

# MARIN GENERAL HOSPITAL: Moving Beyond the Impasse

## SUMMARY

In 1985, the Marin Healthcare District Board (the District Board), believing that private, professional hospital management was needed for the Marin General Hospital (MGH), signed a 30-year lease that transferred its authority to manage MGH to a newly created entity, the Marin General Hospital Corporation (the MGH Corporation). The District Board retained ownership of MGH and under the lease simply became the landlord of the MGH Corporation.

This event has caused dissension in the community to this day. Some people did, and still do, support this arrangement; others believe the transfer was a mistake that benefited special interests at the expense of the public interest.

Over the years, advocates on both sides of this issue have been elected to positions on the 5-member District Board. There have been recalls, lawsuits, and conflict of interest allegations. Recently, multiple conflict of interest allegations have severely constrained the actions of the District Board.

The 2003-2004 Marin County Civil Grand Jury (Grand Jury) became concerned about this current impasse and undertook an investigation of the groups and issues involved. Among its findings are:

- Three parties share responsibility for inhibiting decision-making processes from moving forward: the District Board, MGH Corporation/Sutter Health (Sutter), and a group of public activists (Public Activists) who oppose Sutter control and are a disruptive presence at District Board meetings
- The resulting level of disharmony and dissension is both unusual and unnecessary
- Positive and negative lessons can be learned from studying the operations of other healthcare districts
- The Board of Supervisors (BOS) has broad responsibilities regarding healthcare matters in Marin County

Given these findings, the Grand Jury's primary recommendations are that:

- The District Board should gain control of its process, reformulate its mission, and develop a long-term strategic plan
- MGH Corporation/Sutter should work openly and cooperatively with the District Board
- The public activist group should avoid disruptive behavior
- The BOS should use its good offices to improve the situation

## BACKGROUND

Marin General Hospital (MGH) has a long history in the county. Its construction was funded by local taxes and donations and for 33 years (from 1952 to 1985) it was operated locally. In 1985, however, the District Board contemplated conveying authority to operate and maintain the hospital to another entity, the MGH Corporation, believing that if the hospital were to be leased to a not-for-profit public benefit corporation (i.e. the MGH Corporation), the hospital

could compete more effectively in the healthcare marketplace. At that time, the 1985 Grand Jury carried out an investigation of the proposed action. Their report noted that under the transfer the District Board would continue to exist but "with changed and diminished authority." The Report recommended that future Grand Juries continue to monitor the lease.

As early as 1989, acrimony and distrust arose about the terms of the lease and the altered scope of the District's mission. This was exacerbated by several cost-cutting moves undertaken at MGH. By 1997, after Sutter took over the lease, there were allegations that patient care was being compromised. A further claim alleged that the original lease was tainted by a conflict of interest in that those who prepared and signed the lease were intimately involved with the lessee at the time. The level of acrimony increased when the District Board elected to go to court to break the lease.

At that juncture, the 1998-99 Grand Jury conducted an investigation of the relationship between the parties, providing a thorough history of relevant information and events. Its recommendation that the parties submit their dispute to binding arbitration was not followed. Instead, litigation continued and eventually the courts held that the time allowed by the statute of limitations had expired, and the California Supreme Court refused to hear the appeal.

The determination of the courts did not resolve the underlying conflicts and indeed the prospect of a possible extension of Sutter's lease has roiled the waters once again. Recently, Sutter made a proposal to build and finance a new hospital wing. Contingent on making this investment, however, Sutter wants an immediate long-term extension of the present lease, which would otherwise expire in 2015. Proponents and opponents of this proposal have been typically antagonistic toward one another.

By early March 2004, three of the five current District Board members, as well as the board's legal counsel, had been charged (either by MGH/Sutter or members of the public) with conflicts of interest pertaining to any action related to the District/MGH Corporation lease. This effectively prevented any substantive activity on this issue, as well as plans to expand the hospital, from moving forward.

This entire situation and the high level of acrimony and contention between the groups responsible for solving the problems aroused the concern of the 2003-2004 Grand Jury.

## METHODOLOGY

The Grand Jury conducted interviews with:

- Members of the District Board
- Senior Management of MGH/Sutter
- Representatives of the MGH Board
- Physicians representing differing points of view regarding the current relations between the District and Sutter
- Members of the Marin County BOS
- Management of the Marin County Department of Health and Human Services
- Board members and senior management of the Petaluma Health Care District
- Senior management of the Washington Hospital Healthcare System

- Board members and senior management of the Palm Drive Health Care District
- Leadership of the Marin League of Women Voters

The Grand Jury made personal observations during numerous meetings of the District Board.

The Grand Jury reviewed extensive documentation:

- The Brown Act
- State of California Health and Safety Code (the "Code") - Sections 32000 – 32508
- State of California SB 1953
- "Heath Corrections" (documents distributed by members of the public)
- Letters and other correspondence distributed by members of the public
- The lease agreement, as amended, between the District and MGH Corporation
- Periodic financial records provided to the District in accordance with the lease agreement
- Information pertaining to the conflict and resulting litigation between the District and MGH Corporation
- Several prior Marin County Grand Jury reports concerning healthcare in Marin County
- Material and correspondence regarding the conflict of interest issues
- Material supplied by several California healthcare districts describing their situations
- Information from a number of websites: Marin Healthcare District, Sutter Health, Marin General Hospital, Novato Community Hospital, several California healthcare districts, the Association of California Healthcare Districts, HealthGrades, Pacific Business Group on Health, and California Health Care Foundation
- Material on quality of health care
- Articles published in local newspapers

## DISCUSSION

### **Groups Currently Involved in the Impasse**

The *Marin Healthcare District*, with five members elected to 4-year terms, was organized under provisions of the Health and Safety Code of the State of California (Code) to help under-served areas of the state provide needed healthcare facilities. It was established in 1946 and initially included all of Marin County. In 1959, Novato and parts of West Marin voted to withdraw from the District. The District Board is currently composed of three doctors, one nurse, and a former banker, whose educational background is in health services management.

Section 32121 of the Code gives the District Board the power "... to establish, maintain, and operate...one or more health facilities or health services..." It also gives it the authority "... to transfer, at fair market value, any part of its assets to one or more corporations to operate and maintain the assets."

In attempts to exercise its authority, the District Board has amended its by-laws several times. Most recently, in February of 2003, it redefined its mission as, " the provision of quality health care in the communities served by the District, supporting the highest quality medical, trauma, and psychiatric care at Marin General Hospital, and monitoring and enforcing the lease of Marin

General Hospital to ensure the optimum operation of the hospital for the benefit of the communities it serves.”

Critics contend that this mission statement does not identify concrete goals and actions, or address unmet healthcare needs of the public, that the District Board does not have adequate income to be effective in fulfilling its mission, and that it has unwisely spent its resources on legal services and litigation.

The *Marin General Hospital Corporation* was formed in 1985 at a time when hospitals across the nation were grappling with rising costs and declining revenues. It was established as a private, not-for-profit organization to enable it to negotiate competitively with various healthcare insurers and providers. The MGH Corporation has, over the years, affiliated with a number of hospital management groups to deal with business operations of MGH. In 1996, MGH became an affiliate of Sutter, a private, not-for-profit corporation based in Sacramento, California, when Sutter absorbed the previous management group, California Health Systems.

*Sutter* includes 27 hospitals as well as physician groups and other healthcare facilities primarily located in northern California. In Marin County, Sutter has established the *Marin Community Health Board*, a not-for-profit, tax-exempt corporation to provide a mechanism for Marin General Hospital, Novato Community Hospital, Marin General Hospital Foundation, and Marin Home Care, Inc., to engage in Sutter’s countywide planning and coordination of healthcare services. Neither the District Board nor the Marin County BOS is represented on the boards of the MGH or Marin Community Health. Critics believe that notwithstanding the fact that Sutter is a not-for-profit corporation, its primary concern is with making money and that its tax-exempt status helps towards this end.

The *Public Activists*, a small, organized, vocal anti-Sutter group, attend most if not all District Board meetings. This group, which includes several former members of the District Board, impedes the efforts of the legally elected current board to govern. They challenge board member’s positions on almost every issue under consideration and give the impression that they wish to dictate District Board policy. Their behavior frequently is disruptive to the point of interfering with the District Board’s ability to conduct and maintain an orderly meeting or move forward on any substantive issue. Many interviewees, as well as several Grand Jury members who have attended many District Board meetings, believe this group is primarily responsible for continuing to fuel old hostilities.

The *Board of Supervisors*, as mandated by the State of California, has broad authority and responsibility to provide for the health, safety, and welfare of the citizens of Marin County.

Interviews with some members of the BOS and other county employees have provided insight into their understanding of the meaning of the State mandate. Specifically they expressed the opinions that:

- The county’s role in health care is complementary to that provided by private and public healthcare providers
- The ultimate responsibility of the county is to provide healthcare in emergency situations and to the under-served

The Grand Jury's sense of the position of the BOS is that they and county staff are not unhappy that others are managing MGH. The Grand Jury also believes (based on past interventions) that the BOS has the wherewithal to influence the relationship between the District and Sutter and could act as an advocate for the interests of the people of Marin County in this matter.

### **Issues Concerning the Control of MGH**

The Grand Jury believes that the primary underlying issue dividing the District Board, as well as members of the public, is whether the county would be better served by having MGH return to District control or by having it remain in private corporate hands such as Sutter's.

On the one hand, there are those who argue that Sutter and similar corporate groups are primarily focused on the "bottom line" and that only a publicly elected board can reliably protect both high quality care and broad access to care. Those who support this view contend that the District can do so at less cost to the public since they would not siphon off funds to corporate coffers. On the other hand, there are people who argue that this is an unrealistic position, that in today's costly and competitive healthcare market only those with appropriate business skills and mechanisms can be counted on to ensure that hospitals survive and provide access to state-of-the-art care.

There is a great deal to be said on both sides of this argument and people well beyond the limits of Marin County are engaged in the debate. In some circles, people can agree to disagree; sadly, such tolerance is in little evidence locally.

The question of who will control MGH appears to have taken on a new urgency and stridency because the possibility of renegotiating the present lease has become imminent. The current lease expires in 2015. Sutter, however, proposes to build a new hospital wing, and in order to justify this expenditure, wants an extension of the present lease for another 30 or more years. (The outright purchase of MGH has also been mentioned as a possibility.) Sutter representatives and supporters say that a new long-term lease would offer:

- An up-to-date hospital financed by Sutter using its advantageous corporate bond rating
- The avoidance of some costly interim seismic retrofits that are required on older buildings.

Beyond these bare essentials, Sutter, to the point of arrogance, has been reluctant to divulge their plans for meeting the future healthcare needs of the public or to discuss the specific provisions of any new lease. This behavior has raised suspicions among critics of Sutter who contend:

- Under Sutter the quality of care at the hospital has declined
- Sutter would not be required to retain the types of services that the community might desire
- Sutter would be given free reign to change its mix of services toward services that are more profitable
- Under Sutter, costs at MGH are unusually high
- The District would still lack any level of oversight or control

## **Problems Cited if Sutter Retains Control**

### Level of Care

Among the resources a community hospital is expected to provide is a core of basic services including such things as pediatrics, maternity care, and an emergency room. These services, while vitally important, are not particularly remunerative, and are often a financial drain on a hospital. More specialized services such as cardiac care, orthopedic surgery, and cosmetic surgery generate more money and are frequently found in the mix of services offered.

At present, MGH/Sutter offers a range of basic services. It also offers new high-tech, state-of-the-art services that are much more cost-effective and able to attract patients from outside Marin County. MGH's Electrophysiology Laboratory – touted as one of only 12 in California – is a case in point. Sutter critics are concerned that Sutter will change the mix of services in favor of one that offers more "boutique" services like the Laboratory. Even interviewees from Sutter have not precluded the possibility of a change in the mix of services, although they have not suggested that any basic services would be eliminated. The Grand Jury did hear some reservations about continuing the existing provision of psychiatric care and the projected availability of a hospital-based alcohol and drug detoxification program.

It is important to recognize that all hospitals need to survive financially and that decisions about the mix of services enter into this equation. In contention is whether Sutter would make decisions giving priority to their own financial interests at the expense of the best interests of the local residents.

### Quality of Care

Related to the issue of level of care is that of quality of care. Quality of care involves treatment outcomes and is regularly monitored by agencies such as the Joint Commission on Accreditation Healthcare Organizations.

Critics contend that the quality of care has been compromised since MGH has been in the hands of Sutter and its predecessors. To support this contention, they provided examples of deficiencies drawn from quality of care studies and offered anecdotal reports from patients of poor treatment outcomes and changes in the number and qualifications of the nursing staff.

The erosion of doctor control of care is cited as another indication that the quality of care has been compromised. The argument is that management, instead of doctors, has gained control of medical care through the existence of contracts between MGH/Sutter and doctor groups. If the doctor is not a member of such a group, the doctor will not receive referrals. In this way, the Grand Jury has been told the managing entity determines the doctors' level of business and income.

Recently, MGH was the subject of a federal report that found the hospital had deficiencies in several areas. These include improperly stored and handled drugs, nurses who lacked training on cardiac monitors, incomplete medical records, and instances where supervisors failed to adequately respond to complaints of patient abuse. MGH released these findings and has submitted a plan for correcting them.

Sutter's advocates counter by saying that the quality of care at MGH is quite high pointing to high levels of patient satisfaction. Physician interviewees indicated that their sense was that the level of care was in line with industry averages and was acceptable. These interviewees went on to say that the overall direction of healthcare, is substantially driven by finances, and that this, not Sutter, is the cause of any apparent decline in quality of care. Some interviewees also stressed that, rather than Sutter, MGH's medical staff controlled health care, and thus the quality of care at the MGH.

Beyond positive representations made by those associated with Sutter, the Grand Jury attempted to find independent assessments about quality of care. Accordingly, it reviewed a number of websites that purport to publish independent indicators about this issue. One such website, restricted to 50 Bay Area hospitals, produced results on "Overall Patient Experience." It showed that MGH placed in the middle ranking of all hospitals. In all, 27 other hospitals received an identical middle ranking, 12 hospitals a superior ranking, and 10 hospitals an inferior ranking. A second survey, dealing with clinical results, showed MGH again placing in the middle.

The Grand Jury recognizes that these are simplistic attempts to evaluate the elusive topic of quality of care, that the subject matter is beyond the competence of our membership and is deserving of close scrutiny.

#### Cost of Care

A third area of concern that came to the attention of the Grand Jury was that MGH/Sutter has unusually high costs for treatment. Some interviewees told of ongoing complaints from patients in this regard, and newspaper reports also indicated that a pattern of such behavior exists. As a case in point, a study by Blue Shield showed the costs at Sutter hospitals were 60% to 80% higher than statewide average hospital costs.

#### **Problems Cited if the District Resumes Control**

Although advocates of District control maintain that they could provide all the advantages Sutter offers without the potential disadvantages, it is unclear whether this claim can be supported.

For example, the District Board contends that it could finance any new hospital construction as well as Sutter. A bond expert hired by the district has upheld this conclusion. Under this proposal, Sutter's rent to the District Board would be substantially increased (by \$7,200,000 annually), Sutter would contribute \$16,000,000 to \$20,000,000 it would otherwise spend on seismic upgrades under the current terms of the lease and also pay the District 0.1% of its annual revenues. Not surprisingly, Sutter has found this proposal to be less than satisfactory, claiming that the District Board's proposal would be much more costly than its own. They continue to want a lease extension.

The lease extension has been on hold since 2003 and raises a number of perplexing questions. If the District Board does not sign a new lease, would Sutter simply walk away and build another hospital to compete with MGH? Would the District Board have to endure a number of years during which Sutter would act as a lame duck manager with the public forced to accept the level of healthcare offered during this period? What would be the terms of the return of

MGH to the District, especially the allocation of capital improvements? Since Sutter has already made essentially all the financial contributions for capital improvements required through 2015, would it be motivated to do anything more? Would the "operating hospital" left by Sutter be adequate to meet community needs?

Questions of another kind also present themselves. If the District Board were to take over (either through the early departure of Sutter or at the expiration of the lease), would it hire its own CEO or would it negotiate a new lease with a successor management group? What assurances could it offer that either would be an improvement over Sutter? Would the District Board actually be able to raise funds from bonds or taxes to supplement revenue generated by MGH? Would the tax-paying public be willing to support MGH should the need arise? Would the District board be capable of taking any of these actions given its past or present performance?

The Grand Jury believes the District Board should consider all of the possible scenarios that might develop and address the critical management and financial issues they involve.

## **Interactions**

### Meetings

The District Board holds regular, public meetings every month. A core group of people is always in attendance. In addition to the five members of the District Board and its staff and counsel, the attendees include high-level MGH staff who report to the District Board on the status of healthcare, and members of the public (including many of the Public Activist group).

As virtually all interviewees have remarked (and as all of the observers from the Grand Jury have noted), District Board meetings are unlike board meetings of other organizations. They are unusually and unremittingly contentious, moving from disagreements among District Board members themselves, to challenged staff reports, to hostile declamations from the audience. Especially upsetting is that the board chairs have been incapable of controlling such disruptive behavior.

The Grand Jury also believes such behavior is based on the exploitation and improper implementation of the Brown Act. Section 54954.3. of the act specifies:

- “(a) Every agenda for regular meetings shall provide an opportunity for members of the public to directly address the legislative body on any item of interest to the public, before or during the legislative body’s consideration of the item...
- (b) The legislative body of a local agency may adopt reasonable regulations to ensure that the intent of subdivision (a) is carried out, including, but not limited to, regulations limiting the total amount of time allocated for public testimony on particular issues and for each individual speaker.”

This clearly provides the public with the freedom to speak to legislative bodies; it does not give license to disrupt meetings.



### Recalls and Lawsuits

Apart from contentious meetings, the District Board's effectiveness has been compromised by other hostile actions including multiple conflict of interest allegations. For example, in 1996, charges that two District Board members had financial connections to Sutter resulted in their recall. In 1997, at a time when the prevailing sentiment on the District Board was anti-Sutter, a lawsuit was filed attempting to invalidate the original 1985 lease, and also alleging breaches of the terms of the lease. The latter issue (allegations of breaches of the lease) was settled out of court and resulted in additional income for the District Board. The attempt to invalidate the lease on the basis of a conflict of interest was dismissed based on the statute of limitations. Following appeals, the Supreme Court, in 2003, declined to consider the case, ending the attempt of the District Board to invalidate the lease.

With such a resolution of the court case, it is not surprising that the differences among the parties were not resolved, or that allegations about conflicts of interest have arisen again. The effect of these actions was that:

- The California Fair Practices Commission advised that the District Board member, who was first to be charged with a conflict, did, indeed, have a conflict of interest and could not vote on issues relating to the future of the hospital until one year after issuance of her last paycheck.
- The other District Board directors with charges pending recused themselves from considering key matters regarding the District and Sutter, and the District Board became paralyzed.
- The Attorney General has since ruled that only one of the three accused members has a conflict of interest preventing her from taking part in matters pertaining to the lease.
- At long last, therefore, four members of the District Board finally are able to vote on critical issues.

### Financial Arrangements

Sutter is responsible for \$1,500,000 in annual rent under the terms of the lease drawn in 1985 and amended in 1989. Only a fraction of the rent specified in the lease (initially \$125,000, increasing by about 5% annually, and now exceeding \$250,000) is payable as cash to the District. The remainder of the rent is applied against an existing credit in a capital improvement fund. At this time, it appears that the existing credit balance makes it unnecessary for Sutter to pay any amount of rent in excess of the \$250,000 paid in cash. The District also receives a settlement resulting from litigation in the amount of \$150,000 per year from Sutter. This makes the effective cash income received by the District total slightly more than \$400,000 per year. Of this amount, approximately half is used for overhead, i.e., salary and benefits of its one employee, costs to run elections, and regularly budgeted costs of counsel. Only the remaining \$200,000 is available for healthcare programs.

The lease also stipulates that Sutter pay an additional annual amount (initially, \$1,500,000, increasing at about 5% per year, to a current level of about \$2,500,000) toward capital improvements. Sutter has pre-paid amounts into this second capital improvement fund to the extent necessary to remove the requirement that it make any further payments over the term of the lease. It should be noted, however, that in spite of this, Sutter did make substantial payments for capital improvements in 2002 (the year for which an accounting of this fund was provided to the Grand Jury).

On its part, MGH pays substantial management fees to Sutter (over \$2,900,000 in 2002). Additionally, in the same year, MGH paid over \$1,100,000 in Information System fees. As a justification for this it was represented by Sutter management that because of Sutter's economies of scale, the fees for services paid by MGH are substantially less than they would be if MGH had to purchase the services on the open market.

MGH is also included in Sutter's Excess Cash program and the Sutter Obligated Group program. Under Sutter's Excess Cash program, MGH's excess cash (defined as amounts in excess of 14 days of operating cash, certain restricted funds, and donated money) is remitted to Sutter and can be used to pay for improvements throughout the entire Sutter system. Under the Sutter Obligated Group program, all Sutter affiliates are viewed as a single, large entity, generating economic leverage, reduced interest rates, and access to capital.

### **How Others Do It**

Because the issue of hospital control is so contentious here in Marin County, the Grand Jury wondered if other health districts have the same problems, and if not, whether Marin could benefit from a survey of some of the others. Thus the Grand jury decided to look into how other healthcare districts in California structure the delivery of healthcare and how their hospitals are operated and managed.

The Jury learned that membership in the Association of California Healthcare Districts totals over 70 districts that operate under several types of models:

- *Limited emergency service* – These districts are typically removed from major population centers and provide limited services (e.g., ambulance services in remote areas). This model would be inappropriate for Marin
- *Community healthcare districts that do not own a hospital* – These districts provide services complementary to the healthcare services provided by others within their community. Examples are the Beach Cities Health District and Camarillo Health Care District
- *Community healthcare districts that run their own hospital* – Although such districts are often in remote areas, there are examples, such as Washington Township Health Care District (in Fremont) and Salinas Valley Memorial Healthcare District that are reasonably close to large population centers
- *Community healthcare districts that contract with major providers* (e.g., St. Joseph Health or Sutter) – Typically such districts delegate responsibility for hospital management, but in most circumstances still provide oversight as well as community services that complement the services provided by the hospital. Examples are Petaluma Health Care District and the District itself

### Districts That Do Not Own a Hospital

A community healthcare district may not own its own hospital for a number of reasons. For example, the healthcare district may have been formed without a hospital, or the district's hospital may have been closed if it were no longer essential to the community. Regardless of the reasons, the fact that a community healthcare district does not own a hospital does not prevent it from offering services that complement the healthcare services otherwise provided within the community.

Examples of the types of services offered include: youth health and fitness facilities, mobile clinics, medically-based fitness centers, wellness services, parent education networks, programs to overcome depression, breastfeeding support centers, door-to-door non-emergency medical transportation, adult day care facilities, 24-hour medical alert telephone services, senior nutrition meal-site transportation, and discounts on health-related products.

### Districts That Run Their Own Hospitals

The Grand Jury examined the situation in two districts that run their own hospitals (as is being advocated by some for the District). One of these is very successful, the other less so.

In the more successful case (a hospital with more than 300 beds), the prevailing outlook seems to be that the community needs the hospital, the community takes the initiative to make sure the hospital operates well, and the community intends to control the hospital's future activities. Local involvement has always been the hallmark of the hospital and its associated healthcare system.

This healthcare district employs its own management team to run the hospital, which has been profitable for the last decade. To this end, certain initiatives have been undertaken to keep the hospital financially sound. For example, some profitable specialties have been installed, but not at the expense of other services. In fact the healthcare system annually provides millions of dollars worth of care to the indigent and additional millions to provide uncompensated services.

In contrast to the situation in Marin, the interaction between the healthcare district's board and the hospital management is both supportive and mutually beneficial. The healthcare board reflects a balance of members who have a medical and a business background and they provide guidance to management. On its part, management keeps the board abreast of the ongoing operations of the healthcare system. The ability of management to work closely and in harmony with the board was cited as one of the great strengths of that healthcare district.

The essential feature of this healthcare system seems to be that the community has been, and continues to be, totally involved. It wants the hospital to succeed and takes steps to ensure its success.

The less successful community healthcare district is similar to the first in that it operates its own hospital. That, however, is where the comparison ends. There are many substantial differences.

Unlike the healthcare district mentioned above, this district recently assumed the operation of the local hospital after the management company that owned the hospital withdrew. Following a threat by that company to close the hospital, the local community rallied to purchase the hospital and to undertake its operation through a newly established not-for-profit foundation. In fact, the healthcare district was not even formed until a few years after the community takeover.

In this case, the healthcare district has struggled to make financial ends meet. At first, the community, and later the healthcare district, have taken a number of steps to deal with their financial difficulties. They explored, but ultimately rejected, arrangements with other management companies (Sutter and St. Joseph's), and instead have relied on substantial

donations from local residents and a parcel tax that the community has supported. The district has recently hired a consultant to help formulate a strategic direction, but has not yet elected to divest itself of control of its hospital operations.

Despite a high-level of community involvement, the financial situation continues to be extremely difficult. This suggests that the assumption of the management and operation of a hospital by a healthcare district can carry with it a series of risks.

#### Districts That Contract With a Major Provider

In the Bay Area, there is an example of a district that has entered into a long-term lease with a major not-for-profit hospital management group. In this case, however, there have been virtually none of the problems that plague the relationship between the District and /MGH Corporation/Sutter. Moreover, this healthcare district provides a number of complementary healthcare services to its community, another marked difference from the situation in Marin.

This healthcare district took steps, during the negotiation of its lease, to maintain certain levels of control over the provision of healthcare. Members of the district board represented diverse interests including business, not-for-profit management, and healthcare. This district also had its own professional staff, which provided planning expertise. The staff scrupulously avoided conflict of interest by recusing themselves from negotiations; only the then-current members of the district board and counsel were on the negotiating team. Consultants were employed to assist in providing background to the negotiations.

The following differences between the situation in this district and that in Marin were noted:

- The district transferred control of only a portion of the district's assets. As a result, remaining assets could be used to generate revenue for other purposes
- The district retained the option to opt-out of its 20-year lease at the end of ten years in case the district felt the hospital manager was not performing adequately
- The lease included provisions preserving the right of the healthcare district to prospectively control certain elements of healthcare. In effect, the hospital manager is prohibited from discontinuing certain hospital services that were in effect at the time of the lease, without the consent of the healthcare district
- A substantial amount of money (more than \$3,500,000) was transferred from the hospital manager to the healthcare district, enabling the district to provide other services
- The district has a voting member on the current hospital board
- The district has a member on the quality control group of the not-for-profit alliance that was formed to facilitate the lease arrangement and which controls the hospital and certain other health services providers in the district's territory

The Grand Jury believes that the Marin Healthcare District could benefit by learning from all the successful districts. It specifically believes that the District should emulate, among others, those that have a Chief Executive Officer (CEO), have a seat on the corporate management board, and have a board (or consultants) with a balance of medical and business skills.

## FINDINGS

- F1. Appropriate healthcare planning in the county is being blocked because of poor interactions among three entities: The District Board, MGH Corporation/Sutter, and a small subset of the public that attend District Board meetings (i.e., the Public Activists).
- F2. Each of these groups displays qualities that fuel dissension. The District Board is weak and ineffectual, MGH Corporation/Sutter is arrogant and uncooperative, and the Public Activists are rude and disruptive.
- F3. Several factors appear to undermine the effectiveness of the District Board:
  - a. the terms of the existing lease which conveyed much of the District Board's authority to MGH Corporation/Sutter
  - b. insufficient financial resources to be an effective healthcare provider
  - c. the abuse of the Brown Act by the Public Activists during District Board meetings
  - d. an inability to be forceful in controlling disruptive remarks from the public
  - e. lack of necessary expertise to deal with healthcare management issues
  - f. lack of balance among the membership of the board (a shortage of directors with business acumen)
- F4. The attitude of MGH Corporation/Sutter seems attributable to:
  - a. the ineffectiveness of the District Board
  - b. the terms of the existing lease which conveyed much of the District Board's original authority to MGH Corporation/Sutter
  - c. the professional and financial strength of Sutter
  - d. the ability to do its work in private and without including any members of the District Board on the MGH Board (and the board of Marin Community Health)
- F5. The attitude of the Public Activists seems to stem from:
  - a. a refusal to accept the decision regarding the legal case against MGH Corporation/Sutter
  - b. a desire of some former members of the District Board (and others) to continue to exert influence
  - c. the conviction that MGH Corporation/Sutter is only interested in the "bottom line" and is willing to sacrifice quality healthcare
  - d. a belief that the quality of care at MGH has declined under Sutter's stewardship
- F6. Multiple allegations of conflict of interest have hamstrung the District Board and prevented it from carrying out its duties.
- F7. Valuable lessons, both good and bad, can be learned from studying the operations of other healthcare districts.
- F8. Sutter pays minimal cash rent, receives substantial management fees, but also has made capital improvement payments beyond what is required by the lease.
- F9. The BOS has broad-based responsibilities regarding the healthcare needs of the county.

## RECOMMENDATIONS

### For the District Board

- R1. Reformulate the board's mission and develop a strategic plan for the District with concrete goals and operations. Elements should include:
  - a. specific oversight responsibilities with respect to the mix of services and the quality of care at MGH
  - b. feasible long-term options with regard to hospital management
  - c. feasible long-term options with regard to the provision of other healthcare services within the district
- R2. Develop more effective ways to negotiate privately with MGH Corporation and/or any management group.
- R3. Employ consultants with expertise in hospital management to:
  - a. develop feasible options
  - b. help implement a long-term strategy that would enhance the provision of healthcare in the District
  - c. guide negotiations with Sutter about the terms of any future lease or sale, and with others regarding future management responsibilities
- R4. Negotiate an adequate rent or compensation in any new lease arrangement or sale of the hospital.
- R5. Consider hiring a CEO.
- R6. Control disruptive behavior at meetings by enforcing the Brown Act more strictly. For example:
  - a. Allow comments from the public only before an agenda item is discussed by the District Board (not during the board's discussion)
  - b. Limit comments to one per person per issue
  - c. Limit time for comments to two minutes per person
  - d. Insist that the comments deal only with the agenda item itself
  - e. Do not tolerate personal attacks
  - f. Do not engage in any discussion with the public during the period for public comments
  - g. If necessary, remove those who disrupt meetings and refuse to obey the rules
- R7. Request a seat on the Boards of MGH and Marin Community Health.

### For MGH Corp/Sutter Health

- R8. Be more transparent and comply in a timely fashion with requests for information
- R9. Respect and acknowledge the authority of the District Board and its responsibilities to the public

R10. In future lease or sale arrangements, pay the District adequate compensation

R11. Include a voting representative appointed by the District Board to the MGH/Sutter board.

**For Board of Supervisors**

R12. Use your good offices to improve relations between the District Board and MGH Corporation/Sutter.

**For Public Activists**

R13. Recognize that you are not members of the District Board and at meetings adhere to the rules adopted by the District Board.

**REQUEST FOR RESPONSES**

Pursuant to Penal code section 933.05, the Grand Jury respectfully requests responses from:

- The District Board to F1, F3, F6, F7, F8, and R1 through R7.
- MGH/Sutter to F1, F4, F8, and R8 through R11.
- The BOS to F1, F9, and R12.