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Understanding Health Care Districts and the Role of LAFCo

February 3, 2012
San Jose

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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

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A·C·H·D ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS | ALPHA FUND Proven Performance Shared Success

Overview of Health Care Districts in California:

History, Today's Challenges, Future Directions

Tom Petersen,
Executive Director

David McGhee,
Chief Executive Officer

Association of California Healthcare Districts

California Healthcare Districts

History

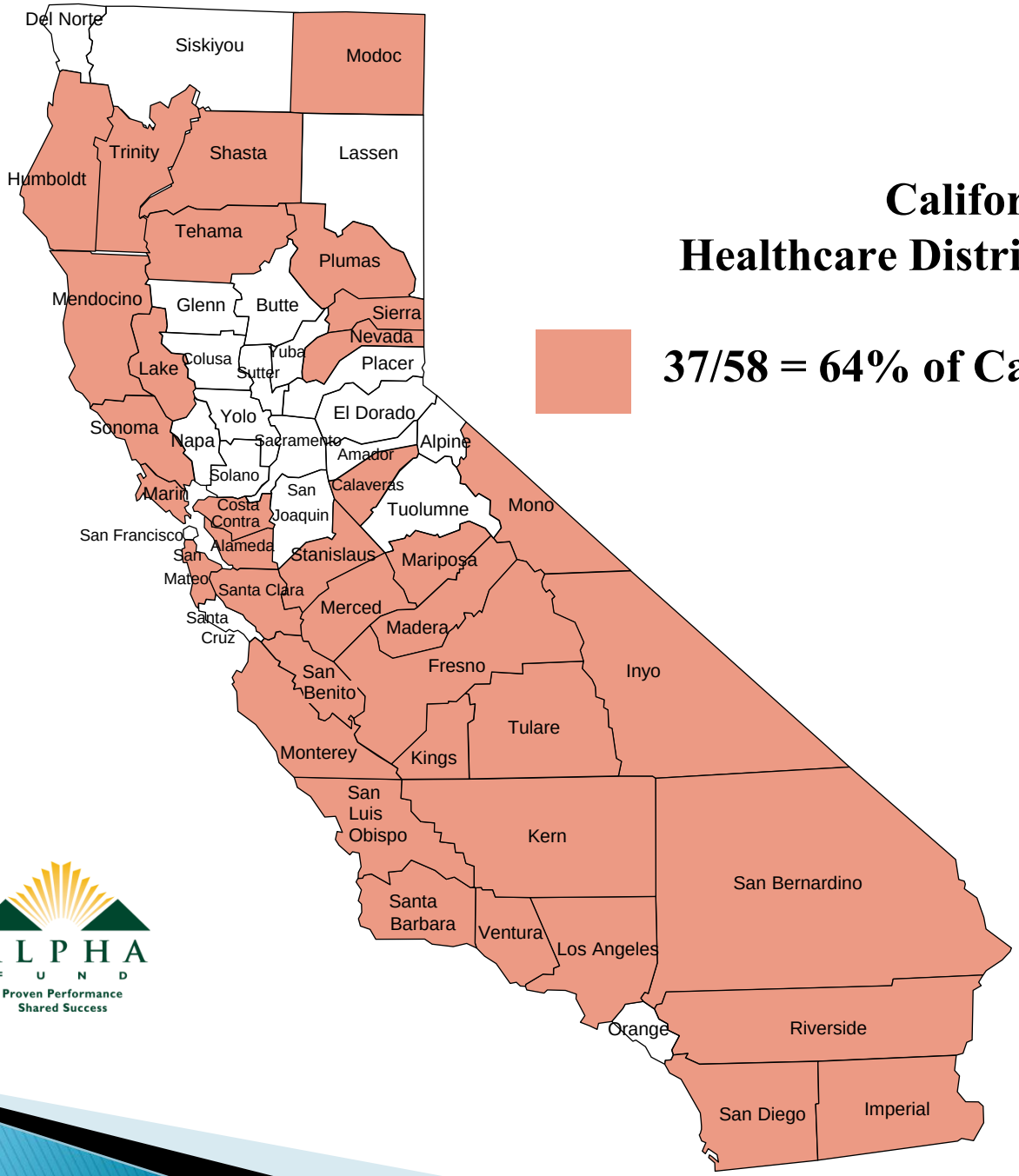
- Established in 1946
- First Healthcare District-Sequoia
- First District Hospital- Lompoc VMC
- Current # active districts-76
- ACHD formed in 1951
- Some, but not all, receive property tax $

District Locations

- Urban
- Rural
- Present in 37 of the 58 counties

California
Healthcare Districts by County

37/58 = 64% of Ca. Counties



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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 ???

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Questions?

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Break

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A PROFESSIONAL LAW CORPORATION

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

Colin J. Coffey,
Partner, Archer Norris, PLC

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.

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The Cortese-Knox-Hertzberg Local Government Reorganization Act and Public Finance and Taxation Law:

Applicability to Health Care Districts

Michael G. Colantuono,
Attorney, Colantuono & Levin, PC

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.

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Lunch Break

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

Oxana Kolomitsyna,
Principal

Jennifer Stephenson,
Managing Partner

Policy Consulting Associates

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, Clinic 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

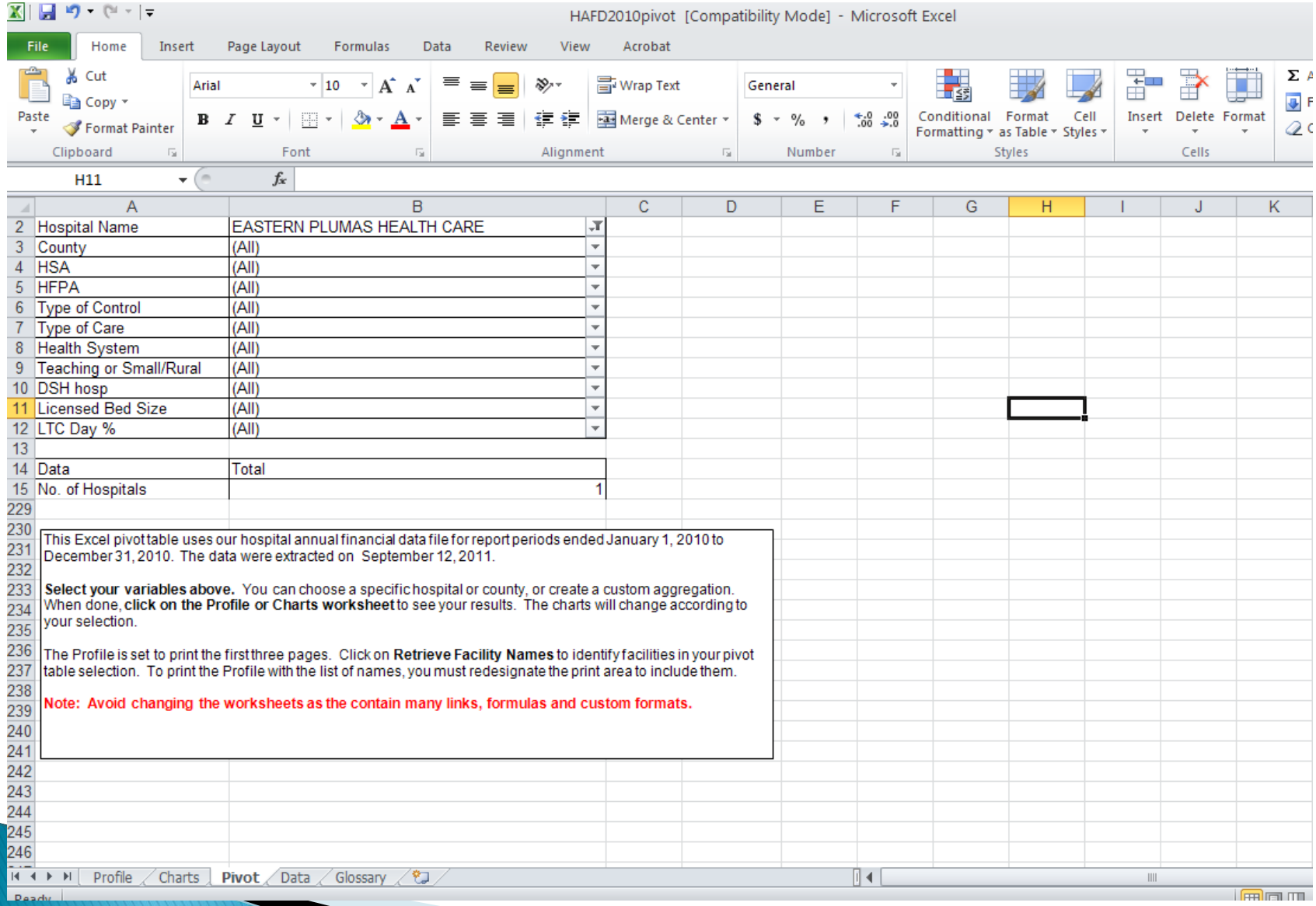
Financial Ability

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

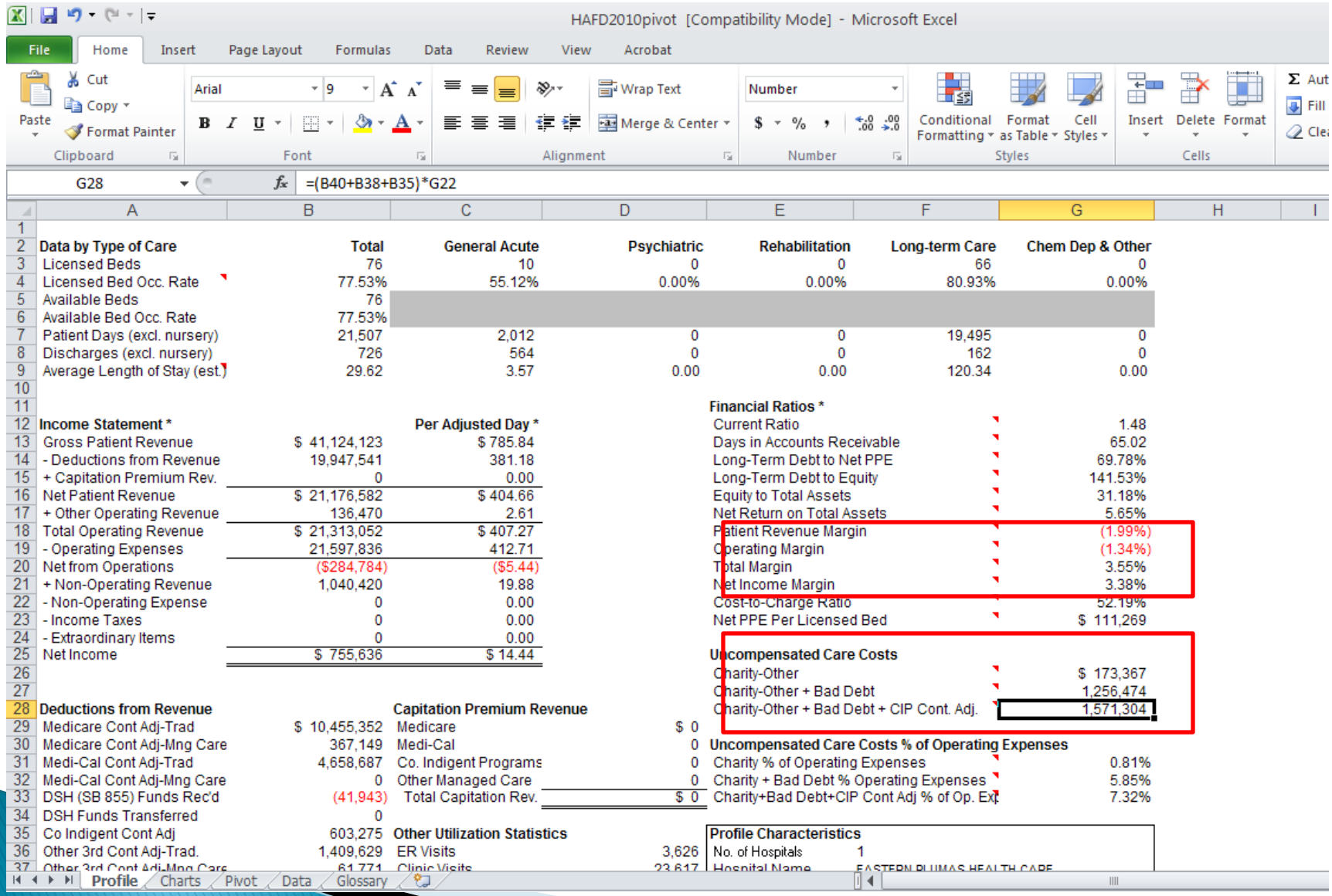
Financial Ability (cont.)

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

Financial Ability (cont.)



Financial Ability (cont.)



	A	B	C	D	E	F	G
2	**Data by Type of Care**	**Total**	**General Acute**	**Psychiatric**	**Rehabilitation**	**Long-term Care**	**Chem Dep & Other**
3	Licensed Beds	76	10	0	0	66	0
4	Licensed Bed Occ. Rate	77.53%	55.12%	0.00%	0.00%	80.93%	0.00%
5	Available Beds	76					
6	Available Bed Occ. Rate	77.53%					
7	Patient Days (excl. nursery)	21,507	2,012	0	0	19,495	0
8	Discharges (excl. nursery)	726	564	0	0	162	0
9	Average Length of Stay (est.)	29.62	3.57	0.00	0.00	120.34	0.00

	A	B	C
12	**Income Statement ***		**Per Adjusted Day ***
13	Gross Patient Revenue	$ 41,124,123	$ 785.84
14	- Deductions from Revenue	19,947,541	381.18
15	+ Capitation Premium Rev.	0	0.00
16	Net Patient Revenue	$ 21,176,582	$ 404.66
17	+ Other Operating Revenue	136,470	2.61
18	Total Operating Revenue	$ 21,313,052	$ 407.27
19	- Operating Expenses	21,597,836	412.71
20	Net from Operations	($284,784)	($5.44)
21	+ Non-Operating Revenue	1,040,420	19.88
22	- Non-Operating Expense	0	0.00
23	- Income Taxes	0	0.00
24	- Extraordinary Items	0	0.00
25	Net Income	$ 755,636	$ 14.44

	E	F
	Financial Ratios *	
	Current Ratio	1.48
	Days in Accounts Receivable	65.02
	Long-Term Debt to Net PPE	69.78%
	Long-Term Debt to Equity	141.53%
	Equity to Total Assets	31.18%
	Net Return on Total Assets	5.65%
	Patient Revenue Margin	(1.99%)
	Operating Margin	(1.34%)
	Total Margin	3.55%
	Net Income Margin	3.38%
	Cost-to-Charge Ratio	52.19%
	Net PPE Per Licensed Bed	$ 111,269
	Uncompensated Care Costs	
	Charity-Other	$ 173,367
	Charity-Other + Bad Debt	1,256,474
	Charity-Other + Bad Debt + CIP Cont. Adj.	1,571,304
	Uncompensated Care Costs % of Operating Expenses	
	Charity % of Operating Expenses	0.81%
	Charity + Bad Debt % Operating Expenses	5.85%
	Charity+Bad Debt+CIP Cont Adj % of Op. Ex	7.32%

	A	B	C	D
28	**Deductions from Revenue**		**Capitation Premium Revenue**	
29	Medicare Cont Adj-Trad	$ 10,455,352	Medicare	$ 0
30	Medicare Cont Adj-Mng Care	367,149	Medi-Cal	0
31	Medi-Cal Cont Adj-Trad	4,658,687	Co. Indigent Programs	0
32	Medi-Cal Cont Adj-Mng Care	0	Other Managed Care	0
33	DSH (SB 855) Funds Rec'd	(41,943)	Total Capitation Rev.	$ 0
34	DSH Funds Transferred	0		
35	Co Indigent Cont Adj	603,275	**Other Utilization Statistics**	
36	Other 3rd Cont Adj-Trad.	1,409,629	ER Visits	3,626
37	Other 3rd Cont Adj-Mng Care	61,771	Clinic Visits	23,617

	E	F
	Profile Characteristics	
	No. of Hospitals	1
	Hospital Name	EASTERN PLUMAS HEALTH CARE

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

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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

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

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)

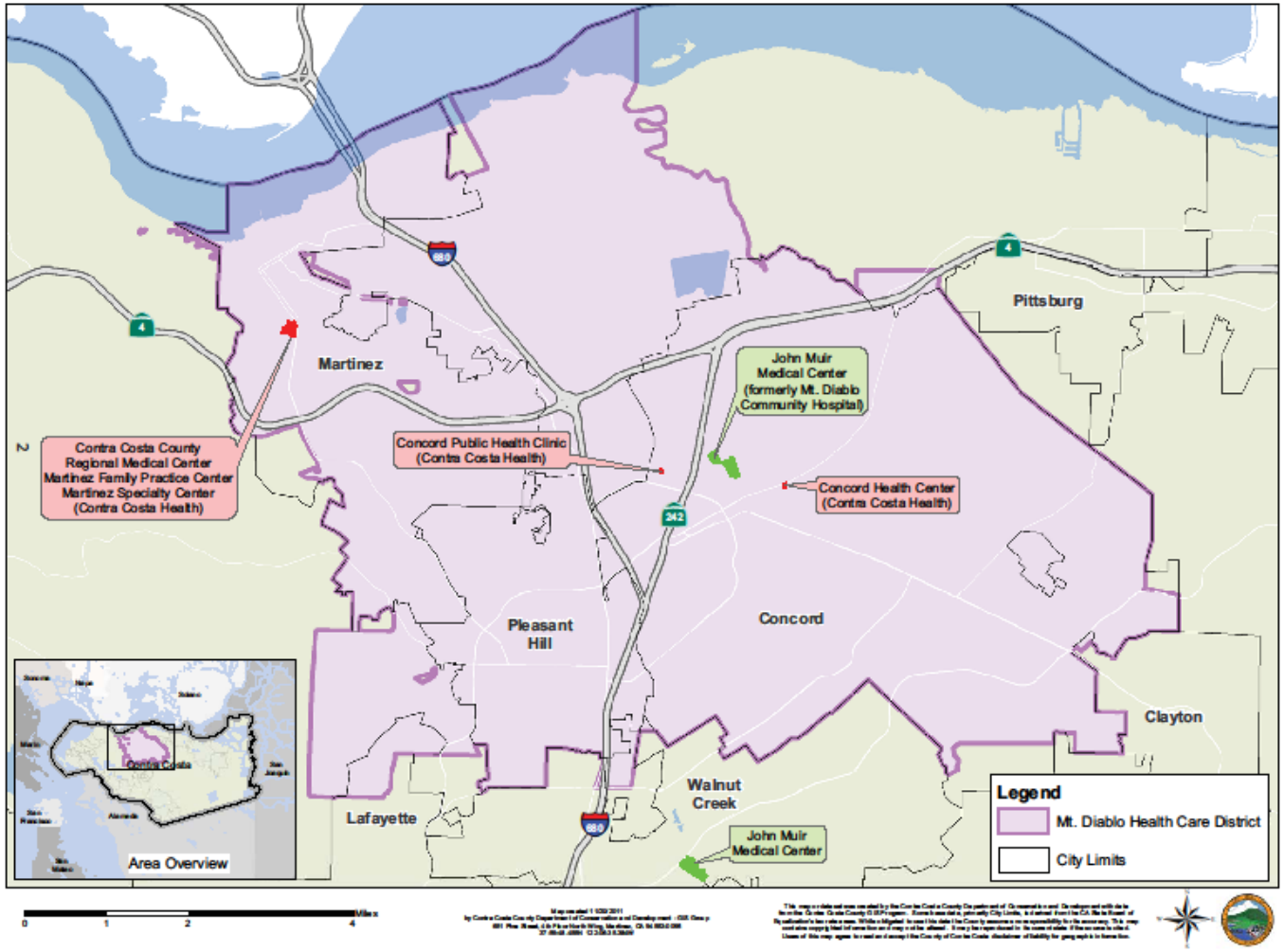
- Formed in 1948 as the Concord Hospital District.
- In 1994 renamed “Health Care District”.
- Annexed Martinez in the1950’s.
- Boundaries: Martinez, Lafayette (portions), Concord, Pleasant Hill (portions), and unincorporated Clyde and Pacheco.

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

Figure 1 District Boundaries MDHCD Special Study



Summary of Findings

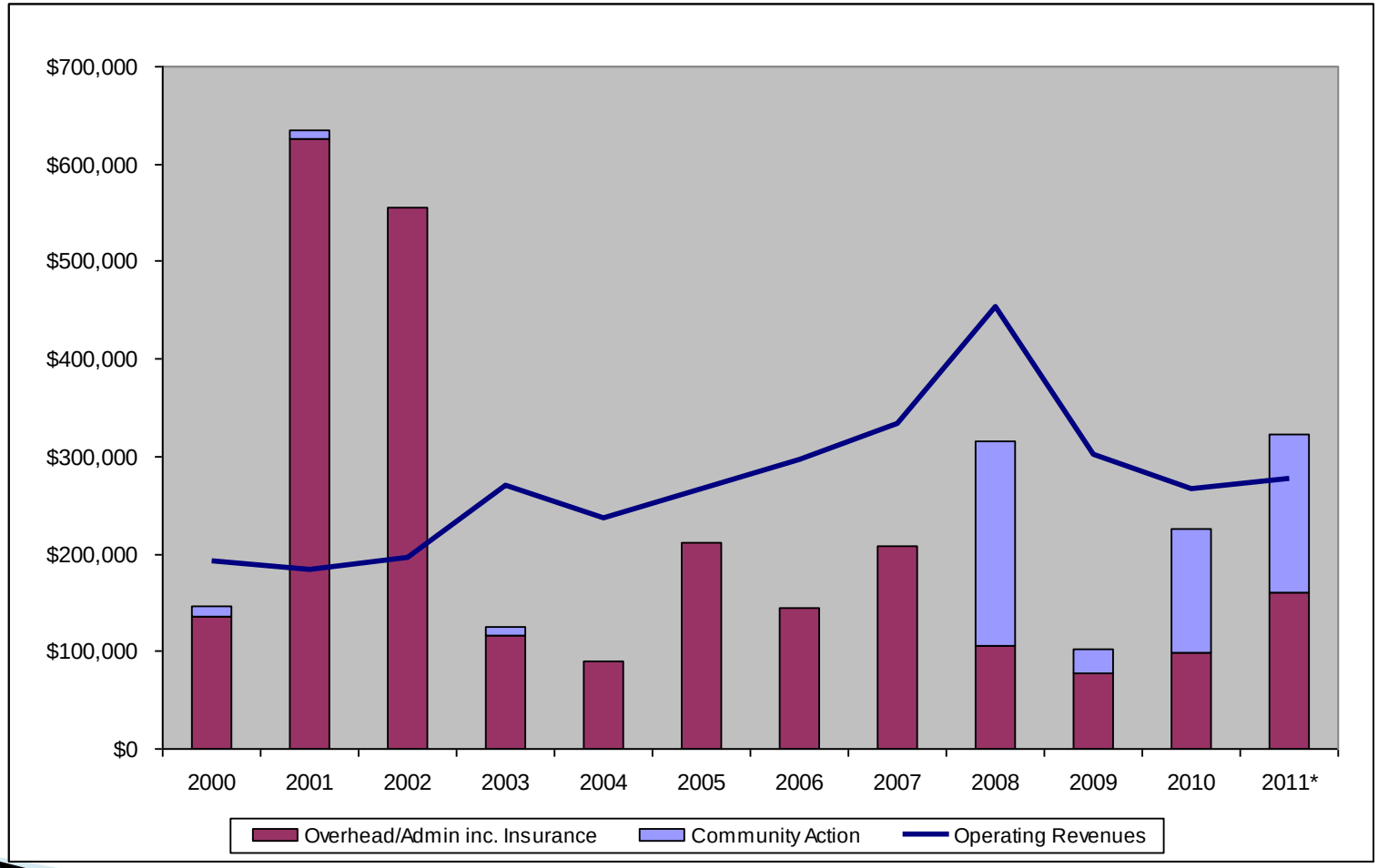
- 2000-2011, approximately 17% of expenditures for Community Action (83% overhead, benefits, legal).
- In 2011, 50% of expenditures spent on Community Action.
- After fund balance depleted, $160,000 or 58% of $276,000 operating revenue available for Community Action (before election costs or FT Executive 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



* Estimate for 2011 from MDHCD

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.

Consolidation – MDHCD/LMCHD

- **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.

MDHCD Services vs. CSA EM-1 and Health Services Department

Service	MDHCD	CSA –EM1	County HealthServices Dept.
Health Facilities			x
Outpatient			x
Retirement			x
Chemical Dependency			x
Other healthcare programs	x	x	x
Health Education	x	x	x
Wellness		x	x
Support other healthcare providers	x	x	x
Ambulance		x	x
Health Insurance			x

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.

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Questions?

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Break

Rural Health Care in California: Soledad Community Health Care District

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

CALAFCO University

Contact Information

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Alameda Hospital

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

Deborah E. Stebbins,
Chief Executive Officer, 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
- $60 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

Jordan Battani

Stewart Chen, DC

Elliott Gorelick

Robert Deutsch, MD

J. Michael McCormick

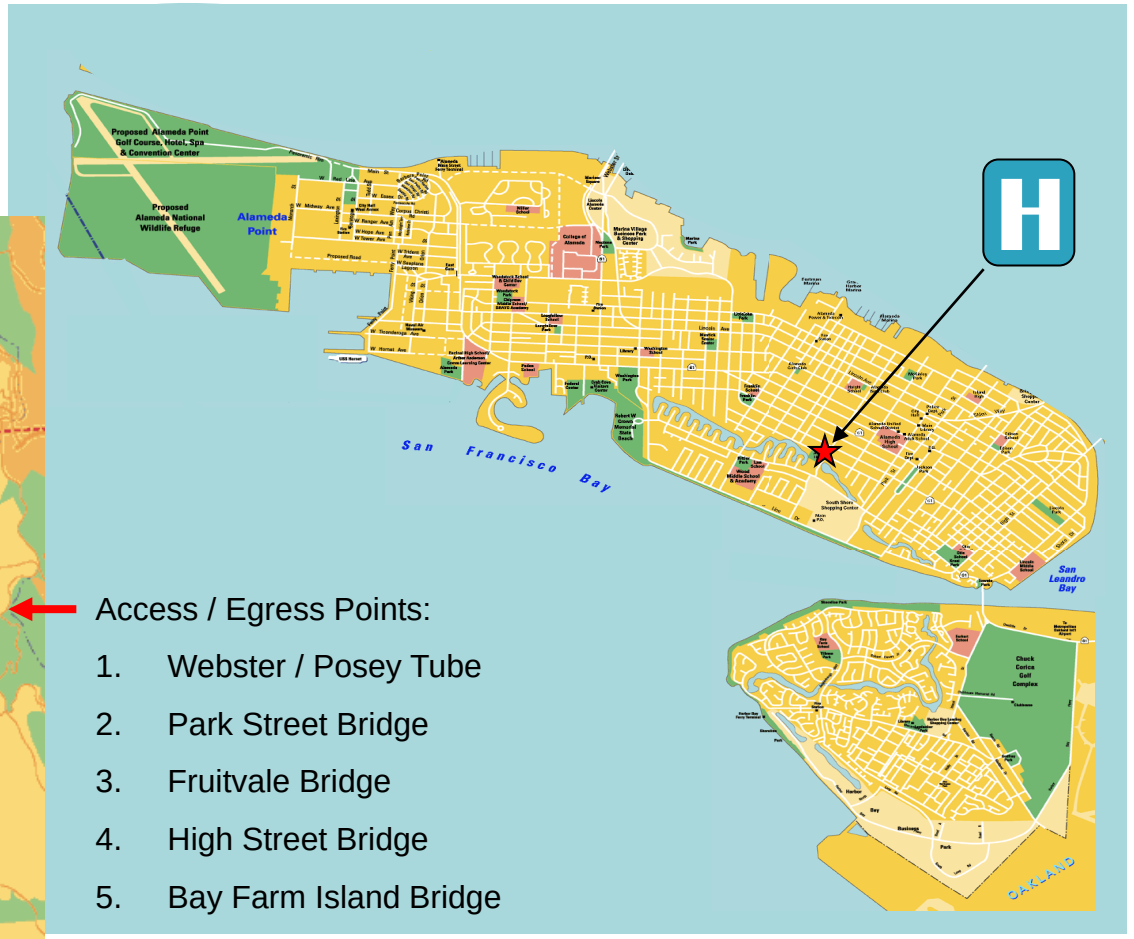
Alameda Hospital: An Abbreviated History

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

*Estimated 2008



Access / Egress Points:

1. Webster / Posey Tube
2. Park Street Bridge
3. Fruitvale Bridge
4. High Street Bridge
5. Bay Farm Island Bridge

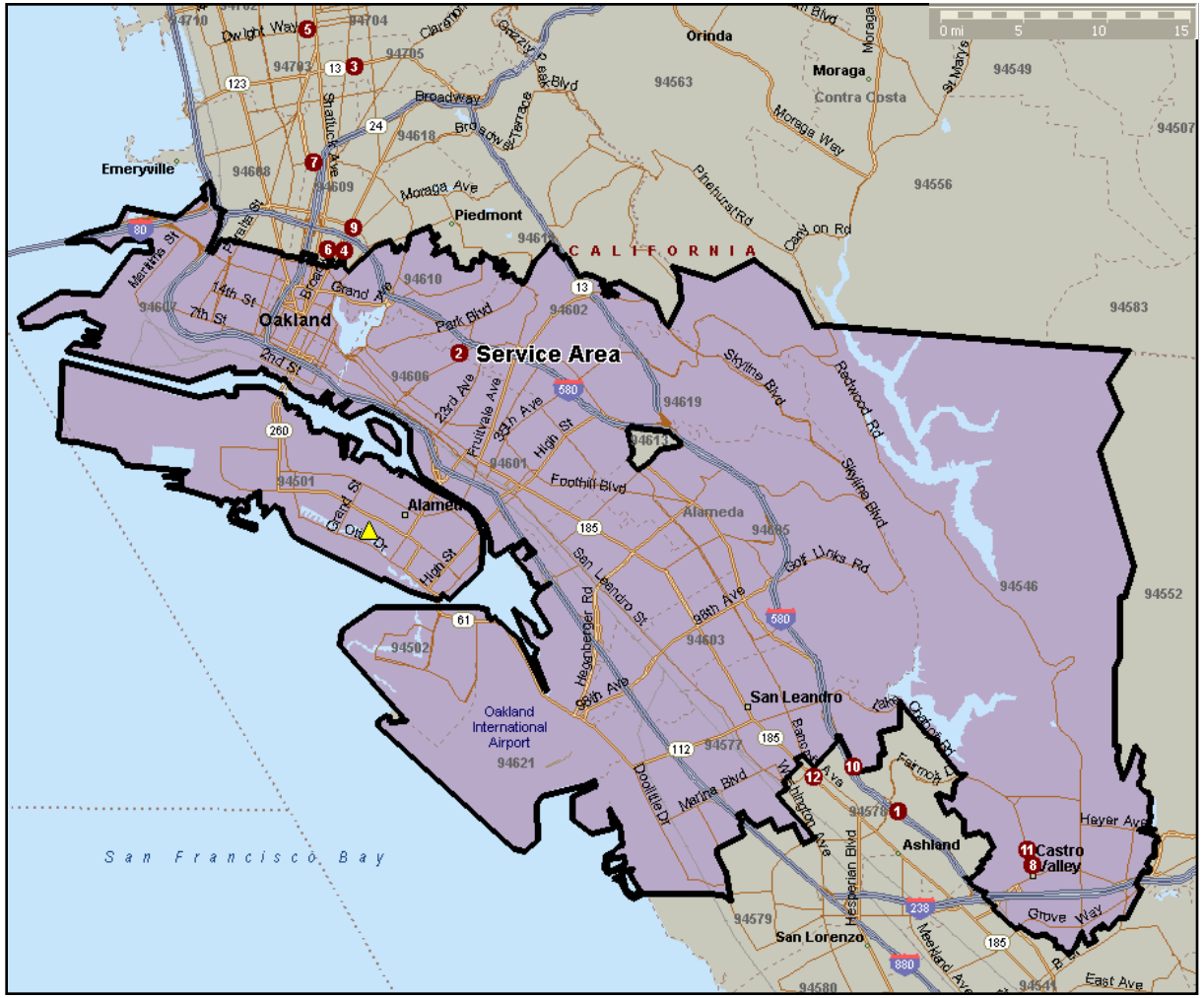
Secondary Service Area

△ **Alameda Hospital**

Area Hospitals

1. Alameda County Medical Center – Fairmont
2. Alameda County Medical Center – Highland
3. Alta Bates Summit Medical Center – Alta Bates
4. Alta Bates Summit Medical Center – Hawthorne
5. Alta Bates Summit Medical Center – Herrick
6. Alta Bates Summit Medical Center – Summit
7. Children's Hospital and Research Center at Oakland
8. Eden Medical Center
9. Kaiser Foundation Hospital – Oakland Campus
10. Kindred Hospital – San Francisco Bay Area
11. Laurel Grove Hospital
12. San Leandro Hospital

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

Alameda Hospital
Main Island (94501) Three-Year Market Share Trend
CY 2004, 2005, and 2006

Hospital	2004	2005	2006
Alameda Hospital	31.9%	33.5%	35.0%
Kaiser Foundation Hospital - Oakland Campus	15.7%	18.8%	18.1%
Alta Bates Summit Medical Center - Alta Bates Campus	10.8%	9.9%	9.9%
Alta Bates Summit Medical Center - Summit Campus - Hawthorne	12.6%	9.0%	8.7%
Alameda County Medical Center - Highland Campus	6.6%	5.9%	5.3%
Childrens Hospital and Research Center at Oakland	3.7%	3.3%	3.3%
UCSF Medical Center	na	1.8%	2.8%
California Pacific Medical Center - Pacific Campus	2.3%	2.1%	2.0%
Subtotal	*83.7%*	*84.3%*	*85.0%*
All Other	16.3%	15.7%	15.0%
Total	**100.0%**	**100.0%**	**100.0%**

Source: OSHPD Inpatient Discharge Database, 2004, 2005, and 2006

Note: Hospitals are sorted based on 2006 discharges; those with less than two percent market share were included in "All Other"

\\perseus\tcg\clients\Alameda Hospital\Market Share Analysis\[94501,94502 Analysis.xls]94501Market Share Trend

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 2013 seismic standards. The three buildings that do not comply are: the “East” building (bldg. 1 & original hospital), the Stephens Wing (bldg. 2), built in 1955 and the West Wing (bldg. 3), built in 1967.

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).

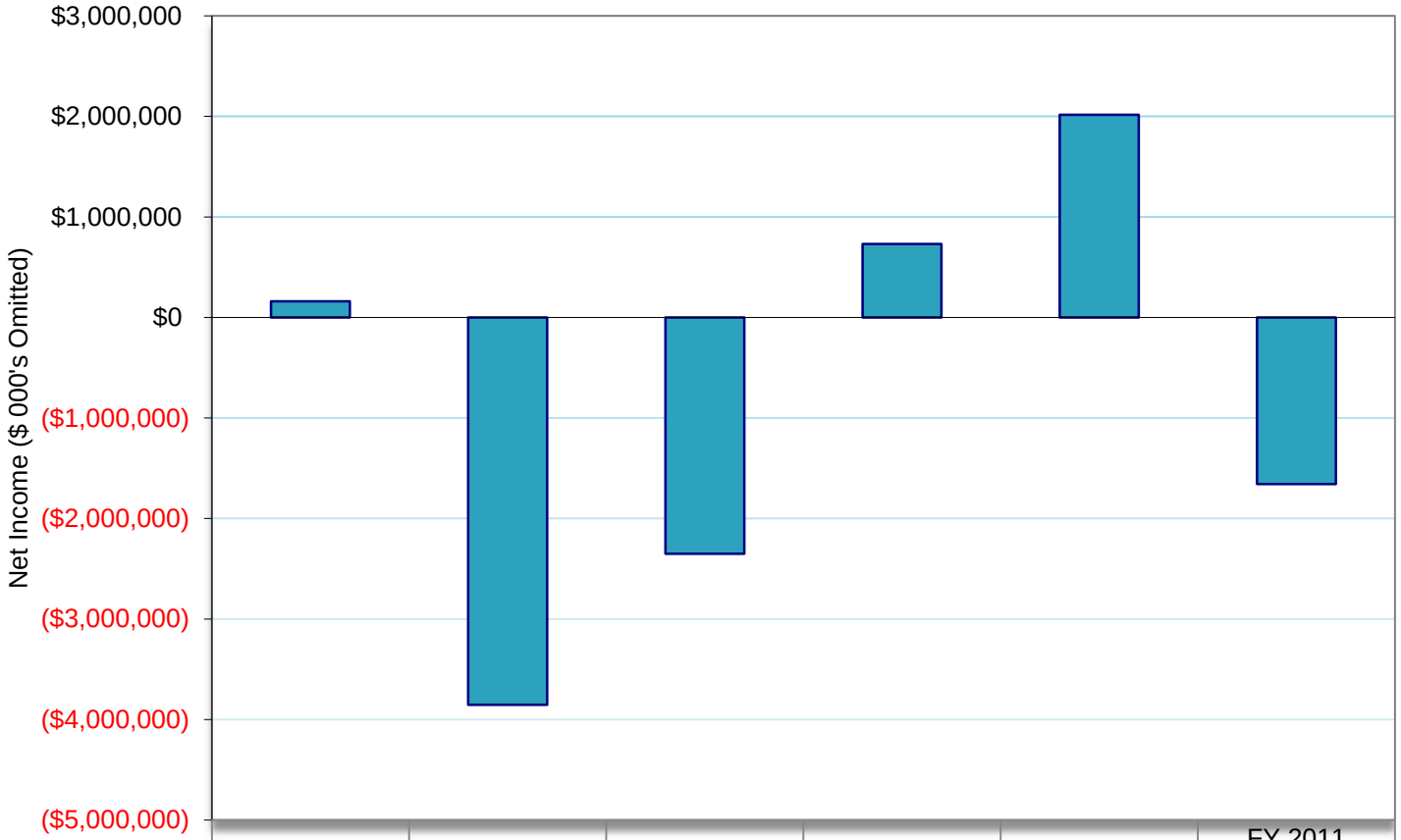
The hospital has engaged Ratcliff Architects who are developing the construction documents for OSHPD review. The hospital has also engaged a construction management firm, Jtec CM, to coordinate and manage this entire project. Our largest challenge at this juncture is the hospital’s ability to obtain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

Current Building Status

Scope of 2013 Seismic Work

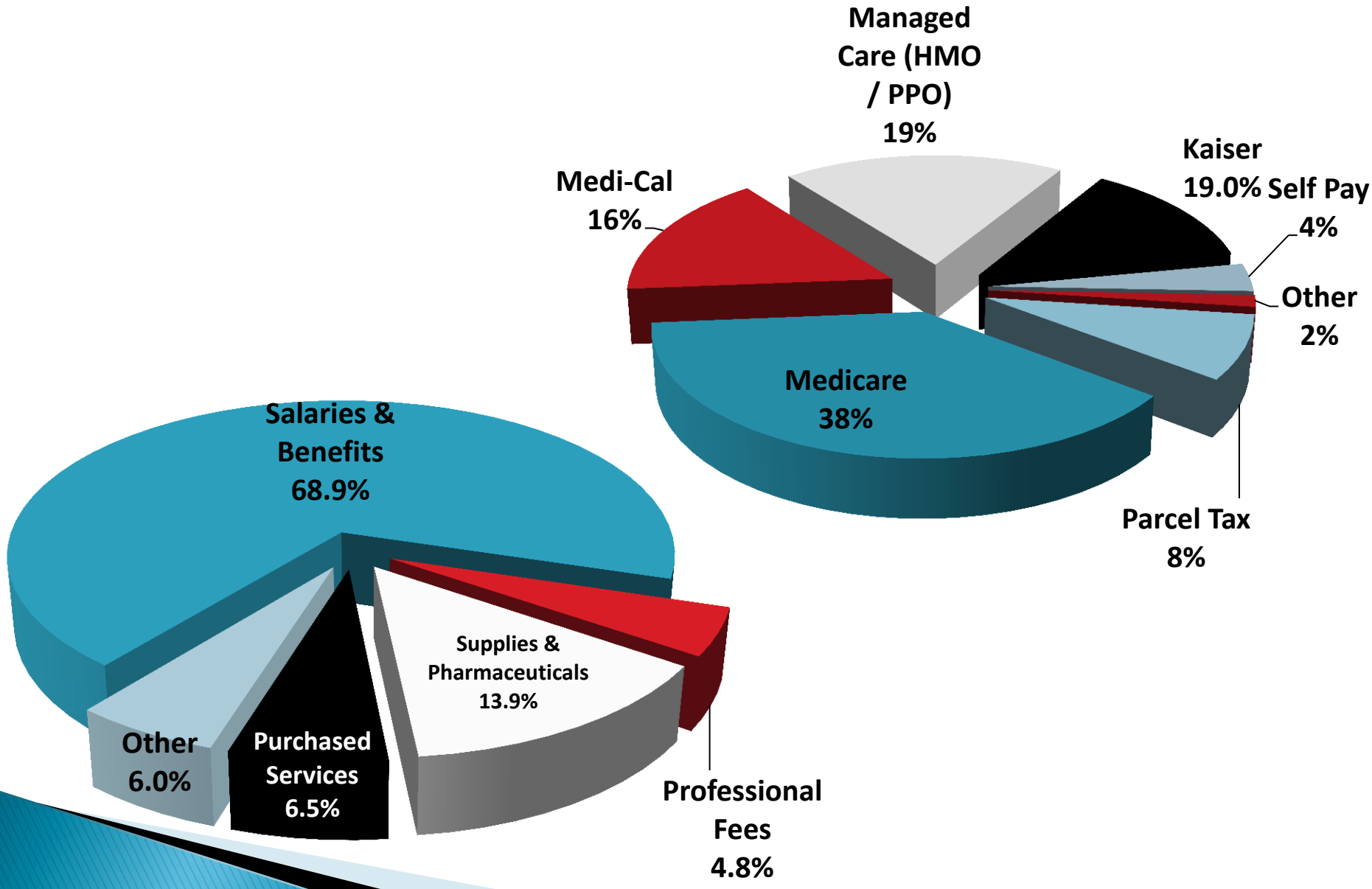
Status of 2013 Planning

Financial Picture



	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011 (unaudited)
Change Net in Net Assets	160,100	(3,853,362)	(2,350,448)	730,307	2,016,539	(1,658,000)

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/s)
- 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)

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Questions?

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Open Questions, Summary and Evaluation

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