HMA

HEALTH MANAGEMENT ASSOCIATES

Analysis of Inpatient Mental Health Delivery Services for the County of Santa Barbara Project 1

BY
HEALTH MANAGEMENT ASSOCIATES

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Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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Executive Summary

In August 2012, the County of Santa Barbara County Executive Office was authorized by the Board of Supervisors to engage Health Management Associates (HMA) to conduct an analysis of the inpatient mental health delivery service [including acute psychiatric inpatient services, crisis residential and Institutions for Mental Disease (IMD)]. In addition to the analysis, the final report needed to provide options and recommendations on new service delivery models or enhancements to the current psychiatric hospital facility (PHF) model in Santa Barbara. The overall goal of the analysis has been to develop options for the County of Santa Barbara and its Board of Supervisors with the following considerations : 1) alternative opportunities for inpatient bed service delivery within the County as a means to provide high quality services in an efficient and cost-effective manner; 2) comparing and contrasting licensing and accreditation standards of the various models; 3) if the current inpatient system service delivery system is the optimal structure and sustainable given the level of service and overall needs of the County; 4) any legal and compliance issues related to the intake process and recommendations and opportunities for improvement to effectively manage inpatient psychiatric facility function and enhance service delivery; and 5) recommendations regarding patient mix within the PHF.

A review of the ADMHS acute continuum of care, including a review of services provided through acute care contractors, identified challenges specific to:

- Inpatient capacity and utilization
  - Consumers are currently experiencing delays in accessing inpatient services resulting in lengthy waits within local emergency rooms.
- PHF operations
  - PHF licensure requirements limit the populations served, contributing to inadequate availability of inpatient services. In addition, a lack of consistency in program policies has contributed to inefficiencies on the unit and vulnerabilities related to state and federal regulatory compliance.
- Access, intake, and discharge practices
  - Crisis teams are being utilized as outpatient treatment teams, weakening the continuum of acute services and opportunities to appropriately divert consumers from inpatient services.
- Legal and compliance issues
  - Evidence of misapplication of the 5150 statute, confirmed by legal opinion of the court.
  - Challenges in maintaining compliance with PHF licensure and CMS standards.
- Designated use and lack of appropriate use of existing resources
  - Use of PHF beds to provide lengthy restorative services on behalf of the courts.

- Underutilization of Crisis and Recovery Emergency Services (CARES) Residential Treatment beds.

- Service system gaps
  - Lack of inpatient resources for voluntary and dually diagnosed individuals, particularly in areas of newer population growth.
  - Shortage of discharge placement resources for homeless and transient populations in addition to individuals with complex medical needs resulting in extended lengths of stay on the PHF.

As the result of the review, the continuum of acute care services was found to be insufficient and, in some cases, inefficient. Supported by stakeholder feedback, HMA is making several recommendations for improving the effectiveness and efficiency of the current inpatient services provided by the county. These are outlined below, and in more specific detail in the body of this report:

1. Standardize and provide written policies associated with ADMHS and contracted programs' eligibility, admission, discharge, and referral criteria.
2. Redesign and strengthen CARES Teams to provide crisis intervention and when possible, reduce the utilization of inpatient services.
3. Maximize use of CARES Residential program.
4. Expand resources available outside of county staff for 5150 eligibility determination.
5. Enhance onsite service delivery and utilize the jail setting for restoration of detainees who are incompetent to stand trial.

Specific to the assurance of adequate inpatient stabilization service capacity to meet the needs of the ADMHS population, the following additional options are available for consideration and discussed in greater detail in this report:

1. Replace the Psychiatric Health Facility (PHF) Unit with a psychiatric unit in one of the acute care hospitals in the County. Under this scenario, the County would contract for indigent care and Medi-Cal patient care, and it would allow the facility to bill and collect directly for Medicare and commercial clients.

2. Replace the beds offered within the Psychiatric Health Facility (PHF) Unit with beds through an experienced PHF operator at significantly reduced costs. The savings would be utilized to significantly enhance eligibility and outpatient services, thus improving access for patients and reducing the financial burden to SBC. Under this scenario, the County would contract with an acute care hospital for a limited number of beds for patients requiring care beyond the licensure capabilities of the PHF.

Introduction

This is a time of unprecedented change for California counties in general, and for the provision of county mental health and substance use services in particular. The mission of Alcohol Drug Mental Health Services (ADMHS) is to promote the prevention of and recovery from addiction and mental illness among individuals, families and communities through effective leadership and delivery of state-of-the art, culturally competent services. According to its website, ADMHS provides treatment, rehabilitation and support services to approximately 7,600 clients with mental illness and 4,500 clients with substance use disorders annually. The Department provides an array of inpatient and outpatient services to both adults and youth residing in Santa Barbara County. As part of the service delivery system, ADMHS provides crisis stabilization, acute residential, and inpatient psychiatric services through contracts with local behavioral health providers and across multiple ADMHS services sites, including crisis clinics in both Santa Barbara and Santa Maria. The psychiatric hospital facility (PHF) is a 16 bed acute psychiatric unit located on the second floor of the former County of Santa Barbara acute care hospital. ADMHS also contracts with Vista Del Mar and Hillmont hospitals for additional inpatient beds. As the County Mental Health Authority, ADMHS also determines who has the ability to evaluate and certify criteria are met for civil commitments under the 5150 statute.

The Patient Protection and Affordable Care Act (ACA) contains numerous incentives, opportunities and mandates for integrating primary care with behavioral health and substance use services, preventing avoidable hospitalizations or institutional levels of care, and improving the coordination of care for individuals with chronic health conditions. At the same time that California county general revenues have decreased with resulting significant program and services reductions, the state government has embarked on an ambitious realignment of mental health and substance use services and funding from the state to the county levels. While consolidation of Medi-Cal functions and other community funding streams presents an opportunity to integrate behavioral, substance use and primary care, a variety of strategies will have to be used to achieve an integrated model of care across the entire continuum of inpatient and outpatient services.

The current request for review of the impact of those efforts and analysis of additional opportunities for service innovation and enhanced operational efficiencies is well timed. In its role as the County's behavioral health safety net, ADMHS has a crucial role to play in the local community. Serving as a payer, provider, and employer, responsibilities are multifaceted, with the added complexity of new opportunities made available through health care reform.

Background and Approach

HMA was engaged by the County of Santa Barbara to provide a focused review of the ADMHS acute care continuum of services, with particular focus on the PHF. This effort included a review of the budgeting and financing practices, other administrative and operational processes, and clinical programming in order to identify existing opportunities for improvement and make recommendations to meet those challenges. HMA conducted a review of past and present policies, procedures, audits, relevant meeting minutes, and regulatory statutes impacting the system. Also reviewed were contracts, financial statements, cost reports, and program budgets. In order to perform a comprehensive analysis and assessment of the ADMHS inpatient continuum of care, tours which included overviews and observation of clinical programming were undertaken on the PHF (including chart reviews), CARES North, South, and Residential units. Additional tours of Vista del Mar and Hillmont Hospitals were also conducted to provide insight on contractor capacity and operations. HMA also conducted a series of interviews with both Santa Barbara County staff and community stakeholders, including physicians, other providers, advocates, mental health commissioners, and corrections. All of those interviewed were asked to give their perspective on the issues facing ADMHS in the provision of inpatient psychiatric care in Santa Barbara County. This multipronged approach allowed HMA to view how health care is provided to the populations served by ADMHS through both contracted and direct care provision. This report provides an overview of the findings and recommendations for consideration as the result of these efforts.

ADMHS has faced multiple financial and regulatory challenges specifically related to the operation of its psychiatric health facility (PHF), impacting the delivery of services across the acute care continuum. In 2010 there was a death on the unit. This resulted in the Centers for Medicare & Medicaid Services (CMS), the federal agency providing certification and oversight for the unit, performing audits in both January and August of 2011. Both audits had significant findings in areas related to environmental requirements and care delivery. ADMHS has responded with action plans to resolve these issues, with approval of these plans by CMS. Follow-up visits to monitor the progress of these items is certain as well as the ongoing scrutiny of community stakeholders. Further complicating ADMHS efforts in efficiently and effectively providing a full continuum of acute care services are the fiscal challenges the Department has faced due to financial audits by the state which lead to recoupments and increased budget requests in excess of $25 million dollars at a time when resources are limited.

The current ADMHS Director has been in this position for over four years. There have been a number of issues that have impacted the department during this time. Along with a death on the unit in 2010 that resulted in a state and federal audit, the Department sought additional funds totaling more than $25 million from the county. A large portion of the dollars were needed to reconcile the incorrect billing in previous years and identified in the aforementioned state audits. These retrospective audits covered a period greater than 5 years ago when ADMHS was under a different administrator. There was also a billing issue from the year prior to new leadership resulting in a 6 million dollar payback. These issues coupled with the death and near loss of both license and certification for the PHF have left the department with numerous challenges over the past year. Substantial changes to the community system (defunding some long term providers) to move to a number of evidence based practice models (for

example, ACT) were undertaken requiring significant adjustment within the community. As of the writing of this report, the ADMHS Director has submitted her resignation.

Review and Observations Regarding Current Inpatient System

1. Current Inpatient Capacity and Utilization

Concerns have been raised regarding the availability and accessibility of acute stabilization services within Santa Barbara County. Concerned stakeholders point to patients left waiting in emergency rooms for extended periods of time and the availability of treatment for persons dually diagnosed with substance abuse and mental health disorders. Currently Santa Barbara ADMHS meets the acute stabilization needs of its consumers through Psychiatric Health Facility (PHF) beds operated by the county and contracts with two vendors for inpatient acute psychiatric beds. For additional detail concerning the PHF, please see section 2. ADMHS contracts with these vendors specify the use of these beds for specific populations. The ADMHS funded inpatient capacity and population served by provider is summarized in the table below.

Provider	Service/Facility Type	Bed Capacity	Population
ADMHS	Acute Inpatient: Psychiatric Health Facility (PHF)	16 beds	Adults
Vista Del Mar	Free-standing Acute IP Care Psychiatric Hospital	Contract for up to 5 beds for indigent adults or Medi-Cal adolescents	Adults and Youth
Ventura County Medical Center, Hillmont Psychiatric Center	General Acute Care Hospital w/Longer term Psychiatric and/or Chemical Dependency Recovery Beds/Services	Contract for 13 beds	Adults and Youth
State Hospital	Acute care	1 bed	Adult

Once it is determined an individual needs acute stabilization services, several presenting factors are considered in the placement of that individual. Determining which acute care resource to access is determined by diagnosis and treatment needs as well as payer source. There is a distinct difference in the licensure requirements between the PHF and acute psychiatric inpatient beds listed above, specific to the clinical populations served and therefore services provided, that is important in understanding challenges and limitations of current resources. These challenges and their subsequent impact on the current system were expressed by internal and external stakeholders and are the basis of some of the recommendations found within this report.

Limitations of PHF Licensure

With the establishment of the psychiatric health facility (PHF) category of licensure, the Legislature clearly intended to offer 24-hour inpatient therapeutic and rehabilitative services to patients with acute psychiatric diagnoses, in a less institutional-like setting. PHFs have the option of providing structured

outpatient services (SOPS) for those patients who could benefit from such a program, and thereby avoiding the need for 24-hour care. SOPS can also serve as a transition for patients who were formerly admitted as an inpatient, to home and community-based supports.

However, this setting also limits the types of patients who can receive care in the PHF. Unlike a psychiatric inpatient unit in a hospital, a PHF cannot accept patients who have acute medical needs, but may accept patients whose medical needs could be met on an outpatient basis. The PHF must be able to meet the medical needs of the patient who are admitted, and have sufficient staff to meet those needs. The PHF also cannot admit any patient with a reportable communicable disease or a non-ambulatory patient. In addition patients cannot have a primary diagnosis of chemical dependency or substance use, chemical intoxication, chemical withdrawal, substance use delirium, require substance use detoxification, or have been diagnosed with an eating disorder. With a significant number of individuals with co-occurring mental health diagnoses and substance use disorders, these restrictions are particularly limiting.

While PHF and psychiatric inpatient beds are viewed as the same level of care in the continuum, the population restrictions under PHF licensure have created confusion and frustration for many community stakeholders making referrals to these services and both PHF and CARES staff. A lack of consistency and applied policy regarding exclusion criteria for persons presenting for admission has contributed to complaints that the PHF arbitrarily denies admissions and conversely staff reported anxiety regarding patients being accepted that they believed were among the excluded populations. There was a lack of a clear and consistently applied exclusion criteria that defined the level of medical needs or substance abuse treatment needs that would clearly indicate another setting, i.e. general acute care psychiatric inpatient, was required. When compared with another PHF provider in California, some ADMHS PHF staff had a more limiting interpretation of the ability to accept persons with co-occurring disorders. The inconsistency was further evidenced by a chart review indicating some PHF admissions were receiving detox intervention, a treatment need that should deny admission.

A specific comparative listing of the differences in statute licensing and federal certification requirements can be found in Appendix C of this report.

Limited Contracted Beds in Number and Geography

The population center of the region has been shifting over the years from Santa Barbara County to the more northern edge of the region. Currently, the majority of services are primarily based in the city of Santa Barbara. While core services need to remain in Santa Barbara to serve its residents, consideration must be given to significant number of homeless and transient individuals within the area. In addition, when considering the inpatient needs of the county both geographically and in number, administrators should be cognizant of the growing population areas of the county outside Santa Barbara.

Current Inpatient Community Resources: Hospitals

Cottage Health System

The Cottage Health System includes hospitals in Santa Barbara, Goleta, and Santa Ynez. The Santa Barbara Cottage is the largest facility with 408 beds, a 28 bay emergency department, and a 20 bed voluntary Acute Care Unit (mental health). The Goleta medical center has eight ED beds, Santa Ynez three to four. All three hospitals will be expanding their EDs with Santa Barbara Cottage increasing to 44 beds, Goleta to 20 and Santa Ynez to eight. During the expansion of SB Cottage Hospital's ED, eight existing beds will be closed; this will be result in additional congestion in an already busy ED.

Approximately 3500 (8.5%) of SB Cottage Hospital's 42,000 annual ED visits are seen and treated by the center's Psychiatric Emergency Services (PES). An average of 8-10 patients are seen each day in the ED by the Psychiatric Emergency Service with approximately one to two on a 5150 hold awaiting medical clearance and transfer to an inpatient facility (PHF, Vista del Mar IMD, Ventura County Medical Center (Hillmont) Psychiatric Treatment Unit). There are times when a notably higher number of 5150s are in the SB Cottage ED. Factors related to the ADMHS handling of 5150 evaluations contributes to lengthy waits in the ED and will be discussed in the *Legal and Compliance Issues* section of this report.

The 20 bed mental health Acute Care Unit (ACU) at Cottage Hospital is a voluntary unit which accepts only Medicare and privately insured patients. The ACU is not licensed or certified to accept patients on 5150 holds and Cottage Hospital does not have nor want a Medi-Cal contract. In the past, the ACU did accept 5150s, but the hospital terminated its contract with ADMHS in 2010 for a variety of reasons, including a disagreement over reimbursement rates. Cottage leadership communicated a hesitant willingness to reconsider re-applying for 5150 status and developing a contract with ADMHS. In order to even considering recertifying as a 5150 center, Cottage Hospital Psychiatric leadership would need additional space, administrative control over staff selection, final decision on admissions and discharges, priority access to post-discharge appointments to CARES and ADMHS, and a mutually agreed upon reimbursement with ADMHS for uninsured admissions.

Aurora Vista del Mar Institution for Mental Diseases

Aurora Vista del Mar (AVDM) in Ventura County is an 87 bed Institution for Mental Diseases (IMD) with four to five locked units and a staff of 210 employees including five psychiatrists and two Internal Medicine physicians. The facility's average length of stay (ALOS) for mentally ill patients is approximately seven days. As an IMD, AVDM can accept patients with substance abuse, dual diagnoses, and certain medical co-morbidities, and provides detoxification treatment but it cannot bill Medi-Cal (except for children < 20 years and geriatric patients).

Santa Barbara County/ADMHS contracts with AVDM for a maximum of five beds per day at a per diem rate of $680 (this rate excludes physician costs). From July 2011-June 2012, AVDM admitted 258 patients referred from SBC for a total of 1443 days with an ALOS of 5.6 days. The source of these SBC funded admissions were:

- Non-ADMHS enrolled 38.4%
- CARES 30.2% (South 19.8%, North 10.4%)
- Adult 15.1% (SB 7%, Lompoc 8.1%)
- ACT 10.5% (SB 7%, Santa Maria 3.5%)
- Children 4.7% (SB and Santa Maria 2.35% each)

SBC faxes or calls AVDM with referrals which are quickly accepted or rejected. All patients must be registered with CARES/ADMHS before AVDM will accept the referral for admission. AVDM will not accept SBC patients with 5150 beyond the 72 hours limit unless voluntary, without medical clearance, who live out-of-state, who have significant developmental disabilities, and/or who are in police or correctional custody. SBC only pays AVDM for patients on 5150 or 5250 holds; once the holds are released, the patients are transferred back to SBC. Those who require more inpatient time are transported by ambulance to the PHF. All patients are discharged with a 14 day supply of medications and must have a pre-scheduled appointment with CARES/ADMHS within seven days of discharge from Aurora Vista del Mar.

AVDM commonly has additional bed capacity and would be open to accepting more referrals from SBC; it could comfortably double the current contract from five to 10 beds per day. However, because of AVDM's status as an IMD, if SBC were to refer Medi-Cal covered individuals the County would be responsible for the full cost rather than allowing for reimbursement through the federal program. Therefore this option may be financially prohibitive.

Ventura County Medical Center Psychiatric Treatment Unit (PTU)

The Psychiatric Inpatient Unit (PIU), a part of the Ventura County Medical Center Santa Paula Hospital (a public hospital locally referred to as Hillmont Hospital), is located just proximate to the hospital's Emergency Department entrance. The PIU is the legally designated 5150 facility for Ventura County and accepts admissions around the clock, 365 days per year. The PIU has 43 beds distributed into three wings with a central nursing station. Five additional one-on-one isolation beds are situated in an adjacent corridor.

Connected to the PIU is the facility's Assessment and Reception Center which is open 24 hours per day, seven days per week. The center is staffed by a psychiatrist eight hours per day with on-call coverage in the evenings. The Assessment and Reception Center sees approximately 500 patients per month, admitting 35-40% to the PIU. Medical clearance is not required on all admissions; if needed the patient is sent via the connecting walkway to the hospital Emergency Department. Occasional police or jail admissions are kept in the isolation rooms with constant monitoring by a correctional officer.

The PIU has a pilot program with Santa Barbara County to accept referrals with Medi-Cal coverage. Requests for transfer are called or faxed, reviewed by a psychiatrist, and accepted or rejected within one to two hours. The referrals must meet the imminent danger to self or others and/or inability to care for self criteria and have an active 5150 or 5250, or they will be rejected. As a hospital-based unit, the PIU can admit patients with substance abuse requiring detoxification, dual diagnoses, and significant

medical co-morbidities (including conditions requiring wheelchairs, naso-gastric tubes, Intravenous lines, catheters, colostomies, CPAP). SBC refers a relatively small number of patients but the volume varies from month to month. Discharges are communicated by PIU social services to the designated contact in SBC. Discharge prescriptions are coordinated by SBC and all patients must have a scheduled follow-up appointment within 7-10 days at CARES or ADMHS.

The PIU is at less than full capacity and the unit's clinical and administrative leadership stated that there might be willingness to accept more patients from Santa Barbara County. Unlike Aurora Vista del Mar, PIU is able to bill Medi-Cal. In 2008 or 2009, the Santa Barbara County Psychiatric Health Facility was temporarily relocated to one wing of the PIU due to a fire that closed the PHF. The PHF staff accompanied the patients and provided all the treatment. This two to three day re-location worked well for both entities. The PIU currently has the capacity to house the entire PHF patient population. Any expanded relationship between SBC and the PIU would require the evaluation and approval by Ventura County Medical Center leadership.

Resulting Challenges

While stakeholders point to patients with long waits in the emergency department as evidence for the need for additional beds, or at minimum, maintenance of the PHF; in looking at the existing resources, alternative opportunities arise for consideration. The PHF licensure limits the ability to meet the needs of a significant portion of patients through the prohibitions against serving individuals with acute substance abuse needs or complex medical conditions that are able to be served on inpatient psychiatric units. Discussed in greater detail later in this report is the impact of ADMHS's administration of the 5150 statute regarding commitments for inpatient psychiatric care. The current process may create inefficiencies in the admission process and limit opportunities for diversion to community programs when clinically appropriate. Contracted beds also have negotiated limits further limiting the options for some patients and requiring lengthy stays in the ED while alternatives, often costly, are explored.

2. PHF Operations

Overview

The PHF is a 16 bed unit operated by Santa Barbara County and ADMHS. It is certified as a free standing acute care facility by CMS and receives its licensure as a PHF from the state of California. The PHF accepts Medi-Cal, Medicare, and Medicare/Medi-Cal (duals), and it receives funding for the uninsured and from the jail (those in need of psychiatric treatment and those in need of competency restoration). Recent state and CMS audits resulted in a need to increase the staffing and services provided by the unit.

The PHF admits approximately 45 patients per month. The average daily census (ADC) was approximately 15-16 for the last few months, however lower at times. Average length of stay (ALOS) reported by staff ranged from 10-12 days to 7 to 14 days. The competency restoration clients skew the LOS upward. Discharge options included Crisis Residential (up to 30 days), home, and shelter as

alternatives for placement. The PHF continues a long standing practice of not discharging patients over the weekend. This practice delays the admission of patients waiting in hospital emergency departments.

Each individual who enters the PHF must have a 5150 completed. The 5150 determines that the individual meets the criteria for a 72 hour hold. In Santa Barbara County, this is completed by county staff members who work within the ADMHS CARES program. In addition, all patients must receive a medical screening exam (MSE) before entering the PHF. This occurs at the local emergency departments.

PHF Staff

The PHF is managed by an experienced RN who is responsible for the day-to-day management of the unit and accountable for the care provided. There is also a licensed mental health provider who manages QA and the inpatient (IP) bed triage. The PHF nurse supervisor is in charge of the nursing and recovery assistant (RA) staff and provides on call supervision along with other duties (staff development and training). There are 1.5 psychiatrists covering the PHF Monday-Friday, and rotating ADMHS psychiatrists cover weekends and evenings. In addition, one FT locum tenens and some contracted providers also assist with coverage. One of the contract physicians lives near the PHF and comes in when a patient needs seclusion/restraints in the evening. The on-call ADMHS physician rarely if ever comes in.

The unit is normally staffed with one RN (it was noted that some days had three RNS), three psych techs (PTs) and two recovery assistants who work mostly 12 hour shifts, but there are some eight hour shifts. Staffing on the second shift is lighter. The discharge planning is completed by the three social workers on the unit.

Challenges and Concerns

Over the past 2 ½ - 3 years the PHF has faced difficult challenges beginning with the death on the unit while a patient was in restraints. Along with the legal ramifications, this led to state audits and a CMS audit which revealed that the unit had been functioning under an acute hospital certification without meeting the required criteria. Under threat of losing Medicare/Medi-Cal certification, it was reported that the staff and administration worked very hard to rectify the situation. They hired more staff, created policies and procedures that were lacking and, generally, created a more effective unit.

The unit continues to face challenges, and some concerns were raised by the staff during the course of this review. Currently while an interim medical director has been assigned part time, there is not a dedicated medical director (one of the CMS requirements). While some patients are denied admission under the PHF license (individuals with substance use disorders in some level of detoxification), the PHF reported inconsistencies in observing this policy and arbitrarily accepting these patients. Another concern raised was that individuals with additional health issues that are beyond the skill of the unit are being admitted and that these individuals are often difficult to return to the community. The PHF also

provides services for individuals in the local jail who are in need of psychiatric assistance that is beyond the ability of the staff at the jail. In addition, they provide competency restoration training to individuals who have committed misdemeanors. While there was some agreement that the CMS audit, while upsetting and difficult, resulted in improved performance for the PHF, it appears that there may still be some level of risk to maintain its license and certification.

The triage process and acuity system are also challenges that affect the availability of beds on the PHF and are discussed in more detail below.

Triage Process

The triage process is vital to the service system and is used to move individuals into the PHF beds from the local hospital Emergency Departments. Each weekday, there is a call at 10:30am that includes the PHF nurse manager, the QA manager, the three regional managers, the acting PHF medical director, and the supervisors of the CARES Units. The QA manager pulls all the information together about the number of available beds, the condition of the individuals waiting for a bed, and the payer source for these individuals, etc. This information is used by the team to determine who will be placed in which bed (PHF or one of the five privately contracted beds) and when this can happen.

A large component of the process is managing the different payer sources within the PHF. The group reserves the five privately purchased beds for individuals without insurance. This is done to increase the likelihood that either patients with Medi-Cal, Medicare, and beds purchased by the jail will be placed in the PHF. The county staff adopted this approach in an effort to manage the cost of the PHF. This approach is a newer one for this unit and some of the staff interviewed expressed discomfort with this process.

Acuity System

The leadership and staff agree that the acuity tool and method of determining appropriate staffing levels is a challenge. Acuity tools for IP settings similar to the PHF were not readily available in spite of efforts to research and adapt other models. It appears there is no evidence based methodology built into the current tool so conclusions drawn from it about how much staff is needed for a patient population often results in either more staff than needed or keeps beds vacant when extra coverage cannot be maintained. In addition, staff is not always readily available to report to the unit with limited notice.

The assignment of the patients to an acuity number is completed twice a day by the staff. The number is somewhat arbitrary and impacts the utilization of beds on the unit. Beds are at times kept open to be available for seclusion. These issues contribute to the waiting time for placement and availability of PHF beds.

3. Access, intake, and discharge practices

In assessing the efficiency and effectiveness of the intake process for the ADMHS Inpatient Service System delivery models, HMA focused on the PHF, as well as the contracted inpatient services. HMA reviewed the ADMHS internal processes for screening and referral to the PHF, management of external requests for PHF beds, and the referral and determination for use of external contracted beds within these processes. Information was gathered through a review of program materials, site visits and interviews with the following stakeholders:

- Interviews with advocacy and family groups
- CARES North site visits and interviews with staff,
- CARES South site visits and interviews with staff,
- Hillmont Psychiatric Center site visit and interviews with staff,
- Meeting with Cottage Hospital Administrators,
- Meeting with Marian Regional Medical Center ED leadership,
- Aurora Vista Del Mar Hospital site visit and interviews with staff,
- Interviews with Santa Barbara County staff including representatives from the County, Counsel's office, Public Health, and ADMHS, and
- Tour of Santa Barbara County Main Jail facility and interviews with staff.(See Appendix A for complete interviewee list)

The core components in creating efficient access and appropriate utilization of inpatient psychiatric care include the availability and accessibility of beds, clear and consistently applied admission criteria, policy and procedures regarding voluntary vs. involuntary admissions, and treatment and discharge planning that actively addresses barriers to discharge and ensures timely return to community based services once inpatient benefit has been maximized. Opportunities for improvement within each of these components were identified by HMA and community stakeholders and are provided within this section of the report. In addition to the components that will be addressed in this report, another consulting group was contracted with to provide an assessment of the outpatient program, and it is assumed they will address gaps in the outpatient continuum, continuity of care concerns, and access issues, all of which may impact the appropriate utilization of inpatient services and contribute to barriers to discharge.

Admission criteria that is clearly and consistently applied

There were several factors identified which contributed to confusion regarding admission criteria for the PHF, as well as contracted beds, amongst external stakeholders and ADMHS staff. The state licensure regulations specific to acute psychiatric inpatient and psychiatric health facilities specify populations to be served and those who are not served. While the regulations prohibit admission to the PHF where substance use disorders are primary or individuals have medical needs that could not be met on an outpatient basis, interpretation and therefore understanding of these parameters varied. This variation has led to inconsistencies in acceptance of patients to the PHF and frustration from the community

when this occurs. The decision to decline certain referrals has been viewed as arbitrary and not based on licensure parameters or clearly and consistently defined and practiced policy. This has led to a distrustful relationship between the ADMHS staff and many of other members of the treatment system.

Despite confusion around populations served within the PHF, there was universal agreement amongst inpatient providers in and around Santa Barbara County regarding the admission criteria for psychiatric inpatient services. These are, specifically, danger to self or others or grave disability secondary to a mental illness. Despite the differences in licensure and certification standards across acute inpatient units and psychiatric health facilities, these criteria remained constant. However, variation in definition and identification of these thresholds exist between the PHF and other providers. While danger to self or others was more clearly and consistently defined, differences of opinion were raised regarding the necessity of *imminent* danger in meeting criteria. One contracted inpatient provider reported declining referrals from ADMHS specific to not meeting this threshold. The same external contractor reported even greater variability in establishing the gravely disabled criteria, again citing lack of specific or imminent threat of harm and reporting that social service needs were the predominant factor rather than acute illness. Chart reviews on the PHF supported these differences in thresholds, with multiple cases lacking support not only for admission and continued stay, but also in application of 5150 and 5250 holds.

Admission criteria reported by all providers meets with nationally recognized standards practiced by both public and private providers and incorporated within managed care practices. However, ADMHS's lack of clear definition and inconsistent application of these criteria has led to inappropriate use of expensive inpatient resources. Consistent with the current trends in behavioral health care delivery, consumers should be served in the least restrictive setting possible with preference given to community based programs. While many stakeholders reported a need for additional inpatient beds in the county, this may not be necessary if beds are currently being utilized for individuals who could be managed through other programs, opening up capacity for those meeting admission criteria and waiting in the emergency departments. If additional beds were added to the system, they need to be placed in the areas identified as growing population centers.

Underutilization of active crisis intervention and use of CARES Residential

CARES Programs

The CARES Program was established to provide crisis intervention, assessment intake services, and one to three follow-up visits either for individuals who do not meet the requirements for inpatient care, and for those returning from an acute inpatient admission. The two to three outpatient visits would allow patients to be treated and stabilized while they wait for an appointment in the ADMHS outpatient centers.

CARES North

CARES North is located on the first floor of relatively new and spacious building in Santa Maria and serves the northern region of Santa Barbara County. The program currently serves about 200 non-duplicated individuals. In the past, the number of individuals served in this setting was much higher but was recently reduced by transferring covered patients to ADHMS. CARES North has one fulltime psychiatrist who sees approximately six to eight patients per day. The psychiatrist does see an occasional crisis patient who has walked-in or who has been brought in by the police and does intake evaluations on new admissions to 2nd Floor 12 bed Residential Unit. The majority of her clinic time is spent with returning clients who are uninsured and/or are waiting for approval of their Medi-Cal applications.

Patients with Medi-Cal are transferred to an ADMHS outpatient mental health center, but the uninsured are not accepted by ADMHS outpatient programs. The uninsured continue to receive their ambulatory mental health care at the CARES North. Most patients are not qualified to receive psychotropic medications from ADMHS so they dispense sample medications from a supply maintained in the CARES North center. Access and capacity to serve outpatient clients regardless of payer source is being explored through a separate project and contractor.

Almost all 5150s in the northern region are sent by the CARES Mobile Crisis workers to Marian Medical Center's Emergency Department (ED) for medical clearance and are held in the ED until a bed becomes available in the Santa Barbara PHF or one of the contracted provide providers. The CARES North team does not provide active treatment while patients on 5150s are in the ED and awaiting an inpatient bed, even when these waits become lengthy.

CARES South

The CARES South team is located in the city of Santa Barbara. The center focuses on the ongoing outpatient care of the uninsured (50%) and Medi-Cal (50%) patients who are waiting to be transitioned over to an ADMHS ambulatory mental health facility. The one psychiatrist at CARES South currently follows nearly 500 unique individual patients; this is more than double the caseload (200) of ADHMS outpatient psychiatrists. The center gives priority (one to two weeks) of outpatient appointments to patients being discharged from the PHF, Aurora Vista Institution for Mental Diseases, and Hillmont Hospital Acute Care Inpatient Unit; all others have to wait four to six weeks for an appointment. Similar to the CARES North program, uninsured patients are given sample psychotropic medication. Because CARES teams were intended to provide only a few follow-up appointments to bridge patients over to the appropriate outpatient program, they lack the breadth of services that are available at the ADMHS outpatient sites.

Only recently has CARES South been allowed to transition six Medi-Cal patients a week to ADMHS clinics. This will hopefully begin to slowly decompress the CARES South panel and allow the center to direct more resources to crisis interventions. The CARES South staff stated that the center could conservatively deflect and safely and effectively manage at least 10% of Cottage Hospital ED referrals if

they had a more reasonable sized panel of patients. The CARES South staff communicated that it is difficult to admit their patients, many of whom have co-morbidities and are active substance abusers, to the PHF whose admission criteria are a barrier to many patients. The CARES South Mobile Crisis workers are stretched to provide timely services and 5150 evaluations throughout the south region.

Active and assertive treatment and discharge planning and appropriate length of stay of the PHF

With the new staffing and the creation of policies and procedures, the PHF unit maintained their CMS designation and continued to be allowed to accept Medicare patients following the aforementioned audits. The PHF unit is physically in adequate repair, but not an inviting treatment space and one that would benefit from a re-design. During the first HMA visit, about an hour after lunch many of the individuals receiving treatment on the unit appeared to be sleeping. Lack of active treatment was noted on subsequent visits to the unit.

The PHF program considers discharge to begin upon admission to the program. The goal is to allow individuals to return to the community as soon as they are stabilized and to minimize their length of stay on an inpatient facility. The PHF has three fulltime social workers who provide all the discharge planning for the unit. This group also provides much of the admission assessment work and provides groups on the unit. Discharge planning was reported by the three social workers, along with other staff from the PHF, as being a challenge. Housing is often an issue, especially for the large number of homeless individuals in Santa Barbara County. When the PHF admits individuals with more complex health issues, the elderly, and individuals with both mental health and substance abuse and dependency diagnoses, the discharge planning process is reportedly more time consuming and difficult. The social workers from the PHF unit reported that they are often still following up with plans for individuals after they have been discharged.

An example was provided of the unit accepting a young man with a developmental disability who had remained on the unit for three weeks. The team members were trying to find an appropriate placement for the young man, but had been unsuccessful and were maintaining him on the unit. The PHF has stretched their criteria of who is admitted to the unit beyond the comfort level of many of the staff. Unfortunately, the community resources are insufficient to meet the needs of many of the individuals who enter the PHF. This results in beds being taken “offline” while the system scrambles to move individuals from the emergency departments into an inpatient facility. It also means the PHF is being used, at times, for individuals who are no longer a risk to self or others, but simply have no other placement option in the community.

Chart reviews supported the reported focus on placement as part of the discharge planning process. However there was a lack of evidence of referrals for outpatient treatment follow-up, including linkage with substance abuse treatment which was commonly identified during the PHF stay. Concerns also arose that outpatient treatment teams, including ACT staff, were not maintaining contact with their clients while on the PHF or participating with inpatient treatment planning. Chart reviews also indicated

a longer length of stay than was reported by ADMHS. Recidivism with many of the clients was also noted.

Santa Barbara Department of Corrections

The Sheriffs' Office is responsible for the operation and supervision of custody operations in the Santa Barbara County. The Sheriff operates three facilities in the county with 1050 available beds and a combined beds average daily census 887 in 2012. The two facilities (Main Jail and Medium Security Facility) that house detainees and prisoners are located on the Santa Barbara County campus. The Main Jail has 765 beds with an average daily census of 664 and the Medium Security Facility has 285 beds with an ADC of 223. The court ordered Main Jail capacity is 605 males and 101 females and the Medium Security Facility 240 men and 43 women. The Branch Jail in Santa Maria was closed for housing in June 2011 but continues to serve as an after- hours processing and holding center with all individuals being detained subsequently transported to the Main Jail in Santa Barbara in the morning. The Santa Barbara facilities house both pre-trial (75%) and sentenced (25%) individuals. The State of California pays SBC to house sentenced men and women mostly with non-violent crimes. Construction of another correctional facility in Santa Maria with a mental health unit is now in the planning stages but will not be completed until 2018.

The health care services at the SBC correctional facilities are provided by CORIZON, a private correctional health care vendor. In 2009 CORIZON also took over responsibility for the mental health services at the SBC facilities; prior to 2009 ADMHS had directed and staffed the mental health care program at the Jail.

As is experienced nationally and in California, Santa Barbara Custody Operations has become a significant provider of care to the mentally ill of SBC. On any given day 12-14% (100-150 individuals) of all detainees and prisoners in SBC Jail have been diagnosed as seriously mentally ill (SMI) and are being administered psychotropic medications. An additional large percentage of the jail population has been diagnosed as having less severe categories of mental illnesses. SBC Custody Operations spends over $150,000 annually to purchase psychotropic medications.

CORIZON's mental health team consists of two mental health clinicians, one mental health registered nurse (RN), and a 0.75 psychiatrist to provide the mental health care services to the 100-150 individuals on psychotropic medications and the other jail residents with less severe mental disorders and conditions. CORIZON assesses the jail's population for the need for psychotropic medication, but is not able to provide mental health programs or non-pharmacological therapy. It is also not certified or licensed to forcibly administer medications.

The Santa Barbara County Jail does not have a dedicated mental health unit where seriously mentally ill are housed and more closely monitored. The jail does house 24 men with mental illnesses in a dorm in the South tank; these individuals are placed in this dorm because they do not fit in well on the general population units. This unit is noticeably crowded and cramped. An additional 16 men are housed in

adjoining single cells; some of these detainees have mental illnesses others have behavior disorders or are receiving administrative discipline. The South Tank is a housing unit not a therapeutic unit.

Given that the SBC Jail does not have a mental health unit or an adequate mental health observation area, it must refer persons with decompensated mental illness who are at risk to themselves or others, or who require forced psychotropic medications, to the Psychiatric Health Facility (PHF) located on a nearby campus (1-2 blocks away). The SBC Jail pays ADMHS a per diem rate of approximately $1500 for each 5150 admission from the Jail. From 2009 through 2012, the Jail reported that it paid ADMHS for 553 PHF days (2009-90, 2010-130, 2011-233, 2012-estimated 100) or 138 days per year.

Neither the psychiatrist at the jail nor any other member of the mental health team is allowed to complete 5150s for patient-inmates who require transfer to the PHF. The CARES mobile crisis worker is called by the Jail to assess the individual and complete the 5150. The Jail administration feels that the length of time for CARES to arrive and assess patients has steadily increased since 2009 and there can be delays of many hours (>4 hours) before CARES can respond. Upon completion of the 5150, the PHF requires medical clearance including toxicology screening prior to admission. The Jail reported that it is not legally empowered to forcibly draw blood and thus has to transport the patient to Cottage Hospital Emergency Department for medical clearance. Using Cottage's ED is costly (officer time, transportation, cost of the ED visit) and delays the admission of the individual to the PHF. A previous practice of having the blood work drawn at the Public Health lab next to the PHF was discontinued.

The clinical and correctional leadership at the SBC Jail voiced frustration with criteria for admission to the PHF. The criteria are not clearly delineated nor in writing and vary from each PHF psychiatrist who approves admissions to the PHF. There is also consistently voiced opinion that the PHF is reluctant to accept potentially violent 5150 admissions from the Jail; this reluctance appears to have been exacerbated following the PHF decision to prohibit the presence of correctional officers at the PHF following a citation by CMS. The Jail has voiced a willingness to consider placing non-uniformed correctional officers at the PHF when an inmate from the Jail is admitted.

While awaiting the arrival of the CARES worker or if a PHF bed is not available after the 5150 is approved, the mentally ill individual is placed in one of the four safety cells at the Jail. The safety cells have metal doors with pass-through slots and a viewing slit, softened wall coverings, no sink, no access to water, no bed, and no toilet. A grated drain in the safety cell is used for urination and defecation. Patients are placed in hospital-like gowns in these cells. Although correctional and mental health staff regularly visits these cells, these cells have limited audiovisual monitoring capability. The correctional and medical staff at the Jail concur that 5150 patients further decompensate when they have to spend any length of time in the safety cells. Individuals frequently have to spend 1-3 days in these sensory deprived cells waiting for a bed in the PHF. A significant percentage of the 5150s at the Jail are rescinded because the patient's condition has improved before they could be transferred to the PHF.

4. Legal and compliance issues

Like most states, California has statutes in place that allow for the detention and involuntary admission of individuals who require inpatient care to stabilize a situation that poses threat and harm to the individual or community. The state of California delegates enforcement of this statute to the counties. As the county's mental health authority, ADMHS determines who has the ability to evaluate and certify criteria are met and that the statute can be imposed. ADMHS has limited this authority to their Crisis and Recovery Emergency Services (CARES) staff. CARES teams in both the North and South areas of the county are designed to provide crisis stabilization, intake, mobile crisis response and access to service for mental health and alcohol and drug emergencies. Staffed by mental health professionals, CARES provides crisis support on a 24/7 basis, serving all ages in the continuum. A review of the intake procedures indicated that several aspects of the ADMHS administration of the 5150 process contributes to longer emergency department stays and difficulties with admissions to the PHF and contracted providers.

5150 Process

5150 holds are used to involuntarily admit patients who are dangerous to themselves or other and/or who are gravely disabled and cannot provide for their basic needs. The hold is valid for 72 hours from the time the 5150 is approved. This time limit is under discussion in SBC as is a question about whether a 5150 can be renewed after 72 hours. Ventura County only allows a 5150 to be in effect for 72 hours, after that a 5250 hearing must be scheduled. Hillmont Hospital will not accept 5150s from SBC that are over 72 hours old. Each county in California has its own rules on who is qualified to do 5150 evaluations and holds; in some counties police officers, emergency room doctors, social workers, psychiatrists, psychologists, other mental health staff, and others are permitted to complete 5150s. In Santa Barbara County only CARES Mobile Crisis workers are permitted by the ADMHS to complete a 5150. These workers have varying educational levels; some are licensed health care or mental health care providers, others do not have licenses or certifications. All have been trained by ADMHS to assess patients and complete the 5150s. Calls to assess possible 5150 patients from any area within the 3789 square miles of Barbara County are to be responded to with two hours by CARES Mobile Crisis staff. Multiple sites in SBC including hospitals and jails strongly voiced concern that the response time had now significantly increased thus delaying patients' discharges or transfers to mental health institutions. In neighboring Ventura County, 5150s can be completed by police, psychiatrists, mobile crisis team members, and PTU and Assessment & Reception Center staff. All must be trained and attend biannual retraining sessions. Comparably, Ventura County has fewer persons awaiting admission in emergency departments having eliminated the additional step in Santa Barbara where CARES workers alone act as the 5150 assessors.

Within SBC, the CARES Crisis Mobile worker does an initial assessment and calls the SBC Psychiatric Health Facility (PHF) and discusses the need for admission with the psychiatrist on duty or on call. If not already in an ED, almost all patients have to be transported to a hospital ED for medical clearance including a blood toxicology screen which is universally required by the PHF. The quality and accuracy of the 5150 CARES Mobile Crisis workers was questioned by some hospital and jail clinical and

administrative leadership. Approximately 40% of all 5150s are eventually rescinded. Data on the reasons for this high percentage of rescinded 5150s were not presented but it was conjectured that some patients improved during the long waits for inpatient admission and others possibly had had inaccurate initial assessments done by the CARES Mobile Crisis team. On any given day the Cottage Health System EDs in Santa Barbara, Goleta and Santa Ynez are stabilizing and holding a number of 5150 patients. CARES Mobile Crisis workers must be called to the ED to assess patients for 5150 holds. This results in delays in initiating the process to transfer patients to the PHF. Cottage Hospital psychiatric leadership was very open to having psychiatrist within its PES trained and certified to complete 5150s; this would eliminate existing delays and enhance the accuracy and quality of clinical decision making on the 5150 evaluations.

SB Cottage Hospital presented data showing the ED length of stays (LOS) for 5150s transferred to PHF, Vista del Mar IMD and Ventura County Medical Center's Psychiatric Treatment Unit has increased from 10 hours in 2010 to 24 hours in 2012 and the LOS for patients with rescinded 5150s has increased from 7.6 hours to 15 hours during that same period. Cottage Hospital clinical and administrative leadership voiced considerable frustration with the increasing LOS for 5150 patients. This has placed a significant burden on the functioning of the ED. It was emphasized the ED is not a therapeutic environment for seriously mentally ill patients and EDs are not designed to manage agitated or disruptive patients for any significant length of time. The increased 5150 stays were attributed to the lack of available beds at the Psychiatric Health Facility (PHF), delays in completion of 5150s by the CARES Mobile Crisis team, use of the ED for medical clearance and toxicology screening of stable patients, occasional inaccurate designation of 5150 status, inconsistent application of acceptance/rejection criteria by the PHF, delays in coordination of referral and transportation to out-of-county inpatient mental health facilities, lack of timely post-ED appointments at ADMHS and CARES outpatient centers, the closure of beds at the PHF when there was a calculated or real shortage of staff, and an apparent cap being placed on uninsured patients at the PHF resulting in less acute Medi-Cal patients being accepted for transfer and the uninsured spending more time in the ED. Marian Medical Center reported similar experiences with the 5150 process.

As the 5150 LOS in the ED has increased, Cottage Hospital has also documented a decrease in the number of 5150s who required transfer to an outside Psychiatric facility. This shift became most noticeable in June 2012 and has continued to the present time. This change is attributed to the stabilization and improvement of some patients during the increasingly longer stays in the ED, including time for alcohol and other drug levels to drop, and administered psychotropic medication having had time to exert an impact on behavior and cognition. This also contributes to the number of patients for whom 5150s are rescinded. Many felt it would decrease 5150 response time and improve the clinical validity of the hold if a selected number of psychiatrists and ED physicians were trained and certified to complete 5150s. While this would increase the number of individuals able to perform the 5150 assessments, it could also result in a loss of control over the quality of the assessments. In addition, by adding more trained professionals to the 5150 assessment pool, this does not increase the number of beds available. The danger would be increasing access to the system on one end (timely evaluations)

without increasing access at the other end of the system (available beds if 5150 is needed). There would also have to be checks and balances in place to ensure that that the non-country staff would achieve no gain to their own service system through the use of the 5150. It is important to point out that these holds should not be utilized when a voluntary patient can be stabilized within the emergency department through either medical intervention or crisis services through the CARES teams.

1370 Process

The PHF also serves as the inpatient unit for restoration of individuals at the Jail classified under provision 1370 as "incompetent to stand trial" (IST). From 2010-2012 there has been an annual average of thirty 1370 admissions with an average of 510 days per year at the PHF. Only 1370 ISTs with misdemeanor charges are referred to the PHF. There is no cost to the jail for 1370 days at the PHF. Felony 1370 ISTs are transferred to the Patton State Hospital. There is no cost to SBC for the first 3 years at the State hospital but thereafter SBC must pay $225,205 per year ($617 per day) for an Intermediate care bed. PHF staff stated that is more cost effective to "restore" the misdemeanor 1370 ISTs in the PHF because the lengths of stays are less than at the State hospital.

The court initially orders a psychiatrist evaluation for misdemeanor 1370 IST for inmates at the Jail; this generally takes approximately 2 weeks. An additional two weeks is then required for the court to determine and order the appropriate placement. In Santa Barbara misdemeanants requiring inpatient restoration of competency are placed in the PHF. These initial processes, which can take up to four weeks, must be completed before a 1370 patient can be admitted to the PHF for restoration. Not uncommonly another 1-2 weeks passes before the court clerk forwards the commitment packet to the PHF and a bed becomes available.

The length of stay at the PHF could be shortened if the Santa Barbara Jail was able to start psychotropic medication once the court has ordered a patient-detainee to be committed to the care and custody of the PHF. This is commonly not done in part because the Jail is not certified to administer involuntary psychotropic medication. However the California Penal Code Section 1369.1 (a) does define county jails as "treatment facilities" for the sole purpose of administering antipsychotic medication as ordered by the court. State Bill 568 does allow the involuntary administration of psychotropic medication for an IST in jail if the Sheriff's Department, the Board of Supervisors, and the ADHMS are in unanimous agreement to permit this. To date there has not been a willingness by all three entities to pursue this agreement.

The forensic caseload is managed by the Criminal Justice Liaison at the PHF. This position monitors the use of the PHF beds by the jail, provides the competency restoration training, ensures that the use of long term beds for individuals who have had their criminal charges dropped (Murphy Inmates) is kept to a minimum (currently there is only one person in a Long Term bed down from four), and has developed and maintains positive relationships with the courts/judges/public defenders. These responsibilities serve an important role for the county and require dedication of a full time position. However, the current staff assigned to this position has also been given other significant responsibilities related to the PHF programming.

The PHF currently provides competency restoration for misdemeanants on behalf of the criminal justice system. The length of stay for individuals working to regain competency can be lengthy, thus increasing the average length of stay for the PHF. When possible, it makes sense to provide the restoration services on site at the jail. This will allow for a more rapid turnover of the beds and ensure that as many beds as possible are available for individuals in need of crisis services.

5. Gaps in service system

There is a lack of integration between the mental health and substance treatment systems within ADMHS acute care services. This lack of an integrated approach to service delivery and access to needed services is heightened by the limitations of the PHF. The licensing for the PHF does not allow for the admission of individuals experiencing any level of detoxification from substance use. A large percentage of individuals who are transported or voluntarily seek treatment in an emergency department are experiencing both mental health and substance use/abuse issues. Many systems that include short term psychiatric facilities allow for the inclusion of both aspects of behavioral health. This lack of integration is also a problem in the outpatient system and will most likely be addressed by the other consulting group.

6. Finance

In evaluating the finances of the inpatient activities of ADMHS, it is clearly evident that efforts expended to date have yielded positive changes. The County replaced the CFO and much if not all the financial staff in this area to increase the qualifications, experience levels and financial expertise of those responsible for the financial and accounting functions. The County Auditor has assigned additional assistance from his office and yet there are still gaps in information and higher than expected subsidies required. Overall reporting is better, but questions remain in terms of the quality of the billing and collections systems, use of the County financial systems versus alternative excel spreadsheets, and the costs of labor-intensive and inefficient processes involving the current billing system. However, the improved quality of reporting overall gives us confidence to rely on certain information for our review.

When reviewing the potential for improved financial performance, we evaluated the following:

1. Has ADMHS maximized available resources?
    a. Does ADMHS ensure that clients eligible for Medi-Cal or Medicare are receiving the benefits to which they are entitled?
    b. Is ADMHS billing Medi-Cal and Medicare timely, properly and consistent with the requirements established by the DHCS and CMS, respectively?
2. Is ADMHS/PHF efficient in delivering services?
    a. See clinical reviews in other portions of this review for opportunities to more effectively and efficiently deliver services.
    b. Is PHF's cost structure competitive and cost-effective with the industry?
    c. Is PHF's census at an efficient level?
3. Are there less costly alternatives?

To the first question, ADMHS used some of the available "Innovation Funds" to implement an eligibility pilot. The total number of indigent patients in the inpatient setting appears high based on the level of acuity required for inpatient care. However, this population tends to struggle to complete the paper work required to obtain the benefits to which they are entitled. Although management staff felt it was too early to assess the progress made in this area, such assessment is critical to success not just in the short term, but also in the post-2014 world. Santa Barbara chose not to take advantage of the Section 1115 waiver (Low-Income Health Program) that would have allowed qualifying individuals to receive Medicaid benefits early as opposed to waiting for 2014. As a result, SBC must now begin the critical tasks of: (1) gathering information and qualifying this high cost group of individuals for benefits now and (2) preparing to assist all qualifiers for 2014 Medicaid changes. In addition, SBC must identify those individuals who are currently enrolled in the County MIA program and also being served by ADMHS, thus increasing continuity of care and improving health outcomes in both the physical and behavioral health arenas. Further, the County clinics which are Federally Qualified Health Centers could reduce the costs of medications and ensure patients stay current with their medications, thus reducing admissions.

Based upon our observations and discussions with staff, billing for individuals with Medicare needs to be improved. Although progress has been made in capturing case notes for accurate diagnoses, additional progress is needed in this area, particularly since Medicare only and dually eligible members account for nearly one-third of all patient days. It should be noted that many of these patients exhaust their Medicare benefit and need to be tracked to ensure that the proper payer is identified for billing and collection. Progress in improving systems has been hampered by poor coordination between Finance and Information Technology, and additional changes – including departmental reporting relationships – should be considered. Further, there should be greater utilization and coordination with public health finance and the auditor controller's office to promote shared learning opportunities for improving systems.

A review, conducted by ADMHS finance, of staffing mix levels indicates that the PHF could save approximately $557,000 per year if the appropriate staffing mix changes were enacted. Many of these changes have been made, but even with these reductions costs per day are still significantly above viable alternatives, and implementation of additional opportunities will not bring PHF costs into line with those alternatives.

Finally, while higher census levels could reduce expenses per patient day, the PHF already is operating at a year-to-date census in excess of 90% of its capacity, which is above the three year average. Maintaining this higher census for the entire year could reduce the full costs per day from $1,539 to $1,313. Even at a 100% capacity census of 16 per day 365 days a year, which is not realistic, the cost per day would only drop to about $1,221. Removing the unallocated administrative costs from the fully loaded costs, the costs per patient day would be $1,415 at the budgeted census, $1,207 at the current census, and $1,123 at 100% occupancy. Each of these costs per patient day is still much higher than the cost for alternative settings in which these services could be provided.

In conclusion there are less costly, viable alternatives that may provide greater flexibility and the capability to expand inpatient behavioral health services in the County. These alternatives could include one or more of the private hospitals or the District Hospital offering mental health services and entering into a contract with the County to provide these services to the Medi-Cal and indigent patients in SBC. The hospital willing to support these efforts would see an increase in its revenue from the hospital assessment and most likely from Medicare Disproportionate Share Hospital (DSH) reimbursement as well. Additionally, the participating hospital would be able to take all patients regardless of medical needs or substance use/abuse issues. Unlike AVDM, an in-County non IMD could be paid by both Medicare and Medi-Cal directly. If the rate that could be negotiated was in the range of $780 per day, the County expenditure should be zero for insurance and minimal for Medicare. Although the net cost for indigent patients would be $780 per patient day, it would be only $390 per day for Medi-Cal due to Federal Financial Participation (FFP). This should create savings that could be used for a more robust case management system that facilitates uninsured individuals obtaining Medi-Cal coverage.

If this is not possible, there are companies that specialize in managing PHFs. These same firms might also be able to reduce the County's cost. The savings here may be utilized in qualifying more patients for Medi-Cal, but also negotiating a smaller contract with one of the hospitals for some inpatient acute services. Our review included discussions with an organization that currently provides services to five other Counties. Their rates range from the low $700s to the mid $800s, inclusive of physician services. These rates are consistent with those currently paid to other facilities by ADMHS. Reimbursement rates per patient day for AVDM and Hillmont average $780 and $700, respectively. If a contract with an in county facility could not be negotiated, Hillmont appears to have the capacity and willingness to handle additional patients that require an acute care hospital setting.

In any event, managing a hospital does not appear to be a core competency of ADMHS. In addition, the lack of economies of scale in a single 16 bed facility makes it difficult to be cost competitive. Finally, the PHF licensing rules will always require some additional acute care availability to meet the needs of the consumers. It appears there is opportunity to work with providers with more robust inpatient operations that are capable of meeting the needs of the consumers while reducing overall expenditures. The savings could be invested in enhancing outpatient services to further reduce the need for and cost of inpatient care. This new partnership would significantly mitigate the patient access and flow issues currently experienced in the hospital emergency departments. The end result of these changes would include (1) better integration of physical and behavioral health services, (2) reduced crowding in all SBC hospital emergency departments, (3) more timely access to behavioral health care for those in need, and (4) an improvement in patient flow for hospital emergency departments across the entire county.

Finally, there is one additional option that deserves SBC's thoughtful consideration. The state of California allows Counties with COHS to have their mental health paid through their managed care entity. Santa Barbara qualifies and Cen Cal is that entity. It allows the County to move from the current CPE formula to a capitation payment that can include a level of profit which can be used to defray some of the cost of the uninsured. In this case, a capitation payment would be made by Cen Cal to ADMHS for mental health coverage for Medi Cal qualified individuals. The County is still responsible to make the

intergovernmental transfer for one half the capitation amounts. This is an option that does carry risk and needs careful evaluation, but can result in increased reimbursement and more timely cash flow.

Findings and Recommendations

1. Inpatient Capacity and Utilization

Finding: Consumers are currently experiencing delays in accessing inpatient services resulting in lengthy waits within local emergency rooms.

Detail: Stakeholders point to patients with long waits in the emergency department as evidence for the need for additional beds, or at minimum, maintenance of the PHF. In looking at the existing resources, alternative opportunities arise for consideration. The PHF licensure limits the ability to meet the needs of a significant portion of patients through the prohibitions against serving individuals with acute substance abuse needs or complex medical conditions that are able to be served on inpatient psychiatric units. Contracted beds also have negotiated criteria for referrals, further limiting the options for some patients and requiring lengthy stays in the ED while alternatives, often costly, are explored. Also impacting the utilization on inpatient services is the ADMHS's administration of the 5150 statute regarding commitments for inpatient psychiatric care. The current process may create inefficiencies in the admission process and limit opportunities for diversion to community programs when clinically appropriate.

Recommendation: Consider the following options for ensuring adequate inpatient capacity along with implementation of the other recommendations that follow in this section:

1. Replace the Psychiatric Health Facility (PHF) Unit with a psychiatric unit in one of the acute care hospitals in the County. Under this scenario, the County would contract for indigent care and Medi-Cal patient care, and it would allow the facility to bill and collect directly for Medicare and commercial clients; or

2. Replace the beds offered within the Psychiatric Health Facility (PHF) Unit with beds through an experienced PHF operator at significantly reduced costs. The savings would be utilized to significantly enhance eligibility and outpatient services, thus improving access for patients and reducing the financial burden to SBC. Under this scenario, the County would contract with an acute care hospital for a limited number of beds for patients requiring care beyond the licensure capabilities of the PHF.

Finding: The role of the community hospitals in the mental health service system is poorly defined.

Detail: The community hospitals play a large role within the mental health system. In addition to several hospitals providing contracted inpatient beds, individuals in need of services are most often transported to local hospital EDs to await disposition. An expanded or better defined role for all hospitals would dramatically impact the inpatient capacity.

Recommendation:

1. The working relationship and communication between the acute care hospitals in Santa Barbara County and ADMHS needs to be improved and there needs to be greater involvement from County administration or public health to increase the comfort level of these potential partners.
2. Psychiatrists on all acute care Psychiatric Emergency Service should be trained and certified to complete 5150s. Similar personnel should be trained at all the acute care hospitals and protocols established.
3. The County and Cottage Hospital should meet to discuss conditions that might enable the reopening of a 5150 unit at the hospital's Acute Care Unit.

2. PHF Operations

Finding: PHF licensure requirements limit the populations served, contributing to inadequate availability of inpatient services.

Detail: PHFs are prohibited from accepting patients who have acute medical needs, but may accept patients whose medical needs could be met on an outpatient basis. The PHF also cannot admit any patient with a reportable communicable disease or a non-ambulatory patient. In addition patients cannot have a primary diagnosis of chemical dependency or substance use, chemical intoxication, chemical withdrawal, substance use delirium, require substance use detoxification, or have been diagnosed with an eating disorder. With a significant number of individuals with co-occurring mental health diagnoses and substance use disorders, these restrictions are particularly limiting.

Recommendation: A differently licensed program would allow for the treatment of individuals who experience psychiatric issues along with substance disorders, medially complex conditions, etc.

Finding: The Acuity System is an inadequate tool to determine patient level of need/care and therefore necessary staffing ratios for the PHF.

Detail: The PHF unit uses an acuity scale that was developed in-house with support from the former medical director. It does not appear to be solidly research based. This acuity scale is used as the basis for staffing and determining when the unit is closed to new admissions. Based on the importance of this scale, it would be best to determine its effectiveness in preventing events on the unit or find another scale in the public domain that has proven effective at predicting safe staff to client/patient ratios. Unfortunately, there are not any state of the art (or even non-state of the art) acuity tools available for this population.

Recommendation: Conduct a time study for a month to determine the amount of staff time certain patients on the unit require over the 30/31 day period. Retrospectively, analyze the staffing levels present when incidents did occur on the unit to determine the impact of staff to

patients on each specific event. The study should include: 1:1 status, close observation status, ability to perform activities of daily living (ADL) independently or with assistance, use of restraints/seclusion, and volume of medication use.

Finding: Continued lack of active treatment on the PHF.

Detail: There was evidence of a lack of active treatment occurring on the PHF, with patients often wandering the halls or sleeping.

Recommendation: Commit a full time position to develop groups and curriculum that address common problems identified upon admission, including substance abuse issues. Currently the person dedicated to this responsibility also serves as the care coordinator for all forensic clients, also a full time job. Institute more curriculum based active treatment opportunities across day and evening shifts, including on the weekends.

3. Access, Intake, and Discharge Practices

Finding: Crisis teams are being utilized as outpatient treatment teams, weakening the continuum of acute services and opportunities to appropriately divert consumers from inpatient services.

Detail: The CARES programs in Santa Barbara County provide limited amounts of acute crisis interventions and treatments. Both CARES teams are serving as outpatient mental health clinics for stable uninsured patients; allowing less time for acute crisis intervention.

Recommendation: The CARES North and South need to refocus their resources on their primary mission of crisis intervention and new patient intake assessment providing only 1-3 bridge outpatient visits until an appointment is scheduled with an ADMHS outpatient program, regardless of payer source. This realignment and expedited transition of patients from CARES to outpatient services will be supported by the expanded Medi-Cal coverage that will occur with Health Care Reform in 2014. Fully functional CARES crisis centers could prevent 10-20% of ED referrals for patients with mental health crises.

Finding: Lack of consistent and universal understanding of admission criteria and population served on PHF. This lack of consistency in understanding and application of program policies contributes to vulnerabilities related to state and federal regulatory compliance.

Detail: Feedback from both ADMHS staff and external stakeholders indicates a lack of agreed upon and consistently applied admission criteria for the PHF. Patients with medical co-morbidities are also frequently rejected even if the conditions are stable. Referring and holding centers complained that the medical clearance acceptance and rejection criteria had not been provided to them in writing and appeared to vary from psychiatrist to psychiatrist at the PHF. This has resulted in approvals and denials for admission being viewed as arbitrary and potentially putting the PHF licensure and certifications at risk.

Recommendation: Create written policy, based upon single interpretation of DMH licensure regulations, regarding admission criteria to PHF. This should include populations served and specific exclusion criteria. This revised policy should be disseminated and reviewed with staff. All staff and facilities involved in the process (jail, ED) should be trained on these policies with measurement of competency in applying the criteria in practice. Discharge of stabilized patients should occur seven days a week. The longstanding practice on not discharging patients on weekends contributes to the length of stay in hospital emergency departments and at the Jail.

Finding: Inefficiencies in service delivery to patients within Santa Barbara County Corrections.

Detail: Twelve to fifteen percent (100-150) of the SBC corrections population is receiving a psychotropic medication. The SBC correctional facilities have limited mental health staffing and inadequate facilities to accommodate this need. Lack of available beds at the PHF, timeliness of 5150 completion, inconsistent application of PHF admission criteria, cumbersome medical clearance processes, and the prohibition of security staff assignment to the PHF contribute to the delay in transfer of patients from the Jail to the PHF.

Recommendations:

1. Full consideration should be given to determining whether the Psychiatric Health Facility model best serves the SBC correctional population. A hospital-based Acute Care Psychiatric Inpatient Unit may more readily facilitate the admission of Jail referrals.
2. The Jail psychiatrist should be trained and allowed to complete 5150s for individuals at the Main Jail and Medium Security Facility. This would expedite the process and free up CARES staff to provide other services.
3. Public Health (PH) should allow referrals to the PHF from the SBC Custody Operations to have blood drawn for medical clearance at the PH. This would deflect the transport of correctional patients to the costly and crowded emergency departments in SBC. There is only approximately one correctional admission per week.
4. The Board of Supervisors, the Sheriff's Department, and the Alcohol, Drug, and Mental Health Services should fully evaluate whether they can develop and approve an agreement as provided by State Bill 568 to allow involuntary (or voluntary) psychotropic medication to be initiated at the SBC Jail once a 1370 IST individual has been committed by the court to the care and custody of ADMHS and is pending transfer to the Psychiatric Health Facility This would decrease the 1370 inpatient length of stays and may even avoid some admissions.
5. Security presence at the PHF is needed. Whether the security staff or correctional officers are uniformed and where they are stationed should be determined so as to meet existing State and Federal regulations.
6. Pending the construction of a mental health unit in Santa Maria, the SBC correctional facilities should modify existing physical space to create a mental health treatment and observation unit where seriously mentally are housed and afforded programs and individuals awaiting transfer to an inpatient facility can be readily observed at all times. The

Safety cells in East Tank and Reception should be eliminated. All concur that these sensory-deprivation cells will cause seriously mentally ill to further decompensate.

Finding: Lack of use of physician extenders throughout the system.

Detail: Psychiatrists throughout the system carry large caseloads. By moving toward the use of physician extenders when possible, a less expensive alternative for medication management would be possible.

Recommendation: Through attrition, hire nurse practitioners and physician assistants for medication management.

Finding: There is a lack of communication and sense of collaboration between local hospitals, their emergency departments and ADMHS.

Detail: While the local hospital emergency departments are an active aspect of the treatment system, there seems to be little formal communication between the administration at ADMHS and the hospitals.

Recommendation: Monthly meeting between the ADMHS administrator and all participating hospitals to ensure joint planning and communication around the shared patients/clients.

4. Legal and Compliance issues

Finding: Evidence of misapplication of the 5150 statute, confirmed by legal opinion of the court, including inconsistent interpretation of criteria for dangerousness and grave disability when considering admission or 5150.

Detail: Only CARES Crisis Mobile workers with varying levels of education and licensure/certification are enabled to complete 5150s in Santa Barbara County. There was a recent court ruling against ADMHS in the interpretation of the 5150 statute. There are reportedly increasing delays in the response time of the CARES Mobile Crisis team and concerns about the validity of some of the 5150s. The high rate (40%) of rescinded 5150s is not fully understood but is in part due to long waits in EDs for inpatient beds and to the quality of the initial 5150 assessment.

Recommendation: External (to ADMHS Counsel) review of legal definition for purpose of 5150 and 5250 holds. HMA also recommends a reexamination or provision of the following:

- Limiting 5150 certification to ADMHS staff
- Competency criteria for staff performing 5150
- Written summary and guidelines regarding the commitment statutes, with examples available to all clinical staff for reference

- Training, certification, and recertification of staff performing 5150 (CARES, PHF and MD Staff) with specific content on civil commitment criteria and proper documentation of supporting evidence
- Interpretation of timelines and associated requirements for 5150, especially for those awaiting services within an emergency department
- Ongoing quality assurance review of all 5150s including, #per month, #rescinded per month, ultimate disposition (admission, rescind, 5250, voluntary, etc.)

Finding: The PHF currently provides competency restoration on behalf of the criminal justice system and this may contribute to a lack of bed availability for patients within the community.

Detail: The length of stay for individuals working to regain competency can be lengthy, thus increasing the average length of stay for the PHF.

Recommendation: ADMHS should consider providing the restoration services on site at the jail or utilize available beds for this purpose at the state operated facilities.

5. Gaps in service system

Finding: There is a lack of integration between the mental health and substance treatment systems within ADMHS acute care services. This lack of an integrated approach to service delivery and access to needed services is heightened by the limitations of the PHF.

Detail: Many of the clients served across the acute care continuum are dually diagnosed and in need of programs and settings that can provide a holistic approach to their behavioral health needs. This lack of integration between mental health and substance abuse programming is likely agency-wide.

Recommendations: Integrate programming across ADMHS to readily address the needs of dually diagnosed individuals and where necessary contract with external providers to ensure access to acute substance abuse treatment.

Finding: There is a lack of housing resources available to patients leaving the PHF and this often extends stays on the unit even when patients have maximized benefit and are ready for discharge.

Detail: PHF staff report placement is one of the largest barriers to discharging patients and maintaining appropriate lengths of stay.

Recommendation: ADMHS has partners in the community willing to assist with increasing the availability of permanent supportive housing units. It is assumed recommendations related to this need will be addressed in the review of ADMHS outpatient programs.

6. Finance

Finding: Billing for certain populations continues to be problematic.

Detail: The information to appropriately bill Medicare and to a lesser degree Medi-Cal is often not available. This includes case notes and sometimes diagnosis.

Recommendation: While ADMHS has taken steps to improve this it has been a slow process. The responsibility for the information technology area of ADMHS should be transferred to finance or at least more control given to finance to make necessary modifications.

Next Steps: Determine if the division should be transferred to Finance in ADMHS or at minimum more control over the components required for billing.

Finding: The cost of the PHF and its lack of ability to take patients with all conditions create a financial burden to the County and is at least partially responsible for some of the delays in care and over reliance in holding patients in emergency rooms.

Detail: The current cost of the PHF on a full cost basis is $1539 which is significantly higher than other alternatives. While certain costs would continue even if these services were shifted, the reduction in subsidy would allow the ADMHS to strengthen its eligibility efforts and outpatient activities. Current contract hospitals charge on average $700 to $780 for similar services. One of which accepts both Medicare and Medi-Cal. A private entity indicated it operates PHFs for five counties and has a variety of billing arrangements, but net costs to the counties runs from the low $700s to mid $800s.

Recommendation: Explore the potential of contracting for inpatient services. The best option would be to find one or more Santa Barbara acute care hospitals willing to operate psychiatric units and contract with ADMHS for care of certain patients. Alternatively, consider a contract with a private PHF provider in combination with a small contract with Cottage for acute care hospital psychiatric care or an expanded relationship with Hillmont.

Next Steps: The County is in discussions with one hospital on this. If this is not successful, begin parallel dialog with the other two acute care systems, private PHF providers, and Hillmont. These discussions will need the added credibility of county administration or public health involvement due to past difficulties.

Finding: Santa Barbara County may have an option to move to a capitated mental health system, by working with Cen Cal.

Detail: The state of California allows counties with COHS to pay for mental health through their managed care entity. The managed care entity actually has no role in the provision of services. They simply contract with ADMHS for provision of these services for a capitated payment. This allows for a small profit to be built into the rates and moving away from CPEs. While this

contains some risk, it has the advantage of allowing for additional resources to be made available to the County. Solano County is the only entity currently using this option.

Recommendation: The potential benefit of this approach could be significant and will grow when eligibility is expanded January 1, 2014. This should be explored as soon as possible.

Next Steps: Contact Solano County to gain an understanding of how there system works and its advantages and disadvantages. Develop a financial model to determine if it can work for Santa Barbara and engage Cen Cal in these discussions.

Finding: As a non Low Income Health Program (LIHP) County, Santa Barbara will start behind in qualifying individuals for the expanded Medicaid eligibility in 2014. Eligibility does not equal coverage if the individuals don't complete an application.

Detail: There are four non LIHP Counties in California. They will need to work hard to get the individuals who qualify to apply and be accepted for eligibility in 2014. This has tremendous financial repercussions. On the positive, some very expensive patients will now have a payment source that does not involve County funds. However, it is likely the state will reduce certain funding the County currently receives to care for these individuals with the belief they are eligible for these benefits. This group of patients often has difficulty completing paper work and receiving the benefits they are entitled to.

Recommendations: Begin the process of gathering the information necessary to qualify them and prepare for a major effort in the fourth quarter of 2013. This should start by getting more people into the MIA program today.

Next Steps: Begin discussions with DPSS, public health, hospital and clinic partners with the goal of a comprehensive strategy that all participate in and help finance.

Appendix A: Interview List

Name	Title	Organization
Albert Marrero	CARES South Doctor	Santa Barbara County Department of Alcohol, Drug, and Mental Health Services
Alesha Silva	Nurse Supervisor	Santa Barbara Psychiatric Health Facility
Andrew Vesper	Regional Manager CARES South	Santa Barbara County Department of Alcohol, Drug, and Mental Health Services
Angela Timmons	Operations	Hillmont Public Hospital Psychiatric Inpatient Unit
Ann Detrick	Director	Santa Barbara County Department of Alcohol, Drug, and Mental Health Services
Anne Eldridge	Appointee Director	Santa Barbara County Mental Health Commission National Alliance on Mental Health Santa Barbara
Beverly Weatherford	Critical Nurse Manager	Hillmont Public Hospital Psychiatric Inpatient Unit
Bob Geis	Auditor/Controller	Santa Barbara County
Bob Macaluso	Director of Government Affairs	Crestwood Behavioral Health
Brad Keller	Psychiatric Inpatient Unit Medical Director	Hillmont Public Hospital Psychiatric Inpatient Unit
Celeste Anderson	Deputy Counsel	Santa Barbara County
Charles Merrill	Vice President of Medical Affairs	Marian Medical Center
Charles Nicholson	Former Medical Director	Santa Barbara County Department of Alcohol, Drug, and Mental Health Services
Craig Miller	Vice President of Professional Services	Marian Medical Center
Craig Park	Program Director, Mental Health Services	Cottage Hospital
Donald Patterson	Chief Deputy Custody Operations	Santa Barbara Office of the Sheriff
Edwin Felciano	Former Medical Director	Santa Barbara County Department of Alcohol, Drug, and Mental Health Services
Emily Allen	Lawyer	Legal Aid Foundation of Santa Barbara's Homeless Education and Legal Project
Enrique Cerrato	Internist	Cottage Psychiatric Hospital
Epi Gomez	CARES North Staff	Santa Barbara County Department of Alcohol, Drug, and Mental Health Services
George Begor	PRN Contracted Physician	Santa Barbara County Department of Alcohol, Drug, and Mental Health Services
Heather Fletcher	Deputy Audit Chief	Santa Barbara County
Herb Geary	VP Patient Care Services	Cottage Hospital
Howard Babus	Part Time Psychiatrist	Cottage Psychiatric Hospital
Irwin Lunianski	Quality Assurance Psychiatrist	Santa Barbara Psychiatric Health Facility
Jeanie Sleigh	QA Manger	Santa Barbara County Department of Alcohol, Drug, and Mental Health Services
Jenny Sams	Commander Custody Operations	Santa Barbara Office of the Sheriff

Name	Title	Organization
Jetta Zellner	Director of Business Development	Aurora Vista del Mar IMD
Jetta Zellner	Office of Development	Aurora Vista Del Mar
Jim Rohde	Chair Chair	Santa Barbara County Mental Health Commission and Santa Barbara County Alcohol Drug Advisory Board
Juliana Koenig	Director of Social Work	Santa Barbara Psychiatric Health Facility
Kerin Maze	COO	Marian Medical Center
Laura Zeitz	Manager	Santa Barbara Psychiatric Health Facility
Leah Kearney	Social Worker	Santa Barbara Psychiatric Health Facility
Leighann Bradley	CORIZON Health Administrator	Santa Barbara County Jail
Lisa Bondietti	Lieutenant Custody Support Division	Santa Barbara Office of the Sheriff
Lisa Moore	VP Clinical Services	Cottage Hospital
Lisa Villa	CARES North Staff	Santa Barbara County Department of Alcohol, Drug, and Mental Health Services
Marianne Garrity	Deputy Director	Santa Barbara County Department of Alcohol, Drug, and Mental Health Services
Mayla Krebsbach	CEO	Aurora Vista del Mar IMD
Michael Craft	Lompoc/Central Coast Regional Manager	Santa Barbara County Department of Alcohol, Drug, and Mental Health Services
Michael Evans	Assistant Director of Finance	Santa Barbara County Department of Alcohol, Drug, and Mental Health Services
Michael Foley	Director	Santa Barbara County Homeless Center
Michelle Bowman	CARES North Manager	Santa Barbara County Department of Alcohol, Drug, and Mental Health Services
Mike Evans	CFO	Santa Barbara County Department of Alcohol, Drug, and Mental Health Services
Ole Behrendtsen	Medical Director	Santa Barbara County Department of Alcohol, Drug, and Mental Health Services
Patty Blum	Vice President	Crestwood Behavioral Health
Paul Erickson	Director of Psychiatric Services	Cottage Hospital
Peggy Atwill	CARES North Staff	Santa Barbara County Department of Alcohol, Drug, and Mental Health Services
Perry Berk	Social Worker	Santa Barbara Psychiatric Health Facility
Phillip Greene	Consultant	Marian Medical Center
Sandra Baum	North Regional Director	Santa Barbara County Department of Alcohol, Drug, and Mental Health Services
Stacy McCrory	Activities Director/Criminal Justice Liaison	Santa Barbara Psychiatric Health Facility
Steve Fellows	COO	Cottage Hospital
Sue Anderson	CFO	Marian Medical Center
Sue Cortez	Nurse	Santa Barbara Psychiatric Health Facility

Name	Title	Organization
Suzanne Grimmesey	Director of Adult/Child/Adolescent Services Mental Health	Santa Barbara County Department of Alcohol, Drug, and Mental Health Services
Suzanne Jacobsen	CFO	Santa Barbara County Public Health Department
Suzanne Riordan	Executive Director	Families ACT
Takashi Wada	Director	Santa Barbara County Public Health Department
Terri Maus-Nisich	Assistant CEO	Santa Barbara County
Tom Alvarez	Budget Director	Santa Barbara County
Tom Eby	CARES South Manger	Santa Barbara County Department of Alcohol, Drug, and Mental Health Services
Tona Wakefield	Jail Discharge Coordinator	Santa Barbara Office of the Sheriff
Zorica Vjaljevic	CARES North Doctor	Santa Barbara County Department of Alcohol, Drug, and Mental Health Services

Appendix B: Documents Reviewed

California Code of Regulations. Accessible at http://ccr.oal.ca.gov/linkedslice/default.asp?SP=CCR-1000&Action=Welcome.

California Health and Safety Code. Accessible at http://www.leginfo.ca.gov/calaw.html.

Federal Code of Regulations. Accessible at http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR.

California Department of Public Health. Santa Barbara Psychiatric Health Facility Exit Conference Deficiencies Letter. Both Original and Revised Versions. February 25, 2011.

California Mental Health Directors Association. 5150's, EMTALA and the Budget. PowerPoint Presentation for Director's Association Meeting. June 24, 2011.

Santa Barbara County. Psychiatric Health Facility Financial Data. FY 2009-2010 through FY 2011-2012.

Santa Barbara County. Psychiatric Health Facility Cost Reports. FY 2007-2008 through FY 2009-2010.

Santa Barbara County. Psychiatric Health Facility Staffing Report. August 20, 2012.

Santa Barbara County Alcohol, Drug and Mental Health Services. 5150 Training and Designation PowerPoint Presentation. August 2012.

Santa Barbara County Alcohol, Drug and Mental Health Services. 5150 Protocol for Evaluation, Training and Designation. August 2012.

Santa Barbara County Alcohol, Drug and Mental Health Services. Annual Core Service Capacity and Cost. Projected FY 2012-2013. September 12, 2012.

Santa Barbara County Alcohol, Drug and Mental Health Services. CARES Service Criteria. July 2011.

Santa Barbara County Alcohol, Drug and Mental Health Services. Contracted Providers List. June 18, 2012.

Santa Barbara County Alcohol, Drug and Mental Health Services. Hold-Transfer Time Data. August 2012.

Santa Barbara County Alcohol, Drug and Mental Health Services. Hospital Admissions between 07/01/2011 and 06/30/2012. August 2012.

Santa Barbara County Alcohol, Drug and Mental Health Services. Mobile Crisis Procedures. July 2012.

Santa Barbara County Alcohol, Drug and Mental Health Services. Policy and Procedures: Administrative Medical Clearance. May 2006.

Santa Barbara County Alcohol, Drug and Mental Health Services. Policy and Procedures: Level of Observation. May 6, 2012.

Santa Barbara County Alcohol, Drug and Mental Health Services. Policy and Procedures: Restraint and Seclusion. March 2011.

Santa Barbara County Alcohol, Drug and Mental Health Services. Psychiatric Health Facility Executive Committee Meeting Materials. April 2011 through May 2012.

Santa Barbara County Alcohol, Drug and Mental Health Services. Psychiatric Health Facility Pharmacy and Therapeutic Committee Meeting Materials. February 2011 through July 2012.

Santa Barbara County Alcohol, Drug and Mental Health Services. Psychiatric Health Facility Quality Assurance and Program Improvement Committee Meeting Materials. March 2011 through June 2012.

Santa Barbara County Alcohol, Drug and Mental Health Services. Quality Assurance and Program Improvement Acuity Reports. April 2011 through May 2012.

Santa Barbara County Alcohol, Drug and Mental Health Services. Quality Assurance and Program Improvement Incident Reports. May 2011 through May 2012.

Santa Barbara County Alcohol, Drug and Mental Health Services. Quality Assurance and Program Improvement Seclusion and Restraint Reports. FY 2012.

Santa Barbara County Alcohol, Drug and Mental Health Services. Quality Assurance and Program Improvement Work Plan. June 2011.

Santa Barbara County Executive Office. Organization Charts for the Alcohol, Drug and Mental Health Services Department and Santa Barbara Psychiatric Health Facility. July 30, 2012.

Santa Barbara County Executive Office. Psychiatric Health Facilities Contracts Comparison, by County. FY 2011-2012.

Santa Barbara County Executive Office. Psychiatric Health Facility Comparison of Santa Barbara and Humboldt County. FY 2011-2012.

Santa Barbara County Executive Office. Psychiatric Health Facility Pay Period Staffing Schedule. September 9, 2011.

Santa Barbara County Executive Office. Psychiatric Health Facility Staffing Review Summary Memo. September 19, 2011.

Santa Barbara County Executive Office. Psychiatric Health Facility Staffing Requirements Summary, per the California Department of Mental Health and the Centers for Medicare & Medicaid Services. September 12, 2011.

Santa Barbara County Executive Office. Psychiatric Health Facility Staffing Needed in Excess of Budget. FY 2011-2012.

Santa Barbara County Psychiatric Health Facility. Daily Patient Acuity Tool. April 2011.

Santa Barbara County Public Health Department. Low Income Health Program MIA-Advantage Program Fact Sheet. August 2011.

Appendix C: Licensing and Certification Comparison

Level of Care/Admissions Comparison

	General Acute Care Hospital w/Psychiatric and/or Chemical Dependency Recovery Beds/Services	Psychiatric Health Facility	Mental Health Rehabilitation Center
General Level of Care Provided	• Admit patients with either/both acute psychiatric and/or acute medical needs, and may have substance use disorders	• Admit patients with acute psychiatric needs, but not acute medical needs	• Admit patients who do not have acute psychiatric needs, or acute medical needs
General characteristics of patients served	• Provides both inpatient and outpatient services for patients with mental disorders or who otherwise meet the criteria for patients who are involuntarily or voluntarily admitted • Any age (although adults and children will be expected to be in separate areas) • May be ambulatory or non-ambulatory (CCR Title 22, Div. 5, Chap. 1, various sections) • Patients with psychiatric, drug abuse, or developmental disabilities, and who have medical needs may be provided services in acute psychiatric beds (CCR Title 22, §70006)	• Involuntary or voluntary patients • Must be ambulatory • Patients must have major mental disorder • May provide care for patients with medical needs that could be met on an outpatient basis (CCR Title 22, §77135)	• 18 years of age or older • Serious or persistent mental disability • Must be ambulatory • Otherwise be placed in a State Hospital or other mental health facility • Least restrictive alternative to meet needs [CCR Title 9, §784.26(c)&(d)]

	General Acute Care Hospital w/Psychiatric and/or Chemical Dependency Recovery Beds/Services	Psychiatric Health Facility	Mental Health Rehabilitation Center
Restrictions on patients receiving care	• Care provided in a psychiatric unit is for patients with mental disorders, or who are admitted involuntarily/voluntarily in accordance with W&I Code Sections 5000, et al and 6000, et al – and who require hospital care (CCR Title 22, §70575 & 70577) • No other statutory or regulatory restrictions related to level of care for inpatient psych	• Patient primary diagnoses may not be an eating disorder • Patient primary diagnosis may not be chemical dependency, chemical intoxication or chemical withdrawal • May not admit patients who need medical interventions beyond the level appropriate for a PHF • May not admit patient who requires detoxification from substance use or who has substance use delirium (CCR Title 22, §77113) • May not admit or retain a patient with a reportable communicable disease • May not admit or retain a patient who requires inpatient medical care. (CCR Title 22, §77135)	• Not appropriate for an acute psychiatric hospital level of care • Cannot require a level of medical care that is not provided by the MHRC • May not have a sole diagnosis of a substance use or eating disorder [CCR Title 9, §784.26(c)&(d)]

Basic and Optional Services Comparison

	General Acute Care Hospital	Psychiatric Health Facility	Mental Health Rehabilitation Center
Basic Services	(CCR Title 22, Sections 70201 through 70279) and (42 CFR 482.60 through 482.62)	(CCR Title 22, Sections 77059 through 77079.13) and (42 CFR 482.60 through 482.62)	(CCR Title 9, Sections 785 through 785.34)
	Medical Staff	Psychiatric, Psychological and Counseling Services	Physician Services
	Nursing Services	Psychiatric Nursing Services	Nursing Services
	Surgery Services		
	Anesthesia Services		
	Clinical Laboratory Services		
	Radiologic Services		
	Dietary Services	Dietetic Services	Dietetic Services
	Pharmaceutical Services	Pharmaceutical Services	Pharmaceutical Services
		Social Services	
		Rehabilitation Services	Rehabilitation Program
	(Psychiatric Service Unit information, below)	Therapeutic Activities Program	Activities Program
		Aftercare Services	
Optional/ Supplemental/ Special Permit Services	Aftercare Plan [H&S Code §1250.2(b) & 1262]		

	General Acute Care Hospital	Psychiatric Health Facility	Mental Health Rehabilitation Center
	Note: There are numerous optional services permitted under a hospital license. Only the requirements for a Psychiatric Services Unit are referenced. (CCR Title 22, Sections 70301 through 70657 for other supplemental services)		Note: The basic services listed above are the minimum services required to operate an MHRC. (See CCR Title 9, §785) This suggests the ability to provide additional services, however the statutes & the regulations do not specify the nature of those potential optional services.
	Psychiatric Services Unit (CCR Title 22, Sections 70572 through 70583) The hospital must provide a therapeutic activities program [42 CFR 482.62(g)]		
	Outpatient Services (CCR Title 22, Sections 70525 through 70533)	Structured Outpatient Services (CCR Title 22, §77070)	
	Substance Use Unit: There are no specific state licensing or federal certification regulatory requirements for hospital substance use/chemical dependency recovery units in general acute care hospitals		

	General Acute Care Hospital	Psychiatric Health Facility	Mental Health Rehabilitation Center
Admissions, Transfer, Discharge Requirements	Admission, Transfer, Discharge Policies (CCR Title 22, §70717) Transfer Summary (CCR Title 22, §70753)	Admissions Policies (CCR Title 22, §77113) Transfer Summary (CCR Title 22, §77075)	Admission of Clients (CCR Title 9, §784.26) Admission Records (CCR Title 9, §784.27) Temporary Medical Client Transfer (CCR Title 9, §784.30)
Contracted Services	Use of Outside Resources (CCR Title 22, §70713) Contracted Services [42 CFR 482.12(e)]	Use of outside resources permitted, in accordance with regulatory requirements. (CCR Title 22, §77109) Contracted Services [42 CFR 482.12(e)]	Use of Outside Resources (CCR Title 9, §784.13)

Minimum Staffing/Personnel Qualifications/Level Comparison[1]

	General Acute Care Hospital (Psychiatric Unit/Services)	Psychiatric Health Facility	Mental Health Rehabilitation Center
Facility/Unit Administration	• Must have a unit administrative director (CCR Title 22, §70579) • Governing body must appoint a Chief Executive Officer who is responsible for managing the hospital [42 CFR 482.12(b)] • Must be primarily engaged in or under the direction of a Doctor of Medicine or Osteopathy, psychiatric services for the diagnosis and treatment of mentally persons [42 CFR 482.60(b)] • Must be under the supervision of a clinical director, service chief or equivalent and must meet the training requirements of the American Board of	• Must have an administrator with primary responsibility for business and support services • The administrator must have direct access to the clinical director (CCR Title 22, §77091) • The clinical director may also be the administrator (CCR Title 22, §77061) • Governing body must appoint a Chief Executive Officer who is responsible for managing the hospital [42 CFR 482.12(b)] • Must be primarily engaged in or under the direction of a Doctor of Medicine or Osteopathy, psychiatric services for the diagnosis and treatment of mentally persons [42 CFR 482.60(b)] • Must be under the supervision of a clinical director, service chief or equivalent and must meet the training requirements of the American Board of Psychiatry and Neurology or the American	• MHRC Director means the licensee or an adult designated by the licensee (CCR Title 9, §782.25)

[1] Please note: State licensing requirements are indicated by reference to" CCR", and "42 CFR" references indicates a federal certification requirements (for Medicare/Medi-Cal). Where the standards are inconsistent, licensed and certified health facilities must meet the higher or more specific standard.

	General Acute Care Hospital (Psychiatric Unit/Services)	Psychiatric Health Facility	Mental Health Rehabilitation Center
	Psychiatry and Neurology or the American Osteopathy Board of Neurology and Psychiatry [42 CFR 482.62(b)]	Osteopathy Board of Neurology and Psychiatry [42 CFR 482.62(b)]	
Medical Staff	• Psychiatrist who is certified • May also be the Unit Administrative Director (CCR Title 22, §70579)	• Must have a clinical director who is a licensed mental health professional and has 3 years of post-graduate experience with the mentally disordered (CCR Title 22, §77061 & 77093) • Physician must be on-call at all times (CCR Title 22, §77061)	• Must have a physician designated as the medical director (CCR Title 9, §785.10) • Physician services provided by a physician under contract with the MHRC (CCR Title 9, §785.11)
	• A doctor of medicine or osteopathy is responsible for each Medicare patient with respect to any psychiatric or medical problem [42 CFR 482.12(c)(4)]	• A doctor of medicine or osteopathy is responsible for each Medicare patient with respect to any psychiatric or medical problem [42 CFR 482.12(c)(4)]	
	• Must be primarily engaged in or under the direction of a Doctor of Medicine or Osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons [42 CFR 482.60(b)]	• Must be primarily engaged in or under the direction of a Doctor of Medicine or Osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons [42 CFR 482.60(b)]	

	General Acute Care Hospital (Psychiatric Unit/Services)	Psychiatric Health Facility	Mental Health Rehabilitation Center
Nursing Staff	• RN with 2-years' experience in psychiatric nursing shall be responsible for the nursing care and management (CCR Title 22, §70579) • Ratio: 1:6 or fewer patients per licensed nurse at all times • Licensed nurses includes, RNs, LVNs, or Psychiatric Technicians • LVNs & PTs cannot constitute more than 50% of licensed nurses on the unit (CCR Title 22, §70217) • Nursing services must be furnished or supervised by a Registered Nurse (42 CFR 482.23) • The 24-hour nursing service must have adequate numbers of R.N.s, L.V.N.s and other personnel to provide nursing care and to ensure the immediate availability of an R.N. for bedside care [42 CFR 482.23(b)] • Must have a qualified director of psychiatric nursing services with a master's degree in psychiatric or mental health nursing or its equivalent from a	• Must have an R.N. working 40 hours per week • An R.N. , L.V.N, or Psych. Tech. that shall be awake and on duty at all times (CCR Title 22, §77061) • Nursing services must be furnished or supervised by a Registered Nurse (42 CFR 482.23) • The 24-hour nursing service must have adequate numbers of R.N.s, L.V.N.s and other personnel to provide nursing care and to ensure the immediate availability of an R.N. for bedside care [42 CFR 482.23(b)] • Must have a qualified director of psychiatric nursing services with a master's degree in psychiatric or mental health nursing or its equivalent from a nursing school accredited by the National League for Nursing	• DON must be an R.N. and employed at least 40 hours per week • Must have one year of nursing supervision within the past 5 years (CCR Title 9, §785.14) • For facilities with 41 beds or less, must have a licensed nurse awake and on duty at all times. (CCR Title 9, §785.15)

	General Acute Care Hospital (Psychiatric Unit/Services)	Psychiatric Health Facility	Mental Health Rehabilitation Center
	nursing school accredited by the National League for Nursing • Must have additional R.N.s, L.V.N.s, and mental health workers to provide nursing care • A Registered Nurse must be available 24 hours per day [42 CFR 482.62(d)]	• Must have additional R.N.s, L.V.N.s, and mental health workers to provide nursing care • A Registered Nurse must be available 24 hours per day [42 CFR 482.62(d)]	
Psychology, Therapy, Rehabilitation, Activities Service Staff	• Clinical Psychologist shall be available full-time, part-time or on a consulting basis • Qualified therapist to conduct therapeutic activity programs (CCR Title 22, §70579) • The number of qualified therapists, support personnel and consultants must be adequate to meet requirements [42 CFR 482.62(g)]	• Rehabilitation services must be provided by an OT, PT or recreational therapist under the direction of the clinical director (CCR Title 22, §77069) • The number of qualified therapists, support personnel and consultants must be adequate to meet requirements [42 CFR 482.62(g)]	Rehabilitation program - • Interdisciplinary Staff: MHRC must provide staff with two of the following disciplines – psychologist, social worker, MFCC, OT, licensed nursing staff or mental health rehabilitation specialist • Program staff must have a minimum of a high school/GED and 2 years' experience working in a mental health program serving clients with SMI. A bachelor's degree may be substituted for the 2 years' experience • MHRC shall provide 1 hour program staff time for each 5 hours of rehabilitation time, excluding the time of nurses, interdisciplinary staff or director (CCR Title 9, §786.12) Activities program – • Program staff must have a

	General Acute Care Hospital (Psychiatric Unit/Services)	Psychiatric Health Facility	Mental Health Rehabilitation Center
			minimum of a high school/GED and 2 years' experience working in a mental health program serving clients with SMI. A bachelor's degree may be substituted for the 2 years' experience • MHRC shall provide 1 hour program staff time for each 7 hours of rehabilitation time, excluding the time of nurses, interdisciplinary staff or director • Activities Director must be an OT, or a music, art, dance or recreational therapist – and must have at least 2 years in a social or recreational program within the past 5 years, one year of which must be working full-time in a mental health setting (CCR Title 9, §786.10)
Social Services Staff	• Social Worker required on a full-time, part-time or consulting basis (CCR Title 22, §70579) • Must have a Director of Social Services who has a master's degree in social work from an accredited school of social work, or who has experience and education in the social	• Social services must be directed by a licensed clinical social worker (CCR Title 22, §77067) • Must have a Director of Social Services who has a master's degree in social work from an accredited school of social work, or who has experience and education in the social services needs of the	

	General Acute Care Hospital (Psychiatric Unit/Services)	Psychiatric Health Facility	Mental Health Rehabilitation Center
	services needs of the mentally ill. If the Director of Social Services does not have a master's degree in social work, at least one other staff person must have this qualification [42 CFR 482.62(f)]	mentally ill. If the Director of Social Services does not have a master's degree in social work, at least one other staff person must have this qualification [42 CFR 482.62(f)]	
Dietetic Service Staff	• A Registered Dietician must be employed on a full-time, part-time or consulting basis on the premises at appropriate times (if not employed full-time, an employee with specified training is required) • Requires sufficient, trained dietetic service personnel (CCR Title 22, §70275) • The hospital must have a full-time employee who serves as the director of food and dietetic services and must have a qualified dietitian full-time, part-time or on a consultant basis [42 CFR 482.28(a)]	• Dietetic services may be provided by the facility or through a contract • A person shall be designated by the administrator to be responsible for dietary services. If that person is not a registered dietician then an RD must be available for 4 hours every 3 months, or if contracted, a PHF staff member shall be designated to monitor the operation of the food service within the facility (CCR Title 22, §77077) • The hospital must have a full-time employee who serves as the director of food and dietetic services and must have a qualified dietitian full-time, part-time or on a consultant basis (42 CFR 482.28(a)]	• Sufficient dietary staff (CCR Title 9, §785.19)
Pharmaceutical Service Staff	• A pharmacist must have overall responsibility for pharmacy services	• Facility must retain a consulting pharmacist who devotes a sufficient number of hours to provide onsite	• MHRC shall retain a consulting pharmacist who devotes a sufficient number of hours during

	General Acute Care Hospital (Psychiatric Unit/Services)	Psychiatric Health Facility	Mental Health Rehabilitation Center
	(CCR Title 22, §70265) • Only pharmacist or individual under supervision of pharmacist may dispense medications (CCR Title 22, §70263) • A full-time, part-time or consulting pharmacist must be responsible for pharmacy services [42 CFR 482.25(a)(1)]	required services, at least on a quarterly basis (CCR Title 22, §77079.12) • A full-time, part-time or consulting pharmacist must be responsible for pharmacy services [42 CFR 482.25(a)(1)]	regularly scheduled visits (CCR Title 9, §785.30)
Other Professional Staff/General Requirements	• Note: No ratios for any other clinical/professional staff, but would have to staff according to the unit staffing plan. • Must have adequate numbers of qualified professional and supportive staff (42 CFR 482.62)	• General – for PHF s with a census of 11 to 20 patients, the minimum staffing requirements for a 24-hour period are: 4 healthcare professionals who are psychiatrists, clinical psychologists, clinical social workers, MFCC, R.N, L.V.N., or Psych. Tech and 3 mental health workers (CCR Title 22, §77061) • Must have adequate numbers of qualified professional and supportive staff (42 CFR 482.62)	• Unlicensed staff may assist clients with personal care, taking and recording vital signs, meals, and monitoring client whereabouts [CCR Title 9, §785.12(b)]
	Chemical Dependency Recovery/Substance Use Unit	(See Level of Care Section for admission of patients with substance use disorders)	(See Level of Care Section for admission of clients with substance use disorders)
	• No specific requirements for this category of unit (except nurse ratios – below), but		

	General Acute Care Hospital (Psychiatric Unit/Services)	Psychiatric Health Facility	Mental Health Rehabilitation Center
	would be similar to a psychiatric unit. • Requirements would be agreed to by the state Licensing and Certification District Office		
	• May be considered a Specialty Care Unit for nurse/patient ratios purposes • Ratio: 1:4 or fewer patients per licensed nurse at all times • No ratios for any other clinical/professional staff, but would have to staff according to the unit staffing plan.		

Reimbursement Comparison

	General Acute Care Hospital (if not an IMD)	Psychiatric Health Facility (if not an IMD)	Mental Health Rehabilitation Center
Medicare	Yes	Yes	No
Medi-Cal	Yes	Yes	No
Private Pay	Yes	Yes	Yes
County Funds	Yes	Yes	Yes

Licensing and Certification Comparison References and Resources

The comparison charts highlight selected key requirements and do not include all statutory or regulatory requirements for state licensure and/or federal certification for Medicare and Medi-Cal. For information about all requirements for each category of licensed facility, please consult the following sources.

- To access California Statutes: http://www.leginfo.ca.gov/calaw.html
- To access California Regulations: http://government.westlaw.com/linkedslice/default.asp?SP=CCR-1000

General Acute Care Hospitals with a PPS-Excluded Psychiatric Unit/Psychiatric Services:

- State Licensing:
  - Health and Safety Code Sections 1250, et al.
  - California Code of Regulations, Title 22, Division 5, Chapter 1, Sections 70001 through 70923
- Federal Certification:
  - 42 Code of Federal Regulations 482.1 through 482.57; and 482.60 through 482.62
  - Recommend State Operations Manual, Appendix A (hospitals) and Appendix AA (Psychiatric Hospitals) for more detailed information about what surveyors use as guidelines to determine compliance:
    - Appendix A: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf
    - Appendix AA: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_aa_psyc_hospitals.pdf

Psychiatric Health Facilities (PHF):

- State Licensing:
  - Health and Safety Code Sections 1250.2, 1266.1, & 1275.1
  - California Code of Regulations, Title 22, Division 5, Chapter 9, Sections 77001 through 77155

- Federal Certification:
  - 42 Code of Federal Regulations (CFR) 482.1 through 482.23 and 482.25 through 482.57; and 42 CFR 482. 60 through 482.62
  - Recommend State Operations Manual, Appendix A and AA for more detailed information about what surveyors use as guidelines to determine compliance:
    - Appendix A: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf
    - Appendix AA: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_aa_psyc_hospitals.pdf

Mental Health Rehabilitation Centers (MHRC):

- State Licensing:
  - Health and Safety Code §1271.15
  - Welfare and Institutions Code §5675 through 5675.2 & 5768
  - California Code of Regulations, Title 9, Division 1, Chapter 3.5, Sections 781 through 788.14

- Federal Certification:
  - The services provided by an MHRC are not a covered benefit under the California Medi-Cal State Plan, or under Medicare, and there are no federal certification standards for this category of facility.

Appendix D: Summary of Santa Barbara County Psychiatric Health Facility CMS Certification Survey Findings (01/14/11)

(Please note: Follow-up certification surveys have determined that the PHF is back in substantial compliance with federal requirements. This is a summary of previously-identified areas of non-compliance)

Federal Conditions of Participation Not Met	Description of Area of Noncompliance
482.12 Governing Body *Note: Some of the deficiencies are repetitive deficiencies written under Patient Rights, QAPI, Nursing, etc. Because the governing body is responsible for the overall operations and compliance of the facility, deficiencies written under other CoPs are also deficient practices under the Governing Body CoP.* *The findings were based on surveyor observation, interviews and record reviews.*	• Failed to consider recommendations of the medical staff prior to appointing members to the medical staff. • Failure to periodically assess members of the medical staff. • Failed to ensure that the governing body had approved the medical staff by-laws. • By-laws state that medical staff privileges are to be suspended for failure to complete medical records, but staff has confirmed that this does not take place, but medical staff is only reminded of the need to complete delinquent medical records. (and there was no documentation to demonstrate compliance with conducting an H&P within 24 hours of admission) • Failed to ensure that written policies and procedures for the appraisal, initial treatment and referral of emergencies was developed. (policy was basically to call 911). • Failed to ensure that contracted services were monitored, evaluated and performed in safe and effective manner. (contracted dietary and pharmaceutical services problematic – see below) • Failed to ensure that patient rights were protected (including failure to report the death of a restrained, secluded patient to CMS). • Failure to ensure that nursing services met the needs of patients was integrated into the QAPI, medications given as prescribed, medication orders were clarified, and that there were adequate numbers of nursing staff. • Failed to ensure that pharmaceutical policies and procedures were approved and implemented, accurate records of medications were maintained, drug formulary established, medication errors and lost/missing medications were investigated. (pharmaceutical services is a contracted service) • Failed to ensure adequate numbers of qualified dietary staff, policies and procedures were developed and implemented, dietary equipment clean and maintained,

Federal Conditions of Participation Not Met	Description of Area of Noncompliance
	and that the dietary needs of patients were met. (food service was often early or late, patients went for more than 14 hours between dinner and breakfast – staff had to feed patients snacks to tide them over)(dietary services are a contracted service) • Failed to ensure that an infection control plan was developed and implemented to minimize infectious and communicable disease, that the infection control officer was qualified, that policies and procedures were reviewed, developed and implemented, and that a comprehensive log of infection was implemented, reviewed, tracked to improve patient care. • No record that the Medical Record Administrator met the qualifications in accordance with job description. MRA had failed to file CEUs which required re-credentialing. Medical records were often incomplete.
482.13 Patient Rights	• Failure to include patient in development of care plan. • Failure to ensure that a discussion and documentation of advanced directives took place. (if patient was admitted in an unstable condition, there was often no re-visitation) • Failure to ensure that patient's valuables were inventoried, monitored and returned to patients upon discharge. • Failure to ensure that patient monies were tracked, safeguarded and protected. • Failure to ensure that restraint and seclusion orders were comprehensive, complete and in compliance with facility policies and procedures. • Failed to report to CMS the death of a patient while in restraints and secluded.
482.21 QAPI	• Failure to develop, maintain and implement and effective quality assessment/performance improvement program that incorporated infection control and pharmaceutical issues that measured, analyzed and tracked qualify indicators, including adverse patient events. • Failure to focus on quality indicator data involving high risk, high volume or problem-prone areas; that results, summaries or trends were shared with hospital administrative staff; and have a system of implementing improvement actions, track performance, and have specific improvement projects. • No data collection to identify problem-prone areas. • DON reported providing data to committees, but unless the QA committee provides specific feedback, the DON

Federal Conditions of Participation Not Met	Description of Area of Noncompliance
	had no data with which to modify the way the facility provides care. • "QAPI" was a utilization review process (concerned with the length of stay rather than quality improvement/improved patient outcomes), not a QAPI process as required by federal requirements.
482.23 Nursing Services	• There was inadequate nurse staffing for all six random days selected for the sample (in accordance with the facility policies and procedures). • Staffing is based on patient acuity rating, and patient acuity is measured only once per day. (this does not take into account fluctuations in acuity) • Failure to ensure that ongoing nursing assessments of medical needs of N-3's were completed by an RN. • Failure to ensure that nursing plans of care were developed for N-4's. • Failure for a licensed nurse to clarify stat medication orders (N-4's), and failed to notify physician if ordered medication was not available for N-3's and N-4's. • Failure to accurately document nursing treatments/care for N-2's. • Failure to ensure that medications were transcribed accurately and administered as prescribed.
482.25 Pharmaceutical Services	• Contract pharmacy not able to provide all services required for the facility. • Facility policies and procedures were not followed by the pharmacy consultant. • Pharmacy refrigerator maintained at incorrect temperature ranges, and no action was taken to correct once this was known. (insulin was discovered to be encased/packed in ice) • There was no apparent pharmaceutical committee to review or have oversight of pharmacy issues. • The facility pharmacy policies and procedures were adopted verbatim from a long-term care pharmacy P&P and not adapted for the PHF. • "Black Box Guidelines" were not provided to staff, and staffs were informed of guidelines based on what each nursing staff person could recall. • There was no approved list of emergency drugs. • Difficulty with controlled substances falling out of the back of narcotic bubble packs, and loss of narcotics occurred on a regular basis. (but hospital reports did not indicate trends of lost controlled substances).

Federal Conditions of Participation Not Met	Description of Area of Noncompliance
	• Failure to investigate medication losses. • Pharmacy was not able to provide all medication for discharged patients. Tape was used to reseal the bubble packs. • List of "house supplies" drugs not approved – list developed by the DON – and quantities of drugs on the list did not coincide with actual inventory. Drugs that were not on the "house supplies" list were also maintained. • No drug formulary for facility. None of the nursing staff interviewed could fine any sort of drug formulary. • Patients are discharged with a 7-day supply of drugs, however, the instructions on the "house supply" bubble packs may not reflect the actual use by that patient. • Pharmacy is located 40 miles away and some medications can take up to 4 hours to arrive. Some patients have already left the facility – without their meds. • Even though the P&P states that a single dose of sample meds can be given, the facility does not permit sample meds to be dispensed. • Medications with expired dates, or medication that should have been determined to be unusable, were still in the drug supply. One drug was found to not have an expiration date. • Patient discharge summaries had errors about the medications administered, and/or the dosage/frequency of medication administration. • Dosages/instructions were not noted on a patient's MAR – resulting in the medication not being given when ordered.
482.28 Food and Dietary Services	• Kitchen of the contractor was visited. Kitchen cluttered and unsanitary, foods not labeled/dated, thermometers not in refrigerators, equipment not working/maintained properly/dirty. (food contractor also provides meals to schools and meals on wheels for seniors) • Food service kitchen closes at noon on Saturdays, so dinner for facility patients is delivered at 1:00 PM. • Food temperature logs not checked/maintained, foods not monitored to ensure cooled down properly. • Staff not knowledgeable about dishwashing and sanitizer testing, served meals that were not at palatable temperature, malfunctioning steam table. • No evidence that the menu had been approved, portion sizes not determined, nutritional value or meals could not be determined, food substitutions were used without posting or determining equivalent food values, portion

Federal Conditions of Participation Not Met	Description of Area of Noncompliance
	sizes for serving not specified. • There was often no record of how much was served to each patient. • Facility registered dietician did not have any role in contracted food service. (RD only at facility 2 hours per week to identify clinical nutritional needs/issues) Patients did not receive a nutritional assessment until the RD's visit. RD's recommendations were not always communicated with the patient's physician. • In one instance, a patient did not receive a meal as recommended by the RD, but the patient's medical record stated that the patient was resistant to meal (to a meal they didn't receive). • Facility could not locate their diet manual (but was found by the end of the survey). • RD was not invited to the Pharmacy and Therapeutics Committee meetings. • Delays in medical nutritional therapy – some meals inconsistent with physician orders. • No food service policies and procedures for use by facility staff. (contract with food service required a P&P that was up-to-date and compliant with requirements) • Facility staff inadequately trained, menu was not consistently followed resulting in patients not receiving adequate food. • Facility did not have a full-time person responsible for food service.
482.41 Physical Environment *Note: The violations of so many serious standards resulted in the entire CoP being determined not met and an Immediate Jeopardy (IJ) was called.*	• Building maintenance was not maintained as evidenced by unrepaired holes, broken door latches – which could result in the spread of smoke or fire (failed to maintain the integrity of fire barriers) • No records that the emergency lighting system had been tested. • One exit sign not illuminated as required. • No documentation that the fire alarm system had been maintained, tested, or inspected as required. • Failure to ensure that at least a local alarm would sound when the sprinkler fire valves are closed. • Failure to ensure that the automatic fire sprinkler system was operational, maintained, tested or inspected as required. • Portable fire extinguishers not tested a required. • Failure to ensure that soiled linen carts (that exceed 32 gallons) were stored in a location protected as a hazardous

Federal Conditions of Participation Not Met	Description of Area of Noncompliance
	area. • Back-up generator not tested as required. • Failure to maintain integrity of electrical system (surge protector plugged into another surge protector). • Broken/cracked window in the hallway. • Empty camera box mounted in a patient's room, and stationary knobs that were not breakaway, creating a possible leverage tool for at risk suicidal patients.
482.42 Infection Control	• Infection control policies and procedures not regulatory reviewed, quality committee not proactively involved with infection control processes. • Under the infection control log, there was a tally of infections (skin, respiratory, UTI), but no indication of the type of infection, treatments used, effectiveness of treatments, antibiotic choices or analysis of order medications. • Infection Control Log often incomplete. • Infection control professional submits data, but doesn't attend the infection control meetings or receive any feedback from the committee, and does not conduct surveillance of staff for proper hand-washing. • Infection control officer did not have necessary qualifications/training in infection control. (and was never provided with a job description as to what he was expected to do) • Infection control committee did not report to the quality committee or the governing body, and there is a lack of communication between the committees and staff. • Environmental cleaning services were not built into an infection control plan. Observations included an air duct covered in debris/dust, nurse station faucet and handles had build-up of green sediment deposits, & countertops covered in white coating.

Appendix E: In-County and Out-of-County Inpatient Medi-Cal Tar/Paid Claims by County, 2011[2]

County	In-County Hospitals	Out-of-County Hospitals	In-County Patient Days	Out-of-County Patient Days	Other Patient Days	Total Patient Days
Alameda	3	13	3,406	1,000	239	4,645
Alpine	n/a	n/a	n/a	n/a	11	11
Amador	n/a	n/a	n/a	n/a	9	9
Butte	0	8	0	1,370	124	1,494
Calaveras	0	2	0	23	21	44
Colusa	0	1	0	6	26	32
Contra Costa	1	11	1,486	1,249	176	2,911
Del Norte	0	4	0	36	34	70
El Dorado	0	2	0	52	26	78
Fresno	1	14	4,512	4,483	375	9,370
Glenn	0	4	0	56	5	61
Humboldt	0	4	0	127	63	190
Imperial	0	7	0	1,134	187	1,321
Inyo	0	4	0	73	21	94
Kern	1	8	1,379	181	310	1,870
Kings	0	5	0	711	101	812
Lake	0	5	0	832	58	890
Lassen	0	4	0	100	3	103
Los Angeles	14	13	92,454	34,297	11,060	137,811
Madera	0	9	0	580	65	645
Marin	1	4	578	234	51	863
Mariposa	0	2	0	16	26	42
Mendocino	0	4	0	576	120	696
Merced	0	8	0	652	48	700
Modoc[3]	0	3	0	67	18	85
Mono	n/a	n/a	n/a	n/a	n/a	n/a

[2] Source: File 34 Consolidation Paid TAR Claims by County and Provider number.
April 2011 -
http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNoticeEnclosure2File34consolidationclaims.pdf
"n/a" indicates that the county did not meet the threshold to be included in the source document. **Please note:** The source document for this chart specifies the county of origin for only disproportionate share hospitals and traditional hospitals. Traditional hospitals are defined in regulation as accounting for five percent or $20,000, whichever is more, of the total FFS/MC psychiatric inpatient hospital payments for the MHP's beneficiaries. (See the following for more information: http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice11-11.pdf) However, there are patient days for other hospitals, which are not identified by county of origin. To account for all patient days paid for in each county, the latter category of hospital is counted in the "Other" column.

[3] Modoc paid for 30 patient days in an out-of-state hospital.

County	In-County Hospitals	Out-of-County Hospitals	In-County Patient Days	Out-of-County Patient Days	Other Patient Days	Total Patient Days
Monterey	1	5	414	512	145	1,071
Napa	1	3	268	224	40	532
Nevada	0	1	0	62	40	102
Orange	3	14	18,422	463	1,614	20,499
Placer	0	7	0	237	49	286
Plumas	0	3	0	40	0	40
Riverside	0	21	0	5,138	887	6,025
Sacramento	3	13	3,643	910	482	5,035
San Benito	0	3	0	33	7	40
San Bernardino	3	17	9,731	2,484	1,407	13,622
San Diego	6	14	26,036	393	3,806	30,235
San Francisco	3	19	2,395	678	306	3,379
San Joaquin	0	9	0	434	123	557
San Luis Obispo	0	8	0	312	46	358
San Mateo	1	10	467	787	251	1,505
Santa Barbara	0	11	0	518	69	587
Santa Clara	2	11	1,507	4,740	617	6,864
Santa Cruz	1	4	1,667	114	84	1,865
Shasta	0	10	0	447	25	472
Sierra	n/a	n/a	n/a	n/a	6	6
Siskiyou	0	5	0	499	41	540
Solano	1	2	17	105	57	179
Sonoma	0	8	0	1,312	253	1,565
Stanislaus	1	6	2,089	360	117	2,566
Sutter/Yuba	0	8	0	605	44	649
Tehama	0	2	0	298	34	332
Trinity	0	1	0	5	0	5
Tulare	1	11	2,681	748	138	3,567
Tuolumne	0	4	0	562	85	647
Ventura	1	16	762	888	131	1,781
Yolo	1	5	238	505	10	753
Yuba/Sutter	See entry for Sutter/Yuba Counties					

Appendix F: In-County and Out-of-County Hospital Inpatient Average Cost of Medi-Cal Tar/Paid Claims by County Effective April, 2011[4]

County	Total Inpatient Days	Total Amount Paid	Unduplicated Clients	Average Cost Per Claim	Average Cost Per Unduplicated Client
Alameda	4,645	$4,155,849.44	571	$894.69	$7,278.20
Alpine	11	$9,389.78	2	$853.62	$4,694.89
Amador	9	$2,397.00	2	$266.33	$1,198.50
Butte	1,494	$1,296,878.84	183	$868.06	$7,086.77
Calaveras	44	$35,643.00	9	$810.07	$3,960.33
Colusa	32	$27,313.68	5	$853.55	$5,462.74
Contra Costa	2,911	$2,844,260.66	330	$977.07	$8,618.97
Del Norte	70	$54,090.72	11	$772.72	$4,917.34
El Dorado	78	$57,798.00	9	$741.00	$6,422.00
Fresno	9,370	$8,014,504.22	1,309	$855.34	$6,122.62
Glenn	61	$56,370.24	9	$924.10	$6,263.36
Humboldt	190	$181,661.49	18	$956.11	$10,092.31
Imperial	1,321	$727,198.86	86	$550.49	$8,455.80
Inyo	94	$62,708.87	9	$667.12	$6,967.65
Kern	1,870	$1,423,951.41	291	$761.47	$4,893.30
Kings	812	$686,689.87	119	$845.68	$5,770.50
Lake	890	$753,804.73	82	$846.97	$9,192.74
Lassen	103	$95,455.68	14	$926.75	$6,818.26
Los Angeles	137,811	$72,862,191.23	14,348	$528.71	$5,078.21
Madera	645	$545,296.31	78	$845.42	$6,990.98
Marin	863	$761,595.94	91	$882.50	$8,369.19
Mariposa	42	$33,400.00	9	$795.24	$3,711.11
Mendocino	696	$593,694.20	70	$853.01	$8,481.35
Merced	700	$536,705.15	59	$766.72	$9,096.70
Modoc	85	$74,400.12	7	$875.30	$10,628.59
Mono[5]	n/a	n/a	n/a	n/a	n/a
Monterey	1,071	$942,587.78	133	$880.10	$7,087.13
Napa	532	$452,129.71	55	$849.87	$8,220.54
Nevada	102	$81,007.75	9	$794.19	$9,000.86
Orange	21,499	$10,967,834.88	1,415	$510.16	$7,751.12
Placer	286	$208,027.60	39	$727.37	$5,334.04
Plumas	40	$39,580.04	6	$989.50	$6,596.67
Riverside	6,025	$3,689,619.17	1,025	$612.38	$3,599.63

[4] Source: File 34 Consolidation Paid TAR Claims by County and Provider number. April 2011 - (http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNoticeEnclosure2File34consolidationclaims.pdf)

[5] Mono County did not have any data in the report.

County	Total Inpatient Days	Total Amount Paid	Unduplicated Clients	Average Cost Per Claim	Average Cost Per Unduplicated Client
Sacramento	5,035	$4,004,627.77	585	$795.36	$6,845.52
San Benito	40	$37,804.00	5	$945.10	$7,560.80
San Bernardino	13,622	$8,923,524.52	2,082	$655.08	$4,286.03
San Diego	30,235	$16,306,628.53	3,154	$539.33	$5,170.14
San Francisco	3,379	$2,473,415.07	446	$732.00	$5,545.77
San Joaquin	557	$448,930.04	68	$805.98	$6,601.91
San Luis Obispo	358	$239,991.62	39	$670.37	$6,153.63
San Mateo	1,505	$1,266,809.73	187	$841.73	$6,774.38
Santa Barbara	587	$348,237.90	71	$593.25	$4,904.76
Santa Clara	728	$5,808,662.63	728	$7,978.93	$7,978.93
Santa Cruz	1,865	$2,080,138.72	188	$1,115.36	$11,064.57
Shasta	471	$384,551.27	53	$816.46	$7,255.68
Sierra	6	$6,505.44	1	$1,084.24	$6,505.44
Siskiyou	540	$514,199.67	58	$952.22	$8,865.51
Solano	179	$124,484.30	12	$695.44	$10,373.69
Sonoma	1,565	$1,304,365.84	182	$833.46	$7,166.85
Stanislaus	2,566	$2,014,491.50	617	$785.07	$3,264.98
Sutter/Yuba	649	$535,504.24	71	$825.12	$7,542.31
Tehama	332	$272,222.64	25	$819.95	$10,888.91
Trinity	5	$3,735.00	1	$747.00	$3,735.00
Tulare	3,567	$3,042,062.91	301	$852.84	$10,106.52
Tuolumne	647	$514,917.96	76	$795.85	$6,775.24
Ventura	1,781	$1,010,655.17	247	$567.47	$4,091.72
Yolo	752	$640,536.61	85	$851.78	$7,535.72
Yuba/Sutter	See Information for Sutter/Yuba Counties				

Appendix G: Opportunities for Inconsistent Application of Medical Necessity Criteria[6]

The following information raises more questions than are answered. However this information will serve to illustrate the opportunity for inconsistent application of the medical necessity criteria, and the lack of available data to identify inconsistencies, better inform program policy decision-making, and improve access to care.

Many Providers Submit Claims to Multiple Counties

- Most providers submit claims to multiple counties for services provided to beneficiaries from those counties.
- There is no publicly-reported data on the denial rate of authorization requests submitted to counties, by provider, to be able to identify potential variance in the medical necessity criteria interpretation.
- The denial rate of claim authorizations submitted by a single provider can vary from county to county.
- There is no summary data of the trends in services provided by which providers/counties, and how that may have changed over time. If a provider decided to stop accepting patients from a particular county because of denied claims, how is that detected, or should it be detected? If counties have stopped using a particular provider over time, how is that detected or should it be detected?
- Additional data is needed to determine the extent to which an individual county has a consistently-high denial rate for all or some providers, and to what extent higher denial rates are tied to fewer patient days.
- The denial rate for pediatric/adolescent care appears to be lower than the denial rate for services provided to adults.
- Table 1 provides a brief snapshot of denial rates, and average length of stay reported by a small number of providers. This information was obtained in response to an informal inquiry and is not to be construed as a statistically-valid data sample.
- Table 2 provides a sample summary of selected providers and the number of counties for which beneficiary services are provided.[7] This table illustrates the large number of different counties to which an individual provider must submit claims.

[6] This information was originally used as a handout for a session at the California Hospital Association's 2010 Behavioral Health Symposium. The information was compiled by Brenda G. Klutz, Senior Consultant, Health Management Associates, November, 2010.

[7] Department of Mental Health, *Information Notice 10-18: Enclosure 2*, Accessed on November 6, 2010, Retrieved from: http://www.dmh.ca.gov/DMHDocs/docs/notices10/10-18_Enclosure2.pdf

Table 1.

County	Average Length of Stay (days)	Percent of Inpatient Days Denied
A	12	0
B	8	62.0
C	4.63	3.2
D	7	0
E	5	8.0
F	8	1.0
G	6	22.0
H	2.6	35.0
I	7	8.0

Table 2.[8]

Provider	# of Counties to which TARs are submitted*
A	33
B	16
C	29
D	11
E	39

*Does not include Counties that do not meet the threshold for inpatient consolidation paid claims

Most Counties Receive Claims from Multiple Providers of Acute Inpatient Services

- Most counties deal with multiple providers, many of which are located beyond the county lines.
- The number of inpatient days, by provider, varies greatly. Some providers account for the majority of inpatient services provided to beneficiaries of a particular county, while others account for only a few days.
- There is no publicly-reported data on the denial rate of authorization requests by county.
- There is no publicly-reported data on the extent to which the denial rates for a particular county is consistent from provider to provider, or if there are variances in the denial rates, depending on whether the authorization request meets the county interpretation of medical necessity.
- There is no publicly-available data on the extent to which a particular provider has a high denial rate in more than one county.

[8] Ibid.

- Do providers with fewer patient days have a higher denial rate than a provider with significant number of patient days?
- Interpretations of the medical necessity criteria can change with additional clarification of federal and state policy and often subsequent to audits.
- Chart 3 provides a sample summary of counties that meet the threshold for consolidated inpatient billing, the number of providers serving beneficiaries of that county , and the number of counties in which those providers are located9.

Table 3.

TAR County	# of Providers	# of Counties in which Providers are Located
Alameda	16	9
Butte*	7	6
Contra Costa	10	7
Humboldt*	13	8
Kern	15	9
Los Angeles	27	9
Monterey	8	8
Orange	21	7
Riverside	22	8
Sacramento	17	11
San Diego	19	5

* County with no acute inpatient beds

[9] Ibid