State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
Director

EDMUND G. BROWN JR.
Governor

OCT 12 2011

The Center for Medicare and Medicaid Innovation
ATTN: Armen H. Thoumaian, Ph.D.
Mail Stop: C3-24-07
Centers for Medicare & Medicaid Services
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Dear Dr. Thoumaian:

The California State Department of Health Care Services (DHCS) is pleased to submit the enclosed application proposal for participation in the Medicaid Emergency Psychiatric Demonstration. Pursuant to Section 2707 of the Affordable Care Act, this 3-year Demonstration will provide federal matching funds to States for Medicaid payments made to private psychiatric hospitals, with 17 or more beds, for inpatient emergency psychiatric care to Medicaid recipients ages 21-64; payments which are otherwise prohibited under Medicaid.

This is an opportunity to collaborate with the Centers for Medicare and Medicaid Services (CMS) in implementing this Demonstration and assist CMS in assessing if this expansion of Medicaid coverage to include certain emergency services in private psychiatric hospitals improves access to and quality of medically necessary care and is cost-effective.

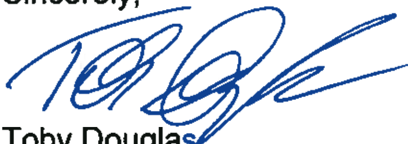
Federal health care reform (the Affordable Care Act), is a priority for California as we continue to explore and implement new and cost-effective ways of delivering, financing, and purchasing health care, while ensuring the highest level of program integrity and health care quality and outcomes. We have been an early implementer of the Affordable Care Act and look forward to participating in the Medicaid Emergency Psychiatric Demonstration.

In California, counties are responsible for the provision and funding of services provided to Medi-Cal beneficiaries ages 21-64 in Institutions for Mental Diseases (IMDs). The counties of Sacramento and Contra Costa are eager to participate in this Demonstration, and believe that their participation will benefit and improve their current systems of care for psychiatric emergency services.

DHCS supports counties in this effort, and looks forward to working with The Center for Medicare and Medicaid Innovation on the implementation of Section 2707 of the Affordable Care Act.

If you have questions regarding this application proposal, please contact Dina Kokkos-Gonzales, Chief of the Waiver Analysis Branch, by phone at (916) 552-9422, by fax at (916) 552-9660 or by e-mail at Dina.Kokkos@dhcs.ca.gov.

Sincerely,



Toby Douglas,
Director

Enclosures

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Executive Summary

On March 23, 2010, President Obama signed the *Patient Protection and Affordable Care Act*, which is intended to expand coverage, control health care costs and improve the health care delivery system. Section 2707 of this Act authorizes a three-year Medicaid Demonstration Project, under which privately owned and operated psychiatric hospitals would receive Medicaid payment for emergency psychiatric admissions for patients ages 21-64, pursuant to an Emergency Medical Treatment and Active Labor Act (EMTALA) transfer from a dedicated hospital emergency department. This demonstration is designed to determine whether this expansion of coverage improves access to and the quality of medically necessary care.

Currently, these patients are subject to the provisions of the federal "IMD exclusion," which limits their eligibility for medically necessary mental health institutional services under the Medicaid program. This exception to Medicaid coverage forms a significant barrier to the timely transfer of patients needing emergency psychiatric treatment under the provisions of EMTALA. To the extent that this is the case, it leads to extended stays in hospital emergency departments and creates a barrier to access to appropriate specialty mental health treatment.

California has experienced a significant reduction in the number of private and public psychiatric hospital beds, according to a study conducted by the California Hospital Association (CHA) (see Appendix). This study came to light more than three years ago and has been the impetus to collaborative efforts to address the loss of this important resource. Yet, despite all of the best efforts of state, county and private hospital representatives, we have not been successful in addressing the reimbursement issues and impediments identified to rebuilding an adequate statewide emergency psychiatric system in California. It is against this backdrop that we welcome the opportunity to apply for this important Federal Demonstration program.

Building on the collaborative efforts already in place in California between the California Hospital Association (CHA), the California Mental Health Directors Association (CMHDA), the California Institute for Mental Health (CiMH) and the California Departments of Health Care Services and Mental Health (DHCS and DMH), we have developed this application with two California counties. Sacramento County, representing the central valley of California, and Contra Costa County, representing the "Bay Area," have been selected to represent California for this Demonstration application. Both of these counties have experienced significant barriers to the timely transfer of psychiatric patients resulting in "psychiatric boarding" in emergency rooms and crisis centers. Both are also dedicated to changing this pattern and have engaged in significant dialogue with representatives of their hospitals, law enforcement and consumer and family communities to develop proposed solutions that engage all of these important constituency groups.

The opportunities and problems outlined in the invitation to apply for this Demonstration are very familiar to these counties. The opportunity to organize a response to the existing Sacramento and Contra Costa County community planning efforts under this Demonstration are welcome and very timely. Both counties have community relationships already in place to expeditiously implement the demonstration, if California is successful in its application.

This proposal was a collaborative effort, and the background and reasons for applying reflected in the Introduction (Section 1.0) and Background (Section 2.0) reflect the unique and common goals for the application developed by each county and its hospital and community partners. Of particular importance is the role that the counties play under the provisions of California's 1915(b) Medi-Cal Specialty Mental Health Services "freedom of choice" waiver and mental health rehabilitation and targeted case management state plan amendments. Under the provisions of this Medicaid waiver, the county Mental Health Plans (MHP) are responsible for providing, arranging and paying for mental health emergency, hospital and post-stabilization and outpatient care statewide for covered Medi-Cal beneficiaries. The counties, as government entities, provide and certify their expenditures as required to obtain federal reimbursement and also arrange for voluntary and involuntary indigent emergency mental health care to the extent that local resources are available. As a result, the risk and responsibility for assuring access to voluntary and involuntary acute psychiatric and uncovered county residents falls squarely on the shoulders of these applicant counties.

The Demonstration Proposal (Section 3.0) summarizes the unique partnership that has been put in place to facilitate the efficient linkage between public and private resources to address this Demonstration opportunity. The selected counties currently operate under contract with DMH and will enter into a contract with DHCS as of July 1, 2012. Their role is already defined and the access, utilization management and financial structures are in place to implement this Medicaid Demonstration. In addition, since the county MHPs have existing contracts with the selected private psychiatric hospitals, this partnership is also already documented. To assure that the evaluation and data management activities are coordinated among the collaborating entities, we have included the California Institute for Mental Health (CiMH), a private non-profit with a long history of successfully contracting with county, state and federal governments. CiMH brings significant professional consultation, evaluation and data management expertise to the table to assure compliance with the extensive evaluation and data requirements specified under this Demonstration.

Finally, since the intergovernmental federal Medicaid interim payment, cost reporting, reconciliation and settlement processes are already in place between the state and the counties, the assurance of full fiscal compliance can be made with little additional administrative burden and cost. In addition to the significant existing partnership benefits outlined above, California has embarked on a Centers for Medicare and Medicaid Services (CMS)-approved Section 1115 Demonstration Waiver ("Bridge to Health Care Reform") to expand health coverage. The Bridge to Health Care Reform Demonstration in addition to this Demonstration will provide California with an additional opportunity to advance and fulfill the goals of the Affordable Care Act.

Medicaid Emergency Psychiatric Demonstration Application Proposal

1.0 Introduction

1.1 Rationale for Participation

Participation in the Medicaid Emergency Psychiatric Demonstration Project (Demonstration) will benefit individuals and organizations in California who receive and provide emergency psychiatric services in the Demonstration regions. These include: individual residents of the counties and their families and extended support systems, community law enforcement and safety net providers, private acute care psychiatric hospitals, local public and private general acute care hospitals and emergency rooms, mental health outpatient providers and local governmental agencies responsible for the funding and coordination of mental health services in the community.

Two decades of shrinking emergency psychiatric inpatient bed capacity, aggravated by lack of access to federal reimbursement for IMD-excluded free-standing private psychiatric hospitals, population growth, an increase in the number of Medicaid-eligibles and historic underfunding of outpatient mental health care, have resulted in a crisis in psychiatric emergency care in California. The two counties participating in the Demonstration – Sacramento and Contra Costa Counties – have a number of inpatient beds available that could meet eligibility for reimbursement through the federal Medicaid program if the IMD exclusion were waived. The circumstances and problems faced by these counties are reflective of problems throughout California. Currently, there are only 12 Medicaid-reimbursable adult psychiatric acute inpatient beds available in Sacramento County and only 23 such beds in Contra Costa County. This places a significant fiscal burden on both local government and emergency inpatient facilities, which must absorb the cost of expensive emergency stabilization and acute inpatient services for individuals otherwise eligible for Medicaid.

The decrease in bed capacity has led to an increase in out-of-county placements, leading to interruptions in the continuity of care for patients who are being treated by providers that are not part of their usual treatment team.

The goals of participation in this project would be to:

- Expand coverage by increasing the number of inpatient facilities in which services are Medi-Cal reimbursable;
- Control costs by reducing patient boarding in medical emergency rooms and inpatient units, and reducing emergency care costs to local hospitals and other emergency service agencies; and
- Improve the delivery system by reducing out-of-county psychiatric facility placements and facilitating more rapid and appropriate clinical services for individuals in crisis.

If selected, California’s unique county mental health realigned financing structure, coupled with its CMS-approved 1115 Demonstration Waiver to expand health care coverage, will provide CMS with quantifiable support that improved care coordination results in improved outcomes for beneficiaries.

2.0 Background

2.1 Mental Health Issues and Service Delivery in the State

The provision of inpatient services for individuals diagnosed with severe mental illness in California in many ways mirrors the rest of the nation. In the first part of the 20th Century, inpatient services were primarily provided in large state-administered institutions (state-owned psychiatric hospitals). As of 1957, there were 14 state hospitals in California, with a population of approximately 36,000.

As deinstitutionalization and community-based care became more "state-of-the-art" in treatment for the mentally ill, large institutions closed and services were focused at the community level. In California, over the terms of several state administrations, nine state hospitals were closed. By 1984, only five state hospitals remained open, and the population of individuals in state hospitals had dropped by 84 percent . Advocates, consumers, families and professionals all agreed that if an individual's psychiatric symptoms could be stabilized, life in the community is far more humane and therapeutic than life in a large institution. Further, it was generally thought that the success of deinstitutionalization and the emphasis on community care would allow funds saved from the closure of the state institutions to follow the consumer into community-based treatment.

In 1991, California realigned responsibility for mental health service funding from the state to counties, and provided a dedicated revenue source for this shift. Included was the responsibility for placement of and payment for civil commitment of individuals in state psychiatric hospitals. It was thought that providing funding and responsibility for all community mental health to counties would provide the proper incentives to create more cost-effective and less restrictive services in the community. This shift in responsibility and funding has been largely successful, allowing counties to invest in the community services and infrastructure needed to serve people with serious mental illness outside of costly institutions.

However, current Medicaid law statutorily prohibits federal Medicaid funds to be used for care provided to Medicaid beneficiaries between the ages of 22 to 64 in psychiatric hospitals, whether they are large state hospitals or smaller, short-term community hospitals. These facilities are deemed "Institutions for Mental Disease" (IMDs). This IMD exclusion was included in the Medicaid law when it was initially enacted in 1965 because in the 1960s, inpatient psychiatric care was provided primarily in state mental hospitals, which were supported by state funds and was generally long-term care. The federal government's view was that inpatient psychiatric care was a state responsibility and the federal government did not want to allocate federal dollars for what was considered a state-supported function. Today, the inpatient psychiatric care delivery system is dramatically changed. There are hundreds of specialty psychiatric hospitals nationwide providing short-term, acute psychiatric services, but they are still not able to receive payment for most adult Medicaid patients.

According to the State Medicaid Manual, a facility meets IMD criteria if its "overall character is that of a facility established and/or maintained for the care and treatment of individuals with mental diseases". Any one of the following criteria defines an IMD: the facility is licensed as a psychiatric facility, the facility is accredited as a psychiatric facility, the facility is under the

jurisdiction of the state's mental health authority, the facility specializes in providing psychiatric-psychological care and treatment, or more than 50 percent of all the patients-residents in the facility require care because of mental diseases. One significant modification occurred in 1988, when Congress, as part of the Medicare Catastrophic Act (P.L. 100-360), indicated that a facility needed to have more than 16 beds to be defined as an IMD.

In 1995, under a Medicaid 1915(b) waiver, California further shifted the responsibility for authorization and local non-federal match funding for all Medi-Cal psychiatric inpatient hospital services from the state to county Mental Health Plans (MHPs), operated by county mental health departments. Since FFP is not available for adults placed in IMDs of more than 16 beds, the counties are responsible for funding the entire cost of hospitalization at these facilities from local resources.

In California, the IMD exclusion has had the unintended effect of leaving severely mentally ill individuals, whose symptoms are so severe that community outpatient treatment is not indicated, with few options for care. Since the early 1990s, many freestanding psychiatric hospitals have reduced their bed capacity and some hospitals closed, affecting access to care. This has meant that emergency rooms in general acute care hospitals are increasingly expected to meet the needs of these individuals while appropriate inpatient placements are sought. Statewide, very few beds for which FFP can be claimed (i.e., non-IMDs) are available, and county resources are extremely limited for payment for placement in facilities that are IMDs. Hardest hit have been the most economically depressed areas of California, particularly the Central Valley (which includes Sacramento as one of the counties which will participate in this Demonstration project).

California's 2011 Community Mental Health Services State Plan that was submitted by the Department of Mental Health to the Substance Abuse and Mental Health Services Administration (SAMHSA) utilized a psychiatric prevalence methodology developed by Dr. Charles Holzer from the University of Texas, Medical Branch. The methodology estimated an average prevalence of 7 percent of the youth population as having Serious Emotional Disabilities and a significant functional impairment, and an average prevalence of 2.6 percent of the adult population as having severe and persistent mental illness. Based on those estimates, for state fiscal year (FY) 2008-09 (July to June), it is estimated there are 358,599 youth and 712,208 adults (for a total of 1,092,909) who meet this threshold.

As an estimate of those who were found to exhibit suicidal gestures, the California Office of Statewide Health Planning and Development (OSHPD) records data on California resident non-fatal hospitalizations for self-inflicted suicidal gestures. In 2009, 16,356 admissions were recorded, including 4,559 in ages 0-19. Additionally, OSHPD recorded a total of 27,866 non-fatal emergency department visits not resulting in hospitalizations for self-inflicted suicidal gestures, including 8,062 for individuals 0-19 years of age. To gain additional information about suicides in California, the California Health Information Survey (CHIS) conducts a telephone survey with random California residents. In 2009, when asked if they ever seriously thought about committing suicide, 8.7 percent of respondents replied affirmatively. California does not record any specific data or estimates of those who were found to exhibit homicidal gestures.

As an estimate of those who were considered a danger to self and/or others, the California Department of Mental Health records data on persons who were provided with involuntary 72-hour evaluations and treatments. In state FY 2008-09, 18,427 children and 127,175 adults were placed on involuntary holds.

A national study by the Treatment Advocacy Center in Arlington, Virginia, published in 2008, showed that the State of California had a severe shortage of government-owned psychiatric hospital beds: only 17.5 beds per 100,000 population.

As a result of the lack of available psychiatric beds and the limited capacity of an already over-burdened outpatient service system, patient boarding in emergency rooms and hospitals has increased. The counties, in partnership with the local private psychiatric facilities, have worked together to serve their partners at the medical facilities by standardizing admission criteria, providing psychiatric assessments in the emergency rooms and providing training to emergency room staff. However, these mitigation efforts do not sufficiently address the overall lack of resources for quickly moving psychiatric patients into an appropriate clinical setting to facilitate the recognition, diagnosis and treatment of mental health conditions.

2.2 Psychiatric Care and Facilities

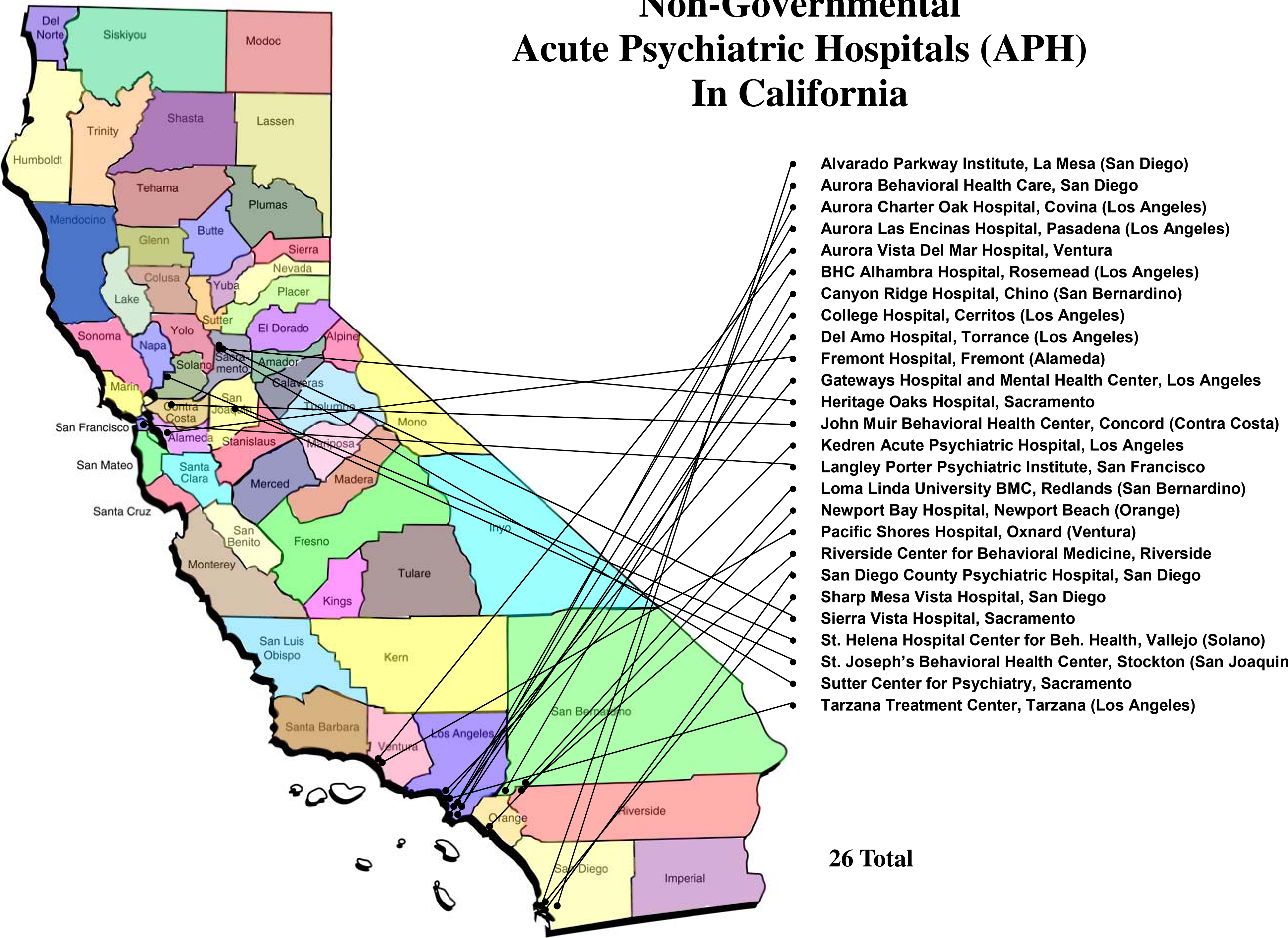
In California, persons requiring emergency psychiatric care will present to psychiatric facilities or local emergency departments for assessment and determination of the appropriate level of care needs. A referral to inpatient care for individuals who are suicidal/homicidal or a danger to self/others will be made. During hospitalization, the individual will receive acute psychiatric care by a multi-disciplinary team consisting of psychiatrists, psychiatric nurses, licensed clinicians, social workers and discharge planners. The goal of treatment is to stabilize acute/severe psychiatric symptoms and, as quickly as clinically safe and reasonable, to discharge these individuals to outpatient and support services that will promote their ongoing recovery efforts.

There are currently four inpatient psychiatric facilities in Sacramento County and two in Contra Costa County. Additionally, Contra Costa utilizes five other out-of-county inpatient psychiatric facilities. All of these entities are licensed to provide emergency services, assessment and treatment of mental health conditions.

In California, there are 26 non-governmental acute psychiatric hospitals (APHs) that meet the IMD exclusion criteria (see Chart 1). These APHs are located in 12 of the 58 counties in our state.

CHART 1

Non-Governmental Acute Psychiatric Hospitals (APH) In California



- Alvarado Parkway Institute, La Mesa (San Diego)
- Aurora Behavioral Health Care, San Diego
- Aurora Charter Oak Hospital, Covina (Los Angeles)
- Aurora Las Encinas Hospital, Pasadena (Los Angeles)
- Aurora Vista Del Mar Hospital, Ventura
- BHC Alhambra Hospital, Rosemead (Los Angeles)
- Canyon Ridge Hospital, Chino (San Bernardino)
- College Hospital, Cerritos (Los Angeles)
- Del Amo Hospital, Torrance (Los Angeles)
- Fremont Hospital, Fremont (Alameda)
- Gateways Hospital and Mental Health Center, Los Angeles
- Heritage Oaks Hospital, Sacramento
- John Muir Behavioral Health Center, Concord (Contra Costa)
- Kedren Acute Psychiatric Hospital, Los Angeles
- Langley Porter Psychiatric Institute, San Francisco
- Loma Linda University BMC, Redlands (San Bernardino)
- Newport Bay Hospital, Newport Beach (Orange)
- Pacific Shores Hospital, Oxnard (Ventura)
- Riverside Center for Behavioral Medicine, Riverside
- San Diego County Psychiatric Hospital, San Diego
- Sharp Mesa Vista Hospital, San Diego
- Sierra Vista Hospital, Sacramento
- St. Helena Hospital Center for Beh. Health, Vallejo (Solano)
- St. Joseph's Behavioral Health Center, Stockton (San Joaquin)
- Sutter Center for Psychiatry, Sacramento
- Tarzana Treatment Center, Tarzana (Los Angeles)

26 Total

August 26, 2011

The following four private psychiatric facilities are proposed for the demonstration project:

1. Contra Costa County: John Muir Behavioral Health has 73 child, adolescent and adult psychiatric beds.

2. Sacramento County: Heritage Oaks Hospital has 125 child, adolescent and adult beds with specialty programs in geriatric psychiatry, dual diagnosis and chemical dependency.

3. Sacramento County: Sierra Vista Hospital has 107 child, adolescent and adult beds with specialty programs in dual diagnosis/chemical dependency and medical detoxification.

4. Sacramento County: Sutter Center for Psychiatry has 67 child, adolescent and adult psychiatric beds. It provides specialty programs in dual diagnosis/chemical dependency, PTSD and Electro-Convulsive Therapy (ECT).

The following three facilities are also part of the inpatient psychiatric bed capacity within Sacramento and Contra Costa Counties, but are not part of the Demonstration. However, these facilities would provide comparison data for the project.

1. Sacramento County: Sacramento County Mental Health Treatment Center (MHTC) is a 50-bed county-operated Psychiatric Health Facility providing inpatient hospitalization for indigent and Medi-Cal patients. It is licensed as a Psychiatric Health Facility by the State Department of Mental Health.

2. Sacramento County: Crestwood Psychiatric Health Facility is a 12-bed facility licensed by the State Department of Mental Health. It provides acute psychiatric inpatient services and is Medi-Cal certified. It is the only Medi-Cal eligible facility for adult inpatient services in Sacramento County.

3. Contra Costa County: Contra Costa Regional Medical Center (a county-owned hospital) has one adult psychiatric inpatient unit, with a total of 23 adult Medi-Cal beds.

2.3 Demonstration Population

Sacramento County, located in Northern California, is the most populous county in the greater Sacramento area region, accounting for 70 percent of the people living in the four-county area that includes Yolo, El Dorado, Placer and Sacramento Counties. Sacramento County's population is the most racially and ethnically diverse, housing nearly 80 percent of Hispanics, Asian-Pacific Islanders and African-Americans in the four-county region.

The county is comprised of 637,220 acres, or 995.7 square miles. The 2010 census reported 1,418,788 residents. In 2009, there were 314,765 Medi-Cal eligible residents, 20,229 of whom received specialty mental health services. For ease of access and service delivery purposes, the county is broken into four service delivery areas. The Sacramento County Mental Health Regional Service Delivery Areas (regions) are Northwest, Northeast, South and Central.

Given the above description of Sacramento's regions, the three acute psychiatric hospitals identified for this Demonstration fit three regions: Heritage Oaks Hospital sits in the Northwest; Sierra Vista is located in the Southern Region and Sutter Center for Psychiatry is located in the Central Region. The county's Mental Health Treatment Center is also located in the Central Region. There are also nine emergency rooms attached to general hospitals across the county.

In FY 2010-11, Sacramento County acute psychiatric hospitals qualifying to participate in the Demonstration admitted 2,024 Medi-Cal beneficiaries between the ages of 21 and 64.

Contra Costa County encompasses nearly 800 square miles. It is the ninth largest county in California, with a population of 1,049,025.[1] In 2010, there were 160,544 Medi-Cal eligible residents, 12,027 of whom received specialty mental health services and 6,483 of whom were between the ages of 22 and 64. The county is divided into three regions: East, West and Central, each with unique geographic and demographic characteristics.

The estimated total additional beneficiaries to be served by Contra Costa County are 500 per year, and 1,500 over the three year period of the Demonstration. The estimated total additional beneficiaries to be served by Sacramento County are 1,355 per year and 4,065 over the three year period of the Demonstration. The total estimate for California for the three year period of the Demonstration is 5,420 additional beneficiaries served.

3.0 Demonstration Proposal

3.1 Staff Designation and Roles

The principal staff responsible for the implementation and management of this Demonstration includes the following:

California Department of Health Care Services

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Waiver Analysis Branch
Medi-Cal Benefits, Waiver Analysis and Rates Division
Department of Health Care Services
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Sacramento, CA 95899
(916) 552-9422

The California Institute for Mental Health (CiMH)
CiMH will provide data consolidation, storage and evaluation services for this project as a contractor for this Demonstration. CiMH is a statewide non-profit corporation established in 1993 to promote excellence in mental health services through training, technical assistance and research. The Institute has a significant history of providing similar data management and related evaluation services to the California Department of Mental Health, to DHCS and to many of California's county behavioral health departments. In its data management and evaluation role,

CiMH will serve as a reliable and accountable conduit between DHCS/DMH and the counties to support the project's data reporting and evaluation requirements.

Contact information for CiMH: Sandra Naylor-Goodwin, Ph.D., MSW
President and CEO
California Institute for Mental Health
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(916) 556-3480

County Representatives

Sacramento County

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3.2 Administration and Management

Sacramento and Contra Costa Counties will provide day-to-day administration and oversight for this Demonstration through a variety of existing processes, communication and contractual agreements. The County Boards of Supervisors have approved the participating hospitals as facilities meeting standards for involuntary treatment. The participating hospitals – Sierra Vista, Heritage Oaks and Sutter Center for Psychiatry in Sacramento, and John Muir Behavioral Health in Contra Costa – have contracts and agreements with their respective counties to provide acute psychiatric care services for all age groups (child, adolescent and adult). Contracts are negotiated annually to establish rates that include the provision of emergency services and inpatient psychiatric care. The counties monitor costs, care and utilization for each hospital through their contract monitoring and budget and fiscal oversight units. Day-to-day patient care is monitored through Hospital Utilization Review Teams that receive a daily census from each hospital, approve Treatment Authorization Requests (TARS) and ensure compliance with Medi-Cal regulations with regard to medical necessity and state and federal regulations. Quality of care

and discharge planning are monitored, and follow-up is tracked on a daily basis. The counties also have contracts and agreements with community-based organizations that provide access to community post-stabilization after emergency care, which is provided as part of the counties' Mental Health Plan (MHP) for Medi-Cal recipients. These contracts and agreements will continue to be part of the day-to-day administration and management of the Demonstration. The counties' MHPs will provide oversight of the continuity of care and relationship between the inpatient and outpatient systems.

Sacramento and Contra Costa Counties conduct a variety of quality assurance and quality improvement activities in order to monitor and track timeliness of access to emergency and post-discharge care, recidivism rates, quality of care and subsequent treatment in the outpatient service systems. Both Sacramento and Contra Costa Counties maintain MHPs with Quality Improvement Committees that inform the counties' monitoring activities and lead to data-driven performance improvement projects focused on access, utilization and quality of services. Both counties have also participated in a state-sponsored project (CalMEND) to develop greater integration of primary care and behavioral health services through data-driven examination of costs and quality at the local level.

Sacramento County engages in a variety of community stakeholder efforts to enhance the management of flow between emergency room settings and inpatient and outpatient services. Agreements have been reached to participate in ongoing partnership meetings to share data and best practices, to determine protocols to provide access to acute psychiatric services as efficiently as possible and to minimize, to the extent possible, psychiatric patient boarding in emergency rooms.

Both Sacramento and Contra Costa Counties participate in bi-monthly Emergency Services Task Force Committees that are led by local emergency room directors from each hospital and include law enforcement, fire and paramedic services, private psychiatric hospitals and other community partners. These committees are charged with monitoring issues affecting emergency rooms (e.g., ambulance diversion hours, drop off wait times, etc.) and set policies for emergency department/stakeholder cooperation affecting the Sacramento and Contra Costa regions.

Contra Costa County is conducting two Performance Improvement Projects (PIPs) related to this Demonstration. One is focused on reducing recidivism in psychiatric emergency departments and the other on reducing recidivism in governmental and non-governmental private psychiatric hospitals. Partners in these PIPs include staff from the county-operated mental health system, the psychiatric emergency department, contracted outpatient mental health agencies and partnering hospitals. Both Sacramento and Contra Costa Counties, as the MHPs managing and delivering specialty mental health care for Medi-Cal beneficiaries, operate and/or contract with community-based organizations and clinics that provide access to community services post-stabilization.

3.3 Facilities Selected for the Demonstration

Specialty mental health services to eligible Medi-Cal beneficiaries are provided in California consistent with the provisions of the 1915(b) "freedom of choice" mandatory enrollment waiver, the Rehabilitation Option and Targeted Case Management State Plan Amendments. Both

Sacramento and Contra Costa Counties deliver specialty mental health services through their MHPs that are designated as Prepaid Inpatient Health Plans (PIHPs) and meet requirements applicable to this designation. Both MHPs directly deliver through county-operated services or manage the delivery of services through contracts and agreements with an array of inpatient and outpatient services.

Memoranda of Understanding (MOUs) are in place with physical health Medi-Cal managed care plans in both counties to fulfill the state-required obligation to coordinate care between providers for physical and mental health care.

Sacramento County MHP coordinates specialty mental and physical health care with four physical health Medi-Cal managed care plans that contract with the state. They are Kaiser Permanente of Northern California, Anthem Blue Cross Partnership Plan, Health Net Community Solutions, Inc. and Molina Healthcare of California Partnership Plan. Contra Costa MHP works with two contracted Medi-Cal managed care plans: Anthem Blue Cross and Contra Costa Health Plan.

After discussions with the State, the California Hospital Association (CHA) and the California Mental Health Directors Association (CMHDA) notified and encouraged all counties with qualifying IMD-excluded, non-governmental hospitals to volunteer to participate in the Demonstration. Two counties, Contra Costa and Sacramento volunteered to participate in the Demonstration if California is a selected participating state.

These Acute Psychiatric Hospitals (APHs) are licensed by the State, certified by CMS and accredited by The Joint Commission. All have been designated by the California DMH to accept and detain individuals under the state's involuntary commitment statute, the *Lanterman-Petris-Short Act* (California Welfare & Institutions Code, sec. 5000 et seq.).

Collectively, these four APHs represent 356 inpatient beds with 278 beds dedicated to the adult population served by this Demonstration, with the remaining 78 beds dedicated for children/adolescents not served by this Demonstration.

A brief description of each APH candidate and the services provided follows:

CONTRA COSTA COUNTY
John Muir Behavioral Health Center, Concord, CA – 37 adult beds, 36 child/adolescent beds.
The adult services include: Geriatric, Dual Diagnosis, Med/Psych and Substance Use Disorder.

SACRAMENTO COUNTY
Heritage Oaks Hospital, Sacramento, CA – 106 adult beds, 19 child/adolescent beds.
The adult services include: Geriatric, Dual Diagnosis and Substance Use Disorder.

Sierra Vista Hospital, Sacramento, CA – 83 adult beds, 24 child/adolescent beds.
The adult services include: Dual Diagnosis and Medical Detox.

Sutter Center for Psychiatry, Sacramento, CA – 43 adult beds, 24 child/adolescent beds.

The adult services include: Dual Diagnosis, Post-Traumatic Stress Disorder and Electro-Convulsive Treatment.

The hospitals that have agreed to participate in the Demonstration not only accept patients from the host county (the county where the hospital is located), but also from surrounding counties across the state. A consensus agreement was reached that only age-qualifying beneficiaries from the host county, who are treated in a host county IMD-excluded hospital, will be considered as participants for the Demonstration project.

The primary referral sources will be general acute care hospitals, local psychiatric emergency teams and local law enforcement agencies. In rare circumstances, an individual may present in person and/or be transported to an APH by family or friends. The host county's mental health department, however, will authorize care for all age-qualifying beneficiaries.

Facilities Selected

Heritage Oaks Hospital
4250 Auburn Boulevard
Sacramento, CA 95841-4164
(916) 489-3336
Contact: Chris Diamond, CEO

Sierra Vista Hospital
8001 Bruceville Road
Sacramento, Ca 95823-2329
(916) 288-0300
Contact: Mike Zauner, CEO

Sutter Center for Psychiatry
100 Howe Avenue, Suite 180N
Sacramento, CA 95825-8202
(916) 386-3010
Mailing Address:
P.O. Box 160100
Sacramento, CA 95816-0100
Contact: John Boyd, CEO

John Muir Behavioral Health
2740 Grant Street
Concord, CA 94520
(925) 674-4100
Contact: Liz Stallings, Chief Operating Officer

These facilities were chosen for the Demonstration as they encompass all of the licensed private acute psychiatric hospitals based in Sacramento and Contra Costa Counties and serving Northern California. Each of these hospitals is a private, freestanding hospital and is designated as an IMD

due to the fact that they have more than 16 beds. These organizations currently collaborate with the counties in providing psychiatric care and participate in health services stakeholder processes aimed at improving access to acute psychiatric services, collaboration between health and behavioral health services and reducing psychiatric boarding in local emergency rooms and hospitals.

Unique characteristics of each county also enhance this proposal. John Muir Behavioral Health Center (JMBHC) is part of John Muir Health (headquartered in Walnut Creek, CA), a private, not-for-profit health system. JMBHC is the only freestanding acute psychiatric hospital in Contra Costa County, which is comprised of over one million people. Contra Costa Regional Medical Center (a "County" hospital) has one adult psychiatric unit with a total of 23 adult Medi-Cal beds. In Sacramento, Sierra Vista and Heritage Oaks are for-profit psychiatric hospitals owned by Universal Health Services (headquartered in King of Prussia, PA), while Sutter Center for Psychiatry is a not-for-profit hospital that is part of the Sutter Health system, headquartered in Sacramento. The three local hospitals work alongside the county-operated Mental Health Treatment Center (50 beds) and the local 12-bed Crestwood Psychiatric Health Facility. Only 12 Sacramento beds (4 percent of total available local beds) meet adult Medi-Cal standards for reimbursement due to the IMD exclusion.

Both counties have been adversely affected by the sustained bed closures in Northern California. The Sacramento inpatient hospitals account for 232 psychiatric beds out of a total of 294 available beds, accounting for 78 percent of the capacity highlighting the shortages in Northern California. At the two John Muir Health Medical Centers, patients wait days in expensive medical-surgical beds awaiting transfer to available Medi-Cal psychiatric beds once they are medically stable. When and if beds are available, patients and families must frequently travel out-of-county to general acute care hospitals with psychiatric units that can take Medi-Cal adults.

JMBHC is a unique provider for the Demonstration in that it is the only freestanding psychiatric hospital in Contra Costa County. Its relationship with John Muir Health (which includes the regional trauma center) provides the opportunity and obligation to assess and treat many patients with acute psychiatric disorders or psychiatric co-morbidities. Psychiatric care is frequently delayed due to the lack of Medi-Cal bed availability. This Demonstration will allow Contra Costa to improve patients' timely access to psychiatric care in a setting close to home. This allows for increased family involvement in the patients' care, which is critical to success. Contra Costa County expects that increased access to acute psychiatric beds for Medi-Cal patients will positively impact the emergency room backups that the general acute care hospitals experience. Moving patients in a timely manner from emergency rooms is crucial to the patients' psychiatric care and safety, as well as the safety of other patients and staff in the emergency departments.

Heritage Oaks Hospital, Sierra Vista Hospital and Sutter Center for Psychiatry also maintain a close collaboration with Sacramento County. They represent a unique opportunity in this demonstration to increase bed capacity for Medi-Cal eligible adults. Currently, Medi-Cal inpatient reimbursement is only available for 4 percent of local psychiatric beds. These hospitals already work closely with the University of California, Davis community hospital in Sacramento (which includes a trauma center), and with nine emergency rooms attached to general hospitals.

The unique geographic spread of the selected hospitals also makes access from emergency rooms to each of the hospitals an asset to timely care.

In Contra Costa County, the likely referral sources for emergency and inpatient care will include: the county's two designated involuntary hold receiving centers, Contra Costa Regional Medical Center PES and John Muir Behavioral Health; county mental health and emergency department staff designated to initiate 72-hour involuntary holds and the police.

Sacramento County's nine emergency rooms that currently provide the first entry point for all emergencies will be referral sources for this project. Both counties have policies and procedures in place outlining the protocols for referral.

3.4 Medicaid Payment System and Accounting

Building on the existing state and county MHP certified public expenditure (CPE) and cost settlement process, the participating county government entities will identify the number of eligible beneficiaries served and the total eligible hospital days reimbursed, under the provisions of this Demonstration, inclusive of patient name, Medicaid identification number, dates of service, location of service and payment amount on a quarterly basis. This information will be certified as an eligible federal expenditure by the county government entity and provided to DHCS, utilizing the state-approved claiming process.

Documentation supporting each claimed patient day will be available in the participating hospital medical record and in the county MHP claims and accounting systems. The counties will review the information provided to support each claimed patient day and certify that they meet all federal and state requirements and do not constitute a duplicate claim. The counties will follow government accounting standards for the interim payment, cost allocation and reconciliation process specified under this Demonstration. The quarterly federal reimbursement received will be considered an interim payment, subject to cost reporting and reconciliation using the CMS-approved cost reporting and reconciliation process. Overpayments of federal funds, should they occur, will be recovered by DHCS and returned to CMS, consistent with federal requirements.

3.5 Patient Administration and Stabilization

The counties currently have Utilization Review/Utilization Management and mechanisms in place to monitor patient flow, eligibility and care. This is described below and will be continued for this Demonstration:

a. Sacramento and Contra Costa Counties have managed 24 hour Utilization Review Teams, which interface with all emergency departments. The function of these teams is to coordinate relevant eligibility and clinical information with the emergency department. If individuals are already receiving outpatient services, the teams are able to coordinate with existing service providers to limit any unnecessary delays in care and, when clinically appropriate, to assist with crisis intervention to prevent unnecessary hospitalization.

b. The Sacramento and Contra Costa acute psychiatric hospitals are required to contact the county MHP of a Medi-Cal admission within 24 business hours. This contact initiates the Utilization Management/Utilization Review function for the inpatient episode of care. For notification, the acute psychiatric hospital generates a Treatment Authorization Request (TAR) for the Medi-Cal patients admitted to the facility and faxes this TAR to the teams.

c. A member of the Utilization Review Team will review daily progress notes, medication and other documentation for medical necessity. The team member will also be available to provide the hospital's Treatment Team with resources for outpatient follow up, family support resources, discharge placement options or to assist with facilitating a referral to the appropriate level of outpatient care.

d. Discharge planning is initiated at the time of admission review. The purpose is to identify discharge planning needs early in order to facilitate coordination of aftercare for a smooth and safe transition through the continuum of care. The hospital discharge planner will coordinate the discharge and aftercare services with county mental health clinic staff or the beneficiary will be referred to the Access Line where he/she can receive a follow-up appointment with one of the outpatient service providers. A Transition Team in each county will assist individuals who previously have not received mental health services or have not been successfully engaged in treatment.

e. Upon discharge of the patient, the entire chart is reviewed and the county approves, modifies or denies days based upon the documentation and records this on the TAR. A copy of the TAR is given to the fiscal department of the acute psychiatric hospital and the original is given to County Intake and Referral Team's Administrative Director. The approved TARs are compared with an invoice sent by the acute psychiatric hospital each month prior to any payment.

f. If the acute psychiatric hospital appeals a denial of days, a second opinion/review is completed, with medical consultation as needed. All grievances and appeals follow the established timelines.

g. Both counties track referrals from specific medical/surgical hospital emergency departments, acute psychiatric hospitals and out-of-county referrals. Statistics are also tracked for Medi-Cal eligible and indigent patients admitted to the local acute psychiatric hospitals.

h. The Utilization Review Teams meet regularly to identify and track patients with multiple hospitalizations and coordinate meetings with outpatient providers to coordinate a comprehensive treatment plan designed to reduce recurrence of hospitalizations.

3.6 Understanding of Waiver Demonstration

Through the 1980s and 1990s, inpatient psychiatric care was dramatically reduced in California for Medi-Cal beneficiaries. Two contract hospitals in Contra Costa County closed, resulting in a loss of more than 100 Medi-Cal eligible beds.

In early 2000, in Sacramento, all of the general acute care hospitals had eliminated all specialty psychiatric beds from their medical hospital systems, leaving only the freestanding acute psychiatric hospitals to provide inpatient psychiatric care. Due to the size of these hospitals (more than 16 beds), all were ineligible for Medi-Cal reimbursement for treatment of persons 21 to 64 years of age under federal IMD exclusion criteria. By 2004, the county-run Mental Health Treatment Center (MHTC) had increased its capacity to 100 beds in an attempt to keep up with the ever-growing population. The MHTC also ran the county Crisis Stabilization Unit (CSU), a 23-hour outpatient stabilization program for individuals needing either voluntary or involuntary treatment. This unit served all of Sacramento County and was the primary involuntary care receiving facility for all individuals who were considered a danger to themselves or others or gravely disabled due to their mental illness.

In 2009, in Sacramento County, severe funding reductions to Behavioral Health Services at the state and local levels resulted in the elimination of the CSU and the reduction of 50 beds at the MHTC. This action led to a significant increase and greater crisis in emergency room boarding of psychiatric patients. IMD excluded acute psychiatric hospitals serving both Medi-Cal eligible and uninsured residents in the community were also negatively impacted.

While the overall population has continued to increase, the number of beds has decreased. The loss of public beds is felt by the community at large, but specifically by the private psychiatric facilities in the state. These facilities have directly confronted the reality of their *Emergency Medical Treatment and Active Labor Act* (EMTALA) obligations to treat patients regardless of their ability to receive reimbursement for services rendered. These institutions have seen a dramatic increase in the number Medi-Cal and indigent patient admissions. In California, there has been a reduction of 2,810 beds and 41 facilities since 1995 (see Attachment 2).

Counties operate and/or fund an array of outpatient services to persons with mental illness. The continuum of care operates outpatient services based on the level of need of the individual. Each county serves approximately 10,000 adults per year. As with the overall lack of public inpatient beds, these outpatient services, while effective for those who receive them, are not sufficient for the needs of these regions' growing populations.

Participation in this Demonstration will assist in strengthening the outpatient and inpatient service structures and provide California with additional compensated care to invest in establishing the appropriate number of acute inpatient psychiatric beds, and enhancing the financially devastated outpatient programs that provide ongoing treatment and pre-crisis services that reduce and prevent hospitalization.

3.7 CMS-State Payment Process – State

For the purposes of this Demonstration CMS will pay each quarter, to each participating State, an amount equal to the Federal medical assistance percentage of expenditures in the quarter for medical assistance paid to participating institutions for inpatient services provided under this Demonstration. Based on this proposed reimbursement process, it is envisioned that on a quarterly basis payment information will be provided to CMS to draw down federal funds. Payment information may include patient name, Medicaid identification number, dates of service, location of service, payment amount and other information necessary to substantiate the invoice.

It is envisioned that a process similar to the current CMS-64 expenditure report process by which the State submits payment information and receives federal Medicaid funding will be established. Currently, the State's Federal Medical Assistance Percentage (FMAP) is 50 percent. As CMS provides further details on the claiming process that will be established for this Demonstration, the State will work with CMS in determining any process changes or special adjustments that may be needed in order to successfully submit claim information to CMS and receive federal financial participation.

3.8 Demonstration Monitoring and Evaluation

As described in 3.1 above, the California Institute for Mental Health (CiMH) will work collaboratively with DHCS, and as applicable with DMH, along with Sacramento and Contra Costa Counties and their hospitals, to consolidate and securely store the data for this demonstration project and report the data (with analysis as required) to DHCS and CMS, as determined by CMS. CiMH will work closely and collaboratively with Sacramento and Contra Costa Counties to assist them in ensuring that their data collection procedures and information management systems (e.g., electronic health record and claim-generating systems) reliably produce the necessary data for this project's reporting requirements and evaluation consistent with HIPAA and other applicable laws/regulations. This includes negotiating the evaluation structure, including what information needs to be collected by counties/hospitals, and what state-level data are to be submitted for CiMH consolidation and reporting. In collaboration with DHCS and the counties, CiMH will provide an appropriate and secure data repository for submission of data/claims from counties/hospitals to assure the integrity of the data and will aggregate and report data to DHCS/CMS according to data reporting formats to be determined by CMS. The counties and hospitals designated in this document will have responsibility for client care and day-to-day oversight and management of the Demonstration project. CiMH will assist counties and hospitals to ensure that documentation of client status, flow, discharge, re-admission, etc. are sufficient to support the outcome measures intended for the Demonstration. As specifics with regard to outcome reporting are identified by CMS, CiMH will work with DHCS and counties/hospitals to refine methods and procedures to satisfy the project's evaluation criteria/protocols. CiMH will serve as a link between CMS, DHCS/DMH and the counties with regard to data consolidation, storage, reporting and evaluation. Descriptions of Sacramento and Contra Costa Counties' data reporting and evaluation requirements are provided below.

Sacramento County Health Information Exchange (SACHIE) is currently implementing the second year of a five-year plan to fully implement the behavioral health Electronic Health Record (EHR) by 2015. The vendor is Netsmart Technologies, a nationally recognized behavioral health provider whose AVATAR product suite is a customizable, scalable software solution that serves as a common platform for Sacramento's mental health and substance use service area. AVATAR has met ambulatory and inpatient certification standards, is compliant with current HIPAA requirements and is poised to meet the 5010 changes anticipated in January 2012. AVATAR was the first national behavioral health product to receive American Recovery and Reinvestment Act (ARRA) certification and carries certification from the Certified Commission for Health Information Technology (CCHIT). The Clinical Work Station and InfoScriber implementation is part of the current accelerated effort to meet all required timelines for meaningful use criteria for health care providers. Sacramento County's AVATAR Practice Management module was implemented in May 2009 with a focus on patient registration, eligibility, state reporting, billing and claiming. Implementation of the Clinical Work Station (CWS) and e-prescribing began in FY 2011-12.

The current SACHIE/AVATAR implementation collects information that is core to the success of this Demonstration. The elements include registration, referral, authorization tracking, demographic and Medi-Cal/Medicare eligibility information, admission, transfer and readmission information. Current practice utilizing AVATAR information with concurrent and retrospective utilization review also provides detailed information pertinent to monitoring successes and failures in discharge planning, access to ambulatory care post-hospitalization, lengths of stay at individual hospitals and across the county inpatient system, and data to evaluate system-wide changes in service use and cost patterns. Data is currently collected and will continue to be available to enable comparisons with similar individuals not eligible for the Demonstration. Through collaboration with the participating hospitals and the county AVATAR system, Sacramento County is committed to utilize all resources to report data sets that demonstrate health outcomes for individuals in the Demonstration.

Contra Costa currently collects all of the indicators being measured by the Demonstration. Through the use of its PSP-Insyst system, as well as hospital databases and medical charts, Contra Costa County will be able to run reports detailing the number of patients admitted and treated under the Demonstration, Medicaid/Medicare/SSI eligibility status, demographic information, geographic residence information and information about how eligibility for the Demonstration was determined. It will also be able to provide information regarding discharge planning, system-wide changes in service use and cost patterns, access to care, individual health outcomes and comparisons to similar individuals not eligible for Demonstration participation.

Sacramento County and Contra Costa Research and Evaluation will process data reports and send them to CiMH/state. Additionally, the local Research and Evaluation Units will assist CiMH and the state to complete any additional data collection and reporting mandated after the start of the Demonstration.

References:

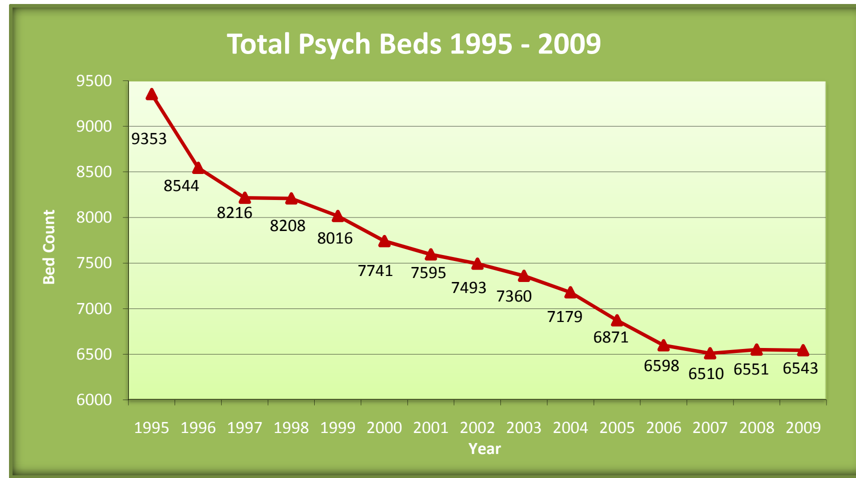
1. US Census Bureau. “2010 Demographic Profile: Contra Costa County California.” *2010 Population Finder*. 2011. Available at: http://www.census.gov/popfinder/.
Accessed on September 28, 2011.

CALIFORNIA HOSPITAL ASSOCIATION
Center for Behavioral Health

Acute Psychiatric Inpatient Bed Closures/Downsizing
California, 1995 - 2009

PSYCH BED LOSS

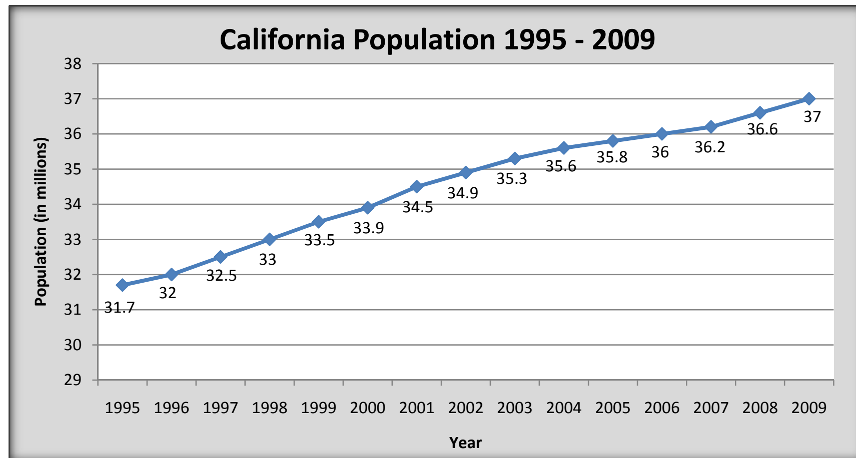
1995	9353
2009	6543
Total Loss	2810
% Loss	30.0%



POPULATION* GROWTH

1995	31.7
2009	37
Total Gain	5.3
% Growth	16.7%

*estimated in millions



PSYCH FACILITY LOSS

1995	181
2009	140
Total Loss	41
% Loss	22.7%

Psych Data Source: OSHPD (General Acute Care Hospitals include city and county hospitals, but not state hospitals.
Acute Psychiatric hospitals include city and county hospitals, but not state hospitals. Also includes county-owned Psychiatric Health Facilities.)
Population Data Source: U.S. Census Bureau
Updated 1/7/11

This document may be found on the CHA website at www.calhospital.org/PsychBedData.

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Psychiatric Inpatient Care Units and Freestanding Psychiatric Hospitals
2009 Comparative Data – Nation and California

	General Hospitals w/Psych	# Psych Beds	Acute Psych Hospitals & PHFs	# Psych Beds	Total Hospitals	Total Beds
Nation	1232	36,919	232	26,004	1464	62,923
49 States	1145	33,259	179	23,121	1326	56,380
California	**87**	**3660**	**53**	**2883**	**138**	**6543**

2009 Population Comparison

Nation	307,006,550	1 psych bed for every 4879 people
49 States	270,044,886	1 psych bed for every 4790 people
California	**36,961,664**	**1 psych bed for every 5649 people**

Experts estimate a need for a ***minimum*** of 1 public psychiatric bed for every **2000** people for hospitalization for individuals with serious psychiatric disorders.* This number is contingent upon the availability of appropriate outpatient services in the community.**

Sources

National data: Health Forum, AHA Annual Survey of Hospitals, 2009 (Hospitals with psychiatric or alcoholism/chemical dependency units are registered community hospitals that reported having such a unit for that year. Freestanding psychiatric hospitals also include children's psychiatric hospitals, but exclude chemical dependency hospitals.)

California data: OSHPD (General Acute Care Hospitals include city and county hospitals, but not state hospitals. Acute Psychiatric hospitals include city and county hospitals, but not state hospitals. Also includes county-owned Psychiatric Health Facilities.)

49 State data: OSHPD data subtracted from AHA data. Includes the District of Columbia.

Population data: U.S. Census Bureau

Torrey, E. F., Entsminger, K., Geller, J., Stanley, J. and Jaffe, D. J. (2008). "The Shortage of Public Hospital Beds for Mentally Ill Persons."

***Stetka, B. (2010). "US Psychiatric Resources: A Country in Crisis."*

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Revised 8/25/11

This document may be found on the CHA website at www.calhospital.org/PsychBedData.

CALIFORNIA HOSPITAL ASSOCIATION
Center for Behavioral Health

Acute Care Inpatient Psychiatric Bed Distribution

Primary Data Source: OSHPD
Not all beds are available to individuals on LPS involuntary holds.
Does not include data from state-operated hospitals.

	County	Child/Adol. Beds*	Adult Beds**	Geriatric Beds*	Chem. Dep. Beds**	PHF Beds**	Population***	
1	Alameda	20	298		74	42	1,491,482	1
2	Alpine						1,041	2
3	Amador						37,876	3
4	Butte		30			16	220,577	4
5	Calaveras						46,731	5
6	Colusa						21,321	6
7	Contra Costa	32	44	15	8		1,041,274	7
8	Del Norte						29,114	8
9	El Dorado					15	178,447	9
10	Fresno		49	12		16	915,267	10
11	Glenn						28,299	11
12	Humboldt			20		16	129,623	12
13	Imperial						166,874	13
14	Inyo						17,293	14
15	Kern	19	91	14		14	807,407	15
16	Kings						148,764	16
17	Lake						65,279	17
18	Lassen						34,473	18
19	Los Angeles	188	1934	159	387	32	9,848,011	19
20	Madera						148,632	20
21	Marin		17				250,750	21
22	Mariposa						17,792	22
23	Mendocino						86,040	23
24	Merced					16	245,321	24
25	Modoc						9,107	25
26	Mono						12,927	26
27	Monterey		36				410,370	27
28	Napa		37				134,650	28
29	Nevada						97,751	29
30	Orange	29	459	39	62	15	3,026,786	30
31	Placer					16	348,552	31
32	Plumas						20,122	32
33	Riverside	21	159	33	131	16	2,125,440	33
34	Sacramento	81	128		8	100	1,400,949	34
35	San Benito						55,058	35
36	San Bernardino	51	259	12	38		2,017,673	36
37	San Diego	77	597	62	95		3,053,793	37
38	San Francisco	36	269	38			815,358	38
39	San Joaquin		12	16	7	40	674,860	39
40	San Luis Obispo					16	266,971	40
41	San Mateo	29	79		12		718,989	41
42	Santa Barbara		20			16	407,057	42
43	Santa Clara		126				1,784,642	43
44	Santa Cruz		28				256,218	44
45	Shasta						181,099	45
46	Sierra						3,174	46
47	Siskiyou						44,634	47
48	Solano	37	10	14		16	407,234	48
49	Sonoma		38				472,102	49
50	Stanislaus		67				510,385	50
51	Sutter					48	92,614	51
52	Tehama						61,138	52
53	Trinity						14,165	53
54	Tulare		47	16			429,668	54
55	Tuolumne		16				55,175	55
56	Ventura	20	140	36			802,983	56
57	Yolo	12	8				199,407	57
58	Yuba						72,925	58
	TOTALS	**652**	**4,998**	**486**	**822**	**450**	**36,961,664**	

44 Counties w/o Child/Adolescent Beds
25 Counties w/o Adult Psychiatric Beds
44 Counties w/o Geriatric Beds
48 Counties w/o Chemical Dependency Beds
25 Counties Have No Inpatient Psych Services At All

* Source: CHA Member Surveys
** Source: OSHPD 2009 Data (Note: To obtain Adult beds, the figures for Child/Adolescent, Geriatric & PHF were subtracted from OSHPD County Total)
*** Source: 2009 data from the U.S. Census Bureau.

PHF (Psychiatric Health Facility) - Defined as a health facility, licensed by the State Department of Mental Health, that provides 24-hour inpatient care. This care includes, but is not limited to: psychiatry, clinical psychology, psychiatric nursing, social work, rehabilitation, drug administration, and appropriate food services for those persons whose physical health needs can be met in an affiliated hospital or in outpatient settings. (Health & Safety Code Section 1250.2)

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