

BUILDING A HEALTHY COYOTE VALLEY
A PROPOSAL FOR COMMUNITY HEALTH CLINICS

WORKING PARTNERSHIPS USA

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EXECUTIVE SUMMARY

When complete, Coyote Valley is expected to house some 80,000 people. In order to succeed and thrive, this new community will need to provide access to affordable health care for all its members. This brief explores a crucial part of any region's health care infrastructure: community health clinics. It analyzes Coyote Valley's future demand for health services, why clinics specifically are necessary for its collective well-being, and how to pay for new clinics.

BUILDING A HEALTHY COYOTE VALLEY

The first step in helping Coyote Valley to grow and thrive is to build the necessary infrastructure to attract residents, industry and commerce. Components of infrastructure include such basics as water supplies, sewage systems, roads, and access to electricity, as well as essential community amenities like schools, parks, and health care facilities.

Doctors' offices and other private health practitioners can be expected to set up shop on their own as Coyote Valley develops. But private practices are often closed to those without private health coverage – a condition likely to be experienced by 7,000 or more of Coyote Valley's residents. Less than half of the county's physicians participate in Medi-Cal, leading to a ratio of just 44 physicians per 100,000 Medi-Cal clients (versus 61 physicians overall per 100,000 county residents). Even fewer MDs serve the uninsured. As a result, only 26% of uninsured Californians and 54% of those enrolled in Medi-Cal or Healthy Families use a doctor's office as their usual source of care. Although doctors' offices are a crucial element of the health care infrastructure, they alone will not be sufficient to maintain a healthy population.

One could propose that existing clinics and hospitals in the region serve Coyote Valley's population. However, not only do existing safety net providers lack the capacity to handle such an influx, they are too far away. From the center of the proposed Mid-Coyote development, the two nearest hospitals will be Santa Teresa and St. Louise, respectively 9 and 17 miles by road. The closest full-service primary care clinics will be East Valley Community Clinic, Mayfair Health Center, and Gardner South County Health Center, all 14-16 miles from Mid-Coyote. This is simply too far to travel to access primary health care, especially for the transit-dependent.

In short, ensuring the health of Coyote Valley's population requires that residents have access to community health clinics, and that those clinics be located in Coyote Valley. But unlike private practices, clinics cannot be expected to arrive purely in response to demand; their construction depends upon community funding and support.

PROPOSAL FOR COYOTE VALLEY CLINICS

Based on the projected demand as well as the characteristics of the geographic area in question, two primary care community health clinics of roughly 50,000 square feet each are recommended for Coyote Valley. Assuming a population of 80,000 at buildout in Coyote Valley, these clinics would each manage about 7,200 annual patient encounters. They should be located on sites accessible to pedestrians, drivers, and transit users, to be near schools and community centers, and to minimize transportation time to a clinic for any resident.

Currently, building two new clinics of this size in Santa Clara County would cost approximately \$60 million, including land, construction, and capital equipment. If paid for by imposing a levy on landowners and issuing 30-year bonds, the total cost would be approximately \$2,100 per acre per year over the next thirty years. From a homeowner's perspective, with an average of 10 units per acre, the price tag would be slightly over \$200 per household per year.

One possible mechanism for funding infrastructure projects, including health clinics, in Coyote Valley could be a Community Facilities and Services District (CFD), a special levy paid by all landowners in a region to finance specified capital projects such as parks, fire stations, roads, sewer systems, or others. A Mid-Coyote CFD may be created to finance many of the proposed infrastructure improvements associated with residential and commercial development; the construction of two health clinics could simply be added to the list of projects which the CFD would be funding. Once construction is complete, a nonprofit or public operator could take over the clinics, which would then be responsible for securing funding for their continuing operations.

INTRODUCTION

Coyote Valley sits south of urban San Jose and east of Morgan Hill, nestled among the foothills of two mountain ranges. Geography has kept this 6,800-acre region largely undeveloped, aside from some farmland and homes in the south and a few isolated industrial sites. Now, the city of San Jose has entered into a multiyear planning process to create a new Coyote Valley community from the ground up.

Development of the Coyote Valley offers the prospects of either an exciting experiment in New Urbanism or an inefficient and costly exercise in urban sprawl. To avoid the latter option, a community coalition spearheaded by the Greenbelt Alliance undertook a “visioning” process to create a model that embodied Smart Growth principles.

The result was the Coyote Valley Vision, a plan calling for developing Mid-Coyote by integrating jobs, housing, schools, parks, shopping, and services to create cohesive and livable communities. When complete, the Coyote region will boast a projected 25,000 homes, 50,000 jobs, and 80,000 people – nearly twice the size of nearby Gilroy.

Critically, the Coyote Valley Vision recognizes that the Valley’s residents and employees will include families of all income levels, and that the planned development must provide for the needs of working families. It calls for affordable units to make up at least twenty percent of all housing, for a strong public transit system providing mobility to all, and for opportunities for small businesses to compete and thrive. It also calls for community amenities to be integrated into planning from the outset, including affordable housing, child care centers, and community health clinics.¹

This brief focuses on one particular element of the Vision: community health clinics. Based on the City’s development goals for Coyote Valley, it projects future residents’ health care needs and analyzes the ability of existing health providers to meet those needs, especially given Coyote Valley’s relative isolation and the demand for affordable healthcare options amid skyrocketing costs. Concluding that two new community health clinics will be needed in Coyote Valley, it estimates their cost and examines a strategy for paying for clinic construction using a funding model known as a Community Facilities District.

Integrating clinics into the infrastructure and financing plans now being created will help to ensure a healthy workforce, healthy families, and a healthy community as Coyote Valley eventually becomes the home for tens of thousands of San Jose residents.

BUILDING A HEALTHY COYOTE VALLEY

In designing an entire new town, the first step is to build the infrastructure that will allow families, businesses and the community to survive and prosper. The people of Coyote Valley will need water, sewage systems, and electricity. They will need roads and public transit. They will need schools for their children and fire stations to protect public safety. And they will need health care facilities to maintain their physical and mental well-being.

Some proportion of these health needs can be met by private doctors and specialists, who will set up shop in Coyote Valley on their own initiative as the population grows. But experience clearly shows that market forces alone do not provide universal access to health care. As in the rest of Santa Clara County (and indeed, the nation), not everyone will have sufficient health coverage or personal financial resources to be able to see private practitioners for all of their health needs. When members of a community – parents, children, workers – have nowhere to turn for their health needs, the entire community pays the price. The health care safety net must be extended into Coyote Valley.

PROJECTED SCALE OF HEALTH NEEDS

Once complete, Coyote Valley is expected to house 80,000 residents. Projections indicate that roughly 14,800 of these residents will have very low household incomes (below 50% of the county median), 14,800 will have low incomes (50-80% of median), 19,200 will have moderate incomes (80-120% of median), and the remaining 31,200 residents will have higher incomes.²

Assuming that the health care needs of Coyote Valley's population will be similar to the needs of people in the rest of the county and state, the table below approximates the number of health professionals that Coyote Valley's population will require. One hundred and fifty-six practicing physicians, 595 nurses, and 216 nurse aides, orderlies and attendants will be necessary, among other occupations.*

Estimated number of health professionals needed to serve Coyote Valley		
Health profession	Per 100,000 population in CA	Needed in Coyote Valley
Physicians	195	156
RNs	568	454
Nurse practitioners	25.6	20

* This presumes that access to health care providers in California is currently adequate for the state's population. If, as has been argued, California suffers from a shortfall of health providers, then the number needed in Coyote Valley might be greater.

LPNs	151	121
Dentists	55.0	44
Dental hygienists	53.0	42
Dental assistants	101	81
Physician assistants	7.7	6
Chiropractors	32.9	26
Podiatrists	4.5	4
Optometrists	11.1	9
Opticians	23.3	19
Pharmacists	51.3	41
Pharmacy aides & technicians	51.0	41
Psychologists	34.4	28
Social workers	140	112
Physical therapists	33.6	27
Physical therapy assistants	20.9	17
Occupational therapists	16.2	13
Occupational therapy assistants	5.1	4
Speech-language pathologists & audiologists	24.6	20
Respiratory therapists	24.8	20
Emergency medical technicians	38.3	31
Radiology technicians	39.4	32
Clinical laboratory technicians	86.4	69
Medical records technicians	29.8	24
Dieticians & nutritionists	14.2	11
Home health aides	71.0	57
Nurse aides, orderlies & attendants	270	216
Assumes population of 80,000 in Coyote Valley. Health professional ratios from Bureau of Health Professions, "HRSA State Health Workforce Profile: California." Rockville, MD: U.S. Dept. of Health and Human Services, December 2000.		

The demand for health services will be filled in several ways. Some parts of the health infrastructure, like private doctors' offices, dentists and specialists, can be expected to move in on their own to take advantage of the new market. Coyote Valley residents will also take advantage of the existing infrastructure (outside of Coyote Valley) available for certain health needs, such as hospital beds and some types of specialty care.

But this base of services still leaves a residual demand for locally based primary health care that is accessible to those without private health insurance—which will include a significant number of Coyote Valley's families. Santa Clara County averages 9.7% uninsured among residents aged 0-64;³ Coyote Valley would have more than 7,000 uninsured residents if it mirrors this trend.

If the emphasis in Coyote Valley will be on smaller companies rather than on large employers, more residents may end up uninsured. While large companies can take advantage of their purchasing power to make a deal with insurance carriers, small businesses with only a handful of employees find it difficult to offer health coverage. Statewide, firms with less than 10 employees provide just 26% of their workers with health insurance, and firms with 10-50 employees cover only 51% of their workers, whereas at the largest firms 79% of employees are covered.^{*,4}

Lack of access to job-based insurance will create an increased need for primary care providers where patients can pay for their own treatment according to their limited financial means. Few, if any, private physicians are able to offer such a sliding scale payment system for uninsured patients.⁵ And a small and diminishing number of private physicians accept Medi-Cal or Healthy Families patients. A doctor's office or HMO office is the usual source of care for 82% of Californians with job-based insurance, yet only 26% of uninsured Californians and 54% of those with Medi-Cal or Healthy Families use a doctor's office as their usual source of care.⁶ Although doctors' offices are a crucial element of the health care infrastructure, they will not alone be sufficient to maintain a healthy population.

In Coyote Valley as in all California, residents will need access to community health clinics. The section below describes the genesis of health clinics, what they are and who they serve. Unlike private practices, clinics cannot be expected to arrive purely in response to demand; their construction generally depends upon community funding and support.

THE EXISTING HEALTH CARE INFRASTRUCTURE

Coyote Valley's need for new health infrastructure will be exacerbated by the shortfall of existing infrastructure in the county, especially near the proposed development site.

Hospitals

Eleven hospitals with 3,277 licensed beds are located in Santa Clara County, providing over 600,000 patient-days in 2002.⁷ The number of acute care hospital beds available in the county has fallen, from 2.2 beds per 1,000 residents in 1996, to just 1.6 beds per 1,000 in 2000. Hospital closures and cutbacks have contributed greatly to this trend.⁸

As there are currently no plans to build a hospital in Coyote Valley, residents needing emergency care or hospitalization will have to use hospitals elsewhere in the county. But even assuming existing hospitals can adjust to the increased patient load, their distance from the new

* The recently passed California bill SB 2, if it withstands legal and electoral challenges, will result in affordable insurance for all employees at medium and large companies, but businesses with less than 50 employees will be exempt.

development will make it impractical for residents to visit hospitals for more routine treatments. The two nearest hospitals will be:

Kaiser's Santa Teresa Community Hospital
250 Hospital Pkwy.
San Jose, CA 95119

and

St. Louise Regional Hospital
9400 No Name Uno
Gilroy, CA 95020-3528.

From the center of the proposed project, it is 9 miles by road to Santa Teresa and 17 miles to St. Louise.

Clinics

The number of primary clinics in Santa Clara County has grown from 25 in 1996 to 31 in 2000, indicating an attempt to respond to unmet needs.⁹ In 2000 these clinics served 87,415 patients with over 300,000 patient visits (or "encounters"). They employed the full-time equivalent of about 32 physicians, 6 physician assistants, 19 family nurse practitioners, 12 registered nurses or certified nurse midwives, and 7 dentists.¹⁰

The nearest primary care clinics to the proposed development site (excluding school clinics which primarily serve youth, and specialty providers such as family planning clinics) are:

East Valley Community Clinic
2470 Alvin Ave.
San Jose, CA 95121-1664

Mayfair Health Center
660 Sinclair Dr.
San Jose, CA 95116-3464

Gardner South County Health Center
700 W 6th St.
Gilroy, CA 95020-6014

These clinics are respectively 14 miles, 16 miles, and 16 miles by road from the planned center of Coyote Valley.

Providers Accepting Medi-Cal or Uninsured

County residents who are not covered by a private health insurance plan often have difficulty locating a physician who will see them, even if they are covered by Medi-Cal or can pay for services themselves. In Santa Clara County, only 47% of physicians participated in Medi-Cal as of 1998, and for those who did participate, only an average 15% of their patients were Medi-Cal clients.

As a result, the county had just 44 Medi-Cal primary care providers per 100,000 Medi-Cal beneficiaries, an availability ratio nearly one-third lower than the county's overall primary care physician ratio (61 physicians per 100,000 residents). The federal workforce standard is 60 to 80 physicians per 100,000; availability of Medi-Cal primary care physicians is thus substantially below standard.¹¹ New patients seeking a provider face higher barriers. In California's urban counties, 91% of physicians were accepting new patients in 2001, but only 50% were accepting new Medi-Cal patients and 38% accepting new uninsured patients.¹²

All this means that Santa Clara County already suffers from a shortfall in primary care access for those without private health insurance, especially children.¹³ (This problem is not unique to Santa Clara; throughout California, families without insurance or with Medi-Cal face increasing challenges finding a doctor.) If Coyote Valley's 80,000 new residents must rely on existing primary care facilities, it will worsen the shortage of providers for Medi-Cal beneficiaries and the uninsured.

COMMUNITY HEALTH CENTERS AND CLINICS

Community health centers and community health clinics are organizations providing health and social services to medically underserved populations. Generally they are public or private non-profit entities. Community clinics seek to ensure that all members of a community have access to culturally competent health care and services; they make up a crucial section of the health care safety net. They provide free or sliding-scale services to patients who do not have insurance and cannot afford to pay the full cost out of pocket, though many of their patients self-pay or have public or private insurance. Most clinics focus on primary or preventative care, which can include medical, dental, and mental care; many specialize in a particular type of care, such as family planning, or a particular population, such as high school students.

The first federally-supported neighborhood health centers – centers providing medical care and other health services to underserved communities, open to all regardless of ability to pay – were created in 1965 as part of the War on Poverty. By 2000, over 9 million Americans were receiving services at health centers each year. Over 700 health centers nationwide operate about 3,000 clinics employing a network of 6,500 primary care clinicians. Community health centers are a

crucial and growing component of our nation's health care system. Between 1990 and 2000, the number of people served by community health centers doubled.¹⁴

The federal health center program is now known as the community/migrant health center (C/MHC) program. It is administered by the Division of Community and Migrant Health (DCMH), part of the Bureau of Primary Health Care (BPHC) within the federal Health Resources and Services Administration (HRSA). The mission of the community health centers is to provide quality primary and preventative health care to people in underserved areas, as part of the BPHC's goal of ensuring that all underserved or vulnerable populations have access to quality health care, and eliminating racial/ethnic disparities in health status. Each center tailors its services to the needs of its local communities, including services that address economic, geographic, or cultural barriers that prevent people from accessing primary health care.¹⁵ Many other health centers are not part of the federal program, but have similar missions.

Today, the California Primary Care Association represents more than 600 community clinics and health centers throughout the state.¹⁶

Who Do Clinics Serve?

According to the State of California's Office of Statewide Health Planning and Development, primary care clinics in Santa Clara County served 87,415 patients in 2000, providing 302,004 medical encounters. Overwhelmingly, those served by the county's clinics are female, Latino/a, and either children or working-age. More than a third (37.5%) of patients were children or youths; about half (49.3%) were aged 20-44; 7.6 % were aged 45-64; and 5.5% were 65 or over. Women and girls made up three-quarters of all patients. Seventy-two percent of patients were Latino and 11% white, with no other reported ethnicity making up more than 5%.

Clinics are not just for the very poor. As of 2000, almost half (48%) of all patients at Santa Clara clinics were from households above the poverty line: 28.1% between 100% and 200% of poverty, and 19.6% above 200%.¹⁷ Clinics provide care to the uninsured, to people with Medi-Cal, Medicare, and other public coverage, and to those with private health insurance who face long waiting periods or inaccessible times and locations for care through their insurance providers.

The uninsured are themselves a large, diverse and growing group. Most are employed; 84% of California's uninsured children live with parents who work, but cannot access affordable health insurance through their job. Older women (ages 40-64) are particularly likely to lack health insurance in Santa Clara County, in part because they are less likely to have a job that provides affordable insurance, and less likely than younger women to be caring for minor children, a necessary qualification for Medi-Cal. This is the time of life when women most need access to preventative care for screenings for cancers, heart disease, osteoporosis, diabetes, and other chronic diseases. Prevention or early detection can help to treat or control these conditions before they become life-threatening. But without health insurance many women are often

unable to seek treatment until the condition becomes dangerous or crippling, a situation which is both harmful to women and far more expensive for the health care system.¹⁸

How Are Community Clinic Services Funded?

Community health centers provide care to all residents, regardless of their ability to pay. This characteristic makes them a crucial part of the 'safety net' health care system. But it does not mean that clinics receive no money from their patients. On the contrary, the bulk of clinics' operating revenue comes from their patients' insurance providers (both public and private) and from payments by the patients themselves. In all Santa Clara County clinics, less than 10% of encounters in 2000 involved non-paying patients. Seventeen percent were self-paying, 32% were covered by Medi-Cal, 7.4% were covered by Medicare, 2.0% had private insurance, and the remainder were covered under other county, state or federal programs.¹⁹

In addition, the state of California funds health centers through the Expanded Access to Primary Care Program, EAPCP (\$31 million in FY2003-04), the Rural Health Services Development Program (\$8.2 million); the Seasonal Agricultural and Migratory Worker Program (\$6.9 million), the Indian Health Program (\$6.5 million), and the Grant-in-Aid for Clinics Program. Total 2003-04 funding for health center programs was \$52.6 million. In 2003, EAPCP funding for federally qualified health centers fell by \$1 million as tobacco tax revenues dropped.²⁰

How Do Clinics Impact the Broader Community?

Because they provide preventative and primary care to those who would otherwise go without, community health clinics improve the overall health of the community and reduce pressure on emergency rooms and hospitals. Health centers reduce infant mortality and low birth weight among their patients. They provide routine cancer screenings, contributing to early detection and treatment; women of all races are much more likely to receive a pap smear, mammography and/or clinical breast exam if they are health center users. One estimate is that every dollar spent on primary and preventative care saves seven dollars in emergency, specialty and long-term care, by finding and treating potential health problems before they become serious.²¹

Clinics also have an economic impact. As employers, they provide relatively well-compensated and career-track jobs, both at the clinic itself and in the manufacturing of medical equipment and other supplies purchased by clinics. For every job created at a clinic in San Jose, about 0.3 additional jobs are created in the city due to the clinic's economic multiplier effect.²² In addition, clinics help to keep workers and children healthy, reducing lost productivity due to employees' illness and lost instructional time for students.²³

What Challenges Do Clinics Face?

The most pressing issue facing community health centers today is a continual increase in the number of patients needing services, without a concomitant increase in the funding which clinics need to treat those new patients. The increasing number of patients at health centers is caused by a combination of factors, including the loss of job-based health insurance, fewer doctors accepting Medicare or Medi-Cal, and the difficulty of navigating the bureaucracy of health plans. At the same time, funding for clinics, especially funding to provide uncompensated care, is falling.

Across the country, health centers are being hit by state budget cuts, as direct health center funding, Medicaid, and SCHIP are all cut. California health centers are among the most challenged. “[O]ur health centers are seeing more patients and less funding,” says the president of a state health center association.²⁴

PROPOSAL FOR COYOTE VALLEY CLINICS

Given the anticipated demand for health care and the lack of existing primary health providers for the uninsured in the region, the need to incorporate new providers into Coyote Valley's development is clear. Any plan for Coyote Valley should incorporate construction and financing of community health clinics. The sections below estimate the cost and scale of such clinics and offer suggestions for financing, location and operations.

CLINIC SCALE AND LOCATION

As demonstrated above, Coyote Valley residents will have considerable health care needs that cannot all be fulfilled by existing providers. Santa Clara County already suffers from a shortfall of health care providers serving Medi-Cal clients and the uninsured. Adding 80,000 new residents, of whom 7,000 or more are likely to lack insurance, would put the county's clinics and emergency rooms under great strain. Add to this situation the 15-mile distance a Mid-Coyote resident would have to travel to even reach a clinic, and relying upon existing facilities to serve Coyote's future population becomes clearly untenable.

If the frequency of clinic visits in Coyote Valley is similar to the rest of the county, we can expect the clinics serving the valley to see about 14,400 total patient encounters per year once the region is fully populated.²⁵ The median Santa Clara clinic has 7,474 total patient encounters annually.²⁶

Based on the projected demand as well as the geographic area in question, two primary care community health clinics of roughly 50,000 square feet each are recommended for Coyote Valley.

Criteria to consider in locating the clinics include:

- Proximity to public transit
- Proximity to schools
- Proximity to "town centers"
- Accessibility to pedestrians
- Accessibility to autos
- Minimization of auto/transit transportation times for all residents to one of the two clinics

COST

The precise cost of building these health clinics will depend on a large number of factors, many of which are still unknown. However, it is possible to extrapolate from current conditions in Santa Clara County to produce a ballpark estimate of construction costs. These estimates follow.

The present-day price tag for a new 50,000-square foot clinic in Santa Clara County averages \$30 million, including land, construction, and equipment.²⁷ The two proposed Coyote Valley clinics, then, would cost about \$60 million to build and supply.

If we assume that the clinics are paid for by bonding tax dollars (more on funding sources in the following section), and that 30-year-bonds are issued at a 6.5% interest rate, the cost over thirty years would be \$137,839,396. With 2,200 acres in the Coyote Valley urban reserve, this comes to \$2,088 per acre per year over the next thirty years.

This is the cost to landowners, but landowners presumably will pass on the expense to all residents in the form of higher housing prices, higher rents, and so forth. If incidence of the cost fell equally on all 80,000 future residents, each individual would pay \$57 per year over a thirty-year period. **From a homeowner's perspective, assuming an average of 10 units per acre, the price tag would be \$209 per household per year.**²⁸ All of these are, of course, only extremely rough estimates; the actual cost will depend heavily upon the financing mechanism, and could vary from the examples given here.

Once the clinics are in place and capital equipment purchased, they would cover their operating costs through a combination of payments from private insurers, public programs such as Medicare, Medi-Cal, and Healthy Families, client payments, and public and private grants, in the same way that Santa Clara County's 31 existing clinics fund their operations.

FUNDING MECHANISM

The funding strategy for Coyote Valley's infrastructure is still under discussion. One possible mechanism, which could be used to fund health clinics as well as other infrastructure projects, is a Community Facilities and Services District (CFSD or CFD).

Community Facilities and Services Districts

In a Community Facilities District, all landowners in the district pay a special levy on their property which is used to finance specified capital projects; some of the projects that can be funded include parks, schools, fire stations, highway interchanges, water and sewer systems, libraries, and child care facilities. A Mid-Coyote CFD may be created to finance many of the proposed infrastructure improvements in Coyote Valley; the construction of two health clinics and their cost could simply be added to the list of projects that the CFD would be funding.

A CFD is *not* a special district; it is a financing mechanism, usually used when a group of landowners has infrastructure needs like roads or sewers that cannot be provided effectively by each landowner acting individually. Using a CFD, a special annual tax is levied on landowners,

secured by a continuing lien on their property; frequently bonds are issued to enable immediate construction based on anticipated tax proceeds. Improvements made using the CFD special tax increase the value of the property in the region, so that over the long term landowners generally expect that the balance of benefits received versus taxes paid will be in their favor. A CFD has the advantage of apportioning the tax burden to the residents that will benefit from the improvements made, rather than requiring residents of nearby neighborhoods to subsidize new development.^{29,30}

The CFD boundaries, special tax rate, and projects to be financed must be approved by a two-thirds vote of all registered voters in the district, or, if there are less than 12 registered voters, by a two-thirds vote of all landowners proportional to their acreage. Creating a Mid-Coyote CFD would involve the following major steps.

- First, the City of San Jose, in consultation with stakeholders, would adopt a resolution of intention for a Mid-Coyote Community Facilities District. This resolution would include the name of the proposed CFD, its boundaries, a detailed description of the types of facilities or services to be funded, a description of the special tax to be levied on landowners, including the rate, method of apportionment, and how the tax would be collected, the time and place of the requisite public hearing, and the proposed procedure for voting on the CFD.
- Next, the city must hold a public hearing, mailing notices in advance to all landowners and registered voters in the proposed district. The city also prepares a report detailing the purpose of the district, the facilities or services to be provided, and the estimated cost. All landowners and registered voters have the opportunity to file protests against the whole concept of the district or against particular details, such as the boundaries or the specific facilities to be built. The city can change the particulars of the proposal to address these concerns. But if more than half the registered voters or the owners of more than half the land area file protests, the CFD proposal cannot go forward, although the city may try again in one year.
- Finally, an election is held on whether to create the CFD and levy the tax. Two-thirds of electors must approve the tax for it to pass.³¹

Community Facilities Districts are authorized by California's Mello-Roos Community Facilities Act of 1982. More information on this subject is available at <http://ceres.ca.gov/planning/financing/chap2.html>, <http://ceres.ca.gov/planning/specific/part6.html>, and http://www.treasurer.ca.gov/cdiac/publications/mello_roos.htm. Chapter 14.27 of the San Jose Municipal Code describes the procedure for creating CFDs in San Jose, incorporating and modifying the Mello-Roos Act; San Jose, Sunnyvale, and Evergreen School District are among the local entities that in the past have made use of Community Facilities Districts.³²

Coyote Valley CFDs

In North Coyote Valley, landowners and the City have already established a Community Facilities District: the North Coyote CFD, officially known as San Jose Community Facilities District No. 9 (Bailey Road/Highway 101). It encompasses 572 acres in northern Coyote, 363 of which are vacant and zoned Campus Industrial (the planned site of the Coyote Valley Research Park), and all belonging to a single landowner, Coyote Valley Research Park LLC. The land has an appraised value of \$55.35 million, assuming the Bailey project is completed.^{33,34}

The City officially formed the CFD on December 17, 2002, and on January 29, 2003 issued \$13,560,000 worth of special tax bonds. \$1,515,000 of the bond proceeds will be used for Phase 1 of the project.³⁵

The North Coyote CFD is set up to finance basic infrastructure including road construction and improvements, but not for community amenities such as childcare centers, parks, or health clinics. Now that Mid-Coyote Valley is also on the verge of development, a CFD may be established for Mid-Coyote (or for Mid-Coyote and North Coyote together) to fund these additional projects, which will be needed to support residential or mixed-use neighborhoods.³⁶

In particular, funding from a new CFD could be used to purchase and assemble land for two clinics and provide assistance with construction and capital equipment. The City of San Jose would not operate the health clinics once built; rather, it would make arrangements with another operator, most likely one of the public or private nonprofit entities already running health clinics elsewhere in Santa Clara Country.

Other Funding Sources

In addition to dedicating a portion of a Community Facilities District levy to health clinics, the City and Coyote Valley landowners may wish to investigate other potential sources of funding, including any federal government assistance that may be available for this purpose. Several other organizations provide resources to help communities fund new clinics. For example, Capital Link is a nonprofit consultant with the mission of assisting community health centers in identifying and securing capital financing. Through a joint program with the Community Clinics Initiative, sponsored by the Tides Center and The California Endowment, Capital Link provides many services at no cost for clinics in California.

More information is available from Capital Link at <http://www.caplink.org> and from The Tides Center at http://www.tidescenter.org/project_detail.cfm?id=60010.0.

Other areas of the city such as North San Jose and Edenvale have used redevelopment tax increment dollars to finance infrastructure prior to development. However, Coyote Valley is not in a redevelopment project area, so this funding source is not available.³⁷

CONCLUSION

As the Coyote Valley development comes into being, its need for a health care safety net will emerge and grow. Accessible community clinics will become necessary to meet that need and ensure the well-being of all residents, of businesses, of families, and of the Valley as a whole.

Understanding that no community can long thrive without adequate health services, we have two choices. We can wait until businesses and residents have already moved into Coyote Valley, wait until the need for health clinics becomes obvious because people are demonstrably unable to get prompt access to care, and wait until property has appreciated, causing the price of clinics to escalate. Or, we can integrate community health clinics into the plan from the start, treating them just as we are treating schools, parks, fire stations and other necessary community infrastructure.

In Coyote Valley, the people of San Jose are designing an entire town nearly from scratch. This is a unique opportunity to get it done right the first time.

REFERENCES

- ¹ Greenbelt Alliance, “Getting it Right: Preventing Sprawl in Coyote Valley.” June 2003.
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