Additional Information Regarding Seismic Compliance Compiled by Chair Lee Finney, 6/8/23

Follow-up Information from Andrew Flanigan, Devenney Group, to Questions raised by Leonardo Bowers at the 5/25/23 MCHCD Regular Meeting:

"Below you will find a few code references I do not see any option for the Hospital to avoid compliance or that there is any sort of exemption. Let me know if you need anything else.

HEALTH AND SAFETY CODE - HSC

DIVISION 107. HEALTH CARE ACCESS AND INFORMATION [127000 - 130079]

(Heading of Division 107 amended by Stats. 2021, Ch. 143, Sec. 28.)

PART 7. FACILITIES DESIGN REVIEW AND CONSTRUCTION [129675 - 130079]

(Part 7 added by Stats. 1995, Ch. 415, Sec. 9.)

CHAPTER 1. Health Facilities [129675 - 130070]

(Chapter 1 added by Stats. 1995, Ch. 415, Sec. 9.)

ARTICLE 1. General Provisions [129675 - 129680]

(Article 1 added by Stats. 1995, Ch. 415, Sec. 9.)

129675.

This chapter shall be known and may be cited as the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983.

(Added by Stats. 1995, Ch. 415, Sec. 9. Effective January 1, 1996.)

129680.

(a) It is the intent of the Legislature that hospital buildings that house patients who have less than the capacity of normally healthy persons to protect themselves, and that must be reasonably capable of providing services to the public after a disaster, shall be designed and constructed to resist, insofar as practical, the forces generated by earthquakes, gravity, and winds. In order to accomplish this purpose, the department shall propose proper building standards for earthquake resistance based upon current knowledge, and provide an independent review of the design and construction of hospital buildings.

(b) Local jurisdictions are preempted from the enforcement of all building standards published in the California Building Standards Code relating to the regulation of hospital buildings and the enforcement of other regulations adopted pursuant to this chapter, and all other applicable state laws, including plan checking and inspection of the design and details of the architectural, structural, mechanical, plumbing, electrical, and fire and panic safety systems, and the observation of construction. The department shall assume these responsibilities.

(c) Where local jurisdictions have more restrictive requirements for the enforcement of building standards, other building regulations, and construction supervision, these requirements shall be enforced by the department.

(d) Each local jurisdiction shall keep the department advised as to the existence of any more restrictive local requirements. Where a reasonable doubt exists as to whether the requirements of the local jurisdiction are more restrictive, the effect of these requirements shall be determined by the Hospital Building Safety Board.

It is further the intent of the Legislature that the department, with the advice of the Hospital Building Safety Board, may conduct or enter into contracts for research regarding the reduction or elimination of seismic or other safety hazards in hospital buildings or research regarding hospital building standards.

(Amended by Stats. 2021, Ch. 143, Sec. 278. (AB 133) Effective July 27, 2021.)

GENERAL ACUTE CARE HOSPITAL as used in Chapter 6, Part 1 means a hospital building as defined in Section 129725 of the Health and Safety Code and that is also licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code, but does not include these buildings if the beds licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code, as of January 1, 1995, comprise 10 percent or less of the total licensed beds of the total physical plant, and does not include facilities owned or operated, or both, by the Department of Corrections. It also precludes hospital buildings that may be licensed under the above mentioned code sections, but provide skilled nursing or acute psychiatric services only.

(a)(1) "Hospital building" includes any building not specified in subdivision (b) that is used, or designed to be used, for a health facility of a type required to be licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2.

(2) Except as provided in paragraph (7) of subdivision (b), hospital building includes a correctional treatment center, as defined in subdivision (j) of Section 1250, the construction of which was completed on or after March 7, 1973.

(b) "Hospital building" does not include any of the following:

(1) Any building where outpatient clinical services of a health facility licensed pursuant to Section 1250 are provided that is separated from a building in which hospital services are provided. If any one or more outpatient clinical services in the building provides services to inpatients, the building shall not be included as a "hospital building" if those services provided to inpatients represent no more than 25 percent of the total outpatient services provided at the building. Hospitals shall maintain on an ongoing basis, data on the patients receiving services in these buildings, including the number of patients seen, categorized by their inpatient or outpatient status. Hospitals shall submit this data annually to the State Department of Public Health.

(2) A building used, or designed to be used, for a skilled nursing facility or intermediate care facility if the building is of single-story, wood-frame, or light steel frame construction.

(3) A building of single-story, wood-frame, or light steel frame construction where only skilled nursing or intermediate care services are provided if the building is separated from a building housing other patients of the health facility receiving higher levels of care.

(4) A freestanding structure of a chemical dependency recovery hospital exempted under subdivision (c) of Section 1275.2.

(5) A building licensed to be used as an intermediate care facility/developmentally disabled habilitative with six beds or less and an intermediate care facility/developmentally disabled habilitative of 7 to 15 beds that is a single-story, wood-frame, or light steel frame building.

(6) A building subject to licensure as a correctional treatment center, as defined in subdivision (j) of Section 1250, the construction of which was completed before March 7, 1973.
(7)(A) A building that meets the definition of a correctional treatment center, pursuant to subdivision (j) of Section 1250, for which the final design documents were completed or the construction of which was initiated before January 1, 1994, operated by or to be operated by the Department of Corrections and Rehabilitation, or by a law enforcement agency of a city, county, or a city and county.
(B) In the case of reconstruction, alteration, or addition to, the facilities identified in this paragraph, and paragraph (6) or any other building subject to licensure as a general acute care hospital, acute psychiatric hospital, correctional treatment center, or nursing facility, as defined in subdivisions (a), (b), (j), and (k) of Section 1250, operated or to be operated by the Department of Corrections and Rehabilitation, or by a law enforcement agency of a city, county, or city and county, only the reconstruction, alteration, or addition, itself, and not the building as a whole, nor any other aspect thereof, shall be required to comply with this chapter or the regulations adopted pursuant thereto.
(8) A freestanding building used, or designed to be used, as a congregate living health facility, as defined in subdivision (i) of Section 1250.
(9) A freestanding building used, or designed to be used, as a hospice facility, as defined in subdivision (n) of Section 1250."

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After sharing the above information with Leonardo Bowers, I received the following comments from Mr. Bowers:

"The States "Seismic Regulation Overview" states that California seismic regulations set by State Regulators ONLY APPLY TO buildings that provide ACUTE CARE SERVICES.

A structural Engineer is the skill set that needs to be employed to determinel seismic adequacy. Only after this evaluation is completed can you make a proper evaluation.
A don't believe your board has been given the complete evaluation.. If last Thursday is the Devenny work product, you haven't been shown the necessary work product.

There are more than just an Acute Care Option. I refer you to AB 869. This bill written by our own legislator, Jim Wood.
Ironically it's again the structural report that is needed to start this process. AB 869 even defers all costs until the State can come up with the funds for us. As I heard your Board meet, your Board
Has taken it upon themselves to review these matters. I have suggest a combination of Rural, emergency room, and transpiration. I'would be happy to talk with you."

I sent the following questions to Andrew Flanigan on 5/27/23:

"Some questions that you or Dave or Jenny might be able to answer came from a Board member during later discussion:
'If we build a new facility what has to be in there? Can the lab, kitchen, pharmacy, and administration stay in the old facility? What is the cost of 10 beds? 15 beds?' I couldn't tell from the Cummings report on a replacement hospital cost what the cost per bed would be.

Also, I am not clear about why you chose the replacement option that you did as the second option in your original proposal that puts a replacement hospital up against the current Outpatient building seems to have merit by making use of existing structures that do not require any changes and that would not use the adjacent field that might then be available for workforce housing. Can you explain this choice a little further please."

Mr. Flanigan's responses:

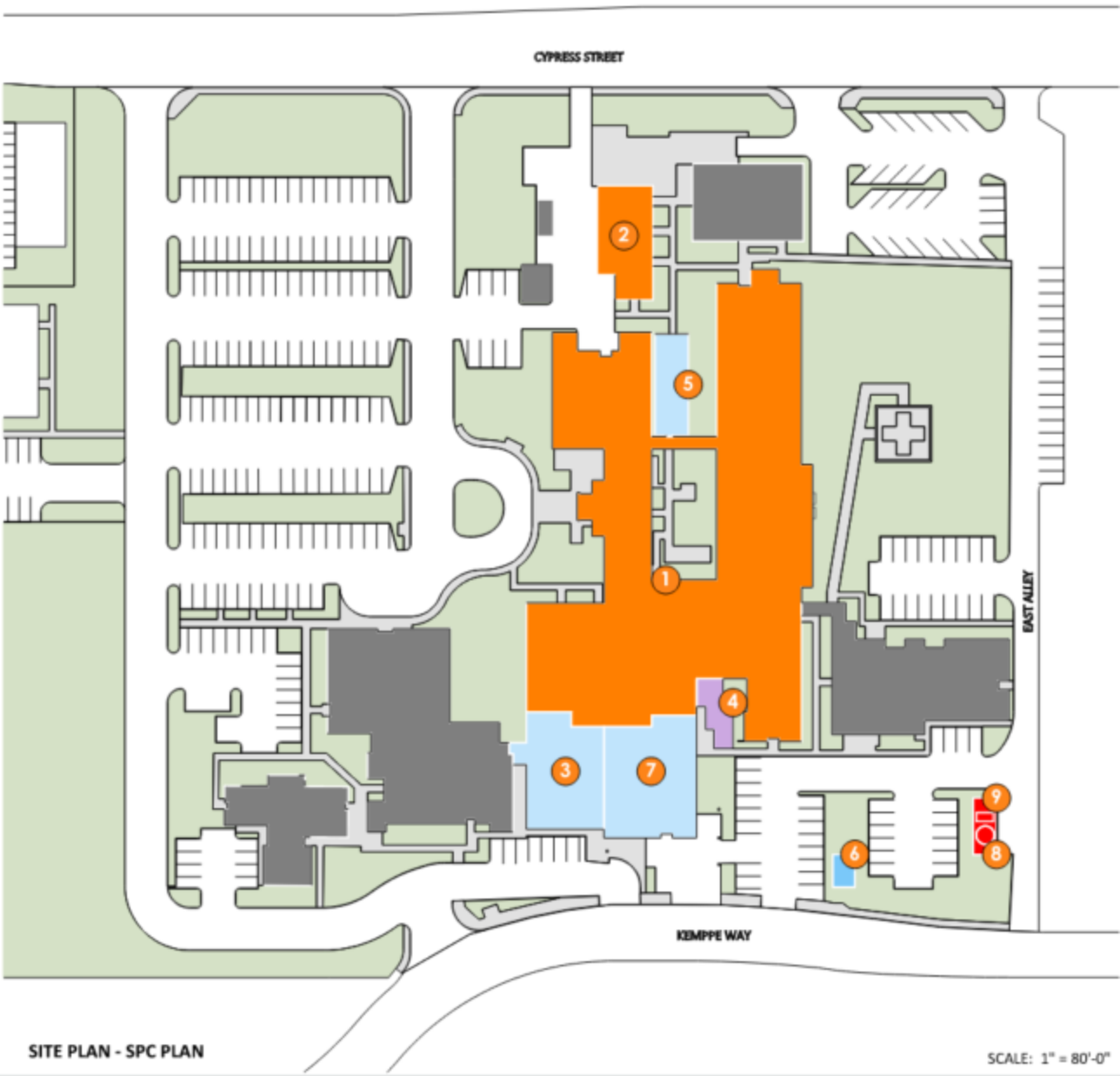
See thoughts on your questions below. Let me know if we need to get on a call and review.

1. "*If we build a new facility what has to be in there? Can the lab, kitchen, pharmacy, and administration stay in the old facility?*
    a. Basic Services and supplemental Services Must be in a seismically compliant structure see definition below. In short if you do not upgrade the existing building they cannot be in the existing building.
        i. **[OSHPD 1]** The provisions of this section shall apply to general acute-care hospitals and general acute-care hospitals providing only acute medical rehabilitation center services. The provisions of Section 1225 shall apply to distinct part skilled nursing and intermediate-care services on a general acute-care hospital license provided in a separate unit.
            1. ***GENERAL ACUTE-CARE HOSPITAL***. A hospital, licensed by the California Department of Public Health, having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff which provides 24-hour inpatient care, including the basic services.

a. ***BASIC SERVICES***. Those essential services required for licensure as a hospital, including medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, dietary services and support services. See "SUPPLEMENTAL SERVICES."

b. ***SUPPLEMENTAL SERVICE***. An inpatient or outpatient service which is not required to be provided by law or regulation for licensure. A supplemental service, when provided, must accommodate the provisions of this section.

2. *What is the cost of 10 beds? 15 beds?" I couldn't tell from the Cummings report on a replacement hospital cost what the cost per bed would be.*
    a. On a facility of this size, we do not recommend correlating the cost per bed, as that metric would be out of scale due to the support and diagnostic and treatment services required for a general acute facility. I have attached the Cumming report in case we had not already sent. This report has a base "16 bed hospital" @ $96.7 M and an add alternate that shows the cost of an additional 9 beds @$10.7 M. This is shown on page 5 of the report. I would also like to point your attention to page 10 of the report as it lists the breakdown of hospital areas (inpatient, support etc)
    b. Do you need us to evaluate a different facility size?
3. *Also, I am not clear about why you chose the replacement option that you did as the second option in your original proposal that puts a replacement hospital up against the current Outpatient building seems to have merit by making use of existing structures that do not require any changes and that would not use the adjacent field that might then be available for workforce housing.*
    a. I have attached an existing SPC plan for reference. There are three areas that are compliant from an SPC perspective # 3 (lab), 5(outpatient and support), 7 (Emergency). Please note that if a decision is made to maintain any of these areas and not upgrade the orange areas then all utilities would have to be rerouted and the rest of the general acute hospital would have to be directly connected to the compliant structures. From a functional and modern standard of Care I would classify the Lab as a good usable condition, and I would classify the ED as an Outdated condition. To directly connect a new structure to the portions that are compliant you would need to demolish the existing outpatient building. This would be a loss of an outpatient structure of 13,400 sqft in order to save 7,300 sqft of acute care. In my opinion it would be costly and highly inefficient to keep the 7,300 sqft of good acute space.
    b. would you like this scenario priced? This would require careful study and would need input from MEP and STRUCTURAL.

4. 

Additional comments from Mr. Bowers:

I only had one day to read the Devenney information in the MCHCD board package. I really don't know how you get all this work done! Since my concerns go beyond Seismic let me express them to you.

I'm advised by ''Supervisor Williams that a sample survey indicates that 25% of all homes in Mendocino Co. are not on the tax rolls.
Mendocino pays approx. 10% higher construction costs than in urban areas.
Cummings proposes that just the anticipated inflation costs 2023 - 2030 to be 29%. It might be higher.
Beyond construction, Contingencies are 51.7%. for hospital work per Cummings.
The MCHCD not just once, but has reciently gone bankrupt twice.
Because the MCHCD is in a poorer area, the health care reimbursement is less than the cost. And that is before one adds a new $100+ Million hospital.

Add all these costs and it's over 100%. !00% over $4 Milliom is $8 million. 100% over $120 Million is $240 Million. 30 Times higher. I don't need to
pay Deveney $162,570 more to know that I personally can't afford a new hospital. I know I have to travel for quality health care. Your boundaries don't seem to be able to support what we would like.

Doing nothing is not a viable option. To my way of thinking the first step is to recognize that the problem is SIEMIC. What's needed is a "collapse probability assessment".
From there you might have something to argue with. This is a more sophicated way
of repeating "Structural Engineer". I would hope that the MCHCD would also get together with Adventist Health Mendocino

To see what can be accomplished. And finally Lee for the $s that your paying, the signature and stamp of those proposing work is not unreasonable.

Best of Luck,

Leonardo Bowers, RCE 21,001

On 6/8/23 I received notice that AB869 has passed out of the Assembly and been referred to the CA Senate Health Committee.