11. SENECA HEALTHCARE DISTRICT

Seneca Healthcare District (SHD) is a small, critical access hospital district, providing comprehensive medical services in the Lake Almanor area of Plumas County through a hospital, skilled nursing facility, an emergency room, and a hospital-based outpatient clinic. This is the first Municipal Service Review for the District.

AGENCY OVERVIEW

Background

SHD was formed in 1947 as an independent special district to meet the healthcare needs of the area residents.[150] The district did not start operating until 1952. The hospital opened its doors in 1954. In 1976, a Skilled Nursing Facility (SNF) was approved by a vote of the district residents and was constructed as a south wing to the existing hospital. In 1996, a hospital-based outpatient clinic including family practice physicians, surgeons, and consulting specialists was established.[151]

The principal act that governs the District is the Local Health Care District Law.[152] The principal act empowers healthcare districts to provide medical services, emergency medical, ambulance, and any other services relating to the protection of residents' health and lives.[153] Districts must apply and obtain LAFCo approval to exercise services authorized by the principal act but not already provided (i.e., latent powers) by the district at the end of 2000.

Boundaries

SHD is located in the town of Chester in northern Plumas County, within the Lake Almanor area. The District's boundary is entirely within Plumas County, and includes the communities of Chester, Lake Almanor Country Club, Hamilton Branch, Lake Almanor West, Prattville, and East Shore. The District starts at the Shasta and Lassen County borders in the north, borders Tehama and Lassen counties in the west and east respectively, and

[150] SBOE records.

[151] http://www.senecahospital.org/

[152] Health and Safety Code §32000-32492.

[153] Health and Safety Code §32121(j).

extends to the southern shore of Lake Almanor. The District's boundaries encompass approximately 283 square miles.[154]

There have been one annexation and two boundary revisions since the formation of SHD. The annexation took place in 1974 and involved 215 acres of property on the west shore of Lake Almanor.

Figure 11-1: SHD List of LAFCo Approved Border Changes

Project Name	*Type of Action*	*Year*	*Recording Agency*
Seneca Healthcare District	Formation	1947	SBOE
Unknown	Exclusion and Boundary Revision	1952	SBOE
Lake Almanor West	Annexation	1974	SBOE, LAFCo
Unknown	Boundary Revision	1975	SBOE
Unknown	Remove Bonds	1979	SBOE

Sphere of Influence

SHD's SOI extends outside its boundaries to the southwest to the Tehama county line. The SOI was originally adopted in 1976,[155] and there have been no updates or amendments since that time. The District's SOI is about 354 square miles compared to 283 square miles of boundary area.

Extra-territorial Services

SHD does not specifically provide services at facilities outside its bounds, but will provide services to patients that reside outside of the District's boundaries and come to SHD-owned facilities. SHD serves both district residents and non-residents, and charges them equal fees notwithstanding of residency status.

Areas of Interest

The District reported that areas of interest include the territories of the Plumas Healthcare District and the Eastern Plumas Healthcare District. SHD expressed possible interest in consolidating with either or both of the districts; however, the District indicated that it did not think such a consolidation would occur in the near future.

[154] Total agency area calculated in GIS software based on agency boundaries as of July 18, 2012. The data is not considered survey quality.

[155] Plumas LAFCo Resolution No. 76-11.

Seneca Healthcare District

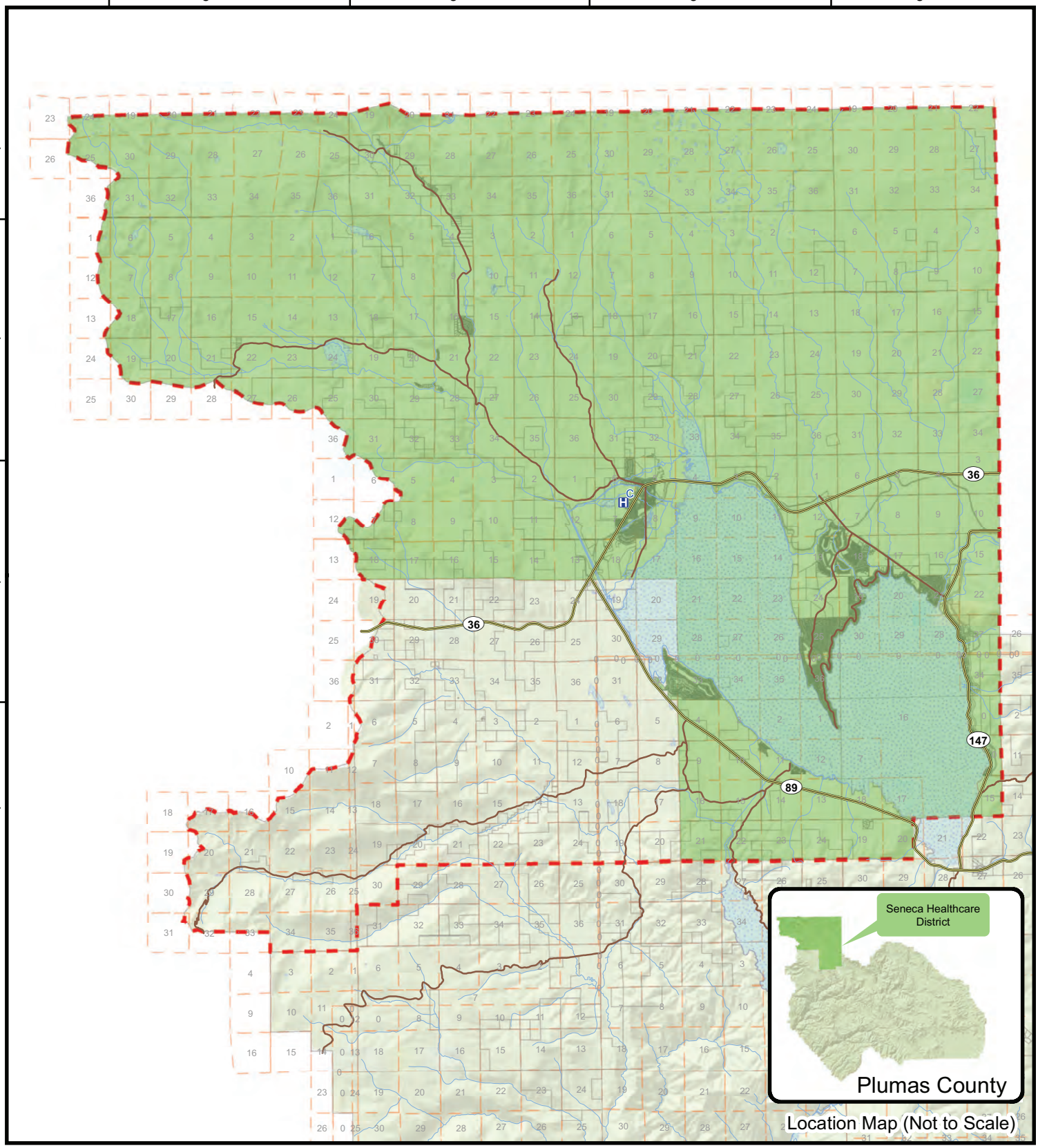
Range 5 East | Range 6 East | Range 7 East | Range 8 East

Township 30 North

Township 29 North

Township 28 North

Township 27 North



Legend

- Highways
- Major Roads
- Stream / River
- Waterbodies
- Parcels
- Sectional Grid (MDB&M)
- H Seneca Hospital
- C Lake Almanor Clinic
- Seneca Healthcare District
- Seneca Healthcare District (SOI)

N W E S

0 1.5 3 6 Miles

Seneca Healthcare District
Resolution:
Formed: July 7, 1947

Seneca Healthcare District (SOI)
Resolution: 76-11
Adopted: January 28, 1976

Source: Plumas LAFCo Map Created 4/20/2012

Accountability and Governance

The principal act orders that the governing body of a healthcare district must have five members. Directors may be appointed or elected, pending circumstances.[156] SHD is governed by a five-member Board of Directors who are elected to staggered four-year terms. The board members were elected at large, and there are currently no vacancies. Current board member names, positions, and term expiration dates are shown in Figure 11-3.

The Board meets once a month on the last Thursday at the Lake Almanor Clinic Conference Center. Board meeting agendas are posted at the post office in Chester, outside of the hospital front door and in the fire halls in the area. They are also made available to the public through a radio station in Susanville and in the local newspaper. Minutes of board meetings are passed out to the board members and the County Clerk. They are available to the general public upon request. Although the District maintains a website, agendas and minutes are not made available on it.

Figure 11-3: Seneca Healthcare District Governing Body

Seneca Healthcare District				
District Contact Information				
Contact:	Linda Wagner, Interim CEO			
Address:	199 Reynolds Road, Chester, CA			
Telephone:	866-507-2195			
Email/website:	www.senecahospital.org			
Board of Directors				
Member Name	**Position**	**Term Expiration**	**Manner of Selection**	**Length of Term**
Ronald Longacre	President	December 2012	Elected	4 years
Loretta Gomez	Vice President	December 2014	Elected	4 years
Bob Caton	Secretary	December 2014	Elected	4 years
David Slusher Jr.	Treasurer	December 2012	Elected	4 years
Richard Rydell	Assistant Secretary/Treasurer	December 2014	Elected	4 years
Meetings				
Date:	Last Thursday of every month at 3pm.			
Location:	Meetings are held at Lake Almanor Clinc Conference Center.			
Agenda Distribution:	Posted at the post office in Chester, outside of the hospital front door and in fire halls. Advertised on radio station in Susanville and in a newspaper.			
Minutes Distribution:	Available upon request. Distributed to the Board and the County Clerk.			

In addition to the required agendas and minutes, SHD does public outreach through its presence at the local health fair and by collaborating with the County to administer free flu shots. The District maintains a website and advertises its elections and upcoming vacancies through articles in a local newspaper.

[156] Health and Safety Code §32100.

If a customer is dissatisfied with the District's services, complaints may be submitted by contacting the administration of SHD in person, sending a letter or addressing the Board directly at a board meeting. The person responsible for handling complaints depends on the nature of the complaint. The District does not keep records of its complaints, but estimated that it had about 15 complaints filed in 2010. The complaints were largely related to billing, charges, patient experience, and hospital administration.

SHD demonstrated accountability and transparency in its disclosure of information and cooperation with Plumas LAFCo. The District participated in an interview and cooperated with the document requests.

Planning and Management Practices

The District employs about 100 full-time equivalents (FTEs)—65 medical and 35 administrative. Altogether, there are 125 employees. In addition there are over 150 volunteers who provide services through membership in the Seneca Hospital Auxiliary, Retired Seniors Volunteer Program, and Sierra Hospice.

The District is administered through four departmental groups—Clinical, Business, Ancillary, and Rural Health. The head of each department, as well as the heads of medical staff and auxiliary, are accountable to the chief executive officer (CEO). The executive assistant and human resource manager also report directly to the CEO who is accountable to the Board of Directors and the contractor organization, Renown Health, by which he is employed.

SHD performs staff evaluations annually. Each department head conducts evaluations of employees within the relevant department. The CEO evaluates the department heads, the executive assistant and the human resources director. The CEO is evaluated by the management of Renown Health.

The District does not evaluate its own performance. However, its performance is evaluated by the Office of Statewide Health Planning and Development (OSHPD) through benchmarking with other providers. Employee workload is tracked through timesheets that help SHD determine if staffing levels and types are correct and effective.

With regard to financial planning, the District adopts an annual budget; financial statements are audited by an independent auditor annually. The District does not have a capital improvement plan. SHD reported that it does not presently have the financial means to produce a capital improvement plan. The District plans its capital improvements by establishing a list of infrastructure needs with a planning horizon of two to three years. The list is compiled with input from the CEO, department heads and physicians. It is then confirmed by the Board and updated annually. The District currently does not have any other planning documents, such as a master or strategic plan; however, is planning to start working on a strategic plan later this year and get it adopted in 2013.

Existing Demand and Growth Projections

Designated land uses within the District consist primarily of general forest, general agriculture and timberland production in the northern part of SHD, and recreational and residential around Lake Almanor.[157] The total boundary area of SHD is approximately 283 square miles.

Population

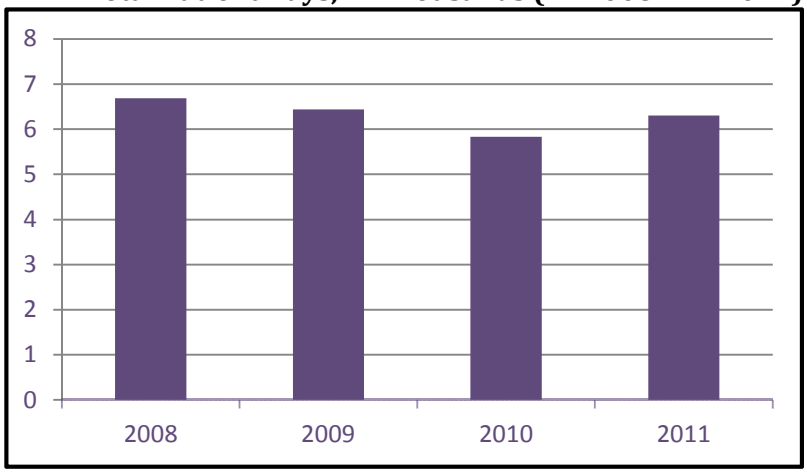
There are approximately 3,957 residents within the District, based on census tract population in the 2010 census.[158]

It is estimated that the population of the Lake Almanor Basin grows to over 20,000 during the summer season from a winter population of 5,000.[159]

Existing Demand

The District reported that service demand has been decreasing in the last few years. Residents have been migrating out of the area, due to the recent recession. The region has been hit especially hard economically, as many residents are only part time and maintain second homes and investment homes that have been increasingly going vacant. In addition, there has been a significant decline in the timber industry, which has caused an outflow of young people seeking employment elsewhere.

Figure 11-4: Total Patient Days, in Thousands (FY 2008 – FY 2011)



The District had a total of 6,302 patient days in FY 10-11,[160] which equates to an estimated population served of about 264 patients.[161] The estimated population served by SHD in FY 10-11 was approximately five percent higher than the estimated population served by SHD in FY 09-10, meaning that more individual patients were

[157] Plumas County Parcel Application.

[158] Census Tracts 5.01 and 5.02 in Plumas County.

[159] www.senecahospital.org

[160] OSHPD, Hospital Summary Individual Disclosure Report, 07/01/2010-06/30/3011.

[161] Author's estimate based on average lengths of stay in days per type of care.

served in FY 10-11. The average length of stay was also slightly longer in FY 10-11 than it was in FY 09-10. There were less patient days in FY 09-10 than in FY 10-11 for both medical/surgical acute and skilled nursing types of care.

The District experiences peak service demand in summer months when the Lake Almanor area attracts a lot of tourists and part-time residents.

Projected Growth and Development

Although no formal population projections have been made by the District, SHD believes there will be limited or no growth in the next few years. SHD attempts to project future demand by reviewing property tax revenue and income from charges. The District forecasts for the future based on trends for revenues and number of patient visits.

The State Department of Finance (DOF) projects that the population of Plumas County will grow by five percent in the next 10 years. Thus, the average annual population growth in the County is anticipated to be approximately 0.5 percent. Based on these projections, the District's population would increase from 3,957 in 2010 to approximately 4,155 in 2020. It is anticipated that demand for service within the District will increase minimally based on the DOF population growth projections through 2020.

There are two potential developments throughout the District, both of which are currently on hold. The Walker Ranch development contains 1,800 undeveloped lots and an 18-hole golf course. Another planned project is the Dyer Mountain Ski Resort, which is stalled due to litigation. If built, it has the potential to not only increase the off-season population in the area, but also result in higher service demand for SHD due to increased ski-related injuries.

The District appears to have the capacity to serve potential growth areas. SHD did not identify any areas where it would have difficulty providing adequate levels of service.

Growth Strategies

The District is not a land use authority, and does not hold primary responsibility for implementing growth strategies. The land use authority for unincorporated areas is the County. The District does not take part in reviewing plans for proposed developments.

With regard to future growth opportunities, SHD identified its willingness to consolidate with other healthcare districts. The District reported that it discussed consolidation with EPHD and PHD, and as a result concluded that there were too many varying interests in the County and each district desired to maintain an independent hospital in order to retain a particular community identity and control. Therefore, SHD has concluded that consolidation of the healthcare districts in the County will likely not occur in the near future.

Financing

The District reported that its current financing level was adequate to deliver services. However, the District faces some minor challenges, due to the current economic climate. SHD observed that tax revenues had declined, because of the population outflow from the area. Income from service charges has also been decreasing, due to a decline in primary care visits and reimbursements from Medicare and Medi-Cal. The District tries to compensate for these losses by offering new services. By adding orthopedic and pain management services, the District was able to raise additional income. In the future, SHD sees an opportunity to add urology services and potentially perform surgeries, which are anticipated to be in demand, due to aging population of the region.

Rates charged to patients for services constitute the District's primary income. The District's rates are determined based on a rate study called Ingenix. Ingenix is a product of the United Health Group, which sells databases of physician and healthcare facility pricing, among other services. SHD serves both district residents and non-residents, and charges them equal fees notwithstanding of residency status. The District also accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to certain established policies of the District. Essentially, these policies define charity services for which no payment is anticipated. Because SHD does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenues.

SHD renders services to patients under contractual arrangements with the Medicare and Medi-Cal programs, health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Patient service revenues from these programs approximate 96 percent of gross patient service revenues.

The Medicare program reimburses the District on a cost-basis payment system for inpatient and outpatient hospital services. The cost based reimbursements is determined based on filed Medicare cost reports. Skilled nursing services are reimbursed at predetermined amounts based on the Medicare rates for the services. The District contracts to provide services to Medi-Cal, HMO and PPO inpatients on negotiated rates. The skilled nursing facility is reimbursed by the Medi-Cal program on a prospective per diem basis subject to audit by the state. Medicare and Medi-Cal revenue accounted for approximately 64 percent of the District's net patient revenues for FY 09-10.

The District divides its revenues into operating and non-operating. Operating revenues result from exchange transactions associated with providing healthcare services, which is the District's primary activity. Non-operating revenues are those transactions not considered directly linked to providing healthcare services.

The District's total operating revenue for FY 09-10 was $12,843,525; the operating revenue for FY 10-11 was $13,412,029. Non-operating revenues for FY 09-10 and FY 10-11 were $756,761 and $655,994 respectively. Total revenue for FY 10-11 was $14,068,023 and consisted of net patient service income (95 percent), other operating revenue (0.6 percent), property tax revenue (three percent), non-capital grant revenues (0.4 percent), other non-operating revenue (0.8 percent) and investment income (0.1 percent). The gross

patient revenues (both inpatient and outpatient) in FY 10-11 were $24 million. After all the deductions in the same year, the District's net income from charges was 51 percent. The deductions consisted of contractual allowances[162] (84 percent), charity discount (less than one percent), other allowances (seven percent), and bad debt (nine percent).

Occasionally, the District receives grants from various governmental agencies and private organizations. The District also receives contributions from related foundations and auxiliary organizations, as well as from individuals and other private organizations. Capital grants and contributions are listed as a separate category in the SHD financial statements. In FY 09-10, they amounted to $90,071 and in FY 10-11 to $36,180.

Similar to revenues the District's expenses are divided into operating and non-operating. Operating expenses are all expenses incurred to provide healthcare services, other than financing costs. Non-operating expenses are transactions that are not considered directly linked to providing healthcare services. The District's operating expenses in FY 09-10 were about $14 million and $13,529,785 in FY10-11. Operating expenditures were composed mainly of salaries and wages (32 percent), professional fees (27 percent), provision for bad debt (eight percent), employee benefits (nine percent), and purchased services (eight percent). Other expenses include supplies, repairs and maintenance, utilities and telephone, rentals and leases, insurance, depreciation and amortization, and other operating expenses. Non-operating expenses are represented by interest expense, which was $88,211 in FY 09-10 and $95,580 in FY 10-11.

The District's operating expenses in FY 10-11 amounted to $2,147 per patient day, or $51,249 per patient.

The District had long-term debt of $2.4 million as of the end of FY 10-11. The debt consisted of loans, notes payable and lease obligations, the details for which are shown in Figure 11-5.

Figure 11-5: SHD Loans and Leases

Payee	*Purpose*	*Beginning Balance*	*Monthly Payment*	*Term*	*Maturity Date*
USDA #1	Generator-LAC Building	$39,500.00	$248.00	20 years	Dec-26
USDA #2	Generator-LAC Building	$27,070.00	$170.00	20 years	Dec-26
USDA #3	Generator-LAC Building	$5,392.00	$34.00	20 years	Dec-26
Siemens Medical	Microsan AS-4 Analyzer	$25,412.00	$525.00	60 months	Feb-13
Siemens Medical	Coagulation Analyzer	$13,000.00	$269.00	60 months	Mar-13
Siemens Medical	Xpand Analyzer	$105,927.00	$2,194.00	60 months	Mar-13
Plumas Bank Loan	LAC	$2,017,317.55	$16,206.99	20 years	Aug-15
Enloe Notes Payable	Unknown	$212,230.00	$2,026.92	120 monts	Jun-15
Total		***$2,445,848.55***	***$21,673.91***		

[162] Contractual allowances are computed deductions based on the difference between gross charges and the contractually agreed upon rates with third party government-based programs such as Medicare and Medi-Cal, and other third party insurers. These allowances are accrued based on estimates derived from historical collection experiences by payor category and type of account (inpatient, outpatient or clinic), adjusted for known exposures attributable to any given account.

The District has a management practice to maintain an emergency reserve fund, the target goal of which is $500,000 or 15 days of operational income. Currently, SHD has $1,050,000 or about 30 days of operational income in its reserve fund.

The District does not participate in any joint power authorities (JPAs) or joint financing mechanisms.

HEALTHCARE SERVICES

Service Overview

The District owns and operates a public general acute care hospital and a skilled nursing facility (SNF). The SNF provides for patients to be transferred from acute care to SNF and not leave the area. Other services provided by the District include outpatient laboratory and x-ray services including mammography, sonography, and CT scanning, including bone density, in-house pharmacy, hospice, anesthesia, inpatient and outpatient surgical services, stress testing, respiratory care, nutritional counseling, EKG, and patient education. In addition, SHD provides emergency services, and runs a hospital-based outpatient clinic that includes family practice physicians, surgeons, and consulting specialists.

SHD occasionally provides services to other organizations in the area. In particular, it frequently performs drug testing for some local employers. The District also contracts with other entities for several services, such as billing that is performed by Healthcare Resources Group, and lab work provided by Lab Core. SHD contracts for CEO services with Renown Health based in Reno, NV.

The District contracts to provide services to Medicare, Medi-Cal, HMO, and PPO inpatients.

The District made multiple attempts to collaborate with other healthcare districts in the County, however, these attempts have failed, due to lack of a common goal.

Staffing

SHD has 125 employees, out of which 65 are medical and 35 are administrative. There are approximately 100 full time equivalents (FTEs). The District's medical staff represents specialties in cardiology, internal medicine, orthopedics, pathology, pediatrics, radiology, podiatry, gastroenterology, ophthalmology, and urology.

The emergency room has a physician on call 24 hours daily. Emergency response is provided by the Chester Fire Department, Westwood Fire Department and the Peninsula Fire Department ambulances. The ambulance services are staffed by paramedics and/or emergency medical technicians qualified to deliver advanced cardiac life support. Emergency transfers to hospitals in Chico, Reno, or other urban areas are available by aircraft and ground transport.

All doctors, nurses, and practitioners are expected to have appropriate certifications, and licenses as mandated by law in order to practice in SHD, or oversee its hospital, emergency room and clinic.

The District also has over 150 volunteers who provide services through membership in the Seneca Hospital Auxiliary, Retired Seniors Volunteer Program, and Sierra Hospice.

Facilities and Capacity

The District owns and operates Seneca Hospital, the Skilled Nursing Facility, and the hospital-based outpatient clinic.

Seneca Hospital, which provides inpatient services, has ten acute care beds and 16 skilled nursing/long-term care beds. The hospital began its operations in 1954 and was reported to be in fair condition. Much of the original acute care structure is still in use today; however, it has been remodeled continuously. The District provides emergency medical services through its emergency room, which is staffed by an on-call physician 24 hours daily.

In 1976, a Skilled Nursing Facility (SNF) was approved by a vote of the district residents and was constructed as a south wing to the existing hospital. This facility was also reported to be in fair condition. It allows for the patients to be transferred from acute care at the hospital to SNF for long-term care without leaving the area.

In 1996, the District established a hospital-based outpatient clinic that now includes family practice physicians, surgeons, and consulting specialists. The clinic is in good condition. Medical staff members provide family practice, cardiology, internal medicine, surgery, orthopedics, pathology, pediatrics, radiology, dermatology, diabetes and nutrition, urology, podiatry, physical therapy, sports medicine, screening colonoscopies, mammography, bone density studies and emergency medical care to the community.

The District owns three vehicles:

- A pickup truck is used primarily for running errands for the District and for plowing snow on district premises.
- A tractor is used primarily for plowing snow and for transporting heavy articles around campus.
- A van is used for transporting SNF/LTC residents as necessary and for running district errands.

Infrastructure Needs

The District has multiple infrastructure needs that are classified by priority. Repair or replacement of emergency ramp roofing was categorized as very high priority. High priority projects include clinic and mechanical building exterior painting, physical therapy

roofing replacement, physical therapy parking area repair, emergency generator battery replacement, staff house roofing material replacement, acute hallway floor cover replacement, professional maintenance of emergency generator, cardiac central monitoring station and antennae replacement, Brentwood house painting, Brentwood house ramp repair and resurface, education building painting, pump house painting, service rite broiler, replacement of dietary hood extinguisher system (currently in progress), hospital parking lot resurfacing, replacement of tires for grounds tractor, computer network upgrade, floor covering replacement in ER and patient rooms, and back fence repair. Medium priority needs are replacement of computer monitors with flat screens, hospital building roof repair, clinic parking lot crack repair, clinic building sealing, Meyers plow replacement, replacement of maintenance vehicle, and software installation. Hospital bed replacement and purchase of high-speed floor burnisher are low priority projects.

Capital improvement projects planned for FY 11-12 are estimated to cost over $99,000 and are as follows:

- Clinic boiler reseal and re-tube;
- Clinic elevator load test;
- Emergency ramp/hospital front entrance roof repair;
- Physical therapy building roof replacement;
- Replacement of emergency generator start batteries;
- Resurface acute corridor;
- CT Ramada painting and repair;
- Brentwood house ramp repair;
- Replacement of front tires on the ground tractor;
- Back fence repair;
- Floor covering replacement in ER hall and ER rooms;
- Clinic and mechanical building painting; and
- Floor covering replacement in patient rooms 1-7.

The District currently does not have any plans to construct new facilities.

Challenges

The District reported the following challenges to providing adequate services:

- Decline in population in the area resulting in a decline in the District's revenues; and

- Dramatically declining reimbursements from Medicare and Medical.

SHD sees opportunities to improve its financing by enhancing specialty services as determined by a needs assessment. The District is anticipating an increasing need for these services, due to the aging population in the area.

Service Adequacy

There are several benchmarks that may define the level of healthcare service provided by an agency, such as complaints, patient outcomes, occupancy rates, staffing levels, costs, emergency room closures and workload, operating room use and the extent to which residents go to other hospitals for service. Complaints, costs and staffing levels were discussed in the previous sections of this chapter. Indicators of service adequacy discussed here include 1) treatment response rates to heart attacks and pneumonia, 2) hospital occupancy rate, 3) pneumonia mortality rates, 4) mortality rates related to other conditions, 5) EMS ambulance diversion rates, 6) operating room use, 7) the extent to which residents go to other hospitals for service, and 8) accreditation information. These indicators for measuring service adequacy are established by the Center for Medicare and Medicaid Studies (CMS)[163] and Office of Statewide Health Planning and Development (OSHPD).

Although this data is not available specifically for SHD or even for Plumas County, it is important to discuss Prevention Quality Indicators (PQIs).[164] Due to small population sizes, twenty-four counties were reported using seven groupings of two to five counties each. Groups were used because the count of selected hospitalizations in some counties was too small for meaningful analysis. Plumas County was grouped together with Lassen, Modoc, Sierra, and Nevada into the Northeastern Group. This group had California's best (lowest) rates for PQIs, suggesting that residents there have the best access to outpatient care. When a person receives early and proper treatment for specific medical conditions, disease complications may be reduced or eliminated, disease progression may be slowed, and hospitalization may be prevented.

Community-acquired pneumonia is one of the leading causes of death both nationwide and in California. For this reason, OSHPD chose it to be one of the conditions studied in the California Hospital Outcomes Program (CHOP), an initiative mandated by the State of

[163] EPHD website, "Quality Measures" document

[164] The Prevention Quality Indicators (PQIs) are a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions" in adult populations. These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. The Prevention Quality Indicators represent hospital admission rates for the following 14 ambulatory care sensitive conditions.

California. The latest reports available are for 2002-2004. In 2004, SHD had lower rates of community-acquired pneumonia than the State average. Rates for Plumas Healthcare District were lower as well, while, Eastern Plumas Healthcare District had similar rates to the State average.

Inpatient Mortality Indicators (IMIs) for SHD are available for congestive heart failure, acute stroke, gastro-intestinal hemorrhage and pneumonia for 2009.[165] Evidence suggests that high mortality may be associated with deficiencies in the quality of hospital care provided. The IMIs are part of a suite of measures called Inpatient Quality Indicators (IQIs), developed by the Federal Agency for Healthcare Research and Quality (AHRQ), that provide a perspective on hospital quality of care. IMIs are calculated using patient data reported to OSHPD by all California-licensed hospitals. All IMIs include risk-adjustment, a process that takes into account patients' pre-existing health problems to "level the playing field" and allow fair comparisons among hospitals. The District's mortality rates in 2009 for congestive heart failure were zero percent compared to three percent statewide, zero percent for gastro-intestinal hemorrhage compared to two percent statewide, zero percent for acute stroke compared to ten percent statewide, and 12.6 percent for pneumonia compared to 4.6 percent statewide. SHD is considered not significantly different from the statewide average for all Inpatient Mortality Indicators.

The District's hospitals had an occupancy rate of 61.4 percent in 2010, compared to a statewide average of 71 percent.[166] According to the report submitted by the District, but unaudited by OSHPD yet, the SHD hospital occupancy rate in 2011 was 66.4 percent. These occupancy rates suggest that service adequacy is satisfactory, and there are enough hospital beds in the area to serve patients as needed.

Emergency room closure data was not available for recent years. The last year when this information was reported was 2007. The SHD was closed for a total of zero hours during that year. For 2010, in lieu of emergency closure rates, EMS ambulance diversion rates were used as an indicator for emergency room use. In 2010, ambulances were not diverted to other hospitals from SHD.

The operating room at the SHD hospital was used for surgeries approximately two percent of the available time in 2010.[167] The operating room was used for outpatient surgery over ten times more than for inpatient surgery. The operating room has abundant capacity to accommodate existing demand and possible future growth.

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[165] OSHPD did not report mortality rates for other conditions (for ecophageal resection, pancreatic resection, abdominal aortic aneurism repair, craniotomy, percutaneous transluminal coronary angioplasty, carotid endaterectomy, acute myocardial infraction, and hip fracture) for the District because fewer than three procedures were performed or conditions were treated.

[166] OSHPD, Annual Financial Disclosure Report, June 30, 2010, 1. CDC, Table 116. Occupancy rates in community hospitals and average annual percent change, by state: United States, selected years 1960–2008. Latest figure found for State of California was 2008.

[167] Operating room use rates are calculated as the number of surgery-minutes divided by the annual capacity of the operating rooms (number of minutes in a year is based on 24-hour use).

The adequacy of hospital facilities and services in meeting the needs of Chester and Lake Almanor residents can be gauged by the extent to which residents travel outside their region to receive hospital services. The rates were calculated based on patient discharge data from OSHPD. Residential location was approximated by zip code. About 34 percent of residents who live within Seneca HD boundaries patronize the district hospital. To compare, approximately 73 percent of Eastern Plumas County residents patronize the hospital in Portola.

There are several major healthcare-related accreditation organizations in the United States: Healthcare Facilities Accreditation Program (HFAP), Joint Commission (JC), Community Health Accreditation Program (CHAP), Accreditation Commission for Health Care (ACHC), The Compliance Team – Exemplary provider programs, Healthcare Quality Association on Accreditation (HQAA), and DNV Healthcare, Inc. (DNVHC). For the State of California the primary accreditation organization is the Joint Commission. The Joint Commission is a not-for-profit organization that accredits and certifies more than 19,000 health organizations and programs in the country. Accreditation can be earned by an entire healthcare organization, for example, hospitals, nursing homes, office-based surgery practices, home care providers, and laboratories. In California, the Joint Commission is part of the joint survey process with State authorities. Hospitals are not required to be accredited in order to operate. Accreditation generally recognizes outstanding performance by a healthcare provider. SHD does not maintain any accreditations.

Figure 11-6: Seneca Healthcare Protection District Profile

Healthcare Services			
Facilities			
Hospitals/Clinics	**Location**	**Condition**	**Owner**
Seneca Hospital	130 Brentwood Drive, Chester, CA	Fair	SHD
Skilled Nursing Facility	130 Brentwood Drive, Chester, CA	Fair	SHD
Lake Almanor Clinic	199 Reynolds Road, Chester, CA	Good	SHD
Service Challenges			
The District's challenges include a decline in residential population and consequently in revenues, and a decline in government reimbursements through Medicare and Medical.			
Facility Needs/Deficiencies			
District infrastructure needs inlude multiple replacements and repairs in all of its facilities. SHD classifies its planned projects by priority. There is one very high priority project, 19 high priority, eight medium priority, and two low priority. Fourteen projects were planned for FY 11-12 that will cost over $99,000.			
Facility Sharing			
Current Practices: The District currently does not share facilities with other agencies.			
Future Opportunities: The District does not see any opportunites for facility sharing in the future. SHD indictated that it tried to collaborate with PHD and EPHD on joint electronic records and common laundry and physician contracts; however, the efforts fell through, due to the lack of a unified common goal among the three districts.			
Service Adequacy			
Occupancy rate, 2010	61.4% (versus statewide average of 71%)		
Hospital usage by residents	34% of residents (versus 73% in EPHD)		
Accreditations	No accreditations maintained		

SENECA HEALTHCARE DISTRICT DETERMINATIONS

Growth and Population Projections

- There are approximately 3,957residents within Seneca Healthcare District (SHD).
- The District experienced a decrease in service demand in the last few years due to residents migrating out of the area because of the recent recession.
- Little or no growth in population and in service demand is expected within the District in the next few years.
- There are two potential developments throughout the District, both of which are currently on hold.

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

- The population threshold by which Plumas LAFCo will define a community is yet to be determined. Specific disadvantaged unincorporated communities and characteristics of the communities will be identified when appropriate as other areas are to be annexed to the District.

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

- The District's existing facilities have the capacity to adequately serve current demand and potential future growth.
- SHD has multiple infrastructure needs classified by priority, including facility and parking lot repairs and equipment replacements.
- The District plans its capital improvements by establishing a list of infrastructure needs with a planning horizon of two to three years.
- The District should consider adopting a capital improvement plan to identify financing needs, potential revenue sources for these needs and timing of the improvements.

Financial Ability of Agencies to Provide Services

- The District reports that current financing levels are adequate to deliver services; however, the District faces some minor challenges, due to the current economic climate.
- The District tries to compensate for the financing challenges by offering new services.
- The District had long-term debt of $2.4 million as of the end of FY 10-11.
- SHD has a management practice to maintain an emergency reserve fund, the target goal of which is $500,000 or 15 days of operational income.

Status of, and Opportunities for, Shared Facilities

- SHD currently does not share facilities with other agencies.
- The District does not see opportunities to share facilities with other agencies in the future.
- SHD indicated that it tried to collaborate with PHD and EPHD on joint electronic records and common laundry and physician contracts; however, the efforts fell through, due to the lack of a unified common goal among the three districts.

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

- SHD demonstrated accountability and transparency by disclosing financial and service related information in response to LAFCo requests.
- The District conducts extensive outreach through its website and in the community.
- A governmental structure option is consolidation with other healthcare districts in Plumas County, possibly with EPHD and/or PHD. However, the District reported that consolidation is not likely to occur in the near future.