



CALIFORNIA
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California's Health Care Districts

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by
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About the Author

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

About the Foundation

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

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I. Introduction

THE PURPOSE OF THIS PAPER ON CALIFORNIA'S HEALTH care districts (originally known as hospital districts) is to provide a basic understanding of their origin, development, and function. Since the goal of such districts is to support the health needs of their communities, there is value in reviewing the role they may play in the California health care environment.

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

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

II. Origin of Local Hospital Districts

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

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

The Local Hospital District Law allowed communities to create a new governmental entity—independent of local and county

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

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

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

III. Changing Nature of Health Care and Hospital Districts

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

By the late 1970s and early 1980s, all hospitals were feeling the impact of major changes in the manner in which they were being reimbursed for services rendered. No longer was a high percentage of acute hospital care funded by tax proceeds and collection of fees, as had been the case up to the early 1960s. Instead hospitals were being paid by insurance companies through carefully controlled contractual relationships, while the public programs, Medicare and MediCal (Medicaid), were beginning to implement their own cost-savings strategies. The rapid growth of managed care and advent of capitation payments, particularly in California, added to the budget deficits hospitals were experiencing. Lower insurance payments and more intense scrutiny of the level of medical care led to earlier discharges of patients, often leaving hospitals with too many empty beds. Added to those changes was the impact of more

advanced technology, improved pharmaceuticals, and new medical procedures that spawned an increase in outpatient services provided in community settings. All these changes, as beneficial as they were for patients, further hurt the bottom line of acute care hospitals. Finally, the emphasis on health promotion and wellness programs, which encouraged people to take better control of their physical well-being, began to have an impact on the way health-insuring organizations spent their resources.

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

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

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

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

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

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

Medi-Cal, and district tax dollars. In fact, ACHD leadership believes that these district hospitals may provide more care to these higher risk, uninsured populations than do the county and university-operated public hospitals in the state, because of their rural locations.

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

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

- **Desert Hospital** (Desert Healthcare District) is operated by for-profit Tenet HealthSystem Hospitals under a 30-year lease agreement.
- **Eden Medical Center** (Eden Township Medical District), **Marin General Hospital** (Marin Healthcare District), and **Mills-Peninsula Hospitals** (Peninsula Health Care District) are operated under various long term arrangements with non-profit Sutter Health.
- **Sequoia Hospital** (Sequoia Healthcare District) is operated under a long term lease to non-profit Catholic Healthcare West (CHW).
- **Petaluma Valley Hospital**, owned by the Petaluma Health Care District, is operated under contract with St. Joseph Health System and is part of a network of Sonoma County health care providers, including Santa Rosa Memorial

Hospital, St. Joseph Home Care Network, and Hospice Care of Sonoma.

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

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

- **Bloss Memorial Healthcare District** (Merced): rural health clinics, dental care, occupational health, services to the developmentally disabled.
- **Camarillo Healthcare District** (Ventura): Adult day support, in-home support, paratransit services, health screenings and education, support groups for patients suffering from catastrophic illnesses.
- **Del Puerto Healthcare District** (Stanislaus): ambulance service.
- **Cambria Healthcare District** (San Luis Obispo): ambulance service, Alzheimer’s day care center, public education.
- **Beach Cities Health District** (Manhattan Beach, Redondo Beach, Hermosa Beach—Los Angeles): health and fitness center, senior housing development, family crisis center, free clinics, community service building leases.

- **Peninsula Health Care District** (San Mateo): children’s health insurance, counseling and substance abuse programs, senior services, free clinic.

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

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

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

IV. Rules Governing Health Care Districts at the Local Level

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

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

- Infrastructure needs or deficiencies
- Growth and population projections
- Financing and rate structuring
- Shared resources and cost avoidance constraints and opportunities
- Local accountability and governance
- Management efficiencies
- Government structure options, including advantages and disadvantages of consolidation or reorganization of service providers.

A question for county attorneys is to determine the scope of a LAFCo municipal services review as it pertains to those districts that have divested themselves of hospitals. It is not clear whether the review would consider the hospital once operated by the district or leased to another management group, whether it would look at all hospitals in the area to determine level of acute care services available, or whether it would limit review to the grant-making, leasing, ambulance, and other services provided by the districts that do not operate hospitals.

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

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

Appendix A: Survey List of California Hospital Districts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Doctor's Medical Center: San Pablo and Pinole, Contra Costa County; see West Contra Costa Healthcare District, below.

East Kern Health Care District: California City, Kern County; developing joint powers agreement with Tehachapi Valley Healthcare District for hospital expansion; see below.

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

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

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

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

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

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

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

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

Hi-Desert Memorial Health Care District: Joshua Tree, San Bernardino County; district operates Hi-Desert Medical Center, a full service hospital with 59 beds

and skilled nursing facility with 120 beds; supports home health and hospice.

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

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

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

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

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

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

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

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

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

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

Mayers Memorial Hospital District: Fall River Mills, Shasta County; 121 beds operated by district.

Mendocino Coast District Hospital: Fort Bragg, Mendocino County; district operates rural hospital with 39 acute beds, 49 total.

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

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

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

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

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

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

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

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

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

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

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

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

Peninsula Health Care District: Burlingame and north-

ern San Mateo County; Peninsula Hospital merged with Mills Hospital in 1985 to form Mills-Peninsula Health Services; 288 acute beds on two campuses in San Mateo and Burlingame, 403 total beds; operated by Sutter Health since 1996; grants program supports children's health insurance, free clinic, senior services, and youth counseling program.

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

Pioneers Memorial Hospital District: Brawley, Imperial County; district operates 99 or 107-bed full services hospital, Phyllis Dillard Family Medical Center (small/rural designation), Calexico urgent care, two health centers (see Heffernan district, above).

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

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

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

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

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

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

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

Selma Healthcare District: Selma, Fresno County; district operates 57-bed Selma Community Hospital; also supports teen pregnancy, diabetes, and health education services

Seneca Healthcare District: Chester, Plumas County; district operates a 10-bed hospital, 26 total beds.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Tulare District Healthcare System: Tulare District Hospital.

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

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

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

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

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

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

Appendix B: About the Health Care District Survey

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

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

Appendix C: References

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

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

California Hospital Association
various materials

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

California Statutes regarding hospital and health care
districts

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

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

Little Hoover Commission report on hospital districts

Newspaper: various articles from throughout California

OSHPD data

Rural and Small Hospital Reports

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

San Mateo County LAFCo
interview with Martha Poyatos, executive director

San Mateo County Grand Jury
report on health care districts

San Mateo County Legislative Director, Mary McMillan

“The Social Transformation of American Medicine”
Paul Starr, 1982

Web sites for Hospital and Health Care Districts



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