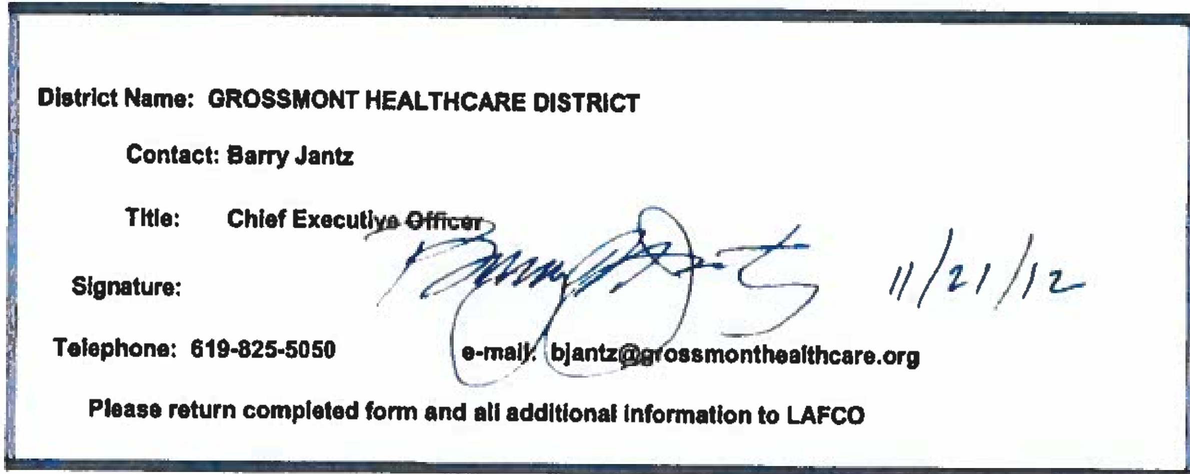
LAFCO – GHD Response to Questionnaire

SAN DIEGO LOCAL AGENCY FORMATION COMMISSION

2012 Health Care District Sphere-of-Influence and Municipal Service Questionnaire



District Name: GROSSMONT HEALTHCARE DISTRICT

Contact: Barry Jantz

Title: Chief Executive Officer

Signature: 11/21/12

Telephone: 619-825-5050 **e-mail: bjantz@grossmonthealthcare.org**

Please return completed form and all additional information to LAFCO

Questionnaire may be downloaded at: www.sdlafco.org/WhatsNew/2012 *HCD Questionnaire.pdf*

Section A: GENERAL INFORMATION

1. Please list all services, including supplemental or special services, which the Health Care District (HCD) provides. Following the example below, identify authorization for providing each service and indicate the area where the service is provided.

FUNCTION or CLASS of SERVICE **AUTHORIZATION** **DISTRICT-WIDE or LIMITED SERVICE AREA**

(a) See Exhibit A.1.(a) – Grossmont Hospital Scope of Services*

(b) Grant Funding* §32121(i),(j),(m)

(c) Public Medical Library* §32121(m)

**All District-Wide*

2. Please provide the following information by sending an electronic copy or a document web-link to:

   Dieu.Ngu@sdcounty.ca.gov

(a) HCD budget for FY2010-11; FY2011-12; and FY2012-13: Exhibits A.2.(a) 1 thru 3

(b) HCD Financial Audit for FY2010-11 and FY2011-12: Exhibit A.2.(b) 1 and 2

(c) Current HCD master service plan or equivalent document

Attachment A.2.(c) is the Executive Summary of the 2004 Grossmont Hospital Master Plan, which was adopted by the District board in 2006 for the projects in the Proposition G (June 2006) bond improvements, which are currently underway. The entire Master Plan documents are housed on several CDs, which can be provided if LAFCO needs additional details.

(d) Adopted HCD capital improvement plan:

- Attachment A.2.(d) 1 – Grossmont Hospital FY 2013 Approved Capital Budget for Infrastructure
- Attachment A.2.(d) 2 – Most recent Prop G District Monthly Project Report, including information on the Prop G General Obligation Bond project budgets and timelines.

(e) HCD organizational chart and staffing schedule that identifies total number of District employees: See Exhibit A.2.(e)

(f) Copy of District Health Facility license pursuant to Health & Safety §1253: See Exhibit A.2.(f) – State of California Department of Public Health License to Grossmont Hospital Corporation.

The May 29, 1991 Lease Agreement (1991 Lease), copy attached as Exhibit A.2.(f) b, between Grossmont Hospital District (District) and Grossmont Hospital Corporation (GHC) requires in §15.5 that GHC continually maintain a valid license issued by the Department of Health Services. In addition, as part of the District's oversight function, compliance with this provision is continuously monitored.

(g) Copy of Hospital Rules pursuant to Health & Safety §32128(a).

See Exhibit A.2.(g) – Grossmont Hospital Medical Staff Bylaws.

§15.9 of the 1991 Lease specifically requires that GHC abide by the provisions of Health & Safety Code §32128 including without limitation, the provisions regarding the self-governance of the Medical Staff. The District continuously monitors compliance with this provision.

(h) Inventory and addresses of HCD facilities pursuant to Health & Safety Code §1250

Attached as Exhibit A.2.(h) is a map provided by Sharp Healthcare showing the facilities on the larger Grossmont Hospital campus and including the District-operated facilities. The facilities owned by the District:

- Grossmont Hospital – 5555 Grossmont Center Drive, La Mesa, CA 91942 (leased to GHC)
- Brier Patch Facility – 9000 Wakarusa St., La Mesa, CA 91942 (leased to GHC)

- Grossmont Healthcare Center – 9001 Wakarusa St., La Mesa, CA 91942 (District-operated conference facilities, community health library, administrative offices)
- All other buildings shown on map are not owned by the District, although some of them are ground leases from the District to GHC, with the buildings currently owned by other entities.

(i) If the District has leased or transferred assets to a corporation, please provide the three most recent annual reports to the community pursuant to Health and Safety § 32121.9

As a requirement of GHC's obligation to enhance the provision of quality healthcare to the communities served by the District (Affiliation Agreement §IV.A.) and the requirement to operate Grossmont Hospital in a manner that will maximize the availability of quality health care services to the communities served by the District (1991 Lease §15.1). Sharp HealthCare issues an annual Community Benefits Plan and Report, a section of it focused on Grossmont Hospital, which is reported to the District and community, as well as annually accepted by the District board. Copies of the last three are attached as follows:

- Exhibit A. 2.(i) 1 – FY 2009 Community Benefits
- Exhibit A. 2.(i) 2 – FY 2010 Community Benefits
- Exhibit D. 2 – FY 2011 Community Benefits (also addressed in Questions D.1 and D.2 below)

Also attached are the District's last three Annual Reports, as well as the Independent Citizens' Bond Oversight Committee's (ICBOC) last four Reports to the Community related to Proposition G Bond Program:

- Exhibit A.2.(i) 4 – District Annual Reports for FYs 2010, 2011, 2012
- Exhibit A.2.(i) 5 – ICBOC last three Annual Reports and one mid-year report

(j) HDC policy for language assistance services pursuant to Health & Safety § 1259(c)(2): See Exhibit A.2.(j) – Grossmont Hospital Policy 01206: Language (Interpretation) Services.

(k) HCD policy for patient screening to detect spousal abuse pursuant to Health & Safety § 1259.5: See Exhibit A.2.(k) – Grossmont Hospital Policy 01803.99, Domestic Violence Screening.

(l) HCD security plan to protect personnel, patients, and visitors from aggressive or violent behavior pursuant to Health & Safety § 1257.7(a): See Exhibit A.2.l – Grossmont Hospital Policy 18452.00, Security Management Plan.

3. San Diego LAFCO maintains a data base of special district service information and a summary profile of each district is published on the LAFCO website. A copy of the HCD profile is enclosed; please review, note changes or additions to the profile, and return to LAFCO with this questionnaire.

   See Exhibit A.3 for changes.

4. A map of the HCD sphere is enclosed. Please describe potential changes to the sphere—for example, reductions or expansions—that may be proposed within the next five years and discuss the reasons or justification for each potential change.

   The District is not looking at any proposed changes to the sphere of influence over the next 5 years.

Section B: FACILITIES, INFRASTRUCTURE and SERVICES

1. Discuss the ability of the HCD's current acute care capacity to meet the community's acute care needs. Identify current capacity and include statistics for: average daily patient load; surge capacity limits; and records of meeting or exceeding surge capacity. Identify provisions for expanding capacity in extraordinary surge circumstances.

   On an annual basis, Grossmont Hospital conducts an environmental assessment plan to evaluate the projected population growth and changing demographic needs in the community. The current inpatient capacity of Grossmont Hospital is 540 licensed acute care beds with an average daily census of 348 patients thereby meeting the ongoing needs of the community. Inpatient census fluctuates on a daily basis depending upon the cyclic community illnesses and diseases and the facility has the staff to care for a surge capacity of 470 inpatient beds.

   With ongoing changes in census, Grossmont Hospital has developed multiple strategies designed to identify and mitigate impediments to efficient patient flow within the Emergency Department (ED) and throughout the hospital (Exhibit noted below.)

   In addition to the policy, *Patient Flow within the Emergency Department and to Patient Care within the Hospital*, a Surge Plan was also developed to deal with high patient volume. (Exhibit for Grossmont Hospital Surge Plan noted below). The hospital team implemented several best practices including: developing a dedicated Short Stay unit, dedicated Ambulatory Care Center for outpatient surgical and procedural patients, dedicated hospitalists meet every morning to review admission from the previous 24 hours, expansion of ED Case Management/ UR to assist with admission and discharge process, standard admission order sets, acute care cardiac monitoring to reduce patient transfers, inpatient psychiatric liaison to assist with patient placement, dedicated Ambulance coordinator to assist with patient discharge, bed huddles and bed placement meetings 3-4 times per day. [See Exhibit B.1.(a) – Grossmont Hospital Surge Plan; and Exhibit B.1.(b) – Emergency Department Guideline: Patient Flow Within the Emergency Department and to Patient Care Areas Within the Hospital.]

2. Describe all existing agreements or arrangements with other agencies to share facilities or infrastructure or to cooperatively provide services. Please explain constraints to expanding existing agreements; for example, limited capacity for providing acute care services.

   - Grossmont Hospital Corporation – GHC is part of Sharp HealthCare, an integrated delivery system serving all of San Diego County. As part of the Sharp HealthCare system, Grossmont Hospital has the ability to access the resources and talents of the entire Sharp HealthCare system which includes the following acute care and specialty hospitals: Sharp Memorial Hospital, Sharp Mary Birch Hospital for Women and Newborns, Sharp Chula Vista Medical Center and Sharp Coronado Hospital.

   - District Facility Usage – The District has determined that its role as a local government agency requires that its resources be shared by the communities served. The board-adopted policy is to make the District auditorium and conference rooms available for public use by community based nonprofit organizations and other government agencies. There is no charge for use of the facilities and grounds. Hundreds of groups and thousands of individuals use the facilities annually (a list of organizations is available if needed).

   - Health Occupations Training Center – A portion ($7.5 million) of the District's Proposition G projects ($247 million overall) includes the potential of the development of a Health Occupations Training Center (HOTC) to assist in the education of the future health care workforce. The District has partnered with

the Grossmont-Cuyamaca Community College District for the program planning of the facility, as the College District has expressed a commitment to utilize the space to train East County students in the health care professions. The conceptual design of the facility is near completion.

- District/City of La Mesa Health Fair – District facilities and the adjacent Briercrest Park, owned by the City of La Mesa, are jointly used annually for a Kids Care Fest, where thousands of families and children avail themselves of free health screenings, health and wellness information, and recreation opportunities. Many families are under-insured and attend to receive screenings for their children from Grossmont Hospital pediatricians, community clinics and several other providers in the community.

3. If the HCD has a lease agreement or has contracted for operation and maintenance of an acute care hospital, please summarize the agreement or contract. Include at a minimum, details concerning each party's responsibilities, including any division of liability for funding CIP programs; assignment of profits and liabilities; terms of lease; the District oversight role; and proposed timetable for receiving voter approval before extending a lease or negotiating a new agreement.

On May 29, 1991, in accordance with California Health & Safety Code section 32121(p), the District and GHC [a non-profit subsidiary corporation of San Diego Hospital Association (SDHA), now Sharp HealthCare], entered into 30-year lease (1991 Lease) and affiliation which, if it is not extended, will end on May 30, 2021. A principal objective of the lease and affiliation was to enhance the provision of quality health care to the communities served by the District.

Grossmont is the only healthcare district in the state allowed through legislation to consider an extension of its lease. In 2005 the District was successful in sponsoring legislation (Assembly Bill 1155, 2005), authored locally, to allow for a potential extension of the lease; the legislature passed Health & Safety Code §32126.3 which specifically provides that the District and GHC may renegotiate or extend the current lease for up to an additional 30-year term, provided the renegotiated lease or extension is presented to and approved by a majority of the voters in the District. The District is in discussions with Sharp HealthCare regarding an extension, which may ultimately be on the ballot in the 2013-2016 time period.

As part of the 1991 transaction, all of the assets of the District, including working capital, reserves, property, plant and equipment were transferred to GHC for the exclusive use in the operation of Grossmont Hospital. The 1991 Lease was subject to a legal challenge which was summarily dismissed and was also subject to a San Diego Grand Jury Report which is attached as Exhibit B.3. The San Diego Grand Jury found that the lease and affiliation was provided for in the Health & Safety Code and was supported by the California courts. Moreover, the Grand Jury Report found that while the daily operations of the hospital became the responsibility of GHC/SDHA, the supervision of the hospital investment and its future remained with the District, the electorate, and the elected board.

In accordance with the terms of the 1991 Lease, GHC agreed to assume all of the liabilities of the District, which included approximately $45 million in Revenue Bonds. During the term of the Lease:

- GHC must continuously operate Grossmont Hospital as a community hospital and use its best efforts to operate the facility in a manner that will maximize the availability of quality health care services to the communities served by the District (§3.1,15.1, 15.3).

- GHC is prohibited from sharing any profits or making any donations or contributions to SDHA (§15.19).

- GHC is prohibited from making any corporate changes (dissolution, merger, consolidation, sale of substantially all assets) without the consent of the District (§15.2).

- GHC cannot assign, sublet or transfer its interest in the Lease or Grossmont Hospital without the consent of the District (§15.2).

- GHC must maintain Grossmont Hospital and related facilities in good condition including making needed repairs, remodeling and improvements (§3.4, 15.7).
- Both the District and GHC Boards meet every year to discuss the status of Grossmont Hospital and meet at least every 3 years to discuss GHC's long range plans and methods of financing major capital projects (§16.13).
- GHC must comply with all applicable laws and regulations relating to the provision of health care (§3.2, 15.5).
- GHC must maintain applicable accreditation and licensing (§15.5).
- GHC cannot discriminate or restrict the admissions of patients (§15.8).
- GHC cannot terminate or material reduce existing "core services" at Grossmont Hospital without obtaining the District's consent which cannot be unreasonably withheld (§15.12).
- GHC is required to keep Grossmont Hospital and all of its operations properly insured, including property, professional liability and worker's compensation insurance (§4.1, 4.2,4.3)

If the foregoing obligations are not met, the District may terminate the 1991 Lease. In the event of termination of the 1991 Lease, all of the assets of GHC, including working capital, reserves, plant, property and equipment will revert to the District.

The 1991 Lease also requires that five (5) of the fifteen (15) member GHC Board of Directors are "District approved Directors" (GHC Bylaws Article V §2b.(i)). In addition, GHC provides a report to the full District Board on a monthly basis at a public meeting relating to the activities of the hospital and compliance with the terms of the 1991 Lease. All books and records (including financial records) are available for review, to the District Directors and the District approved Directors on the GHC Board.

The District has a standing Facilities Committee which inspects the condition of Grossmont Hospital and reports quarterly to the full Board in a public meeting on the results of the inspections, needed repairs and ongoing efforts to address needed repairs, maintenance and facility upgrades.

The District and GHC have collaborated in the development and implementation of the Grossmont Hospital Master Plan which includes the funding of the Capital Improvement Project (CIP) Program. In 2004, GHC constructed a five (5) story Emergency Department and Critical Care Unit. As part of the District's $247 million General Obligation Bond (Prop. G) which was passed in 2006, the District completed the build-out of the facility. With Prop. G funds, the District is constructing a Heart & Vascular Center which will include new state-of-the art operating rooms and interventional suites including catheterization and radiology labs. The District and GHC are also sharing in the cost of a new Central Energy Plant which will include a modern Cogeneration unit as well as new chillers and boilers that will supply the ultimate energy needs at Grossmont Hospital in an efficient, cost effective manner. In addition, Prop G funds are being used to renovate the East Tower of Grossmont Hospital and patient rooms are being remodeled to support future advances for improved patient care. The District and GHC are also continuing to coordinate plans to ensure the future compliance with seismic upgrades as required by SB 1953.

4. Describe federal, state, and local regulatory oversight of HCD facilities and services.

As the operator of a general acute care hospital, GHC must comply with a myriad and almost countless number of federal and state laws relating to provision of health care in California. The 1991 Lease reiterates the requirement that GHC comply with all laws, ordinances, and other governmental regulations including all building requirements and regulations (§3.2).

The District Board monitors compliance with the applicable laws and regulations and the 1991 Lease provides procedures for termination for non-compliance (Article 8).

As a public agency the District is governed by all federal laws applicable to California public agencies as well as all State laws including the provisions of the Health & Safety Code related to Health Care Districts, and numerous state laws relating to conflicts of interest, the FPPC, employment laws, environment regulations, election laws and oversight by the state legislature and California Attorney General where applicable.

GHC describes the regulatory oversight as such: Providers in the health care industry, including Grossmont Hospital, are subject to significant legal and regulatory requirements of federal, state and local governmental agencies and independent professional organizations and accrediting bodies. These legal and regulatory requirements include the federal Balanced Budget Act of 1997, state and federal privacy laws including HIPAA, the HITECH Act, and CMIA (California patient privacy law), state and federal fraud and abuse laws (the Anti-Kickback Law), state and federal false claims laws, federal physician self-referral law (the Stark Law), the federal patient transfer law (EMTALA), certain environmental laws and regulations, state licensing requirements, and tax laws applicable to nonprofit tax exempt corporation under IRS Code 501 (c) (3). Grossmont Hospital is also subject to an accreditation body, the Joint Commission, that accredits and certifies health care organizations and programs in the United States.

5. What is the HCD's time standard/goal for off-loading emergency transport patients? What were the records in FY2010-11 and FY2011-12 for meeting or exceeding the standard? Discuss plans to improve performance that did not meet goals.

   Grossmont Hospital and the County of San Diego have the goal to have every emergency ambulance transported patient off-loaded upon arrival to the hospital with the goal of not exceeding 30 minutes. The ambulance transport companies track individual patient transportation times. Grossmont Hospital does not track this specific data, however the hospital has met and exceeds the aggregate off-load goal of not exceeding 30 minutes.

6. Summarize findings from any HCD population growth projection or study. Discuss actions or plans that have been adopted by the HCD in response to growth studies. Describe how growth projections are integrated into capital improvement plans.

   As a component of its annual strategic planning process, Grossmont Hospital's planning team – consisting of leaders and key personnel – receives an annual environmental assessment for its market, which includes population growth projections and other market information. In the next five years, East County is projected to grow by 4.3 percent, and Grossmont Hospital's service area is projected to grow by 4.1 percent. In addition to service area growth, Grossmont Hospital has seen growth in its East County market share of inpatient discharges, from 39.1 percent in 2007 to 40.0 percent in 2010. Grossmont Hospital had the largest market share gains in the Behavioral Health, Cardiac Surgery, Endocrine, General Medical, General Surgery, and Neonatology service lines.

   From the environmental assessment, the planning team performs strengths, weaknesses, opportunities, and threats analyses, which are used to develop hospital strategies and action plans. These strategies are developed using the market growth projections and expected demand for services. The capital and operating impact of these strategies are forecasted in a Five-Year Operating, Cash and Capital Plan ("Five-Year Plan"), which includes a capital evaluation process that uses quantitative evaluation criteria to provide the best strategic capital initiatives to support the needs of East County community.

   In the most recent Five-Year Plan, strategic capital initiatives generated from this strategic planning process include a new heart and vascular center ($28 million), a new parking structure ($8 million), equipment to fund Prop G expansion ($22 million), and further acute care expansion ($2 million). This strategic capital investment,

totaling $60 million, is in addition to Grossmont Hospital's identified routine equipment and facility renovation of $68 million. In total, Grossmont Hospital expects to invest capital of $128 million over the next five years.

7. Itemize capital improvement projects that will be funded with alternatives to general obligations bonds; include scheduled completion date and identify funding, for example, revenue anticipation bond, voter-approved assessment, pay-go funds or CIP reserves.

    - Grossmont Hospital Corporation Funded Improvements – The District's $247 million bond program is augmented by approximately $183 million in GHC dollars over the life of the program, in addition to GHC's ongoing maintenance to and improvement of the facilities. Included in this is the new Emergency Department and Critical Care Tower, the first phase finished in 2004 by GHC, with the final three floors of the building completed with Prop G bond funds in 2009. GHC continues to invest in Grossmont Hospital by making significant capital improvements. In FY13 those capital improvements are anticipated to amount to over $25 million and include a new CT Scanner, a PET CT, a new DaVinci Robotic Operating System, upgrades to radiology equipment, and numerous infrastructure improvements and replacements. (Further details are shown in Question B.6 above.)

    - New Cogeneration Equipment – Supplementing the general obligation bond-funded Central Energy Plant, is a new state-of-the art Cogeneration Unit. In June 2012 the District completed a tax exempt financing for the Cogen equipment. The financing is over a nine-year term carrying a rate of 2.09 percent. The financing is a true public/private partnership, with GHC making the required monthly payments to the bank; when the financing is completed the Cogen equipment will be transferred over to GHC. Some hi-lights of this partnership:

        - The new Cogeneration unit is estimated to provide 95 percent of the electrical needs of Grossmont Hospital.
        - Using proven technology, estimated 90 percent reduction in nitrogen oxide emissions compared to existing cogeneration system.
        - Duct-fired heat recovery offering 10 to 15 percent increase in steam generation efficiency.
        - Estimated 70 to 80 percent increase in on-site cogeneration annual kWh production from current system.
        - Expansion capability.
        - Both environmental and cost savings benefits to the residents of the District from this "public/private partnership."
        - Safe and secure energy supply ensuring patient care will not be affected by energy outages or other issues from the regional energy grid.

    - Potential Health Occupations Training Center. As noted under Question B. 2 above, a portion of the District's Proposition G projects includes the potential of the development of a Health Occupations Training Center to assist in the education of the future health care workforce in partnership with the Grossmont-Cuyamaca Community College District. General obligation bond funding includes $7.5 million in budgeted monies for this project, with the overall project estimated at more than $12.5 million. The District is looking at funding sources including its general fund for the $5 million or more needed in addition to bond funds.

8. Describe capital improvement plans that address projected infrastructure deficiencies and/or comply with State seismic requirements. Please discuss the District's status regarding seismic requirements.

    As part of the District's Proposition G projects, the District and GHC participated in the Office of Statewide Healthcare Planning and Development's (OSHPD) voluntary HAZUS Re-assessment Program to re-evaluate the seismic risk of Grossmont Hospital buildings classified as Structural Performance Category 1 (SPC-1) and

required to be retrofit, replaced or removed from providing acute care services by 2013. Using HAZARDS U.S. (HAZUS), a state-of-the-art methodology, to re-assess the seismic risk of its SPC-1 buildings, it was determined that Grossmont Hospital SPC-1 buildings used for acute care posed a low seismic risk and OSHPD approved

the application to reclassify the buildings as SPC-2. SPC-2 buildings have until 2030 to comply with seismic safety standards.

As a part of the effort to expand medical facilities and to integrate improved technology to meet the growing medical needs of an expanding community, the Proposition G Projects include the construction of a three story Heart & Vascular Building (H&V Building), having an SPC-5 rating, adjacent to the existing East Tower Nursing Unit. In addition to increasing the number and capabilities of operating rooms, the H&V Building will provide space for the relocation of the hospital pharmacy and lab from existing SPC-2 space. Construction of the H&V Building requires the demolition of an existing loading dock attached to the East Tower, to be reconstructed at a lower level in the H&V Building. Because demolition of the existing dock will affect the seismic capacity of the East Tower, an SPC-3 building, by more than five percent, the District coordinated with OSHPD to provide seismic compensation by upgrading (i.e., stiffening) the foundation of the East Tower. These upgrades include increasing the size of, and providing for tie-downs, for certain column footings.

To supply the power and other utilities required by the H&V Building, the District is constructing a new Central Energy Plant (CEP), also rated as SPC-5. The existing CEP, rated SPC-4, will ultimately house only the electric service box for distributing electric power to various portions of the hospital other than the H&V Building. The Build-Out of Levels 2, 4, and 5 of the Emergency Department/Critical Care Unit Building, rated SPC-5, is already complete.

In all Proposition G Program project areas, the District will be correcting any seismic deficiencies it identifies wherever work is taking place (e.g., piping or conduit systems). The District and GHC are also continuing to coordinate plans to ensure future compliance with seismic upgrades as required by SB 1953.

The following Exhibits also contain information related to infrastructure upgrades and seismic compliance:

- Exhibit B.8 – Grossmont Hospital FY2013 Approved Capital Budget for Infrastructure.
- Exhibit A.2.(d) 2 – As noted previously, the Proposition G Monthly Update for information on the District's project budgets and timelines.

9. Estimate the percentage of HCD patients that were district residents in FY2010-11 and in FY2011-12.

   See Exhibit B.9 – Inpatient Cases by Grossmont Hospital Primary & Secondary Service Area Zip Codes.

Section C: FISCAL

1. List all HCD revenue sources and identify the approximate percent of total funding contributed by each source.

HCD REVENUE by category	PERCENT of TOTAL *(based on 6/30/12 audited balanced)*
• Property Taxes-1% Apportionment	36%
• Property Taxes-Ad Valorem for Debt Service (Prop G Bonds)	55%
• Investment Earnings	9%

2. Please provide the following budget information.

HCD REVENUE by category	FY2009-10	FY2010-11	FY2011-12
Property Taxes -1% Apportionment	$6,240,000	$5,565,900	$5,565,900
Property Taxes – Ad Valorem for Debt Service	$5,796,000	$5,231,280	$8,925,000
Investment Earnings	$777,000	$360,000	$834,000
HCD Budgeted Net Income	$4,333,201	$3,117,054	$4,710,795
Restricted Reserves by Budget Year	$300,000	$500,000	$750,000
Debt Payments (Interest) by Budget Year	$3,072,400	$3,068,300	$5,927,190
Debt Payments (Principal) by Budget Year	$0	$205,000	$380,000
Debt/Equity Ratio (Based on 6/30/12 audited balances)	6.72%	9.63%	6.53%
Debt Service Coverage Ratio (Based on 6/30/12 audited balances	5.31%	6.12%	3.53%

3. Discuss constraints associated with the District's ability to generate increased revenue.

The District is considering the following additional revenue sources in conjunction with its five-year Strategic Plan currently under development:

- Space use fees
- Space and land rental fees
- Energy fees

Constraints have been identified as political and/or economic in nature.

4. Describe contingency plans for the HCD to resume operational responsibility of a leased acute care hospital if necessary. If the District has established a reserve fund for this purpose, discuss the HCD policy concerning maintenance of the reserve fund and adequacy of the current fund balance.

The District's lease is unique in the sense that the entire working capital of the operator, Grossmont Hospital Corporation (GHC), comes back to the District upon termination of the lease. This includes all cash, receivables, buildings and equipment, improvements, accounts payable and debt. Given this scenario and contrary to other district hospital leases, the District will not need to amass large amounts of cash and resources to operate the hospital permanently or during an interim period. The District Board did establish a contingency fund to accumulate resources to engage a management company for transition services should the need arise. Under the lease, the District is able to monitor the balance sheet and financial operations of GHC through receipt of audited financial statements and monthly financial reporting and participation at GHC's monthly Board meetings, and other required reporting to the District by GHC. The District has established relationships with several qualified firms to provide transition services should the need arise and has a goal of $7,500,000 for the reserve, which represents adequate resources if ever needed for transition services.

5. Describe District investment policies and practices.

   The District has a very conservative investment policy which is required under the California Government Code to come before the Board annually. A copy of the current policy is attached as Exhibit C.5.

6. Identify the District's current bond rating and briefly discuss any change in District rating change that occurred within the previous five years.

   The District is currently rated Aa2 by Moody's Investors Service. The only changes to rating were a result of factors affecting AMBAC and a change in Moody's rating methodology. Attached as Exhibits C.6 and C.6.(b) are the SEC Rule 15c2-12 EMMA filing and most recent rating report from Moody's.

7. Itemize existing HCD bond debt according to: (1) revenue, general obligation, or other; (2) Year of issue; (3) Maturity date; (4) amount authorized; (5) amount issued; (6) authorized activity; and (7) FY2011-12 end-of-year outstanding debt.

   The District's debt is summarized in Note F of the FY12 audit report which is attached as Exhibit A.2.(b).

8. Please provide the schedule for subsequent sale(s) of an authorized bond balance and identify the project/activity related to each sale.

   The District has its final bond sale set for FY14 or FY15 in the approximate amount of $25,512,925. Proceeds will fund the final construction of the Heart & Vascular Center and East Tower renovations. See Proposition G Monthly Update [previously noted as Exhibit A.2.(d) 2] for related information on the District's project budgets and timelines.

9. Describe established HCD oversight protections that ensure that public funds are expended for the authorized project.

   As part of 2006's Proposition G and as a promise to the District taxpayers at the request of the San Diego County Taxpayers Association, the District Board established an Independent Citizens' Bond Oversight Committee (ICBOC) to establish public oversight protection and ensure that public funds are expended for authorized projects and purposes. The ICBOC began meeting prior to the sale of bonds and project commencement. Attached is the most recent annual report from the ICBOC as Exhibit C.9.(a). The District Board authorizes a $100,000 annual budget for the work of the ICBOC, paid by general operations (not bond funds) for related expenses such as audits, meeting coordination, performance reviews, and the like. Attached are the most recent bond related financial audits and performance audit as follows:

   - Exhibit C.9.(b) 1 – GHD FY12 Bond Funds Final Audit Report
   - Exhibit C.9.(b) 2 – GHD FY12 Bond Agreed Upon Procedures (AUP) Audit Report
   - Exhibit C.9.(b) 3 – Prop G 2010 Independent Performance Audit

10. Describe HCD policies and procedures pertaining to competitive bidding of public improvement projects and sole-source procurement.

    The District strictly adheres to the legal requirements applicable to California Healthcare Districts relating to competitive bidding and sole-source procurement. These include Health & Safety Code sections 32132, 32136, 32138 and Public Contract Code sections 20100 et. seq., 20104, and 22200 et. seq. The District also follows the prevailing wage laws applicable to public agencies and the construction of public improvements.

Section D: OPERATIONAL EFFICIENCIES and ACCOUNTABILITY FOR COMMUNITY SERVICE NEEDS

1. Itemize agreements, partnerships, or contracts with health-care provider groups, community service groups, independent physicians and surgeons, or other agencies to share facilities or infrastructure or to cooperatively provide health services within the HCD. Itemize HCD assistance or grant programs that support health-related services provided by local community non-profit provider groups.

    - Community Grants Program – In recognition that community health care is not just limited to the hospital, the District as part of its mission has established a community grants program to address unmet healthcare needs in the District. Since 1996 the District has provided about $37 million in grants for health care services in the community, benefitting community clinics, health providers and the underinsured population, with approximately 45 percent of that amount ($17 million) going directly to Grossmont Hospital for medical equipment, indigent care, and support of hospital based programs that enhance patient care. (See Exhibit D.1. for list of FY 2011-12 grant recipients.)

    - Facilities Use – As noted in Question B. 2 above, the District has determined that its role as a local government agency require that its resources be shared by the communities served. The board-adopted policy is to make the District auditorium and conference rooms available for public use by community based nonprofit organizations and other government agencies. There is no charge for use of the facilities and grounds. Hundreds of groups and thousands of individuals use the facilities annually (a list of organizations is available if needed).

    - Inter-Governmental Transfer (IGT) – For three years, the District's $1 million dollars per year in budgeted support to Grossmont Hospital has translated into significantly more than that by means of a federal matching funds program administered by the State of California. The IGT program has increased Medi-Cal reimbursements to Grossmont Hospital, as follows: In FY 2010-11, the District's $1 million was increased to about $2.3 million, and in FY 2011-12 another $1 million allocation was increased to about $1.6 million in funding to Grossmont Hospital. This year, FY 2012-13, the board approved another $1 million, with the supplemental funding to the Hospital in process, the amount not yet determined.

    - See Exhibit D.2 – Sharp HealthCare Community Benefits Plan and Report: Fiscal Year 2011 – Grossmont Hospital

    - Grossmont Hospital also has a number of agreements. Those arrangements are confidential.

2. Describe additional community health care services or needs that been identified by the HCD or hospital operator. Summarize capital improvements that would be required to implement additional services and explain how the improvement projects would be funded. Identify other organizations with which the District could partner or support in the production of new community health care services.

    As noted above in Question D.1., see Exhibit D.2 – Sharp HealthCare Community Benefits Plan and Report: Fiscal Year 2011 – Grossmont Hospital

    As noted under Questions B.2 and B.7 above, a portion of the District's Proposition G projects includes the potential of the development of a Health Occupations Training Center to assist in the education of the future health care workforce in partnership with the Grossmont-Cuyamaca Community College District. General obligation bond funding includes $7.5 million in budgeted monies for this project, with the overall project estimated at more than $12.5 million. The District is looking at funding sources including its general fund for the $5 million or more needed in addition to bond funds.

3. Describe experiments that the HCD has underwritten for new methods of providing adequate health care in communities served by the HCD (Health and Safety § 32126.5(a)(3).

   Grossmont Hospital provides prenatal care which includes a midwife and Medical Director oversight to two community clinics (La Maestra and Neighborhood Healthcare) within East San Diego County.

4. Describe Board of Director actions within the past five years, which were taken to evaluate the District's internal organization including evaluation of management efficiencies.

   Approximately two and one-half years ago, the Proposition G Independent Citizens' Oversight Committee (ICBOC) requested and District staff recommended that the Board approve an independent third party consultant to review the construction program management processes in place, with one project then complete, to ensure best practices and program efficiencies going forward. The contracted consultant provided a detailed report indicating the quality of the program management and reasonableness of the related costs, as well as several recommendations for improvements (previously noted as Exhibit C.9.(b) 3 – Prop G 2010 Independent Performance Audit). The recommendations have been implemented by District staff and the Prop G Program Management Team, with all changes reported publicly to the board and ICBOC.

   The District board is currently in a Risk Assessment and Strategic Planning process with a management consultant. Input has been received in advertised public meetings, stakeholder meetings, individual board member interviews, and a board workshop. The recent (October 13, 2012) public workshop discussion focused on identified District strengths, weaknesses, opportunities, threats, and risks. The Board members narrowed the list to what they viewed as the top risks, reviewed the District's existing Mission Statement and provided direction to update it accordingly, and worked on the development of a draft Vision Statement. The consultant is currently formulating the output from this workshop and developing a draft five-year strategic plan for future presentation to – and eventual adoption by – the board.

5. Describe staff reorganizations that have occurred within the past three years.

   The sole staff reorganization in the last three years was to go to part time contracting for after regular hours coordination for use of the District conference room facilities and janitorial needs, replacing a full time directly employed position, a dollar savings as well as the position no longer being part of the public retirement or benefits system.

   There have been continuing changes in contracted staffing in the Proposition G Bond Construction Program Management Team, as the various projects have moved from the design stage into construction. These changes have been planned and anticipated based on the level of construction taking place.

6. Describe the HCD's most challenging issues, and discuss the continuing ability of the District to meet community health care needs.

   As identified thus far as part of the Strategic Planning process described under Question D.4 above, the most challenging issues facing the District include the potential of state legislative mandates and/or regulations on resources, other increased pressure for District resources, and the potential, however unlikely, of a lease extension of Grossmont Hospital not being approved. The potential of the legislature looking at healthcare districts as a source of funding, and/or creating mandates on how districts use their monies, is an increasing reality and challenge to the District. Such legislative changes could severely impact the District's ability to function at present levels, including the continuation of its Community Grants Program (described in Question D.1 above) and even potentially jeopardizing proper administration of the Prop G bond-funded projects improvements.

   However, as the lone healthcare district in the state that has leased hospital operations <u>and</u> has voter approved bonds for improvements of that hospital, we believe we are in a unique position to effectively educate our

legislators as to the differences between various districts in this regard, as well as that our governance structure via the 1991 Lease with GHC provides for proper board oversight, including seats on the GHC board and authority to approve any GHC requested changes to hospital core services.

As well, an extension of the lease of Grossmont Hospital is in process at the discussion level with Sharp HealthCare and anticipated for possible voter approval in the next three to four years. The positive relationship between the entities and the view of the District and Sharp by the public speaks well for the possibility of approval. Such a vote would require simple majority; the District did achieve 77.8 percent approval of Prop G in 2006, which was a 66.67 percent-required tax measure.

The District is in an excellent position to continue to meet the needs of the community. The five-year Strategic Planning process underway is helping to identify and mitigate risks that could keep those needs from being met.

7. Have HCD facilities been designated as a critical access hospital pursuant to Health and Safety §1250.7?

   No; this applies to rural hospitals that receive cost based reimbursements.

8. Have HCD facilities been designated as a safe surrender site pursuant to Health and Safety §1255.7?

   Yes. Grossmont Hospital is a safe surrender facility.

Section E: GOVERNMENTAL STRUCTURE

1. Discuss circumstances surrounding HCD Directors who also fill positions on hospital corporation boards or committees and summarize HCD policy regarding possible conflicts-of-interest.

   In accordance with its bylaws each District board member designates a nominee for service as that board member's representative on the Grossmont Hospital Corporation (GHC) board. This includes each District board member potentially designating him or herself as the representative. Each designee serves on the GHC board at the pleasure of the appointing District board member, and the designee's term cannot exceed the term of the appointing District board member. To ensure that the District board members are kept informed of confidential information provided to the GHC board, the District has adopted a Quality Assurance Patient Care policy (Exhibit E.1) that includes the allowance for all GHC board members and the District's CEO to report to the District board on confidential information relating to hospital quality assurance, patient care or patient safety issues.

2. Please provide the following information concerning Director compensation:

(a)	Rate of Directors' compensation for attending meetings:	$100/meeting, maximum of $500/month (state law establishes a max of $100 per meeting and $500 per month)
(b)	Total cost in FY2011-12 for attendance at meetings:	$30,000
(c)	Total cost in FY2011-12 for Directors' travel expense:	$16,986
(d)	Total cost in FY2011-12 for Directors' healthcare:	$110,514
(e)	Total cost in FY2011-12 for Directors' post-employment benefits:	No current Directors are eligible for post-employment benefits.

3. Describe how HCD Board members are involved in the administrative, management, or personnel matters of the District.

   Board members set policy and communicate through the District Chief Executive Officer. Board members are not involved in the administrative, management, or personnel matters of the District.

4. Describe HCD policies or rules that regulate communication between board members and HCD employees.

   The District has in place a board-adopted policy setting forth the method of communication. In part, the policy directs that board members shall deal exclusively with the CEO concerning all questions or activities related to the District; and that "Individual board members shall not direct or assign tasks to the District's employees, consultants or contractors."

   Through attendance at seminars and programs sponsored by the Association of California Healthcare Districts, the California Special Districts Association and other organizations, including mandated ethics training, District board members have been educated in the appropriate role of directors and communications with District employees.

5. What is the HCD policy regarding staff expenditures without Board approval.

   The District CEO is the only employee authorized to approve expenditures within board approved limitations.

General fund expenditures of $10,000 or less and Bond fund project expenditures of $25,000 or less may be approved by the CEO within board-approved budget authorizations; expenditures above that require board approval and an authorized board member as a second signer/authorizer.

6. Please discuss any jurisdictional change such as dissolution or consolidation with another local agency, which the HCD may have considered, and describe the desired outcome from the action.

   The District has not considered a dissolution or consolidation with another local agency.

   Not a consolidation, but the District has entered into two Health Facilities Bond Financing JPAs, one with Palomar Health and Tri-City, another solely with Palomar Health, both for the facilitation of bond sales. These JPAs are efficient and cooperative in nature.

7. Please provide any additional information that LAFCO should evaluate. If information that is relevant to the MSR program could be available from other agencies, please provide a summary of the information and a list of the agencies where the information might be located.

   The District does not have any additional information to provide LAFCO at this time.

Please return completed questionnaire and additional information by **October 24, 2012** to:

San Diego Local Agency Formation Commission
9335 Hazard Way, Suite 200
San Diego, CA 92123
or
Dieu.Ngu@sdcounty.ca.gov

For information, please contact:
Robert Barry at 858/614-7762; or *Robert.Barry@sdcounty.ca.*

LAFCO – Executive Summary of 2015 Service Review
(Entire report is available electronically)

9335 Hazard Way • Suite 200 • San Diego, CA 92123
(858) 614-7755 • FAX (858) 614-7766
Website: www.sdlafco.org

San Diego Local Agency Formation Commission

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Vacant
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Alternate Members

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Chris Cate
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City of Lemon Grove

Ed Sprague
Olivenhain Municipal
Water District

Harry Mathis
Public Member

Executive Officer

Michael D. Ott

Legal Counsel

Michael G. Colantuono

6A
6B
6C

May 4, 2015

TO: Local Agency Formation Commission

FROM: Executive Officer
Local Governmental Analyst

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)

- 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 and Sphere Review* in 2020.
- *Special 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 next *Health Care Services and Sphere Review* in 2020, 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 next *Health Care Services and Sphere Review* in 2020, 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.

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 San Diego County Health Care MSR reviews the provision of health care services in the 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 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).

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.

The four 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

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.

Population/Projections

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 service area populations 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%

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 *2015 Health Care Services 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

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). 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.

Proposed San Diego County Special Study Areas

As 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 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).

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;

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 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 the potential for inclusion into one or more of the Health Care Districts' 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 QI evaluations 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 this MSR are produced by: the Federal Agency for Health Care Research and Quality (AHRQ), which compiles statistics on hospital performance for selected medical procedures and conditions, and compares them with county and statewide averages; and by *CalQualityCareCare.org*, which establishes hospital ratings from patient survey responses on their personal experiences receiving a broad range of medical services and procedures.

The MSR determinations conclude that the Health Care District's 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 QI 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 San Diego Health Care Services MSR and Sphere 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 Districts' acute-care hospital facilities are adequately sized for present and probable demands.

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.

SPC/NPC 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 current OSHPD seismic safety ratings for the local Health Care District hospital facilities, building components, and non-structural features:

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 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

OSHPD annual financial disclosure reports 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.

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 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.

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 determinations state that the Districts' annual property tax revenue stream is primarily used by the HDs to underwrite local community grant programs to financially

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 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 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. The MSR 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 *2015 Health Care Services MSR and Sphere Review* identify 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.

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.

The County of San Diego is the only local public agency responsible for and currently providing county-wide health care services. Therefore, without annexation into one or more existing Health Care Districts, the County would be the more likely successor agency to assume provisional responsibility for a dissolved HD's facilities and to be capable for the continued provision of health care services in either incorporated or unincorporated HD service area territory; or to administratively contract those responsibilities within the dissolved district's service area following a bid and award process.

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.

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 is a summary of our 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 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,

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 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

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. Subsequent health care service and sphere reviews should evaluate the Special Study Area 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 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 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.

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 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 benefit the region.

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 Health Care Services and Sphere Review 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 Health Care Services and Sphere Review 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.