DATE: June 26, 2024 **VENDOR PAYMENT LIST** **Board approval ___________**

VENDOR	MEMO LINE	AMOUNT
Aleshire & Wynder	2024 – May, Inv #87305 General Retainer - $1236.00 Retainer Excess - $3720.00	$4956.00
Crossbolt Electric	2024 – 0625, Inv. 85, West Point Upgrade to LED lights in office	$200.00
Digitech	2024 – 0601 to 0630, Inv 18074 Bay Ave Building	$42.99
Frontier	2024 – 0528 to 0627 760-373-2804-102413-5 New charges $203.03 Bal Due $4.77	$207.80
Hebebrand, D David	2024 – 0101 to 0301, Inv 24-1763	$4692.50
Lost City Junk Removal	Stop payment and replace lost check #40378 with check # 40391	
Miranda, Luciano	2024 – June, N Loop	$500.00
Quality Survey	Per contract approved by Board 5/21/2024 for N Loop property surveys HOLD CHECK PENDING RECEIPT OF FINAL DOCUMENTS	$8750.00
Regional Government Services P O Box 1350 Carmel Valley, CA 93924	2024 – 0531, Inv 16946 Staff hours 8.15	$1382.40
Reliable A/C and Heating	2024 – 0531, Inv 21625 9300 N Loop, West Point, $90.00 2024 – 0637, Inv 21634 9278 N Loop, Cajon Medical, $3800.00 2024 – 0617, Inv 21635 9300 N Loop, EKHCD offices, $480.00	$4370.00
SDRMA	2024/24 Property/Liability Coverage Inv #75645, $29,427.33	$30,445.89

	2024/25 Workers Compensation Inv #76074, $1018.56	
Southern California Edison	2024 – 0508 to 0606 9300 N Loop, 8000222683, $594.50 8100 Aspen Mall, 8001112753, $117.19 8100 Aspen Mall #B, 8001112989, $67.64 Late Fee $ 0.71	$780.04
Southern California Gas Co	2024 – 0509 to 0610, 049 013 9910 7 9300 N Loop	$20.31
Spectrum	2024 – 0601 to 0630 8101 Bay, 212948401, $269.97 9300 N Loop, 127902701, $159.98 VERIFY APPLICATION OF CHECK FROM 4/16/2024 – ONLY PARTIALLY APPLIED	$$429.95
		Total 15 vendors, 14 checks $56,777.88

June 26. 2024

Staff Report

From: Karen Macedonio, President

Topic: Goals and Objectives for East Kern Health Care District from about 1975

Background:

The included document titled Primary Care Goals and Objectives was located in a file folder marked 1975 Formation Documents. Unfortunately there is no actual date or attribution of source included on the unnumbered pages.

The Goals and Objective would have been developed before the LAFCo process in 1978. We are engaged in an update of the LAFCo process now, and it is appropriate that we review and build upon our original documents.

What have we accomplished?

What is still a need?

What has changed that will require adjustment, flexibility, and new focus?

Recommendation:

Define the direction for East Kern Health Care District under current law, and with the development in medical care access beyond Primary Care.

Review document and incorporate into the Strategic Plan currently being developed.

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PRIMARY CARE

GOALS AND OBJECTIVES

Goal I

To assure the availability of an adequate number of primary care physicians to meet the needs of the residents of HSA-9.

Objective I.I

By 1985, to increase the number of primary care physicians such that no medical service area will have a population - to - primary care physician ratio greater than 2,000 : 1.

Objective I.1

By 1980, to increase the number of primary care physicians such that no medical service area will have a population - to - primary care physician ratio greater than 3,000 : 1.

Rationale:

One of the most pressing problems in HSA-9 is the lack of primary care providers. The range of population-to-primary care physicians ratios in HSA-9 vary from a low of 1,200:1 in Visalia-Tulare in Tulare County to a high of 19,305:1 in Boron in Kern County. In addition to this high variation, other factors play in the lack of primary care providers: (1) overutilization of hospital-based primary care clinics, (2) overutilization of emergency rooms as an alternative to primary care, (3) private physicians not taking new patients, (4) private physicians not utilizing publically-supported third-party reimbursements (i.e., Medi-Cal, etc.), (5) socio-cultural barriers, and (6) distance to suitable primary care providers.

While Fresno County is providing a model-role in decentralizing county health services and expansively coordinating among numerous medical/health care resources, this development is lacking in other counties. The need to raise the level of population-to-primary care physician ratios in the HSA-9 is to increase the availability of primary care providers.

RECOMMENDED ACTIONS

I.a The CCHSA will serve as a focal point and resource for assisting in the active recruitment of physicians through identification of areas of unmet need, dissemination of the resultant findings and coordination with appropriate community organizations including medical societies, hospitals, community groups and other health related organizations.

I.b The CCHSA will serve as a catalyst for fostering federal designation of underserved areas, particularly rural, through analysis of potentially conforming geographic areas, encouragement of grant appliation submittals, and provision of technical assistance to local groups applying for such designation.

I.c The CCHSA will offer technical assistance to community groups in t the preparation of grant applications for state funding to already designated rural medically underserved and primary care physician shortage areas.

I.d Existing primary care residency programs at Valley Medical Center in Fresno and Kern Medical Center in Bakersfield should be expanded, with particular emphasis on increasing resident availability in decentralized primary care sites.

I.e Existing practicing private primary care physicians should be encouraged to expand their practices thorugh such mechanisms as the addition of partners.

I.f Existing organized health providers, such as hospitals and county health departments, should investigate the feasibility of providing primary care services, particularly as a satellite program.

I.g Appropriate community organizations including medical education programs, hospital and professional organizations should expand continuing education programs with emphasis on inclusion of rural practitioners and should establish linkages between rural and urban-based physicians to develop mechanisms for peer support and exchange of information.

Goal 2

To ensure the availability of adequate primary care services in the rural areas of HSA-9.

Objective 2.1

By 1985, the following medical service areas should have primary care services:

Kings County - North Western Tulare County

15. Avenal, Corcoran
16. Hanford, Lemoore
17. Dinuba
18. Visalia
19. Tulare

Western Madera County

6. Madera

Northeastern Kern County

26. Lake Isabella

Objective 2.2

By 1980, the following medical service areas in Kings County - Northwestern Tulare County should have adequate primary care services:

15. Avenal, Corcoran
16. Hanford, Lemoore
17, Dinuba
18. Visalia
19. Tulare

Rationale:

Two of the areas in need of action regarding an increase of availability of primary care providers is the County of Kings and Northwestern Tulare County. In Kings County, a perceptions of the availability of primary care is that there is a definite need to increase this availability. While the ratio of population-to-primary care physician in Kings County is 2,324:1 in Avenal-Corcoran and 1,102:1 in Hanford, other factors enter into the decision to provide primary action to this area: (1) Kings County has a 1976 poverty level of nearly 15% of its population, and a low-income level of about 45% of its population. (2) Nearly 15% of its population is unemployed, about 25% of its population are farm workers, and nearly 30% of its population have low occupational statuses.

(3) Nearly 55% of its population have less than 12 years of schooling, indicating a trend to the low-income status due to lack of higher status occupations. (4) Nearly 30% of its population is Spanish Heritage, indicating a cultural difference and language barrier to primary care. (5) And, there is lack of private physician availability despite the adequate population-to-primary care ratio. This lack is a result of physicians not accepting new patients and not participating in the Medi-Cal program. Also, there are no decentralized clinics in Kings County.

The factors precipitating the decision to include Northwestern Tulare County are basically similar to those for Kings County but include: (1) There are no decentralized clinics in the Visalia-Tulare area, (2) the ratio of population-to-primary care physician ratio in Dinuba area and the Earlimart area are 3,098:1 and 14,903:1, respectively. These ratios are relatively high. (3) In the Northwestern Tulare County area, there is a high percentage of Spanish Heritage (approximately 30%), again indicating cultural and language problems in entry and utilization of the primary health care system. (4) The proportion of poverty level and low-income level of the population is about 27% and 30% respectively. (5) Nearly 50% of the population is below high school level education. (6) The unemployment rate is approximately 12%, and the proportion of farm workers and low skilled occupation workers is high, about 20% and 30%, respectively.

RECOMMENDED ACTIONS:

2.a The CCHSA, in cooperation with local providers and community groups, will analyze the feasibility of and seek to implement a coordinated system of comprehensive primary care services in selected geographic areas of priority need which will serve as a demonstration project and model for subsequent service development in other areas.

Goal 3

To assure the accessibility of primary care services to the population of HSA-9 from a financial, geographic, socio-cultural and administrative standpoint.

Objective 3.1

By 1985, to increase the financial accessibility of primary care services to CCHSA residents.

Rationale

It is estimated that in 1976 approximately 10% of HSA-9's population is at poverty level, and that approximately 27% of the population is low-income. Too, the unemployment rate in 1970 of HSA-9 was about 15%, and is considered to approximate that proportion today. These statistics point to the fact that a large segment of HSA-9's population find it difficult to pay for primary care on an out-of-pocket basis. Too, large proportion of the population is not covered by health insurance, or have inadequate coverage to compensate for the high cost of health care. Because of the reluctance on the part of many private physicians to participate in the Medi-Cal program (i.e., approximately 10%) or limit their acceptance of Medi-Cal patients (i.e., approximately 25%). These problems affect the accessibility of a large number of people to primary care. Although Valley Medical Center and Kern Medical Center in Fresno and Bakersfield, respectively, are Medi-Cal providers, their primary care services are over-utilized, including their alternative, the emergency room. District hospitals in HSA-9 have not developed a primary care provider role and represents an untapped and undeveloped resource. HSA-9 also has not utilized the many effective programs offered by the U.S. Department of Health, Education, and Welfare, in alleviating

the primary care shortage situation. In summary, there is a considerable proportion of HSA-9 residents which are financially in need of alternative sources of payment for primary care.

RECOMMENDED ACTIONS

3.1a The CCHSA, working with appropriate representatives of the physicians, hospitals, county health services and other groups, should analyze the problems of lack of acceptance of medi-cal patients and make recommendations to the State Health Department and legislators accordingly.

3.1b The CCHSA should encourage the development of prepaid health plans.

3.1c Those county health departments not now actively providing primary medical care services should investigate the feasibility of initiating such programs.

3.d Community hospitals with Hill-Burton funding should be encouraged to meet their requirements for the provision of charit- care in conjunction with primary services.

3.1e District hospitals should investigate the feasibility of establishing a consortium to provide for the primary care needs of their constituents.

3.1f Maximum potential use should be made of operational support funds available through state and federal rural health grant programs. (Reference Actions 1.b & 1.c)

Objective 3.2

By 1985, to assure that primary care services are geographically accessible to 90% of the population within 15 minutes travel time.

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Rationale

While urban area residents in HSA-9 are reasonably within 15 minutes driving time to some primary care resource, the rural areas are not because of geographical and availability considerations. Although availability of primary care is deficient, accessibility to primary care is also deficient. Availability of public transportation, or other organized transportation is limited to the large urban areas of Fresno and Bakersfield. Bus service between the rural communities is very limited. As transportation of people to primary care resources is an important aspect in accessibility to providers, it must be addressed. The recommended actions for Objective 3.2 are limited to evaluation of the present transportation availability and consideration of a mobile unit component. Other alternatives not addressed in the recommended actions are: (1) utilization ofschool transportation as a complement to other transportation systems, and (2) utilization of private transportation avenues (e.g., church busses, etc.).

RECOMMENDED ACTIONS

3.2a Proposals for new and/or expanded primary care services should show evidence of evaluation of the feasibility of transportation services.

3.2b Proposals for new and/or expanded primary care services should show evidence of consideration of the inclusion of a mobile unit component. (Reference Actions 1a - 1g and Action 2a)

Objective 3.3

By 1985, to assure that all primary care services are accessible to the socio-cultural groups served.

Rationale:

As the population of HSA-9 is approximately 30% Spanish Heritage, Spanish as a primary language must figure in strongly as a barrier to primary care. Primary care terminology and medical instructions are often times beyond the full understanding of the Spanish speaking person, and create barriers to the successful utilization of primary care and continuity of care. Bilingual personnel to intervene on the Spanish speaking person's behalf is a necessity to overcome these barriers.

RECOMMENDED ACTIONS

3.3a All existing services and proposals for new or expanded services should provide adequate bi-lingual personnel appropriate to patient needs.

Objective 3.4

By 1985, to assure that administrative and operational policies do not create access barriers to primary care services.

Rationale:

Very few primary care providers offer their services after working hours. For many people, the convenience of after hours services availability would open avenues of greater accessibility. For example, a significant number of emergency room visits occur after 6:00 PM and before 8:00 AM.

RECOMMENDED ACTIONS

3.4a Existing and new programs should make their full complement of services available to patients at a minimum of one night a week and/or one day a weekend.

3.4b Existing and new programs should ensure the availability of complete and expeditious registration procedures which include information and guidance on the type and scope of financial assistance for which a patient is eligible.

Objective 3.5

By 1985, to increase public knowledge with respect to the availability and appropriate use of primary care services.

Rationale:

Much pre-registration and registration for primary care is cursory, omitting essential information, one item of which is one's financial situation and alternatives to deal with it. The discouragement of knowing one cannot pay for primary care and not knowing what alternatives there are to compensate for this factor is a barrier to accessibility to primary care. This factor also figures in greatly in the availability of alternatives to primary care providers. Where one provider may be denied a person due to financial or other

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consideration, another provider may be available and accessible. It is important to encourage the users of primary care to decide upon the alternatives open to them.

RECOMMENDED ACTIONS

3.5a The CCHSA should develop and publish a resource directory describing existent primary care services and should develop public education programs which utilize local media resources.

Goal 4

To assure the continuity of care throughout a continuum of comprehensive primary care services.

Objective 4.1

By 1985, to increase the range of preventive, diagnostic, therapeutic and rehabilitative services available within any given primary care program.

Objective 4.2

By 1985, to increase the provision of outreach services by primary care programs.

Objective 4.3

By 1985, to increase the existence of networks of primary care centers which facilitate the provision of shared services, personnel and resources.

Objective 4.4

By 1985, to assure that all primary care programs have linkages with secondary care resources as exemplified by formal, on-going referral arrangements which provide expeditious patient access to such services when required, continuity of information and care and opportunities for shared services. Such secondary services should include physician specialty services, diagnostic and therapeutic services and inpatient care.

Rationale

An examination of our data on the availability of primary care clinics showed that all have linkagesto secondary and tertiary medical care. Most linkages are through informal arrangements, and some are through written, formal agreements. The development of inter-provider linkages through HSA-9 has not been rapid, and formal networks between providers,-to include private providers and public providers - through HSA-9 is virtually non-existent.

RECOMMENDED ACTIONS

4.a The CCHSA, in conjunction with appropriate representatives of community and provider groups should develop a list of the minimum and optimum scope of services which should be provided by all primary care programs.

4.b The CCHSA, in cooperation with community and provider groups should encourage the development of formal networks which provide:

1. linkages among primary care services;
2. linkages between primary care centers and existing outreach programs;
3. linkages between primary care centers and secondary care resources.

4.c All proposals for new and/or expanded primary care centers must include evidence of a formal relationship with a secondary center including admitting priviledges and exchange of medical records.

4.d Community hospitals should investigate the feasibility of developing primary care networks.

4.e Community hospitals, district hospitals and other health providers should investigate the feasibility of formulating multi-institutional arrangements for the provision of primary care.

Goal 5

To assure the provision of primary care in the most cost-effective manner.

Objective 5.1

In an effort to reduce inappropriate use of emergency rooms by non-urgent patients, by 1985, emergency room visits per 1,000

population should be reduced 10% from 1976 levels.

Rationale

It has been estimated that approximately two-thirds of emergency room visits are of a non-emergent nature, and that emergency room facilities do not separate out those which are and those which are not. Emergency rooms are not equipped to set up a "non-emergent facility" and an "emergent facility", especially after 6:00 p.m. and before 6:00 a.m. As the availability of primary care providers increases it is expected that utilization of emergency rooms will decrease, and one way to accomplish this is to provide more after hours providers.

RECOMMENDED ACTIONS

5.1a Where, justified by workload volume, hospitals should be encouraged to provide a separate, identifiable area for non-urgent drop-in patients with facilities, equipment and personnel appropriate to the needs of these patients.

5.1b Where a demonstrated need for capital resource development of emergency facilities exists, the CCHSA will give preference to projects which include the provision of a separate, identifiable area for non-urgent drop-in patients.

5.1c The CCHSA will encourage primary care programs to provide services during evening and weekend hours.

5.1d The CCHSA, in conjunction with community and provider groups, will promote expanded third-party coverage of non-hospital-based primary care services in conjunction with appropriate state, federal and private third-party reimbursement proposals.