RIVERSIDE COUNTY HEALTHCARE DISTRICTS MUNICIPAL SERVICE REVIEW & SPHERE OF INFLUENCE UPDATE PUBLIC REVIEW DRAFT

September 24, 2020

Prepared for the
Riverside Local Agency Formation Commission
by Policy Consulting Associates, LLC.

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ACRONYMS AND DEFINITIONS

AAA Repairs:	abdominal aortic aneurysm repairs
AB:	Assembly Bill
ACA:	Affordable Care Act
ACHC:	Accreditation Commission for Health Care
ADA:	Americans with Disabilities Act
ALS:	amyotrophic lateral sclerosis
CABG:	coronary artery bypass graft surgery
CAH:	critical access hospital
CAO:	Chief Administration Officer
CEO:	Chief Executive Officer
CEQA:	California Environmental Quality Act
CFD:	community facilities district
CHA:	California Hospital Association
CHAP:	Community Health Accreditation Program
CHHS:	California Health and Human Services Agency
CHIP:	Community Health Improvement Plan
CHNA:	Community Health Needs Assessment
CIHQ:	Center for Improvement in Healthcare Quality
CIP:	Capital Improvement Plan or Program
CKH:	Cortese-Knox-Hertzberg Local Government Reorganization Act of 2000
CMS:	Centers for Medicare and Medicaid Services
CPO:	Chief Program Officer
CPSP:	Comprehensive Perinatal Services Program
CVAG:	Coachella Valley Agency Governments
CY:	Calendar year
DHD:	Desert Healthcare District
DHCS:	Department of Health Care Services
DMHC:	Department of Managed Health Care
DNV:	Det Norske Veritas
DNVHC:	DNV Healthcare, Inc.
DPH:	Department of Public Health
DPPS:	Department of Public Social Services
DRMC:	Desert Regional Medical Center
DSH:	disproportionate-share hospital
DUC:	disadvantaged unincorporated community
ED:	emergency department
EMS:	emergency medical service
FPPC:	Fair Political Practices Commission
FTE:	full-time equivalent
FY:	Fiscal year
GIS:	Geographic Information Systems
HARC:	Health Access Resource Center
HCAHPS:	Hospital Consumer Assessment of Healthcare Providers and Systems
HFAP:	Healthcare Facilities Accreditation Program

HHS:	U.S. Department of Health and Human Services
HMO:	Health Maintenance Organization
HPSA:	Health Care Professional Shortage Areas
HQAA:	Healthcare Quality Association on Accreditation
HQAF:	hospital quality assurance fee
ICU:	intensive care unit
IMI:	inpatient mortality indicators
JC:	Joint Commission
JPA:	Joint Powers Authority or Agency
LDR:	labor, delivery, and recovery
LAFCO:	Local Agency Formation Commission
MD:	medical doctors
Medi-Cal:	California Medical Assistance Program
MUA:	medically underserved area
NP:	nurse practitioner
NPC:	Non-Structural Performance Category
OPEB:	other postemployment benefits
OSHPD:	Office of Statewide Health Planning & Development
PA:	physician's assistant
PCI:	percutaneous coronary intervention
PPACA:	Patient Protection and Affordable Care Act
PQI:	Prevention Quality Indicators
PRIME:	Public Hospital Redesign and Incentives in Medi-Cal
PVHD:	Palo Verde Healthcare District
RAP:	Regional Access Project
RN:	registered nurse
SB:	Senate Bill
SCAG:	Southern California Association of Governments
SCHIP:	State Children's Health Insurance Program
SGMH:	San Gorgonio (Pass) Memorial Hospital
SGMHD:	San Gorgonio Memorial (Pass) Healthcare District
SOI:	Sphere of influence
SPC:	Structural Performance Category
TCPI:	Transforming Clinical Practice Initiative
UCR:	University of California in Riverside

PREFACE

Prepared for the Local Agency Formation Commission of Riverside County (LAFCO), this report is a Municipal Service Review (MSR) and Sphere of Influence (SOI) Update for the Desert, Palo Verde, and San Gorgonio Memorial Healthcare Districts.

CONTEXT

Riverside LAFCO is required to prepare this Service Review by the Cortese-Knox-Hertzberg Local Government Reorganization Act of 2000 (CKH), (Government Code §56000, et seq.), which took effect on January 1, 2001. The MSR examines services provided by public agencies whose boundaries and governance are subject to LAFCO. Those agencies providing healthcare services in Riverside County are the focus of this review. In order to provide comprehensive information on service provision, other service providers—private healthcare providers—are mentioned for context in this Service Review.

CREDITS

The authors extend their appreciation to those individuals at the agencies that provided planning and financial information and documents used in this report. The contributors are listed individually at the end of this report.

LAFCO staff provided project coordination and GIS support. This report was prepared by Policy Consulting Associates, LLC, and was co-authored by Oxana Wolfson, Jennifer Stephenson, and Jill Hetland. Oxana Wolfson served as project manager.

1. EXECUTIVE SUMMARY

This report is a municipal service review report on healthcare services prepared for Riverside LAFCO. A service review is a State-required comprehensive study of services within a designated geographic area, in this case, the County of Riverside. The service review requirement is codified in the CKH (Government Code Section 56000 et seq.).

The intent of this municipal service review is to conduct comprehensive Sphere of Influence (SOI) updates for each of the subject healthcare districts. The proposed MSR and SOI Update determinations, as well as SOI recommendation, are located at the end of each district's chapter in this report.

PROVIDERS

This report covers three healthcare districts—Desert Healthcare District, Palo Verde Healthcare District, and San Gorgonio Memorial Healthcare District. These three districts provide healthcare services and programs in varying structures and manners.

- Desert Healthcare District (DHD) owns and maintains a hospital facility and medical clinics that are leased to providers. Revenues are used to issue grants for healthcare programs.
- Palo Verde Healthcare District (PVHD) owns and directly operates a hospital facility.
- San Gorgonio Memorial Healthcare District (SGMHD) owns and maintains a hospital facility and Behavioral Health Center and contracts for management and operations of the facilities.

The location of the districts is shown in Figure 1-1.

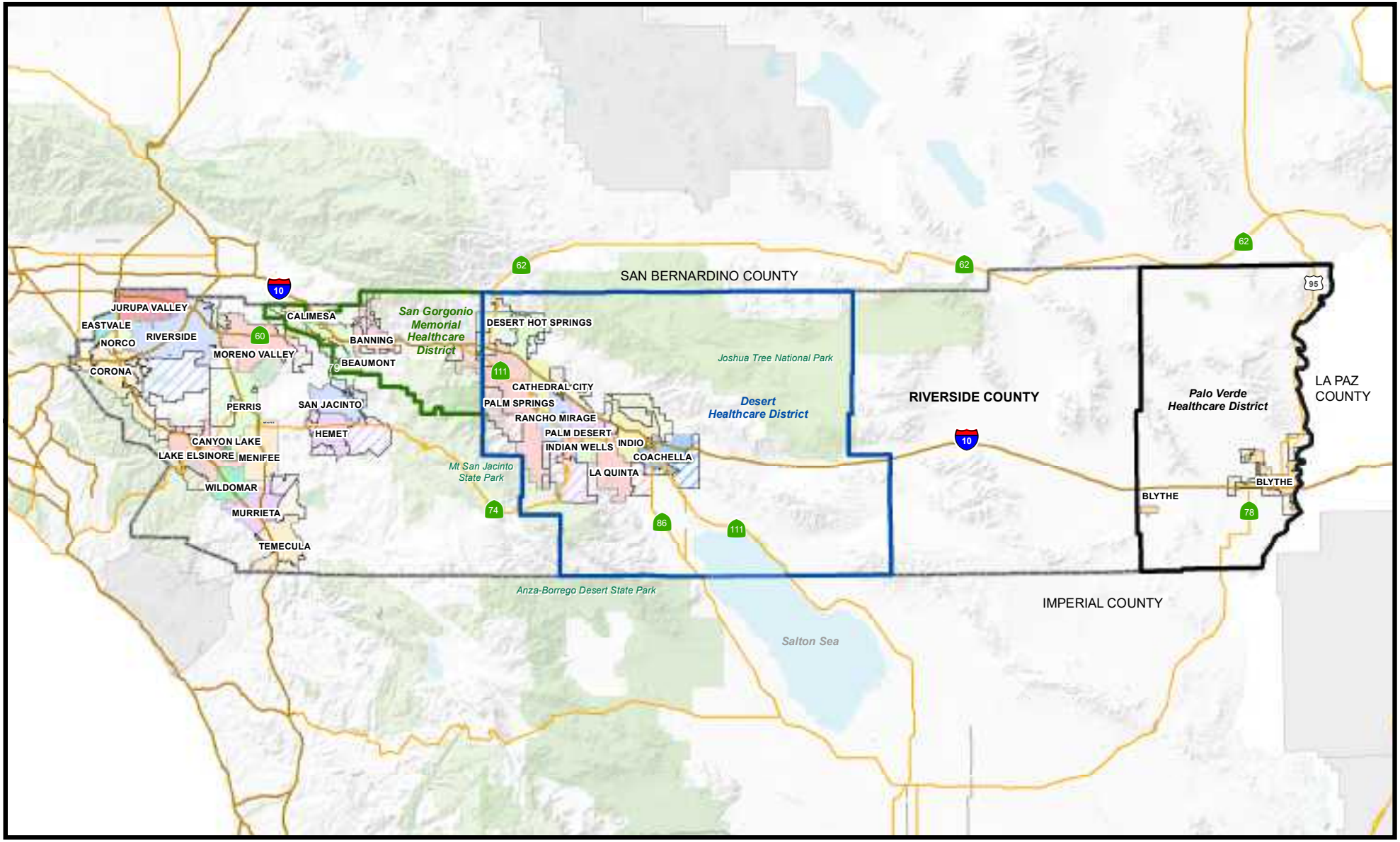
GOVERNANCE AND ACCOUNTABILITY

The healthcare districts reviewed in the MSR meet Brown Act requirements including noticing and posting of meetings and agendas, communication and outreach to residents, and websites that provide links to meeting information, contacts, and documents including financial reports.

There are extensive website requirements for healthcare districts as outlined in Senate Bill 929, Assembly Bill 2257, and Assembly Bill 2019. The districts generally meet the requirements outlined; however, it is recommended that they ensure compliance and continue to practice diligence to ensure that all relevant and recent documents and reports are up-to-date and readily available to the public on their websites.

All districts demonstrated accountability and transparency in their disclosure of information and cooperation during the process of this MSR. The districts generally responded in a timely manner to the questionnaires and cooperated with document requests; however, follow up attempts with PVHD to gather remaining missing information were unsuccessful.

Figure 1-1: Riverside County Healthcare Districts



Data Sources: County of Riverside; LAFCo

0 2.5 5 10 15 20 Miles

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Disclaimer: The information shown is intended to be used for reference and general display purposes only and is not to be used as an official map.

Healthcare services provided for District residents

Legend

- Desert Healthcare District
- Palo Verde Healthcare District
- San Gorgonio Memorial Healthcare District
- Riverside Couinty Boundary

Map Created on 9/14\2020

PLANNING AND MANAGEMENT

Significant planning documents for many healthcare districts are the Community Healthcare Needs Assessment (CHNA) and Community Healthcare Implementation Plan (CHIP) that are required as part of the Affordable Care Act. Both DHD and SGMHD have compiled or are in the process of compiling CHNA and CHIP reports. As an alternative, PVHD has developed a strategic plan and annual strategic goals to guide future program and service efforts.

GROWTH AND POPULATION PROJECTIONS

The districts vary greatly by size and degree of urbanization. DHD and SGMHD serve expansive areas comprised of multiple cities with greater potential for growth and development. PVHD serves a largely rural area. Future growth as projected by the Southern California Association of Governments ranges from one percent in DHD and PVHD to 1.6 percent in SGMHD.

Figure 1-3: District Populations and Growth Projections

District	Population (2020)	Projected Annual Growth Rate	Projected Population (2030)	Projected Population (2045)
Desert Healthcare District	445,721	1%	501,332	571,695
Palo Verde Healthcare District	21,376	1%	24,785	30,049
San Gorgonio Memorial Healthcare District	105,556	1.6%	123,714	156,561

FINANCING

Financing is frequently a significant challenge for healthcare districts in the State as they struggle to compete with for-profit providers and dedicate high levels of funding to charity care in an attempt to address the problem of the underserved population. The three districts reviewed in this MSR are no exception. They all generally struggle with the uncertainty of the existing funding sources, limited additional financing options, and high capital improvement costs.

Despite these challenges, all three districts consistently operate with operational surpluses and balanced budgets, and have positive net positions indicating stability with ongoing operations. All the districts were determined to have sufficient cash on hand to operate for several months or more, have low or no pension, retirement and OPEB obligations, possess sufficient liquidity to pay liabilities as they become due, and have healthy financial reserves.

SPHERE OF INFLUENCE RECOMMENDATIONS

All three districts have SOIs that are coterminous with their boundaries. DHD's SOI was last updated in 2018 when it conducted a large land expansion through special legislation of the State legislature. The SOIs of PVHD and SGMHD were last updated in 2005 and confirmed as coterminous at that time.

The following SOI update recommendations are made for the Commission's consideration for the districts resulting from the comprehensive review and analysis in this report:

- DHD has undergone a recent SOI change and annexation that more than doubled the District's boundary area and its population. The District does not currently have adequate capacity to accommodate or plan for additional growth. It is recommended that the Commission maintain a coterminous SOI for DHD.
- The communities of Desert Center, Eagle Mountain and Lake Tamarisk are currently not included in any healthcare district and located between DHD and PVHD. Given that the area around Desert Center is considered PVHD's secondary service area, DHD's lack of existing capacity to extend services further, and the distance from Desert Center to the DHD's hospital, it is recommended that PVHD's SOI be expanded to include the territory between DHD and PVHD.
- At present, the cities of Calimesa and Beaumont are only partially included in SGMHD's boundary and SOI. One of LAFCO's objectives is to eliminate illogical boundaries and associated service inefficiencies, such as the areas in question. It is recommended that SGMHD's SOI be expanded to include the entirety of the cities of Calimesa and Beaumont and their SOIs in order to address the divided communities of interest, lack of inclusion of some of the District's patrons within its boundaries, and illogical boundaries.

2. BACKGROUND

This report is prepared pursuant to legislation enacted in 2000 that requires LAFCO to conduct a comprehensive review of municipal service delivery and update the spheres of influence (SOIs) of all agencies under LAFCO's jurisdiction. This chapter provides an overview of LAFCO's powers and responsibilities. It discusses legal requirements for preparation of the municipal services review (MSR), and describes the process for MSR review, MSR approval and SOI updates.

LAFCO OVERVIEW

LAFCO regulates, through approval, denial, conditions and modification, boundary changes proposed by public agencies or individuals. It also regulates the extension of public services by cities and special districts outside their boundaries. LAFCO is empowered to initiate updates to the SOIs and proposals involving the dissolution or consolidation of special districts, mergers, establishment of subsidiary districts, and any reorganization including such actions. Otherwise, LAFCO actions must originate as petitions or resolutions from affected voters, landowners, cities or districts.

The composition of LAFCO Commissions varies from county to county. Riverside LAFCO consists of members who represent all levels of local government. They include two County supervisors selected by the Board of Supervisors, two city council representatives selected by the City Selection Committee within Riverside County, two special district board members selected by the Special District Selection Committee within Riverside County, and one public member selected by the other members of the Commission. For each category of commissioner represented (county, city, special district, and public) there is one alternate. Alternate members may attend LAFCO meetings but only vote on items when a regular member from their category is absent. Each Commission member serves a four-year term.

MUNICIPAL SERVICES REVIEW LEGISLATION

The CKH requires LAFCO review and update SOIs not less than every five years and to review municipal services before updating SOIs. The requirement for service reviews arises from the identified need for a more coordinated and efficient public service structure to support California's anticipated growth. The service review provides LAFCO with a tool to study existing and future public service conditions comprehensively and to evaluate organizational options for accommodating growth, preventing urban sprawl, and ensuring that critical services are provided efficiently.

Government Code §56430 requires LAFCO to conduct a review of municipal services provided in the county by region, sub-region or other designated geographic area, as appropriate, for the service or services to be reviewed, and prepare a written statement of determination with respect to each of the following topics:

- Growth and population projections for the affected area;
- The location and characteristics of any disadvantaged unincorporated communities within or contiguous to the SOI (effective July 1, 2012);

- Present and planned capacity of public facilities and adequacy of public services, including infrastructure needs or deficiencies (including needs or deficiencies related to sewers, municipal and industrial water, and structural fire protection in any disadvantaged unincorporated communities within or contiguous to the SOI);
- Financial ability of agencies to provide services;
- 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.

MUNICIPAL SERVICES REVIEW PROCESS

The MSR process does not require LAFCO to initiate changes of organization based on service review findings, only that LAFCO identify potential government structure options. However, LAFCO, other local agencies, and the public may subsequently use the determinations to analyze prospective changes of organization or reorganization or to establish or amend SOIs. Within its legal authorization, LAFCO may act with respect to a recommended change of organization or reorganization on its own initiative (e.g., certain types of consolidations), or in response to a proposal (i.e., initiated by resolution or petition by landowners or registered voters).

MSRs are exempt from California Environmental Quality Act (CEQA) pursuant to §15306 (information collection) of the CEQA Guidelines. LAFCO's actions to adopt MSR determinations are not considered "projects" subject to CEQA.

SPHERE OF INFLUENCE UPDATES

The Commission is charged with developing and updating the SOI for each city and special district within the county.[1] SOIs must be updated every five years or as necessary. In determining the SOI, LAFCO is required to complete an MSR and adopt the seven determinations previously discussed.

An SOI is a LAFCO-approved plan that designates an agency's probable future boundary and service area. Spheres are planning tools used to provide guidance for individual boundary change proposals and are intended to encourage efficient provision of organized community services and prevent duplication of service delivery. Territory cannot be annexed by LAFCO to a city or a district unless it is within that agency's sphere.

The purposes of the SOI include the following: to ensure the efficient provision of services, discourage urban sprawl and premature conversion of agricultural and open space lands, and prevent overlapping jurisdictions and duplication of services.

LAFCO cannot regulate land use, dictate internal operations or administration of any local agency, or set rates. LAFCO is empowered to enact policies that indirectly affect land use decisions. On a regional level, LAFCO promotes logical and orderly development of

[1] The initial statutory mandate, in 1971, imposed no deadline for completing sphere designations. When most LAFCOs failed to act, 1984 legislation required all LAFCOs to establish spheres of influence by 1985.

communities as it considers and decides individual proposals. LAFCO has a role in reconciling differences between agency plans so that the most efficient urban service arrangements are created for the benefit of current and future area residents and property owners.

The Cortese-Knox-Hertzberg (CKH) Act requires LAFCOs to develop and determine the SOI of each local governmental agency within the county and to review and update the SOI every five years. LAFCOs are empowered to adopt, update and amend the SOI. They may do so with or without an application and any interested person may submit an application proposing an SOI amendment.

LAFCO may recommend government reorganizations to particular agencies in the county, using the SOIs as the basis for those recommendations.

In addition, in adopting or amending an SOI, LAFCO must make the following determinations:

- Present and planned land uses in the area, including agricultural and open-space lands;
- Present and probable need for public facilities and services in the area;
- Present capacity of public facilities and adequacy of public service that the agency provides or is authorized to provide;
- Existence of any social or economic communities of interest in the area if the Commission determines these are relevant to the agency; and
- Present and probable need for water, wastewater, and structural fire protection facilities and services of any disadvantaged unincorporated communities within the existing SOI.

By statute, LAFCO must notify affected agencies 21 days before holding the public hearing to consider the SOI and may not update the SOI until after that hearing. The LAFCO Executive Officer must issue a report including recommendations on the SOI amendments and updates under consideration at least five days before the public hearing.

DISADVANTAGED UNINCORPORATED COMMUNITIES

On October 7, 2011, Governor Brown signed SB 244, which makes two principal changes to the CKH. SB 244 requires LAFCOs to: (1) deny any application to annex to a city territory that is contiguous to a disadvantaged unincorporated community (DUC) unless a second application is submitted to annex the disadvantaged community as well; and (2) evaluate disadvantaged unincorporated communities in a MSR upon the next update of a SOI after June 30, 2012.

The intent of the statute is to encourage investment in disadvantaged unincorporated communities that often lack basic infrastructure by mandating cities and LAFCOs to include them in land use planning.

SB 244 defines a DUC as any area with 12 or more registered voters, or as determined by commission policy, where the median household income is less than 80 percent of the statewide annual median.

SB 244 also requires LAFCOs to consider disadvantaged unincorporated communities when developing spheres of influence. Upon the next update of a SOI on or after July 1, 2012, SB 244 requires LAFCO to include in an MSR (in preparation of a SOI update): 1) The location and characteristics of any disadvantaged unincorporated communities within or contiguous to the sphere; and 2) The present and planned capacity of public facilities, adequacy of public services and infrastructure needs or deficiencies including needs or deficiencies related to sewers, municipal and industrial water, and structural fire protection in any DUC within or contiguous to the SOI.

In determining spheres of influence, SB 244 authorizes LAFCO to assess the feasibility of a reorganization and consolidation of local agencies to further orderly development and improve the efficiency and affordability of infrastructure and service delivery. LAFCOs should revise their local policies to include the requirements imposed by SB 244 to ensure they fulfill their obligations under this legislation.

3. OVERVIEW

CALIFORNIA HEALTHCARE DISTRICTS

The Local Hospital District Law was originally enacted in 1945 (Division 23, Section 32000 et seq. of the Health and Safety Code, now referenced as the "Local Health Care District Law"). The law enabled local communities to establish special districts and utilize public financing options for construction and operation of local community hospitals and healthcare institutions in rural, low income areas without access to acute-care hospital facilities, and to recruit physicians for medically unserved areas. Formed by voter approval, local hospital districts were empowered to impose property taxes, enter into contracts, purchase property, exercise the power of eminent domain, issue debt, and hire staff.

Following the establishment of local hospital districts in the 1940's and 1950's, many of the previously rural service areas have grown into highly populated urban and suburban communities. The current residents of these urbanized communities may now have multiple options for local and regional health care facilities and health care service opportunities from both private and public providers.

During the 1970s and 1980s, the nonprofit health care market dramatically changed with the advent of Health Maintenance Organizations (HMO), which introduced managed care and created large health systems comprised of network-affiliated hospitals, physician groups, and medical service providers that pool resources and direct patients to preferred facilities and groups. The conglomeration of health care providers and incentivized patient referrals within affiliated health system networks placed independent fee-for-service hospitals at a competitive disadvantage for attracting patients.

In response to the competitive market environment, the focus of hospital districts expanded from primarily owning and operating local acute-care hospital facilities to also supporting community healthcare and healthcare-related programs and services within their service areas. In 1994, the State Legislature broadened the scope of hospital districts and renamed the statute to its current reference, "The Local Health Care District Law.'' This action redesignated hospital districts to healthcare districts to better reflect the diverse healthcare services provided in addition to operation of local hospital facilities.

The 1994 legislative update also expanded the definition of healthcare facilities as improvements in technology have allowed many medical procedures and services that previously required acute-care facilities and services to be handled on an out-patient basis. Authorized services granted to healthcare districts under current law includes, but is not limited to:

- Operating healthcare facilities such as hospitals, clinics, skilled nursing facilities, adult day health centers, nurses' training school, and childcare facilities.
- Operating ambulance services within and outside of the district.
- Operating programs that provide chemical dependency services, health education, wellness and prevention, rehabilitation, and aftercare.
- Carrying out activities through corporations, joint ventures, or partnerships.

- Establishing or participating in managed care.
- Contracting with and making grants to provider groups and clinics in the community.
- Other activities that are necessary for the maintenance of good physical and mental health in communities served by the district.

The move towards managed care and large healthcare systems with preferred providers created significant financial sustainability problems for many stand-alone healthcare district hospitals in the State.

While many healthcare districts receive a portion of local property taxes, the enactment of Proposition 13 in 1978 resulted in restricted access to property tax revenues for local public agencies, including healthcare district. Healthcare districts can utilize bonded debt financing to fund capital projects such as hospital construction. Issuance of General Obligation bonds requires approval by two-thirds of the local electorate, and revenue bonds are backed by user fees. Healthcare districts may also issue promissory notes and receive loans from state and federal governments.

Healthcare districts have generally evolved to meet the changing healthcare market demands; however, many have been dissolved and only about half of the ones remaining still operate hospitals.

To retain their local acute-care hospital facilities and services, many healthcare districts have created nonprofit corporations to transfer or sell their local hospital facilities and/or contract their hospital facility operations with for-profit or nonprofit health systems. The divestitures of district hospital facilities and/or operations are allowed under current law, and approval by local voters is required when certain thresholds of district assets are proposed for transfer or sale.

Regulatory Environment

Federal

The U.S. Department of Health and Human Services (HHS) is the U.S. federal government's principal healthcare agency. The Centers for Medicare and Medicaid Services (CMS), a component of HHS, administers Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and most aspects of the Patient Protection and Affordable Care Act (PPACA) of 2010. Medicare and Medicaid together provide healthcare insurance for one in four Americans.

Medicare is a national social insurance program, administered by the U.S. federal government since 1966. Medicare is the nation's largest health insurer, handling more than one billion claims per year. Medicare uses approximately 30 private insurance companies across the United States to provide health insurance for Americans aged 65 and older who have worked and paid into the system. Medicare also provides health insurance to younger people with disabilities, end stage renal disease and amyotrophic lateral sclerosis (ALS).

The Social Security Administration is responsible for determining Medicare eligibility and for determining eligibility for and payment of Extra Help/Low Income Subsidy payments. Reimbursement to healthcare providers averages approximately 48 percent of the charges for the patients enrolled in Medicare. The remaining approved healthcare

charges are the responsibility of the Medicare patient and are generally covered with supplemental insurance or with another form of out-of-pocket coverage.

Medicaid is a social health care program for U.S. families and individuals with low income and limited resources. Medicaid recipients must be U.S. citizens or legal permanent residents, and may include low-income adults, their children, and people with certain disabilities. Medicaid is jointly funded by the state and federal governments and is the largest source of funding for medical and health-related services for people with low income in the United States. Medicaid is a means-tested program managed by the states, with each state currently having broad discretion to determine eligibility and for implementation of the program. All states currently participate in the program but are not required to do so.

The Patient Protection and Affordable Care Act (PPACA), known as the Affordable Care Act (ACA), is a United States federal statute signed into law by President Barack Obama on March 23, 2010. The ACA is regarded as the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965. Enactment of the ACA was intended to increase the quality and affordability of health insurance, lower the uninsured rate by expanding public and private insurance coverage, and reduce the costs of healthcare for individuals and the government.

The ACA requires healthcare insurance companies to cover all applicants within new minimum standards and offer the same rates regardless of pre-existing conditions or sex. The ACA introduced mechanisms like subsidies, and insurance exchanges, and restructured Medicare reimbursements.

The ACA expanded both eligibility for and federal funding of Medicaid by qualifying all U.S. citizens and legal residents with income up to 133 percent of the poverty line, including adults without dependent children; however, some states have declined the expansion and continue their previously existing Medicaid eligibility requirements and funding levels.

State

The California Health and Human Services Agency (CHHS) is the state agency responsible for administration and oversight of "state and federal programs for healthcare, social services, public assistance and rehabilitation" in California. CHHS oversees 11 departments and boards, and four offices that provide a wide range of healthcare services, social services, mental health services, alcohol and drug treatment services, public health services, income assistance, and services to people with disabilities.

The California Department of Health Care Services (DHCS) is department within the CHHS that finances and administers a number of individual healthcare service delivery programs, including Medi-Cal, which provides healthcare services to people with low incomes.

The California Medical Assistance Program (Medi-Cal) is the name of the California implementation of the federal Medicaid program that serves low-income families, seniors, persons with disabilities, children in foster care, pregnant women, and certain low-income adults. Approximately 30 percent of California's population is enrolled in Medi-Cal. Medi-Cal is jointly administered by the California DHCS and the federal CMS, with many services implemented at the local level by the counties of California.

Covered California is the health insurance marketplace in California, the state's implementation of the American Health Benefit Exchange provisions of the PPACA. Beginning in 2014, those with family incomes up to 138 percent of the federal poverty level became eligible for Medi-Cal, and individuals with higher incomes and some small businesses may choose a plan in Covered California with potential federal subsidies.

The California Office of Statewide Health Planning & Development (OSHPD) was created in 1978 to review and report on the structure and function of healthcare delivery systems in California. OSHPD collects and disseminates healthcare data and information about California's healthcare infrastructure, monitors the construction, renovation, and seismic safety of hospitals and skilled nursing facilities, and provides loan insurance to not-for-profit healthcare facilities.

The Alfred E. Alquist Seismic Safety Act of 1983 (California Health and Safety Code Section 129675 et. seq.) provides a seismic safety building standards program under OSHPD's jurisdiction for hospitals built on or after March 7, 1973. The Act was originally established in response to the loss of life from the collapse of hospitals during the Sylmar earthquake of 1971. Following the Northridge earthquake in 1994, Senate Bill (SB) 1953 was enacted which amended the Alquist Act to require that all licensed acute-care hospitals in California be capable of remaining operational after a seismic event or other natural disaster with an initial compliance deadline of 2013.

SB 1953 required OSHPD to develop seismic performance categories for evaluating both the seismic resistance of the hospital structures as well as the adequate anchorage and bracing of non-structural features such as electrical, mechanical, plumbing and fire safety systems for their continued use following a disaster event. Hospitals are required to prepare both a comprehensive evaluation report and compliance plan to attain the specified structural and nonstructural performance categories.

Subsequent changes to the legislation have established a final compliance deadline of 2030, by which any licensed acute-care hospital facilities not in compliance with seismic safety standards must be replaced or cease acute-acre operations.

Private Health Care Providers in the state are licensed and regulated by the California Department of Managed Health Care (DMHC). The DMHC oversees full-service health plans, including all California HMOs, as well as specialized plans such as dental and vision. Health plans are required to apply for and maintain a license from the DMHC to operate as a health plan in California. The DMHC reviews all aspects of the plan's operations to ensure compliance with California law. This includes, but is not limited to, Evidences of Coverage, contracts with doctors and hospitals, provider networks, and complaint and grievance systems. Overall, the DMHC regulates more than 90 percent of the commercial healthcare marketplace in California.

County

The County of Riverside Department of Public Social Services (DPSS) is responsible for providing a broad range of health and social services in Riverside County. The DPSS includes seven primary program areas, which cover the various aspects of health and social services including adult services, children's services, self-sufficiency, in-home supportive services, continuum of care, family resources, and community outreach. Services are provided

through five departments: Administration, Adult Services, Children's Services, Self-Sufficiency and Public Authority.

The Riverside DPSS is responsible for providing county-administered health and social programs related to welfare in California, such as Medi-Cal, CalFresh (food stamps), CalWORKs, and the Low-Income Health Program (ACA).

SETTING

The study area of this Municipal Service Review (MSR) covers four healthcare districts in Riverside County that include Desert Healthcare District (DHD), Palo Verde Healthcare District (PVHD), San Gorgonio Memorial Healthcare District (SGMHD), and Valley Health System Healthcare District (VHSHD).

VHSHD is an inactive district and does not currently provide any services. The District covers vast 882 square mile territory in the greater San Jacinto and Menifee Valley areas and includes the cities of Hemet and San Jacinto. VHSHD was formed in 1946 to provide healthcare services to an existing 18-bed hospital, at that time, in the City of Hemet but after providing services for many decades filed for Chapter 9 bankruptcy protection in 2007. VHSHD had completed sale of all its assets by the end of 2010 and terminated all of its employees. Riverside LAFCO approved the adoption of a "zero" sphere of influence (SOI) designation in 2019 and the district dissolution on June 25, 2020.

The three other healthcare districts in Riverside County remain operational and continue to serve their respective communities. DHD, PVHD, and SGMHD were formed in 1948, 1948, and 1947, respectively, bringing these underserved areas located away from urban centers vital and convenient healthcare options.

The DHD service area represents the largest service area of all three districts. The 2018 boundary expansion more than doubled the geographic and demographic size of the District to include almost the entirety of the Coachella Valley region. Population within DHD fluctuates seasonally due to tourism and second homes in this resort area and represents the largest served population among the three active healthcare districts. DHD's western boundary is adjacent to that of San Gorgonio Memorial District, which claims the western portions of the cities of Palm Springs and Desert Hot Springs in its boundaries and SOI. The eastern boundary of DHD stretches to include the unincorporated community of Chiriaco Summit as well as portions of Joshua Tree National Park and the Salton Sea. The District is bound by the San Bernardino county border in the north and the San Diego and Imperial county lines in the south.

PVHD is located to the east of DHD; however, the two districts do not share a boundary. The stretch of land between PVHD and DHD includes the unincorporated communities of Desert Center, Eagle Mountain and Lake Tamarisk, just about 20 miles east of DHD's eastern boundary and uninhabited areas characterized by rough terrains including Eagle Mountains, Chuckwalla Valley and Chuckwalla Mountains. The PVHD's boundaries generally include the City of Blythe and surrounding unincorporated communities. The District covers the entirety of Riverside County land in the north, east and south; its western border is marked by the Blythe's western boundary. Although the unincorporated communities of Desert Center, Eagle Mountain and Lake Tamarisk that are not located in any healthcare district are generally closer to DHD's eastern boundary, PVHD considers these areas its secondary

service area, presumably because the Palo Verde Hospital is much closer to these communities than the Desert Regional Medical Center owned by DHD.

In comparison to DHD and PVHD, SGMHD's boundaries cover the smallest area. However, because the territory within the District is largely urban (particularly in its western portions) served population is disproportionately large, especially compared to mostly rural PVHD. The SGMHD's boundary area generally stretches to include most of the cities of Beaumont and Calimesa in the west and small portions of the cities of Palm Springs and Desert Hot Springs in the east. The eastern portion of the District between the cities of Banning and Palm Springs is largely unincorporated with a more rural character and lower population density. SGMHD also provides services to the secondary service area outside of its boundaries that include the cities of San Jacinto and Hemet, previously served by Valley Health System Healthcare District.

The rest of Riverside County to the west of SGMHD is not included in the boundaries of any healthcare district.

The spheres of influence for all three reviewed districts are currently coterminous, which means they are the same as their respective boundaries.

SERVICES

Each healthcare district reviewed in this MSR offers an array of services, whether they be medical care, preventive programs or providing funding for healthcare programs and services.

Although DHD owns the Desert Regional Medical Center (DRMC), the District does not operate the hospital directly and has a lease for the facility with Tenet Health Systems, Inc. DHD's direct services include providing grant funding for community health initiatives within its boundary area. The District supports a variety of health-related programs, through financial assistance to nonprofit entities and public agencies. DHD has taken a leadership role in the collective efforts in the areas of access to healthcare, medically underserved populations, shortage of healthcare workers, health disparities, homelessness, behavioral health, socioeconomic determinants of health, and public health issues.

Despite not being the direct hospital service provider, the Desert Healthcare District Board of Directors retains significant oversight responsibilities over the Desert Regional Medical Center. This medical facility is a 385-bed hospital that provides comprehensive medical care covering a number of serious medical conditions that include but are not limited to advanced brain and spinal injuries, stroke, cancer, heart disorders and others in its inpatient and outpatient departments that are fully equipped with state-of-the-art medical technology.

SGMHD, similar to DHD, is not a direct hospital service provider. The District does, however, own a hospital, which is managed by the SGMH Corporation under contract. The District itself works hand in hand with its foundation to help provide funding through grants, donations, and fundraising for hospital related services. From orthopedic care and obstetrics, to emergency services, cardiac rehabilitation, and behavioral health, San Gorgonio Memorial Hospital (SGMH) offers comprehensive medical care and related health and wellness programs. While some of these services take place at the hospital itself, there

is also a Women's Center on the hospital's campus, and the San Gorgonio Memorial Medical Clinic located in the city of Banning.

Currently a small facility of 79 hospital beds, SGMH is undergoing continuous expansion. Upon completion, renovations will ultimately add more bed capacity and functional space for a variety of needs.

Unlike DHD and SGMHD, Palo Verde Healthcare District provides hospital services directly. PVHD owns and operates a small facility of 51 hospital beds. The hospital offers a full range of services from maternity to end of life palliative and/or hospice care. A variety of low or no-cost services are also provided to the community such as medical and wellness education programs, medical screenings, and support groups.

In comparison to the other two districts however, Palo Verde Hospital (PVH) serves a relatively small population throughout a largely rural community, which is reflected in more limited service offerings. For instance, the hospital does not perform invasive, interventional cardiac or surgical procedures, and pediatric patients or newborns in need of intensive care services are transferred from the hospital's emergency department to other facilities capable of fulfilling those needs.

KEY FINDINGS

Service Needs and Challenges

Overall, this MSR has found that all three districts reviewed offer valuable and needed services in Riverside County through providing and/or financing a range of hospital, clinic and other healthcare related services in their respective communities.

However, despite their very different roles and locations, all three districts face similar challenges related to underserved residents as reflected by extensive medically underserved areas (MUAs) and Primary Care Health Care Professional Shortage Areas (HPSA) in all three districts and racial and ethnic disparities in health outcomes and in access to healthcare services.[2] The chronic disease and behavioral health burden in Riverside County is significant, there are not enough nurses and physicians, and a high percentage of the population is uninsured.

There are concerns that if the Affordable Care Act (ACA) is repealed the situation will be dramatically exacerbated as high ratios of people in the reviewed healthcare districts currently rely on the ACA for their health coverage. The loss of coverage for a significant fraction of the population would in turn place additional financial burden on the districts that are already financially challenged.

Overall, medical care in Riverside County appears to be comparable to the rest of the state based on Prevention Quality Indicators (PQIs). Figure 3-1 shows that Riverside County's PQI rates do not largely differ from statewide rates. 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.

[2] Riverside County recognizes higher rates of diabetes in African Americans (11 percent) and Hispanics (10 percent), than whites (7 percent). Hispanics experience a higher rate of teen pregnancy than whites. 89 percent of whites have health insurance coverage, compared with 75 percent of Hispanics.

For uncontrolled diabetes and asthma in young adults, the Riverside County rates are lower than statewide rates by a larger margin than all other indicators, suggesting that residents in the County have better access to outpatient care for these diseases compared to statewide. The short-term diabetes complications and community acquired pneumonia rates in Riverside County, on the other hand, were higher than statewide rates by a large margin. Riverside County Department of Public Health (DPH) reports that Riverside County residents generally struggle with such health issues as diabetes, COPD and heart disease.

Figure 3-1: Risk Adjusted Rates per 1,000 Population

Year	Region	Diabetes Short-term Complications	Diabetes Long-Term Complications	COPD or Asthma in Older Adults (Ages 40+)	Hypertension	Heart Failure	Community-Acquired Pneumonia	Urinary Tract Infection
2017	Statewide	38.4	90.6	299.1	40.5	330.4	108.4	101.3
	Riverside	41.9	89.5	286	37.7	292.5	115.1	104
	Difference with statewide	9%	-1%	-4%	-7%	-11%	6%	3%
2018	Statewide	58.1	88.4	229	41.5	335.4	107	93.3
	Riverside	67.4	92.9	208.3	41.2	309.5	125.1	98.9
	Difference with statewide	16%	5%	-9%	-1%	-8%	17%	6%

Year	Region	Uncontrolled Diabetes	Asthma in Young Adults (Ages 18-39)	Lower-Extremity Amputations Among Patients with Diabetes	Overall Composite	Acute Composite	Chronic Composite	Diabetes Composite
2017	Statewide	31.9	19.5	24.7	947.1	209.7	736.3	172.5
	Riverside	26	16.5	23.1	905.6	219.6	683.6	168.2
	Difference with statewide	-18%	-15%	-6%	-4%	5%	-7%	-2%
2018	Statewide	30.3	18.5	25.9	919.6	200.3	718.3	189.8
	Riverside	26.1	15.7	25.8	916	224.2	689.7	196.8
	Difference with statewide	-14%	-15%	0%	0%	12%	-4%	4%

Source: The Office of Statewide Health Planning and Development (OSHPD)

Financing

As was mentioned in the *California Healthcare Districts* section, financing is frequently a significant challenge for healthcare districts in the state as they struggle to compete with for-profit providers and dedicate high level of funding to charity care in an attempt to address the problem of underserved population. The three districts reviewed in this MSR are no exception. They all generally struggle with the uncertainty of the existing funding sources, limited additional financing options and high capital improvement costs.

Despite these challenges, all three districts consistently operate with operational surpluses and balanced budgets, and have positive net positions indicating stability with ongoing operations. Figure 3-2 depicts the comparison of the three districts in regard to several financial indicators. Although the information for PVHD was not available for FY 18-19[3] the data available for FY 17-18 nevertheless allows for general conclusions regarding the District's financial health. As can be seen in Figure 3-2, all the districts have sufficient cash on hand to operate for several months or more, have low or no pension, retirement and OPEB obligations, and possess sufficient liquidity to pay liabilities as they become due. DHD and SGMHD additionally have healthy financial reserves.

[3] PVHD conducts biennial audits. The next audit will be performed for both, FYs 18-19 and 19-20.

Figure 3-2: Healthcare District Financial Health

Category	*DHD (FY 18-19)*	*PVHD (FY 17-18)*	*SGHD (FY 18-19)*
Balanced Budget (Net Operating Revenue)	$ 2,121,249	$ 1,323,494	$ 6,951,059
Operating Ratio (op rev/exp incl debt&deprec)	0.5	1.1	1.1
Unrestricted Net Position/Operating Revenues	521%	30%	55%
Net Position	$ 55,207,356	$ 7,154,718	$ 7,313,647
Current Ratio (Short-term Liquidity)	3.3	2.8	4.6
Months Cash on Hand (current cash assets/expenses incl debt)	24	10	6
Change in Net Depreciable Capital Assets (FY 18-FY 19)	-5%	-18%	-5%
Total Reserves (% of op. expend)	942%	NP	50%
Pension and Retirement Liabilities as % of Revenues	6%	0.4%	0%
OPEB Liability Payments as % of revenue	0.2%	0%	0%

Notes: NP = Not Provided

Besides San Gorgonio Memorial Healthcare District, the other two districts have very low or no long-term debt. However, SGMHD took on significant amount of debt to finance the legally required capital improvement requirements, which DHD and PVHD would also need to address. These infrastructure upgrades would also potentially offset the depreciation of capital assets which is depicted in Figure 3-2.

OSHPD has developed a Structural Performance Category (SPC 1-5) rating for hospitals that indicates the building's compliance with seismic safety standards and a Non- Structural Performance Category (NPC 1-5) rating that indicates the hospital facility's equipment and systems conformance with seismic standards for adequate anchorage and bracing of non-structural features such as electrical, mechanical, plumbing and fire safety systems for their continued use following a disaster event. State law allows general acute care hospitals until 2030 to achieve seismic compliance.

Both DHD and PVHD require significant upgrades to achieve compliance with SPC and NPC requirements. The districts are yet to develop plans as to what capital improvements are required and potential sources of funding to finance them.

Service Demand

All three reviewed districts currently own general acute care hospitals, although PVHD has applied to be designated critical access hospital (CAH). The decision on this application is currently pending. Out of the three districts, only PVHD operates its hospital directly. The two other districts outsource the operation of their facilities to other operators: DHD – to a for-profit corporation and SGMHD – to a nonprofit corporation. Figure 3-2 depicts hospital service demand and utilization comparison data for the calendar year (CY) 2019 for the three reviewed healthcare districts. As can be seen in the table, hospitals owned by PVHD and SGMHD are much smaller than the one owned by DHD. The sizes directly correspond to the range of services provided by the three hospitals. The DRMC has a wider range of hospital bed types and provides a greater array of services.

Figure 3-3: Hospital Service Demand and Utilization

2019 Hospital Utilization						
Facility	***Type of Hospital***	***Hospital Beds***	***ED Encounters***	***Discharges***	***Average Length of Stay***	***Ambulatory Surgery***
Desert Regional Medical Center	General Acute	385	63,314	22,265	4.5	10,539
Palo Verde Hospital	General Acute	51	8,653	618*	3.2	218
San Gorgonio Memorial Hospital	General Acute	79	41,372	3,134	3.4	1,989

2019 Hospital Discharge Data						
Type of Care	***DRMC***		***PVH***		***SGMH***	
Acute Care	21,257	95.47%	618	100%	3,134	100%
Physical Rehabilitation Care	224	1.01%				
Skilled Nursing/Intermediate Care	784	3.52%				
Total	**22,265**	**100%**	**618***	**100%**	**3,134**	**100%**

2019 Hospital Discharges by Payer						
2019 Discharges by payer	***DRMC***		***PVH***		***SGMH***	
County Indigent Programs	1	0%				
Medi-Cal	7,686	34.52%	254	41.10%	1,103	35.19%
Medicare	8,300	37.28%	186	30.10%	1,270	40.52%
Private Coverage	5,364	24.09%	160	25.89%	627	20.01%
Self Pay	263	1.18%	18	2.91%	56	1.79%
Workers Compensation	52	0.23%			9	0.29%
Other Government	415	1.86%			68	2.17%
Other Indigent	107	0.48%				
Other Payer	77	0.35%			1	0.03%
Total	**22,265**	**100%**	**618***	**100%**	**1,134**	**100%**

Notes: *Discharge data for PV Hospital has been approximated since the information is only avaiable for the period of 1/1/2019-6/30/2019.

DRMC also serves the greatest number of patients, while Palo Verde Hospital the lowest number as reflected by the total volume of hospital discharges, discharges per hospital bed and emergency room visits. In fact, PVHD's hospital utilization is much lower than of the other two providers, which is attributed to the Palo Verde Hospital's rural remote location and a limited selection of medical services offered. This is also supported by the average length of stay data, which suggests that for more complicated conditions and procedures people generally stay at a hospital longer.

In addition, Figure 3-3 shows that the largest ratio of patients served by all three hospitals are covered by the government programs – Medi-Cal and Medicare, followed by private insurance and self-pay. This may be due to the general assumption that older, disabled and vulnerable and disadvantaged populations that are covered by these government programs inherently make greater use of hospital services.

Service Adequacy

Services provided by all three hospitals were generally found to be satisfactory. As shown in Figure 3-3, all three hospitals are accredited by various accreditation institutions, which indicates high level of service provision. Hospitals are not required to be accredited in order to operate. Accreditation generally recognizes outstanding performance by a healthcare provider. Another service adequacy indicator is ambulance diversion hours, which shows the amount of time the hospital's emergency department was unavailable to incoming ambulance traffic. Ambulance diversion may occur due to emergency room closure, inability to accommodate the incoming volume of patients or the inability to transfer admitted patients from the ED to inpatient beds. Ambulance diversion has been found unsafe for

patients because it increases transport times, which interferes with continuity of care, causes delays, and increases mortality for severe trauma patients.[4] Generally, all three hospitals are largely able to accommodate the incoming volume of patients at all times. Overall, all three hospitals also appear to be performing adequately in terms of inpatient mortality indicators (IMIs) that measure inpatient mortality rates for individual hospitals against state averages for specific medical conditions and surgical procedures. In terms of the hospital readmission rate, all the reviewed hospitals are likewise comparable to the statewide average readmission rate, which indicates satisfactory performance. Generally, the more adequately a patient is treated for a specific condition the less likely that patient would have to be readmitted for the same condition.

However, in terms of patient satisfaction, DRMC and SGMH outperform the Palo Verde Hospital as can be seen in Figure 3-4. Only 23 percent of patients that patronize Palo Verde Hospital would recommend this hospital to others.

Figure 3-4: Hospital Service Adequacy

Hospital Service Adequacy

Service Adequacy Indicator	*Desert Regional Medical Center*	*Palo Verde Hospital*	*San Gorgonio Memorial Hospital*
Hospital Accredication	Accredited	Accredited	Accredited
Percentage of patients that would recommend the hospital	70%	23%	66%
Amulance Diversion Hours (2018)	0	9	0
Inpatient Mortality Indicators	Worse than statewide only for acute myocardial infraction	Not statistically different than statewide	Not statistically different than statewide
Hospital Readmission Rate	15.6%	15%	15.8%

In addition to owning a hospital DHD also actively engages in grant funding as was described in the *Services* section. The DHD's grant funding services were found to be adequate based on community outreach and transparency in its operations, District resident satisfaction and particularly in terms of following best management practices with regard to grant approval and management. The other two districts do not provide grant funding in their respective communities.

COVID-19 Pandemic

Residents of all the three districts, as well as districts' financing, service demand and service adequacy have been affected by the currently ongoing COVID-19 disease pandemic caused by SARS-CoV-2 virus. All the districts reported that generally hospital and clinic utilization and demand for medical services have decreased since many people currently

[4] *Reducing Ambulance Diversion in California: Strategies and Best Practices*, California Healthcare Foundation, July 2009 https://www.chcf.org/wp-content/uploads/2017/12/PDF-ReducingAmbulanceDiversionInCA.pdf

choose or are directed to avoid visiting medical establishments if possible and postpone elective surgeries and other procedures. The reduction in utilization, in turn, is negatively affecting hospitals' and clinics' revenues, which is causing temporary staff layoffs and furloughs. The hospitals' financial health has also been impacted by the increased costs associated with the pandemic. Hospitals had to purchase additional equipment, such as ventilators and prepare their ICU units and other departments for a possible influx of COVID-19 patients.

Apart from the financial impacts, hospitals and other healthcare providers within the healthcare districts have been struggling with obtaining COVID-19 tests and reagents and in many cases necessary protective equipment, which are problems of national concern.

Medical professionals also had to transition to providing services via telehealth systems and the districts' Boards of Directors had to adjust to holding their regular meetings electronically similar to most other public agency Boards in California.

4. DESERT HEALTHCARE DISTRICT

DISTRICT OVERVIEW

Desert Healthcare District			
Contact Information			
Contact:	Chris Christensen, Chief Administration Officer		
Address:	1140 N. Indian Canyon Dr Palm Springs, CA 92262	*Website:*	www.dhcd.org
Phone:	760-323-6365	*Email:*	https://www.dhcd.org/Contact-Us
Formation Information			
Date of Formation:	1948	*District type:*	Independent Special District
Governing Body			
Governing Body:	Board of Directors	*Members:*	7
Manner of Selection:	Election by voting district	*Length of term:*	4 years
Meeting Location:	Regional Access Project Foundation Building, 41550 Eclectic Street, Palm Desert, CA, 92260	*Meeting date:*	4th Tuesday of the month at 5:30 p.m.
Mapping and Population			
GIS Date:	7/30/19	*Population (2020):*	445,721
Purpose			
Enabling Legislation:	Local Healthcare District Law Health and Safety Code §32000-32492.	*Empowered Services:*	Medical services, emergency medical, ambulance, and services relating to the protection of residents' health and lives
Services Provided	Hospital (30-year lease with Tenet Health Systems that expires 5/30/2027), grant funding, leasing of medical offices and park.		
Area Served			
Size:	2,275 square miles	*Location:*	Central Riverside County (Coachella Valley)
Current SOI:	2,275 square miles	*Most recent SOI update:*	2018
Facilities			
Hospital Name:	Desert Regional Medical Center (DRMC)	*Location:*	1150 N. Indian Canyon Dr, Palm Springs, CA 92262
Number of Licensed Beds:	385	*Other Facilities:*	Las Palmas Medical Plaza, Wellness Park

Boundaries

Desert Healthcare District's (DHD's) boundaries encompass approximately 2,275[5] square miles. The most recent boundary change occurred in 2018 through special legislation. AB 2414, signed into law by the Governor in 2016, increased the size of the District from 515 square miles to 2,275 square miles[6] to include the entire Coachella Valley region. The annexed area included the eastern Coachella Valley to expand access to healthcare services by the underserved population that suffers from a higher than average prevalence of preventable disease. As required by the new law, LAFCO was obligated to approve the annexation application submitted by the District. In addition, the County Board of Supervisors were mandated to place the approval of the District expansion on the ballot for voter approval. Voters of the annexed area have subsequently approved the annexation.

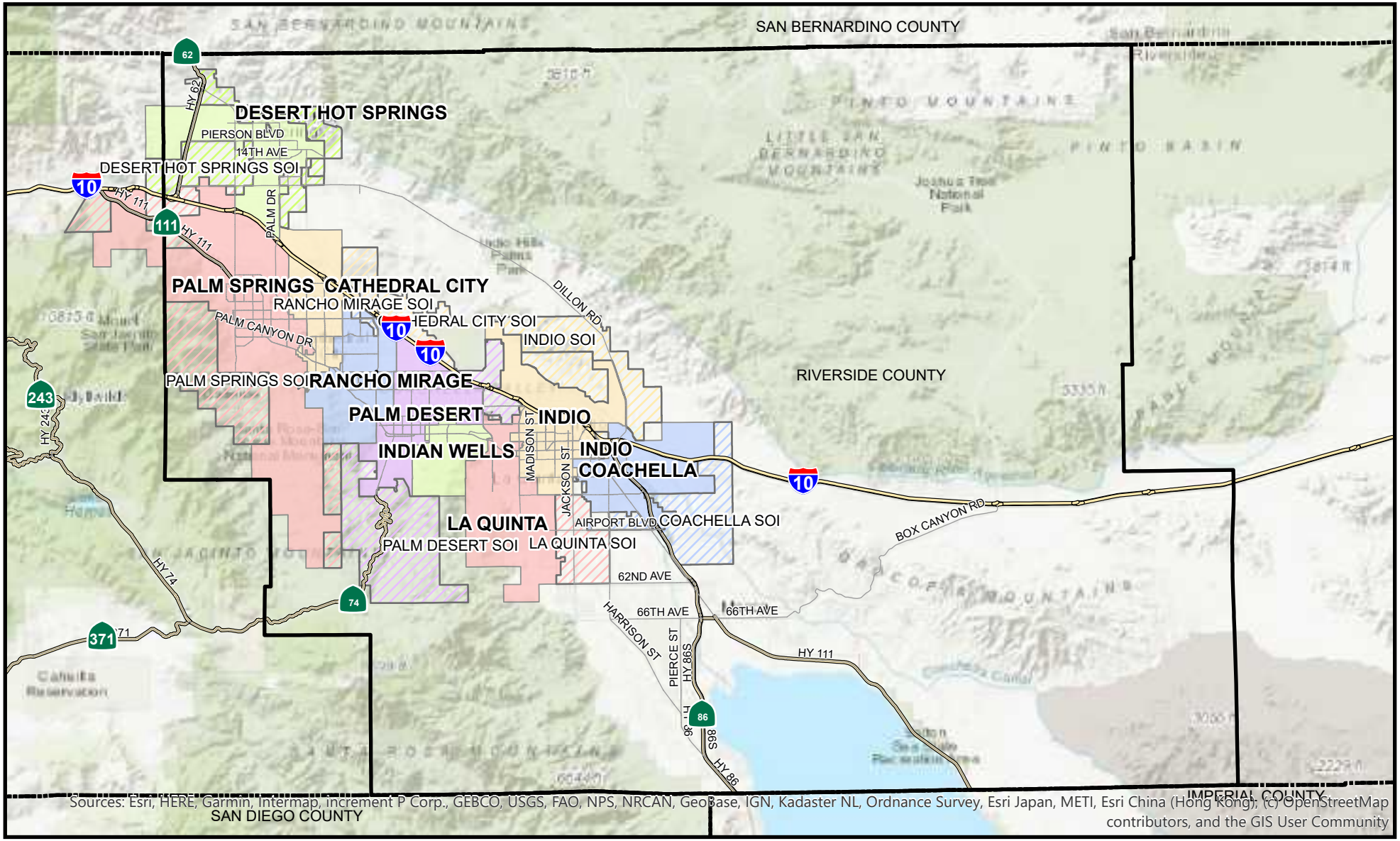
DHD's current boundaries are shown in Figure 4-1.

Sphere of Influence

The District's current SOI is coterminous with its boundaries. The last SOI amendment took place in 2018 concurrently with the boundary expansion described above. The SOI expansion and concurrent annexation included the territory east from the previous DHD boundaries near Cook Street in Palm Desert to an area east of Chiriaco Summit and west of Eagle Mountain and Desert Center, extending to the northern and southern County boundaries, encompassing all or the remaining portions of the cities of Rancho Mirage, Palm Desert, Indian Wells, La Quinta, Indio and Coachella and the unincorporated communities of Bermuda Dunes, Vista Santa Rosa, Thermal, Mecca, Oasis, North Shore, and Chiriaco Summit, as well as portions of Joshua Tree National Park and the Salton Sea.[7]

[5] Desert Healthcare District Plan of Services, 2017, p. 1
[6] LAFCO Staff Report, 4/26/2018, Executive Summary from George J. Spiliotis, Sphere of Influence Amendment to the Desert Healthcare District
[7] LAFCO Staff Report, 4/26/2018, Executive Summary from George J. Spiliotis, Sphere of Influence Amendment to the Desert Healthcare District

Figure 4-1: Desert Healthcare District and Sphere of Influence



Data Sources: County of Riverside; LAFCO

9 4.5 0 9 Miles

N

Legend

Desert Healthcare District**

** SOI is coterminous with District Boundary

Disclaimer: The information shown is intended to be used for reference and general display purposes only and is not to be used as an official map.

Healthcare services provided for District residents

Author: Crystal M. Craig

Map Created on 7/30/19

ACCOUNTABILITY AND GOVERNANCE

DHD is organized as a special district, meaning it is a form of local government that is guided by its own Board of Directors in order to serve the particular healthcare needs of the community it represents. From its formation in 1948 to January 2019, the District was governed by a five-member Board elected by the residents of the communities within its boundaries. In 2018, however, following the expansion of the District's boundaries, DHD was divided into seven voting districts with the representation in accordance with demographic and geographic factors of the entire area, pursuant to AB 2414. Each Board member is to be elected by voters within their respective voting districts. The initial extra two board members were appointed by the five-member District's Board of Directors that was in place at that time. The first elections to replace the appointed Board members will take place on November 3rd, 2020.

The District's Board of Directors consists of a President, a Vice-President/Secretary, a Treasurer, and four Directors. There are no current vacancies on the Board. The term of office for Board members is four years and the terms are staggered for election cycles every two years. Additionally, there are five committees that meet to provide more specified leadership in certain areas. These five committees include: 1) Finance, Administration, Real Estate and Legal, 2) Hospital Lease Oversight, 3) Program, 4) Strategic Planning, and 5) the Board and Staff Policies Committee. Each committee is run by three Directors; however, the Program Committee is comprised of four community members as well.

The District reported that the Board and designated staff have all completed and filed Form 700 for 2020 as required by the California Fair Political Practices Commission (FPPC). Form 700 is a Statement of Economic Interests that is required to be submitted annually by elected officials and public employees who are influential in governmental decisions to allow for transparency and accountability about potential personal and financial conflicts of interest. The District also indicated that all Board members are current on ethics and harassment training, with the latest training having been completed in February 2020.

Per district policy, the regular District Board meetings are scheduled on the fourth Tuesday of each month, except during the month of August. These meetings are held at 5:30 p.m. in the Regional Access Project (RAP) Foundation Building, located at 41550 Eclectic Street, Palm Desert, California, 92260, unless otherwise designated in the meeting Agenda. If the regular meeting date falls on a legal holiday or the required number of Board Directors are unavailable, the meeting will be held at the same time on the next business day. The meeting location may change, as long as it is held within the District's service boundaries, and a notification of such a change is posted on the District's website. Since March 2020, in accordance with the Governor's Executive Order No. N-25-20 related to COVID-19, all meetings of the Board have been conducted via teleconferencing.

Meeting agendas are posted on the District's website under the "Agendas & Documents" tab in the menu as well as on the home page at least 72 hours prior to the meeting. Likewise, all Board approved minutes are also available in the District office and on the District's website, including audio recordings, for public access.

As mentioned, DHD maintains a website with information readily available for the public. The Special District Transparency Act (SB 929), signed into law in 2018, requires special

districts in California to have websites by January 1st, 2020. The website is mandated to clearly list the district's contact information in addition to the recommended agendas and minutes, budgets and financial statements, compensation reports, and other relevant public information and documents. A district may be exempt from the law by a resolution adopted by a majority vote of its governing body declaring detailed findings regarding a hardship that prevents the district from establishing or maintaining a website. The resolution must be adopted annually as long as the hardship exists.[8] The District's website meets the requirements of SB 929.

In 2016, the State Legislature enacted Assembly Bill (AB) 2257 (Government Code §54954.2) to update the Brown Act with new requirements governing the location, platform and methods by which an agenda must be accessible on the agency's website for all meetings occurring on or after January 1, 2019. AB 2257 provides two options for compliance. Under the first option, an agency that maintains a website must post a direct link to the current agenda on its primary homepage. The link may not be placed in a "contextual menu," such as a drop-down tab, that would require a user to perform an action to reveal the agenda link. Additionally, the agenda must be: (a) downloadable, indexable, and electronically searchable by common internet browsers; (b) platform independent and machine readable; and (c) available to the public, free of charge and without restrictions that might interfere with the reuse or redistribution of the agenda. Under the second option, an agency may implement an "integrated agenda management platform," meaning a dedicated webpage that provides the necessary agenda information. The most current agenda must be located at the top of the page. Under this option, a direct link to the current agenda does not need to be posted on the homepage; however, the agency *is* required to post a link to the platform containing the agenda information. Again, this link may not be hidden in a contextual menu.[9] DHD is compliant with the AB 2257 requirements as it has a dedicated webpage that provides the required agenda information.

AB 2019, signed into law in 2018 by Governor Jerry Brown, imposes additional posting requirements on California's healthcare districts. Healthcare districts must now post the following information on their websites:

- the district's annual budget,
- a list of current board members,
- information regarding public meetings,
- recipients of grant funding or assistance provided by the district,
- the district's policy for providing grants or assistance, and
- audits, financial reports and MSRs or LAFCO studies, if any, or a link to another government website containing this information.

DHD currently meets all posting requirements of AB 2019.

There are additional requirements outlined in this bill for healthcare districts that provide assistance or grant funding, which are discussed in more detail in the *Service*

[8] California Government Code, §6270.6 and 53087.8
[9] https://www.jdsupra.com/legalnews/ab-2257-new-brown-act-requirements-for-35346/

Adequacy section. AB 2019 also requires all healthcare districts to notify LAFCO if they file for bankruptcy.

In order to facilitate communication with the public and encourage voter interest, district staff and Board members actively support community involvement. DHD frequently holds meetings to solicit public engagement in various district initiatives. Notices of all public meetings are published on the District's website and emailed to the public through Constant Contact, an email marketing tool.

The District largely conducts public outreach online, including its own website, Constant Contact, Facebook, Twitter, and Instagram social media channels, as well as an e-newsletter. In addition, the District advertises in local publications and newspapers and takes part in various health fairs and promotional events.

The public may submit comments or complaints on the District's website through a "Contact Us" link. In accordance with District Policy #OP-07, when a complaint is received regarding the Desert Regional Medical Center (DRMC) by either administration or a board member, the complaint is referred to the District CEO who forwards a copy of the complaint to the CEO and Compliance Officer of DRMC with a request to address the complaint in writing and provide copies to the Board of Directors. Hospital administration reviews the complaint, and the response is addressed at a subsequent public board meeting. When legal complaints are received, they are referred to the District's General Counsel. During the 2019 CY, the District indicates there were no complaints received in relation to district operations, and there were two complaints related to the hospital.

DHD is a recipient of the Association of California Healthcare District's (ACHD) certification of Best Practices in Governance and the California Special Districts Association's (CSDA) District Transparence Certificate of Excellence, which speaks to the District's commitment to accountability and transparency.

The District has also demonstrated transparency and accountability throughout the MSR process by responding promptly and thoroughly to requests for information, other means of communication, and reviewing draft reports comprehensively.

GROWTH AND POPULATION PROJECTIONS

The population of the District is difficult to estimate since Coachella Valley is a resort destination, and the number of people in the area fluctuates between 200,000 in the summer and 800,000 in the winter. The population of the District significantly increased after the annexation of 2018, adding an estimated 240,000 residents and more than doubling the number of residents within DHD.

It is challenging to estimate the current population of the District, since Census 2020 data will not be available until after the adoption of this report. The most recent population estimates for the cities within DHD is available for 2020; however, unincorporated level population data is hard to categorize at the district level as it generally dates from 2010 when the last Census occurred. In 2020, the population in the incorporated portion of the District was approximately 386,767, as reported by the Department of Finance. In order to determine the unincorporated portion of the District's population, the report makes use of the Census County Division level estimates for 2018, which is the most recent districtwide population estimate available. It was estimated that the number of residents within the

entirety of the District as of 2018 was 439,765, which equates to an unincorporated population of 57,689, based on Department of Finance city population estimates at that time. Department of Finance estimates show 2.2 percent growth in unincorporated Riverside County between 2018 and 2020, resulting in an estimated total population of 445,721 within the District as of January 1, 2020.

Figure 4-2: Desert Healthcare District Population Estimate, 2018-2020

	Population Estimate 1/1/2018	Population Estimate 1/1/2019	Population Estimate 1/1/2020
DHD Incorporated	382,076	384,836	386,767
DHD Unincorporated	57,689	58,504	58,954
Total	439,765 [1]	443,340	445,721

Source: Department of Finance
Notes:
(1) U.S. Census Bureau (2018). American Community Survey 5-year estimates. Retrieved from Census Reporter Profile page for Palm Springs CCD, Riverside County, CA <http://censusreporter.org/profiles/06000US0606592340-palm-springs-ccd-riverside-county-ca/>E36

Overall, since the end of the Great Recession, Coachella Valley displayed relatively low population growth rates of close to one percent annually.[10] Slow growth is expected to continue based on the Southern California Association of Governments (SCAG) forecast conducted in 2020. According to SCAG, the population of Riverside County will grow by 30 percent between 2020 and 2045 or approximately one percent annually. The projected annual growth for each of the cities and the unincorporated area in DHD is one percent, with the exception of the cities of Coachella and Desert Hot Springs, which are estimated to grow by four and three percent a year, respectively. Based on the average growth rates of all the cities and unincorporated county territory, the annual growth rate in the District is estimated to be about one percent.[11] Based on these estimates, the District's population is projected to be approximately 501,332 in 2030 and 571,695 in 2045.

The District reported that based on available information, it is anticipated that there will be a significant increase of the population over 65 years of age, while the age groups of 15 to 44 and 0 to 14 are estimated to grow at a moderate and slow rate respectively over the next 10 years.[12]

DISADVANTAGED UNINCORPORATED COMMUNITIES

LAFCO is required to evaluate disadvantaged unincorporated communities as part of this service review, including the location and characteristics of any such communities.

The purpose of SB 244 (Wolk, 2011) is to begin to address the complex legal, financial, and political barriers that contribute to regional inequity and infrastructure deficits within disadvantaged unincorporated communities (DUCs). Identifying and including these communities in the long-range planning of a city or a special district is required by SB 244.

Government Code §56033.5 defines a DUC as 1) all or a portion of a "disadvantaged community" as defined by §79505.5 of the Water Code, and as 2) "inhabited territory" (12 or

[10] Innovate, The Greater Palm Springs Economic Report, 2019 http://cvep.com/wp-content/uploads/2019/11/CVEP_2019_EconomicReport_FINAL.pdf
[11] Southern California Association of Governments, *Demographics and Growth Forecast*, Technical Report, Adopted on May 7, 2020 https://www.connectsocal.org/Documents/Adopted/fConnectSoCal_Demographics-And-Growth-Forecast.pdf.
[12] Desert Healthcare District Plan of Services, 2017, p. 4

more registered voters), as defined by §56046, or as determined by commission policy. The statute allows some discretion to LAFCOs in the determination of DUCs.

In 2012, Riverside County LAFCO adopted a policy for Disadvantaged Unincorporated Communities. The guidelines for identifying DUCS are described as interim in this policy, since it was anticipated that the methods of identifying and analyzing DUCs would evolve over time. LAFCO will be revising its guidelines when Census 2020 data becomes available.[13]

According to the 2012 guidelines, a DUC in Riverside County is defined as a community of a minimum of 50 dwellings or 50 registered voters, whichever is less. LAFCO has also clarified the definition of an "inhabited area" by excluding vacant land, non-residential land and freeway/state highway rights of way on the periphery of residential areas from DUCs. Since the smallest geographic area with available median income information is a Census Block Group, LAFCO further determined that in identifying DUCs it will make an effort to differentiate between areas within a block group that are likely to have income above the specified criteria and exclude such areas from the DUC. Factors that could be considered include markedly different housing types or densities in portions of the block group.[14]

Riverside LAFCO has identified that there are 40 disadvantaged unincorporated communities in Riverside County within or near cities' spheres of influence. There are 13 DUCs in DHD including:

- San Miguel Drive, Tri Palm Estates Country Club and Ivey Ranch near Cathedral City,
- 54th Avenue/Harrison Street, Thermal, Fillmore Street/54th Street, and Fillmore Street/Airport Boulevard around Coachella,
- Dillon Drive/North Indian Canyon drive (2 communities in North Palm Springs), Mission Lakes Country Club and Palm Drive/Dillon Road surrounding Desert Hot Springs, and
- Carver Tract near Indio, and Dillon Road/North Indian Canyon Drive (Carefree MHP) around Palm Springs.[15]

[13]SB 244 Implementation-Interim Policy for Disadvantaged Unincorporated Communities, 3/22/12, https://lafco.org/wp-content/uploads/documents/archives/7.SB_244_Interim_Policy_3_22_12.pdf

[14] LAFCO, SB 244 Implementation-Interim Policy for Disadvantaged Unincorporated Communities, 3/22/12, https://lafco.org/wp-content/uploads/documents/archives/7.SB_244_Interim_Policy_3_22_12.pdf

[15] https://lafco.org/wp-content/uploads/documents/ducs/RIVCO%20Master%20DUC%20Chart.pdf

FINANCIAL ABILITY TO PROVIDE SERVICES

The financial ability of agencies to provide services is affected by available financing sources and financing constraints. This section discusses the major financing constraints faced by DHD and identifies the revenue sources currently available to the District.

The District's operations that consists of grant funding for community health initiatives are funded by property taxes, income from medical office building leases, interest on investments, and grants and contributions from other public and private sources.[16] With an annual operating budget of roughly $9 million, DHD provides grant funding of over $3.5 million a year.[17] Additionally, the District has passed a resolution that declared the District's commitment of spending $6 million over 20 years ($300,000 annually) to support programs and services in the areas that were annexed in 2018.[18] More details regarding the District's financial health are available in Figure 4-3 and in the next several sub-sections.

[16] Desert Healthcare District Request for Information, February 11, 2020
[17] Desert Healthcare District Request for Information, February 11, 2020
[18] Desert Healthcare District Plan of Services, 2017

Figure 4-3: Desert Healthcare District Financial Overview, FY 18-19

Desert Healthcare District Financial Overview		
Category		***FY 18-19***
Balanced Budget (rev/exp incl debt)		
Total Operating Revenues	$	8,301,823
Total Operating Expenditures (incl debt)	$	6,180,574
Net	$	2,121,249
Operating Ratio (op rev/exp incl debt&deprec)		1.3
Operating Revenues	$	8,301,823
Operating Expenditures (excl. depr. and debt)	$	5,543,200
Debt Service	$	-
Depreciation	$	637,374
Total Expenses	$	6,180,574
Current Assets		
Cash and cash equivalents	$	12,052,794
Investments	$	13,491,775
Accounts receivable	$	193,311
Prepaid items and deposits	$	55,883
Total current assets	$	25,793,763
Current Liabilities		
Accounts payable and accrued liabilities	$	387,096
Grants payable	$	7,409,355
Compensated absences	$	31,110
Disability claims, reserve, current portion	$	14,803
Total current liabilities	$	7,842,364
Long-term Liabilities		
Grants payable	$	5,400,000
Long-term disability claims reserve	$	40,626
net pension liability	$	3,395,623
Net OPEB liability	$	87,973
Deposits payable	$	58,517
Total long-term liabilities	$	8,982,739
Unrestricted Net Position/Operating Revenues		521%
Net Position	$	55,207,356
Unrestricted Net Position	$	43,234,798
Operating Revenues	$	8,301,823
Current Ratio (Short-term Liquidity)		3.3
Current Assets	$	25,793,763
Current Liabilities	$	7,842,364
Months Cash on Hand (current cash assets/expenses incl debt)		24
Current Cash Assets	$	12,052,794
Operating Expenditures (inc. debt)	$	6,180,574
Operating expenditures per day	$	16,933
Change in Net Depreciable Capital Assets (FY 18-FY 19)		-3%
Net Capital Assets, FY 18	$	12,382,164
Net Capital Assets, FY 19	$	11,972,558
Total Assets being depreciated (FY 19)	$	22,348,945
Depreciation	$	637,373
Total Reserves (% of op. expend)		942%
Reserve	$	58,231,372
Pension Liabilities as % of Revenues		6%
Total Pension Liability	$	8,309,530
Unfunded Pension Liability	$	3,395,623
% Pension Liability Funded		59%
Total Payments FY 17-18 (funded+unfunded)	$	511,792
OPEB Liabilities (as of June 30, 2019)	$	67,364
OPEB Liability Payments as % of revenue		0.2%
Unfunded OPEB Liability	$	67,364
Total OPEB Payments	$	20,321

Financial Planning and Reporting

The California Office of Statewide Health Planning and Development (OSHPD) produces annual financial disclosure reports that provide audited data on hospital revenues, expenditures, net operating margins, and other measures of fiscal performance. Healthcare districts are also required to submit annual financial disclosure reports to the California State Controller, which uses the submitted financial data to produce an Annual Special Districts Report that provides detailed financial information by fiscal year (FY) regarding special district revenues, expenditures, property taxes, and bonded debt. The County of Riverside Auditor and Controller produces a detailed summary of local tax information for each FY that identifies the amount of property tax allocated to the healthcare districts and reports any bonded indebtedness held by the districts. The annual healthcare district and hospital financial disclosure reports produced by the California State Controller, the County of Riverside, and OSHPD provide the public with a comprehensive overview of the annual financial status of a healthcare district, as well as the hospital facilities the district owns and/or operates.

DHD's internal financial planning efforts include the annual budget and annually audited financial statements. The District, under its umbrella, makes use of the Desert Healthcare Foundation as its operational component. The Foundation's financial information is generally included as a component of DHD's financials; however, the Foundation is considered a Private-Purpose Trust Fund fiduciary fund type for accounting purposes and separate financial statements and a budget are also available for this fund.

Balanced Budget

The District receives revenue from property taxes, investment income from the Facility Replacement Fund that was established to provide working capital in the event that the lease with Tenet Health System is terminated prematurely or for future seismic retrofit needs, and rental income from Las Palmas Plaza. DHD's primary income source is property taxes, as can be seen from Figure 4-4. Rental income is derived from renting out commercial office suites at Las Palmas Plaza subject to lease terms ranging from three to five years and includes the base monthly rental payments plus the common area maintenance fee.

Figure 4-4: Desert Healthcare District Revenues and Expenditures, FY 18-19, FY 17-18 and FY 16-17

Desert Healthcare District Revenues and Expenditures						
Category	***FY 18-19***	***%***	***FY 17-18***	***%***	***FY 16-17***	***%***
Operating Revenue	**$ 8,301,823**	**100%**	**$ 7,839,945**	**100%**	**$ 7,474,009**	**100%**
Property Tax Revenue	$ 6,972,196	84.0%	$ 6,559,800	83.7%	$ 6,082,391	81.4%
Rental Income	$ 1,203,940	14.5%	$ 1,113,241	14.2%	$ 1,178,485	15.8%
Other income	$ 125,687	1.5%	$ 166,904	2.1%	$ 213,133	2.9%
Operating Expenditures	**$ 6,180,574**	**100.0%**	**$ 8,144,735**	**100.0%**	**$ 5,631,036**	**100.0%**
Grant allocations	$ 3,626,871	58.7%	$ 5,076,039	62.3%	$ 3,453,749	46.2%
General expenses	$ 560,859	9.1%	$ 1,187,283	14.6%	$ 436,175	5.8%
Rental expenses	$ 941,062	15.2%	$ 904,904	11.1%	$ 894,421	12.0%
Salaries and benefits	$ 304,560	4.9%	$ 329,056	4.0%	$ 190,859	2.6%
Legal Fees	$ 235,836	3.8%	$ 250,443	3.1%	$ 117,593	1.6%
Depreciation	$ 193,276	3.1%	$ 194,483	2.4%	$ 194,979	2.6%
Other	$ 208,410	3.4%	$ 199,606	2.5%	$ 146,333	2.0%
Election fees	$ 109,347	1.8%	$ -	0.0%	$ 196,467	2.6%
Security	$ 353	0.0%	$ 2,921	0.0%	$ 460	0.0%
Net Operating Income	**$ 2,121,249**		**$ (304,790)**		**$ 1,842,973**	
Debt Service	**$ -**		**$ -**		$ -	
Net Operating Income After Debt	**$ 2,121,249**		**$ (304,790)**		**$ 1,842,973**	
Non-operating Income and Expenditures						
Investment Income	$ 1,245,953		$ 111,318		$ 30,049	
Loss on Disposal of Capital Assets	$ (727)		$ -		$ -	
Investment Expenses	$ (113,967)		$ (119,055)		$ (118,550)	
Total Non-operating income (loss)	$ 2,131,259		$ (7,737)		$ (88,501)	
Net After Non-Operating Income/Expenditures	**$ 4,252,508**		**$ (312,527)**		$ 1,754,472	
Beginning Net Position	**$ 50,954,848**		**$ 51,276,755**		**$ 49,522,283**	
Ending Net Position	**$ 55,207,356**		**$ 50,954,848**		**$ 51,276,755**	

The District's primary expense is grant allocations. Grant awards not fully funded in the current FY are carried over to the subsequent FY. As can be seen from Figure 4-4, the District experienced an operational deficit in FY 17-18; however, in FYs 16-17 and 18-19, it had operational surpluses. The deficit in FY 17-18 occurred as a result of the DHD Board awarding approximately $1.5 million in additional grant funding; grants are accrued at 100 percent when awarded although are usually disbursed over time.

For any agency, recurring operating deficits are a warning sign. In the short-term, reserves can backfill deficits and maintain services. However, ongoing deficits eventually will deplete reserves. In the case of DHD, however, the deficit that the District experienced in FY 17-18 does not appear to be a persisting issue. In FYs 16-17 and 18-19, the District operated in the black. The FY 19-20 budget similarly shows a projected positive operating balance.

Fund Balances, Reserves and Liquidity

Fund balances and reserves should include adequate funds for cash flow and liquidity, in addition to funds to address longer-term needs. The District's FY 18-19 financial statements report a total of $25,793,763 in current assets out of which $12,052,794 is cash or cash equivalents with $7,842,364 of current liabilities,[19] as shown in Figure 4-3. The District has enough cash on hand to cover about 24 months of its operating expenditures.

The District has no outstanding bond debt and has not issued bonds since prior to the lease of the hospital in 1997. DHD's long-term liabilities include grants payable, long-term

[19] Audited Financial Statements, FY 18-19, p. 8.

disability claims reserve, pension and OPEB liabilities, and deposits payable, as shown in Figure 4-3.

The District also established a reserve fund (Replacement Facility Reserve Fund) of $58,231372 (as of June 30, 2019) to cover grant liabilities, hospital operating expenses for a short period of time should the lease with Tenet Health Systems terminate prior to May 30, 2027, and seismic and other facility costs. The hospital will be required to meet SB 1953 and OSHPD regulations for seismic retrofit standards by 2030, as is described in more detail in the *Infrastructure Needs* section later in this report. The District is currently assessing the seismic retrofit needs and costs, which may be substantial and reviewing options for timely completion of the seismic upgrades.[20] While the reserve fund balance is significant in terms of the percentage of the operating expenditures and provides a substantial safeguard to the District, it would provide only a portion of the projected required financing that may be needed in case Tenet terminates the lease.[21]

Net Position

An agency's "Net Position" as reported in its audited financial statements represents the amount by which assets (e.g., cash, capital assets, other assets) exceed liabilities (e.g., debts, unfunded pension and OPEB liabilities, other liabilities). A positive Net Position provides an indicator of financial soundness over the long-term. The FY 18-19 ending net position for the District was $55,207,356 indicating stability with its ongoing general operations. However, as was already mentioned before, if the District has to take over the operations of the hospital the DHD's current financial resources may only cover its operations in the short-term.

DHD reported that it is unlikely that Tenet will terminate the lease with only seven years remaining on a 30-year lease and since the DRMC is one of the most profitable hospitals in its network.

Pension and OPEB Liabilities

Unfunded pension and OPEB liabilities present one of the most serious fiscal challenges facing many special districts in California today.

In 2014, the District converted from a 401(k) retirement plan to a 457(B) and 401(A) retirement plans. DHD contributes a dollar for dollar match for the first four percent of employee salary deferral. However, additionally, in 1971, the Desert Hospital Corporation (discussed later in the *Healthcare Services* section) established a defined benefit pension plan covering eligible employees of the DRMC. All the participants of the plan have been 100 percent vested since 1997. At the end of FY 18-19, 183 employees were covered under this plan. There have been no contribution requirements by the District since that time. It was estimated that at the end of FY 18-19 unfunded pension liability was $3,395,623. The District's Board of Directors elected not to fund the plan in FY 17-18 or FY 18-19. At the end of FY 18-19, 59 percent of the liability was funded, as shown in Figure 4-3.

The District has a separate investment account of approximately $5 million specifically for this defined pension plan. The account is reportedly sufficient to pay all of the

[20] Audited Financial Statements, FY 18-19 and RFI.
[21] Desert Healthcare District Plan of Services, 2017

participants' principal balances. Per Government Accounting Standards Board (GASB) 67 & 68, the total pension liability of $8,309,530 is based on the present value of annuity payments for the actuarial life of the participants. The actuarial present value creates the $3,395,623 net pension liability, which must be reported in the District's financial statements. However, the practice of the District is to disburse 100 percent of the participant's funds when employment is terminated from the hospital, which means that there are no actual lifetime annuities.

Total annual pension payments and potential changes in current District pension costs do not appear to be a significant adverse factor relative to its total budget, as can be seen in Figure 4-3.

The District's defined benefit OPEB (other postemployment benefits) plan provides OPEB for the two retired Board directors of the DHD. The plan is a single employer defined benefit OPEB plan administered by the District. The plan provides lifetime medical and dental coverage for directors and their dependents. The District contributes 100 percent with no cap.[22] In regard to its OPEB liabilities, the District uses pay-as-you-go approach.[23] As shown in Figure 4-3, the total District's OPEB liability at the end of FY 18-19 was $67,364.[24] With the annual payments at the current level (which amount to about 0.2 percent of the District's operating revenues), the District will largely pay off the liability in about three years.

Capital Assets

Capital assets must be adequately maintained and replaced over time and expanded as needed to accommodate future demand and respond to regulatory and technical changes.

As a general indicator, the California Municipal Financial Health Diagnostic compares changes in the value of assets and asset improvements.[25] Persistent and substantially negative trends, particularly without a reasonable plan for stabilizing declines, raise caution and warning signs. This negative condition can occur if repairs and replacements do not keep pace with aging infrastructure.

Depreciation typically spreads the life of a facility over time to calculate a depreciation amount for accounting purposes. The actual timing and amount of annual capital investments require detailed engineering analysis and will differ from the annual depreciation amount, although depreciation is a useful initial indicator of sustainable capital expenditures.

The District's capital assets include land (which is non-depreciable) and buildings and improvements, as well as furniture and equipment (which all depreciate). The depreciation expense consists of operating expense depreciation (30 percent) and rental expense depreciation (70 percent). At June 30, 2019 the District had $22,348,945 in capital assets (depreciable and non-depreciable) and $10,376,387 in accumulated depreciation, resulting

[22] Audited Financial Statement, FY 18-19, p. 30.
[23] Total Compensation Systems Inc., *Desert Health Care District Actuarial Study of Retiree Health Liabilities Under GASB 74/75*, December 20, 2019, p. 2.
[24] Total Compensation Systems Inc., *Desert Health Care District Actuarial Study of Retiree Health Liabilities Under GASB 74/75*, December 20, 2019, p. 10.
[25] The California Municipal Financial Health Diagnostic: Financial Health Indicators, League of California Cities, 2014.

in $11,972,558 net capital assets.[26] The value of depreciable capital assets decreased by about three percent from FY 17-18 to FY 18-19, as shown in Figure 4-3. The District's FY 18-19 financial statements do not show enough additions to depreciable asset value to offset the depreciation of $637,373 (after deducting depreciation attributed to retired assets)[27] for that year.

The District does not have a Capital Improvement Plan (CIP) for its Las Palmas Plaza property. However, DHD has recently completed a number of upgrades at Las Palmas Plaza and no other infrastructure needs have been identified at this time, as is described in more detail in the *Infrastructure Needs* section. The infrastructure needs for the hospital facility are also discussed in the *Infrastructure Needs* section later in this report.

Hospital Financing

In 1997, the District entered into a 30-year lease of the DRMC with Tenet Health System. Terms of the lease included payment by Tenet of the hospital revenue certificates of participation issued in 1990 and 1992 (approximately $80,000,000) as prepaid rent. Tenet also paid the District $15,400,000 cash, representing additional prepaid rent.[28]

In the event that Tenet or the District decide to terminate the lease, the District would be responsible for operating the hospital, which would require upfront operating capital of approximately $125,000,000 to maintain the operations without interruption during the transition period. The District, recognizing this obligation, established an investment fund, with a net value of $58,231,372 as of June 30, 2019, identified as the facility replacement fund.[29]

The lease agreement contains provisions in the event the lease terminates prior to May 30, 2027. According to the agreement, Tenet has a number of options to terminate or abandon the lease prior to its expiration, including if seismic upgrades exceed $12.5 million. In the event that Tenet elects to terminate or abandon the lease, the District would be legally obligated to reimburse Tenet for prepaid rent. However, as of June 30, 2020, the prepaid lease balance was $2,835,230 and will be zero by June 30, 2021.

Additionally, according to the 1997 lease, at the end of the lease term in 2027 or at the time of lease termination, the District is required to purchase the termination assets, which are assets constructed or installed by Tenet Health Systems in the hospital during the lease period. The purchase can also be satisfied with a five-year promissory note. The lease also provides the option of lease extension if the termination assets exceed $10 million. The current value of the termination assets are estimated to be approximately $50 million.

The DRMC's financial ability to provide services and its financial health are not discussed in this report as the hospital's operations are entirely privately financed. Extensive financial information relating to Desert Regional Medical Center is available to the public on the Office of Statewide Health Planning and Development (OSHPD) website.

[26] Audited Financial Statement, FY 18-19, p. 6.
[27] Audited Financial Statement, FY 18-19, p. 6.
[28] Audited Financial Statements, FY 18-19, p. 14.
[29] Audited Financial Statements, FY 18-19.

HEALTHCARE SERVICES

Service Overview

Background

Desert Hospital District (later renamed Desert Healthcare District) was formed in 1948 to provide hospital services in the western Coachella Valley. DHD built and operated the hospital, now known as the Desert Regional Medical Center (DRMC), until 1986 when the facility was leased to Desert Hospital Corporation—a not-for-profit organization formed by local residents to operate the hospital. The Desert Hospital Foundation (created in 1967 as a subsidiary of the Desert Hospital Corporation) conducted fundraising activities for the hospital. The Foundation was later absorbed by the District. In the 1990s, the hospital struggled financially, and the District's Board of Directors decided to lease the facility to the for-profit Tenet Health Systems for a term of 30 years.[30]

Services

Currently, the District supports a variety of health-related programs, primarily through grants and similar assistance to nonprofit entities and public agencies. Assistance can be provided in the form of one-time grants or multi-year commitments.[31] The District provides funding for community health initiatives and grants of over $3.5 million annually. The District's grant funding is linked to the fulfillment of a comprehensive strategic plan, which focuses on enhancing and optimizing the health of district residents.[32] In FY 18, the District adopted a three-year strategic plan with four community health focus areas that include homelessness, primary care and behavioral health access, healthy eating and active living, and quality, safety, accountability and transparency.[33]

The District has taken a leadership role in the collective efforts in the areas of access to healthcare, medically underserved populations, shortage of healthcare workers, health disparities, homelessness, behavioral health, social determinants of health, and public health issues. An example of such efforts is the recent Homelessness Initiative. In conjunction with the efforts conducted by the Coachella Valley Association of Governments (CVAG), the District has allocated funding of up to $3 million in matching grants to local cities in the Coachella Valley. Another major initiative in recent years has been the District's focus on improving access to primary care, particularly in underserved areas of the District. The District helped establish the UCR School of Medicine's Family Residency Program. The first group of family practice residents arrived at DRMC in 2014. Today there are residency programs in internal medicine, neurosurgery, and emergency medicine with more in development. Ten family medicine physicians are now in place. Also funded by the District, a new 13,000-square foot UCR primary care clinic is open with physicians seeing hundreds of patients, regardless of ability to pay.[34]

[30] Desert Healthcare District Website, Desert Healthcare District Request for Information, February 11, 2020
[31] LAFCO Staff Report, 4/26/2018, Executive Summary from George J. Spiliotis, Sphere of Influence Amendment to the Desert Healthcare District
[32] Desert Healthcare District Request for Information, February 11, 2020
[33] Audited Financial Statements, FY 2018-2019, p. 7.
[34] Desert Healthcare District Request for Information, February 11, 2020

District funding has also helped create a number of new and expanded clinics to increase access to care, including dental and family care clinics in Desert Hot Springs, Cathedral City and Palm Springs. The number of dental providers who accept MediCal and new patients has doubled. The District has also provided funding to more than double the size of the Borrego Community Health Foundation's family care clinic in Cathedral City, as well as added mobile clinic outreach to remote areas to serve the disadvantaged and those most in need.[35]

The Desert Hospital Foundation, now under the umbrella of DHD, has also developed numerous programs and services over time to address community health needs. More than three decades ago, the Foundation launched a free breast screening program, now operated by the Desert Cancer Foundation. The Foundation also created the Smile Factory mobile dental clinic that visits local schools to provide free and reduced cost dental screening and treatment, now operated by Borrego Community Health Foundation. With funding from the California Endowment, the Foundation created the Health Access Resource Center (HARC) to launch the triennial community health survey to identify health status and priority needs. The District continues as its primary funder to this day.[36]

Although the District is no longer responsible for operating the DRMC, as the facility owner, DHD retains significant oversight responsibilities and must ensure that Tenet maintains the hospital in good condition, that the hospital has appropriate accreditations, valid licenses, is adequately insured, and that essential services to the community are maintained.

Collaboration and Partnerships

The District participates extensively in various partnerships and collaborations, locally and regionally. DHD partners with over 35 community-based organizations and agencies, including the three Coachella Valley school districts, the College of the Desert, UCR, California State University in San Bernardino, Loma Linda University, the three Valley hospitals, local and regional government agencies, and state and national foundations, such as the California Endowment. Other nonprofit organizations that have partnered with the District on projects comprise Borrego Community Health Foundation, Clinicas de Salud del Pueblo, Desert AIDS Project, CV Volunteers in Medicine, Catholic Charities, Planned Parenthood of the Pacific Southwest, Boys and Girls Club of Palm Springs, and YMCA of the Desert.[37]

Examples of partnerships and funding support are shown in Figure 4-5.

[35] Desert Healthcare District Request for Information, February 11, 2020
[36] Desert Healthcare District Request for Information, February 11, 2020
[37] Desert Healthcare District Request for Information, February 11, 2020

Figure 4-5: Desert Healthcare District Grand Funding

Grant Receiver	Amount	Term	Purpose
Act for Multiple Sclerosis	$368,228	Two-year	Grant for program offering strength training and professional therapeutic massage to maintain mobility for Coachella Valley residents. Services provided at designated local facilities, and in-home when necessary.
Angel View	$144,600	Two-year	Grant to support at least 25 families with special needs children in the Coachella Valley and High Desert, including transportation and case management.
Arrowhead Neuroscience Foundation	$373,540	Two-year	Grant for a fellowship program in interventional neurology to train the next generation of physician sub-specialists at Desert Regional Medical Center's Advanced Comprehensive Stroke Center. Researches cures for stroke, brain tumors, Alzheimer's, Parkinson's and other conditions that alter brain and spinal cord function.
Boys and Girls Club of Cathedral City	$150,000		For clubhouse improvements. This non-profit provides all day after school care, including transportation from schools, for 700 youth members in Cathedral City and neighboring areas. Programs promote academic success, healthy lifestyles, good character and citizenship.
CVAG	$10,000,000		For support of CV Link, a 52-mile alternative transportation corridor along the Whitewater River for bicyclists, pedestrians and low-speed electric vehicles. Corridor will connect all nine Coachella Valley cities, providing a safe route to schools, improved air quality and healthier lifestyles.
Coachella Valley Economic Partnership	$500,000	Three-year	For CV/iHub Accelerator Campus, an incubator that provides office space, administrative support and incentives to start-up businesses focused on medical technology, clean technology and renewable energy.
Coachella Valley Economic Partnership	$737,900	Two-year	Grant for Mental Health College and Career Pathways Development Initiative to increase opportunities for college students from the Coachella Valley to obtain exposure, experience and mentoring to further their health career pursuit and increase their commitment to become health leaders and professionals serving the Valley.
CV Volunteers in Medicine Clinic in Indio	$120,798		To provide access to healthcare post-implementation of the Affordable Care Act at Coachella Valley's only free clinic for those without insurance.

Source: LAFCO Request for Information, Responded to by Desert Healthcare District

Figure 4-5: Desert Healthcare District Grand Funding (cont.)

Grant Receiver	Amount	Term	Purpose
Desert AIDS Project	$498,625	Three-year	Grant for the Get Tested Coachella Valley, a region-wide, bilingual, public health campaign dedicated to dramatically reducing the spread of HIV by making voluntary HIV testing a routine medical practice and ensuring linkage to care.
Desert AIDS Project	$800,000	Three-year	Grant for sexually transmitted infection clinic at The DOCK in Palm Springs. Services include free HIV testing, and testing and treatment for other diseases, including syphilis, gonorrhea, chlamydia, HPV, and Hepatitis B and C; and well-woman exams. Service regardless of the ability to pay.
Desert Cancer Foundation	$187,000		For cancer-related medical costs such as outpatient services for uninsured clients, co-insurance, Medi-Cal monthly share of cost, prescriptions, inpatient hospital costs and insurance premiums for about 700 residents within the District.
FIND Food Bank	$390,151		For the Hunger to Health program. FIND, based in Indio, is the only regional food bank in Southern California that serves eastern Riverside County and southern San Bernardino County, distributes more than 10 million pounds of food to about 90,000 people per month, works with soup kitchens, senior centers, homeless shelters and schools.
Health Assessment and Research for Communities	$499,955	Three-year	Grant for the Community Health Monitor, a phone survey conducted every three years to gather data on health and well-being in the Coachella Valley. The information is used to design programs and services to meet health needs in the Valley.
Health Assessment and Research for Communities	$11,425	Three-year	Grant for a health evaluation component of @LIKE - the Linking Innovation, Knowledge and Employment program, which reconnects adults ages 18 to 24 to education and/or stable employment.
HealthCorps	$555,968	24-month support	For coordinators to teach wellness-related classes at high-need high schools in the Coachella Valley and give students the tools to make healthier living choices.
Hidden Harvest	$102,800		For a produce recovery program that employs low-income farm workers to salvage produce left behind in fields and orchards after harvest. The grant supports free distribution of the produce to senior citizens and families whose children attend schools in high poverty areas in the Coachella Valley.

Source: LAFCO Request for Information, Responded to by Desert Healthcare District

Figure 4-5: Desert Healthcare District Grant Funding (cont.)

Grant Receiver	Amount	Term	Purpose
Jewish Family Services of the Desert	$570,000	Three-year	Grant for mental health counseling services to adults, couples, families, children, adolescents and seniors from throughout the greater Coachella Valley.
LGBT Center of Palm Springs	$140,000	Three-year	Grant for a clinic that provides low-cost counseling for individuals, couples and families.
Mizell Senior Center	$403,300	Two-year	Grant for a fall prevention program for individuals over 50 in the Coachella Valley. The course includes education about falls, support group activities and basic core-strength exercises to maintain health and independence.
Pegasus Therapeutic Riding Academy	$102,544		For Hippo Therapy Helping to Heal program, which provides equine therapy and transportation for more than 210 special, needs riders of all ages from across the Coachella Valley.
Ranch Recovery Centers	$21,500		To purchase electronic records management system for facilities in Desert Hot Springs that provide alcohol and drug treatment, detox and transition to sober living for men and women.
United Cerebral Palsy of Inland Empire	$178,894	Two-year	Grant for Skill Builders, which offers after-school and summer programs to 66 children across the Coachella Valley to improve socialization, independence, communication, safety and health.
Visiting Nurses Association of California	$125,000		For point-of-care McKesson technology upgrade for this non-profit that provides in-home care, palliative services and hospice throughout the Coachella Valley.
Desert Healthcare Foundation	$110,000		To develop a strategic plan for the Desert Highland Gateway Community Health & Wellness initiative affecting 800 minority families in north Palm Springs.
Neuro-Vitality Center	$261,340		To support operations related to improving the quality of life of individuals and their families living with stroke and related neurological conditions by offering rehabilitation, prevention and resources.
UC Riverside School of Medicine	$70,899		For equipment and set-up costs for a volunteer-staffed Street Medicine Clinic offering free primary care to the homeless and underserved in north Palm Springs.
Well in the Desert	$44,800		For daily hot meals, emergency food assistance, weekly supplemental food distribution, transportation and other services for the poor in western Coachella Valley.

Source: LAFCO Request for Information, Responded to by Desert Healthcare District

Additional grant funding has been utilized in the District's service area to provide greater opportunities for healthy living through collaborative partnerships and include:[38]

- Working with the City of Desert Hot Springs to design and build a clinic in conjunction with a gym in the Boys and Girls Club.
- Funding a two-year fellowship program at the Comprehensive Stroke Center at DRMC that has changed the way stroke victims are assessed and treated thus improving their outcomes.
- Funding certified enrollment counselors to educate and connect residents to affordable insurance and local care.
- Increasing the number of local physicians and enhancing the regional medical workforce by funding UCR Medical School residency programs.
- Fostering the next generation of healthcare workers by financing K-12 school-based health care academies, mentoring, internships, and scholarship programs.
- Supporting the Health and Medical Innovations Center, which offers a coordinated regional approach to attracting healthcare-related businesses to the Coachella Valley.
- Partnering with the City of Palm Springs for the Ready, Set, Swim! Program, which combines physical activity, nutrition education and water safety for children.
- Supporting CVHip.com—the Coachella Valley Health Information Portal—an online directory of resources such as health insurance, medical care, dental care, shelter, food pantries, recreation, behavioral health care and counseling.

The District has also historically funded the Arthritis Foundation, Borrego Community Health Foundation, Cathedral City clinic, California State University San Bernardino, Palm Desert Campus, College of the Desert Public Safety Academy, El Sol Neighborhood Educational Center, Family Services of the Desert, Loma Linda University Institute for Community Partnerships, Riverside County Office on Aging, San Gorgonio Memorial Hospital (SGMH) Behavioral Health Center, and UCR School of Medicine Primary Care Residency Program at DRMC.[39]

Memberships and Regional Partnerships

The District takes active part in the work of many regional organizations that dedicate their time to public health and well-being. One example of such collaboration is with CVAG. One of the CVAG's initiatives that DHD participates in is the Homeless Committee that was designed to combat the problem of homelessness in the Coachella Valley. DHD also collaborates with CVAG on the development of CV Link — a 52-mile alternative transportation corridor for bicyclists, pedestrians and low-speed electric vehicles connecting all of the Coachella Valley cities.[40] This collaboration includes developing an updated health assessment tool/plan that will determine the long-term health benefits of CV-Link

[38] Desert Healthcare District Request for Information, February 11, 2020
[39] Desert Healthcare District Request for Information, February 11, 2020
[40] Desert Healthcare District Request for Information, February 11, 2020

DHD has also been participating as a major partner in OneFutureCoachella Valley's Regional Plan for College and Career Success since 2012 (originally called Coachella Valley Economic Partnership Workforce Excellence). The plan aims to advance college attendance through a variety of initiatives. The District's partnership entails matching funds for scholarships and building out the healthcare academies and pipelines.[41]

Another regional plan the District has been a major partner in is the Lift To Rise Regional Plan (originally founded as Collaborating for Clients) since 2014. The goal of the plan is to address income disparities, the social determinants of health, and associated impacts on housing, health, food security, and transportation. The District's partnership entails representation as a "collective impact" participant in various collaborative action networks.[42]

The District is also a major partner in a regional plan to develop and implement an Emergency Communication Plan related to prevention, mitigation, and emergency preparedness associated with airborne environmental hazards in the eastern Coachella Valley. The District partnership entails the convening and support of partners and providing funding support.[43]

Additionally, DHD has participated in the regional expansion of the UCR and California State University in San Bernardino campuses to Coachella Valley. The District's goal is to strengthen the region's healthcare workforce by adding nurses and physicians.[44]

Contract Services

In 1997, DHD entered into a lease contract with Tenet Health Systems to operate the DRMC for the term of 30 years. Although the District is no longer responsible for operating the hospital, the hospital is still owned by the District and pursuant to the lease agreement, DHD Board retains significant oversight responsibilities. For example, two DHD Board Members sit on the hospital's governing board. The District has established a Hospital Lease Oversight Committee, which includes three DHD Board Members and DHD staff. The District also must ensure that Tenet maintains the facility in good condition, which includes compliance with California Hospital Seismic Safety Law (SB 1953), and the hospital has appropriate accreditations, valid licenses and adequate insurance and that essential services to the community are maintained.[45]

Pursuant to the terms of the 1997 Lease, Tenet has a number of options to terminate or abandon the lease prior to its expiration, including an option to terminate if seismic upgrades exceed $12.5 million. In the event Tenet elects to terminate or abandon the lease, the District will be legally obligated to reimburse Tenet for prepaid rent. However, the original $92 million reimbursement obligation has been reduced to $2.8 million as of June 2020. In addition, the District is obligated to pay the fair market value of unamortized improvements that Tenet has made to the hospital, which are currently estimated to be $50 million.[46]

In July 2019, Tenet provided the District with a proposal to purchase the DRMC for $120 million with the commitment to comply with the 2030 seismic regulations and a

[41] Desert Healthcare District Request for Information, February 11, 2020
[42] Desert Healthcare District Request for Information, February 11, 2020
[43] Desert Healthcare District Request for Information, February 11, 2020
[44]Desert Healthcare District Request for Information, February 11, 2020
[45] Desert Healthcare District Plan of Services, 2017
[46] Desert Healthcare District Request for Information, February 11, 2020

commitment to making future investments in healthcare services and capital projects over the next eight years. After reviewing the proposal and receiving public input at a public meeting, the District Board recommended that the proposal be resubmitted with more substantial financial considerations as well as the specifics of the future configuration of the hospital and additional specifics of the proposed investments in healthcare series and capital projects in the entire Coachella Valley. To date, Tenet has not returned with an amended proposal for consideration by the District. It is anticipated that, due to impacts of the COVID-19 pandemic, sale of the hospital will not occur in the near future, and renewal of the lease is more likely. However, should the sale occur, the District reported that it would create more financial resources which would enable the District to offer expanded services to its residents. Pursuant to the applicable provisions of the Health and Safety Code, any sale of Desert Regional would be subject to voter approval.[47] Similarly, if the District were to extend the lease for another 30 years, it would require another vote of District residents.[48]

At the end of the lease term, in 2027, if DHD chooses to take over the operations of the hospital, the District would need to finance a minimum of 90-days' worth of working capital, which is approximately $105 million. In addition, the District will have to complete significant capital improvements, which are discussed later in the *Infrastructure Needs* section.

Service Demand

As previously mentioned, in 2018, the territory of the District was greatly expanded to include incorporated and unincorporated areas of eastern Coachella Valley. The rationale for the boundary expansion was to promote the extension of healthcare services to the underserved population that suffers from a higher than average prevalence of preventable disease. Many residents in the eastern Coachella Valley are low-income and experience more significant health disparities compared to residents in western Coachella Valley. Residents of eastern Coachella Valley are also more likely to be uninsured compared to the rest of the State, and have a higher incidence of obesity, diabetes and childhood asthma. The District expansion, that was finalized two years ago, was undertaken to improve access to healthcare programs in this underserved area and narrow some of the disparities.[49]

Overall, a large portion of the entire District's population is Hispanic. Since the Hispanic population statistically has a higher incidence of diabetes, heart disease and obesity, DHD typically experiences a high demand for cardiovascular services, endocrinology, gastroenterology and orthopedics. Additionally, Riverside County generally has higher mortality rates from cancer, Alzheimer's disease, coronary heart disease, unintentional injuries, stroke, suicide, motor vehicle accidents, and for infants when compared to the State overall. There are also higher rates of high blood pressure, smoking and low-birth-weight infants.[50] This implies demand for services such as primary care, cardiovascular, neurosciences, oncology, general surgery, orthopedics, pulmonary medicine, urology, obstetrics and perinatology, neonatology, pediatrics and chronic disease management.[51]

[47] Desert Healthcare District Request for Information, February 11, 2020
[48] Desert Healthcare District Plan of Services, 2017
[49] Desert Healthcare District Plan of Services, 2017
[50] Desert Healthcare District Plan of Services, 2017
[51] Desert Healthcare District Plan of Services, 2017

As was previously discussed in the *Growth and Population* section, the population over 65 years of age is projected to experience the highest growth in the next 10 years within the District. As the population ages, the community and its healthcare providers are likely to experience an increased demand for services such as internal medicine, cardiovascular services, gastroenterology, neurosciences, oncology, orthopedics, pulmonary medicine and urology, and see a greater need for chronic disease management. Moderate growth of the 15 to 44 years of age population indicates that demand for elective sub-specialty care and obstetrics is also anticipated to grow. The District also estimates that the demand for inpatient and outpatient pediatric services will remain approximately the same, due to anticipated slow growth in the population between 0 and 14 years old.[52]

Hospital Service Demand

Figure 4-6 shows service demand at the Desert Regional Medical Center between 2014 and 2018.

Figure 4-6: Desert Regional Medical Center Utilization Data

Desert Regional Medical Center Utilization				
2018	***2017***	***2016***	***2015***	***2014***
Total Licensed Bed Days				
140,525	140,525	140,910	140,525	141,133
Total Census Days				
101,543	92,724	97,083	88,849	87,775
Total Discharges				
25,003	19,621	20,200	19,725	19,241
Emergency Department Total Traffic				
73,426	75,098	74,952	71,937	67,971
Ambulance Diversion Hours				
0	5	0	678	0
Inpatient Surgeries Operating Room Minutes				
637,477	632,406	726,615	624,555	628,470
Outpatient Surgeries Operating Room Minutes				
272,447	271,157	262,095	226,395	218,595
Inpatient Surgical Operations				
4,691	4,657	5,487	5,258	4,348
Outpatient Surgical Operations				
3,004	2,844	2,641	2,476	2,366

Source: The Office of Statewide Health Planning and Development (OSHPD)

As is shown in Figure 4-6, the utilization data indicates that service demand at the DRMC stayed relatively constant with slight variations over the course of five years, with only a minimal steady increase over time for some indicators (licensed bed days, census days, ED use, and outpatient surgeries).

The ambulance diversion hours indicator shows the emergency room unavailability over the course of the year. It appears that in four out of five years the DRMC's emergency room largely remained open and accepting ambulance transport full time; in 2015, the hospital's emergency room diverted ambulance transport for 678 hours or 28 days.

Figure 4-7 depicts patient demand information for the DRMC in 2018 (the most recent complete year of information available at the time of drafting of this report). The Figure shows the breakdown of the hospital licensed beds by type and service demand for each bed type. It appears that intensive care beds experience the highest demand per bed, followed by perinatal beds.

[52] Desert Healthcare District Plan of Services, 2017

Figure 4-7: Hospital Service Demand, 2018

Inpatient Bed Utilization			
Licensed Bed Classification / Designation	***Licensed Beds (incl. in susp.)***	***Patient Days***	***Hospial Discharges***
Medical/Surgical Acute (includes GYN/DOU)	238	63,626	16,836
Perinatal (includes LDRP, excludes nursery)	28	7,976	3,159
Pediatric Acute	14	1,109	629
Intensive Care	23	8,571	2,731
Coronary Care	8	1,446	105
Acute Respiratory Care	0	0	0
Burn Center	0	0	0
Intensive Care Newborn Nursery	30	7,668	510
Rehabilitation Center	12	2,628	197
Sub-total - General Acute Care	**353**	**93,024**	**24,167**
Acute Psychiatric	0	0	0
Chemical Dependency Recovery Hospital (CDRH)	0	0	0
Intermediate Care	0	0	0
Intermediate Care/Developmentally Disabled	0	0	0
Skilled Nursing	32	8,519	836
Hospital Total	**385**	**101,543**	**25,003**
Source: The Office of Statewide Health Planning and Development (OSHPD)			

Figure 4-8 further demonstrates the highest demand for intensive care and perinatal beds. The Figure also indicates that patients generally stay longer in the intensive care newborn nursery and rehabilitation center units.

Figure 4-8: Hospital Service Demand by Inpatient Bed Type, 2018

Inpatient Bed Utilization			
Licensed Bed Classification / Designation	***Average Length of Stay***	***Licensed Bed Days***	***Licensed Bed Occupancy Rate (%)***
Medical/Surgical Acute (includes GYN/DOU)	3.8	86,870	73%
Perinatal (includes LDRP, excludes nursery)	2.5	10,220	78%
Pediatric Acute	1.8	5,110	22%
Intensive Care	1.7	8,395	102%
Coronary Care	1.6	2,920	50%
Acute Respiratory Care	0.0	0	0%
Burn Center	0.0	0	0%
Intensive Care Newborn Nursery	14.3	10,950	70%
Rehabilitation Center	13.3	4,380	60%
Sub-total - General Acute Care	**3.8**	**128,845**	**72%**
Acute Psychiatric	0.0	0	0%
Chemical Dependency Recovery Hospital (CDRH)	0.0	0	0%
Intermediate Care		0	0%
Intermediate Care/Developmentally Disabled		0	0%
Skilled Nursing	9.3	11,680	73%
Hospital Total		**140,525**	**72%**
Source: The Office of Statewide Health Planning and Development (OSHPD)			

Planning and Management

As part of the District's ongoing strategic planning efforts, the District regularly reviews and utilizes a wide range of information about the communities it serves. DHD collects and analyzes demographic and market data to assess, evaluate and plan for future health needs in the community. The most recent Service Plan was completed at the time of the 2018 annexation to illustrate how the District was planning to serve the annexed area.[53]

The DHD has additionally completed annual reports over the years that described to the community the annual investments the District had made through grant funding to many nonprofit and community-based organizations that serve the healthcare needs of district residents.[54]

As DHD does not provide direct services, but rather funds nonprofit and community-based organizations that do provide various healthcare services, performance measures such as progress and program deliverables and outcomes are collected by the District and utilized to determine the impact on DHD residents. Also, the DHD Board of Directors approved a community engagement policy to ensure that key stakeholders across the Coachella Valley have a voice to influence the development of policies and strategies that will affect their lives and inform the way in which District and Foundation services are planned and implemented.[55]

DHD's long term objectives and goals are determined and established by the Board of Directors with input from the CEO and staff. The District's Strategic Plan guides and informs the focus areas for program and service implementation.

The District forecasts community service needs through various data-driven sources, including a regional triennial community health monitor/survey, Riverside County health rankings, Office of Statewide Health Planning and Development (OSHPD), and others. The District is in the process of conducting a valley-wide Community Health Needs Assessment (CHNA) and a 10-year Community Health Improvement Plan (CHIP) that will assist the District and all community partners (funders, nonprofits, cities, legislature, etc.). These planning efforts will help determine the magnitude of the needs, guide the District's strategic plan and grant awards, and aid DHD in improving the health of district residents.[56] The CHNA process has been delayed due to the COVID-19 pandemic creating challenges in conducting meetings aimed at obtaining involvement of community stakeholders. Presently, the District is planning to have CHNA process complete by March 2021, in order to inform grant funding and budgeting in FY 21-22. In the meantime, DHD has identified some areas of focus for FY 20-21 to address immediate needs.

The District has identified a number of deficiencies affecting Coachella Valley residents' health and wellbeing, including homelessness, insufficient behavioral health services, environmental hazards, lack of evidence-based knowledge and solutions to healthcare challenges, insufficient school-based healthcare services and preventative care, and the lack of healthcare workforce.[57]

[53] Desert Healthcare District Plan of Services, 2017
[54] Desert Healthcare District Request for Information, February 11, 2020
[55] Desert Healthcare District Request for Information, February 11, 2020
[56] Desert Healthcare District Request for Information, February 11, 2020
[57] Desert Healthcare District Request for Information, February 11, 2020

Staffing

The District employs 10 full-time equivalents (FTE), of which approximately seven FTEs are engaged in Foundation activities, which is under the umbrella of the District. The Foundation, which is now a part of the District's overall organizational structure, was once a subsidiary of DHD with its own Board of Directors. It was first created in 1967 to support the activities of and conduct fundraising for the DRMC. In 1997, when the hospital became a for-profit facility and was leased to Tenet Health Systems, the need for fundraising activities aimed at supporting the medical center ceased. In 2003, the Foundation Board was dissolved, and the District Board assumed responsibility. Currently, the roles of the Foundation include fiscal sponsor and incubator of new collaborative projects.[58]

The District's staff consists of a chief executive officer (CEO), chief administrative officer, chief program officer (CPO), program officer and director of outreach, director of communications and marketing, special assistant to the CEO and Board Relations Officer, program and research analyst, special programs project manager, accounting manager, and administrative and program assistant. The District performs employee evaluations of all its staff annually. The employee's supervisor performs the evaluations. The Chief Administration Officer (CAO) and CPO evaluate employees in their respective departments. The CEO evaluates the performance of the CAO, CPO, and Assistant to the CEO/Board Liaison. The Board of Directors performs the evaluation of the CEO.[59]

In relation to the DRMC, the staffing information for 2017 (the most recent available year as of the drafting of this report) is included in Figure 4-9. The medical center staff are employees of Tenet Healthcare Systems, not DHD.

Figure 4-9: DRMC Staffing, 2017

Desert Regional Medical Center Staff	
Clinical Specialty	***Number***
Active Medical Staff - Non-Hospital Based - Board Certified	
Other Specialties	83
Pediatric-Cardiology	2
Pediatric Medicine	9
Plastic & Reconstructive Surgery	7
Physical Medicine/Rehabilitation	3
Podiatry	2
Urology	4
Psychiatry	1
Thoracic Surgery	3
Pulmonary Disease	2
Vascular Surgery	4
Internal Medicine	37
Neurology	14
General Surgery	12
Neurological Surgery	9
Ophthalmology	11
Orthopedic Surgery	12
Obstetrics and Gynecology	13
Oral Surgery (Dentists Only)	5
Occupational Medicine	1
Oncology	5
Otolaryngology	4
Allergy and Immunology	1
Gastroenterology	7
Colon and Rectal Surgery	1
Cardiovascular Diseases	10
General/Family Practice	25
Dermatology	2
Active Medical Staff - Hospital Based - Board Certified	
Pathology	6
Diagnostic Radiology	22
Anesthesiology	21
Medical Students - Residents and Fellows	
Neurology	10.56
Neurological Surgery	6.86
Internal Medicine	15.82
Other Specialties	14.8
General/Family Practice	19.35

Source: The Office of Statewide Health Planning and Development (OSHPD)

[58] https://www.dhcd.org/Foundation
[59] Desert Healthcare District Request for Information, February 11, 2020

Facilities

The District owns a hospital, the Las Palmas Medical Plaza, and the Wellness Park.

The District's hospital—Desert Regional Medical Center (DRMC)—was established in 1948 on what was a portion of the grounds of the El Mirador Hotel in Palm Springs. Initially, the hospital was a 33-bed facility, but in 1970s the District purchased the remainder of the hotel property and built what is now the 385-bed acute care medical center. In 1986, the District leased the hospital to the nonprofit Desert Hospital Corporation; in 1997, DHD entered into a lease agreement with Tenet Healthcare Systems, which continues to operate the hospital.

DRMC provides comprehensive medical care and has the only designated trauma center in the 8,000-square mile region from the San Gorgonio Pass to the Arizona border, as well as Coachella Valley's only neonatal intensive care unit. The Institute of Clinical Orthopedics and Neurosciences at DRMC features advanced brain and spinal care treatment and rehabilitation. The hospital also contains an expanded certified comprehensive Stroke Center with new technology and runs a new medical fellowship program. DRMC has a state-of-the-art linear accelerator for radiation therapy in cancer treatment and the Coachella Valley's only Joint Commission (JC) -certified program in hip and knee replacement. The DRMC's Advanced Congestive Heart Failure Program is the only robotic system for the treatment of atrial fibrillation and other heart disorders in the Coachella Valley. The hospital treats a number of other serious medical conditions in its Comprehensive Cancer Center, El Mirador Imaging Center, the Pulmonary Laboratory, the Center for Weight Management, and inpatient and outpatient rehabilitation departments.

Additionally, the District owns and operates the Las Palmas Medical Plaza, which it leases to various healthcare providers. Las Palmas, located adjacent to the DRMC, is an approximately 50,000-square foot professional medical office complex. It houses a 13,000-square foot family medical clinic, pharmacy, labs, urology, OB/GYN, cardiology, surgery, and other specialists. The DRMC's outpatient surgery center is also located in the El Mirador Medical Plaza.

DHD also owns the Wellness Park, which is a 5.5-acre park located across the street from the DRMC. It consists of walkways, landscaping, a fitness course, park benches, and water fountains. This neighborhood park is maintained by the City of Palm Springs under a lease agreement with DHD.

Facility Sharing

As described, the District practices facility sharing by leasing the DRMC and Las Palmas Medical Plaza to healthcare providers, as well as through its maintenance agreement with the City of Palm Springs for the Wellness Park.

The District anticipates that future facility sharing opportunities will be identified during the development of the CHNA, which will guide facility needs in the eastern portion of the District. Depending on the needs identified, the structure may resemble the existing Las Palmas Medical Plaza set up, where DHD makes available affordable clinic space.

Infrastructure Needs

Over the last 23 years, Tenet Health Systems has invested over $165 million into the DRMC, including capital upgrades and improvements in technology and equipment.[60] The hospital requires additional significant capital improvements in order to comply with 2030 seismic requirements. In this regard, the DRMC's North Wing and East Tower have both been re-evaluated under HAZUS to SPC-2 ratings,[61] giving the facility until January 1, 2030, to be brought into compliance. In January 2019, the District commissioned a comprehensive Seismic Evaluation and Compliance Planning Study, which estimated that seismic compliance costs would range from $119 to $180 million.[62] Actual capital costs will greatly depend on the degree to which the District plans to make use of the hospital facility in the long term, which will be determined by facility needs identified in the CHNA in progress. The plan for financing the seismic retrofit will likely be from two sources—income from the lease renewal or sale of the hospital and/or general obligation bonds. Additionally, there is the potential that the State could postpone the deadline for addressing seismic needs until 2037.[63] Postponement would allow DHD to complete the CHNA, resolve whether to sell or lease the hospital, and then address seismic infrastructure needs.

With regard to the Las Palmas Medical Plaza, many upgrades have been completed in the recent years, including replacement of the parking lot and replacement of the public restrooms to ensure Americans with Disabilities Act (ADA) compliance. Additionally, there is a property maintenance company on site to maintain the facility promptly and on a daily basis. No further infrastructure needs were identified.

Capacity

The recent expansion of DHD more than doubled the District's service area and the population; however, the expansion has not resulted in any additional funding sources. The District has increased its fundraising efforts to cope with additional demand. As the population of DHD continues to grow, the District is anticipating that additional funding sources will be essential to increase grant funding and other efforts to address the healthcare needs of district residents. It was reported by DHD that the CHNA will identify the projected needs as well as duplicative healthcare services and facilities. Additionally, the CHIP, which will be informed by the Assessment, will guide efforts to create efficiencies and collaboration in meeting the healthcare needs of district residents. DHD also reports that it has sufficient current and planned staffing capacity to develop continued grant funding opportunities and other collaborative programs.[64]

[60] Desert Healthcare District Request for Information, February 11, 2020
[61] OSHPD has developed a Structural Performance Category (SPC 1-5) rating for hospitals that indicates the building's compliance with seismic safety standards; and a Non- Structural Performance Category (NPC 1-5) rating that indicates the hospital facility's equipment and systems conformance with seismic standards for adequate anchorage and bracing of non-structural features such as electrical, mechanical, plumbing and fire safety systems for their continued use following a disaster event. Structural/Non-Structural Performance Category 4-5 designations indicate facility conformance with the seismic standards; SPC/NPC 1-3 designations indicate nonconformance with seismic standards and include specific required deadlines to achieve conformance.
[62] Desert Healthcare District Request for Information, February 11, 2020
[63] Senate Bill 758 would extend the deadline to January 1, 2037.
[64] Desert Healthcare District Request for Information, February 11, 2020

The District is presently recruiting a Senior Development Officer to help secure funding and resources on a large scale to advance a collective impact approach and leverage funding from foundations, government, and corporate fundraising. Other potential revenue streams include creation of a community facilities district (CFD) or joint powers authority (JPA) and future hospital lease revenue.[65]

In regard to DRMC's capacity, Figure 4-8 in the *Service Demand* section indicates that in 2018, there was overall sufficient capacity to accommodate patient demand for its inpatient services based on the occupancy rate of licensed beds. However, it appears that the ICU is over capacity with an occupancy rate of 102 percent of available beds throughout the year, indicating that DRMC lacks sufficient intensive care beds to address demand. The District reported that due to the seasonal impact of tourism to the area during winter months creating peaks in demand, that there may be high usage during those periods, but overall there has not been a long-term strain on intensive care beds throughout Coachella Valley. However, the potential need for additional intensive care beds, as well as placement, will be addressed as part of the CHNA.

Although there appears to be overall sufficient capacity in terms of hospital beds, the presence of MUAs and healthcare shortage areas within the District discussed in the *Challenges* section indicates that medical staffing increases are necessary in the District's service area. DHD is aware of the problem and has reported that one of its grant funding efforts is to increase the availability of healthcare professionals within the District and expand healthcare into the underserved areas.

While the District has greatly increased in size in the last two years, this has not inherently led to an increase in demand for existing services, as district facilities are available to non-residents and draw patients from the entire region. However, there is now greater demand to provide expanded services to new district residents, such as locating new facilities or funding of services in the newly annexed territory. As mentioned, no additional funding was allocated to the District to accommodate the increase in demand, which dilutes the existing revenue across a significantly larger territory, which poses a constraint on the District's capacity to provide services.

Future district services will need to address anticipated needs resulting in changes in demographics, such as an aging population. The District reports that it is aware of demographic trends and already provides services to fulfill needs of the various age groups, such as funding and resources to senior care nonprofit organizations. Further service needs will be identified and fulfilled as part of the CHNA.

Challenges

DHD reported that residents in many areas of the District, particularly in the eastern Coachella Valley are significantly underserved. The District is challenged with identifying the gaps in services, facilities and providers in these areas. To address this challenge, DHD is currently developing The CHNA and CHIP that will provide more clarity on the issues. The

[65] Desert Healthcare District Request for Information, February 11, 2020.

District also reported that it is struggling with developing additional funding sources to address the needs in the expanded service area.[66]

The District stresses that the needs of the community it is serving have changed significantly since its formation due to demographic changes and advances in healthcare. Previously, the District was serving a smaller population with a lower life expectancy and healthcare needs that frequently required long hospitalization periods. DHD's services are now oriented towards a much larger population with a longer life expectancy and mostly ambulatory healthcare needs. Consequently, the District largely focuses on building local and regional partnerships and grant funding for healthcare providers that help address these needs.

Racial and ethnic disparities in health outcomes and in access to healthcare services are highly prevalent in the District, especially in the newly annexed areas. These disparities result in significant complexities that the District is projected to be challenged with as the population continues to grow.[67]

The California Office of Statewide Health Planning and Development (OSHPD) produces maps for all California counties that define MUAs and HPSAs. MUAs are based on the evaluation criteria established through federal regulation to identify geographic areas or population groups based on percentage of population at 100 percent below poverty, population over 65 years old, infant mortality rate, and primary care physicians per 1,000 people. HPSAs are identified for primary care, nursing, mental health, and dental healthcare professionals. OSHPD has identified three MUAs and four primary care HPSAs within the District's boundaries, as can be seen in Figures 4-10, 4-11, 4-12.

There are significant concerns for district residents should the ACA be repealed. The hospital has a high ratio of patients receiving healthcare through the ACA, and although DHD does not operate the hospital, the District would need to address how healthcare could be offered to all district residents, particularly given a loss of coverage.

[66] Desert Healthcare District Request for Information, February 11, 2020
[67] Desert Healthcare District Request for Information, February 11, 2020

Figure 4-10: Shortage Areas in Desert Healthcare District

Medically Underserved Areas and Health Care Professional Shortage Areas in Desert Healthcare District	
Medically Underserved Area	**Chairaco Summit/Desert Center Service Area 00256**
Census Tract	469
Census Tract	9810
Medically Underserved Area	**Riverside Service Area 04012**
Census Tract	456.04
Census Tract	456.06
Census Tract	456.08
Census Tract	456.09
Medically Underserved Area	**Riverside Service Area 00380**
Census Tract	456.04
Census Tract	456.06
Census Tract	456.08
Census Tract	456.09
Primary Care Health Care Professional Shortage Area	**MSSA 126&127/Blythe/ Chiriaco Summit**
Census Tract	459
Census Tract	461.01
Census Tract	461.02
Census Tract	461.03
Census Tract	462
Census Tract	469
Census Tract	470
Census Tract	9401
Census Tract	9810
Primary Care Health Care Professional Shortage Area	**Low Income - MSSA 129.2/Indio North**
Census Tract	452.09
Census Tract	452.16
Census Tract	452.17
Census Tract	452.22
Census Tract	452.28
Census Tract	452.33
Census Tract	453.02
Census Tract	453.03
Census Tract	453.04
Census Tract	455.02
Census Tract	494
Census Tract	514
Primary Care Health Care Professional Shortage Area	**Low Income - MSSA 129.3/Agua Caliente**
Census Tract	448.04
Census Tract	448.05
Census Tract	448.07
Census Tract	449.16
Census Tract	450
Census Tract	9405
Census Tract	9407
Census Tract	9408
Census Tract	9409
Census Tract	9410
Census Tract	9411
Primary Care Health Care Professional Shortage Area	**MSSA 130/Idyllwild/ Pine Cove**
Census Tract	444.02
Census Tract	444.03
Census Tract	444.04
Census Tract	444.05

Figure 4-11: Medically Underserved Area Map

Figure 4-12: Primary Care Health Care Professional Shortage Area Map

Many government agencies, as well as communities in California have been impacted by the COVID-19 pandemic. Although DHD has not yet seen the full effect of the pandemic on its revenues and operations, the District is continuously monitoring the ongoing changing scenarios. DHD reported, however, that many healthcare providers within the District boundaries have experienced significant revenue reductions. This in turn has created additional demand for DHD funding. Some of the increased demand has shifted from traditional programmatic needs to new necessities that include personal protective equipment, disinfectant wipes, thermometers, and food.[68]

Desert Healthcare District conducted a local survey with the participation of numerous community partners. Through this assessment, the District was able to identify community needs and respond accordingly. Over the weeks that followed the COVID-19 outbreak the District awarded over $2.5million to local nonprofit organizations. The funds were primarily destined to cover ongoing access to healthcare for the underserved through three Federally Qualified Health Centers including Borrego Community Health Foundation, Desert AIDS Project and Clinicas de Salud del Pueblo. Additionally, the Coachella Valley Volunteers in Medicine and the University of California Riverside, School of Medicine were also awarded grants to serve farmworkers in the easternmost areas of the District. DHD also purchased COVID-19 tests to distribute among healthcare partners and allow mobile testing sites. These efforts have been coordinated with the County Department of Public Health. [69]

In addition, the District has partnered with a local foundation to establish a collective impact fund and made small grants, up to $10,000 available to 20 organizations. Since DHD expects the impact of COVID-19 pandemic to be ongoing and long-lasting the District has allocated a grant-making budget of over $4 million for the current fiscal year (FY 20-21). [70]

The Desert Regional Medical Center has also been impacted by the pandemic. The hospital followed all the required protocols early in the pandemic while preparing for a potential surge. The early measures included temporarily closing and/or reducing hours of operation of multiple procedural and outpatient areas, which have since been resumed. Based on the closure/reduction of some services during the early months of the pandemic, DRMC reallocated clinical staff where possible to provide additional manpower in the areas of greatest need. DRMC also secured travelers for nursing and respiratory therapy to ensure adequate coverage and allow for hospital staff some flexibility with time off. [71]

Since the beginning of the pandemic, the DRMC had seen the decline in emergency room visits and demand for elective surgeries. Although the demand has gradually recovered it remains lower than in the previous year. The hospital has launched a "safe care" campaign to educate the community on the need to seek care for episodes such as stroke, heart attack, accidents or other needs requiring immediate medical attention. [72]

Desert Regional Medical Center maintains an Emergency Operations Center Plan for all types of disasters/episodes that may require operations above and beyond the normal functioning of the hospital. The hospital's focus moving into the fall of 2020 is to ensure that all COVID-19 protocols are followed, vaccinate hospital staff for flu in a timely manner while

[68] Desert Healthcare District Request for Information, COVID-19 Questionnaire, August 6, 2020.
[69] Desert Healthcare District Request for Information, COVID-19 Questionnaire, August 6, 2020.
[70] Desert Healthcare District Request for Information, COVID-19 Questionnaire, August 6, 2020.
[71] Desert Healthcare District Request for Information, COVID-19 Questionnaire, August 6, 2020.
[72] Desert Healthcare District Request for Information, COVID-19 Questionnaire, August 6, 2020.

educating the community to do the same, and continue its collaboration with other hospitals and clinics throughout the County. The DRMC has also, as usual for the winter season, planned for adequate staffing through travelers so that it can appropriately respond to any changes/fluctuations in census.[73]

Additionally, the challenge that both the District and the hospital are currently experiencing is with testing supplies/reagents. The lack of COVID-19 tests and reagents at the DRMC results in longer wait times for lab result, which is a problem of national concern. To mitigate reagent shortages, DRMC is using three testing methodologies to have the ability to process in-house lab tests based on supply availability. DRMC also uses Lab Corp as a back-up while conserving in-house supplies for in-house patients.[74]

The District, on the other hand, supports access to COVID-19 tests for traditionally underserved communities by providing financial assistance/grants to local community clinics or Federally Qualified Health Centers. Accessing these tests has been very challenging given the limited availability of tests nationwide. Finding personal protective equipment (PPE) for essential workers (farm workers, healthcare and service workers, and those serving the homeless) has been almost impossible as supply is prioritized for hospital workers only. However, the District has been able to secure access to face shields and masks to distribute among its community partners.[75]

Service Adequacy

Grant Funding

Since DHD does not directly provide healthcare services and instead largely operates as a financing mechanism for projects and programs managed by other agencies by providing grant funds, the District's service adequacy assessment is based on 1) public outreach and accountability efforts, 2) grant management practices, and 3) resident satisfaction.

Essential in issuing grants, is follow up and review with the agency receiving the funds to 1) ensure that the money is used appropriately, 2) confirm that funded projects are carried out to completion, 3) review project challenges and outcomes to make appropriate improvements/changes to successive project approvals, and 4) guarantee that the grantee organization continues to viably operate during the course of the project.

There are several best management practices with regard to grant approval and management discussed briefly in Appendix A. It is recommended that all grant funding healthcare districts follow these guidelines.

DHD is extensively involved in the community and engages its residents in the assessment of service needs and service planning. The District maintains the website where it posts a large volume of material to keep its constituents informed of the District's activities, including the required information in compliance with SB 929, AB 2257 and AB 2019 as was previously described in the *Accountability and Governance* section. AB 2019, however, in addition to the website posting obligations, has set out additional requirements for the districts that provide assistance or grant funding. The bill requires these healthcare districts

[73] Desert Healthcare District Request for Information, COVID-19 Questionnaire, August 6, 2020.
[74] Desert Healthcare District Request for Information, COVID-19 Questionnaire, August 6, 2020.
[75] Desert Healthcare District Request for Information, COVID-19 Questionnaire, August 6, 2020.

to adopt annual policies that include certain elements in addition to the current requirement that the policy describe the nexus between the assistance or grant funding and the district's mission. The new requirements include:

- the requisites that a grant recipient must meet, such as grant contract terms and conditions, fiscal and programmatic monitoring by the district, and reporting to the district,
- the district's plan for distributing grant funds for each FY
- a process for providing, accepting and reviewing grant applications and
- a prohibition against individual meetings regarding grant applications between a grant applicant and a district board member, officer or staff member outside of the district's established awards process.

AB 2019 also requires districts to develop additional grant guidelines for all of the following by January 1, 2020:

- awarding grants to underserved individuals and communities and the organizations that serve them,
- evaluating the financial need of applicants,
- considering the types of programs eligible for funding,
- considering the circumstances under which grants may be provided to prior grant recipients,
- funding other government agencies, and
- awarding grants to, and limiting funds for, foundations that are associated with a separate grant recipient.

DHD complies with the new requirements and has adopted all the necessary policies and guidelines including a grant oversight process, last updated in 2020.[76] All of DHD's grant investments are vetted and evaluated by the District's standing committees and the Board of Directors. The grantee agencies submit progress and final reports and budget reports, delivering the outcomes and measurements of the District's investments in their projects and programs.[77]

Based on the absence of complaints in 2019, District residents appear to be generally satisfied with DHD performance and services in the community.

Hospital Services

There are several benchmarks that may define the level of healthcare service provided by a hospital. Indicators of service adequacy discussed here include 1) PQIs, 2) IMIs, 3) hospital volume indicators, 4) EMS ambulance diversion rates, 5) the extent to which residents go to other hospitals for service, 6) patient satisfaction, 7) hospital safety, and 8) accreditation.

[76] Grant & Mini-Grant Policy, Desert Healthcare District Board, Approved 3/24/2020
https://www.dhcd.org/media/1116/Board%20Policies_Grants_OP5.pdf
[77] Desert Healthcare District Request for Information, February 11, 2020

Although this data is not available specifically for DHD or even for Coachella Valley, it is important to discuss PQIs.[78] Figure 4-13 shows that overall Riverside County's rates do not largely differ from statewide rates. For uncontrolled diabetes and asthma in young adults, the Riverside County rates were lower than statewide rates by a larger margin than all other indicators, suggesting that residents in the County have better access to outpatient care for these diseases compared to statewide. 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. The short-term diabetes complications and community acquired pneumonia rates in Riverside County, on the other hand, were higher than statewide rates by a large margin.

[78] 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 hospitalization or for which early intervention can prevent complications or more severe disease. The Prevention Quality Indicators represent hospital admission rates for 4 ambulatory care sensitive conditions.

Figure 4-13: Risk Adjusted Rates per 1,000 Population

Year	Region	Diabetes Short-term Complications	Diabetes Long-Term Complications	COPD or Asthma in Older Adults (Ages 40+)	Hypertension	Heart Failure	Community-Acquired Pneumonia	Urinary Tract Infection
2017	Statewide	38.4	90.6	299.1	40.5	330.4	108.4	101.3
	Riverside	41.9	89.5	286	37.7	292.5	115.1	104
	Difference with statewide	9%	-1%	-4%	-7%	-11%	6%	3%
2018	Statewide	58.1	88.4	229	41.5	335.4	107	93.3
	Riverside	67.4	92.9	208.3	41.2	309.5	125.1	98.9
	Difference with statewide	16%	5%	-9%	-1%	-8%	17%	6%

Year	Region	Uncontrolled Diabetes	Asthma in Young Adults (Ages 18-39)	Lower-Extremity Amputations Among Patients with Diabetes	Overall Composite	Acute Composite	Chronic Composite	Diabetes Composite
2017	Statewide	31.9	19.5	24.7	947.1	209.7	736.3	172.5
	Riverside	26	16.5	23.1	905.6	219.6	683.6	168.2
	Difference with statewide	-18%	-15%	-6%	-4%	5%	-7%	-2%
2018	Statewide	30.3	18.5	25.9	919.6	200.3	718.3	189.8
	Riverside	26.1	15.7	25.8	916	224.2	689.7	196.8
	Difference with statewide	-14%	-15%	0%	0%	12%	-4%	4%

Source: The Office of Statewide Health Planning and Development (OSHPD)

IMIs reflect quality of care by measuring inpatient mortality rates for individual hospitals against state averages for specific medical conditions and surgical procedures. Evidence suggests that high mortality rates may be associated with deficiencies in the quality of hospital care provided. The most recent information regarding IMIs is available from OSHPD for 2015 (January-September).[79] The information available includes risk-adjusted mortality rates for six medical conditions treated (Acute Stroke, Acute Myocardial Infarction, Heart Failure, Gastrointestinal Hemorrhage, Hip Fracture and Pneumonia) and six procedures performed (Abdominal Aortic Aneurysm Repair, Carotid Endarterectomy, Craniotomy, Esophageal Resection, Pancreatic Resection, Percutaneous Coronary Intervention (PCI) in California hospitals. DRMC's mortality rates for all but one medical conditions and procedures were not statistically different from the statewide rates. The DRMC had a higher than an average mortality rate compared to hospitals statewide in regard to the acute myocardial infraction.

The ambulance diversion rate is another indicator of a hospital's service adequacy. Ambulance diversion may occur due to emergency room closure, inability to accommodate the incoming volume of patients or the inability to transfer admitted patients from the ED to inpatient beds. Ambulance diversion has been found unsafe for patients because it increases transport times, which interferes with continuity of care, causes delays, and increases mortality for severe trauma patients.[80] Figure 4-6 in the *Service Demand* section indicates that in one out of five years shown the DRMC's ED was unable to receive patients for a significant number of hours (678 hours or 28 days). In all other years, the hospital's ED was largely able to accommodate the incoming volume of patients at all times.

The adequacy of hospital facilities and services in meeting the needs of district residents can be gauged by the extent to which residents travel outside their region to receive hospital

[79] Data is reported for January-September due to coding changes for diagnosis and procedures, which began on October 1, 2015.
[80] *Reducing Ambulance Diversion in California: Strategies and Best Practices*, California Healthcare Foundation, July 2009 https://www.chcf.org/wp-content/uploads/2017/12/PDF-ReducingAmbulanceDiversionInCA.pdf

services. The rates were calculated based on patient origin discharge data from OSHPD.[81] Residential location was approximated by the zip codes. About 35 percent of residents who live within DHD boundaries patronize the DRMC for needed services based on the data available for 2016 and 2017.

The hospital volume indicators measure the number of medical procedures of a given type that are performed by a hospital within the one-year reporting period. OSHPD states that higher hospital volumes for some complex surgical procedures may be associated with better patient outcomes such as lower mortality rates; however, OSHPD does not recommend the use of volume indicators as stand-alone measures of hospital quality. The data is available for six selected inpatient procedures, including esophageal resection,[82] pancreatic resection,[83] abdominal aortic aneurysm repairs (AAA Repairs),[84] carotid endarterectomy,[85] coronary artery bypass graft surgery (CABG),[86] and PCI[87] performed in California hospitals. The most recent information as of the drafting of this report was available for 2017. Based on the data from 2016 and 2017, DRMC performs consistently high volumes of the aforementioned procedures, particularly for CABG and PCI. The lowest volume is attributed to esophageal resection and pancreatic resection.[88]

Cal Hospital Compare is a performance reporting initiative that was established for the purposes of developing a statewide hospital performance reporting system using publicly available data sources. The data includes measures for clinical care, patient safety, and patient experience for all acute care hospitals in California. In FY 18-19, DRMC received an overall Patient Experience Rating of below average. Patient responses further indicate that 70 percent would recommend DRMC services, which is comparable to the statewide average of 71 percent. The hospital had a 15.6 percent (rated as average) readmission rate[89] compared to the statewide average of 15 percent. For indicators of clinical care and patient safety, DRMC's scores appear to be largely consistent with statewide average levels.[90]

The Leapfrog Group is another independent nonprofit organization that provides hospital safety grading. Its scores are based on infection rates, problems with surgery, safety problems, and performance of doctors, nurses and hospital staff. According to Leapfrog Group ratings, the DRMC has a safety rating of C as of spring 2020.[91] The rating details are shown in Figure 4-14.

[81] Discharge data includes discharges from ambulatory surgery center, emergency department, inpatient discharges, and inpatient discharges that originated in the emergency department.
[82] Surgical removal of the esophagus due to cancer
[83] Surgical removal of the pancreas/gall bladder due to cancer
[84] Surgical repair of abdominal aneurysm
[85] Surgical removal of plaque within the carotid artery
[86] Surgical heart artery procedure
[87] Non-surgical heart artery procedure
[88] https://data.chhs.ca.gov/dataset/number-of-selected-inpatient-medical-procedures-in-california-hospitals
[89] The readmission rate is considered to be better the lower it is
[90] https://calhospitalcompare.org/hospital/?id=106331164&n=Desert+Regional+Medical+Center
[91] https://www.hospitalsafetygrade.org/h/desert-regional-medical-center?findBy=hospital&hospital=Desert+Regional+Medical+Center&rPos=124&rSort=grade

Figure 4-14: Leapfrog Group Safety Grade for the Desert Regional Medical Center

Infections						
Indicator	*MRSA Infection* [1]	*C. Diff Infection* [2]	*Infection in the Blood*	*Infection in the Urinary Tract*	*Surgical Site Infection after Colon Surgery*	
Score	Below Average	Average	Below Average	Average	Above Average	
Complications with Surgery						
Indicator	*Dangerous Object Left in Patient's Body*	*Surgical Wound Splits Open*	*Deaths from Serious Treatable Complications*	*Collapsed Lung*	*Serious Breathing Problem*	*Dangerous Blood Clot*	*Accidental Cuts and Tears* [3]
Score	Above Average	Below Average	Below Average	Below Average	Below Average	Below Average	Above Average
Practices to Prevent Errors						
Indicator	*Doctors Order Medications through Computer* [4]	*Safe Medication Administration* [5]	*Handwashing*	*Communication about Medicines*	*Communication about Discharge*	*Staff Collaboration to Prevent Errors*
Score	Above Average	Above Average	Above Average	Above Average	Below Average	Above Average
Safety Problems						
Indicator	*Dangerous Bed Sores*	*Patient Falls and Injuries*	*Air or Gas Bubble in the Blood*	*Track and Reduce Risks to Patients* [6]		
Score	Below Average	Above Average	Above Average	Below Average		
Practices to Prevent Errors						
Indicator	*Effective Leadership to Prevent Errors* [7]	*Sufficient Qualified Nurses* [8]	*Specialty Trained Doctors Care for ICU Patients*	*Communication with Nurses*	*Communication with Doctors*	*Responsiveness of Hospital Staff*
Score	Above Average	Above Average	Above Average	Below Average	Below Average	Below Average

Notes:
(1) Methicillin-resistant Staphylococcus aureus (MRSA)
(2) Clostridium difficile (C. diff)
(3) For procedures of the abdomen and pelvis, there is a chance that the patient will suffer an accidental cut or tear of their skin or other tissue. This problem can happen during surgery or a procedure where doctors use a tube to look into a patient's body.
(4) Hospitals can use Computerized Physician Order Entry (CPOE) systems to order medications for patients in the hospital, instead of writing out prescriptions by hand. Good CPOE systems alert the doctor if they try to order a medication that could cause harm, such as prescribing an adult dosage for a child. CPOE systems help to reduce medication errors in the hospital.
(5) Using barcodes on medications, nurses can scan the medication and then the patient's ID bracelet to make sure the patient is receiving the right medications. If the bar codes do not match, this signals there is an error, giving nurses and doctors the chance to confirm they have the right patient, right medication, and right dose. Bar code medication administration (BCMA) systems are proven to reduce the risk that a hospital accidentally gives the wrong medication to a patient.
(6) Hospitals should be aware of all potential errors that could harm patients. Hospital leaders should evaluate their hospital's record of past errors to prevent the same error from happening again. If all hospital staff is aware of safety risks, they can work together and take all possible action to prevent harm.
(7) Errors are much more common if hospital leaders don't make patient safety a priority. Leaders must make sure that all hospital staff knows what they need to work on and that they are held accountable for improvements. The hospital should also budget money towards improving safety.
(8) Patients receive most of their care from nurses, not doctors. When hospitals do not have enough nurses or the nurses don't have the right training, patients face a much greater risk of harm. Without enough qualified nurses, patients might face more complications, longer hospital stays, and even death.

There are several major healthcare-related accreditation organizations in the United States, including Healthcare Facilities Accreditation Program (HFAP), 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 California, the primary accreditation organization is the Joint Commission (JC). The JC 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 JC 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.

DRMC is fully licensed by the Department of Health Services and accredited by the JC on Accreditation of Healthcare Organizations and the California Medical Association. According to the JC Quality Report for October 2018 – September 2019, DRMC's performance is comparable to hospital performance nationwide.[92]

[92] https://www.qualitycheck.org/quality-report/?bsnId=10009

DESERT HEALTHCARE DISTRICT MSR DETERMINATIONS

Growth and Population Projections

- The population of DHD is difficult to estimate since Coachella Valley is a resort destination. Based on Department of Finance estimates for 2020, the number of permanent residents within the District is approximately 445,721.
- According to SCAG, the annual growth rate in the District is estimated to be about one percent through 2045.[93] Based on these estimates, the District's population is projected to be approximately 501,332 in 2030 and 571,695 in 2045.
- There is anticipated to be a significant increase of the population over 65 years of age, while the age groups of 15 to 44 and 0 to 14 are estimated to grow at a moderate and slow rate respectively over the next 10 years.

The Location and Characteristics of Disadvantaged Unincorporated Communities Within or Contiguous to the Agency's SOI

- Riverside LAFCO has identified 40 disadvantaged unincorporated communities in Riverside County within or near cities' spheres of influence, 13 of which are within or adjacent to DHD's boundaries.

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

- Present capacity of the District's services is constrained by finite funding and lack of sufficient medical staffing. Additional challenges to providing services consist of the presence of MUAs and healthcare shortage areas.
- The greatest impact on the District's capacity to provide services is the addition of significant territory and population from annexation in 2018, which resulted in greater demand to provide expanded services to new district residents with no additional funding. The District is working to address this issue by securing funding and resources on a large scale to advance a collective impact approach and leverage funding from foundations, government, and corporate fundraising.
- In regard to DRMC's capacity, there is overall sufficient capacity to accommodate patient demand for its inpatient services. However, it appears that the ICU is at maximum capacity. The potential need for additional intensive care beds, as well as placement, will be addressed as part of the CHNA that is underway.

[93] Southern California Association of Governments, *Demographics and Growth Forecast*, Technical Report, Adopted on May 7, 2020, https://www.connectsocal.org/Documents/Adopted/fConnectSoCal_Demographics-And-Growth-Forecast.pdf.

- Future district services will need to address anticipated needs resulting in changes in demographics, such as an aging population. Future service needs will be identified and fulfilled as part of the CHNA.
- Service adequacy of healthcare districts that provide grant funding is defined by public outreach and accountability efforts, grant management practices, and resident satisfaction. Based on these indicators, DHD provides adequate services. In particular, DHD excels at issuing grant funds and follows best management practices with regard to grant approval and management.
- Service adequacy of hospital services are defined by 1) PQIs, 2) IMIs, 3) hospital volume indicators, 4) EMS ambulance diversion rates, 5) the extent to which residents go to other hospitals for service, 6) patient satisfaction, 7) hospital safety, and 8) accreditation. Based on these indicators, the DRMC's services appear to be mostly adequate and comparable to similar providers statewide.
- The hospital requires additional significant capital improvements, estimated between $119 and $180 million, in order to comply with 2030 seismic requirements. Actual capital costs will greatly depend on the degree to which the District plans to make use of the hospital facility in the long term, which will be determined by facility needs identified in the CHNA.

Financial Ability of Agencies to Provide Services

- The District has the financial ability to provide services. The District generally operates with an operational surplus, has established a reserve fund to meet infrastructure and other contingency needs, has sufficient reserves to operate for approximately two years, maintains limited debt, and has low pension and OPEB liabilities.
- Given the stability of the District's existing revenue sources, and the District's conservative budgeting practices, it appears that DHD is low risk for financial distress.
- Despite its strong financial position, the District may face challenges presented by hospital infrastructure needs, the potential necessity to take over the operations of the hospital, and the need to fund and extend healthcare services to the underserved areas of the recently annexed territory.

Status of, and Opportunities for, Shared Facilities

- The District practices facility sharing by leasing the DRMC and Las Palmas Medical Plaza to healthcare providers, as well as through its maintenance agreement with the City of Palm Springs for the Wellness Park.
- The District anticipates that future facility sharing opportunities will be identified during the development of the CHNA, which will guide facility needs, and thus sharing opportunities, in the eastern portion of the District.

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

- The District primarily conducts outreach via its website, which makes available comprehensive information and documents to the public and solicits input from customers. The website complies with SB 929, AB 2257, and AB 2019 requirements.
- Accountability is best ensured when contested elections are held for governing body seats, constituent outreach is conducted to promote accountability and ensure that constituents are informed and not disenfranchised, and public agency operations and management are transparent to the public. The District demonstrated accountability with respect to these factors.
- No governance structure options were identified over the course of this review with regard to DHD.

DESERT HEALTHCARE DISTRICT SPHERE OF INFLUENCE UPDATE

Existing Sphere of Influence

Desert Healthcare District's (DHD's) current SOI is coterminous with its boundaries. The last SOI amendment took place in 2018 concurrently with the boundary expansion. The current SOI expands west to include most of the cities of Desert Hot Springs and Palm Springs, east to include portions of Joshua Tree National Park and the Salton Sea, north to the San Bernardino County border and south to the San Diego and Imperial county borders. To the west, DHD shares the border with San Gorgonio Healthcare District, while in the east it borders Eagle Mountains, Chuckwalla Valley and Chuckwalla Mountains, which are all situated between DHD and PVHD.

Sphere of Influence Options

Two options were identified with respect to DHD's SOI.

Option #1: Maintain coterminous SOI

Should the Commission wish to continue to reflect the existing service boundary, then a coterminous SOI would be appropriate.

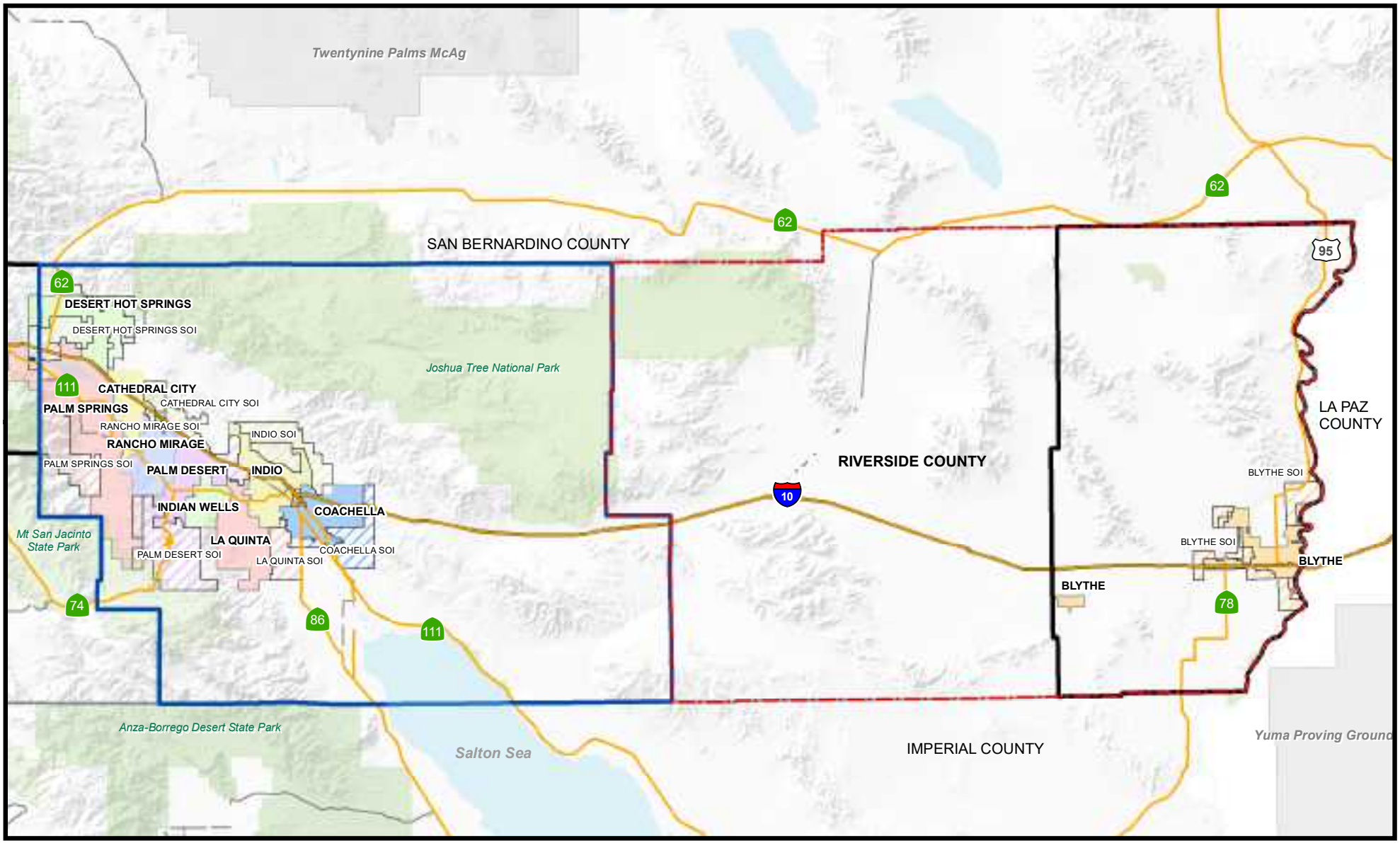
Option #2: Expand the current SOI to add the communities of Desert Center, Eagle Mountain, Lake Tamarisk and the rest of the territory between DHD and PVHD.

If the Commission decides that it would be prudent to close the gap between the borders of DHD and PVHD and annex the areas between the two healthcare districts into the DHD's boundaries to promote logical boundaries, then extension of the District's SOI would be appropriate to indicate the future annexation intent.

Sphere of Influence Analysis and Recommendations

DHD has undergone a recent SOI change and annexation that more than doubled the District's boundary area and its population. The District does not currently have adequate capacity to accommodate or plan for additional growth. Additionally, PVHD considers the area around the community of Desert Center its secondary service area, which means that it may be more appropriate to consider including these communities in the PVHD's SOI, as is shown in Figure 4-15. It is recommended that the Commission adopt Option #1 and maintain a coterminous SOI for DHD.

Figure 4-15: Desert Healthcare District and Palo Verde Healthcare District



Data Sources: County of Riverside; LAFCo

0 1.5 3 6 9 12 Miles

N

Disclaimer: The information shown is intended to be used for reference and general display purposes only and is not to be used as an official map.

Healthcare services provided for District residents

Legend

- Palo Verde Healthcare District
- Palo Verde HealthCare District Proposed Sphere of Influence
- Desert Healthcare District

Map Created on 9/14\2020

Sphere of Influence Determinations

Nature, location, extent, functions, and classes of services provided

- DHD provides support to a variety of health-related programs, primarily through grants and similar assistance to nonprofit entities and public agencies within the District boundaries that encompass Coachella Valley and stretch from the cities of Palm Springs and Desert Hot Springs in the west to Joshua Tree National Park and Salton Sea in the east. DHD additionally provides oversight of the DRMC, which is currently privately operated by Tenet Health System under a lease agreement.
- While services are provided only within the District's boundaries, they benefit both DHD residents and non-residents through the use of district funded facilities and programs.

Present and planned land uses, including agricultural and open-space lands

- DHD encompasses all land uses designated by the cities within its boundaries and the County of Riverside including agricultural and open space land.
- DHD's SOI does not conflict with planned land uses; the District has no authority over land use, and both urban and agricultural areas within the District are in need of the services offered by DHD.
- Hospital and healthcare services are needed in all areas, and do not, by themselves induce or encourage growth on agricultural or open space lands.

Present and probable need for public facilities and services

- As indicated by DHD's service demand and projected growth, there is a present and anticipated continued need for healthcare funding and hospital oversight services offered by the District.
- The areas that were annexed into DHD in 2018 are significantly underserved and require the extension of healthcare services to accommodate demand.

Present capacity of public facilities and adequacy of public services that the agency provides or is authorized to provide

- Present capacity of the District's services is constrained by finite funding and lack of sufficient medical staffing. Additional challenges to providing services consist of the presence of MUAs and healthcare shortage areas.
- The greatest impact on the District's capacity to provide services is the addition of significant territory and population from annexation in 2018, which resulted in greater demand to provide expanded services to new district residents with no additional funding. The District is working to address this issue by securing funding and resources on a large scale to advance a collective impact approach and leverage funding from foundations, government, and corporate fundraising.
- Future district services will need to address anticipated needs resulting in changes in demographics, such as an aging population. Future service needs will be identified and fulfilled as part of the CHNA.

- The hospital, owned by DHD and operated by Tenet Health System, requires additional significant capital improvements, estimated between $119 and $180 million, in order to comply with 2030 seismic requirements. Actual capital costs will greatly depend on the degree to which the District plans to make use of the hospital facility in the long term, which will be determined by facility needs identified in the CHNA.
- The District provides adequate services based on public outreach and accountability efforts, grant management practices, and resident satisfaction. DHD excels at issuing grant funds and follows best management practices related to grant approval and management.

Existence of any social or economic communities of interest

- All the areas inhabited by District residents represent social and economic communities of interest, as DHD residents pay for its services through property taxes.
- Seasonal tourists and area visitors also use District services and have an interest in adequacy of such services.
- Additionally, MUAs and healthcare shortage areas within DHD boundaries represent particular social and economic interest since they are underserved and require increased attention from the District.

5. PALO VERDE HEALTHCARE DISTRICT

DISTRICT OVERVIEW

Palo Verde Healthcare District			
Contact Information			
Contact:	Sandra Anaya, Chief Executive Officer		
Address:	250 N First Street, Blythe, CA 92225	*Website:*	Paloverdehospital.org
Phone:	760-922-4115	*Email:*	sandra.anaya@paloverdehospital.org
Formation Information			
Date of Formation:	1948	*District type:*	Independent Special District
Governing Body			
Governing Body:	Board of Directors	*Members:*	5
Manner of Selection:	Elected at Large	*Length of term:*	4 years
Meeting Location:	Palo Verde Hospital Conference Room	*Meeting date:*	Every 4th Wednesday at 5 p.m.
Mapping and Population			
GIS Date:	7/30/19	*Population (2020):*	21,376
Purpose			
Enabling Legislation:	Local Healthcare District Law Health and Safety Code §32000-32492.	*Empowered Services:*	Medical services, emergency medical, ambulance, and services relating to the protection of residents' health and lives
Services Provided	Hospital services		
Area Served			
Size:	1,033 square miles	*Location:*	Eastern Riverside County
Current SOI:	1,033 square miles	*Most recent SOI update:*	2005
Facilities			
Hospital Name:	Palo Verde Hospital	*Location:*	250 N First Street, Blythe CA 92225
Number of Licensed Beds:	51	*Other Facilities:*	Hospital-based clinic

Boundaries

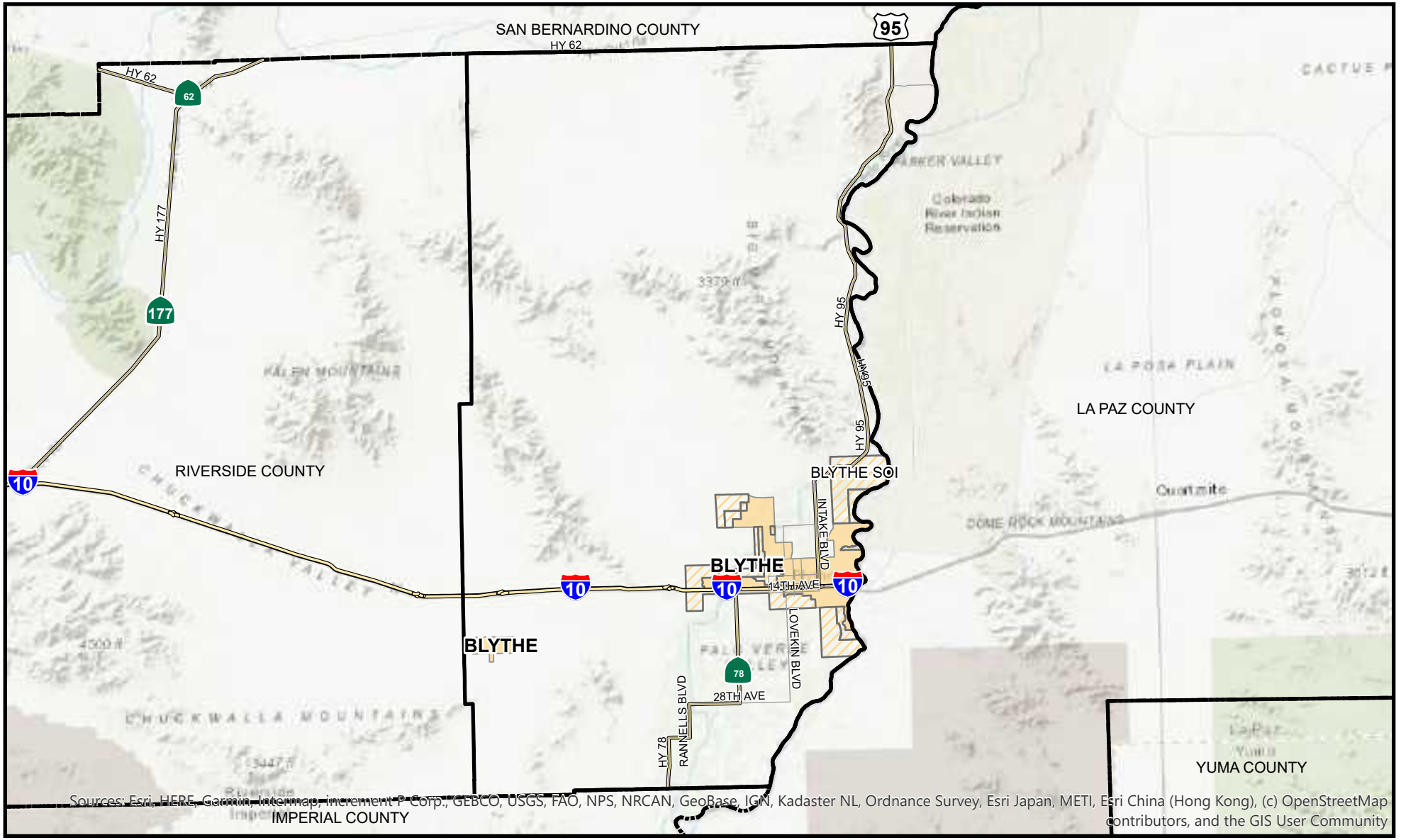
PVHD's boundaries encompass 1,033 square miles and generally include the City of Blythe and the communities of Mesa Verde, Ripley and Midland. The District borders the State of Arizona in the east, San Bernardino County in the north, Imperial County in the south, and in the west by Blythe's western boundary, as shown in Figure 5-1. The boundaries of PVHD have remained the same since the District's formation in 1948.

Sphere of Influence

The District's SOI was established in 1985 as coterminous with its boundaries.[94] In 2005, Riverside LAFCO reaffirmed the District's coterminous SOI.[95]

[94] LAFCO #84-112-4-Sphere of Influence Study – Palo Verde Valley Hospital District.
[95] LAFCO 2005-07-4 -Sphere of Influence Review and Potential Amendment – Palo Verde Healthcare District.

Figure 5-1: Palo Verde Healthcare District and Sphere of Influence



Data Sources: County of Riverside; Registrar of Voters, LAFCO

9.5 4.75 0 9.5 Miles

N

Disclaimer: The information shown is intended to be used for reference and general display purposes only and is not to be used as an official map.

Healthcare services provided for District residents

Legend

Palo Verde Healthcare District**

** SOI is coterminous with District Boundary

Author: Crystal M. Craig

Map Created on 7/30/19

ACCOUNTABILITY AND GOVERNANCE

The District is governed by a five-member Board of Directors comprised of a President, a Secretary and three directors. These Board Members are elected at-large to facilitate the hospital's goals and represent the community's healthcare needs. Each board member serves a four-year term. While there are no board vacancies currently reported in the District, per District Bylaws, if a vacancy occurs, the Board may fill this position by appointment until the next district general election scheduled 130 or more days after the date of the vacancy. The appointment, however, must be made within 60 days immediately following the date of the vacancy as long as a notice of the vacancy is posted in a minimum of three conspicuous places at least 15 days before the appointment is made. If a vacancy is not filled in accordance with these regulations, the Board of Supervisors of the County of Riverside is allowed to fill the vacancy within 90 days of the vacancy date or direct the District to call an election to fill the vacancy. It is also required that all Board Members must be registered voters in the District.

The District's Board meetings are held in accordance with the Ralph M. Brown Act, Government Code §54950. The meetings take place on the fourth Wednesday of every month at 5 p.m. at the Palo Verde Hospital Conference Room. The minutes and agendas for the PVHD Board meetings are available via the home page of the District's website as well as on subsequent pages accessed through the navigation tabs.

PVHD maintains a website with information readily available for the public. The Special District Transparency Act (SB 929), signed into law in 2018, requires special districts in California to have websites by January 1st, 2020. The website is mandated to clearly list the district's contact information in addition to the recommended agendas and minutes, budgets and financial statements, compensation reports, and other relevant public information and documents. A district may be exempt from the law by a resolution adopted by a majority vote of its governing body declaring detailed findings regarding a hardship that prevents the district from establishing or maintaining a website. The resolution must be adopted annually as long as the hardship exists.[96] The District's website meets the requirements of SB 929. PVHD needs to ensure that all the information posted on its website is up to date.

In 2016, the State Legislature enacted AB 2257 (Government Code §54954.2) to update the Brown Act with new requirements governing the location, platform and methods by which an agenda must be accessible on the agency's website for all meetings occurring on or after January 1, 2019. AB 2257 provides two options for compliance. Under the first option, an agency that maintains a website must post a direct link to the current agenda on its primary homepage. The link may not be placed in a "contextual menu," such as a drop-down tab, that would require a user to perform an action to reveal the agenda link. Additionally, the agenda must be: (a) downloadable, indexable, and electronically searchable by common internet browsers; (b) platform independent and machine readable; and (c) available to the public, free of charge and without restrictions that might interfere with the reuse or redistribution of the agenda. Under the second option, an agency may implement an "integrated agenda management platform," meaning a dedicated webpage that provides the necessary agenda information. The most current agenda must be located at the top of the page. Under this option, a direct link to the current agenda does not need to be posted on the homepage; however, the agency *is* required to post a link to the platform containing the

[96] California Government Code, §6270.6 and 53087.8

agenda information. Again, this link may not be hidden in a contextual menu.[97] PVHD is compliant with the AB 2257 requirements as it has a dedicated webpage that provides the required agenda information.

AB 2019, signed into law in 2018 by Governor Jerry Brown, imposes additional posting requirements on California's healthcare districts. Healthcare districts must now post the following information on their websites:

- the district's annual budget,
- a list of current board members,
- information regarding public meetings,
- recipients of grant funding or assistance provided by the district,
- the district's policy for providing grants or assistance, and
- audits, financial reports and MSRs or LAFCO studies, if any, or a link to another government website containing this information.

PVHD needs to ensure that all required up-to-date documents are posted on its website, including annual budgets and audited financial statements.

There are additional requirements outlined in this bill for healthcare districts that provide assistance or grant funding, which are not relevant to PVHD. AB 2019 also requires all healthcare districts to notify LAFCO if they file for bankruptcy.

The District uses a combination of strategies in its outreach efforts to inform the public of its services and programs. Mainly, the PVHD relies on digital communications to reach its users and encourage voter interest. The District's website is its primary avenue for disseminating information. The site has a tab for news, links to external sites for resources, and an online calendar that lists health promoting events. The District also incorporates social media channels such as Facebook and Instagram as well as a newsletter and a link to file complaints, however, the links to many webpages are currently not functioning properly. PVHD needs to ensure that its website is fully functional and contains all the required and appropriate information.

The District has demonstrated marginal transparency and accountability in regard to the MSR process. Although PVHD responded to the initial request for information and participated in an interview, further numerous follow-up attempts to obtain the remaining missing information were unsuccessful.

GROWTH AND POPULATION PROJECTIONS

The District's boundaries include the City of Blythe and unincorporated communities of Mesa Verde, Ripley and Midland (currently an unpopulated ghost town). It is challenging to estimate the current population of the District, since Census 2020 data will not be available until after the adoption of this report. The most recent population estimate for the City of Blythe (the only incorporated area in PVHD) is available for 2020; however, unincorporated level population data is difficult to categorize at the district level as it generally dates from 2010 when the last Census occurred. In order to determine the current District's population,

[97] https://www.jdsupra.com/legalnews/ab-2257-new-brown-act-requirements-for-35346/

the report makes use of the Census County Tract level estimates for 2018, which is the most recent districtwide population estimate available. It was estimated that the number of residents within the entirety of the District as of 2018 was 21,247, which equates to an unincorporated population of 1,723, based on the Department of Finance Blythe population at that time. The Department of Finance estimates show 2.2 percent growth in unincorporated Riverside County between 2018 and 2020 but negative population growth (-1.4 percent) in the City of Blythe during the same time frame. Thus, the estimated population in the entire District as of January 1, 2020 was 21,376, as shown in Figure 5-2.

Figure 5-2: Palo Verde Healthcare District Population Estimate, 2018-2020 and Population Projections 2030, 2045.

	Population Estimate 1/1/2018	Population Estimate 1/1/2019	Population Estimate 1/1/2020	Population Projection 2030	Population Projection 2045
PVHD Incorported	19,524	19,256	19,255	22,797	27,671
PVHD Unincorporated	1,723	1,964	2,121	1,988	2,378
Total	21,247	21,220	21,376	24,785	30,049

Sources:
Department of Finance
U.S. Census Bureau (2018). American Community Survey 5-year estimates. Retrieved from Census Reporter Profile page for Census Tract 469, Riverside, CA <http://censusreporter.org/profiles/14000US06065046900-census-tract-469-riverside-ca/>
Southern California Association of Governments, Population Projections, 2016.

The estimated population includes Ironwood and Chuckawalla State Prisons, which together house approximately 7,000 inmates.[98] The seasonal visitors to Blythe and the surrounding area during the months of October through May also have a significant impact on the population of the area.[99] Blythe is the second largest portal of entry in California with over one million vehicles entering the portal annually.[100]

The District is expected to experience slow growth based on the SCAG forecast conducted in 2020. According to SCAG, the population of Riverside County will grow by 30 percent between 2020 and 2045 or approximately one percent annually. The projected annual growth for Blythe and the unincorporated area in PVHD is also approximately one percent.[101] Based on these estimates, the District's population is projected to be approximately 24,785 in 2030 and 30,049 in 2045 as shown in Figure 5-2.

DISADVANTAGED UNINCORPORATED COMMUNITIES

LAFCO is required to evaluate disadvantaged unincorporated communities as part of this service review, including the location and characteristics of any such communities.

The purpose of SB 244 (Wolk, 2011) is to begin to address the complex legal, financial, and political barriers that contribute to regional inequity and infrastructure deficits within disadvantaged unincorporated communities (DUCs). Identifying and including these communities in the long-range planning of a city or a special district is required by SB 244.

Government Code §56033.5 defines a DUC as 1) all or a portion of a "disadvantaged community" as defined by §79505.5 of the Water Code, and as 2) "inhabited territory" (12 or

[98] Palo Verde Healthcare District, Strategic Plan, 2014, p. 1.
[99] Palo Verde Healthcare District, Strategic Plan, 2014, p. 1.
[100] Palo Verde Healthcare District, Strategic Plan, 2014, p. 2.
[101] Southern California Association of Governments, *Demographics and Growth Forecast*, Technical Report, Adopted on May 7, 2020 https://www.connectsocal.org/Documents/Adopted/fConnectSoCal_Demographics-And-Growth-Forecast.pdf.

more registered voters), as defined by §56046, or as determined by commission policy. The statute allows some discretion to LAFCOs in the determination of DUCs.

In 2012, Riverside County LAFCO adopted a policy for Disadvantaged Unincorporated Communities. The guidelines for identifying DUCS are described as interim in this policy, since it was anticipated that the methods of identifying and analyzing DUCs would evolve over time. LAFCO will be revising its guidelines when Census 2020 data becomes available.[102]

According to the 2012 guidelines, a DUC in Riverside County is defined as a community of a minimum of 50 dwellings or 50 registered voters, whichever is less. LAFCO has also clarified the definition of an "inhabited area" by excluding vacant land, non-residential land and freeway/state highway rights of way on the periphery of residential areas from DUCs. Since the smallest geographic area with available median income information is a Census Block Group, LAFCO further determined that in identifying DUCs it will make an effort to differentiate between areas within a block group that are likely to have income above the specified criteria and exclude such areas from the DUC. Factors that could be considered include markedly different housing types or densities in portions of the block group.[103]

Riverside LAFCO has identified that there are 40 disadvantaged unincorporated communities in Riverside County within or near cities' spheres of influence.

There are two DUCs in PVHD near the City of Blythe including:[104]

- 10th Avenue/N. Broadway (agricultural area) and
- Colorado River Road.

[102]SB 244 Implementation-Interim Policy for Disadvantaged Unincorporated Communities, 3/22/12, https://lafco.org/wp-content/uploads/documents/archives/7.SB_244_Interim_Policy_3_22_12.pdf

[103] LAFCO, SB 244 Implementation-Interim Policy for Disadvantaged Unincorporated Communities, 3/22/12, https://lafco.org/wp-content/uploads/documents/archives/7.SB_244_Interim_Policy_3_22_12.pdf

[104] https://lafco.org/wp-content/uploads/documents/ducs/RIVCO%20Master%20DUC%20Chart.pdf

FINANCIAL ABILITY TO PROVIDE SERVICES

The financial ability of agencies to provide services is affected by available financing sources and financing constraints. This section discusses the major financing constraints faced by PVHD and identifies the revenue sources currently available to the District.

For years the District found itself in a dire financial situation and experienced continuous operational losses. In FY 13-14, PVHD experienced a loss from operations of over $6 million.[105] To address the looming crisis the District adopted a strategic plan that outlined PVHD's plan to achieve financial solvency. Since then (2015-2020), the District reorganized the hospital's departments and started controlling expenses through negotiating service contracts, purchasing new and/or refurbished equipment to reduce repair cost, and eliminating and/or combining positions and duties when staff leave. These efforts can be challenging in a rural community such as Blythe, as new recruits or agencies may require higher pay, and service vendors frequently charge higher prices due to the distance.[106]

As a result of these efforts, the financial health of the District has improved over time as is reflected by the elimination of operational losses. However, until PVHD started receiving supplemental funding through Public Hospital Redesign and Incentives in Medi-Cal (PRIME),[107] Inter-Government Transfers, disproportionate-share hospital (DSH), hospital quality assurance fee (HQAF) and other programs, the District operated at a profit margin of less than one percent. This additional program funding and expense control has allowed PVHD to continue operating and improve its profit margin.[108]

PVHD management is currently working on four new revenue streams that include Comprehensive Perinatal Services Program (CPSP) for Medi-Cal members to receive prenatal care, Medicare Wellness Program, additional services with a new Cat Scanner, and licensing for swing beds. In the near future the District is planning to expand the clinic when another nurse practitioner (NP) or a physician's assistant (PA) can be retained.[109]

Currently the hospital is in the process of converting from a General Acute Care Hospital to a CAH with swing beds, which will change the reimbursement structure providing increased funds to the hospital. In addition, the clinic is in the process of converting from an outpatient service of the hospital to a Rural Health Clinic designation, which will also increase reimbursements.[110]

After many years of financial struggles that lasted since the early 2000s, the District has now significantly improved both its financial health and the level of services provided to its constituents. More details regarding the District's financial health are available in Figure 5-3 and in the subsequent sub-sections.

[105] Palo Verde Hospital, Newsletter, March 2014.
[106] Palo Verde Healthcare District Request for Information, February 11, 2020.
[107] Through implementation of a plan approved over a five-year period, the hospital has received incentive dollars and special funding for meeting or exceeding established performance measures and the achievement of defined milestones.
[108] Palo Verde Healthcare District Request for Information, February 11, 2020.
[109] Palo Verde Healthcare District Request for Information, February 11, 2020.
[110] Palo Verde Healthcare District Request for Information, February 11, 2020.

Figure 5-3: Palo Verde Healthcare District Financial Overview, FY 17-18

Palo Verde Healthcare District Financial Overview		
Category		***FY 17-18***
Balanced Budget (rev/exp incl debt)		
Total Operating Revenues	$	21,394,966
Total Operating Expenditures (incl debt)	$	20,071,472
Net	$	1,323,494
Operating Ratio (op rev/exp incl debt&deprec)		1.1
Operating Revenues	$	21,394,966
Operating Expenditures (inc. debt & deprec.)	$	20,071,472
Debt Service	$	103,318
Depreciation	$	377,234
Current Assets		
Cash and cash equivalents	$	4,955,338
Patient accounts receivable, net allowance for doubtful accounts	$	3,971,784
Inventories	$	279,854
Estimated third-party payor settlements, net	$	442,933
Prepaid expenses and other current assets	$	162,272
Total current assets	$	9,812,181
Current Liabilities		
Accounts payable and accrued expenses	$	2,738,836
Accrued payroll and related liabilities	$	652,210
Notes payable, current portion	$	149,421
Total current liabilities	$	3,540,467
Long-term Liabilities		
Notes payable, net of current portion	$	276,791
Total long-term liabilities	$	276,791
Unrestricted Net Position/Operating Revenues		30%
Net Position	$	7,154,718
Unrestricted Net Position	$	6,421,135
Operating Revenues	$	21,394,966
Current Ratio (Short-term Liquidity)		2.8
Current Assets	$	9,812,181
Current Liabilities	$	3,540,467
Months Cash on Hand (current cash assets/expenses incl debt)		10
Current Cash Assets	$	4,955,338
Operating Expenditures (inc. debt)	$	20,071,472
Operating expenditures per day	$	54,990
Change in Net Depreciable Capital Assets (FY 18-FY 19)		-18%
Net Capital Assets, FY 17	$	1,409,504
Net Capital Assets, FY 18	$	1,159,795
Total Assets being depreciated (FY 18)	$	6,368,098
Depreciation	$	377,234
Total Reserves (% of op. expend)		
Reserve		NP
Pension and Retirement Liabilities as % of Revenues		0.4%
Total Payments FY 17-18	$	81,954
OPEB Liabilities (as of June 30, 2018)		N/A
Notes: NP = Not Provided; N/A = Not Applicable		

Financial Forecast

The District remains concerned about its future financial health. The evolving reimbursement structures of the federal, State, and private payers, along with supplemental funding continue to have an impact on hospitals like Palo Verde Hospital.[111] One of the main challenges is the uncertainty of reimbursement from Medicare. The reimbursements are not expected to increase at a rate that would match the expected operational cost increases. Medicare continues to change its reimbursement methodologies and the effect of these changes is currently unknown. Additionally, the proposed changes to Medicaid by Congress and the President may significantly impact the fiscal health of California. The State could see an estimated reduction in federal funding of $4.3 billion with the repeal of the ACA as presented. This could impact approximately five million California residents who have health plans through the Act.[112]

The District continues to participate in the AB113 program.[113] However, given the fiscal stress and cash pressures currently facing the State, it is unknown whether obtaining these funds will become more difficult or if the program will be canceled.

Although the District has made significant reductions to the bottom line it continues to review all contracts and expenditures and manage cash with payables. In addition, PVHD addresses other aspects that impact the financial status of the hospital, such as deemed status, accreditation, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores, which include patient surveys, quality of care and customer service.[114]

Financial Planning and Reporting

The California Office of Statewide Health Planning and Development (OSHPD) produces annual financial disclosure reports that provide audited data on hospital revenues, expenditures, net operating margins, and other measures of fiscal performance. Healthcare districts are also required to submit annual financial disclosure reports to the California State Controller, which uses the submitted financial data to produce an Annual Special Districts Report that provides detailed financial information by FY regarding special district revenues, expenditures, property taxes, and bonded debt. The County of Riverside Auditor and Controller produces a detailed summary of local tax information for each FY that identifies the amount of property tax allocated to the healthcare districts and reports any bonded indebtedness held by the districts. The annual healthcare district and hospital financial disclosure reports produced by the California State Controller, the County of Riverside, and OSHPD provide the public with a comprehensive overview of the annual financial status of a healthcare district, as well as the hospital facilities the district owns and/or operates.

PVHD's internal financial planning efforts include the annual budget and biennially audited financial statements. Annually the Operating Budget is presented to the PVHD Board

[111] Palo Verde Healthcare District Request for Information, February 11, 2020.
[112] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 9.
[113] California Health Facilities Financing Authority Fund provides grants to participating health institutions for financing or refinancing the acquisition, construction, or remodeling of health facilities.
[114] Palo Verde Hospital, Newsletter, March 2014.

of Directors to review and vote on acceptance. It is prepared using historical data, current information, and administration discussion.

The District, under its umbrella, makes use of the Palo Verde Healthcare Foundation, a charitable, nonprofit corporation formed in October 2005, for which the District is the sole voting member. The District's financial statements include all the assets, liabilities, and net assets of this component unit, and the foundation's financial statements are combined with those of the District. The Foundation's assets, liabilities, and net assets are not material to the District.[115]

Balanced Budget

The District's vast majority of revenue comes from patient service fees. Other sources include other operating revenue, property taxes and interest income, as can be seen in Figure 5-4.

The District receives approximately one percent of its financial support from property taxes. These funds are used to support hospital operations and are classified as non-operating revenue as the revenue is not directly linked to patient care.[116]

Operating revenues for PVHD result from exchange transactions associated with providing healthcare services, which is the District's principal activity.[117]

In FYs 16-17 and 17-18, the District derived approximately 99 percent of its total revenue from operations. Net patient service revenue includes patient care revenue from Medicare, Medi-Cal, other federal, state and local government programs, commercial insurance payers, California Department of Corrections, and self-pay patient revenue.[118] Medicare and Medi-Cal revenue accounts for just under half (42 percent in FY 17-18 and 48 percent in FY 16-17) of the District's net patient revenues.[119]

The hospital provides medical care to the community regardless of ability to pay. A patient who meets certain criteria is classified as a charity patient by reference to established policies of the District. Essentially, these policies define charity services as those services for which no payment is anticipated. Because the District does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenues. Services provided are recorded as gross patient service revenues and then written off as an adjustment to net patient service revenues. For the years ended June 30, 2018 and 2017 unbilled gross charges and amounts written off associated with charity care provided were $62,244 and $200,876 or 0.4 percent and one percent of the total net patient service revenue, respectively. The estimated costs for services and supplies furnished under the charity care policy totaled approximately $16,175 and $56,024 in 2018 and 2017, respectively.[120]

From time to time, the District receives contributions from individuals and private organizations. Revenues from contributions are recognized when all eligibility

[115] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 16.
[116] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 20.
[117] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 21.
[118] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 7.
[119] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 23.
[120] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 20.

requirements, including time requirements are met. Grants and contributions may be restricted for either specific operating purposes or capital acquisitions.[121]

Figure 5-4: Palo Verde Healthcare District Revenues and Expenditures, FY 17-18 and FY 16-17

Palo Verde Healthcare District Revenues and Expenditures				
Category	***FY 17-18***	***%***	***FY 16-17***	***%***
Operating Revenue	**$ 21,394,966**	**100%**	**$ 21,752,064**	**100%**
Net patient service revenue	$ 17,726,695	82.9%	$ 18,004,084	82.8%
Other operating revenue	$ 3,668,271	17.1%	$ 3,747,064	17.2%
Operating Expenditures	**$ 20,071,472**	**100.0%**	**$ 21,426,134**	**100.0%**
Salaries and wages	$ 8,214,428	40.9%	$ 8,970,367	41.9%
Employee benefits	$ 1,598,015	8.0%	$ 1,956,512	9.1%
Physician fees and medical professional fees	$ 2,256,030	11.2%	$ 2,131,178	9.9%
Purchased services	$ 3,202,276	16.0%	$ 2,865,105	13.4%
Professional fees	$ 154,944	0.8%	$ 442,170	2.1%
Supplies	$ 1,769,604	8.8%	$ 2,081,134	9.7%
Facilities, equipment and maintenance	$ 1,203,123	6.0%	$ 1,161,334	5.4%
Insurance	$ 797,625	4.0%	$ 767,186	3.6%
Depreciation and amortization	$ 377,234	1.9%	$ 458,395	2.1%
Interest	$ 11,462	0.1%	$ 18,206	0.1%
Other expenses	$ 486,731	2.4%	$ 574,547	2.7%
Net Operating Income	**$ 1,323,494**		**$ 325,930**	
Debt Service				
Net Operating Income After Debt				
Non-operating Income and Expenditures				
District tax revenues	$ 161,892		$ 142,147	
Interest income	$ 7,613		$ 10,354	
Total Non-operating income (loss)	$ 169,505		$ 152,501	
Net After Non-Operating Income/Expenditures	**$ 1,492,999**		**$ 478,431**	
Beginning Net Position	**$ 5,661,719**		**$ 5,183,288**	
Ending Net Position	**$ 7,154,718**		**$ 5,661,719**	

Operating expenses are all expenses incurred to provide healthcare services, other than financing costs.[122] The District's largest expenditure is salaries, wages and benefits. The shortage in the area for nurses, health professionals, and qualified hospital managers requires the use of contract labor. Contract labor increased from FY 16-17 to FY 17-18 by approximately $526,386. The hospital continues its efforts to minimize the use of contract labor.[123]

A part of the District's ongoing expenses are facility rental fees. The District leases office space and equipment under non-cancelable operating lease agreements expiring at various dates through September 2020. The District subleases suites within its leased medical office building under sublease agreements expiring through August 2018. The medical office building lease was renewed effective September 1, 2018 for a 10-year period with initial rent of $16,581 per month, increasing annually by three percent. The subleases were renewed

[121] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 21.
[122] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 21.
[123] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 8.

upon their expiration for a three-year period with substantially the same terms. Total building and equipment rent expense for the year ended June 30, 2018 was $383,634. Total rental income during the same year was $88,908.[124]

Fund Balances, Reserves and Liquidity

Fund balances and reserves should include adequate funds for cash flow and liquidity, in addition to funds to address longer-term needs. The District's FY 17-18 financial statements report a total of $9,812,181 in current assets out of which $4,955,338 is cash or cash equivalents with $3,540,467 of current liabilities, as shown in Figure 5-3. The District has enough cash on hand to cover about 10 months of its operating expenditures.

The District's long-term debt consists of a mortgage of $199,380 as of June 30, 2018 owed to Berkadia Commercial Mortgage, LLC under a USDA loan program. The annual payment including interest is $103,318. The final payment of the note was due in October 2019. Additionally, Palo Verde Valley Community Improvement Fund loaned the District funds to aid in the new electronic health record software implementation in 2016. As of June 30, 2018, the District owed $226,832 under this loan agreement. The payments started on October 1, 2018; they amount to $76,782 annually including interest.[125] This loan is due September 2021 and payable in monthly principal and interest payments of $6,398. Based on the repayment schedules for these two loans, PVHD will be debt-free by FY 22-23.

The District reported that any funds remaining at the end of the FY are used towards capital purchases or infrastructure projects in the following FY. This allows the District to retain low long-term debt. The District has also established reserves to pay for the approved infrastructure projects and capital expenditures, along with funds held for a "rainy day." PVHD assesses annually the needs and available funds. As funds are generally limited, the District constantly looks for other sources of financing such as programs provided from Medi-Cal and USDA.[126] PVHD has not provided the information on its current reserve balance.

Net Position

An agency's "Net Position" as reported in its audited financial statements represents the amount by which assets (e.g., cash, capital assets, other assets) exceed liabilities (e.g., debts, unfunded pension and OPEB liabilities, other liabilities). A positive Net Position provides an indicator of financial soundness over the long-term. As shown in Figure 5-3, the FY 17-18 ending net position for the District was $7,154,718 indicating stability with its ongoing general operations. PVHD had an unrestricted net balance of $6,421,135 (or 90 percent of the total net position) at the end of FY 17-18; the balance of its net position (assets exceeding liabilities) is invested in capital assets.

As a matter of possible future obligations, the District is involved in numerous legal proceedings arising out of the normal course of its business. However, these matters are expected to be resolved without material adverse effect on the District's future financial position.[127]

[124] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 26.
[125] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 5.
[126] Palo Verde Healthcare District Request for Information, February 11, 2020.
[127] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 26.

Pension and OPEB Liabilities

Unfunded pension and OPEB liabilities present one of the most serious fiscal challenges facing many special districts in California today. PVHD does not have any liabilities related to defined benefit pension plan or defined benefit OPEB plan.

The Palo Verde Hospital 401(a) Retirement Plan is a defined contribution money purchase retirement savings plan established to provide retirement benefits for all eligible employees. The hospital makes a matching contribution equal to 100 percent of eligible employee contributions, up to a maximum of three percent of employee compensation. Employer contributions to this plan in FYs 17-18 and 16-17 were $81,954 and $109,561 representing 0.4 and 0.5 percent of operating revenues, respectively.

Capital Assets

Capital assets must be adequately maintained and replaced over time and expanded as needed to accommodate future demand and respond to regulatory and technical changes.

As a general indicator, the California Municipal Financial Health Diagnostic compares changes in the value of assets and asset improvements.[128] Persistent and substantially negative trends, particularly without a reasonable plan for stabilizing declines, raise caution and warning signs. This negative condition can occur if repairs and replacements do not keep pace with aging infrastructure.

Depreciation typically spreads the life of a facility over time to calculate a depreciation amount for accounting purposes. The actual timing and amount of annual capital investments require detailed engineering analysis and will differ from the annual depreciation amount, although depreciation is a useful initial indicator of sustainable capital expenditures.

Capital assets acquisitions are recorded at cost. Donated property is recorded at the asset's estimated fair market value at the time the donated property is received. Equipment under capital lease and leasehold improvements are amortized on the straight-line method over the shorter of the lease term or the assets estimated useful life. [129]

The District's capital assets include land and construction-in-progress (which are non-depreciable) and buildings and improvements, as well as equipment and clinic (which all depreciate). As of June 30, 2018, the District had $7,163,095 in capital assets (depreciable and non-depreciable) and $6,003,300 in accumulated depreciation, resulting in $1,159,795 net capital assets. [130] The value of depreciable assets decreased by about 18 percent from FY 16-17 to FY 17-18, as shown in Figure 5-3. The District's FY16-17/FY 17-18 financial statements do not show enough additions to depreciable asset value to offset the depreciation of $377,234 for that year. The District, however, determined that no capital assets are currently significantly impaired.[131]

The District plans for its infrastructure needs in the capital budget updated every three years through a review process by hospital management and approved by the PVHD Board

[128] The California Municipal Financial Health Diagnostic: Financial Health Indicators, League of California Cities, 2014.
[129] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 19.
[130] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 24.
[131] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 19.

of Directors. For the immediate future, any major facilities projects will be focusing on meeting the requirements of the California seismic safety law – SB 1953. The District's infrastructure needs are discussed in more detail in the *Infrastructure Needs* section.

HEALTHCARE SERVICES

Service Overview

Background

PVHD was formed in 1948 to purchase, reopen and operate the already existing hospital owned at the time by the Palo Verde Healthcare Association.[132] In the 1990s, the hospital encountered financial difficulties as a result of which the District leased it to Brim Healthcare, Inc. for management and operation. In 2002, the newly elected PVHD Board of Directors challenged the lease and made the decision to terminate the lease agreement.[133] Lifepoint Hospital Inc. took over the operations of the hospital under the new lease agreement. However, in 2005, Lifepoint Hospital, Inc. terminated the lease and the District took back control of the hospital operations.[134] PVHD continues to be responsible for operating the Palo Verde Hospital. While the Board is the governing body of the District, it works in conjunction with Palo Verde Hospital's CEO to manage the day-to-day operations of the hospital.

Services

The Palo Verde Hospital operates twenty-four hours a day[135] and offers a full range of services from maternity to end of life palliative and/or hospice care.[136] The hospital is licensed for 51 acute care beds and is designated as a sole community government hospital offering a continuum of medical, surgical and obstetrical services. The hospital also provides basic emergency services with a physician on duty at all times. Patients of all ages are evaluated and treated in the ED. Major trauma patients are not routed to the facility by emergency medical service (EMS) providers.[137]

General acute medical, surgical and obstetrical services are offered on an inpatient and outpatient basis. The hospital does not perform invasive, interventional cardiac or surgical procedures. Pediatric patients with non-life-threatening conditions are admitted to the facility on an infrequent basis. Pediatric patients or newborns needing intensive care services are transferred from the ED to facilities providing those services.[138]

PVHD has recently decided to convert the hospital from a general acute to a critical access facility with implementation of swing bed program and applied for this designation to the Center for Medicare and Medicaid Services (CMS).[139] The conversion was expected to be completed in August 2020;[140] however, the process was reportedly delayed due to the COVID-

[132] https://www.paloverdehospital.org/54/About-Us
[133] LAFCO 2005-07-4 -Sphere of Influence Review and Potential Amendment – Palo Verde Healthcare District.
[134] https://www.paloverdehospital.org/62/History
[135] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 3.
[136] https://www.paloverdehospital.org/54/About-Us
[137] Palo Verde Healthcare District, Strategic Plan, 2014, p. 1.
[138] Palo Verde Healthcare District, Strategic Plan, 2014, p. 1.
[139] Critical access hospitals (CAHs) have a unique reimbursement and organizational structure. They are small, located in remote or rural parts of the state, and are frequently the only provider of health care services in a community. To be designated a critical access hospital, an institution must: 1. Maintain a maximum of 25 acute care beds and up to ten additional beds for psychiatric and rehabilitative services; 2. Be located in a rural area or 35 miles from the nearest hospital (15 miles in areas with secondary roads); 3. Furnish 24-hour emergency care services (staff may be on-call versus on-site); and 4. Have an average annual length of stay of 96 hours or less.
[140] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 3.

19 pandemic. The conversion is expected to take another year. This designation is aimed at reducing the financial vulnerability of rural hospitals and improving access to healthcare by keeping essential services in rural communities.[141]

The Palo Verde Hospital is supported by the Palo Verde Hospital Foundation that operates under the umbrella of the District and was formed in 2006 with the purpose of fundraising and building a donor base to support hospital operations.[142]

PVHD additionally operates a hospital-based clinic, which was licensed and started providing outpatient services in 2014.[143]

The District also provides a number of benefits and services to the community for which it receives no reimbursement or where only a nominal fee is charged. These services include community medical and wellness education programs, medical screenings, support groups and other services. [144]

Collaboration and Partnerships

The hospital, since 2016, has participated in a State-funded incentive program called Public Hospital Redesign and Incentives in Medi-Cal Program (PRIME). The program is a funding mechanism for the District, but the most important component of the program is the integration of physical and behavioral health delivery services through our hospital-based clinic and hospital outreach personnel who work to implement the required strategies for referrals, collaboration, and data retrieval. These post-hospital outreach services are designed to help residents manage chronic illnesses and conditions through education and referral to community resources. [145]

In addition to the PRIME Program, the hospital has worked with the National Rural Accountable Care Organization, a not-for-profit organization that supports healthcare transformation. The aim of the program is to transform rural practice in order to improve care, while reducing unnecessary healthcare costs, and improve patient satisfaction. Through a working relationship with the organization, the hospital has linked into physical and behavioral health delivery services that promotes wellness for older patients while assisting them with their integrated health needs. These health and wellness services include alcohol screening, depression screening, vaccination screening and fall-prevention screening. [146]

The hospital is a member of the Hospital Association of Southern California.[147] The District also works with California Hospital Association (CHA) approved vendors to participate in Health Information Exchange.[148]

PVHD additionally aims to establish affiliations with larger hospital facilities, systems or teaching institutions. One potential partner that the District is interested in collaborating

[141] https://www.ruralhealthinfo.org/topics/critical-access-hospitals
[142] https://www.paloverdehospital.org/129/Palo-Verde-Hospital-Foundation
[143] Palo Verde Hospital, Newsletter, March 2014.
[144] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 20.
[145] Palo Verde Hospital, Newsletter, Third Quarter 2019.
[146] Palo Verde Hospital, Newsletter, Third Quarter 2019.
[147] https://www.hasc.org/member-hospital/palo-verde-hospital
[148] Palo Verde Hospital, Strategic Goals for Calendar Year 2020, Updated April 2020.

with is Adventist Health System. The District is also working on establishing links with healthcare organizations in Indio through the ED.[149]

PVHD continuously attempts to build community partnerships through the donations of time and funds to such projects as the local schools, youth sports programs, scholarships and various service clubs that are active in the community.[150]

Contract Services

The District currently does not contract with an independent company or an organization for the lease and operation of the Palo Verde Hospital. PVHD is the direct provider of hospital services. However, the District has service contracts with various health professionals and hospital managers, as was previously discussed in the *Financial Ability to Provide Services* section.

Service demand

Since Palo Verde Hospital is located in Blythe, which is a rural community, the nearest hospitals are in Brawley, 95 miles south, Needles 97 miles northeast, and Indio 112 miles west.[151] This is why the PVHD hospital serves secondary service area outside of its boundaries, which extends to the town of Palo Verde to the south, Quartzsite to the east, Desert Center and Brawly to the west, and Parker Arizona to the north. Other out of area hospital patients include seasonal visitors and travelers passing through the area between Arizona and California.[152] There is a significant Medicare population within the primary and secondary service areas. [153] The District is urged to consider annexing its secondary service area in Riverside County, which is currently outside of a healthcare district. The annexation would better reflect its service area and provide additional revenue in the form of property taxes which would in turn improve the District's ability to continue providing services to these communities. PVHD reported that it would need to identify the impact of the annexation to be able to determine its feasibility.

[149] Palo Verde Hospital, Strategic Goals for Calendar Year 2020, Updated April 2020.
[150] https://www.paloverdehospital.org/54/About-Us
[151] Grand Jury Report, Palo Verde Healthcare District, 2007-2008.
[152] Palo Verde Healthcare District, Strategic Plan, 2014, p. 1.
[153] Palo Verde Healthcare District, Strategic Plan, 2014, p. 6.

Figure 5-5: Palo Verde Hospital Utilization Data

Palo Verde Hospital Utilization				
2018	***2017***	***2016***	***2015***	***2014***
Total Licensed Bed Days				
18,615	18,615	18,666	18,615	18,615
Total Census Days				
2,110	2,336	2,520	3,007	3,432
Total Discharges				
785	860	843	1,023	963
Emergency Department Total Traffic				
9,433	9,492	9,664	10,386	9,664
Ambulance Diversion Hours				
9	2	0	0	0
Inpatient Surgeries Operating Room Minutes				
9,846	11,467	18,465	21,263	18,678
Outpatient Surgeries Operating Room Minutes				
15,331	18,780	37,800	42,234	50,864
Inpatient Surgical Operations				
272	323	261	245	271
Outpatient Surgical Operations				
501	596	698	824	745

Source: The Office of Statewide Health Planning and Development (OSHPD)

Figure 5-5 shows service demand at the Palo Verde Hospital between 2014 and 2018. As is shown, hospital utilization went down over the five-year period, particularly in the case of surgeries. The District reported that the decline in demand may be attributed to the lack of medical specialists at the Palo Verde Hospital which causes residents to seek medical care outside of the area, especially when major surgeries are required. On the other land, the demand for emergency room services had remained largely the same over the same time period. However, the District reported that since the hospital-based clinic opened the demand for ER services declined because some of the traffic shifted from the ED to the clinic, particularly for non-emergency cases. The primary care clinic currently provides approximately 200 visits per month.[154]

The District also reported that the PVHD's service demand has been negatively affected by the COVID-19 pandemic since many people choose to avoid visiting the hospital if possible and postpone elective surgeries.

The ambulance diversion hours indicator shows emergency room unavailability over the course of the year. It appears that in every one of the five years shown in Figure 5-5 the emergency room was largely available full time. In 2018, the ED did not accept ambulance transport for only nine hours during the entire year.

Figure 5-6 depicts patient demand information for Palo Verde Hospital in 2018 (the most recent complete year of information available at the time of drafting of this report). The Figure shows the breakdown of the hospital licensed beds by type and service demand for each bed type. It appears that medical/surgical acute and perinatal beds have equally high demand per bed, with intensive care beds experiencing much lower demand.

[154] California Department of Health Care Services, *Public Hospital Redesign and Incentives in Medi-Cal (PRIME) 5-Year PRIME Project Plan*, 2016.

Figure 5-6: Hospital Service Demand, 2018

Inpatient Bed Utilization			
Licensed Bed Classification / Designation	***Licensed Beds (incl. in susp.)***	***Patient Days***	***Hospial Discharges***
Medical/Surgical Acute (includes GYN/DOU)	41	1841	650
Perinatal (includes LDRP, excludes nursery)	6	250	125
Pediatric Acute	0	0	0
Intensive Care	4	19	10
Coronary Care	0	0	0
Acute Respiratory Care	0	0	0
Burn Center	0	0	0
Intensive Care Newborn Nursery	0	0	0
Rehabilitation Center	0	0	0
Sub-total - General Acute Care	**51**	**2110**	**785**
Acute Psychiatric	0	0	0
Chemical Dependency Recovery Hospital (CDRH)	0	0	0
Intermediate Care	0	0	0
Intermediate Care/Developmentally Disabled	0	0	0
Skilled Nursing	0	0	0
Hospital Total	**51**	**2110**	**785**

Figure 5-7 also demonstrates high demand for medical/surgical acute beds. The Figure also indicates that patients generally stay longer in the Acute Care Unit than the Perinatal unit or the ICU.

The chronic disease burden in Riverside County is significant, which is also reflected in the PVHD population. Thirty three percent of residents report having one chronic condition, 11 percent report two, and three percent report having three to five chronic conditions. The most significant health issues facing PVHD community are heart disease, COPD and diabetes.[155]

Behavioral health issues are also a challenge for the District. Nine percent of local residents reported serious psychological distress. Residents also report having four poor mental health days per month. Eighteen percent of local residents self-report excessive drinking, and 25 percent of residents report insufficient social/emotional support and are thereby challenged in navigating daily life and maintaining good mental health.[156]

Nearly 15 percent of the population in the Blythe community are disabled. [157]

Although the utilization data indicates a decline in service demand, the District is expecting that the need for hospital services will grow as the community grows and as the hospital continues improving its service levels and offers a greater range of services.

[155] California Department of Health Care Services, *Public Hospital Redesign and Incentives in Medi-Cal (PRIME) 5-Year PRIME Project Plan*, 2016.
[156] California Department of Health Care Services, *Public Hospital Redesign and Incentives in Medi-Cal (PRIME) 5-Year PRIME Project Plan*, 2016.
[157] California Department of Health Care Services, *Public Hospital Redesign and Incentives in Medi-Cal (PRIME) 5-Year PRIME Project Plan*, 2016.

Figure 5-7: Hospital Service Demand by Inpatient Bed Type, 2018

Inpatient Bed Utilization			
Licensed Bed Classification / Designation	***Average Length of Stay***	***Licensed Bed Days***	***Licensed Bed Occupancy Rate (%)***
Medical/Surgical Acute (includes GYN/DOU)	2.8	14,965	12.3%
Perinatal (includes LDRP, excludes nursery)	2.0	2,190	11.42%
Pediatric Acute	0.0	-	0%
Intensive Care	1.9	1,460	1.3%
Coronary Care	0.0	-	0%
Acute Respiratory Care	0.0	-	0%
Burn Center	0.0	-	0%
Intensive Care Newborn Nursery	0.0	-	0%
Rehabilitation Center	0.0	-	0%
Sub-total - General Acute Care	**2.7**	**18,615**	**11.33%**
Acute Psychiatric	0.0	-	0%
Chemical Dependency Recovery Hospital (CDRH)	0.0	-	0%
Intermediate Care		-	0%
Intermediate Care/Developmentally Disabled		-	0%
Skilled Nursing	0.0	-	0%
Hospital Total		**18,615**	**11.33%**

Planning and Management

As part of its planning efforts, PVHD has adopted a CIP and a strategic plan. The CIP addresses the District's infrastructure needs and was previously discussed in the *Financial Ability to Provide Services* section.

The District first adopted a strategic plan in 2014 to address the growing financial and service concerns. Since then, PVHD annually updates the strategic goals and monitors their implementation. Of primary importance to strategic planning is the economic environment of the State of California and Riverside County, the fiscal policies of the state and federal governments, the availability and affordability of labor, the general rise in healthcare related costs, the impact of healthcare reform and the local and regional competition for healthcare service. [158]

The Palo Verde Hospital also operates with guidance from its Strategic Plan document.

[158] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 9.

Staffing

Figure 5-8: Palo Verde Hospital Staffing, 2017

Palo Verde Hospital Staff	
Clinical Specialty	***Number***
Active Medical Staff - Hospital Based - Board Certified	
General Surgery	2
Internal Medicine	1
Obstetrics and Gynecology	1
Colon and Rectal Surgery	2
Gastroenterology	1
Diagnostic Radiology	1
General/Family Practice	3
Radiology	1
Active Medical Staff - Non-Hospital Based - Board Certified	
Urology	1
Pathology	1
Active Medical Staff - Non-Hospital Based - Other	
Anesthesiology	2

Source: The Office of Statewide Health Planning and Development (OSHPD)

PVHD operations are broken down into multiple departments that consist of accounts payable, administration, cardio, dietary, HIM, IT, laboratory, nursing, pharmacy, plant operations, radiology, and human resources.[159]

The staffing information for Palo Verde Hospital provided by OSHPD for 2017 (the most recent available year as of the drafting of this report) is included in Figure 5-8. In 2017, the hospital contracted with 16 FTE medical doctors (MDs).

The hospital is considered a rural facility and has a limited number of physicians and allied professionals on the active medical staff.[160] Currently, PVHD employs or contracts with approximately 120 FTEs. The hospital does not have any unionized labor at the facility. [161] The District's Board along with the hospital's CEO manage the day-to-day operations of the hospital.

The District continues to recruit and retain the services of physician specialists. The primary focus is on the specialties of anesthesia, orthopedic surgery, general surgery, pediatrics, cardiology, nephrology, and urology. There is also a need for a female obstetrician. Currently, patients in need of tertiary care services are referred or transferred to regional centers.[162]

The District reported that it recently had to institute temporary lay-offs and furloughs caused by the COVID-19 pandemic which negatively affected the hospital's utilization.

Facilities

PVHD owns and operates the Palo Verde Hospital. The facility is located in the city of Blythe, approximately 225 miles east of Los Angeles. [163]

The hospital was first established in 1925 when the American Legion turned over its clubhouse to be used as a hospital, named Palo Verde Health Center. In 1937, the facility which is now known as the Palo Verde Hospital opened its doors as an official unit of the County Medical Administration, as the Blythe Branch of Riverside County Hospital. Over the

[159] Palo Verde Healthcare District, Annual Review of Contract Services, 2019.
[160] Palo Verde Healthcare District, Strategic Plan, 2014, p. 1.
[161] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 3.
[162] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 10.
[163] Palo Verde Healthcare District, Strategic Plan, 2014, p. 1.

years, the hospital has changed hands and been periodically temporarily closed especially during hot summer months.[164]

The hospital was first a small 25-bed facility that provided healthcare services to the Blythe community and surrounding areas until the early 1960s. As the community continued to grow and demand for additional services increased, the hospital expanded in 1962 and again in 1979.[165]

The hospital is comprised of five separate structures that include buildings A, B, C, D, and E. Buildings A, D and E are the original hospital structures. They were constructed in 1937. Buildings B and C were built in 1961 and 1978, respectively.[166] Now, the hospital includes 51 patient beds consisting of 41 medical-surgical beds, six perinatal beds, four intensive care beds, and two surgical suites[167] and has a total building area of approximately 39,000 square feet on a site of 1.7 acres.[168]

The District also operates a hospital-based clinic, which is licensed as an outpatient service of the hospital and is organized to deliver integrated health care services for the community. The clinic currently provides services Monday through Thursday, 9:00 a.m. until 5:30 p.m. It is operated by a NP, and the District is in the process of recruiting a second NP in order to open the clinic at least six days a week.[169] PVHD is also currently seeking to obtain the accreditation of a rural health clinic for this facility, which is expected to be finalized by fall 2020.

Infrastructure Needs

In terms of the PVHD's short-term infrastructure projects, the District's 2019-2020 strategic goal is to obtain funding to purchase and/or replace aging and outdated hospital equipment. Additionally, the District has plans to purchase IV controllers, institute a Mindray integration program, replace of boiler tanks, and conduct CT architectural plans. The hospital also recently had to make some unplanned equipment purchases related to the COVID-19 pandemic, as was mentioned before in the *Challenges* section.

Larger-scale infrastructure needs for the immediate future will be focusing on meeting the requirements of the California seismic safety law – SB 1953. While the hospital engaged the services of an outside architectural and engineering firm to assist in this endeavor, anticipated costs are not currently available for the non-structural repairs associated with NPC-2 and NPC-3 requirements.[170] The hospital will identify and evaluate the planning concepts and associated costs to affect the structural repairs (SPC-2) required for the

[164] https://www.paloverdehospital.org/54/About-Us
[165] https://www.paloverdehospital.org/62/History
[166] Grand Jury Report, Palo Verde Healthcare District, 2007-2008.
[167] https://www.paloverdehospital.org/54/About-Us
[168] https://www.paloverdehospital.org/62/History
[169] Palo Verde Hospital, Newsletter, Third Quarter 2019.
[170] OSHPD has developed a Structural Performance Category (SPC 1-5) rating for hospitals that indicates the building's compliance with seismic safety standards; and a Non- Structural Performance Category (NPC 1-5) rating that indicates the hospital facility's equipment and systems conformance with seismic standards for adequate anchorage and bracing of non-structural features such as electrical, mechanical, plumbing and fire safety systems for their continued use following a disaster event. Structural/Non-Structural Performance Category 4-5 designations indicate facility conformance with the seismic standards; SPC/NPC 1-3 designations indicate nonconformance with seismic standards and include specific required deadlines to achieve conformance.

ongoing use of building B. The District has three SPC1 buildings which the State has listed as general acute care, providing patient care and/or patient support services. [171]

State law allows general acute care hospitals until 2030 to update SPC-2 buildings used for patient care to seismic compliance. [172]

Capacity

The population in Blythe has decreased over the past five to seven years, so the majority of the services offered by PVHD is adequate to serve the existing community, as reported by the District. The hospital-based clinic, however, currently has limited capacity due to the lack of medical professionals available to staff it.[173]

The capacity of the hospital is additionally strained by the lack of available medical professionals in the area. The community struggles with the availability of physicians, many of whom are expected to retire in the near future. PVHD has a goal of filling this anticipated service gap.[174]

In regard to facility capacity, Figure 5-7 in the *Service Demand* section depicts that there is an overall sufficient capacity to accommodate patient demand for the hospital's inpatient services based on the occupancy rate of licensed beds. However, although there appears to be overall sufficient capacity in terms hospital beds, the presence of MUAs and healthcare shortage areas within the District discussed in the *Challenges* section once again reaffirm the previously discussed problem with the availability of medical staffing in the area.

Challenges

The District reported that the community as a whole is struggling with such issues as a significant homeless population including transients from Arizona and Brawly, drug abuse, a significant percentage of the population with mental health issues and limited related services, diabetes, obesity, chronic conditions common in elderly patient population including heart disease, hypertension and arthritis, and wounds of the lower extremities due to peripheral vascular disease and diabetes. [175]

In the context of these challenges, there is little preventative care for the uninsured, few prenatal services for women, and hesitancy to seek prenatal healthcare, the overload of the ED with patients that are unable to pay and treat the department as a clinic, limited home health services in the community, only one skilled nursing facility for the community, absence of a registered nurse (RN) program associated with Palo Verde College, and limited social services resources available.[176]

[171] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 27.
[172] Armanino, Palo Verde Healthcare District Financial Statements, June 30, 2018 and 2017, p. 10.
[173] Palo Verde Healthcare District Request for Information, February 11, 2020.
[174] Palo Verde Healthcare District Request for Information, February 11, 2020.
[175] Palo Verde Healthcare District, Strategic Plan, 2014, p. 4.
[176] Palo Verde Healthcare District, Strategic Plan, 2014, p. 5.

One-third of the population receives Medi-Cal benefits. Despite recent insurance enrollment efforts, 28 percent of adults in the Blythe community remain uninsured, as do 10 percent of children under age 19.[177]

In addition, if the ACA is repealed, a high ratio of PVHD constituents will lose their healthcare coverage, which in turn will negatively affect the hospital's revenue stream. The District is already challenged with limited financial resources as was previously described in the *Financial Ability to Provide Services* section. The District's revenues have also been negatively affected by the COVID-19 pandemic since people largely choose to postpone hospital visits, which affects the facility utilization. Moreover, the hospital had to purchase additional equipment, such as ventilators to prepare for a possible surge in COVID-19 cases in the community. Obtaining Personal Protective Equipment (PPE) was identified by PVHD as one of the major challenges during this pandemic. The District also has been experiencing some staffing challenges due to the COVID-19 where there is an excess of staff within certain job categories and an increase of workload for staff within others. PVHD had to recreate work schedules and rearrange work space to allow for the appropriate distancing between staff. The demand and the costs for traveling medical professionals have been identified as significant challenges during this pandemic as well.

The District additionally struggles with attracting qualified medical and professional employees to fulfill the existing service needs and allow for the expansion of both the clinic and hospital services. The shortage in the area for nurses, healthcare professionals, and qualified hospital managers requires the use of contract labor, which increases the costs.

Figure 5-9: Medically Underserved Areas and Primary Care Health Care Professional Shortage Areas in Palo Verde Healthcare District

The lack of available medical professionals in the District's service area and the surroundings is further reflected in the presence of MUAs and healthcare professional shortage areas in PVHD. OSHPD produces maps for all California counties that define medically underserves areas (MUAs) and HPSAs. MUAs are based on the evaluation criteria established through federal regulation to identify geographic areas or population groups based on percentage of population at 100 percent below poverty, population over 65 years old, infant mortality rate, and primary care physicians per 1,000 people. HPSAs are identified for primary care, nursing, mental health, and dental healthcare professionals. OSHPD has identified one MUA and one HPSA in PVHD;

Medically Underserved Areas and Health Care Professional Shortage Areas in Desert Healthcare District

Medically Underserved Area	**Chairaco Summit/Desert Center Service Area 00256**	**Location**
Census Tract	469	Outside of PVHD
Census Tract	9810	In PVHD
Primary Care Health Care Professional Shortage Area	**MSSA 126&127/Blythe/ Chiriaco Summit**	
Census Tract	459	In PVHD
Census Tract	461.01	In PVHD
Census Tract	461.02	In PVHD
Census Tract	461.03	In PVHD
Census Tract	462	In PVHD
Census Tract	469	Outside of PVHD
Census Tract	470	In PVHD
Census Tract	9401	In PVHD
Census Tract	9810	In PVHD

Source: Health Resources and Services Administration

[177] California Department of Health Care Services, *Public Hospital Redesign and Incentives in Medi-Cal (PRIME) 5-Year PRIME Project Plan*, 2016.

however, both stretch outside of the District's boundaries, as shown in Figures 5-9. As can be seen from Figures 5-10 and 5-11, almost the entirety of the District is considered medically underserved.

Figure 5-10: Medically Underserved Area Map

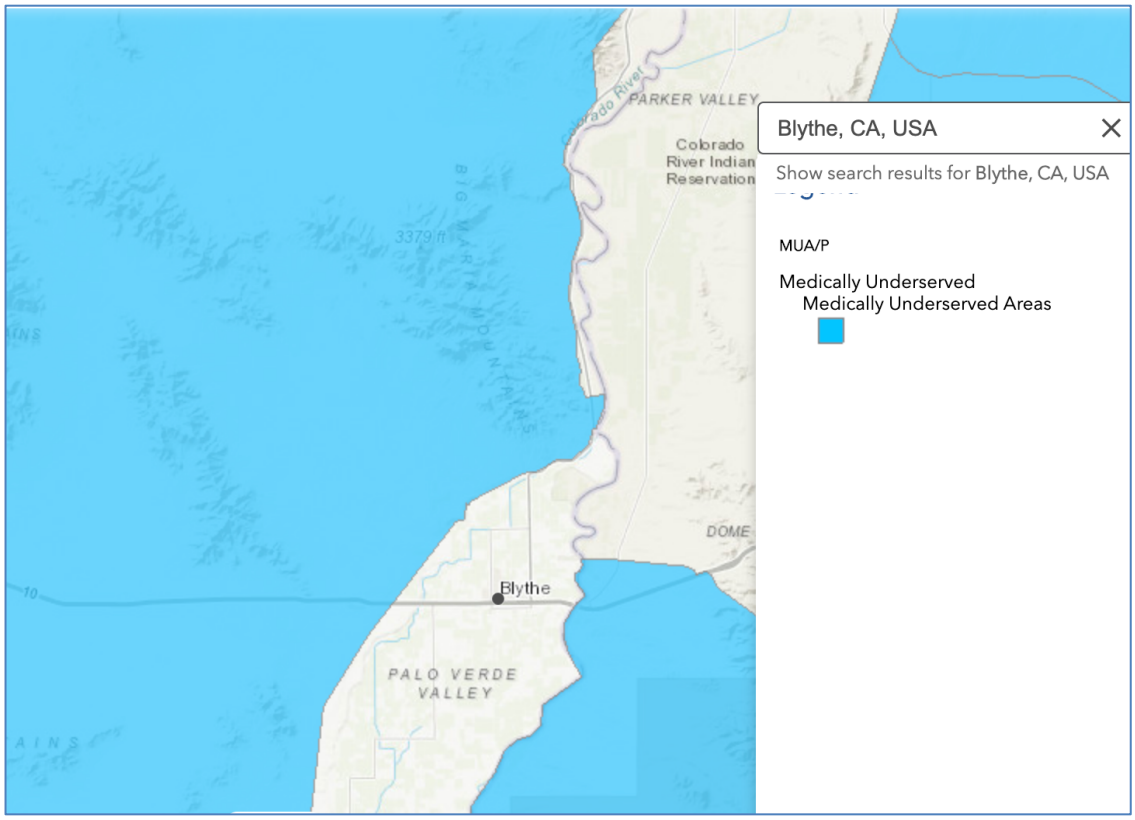
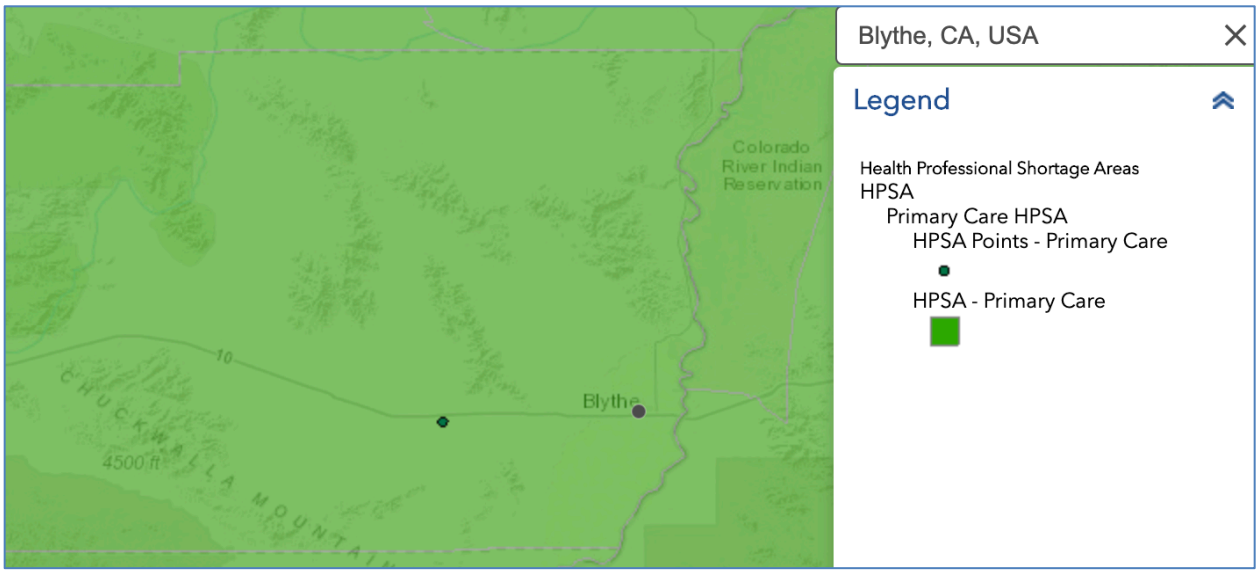


Figure 5-11: Primary Care Health Care Professional Shortage Area Map



Service Adequacy

There are several benchmarks that may define the level of healthcare service provided by a healthcare district that operates a hospital. Indicators of service adequacy discussed here include 1) PQIs, 2) IMIs, 3) hospital volume indicators, 4) EMS ambulance diversion rates, 5) the extent to which residents go to other hospitals for service, 6) patient satisfaction, 7) hospital safety, and 8) accreditation.

Although this data is not available specifically for PVHD or even for Coachella Valley, it is important to discuss PQIs.[178] Figure 5-12 shows that overall Riverside County's rates do not largely differ from statewide rates. For uncontrolled diabetes and asthma in young adults, the Riverside County rates were lower than statewide rates by a larger margin than all other indicators, suggesting that residents in the County have better access to outpatient care for these diseases compared to statewide. 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. The short-term diabetes complications and community acquired pneumonia rates in Riverside County, on the other hand, were higher than statewide rates by a large margin.

Figure 5-12: Risk Adjusted Rates per 1,000 Population

Year	*Region*	*Diabetes Short-term Complications*	*Diabetes Long-Term Complications*	*COPD or Asthma in Older Adults (Ages 40+)*	*Hypertension*	*Heart Failure*	*Community-Acquired Pneumonia*	*Urinary Tract Infection*
2017	Statewide	38.4	90.6	299.1	40.5	330.4	108.4	101.3
	Riverside	41.9	89.5	286	37.7	292.5	115.1	104
	Difference with statewide	9%	-1%	-4%	-7%	-11%	6%	3%
2018	Statewide	58.1	88.4	229	41.5	335.4	107	93.3
	Riverside	67.4	92.9	208.3	41.2	309.5	125.1	98.9
	Difference with statewide	16%	5%	-9%	-1%	-8%	17%	6%

Year	*Region*	*Uncontrolled Diabetes*	*Asthma in Young Adults (Ages 18-39)*	*Lower-Extremity Amputations Among Patients with Diabetes*	*Overall Composite*	*Acute Composite*	*Chronic Composite*	*Diabetes Composite*
2017	Statewide	31.9	19.5	24.7	947.1	209.7	736.3	172.5
	Riverside	26	16.5	23.1	905.6	219.6	683.6	168.2
	Difference with statewide	-18%	-15%	-6%	-4%	5%	-7%	-2%
2018	Statewide	30.3	18.5	25.9	919.6	200.3	718.3	189.8
	Riverside	26.1	15.7	25.8	916	224.2	689.7	196.8
	Difference with statewide	-14%	-15%	0%	0%	12%	-4%	4%

Source: The Office of Statewide Health Planning and Development (OSHPD)

IMIs reflect quality of care by measuring inpatient mortality rates for individual hospitals against state averages for specific medical conditions and surgical procedures. Evidence suggests that high mortality rates may be associated with deficiencies in the quality of hospital care provided. The most recent information regarding IMIs is available from OSHPD for 2015 (January-September).[179] The information available includes risk-adjusted mortality rates for six medical conditions treated (acute stroke, acute myocardial infarction, heart failure, gastrointestinal hemorrhage, hip fracture and pneumonia) and six procedures

[178] 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 hospitalization or for which early intervention can prevent complications or more severe disease. The Prevention Quality Indicators represent hospital admission rates for 4 ambulatory care sensitive conditions.

[179] Data is reported for January-September due to coding changes for diagnosis and procedures, which began on October 1, 2015.

performed (abdominal aortic aneurysm repair, carotid endarterectomy, craniotomy, esophageal resection, pancreatic resection, PCI in California hospitals. PVHD's mortality rates for all medical conditions and procedures were not statistically different from the statewide rates.

The ambulance diversion rate is another indicator of a hospital's service adequacy. Ambulance diversion may occur due to emergency room closure, inability to accommodate the incoming volume of patients or the inability to transfer admitted patients from the ED to inpatient beds. Ambulance diversion has been found unsafe for patients because it increases transport times, which interferes with continuity of care, causes delays, and increases mortality for severe trauma patients.[180] Figure 5-5 in the *Service Demand* section indicates that the hospital's ED is largely able to accommodate the incoming volume of patients at all times.

The adequacy of hospital facilities and services in meeting the needs of district 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 origin discharge data from OSHPD.[181] Residential location was approximated by the zip codes. About 75 percent of all the hospital patients from the District patronize the Palo Verde Hospital based on the OSHPD data from 2016 and 2017. This is partially due to the lack of alternative hospitals in the area.

The hospital volume indicators measure the number of medical procedures of a given type that are performed by a hospital within the one-year reporting period. OSHPD states that higher hospital volumes for some complex surgical procedures may be associated with better patient outcomes such as lower mortality rates; however, OSHPD does not recommend the use of volume indicators as stand-alone measures of hospital quality. The data is available for six selected inpatient procedures, including esophageal resection,[182] pancreatic resection,[183] AAA Repairs,[184] carotid endarterectomy,[185] CABG,[186] and PCI[187] performed in California hospitals. The most recent information as of the drafting of this report was available for 2017. Based on the data from 2016 and 2017, the Palo Verde Hospital does not perform any of the aforementioned procedures.[188] This data is consistent with the District reports that there is a lack of medical specialists and an inability to perform more complicated procedures and surgeries at the hospital.

Cal Hospital Compare is a performance reporting initiative that was established for the purposes of developing a statewide hospital performance reporting system using publicly available data sources. The data includes measures for clinical care, patient safety, and patient experience for all acute care hospitals in California. The most recent evaluation of the Palo Verde Hospital was performed in FY 18-19. Although the hospital was not rated for the overall patient experience, patient responses indicate that 23 percent would recommend

[180] *Reducing Ambulance Diversion in California: Strategies and Best Practices*, California Healthcare Foundation, July 2009 https://www.chcf.org/wp-content/uploads/2017/12/PDF-ReducingAmbulanceDiversionInCA.pdf
[181] Discharge data includes discharges from ambulatory surgery center, emergency department, inpatient discharges, and inpatient discharges that originated in the emergency department.
[182] Surgical removal of the esophagus due to cancer
[183] Surgical removal of the pancreas/gall bladder due to cancer
[184] Surgical repair of abdominal aneurysm
[185] Surgical removal of plaque within the carotid artery
[186] Surgical heart artery procedure
[187] Non-surgical heart artery procedure
[188] https://data.chhs.ca.gov/dataset/number-of-selected-inpatient-medical-procedures-in-california-hospitals

PVHD services, which is a much lower ratio than the statewide average of 71 percent. The hospital had a 15 percent (rated as average) readmission rate[189] which is the same as the statewide average. For indicators of clinical care and patient safety, most of the Palo Verde Hospital's scores appear to be largely consistent with statewide average levels; however, in several areas the hospital's performance is considered to be poor.[190]

There are several major healthcare-related accreditation organizations in the United States, including HFAP, JC, CHAP, ACHC, The Compliance Team – Exemplary provider programs, HQAA, and DNVHC. Hospitals are not required to be accredited in order to operate. Accreditation generally recognizes outstanding performance by a healthcare provider. In 2017, the Palo Verde Hospital is accredited through Det Norske Veritas (DNV).

Additionally, from July 15 to July 19, 2019 the hospital underwent a triannual unannounced licensing survey, which is required for all California hospitals. Surveyors from Riverside County look at compliance with state-defined standards, CMS standards and standards that relate to medication management, infection prevention and control, and overall employee and hospital performance related to numerous hospital functions and activities. Five surveyors reviewed policies and procedures, observed clinical practices and procedures, reviewed medical records and clinical documentation, and evaluated the Quality and Risk Management Program. The hospital achieved standards for licensure with few findings. A corrective action plan was submitted to address improvement opportunities. The next unannounced triannual survey is anticipated in 2022.[191]

The Palo Verde Hospital's performance was also recognized through the Transforming Clinical Practice Initiative (TCPI) program,[192] which concluded in November of 2019. The hospital achieved special recognition for improving quality.[193]

[189] The readmission rate is considered to be better the lower it is
[190] https://calhospitalcompare.org/hospital/?id=106331288&n=Palo+Verde+Hospital#viewall
[191] Palo Verde Hospital, Newsletter, Third Quarter 2019.
[192] CMS launched the Transforming Clinical Practice Initiative (TCPI) in 2015 to provide technical assistance to more than 140,000 clinicians (both primary and specialty care) over a four-year period in sharing, adapting, and further developing their comprehensive quality improvement strategies. TCPI created a nationwide, collaborative, and peer-based learning network designed to prepare practices to successfully participate in value-based payment arrangements.
[193] Palo Verde Hospital, Strategic Goals for Calendar Year 2020, Updated April 2020.

PALO VERDE HEALTHCARE DISTRICT MSR DETERMINATIONS

Growth and Population Projections

- Based on the 2018 Census Tract population estimates and California Department of Finance 2019 and 2020 population estimates, the estimated population of PVHD is approximately 21,376.
- The population of PVHD fluctuates due to seasonal visitors to the area.
- According to SCAG, the annual growth rate in the District is estimated to be about one percent through 2045.[194] Based on these estimates, the District's population is projected to be approximately 24,785 in 2030 and 30,049 in 2045.

The Location and Characteristics of Disadvantaged Unincorporated Communities Within or Contiguous to the Agency's SOI

- Riverside LAFCO has identified 40 disadvantaged unincorporated communities in Riverside County within or near cities' spheres of influence, two of which are within or adjacent to PVHD's boundaries.

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

- Present capacity of the District's services is constrained by financing challenges and a lack of sufficient medical staffing. Additional challenges to service provision consist of the presence of MUAs and healthcare shortage areas.
- The Palo Verde Hospital has an overall sufficient capacity to accommodate the existing and projected demand for the existing bed types. However, the hospital provides a limited range of services and District residents frequently have to travel outside of the area to seek necessary medical care.
- Despite current financing challenges and a limited range of services, PVHD has significantly improved its financial health and service adequacy in the last several years.
- Service adequacy of hospital services are defined by 1) PQIs, 2) IMIs, 3) hospital volume indicators, 4) EMS ambulance diversion rates, 5) the extent to which residents go to other hospitals for service, 6) patient satisfaction, 7) hospital safety, and 8) accreditation. Based on these indicators, the Palo Verde Hospital's services appear to be marginally adequate given the challenges it is facing. However, the District continues to make improvements towards achieving better service levels. Its

[194] Southern California Association of Governments, *Demographics and Growth Forecast*, Technical Report, Adopted on May 7, 2020, https://www.connectsocal.org/Documents/Adopted/fConnectSoCal_Demographics-And-Growth-Forecast.pdf.

efforts and improvements are recognized by accrediting, grant-giving and regulating agencies and organizations.

- The hospital requires significant capital improvements in order to comply with the 2030 seismic requirements. PVHD is yet to identify and plan for the infrastructure needs and sources of financing that would be necessary to achieve compliance.

Financial Ability of Agencies to Provide Services

- The District has the financial ability to provide services. The District generally operates with an operational surplus, has financial reserves to meet infrastructure and other contingency needs, maintains limited debt, and has no pension and OPEB liabilities.
- Although PVHD has significantly improved its financial health in the last several years the District remains concerned about financing challenges it continues to encounter. The District continuously looks for new sources of funding and ways to cut costs and reduce expenditures.
- Given the instability of the District's existing revenue sources it appears that PVHD is high risk for financial distress. This risk is mitigated however by the District's conservative budgeting practices and proactive approach to finding innovative financing solutions.

Status of, and Opportunities for, Shared Facilities

- The District practices facility sharing by renting some of its medical facilities and leasing or sub-leasing its facilities to healthcare providers.
- PVHD aims to establish affiliations with larger hospital facilities, systems or teaching institutions. The District is working on establishing links with healthcare organizations in Indio through the ED.
- Facility sharing opportunities are generally limited due to the hospital's remote location.

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

- The District primarily conducts outreach via its website, which makes available information and documents to the public and solicits input from customers. The website generally complies with SB 929, AB 2257, and AB 2019 requirements; however, PVHD needs to ensure that its website is fully functional and has all the required and appropriate up-to-date information.
- Accountability is best ensured when contested elections are held for governing body seats, constituent outreach is conducted to promote accountability and ensure that constituents are informed and not disenfranchised, and public agency operations and management are transparent to the public. The District demonstrated accountability with respect to these factors.

- One government structure option was identified in the process of this MSR. This option includes the annexation of the territory between DHD and PVHD.

PALO VERDE SPHERE OF INFLUENCE UPDATE

Existing Sphere of Influence

PVHD's current SOI is coterminous with its boundaries. The last SOI update took place in 2005 when LAFCO reaffirmed the District's coterminous sphere.

Sphere of Influence Options

Two options were identified with respect to PVHD's SOI.

Option #1: Expand the current SOI to include the communities of Desert Center, Eagle Mountain, Lake Tamarisk and the rest of the territory between DHD and PVHD.

If the Commission determines that it would be appropriate to include the communities that are already served by PVHD into the District's boundaries, close the gap between the borders of DHD and PVHD and annex the areas between the two healthcare districts into the PVHD's boundaries then the extension of the District's SOI would be appropriate to indicate the future annexation intent.

Option #2: Maintain coterminous SOI

Should the Commission wish to continue to reflect the existing service boundary, then a coterminous SOI would be appropriate.

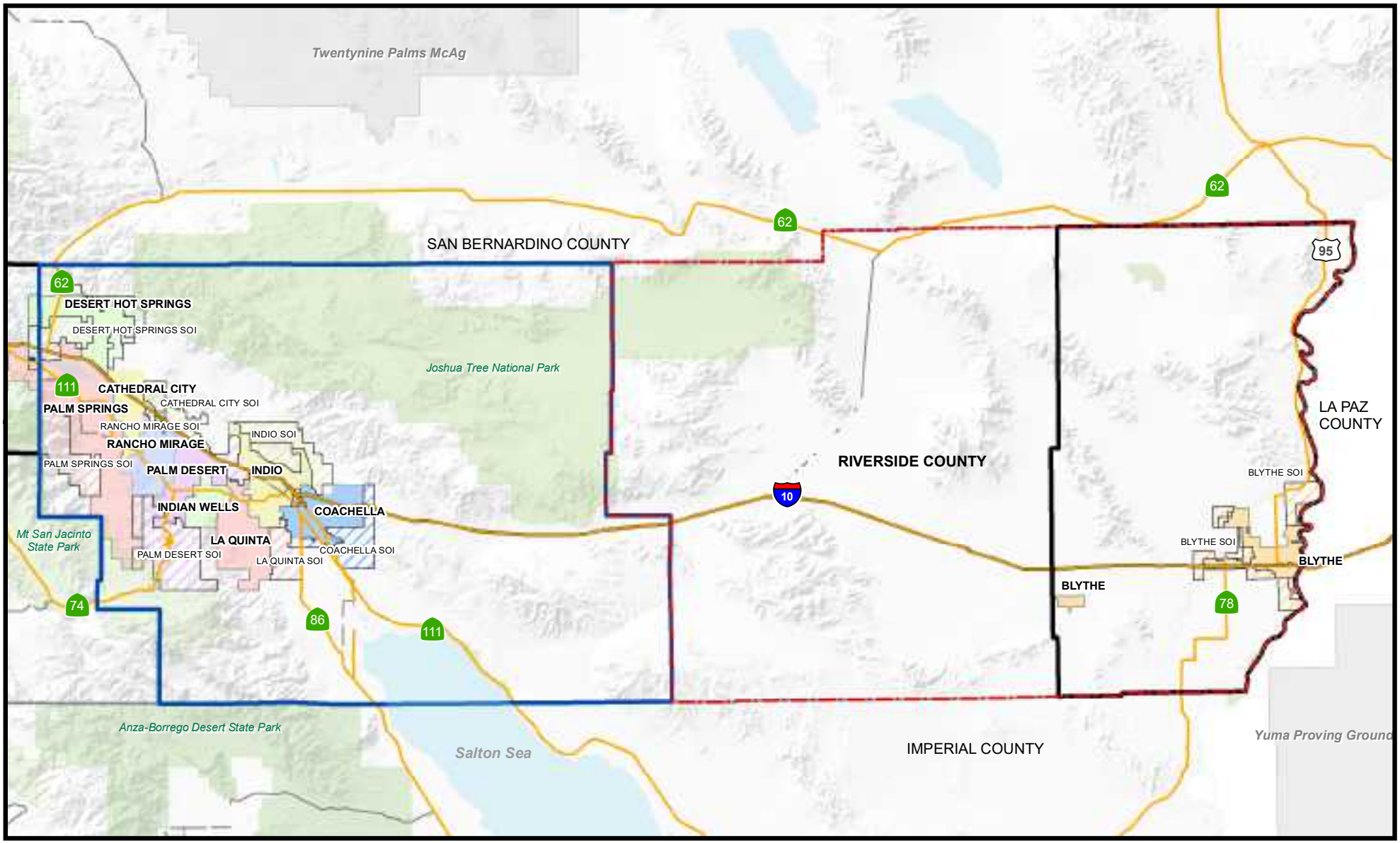
Sphere of Influence Analysis and Recommendations

The communities of Desert Center, Eagle Mountain and Lake Tamarisk are currently not included in any healthcare district and located between DHD and PVHD. The most recent significant eastward boundary expansion for DHD that occurred two years ago included Chiriaco Summit as the most eastern community. DHD currently lacks capacity to expand further east. Additionally, PVHD reported that areas in and around Desert Center are considered the District's secondary service area. Thus, PVHD may be a better district to annex these communities. Moreover, the distance between Desert Center and the DRMC is significantly longer than between Desert Center and the Palo Verde Hospital, which means that utilizing the PVHD facility is a better alternative for the population that resides in Desert Center, Eagle Mountain and Lake Tamarisk.

The annexation of these areas to PVHD would further promote logical boundaries by closing the gap between the boundaries of the two healthcare districts and reflecting the PVHD's service area, as is shown in Figure 5-13. This annexation would also benefit PVHD in terms of additional property tax revenue received from the areas that it is already serving.

As the first step towards the annexation, it is recommended that the Commission adopt Option #1 and expand PVHD's SOI to include the territory between DHD and PVHD. The proposed PVHD SOI is depicted in Figure 5-14.

Figure 5-13: Palo Verde Healthcare District and Desert Healthcare District



Data Sources: County of Riverside; LAFCo

0 1.5 3 6 9 12 Miles

N

Disclaimer: The information shown is intended to be used for reference and general display purposes only and is not to be used as an official map.

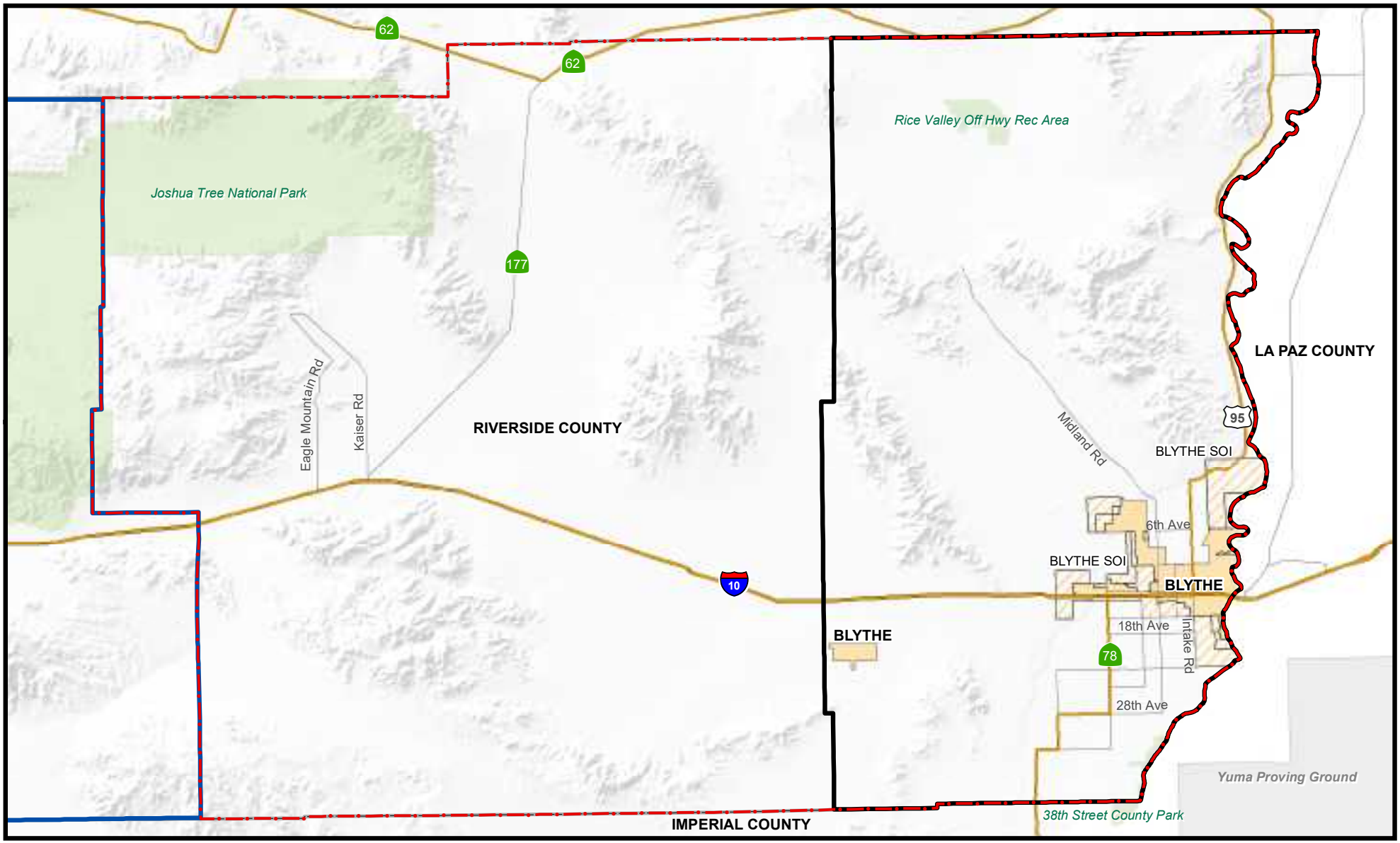
Healthcare services provided for District residents

Legend

- Palo Verde Healthcare District
- Palo Verde HealthCare District Proposed Sphere of Influence
- Desert Healthcare District

Map Created on 9/14\2020

Figure 5-14: Palo Verde Healthcare District Proposed Sphere of Influence



Data Sources: County of Riverside; LAFCo

0 1 2 4 6 8 Miles

N

Disclaimer: The information shown is intended to be used for reference and general display purposes only and is not to be used as an official map.

Healthcare services provided for District residents

Legend

- Palo Verde Healthcare District
- Palo Verde HealthCare District Proposed Sphere of Influence

Map Created on 9/14\2020

Sphere of Influence Determinations and Recommendations

Nature, location, extent, functions, and classes of services provided

- PVHD provides hospital services within the District boundaries that include the City of Blythe and the communities of Mesa Verde, Ripley and Midland. PVHD also provides services to its secondary service area which extends to the town of Palo Verde to the south, Quartzsite to the east, Desert Center and Brawly to the west, and Parker Arizona to the north. District services also benefit area visitors and commuters.
- The 51-bed hospital operates 24 hours a day, seven days a week and offers a full range of services. PVHD additionally operates an outpatient hospital-based clinic.
- The District also provides community medical and wellness education programs, medical screenings, support groups and other services to the community.

Present and planned land uses, including agricultural and open-space lands

- PVHD encompasses all land uses designated by the City of Blythe and the County of Riverside including agricultural and open space land.
- PVHD's SOI does not conflict with planned land uses; the District has no authority over land use, and both urban and agricultural areas within the District are in need of the services offered by PVHD.
- Hospital and healthcare services are needed in all areas, and do not, by themselves induce or encourage growth on agricultural or open space lands.

Present and probable need for public facilities and services

- As indicated by PVHD's service demand and projected growth, there is a present and anticipated continued need for hospital and clinic services offered by the District.
- The District continues to improve its service levels and expand its range of services to accommodate the service demand in the community, particularly considering its remote location.

Present capacity of public facilities and adequacy of public services that the agency provides or is authorized to provide

- Present capacity of the District's services is constrained by financing challenges and a lack of sufficient medical staffing. Additional challenges to service provision consist of the presence of MUAs and healthcare shortage areas.
- The Palo Verde Hospital has an overall sufficient capacity to accommodate the existing and projected demand for the existing bed types. However, the hospital provides a limited range of services and District residents frequently have to travel outside of the area to seek necessary medical care.
- Despite current financing challenges and a limited range of services, PVHD has significantly improved its financial health and service adequacy in the last several years.

- Service adequacy of hospital services are defined by 1) PQIs, 2) IMIs, 3) hospital volume indicators, 4) EMS ambulance diversion rates, 5) the extent to which residents go to other hospitals for service, 6) patient satisfaction, 7) hospital safety, and 8) accreditation. Based on these indicators, the Palo Verde Hospital's services appear to be marginally adequate given the challenges it is facing. However, the District continues to make improvements towards achieving better service levels. Its efforts and improvements are recognized by accrediting, grant-giving and regulating agencies and organizations.
- The hospital requires significant capital improvements in order to comply with the 2030 seismic requirements. PVHD is yet to identify and plan for the infrastructure needs and sources of financing that would be necessary to achieve compliance.

Existence of any social or economic communities of interest

- All the areas inhabited by District residents represent social and economic communities of interest, as PVHD residents pay for its services through property taxes.
- Communities in the District's secondary service area are considered to be social and economic communities of interest for PVHD.
- Seasonal tourists and area visitors also use District services and have an interest in adequacy of such services.
- Additionally, MUAs and healthcare shortage areas within PVHD boundaries represent particular social and economic interest since they are underserved and require increased attention from the District.

6. SAN GORGONIO MEMORIAL HEALTHCARE DISTRICT

San Gorgonio Memorial Healthcare District			
Contact Information			
Contact:	Steven Barron, Chief Executive Officer		
Address:	600 N. Highland Springs Ave., Banning, CA 92220	*Website:*	www.sgmh.org
Phone:	512-661-2813	*Email:*	https://sgmh.org/contact/
Formation Information			
Date of Formation:	October 6, 1947	*District type:*	Independent Special District
Governing Body			
Governing Body:	Board of Directors	*Members:*	5
Manner of Selection:	Election by voting district	*Length of term:*	4 years
Meeting Location:	Modular C Classroom on the hospital campus	*Meeting date:*	First Tuesday of each month at 4pm
Mapping and Population			
GIS Date:	7/30/19	*Population (2020):*	105,556
Purpose			
Enabling Legislation:	Local Healthcare District Law Health and Safety Code §32000-32492.	*Empowered Services:*	Medical services, emergency medical, ambulance, and services relating to the protection of residents' health and lives
Services Provided	Hospital (through San Gorgonio Memorial Hospital Corporation)		
Area Served			
Size:	356 square miles	*Location:*	Northwestern Riverside County
Current SOI:	356 square miles	*Most recent SOI update:*	2005
Facilities			
Hospital Name:	San Gorgonio Memorial Hospital	*Location:*	600 N. Highland Springs Ave., Banning, CA 92220
Number of Licensed Beds:	79	*Other Facilities:*	None

DISTRICT OVERVIEW

SGMHD was formed October 6, 1947 to provide healthcare services to an area that includes the cities of Beaumont, Banning, Calimesa, and the unincorporated areas of the Cherry Valley and Cabazon.[195]

Boundaries

The District's boundaries encompass approximately 356 square miles in the northwest portion of Riverside County and includes the cities of Banning and Beaumont, a portion of the City of Calimesa, the western portion of Palm Springs, and the neighboring unincorporated areas of Cabazon, Cherry Valley and Whitewater.[196]

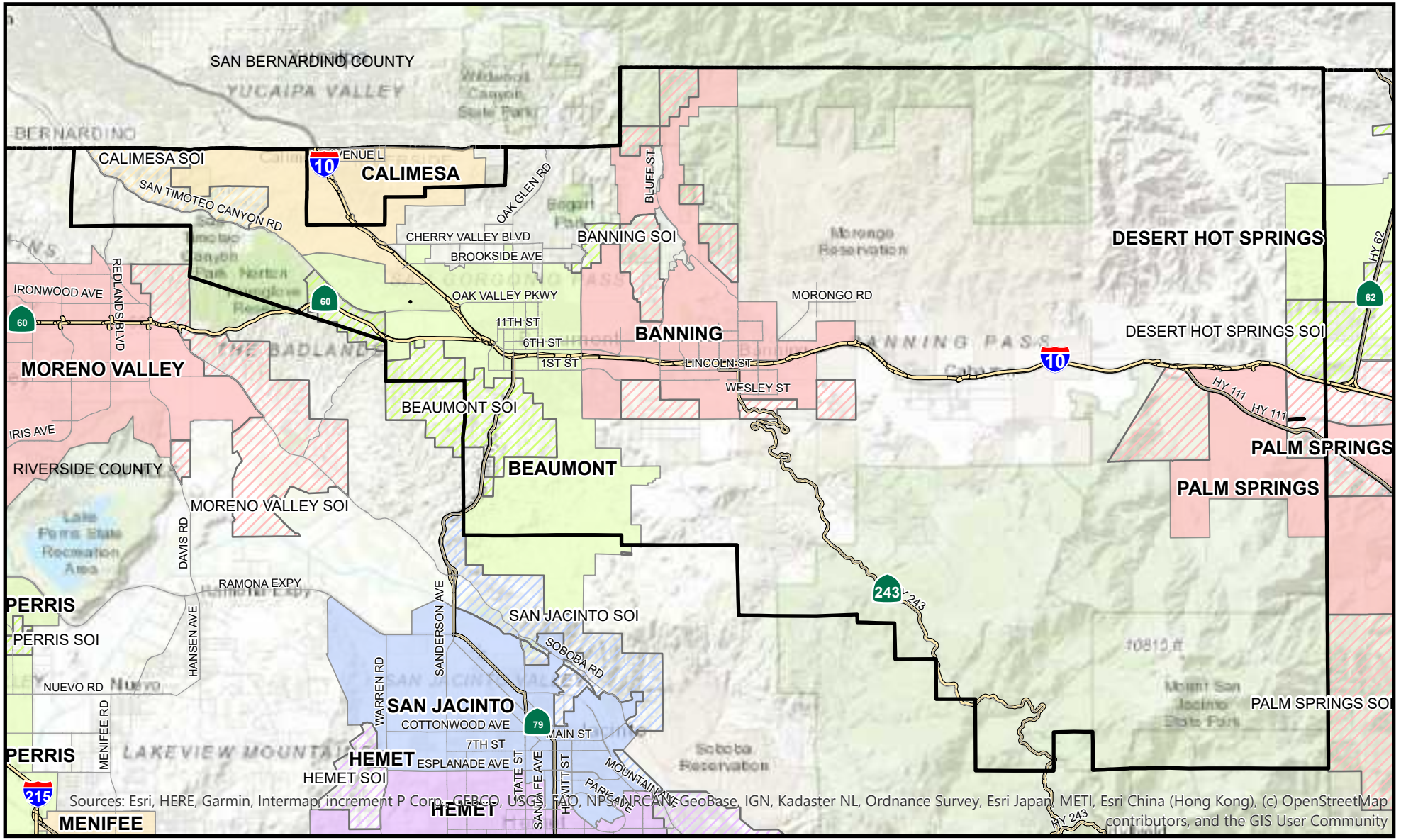
The boundaries of SGMHD can generally be described as being west of Highway 62, south of the Riverside/San Bernardino county line, north of the City of San Jacinto and east of Moreno Valley.

Sphere of Influence

SGMHD's SOI was confirmed in 1984 and again in 2005 as coterminous with District's boundaries.[197] The District's boundaries and SOI are shown in Figure 6-1.

[195] LAFCO #84-75-3, Sphere of Influence Study for San Gorgonio Pass Memorial Hospital District, August 23, 1984.
[196] LAFCO 2005-07-4, SOI Reviews, June 23, 2005.
[197] Ibid.

Figure 6-1: San Gorgonio Memorial Healthcare District and Sphere of Influence



Data Sources: County of Riverside; Registrar of Voters, LAFCO

4 2 0 4 Miles

N

Disclaimer: The information shown is intended to be used for reference and general display purposes only and is not to be used as an official map.

Healthcare services provided for District residents

Legend

San Gorgonio Memorial Healthcare District**

** SOI is coterminous with District Boundary

Author: Crystal M. Craig

Map Created on 7/30/19

ACCOUNTABILITY AND GOVERNANCE

Since formation, the District has been governed by a five-member district board elected by the residents of the communities within its boundaries. Until 1990, the SGMHD Board governed all operations of the SGMH. At that time, the operations of the hospital were taken over by the non-profit SGMH Corporation and a 13-member corporate board was formed, which consists of the five members of the district Board, plus eight appointed directors. The District remains the owner of the hospital while leasing the facility to the non-profit.

The organization of the SGMH system is comprised of three separate legal entities that work closely together. These three entities are SGMHD, the SGMH Foundation, and the SGMH. The hospital and the foundation are each registered as 501 (c)(3) non-profit corporations.

According to their bylaws, the Boards must each consist of a Chair, a Vice Chair, a Treasurer, a Secretary, and may include other officers authorized by the Board. The five-member district Board meets for regular meetings on the first Tuesday of each month at 4pm in Modular C Classroom on the hospital campus at 600 N. Highland Springs Avenue, Banning, CA. The hospital Board's 13 members (the five elected district board members and eight appointed hospital board members) also meet for regular meetings on the first Tuesday of each month at 5pm in Modular C Classroom on the hospital campus. Special meetings may be called by the chair or by written request of three board members. Board meetings are open to the public.

The two Boards work in conjunction with six committees: The Hospital Board of Directors Executive Committee, the Finance Committee, the Human Resources Committee, the Community Planning Committee, the Measure D Community Oversight Committee, and the Measure A Community Oversight Committee.

Per the Brown Act, meeting agendas are to be clearly posted in the district office for public review 72 hours in advance of all regular meetings and 24 hours before all special meetings. Agendas may be found on the District's website as a submenu under the "About Us" tab in the menu. Likewise, all Board approved minutes are also available in the District's administration office.

SGMHD maintains a website with information readily available for the public. The Special District Transparency Act (SB 929), signed into law in 2018, requires special districts in California to have websites by January 1st, 2020. The website is mandated to clearly list the district's contact information in addition to the recommended agendas and minutes, budgets and financial statements, compensation reports, and other relevant public information and documents. A district may be exempt from the law by a resolution adopted by a majority vote of its governing body declaring detailed findings regarding a hardship that prevents the district from establishing or maintaining a website. The resolution must be adopted annually as long as the hardship exists.[198] The District's website meets the requirements of SB 929. SGMHD needs to ensure that all the information posted on its website is up to date.

In 2016, the State Legislature enacted AB 2257 (Government Code §54954.2) to update the Brown Act with new requirements governing the location, platform and methods by which an agenda must be accessible on the agency's website for all meetings occurring on or

[198] California Government Code, §6270.6 and 53087.8

after January 1, 2019. AB 2257 provides two options for compliance. Under the first option, an agency that maintains a website must post a direct link to the current agenda on its primary homepage. The link may not be placed in a "contextual menu," such as a drop-down tab, that would require a user to perform an action to reveal the agenda link. Additionally, the agenda must be: (a) downloadable, indexable, and electronically searchable by common internet browsers; (b) platform independent and machine readable; and (c) available to the public, free of charge and without restrictions that might interfere with the reuse or redistribution of the agenda. Under the second option, an agency may implement an "integrated agenda management platform," meaning a dedicated webpage that provides the necessary agenda information. The most current agenda must be located at the top of the page. Under this option, a direct link to the current agenda does not need to be posted on the homepage; however, the agency *is* required to post a link to the platform containing the agenda information. Again, this link may not be hidden in a contextual menu.[199]

SGMHD is not compliant with the AB 2257 requirements. In order to meet this requirement, the District needs to implement either a direct link to the webpage containing the meeting agendas or direct users to an integrated agenda management platform where the agenda is located at the top of the page.

AB 2019, signed into law in 2018 by Governor Jerry Brown, imposes additional posting requirements on California's healthcare districts. Healthcare districts must now post the following information on their websites:

1. the district's annual budget,
2. a list of current board members,
3. information regarding public meetings,
4. recipients of grant funding or assistance provided by the district,
5. the district's policy for providing grants or assistance, and
6. audits, financial reports and MSRs or LAFCO studies, if any, or a link to another government website containing this information.

SGMHD needs to ensure that all required up-to-date documents are posted on its website, including annual budgets and audited financial statements.

There are additional requirements outlined in this bill for healthcare districts that provide assistance or grant funding, which are not relevant to SGMHD. AB 2019 also requires all healthcare districts to notify LAFCO if they file for bankruptcy.

In order to facilitate communication with the public and encourage voter interest, SGMHD incorporates the following methods to support community involvement. In large part, the District utilizes its online presence to connect with residents through Facebook and Twitter as well as its website to share information, news, and resources. There is a calendar available on the District website that lists available classes and events. There are also links posted to information on becoming a volunteer and contributing financial donations. Through the District's online news center, there are a variety of healthcare e-newsletters

[199] https://www.jdsupra.com/legalnews/ab-2257-new-brown-act-requirements-for-35346/

available in addition to a monthly e-newsletter that relays healthcare information as well as updates regarding the hospital.

SGMHD and the Hospital are committed to non-discrimination practices, and the Hospital has been accredited through the Center for Improvement in Healthcare Quality (CIHQ). As of 2019, the Hospital was also listed as one of the Inland Empire's Top Workplaces for the third year straight.

The District has demonstrated transparency and accountability throughout the MSR process by responding promptly and thoroughly to requests for information, participating in an interview and workshops, and reviewing draft reports comprehensively.

GROWTH AND POPULATION PROJECTIONS

The western portion of SGMHD encompasses largely developed incorporated areas within the cities of Calimesa, Banning, and Beaumont. The eastern portion of the District is largely unincorporated, with the exception of the western tip of the City of Palm Springs. The unincorporated area largely consists of the Morongo Reservation, Mount San Jacinto State Park and the San Jacinto Mountains, and as such, these areas have a more rural character and lower population density then the western portion of the District.

It is challenging to estimate the current population of the District, since Census 2020 data will not be available until after the adoption of this report. The most recent population estimates for the cities within SGMHD are available for 2020; however, unincorporated population data is hard to categorize at the district level as it generally dates from 2010 when the last Census occurred. In 2020, the population in the incorporated portion of the District was approximately 93,193, as reported by the Department of Finance. In order to determine the unincorporated portion of the District's population, the report makes use of the Census County Division level estimates for 2018, which are the most recent districtwide population estimates available. It was estimated that the number of residents within the entirety of the District as of 2018 was 96,859. This equates to an unincorporated population of 12,098, based on Department of Finance city population estimates at that time. Department of Finance estimates show 2.2 percent growth in unincorporated Riverside County between 2018 and 2020, resulting in an estimated total population of 105,556 within the District as of January 1, 2020.

Figure 6-2: San Gorgonio Memorial Healthcare District Population Estimate, 2018-2020

	Population Estimate 1/1/2018	Population Estimate 1/1/2019	Population Estimate 1/1/2020
SGMHD Incorporated[1]	84,761	91,099	93,193
SGMHD Unincorporated	12,098	12,269	12,363
Total	96,859 [2]	103,368	105,556

Source: Department of Finance
Notes:
(1) Based on the assumption that approximately 1/2 percent of the City of Calimesa and 1/8 of the City of Palm Springs is within the District's boundaries.
(2) U.S. Census Bureau (2018). American Community Survey 5-year estimates. Retrieved from Census Reporter Profile based on inclusion of Cherry Valley, Cabazon, and Whitewater CDPs.

Historical growth within the District has been largely within cities. In particular, the City of Beaumont experienced 7.7 percent growth between 2018 and 2020, while Calimesa experienced 6.1 percent growth. As mentioned, the unincorporated areas in Riverside County had a 2.2 percent growth in population during that same time period. Slower growth is expected based on the SCAG forecast conducted in 2020. According to SCAG, the population of Riverside County will grow by 30 percent between 2020 and 2045 or approximately one percent annually.

The projected annual growth for the unincorporated area and cities of Banning and Palm Springs is one percent. The cities of Beaumont and Calimesa are anticipated to have higher annual growth of two and three percent, respectively. Based on the average growth rates of all the cities and unincorporated county territory, the annual growth rate in the District is estimated to be about 1.6 percent.[200] Based on these estimates, the District's population is projected to be approximately 123,714 in 2030 and 156,561 in 2045.

DISADVANTAGED UNINCORPORATED COMMUNITIES

LAFCO is required to evaluate disadvantaged unincorporated communities as part of this service review, including the location and characteristics of any such communities.

The purpose of SB 244 (Wolk, 2011) is to begin to address the complex legal, financial, and political barriers that contribute to regional inequity and infrastructure deficits within disadvantaged unincorporated communities (DUCs). Identifying and including these communities in the long-range planning of a city or a special district is required by SB 244.

Government Code §56033.5 defines a DUC as 1) all or a portion of a "disadvantaged community" as defined by §79505.5 of the Water Code, and as 2) "inhabited territory" (12 or more registered voters), as defined by §56046 or as determined by commission policy. The statute allows some discretion to LAFCOs in the determination of DUCs.

In 2012, Riverside County LAFCO adopted a Policy for Disadvantaged Unincorporated Communities. The guidelines for identifying DUCS are described as interim in this policy since it was anticipated that the methods of identifying and analyzing DUCs would evolve over time. LAFCO will be revising its guidelines as soon as 2020 Census data is available.[201]

According to the 2012 guidelines, a DUC in Riverside County is defined as a community of a minimum of 50 dwellings or 50 registered voters, whichever is less. LAFCO has also clarified the definition of an "inhabited area" by excluding vacant land, non-residential land and freeway/state highway rights of way on the periphery of residential areas from DUCs. Since the smallest geographic area with available median income information is a Census Block Group, LAFCO further decided that in identifying DUCs it will make an effort to differentiate between areas within a block group that are likely to have income above the specified criteria and exclude such areas from the DUC. Factors that could be considered include markedly different housing types or densities in portions of the block group.[202]

[200] Southern California Association of Governments, *Demographics and Growth Forecast*, Technical Report, Adopted on May 7, 2020 https://www.connectsocal.org/Documents/Adopted/fConnectSoCal_Demographics-And-Growth-Forecast.pdf.
[201] https://lafco.org/wp-content/uploads/documents/archives/7.SB_244_Interim_Policy_3_22_12.pdf
[202] https://lafco.org/wp-content/uploads/documents/archives/7.SB_244_Interim_Policy_3_22_12.pdf

Riverside LAFCO has identified 40 disadvantaged unincorporated communities in Riverside County within or near cities' spheres of influence. There is one DUC in SGMHD near the City of Beaumont in the community of Highland Springs.[203]

FINANCIAL ABILITY TO PROVIDE SERVICES

The financial ability of agencies to provide services is affected by available financing sources and financing constraints. This section discusses the major financing constraints faced by SGMHD and identifies the revenue sources currently available to the District.

SGMHD, the owner of the hospital facility, and the SGMH, as the operator of the hospital, function in an interdependent relationship referred to cumulatively as the San Gorgonio Health Care System. The finances of the two entities are intertwined to the point that annual audits are conducted on the combined system, as opposed to each individual entity.

SGMHD receives a substantial portion of its revenues from property taxes.[204] These funds are used to support hospital operations and meet the required debt service agreements. In the past, the District received a portion of its revenues from charges for patient services associated with the Orthopedic clinic. The clinic has closed as of August 2020 as it was not a financial solvent venture. The District also receives other sources of revenue, including fundraising conducted by the Foundation.

The Foundation is a California nonprofit 501(c)(3) public benefit corporation organized for the charitable purpose of promoting and supporting the Hospital and SGMHD. The Foundation's primary activities consist of raising funds through donations, grants and fundraising activities for the sole benefit of the Hospital and the District. The Foundation's unrestricted funds are distributed to the District and/or the Hospital in amounts and in periods determined by the Foundation's Board of Trustees, which may also designate the use of these unrestricted funds for specific land, building or equipment acquisitions, or for other specific purposes. The Foundation has raised over $8 million for the District and Hospital since 1996.

With an annual budget of approximately $6.3 million per year, the District funds hospital facility maintenance, repayment of bonds associated with capital improvements on the facility, and augmenting financing for the Hospital's programs and services. More details regarding the District's financial health are available in Figure 6-3 and in the next several sub-sections.

[203] https://lafco.org/wp-content/uploads/documents/ducs/RIVCO%20Master%20DUC%20Chart.pdf
[204] For the purposes of the SGMHD's audited financial statements, the property tax revenue used for operations are classified under unrestricted revenues, gains, and other support, whiles taxes used to service debt borrowings are classified as non-operating revenue as the revenue is not directly linked to the operation of patient care. In the tables and analysis included in this report, property taxes are all included as operating revenue sources in order to appropriately portray the District's financial position and budget surplus.

Figure 6-3: San Gorgonio Memorial Healthcare District Financial Overview, FY 18-19

San Gorgonio Memorial Healthcare District		
Category		***FY 18-19***
Balanced Budget (rev/exp incl debt)		
Total Operating Revenues	$	13,260,037
Total Operating Expenditures (incl debt)	$	6,308,978
Net	$	6,951,059
Operating Ratio (op rev/exp incl debt & deprec)		1.1
Operating Revenues	$	13,260,037
Operating Expenditures	$	1,483,581
Debt Service	$	4,825,397
Depreciation	$	5,973,693
Total Expenses	$	12,282,671
Current Assets		
Cash and Cash Equivalents	$	3,126,083
Assets Limited as to Use	$	4,150,146
Accounts Receivable	$	11,961,335
Prepaid Items and Deposits	$	72,820
Total Current Assets	$	19,310,384
Current Liabilities		
Accounts Payable	$	89,989
Current Debt Maturities	$	2,095,000
Accrued Interest Payable	$	2,055,146
Grants Payable	$	-
Compensated Absences	$	-
Disability Claims, Reserve, Current Portion	$	-
Total Current Liabilities	$	4,240,135
Long-term Liabilities		
Debt Borrowings, Less Current	$	110,739,214
Grants Payable	$	-
Long-term Disability Claims Reserve	$	-
Net Pension Liability	$	-
Net OPEB Liability	$	-
Deposits Payable	$	-
Total Long-term Liabilities	$	110,739,214
Unrestricted Net Position/Operating Revenues		55%
Net Position	$	7,313,647
Unrestricted Net Position	$	7,313,647
Operating Revenues	$	13,260,037
Current Ratio (Short-term Liquidity)		4.6
Current Assets	$	19,310,384
Current Liabilities	$	4,240,135
Months Cash on Hand (current cash assets/expenses incl debt)		6
Current Cash Assets	$	3,126,083
Operating Expenditures (inc. debt)	$	6,308,978
Operating Expenditures per Day	$	17,285
Change in Net Depreciable Capital Assets (FY 18-FY 19)		-5%
Net Capital Assets, FY 18	$	102,497,060
Net Capital Assets, FY 19	$	97,000,465
Total Assets being Depreciated (FY 19)	$	97,000,465
Depreciation	$	5,973,693
Total Reserves (% of op. expend)		50%
Reserve	$	3,126,083
Pension Liabilities as % of Revenues		0%
Total Pension Liability	$	-
Unfunded Pension Liability	$	-
% Pension Liability Funded		0%
Total Payments FY 17-18 (funded+unfunded)	$	-
OPEB Liabilities (as of June 30, 2019)		
OPEB Liability Payments as % of revenue		0.0%
Unfunded OPEB Liability	$	-
Total OPEB Payments	$	-

Financial Planning and Reporting

The California Office of Statewide Health Planning and Development (OSHPD) produces annual financial disclosure reports that provide audited data on hospital revenues, expenditures, net operating margins, and other measures of fiscal performance. Healthcare districts are also required to submit annual financial disclosure reports to the California State Controller, which uses the submitted financial data to produce an Annual Special Districts Report that provides detailed financial information by FY regarding special district revenues, expenditures, property taxes, and bonded debt. The County of Riverside Auditor and Controller produces a detailed summary of local tax information for each FY that identifies the amount of property tax allocated to the healthcare districts and reports any bonded indebtedness held by the districts. The annual healthcare district and hospital financial disclosure reports produced by the California State Controller, the County of Riverside, and OSHPD provide the public with a comprehensive overview of the annual financial status of a healthcare district, as well as the hospital facilities the district owns and/or operates.

SGMHD's internal financial planning efforts include the annual budget and annually audited financial statements that are conducted jointly with the contract hospital operator (San Gorgonio Memorial Hospital). SGMHD also prepares a multi-year CIP and, as a part of the bond issuance process, has produced several bond official statements with substantial information.

Balanced Budget

The District receives revenue from property taxes, charges for patient services, and contributions from the Foundation. SGMHD's primary income source is property taxes, as can be seen in Figure 6-4.

The District's primary expense is repayment on bonds issued for substantial capital improvements completed between 2006 and 2010. The District's efforts and thus expenditures are focused on maintenance and past and future improvement of the hospital facility. Additional funds have been expended on professional services, building and equipment rent, as well as other operating expenses during FYs 17-18 and 18-19. As can be seen in Figure 6-4, the District has consistently experienced operational surpluses in each of the past three FYs (FYs 16-17, 17-18 and 18-19).

For any agency, recurring operating deficits are a warning sign. In the short-term, reserves can backfill deficits and maintain services, but ongoing deficits eventually will deplete reserves. In the case of SGMHD, however, the District has not practiced deficit spending in at least the last three years. The FY 19-20 and 20-21 budget similarly shows a projected positive operating balance.

Figure 6-4: SGMHD Revenues and Expenditures, FY 18-19, FY 17-18, and FY 16-17

San Gorgonio Healthcare District Revenues and Expenditures						
Category	***FY 18-19***	***%***	***FY 17-18***	***%***	***FY 16-17***	***%***
Operating Revenue	**$ 13,260,037**	**100%**	**$ 12,491,761**	**100%**	**$ 11,572,449**	**100%**
Property Tax Revenue	$ 12,247,343	92.4%	$ 11,394,883	91.2%	$ 10,732,517	92.7%
Patient Service Income	$ 311,215	2.3%	$ 241,272	1.9%	$ -	0.0%
Other income	$ 701,479	5.3%	$ 855,606	6.8%	$ 839,932	7.3%
Operating Expenditures	**$ 1,483,581**	**100.0%**	**$ 1,140,508**	**100.0%**	**$ 554,154**	**100.0%**
Professional and other fees	$ 228,499	15.4%	$ -	0.0%		0.0%
Supplies	$ 664	0.0%	$ 714	0.1%	$ 803	0.1%
Building and equipment rent	$ -	0.0%	$ 565,534	49.6%	$ 26,507	4.8%
Purchased services	$ 103,437	7.0%	$ -	0.0%	$ 322,439	58.2%
Other operating expenses	$ 1,150,981	77.6%	$ 574,260	50.4%	$ 204,405	36.9%
Net Operating Income	**$ 11,776,456**		**$ 11,351,253**		**$ 11,018,295**	
Debt Service	**$ 4,825,397**		**$ 4,855,092**		**$ 5,021,267**	
Net Operating Income After Debt	**$ 6,951,059**		**$ 6,496,161**		**$ 5,997,028**	
Non-operating Income	**$ -**		**$ 94,385**		**$ 225,000**	
Capital contributions	$ -		$ 94,385		$ 225,000	
Non-operating Expenditures	**$ 5,973,693**		**$ 6,149,586**		**$ 6,631,041**	
Depreciation and amoritization	$ 5,973,693		$ 6,149,586		$ 6,631,041	
Net Non-operating income (loss)	$ (5,973,693)		$ (6,055,201)		$ (6,406,041)	
Net After Non-Operating Income/Expenditures	**$ 977,366**		**$ 440,960**		**$ (409,013)**	
Beginning Net Position	**$ 6,336,281**		**$ 6,557,894**		**$ 6,632,458**	
Ending Net Position	**$ 7,313,647**		**$ 6,998,854**		**$ 6,223,445**	
Sources: Audited Financial Statements Fys 16-17, 17-18 and 18-19.						

Fund Balances, Reserves and Liquidity

Fund balances and reserves should include adequate funds for cash flow and liquidity, in addition to funds to address longer-term needs. The District's FY 18-19 financial statements report a total of $19.3 million in current assets out of which $3.1 million is cash or cash equivalents with $4.2 million in current liabilities and $110.7 million in long-term liabilities, as shown in Figure 6-3. The District has enough cash on hand to cover about six months of its operating expenditures.

The District's current and long-term debt is primarily attributable to bonds issued in 2006, 2008, and 2009 for the financing of significant hospital improvements. Proceeds from the bonds financed the construction, expansion, equipping and renovation of the Hospital and related facilities. Work on the Project began in July 2006, was undertaken in phases and was completed in 2010. In 2013, 2014 and 2015, the District issued General Obligation Refunding Bonds to advance refund the previously issued bonds from 2006, 2008 and 2009. These bonds will mature in 2036, 2039, and 2038, respectively. From 2020 to 2024, between $2.1 million to $3.2 million of the bond principal will mature annually. SGMHD ad valorem property tax revenue is used to make principal and interest payments on these bonds.

The System reportedly regularly monitors the availability of resources required to meet its operating needs and other contractual commitments while striving to maximize the investment of its available funds. For purposes of analyzing the resources available to meet general expenditures over a 12-month period, all expenditures related to ongoing activities that provide health care services, as well as the conduct of services undertaken to support those activities, are considered to be general expenditures. The System strives to maintain liquid financial assets sufficient to cover at least 30 days of expenditures. The System's policy

is that excess cash on hand is invested in investment instruments with liquidity requirements to enable usage of those assets within a short time period. In addition to having financial assets available to meet general expenditures over the next 12-month period, the System operates a balanced budget and anticipates collecting sufficient patient service revenue to cover general expenditures not otherwise covered by assets that are limited as to use and donor restricted resources.[205]

Net Position

An agency's "Net Position" as reported in its audited financial statements represents the amount by which assets (e.g., cash, capital assets, other assets) exceed liabilities (e.g., debts, unfunded pension and OPEB liabilities, other liabilities). A positive Net Position provides an indicator of financial soundness over the long-term. The FY 18-19 ending net position for the District was $7.3 million, which is a 4.5 percent increase from the previous FY, indicating stability with its ongoing general operations.

Pension and OPEB Liabilities

Unfunded pension and OPEB liabilities present one of the most serious fiscal challenges facing many special districts in California today. The District does not employ any staff directly, and instead relies on Hospital staff to conduct its operations. Therefore, SGMHD is not burdened by related pension and OPEB liabilities typically faced by many other special districts.

Capital Assets

Capital assets must be adequately maintained, replaced over time, and expanded as needed to accommodate future demand and to respond to regulatory and technical changes.

As a general indicator, the California Municipal Financial Health Diagnostic compares changes in the value of assets and asset improvements.[206] Persistent and substantially negative trends, particularly without a reasonable plan for stabilizing declines, raise caution and warning signs. This negative condition can occur if repairs and replacements do not keep pace with aging infrastructure.

Depreciation typically spreads the life of a facility over time to calculate a depreciation amount for accounting purposes. The actual timing and amount of annual capital investments require detailed engineering analysis and will differ from the annual depreciation amount, although depreciation is a useful initial indicator of sustainable capital expenditures.

The District's capital assets include land (which is non-depreciable) and the hospital and improvements, as well as furniture and equipment (which all depreciate). Depreciation constituted 49 percent of the District's expenses in FY 18-19. As of June 30, 2019, the District had $97 million in capital assets (depreciable and non-depreciable) and $6 million in accumulated depreciation.[207] The value of depreciable capital assets decreased by about 5.4

[205] Audited Financial Statement, FY 18-19, p. 20.
[206] The California Municipal Financial Health Diagnostic: Financial Health Indicators, League of California Cities, 2014.
[207] Audited Financial Statement, FY 18-19, p. 24

percent from FY 17-18 to FY 18-19, as shown in Figure 6-3. In FY 18-19, the District reported $8.4 million in construction-in-progress. While there were not sufficient additions to depreciable asset value to offset depreciation of $5.97 million, it is anticipated that construction that is underway will exceed annual depreciation.

Additionally, the District made substantial capital improvements of $137 million on the facility between 10 and 15 years ago and plans for existing and future capital needs in a three-year CIP. Between 2020 and 2023, the District plans to expend $3.9 million on facility improvements and equipment purchases.

HEALTHCARE SERVICES

Service Overview

Background

Located in Banning, California, SGMH is an accredited, general acute care hospital managed by the not-for-profit SGMH Corporation.

In 1947, the San Gorgonio Pass Memorial Hospital District Central Committee was formed in order to create a living memorial to World War veterans. The District oversaw the operations of the San Gorgonio Pass Memorial Hospital (SGMH), which was officially dedicated in 1951, for nearly 40 years before this responsibility was taken over by the not-for-profit SGMH Corporation. The District remains the owner of the hospital, which is the only acute care hospital within the District's boundaries, while contracting out management responsibilities of the facility to the nonprofit. This original lease was set to expire on June 30, 2020 and was transitioned into a contract management agreement as of July 1, 2020 with a term of five years.[208]

In 1991, the word "Pass" was dropped from the District's and Hospital's name, leaving it the San Gorgonio Memorial Hospital. This period of time also ushered in many expansion projects including remodeling, the acquisition of new equipment, and the construction of new buildings, and a helicopter pad.

There are three entities that compose the SGMH organization: The District, the Hospital (also known as the Corporation), and the Foundation. While all three work closely together and are represented as SGMH, they are separate legal entities. Together, SGMH and the District are referred to as the San Gorgonio Memorial Healthcare System, also referred to as the System. Furthermore, SGMH and the SGMH Foundation are both registered as tax exempt 501 (c)(3) non-profit corporations.

Services

SGMHD contributes to the services provided by the Hospital by owning, maintaining and making improvements to the hospital, land, building, equipment, and the Behavioral Health Center. The Corporation provides healthcare services on the District's behalf under a management contract.[209] While the two entities have a formal agreement, the two organizations act in an interdependent manner with linked governing bodies, shared staffing, and joint financial planning and management practices. SGMHD also supplements the operations of the Hospital by providing financial support in hospital operations and community health programs.

The operations and capital needs of the Hospital are also supplemented by the SGMH Foundation which makes use of donations, grants, and fundraising proceeds. Unrestricted funds are able to be used for equipment, promotional programs, and other designated needs.

SGMH is the only hospital in the District's boundaries and serves a primary and secondary service area. The primary service area includes the cities of Banning and

[208] San Gorgonio Memorial Healthcare District, Official Statement, 2015.
[209] https://sgmh.org/about-us/organizational-structure/

Beaumont. The secondary service area includes the City of Calimesa (which is partially within the District's boundaries) and the unincorporated community of Cabazon. The secondary service area also includes the cities of Yucaipa, San Jacinto, and Hemet, which are outside of SGMHD's boundaries and SOI.[210] Approximately 90 percent of users are from the District's primary service area.[211]

SGMH operates 79 licensed beds and offers a number of services for which the hospital holds the necessary licenses and permits to be able to provide these services on behalf of the District.

The SGMH accepts numerous forms of insurance for coverage of services, including Medicare and Medi-Cal, and is actively working to ensure access to healthcare for underinsured, uninsured, and vulnerable community members.[212]

There are both inpatient and outpatient services available at the hospital, as well as services that are performed offsite at the Behavioral Health Center. Services the Hospital offers include:

- **Emergency Services**– The Hospital's ED is a 28-bed emergency treatment facility open 24 hours, every day of the year, to provide comprehensive care for people of all ages who experience a variety of illnesses and injuries. The ED also includes a five-room Rapid Care area with operating hours between 10am to 10pm every day. Rapid Care is a section of the ED where patients are able to be treated by a physician's assistant and a licensed vocational nurse for less serious conditions (cuts, fractures, the flu, etc.). It has access to all of the resources of the ED but offers a shorter wait time. Typically, patients are examined, treated and discharged within 90 minutes.
- **Intensive Care Services** – The ICU at SGMH allows for an extra level of around the clock care from highly skilled physicians and nurses. As a result of an expansion project, the ICU grew to be a 16-bed unit with rooms large enough for families to stay together overnight.
- **Behavioral Health Services** – The Behavioral Health Center associated with SGMH is owned by SGMHD and is located offsite in Palm Springs, CA. It exists to bring intensive, outpatient psychiatric services to adults coping with conditions such as schizophrenia, bipolar disorder, depression, and anxiety. The area served is from Yucaipa to Cabazon and from Palm Springs to Indio. Services offered at the center include group psychotherapy, medication management, psychoeducation and therapeutic activities.
- **Cardiac Rehabilitation** – This department offers physician prescribed exercise recovery programs monitored by nursing staff to allow patients to safely receive cardiac care. This facility provides equipment such as treadmills, bicycles, stair steppers, and weights.
- **Clinical Laboratory Services** – The SGMH offers an on-site, clinical laboratory that is licensed by the state of California, certified by the CMS, and accredited by the JC. Staffed by licensed scientists and phlebotomists, the full-service lab is open 24 hours

[210] San Gorgonio Memorial Healthcare District, Community Healthcare Needs Assessment, 2019.
[211] San Gorgonio Memorial Healthcare District, Official Statement, 2015.
[212] San Gorgonio Memorial Healthcare District, Community Healthcare Needs Assessment, 2019.

a day. There is also an outpatient lab that operates from 6am-6pm on weekdays and is open for STAT testing on the weekends.

- **Diagnostic Imaging Services**– The Radiology Department extends a full range of diagnostic testing capabilities to its patients in order to diagnose and treat various medical issues. SGMH's diagnostic imaging services include MRIs, X-Rays, Ultrasound, CT Scans, Nuclear Medicine, and Mammography.
- **Hospitalist Services** – SGMH Hospitalists are assigned by medical groups to act as primary care physicians for patients admitted to the hospital. Hospitalists are responsible for coordinating care and monitoring progress, communicating with the patient's primary care physician when needed, assisting with discharge, and facilitating consultations with specialists, as necessary.
- **Nutritional Services** – The Department of Food and Nutrition Services handles the preparation and serving of food to patients, employees, medical staff, and visitors at the SGMH. The director collaborates with a dietitian to ensure nutritional needs are addressed in patient care.
- **Obstetrics** – SGMH provides care for expecting mothers through the birthing experience. This unit of the hospital has four private Labor, Delivery and Recovery (LDR) rooms intended to keep the mother and baby in the same space from labor to recovery. Between the perinatal unit and obstetrics, there are a total of 15 licensed beds.[213] Additionally, there are eight private postpartum rooms equipped with bathrooms and showers available for patients.[214] There is also a nursery that may accommodate infants in the event they are unable to room with the mother due to health reasons.
- **Orthopedic Services** – SGMH offers outpatient and inpatient orthopedic services. The hospital indicates that it is nationally recognized for services such as hip fracture care, complex shoulder surgery, and same day joint replacement. It also reports that SGMH is the only hospital in California to receive the highest award (CORE certification) from the International Geriatric Fracture Society.[215]
- **Physical Therapy** – SGMH's Physical Therapy Department offers a full range of services including postoperative care, arthritis treatment, care for congenital and neurologic disorders, sports medicine, ergonomic evaluations, and work-related injuries. Likewise, the department also consists of inpatient and outpatient speech and language pathology services.
- **Social Services** – A variety of social services and programs are offered through SGMH to assist patients and their families with any concerns about their illness or hospitalization. Such services include discharge planning, counseling, the coordination of home healthcare, and referrals for community resources.
- **Surgery Services** – Elective and emergency surgery is performed at SGMH. There are same-day outpatient services rendered as well. The hospital has 48 licensed, acute care medical/surgical beds available for inpatient procedures.

[213] San Gorgonio Memorial Healthcare District, Official Statement, 2015.
[214] https://sgmh.org/services/obstetrics/
[215] https://sgmh.org/services/orthopedics/

- **The Women's Center** – The SGMH Women's Center is a 15,000 square foot facility on the hospital's campus that specializes in healthcare for women of all ages. The services provided range from birthing to diagnostic, surgical, and preventive medicine. There are a variety of specialized services offered as well, including breast cancer and fertility treatments, physical rehabilitation, and educational and emotional support programs that cater to all women's' needs such as the Nurse-Family Partnership.

Aside from the aforementioned departments, SGMH also offers a number of programs, classes, support groups, and events for the community. Examples include Narcotics Anonymous and Basic Life Support classes.

Collaboration and Partnerships

The District and Hospital take part in a number of collaborative efforts to provide the community with the best access to healthcare resources. Some of these active partnerships and collaborations include:

- **Nurse-Family Partnership** – This is a community health program designed for first-time mothers who are less than 28 weeks in their pregnancy. The program assigns new mothers a private RN with the intent of educating, empowering, and preparing these women for a healthy, successful transition into motherhood.
- **California Coalition for Compassionate Care** – In partnership with the Education for Life's Issues program, individuals are empowered to make informed end of life decisions and decisions as they relate to other healthcare concerns.
- **BioVigil** – In partnership with the Hospital, BioVigil is an electronic hand hygiene solution that was implemented. It is reported to have increased hand hygiene compliance from 65 percent to 92 percent, playing an important role in infection prevention and risk management.[216]
- **California Bridge Program** – SGMH was selected to participate in the California Bridge Program through the Public Health Institute to help combat the opioid crisis. Riverside County has been impacted at a disproportionate rate, registering more than two times as many opioid overdose deaths compared to the rest of the State of California.[217] The program is made possible due to a grant, funded by the Public Health Institute, that allows for funding, training, and technical assistance for hospitals while making treatment accessible to anyone in the community at any time.
- **Riverside Transit Agency** – In accordance with the ADA, SGMH works with the Riverside Transit Agency to provide priority transportation service to individuals unable to use the fixed route bus system.
- **Farmer's Market** - SGMH collaborated with the Nutrition Education and Obesity Prevention Program and Cal Fresh/Market Match to design a farmer's market. This market opened in 2019 and is part of an effort to combat diabetes and obesity.

The District also reports SGMH's working relationship with EPIC Management L.P., a California based management and consulting firm for physician groups and independent

[216] https://sgmh.org/biovigil-hand-hygiene-compliance/
[217] https://sgmh.org/grant-to-combat-the-opioid-crisis/

physician associations. Other partnerships identified in the CHNA and the Community Health Implementation Plan are:

- 211 Community Connect, Riverside County
- American Cancer Society
- Arrowhead Regional Medical Center
- Beaumont Unified School District
- Boys & Girls Clubs of Pass
- Building A Generation
- City of Redlands, Police and Recreation Departments
- Dignity Health — St. Bernardine Medical Center
- Inland Empire Community Benefit Collaborative
- Healthy Cities
- LifeStream Blood Bank
- Loma Linda University Health System
- Mercy Air Helicopter Service
- REACH
- Family Service Association of Redlands
- Redlands Unified School District
- Riverside, 211 United Way
- Rotary Club of San Gorgonio Pass
- Riverside Community Hospital
- Riverside County Fire Department
- Riverside County Paramedics Service Demand

The District is affiliated with organizations that are dedicated to the health and wellbeing of the public. It holds an annual membership with the American Hospital Association, CHA, and Association of California Healthcare Districts.

The District has, in the past, considered affiliating with Loma Linda University Health in order to accommodate the growing needs of its service area; however, this never came to fruition. The District reported that at present and near future there are no considerations for affiliations of this type.

Service Demand

The District reports that there is growing demand for services provided by SGMH.[218] With SGMH being the only hospital in the District's boundaries, and serving a largely rural area,

[218] San Gorgonio Memorial Healthcare District, Response to Request for Information, April 4, 2020.

accommodations have had to be made to meet the community's needs. This has largely occurred through expansion projects that have taken place due to the passing of three general obligation bonds and with the implementation of strategies pinpointed in the Community Healthcare Needs Assessment Implementation Strategy Report.

Hospital utilization data available for FYs 2011-2015 does show a gradual increase in most categories year over year and more substantial increases from 2011 to 2015. Emergency room visits, outpatient visits, and acute patient days saw the most significant increases, as did the total occupancy percentage which increased from 51 percent in 2011 to 60 percent in 2015.[219]

Figure 6-5: San Gorgonio Memorial Hospital Utilization Data

San Gorgonio Memorial Hospital Utilization				
2018	***2017***	***2016***	***2015***	***2014***
Total Licensed Bed Days				
2,600	28,835	27,946	25,915	25,915
Total Census Days				
10,326	11,815	15,078	15,799	16,325
Total Discharges				
2,600	2,887	3,634	3,658	4,002
Emergency Department Total Traffic				
43,984	44,552	42,788	44,001	42,480
Ambulance Diversion Hours				
0	0	0	0	0
Inpatient Surgeries Operating Room Minutes				
49,031	55,946	68,024	71,950	91,917
Outpatient Surgeries Operating Room Minutes				
48,226	67,764	70,920	75,640	83,532
Inpatient Surgical Operations				
437	484	569	644	744
Outpatient Surgical Operations				
745	970	1,025	1,080	1,263

Source: The Office of Statewide Health Planning and Development (OSHPD)

Figure 6-5 shows service demand at the SGMH between 2014 and 2018. As is shown, hospital utilization went down over the five-year period, particularly in the case of surgeries and total licensed bed days. The waning in demand was reportedly due to disagreement with a medical group that resulted in a decline in usage of the Hospital's services. Since then, changes in the Hospital's operations have been made, the conflict resolved, and demand is returning to previous levels. The demand for emergency room services had remained largely the same over the same time period.[220]

The District also reported that service demand at the hospital has declined since the onset of the COVID-19 pandemic because many people choose to avoid visiting the hospital, if possible, and postpone elective surgeries.

The ambulance diversion hours indicator shows emergency room unavailability over the course of the year. It appears that in every one of the five years shown in Figure 6-5 the emergency room was available at all times. There were no hours in that five-year period in which ambulances were diverted to other emergency rooms.

Figure 6-6 depicts patient demand information for SGMH in 2018 (the most recent complete year of information available at the time of drafting of this report). The Figure

[219] San Gorgonio Memorial Healthcare District, Official Statement, 2015.
[220] California Department of Health Care Services, *Public Hospital Redesign and Incentives in Medi-Cal (PRIME) 5-Year PRIME Project Plan*, 2016.

shows the breakdown of hospital licensed beds by type and service demand for each bed type. It appears that there is the highest demand for medical/surgical acute beds at SGMH.

Figure 6-6: San Gorgonio Memorial Hospital Service Demand, 2018

Inpatient Bed Utilization			
Licensed Bed Classification / Designation	***Licensed Beds (incl. in susp.)***	***Patient Days***	***Hospial Discharges***
Medical/Surgical Acute (includes GYN/DOU)	48	8,308	2,064
Perinatal (includes LDRP, excludes nursery)	15	594	275
Pediatric Acute	0	0	0
Intensive Care	16	1,424	261
Coronary Care	0	0	0
Acute Respiratory Care	0	0	0
Burn Center	0	0	0
Intensive Care Newborn Nursery	0	0	0
Rehabilitation Center	0	0	0
Sub-total - General Acute Care	**79**	**10,326**	**2,600**
Acute Psychiatric	0	0	0
Chemical Dependency Recovery Hospital (CDRH)	0	0	0
Intermediate Care	0	0	0
Intermediate Care/Developmentally Disabled	0	0	0
Skilled Nursing	0	0	0
Hospital Total	**79**	**10,326**	**2,600**

Figure 6-7 also demonstrates high demand for medical/surgical acute beds. The Figure also indicates that patients generally stay longer in the acute care unit than the perinatal unit or the ICU.

Figure 6-7: San Gorgonio Memorial Hospital Service Demand by Inpatient Bed Type, 2018

Inpatient Bed Utilization			
Licensed Bed Classification / Designation	***Average Length of Stay***	***Licensed Bed Days***	***Licensed Bed Occupancy Rate (%)***
Medical/Surgical Acute (includes GYN/DOU)	4.0	17,520	47.4%
Perinatal (includes LDRP, excludes nursery)	2.2	5,475	10.85%
Pediatric Acute	0.0	-	0%
Intensive Care	1.9	5,840	24.4%
Coronary Care	0.0	-	0%
Acute Respiratory Care	0.0	-	0%
Burn Center	0.0	-	0%
Intensive Care Newborn Nursery	0.0	-	0%
Rehabilitation Center	0.0	-	0%
Sub-total - General Acute Care	**4.0**	**28,835**	**35.81%**
Acute Psychiatric	0.0	-	0%
Chemical Dependency Recovery Hospital (CDRH)	0.0	-	0%
Intermediate Care		-	0%
Intermediate Care/Developmentally Disabled		-	0%
Skilled Nursing	0.0	-	0%
Hospital Total		**28,835**	**35.81%**

The chronic disease burden in Riverside County is significant and is also reflected in the SGMHD population. In terms of health specific survey results, Riverside County reported 19.2 percent of adults rate their health as poor or fair compared to the State estimate of 17.5 percent. Also, with respect to five chronic disease indicators, Riverside County ranks higher than the State with regard to adults with a body mass index over 30 and the Medicare population with heart disease.

Confounding variables affecting the health of SGHMD's residents include poverty levels and drug use. Findings in the CHNA show that residents in the primary service area for SGMHD have slightly higher percentages of both children and the total population that are under the federal poverty level. There was a 21 percent increase in homeless adults and children over 2018. In comparison to the rest of the state, Riverside County also has the highest rate of drug-induced deaths. For these reasons, recommendations to improve the community's education and employment rates are indicated as having exponential positive effects on education, physical health, and mental health. Programs like the Nurse-Family Partnership, Narcotics Anonymous, the California Bridge Program, the Tiered Weight Management Program, and the operation of a local Farmer's Market have all been instituted as a way to address the current service demands revealed in the 2019 CHNA.

Although the utilization data indicates a decline in service demand, the District is expecting that the need for hospital services will grow as the community grows.

Planning and Management

As part of the SGMHD's ongoing strategic planning efforts, it regularly reviews and utilizes a wide range of information about the communities it serves. SGMHD collects and

analyzes demographic and market data to assess, evaluate and plan for future health needs in the community. The District's most recent planning documents include the Implementation Strategy Report for 2020-22 and the 2019 CHNA. The data reported in the CHNA is collected as required by the ACA and used to inform the next steps outlined in the Implementation Strategy Report. These reports highlight pressing healthcare needs of the community, demographic information, and various factors that impact access to, risks and need for healthcare services.

While SGMHD does not directly provide services, it does source data from residents, stakeholders, public state and national records, and works alongside its partners to determine policies that, in collaboration with the nonprofit corporation that operates the hospital, fulfill the needs of the community through programs and healthcare services.

The District's additional materials that contribute to planning efforts include an annually adopted budget and a CIP. The District also follows bylaws in order to fulfill four distinct purposes: 1) Establishing and maintaining a hospital for patient care, 2) Holding activities related to health services, 3) Promoting and carrying on scientific research related to caring for the sick and injured, and 4) Participating in activities intended to promote the general health of the community.

Looking forward, there are also steps being taken to address the following goals that were identified in the CHNA:

1. Prevent and manage chronic disease through increased community education,
2. Increase access to healthcare services, particularly to underinsured, uninsured and vulnerable community members, and
3. Increase knowledge and management of mental and behavioral health.

Staffing

Figure 6-8: San Gorgonio Memorial Hospital Physician Staffing, 2017

San Gorgonio Memorial Hospital Staff	
Clinical Specialty	***Number***
Active Medical Staff - Hospital Based - Board Certified	
Diagnostic Radiology	12
Dental	1
Active Medical Staff - Non-Hospital Based - Board Certified	
Pediatric Medicine	2
Pathology	2
Urology	1
Psychiatry	2
Pulmonary Disease	2
Vascular Surgery	1
Neurology	1
General Surgery	2
Opthamology	1
Orthopedic Surgery	5
Obstetrics and Gynecology	1
Oncology	1
Otolaryngology	1
Dental	1
Cardiovascular	7
Gastroenterology	2
Active Medical Staff - Non-Hospital Based - Board Eligible	
Obstetrics and Gynecology	1
General Surgery	2

Source: The Office of Statewide Health Planning and Development (OSHPD)

SGMHD does not employ any staff. SGMH Corporation employs staff that provide administrative services for SGMHD as well.

In relation to the SGMH, the physician staffing information for 2017 (the most recent available year as of the drafting of this report) is included in Figure 6-8. Hospital staff are employees of SGMH, not SGMHD. Between FYs 16 and 19, there was a general decline in staffing level at the Hospital from 517.6 to 468.3. In FY 19-20, SGMH budgeted for a total of 489.6 FTEs to administer and operate the Hospital, which was a 4.6 percent increase in staffing from the previous FY.

Operations at the Hospital are supplemented by the SGMH Auxiliary. The SGMH Auxiliary began in 1951 when the Hospital was dedicated. The Auxiliary provides volunteers to support the Hospital in numerous capacities, including operating the Hospital's Thrift Shop and gift shop, staffing health fairs and the lobby. The District states that more than 25,000 hours are spent annually assisting the Hospital and patients. Any monetary earnings generated by the Auxiliary are donated to the Foundation to support the Hospital.

While the District itself does not employ staff and has therefore not had staffing levels impacted by the COVID-19 pandemic, the Hospital has recently had to institute layoffs of seven positions. The District reports that grant funds have been able to generally make up lost revenue in the 4th quarter of FY 19-20; consequently, staffing levels have remained relatively stable.

Facilities

The SGMH is located in Banning, in a rural area between the cities of Riverside and Palm Springs. The Behavioral Health Center is in Palm Springs. The District owns the Hospital, land

and related equipment, as well as the Behavioral Health Center, all of which are managed under contract by the nonprofit corporation that operates the facilities.

The Hospital is a 79-bed facility with 16 intensive care beds, 15 perinatal beds, and 48 general acute care beds. The Hospital has undergone significant capital improvements over the last 15 years and is considered to be in very good condition.

In 2006, the community passed a general obligation bond known as Measure A to fund the construction of a new ED and ICU, helicopter pad, central plant, and other services to support the upgrade and modernization of SGMH facilities. In total, $137 million in improvements were made. The bonds are repaid with SGMHD's property tax revenue. Major improvements made include:

- Fixed hospital equipment; construction & upgrades to ensure quality of patient care (i.e., 64-slice CT scanner and computerized record keeping),
- Improved access with additional entrance and helipad,
- Replacement and movement of underground utilities, improved parking lot safety, installation of a sewer holding tank, and construction of a cooling tower and oxygen tank farm,
- Construction of underground tunnel housing utilities for current and planned future facilities and the Central Utility Plant with computerized operations and manual back-up protection,
- Construction of a two-story clinical building plus a mechanical room on the roof with 23 private ED rooms, five rapid care rooms, 16 private ICU rooms, and a Respiratory Therapy Department,
- Expansion of the kitchen facilities, and
- Addition of a loading dock, repurposing of former ED to materials management and housekeeping, and creation of office space.

A new Patient Care Building with 60 beds was planned to address additional seismic safety requirements and expansion needs as Phase 2 of the improvements; however, demands for services, program needs, funding availability, and timing of regulation implementation have all changed over the last 15 years. While the District has substantially met seismic requirements to continue operations following an earthquake for critical care and some other services, there is a continued need to address ability to operate surgical beds following an earthquake disaster. In anticipation of further evolution of requirements and needs, the District is postponing moving forward with this expansion. The District indicated that it would likely look at moving forward with improvements in about five years.

Infrastructure Needs

An adequate healthcare system is capable of providing preventive, diagnostic, and treatment care according to the requirements of the people being served. The 2019 CHNA identified areas of growth and community service demand that represent the foundation of infrastructure needs. For SGMH, recommended improvements centered around communication and partnership and health care infrastructure investment (including mental health facilities and education programs) as ways to advance services in the

community. Specifically, in 2016, SGMH began building the infrastructure for a Tiered Weight Management Program as well as a Healthy Children and Families Program. Both of these programs directly address community health needs recognized in the CHNA.

While SGMH has undergone several expansion efforts, broadening the footprint of the hospital's campus and adding vital equipment to offer various services, the passing of the general obligation bond by Measure A afforded the System an even greater ability to make substantial needed improvements.

The Measure A bond has also allowed SGMHD to meet state mandated seismic requirements (California Seismic Safety Law SB 1953) through updates and improvements to hospital facilities.[221] State law allows general acute care hospitals until 2030 to update SPC-2 buildings used for patient care to seismic compliance. Achieving compliance with these requirements is costly and has been particularly challenging for most healthcare districts; however, SGMHD has preemptively achieved seismic compliance of the existing hospital buildings through the significant improvements conducted and a HAZUS review process, which allows acute care operations to continue up to 2030.

The most significant immediate plan for capital improvement is for a Stroke Center, which would involve the replacement of the existing CT Scanner, purchase of another CT Scanner and MRI machine, and locating these items in a new department. SGMHD has applied for grant funding for this project and plans to complete it over the next three years.

Capacity

In regard to facility capacity, Figure 6-7 in the *Service Demand* section depicts that there is overall sufficient existing capacity to accommodate patient demand for the hospital's inpatient services based on the occupancy rate of licensed beds. However, although there appears to be overall sufficient capacity in terms of hospital beds, there are identified MUAs and healthcare shortage areas within the District as discussed in the *Challenges* section.

Additionally, historical hospital utilization figures and the community health assessment demonstrated the increased need for expanded facilities and services in the SGMH service area. Thus, the previously discussed extensive capital improvement and expansion efforts. As a reflection of the historical and anticipated growth, planned renovations at the Hospital will increase capacity to 91 licensed beds from 79. Added medical and surgical beds will provide extra capacity during flu season and also allows for continued revenue growth and increase in census.

Currently, although overall bed capacity appears to be sufficient, the CHNA discusses the growing need for healthcare based on particular demographic trends, such as a rise in

[221] OSHPD has developed a Structural Performance Category (SPC 1-5) rating for hospitals that indicates the building's compliance with seismic safety standards; and a Non- Structural Performance Category (NPC 1-5) rating that indicates the hospital facility's equipment and systems conformance with seismic standards for adequate anchorage and bracing of non-structural features such as electrical, mechanical, plumbing and fire safety systems for their continued use following a disaster event. Structural/Non-Structural Performance Category 4-5 designations indicate facility conformance with the seismic standards; SPC/NPC 1-3 designations indicate nonconformance with seismic standards and include specific required deadlines to achieve conformance.

homelessness that suggests the need for more access to mental and behavioral health programs.[222]

The District reported that staffing levels were generally sufficient and did not pose a constraint to providing services. The COVID-19 pandemic has resulted in staffing demands and irregularities which are a challenge to meet, but under regular circumstances hospital staffing is adequate.

Challenges

In the past, while availability of funding to expand and replace current facilities to meet the demand of its residents was recognized as the District's primary challenge,[223] SGMHD has since identified and made use of bond funding to make a majority of the necessary facility improvements. However, completion of Phase 2, consisting of construction of the Patient Care Building, has not yet come to fruition.

SGMHD and the Hospital continue to face financial constraints related to the operations of the Hospital. The District has reported recent budget cuts of $4.25 million in FY 18-19. The District indicated that operational shifts as a result of the cuts reflect the ability to improve hospital efficiencies while patient volume increased, despite lowering expenses.[224]

The CHNA has also identified challenges to achieving better overall quality of healthcare. Such barriers include lower rates of reading proficiency, higher levels of poverty, homelessness rates, and access to transportation and financial ability to pay for services. These factors impact the community's ability to learn about prevention of illnesses and chronic disease, access to care and preventative measures, and an increased likeliness to succumb to alcohol and drug abuse and dependency.

The rural environment and subsequent socio-economic status of the SGMH service area affects the need for and accessibility to healthcare services. Medically underserved areas also pose a challenge to providing healthcare services. OSHPD produces maps for all California counties that define medically underserves areas (MUAs) and Health Care Professional Shortage Areas (HPSAs). MUAs are based on the evaluation criteria established through federal regulation to identify geographic areas or population groups based on percentage of population at 100 percent below poverty, population over 65 years old, infant mortality rate, and primary care physicians per 1,000 people. HPSAs are identified for primary care, nursing, mental health, and dental healthcare professionals. OSHPD has identified two MUAs in SGMHD that encompasses almost all territory within the District and extends outside of the District in all directions as shown in Figure 6-9. As can be seen, almost the entirety of the District is considered medically underserved. There is one area considered an HPSA within SGMHD, shown in 6-10, that is located just south of Cabazon and extends outside of the District's boundaries to the south.

[222] San Gorgonio Memorial Healthcare District, Community Healthcare Needs Assessment Implementation Plan, 2020.
[223] LAFCO 2005-07-4, SOI Reviews, June 23, 2005.
[224] San Gorgonio Memorial Healthcare District, Request for Information, April 10, 2020.

Figure 6-9: Medically Underserved Area Map

Figure 6-10: Primary Care Health Care Professional Shortage Area Map

COVID-19 has also presented challenges for the System. Board meetings have transitioned to being held entirely electronically. Elective surgeries have been cancelled and elderly patients have been directed to stay home. This has negatively impacted patient volume, although there has been a push to schedule telehealth appointments. Orthopedic patient volume and Emergency Department volume have also decreased.[225] The District reported that it had lost approximately $5 million in net revenue during the 4th quarter of FY 19-20 due to the postponement of elective surgeries and decline in emergency room visits which resulted in a decline in demand of approximately 40 percent.

[225] San Gorgonio Memorial Healthcare District, Board of Directors Meeting Minutes, May 5, 2020.

Service Adequacy

There are several benchmarks that may define the level of healthcare service provided by a hospital. Since SGMHD does not directly provide healthcare services and instead largely operates as a financing mechanism for projects and programs operated by the Hospital, the District's service adequacy assessment is based on: 1) prevention quality indicators, 2) inpatient mortality indicators, 3) hospital volume indicators, 4) EMS ambulance diversion rates, 5) the extent to which residents go to other hospitals for service, 6) patient satisfaction, 7) hospital safety, and 8) accreditation.

Although this data is not available specifically for SGMH, it is important to discuss Prevention Quality Indicators (PQIs).[226] Figure 6-11 shows that overall Riverside County's rates do not largely differ from statewide rates. For uncontrolled diabetes and asthma in young adults, the Riverside County rates were lower than statewide rates by a larger margin than all other indicators, suggesting that residents in the County have better access to outpatient care for these diseases compared to statewide. 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. The short-term diabetes complications and community acquired pneumonia rates in Riverside County, on the other hand, were higher than statewide rates by a large margin.

Figure 6-11: Risk Adjusted Rates per 1,000 Population

Year	Region	Diabetes Short-term Complications	Diabetes Long-Term Complications	COPD or Asthma in Older Adults (Ages 40+)	Hypertension	Heart Failure	Community-Acquired Pneumonia	Urinary Tract Infection
2017	Statewide	38.4	90.6	299.1	40.5	330.4	108.4	101.3
	Riverside	41.9	89.5	286	37.7	292.5	115.1	104
	Difference with statewide	9%	-1%	-4%	-7%	-11%	6%	3%
2018	Statewide	58.1	88.4	229	41.5	335.4	107	93.3
	Riverside	67.4	92.9	208.3	41.2	309.5	125.1	98.9
	Difference with statewide	16%	5%	-9%	-1%	-8%	17%	6%

Year	Region	Uncontrolled Diabetes	Asthma in Young Adults (Ages 18-39)	Lower-Extremity Amputations Among Patients with Diabetes	Overall Composite	Acute Composite	Chronic Composite	Diabetes Composite
2017	Statewide	31.9	19.5	24.7	947.1	209.7	736.3	172.5
	Riverside	26	16.5	23.1	905.6	219.6	683.6	168.2
	Difference with statewide	-18%	-15%	-6%	-4%	5%	-7%	-2%
2018	Statewide	30.3	18.5	25.9	919.6	200.3	718.3	189.8
	Riverside	26.1	15.7	25.8	916	224.2	689.7	196.8
	Difference with statewide	-14%	-15%	0%	0%	12%	-4%	4%

Source: The Office of Statewide Health Planning and Development (OSHPD)

In order to prevent the perpetuation of chronic and preventable health concerns, SGMH identified five Prevention Quality Indicators (PQI) of concern to assess quality of care and potentially prevent hospitalizations: 1) Diabetes Short-term Complications, 2) Diabetes Long-term Complications, 3) Hypertension, 4) Uncontrolled Diabetes, and 5) Asthma in Younger Adults (Ages 18-39). Based on these PQIs, the Implementation Strategy Report denotes the following needs to address for 2019-2022: Better prevention and management

[226] 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 hospitalization or for which early intervention can prevent complications or more severe disease. The Prevention Quality Indicators represent hospital admission rates for 4 ambulatory care sensitive conditions.

of chronic diseases, access to health services, mental and behavioral health. The report also pinpoints strategies and best practices to achieve these goals.

Inpatient Mortality Indicators (IMIs) reflect quality of care by measuring inpatient mortality rates for individual hospitals against state averages for specific medical conditions and surgical procedures. Evidence suggests that high mortality rates may be associated with deficiencies in the quality of hospital care provided. The most recent information regarding IMIs is available from OSHPD for 2015 (January-September).[227] The information available includes risk-adjusted mortality rates for six medical conditions treated (Acute Stroke, Acute Myocardial Infarction, Heart Failure, Gastrointestinal Hemorrhage, Hip Fracture and Pneumonia) and six procedures performed (Abdominal Aortic Aneurysm Repair, Carotid Endarterectomy, Craniotomy, Esophageal Resection, Pancreatic Resection, Percutaneous Coronary Intervention) in California hospitals. SGMH's mortality rates for all but three medical conditions and procedures were not statistically different from the statewide rates. SGMH had a higher than average mortality rates compared to hospitals statewide in regard to the acute stroke, hip fracture, and pneumonia.

The hospital volume indicators measure the number of medical procedures of a given type that are performed by a hospital within the one-year reporting period. OSHPD states that higher hospital volumes for some complex surgical procedures may be associated with better patient outcomes such as lower mortality rates; however, OSHPD does not recommend the use of volume indicators as stand-alone measures of hospital quality. The data is available for six selected inpatient procedures, including esophageal resection,[228] pancreatic resection,[229] abdominal aortic aneurysm repairs (AAA Repairs),[230] carotid endarterectomy,[231] coronary artery bypass graft surgery (CABG),[232] and percutaneous coronary intervention (PCI)[233] performed in California hospitals. The most recent information as of the drafting of this report was available for 2017. Based on the data from 2016 and 2017, SGMH has not performed any of these procedures in the two-year period.[234]

The ambulance diversion rate is another indicator of a hospital's service adequacy. Ambulance diversion may occur due to emergency room closure, inability to accommodate the incoming volume of patients or the inability to transfer admitted patients from the emergency department to inpatient beds. Ambulance diversion has been found unsafe for patients because it increases transport times, which interferes with continuity of care, causes delays, and increases mortality for severe trauma patients.[235] Figure 6-5 in the *Service Demand* section indicates that during the five years shown SGMH had no periods in which it was unable to receive patients. In all five years, the Hospital's Emergency Department was able to accommodate the incoming volume of patients at all times.

[227] Data is reported for January-September due to coding changes for diagnosis and procedures, which began on October 1, 2015.
[228] Surgical removal of the esophagus due to cancer
[229] Surgical removal of the pancreas/gall bladder due to cancer
[230] Surgical repair of abdominal aneurysm
[231] Surgical removal of plaque within the carotid artery
[232] Surgical heart artery procedure
[233] Non-surgical heart artery procedure
[234] https://data.chhs.ca.gov/dataset/number-of-selected-inpatient-medical-procedures-in-california-hospitals
[235] *Reducing Ambulance Diversion in California: Strategies and Best Practices*, California Healthcare Foundation, July 2009 https://www.chcf.org/wp-content/uploads/2017/12/PDF-ReducingAmbulanceDiversionInCA.pdf

The adequacy of hospital facilities and services in meeting the needs of district 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 origin discharge data from OSHPD.[236] Residential location was approximated by the zip codes. About 45 percent of residents who live within SGMHD boundaries patronize the SGMH for needed services based on the data available for 2016 and 2017.

Cal Hospital Compare is a performance reporting initiative that was established for the purposes of developing a statewide hospital performance reporting system using publicly available data sources. The data includes measures for clinical care, patient safety, and patient experience for all acute care hospitals in California. In FY 18-19, SGMH received an overall Patient Experience Rating of average. Patient responses further indicate that 66 percent would recommend SGMH services, which is comparable to the statewide average of 71 percent. The Hospital had a 15.8 percent (rated as average) readmission rate[237] compared to the statewide average of 15 percent. For indicators of clinical care and patient safety, SGMH's scores appear to be largely consistent with statewide average levels.[238]

The Leapfrog Group is another independent nonprofit organization that provides hospital safety grading. Its scores are based on infection rates, problems with surgery, safety problems, and performance of doctors, nurses and hospital staff. According to Leapfrog Group ratings, the SGMH has a safety rating of C as of spring 2020.[239] The rating details are shown in Figure 6-12.

There are several major healthcare-related accreditation organizations in the United States, including 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 California, the primary accreditation organization is the Joint Commission. (JC). The JC 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 JC is part of the joint survey process with State authorities. Hospitals are not required to be accredited in order to operate. Accreditation, however, generally recognizes outstanding performance by a healthcare provider.

SGMH has been fully accredited since it was opened in 1951. Its most recent three-year accreditation from the Center for Improvement in Healthcare Quality was awarded on May 26, 2018 and is valid for three years. At this time, management of the Hospital does not anticipate any difficulty in renewing its accreditation. Additionally, it is the only hospital in California to be awarded the CORE Certification from the International Geriatric Fracture Society and is accredited by the Joint Commission.

[236] Discharge data includes discharges from ambulatory surgery center, emergency department, inpatient discharges, and inpatient discharges that originated in the emergency department.
[237] The readmission rate is considered to be better the lower it is
[238] https://calhospitalcompare.org/hospital/?id=106331164&n=Desert+Regional+Medical+Center
[239] https://www.hospitalsafetygrade.org/h/desert-regional-medical-center?findBy=hospital&hospital=Desert+Regional+Medical+Center&rPos=124&rSort=grade

Figure 6-12: Leapfrog Group Safety Grade for the San Gorgonio Memorial Hospital

Infections							
Indicator	*MRSA Infection* [1]	*C. Diff Infection* [2]	*Infection in the Blood*	*Infection in the Urinary Tract*	*Surgical Site Infection after Colon Surgery*		
Score	Not available	Above average	Not available	Below average	Not available		
Complications with Surgery							
Indicator	*Dangerous Object Left in Patient's Body*	*Surgical Wound Splits Open*	*Deaths from Serious Treatable Complications*	*Collapsed Lung*	*Serious Breathing Problem*	*Dangerous Blood Clot*	*Accidental Cuts and Tears* [3]
Score	Above Average	Average	Not available	Below average	Above average	Below Average	Above Average
Practices to Prevent Errors							
Indicator	*Doctors Order Medications through Computer* [4]	*Safe Medication Administration* [5]	*Handwashing*	*Communication about Medicines*	*Communication about Discharge*	*Staff Collaboration to Prevent Errors*	
Score	Below average	Below average	Declined to report	Below average	Above average	Declined to report	
Safety Problems							
Indicator	*Dangerous Bed Sores*	*Patient Falls and Injuries*	*Air or Gas Bubble in the Blood*	*Track and Reduce Risks to Patients* [6]			
Score	Above Average	Above Average	Above Average	Declined to report			
Practices to Prevent Errors							
Indicator	*Effective Leadership to Prevent Errors* [7]	*Sufficient Qualified Nurses* [8]	*Specialty Trained Doctors Care for ICU Patients*	*Communication with Nurses*	*Communication with Doctors*	*Responsiveness of Hospital Staff*	
Score	Declined to report	Declined to report	Below average	Below Average	Below Average	Above average	

Notes:
(1) Methicillin-resistant Staphylococcus aureus (MRSA)
(2) Clostridium difficile (C. diff)
(3) For procedures of the abdomen and pelvis, there is a chance that the patient will suffer an accidental cut or tear of their skin or other tissue. This problem can happen during surgery or a procedure where doctors use a tube to look into a patient's body.
(4) Hospitals can use Computerized Physician Order Entry (CPOE) systems to order medications for patients in the hospital, instead of writing out prescriptions by hand. Good CPOE systems alert the doctor if they try to order a medication that could cause harm, such as prescribing an adult dosage for a child. CPOE systems help to reduce medication errors in the hospital.
(5) Using barcodes on medications, nurses can scan the medication and then the patient's ID bracelet to make sure the patient is receiving the right medications. If the bar codes do not match, this signals there is an error, giving nurses and doctors the chance to confirm they have the right patient, right medication, and right dose. Bar code medication administration (BCMA) systems are proven to reduce the risk that a hospital accidentally gives the wrong medication to a patient.
(6) Hospitals should be aware of all potential errors that could harm patients. Hospital leaders should evaluate their hospital's record of past errors to prevent the same error from happening again. If all hospital staff is aware of safety risks, they can work together and take all possible action to prevent harm.
(7) Errors are much more common if hospital leaders don't make patient safety a priority. Leaders must make sure that all hospital staff knows what they need to work on and that they are held accountable for improvements. The hospital should also budget money towards improving safety.
(8) Patients receive most of their care from nurses, not doctors. When hospitals do not have enough nurses or the nurses don't have the right training, patients face a much greater risk of harm. Without enough qualified nurses, patients might face more complications, longer hospital stays, and even death.

SAN GORGONIO MEMORIAL HEALTHCARE DISTRICT MSR DETERMINATIONS

Growth and Population Projections

- The population of San Gorgonio Memorial Healthcare District (SMGHD) is estimated to be 105,556 as of January 1, 2020.
- Historical growth within the District has been largely within cities. In particular, the City of Beaumont experienced 7.7 percent growth between 2018 and 2020, while Calimesa experienced 6.1 percent growth.
- According to SCAG, the annual growth rate in the District is estimated to be about 1.6 percent through 2045. Based on these estimates, the District's population is projected to be approximately 123,714 in 2030 and 156,561 in 2045.

The Location and Characteristics of Disadvantaged Unincorporated Communities Within or Contiguous to the Agency's SOI

- Riverside LAFCO has identified 40 disadvantaged unincorporated communities in Riverside County within or near cities' spheres of influence, one of which is within the SMGHD's boundaries near the City of Beaumont in the community of Highland Springs.

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

- Based on use of facilities and demand for services, there is sufficient facility capacity at present; however, given the anticipated high rate of growth in Banning and Calimesa, there will likely need to be plans for expansion to address associated additional demand.
- In addition to facility capacity and population growth, the Community Healthcare Needs Assessment identified a growing need for healthcare based on particular demographic trends, such as a rise in homelessness that suggests the need for more access to mental and behavioral health programs.
- Service adequacy of hospital services are defined by 1) prevention quality indicators, 2) inpatient mortality indicators, 3) hospital volume indicators, 4) EMS ambulance diversion rates, 5) the extent to which residents go to other hospitals for service, 6) patient satisfaction, 7) hospital safety, and 8) accreditation. Based on these indicators, the San Gorgonio Memorial Hospital's services appear to be mostly adequate and comparable to similar providers statewide.
- The Hospital has undergone significant capital improvements over the last 15 years and is considered to be in very good condition. In total $137 million in improvements

were made, bringing the existing facilities into compliance with certain state seismic requirements. There is a continued need to address the 2030 seismic needs, which is planned to be addressed as part of the District's Patient Care Building over the next decade.

- The most significant immediate plan for capital improvement is for a Stroke Center, which would involve the replacement of the existing CT Scanner, purchase of another CT Scanner and MRI machine and locating these items in a new department. SGMHD has applied for grant funding for this project and plans to complete it over the next three years.

Financial Ability of Agencies to Provide Services

- The District has the financial ability to provide services. The District generally operates with an operational surplus, has established a reserve fund to meet infrastructure and other contingency needs, has sufficient reserves to operate for approximately six months, and has no pension and OPEB liabilities.
- Given the stability of the District's existing revenue sources, and the District's conservative budgeting practices, it appears that SGMHD is low risk for financial distress.
- While SGMHD has a relatively high ratio of long-term debt attributable to the bonds issued to fund infrastructure needs, the bond payments are made with property tax revenues, which are relatively secure and sufficient to fund the debt payments.

Status of, and Opportunities for, Shared Facilities

- The District practices facility sharing by leasing the San Gorgonio Memorial Hospital to the San Gorgonio Memorial Hospital Corporation for operation. Additionally, the District practices extensive partnering and collaboration in order to provide and extend a variety of programs.
- No additional opportunities for facility sharing were identified.

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

- The District primarily conducts outreach via its website, which makes available comprehensive information and documents to the public and solicits input from customers. The website complies with SB 929 requirements; however, SGMHD needs to address AB 2257 agenda posting requirements, and ensure that all required up-to-date documents are posted on its website, including annual budgets and audited financial statements in order to comply with AB 2019.
- Accountability is best ensured when contested elections are held for governing body seats, constituent outreach is conducted to promote accountability and ensure that constituents are informed and not disenfranchised, and public agency operations and management are transparent to the public. The District demonstrated accountability with respect to these factors.

- No governance structure options were identified over the course of this review with regard to SGMHD.

SAN GORGONIO MEMORIAL HEALTHCARE DISTRICT SPHERE OF INFLUENCE UPDATE

Existing Sphere of Influence

San Gorgonio Memorial Healthcare District's (SGMHD) existing sphere of influence is coterminous with its boundaries.

Sphere of Influence Options

Two options were identified with respect to SGMHD's SOI.

Option #1: Expand SGMHD's current SOI to include the remainder of the City of Calimesa and the remainder of the City of Beaumont and its SOI.

If the Commission determines that it would be appropriate to include the entirety of these two cities and anticipated future growth (as represented by their SOIs) within SGMHD, to create logical boundaries and eliminate divided communities of interest, then it would be appropriate to indicate support of eventual annexation of that territory by including it in SGMHD's SOI.

Option #2: Maintain coterminous SOI

Should the Commission wish to continue to reflect the intention to maintain SGMHD's existing boundary, then a coterminous SOI would be appropriate.

Sphere of Influence Analysis

At present, the cities of Calimesa and Beaumont are only partially included in SGMHD's boundary and SOI. It is unclear why a portion of the City of Calimesa was excluded from SGMHD when it was originally formed. SGMHD's boundaries surround that portion of the City on three sides and the San Bernardino county line lies to the north, forming an island of sorts and illogical boundaries.

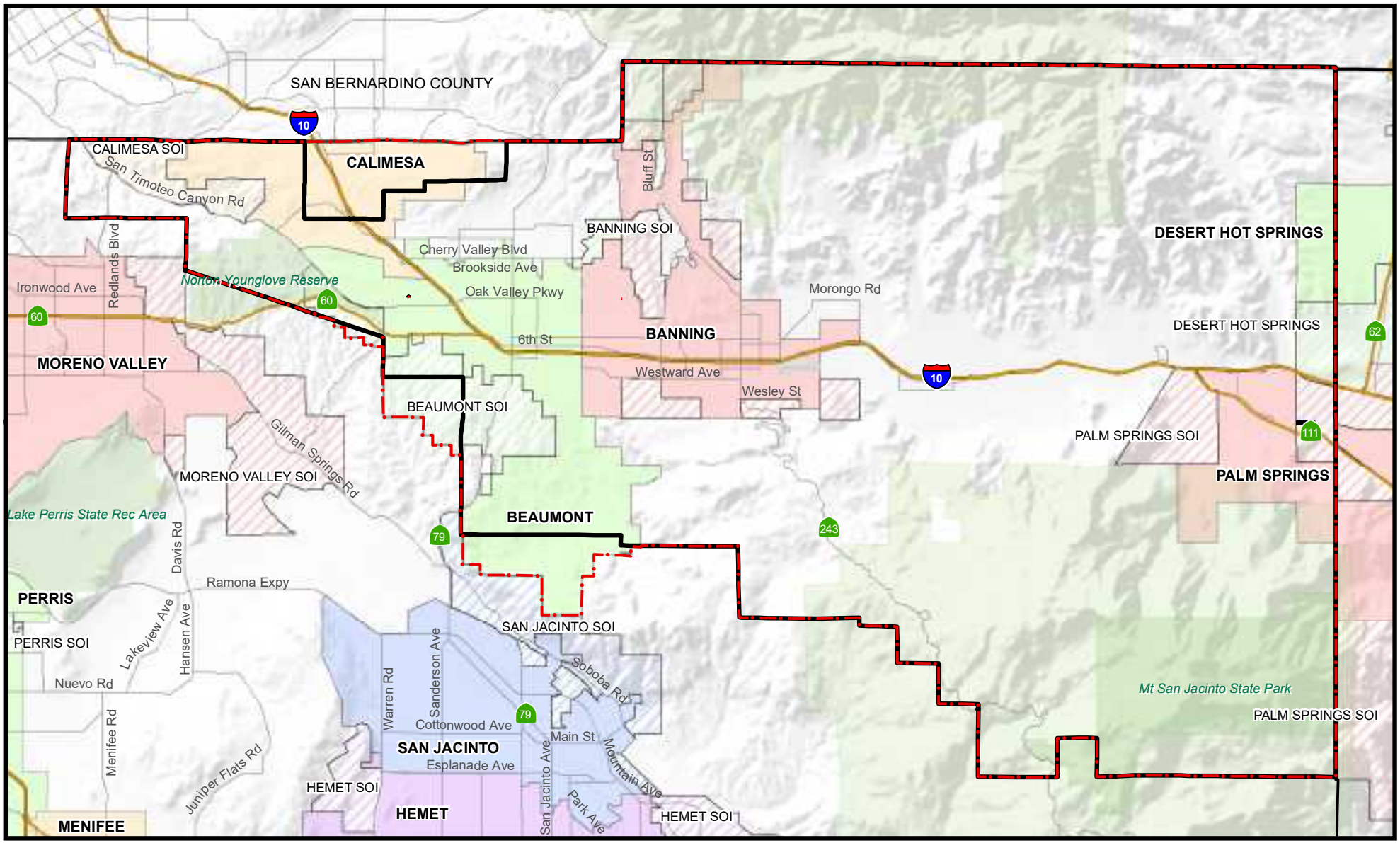
To the south, the City of Beaumont's city limits extend outside of SGMHD's boundaries, leaving a small portion of the City outside of a designated healthcare district, resulting in a divided community, and once again creating illogical boundaries. Additionally, the City of Beaumont's SOI extends outside of SGMHD's boundaries to the west. Should the area become developed and annex into the City of Beaumont, the area would become a divided community without a designated healthcare district similar to the southern territory of the City.

Analysis of patronage of SGMHD's facilities shows that the City of Beaumont is a part of the District's primary service area and the City of Calimesa is a part of the District's secondary service area. The primary service area comprises 70 percent of the District's demand, of which Beaumont is 31 percent. Residents from the City of Calimesa constitutes 2.29 percent of the District's patrons.

SGMHD indicated it supported including these areas in its SOI in order to appropriately include its customers in its boundaries.

One of LAFCO's objectives is to eliminate illogical boundaries and associated service inefficiencies, such as the areas in question. It is recommended that SGMHD's boundaries be expanded to include the entirety of the cities of Calimesa and Beaumont and their SOIs, as is shown in Figure 6-13. This would address the issues outlined, including divided communities of interest, lack of inclusion of some of the District's patrons within its boundaries, and illogical boundaries.

Figure 6-13: San Gorgonio Memorial Healthcare District Proposed Sphere of Influence



Data Sources: County of Riverside; LAFCo

0 0.5 1 2 3 4 Miles

N

Disclaimer: The information shown is intended to be used for reference and general display purposes only and is not to be used as an official map.

Healthcare services provided for District residents

Legend

- San Gorgonio Memorial Healthcare District
- San Gorgonio Memorial HealthCare District Proposed Sphere of Influence

Map Created on 9/14\2020

Sphere of Influence Determinations

Nature, location, extent, functions, and classes of services provided

- SGMHD contributes to the services provided by the Hospital by owning, maintaining and making improvements to the hospital, land, building, equipment, and the Behavioral Health Center. The San Gorgonio Memorial Hospital Corporation provides healthcare services at the facilities. SGMHD also supplements the operations of the Hospital by providing financial support in hospital operations and community health programs.
- The District's boundaries encompass approximately 356 square miles in the northwest portion of Riverside County and includes the cities of Banning and Beaumont, a portion of the City of Calimesa, the western portion of Palm Springs, and the neighboring unincorporated areas of Cabazon, Cherry Valley and Whitewater.
- The District's primary service area includes the cities of Banning and Beaumont. The secondary service area includes the City of Calimesa and the unincorporated community of Cabazon. The secondary service area also includes the cities of Yucaipa, San Jacinto, and Hemet, which are outside of SGMHD's boundaries and sphere of influence.

Present and planned land uses, including agricultural and open-space lands

- The western portion of SGMHD encompasses largely developed incorporated areas within the cities of Calimesa, Banning, and Beaumont, while the eastern portion of the District is largely unincorporated, with the exception of the western tip of the City of Palm Springs. The unincorporated area largely consists of the Morongo Reservation, Mount San Jacinto State Park and the San Jacinto Mountains, and as such, these areas have a more rural character and lower population density then the western portion of the District.
- Due to the expansive nature of the District, it encompasses all land use types, including significant open space lands in the eastern portion of the District in the mountains.

Present and probable need for public facilities and services

- As indicated by SGMHD's service demand and projected growth, there is a present and anticipated continued need for healthcare funding and hospital oversight services offered by the District.

Present capacity of public facilities and adequacy of public services that the agency provides or is authorized to provide

- Based on use of facilities and demand for services, there is sufficient facility capacity at present; however, given the anticipated high rate of growth in Banning and Calimesa, there will likely need to be plans for expansion to address associated additional demand.
- In addition to facility capacity and population growth, the Community Healthcare Needs Assessment identified a growing need for healthcare based on particular

demographic trends, such as a rise in homelessness that suggests the need for more access to mental and behavioral health programs.

- Service adequacy of hospital services are defined by 1) prevention quality indicators, 2) inpatient mortality indicators, 3) hospital volume indicators, 4) EMS ambulance diversion rates, 5) the extent to which residents go to other hospitals for service, 6) patient satisfaction, 7) hospital safety, and 8) accreditation. Based on these indicators, the San Gorgonio Memorial Hospital's services appear to be mostly adequate and comparable to similar providers statewide.
- The Hospital has undergone significant capital improvements over the last 15 years and is considered to be in very good condition. In total, $137 million in improvements were made, bringing the existing facilities into compliance with certain state seismic requirements. There is a continued need to address the 2030 seismic needs, which is planned to be addressed as part of the District's Patient Care Building over the next decade.

Existence of any social or economic communities of interest

- All the areas inhabited by district residents represent social and economic communities of interest, as SGMHD residents pay for its services through property taxes.
- Communities in the District's secondary service area are considered to be social and economic communities of interest for SGMHD.
- Additionally, medically underserved areas within SGMHD boundaries represent a particular social and economic interest since they are underserved and require enhanced attention from the District.

APPENDIX A

BEST MANAGEMENT PRACTICES FOR GRANT GIVERS

Internal Control Systems

1. Prepare department-wide policies and make available on the internet:

Having regulations and internal operating procedures in place prior to awarding grants enables agencies to set clear expectations. Policies serve as guidelines for ensuring that new grant programs include provisions for holding awarding organizations and grantees accountable for properly using funds and achieving agreed-upon results. Although different programs may need different procedures, general policies should be established that all programs must follow.

Both large and small agencies and foundations have found that establishing department-wide policies and procedures on an internet site is beneficial.

The website also provides applicants with one location for finding detailed information about funding opportunities, applications, forms, submission dates, awarded grants, and grant policies.

2. Providing grant management training to staff and grantees:

Agencies are responsible for ensuring that staff is properly trained to fulfill grant requirements. It is essential that grantees also receive training, particularly small entities not familiar with all of the regulations and policies.

3. Working with grantees to develop performance measures:

It is imperative that grantors and grantees determine how best to measure performance to meet all parties' needs. If there are no common measures, each grantee may establish its own individual program goals and measures. By working with grantees, the agency can encourage the creation and maintenance of a learning environment.

Pre-Grant Review

1. Assess the managerial competence and fiscal accountability of the prospective grantee:

- ❖ Are the grantee institution and project director(s) capable of carrying out the work described in the proposal?
- ❖ Are systems in place to ensure that grant funds will be managed within the terms and conditions of the grant agreement?
- ❖ Is the organization functioning without the threat of liquidation in the foreseeable future with an established governance structure and good management systems, financial systems and staff? Organizations that are not well established may be seen as too risky. Alternatively, agencies may provide grants to these organizations with the explicit goal of assisting them to become established.

- ❖ Is there evidence of mismanagement or fraud and abuse in the organization's recent history?
- ❖ Is the organization's legal status current?

2. Review the proposal and budget for internal consistency and for compliance with agency's policies:
   - ❖ Is the proposed budget appropriate and sufficient for carrying out the project?
   - ❖ Does the plan need to be adjusted to reflect effort or materials necessary to carry out tasks?
   - ❖ Is sufficient justification provided for the budget line items, and does it support the work plan laid out in the proposal?
   - ❖ Are cost assumptions in accordance with the agency's policies?
   - ❖ Does the budget include overhead/indirect cost? If so, could the organization find another source for this cost?
3. Encourage outside reviews of the proposed activity:
   - ❖ When appropriate, obtain reviews of the proposed activity by outside experts or other donors in the field. These reviews can evaluate the rationale for the request, the appropriateness of the approach, the soundness of the methodology, the suitability of the budget or of the proposed grant recipient, and project leadership.
   - ❖ Has the grantee organization or project director substantially been in compliance with the requirements and conditions of its previous or currently active grants? Or are there indicators for concern, such as consistently and unreasonably late or inaccurate narrative reports; extremely late, questionable or inaccurate financial reports; or a failure to obtain approvals required by the existing grant agreements?

Pre-award Process

1. Preparing work plans to provide framework for grant accountability:

   The work plan serves as a written record of what the grantee will do with funds. Through the work plan, the awarding agency and grantee ensure a clear understanding of the intended purpose and results for the grant funds. Agencies need to take specific actions to obtain information from applicants and evaluate the information when preparing the grant award.

2. Including clear terms and conditions in grant award documents:

   The terms, conditions, and provisions in the award agreement, if well designed, can render all parties more accountable for the award. When award documents are not well written, they can impact an agency's ability to ensure funds are used as intended.

Managing performance

1. Monitoring the financial status of grants:

The timely receipt of financial records and reports from grantees is necessary for agencies to effectively monitor the financial status of grants. Ineffective grant monitoring increases the risk of improper payments and untimely grant expenditures. It may also result in the misuse or waste of funds. One way agencies have addressed this issue is by developing systems that make information on the financial status of grants readily available to staff. Also, agencies have addressed the issue through on-site reviews.

2. Ensuring results through performance monitoring:

Monitoring grantee performance helps ensure that grant goals are reached and required deliverables completed. In addition, monitoring performance can address potential problems early in the grant period and keep grantees on course toward goals. A grants management system and site visits allow agencies to effectively monitor grants by providing timely and accessible information on grant performance and deliverables. Given the limited resources and the number of grants awarded, it is important that agencies identify, prioritize, and manage potential at-risk recipients. Some agencies monitor grants through telephone monitoring or regular status reports and end-of-the-project reports.

3. Using audits to provide valuable information about grantees:

Agencies can use internal and external audits of grantees to identify problems with grantee financial management and program operations. Awareness of problems allows grant officials to implement additional controls to effectively monitor a grantee's use of funds and activities.

4. Monitoring sub-recipients:

Grantees may further distribute funds to other organizations, known as sub-recipients. Sub-recipients, many of which are small organizations, often lack experience and training in grants management. It is important that recipients identify, prioritize, and manage potential at-risk sub-recipients to ensure that grant goals are reached, and resources properly used.

Assessing and Using results

1. Providing evidence of program success:

Measuring the results of a program can provide evidence of its successful performance against goals and objectives. Program results information is important for making budgetary and programmatic decisions. Program managers can use program results information to defend their programs against budgetary challenges and make decisions on resource allocation. One challenge in obtaining information on results is that results can take time to develop and cannot be measured during a grant's life. A second challenge is that agencies may not have direct access to information on program results, and will need to obtain that information through grantees that may lack data collection skills.

2. Identifying ways to improve program performance:

Evaluation results can reveal approaches that help to achieve program goals and objectives, as well as illustrate ineffective approaches. Also, evaluations can help clarify which effects are attributable to a program, identify reasons for success or failure, and recommend changes that can help a program achieve its goals and objectives.

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