Joint Planning Committee

AHS - City of Alameda Health Care District

Date: March 23, 2023

Time: 4 - 6 p.m.

Location: Alameda Hospital Admin Conference Room

Join Zoom Meeting
https://us02web.zoom.us/j/84675758325?pwd=akZCZDZKai9iaXJCSTMwVnRxTGdyZz09
Meeting ID: 846 7575 8325
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Dial by your location
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<table>
<tr><td>District Board:
Dr. Robert Deutsch – President
Gayle Codiga - 1st Vice President
Debi Stebbins - Executive Director</td><td colspan="2">Alameda Health Systems:
Jeanette Dong - AHS Chief Strategy Officer
Richard Espinoza - AHS CAO Post-Acute Services Mark Fratzke - AHS COO
Mark Friedman - AHS Board of Trustees
Eric Gulley - Director of Business Intelligence
Mario Harding - AHS CAO Community Hospitals
James Helena - AHS Director of Facilities
Kimberly Miranda - AHS Chief Financial Officer</td></tr>
<tr><td>District Board / AHS Liaison:
David Sayen</td><td colspan="2">Alameda Health System Fellows:
Ashley Brizuela
Ethan Torrence</td></tr>
<tr><td>Alameda Hospital Medical Staff:
Dr. Nikita Joshi - AH Chief of Staff and Medical Director of AH ED
Dr. Pirnia - Orthopedic Surgeon and AH Vice Chief of Staff
Dr. Tamina Isolani- Nagarvala - AH Hospitalist Medical Director</td><td>Consultants:
Katy Ford - Ratcliff Architects</td><td>Community Representatives:
Rowena Manlapaz -</td></tr>
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1. Call to Order — Dr. Robert Deutsch, Mark Fratzke
2. Approval of Meeting Minutes from January 26, 2023, ENCLOSURE — Dr. Robert Deutsch
3. Attendance Requirements Under Terminated State of Emergency — Debi Stebbins
4. AHS Strategic Program Consideration — Mark Fratzke
5. Sources for Financing 2030 Retrofit — All
6. Status of Alameda Hospital Capital Projects — Mario Harding
   A. South Shore Convalescent
   B. HVAC System – Surgery

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7. Frequency of Future Meetings

8. Adjournment — Dr. Robert Deutsch

Joint Planning Committee Minutes
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District Board: Dr. Robert Deutsch – President Gayle Codiga - 1st Vice President Debi Stebbins - Executive Director	**Alameda Health Systems:** Jeanette Dong - AHS Chief Strategy Officer Richard Espinoza - AHS CAO Post-Acute Services Mark Fratzke - AHS COO Mark Friedman - AHS Board of Trustees Eric Gulley - Director of Business Intelligence Mario Harding - AHS CAO Community Hospitals James Helena - AHS Director of Facilities Kimberly Miranda - AHS Chief Financial Officer - (Absent)
District Board / AHS Liaison: David Sayen	**Alameda Health System Fellows:** Ashley Brizuela Ethan Torrence
Alameda Hospital Medical Staff: Dr. Nikita Joshi - AH Chief of Staff and Medical Director of AH ED Dr. Pirnia - Orthopedic Surgeon and AH Vice Chief of Staff	**Consultants:** Katy Ford - Ratcliff Architects

Agenda Item/Topic	Presentation and Discussion Notes	Action/Follow-Up
Call to Order	The meeting was called to order at 4:05 pm by Dr. Robert Deutsch. Dr. Deutsch suggested that the committee also consider the short-term planning needs that involve major capital expenses and policies.	
Introductions	Each attendee briefly introduced themselves and their role.	

Joint Planning Committee Minutes
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Joint Planning Committee History	Ms. Stebbins reviewed the History of the Joint Planning Committee between AHS and the Alameda Health Care District. The June 2020 report provided in the agenda was approved by the District prior to the committee's hiatus. Ms. Stebbins informed the group that the original charge of the committee was to; "review current and future capital, and operational needs and service demands as well as possible sources and applications of funds. The intent is to address the health care needs of the residents of Alameda consistent with the mission operational capacity and fiscal constraints of both the Health Care District and the Health Care System." There were two complete studies done by the previous committee members: 1. Kaufman Hall Study: This study projected acute bed needs by 2030 based on population projections, demographic trends and the expectation that health care delivery will continue to shift from inpatient to outpatient in the future. The conclusion based on the previous 2018/2019 utilization was that; in 2029 there would be a need for 25 acute care beds at Alameda Hospital. It was noted that the average census at Alameda Hospital currently exceeds that projection. About one third of the patients in acute care are admitted through the ED. It is noteworthy that there about six skilled nursing facilities on the island; when those patients need acute hospitalization, they are admitted though the ED Therefore, there is a higher percentage of admissions through the ED than an average community hospital would have 2. Ratcliff Architects: The District Board commissioned Ratcliff to complete an assessment of the four buildings at the Alameda Hospital Campus. The Ratcliff study at that time resulted in a plan that would put all acute care services and supporting departments that are required under Title 22 into the South Wing, a building that is already compliant with 2030 SPC standards. The South Wing, built in 1983, is the newest building on the Alameda Hospital Campus and is compliant with all 2030 SPC structural requirements. Ratcliff projected a project cost of $200 M. - It was felt that this approach would not only be prohibitively expensive and also operationally so disruptive that closure of the hospital would probably be required during construction. Four Recommendations were referred to at both the District and AHS Boards at the conclusion of the first Joint Committee's work:1. Review and Approval by Both Boards: 2. Legislative Advocacy Effort with the Support of AHS:	

	The goal was to modify the nature of the requirements for 2030. Alameda Hospital is not the only hospital facing the possibility of closure in 2030 if the requirements are not met. There have been efforts including the possibility of extending the deadline, however that is not always a guarantee. 3.Exploring New Programs: To increase the utilization of Alameda Hospital and to meet the needs of what is provided on the island. Such as a Geriatric Med-Psych Unit and a Certified Geriatric ED. Service Line Distribution and Optimization AHS management could expedite the strategic planning efforts and look at distribution of services within the AHS system that utilized both the strengths of AHS and Alameda Hospital. Although circumstances are very different than in 2020 the charge seems to be still very fitting for this time.	

Joint Powers Agreement	Ms. Stebbins reviewed the history of the District's search for an appropriate affiliation partner that began in 2012.The District realized it could not survive as a standalone hospital, and needed access to capital, Being the only hospital on the island created a situation of vulnerability for residents of Alameda in the case of a disaster. AHS and the District have a common mission and vision and it is far easier legally to create an affiliation with two public entities. The terms of the JPA provide that AHS would fund the 2020 seismic requirements, the largest being moving the kitchen to the Stephens Wing. This also included moving everything out of the administration building. AHS took over hospital operations and the license, but the District retains ownership of the real property. AHS could determine what capital contributions they wanted to make beyond the yearly Parcel Tax contribution. Ms. Stebbins added that AHS has no obligation to fund the 2030 seismic requirements. AHS also agreed that they would not reduce the number of AHS licenses to less than 50 beds or eliminate or close the basic emergency department without the consent of both parties. Dr. Deutsch added that the affiliation created political support for the County safety net which has been beneficial to AHS. There was a ballot measure in Alameda County to "leavy a 0.5 percent sales tax throughout the county to fund operations at the County Healthcare System which included Highland Hospital and AHS. The measure did pass by a two thirds majority. Alameda Hospital now serves overflow patients from Highland when, as is often the case, the census there is at capacity. The bed capacity at Highland Hospital does not meet the needs of the community. However, through the affiliation, patients can be assisted at Alameda and San Leandro Hospitals. Overall, this has been a mutually beneficial affiliation. There was a suggestion that it could be part of the work of the Joint Planning Committee to evaluate whether the JPA terms have been successful for both organizations.	
Review of Architectural Options	Ms. Katy Ford, partner at Ratcliff Architects, presented an overview of the four main buildings at Alameda Hospital. The administration building has been decanted, the bridge that connected it to the Stephens Wing has been removed. The Stephens Wing and West Wing have been updated to SPC 2 (is compliant until 2030). The South	

Wing is updated to SPC 3 and is 2030 compliant. There will be some required NPC upgrades in the South Wing. There will also be a requirement for a larger septic tank and a larger emergency water storage tank.

Ms. Ford noted that it wasn't feasible to combine everything into the South Wing; a new central plant would have to be built and everyone would have to be relocated.

The projects have been grouped into the following:

1) Upgrade Stephens Wing to SPC-4D- Seismic Upgrade
2) Upgrade West Wing to SPC-4D Seismic Upgrade
3) NPC 10,000 Gallon Sewer Holding Tank
4) NPC 5 – Emergency Generator
5) NPC 4 Upgrade

Ms. Ford noted tackling number 1 first due to it being a larger project and taking more time.

Ms. Stebbins presented the four options to Upgrade the Campus. There may well be additional options but this provides alternatives that result in different inventories of acute and long-term care beds.

1) Not to Upgrade the Stephens Wing – Relocating the Kitchen and Displacement of South Wing Operations. This was determined not to be a reasonable option given its cost.

   Estimation 82-100 Million

2) Upgrade the Stephens Wing and Keep the Existing Bed Configuration

   This does not add any capacity for Skilled Nursing beds.

   Estimation 52-60 Million

3) Converting the 29 Med Surg Beds in the Stephens Wing to SNF Beds

   The ADA requirements would change, rooms need to be larger, there would be an increase in the number of bathrooms to rooms.

   Estimation 62-75 Million

4) Maximize SNF Long term care.

   Estimation 100-120 Million

	Ms. Stebbins noted that this is similar to an approach taken at Seton coast side, another remotely located facility which has permission from the State to operate a small acute care unit associated with a large hospital based SNF and an Emergency Department. Ms. Stebbins stated alternatives can be added or subtracted. The goal is to get down to a manageable project which provides the right complement of beds to support the AHS system and serve the Alameda community. Mr. Harding added that there are also additional upgrades that need to be taken into consideration. The cooling towers and chillers that impact the surgery suits need to be updated. Mr. Harding also noted that as of March 2020 the Sterile Processing Unit had been discontinued at the Alameda campus and is managed by the Highland Campus. Mr. Harding noted that to update the Sterile Processing Unit would cost an estimated 6-8 million dollars. A final infrastructure report will be coming in February 2023. Mr. Fratzke added that by the end of March 2023 there will be a portable Sterile Processing Unit at the San Leandro hospital that can service all of the OR needs for San Leandro and Alameda Hospitals. Mr. Fratzke added that there is also approximately $1 million being spent to repair and renovate the South Shore SNF. Dr. Pirnia noted it is becoming increasingly challenging to use the operating rooms at Alameda Hospital given these issues. The Sterile Processing issue is a large problem due to the requirements to use as little flashing as possible. This limits the number of cases physicians can perform to meet those requirements. There is a degree of uncertainty when coming to the hospital if physicians can operate and remain in the parameters. Dr. Pirnia also noted the OR size should be taken into consideration as equipment is getting larger. Mr. Helena added that the building needs to be brought up to speed. Along with updating the chillers and cooler, the temperature and humidity need to be able to be adjusted without human intervention. These are some capabilities that are provided at Highland.	
Advocacy Efforts	Ms. Stebbins informed the group the District has been active in their advocacy efforts. AB 2904 was approved by both houses without objection. This bill would have given an extension of time however, the governor vetoed the bill two days before signatures were due. The Governor does not like one off legislation that would make an exception for one entity.	

	The District is working with the state and assemblymen on another bill that would grant a time extension to hospitals. Ms. Stebbins informed the group that funding is the biggest concern of the Committee. Districts are legally subdivisions of the state. Districts and public institutions have to go back to voters to get funding for these projects.	
Data Overview Administrative Fellows	Mr. Torrence presented the statistical data that he and Ms. Alvarez gathered from Epic EHR and Power BI Dashboards. Mr. Torrence highlighted some of the facts of Alameda Hospital - There are 66 General Acute Beds - 58 Unspecified GAC Beds - 8 Coronary Care Critical Care Unit Beds) The volume of patients at Alameda Hospital for 2022 was 25,662 patients' days with 2,711 inpatient admissions. This compares to San Leandro Hospital with about 37,000 patients' days. The average daily census was 43.2 which is about a 65 percent occupancy rate compared to San Leandro Hospital with 42.2. The Case Mix at Alameda Hospital is 1.29 compared to 1.28 San Leandro Hospital. - The Length of stay at AH is 5.1 which is on par to Highland Hospital, San Leandro Hospital has an average length of stay of 4.2 days. - The payor mix for all inpatient admissions was 42.9% Medicare and 17.8 % Medical Managed Care. - Transfers to Alameda Hospital totaled 675 with a large majority coming from Highland Hospital. Compared to San Leandro's 606 transfers. - Transfers out of Alameda Hospital totaled 340 compared to San Leandro Hospital with 522, with a majority going to Highland Hospital. Many of the transfers from San Leandro to Alameda are from ED to ED. If there is a stroke patient that comes into San Leandro they are transferred to Alameda because of the stroke program. Dr. Deutsch made a motion to have Dr. Isolani to join the Committee, the motion was unanimously carried. Dr. Deutsch suggested the committee meet every two months.	Follow up with data to see where each transfer is coming from

Joint Planning Committee Minutes
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Next Meeting
Date: March 23, 2023
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Confernce Room

Minutes submitted by: Alix Williams, Clerk of the District Board of Directors.

Approved: _____

March 15, 2023

Memorandum to: AHS-City of Alameda Health Care District
Joint Planning Committee

From: Debi Stebbins
Executive Director
City of Alameda Health Care District

RE: AB 869 (Wood)

Attached is a bill introduced by Assemblymember Wood (AB 869) which currently provides for a 5-year extension to the 2030 seismic retrofit deadline for District hospitals that meet certain criteria. It is expected that the bill will undergo several amendments. The bill has been crafted by the Association of California District Hospitals (ACHD) and so far, has the support of SEIU.

I plan to review the terms of the bill as they relate to Alameda Hospital at our Joint Planning Meeting on March 23, 2023.

AB-869 Hospitals: seismic safety compliance. (2023-2024)

Date Published: 03/07/2023 09:00 PM

AMENDED IN ASSEMBLY MARCH 07, 2023

CALIFORNIA LEGISLATURE— 2023–2024 REGULAR SESSION

ASSEMBLY BILL NO. 869

Introduced by Assembly Member Wood

February 14, 2023

An act to add Section 130078.5 to, and to add Chapter 1.6 (commencing with Section 130080) to Part 7 of Division 107 of, the Health and Safety Code, relating to hospitals.

LEGISLATIVE COUNSEL'S DIGEST

AB 869, as amended, Wood. Hospitals: seismic safety compliance.

Existing law requires, no later than January 1, 2030, owners of all acute care inpatient hospitals to either demolish, replace, or change to nonacute care use all hospital buildings not in substantial compliance with specified seismic safety standards or to seismically retrofit all acute care inpatient hospital buildings so that they are in substantial compliance with those seismic safety standards. Existing law requires the Department of Health Care Access and Information to issue a written notice upon compliance with those requirements.

Existing law establishes the Small and Rural Hospital Relief Program under the administration of the Department of Health Care Access and Information for the purpose of funding seismic safety compliance with respect to small hospitals, rural hospitals, and critical access hospitals in the state. Existing law requires the department to provide grants to small, rural, and critical access hospital applicants that meet certain criteria, including that seismic safety compliance, as defined, imposes a financial burden on the applicant that may result in hospital closure. Existing law also creates the Small and Rural Hospital Relief Fund and continuously appropriates the moneys in the fund for purposes of administering and funding the grant program.

Existing law provides for the formation and administration of health care districts.

This bill would require the department to give first priority to grants for single- and 2-story general acute care hospitals located in remote or rural areas with less than 80 general acute care beds and general acute care hospital revenue of $75 million or less. The bill would require grants under the program to provide general acute care hospitals with funds to secure an SPC-4D assessment for purposes of planning for, and estimating the costs

acute care hospitals to apply for a grant for purposes of complying with those seismic safety standards.

The bill would delay the requirement to meet those and other building standards for specified general acute care hospitals until January 1, 2035, and would exempt a general acute care hospital with an SPC-4D assessment and with a certain estimated cost from those seismic safety standards if the department determines that the cost of design and construction for compliance results in a financial hardship for the hospital and certain funds are not available to assist with the cost of compliance.

The bill would also authorize a health care district *that meets certain criteria* to submit financial information to the ~~department~~ *department, on a form required by the department,* to allow the department to determine if the health care district is financially distressed and if so, would allow the health care district to apply for a grant for the purpose of meeting those seismic safety standards. ~~The bill would require a health care district to provide financial information to the department for the purposes of, among other things, demonstrating whether the health care district has attempted to secure other methods of funding, prior to being awarded state funds.~~ The bill would delay the requirement to meet the seismic safety standards until January 1, 2035, for a health care district that qualifies for those grants. The bill would exempt a health care district hospital from those requirements until funds are made available to meet those requirements if the department determines that the cost of design and construction for compliance with those requirements results in a financial hardship that may result in hospital closure.

The bill would require, by January 1, 2030, and at 2-year intervals thereafter, a hospital or health care district that meets the criteria for the above-described abeyances to provide any information that the department deems necessary to assess whether the hospital or health care district continues to meet those criteria. *The bill would require the department to inform a hospital or health care district in writing if it deems the hospital or health care district is no longer qualified for the above-described abeyances.* The bill would require the department to post on its internet website a list of hospitals and health care districts that continue to meet the criteria for abeyance.

~~The bill would condition implementation of its provisions on an appropriation of funds by the Legislature.~~

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 130078.5 is added to the Health and Safety Code, to read:

130078.5. (a) The department shall give the first priority to grants for single- and two-story general acute care hospitals located in remote or rural areas with less than 80 general acute care beds and general acute care hospital revenue of seventy-five million dollars ($75,000,000) or less, as reported to the department pursuant to Section 128740 in 2020.

(b) (1) Grants pursuant to this chapter shall provide general acute care hospitals described in subdivision (a) with funds to secure an SPC-4D assessment for purposes of planning for, and estimating the costs of, complying with Section 130065.

(2) The department shall conduct outreach to general acute care hospitals described in subdivision (a) regarding the availability of these grants and provide technical assistance to hospitals applying for the grants.

(3) A general acute care hospital receiving a grant for an assessment pursuant to this subdivision shall provide the estimated cost of SPC-4D compliance to the department as soon as possible.

(4) The department shall provide grants to secure assessments to general acute care hospitals that qualify within 18 months of the implementation of this section.

(c) (1) (A) Subject to paragraphs (2) and (3), general acute care hospitals that have received a grant for an assessment pursuant to subdivision (b) may apply for a grant for purposes of complying with Section 130065.

(B) Subject to paragraphs (2) and (3), general acute care hospitals that already have a completed SPC-4D assessment may provide that assessment to the department and the department may award the general acute care hospital grant money for purposes of complying with Section 130065.

being awarded state funds, a hospital that qualified for assessment grants under subdivision (b) shall provide the department with financial information on a form as required by the department for the following purposes:

(A) Demonstrating whether or not the hospital has attempted to secure other methods of funding for SPC-4D compliance, including federal funding, and if not, why.

(B) Confirming the accuracy of the SPC-4D cost estimate, and that estimated costs are only for the purpose of SPC-4D compliance.

(C) Demonstrating the hospital's need for assistance due to financial hardship and lack of ability to finance the required improvements, in order to access state funds.

(3) In awarding grants, the department shall have the authority to deny costs from the assessment completed pursuant to subdivision (b) that the department determines are not necessary to comply with SPC-4D requirements.

(d) General acute care hospitals that qualify for grants as described in subdivision (b) shall be required to comply with NPC-3 standards no later than January 1, 2035.

(e) General acute care hospitals as described in subdivision (a) that apply, and qualify, for grants pursuant to subdivision (c) shall be required to comply with Section 130065 by January 1, 2035.

(f) (1) A general acute care hospital as described in subdivision (a) with a completed assessment pursuant to subdivision (b), with an estimated cost over one million dollars ($1,000,000), or 2 percent of the hospitals revenue, whichever is greater, shall not be required to comply with Section 130065 if the department determines that the cost of design and construction for SPC-4D compliance results in a financial hardship for the hospital and state funds, federal grants, or private foundation funds are not available to assist with the cost of compliance.

(2) The department shall confirm a hospital's lack of ability to comply with Section 130065 and that the cost of compliance may result in hospital closure, or would substantially impact the accessibility to health care in communities surrounding the hospital.

(g) (1) By January 1, 2030, and at two-year intervals thereafter, each hospital whose compliance with the requirements of Section 130065 is in abeyance according to subdivision (f) shall provide to the department any information that the department deems necessary to assess whether the hospital continues to meet the criteria of subdivision (f). If a hospital's circumstances have not significantly altered, the department shall not require an updated SPC-4D assessment. *If the department deems a hospital is no longer qualified for an abeyance, it shall inform the hospital in writing, and the hospital shall comply with Section 130065 within five years of the date of notification, or the length of time spent in abeyance, whichever is greater. The department shall have the discretion to extend the amount of time by which a hospital shall comply with Section 130065 for an additional two years based on the estimated cost of compliance.*

(2) The department shall post on its internet website a list of hospitals that continue to meet the criteria for an abeyance from the requirements of Section 130065 pursuant to subdivision (f).

~~(h)This section shall be implemented only upon appropriation of funds by the Legislature.~~

SEC. 2. Chapter 1.6 (commencing with Section 130080) is added to Part 7 of Division 107 of the Health and Safety Code, to read:

CHAPTER 1.6. Health Care district relief program

130080. (a) (1) A health care district hospital authorized pursuant to Division 23 (commencing with Section 32000) *that meets the criteria described in subdivision (b),* may submit financial information to the Department of Health Care Access and Information to allow the department to determine if the health care district hospital is financially distressed, including, but not limited to, the health care district hospital's percentage of patients on ~~Medi-Cal and Medicare.~~ *Medi-Cal. The health care district hospital shall provide the department with financial information on a form required by the department for the following purposes:*

(A) Demonstrating whether or not the hospital has attempted to secure other methods of funding for coming into compliance with Section 130065, including federal funding, and if not, why.

the required improvements, in order to access state funds.

(2) If the department determines the hospital is financially distressed according to the information submitted pursuant to ~~paragraph (1),~~ *this subdivision,* the health care district hospital may apply to the department for a grant for the purpose of complying with Section 130065. When applying for a grant, the health care district hospital shall provide the department with an estimate of the cost for the hospital to comply with Section 130065.

(b) A health care district hospital may submit information to the department pursuant to subdivision (a) if it meets any of the following requirements:

(1) The health care district meets the requirements for rural hospitals pursuant to subdivision (a) of Section 130078.5.

(2) The health care district has placed a bond measure on the ballot within the last five years regarding compliance with Section 130065 and the measure did not pass.

(3) The Medi-Cal revenue for the health care district exceeds the statewide average percentage of Medi-Cal revenue for hospitals.

(4) The health care district hospital is more than 30 minutes or 30 miles from the nearest hospital.

~~(b)~~

(c) (1) If state funds are ~~appropriated in the future~~ *made available* for the purpose of complying with Section 130065, prior to ~~being awarded state funds, a health care district hospital that qualifies for a grant pursuant to subdivision (a) shall provide the department with financial information on a form as required by the department for both of the following purposes:~~ *awarding state funds, the department shall confirm the accuracy of the health care district's seismic cost estimate, and that estimated costs are only for the purpose of compliance with Section 130065.*

~~(A)Demonstrating whether or not the health care district has attempted to secure other methods of funding for compliance with Section 130065, including, but not limited to, federal funding, and if not, an explanation for why the hospital has not attempted to secure other funding.~~

~~(B)Demonstrating the health care district's need for assistance due to financial hardship and lack of ability to finance the required improvements, in order to access state funds.~~

~~(2)The department shall confirm the accuracy of the health care district's seismic cost estimate, and that estimated costs are only for the purpose of compliance with Section 130065.~~

~~(3)~~

(2) In awarding grants, the department shall have the authority to deny costs that the department determines are not necessary to comply with Section 130065.

~~(c)~~

(d) (1) Health care district hospitals that qualify for grants as described in subdivision (a) shall be required to comply with Section 130065 no later than January 1, 2035. If the department determines that the cost of design and construction for compliance with Section 130065 results in a financial hardship that may result in hospital closure and state funds, federal grants, or private foundation funds are not available to assist with the cost of compliance, ~~and the health care district hospital is more than 30 minutes or 30 miles from the closest hospital,~~ the health care district hospital shall not be required to comply with Section 130065 until funds are made available for the purpose of complying with Section 130065.

(2) The department shall confirm a health care district hospital's lack of ability to comply with Section 130065 and that the cost of compliance may result in hospital closure, or would substantially impact the accessibility to health care in communities surrounding the health care district hospital.

~~(d)~~

compliance with the requirements of Section 130065 is in abeyance according to subdivision ~~(c)~~ *(d)* shall provide to the department any information the department deems necessary to assess whether the hospital continues to meet the requirements of subdivision ~~(c).~~ *(d). If the department deems a hospital is no longer qualified for an abeyance, it shall inform the hospital in writing, and the hospital shall comply with Section 130065 within five years of the date of notification, or the length of time spent in abeyance, whichever is greater. The department shall have the discretion to extend the amount of time by which a hospital shall comply with Section 130065 for an additional two years based on the estimated cost of compliance.*

(2) The department shall post on its internet website a list of hospitals that continue to meet the requirements for an abeyance form the requirements of Section 130065 pursuant to subdivision ~~(c).~~ *(d).*

~~(e)This section shall only be implemented upon appropriation of funds by the Legislature.~~

ALAMEDA HEALTH SYSTEM

Alameda Hospital Planning Group
March 23, 2023

Program Considerations for Alameda Health System

Mental Health

- Inpatient Medical Psychiatric Unit
- Institute for Mental Disease (closed)
- Crisis Treatment Unit (open)
- Addiction Services – outpatient
- Outpatient Behavioral Health Clinic
- Mental Health Urgent Care

Acute Care

- Observation unit

Skilled Nursing

- Medical Skilled Nursing Unit
- More Skilled Nursing Beds in General