I AM RICHARD SEIDEN OF FOLEY & LARDNER, OUTSIDE GENERAL COUNSEL FOR VISTA HOSPITAL SYSTEMS AND FRENCH HOSPITAL MEDICAL CENTER. I AM JOINED HERE TODAY BY DONALD ALLEN, EXECUTIVE VICE PRESIDENT OF VISTA HOSPITAL SYSTEMS.

SINCE 1992, VISTA HAS OWNED AND OPERATED CORONA REGIONAL MEDICAL CENTER AND ARROYO GRANDE COMMUNITY HOSPITAL. IN 1997, AS A RESULT OF A DIVESTITURE ORDER ISSUED BY THE FEDERAL TRADE COMMISSION, VISTA ACQUIRED FRENCH HOSPITAL HERE IN SAN LUIS OBISPO. ACCORDING TO THE FTC, "THE PURPOSE OF THE DIVESTITURE WAS TO ENSURE THE CONTINUATION OF FRENCH HOSPITAL AS AN ONGOING, INDEPENDENT AND VIABLE ACUTE CARE HOSPITAL, AND TO REMEDY THE LESSENING OF COMPETITION RESULTING FROM THE ACQUISITION OF ORNDA HEALTHCARE BY TENET HEALTHCARE."

OVER THE COURSE OF THE PAST TEN YEARS, VISTA HAS INCURRED A TOTAL OF $180 MILLION IN DEBT UNDER TAX-EXEMPT BONDS IN ORDER TO ACQUIRE THE THREE HOSPITALS AND RELATED REAL AND PERSONAL PROPERTY, AND TO MAKE CAPITAL IMPROVEMENTS AT EACH OF THE HOSPITALS. SHORTLY AFTER ACQUIRING FRENCH HOSPITAL, VISTA WAS FORCED TO DISCONTINUE ONE PARTICULAR PROGRAM OF SERVICES, WHICH CAUSED A SIGNIFICANT CASH FLOW PROBLEM FOR FRENCH AND THE OTHER VISTA HOSPITALS.

STARTING IN 1999, VISTA HAS BEEN UNABLE TO MAKE THE REQUIRED PRINCIPAL AND INTEREST PAYMENTS UNDER THE BONDS. IN ORDER TO AVOID FORECLOSURE, VISTA HAS ENTERED INTO A SERIES OF AGREEMENTS WITH THE BONDHOLDERS WHEREBY THE BONDHOLDERS AGREED TO SUBSTANTIALLY REDUCED PAYMENTS OF AMOUNTS DUE, AND TO DELAY EXERCISING THEIR RIGHTS AND REMEDIES UNDER THE BOND DOCUMENTS IN EXCHANGE FOR RESTRICTIONS THAT WERE IMPOSED ON VISTA'S OPERATIONS AND CASH FLOW. THESE RESTRICTIONS HAVE PREVENTED VISTA FROM MAKING CERTAIN NECESSARY CAPITAL INVESTMENTS IN THE HOSPITALS, PARTICULARLY AT FRENCH.

IN MAY 2002, THE BONDHOLDERS DECIDED THAT THEY WERE NO LONGER WILLING TO ALLOW VISTA TO CONTINUE TO OWN AND OPERATE THE HOSPITALS WITHOUT ANY PAYMENT OF THEIR DEBT. AT THE DIRECTION OF THE BONDHOLDERS, VISTA BEGAN A PROCESS TO LOCATE A BUYER FOR ALL THREE HOSPITALS. VISTA HAD OPERATED THE HOSPITALS AS A SYSTEM, WHICH HAD ENABLED VISTA TO USE EXCESS REVENUES FROM ONE HOSPITAL TO SUBSIDIZE THE OPERATIONS AT THE OTHER HOSPITALS. VISTA AGREED TO NEGOTIATE A PURCHASE AGREEMENT FOR ALL THREE HOSPITALS WITH UNIVERSAL HEALTH SERVICES, A NATIONAL, FOR-PROFIT HOSPITAL SYSTEM. . ON APRIL 3, 2003, VISTA AND FRENCH ENTERED INTO AN ASSET PURCHASE AGREEMENT, WHICH WAS AN AGREEMENT TO SELL TO UNIVERSAL

SUBSTANTIALLY ALL OF THEIR ASSETS, INCLUDING CORONA, ARROYO AND FRENCH HOSPITAL.

THE ASSET PURCHASE AGREEMENT REQUIRED THAT THE SELLERS FILE PETITIONS UNDER CHAPTER 11 OF THE BANKRUPTCY CODE, AND THESE PETITIONS WERE FILED IN THE U.S. BANKRUPTCY COURT IN RIVERSIDE COUNTY ON JUNE 11, 2003. THE PURCHASE PRICE UNDER THE ASSET PURCHASE PRICE WILL BE INSUFFICIENT TO PAY ALL OF THE DEBTS OF VISTA, INCLUDING PAYMENTS DUE TO THE BONDHOLDERS AND THE UNSECURED CREDITORS. THERFORE, ONCE THE BANKRUPTCY PLAN IS ADOPTED, THERE WILL BE NO NET PROCEEDS REMAINING FOLLOWING PAYMENTS CONTEMPLATED UNDER THE BANKRUPTCY PLAN , AND UPON CONSUMMATION OF THE SALE OF ASSETS TO UNIVERSAL, VISTA HOSPITAL SYSTEMS WILL HAVE BEEN LIQUIDATED AND IT WILL BE DISSOLVED. VISTA ANTICIPATES THAT THE BANKRUPTCY COURT WILL APPROVE AN ORDER ADOPTING THE PLAN OF LIQUIDATION BY THE END OF NOVEMBER. THE ASSET PURCHASE AGREEMENT SHOULD BE CONSUMMATED AT OR BEFORE THE END OF DECEMBER, SUBJECT TO REGULATORY AND JUDICIAL APPROVALS.

AS A NONPROFIT HOSPITAL SYSTEM OWNING AND OPERATING COMMUNITY HOSPITALS, VISTA HAS ALWAYS RECOGNIZED THE IMPORTANCE OF EACH OF ITS HOSPITALS TO ITS RESPECTIVE COMMUNITY. HERE IN SAN LUIS OBISPO, VISTA HAS BEEN WILLING TO MAINTAIN ITS LEVEL OF CRITICAL HEALTH CARE SERVICES, DESPITE OPERATING AT A LOSS OR EXTREMELY LOW LEVELS OF REVENUES IN EXCESS OF EXPENSES AND PERIODIC NEGATIVE CASH FLOWS BECAUSE OF ITS COMMITMENT AND OBLIGATION TO THE COMMUNITY. VISTA IS ALSO WELL AWARE OF THE CLOSURE OF THE COUNTY GENERAL HOSPITAL, AND THE DISPLACEMENT AND DEMANDS THAT CLOSURE HAS PLACED ON ALL OF THE CITY'S HEALTH CARE DELIVERY PROVIDERS, AND PARTICULARLY TO THE EMERGENCY DEPARTMENT AT FRENCH HOSPITAL. IT IS VITALLY IMPORTANT WHEN SOMEONE IS STRUCK WITH A LIFE-THREATENING CONDITION THAT THERE BE TIMELY ACCESS TO COMPREHENISIVE, QUALITY HEALTH CARE FACILITIES. VISTA UNDERSTANDS THE INCREASED BURDEN THAT THE COMMUNITY CLINICS HAVE BORNE AS WELL.

IN NEGOTIATING THE ASSET PURCHASE AGREEMENT, VISTA INSISTED THAT THE BUYER DO EACH OF THE FOLLOWING:

(A) CONTINUE TO OPERATE EACH OF THE HOSPITALS AS A GENERAL ACUTE CARE HOSPITAL FOR AS LONG AS THE BUYER OWNED THE HOSPITALS, AND TO MAINTAIN AN EMERGENCY DEPARTMENT AT THE HOSPITAL FOR AT LEAST FIVE YEARS AFTER THE SALE.

(B) MAINTAIN A LOCAL GOVERNING BOARD, TO ADVISE BUYER AS TO THE OPERATIONS OF THE HOSPITAL. THAT BOARD WILL INCLUDE LOCAL

COMMUNITY LEADERS, MEMBERS OF THE MEDICAL STAFF, AND OTHER PHYSICIANS IN THE COMMUNITY.

(c) MAINTAIN CHARITY AND INDIGENT CARE PROVIDED BY THE HOSPITALS AT THE SAME LEVEL AS PROVIDED BY VISTA PRIOR TO THE SALE.

AS A NONPROFIT HOSPITAL SYSTEM, VISTA ACQUIRED EXISTING COMMUNITY HOSPITAL FACILITIES THAT WERE BEING SOLD BY THIRD PARTIES IN THREE DIFFERENT CALIFORNIA COMMUNITIES. VISTA HAS USED WHATEVER RESOURCES IT HAD AVAILABLE TO IT, IN BORROWED MONEY AND REVENUES FROM OPERATIONS, AND REINVESTED THAT MONEY IN ITS HOSPITAL FACILITIES. UNFORTUNATELY, LIKE MANY OTHER HOSPITAL OPERATORS, VISTA HAS ENDURED SIGNIFICANT ECONOMIC AND COMPETITIVE CHALLENGES IN ATTEMPTING TO MEET THE HEALTH CARE NEEDS OF EACH OF ITS COMMUNITIES. ASSUMING THE RESPONSIBILITY FOR THE DELIVERY OF QUALITY HEALTH CARE, VISTA HAS PLAYED A STEWARDSHIP ROLE RELATIVE TO VALUABLE COMMUNITY ASSETS.

IN THE PROCESS OF EVALUATING BIDS, VISTA BECAME COMFORTABLE THAT UNIVERSAL HEALTH SERVICES IS A VERY CAPABLE OWNER AND OPERATOR OF GENERAL ACUTE CARE HOSPITALS AT ITS MANY LOCATIONS IN THE UNITED STATES. UNIVERSAL HAS AGREED TO ALL OF THE REQUIREMENTS IN THE ASSET PURCHASE AGREEMENT, AND VISTA EXPECTS THAT UNIVERSAL WILL COMPLY WITH THESE PROVISIONS.

WILLIAM M. THOMAS
22ND DISTRICT, CALIFORNIA

CHAIRMAN
COMMITTEE ON WAYS AND MEANS
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Congress of the United States
House of Representatives
Washington, DC

September 10, 2003

The Honorable Bill Lockyer
Attorney General
California Department of Justice
1300 "I" Street, Suite 1740
Sacramento, California 95814

Dear Mr. Lockyer:

I write to express my support for the San Luis Obispo Board of Supervisors' recent letter that examines issues related to the possible sale of French Hospital Medical Center and Arroyo Grande Hospital. I have attached that letter for your perusal.

As noted in the Board's recent letter, dated August 19, 2003, we must ensure that any action that would lead to the consolidation of French Hospital Medical Center into Arroyo Grande Hospital is carefully scrutinized. San Luis Obispo County faces various health care challenges, and since the recent closure of San Luis Obispo General Hospital, county residents are especially wary about access to quality care if another hospital, such as French, were closed due to consolidation.

I appreciate your attention to these strongly expressed concerns from the Board of Supervisors.

Best regards,

Bill Thomas

WILLIAM M. THOMAS
Member of Congress

Attachment

cc: San Luis Obispo Board of Supervisors
County Government Center, Room 370
San Luis Obispo, California 93408-2040

BOARD OF SUPERVISORS

COUNTY GOVERNMENT CENTER, Room 370 • SAN LUIS OBISPO, CALIFORNIA 93408-2040 • 805.781.5450

August 19, 2003

Honorable Bill Lockyer, Attorney General
California Department of Justice
1300 "I" Street, Ste. 1740
Sacramento, CA 95814

Re: Sale of Hospitals by Vista Hospital Systems, Inc. and French Hospital Medical Center to Universal Health Services, Inc.

Dear Mr. Lockyer:

On behalf of the San Luis Obispo County Board of Supervisors, I respectfully request that you actively oppose any option or proposal to consolidate French Hospital Medical Center and Arroyo Grande Hospital. County officials and the residents of San Luis Obispo County have repeatedly and consistently been assured by representatives of Vista Hospital Systems and French Medical Center that, while an ownership change may take place, French Hospital will continue to operate.

Our understanding is that your office is statutorily obligated to review this transaction and, among other things, analyze the impact this transaction will have on communities surrounding these hospitals. The County recently went through a very detailed analysis of the impact of closing its general acute care facility. The decision to close County General Hospital on June 19, 2003 was based on a number of factors, including assurances from the private hospitals that they would and could provide access to all residents of our county, regardless of their ability to pay. Sale of these two hospitals to a for-profit entity in and of itself presents concerns to some members of our community. These concerns are exacerbated when we are told that, in order to make the transaction more profitable for the buyer, French Hospital may be closed.

We have contacted your office and been told that you will solicit testimony from the public and other impacted organizations regarding this matter. Our understanding is that formal notice of this process, including specific dates for public hearings, will be sent out within the next week. We are confident that you will hear significant concerns about capacity and access at these hearings. We appreciate your assistance in ensuring that the residents of San Luis Obispo County will be appropriately represented in this transaction.

Sincerely,

Michael P. Ryan
Chairman, San Luis Obispo County Board of Supervisors

Consumers Union

Publisher of Consumer Reports

Proposed Sale of French Hospital Medical Center, Arroyo Grande Community Hospital and Corona Regional Medical Center to Universal Health Services
San Luis Obispo
Public Hearing
September 15, 2003

My name is Michelle Jun, Staff Attorney at Consumers Union. Since 1936, Consumers Union's mission has been to test products, inform consumers and protect the public. I am here today under the third prong, as a member of the Community Health Assets Project, a national project dedicated to the preservation of charitable assets across the country. We have worked in 44 states seeking to improve conditions and outcomes for communities when their nonprofit hospital or health plan converts to for-profit status.

In a letter dated August 8, 2003, Vista Hospital Systems and French Hospital Medical Center provided a list of documents that have not been submitted in their filing to the Attorney General regarding the sale of its hospitals.[1] After reviewing the filing, we believe other documents have not been submitted despite the legal requirements for the review of this sale. The following submissions are either insufficient or missing entirely for Arroyo Grande and French:[2]

- the two most recent community needs assessments;[3]
- a breakdown of inpatient, outpatient emergency room charity care spending and the annual number of such visits for the past 5 years;[4]
- all services to Medi-Cal patients, county indigent patients and other class of patients and the type of services provided, the payor and the cost of services provided for the past 5 years;[5]
- all material effects that this proposed sale may have on the delivery of health care services to the surrounding communities and a statement on how this sale will affect the availability and accessibility of health care in these communities;[6] and
- "[a] description of each measure proposed by the applicant to mitigate or eliminate any significant adverse effect on the availability or accessibility of health care services" to these communities.[7]

Finally, the only board meeting minutes submitted are from April 1, 2003 despite the requirement to include board minutes and other documents "reflecting the deliberative process" used by Vista

[1] Letter from Richard F. Seiden, Foley & Lardner to Mark J. Urban, Office of the Attorney General dated August 8, 2003.
[2] Cal. Code Regs. tit. 11 § 999.5.
[3] Cal. Code Regs. tit. 11 § 999.5(d)(5)(A); Schedule J of the Asset Purchase Agreement.
[4] Cal. Code Regs. tit. 11 § 999.5(d)(5)(B); Schedule P of the Asset Purchase Agreement.
[5] Cal. Code Regs. tit. 11 § 999.5(d)(5)(C).
[6] Cal. Code Regs. tit. 11 § 999.5(d)(5)(G).
[7] Cal. Code Regs. tit. 11 § 999.5(d)(5)(H).

and French in selecting Universal Health Systems.[8] It is imperative that these documents be made available so that the Attorney General can review the process Vista underwent in making the decision to sell its hospitals and to sell to a for-profit system. After all, Vista's assets are those of the San Luis Obispo community.

The closure of San Luis Obispo General Hospital and the proposed sale and conversion of the county's last nonprofit hospitals to for-profit facilities may bring San Luis Obispo devastating changes in health access and services to its community, particularly to its uninsured and underinsured residents.

UHS has promised to "use its best efforts to provide charity and indigent care at a level that is equivalent, in the aggregate, to the leve of such charity and indigent care that was previously provided by Seller through the Hospital Businesses.[9]" Such broadly versed promises are not sufficient given the recent closure of the county's major indigent and charity care provider. This community deserves a firm response and a definite policy on indigent and charity care.

San Luis Obispo County is statutorily mandated to provide indigent care, or CMSP.[10] The San Luis Obispo County Hospital Authority has acknowledged the county's responsibility to provide indigent care.[11]

We understand that General Hospital was a major provider in indigent care and in its absence, French agreed to continue providing certain levels of indigent care. San Luis Obispo General served from two to five times the number of indigent patients compared to the other facilities in the county when you consider patient days, outpatient visits and hospital discharges.[12]
(*See Graph 1 of Appendix A*)

The delivery of services to Medi-Cal patients should also be reviewed. General Hospital treated the lion's share of Medi-Cal patients in the county. In fact, General provided at the least three times, and at the most, twelve times the number of Medi-Cal patient days and outpatient visits.[13] (*See Graph 2 of Appendix B*)

It is appropriate to find out what guarantees are being made to serve that population and who will carry out the county's responsibility to provide indigent care to its uninsured and underinsured residents. Historically, for-profit facilities have not had to pick up indigent care responsibilities, but the context will now be radically changed with the possibility of all acute care facilities being operated by for-profit systems. We ask, will Universal Health Systems be consolidating Arroyo Grande Community Hospital and French Hospital Medical Center? And will the French facility be subsequently closed?

As I have stated, the submitted filing does not even begin to provide answers to these important issues regarding health access and delivery to the county's uninsured and underinsured. We understand that the Camden Group has been hired to ascertain the health impact of this proposed

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[8] Cal. Code Regs. tit. 11 § 999.5(d)11)(A)&(D).
[9] Vista Hospital Systems, Inc. and French Hospital Medical Center and Universal Health Systems, Submission to the Attorney General, Section 13.15 "Maintenance of Charity and Indigent Care Policies."
[10] Cal. Welf. & Inst. § 17000 (Deering, 2003).
[11] Cal. Health & Safety § 101836 (2003).
[12] See Appendix A (Comparison of CMSP Patient Days, Comparison of CMSP Outpatient Visits, Comparison of CMSP Discharges).
[13] See Appendix B (Percentage of Medic-Cal to Total Patient Days and Outpatient Visits).

acquisition. We strongly recommend that Camden thoroughly address these issues and investigate how the county and its health facilities will provide indigent care to this community.

The issue of charity care is important because if this sale is approved, there will be no remaining public or nonprofit hospitals left in the county. And certainly the data shows that the hospitals in the county generally left that responsibility up to General Hospital.[14] We recommend that the Attorney General address the county's pressing concern over the increasing lack of charity care which is likely to result if these hospitals are converted to for-profit facilities.
(*See Graph 3 of Appendix C*)

The Arroyo Grande and French facilities share the same written charity care policies, providing care to all whose income is at or below 200% of the federal poverty level. This charitable assistance policy is of great importance, particularly because nearly a quarter of the population of San Luis Obispo County would qualify.[15] In addition, approximately 42,500 residents in San Luis Obispo County are uninsured.[16] Without establishing conditions on this sale, many residents would be left with the difficult choice of either facing huge debt from medical costs, or being unable to access medical care at all.

Tenet, the owner of the two other hospitals in the county (Sierra Vista and Twin Cities Community Hospital), proposed their "Compact With Uninsured Patients" earlier this year to address the treatment and pricing for uninsured patients.[17] The following are among the promises made to indigent patients:

- to refrain from pursuing legal action for the nonpayment of bills by unemployed patients or placing a lien on the uninsured patient's home if that is their only asset; and

- to provide uninsured patients treatment and in addition to offer patients "discounted pricing for services at rates equivalent to the hospital's current managed care rates, which are substantially discounted rates, or 'gross' charges." [18]

We now ask Universal Health Systems, will it commit to similar promises to assist the county's uninsured and underinsured residents?

Thank you for the opportunity to speak and I now turn to my colleague, Leslie Bennett.

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[14] See Appendix C (Charity Care as a Percentage of Gross Patient Revenue).

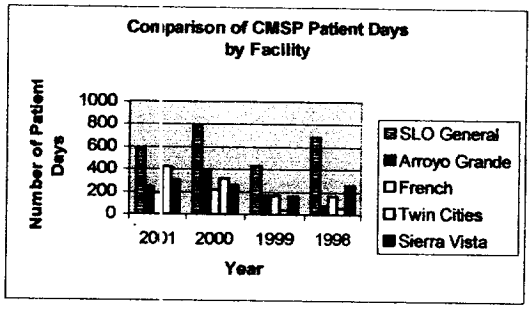
[15] [15] "Uninsured Californians in Assembly and Senate Districts, 2000," UCLA Center for Health Policy Research, E. Richard Brown, Ying Ying Meng et al (May, 2001).

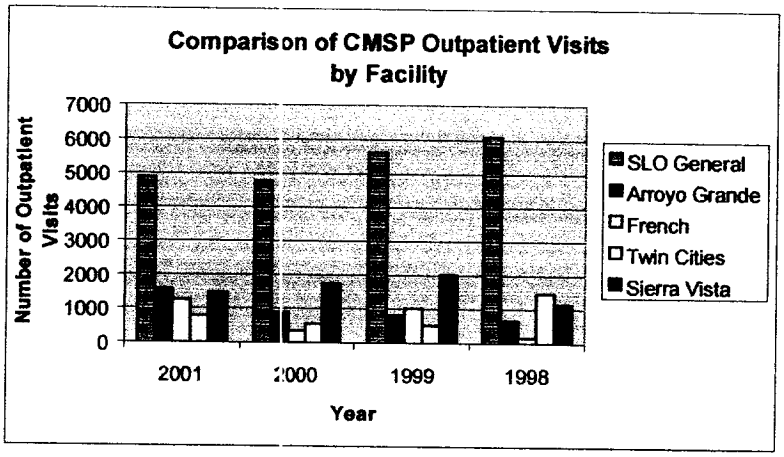
[16] "Uninsured Californians in Assembly and Senate Districts, 2000," UCLA Center for Health Policy Research, E. Richard Brown, Ying Ying Meng et al (May, 2001).

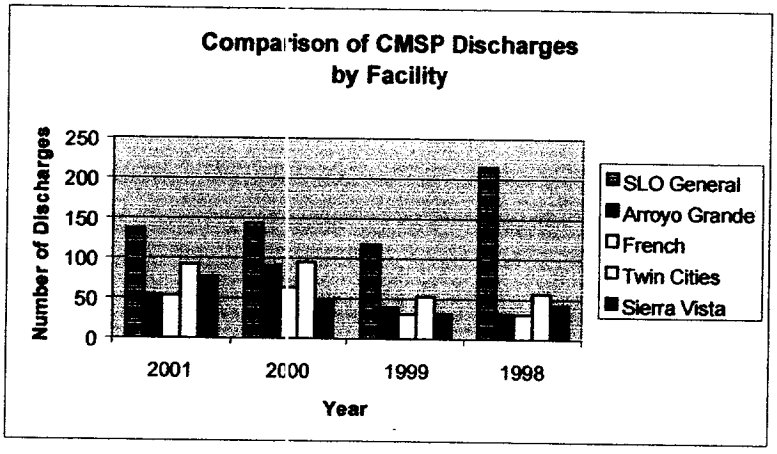
[17] "Tenet Pledges Fair Treatment, Discount Prices for Uninsured," Tenet Press Release, January 28, 2003.

[18] Id.

Appendix A
Comparison of CMSP Patient Days, Outpatient Visits and Discharges by Facility.
(Data obtained from Office of Statewide Health Planning and Development filings.)



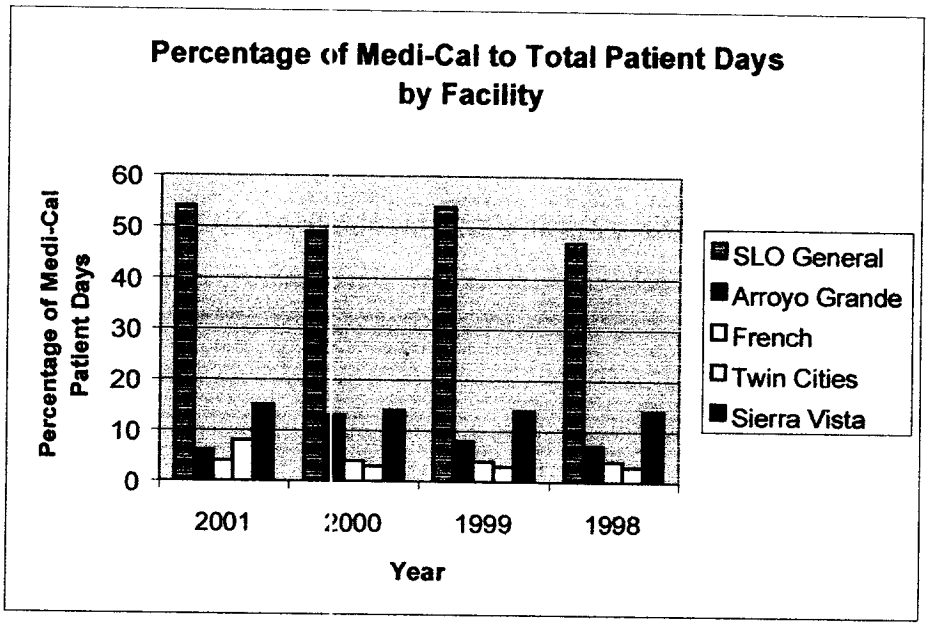


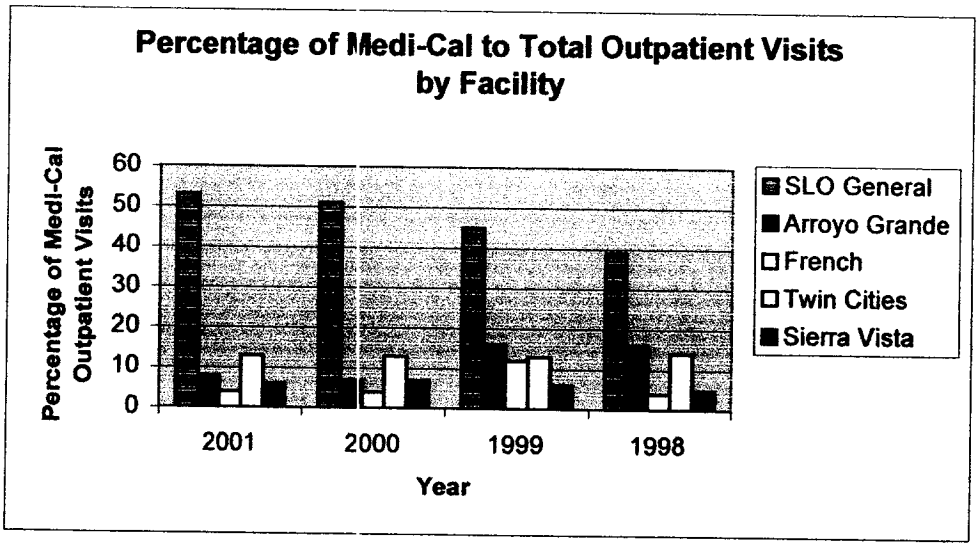


Appendix B

Percentage of Medic-Cal to Total Patient Days and Outpatient Visits.

(Data obtained from Office of Statewide Health Planning and Development filings.)

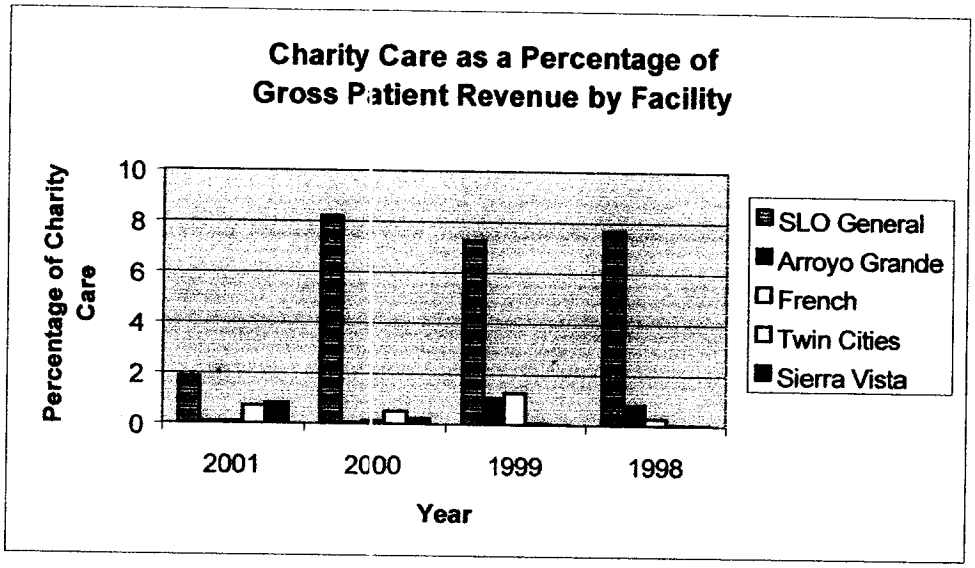




Appendix C

Charity Care as a Percentage of Gross Patient Revenue by Facility.

(Data obtained from Office of Statewide Health Planning and Development filings.)



Consumers Union

Publisher of Consumer Reports

Proposed Sale of French Hospital Medical Center, Arroyo Grande Community Hospital and Corona Regional Medical Center to Universal Health Services
San Luis Obispo
Public Hearing
September 15, 2003

I am Leslie Bennett, staff attorney at Consumers Union. In addition to the comments made by my colleague, we ask that the Attorney General investigate several other issues, including the sale price, whether there has been a breach of fiduciary duty, and the impact of this transaction on the health care environment in San Luis Obispo.

The law requires that the assets be sold at "fair market value."[1] The regulations state that the seller must provide "[t]he estimated market value of each health facility or other asset to be sold."[2] We ask that the value of each of the facilities and the property associated with each. Also required is "[a] description of the methods used by the applicant to determine the market value of any assets involved in the proposed . . . transaction."[3] The seller addresses this issue by saying "[w]e have reason to believe that this price [$120,600,000] is based upon a multiple of earnings at approximately 5 times trailing EBIDA (earning before interest, depreciation and amortization) for the fiscal year ended December 31, 2001."[4]

That is not sufficient to state with any certainty the market value of these nonprofit charitable health assets. These assets do not belong to Vista or Permian. They were charged with the responsibility of ensuring that these assets were adequately protected for the public. Which leads me to the next issue.

The law requires that the Attorney General determine whether "[t]he market value has been manipulated by the actions of the parties in a manner that causes the value of the assets to decrease."[5] The filing says French is "currently suffering from a capital deficiency which affects the level of services that it is able to provide to its constituent community."[6] Approximately $180 million in bonds was obtained for Vista and French over the last 11 years. In addition, there is now $50 million in accrued and unpaid interest on that money amounting to a debt load of $230 million. We have questions about how French got into this financial turmoil and where the bond money has gone. We request that the Attorney General obtain the official statements

[1] California Corporations Code § 5917(c).
[2] Cal. Code Regs. tit. 11 § 999.5(B).
[3] *Id.* at § 999.5(C).
[4] Vista Hospital Systems, Inc. and French Hospital Medical Center and Universal Health Services, Submission to the Attorney General, Description of the Transaction at 3.
[5] California Corporations Code § 5917(d).
[6] Vista Hospital Systems, Inc. and French Hospital Medical Center and Universal Health Services, Submission to the Attorney General, Appendix A.

for the bonds to ensure that the money was used appropriately. The boards of directors of these organizations have a fiduciary duty to protect these assets and ensure that resources were not mismanaged and it is the Attorney General's responsibility to oversee the state's nonprofit organizations.

Along that line we have a question about why earthquake insurance for French and Arroyo Grande has been cancelled.[7] We would like to know when these policies were cancelled and the reasons for cancellation. It seems highly inappropriate to cancel those policies, unless there are plans to close those facilities, in which case that information should be made available.

The Attorney General must determine whether "[t]he proposed use of the proceeds from the . . . transaction is consistent with the charitable trust on which the assets are held by the health facility." At issue here is what will happen to the money held by the supporting organizations. The filing states that there are three nonprofit corporations that provide financial support to each of the hospitals, namely the Corona Regional Medical Center Foundation, Arroyo Grande Community Hospital Foundation and French Hospital Medical Center Foundation. Each of those organizations is tied to supporting these tax-exempt facilities. Since the Attorney General has the responsibility over nonprofits, it is appropriate that the future of these resources be made clear.

In particular, the filing states that Arroyo Grande and French foundations have not conducted any fundraising since their formation in 2002.[8] However, the Arroyo Grande Auxiliary, another nonprofit public benefit corporation that provides financial support to the Arroyo facility has, since 1961, "generously donated hundreds of thousands of dollars to the hospital."[9] It is, therefore, appropriate for the Attorney General to determine if there were any restricted funds that donated to the auxiliary, which should be protected for their intended use.

The filing states that there will be assistance that "may include, but will not be limited to" such things as "[c]ommunity health education," "[h]ealth screening[s]," "[s]upport for community clinics," "[f]ree health services," a "[c]hildren's preventative health center," and "[s]cholarships for high school students." If the articles of incorporation are to be amended as the law requires for these supporting organizations (removing their association with what will become for-profit hospitals), it is appropriate for them to be made available so the Attorney General may more adequately evaluate the proposals.

Without careful review and analysis, it is impossible to know, as the law mandates, whether this transaction will "create a significant effect on the availability or accessibility of health care services to the affected community."[10]

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[7] Vista Hospital Systems, Inc. and French Hospital Medical Center and Universal Health Services, Submission to the Attorney General, Schedule 5.18(c).

[8] Vista Hospital Systems, Inc. and French Hospital Medical Center and Universal Health Services, Submission to the Attorney General, Description of the Transaction at 11.

[9] Arroyo Grande Community Hospital and French Hospital Medical Center website, <http://www.agfh.org/volunteeragch.shtml>.

[10] *See* California Corporations Code § 5917(h).

Before this sale can be approved, the Attorney General must determine whether it is "in the public interest."[11] Universal says that it is currently in the process of negotiating a sale of French and Arroyo to a nonprofit system. We encourage you to obtain all the details you can about this proposal before issuing any decision as it seems highly inappropriate that Universal would be permitted to purchase these facilities at a "fire sale," clear them of accumulated debts through a bankruptcy court and then be able to turn them around for a profit. We recommend that the bankruptcy court hold an auction for these assets and allow the nonprofit system and any other interested bidder to participate.

Further, Universal is asking for the Attorney General's "support" for a consolidation of French and Arroyo Hospitals if a sale is not completed and French is "an undue hardship on Universal."[12] We would encourage the Attorney General not to issue such a recommendation unless there is ample documentation that that action is appropriate for the community. In 2002, French handled more than 44 thousand outpatient visits, more than 14 thousand emergency services visits in the hospital, and more than a thousand patient days in the Birthing Center.[13] French also handled a significant number of Medi-Cal patients, more than 4,800 outpatient and 1,600 emergency visits in 2002.[14]

While Universal says that the closure of French would provide for "increased investment in patient services at Arroyo Hospital,"[15] we would ask that those guarantees be made in writing. What investments will be made at Arroyo? How much money will be spent? Over what period of time? And how will those implied improvements in patient services be measured? Will Universal agree to conduct quality surveys of patients modeled on the Patients' Evaluation of Performance in California or PEP-C surveys?[16] And will Universal provide that information to the Attorney General?

Universal says Sierra Vista, Twin Cities and Arroyo Hospital can handle the health care needs of the area because there are plenty of patient beds. If this sale is approved, Universal will own 179 of the 464 hospital beds in San Luis Obispo. Universal asserts that if French Hospital is closed the loss of 112 beds is inconsequential and says "it is practical to assume the three competing hospitals could absorb French Hospital's volume if Universal exercised its option to consolidate."[17] Universal seems to imply that these three hospitals will compete. It's hard to believe that Sierra Vista and Twin Cities will compete with each other when they are owned by the same for-profit company, Tenet Healthcare. In fact, Tenet will own more than 80% of the

[11] California Corporations Code § 5917(i).

[12] Vista Hospital Systems, Inc. and French Hospital Medical Center and Universal Health Services, Submission to the Attorney General, Appendix A.

[13] French Hospital, Office of Statewide Health Planning and Development 2002 filing.

[14] *See* French Hospital Medical Center's Office of Statewide Health Planning and Development filings.

[15] Vista Hospital Systems, Inc. and French Hospital Medical Center and Universal Health Services, Submission to the Attorney General, Appendix A.

[16] *See* Appendix A. (Patients' Evaluation of Performance in California (PEP-C) for surgical and maternity patients).

[17] Vista Hospital Systems, Inc. and French Hospital Medical Center and Universal Health Services, Submission to the Attorney General, Appendix A.

beds in San Luis Obispo if French is closed.[18] So, while Universal believes that there would be no "significant adverse effects on health care," a serious question exists about this assertion.[19]

Therefore, we respectfully request that the Attorney General impose conditions on this transaction relating to the delivery of health care to this community, modeled after the provisions placed on the Daniel Freeman Hospitals transaction.[20]

In particular, Universal should be required to:

- maintain the current level of emergency room capacity and services delivered by these hospitals. If there is any intention to eliminate emergency services, Universal should be required to meet with the Attorney General and conduct a comprehensive planning process.
- maintain the same charity care policies, not merely use "best efforts," and provide a designated level of charity care that is specified. A penalty should be imposed if that does not occur.[21]
- provide a certain number of patient days for Medi-Cal patients at French Hospital. If that facility is closed or sold that requirement should be continued.
- provide for alternatives in the event that French Hospital ceases to operate as an acute care hospital with 24-hour emergency room services.

We appreciate the opportunity to comment and hope that our testimony will help inform the contents of the health impact statement, evaluating this transaction in more detail.

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[18] Appendix B (Available Beds by System in 2002).

[19] Vista Hospital Systems, Inc. and French Hospital Medical Center and Universal Health Services, Submission to the Attorney General, Appendix A.

[20] Mark Urban, Deputy Attorney General, letter to James R. Schwartz, Manatt, Phelps & Phillips, December 7, 2001.

[21] The annual financial statements report that the gross charges for charity care in 2001 and 2002 were $1.2 million and $1 million, respectively. Vista Hospital Systems, Inc. and French Hospital Medical Center and Universal Health Services, Submission to the Attorney General, Schedule AA, Annual Financial Statements at 9.

Appendix A

Patients Evaluation of Performance in California (PEP-C) for surgical and maternity patients.

YOUR LOGO HERE

Please use the enclosed envelope and mail the completed survey to:

National Research Corporation
Survey Processing Center
P.O. BOX 82660
Lincoln, NE 68501-9465

** 0060421-A12345 **
MR CHRISTOPHER JOHNSON
1245 Q ST
LINCOLN, NE 68508-1430

Dear Christopher Johnson:

Alpha Hospital is working with National Research Corporation to survey people who were recently hospitalized. We hope to learn more about what patients and family members experience and how we can improve the quality of our care. Alpha Hospital is pleased to have this opportunity to learn more about your experiences with the care you received.

We hope you decide to help us. Enclosed is a questionnaire asking about your experiences. The questionnaire will take about 15 minutes of your time. Your name will not be identified in any reports.

This survey is part of a statewide effort to survey patients and improve care for all Californians. Your participation in this survey will be of great help to us and to future patients. It will help improve our understanding of the needs of our patients and their families, and how we can improve the quality of care we provide. **You may have received other surveys, but we ask you to participate in this survey as well.**

Thank you in advance for your cooperation and assistance.

Sincerely,

John Doe
Chief Executive Officer

YOUR LOGO HERE

Please use the enclosed envelope and mail the completed survey to:

National Research Corporation
Survey Processing Center
P.O. BOX 82660
Lincoln, NE 68501-9465

Your hospital stay...

Please fill in the bubble that best describes your experience during your recent hospital stay ending on March 3, 2000. Only the patient who was hospitalized should fill out this questionnaire.

EMERGENCY ROOM...

1. **How organized was the care you received in the emergency room?**
   ○ Not at all organized ○ Somewhat organized ○ Very organized ○ Didn't use emergency room
2. **While you were in the emergency room, did you get enough information about your medical condition and treatment?**
   ○ Yes, definitely ○ No ○ Didn't use emergency room
   ○ Yes, somewhat ○ Didn't want information

ADMISSION...

3. **How organized was the admission process?**
   ○ Not at all organized ○ Somewhat organized ○ Very organized
4. **Do you feel you had to wait an unnecessarily long time to go to your room?**
   ○ Yes, definitely ○ Yes, somewhat ○ No
5. **If you had to wait to go to your room, did someone from the hospital explain the reason for the delay?**
   ○ Yes ○ No ○ Didn't have to wait
6. **How would you rate the courtesy of the staff who admitted you?**
   ○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent

DOCTORS...

7. **Was there one particular doctor in charge of your care in the hospital?**
   ○ Yes ○ No ○ Not sure
8. **When you had important questions to ask a doctor, did you get answers you could understand?**
   ○ Yes, always ○ Yes, sometimes ○ No ○ Didn't have questions
9. **If you had any anxieties or fears about your condition or treatment, did a doctor discuss them with you?**
   ○ Yes, completely ○ Yes, somewhat ○ No ○ Didn't have anxieties or fears
10. **Did you have confidence and trust in the doctors treating you?**
    ○ Yes, always ○ Yes, sometimes ○ No
11. **Did doctors talk in front of you as if you weren't there?**
    ○ Yes, often ○ Yes, sometimes ○ No
12. **How would you rate the courtesy of your doctors?**
    ○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent
13. **How would you rate the availability of your doctors?**
    ○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent

NURSES...

14. **When you had important questions to ask a nurse, did you get answers you could understand?**
    ○ Yes, always ○ Yes, sometimes ○ No ○ Didn't have questions
15. **If you had any anxieties or fears about your condition or treatment, did a nurse discuss them with you?**
    ○ Yes, completely ○ Yes, somewhat ○ No ○ Didn't have anxieties or fears
16. **Did you have confidence and trust in the nurses treating you?**
    ○ Yes, always ○ Yes, sometimes ○ No
17. **Did nurses talk in front of you as if you weren't there?**
    ○ Yes, often ○ Yes, sometimes ○ No

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18. **How would you rate the courtesy of your nurses?**
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent

19. **How would you rate the availability of your nurses?**
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent

HOSPITAL STAFF...

20. **Sometimes in the hospital, one doctor or nurse will say one thing and another will say something quite different. Did this happen to you?**
○ Yes, always ○ Yes, sometimes ○ No

21. **Did you have enough say about your treatment?**
○ Yes, definitely ○ Yes, somewhat ○ No

22. **Did your family or someone else close to you have enough opportunity to talk to your doctor?**
○ Yes, definitely ○ No ○ Family didn't want or need to talk
○ Yes, somewhat ○ No family or friends were involved

23. **How much information about your condition or treatment was given to your family or someone close to you?**
○ Not enough ○ Too much ○ Family didn't want or need information
○ Right amount ○ No family or friends involved

24. **Was it easy for you to find someone on the hospital staff to talk to about your concerns?**
○ Yes, definitely ○ Yes, somewhat ○ No ○ Didn't want to talk/no concerns

25. **When you needed help getting to the bathroom, did you get it in time?**
○ Yes, always ○ Yes, sometimes ○ No ○ Didn't need help

26. **How many minutes after you used the call button did it usually take before you got the help you needed?**
○ 0 minutes/right away ○ 6-10 minutes ○ 16-30 minutes ○ Never used call button
○ 1-5 minutes ○ 11-15 minutes ○ More than 30 minutes ○ Never got help

27. **Did a doctor or nurse explain the results of tests in a way you could understand?**
○ Yes, completely ○ Yes, somewhat ○ No ○ No tests were done

28. **Were your scheduled tests and procedures performed on time?**
○ Yes, always ○ Yes, sometimes ○ No ○ No tests/procedures

29. **Did you feel like you were treated with respect and dignity while you were in the hospital?**
○ Yes, always ○ Yes, sometimes ○ No

PAIN...

30. **Were you ever in any pain?**
○ Yes ○ No (Go to #37)

31. **When you had pain, was it usually severe, moderate, or mild?**
○ Severe ○ Moderate ○ Mild

32. **Did you have a machine that you could use to give yourself pain medicine?**
○ Yes (Go to #35) ○ No

33. **Did you ever request pain medicine?**
○ Yes ○ No (Go to #35)

34. **How many minutes after you requested pain medicine did it usually take before you got it?**
○ 0 minutes/right away ○ 6-10 minutes ○ 16-30 minutes ○ Never got medicine
○ 1-5 minutes ○ 11-15 minutes ○ More than 30 minutes

35. **Do you think that the hospital staff did everything they could to help control your pain?**
○ Yes, definitely ○ Yes, somewhat ○ No

36. **Overall, how much pain medicine did you get?**
○ Not enough ○ Right amount ○ Too much

SURGERY...

37. **Did the surgeon explain the risks and benefits of the surgery in a way you could understand?**
○ Yes, completely ○ No ○ I didn't want anything explained
○ Yes, somewhat ○ Explained to spouse or someone else

38. **Did the surgeon or any of your other doctors answer your questions about the surgery in a way you could understand?**
○ Yes, completely ○ Yes, somewhat ○ No ○ I didn't have any questions

39. **Did a doctor or nurse tell you accurately how you would feel after surgery?**
○ Yes, completely ○ Yes, somewhat ○ No

40. **Were the results of the surgery explained in a way you could understand?**
○ Yes, completely ○ Yes, somewhat ○ No ○ Explained to spouse or someone else

GOING HOME...

41. **Did someone on the hospital staff explain the purpose of the medicines you were to take at home in a way you could understand?**
○ Yes, completely ○ Yes, somewhat ○ No ○ Didn't need explanation ○ No medicines at home

42. **Did someone tell you about medication side effects to watch for when you went home?**
○ Yes, completely ○ Yes, somewhat ○ No ○ Didn't need explanation ○ No medicines at home

43. **Did they tell you what danger signals about your illness or operation to watch for after you went home?**
○ Yes, completely ○ Yes, somewhat ○ No

44. **Did they tell you when you could resume your usual activities, such as when to go back to work or drive a car?**
○ Yes, completely ○ Yes, somewhat ○ No

45. **Did the doctors and nurses give your family or someone close to you all the information they needed to help you recover?**
○ Yes, definitely ○ No ○ Family didn't want or need information
○ Yes, somewhat ○ No family or friends involved

46. **While you were in the hospital, how worried were you about how you would pay your hospital bill?**
○ Very worried ○ Somewhat worried ○ Not at all worried

47. **Did you get as much help as you wanted from someone on the hospital staff in figuring out how to pay your hospital bill?**
○ Yes, definitely ○ Yes, somewhat ○ No ○ Didn't want or need any help

OVERALL IMPRESSION...

48. **How would you rate how well the doctors and nurses worked together?**
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent

49. **Overall, how would you rate the care you received at the hospital?**
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent

50. **Would you recommend this hospital to your friends and family?**
○ Yes, definitely ○ Yes, probably ○ No

The next questions are used to make sure we hear from all our patients. Please tell us a little about yourself.

YOUR BACKGROUND...

51. **In general, how would you rate your health?**
○ Poor ○ Fair ○ Good ○ Very good ○ Excellent

52. **During the past month, how many days did illness or injury keep you in bed all or part of the day?**
○ None ○ Two Days ○ Four Days ○ Eight-to-Ten Days
○ One Day ○ Three Days ○ Five-to-Seven Days ○ More than Ten Days

53. **Including this hospital stay, how many times in the last six months have you been in a hospital overnight or longer?**
○ Only this time ○ This time and one other time ○ This time and more than one other time

54. **Do you belong to an HMO or health plan that has a list of people or places you go to, in order for the plan to cover your health care costs?**
○ Yes ○ No ○ Not sure

55. **What health insurance plan do you use to cover most or all of your medical care?**
○ Medicare ○ Medicaid ○ Something else ○ I have no insurance ○ Not sure

56. **What was the last year of school you completed?**
○ Less than high school graduate ○ College graduate
○ High school graduate or GED ○ Post college graduate education
○ Some college, trade, or tech school

57. **What is your current marital status?**
○ Married ○ Living with a partner ○ Divorced ○ Separated ○ Widowed ○ Never married

58. **Are you of Hispanic or Spanish family background?**

- ○ No
- ○ Yes, North American (Mexican, Mexican American, Chicano)
- ○ Yes, Central American
- ○ Yes, South American
- ○ Yes, Other Spanish/Hispanic/Latino

59. **Which of the following best describes your racial background?**

- ○ White
- ○ Black, African American, or Negro
- ○ American Indian or Alaska Native (North, South, and Central American Indian)
- ○ Native Hawaiian
- ○ Guamanian
- ○ Samoan
- ○ Other Pacific Islander
- ○ Asian Indian
- ○ Cambodian
- ○ Chinese
- ○ Filipino
- ○ Japanese
- ○ Hmong
- ○ Korean
- ○ Laotian
- ○ Vietnamese
- ○ Other Asian
- ○ Other

60. **What language do you speak at home most of the time?**

○ English ○ Chinese ○ Korean ○ Russian ○ Other
○ Spanish ○ Vietnamese ○ Tagalog ○ Armenian

MORE QUESTIONS ABOUT YOUR NURSES...

61. **How often did a nurse ask you if you had pain?**

○ At least once a day ○ Less than once a day ○ Don't remember

62. **Did you receive information from your nurses about your care and treatment?**

○ Yes ○ No

63. **Was it as much information as you needed or would you have liked more?**

- ○ Enough assistance was provided.
- ○ Additional assistance would have been helpful.

64. **Did you need help planning for your needs after discharge from the hospital?**

○ Yes ○ No (Go to comment question)

65. **Did you receive help from your nurses in planning for your needs after discharge?**

○ Yes ○ No

66. **Was the help you received as much as you needed or would you have liked more?**

○ As much as I needed ○ Would have liked more

67. **An interpreter is someone who repeats or signs what one person says in a language used by another person. Did you need an interpreter to help you speak with doctors or other health providers?**

○ Yes ○ No

68. **When you needed an interpreter to help you speak with doctors or other health providers, how often did you get one?**

○ Never ○ Sometimes ○ Usually ○ Always ○ I didn't need an interpreter

69. **If you could change one thing about the hospital, what would it be?**

_____

_____

_____

_____

_____

Thank you for taking the time to complete this questionnaire! Your answers are greatly appreciated.

00014723 - March 3, 2000 - Radiology

001AMD47 0060421

YOUR LOGO HERE

Please use the enclosed envelope and mail the completed survey to:
National Research Corporation
Survey Processing Center
PO BOX 82660
Lincoln, NE 68501-9465

** 0060169-A12345 **
MS CHRISTINA JOHNSON
1245 Q ST
LINCOLN, NE 68508-1430

Dear Christina Johnson:

Alpha Hospital is working with National Research Corporation to survey people about their experiences at the hospital. We hope to learn more about what patients and family members experience and how we can improve the quality of our care. Alpha Hospital is pleased to have this opportunity to learn more about your experiences with the care you received.

We hope you decide to help us. Enclosed is a questionnaire asking about your experiences. The questionnaire will take about 15 minutes of your time. Your name will not be identified in any reports.

Your participation in this survey will be of enormous help to us and to future patients. It will help improve our understanding of the needs of our patients and their families, and how we can improve the quality of care we provide. You may have already received a survey from our hospital, but we would appreciate you taking the time to complete this one as well.

If you have any questions about the survey, please call me at 402-475-2525. Thank you in advance for your cooperation and assistance.

Sincerely,

John Doe
President and Chief Executive Officer

YOUR LOGO HERE

Please use the enclosed envelope and mail the completed survey to:

National Research Corporation
Survey Processing Center
PO BOX 82660
Lincoln, NE 68501-9465

Your Hospital Stay...

Please fill in the bubble that best describes your experience during your recent hospital stay ending **on March 3, 2000**. Only the patient who was hospitalized should fill out this questionnaire.

ADMISSION...

1. **How organized was the admission process?**
   ○ Not at all organized ○ Somewhat organized ○ Very organized
2. **Do you feel you had to wait an unnecessarily long time to go to your room?**
   ○ Yes, definitely ○ Yes, somewhat ○ No
3. **If you had to wait to go to your room, did someone from the hospital explain the reason for the delay?**
   ○ Yes ○ No ○ Didn't have to wait
4. **How would you rate the courtesy of the staff who admitted you?**
   ○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent

DOCTORS AND MIDWIVES...

5. **Was there one particular doctor or midwife in charge of your care in the hospital?**
   ○ Yes ○ No ○ Not sure
6. **When you had important questions to ask a doctor or a midwife, did you get answers you could understand?**
   ○ Yes, always ○ Yes, sometimes ○ No ○ Didn't have questions
7. **If you had any anxieties or fears about your condition or treatment, did a doctor or a midwife discuss them with you?**
   ○ Yes, completely ○ Yes, somewhat ○ No ○ Didn't have anxieties or fears
8. **Did you have confidence and trust in the doctors and midwives treating you?**
   ○ Yes, always ○ Yes, sometimes ○ No
9. **Did doctors or midwives talk in front of you as if you weren't there?**
   ○ Yes, often ○ Yes, sometimes ○ No
10. **How would you rate the courtesy of your doctors or midwives?**
    ○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent
11. **How would you rate the availability of your doctors or midwives?**
    ○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent

NURSES...

12. **When you had important questions to ask a nurse, did you get answers you could understand?**
    ○ Yes, always ○ Yes, somewhat ○ No ○ Didn't have questions
13. **If you had any anxieties or fears about your condition or treatment, did a nurse discuss them with you?**
    ○ Yes, completely ○ Yes, somewhat ○ No ○ Didn't have anxieties or fears
14. **Did you have confidence and trust in the nurses treating you?**
    ○ Yes, always ○ Yes, sometimes ○ No
15. **Did nurses talk in front of you as if you weren't there?**
    ○ Yes, often ○ Yes, sometimes ○ No
16. **How would you rate the courtesy of your nurses?**
    ○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent
17. **How would you rate the availability of your nurses?**
    ○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent

001AFD1/ 0060169

HOSPITAL STAFF...

18. **Sometimes in the hospital, one doctor, midwife or nurse will say one thing and another will say something quite different. Did this happen to you?**
    ○ Yes, always ○ Yes, sometimes ○ No

19. **Did you have enough say about your treatment?**
    ○ Yes, definitely ○ Yes, somewhat ○ No

20. **Did your family or birthing partner have enough opportunity to talk to your doctor or midwife?**
    ○ Yes, definitely ○ No ○ Family didn't want or need to talk
    ○ Yes, somewhat ○ No family or birthing partner involved

21. **How much information about your condition or treatment was given to your family or birthing partner?**
    ○ Not enough ○ Too much ○ Family didn't want or need information
    ○ Right amount ○ No family or birthing partner involved

22. **Was it easy for you to find someone on the hospital staff to talk to about your concerns?**
    ○ Yes, definitely ○ Yes, somewhat ○ No ○ Didn't want to talk/no concerns

23. **When you needed help getting to the bathroom, did you get it in time?**
    ○ Yes, always ○ Yes, sometimes ○ No ○ Didn't need help

24. **In general, how many minutes after you used the call button did it usually take before you got the help you needed?**
    ○ 0 minutes/right away ○ 6-10 minutes ○ 16-30 minutes ○ Never used the call button
    ○ 1-5 minutes ○ 11-15 minutes ○ More than 30 minutes ○ Never got help

25. **Did a doctor, midwife or nurse explain the results of tests in a way you could understand?**
    ○ Yes, completely ○ Yes, somewhat ○ No ○ No tests were done

26. **Were your scheduled tests and procedures performed on time?**
    ○ Yes, always ○ Yes, sometimes ○ No ○ No tests/procedures

27. **Did you feel like you were treated with respect and dignity while you were in the hospital?**
    ○ Yes, always ○ Yes, sometimes ○ No

YOUR DELIVERY...

28. **Did you have a vaginal delivery or a C-Section?**
    ○ Vaginal ○ C-Section

29. **Did your doctor or midwife answer your questions about your delivery in a way you could understand?**
    ○ Yes, completely ○ Yes, somewhat ○ No ○ I didn't have any questions

30. **Did your doctor or midwife discuss your options for pain control during the labor and delivery with you?**
    ○ Yes, completely ○ Yes, somewhat ○ No

31. **Did you have enough say about your pain control during labor and delivery?**
    ○ Yes, definitely ○ Yes, somewhat ○ No

32. **How much anesthesia and pain medicine did you get during labor and delivery?**
    ○ Not enough ○ Right amount ○ Too much

33. **Did a doctor, midwife or nurse tell you accurately how you would feel after your delivery?**
    ○ Yes, completely ○ Yes, somewhat ○ No

PAIN AFTER YOUR DELIVERY...

34. **After your delivery, were you ever in any pain?**
    ○ Yes ○ No (Go to #41)

35. **When you had pain after your delivery, was it usually severe, moderate, or mild?**
    ○ Severe ○ Moderate ○ Mild

36. **After your delivery, did you have a machine that you could use to give yourself pain medicine?**
    ○ Yes (Go to #39) ○ No

37. **After your delivery, did you ever request pain medicine?**
    ○ Yes ○ No (Go to #39)

38. **How many minutes after you requested pain medicine did it usually take before you got it?**
    ○ 0 minutes/right away ○ 6-10 minutes ○ 16-30 minutes ○ Never got medicine
    ○ 1-5 minutes ○ 11-15 minutes ○ More than 30 minutes

39. **Do you think that the hospital staff did everything they could to help control your pain after delivery?**
    ○ Yes, definitely ○ Yes, somewhat ○ No

40. **Overall, how much pain medicine did you get?**
○ Not enough ○ Right amount ○ Too much

GOING HOME...

41. **Did you get enough information about caring for the baby?**
○ Yes, definitely ○ Yes, somewhat ○ No

42. **Did someone on the hospital staff explain the purpose of the medicines you were to take at home in a way you could understand?**
○ Yes, completely ○ Yes, somewhat ○ No ○ Didn't need explanation ○ No medicines at home

43. **Did someone tell you about medication side effects to watch for when you went home?**
○ Yes, completely ○ Yes, somewhat ○ No ○ Didn't need explanation ○ No medicines at home

44. **Did they tell you what danger signals in you and your baby to watch for after you went home?**
○ Yes, completely ○ Yes, somewhat ○ No

45. **Did they tell you when you could resume your activities, such as when to go back to work or drive a car?**
○ Yes, completely ○ Yes, somewhat ○ No

46. **Did the doctors, midwives and nurses give your family or someone close to you all the information they needed to help you recover?**
○ Yes, definitely ○ No ○ Family didn't want or need information
○ Yes, somewhat ○ No family or friends involved

47. **While you were in the hospital, how worried were you about how you would pay your hospital bill?**
○ Very worried ○ Somewhat worried ○ Not at all worried

48. **Did you get as much help as you wanted from someone on the hospital staff in figuring out how to pay your hospital bill?**
○ Yes, definitely ○ Yes, somewhat ○ No ○ Didn't want or need any help

OVERALL IMPRESSION...

49. **How would you rate how well the doctors, midwives, and nurses worked together?**
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent

50. **Overall, how would you rate the care you received at the hospital?**
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent

51. **Would you recommend this hospital to your friends and family?**
○ Yes, definitely ○ Yes, probably ○ No

YOUR BACKGROUND...

52. **Was this your first childbirth experience?**
○ Yes ○ No

53. **In general, how would you rate your health?**
○ Poor ○ Fair ○ Good ○ Very Good ○ Excellent

54. **During the past month, how many days did illness or injury keep you in bed all or part of the day?**
○ None ○ Two Days ○ Four Days ○ Eight-to-Ten Days
○ One Day ○ Three Days ○ Five-to-Seven Days ○ More than Ten Days

55. **Including this hospital stay, how many times in the last six months have you been in a hospital overnight or longer?**
○ Only this time ○ This time and one other time ○ This time and more than one other time

56. **Do you belong to an HMO or health plan that has a list of people or places you go to, in order for the plan to cover your health care costs?**
○ Yes ○ No ○ Not sure

57. **What health insurance plan do you use to cover most or all of your medical care?**
○ Medicare ○ Medicaid ○ Something else ○ I have no insurance ○ Not sure

58. **What was the last year of school you completed?**
○ Less than high school graduate ○ College graduate
○ High school graduate or GED ○ Post college graduate education
○ Some college, trade, or tech school

59. **What is your current marital status?**
○ Married ○ Living with a partner ○ Divorced ○ Separated ○ Widowed ○ Never married

60. **Are you of Hispanic or Spanish family background?**
- ○ No
- ○ Yes, North American (Mexican, Mexican American, Chicano)
- ○ Yes, Central American
- ○ Yes, South American
- ○ Yes, Other Spanish/Hispanic/Latino

61. **Which of the following best describes your racial background?**
- ○ White
- ○ Black, African American, or Negro
- ○ American Indian or Alaska Native (North, South, and Central American Indian)
- ○ Native Hawaiian
- ○ Guamanian
- ○ Samoan
- ○ Other Pacific Islander
- ○ Asian Indian
- ○ Cambodian
- ○ Chinese
- ○ Filipino
- ○ Japanese
- ○ Hmong
- ○ Korean
- ○ Laotian
- ○ Vietnamese
- ○ Other Asian
- ○ Other

62. **What language do you speak at home most of the time?**
- ○ English ○ Chinese ○ Korean ○ Russian ○ Other
- ○ Spanish ○ Vietnamese ○ Tagalog ○ Armenian

MORE QUESTIONS ABOUT YOUR NURSES...

63. **How often did a nurse ask you if you had pain?**
- ○ At least once a day ○ Less than once a day ○ Don't remember

64. **Did you receive information from your nurses about your care and treatment?**
- ○ Yes ○ No

65. **Was it as much information as you needed or would you have liked more?**
- ○ Enough assistance was provided.
- ○ Additional assistance would have been helpful.

66. **Did you need help planning for your needs after discharge from the hospital?**
- ○ Yes ○ No (Go to comment question)

67. **Did you receive help from your nurses in planning for your needs after discharge?**
- ○ Yes ○ No

68. **Was the help you received as much as you needed or would you have liked more?**
- ○ As much as I needed ○ Would have liked more

69. **An interpreter is someone who repeats or signs what one person says in a language used by another person. Did you need an interpreter to help you speak with doctors or other health providers?**
- ○ Yes ○ No

70. **When you needed an interpreter to help you speak with doctors or other health providers, how often did you get one?**
- ○ Never ○ Sometimes ○ Usually ○ Always ○ I didn't need an interpreter

71. **If you could change one thing about the hospital, what would it be?**

_____

_____

_____

_____

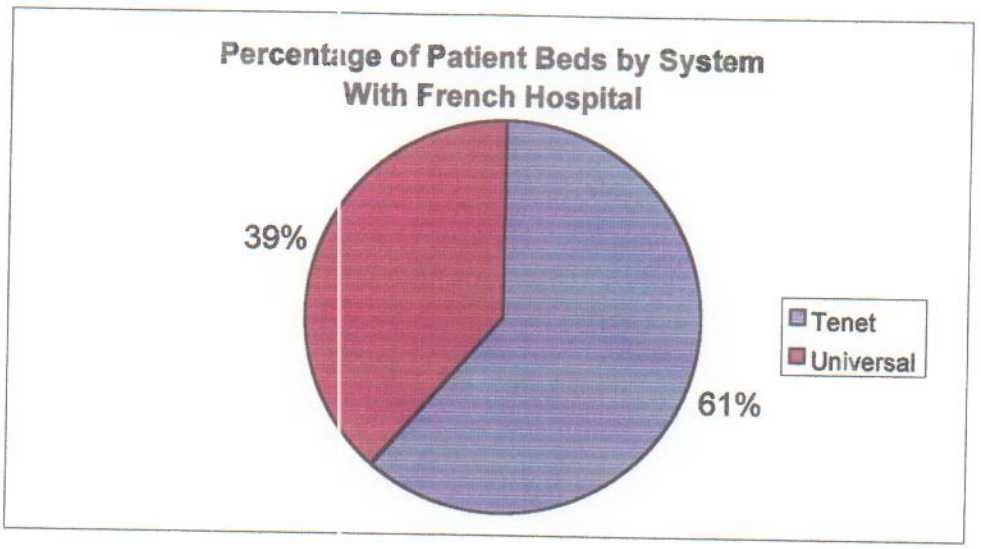
_____

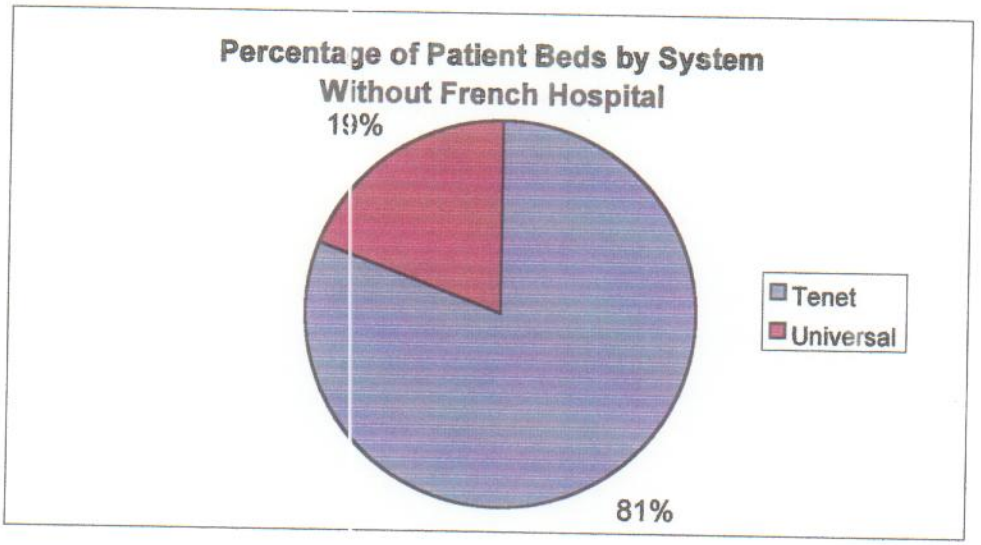
Thank you for taking the time to complete this questionnaire! Your answers are greatly appreciated.

00014723 - March 3, 2000 - 04W

001AFD40 0060169

Appendix B
Available Beds by System in 2002.
(Data obtained from Office of Statewide Health Planning and Development filings.)





September 15, 2003

Thank you for giving us the opportunity to express our view at this public forum.

My name is Avis Austin, ...and I am here today representing the volunteers from French Hospital Medical Center.

In 1947, one local doctor saw the need for a medical facility and opened a new hospital. As the town grew, the need for health care was even greater and the new French hospital was opened in 1970. French hospital built its reputation on the excellent care, concern and quality of health services they provided. Now, many years later, they still continue to provide the "top of the line" in care & quality.

As volunteers we hear & see the importance of keeping French Hospital open to the community. We are in a position to hear many patients and their families comments regarding the excellent service received, as well as the physical plant. We cover twelve sections of the hospital, such as floor duty, rehab, reception desk, surgical waiting room, and many of the jobs that are behind public view.

With the decline in our health care programs, to take away the security of medical care would be detrimental to the needs of the general public. We urgently ask that you keep French Hospital open, taking into consideration the responsibility of providing excellent health services for the San Luis Obispo community.

Sincerely,

Volunteers
French Hospital Medical Center

Department of Justice Public Hearing on the Asset Purchase Agreement between Universal Health Systems and Vista Hospital Systems / French Hospital Medical Center – September 15, 2003

Comments by Frank Lebens – French Hospital Local Governing Board Member

As members of the Local Governing Board of French Hospital it is our role to protect community interests and needs in fulfillment of the mission of the hospital. As members of the board we have no financial interest in the hospital .

I am here today to convey the strong sentiment of the Local Governing Board that the continued operation of French Hospital is a critical to responding to the healthcare needs of the community. Toward that end, we support the acquisition of French Hospital by an entity that is financially strong and well capitalized.

The asset purchase agreement under consideration, however, speaks to the possibility of consolidation of French Hospital into Arroyo Grande Hospital. This we cannot support based on our concern that the community needs will not be adequately served. The data cited in the asset purchase agreement document that is used to support a potential consolidation is wrought with inaccuracies and in some cases is dated so as to be no longer applicable. In fact, some services cited in Schedule O have not existed for at least three years. We urge the Department of Justice consultants to take an objective view of current capabilities / capacities in San Luis Obispo hospitals such as available bed spaces (versus licensed bed spaces), operating room capacity, emergency room capacity, and obstetrics capacity in assessing community need.

We are confident that an analysis based on current and accurate data will lead to the conclusion that the community healthcare needs will best be served with the continued operation of French Hospital by a financially sound buyer.

Thank you for your consideration.

Frank Lebens
114 La Colima
Pismo Beach, Ca. 93449
(805)773-5364
franklebens@earthlink.net

STATEMENT TO THE ATTORNERY GENERAL'S OFFICE
September 8, 2003

I am Sara Horne, speaking as an individual.

I received a report "The Community Health Status Report" dated January 2003. I have copied the pertinent pages for you and would like you to refer to that report. You will see that on page 5-3 there is a Table 5-2 that compares hospital bed capacity for selected areas of Calif.—during the year of 2000-that comparison is for SLO County hospitals. This is a comparison of the licensed # of beds, available beds, staffed beds and occupancy rates for SLO County. At that time General hospital was still open but has subsequently been closed by the county. That leaves the county 46 beds/day short. The occupancy rate of staffed beds, excluding County Hospital, was running 96%. The four remaining hospitals are forced to absorb the patients from General and in all likelihood if we had the figures from the current censuses would run at approx. 99%. If you allow French to become a for- profit hospital there is a high probability that French will be closed and there will not be sufficient staffed beds to accommodate SLO county population, which is growing.

I urge you to deny the request for a change from non-profit to profit status.

Table 5-2: Hospital Bed Capacity Data for Selected Areas of California, 2000						
	Number of Beds			Occupancy Rate		
Region	Licensed (End of Period)	Available (Average)	Staffed (Average)	Licensed Beds	Available Beds	Staffed Beds
California	83,474	75,380	66,515	55.8%	61.9%	70.1%
San Luis Obispo County	566	481	298	44.0%	51.7%	83.9%
Sierra Vista	*201*	*201*	*93*	*45.7%*	*45.7%*	*99.3%*
French	*124*	*71*	*48*	*35.2%*	*61.2%*	*90.9%*
Twin Cities	*84*	*84*	*56*	*65.5%*	*65.5%*	*99.2%*
Arroyo Grande	*65*	*65*	*41*	*59.7%*	*59.7%*	*95.1%*
General Hospital	*78*	*46*	*46*	*13.7%*	*23.2%*	*23.2%*

Data source: Office of Statewide Health Planning and Development website (www.oshpd.state.ca.us), Healthcare Information, Internet Hospital Profile Characteristics query. Data obtained from the Internet Hospital Profile Characteristics (IHPC) query for the calendar year 2000.

Table 5-3 shows a summary comparison of the licensed bed numbers and licensed bed occupancy rates by selected bed classifications (medical/surgical acute, intensive care, general acute care subtotal, and hospital total) for California and San Luis Obispo County. In 2001, the licensed bed occupancy rate for San Luis Obispo County was lower compared to California for medical/surgical acute, intensive care, general acute care subtotal, and hospital total. Similar data for "available beds" and "staffed beds" is not available at this time.

Table 5-3: Hospital Bed Capacity Data for Selected Areas of California, 2001, by Licensed Bed Classification / Designation								
	Number of Licensed Beds				Licensed Bed Occupancy Rate*			
Region	Medical/ Surgical	Intensive Care	Acute Care Subtotal**	Hospital Total	Medical/ Surgical	Intensive Care	Acute Care Subtotal**	Hospital Total
California	49,773	5,644	73,685	106,378	50.7%	64.7%	52.5%	57.0%
San Luis Obispo	373	40	504	560	43.4%	58.1%	46.8%	45.3%
Sierra Vista	*129*	*11*	*192*	*207*	*34.1%*	*65.9%*	*48.0%*	*44.4%*
French	*75*	*8*	*97*	*112*	*47.4%*	*66.2%*	*45.8%*	*39.7%*
Twin Cities	*72*	*8*	*84*	*84*	*64.4%*	*80.8%*	*67.4%*	*67.4%*
Arroyo Grande	*45*	*8*	*53*	*65*	*66.2%*	*43.4%*	*62.8%*	*62.8%*
General Hospital	*52*	*5*	*78*	*92*	*12.2%*	*15.2%*	*12.2%*	*21.7%*

Data source: Office of Statewide Health Planning and Development website (www.oshpd.state.ca.us), Annual Utilization Report of Hospital Data, 2001 (hosp01.exe).
* Licensed Bed Occupancy Rate calculated by Health Care Analyst, San Luis Obispo County Public Health Department by dividing the Patient Census Days by the Licensed Bed Days.
** General Acute Care Subtotal includes medical/surgical, perinatal, pediatric, intensive care, intensive care newborn nursery, coronary care, acute respiratory care, and burn center, and acute rehabilitation. San Luis Obispo County does not have licensed beds for coronary care, acute respiratory care, or burn center.

Comparison data for San Luis Obispo County registered nurses, dentists, pharmacists, and social workers are not available at this time.

Nursing Shortage:

In 2000, the United States national supply of full time equivalent registered nurses was estimated to be 110,000 (6%) less than the demand in the United States and 12,663 (8%) less than the demand in California. According to the National Center for Health Workforce Analysis, if the causes for the shortage are not addressed, and if the current trends continue, by 2020 the shortage is projected to grow to 29% in the United States and 46% in California, as shown in Table 5-1. Factors affecting the supply of registered nurses include the declining number of nursing school graduates, the aging of the RN workforce, declines in relative earnings, and the emergence of alternative job opportunities.

Table 5-1: Supply and Demand Projections for Full Time Equivalent Registered Nurses

United States				
Year	**Supply**	**Demand**	**Shortage**	**Percent Shortage**
2000	1,889,243	1,999,950	(110,707)	6%
2005	2,012,444	2,161,831	(149,387)	7%
2010	2,069,369	2,344,584	(275,215)	12%
2015	2,055,491	2,562,554	(507,063)	20%
2020	2,001,998	2,810,414	(808,416)	29%
California				
Year	**Supply**	**Demand**	**Shortage**	**Percent Shortage**
2000	154,002	166.665	(12,663)	8%
2005	162,645	181,054	(18,409)	10%
2010	161,337	203,511	(42,174)	21%
2015	153,654	231,711	(78,057)	34%
2020	142,978	263,673	(120,695)	46%

Data source: Projected Supply, Demand, and Shortages of Registered Nurses: 2000-2020; U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, National Center for Health Workforce Analysis, July 2002. Report is available on the Internet at http://bhpr.hrsa.gov/healthworkforce/reports/rnproject/default.htm.

Hospital Bed Capacity:

Table 5-2 provides a summary of calendar year 2000 results for California and San Luis Obispo County hospital bed capacity by three different categories: licensed beds, available beds, and staffed beds. The available bed occupancy rate was lower in San Luis Obispo County compared to California (51.7% versus 61.9%, respectively). For all hospitals in San Luis Obispo County except General Hospital, the staffed bed occupancy rate was higher than 95%, compared to an average of 70.1% for California.

Good Morning. I am Marguerite Bader, President of the League of Women Voters of San Luis Obispo County.

The League of Women Voters of San Luis Obispo supports an integrated and comprehensive county health system. We also support and encourage cooperation among public and private sectors in order to provide the most efficient and effective public health and hospital services. The Health Commission recently produced some statistics on the occupancy of hospital beds in our county. Each of the four hospitals averaged a 90% rate of occupancy. If one of them were to be closed, it is quite clear that the county would have insufficient beds to meet the needs of the population.

To that end, The League of Women Voters wishes to express our approval of Supervisor Achadjian's letter to the Attorney General, and the board of Supervisors' ~~handling of~~ ACTION ON the matter.

San Luis Obispo Physician's Health Alliance LLC
"Committed To Our Community's Health"

1029 Trevor Way
San Luis Obispo, CA 93401

Ph: 805.471.4987
Fax: 805.786.4575

Attorney General
State of California
Public Hearing Testimony
September 15, 2003

Good Morning.

My name is Lionel Chadwick and I speak with you today on behalf of the San Luis Obispo Physician's Health Alliance.

The San Luis Obispo Physician's Health Alliance is a group of over 90 community physicians who have come together in an unprecedented way and with extraordinary clarity of purpose. These highly regarded and respected citizens in our community have committed their personal resources toward the common objective of ensuring the enduring stability and community responsiveness of Arroyo Grande and French Hospitals.

They have formed to take action aimed to return ownership and accountability of these hospitals to our community. While both of these hospitals were initially formed under physician guidance and leadership, during most of their operational existence corporations have operated them in accordance with objectives defined in other cities and states. While the hospitals have struggled periodically during previous owners, the financial duress has escalated during current ownership culminating in the very unfortunate bankruptcy proceedings.

While participants in this organization are individually as diverse as their medical specialties, all have significant misgivings about the current owner's stewardship of these facilities. While we do not know all the factors leading to the current distressed state of affairs, we suspect it is a combination of well financed investor-owned competition, insufficient capitalization, an excessive debt burden resulting from overly ambitious financial projections, missed management opportunities, and finally, unfulfilled pledges to the medical staff, resulting in an erosion of confidence by both the medical staff and the community alike.

Thus, we support the proposed sale of these facilities.

Since the early stages of Universal Health Services' interest in acquiring the Vista facilities, they have expressed an interest in divesting of Arroyo Grande and French Hospital. It was that expressed interest in divestiture that prompted the physicians to incorporate, make personal investment, and seek additional investor partners to prepare a formal bid for ownership.

Universal's recent expressed interest in considering the closure of French as a near-term option furthers the physicians' interest in acquiring the hospitals. We strongly feel the viability of both hospitals is without question. They are needed resources for members of our communities, and serve as a healthy alternative to the Tenet Healthcare facilities in the community.

Inasmuch as the physicians and their investor partners do not desire operational responsibilities, they have identified hospital-operating companies who are interested in entering into long-term agreements to lease the facilities.

The successful selected lessee will be a not-for-profit organization and have all operational and management responsibilities. Potential lessees have committed to the continued operation and capitalization of both French and Arroyo Grande Hospitals. We have completed preliminary valuation, identified the required sources of funding, and begun lease discussions with potential operators. We are eager to begin purchase discussions in the near future, and have been in regular contact with Universal in that regard.

In closing, we stand ready to assume ownership of these hospitals and to secure a seasoned, professional operating company who is financially and managerially able to return both facilities to a strong footing, while being sensitive to community needs, expectations, and clinical needs.

It is our strong opinion that a hospital is a community asset, and that the community must be heard in matters pertaining to ownership as well as operations. Thus we are appreciative of these hearings and are hopeful that the community's voice will have a bearing upon your deliberations and the circumstances of future ownership.

Thank you.

SCHA

SOUTH COUNTY HEALTHCARE ALLIANCE

South County Healthcare Alliance
C/o Chadwick and Associates
1029 Trevor Way
San Luis Obispo, CA 93401

September 15, 2003

Attorney General
State of California
Sacramento, CA.

Re: Vista Hospital Systems, Inc. sale to Universal Health Services

Dear Sir:

My name is Dr. Ernest Jones. I am a physician and the Immediate Past Chief of the Medical Staff at Arroyo Grande Community Hospital. I have been a member of the medical community in this county for over 20 years. I currently serve as President of the South County Healthcare Alliance, a public benefit corporation.

I speak to you today representing the South County Healthcare Alliance.

The Alliance was formed to advocate the community's interests pertaining to the ownership of Arroyo Grande Community Hospital. Members include physician leadership, civic leaders, past and present elected officials, and emergency response officials. South San Luis Obispo County has 3 incorporated cities. The County Board of Supervisors and all three of those cities, Arroyo Grande, Grover Beach, and Pismo Beach have endorsed the Alliance.

Although the South County Healthcare Alliance has not yet completed its' deliberations regarding establishing a position pertaining to the various ownership scenarios which may, over time, become available, we have come to consensus on the following:

1. The Alliance supports the change of ownership of Arroyo Grande Hospital. Current ownership by Vista Hospital Systems has resulted in concerns about community responsiveness, excessive corporate overhead expenses and use of consultants, as well as the redirection of earnings to other communities. We feel the result has been the local community's lack of confidence in the hospital.

2. We have not had discussions with Universal Health Services, so we are unprepared to comment on the prospect of their ownership. We are concerned, however, that another proprietary company in the county may prove problematic in light of Tenet's very strong presence here. Should UHS become the owner of French Hospital Medical Center and Arroyo Grande Community Hospital, all hospitals in the county will be for-profit institutions.

3. The South County Healthcare Alliance is very concerned with Universal's proposed option to close French Hospital Medical Center and consolidate its services with Arroyo Grande Community Hospital. Such a move will place a severe burden upon Arroyo Grande Community Hospital, and quality and content of services to our citizens will surely suffer.

4. In that regard, we strongly encourage the Attorney General to place an obligation on the new owner to operate, and support financially through adequate capitalization, both Arroyo Grande Hospital and French Hospital Medical Center.

5. We are encouraged by the prospect of a local physicians group purchasing Arroyo Grande and French hospitals. Representatives of the physician group have assured us that, if successful, they intend to lease the hospitals to a large not-for-profit hospital operating company. Such an outcome could permit the county to continue to be served by a not for profit corporation.

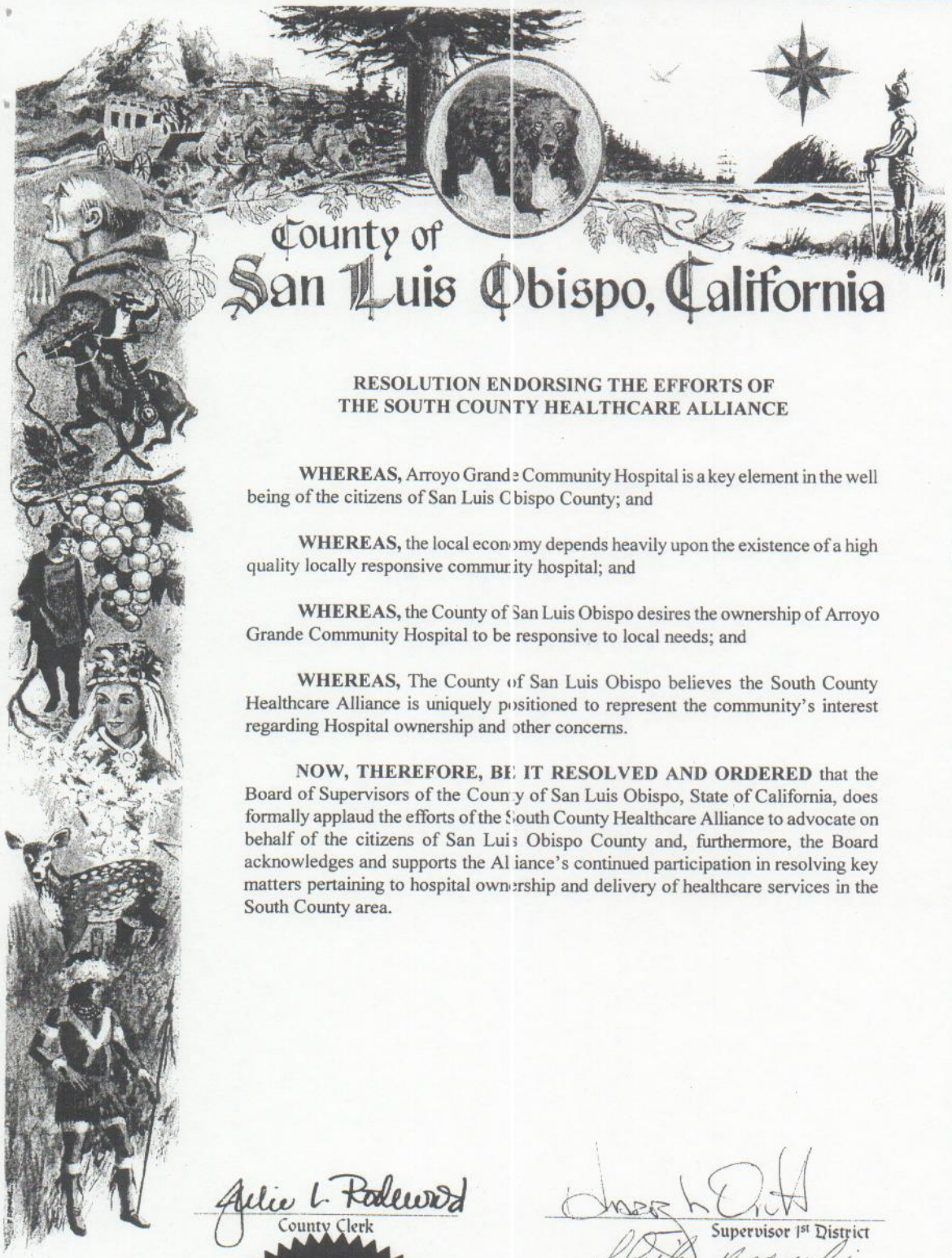
The mission of the South County Healthcare Alliance is to ensure this county has quality hospitals that will serve the health care needs of the community. We are local doctors, nurses, first responders, elected officials and civic leaders. We know the health care needs of our community and therefore request our comments be given weight in your decision making process

If you would like to contact the Alliance to discuss our testimony today or ask any questions regarding the effect of the sale on healthcare in this county, you may do so by contacting me at phone number (805) 474-2600, e-mail me at lchadwick@hotmail.com, or correspond to the address above.

Thank you for the opportunity to speak you on this very important topic.

Sincerely yours,

Ernest Jones
President
South County Healthcare Alliance



County of San Luis Obispo, California

RESOLUTION ENDORSING THE EFFORTS OF THE SOUTH COUNTY HEALTHCARE ALLIANCE

WHEREAS, Arroyo Grande Community Hospital is a key element in the well being of the citizens of San Luis Obispo County; and

WHEREAS, the local economy depends heavily upon the existence of a high quality locally responsive community hospital; and

WHEREAS, the County of San Luis Obispo desires the ownership of Arroyo Grande Community Hospital to be responsive to local needs; and

WHEREAS, The County of San Luis Obispo believes the South County Healthcare Alliance is uniquely positioned to represent the community's interest regarding Hospital ownership and other concerns.

NOW, THEREFORE, BE IT RESOLVED AND ORDERED that the Board of Supervisors of the County of San Luis Obispo, State of California, does formally applaud the efforts of the South County Healthcare Alliance to advocate on behalf of the citizens of San Luis Obispo County and, furthermore, the Board acknowledges and supports the Alliance's continued participation in resolving key matters pertaining to hospital ownership and delivery of healthcare services in the South County area.

Julie L. Rodewald
County Clerk

Supervisor 1st District

Supervisor 2nd District

Supervisor 3rd District

Supervisor 4th District

Supervisor 5th District

15 years

Good morning, I appreciate the opportunity to speak today. My name is Carlyn Christianson and I live in San Luis Obispo. I am here as an individual and also as the Practice Administrator for a 20-physician group of anesthesiologists who provide services to our local hospitals. I've been working with this group for six years, and before that I have another 10 years of **local** experience in managing both **nonprofit** and for-profit medical practices, including working a number of years for OB/GYNs. In addition, I served as the **Chair** of the County Health Commission for three years, and I now sit on the San Luis Obispo Chamber of Commerce Board of Directors and I am also a City Planning Commissioner.

I am here first to say that I, and my physicians, do not oppose the sale of French and Arroyo Grande Hospitals. I am here second to say that we are not supportive of the closure or consolidation of either facility.

The reasons for our opposition to any proposed consolidation are multiple.

First, from our experience and data, we believe that were French to close, Sierra Vista and Arroyo Grande simply could not handle the combined level of cases in its Operating Rooms. Indeed, since the closure of General Hospital, Sierra Vista anesthesia services to the obstetrics dept has increased.

We don't understand how ~~[illegible]~~ can handle the volume of 5 ORs & 2 heart ORs can be added to already busy hospitals, even if not all those ORs are working at full capacity now.

The cases could not simply be shifted up north to Twin Cities Hospital. It's important to understand that geographically, the Cuesta grade pass (an expanded) forms a serious **physical barrier** for many patients who lack the resources or physical ability to make the drive north to Twin Cities Hospital. **Insurance carriers** actually have different plans available or no coverage at all depending on the geographic demarcation of the Grade. And **certainly**, there are many types of healthcare staff and physicians, including **anesthesiologists and obstetricians**, who need to live near the hospital and cannot just pick up their work and move north.

Second, we are concerned about what consolidation would mean in terms of lack of competition, a concern that comes directly from our experience with the Valley Hospital closure down in Santa Maria in 1999. When **Valley** Hospital closed over four years ago in **Santa Maria**, which is our neighboring town about 30 miles south, regulators said that patients would be able to find healthcare elsewhere. What actually happened proved those regulators right, but in an unforeseen way.

What happened was that the remaining hospital in Santa Maria was completely overwhelmed--unable to provide the beds, operating rooms, staffing levels and other services to maintain the higher quality that Valley patients were used to, and so the patients, staff and doctors who **could** leave abandoned it in droves, and still are doing so. Our practice alone lost two physicians who moved out of the area.

Patients and doctors **who could afford it** did find their healthcare elsewhere, but meanwhile, the patients and doctors who are left cannot support the remaining hospital even though it's the only one there. In January 2004, five years after Valley's closure, half of the OB/GYNs in Santa Maria will abandon their practice at the remaining hospital. Even though it will be almost five years, there is still a connection between Valley's closure and what is happening with healthcare in Santa Maria even now.

I am not equating San Luis's hospitals or payer mix to Santa Maria's, but I **am** saying that healthcare is a system where what will happen cannot easily be predicted and isn't based just on data about licensed beds.

Third, we believe that major changes such as a hospital closure should be more carefully approached. The County took 25 years to examine its recent closure of our public hospital, and while I certainly don't think we need to study this current situation for 25 years, Universal's almost **casual** suggestion of closure for French doesn't seem to be based on any detailed data or on an understanding of the **history, economics or the realities of medical practice** in this area.

For instance, we live in an enormously expensive place when compared with our reimbursement rates. The **only** reason our practice is able to attract top-quality anesthesiologists is because the practice ***is*** located in San Luis Obispo, and because of the close proximity of our main hospitals, which means we can run a very efficient practice. I'm sure this is true for the majority of the hospital-related medical practices in the area. Should French be closed or consolidated, I know that we would ultimately lose not only a number of our best young physicians who live and practice here now, but just as importantly, we would lose our ability to hire new doctors and our ability to maintain an economically viable, high quality anesthesia practice.

Fourth, speaking with my other hats too, the very viability of our City's healthcare, and, thus, of its overall economic vitality, **certainly** would be severely threatened by the closure of French Hospital.

So, I am again stating that I and my 20 physicians do not oppose the sale of French and Arroyo Grande, but we **are** opposed to closure or consolidation of either hospital. Both hospitals need to be operated, both deserve to be invested in, both serve vital functions as part of the complicated, inter-twined, and somewhat precarious healthcare system we have today.

I'm hoping the Atty Gen's office ~~you~~ will make the situation a little less precarious, and take **strong action** to ensure that any buyer keeps both French Hospital and Arroyo Grande Hospital **open, operating, and properly capitalized** for the foreseeable future.

Contact: Gregory W. Thomas, M.D., M.P.H., Health Officer, Public Health Director
Telephone: (805) 781-5519 E-mail: gthomas@co.slo.ca.us

Hospital Bed Capacity: San Luis Obispo

Definitions

A brief definition of key terms used in this report include:

- Licensed beds (average): The average number of beds licensed by the Licensing and Certification Division of the Department of Health Services, less those beds in suspense, during the reporting period. [*Note: Most hospitals do not operate all of the beds for which they are licensed. In fact, for some hospitals, it would be physically impossible to do so due to lack of space.*]
- Available beds: The average number of beds (excluding bassinets) that are licensed, physically existing and actually available for overnight use, regardless of staffing levels. Beds in suspense and beds in nursing units converted to uses other than inpatient overnight accommodations (which cannot be placed back into service within 24 hours) are not included.
- Staffed beds: The averaged number of beds that are licensed, available and for which there are staff on hand to attend to the patient who occupies the bed.
- Occupancy rate: A measure of the usage of the beds during the reporting period that is derived by dividing the patient days in the reporting period by the bed days in the reporting period. The bed days (and, therefore, the occupancy rate) can be calculated using licensed beds, available beds, or staffed beds.

Key Findings

The California Office of Statewide Heath Planning and Development (OSHPD) collects data regarding hospital utilization for the State of California. The data are available on the Internet at the OSHPD website: http://www.oshpd.state.ca.us. Per OSPHD, there have traditionally been challenges with the data provided by hospitals; therefore, the accuracy is not perfect. Table 1-1 provides a summary of results for hospital bed capacity by three different categories: licensed beds, available beds, and staffed beds. The data in these tables were based on information provided in the Quarterly Financial Report reports submitted by hospitals to OSHPD. Per OSHPD staff, the utilization data listed in this report is an estimate by the hospital; the actual occupancy rate numbers may be different once the patient census data is available, since the actual rates are calculated based upon these census data. The raw data needed to calculate the occupancy rates is approximately two years old. Once the new Internet-based data entry system is operational, the lag time in obtaining data is anticipated to be reduced. Note that data for San Luis Obispo General Hospital are included, even though this hospital closed in June 2003.

Utilizing the first quarter, 2003, data in Table 1-1:

- **French Hospital represents 24% (112 / 462) of available non-psychiatric beds and 23% (65 / 285) of staffed beds in San Luis Obispo County.**
- **French Hospital represents 36% (112 / 313) of available non-psychiatric beds and 39% (65 / 165) of staffed beds in San Luis Obispo City.**

Table 1-1: Hospital Bed Capacity Data
California and San Luis Obispo County, 2000 – Quarter 1, 2003

Region / SLO County Hospital	Number of Beds (N)			Occupancy Rate (%)		
	Licensed[1]	Available[2]	Staffed[2]	Licensed Beds	Available Beds	Staffed Beds
California						
2000	83,474	75,380	66,515	55.8%	61.9%	70.1%
2001	82,489	74,263	66,073	57.9%	64.4%	72.4%
2002	81,752	73,870	66,076	59.1%	65.4%	73.1%
1st Quarter – 2003[3]	*81,577*	*73,904*	*66,452*	*61.7%*	*68.1%*	*75.7%*
San Luis Obispo Co.						
2000	566	481	298	44.0%	51.7%	83.9%
2001	554	475	319	46.0%	53.7%	80.2%
2002	554	522	331	45.3%	48.0%	75.8%
1st Quarter – 2003[3]	*554*	*522*	*345*	*47.4%*	*50.3%*	*76.1%*
Sierra Vista						
2000	201	201	93	45.7%	45.7%	99.3%
2001	201	201	91	44.8%	44.8%	99.6%
2002	201	201	89	43.8%	43.8%	99.2%
1st Quarter – 2003[3]	*201*	*201*	*100*	*49.3%*	*49.3%*	*99.2%*
Twin Cities						
2000	84	84	56	65.5%	65.5%	99.2%
2001	84	84	58	67.6%	67.6%	98.8%
2002	84	84	60	71.2%	71.2%	99.4%
1st Quarter – 2003[3]	*84*	*84*	*63*	*73.9%*	*73.9%*	*98.6%*
French						
2000	124	71	48	35.2%	61.2%	90.9%
2001	112	65	60	41.7%	71.9%	77.9%
2002	112	112	65	39.8%	39.8%	68.5%
1st Quarter – 2003[3]	*112*	*112*	*65*	*36.0%*	*36.0%*	*62.0%*
Arroyo Grande						
2000	65	65	41	59.7%	59.7%	95.1%
2001	65	65	50	63.7%	63.7%	82.8%
2002	65	65	57	55.7%	55.7%	63.5%
1st Quarter – 2003[3]	*65*	*65*	*57*	*69.9%*	*69.9%*	*79.7%*
SLO General Hospital						
2000	78	46	46	13.7%	23.2%	23.2%
2001	78	46	46	12.2%	20.7%	20.7%
2002	78	46	46	15.0%	25.5%	25.5%
1st Quarter – 2003[3]	*78*	*46*	*46*	*8.6%*	*14.6%*	*14.6%*
SLO Mental Health						
2000	14	14	14	65.1%	65.1%	65.1%
2001	14	14	14	74.1%	74.1%	74.1%
2002	14	14	14	74.3%	74.3%	74.3%
1st Quarter – 2003[3]	*14*	*14*	*14*	*63.6%*	*63.6%*	*63.6%*

Data source: Office of Statewide Health Planning and Development website (www.oshpd.state.ca.us). Data obtained from the Internet Hospital Profile Characteristics (IHPC) query program, located in the Healthcare Information Resources, Quarterly Financial section of the Hospital Data. *Note: Per OSPHD Healthcare Information Analyst, the utilization data listed in this report is an estimate by the hospital and may not be based on actual patient census data.*

[1] The number of licensed beds are calculated at end of time period

[2] The average number of beds and staffed number of beds is based on an average for the time period

[3] The data for 2003 is for 1/1/2003 through 3/31/2003; 2nd quarter data will be released on 10/20/2003.

As a supplement to the data obtained from OSHPD, the Public Health Department requested hospital bed, operating room, and emergency room capacity data from each hospital in San Luis Obispo County. See Table 1-2 for a summary of the responses from each hospital. Data for San Luis Obispo General Hospital are not provided in this table, due to the recent closure of this hospital.

Table 1-2: Hospital Bed Capacity Data Based on Interviews with Hospital Staff San Luis Obispo County, August 2003

Hospital	Hospital Bed / Operating Room/ Emergency Room Capacity
Sierra Vista	Number of licensed beds by category: ➢ Medical/Surgical = 36 ➢ Intensive Care Unit (ICU) = 11 + 6 = 17 ➢ Neonatal ICU = 16 ➢ Pediatrics = 6 ➢ DOU = 23 ➢ Acute rehabiltation = 18 ➢ Perinatal = 46 Number of Operating Rooms = 9 (2 are C-section Ors) Number of Surgeries per month = 500 Number of Emergency Room Beds = 9-12 ➢ Estimated number of additional adult beds that could be handled, if staffing available: ~20 immediately; ~88 within 24 hours
Twin Cities	Number of licensed beds by category: ➢ General Acute Care = 64 ➢ General Acute Care- DCU = 8 ➢ Intensive Care Unit (ICU) = 8 ➢ Perinatal = 4 Number of Operating Rooms = 4 Number of Surgeries per month = 310 Number of Emergency Room Beds = 10 ➢ Estimated number of additional adult beds that could be handled, if staffing available: ~34
French	Number of licensed beds by category: ➢ Medical/Surgical = 31 ➢ Intensive Care Unit (ICU) = 8 ➢ Step-down = 21 ➢ Pediatrics = 6 (these beds now closed) ➢ OB = 12 (6 labor & delivery + 6 post-partum) ➢ Perinatal = 4 Number of Operating Rooms = 7 Number of Surgeries per month = 350 Number of Emergency Room Beds = 8 ➢ Estimated number of additional adult beds that could be handled, if staffing available: ~13 immediately; ~47 within 24 hours
Arroyo Grande	Number of licensed beds by category: ➢ Medical/Surgical = 45 ➢ Intensive Care Unit (ICU) = 8 ➢ Transitional Care = 12 Number of Operating Rooms = 3 (running 2) Number of Surgeries per month = 163 Number of Emergency Room Beds = 12 ➢ Estimated number of additional adult beds that could be handled, if staffing available: ~15
All Hospitals	In an emergency, the number of additional adults that could be handled, *if staffing were available*, would range from 82 (immediately) to 184 (within 24 hours).

Table 1-3 shows the OSHPD number of Emergency Medical Service (EMS) Visits data for California and San Luis Obispo County Hospitals for 2001, including the number of EMS Visits that resulted in hospital admissions. The definitions of the categorizations of non-urgent, urgent, and critical are provided at the end of the table. As of 2002, the EMS visit data will be classified differently utilizing CPT Codes (i.e., Non-urgent = CPT 99281; Urgent = CPT 99282; Moderate = CPT 99283; Severe = CPT 99284; and Critical = 99285).

Utilizing the data in Table 1-3, *however, excluding the data for General Hospital which closed June 19, 2003:*

- **Emergency Room Visits: French Hospital represents 15% (12,798 / 85,924) in SLO County and 38% (12,798 / 33,809) in SLO City**
- **EMS visits resulting in hospital admission: French Hospital represents 22% (2,042 / 9,194) for SLO County and 53% (2,042 / 3,877) for SLO City**

Table 1-3: Emergency Medical Service Visits Data California and San Luis Obispo County, 2001

	EMS Visits (N)				EMS Visits Resulting in Hospital Admissions	
	Non-Urgent[1]	Urgent[2]	Critical[3]	**Total**	Number (N)	Percent of Total (%)
California						
Number	3,448,567	5,232,623	1,303,522	**9,984,712**	1,450,300	14.5%
Percent of Total	34.5%	52.4%	13.1%	100%		
San Luis Obispo Co.						
Number	32,475	47,443	17,257	**97,175**	9,542	9.8%
Percent of Total	33.4%	48.8%	17.8%	100%		
Sierra Vista						
Number	9,455	7,354	4,202	**21,011**	1,835	8.7%
Percent of Total	45.0%	35.0%	20.0%	100%		
Twin Cities						
Number	13,243	16,261	2,256	**31,760**	2,947	9.3%
Percent of Total	41.7%	51.2%	7.1%	100%		
French						
Number	1,589	6,647	4,562	**12,798**	2,042	16.0%
Percent of Total	12.4%	51.9%	35.7%	100%		
Arroyo Grande						
Number	1,544	12,574	6,237	**20,355**	2,370	11.6%
Percent of Total	7.6%	61.8%	30.6%	100%		
SLO General Hospital						
Number	6,644	4,607	0	**11,251**	348	3.1%
Percent of Total	59.0%	41.0%	0%	100%		

Data source: Office of Statewide Health Planning and Development website (www.oshpd.state.ca.us). Data obtained from the Hospital Annual Utilization Data Profile, 2001, located in the Healthcare Information Resources, Utilization section of the Hospital Data.

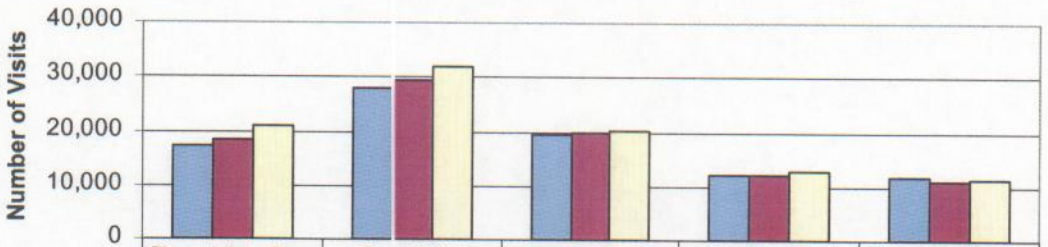
[1] Non Urgent EMS Visits = Visit by a patient with a non-emergency injury, illness, or condition; sometimes chronic; that can be treated in a non-emergency setting and not necessarily on the same day they are seen in the EMS Department. The CPT Code is 99281 (single problem with straightforward medical decision making).

[2] Urgent EMS Visits = Visit by a patient with an acute injury or illness where loss of life or limb is not an immediate threat to his/her well being, or by a patient who needs a timely evaluation (fracture or laceration). The CPT Code for this level of service is 99282 (low complexity) or 99283 (low to moderate complexity).

[3] Critical EMS Visits = Visit by a patient with an acute injury or illness that could result in permanent damage, injury or death (head injury, vehicular accident, a shooting). The CPT Code for this level of service is 99284 (no immediate significant threat to life) or 99285 (immediate threat to life).

Figure 1-1 shows the number of Emergency Medical Service Visits data for San Luis Obispo by hospital or medical center for the years 1999 through 2001.

Figure 1-1: Emergency Services Visits in San Luis Obispo County by Hospital or Medical Center, 1999-2001



	Sierra Vista Reg. Med. Ctr.	Tw n Cities Comm. Hospital	Arroyo Grande Comm. Hospital	French Hospital	San Luis Obispo General Hospital
1999	17,215	27,716	19,368	12,049	11,804
2000	18,240	29,526	20,000	11,950	11,005
2001	21,011	31,760	20,355	12,798	11,251

Data source: Office of Statewide Health Planning and Development website (www.oshpd.state.ca.us); Hospital Annual Utilization Data Profile, 2001, located in the Healthcare

Summary

French Hospital represents a significant percentage of the available and staffed beds in San Luis Obispo County. In addition, the French Hospital Emergency Room handles a significant number of Emergency Room Visits. Compared to other area hospitals, French Hospital has the highest percentage of emergency room patients that are categorized as critical and the highest percentage of Emergency Medical Service Visits resulting in hospital admissions. Per various hospital representatives, there are sometimes significant delays in treatment and hospitalization of emergency room patients. In addition, with the recent closure of San Luis Obispo General Hospital and the French Hospital pediatrics unit, there have been some challenges for other hospitals in accommodating these additional patients.

Medical Staff Office
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TO: Mark J Urban
Deputy Attorney General
Department of Justice

RE: Comment on the proposed Vista Hospital Transaction

My name is Jim Hawthorne. I am the current President of the Medical staff of Arroyo Grande Community Hospital and am speaking on behalf of the medical staff. Additionally, my concern about the future of the hospital has led to my involvement in the South County Healthcare Alliance. And as a long-term member of the medical staff of the hospital, I have experienced or participated in many of the events though more than half its history.

The Medical Staff of AGCH is on record as endorsing a change in the ownership of the hospital. There are a number of reasons the Medical Staff has come to this position. The bankruptcy itself certainly speaks for the problems of the hospital, but I will sketch out other concerns.

Perhaps one of the most illustrative of the concerns is the fact that AGCH has had 5 CEO's in the last 6 years. There can be many explanations for these transitions but it is indisputable that it cannot be good for the hospital and a significant responsibility must fall to the hospital owners. These frequent management changes have resulted in missed opportunities for the hospital, difficulty in making and carrying out long-term plans and in employee uncertainty.

Related to this management uncertainty has been the fact that important decisions have been made by the management organization or by the owners who do not understand all the factors involved in the local situation. While there is a local governing board, capable people have left this board resigned to the fact that they are provided inadequate information and or lack a voice.

Finally, although AGCH has been operated as a not-for-profit public benefit corporation, it has failed to utilize the substantial interest and concern for

the hospital that is latent in the community. This community has substantial resources that could and should be recruited to the benefit of the hospital.

But this is the past and not what we anticipate for the future.

What I hear from my colleagues as the topic of the hospital sale and future direction is discussed is precisely what I conclude from observing the hospital over the last 25 years: AGCH has potential that has not been realized; the hospital could be much more than it yet is. The reason for this catalogue of concerns is not just to explain why we endorse change, but also to delineate what we would hope for in the future and what we think the hospital needs to realize this potential.

We believe the hospital needs an owner with a long-term commitment to the hospital.

We believe the hospital needs an owner that has an active interest in the community and is responsive to both its needs and its potential.

We believe the hospital needs an owner that will reinvest a substantial part of the profits of the hospital back into the hospital for upgrading of services and maintenance of facilities.

Finally, we would agree that the closure of French hospital would create demands on AGCH that it is not currently capable of meeting. Neither hospital beds, emergency department capacity, or operating room facilities could meet the demand for services if French were closed. This is apart from the fact that French and Arroyo Grande Hospitals largely serve different communities.

Thank you for this opportunity to speak to you and for your consideration of the Arroyo Grande Community Hospital medical staff concerns.

Sincerely,

N. James Hawthorne, M.D.
President of the Medical Staff
Arroyo Grande Community Hospital

September 15, 2003

State of California
Department of Justice
Mark J. Urban
Deputy Attorney General
1300 I Street, Suite 125
Sacramento, CA 94244-2550

RE: Vista Hospitals Transaction

Let me begin by thanking you for this opportunity to present my views. I also appreciate the copy of the Transaction documents and being added to the mailing list for this proposal. I currently sit as vice-chair of the San Luis Obispo County Health Commission. I served on the Interim Hospital Authority Board for San Luis Obispo County General Hospital and I am one of the founding directors of the San Luis Obispo County General Hospital and Family Care Clinics Charitable Foundation.

What is happening in San Luis Obispo is not unique. Today, a non-profit public benefit medical corporation aspiring to for-profit status is generally the rule not the exception. But let me remind you that non-profit organizations have a moral obligation and ethical responsibility to the community they do business in. I have many concerns.

My first area of concern is that Vista Health Systems, the non-profit organization running French, Arroyo Grande and Corona Hospitals, has squandered the charitable assets that were to be held in trust for this community. While the Bond Holders have certain rights to revenue how do you propose to protect the community's interest or return on investment? Where are we in the line of creditors? Bankruptcy laws are supposed to protect the community from mismanagement. The community should be the first debtor paid.

My second area of concern revolves around the recent decision by the County Board of Supervisors to close San Luis Obispo County General Hospital. The County of San Luis Obispo knew or had been advised that the sale of French, Arroyo Grande and Corona Hospitals could result in the spin-off of any one of the hospitals, leaving an already fragmented medical delivery service system more vulnerable. The County based their closure decision on erroneous information and failed to protect "charitable assets" of the community. Much of this decision was based on an agreement with Vista Health Systems that French Hospital would continue to operate and take care of the medical needs of the community, specifically the psychiatric patients that would continue to be cared for at the General Hospital complex. It is incumbent upon the Attorney General to investigate to the full extent of the law who knew what and when they knew it.

A third area of concern is if there are any constraints on the property known as French Hospital located at 1911 Johnson Ave. There have been many transactions surrounding this property. It is a known fact that often property that is in the hands of a

non-profit may have restrictions on future uses. It is hard to ascertain if this is the case with French Hospital because real estate records are not included in the Transaction records that are available for review. Please scrutinize these documents for any considerations or constraints given to Vista Health Systems by the City of San Luis Obispo or the County of San Luis Obispo because it operated as a non-profit entity in our community.

My fourth and final area of concern, at this time, is protection for the most vulnerable populations in our community. With our County Hospital closed and the potential for the only other non-profit hospital being sold to a for-profit conglomerate, what will happen to the people who cannot afford for-profit medicine? Please consider them in your deliberations. For-profit, Tenet Health Systems, the owner of Sierra Vista Hospital in San Luis Obispo, is under Federal investigation for fraud. The possibility of having Sierra Vista the only hospital in the San Luis Obispo City area, if Universal Health Systems exercises its request to consolidate/close French Hospital, is frightening. They are not known for their charity care.

In closing, I want to remind you that you are dealing with Vista Health Systems, a bankrupt company that has defrauded the public and lied to this community. Perhaps one of the conditions of sale should be that they donate the French Hospital facility to the community through a conversion foundation. What a wonderful thought to leave you with, a true community hospital. Thank you for your attention.

Sincerely,

Pam Heatherington

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Task Force on the Future of the Health Care Safety Net in San Luis Obispo County

Public Meeting on Proposed Transaction Involving Arroyo Grande Community Hospital and French Hopsital Medical Center

Testimony before the the California Attorney General

September 15, 2003
San Luis Obispo, California

Joel Diringer, JD, MPH

My name is Joel Diringer and I am the facilitator of the Future Vision Task Force on the Future of the Health Care Safety Net in San Luis Obispo County.

The Task Force was formed in January 2003 to study the safety net in light of the closure of San Luis Obispo General Hospital earlier this year. The Task Force is composed of representatives from 17 San Luis Obispo organizations including the San Luis Obispo County Medical Society, County Public Health Department, County Administrative Office, Economic Opportunity Commission of San Luis Obispo County, and numerous other agencies. The Task Force recently completed a six month study of the safety net in San Luis Obispo County and formulated a series of recommendations for community consideration. The report and recommendations were presented to the County Board of Supervisors in August 2003. A copy of the report and recommendations is attached for your reference.

Among the issues studied by the Task Force was the adequacy of hospital inpatient and emergency room services without General Hospital. According to the Community Health Status Report prepared by the County Public Health Department in January 2003 there was the following hospital licensed bed capacity and occupancy in 2001.

Hospital	Number of Licensed Beds	Licensed Bed Occupancy Rate
Sierra Vista	207	44.4%
French	112	39.7%
Twin Cities	84	67.4%
Arroyo Grande	65	62.8%
General Hospital	92	21.7%
Total	560	45.3%

The closure of General Hospital resulted in the loss of 92 licensed beds; with closure of French Hospital an additional 112 beds would be lost to the community. The total loss with the closure of French and General would be 204 licensed beds, or 36% of the community capacity.

In general, the Task Force heard from presenters that without General Hospital, there appeared to be sufficient capacity to serve both inpatient and emergency services, assuming all four other county hospitals remained operating at the same levels.

It was observed that certain capacities could be strained with the outbreak of epidemics and other increases in demand. A flu epidemic or other emergency could easily strain the existing hospitals.

In addition, there was discussion of the impact of obstetrical (OB) capacity with the closure of General. Many of General's OB patients are now being seen at French Hospital with their capacity near its limits.

One particular hospital capacity issue involves surgery time for dentists who need to treat their patients under anesthesia. This affects predominantly developmentally disabled adults, and also young children who require extensive treatment. Already there is a gap in dental access to operating rooms with the closure of General Hospital. French Hospital has taken up some of the slack, but there is still insufficient capacity and many patients are going untreated. A dentist who formerly came from Sacramento to treat developmentally disabled adults, is no longer coming due to the inadequacy of ER time. Closure of French Hospital would further exacerbate the situation.

Lastly, the Task Force discussed the potential impact of additional patients that might present to French and Sierra Vista Hopsitals emergency departments with the closure of the General Hospital walk-in clinic. The current impact is not known, but eliminating an emergency department would reduce community capacity.

Clearly, the closure of French Hospital would put a strain the safety net in San Luis Obispo County and would impact access to care for the entire community. We urge you to maintain the current hospital structure in the San Luis Obispo County.

Thank you for your consideration.

Task Force on the Future of the Health Care Safety Net in San Luis Obispo County

Final Report and Recommendations

July, 2003

Future Vision

Task Force on the Future of the Health Care Safety Net in San Luis Obispo County

Final Report and Recommendations

July, 2003

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Executive Summary

Background

On October 15, 2002 the San Luis Obispo County Board of Supervisors took the historic step of voting to close the inpatient services at General Hospital. After nearly two decades of debate over General Hospital and ensuring access to care, the Board directed County staff to develop a plan for eliminating the hospital inpatient services and contracting with local private hospitals for inpatient care. The Board endorsed concentrating county services in its outpatient clinics, and reiterated its funding support for safety net services.

The Economic Opportunity Commission of San Luis Obispo County, Inc. (EOC) in collaboration with the County Administrative Office, Public Health Department, County Medical Society, and the Community Health Foundation, obtained a grant from The California Endowment to fund a facilitated public planning process to involve local residents in a series of meetings and forums to develop recommendations on:

- The future configuration of safety net health services, and
- Ensuring and monitoring continued access to care for the uninsured and underserved.

A task force was established with a priority on seeking a balanced membership – geographic, gender, ethnic, and income. The role of the task force was to study the issues, interview key public and private officials, solicit input from community members in bilingual forums, and formulate a series of recommendations to the Board of Supervisors.

Task force meetings involved presentations by local, regional and statewide experts. Task force members had opportunity to question and dialogue with presenters, and were then guided by the facilitator to generate solutions for the County's unique safety net issues using a series of questions to assist in framing input. In addition, four community forums were held throughout the county during April and May 2003, one each in Paso Robles, San Luis Obispo, Morro Bay, and Oceano.

Over the course of the eight task force meetings from January to June 2003, Future Vision examined the current configuration of the safety net and discussed recommendations for the future of the system. The topics discussed included:

- Outpatient Care
- Inpatient Care
- Behavioral Health Care
- Dental Care
- Needs of Limited English Proficient Patients

- Financing
- Monitoring

FINDINGS

Provider and Services issues

Outpatient care

Discussion on outpatient care dominated the task force sessions due to its importance in appropriate management of health care. There are two main safety net issues with outpatient care: location of clinics and scope of services. There are few or no services in some of the more remote population centers. Along the coast, the North Coast and Estero Bay areas have no clinics, except for limited services in Morro Bay. Nor do the rural areas of San Miguel, Shandon and Creston have any clinical services. With the general lack of public transportation in the remote parts of the county, much of the population in these areas has difficulty in accessing the available services.

A recent report by the County Administrative Office to the Board of Supervisors demonstrates that a full range of primary care services are not available at all clinics throughout the week. Community comment at each meeting stressed that extended and weekend hours are necessary to ensure access to services for those who work long daytime hours, particularly during harvest season, and cannot come to the clinics during the week. Walk-in clinics without appointment are viewed by the community as a minimum need for access for non-routine health problems and for those who could not make appointments.

Urgent/emergent care

The Task Force considered the urgent and emergent needs for the safety net. With the closing of General Hospital's emergency room, there are four remaining emergency departments in the county. For true emergencies, this appears to be adequate. There is, however, a serious issue of availability of on-call specialists, and access to primary care physicians for follow-up and referrals. Currently, many specialists, particularly neurology and plastic surgery, are on call simultaneously for several hospitals. Also, not all emergency rooms have all specialties covered at all times, although there is at least one specialist on call in the county.

Inpatient care

The issues with hospital access for the safety net appear to be much more related to financing rather than services. The County has long-standing contracts through CMSP with the four remaining hospitals for care of CMSP eligible patients. These contracts will continue. All the hospitals also take Medi-Cal.

However, for patients with no payer source such as CMSP or Medi-Cal, there are questions related to full access, particularly for surgeries for non-life threatening conditions. For these "elective" procedures, hospitals can require deposits or other form of advance financial payments

"Self-pay" patients are not generally aware of their ability to individually negotiate reduced rates similar to what health plans or other programs pay. And patients who are potentially eligible for CMSP or Medi-Cal do not always have adequate information or resources to apply for these programs within the prescribed time limits.

Mental Health and Substance Abuse

The Task Force devoted a full session to the discussion of issues in the delivery of mental health care. The magnitude of the issues and the limited time available meant that there would only be cursory review of mental health issues. Further in depth study limited to mental health is advisable.

The closure of SLOGH required the transfer of the County's license for the inpatient mental health unit, the only inpatient unit in the county. The County was successful in obtaining a license as a "psychiatric health facility." Medical coverage for those mental health patients requiring outpatient medical care will be provided by FCC, and inpatient medical needs will now be provided through a transfer agreement with French Hospital. In addition, the inpatient facility will increase its bed capacity from 14 to 16.

For substance abuse issues, one of the most frequent comments in community meetings was the lack of a residential detox unit in the county. Outpatient detox is available on a limited basis, but those who require more intensive interventions must be sent out of the county. Those with a medical condition, e.g. severe withdrawal syndrome, are treated at local hospitals.

Dental care

Access to dental services for low income persons is limited in the county, as it is elsewhere in the State. For children, numerous programs attempt to link children to services and pay for their care. Young children with severe dental conditions and disabled children have particular needs that are difficult to meet. Seniors citizens also face access barriers in obtaining dental care, since Medicare does not pay for dental services. Few private providers accept Denti-Cal (Medi-Cal) or Healthy Families on a regular basis. Referrals from public health programs or other providers are often necessary to obtain care. Low reimbursement rates are the most often cited reason for not accepting Denti-Cal and Healthy Families.

Pharmaceuticals

Access to pharmaceuticals is a problem well known to young and old alike. Medicare does not have prescription drug coverage and low-income seniors without supplemental coverage must pay out of pocket for drugs. The uninsured also face barriers in paying for prescriptions.

Provider shortages and participation

Medical provider shortages exist for both family practice and specialists throughout San Luis Obispo County. Although these problems exist for both the "haves" and "have-nots," the shortages exacerbate an already fragile safety net. Due to low reimbursement rates and the high cost of living, particularly housing, many physicians have given up their private practices for institutional employment or have left the county altogether. As physicians retire, new physicians are not moving to the area to fill the void. The remaining physicians are already overloaded with privately insured patient, and are less likely to take lower paying publicly insured patients, or uninsured patients. They have less time to volunteer, and are reluctant to take on additional burdens.

Patient issues

As discussed above, access to safety net services is not available in all areas of the county. The rural and remote areas, such as Shandon and Creston, lack services, as does the north coast and Estero Bay. Even where there are clinics, services are limited at many sites. Residents in the far south of the county reported that they often go to Santa Maria for care. Not only are they closer to Santa Maria, but there are more providers who speak Spanish and accept Medi-Cal. With very limited public transportation, families face additional barriers in accessing the available services.

Patients and providers alike reported frustration regarding communications with persons of limited English proficiency (LEP). Although federal law requires minimal standards for interpretation (oral communication) and translations (written communication), such as the ATT Language Line, confidential provider-patient communication is impeded. Reliance on young family members, nonmedical staff, or providers with minimal proficiency in Spanish, does not substitute for communication with trained medical interpreters.

Over the years, General Hospital has been considered the safety net institution where uninsured, Medi-Cal, and CMSP patients could go to obtain a range of services. With the closure of SLOGH, and the full privatization of indigent inpatient care, community members want to ensure that full access will be maintained. The Task Force and community members discussed the possible structures of an independent program that could monitor access and advocate on behalf of consumers having difficulty accessing the system. The program could also assist patients in qualifying for public coverage programs (e.g. Healthy Families and Medi-Cal), or negotiating medical bills.

Uninsured patients also were unaware that they could negotiate their bills at the hospitals. The "charges" invoiced to uninsured patients are the full "retail" charge, which is rarely, if ever, paid by health plans, insurance companies, or government payers. The hospital is also willing to accept a reduced fee, since they have little chance of collecting the entire bill. Uninsured patients are also willing to pay their bills, but it has to be within their means without sacrificing other necessities of life.

Financing issues

The current County General Fund annual contribution towards health care is estimated to be $10.3 million. Should the Board of Supervisors maintain that level of funding, with the closure of General Hospital there is approximately $1 million available for system enhancements, increases in costs, particularly pharmacy, and cost of living adjustments. Even with the County's continued generous funding of indigent health care, there is insufficient funding in the system for the safety net. The Task Force discussed maximizing existing sources of revenues and reimbursements as well as developing new sources.

Certain health clinics, known as Federally Qualified Health Centers (FQHC), receive payments based on their actual costs, rather than a schedule of reimbursement rates. This makes Medi-Cal a highly favored source of income to a non-profit clinic. Community Health Centers of the Central Coast is the FQHC in the County, although FCC is examining the risks and benefits in applying to the federal government for FQHC "Look Alike" status.[1] FQHC status is key to the financial stability of the FCC.

Existing revenue sources may also be maximized by ensuring that all eligible persons are enrolled in available programs. Institutions and patients alike benefit from a third party payer, such as Medi-Cal or Healthy Families.

One local effort of note is to provide health coverage to all children in the County. Spearheaded by the First 5 Commission, the program will maximize enrollment in Healthy Families and Medi-Cal, and create a new local coverage program for those low -income children who are not eligible for Healthy Families or Medi-Cal.

An additional source of funding for the safety net is tobacco litigation Master Settlement Agreement which provides approximately $2.5 million annually to San Luis Obispo County. Measure A, passed by the voters in March 2002, sets specific allocations for the funds.

The Task Force noted that regardless of maximizing the current sources of revenue, there is still additional funding needed for the safety net. With one in

[1] FQHC "Look Alike" is very similar to the FQHC status, except that the "Look Alike" clinics do not get federal grants, but do get the enhanced reimbursement.

seven persons uninsured, inadequate reimbursement from Medi-Cal, and double digit increases in private insurance premiums, the gap needs to be closed with new revenues earmarked for the safety net.

A new ½ cent sales tax would yield approximately $13.5 million annually. Santa Maria is already ½ cent higher than San Luis Obispo County. The Task Force discussed the possibility of an "A to Z" tax for multiple community purposes, such as health, homeless, library, and recreation.

Governance and administration issues

The task force noted that the safety net in San Luis Obispo is a patchwork of providers, programs, and financing mechanisms in the public and private sectors. There is no body or organization overseeing the safety net to coordinate services, ensure that there is adequate access to providers in all areas of the county, or monitor the system. The various governance structures of county departments, nonprofit organizations and private businesses make it impossible to have one overall governing body. However, the Task Force did see a need for a coordinating body that ensures the viability of the safety net.

RECOMMENDATIONS

The following are the recommendations of the Task Force. The recommendations are divided into three sections. The first are those recommendations that the Task Force considers the basic minimum for a safety net in San Luis Obispo County. The second includes enhancements to the safety net that the Task Force considers highly desirable should funding be available. The third set of recommendations are those that would provide for an optimal system. As additional funding sources become available – FQHC, grants, or new taxes – the system can be enhanced.

Basic level of services	Enhanced Services	Optimal services
1. Clinics Two in North County Two in South County One in San Luis Obispo One on North Coast	Mobile unit for rural and remote communities	Satellite clinics in rural, remote areas
2. Services Primary care physician services for adults and pediatrics Obstetrical services Primary care services on	Referrals to specialists in *regions* X-ray available regionally Space for community providers (e.g. WIC, ASN)	Model regional health and human services center on the North Coast (possibly in vacant San Luis Coastal Unified School District facility). Transportation

Basic level of services	Enhanced Services	Optimal services
appointment basis, with a walk-in capability Integration of Public health and preventive services Referrals to specialists *centrally* orthopedics, gastrointestinal, cardiology, surgery, infectious disease, HIV/Hepatitis C, psychiatric liaison, emergency mental health Mental health treatment for non-severe cases Extended and weekend hours available regionally Pharmacy (some local, some centralized Emergency dental available regionally Operating room capacity for complicated dental cases Laboratory draw stations in clinics, central lab Vision and hearing screening and referral	Specialists in neurology (consults) and dermatology Integration of application processes for public programs, e.g. Medi-Cal, Healthy Families, CMSP Regional substance abuse detox programs – social and outpatient and crisis evaluation Central residential substance abuse detox Regional laboratory Pharmacies in all clinics or regions Dental services (preventive and restorative) available regionally	assistance (vouchers, vans, etc.) Vision services Community meeting rooms at clinics Universal and on-line applications for public programs (One-E-App) Inpatient substance abuse facility
3. Patient Services Eligibility and billing assistance at all sites Outstationed eligibility workers in clinics and hospitals		Acceptance of all coverages by all providers

Basic level of services	Enhanced Services	Optimal services
Social services information and referral Linkages to community services, e.g. IHSS, Home Care, SAFE System of Care Accept all coverages Advertised sliding fee scales Acceptance of "Medi-Cal pending" patients at all safety net providers.		
4. Provider shortages Support the Medical Society application for designation as a Health Professional Shortage Area Support increased reimbursement rates for Medi-Cal and Medicare Support use of "physician extenders" Support recruitment and retention efforts for all health care providers Encourage private provider participation through community clinics	Examine the possibility of incentives for new physicians, e.g. loan forgiveness or housing subsidies Expand coverage for the uninsured starting with children (through the First 5 Health Insurance Initiative)	Universal health care coverage Physician residency program
5. Services for limited English proficient (LEP)	Development of local community resources to assist with interpretation	

Basic level of services	Enhanced Services	Optimal services
and hearing impaired patients Bilingual written material for prescriptions, discharge instructions, billing, and education Trained medical interpreters for Spanish at all sites for both phone calls and providers Preference for bilingual personnel in hiring Sign interpreters at all sites by appointment Language line interpreters for non-Spanish LEPs		
6. Consumer assistance program Bilingual staff Monitor access at safety net facilities (e.g. waiting times, services, twenty-four hour access). Act on patient complaints on cost, quality and access Quarterly reporting to County and community at large on safety net issues Advisory committee of providers, patients and community representatives	Assistance with sliding scale fees and in negotiating medical bills with providers On-site assistance at clinics in understanding and applying for all public programs (Medi-Cal, Healthy Families, CMSP, CHDP, etc.) Education of staff and patients on appropriate processes	Assistance with patient compliance and prevention education
7. Financing	Grant funding be pursued	Local, dedicated funding

Basic level of services	Enhanced Services	Optimal services
County "Maintenance of Effort" to reflect its current general fund contribution with annual cost of living adjustments County apply for FQHC status Efforts be made to maximize other funding such as reimbursement for Medi-Cal Admin. Activities, etc. Polling of potential voters in San Luis Obispo to determine the likelihood of success and the scope of a ballot measure to enhance revenues	in a public-private partnership from federal and state sources as well as private foundations	streams for safety net
8. Governance The current provider independent governing boards remain intact. Governing boards be established or expanded according to needs (e.g. FQHC Look-Alike consumer board). Establish a health care council consisting of providers, and public and private representatives similar to the Task Force, to promote collaborative efforts for system, monitor access and make recommendations		

CONCLUSION

The notion of convening community residents about the safety net arose at the time that the Board of Supervisors voted to close General Hospital in Fall 2002. Since that time a number of changes have taken place in the health care environment in the county. General Hospital has closed. French and Arroyo Grande Hospitals have filed for bankruptcy and a sale is pending. A new dental clinic for low-income children opened in Paso Robles.

Relationships have developed, in part due to the Future Vision process that will provide further opportunities for partnership between the various sectors in the County. There is increased dialogue between the public and private sectors on ensuring a healthy safety net. The County Family Care Center has entered into a contract with the non-profit Community Health Centers of the Central Coast for physician services – the framework of a potential long-term partnership.

Universal health coverage and adequate reimbursement for providers for safety net patients will ultimately require federal or state solutions to the access problem. Providing universal health insurance locally for children through collaboration with potential partners such as the First Five Commission and other funders would provide significant progress in health access and is under evaluation at this time.

The recommendations of the Future Vision Task Force echo similar recommendations made by past committees. The current debate is no longer about "saving General Hospital" but rather how to have the best system possible in our County. Also, there is a realization that the generous commitment from the Board of Supervisors for supporting the safety net will not be sufficient for maintaining a strong system. New and secure revenue streams are essential. With the current economic and State budget climate, it will be a challenge to increase support for the system. But the Task Force believes that if the residents of San Luis Obispo County put their collective resources together, a solution is possible.

INTRODUCTION

Background

On October 15, 2002 the San Luis Obispo County Board of Supervisors took the historic step of voting to close the inpatient services at General Hospital. After nearly two decades of debate over General Hospital and ensuring access to care, the Board directed County staff to develop a plan for eliminating the hospital inpatient services and contracting with local private hospitals for inpatient care. The Board endorsed concentrating county services in its outpatient clinics, and reiterated its funding support for safety net services.

The Economic Opportunity Commission of San Luis Obispo County, Inc. (EOC), on behalf of a coalition of community and public organizations, including the County Administrative Office, Public Health Department, County Medical Society, and the Community Health Foundation, obtained a grant from The California Endowment to fund a facilitated public planning process to involve local residents in a series of meetings and forums to develop recommendations on:

- The future configuration of safety net health services, and
- Ensuring and monitoring continued access to care for the uninsured and underserved.

Steering Committee

A steering committee was convened to facilitate the public planning process. The committee was comprised of a representative of the Economic Opportunity Commission, the Public Health Director, a representative of the County Medical Society, and a member of the County administrative staff. The role of the steering committee was to plan and implement task force meetings and community forums, and to direct a contract facilitator in guiding the overall process. The steering committee commenced its work in January, 2003, by developing membership of the task force, setting the topic agendas for each task force meeting, recommending expert guests to provide information to the task force, and ensuring that all meetings were accurately recorded and reported to the task force. The steering committee's tenure is completed with the provision of this report to the County Board of Supervisors.

Future Vision Task Force

Solicitation of task force members was by public announcement. Selection was made by the steering committee with a priority on seeking a balanced membership – geographic, gender, ethnic, and income. The role of the task force was to study the issues, interview key public and private officials, solicit input from community members in bilingual forums, and formulate a series of recommendations to the Board of Supervisors. A facilitator familiar with county health, indigent and health access issues was recruited to provide support to the task force, facilitate its meetings, and draft the final reports for the task force.

Members of the Task Force included representatives from:

Adult Services Policy Council
Children's Services Network
Community Health Centers of the Central Coast
Economic Opportunities Commission
Consumer advocates
County Administrative Office
County Board of Supervisors
County Health Commission
County Health Department
Tri-Counties Regional Center
Family Care Center
AIDS Support Network
Hospital Council of Northern and Central California
Hotline of SLO
Mental Health Board
SLO Community Health Foundation
SLO County Medical Society

Task force meetings involved presentations by local, regional and statewide experts in topic areas recommended by the steering committee. Task force members had opportunity to question and dialogue with presenters, and were then guided by the facilitator to generate solutions for the County's unique safety net issues using a series of questions to assist in framing input:

The input from the task force was recorded in the form of minutes that were subsequently provided to each task force member.

Community Forums

Four community forums were held throughout the county during April and May 2003, one each in Paso Robles, San Luis Obispo, Morro Bay, and Oceano. Following a brief introduction by the facilitator, community members were engaged in a dialogue and contributed ideas, stories and solutions for pressing community safety net issues. All responses were recorded on flip charts and transcribed into notes for review by the steering committee. Childcare, bilingual translation and refreshments were provided for each meeting, which were held from 6:30 - 8:30 pm. Approximately 100 persons attended the forums, including task force members, community service providers, and local residents. Approximately 20 monolingual Spanish speaking persons participated in the forums.

WORKING DEFINITION OF "SAFETY NET"

In order the frame the work of the task force, the members developed a working definition of the health care safety net. The definition was derived from "The Status of Local Health Care Safety Nets," written by Raymond J. Baxter, and published in Health Affairs, July/August 1997, and then augmented with local concerns.

Who the safety net serves:

- the uninsured
- the difficult to serve
- those who might be discriminated against, and
- those who cannot get care elsewhere.
- Examples include the uninsured, Medi-Cal recipients, those who are eligible for County Medical Services Program (CMSP), people with HIV/AIDS, substance abusers, frail elderly, low income children and pregnant women, homeless, mentally ill, developmentally disabled, disabled, limited English proficient, Hepatitis C, and the underinsured.

Who provides the care:

- Institutions, programs, professionals devoting substantial resources to serving uninsured and socially disadvantaged
- Public hospitals and clinics; private and not-for-profit hospitals
- Emergency/urgent care centers
- Community health centers
- Local health department
- Private providers – as "pro bono" or as contracting providers, and providers of community and technical support
- Other "ancillary" services – transportation, referrals for housing and food, translation, advocacy in gaining entitlements; social services; health and human services systems; pharmacy

What finances the system:

- Medi-Cal, Healthy Families, County Medical Services Program (CMSP), Children Health and Disability Prevention Program (CHDP)
- Federal and state funding for clinics- Expanded Access to Primary Care (EAPC)
- Local funds –County General Fund, First 5 Prop. 10 funds
- Tobacco litigation master settlement agreement
- Charity care and billing adjustments by private providers and institutions;
- Grants and donations

WHAT WE LEARNED

Over the course of the eight task force meetings, Future Vision examined the current configuration of the safety net and discussed recommendations for the future of the system. The topics discussed included:

- Outpatient Care
- Inpatient Care
- Behavioral Health Care
- Dental Care
- Needs of Limited English Proficient Patients
- Financing
- Monitoring

This section presents the findings of the Future Vision task force. The following section presents the recommendations. The findings are presented under four main headings:

- Provider and services issues
- Patient Issues
- Financing Issues
- Governance and administration issues

Provider and services issues

a) Outpatient

Location of clinics
There are clinics operated by the Family Care Centers (FCC), Community Health Centers of the Central Coast (CHC), and the Public Health Department (PHD) in the major population centers of the county. The County Health Commission recently completed a review of these services, and the County Administrative Office has charted and mapped the clinics to identify the locations and the services provided. (See Attached)

The major issue with the location of the clinics is that there are few or no services in some of the more remote population centers. Along the coast, the North Coast and Estero Bay areas have no clinics, except for limited services in Morro Bay. Nor do the rural areas of San Miguel, Shandon and Creston have any clinical services. With the general lack of public transportation in the remote parts of the county, much of the population in these areas has difficulty in accessing the available services.

While it may be unreasonable to expect full on-site clinical services in these locations, the Task Force discussed the possibilities of mobile clinics to serve these areas on a regular basis. Apparently, CHC may have mobile services

available to provide some of these services in the near future. The costs and suitability of mobile clinics needs to be examined more fully.

In addition, enhancement to health related public transportation should be considered since even with primary care services, specialty services will require access to centralized locations.

Range of services at clinics

The Health Commission and County Administrative Office report demonstrate that a full range of primary care services are not available at all clinics throughout the week. Public comments at all the community meetings reiterated this point. For instance, FCC is only in Paso Robles two days per week, and adult care is not provided in Grover Beach. It is confusing to patients as to which clinics provide which services and on what days. While, co-location of FCC and PHD clinics is seen as a good idea, integration of their services would be less confusing to patients and possibly less costly to the County.

In addition, clinic hours need to reflect the needs of the working population. Community comment at each meeting stressed that extended and weekend hours are necessary to ensure access to services for those who work long daytime hours, particularly during harvest season, and cannot come to the clinics during the week. Walk-in clinics without appointment are viewed as a minimum need for access for non-routine health problems and for those who could not make appointments.

b) Urgent/emergent care

The Task Force considered the urgent and emergent needs for the safety net. With the closing of General Hospital's emergency room, there are four remaining emergency departments in the county. For true emergencies, this appears to be adequate. In accordance with the federal Emergency Medical Treatment and Active Labor Act, all emergency departments in the county provide screening and necessary treatment of all patients, prior to inquiring about financial ability to pay

The "urgent care" centers throughout the county are basically private physician offices providing an enhanced level of care. They do not generally accept Medi-Cal, and for the uninsured they operate on a cash basis. As such, they do not act as a major component of the safety net for low-income patients, although they are an important source of care for those that can afford the services.

There is a perception that the closing of the General Hospital walk-in clinic may adversely impact the other emergency departments. However, recent

data from the County show that only an average of fourteen patients a day used the walk-in clinic. Nevertheless, community members at every meeting were concerned about the lack of walk-in services for those without appointments. The primary concern with emergency care among the community was one of cost.

Regardless of the closing of General's ER, there are other issues concerning emergent care throughout the County. Clinical issues include availability of on-call specialists, and access to primary care physicians for follow-up and referrals. Currently, many specialists, particularly neurology and plastic surgery, are on call simultaneously for several hospitals. Also, not all emergency rooms have all specialties covered at all times, although there has been to date one of each needed specialist on call in the County. This fact may not continue without considerable effort.

c) Inpatient care

With the closure of General Hospital's inpatient unit, the County will be left with four acute care hospitals. The Community Health Status Report prepared by the County Public Health Department in January 2003 shows hospital licensed bed capacity and occupancy in 2001. However, similar data were not available for "available beds" or "staffed beds" which would be more accurate in determining capacity. Also, since the data were obtained from the Office of Statewide Health Planning and Development (OSHPD) General Hospital has closed.

Hospital	Number of Licensed Beds	Licensed Bed Occupancy Rate
Sierra Vista	207	44.4%
French	112	39.7%
Twin Cities	84	67.4%
Arroyo Grande	65	62.8%
General Hospital	92	21.7%
Total	560	45.3%

The closure of General Hospital would result in the loss of 92 licensed beds; however the average daily census was fewer than 12 per day.

The two hospitals owned by Vista Health Systems, French and Arroyo Grande Community Hospitals are currently in bankruptcy proceedings and being sold to another hospital investor. Reports have indicated that local physicians are attempting to purchase the hospitals from the buyer which would give local control to their management. The sales are not expected to change the current services in the short term.

Questions were raised as to whether there is sufficient capacity for labor and delivery in the other hospitals with the closure of SLOGH. Since many of the Medi-Cal labor and delivery patients are County patients (through PHD and FCC), regional hospital issues, such as physician and midwife coverage, need to be determined. The three remaining private hospitals that provide labor and delivery have indicated that there are no capacity issues. Many south county residents are reported to deliver at Marian Hospital in Santa Maria. There are also discussions of a newly formed private, nonprofit group operating a labor and delivery service at the vacated SLOGH site.

One clinical issue with the inpatient safety net care is the inability to arrange follow-up care with a "medical home." Safety net patients often do not have a primary care provider making it difficult for discharge planning and continued care after hospitalization.

The issues with hospital access for the safety net appear to be much more related to financing rather than services. The County has long-standing contracts through CMSP with the four remaining hospitals for care of CMSP eligible patients. These contracts will continue. All the hospitals also take Medi-Cal. However, for patients with no payer source such as CMSP or Medi-Cal, there are questions related to full access, particularly for surgeries for non-life threatening conditions. For these "elective" procedures, hospitals can require deposits or other form of advance financial payments.

"Self-pay" patients are not generally aware of their ability to individually negotiate reduced rates similar to what health plans or other programs pay. And patients who are potentially eligible for CMSP or Medi-Cal do not always have adequate information or resources to apply for these programs within the prescribed time limits. For instance, application for CMSP must be made within seven days of admission, while Medi-Cal can sometimes authorize payment for services provided within three months of application.

d) Access to specialists

Perhaps the most persistent difficulty in providing physician care for safety net patients is the inability to access specialists for referrals. This problem exists both for primary care doctors and emergency departments for patients not admitted who need outpatient follow-up specialty services. CHC has some specialists on contract, while FCC has had some success in contracting and using volunteer specialists. The two major issues cited by those familiar with the problem are the general lack of providers in the county and the poor reimbursement rates for Medi-Cal and other public programs. Physicians are also concerned about becoming the patient's primary provider after they have

provided specialist services. The Task Force discussed the need to create incentives to take care of uninsured/underinsured patients

e) Mental health

The Task Force devoted a full session to the discussion of issues in the delivery of mental health care. The magnitude of the issues and the limited time available meant that there would only be cursory review of mental health issues. Further in depth study limited to mental health is advisable.

The closure of SLOGH required the transfer of the County's license for the inpatient mental health unit, the only inpatient unit in the county. The County was successful in obtaining a license as a "psychiatric health facility." Medical coverage for those mental health patients requiring outpatient medical care will be provided by FCC, and inpatient medical needs will now be provided through a transfer agreement with French Hospital. In addition, the inpatient facility will increase its bed capacity from 14 to 16.

Outpatient mental health services were also addressed at length. Since there are insufficient funds to cover all needs, the public programs have focused on "mandatory populations" that the county is required to serve by state law. Eligibility for programs offered by the Behavioral Health Department is limited by diagnosis and functional impairment. The populations served include primarily those on Medi-Cal, those in custody, or those who are referrals from schools for individualized educational programs.

There are a wide variety of innovative programs in the mental health system, but funding restraints limit their scope. The programs are seen as being "a mile wide and an inch thick." Only about 40% of those who need services can get treatment.

Services for those with private coverage are not necessarily any better that for those with public coverage. Services are limited countywide. Although there are many psychiatrists in the county, only nine psychiatrists are in private practice. The remainder work for public institutions such as Atascadero State Hospital, California Men's Colony and the County.

Youth services are available through school linked and community based services. The SAFE System of Care program in North County and South County works with families in need and provides services and referrals. Once again, services are "a mile wide and an inch thick," and state mandated clients receive priority. Transportation remains an issue for many families. There is a small adolescent day treatment program, but no inpatient youth services are available in the county except at the general inpatient mental health unit. .

Adult services are also limited. With the elderly population growing faster that the youth population, the gap in services will continue to grow. With categorical funding, it is difficult to place patients with multiple problems of mental illness, physical illness and substance abuse. Discharge and housing issues are particularly difficult for the homeless.

Emergency mental health was also discussed. Persons with serious mental health issues are brought to hospital emergency rooms for evaluation. Under section 5150 of the Welfare and Institutions Code, an involuntary 72 hour hold may be placed on a person who meets the criteria of being gravely disabled or a danger to self or others. In this county, only county mental health workers and peace officers are allowed to place a person in an involuntary hold. Physicians and private providers do not have that authority.

Emergency department physicians reported delays in the response time by the county crisis team. They stated that it often takes hours to respond while the patient remains in the emergency department, although it was reported that the crisis team is very good in it role. The Behavioral Health Department has recently received additional funding to enhance their crisis response contract.

Recruiting and retaining qualified bilingual staff remains very difficult in both the public and private sector in the mental health field.

f) Substance abuse

County Drug and Alcohol Services takes a non-medical model approach to providing services. It has a strong bilingual staff located in numerous programs throughout the county. However, once again, the programs are underfunded, and the state budget deficit is requiring additional cuts to the already limited services.

One of the most frequent comments in community meetings was the lack of a residential detox unit in the county. Outpatient detox is available on a limited basis, but those who require more intensive interventions must be sent out of the county. Those with a medical condition, e.g. severe withdrawal syndrome, are treated at local hospitals.

g) Dental

Access to dental services for low income persons is limited in the county, as it is elsewhere in the State.

For children, numerous programs in the Public Health Department attempt to link children to services and pay for their care. Head Start and Migrant Head Start report large expenditures for dental care for their children. Young

children with severe dental conditions and disabled children have particular needs that are difficult to meet.

Community Health Centers has offered dental services at its Nipomo site, including a walk-in service, for many years. CHC has also expanded recently to Templeton. Appointment waiting times for routine care can be up to three months. A new nonprofit community dental clinic, Clinica de Tolosa, opened in June in Paso Robles. This clinic is open to all children regardless of ability to pay, and adults on an emergency basis. Demand for appointments is reported to be high.

Few private providers accept Denti-Cal (Medi-Cal) or Healthy Families on a regular basis. Referrals from public health programs or other providers are often necessary to obtain care. Low reimbursement rates are the most often cited reason for not accepting Denti-Cal and Healthy Families.

The disabled population and young children with complex needs are more difficult to serve. They often require anesthesia in order to be treated. Several dentists from both in and out of the county agree to treat these patients, and have provided services through the SLOGH's operating rooms. With SLOGH closing the issue of operating room time in the other hospitals has become critical. It is unclear whether all these cases need to be done in a hospital setting, but the problem remains that willing providers cannot treat this population without adequate hospital OR availability.

Seniors citizens also face access barriers in obtaining dental care. Several people commented at the community meetings that they were unable to replace dentures or receive other necessary services for lack of money. Since Medicare does not pay for dental services, most have to pay out of pocket.

h) Pharmacy

Access to pharmaceuticals is a problem well known to young and old alike. Medicare does not have prescription drug coverage and low-income seniors without supplemental coverage must pay out of pocket for drugs. The uninsured also face barriers in paying for prescriptions.

Providing pharmacy services has become a large and increasing cost to the county. The pharmacy based at SLOGH will continue with limited Atascadero coverage. The pharmacy provides prescription drugs for CMSP and other patients with and without coverage. Weekend prescription coverage has emerged as an issue for self-pay and Medi-Cal pending patients, and it is not clear how the indigent will be able to get prescriptions filled.

The community expressed a need for greater access to pharmacy services on a local basis, and suggested such things as mail order, or pick up in local

pharmacies. CHC provides pharmaceuticals as part of it services, with the use of on-site dispensaries and pick up at local pharmacies. FQHC status for FCC may allow for more joint purchasing or drugs and enhanced reimbursement.

Spanish-speaking community members also were concerned that prescriptions were sometimes not labeled in Spanish.

i) Provider shortages and participation

Medical provider shortages exist for both family practice and specialists throughout San Luis Obispo County. Although these problems exist for both the "haves" and "have-nots," the shortages exacerbate an already fragile safety net. Due to low reimbursement rates and the high cost of living, particularly housing, many physicians have given up their private practices for institutional employment or have left the county altogether. As physicians retire, new physicians are not moving to the area to fill the void. The remaining physicians are already overloaded with privately insured patient, and are less likely to take lower paying publicly insured patients, or uninsured patients. They have less time to volunteer, and are reluctant to take on additional burdens.

To overcome the low Medicare reimbursement rates, the Medical Society has filed an application with the federal Health Resources and Services Administration to designate San Luis Obispo County a Health Professional Shortage Area (HPSA). A HPSA designation would increase the Medicare reimbursement rates for all providers in the county. The very low Medi-Cal rates would not be affected.

Private provider participation in Medi-Cal has always been low due to low reimbursement rates, the onerous paperwork, and a population that is often not educated with the private practice model. CMSP participation has been similar.

Community clinics have relied upon recruitment of full time physicians. In a new partnership, FCC is entering into short-term contract with CHC to provide physician services at FCC clinics. If successful, a renewal of the contract is possible and it may become a model for future service delivery at FCC.

Access to specialists for safety net patients has also historically been limited, particularly in orthopedics. Both FCC and CHC have contracted with physicians, and FCC has also relied upon volunteer physicians to staff certain clinics. Some out of town specialists have also come to provide clinical services for children.

Community members had a number of suggestions for recruiting and retaining physicians. They proposed loan forgiveness programs for new physicians coming into the area, housing subsidy programs for new physicians, and development of residency programs.

Patient issues

a) Geographic access

As discussed above, access to safety net services is not available in all areas of the county. The rural and remote areas, such as Shandon and Creston, lack services, as does the north coast community of Cambria. Even where there are clinics, services are limited at many sites.

Residents in the far south of the county reported that they often go to Santa Maria for care. Not only are they closer to Santa Maria, but there are more providers who speak Spanish and accept Medi-Cal.

With very limited public transportation, families face additional barriers in accessing the available services. Unless they can spend all day coordinating with infrequent bus schedules, they need to rely on private transportation. Dial-a-ride services are not always available and the costs are barriers. Often they don't have a working vehicle, or the wage earner in the family has the car. They often rely on informal private transportation and pay dearly for the health care services they subsequently receive.

b) Limited English Proficient access

Patients and providers alike reported frustration regarding communications with persons of limited English proficiency (LEP). Although federal law requires minimal standards for interpretation (oral communication) and translations (written communication), such as the ATT Language Line, confidential provider-patient communication is impeded. Reliance on young family members, nonmedical staff, or providers with minimal proficiency in Spanish, does not substitute for communication with trained medical interpreters.

It was reported that many of the clinics have bilingual administrative staff. Some providers speak Spanish, particularly in the community clinics, and others rely on available interpreters, whether they are family members or other staff. While many providers have Spanish speaking staff, they rely on the ATT Language Line for less common language and dialects.

c) Ombudsman and consumer assistance

Over the years, General Hospital has been considered the safety net institution where uninsured, Medi-Cal, and CMSP patients could go to obtain a range of services. While all the other hospitals in the county serve the uninsured and Medi-Cal, and CHC has long served this population, the common advice to those struggling to find care was "Go to General, and they will take care of you."

With the closure of SLOGH, and the full privatization of indigent inpatient care, community members want to ensure that full access will be maintained. Without the safety valve of the General emergency room and walk-in clinic, there is a concern that the other hospital's emergency rooms are ill-equipped to handle both the increased volume of patients and the diversity of patients that were seen at General. There is also apprehension that the high cost of care and billing practices for non-emergency care will act as a barrier to obtaining care.

The Task Force and community members discussed the possible structures of an independent program that could monitor access and advocate on behalf of consumers having difficulty accessing the system. The program could also assist patients in qualifying for public coverage programs (e.g. Healthy Families and Medi-Cal), or negotiating medical bills.

Suggestions for staffing an 'ombudsman" program were made at community meetings including use of volunteers or AmeriCorps participants to supplement the professional staff.

d) Hospital and provider billing

It was reported that medical debt was the number one reason for bankruptcy filing in the country. The consequences of medical debt are obvious – choices between housing, food, education, gas etc, must be made. The health consequences are not always obvious, but were strongly voiced by community members. Several community participants stated that due to large bills incurred in prior visits to the hospital, they delayed care and did not pursue care even though they knew it was needed. This resulted in increased pain and suffering, increased severity of the condition, and ultimately more expensive care.

Uninsured patients also were unaware that they could negotiate their bills at the hospitals. The "charges" invoiced to uninsured patients are the full "retail" charge, which is rarely, if ever, paid by health plans, insurance companies, or Medi-Cal. The hospital is often willing to accept a reduced fee, since they have little chance of collecting the entire bill. Uninsured patients are also willing to pay their bills, but it has to be within their means without sacrificing other necessities of life.

Financing issues

The current County General Fund annual contribution towards health care is estimated to be $10.3 million. Should the Board of Supervisors maintains that level of funding, it could be structured as follows:

- Approximately $9 million needs to be allocated to the current FCC operations, additional hospital payments for CMSP patients, and changes in Behavioral Health revenues and expenses.
- An additional $200,000 is required to fully fund physician services and provide enhanced on-call services for county patients.
- $100,000 will be made available for a patient hotline and advocacy services
- $1 million is available for enhancements, increases in costs, particularly pharmacy, and cost of living adjustments.

Even with the County's continued generous funding of indigent health care, there is insufficient funding in the system for the safety net. The Task Force discussed maximizing existing sources of revenues and reimbursements as well as developing new sources.

The dominant source of safety net funding in the United States is the federal/state Medicaid program, known as Medi-Cal in California. The federal government pays for approximately half of Medi-Cal expenditures, and the State pays the rest. Payments to primary care providers are generally accomplished in one of three methods: fee for service, managed care, and cost based reimbursement. We do not have Medi-Cal managed care in this county. Unless an entity qualifies for a special federal designation, they are paid on a fee for service basis which is often below the actual cost of providing the services. Hospital based clinics, such as FCC under General Hospital, received an additional per visit payment. That enhancement is unavailable with the closure of General Hospital.

Certain health clinics, known as Federally Qualified Health Centers (FQHC), receive payments based on their actual costs, rather than a schedule of reimbursement rates. This makes Medi-Cal a highly favored source of income to a non-profit clinic. Community Health Centers of the Central Coast is the FQHC in the County, although FCC is examining the risks and benefits in applying to the federal government for FQHC "Look Alike" status.[2] FQHC status is key to the financial stability of the FCC.

In addition to provider payments for seeing patients, certain safety net institutions, deemed "disproportionate share hospitals" (DSH) received grant funding from the federal government. General Hospital was the only DSH in

[2] FQHC "Look Alike" is very similar to the FQHC status, except that the "Look Alike" clinics do not get federal grants, but do get the enhanced reimbursement.

the county, and received approximately $1 million per year. Those payments are lost with the closure of the hospital.

Existing revenue sources may also be maximized by ensuring that all eligible persons are enrolled in available programs. Institutions and patients alike benefit from a third party payer, such as Medi-Cal or Healthy Families. It was noted that not all safety net facilities have "outstationed" Medi-Cal eligibility workers that could enroll eligible patients in the program. Similarly, CMSP enrollment takes place at the office on the SLOGH site, but there are plans to make applications available on line at all hospitals. Some providers are more diligent than others in trying to assist patients enroll in coverage programs.

Statewide there is an effort to allow on-line application for Medi-Cal and Healthy Families through Health-E-App. An extension of that pilot project, One-E-App would include local coverage programs such as CMSP.

One local effort of note is to provide health coverage to all children in the County. Spearheaded by the First 5 Commission, the program will maximize enrollment in Healthy Families and Medi-Cal, and create a new local coverage program for those low -income children who are not eligible for Healthy Families or Medi-Cal. The program, yet to be named, is in its planning stages with funding from First 5 and the County.

It was noted that bilingual and culturally competent staff were essential to maximizing enrollment in programs.

An additional source of funding for the safety net is tobacco litigation Master Settlement Agreement which provides approximately $2.5 million annually to San Luis Obispo County. Measure A, passed by the voters in March 2002, sets specific allocations for the funds. Included in the allocations are funds for community clinics (20%), and reimbursement of emergency room physicians (23%) and hospitals (6%) for non-paying patients.

New revenue streams. The Task Force noted that regardless of maximizing the current sources of revenue, there is still additional funding needed for the safety net. With one in seven persons uninsured, inadequate reimbursement from Medi-Cal, and double digit increases in private insurance premiums, the gap needs to be closed with new revenues earmarked for the safety net.

The Task Force explored various possibilities for new sources of revenue. The following table summarizes possible options for public funding:

Type of tax	Necessary vote	Potential revenue	Comments
Property tax	None if no	Variable	Need to form district through

	increase in tax		LAFCO, and negotiate with municipalities for a share of current revenues
Property tax	2/3 vote	Variable	For capital projects only
Parcel tax	2/3 vote	$500,000 per year if $7 on unimproved and $20 on improved parcels	Similar to Cambria Health Care District and recent LA County Trauma Care Center tax
Transient occupancy tax	2/3 Board vote for designated purpose; Maj. vote if not earmarked	1% increase yields approx. $500,000	Only available in unincorporated areas of county
Sales Tax	2/3 vote for designated purpose; Majority if not earmarked	½ cent yields $13.5 million; 80% from city areas; 20% from uninc. areas	Santa Maria is already ½ cent higher. Could do "A to Z" tax for multiple community purposes
Development fees	?		Can only be directly related to impact of development

Comments at the community meetings were supportive of increased taxes to support the safety net, but this support came from those who were interested in the safety net. They also had additional ideas such as "sin" taxes on alcohol and tobacco, bake sales and rental of advertising space on county vehicles and buildings.

Unlike other counties, San Luis Obispo County has for the most part not aggressively pursued grants to fund health programs and services. These potential sources of revenues from with public sources or private foundations often involve competitive processes with funds for demonstration projects, enhancements, start-ups, and innovations. Funds for ongoing services are generally limited.

Governance and administration

The task force noted that the safety net in San Luis Obispo is a patchwork of providers, programs, and financing mechanisms in the public and private sectors. There is no body or organization overseeing the safety net to coordinate services, ensure that there is adequate access to providers in all areas of the county, or monitor the system. The various governance structures of county departments, nonprofit organizations and private businesses make it impossible to have one overall governing body. However,

the Task Force did see a need for a coordinating body that ensures the viability of the safety net.

Services are provided by the public, nonprofit and private sectors. Although there did not appear to be much duplication of services, it was expressed that enhanced public-private partnerships are essential to an efficient system. There is an emerging relationship between the County and CHC. However, further involvement of the private physicians remains a challenge. With a limited supply of doctors due to the current physician shortage, it will take much effort to enlist more private providers into safety net services. Enhanced reimbursement rates would help, but there is an acknowledgment that safety net funding is limited and the State budget precludes any rate increases. Sharing on-call, easing referrals back to primary care providers, and making the payments system as painless as possible are potential ways to lure private providers back into the system.

The Medical Society has been working to bridge the gap between the private practitioners and the safety net clinic. The efforts are to be encouraged and should be expanded.

WHAT WE RECOMMEND

The following section contains the recommendations of the Task Force. The recommendations are divided into three sections. The first are those recommendations that the Task Force considers the basic minimum for a safety net in San Luis Obispo County. The second includes enhancements to the safety net that the Task Force considers highly desirable should funding be available. The third set of recommendations are those that would provide for an optimal system.

The recommendations are also presented in a chart in the Executive Summary.

Provider and services issues

1. Outpatient

Basic level of services

The Task Force recommends that there be a minimum of six primary care clinics located throughout the county as follows:

- Two in North County
- Two in South County
- One in San Luis Obispo and
- One on the North Coast

Services in *all* these locations should include:

Health Services

- Primary care physician services for adults and pediatrics
- Obstetrical services
- Primary care services on appointment basis with a walk-in capability
- Integration of public health and preventive services, e.g. immunizations, well baby
- Referrals to specialists in regions
- Mental health treatment for non-severe cases
- Pharmacy (some local, some centralized
- Laboratory draw stations
- Vision and hearing screening and referral

Patient Services

- Outstationed eligibility workers
- Billing and payment assistance
- Social services information and referral
- Linkages to community services such as in home supportive services (IHSS), SAFE System of Care, etc.
- Accept all coverages, and Medi-Cal- and CMSP-pending

- Advertised sliding fee scales

Regional services in north, central, and south should include:
- Extended and weekend hours
- Emergency dental care
- Substance abuse detox programs – social and outpatient and crisis evaluation
- Laboratory

Centralized services should include:
- Specialists in orthopedics, gastrointestinal, cardiology, surgery, infectious disease, HIV/Hepatitis C, psychiatric liaison, emergency mental health
- Pharmacy
- Operating room availability for complicated dental cases
- Residential detox program

Enhanced level of services

Health Services
- Vision services
- Inpatient detox program
- Regional dental services for restorative and preventive care
- Mobile clinics for basic services in rural, remote areas
- X-ray available regionally
- Referral to specialists in *regions*
- Specialists in neurology (consults) and dermatology
- Pharmacy in all regions

Patient Services
- Transportation assistance (vouchers, vans, etc.)
- Space for community providers at clinic sites (e.g. WIC, ASN)
- Integration of application processes for public programs, e.g. Medi-Cal, CMSP, Healthy Families

Optimal level of services

Health Services
- Model regional health and human services center on the North Coast (possibly in vacant San Luis Coastal Unified School District facility)
- Satellite clinics in rural, remote regions
- Vision services
- Inpatient substance abuse facility

Patient Services
- Acceptance of all coverages by all providers
- Community meeting room at clinics

- Universal and on line applications for public programs (One-E-App)

The exact services to be provided in each clinic should be subject to an inventory of available services in the community and patient needs. Determinations of specific services should be based upon ensuring that there is access to those services as noted above.

In addition, further study is needed on the issue of mental health services, and the County should develop a plan for further study and recommendations.

2. Provider shortage issues

The issue of provider shortages is being addressed on several levels. The Task Force recommendations include:

Basic level

- Support the Medical Society application for designation as a Health Professional Shortage Area
- Support increases in reimbursement rates for Medi-Cal and Medicare
- Support the use of physician extenders
- Support recruitment and retention efforts for all health care providers

Enhanced level

- Expand coverage for the uninsured starting with children (through the First 5 Health Insurance Initiative)
- Examine the possibility of incentives for new physicians, e.g. loan forgiveness or housing subsidies

Optimal level

- Universal health coverage
- Support the creation of a medical residency program

3. Public private partnership

- Encourage private provider participation through community efforts
- Encourage and expand partnerships between community and public agencies to increase coverage and avoid duplication. The CHC/FCC physician services agreement appears to be a good first step.

Patient Issues

1. Services for limited English proficient and hearing impaired patients

The Task force recommends:
Basic level

- Bilingual written material for prescriptions, discharge instructions, billing and education
- Trained medical interpreters for Spanish at all sites for both phone calls and providers
- Preference for bilingual personnel in hiring
- Sign interpreters at all sites by appointment
- Language line interpreters for non-Spanish LEPs

Enhanced level

- Development of local community resources to assist with interpretation

2. Consumer Assistance

The Task Force recommends the following for a consumer assistance program:

Basic level

- Bilingual staff
- Monitor access at safety net facilities (e.g. waiting times, services, twenty-four hour access).
- Act on patient complaints on cost, quality and access
- Quarterly reporting to County and community at large on safety net issues
- Program should be
    - Independent of providers and payers
    - Countywide
    - Community based
    - Have authority to act on complaints
    - Have an advisory committee of providers, patients and community representatives
    - Funded by public and private sources, including County, private providers and foundations
    - Selected through an RFP

Enhanced level

- Assistance with sliding scale fees and in negotiating medical bills with providers
- On-site assistance at clinics in understanding and applying for all public programs (Medi-Cal, Healthy Families, CMSP, CHDP, etc.)
- Education of staff and patients on appropriate processes

Optimal level

- Assistance with patient compliance and prevention education

Financing

The Task Force recommends:

Basic level

- County maintain its current $10.3 million general fund contribution with annual cost of living adjustments
- County apply for FQHC status should "due diligence" show it to be possible and advisable
- Efforts be made to maximize other funding such as reimbursement for Medi-Cal Administrative Activities and others
- New revenues be explored to supplement, not supplant, current sources including tax increases specifically designated for health services. As a first step, there should be polling of potential voters in San Luis Obispo to determine the likelihood of success and the scope of a ballot measure

Enhanced level

- Grant funding be pursued in a public-private partnership from federal and state sources as well as private foundations

Optimal level

- Local, dedicated funding stream for safety net

Governance

The Task Force recommends:

- The current provider independent governing boards remain intact
- Governing boards be established or expanded according to needs (e.g. FQHC Look-Alike consumer board).
- A health care council be created consisting of providers, and public and private representatives similar to the Task Force, to promote collaborative efforts, monitor access and make recommendations

CONCLUSION

The notion of convening community residents about the safety net arose at the time that the Board of Supervisors voted to close General Hospital. Since that time a number of changes have taken place in the health care environment in the county. General Hospital has closed; French and Arroyo Grande Hospitals have filed for bankruptcy and a sale is pending. A new dental clinic for low-income children opened in Paso Robles.

There is increased dialogue between the public and private sectors on ensuring a healthy safety net. The County Family Care Center has entered into a contract with the non-profit Community Health Centers of the Central Coast for physician services – the framework of a potential long-term partnership. Other relationships

have developed, in part due to the Future Vision process that will provide further opportunities for partnership between the various sectors in the County.

Universal health coverage and adequate reimbursement for providers for safety net patients will ultimately require federal or state solutions to the access problem. Providing universal health insurance locally for children through collaboration with potential partners such as the First Five Commission and other funders would provide significant progress in health access and is under evaluation at this time.

The recommendations of the Future Vision Task Force echo similar recommendations made by past committees. The debate is no there is longer about "saving General Hospita " but rather how to have the best system possible in our County. There is also a realization that the strong commitment from the Board of Supervisors for supporting the safety net will not be sufficient for maintaining a strong system. New and secure revenue streams are essential, and the community needs to support them. With the current economic and State budget climate, it will be a challenge to increase support for the system. The Task Force believes that if the residents of San Luis Obispo County put their collective resources together, a solution is possible.

County of San Luis Obispo • Public Health Department

Health Commission

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September 15, 2003

To: San Luis Obispo County Board of Supervisors

Re: Vista Hospitals

The Health Commission, at its meeting of September 8, 2003, discussed the proposed sale of the non-profit Vista Hospitals (French and Arroyo Grande) to United Health Systems. The commission has two concerns about such a possible sale. United Health Systems has asked for the right to close French Hospital and sell its assets (since French Hospital is bankrupt the asset is the large amount of land that it sits upon). The charitable assets that belong to the community will no longer be available.

The second concern we have is the shortage of staffed available beds that will result from such a closure. If you look at the January 2003, "Community Health Status" report you will find on page 5-2, under Bed Capacity, the following statement "For all hospitals in San Luis Obispo County except General Hospital, the staffed bed occupancy rate was higher than 95%." If you allow French to close we will see a 20% decrease of available staffed beds. The three remaining hospitals will average 25% increase in the number of patients who need beds that will not be available.

Our concern is where will those patients go when the beds are full?
What will the community do in the case of a small disaster? How will patients be prioritized to receive treatment in a hospital?

The Health Commission has two conditions if the sale is allowed to go through:

1. The hospital MUST remain open for at least five (5) years after the new company takes over, and
2. The hospital MUST be fully capitalized, i.e. the facility must be brought up to acceptable code and equipment must be upgraded.

Thank you for taking the time to read this communication.

Sincerely,

Pamela Heatherington/ji

Pamela Heatherington
Acting Chair

cc: Mark Urban-DOJ State of California