to appropriation of any available fund balances. Administrative, legal, and other overhead costs including election costs consume a majority of these resources, as described below, limiting the amount available to provide or expand health care programs.

3. District’s Accountability for its Financial Resources

   Funds Allocated to Purposes other than Health Care – From 2000 through 2011, approximately 83 percent of expenditures went towards overhead and administrative costs, including office staff, health insurance benefits, legal and litigation fees, and election costs.

¹ Comments and Questions by the Mt. Diablo Health Care District, December 27, 2011

² Reported to be $10,000 if termination occurs within first three months.


⁴ Roy Larkin, MDHCD Secretary/Treasurer, email transmittal received by EPS 10/21/11.
A significant portion of the $740,000 in legal fees spent in 2001-2002 was for litigation pursued in furtherance of the MDHCD’s mission.

In 2011, overhead and administrative expenditures accounted for about 38 percent of total expenditures. However, after fund balances are drawn down and unavailable, overhead and administrative costs could equal at least 45 percent of total expenditures (before accounting for increases in staff costs, reduced health insurance costs, and potential added legal costs in 2012). After adding election costs, overhead will consume nearly all of the MDHCD’s annual operating revenues (before including the use of any available fund balances).

**Funds Allocated to Health Care** – From 2000 through 2011, approximately 17 percent of MDHCD expenditures were allocated to its Community Action programs, including grants and direct services (e.g., its CPR program). As noted above, a significant portion of the $740,000 in legal fees spent in 2001-2002 were for litigation pursued in furtherance of the MDHCD’s mission.

In 2011, the MDHCD budgeted about $620,000, or 80 percent of its expenditures to Community Action programs; however, actual expenditures for Community Action programs totaled $162,000 or about 50 percent of total expenditures.

2011 budgeted expenditures slightly exceed annual revenues by drawing upon current fund balances. After those fund balances are substantially reduced, which could occur in about one to two years depending on future expenditures, MDHCD expenditures will be limited to current annual revenues of approximately $277,000 including property tax and John Muir contributions.

After deducting 2011 budgeted overhead costs of $160,000 (including insurance benefits), approximately $117,000 or 42 percent would remain for Community Action funding. Overhead expenditures are likely to increase in 2012 with the addition of an interim Executive Director, with offsets resulting from expected reductions in health insurance benefit costs. In addition, election costs could add a cost of $128,400 in 2012, pushing overhead expenditures to about $288,400 leaving no annual revenue available for health care (before utilizing fund balances or considering insurance benefits and Executive Director costs).

**4. District’s Accountability for the Community Services Needs**

The MDHCD is run by locally elected directors within the boundaries of the District. However, there have been instances where board seats were uncontested resulting in no election, and instances where vacancies have been filled by appointment. The relatively small size of the MDHCD budget and minimal financial resources (after accumulated fund balances are utilized) limit its ability to undertake significant actions and increase its visibility within the community, which otherwise might mitigate these issues.

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5 Estimated election cost based on 102,701 registered voters within the MDHCD boundaries as of June 24, 2011, and a cost of $1.25 per voter (Contra Costa County Elections Department). If a measure to dissolve the District is also on the ballot there would be an additional $25,675 cost.
In the event of dissolution, any potential successor agency should have an established record of achieving accountability regarding its ability to meet health service needs. Potential successor agencies include the City of Concord, County Service Area EM-1, and the Los Medanos Community Healthcare District.

5. **Public Access and Transparency of the District**

The MDHCD recently hired an Executive Director; the District anticipates that this action will help to remedy public accessibility issues, both recent and historic, i.e., compliance with open meeting laws, public records requests, development of a needs analysis and strategic plan, noticing requirements, use of a more open and explicit grant process, and grant monitoring. The current interim Executive Director has been hired for a 3-month period, and may be utilized after that period and paid on an hourly basis. The MDHCD may hire a permanent Executive Director, or similar staff position, after the current interim Executive Director's contract expires.6

6. **Other Agencies Providing Similar Health Care Services**

Other agencies operating within the boundaries of the District, including both public and private organizations, provide health care services similar services similar to those provided by the MDHCD. For example, Contra Costa Emergency Services currently provides CPR training to students in partnership and with funding provided by the MDHCD. These agencies, notably, CSA EM-1, are identified in this report as being capable of providing services comparable to the MDHCD.

7. **Public Costs and/or Savings Resulting from Dissolution or Consolidation as Compared to Maintaining the Status Quo**

Dissolution without any further continuation of service would reduce expenditures for overhead, administration, legal and election costs. Annual expenditures for ongoing health Insurance benefits will remain for the life of each of the two benefiting Directors; these insurance expenditures currently are about $45,000 annually, with a total estimated liability of $800,000. Recent reductions of $17,420 negotiated by the MDHCD have reduced these annual expenditures to about $27,580. An actuarial analysis has not been conducted of the total liability assuming the reduced insurance costs, however, the liability may be reduced by as much as half.

Dissolution with the appointment of a successor to continue services would eliminate approximately $75,000, which is the amount currently spent by the MDHCD on overhead and administration (not including health insurance costs, or future increases in MDHCD staff costs for an Executive Director, and potential legal charges). In addition, there would be no need for bi-annual election expenditures of about $128,400. These administrative savings would be available for health care purposes. Potential successor agencies for continuation of services are expected to continue the District’s services largely through the use of existing staff capabilities, however additional part-time staff may be required depending on the type of programs implemented, as well as the level of program oversight and management of

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6 EPS interview with Dyamon Doss, Executive Director, MDHCD, 12/30/11.
public participation. For example, CSA EM-1, which is recommended as a successor in Recommendation #3, below, estimated that it could require 0.5 to 0.8 of an additional staff position, which could equate approximately $40,000 to $60,000. Annual obligations for ongoing health insurance benefits would continue, as noted above.

For the initial years that the CSA EM-1 zone is in operation, if it is designated as successor agency, the Commission could impose a condition requiring CSA EM-1 to provide an annual report outlining how the zone funds are spent. As part of the MSR process, the Commission could consider whether annual reports are necessary and should be continued.

8. Certain successor responsibilities could be shared between CSA EM-1 and the City of Concord.

One of the key successor functions, in the event of dissolution of the District, is the administration of the Community Benefit Agreement (CBA) originally established between the MDHCD and JMH as a condition of the transfer of certain assets to JMH. The CBA established the Community Health Fund (CHF) that provides for the granting of $1 million in annual funding for health care services within the CHF Service Area.

While not an issue that can be resolved through the LAFCO action, some cooperation between affected agencies as well as changes to the CBA may be in order to assure effective management, enfranchisement of the affected electorate, and continuity. For example, CSA EM-1 could work with JMH to monitor the CBA and its terms, appoint members to a newly constituted Board of the CHF, and to continue participation in CHF annual allocations of $1 million, and finally assume responsibility for other aspects of the CBA. The County would assure that obligations of the MDHCD, including payment of lifetime health insurance benefits to two directors, were met entirely through the use of MDHCD reserves and property tax revenues.

The City of Concord also could be a new signator to the CBA, in addition to the County; termination and changes to the CBA would require the concurrence of both the City, which has a vested interest in the JMH Concord campus, and the County. This arrangement would provide for local control and oversight of CBA terms, as well as for regional involvement and oversight. The John Muir Concord campus serves not only Central County (53.8 percent of patients reside in Central County) but other parts of the County as well.

Representation on the CHF Board could consist of the same membership as for the CSA EM-1 zone advisory board, i.e., to include representatives of the City of Concord, the unincorporated areas, and other cities currently within the MDHCD. This arrangement helps to maintain a local and regional perspective, which is important considering that the CHF service area includes Central County and East County.

The CBA includes a termination provision requiring 180 days written notice in advance of the end of each 50-year term (the first term ends December 31, 2049). This provision provides an opportunity for public control if John Muir Health fails to maintain its high level of service and commitment to the community. A longer notice period, e.g., five years, would minimize potential John Muir Health disinvestment in the facility that could occur due to protracted uncertainties about possible termination. The future signators to the CBA could revise terms
of the CBA as appropriate to address local concerns about the future of the JMH Concord facilities, as well as to assure long-term site of the public's interests.

Recommendations

1. Justification exists for dissolution of the MDHCD, considering that over the past ten years only 17 percent of MDHCD expenditures have been applied towards community health care purposes.

From 2000 through 2007, virtually no funds were spent for community health care purposes (with the exception of funds spent on litigation related to the CBA). While the MDHCD recently has undertaken efforts to increase allocations to community health care, reduce insurance costs, and hire professional staff to implement a strategic plan, the latter action will also increase administrative costs and not necessarily result in additional community health programs or services.

After the MDHCD has drawn down its fund balances, overhead expenses will account for 45 percent or more of total expenditures. Potential insurance cost savings are unlikely to offset added costs for an Executive Director, unless the Executive Director position is limited to the equivalent of approximately one day per week, or a future staff position providing similar functions is filled at a cost lower than the current interim Executive Director.

2. Organizational options exist that could better utilize existing MDHCD resources.

In addition to the "status quo" and "dissolution", this Special Study considers consolidation with other entities currently providing health care services within or adjacent to the District boundary, including the County Service Area EM-1 (CSA EM-1) and the Los Medanos Community Healthcare District (LMCHD). These options could very likely provide comparable health care services at lower cost relative to the "status quo".

3. If reorganization occurs, evaluation of options considered in this Study favors dissolving the MDHCD and naming the existing CSA EM-1 as the successor agency.

CSA EM-1 is under the oversight of the County of Contra Costa and management of County Health Services Department. Creation of a zone coterminal with the existing MDHCD boundaries within CSA EM-1 and appointment of an advisory board would substantially eliminate existing MDHCD administrative costs and election costs (with the exception of mandatory commitments to lifetime health care benefits). This option would reduce existing overhead costs, since the County Health Services Department (which operates CSA EM-1) has the administrative and professional staff to provide services without a significant increase in their current costs, though some administrative costs may be necessary depending on programs provided.

Public access and accountability would be promoted by use of existing County governance, finance and management structure, creation of a zone to assure the use of funds for health care needs within the existing MDHCD boundaries, and establishment of an advisory board from residents of the zone (existing District boundaries) consisting of knowledgeable, experienced professionals and members of the community. The initial membership of the advisory board could include members of the current MDHCD Board, to facilitate continuity.
3. **HEALTH CARE DISTRICTS**

**Health Care Districts in California**

California at the end of World War II faced a shortage of hospital beds and acute care facilities, especially in rural areas of the state. In 1945 the Legislature enacted the Local Hospital District Law\(^7\) to establish local agencies to provide and operate community hospitals and other health care facilities in underserved areas, and to recruit and support physicians. In 1993 the State Legislature amended the enabling legislation renaming hospital districts to health care districts. The definition of health care facilities was expanded to reflect the increased use and scope of outpatient services.

In total, 82 health care districts in California provide a variety of services. Some of the characteristics are displayed in **Table 1**. The table shows that 30 districts do not operate hospitals, five provide ambulance service, and 29 are located in rural areas. Many districts have been dissolved, and/or transferred ownership or operation of facilities to other entities.

As further described in the MSR, the health care industry "in general is going through changes, many of which are financially driven." Hospitals and their medical staffs are experiencing declining public financing through Medi-Cal and Medicare. Costs for construction and personnel are rising, and the overall emphasis by consumers and their medical providers for expensive technologies are driving costs up. In addition, human resources gaps at all health provider levels threaten the stability of providers in the provision of services, especially hospitals when attempting to staff beds. Other unique legislative parameters also face California hospital providers. California remains the only state with required nurse staffing ratios, and hospitals are continuing to grapple with the State-mandated seismic retrofit requirements due to impact the hospitals as early as 2013.\(^8\)

Dissolution of hospital/health care districts has been considered in the past in Contra Costa County. The dissolution of the LMCHD was considered in 1999, but never completed. Other districts in Fresno, Sierra, and Plumas counties have been dissolved and/or consolidated into other districts.

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\(^7\) Health and Safety Code section 32000 et seq.

\(^8\) Excerpted from the Public Healthcare Services MSR, 2007.
January 11, 2012 (Agenda)

Contra Costa Local Agency Formation Commission
651 Pine Street, Sixth Floor
Martinez, CA 94553

Mt. Diablo Health Care District Special Study and Governance Options

Dear Members of the Commission:

SYNOPSIS

This report presents the LAFCO special study of governance options for the Mt. Diablo Health Care District (MDHCD) (Attachment 1), and a discussion of LAFCO's authority and governance options. The report also provides general background and process information, highlights from the special study and public comments, and a summary of next steps.

On January 11, the Commission will conduct a public hearing at which time it will receive the Final Draft Special Study and be asked to consider selection of a governance option and related actions. Representatives of the MDHCD will also provide a presentation at the hearing.

COMMISSION'S AUTHORITY

A number of the public comment letters received in response to the MDHCD special study raised questions regarding LAFCO's authority.

LAFCOs were formed in 1963 to 1) encourage the logical and orderly formation of local government agencies, 2) preserve agricultural resources, and 3) discourage urban sprawl. LAFCO's authority is vested in the Cortese-Knox-Hertzberg Local Government Act of 2000 (Gov. Code §56000 et seq.). All references in this staff report are to the Government Code, unless otherwise noted.

LAFCO can regulate changes of organization (e.g., annexation/detachment, incorporation/dissolution, consolidation/merger, etc.), establish and amend spheres of influence (SOIs), authorize the extension of services outside a local agency's jurisdictional boundary, conduct municipal service reviews (MSRs), and initiate certain changes of organization (i.e., consolidation, dissolution, merger, establishing subsidiary districts). LAFCO-initiated actions must be supported by an SOI update, MSR or special study.
LAFCO can conditionally approve a change of organization or SOI amendment by including terms and conditions (Gov. Code §§56375, 56428, 56880). The Commission may condition its approval on an array of factors including those set forth in Government Code Section 56886 (Attachment 2).

LAFCO’s mandate to conduct MSRs of cities and special districts involves the review of various factors including 1) growth and population projections; 2) present and planned capacity of public facilities and adequacy of public services, including infrastructure needs or deficiencies; 3) financial ability of agencies to provide services; 4) status of, and opportunities for, shared facilities; and 5) accountability for community service needs, including governmental structure and operational efficiencies. The outcome of a LAFCO MSR may result in improved efficiencies, operations and accountability of local agencies.

LAFCO does not directly oversee local agencies, nor does LAFCO establish local agency policies and standards. The Board of Supervisors, city councils and special district boards are responsible for setting policy and directing the operations of their respective local agencies.

BACKGROUND

History of Mt. Diablo Health Care District - The MDHCD, previously the Concord Hospital District, was formed in 1948, with voters approving the District formation and a special parcel tax to build the Mt. Diablo Community Hospital. The MDHCD boundaries include the cities of Martinez, Lafayette (portions), Concord, and Pleasant Hill (portions), along with the unincorporated communities of Clyde and Pacheco.

The District is funded primarily by property tax revenues (ad valorem). In 1996, MDHCD faced bankruptcy and the voters approved a Community Benefit Agreement (CBA) which transferred the assets of the District to John Muir Health (JMH), in exchange for certain assurances regarding health care services to be provided within the District. Per the Agreement, JMH provides funding for administrative expenses and contributes $1 million per year to fund programs and events that address health issues and promote a health community.

The MDHCD does not own or operate any facilities. Per the Agreement between MDHCD and JMH, all rights and title in the Mt. Diablo Medical Center, including land, buildings and equipment, were transferred to JMH. In return, JMH is required to operate and maintain the District’s healthcare facilities and assets for the benefit of the communities served by the District.

The CBA is effective until December 31, 2049, will automatically renew for three additional successive 50-year terms, and includes provisions that allow for termination. The CBA also provides that the MDHCD Directors serve on the Community Health Fund Board and participate in the decisions to allocate funds to health care causes within the District. MDHCD does not control the Community Health Fund Board, although it has the power to appoint one half of the board members.

Chronology of Events Leading to Special Study - On May 11, 2011, the Commission received a report relating to the MDHCD, its history and background, a summary of the findings contained in the 2007 Health Care Services MSR (available on the Contra Costa LAFCO website), and an overview of ongoing concerns relating to the District’s finances and operations as presented in the 2007 MSR, and raised by the Contra Costa Civil Grand Jury (in four separate reports) and the Contra Costa Taxpayers Association.
Following discussion and public comment, the Commission directed staff to prepare a task list, timeline and estimated budget to proceed with a special study relating to governance options, including dissolution, for the MDHCD.

On July 13, 2011, the Commission received information relating to district dissolution (i.e., initiation, timing, election, public hearings, effects of dissolution, special study, etc.). Following discussion and public comment, the Commission directed LAFCO staff to prepare a scope of work and timeline for the special study, distribute a Request for Proposals (RFP), and bring a report and recommendation back to the Commission in August 2011. It should be noted that a detailed timeline for the special study, including release date of the Public Review Draft Study and deadline for public comment, was provided in July 2011. This report is available on the Contra Costa LAFCO website.

On August 10, 2011, LAFCO staff presented a summary of the proposals received in response to the RFP, along with a recommendation. Following discussion and public comment, the Commission authorized LAFCO staff to execute a contract with Economic & Planning Systems (EPS) to prepare the special study relating to MDHCD, and approved a budget adjustment to fund the study. This report is available on the Contra Costa LAFCO website.

In late August, EPS initiated the special study. As provided for in the scope of work, the consultants collected and reviewed information and interviewed affected and interested parties, including MDHCD, John Muir Health, Los Medanos Community Healthcare District, City of Concord, Contra Costa County Health Services Department, County Auditor and others.

The Public Review Draft Special Study was released on December 4, 2011. The Draft study was posted on the LAFCO website and notices were sent to affected agencies and interested parties informing them of the availability of the study. The deadline for submitting comments on the Draft study was December 27, 2011. LAFCO received a total of 25 comment letters and emails.

On December 14, 2011, the consultants presented to LAFCO an overview of the special study, and the Commission received public comments and provided input and direction to the project team.

On January 11, 2012, the Commission will conduct a public hearing at which time it will receive the Final Draft Special Study and summary of comments and responses to comments, and be asked to consider governance options and related actions.

SPECIAL STUDY

The special study was initiated in response to past and ongoing community concerns as to whether MDHCD should continue as a special district, and in response to findings contained in the 2007 LAFCO MSR. The special study provides an overview of the MDHCD - its history, population, operations and services, governance and fiscal condition.

The special study underwent a public review process; 25 comment letters and emails were received. The consultants have prepared a comment log with responses to comments. The comments letters and comment log/responses to comments are presented in the Special Study.

Based on the comments received, the consultants have made several significant additions to the report, including the following:
• Added discussion relating to Concord as a successor agency to continue the service via a subsidiary district
• Added information regarding services/programs provided by CSA EM-1 and related staffing needs
• Added updated information regarding MDHCD staff and budget
• Added a table depicting MDHCD expenditures and revenues 2000-2011 comparing overhead/administrative, insurance, and community action expenditures

The special study identifies a number of governance options, and discusses the advantages, disadvantages, effects and process associated with the various options as summarized below.

The special study recommends and provides justification for the dissolution of MDHCD. If services are to be continued, the special study recommends the appointment of CSA EM-1 as the successor agency to continue services.

GOVERNANCE OPTIONS:

1. Maintain status quo – Under this option, MDHCD would continue to exist and function under its current organization.

Advantages of this option are: that property taxes collected in the District would continue to be spent in the District; and it would provide the MDHCD with time to make changes to its operations. The District recently hired an interim professional Executive Director with health care district experience to assist MDHCD in developing its 2012 budget and operational plan.

Disadvantages are that MDHCD may continue past practices of lack of program activity and high administrative/overhead expenditures.

2. Consolidation with Los Medanos Community Healthcare District (LMCHD) – Under this option, MDHCD and LMCHD would be consolidated into one district.

Advantages include: the continuation of health related services to the MDHCD area; continues the community role in the CBA with JMH; combined revenues from the two districts could be used to enhance services of the consolidated district; and economies of scale could reduce administrative costs.

Disadvantages are that the revenues generated by the MDHCD would be expended for the benefit of all residents of the new, larger district, potentially reducing benefits to existing MDHCD taxpayers. Also, there would be reduced local representation, and likely political opposition to consolidation due to differing communities of interest.

3. Dissolve MDHCD and appoint City of Concord as successor to wind up affairs of MDHCD – Under this option, MDHCD ceases all functions and services. The City would be named as the successor agency to wind up the affairs of the MDHCD and would assume responsibility for the District’s assets and liabilities.

Advantages include elimination of MDHCD administrative expenses, although the City of Concord would incur its own administrative expenses associated with winding up the affairs of the District. Existing property tax revenues would revert to other agencies (after payment of MDHCD obligations), as determined by the County Auditor; and avoids duplication of services provided by other public and private entities.

Disadvantages include: no further provision of MDHCD services/programs; loss of the property tax allocation to fund community health needs; loss of those benefits provided for in the CBA with JMH,
such as participation on the Community Health Foundation, oversight of certain aspects of JMH facilities and licenses. Dissolution of the District under this option will involve terminating the CBA. The Commission would need to decide whether the District's potential future right to reacquire the facilities now owned by JMH is to be treated as an asset of the District, or whether that future right is sufficiently remote and uncertain that when the CBA is terminated any reversionary right to the hospital facilities is also terminated, in which case JMH would have the exclusive rights to those facilities now and in the future.

4. **Dissolve MDHCD and appoint County Service Area (CSA) EM-1 as the successor to continue services** - Under this option, MDHCD would no longer exist. CSA EM-1 would take over the District's obligations including those of the lifetime health insurance benefits of the two MDHCD Board members using the District's reserves and/or property tax revenues.

CSA EM-1 would also continue health care related services. CSA EM-1 provides a range of programs and services including, but not limited to, the following:

- CPR – *How to Save a Life* and *CPR at Home* programs
- Placement of Public Access Defibrillators (AEDs) in community locations
- Public awareness campaigns (e.g., stroke system program – *Act in Time*, cardiovascular emergencies symptoms and actions/response, etc.)
- Child and senior injury prevention programs
- Community disaster preparedness to promote resiliency

As suggested in the special study, LAFCO could condition appointing CSA EM-1 and the flow of the MDHCD property tax allocation on the formation of a zone and establishing an advisory body, and provisions to continue the provisions provided for in the CBA.

Advantages are that the existing territory served by MDHCD would continue to be served by CSA EM-1 (zone), and a portion of the property tax would continue to be directed to community health care needs. Local representation could be achieved by establishing an advisory body. The MDHCD administrative/overhead costs would be eliminated. However, some staffing costs could be incurred as a result of increased programs/services and oversight. It is estimated that a 0.5 to 0.8 position would likely be required depending on the extent of services and activities (e.g., implementing new programs, staffing an advisory body, etc.). We believe these costs would be less than the costs of a District General Manager and/or other administrative costs. CSA EM-1 indicates that it would work to design a program that would be both efficient and accountable so that most of the funding would go to community benefit rather than administrative activities.

Disadvantages are that CSA EM-1 programs are primarily focused on ambulance and emergency medical services; loss of a locally elected board; and the potential for some of the cities to opt out of the zone resulting in reduced future property tax.

5. **Dissolve MDHCD and appoint City of Concord as the successor to continue services** – Under the current configuration of the MDHCD, the City of Concord could not be appointed as the successor agency, as the District bounds extend well beyond the Concord City limits and overlap with other cities.

However, it is possible for the City of Concord to be appointed the successor agency under specific conditions. The City of Concord could apply to LAFCO to form a subsidiary district (i.e., a district of limited powers where the city council serves as ex-officio board of directors of the district). Pursuant to Government Code §57105, a subsidiary district must contain either the
entire territory of the district, or represent 70% or more of the area of land within the district and 70% or more of the registered voters who reside within the district.

Under this option, the District's boundary would need to be reduced to include only the City of Concord and some surrounding unincorporated areas (e.g., Ayers Ranch, Clyde, Pacheco).

Advantages are that some property tax funding would continue to be directed to community health care needs; and reduced administrative/overhead and election costs, although the City would likely incur some administrative costs associated with services and programs.

Disadvantages are related to costs/benefits. The City would receive only a portion of the property tax allocation from those areas within the bounds of the new subsidiary district; the City may incur election costs as establishment of a subsidiary district is subject to protest proceedings; and the City would incur costs associated with preparing an application to LAFCO to form a subsidiary district. LAFCO cannot form a subsidiary district in this situation as it is not consistent with the recommendation/termination of an MSR or special study.

NEXT STEPS/TIMELINE

The process and next steps are dependent on the selected governance option. The process for a change of organization (e.g., dissolution) includes several basic steps as summarized below. An approximate timeline is also provided. There may be some variation in the process and timeline depending on what action LAFCO takes.

a. At a noticed public hearing, the Commission accepts the special study, considers adopting a zero SOI to signal proposed dissolution and, for consistency with SOI (GC §56375.5), considers making findings in accordance with the conclusion/recommendation of the special study and considers adopting a resolution initiating dissolution. **January 2012**

b. LAFCO notifies State agencies per GC §56131.5 and allows a 60-day comment period. **January 2012**

c. At a noticed public hearing, LAFCO considers approving dissolution, naming a successor agency and imposing terms and conditions. **April 2012**

d. Following a 30-day reconsideration period (GC §56895), LAFCO staff holds protest hearing in the affected territory (GC §57008). The protest hearing is a ministerial action. While the Commission is the conducting authority, it often designates the Executive Officer to conduct the hearing. **May 2012**

e. Absent requisite protest, Commission orders dissolution after determining whether an election is required. **June 2012**

f. If there is no election or the dissolution is approved by the voters, LAFCO staff records dissolution paperwork and files with the State Board of Equalization making dissolution effective. **June 2012**

RECOMMENDATIONS

I. Accept the Special Study: Mt. Diablo Health Care District Governance Options.

II. Select a governance option.

III. If the selected option involves dissolution, take the following actions:

A. Find that the dissolution is categorically exempt from CEQA pursuant to CEQA Guidelines General Rule exemption Section §15061.(b)(3), and pursuant to Class 20—Changes in the organization or reorganization of local governmental agencies where the
changes do not change the geographical area in which previously existing powers are exercised.

B. Approve the attached resolution adopting a zero SOI (Attachment 3) to allow for dissolution of the MDHCD, and find that the proposed dissolution is consistent with the District's SOI;

C. Adopt the appropriate resolution initiating dissolution of the MDHCD and either appointing the City of Concord to wind up the affairs of the District (Attachment 4), or appointing CSA EM-1 to continue the services (Attachment 5);

D. Provide direction to staff regarding desired terms and conditions;

E. Direct staff to return to the Commission in April 2012 with a report and recommended terms and conditions. It should be noted that draft resolutions were not provided for the other governance options identified in the special study (i.e., consolidating MDHCD and LMCHD, establishing a subsidiary district) as neither of these options are consistent with the special study or are recommended.

F. Determine that the District is legally inhabited.

G. In accordance with the special study, make the following findings:
   1. Determine that the public service costs resulting from a dissolution or change of organization would be less than or substantially similar to the costs of alternative means of providing the service.
   2. Determine that the dissolution or change of organization would promote public access and accountability for the community services needs and financial resources.

Sincerely,

LOU ANN TEXEIRA
EXECUTIVE OFFICER

c: Distribution

Attachments:
1 – Final Draft Special Study: Mt. Diablo Health Care District Governance Options w/Comment Log
2 - Government Code Section 56886 – Terms and Conditions
3 – Draft Resolution Adopting a Zero SOI for the MDHCD
4 – Draft Resolution Initiating Dissolution of the MDHCD and Appointing the City of Concord as the Successor Agency to Wind up the Affairs of the District
5 – Draft Resolution Initiating Dissolution of the MDHCD and Appointing CSA EM-1 to Continue the Service
Case Study #2 - Rural Health Care in California: Soledad Community Health Care District

- District Map
- Rural Health: Nurturing a Culture of Caring, Prepared by Steven Pritt, CEO, Soledad Community Health Care District, January 2012
PERSPECTIVES OF A RURAL HEALTH CARE ADMINISTRATOR

February 3, 2012

A. Rural Health Care Challenges

• Medical Billing: Our margin for error is slight.
• Physician Shortage: Recruiting and Retraining Physicians.
• Transportation: Barrier to Access.
• Cultural: Managing with Sensitivity and Preserving Dignity.
• Recruiting Staff and Building a Team: More difficult than you think.
• Chronic Disease: Patient Education and Lifestyle.
• Support Services: Developing a network of competent services.
• Immense Pressures on Current Capacity: A Product of Our Success.
• Managing through yearly state budget crisis and threats to Medicare funding.
• Moving from Volume to Value.

B. Partners in Our Success

• Association of California Healthcare Districts
• Beta Healthcare
• Alpha Fund
• Central California Alliance for Health

C. Building for the Future

• “We are here to serve the community”
• Affordable Care Act
• Neighborhood Health Models
• Building Capacity
• Strategically Positioned
Soledad Community Health Care District

Rural Health: Nurturing a Culture of Caring

Steven Pritt, CEO

Overview of the Soledad Community Health Care District

The Soledad Community Health Care District (SCHCD) is federally designated as a Medically Underserved Area which serves a Medically Under-Served Population.

SCHCD was originally named The Soledad Community Hospital District when established in 1948. In the early years, the district’s service to the community was limited to providing ambulance service to the City of Soledad and surrounding areas.

As the years passed, it became apparent that developing a hospital was not feasible. Yet the need for medical care was still present so efforts were redirected toward establishing a medical clinic and skilled nursing facility.

In 1989, the Soledad Medical Clinic was opened as an outpatient, family medicine, rural health clinic.

The Soledad Medical Clinic provides high quality healthcare services to the people of Soledad and surrounding communities. SCHCD is committed to providing broad access to high quality health care for infants, children, adults, and seniors, and to administering a wide range of programs which enhance patient access.

In 1993, Eden Valley Care Center, a skilled nursing facility, was opened adjacent to the medical clinic on our 2 ½ acre campus.

The Eden Valley Care Center provides an exceptionally high level of patient care and was designed to include amenities that provide a high quality of life for residents. Professional care and related resident services are provided by highly trained and conscientious employees. The quality of the living environment is further enhanced by a legion of dedicated community volunteers who support resident activities and programs. Volunteer support includes assisting with bingo, singing, visiting, gardening, off-site field trips and social and religious activities.

The success of SCHCD in achieving its mission to meet the health care needs of the community is based on our “Culture of Caring.” This culture is built on many levels and attention is paid to each. We stress an expectation of exceptional service and caring at all levels of the organization.
Community Care

The Soledad Community Health Care District is an organization established by the community to care for its people. We work to reflect that community value by being a viable, visible, vibrant, caring part of our community. We invite the community to use our facilities throughout the year at a number of exciting events. Engagement with the community positively contributes to keeping our Eden Valley residents engaged with the community they live in, the community comes to their door throughout the year.

- **Classic Car Show** – The community is invited to participate in this annual event. Awards are presented and the Eden Valley residents are able to attend the event.
- **Cinco de Mayo Celebration** – This is a huge community celebration in the garden with Mexican foods, music, and sometimes with presentations by school children.
- **4th of July BBQ** – This event includes community members who visit the campus on that date. All are invited to eat and to celebrate with the residents.
- **Veteran’s Day** – The Junior ROTC visits with the Eden Valley residents to honor their service, to raise the flag, and to parade in formation.
- **Superbowl Party** – Eden Valley residents and their visitors are treated to a special Superbowl party meal and the game shown on the big screen, snacks, and drinks.
- **Yard Sale** – Each year a sale is held of all unused equipment and supplies to clean out the store room. This is held silent-auction-style in the parking lot and is a big hit within the community.

School District Partnership

SCHCD has established strong ties to the Soledad Unified School District. We host many performing groups from the District and we are a partner with Soledad High School in development of a medical career pathway.

- **Medical Career Pathway - Job Shadowing**
- **Perform for residents.**
  - High School Choir
  - Classical Guitar Class
  - High School Band
  - Junior ROTC
- **4-H Activities**
Vocational and College Training Partnerships and Opportunities

SCHCD coordinates with many local health care education providers to give access to the beautiful garden for graduation events. We also partner with some of these agencies to provide access to clinical training which may be requirements of their educational program.

- Graduation ceremonies for LVN, CNA, Pharmacy Technicians, and Clinical Medical Assistants in which a ceremony is held followed by lunch and dessert.
- CNA Training Program
- LVN Candidates from Hartnell College School of Nursing receive clinical training
- Physician assistant student clinical training from Stanford’s School of Medicine.
- Physician skilled nursing care clinical training through Natividad Medical Center’s Residency Program.

Organizational Care

We recognize that our staff is the cornerstone of the Culture of Caring so we nurture and model our caring expectations in many ways. We consistently work to reinforce the fact that we care deeply about every staff member.

Facility Care – Visitors to SCHCD immediately recognize that caring ever extends to our facilities. We work diligently to keep our facilities clean, fresh, and in premium working order. Our buildings are maintained meticulously and every inch of the campus is landscaped beautifully.

Patient Care is the center of our culture of caring at an organizational level and this supports and builds our caring reputation within the community. We recognize that the bulk of personal care for patients in our organization is done by our Certified Nursing Assistants.

Staff Care is carried out in large and small ways, through expectations, rewards, recognition of effort, and through ongoing engagement in the vibrant community atmosphere at SCHCD. The result for our efforts to demonstrate caring for our staff is that turnover is nearly non-existent.

All staff members are provided with uniforms that are clean, bright and which feature our SCHCD patch and the American flag. Staff members are proud of these uniforms and are frequently seen wearing them within the community to events. Our staff is proud of the work they do and that they are part of a caring team and community. A monthly meeting is held with each staff grouping in order to best meet the needs of all job-alike groups. A number of activities are planned throughout the year to ensure that our experiences the Culture of Caring too!

- Caught in the Act Awards - A monthly “Caught in the Act” award may be given to any staff member. These awards are identified by someone has submitted a form describing service above and beyond the call of duty. These forms are submitted anonymously and may be submitted by staff, by patients, by visitors, or by family members of residents. The forms are
read aloud at staff meetings and the staff member is asked to stand up to be recognized with applause and a certificate. It is a celebration and reinforcement of the culture of caring that is valued by the all staff.

- **Holiday Meals** – The dietary staff takes special care of the staff at SCHCD by cooking a full holiday meal for staff who must work on the Thanksgiving and Christmas holidays. We recognize the special sacrifice these staff members are making to provide continuity of our excellent care so the dietary staff goes all out to prepare a bountiful holiday meal.

- **Christmas Party** – All staff members and their families are treated to a huge Christmas party. The facilities are extravagantly decorated for Christmas each year with five stupendous Christmas trees. Nobody can come into the facility and leave without feeling the holiday spirit. A drawing for all staff is held each year for two nativity scenes.

- **Superbowl Staff Lunch** – The CEO buys lunch on Superbowl Sunday for all staff members working on that Sunday. The Rotary Club holds an annual BBQ chicken sale on that Sunday so the CEO buys each staff member a huge lunch of a half chicken with beans, salad, a dinner roll, and soft drinks.

- **Valentines Day Potluck** – All staff are challenged to bring their best recipe to this event and the competition is stiff! The staff loves to produce some really special dishes to share with each other.

- **Easter Meal** – Dietary staff members prepare a special full meal for the staff working on this Sunday.

- **Halloween Dress Up Day** – All staff participate and a “parade of characters” is held in the afternoon where residents judge the worst and best costumes. Winners of the 10 categories receive door prizes and gift cards.

**Direct Patient Care**

Our 35-40 Certified Medical Assistants do most of the heavy lifting in our organization and everyone recognizes the value of their service and the important role they play in creating a caring culture at SCHCD. We take special care of our Certified Nursing Assistants so they are motivated and able to take special care of our residents.

**Perfect Attendance Awards** – We believe that *perfect attendance equals perfect patient care*. The purpose of this award is to ensure that we can offer seamless patient care at all times. A monthly award drawing is held for everyone who has had perfect attendance the previous month. Perfect means *no absence* for any reason, no matter how justifiable it is. Among those that qualify for the month are eligible for a drawing for nice prizes as a reward such as a Macy’s gift card, a Starbucks card, or gift certificates to a local restaurant.

**Most Valuable Player Award** – The Director of Nurses and the Charge Nurses identify a CNA each month who has given superior service during the month. These special nurses are given a framed Certificate of Recognition at the nursing staff meetings. A copy is given to the recipient and copies
of the poster are also published and hung in the staff break rooms and on the front door of the facility. At times these posters are also published in the local newspaper.

**Clinic Medical Staff Care**

Our medical staff accomplishes as much per square foot as any medical staff anywhere in the region. We appreciate their tremendous effort on behalf of the community and their level of care and concern and skill is without equal.

Our Clinic staff meets each month and “Caught in the Act” awards are given to deserving staff members. Special events are produced on a regular basis to show appreciation to all the staff. Some of these events include Pizza Day, All-you-can-eat Waffle Day, staff baking contests and holiday-themed raffle days.

**Dietary Staff Care**

Food is symbolic of caring and the dietary staff takes great pride in creating a menu for our residents that meets their nutritional requirements and is also worthy of a five star restaurant in terms of flavor and presentation.

**Garnish Award** – The dietary staff is challenged to produce beautiful as well as nutritious and delicious food. All staff are invited to compete to produce plates that include the most unique and edible garnishes.

The dietary staff is treated each year by the CEO to a special Christmas luncheon at a restaurant off site as a thank you for their service to residents and to staff members.

**Examples of Special Staff Events**

**Waffle Day** – Dietary staff sets up waffle irons and produces gigantic, delicious waffles and provides all the trimmings from whipped cream to fresh berries. An all-you-can eat affair of course.

**Summer BBQ’s** – About three times each summer the BBQ is rolled out into the garden and the administrator cooks up high quality burgers, swiss sausage, beans and more. All staff, visitors, residents and resident family members are invited to partake.

**Patient Care**

The output of all these many activities, plans, designs, awards, banquets, events, smiles, laughs, and attention to detail is that SCHCD gives superior patient care. Our staff cares about our community members from each newborn baby to our senior citizens.

Everyone on the team strives to give each patient individualized attention and make them feel at home and well-cared for. From the landscaped parking lot to the exam room, our patients can see, hear, feel, and experience superior care. Demand for our services has increased to the point that we
are seeking funds to expand in a number or areas that will produce new services and expand our capacity for caring.

We know that caring is all about attending to the details in everything we do. These small and large details add up to superior service delivery that consistently validates the efficacy of our Culture of Caring.

As you can see, a Culture of Caring is built layer upon layer from the smallest details in recognizing excellence among individual staff members to the big picture; that we exist only because we are part of a community that cares about its citizens.
Deborah A. Stebbins, Chief Executive Officer, City of Alameda Health Care District

Case Study #3 Building Partnerships and Generating Growth: City of Alameda Health Care District

- Alameda Hospital: A Snapshot
Our History:
1894—Alameda Sanatorium, a 6-bed hospital at 2116 San Jose Avenue, is founded by Nurse Kate Creedon.
1925—The 110-bed hospital at 2070 Clinton Avenue opened as “Alameda Sanatorium on South Shore”.
1939—The “Alameda Sanatorium on South Shore” becomes “Alameda Hospital”, a new non-profit corporation.
2002—On April 9th, over 2/3 of voters passed $298 parcel tax measure to form the City of Alameda Health Care District.
2008—Alameda Hospital acquires South Shore Convalescent Hospital.
2009—Establishment of Hospital Community Clinic (Alameda Hospital Physicians) at Alameda Towne Centre
2010—Wound Care Program planning begins with an anticipated opening in early 2012 at Marina Village.
2011—Diagnostic Imaging Upgrades begin, including PACS and Digital Mammography

Alameda Hospital Today:
2070 Clinton Avenue
100 Acute Care Beds, 35 Subacute Beds
South Shore Skilled Nursing Unit at 625 Willow Street
26 Skilled Nursing Beds
2011 Patient Activity:
2,527 Inpatient Discharges
40,612 Outpatient Visits
(Includes 16,816 Emergency Care Center visits)

Alameda Hospital offers a full range of health care services:

- Asian Health Outreach
- Cardiology
- Clinical Laboratory
- Diagnostic Imaging:
  - C.T. Scan
  - M.R.I.
  - Mammography
  - Ultrasound
  - Nuclear Medicine
  - Bone Densitometry
  - Radiology
- Emergency Care Center
- Inpatient care
  - Critical Care
  - Medical Surgical Care
  - Telemetry
- Specialty Inpatient Care
  - Subacute Care
  - Skilled Nursing Facility
- Mulvany Infusion Center
- and Cancer Services
- Nutritional Counseling
- Pulmonary & Respiratory Care
- Rehabilitation Services
  - Physical therapy and sports injury services
  - Occupational therapy
  - Speech therapy
- Certified Primary Stroke Center
- Surgical Services
  - Comprehensive inpatient and outpatient surgical services
- Wellness Programs
- Wound Care Center (coming 2012)

City of Alameda Health Care District Board of Directors:
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Board meetings are held the first Monday of each month and are open to the public.
Visit www.alamedahospital.org for meeting schedules and agendas.

Providing compassionate, personalized and quality health care close to home.
Our Physicians
Alameda Hospital's Medical Staff is composed of nearly 200 physicians trained by some of the best medical schools in the country. Approximately 85% are board certified in their area of expertise.

- Allergy & Immunology
- Anesthesiology
- Cardiology
- Critical Care Medicine
- Dermatology
- Emergency Medicine
- Family Practice
- Gastroenterology
- General Medicine
- General Surgery
- Hand Surgery
- Hospitalist Medicine
- Infectious Disease
- Internal Medicine
- Nephrology
- Neurology
- Nuclear Medicine
- Obstetrics and Gynecology
- Occupational Medicine
- Oncology and Hematology
- Ophthalmology
- Orthopaedic Surgery
- Otolaryngology (ENT)
- Pain Management
- Pathology
- Pediatrics
- Plastic and Reconstructive Surgery
- Podiatry
- Pulmonary Medicine
- Radiology
- Spine Surgery
- Sports Medicine
- Thoracic Surgery
- Urology
- Vascular Surgery

Our Financial Picture
Fiscal Year 2011

Recent Milestones:
- Received Certification as Primary Stroke Center
- VA contract to provide inpatient and emergency care
- Physician Recruitment
  - Orthopaedic surgeons
  - Neurologists
  - General surgeons
  - Primary care (family practice and internal medicine)
- HealthGrades 5-star recognition for heart attack, heart failure and pneumonia.
- American Heart Association Gold Award for Treatment of Coronary Artery Disease
- Child Friendly ER
- Asian Health Outreach
- Information Technology Initiatives
- Diagnostic Imaging: PACS, Digital Systems
- Successful labor negotiations

Our Challenges:
- Discontinuation of Kaiser Contract (April 2010)
- Seismic requirements (SB1953)
- Implementation of Electronic Medical Record
- Decreases in reimbursement
- Increases in operating expenses and capital needs
- Keeping pace with advances in medical and information technology
- Physician Recruitment
- Increasing market share, particularly in 94502 and surrounding communities such as San Leandro and Oakland.

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