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FIVE – YEAR SPHERE OF INFLUENCE AND SERVICE REVIEW REPORT

SAN DIEGO COUNTY HEALTH CARE SERVICES
Fallbrook HD: MSR13-65; SR13-65; SA13-65
Grossmont HD: MSR13-67; SR13-67; SA13-67
Palomar Health HD: MSR13-77; SR13-77; SA13-77
Tri-City HD: MSR13-92; SR13-92; SA13-92

Submitted by:

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May 5, 2015
(Corrected)

SAN DIEGO COUNTY HEALTH CARE SERVICES MSR AND HEALTH CARE DISTRICT SPHERE OF INFLUENCE REVIEW
TABLE OF CONTENTS and ATTACHMENTS

EXECUTIVE SUMMARY 1
MUNICIPAL SERVICE REVIEW AND SPHERE OF INFLUENCE REPORT 33
FALLBROOK HD 47
GROSSMONT HD 80
PALOMAR HEALTH HD 111
TRI–CITY HD 155
MUNICIPAL SERVICE REVIEW AND SPHERE OF INFLUENCE RECOMMENDATIONS . 189

MAPS

SAN DIEGO COUNTY HEALTH CARE SERVICES MSR STUDY AREAS

MAP 1A: MSR Study Area: San Diego County
MAP 1B: Medical Service Study Areas (MSSA): 2010 Census Tracts
MAP 1C: Disadvantaged Unincorporated Communities (DUC)
MAP 1D: Medical Service Study Areas (MSSA): Percentage of Elderly Population (65-85+)
MAP 1E: Medical Service Study Areas (MSSA): Percentage of Poverty Rate
MAP 1F: Medically Underserved Areas (MUA)
MAP 1G: Health Professional Shortage Areas (HPSA): Primary Care
MAP 1H: Primary Care Shortage Areas (PCSA)
MAP 1I: Health Professional Shortage Areas (HPSA): Mental Health
MAP 1J: Health Professional Shortage Areas (HPSA): Dental
MAP 1K: Registered Nurse Shortage Areas (RNSA)
MAP 1L: Proposed Special Study Areas

FALLBROOK HD (MSR13-65; SR13-65; SA13-65)

MAP 2A: Fallbrook HD Authorized Service Area and Adopted Sphere of Influence
MAP 2B: Fallbrook HD Medical Service Study Areas (MSSA): Percentage of Elderly Population (65-85+)
MAP 2C: Fallbrook HD Medical Service Study Areas (MSSA): Percentage of Poverty Rate
MAP 2D: Fallbrook HD Medically Underserved Areas (MUA)
MAP 2E: Fallbrook HD Health Professional Shortage Areas (HPSA): Primary Care
MAP 2F: Fallbrook HD Primary Care Shortage Areas (PCSA)
MAP 2G: Fallbrook HD Proposed Special Study Areas

SAN DIEGO COUNTY HEALTH CARE SERVICES MSR AND HEALTH CARE DISTRICT SPHERE OF INFLUENCE REVIEW
TABLE OF CONTENTS and ATTACHMENTS

GROSSMONT HD (MSR13-67; SR13-67; SA13-67)

MAP 3A: Grossmont HD Authorized Service Area and Adopted Sphere of Influence

MAP 3B: Grossmont HD Medical Service Study Areas (MSSA): Percentage of Elderly Population (65-85+)

MAP 3C: Grossmont HD Medical Service Study Areas (MSSA): Percentage of Poverty Rate

MAP 3D: Grossmont HD Medically Underserved Areas (MUA)

MAP 3E: Grossmont HD Health Professional Shortage Areas (HPSA): Primary Care

MAP 3F: Grossmont HD Primary Care Shortage Areas (PCSA)

MAP 3G: Grossmont HD Health Professional Shortage Areas (HPSA): Mental Health

MAP 3H: Grossmont HD Health Professional Shortage Areas (HPSA): Dental

MAP 3I: Grossmont HD Proposed Special Study Areas

PALOMAR HEALTH HD (MSR13-77; SR13-77; SA13-77)

MAP 4A: Palomar Health HD Authorized Service Area and Adopted Sphere of Influence

MAP 4B: Palomar Health HD Medical Service Study Areas (MSSA): Percentage of Elderly Population (65-85+)

MAP 4C: Palomar Health HD Medical Service Study Areas (MSSA): Percentage of Poverty Rate

MAP 4D: Palomar Health HD Medically Underserved Areas (MUA)

MAP 4E: Palomar Health HD Health Professional Shortage Areas (HPSA): Primary Care

MAP 4F: Palomar Health HD Primary Care Shortage Areas (PCSA)

MAP 4G: Palomar Health HD Proposed Special Study Areas

TRI-CITY HD (MSR13-92; SR13-92; SA13-92)

MAP 5A: Tri-City HD Authorized Service Area and Adopted Sphere of Influence

MAP 5B: Tri-City HD Medical Service Study Areas (MSSA): Percentage of Elderly Population (65-85+)

MAP 5C: Tri-City HD Medical Service Study Areas (MSSA): Percentage of Poverty Rate

MAP 5D: Tri-City HD Medically Underserved Areas (MUA)

MAP 5E: Tri-City HD Primary Care Shortage Areas (PCSA)

MAP 5F: Tri-City HD Proposed Special Study Areas

LAFCO
San Diego Local Agency Formation Commission

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May 4, 2015

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TO: Local Agency Formation Commission

FROM: Executive Officer
Local Governmental Analyst III

SUBJECT: Five–Year Sphere of Influence and Service Review
San Diego County Health Care Services Municipal Service Review and Health Care District Sphere of Influence Review

Fallbrook Health Care District: MSR13-65; SR13-65; SA13-65
Grossmont Health Care District: MSR13-67; SR13-67; SA13-67
Palomar Health Care District: MSR13-77; SR13-77; SA13-77
Tri–City Health Care District: MSR13-92; SR13-92; SA13-92

EXECUTIVE SUMMARY

Local Agency Formation Commissions (LAFCOs) are required to establish a *sphere of influence* for each local governmental agency under LAFCO jurisdiction. A sphere of influence is defined in State Law as *"…a plan for the probable physical boundaries and service areas of a local agency"* (Government Code § 56076) and is intended to promote logical and orderly development and coordination of local agencies; inhibit duplication of services; and support efficient public service delivery. In order to prepare and update spheres in accordance with provisions in State Law, LAFCO must conduct a Municipal Service Review (MSR) per Government Code Section 56430.

In 2007, the San Diego LAFCO conducted a sphere and service review of all special districts in San Diego County, including the four local Health Care Districts (HDs) formed under the *Local Health Care District Law* (California Health and Safety Code, Division 23. Hospital Districts [32000 et. seq.]: Fallbrook HD, Grossmont HD, Palomar Health HD, and Tri–City HD (Map 1A). It was concluded in 2007 that no anticipated changes in service areas would be necessary for three of the Health Care Districts: Fallbrook HD, Grossmont HD and Palomar Health HD. However, the 2007 LAFCO action also concluded that the Tri–City HD had been considering a potential sphere expansion to include (annex) areas within the Cities of Carlsbad (La Costa)

(Shadowridge). Discussions between the Tri–City HD and LAFCO staff were preliminary and it was uncertain whether a proposal would ever be filed with LAFCO. Therefore, additional territory was not placed in Tri–City HD's coterminous sphere of influence. It was also concluded that each of the Health Care Districts was adequately coordinating hospital facility upgrade programs to comply with Federal and State mandated programs for seismic safety standards by 2012. Based on these facts, the Commission accepted the service review data on file and reaffirmed the coterminous spheres for the Fallbrook; Grossmont; Palomar–Pomerado (since renamed as *Palomar Health*); and Tri–City HDs.

LAFCO's *2015 San Diego County Health Care Services MSR and Sphere Review* picks up where the 2007 LAFCO study left off. The 2015 review also fulfills requirements in State Law to periodically review and update, as necessary, the spheres and service reviews for each local governmental agency under LAFCO jurisdiction.

The *MSR and Sphere Review* concludes that the Tri-City, Palomar Health, and Grossmont HDs are accountable for local community service needs; are capable of adequately providing health care services within their respective service areas and adopted spheres of influence; and have reported a wide variation in both financial activity and fiscal health. We have concluded that the Fallbrook HD has experienced significant local hospital operational issues that have resulted in the December 2014 closure of its acute-care Fallbrook Hospital, and that these issues may become jurisdictional issues of Commission consideration in the future.

We also conclude that Palomar Health HD and Tri-City HD independently operate their regional acute-care hospitals in a subregion of the San Diego County that includes other acute-care hospitals that currently serve patients residing within the Districts' respective authorized service areas. This highly competitive market environment for local healthcare patients has presented financial challenges for both Health Care Districts as independent acute-care hospital operators that are unaffiliated with larger, managed healthcare systems.

We have also documented what has been widely reported in the media regarding the considerable accumulated bonded debt that Palomar Health HD is carrying; and that both Tri-City HD and Palomar Health HD have recently experienced significant operating losses.

These fundamental financial issues undoubtedly will be addressed by each of the Health Care Districts, but continued hospital facility operating losses could also raise questions as to future sustainability, especially if the publicly-elected Boards of Directors do not take corrective actions. Below is a summary of the major conclusions reached in the *2015 San Diego County Health Care Services MSR and Sphere Review*:

- Each of the four local Health Care Districts has demonstrated accountability for community service needs.
- Each of the four local Health Care Districts has the capability to adequately provide and/or support the provision of healthcare services within their respective service areas and adopted spheres of influence.

- The respective coterminous spheres presently adopted by the Commission for the Fallbrook, Tri-City, Palomar Health, and Grossmont Health Care Districts should be reaffirmed.
- *Special Study Area* designations should be applied to large tracts of incorporated and unincorporated territory abutting the Fallbrook, Tri-City, Palomar Health, and Grossmont Health Care District service areas and spheres of influence (Map 1L).
- The proposed *Special Study Area* designations include local areas designated by the California Office of Statewide Health Planning and Development (OSHPD) as medically underserved or understaffed with physicians, registered nurses, or other healthcare professionals; and local areas identified with poverty levels higher than the regional average of 14.4%. The Commission is recommended to consider determining such designated areas as containing *social or economic communities of interest* relevant to the local Health Care Districts.
- The Health Care Districts are recommended to evaluate potential sphere of influence options that would facilitate the submittal of future annexation proposals of *Special Study Area* designated territory for Commission consideration. This matter should be the subject of the next *Health Care Services MSR and Sphere Review* in 2020.
- S*pecial Study Area* designations should be considered for local areas within and between certain local Health Care Districts (e.g., Tri-City and Palomar Health) to encourage discussions and to evaluate potential reorganizations of identified incorporated territory in accordance with requirements in State Law for the Health Care Districts' authorized service areas.
- Prior to the *2020 Health Care Services MSR and Sphere Review*, each of the local Health Care Districts should determine if territory located within the proposed *Special Study Area* designations would benefit from inclusion within their spheres and/or authorized service areas through future annexation proposals or other changes of organization..
- Prior to the *2020 Health Care Services MSR and Sphere Review*, the Fallbrook HD and LAFCO staff should confer to evaluate potential sphere of influence designation options for the District's authorized service area, including potential assignment of a transitional sphere designation indicating that its service responsibilities should be reallocated to any or all of the remaining Health Care Districts in San Diego County.

BACKGROUND

In 1972, the California State Legislature directed Local Agency Formation Commissions (LAFCO) to establish a *sphere of influence* for each local governmental agency under LAFCO jurisdiction. A sphere of influence is defined in State Law as "...*a plan for the probable physical boundaries and service areas of a local agency"* (Government Code §56076) and is intended to promote logical and orderly development and coordination of local agencies; inhibit duplication of services; and support efficient public service delivery.

State Law requires that LAFCOs shall, as necessary, review and update each adopted sphere of influence commencing in 2008 and every five years thereafter, [Government Code 56425(g)]. When determining an agency's sphere of influence, LAFCO must consider and prepare a written statement of determinations that addresses each of the following categories:

(1) The present and planned land uses in the area, including agricultural and open space lands.

(2) The present and probable need for public facilities and services in the area.

(3) The present capacity of public facilities and adequacy of public services that the agency provides or is authorized to provide.

(4) The existence of any social or economic communities of interest in the area if the commission determines that they are relevant to the agency.

(5) For an update of a sphere of influence of a city or special district that provides public facilities or services related to sewers, municipal and industrial water, or structural fire protection, that occurs pursuant to subdivision (g) on or after July 1, 2012, the present and probable need for those public facilities and services of any disadvantaged unincorporated communities within the existing sphere of influence.

[Government Code 56425(e)]

To help prepare and update spheres of influence, LAFCO is required to conduct a service review (referred to as a Municipal Service Review or MSR), which analyzes and evaluates the provision of the services within the specified geographic area. The MSR evaluation requirements are codified in Government Code Section 56430 and involve a broad spectrum of service delivery, operational, infrastructure, community services accountability, financial, and jurisdictional issues.

2015 San Diego County Health Care Services MSR and Sphere Review Study Area

The study area for the *2015 Health Care Services MSR and Sphere Review* is San Diego County, also known as the *San Diego–Carlsbad Metropolitan Statistical Area*, or the San Diego Region. The U.S. Census Bureau reports that San Diego County has a total area of approximately 4,526 square miles, including 4,207 square miles of land and 319 square miles of water bodies (Map 1A).

The 2010 Census calculated the total population of San Diego County at 3,095,308, ranking as the second-most populous county in California and the fifth-most populous in the United States 2013 population estimates by the San Diego Association of Governments (SANDAG) reflect a total population of 3,150,178 in San Diego County.

Health Care Districts were originally formed and authorized by the California State Legislature as *local hospital districts* under the *Local Hospital District Act of 1945* (Health and Safety Code, Division 23. Hospital Districts [32000 et. seq.]). At that time, rural areas in California were in need of new acute-care hospital facilities and additional physicians to serve a rapidly expanding populace and the return of World War Two veterans requiring ongoing medical care.

The *Local Hospital District Law* empowered medically underserved communities in rural areas of the State with the ability to establish local hospital districts and utilize public financing mechanisms to fund, construct, and operate acute-care hospital facilities, and to increase the number of physicians to provide professional medical services.

The *Local Hospital District Law* was amended in 1994 and renamed the *Local Health Care District Law* to better represent the variety of modern healthcare services and programs provided by hospital districts. Authority granted to Health Care Districts under current law includes:

- Operating health care facilities such as hospitals, clinics, skilled nursing facilities, adult day health centers, nurses' training school, and child care 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.

Agencies Included in 2015 Health Care Services MSR and Sphere Review

The *2015 San Diego County Health Care Services MSR and Sphere Review* reviews the provision of health care services in the MSR study area by the four local Health Care Districts (HD) that were formed under the *Local Health Care District Law*:

- *Fallbrook HD (formed in 1948)*, which owns the recently-closed Fallbrook Hospital within the unincorporated community of Fallbrook (Map 2A).
- *Grossmont HD (formed in 1952)*, which owns the Grossmont Hospital in the City of La Mesa, and leases the facility to the non-profit Sharp HealthCare System under a 30-year operating agreement (Map 3A).
- *Palomar Health HD (formed in 1950*), which owns and independently operates three acute-care hospitals: the Palomar Medical Center and the Palomar Health Downtown Campus within the City of Escondido; and the Pomerado Hospital in the City of Poway (Map 4A).
- *Tri-City HD (formed in 1957)*, which owns and independently operates the Tri-City Medical Center within the City of Oceanside (Map 5A).

The recent termination of the lease/operating agreement for Fallbrook Hospital between the Fallbrook HD and its for-profit operating partner, Community Health Systems, Inc. (CHS) has resulted in the closure of the hospital facility. Additional discussion regarding the current status of the Fallbrook Hospital is included in the Fallbrook HD section of the MSR.

2015 Health Care Services and Sphere Review: Major Topics

The *2015 Health Care Services MSR and Sphere Review* provides discussions and evaluations of each of the major topics required for the adoption of a service and sphere review. The service review categories and relevant health care topics provide a broad base of data and quality indicators regarding: the provision of health care services; the status of local hospital infrastructure; annual hospital financial performance; and an overview of governmental structure options available to the Health Care Districts. Below are the major topics covered in the *MSR and Sphere Review*:

1. District Overview: Formation, Governance, Hospital Facilities
2. Service Area/Sphere of Influence: Population/Projections, Social or Economic Communities of Interest, Medically Underserved Areas
3. Services/Facilities: Adequacy of Services, Infrastructure Needs & Deficiencies
4. Finance: Fiscal Performance, Property Taxes, Debt
5. Governance: Community Service Accountability, Hospital Operations
6. Governance: Opportunities for Shared Facilities, Governance Options
7. MSR Determinations: Sphere Recommendations

Service Area and Spheres of Influence

The four local Health Care Districts combined service areas and spheres include a total population of approximately 1,419,636 (2014) within approximately 1,848.7 square miles (1,183,168 acres). On June 6, 1986, San Diego LAFCO established coterminous spheres for each of the HDs; no annexations or detachments involving HD territory have occurred since the spheres were adopted.

The County of San Diego also provides county-wide public health care services; however, the *2015 San Diego County Health Care Services MSR and Sphere Review* concentrates on the four public Health Care Districts that have spheres of influence established by LAFCO and provide health care services only within their respective service areas. The County of San Diego's health care services and programs are referenced in relation to the four Health Care Districts.

Population/Projections

SANDAG Special District Population Estimates indicate that local populations within the Health Care District service areas have not experienced significant growth during 2008-2014; however, the SANDAG 2050 Regional Growth Forecast (2011) anticipates that the San Diego region will grow approximately 40% by 2050. Growth rates for the local Health Care District service area populations over 2013-2050 are anticipated to range from 20-50%.

Population	2014	2008-2014	2050	2013-2050
Fallbrook HD	57,515	+6.0%	72,681	+50.7%
Grossmont HD	498,684	-1.5%	752,365	+34.0%
Palomar Health HD	510,041	+2.0%	838,139	+32.4%
Tri-City HD	353,396	-3.3%	517,893	+20.3%

2013-2030 Elderly Population Projections

SANDAG 2050 population forecasts indicate the 65-85^{+} age ranges will grow by approximately 98% to 214% over today's levels. The anticipated population increases are projected to include significant increases in elderly population segments from 2010-2030. The *MSR and Sphere Review* determinations indicate that the local Health Care Districts should utilize SANDAG's estimated population projections and anticipated demographic changes for planning future health care facilities and services. In particular, the projected expansion of the elderly population by 2030 will necessitate Health Care District planning for sufficient local services and programs to serve the specific needs of older patients (Map 1D).

Medically Underserved Areas/Health Care Professional Shortage Areas

The California Office of Statewide Health Planning and Development (OSHPD) produces maps for all California counties that use 2010 census tract geographic boundaries to define local Medical Service Study Areas (MSSA) (Map 1B). The county maps identify local MSSAs that qualify for designation as a *Medically Underserved Area* (MUA) or contain a *Medically Underserved Population* (MUP) (Map 1F).

Medically Underserved Areas or Medically Underserved Populations are based on the evaluation of criteria established through federal regulation to identify geographic areas or population groups on the following demographic data:

- Percentage of population at 100% below poverty;
- Percentage of population over > 65;
- Infant mortality rate; and
- Primary care physicians per 1,000 population

OSHPD also provides maps for local MSSAs that qualify as *Primary Care Shortage Areas* (PCSA) and/or as *Health Care Professional Shortage Areas* (HPSA) for *Primary Care*, *Nursing*, *Mental Health*, or *Dental* health care professionals. OSHPD has designated all of San Diego County as a *Registered Nursing Shortage Area* (RNSA), but has not designated any *Medically Underserved Populations* in the County (Maps 1G-1K).

The *Health Care Services MSR and Sphere Review* determinations identify the designated MUA, MUP, PCSA, or HPSA territory within or adjacent to the Health Care District service areas and spheres. The MSR determinations conclude that *Medically Underserved Areas* and *Health Care Professional Shortage Areas* presently exist within and adjacent to each of the Health Care District service areas and spheres and include both urban and rural areas within the County.

The *MSR and Sphere Review* determinations state that local OSHPD-designated medically underserved or healthcare professional shortage areas that consist of inhabited territory are primarily located in urban areas of the coastal incorporated cities.

Rural territory containing OSHPD-designated areas are generally located within the unincorporated northeast and southeast areas of San Diego County, including the Borrego Springs-Desert and Mountain Empire Community Planning Areas; however, much of the identified rural areas consist of uninhabited territory, including state/national parklands and Indian reservation areas.

The *MSR and Sphere Review* determinations recommend consideration of *Special Study Area* designations for urban and rural inhabited territory not currently located within the HD service areas and spheres that contains OSHPD-designated *Medically Underserved Areas* and/or *Health Care Professional Shortage Areas* (Map 1L).

Medical Service Study Areas with High Poverty Levels

OSHPD provides demographic data for each MSSA, including population densities and poverty levels. The MSSA data for San Diego County shows that areas with poverty levels above the regional average of 14.4% exist in both low-population rural and high-population urban Medical Service Study Areas (Map 1E).

Local areas with high poverty are also associated with identified medically underserved areas, health care professional shortage areas, and disadvantaged unincorporated communities. Identification of high poverty levels within and adjacent to the Health Care Districts' service areas and spheres may help to reflect areas where relevant *social or economic communities of interest* to the districts exist.

The *MSR and Sphere Review* determinations recommend consideration of *Special Study Area* designations for identified inhabited areas with high poverty levels. Subsequent Health Care District MSRs should evaluate these relevant areas for their potential inclusion within the Health Care District spheres.

Potential Social or Economic Communities of Interest

MSR and Sphere Review determinations are required to identify any *social or economic communities of interest* existing in the review area, if LAFCO determines that they are relevant to the subject agency. The Commission is recommended to consider local areas designated by OSHPD as *Medically Underserved Areas* and/or *Health Care Professional Shortage Areas*, and local areas identified with poverty levels above the regional average of 14.4%, as containing *social or economic communities of interest* relevant to the local Health Care Districts.

Location & Characteristics of Disadvantaged Unincorporated Communities

The *MSR and Sphere Review* determinations include identification of existing disadvantaged unincorporated communities (DUC) located within or contiguous to a public agency's sphere of influence (Map 1C). The *MSR and Sphere Review* determinations reflect that the local Health Care Districts each include one of more DUCs within or contiguous to their sphere of influence. The identified DUCs are each described and discussed within the individual district sections of the MSR in regards to their respective land use authority.

Proposed San Diego County Special Study Areas

OSHPD-designated *Medically Underserved Areas, Health Care Professional Shortage Areas*, and local areas identified with high poverty levels areas all presently exist in both urban coastal incorporated territory and rural unincorporated desert and mountain communities of San Diego County.

The *MSR and Sphere Review* determinations recommend Commission consideration of *Special Study Area* designations for the following 4 major areas of the County that contain inhabited territory not currently located within any of the local Health Care District service areas and spheres, and which contain *social or economic communities of interest* relevant to the local Health Care Districts (Map 1L):

Special Study Area No. 1: Fallbrook HD/Camp Pendleton

The proposed *Special Study Area No. 1* territory includes inhabited urban and rural areas of the northwest corner of San Diego County, including Camp Pendleton and the unincorporated De Luz community, and portions of the Tri-City HD and Fallbrook HD service areas and spheres that overlap the Camp Pendleton boundary. The existing Fallbrook HD service area and sphere extends to the northwest and includes a portion of the unincorporated community of De Luz located between Camp Pendleton to the south and Riverside County to the north (Pendleton-De Luz Community Planning Area).

The remainder of the De Luz unincorporated territory that is not currently within the Fallbrook HD service area and sphere should be considered for designation as a *Special Study Area* so that the County of San Diego's Pendleton-De Luz Community Planning Area territory not presently located within Camp Pendleton is joined with the Fallbrook HD service area (Maps 2G and 5F).

The Tri-City HD's Tri-City Medical Center in Oceanside, and the Palomar Health HD's Palomar Medical Center in Escondido, are among the closest acute-care hospitals in San Diego County to the recently-closed Fallbrook Hospital and the Fallbrook HD's service area. The Fallbrook HD and the Tri-City HD have previously adopted a Joint Powers Agreement (JPA) to coordinate the referral of patients between the Districts' facilities; however, the closure of the Fallbrook Hospital appears to have functionally ended the reciprocal nature of the JPA.

The Fallbrook HD and the Palomar Health HD have also partnered in a JPA to enable the Palomar Health HD to assist the Fallbrook HD in the continued provision of health care services in the Fallbrook community. The proposed *Special Study Area No. 1* and the Fallbrook HD service area should be further evaluated by the Palomar Health HD and the Tri-City HD to determine if inclusion within one or more of the districts' service areas would promote the efficient delivery of health care services to the subject territory (Maps 4G and 5F).

While State Law allows for both incorporated and unincorporated territory to be served by Health Care Districts and included within their service areas, Health and Safety Code Section 32001 prohibits the division of incorporated territory within a Health Care District unless LAFCO determines that the area would not be benefitted by inclusion.

The majority of the City of Oceanside is currently located within the Tri-City HD service area and sphere; however, a small portion of Oceanside incorporated territory is located within the adjacent Fallbrook HD service area and sphere. The subject Oceanside territory should accordingly be reviewed for a possible reorganization (detachment and annexation) within Tri-City HD. The adjacent Health Care Districts should discuss and collaboratively evaluate the affected area to determine if inclusion within the Tri-City HD service area and sphere would benefit the local area (Maps 2G and 5F).

Special Study Area No. 2: Shadowridge

The Shadowridge area consists of approximately 2,500-acres that is primarily located with the City of Vista's incorporated territory (Map 1L). The Shadowridge area constitutes an island of territory that is not presently located within a Health Care District service area, but is surrounded by both the Tri-City HD and the Palomar Health HD service areas and spheres (Maps 4G and 5F). Each of the surrounding Health Care Districts has previously explored the potential annexation of the Shadowridge area; however, no annexation proposal has been submitted from either district for LAFCO consideration.

As the majority of the City of Vista is currently located within the Tri-City HD service area and sphere, the Shadowridge area should accordingly be considered for annexation to the Tri-City HD; however, both of the adjacent Health Care Districts should discuss and collaboratively evaluate the Shadowridge area to determine if inclusion within either Health Care District would benefit the local area.

Special Study Area No. 3: Western San Diego County Incorporated Areas

The proposed *Special Study Area No. 3* includes urban territory comprised of the coastal incorporated cities from Encinitas south to Imperial Beach, as well as the adjacent unincorporated urban communities of Rancho Santa Fe, Bonita, and Otay Mesa (Map 1L). These areas are not presently located within any of the local Health Care Districts service areas or spheres, and have been identified as containing designated *Medically Underserved Areas*, *Health Care Professional Shortage Areas*, and/or areas of high poverty. The service areas and spheres of the Tri-City HD, Palomar HD, and Grossmont HD are each adjacent to the proposed *Special Study Area No. 3*.

The Tri-City HD service area and sphere includes the majority of the City of Carlsbad's incorporated territory; however, a southern portion of Carlsbad is located outside of the Tri-City HD area and is within *Special Study Area No. 3.* The potential inclusion of the remainder of the City of Carlsbad's incorporated territory within the Tri-City HD service area and sphere should be addressed in subsequent service and sphere reviews to determine if inclusion within the Health Care District would benefit the local area.

The Palomar Health HD and Grossmont HD service areas and spheres are contiguous to *Special Study Area No. 3* and the districts should each evaluate adjacent study area communities to determine if inclusion within the service area and sphere would benefit the local area (Map 5F).

Special Study Area 4: Eastern San Diego County Unincorporated Areas

The proposed *Special Study Area No. 4* includes rural and frontier territory comprised of the mountain and desert unincorporated areas of eastern San Diego County, from the Riverside County to the north to the US/Mexico International Border to the south (Map 1L).

These unincorporated areas are not presently located within any of the local Health Care Districts service areas or spheres, and have been identified as containing designated *Medically Underserved Areas*, *Health Care Professional Shortage Areas*, and/or areas of high poverty. The Tri-City HD and Fallbrook HD service areas and spheres are not adjacent to *Special Study Area No. 4*. However, the Palomar Health HD and Grossmont HD service areas and spheres are each contiguous to *Special Study Area No. 4* (Maps 3I and 4G).

The Districts should each evaluate the adjacent communities within the proposed *Special Study Area* to determine if inclusion within the Health Care District's service area and sphere would benefit the local area. The proposed *Special Study Areas* are not recommended for inclusion within the Health Care District service areas or spheres at this time; however, subsequent health care service and sphere reviews should evaluate the

Special Study Areas for resolution of the study area designations and the potential for inclusion into one or more of the Health Care District spheres.

Services and Facilities

Adequacy of Services

Health care services provided by hospitals are measured for quality by several public and private organizations using a variety of quality indicators including: patient experience survey responses and ratings; annual volume and frequency of selected medical procedures; and annual inpatient mortality rates for selected medical procedures and conditions. The quality indicators establish annual rates for the subject hospitals that are measured against county and/or state averages to evaluate the ongoing adequacy of services provided by the districts.

The health care service quality indicators used in the *2015 San Diego County Health Care Services MSR and Sphere Review* are produced by: the Federal Agency for Health Care Research and Quality (AHRQ), which compiles statistics from OSHPD on local hospital performance for selected medical procedures and conditions, and compares them with county and statewide averages; and by the California HealthCare Foundation (CHCF) through *CalQualityCare.org*, which establishes hospital ratings from patient survey responses on their personal experiences receiving a broad range of medical services and procedures.

The *MSR and Sphere Review* determinations conclude that the Health Care District quality indicators and hospital rankings are generally equivalent to or exceed state averages. Any significant +/- deviations from annual state averages are highlighted in the individual district sections. Annual hospital quality indicator rates that are consistently lower or higher than county and/or state averages are also noted for additional consideration within the MSR's adequacy of services determinations.

The *MSR and Sphere Review* determinations conclude that, with exception of the Fallbrook HD and the now-closed Fallbrook Hospital, hospital-based health care services are generally being adequately provided by local Health Care Districts. In particular, the MSR determinations reflect that most of the Health Care District acute-care hospital facilities are adequately sized for present and probable demands.

The local Health Care District licensed acute-care bed occupancy rates indicate that hospital bed capacity exists in most facilities; however, proportionate hospital staffing increases, especially in designated shortage areas for health care professionals in primary care and nursing, would also be necessary to maximize any available facility capacities.

The local Health Care District annual financial disclosure reports reflect that inpatient revenues have been generally sufficient to maintain hospital facilities and health care services; however, the reported hospital financial data shows significant differences between operating margins for local HD hospitals that have partnered with non-profit health care systems, and HDs that independently operate their local hospital facilities or contract with a for-profit health care system.

The *MSR and Sphere Review* determinations conclude that compliance with state seismic safety requirements by 2030 and meeting service demands from projected growth in older population segments will be planning issues of priority for the Health Care Districts over the next 10-15 years.

The following is a summary of the *2015 San Diego County Health Care Services MSR and Sphere Review* conclusions and determinations regarding the current and anticipated provision of local health care services in San Diego County.

Future Service & Facility Opportunities

The *MSR and Sphere Review* determinations state that the authorized powers available to Heath Care Districts involve a number of diverse local health care facilities and services in addition to owning and/or operating acute-care hospitals, including: community clinics, urgent care facilities, and child care facilities; ambulance and emergency medical transport; skilled nursing and long-term care; community programs for chemical dependency services, health education, wellness and prevention, rehabilitation; and the local recruitment and retention of medical professionals in primary care, nursing, mental health, and dental services.

The *MSR and Sphere Review* determinations encourage the local Health Care Districts to collaboratively explore partnerships with the County and other agencies for the provision of the full range of the available Health Care District services and programs, and to focus those programmatic efforts where most needed in the community and neighborhood levels of both urban and rural areas.

Infrastructure Needs and Deficiencies

In addition to projected population and demographic changes, the local Health Care Districts are faced with significant facility questions regarding compliance with seismic safety standards by State-mandated deadlines.

The Alfred E. Alquist Seismic Safety Act of 1983 [California Health and Safety Code Section 129675 et. seq.] requires that all licensed acute-care hospitals in California built on or after March 7, 1973 be capable of remaining operational after a seismic event or other natural disaster with an initial compliance deadline of 2013.

The MSR determinations reflect that all of the local Health Care District hospital facilities are affected by the seismic requirements. Subsequent legislative changes 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.

All licensed acute-care hospitals are required to prepare both a comprehensive evaluation report and compliance plan to attain specified structural and nonstructural performance standards by the mandated timeframes.

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 non-conformance with seismic standards and include specific required deadlines to achieve conformance.

The following is a summary of OSHPD seismic safety ratings for the local Health Care District hospital facilities, building components, and non-structural features, as of January 2015:

Fallbrook HD

Fallbrook Hospital - SPC 2, SPC 4; NPC 1

Grossmont HD

Grossmont Hospital - SPC 1, SPC 2, SPC 4, SPC 5; NPC 2

Palomar Health HD

Palomar Downtown Campus - SPC 2, SPC 4; NPC 2

Pomerado Hospital - SPC 4, SPC 5; NPC 2

Palomar Medical Center - SPC 5

Tri-City HD

Tri-City Medical Center - SPC 1, SPC 2, SPC 3, SPC 4; NPC 2

The *MSR and Sphere Review* determinations reflect that the seismic requirements for hospital facilities create significant organizational demands on the local HDs to achieve compliance by the statutory deadlines. As the Palomar Health HD's recently constructed Palomar Medical Center embodies, the financial commitments for construction of new state-of-the-art regional acute-care medical facilities are quite significant. Coupled with estimated remodel/replacement costs for seismic improvements by 2030, many Health Care Districts will have to consider strategic options regarding their local hospital facilities and programs in the next 5-10 years.

Finance

Fiscal Performance Indicators

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. The local HD's annual financial disclosure reports reflect that hospital revenues have been generally sufficient to maintain facilities and services.

Health Care 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 regarding special district revenues, expenditures, property taxes, and bonded debt.

The County of San Diego Auditor and Controller produces a detailed summary of local tax information for each fiscal year that identifies the amount of property tax allocated to the Health Care Districts and reports any bonded indebtedness held by the Districts.

The annual Health Care District and hospital financial disclosure reports produced by the California State Controller, the County of San Diego, and OSHPD provide the public with a comprehensive overview of the annual financial status of the Health Care District, as well as the hospital facilities the district owns and/or operates.

The *MSR and Sphere Review* determinations reflect significant differences between operating margins of the local HDs that have partnered with non-profit health care systems to lease and operate their hospital facilities, and the local HDs that independently operate their hospital facilities or contract operations with a for-profit health care system.

Review of the Health Care Districts' 2007-2013 average *net from operations* reveals consistent trends to support the benefits of HD partnerships with non-profit regional health care systems for ongoing sustainability of local HD facilities and operations.

Revenues/Expenditure Characteristics

Fallbrook HD

Fallbrook Hospital Revenue - Expenditure Characteristics (FY2012-2013)

Net Patient Revenue: $37,814,952
Inpatient: $23,060,542; Outpatient: $14,754,410
Net from Operations: ($7,654,653)
Operating Margin: (20.0%)

For the 2012-2013 fiscal year, Fallbrook Hospital reported total net operating revenues of $38,306,345 and total operating expenses of $45,960,998, for a total net-from-operations loss of ($7,654,653) and a total annual loss of ($8,072,323). This loss follows a total loss of ($4,485,824) for the preceding 2011-2012 fiscal year.

The following table summarizes the Fallbrook Hospital's financial performance over 2007-2013:

Fallbrook HD Revenues - Expenditures (FY2007-2013)

Year	Net Operating Rev.	Operating Exp.	Net from Op	Income (Loss)
2007-08	$40,536,271	$38,830,208	$1,706,063	$310,575
2008-09	$38,228,212	$39,643,752	($1,415,540)	($2,215,188)
2009-10	$38,611,196	$43,401,067	($4,789,871)	($4,976,738)
2010-11	$47,432,230	$44,670,421	$2,761,809	$2,607,623
2011-12	$41,937,343	$45,803,732	($3,866,389)	($4,485,824)
2012-13	$38,306,345	$45,960,998	($7,654,653)	($8,072,323)

During the 2007-2008 to 2012-2013 fiscal years, Fallbrook HD has reported a cumulative total loss of ($16,831,875) and has reported an average net-from-operations loss of ($2,209,763) per year. The 2014 termination of the leasing/operating agreement with CHS for Fallbrook Hospital was directly attributed to the on-going operational losses experienced between 2008 and 2013.

Grossmont HD

Grossmont Hospital Revenue - Expenditure Characteristics (FY2012-2013)

Net Patient Revenue: $619,558,759
Inpatient: $414,828,597; Outpatient: $204,730,162
Net from Operations: $52,258,084
Operating Margin: 8.3%

For the 2012-2013 fiscal year, the Grossmont HD reported total net operating revenues of $627,960,886 and total operating expenses of $575,702,802, for a total net-from-operations gain of $52,258,084 and total annual income of $69,354,471. This income follows a total gain of $55,297,521 for the preceding 2011-2012 fiscal year.

From 2007-2008 to 2012-2013, the Grossmont Hospital reported an average annual net-from-operations total of $19,203,744, with a cumulative total income of $169,453,380.

The following table summarizes the Grossmont Hospital's financial performance over FY2007-FY2013:

Grossmont HD Revenues - Expenditures (FY2007-2013)

Year	Net Operating Rev.	Operating Exp.	Net from Op	Income / Loss
2007-08	$414,434,860	$410,101,389	$4,333,471	$4,936,702
2008-09	$448,942,410	$441,062,114	$7,880,296	$15,855,154
2009-10	$471,429,434	$470,509,231	$920,203	$9,504,778
2010-11	$533,428,957	$517,332,010	$16,096,947	$14,504,754
2011-12	$583,289,377	$549,555,914	$33,733,463	$55,297,521
2012-13	$627,960,886	$575,702,802	$52,258,084	$69,354,471

Palomar Health HD

Palomar Health HD owns and operates three licensed acute-care hospital facilities within its service area and sphere: the Palomar Health Downtown Campus in central Escondido; the Pomerado Hospital in Poway; and the Palomar Medical Center in western Escondido, which opened in 2012. Annual financial data for Palomar Medical Center operations has not yet been reported by OSHPD.

Palomar Health Downtown Campus

Palomar Health Downtown Campus Revenue/Expenditure Characteristics (FY2012-2013)

Net Patient Revenue: $441,246,759
Inpatient: $281,655,255; Outpatient: $159,591,504
Net From Operations: ($30,055,593)
Operating Margin: (6.7%)

For the 2012-2013 fiscal year, the Palomar Health Downtown Campus reported total net operating revenues of $449,316,088 and total operating expenses of $479,371,681, for a total net-from-operations loss of ($30,055,593) and total annual income loss of ($20,399,435). This income loss follows a total income gain of $21,547,191 for the preceding 2011-2012 fiscal year.

From the 2007-2008 to 2012-2013 fiscal years, the Palomar Health Downtown Campus reported an average annual net-from-operations total of ($6,520,331); however, the hospital also reported a cumulative total income of $69,899,369 during that time.

The following table summarizes the Palomar Health Downtown Campus's financial performance over the 2007-2013 fiscal years:

Palomar Health Downtown Campus Revenues - Expenditures (FY2007-2013)

Year	Net Operating Rev.	Operating Exp.	Net from Op	Income / Loss
2007-08	$246,190,848	$295,562,027	($49,371,179)	$9,798,459
2008-09	$315,379,403	$305,889,199	$9,490,204	$19,900,125
2009-10	$326,283,685	$316,417,510	$9,866,175	$19,505,684
2010-11	$339,398,456	$330,628,878	$8,769,578	$19,547,345
2011-12	$364,248,763	$352,069,937	$12,178,826	$21,547,191
2012-13	$449,316,088	$479,371,681	($30,055,593)	($20,399,435)

Pomerado Hospital

Pomerado Hospital Revenue/Expenditure Characteristics (FY2012-2013)

Net Patient Revenue: $156,905,072
Inpatient: $101,589,003; Outpatient: $55,316,069
Net From Operations: $7,873,516
Operating Margin: 5.0%

For the 2012-2013 fiscal year, the Pomerado Hospital reported total net operating revenues of $157,750,160 and total operating expenses of $149,876,644, for a total net-

from-operations gain of $7,873,516 and total annual income of $11,801,857. This income follows a total income gain of $6,162,918 for the preceding 2011-2012 fiscal year.

From the 2007-2008 to 2012-2013 fiscal years, the Pomerado Hospital reported an average annual net-from-operations total gain of $2,494,551, and has reported a cumulative total income of $35,680,566 during that time.

The following table summarizes the Pomerado Hospital's financial performance over the 2007-2013 fiscal years:

Pomerado Hospital Revenues/Expenditures (FY2007-FY2013)

Year	Net Operating Rev.	Operating Exp.	Net from Op	Income / Loss
2007-08	$113,626,533	$120,523,650	($6,897,117)	($2,588,206)
2008-09	$126,872,907	$125,775,194	$1,097,713	$4,190,870
2009-10	$139,119,318	$131,767,117	$7,352,201	$10,140,022
2010-11	$146,547,200	$144,109,554	$2,437,646	$5,973,105
2011-12	$152,131,106	$149,027,760	$3,103,346	$6,162,918
2012-13	$157,750,160	$149,876,644	$7,873,516	$11,801,857

Tri-City HD

Tri-City Medical Center Revenue/Expenditure Characteristics (FY2013-2014)

Net Patient Revenue: $304,085,269
Inpatient: $192,684,676; Outpatient: $111,400,593
Net from Operations: ($11,819,558)
Net Income: $1,933,170
Operating Margin: (-3.84%)

For the 2013-2014 fiscal year, the Tri-City Medical Center reported total operating revenues of $307,831,204 and total operating expenses of $319,650,762, resulting in a n*et from operations* loss of ($11,819,558) and a total net income $1,933,170. This income follows a total loss of ($13,615,081) for the preceding 2012-2013 fiscal year.

During the 2007-2008 to 2013-2014 fiscal years, Tri-City HD has reported a cumulative total income loss of ($5,035,711) and has reported an average net-from-operations loss of ($9,373,578) per year.

The following table summarizes the Tri-City Medical Center's financial performance over the 2007-2014 fiscal years:

Tri-City Medical Center Revenues/Expenditures (FY2007-FY2014)

Year	Net Operating Rev.	Operating Exp.	Net from Op	Income / Loss
2007-08	$266,190,375	$267,956,035	($1,765,660)	$9,258,017
2008-09	$278,070,805	$289,199,816	($11,129,011)	($5,014,909)
2009-10	$267,223,963	$292,530,964	($25,307,001)	($18,532,882)
2010-11	$297,524,801	$289,665,465	$7,859,336	$14,848,941
2011-12	$306,939,626	$308,322,785	($1,383,159)	$6,087,033
2012-13	$296,249,104	$318,319,098	($22,069,994)	($13,615,081)
2013-14	$307,831,204	$319,650,762	($11,819,558)	$1,933,170

Bonded Debt

As of FY 2013-2014, only the Grossmont HD and the Palomar Health HD report outstanding general obligation Bonds; The Fallbrook HD and Tri-City HD have no reported long-term bonded indebtedness. The Grossmont HD and the Palomar Health HD have used bond revenues to remodel/rehabilitate local acute-care facilities, and to support ongoing operations of needed health care programs and services. General Obligation bonded debt requires 2/3 local voter approval, which was achieved by Palomar Health HD in 2004 and by Grossmont HD in 2006.

	Total Bond Amt.	Election	Approval%
Grossmont HD - Prop G	$247,000,000	6/2006	77.68%
Palomar Health HD - Prop BB	$496,000,000	11/2004	69.84%

The Tri-City HD did not achieve the required 2/3 voter approval for proposed bond measures over three separate elections: June 2006 (65.9%), November 2006 (64.8%), and August 2008 (62.5%). The repeated inability to secure sufficient voter approval for long-term capital financing has created uncertainty in the availability of sufficient funding for needed Tri-City HD facility improvements and expansions. The MSR determinations encourage Tri-City HD to investigate additional financing and governance options.

Property Tax Revenues

As special districts formed prior to the passage of Prop 13 in 1978, the local HDs receive an annual allocation from the 1% ad valorum property tax for property within its respective service area. The MSR determinations state that Health Care District annual property tax revenues account for approximately 1.0-2.5% of the Districts' total net operating revenues.

The *MSR and Sphere Review* determinations state that the Districts' annual property tax revenue stream is primarily used by the HDs to underwrite local community grant programs to financially assist local non-profit groups that provide health care programs and services within the HD service area, and/or to fund reserves to repay voter-approved bonded debt. County of San Diego annual tax reports indicate that HDs have received consistent levels of annual property tax revenues from FY2008-2009 to FY2012-2013.

County of San Diego Tax Summary

Allocated Property Tax Revenue FY2013-2014

Health Care District	Prop. Tax Revenue	% of Net Operating Revenues	
Fallbrook HD	$1,488,294	2.5%	
Grossmont HD	$5,904,774	1.0%	
Palomar Health HD	$13,199,623	2.1%*	(DTC + Pomerado Hospital)
Tri-City HD	$7,612,806	2.5%	

Allocated Property Tax Revenue FY2008-2009 to FY2013-2014

Health Care District	Annual Average
Fallbrook HD	$1,480,332
Grossmont HD	$5,758,889
Palomar Health HD	$12,786,052
Tri-City HD	$7,476,428

Budgets/Audits

Each of the local HDs holds regular public Board meetings to review and adopt annual budgets. The HDs undergo annual independent audits; no financial violations have been reported. The *MSR and Sphere Review* determinations state that the HD Boards comply with all financial disclosure requirements of state and federal regulatory agencies.

Governance and Operations

Community Service Accountability

The *MSR and Sphere Review* determinations reflect that the HDs are adequately accountable for their local community's health care service needs. The HDs each provide community accountability through their provision of local non-profit grant programs; health care related educational programs; community health care events; noticed public meetings; district and hospital internet websites; as well as providing local acute-care hospital facilities, emergency departments, trauma centers, and surgical services.

Board of Directors

Each of the HDs is governed by a publically-elected Board of Directors consisting of 5 or 7 members. The Board members are elected-at-large for four-year terms. All recent district Board elections have generated sufficient numbers of candidates to fill available seats.

The *MSR and Sphere Review* determinations state that the HD Boards have each adopted bylaws, policies, and procedures; utilize annual budgets and undergo independent financial audits; and comply with all operational and financial disclosure requirements of state and federal regulatory agencies.

2008-2012 San Diego County Grand Jury Reports on Tri-City HD

In response to local citizen complaints regarding the Tri-City HD Board, the 2008-2012 San Diego County Grand Juries conducted investigations and produced reports in 2009, 2010, and 2011 that identified issues concerning Board dysfunction and alleged Brown Act violations. The Grand Jury reports concluded with findings and recommendations for Tri-City HD correction and improvement, and posed general questions of governance options for the Health Care Districts and their elected Boards.

Ultimately, it was determined that the Tri-City HD Board had committed no violations, and an audit of Tri-City HD financial and pension data was successfully completed. The Grand Jury recommended additional training for Tri-City HD Board members regarding the Brown Act.

The *MSR and Sphere Review* determinations state that the specific Tri-City HD Board controversies that led to the Grand Jury reports appear to have been functionally resolved through normal electoral Board member turnover in the 2012 elections, and subsequent Tri-City HD administrative staffing changes.

The *MSR and Sphere Review* also discusses the process of publically electing Board members, which may allow for potential dysfunction with uncooperative elected Board members, and involves significant election costs to the Health Care Districts; however, following the initial appointment of Board members by the County Board of Supervisors when a Health Care District is originally formed, State Law requires Health Care District Boards to be publically elected [Health and Safety Code Section 32001].

The *MSR and Sphere Review* determinations conclude that an elected Board ensures local control over district finances, facilities and programs through community-determined Board members that are subject to reelection by the local voters in subsequent election cycles.

The 2009-12 Grand Jury reports recommended a review of the model of governance at Tri-City Healthcare District, as well as governance models in use by other health care organizations. The Grand Jury recommended the consideration of several governance alternatives for Tri-City, including merging the district with the neighboring Palomar Pomerado Health district, turning over hospital operations to an outside party or selling the hospital to another health system. The *MSR and Sphere Review* identifies the governance options available to Health Care Districts, as follows below.

Hospital Operations

The local Health Care Districts in San Diego County have varying hospital operating arrangements for their local facilities that include both contracted and independent hospital operators: the Palomar Health and Tri-City HDs each independently operate their hospital facilities; Grossmont HD partners with the non-profit Sharp HealthCare System under a leasing/operating agreement originally approved by local voters in 1988 and recently extended to 2051 by voter approval in June 2014.

Since 1998, the Fallbrook HD had been engaged in a voter-approved 30-year leasing/operating agreement for the Fallbrook Hospital with the for-profit Community Health Systems, Inc. (CHS). The contractual arrangement was recently terminated in 2014 by CHS due to experiencing ongoing financial losses as the operator for Fallbrook Hospital. The Fallbrook Hospital has subsequently closed and the Fallbrook HD is currently exploring options for its future use.

The *MSR and Sphere Review* determinations state that annual OSHPD financial disclosure reports reflect ongoing financial sustainability issues with the independent Health Care District hospital operators in comparison with annual financial returns of the local Health Care District hospital that is operated under arrangement with a non-profit health care system.

Status of and Opportunities for Shared Facilities

The *MSR and Sphere Review* acknowledges that regional and local health care market competition will continue to encourage the local Health Care Districts towards collaboration with providing sustainable health care facilities and operations, especially within shared county subregions and transportation corridors.

The existing Joint Powers Agreements (JPAs) between Fallbrook HD and Tri-City HD and between Fallbrook HD and Palomar Health HD may serve as models to promote future opportunities for local and regional HD partnerships to help maximize use of HD acute-care facilities, trauma centers, and surgical facilities. Increased regional and subregional coordination between the Districts may also create new opportunities for expansion into the provision of other needed local health care services such as ambulance/emergency medical transport and urgent-care, and to promote programs for the recruitment and retention of health care professionals for primary care, dental, mental health, and nursing.

The *MSR and Sphere Review* determinations conclude that these types of local services coordinated through regional/subregional JPAs or other collaborative arrangements should be encouraged.

Governmental Structure Options

As locally-formed special districts, multiple governmental structure options are available to the Health Care Districts, including jurisdictional changes such as a reorganization that may involve dissolution of one or more HDs with annexation into one or more successor districts; a consolidation of two or more districts into one or more successor districts; or a combination of governance actions.

Proposed changes of organization or reorganization for Health Care Districts may be initiated by: petition of local voters or landowners within the proposal area; a resolution of subject/affected agencies; or by LAFCO action.

If LAFCO approves a proposed reorganization or consolidation/merger involving one or more Health Care Districts, State Law allows for written protest to be filed with the Commission by registered voters or landowners within the proposal area. There are different initiation threshold requirements for the various proposal types; as well as corresponding protest provisions following LAFCO approval, with specified minimum protest thresholds to require subsequent voter approval, or termination of the proposal with a sufficient majority protest.

If LAFCO approves a proposed jurisdictional change that involves dissolution of one or more Health Care Districts, or a Health Care District proposes to transfer more than 50% of the district's assets, State Law requires the dissolution or transfer agreement to be approved by local voters. [Health and Safety Code Section 32121(p)(1)]

Successor Agency

A key issue to be determined for consideration of the potential governmental structure options for Health Care Districts involves the identification of a successor agency that is authorized, capable, and willing to sustain the provision and level of health care services provided by the dissolved Health Care District. A proposed reorganization involving dissolution/annexation, or a consolidation/merger, would transfer the extinguished HD's assets and facilities to the successor agency, along with responsibilities for any HD bonded indebtedness. A *plan for service* is also required to be submitted to LAFCO by the annexing agency/successor agency with these types of jurisdictional changes.

If the terms and conditions of the dissolution call for annexation of the district into a single existing Health Care District, the remaining assets of the dissolved district are distributed to the existing successor district. [Government Code Sections 57451(d) and 56886] If the dissolution involves annexation and distribution of remaining assets of a dissolved district into two or more existing Health Care Districts, then the existing district containing the greater assessed value of all taxable property within the territory of the dissolved district shall become the successor district. [Government Code Section 57451(e)]

If a Health Care District is dissolved without annexation of its service territory into one or more special districts, a city or county will become the successor agency for the dissolved district depending on which one contains the greatest assessed value of all taxable property within the territory of the dissolved district. [Government Code Section 57451(c)]. In San Diego County, five of the six Health Care District owned acute-care hospitals are located within incorporated cities (Escondido, La Mesa, Oceanside, and Poway); however, the local cities do not presently provide health care services, and would presumably not wish to serve as a successor agency to a dissolved HD.

In the San Diego Region, the County of San Diego is the primary local public agency currently responsible for and presently providing county-wide health care services. Unless one or more of the existing Health Care Districts were designated as a successor agency, the County of San Diego would be the logical successor agency with capacity to assume operational responsibility for a dissolved Health Care District's facilities and assure the continued provision of health care services in either incorporated or unincorporated Health Care District service area territory.

While the County of San Diego does not directly operate acute-care public hospitals, the County could consider options for leasing the district hospital facilities and/or contracting the health care service responsibilities within a dissolved Health Care District's service area. The *MSR and Sphere Review* determinations recommend that additional study be conducted by the Health Care Districts to determine if any of the available governance options may be feasible, beneficial, and desirable for sustainably meeting future community health care demands and local facility and service needs.

2015 SAN DIEGO COUNTY HEALTH CARE SERVICES MSR AND SPHERE REVIEW CONCLUSIONS

Spheres of Influence are used by LAFCO to guide future jurisdictional changes, such as annexations, detachments, reorganizations, and consolidations. Spheres may be larger or smaller than an agency's boundaries, and in some cases, a sphere may include no territory when an agency should be dissolved and its service responsibility reassigned to another public agency. In other situations, a *Special Study Area* designation may be assigned when additional study is required. Service reviews are conducted by LAFCO to help prepare or update spheres of influence.

In terms of the *2015 San Diego County Health Care Services MSR and Sphere Review*, a service review was conducted in conjunction with the update of the respective adopted spheres of influence for the Fallbrook, Tri-City, Palomar Health, and Grossmont HDs. The

MSR and Sphere Review concludes that the Tri-City, Palomar Health, and Grossmont HDs are generally accountable for local community service needs; are capable of adequately providing health care services within their respective service areas and spheres of influence; and have a wide variation in both financial activity and fiscal health.

Our research shows that the Fallbrook HD is experiencing significant operational issues, and that these issues may become jurisdictional issues in the future. We also conclude that Palomar Health HD and Tri-City HD are located in a similar subregion of the County where a number of additional hospital operators exist. This has created a competitive health care environment for both Districts.

It has also been widely reported in the media, and independently confirmed by LAFCO staff, that Palomar Health HD has considerable bonded debt, and that both Tri-City and Palomar Health have experienced recent financial losses. These financial issues represent serious challenges, but we believe that each of the Districts have sufficient resources and political support to reach a resolution.

The *MSR and Sphere Review* determinations are required to identify any *social or economic communities of interest* existing in the review area, if LAFCO determines that they are relevant to the subject agency. The Commission is therefore recommended to consider local areas designated as *Medically Underserved Areas* and/or *Health Care Professional Shortage Areas*, and local areas identified with poverty levels above the regional average of 14.4%, as containing *social or economic communities of interest* relevant to the local Health Care Districts.

The *2015 MSR and Sphere Review* determinations recommend Commission consideration of *Special Study Area* designations for four major areas of the County that contain inhabited territory not currently located within any of the local Health Care District service areas and spheres, and which contain *social or economic communities of interest* relevant to the local Health Care Districts. Jurisdictional changes and sphere expansions associated with the proposed *Special Study Areas* are not recommended at this time; however, subsequent service and sphere reviews should be conducted to determine if sphere amendments and jurisdictional boundary changes are warranted.

Below are summaries of the *2015 San Diego County Health Care Services MSR and Sphere Review* major conclusions for each of the local Health Care Districts:

Fallbrook HD

For the 2012-2013 fiscal year, Fallbrook Hospital reported total net operating revenues of $38,306,345 and total operating expenses of $45,960,998, for a total net-from-operations loss of ($7,654,653) and a total annual loss of ($8,072,323). This loss follows a total loss of ($4,485,824) for the preceding 2011-2012 fiscal year. As of December 2014, the Fallbrook Hospital has closed operations as an acute-care hospital and its long-term operational status is undetermined.

The Fallbrook Hospital's closure followed the termination of a lease and operational agreement between the Fallbrook HD (as the non-profit Fallbrook Hospital Corporation)

and the for-profit operating partner, Community Health Systems Inc., due to continuing financial losses from Fallbrook Hospital core service operations. The Fallbrook HD and the continuing status of the Fallbrook Hospital remain uncertain, with reliance on Oceanside, Escondido, or Riverside County for the closest acute-care hospital facilities.

The current coterminous sphere for Fallbrook HD should be reaffirmed. However, it may be appropriate in the future to assign the Fallbrook HD a *Special Study Area* designation overlaying the entire Health Care District; or assign a transitional (zero) sphere designation in anticipation of a potential dissolution of the district or a reorganization of the Fallbrook HD service area into one or more of the local Health Care Districts. These sphere designation options would be intended to encourage discussions among any of the three other Health Care Districts regarding a potential reorganization or consolidation with Fallbrook HD.

Grossmont HD

The Grossmont HD enjoys considerable local support and has received excellent financial returns. For the 2012-2013 fiscal year, the Grossmont HD reported total net operating revenues of $627,960,886 and total operating expenses of $575,702,802, for a total net-from-operations gain of $52,258,084 and total annual income of $69,354,471. This income follows a total gain of $55,297,521 for the preceding 2011-12 fiscal year.

Two of the four proposed *Special Study Areas* that are recommended are adjacent to the Grossmont HD service area and sphere. The *Special Study Area No. 3: Western San Diego County Incorporated Areas* includes urban territory comprised of the coastal incorporated cities from Encinitas south to Imperial Beach, as well as the adjacent unincorporated urban communities of Rancho Santa Fe, Bonita, and Otay Mesa.

These incorporated and unincorporated areas are not presently located within any of the local Health Care Districts service areas or spheres, and have been identified as containing designated Medically Underserved Areas, Health Care Professional Shortage Areas, and/or areas of high poverty. The Grossmont HD service area and sphere is contiguous to the southern portion of *Special Study Area No. 3*.

While State Law allows for both incorporated and unincorporated territory to be served by Health Care Districts and included within their service areas, Health and Safety Code Section 32001 prohibits the division of incorporated territory within a Health Care District unless LAFCO determines that the area would not be benefitted by inclusion.

Small portions of City of San Diego incorporated territory are located within the Grossmont HD and Palomar Health HD service areas and spheres; however, the majority of the City of San Diego is not currently located within a Health Care District service area and sphere. Accordingly, the affected Health Care Districts should discuss and collaboratively evaluate the City of San Diego to determine if inclusion within either or portions of the Districts' service areas and spheres would benefit the local area.

The proposed *Special Study Area No. 4* includes rural and frontier territory comprised of the mountain and desert unincorporated areas of eastern San Diego County, from the Riverside County to the north to the US/Mexico International Border to the south.

These unincorporated areas are not presently located within any of the local Health Care Districts service areas or spheres, and have been identified as containing designated *Medically Underserved Areas*, *Health Care Professional Shortage Areas*, and/or areas of high poverty. The Grossmont HD service area and sphere is contiguous to the southern portion of *Special Study Area No. 4*. The subsequent *San Diego County Health Care Services MSR and Sphere Review* in 2020 should evaluate the *Special Study Area* for resolution of the study area designation and potential sphere inclusion.

Palomar Health HD

The Palomar Health HD's financial position is relatively complex to summarize and evaluate in comparison to the other Health Care Districts in San Diego County. Palomar Health consists of three distinct operational units / health care facilities: Palomar Health Downtown Campus; Pomerado Hospital; and Palomar Medical Center. The availability of financial data for these three facilities is also different when compared to the other Health Care Districts.

For the 2012-2013 fiscal year, the Palomar Health Downtown Campus reported total net operating revenues of $449,316,088 and total operating expenses of $479,371,681, for a total net-from-operations loss of ($30,055,593) and total annual income loss of ($20,399,435). This income loss follows a total income gain of $21,547,191 for the preceding 2011-2012 fiscal year. From the 2007-2008 to 2012-2013 fiscal years, the Palomar Health Downtown Campus reported an average annual net-from-operations total of ($6,520,331); however, the hospital also reported a cumulative total income of $69,899,369 during that time.

For the 2012-2013 fiscal year, the Pomerado Hospital reported total net operating revenues of $157,750,160 and total operating expenses of $149,876,644, for a total net-from-operations gain of $7,873,516 and total annual income of $11,801,857. This income follows a total income gain of $6,162,918 for the preceding 2011-2012 fiscal year. From the 2007-2008 to 2012-2013 fiscal years, the Pomerado Hospital reported an average annual net-from-operations total gain of $2,494,551, and has reported a cumulative total income of $35,680,566 during that time.

With respect to the Palomar Medical Center, local voters approved Proposition BB in the November 2004 election by 69.84%, which authorized the issuance of up to $496,000,000 in General Obligation bonds for the Palomar Health HD. Prop BB also authorized the Palomar Health HD to issue $210 million in revenue bonds for a combined total of $706 million. The proceeds from the sale of the Prop BB bonds were intended to be used to: fund the construction of the Palomar Medical Center in west Escondido ($531 million); renovate the Palomar Health Downtown Campus ($73 million); and expand Pomerado Hospital ($139 million); for a total cost of $753 million. The $47 million of needed additional

funding was projected to be financed through district cash reserves and philanthropic donations.

As of June 30, 2014, the Palomar Health HD reports net general obligation bond debt of $561,091,000 along with financing obligations of $9,126,000, for a total long-term debt liability balance of $570,217,000. The Palomar Health HD's audited financial statements for FY 2014 reports long-term Palomar Health HD debt service requirements from 2015-2043 will total $2,483,596,000, including principal of $1,044,653,000 and interest of $1,438,961,000.

Approximately three-fourths of the Palomar Health HD service area is unincorporated territory governed by the County of San Diego, including the unincorporated communities of Harmony Grove/Elfin Forest, Eden Valley, Rainbow, Pala/Pauma Valley, Julian, Ramona, Pine Valley, Palomar Mountain, Twin Oaks, and Valley Center.

The Palomar Health HD service area is bordered by Riverside County to the north; unincorporated mountain and desert territory to the east; the Cities of San Diego, Santee and El Cajon to the south; and the coastal Cities of Oceanside, Vista, Carlsbad, Encinitas, Solana Beach, Del Mar, and San Diego, and the unincorporated communities of Fallbrook, Rainbow, and Rancho Santa Fe on the west. The Palomar Health HD service area and sphere is also bordered to the west by the Fallbrook HD and the Tri-City HD; and to the south by the Grossmont HD.

On June 2, 1986, San Diego LAFCO adopted a sphere of influence for the Palomar Health HD that was coterminous with the HD's service area. There have been no annexations or detachments to the Palomar Health HD service area nor any changes to the sphere since it was originally established and affirmed/updated in 2007. The Palomar Health HD's adopted sphere was most recently reviewed and affirmed by the Commission on August 6, 2007 as coterminous with the service area. The four proposed *Special Study Areas* for San Diego County are each adjacent to the Palomar Health HD service area and sphere.

Special Study Area No. 1: Fallbrook HD/Camp Pendleton

The proposed *Special Study Area No. 1* territory includes inhabited urban and rural areas of the northwest corner of San Diego County, including Camp Pendleton and the unincorporated De Luz community, and portions of the Tri-City HD and Fallbrook HD service areas and spheres that overlap the Camp Pendleton boundary.

The Palomar Medical Center in west Escondido is one of closest acute-care hospitals to the recently closed Fallbrook Hospital and the Fallbrook HD's service area. The Fallbrook HD and the Palomar Health HD have adopted a Joint Powers Agreement (JPA) to identify potential health care service providers for the Fallbrook HD's service area and sphere.

Special Study Area No. 2: Shadowridge

The Shadowridge area consists of approximately 2,500-acres that is primarily located with the City of Vista's incorporated territory. The Shadowridge area constitutes an island of territory that is not presently located within a Health Care District service area, but is

surrounded by both the Palomar Health HD and the Tri-City HD service areas and spheres. Both of the surrounding Health Care Districts have previously explored the potential annexation of the Shadowridge area; however, no annexation proposal has been submitted from either district for LAFCO consideration.

Health and Safety Code Section 32001 prohibits the division of incorporated territory within a Health Care District unless LAFCO determines that the area would not be benefitted by inclusion. As the majority of the City of Vista is currently located within the Tri-City HD service area and sphere, the Shadowridge area should probably be unified within Tri-City HD; however, Tri-City and Palomar should discuss and collaboratively evaluate the Shadowridge area to ensure that the community benefits are addressed satisfactorily from inclusion in one of the Health Care Districts.

Special Study Area No. 3: Western San Diego County Incorporated Areas

The proposed *Special Study Area No. 3* includes urban territory comprised of the coastal incorporated cities from Encinitas south to Imperial Beach, as well as the adjacent unincorporated urban communities of Rancho Santa Fe, Bonita, and Otay Mesa. These areas are not presently located within any of the local Health Care Districts service areas or spheres, and have been identified as containing designated *Medically Underserved Areas*, *Health Care Professional Shortage Areas*, and/or areas of high poverty. The Palomar Health HD service area and sphere is contiguous to *Special Study Area No. 3*.

Small portions of City of San Diego incorporated territory are presently located within the Palomar Health HD and Grossmont HD service areas and spheres; however, the majority of the City of San Diego is not currently located within a Health Care District service area and sphere.

Accordingly, Palomar Health HD should discuss and collaboratively evaluate with the other Health Care Districts the possible inclusion of the northern part of Special Study Area 3 (City of San Diego) within its sphere to determine if inclusion would benefit the region.

Special Study Area 4: Eastern San Diego County Unincorporated Areas

The proposed *Special Study Area No. 4* includes rural and frontier territory comprised of the mountain and desert unincorporated areas of eastern San Diego County, from the Riverside County to the north to the US/Mexico International Border to the south. These unincorporated areas are not presently located within any of the local Health Care Districts service areas or spheres, and have been identified as containing designated *Medically Underserved Areas*, *Health Care Professional Shortage Areas*, and/or areas of high poverty.

The Palomar Health HD service area and sphere is contiguous to *Special Study Area No. 4*. The subsequent *San Diego County Health Care Services MSR and Sphere Review* in 2020 should evaluate the *Special Study Area* territory for resolution of the study area designation and potential sphere inclusion.

Tri-City HD

For the 2013-2014 fiscal year, the Tri-City Medical Center reported total operating revenues of $307,831,204 and total operating expenses of $319,650,762, resulting in a net from operations loss of ($11,819,558) and total net income of $1,933,170. This income follows a total loss of ($13,615,081) for the preceding 2012-2013 fiscal year.

The Tri-City HD service area and sphere is bordered by Palomar Health HD to the east and by Fallbrook HD to the north. Three of the four proposed *Special Study Areas* are adjacent to the Tri-City HD and are associated with the District as summarized below:

Special Study Area No. 1: Fallbrook HD/Camp Pendleton

The proposed *Special Study Area No. 1* territory includes inhabited urban and rural areas of the northwest corner of San Diego County, including Camp Pendleton and the unincorporated De Luz community, and portions of the Tri-City HD and Fallbrook HD service areas and spheres that overlap the Camp Pendleton boundary.

The Tri-City Medical Center in Oceanside is one of closest acute-care hospitals to the recently closed Fallbrook Hospital and the Fallbrook HD's service area. The Fallbrook HD and the Tri-City HD have previously adopted a Joint Powers Agreement (JPA) to coordinate the referral of patients between the Districts' facilities; however, the closure of the Fallbrook Hospital has functionally ended the reciprocal nature of the JPA.

Health and Safety Code Section 32001 prohibits the division of incorporated territory within a Health Care District unless LAFCO determines that the area would not be benefitted by inclusion. As the majority of the City of Oceanside is currently located within the Tri-City HD service area and sphere, the small portion of Oceanside incorporated territory located within the Fallbrook HD service area and sphere should accordingly be unified with the Tri-City HD; however, before a sphere amendment and reorganization proposal is initiated, the adjacent Health Care Districts should discuss and collaboratively evaluate the affected area. This would help in LAFCO's eventual determination and ensure that the sphere and boundary change would benefit the area.

Special Study Area No. 2: Shadowridge

The Shadowridge area consists of approximately 2,500-acres that is primarily located with the City of Vista's incorporated territory. The Shadowridge area constitutes an island of territory that is not presently located within a Health Care District service area, but is surrounded by both the Tri-City HD and the Palomar Health HD service areas and spheres.

Both of the surrounding Health Care Districts have previously explored the potential annexation of the Shadowridge area; however, no annexation proposal has been submitted from either district for LAFCO consideration.

As the majority of the City of Vista is currently located within the Tri-City HD service area and sphere, the Shadowridge area should probably be unified within Tri-City HD because of provisions within the Health Care District Act prohibiting the division of a municipality into multiple Health Care Districts. However, the adjacent Palomar Health HD should be consulted with in order to reach a collaborative solution that would benefit the region.

Special Study Area No. 3: Western San Diego County Incorporated Areas

The proposed Special Study Area No. 3 includes the coastal incorporated cities from Encinitas south to Imperial Beach, as well as the unincorporated communities of Rancho Santa Fe, Bonita, and Otay Mesa. These areas are not presently located within any of the local Health Care Districts service areas or spheres, and have been identified as containing designated Medically Underserved Areas, Health Care Professional Shortage Areas, and/or areas of high poverty. The Tri-City HD service area and sphere is contiguous to the northern portion of Special Study Area No. 3.

The potential inclusion of the remainder of the City of Carlsbad's incorporated territory within the Tri-City HD service area and sphere should be addressed in subsequent health care service and sphere reviews to determine if inclusion within the Health Care District would benefit the local area.

Special Study Area 4: Eastern San Diego County Unincorporated Areas

The proposed *Special Study Area No. 4* includes rural and frontier territory comprised of the mountain and desert unincorporated areas of eastern San Diego County, from the Riverside County to the north to the US/Mexico International Border to the south.

These unincorporated areas are not presently located within any of the local Health Care Districts service areas or spheres, and have been identified as containing designated *Medically Underserved Areas*, *Health Care Professional Shortage Areas*, and/or areas of high poverty. The Tri-City HD service area and sphere is not contiguous to Special Study Area No. 4, and it does not appear that this area should be included within the Tri-City HD or its sphere.

California Environmental Quality Act (CEQA) Review

The *2015 San Diego County Health Care Services Municipal Service Review (MSR)* is exempt from the CEQA environmental impact evaluation process as it involves data collection, research, and evaluation activities that will not result in a disturbance to environmental resources (CEQA Guidelines, Section 15306). The *2015 San Diego County Health Care District Sphere of Influence Review (SR)* is also exempt from CEQA because it can be concluded with certainty that there will be no adverse impact on the environment [CEQA Guidelines, Section 15061b (3)].

EXECUTIVE OFFICER'S RECOMMENDATIONS

1. Find in accordance with the Executive Officer's determination that pursuant to Section 15061(b)(3) of the State CEQA Guidelines, sphere updates, affirmations, and amendments are not subject to the environmental impact evaluation process because it can be seen with certainty that there is no possibility that the activity in question may have a significant effect on the environment and the activity is not subject to CEQA.
2. Find in accordance with the Executive Officer's determination that pursuant to Section 15306 of the State CEQA Guidelines, the service review is not subject to the environmental impact evaluation process because the service review consists of basic data collection, research, management, and resource evaluation activities that will not result in a serious or major disturbance to an environmental resource. The project is strictly for information gathering purposes and is a part of a study leading to an action that has not yet been approved, adopted or funded.
3. Determine, pursuant to Government Code Section 56430, the San Diego Local Agency Formation Commission is required to conduct a service review before, or in conjunction with an action to establish or update a sphere of influence.
4. Determine, pursuant to Government Code Section 56425, the San Diego Local Agency Formation Commission is required to develop and determine a sphere of influence for each local governmental agency within the County, and review and update, as necessary.
5. Determine that on June 2, 1986, the San Diego LAFCO adopted coterminous spheres of influence for the Fallbrook HD, Tri-City HD, Palomar Health HD, and Grossmont HD, and that the Commission affirmed, established, and updated each sphere and service review on August 6, 2007.
6. Determine that the Fallbrook HD, Tri-City HD, Palomar Health HD, and Grossmont HD have undergone a sphere of influence and service review in 2015 and for the reasons contained in the Executive Officer's report, affirm, update, and amend the spheres by designating territory as Special Study Areas as shown on the maps, attached hereto.
7. Determine that prior to the next *San Diego County Health Care Municipal Service Review (MSR) and Health Care District Sphere of Influence Review (SR)* in 2020, the Fallbrook HD and LAFCO staff should confer to determine if the Fallbrook HD should receive a Special Study Area Designation and/or be assigned a transitional sphere designation indicating that the Fallbrook HD should be dissolved and its service responsibilities reallocated to anyone or all of the remaining Health Care Districts in San Diego County.
8. Determine that prior to the next *San Diego County Health Care Services Municipal Service Review (MSR) and Health Care District Sphere of Influence Review (SR)* in

2020, each of the Health Care Districts should evaluate if the territory located within the Special Study designations should be included within their spheres and/or jurisdictional boundaries.

9. Determine that per Government Code Section 56425(i), the written statements on file with the Commission specifying the nature, location, and extent of any functions or classes of services provided by each of the Health Care Districts shall be reaffirmed.

10. Direct the Executive Officer to prepare Statements of Determinations pursuant to Government Code Sections 56425 and 56430 affirming, updating, and amending the respective spheres of influence and service review associated with the *2015 San Diego County Health Care Services Municipal Service Review (MSR) and Health Care District Sphere of Influence Review (SR), based on the reasons contained in the Executive Officer's report and recommendations.*

11. Direct the Executive Officer to include the Commission's actions per these recommendations in a resolution of approving the affirmation, update, and amendment of the spheres of influence and service review for the Fallbrook HD, Tri-City HD, Palomar Health HD, and Grossmont HD.

2015

San Diego County Health Care Services Municipal Service Review (MSR) and Health Care District Sphere of Influence Review (SR)

Fallbrook Health Care District (MSR13-65; SR13-65; SA13-65)
Grossmont Health Care District (MSR13-67; SR13-67;SA13-67)
Palomar Health Care District (MSR13-77; SR13-77; SA13-77)
Tri-City Health Care District (MSR13-92; SR13-92; SA13-92)

INTRODUCTION

The *2015 San Diego County Health Care Services Municipal Service Review (MSR) and Health Care District Sphere Review (SR)* fulfills requirements in state law to comprehensively review the spheres of influence and the provision of health care services within San Diego County of the four primary local Health Care Districts (HD) that were formed under the *Local Health Care District Law*:

- *Fallbrook HD (formed in 1948)*, which owns the recently-closed Fallbrook Hospital within the unincorporated community of Fallbrook (Map 2A).
- *Grossmont HD (formed in 1952)*, which owns the Grossmont Hospital in the City of La Mesa, and leases the facility to the non-profit Sharp Health Care Systems under a 30-year operating agreement (Map 3A).
- *Palomar Health HD (formed in 1950*), which owns and independently operates three acute-care hospitals: the Palomar Medical Center and the Palomar Health Downtown Campus within the City of Escondido; and the Pomerado Hospital in the City of Poway (Map 4A).
- *Tri-City HD (formed in 1957)*, which owns and independently operates the Tri-City Medical Center within the City of Oceanside (Map 5A).

2015 San Diego County Health Care Services MSR and Sphere Review Study Area

The study area for the *Health Care Services MSR and Sphere Review* is San Diego County, also known as the *San Diego–Carlsbad Metropolitan Statistical Area*, or the San Diego Region (Map 1A). The U.S. Census Bureau reports that San Diego County has a total area of approximately 4,526 square miles, including 4,207 square miles of land and 319 square miles of water bodies.

The 2010 Census calculated the total population of San Diego County at 3,095,308, ranking as the second-most populous county in California and the fifth-most populous in the United States. 2013 population estimates by the San Diego Association of Governments (SANDAG) reflect a total population of 3,150,178 in San Diego County. Current estimates reflect a total population of 3,211,252 in San Diego County (2013).

According to SANDAG population projections for 2050, the San Diego region is anticipated to grow to 4.4 million, with the 65-85+ age range representing over 20% of the 2050 population compared to 12.3% in 2013.

Primary Agencies

The *2015 San Diego County Health Care Services MSR and Sphere Review* evaluates the adopted spheres of influence for the four primary public agencies that were formed under the *Local Health Care District Law*: Fallbrook Health Care District (HD); Grossmont HD; Palomar Health HD; Tri-City HD. The four primary agencies' combined service areas and spheres total approximately 1,848.7 square miles (1,183,168 acres) and include a total population of approximately 1,402,422 (2013) (Map 1A).

The County of San Diego also provides county-wide public health care services; however, the *MSR and Sphere Review* concentrates on the four public Health Care Districts that have spheres of influence established by LAFCO and provide health care services within their respective service areas. The County of San Diego's health care services and programs are referenced in relation to the four Health Care Districts.

Recent changes have resulted in the closure of the Fallbrook Hospital following the termination of the lease/operation agreement between the Fallbrook HD and its operating partner, Community Health Services, Inc. (CHS). Additional discussion regarding the Fallbrook Hospital is included in the Fallbrook HD section of the MSR.

Environmental Review

The *2015 San Diego County Health Care Services Municipal Service Review (MSR)* is exempt from the CEQA environmental impact evaluation process as it involves data collection, research, and evaluation activities that will not result in a disturbance to environmental resources (CEQA Guidelines, Section 15306). The *2015 San Diego County Health Care Districts Sphere Review (SR)* is also exempt from CEQA because it can be concluded with certainty that there will be no adverse impact on the environment [CEQA Guidelines, Section 15061b (3)].

SPHERE of INFLUENCE BACKGROUND

In 1972, the California State Legislature directed LAFCOs to establish a *sphere of influence* for each local governmental agency under LAFCO jurisdiction. Spheres are defined in State Law as "...*a plan for the probable physical boundaries and service areas of a local agency"* (Government Code §56076) and are intended to promote logical and orderly development and coordination of local agencies; inhibit duplication of services; and support efficient public service delivery.

Accordingly, San Diego LAFCO maintains spheres of long standing for each independent special district and incorporated city in San Diego County. LAFCO decisions on proposed jurisdictional changes are required to be consistent with adopted spheres; therefore, to remain an effective planning tool, each agency's adopted sphere must be periodically reevaluated to ensure that it reflects current local conditions and circumstances.

Sphere Determinations

State Law requires that LAFCOs shall, as necessary, review and update each sphere of influence commencing in 2008 and every five years thereafter, [Government Code 56425(g)]. When determining an agency's sphere, LAFCO is required to consider and prepare a written statement of determinations that addresses each of the following categories:

(1) The present and planned land uses in the area, including agricultural and open space lands.
(2) The present and probable need for public facilities and services in the area.
(3) The present capacity of public facilities and adequacy of public services that the agency provides or is authorized to provide.
(4) The existence of any social or economic communities of interest in the area if the commission determines that they are relevant to the agency.
(5) For an update of a sphere of influence of a city or special district that provides public facilities or services related to sewers, municipal and industrial water, or structural fire protection, that occurs pursuant to subdivision (g) on or after July 1, 2012, the present and probable need for those public facilities and services of any disadvantaged unincorporated communities within the existing sphere of influence.

[Government Code 56425(e)]

LAFCO may assess the feasibility of governmental reorganization of particular agencies when determining a sphere of influence, and the Commission may recommend reorganization of those agencies when reorganization is found to be feasible and if reorganization will further the goals of orderly development and the promotion of efficient and affordable infrastructure and service delivery within and contiguous to the sphere.

It should also be noted that, while inclusion of territory within an agency's sphere of influence is a prerequistite of annexation, spheres are only one of several factors that must be considered by the Commission when reviewing proposed jurisdictional changes.

San Diego LAFCO Sphere Policies

In 1990, San Diego LAFCO adopted Policy L-102, which combined with implementing procedures, requires all local adopted spheres to be reevaluated at five-year intervals. This policy requirement was subsequently codified for all LAFCOs as part of the Cortese-Knox-Hertzberg (CKH) Act of 2001. Policy L-102 also discourages major amendments to a agency's sphere that has been adopted, affirmed, or updated unless one of the following is demonstrated by the proponent: (1) a documented public health or safety risk such as a septic system failure; (2) a proposal involving property split by a sphere boundary; (3) a reorganization involving two or more jurisdictions if the sphere of influence boundaries are coterminous and each jurisdiction agrees to the proposed sphere amendments and reorganization; and (4) situations where the previous sphere review did not anticipate a need for public services—and local conditions or circumstances have significantly changed to warrant a sphere amendment.

MUNICIPAL SERVICE REVIEW

When LAFCO establishes or updates spheres of influence, a Municipal Service Review (MSR) is required to be produced that analyzes and evaluates the provision of the subject services within the specified geographic area. The MSR evaluation requirements are codified in Government Code Section 56430 and involve a broad spectrum of service delivery, operational, and jurisdictional issues.

MSR Determinations

In conducting a MSR, LAFCO must prepare a written statement of determinations with respect to the following categories:

(1) Growth and population projections for the affected area.
(2) The location and characteristics of any disadvantaged unincorporated communities within or contiguous to the sphere of influence
(3) 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 disadvantaged unincorporated communities within or contiguous to the sphere of influence.
(4) Financial ability of agencies to provide services.
(5) Status of, and opportunities for, shared facilities.
(6) Accountability for community service needs, including governmental structure and operational efficiencies.
(7) Any other matter related to effective or efficient service delivery, as required by commission policy.

San Diego LAFCO Municipal Service Review Program

Since San Diego LAFCO initiated its first sphere review and MSR program in 2001, all local agency spheres have been included in at least one cycle of review and affirmation or update. In 2003, San Diego LAFCO adopted Policy L-106, which provides guidance for conducting Municipal Service Reviews while maintaining a focus on the service review determinations specified in State Law.

The current *Five-Year Sphere of Influence and Service Review Program* was initiated by sending a service-specific questionnaire to each of the 100 local public agencies under San Diego LAFCO's jurisdiction. All affected agencies responded to the questionnaire with detailed information regarding their current provision of services and any anticipated need for changes to service areas or adopted spheres of influence. The four primary Health Care Districts each provided questionnaire responses, which are referenced within the respective district section of the service review.

Disadvantaged Unincorporated Communities

In 2012, enactment of Senate Bill 244 (Wolk) resulted in changes to Government Code Sections 56425 and 56430 that require LAFCO to evaluate the present and probable need for public facilities and services within *disadvantaged unincorporated communities* (DUC) that are located within or contiguous to the sphere of influence of cities or special districts that provide wastewater, municipal or industrial water, or structural fire protection services. LAFCOs must make additional determinations relative to DUCs when conducting MSRs and updating spheres of influence.

While the subject Health Care Districts do not provide the affected services, the *2015 San Diego County Health Care Services MSR and Sphere Review* determinations identify any existing DUCs within or contiguous to each of the HD service areas and spheres, and describes the respective land use authority and local community planning area (Map 1C).

HEALTH CARE DISTRICT BACKGROUND

The California State Legislature originally enacted the *Local Hospital District Law* in 1945 (Division 23, Section 32000 et seq. of the Health and Safety Code, now referenced as the *"Local Health Care District Law"*) which enabled local communities to establish a special district and utilize public financing options for construction and operation of local community hospitals and health care 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 are empowered with authority to impose property taxes, enter into contracts, purchase property, exercise the power of eminent domain, issue debt, and hire staff.

While many Health Care 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 Health Care Districts. Health Care 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; revenue bonds are backed by user fees. Health Care Districts may also issue promissory notes and receive loans from state and federal governments.

Evolving from Hospital Districts to Health Care Districts

Following the establishment of local Health Care Districts in the 1940's and 1950's, many of the previously-rural Health Care District service areas in 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 1970's-1980's, the non-profit 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 health care patients.

In response to the competitive market environment, the focus of Health Care Districts expanded from primarily owning and operating local acute-care hospital facilities to also supporting community health care and health care-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 re-designated "*Hospital Districts*" to "*Health Care Districts*" to better reflect the diverse health care services provided in addition to operation of local hospital facilities.

The 1994 legislative update also expanded the definition of health care 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 health care services granted to Health Care Districts under current law includes, but is not limited to:

- Operating health care facilities such as hospitals, clinics, skilled nursing facilities, adult day health centers, nurses' training school, and child care 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 health care systems with preferred providers created significant financial sustainability problems for many stand-alone Health Care District hospitals in the State. Health Care Districts have generally evolved to meet the changing health care market demands; however, of the 85 Health Care Districts formed under the *Health Care District Law*, 73 Health Care Districts remain in 40 of the California's 58 counties. Only 43 of the 73 remaining Health Care Districts still own or operate acute-care hospitals, while 12 have declared bankruptcy since 1996.

To retain their local acute-care hospital facilities and services, many Health Care Districts have created non-profit corporations to transfer or sell their local hospital facilities and/or contract their hospital facility operations with for-profit or non-profit 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.

However, the divestitures of local Health Care District facilities and services have raised significant governance questions by public and private groups as to the necessity of retaining the public Health Care District model supported by local property tax revenues in

such a competitive, for-profit market environment. The 2015 *San Diego County Health Care Services MSR and Sphere Review* provides discussions on governance options for the local Health Care Districts, including potential jurisdictional changes such as consolidation, reorganization, and dissolution.

U.S. Federal Health Care Regulation

U.S. Department of Health and Human Services (HHS)

The U.S. Department of Health and Human Services (HHS) is the U.S. federal government's principal health care 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 health care insurance for one in four Americans.

Medicare

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 1 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 health care providers averages approximately 48% of the charges for the patients enrolled in Medicare. The remaining approved health care 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

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.

Patient Protection and Affordable Care Act (ACA)

The Patient Protection and Affordable Care Act (PPACA), known as the Affordable Care Act (ACA) or "Obamacare", 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 health care 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 mandates, subsidies, and insurance exchanges, and restructured Medicare reimbursements from fee-for-service to bundled payments in which a single payment is paid to a hospital and a physician group for a defined episode of care rather than individual payments to individual service providers.

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% 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 of California Health Care Regulation

California Health and Human Services Agency (CHHS)

The California Health and Human Services Agency (CHHS) is the state agency responsible for administration and oversight of "state and federal programs for health care, social services, public assistance and rehabilitation" in California. The California Health and Human Services Agency oversees 11 departments and boards, and 4 offices that provide a wide range of health care services, social services, mental health services, alcohol and drug treatment services, public health services, income assistance, and services to people with disabilities. Specific CHHS departments providing information used in the *2015 Health Care Services MSR and Sphere Review* are: the California Department of Health Care Services (DHCS); and the California Office of Statewide Health Planning and Development (OSHPD).

Department of Health Care Services (DHCS)

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

Medi-Cal

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 11.3 million citizens were enrolled in Medi-Cal as of October 30, 2014, or about 30% of California's population. Medi-Cal is jointly administered by the California DHCS and the federal Centers for Medicare and Medicaid Services (CMS), with many services implemented at the local level by the counties of California.

Covered California

Covered California is the health insurance marketplace in California, the state's implementation of the American Health Benefit Exchange provisions of the Patient Protection and Affordable Care Act (ACA). Beginning in 2014, those with family incomes up to 138% 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.

Office of Statewide Health Planning and Development (OSHPD)

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

The OSHPD Divisions that provide hospital and health care data used in the *2015 San Diego County Health Care Services MSR and Sphere Review* are:

- *Facilities Development Division:* Reviews and inspects health facility construction projects and state seismic safety standards.
- *Healthcare Information Division:* Collects data from nearly 5,000 licensed health care facilities, and produces annual reports relating to financial performance, utilization, patient characteristics, and health care services provided to the public.
- *Healthcare Workforce Development:* Collects, analyzes and publishes data regarding California's health care workforce; identifies areas of the state in which there are shortages of health professionals and service capacities; and coordinates with other state departments in addressing the unique medical care issues facing California's rural areas.

The OSHPD Facilities Development Division regulates the design and construction of healthcare facilities to ensure they are safe and capable of providing services to the public.

The OSHPD Healthcare Information Division provides annual license and utilization reports through its *Automated Licensing Information and Report Tracking System* (ALIRTS) for all Hospitals, Long Term Care Facilities, Primary Care and Specialty Clinics, Home Health and Hospices licensed in California, including facility type and medical services, total licensed beds and specified bed types.

The OSHPD Healthcare Information Division produces annual *Hospital Facility Summary Reports* for all licensed acute-care hospitals regarding the provision of Inpatient Services, Ambulatory Surgery, and Emergency Department Services.

The OSHPD Healthcare Information Division produces *Annual Financial Disclosure Reports* for each licensed acute-care hospital that provides financial information regarding hospital operations, including: patient revenues; operating and non-operating expenses; breakdowns of expenditures by category; net operating income; and total income or loss. These reports are available to the public through *MIRCal* – the *Medical Information Reporting for California*.

The OSHPD Healthcare Workforce Development Division (HWDD) administers programs intended to increase access to health care for underserved populations by providing grants and loan repayment programs to recruit, train, and encourage health professionals to serve in these areas. The HWDD also provides data and geographic information systems (GIS) information on California's health care workforce infrastructure.

State Seismic Requirements for Hospital 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 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.

Regulation of Private Health Care Providers

Private Health Care Providers are licensed and regulated by the California Department of Managed 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 health care marketplace in California.

County of San Diego Health Care Services

San Diego County Health and Human Services Agency (HHSA)

The San Diego County Health and Human Services Agency (HHSA) is the division of San Diego County government that is responsible for providing a broad range of health and social services in San Diego County. The San Diego County HHSA includes seven primary program areas which cover the various aspects of public health and social services: Aging and Independence Services; Behavioral Health Services; Children's Services; Public Administrator/Public Guardian; Public Health Services; Self-Sufficiency Programs; and Support Divisions.

The San Diego County HHSA is responsible for providing county-administered health and social programs related to welfare in California, such as Medi-Cal (Medicaid), CalFresh (food stamps), CalWORKs, and the Low Income Health Program (Obamacare). The San Diego County HHSA operates Family Resource Centers, Mental Health Clinics, and Public Health Centers for county residents, but does not directly operate acute-care hospital facilities.

San Diego Region – Existing Health Care Facilities

The San Diego Region includes a number of existing public and private health care facilities licensed by the State of California to provide a wide range of medical services and programs. The licensed health care facilities include: acute-care hospitals; long-term care facilities; home health and hospice facilities; primary care clinics; and specialty care clinics.

Acute Care Hospitals/Emergency Rooms

A licensed general acute-care hospital provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. An acute psychiatric hospital provides 24-hour inpatient care for mentally disordered, incompetent or other patients referred to in Division 5 (commencing with section 5000) or Division 6 (commencing with section 6000) of the California Welfare and Institutions Code, including the following basic services: medical, nursing, rehabilitative, pharmacy and dietary services.

As of December 2014, the OSHPD Healthcare Information Division (HID) lists a total of 34 licensed hospitals in San Diego County, with a combined total of 7,632 licensed beds. The licensed hospital types include 28 general acute-care hospitals with a total of 17 emergency departments; 5 acute-care psychiatric hospitals; and one chemical dependence recovery hospital.

San Diego County Trauma System

Established in 1984, the San Diego County Trauma System is a public-private partnership between the County of San Diego's Emergency Medical Services (EMS) and six licensed acute-care hospitals with emergency departments that are designated as regional Trauma Centers for treatment of traumatic injuries requiring immediate medical interventions to save life and limb.

The California Emergency Medical Services Authority (EMSA) defines trauma center levels as follows:

- *Level I and Level II* trauma centers have similar personnel, services, and resource requirements. Level I trauma centers are generally associated with research and teaching facilities.
- *Level III and Level IV* trauma centers generally provide initial stabilization of trauma patients. Level III facilities also provide surgical facility capabilities.
- *Pediatric* trauma centers specifically treat pediatric trauma patients. Level I pediatric centers provide additional pediatric specialties, research, and teaching responsibilities.

The six current California Emergency Medical Services Authority (EMSA) designated Trauma Centers for San Diego County are as follows:

- Palomar Health Downtown Campus (Level II Trauma Center)
- Scripps Memorial Hospital-La Jolla (Level II Trauma Center)
- Scripps Mercy Hospital-Hillcrest (Level I Trauma Center)
- Sharp Memorial Hospital (Level II Trauma Center)
- Rady Children's Hospital (Level I Pediatric Trauma Center)
- UC San Diego Medical Center (Level I Trauma Center)

Skilled Nursing Facilities (Long Term Care Facilities)

Long-term care facilities in San Diego County include skilled nursing facilities, congregate living health facilities, and intermediate care facilities for the developmentally disabled:

- A *skilled nursing facility* is described as a health facility or a distinct part of a hospital which provides continuous skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. A skilled nursing facility provides 24-hours inpatient care and, as a minimum, includes physician, skilled nursing, dietary, pharmaceutical services and an activity program.
- A *congregate living health facility* is described as a residential home with a capacity of no more than 12 beds (except those operated by a city or county which may have a capacity of 59 beds), that provides inpatient care, including the following basic services: medical supervision, 24-hour skilled nursing and supportive care, pharmacy, dietary, social, recreational, and at least one type of the following services: services for persons who are mentally alert, physically disabled persons, who may be ventilator dependent; services for persons who have a diagnosis of terminal illness, a diagnosis of a life threatening illness, or both; and/or services for persons who are catastrophically and severely disabled.
- An *intermediate care facility for the developmentally disabled* (ICF-DD) is a health facility which provides care and support services to developmentally disabled clients whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services.

As of December 2014, OSHPD lists a total of 90 licensed long-term care facilities in San Diego County with a combined total of 5,475 licensed beds, including 82 skilled nursing facilities; 7 congregated living health facilities; and one intermediate care facility/developmentally disabled (ICF/DD).

Home Health and Hospice Facilities

Hospice care is described as a type of care and philosophy of care that focuses on the palliation of a chronically ill, terminally ill or seriously ill patient's pain and symptoms, and attending to their emotional and spiritual needs. Most hospice care is delivered in the patient's home, but hospice care is also available to people in home-like hospice residences, nursing homes, assisted living facilities, veterans' facilities, hospitals, and prisons. As of December 2014, OSHPD lists a total of 101 licensed home health and hospice facilities in San Diego County, including 78 home health agencies and 23 hospices.

Primary Care Clinics

A clinic is defined in State Law as an outpatient health facility operated by a tax-exempt nonprofit corporation that provides direct medical, surgical, dental, optometric, or podiatric advice, services, or treatment to patients who remain less than 24 hours. Primary care clinics are licensed as *community* or *free clinics*, as defined under Section 1204 of the California Health and Safety Code, and provide services to patients on a sliding fee scale basis or, in the case of free clinics, at no charge to the patients.

Community clinics and free clinics provide comprehensive health care services, primarily for low-income, uninsured and underserved Californians with limited access to health care.

California's community primary care clinics are considered the backbone of the state's health care safety net, annually serving more than 2.8 million primarily low-income, minority, and immigrant patients. As of December 2014, OSHPD lists a total of 108 licensed primary care clinics in San Diego County, including 104 community clinics and 4 free clinics.

Specialty Care Clinics

Specialty care clinics are outpatient health facilities operated by a tax-exempt nonprofit corporation that not part of hospitals and only serve patients who remain less than 24 hours. Specialty care clinics are licensed to provide specialty medical services including:

- *Surgical clinics* that provide ambulatory surgical services;
- *Chronic dialysis clinics* that provide treatment of patients with end-stage renal disease, including renal dialysis services;
- *Rehabilitation clinics*, which are required to provide at least two of the following rehabilitation services: physical therapy, occupational therapy, social, speech pathology, and audiology services;
- *Psychology clinics*, which provide psychological advice, services, or treatment under the direction of a clinical psychologist; and

- *Alternative birthing centers* that provide comprehensive perinatal services and delivery care to pregnant women.

Alternative birthing centers are required to be located in proximity to a health facility with the capacity for management of obstetrical and neonatal emergencies, including the ability to provide cesarean section delivery, within 30 minutes from time of diagnosis of the emergency.

Alternative birthing centers are also required to provide at least two attendants at all times during birth, with at least one of the attendants being a physician and surgeon, a licensed midwife, or a certified nurse-midwife.

As of December 2014, OSHPD lists a total of 36 licensed specialty care clinics in San Diego County, including 30 chronic dialysis clinics; 3 surgical clinics; 1 alternative birthing center; 1 rehabilitation clinic; and 1 psychology clinic.

San Diego County Health Care Issues and Topics

The *2015 San Diego County Health Care Services MSR and Sphere Review* contains a discussion of each of the major topics required for LAFCO adoption of a service and sphere review.

The service review categories and relevant health care topics provide a broad base of data and quality indicators regarding: the provision of health care services; the status of local hospital infrastructure; annual hospital financial performance; and an overview of governmental structure options available to the Health Care Districts. Below are the major topics covered in the *2015 San Diego County Health Care Services MSR and Sphere Review*:

1. District Overview: Formation, Governance, Hospital Facilities
2. Service Area/Sphere of Influence: Population/Projections, Social or Economic Communities of Interest, Medically Underserved/Understaffed Areas
3. Services/Facilities: Adequacy of Services, Infrastructure Needs & Deficiencies
4. Finance: Fiscal Performance, Property Taxes, Bonded Debt
5. Governance: Community Service Accountability, Hospital Operations
6. Governance: Opportunities for Shared Facilities, Governance Options
7. MSR Determinations: Sphere Recommendations

FALLBROOK HEALTH CARE DISTRICT (MSR13-65; SR13-65; SA13-65)

District Overview: Formation, Governance, Hospital Facilities

District Background

The Fallbrook Health Care District (HD) provides hospital and skilled nursing facility-based services within an approximate 111-square mile service area and *coterminous* sphere of influence located in unincorporated northern San Diego County. Fallbrook HD owns the 47-bed Fallbrook Hospital and leases the 93-bed Fallbrook Skilled Nursing Facility, both located in the unincorporated community of Fallbrook. The Fallbrook HD serves a total population of approximately 57,000 within the unincorporated north county communities of Fallbrook, Rainbow, De Luz, and Bonsall (Map 2A).

As of December 2014, the Fallbrook Hospital has closed operations as an acute-care hospital and its long-term operational status is undetermined. The hospital's closure followed the termination of a lease and operational agreement between the Fallbrook HD (as the non-profit Fallbrook Hospital Corporation) and the for-profit operating partner, Community Health Systems Inc., due to continuing financial losses from Fallbrook Hospital core service operations. Additional discussion on the Fallbrook Hospital closure and future options for the Fallbrook HD follow below in the Governance section.

District Formation

The Fallbrook Health Care District was originally formed by vote of local residents in 1950 as the *Fallbrook Hospital District*. In 1959, the Fallbrook Hospital was constructed as an 18-bed hospital facility on the present location. The hospital was expanded in 1960 to include surgery, a delivery room, central supply, and emergency services. In 1971, the Fallbrook Hospital was enlarged to its present 47-bed capacity.

Governance

The Fallbrook is governed by a five-member Board of Directors that is elected at-large by local voters and serve four-year terms. The Fallbrook HD Board establishes District policy and administers community health care programs funded by local property tax revenues. The Fallbrook HD Board is responsible for maintenance of the Fallbrook Hospital and for compliance with hospital licensing and health care regulation requirements. Regular Board meetings occur monthly, on the 2nd Wednesday at 6:00 p.m.

Fallbrook Hospital

Fallbrook HD owns the Fallbrook Hospital (OSHPD ID No. 106370705), located at 624 East Elder Street, Fallbrook. The 47-bed Fallbrook Hospital has been licensed as a General Acute Care Hospital since December 19, 1960 (License No. 080000005).

Fallbrook Skilled Nursing Facility

The Fallbrook HD leases and operates a 93-bed skilled nursing facility for long-term care (OSHPD ID No. 206370704) located at 325 Potter Street, Fallbrook. The Fallbrook Skilled Nursing Facility (SNF) has been licensed as General Acute Care Hospital since October 21, 1963 (License No. 080000005).

District Service Area and Sphere of Influence

Service Area

The Fallbrook HD authorized service area includes approximately 70,764 acres (110.57 square miles) primarily within unincorporated northern San Diego County. The Fallbrook HD service area and sphere territory includes the unincorporated communities of Fallbrook, Bonsall, De Luz, Rainbow and the I-15 corridor between Gopher Canyon Road and the Riverside County line. A small portion of City of Oceanside incorporated territory is also within the southwest corner of the Fallbrook HD service area.

The Fallbrook HD is bordered by Camp Pendleton on the west, Riverside County to the north, the unincorporated communities of Pala and Valley Center to the east, the City of Oceanside to the south, and is traversed east-west by the Santa Margarita and the San Luis Rey Rivers. The Fallbrook HD service area and sphere is also bordered by the Palomar Health HD to the east, and the Tri-City HD to the south.

Sphere of Influence

On June 2, 1986, San Diego LAFCO adopted a sphere of influence for the Fallbrook HD that was coterminous with the HD's service area. There have been no annexations or detachments to the Fallbrook HD service area nor any changes to the sphere since it was originally established. The Fallbrook HD's adopted sphere was most recently reviewed and affirmed by the Commission on August 6, 2007 as coterminous with the service area.

Land Uses

The Fallbrook HD's service area consists primarily of rural, unincorporated territory, and is generally located within the unincorporated Fallbrook, Rainbow, and De Luz Community Planning Areas. Land uses within the unincorporated territory are governed by County of San Diego General Plan land use designations and zoning. The small portion of Fallbrook HD within the incorporated territory of the City of Oceanside is governed by the City's General Plan and zoning designations.

Location and Characteristics of Disadvantaged Unincorporated Communities

When conducting a municipal service review, recent Legislative changes require LAFCO to identify the location and characteristics of any existing *disadvantaged unincorporated communities* that are within or contiguous to the public agency's sphere of influence.

A disadvantaged unincorporated community is defined as an inhabited, unincorporated area in which the median household income is 80% or less of the statewide median household income (Map 1C).

The Fallbrook HD has one disadvantaged unincorporated community within its sphere, but none adjacent to the sphere. The identified disadvantaged unincorporated community is located in the Fallbrook town center within the Fallbrook Community Planning Area of unincorporated San Diego County.

Service Area Population

The San Diego Association of Governments (SANDAG) is the designated regional clearinghouse for the US Census Bureau and provides current population estimates and future population projections for the San Diego Region. LAFCO annually receives SANDAG population estimates for all local independent and dependent special districts in San Diego County. The SANDAG special district population estimates are based on the subject agency's geographic service area and are calculated using SANDAG's demographic modeling programs. 2014 SANDAG Special District Population Estimates for the Fallbrook HD service area and sphere report a total population of 57,515.

2008-2014 Fallbrook HD Population Totals (SANDAG Estimates)

Year	Total Population
2008	54,276
2009	55,642
2010	57,075 (Based on Census 2000 estimates)
2011*	54,304 (Based on Census 2010 estimates)
2012	56,225
2013	56,537
2014	57,515

From 2008-2014, the Fallbrook HD rate of growth was approximately 6.0%. The Fallbrook HD has maintained a consistent population of approximately 55,000; therefore significant local population growth is not anticipated over the next 5 years.

2050 Service Area Population Projection

The Fallbrook HD service area and sphere are included within defined geographic units of San Diego County called Subregional Areas (SRA) that are used by SANDAG for local population estates and projections. The Fallbrook Subregional Area (SRA 55) comprises the majority of the populated areas within the Fallbrook HD service area and sphere. The Fallbrook SRA is also partially located within the Palomar Health HD service area and sphere.

Projected 2020-2050 Subregional Area Population Totals – Growth Rate

SRA	2020	2030	2040	2050	2013-2050
55-Fallbrook	51,805	61,001	68,461	72,681	+50.7%

The 2013 estimated total population for the Fallbrook SRA was 48,346. SANDAG's 2050 Regional Growth Forecast Population Estimates (2011) projects the Fallbrook Subregional Area to grow approximately 51% from 2013-2050, to a total population of 72,681.

2013-2030 Elderly Population Projections

Following the assessment of 2010 Census data, national and state population projections have indicated that the older population segments (65-85+ years) will grow from approximately 10-12% of the current total population to over 20% by 2030 (Map 1D). Census data also reflect that older population segments generally live with high poverty

levels and are reliant on fixed incomes. The projected doubling of older residents in the next 10-15 years is anticipated to create significant demands for local facilities, services, and resources to meet expected health care demands in underserved and high poverty areas.

Projected 2013-2030 Subregional Area 65-85+ Population Totals & Growth Rate

SRA	2013	2020	2030	2013-2030
55-Fallbrook	9,054	10,191	14,607	+61.3%
% of total pop.	18.7%	19.7%	23.9%	

While the Fallbrook Subregional Area population is projected to increase by approximately 26% by 2030, the number of people in the 65-85+ age range is estimated to increase by approximately 61% during the same time (Map 2B).

Fallbrook HD Medical Service Study Areas (MSSAs)

The California Office of Statewide Health Planning and Development (OSHPD) produces maps for each county in the state that designate geographic Medical Service Study Areas (MSSAs) based on local 2010 Census Tract boundaries. OSHPD's Health Care Workforce Development Division (HWDD) reviews the Medical Service Study Areas to assess local population density, provider-to-population ratios, poverty levels, and public health indicators. OSHPD defines Medical Service Study Areas as Frontier*, Rural, or Urban*, based on local population density per square mile. A *Frontier* MSSA has a population density less than 11 persons per square mile (sq. mi.); a *Rural* MSSA is one with a population density greater than 11 per sq. mi. and less than 250 persons per sq. mi.; and, an *Urban* MSSA, which are all MSSAs with a population density higher than 250 persons per sq. mi. (Map 1B).

Fallbrook Hospital is located in San Diego County Medical Service Study Area (MSSA) 160, which is designated as *Rural* and includes the unincorporated communities of Fallbrook and Bonsall, and Camp Pendleton. OSHPD reports that MSSA 160 includes a total population of 84,756 with a population density of 249.09 residents per square mile. MSSA 160 is officially designated as *Rural*; however, the reported population density per square mile is virtually the same as the lowest range to be considered *Urban*.

The following table identifies the Medical Service Study Areas that include all or portions of the Fallbrook HD service area and sphere territory, and provides a comparison of population densities, poverty rates, and local communities:

Fallbrook HD Medical Service Study Areas

MSSA	Type	Pop. Den. per sq.ml.	Poverty rate	Communities
160	Rural	249.1	9.6%	Fallbrook, Bonsall, Camp Pendleton
153.1	Rural	73.8	17.7%	Pala, Pauma Valley
153.2	Rural	139.7	9.6%	Rincon, San Pasqual, Valley Center
156d	Urban	2,195.3	14.4%	Oceanside, San Marcos

Fallbrook HD is bordered by Palomar Health HD to the east and by Tri-City HD to the south. While the majority of Fallbrook HD is located within MSSA 160, small portions of the Fallbrook HD service area and sphere are also located within adjacent MSSAs 153.1, 153.2, and 156d, which are primarily located within Palomar Health HD and Tri-City HD, respectively.

Medically Underserved Areas - Health Care Professional Shortage Areas

OSHPD produces county maps which identify local Medical Service Study Areas that qualify for designation as a *Medically Underserved Area* (MUA) and/or a *Primary Care Shortage Area* (PCSA). The Federal Agency for Health Care Research and Quality (AHRQ) also designates MSSAs with a shortage of professional health care providers as a *Health Professional Shortage Area* (HPSA) for the *Primary Care, Dental Health, and Mental Health* disciplines (Maps 2D-2F).

Health Care Professional Shortage Areas and *Primary Care Shortage Areas* are designated where there are local population-to-physician ratios that demonstrate a high need for services combined with a general lack of access to health care in surrounding areas because of excessive distance, overutilization, or access barriers. The designated MSSA maps can be used to identify areas of potential concern for Health Care Districts when addressing future health care needs and demands and sufficiently planning for needed local infrastructure and services.

Fallbrook HD Medically Underserved Areas / Health Care Professional Shortage Areas

MSSA	Type	Communities	Designated MUA/HPSA
160	Rural	Fallbrook, Bonsall, Camp Pendleton	MUA, RNSA (County-wide)
153.1	Rural	Pala, Pauma Valley	MUA, HPSA-PC, PCSA, RNSA
153.2	Rural	Valley Center, Rincon, San Pasqual	MUA, RNSA
156d	Urban	Vista, East Oceanside, West San Marcos	MUA, RNSA

The Fallbrook HD service area and sphere MSSAs each have territory that is within or adjacent to areas designated as *Medically Underserved Areas* (MUA) and/or *Health Care Professional Shortage Areas* for primary care (HPSA-PC, PCSA) and for registered nursing professionals (RNSA). As the Fallbrook HD service area is bordered by the Palomar Health HD and the Tri-City HD service areas, all of the MSSAs with designated underserved and shortage areas are currently located within existing Health Care District territory.

Potential Social or Economic Communities of Interest

The *2015 Health Care Services MSR and Sphere Review* determinations are required to identify any *social or economic communities of interest* existing in the review area, if LAFCO determines that they are relevant to the subject agency. The Commission is recommended to consider local areas designated by OSHPD as *Medically Underserved Areas* and/or *Health Care Professional Shortage Areas*, and local areas identified with poverty levels above the regional average of *14.4%*, as containing *social or economic communities of interest* relevant to the local Health Care Districts (Maps 2B-2F).

Proposed San Diego County Special Study Areas

As OSHPD-designated *Medically Underserved Areas* and/or *Health Care Professional Shortage Areas*, and local areas identified with high poverty levels areas exist in both urban coastal incorporated territory and rural unincorporated desert and mountain communities of San Diego County, the *2015 Health Care Services MSR and Sphere Review* determinations recommend Commission consideration of *Special Study Area* designations for 4 major areas of the County that contain inhabited territory not currently located within any of the local Health Care District service areas and spheres, and which contain *social or economic communities of interest* relevant to the local Health Care Districts (Map 1L).

Potential Fallbrook HD Special Study Areas

One of the four proposed *Special Study Areas* for San Diego County is adjacent to the Fallbrook HD service area and sphere: *Special Study Area No. 1: Fallbrook HD/Camp Pendleton* (Maps1L and 2G).

The proposed *Special Study Area No. 1* territory includes inhabited urban and rural areas of the northwest corner of San Diego County, including Camp Pendleton and the unincorporated De Luz community, and portions of the Tri-City HD and Fallbrook HD service areas and spheres that overlap the Camp Pendleton boundary.

The Fallbrook HD service area and sphere extends to the northwest and includes a portion of the unincorporated community of De Luz located between Camp Pendleton to the south and Riverside County to the north (Pendleton-De Luz Community Planning Area).

The remainder of the De Luz community that is not currently within the Fallbrook HD service area and sphere should be considered for designation as a *Special Study Area* so that the unincorporated Pendleton-De Luz Community Planning Area territory not located within Camp Pendleton is joined with the Fallbrook HD territory.

While State Law allows for both incorporated and unincorporated territory to be served by Health Care Districts and included within their service areas, Health and Safety Code Section 32001 prohibits the division of incorporated territory within a Health Care District unless LAFCO determines that the area would not be benefitted by inclusion.

As the majority of the City of Oceanside is currently located within the Tri-City HD service area and sphere, the small portion of Oceanside incorporated territory located within the Fallbrook HD service area and sphere should accordingly be consolidated within Tri-City HD; however, the adjacent Health Care Districts should discuss and collaboratively evaluate the affected area to determine if inclusion within either the Tri-City HD service area and sphere would benefit the local area.

The proposed *Special Study Area No. 1* is not recommended for inclusion within the Fallbrook HD service area or sphere at this time; however, subsequent health care service and sphere reviews should evaluate the *Special Study Area* for resolution of the study area designation and potential sphere inclusion.

Healthcare Facilities & Services

Fallbrook Hospital

The California Office of Statewide Health Planning and Development (OSHPD) provides licensing, facility, and services information for each licensed acute-care hospital through its Automated Licensing Information and Report Tracking System (ALIRTS).

Fallbrook HD owns the 47-bed Fallbrook Hospital (OSHPD ID No. 106370705), located at 624 East Elder Street, Fallbrook. The Fallbrook Hospital's 47 licensed beds include 4 for coronary care, 4 for intensive care, 4 for perinatal care, and 35 for unspecified general acute care (License Number: 080000005). The Fallbrook Hospital reported a total of 282 full-time employees for 2012-2013, with 86 nursing employees. The Fallbrook Hospital medical staff included a total of 75 physicians (including MDs, DOs, and Podiatrists).

OSHPD reports the following medical services were licensed to be provided at the Fallbrook Hospital up to December 20, 2014: Emergency – Basic, Nuclear Medicine, Occupational Therapy, Physical Therapy, Respiratory Care Services, Social Services, Mobile Unit – MRI, Speech Therapy. Following the closure of Fallbrook Hospital, the current license (12/21/14 – 10/31/15) only allows Social Services to be provided at the facility.

Fallbrook Skilled Nursing Facility

The Fallbrook HD also leases and operates a 93-bed skilled nursing facility for long-term care (OSHPD ID No. 206370704) located at 325 Potter Street, Fallbrook.

Fallbrook Hospital Operations and 2014 Closure

The Fallbrook Hospital was independently operated by the Fallbrook HD from 1960-1998. In 1998, Fallbrook HD entered into a 30-year agreement to lease and operate the Fallbrook Hospital with Community Health Systems, Inc. (CHS), a for-profit health care system company headquartered in Franklin, Tennessee.

As of December 2014, the Fallbrook Hospital has closed operations as an acute-care hospital and its long-term operational status is undetermined. The hospital's closure followed the termination of the lease and operational agreement by Community Health Systems due to continuing financial losses. Additional discussion on the Fallbrook Hospital closure and future options for the Fallbrook HD follow below in the Governance section.

Hospital Facility Capacity and Utilization

The OSHPD Healthcare Information Division (HID) uses submitted financial and operational data for each licensed acute-care hospital to produce an *Annual Financial Disclosure Report* that includes detailed information regarding the hospital's operations, and annual *Hospital Facility Summary Reports* for the hospital's provision of *Inpatient Services, Emergency Department Services, and Ambulatory Surgery*.

Licensed Bed Occupancy Rates

During 2012-2013, the Fallbrook HD reported an occupancy rate of 57.8% for its 140 licensed acute-care beds. During fiscal years 2010-2013, the Fallbrook HD reported an average overall occupancy rate for its licensed and available acute-care beds as 62.5%; however, the annual occupancy rate declined from 65.9% to 57.8%.

Occupancy Rate	**2009-2010**	**2010-2011**	**2011-2012**	**2012-2013**
Licensed beds (140)	65.8%	65.9%	60.3%	57.8%

Total Live Births

The Fallbrook Hospital reported a total of 8 bassinets in its nursery. During the 2012-2013 reporting period, the Fallbrook HD reported a total of 413 live births, with 330 natural births and 83 deliveries by caesarian section. Reported Fallbrook Hospital data for 2009-2013 reflects an annual average of approximately 428 live births, with generally consistent ratios of natural births to caesarian sections.

Fallbrook Hospital	**2009-2010**	**2010-2011**	**2011-2012**	**2012-2013**
Total Live Births	388	486	425	413
Natural births	259	363	315	330
Caesarian section	129	123	110	83

Inpatient Discharges

The 2014 *Facility Summary Report* for Fallbrook Hospital reported a total of 1,815 inpatient discharges, with 76.3% for Acute Care (1,385) and 23.7% for Skilled Nursing/Intermediate Care (430). Total number of inpatient discharge days for 2014 were reported as 24,868, with an average length of stay at 13.7 days.

Fallbrook HD Inpatient Discharges 2010-2014:

Year	Discharges	Days	Average Stay
2010	3,365	22,213	6.6 days
2011	3,349	20,831	6.2 days
2012	3,052	26,218	8.6 days
2013	2,823	22,414	7.9 days
2014	1,815	24,868	13.7 days

Reported data reflects that annual Fallbrook HD total inpatient discharges have decreased by approximately 85% overall from 2010-2014. The average length of stay increased by approximately 73% from 2013-2014.

Fallbrook HD Inpatient Age Ranges 2010-2014

Year	Under 1 yr.	10-19	20-39	40-59	60-80+
2010	13.3%	2.1%	17.4%	14.5%	52.7%
2011	13.3%	1.5%	16.5%	15.5%	53.2%
2012	13.9%	1.8%	18.7%	15.4%	50.1%
2013	13.4%	1.4%	17.3%	13.5%	53.4%
2014	9.1%	0.6%	19.3%	15.5%	62.5%

Demographics for Fallbrook Hospital inpatient discharges for 2014 were 62.4% female and 37.6% male. This female/male patient ratio is consistent with 2007-2013 reported data. Fallbrook Hospital patients between 60 and 80+ years represented 62.5% of all discharges. Highest reported age range frequency for 2014 Fallbrook Hospital inpatient discharges was 80+ years (32.4% of all inpatient discharges); 70-79 years (17.4%); 60-69 years (12.7%); all other age ranges were less than 10% of total discharges.

Emergency Department (ED) Services

As of 2013, the Fallbrook Hospital included a licensed Basic Emergency Department (ER). The Fallbrook HD reported 24-hour emergency physician services, with on-call services for: anesthesiologist, laboratory services, operating room, pharmacist, psychiatric ER, and radiology.

The Fallbrook HD 2014 Emergency Department (ED) *Facility Summary Report* states that a total of 9,490 ED Encounters occurred during the reporting period. Total annual Fallbrook Hospital ED encounters have varied over 2010-2014 but have remained between 9,300 and 10,300 per year. In 2014, Fallbrook Hospital ED Encounters most often resulted in routine discharges where the patient was released to home or self-care (92.7%).

Fallbrook Hospital ED Encounters and Dispositions 2010-2014

Year	Encounters	Routine Discharges (%)
2010	9,373	8,840 (94.3%)
2011	8,934	8,475 (94.9%)
2012	9,648	9,107 (94.4%)
2013	10,394	9,711 (93.4%)
2014	9,490	8,800 (92.7%)

Demographics for Fallbrook Hospital ED Encounters in 2014 were reported as 57.1% female and 42.9% male, with top age ranges reported as 20-29 years (14.5% of all ES encounters); 1-9 years (13.4%); 50-59 years (12.6%); and, 30-39 years (11.6%). The highest frequency of ED diagnosis type was reported as *Injuries/Poisonings/Complications*, at 28.5%; *Symptoms*, at 18.9%; and, *Respiratory System*, at 10.1%; all other ED diagnosis types were less than 6%.

Emergency Department Ambulance Diversion Hours

The OSHPD *Annual Utilization Reports* for 2012-2014 state that the Fallbrook Hospital had no *Ambulance Diversion* hours when the ED was unable to receive ambulance patients which resulted in ambulances being diverted to other hospitals.

Ambulatory Surgery

The Fallbrook HD's submitted 2013 *Facility Utilization Report* for Fallbrook Hospital states that the hospital had a total of 3 operating rooms that performed a total of 2,170 surgical operations, with a total of 883 inpatient procedures and 1,287 outpatient procedures.

The 2014 OSHPD *Facility Summary Report* for the Fallbrook Hospital reports a total of 1,003 Ambulatory Surgery Encounters, with the principal procedure groups as *Respiratory System* at 19.5%; *Digestive System*, at 15.0%; and *Cancer*, at 15.0%. A total of 997 (99.4%) of the 2014 Ambulatory Surgery Encounters resulted in routine patient discharges to home or self-care. The following table reflects that total Fallbrook Hospital Ambulatory Surgery encounters decreased by approximately 50% from 2010-2014.

Fallbrook Hospital Ambulatory Surgery Encounters 2010-2014

Year	Encounters	Principal Surgery (%)
2010	2,071	Digestive System (34.6%)
2011	2,024	Digestive System (32.5%)
2012	1,780	Digestive System (35.2%)
2013	1,306	Digestive System (29.2%)
2014	1,003	Respiratory System (19.5%)

Demographics for 2014 Fallbrook Hospital Ambulatory Surgery Encounters were reported as 53.8% female and 46.2% male. Total 2014 Ambulatory Surgery Encounters were primarily performed on older patients, with 42.3% of total encounters performed on patients from 30-59 years; 40.9% performed on patients from 60 to 80+ years; and only 16.6% performed on patients in the 1-29 years range. Top age range frequency was 50-59 years (18.3% of total encounters); 70-79 years (16.4%); 60-69 years (16.0%); and, 40-49 years (14.4%).

Adequacy of Services

Hospital Quality Indicators

The health care services provided by hospitals are measured for quality by several public and private organizations using a variety of *quality indicators* (QIs), including patient experience ratings; inpatient mortality rates for selected medical procedures and conditions; and the volume and frequency of selected medical procedures. The *quality indicators* establish annual rates for the subject hospitals that are measured against county and/or state averages.

The healthcare service quality indicators used in the *2015 San Diego County Health Care Services MSR and Sphere Review* are produced by: the California HealthCare Foundation (CHCF) through *CalQualityCare.org*, which establishes hospital ratings from patient survey responses on their experiences receiving medical services; and by the federal *Agency for Healthcare Research and Quality (AHRQ)*, which compiles OSHPD statistics on hospital performance for selected medical procedures and conditions in comparison to county and/or statewide averages.

The annual quality indicator results and hospital ratings provide a comprehensive set of data for evaluating the ongoing adequacy of services provided by the local Health Care Districts. Quality indicator category rates that are consistently lower or higher than county and state averages are noted for additional consideration within the Fallbrook HD's adequacy of services determinations.

CalQualityCare.org Hospital Ratings

The California HealthCare Foundation (CHCF), a non-profit philanthropic foundation, produces hospital quality ratings through *CalQualityCare.org* for 332 acute care hospitals in the state of California. CalQualityCare.org hospital ratings are based on patient survey responses regarding their healthcare service experiences, and provide hospital clinical care, patient safety, and patient experience indicators in relation to statewide averages to produce a Patient Experience Rating of:

- Superior, where the provider performed well above average;
- Above Average, where the provider performed better than average;
- Average, where the provider performed within the average;
- Below Average, for performance worse than average; and,
- Poor, for performance well below the average level.

For 2012-2013, CalQualityCare.org reports that Fallbrook Hospital received an overall *Patient Experience Rating* of ***Average*** and a total score of 65%, compared to the California state average of 68%. The Fallbrook Hospital *Readmission Rate* was rated as ***Average*** (16.10%), compared to the California state average of 15.90%. Patient responses indicate that 63% would recommend Fallbrook Hospital compared to the State average of 70%.

Fallbrook Hospital 2012-2013 CalQualityCare.Org Indicators and Ratings

Indicator	Rating (Score)	State Average
Patient Experience		
Hospital Rating	*Average* (65%)	68%
Hospital Readmission Rate	*Average* (16.10%)	15.9%
Patient Safety		
Surgical Care Measures	***Superior*** (98%)	97%
Unplanned Surgical Wound Reopening	*Average* (0.08%)	0.09%
Death after Serious Treatable Complication	*N/A*	10.84%
Accidental Lung Puncture	*Average* (0.03%)	0.03%
Heart Attack		
Death Rate	*Average* (15.30%)	14.90%
Quality of Care	*N/A*	98%
Timeliness of Care	*N/A*	N/A
Readmission Rate	*N/A*	18.20%
Heart Bypass Surgery		
Death Rate	*N/A*	2.17%
Internal Mammary Artery Usage	*N/A*	97%
Postoperative Stroke	*N/A*	1.31%
Heart Failure		
Death Rate	*Average* (12.10%)	11.20%
Quality of Care	***Above Average*** (95%)	96%
Readmission Rate	*Average* (22.80%)	22.80%

Indicator	Rating (Score)	State Average
Mother & Baby		
C-Section Rate	***Above Average*** (25.80%)	27.80%
Breastfeeding Rate	***Below Average*** (35.50%)	63.20%
Episiotomy Rate	*Average* (12.20%)	13.50%
VBAC Rate	*Average* (7.80%)	8.30%
Pneumonia		
Death Rate	*Average* (11.80%)	11.70%
Quality of Care	***Above Average*** (94%)	96%
Readmission Rate	*Average* (17.70%)	17.50%
Surgeries / Other Conditions		
Acute Stroke Death Rate	*Average* (8.80%)	9.91%
Craniotomy Death Rate	*N/A*	7.81%
Gastrointestinal Hemorrhage Death Rate	*Average* (2.80%)	2.31%
Hip Fracture Death Rate	*Average* (2.50%)	2.47%
Hip or Knee Surgery Readmission Rate	*Average* (4.70%)	5.20%
Hip or Knee Surgery Complication Rate	*Average* (2.90%)	3.30%
Emergency Department Care		
Time in ED before being admitted	282 minutes	338 minutes
Time in ED before being sent home	140 minutes	165 minutes
Time in ED before being seen	14 minutes	32 minutes
Patients who left ED without being seen	2%	2%

The 2012-2013 CalQualityCare.org indicators and ratings for Fallbrook Hospital medical procedures are generally consistent with state levels.

The Fallbrook Hospital indicator ratings range from a *Superior* rating for surgical care measures, to a *Below Average* rating for the percentage of new mothers utilizing breastfeeding. However, more significant is that patient responses indicate that only 63% would recommend Fallbrook Hospital compared to the State average of 70%, which is the lowest patient-rated hospital facility of the Health Care Districts evaluated in this service and sphere review.

Inpatient Quality Indicators (IQIs)

The Federal Agency for Health Care Research and Quality (AHRQ) supplies Inpatient Quality Indicators (IQIs) at the Area Level (county, statewide) and Facility Level (hospital) based on inpatient data provided to OSHPD by all California-licensed acute-care hospitals.

The *Facility Level Indicators* for hospitals are compared to statewide results to provide a consumer perspective on hospital quality of care. These hospital indicators include*:*

- *Volume Indicators* for the numbers performed of six selected medical procedures; and,
- *Inpatient Mortality Indicators (IMIs)* for the six medical procedures and other conditions.

Hospital Volume Indicators

The *Hospital Volume* indicators measure the number of selected medical procedures 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 six volume indicators provide the number of the following medical procedures performed within each hospital:

- Esophageal Resection (Surgical removal of the esophagus due to cancer)
- Pancreatic Resection (Surgical removal of the pancreas/gall bladder due to cancer)
- Abdominal Aortic Aneurysm (AAA) Repairs (Surgical repair of abdominal aneurysm)
- Carotid Endarterectomy (Surgical removal of plaque within the carotid artery)
- Coronary Artery Bypass Graft Surgery (CABG) (Surgical heart artery procedure)
- Percutaneous Coronary Intervention (PCI) (Non-surgical heart artery procedure)

Fallbrook Hospital 2011-2013 Volume Indicators

Volume	**Statewide Totals**			**Fallbrook Hospital**		
Medical Procedure	**2011**	**2012**	**2013**	**2011**	**2012**	**2013**
Esophageal Resection	482	484	480	0	0	0
Pancreatic Resection						
Total	1,693	1,736	1,770	0	0	0
Cancer	904	933	968	0	0	0
Other	789	803	802	0	0	0
AAA Repair						
Total	2,765	2,728	2,877	0	0	0
Ruptured, Open	168	133	136	0	0	0
Un-ruptured, Open	351	319	280	0	0	0
Ruptured, Endovascular	120	142	171	0	0	0
Un-ruptured, Endovascular	2,133	2,137	2,301	0	0	0
CABG	16,283	15,125	15,488	0	0	0
PCI	46,677	42,797	39,792	0	0	0
Carotid Endarterectomy	6,696	6,457	6,171	1	0	0

Inpatient Mortality Indicators

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. During 2011-2013, OSHPD reported the following Risk-Adjusted Mortality Rates (RAMR) for the selected procedures and conditions performed at Fallbrook Hospital:

Fallbrook Hospital 2011 Risk-Adjusted Mortality Rates (RAMR)

Inpatient Mortality Indicator (IMI)	**2011 Mortality Rate (total deaths; total cases)**	
Procedure	**Statewide**	**Fallbrook Hospital**
Esophageal Resection	3.8% (15;391)	0
Pancreatic Resection	3.1% (23;750)	0
Abdominal Aortic Aneurism Repair	1.9% (46;2,478)	0
Craniotomy	6.8% (980;14,331)	0
Percutaneous Coronary Intervention	2.3% (1,051;44,775)	0
Carotid Endarterectomy	0.5% (34;6,660)	0

Condition		
Acute Myocardial Infarction	6.5% (3,005;46,278)	23.5% (4;10) ***Worse***
Heart Failure	3.0% (2,538;85,338)	4.2% (1;32)
Acute Stroke	9.4% (5,100;54,088)	8.8% (1;12)
Gastro-Intestinal Hemorrhage	2.2% (1,084;48,347)	2.8% (1;60)
Hip Fracture	2.3% (560;23,955)	2.5% (1;39)
Pneumonia	4.1% (2,993;73,002)	6.5% (5;113)

Fallbrook Hospital 2012 Risk-Adjusted Mortality Rate (RAMR)

Inpatient Mortality Indicator (IMI)	**2012 Mortality Rate (total deaths; total cases)**	
Procedure	**Statewide**	**Fallbrook Hospital**
Esophageal Resection	5.7% (22;387)	0
Pancreatic Resection	2.4% (41;1,724)	0
Abdominal Aortic Aneurism Repair	1.1% (26;2,437)	0
Craniotomy	7.1% (1,065;15,030)	0
Percutaneous Coronary Intervention	2.5% (1,015;40,790)	0
Carotid Endarterectomy	0.5% (31;6,407)	0
Condition		
Acute Myocardial Infarction	6.3% (2,938;46,663)	6.9% (1;14)
Heart Failure	3.0% (2,458;81,250)	12.1% (3;41)
Acute Stroke	9.6% (5,227;54,191)	0.0% (0;7)
Gastro-Intestinal Hemorrhage	2.1% (1,024;47,893)	6.2% (5;60) ***Worse***
Hip Fracture	2.3% (552;23,774)	0.0% (0;30)
Pneumonia	4.0% (2,606;64,400)	7.6% (5;78)

Fallbrook Hospital 2013 Risk-Adjusted Mortality Rate (RAMR)

Inpatient Mortality Indicator (IMI)	**2013 Mortality Rate (total deaths; total cases)**	
Procedure	**Statewide**	**Fallbrook Hospital**
Esophageal Resection	4.8% (18;377)	0
Pancreatic Resection	3.5% (62;1,763)	0
Abdominal Aortic Aneurism Repair	1.4% (36;2,560)	0
Craniotomy	7.2% (1,094;15,187)	0
Percutaneous Coronary Intervention	2.7% (1,013;37,885)	0
Carotid Endarterectomy	0.5% (29;6,139)	0
Condition		
Acute Myocardial Infarction	6.0% (2,803;46,984)	5.3% (1;13)
Heart Failure	3.0% (2,510;83,220)	2.2% (1;70)
Acute Stroke	9.2% (5,072;54,983)	14.7% (2;23
Gastro-Intestinal Hemorrhage	2.3% (1,087;47,723)	3.4% (1;43)
Hip Fracture	2.0% (494;24,103)	0.0% (0;36)
Pneumonia	3.9% (2,487;63,853)	0.0% (0;69)

In the 2010-2013 reporting periods, Fallbrook HD performed none of the selected indicator procedures and served a limited number of patients experiencing the selected conditions; however, for most of the condition indicators with reported totals, Fallbrook HD mortality rates were generally consistent with state averages.

As the majority of Fallbrook Hospital's inpatients are older (65-85+), limited numbers of selected conditions and large year-to-year mortality rate fluctuations make overall deficiencies difficult to gauge. Repeated annual mortality rate deficiencies for particular indicator procedures or conditions should be addressed and corrected by the Health Care Districts; however, no consistent Fallbrook Hospital mortality rate deficiencies were identified from 2010-2012.

Hospital Infrastructure Needs and Deficiencies

State Seismic Safety Requirements for Hospital 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 Seismic Safety 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 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 2008 that was extended to 2013. Subsequent legislative changes 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.

Senate Bill 1953 also required OSHPD to develop a Structural Performance Category (SPC) rating for each licensed general acute care hospital facility that indicates the building's compliance with seismic safety standards; and a Non-Structural Performance Category (NPC) 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. Following OSHPD determination of SPC/NPC facility ratings, the hospital licensee must prepare a comprehensive evaluation report and compliance plan for the hospital to attain the specified structural and nonstructural performance categories by the specified timeframes, with an ultimate compliance date of 2030.

Fallbrook Hospital Seismic Safety Ratings

As of September 2014, the Fallbrook Hospital has the following OSHPD Structural Performance Category (SPC) and Non-Structural Performance Category (NPC) seismic ratings and extension review status:

Fallbrook HD	SPC	HZ Score	NPC	SB499 Extension
Main hospital	2	0.42	1	In Review
Medical/Surgical Addition	2	0.14	1	In Review
ICU/CCU	2	0.03	1	In Review
ER Addition	4		1	In Review
Perinatal Addition	4s		1	In Review

As the OSHPD ratings reflect, the Fallbrook Hospital has a number of buildings and structures that will require rehabilitation or replacement per the following criteria and deadlines for conformance:

- SPC-2: These buildings are in compliance with pre-1973 California Building Code or other applicable standards, but are not in compliance with the structural provisions of the Alquist Hospital Facilities Seismic Safety Act. They do not significantly jeopardize life but may not be repairable or functional following strong ground

motion. These buildings must be brought into compliance with the Alquist Act by January 1, 2030 or be removed from acute care service.

- SPC-4: These buildings are in compliance with the Alquist Act but may experience structural damage which could inhibit the building's availability following a strong earthquake. These buildings will have been constructed or reconstructed under a building permit obtained through OSHPD. They may be used to 2030 and beyond.
- NPC-1: Buildings where basic systems essential to life safety and patient care are inadequately anchored to resist earthquake forces. Designated hospitals were required to brace the communications, emergency power, bulk medical gas and fire alarm systems in these buildings by January 1, 2002.

Per OSHPD's SPC 2 and NPC 1 facility designations, the main Fallbrook Hospital building, the medical/surgical addition, and the ICU/CCU are required to be brought into compliance with the seismic requirements by January 1, 2030 or be removed from acute care service. SB 499-related extensions on NPC requirements have been requested by Fallbrook HD and were under review by OSHPD as of this report.

Under the recently-terminated operating agreement for Fallbrook Hospital, all seismic improvement costs were to be the responsibility of the contracted operator, Community Health Systems. Now that the leasing/operating agreement is no longer in effect, the seismic compliance responsibility reverts to the Fallbrook HD as the owner of the facilities; however, the Fallbrook Hospital's operational closure in December 2014 may make the 2030 seismic compliance deadline a moot point if the facilities are no longer used for acute-care services.

Fallbrook Hospital Facility Reutilization Options

In June 2014, the Fallbrook HD accepted an update to the district's contingency plan for assuming operational responsibility of Fallbrook Hospital. The update to the contingency plan included a re-use study for the hospital facilities that evaluated 12 different reutilization scenarios. Each of the reutilization scenarios demonstrated significant constraints to successful reuse because of seismic or ADA requirements, market competition with existing regional and local providers, licensing restrictions, or insufficient expected financial return. While some of the options had limited potential, none of the 12 scenarios were determined to be viable reutilization solutions for the Fallbrook Hospital.

Future Service and Facility Opportunities

Following the closure of Fallbrook Hospital, the nearest acute-care hospital facilities for Fallbrook HD service area residents are now located in Escondido, Oceanside, and Riverside County (Temecula/Murrieta), each approximately 20-30 miles from the Fallbrook community. Future local/regional health care facility planning may need to consider additional options for ambulance and emergency medical transportation to regional acute-care and Emergency Room facilities, and consider providing or supporting local opportunities for urgent care and outpatient programs and services.

Finance: Financial Ability to Provide Services

Annual Financial Disclosure Reports

The Fallbrook HD is required to submit annual financial disclosure reports for its licensed acute-care hospital facilities to OSHPD within four months of the close of the district's fiscal year that include a detailed income statement, balance sheet, statements of revenue and expense, and supporting schedules. OSHPD uses the submitted hospital financial data to produce an *Annual Financial Disclosure Report* for each licensed acute-care hospital that discloses annual totals for: patient revenues; operating and non-operating expenses; breakdowns of expenditures by category; net operating income; and total income or loss.

Health Care 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 regarding special district revenues, expenditures, property taxes, and bonded debt. The County of San Diego Auditor and Controller produces a detailed summary of local tax information for each fiscal year that identifies the amount of property tax allocated to the Health Care Districts and reports any bonded indebtedness held by the districts.

The annual Health Care District and hospital financial disclosure reports produced by the California State Controller, the County of San Diego, and OSHPD provide the public with a comprehensive overview of the annual financial status of the Fallbrook HD and the Fallbrook Hospital operations.

Financial Performance Indicators

The financial performance of a Health Care District and associated provision of health care services can be evaluated by several fiscal totals annually disclosed in the financial reports, including: revenues and expenditures; net-from-operations; annual profit or loss; total bonded indebtedness; and operating margin.

A hospital's *net-from-operations* indicator compares a hospital's total operating revenue against its total operating expenses and is the most commonly used financial ratio to measure a hospital's financial performance. A positive net-from-operations indicates that a hospital is operating at a profit; a negative figure indicates that the hospital is operating at a financial loss for the reporting period.

Fallbrook Hospital Revenue - Expenditure Characteristics (FY2012-2013)

Net Patient Revenue: $37,814,952
Inpatient: $23,060,542; Outpatient: $14,754,410
Net from Operations: ($7,654,653)
Operating Margin: (20.0%)

For the 2012-2013 fiscal year, Fallbrook Hospital reported total net operating revenues of $38,306,345 and total operating expenses of $45,960,998, for a total net-from-operations loss of ($7,654,653) and a total annual loss of ($8,072,323). This loss follows a total loss of ($4,485,824) for the preceding 2011-2012 fiscal year. The following table summarizes the Fallbrook Hospital's financial performance over 2007-2013:

Fallbrook HD Revenues - Expenditures (FY2007-2013)

Year	Net Operating Rev.	Operating Exp.	Net from Op	Income (Loss)
2007-08	$40,536,271	$38,830,208	$1,706,063	$310,575
2008-09	$38,228,212	$39,643,752	($1,415,540)	($2,215,188)
2009-10	$38,611,196	$43,401,067	($4,789,871)	($4,976,738)
2010-11	$47,432,230	$44,670,421	$2,761,809	$2,607,623
2011-12	$41,937,343	$45,803,732	($3,866,389)	($4,485,824)
2012-13	$38,306,345	$45,960,998	($7,654,653)	($8,072,323)

During the 2007-2008 to 2012-2013 fiscal years, Fallbrook HD has reported a cumulative total loss of ($16,831,875) and has reported an average net-from-operations loss of ($2,209,763) per year. The 2014 termination of the leasing/operating agreement with CHS for Fallbrook Hospital was directly attributed to the on-going operational losses experienced between 2008 and 2013.

Fallbrook HD Budgets/Audits

The Fallbrook HD Board of Directors adopts a budget for each fiscal year following public hearings. The Fallbrook HD budgets and financial information are regularly audited by certified auditors in conformity with the format prescribed by the provisions of Government Accounting Standards Board Statement No. 34 (GASB 34); no financial violations have been reported. The audited financial statements state that the Fallbrook HD complies with all financial disclosure requirements of state and federal regulatory agencies. The Fallbrook HD budget is funded by the district's annual property tax revenues, which are primarily used to finance the Community Grant Program, to sustain adequate contingency reserve funds, and pay for the Fallbrook HD's administrative costs.

Lease Termination Contingency Reserve

Under terms of the 1998 agreement with CHS, Fallbrook HD would be expected to assume financial responsibility for the Fallbrook Hospital facilities and operations upon termination of the 30-year agreement in 2028, or if terminated prior to the end of term.

In 2011, the Fallbrook HD Board established a lease termination contingency reserve to address the anticipated expenses required to assume operational responsibility for the Fallbrook Hospital at the time that the lease with Fallbrook Hospital Corporation ends.

As of June 30, 2014, the balance of the lease termination contingency reserve was reported as $9,838,159, all of which was invested with CalTrust. The termination of the agreement with CHS and subsequent closure of Fallbrook Hospital in December 2014 will likely require reevaluation of the contingency fund by the Fallbrook HD Board.

Independent Auditor's Reports

The independent auditor's reports for fiscal years 2012-2013 and 2013-2014 states that the Fallbrook HD operating revenues were principally derived from annual property tax allocations, while non-operating income was the interest received from the district's contingency reserve fund. Administrative services, salaries and benefits represented

approximately 44.9% of the Fallbrook HD operating expenses in FY2014, and approximately 31.0% in FY2013. The following table summarizes the budgeted/audited revenues and expenses for the Fallbrook HD for the two most recent fiscal years (FY2012-2013 and FY2013-2014):

Fallbrook HD Revenues/Expenditures	**FY2013-2014**	**FY2012-2013**
Operating Revenues		
Property Tax Revenue	$1,511,120	$1,465,253
Operating Expenses		
Community Grant Program	576,127	663,757
Administrative services	337,736	149,323
Salaries and benefits	132,592	149,496
Depreciation	1,821	1,657
Total Operating Expenses	$1,048,276	$964,233
Operating Income	$462,844	$501,020

Fallbrook HD Property Tax Revenues

As a special district formed prior to the passage of Prop 13 in 1978, the Fallbrook HD receives an annual allocation from the 1% ad valorum property tax for property within its respective service area. The District receives a share of this basic tax levy proportionate to what it received during the years 1976-1978.

The County of San Diego Tax Summary for fiscal year 2013-2014 states that the annual allocation of property tax revenue totaled $1,449,405, which is equivalent to approximately 2.5% of the Fallbrook Hospital's total net operating revenues.

County of San Diego annual tax reports from fiscal years 2008-2009 to 2012-2013 indicate that the Fallbrook HD has received consistent levels of annual property tax revenues, with an average total of $1,478,740 allocated to the district.

County of San Diego Tax Summary

Allocated Property Tax Revenue FY2013-2014

	Prop. Tax Revenue	Net Operating Revenues	Annual Average (FY2008-2014)
Fallbrook HD	$1,488,294	2.5%	$1,484,441

Fallbrook HD Bonded Debt

As of FY 2013-2014, the State Controller reports that Fallbrook HD has no long-term bonded indebtedness. Previous Fallbrook HD bonded indebtedness was redeemed by payment of the Fallbrook Hospital Corporation under terms of the 1998 Fallbrook Hospital leasing and operation agreement with CHS.

Governance and Operations

Board of Directors

The Fallbrook HD has a five-member Board of Directors that meets on the second Wednesday of each month at 6:00 p.m. The Board meeting agendas are posted 72-hours in advance of each meeting at the Fallbrook Hospital outpatient entrance and at the Fallbrook HD's administrative office at 577 East Elder Street, Unit U. The Board Members are elected-at-large to four-year terms and are responsible for establishing policy and administering programs funded by property tax revenue.

The Board members are compensated as authorized by the Local Health Care District Law (Health & Safety Code 32103) at a rate of $100 per meeting, with limit of five meetings a month. The Fallbrook HD Board has five standing subcommittees:

- *Finance/Audit/Grant/Investment*: subcommittee responsible for review of district budgetary and financial matters, including the annual audit, community grant program, and review of district investments.
- *Facilities*: subcommittee responsible for periodic inspection of hospital facilities and for review and consideration of real estate matters.
- *Long Range Planning*: subcommittee responsible for district long range planning matters.
- *Governmental and Public Relations*: subcommittee responsible for monitoring of healthcare legislation, public policy, and for district communication with other agencies and the public.
- *Community Programs*: subcommittee responsible for development, execution and monitoring of community healthcare programs, including the Community Collaborative Committee, the annual health fair; and for identification and preliminary evaluation of potential community grant applicants.

Community Service Accountability

The Fallbrook HD operates a public website for the district and hospital. The Fallbrook HD website regularly posts news releases, annual reports, budgets, audits, Board meeting notices, Board agendas & minutes, and community health care program information.

State Law requires a Health Care District that has leased or transferred its assets to a corporation to act as an advocate for the community to the operating corporation, and to annually report to the community on the progress made in meeting the community's health needs (Health & Safety Code Section 32121.9). The Fallbrook HD produces an Annual Report for the community on the progress made in meeting the community's health needs that is presented at the annual Community Collaborate event and is posted to the district's website.

The Fallbrook HD approach for addressing the community's health care needs is described by the district as: Prevention, Education, and Treatment. Fallbrook HD supports community health care services within its service area and sphere through the following programs and services: the *Community Grant Program*, which allocates a portion of the district's annual property tax revenues as grants to non-profit health-related programs serving residents within the Fallbrook HD service area and sphere; the *Community Health & Fitness Fair*, which provides health screenings and access to health care information to local residents in the community; and *Community Collaborative*, in which the district partners with several community entities to develop and deliver programs and events for the health and well-being of the residents of the community.

Community Grant Program

The Fallbrook HD Community Grant Program was initiated in 2000 to fund non-profit programs and services that benefit the health and well-being of the residents within the Fallbrook HD, including both physical and mental health. Awarded grant funding is distributed to approved 501(c)3 non-profit organizations that provide health education, health promotion (disease/injury control and prevention), health maintenance, health treatment (including medical, dental, vision, mental health, or therapy services), and programmatic efforts to develop and test new health care approaches. The following table summarizes the Fallbrook HD community grant totals since FY2009:

2009-2014 Fallbrook HD Community Grants

Fiscal Year	Grants	Total Amount
2008-2009	17	$417,524
2009-2010	16	$490,767
2010-2011	19	$506,600
2011-2012	20	$571,650
2012-2013	23	$646,559
2013-2014	21	$556,159
Total	116	$3,189,259

During fiscal year 2013-2014, the Fallbrook HD received a total of $634,227 in grant requests and approved distribution of $556,159 to 21 approved applicants. All recipients of grant funding are required to present periodic reports to the Fallbrook HD Board specific to their funded program and the utilization of awarded grant funds. The Fallbrook HD reports the cumulative total amount granted since the program was established in 2000 as $5,907,362.

Fallbrook Hospital Operations

From the 1960s to 1990s, the Fallbrook HD independently operated the Fallbrook Hospital, using patient revenues to fund hospital operations and using bond financing and local property tax revenues to fund facility improvements and maintenance. In the mid-1990s, rising hospital operational costs and increased regional health care market competition compelled the Fallbrook HD to readdress its status as an independent hospital operator and explore partnership options to retain acute-care services and operations at the Fallbrook Hospital.

In 1998, Fallbrook HD formed the non-profit Fallbrook Hospital Corporation which entered into a 30-year agreement to lease and manage operations for the Fallbrook Hospital with *Community Health Systems, Inc*. (CHS), a for-profit hospital system based in Tennessee. After local discussion and debate, the contractual arrangement with CHS was approved by a subsequent 90%+ vote of the local electorate as a means to retain the local Fallbrook Hospital's acute-care services and retire the Fallbrook HD's $4,400,000 accumulated bonded indebtedness from Revenue Bonds issued in 1985 and 1987.

2014 Fallbrook Hospital Lease Termination

The 1998 lease agreement required CHS (as the Fallbrook Hospital Corporation) to provide core services for the first ten years of the lease; the lease also provided CHS with the right to discontinue one or more core services after November 2008 under certain circumstances. Prior to closing an unprofitable core service, the lease provides an option for the Fallbrook HD to reimburse CHS (as the Fallbrook Hospital Corporation) for financial losses upon written request with reasonable documentation to support the claimed losses. In December 2013, Fallbrook HD received a claim from CHS (as the Fallbrook Hospital Corporation) for reimbursement of its operating losses for several Fallbrook Hospital's core services.

On May 21, 2014, Fallbrook HD received formal notice from CHS (as the Fallbrook Hospital Corporation) of its intent to initiate termination proceedings under terms of the leasing agreement for closing many core services at the Fallbrook Hospital due to significant and ongoing financial losses from core service operations. The Fallbrook Hospital Corporation (Community Health Systems) announced on June 12 that it intended to discontinue providing the following core services at Fallbrook Hospital in October 2014 (approximately 130 days from the announcement):

- Obstetric Services (Labor and delivery birthing rooms)
- Surgical Services (General, Gynecological, Kidney, OphthaImologic, orthopedic, Pediatric, Plastic, Podiatric, and Urologic)
- Anesthesia Services
- Endoscopy Procedure Services
- Emergency Services (Emergency communication systems, Emergency Room services, Orthopedic emergency services)

Following discussions with CHS/Fallbrook Hospital Corporation to reconfigure core services and/or find an alternative operator/lessee of the hospital, on June 24, 2014, the Fallbrook HD released a *Request for Proposals* (RFP) to 12 hospital management organizations for proposals to assume operational responsibility for Fallbrook Hospital.

The RFP resulted in three submittals from health care entities; however, only two proposals were considered viable: a joint proposal involving both Palomar Health HD and Tri-City HD; and a proposal from Strategic Global Management (SGM), a for-profit hospital operator located in Riverside County. None of the submitted proposals involved sustaining Fallbrook Hospital's acute-care core services beyond 5 years.

Fallbrook HD commissioned two separate community groups to review and study the submitted proposals and provide additional input: a Physician Advisory Committee that consisted of local physicians; and a Citizen Advisory Committee that consisted of non-physician residents of the local community with related healthcare experience. The Fallbrook HD held two public meetings to inform the local community of the RFP process, including public presentation of the submitted proposals, and provided an opportunity for public comment.

The Fallbrook HD Board rejected the Strategic Global Management proposal because the HD would bear all of the liability for continuing acute-care operations at Fallbrook Hospital in addition to providing substantial upfront funding. The Board determined that the district's limited property tax revenues could not sustain the hospital's potential operational costs for more than a few months.

The Tri-City HD and Palomar Health HD offered a proposal that would convert the current emergency center into a 24-hour urgent care center for a term of six months, but does not include keeping inpatient services, such as emergency, obstetrics or intensive care open. The Fallbrook HD, Tri-City HD, and Palomar Health HD would enter a Joint Powers Agreement (JPA) in order to provide the services.

On October 8, 2014, the Fallbrook HD Board voted to pursue the JPA with Palomar Health HD and Tri-City HD; however, the proposal stated that the Palomar Health and Tri-City Health Care Districts would have to obtain final approvals from their respective boards of directors to complete the JPA process. Following the Fallbrook HD Board approval for the proposed joint JPA, Tri-City HD withdrew from the proposal, leaving Palomar Health HD and Fallbrook HD as the sole members of the agreement to continue the provision of health care services at Fallbrook Hospital and the Fallbrook Skilled Nursing Facility.

Fallbrook Hospital Current Status

The Fallbrook HD negotiated an extension of Fallbrook Hospital core services to November 17, 2014 with a $711,000 payment from the HD's reserve contingency funds to CHS. Provision of urgent care services at Fallbrook Hospital were extended to December 20, 2014 by CHS (as the Fallbrook Hospital Corporation) to assist the Fallbrook HD with transition to a new operator.

As of December 21, 2014, the Fallbrook Hospital has closed operations as an acute-care hospital. In January 2015, the Fallbrook HD reached a tentative settlement with CHS (as the Fallbrook Hospital Corporation) that will indemnify the District. The settlement with CHS is intended to preserve ongoing funding to support the Fallbrook community's future healthcare needs.

In consideration of the anticipated closure of the Fallbrook Hospital for acute-services, the Fallbrook HD Board approved renaming the facility to the *Fallbrook Community Health Center.* The Fallbrook HD intends to utilize the Fallbrook Hospital facility as the Fallbrook Community Health Center to provide outpatient services that may include: an Ambulatory Surgery Center; a central laboratory, central imaging, post-surgery rehabilitation services;

dialysis, and bariatric wound care. Additional discussion follows below regarding the 2014 JPA between Fallbrook HD and Palomar Health HD.

Status of and Opportunities for Shared Facilities

The Fallbrook HD has engaged in a number of partnerships with other health care entities to maximize its ability to provide and maintain health care programs and services to its service area residents. Due to its far North County location, the Fallbrook HD is close to many Riverside County hospital facilities in the Temecula/Murrieta area in addition to the existing San Diego County regional hospital facilities in Oceanside (Tri-City Medical Center) or Escondido (Palomar Medical Center). Approximate driving distances from Fallbrook to nearby acute-care hospital facilities are as follows:

San Diego County

- Tri-City Medical Center, Oceanside, CA – 17.5 miles
- Palomar Health Medical Center, Escondido, CA – 24.5 miles
- Palomar Health (Downtown Campus), Escondido, CA – 26.1 miles
- Scripps Memorial, Encinitas, CA – 32.6 miles
- Pomerado Hospital, Poway, CA – 35.0 miles

Riverside County/Orange County

- Southwest Health Care System, Murrieta, CA – 23.2 miles
- Loma Linda University Medical Center, Murrieta, CA – 23.0 miles
- Menifee Valley Medical Center, Sun City, CA – 30.6 miles
- Mission Hospital Regional Medical Center, Mission Viejo, CA – 52.1 miles

2013 Fallbrook HD - Tri-City HD JPA

In June 2013, the Fallbrook HD and the Tri-City HD entered into a Joint Powers Agreement (JPA) that allows doctors at Fallbrook Hospital to refer patients who need specialized tertiary care not offered at Fallbrook Hospital to the Tri-City Medical Center in Oceanside. Tertiary care is described as a higher level of specialty care requiring highly specialized equipment and expertise such as: specialized cardiac procedures such as a catheterization lab and bypass surgery, stroke care/recovery, broader oncology services, renal or hemodialysis, robotic and minimally-invasive surgeries, and many other complex treatments and/or procedures.

Tertiary care provided at the Tri-City Medical Center includes acute rehabilitation care, orthopedic and neurosurgical services, specialized spine surgery, cardiovascular services, behavioral health services, neonatal intensive care services and hyperbaric medicine. Per the JPA, Tri-City doctors reciprocally refer patients who live between the two hospitals and who are not in need of tertiary care to the Fallbrook Hospital.

The 2013 JPA was intended to provide mutual benefits to the two Districts by maximizing efficiency and reducing duplicative services and facilities; however, the closure of the Fallbrook Hospital in December 2014 does not allow for the reciprocal services identified in the JPA to be provided by Fallbrook HD. While the JPA has not been officially terminated by action of the Health Care District Boards, the closure of Fallbrook Hospital has functionally concluded the 2013 JPA relationship between the Districts.

2014 Fallbrook HD - Palomar Health HD JPA

The 2014 proposed Joint Powers Agreement (JPA) between the Fallbrook HD, Tri-City HD, and Palomar Health HD involved the identification of providers to continue the following health care services in Fallbrook: urgent care, skilled nursing, home health care and hospice, physical therapy, wound care, laboratory services and imaging services. The proposed JPA also involved assessment of the use of part of the Fallbrook Hospital to operate an ambulatory surgery center, provide dialysis services, and operate a pharmacy.

Following the withdrawal of Tri-City HD from the proposed JPA, Palomar Health HD applied for licensing to assume operational responsibility for the Fallbrook Skilled Nursing Facility; however, the federal Centers for Medicare and Medicaid Services (CMS) subsequently declined the Palomar Health HD's application for licensing the operation because federal regulations require the skilled nursing facility to be affiliated with an acute-care hospital that is located within 250 yards of the nursing facility. The Palomar Health HD's closest hospital, the Palomar Medical Center, is located more than 20 miles from the Fallbrook Skilled Nursing Facility.

The Fallbrook Skilled Nursing Facility operations are currently being provided by CHS (as the Fallbrook Hospital Corporation) under the existing lease agreement with Fallbrook HD until the private owners of the facility can obtain licensing approval as a stand-alone skilled nursing facility. The Fallbrook HD and Palomar Health HD continue to explore options under the JPA to identify and secure health care providers for the Fallbrook community.

Fallbrook Urgent Care Facilities

Following the 2014 closure of the Fallbrook Hospital and its Emergency Department, two local urgent care clinics have opened in Fallbrook to serve the local community for non-emergency illnesses and injuries, laboratory services, and preventative care: the Fallbrook Medical Center, which opened in September 2014 and offers urgent care services by appointment or walk-in at 593 East Elder Street, (across from the Fallbrook Hospital facility); and A+ Urgent Care, which opened in April 2015 and offers walk-in urgent care services within the Fallbrook HD's facility at 617 Alvarado Street via a March 2015 leasing agreement with the Fallbrook HD.

Governance Structure Options

Governmental structure options available to the Fallbrook HD include several different changes of organization or reorganization, including: dissolution of one or more districts with annexation of the dissolved district's service area into one or more successor districts; consolidation of two or more districts into one or more successor districts; or a combination

of governance actions involving annexations or detachments of district service area and sphere territory.

A proposed reorganization involving dissolution/annexation, or a consolidation/merger of Health Care Districts would transfer the district's assets and liabilities to a designated successor agency, including responsibility for assuming any voter-approved bonded indebtedness. Therefore, a key issue to be determined when considering potential governmental structure options for Health Care Districts involves the identification of a successor agency that is both authorized and capable of sustaining the provision and level of health care services presently provided by the affected Health Care District(s).

Proposed changes of organization or reorganization for Health Care Districts may be initiated by: sufficient petition of local voters or landowners; a resolution of subject/affected agencies; or by LAFCO action. If LAFCO approves a proposed reorganization or consolidation/merger involving one or more Health Care Districts, State Law allows for written protest to be filed with the Commission by affected registered voters or landowners. If LAFCO approves a proposed jurisdictional change that involves dissolution of one or more Health Care Districts, or a Health Care District proposes to transfer more than 50% of the district's assets, State Law requires the dissolution or transfer agreement to be approved by local voters.

Conclusion: MSR Determinations / Sphere Recommendations

The 2014 termination of the leasing and operating agreement between the Fallbrook HD and Community Health Services (as the Fallbrook Hospital Corporation), and the subsequent closure of Fallbrook Hospital, represents the conclusion of more than 50 years of district-provided acute-care hospital services in the Fallbrook community.

During that time, advances in medical technologies and the evolution of a highly competitive health care market has shifted the hospital operational model from independent local operators to large affiliated health systems with networks of medical service providers. These changes have made stand-alone local hospital facilities financially difficult to sustain, as exemplified by the Fallbrook Hospital's closure due to its on-going annual operational losses.

The Fallbrook community will need to work closely with the Fallbrook HD to determine the future role of the Health Care District and to address the ongoing health care needs of the local Fallbrook area residents. While the costs to construct and operate a replacement acute-care hospital facility may be more than the local Fallbrook tax base and patient levels can sustain, the need for local health care services will continue to expand as the population grows and increases in age.

The following is a summary of the *2015 Health Care Services MSR and Sphere Review* conclusions for the Fallbrook HD in relation to the associated service and sphere determinations; and sphere of influence recommendations for the Fallbrook HD:

Municipal Service Review Determination Summaries

Growth and Population Projections

2014 SANDAG Special District Population Estimates for the Fallbrook HD service area and sphere report a total population of 57,515. From 2008-2014, the Fallbrook HD rate of growth was approximately 6.0%. The Fallbrook HD has maintained a population of approximately 55,000; therefore significant local population growth is not anticipated over the next 5 years. The population located within the Fallbrook HD service area and sphere is projected to grow approximately 51% from 2013-2050, to a total population of 72,681.

Location and Characteristics of Disadvantaged Unincorporated Communities

The Fallbrook HD has one disadvantaged unincorporated community within its sphere, but none adjacent to the sphere. The identified disadvantaged unincorporated community is located in the Fallbrook town center within the Fallbrook Community Planning Area of unincorporated San Diego County.

Present and Planned Capacity of Public Facilities

Fallbrook HD owns the recently-closed 47-bed Fallbrook Hospital, which includes 4 beds for coronary care, 4 beds for intensive care, 4 beds for perinatal care, and 35 beds for unspecified general acute care. During the 2012-2013 fiscal year, the Fallbrook HD reported an occupancy rate of 57.8% for its 140 licensed acute-care beds (including the Fallbrook Skilled Nursing Facility). During fiscal years 2010-2013, the Fallbrook HD reported an average overall occupancy rate for its licensed and available acute-care beds as 62.5%; however, the annual occupancy rate declined from 65.9% to 57.8%.

The 2014 *Facility Summary Report* for Fallbrook Hospital reported a total of 1,815 inpatient discharges, with 76.3% for Acute Care (1,385) and 23.7% for Skilled Nursing/Intermediate Care (430). Total number of inpatient discharge days for 2014 were reported as 24,868, with an average length of stay at 13.7 days. Reported data reflects that annual Fallbrook HD total inpatient discharges have decreased by approximately 85% overall from 2010-2014. The average length of stay increased by approximately 73% from 2013-2014.

Following the 2014 Fallbrook Hospital closure, the Fallbrook HD has partnered with Palomar Health HD in a Joint Powers Agreement (JPA) to explore opportunities for reuse of the Fallbrook Hospital facilities.

Adequacy of Public Services

Prior to the 2014 closure, the Fallbrook HD and the Fallbrook Hospital were providing health care services adequately within the district's service area and sphere. For 2012-2013, CalQualityCare.org reports that Fallbrook Hospital received an overall *Patient Experience Rating* of ***Average*** and a total score of 65%, compared to the California state average of 68%. The Fallbrook Hospital *Readmission Rate* was rated as ***Average*** (16.10%), compared to the California state average of 15.90%. Patient responses indicate that 63% would recommend Fallbrook Hospital compared to the State average of 70%. The 2012-2013 CalQualityCare.org indicators and ratings for Fallbrook Hospital medical procedures are generally consistent with state levels. The Fallbrook Hospital indicator

ratings range from a Superior rating for surgical care measures, to a Below Average rating for the percentage of new mothers utilizing breastfeeding.

In the 2010-2013 Inpatient Mortality Indicators (IMIs) reporting periods, Fallbrook HD performed none of the selected indicator procedures and served a limited number of patients experiencing the selected conditions; however, for most of the condition indicators with reported totals, Fallbrook HD mortality rates were generally consistent with state averages; no consistent Fallbrook Hospital mortality rate deficiencies were identified from 2010-2012.

Infrastructure Needs or Deficiencies

State seismic safety requirements for acute-care hospital facilities have mandated deadlines that create significant capital investment needs for hospital facility compliance over the next 10-15 years. Per OSHPD's seismic safety ratings, the main Fallbrook Hospital building, the medical/surgical addition, and the ICU/CCU are required to be brought into compliance with the seismic requirements by January 1, 2030 or be removed from acute care service. Under the recently-terminated operating agreement for Fallbrook Hospital, all seismic improvement costs were to be the responsibility of the contracted operator, Community Health Systems. Now that the leasing/operating agreement is no longer in effect, the seismic compliance responsibility reverts to the Fallbrook HD as the owner of the facilities; however, the Fallbrook Hospital's operational closure in December 2014 may make the 2030 seismic compliance deadline a moot point if the facilities are no longer used for acute-care services.

In June 2014, the Fallbrook HD accepted an update to the district's contingency plan for assuming operational responsibility of Fallbrook Hospital. The update to the contingency plan included a re-use study for the hospital facilities that evaluated 12 different reutilization scenarios. Each of the reutilization scenarios demonstrated significant constraints to successful reuse because of seismic or ADA requirements, market competition with existing regional and local providers, licensing restrictions, or insufficient expected financial return. While some of the options had limited potential, none of the 12 scenarios were determined to be viable reutilization solutions for the Fallbrook Hospital.

The *2015 Health Care Services MSR and Sphere Review* determinations state that the Fallbrook HD and community will need to address options for local health care facilities, including transport to regional acute-care facilities and emergency department/trauma centers; and considering potential needs for local urgent care, community clinic, and other outpatient facilities and services.

Financial Ability to Provide Services

The annual hospital financial disclosures for the Fallbrook HD reflect inadequate patient revenues to fund independent operations at Fallbrook Hospital. For the 2012-2013 fiscal year, Fallbrook Hospital reported total net operating revenues of $38,306,345 and total operating expenses of $45,960,998, for a total net-from-operations loss of ($7,654,653) and a total annual loss of ($8,072,323). This loss follows a total loss of ($4,485,824) for the preceding 2011-2012 fiscal year.

During the 2007-2008 to 2012-2013 fiscal years, Fallbrook HD has reported a cumulative total loss of ($16,831,875) and has reported an average net-from-operations loss of ($2,209,763) per year. The 2014 termination of the leasing/operating agreement with CHS for Fallbrook Hospital was directly attributed to the on-going operational losses experienced between 2008 and 2013.

The Fallbrook HD receives an annual average of $1,484,441 in allocated property tax revenues; however, these funds are used to provide community grants to local non-profit health care programs within the district service area, and to fund the administrative operations of the district. The *2015 Health Care Services MSR and Sphere Review* determinations conclude that local property tax revenues allocated to the Fallbrook HD are insufficient to sustain acute-care hospital operations.

Accountability for Community Service Needs,

The *2015 Health Care Services MSR and Sphere Review* determinations reflect that the Fallbrook HD has demonstrated accountability for community service needs by supporting community health care services within its service area and sphere through the following programs and services: the Community Grant Program, which allocates a portion of the district's annual property tax revenues as grants to non-profit health-related programs serving residents within the Fallbrook HD service area and sphere; the Community Health & Fitness Fair, which provides health screenings and access to health care information to local residents in the community; and Community Collaborative, in which the district partners with several community entities to develop and deliver programs and events for the health and well-being of the residents of the community. The Fallbrook HD operates a public website for the district and hospital. The Fallbrook HD website regularly posts news releases, annual reports, budgets, audits, Board meeting notices, Board agendas & minutes, and community health care program information.

During fiscal year 2013-2014, the Fallbrook HD received a total of $634,227 in grant requests and approved distribution of $556,159 to 21 approved applicants. All recipients of grant funding are required to present periodic reports to the Fallbrook HD Board specific to their funded program and the utilization of awarded grant funds. The Fallbrook HD reports the cumulative total amount granted since the program was established in 2000 as $5,907,362.

Governmental Structure

Governmental structure options available to the Fallbrook HD include several different changes of organization or reorganization, including: dissolution of one or more districts with concurrent annexation of the dissolved district’s service area into one or more successor districts; consolidation of two or more districts into one or more successor districts; or a combination of governance actions involving annexations or detachments of district service area and sphere territory. A proposed reorganization involving dissolution/annexation, or a consolidation/merger of Health Care Districts would transfer the district’s assets and liabilities to a designated successor agency, including responsibility for assuming any voter-approved bonded indebtedness. Therefore, a key issue to be

determined when considering potential governmental structure options for Health Care Districts involves the identification of a successor agency that is both authorized and capable of sustaining the provision and level of health care services presently provided by the affected Health Care District(s). If LAFCO approves a proposed jurisdictional change that involves dissolution of one or more Health Care Districts, or a Health Care District proposes to transfer more than 50% of the district's assets, State Law requires the dissolution or transfer agreement to be approved by local voters.

Operational Efficiencies

Prior to the 2014 Fallbrook Hospital closure, the facility was leased and operated under a 1998 agreement with *Community Health Systems, Inc*. (CHS), a for-profit hospital system based in Tennessee. The agreement with CHS was approved by more than 90% of the local voters; however, ongoing financial losses experienced by CHS led to the termination of the agreement and the subsequent closure of the hospital for acute-care services.

The *2015 Health Care Services MSR and Sphere Review* determinations state that the continued operational losses at Fallbrook Hospital indicate that stand-alone independent operations of acute-care hospital facilities are inefficient without adequate numbers of patients to provide sustainable revenues to financially support hospital operations.

Status and Opportunities for Shared Facilities

The *2015 Health Care Services MSR and Sphere Review* determinations state that the Fallbrook HD has engaged in a number of partnerships with other health care entities to maximize its ability to provide and maintain health care programs and services to its service area residents. Due to its far North County location, the Fallbrook HD is close to many Riverside County hospital facilities in the Temecula/Murrieta area in addition to the existing San Diego County regional hospital facilities in Oceanside (Tri-City Medical Center) or Escondido (Palomar Medical Center). The Fallbrook HD has collaborated with the Tri-City HD and Palomar Health HD by forming Joint Powers Agreements (JPAs) that are designed to manage patients, facilities, and programs between the Districts to maximize efficiencies; however, the closure of the Fallbrook Hospital has removed the Fallbrook HD's ability to provide a reciprocal service relationship with its JPA partners.

The 2014 Joint Powers Agreement (JPA) between the Fallbrook HD and Palomar Health HD involved the identification of providers to continue the following health care services in Fallbrook: urgent care, skilled nursing, home health care and hospice, physical therapy, wound care, laboratory services and imaging services. The proposed JPA also involved assessment of the use of part of the Fallbrook Hospital to operate an ambulatory surgery center, provide dialysis services, and operate a pharmacy.

Palomar Health HD applied for licensing to assume operational responsibility for the Fallbrook Skilled Nursing Facility; however, the federal Centers for Medicare and Medicaid Services (CMS) subsequently declined the Palomar Health HD's application for licensing the operation because federal regulations require the skilled nursing facility to be affiliated with an acute-care hospital that is located within 250 yards of the nursing facility. The

Palomar Health HD's closest hospital, the Palomar Medical Center, is located more than 20 miles from the Fallbrook Skilled Nursing Facility.

The Fallbrook HD and Palomar Health HD are continuing to explore opportunities under the JPA to identify potential health care service providers for the Fallbrook HD service area.

Sphere of Influence Determination Summaries

Present and Planned Land Uses

The Fallbrook HD's service area consists primarily of rural, unincorporated territory, and is generally located within the unincorporated Fallbrook, Rainbow, and De Luz Community Planning Areas. Land uses within the unincorporated territory are governed by County of San Diego General Plan land use designations and zoning. The small portion of Fallbrook HD within the incorporated territory of the City of Oceanside is governed by the City's General Plan and zoning designations (Map 2A).

Present and Probable Need for Public Facilities and Services

The *2015 Health Care Services MSR and Sphere Review* determinations reflect that the rate of population growth with the Fallbrook HD service area and sphere was approximately 6.0% from 2008-2014, and that significant local population growth is not anticipated over the next 5 years. SANDAG's 2050 Regional Growth Forecast Population Estimates (2011) projects the Fallbrook Subregional Area to grow approximately 51% from 2013-2050. The Fallbrook HD service review determinations state that the local population of elderly residents (65-85+) within the Fallbrook Subregional Area is projected to increase by approximately 61% during 2013-2030. In addition, each of the Medical Service Study Areas within the Fallbrook HD service area and sphere have territory that is within or adjacent to areas designated by the California Office of Statewide Health Planning and Development (OSHPD) as *Medically Underserved Areas* (MUA) and/or *Health Care Professional Shortage Areas* for primary care (HPSA-PC, PCSA) and registered nursing professionals (RNSA) (Maps 2D-2F).

Present Capacity of Public Facilities, Adequacy of Public Services

The *2015 Health Care Services MSR and Sphere Review* determinations report that the 47-bed Fallbrook Hospital's occupancy rates and total inpatient discharges decreased significantly from 2010 to 2013. The Fallbrook HD service review indicates that the quality indicators and ratings for health care services provided at the Fallbrook Hospital were generally consistent with state averages; no consistent inpatient mortality rate deficiencies were identified.

Social or Economic Communities of Interest

The Commission has not determined that *social or economic communities of interest* of relevance to Fallbrook HD exist in the local area. The *2015 Health Care Services MSR and Sphere Review* determinations recommend that the Fallbrook HD service area and sphere territory that has been designated as a *Medically Underserved Are*a or a *Health Care Professional Shortage Area*, and the local areas containing high poverty levels, should

each be considered by the Commission for potential determination as relevant *social or economic communities of interest* to Health Care Districts.

Disadvantaged Unincorporated Communities: For an update of a sphere of influence of a city or special district that provides public facilities or services related to sewers, municipal and industrial water, or structural fire protection, that occurs pursuant to subdivision (g) on or after July 1, 2012, the present and probable need for those public facilities and services of any disadvantaged unincorporated communities within the existing sphere of influence.

Fallbrook HD is a special district authorized to provide health care services and does not provide public facilities or services related to sewers, municipal/industrial water, or structural fire protection; therefore, the sphere determination does not apply to the Fallbrook HD sphere review and update.

Sphere of Influence Recommendations

The December 2014 closure of the Fallbrook Hospital has created uncertainty regarding the Fallbrook HD's future provision of local acute-care hospital services; however, the Fallbrook HD's ongoing community grants program is financially supported by a portion of the district's allocated annual property tax revenues and will continue to provide health care services and programs within its service area and sphere through the local non-profit grant awardees.

The closure of the Fallbrook Hospital has also created a need to identify replacement acute-care service providers for the local community. The existing JPA between the Fallbrook HD and the Palomar Health HD is intended to accomplish this task; however, the proximity of existing acute-care hospital facilities in the Cities of Oceanside and Escondido, as well as the acute-care hospital facilities in the adjacent Riverside County communities of Temecula and Murrieta, indicates that the residents within Fallbrook HD service area and sphere are likely to be served by either the adjacent Tri-City HD and Palomar Health HD hospital facilities, or other regional facilities.

Potential Social or Economic Communities of Interest

The *2015 Health Care Services MSR and Sphere Review* determinations are required to identify any *social or economic communities of interest* existing in the review area, if LAFCO determines that they are relevant to the subject agency. The Commission is recommended to consider local areas designated by OSHPD as *Medically Underserved Areas* and/or *Health Care Professional Shortage Areas*, and local areas identified with poverty levels above the regional average of *14.4%*, as containing *social or economic communities of interest* relevant to the local Health Care Districts.

Proposed San Diego County Special Study Areas

As OSHPD-designated *Medically Underserved Areas* and/or *Health Care Professional Shortage Areas*, and local areas identified with high poverty levels areas each exist in both urban coastal incorporated territory and rural unincorporated desert and mountain communities of San Diego County, the *2015 Health Care Services MSR and Sphere Review* determinations recommend Commission consideration of *Special Study Area*

designations for 4 major areas of the County that contain inhabited territory not currently located within any of the local Health Care District service areas and spheres, and which contain *social or economic communities of interest* relevant to the local Health Care Districts (Map 1L).

Potential Fallbrook HD Special Study Areas

One of the four proposed *Special Study Areas* for San Diego County is adjacent to the Fallbrook HD service area and sphere: *Special Study Area No. 1: Fallbrook HD/Camp Pendleton.* The proposed *Special Study Area No. 1* territory includes inhabited urban and rural areas of the northwest corner of San Diego County, including Camp Pendleton and the unincorporated De Luz community, and portions of the Tri-City HD and Fallbrook HD service areas and spheres that overlap the Camp Pendleton boundary.

The Fallbrook HD service area and sphere extends to the northwest and includes a portion of the unincorporated community of De Luz located between Camp Pendleton to the south and Riverside County to the north (Pendleton-De Luz Community Planning Area). The remainder of the De Luz community that is not currently within the Fallbrook HD service area and sphere should be considered for designation as a *Special Study Area* so that the unincorporated Pendleton-De Luz Community Planning Area territory not located within Camp Pendleton is joined with the Fallbrook HD territory (Map 2G).

As the majority of the City of Oceanside is currently located within the Tri-City HD service area and sphere, the small portion of Oceanside incorporated territory located within the Fallbrook HD service area and sphere should accordingly be consolidated within Tri-City HD; however, the adjacent Health Care Districts should discuss and collaboratively evaluate the affected area to determine if inclusion within either the Tri-City HD service area and sphere would benefit the local area.

Fallbrook HD Sphere of Influence Recommendation

As the Health Care Districts are restricted from providing services and facilities outside of their authorized service areas and spheres, the Commission is recommended to consider Fallbrook HD sphere designation options that will assist the local provision of health care services while the Fallbrook HD transitions away from operating the Fallbrook Hospital. These options include affirming the currently adopted coterminous sphere; designating the Fallbrook HD service area and sphere as a *Special Study Area;* or assigning a transitional (zero) sphere designation in anticipation of a potential dissolution of the district or a reorganization of the Fallbrook HD service area into one or more of the local Health Care Districts. The Fallbrook HD community grants program and other district-sponsored community health events indicate that the Fallbrook HD will continue to play a role in providing and supporting non-profit health care programs and services to the local community within its service area and sphere. Therefore, the Fallbrook HD sphere of influence is recommended to be affirmed as coterminous with its authorized service area. Additional Commission discussion and consideration for designation of *social or economic communities of interest*, *Special Study Areas,* and the sphere designation options for the Fallbrook HD is also recommended.

GROSSMONT HEALTHCARE DISTRICT (MSR13-67; SR13-67; SA13-67)

District Overview: Formation, Governance, Hospital Facilities

District Background

The Grossmont Health Care District (HD) provides hospital-based health care services to an approximate 762 square-mile service area and coterminous sphere of influence within the eastern and southern portions of San Diego County. Grossmont HD owns the 540-bed Grossmont Hospital in the City of La Mesa, which is leased and operated by agreement with the non-profit Sharp HealthCare System (Map 3A).

District Formation

The Grossmont Healthcare District was established by local voters in 1952 as the *Grossmont Hospital District* to create a new hospital to serve the public healthcare needs of the residents of San Diego's East County. Grossmont Hospital was constructed with local property tax revenues and has been licensed to operate as a General Acute-Care Hospital since August 10, 1955. The Grossmont Hospital District changed its name to the Grossmont Healthcare District in 1997 to better represent the district's broadened general health care services.

Governance

The Grossmont HD is governed by a five-member Board of Directors that is elected at-large by local voters and serve four-year terms. The Board of Directors establishes policy and administers community healthcare programs funded by local property tax revenues. Regular Board meetings occur monthly, on the 3rd Friday at 7:30 a.m.

Grossmont Hospital

The Grossmont HD owns the 540-bed Grossmont Hospital (OSHPD ID No. 106370714), located at 5555 Grossmont Center Drive, La Mesa. The Grossmont Hospital has been licensed as a General Acute Care Hospital since August 10, 1955 (License No. 080000006). Since 1991, the Grossmont Hospital has been leased and operated by the non-profit Sharp HealthCare Systems as the Grossmont Hospital Corporation under a 30-year agreement with the Grossmont HD. In 2014, the agreement with Sharp HealthCare was extended to 2051 by affirmative local vote.

District Service Area & Sphere of Influence

Service Area

The Grossmont HD's approximate 762 square-mile service area and coterminous sphere of influence is located within southern San Diego County, including incorporated territory located within the Cities of La Mesa, El Cajon, Lemon Grove, Santee, and the East Elliott and San Carlos communities of the City of San Diego; and adjacent unincorporated territory governed by the County of San Diego, including the unincorporated communities of Alpine, Buckman Springs, Blossom Valley, Bostonia, Campo, Crest, Dehesa, Descanso,

Dulzura, Eucalyptus Hills, Jamul, Lakeside, Morena Village, Pine Valley, Potrero, and Spring Valley.

The Grossmont HD service area and sphere is bordered by the Cities of Imperial Beach, Chula Vista, San Diego, Poway, additional East County unincorporated communities, and the US/Mexico International Border. The Grossmont HD is also bordered by the Palomar Health HD to the north.

Sphere of Influence

On June 2, 1986, San Diego LAFCO established a sphere of influence for the Grossmont HD that was coterminous with the HD's service area. There have been no proposed annexations or detachments to the Grossmont HD service area nor any changes to the sphere since it was originally established. The HD's adopted sphere was most recently reviewed and affirmed by the Commission on August 6, 2007 as coterminous with the service area.

Land Uses

Land use designations within the Grossmont HD service area and sphere, including agricultural and open space uses, are governed by the adopted General Plans of the cities of La Mesa, El Cajon, Lemon Grove, Santee, and San Diego for the territory within their respective incorporated boundaries; and by the County of San Diego General Plan and local Community Plans for the unincorporated territory.

Location & Characteristics of Disadvantaged Unincorporated Communities

When conducting a municipal service review, LAFCO is required to identify the location and characteristics of any *disadvantaged unincorporated communities (DUC)* that exist within or contiguous to a public agency's sphere of influence. A DUC is defined as an inhabited, unincorporated area in which the median household income is 80% or less of the statewide median household income (Map 1C).

The Grossmont HD has seven disadvantaged unincorporated communities within or contiguous to its sphere. These identified disadvantaged unincorporated communities are located within and are governed by the General Plan of the County of San Diego and the community plans for the Community Planning Areas of: Lakeside/Pepper Drive/Bostonia; Crest/Dehesa/Harbison Canyon/Granite Hills; Valle De Oro; and Spring Valley.

Service Area Population

The San Diego Association of Governments (SANDAG) is the designated regional clearinghouse for the US Census Bureau and provides current population estimates and future population projections for the San Diego Region.

LAFCO annually receives SANDAG population estimates for all local independent and dependent special districts in San Diego County.

The SANDAG Special District Population Estimates are based on the subject agency's geographic service area and are calculated using SANDAG's demographic modeling programs.

Following the 2010 Census, the SANDAG demographic modeling program baselines were updated from the 2000 Census data and recalibrated with new 2010 Census data, which resulted in a -3% readjustment to the calculated Grossmont HD population estimate for 2011. The new 2010 Census data allows for a more precise local population estimate and has resulted in a more consistent annual total.

2008-2014 Grossmont HD Population Totals (SANDAG Estimates)

Year	Total Population
2008	491,159
2009	495,699
2010	503,410 (Based on Census 2000 estimates)
2011*	488,113 (Based on Census 2010 estimates)
2012	493,325
2013	494,141
2014	498,684

As of 2014, SANDAG reports an estimated total population of 498,684 within the Grossmont HD service area and sphere.

According to SANDAG Special District Population Estimates over 2008-2014, the Grossmont HD has maintained a consistent population of approximately 500,000 and experienced an approximate 1.5% growth rate; therefore, significant population growth is not anticipated over the next 5 years.

2050 Service Area Population Projection

The Grossmont HD service area and sphere are included within defined geographic units of San Diego County called *Subregional Areas* (SRA) that are used by SANDAG for local population estates and projections. The Grossmont HD service area includes all or portions of 16 of the 41 SRAs covering San Diego County, including SRAs 31 (Spring Valley), 32 (Lemon Grove), 33 (La Mesa), 34 (El Cajon), 35 (Santee), and 36 (Lakeside).

The current (2013) total population for the 12 primary Subregional Areas that comprise the majority of the Grossmont HD service area and sphere is estimated at 561,541.

According to 2050 SANDAG Regional Growth Forecast Population Estimates (2011), the population within the Grossmont HD is projected to grow approximately 34.0% from 2013-2050 to a total of 752,365.

Projected 2013-2050 population estimates for the 4 SRAs that include only portions of the Grossmont HD service area and sphere territory show an overall growth rate of 44.2% and a total population of 719,767 by 2050.

The following tables identify the 12 primary and 4 partial SRAs that include all or portions of the Grossmont HD service area and sphere territory, their population estimates for 2020-2050, and projected growth rates from 2013-2050:

Projected 2020-2050 Subregional Area Population Totals & Growth Rate

Primary Grossmont HD SRAs

SRAs	2020	2030	2040	2050	2013-2050
17 Elliott-Navajo	103,170	111,704	120,190	131,255	+45.1%
30 Jamul	18,286	25,935	29,299	29,877	+62.4%
31 Spring Valley	87,737	92,326	94,717	95,739	+16.3%
32 Lemon Grove	31,387	32,796	35,570	37,114	+23.5%
33 La Mesa	64,330	68,128	75,553	80,413	+33.4%
34 El Cajon	135,757	156,326	171,956	172,890	+37.2%
35 Santee	61,726	66,191	68,985	69,071	+32.2%
36 Lakeside	61,556	68,022	72,371	73,236	+28.1%
37 Crest	16,274	18,133	19,216	19,552	+30.5%
38 Alpine	16,047	19,210	22,362	23,421	+51.8%
61 Pine Valley	6,077	6,921	7,304	7,718	+37.1%
62 Mtn. Empire	7,122	9,012	10,657	12,079	+40.8%
Total	609,469	674,704	728,180	752,365	+34.0%

Partial Grossmont HD SRAs

SRAs	2020	2030	2040	2050	2013-2050
05 SE San Diego	170,473	177,687	185,851	193,486	+25.0%
06 Mid San Diego	192,690	211,899	232,793	270,909	+64.6%
20 Sweetwater	164,350	183,946	206,864	205,279	+44.8%
39 Ramona	38,692	44,137	47,531	50,093	+39.9%
Total	566,205	617,669	673,039	719,767	+44.2%

The Grossmont HD's subregional population projections for 2020-2050 show steady growth within and adjacent to the service area and sphere, with higher increases identified for the rural eastern areas of the county, including the unincorporated communities of Ramona, Jamul, Pine Valley, and the Mountain Empire.

Strong population growth is also projected for the core urban areas of the east county cities, including La Mesa, El Cajon, and eastern portions of San Diego. SRAs 36 (Lakeside), 39 (Ramona) and 61 (Pine Valley) are also partially located within the Palomar Health HD service area and sphere.

2013-2030 Elderly Population Projections

Following the assessment of 2010 Census data, national and state population projections have indicated that the older population segments (65-85+ years) will grow from approximately 10% of the current total population to 20% by 2030. The projected doubling of older residents in the next 15-20 years is anticipated to create significant demands for local facilities, services, and resources to meet expected health care demands in underserved and high poverty areas (Map 1D).

The following tables provide population estimates for 2013-2030 for the 65-85+ year populations within the 12 primary and 4 partial SRAs covering the Grossmont HD service area and sphere territory:

Projected 2013-2030 Subregional Area 65-85+ Population Totals & Growth Rate

Primary Grossmont HD SRAs

SRAs	2013	2020	2030	2013-2030
17 Elliott-Navajo	14,597	21,612	29,464	+101.8%
30 Jamul	2,343	3,279	6,050	+158.2%
31 Spring Valley	10,438	11,819	15,690	+50.3%
32 Lemon Grove	3,612	4,268	5,808	+60.8%
33 La Mesa	9,310	12,497	16,534	+77.6%
34 El Cajon	16,115	20,038	28,185	+74.9%
35 Santee	6,789	9,417	13,046	+92.2%
36 Lakeside	7,195	9,694	13,648	+89.7%
37 Crest	2,928	3,561	5,072	+73.2%
38 Alpine	2,570	5,570	8,432	+228.1%
61 Pine Valley	1,016	1,304	1,902	+87.2%
62 Mtn. Empire	1,467	1,501	2,358	+60.7%
Total 65-85+	78,380	104,560	146,189	+86.5%
% of total pop.	14.0%	17.2%	21.7%	

Partial Grossmont HD SRAs

SRAs	2013	2020	2030	2013-2030
05 SE San Diego	15,299	20,997	29,176	+90.7%
06 Mid San Diego	13,434	16,540	20,981	+56.2%
20 Sweetwater	13,307	21,475	31,002	+133.0%
39 Ramona	4,610	5,750	8,432	+82.9%*
Total 65-85+	46,650	64,762	89,591	+92.0%
% of total pop.	9.3%	11.4%	14.5%	

The current SANDAG population estimates for the 12 primary Grossmont Subregional Areas (SRA) indicate a 65-85+ age range population of 78,380, which represents approximately 14.0% of the total 2013 population. The SANDAG projections show the older population within the primary Grossmont HD SRAs growing significantly from 2013-2030 (+86.5%), to 146,789, or 21.7% of the total population. The growth in older populations from 2015-2030 should be further evaluated by the Health Care Districts to effectively manage the future demographic needs with planned local facilities and services.

Grossmont HD Medical Service Study Areas (MSSAs)

The California Office of Statewide Health Planning and Development (OSHPD) produces maps for each county in the state that designate geographic Medical Service Study Areas (MSSAs) based on local 2010 Census Tract boundaries. OSHPD's Health Care Workforce Development Division (HWDD) reviews the Medical Service Study Areas to assess local population density, provider-to-population ratios, poverty levels, and public health indicators. OSHPD defines Medical Service Study Areas as Frontier*, Rural, or Urban*, based on local population density per square mile.

A *Frontier* MSSA has a population density less than 11 persons per square mile (sq. mi.); a *Rural* MSSA is one with a population density greater than 11 per sq. mi. and less than 250 persons per sq. mi.; and, an *Urban* MSSA, which are all MSSAs with a population density higher than 250 persons per sq. mi. (Map 1B).

The Grossmont HD service area and sphere includes all or portions of 15 of the 38 Medical Service Study Areas (MSSA) covering San Diego County. The types of MSSAs within the Grossmont HD service area include Frontier (less than 11 persons per square mile), Rural (less than 250 residents per sq. ml.), and Urban (more than 250 residents per sq. ml.), which reflects the large and diverse territory within the 762-square mile service area. The Grossmont Hospital is located in MSSA 161f (La Mesa), which is designated as Urban.

The following table identifies the 9 primary and 6 partial Grossmont HD MSSAs and provides a comparison of their population density, poverty rate, and associated communities:

Grossmont HD Primary Medical Service Study Areas

MSSA	Type	Pop. Den. per sq.ml.	Poverty rate	Communities
154	Rural	48.7	6.1%	Barona, Moreno
155	Rural	230.0	6.0%	Alpine, Blossom Valley, Crest, Descanso
157	Rural	91.0	7.2%	Dulzura, Jamul
159	Rural	16.8	22.1%	Buckman Springs, Jacumba
161f	Urban	6,954.8	14.9%	La Mesa, Rolando
161h	Urban	7,617.9	22.8%	El Cajon, Fletcher Hills
161i	Urban	3,980.6	9.3%	Spring Valley, Rancho San Diego
161m	Urban	2,292.6	5.9%	Eucalyptus Hills, Santee, San Carlos
161u	Urban	3,470.4	9.3%	Bostonia, Granite Hills, Lakeside

Grossmont HD Partial Medical Service Study Areas

MSSA	Type	Pop. Den. per sq.ml.	Poverty rate	Communities
152	Frontier	7.2	10.3%	Julian, Pine Valley, Borrego Springs
158.1	Rural	234.2	9.9%	Ramona
161g	Urban	7901.06	23.0%	National City, Lincoln Acres
161l	Urban	8,843.9	11.9%	Lemon Grove
161o	Urban	1,089.6	7.4%	Grantville, Miramar, Tierrasanta
161t	Urban	3224.6	6.2%	Bonita, Chula Vista

Medically Underserved Areas - Health Care Professional Shortage Areas

The California Office of Statewide Health Planning and Development (OSHPD) produces county maps which identify local Medical Service Study Areas that qualify for designation as a *Medically Underserved Area* (MUA) and/or a *Primary Care Shortage Area* (PCSA). The Federal Agency for Health Care Research and Quality (AHRQ) also designates MSSAs with a shortage of professional health care providers as a *Health Professional Shortage Area* (HPSA) for the *Primary Care, Dental Health, and Mental Health* disciplines (Maps 3D-3H).

Health Care Professional Shortage Areas and *Primary Care Shortage Areas* are designated where there are local population-to-physician ratios that demonstrate a high need for services combined with a general lack of access to health care in surrounding areas because of excessive distance, overutilization, or access barriers. The MSSA-designated maps can be used to identify areas of potential concern for Health Care Districts when addressing future health care needs and demands and sufficiently planning for needed local infrastructure and services.

Medically Underserved Areas / Health Care Professional Shortage Areas

Grossmont HD Primary Medical Service Study Areas

MSSA	Type	Communities	MUA/HPSA
154	Rural	Barona, Moreno	MUA, HPSA-PC, PCSA, RNSA
155	Rural	Alpine, Crest, Descanso	PCSA, RNSA
157	Rural	Dulzura, Jamul	MUA, PCSA, RNSA
159	Rural	Buckman Springs, Jacumba	MUA, HPSA-PC/MH/DT, PCSA, RNSA
161f	Urban	La Mesa, Rolando	MUA, RNSA
161h	Urban	El Cajon, Fletcher Hills	HPSA-PC, PCSA, RNSA
161i	Urban	Spring Valley, Rancho San Diego	PCSA, RNSA
161m	Urban	Eucalyptus Hills, Santee, San Carlos	PCSA, RNSA
161u	Urban	Bostonia, Granite Hills, Lakeside	PCSA, RNSA

Grossmont HD Partial Medical Service Study Areas

MSSA	Type	Communities	MUA/HPSA
152	Frontier	Julian, Pine Valley, Borrego Springs	MUA, PCSA, RNSA
158.1	Rural	Ramona	MUA, RNSA
161g	Urban	National City, Lincoln Acres	MUA, HPSA-PC, PCSA, RNSA
161l	Urban	Lemon Grove	HPSA-PC, PCSA, RNSA
161o	Urban	Grantville, Miramar, Tierrasanta	RNSA
161t	Urban	Bonita, Chula Vista	RNSA

Potential Social or Economic Communities of Interest

The *2015 Health Care Services MSR and Sphere Review* determinations are required to identify any *social or economic communities of interest* existing in the review area, if LAFCO determines that they are relevant to the subject agency. The Commission is recommended to consider local areas designated by OSHPD as *Medically Underserved Areas* and/or *Health Care Professional Shortage Areas*, and local areas identified with poverty levels above the regional average of *14.4%*, as containing *social or economic communities of interest* relevant to the local Health Care Districts (Maps 1E-K).

Proposed San Diego County Special Study Areas

OSHPD-designated *Medically Underserved Areas, Health Care Professional Shortage Areas*, and local areas identified with high poverty levels areas all presently exist in both urban coastal incorporated territory and rural unincorporated desert and mountain communities of San Diego County.

The *2015 San Diego County Health Care Services MSR and Sphere Review* determinations recommend Commission consideration of *Special Study Area* designations for the following 4 major areas of the County that contain inhabited territory not currently located within any of the local Health Care District service areas and spheres, and which contain *social or economic communities of interest* relevant to the local Health Care Districts (Map 1L):

Potential Grossmont HD Special Study Areas

Two of the four proposed *Special Study Areas* for San Diego County are adjacent to the Grossmont HD service area and sphere. These proposed *Special Study Areas* are related to the Grossmont HD service area and sphere as follows:

Special Study Area No. 3: Western San Diego County Incorporated Areas

The proposed *Special Study Area No. 3* includes the coastal incorporated cities from Encinitas south to Imperial Beach, as well as the unincorporated communities of Rancho Santa Fe, Bonita, and Otay Mesa.

These incorporated and unincorporated areas are not presently located within any of the local Health Care Districts service areas or spheres, and have been identified as containing designated *Medically Underserved Areas*, *Health Care Professional Shortage Areas*, and/or areas of high poverty. The Grossmont HD service area and sphere is contiguous to *Special Study Area No. 3* (Map 3I).

While State Law allows for both incorporated and unincorporated territory to be served by Health Care Districts and included within their service areas, Health and Safety Code Section 32001 prohibits the division of incorporated territory within a Health Care District unless LAFCO determines that the area would not be benefitted by inclusion.

Small portions of City of San Diego incorporated territory are located within the Grossmont HD and Palomar Health HD service areas and spheres; however, the majority of the City of San Diego is not currently located within a Health Care District service area and sphere. Accordingly, the adjacent Health Care Districts should discuss and collaboratively evaluate the City of San Diego to determine if inclusion within either or both of the Districts' service areas and spheres would benefit the local area.

Special Study Area 4: Eastern San Diego County Unincorporated Areas

The proposed Special Study Area No. 4 includes rural and frontier territory comprised of the mountain and desert unincorporated areas of eastern San Diego County, from the Riverside County to the north to the US/Mexico International Border to the south.

These unincorporated areas are not presently located within any of the local Health Care Districts service areas or spheres, and have been identified as containing designated Medically Underserved Areas, Health Care Professional Shortage Areas, and/or areas of high poverty. The Grossmont HD service area and sphere is contiguous to *Special Study Area No. 4*. Subsequent health care service and sphere reviews should evaluate the *Special Study Area* for resolution of the study area designation and potential sphere inclusion.

Healthcare Facilities & Services

Grossmont Hospital

The California Office of Statewide Health Planning and Development (OSHPD) provides licensing, facility, and services information for each licensed acute-care hospital through its Automated Licensing Information and Report Tracking System (ALIRTS).

The Grossmont HD owns the 540-bed Grossmont Hospital (OSHPD ID No. 106370714), located at 5555 Grossmont Center Drive, La Mesa. The Grossmont Hospital has been licensed as a General Acute Care Hospital since August 10, 1955 (License No. 080000006). The Grossmont Hospital's 540 licensed bed types include: 5 for coronary care, 70 for intensive care, 24 for intensive care-newborn nursery, 24 for perinatal care, 30 for the rehabilitation center, 46 for acute psychiatric care, 30 for skilled nursing, and 311 for unspecified general acute care.

OSHPD reports the following medical services are licensed to be provided at the Grossmont Hospital: Basic Emergency Room, Cardiovascular Surgery, Mobile Unit – Lithotripsy, Nuclear Medicine, Occupational Therapy, Physical Therapy, Respiratory Care Services, Speech Pathology, Cardiac Catheterization Laboratory, Mobile Unit – PET, Social Services, and Radiation Therapy.

Since 1991, the Grossmont Hospital has been leased and operated by the non-profit Sharp HealthCare Systems as the Grossmont Hospital Corporation under a 30-year agreement with the Grossmont HD. In 2014, the agreement with Sharp HealthCare was extended to 2051 by affirmative local vote.

The OSHPD 2012-2013 *Annual Financial Disclosure Report* for the Grossmont Hospital reports a total of 2,484 full-time employees, with 1,143 nursing employees. The Grossmont Hospital medical staff includes a total of 133 hospital-based physicians (including MDs, DOs, and Podiatrists), and a total of 557 non-hospital based physicians.

Hospital Facility Capacity and Utilization

The OSHPD Healthcare Information Division (HID) provides annual *Hospital Facility Summary Reports* for all licensed acute-care hospitals regarding the provision of Inpatient Services, Ambulatory Surgery, and Emergency Department Services.

Licensed Bed Occupancy Rates

Between 2010-2013, the Grossmont HD reports an average overall occupancy rate for its licensed acute-care beds as 61.6%; however, the district reports that its available beds have an average occupancy rate of 67.5% during the same time period.

Occupancy Rate	2010-2011	2011-2012	2012-2013
Licensed beds (total)	60.9% (536)	61.3% (540)	62.5% (540)
Available Beds	64.2% (509)	68.4% (484)	69.8% (484)

Total Live Births

The Grossmont Hospital reported a total of 3,823 live births in 2012-2013, including 2,602 natural births and 1,221 births by Caesarian section. 2010-2013 reported data reflects approximately 3,600 annual live births at Grossmont Hospital, with consistent ratios of natural births to caesarian sections.

Grossmont Hospital	**2010-2011**	**2011-2012**	**2012-2013**
Live Births	3,534	3,556	3,823
Natural births	2,395	2,507	2,602
Caesarian section	1,139	1,049	1,221

Inpatient Discharges

The OSHPD *Facility Summary Report* for 2013 states that Grossmont Hospital had a total of 32,541 inpatient discharges, with 94.2% for Acute Care (30,663) and 4.6% for Psychiatric Care (1,481). Total number of inpatient discharge days for 2013 were reported as 131,176, with an average length of stay at 4.0 days.

Grossmont Hospital - Inpatient Discharges 2007-2013

Year	**Discharges**	**Days**	**Ave. Stay**
2007	29,018	127,177	4.4 days
2008	29,606	123,049	4.2 days
2009	30,455	125,856	4.1 days
2010	31,792	127,110	4.0 days
2011	31,925	125,266	3.9 days
2012	32,573	128,436	3.9 days
2013	32,541	131,176	4.0 days

Demographics for Grossmont HD inpatient discharges for 2013 were 58.5% female and 41.6% male. This female/male patient ratio is generally consistent with 2007-2013 reported data. Highest age range frequency for Grossmont Hospital total inpatient discharges in 2013 was 14.7% at 50-59 years; 14.5% at 80+ years; 13.9% at 60-69 years; 12.0% at 70-79 years; 11.9% under one year; 11.7% at 20-29; 9.8% at 30-39 years; and 9.7% at 40-49 years.

In 2013, Grossmont Hospital patients between 60 and 80+ years totaled 40.4% of all discharges; patients between 20-59 years totaled 45.9%.

Grossmont Hospital - Inpatient Age Ranges 2007-2013

Year	Under 1 yr.	10-19	20-39	40-59	60-80+
2007	13.2%	2.7%	20.8%	23.6%	40.6%
2008	13.2%	2.4%	21.3%	22.6%	40.6%
2009	11.7%	2.1%	20.9%	24.2%	41.0%
2010	11.4%	2.1%	21.2%	24.9%	40.5%
2011	11.1%	2.0%	21.2%	25.4%	40.4%
2012	11.0%	1.9%	21.1%	25.5%	40.6%
2013	11.9%	1.7%	21.5%	24.4%	40.4%

Emergency Department (ED) Services

The Grossmont Hospital includes a licensed Basic Emergency Department (ER), but is not designated as a regional Trauma Center. The Grossmont HD reports that emergency physician services are available 24-hour, while on-call services include: anesthesiologist, laboratory services, operating room, pharmacist, psychiatric ER, and radiology.

Grossmont Hospital ED Encounters and Dispositions 2007-2013

Year	ED Encounters	Routine Discharges (%)
2007	61,900	54,039 (87.3%)
2008	65,590	54,993 (83.8%)
2009	68,706	58,283 (84.8%)
2010	66,128	56,178 (85.0%)
2011	70,423	60,962 (86.6%)
2012	76,580	67,490 (88.1%)
2013	81,638	72,509 (88.8%)

The Grossmont HD 2013 Emergency Department (ED) *Facility Summary Report* states that a total of 81,638 ED Encounters occurred during the reporting period. Highest frequency of Emergency Department diagnosis type was reported as *Symptoms*, at 25.6%; *Injuries/Poisonings/Complications*, at 19.6%; and, *Respiratory System*, at 8.0%; all other ED diagnosis types were less than 8%. In 2013, Grossmont Hospital ED Encounters most often (88.8%) resulted in routine discharges where the patient was released to home or self-care.

Demographics for Grossmont Hospital ED Encounters in 2013 were reported as 57.4% female and 42.6% male, with top age ranges as 20.5% for 20-29 years; 15.9%, for 30-39 years; 14.1%, for 50-59 years; and 13.8%, for 40-49 years. Total 2013 ED Encounters for the 0-29 years range was 38.3%; with 43.8% from 30-59 years, and 17.9% from 60 to 80+ years.

Emergency Department Ambulance Diversion Hours

The OSHPD *Annual Utilization Report* for 2013 states that the Grossmont Hospital had a total of 1,978 *Ambulance Diversion* hours during the year when the Emergency Department was unable to receive ambulance patients, and which resulted in ambulances being diverted to other hospitals. The Grossmont HD reported a total of 1,639 ambulance diversion hours in 2012.

Ambulatory Surgery Services

The Grossmont HD's submitted 2013 *Facility Utilization Report* for Grossmont Hospital states that the hospital had a total of 21 operating rooms that performed a total of 13,635 surgical operations, with a total of 7,421 inpatient procedures and 6,214 outpatient procedures.

The 2013 OSHPD *Facility Summary Report* for the Grossmont Hospital reports a total of 9,715 Ambulatory Surgery Encounters, with the principal procedure groups as *Digestive System* at 44.1%; *Musculoskeletal System*, at 12.9%; *Eye and Ocular System*, at 8.4%; and *Integumentary (Skin) System*, at 6.6%.

Dispositions for 9,638 (99.2%) of the 2013 Ambulatory Surgery Encounters were reported as routine discharges to home or self-care. The following table reflects the Grossmont Hospital' surgical encounters from 2007-2013:

Grossmont Hospital - Ambulatory Surgery Encounters 2007-2013

Year	AS Encounters	Principal Surgery (%)
2007	11,367	Digestive System (51.3%)
2008	11,239	Digestive System (52.0%)
2009	11,320	Digestive System (46.3%)
2010	9,916	Digestive System (46.4%)
2011	9,865	Digestive System (46.1%)
2012	9,918	Digestive System (44.6%)
2013	9,715	Digestive System (44.1%)

The total Grossmont Hospital Ambulatory Surgery encounters have averaged approximately 10,500 per year from 2007-2013; however, total annual encounters have decreased by approximately 17% from during that time.

Demographics for Grossmont Hospital Ambulatory Surgery Encounters in 2013 were reported as 57.0% female and 43.0% male, with top age ranges as 23.2% for 50-59 years; 22.0%, for 60-69 years; 17.2%, for 70-79 years; and 11.5 for 40-49 years. Total 2013 Ambulatory Surgery Encounters for the 10-29 years range was 6.9%; with 42.9% from 30-59 years, and 50.3% from 60 to 80+ years.

Adequacy of Services

Hospital Quality Indicators

The health care services provided by hospitals are measured for quality by several public and private organizations using a variety of *quality indicators* (QIs), including patient experience ratings; inpatient mortality rates for selected medical procedures and conditions; and the volume and frequency of selected medical procedures. The quality indicators establish annual rates for the subject hospitals that are measured against county and/or state averages.

The healthcare service quality indicators used in the *2015 San Diego County Health Care Services MSR and Sphere Review* are produced by: the California HealthCare Foundation (CHCF) through *CalQualityCare.org*, which establishes hospital ratings from patient survey responses on their experiences receiving medical services; and by the federal *Agency for Healthcare Research and Quality (AHRQ)*, which compiles OSHPD statistics on hospital performance for selected medical procedures and conditions in comparison to county and/or statewide averages.

The annual quality indicator results and hospital ratings provide a comprehensive set of data for evaluating the ongoing adequacy of services provided by the local Health Care Districts. Quality indicator category rates that are consistently lower or higher than county and state averages are noted for additional consideration within the Grossmont HD's adequacy of services determinations.

CalQualityCare.org Hospital Ratings

The California HealthCare Foundation (CHCF), a non-profit philanthropic foundation, produces hospital quality ratings through *CalQualityCare.org* for 332 acute care hospitals in the state of California. CalQualityCare.org hospital ratings are based on patient survey responses regarding their healthcare service experiences, and provide hospital clinical care, patient safety, and patient experience indicators in relation to statewide averages to produce a Patient Experience Rating of:

- *Superior*, where the provider performed well above average;
- *Above Average*, where the provider performed better than average;
- *Average*, where the provider performed within the average;
- *Below Average*, for performance worse than average; and,
- *Poor*, for performance well below the average level.

CalQualityCare.org Indicators

For the 2012-2013 reporting period, Grossmont Hospital has a Patient Experience Rating of ***Average*** and scored 71%, compared to the California state average of 68%. Hospital Readmission Rate was ***Average*** (16.9%), compared to the California state average of 15.9%. Patient responses indicate that **75%** would recommend Grossmont Hospital compared to the State average of 70%.

Selected 2012-2013 CalQualityCare.org indicators and ratings for Grossmont Hospital include:

Grossmont Hospital 2012-2013 CalQualityCare.org Indicators and Ratings

Indicator	Rating (Score)	State Average
Patient Experience		
Hospital Rating	*Average* (71%)	68%
Hospital Readmission Rate	*Average* (16.90%)	15.9%
Patient Safety		
Surgical Care Measures	***Superior*** (99%)	97%
Unplanned Surgical Wound Reopening	*Average* (0.04%)	0.09%
Death after Serious Treatable Complication	*Average* (10.93%)	10.84%
Accidental Lung Puncture	*Average* (0.05%)	0.03%
Heart Attack		
Death Rate	*Average* (16.10%)	14.90%
Quality of Care	***Superior*** (100%)	98%
Timeliness of Care	***Superior*** (100%)	N/A
Readmission Rate	*Average* (18.60%)	18.20%
Heart Bypass Surgery		
Death Rate	*Average* (0.0%)	2.17%
Internal Mammary Artery Usage	*Average* (100%)	97%
Postoperative Stroke	*Average* (2.23%)	1.31%
Heart Failure		
Death Rate	***Poor*** (14.10%)	11.20%
Quality of Care	***Superior*** (98%)	96%
Readmission Rate	*Average* (23.70%)	22.80%

Indicator	Rating (Score)	State Average
Mother & Baby		
C-Section Rate	*Average* (25.90%)	27.80%
Breastfeeding Rate	***Above Average*** (77%)	63.20%
Episiotomy Rate	*Average* (19.40%)	13.50%
VBAC Rate	***Above Average*** (15.70%)	8.30%
Pneumonia		
Death Rate	***Poor*** (14.70%)	11.70%
Quality of Care	***Superior*** (98%)	96%
Readmission Rate	*Average* (18.30%)	17.50%
Surgeries / Other Conditions		
Acute Stroke Death Rate	***Poor*** (12.30%)	9.91%
Craniotomy Death Rate	*Average* (8.40%)	7.81%
Gastrointestinal Hemorrhage Death Rate	*Average* (3.10%)	2.31%
Hip Fracture Death Rate	*Average* (3.40%)	2.47%
Hip or Knee Surgery Readmission Rate	*Average* (4.50%)	5.20%
Hip or Knee Surgery Complication Rate	*Average* (2.90%)	3.30%
Emergency Department Care		
Time in ED before being admitted	376 minutes	338 minutes
Time in ED before being sent home	239 minutes	165 minutes
Time in ED before being seen	56 minutes	32 minutes
Patients who left ED without being seen	5%	2%

The 2012-2013 CalQualityCare.org indicators and ratings for Grossmont Hospital medical procedures are generally consistent with or exceed state average levels. The Grossmont Hospital indicator ratings include five categories rated as ***Superior*** and three categories rated as ***Poor***. More significant is that patient responses indicate that ***75%*** would recommend Grossmont Hospital compared to the State average of 70%, which is the second highest patient-rated hospital facility of the Health Care Districts evaluated in this service and sphere review.

Inpatient Quality Indicators (IQIs)

The Federal Agency for Health Care Research and Quality (AHRQ) supplies Inpatient Quality Indicators (IQIs) at the Area Level (county, statewide) and Facility Level (hospital) based on inpatient data provided to OSHPD by all California-licensed acute-care hospitals. The *Facility Level Indicators* for hospitals are compared to statewide results to provide a consumer perspective on hospital quality of care. These hospital indicators include*:*

- Volume Indicators for the numbers performed of six selected medical procedures; and,
- Inpatient Mortality Indicators (IMIs) for the six medical procedures and other conditions.

Hospital Volume Indicators

The *Hospital Volume* indicators measure the number of selected medical procedures 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 six volume indicators provide the number of the following medical procedures performed within each hospital:

- Esophageal Resection (Surgical removal of the esophagus due to cancer)
- Pancreatic Resection (Surgical removal of the pancreas/gall bladder due to cancer)
- Abdominal Aortic Aneurysm (AAA) Repairs (Surgical repair of abdominal aneurysm)
- Carotid Endarterectomy (Surgical removal of plaque within the carotid artery)
- Coronary Artery Bypass Graft Surgery (CABG) (Surgical heart artery procedure)
- Percutaneous Coronary Intervention (PCI) (Non-surgical heart artery procedure)

From 2011-2013, the Grossmont Hospital reported consistent levels of performed volume indicator procedures. Highest volumes were reported for Coronary Artery Bypass Graft Surgeries (CABG), Percutaneous Coronary Interventions (PCI), and Carotid Endarterectomies.

Grossmont Hospital Volume 2011-2013

Volume	**Statewide**			**Grossmont Hospital**		
Medical Procedure	**2011**	**2012**	**2013**	**2011**	**2012**	**2013**
Esophageal Resection	482	484	480	3	0	6
Pancreatic Resection						
Total	1,693	1,736	1,770	2	4	2
Cancer	904	933	968	0	0	0
Other	789	803	802	2	4	2
AAA Repair						
Total	2,765	2,728	2,877	22	20	23
Ruptured, Open	168	133	136	0	1	2
Un-ruptured, Open	351	319	280	2	4	1
Ruptured, Endovascular	120	142	171	3	2	0
Un-ruptured, Endovascular	2,133	2,137	2,301	17	13	20
CABG	16,283	15,125	15,488	184	177	151
PCI	46,677	42,797	39,792	522	494	437
Carotid Endarterectomy	6,696	6,457	6,171	96	89	99

Inpatient Mortality Indicators

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.

The following tables reflect the 2011-2013 Risk-Adjusted Mortality Rates (RAMR) produced by Grossmont HD compared to statewide averages, with ratings where specified:

Grossmont Hospital 2011 Risk-Adjusted Mortality Rate (RAMR)

Inpatient Mortality Indicator (IMI)	**2011 Mortality Rate (total deaths; total cases)**	
Procedure	Statewide	Grossmont Hospital
Esophageal Resection	3.8% (15;391)	0
Pancreatic Resection	3.1% (23;750)	0
AAA Repair	1.9% (46;2,478)	0.0% (0;19)
Craniotomy	6.8% (980;14,331)	8.4% (14;117)
Percutaneous Coronary Intervention	2.3% (1,051;44,775)	1.6% (10;504)
Carotid Endarterectomy	0.5% (34;6,660)	0.0% (0;95)

Inpatient Mortality Indicator (IMI)	**2011 Mortality Rate (total deaths; total cases)**	
Condition	Statewide	Grossmont Hospital
Acute Myocardial Infarction	6.5% (3,005;46,278)	7.0% (24;385)
Heart Failure	3.0% (2,538;85,338)	4.5% (32;832) ***Worse***
Acute Stroke	9.4% (5,100;54,088)	12.3% (75;604) ***Worse***
Gastro-Intestinal Hemorrhage	2.2% (1,084;48,347)	3.1% (12;433)
Hip Fracture	2.3% (560;23,955)	3.4% (7;233)
Pneumonia	4.1% (2,993;73,002)	5.4% (27;636)

Grossmont Hospital 2012 Risk-Adjusted Mortality Rate (RAMR)

Inpatient Mortality Indicator (IMI)	**2012 Mortality Rate (total deaths; total cases)**	
Procedure	Statewide	Grossmont Hospital
Esophageal Resection	5.7% (22;387)	0
Pancreatic Resection	2.4% (41;1,724)	0.0% (0;4)
AAA Repair	1.1% (26;2,437)	12.7% (1;16)
Craniotomy	7.1% (1,065;15,030)	8.6% (10;116)
Percutaneous Coronary Intervention	2.5% (1,015;40,790)	2.6% (13;467)
Carotid Endarterectomy	0.5% (31;6,407)	1.4% (1;89)
Condition		
Acute Myocardial Infarction	6.3% (2,938;46,663)	10.0% (33;366) ***Worse***
Heart Failure	3.0% (2,458;81,250)	4.6% (33;830) ***Worse***
Acute Stroke	9.6% (5,227;54,191)	15.1% (82;620) ***Worse***
Gastro-Intestinal Hemorrhage	2.1% (1,024;47,893)	1.7% (7;415)
Hip Fracture	2.3% (552;23,774)	3.1% (5;219)
Pneumonia	4.0% (2,606;64,400)	5.4% (25;529)

Grossmont Hospital 2013 Risk-Adjusted Mortality Rate (RAMR)

Inpatient Mortality Indicator (IMI)	**2013 Mortality Rate (total deaths; total cases)**	
Procedure	Statewide	Grossmont Hospital
Esophageal Resection	4.8% (18;377)	0.0% (0;4)
Pancreatic Resection	3.5% (62;1,763)	0
AAA Repair	1.4% (36;2,560)	0.0% (0;21)
Craniotomy	7.2% (1,094;15,187)	6.5% (12;150)
Percutaneous Coronary Intervention	2.7% (1,013;37,885)	2.2% (10;414)
Carotid Endarterectomy	0.5% (29;6,139)	0.0% (0;98)
Condition		
Acute Myocardial Infarction	6.0% (2,803;46,984)	5.9% (19;349)
Heart Failure	3.0% (2,510;83,220)	3.6% (6;206)
Acute Stroke	9.2% (5,072;54,983)	10.4% (71;665)
Gastro-Intestinal Hemorrhage	2.3% (1,087;47,723)	3.0% (13;447)
Hip Fracture	2.0% (494;24,103)	3.2% (6;206)
Pneumonia	3.9% (2,487;63,853)	3.0% (15;531)

In the 2010-2012 reporting periods, the Grossmont Hospital performed a limited number of the selected indicator procedures, but served an adequate number of patients experiencing the selected conditions to evaluate the subject patient mortality rates.

Grossmont Hospital reported mortality rates were generally consistent with state averages for most of the condition indicators; however, repeated annual mortality rate deficiencies for particular indicator procedures or conditions should be addressed and corrected by the Health Care Districts. No consistent Grossmont Hospital mortality rate deficiencies were identified from 2011-2013 and overall provision of Grossmont Hospital services are accordingly determined to be adequate.

Hospital Infrastructure Needs and Deficiencies

State Seismic Safety Requirements for Hospital 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 Seismic Safety 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 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 2008 that was extended to 2013. Subsequent legislative changes 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.

Senate Bill 1953 also required OSHPD to develop a Structural Performance Category (SPC) rating for each licensed general acute care hospital facility that indicates the building's compliance with seismic safety standards; and a Non-Structural Performance Category (NPC) 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.

Following OSHPD determination of SPC/NPC facility ratings, the hospital licensee must prepare a comprehensive evaluation report and compliance plan for the hospital to attain the specified structural and nonstructural performance categories by the specified timeframes, with an ultimate compliance date of 2030.

Grossmont Hospital Seismic Safety Ratings

The Grossmont HD's Grossmont Hospital facilities include seismic safety ratings that require rehabilitation or replacement of non-compliant buildings or structures by the mandated deadlines. Local voters have approved bond measures that are intended to fund needed seismic improvements at the Grossmont Hospital and compliance with the seismic safety standards is anticipated prior to the required deadlines.

As of September 2014, the Grossmont Hospital has the following OSHPD SPC/NPC seismic ratings and extension review status:

Grossmont	SPC	HZ	NPC	SB499Item 2 Ext
Emerg.Gen.Bldg	4		2	1/1/2030
West Wing W	2	0.12	2	
North Wing	2	0.03	2	
South Wing	2	0.09	2	
Cent.Plant	4		2	
East Wing	4		2	
Phys.Rhb	4		2	
Heart/Vasc*	5s			
New Ctr.Plant*	5s			
Old Admin.	2	0.00	2	
Grossmont	**SPC**	**HZ**	**NPC**	**SB499Item 2 Ext**
Wmn.Hth.Ctr.	3		2	
East Wind Add. 4		2		
West Wing E	2	0.09	2	
West Wing N	2	0.15	2	
Mental.Hlth	N/A			
ED/CCU	5s		2	
Phys.Rhb	4s		2	
MRI/Angio Add	4		2	
Emerg.Gen.	1/2		N/A	

As the OSHPD ratings reflect, the Grossmont Hospital has a number of buildings and structures that will require rehabilitation or replacement per the following criteria and deadlines for conformance:

- SPC-2: These buildings are in compliance with pre-1973 California Building Code or other applicable standards, but are not in compliance with the structural provisions of the Alquist Hospital Facilities Seismic Safety Act. They do not significantly jeopardize life but may not be repairable or functional following strong ground motion. These buildings must be brought into compliance with the Alquist Act by January 1, 2030 or be removed from acute care service.
- SPC-3: These buildings are in compliance with the structural provisions of the Alquist Act. In a strong earthquake, they may experience structural damage that does not significantly jeopardize life but may not be repairable or functional following strong ground motion. These buildings will have been constructed or reconstructed under a building permit obtained through OSHPD. They can be used to 2030 and beyond.
- SPC-4: These buildings are in compliance with the Alquist Act but may experience structural damage which could inhibit the building's availability following a strong earthquake. These buildings will have been constructed or reconstructed under a building permit obtained through OSHPD. They may be used to 2030 and beyond.
- SPC-5: These buildings are in compliance with the structural provisions of the Alquist Act and are reasonably capable of providing services to the public following strong ground motion.

- NPC-2: In these buildings, essential systems vital to the safe evacuation of the building are adequately braced. The building is expected to suffer significant nonstructural damage in a strong earthquake.

Grossmont Hospital Facility Improvements

The Grossmont HD adopted a Master Plan in 2004 for the Grossmont Hospital to address needed facility improvements. In June 2006, local voters approved Proposition G, a $247 million bond measure to fund capital infrastructure improvements proposed in the Grossmont Hospital Master Plan. The improvements to Grossmont Hospital include capital projects for compliance with the required seismic safety standards within the mandated deadlines.

Finance: Financial Ability to Provide Services

Annual Financial Disclosure Reports

The Grossmont HD is required to submit annual financial disclosure reports for its licensed acute-care hospital facilities to OSHPD within four months of the close of the district's fiscal year that include a detailed income statement, balance sheet, statements of revenue and expense, and supporting schedules.

OSHPD uses the submitted hospital financial data to produce an *Annual Financial Disclosure Report* for each licensed acute-care hospital that discloses annual totals for: patient revenues; operating and non-operating expenses; breakdowns of expenditures by category; net operating income; and total income or loss.

Health Care 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 regarding special district revenues, expenditures, property taxes, and bonded debt. The County of San Diego Auditor and Controller produces a detailed summary of local tax information for each fiscal year that identifies the amount of property tax allocated to the Health Care Districts and reports any bonded indebtedness held by the Districts.

The annual Health Care District and hospital financial disclosure reports produced by the California State Controller, the County of San Diego, and OSHPD provide the public with a comprehensive overview of the annual financial status of the Grossmont HD, as well as the Grossmont Hospital operations.

Financial Performance Indicators

The financial performance of a Health Care District and associated provision of health care services can be evaluated by several fiscal totals disclosed in the annually financial reports, including: revenues and expenditures; net-from-operations; annual profit or loss; total bonded indebtedness; and operating margin. *A* hospital's *net-from-operations* indicator compares a hospital's total operating revenue against its total operating expenses and is the most commonly used financial ratio to measure a hospital's financial performance. A positive net-from-operations indicates that a hospital is operating at a

profit; a negative figure indicates that the hospital is operating at a financial loss for the reporting period.

Grossmont Hospital Revenue - Expenditure Characteristics (FY2012-2013)

Net Patient Revenue: $619,558,759
Inpatient: $414,828,597; Outpatient: $204,730,162
Net from Operations: $52,258,084
Operating Margin: 8.3%

For the 2012-2013 fiscal year, the Grossmont HD reported total net operating revenues of $627,960,886 and total operating expenses of $575,702,802, for a total net-from-operations gain of $52,258,084 and total annual income of $69,354,471. This income follows a total gain of $55,297,521 for the preceding 2011-2012 fiscal year.

The following table summarizes the Grossmont Hospital's financial performance over FY2007-FY2013:

Grossmont HD Revenues - Expenditures (FY2007-2013)

Year	Net Operating Rev.	Operating Exp.	Net from Op	Income / Loss
2007-08	$414,434,860	$410,101,389	$4,333,471	$4,936,702
2008-09	$448,942,410	$441,062,114	$7,880,296	$15,855,154
2009-10	$471,429,434	$470,509,231	$920,203	$9,504,778
2010-11	$533,428,957	$517,332,010	$16,096,947	$14,504,754
2011-12	$583,289,377	$549,555,914	$33,733,463	$55,297,521
2012-13	$627,960,886	$575,702,802	$52,258,084	$69,354,471

From 2007-2008 to 2012-2013, the Grossmont Hospital reported an average annual net-from-operations total of $19,203,744, with a cumulative total income of $169,453,380.

Bonded Debt

On June 6, 2006, Grossmont HD local voters approved Proposition G, which authorized the issuance of up to $247,000,000 in general obligation bonds and was approved by a total of 77.68% of the electorate. The proceeds from the sale of the Prop G bonds were intended to be used to:

- Improve emergency care in eastern San Diego County, including the completion of Sharp Grossmont Hospital's Emergency and Critical Care Center;
- Improve seismic safety for Grossmont Hospital facilities;
- Improve access to medical facilities in the event of earthquakes, wildfires or other disasters;
- Expand cardiac care services and facilities;
- Increase the number of patient beds; and,
- Acquire, construct, repair, and improve certain medical facilities.

Sharp HealthCare, via the Grossmont Hospital Corporation, will be largely responsible for the execution of the projects, under the purview and authority of the Grossmont HD. On August 2, 2007, the Grossmont HD issued $85,627,076 of general obligation bonds; and on February 23, 2011, issued $136,860,000 of general obligation bonds. Grossmont HD financial statements report that all district bonded debt is rated as AA2 by the Moody's

Investors Service. One final Proposition G bond sale estimated to be in the range of $24,512,000 is tentatively scheduled for mid-2015, depending on construction progress and market conditions.

As of June 30, 2014, the Grossmont HD reports net general obligation bond debt of $233,609,053 along with financing obligations of $14,287,116, for a total long-term debt liability balance of $247,896,169. The audited financial statement for FY2014 reports long-term Grossmont HD debt service requirements from 2015-2041 will total $505,959,684, including principal of $220,597,076 and interest of $285,392,608.

Property Tax Revenues

As a special district formed prior to the passage of Prop 13 in 1978, the Grossmont HD receives an annual allocation from the 1% ad valorum property tax for property within its respective service area. The District receives a share of this basic tax levy proportionate to what it received during the years 1976-1978. Each year the Grossmont HD is required to provide the County with its calculation of the required property tax levy to assess for the following year's scheduled bond debt service payments. The Grossmont HD current levy is $20.05 per $100,000 of assessed valuation.

Property taxes are the Grossmont HD's primary source of revenue and are also levied to pay the debt service on the outstanding Proposition G general obligation bonds. Property tax revenues increased $61,327 from FY 2013 to FY 2014 and increased $1,223,398 from FY 2012 to 2013. The County of San Diego Tax Summary for fiscal year 2013-2014 states that the annual allocation of unrestricted property tax revenues was equivalent to approximately 1.0% of the Grossmont HD’s total net operating revenues.

County of San Diego annual tax reports from FY2008-2009 to FY2012-2013 indicate that the Grossmont HD has received consistent levels of unrestricted annual property tax revenues, with an average total of $5,729,713 annually allocated to the district.

County of San Diego Tax Summary

Allocated Property Tax Revenue FY2013-2014

	Prop. Tax Revenue	% of Net Operating Revenues
Grossmont HD	$5,904,774	1.0%

Allocated Property Tax Revenue FY2007-2008 to FY2013-2014

	Annual Average
Grossmont HD	$5,761,311

Budgets/Audits

The Grossmont HD Board of Directors adopts a budget for each fiscal year following public hearings. The adopted budgets and district financial information are regularly audited by certified auditors in conformity with the format prescribed by the provisions of Government Accounting Standards Board Statement No. 34 (GASB 34) for governmental accounting financial reporting purposes; no financial violations have been reported. The audited

financial statements state that the Grossmont HD complies with all financial disclosure requirements of state and federal regulatory agencies

The Grossmont HD budget includes six expense categories: administrative, community healthcare, non-operating, library operating, facility and Prop. G expenses.

- Administrative expenses include costs incurred for the day-to-day operations of the District.
- Community healthcare expenses include community healthcare grants, support and related costs for programs.
- Non-operating expenses include costs incurred for expenses not attributed to the District's day-to-day operations.
- Library operating expenses include costs incurred to operate the District's health library.
- Facility expenses include costs incurred for the operation and maintenance of all District facilities and land.
- Proposition G expenses include debt service and estimated administrative costs related to the bond financing for Proposition G funded improvements. Some costs may be reimbursed to the district from the Proposition G Building Fund

The Grossmont Board has established a contingency reserve fund that was raised from a total of $5,350,000 in FY2013 to $7,350,000 in FY14. The independent auditor's reports for fiscal years 2012-2013 and 2013-2014 states that the Grossmont HD budget is funded by the district's annual property tax revenues, which are used to finance the Community Grant Program, pay for the Grossmont HD's administrative costs, and to contribute payments to the Grossmont Hospital for general operating support or equipment and repayment of the Proposition G bonded indebtedness program.

Administration, library, and facility expenses accounted for approximately 12.5% of the Grossmont HD's allocated property tax revenues in FY2014, and approximately 13.4% in FY2013. The following table summarizes the Grossmont HD budgeted/audited revenues and expenses reported for the two most recent fiscal years (FY2012-2013 and FY2013-2014):

Grossmont HD Revenues/Expenditures	**FY2013-2014**	**FY2012-2013**
Revenues		
Property Tax Revenue	$15,250,590	$15,189,263
Investment Income	431,681	422,801
Other Income	674,741	333
Total Revenues	16,357,012	15,612,397
Expenses		
Community Grant Program	1,048,883	1,062,209
Administration, library, facilities	1,900,944	2,097,575
Interest Expense	12,959,917	12,952,987
Other Expenses	1,821	1,657
Contributions to Grossmont Hospital	44,673,320	34,386,162
Total Expenses	$60,850,538	$50,896,73
Change in Net Position	($44,493,525)	($35,284,306)

During the fiscal years ending 2014 and 2013, contributions to the Grossmont Hospital Corporation were $44,673,320 and $34,386,162, including $1,000,000 per year for general operating support. Contributions increased $10,287,158 from FY2014 to FY2013 resulting primarily from the phasing and timing of Proposition G program expenses financed by Proposition G general obligation bonds. Interest expenses were reported as $12,952,987 for the 2013 fiscal year, and $12,959,917 for the 2014 fiscal year.

Governance and Operations

Board of Directors

The Grossmont HD is governed by an elected five-member Board of Directors that meets regularly on the 3rd Friday of each month at 7:30 a.m. The Board meeting notices and agendas are posted 72-hours in advance of each meeting at the Grossmont HD's administrative office at 9001 Wakarusa Street, La Mesa. The Board Members are elected at-large to 4-year terms and are responsible for establishing policy and administering programs funded by property tax revenue.

Grossmont Hospital Operations

In 1991, Grossmont HD entered into an affiliation agreement with Sharp HealthCare, a non-profit healthcare system in the San Diego region, to lease and operate Grossmont Hospital for a 30-year term. The agreement involved the establishment of a non-profit public corporation, the Grossmont Hospital Corporation, which serves as a subsidiary of Sharp HealthCare. The Grossmont HD then transferred the Grossmont Hospital and assets to the Grossmont Hospital Corporation, which is responsible for payment on the HD's accumulated bonded indebtedness and operates the facility on a fee-for-service basis. In June 2014, the local Grossmont HD voters approved a measure by over 80% to extend the Grossmont Hospital lease with Sharp HealthCare for an additional 30 years. The extended Grossmont Hospital lease agreement will expire in May 2051.

Community Service Accountability

The Grossmont HD operates a public website for the district which regularly posts news releases, annual community benefit reports, budgets, audited financial statements, Board meeting notices, Board agendas & minutes, and community health care program information. The Grossmont HD also holds and sponsors community health fairs and open community events for public health education, information and recognition.

State Law requires a Health Care District that has leased or transferred its assets to a corporation to act as an advocate for the community to the operating corporation, and to annually report to the community on the progress made in meeting the community's health needs (Health & Safety Code Section 32121.9).

Sharp HealthCare produces an annual *Community Benefit Plan and Report* on the progress made in meeting the community's health needs that is presented and posted to the Sharp HealthCare's website. The Grossmont HD also produces an annual report of the Independent Citizen's Bond Oversight Committee (ICBOC), which is a volunteer citizens

group that represents local taxpayers and provides guidance and oversight for the use of Proposition G general obligation bonds for improvements to the Grossmont Hospital.

Community Grants Program

The Grossmont HD has awarded nearly $42 million dollars in grants, scholarships, and sponsorships since the Community Grants Program began in 1996. Those public monies have benefited community-based non-profit organizations, government agencies and the Grossmont Hospital. The Grossmont HD Board has adopted a budget allocation equal to 35% of its general fund revenue in the last audited fiscal year (2012-13), which provides a maximum of $2,046,878 for the 2014-15 fiscal year for the district's community health care programs and grants. About half of this revenue is provided to local non-profit, health-related organizations. The other half is allocated to enhance services at Grossmont Hospital. Grossmont HD funds allocated to Grossmont Hospital assist acquisitions of needed, high-cost medical equipment and to make improvements to the physical plant.

The Grossmont HD Community Grant Program accepts applications for non-profit programs that serve to meet health care goals or address health care risks as identified by Grossmont Hospital or as included in the County of San Diego's Health Strategy for the East Region population. Priority consideration is given to the grant proposals that demonstrate a collaboration of like providers of service. The grant application must demonstrate how an applicant organization's innovations, provision of patient service improvements and/or operational improvements are proposed to contribute to the expansion of the mission of the Grossmont HD.

Status of and Opportunities for Shared Facilities

The 1991 affiliation agreement with Sharp HealthCare to lease and operate the Grossmont Hospital brought the facility into the network of affiliated Sharp HealthCare facilities, including three additional acute-care hospitals, three specialty hospitals, two medical groups, urgent care centers and a number of other health care facilities such as labs and pharmacies. As the Grossmont HD shares its service area and sphere boundaries on the north with the Palomar Health HD, the Health Care Districts should be encouraged to collaborate on potential shared facilities and services for medically underserved and understaffed areas outside of their respective service areas and spheres.

Governance Structure Options

Governmental structure options available to the Grossmont HD include several different changes of organization or reorganization, including: dissolution of one or more districts with annexation of the dissolved district's service area into one or more successor districts; consolidation of two or more districts into one or more successor districts; or a combination of governance actions involving annexations or detachments of district service area and sphere territory.

A proposed reorganization involving dissolution/annexation, or a consolidation/merger of Health Care Districts would transfer the district's assets and liabilities to a designated successor agency, including responsibility for assuming any voter-approved bonded indebtedness. Therefore, a key issue to be determined when considering potential

governmental structure options for Health Care Districts involves the identification of a successor agency that is both authorized and capable of sustaining the provision and level of health care services presently provided by the affected Health Care District(s).

Proposed changes of organization or reorganization for Health Care Districts may be initiated by: sufficient petition of local voters or landowners; a resolution of subject/affected agencies; or by LAFCO action. If LAFCO approves a proposed reorganization or consolidation/merger involving one or more Health Care Districts, State Law allows for written protest to be filed with the Commission by affected registered voters or landowners. If LAFCO approves a proposed jurisdictional change that involves dissolution of one or more Health Care Districts, or a Health Care District proposes to transfer more than 50% of the district's assets, State Law requires the dissolution or transfer agreement to be approved by local voters.

Conclusion: MSR Determinations / Sphere Recommendations

The *2015 San Diego County Health Care Services MSR and Sphere Review* determinations conclude that the Grossmont HD is adequately providing health care services within its service area and sphere and is accountable for the local community's service needs. The *2015 San Diego County Health Care Services MSR and Sphere Review* determinations also reflect that the Grossmont Hospital has adequate capacities for patient needs; facility improvements are being undertaken to address any infrastructure deficits or needs; hospital ratings and quality indicators are consistent with state averages and reflect adequate provision of health care services; and that patient revenues are adequate to support the Grossmont HD's financial ability to provide services.

The following is a summary of the *2015 Health Care Services MSR and Sphere Review* conclusions for the Grossmont HD in relation to the associated service and sphere determinations; and the sphere of influence recommendations for the Grossmont HD:

Municipal Service Review Determination Summaries

Growth and Population Projections

As of 2014, SANDAG reports an estimated total population of 498,684 within the Grossmont HD service area and sphere. According to SANDAG Special District Population Estimates over 2008-2014, the Grossmont HD has maintained a consistent population of approximately 500,000 and experienced an approximate 1.5% growth rate; therefore, significant population growth is not anticipated over the next 5 years. SANDAG 2050 Regional Growth Forecast Population Estimates (2011) project the population within the Grossmont HD to grow approximately 34.0% from 2013-2050, to a total population of 752,365.

Location and Characteristics of Disadvantaged Unincorporated Communities

The Grossmont HD has seven disadvantaged unincorporated communities within or contiguous to its sphere. These identified disadvantaged unincorporated communities are located within and are governed by the General Plan of the County of San Diego and the

community plans for the Community Planning Areas of: Lakeside/Pepper Drive/Bostonia; Crest/Dehesa/Harbison Canyon/Granite Hills; Valle De Oro; and Spring Valley (Map 1C).

Present and Planned Capacity of Public Facilities

The Grossmont HD's 540-bed Grossmont Hospital licensed bed types include: 5 for coronary care, 70 for intensive care, 24 for intensive care-newborn nursery, 24 for perinatal care, 30 for the rehabilitation center, 46 for acute psychiatric care, 30 for skilled nursing, and 311 for unspecified general acute care. During the 2010-2013 fiscal years, the Grossmont HD reports an average overall occupancy rate for its licensed acute-care beds as 61.6%; however, the district reports that its available beds have an average occupancy rate of 67.5% during the same time period. The 2013 OSHPD *Facility Summary Report* for the Grossmont Hospital reports a total of 32,541 inpatient discharges, with 94.2% for Acute Care (30,663) and 4.6% for Psychiatric Care (1,481). Total number of inpatient discharge days for 2013 were reported as 131,176, with an average length of stay at 4.0 days.

The Grossmont HD 2013 Emergency Department (ED) *Facility Summary Report* states that a total of 81,638 ED Encounters occurred during the reporting period. The OSHPD Annual Utilization Report for 2013 states that the Grossmont Hospital had a total of 1,978 Ambulance Diversion hours during the year when the ED was unable to receive ambulance patients which resulted in ambulances being diverted to other hospitals. The Grossmont HD reported a total of 1,639 ambulance diversion hours in 2012.

The Grossmont HD's submitted 2013 *Facility Utilization Report* for Grossmont Hospital states that the hospital had a total of 21 operating rooms that performed a total of 13,635 surgical operations, with a total of 7,421 inpatient procedures and 6,214 outpatient procedures.

The Grossmont HD has an adopted Master Facility Plan for the Grossmont Hospital that identifies current and future facility improvements designed to accommodate expected demands and regulatory requirements.

Adequacy of Public Services

Grossmont Hospital ratings and quality indicators reflect that health care services are being adequately provided. The 2012-2013 CalQualityCare.org indicators and ratings for Grossmont Hospital medical procedures are generally consistent with or exceed state average levels. More significant is that patient responses indicate that ***75%*** would recommend Grossmont Hospital compared to the State average of 70%, which is the second highest patient-rated hospital of the local Health Care Districts rated hospital facilities. Grossmont Hospital inpatient mortality rates were generally consistent with state averages for most of the condition indicators; no consistent Grossmont Hospital mortality rate deficiencies were identified from 2011-2013.

The Grossmont HD supports local non-profit health care programs and services within its service area and sphere through its community grants program and provides oversight on hospital facility maintenance expansion. The MSR determinations reflect that Grossmont HD is adequately providing its authorized services.

Infrastructure Needs or Deficiencies

California seismic safety standards for acute-care hospital facilities are mandated for compliance by 2030. The Grossmont Hospital facilities include seismic safety ratings that require rehabilitation or replacement of non-compliant buildings or structures by the mandated deadlines. Local voters have approved bond measures that will fund needed seismic improvements at the Grossmont Hospital and facility compliance with the seismic safety standards is anticipated prior to the required deadlines.

Financial Ability to Provide Services

OSHPD Annual Financial Disclosure Reports for the Grossmont Hospital reflect that the facility is generating adequate inpatient revenues to fund operations and repay bonded indebtedness. For the 2012-2013 fiscal year, the Grossmont HD reported total net operating revenues of $627,960,886 and total operating expenses of $575,702,802, for a total net-from-operations gain of $52,258,084 and total annual income of $69,354,471. This income follows a total gain of $55,297,521 for the preceding 2011-2012 fiscal year.

During the 2007-2008 to 2012-2013 fiscal years, the Grossmont Hospital reported an average annual net-from-operations total of $19,203,744, with a cumulative total income of $169,453,380. As of June 30, 2014, the Grossmont HD reports net general obligation bond debt of $233,609,053 along with financing obligations of $14,287,116, for a total long-term debt liability balance of $247,896,169. The audited financial statement for FY2014 reports long-term Grossmont HD debt service requirements from 2015-2041 will total $505,959,684, including principal of $220,597,076 and interest of $285,392,608. The MSR determinations conclude that the Grossmont HD has adequate financial ability to provide its authorized services within the District's service area and sphere.

Accountability for Community Service Needs

The Grossmont HD operates a public website which regularly posts news releases, annual community benefit reports, budgets, audited financial statements, Board meeting notices, Board agendas & minutes, and community health care program information. The Grossmont HD also holds and sponsors community health fairs and open community events for public health education, information and recognition.

Sharp HealthCare produces an annual *Community Benefit Plan and Report* on the progress made in meeting the community's health needs that is presented and posted to the Sharp HealthCare's website. The Grossmont HD also produces an annual report of the Independent Citizen's Bond Oversight Committee (ICBOC), which is a volunteer citizens group that represents local taxpayers and provides guidance and oversight for the use of Proposition G general obligation bonds for improvements to the Grossmont Hospital.

Grossmont HD local voters have shown support for the Grossmont HD and the Grossmont Hospital by approving bond measures and leasing agreements by overwhelming margins. The MSR determinations conclude that the Grossmont HD is adequately accountable for the health care service needs of the community within the District's service area and sphere.

Governmental Structure

Governmental structure options available to the Grossmont HD include several different changes of organization or reorganization, including: dissolution of one or more districts with concurrent annexation of the dissolved district's service area into one or more successor districts; consolidation of two or more districts into one or more successor districts; or a combination of governance actions involving annexations or detachments of district service area and sphere territory.

A proposed reorganization involving dissolution/annexation, or a consolidation/merger of Health Care Districts would transfer the district's assets and liabilities to a designated successor agency, including responsibility for assuming any voter-approved bonded indebtedness. Therefore, a key issue to be determined when considering potential governmental structure options for Health Care Districts involves the identification of a successor agency that is both authorized and capable of sustaining the provision and level of health care services presently provided by the affected Health Care District(s). If LAFCO approves a proposed jurisdictional change that involves dissolution of one or more Health Care Districts, or a Health Care District proposes to transfer more than 50% of the district's assets, State Law requires the dissolution or transfer agreement to be approved by local voters.

Operational Efficiencies

The Grossmont HD's operational relationship with Sharp HealthCare for the Grossmont Hospital has demonstrated operational efficiencies as reflected in the positive financial returns and local voter approval for extension of the agreement with Sharp HealthCare to 2051.

Status and Opportunities for Shared Facilities

The 1991 affiliation agreement with Sharp HealthCare to lease and operate the Grossmont Hospital brought the facility into the network of affiliated Sharp HealthCare facilities, including three additional acute-care hospitals, three specialty hospitals, two medical groups, urgent care centers and a number of other health care facilities such as labs and pharmacies. As the Grossmont HD shares its service area and sphere boundaries on the north with the Palomar Health HD, the Health Care Districts should be encouraged to collaborate on potential shared facilities and services for medically underserved and understaffed areas outside of their respective service areas and spheres.

Sphere of Influence Determination Summaries

Present and Planned Land Uses

Land use designations within the Grossmont HD service area and sphere, including agricultural and open space uses, are governed by the adopted General Plans of the cities of La Mesa, El Cajon, Lemon Grove, Santee, and San Diego for the territory within their respective incorporated boundaries; and by the County of San Diego General Plan and local Community Plans for the unincorporated territory.

Present and Probable Need for Public Facilities and Services

The *2015 Health Care Services MSR and Sphere Review* determinations reflect that the rate of population growth with the Grossmont HD service area and sphere was approximately 1.5% from 2008-2014, and that significant local population growth is not anticipated over the next 5 years. SANDAG's 2050 Regional Growth Forecast Population Estimates (2011) projects the Fallbrook Subregional Area to grow approximately 34% from 2013-2050.

The Grossmont HD service review determinations state that the local population of elderly residents (65-85+) within the local Subregional Areas is projected to increase by approximately 86.5% during 2013-2030. In addition, each of the Medical Service Study Areas within the Grossmont HD service area and sphere have territory that is within or adjacent to areas designated by the California Office of Statewide Health Planning and Development (OSHPD) as *Medically Underserved Areas* (MUA) and/or *Health Care Professional Shortage Areas* for primary care (HPSA-PC, PCSA) and registered nursing professionals (RNSA). The population projections and medically underserved and understaffed areas designations reflect that the Grossmont HD will continue to experience health care service needs within its service area and sphere.

Present Capacity of Public Facilities, Adequacy of Public Services

The *2015 Health Care Services MSR and Sphere Review* determinations reflect adequate facility capacities and provided services at the Grossmont Hospital. During the 2010-2013 fiscal years, the Grossmont HD reports an average overall occupancy rate for its licensed acute-care beds as 61.6%; however, the district reports that its available beds have an average occupancy rate of 67.5% during the same time period. Grossmont Hospital patient ratings and inpatient quality indicators reflect that health care services are being adequately provided within the Grossmont HD service area and sphere.

Potential Social or Economic Communities of Interest

The *2015 Health Care Services MSR and Sphere Review* determinations are required to identify any *social or economic communities of interest* existing in the review area, if LAFCO determines that they are relevant to the subject agency. The Commission has not determined that *social or economic communities of interest* of relevance to the Grossmont HD exist in the local area; however, territory adjacent to the Grossmont HD service area and sphere which has been designated by OSHPD as a *Medically Underserved Are*a or a *Health Care Professional Shortage Area*, and local areas identified with poverty levels above the regional average of *14.4%*, should each be considered by the Commission for potential determination as relevant *social or economic communities of interest* to Health Care Districts.

Disadvantaged Unincorporated Communities: For an update of a sphere of influence of a city or special district that provides public facilities or services related to sewers, municipal and industrial water, or structural fire protection, that occurs pursuant to subdivision (g) on

or after July 1, 2012, the present and probable need for those public facilities and services of any disadvantaged unincorporated communities within the existing sphere of influence.

The Grossmont HD is a special district authorized to provide health care services and does not provide public facilities or services related to sewers, municipal/industrial water, or structural fire protection; therefore, the determination does not apply to the Grossmont HD sphere review and update.

Sphere of Influence Recommendations

The Grossmont HD and its operational relationship with Sharp HealthCare for the Grossmont Hospital successfully demonstrates that a public Health Care District can effectively and efficiently provide acute-care hospital services in a competitive modern health care market. The local electorate has repeatedly shown its support for the Grossmont HD and the Grossmont Hospital by approving local bond measures for needed capital facility improvements and by approving and extending the leasing and operational agreement between the Grossmont HD and Sharp HealthCare. Therefore, the Grossmont HD sphere of influence is recommended to be affirmed as coterminous with the HD's service area. The potential designation of local *social or economic communities of interest* and Special Study Areas is also recommended as identified below.

Potential Social or Economic Communities of Interest

The *2015 Health Care Services MSR and Sphere Review* determinations are required to identify any *social or economic communities of interest* existing in the review area, if LAFCO determines that they are relevant to the subject agency. The Commission is recommended to consider local areas designated by OSHPD as *Medically Underserved Areas* and/or *Health Care Professional Shortage Areas*, and local areas identified with poverty levels above the regional average of *14.4%*, as containing *social or economic communities of interest* relevant to the Grossmont HD.

Proposed San Diego County Special Study Areas

As OSHPD-designated *Medically Underserved Areas* and/or *Health Care Professional Shortage Areas*, and local areas identified with high poverty levels areas each exist in both urban coastal incorporated territory and rural unincorporated desert and mountain communities of San Diego County, the *2015 Health Care Services MSR and Sphere Review* determinations recommend Commission consideration of *Special Study Area* designations for 4 major areas of the County that contain inhabited territory not currently located within any of the local Health Care District service areas and spheres, and which contain *social or economic communities of interest* relevant to the local Health Care Districts (Map 1L).

Potential Grossmont HD Special Study Areas

Two of the four proposed *Special Study Areas* for San Diego County are adjacent to the Grossmont HD service area and sphere (Maps 1L and 3I). The proposed *Special Study Areas* are related to the Grossmont HD service area and sphere as follows:

Special Study Area No. 3: Western San Diego County Incorporated Areas

The proposed *Special Study Area No. 3* includes urban territory comprised of the coastal incorporated cities from Encinitas south to Imperial Beach, as well as the adjacent unincorporated urban communities of Rancho Santa Fe, Bonita, and Otay Mesa. These areas are not presently located within any of the local Health Care Districts service areas or spheres, and have been identified as containing designated *Medically Underserved Areas*, *Health Care Professional Shortage Areas*, and/or areas of high poverty. The Grossmont HD service area and sphere is contiguous to the southern portion of *Special Study Area No. 3*.

While State Law allows for both incorporated and unincorporated territory to be served by Health Care Districts and included within their service areas, Health and Safety Code Section 32001 prohibits the division of incorporated territory within a Health Care District unless LAFCO determines that the area would not be benefitted by inclusion. Small portions of City of San Diego incorporated territory are located within the Grossmont HD and Palomar Health HD service areas and spheres; however, the majority of the City of San Diego is not currently located within a Health Care District service area and sphere.

Accordingly, the adjacent Health Care Districts should discuss and collaboratively evaluate the City of San Diego to determine if inclusion within either or both of the Districts' service areas and spheres would benefit the local area.

Special Study Area 4: Eastern San Diego County Unincorporated Areas

The proposed Special Study Area No. 4 includes rural and frontier territory comprised of the mountain and desert unincorporated areas of eastern San Diego County, from the Riverside County to the north to the US/Mexico International Border to the south. These unincorporated areas are not presently located within any of the local Health Care Districts' service areas or spheres, and have been identified as containing designated *Medically Underserved Areas*, *Health Care Professional Shortage Areas*, and/or areas of high poverty. The Grossmont HD service area and sphere is contiguous to the southern portion of *Special Study Area No. 4*. Subsequent Grossmont HD service and sphere reviews should evaluate the *Special Study Area No. 4* for resolution of the study area designation and potential sphere inclusion.

Grossmont HD Sphere of Influence Recommendation

The *2015 Health Care Services MSR and Sphere Review* determinations demonstrate that the Grossmont HD is adequately providing its authorized services within its service area and adopted sphere of influence; therefore, the Grossmont HD sphere is recommended to be affirmed as coterminous with the Grossmont HD's service area. Additional Commission discussion and consideration of designations of *social or economic communities of interest*, and *Special Study Areas* is also recommended.

PALOMAR HEALTH CARE DISTRICT (MSR13-77; SR13-77; SR13-77)

District Overview: Formation, Governance, Hospital Facilities

District Background

The Palomar Health Care District (HD) provides hospital-based health services within an approximate 844-square mile service area and *coterminous* sphere of influence in north inland San Diego County. Palomar Health HD owns and independently operates three licensed acute-care hospitals: the 294-bed Palomar Health Downtown Campus in Escondido; the 107-bed Pomerado Hospital in Poway; and the 288-bed Palomar Medical Center that opened in August 2012 in western Escondido (Map 4A).

District Formation

The Palomar Health HD was originally formed by local voters in 1948 as the Northern San Diego County Hospital District. Palomar Memorial Hospital was constructed and opened in Escondido in 1950 with 37 licensed beds. The hospital was expanded to 294-beds in 1970 with construction of the McLeod Tower. The Palomar Memorial Hospital was designated as a regional trauma center in 1987 and was renamed in 2012 as the Palomar Health Downtown Campus.

In 1977, the Health Care District constructed a second acute-care hospital facility, the 107-bed Pomerado Hospital, in Poway. The Northern San Diego County Hospital District changed its name to the Palomar Pomerado Hospital District in 1984, and became a Health Care District in 1994, when Health and Safety Codes were amended to change the *Local Hospital District Law* (Health and Safety Code § 32000 et seq.) to the *Local Health Care District Law.*

In November 2004, Palomar Health HD voters approved a $496 million bond measure to fund construction of a new hospital in Escondido. In 2012, the Palomar Health HD's third acute-acre hospital, the 288-bed Palomar Medical Center, opened in western Escondido, and the district was renamed to its current form, the Palomar Health Care District (HD).

Governance

The Palomar Health HD is governed by a seven-member Board of Directors that is elected at-large by local voters and serve four-year terms. Regular Board meetings occur monthly at 6:30 p.m. on the 2nd Monday.

Palomar Health HD hospital operations are administered by the Palomar Health HD Board of Directors and are overseen by an Executive Management Team, including a President/Chief Executive Officer that is recruited, employed, and evaluated by the Board of Directors.

Palomar Health HD Hospital Facilities

- Palomar Health Downtown Campus
  The 294-bed Palomar Health Downtown Campus (OSHPD ID No. 106370755) is located at 555 E. Valley Parkway, Escondido, and has been licensed as a General Acute Care Hospital since August 2, 1950 (License No. 080000083). The Palomar Health Downtown Campus is designated as a Level II Trauma Center for the San Diego Region.
- Pomerado Hospital
  The 107-bed Pomerado Hospital (OSHPD ID No. 106370977) is located at 15615 Pomerado Road, Poway, and has been licensed as a General Acute Care Hospital since June 6, 1977 (License No. 080000127). The Pomerado Hospital's 236 total licensed beds include 129 skilled nursing care beds at the adjacent Villa Pomerado Convalescent Care Center.
- Palomar Medical Center
  The 288-bed Palomar Medical Center (OSHPD ID No. 106374382) is located at 2185 W. Citracado Parkway, Escondido, and has been licensed as a General Acute Care Hospital since November 21, 2012 (License No. 080000005).

Additional Palomar Health HD Facilities

Palomar Health HD facilities also include Palomar Health at San Marcos, which provides rehabilitation services, a wound care center, a diabetes health center, and corporate health services; and the Palomar Health Expresscare Clinics, which are located within select grocery/pharmacy stores in San Diego County.

District Service Area & Sphere of Influence

Service Area

The Palomar Health HD authorized service area covers approximately 844.0-square miles within northern San Diego County and constitutes the largest hospital district in California. The Palomar Health HD service area includes the Cities of Poway and Escondido and portions of incorporated territory of the adjacent Cities of San Diego, San Marcos, and Vista. Approximately three-fourths of the Palomar Health HD service area is unincorporated territory governed by the County of San Diego, including the unincorporated communities of Harmony Grove/Elfin Forest, Eden Valley, Rainbow, Pala/Pauma Valley, Julian, Ramona, Pine Valley, Palomar Mountain, Twin Oaks, and Valley Center.

The Palomar Health HD is bordered by Riverside County to the north; unincorporated mountain and desert territory to the east; the Cities of San Diego, Santee and El Cajon to the south; and the coastal Cities of Oceanside, Vista, Carlsbad, Encinitas, Solana Beach, Del Mar, and San Diego, and the unincorporated communities of Fallbrook, Rainbow, and Rancho Santa Fe on the west.

The Palomar Health HD service area and sphere is also bordered to the west by the Fallbrook HD and the Tri-City HD; and to the south by the Grossmont HD.

Sphere of Influence

On June 2, 1986, San Diego LAFCO adopted a sphere of influence for the Palomar Health HD that was coterminous with the HD's service area. There have been no annexations or detachments to the Palomar Health HD service area nor any changes to the sphere since it was originally established. The Palomar Health HD's adopted sphere was most recently reviewed and affirmed by the Commission on August 6, 2007 as coterminous with the service area.

Land Uses

Land uses within the Palomar Health HD service area and sphere, including agricultural and open space uses, are governed by the adopted General Plans and land use designations of the cities of Cities of Carlsbad, Escondido, Poway, San Diego, San Marcos, and Vista for the territory within their respective incorporated boundaries; and by the County of San Diego General Plan for the unincorporated territory located within the communities of Harmony Grove/Elfin Forest, Eden Valley, Rainbow, Pala/Pauma Valley, Julian, Ramona, Pine Valley, Palomar Mountain, Twin Oaks, and Valley Center.

Location & Characteristics of Disadvantaged Unincorporated Communities

When conducting a municipal service review, recent Legislative changes require LAFCO to identify the location and characteristics of existing *disadvantaged unincorporated communities* that are within or contiguous to a public agency's sphere of influence. A *disadvantaged unincorporated community* is defined as an inhabited, unincorporated area in which the median household income is 80% or less of the statewide median household income (Map 1C).

As of 2012, the Palomar Health HD has seven disadvantaged unincorporated communities existing within or contiguous to its sphere of influence. The identified disadvantaged unincorporated communities are located in the Hidden Meadows, Harmony Grove/Elfin Forest, Lake Hodges, East Escondido, and San Pasqual areas, and are governed by the General Plan of the County of San Diego and the community plans for the Community Planning Areas of North County Metro (Hidden Meadows, East Escondido); San Dieguito (Harmony Grove/Elfin Forest, Lake Hodges); and Ramona (San Pasqual).

Service Area Population

The San Diego Association of Governments (SANDAG) is the designated regional clearinghouse for the US Census Bureau and provides current population estimates and future population projections for the San Diego Region. LAFCO annually receives SANDAG population estimates for all local independent and dependent special districts in San Diego County. The special district population estimates are based on the subject agency's geographic service area and are calculated using SANDAG's demographic modeling programs.

Following the 2010 Census, the SANDAG demographic modeling programs were updated from 2000 Census baselines and recalibrated with new 2010 Census data, which resulted in a -2.4% readjustment to the calculated Grossmont HD population estimate for 2011. As of 2014, SANDAG estimates a total population of 510,041 within the Palomar Health HD service area and coterminous sphere of influence.

2008-2014 Palomar Health HD Population Totals (SANDAG Estimates)

Year	Total Population
2008	500,126
2009	498,360
2010	505,551 (Based on Census 2000 estimates)
2011	493,840 (Based on Census 2010 estimates)
2012	503,064
2013	504,051
2014	510,041

According to 2008-2014 SANDAG population estimates, the Palomar Health HD service area has generally maintained a consistent population of 500,000 and experienced an approximate growth rate of +2.0%; therefore, significant population growth is not anticipated over the next 5 years.

2020-2050 Service Area Population Projection

The Palomar Health HD service area and sphere are included within defined geographic units of San Diego County called Subregional Areas (SRA) that are used by SANDAG for local population estates and projections. The Palomar Health HD service area includes all or portions of 15 of the 41 SRAs covering San Diego County.

The majority of the Palomar Health HD service area territory is located in 9 of the 15 SRAs, including Escondido (SRA 50), San Marcos (51), Vista (52), Valley Center (53), Poway (15), North San Diego (14), and Ramona (39). SRAs 41 (Carlsbad) and 52 (Vista) are also partially located within the Palomar Health HD service area and sphere; SRA 55 (Fallbrook) is also located within the Fallbrook HD service area and sphere.

The total population for the nine primary Palomar Health HD Subregional Areas is estimated as 633,125 (2013). According to 2050 SANDAG Regional Growth Forecast Population Estimates (2011), the population within the Palomar Health HD primary Subregional Areas is projected to grow to a total of 838,139, or 32.4% from 2013-2050.

The 2050 projected populations indicate that the highest rates of growth will occur in rural, unincorporated communities, especially the Fallbrook, Vista, Pauma, Valley Center, Palomar-Julian, and Ramona Subregional areas.

The following table shows the 2020-2050 projected populations for the 9 primary Subregional Areas, and the six Subregional Areas partially within the Palomar Health HD service area and sphere:

Projected 2020-2050 Subregional Area Population Totals – Growth Rate

Palomar HD - Primary SRAs

SRAs –	2020	2030	2040	2050	2013-2050
14 North San Diego	119,931	122,609	126,486	130,143	+16.7%
15 Poway	94,588	99,175	101,530	103,554	+18.2%
39 Ramona	38,692	44,137	47,531	50,093	+39.9%
50 Escondido,	179,109	197,215	207,407	213,153	+28.6%
51 San Marcos,	97,783	107,658	111,658	112,018	+22.1%
52 Vista	110,989	123,081	146,468	162,866	+58.7%*
53 Valley Center	24,887	32,521	40,211	43,679	+84.8%
54 Pauma	6,314	8,082	10,981	12,785	+62.8%
60 Palomar-Julian	7,450	8,405	9,313	9,848	+50.4%
Total	679,743	742,883	801,585	838,139	+32.4%

Palomar Health HD - Partial/Adjacent SRAs

SRAs	2020	2030	2040	2050	2013-2050
13 Del Mar, Mira Mesa	191,481	216,013	224,669	231,328	+43.8%
36 Lakeside	61,556	68,022	72,371	73,236	+28.1%
40 San Dieguito	102,437	109,706	114,007	117,193	+22.0%
41 Carlsbad	132,755	138,896	142,881	144,721	+22.6%*
55 Fallbrook	51,805	61,001	68,461	72,681	+50.3%*
61 Pine Valley	6,077	6,921	7,304	7,718	+37.1%
Total	546,111	600,559	629,693	646,877	+33.1%

2013-2030 Elderly Population Projections

Following the assessment of 2010 Census data, national and state population projections have indicated that the older population segments (65-85+ years) will grow from approximately 10-12% of the current total population to over 20% by 2030. Census data also reflect that older population segments generally live with high poverty levels and are reliant on fixed incomes. The projected doubling of older residents in the next 10-15 years is anticipated to create significant demands for local facilities, services, and resources to meet expected health care demands in underserved and high poverty areas (Map 4B).

The following table shows the projected 65-85+ populations over 2013-2030 for the primary and partial Subregional Areas within the Palomar Health HD service area and sphere:

Projected 2013-2030 Subregional Area 65-85+ Population Totals – Growth Rate

Palomar HD - Primary SRAs

SRAs	2013	2020	2030	2013-2030
14 North San Diego	14,568	20,322	26,388	+81.1%
15 Poway	12,426	15,372	20,510	+65.1%
39 Ramona	4,610	5,750	8,432	+82.9%
50 Escondido	18,772	22,965	30,180	+60.8%
51 San Marcos	12,426	16,234	21,801	+75.4%
52 Vista	10,896	13,481	18,489	+69.7%
53 Valley Center	4,408	6,415	10,619	+140.9%
54 Pauma	877	901	1,513	+72.5%
60 Palomar-Julian	1,784	2,142	3,055	+71.2%
Total	80,767	103,582	140,987	+74.6%
% of total pop.	12.8%	15.2%	19.0%	

Projected 2013-2030 Subregional Area 65-85+ Population Totals – Growth Rate

Palomar Health HD - Partial/Adjacent SRAs

SRAs –	2013	2020	2030	2013-2030
13 Del Mar, Mira Mesa	16,300	24,482	35,375	+117.0%
36 Lakeside	7,195	9,694	13,648	+89.7%
40 San Dieguito	15,348	18,187	25,115	+63.6%
41 Carlsbad	19,824	28,746	38,651	+95.0%
55-Fallbrook	9,054	10,191	14,607	+61.3%
61 Pine Valley	1,016	1,304	1,902	+87.2%
Total	68,737	92,604	129,298	+88.1%
% of total pop.	14.3%	17.0%	21.5%	

The SANDAG 2050 Regional Forecast indicates that the older population in the Palomar Health HD service area is anticipated to grow significantly from 2013-2030 in comparison to the overall population (75% to 23%).

The current (2013) SANDAG population estimates for the nine primary Palomar Health HD Subregional Areas (SRA) indicate a total 65-85+ age range population of 80,767, which is approximately 13% of the total population of 633,125. The SANDAG 2050 Regional Forecast estimates (2011) project that Palomar's total population in the 65-85+ years age range will grow to 19% by 2030.

The highest rates of growth in the 65-85+ populations are projected to occur in rural, unincorporated communities, especially the Pauma, Valley Center, Palomar-Julian, Ramona, and Vista Subregional Areas. SRAs 41 (Carlsbad) and 52 (Vista) are also partially located within the Palomar Health HD service area and sphere; SRA 55 (Fallbrook) is also located within the Fallbrook HD service area and sphere; SRA 61 is partially located within Grossmont HD.

Palomar Health HD Medical Service Study Areas (MSSAs)

The California Office of Statewide Health Planning and Development (OSHPD) produces maps for each county in the state that designate geographic Medical Service Study Areas (MSSAs) based on local 2010 Census Tract boundaries. OSHPD's Health Care Workforce Development Division (HWDD) reviews the Medical Service Study Areas to assess local population density, provider-to-population ratios, poverty levels, and public health indicators. OSHPD defines Medical Service Study Areas as *Frontier, Rural, or Urban*, based on local population density per square mile.

A *Frontier* MSSA has a population density less than 11 persons per square mile (sq. mi.); a *Rural* MSSA is one with a population density greater than 11 per sq. mi. and less than 250 persons per sq. mi.; and, an *Urban* MSSA, which are all MSSAs with a population density higher than 250 persons per sq. mi. (Map 1B). The Palomar Health HD service area and sphere includes all or portions of 14 of the 38 Medical Service Study Areas (MSSA) covering San Diego County.

The Palomar Downtown Campus Hospital and Palomar Medical Center are located in MSSAs 156e and 156f (Escondido); the Pomerado Hospital is located in MSSA 161q (Poway), each of which is designated as Urban. The following table identifies the Palomar Health HD MSSAs and provides a comparison of their population density, poverty rate, and associated communities:

Palomar Health HD Primary Medical Service Study Areas

MSSA	Type	Pop. Den. (sq.ml.).	Poverty rate	Communities
153.1	Rural	66.0	10.5%	Pala, Pauma Valley
153.2	Rural	185.8	5.8%	Valley Center, Rincon, San Pasqual
158.1	Rural	234.2	9.9%	Ramona
156d	Urban	2,335.0	13.2%	San Marcos/Vista
156e	Urban	5,153.4	17.1%	Escondido/San Marcos
156f	Urban	737.7	6.9%	Escondido/Poway
158.2	Urban	323.8	4.1%	San Diego Country Estates

Palomar Health HD Partial/Adjacent Medical Service Study Areas

MSSA	Type	Pop. Den. (sq.ml.).	Poverty rate	Communities
152	Frontier	7.2	10.3%	Palomar, Pine Valley, Borrego
154	Rural	48.7	6.1%	Barona, Moreno
160	Rural	249.1	9.6%	Fallbrook, Bonsall, Camp Pendleton
156c	Urban	1,872.8	7.1%	Rancho Santa Fe/San Marcos
161p	Urban	2,200.5	5.1%	Escondido/Poway/Rancho Bernardo
161q	Urban	1,818.8	4.3%	Carmel Valley, Rancho Bernardo
161v	Urban	3,933.0	5.9%	Mira Mesa/Scripps Miramar Ranch

Medically Underserved Areas/Health Care Professional Shortage Areas

OSHPD produces county maps which identify local Medical Service Study Areas that qualify for designation as a *Medically Underserved Area* (MUA) and/or a *Primary Care Shortage Area* (PCSA). The Federal Agency for Health Care Research and Quality (AHRQ) also designates MSSAs with a shortage of professional health care providers as a *Health Professional Shortage Area* (HPSA) for the *Primary Care, Dental Health, and Mental Health* disciplines. (Maps 4D-4F)

Health Care Professional Shortage Areas and *Primary Care Shortage Areas* are designated where there are local population-to-physician ratios that demonstrate a high need for services combined with a general lack of access to health care in surrounding areas because of excessive distance, overutilization, or access barriers.

The designated MSSA maps can be used to identify areas of potential concern for Health Care Districts when addressing future health care needs and demands and sufficiently planning for needed local infrastructure and services. The following tables identify the OSHPD designations for the MSSAs within the Palomar Health HD service area and sphere:

Medically Underserved Areas / Health Care Professional Shortage Areas

Palomar Health HD Primary Medical Service Study Areas

MSSA	Type	Communities	MUA/HPSA
153.1	Rural	Pala, Pauma Valley	MUA, HPSA-PC, PCSA, RNSA
153.2	Rural	Valley Center, Rincon, San Pasqual	MUA, RNSA
158.1	Rural	Ramona	MUA, RNSA
156d	Urban	San Marcos/Vista	MUA, RNSA
156e	Urban	Escondido/San Marcos	MUA, RNSA
156f	Urban	Escondido/Poway	MUA, PCSA, RNSA
158.2	Urban	San Diego Country Estates	MUA, HPSA-PC, PCSA, RNSA

Palomar Health HD Partial/Adjacent Medical Service Study Areas

MSSA	Type	Communities	MUA/HPSA
152	Frontier	Palomar, Pine Valley, Borrego	MUA, PCSA, RNSA (County-wide)
154	Rural	Barona, Moreno	MUA, HPSA-PC, PCSA, RNSA
160	Rural	Fallbrook, Bonsall, Camp Pendleton	MUA, RNSA
156c	Urban	Rancho Santa Fe/San Marcos	MUA, RNSA
161p	Urban	Carmel Valley, Rancho Bernardo	RNSA
161q	Urban	Poway/Rancho Bernardo	RNSA
161v	Urban	Mira Mesa/Scripps Miramar Ranch	RNSA

Potential Social or Economic Communities of Interest

The *2015 Health Care Services MSR and Sphere Review* determinations are required to identify any *social or economic communities of interest* existing in the review area, if LAFCO determines that they are relevant to the subject agency.

The Commission is recommended to consider local areas designated by OSHPD as *Medically Underserved Areas* and/or *Health Care Professional Shortage Areas*, and local areas identified with poverty levels above the regional average of *14.4%*, as containing *social or economic communities of interest* relevant to the local Health Care Districts.

Proposed San Diego County Special Study Areas

OSHPD-designated *Medically Underserved Areas, Health Care Professional Shortage Areas*, and local areas identified with high poverty levels areas all presently exist in both urban coastal incorporated territory and rural unincorporated desert and mountain communities of San Diego County.

The *2015 San Diego County Health Care Services MSR and Sphere Review* determinations recommend Commission consideration of *Special Study Area* designations for the following 4 major areas of the County that contain inhabited territory not currently located within any of the local Health Care District service areas and spheres, and which contain *social or economic communities of interest* relevant to the local Health Care Districts (Map 1L).

Potential Palomar Health HD Special Study Areas

The four proposed *Special Study Areas* for San Diego County are each adjacent to the Palomar Health HD service area and sphere (Map 1L). The proposed *Special Study Areas* are related to the Palomar Health HD service area and sphere as follows:

Special Study Area No. 1: Fallbrook HD/Camp Pendleton

The proposed *Special Study Area No. 1* territory includes inhabited urban and rural areas of the northwest corner of San Diego County, including Camp Pendleton and the unincorporated De Luz community, and portions of the Tri-City HD and Fallbrook HD service areas and spheres that overlap the Camp Pendleton boundary (Map 4G).

The Palomar Medical Center in west Escondido is one of closest acute-care hospitals to the recently closed Fallbrook Hospital and the Fallbrook HD's service area. The Fallbrook HD and the Palomar Health HD have adopted a Joint Powers Agreement (JPA) to identify potential health care service providers for the Fallbrook HD's service area and sphere and HD to assist the Fallbrook HD in the continued provision of health care services in the Fallbrook community.

The proposed *Special Study Area No. 1* and the Fallbrook HD service area should be further evaluated by the Palomar Health HD to determine if inclusion within the district's service area would promote the efficient delivery of health care services to the subject territory.

Special Study Area No. 2: Shadowridge

The Shadowridge area consists of approximately 2,500-acres that is primarily located with the City of Vista's incorporated territory. The Shadowridge area constitutes an island of territory that is not presently located within a Health Care District service area, but is surrounded by both the Palomar Health HD and the Tri-City HD service areas and spheres. Both of the surrounding Health Care Districts have previously explored the potential annexation of the Shadowridge area; however, no annexation proposal has been submitted from either district for LAFCO consideration.

While State Law allows for both incorporated and unincorporated territory to be served by Health Care Districts and included within their service areas, Health and Safety Code Section 32001 prohibits the division of incorporated territory within a Health Care District unless LAFCO determines that the area would not be benefitted by inclusion.

As the majority of the City of Vista is currently located within the Tri-City HD service area and sphere, the Shadowridge area should accordingly be consolidated within Tri-City HD; however, the adjacent Health Care Districts should discuss and collaboratively evaluate the Shadowridge area to determine if inclusion within either Health Care District would benefit the local area.

Special Study Area No. 3: Western San Diego County Incorporated Areas

The proposed *Special Study Area No. 3* includes urban territory comprised of the coastal incorporated cities from Encinitas south to Imperial Beach, as well as the adjacent unincorporated urban communities of Rancho Santa Fe, Bonita, and Otay Mesa. These areas are not presently located within any of the local Health Care Districts' service areas or spheres, and have been identified as containing designated *Medically Underserved Areas*, *Health Care Professional Shortage Areas*, and/or areas of high poverty. The Palomar Health HD service area and sphere is contiguous to *Special Study Area No. 3*.

Small portions of City of San Diego incorporated territory are located within the Palomar Health HD and Grossmont HD service areas and spheres; however, the majority of the City of San Diego is not currently located within a Health Care District service area and sphere. Accordingly, the adjacent Health Care Districts should discuss and collaboratively evaluate the City of San Diego to determine if inclusion within either or both of the Districts' service areas and spheres would benefit the local area.

Special Study Area 4: Eastern San Diego County Unincorporated Areas

The proposed *Special Study Area No. 4* includes rural and frontier territory comprised of the mountain and desert unincorporated areas of eastern San Diego County, from the Riverside County to the north to the US/Mexico International Border to the south. These unincorporated areas are not presently located within any of the local Health Care Districts service areas or spheres, and have been identified as containing designated *Medically Underserved Areas*, *Health Care Professional Shortage Areas*, and/or areas of high poverty.

The Palomar Health HD service area and sphere is contiguous to *Special Study Area No. 4*. The district should each evaluate the adjacent communities within the proposed *Special Study Area* to determine if inclusion within the Health Care District's service area and sphere would benefit the local area.

Health Care Facilities & Services

The California Office of Statewide Health Planning and Development (OSHPD) provides licensing, facility, and services information for each licensed acute-care hospital through its Automated Licensing Information and Report Tracking System (ALIRTS). The Palomar Health HD owns and operates three licensed acute-care hospital facilities within its service area and sphere: the Palomar Health Downtown Campus in central Escondido; the Pomerado Hospital in Poway; and the Palomar Medical Center in western Escondido.

Palomar Health Downtown Campus

The 294-bed Palomar Health Downtown Campus (OSHPD ID No. 106370755) is located at 555 E. Valley Parkway, Escondido, and has been licensed as a General Acute Care Hospital since August 2, 1950 (License No. 080000083).

The Palomar Health Downtown Campus is designated as a Level II Trauma Center, which is one of six regional trauma centers that serve all of San Diego County.

OSHPD facility detail information reports a total of 294 licensed beds, with 42 for perinatal care, 21 for intensive care, 14 for coronary care, 18 for rehabilitation center care, 25 for acute psychiatric care, and 174 for general acute care.

OSHPD reports the following licensed medical services are provided at the Palomar Health Downtown Campus: Basic Emergency Room, Nuclear Medicine, Occupational Therapy, Physical Therapy, Radiation Therapy, Respiratory Care Services, Social Services, Speech Pathology, Mobile Unit – Prostatron, Cardiac Catheterization Laboratory, Mobile Unit – MRI, Mobile Unit - CAT Scan, Speech Pathology

The 2013-2014 OSHPD hospital summary individual disclosure report states that the Palomar Health Downtown Campus had a total of 2,071 full time employees, as well as 935 full time nursing employees, and 47 full time nursing registry employees. The Active Medical Staff Profile (MD's, DO's, and Podiatrists) for the Palomar Health Downtown Campus reports a total hospital based staff of 141, and a total non-hospital based staff of 709.

Pomerado Hospital

The 107-bed Pomerado Hospital (OSHPD ID No. 106370977) is located at 15615 Pomerado Road, Poway, and has been licensed as a General Acute Care Hospital since June 6, 1977 (License No. 080000127). OSHPD facility detail information reports a total of 236 licensed beds, with 68 for general acute care, 12 for intensive care, 4 for intensive care-newborn nursery, 11 for perinatal care, 12 for acute psychiatric care, and 129 for skilled nursing care at the adjacent Villa Pomerado Convalescent Care Center.

OSHPD reports the following licensed medical services are provided at the Pomerado Hospital: Basic Emergency Room, Audiology, Nuclear Medicine, Respiratory Care Services, Social Services, Mobile Unit – MRI.

The 2013-2014 OSHPD hospital summary individual disclosure report states that the Pomerado Hospital had a total of 716 full time employees, as well as 354 full time nursing employees, and 9 full time nursing registry employees. The Active Medical Staff Profile (MD's, DO's, and Podiatrists) for the Pomerado Hospital reports a total hospital based medical staff of 129, and a total non-hospital based medical staff of 140.

Palomar Medical Center

The 288-bed Palomar Medical Center (OSHPD ID No. 106374382) is located at 2185 W. Citracado Parkway, Escondido, and has been licensed as a General Acute Care Hospital since November 21, 2012 (License No. 080000083). OSHPD facility detail information reports the Palomar Medical Center has a total of 288 licensed beds, with 24 for Coronary Care, 24 for Intensive Care, and 240 for Unspecified General Acute Care.

OSHPD reports the following medical services are licensed to be provided at the Palomar Medical Center: Cardiovascular Surgery, Nuclear Medicine, Occupational Therapy, Physical Therapy, Podiatric Services, Radiation Therapy, Respiratory Care Services, Social Services, and Speech Pathology. As the Palomar Medical Center recently opened in August 2012, there is a limited amount of available OSHPD reported data on the facility's annual performed services and finances.

Hospital Facility Capacity and Utilization

The OSHPD Healthcare Information Division (HID) uses submitted financial and operational data for each licensed acute-care hospital to produce an *Annual Financial Disclosure Report* that includes detailed information regarding the hospital's operations, and *Hospital Facility Summary Reports* for the hospital's provision of *Inpatient Services, Emergency Department Services, and Ambulatory Surgery*.

The OSHPD Healthcare Information Division (HID) has not yet posted *Facility Summary Reports* or *Annual Financial Disclosure Reports* for the Palomar Medical Center. The OSHPD *Annual Utilization Report* is used below to evaluate the utilization of the Palomar Medical Center for inpatient services, emergency department services and ambulatory surgery during 2012, 2013, and 2014; however, the report does not provide an equivalent level of demographic detail as the *Facility Summary Reports* for the Palomar Health Downtown Campus and the Pomerado Hospital.

Licensed Bed Occupancy Rates

During 2013-2014, the Palomar Health HD reports an average overall occupancy rate for its licensed acute-care beds at the Palomar Health Downtown Campus and the Pomerado Hospital as 69.8%. Over 2010-2014, the Palomar Health HD reports an average overall occupancy rate for its licensed acute-care beds as 74.3%.

Palomar Health Downtown Campus

Occupancy Rate	2010-2011	2011-2012	2012-2013	2013-2014
Licensed beds (total)	69.5% (426)	71.3% (414)	76.0% (414)	59.8% (431)
Available Beds	69.5% (426)	71.3% (414)	76.0% (414)	59.8% (431)

Pomerado Hospital

Occupancy Rate	2010-2011	2011-2012	2012-2013	2013-2014
Licensed beds (total)	81.4% (236)	78.4% (236)	78.3% (236)	79.8% (236)
Available Beds (236)	81.4% (236)	78.4% (236)	78.3% (236)	79.8% (236)

Palomar Medical Center - Inpatient Discharges 2012-2014

Year	Discharges	Patient Days	Occupancy Rate
2012	15,574	57,781	(partial year)
2013	16,933	70,308	66.9%
2014	18,180	74,266	70.6%

The 2014 OSHPD Annual Utilization Report for Palomar Medical Center states a total of 105,120 bed days for the facility's 288 licensed beds, which indicates a 70.6% occupancy rate for the year.

Total Live Births

During 2013-2014, the Palomar Health HD reports a combined total of 4,525 live births at the Downtown Campus and Pomerado Hospital, with 3,046 natural births and 1,479 caesarian sections.

Reported Palomar Health HD data for 2010-2014 reflects an combined average of approximately 4,600 annual live births, with consistent ratios of natural births to caesarian sections. The OSHPD Annual Utilization Reports for the Palomar Medical Center state that no live births occurred at the facility during 2012-2014.

Palomar Health Downtown Campus	**2010-2011**	**2011-2012**	**2012-2013**	**2013-2014**
Live Births	3,599	3,548	3,361	3,141
Natural births	2,533	2,407	2,263	2,072
Caesarian section	1,066	1,141	1,098	1,069
Pomerado Hospital	**2010-2011**	**2011-2012**	**2012-2013**	**2013-2014**
Live Births	1,142	1,178	1,189	1,384
Natural births	756	797	800	974
Caesarian section	386	381	389	410

Inpatient Discharges

Palomar Health Downtown Campus

The OSHPD *Facility Summary Report* for 2014 states that Palomar Health Downtown Campus had a total of 13,287 inpatient discharges, with 92.6% for Acute Care (12,307); 5.7% for Psychiatric Care (757); and 1.7% for Physical Rehabilitation Care. Total number of inpatient discharge days for 2014 were reported as 50,697, with an average length of stay at 3.8 days.

Palomar Health Downtown Campus - Inpatient Discharges 2007-2014

Year	Discharges	Days	Ave. Stay
2007	26,374	114,247	4.3 days
2008	25,795	116,053	4.5 days
2009	24,471	112,346	4.6 days
2010	24,369	114,413	4.7 days
2011	23,651	109,180	4.6 days
2012	23,631	122,049	5.2 days
2013	25,821	166,090	6.4 days
2014	13,287	50,697	3.8 days

From 2007-2014, Palomar Health Downtown Campus total inpatient discharges averaged approximately 25,000 per year; however, from 2013-2014, total inpatient discharges have decreased by approximately 51%.

Demographics for Palomar Health Downtown Campus inpatient discharges for 2014 were reported as 55.9% female and 44.1% male. This female/male patient ratio is generally consistent with 2007-2014 reported data. In 2014, Palomar Health Downtown Campus patients between 0-19 totaled 13.5% of all discharges; patients between 20-59 years totaled 41.5%; and patients from 60-80+ totaled 45.2%.

Palomar Health Downtown Campus - Inpatient Age Ranges 2007-2014:

Year	Under 1 yr.	10-19	20-39	40-59	60-80+
2007	17.6%	4.4%	23.0%	18.0%	36.9%
2008	17.3%	4.3%	23.0%	17.8%	37.6%
2009	17.4%	4.5%	22.2%	18.5%	37.4%
2010	16.5%	3.8%	22.2%	19.4%	39.3%
2011	15.1%	2.7%	22.7%	20.0%	39.3%
2012	15.0%	2.7%	22.2%	19.8%	40.3%
2013	12.4%	2.3%	21.7%	20.4%	43.3%
2014	11.6%	1.9%	20.5%	21.0%	45.2%

Highest age range frequency for Palomar Health Downtown Campus inpatient discharges in 2014 was 80+ years (16.6%); 60-69 years (15.2%); and 70-79 years (13.4%). A review of inpatient age ranges for 2007-2014 indicates a decreasing patient trend for the 0-19 year age ranges, and an increasing trend towards patients in the 60-80+ age ranges.

Pomerado Hospital

The OSHPD *Facility Summary Report* for 2013 states that Pomerado Hospital had a total of 7,730 inpatient discharges, with 89.2% for Acute Care (6,894); 7.7% for Skilled Nursing/Intermediate Care (593); and 3.1% for Psychiatric Care (243). Total number of inpatient discharge days for 2013 were reported as 69,400, with an average length of stay at 9.0 days.

Pomerado Hospital - Inpatient Discharges 2007-2013

Year	Discharges	Days	Ave. Stay
2007	8,791	65,932	7.5 days
2008	8,965	70,846	7.9 days
2009	8,300	71,288	8.6 days
2010	8,271	58,926	7.1 days
2011	8,161	62,687	7.7 days
2012	7,725	65,249	8.4 days
2013	7,730	69,400	9.0 days

The table reflects that total Pomerado Hospital inpatient discharges averaged approximately 8,275 per year from 2007-2013; however, annual total discharges have decreased by approximately 14% during that time period. Demographics for Pomerado Hospital inpatient discharges for 2013 were 62.5% female and 37.5% male. This female/male patient ratio is generally consistent with 2007-2013 reported data. In 2013, *Pomerado Hospital* patients between 20-59 years totaled 36.3% of all discharges; patients between 60-80+ totaled 47.0%; and patients from 0-19 totaled 17.3%.

Pomerado Hospital - Inpatient Age Ranges 2007-2013:

Year	Under 1 yr.	1-19	20-39	40-59	60-80+
2007	13.5%	1.6%	18.6%	17.4%	49.0%
2008	13.3%	1.5%	19.0%	16.8%	49.4%
2009	14.4%	1.5%	19.8%	17.3%	47.0%
2010	13.3%	1.2%	18.6%	16.3%	40.7%
2011	14.3%	1.1%	19.1%	16.3%	49.2%
2012	15.0%	0.8%	20.1%	15.9%	48.1%
2013	16.3%	1.0%	20.6%	15.1%	47.0%

Highest age range frequency for *Pomerado Hospital* total inpatient discharges in 2013 was 22.0% at 80+ years; 16.3% under 1 year; 14.0% at 70-79 years; and 12.6% at 70-79 years. A review of inpatient age ranges for 2007-2013 indicates a slightly increasing trend for the *Under 1 year* age range, and a slightly decreasing trend for patients in the 40-80+ age ranges. Review of Pomerado Hospital inpatient age ranges for 2007-2013 indicates a decreasing trend for the 20-80+ year patient age ranges, and an increasing trend towards patients in the Under 1 to the 20-39 year age ranges.

Palomar Medical Center

The OSHPD Annual Utilization Report for 2014 states that Palomar Medical Center had a total of 18,180 inpatient discharges, with a total of 74,266 patient days (average stay of 4.1 days). The Palomar Medical Center reports an annual total of 105,120 bed days for the 288 licensed beds, which indicates a 70.6% occupancy rate for 2014. The 2013 Annual Utilization Report states a total of 16,933 inpatient discharges, with a total of 70,308 patient days.

Palomar Medical Center - Inpatient Discharges 2012-2014

Year	Discharges	Patient Days	Occupancy Rate
2012	15,574	57,781	(partial year)
2013	16,933	70,308	66.9%
2014	18,180	74,266	70.6%

Emergency Department (ED) Services

Palomar Health Downtown Campus

As of 2014, the Palomar Health Downtown Campus is a designated Level II Trauma Center with a 24-hour Basic Emergency Department. The OSHPD *Facility Summary Report* for 2014 states that Palomar Health Downtown Campus had a total of 40,589 ED encounters. Total annual Palomar Health Downtown Campus ED encounters have averaged approximately 50,000 per year from 2007-2014.

In 2014, Palomar Health Downtown Campus ED Encounters most often resulted in routine discharges where the patient was released to home or self-care (94.6%).

Emergency Department Encounters and Dispositions 2007-2014

Year	ED Encounters	Routine Discharges (%)
2007	45,356	42,600 (93.9%)
2008	46,964	44,439 (94.6%)
2009	49,005	46,686 (95.3%)
2010	48,831	42,269 (94.8%)
2011	52,818	49,659 (94.0%)
2012	54,973	51,506 (93.7%)
2013	72,266	68,351 (94.6%)
2014	40,589	38,400 (94.6%)

Demographics for Palomar Health Downtown Campus ED Encounters in 2014 were reported as 56.1% female and 43.4% male, with top age ranges reported as 20-29 years (16.4% of all encounters); 30-39 years (13.3%); and 1-9 years (12.7%). Total 2014 ED Encounters for the 1-29 years range was 43.4%; with 36.8% from 30-59 years, and 19.9%

from 60 to 80+ years. The highest frequency of ED diagnosis type for 2014 was reported as *Symptoms*, at 24.8%; *Injuries/Poisonings/Complications*, at 22.9%; and, *Respiratory System*, at 9.2%; all other ED diagnosis types were less than 7%.

Emergency Department Ambulance Diversion Hours

The OSHPD *Annual Utilization Report* for 2014 states that Palomar Health Downtown Campus had no *Ambulance Diversion Hours* during the year when the ED was unable to receive ambulance patients and which resulted in ambulances being diverted to other hospitals. The Palomar Health HD also reported that no *Ambulance Diversion Hours* occurred at the Palomar Health Downtown Campus in 2013 and 2012.

Pomerado Hospital

As of 2014, the Pomerado Hospital has a licensed Basic Emergency Department (ER), but is not licensed as a regional Trauma Center. The OSHPD *Facility Summary Report* for 2013 states that Pomerado Hospital had a total of 24,441 ED encounters.

Pomerado Hospital ED Encounters and Dispositions 2007-2013

Year	ED Encounters	Routine Discharges (%)
2007	22,727	21,293 (93.7%)
2008	23,377	21,577 (92.3%)
2009	23,894	22,328 (93.5%)
2010	23,269	21,899 (94.1%)
2011	25,262	23,712 (93.9%)
2012	25,436	23,644 (93.0%)
2013	24,441	22,660 (92.7%)

From 2007-2013, total ED encounters have averaged approximately 24,000 per year. Pomerado Hospital ED Encounters most often result in routine discharges where the patient was released to home or self-care (92.7% in 2013). Demographics for Pomerado Hospital ED Encounters in 2013 were reported as 57.3% female and 42.7% male, with top age ranges reported as 20-29 years (14.8% of all ES encounters); 30-39 years (13.1%); 40-49 years (12.9%); 50-59 years and 80+ years (both at 11.3%).

Total 2013 Pomerado Hospital ED Encounters for the 0-29 year ranges was 36.4%; with 37.3% in the 30-59 years ranges, and 26.4% in the 60 to 80+ year ranges. The highest frequency of ED diagnosis type for 2013 was reported as *Symptoms*, at 24.7%; *Injuries/Poisonings/Complications*, at 23.9%; and, *Respiratory System*, at 8.6%; all other ED diagnosis types were less than 7%.

Emergency Department Ambulance Diversion Hours

The OSHPD Annual Utilization Report for 2014 states that Pomerado Hospital had a total of 563 *Ambulance Diversion* hours during the year when the ED was unable to receive ambulance patients, and which resulted in ambulances being diverted to other hospitals. The Palomar Health HD reported a total of 312 ambulance diversion hours occurred at the Pomerado Hospital in 2013 and 173 total ambulance diversion hours in 2012.

Palomar Medical Center

As of 2014, the Palomar Medical Center has a licensed Basic Emergency Department (ED), but is not designated as a regional Trauma Center. The Palomar Medical Center ED reports the following services are provided 24-hours: Anesthesiologist, Laboratory Services, Operating Room, Pharmacist, Physician, and Radiology Services; Psychiatric ER services are provided on-call. The OSHPD Annual Utilization Report for 2014 states that Palomar Medical Center had a total of 51,582 ED encounters, with a total of 9,376 admitted to the hospital from the ED.

Palomar Medical Center ED Traffic 2012-2014

Year	Total ED traffic	Routine Visits	Admitted to Hospital from ED
2012	67,290	58,052 (86.3%)	9,238 (13.7%)
2013	45,812	37,736 (82.4%)	8,076 (17.6%)
2014	51,582	42,206 (81.8%)	9,376 (18.2%)

Emergency Department Ambulance Diversion Hours

The OSHPD Annual Utilization Report for 2014 states that Palomar Medical Center had a total of 979 *Ambulance Diversion* hours during the year when the ED was unable to receive ambulance patients which resulted in ambulances being diverted to other hospitals. The HD reported a total of 518 ambulance diversion hours in 2013, and 848 total ambulance diversion hours in 2012.

Ambulatory Surgery Services

Palomar Health Downtown Campus

The Palomar Health HD's submitted 2013 *Facility Utilization Report* for Palomar Health Downtown Campus states that the hospital had a total of 14 operating rooms that performed a total of 2,757 surgical operations, with a total of 1,229 inpatient procedures and 1,528 outpatient procedures.

The 2014 OSHPD *Facility Summary Report* for the Palomar Health Downtown Campus reports a total of Palomar Health Downtown Campus reported a total of 3,633 Ambulatory Surgery Encounters for 2014, with the principal procedure groups as *Digestive System*, at 28.2%; *Musculoskeletal System* at 12.4%; and *Female Genital System*, at 9.1%.

A total of 3,607 (99.3%) of the 2014 Ambulatory Surgery Encounters resulted in routine patient discharges to home or self-care.

Ambulatory Surgery Encounters 2010-2014

Year	AS Encounters	Principal Surgery (%)
2007	2,887	Digestive System (36.1%)
2008	6,714	Digestive System (36.0%)
2009	6,663	Digestive System (33.8%)
2010	6,290	Digestive System (34.2%)
2011	5,569	Nervous System (23.0%)
2012	5,590	Digestive System (28.8%)
2013	6,549	Digestive System (29.0%)
2014	3,633	Digestive System (28.2%)

The table reflects that total Palomar Health Downtown Campus Ambulatory Surgery encounters averaged approximately 6,250 per year from 2008-2013; however, total encounters have decreased by approximately 56% from 2013-2014.

Demographics for 2014 Palomar Health Downtown Campus Ambulatory Surgery Encounters were reported as 59.0% female and 40.1% male. Total 2014 Ambulatory Surgery Encounters were primarily performed on older patients, with 49.6% of total surgical encounters performed on patients from 60 to 80+ years; 43.6% from 30-59 years; and only 6.8% performed on patients in the 1-29 years range. Top age range frequency was 60-69 years (21.4% of total AS encounters); 50-59 years (20.9%); 70-79 years (17.1%); and, 40-49 years (13.9%).

Pomerado Hospital

The Palomar Health HD's submitted 2014 *Facility Utilization Report* for Pomerado Hospital states that the hospital had a total of 4 operating rooms that performed a total of 3,045 surgical operations, with a total of 1,251 inpatient procedures and 1,794 outpatient procedures.

The 2013 OSHPD *Facility Summary Report* for the Pomerado Hospital reports a total of 2,640 Ambulatory Surgery Encounters, with the principal procedure groups as *Digestive System*, at 43.9%; *Musculoskeletal System* at 15.5%; and *Female Genital System*, at 9.6%. A total of 2,632 (99.7%) of the 2013 Ambulatory Surgery Encounters resulted in routine patient discharges to home or self-care.

Pomerado Hospital Ambulatory Surgery Encounters 2010-2013

Year	AS Encounters	Principal Surgery (%)
2007	3,197	Digestive System (51.7%)
2008	3,475	Digestive System (52.8%)
2009	3,591	Digestive System (49.5%)
2010	2,964	Digestive System (47.2%)
2011	3,083	Digestive System (49.0%)
2012	3,247	Digestive System (52.2%)
2013	2,640	Digestive System (43.9%)

The table reflects that total Pomerado Hospital Ambulatory Surgery encounters averaged approximately 3,200 per year from 2007-2013; however, total encounters have decreased by approximately 23% from 2012-2013. Demographics for 2013 Pomerado Hospital Ambulatory Surgery Encounters were reported as 59.2% female and 40.8% male. Total 2013 Ambulatory Surgery Encounters were primarily performed on older patients, with 44.9% of total surgical encounters performed on patients from 60 to 80+ years; 47.2% from 30-59 years; and only 8.1% performed on patients in the 1-29 years range. Top age range frequency was 50-59 years (24.3% of total AS encounters); 60-69 years (21.6%); 70-79 years (14.4%); and, 40-49 years (13.5%).

Palomar Medical Center

The 2014 OSHPD *Annual Utilization Report* for the Palomar Medical Center reports a total of 8,751 surgical operations, with a total of 5,575 inpatient services and a total of 3,176

outpatient services. The HD reports a total of 11 operating rooms, with 2 licensed for Cardiovascular Surgery Services. A total of 74 cardiovascular surgical operations were performed at the Palomar Medical Center in 2014.

Palomar Medical Center Surgical Operations 2012-2013

Year	Total	Inpatient	Outpatient	Cardiovascular
2012	2,971	1,724	1,247	0
2013	8,021	4,565	3,456	87
2014	8,751	5,575	3,176	74

Adequacy of Services

Hospital Quality Indicators

The health care services provided by hospitals are measured for quality by several public and private organizations using a variety of *quality indicators* (QIs), including patient experience ratings; inpatient mortality rates for selected medical procedures and conditions; and the volume and frequency of selected medical procedures. The QI evaluations establish annual rates for the subject hospitals that are measured against county and/or state averages.

The healthcare service quality indicators used in the *2015 San Diego County Health Care Services MSR and Sphere Review* are produced by: the California HealthCare Foundation (CHCF) through *CalQualityCare.org*, which establishes hospital ratings from patient survey responses on their experiences receiving medical services; and by the federal *Agency for Healthcare Research and Quality (AHRQ)*, which compiles OSHPD statistics on hospital performance for selected medical procedures and conditions in comparison to county and/or statewide averages.

The annual quality indicator results and hospital ratings provide a comprehensive set of data for evaluating the ongoing adequacy of services provided by the local Health Care Districts. Quality indicator category rates that are consistently lower or higher than county and state averages are noted for additional consideration within the Palomar Health HD's adequacy of services determinations.

CalQualityCare.org Hospital Ratings

The California HealthCare Foundation (CHCF), a non-profit philanthropic foundation, produces hospital quality ratings through *CalQualityCare.org* for 332 acute care hospitals in the state of California. CalQualityCare.org hospital ratings are based on patient survey responses regarding their healthcare service experiences, and provide hospital clinical care, patient safety, and patient experience indicators in relation to statewide averages to produce a Patient Experience Rating of:

- Superior, where the provider performed well above average;
- Above Average, where the provider performed better than average;
- Average, where the provider performed within the average;
- Below Average, for performance worse than average; and,
- Poor, for performance well below the average level.

CalQualityCare.org Indicators

Palomar Health Downtown Campus

For 2012-2013, CalQualityCare.org reports that the Palomar Health Downtown Campus received an overall Patient Experience Rating of ***Above Average*** and a total score of ***76%***, compared to the California state average of 68%. Hospital Readmission Rate was ***Average*** (16.0%), compared to the California state average of 15.9%.

Patient responses indicate that ***79%*** would recommend Palomar Health Downtown Campus compared to the State average of 70%. Selected 2012-2013 CalQualityCare.org indicators and ratings for Palomar Health Downtown Campus include:

Palomar Health Downtown Campus 2012-2013 CalQualityCare.org Indicators and Ratings

Indicator	Rating (Score)	State Average
Patient Experience		
Hospital Rating	***Above Average*** (76%)	68%
Hospital Readmission Rate	*Average* (16.0%)	15.9%
Patient Safety		
Surgical Care Measures	***Superior*** (98%)	97%
Unplanned Surgical Wound Reopening	*Average* (0.05%)	0.09%
Death after Serious Treatable Complication	*Average* (10.61%)	10.84%
Accidental Lung Puncture	*Average* (0.03%)	0.03%
Heart Attack		
Death Rate	*Average* (16.20%)	14.90%
Quality of Care	***Superior*** (100%)	98%
Timeliness of Care	***Above Average*** (95%)	N/A
Readmission Rate	*Average* (16.70%)	18.20%
Heart Bypass Surgery		
Death Rate	*Average* (2.86%)	2.17%
Internal Mammary Artery Usage	*Average* (100%)	97%
Postoperative Stroke	*Average* (1.80%)	1.31%
Heart Failure		
Death Rate	*Average* (10.30%)	11.20%
Quality of Care	***Superior*** (99%)	96%
Readmission Rate	*Average* (23.10%)	22.80%
Mother & Baby		
C-Section Rate	*Average* (32.20%)	27.80%
Breastfeeding Rate	*Average* (67.50%)	63.20%
Episiotomy Rate	*Average* (11.50%)	13.50%
VBAC Rate	***Above Average*** (10.50%)	8.30%
Pneumonia		
Death Rate	*Average* (12.10%)	11.70%
Quality of Care	***Superior*** (99%)	96%
Readmission Rate	*Average* (16.50%)	17.50%

Indicator	Rating (Score)	State Average
Surgeries / Other Conditions		
Acute Stroke Death Rate	*Average* (11.40%)	9.91%
Craniotomy Death Rate	***Poor*** (14.30%)	7.81%
Gastrointestinal Hemorrhage Death Rate	*Average* (2.80%)	2.31%
Hip Fracture Death Rate	*Average* (2.70%)	2.47%
Hip or Knee Surgery Readmission Rate	*Average* (4.60%)	5.20%
Hip or Knee Surgery Complication Rate	*Average* (3.30%)	3.30%
Emergency Department Care		
Time in ED before being admitted	330 minutes	338 minutes
Time in ED before being sent home	186 minutes	165 minutes
Time in ED before being seen	21 minutes	32 minutes
Patients who left ED without being seen	1%	2%

The 2012-2013 CalQualityCare.org indicators and ratings for Palomar Health Downtown Campus medical procedures are generally consistent with or exceed state average levels. The Palomar Health Downtown Campus indicator ratings include four categories rated as ***Superior*** and one category rated as ***Poor***. More significant is the overall *Patient Experience Rating* of ***Above Average*** and a total score of ***76%***, compared to the California state average of 68%.

Patient responses indicate that ***79%*** would recommend Palomar Health Downtown Campus compared to the State average of 70%, which is the highest patient-rated hospital facility of the Health Care Districts evaluated in this service and sphere review.

Pomerado Hospital

For 2012-2013, CalQualityCare.org reports that Pomerado Hospital received an overall Patient Experience Rating of ***Average*** and a total score of ***67%***, compared to the California state average of 68%. Pomerado Hospital readmission Rate was ***Average*** (15.90%), compared to the California state average of 15.90%.

Patient responses indicate that ***72%*** would recommend Pomerado Hospital compared to the State average of 70%.

Selected 2012-2013 CalQualityCare.org indicators and ratings for Pomerado Hospital include:

Pomerado Hospital 2012-2013 CalQualityCare.org Indicators and Ratings

Indicator	Rating (Score)	State Average
Patient Experience		
Hospital Rating	*Average* (67%)	68%
Hospital Readmission Rate	*Average* (15.90%)	15.90%
Patient Safety		
Surgical Care Measures	*Average* (97%)	97%
Unplanned Surgical Wound Reopening	*Average* (0.07%)	0.09%
Death after Serious Treatable Complication	N/A	10.84%
Accidental Lung Puncture	*Average* (0.03%)	0.03%

Indicator	Rating (Score)	State Average
Heart Attack		
Death Rate	*Average* (17.20%)	14.90%
Quality of Care	N/A	98%
Timeliness of Care	N/A	N/A
Readmission Rate	*Average* (17.20%)	18.20%
Heart Bypass Surgery		
Death Rate	N/A	2.17%
Internal Mammary Artery Usage	N/A	97%
Postoperative Stroke	N/A	1.31%
Heart Failure		
Death Rate	*Average* (12.50%)	11.20%
Quality of Care	***Superior*** (98%)	96%
Readmission Rate	*Average* (20.30%)	22.80%
Mother & Baby		
C-Section Rate	*Average* (29.30%)	27.80%
Breastfeeding Rate	***Superior*** (86.80%)	63.20%
Episiotomy Rate	*Average* (25.30%)	13.50%
VBAC Rate	*Average* (8.50%)	8.30%
Pneumonia		
Death Rate	*Average* (12.20%)	11.70%
Quality of Care	***Above Average*** (96%)	96%
Readmission Rate	*Average* (15.90%)	17.50%
Surgeries / Other Conditions		
Acute Stroke Death Rate	*Average* (12.40%)	9.91%
Craniotomy Death Rate	*Average* (0.00%)	7.81%
Gastrointestinal Hemorrhage Death Rate	*Average* (1.60%)	2.31%
Hip Fracture Death Rate	*Average* (3.20%)	2.47%
Hip or Knee Surgery Readmission Rate	*Average* (5.30%)	5.20%
Hip or Knee Surgery Complication Rate	*Average* (3.00%)	3.30%
Emergency Department Care		
Time in ED before being admitted	298 minutes	338 minutes
Time in ED before being sent home	156 minutes	165 minutes
Time in ED before being seen	17 minutes	32 minutes
Patients who left ED without being seen	0%	2%

2012-2013 CalQualityCare.org indicators and ratings for Pomerado Hospital medical procedures are generally consistent with state levels. The Pomerado Hospital indicator ratings include two categories rated as ***Superior*** and no categories rated *Below Average* or *Poo*r.

Palomar Medical Center

The Palomar Medical Center does not have CalQualityCare.org hospital ratings posted since its opening in late 2012. Subsequent service and sphere reviews will provide evaluation of available hospital ratings for the Palomar Medical Center.

Inpatient Quality Indicators (IQIs)

The Federal Agency for Health Care Research and Quality (AHRQ) supplies Inpatient Quality Indicators (IQIs) at the Area Level (county, statewide) and Facility Level (hospital) based on inpatient data provided to OSHPD by all California-licensed acute-care hospitals. The *Facility Level Indicators* for hospitals are compared to statewide results to provide a consumer perspective on hospital quality of care. These hospital indicators include*:*

- Volume Indicators for the numbers performed of six selected medical procedures; and,
- Inpatient Mortality Indicators (IMIs) for the six medical procedures and other conditions.

Hospital Volume Indicators

The *Hospital Volume* indicators measure the number of selected medical procedures 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 six volume indicators provide the number of the following medical procedures performed within each hospital:

- Esophageal Resection (Surgical removal of the esophagus due to cancer)
- Pancreatic Resection (Surgical removal of the pancreas/gall bladder due to cancer)
- Abdominal Aortic Aneurysm (AAA) Repairs (Surgical repair of abdominal aneurysm)
- Carotid Endarterectomy (Surgical removal of plaque within the carotid artery)
- Coronary Artery Bypass Graft Surgery (CABG) (Surgical heart artery procedure)
- Percutaneous Coronary Intervention (PCI) (Non-surgical heart artery procedure)

Palomar Health Downtown Campus

From 2011-2013, the Palomar Health Downtown Campus reported consistent levels of performed volume indicator procedures. Highest volumes were reported for AAA Repairs, Coronary Artery Bypass Graft Surgeries (CABG), Percutaneous Coronary Interventions (PCI), and Carotid Endarterectomies.

Palomar Health Downtown Campus Volume 2012-2013

Medical Procedure	**Statewide Totals**			**Palomar Health DTC**		
	2011	2012	2013	2011	2012	2013
Esophageal Resection	482	484	480	0	2	1
Pancreatic Resection						
Total	1,693	1,736	1,770	2	0	2
Cancer	904	933	968	0	0	2
Other	789	803	802	2	0	0
AAA Repair						
Total	2,765	2,728	2,877	42	31	44
Ruptured, Open	168	133	136	0	1	2
Un-ruptured, Open	351	319	280	0	0	1
Ruptured, Endovascular	120	142	171	3	4	3
Un-ruptured, Endovascular	2,133	2,137	2,301	39	26	38
CABG	16,283	15,125	15,488	66	67	50
PCI	46,677	42,797	39,792	388	385	414
Carotid Endarterectomy	6,696	6,457	6,171	43	35	27

Pomerado Hospital

From 2011-2013, the Pomerado Hospital performed a small number of the volume indicator procedures. Highest volumes were reported for AAA Repairs, Coronary Artery Bypass Graft Surgeries (CABG), Percutaneous Coronary Interventions (PCI), and Carotid Endarterectomies.

Pomerado Hospital Volume 2012-2013

Medical Procedure	**Statewide Totals**			**Pomerado Hospital**		
	2011	2012	2013	2011	2012	2013
Esophageal Resection	482	484	480	0	0	0
Pancreatic Resection						
Total	1,693	1,736	1,770	0	0	1
Cancer	904	933	968	0	0	1
Other	789	803	802	0	0	0

Palomar Health Downtown Campus Volume 2012-2013

Medical Procedure	**Statewide Totals**			**Palomar Health DTC**		
	2011	2012	2013	2011	2012	2013
AAA Repair						
Total	2,765	2,728	2,877	8	3	2
Ruptured, Open	168	133	136	0	0	0
Un-ruptured, Open	351	319	280	1	0	0
Ruptured, Endovascular	120	142	171	1	1	0
Un-ruptured, Endovascular	2,133	2,137	2,301	6	2	2
CABG	16,283	15,125	15,488	0	0	0
PCI	46,677	42,797	39,792	0	11	1
Carotid Endarterectomy	6,696	6,457	6,171	4	2	4

Inpatient Mortality Indicators

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.

The following tables reflect the Risk-Adjusted Mortality Rates (RAMR) produced by the Palomar Health Downtown Campus and the Pomerado Hospital during 2011-2013:

Palomar Health Downtown Campus

Palomar Health Downtown Campus 2011 Risk-Adjusted Mortality Rates (RAMR)

Inpatient Mortality Indicator (IMI)	2011 Mortality Rate (total deaths; total cases)	
Procedure	**Statewide**	**Palomar Health Downtown Campus**
Esophageal Resection	3.8% (15;391)	0
Pancreatic Resection	3.1% (23;750)	0
Abdominal Aortic Aneurism Repair	1.9% (46;2,478)	0.0% (0;39)
Craniotomy	6.8% (980;14,331)	14.3% (10;77) ***Worse***
Percutaneous Coronary Intervention	2.3% (1,051;44,775)	2.3% (12;375)
Carotid Endarterectomy	0.5% (34;6,660)	0.0% (0;43)

Inpatient Mortality Indicator (IMI) 2011 Mortality Rate (total deaths; total cases)

Condition	Statewide	Palomar Health Downtown Campus Acute
Myocardial Infarction	6.5% (3,005;46,278)	8.5% (30;383)
Heart Failure	3.0% (2,538;85,338)	3.7% (20;477)
Acute Stroke	9.4% (5,100;54,088)	11.4% (50;473)
Gastro-Intestinal Hemorrhage	2.2% (1,084;48,347)	2.8% (7;302)
Hip Fracture	2.3% (560;23,955)	2.7% (4;170)
Pneumonia	4.1% (2,993;73,002)	4.2% (20;482)

Palomar Health Downtown Campus 2012 Risk-Adjusted Mortality Rate (RAMR)

Inpatient Mortality Indicator (IMI) 2012 Mortality Rate (total deaths; total cases)

Procedure	Statewide	Palomar Health Downtown Campus
Esophageal Resection	5.7% (22;387)	0
Pancreatic Resection	2.4% (41;1,724)	0
Abdominal Aortic Aneurism Repair	1.1% (26;2,437)	3.3% (1;26)
Craniotomy	7.1% (1,065;15,030)	14.7% (14;71) ***Worse***
Percutaneous Coronary Intervention	2.5% (1,015;40,790)	4.4% (20;370) ***Worse***
Carotid Endarterectomy	0.5% (31;6,407)	0.0% (0;35)

Condition		
Acute Myocardial Infarction	6.3% (2,938;46,663)	10.5% (35;433) ***Worse***
Heart Failure	3.0% (2,458;81,250)	5.6% (30;493) ***Worse***
Acute Stroke (Total)	9.6% (5,227;54,191)	15.3% (67;463) ***Worse***
Gastro-Intestinal Hemorrhage	2.1% (1,024;47,893)	3.1% (8;314)
Hip Fracture	2.3% (552;23,774)	3.3% (4;170)
Pneumonia	4.0% (2,606;64,400)	4.8% (23;473)

Palomar Health Downtown Campus 2013 Risk-Adjusted Mortality Rate (RAMR)

Inpatient Mortality Indicator (IMI) 2013 Mortality Rate (total deaths; total cases)

Procedure	Statewide	Palomar Health Downtown Campus
Esophageal Resection	4.8% (18;377)	0
Pancreatic Resection	3.5% (62;1,763)	0
Abdominal Aortic Aneurism Repair	1.4% (36;2,560)	0.0% (0;39)
Craniotomy	7.2% (1,094;15,187)	17.9% (21;76) ***Worse***
Percutaneous Coronary Intervention	2.7% (1,013;37,885)	3.9% (16;402)
Carotid Endarterectomy	0.5% (29;6,139)	0.0% (0;27)

Condition		
Acute Myocardial Infarction	6.0% (2,803;46,984)	9.3% (36;436) ***Worse***
Heart Failure	3.0% (2,510;83,220)	3.8% (26;665)
Acute Stroke	9.2% (5,072;54,983)	13.0% (88;630) ***Worse***
Gastro-Intestinal Hemorrhage	2.3% (1,087;47,723)	1.8% (5;351)
Hip Fracture	2.0% (494;24,103)	1.9% (3;182)
Pneumonia	3.9% (2,487;63,853)	3.7% (23;578)

Pomerado Hospital

Pomerado Hospital 2011 Risk-Adjusted Mortality Rate (RAMR)

Inpatient Mortality Indicator (IMI) 2011 Mortality Rate (total deaths; total cases)

Procedure	Statewide	Pomerado Hospital
Esophageal Resection	3.8% (15;391)	0
Pancreatic Resection	3.1% (23;750)	0
Abdominal Aortic Aneurism Repair	1.9% (46;2,478)	0.0% (0;7)

Craniotomy	6.8% (980;14,331)	0.0% (0;3)
Percutaneous Coronary Intervention	2.3% (1,051;44,775)	0
Carotid Endarterectomy	0.5% (34;6,660)	0.0% (0;4)
Condition		
Acute Myocardial Infarction	6.5% (3,005;46,278)	13.8% (13;52) ***Worse***
Heart Failure	3.0% (2,538;85,338)	3.7% (12;229)
Acute Stroke	9.4% (5,100;54,088)	12.4% (15;138)
Gastro-Intestinal Hemorrhage	2.2% (1,084;48,347)	1.6% (2;156)
Hip Fracture	2.3% (560;23,955)	3.2% (3;114)
Pneumonia	4.1% (2,993;73,002)	3.1% (9;190)

Pomerado Hospital 2012 Risk-Adjusted Mortality Rate (RAMR)

Inpatient Mortality Indicator (IMI)	2012 Mortality Rate (total deaths; total cases)	
Procedure	**Statewide**	**Pomerado Hospital**
Esophageal Resection	5.7% (22;387)	0
Pancreatic Resection	2.4% (41;1,724)	0
Abdominal Aortic Aneurism Repair	1.1% (26;2,437)	0
Craniotomy	7.1% (1,065;15,030)	0
Percutaneous Coronary Intervention	2.5% (1,015;40,790)	0.0% (0;10)
Carotid Endarterectomy	0.5% (31;6,407)	0
Condition		
Acute Myocardial Infarction	6.3% (2,938;46,663)	3.8% (3;54)
Heart Failure	3.0% (2,458;81,250)	4.2% (10;179)
Acute Stroke (Total)	9.6% (5,227;54,191)	11.9% (13;127)
Gastro-Intestinal Hemorrhage	2.1% (1,024;47,893)	5.3% (6;132)
Hip Fracture	2.3% (552;23,774)	5.2% (6;105)
Pneumonia	4.0% (2,606;64,400)	5.6% (12;159)

Pomerado Hospital 2013 Risk-Adjusted Mortality Rate (RAMR)

Inpatient Mortality Indicator (IMI)	2013 Mortality Rate (total deaths; total cases)	
Procedure	**Statewide**	**Pomerado Hospital**
Esophageal Resection	4.8% (18;377)	0
Pancreatic Resection	3.5% (62;1,763)	0
Abdominal Aortic Aneurism Repair	1.4% (36;2,560)	0
Craniotomy	7.2% (1,094;15,187)	0
Percutaneous Coronary Intervention	2.7% (1,013;37,885)	0
Carotid Endarterectomy	0.5% (29;6,139)	0.0% (0;4)
Condition		
Acute Myocardial Infarction	6.0% (2,803;46,984)	1.8% (1;33)
Heart Failure	3.0% (2,510;83,220)	3.8% (10;187)
Acute Stroke	9.2% (5,072;54,983)	14.8% (10;110)
Gastro-Intestinal Hemorrhage	2.3% (1,087;47,723)	2.0% (3;147)
Hip Fracture	2.0% (494;24,103)	3.8% (3;84)
Pneumonia	3.9% (2,487;63,853)	6.6% (17;166) ***Worse***

In the 2010-2013 reporting periods, Palomar Health HD Hospitals performed a limited number of the selected indicator procedures and served a limited number of patients experiencing the selected conditions; however, for most of the condition indicators with reported totals, Palomar Health HD Hospital mortality rates were generally consistent with state averages and only one of the mortality rate indicators for the Palomar Health Downtown Campus had deficiencies that was rated as ***Worse*** in each of the three reported years.

Hospital Infrastructure Needs and Deficiencies

State Seismic Safety Requirements for Hospital Facilities

The Alfred E. Alquist Seismic Safety Act of 1983 [California Health and Safety Code Section 129675 et. seq.] provides seismic safety building standards program under OSHPD's jurisdiction for hospitals built on or after March 7, 1973. The Seismic Safety 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 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 2008 that was extended to 2013. Subsequent legislative changes 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.

Senate Bill 1953 also required OSHPD to develop a Structural Performance Category (SPC) rating for each licensed general acute care hospital facility that indicates the building's compliance with seismic safety standards; and a Non-Structural Performance Category (NPC) 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.

Following OSHPD determination of SPC/NPC facility ratings, the hospital licensee must prepare a comprehensive evaluation report and compliance plan for the hospital to attain the specified structural and nonstructural performance categories by the specified timeframes, with an ultimate compliance date of 2030.

Palomar Health HD Hospital Seismic Safety Ratings

The Palomar Health HD's Downtown Campus and Pomerado Hospital facilities include seismic safety ratings that require rehabilitation or replacement of non-compliant buildings or structures by the mandated deadlines.

The Palomar Health HD's recently constructed Palomar Medical Center buildings and structures were designed in compliance with the seismic safety standards. As of September 2014, the Palomar HD hospital facilities have the following OSHPD SPC/NPC seismic ratings and extension review status:

Palomar Health Downtown Campus

Facility	SPC	Hz	NPC	SB499Item 2 Extension
Mcleod Tower	2	0.17	2	1/1/2030
McLeod Tower E	2	0.10	2	
Adams Wing	2	0.13	2	
West Wing	4s		2	
South Wing	4s		2	
Co-Gen. Plant	4		2	
Park. Garage	2		2	
Med. Records	4s		2	
Rad. Therapy	4		2	
Cafeteria	4s		2	

Pomerado Hospital

Facility	SPC	Hz	NPC	SB499Item 2 Extension
Patient Tower	4s		2	1/1/2030
Anc. Bldg.	4s		2	
Central Plant	4s		2	
Angio/Cath Lab	4		2	
ER Add.	5		2	
Co-Gen. Bldg.	4		2	
Entrance Canopy	4		2	
Pedestrian Link	4		2	

Palomar Medical Center

Facility	SPC	Hz	NPC
Hospital	5s		
Central Plant	5s		

As the OSHPD ratings reflect, the Palomar Health Downtown Campus and the Pomerado Hospital each has a number of buildings and structures that will require rehabilitation or replacement per the following criteria and deadlines for conformance:

- SPC-2: These buildings are in compliance with pre-1973 California Building Code or other applicable standards, but are not in compliance with the structural provisions of the Alquist Hospital Facilities Seismic Safety Act. They do not significantly jeopardize life but may not be repairable or functional following strong ground motion. These buildings must be brought into compliance with the Alquist Act by January 1, 2030 or be removed from acute care service.
- SPC-4: These buildings are in compliance with the Alquist Act but may experience structural damage which could inhibit the building's availability following a strong earthquake. These buildings will have been constructed or reconstructed under a building permit obtained through OSHPD. They may be used to 2030 and beyond.
- SPC-5 - These buildings are in compliance with the structural provisions of the Alquist Act and are reasonably capable of providing services to the public following strong ground motion.
- NPC-2: In these buildings, essential systems vital to the safe evacuation of the building are adequately braced. The building is expected to suffer significant nonstructural damage in a strong earthquake.

Local Palomar Health HD voters have approved bond financing measures that are intended to fund needed seismic improvements at the two affected Palomar Health HD acute-care hospitals and compliance with the seismic safety standards is anticipated prior to the required state deadlines.

Finance: Financial Ability to Provide Services

Annual Financial Disclosure Reports

The Palomar Health HD is required to annually submit a financial disclosure report for its licensed acute-care hospital facilities to OSHPD within four months of the close of the district's fiscal year that includes a detailed income statement, balance sheet, statements of revenue and expense, and supporting schedules. OSHPD uses the submitted hospital financial data to produce an *Annual Financial Disclosure Report* for each licensed acute-care hospital that provides financial information regarding hospital operations, including: patient revenues; operating and non-operating expenses; breakdowns of expenditures by category; net operating income; and total income or loss.

Health Care 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 regarding special district revenues, expenditures, property taxes, and bonded debt. The County of San Diego Auditor and Controller produces a detailed summary of local tax information for each fiscal year that identifies the amount of property tax allocated to the Health Care Districts and reports any bonded indebtedness held by the Districts.

The annual Health Care District and hospital financial disclosure reports produced by the California State Controller, the County of San Diego, and OSHPD provide the public with a comprehensive overview of the annual financial status of the Palomar Health HD, as well as the hospital facilities the district owns and operates.

Financial Performance Indicators

The financial performance of a Health Care District and associated provision of health care services can be evaluated by several fiscal totals disclosed in the annually financial reports, including: revenues and expenditures; net-from-operations; annual profit or loss; total bonded indebtedness; and operating margin.

A hospital's *net-from-operations* indicator compares a hospital's total operating revenue against its total operating expenses and is the most commonly used financial ratio to measure a hospital's financial performance. A positive net-from-operations indicates that a hospital is operating at a profit; a negative figure indicates that the hospital is operating at a financial loss for the reporting period.

The following discussions and tables provide summaries of the Palomar Health HD acute-care hospitals' financial performance over FY2007-FY2013.

Palomar Health Downtown Campus Revenue/Expenditure Characteristics (FY2012-2013)

Net Patient Revenue: $441,246,759
Inpatient: $281,655,255; Outpatient: $159,591,504
Net From Operations: ($30,055,593)
Operating Margin: (6.7%)

For the 2012-2013 fiscal year, the Palomar Health Downtown Campus reported total net operating revenues of $449,316,088 and total operating expenses of $479,371,681, for a total net-from-operations loss of ($30,055,593) and total annual income loss of ($20,399,435). This income loss follows a total income gain of $21,547,191 for the preceding 2011-2012 fiscal year. The following table summarizes the Palomar Health Downtown Campus's financial performance over the 2007-2013 fiscal years:

Palomar Health Downtown Campus Revenues - Expenditures (FY2007-2013)

Year	Net Operating Rev.	Operating Exp.	Net from Op	Income / Loss
2007-08	$246,190,848	$295,562,027	($49,371,179)	$9,798,459
2008-09	$315,379,403	$305,889,199	$9,490,204	$19,900,125
2009-10	$326,283,685	$316,417,510	$9,866,175	$19,505,684
2010-11	$339,398,456	$330,628,878	$8,769,578	$19,547,345
2011-12	$364,248,763	$352,069,937	$12,178,826	$21,547,191
2012-13	$449,316,088	$479,371,681	($30,055,593)	($20,399,435)

From the 2007-2008 to 2012-2013 fiscal years, the Palomar Health Downtown Campus reported an average annual net-from-operations total of ($6,520,331); however, the hospital also reported a cumulative total income of $69,899,369 during that time.

Pomerado Hospital Revenue/Expenditure Characteristics (FY2012-2013)

Net Patient Revenue: $156,905,072
Inpatient: $101,589,003; Outpatient: $55,316,069
Net From Operations: $7,873,516
Operating Margin: 5.0%

For the 2012-2013 fiscal year, the Pomerado Hospital reported total net operating revenues of $157,750,160 and total operating expenses of $149,876,644, for a total net-from-operations gain of $7,873,516 and total annual income of $11,801,857. This income follows a total income gain of $6,162,918 for the preceding 2011-2012 fiscal year. The following table summarizes the Pomerado Hospital's financial performance over the 2007-2013 fiscal years:

Pomerado Hospital Revenues/Expenditures (FY2007-FY2013)

Year	Net Operating Rev.	Operating Exp.	Net from Op	Income / Loss
2007-08	$113,626,533	$120,523,650	($6,897,117)	($2,588,206)
2008-09	$126,872,907	$125,775,194	$1,097,713	$4,190,870
2009-10	$139,119,318	$131,767,117	$7,352,201	$10,140,022
2010-11	$146,547,200	$144,109,554	$2,437,646	$5,973,105
2011-12	$152,131,106	$149,027,760	$3,103,346	$6,162,918
2012-13	$157,750,160	$149,876,644	$7,873,516	$11,801,857

From the 2007-2008 to 2012-2013 fiscal years, the Pomerado Hospital reported an average annual net-from-operations total gain of $2,494,551, and has reported a cumulative total income of $35,680,566 during that time.

Palomar Medical Center

The Palomar Medical Center does not have OSHPD *Annual Financial Disclosure Reports* posted since its opening in late 2012. Subsequent service and sphere reviews will provide evaluation of available financial data for the Palomar Medical Center operations.

Bonded Debt

The Palomar Health HD local voters approved Proposition BB in the November 2004 election by 69.84%, which authorized the issuance of up to $496,000,000 in General Obligation bonds for the Palomar Health HD. Prop BB also authorized the Palomar Health HD to issue $210 million in revenue bonds for a combined total of $706 million.

The proceeds from the sale of the Prop BB bonds were intended to be used to: fund the construction of the Palomar Medical Center in west Escondido ($531 million); renovate the Palomar Health Downtown Campus ($73 million); and expand Pomerado Hospital ($139 million); for a total cost of $753 million. The $47 million of needed additional funding was projected to be financed through district cash reserves and philanthropic donations.

As of June 30, 2014, the Palomar Health HD reports net general obligation bond debt of $561,091,000 along with financing obligations of $9,126,000, for a total long-term debt liability balance of $570,217,000.

The Palomar Health HD's audited financial statements for FY2014 reports long-term Palomar Health HD debt service requirements from 2015-2043 will total $2,483,596,000, including principal of $1,044,653,000 and interest of $1,438,961,000.

Property Tax Revenues

As a special district formed prior to the passage of Prop 13 in 1978, the Palomar Health HD receives an annual allocation from the 1% ad valorum property tax for property within its respective service area. The District receives a share of this basic tax levy proportionate to what it received during the years 1976-1978.

Property taxes are the Palomar Health HD's primary source of revenue and are also levied to pay the debt service on the outstanding Proposition BB general obligation bonds.

The County of San Diego Tax Summary for fiscal year 2013-2014 states that the annual allocation of unrestricted property tax revenues accounts for approximately 2.1% of the Palomar Health HD's total net operating revenues of the Palomar Health Downtown Campus and the Pomerado Hospital.

County of San Diego annual tax reports from FY2008-2009 to FY2012-2013 indicate that the Palomar Health HD has received consistent levels of annual property tax revenues, with an average unrestricted total of $12,703,337 allocated to the district.

County of San Diego Tax Summary

Allocated Property Tax Revenue FY2013-2014

	Prop. Tax Revenue	% of Net Operating Revenues	
Palomar Health HD	$13,199,623 (Unrestricted)	2.1%*	(DTC + Pomerado Hospital)

Allocated Property Tax Revenue FY2007-2008 to FY2013-2014

	Annual Average
Palomar Health HD	$12,753,913 (Unrestricted)

Each year the Palomar Health HD is required to provide the County with its calculation of the required property tax levy to assess for the following year's scheduled bond debt service payments. The Palomar Health HD current levy is $23.50 per $100,000 of assessed valuation.

Palomar Health HD audited financial statements from FY2012-2013 and FY2013-2014 reported a total of $15,799,000 in restricted property tax revenue was allocated to the district in FY2012-2013, and a total of $16,417,000 in FY2013-2014.

Budgets/Audits

The Palomar Health HD Board of Directors adopts a budget for each fiscal year following public hearings. The Palomar Health HD adopted budgets and financial statements are regularly audited by certified auditors as required by State Law (Health and Safety Code Section 32133). The following table summarizes the Palomar Health HD budgeted/audited revenues and expenses reported for the two most recent fiscal years (FY2012-2013 and FY2013-2014):

Palomar Health HD **Operating Revenues/Expenditures**	**FY2013-2014**	**FY2012-2013**
Operating Revenues		
Patient Services	$555,664,000	$545,689,000
Other Revenues	58,538,000	48,438,000
Total Operating Revenue	$614,200,000	$594,127,000
Operating Expenses		
Total Expenses	$620,480,000	$616,425,000
(Loss) Income from Operations	($6,280,000)	($22,298,000)

Palomar Health HD **Non-Operating Revenues/Expenditures**	**FY2013-2014**	**FY2012-2013**
Revenues		
Property Tax Revenue (Unrestricted)	$13,451,000	$12,914,000
Property Tax Revenue (G.O. Bonds)	16,417,000	$15,799,000
Investment Income	2,591,000	1,571,000
Other Income	7,183,000	16,863,000
Total Non-Operating Revenues	$39,642,000	$47,147,000
Expenses		
Interest Expense	$64,861,000	$55,692,000
Other Expenses	185,000	0
Total Non-Operating Expenses	$65,046,000	$55,692,000
Change in Net Position	($25,404,000)	($8,545,000)

For the 2013 and 2014 fiscal years, the Palomar Health HD reported respective operational losses of ($22,298,000) and ($6,280,000). The Palomar Health HD also reported non-operational losses of ($8,545,000) in FY2013 and ($25,404,000) in FY2014, with respective non-operating bonded debt interest expenses of $55,692,000 and $64,861,000.

Governance and Operations

Board of Directors

The Palomar Health HD is governed by an elected seven-member Board of Directors that meets regularly on the second Monday of each month at 6:30 p.m. The Board meeting notices and agendas are posted 72-hours in advance of each meeting at the Palomar Health HD's administrative office at 555 E. Valley Parkway, Escondido.

Palomar HD Hospital Operations

The Palomar Health HD independently operates its licensed acute-care hospital facilities. Palomar Health HD hospital operations are administered by the Palomar Health HD Board of Directors and are overseen by an Executive Management Team, including a President/Chief Executive Officer that is recruited, employed, and evaluated by the Board of Directors.

Community Service Accountability

The Palomar Health HD operates a public website for the district which regularly posts news releases, annual reports, budgets, audited financial statements, Board meeting notices, Board agendas & minutes, and community health care program information. All local property tax revenues allocated to the Palomar Health HD are utilized for debt service payments for district bond measures that were approved in 2004 by over 69% of the local voters.

Status of and Opportunities for Shared Facilities

The Palomar Health HD has engaged in a number of partnerships with other health care entities to maximize its ability to provide and maintain health care programs and services to its service area residents. The multiple acute-care hospitals owned and operated by the Palomar Health HD also cooperate and collaboratively serve their patients in a similar capacity as an affiliated regional health system network.

The Palomar Health HD leases space at the Palomar Health Downtown Campus to Rady Children's Hospital which provides pediatric and neonatal intensive care units within the facility. Palomar Health has joined the Mayo Clinic Care Network (MCCN) in which Palomar Health physicians and providers have access to additional tools and resources in specialty areas where Mayo Clinic's knowledge and expertise may be helpful to enhance patient care. Palomar Health is the first hospital in California, and one of only 24 hospitals nationwide, to become a member of the Mayo Clinic Care Network.

2014 Fallbrook HD - Palomar Health HD JPA

The 2014 Joint Powers Agreement (JPA) between the Fallbrook HD and Palomar Health HD involves the identification of providers to continue the following health care services in

Fallbrook following the closure of the Fallbrook Hospital: urgent care, skilled nursing, home health care and hospice, physical therapy, wound care, laboratory services and imaging services. The proposed JPA also involved assessment of the use of part of the Fallbrook Hospital to operate an ambulatory surgery center, provide dialysis services, and operate a pharmacy.

Palomar Health HD applied for licensing to assume operational responsibility for the Fallbrook Skilled Nursing Facility; however, the federal Centers for Medicare and Medicaid Services (CMS) subsequently declined the Palomar Health HD's application for licensing the operation because federal regulations require the skilled nursing facility to be affiliated with an acute-care hospital that is located within 250 yards of the nursing facility. The Palomar Health HD's closest hospital, the Palomar Medical Center, is located more than 20 miles from the Fallbrook Skilled Nursing Facility. The Fallbrook HD and Palomar Health HD continue to explore options under the JPA to identify and secure health care providers for the Fallbrook community.

As the Palomar Health HD shares its service area and sphere boundaries on the west with the Tri-City HD, and on the south with the Grossmont HD, the Health Care Districts should be encouraged to collaborate on potential shared facilities and services for medically underserved and understaffed areas outside of their respective service areas and spheres.

Governance Structure Options

Governmental structure options available to the Palomar Health HD include several different changes of organization or reorganization, including: dissolution of one or more districts with annexation of the dissolved district's service area into one or more successor districts; consolidation of two or more districts into one or more successor districts; or a combination of governance actions involving annexations or detachments of district service area and sphere territory.

A proposed reorganization involving dissolution/annexation, or a consolidation/merger of Health Care Districts would transfer the district's assets and liabilities to a designated successor agency, including responsibility for assuming any voter-approved bonded indebtedness. Therefore, a key issue to be determined when considering potential governmental structure options for Health Care Districts involves the identification of a successor agency that is both authorized and capable of sustaining the provision and level of health care services presently provided by the affected Health Care District(s).

Proposed changes of organization or reorganization for Health Care Districts may be initiated by: sufficient petition of local voters or landowners; a resolution of subject/affected agencies; or by LAFCO action. If LAFCO approves a proposed reorganization or consolidation/merger involving one or more Health Care Districts, State Law allows for written protest to be filed with the Commission by affected registered voters or landowners. If LAFCO approves a proposed jurisdictional change that involves dissolution of one or more Health Care Districts, or a Health Care District proposes to transfer more than 50% of the district's assets, State Law requires the dissolution or transfer agreement to be approved by local voters.

Conclusion: MSR Determinations / Sphere Recommendations

The *MSR and Sphere Review* determinations conclude that the Palomar Health HD is adequately providing health care services within its service area and sphere and is accountable for the local community's service needs. The *2015 San Diego County Health Care Services MSR and Sphere Review* determinations also reflect that the Palomar Health HD hospital facilities have adequate capacities for patient needs; facility improvements are being undertaken to address any infrastructure deficits or needs; hospital ratings and quality indicators are consistent with state averages and reflect adequate provision of health care services; however, recent inpatient revenues have been inadequate to support the Palomar Health HD's financial ability to provide services and repay its long-term bonded indebtedness and have led to recent reported income losses.

The following is a summary of the *2015 San Diego County Health Care Services MSR and Sphere Review* conclusions for the Palomar Health HD in relation to the associated service and sphere determinations; and the sphere of influence recommendations for the Palomar Health HD:

Municipal Service Review Determination Summaries

Growth and Population Projections

As of 2014, SANDAG estimates a total population of 510,041 within the Palomar Health HD service area and coterminous sphere of influence. According to 2008-2014 SANDAG population estimates, the Palomar Health HD service area has generally maintained a consistent population of 500,000 and experienced an approximate growth rate of +2.0%; therefore, significant population growth is not anticipated over the next 5 years. SANDAG 2050 Regional Growth Forecast Population Estimates (2011), projects the population within the Palomar Health HD primary Subregional Areas to grow to a total of 838,139, or 32.4% from 2013-2050.

Location and Characteristics of Disadvantaged Unincorporated Communities

As of 2012, the Palomar Health HD has seven disadvantaged unincorporated communities existing within or contiguous to its sphere of influence. The identified disadvantaged unincorporated communities are located in the Hidden Meadows, Harmony Grove/Elfin Forest, Lake Hodges, East Escondido, and San Pasqual areas, and are governed by the General Plan of the County of San Diego and the community plans for the Community Planning Areas of North County Metro (Hidden Meadows, East Escondido); San Dieguito (Harmony Grove/Elfin Forest, Lake Hodges); and Ramona (San Pasqual). (Map 1C)

Present and Planned Capacity of Public Facilities

Palomar Health HD reports a combined total of 818 licensed beds within the three district acute-care hospitals. During 2013-2014, the Palomar Health HD reports an average overall occupancy rate for its licensed acute-care beds at the Palomar Health Downtown Campus and the Pomerado Hospital as 69.8%. Over 2010-2014, the Palomar Health HD reports an average overall occupancy rate for its licensed acute-care beds at the Palomar Health

Downtown Campus and the Pomerado Hospital as 74.3%. The 2014 OSHPD Annual Utilization Report for Palomar Medical Center states a total of 105,120 bed days for the facility's 288 licensed beds, which indicates a 70.6% occupancy rate for the year.

The following discussions provide summaries of the present and planned capacities for the three Palomar Health HD acute-care hospitals.

Palomar Health Downtown Campus

The OSHPD *Facility Summary Report* for 2014 states that Palomar Health Downtown Campus had a total of 13,287 inpatient discharges, with 92.6% for Acute Care (12,307); 5.7% for Psychiatric Care (757); and 1.7% for Physical Rehabilitation Care. Total number of inpatient discharge days for 2014 were reported as 50,697, with an average length of stay at 3.8 days. From 2007-2014, Palomar Health Downtown Campus total inpatient discharges averaged approximately 25,000 per year; however, from 2013-2014, total inpatient discharges have decreased by approximately 51%.

As of 2014, the Palomar Health Downtown Campus is a designated Level II Trauma Center with a 24-hour Basic Emergency Department. The OSHPD *Facility Summary Report* for 2014 states that Palomar Health Downtown Campus had a total of 40,589 ED encounters.

Total annual Palomar Health Downtown Campus ED encounters have averaged approximately 50,000 per year from 2007-2014. The OSHPD *Annual Utilization Report* for 2014 states that Palomar Health Downtown Campus had no *Ambulance Diversion Hours* during the year when the ED was unable to receive ambulance patients, and which resulted in ambulances being diverted to other hospitals. The Palomar Health HD also reported that no *Ambulance Diversion Hours* occurred at the Palomar Health Downtown Campus in 2013 and 2012.

The Palomar Health HD's submitted 2013 *Facility Utilization Report* for Palomar Health Downtown Campus states that the hospital had a total of 14 operating rooms that performed a total of 2,757 surgical operations, with a total of 1,229 inpatient procedures and 1,528 outpatient procedures. Total Palomar Health Downtown Campus Ambulatory Surgery encounters averaged approximately 6,250 per year from 2008-2013; however, total encounters have decreased by approximately 56% from 2013-2014.

Pomerado Hospital

The OSHPD *Facility Summary Report* for 2013 states that Pomerado Hospital had a total of 7,730 inpatient discharges, with 89.2% for Acute Care (6,894); 7.7% for Skilled Nursing/Intermediate Care (593); and 3.1% for Psychiatric Care (243). Total number of inpatient discharge days for 2013 were reported as 69,400, with an average length of stay at 9.0 days. Total Pomerado Hospital inpatient discharges averaged approximately 8,275 per year from 2007-2013; however, annual total discharges have decreased by approximately 14% during that time period.

As of 2014, the Pomerado Hospital has a licensed Basic Emergency Department (ER), but is not licensed as a regional Trauma Center. The OSHPD *Facility Summary Report* for

2013 states that Pomerado Hospital had a total of 24,441 ED encounters. From 2007-2013, total Pomerado Hospital ED encounters have averaged approximately 24,000 per year. The OSHPD Annual Utilization Report for 2014 states that Pomerado Hospital had a total of 563 *Ambulance Diversion* hours during the year when the ED was unable to receive ambulance patients, and which resulted in ambulances being diverted to other hospitals. The Palomar Health HD reported a total of 312 ambulance diversion hours occurred at the Pomerado Hospital in 2013 and 173 total ambulance diversion hours in 2012.

The Palomar Health HD's submitted 2014 *Facility Utilization Report* for Pomerado Hospital states that the hospital had a total of 4 operating rooms that performed a total of 3,045 surgical operations, with a total of 1,251 inpatient procedures and 1,794 outpatient procedures. Total Pomerado Hospital Ambulatory Surgery encounters averaged approximately 3,200 per year from 2007-2013; however, total encounters have decreased by approximately 23% from 2012-2013.

Palomar Medical Center

The OSHPD Annual Utilization Report for 2014 states that Palomar Medical Center had a total of 18,180 inpatient discharges, with a total of 74,266 patient days (average stay of 4.1 days). As of 2014, the Palomar Medical Center has a licensed Basic Emergency Department (ED), but is not designated as a regional Trauma Center. The OSHPD Annual Utilization Report for 2014 states that Palomar Medical Center had a total of 51,582 ED encounters, with a total of 9,376 admitted to the hospital from the ED.

The OSHPD Annual Utilization Report for 2014 states that Palomar Medical Center had a total of 979 *Ambulance Diversion* hours during the year when the ED was unable to receive ambulance patients which resulted in ambulances being diverted to other hospitals. The HD reported a total of 518 ambulance diversion hours in 2013, and 848 total ambulance diversion hours in 2012.

The 2014 OSHPD *Annual Utilization Report* for the Palomar Medical Center reports a total of 8,751 surgical operations, with a total of 5,575 inpatient services and a total of 3,176 outpatient services. The HD reports a total of 11 operating rooms, with 2 licensed for Cardiovascular Surgery Services. A total of 74 cardiovascular surgical operations were performed at the Palomar Medical Center in 2014.

Adequacy of Public Services

Palomar HD hospital ratings and quality indicators reflect that health care services are being adequately provided at the Palomar Health Downtown Campus and Pomerado Hospital; no rating or inpatient quality indicators are yet available for the Palomar Medical Center. The 2012-2013 CalQualityCare.org indicators and ratings for Palomar HD hospital inpatient medical procedures are generally consistent with or exceed state average levels.

For 2012-2013, CalQualityCare.org reports that the Palomar Health Downtown Campus received an overall Patient Experience Rating of *Above Average* and a total score of *76%*, compared to the California state average of 68%. Hospital Readmission Rate was *Average* (16.0%), compared to the California state average of 15.9%. Patient responses indicate

that *79%* would recommend Palomar Health Downtown Campus compared to the State average of 70%, which is the highest patient-rated hospital facility of the Health Care Districts evaluated in this service and sphere review.

For 2012-2013, CalQualityCare.org reports that Pomerado Hospital received an overall Patient Experience Rating of *Average* and a total score of *67%*, compared to the California state average of 68%. Pomerado Hospital readmission Rate was *Average* (15.90%), compared to the California state average of 15.90%. Patient responses indicate that *72%* would recommend Pomerado Hospital compared to the State average of 70%.

Infrastructure Needs or Deficiencies

California seismic safety standards for acute-care hospital facilities are mandated for compliance by 2030. The Palomar Health HD's Downtown Campus and Pomerado Hospital facilities include seismic safety ratings that require rehabilitation or replacement of non-compliant buildings or structures by the mandated deadlines. The Palomar Health HD's recently constructed Palomar Medical Center buildings and structures were designed in compliance with the seismic safety standards. The Palomar Health HD has an adopted Master Facility Plan for the three district acute-care hospitals that identifies current and future facility improvements designed to accommodate expected demands and regulatory requirements. Local voters have approved bond measures that will fund needed seismic improvements at the Palomar Health HD hospitals and facility compliance with the seismic safety standards is anticipated prior to the required deadlines.

Financial Ability to Provide Services

OSHPD Annual Financial Disclosure Reports for the Palomar Health HD's hospital reflect that the facilities are generating inadequate inpatient revenues to fund operations and repay bonded indebtedness. For the 2012-2013 fiscal year, the Palomar Health Downtown Campus reported total net operating revenues of $449,316,088 and total operating expenses of $479,371,681, for a total net-from-operations loss of ($30,055,593) and total annual income loss of ($20,399,435). This income loss follows a total income gain of $21,547,191 for the preceding 2011-2012 fiscal year.

From the 2007-2008 to 2012-2013 fiscal years, the Palomar Health Downtown Campus reported an average annual net-from-operations total of ($6,520,331); however, the hospital also reported a cumulative total income of $69,899,369 during that time.

For the 2012-2013 fiscal year, the Pomerado Hospital reported total net operating revenues of $157,750,160 and total operating expenses of $149,876,644, for a total net-from-operations gain of $7,873,516 and total annual income of $11,801,857. This income follows a total income gain of $6,162,918 for the preceding 2011-2012 fiscal year. From the 2007-2008 to 2012-2013 fiscal years, the Pomerado Hospital reported an average annual net-from-operations total gain of $2,494,551, and has reported a cumulative total income of $35,680,566 during that time.

The Palomar Medical Center does not have OSHPD *Annual Financial Disclosure Reports* posted since its opening in late 2012. Subsequent service and sphere reviews will provide evaluation of available financial data for the Palomar Medical Center operations.

As of June 30, 2014, the Palomar Health HD reports net general obligation bond debt of $561,091,000 along with financing obligations of $9,126,000, for a total long-term debt liability balance of $570,217,000. The Palomar Health HD's audited financial statements for FY2014 reports long-term Palomar Health HD debt service requirements from 2015-2043 will total $2,483,596,000, including principal of $1,044,653,000 and interest of $1,438,961,000.

Accountability for Community Service Needs

The Palomar Health HD operates a public website for the district which regularly posts news releases, annual reports, budgets, audited financial statements, Board meeting notices, Board agendas & minutes, and community health care program information. All local property tax revenues allocated to the Palomar Health HD are utilized for debt service payments for district bond measures that were approved in 2004 by over 69% of the local voters. The local voter support for bond measure to sustain and improve the Palomar HD hospital facilities indicates the district is accountable for community service needs.

Governmental Structure

Governmental structure options available to the Palomar Health HD include several different changes of organization or reorganization, including: dissolution of one or more districts with concurrent annexation of the dissolved district's service area into one or more successor districts; consolidation of two or more districts into one or more successor districts; or a combination of governance actions involving annexations or detachments of district service area and sphere territory.

A proposed reorganization involving dissolution/annexation, or a consolidation/merger of Health Care Districts would transfer the district's assets and liabilities to a designated successor agency, including responsibility for assuming any voter-approved bonded indebtedness. Therefore, a key issue to be determined when considering potential governmental structure options for Health Care Districts involves the identification of a successor agency that is both authorized and capable of sustaining the provision and level of health care services presently provided by the affected Health Care District(s).

If LAFCO approves a proposed jurisdictional change that involves dissolution of one or more Health Care Districts, or a Health Care District proposes to transfer more than 50% of the district's assets, State Law requires the dissolution or transfer agreement to be approved by local voters.

Operational Efficiencies

The multiple acute-care hospitals owned and operated by the Palomar Health HD cooperate and collaboratively serve their patients in a similar capacity as an affiliated

regional health system network; however, district's operational losses raise questions as to the long-term operational efficiencies of independent hospital operations.

Status and Opportunities for Shared Facilities

The Palomar Health HD has engaged in a number of partnerships with other health care entities to maximize its ability to provide and maintain health care programs and services to its service area residents. The Palomar Health HD leases space at the Palomar Health Downtown Campus to Rady Children's Hospital which provides pediatric and neonatal intensive care units within the facility.

Palomar Health has joined the Mayo Clinic Care Network (MCCN) in which Palomar Health physicians and providers have access to additional tools and resources in specialty areas where Mayo Clinic's knowledge and expertise may be helpful to enhance patient care. Palomar Health is the first hospital in California, and one of only 24 hospitals nationwide, to become a member of the Mayo Clinic Care Network.

2014 Fallbrook HD - Palomar Health HD JPA

The 2014 proposed Joint Powers Agreement (JPA) between the Fallbrook HD, Tri-City HD, and Palomar Health HD involved the identification of providers to continue the following health care services in Fallbrook following the closure of the Fallbrook Hospital: urgent care, skilled nursing, home health care and hospice, physical therapy, wound care, laboratory services and imaging services. The proposed JPA also involved assessment of the use of part of the Fallbrook Hospital to operate an ambulatory surgery center, provide dialysis services, and operate a pharmacy.

Palomar Health HD applied for licensing to assume operational responsibility for the Fallbrook Skilled Nursing Facility; however, the federal Centers for Medicare and Medicaid Services (CMS) subsequently declined the Palomar Health HD's application for licensing the operation because federal regulations require the skilled nursing facility to be affiliated with an acute-care hospital that is located within 250 yards of the nursing facility. The Palomar Health HD's closest hospital, the Palomar Medical Center, is located more than 20 miles from the Fallbrook Skilled Nursing Facility. The Fallbrook HD and Palomar Health HD continue to explore options under the JPA to identify and secure health care providers for the Fallbrook community.

Sphere of Influence Determination Summaries

Present and Planned Land Uses

Land uses within the Palomar Health HD service area and sphere, including agricultural and open space uses, are governed by the adopted General Plans and land use designations of the cities of Cities of Carlsbad, Escondido, Poway, San Diego, San Marcos, and Vista for the territory within their respective incorporated boundaries; and by the County of San Diego General Plan for the unincorporated territory located within the communities of Harmony Grove/Elfin Forest, Eden Valley, Rainbow, Pala/Pauma Valley, Julian, Ramona, Pine Valley, Palomar Mountain, Twin Oaks, and Valley Center.

Present and Probable Need for Public Facilities and Services

The *2015 San Diego County Health Care Services MSR and Sphere Review* determinations reflect that the rate of population growth with the Palomar Health HD service area and sphere was approximately 2.0% from 2008-2014, and that significant local population growth is not anticipated over the next 5 years. SANDAG's 2050 Regional Growth Forecast Population Estimates (2011) projects the Palomar Health HD Subregional Areas to grow approximately 32% from 2013-2050.

The Palomar Health HD service review determinations state that the local population of elderly residents (65-85+) within the local Subregional Areas is projected to increase by approximately 74.6% during 2013-2030.

In addition, each of the Medical Service Study Areas within the Palomar Health HD service area and sphere have territory that is within or adjacent to areas designated by the California Office of Statewide Health Planning and Development (OSHPD) as *Medically Underserved Areas* (MUA) and/or *Health Care Professional Shortage Areas* for primary care (HPSA-PC, PCSA) and registered nursing professionals (RNSA). The population projections and medically underserved and understaffed areas designations reflect that the Palomar Health HD will continue to experience health care service needs within its service area and sphere.

Present Capacity of Public Facilities, Adequacy of Public Services

Palomar Health HD reports a combined total of 818 licensed beds within the three district acute-care hospitals. During 2013-2014, the Palomar Health HD reports an average overall occupancy rate for its licensed acute-care beds at the Palomar Health Downtown Campus and the Pomerado Hospital as 69.8%. Over 2010-2014, the Palomar Health HD reports an average overall occupancy rate for its licensed acute-care beds at the Palomar Health Downtown Campus and the Pomerado Hospital as 74.3%. The 2014 OSHPD Annual Utilization Report for Palomar Medical Center states a total of 105,120 bed days for the facility's 288 licensed beds, which indicates a 70.6% occupancy rate for the year.

Palomar Health HD hospital patient ratings and inpatient quality indicators reflect that health care services are being adequately provided within the Palomar Health HD authorized service area and coterminous sphere.

Social or Economic Communities of Interest

The Commission has not determined that *social or economic communities of interest* of relevance to Palomar Health HD exist in the local area; however, territory adjacent to the Palomar Health HD service area and sphere which has been designated by OSHPD as a *Medically Underserved Are*a or a *Health Care Professional Shortage Area*, and local areas identified with poverty levels above the regional average of *14.4%*, should each be considered by the Commission for potential determination as relevant social or economic communities of interest to Health Care Districts.

Disadvantaged Unincorporated Communities: For an update of a sphere of influence of a city or special district that provides public facilities or services related to sewers, municipal and industrial water, or structural fire protection, that occurs pursuant to subdivision (g) on or after July 1, 2012, the present and probable need for those public facilities and services of any disadvantaged unincorporated communities within the existing sphere of influence.

Palomar Health HD is a special district authorized to provide health care services and does not provide public facilities or services related to sewers, municipal/industrial water, or structural fire protection; therefore, the determination does not apply to the Palomar Health HD sphere review and update.

Sphere of Influence Recommendations

The *MSR and Sphere Review* determinations demonstrate that the Palomar Health HD is adequately providing its authorized services within its service area and adopted sphere of influence; therefore, the Palomar Health HD sphere of influence is recommended to be affirmed as coterminous with the HD's service area. The potential designation of local *social or economic communities of interest* and Special Study Areas is also recommended as identified below.

Potential Social or Economic Communities of Interest

The *MSR and Sphere Review* determinations are required to identify any *social or economic communities of interest* existing in the review area, if LAFCO determines that they are relevant to the subject agency. The Commission is recommended to consider local areas designated by OSHPD as *Medically Underserved Areas* and/or *Health Care Professional Shortage Areas*, and local areas identified with poverty levels above the regional average of *14.4%*, as containing *social or economic communities of interest* relevant to the Palomar Health HD.

Proposed San Diego County Special Study Areas

OSHPD-designated *Medically Underserved Areas, Health Care Professional Shortage Areas*, and local areas identified with high poverty levels areas all presently exist in both urban coastal incorporated territory and rural unincorporated desert and mountain communities of San Diego County.

The *MSR and Sphere Review* determinations recommend Commission consideration of *Special Study Area* designations for the following 4 major areas of the County that contain inhabited territory not currently located within any of the local Health Care District service areas and spheres, and which contain *social or economic communities of interest* relevant to the local Health Care Districts (Map 1L).

Potential Palomar Health HD Special Study Areas

The four proposed *Special Study Areas* for San Diego County are each adjacent to the Palomar Health HD service area and sphere (Map 1L). These proposed *Special Study Areas* are related to the Palomar Health HD service area and sphere as follows:

Special Study Area No. 1: Fallbrook HD/Camp Pendleton

The proposed *Special Study Area No. 1* territory includes inhabited urban and rural areas of the northwest corner of San Diego County, including Camp Pendleton and the unincorporated De Luz community, and portions of the Tri-City HD and Fallbrook HD service areas and spheres that overlap the Camp Pendleton boundary (Map 4G).

The Palomar Medical Center in west Escondido is one of closest acute-care hospitals to the recently closed Fallbrook Hospital and the Fallbrook HD's service area. The Fallbrook HD and the Palomar Health HD have adopted a Joint Powers Agreement (JPA) to identify potential health care service providers for the Fallbrook HD's service area and sphere and HD to assist the Fallbrook HD in the continued provision of health care services in the Fallbrook community. The proposed *Special Study Area No. 1* and the Fallbrook HD service area should be further evaluated by the Palomar Health HD to determine if inclusion within the district's service area would promote the efficient delivery of health care services to the subject territory.

Special Study Area No. 2: Shadowridge

The Shadowridge area consists of approximately 2,500-acres that is primarily located with the City of Vista's incorporated territory. The Shadowridge area constitutes an island of territory that is not presently located within a Health Care District service area, but is surrounded by both the Palomar Health HD and the Tri-City HD service areas and spheres. Both of the surrounding Health Care Districts have previously explored the potential annexation of the Shadowridge area; however, no annexation proposal has been submitted from either district for LAFCO consideration.

As the majority of the City of Vista is currently located within the Tri-City HD service area and sphere, the Shadowridge area should accordingly be consolidated within Tri-City HD; however, the adjacent Health Care Districts should discuss and collaboratively evaluate the Shadowridge area to determine if inclusion within either Health Care District would benefit the local area.

Special Study Area No. 3: Western San Diego County Incorporated Areas

The proposed *Special Study Area No. 3* includes urban territory comprised of the coastal incorporated cities from Encinitas south to Imperial Beach, as well as the adjacent unincorporated urban communities of Rancho Santa Fe, Bonita, and Otay Mesa.

These areas are not presently located within any of the local Health Care Districts service areas or spheres, and have been identified as containing designated *Medically Underserved Areas*, *Health Care Professional Shortage Areas*, and/or areas of high

poverty. The Palomar Health HD service area and sphere is contiguous to *Special Study Area No. 3*.

Small portions of City of San Diego incorporated territory are located within the Palomar Health HD and Grossmont HD service areas and spheres; however, the majority of the City of San Diego is not currently located within a Health Care District service area and sphere. Accordingly, the adjacent Health Care Districts should discuss and collaboratively evaluate the City of San Diego to determine if inclusion within either or both of the Districts' service areas and spheres would benefit the local area.

Special Study Area 4: Eastern San Diego County Unincorporated Areas

The proposed *Special Study Area No. 4* includes rural and frontier territory comprised of the mountain and desert unincorporated areas of eastern San Diego County, from the Riverside County on the north to the US/Mexico International Border on the south.

These unincorporated areas are not presently located within any of the local Health Care Districts service areas or spheres, and have been identified as containing designated *Medically Underserved Areas*, *Health Care Professional Shortage Areas*, and/or areas of high poverty.

The Palomar Health HD service area and sphere is contiguous to *Special Study Area No. 4*. The district should each evaluate the adjacent communities within the proposed *Special Study Area* to determine if inclusion within the Health Care District's service area and sphere would benefit the local area.

Palomar Health HD Sphere of Influence Recommendation

The *2015 San Diego County Health Care Services MSR and Sphere Review* determinations demonstrate that the Palomar Health HD is adequately providing its authorized services within its service area and adopted sphere of influence; therefore, the Palomar Health sphere is recommended to be affirmed as coterminous with the Palomar Health's service area. Additional Commission discussion and consideration of designations of *social or economic communities of interest*, and *Special Study Areas* is also recommended.

TRI-CITY HEALTHCARE DISTRICT (MSR13-92; SR13-92; SR13-92)

District Overview: Formation, Governance, Hospital Facilities

District Background

The Tri-City Healthcare District (HD) provides hospital-based health services to an approximate 132 square-mile service area and *coterminous* sphere of influence in the northern coastal area of San Diego County. Tri-City HD owns and independently operates the 397-bed Tri-City Medical Center located in the City of Oceanside (Map 5A).

District Formation

The Tri-City Healthcare District was formed in 1957 by local voters as the *Tri-City Hospital District* to establish a new hospital to serve the north county coastal area. Tri-City Hospital was subsequently constructed with local property tax revenues and opened in 1961. The Tri-City Hospital was expanded in the 1970s and 1980s to include a helipad, cardiopulmonary lab, a 56-bed north wing, additional surgical suites, a 42-bed maternity unit, a four-story wing, and remodeled facilities.

Tri-City Hospital was renamed as the Tri-City Medical Center in 1985, and in 1994, when Health and Safety Codes were amended to change *Local Hospital District Law* (Health and Safety Code § 32000 et seq.) to *Local Health Care District Law,* the district became the Tri-City Health Care District.

Governance

The Tri-City Healthcare District is governed by a seven-member Board of Directors that is elected at-large by local voters and serve four-year terms. Regularly scheduled Board meetings occur on the 4th Thursday of each month at 3:30 pm. Board meeting schedules, agendas, and minutes are posted on the Tri-City website and at the Tri-City Medical Center.

Tri-City Medical Center

Tri-City HD owns and independently operates the 397-bed Tri-City Medical Center (OSHPD ID No. 106370780), located at 4002 Vista Way, Oceanside. The Tri-City Medical Center has been licensed as a General Acute Care Hospital since July 11, 1961 (License No. 080000099).

The Tri-City Medical Center's 397 licensed acute-care beds include 48 for Intensive Care (14 for Coronary Care; 20 for Intensive Care - Newborn Nursery; 14 for Intensive Care); and 349 for Acute Care (38 for Perinatal; 10 for the Rehabilitation Center; 29 for Acute Psychiatric; and 272 for Unspecified General Acute Care).

District Service Area & Sphere of Influence

Service Area

Tri-City HD has an approximate 132.0 square-mile authorized service area within northern San Diego County that includes all or portions of the incorporated Cities of Carlsbad, Oceanside, and Vista; and adjacent unincorporated territory, including a portion of the Camp Pendleton U.S. Marine Corps Base. The Tri-City HD service area and sphere is bordered by the Cities of San Marcos and Encinitas; and the unincorporated communities of Bonsall and Twin Oaks Valley. The Tri-City HD is also bordered by the Fallbrook HD to the north, and the Palomar HD to the east.

Sphere of Influence

On June 2, 1986, San Diego LAFCO established a sphere of influence for the Tri-City HD that was adopted as coterminous with the HD's service area. There have been no annexations or detachments to the Tri-City HD service area nor any changes to the sphere since it was originally established. The Tri-City HD's adopted sphere was most recently reviewed and affirmed by the Commission on August 6, 2007 as coterminous with the service area.

Land Uses

Land uses within the Tri-City HD service area and sphere, including agricultural and open space uses, are governed by the General Plans and land use designations of the cities of Carlsbad, Oceanside, and Vista for the properties within their respective incorporated boundaries; and by the County of San Diego General Plan for the adjacent unincorporated territory located within portions of the Bonsall and North County Metro Community Planning Areas.

Service Area Population

The San Diego Association of Governments (SANDAG) is the designated regional clearinghouse for the US Census Bureau and provides current population estimates and future population projections for the San Diego Region. LAFCO annually receives SANDAG population estimates for all local independent and dependent special districts in San Diego County based on the subject agency's geographic service area.

Following the 2010 Census, the SANDAG demographic modeling program baselines were updated from the 2000 Census data and recalibrated with new 2010 Census data, which resulted in a -9% readjustment to the calculated Tri-City HD population estimate for 2011.

According to SANDAG Special District Population Estimates for 2008-2014, the cumulative growth rate within the Tri-City HD service area was -3.3%; however, The 2010-2011 reduction in the Tri-City HD's estimated population is attributed to the SANDAG modeling differences between the 2000 and 2010 Census baselines and is not considered to be representative of actual population loss.

The new 2010 Census data allows for a more precise local population estimate and has resulted in a more consistent annual total; therefore, significant population growth is not anticipated over the next 5 years.

As of 2014, SANDAG reports an estimated total population of 353,396 within the Tri-City HD service area and sphere. The following table reflects the Tri-City HD estimated total populations from 2008-2014:

2008-2014 Tri-City HD Population Totals (SANDAG Estimates)

Year	Total Population
2008	365,182
2009	369,695
2010	375,059 (Based on Census 2000 estimates)
2011*	343,484 (Based on Census 2010 estimates)
2012	348,080
2013	347,693
2014	353,396

2050 Service Area Population Projection

The Tri-City HD service area and sphere are included within defined geographic units of San Diego County called Subregional Areas (SRA) that are used by SANDAG for local population estates and projections. The Tri-City HD service area is primarily located within the combined territory of SRAs 41 (Carlsbad), 42 (Oceanside), and 52 (Vista). The current (2013) estimated total population for the Tri-City HD Subregional Areas is 381,975.

Projected 2020-2050 Subregional Area Population Totals – Growth Rate

SRA	2020	2030	2040	2050	2013-2050
41-Carlsbad	132,755	138,896	142,881	144,721	+22.6%
42-Oceanside	186,615	200,683	205,541	210,282	+30.4%
52-Vista	110,989	123,081	146,468	162,866	+58.7%
Total	430,359	462,660	494,890	517,893	+35.6%

According to 2050 SANDAG Subregional Population Estimates (2011), the cumulative population of SRAs 41, 42, and 52 is projected to grow by approximately 36% during 2013-2050 to a total of 517,893. Highest proportional growth is projected for the Vista Subregional Area at 58.7%. SRAs 41 (Carlsbad) and 52 (Vista) are also partially located within the Palomar Health HD service area and sphere; SRA 42 (Oceanside is also partially located within Fallbrook HD.

2013-2030 Elderly Population Projections

Following the assessment of 2010 Census data, national and state population projections have indicated that the older population segments (65-85+ years) will grow from approximately 10-12% of the current total population to over 20% by 2030. Census data also reflects that older population segments generally live with high poverty levels and are reliant on fixed incomes.

The projected doubling of older residents in the next 10-15 years is anticipated to create significant demands for local facilities, services, and resources to meet expected health care demands in underserved and high poverty areas (Map 1D).

Projected 2013-2030 Subregional Area 65-85+ Population Totals & Growth Rate

SRA	2013	2020	2030	2013-2030
41 Carlsbad	19,824	28,746	38,651	+95.0%
42-Oceanside	19,426	25,680	35,342	+81.9%
52 Vista	10,896	13,481	18,489	+69.7%
Total	50,146	67,907	92,482	+84.4%
% of total pop.	13.1%	15.8%	20.0%	

The current (2013) SANDAG population estimates for the Tri-City Subregional Areas show a 65-85+ age range population of 50,146, representing approximately 13.1% of the total population of 430,359.

While SANDAG 2050 population estimates project that Tri-City's total population will grow approximately 20% from 2013-2030, the 65-85+ years age ranges are projected to grow approximately 84% during the same time. By 2030, the older population is estimated at 92,482, representing approximately 20.0% of the total population.

Tri-City HD Medical Service Study Areas (MSSAs)

The California Office of Statewide Health Planning and Development (OSHPD) produces maps for each county in the state that designate geographic Medical Service Study Areas (MSSAs) based on local 2010 Census Tract boundaries. OSHPD's Health Care Workforce Development Division (HWDD) reviews the Medical Service Study Areas to assess local population density, provider-to-population ratios, poverty levels, and public health indicators. OSHPD defines each Medical Service Study Area as Frontier*, Rural, or Urban*, based on local population density per square mile.

A *Frontier* MSSA has a population density less than 11 persons per square mile (sq. mi.); a *Rural* MSSA is one with a population density greater than 11 per sq. mi. and less than 250 persons per sq. mi.; and, an *Urban* MSSA, which are all MSSAs with a population density higher than 250 persons per sq. mi. (Map 1B).

The Tri-City HD service area and sphere includes all or portions of 4 of the 38 Medical Service Study Areas (MSSA) covering San Diego County: MSSAs 156a (Oceanside), 156b (Carlsbad), 156d (Vista), and 160 (Fallbrook). The Tri-City Medical Center is located in MSSA 156a (Oceanside), which is designated as Urban.

The following table lists the Tri-City HD MSSAs and provides their population density, poverty rate (Map 5B), and associated communities:

Tri-City HD Medical Service Study Areas

MSSA	Type	Pop. Den. (sq.ml.).	Poverty rate	Communities
156a	Urban	4,695.5	13.4%	Oceanside, Leucadia
156b	Urban	3,053.1	6.2%	Carlsbad, Encinitas
156d	Urban	2,335.0	13.2%	Vista, San Marcos
160	Rural	249.9	9.6%	Fallbrook, Bonsall, Camp Pendleton

The Tri-City HD service area and sphere is bordered by Palomar Health HD to the east and by Fallbrook HD to the north. While the majority of Tri-City HD is located within MSSAs 156a and 156b, portions of the district's service area and sphere are also located within adjacent MSSAs 156d and 160, which are shared with the Palomar Health HD and the Fallbrook HD, respectively.

Medically Underserved Areas - Health Care Professional Shortage Areas

OSHPD produces county maps which identify local Medical Service Study Areas that qualify for designation as a *Medically Underserved Area* (MUA) and/or a *Primary Care Shortage Area* (PCSA). The Federal Agency for Health Care Research and Quality (AHRQ) also designates MSSAs with a shortage of professional health care providers as a *Health Professional Shortage Area* (HPSA) for the *Primary Care, Dental Health, and Mental Health* disciplines (Maps 5D and 5E).

Health Care Professional Shortage Areas and *Primary Care Shortage Areas* are designated where there are local population-to-physician ratios that demonstrate a high need for services combined with a general lack of access to health care in surrounding areas because of excessive distance, overutilization, or access barriers. The MSSA-designated maps can be used to identify areas of potential concern for Health Care Districts when addressing future health care needs and demands and sufficiently planning for needed local infrastructure and services.

Tri-City HD Medically Underserved Areas / Health Care Professional Shortage Areas

MSSA	Type	Communities	MUA/HPSA
156a	Urban	Oceanside, Leucadia	MUA RNSA
156b	Urban	Carlsbad, Encinitas	PCSA RNSA
156d	Urban	Vista, San Marcos	MUA RNSA
160	Rural	Fallbrook, Bonsall, Camp Pendleton	MUA RNSA

Potential Social or Economic Communities of Interest

The *2015 Health Care Services MSR and Sphere Review* determinations are required to identify any *social or economic communities of interest* existing in the review area, if LAFCO determines that they are relevant to the subject agency.

The Commission is recommended to consider local areas designated by OSHPD as Medically Underserved Areas and/or Health Care Professional Shortage Areas, and local areas identified with poverty levels above the regional average of *14.4%*, as containing *social or economic communities of interest* relevant to the local Health Care Districts.

Proposed San Diego County Special Study Areas

OSHPD-designated *Medically Underserved Areas, Health Care Professional Shortage Areas*, and local areas identified with high poverty levels areas all presently exist in both urban coastal incorporated territory and rural unincorporated desert and mountain communities of San Diego County.

The *2015 San Diego County Health Care Services MSR and Sphere Review* determinations recommend Commission consideration of *Special Study Area* designations for the following 4 major areas of the County that contain inhabited territory not currently located within any of the local Health Care District service areas and spheres, and which contain *social or economic communities of interest* relevant to the local Health Care Districts (Map 1L):

Potential Tri-City HD Special Study Areas

Three of the four proposed *Special Study Areas* for San Diego County are adjacent to the Tri-City HD service area and sphere (Map 5F). These proposed *Special Study Areas* are related to the Tri-City HD service area and sphere as follows:

Special Study Area No. 1: Fallbrook HD/Camp Pendleton

The proposed *Special Study Area No. 1* territory includes inhabited urban and rural areas of the northwest corner of San Diego County, including Camp Pendleton and the unincorporated De Luz community, and portions of the Tri-City HD and Fallbrook HD service areas and spheres that overlap the Camp Pendleton boundary.

The Tri-City Medical Center in Oceanside is one of closest acute-care hospitals to the recently closed Fallbrook Hospital and the Fallbrook HD's service area. The Fallbrook HD and the Tri-City HD have previously adopted a Joint Powers Agreement (JPA) to coordinate the referral of patients between the Districts' facilities; however, the closure of the Fallbrook Hospital has functionally ended the reciprocal nature of the JPA.

While State Law allows for both incorporated and unincorporated territory to be served by Health Care Districts and included within their service areas, Health and Safety Code Section 32001 prohibits the division of incorporated territory within a Health Care District unless LAFCO determines that the area would not be benefitted by inclusion.

As the majority of the City of Oceanside is currently located within the Tri-City HD service area and sphere, the small portion of Oceanside incorporated territory located within the Fallbrook HD service area and sphere should accordingly be consolidated within Tri-City HD; however, the adjacent Health Care Districts should discuss and collaboratively evaluate the affected area to determine if inclusion within either the Tri-City HD service area and sphere would benefit the local area.

Special Study Area No. 2: Shadowridge

The Shadowridge area consists of approximately 2,500-acres that is primarily located with the City of Vista's incorporated territory. The Shadowridge area constitutes an island of territory that is not presently located within a Health Care District service area, but is surrounded by both the Tri-City HD and the Palomar Health HD service areas and spheres. Both of the surrounding Health Care Districts have previously explored the potential annexation of the Shadowridge area; however, no annexation proposal has been submitted from either district for LAFCO consideration.

As the majority of the City of Vista is currently located within the Tri-City HD service area and sphere, the Shadowridge area should accordingly be consolidated within Tri-City HD; however, the adjacent Health Care Districts should discuss and collaboratively evaluate the Shadowridge area to determine if inclusion within either Health Care District would benefit the local area.

Special Study Area No. 3: Western San Diego County Incorporated Areas

The proposed *Special Study Area No. 3* includes urban territory comprised of the coastal incorporated cities from Encinitas south to Imperial Beach, as well as the adjacent unincorporated urban communities of Rancho Santa Fe, Bonita, and Otay Mesa. These areas are not presently located within any of the local Health Care Districts service areas or spheres, and have been identified as containing designated *Medically Underserved Areas*, *Health Care Professional Shortage Areas*, and/or areas of high poverty.

The Tri-City HD service area and sphere is contiguous to *Special Study Area No. 3* and potential inclusion of the remainder of the City of Carlsbad's incorporated territory within the Tri-City HD service area and sphere should be addressed in subsequent service and sphere reviews to determine if inclusion within the Health Care District would benefit the local area.

Special Study Area 4: Eastern San Diego County Unincorporated Areas

The proposed *Special Study Area No. 4* includes rural and frontier territory comprised of the mountain and desert unincorporated areas of eastern San Diego County, from the Riverside County to the north to the US/Mexico International Border to the south.

These unincorporated areas are not presently located within any of the local Health Care Districts service areas or spheres, and have been identified as containing designated *Medically Underserved Areas*, *Health Care Professional Shortage Areas*, and/or areas of high poverty. The Tri-City HD service area and sphere is not contiguous to *Special Study Area No. 4*.

Location & Characteristics of Disadvantaged Unincorporated Communities

When conducting a municipal service review, LAFCO is required to identify the location and characteristics of any *disadvantaged unincorporated communities* (DUC) that exist within or contiguous to a public agency's sphere of influence. A DUC is defined as an inhabited, unincorporated area in which the median household income is 80% or less of the statewide median household income (Map 1C).

The Tri-City HD has one disadvantaged unincorporated community within its sphere that is located within an unincorporated island bordered by the Cities of Oceanside and Vista. The identified disadvantaged unincorporated community is located within and is governed by the General Plan of the County of San Diego and the community plan for the North County Metro Community Planning Area.

Healthcare Facilities & Services

Tri-City Medical Center

The California Office of Statewide Health Planning and Development (OSHPD) provides licensing, facility, and services information for each licensed acute-care hospital through its Automated Licensing Information and Report Tracking System (ALIRTS).

Tri-City HD owns and independently operates the 397-bed Tri-City Medical Center (OSHPD ID No. 106370780), located at 4002 Vista Way, Oceanside. The Tri-City Medical Center has been licensed as a General Acute Care Hospital since July 11, 1961 (License No. 080000099).

The Tri-City Medical Center's 397 licensed acute-care beds include 48 for Intensive Care (14 for Coronary Care; 20 for Intensive Care - Newborn Nursery; 14 for Intensive Care); and 349 for Acute Care (38 for Perinatal; 10 for the Rehabilitation Center; 29 for Acute Psychiatric; and 272 for Unspecified General Acute Care).

OSHPD reports the following medical services are licensed to be provided at the Tri-City Medical Center: Basic Emergency Room, Physician, Operating Room, Surgery, Laboratory Services, Radiology Services, Anesthesiologist, Intensive Care Services, Acute Care Services, Newborn Care Services, Diagnostic Imaging Services, Diagnostic/Therapeutic, Home Care Services, Home Health Aide, Home Nursing care (Visiting Nurse), Home Physical Medicine Care, Home Social Service, and Obstetric Services.

The submitted 2012-2013 *Annual Financial Disclosure Report* for the Tri-City Medical Center reports a total of 1,646 full-time employees, with 655 nursing employees. Total full-time Nursing Registry and temporary help is reported as 21. The Tri-City Medical Center medical staff (including MDs, DOs, and Podiatrists) consists of a total of 93 hospital-based physicians and a total of 433 non-hospital based physicians.

Tri-City Wellness Center

The Tri-City HD also owns and operates the Tri-City Wellness Center, located at 6250 Elk Camino Real, Carlsbad. The Tri-City Wellness Center is a 58,000 square foot, medically-integrated fitness center with a pool area (including a lap pool and warm water therapy pool), an indoor track, and personal training team.

Services offered at the Tri-City Wellness Center include: accredited personal training, aquatic classes, group exercise classes, swimming lessons for adults, physical therapy, cardiac rehab, pool therapy, posture therapy, nutrition counseling, wellness programs, health education programs, childcare, a spa, and a café.

Hospital Facility Capacity and Utilization

The OSHPD Healthcare Information Division (HID) uses submitted financial and operational data for each licensed acute-care hospital to produce an *Annual Financial Disclosure Report* that includes detailed information regarding the hospital's operations, and annual *Hospital Facility Summary Reports* for the hospital's provision of *Inpatient Services, Emergency Department Services, and Ambulatory Surgery*.

Licensed Bed Occupancy Rates

During 2013-2014, the Tri-City HD reports an occupancy rate of 48.7% for its 397 licensed acute-care beds, and 54.6% for its 354 available beds. Over 2010-2014, the Tri-City HD reports an average occupancy rate for its licensed beds as 47.7%; however, the district reports that its available beds have an average occupancy rate of 54.3% during the same time period.

	Occupancy Rate			
Tri-City Medical Center	**2010-2011**	**2011-2012**	**2012-2013**	**2013-2014**
Licensed beds (total)	45.8% (397)	49.9% (397)	47.4% (397)	48.7% (397)
Available Beds (total)	52.6% (346)	57.1% (347)	53.2% (354)	54.6% (354)

Total Live Births

The Tri-City HD reports a total of 2,567 live births at the Tri-City Medical Center in 2013-2014, with 1,712 natural births and 855 caesarian sections. Reported Tri-City HD data for 2010-2014 reflects an annual average of approximately 2,800 live births, with consistent ratios of natural births to caesarian sections.

Tri-City Medical Center	**2010-2011**	**2011-2012**	**2012-2013**	**2013-2014**
Live Births	2,816	2,892	2,892	2,567
Natural births	1,970	1,970	1,994	1,712
Caesarian section	822	922	922	855

Inpatient Discharges

The OSHPD *Facility Summary Report* for 2013 states that Tri-City Medical Center had a total of 17,641 inpatient discharges, with 91.8% for Acute Care (16,195); 7.1% for Psychiatric Care (1,252); and 1.1% for Physical Rehabilitation Care. Total number of inpatient discharge days for 2013 were reported as 74,158, with an average length of stay at 4.2 days. Tri-City Medical Center total inpatient discharges have decreased by approximately 18% overall from 2007-2013.

Tri-City Medical Center - Inpatient Discharges 2007-2013

Year	Discharges	Days	Ave. Stay
2007	21,458	84,443	3.9 days
2008	20,715	83,090	4.0 days
2009	19,855	79,559	4.0 days
2010	19,169	73,549	3.8 days
2011	18,991	75,063	4.0 days
2012	18,803	76,728	4.1 days
2013	17,641	74,158	4.2 days

Demographics for Tri-City Medical Center inpatient discharges for 2013 were 57.6% female and 42.3% male. This female/male patient ratio is generally consistent with 2007-2013 reported data. In 2013, Tri-City Medical Center patients between 20-59 years totaled 43.5% of all discharges; patients between 60-80+ totaled 39.4%; and patients from 0-19 totaled 17.1%. Highest age range frequency for Tri-City Medical Center total inpatient discharges in 2013 was: 17.2% at 80+ years; 14.9% under 1 year; and 12.8% at 20-29 years.

Tri-City Medical Center - Inpatient Age Ranges 2007-2013

Year	Under 1 yr.	1-19	20-39	40-59	60-80+
2007	19.2.0%	3.7%	23.7%	16.4%	37.1%
2008	19.1%	3.4%	23.6%	16.2%	37.8%
2009	16.7%	3.7%	23.5%	18.6%	36.6%
2010	15.8%	3.3%	22.5%	18.4%	40.0%
2011	15.8%	2.9%	23.2%	19.3%	38.8%
2012	15.2%	2.6%	22.9%	19.9%	39.4%
2013	14.9%	2.2%	23.2%	20.3%	39.4%

Tri-City Medical Center 2007-2013 inpatient demographic trends show a decrease in the number of inpatients within the 0-19 age ranges and a slight increase in the number of inpatients within the 40-80+ age ranges.

Emergency Department (ED) Services

The Tri-City Medical Center includes a licensed Basic Emergency Department (ER), but is not designated as a regional Trauma Center. The Tri-City HD reports that emergency physician services are available 24-hour, while on-call services include: anesthesiologist, laboratory services, operating room, pharmacist, psychiatric ER, and radiology.

Tri-City Medical Center ED Encounters and Dispositions 2007-2013

Year	Encounters	Routine Discharges (%)
2007	56,226	53,511 (95.2%)
2008	57,218	54,342 (95.0%)
2009	57,163	53,521 (93.6%)
2010	56,750	53,238 (93.8%)
2011	57,771	53,992 (93.5%)
2012	55,462	52,001 (93.8%)
2013	56,604	53,159 (93.9%)

The Tri-City Medical Center 2013 Emergency Department (ED) *Facility Summary Report* states that a total of 56,604 ED Encounters occurred during the reporting period. In 2013, Tri-City Medical Center ED Encounters most often (93.9%) resulted in routine discharges where the patient was released to home or self-care.

The most frequent diagnosis types for 2013 ED encounters were reported as *Injuries/Poisonings/Complications*, at 24.3%; *Symptoms*, at 21.8%; and, *Respiratory System*, at 9.3%; all other ED diagnosis types were less than 7%. Demographics for Tri-City Medical Center ED Encounters in 2013 were reported as 55% female and 45.0% male.

Total 2013 ED Encounters for the 0-19 years age range was 23.2%; with 42.8% from 20-49 years, and 34.1% from 50 to 80+ years. Highest frequency age ranges were reported as 17.2% for 20-29 years; 13.5%, for 30-39 years; 12.1%, for 40-49 years; and 11.8%, for 50-59 years.

Emergency Department Ambulance Diversion Hours

The OSHPD *Annual Utilization Report* for 2013 states that the Tri-City Medical Center had a total of 124 *Ambulance Diversion* hours during the year when the ED was unable to receive ambulance patients which resulted in ambulances being diverted to other hospitals. The HD reported a total of 209 ambulance diversion hours in 2012, and 238 in 2011.

Ambulatory Surgery

The Tri-City HD's submitted 2013 *Facility Utilization Report* for the Tri-City Medical Center states that the hospital had a total of 12 operating rooms that performed a total of 6,467 surgical operations, with a total of 3,621 inpatient procedures and 2,846 outpatient procedures.

The 2013 OSHPD *Facility Summary Report* for the Tri-City Medical Center reports a total of reported a total of 6,563 Ambulatory Surgery Encounters, with the principal procedure groups as *Cardiovascular System* at 29.6%; *Digestive System* at 15.7%; and *Urinary System* at 8.9%. Dispositions for 6,286 (95.8%) of the 2013 Ambulatory Surgery Encounters were reported as routine discharges to home or self-care.

Tri-City Medical Center Ambulatory Surgery Encounters 2010-2013

Year	AS Encounters	Principal Surgery (%)
2007	11,072	Cardiovascular System (21.0%)
2008	10,817	Cardiovascular System (23.1%)
2009	8,802	Cardiovascular System (25.8%)
2010	8,045	Cardiovascular System (30.1%)
2011	7,038	Cardiovascular System (31.0%)
2012	6,504	Cardiovascular System (32.2%)
2013	6,563	Cardiovascular System (29.6%)

The total Tri-City Medical Center Ambulatory Surgery encounters have averaged approximately 8,400 per year from 2007-2013; however, total annual encounters have decreased by approximately 41% from during that time.

Demographics for Tri-City Medical Center Ambulatory Surgery Encounters in 2013 were reported as 50.3% female and 49.7% male, with top age ranges as 21.4% for 70-79 years; 19.8% for 80+ years; 19.6%, for 60-69 years; and 17.0% for 50-59 years. Total 2013 Ambulatory Surgery Encounters for the 1-19 years range was 0.9%; with 21.3% from 20-49 years, and 77.8% from 50 to 80+ years.

Adequacy of Services

Hospital Quality Indicators

The health care services provided by hospitals are measured for quality by several public and private organizations using a variety of *quality indicators* (QIs), including patient experience ratings; inpatient mortality rates for selected medical procedures and conditions; and the volume and frequency of selected medical procedures. The quality indicators establish annual rates for the subject hospitals that are measured against county and/or state averages.

The healthcare service quality indicators used in the *2015 San Diego County Health Care Services MSR and Sphere Review* are produced by: the California HealthCare Foundation (CHCF) through *CalQualityCare.org*, which establishes hospital ratings from patient survey responses on their experiences receiving medical services; and by the federal *Agency for Healthcare Research and Quality (AHRQ)*, which compiles OSHPD statistics on hospital performance for selected medical procedures and conditions in comparison to county and/or statewide averages.

The annual quality indicator results and hospital ratings provide a comprehensive set of data for evaluating the ongoing adequacy of services provided by the local Health Care Districts. Quality indicator category rates that are consistently lower or higher than county and state averages are noted for additional consideration within the Tri-City HD's adequacy of services determinations.

CalQualityCare.org Hospital Ratings

The California HealthCare Foundation (CHCF), a non-profit philanthropic foundation, produces hospital quality ratings through *CalQualityCare.org* for 332 acute care hospitals in the state of California. CalQualityCare.org hospital ratings are based on patient survey responses regarding their healthcare service experiences, and provide hospital clinical care, patient safety, and patient experience indicators in relation to statewide averages to produce a Patient Experience Rating of:

- Superior, where the provider performed well above average;
- Above Average, where the provider performed better than average;
- Average, where the provider performed within the average;
- Below Average, for performance worse than average; and,
- *Poor*, for performance well below the average level.

CalQualityCare.org Indicators

For 2012-2013, CalQualityCare.org reports that Tri-City Medical Center received an overall *Patient Experience Rating* of ***Below Average*** and a total score of ***59%***, compared to the California state average of 68%. The Tri-City Medical Center *Hospital Readmission Rate* was rated as ***Average*** (15.70%), compared to the California state average of 15.9%.

Patient responses indicate that ***65%*** would recommend the Tri-City Medical Center compared to the State average of 70%. 2012-2013 CalQualityCare.org indicators and ratings for the Tri-City Medical Center are as follows:

Tri-City Medical Center 2012-2013 CalQualityCare.org Indicators and Ratings

Indicator	Rating (Score)	State Average
Patient Experience		
Hospital Rating	***Below Average*** (59%)	68%
Hospital Readmission Rate	*Average* (15.70%)	15.9%
Patient Safety		
Surgical Care Measures	***Superior*** (98%)	97%
Unplanned Surgical Wound Reopening	*Average* (0.18%)	0.09%
Death after Serious Treatable Complication	*Average* (8.65%)	10.84%
Accidental Lung Puncture	*Average* (0.03%)	0.03%
Heart Attack		
Death Rate	*Average* (15.80%)	14.90%
Quality of Care	***Superior*** (100%)	98%
Timeliness of Care	***Superior*** (98%)	N/A
Readmission Rate	*Average* (17.20%)	18.20%
Heart Bypass Surgery		
Death Rate	*Average* (2.33%)	2.17%
Internal Mammary Artery Usage	*Average* (100%)	97%
Postoperative Stroke	*Average* (0.74%)	1.31%
Heart Failure		
Death Rate	*Average* (13.50%)	11.20%
Quality of Care	***Superior*** (100%)	96%
Readmission Rate	*Average* (21.10%)	22.80%
Mother & Baby		
C-Section Rate	*Average* (25.90%)	27.80%
Breastfeeding Rate	*Average* (53.7%)	63.20%
Episiotomy Rate	*Average* (8.80%)	13.50%
VBAC Rate	*Average* (10.50%)	8.30%
Pneumonia		
Death Rate	*Average* (13.30%)	11.70%
Quality of Care	***Above Average*** (95%)	96%
Readmission Rate	*Average* (15.90%)	17.50%
Surgeries / Other Conditions		
Acute Stroke Death Rate	***Poor*** (13.80%)	9.91%
Craniotomy Death Rate	***Poor*** (23.0%)	7.81%
Gastrointestinal Hemorrhage Death Rate	*Average* (4.20%)	2.31%
Hip Fracture Death Rate	*Average* (3.10%)	2.47%
Hip or Knee Surgery Readmission Rate	*Average* (5.20%)	5.20%
Hip or Knee Surgery Complication Rate	*Average* (3.80%)	3.30%
Emergency Department Care		
Time in ED before being admitted	364 minutes	338 minutes
Time in ED before being sent home	221 minutes	165 minutes
Time in ED before being seen	43 minutes	32 minutes
Patients who left ED without being seen	5%	2%

The 2012-2013 CalQualityCare.org indicators and ratings for Tri-City Medical Center medical procedures are generally consistent with or exceed state average levels. The Tri-City Medical Center indicator ratings include four categories rated as ***Superior*** and two categories rated as ***Poor***.

However, more significant is the overall *Patient Experience Rating* of ***Below Average*** and a total score of ***59%***, compared to the California state average of 68%; and that patient responses indicate that only ***65%*** would recommend Tri-City Medical Center compared to the State average of 70%.

Inpatient Quality Indicators (IQIs)

The Federal Agency for Health Care Research and Quality (AHRQ) supplies Inpatient Quality Indicators (IQIs) at the Area Level (county, statewide) and Facility Level (hospital) based on inpatient data provided to OSHPD by all California-licensed acute-care hospitals. The *Facility Level Indicators* for hospitals are compared to statewide results to provide a consumer perspective on hospital quality of care. These hospital indicators include*:*

- Volume Indicators for the numbers performed of six selected medical procedures; and,
- Inpatient Mortality Indicators (IMIs) for the six medical procedures and other conditions.

Hospital Volume Indicators

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 six volume indicators provide the number of the following medical procedures performed within each hospital:

- Esophageal Resection (Surgical removal of the esophagus due to cancer)
- Pancreatic Resection (Surgical removal of the pancreas/gall bladder due to cancer)
- Abdominal Aortic Aneurysm (AAA) Repairs (Surgical repair of abdominal aneurysm)
- Carotid Endarterectomy (Surgical removal of plaque within the carotid artery)
- Coronary Artery Bypass Graft Surgery (CABG) (Surgical heart artery procedure)
- Percutaneous Coronary Intervention (PCI) (Non-surgical heart artery procedure)

From 2011-2013, the Tri-City Medical Center reported consistent levels of performed volume indicator procedures. Highest volumes were reported for Abdominal Aortic Aneurysm (AAA) Repairs, Carotid Endarterectomies, Coronary Artery Bypass Graft Surgeries (CABG), and Percutaneous Coronary Interventions (PCI).

Tri-City Medical Center Volume 2011-2013

Volume	Statewide			Tri-City Medical Center		
Medical Procedure	**2011**	**2012**	**2013**	**2011**	**2012**	**2013**
Esophageal Resection	482	484	480	0	1	0
Pancreatic Resection						
Total	1,693	1,736	1,770	2	1	2
Cancer	904	933	968	1	0	1
Other	789	803	802	1	1	1
Volume	**Statewide**			**Tri-City Medical Center**		
Medical Procedure	**2011**	**2012**	**2013**	**2011**	**2012**	**2013**
AAA Repair						
Total	2,765	2,728	2,877	19	24	19
Ruptured, Open	168	133	136	0	3	1
Un-ruptured, Open	351	319	280	2	1	3
Ruptured, Endovascular	120	142	171	2	5	2
Un-ruptured, Endovascular	2,133	2,137	2,301	15	15	13
CABG	16,283	15,125	15,488	81	95	80
PCI	46,677	42,797	39,792	224	245	218
Carotid Endarterectomy	6,696	6,457	6,171	60	44	34

Inpatient Mortality Indicators

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. During 2011-2013, OSHPD reported the following Risk-Adjusted Mortality Rates (RAMR) for the selected procedures and conditions performed at the Tri-City Medical Center:

Tri-City Medical Center 2011 Risk-Adjusted Mortality Rate (RAMR)

Inpatient Mortality Indicator (IMI)	2011 Mortality Rate (total deaths; total cases)	
Procedure	*Statewide*	*Tri-City Medical Center*
Esophageal Resection	3.8% (15;391)	0
Pancreatic Resection	3.1% (23;750)	0
Abdominal Aortic Aneurism Repair	1.9% (46;2,478)	4.4% (1;17)
Craniotomy	6.8% (980;14,331)	23.0% (10;49) ***Worse***
Percutaneous Coronary Intervention	2.3% (1,051;44,775)	3.0% (3;211)
Carotid Endarterectomy	0.5% (34;6,660)	0.0% (0;60)
Condition		
Acute Myocardial Infarction (Heart attack)	6.5% (3,005;46,278)	5.3% (14;303)
Heart Failure	3.0% (2,538;85,338)	3.4% (11;382)
Acute Stroke	9.4% (5,100;54,088)	13.8% (55;407) ***Worse***
Gastro-Intestinal Hemorrhage	2.2% (1,084;48,347)	4.2% (7;272)
Hip Fracture	2.3% (560;23,955)	3.1% (5;212)
Pneumonia	4.1% (2,993;73,002)	3.8% (16;435)

Tri-City Medical Center 2012 Risk-Adjusted Mortality Rate (RAMR)

Inpatient Mortality Indicator (IMI)	2012 Mortality Rate (total deaths; total cases)	
Procedure	*Statewide*	*Tri-City Medical Center*
Esophageal Resection	5.7% (22;387)	0
Pancreatic Resection (Total)	2.4% (41;1,724)	0
Abdominal Aortic Aneurism Repair	1.1% (26;2,437)	6.6% (1;16)
Craniotomy	7.1% (1,065;15,030)	11.9% (8;66)
Percutaneous Coronary Intervention	2.5% (1,015;40,790)	2.2% (3;232)
Carotid Endarterectomy	0.5% (31;6,407)	2.7% (1;44)
Condition		
Acute Myocardial Infarction (Heart attack)	6.3% (2,938;46,663)	10.8% (32;328) ***Worse***
Heart Failure	3.0% (2,458;81,250)	3.5% (12;358)
Acute Stroke (Total)	9.6% (5,227;54,191)	14.3% (45;395) ***Worse***
Gastro-Intestinal Hemorrhage	2.1% (1,024;47,893)	2.9% (7;302)
Hip Fracture	2.3% (552;23,774)	3.6% (7;218)
Pneumonia	4.0% (2,606;64,400)	4.0% (10;339)

Tri-City Medical Center 2013 Risk-Adjusted Mortality Rate (RAMR)

Inpatient Mortality Indicator (IMI)	2013 Mortality Rate (total deaths; total cases)	
Procedure	*Statewide*	*Tri-City Medical Center*
Esophageal Resection	4.8% (18;377)	0
Pancreatic Resection	3.5% (62;1,763)	0
Abdominal Aortic Aneurism Repair	1.4% (36;2,560)	0.0% (0;16)
Craniotomy	7.2% (1,094;15,187)	10.6% (4;45)
Percutaneous Coronary Intervention	2.7% (1,013;37,885)	0.6% (1;208)
Carotid Endarterectomy	0.5% (29;6,139)	0.0% (0;34)
Condition		
Acute Myocardial Infarction (Heart attack)	6.0% (2,803;46,984)	6.9% (21;302)
Heart Failure	3.0% (2,510;83,220)	4.5% (16;382)
Acute Stroke	9.2% (5,072;54,983)	11.3% (45;386)
Gastro-Intestinal Hemorrhage	2.3% (1,087;47,723)	3.7% (12;273)
Hip Fracture	2.0% (494;24,103)	4.4% (7;188)
Pneumonia	3.9% (2,487;63,853)	4.8% (12;320)

In the 2010-2012 reporting periods, the Tri-City Medical Center performed a limited number of the selected indicator procedures and served a limited number of patients experiencing the selected conditions; however, the Tri-City Medical Center mortality rates were generally consistent with state averages for most of the condition indicators with reported totals.

Repeated annual mortality rate deficiencies for particular indicator procedures or conditions should be addressed and corrected by the Health Care Districts; however, no consistent Tri-City Medical Center mortality rate deficiencies were identified from 2011-2013.

Hospital Infrastructure Needs and Deficiencies

State Seismic Requirements for Hospital 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 Seismic Safety 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 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 2008 that was extended to 2013. Subsequent legislative changes 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.

Senate Bill 1953 also required OSHPD to develop a Structural Performance Category (SPC) rating for each licensed general acute care hospital facility that indicates the building's compliance with seismic safety standards; and a Non-Structural Performance Category (NPC) 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.

Following OSHPD determination of SPC/NPC facility ratings, the hospital licensee must prepare a comprehensive evaluation report and compliance plan for the hospital to attain the specified structural and nonstructural performance categories by the specified timeframes, with an ultimate compliance date of 2030.

Tri-City Medical Center Seismic Safety Ratings

The Tri-City Medical Center facilities include seismic safety ratings that require rehabilitation or replacement of non-compliant buildings or structures by the mandated deadlines. Local voters have not approved several proposed bond financing measures (June 2006, November 2006, August 2008) that were intended to fund needed seismic improvements at the Tri-City Medical Center. Without identified capital improvement financing, it is unclear if compliance with the seismic safety standards will occur prior to the required state deadlines.

As of September 2014, the Tri-City Medical Center has the following OSHPD Structural Performance Category (SPC) and Non-Structural Performance Category (NPC) seismic ratings and extension review status:

Tri-City	SPC	Hz	NPC	SB499It2 Ext	SB306Ext
Center Tower	2	0.57	2	1/1/2030	Denied
North Wing	4		2		
Center Complex N	4		2		
South Tower	2	0.71	2		
Elect. Bldg.	4s		2		
Ctr.Cmplx.Add	4		2		
Mat/Lab Bldg	4		2		
Radiology Add	4		2		
ER Add	4s		2		
Admin.	4		2		
Pavilion Bldg/Can	4		2		
Anc. Bldg	4		2		
S Tower Stair Sft	1		2	SB90 Ext: In Review	SB499It2: 1/1/2030
Perinatal /Wmn	4s		2		
Surg. Add 1 & 2	3		2		
Central Plant	4s		2		
Center Complex S	3		2		
Behav.Hth Unit	N/A				

As the OSHPD ratings reflect, the Tri-City Medical Center has several buildings and structures that will require rehabilitation or replacement per the following criteria and deadlines for conformance:

- SPC-2: These buildings are in compliance with pre-1973 California Building Code or other applicable standards, but are not in compliance with the structural provisions of the Alquist Hospital Facilities Seismic Safety Act. They do not significantly jeopardize life but may not be repairable or functional following strong ground motion. These buildings must be brought into compliance with the Alquist Act by January 1, 2030 or be removed from acute care service.
- SPC-4: These buildings are in compliance with the Alquist Act but may experience structural damage which could inhibit the building's availability following a strong earthquake. These buildings will have been constructed or reconstructed under a building permit obtained through OSHPD. They may be used to 2030 and beyond.
- NPC-2: In these buildings, essential systems vital to the safe evacuation of the building are adequately braced. The building is expected to suffer significant nonstructural damage in a strong earthquake.

Per OSHPD's SPC 2 and NPC 2 facility designations, the Tri-City Medical Center's Center Tower and South Tower buildings are required to be brought into compliance with the seismic requirements by January 1, 2030 or be removed from acute care service. SB 499-related extensions on NPC requirements have been requested by Tri-City HD and are in review by OSHPD as of this report. Options for retention of the Tri-City Medical Center acute-care hospital facilities may require additional efforts to obtain sufficient local voter approval for bond financing to fund the needed rehabilitation or replacement of the deficient facilities.

Tri-City HD Campus Development Plan

In response to the seismic requirements and the unavailability of local bond financing, the Tri-City HD has approved concept plans for development of additional self-funded capital expansions, including the construction of a central power plant, an outpatient services building, and/or a new hospital building for its intensive care unit and emergency department. Preliminary district studies plan for a phased approach involving a medical office building (currently under construction), a parking lot and a six-story parking structure in the first phase. Plans for phase 2 could include construction of a central power plant, an outpatient services building and administrative offices. Phase 3 plans for the addition of 216 private medical/surgical/OB rooms in a seven-story tower. The final phase is anticipated to involve replacement and reuse of the Tri-City Medical Center facility.

The Tri-City HD has also been expanding the Tri-City Medical Center facilities to increase its range of services. Tri-City HD has recently constructed the Orthopedic and Spine Institute (2011), the Cardiovascular Health Institute (2010), the Tri-City Medical Office Building in Carlsbad (2010), the Tri-City Wellness Center (2009), and the Center for Wound Care and Hyperbaric Medicine (2008).

Finance: Financial Ability to Provide Services

Annual Hospital Financial Disclosure Reports

The Tri-City HD is required to submit annual financial disclosure reports for its licensed acute-care hospital facilities to OSHPD within four months of the close of the district's fiscal year that include a detailed income statement, balance sheet, statements of revenue and expense, and supporting schedules.

OSHPD uses the submitted hospital financial data to produce an *Annual Financial Disclosure Report* for each licensed acute-care hospital that discloses annual totals for: patient revenues; operating and non-operating expenses; breakdowns of expenditures by category; net operating income; and total income or loss.

Health Care 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 regarding special district revenues, expenditures, property taxes, and bonded debt.

The County of San Diego Auditor and Controller produces a detailed annual summary of local tax information for each fiscal year that identifies the amount of property tax allocated to the Health Care Districts and reports any bonded indebtedness held by the Districts.

The annual Health Care District and hospital financial disclosure reports produced by the California State Controller, the County of San Diego, and OSHPD provide the public with a comprehensive overview of the annual financial status of the Tri-City HD, as well as the Tri-City Medical Center operations.

Financial Performance Indicators

The financial performance of a Health Care District and associated provision of health care services can be evaluated by several fiscal totals disclosed in the annual financial reports, including: revenues and expenditures; net-from-operations; annual profit or loss; total bonded indebtedness; and operating margin.

A hospital's *net-from-operations* indicator compares a hospital's total operating revenue against its total operating expenses and is the most commonly used financial ratio to measure a hospital's financial performance. A positive net-from-operations indicates that a hospital is operating at a profit; a negative figure indicates that the hospital is operating at a financial loss for the reporting period.

Tri-City Medical Center Revenue/Expenditure Characteristics (FY2013-2014)

Net Patient Revenue: $304,085,269
Inpatient: $192,684,676; Outpatient: $111,400,593
Net from Operations: ($11,819,558)
Net Income: $1,933,170
Operating Margin: (-3.84%)

For the 2013-2014 fiscal year, the Tri-City Medical Center reported total operating revenues of $307,831,204 and total operating expenses of $319,650,762, resulting in a n*et from operations* loss of ($11,819,558) and a total net income $1,933,170. This income follows a total loss of ($13,615,081) for the preceding 2012-2013 fiscal year.

The following table summarizes the Tri-City Medical Center's financial performance over the 2007-2014 fiscal years:

Tri-City Medical Center Revenues/Expenditures (FY2007-FY2014)

Year	Operating Rev.	Operating Exp.	Net from Op	Income / Loss
2007-08	$266,190,375	$267,956,035	($1,765,660)	$9,258,017
2008-09	$278,070,805	$289,199,816	($11,129,011)	($5,014,909)
2009-10	$267,223,963	$292,530,964	($25,307,001)	($18,532,882)
2010-11	$297,524,801	$289,665,465	$7,859,336	$14,848,941
2011-12	$306,939,626	$308,322,785	($1,383,159)	$6,087,033
2012-13	$296,249,104	$318,319,098	($22,069,994)	($13,615,081)
2013-14	$307,831,204	$319,650,762	($11,819,558)	$1,933,170

During the 2007-2008 to 2013-2014 fiscal years, Tri-City HD has reported a cumulative total income loss of ($5,035,711) and has reported an average net-from-operations loss of ($9,373,578) per year.

Bonded Debt

As of FY 2013-2014, the Tri-City HD reports no long-term bonded indebtedness. The Tri-City HD did not achieve the required 2/3 voter approval for proposed bond measures over three separate elections: June 2006 (65.91%), November 2006 (64.8%), and August 2008 (62.45%). The repeated inability to secure sufficient voter approval for long-term capital financing has created uncertainty in the availability of sufficient funding for needed Tri-City HD facility improvements and expansions.

Property Tax Revenues

As a special district formed prior to the passage of Prop 13 in 1978, the Tri-City HD receives an annual allocation from the 1% ad valorum property tax for property within its respective service area. The District receives a share of this basic tax levy proportionate to what it received during the years 1976-1978.

The County of San Diego Tax Summary for fiscal year 2013-2014 states that the annual allocation of property tax revenues accounts for approximately 2.5% of the Tri-City HD's total net operating revenues. County of San Diego annual tax reports from FY2008-2009 to FY2012-2013 indicate that the Tri-City HD has received consistent levels of annual property tax revenues, with an average unrestricted total of $7,449,153 allocated to the district.

County of San Diego Tax Summary

Allocated Property Tax Revenue FY2013-2014

	Prop. Tax Revenue	% of Net Operating Revenues
Tri-City HD	$7,612,806	2.5%

Allocated Property Tax Revenue FY2008-2009 to FY2012-2013

	Annual Average
Tri-City HD	$7,451,453

Budgets/Audits

The Tri-City HD Board of Directors adopts a budget for each fiscal year following public hearings. The Tri-City HD budgets and financial information are regularly audited by certified independent auditors, and the audited financial statements are publically disclosed and published, as required by State Law (Health and Safety Code Section 32133); no financial violations have been reported.

The following table summarizes the Palomar Health HD budgeted/audited revenues and expenses reported for the two most recent fiscal years (FY2012-2013 and FY2013-2014):

Tri-City HD

Operating Revenues/Expenditures	**FY2013-2014**	**FY2012-2013**
Operating Revenues	$319,743,000	$308,193,000
Operating Expenses	$325,398,000	$322,548,000
(Loss) Income from Operations	($5,655,000)	($14,355,000)
Change in Net Position	$2,748,000)	($14,933,000)
Ending Net Position	$94,623,000	$91,875,000

Governance and Operations

Board of Directors

The Tri-City HD is governed by an elected five-member Board of Directors that meets regularly on the 4th Thursday of each month at 3:30 p.m. The Board meeting notices and agendas are posted 72-hours in advance of each meeting at the Tri-City HD's administrative office at 4002 Vista Way, Oceanside.

The Board Members are elected at-large to 4-year terms. The Tri-City HD Board includes the following standing subcommittees: Audit & Compliance Committee; Community Healthcare Alliance Committee (CHAC); Finance, Operations, & Planning Committee; Governance and Legislative Committee; Human Resources Committee; and the Professional Affairs Committee

Tri-City Medical Center Operations

The Tri-City HD independently administers and operates the Tri-City Medical Center.

Community Service Accountability

The HDs Tri-City HD provide community accountability through their provision of local non-profit grant programs; health care related educational programs; community health care events; noticed public meetings; district and hospital internet websites; as well as providing local acute-care hospital facilities, emergency department services, surgical services, and offering the only Level III neonatal intensive care unit (NICU) in North County.

District Resident Benefit Program

The Tri-City HD has established a *District Resident Benefit Program* to recognize the local resident's contributions and support; non-district residents can access the benefits only upon annual payment of $100. Residents within the Tri-City HD service area and sphere are eligible for the following benefits at the Tri-City Medical Center:

- *Cafeteria Discount* - Discounted food purchases in the Hospital Cafeteria during non-peak hours.
- *Patient Co-Payment Credit* – Residents with commercial insurance or paying cash for Tri-City Medical Center services will be eligible for up to a $50 annual credit on the patient liability portion of their Tri-City Medical Center bill(s).
- *Preferential Scheduling and Free Flu Shots* - Residents will receive preferential appointment scheduling over non-district residents and receive free flu shots.
- *Free Valet Parking* - Residents will receive free valet parking; non-district residents will be charged a fee for valet parking.

Tri-City Medical Center Accreditations

The Joint Commission, the national organization that establishes standards for healthcare quality and safety, has awarded the Tri-City Medical Center its Gold Seal of Approval and

accreditation. The accreditation is for a three-year period, the maximum period awarded by the Joint Commission. The Joint Commission's standards are designed to address the organization's performance in key functional areas, such as patient rights, medication management and infection control.

The Joint Commission survey focused on all Tri-City HD programs including Home Care, Hospice, Behavioral Health and the Wellness Center. The Joint Commission has also awarded Tri-City Medical Center with a Gold Seal of Approval for Primary Stroke Care and a Certificate of Distinction for Inpatient Diabetes Care.

Additional Tri-City Medical Center accreditations include:

- Clinical Laboratory - Nationally Accredited
- Chest Pain Center - First Accredited in San Diego County
- Commission on Cancer - Nationally Accredited
- Radiology Department - Nationally Accredited for Nuclear Medicine, Magnetic Resonance Imaging, and Ultrasound
- International Board of Lactation Consultant Examiners and the International Lactation Consultant Association - Recognized Tri-City Medical Center for their service of excellence in maternal-child health team and breast feeding programs.

Community Grant Program

The Tri-City HD Community Grant Program funds local health care projects of non-profit programs that benefit the health and well-being of the residents within the Tri-City HD. Awarded grant funding is distributed to approved 501(c)3 non-profit organizations that provide programs and services to support: health care access; health conditions related to lifestyle, including obesity and overweight, physical activity and exercise, diabetes, and heart disease; and mental health.

Status of and Opportunities for Shared Facilities

The Tri-City HD has engaged in a number of partnerships with other health care entities to maximize its ability to provide and maintain health care programs and services to its service area residents, including Joint Powers Agreements (JPA) with adjacent Health Care Districts as described below.

2013 Fallbrook HD - Tri-City HD JPA

In June 2013, the Fallbrook HD and the Tri-City HD entered into a Joint Powers Agreement (JPA) that allows doctors at Fallbrook Hospital to refer patients who need specialized tertiary care not offered at Fallbrook Hospital to the Tri-City Medical Center in Oceanside. Tertiary care is described as a higher level of specialty care requiring highly specialized equipment and expertise such as: specialized cardiac procedures such as a catheterization lab and bypass surgery, stroke care/recovery, broader oncology services, renal or

hemodialysis, robotic and minimally-invasive surgeries, and many other complex treatments and/or procedures.

Tertiary care provided at the Tri-City Medical Center includes acute rehabilitation care, orthopedic and neurosurgical services, specialized spine surgery, cardiovascular services, behavioral health services, neonatal intensive care services and hyperbaric medicine. Per the JPA, Tri-City doctors reciprocally refer patients who live between the two hospitals and who are not in need of tertiary care to the Fallbrook Hospital.

The 2013 JPA was intended to provide mutual benefits to the two Districts by maximizing efficiency and reducing duplicative services and facilities; however, the closure of the Fallbrook Hospital in December 2014 does not allow for the reciprocal services identified in the JPA to be provided by Fallbrook HD. While the JPA has not been officially terminated by action of the Health Care District Boards, the closure of Fallbrook Hospital has functionally concluded the 2013 JPA relationship between the Districts.

The existing Joint Powers Agreements (JPAs) between Fallbrook HD and Tri-City HD and between Fallbrook HD and Palomar Health HD may serve as models to promote future opportunities for local and regional HD partnerships to help maximize use of HD acute-care facilities, trauma centers, and surgical facilities.

2009-2012 San Diego County Grand Jury Reports on Tri-City HD

In 2008, following local citizen complaints, the San Diego County Grand Jury first investigated Tri-City HD Board controversies and ultimately produced three reports from 2009-2012 that identified issues concerning Board dysfunction and alleged Brown Act violations. The Grand Jury reports concluded with findings and recommendations for Tri-City HD correction and improvement, and posed general questions of governance options for the Health Care Districts and their elected Boards.

In 2011, an audit of Tri-City HD financial and pension data was successfully completed and the Grand Jury investigations concluded that the HD had committed no violations. The Grand Jury recommended additional training for Tri-City HD Board members regarding the Brown Act. The specific Tri-City Board controversies that led to the Grand Jury reports appear to have been functionally resolved through normal electoral turnover of Board members in the 2012 Board elections, and subsequent Tri-City HD administrative staffing changes.

The Grand Jury reports also questioned the process of publically electing Board members, which may allow for potential Board dysfunction when Board members are unable to effectively collaborate for the mutual benefit of the district, and involves significant election costs to the Health Care Districts; however, following the initial appointment of Board members by the County Board of Supervisors when a Health Care District is originally formed, State Law requires subsequent Health Care District Boards to be publically elected [Health and Safety Code Section 32001].

An elected Board also ensures local control over district finances, facilities and programs through community-determined representatives that are subject to the reelection by the local voters in subsequent election cycles.

The 2009-12 Grand Jury reports also recommended a review of the model of governance at Tri-City Healthcare District, as well as governance models in use by other health care organizations. The Grand Jury recommended the consideration of several governance alternatives for Tri-City, including merging the district with the neighboring Palomar Health HD, turning over hospital operations to an outside party, or selling the Tri-City Medical Center to another health system. These governance options are discussed below.

Governance and Governmental Structure Options

Governmental structure options available to Health Care Districts include several different changes of organization or reorganization, including: dissolution of one or more districts with annexation of the dissolved district's service area into one or more successor districts; consolidation of two or more districts into one or more successor districts; or a combination of governance actions involving annexations or detachments of district service area and sphere territory.

A proposed reorganization involving dissolution/annexation, or a consolidation/merger of Health Care Districts would transfer the district's assets and liabilities to a designated successor agency, including responsibility for assuming any voter-approved bonded indebtedness. Therefore, a key issue to be determined when considering potential governmental structure options for Health Care Districts involves the identification of a successor agency that is both authorized and capable of sustaining the provision and level of health care services presently provided by the affected Health Care District(s).

In the San Diego Region, the County of San Diego is the primary local public agency currently responsible for and presently providing county-wide health care services. Unless one or more of the existing Health Care Districts were designated as a successor agency, the County of San Diego would be the logical successor agency with capacity to assume operational responsibility for a dissolved Health Care District's facilities and assure the continued provision of health care services in either incorporated or unincorporated Health Care District service area territory. While the County of San Diego does not directly operate acute-care public hospitals, the County could consider options for leasing the district hospital facilities and/or contracting the health care service responsibilities within a dissolved Health Care District's service area.

Proposed changes of organization or reorganization for Health Care Districts may be initiated by: sufficient petition of local voters or landowners; a resolution of subject/affected agencies; or by LAFCO action.

If LAFCO approves a proposed reorganization or consolidation/merger involving one or more Health Care Districts, State Law allows for written protest to be filed with the Commission by affected registered voters or landowners. If LAFCO approves a proposed jurisdictional change that involves dissolution of one or more Health Care Districts, or a

Health Care District proposes to transfer more than 50% of the district's assets, State Law requires the dissolution or transfer agreement to be approved by local voters.

Additional study should be conducted by the Health Care Districts to determine if any of the available governance options may be feasible, beneficial, and desirable for sustainably meeting future community health care demands and local facility and service needs.

Conclusion: MSR Determinations / Sphere Recommendations

The *2015 San Diego County Health Care Services MSR and Sphere Review* determinations conclude that the Tri-City HD is adequately providing health care services within its service area and sphere and is accountable for the local community's service needs. The *MSR and Sphere Review* determinations also reflect that the Tri-City Medical Center has adequate capacities for patient needs; facility improvements are being undertaken to address any infrastructure deficits or needs; hospital ratings and quality indicators are consistent with state averages and reflect adequate provision of health care services; however, annual financial disclosures report that inpatient revenues are insufficiently adequate to support the Tri-City HD's financial ability to provide services as an independent acute-care hospital operations.

The Tri-City HD did not achieve the required 2/3 voter approval for proposed bond measures over three separate elections: June 2006 (65.91%), November 2006 (64.8%), and August 2008 (62.45%). The repeated inability to secure sufficient voter approval for long-term capital financing has created uncertainty in the availability of sufficient funding for needed Tri-City HD facility improvements and expansions.

The following is a summary of the *2015 San Diego County Health Care Services MSR and Sphere Review* conclusions for the Tri-City HD in relation to the associated service and sphere determinations; and the sphere of influence recommendations for the Tri-City HD:

Municipal Service Review Determination Summaries

Growth and Population Projections

As of 2014, SANDAG reports an estimated total population of 353,396 within the Tri-City HD service area and sphere (Map 5A). According to 2050 SANDAG Subregional Population Estimates (2011), the cumulative population of Tri-City Subregional Areas is projected to grow by approximately 36% during 2013-2050 to a total of 517,893; however, significant population growth is not anticipated over the next 5 years.

According to 2050 SANDAG Subregional Population Estimates (2011), the cumulative population of Tri-City Subregional Areas is projected to grow by approximately 36% during 2013-2050 to a total of 517,893.

Location and Characteristics of Disadvantaged Unincorporated Communities

The Tri-City HD has one disadvantaged unincorporated community within its sphere that is located within an unincorporated island bordered by the Cities of Oceanside and Vista. The

identified disadvantaged unincorporated community is located within and is governed by the General Plan of the County of San Diego and the community plan for the North County Metro Community Planning Area (Map 1C).

Present and Planned Capacity of Public Facilities

During 2013-2014, the Tri-City HD reports an occupancy rate of 48.7% for its 397 licensed acute-care beds, and 54.6% for its 354 available beds. Over 2010-2014, the Tri-City HD reports an average occupancy rate for its licensed beds as 47.7%; however, the district reports that its available beds have an average occupancy rate of 54.3% during the same time period

The OSHPD *Facility Summary Report* for 2013 states that Tri-City Medical Center had a total of 17,641 inpatient discharges, with 91.8% for Acute Care (16,195); 7.1% for Psychiatric Care (1,252); and 1.1% for Physical Rehabilitation Care. Total number of inpatient discharge days for 2013 were reported as 74,158, with an average length of stay at 4.2 days. Tri-City Medical Center total inpatient discharges have decreased by approximately 18% overall from 2007-2013.

The Tri-City Medical Center 2013 Emergency Department (ED) *Facility Summary Report* states that a total of 56,604 ED Encounters occurred during the reporting period. The OSHPD *Annual Utilization Report* for 2013 states that the Tri-City Medical Center had a total of 124 *Ambulance Diversion* hours during the year when the ED was unable to receive ambulance patients which resulted in ambulances being diverted to other hospitals. The HD reported a total of 209 ambulance diversion hours in 2012, and 238 in 2011.

The Tri-City HD's submitted 2013 *Facility Utilization Report* for the Tri-City Medical Center states that the hospital had a total of 12 operating rooms that performed a total of 6,467 surgical operations, with a total of 3,621 inpatient procedures and 2,846 outpatient procedures. The total Tri-City Medical Center Ambulatory Surgery encounters have averaged approximately 8,400 per year from 2007-2013; however, total annual encounters have decreased by approximately 41% from during that time.

The Tri-City HD has an adopted *Campus Development Plan* for the Tri-City Medical Center that identifies current and future facility improvements designed to accommodate expected demands and regulatory requirements.

Adequacy of Public Services

For 2012-2013, CalQualityCare.org reports that Tri-City Medical Center received an overall *Patient Experience Rating* of *Below Average* and a total score of *59%*, compared to the California state average of 68%. The Tri-City Medical Center *Hospital Readmission Rate* was rated as *Average* (15.70%), compared to the California state average of 15.9%. Patient responses indicate that only *65%* would recommend the Tri-City Medical Center compared to the State average of 70%. The 2012-2013 CalQualityCare.org indicators and ratings for Tri-City Medical Center medical procedures are generally consistent with or exceed state average levels.

Tri-City Medical Center inpatient mortality rates were also generally consistent with state averages for most of the condition indicators; no consistent Tri-City Medical Center mortality rate deficiencies were identified from 2011-2013.

Infrastructure Needs or Deficiencies

California seismic safety standards for acute-care hospital facilities are mandated for compliance by 2030. The Tri-City Medical Center facility includes seismic safety ratings that require rehabilitation or replacement of non-compliant buildings or structures by the mandated deadlines. The Tri-City HD has an adopted *Campus Development Plan* for the Tri-City Medical Center that identifies current and future facility improvements designed to accommodate expected demands and regulatory requirements.

Financial Ability to Provide Services

OSHPD Annual Financial Disclosure Reports for the Tri-City Medical Center reflect that the facility is generating inadequate levels of inpatient revenues to fund sustainable independent hospital operations. For the 2013-2014 fiscal year, the Tri-City Medical Center reported total operating revenues of $307,831,204 and total operating expenses of $319,650,762, resulting in a n*et from operations* loss of ($11,819,558) and a total net income $1,933,170. This income follows a total loss of ($13,615,081) for the preceding 2012-2013 fiscal year. During the 2007-2008 to 2013-2014 fiscal years, Tri-City HD has reported a cumulative total income loss of ($5,035,711) and has reported an average net-from-operations loss of ($9,373,578) per year.

The County of San Diego Tax Summary for fiscal year 2013-2014 states that the annual allocation of property tax revenues accounts for approximately 2.5% of the Tri-City HD's total net operating revenues. County of San Diego annual tax reports from FY2008-2009 to FY2012-2013 indicate that the Tri-City HD has received consistent levels of annual property tax revenues, with an average unrestricted total of $7,449,153 allocated to the district.

The Tri-City HD reports no bonded indebtedness. The Tri-City HD did not achieve the required 2/3 voter approval for proposed bond measures over three separate elections: June 2006 (65.91%), November 2006 (64.8%), and August 2008 (62.45%). The repeated inability to secure sufficient voter approval for long-term capital financing has created uncertainty in the availability of sufficient funding for needed Tri-City HD facility improvements and expansions.

Accountability for Community Service Needs

The Tri-City HD provides community accountability through their provision of local non-profit grant programs; resident benefit program; health care related educational programs; community health care events; noticed public meetings; district and hospital internet websites; as well as providing local acute-care hospital facilities, emergency department services, surgical services, and offering the only Level III neonatal intensive care unit (NICU) in North County.

The Tri-City HD Community Grant Program funds local health care projects of non-profit programs that benefit the health and well-being of the residents within the Tri-City HD. Awarded grant funding is distributed to approved 501(c)3 non-profit organizations that provide programs and services to support: health care access; health conditions related to lifestyle, including obesity and overweight, physical activity and exercise, diabetes, and heart disease; and mental health.

Governmental Structure

The 2009-12 San Diego County Grand Jury investigative reports recommended a review of the model of governance at Tri-City HD, as well as governance models in use by other health care organizations. The Grand Jury recommended the consideration of several governance alternatives for Tri-City, including merging the district with the neighboring Palomar Health HD, turning over hospital operations to an outside party, or selling the Tri-City Medical Center to another health system.

Governmental structure options available to Health Care Districts include several different changes of organization or reorganization, including: dissolution of one or more districts with annexation of the dissolved district's service area into one or more successor districts; consolidation of two or more districts into one or more successor districts; or a combination of governance actions involving annexations or detachments of district service area and sphere territory.

A proposed reorganization involving dissolution/annexation, or a consolidation/merger of Health Care Districts would transfer the district's assets and liabilities to a designated successor agency, including responsibility for assuming any voter-approved bonded indebtedness. Therefore, a key issue to be determined when considering potential governmental structure options for Health Care Districts involves the identification of a successor agency that is both authorized and capable of sustaining the provision and level of health care services presently provided by the affected Health Care District(s).

In the San Diego Region, the County of San Diego is the primary local public agency currently responsible for and presently providing county-wide health care services. Unless one or more of the existing Health Care Districts were designated as a successor agency, the County of San Diego would be the logical successor agency with capacity to assume operational responsibility for a dissolved Health Care District's facilities and assure the continued provision of health care services in either incorporated or unincorporated Health Care District service area territory. While the County of San Diego does not directly operate acute-care public hospitals, the County could consider options for leasing the district hospital facilities and/or contracting the health care service responsibilities within a dissolved Health Care District's service area.

Proposed changes of organization or reorganization for Health Care Districts may be initiated by: sufficient petition of local voters or landowners; a resolution of subject/affected agencies; or by LAFCO action.

If LAFCO approves a proposed reorganization or consolidation/merger involving one or more Health Care Districts, State Law allows for written protest to be filed with the

Commission by affected registered voters or landowners. If LAFCO approves a proposed jurisdictional change that involves dissolution of one or more Health Care Districts, or a Health Care District proposes to transfer more than 50% of the district's assets, State Law requires the dissolution or transfer agreement to be approved by local voters.

Additional study should be conducted by the Health Care Districts to determine if any of the available governance options may be feasible, beneficial, and desirable for sustainably meeting future community health care demands and local facility and service needs.

Operational Efficiencies

The *MSR and Sphere Review* determinations state that the continued operational losses at the Tri-City Medical Center indicate that stand-alone independent operations of acute-care hospital facilities are not efficient without adequate numbers of patents to provide sustainable revenues to financially support hospital operations.

The Tri-City HD's repeated inability to secure sufficient local voter approval for bond measures intended to sustain and improve the Tri-City Medical Center facilities may indicate that the local community feels that Tri-City HD operational efficiencies need improvement.

Status and Opportunities for Shared Facilities

In June 2013, the Fallbrook HD and the Tri-City HD entered into a Joint Powers Agreement (JPA) that allows doctors at Fallbrook Hospital to refer patients who need specialized tertiary care not offered at Fallbrook Hospital to the Tri-City Medical Center in Oceanside. Tertiary care is described as a higher level of specialty care requiring highly specialized equipment and expertise such as: specialized cardiac procedures such as a catheterization lab and bypass surgery, stroke care/recovery, broader oncology services, renal or hemodialysis, robotic and minimally-invasive surgeries, and many other complex treatments and/or procedures.

Tertiary care provided at the Tri-City Medical Center includes acute rehabilitation care, orthopedic and neurosurgical services, specialized spine surgery, cardiovascular services, behavioral health services, neonatal intensive care services and hyperbaric medicine. Per the JPA, Tri-City doctors reciprocally refer patients who live between the two hospitals and who are not in need of tertiary care to the Fallbrook Hospital.

The 2013 JPA was intended to provide mutual benefits to the two Districts by maximizing efficiency and reducing duplicative services and facilities; however, the closure of the Fallbrook Hospital in December 2014 does not allow for the reciprocal services identified in the JPA to be provided by Fallbrook HD. While the JPA has not been officially terminated by action of the Health Care District Boards, the closure of Fallbrook Hospital has functionally concluded the 2013 JPA relationship between the Districts.

Sphere of Influence Determination Summaries

Present and Planned Land Uses

Land uses within the Tri-City HD service area and sphere (Map 5A), including agricultural and open space uses, are governed by the General Plans and land use designations of the cities of Carlsbad, Oceanside, and Vista for the properties within their respective incorporated boundaries; and by the County of San Diego General Plan for the adjacent unincorporated territory located within portions of the Bonsall and North County Metro Community Planning Areas.

Present and Probable Need for Public Facilities and Services

The *2015 San Diego County Health Care Services MSR and Sphere Review* determinations reflect that the rate of population growth with the Tri-City HD service area and sphere was approximately 0.0% from 2008-2014, and that significant local population growth is not anticipated over the next 5 years. SANDAG's 2050 Regional Growth Forecast Population Estimates (2011) projects the Tri-City Subregional Area to grow approximately 36% from 2013-2050.

The Tri-City HD service review determinations state that the local population of elderly residents (65-85+) within the local Subregional Areas is projected to increase by approximately 84.4% during 2013-2030. In addition, each of the Medical Service Study Areas within the Tri-City HD service area and sphere have territory that is within or adjacent to areas designated by the California Office of Statewide Health Planning and Development (OSHPD) as *Medically Underserved Areas* (MUA) and/or *Health Care Professional Shortage Areas* for primary care (HPSA-PC, PCSA) and registered nursing professionals (RNSA) (Maps 5D and 5E). The population projections and medically underserved and understaffed areas designations reflect that the Tri-City HD will continue to experience health care facility and service needs within its service area and sphere.

Present Capacity of Public Facilities, Adequacy of Public Services

During 2013-2014, the Tri-City HD reports an occupancy rate of 48.7% for its 397 licensed acute-care beds, and 54.6% for its 354 available beds. Over 2010-2014, the Tri-City HD reports an average occupancy rate for its licensed beds as 47.7%; however, the District reports that its available beds have an average occupancy rate of 54.3% during the same time period. The Tri-City Medical Center hospital ratings and inpatient quality indicators reflect that health care services are being adequately provided within the Tri-City HD service area and sphere.

Social or Economic Communities of Interest

The *MSR and Sphere Review* determinations are required to identify any *social or economic communities of interest* existing in the review area, if LAFCO determines that they are relevant to the subject agency.

The Commission has not determined that social or economic communities of interest of relevance to Tri-City HD exist in the local area; however, territory adjacent to the Tri-City HD service area and sphere which has been designated by OSHPD as a *Medically Underserved Are*a or a *Health Care Professional Shortage Area*, and local areas identified with poverty levels above the regional average of *14.4%*, should each be considered by the Commission for potential determination as relevant social or economic communities of interest to Health Care Districts (Maps 5B-5E).

Disadvantaged Unincorporated Communities: For an update of a sphere of influence of a city or special district that provides public facilities or services related to sewers, municipal and industrial water, or structural fire protection, that occurs pursuant to subdivision (g) on or after July 1, 2012, the present and probable need for those public facilities and services of any disadvantaged unincorporated communities within the existing sphere of influence.

Tri-City HD is a special district authorized to provide health care services and does not provide public facilities or services related to sewers, municipal/industrial water, or structural fire protection; therefore, the determination does not apply to the Tri-City HD sphere review and update.

Sphere of Influence Recommendations

The *MSR and Sphere Review* determinations demonstrate that the Tri-City HD is adequately providing its authorized services within its service area and adopted sphere of influence; therefore, the Tri-City HD sphere is recommended to be affirmed as coterminous with the HD's service area. Additional Commission discussion and consideration of designations of *social or economic communities of interest*, and *Special Study Areas* is also recommended for the areas identified below.

Potential Social or Economic Communities of Interest

The *MSR and Sphere Review* determinations are required to identify any *social or economic communities of interest* existing in the review area, if LAFCO determines that they are relevant to the subject agency. The Commission is recommended to consider local areas designated by OSHPD as *Medically Underserved Areas* and/or *Health Care Professional Shortage Areas*, and local areas identified with poverty levels above the regional average of *14.4%*, as containing *social or economic communities of interest* relevant to the Tri-City HD (Maps 5B-5E).

Proposed San Diego County Special Study Areas

As OSHPD-designated *Medically Underserved Areas* and/or *Health Care Professional Shortage Areas*, and local areas identified with high poverty levels areas each exist in both urban coastal incorporated territory and rural unincorporated desert and mountain communities of San Diego County, the *2015 San Diego County Health Care Services MSR and Sphere Review* determinations recommend Commission consideration of *Special Study Area* designations for 4 major areas of the County that contain inhabited territory not currently located within any of the local Health Care District service areas and spheres, and

which contain *social or economic communities of interest* relevant to the local Health Care Districts (Map 1L).

The proposed *Special Study Areas* are not recommended for inclusion within the Health Care Districts' service area or sphere at this time; however, subsequent health care service and sphere reviews should evaluate the *Special Study Areas* for resolution of the study area designations and potential sphere inclusion.

Potential Tri-City HD Special Study Areas

Three of the four proposed *Special Study Areas* for San Diego County are adjacent to the Tri-City HD service area and sphere (Map 5F). These proposed *Special Study Areas* are related to the Tri-City HD service area and sphere as follows:

Special Study Area No. 1: Fallbrook HD/Camp Pendleton

The proposed *Special Study Area No. 1* territory includes inhabited urban and rural areas of the northwest corner of San Diego County, including Camp Pendleton and the unincorporated De Luz community, and portions of the Tri-City HD and Fallbrook HD service areas and spheres that overlap the Camp Pendleton boundary. The Tri-City Medical Center in Oceanside is one of closest acute-care hospitals to the recently closed Fallbrook Hospital and the Fallbrook HD's service area. The Fallbrook HD and the Tri-City HD have previously adopted a Joint Powers Agreement (JPA) to coordinate the referral of patients between the Districts' facilities; however, the closure of the Fallbrook Hospital has functionally ended the reciprocal nature of the JPA.

While State Law allows for both incorporated and unincorporated territory to be served by Health Care Districts and included within their service areas, Health and Safety Code Section 32001 prohibits the division of incorporated territory within a Health Care District unless LAFCO determines that the area would not be benefitted by inclusion.

As the majority of the City of Oceanside is currently located within the Tri-City HD service area and sphere, the small portion of Oceanside incorporated territory located within the Fallbrook HD service area and sphere should accordingly be consolidated within Tri-City HD; however, the adjacent Health Care Districts should discuss and collaboratively evaluate the affected area to determine if inclusion within either the Tri-City HD service area and sphere would benefit the local area.

Special Study Area No. 2: Shadowridge

The Shadowridge area consists of approximately 2,500-acres that is primarily located with the City of Vista's incorporated territory. The Shadowridge area constitutes an island of territory that is not presently located within a Health Care District service area, but is surrounded by both the Tri-City HD and the Palomar Health HD service areas and spheres. Both of the surrounding Health Care Districts have previously explored the potential annexation of the Shadowridge area; however, no annexation proposal has been submitted from either district for LAFCO consideration.

As the majority of the City of Vista is currently located within the Tri-City HD service area and sphere, the Shadowridge area should accordingly be consolidated within Tri-City HD; however, the adjacent Health Care Districts should discuss and collaboratively evaluate the Shadowridge area to determine if inclusion within either Health Care District would benefit the local area.

Special Study Area No. 3: Western San Diego County Incorporated Areas

The proposed *Special Study Area No. 3* includes urban territory comprised of the coastal incorporated cities from Encinitas south to Imperial Beach, as well as the adjacent unincorporated urban communities of Rancho Santa Fe, Bonita, and Otay Mesa. These areas are not presently located within any of the local Health Care Districts service areas or spheres, and have been identified as containing designated *Medically Underserved Areas*, *Health Care Professional Shortage Areas*, and/or areas of high poverty.

The Tri-City HD service area and sphere is contiguous to *Special Study Area No. 3* and potential inclusion of the remainder of the City of Carlsbad's incorporated territory within the Tri-City HD service area and sphere should be addressed in subsequent service and sphere reviews to determine if inclusion within the Health Care District would benefit the local area.

Special Study Area 4: Eastern San Diego County Unincorporated Areas

The proposed *Special Study Area No. 4* includes rural and frontier territory comprised of the mountain and desert unincorporated areas of eastern San Diego County, from the Riverside County to the north to the US/Mexico International Border to the south. These unincorporated areas are not presently located within any of the local Health Care Districts service areas or spheres, and have been identified as containing designated *Medically Underserved Areas*, *Health Care Professional Shortage Areas*, and/or areas of high poverty. The Tri-City HD service area and sphere is not contiguous to *Special Study Area No. 4*.

Tri-City HD Sphere of Influence Recommendation

The *2015 San Diego County Health Care Services MSR and Sphere Review* determinations demonstrate that the Tri-City HD is adequately providing its authorized services within its service area and adopted sphere of influence; therefore, the Tri-City HD sphere is recommended to be affirmed as coterminous with the Tri-City HD's service area. Additional Commission discussion and consideration of designations of *social or economic communities of interest*, and *Special Study Areas* is also recommended.

2015 SAN DIEGO COUNTY HEALTH CARE SERVICES MSR AND SPHERE REVIEW CONCLUSIONS AND RECOMMENDATIONS

The *2015 San Diego County Health Care Services MSR and Sphere Review* discussions and evaluations conclude that each of the local Health Care Districts are adequately providing and/or supporting healthcare services within their respective service areas and spheres of influence.

The Health Care Districts are accountable for their local community service needs; however, annual hospital financial performance results are varied, with the independent hospital operators experiencing significant operational income losses and the health system-operated hospital reporting significant positive operational income results.

The following is a summary of the *MSR and Sphere Review* conclusions in relation to the associated service and sphere determinations:

Municipal Service Review Determinations

Growth and Population Projections

SANDAG Special District Population Estimates show that local populations within the Health Care Districts' service areas have not experienced significant growth during 2008-2014; however, the SANDAG 2050 Regional Growth Forecast (2011) anticipates that the population residing in the San Diego region will grow approximately 40% by 2050. Projected population growth rates for the local Health Care District areas over 2013-2050 are anticipated to range from 20-50%.

SANDAG Special District Population Totals (2014) – Growth Rate 2008-2014

Fallbrook HD	57,515	+6.0%
Grossmont HD	498,684	+1.5%
Palomar Health HD	510,041	+2.0%
Tri-City HD	353,396	-3.3%

Projected 2050 Subregional Area Population Totals – Growth Rate 2013-2050

Fallbrook HD	72,681	+50.7%
Grossmont HD	752,365	+34.0%
Palomar Health HD	838,139	+32.4%
Tri-City HD	517,893	+20.3%

SANDAG 2050 population forecasts indicate the 65-85+ age ranges will grow by approximately 98% to 214% over today's levels. The anticipated population increases are projected to include significant increases in elderly population segments from 2010-2030.

The *MSR and Sphere Review* determinations indicate that the local Health Care Districts should utilize SANDAG's estimated population projections and anticipated demographic changes for planning future health care facilities and services.

In particular, the projected expansion of the elderly population by 2030 will necessitate Health Care District planning for sufficient local services and programs to serve the specific needs of older patients.

Medically Underserved Areas / Health Care Professional Shortage Areas

The California Office of Statewide Health Planning and Development (OSHPD) produces maps for all California counties that use 2010 census tract geographic boundaries to define local Medical Service Study Areas (MSSA). The county maps identify local MSSAs that qualify for designation as a *Medically Underserved Area* (MUA) or contain a *Medically Underserved Population* (MUP). *Medically Underserved Areas or Medically Underserved Populations* are based on the evaluation of criteria established through federal regulation to identify geographic areas or population groups on the following demographic data:

- Percentage of population at 100% below poverty;
- Percentage of population over > 65;
- Infant mortality rate; and
- Primary care physicians per 1,000 population

OSHPD also provides maps for local MSSAs that qualify as *Primary Care Shortage Areas* (PCSA) and/or as *Health Care Professional Shortage Areas* (HPSA) for *Primary Care*, *Nursing*, *Mental Health*, or *Dental* health care professionals. OSHPD has designated all of San Diego County as a *Registered Nursing Shortage Area* (RNSA), but has not designated any *Medically Underserved Populations* in the County.

The *MSR and Sphere Review* determinations identify the designated MUA, MUP, PCSA, or HPSA territory within or adjacent to the Health Care Districts' service areas and spheres. The MSR determinations conclude that *Medically Underserved Areas* and *Health Care Professional Shortage Areas* presently exist within and adjacent to each of the Health Care Districts' service areas and spheres and include both urban and rural areas within the County (Maps 1F-1K).

The *MSR and Sphere Review* determinations state that local OSHPD-designated medically underserved or healthcare professional shortage areas that consist of inhabited territory are primarily located in urban areas of the incorporated cities.

Rural territory containing OSHPD-designated areas are generally located within the unincorporated northeast and southeast areas of San Diego County, including the Borrego Springs-Desert and Mountain Empire Community Planning Areas; however, much of the identified rural areas consist of uninhabited territory, including state/national parks and Indian reservation areas.

The *MSR and Sphere Review* determinations recommend consideration of *Special Study Area* designations for the inhabited territory not currently located within the HD service areas and spheres that contains OSHPD-designated medically underserved or healthcare professional shortage areas (Map 1L).

Social or Economic Communities of Interest

The *MSR and Sphere Review* determinations are required to identify any *social or economic communities of interest* existing in the review area, if LAFCO determines that they are relevant to the subject agency. The Commission is recommended to consider

local areas designated by OSHPD as *Medically Underserved Areas* and/or *Health Care Professional Shortage Areas*, and local areas identified with poverty levels above the regional average of *14.4%*, as containing *social or economic communities of interest* relevant to the local Health Care Districts.

Potential San Diego County Special Study Areas

OSHPD-designated *Medically Underserved Areas, Health Care Professional Shortage Areas*, and local areas identified with high poverty levels areas all presently exist in both urban coastal incorporated territory and rural unincorporated desert and mountain communities of San Diego County.

Accordingly, the *MSR and Sphere Review* determinations recommend Commission consideration of potential *Special Study Area* designations for four major areas of the County that contain inhabited territory not currently located within any of the local Health Care District service areas and spheres, and which contain *social or economic communities of interest* relevant to the local Health Care Districts (Map 1L):

- *Special Study Area No. 1: Fallbrook HD/Camp Pendleton*
- *Special Study Area No. 2: Shadowridge*
- *Special Study Area No. 3: Western San Diego County Incorporated Areas*
- *Special Study Area 4: Eastern San Diego County Unincorporated Areas*

The four proposed *Special Study Areas* are each discussed and evaluated in relation to the existing local Health Care District authorized service areas and adopted spheres of influence. Summaries of the proposed *Special Study Areas* are included in the following *2015 San Diego County Health Care Services MSR and Sphere Review* sphere recommendations.

Location and Characteristics of Disadvantaged Unincorporated Communities

Each of the local Health Care Districts has existing disadvantaged unincorporated communities identified within or adjacent to their adopted spheres. The *2015 MSR and Sphere Review* determinations describe the location and characteristics of the existing disadvantaged unincorporated communities as required by State Law.

Present and Planned Capacity of Public Facilities

The *MSR and Sphere Review* determinations conclude that local Health Care District hospital inpatient statistics reported in OSHPD Facility Utilization Reports and OSHPD Annual Facility Summary Reports for Inpatient, Emergency Department, and Ambulatory Surgery Services show that the Health Care District's present hospital facility capacities are adequate for present health care needs.

The local Health Care Districts' licensed acute-care bed occupancy rates indicate that bed capacity exists in most hospital facilities; however, proportionate hospital staffing increases, especially in designated shortage areas for health care professionals in primary

care and nursing, would also be necessary to maximize any available facility capacities. The service and sphere determinations recommend that future hospital facility capacity planning be coordinated regionally and sub-regionally to avoid investment of district funds in duplicative facilities or services.

Adequacy of Public Services

The *MSR and Sphere Review* determinations state that the local Health Care Districts' hospitals are generally consistent with state averages for the health care services and medical procedures evaluated by *CalQualityCare.Org* Hospital Ratings and OSHPD Inpatient Quality Indicators. Any significant +/- deviations from annual state averages are noted in the individual district sections. The Health Care Districts' hospital data reflects that the provision of health care services are generally adequate, with no consistent quality deficiencies reported during the time since the previous service review in 2007.

Infrastructure Needs or Deficiencies.

The local Health Care District licensed acute-care hospital facilities must be in compliance with state seismic regulations by 2030 or be removed from acute-care uses. In addition to projected population and demographic changes, the local Health Care Districts are faced with significant facility questions regarding compliance with seismic safety standards by the state-mandated deadlines. The *2015 MSR and Sphere Review* determinations reflect that all of the local Health Care District hospital facilities are affected by the seismic requirements. Following seismic evaluation and rating by OSHPD, all licensed acute-care hospitals are required to prepare both a comprehensive evaluation report and compliance plan to attain the specified structural and nonstructural performance categories by the specified timeframes.

Hospital facilities rated with SPC/NPC 4-5 designations indicate conformance with the seismic standards; hospitals rated with SPC/NPC 1-3 designations indicate non-conformance with seismic standards and include specific required deadlines to achieve conformance. The following is a summary of OSHPD seismic safety ratings for the local Health Care Districts' hospital facilities, including building components and non-structural features, as of January 2015:

Fallbrook HD

Fallbrook Hospital - SPC 2, SPC 4; NPC 1

Grossmont HD

Grossmont Hospital - SPC 1, SPC 2, SPC 4, SPC 5; NPC 2

Palomar Health HD

Palomar Downtown Campus - SPC 2, SPC 4; NPC 2
Pomerado Hospital - SPC 4, SPC 5; NPC 2
Palomar Medical Center - SPC 5

Tri-City HD

Tri-City Medical Center - SPC 1, SPC 2, SPC 3, SPC 4; NPC 2

The *MSR and Sphere Review* determinations report that the seismic safety requirements for hospital facilities will create significant organizational demands on the local Districts to achieve compliance by the statutory deadlines. As the Palomar Health HD's recently constructed Palomar Medical Center embodies, the financial commitments for construction of new state-of-the-art regional acute-care medical facilities are quite significant.

Coupled with estimated remodel and/or replacement costs for seismic improvements by 2030, many Health Care Districts will have to consider strategic options regarding their local hospital facilities and programs in the next 5-10 years.

Financial Ability to Provide Services

The *San Diego County Health Care Services MSR and Sphere Review* determinations reflect varying financial results from the individual Health Care Districts.

The OSHPD Annual Financial Disclosure Reports show that inpatient revenues have been generally sufficient to maintain local hospital facilities and health care services; however, the reported hospital financial data also shows significant differences between operating margins for local district hospitals that have leased and contracted with a non-profit health care system, and the district hospitals that are independently operated by the Health Care District or were partnered with a for-profit health care system.

Revenues/Expenditure Characteristics

Fallbrook HD

Fallbrook Hospital Revenue - Expenditure Characteristics (FY2012-2013)

Net Patient Revenue: $37,814,952
Inpatient: $23,060,542; Outpatient: $14,754,410
Net from Operations: ($7,654,653)
Operating Margin: (20.0%)

For the 2012-2013 fiscal year, Fallbrook Hospital reported total net operating revenues of $38,306,345 and total operating expenses of $45,960,998, for a total net-from-operations loss of ($7,654,653) and a total annual loss of ($8,072,323). This loss follows a total loss of ($4,485,824) for the preceding 2011-2012 fiscal year.

The following table summarizes the Fallbrook Hospital's financial performance over 2007-2013:

Fallbrook HD Revenues - Expenditures (FY2007-2013)

Year	Net Operating Rev.	Operating Exp.	Net from Op	Income (Loss)
2007-08	$40,536,271	$38,830,208	$1,706,063	$310,575
2008-09	$38,228,212	$39,643,752	($1,415,540)	($2,215,188)
2009-10	$38,611,196	$43,401,067	($4,789,871)	($4,976,738)
2010-11	$47,432,230	$44,670,421	$2,761,809	$2,607,623
2011-12	$41,937,343	$45,803,732	($3,866,389)	($4,485,824)
2012-13	$38,306,345	$45,960,998	($7,654,653)	($8,072,323)

During the 2007-2008 to 2012-2013 fiscal years, Fallbrook HD has reported a cumulative total loss of ($16,831,875) and has reported an average net-from-operations loss of ($2,209,763) per year. The 2014 termination of the leasing/operating agreement with CHS for Fallbrook Hospital was directly attributed to the on-going operational losses experienced between 2008 and 2013.

Grossmont HD

Grossmont Hospital Revenue - Expenditure Characteristics (FY2012-2013)

Net Patient Revenue: $619,558,759
Inpatient: $414,828,597; Outpatient: $204,730,162
Net from Operations: $52,258,084
Operating Margin: 8.3%

For the 2012-2013 fiscal year, the Grossmont HD reported total net operating revenues of $627,960,886 and total operating expenses of $575,702,802, for a total net-from-operations gain of $52,258,084 and total annual income of $69,354,471. This income follows a total gain of $55,297,521 for the preceding 2011-2012 fiscal year.

From 2007-2008 to 2012-2013, the Grossmont Hospital reported an average annual net-from-operations total of $19,203,744, with a cumulative total income of $169,453,380.

The following table summarizes the Grossmont Hospital's financial performance over FY2007-FY2013:

Grossmont HD Revenues - Expenditures (FY2007-2013)

Year	Net Operating Rev.	Operating Exp.	Net from Op	Income / Loss
2007-08	$414,434,860	$410,101,389	$4,333,471	$4,936,702
2008-09	$448,942,410	$441,062,114	$7,880,296	$15,855,154
2009-10	$471,429,434	$470,509,231	$920,203	$9,504,778
2010-11	$533,428,957	$517,332,010	$16,096,947	$14,504,754
2011-12	$583,289,377	$549,555,914	$33,733,463	$55,297,521
2012-13	$627,960,886	$575,702,802	$52,258,084	$69,354,471

Palomar Health HD

Palomar Health HD owns and operates three licensed acute-care hospital facilities within its service area and sphere: the Palomar Health Downtown Campus in central Escondido; the Pomerado Hospital in Poway; and the Palomar Medical Center in western Escondido, which opened in 2012.

Annual financial data for Palomar Medical Center operations has not yet been reported by OSHPD. The Palomar Health Downtown Campus and Pomerado Hospital are summarized as follows:

Palomar Health Downtown Campus Revenue/Expenditure Characteristics (FY2012-2013)

Net Patient Revenue: $441,246,759
Inpatient: $281,655,255; Outpatient: $159,591,504
Net From Operations: ($30,055,593)
Operating Margin: (6.7%)

For the 2012-2013 fiscal year, the Palomar Health Downtown Campus reported total net operating revenues of $449,316,088 and total operating expenses of $479,371,681, for a total net-from-operations loss of ($30,055,593) and total annual income loss of ($20,399,435). This income loss follows a total income gain of $21,547,191 for the preceding 2011-2012 fiscal year.

From the 2007-2008 to 2012-2013 fiscal years, the Palomar Health Downtown Campus reported an average annual net-from-operations total of ($6,520,331); however, the hospital also reported a cumulative total income of $69,899,369 during that time. The following table summarizes the Palomar Health Downtown Campus's financial performance over the 2007-2013 fiscal years:

Palomar Health Downtown Campus Revenues - Expenditures (FY2007-2013)

Year	Net Operating Rev.	Operating Exp.	Net from Op	Income / Loss
2007-08	$246,190,848	$295,562,027	($49,371,179)	$9,798,459
2008-09	$315,379,403	$305,889,199	$9,490,204	$19,900,125
2009-10	$326,283,685	$316,417,510	$9,866,175	$19,505,684
2010-11	$339,398,456	$330,628,878	$8,769,578	$19,547,345
2011-12	$364,248,763	$352,069,937	$12,178,826	$21,547,191
2012-13	$449,316,088	$479,371,681	($30,055,593)	($20,399,435)

Pomerado Hospital Revenue/Expenditure Characteristics (FY2012-2013)

Net Patient Revenue: $156,905,072
Inpatient: $101,589,003; Outpatient: $55,316,069
Net From Operations: $7,873,516
Operating Margin: 5%

For the 2012-2013 fiscal year, the Pomerado Hospital reported total net operating revenues of $157,750,160 and total operating expenses of $149,876,644, for a total net-from-operations gain of $7,873,516 and total annual income of $11,801,857. This income follows a total income gain of $6,162,918 for the preceding 2011-2012 fiscal year.

From the 2007-2008 to 2012-2013 fiscal years, the Pomerado Hospital reported an average annual net-from-operations total gain of $2,494,551, and has reported a cumulative total income of $35,680,566 during that time. The following table summarizes the Pomerado Hospital's financial performance over the 2007-2013 fiscal years:

Pomerado Hospital Revenues/Expenditures (FY2007-FY2013)

Year	Net Operating Rev.	Operating Exp.	Net from Op	Income / Loss
2007-08	$113,626,533	$120,523,650	($6,897,117)	($2,588,206)
2008-09	$126,872,907	$125,775,194	$1,097,713	$4,190,870
2009-10	$139,119,318	$131,767,117	$7,352,201	$10,140,022
2010-11	$146,547,200	$144,109,554	$2,437,646	$5,973,105
2011-12	$152,131,106	$149,027,760	$3,103,346	$6,162,918
2012-13	$157,750,160	$149,876,644	$7,873,516	$11,801,857

Tri-City HD

Tri-City Medical Center Revenue/Expenditure Characteristics (FY2013-2014)

Net Patient Revenue: $304,085,269
Inpatient: $192,684,676; Outpatient: $111,400,593
Net from Operations: ($11,819,558)
Net Income: $1,933,170
Operating Margin: (-3.84%)

For the 2013-2014 fiscal year, the Tri-City Medical Center reported total operating revenues of $307,831,204 and total operating expenses of $319,650,762, resulting in a n*et from operations* loss of ($11,819,558) and a total net income $1,933,170. This income follows a total loss of ($13,615,081) for the preceding 2012-2013 fiscal year.

During the 2007-2008 to 2013-2014 fiscal years, Tri-City HD has reported a cumulative total income loss of ($5,035,711) and has reported an average net-from-operations loss of ($9,373,578) per year. The following table summarizes the Tri-City Medical Center's financial performance over the 2007-2014 fiscal years:

Tri-City Medical Center Revenues/Expenditures (FY2007-FY2014)

Year	Operating Rev.	Operating Exp.	Net from Op	Income / Loss
2007-08	$266,190,375	$267,956,035	($1,765,660)	$9,258,017
2008-09	$278,070,805	$289,199,816	($11,129,011)	($5,014,909)
2009-10	$267,223,963	$292,530,964	($25,307,001)	($18,532,882)
2010-11	$297,524,801	$289,665,465	$7,859,336	$14,848,941
2011-12	$306,939,626	$308,322,785	($1,383,159)	$6,087,033
2012-13	$296,249,104	$318,319,098	($22,069,994)	($13,615,081)
2013-14	$307,831,204	$319,650,762	($11,819,558)	$1,933,170

The *MSR and Sphere Review* conclude that the financial indicators for the local Health Care District hospitals show marked differences between annual net incomes and operational margins. The annual financial disclosures reflect that positive hospital operational income in the modern health care market appear to be more associated with the district hospitals that are affiliated with larger health system networks compared to the independently-operated district hospitals.

Property Tax Revenues

As special districts formed prior to the passage of Prop 13 in 1978, the local Health Care Districts receive an annual allocation from the 1% ad valorum property tax for property within its respective service area. The MSR determinations state that Health Care District annual property tax revenues represent very small proportions of the operating budgets for local hospital facilities and account for approximately 1.0-2.5% of the Districts' total net operating revenues.

The *MSR and Sphere Review* determinations state that the Health Care Districts' annual property tax revenue stream is primarily used to underwrite local community grant programs that financially support local non-profit groups providing health care programs and services within the HD service area, and/or to fund reserves to repay voter-approved

bonded debt. County of San Diego annual tax reports indicate that HDs have received consistent levels of annual property tax revenues from FY2008-2009 to FY2013-2014.

County of San Diego Tax Summary

Allocated Property Tax Revenue FY2013-2014

Health Care District	Prop. Tax Revenue	% of Net Operating Revenues
Fallbrook HD	$1,488,294	2.5%
Grossmont HD	$5,904,774	1.0%
Palomar Health HD	$13,199,623	2.1%* (DTC + Pomerado Hospital)
Tri-City HD	$7,612,806	2.5%

Allocated Property Tax Revenue FY2008-2009 to FY2013-2014

Health Care District	Annual Average
Fallbrook HD	$1,480,332
Grossmont HD	$5,758,889
Palomar Health HD	$12,786,052
Tri-City HD	$7,476,428

Budgets/Audits

The *Health Care Services MSR and Sphere Review* determinations state that each of the local Health Care Districts holds regular public Board meetings to review and adopt annual budgets. The Health Care Districts undergo annual independent financial audits; no financial violations have been reported. The determinations report that the Health Care Districts Boards comply with all financial disclosure requirements of state and federal regulatory agencies.

Bonded Indebtedness

The *MSR and Sphere Review* determinations state that as of FY 2013-2014, only the Grossmont HD and the Palomar Health HD report outstanding *General Obligation* Bonds; The Fallbrook HD and Tri-City HD have no reported long-term bonded indebtedness.

The Grossmont HD and the Palomar Health HD have used bond revenues to construct, remodel, and rehabilitate their local acute-care hospital facilities, and to support ongoing operations of hospital programs and services. *General Obligation* bonded debt requires 2/3 local voter approval, which was achieved by Palomar Health HD in 2004 and by Grossmont HD in 2006:

	Total Bond Amt.	Election	Approval%
Grossmont HD - Prop G	$247,000,000	6/2006	77.68%
Palomar Health HD - Prop BB	$496,000,000	11/2004	69.84%

The Tri-City HD has attempted several times to obtain voter approval for bond measures intended to expand the Tri-City Medical Center facilities and comply with seismic safety requirements. The Tri-City HD did not achieve the required 2/3 voter approval for proposed

bond measures over three separate elections: June 2006 (65.91%), November 2006 (64.8%), and August 2008 (62.45%).

The repeated inability to secure sufficient voter approval for long-term capital financing has created uncertainty in the availability of sufficient funding for needed Tri-City HD facility improvements and expansions. The MSR determinations encourage Tri-City HD to investigate additional financing and governance options

The Fallbrook HD retired its previous bonded indebtedness; however, the recent closure of the Fallbrook Hospital may compel the Fallbrook community to evaluate utilizing the Fallbrook HD's pubic financing mechanisms to fund needed health care facilities and services.

Accountability for Community Service Needs

The *MSR and Sphere Review* determinations state that the Health Care Districts are adequately accountable for their local community's health care service needs.

The local Health Care Districts have demonstrated accountability for their respective community service needs through district-sponsored community grant programs for local non-profit health care providers; annual community reports; independently audited financial statements; health care related educational programs; community health care events; noticed public Board meetings; district and hospital internet websites; as well as providing local acute-care hospital facilities, emergency departments, trauma centers, and surgical services.

The local voters within the Health Care District service area communities have demonstrated support for the Districts and the continuation of district hospital facilities and services by approving local bond measures for new and rehabilitated hospital facilities, and by producing sufficient candidates to fill local district Board elections.

Governance and Governmental Structure Options

Governmental structure options available to Health Care Districts include several different changes of organization or reorganization, including: dissolution of one or more districts with annexation of the dissolved district's service area into one or more successor districts; consolidation of two or more districts into one or more successor districts; or a combination of governance actions involving annexations or detachments of district service area and sphere territory.

A proposed reorganization involving dissolution/annexation, or a consolidation/merger of Health Care Districts would transfer the district's assets and liabilities to a designated successor agency, including responsibility for assuming any voter-approved bonded indebtedness. Therefore, a key issue to be determined when considering potential governmental structure options for Health Care Districts involves the identification of a successor agency that is both authorized and capable of sustaining the provision and level of health care services presently provided by the affected Health Care District(s).

In the San Diego Region, the County of San Diego is the primary local public agency currently responsible for and presently providing county-wide health care services. Unless one or more of the existing Health Care Districts were designated as a successor agency, the County of San Diego would be the logical successor agency with capacity to assume operational responsibility for a dissolved Health Care District's facilities and assure the continued provision of health care services in either incorporated or unincorporated Health Care District service area territory. While the County of San Diego does not directly operate acute-care public hospitals, the County could consider options for leasing the district hospital facilities and/or contracting the health care service responsibilities within a dissolved Health Care District's service area.

Proposed changes of organization or reorganization for Health Care Districts may be initiated by: sufficient petition of local voters or landowners; a resolution of subject/affected agencies; or by LAFCO action. If LAFCO approves a proposed reorganization or consolidation/merger involving one or more Health Care Districts, State Law allows for written protest to be filed with the Commission by affected registered voters or landowners. If LAFCO approves a proposed jurisdictional change that involves dissolution of one or more Health Care Districts, or a Health Care District proposes to transfer more than 50% of the district's assets, State Law requires the dissolution or transfer agreement to be approved by local voters.

The *MSR and Sphere Review* recommends that additional study be conducted by the Health Care Districts to determine if any of the available governance options may be feasible, beneficial, and desirable for sustainably meeting future community health care demands and local facility and service needs.

Operational Efficiencies

Each of the local Health Care Districts has different operational approaches for its hospital facilities, including both independent hospital operators and contracted hospital operators: the Fallbrook HD formed the non-profit Fallbrook Hospital Corporation, which leased and contracted hospital operations with a for-profit health system corporation; the Grossmont HD formed the non-profit Grossmont Hospital Corporation, which leased and contracted hospital operations with the non-profit Sharp Healthcare System; the Palomar Health HD independently owns and operates its 3 acute-care hospitals; and the Tri-City HD, which owns and independently operates its stand-alone Tri-City Medical Center.

The recent closure of the Fallbrook Hospital underlines the difficulty in financial sustaining acute-care hospital operations with small, stand-alone hospitals located in less populated rural areas. The Tri-City HD has also experienced significant cumulative annual losses as an independent hospital operator; however, the Tri-City Medical Center is located within a highly populated urban service area consisting of three incorporated cities and adjacent unincorporated territory.

The Tri-City HD financial results are attributed to the fiercely competitive regional market for health care patients within and adjacent to the Tri-City HD service area and sphere.

As an independent hospital operator, the Tri-City HD must compete with affiliated local health care systems to attract sufficient levels of patients to sustain hospital operations. Ongoing annual financial losses from hospital operations indicate that the long-term sustainability of independent hospital operators is questionable. In addition, the repeated inability of Tri-City HD to successfully receive voter approval for bond measures to finance improvements at the Tri-City Medical Center indicates a lack of local confidence in the district and its facilities.

The Palomar Health HD is also an independent hospital operator; however, the district owns and operates three acute-care hospitals, which allows for the district to serve as its own affiliated health system and mange patient levels between the facilities. Palomar Health HD financial data is mixed, with the Pomerado Hospital experiencing consistent positive annual income and the Palomar Health Downtown Campus experiencing wide annual swings between positive and negative operational income. The recently-opened Palomar Medical Center does not yet have financial results posted by OSHPD; however, the facility's Annual Utilization Reports reflect high inpatient levels and future service reviews will evaluate the hospital's financial disclosures when available.

In contrast with the other Health Care Districts, partnership with large non-profit health system has yielded positive financial results for the Grossmont HD and its non-profit operator, Sharp HealthCare. In addition, the repeated ability of the Grossmont HD to successfully receive sufficient voter approval for bond measures to finance Grossmont Hospital improvements, and voter approval for the original leasing/transfer agreement with Sharp, and the recently-approved extension of the leasing agreement, indicates local community confidence in the Grossmont HD and the Grossmont Hospital.

The *MSR and Sphere Review* determinations state that the Health Care Districts should continue to evaluate and consider operational efficiencies including JPAs, affiliations with local non-profit health care systems, or other potential governmental reorganization options.

Status and Opportunities for Shared Facilities

The *MSR and Sphere Review* determinations conclude that the local Health Care Districts have engaged in a number of partnerships with other health care entities to maximize its ability to provide and maintain health care programs and services to its service area residents. The local Health Care Districts have engaged in Joint Powers Agreements (JPA) that involve operational and facility sharing agreements to maximize health care resources. Current JPAs include: Fallbrook HD-Tri-City HD; and Fallbrook HD-Palomar Health HD; however, the recent closure of the Fallbrook Hospital has removed the Fallbrook HD's ability to provide a reciprocal service relationship with its JPA partners.

Regional and local health care market competition will continue to encourage the Health Care Districts towards collaboration on providing sustainable health care facilities and operations, especially within shared county subregions and transportation corridors. The existing Joint Powers Agreements (JPAs) between Fallbrook HD and Tri-City HD and between Fallbrook HD and Palomar Health HD may serve as models to promote future

opportunities for local and regional Health Care District partnerships to help maximize use of the Health Care Districts' acute-care facilities, trauma centers, and surgical facilities.

Increased regional and subregional coordination between the Health Care Districts may also create new opportunities for expansion into the provision of other needed local health care services such as ambulance and emergency medical transport and urgent-care, and to promote programs for the recruitment and retention of health care professionals for primary care, dental, mental health, and nursing. The *2015 San Diego County Health Care Services MSR and Sphere Review* determinations conclude that these types of local services coordinated through regional/subregional JPAs or other collaborative arrangements should be encouraged.

Sphere of Influence Determinations

Present and Planned Land Uses

The four local Health Care Districts combined service areas and spheres (Map 1A) include a total population of approximately 1,419,636 (2014) within approximately 1,848.7 square miles (1,183,168 acres). The land uses in the Health Care Districts' local service areas and spheres are governed by the respective City General Plan and zoning designations for incorporated territory; and by the County of San Diego's General Plan, Community Plans and zoning designations for unincorporated territory.

Present and Probable Need for Public Facilities and Services

The 2010 Census calculated the total population of San Diego County at 3,095,308, ranking as the second-most populous county in California and the fifth-most populous in the United States. 2013 population estimates by the San Diego Association of Governments (SANDAG) reflect a total population of 3,150,178 in San Diego County.

Populations within the local Health Care District service areas have not experienced significant growth during 2008-2014; however, the SANDAG 2050 Regional Growth Forecast (2011) anticipates that the San Diego region will grow approximately 40% by 2050. Growth rates for the local Health Care District areas over 2013-2050 are anticipated to range from 20-50%. SANDAG 2050 population forecasts also indicate the 65-85+ age ranges (Map 1D) will grow by approximately 98% to 214% over today's levels. The anticipated population increases are projected to include significant increases in elderly population segments from 2010-2030.

The *MSR and Sphere Review* determinations indicate that the local Health Care Districts should utilize SANDAG's estimated population projections and anticipated demographic changes for planning future health care facilities and services. In particular, the projected expansion of the elderly population by 2030 will necessitate Health Care District planning for sufficient local services and programs to serve the specific needs of older patients.

The *MSR and Sphere Review* determinations reflect that the seismic requirements for hospital facilities create significant organizational demands on the local HDs to achieve compliance by the statutory deadlines. As the Palomar Health HD's recently constructed

Palomar Medical Center embodies, the financial commitments for construction of new state-of-the-art regional acute-care medical facilities are quite significant. Coupled with estimated remodel/replacement costs for seismic improvements by 2030, many Health Care Districts will have to consider strategic options regarding their local hospital facilities and programs in the next 5-10 years.

The *MSR and Sphere Review* determinations state that the authorized powers available to Heath Care Districts involve a number of diverse local health care facilities and services in addition to owning and/or operating acute-care hospitals, including: community clinics, urgent care facilities, and child care facilities; ambulance and emergency medical transport;, skilled nursing and long-term care; community programs for chemical dependency services, health education, wellness and prevention, rehabilitation; and the recruitment and retention of medical professionals in primary care, nursing, mental health, and dental services.

The *MSR and Sphere Review* determinations encourage the local Health Care Districts to collaboratively explore partnerships with the County and other agencies for the provision of the full range of the available Health Care District services and programs, and to focus those programmatic efforts where most needed in the community and neighborhood levels of both urban and rural areas.

Present Capacity of Public Facilities, Adequacy of Public Services

The *MSR and Sphere Review* determinations conclude that the Health Care Districts' inpatient quality indicators and hospital rankings are generally equivalent to or exceed state averages. Any significant +/- deviations from annual state averages are highlighted in the individual district sections. Annual hospital quality indicator rates that are consistently lower or higher than county and/or state averages are also noted for additional consideration within the MSR's adequacy of services determinations.

The *MSR and Sphere Review* determinations conclude that with exception of the Fallbrook HD and the now-closed Fallbrook Hospital, hospital-based health care services are generally being adequately provided by local Health Care Districts.

In particular, the *2015 MSR and Sphere Review* determinations reflect that most of the Health Care Districts' acute-care hospital facilities are adequately sized for present and probable demands. The local Health Care Districts' licensed acute-care bed occupancy rates indicate that hospital bed capacity exists in most facilities; however, proportionate hospital staffing increases, especially in designated shortage areas for health care professionals in primary care and nursing, would also be necessary to maximize any available facility capacities.

The local HD's annual financial disclosure reports reflect that inpatient revenues have been generally sufficient to maintain hospital facilities and health care services; however, the reported hospital financial data shows significant differences between operating margins for local HD hospitals that have partnered with non-profit health care systems, and HDs that independently operate their local hospital facilities or contract with a for-profit health care system.

Sphere of Influence Recommendations

Spheres of Influence are used by LAFCO to guide future jurisdictional changes, such as annexations, detachments, reorganizations, and consolidations. Spheres may be larger or smaller than an agency's boundaries, and in some cases, a sphere may include no territory when an agency should be dissolved and its service responsibility reassigned to another public agency. In other situations, a *Special Study Area* designation may be assigned when additional study is required.

Service reviews are conducted by LAFCO to help prepare or update spheres of influence. The *2015 San Diego County Health Care Services MSR and Sphere Review* has been conducted in conjunction with the update of the respective adopted spheres of influence for the Fallbrook, Tri-City, Palomar Health, and Grossmont HDs.

The *MSR and Sphere Review* concludes that the Tri-City, Palomar Health, and Grossmont HDs are generally accountable for local community service needs; are capable of adequately providing health care services within their respective service areas and spheres of influence; and have a wide variation in both financial activity and fiscal health.

The *2015 MSR and Sphere Review* determinations conclude that each of the respective coterminous spheres for Fallbrook, Tri-City, Palomar Health, and Grossmont Health Care Districts should be reaffirmed.

Special Study Area designations should be applied to large tracts of incorporated and unincorporated territory abutting the Fallbrook, Tri-City, Palomar Health, and Grossmont Health Care Districts in order for the Districts to evaluate whether the respective spheres should be increased to allow for future annexations. This matter should be the subject of the *2020 San Diego County Health Care Services MSR and Sphere Review*. *Special Study Area* designations should also be considered within and between certain Health Care Districts (e.g., Tri-City and Palomar Health) to facilitate discussions and future boundary changes between Districts.

Prior to the *2020 MSR and Sphere Review*, each of the Health Care Districts should determine if the territory located within the proposed *Special Study* designations should be included within their spheres and/or a future jurisdictional change of organization proposal. Prior to the *2020 MSR and Sphere Review*, the Fallbrook HD and LAFCO staff should confer to determine if the Fallbrook HD should be assigned a transitional sphere designation indicating that its service responsibilities should be reallocated to any or all of the remaining Health Care Districts in San Diego County.

Social or Economic Communities of Interest

The *MSR and Sphere Review* determinations are required to identify any *social or economic communities of interest* existing in the review area, if LAFCO determines that they are relevant to the subject agency. The Commission has not determined that social or economic communities of interest of relevance to the Grossmont HD exist in the local area; however, territory adjacent to the local Health Care Districts service areas and spheres which has been designated by OSHPD as a *Medically Underserved Are*a or a *Health Care*

Professional Shortage Area, and local areas identified with poverty levels above the regional average of *14.4%*, should each be considered by the Commission for potential determination as relevant social or economic communities of interest to Health Care Districts.

Proposed San Diego County Special Study Areas

OSHPD-designated *Medically Underserved Areas, Health Care Professional Shortage Areas*, and local areas identified with high poverty levels areas all presently exist in both urban coastal incorporated territory and rural unincorporated desert and mountain communities of San Diego County.

The *MSR and Sphere Review* determinations recommend Commission consideration of *Special Study Area* designations for the following 4 major areas of the County that contain inhabited territory not currently located within any of the local Health Care District service areas and spheres, and which contain *social or economic communities of interest* relevant to the local Health Care Districts (Map 1L):

The *2015 San Diego County Health Care Services MSR and Sphere Review* proposed *Special Study Areas* are described as follows:

Special Study Area No. 1: Fallbrook HD/Camp Pendleton

The proposed *Special Study Area No. 1* territory includes inhabited urban and rural areas of the northwest corner of San Diego County, including Camp Pendleton and the unincorporated De Luz community, and portions of the Tri-City HD and Fallbrook HD service areas and spheres that overlap the Camp Pendleton boundary.

The Palomar Medical Center in west Escondido is one of closest acute-care hospitals to the recently closed Fallbrook Hospital and the Fallbrook HD's service area. The Fallbrook HD and the Palomar Health HD have adopted a Joint Powers Agreement (JPA) to identify potential health care service providers for the Fallbrook HD's service area and sphere.

Special Study Area No. 2: Shadowridge

The Shadowridge area consists of approximately 2,500-acres that is primarily located with the City of Vista's incorporated territory. The Shadowridge area constitutes an island of territory that is not presently located within a Health Care District service area, but is surrounded by both the Tri-City HD and the Palomar Health HD service areas and spheres. Both of the surrounding Health Care Districts have previously explored the potential annexation of the Shadowridge area; however, no annexation proposal has been submitted from either district for LAFCO consideration.

Health and Safety Code Section 32001 prohibits the division of incorporated territory within a Health Care District unless LAFCO determines that the area would not be benefitted by inclusion. As the majority of the City of Vista is currently located within the Tri-City HD service area and sphere, the Shadowridge area should accordingly be consolidated within Tri-City HD; however, the adjacent Health Care Districts should discuss and collaboratively

evaluate the Shadowridge area to determine if inclusion within either Health Care District would benefit the local area.

Special Study Area No. 3: Western San Diego County Incorporated Areas

The proposed *Special Study Area No. 3* includes urban territory comprised of the coastal incorporated cities from Encinitas south to Imperial Beach, as well as the adjacent unincorporated urban communities of Rancho Santa Fe, Bonita, and Otay Mesa. These areas are not presently located within any of the local Health Care Districts service areas or spheres, and have been identified as containing designated *Medically Underserved Areas*, *Health Care Professional Shortage Areas*, and/or areas of high poverty.

Special Study Area 4: Eastern San Diego County Unincorporated Areas

The proposed *Special Study Area No. 4* includes rural and frontier territory comprised of the mountain and desert unincorporated areas of eastern San Diego County, from the Riverside County to the north to the US/Mexico International Border to the south. These unincorporated areas are not presently located within any of the local Health Care Districts service areas or spheres, and have been identified as containing designated *Medically Underserved Areas*, *Health Care Professional Shortage Areas*, and/or areas of high poverty.

STAFF CONCLUSION AND RECOMMENDATIONS

The *2015 San Diego County Health Care Services MSR and Sphere Review* concludes that the Tri-City, Palomar Health, and Grossmont HDs are accountable for local community service needs; are capable of adequately providing health care services within their respective service areas and adopted spheres of influence; and have reported a wide variation in both financial activity and fiscal health.

We have concluded that the Fallbrook HD has experienced significant local hospital operational issues that have resulted in the December 2014 closure of its acute-care Fallbrook Hospital, and that these issues may become jurisdictional issues of Commission consideration in the future.

We also conclude that Palomar Health HD and Tri-City HD independently operate their regional acute-care hospitals in a subregion of the San Diego County that includes other acute-care hospitals that currently serve patients residing within the Districts' respective authorized service areas. This highly competitive market environment for local healthcare patients has presented financial challenges for both Health Care Districts as independent acute-care hospital operators that are unaffiliated with larger, managed healthcare systems.

We have also documented what has been widely reported in the media regarding the considerable accumulated bonded debt that Palomar Health HD is carrying; and that both Tri-City HD and Palomar Health HD have recently experienced significant operating losses.

These fundamental financial issues undoubtedly will be addressed by each of the Health Care Districts, but continued hospital facility operating losses could also raise questions as to future sustainability, especially if the publicly-elected Boards of Directors do not take corrective actions.

Below is a summary of the major conclusions reached in the *2015 San Diego County Health Care Services MSR and Sphere Review*:

- Each of the four local Health Care Districts has demonstrated accountability for community service needs.
- Each of the four local Health Care Districts has the capability to adequately provide and/or support the provision of healthcare services within their respective service areas and spheres of influence.
- The respective coterminous spheres presently adopted by the Commission for the Fallbrook, Tri-City, Palomar Health, and Grossmont Health Care Districts should be reaffirmed.
- *Special Study Area* designations should be applied to large tracts of incorporated and unincorporated territory abutting the Fallbrook, Tri-City, Palomar Health, and Grossmont Health Care District service areas and spheres of influence (Map 1L).
- The proposed *Special Study Area* designations include local areas designated by the California *Office of Statewide Health Planning and Development* (OSHPD) as medically underserved or understaffed with physicians, registered nurses, or other healthcare professionals; and local areas identified with poverty levels higher that the regional average of 14.4%. The Commission is recommended to consider determining such designated areas as containing *social or economic communities of interest* relevant to the local Health Care Districts.
- The Health Care Districts are recommended to evaluate potential sphere of influence options that would facilitate the submittal of future annexation proposals of *Special Study Area* designated territory for Commission consideration. This matter should be the subject of the next *Health Care Services MSR and Sphere Review* in 2020.
- S*pecial Study Area* designations should be considered for local areas within and between certain local Health Care Districts (e.g., Tri-City and Palomar Health) to encourage discussions and to evaluate potential reorganizations of identified incorporated territory in accordance with requirements in State Law for the Health Care Districts' authorized service areas.
- Prior to the *2020 San Diego County Health Care Services MSR and Sphere Review*, each of the local Health Care Districts should determine if territory located within the proposed *Special Study Area* designations would benefit from inclusion within their spheres and/or authorized service areas through future annexation proposals or other changes of organization.

- Prior to the *2020 San Diego County Health Care Services MSR and Sphere Review*, the Fallbrook HD and LAFCO staff should confer to evaluate potential sphere of influence designation options for the District's authorized service area, including potential assignment of a transitional sphere designation indicating that its service responsibilities should be reallocated to any or all of the remaining Health Care Districts in San Diego County.

It is therefore

RECOMMENDED: That your Commission

1. Find in accordance with the Executive Officer's determination that pursuant to Section 15061(b)(3) of the State CEQA Guidelines, sphere updates, affirmations, and amendments are not subject to the environmental impact evaluation process because it can be seen with certainty that there is no possibility that the activity in question may have a significant effect on the environment and the activity is not subject to CEQA.
2. Find in accordance with the Executive Officer's determination that pursuant to Section 15306 of the State CEQA Guidelines, the service review is not subject to the environmental impact evaluation process because the service review consists of basic data collection, research, management, and resource evaluation activities that will not result in a serious or major disturbance to an environmental resource. The project is strictly for information gathering purposes and is a part of a study leading to an action that has not yet been approved, adopted or funded.
3. Determine, pursuant to Government Code Section 56430, the San Diego Local Agency Formation Commission is required to conduct a service review before, or in conjunction with an action to establish or update a sphere of influence.
4. Determine, pursuant to Government Code Section 56425, the San Diego Local Agency Formation Commission is required to develop and determine a sphere of influence for each local governmental agency within the County, and review and update, as necessary.
5. Determine that on June 2, 1986, the San Diego LAFCO adopted coterminous spheres of influence for the Fallbrook HD, Tri-City HD, Palomar Health HD, and Grossmont HD, and that the Commission affirmed, established, and updated each sphere and service review on August 6, 2007.
6. Determine that the Fallbrook HD, Tri-City HD, Palomar Health HD, and Grossmont HD have undergone a sphere of influence and service review in 2015 and for the reasons contained in the Executive Officer's report, affirm, update, and amend the spheres by designating territory as Special Study Areas as shown on the maps, attached hereto.
7. Determine that prior to the next *San Diego County Health Care Services Municipal Service Review (MSR) & Health Care District Sphere of Influence Review (SR)* in 2020, the Fallbrook HD and LAFCO staff should confer to determine if the Fallbrook

HD should receive a Special Study Area Designation and/or be assigned a transitional sphere designation indicating that the Fallbrook HD should be dissolved and its service responsibilities reallocated to anyone or all of the remaining Health Care Districts in San Diego County.

8. Determine that prior to the next *San Diego County Health Care Services Municipal Service Review (MSR) & Health Care District Sphere of Influence Review (SR)* in 2020, each of the Health Care Districts should evaluate if the territory located within the Special Study designations should be included within their spheres and/or jurisdictional boundaries.

9. Determine that per Government Code Section 56425(i), the written statements on file with the Commission specifying the nature, location, and extent of any functions or classes of services provided by each of the Health Care Districts shall be reaffirmed.

10. Direct the Executive Officer to prepare Statements of Determinations pursuant to Government Code Sections 56425 and 56430 affirming, updating, and amending the respective spheres of influence and service review associated with the *2015 San Diego County Health Care Services Municipal Service Review (MSR) & Health Care District Sphere of Influence Review (SR), based on the reasons contained in the Executive Officer's report and recommendations.*

11. Direct the Executive Officer to include the Commission's actions per these recommendations in a resolution of approving the affirmation, update, and amendment of the spheres of influence and service review for the Fallbrook HD, Tri-City HD, Palomar Health HD, and Grossmont HD.

Respectfully submitted,

MICHAEL D. OTT
Executive Officer

ROBERT B. BARRY, AICP
Local Governmental Analyst III

MDO:RB:trl

Attachments:
Map 1: San Diego County Public Healthcare Services MSR Study Area (Maps 1A-1L)
Map 2: Fallbrook HD Service Area & Sphere (Special Study Area) (Maps 2A-2G)
Map 3: Grossmont HD Service Area and Sphere (Special Study Area) (Maps 3A-3I)
Map 4: Palomar Health HD Service Area & Sphere (Special Study Area) (Maps 4A-4G)
Map 5: Tri-City HD Service Area & Sphere (Special Study Area) (Maps 5A-5F)

SAN DIEGO COUNTY HEALTH CARE SERVICES MSR AND HEALTH CARE DISTRICT SPHERE OF INFLUENCE REVIEW
TABLE OF CONTENTS and ATTACHMENTS

EXECUTIVE SUMMARY 1
MUNICIPAL SERVICE REVIEW AND SPHERE OF INFLUENCE REPORT 33
FALLBROOK HD 47
GROSSMONT HD 80
PALOMAR HEALTH HD 111
TRI–CITY HD 155
MUNICIPAL SERVICE REVIEW AND SPHERE OF INFLUENCE RECOMMENDATIONS . 189

MAPS

SAN DIEGO COUNTY HEALTH CARE SERVICES MSR STUDY AREAS

MAP 1A: MSR Study Area: San Diego County
MAP 1B: Medical Service Study Areas (MSSA): 2010 Census Tracts
MAP 1C: Disadvantaged Unincorporated Communities (DUC)
MAP 1D: Medical Service Study Areas (MSSA): Percentage of Elderly Population (65-85+)
MAP 1E: Medical Service Study Areas (MSSA): Percentage of Poverty Rate
MAP 1F: Medically Underserved Areas (MUA)
MAP 1G: Health Professional Shortage Areas (HPSA): Primary Care
MAP 1H: Primary Care Shortage Areas (PCSA)
MAP 1I: Health Professional Shortage Areas (HPSA): Mental Health
MAP 1J: Health Professional Shortage Areas (HPSA): Dental
MAP 1K: Registered Nurse Shortage Areas (RNSA)
MAP 1L: Proposed Special Study Areas

FALLBROOK HD (MSR13-65; SR13-65; SA13-65)

MAP 2A: Fallbrook HD Authorized Service Area and Adopted Sphere of Influence
MAP 2B: Fallbrook HD Medical Service Study Areas (MSSA): Percentage of Elderly Population (65-85+)
MAP 2C: Fallbrook HD Medical Service Study Areas (MSSA): Percentage of Poverty Rate
MAP 2D: Fallbrook HD Medically Underserved Areas (MUA)
MAP 2E: Fallbrook HD Health Professional Shortage Areas (HPSA): Primary Care
MAP 2F: Fallbrook HD Primary Care Shortage Areas (PCSA)
MAP 2G: Fallbrook HD Proposed Special Study Areas

SAN DIEGO COUNTY HEALTH CARE SERVICES MSR AND HEALTH CARE DISTRICT SPHERE OF INFLUENCE REVIEW
TABLE OF CONTENTS and ATTACHMENTS

GROSSMONT HD (MSR13-67; SR13-67; SA13-67)

MAP 3A: Grossmont HD Authorized Service Area and Adopted Sphere of Influence

MAP 3B: Grossmont HD Medical Service Study Areas (MSSA): Percentage of Elderly Population (65-85+)

MAP 3C: Grossmont HD Medical Service Study Areas (MSSA): Percentage of Poverty Rate

MAP 3D: Grossmont HD Medically Underserved Areas (MUA)

MAP 3E: Grossmont HD Health Professional Shortage Areas (HPSA): Primary Care

MAP 3F: Grossmont HD Primary Care Shortage Areas (PCSA)

MAP 3G: Grossmont HD Health Professional Shortage Areas (HPSA): Mental Health

MAP 3H: Grossmont HD Health Professional Shortage Areas (HPSA): Dental

MAP 3I: Grossmont HD Proposed Special Study Areas

PALOMAR HEALTH HD (MSR13-77; SR13-77; SA13-77)

MAP 4A: Palomar Health HD Authorized Service Area and Adopted Sphere of Influence

MAP 4B: Palomar Health HD Medical Service Study Areas (MSSA): Percentage of Elderly Population (65-85+)

MAP 4C: Palomar Health HD Medical Service Study Areas (MSSA): Percentage of Poverty Rate

MAP 4D: Palomar Health HD Medically Underserved Areas (MUA)

MAP 4E: Palomar Health HD Health Professional Shortage Areas (HPSA): Primary Care

MAP 4F: Palomar Health HD Primary Care Shortage Areas (PCSA)

MAP 4G: Palomar Health HD Proposed Special Study Areas

TRI-CITY HD (MSR13-92; SR13-92; SA13-92)

MAP 5A: Tri-City HD Authorized Service Area and Adopted Sphere of Influence

MAP 5B: Tri-City HD Medical Service Study Areas (MSSA): Percentage of Elderly Population (65-85+)

MAP 5C: Tri-City HD Medical Service Study Areas (MSSA): Percentage of Poverty Rate

MAP 5D: Tri-City HD Medically Underserved Areas (MUA)

MAP 5E: Tri-City HD Primary Care Shortage Areas (PCSA)

MAP 5F: Tri-City HD Proposed Special Study Areas

MAP 1A

Orange County

Riverside County

Imperial County

Baja California, Mexico

Pacific Ocean

Marine Corps Base Camp Pendleton

Fallbrook Hospital

Fallbrook HD

Tri-City HD

Tri-City Medical Center

Palomar Health HD

Palomar Downtown Center

Palomar Health Medical Center

Pomerado Hospital

Grossmont Hospital

Grossmont HD

5 15 8 76 78 79 67 52 94

N W E S

0 3.75 7.5 15 22.5 30 Miles

MSR Study Area: San Diego County

Health Care Districts (HD)

Fallbrook HD: MSR/SR/SA13-65
Grossmont HD: MSR/SR/SA13-67
Palomar Health HD: MSR/SR/SA13-77
Tri-City HD: MSR/SR/SA13-92

- Fallbrook HD
- Fallbrook HD SOI
- Grossmont HD
- Grossmont HD SOI
- Palomar Health HD
- Palomar Health HD SOI
- Tri-City HD
- Tri-City HD SOI
- HD Hospitals
- Non-HD Hospitals
- Cities
- Camp Pendleton

SOI = Sphere of Influence

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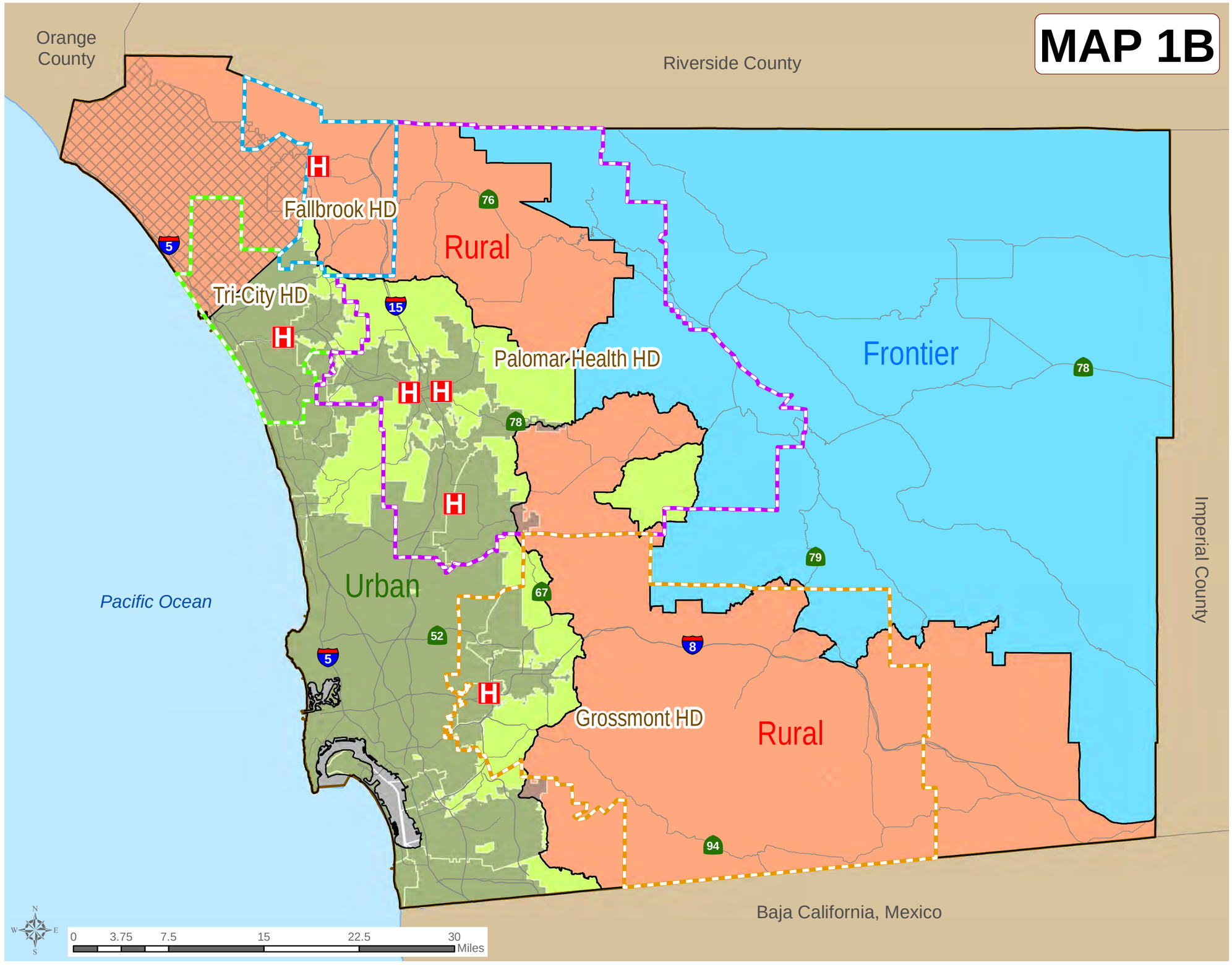
MAP 1B

Medical Service Study Area (MSSA) 2010 Census Tracts

MSSA Data from June 2012



- MSSA Frontier
- MSSA Rural
- MSSA Urban
- Fallbrook HD
- Grossmont HD
- Palomar Health HD
- Tri-City HD
- HD Hospitals
- Cities
- Camp Pendleton

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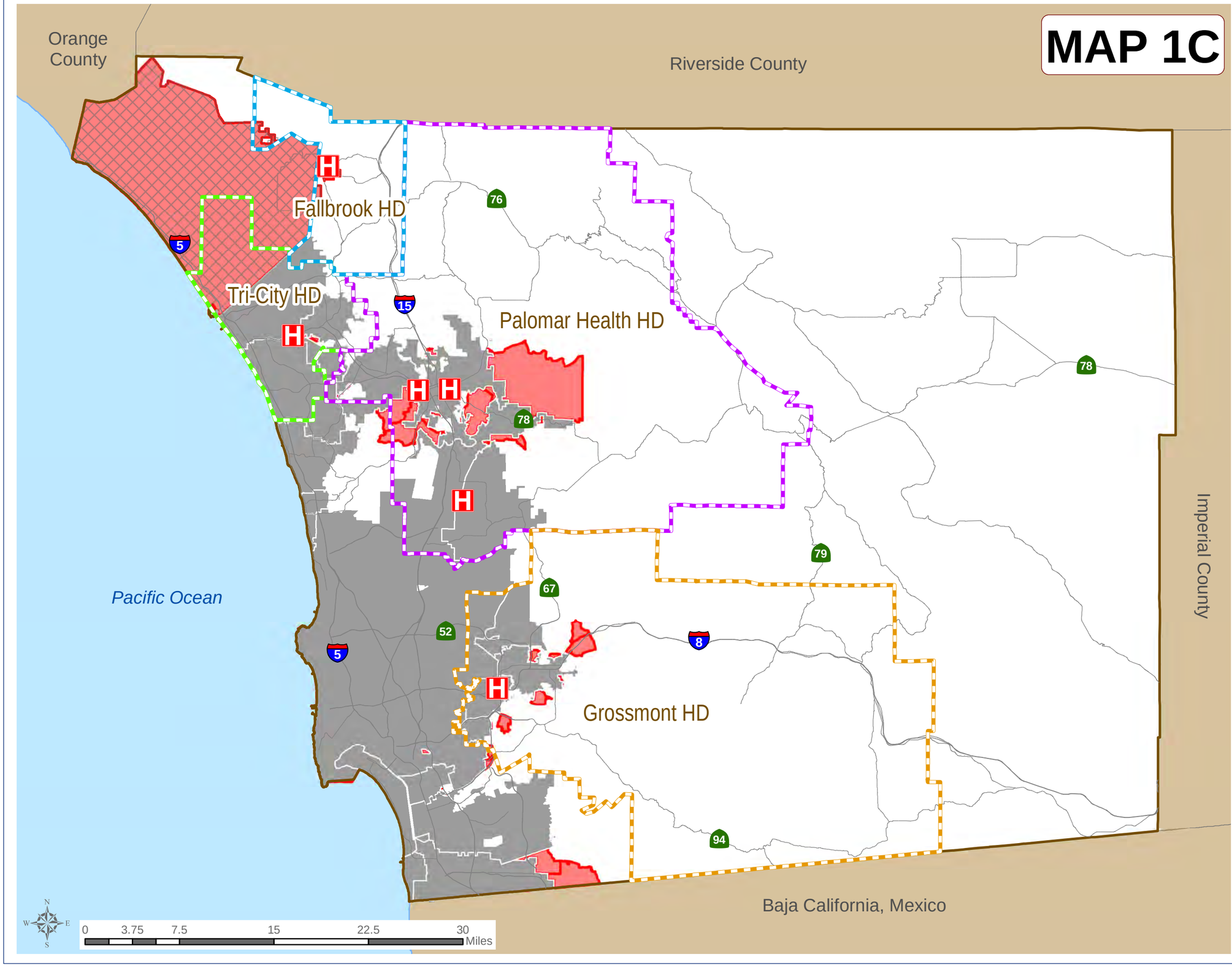
MAP 1C

Disadvantage Unincorporated Community (DUC): Median Household of $46,166 or less (Census Tracts)



- Fallbrook HD
- Grossmont HD
- Palomar Health HD
- Tri-City HD
- HD Hospitals
- Cities
- Camp Pendleton

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MAP 1D

Orange County

Riverside County

Imperial County

Baja California, Mexico

Pacific Ocean

Fallbrook HD

Tri-City HD

Palomar Health HD

Grossmont HD

H

0 3.75 7.5 15 22.5 30 Miles

N W E S

Medical Service Study Area (MSSA): Percentage of Elderly Population (65 - 85+)

MSSA Data from June 2012

MSSA: % of Elderly Pop.

- 0 - 11%
- 12 - 25%
- 26% and greater
- Fallbrook HD
- Grossmont HD
- Palomar Health HD
- Tri-City HD
- HD Hospitals
- Cities
- Camp Pendleton

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MAP 1E

Orange County

Riverside County

Imperial County

Baja California, Mexico

Pacific Ocean

Fallbrook HD

Tri-City HD

Palomar Health HD

Grossmont HD

5 15 76 78 79 67 52 8 94

N W E S

0 3.75 7.5 15 22.5 30 Miles

Medical Service Study Area (MSSA): Percentage of Poverty Rate

MSSA Data from June 2012

MSSA: % of Poverty Rate

- Above 14.40% (ACS 5 year average)
- Fallbrook HD
- Grossmont HD
- Palomar Health HD
- Tri-City HD
- HD Hospitals
- Cities
- Camp Pendleton

SAN DIEGO LAFCO

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MAP 1F

Orange County

Riverside County

Imperial County

Baja California, Mexico

Pacific Ocean

Fallbrook HD

Tri-City HD

Palomar Health HD

Grossmont HD

5 15 76 78 79 67 52 8 94

N W E S

0 3.75 7.5 15 22.5 30 Miles

Medically Underserved Areas (MUA)

MUA Data from July 2012

- MUA
- Fallbrook HD
- Grossmont HD
- Palomar Health HD
- Tri-City HD
- HD Hospitals
- Cities
- Camp Pendleton

SAN DIEGO LAFCO

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Printed April 2015.

MAP 1G

Orange County

Riverside County

Imperial County

Baja California, Mexico

Pacific Ocean

Fallbrook HD

Tri-City HD

Palomar Health HD

Grossmont HD

5 15 76 78 79 67 52 8 94

N W E S

0 3.75 7.5 15 22.5 30 Miles

Health Professional Shortage Area (HPSA): Primary Care

HPSA Data from November 2013

- HPSA Primary Care
- Fallbrook HD
- Grossmont HD
- Palomar Health HD
- Tri-City HD
- HD Hospitals
- Cities
- Camp Pendleton

SAN DIEGO LAFCO

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MAP 1H

Orange County

Riverside County

Imperial County

Baja California, Mexico

Pacific Ocean

Fallbrook HD

Tri-City HD

Palomar Health HD

Grossmont HD

5 15 76 78 79 67 52 8 94

N W E S

0 3.75 7.5 15 22.5 30 Miles

Primary Care Shortage Area (PCSA)

PCSA Data from October 2013

- PCSA
- Fallbrook HD
- Grossmont HD
- Palomar Health HD
- Tri-City HD
- HD Hospitals
- Cities
- Camp Pendleton

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MAP 1I

Orange County

Riverside County

Imperial County

Baja California, Mexico

Pacific Ocean

Fallbrook HD

Tri-City HD

Palomar Health HD

Grossmont HD

5 15 76 78 79 67 52 8 94

0 3.75 7.5 15 22.5 30 Miles

N W E S

Health Professional Shortage Area (HPSA): Mental Health

HPSA Data from November 2013

- HPSA Mental Health
- Fallbrook HD
- Grossmont HD
- Palomar Health HD
- Tri-City HD
- HD Hospitals
- Cities
- Camp Pendleton

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MAP 1J

Orange County

Riverside County

Imperial County

Baja California, Mexico

Pacific Ocean

Fallbrook HD

Tri-City HD

Palomar Health HD

Grossmont HD

5 15 76 78 79 67 52 8 94

0 3.75 7.5 15 22.5 30 Miles

N W E S

Health Professional Shortage Area (HPSA): Dental

HPSA Data from November 2013

- HPSA Dental
- Fallbrook HD
- Grossmont HD
- Palomar Health HD
- Tri-City HD
- HD Hospitals
- Cities
- Camp Pendleton

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MAP 1K

Orange County

Riverside County

Imperial County

Baja California, Mexico

Pacific Ocean

Fallbrook HD

Tri-City HD

Palomar Health HD

Grossmont HD

5 15 76 78 79 67 52 8 94

0 3.75 7.5 15 22.5 30 Miles

N W E S

Registered Nurse Shortage Area (RNSA)

RNSA Data from March 2014

- RNSA
- Fallbrook HD
- Grossmont HD
- Palomar Health HD
- Tri-City HD
- HD Hospitals
- Cities
- Camp Pendleton

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MAP 1L

Orange County

Riverside County

Imperial County

Baja California, Mexico

Pacific Ocean

Marine Corps Base Camp Pendleton

Proposed Special Study Area 1: 123,267 acres

Proposed Special Study Area 2: 2,553 acres

Proposed Special Study Area 3: 317,775 acres

Proposed Special Study Area 4: 1,100,221 acres

Fallbrook HD

Tri-City HD

Palomar Health HD

Grossmont HD

5 15 8 76 78 79 67 52 94

0 3.75 7.5 15 22.5 30 Miles

N W E S

Health Care Districts (HD) Proposed Special Study Area

Fallbrook HD: MSR/SR/SA13-65
Grossmont HD: MSR/SR/SA13-67
Palomar Health HD: MSR/SR/SA13-77
Tri-City HD: MSR/SR/SA13-92

- Proposed Special Study Area
- Fallbrook HD
- Fallbrook HD SOI
- Grossmont HD
- Grossmont HD SOI
- Palomar Health HD
- Palomar Health HD SOI
- Tri-City HD
- Tri-City HD SOI
- HD Hospitals
- Cities
- Camp Pendleton

SOI = Sphere of Influence

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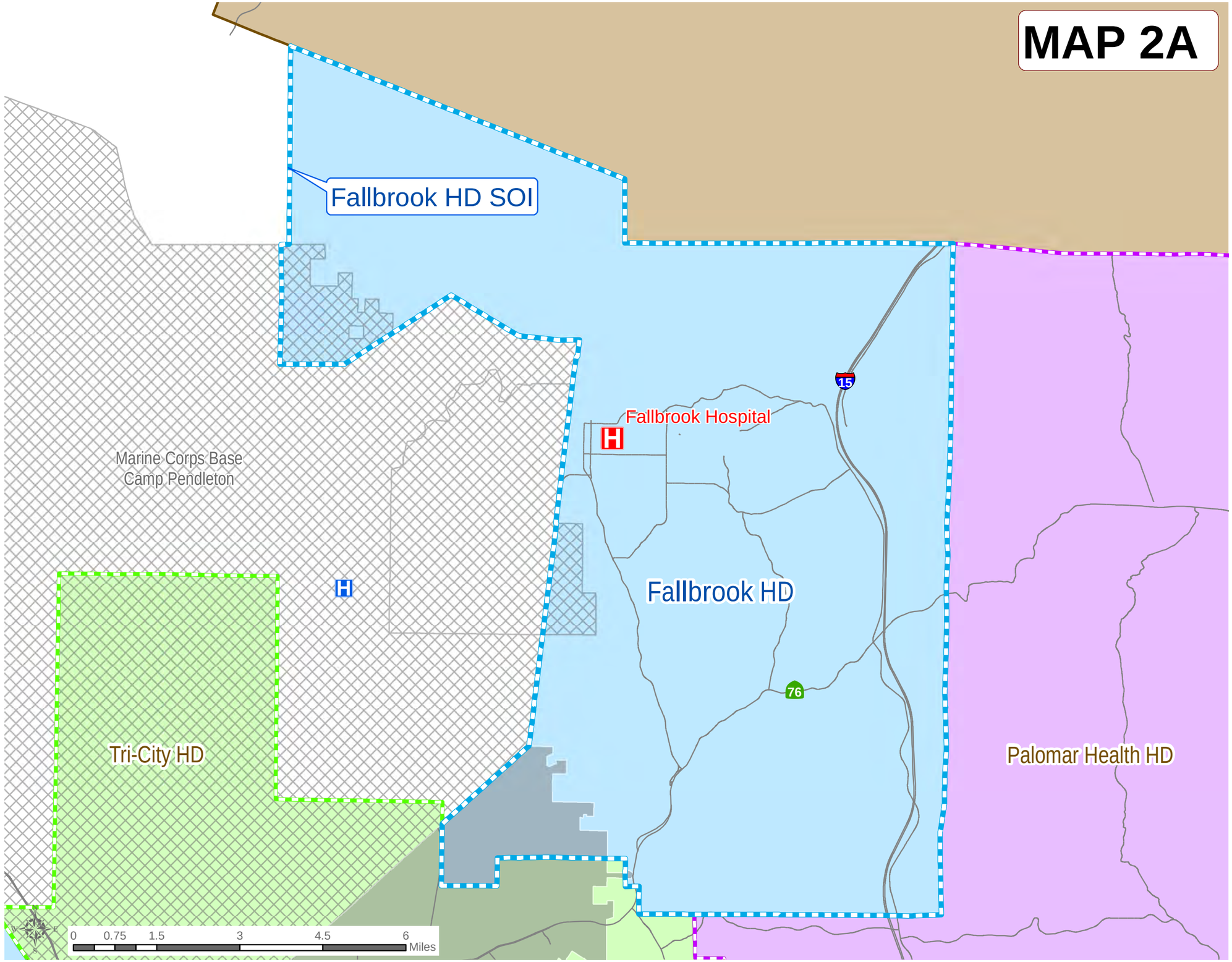
MAP 2A



Fallbrook HD

Fallbrook HD: MSR/SR/SA13-65

- Fallbrook HD
- Fallbrook HD SOI
- Palomar Health HD
- Palomar Health HD SOI
- Tri-City HD
- Tri-City HD SOI
- HD Hospitals
- Non-HD Hospitals
- Cities
- Camp Pendleton

SOI = Sphere of Influence

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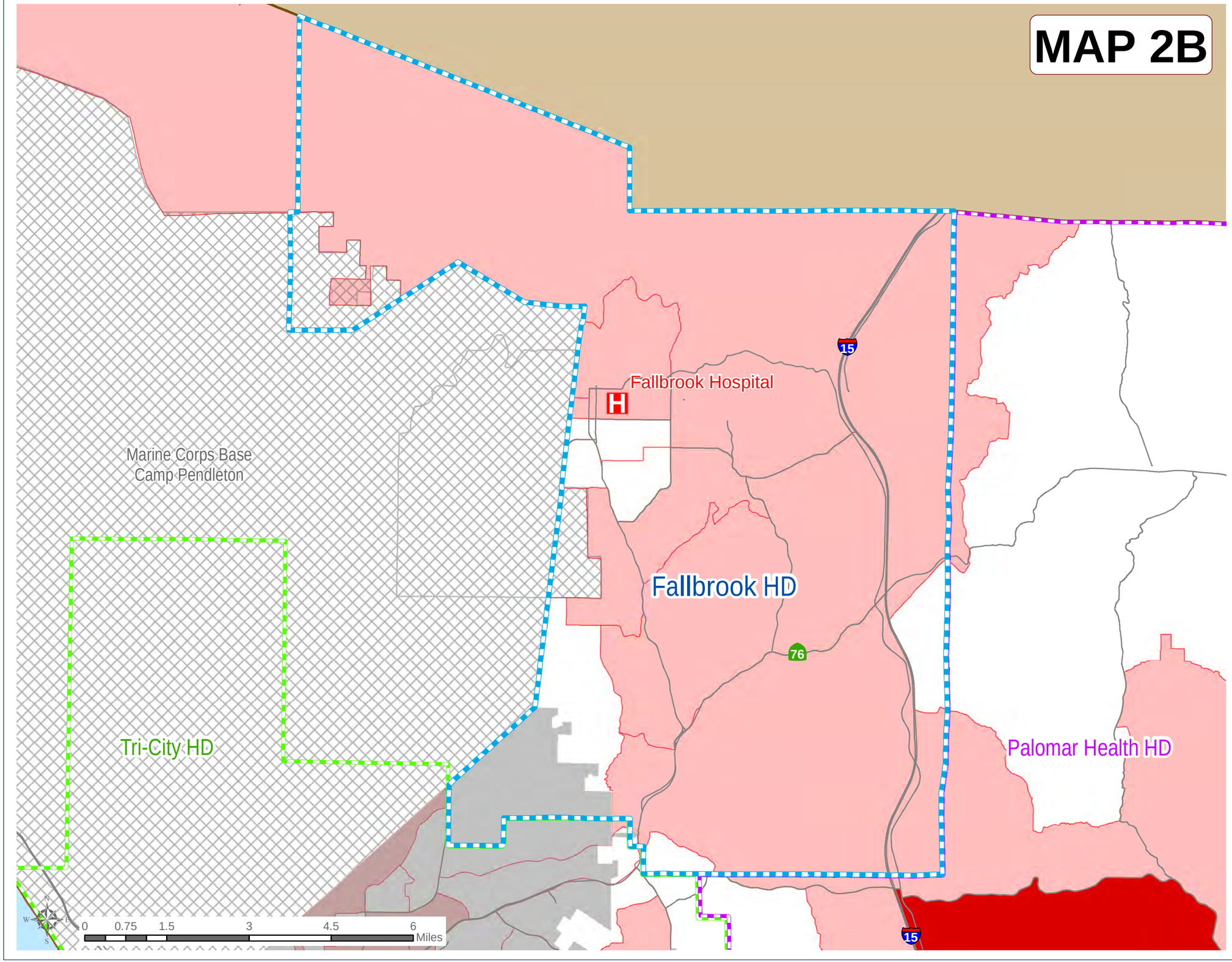
MAP 2B



Fallbrook HD

Medical Service Study Area (MSSA): Percentage of Elderly Population (65 - 85+)

MSSA: % of Elderly Pop.

- 0 - 11%
- 12 - 25%
- 26% and greater
- Fallbrook HD
- HD Hospitals
- Cities
- Camp Pendleton

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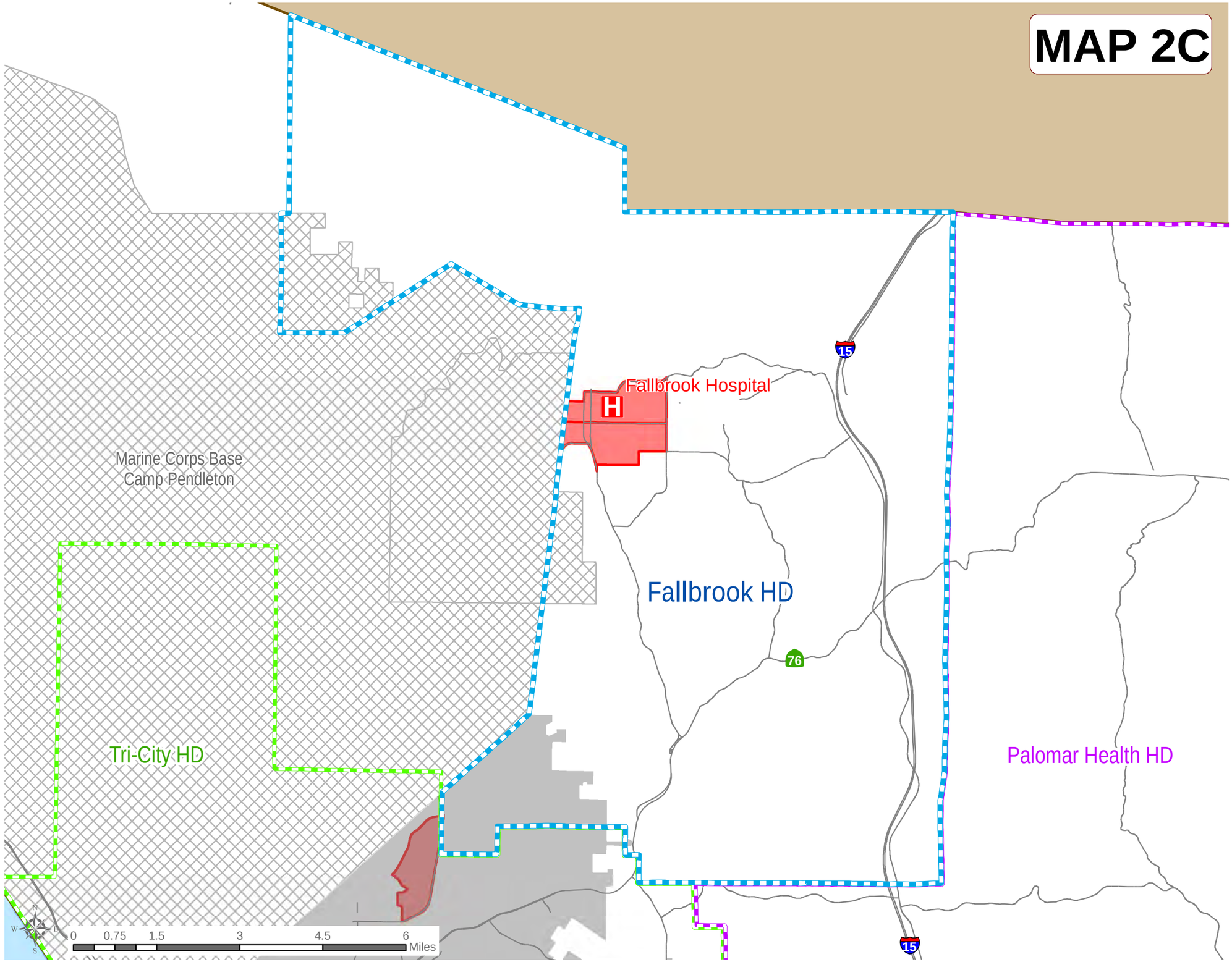
MAP 2C



Fallbrook HD

Medical Service Study Area (MSSA): Percentage of Poverty Rate

MSSA: % of Poverty Rate

- Above 14.40% (ACS 5 year average)
- Fallbrook HD
- HD Hospitals
- Cities
- Camp Pendleton

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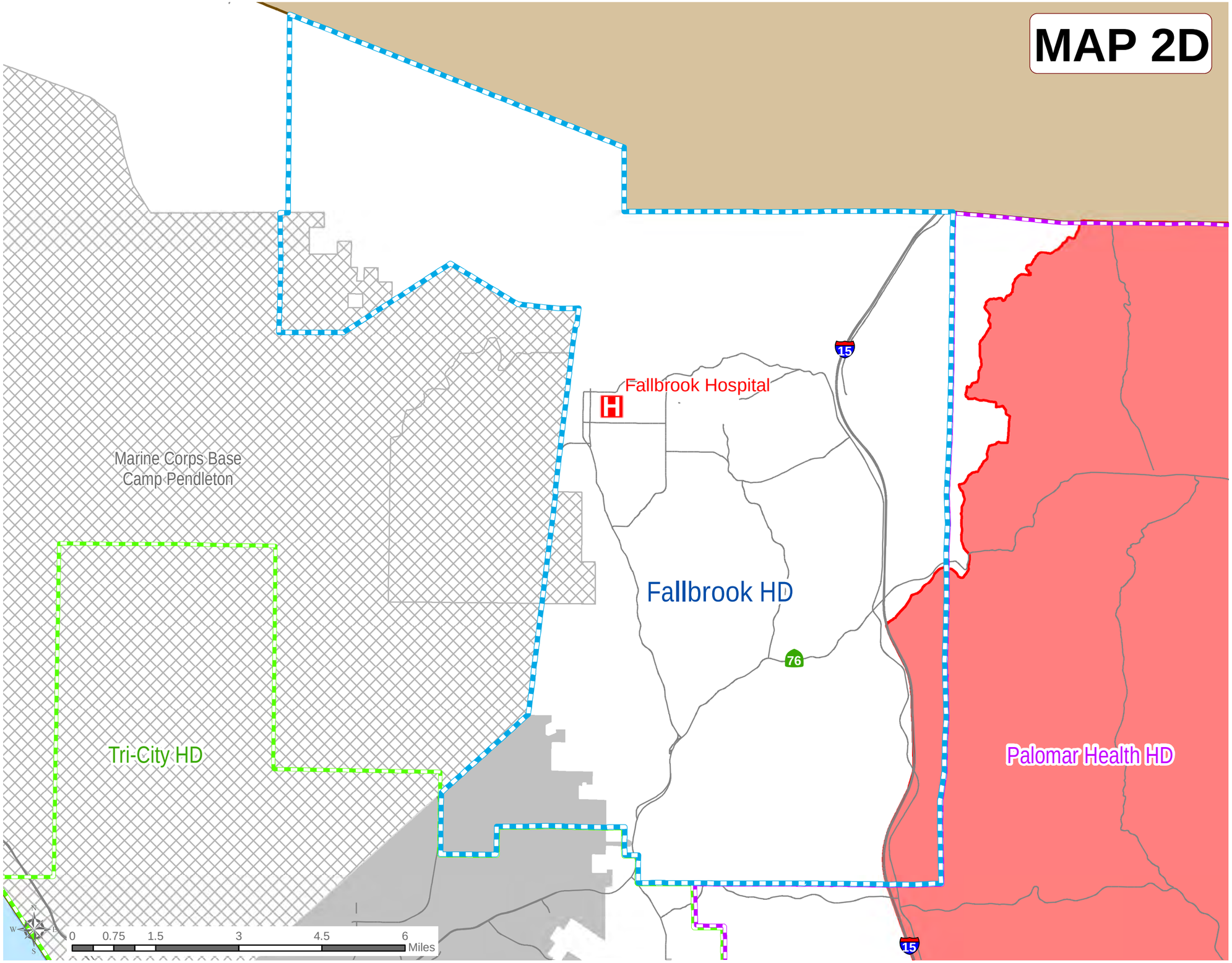
MAP 2D

Fallbrook HD

Medically Underserved Areas (MUA)



MUA
Fallbrook HD
HD Hospitals
Cities
Camp Pendleton

SAN DIEGO LAFCO

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MAP 2E

Fallbrook Hospital

Marine Corps Base
Camp Pendleton

Fallbrook HD

Tri-City HD

Palomar Health HD

15

76

0 0.75 1.5 3 4.5 6 Miles

Fallbrook HD

Health Professional Shortage Area (HPSA): Primary Care

- HPSA Primary Care
- Fallbrook HD
- HD Hospitals
- Cities
- Camp Pendleton

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MAP 2F

Fallbrook Hospital

Marine Corps Base
Camp Pendleton

Fallbrook HD

Tri-City HD

Palomar Health HD

15

76

0 0.75 1.5 3 4.5 6 Miles

Fallbrook HD

Primary Care
Shortage Area (PCSA)

- PCSA
- Fallbrook HD
- HD Hospitals
- Cities
- Camp Pendleton

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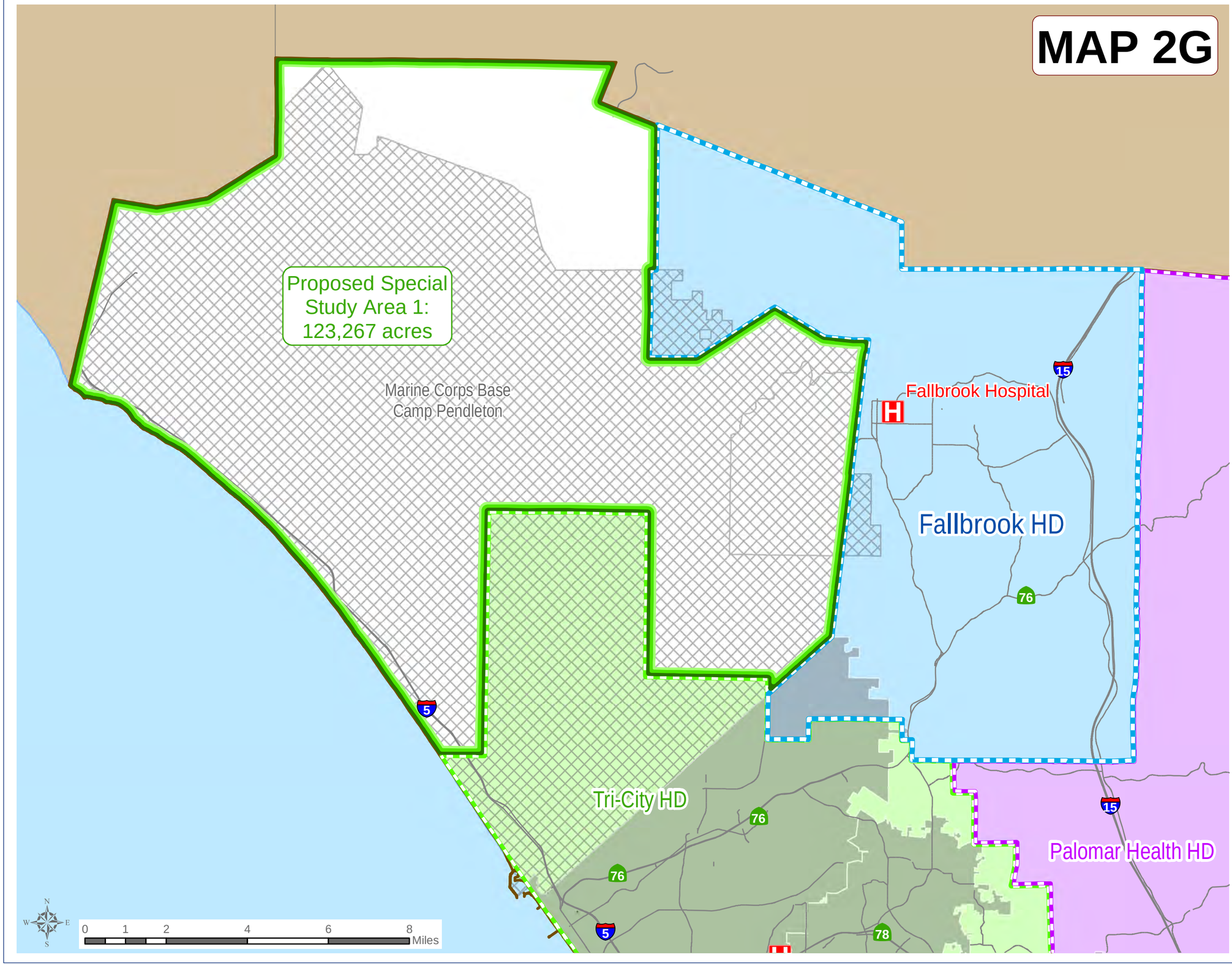
MAP 2G



Proposed Special Study Area

Fallbrook HD Area

Fallbrook HD: MSR/SR/SA13-65

- Proposed Special Study Area
- Fallbrook HD
- Palomar Health HD
- Tri-City HD
- HD Hospitals
- Cities
- Camp Pendleton

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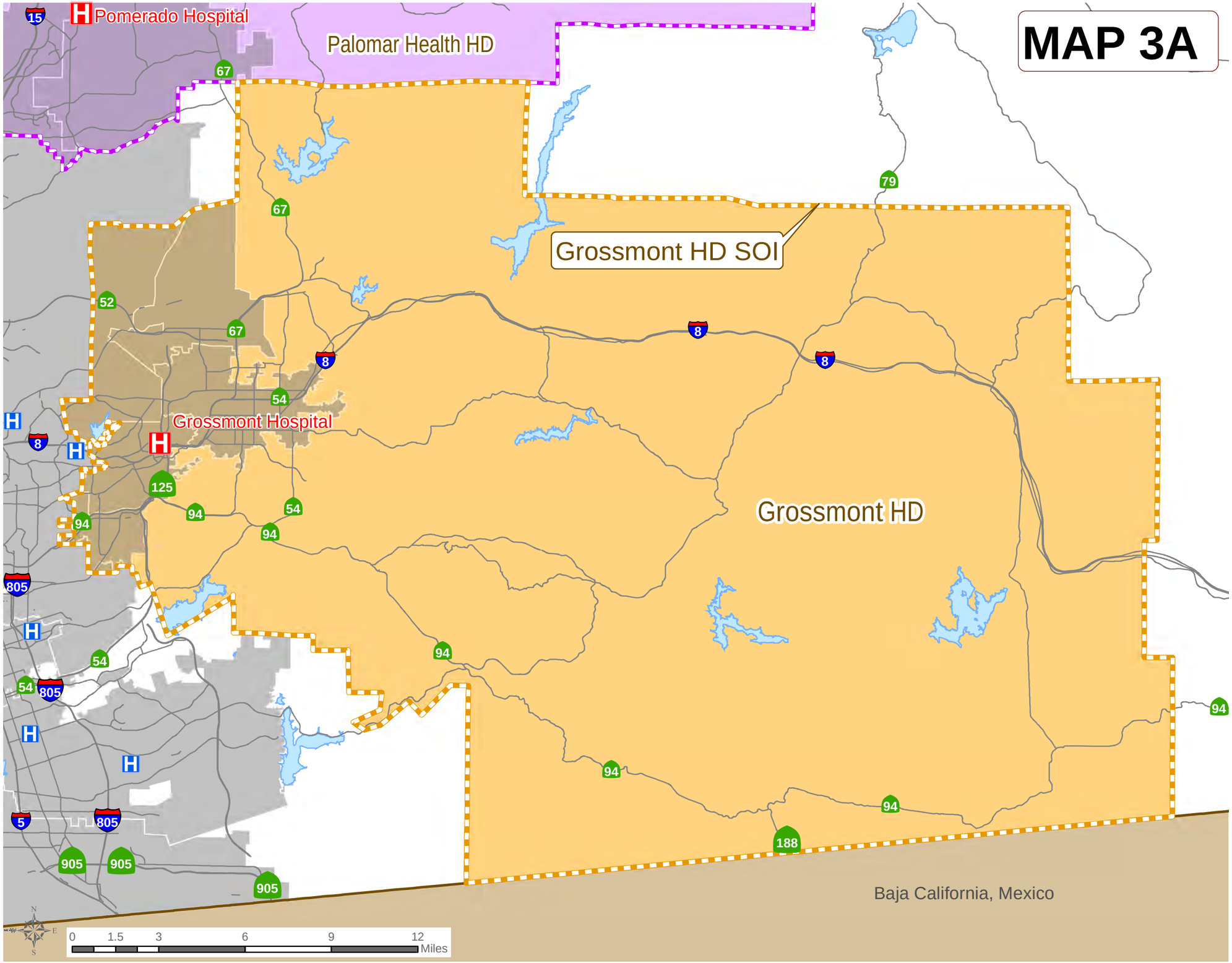
MAP 3A

Grossmont HD

Grossmont HD: MSR/SR/SA13-67



- Grossmont HD
- Grossmont HD SOI
- Palomar Health HD
- Palomar Health HD SOI
- HD Hospitals
- Non-HD Hospitals
- Cities

SOI = Sphere of Influence

SAN DIEGO LAFCO

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MAP 3B

Tri-City Medical Center

Palomar Downtown Center

Palomar Health Medical Center

Palomar Health HD

Pomerado Hospital

Grossmont Hospital

Grossmont HD

Baja California, Mexico

0 2.5 5 10 15 20 Miles

Grossmont HD

Medical Service Study Area (MSSA): Percentage of Elderly Population (65 - 85+)

MSSA: % of Elderly Pop.

- 0 - 11%
- 12 - 25%
- 26% and greater
- Grossmont HD
- HD Hospitals
- Cities

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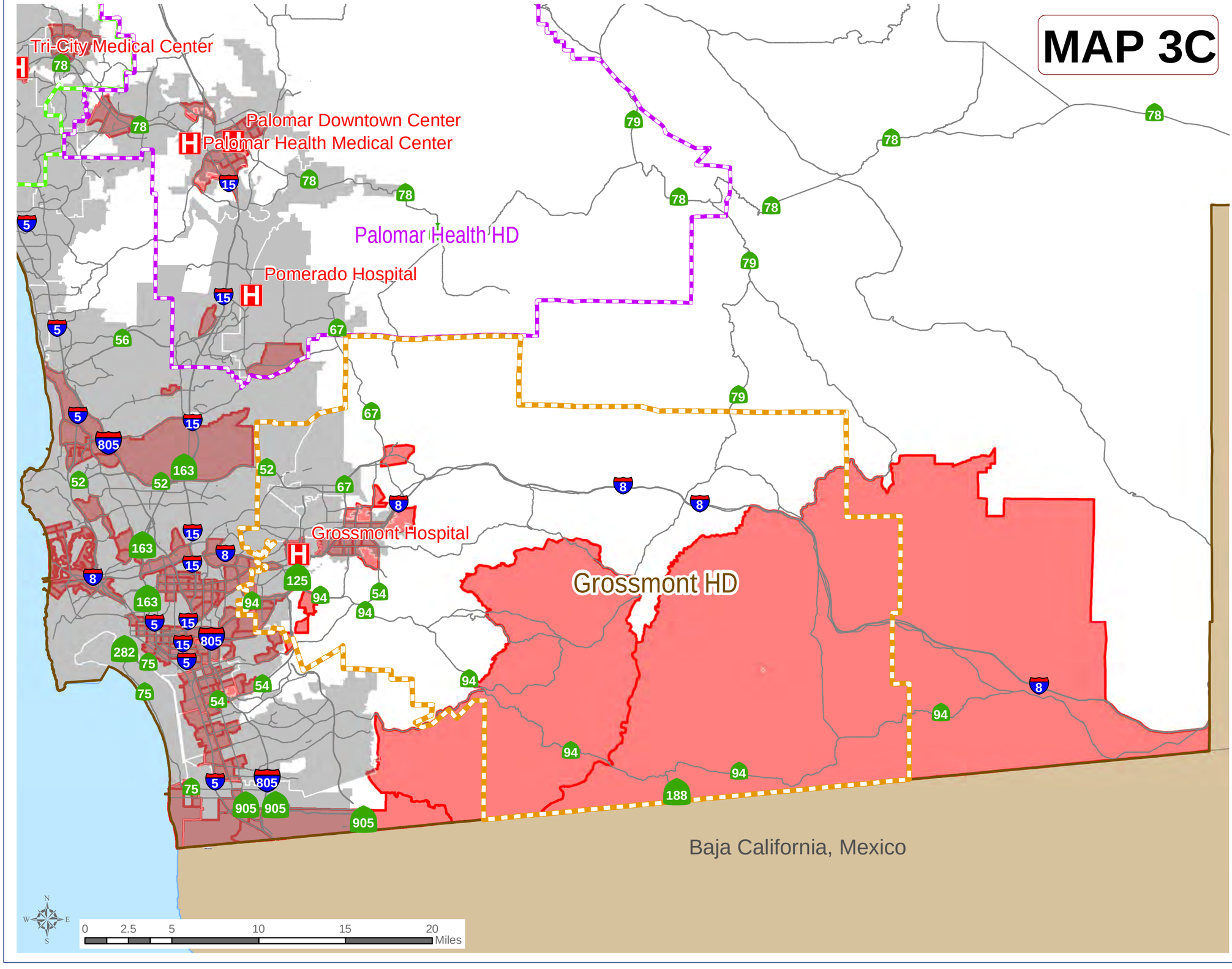
MAP 3C



Grossmont HD

Medical Service Study Area (MSSA): Percentage of Poverty Rate

MSSA: % of Poverty Rate

- Above 14.40% (ACS 5 year average)
- Grossmont HD
- HD Hospitals
- Cities

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MAP 3D

Tri-City Medical Center

Palomar Downtown Center

Palomar Health Medical Center

Palomar Health HD

Pomerado Hospital

Grossmont Hospital

Grossmont HD

Baja California, Mexico

0 2.5 5 10 15 20 Miles

Grossmont HD

Medically Underserved Areas (MUA)

- MUA
- Grossmont HD
- HD Hospitals
- Cities

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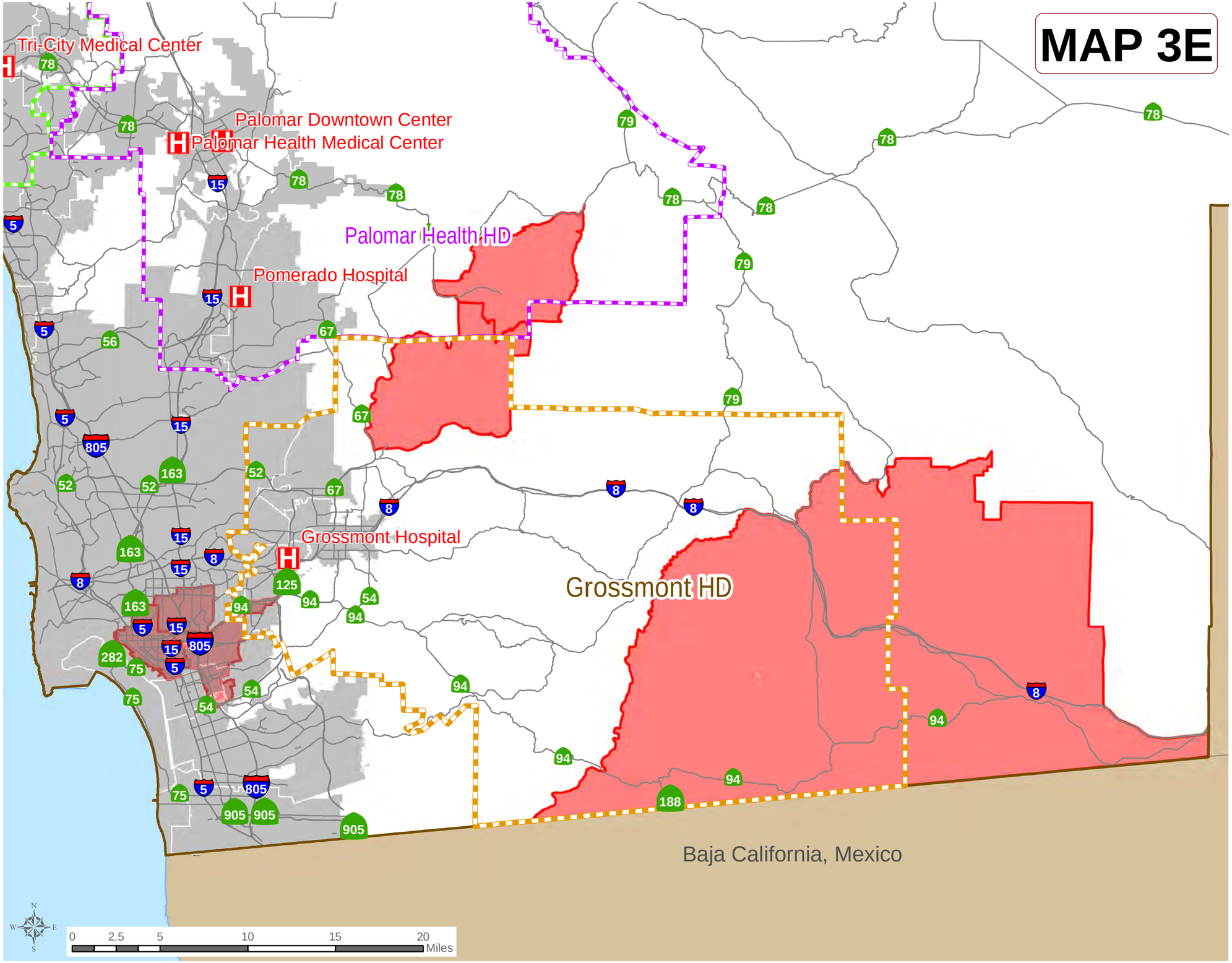
MAP 3E

Grossmont HD

Health Professional Shortage Area (HPSA): Primary Care



- HPSA Primary Care
- Grossmont HD
- HD Hospitals
- Cities

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MAP 3F

Grossmont HD

Primary Care
Shortage Area (PCSA)

Tri-City Medical Center
Palomar Downtown Center
Palomar Health Medical Center
Palomar Health HD
Pomerado Hospital
Grossmont Hospital
Grossmont HD
Baja California, Mexico

PCSA
Grossmont HD
HD Hospitals
Cities

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0 2.5 5 10 15 20 Miles

MAP 3G

Palomar Downtown Center

Palomar Health Medical Center

Palomar Health HD

Pomerado Hospital

Grossmont Hospital

Grossmont HD

Baja California, Mexico

0 2.5 5 10 15 20 Miles

N W E S

Grossmont HD

Health Professional Shortage Area (HPSA): Mental Health

- HPSA Mental Health
- Grossmont HD
- HD Hospitals
- Cities

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MAP 3H

Palomar Downtown Center

Palomar Health Medical Center

Palomar Health HD

Pomerado Hospital

Grossmont Hospital

Grossmont HD

Baja California, Mexico

0 2.5 5 10 15 20 Miles

Grossmont HD

Health Professional Shortage Area (HPSA): Dental

- HPSA Dental
- Grossmont HD
- HD Hospitals
- Cities

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MAP 3I

Tri-City Medical Center

Proposed Special Study Area 2: 2,553 acres

Palomar Downtown Center

Palomar Health Medical Center

Palomar Health HD

Pomerado Hospital

Proposed Special Study Area 4: 1,100,221 acres

Proposed Special Study Area 3: 317,775 acres

Grossmont Hospital

Grossmont HD

Baja California, Mexico

0 2.5 5 10 15 20 Miles

Proposed Special Study Area

Grossmont HD

Grossmont HD: MSR/SR/SA13-67

- Proposed Special Study Area
- Grossmont HD
- Palomar Health HD
- Tri-City HD
- HD Hospitals
- Cities

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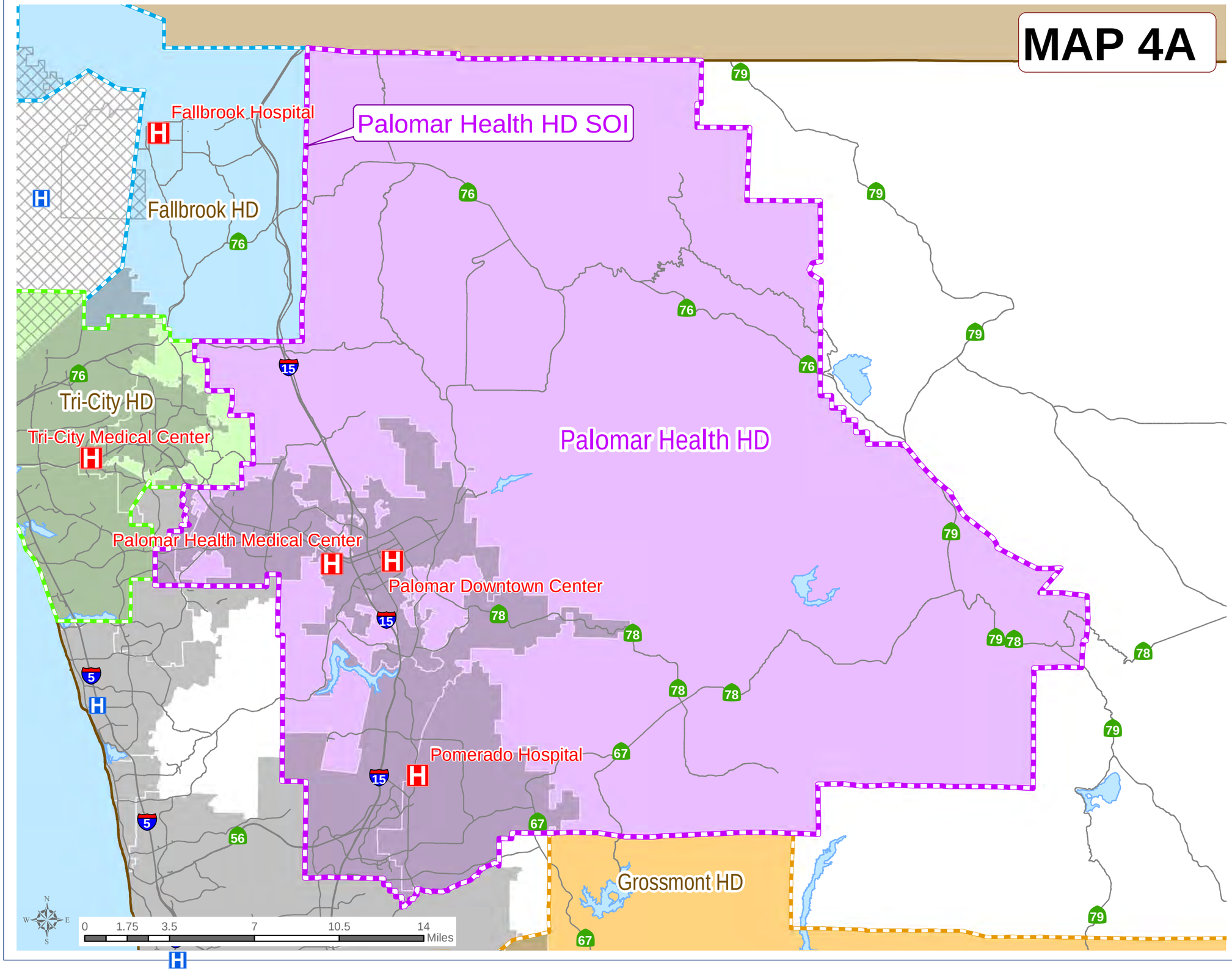
MAP 4A



Palomar Health HD

Palomar Health HD: MSR/SR/SA13-77

- Palomar Health HD
- Palomar Health HD SOI
- Grossmont HD
- Grossmont HD SOI
- Tri-City HD
- Tri-City HD SOI
- Fallbrook HD
- Fallbrook HD SOI
- HD Hospitals
- Non-HD Hospitals
- Cities
- Camp Pendleton

SOI = Sphere of Influence

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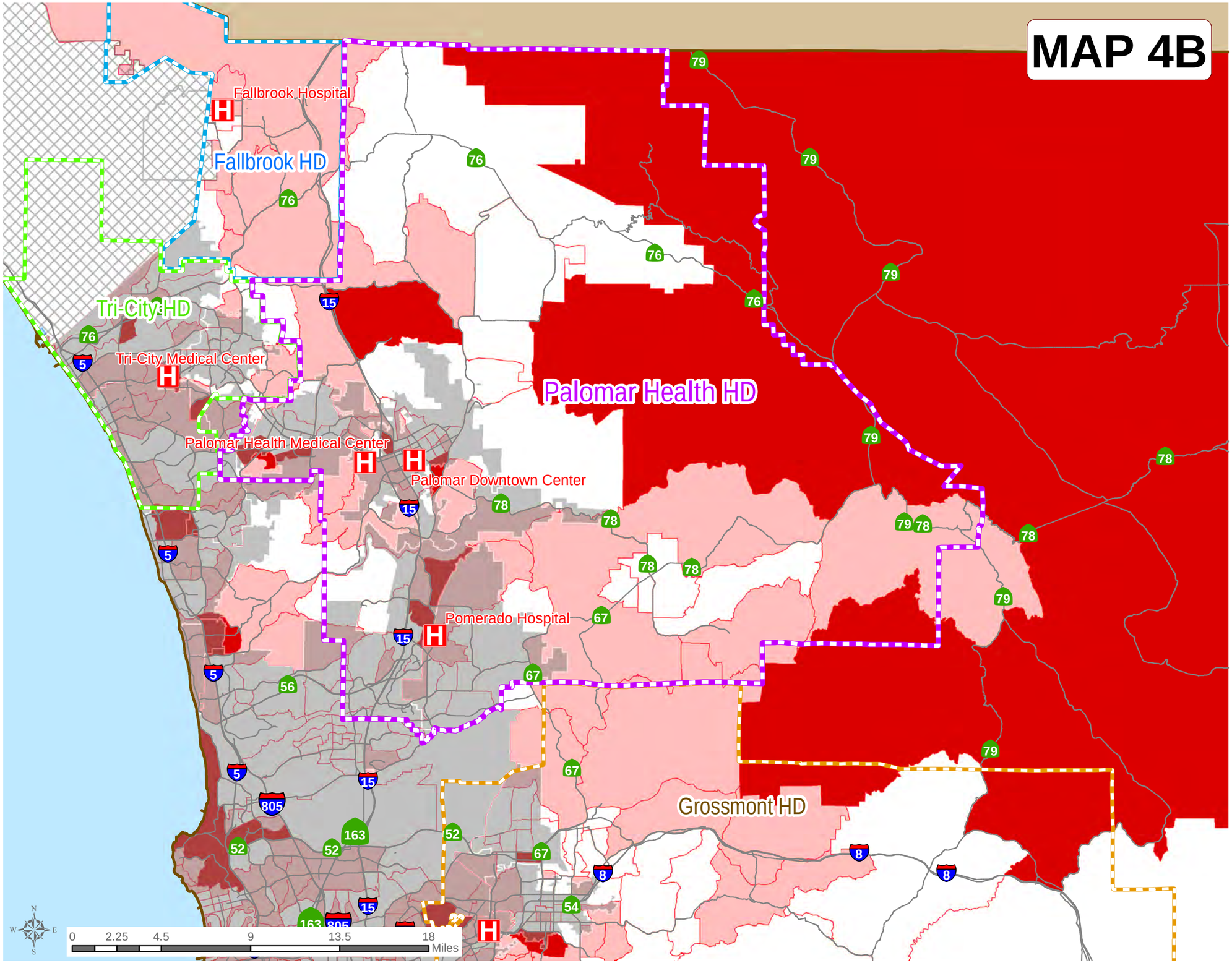
MAP 4B



Palomar Health HD

Medical Service Study Area (MSSA): Percentage of Elderly Population (65 - 85+)

MSSA: % of Elderly Pop.

- 0 - 11%
- 12 - 25%
- 26% and greater
- Palomar Health HD
- HD Hospitals
- Cities
- Camp Pendleton

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MAP 4C

Fallbrook Hospital

Fallbrook HD

Tri-City HD

Tri-City Medical Center

Palomar Health HD

Palomar Health Medical Center

Palomar Downtown Center

Pomerado Hospital

Grossmont HD

0 2.25 4.5 9 13.5 18 Miles

N W E S

Palomar Health HD

Medical Service Study Area (MSSA): Percentage of Poverty Rate

MSSA: % of Poverty Rate

- Above 14.40% (ACS 5 year average)
- Palomar Health HD
- HD Hospitals
- Cities
- Camp Pendleton

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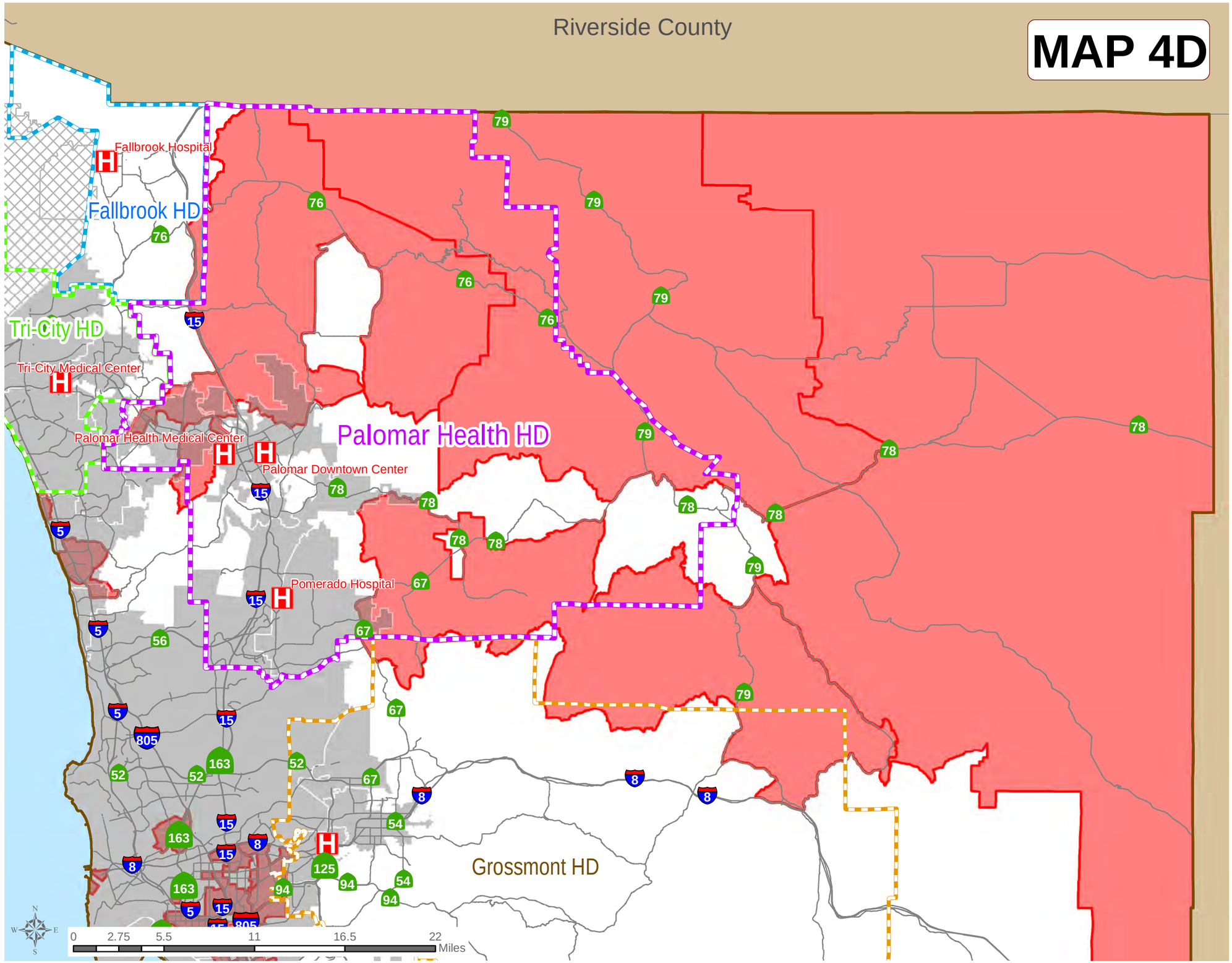

Palomar Health HD

Medically Underserved Areas (MUA)

- MUA
- Palomar Health HD
- HD Hospitals
- Cities
- Camp Pendleton

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MAP 4E

Fallbrook Hospital

Fallbrook HD

Tri-City HD

Tri-City Medical Center

Palomar Health Medical Center

Palomar Downtown Center

Palomar Health HD

Pomerado Hospital

Grossmont HD

0 2 4 8 12 16 Miles

N W E S

Palomar Health HD

Health Professional Shortage Area (HPSA): Primary Care

- HPSA Primary Care
- Palomar Health HD
- HD Hospitals
- Cities
- Camp Pendleton

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MAP 4F

Fallbrook Hospital

Fallbrook HD

Tri-City HD

Tri-City Medical Center

Palomar Health Medical Center

Palomar Health HD

Palomar Downtown Center

Pomerado Hospital

Grossmont HD

0 2 4 8 12 16 Miles

Palomar Health HD

Primary Care
Shortage Area (PCSA)

- PCSA
- Palomar Health HD
- HD Hospitals
- Cities
- Camp Pendleton

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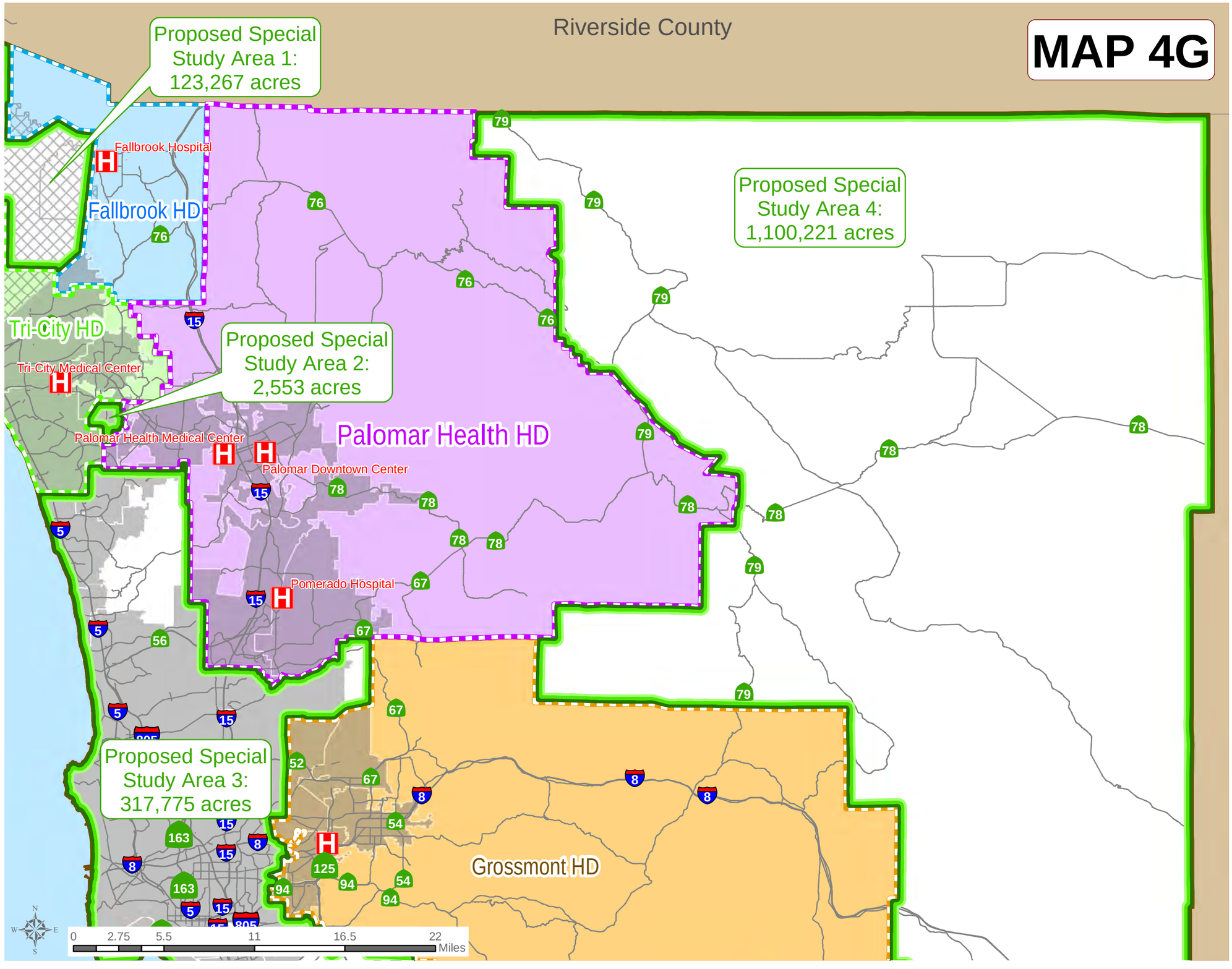

Proposed Special Study Area

Palomar Health HD

Palomar Health HD: MSR/SR/SA13-77

- Proposed Special Study Area
- Fallbrook HD
- Grossmont HD
- Palomar Health HD
- Tri-City HD
- HD Hospitals
- Cities
- Camp Pendleton

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MAP 5A

Marine Corps Base
Camp Pendleton

Tri-City HD SOI

Fallbrook HD

Tri-City HD

Palomar Health HD

Tri-City Medical Center

Palomar Health Medical Center

5
76
15
78

N
W E
S

0 0.75 1.5 3 4.5 6
Miles

Tri-City HD

Tri-City HD: MSR/SR/SA13-92

- Tri-City HD
- Tri-City HD SOI
- Fallbrook HD
- Fallbrook HD SOI
- Palomar Health HD
- Palomar Health HD SOI
- HD Hospitals
- Non-HD Hospitals
- Cities
- Camp Pendleton

SOI = Sphere of Influence

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MAP 5B

Marine Corps Base
Camp Pendleton

Fallbrook HD

Tri-City HD

Palomar Health HD

Tri-City Medical Center

Palomar Downtown Center

Palomar Health Medical Center

5
76
15
78

0 1 2 4 6 8 Miles

N
W E
S

Tri-City HD

Medical Service Study Area (MSSA): Percentage of Elderly Population (65 - 85+)

MSSA: % of Elderly Pop.

- 0 - 11%
- 12 - 25%
- 26% and greater
- Tri-City HD
- HD Hospitals
- Cities
- Camp Pendleton

SAN DIEGO LAFCO

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MAP 5C

Marine Corps Base
Camp Pendleton

Fallbrook HD

Tri-City HD

Tri-City Medical Center

Palomar Health HD

Palomar Downtown Center

Palomar Health Medical Center

0 1 2 4 6 8 Miles

Tri-City HD

Medical Service Study Area (MSSA): Percentage of Poverty Rate

MSSA: % of Poverty Rate

- Above 14.40% (ACS 5 year average)
- Tri-City HD
- HD Hospitals
- Cities
- Camp Pendleton

SAN DIEGO LAFCO

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MAP 5D

Marine Corps Base
Camp Pendleton

Fallbrook HD

Tri-City HD

Tri-City Medical Center

Palomar Health HD

Palomar Health Medical Center

Palomar Downtown Center

Pomerado Hospital

5 76 15 78

N W E S

0 1.25 2.5 5 7.5 10 Miles

Tri-City HD

Medically Underserved Areas (MUA)

- MUA
- Tri-City HD
- HD Hospitals
- Cities
- Camp Pendleton

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MAP 5E

Marine Corps Base
Camp Pendleton

Fallbrook Hospital

Fallbrook HD

Tri-City HD

Tri-City Medical Center

Palomar Health HD

Palomar Health Medical Center

Palomar Downtown Center

5
76
15
78

0 1 2 4 6 8 Miles

N
W E
S

Tri-City HD

Primary Care
Shortage Area (PCSA)

- PCSA
- Tri-City HD
- HD Hospitals
- Cities
- Camp Pendleton

SAN DIEGO LAFCO

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MAP 5F

Marine Corps Base
Camp Pendleton

Proposed Special Study Area 1: 123,267 acres

Fallbrook HD

Tri-City HD

Tri-City Medical Center

Palomar Health HD

Palomar Health Medical Center

Palomar Downtown Center

Pomerado Hospital

Proposed Special Study Area 2: 2,553 acres

Proposed Special Study Area 3: 317,775 acres

0 1.25 2.5 5 7.5 10 Miles

Proposed Special Study Area

Tri-City HD Area

Tri-City HD: MSR/SR/SA13-92

- Proposed Special Study Area
- Fallbrook HD
- Palomar Health HD
- Tri-City HD
- HD Hospitals
- Cities
- Camp Pendleton

SAN DIEGO LAFCO

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