

Surprise Valley Healthcare District
Municipal Service Review

PUBLIC REVIEW DRAFT

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Prepared for Modoc LAFCo
Submitted by Policy Consulting Associates, LLC

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ACRONYMS AND DEFINITIONS

AAA:	Abdominal aortic aneurysm repair
AMSL:	Above Mean Sea Level
AB:	Assembly Bill
ACA:	Affordable Care Act
ACHC:	Accreditation Commission for Health Care
AHRQ:	Agency for Healthcare Research and Quality
AMSL:	Above Main Sea Level
ALS:	Amyotrophic Lateral Sclerosis
BLM:	Bureau of Land Management
CABG:	Coronary Artery Bypass Graft
CAFR:	Comprehensive Annual Financial Report
CAH:	Critical Access Hospital
CARF:	Commission on Accreditation of Rehabilitation Facilities
CDPH:	California Department of Public Health
CEQA:	California Environmental Quality Act
CHA:	California Hospital Association
CHAP:	Community Health Accreditation Program
CHHS:	California Health and Human Services Agency
CHIP:	Community Healthcare Implementation Plan
CHNA:	Community Healthcare Needs Assessment
CIP:	Capital Improvement Plan or Program
CKH:	Cortese-Knox-Hertzberg Local Government Reorganization Act of 2000
CMS:	Centers for Medicare and Medicaid Services
COPD:	Chronic Obstructive Pulmonary Disease
DAC:	Disadvantaged Community
DHCS:	Department of Health Care Services
DNVHC:	DNV Healthcare, Inc.
DOF:	California Department of Finance
DUCs:	Disadvantaged Unincorporated Communities
ED:	Emergency Department

EKG:	Electrocardiogram
EMS:	Emergency Medical Services
FPPC:	California Fair Political Practices Commission
FTE:	Full-Time Equivalent
FY:	Fiscal Year
GIS:	Geographic Information Systems
GP:	General Plan
HCAHPS:	Hospital Consumer Assessment of Healthcare Providers and Systems
HCAI:	Department of Health Care Access and Information
HFAP:	Healthcare Facilities Accreditation Program
HHS:	Health and Human Services
HMO:	Health Maintenance Organization
HQAA:	Healthcare Quality Association on Accreditation
IHHS:	In-Home Support Services
IMI:	Inpatient Mortality Indicators
JC:	Joint Commission
LAFCo:	Local Agency Formation Commission
Medi-Cal:	California Medical Assistance Program
MCPHD:	Modoc County Public Health Department
MSR:	Municipal Service Review
NPC:	Non-structural Performance Categories
OPEB:	Other Post-Employment Benefits
OSHPD:	Office of Statewide Health Planning and Development (now HCAI)
PCI:	Percutaneous Coronary Intervention
PPACA:	Patient Protection and Affordable Care Act
PQI:	Prevention Quality Indicators
PSI:	Patient Safety Indicators
SB:	Senate Bill
SCHIP:	State Children's Health Insurance Program
SOI:	Sphere of Influence
SPC:	Structural Performance Categories
SVCH:	Surprise Valley Community Hospital

SVHD: Surprise Valley Healthcare District
USFS: U.S. Forest Service

PREFACE

Prepared for the Local Agency Formation Commission of Modoc County (LAFCo), this report is a Municipal Service Review (MSR) for the Surprise Valley Healthcare District (SVHD).

CONTEXT

Modoc LAFCo is required to prepare this Service Review by the Cortese-Knox- Hertzberg Local Government Reorganization Act of 2000 (CKH), (Government Code §56000, et seq.), which took effect on January 1, 2001. The MSR examines services provided by public agencies whose boundaries and governance are subject to LAFCo. The agency providing healthcare services in Modoc County is the focus of this review.

CREDITS

The authors extend their appreciation to those individuals at the agencies that provided planning and financial information and documents used in this report.

LAFCo staff provided project coordination and GIS support. This report was prepared by Policy Consulting Associates, LLC, and Jill Hetland was the primary author.

1. EXECUTIVE SUMMARY

This report is a municipal service review (MSR) report on healthcare services prepared for Modoc LAFCo. A service review is a State-required comprehensive study of services within a designated geographic area, in this case, the County of Modoc. The service review requirement is codified in the CKH (Government Code Section 56000 et seq.).

The intent of this MSR is to conduct comprehensive review of services provided by the Surprise Valley Healthcare District (SVHD). The proposed MSR determinations are located at the end of chapter 4. The MSR conducted prior to this was completed in April 2012.

PROVIDERS

This report covers the Surprise Valley Healthcare District, which consists of the Surprise Valley Community Hospital and the Surprise Valley Clinic. Each provides healthcare services and programs in Modoc County.

SVHD owns and maintains the hospital facility and medical clinic which are leased to providers. Revenues are used to issue grants for healthcare programs.

The location of the district is shown in Figure 1-1.

GOVERNANCE AND ACCOUNTABILITY

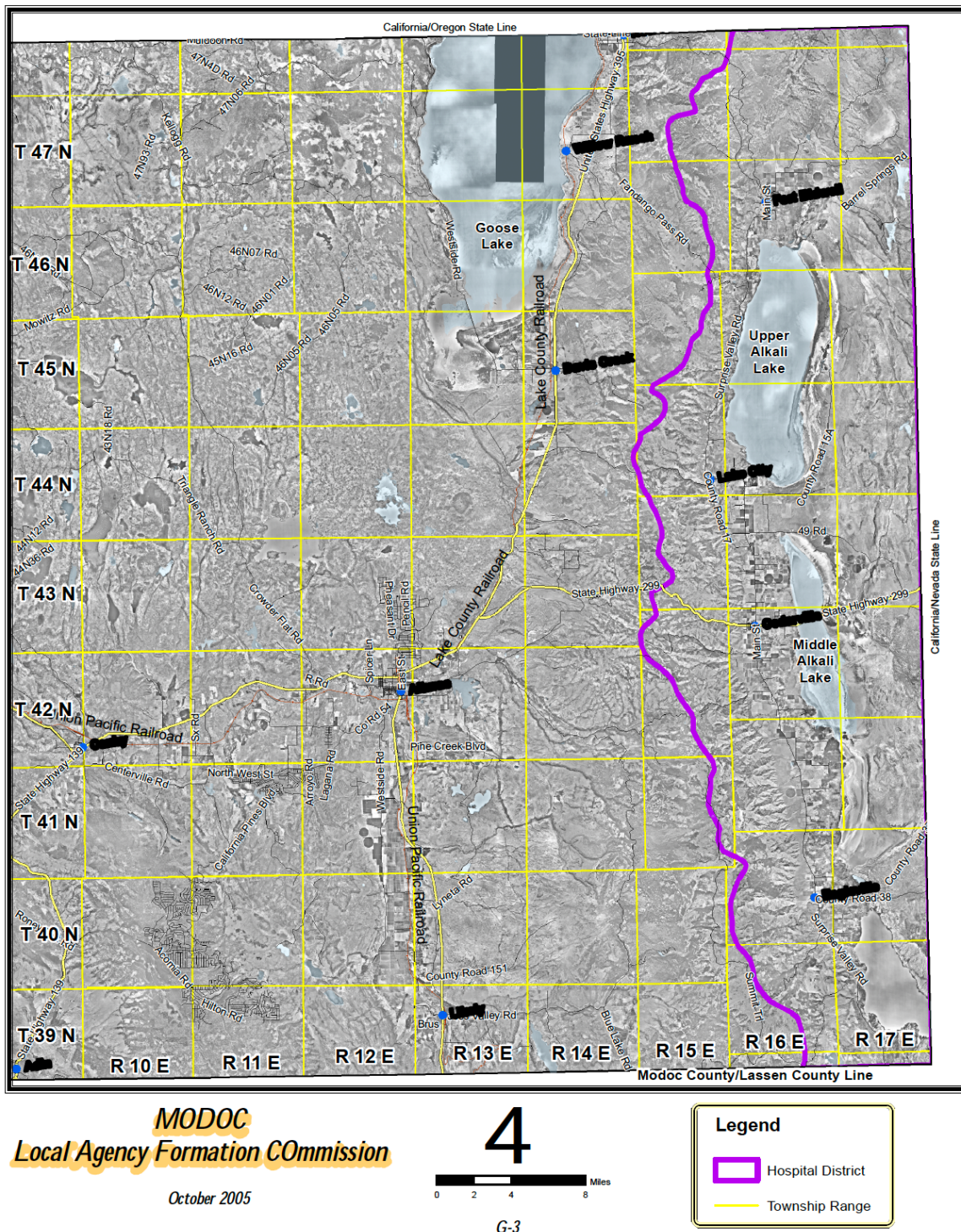
The healthcare district reviewed in this MSR must meet Brown Act requirements, including public noticing and posting of meetings and agendas, communication and outreach to residents, and websites that provide links to meeting information, contacts, and documents such as financial reports.

There are extensive website requirements for healthcare districts as outlined in Senate Bill 929, Assembly Bill 2257, and Assembly Bill 2019. The District meets the majority of the requirements outlined. To ensure compliance with all regulations, it is recommended that SVHD create and provide up-to-date financial reports such as annual budgets and consolidate the two websites that are currently hosted by the District. With the disconnection of its unused website, the District should verify functionality of links and updated resources on its live site.

Overall, the District demonstrated accountability and transparency in their disclosure of information and cooperation during the process of this MSR. The District responded in a timely manner and cooperated with document requests.

Figure 1-1: Provider Map

Surprise Valley Hospital District



PLANNING AND MANAGEMENT

As mandated by the Affordable Care Act, many healthcare districts prepare significant planning documents, including the Community Health Needs Assessment (CHNA) and Community Health Implementation Plan (CHIP). SVHD compiled the CHNA report and, as an alternative to the CHIP, developed a 2025 strategic plan and goals to guide future program and service efforts according to five pillars: Service, People, Financial, Quality, and Growth.

GROWTH AND POPULATION PROJECTIONS

The District is located in a remote, rural region of California's eastern Sierra Nevada Mountains. It primarily serves four towns (Fort Bidwell, Lake City, Cedarville, and Eagleville) and two Native American groups (the Warner Mountain Indians and the Cedarville Rancheria) with a secondary service area that also includes portions of Oregon and Nevada.

According to the 2020 US Census, Modoc County has a population of 8,700. The population within the District, however, was estimated to be 1,200, based on the census data available for the communities within the District bounds at the time the last MSR was conducted in 2012. Population projections for the county have been decreasing each year. Limited employment opportunities and geographical challenges further reflect declining growth and impacts on the healthcare district.

Currently, the annual growth projections are -1 percent with an estimated population total of 6,661 by 2045.

Figure 1-2: Modoc County Population and Growth Projection

DISTRICT	POPULATION (2020)	PROJECTED ANNUAL GROWTH RATE	PROJECTED POPULATION (2030)	PROJECTED POPULATION (2045)
Modoc County	8700	-1%	8,127	6,661

FINANCING

Financing is frequently a significant challenge for healthcare districts in the State as they struggle to compete with for-profit providers and dedicate high levels of funding to charity care in an attempt to address the problem of an underserved population. SVHD is no exception. It has struggled with the uncertainty of the existing funding sources, limited additional financing

options, and high capital improvement costs, which resulted in filing for Chapter 9 bankruptcy in 2018.

Despite these challenges, the District has functioned with an operational surplus over the last year, despite fluctuations month to month, which indicates a stabilizing effect of the bankruptcy proceedings and an ability to adequately continue operations. Still, the District would benefit from creating planning documents such as an adopted formal budget, an annual report, and a Capital Improvement Plan (CIP) to better track its progress and increase transparency and financial accountability.

SPHERE OF INFLUENCE

SVHD has a sphere of influence (SOI) that is coterminous with its boundaries. The SOI was reaffirmed in 2012. No need for changes has been indicated and it is therefore recommended that the SOI be reaffirmed once again.

SUMMARY OF DETERMINATIONS

Throughout this MSR, determinations are made regarding various aspects of the administration and operation of the agency and its services. There are challenges faced by the District that are unique to rural areas and special districts. In the case of SVHD, the primary difficulty is financial sustainability. This not only effects the hiring and retention of staff and physicians but their workload, funding for capital improvements, and the types of services offered. The following is an overview of recommendations for the District:

- Develop and provide more comprehensive financial reports such as an annual adopted budget and a capital improvement plan;
- Implement a process to remove the District's Google site, making www.svhospital.org the sole website for SVHD and ensuring all information and documents are uploaded and up-to-date;
- The fiscal position of the District is improving since filing for Chapter 9 bankruptcy. However, the population of Modoc County and that of the District is expected to continue decreasing while the age of the population will increase. Therefore, finding ways to lessen the long-term financial burden on SVHD should be a priority. This could include partnerships with Modoc Medical Center, a healthcare system, or state or federal assistance;

- Current and future submissions of Form 700 need to be provided to the California Fair Political Practices Commission website for posting;
- Complete ethics training for necessary staff and board members;
- Continue with next steps to complete the seismic compliance needs of the District's facilities with the grant money allocated for this project;
- Engage in outreach to ensure the community is aware of all services provided by the District.

2. BACKGROUND

This report is prepared pursuant to legislation enacted in 2000 that requires LAFCo to conduct a comprehensive review of municipal service delivery and update the spheres of influence (SOIs) of all agencies under LAFCo's jurisdiction. This chapter provides an overview of LAFCo's powers and responsibilities. It discusses legal requirements for preparation of the municipal services review (MSR), and describes the process for MSR review, MSR approval and SOI updates.

LAFCo OVERVIEW

LAFCo regulates boundary changes proposed by public agencies or individuals through approval, denial, conditions, and modification. It also regulates the extension of public services by cities and special districts outside their boundaries. LAFCo is empowered to initiate updates to the SOIs and proposals involving the dissolution or consolidation of special districts, mergers, establishment of subsidiary districts, and any reorganization, including such actions. Otherwise, LAFCo actions must originate as petitions or resolutions from affected voters, landowners, cities, or districts. The composition of LAFCo Commissions varies from county to county but typically consists of members who represent all levels of local government.

MUNICIPAL SERVICES REVIEW LEGISLATION

The Cortese-Knox-Hertzberg Act (CKH) requires LAFCo review and update SOIs not less than every five years and to review municipal services before updating SOIs. The requirement for service reviews arises from the identified need for a more coordinated and efficient public service structure to support California's anticipated growth. The service review provides LAFCo with a tool to study existing and future public service conditions comprehensively and to evaluate organizational options for accommodating growth, preventing urban sprawl, and ensuring that critical services are provided efficiently.

Government Code §56430 requires LAFCo to conduct a review of municipal services provided in the county by region, sub-region or other designated geographic area, as appropriate, for the service or services to be reviewed, and prepare a written statement of determination with respect to each of the following topics:

- Growth and population projections for the affected area;
- The location and characteristics of any disadvantaged unincorporated communities (DUCs) within or contiguous to the SOI;
- Present and planned capacity of public facilities and adequacy of public services, including infrastructure needs or deficiencies (including needs or deficiencies related to sewers, municipal and industrial water, and structural fire protection in any DUCs within or contiguous to the sphere of influence);
- Financial ability of agencies to provide services;
- Status of and opportunities for shared facilities;
- Accountability for community service needs, including governmental structure and operational efficiencies; and
- Any other matter related to effective or efficient service delivery, as required by commission policy.

MUNICIPAL SERVICES REVIEW PROCESS

The MSR process does not require LAFCo to initiate changes of organization based on service review findings, only that LAFCo identify potential government structure options. However, LAFCo, other local agencies, and the public may subsequently use the determinations to analyze prospective changes of organization or reorganization or to establish or amend SOIs. Within its legal authorization, LAFCo may act with respect to a recommended change of organization or reorganization on its own initiative (e.g., certain types of consolidations), or in response to a proposal (i.e., initiated by resolution or petition by landowners or registered voters).

MSRs are exempt from the California Environmental Quality Act (CEQA) pursuant to §15306 (information collection) of the CEQA Guidelines. LAFCo's actions to adopt MSR determinations are not considered "projects" subject to CEQA.

SPHERE OF INFLUENCE UPDATES

The Commission is charged with developing and updating the SOI for each city and special district within the county.¹ SOIs must be updated every five years or as necessary. In determining the SOI, LAFCo is required to complete an.

An SOI is a LAFCo-approved plan that designates an agency's probable future boundary and service area. Spheres are planning tools used to provide guidance for individual boundary change proposals and are intended to encourage efficient provision of organized community services and prevent duplication of service delivery. Territory cannot be annexed by LAFCo to a city or a district unless it is within that agency's sphere.

The purposes of the SOI include the following: to ensure the efficient provision of services, discourage urban sprawl and premature conversion of agricultural and open space lands, and prevent overlapping jurisdictions and duplication of services.

LAFCo cannot regulate land use, dictate internal operations or administration of any local agency, or set rates. LAFCo is empowered to enact policies that indirectly affect land use decisions. On a regional level, LAFCo promotes logical and orderly development of communities as it considers and decides individual proposals. LAFCo has a role in reconciling differences between agency plans so that the most efficient urban service arrangements are created for the benefit of current and future area residents and property owners.

CKH requires LAFCOs to develop and determine the SOI of each local governmental agency within the county and to review and update the SOI every five years. LAFCOs are empowered to adopt, update and amend the SOI. They may do so with or without an application and any interested person may submit an application proposing an SOI amendment.

LAFCo may recommend government reorganizations to particular agencies in the county, using the SOIs as the basis for those recommendations.

In addition, in adopting or amending an SOI, LAFCo must make the following determinations:

- Present and planned land uses in the area, including agricultural and open-space lands;
- Present and probable need for public facilities and services in the area;
- Present capacity of public facilities and adequacy of public service that the agency

¹ The initial statutory mandate, in 1971, imposed no deadline for completing sphere designations. When most LAFCOs failed to act, 1984 legislation required all LAFCOs to establish spheres of influence by 1985.

provides or is authorized to provide;

- Existence of any social or economic communities of interest in the area if the Commission determines these are relevant to the agency; and
- Present and probable need for water, wastewater, and structural fire protection facilities and services of any disadvantaged unincorporated communities within the existing SOI.

By statute, LAFCo must notify affected agencies 21 days before holding the public hearing to consider the SOI and may not update the SOI until after that hearing. The LAFCo Executive Officer must issue a report including recommendations on the SOI amendments and updates under consideration at least five days before the public hearing.

DISADVANTAGED UNINCORPORATED COMMUNITIES

On October 7, 2011, Governor Brown signed SB 244, which makes two principal changes to the CKH. SB 244 requires LAFCos to: (1) deny any application to annex to a city territory that is contiguous to a disadvantaged unincorporated community (DUC) unless a second application is submitted to annex the disadvantaged community as well; and (2) evaluate disadvantaged unincorporated communities in a MSR upon the next update of a SOI after June 30, 2012.

The intent of the statute is to encourage investment in disadvantaged unincorporated communities that often lack basic infrastructure by mandating cities and LAFCos to include them in land use planning.

SB 244 defines a DUC as any area with 12 or more registered voters, or as determined by commission policy, where the median household income is less than 80 percent of the statewide annual median.

SB 244 also requires LAFCos to consider disadvantaged unincorporated communities when developing spheres of influence. Upon the next update of a SOI on or after July 1, 2012, SB 244 requires LAFCo to include in an MSR (in preparation of a SOI update): 1. The location and characteristics of any disadvantaged unincorporated communities within or contiguous to the sphere; and 2. The present and planned capacity of public facilities, adequacy of public services and infrastructure needs or deficiencies including needs or deficiencies related to sewers, municipal and industrial water, and structural fire protection in any DUC within or contiguous to the SOI.

In determining spheres of influence, SB 244 authorizes LAFCo to assess the feasibility of a reorganization and consolidation of local agencies to further orderly development and improve the efficiency and affordability of infrastructure and service delivery. LAFCOs should revise their local policies to include the requirements imposed by SB 244 to ensure they fulfill their obligations under this legislation.

3. OVERVIEW

CALIFORNIA HEALTHCARE DISTRICTS

The Local Hospital District Law was originally enacted in 1945 (Division 23, Section 32000 et seq. of the Health and Safety Code, now referred to as the "Local Health Care District Law"). The law enabled local communities to establish special districts and utilize public financing options for the construction and operation of local community hospitals and healthcare institutions in rural, low-income areas without access to acute-care hospital facilities, and to recruit physicians for medically unserved areas. Formed by voter approval, local hospital districts were empowered to impose property taxes, enter into contracts, purchase property, exercise the power of eminent domain, issue debt, and hire staff.

Following the establishment of local hospital districts in the 1940's and 1950's, many of the previously rural service areas have grown into highly populated urban and suburban communities. The current residents of these urbanized communities may now have multiple options for local and regional healthcare facilities and healthcare service opportunities from both private and public providers.

During the 1970s and 1980s, the nonprofit health care market dramatically changed with the advent of Health Maintenance Organizations (HMOs), which introduced managed care and created large health systems comprised of network-affiliated hospitals, physician groups, and medical service providers that pool resources and direct patients to preferred facilities and groups. The conglomeration of healthcare providers and incentivized patient referrals within affiliated health system networks placed independent fee-for-service hospitals at a competitive disadvantage for attracting patients.

In response to the competitive market environment, the focus of hospital districts expanded from primarily owning and operating local acute-care hospital facilities to also supporting community healthcare and healthcare-related programs and services within their service areas. In 1994, the State Legislature broadened the scope of hospital districts and renamed the statute to its current reference, "The Local Health Care District Law". This action redesignated hospital districts to healthcare districts to better reflect the diverse healthcare services provided, in addition to the operation of local hospital facilities.

The 1994 legislative update also expanded the definition of healthcare facilities as improvements in technology have allowed many medical procedures and services that

previously required acute-care facilities and services to be handled on an out-patient basis. Authorized services granted to healthcare districts under current law includes, but is not limited to:

- Operating healthcare facilities such as hospitals, clinics, skilled nursing facilities, adult day health centers, nurses' training school, and childcare facilities;
- Operating ambulance services within and outside of the district;
- Operating programs that provide chemical dependency services, health education;
- Wellness and prevention, rehabilitation, and aftercare;
- Carrying out activities through corporations, joint ventures, or partnerships;
- Establishing or participating in managed care;
- Contracting with and making grants to provider groups and clinics in the community;
- Other activities that are necessary for the maintenance of good physical and mental health in communities served by the district.

The move towards managed care and large healthcare systems with preferred providers created significant financial sustainability problems for many stand-alone healthcare district hospitals in the State.

While many healthcare districts receive a portion of local property taxes, the enactment of Proposition 13 in 1978 resulted in restricted access to property tax revenues for local public agencies, including healthcare districts. Healthcare districts can utilize bonded debt financing to fund capital projects such as hospital construction. Issuance of General Obligation bonds requires approval by two-thirds of the local electorate, and revenue bonds are backed by user fees. Healthcare districts may also issue promissory notes and receive loans from state and federal governments.

Healthcare districts have generally evolved to meet the changing demands of the healthcare market; however, many have been dissolved, and only about half of the remaining ones still operate hospitals.

To retain their local acute-care hospital facilities and services, many healthcare districts have created nonprofit corporations to transfer or sell their local hospital facilities and/or contract their hospital facility operations with for-profit or nonprofit health systems. The divestitures of district hospital facilities and/or operations are allowed under current law, and approval by local voters is required when certain thresholds of district assets are proposed for transfer or sale.

REGULATORY ENVIRONMENT

Federal

The U.S. Department of Health and Human Services (HHS) is the principal healthcare agency of the U.S. federal government. The Centers for Medicare and Medicaid Services (CMS), a component of HHS, administers Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and most aspects of the Patient Protection and Affordable Care Act (PPACA) of 2010. Medicare and Medicaid together provide healthcare insurance for one in four Americans.

Medicare is a national social insurance program, administered by the U.S. federal government since 1966. Medicare is the nation's largest health insurer, handling more than one billion claims per year. Medicare uses approximately 30 private insurance companies across the United States to provide health insurance for Americans aged 65 and older who have worked and paid into the system. Medicare also provides health insurance to younger people with disabilities, end-stage renal disease, and amyotrophic lateral sclerosis (ALS).

The Social Security Administration is responsible for determining Medicare eligibility and for determining eligibility for and payment of Extra Help/Low Income Subsidy payments. Reimbursement to healthcare providers averages approximately 48 percent of the charges for the patients enrolled in Medicare. The remaining approved healthcare charges are the responsibility of the Medicare patient and are generally covered with supplemental insurance or with another form of out-of-pocket coverage.

Medicaid is a social health care program for U.S. families and individuals with low income and limited resources. Medicaid recipients must be U.S. citizens or legal permanent residents, and may include low-income adults, their children, and people with certain disabilities. Medicaid is jointly funded by the state and federal governments and is the largest source of funding for medical and health-related services for people with low income in the United States. Medicaid is a means-tested program managed by the states, with each state currently having broad discretion to determine eligibility and for implementation of the program. All states currently participate in the program but are not required to do so.

The Patient Protection and Affordable Care Act (PPACA), known as the Affordable Care Act (ACA), is a United States federal statute signed into law by President Barack Obama on March 23, 2010. The ACA is regarded as the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965. Enactment of the ACA was intended to increase the quality and affordability of health insurance, lower the

uninsured rate by expanding public and private insurance coverage, and reduce the costs of healthcare for individuals and the government.

The ACA requires healthcare insurance companies to cover all applicants within new minimum standards and offer the same rates regardless of pre-existing conditions or sex. The ACA introduced mechanisms like subsidies, and insurance exchanges, and restructured Medicare reimbursements.

The ACA expanded both eligibility for and federal funding of Medicaid by qualifying all U.S. citizens and legal residents with income up to 133 percent of the poverty line, including adults without dependent children; however, some states have declined the expansion and continue their previously existing Medicaid eligibility requirements and funding levels.

State

The California Health and Human Services Agency (CHHS) is the state agency responsible for administration and oversight of "state and federal programs for healthcare, social services, public assistance and rehabilitation" in California. CHHS oversees 11 departments and boards, and four offices that provide a wide range of healthcare services, social services, mental health services, alcohol and drug treatment services, public health services, income assistance, and services to people with disabilities.

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

The California Medical Assistance Program (Medi-Cal) is the name of the California implementation of the federal Medicaid program that serves low-income families, seniors, persons with disabilities, children in foster care, pregnant women, and certain low-income adults. Approximately 30 percent of California's population is enrolled in Medi-Cal. Medi-Cal is jointly administered by the California DHCS and the federal CMS, with many services implemented at the local level by the counties of California.

Covered California is the health insurance marketplace in California, the state's implementation of the American Health Benefit Exchange provisions of the PPACA. Beginning in 2014, those with family incomes up to 138 percent of the federal poverty level became eligible for Medi-Cal, and individuals with higher incomes and some small businesses may choose a plan in Covered California with potential federal subsidies.

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

The Alfred E. Alquist Seismic Safety Act of 1983 (California Health and Safety Code Section 129675 et. seq.) provides a seismic safety building standards program under OSHPD's jurisdiction for hospitals built on or after March 7, 1973. The Act was originally established in response to the loss of life from the collapse of hospitals during the Sylmar earthquake of 1971. Following the Northridge earthquake in 1994, Senate Bill (SB) 1953 was enacted, which amended the Alquist Act to require that all licensed acute-care hospitals in California be capable of remaining operational after a seismic event or other natural disaster, with an initial compliance deadline of 2013.

SB 1953 required OSHPD to develop seismic performance categories for evaluating both the seismic resistance of the hospital structures as well as the adequate anchorage and bracing of non-structural features such as electrical, mechanical, plumbing, and fire safety systems for their continued use following a disaster event. Hospitals are required to prepare both a comprehensive evaluation report and a compliance plan to attain the specified structural and nonstructural performance categories.

Subsequent changes to the legislation have established a final compliance deadline of 2030, by which any licensed acute-care hospital facilities not in compliance with seismic safety standards must be replaced or cease acute-care operations.

Private Health Care Providers in the state are licensed and regulated by the California Department of Managed Health Care (DMHC). The DMHC oversees full-service health plans, including all California HMOs, as well as specialized plans such as dental and vision. Health plans are required to apply for and maintain a license from the DMHC to operate as a health plan in California. The DMHC reviews all aspects of the plan's operations to ensure compliance with California law. This includes, but is not limited to, Evidence of Coverage, contracts with doctors and hospitals, provider networks, and complaint and grievance systems. Overall, the DMHC regulates more than 90 percent of the commercial healthcare marketplace in California.

County

The Modoc County Public Health Department (MCPHD), located in the City of Alturas, is responsible for providing a broad range of health and social services in Modoc County that augment the District's care. MCPHD offers a range of services in the areas of behavioral health, public health, and environmental health. These services are rooted in educational opportunities, prevention, testing, and emergency preparedness. While clinical support is available, including immunizations, reproductive health services, and various testing options, the primary focus of the County healthcare system is on informative and preventive care, with an emphasis on community outreach.

4. SURPRISE VALLEY HEALTHCARE DISTRICT

DISTRICT OVERVIEW

The Surprise Valley Healthcare District is comprised of the Surprise Valley Community Hospital (SVCH) and the Surprise Valley Clinic. Located in Cedarville, California in Modoc County, the District is an area roughly 60 miles in length from north to south. This area is considered the "Tricorner Region" of the northeastern portion of the state because of its intersection with Oregon to the north and Nevada to the east. The District covers the entirety of a medically underserved area which is comprised of four towns – Fort Bidwell, Cedarville, Eagleville, and Lake City – along with two Native American groups – the Cedarville Rancheria and the Warner Mountain Indians. Patients are seen from all throughout the county and from parts of Oregon and Nevada as well.

Topographically, this is part of the Sierra Nevada Mountain region. The District sits in the valley, east of the seat of Modoc County which is in Alturas, California. This area is considered part of the Great Basin, east of the Cedar Pass, and extends across most of the northern half of Nevada and into Utah. The majority of the valley is more than 4,000 feet above mean sea level (AMSL) and is described as a high-altitude desert valley with alkaline lakes throughout low-lying areas and forested mountains on the west side of the valley. In the east is the Hays Canyon Range (mostly across the Nevada state line), and the Warner Mountains border the District in the west.

In relation to SVHD, most of the land west of Surprise Valley Road, which is the main north-south highway in the area, is U.S. Forest Service (USFS) land. Most land to the east of the road is owned by the Bureau of Land Management (BLM) and its recreational facilities are generally part of the US Fish and Wildlife Service and Sheldon National Wildlife Refuge in Nevada (formerly called Sheldon Antelope Refuge). There are many opportunities to hike, fish, camp, and mountain bike in the region. Big game and bird hunting are other popular activities for some area visitors. May to June snowstorms are not unusual and the area is home to many hot springs and abandoned mine shafts as well.²

² Modoc County LAFCo, Last Frontier Healthcare District and Surprise Valley Healthcare District MSR, Adopted April 2012.

The District began as Cedarville Hospital in the 1940s. It was closed in March of 1983 by Mercy Hospital in Redding; however, Surprise Valley residents endeavored to form a hospital district. SVHD eventually opened the Surprise Valley Clinic in January of 1985 and then, proceeded to lease the hospital from the County due to the discovery of a lease of the land from the Alice Wylie family that indicated the land could only be used for a healthcare facility. At that point, legislation was introduced by a State Senator requesting \$200,000 in funding to reopen SVCH. While the bill never passed, the money was nevertheless apportioned as a budget item and the money was presented to the District in July 1985. This funding, in addition to the area tax assessment and donations, allowed the hospital to reopen.

Now, SVCH is a critical access hospital (CAH) with 26 beds. It is the smallest hospital in California but still maintains a wide variety of services from outpatient physical therapy to skilled nursing and laboratory services. Despite its size, it does offer 24-hour care and the ability to stabilize critical care patients who can then be flown to hospitals in Redding, California or Klamath Falls, Oregon. There is also provides basic life support ambulance service that is operated on a rotating basis by volunteer first responders in the area.³

See the table in Figure 4-1 below for a summarized profile of the District.

Figure 4.1: Surprise Valley Healthcare District Profile

SURPRISE VALLEY HEALTHCARE DISTRICT			
Contact Information			
Contact:	Frances Hannah, Administrator		
Email:	hannah@svhospital.org		
Mailing Address:	Surprise Valley Healthcare District PO Box 246 Cedarville, CA 96104	Website:	https://www.svhospital.org/
Physical Address:	Surprise Valley Hospital 741 North Main Street Cedarville, CA 96104		
Hospital Phone:	530-279-6115		
Formation Information			
Date of Formation:	1985	District type:	Hospital District
Governing Body			
Governing Body:	Board of Directors	Members:	5
Manner of Selection:	Election	Length of term:	4 years

³ SVHD, <https://www.svhospital.org/about-us/>, 2025.

Meeting Location:	Cedarville Community Hall Bonner St. Cedarville, CA 96104	Meeting date:	4th Wednesday of the month at 1:30 p.m.
Mapping and Population			
GIS Date:	Unknown	Population (2020):	8,700 Modoc County/~1,200 SVHD
Purpose			
Enabling Legislation:	Local Healthcare District Law Health and Safety Code §32000-32492	Empowered Services:	Medical services, emergency medical, ambulance, and services relating to the protection of residents' health and lives
Services Provided	Hospital, 24-hour emergency room, clinic, ambulance, long-term care, dental care		
Area Served			
Size:	3,700 square miles	Location:	Modoc County/Surprise Valley (Ft. Bidwell, Cedarville, Lake City, Eagleville, The Warner Mountain Indians, the Cedarville Rancheria), parts of Oregon and Nevada
Current SOI:	3,700 square miles	Most recent SOI update:	2012
Facilities			
Hospital Name:	Surprise Valley Community Hospital	Location:	741 North Main Street Cedarville, CA 96104
Number of Licensed Beds:	26	Other Facilities:	Surprise Valley Clinic

BOUNDARIES

Altogether, the service area of SVHD covers approximately 3,700 square miles. Its boundaries span roughly 60 miles north-south from Fort Bidwell down to Eagleville along Highway 1. The towns of Cedarville and Lake City are located within these bounds.

Again, this northeastern most portion of the state is referred to as the "Tricorner Region" due to the California state line abutting those of Oregon and Nevada. People from these communities are able to cross the Cedar Pass through the Warner Mountain range to access the district.

As mentioned in the District Overview, the Surprise Valley is east of Alturas, the seat of Modoc County, and is considered part of the Great Basin which is a desert region that covers approximately the northern half of Nevada, stretching into Utah. To the west, most of the land past Surprise Valley Road, a main north-south highway, is forested mountains and belongs to the USFS. On the east side of the road, most of the land is owned by the Bureau of Land

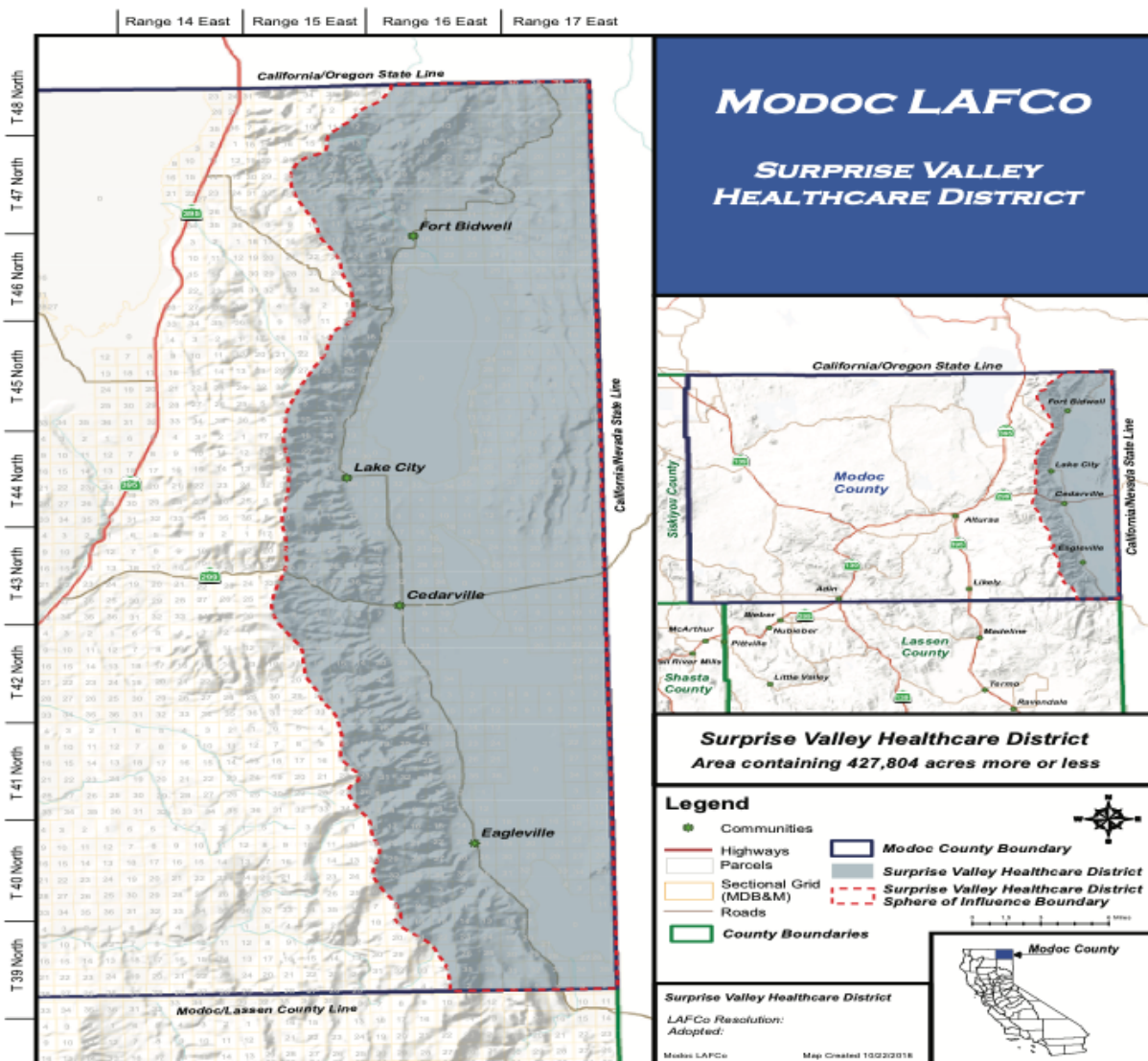
Management (BLM) and includes recreational facilities such as the Sheldon National Wildlife Refuge.

SVHD's current boundaries are shown in Figure 4-2 in the next section.

SPHERE OF INFLUENCE

The District's SOI was reaffirmed in 2012 at the time of the last Municipal Service Review and is coterminous with its boundaries. There has been no indication from the District that any updates are wanted or needed.

Figure 4-2: Surprise Valley Healthcare District Boundaries and SOI



ACCOUNTABILITY AND GOVERNANCE

As a special district, SVHD is a form of local government guided by its own Board of Directors to represent the distinct healthcare needs of its community. The District is governed by a five-member Board elected by the residents of the communities within its boundaries. The Board consists of a president, vice-president, secretary, treasurer, and a board member. The term of office for Board members is four years, and the terms are staggered for election cycles every two years.

Regular District Board meetings are held on the fourth Wednesday of each month at 1:30 pm. These meetings are located at the Cedarville Community Hall at the corner of Bonner and Center Streets, unless otherwise posted, and the public is invited to attend.

Meeting agendas are posted on the District's website in compliance with the Brown Act⁴ (Government Code §§ 54954.2 and 54956), as amended by California Assembly Bill (AB) 2257. This bill governs the location, platform, and methods by which an agenda must be made accessible on an agency's website for all meetings occurring on or after January 1, 2019. This includes requirements for not placing links to agendas in a "contextual menu" (such as a drop-down tab), and that agendas be shared in a publicly accessible physical location at least 72 hours prior to regular meetings and at least 24 hours prior to special meetings. Board approved minutes are also available in the District office and on the District's website.

SVHD maintains a website with various information readily available to the public, as required by the Special District Transparency Act (SB 929), signed into law in 2018. This act requires that special districts in California have websites as of January 1st, 2020. The website is mandated to clearly list the District's contact information in addition to the recommended agendas and minutes, budgets and financial statements, compensation reports, and other relevant public information and documents. A district may be exempt from the law by a resolution adopted by a majority vote of its governing body declaring detailed findings regarding a hardship that prevents the district from establishing or maintaining a website. The resolution must be adopted annually as long as the hardship exists. While the District does abide by some of these mandates, it would need to develop and post more comprehensive financial documents such as an annual budget, an annual report and compensation reports, as well as all completed MSRs, to meet all website requirements pertaining to SB 929.

⁴ California Government Code, Section 54950, commonly known as the "Brown Act" or "Open Meeting Law," establishes requirements and restrictions for meetings of local legislative bodies. The law ensures public access to these meetings, facilitating public participation and promoting transparency in local government decision-making.

Of note, SVHD currently hosts two websites online. The District explained its primary website is www.svhospital.org, and that they have been unsuccessful in removing a second site on Google (<https://sites.google.com/view/svhealthcaredistrict/home>). To eliminate confusion and streamline online traffic, it is still advised that the District pursue avenues to ensure the Google site is removed. Many online search results point to the Google site which can cause confusion, particularly since it is not being updated.

The District's Board and designated staff have completed Form 700 as required by the California Fair Political Practices Commission (FPPC). The District, however, has not yet submitted the completed forms to the FPPC website. Form 700 is a Statement of Economic Interests that is required to be submitted annually by elected officials and public employees who are influential in governmental decisions to allow for transparency and accountability regarding potential personal and financial conflicts of interest.

Ethics training is also required once every two years, beginning with an odd-numbered year (AB 1234, Chapter 700, Statutes of 2005). Training is available online on the FPPC website. The District has indicated that it does not currently engage in ethics and harassment training. It is recommended that all appropriate District staff complete timely ethics training.

SVHD maintains a website with various information readily available to the public, as required by the Special District Transparency Act (SB 929), signed into law in 2018. This act requires that special districts in California have websites as of January 1st, 2020. The website is mandated to clearly list the District's contact information in addition to the recommended agendas and minutes, budgets and financial statements, compensation reports, and other relevant public information and documents. A district may be exempt from the law by a resolution adopted by a majority vote of its governing body declaring detailed findings regarding a hardship that prevents the district from establishing or maintaining a website. The resolution must be adopted annually as long as the hardship exists. While the District does abide by some of these mandates, it would need to develop and post more comprehensive financial documents such as an annual budget, an annual report, and compensation reports, in order to meet all website requirements pertaining to SB 929.

AB 2019, signed into law in 2018 by Governor Jerry Brown, imposes additional posting requirements on California's healthcare districts. Healthcare districts must now post the following information on their websites:

- The district's annual budget
- A list of current board members
- Information regarding public meetings
- Recipients of grant funding or assistance provided by the district
- The district's policy for providing grants or assistance
- Audits, financial reports and MSRs or LAFCo studies, if any, or a link to another government website containing this information

Lastly, there are additional requirements outlined in this bill for healthcare districts that provide assistance or grant funding, which are discussed in more detail in the Service Adequacy section. AB 2019 also requires all healthcare districts to notify LAFCo if they file for bankruptcy.

In order to facilitate communication with the public and encourage voter interest, District staff and Board members actively promote community involvement through various in-person promotional events and trainings such as an annual health fair, Halloween Trick-or-Treating at SVCH, onsite mobile mammograms, and blood pressure checks. This public outreach is primarily conducted online using its own website, an electronic newsletter, and Facebook, LinkedIn, and Nextdoor social media channels.

The public may submit comments or complaints on the District's website through a "Contact Us" link. SVHD indicated that complaints are typically brought straight to the hospital administrator, who handles issues directly. Occasionally, complaints will be brought to the Board first.

The District has demonstrated transparency and accountability throughout the MSR process by responding promptly and thoroughly to requests for information and other means of communication.

DISADVANTAGED UNINCORPORATED COMMUNITIES

LAFCo is required to evaluate disadvantaged unincorporated communities as part of this service review, including the location and characteristics of any such communities.

The purpose of SB 244 (Wolk, 2011) is to begin to address the complex legal, financial, and political barriers that contribute to regional inequity and infrastructure deficits within

disadvantaged unincorporated communities (DUCs). Identifying and including these communities in the long-range planning of a city or a special district is required by SB 244.

Government Code §56033.5 defines a DUC as 1) all or a portion of a "disadvantaged community" as defined by §79505.5 of the Water Code, and as 2) "inhabited territory" (12 or more registered voters), as defined by §56046, or as determined by commission policy. The statute allows some discretion to LAFCOs in the determination of DUCs.

There are ten DUCs within Modoc County, according to its General Plan. Four of these communities are within the SVHD: Cedarville, Eagleville, Fort Bidwell, and Lake City. Also, while not technically DUCs, the tribal lands that are part of the District are considered Disadvantaged Communities (DACs), according to SB535.⁵

GROWTH AND POPULATION PROJECTIONS

Modoc County had a population estimate of 8,700 in 2020, according to the US Census Bureau, equating to 2.2 people per square mile (see figure 4-3). Meanwhile, the General Plan indicates that density can be up to two persons per acre.⁶ There has been a downward trend in the population of the County though, with a decline of 10.2 percent between 2010 and 2020. This trend is expected to continue with the County's population anticipated to decline 23 percent to 6,661 by 2045.

Amongst the four DUCS within the District boundaries, the population is estimated to be 733, according to 2020 census numbers. Additionally, the Cedarville Rancheria and the off-reservation trust land is listed as having a population of 19 in the 2020 US Census. Although the Warner Mountain Indians are not specifically identified as a Native tribe in the census, they are considered part of the Fort Bidwell Indian Community which has a population of 97. For the sake of this section, we will refer to the numbers for the county due to the population within the District being significantly smaller.

Modoc County has an older population with a median age of 49 years which is much higher than both the state and national median of 37.6 and 38.7, respectively. The majority of the population, 75.1 percent, is white, not of Hispanic or Latin background, followed by 15.8 percent being Hispanic or Latino American. The third largest demographic group by race is Indian and Alaskan Native, who represent 5.7 percent of the population. Females constitute 50.4 percent

⁵ ArcGIS, SB535 Disadvantaged Communities layer, updated 2024:

<https://www.arcgis.com/apps/mapviewer/index.html?panel=gallery&layers=15b93bb7650943dab83038359b6240ec>

⁶ County of Modoc, 1998 General Plan – 2018 Update, p. 33.

of the population. Additionally, people over the age of 65 constitute 30.7 percent of Modoc's population which is nearly double that of both the state and the nation which are listed as 15.2 and 16.8 percent, respectively.

The median household income in the District is \$56,648 and 20 percent of the population is living in poverty. Less than half of persons 16 and older, 46 percent, were reported to be in the civilian labor force, likely due to the advanced age of the population within the County. Health data provided by the census shows that 10.9 percent of Modoc County lives with a disability and 8 percent of persons under age 65 do not have health insurance.⁷

Considering declining population projections, an aging county, the District's rural landscape, and lack of employment opportunities, the County's General Plan is essential for understanding growth opportunities. In the most recent plan update, it indicates that any small lot and higher residential land use should be located within existing towns or unincorporated areas, providing attention is given to hazard areas and conservation of open space and wildlife habitats. That said, it is vital that any rural developments can be sustained by the availability of public services and facilities.⁸ Rural, agricultural land use is closely tied to economic viability; therefore, it is important that a balance be struck between the two, although there has been little consensus on how to achieve this. It is recommended, however, to keep small parcels to a minimum, and that 15-20 acre buffering areas should exist between subdivided land while simultaneously developing a right-to-farm ordinance to accompany the buffering policy.⁹

No major development projects within the District are known to be taking place at the time of this report.

Figure 4-3: Surprise Valley Healthcare District Population Estimate 2018-2020

MODOC COUNTY	POPULATION ESTIMATE 1/1/2018	POPULATION ESTIMATE 1/1/2019	POPULATION ESTIMATE 1/1/2020
Alturas	2,734	2,764	2,729
Incorporated	2,734	2,764	2,720
Balance of County	6,209	6,116	5,993
Total County Population Outside of Alturas	8,943	8,722	8,700
Source: California Department of Finance			
Note: years selected to align with the US Census data that was previously referred to from the 2020 census.			

⁷ US Census Data: https://www.census.gov/quickfacts/fact/table/modoccountycalifornia/INC110223?_lang=en.

⁸ County of Modoc, 1998 General Plan - Update 2018, p. 16.

⁹ County of Modoc, 1998 General Plan - Update 2018, p. 30-31.

FINANCIAL ABILITY TO PROVIDE SERVICES

The financial ability of agencies to provide services is affected by available financing sources and financing constraints. This section discusses the major financing constraints faced by SVHD and identifies the revenue sources currently available to the District.

The District's operations consist of grant funding, property tax revenue, income from medical office building leases, interest on investments, and contributions from other public and private sources.

The balance sheets provided by the District and publicly available data showed total operating revenue of \$8,492,396.32 for seven months ending January 31, 2025. Meanwhile, total expenses for the same period were \$6,435,486.77 and the operating income was \$1,669,371.35. Non-operating income is comprised of grants and contributions, \$13,110.00, District tax revenue, \$104,884.04, and investment income, \$1,425.58.¹⁰

FINANCIAL PLANNING AND REPORTING

The California Department of Healthcare Access and Information (HCAI) produces annual financial disclosure reports that provide audited data on hospital revenues, expenditures, net operating margins, and other measures of fiscal performance. HCAI also lists available audits for the District. The audits for Fiscal Year (FY) 23 and FY24 are currently listed as pending.

Healthcare districts are also required to submit annual financial disclosure reports to the California State Controller, which uses the submitted financial data to produce an Annual Special Districts Report that provides detailed financial information by fiscal year regarding special district revenues, expenditures, property taxes, and bonded debt. The IRS also keeps copies of Form 990 available which outlines an organization's eligibility to receive charitable contributions that are tax deductible. The most recent filing available for SVHD is for FY22.

SVHD's internal financial planning efforts are minimal, particularly since the District filed for Chapter 9 bankruptcy in 2018. The District does not maintain a budget, nor do they have a Capital Improvement Plan, Annual Report, or a Comprehensive Annual Financial Review (CAFR).

¹⁰ SVHD, Operating/Income Statement ending 1/31/25.

BALANCED BUDGET

As mentioned, the District does not maintain an adopted operating budget but did provide monthly balance sheets. Its revenue comes from a combination of property taxes, investment income, grants, and contributions for its clinic and the community hospital. Taxes are SVHD's primary source of income while the majority of operating revenue is from inpatient services. According to FY25's income statement, the District's net revenue was \$8,104,858.12 and net income was \$1,614,811.43. In contrast, during FY24, net revenue and net income were \$6,276,615.84 and \$-199,110.00, respectively.

SVHD's leading expense is salaries and wages. In FY23, according to the California State Controller's Office, wages accounted for \$5,291,683.00. By FY24, that figure was \$3,064,184.06, and by FY25, while still the largest percentage of operating expenses, wages had dropped to \$2,944,283.89, a change of roughly 45 percent.

For any agency, recurring operating deficits are a warning sign. In the short-term, reserves can backfill deficits and maintain services. However, ongoing deficits eventually will deplete reserves. In the case of SVHD, their financial position has fluctuated since its bankruptcy filing. Based on financial reports listed on the HCAI website, however, it appears numbers have generally trended in a positive direction/operated in the black year-to-year since 2018.

FUND BALANCES, RESERVES AND LIQUIDITY

Fund balances and reserves should include adequate funds for cash flow and liquidity, in addition to funds to address longer-term needs. As of the most recent balance sheet available at the time of this MSR (March 31, 2025), the District reported \$3,127,545.13 in current assets, of which \$1,312,708.23 was held in cash and cash equivalents. These assets are set against \$7,135,807.71 in current liabilities, resulting in a current asset-to-liability ratio of 43.8%. While cash levels have improved compared to the prior year, the District's reserves are strained, underscoring the need for stronger liquidity planning. For a yearly comparison, see Figure 4-4 below.

Figure 4-4: Surprise Valley Healthcare District One Year Financial Snapshot

SURPRISE VALLEY HEALTHCARE DISTRICT ONE YEAR FINANCIAL SNAPSHOT			
Category	March 31, 2024	March 31, 2025	Difference +/-
Cash & Cash Equivalents	\$704,999.75	\$1,312,708.23	+\$607,708.48
Total Current Assets	\$1,525,370.00	\$3,127,545.13	+\$1,602,175.13
Total Liabilities	\$7,052,401.18	\$7,135,807.71	+\$83,406.53
Operating Income	(\$128,302.50)	\$1,014,279.49	+\$1,142,581.99
Net Revenue	\$8,052,991.43	\$9,149,407.41	+\$1,096,415.98
Total Expenses	\$8,181,293.93	\$8,135,127.92	(\$46,166.01)
Net Income	(\$131,979.80)	\$930,275.03	+\$1,062,254.93

NET POSITION

An agency's "Net Position", as reported in its audited financial statements, represents the amount by which assets (e.g., cash, capital assets, other assets) exceed liabilities (e.g., debts, unfunded pension and OPEB liabilities, other liabilities). A positive Net Position provides an indicator of financial soundness over the long-term.

Monthly balance sheets and publicly reported information are the source of all the financial information for this report. As mentioned, the District does not currently have a budget or other financial documents for reference. Based on the balance sheets, over the course of the year from March 31, 2024 to March 31, 2025, the net position of the District changed from \$227,976.41 to -\$36,873.65. This is due in large part to negative operating income and liabilities, including accounts payable and accrued expenses, that nearly doubled from roughly \$5.5 million and \$12.8 million between April and November of 2024, respectively. There was an immediate negative effect on the District's net position but, in the context of monthly reporting, operating revenue steadily rose from \$301,869.25 in November 2024 to \$10,089,010.96 by April 2025, marking an overall improvement.

PENSION AND OPEB LIABILITIES

Unfunded pension and Other Post-Employment Benefits (OPEB) liabilities present one of the most serious fiscal challenges facing many special districts in California today.

As mentioned above, SVHD has not made any contributions to its retirement or health plans since 2017, after which it filed for bankruptcy. The District stated retirement contributions are voluntary, and they are not participating at this time.

CAPITAL ASSETS

Capital assets must be adequately maintained and replaced over time and expanded as needed to accommodate future demand and respond to regulatory and technical changes.

As a general indicator, the California Municipal Financial Health Diagnostic compares changes in the value of assets and asset improvements.¹¹ Persistent and substantially negative trends, particularly without a reasonable plan for stabilizing declines, raise caution and warning signs. This negative condition can occur if repairs and replacements do not keep pace with aging infrastructure.

Depreciation typically spreads the life of a facility over time to calculate a depreciation amount for accounting purposes. The actual timing and amount of annual capital investments require detailed engineering analysis and will differ from the annual depreciation amount, although depreciation is a useful initial indicator of sustainable capital expenditures.

The District's capital assets include land (which is non-depreciable), as well as buildings, improvements, furniture, and equipment (which all depreciate). Depreciation is reported as part of SVHD's operating expenses. The April 2025 balance sheet indicates that the District had \$8,566,841.81 in total capital assets (depreciable and non-depreciable) with \$4,622,396.15 in accumulated depreciation, resulting in \$3,944,445.66 total net capital assets. Compared to the prior year, the value of total net capital assets increased only slightly by 1.53%.

The District does not have a Capital Improvement Plan (CIP); however, SVHD has stated it received a \$2.5 million grant to pursue seismic compliance for the facilities. Overall facility updates would be completed as part of that work. The District also stated that they already replaced their HVAC system with funds on hand.

¹¹ The California Municipal Financial Health Diagnostic: Financial Health Indicators, League of California Cities, 2014.

HEALTHCARE SERVICES

SERVICE OVERVIEW

Background

After the Cedarville Hospital closed in 1983, the residents created a hospital district to offer much needed care to their outlying community. By 1985, a rural health clinic was opened, however, the fate of the local hospital was embattled between the County Board of Supervisors, the Modoc Medical Center, and Mercy Hospital. Once it was discovered that the deed specified the land could only be used for a healthcare facility though, the County relented and leased the hospital to the District for one dollar per year. Eventually, with donations, a tax assessment, and help from a State Senator who managed to earmark \$200,000 in the budget, enough money was available to remodel and reopen the hospital. Today, the Surprise Valley Community Hospital is the state's smallest Critical Access Hospital.

The District prioritizes its patients' physical emotional and spiritual wellbeing. To achieve this, its mission is to provide an array of services that are safe, high-quality, and provide professional excellence to all while striving to contain costs in a way that will not diminish the high level of services.

Services

The District offers a comprehensive menu of health-related services, ranging from basic needs to ongoing care. Both inpatient and outpatient care are available, and an emergency room is staffed 24 hours a day. Critical patients can be stabilized locally, and air transportation is able to transfer patients to larger nearby hospitals in Redding, CA, Reno, NV, or Klamath Falls, OR. A basic life support ambulance is available 24 hours a day, staffed by volunteer EMTs. In fact, the District indicates many of its staff have become nationally registered EMTs.

Hospital inpatient services include 24-hour coverage for nursing care for acute, emergency, and skilled nursing patients, nutritional needs, and respite care while physical therapy is available Monday through Friday.

At the District's rural clinic, outpatient services are available Monday through Thursday from 9 am to 5 pm and include:

- Telemedicine Appointments

- Family Medicine
- Immunizations
- Wound Care
- Telemedicine Consultations
- Diagnostic and Therapeutic Services
- Physical Therapy
- Diabetic Teaching
- Podiatry Services - one day per month, by appointment only
- Holter Monitoring

Diagnostic services include X-Ray (available Monday through Friday from 8am to 4:30 pm or 24 hours from emergency services), EKG, (available 24 hours as an emergency service) general hematology testing and chemistry testing as well as prothrombin time (available Monday through Friday 8 am - 5 pm or as an emergency service on a 24-hour basis), laboratory, pathology and transfusion services.

The District's skilled nursing facility also incorporates services such as 24-hour nursing care, physical therapy, podiatry, social services, activities, and a dietitian.

SVHD's CHNA describes the District's most requested services as largely being met by offerings already being provided such as emergency services, immunizations, and primary care. In fact, the needs assessment explained that 63% of survey respondents use SVHD or one of its related locations for their primary healthcare needs which emphasizes the loyalty of the residents and their satisfaction with the quality of services they receive.¹²

Considering the small population of the District and its limited funding, SVHD strives to balance the need for services with the types of services that won't compromise the financial sustainability of the District. This can impact offerings such as specialty services but ensures the District is keenly aware of the needs of the community to be able to focus on what results in a cost benefit for patient and provider. One such example is that of Assisted Living and Home Health and Hospice care. These services would help meet the needs of the aging population within the District but are a challenging prospect financially and with respect to the

¹² Surprise Valley Healthcare District, CHNA and Strategic Plan, 2021, p. 14.

ability to provide these services. Pharmacy services is another example that needs to continue to be weighed by the board.¹³

Generally, users are pleased with the services already provided by SVHD; however, in the CHNA, there are areas that patients have identified as needing improvement, including:

- Outreach
- Counseling/Assessment
- Health Education
- Transportation
- Facilitated Enrollment Services for Medicaid

It was also outlined in the CHNA that specific populations within SVHD may not be having their particular needs met and that the District should improve services to do so. Children were listed as number one on this list followed by adults, seniors, women of childbearing age, and people underserved with minimum insurance coverage. These needs should continue to be addressed along with further reviews of the community's desire to add services that do not yet exist within the District as mentioned above, e.g. Home Health and Hospice care.

Lastly, it was determined in the 2021 CHNA that the community was unaware that certain services were provided by the District, such as tele-health and podiatry. Therefore, patients were traveling outside of the service area to fulfill these needs. It is recommended that the District enhance its marketing and outreach efforts to better engage the community. This could be done through creating more active online engagement, offering more mobile clinics, or publicly posting flyers in strategic areas within the District's communities.

Collaboration and Partnerships

Although SVHD encompasses a rural region of the state, that has not limited its ability to pursue collaborative relationships that support healthcare throughout the community. By and large, these are informal relationships rather than contractual agreements. One such partnership is between SVHD and the California Department of Public Health which oversees local health services and provides information, coordination and assistance with matters of public health. Of course, there is also the collaborative relationship between the District's clinic and the hospital to coordinate care.

¹³ Surprise Valley Healthcare District, CHNA and Strategic Plan, 2021, p. 16.

Memberships and Regional Partnerships

SVHD is a member of the California Hospital Association (CHA), an organization that provides information and resources to local hospitals and is dedicated to influencing policy decisions that advocate for better and more accessible healthcare in the state. The CHA also works with the Hospital Quality Institute and the Patient Safety Movement Foundation to share publicly available quality data for its member hospitals.

One of the most notable membership services used by the District is its transportation services. SVHD categorizes available companies in two ways. One is for non-emergent health transport, which is provided by Southern Cascades Community Services District for pharmacy, medical, dental, and vision appointments. The other category is air ambulance membership services which encompasses emergency and acute care needs. Companies providing these services are: PHI Air Medical (based in Redding and Susanville, CA), AirMedCare Network which includes REACH Air and is based out of Redding, CA, and SEMSA Air (based in Susanville and Adin, CA). Use of these services requires coordination with receiving hospital facilities that are outside of the District. For emergent situations, SVHD relies on assistance from first responders who are volunteer firemen from Fort Bidwell, Lake City, Cedarville, and Eagleville. Typically, dispatch services are provided by the County Sheriff's Office.

The District indicated it has applied for and receives grant funding that is responsible for services related to the SVHD ambulance transport. It relies on these monies as well as donations for equipment and ambulances.

According to the 2021 CHNA, the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute collaborate with County Health Rankings. The program they've created awards grants to local coalitions and partnerships. Although this type of grant funding is possible, it appears that the District has never been awarded these funds to date.¹⁴

Contract Services

SVHD has contracts with four physicians on staff. The District did not report any other contract services or formal agreements.

¹⁴ Surprise Valley Healthcare District, CHNA and Strategic Plan, 2021, p. 6.

SERVICE DEMAND

The District was created out of a need for healthcare services to accommodate a rural area in an underserved portion of the state in the County of Modoc. Due to the District's terrain and broad coverage area, other healthcare facilities are not easily accessible to the community. For example, Mercy Hospital in Redding, CA called for the closure of what is now SVCH (formerly the Cedarville Hospital), yet that facility is approximately 170 miles away across mountainous topography. Modoc Medical Center is the nearest hospital facility outside of the District, yet it is still nearly 25 miles away. Eventually, due in large part to community advocacy, the rural clinic opened, followed by the Surprise Valley Community Hospital which is a general acute care hospital that provides 26 licensed beds: 22 long-term care beds and four acute care beds.

As previously mentioned, even though the population projections for the County are expected to decrease, SVHD is still home to one of the oldest populations in the nation with more than 30 percent being over age 65. This certainly affects an ongoing need for healthcare and potentially changing or adding services to accommodate this demographic through home health and hospice needs. Additionally, the CHNA highlights a high ratio of risk factors necessitating care, despite boasting near top ranking physician to population ratios across types of care.

For instance, in Modoc County, adult smoking is 14 percent compared to 11 percent across the rest of the state. Adult obesity is also higher than in California as a whole, with 28 percent of the adult population being obese compared to 24 percent. Excessive drinking is on par with the rest of the state at 18 percent, but alcohol impaired driving deaths are drastically higher at 67 percent versus 30 percent and 11 percent for top performers. Other factors contributing to demand for services are the large percentage of the population that is living in poverty (18.8 percent, 31 percent of which are children), a higher rate of teen pregnancies, and a lack of access to exercise by essentially half compared to the rest of California (46 percent compared to 93 percent). These statistics imply a need for primary care, affordable care, and chronic disease prevention and management.

Hospital Service Demand

Basic utilization data from the Department of Health Care Access and Information (HCAI) is available for the most recent years between 2018 and 2022 (see figure 4-5).

Figure 4-5: Surprise Valley Community Hospital 5 Year Utilization Data

UTILIZATION DATA FOR SURPRISE VALLEY COMMUNITY HOSPITAL FROM 2018-2022					
Utilization Data Type	2018	2019	2020	2021	2022
Licensed Beds	26	26	26	28	28
Discharges	25	51	40	40	65
Patient Days	7,161	6,994	7,756	7,292	8,202
Outpatient Visits	4,464	4,079	4,053	4,533	6,171
Total Full-Time Equivalents	92	40	44	44	37
Surgeries (inpatient and outpatient)	0	0	0	0	0
Avg. Length of Stay (excl. nursery)	286.44	137.14	193.90	182.30	126.18

It should be noted that even though licensed beds increased during 2021 and 2022, more recent HCAI data, including statements directly made by the District, indicates the number of beds has returned to 26.

According to the datasets from July 1, 2021 to June 30, 2022, the majority of inpatient and outpatient revenue comes from Medicare with a fee for service. In general, inpatient revenue was responsible for \$6,582,722.00 during that time frame. This was more than 2.5 times that of outpatient revenue \$2,424,270.00. For inpatient care, the revenue payments represented 27.7 percent, 6 percent more than the remainder of the state, and this number increases significantly to 49 percent for outpatient care which is more than double statewide statistics. Meanwhile, average patient days were also drastically higher than statewide averages, due to Medi-Cal managed care plans which accounted for more than 41 times the average patient days compared to statewide averages. Overall, the average patient days for SVCH were 126.2 versus 6.4 statewide.¹⁵

The data presented indicates a high demand for healthcare services in SVHD as is evident by the dramatic differences compared to averages for statewide care. The reliance on Medicare and long inpatient stays in relation to the rest of the state is particularly significant. This utilization aligns with that of an aging, rural population that is heavily reliant on government funded insurance and likely managing chronic disease or facing the limitations of rural facilities without other places to turn for care. Despite inevitable obstacles to services within the District,

¹⁵ Department of Health Care Access and Information, 7/1/21-6/30/22 reporting timeframe: https://hcai.ca.gov/facility/surprise-valley-community-hospital/?utm_source=chatgpt.com

it is clear that there is an overwhelming need for access to healthcare within the Surprise Valley.

Utilization reports are not available specifically for the Surprise Valley Clinic.

PLANNING AND MANAGEMENT

As part of the District's ongoing strategic planning efforts, the District regularly reviews and utilizes a wide range of information about the communities it serves. SVHD collects and analyzes demographic and market data to assess, evaluate and plan for future health needs in the community. The most recent planning document is its Strategic Plan that was completed in early 2025 and guides long-term goal planning and implementation for the District.

SVHD has completed many documents that provide transparency into how the District operates, especially those which are legally mandated. For example, as mentioned in a previous section, the ACA requires strategic planning documents such as a Community Health Needs Assessment, the most recent of which was published in 2021. The District also submits yearly Form 990 reports, which are required IRS filings relating to its tax-exempt status as a nonprofit entity. The most recent Form 990 was completed for fiscal year ending in June 2023. Additionally, financial balance sheets are posted monthly on its website.

The County of Modoc is considered the land use authority for the area that includes the District. Guided by its General Plan, most recently updated in 2018, it provides a thorough review of long-term planning and implementation policies that impact SVHD with regard to growth and development.

Still, there are opportunities for the District to improve and provide additional documentation that would benefit its transparency and planning efforts. A Capital Improvement Plan is one such document, along with yearly adopted budgets, as previously stated. Annual audits have been conducted in the past, but the report for 2010-2011 was the most current provided.

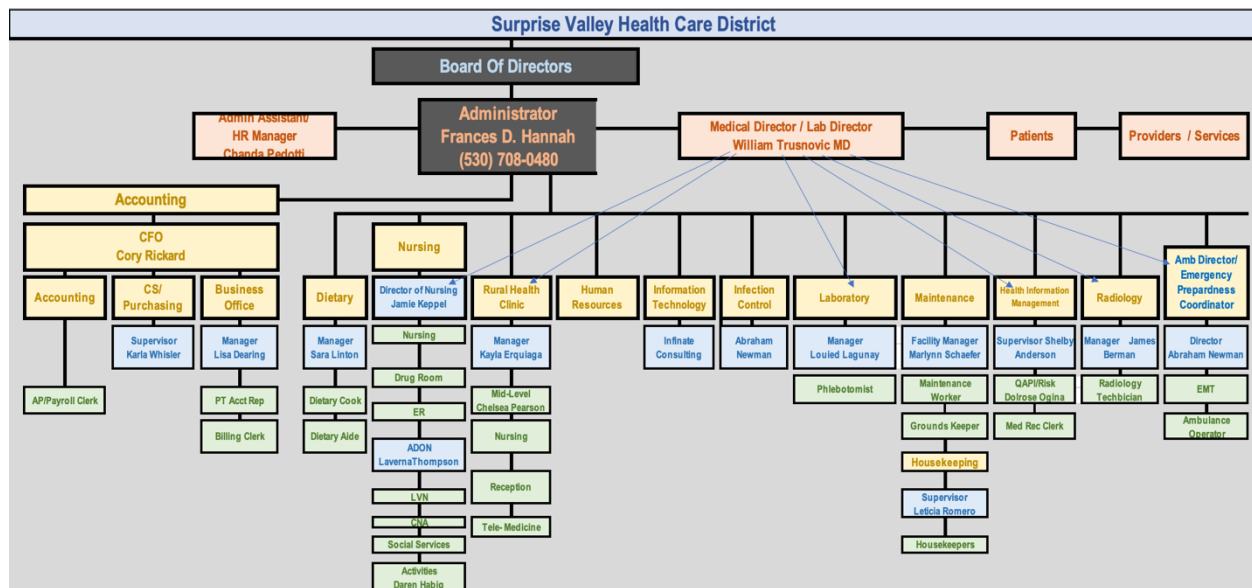
STAFFING

The District indicated it currently employs nearly 37 full-time equivalent staff positions across both the hospital and clinic. This is consistent with the numbers listed in FY22 reports published by the HCAI. The FY22 breakdown classified these positions as follows: 10 licensed vocational nurses, nine administrative staff, eight management staff, five environmental/food services staff, three registered nurses, one technical specialist, and one position listed as "other". As stated previously, four doctors are contracted with the District. Each work eight

hours at the clinic during the week and one physician is always available around the clock to provide 24-hour emergency coverage at the hospital on a seven day rotation.

The District conducts annual employee evaluations for all its staff. The employee's supervisor performs the evaluations in their respective departments. The Board of Directors performs the evaluation of the Administrator. The District's organizational chart is provided in Figure 4-6.

Figure 4-6: Surprise Valley Healthcare District Organizational Chart



FACILITIES

The District operates the 26 bed Surprise Valley Community Hospital. The number of beds includes mostly general beds with four for acute care and one for the emergency room. Original construction was completed in 1952 and renovated under the newly formed healthcare district in 1985.

SVHD also owns and operates a basic life support ambulance, which is made possible by grants and donations to the District.

Seismic requirements exist for all general acute care facilities in California, as outlined in SB 1953. This bill developed compliance deadlines to ensure these facilities would remain operational after an earthquake by January 1, 2030. There are different categories to measure structural (SPC) and non-structural performance (NPC) and they range from 1 to 5, which is the highest level of performance. Figure 4-7 lists the facilities, along with their corresponding

performance category, as determined by the HCAI. There are six buildings associated with the hospital. SVHD specified that the buildings are in good condition and only have typical cosmetic and preventive maintenance needs.

Figure 4-7: Structural Performance Categories for SVCH Facilities

STRUCTURAL PERFORMANCE CATEGORIES FOR SVCH FACILITIES		
BUILDING	CATEGORY	YEAR BUILT
Main Hospital	SPC2, NPC2	1949
Pump House Building	SPC2, NPC2	1949
Heating and Storage Building	SPC2, NPC2	1949
Generator Building	SPC2, NPC2	1970
South Wing Addition	SPC5s, NPC2	1996
Walk-in Box	SPC5s, NPC4	1996

FACILITY SHARING

Being that SVHD is a rural District and provides the only healthcare options in the area, there is currently no reported facility sharing. The Surprise Valley Community Hospital and the Surprise Valley Medical Clinic do not explicitly share facilities — each has its own infrastructure — they are, however, closely connected and are used to coordinate care between inpatient and outpatient needs.

As discussed in the Services section, offerings are continually being considered as to what would best meet the community's needs while balancing costs. That said, if the District were to add Home Health and Hospice care, which is currently provided by California's In-Home Supportive Services (IHSS), that would be an opportunity for resource sharing in partnership with the hospital.¹⁶

INFRASTRUCTURE NEEDS

Infrastructure needs facing the District are minimal and largely due to wear and tear on the facilities. As mentioned above, the significant, ongoing effort is the need to make the buildings compliant with seismic requirements (at least achieving an SPC3 rating) by 2030. The District explained that most other infrastructure needs are cosmetic in nature and will be addressed as the seismic remediation is completed. At present, the District only has a master plan for these seismic requirements and construction has not begun.

¹⁶ Surprise Valley Healthcare District, CHNA, 2021, p. 22

CAPACITY

Based on current demand, the District has sufficient capacity to accommodate service needs. This is exemplified by the 23.15 percent utilization rate as it relates to the District's four acute care beds with a total of 338 inpatient days (in FY22 – the most recent data). Capacity is also affected by the lack of growth throughout the District. Not only is there a declining population, the geography of the region also prohibits substantial development due to the need for appropriate infrastructure access. Based on the utilization rate along with the diminishing growth and population projections, this demonstrates that capacity is sufficient for acute care.

Conversely, the utilization rate across 22 skilled nursing beds was 7,864 patient days (FY22) over the course of the year, leaving a utilization rate of 97.9 percent. This will be a growing concern in the years to come with the District's population aging at a disproportionate rate compared to elsewhere in the country. This indicates the need for the District to reassess services to consider if the burden of long-term and chronic care patients can be met in other ways, such as through home health and hospice care, as previously mentioned.

CHALLENGES

As a rural district, SVHD faces significant financial challenges, highlighted by the bankruptcy proceedings it initiated in 2018. With a limited population and limited room for development, as well as all the towns within the District being DUCs, revenue options are limited, and expenses need to be frequently reviewed and monitored. The District will need to continue working to stabilize its financial situation, perhaps through health system partnerships or state or federal assistance.

Due to its location, staffing is often a serious challenge as well. It is a matter of both finding and retaining staff that is difficult, given the rural lifestyle presented. Hiring people who understand the limitations the geography and financial situation the area presents, and the ability to assimilate in a tight-knit community, all plays a role.¹⁷ Currently, many positions are multi-fold to be able to provide the necessary task coverage. According to the District, this also makes hiring difficult in terms of how to market job listings.

Demographic disparities and healthcare issues identified in previous sections impact the efficiency of the District as well. Again, with a drastically aging population compared to the rest of the country, and higher than average rates of risk factors tied to chronic disease, steps will

¹⁷ Surprise Valley Healthcare District, CHNA, 2021, p. 14.

need to be taken to address preventative measures and partnerships that ease the workload associated with higher hospital utilization rates.

Lastly, the District has concerns that potential cuts to Medicare and Medicaid programs could have a negative impact on its sustainability.

SERVICE ADEQUACY

Grant Funding

Grant funding is a vital method for the District to be able to conduct various infrastructure upgrades to adequately provide services. SVHD stated that grant funding has most recently resulted in the installation of a new and needed HVAC system, as well as new CT scanning equipment. Grant funding is also responsible for the District's ability to undergo facility upgrades to meet seismic requirements.

Hospital Services

There are several benchmarks that may define the level of healthcare service provided by a hospital. Indicators of service adequacy discussed here include 1) Prevention Quality Indicators (PQIs), 2) Inpatient Mortality Indicators (IMIs), 3) hospital volume indicators, 4) Emergency Medical Services (EMS) ambulance diversion rates, 5) the extent to which residents go to other hospitals for service, 6) patient satisfaction, 7) hospital safety, and 8) accreditation.

As discussed in the service demand section, according to the District's CHNA, there are several areas where SVHD's population falls above average for health risks, correlating to the potential for more needed care.

The HCAI has compiled a variety of data across California hospitals including the types and number of medical procedures based on information provided from inpatient quality indicators, HCAI patient discharge data, and the Agency for Healthcare Research and Quality (AHRQ). For example, in the five years from 2010 to 2015¹⁸, no procedures were done at SVCH for 6 types of procedures including, esophageal resection, abdominal aortic aneurysm (AAA) repair, coronary artery bypass graft surgery (CABG), percutaneous coronary intervention (PCI), and carotid endarterectomy.

Rates of preventable hospitalizations are also listed by county in HCAI data. Conditions that are tracked include:

¹⁸ Note: 2015 data is for the months of January through September - coding changes took place beginning in October and therefore, reflects a shorter time frame of comparison as well as a more accurate procedural analysis.

- Diabetes short-term complications
- Diabetes long-term complications
- Chronic obstructive pulmonary disease (COPD) or asthma in older adults (age 40 and over)
- Hypertension
- Heart failure
- Community-acquired pneumonia
- Urinary tract infection
- Uncontrolled diabetes
- Asthma in younger adults (age 18-39)
- Lower-extremity amputation among patients with diabetes

Based on these categories, rates of these conditions were consistent with elevated risk factors for the population of SVHD as described in the CHNA. This includes increased levels of smoking, older adults, and obesity throughout the District. This is most apparent in terms of COPD or asthma, which has an observed rate that is 188.5 percent more than statewide figures and a 33 percent higher risk adjusted rate.¹⁹ This is particularly notable considering the obviously vast difference in the size of the two populations. Also, considering these are generally preventable chronic diseases, the data could suggest that early interventions in terms of preventive care and informational resources might help reduce these statistics. Four of the PQIs and how they compare to statewide statistics are shown in the following Figure 4-8.

¹⁹ AHRQ Prevention Quality Indicators (PQIs), 2023.

Figure 4-8: Surprise Valley Healthcare District PQI Comparison Chart

PERFORMANCE QUALITY INDICATORS		MODOC COUNTY	STATEWIDE
Diabetes Short-Term Care	Cases	0	21,485
	Population	6,906	30,519,524
	Observed Risk	0	70.4
	Risk Adjusted Rate	0	72.3
Diabetes Long-Term Care	Cases	2	33,067
	Population	6,906	30,519,516
	Observed Risk	29	108.3
	Risk Adjusted Rate	15.2	114.9
COPD or Asthma in Older Adults (40+)	Cases	20	24,904
	Population	5,145	18,484,430
	Observed Risk	388.7	134.7
	Risk Adjusted Rate	214	144.1
Hypertension	Cases	1	14,944
	Population	6,906	30,519,524
	Observed Risk	14.5	49
	Risk Adjusted Rate	7.3	52.2

IMIs reflect quality of care by measuring inpatient mortality rates for individual hospitals against state averages for specific medical conditions and surgical procedures. Evidence suggests that high mortality rates may be associated with deficiencies in the quality of hospital care provided. In the case of SVHD, IMIs are not available. HCAI explains that, as of 2022, the most recent reporting data available, AHRQ software does not report results for IMIs if a given hospital has fewer than three cases for all indicators.²⁰ Those indicators are comprised of:

²⁰ HCAI, <https://data.chhs.ca.gov/dataset/california-hospital-inpatient-mortality-rates-and-quality-ratings/resource/f8f27af4-35f0-4d90-966b-e79272f53c8>, pgs. 10-11

Five surgical procedures

- Abdominal aortic aneurysm repair – open and unruptured
- Abdominal aortic aneurysm repair – endovascular and unruptured
- Carotid endarterectomy
- Pancreatic resection
- Percutaneous coronary intervention

And six medical conditions

- Acute myocardial infarction
- Acute stroke
- Acute stroke, hemorrhagic
- Acute stroke, ischemic
- Acute stroke, subarachnoid
- Gastrointestinal hemorrhage
- Heart failure
- Hip fracture
- Pneumonia

The ambulance diversion rate is another indicator of a hospital's service adequacy. Ambulance diversion may occur due to emergency room closure, inability to accommodate the incoming volume of patients or the inability to transfer admitted patients from the emergency department (ED) to inpatient beds. Ambulance diversion has been found unsafe for patients because it increases transport times, which interferes with continuity of care, causes delays, and increases mortality for severe trauma patients.²¹

According to California's open data portal for emergency department services trends for 2013-2017 (most recent statistics), SVCH had no ambulance diversion hours, indicating the hospital's ED was always able to accommodate the incoming volume of patients.²²

²¹ Reducing Ambulance Diversion in California: Strategies and Best Practices, California Healthcare Foundation, July 2009 <https://www.chcf.org/wp-content/uploads/2017/12/PDF-ReducingAmbulanceDiversionInCA.pdf>

²² State of California, www.ca.gov, <https://lab.data.ca.gov/dataset/emergency-department-services-trends/7840bcc0-bf99-4992-bfda-72e0897b47bd>, data tab.

The adequacy of hospital facilities and services in meeting the needs of district 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 origin and market share data from the California Health and Human Services (CHHS) open data portal. Here, it indicates that 6,781 patients were treated in Modoc County in 2023, of which 672, or 9.9 percent, originated in one of the four communities within the District. Primarily, these patients originated in Cedarville (451 patients), and Fort Bidwell (123 patients). In total, 513 patients were cared for at SVCH during 2023, the date of the most recently reported data. These numbers were similar in 2022, although elevated compared to 2020 and 2021, likely due to challenges associated with the COVID-19 pandemic (see figure 4-9).

Figure 4-9: Surprise Valley Healthcare District Patient Origin Data

PATIENT ORIGIN IN MODOC COUNTY				
Zip Code/City	2020	2021	2022	2023
96104/Cedarville	271	349	450	451
96110/Eagleville	38	34	23	30
96112/Fort Bidwell	80	100	79	123
96115/Lake City	36	35	44	68

There are multiple ways hospital performance is evaluated. Medicare, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) as well as Cal Hospital Compare each have a reporting system that reports data regarding clinical care, patient safety, and patient experience. In the case of Cal Hospital Compare, their reporting initiative was established to develop a statewide reporting system using public data for all acute care hospitals in California. As with IMIs, however, there is no data available for SVCH likely due to not meeting the reporting requirements. For HCAHPS, for example, hospitals need a minimum of 25 surveys completed over the course of a four-quarter period to be publicly reported.²³

Patient safety indicators (PSIs) are recorded by a number of entities, including AHRQ and the Leapfrog Group which is an independent nonprofit organization that provides hospital safety grading. It bases its scores on infection rates, problems with surgery, safety issues, and the

²³ HCAHPS, <https://hcahpsonline.org/en/technical-specifications>

performance of doctors, nurses, and hospital staff. The Leapfrog Group states that SVCH did not participate in its ratings survey.

There are several major healthcare-related accreditation organizations in the United States, including 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 JC 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 JC is part of the joint survey process with State authorities. Hospitals are not required to be accredited in order to operate, however. Accreditation generally recognizes outstanding performance by a healthcare provider.

SVCH is accredited by the state of California as a general acute care hospital. It is also accredited as a Critical Access Hospital (CAH) for Medicare and by CARF Inpatient Rehabilitation (the Commission On Accreditation Of Rehabilitation Facilities Inpatient Rehabilitation).

SURPRISE VALLEY HEALTHCARE DISTRICT MSR DETERMINATIONS

GROWTH AND POPULATION PROJECTIONS

- The population of SVHD is roughly 1,200, compared to 8,700 for Modoc County as a whole, with growth projections expected to decline 23% by 2045.
- The District's demographics pinpoint a median age of 49 that is much higher than both the state and national median and in general, it's a population at higher risk of many preventable and chronic conditions. This means that with the anticipated increase of an elderly population prone to health issues, comes changing needs related to healthcare. SVHD will need to be proactive to address this, perhaps considering more services related to home care and long-term care.

THE LOCATION AND CHARACTERISTICS OF DISADVANTAGED UNINCORPORATED COMMUNITIES WITHIN OR CONTIGUOUS TO THE AGENCY'S SOI

- SVHD is in a medically underserved area. Each community within the District is considered a DUC.

PRESENT AND PLANNED CAPACITY OF PUBLIC FACILITIES AND ADEQUACY OF PUBLIC SERVICES, INCLUDING INFRASTRUCTURE NEEDS AND DEFICIENCIES

- Present capacity of the District's services considered sufficient with a 23.15% utilization rate among 4 acute care beds, however, when skilled nursing beds were considered, the utilization rate is a concerning 97.9%.
- Services will need to be assessed. Adding home health and/or hospice care will need to be considered by the District to address the long-term and chronic needs of an aging population. These evolving needs will need to be weighed against the financial constraints of the District, however.
- SVHD is currently providing adequate services and is, by all accounts, considered a much-needed part of the community despite its limitations.

- The amount of cosmetic infrastructure needs for the District are minimal and mostly considered part of typical maintenance due to wear and tear. What is needed to achieve seismic compliance, however, is significant, with a \$2.5 million dollar grant allocated for this undertaking. Currently, SVHD has developed a master plan for these upgrades and steps should be taken to reach the next phase of the project.

FINANCIAL ABILITY OF AGENCIES TO PROVIDE SERVICES

- The District currently has sufficient financial ability to provide services. Since filing for Chapter 9 bankruptcy, SVHD's financial improvement has been encouraging. Considering ongoing challenges, however, careful oversight and continued strategic planning remain necessary to ensure the District's long-term stability and sustainability. To start, SVHD should develop and provide detailed financial documents such as an annual budget, an annual report, audits, and a Capital Improvement Plan to better view the overall financial health of the District.
- SVHD is not unlike other rural healthcare districts with the difficulties it faces, whether it is funding, a decreasing and aging population, or retaining staff. Despite these realities, the District will need to address ways to stabilize its financial situation, build up reserves, and evaluate the ability to once again fund for OPEB. Long-term, state or federal assistance programs should be evaluated to determine the benefits to District operations.
- The District is currently still in bankruptcy and indicated it is possible they will be out of bankruptcy by the end of the year. There is no firm deadline, however, so it remains imperative that SVHD continue to follow the steps outlined in their bankruptcy plan.

STATUS OF, AND OPPORTUNITIES FOR, SHARED FACILITIES

- SVHD does not currently share facilities, although the clinic and the hospital have a collaborative relationship. There is potential to collaborate with an entity like Modoc Medical Center by inviting them into the District in a way that is mutually beneficial.

ACCOUNTABILITY FOR COMMUNITY SERVICE NEEDS, INCLUDING GOVERNMENTAL STRUCTURE AND OPERATIONAL EFFICIENCIES

- The District mainly conducts outreach via its website and social media. It makes information and documents available to the public and partakes in in-person events to

encourage community involvement. Magnifying these efforts to make SVHD's offerings more widely known and to reach the most at-risk populations within the District is still recommended, however.

- The website complies with most SB 929, AB 2257, and AB 2019 requirements, however, SVHD should also develop and make additional documents available online such as an annual budget, an annual report, and a capital improvement plan to ensure all legislative requirements are met. All previously completed MSRs, current Strategic Plans, CHNAs, and similar documents should be updated online as well. Additionally, the District should take steps to discontinue hosting the outdated Google site to ensure it is removed from search engine results and that all traffic is directed to www.svhospital.org.
- The District stated that all board members and necessary staff have completed Form 700. However, these forms are not available on the California Fair Political Practices Commission website. It is advised that current forms be submitted and that future forms are provided in a timely manner annually. This applies to submitting Form 990 as well.
- Accountability is best ensured when contested elections are held for governing body seats, constituent outreach is conducted to promote accountability and ensure that constituents are informed and not disenfranchised, and public agency operations and management are transparent to the public. The District demonstrated accountability with respect to these factors and was eager to assist in the MSR process.