Case Nos. C097671 and C098311

IN THE

Court of Appeal of the State of California

THIRD APPELLATE DISTRICT

SISKIYOU HOSPITAL, INC. d/b/a Fairchild Medical Center, a California nonprofit public benefit corporation,

Plaintiff and Appellant,

vs.

COUNTY OF SISKIYOU; SARAH COLLARD, in her official capacity as the Director of the County of Siskiyou Health and Human Services Agency; CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES; MICHELLE BAASS, in her official capacity as the Director of the California Department of Health Care Services,

Defendants and Respondents.

[PROPOSED] BRIEF OF THE CALIFORNIA HOSPITAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PLAINTIFF AND APPELLANT FAIRCHILD MEDICAL CENTER

Appeal from the Superior Court of California, County of Siskiyou,
Case No. SCCVCVPT20191501
Hon. Karen L. Dixon

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CERTIFICATE OF INTERESTED ENTITIES OR PERSONS

Pursuant to Rule 8.208(e)(3) of the California Rules of Court, the undersigned certifies that it knows of no entity or person, other than the parties themselves, that either has a financial interest in the subject matter in controversy or in a party to the proceeding, or has a non-financial interest in that subject matter or in a party that could be substantially affected by the outcome of the proceeding.

DATED: October 8, 2024

By: 

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INTRODUCTION

The California Hospital Association ("CHA") submits this brief in support of Appellant Siskiyou Hospital, Inc. d/b/a Fairchild Medical Center ("Fairchild") to elaborate for the Court the profound issue this case presents regarding the obligations of Siskiyou County and the state to care for patients experiencing mental health crises. This issue is of widespread concern to California hospitals, many of which are small, rural hospitals not equipped to provide psychiatric care to these patients. The hospital's emergency departments ("ED" or "EDs"), are too often left to house them, sometimes for days on end, at the hospital's expense, resulting in these patients being deprived of needed psychiatric treatment and other patients being deprived of ED beds.

CHA is a non-profit association dedicated to representing the interests of California's hospitals. CHA is one of the largest hospital trade associations in the nation, serving more than 400 hospitals and health systems and 97 percent of the patient beds in California. CHA's members include general acute care hospitals, acute psychiatric hospitals, academic medical centers, county hospitals, and multi-hospital health systems. These hospitals furnish vital health care services to millions of the State's residents every year, including Medi-Cal beneficiaries and patients who otherwise require free or discounted care.

CHA is the largest advocacy organization for hospitals in California and provides its members with state and federal representation in the legislative, judicial, and regulatory arenas

in its continuing efforts to improve healthcare quality, access, and coverage. In order to help establish and maintain a financial and regulatory environment in which hospitals and health systems can continue to provide high-quality care to their patients—including those patients requiring behavioral health care—CHA participates regularly as an *amicus curiae* in appeals that may have a substantial impact on hospitals and health systems. (See, e.g., *American Hospital Association v. Becerra* (2022) 142 S.Ct. 1896; *County of Santa Clara v. Superior Court* (2023) 14 Cal.5th 1034; *Gerard v. Orange Coast Memorial Med. Ctr.* (2018) 6 Cal.5th 443; *Rashidi v. Moser* (2014) 60 Cal.4th 718; *Fahlen v. Sutter Central Valley Hospitals.* (2014) 58 Cal.4th 655; *UFCW & Employers Benefit Trust v. Sutter Health* (2015) 241 Cal.App.4th 909; and *Sutter Health v. Superior Court* (2014) 227 Cal.App.4th 1546.)

Among its activities, CHA participates directly in the development of health care law and policy related to behavioral health care and involuntary holds, including the intersection between state law, the Emergency Medical Treatment & Labor Act ("EMTALA"), 42 U.S.C. § 1395dd, and other Federal obligations on hospitals. CHA is therefore well-situated to assist this Court in understanding the impact of the positions argued by Siskiyou County and its Director of Health and Human Services, Sarah Collard (together, the "County"), and California's Department of Health Care Services and its Director, Michelle Baass (together, the "Department" or "DHCS") (collectively, "Defendants").

As a trade association representing most of the hospitals in California, CHA has first-hand background and experience concerning the state's behavioral health care systems, counties' approaches to caring for patients requiring involuntary treatment, and the disruptive impacts on hospitals, patients, and the community when counties and the state fail to provide patients appropriate and timely mental health care, as is at issue in this case. CHA thus offers this brief to assist the Court in its understanding of the consequences that arise for hospitals that are inappropriately made to provide beds, care, and resources to these patients beyond the hospitals' capabilities.

STATEMENT OF THE CASE, APPEALABILITY, AND FACTS

CHA adopts by reference the statements regarding the nature of the action, the relief sought in the trial court, the judgments appealed from and their finality, and the significant facts provided by Appellant Fairchild. (Appellant's Opening Brief ("AOB") at 14–26.)

ARGUMENT

The County, like many counties throughout the state, is experiencing a behavioral health care crisis. Due to serial failures to act by Defendants, Fairchild is left to bear the brunt of this crisis, despite lacking the beds or the specialized treatment capability to provide intensive psychiatric care. The circumstances of this case, and the positions taken by Defendants, are of immense concern to California hospitals and could establish harmful precedent statewide. First, Defendants

have failed to provide suitable mental health supports, both to mitigate psychiatric crises and to properly treat them, and instead rely on Fairchild's ED to house patients undergoing psychological crises, a practice which denies patients needed care and further harms other patients, the hospital, and the community. Second, the County's legal answer for why its harmful reliance on Fairchild's ED is authorized by state law is unprecedented, antithetical to legislative intent, and raises constitutional concerns. Finally, the County's argument (and the trial court's interpretation thereof) regarding the intersection of state and Federal law fundamentally misunderstands the important differences between the two statutory frameworks and Fairchild's and the County's respective obligations.

I. DEFENDANTS' UPSTREAM AND DOWNSTREAM FAILURES TO PROVIDE SUITABLE MENTAL HEALTH CARE HARMS PATIENTS, HOSPITALS, AND COMMUNITIES

Hospitals across the state are seeing increasing numbers of Californians experiencing mental and behavioral health crises. At times, it is critical for the safety and health of individuals experiencing these crises and refusing treatment, as well as for the safety of others, that these individuals receive involuntary psychiatric treatment. Accordingly, the Lanterman-Petris-Short ("LPS") Act authorizes temporary involuntary treatment for a person who is a danger to themselves or others, or gravely disabled, due to a mental disorder. (Cal. Welf. & Inst. Code, § 5150, subd. (a).[1]) This law "is intended to provide prompt,

[1] All further references herein are to the Cal. Welf. & Inst. Code

short-term, community-based intensive treatment, without stigma or loss of liberty," while "preventing inappropriate, indefinite commitments of mentally disordered persons." (*Ford v. Norton* (2001) 89 Cal.App.4th 974, 977, 979.) Thus, § 5150 authorizes a preliminary 72-hour involuntary hold for assessment, evaluation, and crisis intervention, or treatment and evaluation, after which time a patient may be separately certified for additional involuntary detention and treatment, and ultimately conserved, if necessary. (See Welf. & Inst. Code §§ 5150, 5250, et seq.)

The LPS Act contemplates that individuals involuntarily held pursuant to § 5150 (hereinafter "5150 patients") will be taken to a facility designated pursuant to the LPS Act. But for myriad practical reasons, there may be an intervening step wherein a 5150 patient is brought to an ED of a hospital that does not provide psychiatric treatment so that the patient can receive care for any co-occurring physical health conditions and, depending on the hospital, preliminary emergency stabilizing treatment; after this, the patient is then transferred for inpatient psychiatric treatment or released for further follow up care. If the hospital does not have the resources to provide psychiatric treatment, as is the case with Fairchild, a 5150 patient must be transferred to another facility to receive such treatment or, in appropriate cases, discharged and referred for follow-up care.

As Fairchild has amply shown (see 1 JA 00074) the County has failed to timely effectuate these necessary transfers,

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unless otherwise specified.

detaining 5150 patients in the Fairchild ED for prolonged periods of time without access to the appropriate level of treatment or supervision and creating dangerous and unworkable conditions for 5150 patients, other patients, and the hospital. The County's reliance on this so-called ED "boarding" (*i.e.*, holding a patient in the ED while awaiting an inpatient psychiatric bed) in lieu of enacting appropriate upstream and downstream interventions, harms all Fairchild ED patients—those held pursuant to § 5150 and those who are at the ED for other reasons—as well as the hospital and its staff and visitors.

A. The Harms of ED Boarding to Patients, the Hospital, and the Community

The serious and widespread issue of ED boarding is well documented nationally. (See, e.g., McClure, *Psychiatric Boarding in New Hampshire: Violation of a Statutory Right to Treatment* (2016) 14 U.N.H. L. Rev. 198, 208–09 (hereafter McClure); Santillanes, Axeen, Lam & Menchine, *National trends in mental health-related emergency department visits by children and adults, 2009–2015* (2020) 38 Am. J. Emergency Med., 2536, 2536–37, 2539–41.) Studies have found the average boarding times for adult psychiatric patients in California EDs are between seven and 10 hours. (Zeller, Calma & Stone, *Effects of a Dedicated Regional Psychiatric Emergency Service on Boarding of Psychiatric Patients in Area Emergency Departments* (2014) 15 West J. Emergency Medicine, 1, 2.) Fairchild's wait times are above these averages: the average length of detention in the Fairchild ED for 5150 patients from arrival to discharge or transfer is 12 to 13 hours, and some patients are detained and

secluded for more than 36 hours. (AOB at 22 [citing 1 JA 00074].)

Numerous empirical studies have evidenced the adverse effects of boarding psychiatric patients in EDs that are not equipped to provide specialty psychiatric care.[2] Most importantly, patients boarded in an ED may not be receiving the specialized care their conditions require. (McClure, *supra*, at page 209.) For patients with mental health issues, prolonged stays in the ED are also associated with increased risk of symptom exacerbation for patients; external stimuli from the ED environment can also increase these patients' anxiety and agitation, which is potentially harmful to them, staff, and others in the ED. (See McClure, *supra,* at p. 209; Nicks & Manthey, *The Impact of Psychiatric Patient Boarding in Emergency Departments* (2012) 2012 Emergency Medicine Internat., 1, 2; see also Major, Rittenbach, MacMaster, Walia & VandenBerg, *Exploring the experience of boarded psychiatric patients in adult emergency departments* (2021) 21 BMC Psychiatry 1, 5 [quantifying and evaluating the scope of adverse events that

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[2] This is the case at Fairchild. As the Hospital evidenced, its ED does not have any psychiatrists on its medical staff and does not have the capability to provide mental health services such as behavioral health management, crisis stabilization, or licensed professional mental health services from psychiatrists or psychologists. Further, there is no statutory or regulatory requirement for a hospital that provides basic emergency medical services to make psychiatric specialty services available. (Cf. Cal. Code Regs., tit. 22, §§ 70411–19 [noting requirements for basic emergency medical services].) The County is aware of Fairchild's capabilities. (See AOB at 15 [citing 1 JA 00042, 00049–50, 00073, 00602, 00610].)

psychiatric patients experience while boarded at the ED].) These delays in care contravene the California legislature's intent in passing the LPS Act, which sought to end "inappropriate, indefinite, and involuntary commitment of persons with mental health disorders, developmental disabilities, and chronic alcoholism." (Welf. & Inst. Code, § 5001, subd. (a).)

Indeed, Defendant DHCS has recognized the harms of ED boarding in a 2022 Report on Assessing the Continuum of Care for Behavioral Health Services in California. (See 1 JA 00345 ["[P]eople in behavioral health crisis can end up 'boarding' (i.e., staying under watch without receiving treatment while they await a placement elsewhere) in the ED, sometimes for days. In such situations, they may be transferred to an inpatient psychiatric hospital even if they could have been treated in a less restrictive setting if such care were readily available."].)

Courts have similarly acknowledged the harms to 5150 patients who, upon being involuntarily detained and transported to an ED on a 5150 hold, are not timely provided psychiatric treatment. In *Spath v. County of Santa Clara* (N.D.Cal. 2023) 669 F.Supp.3d 835, 839–43, a federal district court found that a 5150 patient-plaintiff plausibly alleged that the lack of psychiatric care he received while involuntarily detained—first overnight in an ED not approved for 5150 evaluation and treatment, and then at the county medical center, where he was moved from the emergency psychiatric services back into its general ED—fell substantially below the generally accepted standards or constituted a substantial departure from accepted

professional judgment. The Northern District of California in *Spath* found these allegations were adequate at the motion to dismiss phase to assert the plaintiff had Fourteenth Amendment rights of which he was deprived. (*Id.* at 842–43.)

And, in the context of a related statutory scheme, in 2014, the Supreme Court of Washington, *en banc*, held that a county violated the state's involuntary treatment act when it used psychiatric boarding in non-authorized EDs as a method to avoid overcrowding its certified evaluation and treatment facilities. (*Detention of D.W. v. Department of Social and Health Services* (2014) 181 Wash.2d 201, 211 [en banc].) In this case, the county "frequently lack[ed] sufficient space in certified evaluation and treatment facilities for all those it involuntarily detains," and thus "regularly resort[ed] to temporarily placing those it involuntarily detains in emergency rooms and acute care centers via 'single bed certifications' to avoid overcrowding certified facilities." (*Id.* at 204.) The Court pointed to testimony that "patients involuntarily held in single bed certifications 'are getting less care than they would if they were in an evaluation and treatment center'" and similar findings that "a patient involuntarily detained in a single bed certification 'gets no psychiatric care or other therapeutic care for their mental illness.'" (*Id.* at 206.) While the Court found the state law to authorize single bed certifications for specific statutorily recognized reasons individual to specific patients, it concluded that the law did not authorize such psychiatric boarding "merely because there is a generalized lack of room at certified facilities."

(*Id.* at 211.)

As Fairchild evidenced (see 1 JA 00043, 00073–75, 00068–69), ED psychiatric boarding also harms hospitals and other, non-5150 patients. Especially for small, rural hospitals operating at a relatively high capacity, like Fairchild (which has *ten* ED beds, total, see AOB at 15), boarding 5150 patients for extended times in the ED can overstretch the ED's capacity in beds, staffing, and resources. (See McClure, *supra*, at pp. 209–10 [ED boarding contributes to overcrowding and diverts staff and resources from non-psychiatric patients who require emergency medical services].) This is dangerous for *all* the hospital's patients: ED overcrowding and a lack of available emergency beds have been directly associated with poor clinical outcomes, including increases in morbidity and mortality. (See, e.g., McClure, *supra*, at pp. 209, Pearce, Marchand, Shannon, Ganshorn & Lang, *Emergency department crowding: an overview of reviews describing measures causes, and harms* (2023) 18 Internal and Emergency Medicine 1137, 1140, 1142, 1155).

For all these reasons, the County's accusation that Fairchild's objective is merely to "dump" 5150 patients (see County Respondent's Brief at 50), has no basis in fact. The County's failures to transfer 5150 patients to appropriate places of care creates very real harms to the hospital *and* patients and the community, and runs counter to the County's obligations to these patients. (See AOB 43–46; see also, e.g., Cal. Welf. & Inst. Code, § 5651, subd. (b)(2) [the County is obligated to "[p]rovide services to persons receiving involuntary treatment as required

by Part 1 (commencing with Section 5000) . . . ."].)

To be sure, the harms of ED boarding to the hospital *alone* should be sufficient to require Defendants to act differently. A federal district court in New Hampshire held the state's practice of psychiatric boarding constituted an unreasonable seizure of the hospitals' emergency departments where the statutory scheme required patients to be brought to a designated facility. (*Doe v. Commissioner, N.H. Dept. of Health and Human Services* (D.N.H. 2023) 657 F.Supp.3d 206, 218.) The Court found the state Commissioner was not meeting her responsibilities to provide services to patients and, as a result, found "the Commissioner [was] seizing the Hospitals' emergency departments by boarding her patients there without the permission of the hospitals." (*Id.* at 217.) This seizure was unreasonable: "the Commissioner's boarding practice commandeers space, staff, and resources in the Hospitals' emergency departments that is needed for other patients and services," and the Hospitals had "a weighty interest in operating their emergency departments and using both the space and the resources in the emergency departments to their fullest extent and for their intended purposes." (*Id.* at 217–18.) In contrast, "[i]n light of the statutory obligations imposed on the Commissioner under [the state law], the Commissioner has no governmental interest in failing to receive [psychiatric hold] patients in designated receiving facilities." (*Id.* at 218.)[3]

[3] (See also McClure, *supra*, at pp. 209–10 [detailing the expense and burden of ED boarding for hospitals].)

Boarding 5150 patients in a small ED that lacks psychiatric care is dangerous for 5150 patients, other patients, visitors, hospital staff, and the hospital itself. The County is obligated to address these harms and is failing to do so.

B. The County's Upstream and Downstream Failures Produce ED Boarding

The County's reliance on ED boarding is a result of the County's improper prioritization of behavioral health care supports. The County (at 21–22) argues that, because there is a shortage of psychiatric beds in the region, it has no choice but to utilize Fairchild's ED beds for 5150 holds until a bed can be located. But the County (and State) ignore multiple available options to ensure 5150 patients can receive appropriate treatment and evaluation without a visit to or prolonged stay at Fairchild's ED.

At base, the County's alternatives stem from the County's optimization and prioritization of state and federal resources. If these resources were used properly, the County would be able to develop, operate, and support programs that replace and/or reduce the need for ED visits.

The State of California has provided Siskiyou and other counties with several recent opportunities to enact such behavioral health programs. For example, the Investment of Mental Health Wellness Act of 2013 made available $142.5 million in capital funding to counties for crisis service facilities and $6.8 million for mobile crisis support teams. (See Cal. Welf. & Instit. Code, § 5848.5, et seq.; see also Cal. Health Facilities Financing Authority, Report to the Legislature: Investment in

Mental Health Wellness Act of 2013 (Dec. 2023), p. 1) In 2016, the program also made available approximately $42 million in capital funding and $4 million in personnel funding to counties to develop crisis services for children and youth. (Cal. Health Facilities Financing Authority, Report to the Legislature: Investment in Mental Health Wellness Grant Program for Children and Youth (Jan. 2024), p. 5.) In 2021, the Behavioral Health Continuum Infrastructure Program authorized DHCS to award $2.2 billion in capital funding through grant awards for mobile crisis infrastructure and facilities that provide a wide array of community-based inpatient and outpatient behavioral health services. (See Cal. Welf. & Instit. Code, § 5960, et seq.; see also DHCS, Behavioral Health Continuum Infrastructure Program, https://www.dhcs.ca.gov/services/MH/Pages/BHCIP-Home.aspx)

In CHA's experience, the differences in distribution of inpatient psychiatric beds throughout the state are due, in part, to how counties choose to use their available state and federal resources to develop the needed levels of behavioral health care for their citizens—by, for example using a portion of those resources to adequately reimburse providers for acute behavioral health services, thereby encouraging providers to provide these services. Whether an individual county is considered to have a "shortage" of inpatient psychiatric beds depends on whether there is adequate access to available community resources that *prevent* acute crises and hospitalization. (See 1 JA 00263 ¶ 11.) Defendant DHCS has agreed, emphasizing the role of "'upstream'

behavioral health services that maximize well-being and recovery; promote resiliency and community-based care; and *minimize utilization of crisis services, emergency departments, inpatient admissions,* incarceration, and involvement with the criminal and juvenile justice systems." (1 JA 00296 [emphasis added].) These sorts of upstream services can include preventative and wellness services, outpatient services (including various options to access individual and group therapy, ambulatory detoxification services, and intensive outpatient treatment services), peer and recovery services, and community services and supports (including, but not limited to, case management, housing supports, and caregiver supports). (See 1 JA 00297–300.)

The County has also explicitly failed to optimize its resources to create any access to inpatient psychiatric hospitalization or to operate entities that can provide specific psychiatric care for acute crises in lieu of the County's hospitals. Beyond operating an inpatient psychiatric facility, the County could operate entities which include, but are not limited to, *crisis stabilization units*, which can treat behavioral health patients for up to 23 hours to stabilize an individual's mental health crisis and avert trips to the hospital ED or hospital admissions, (see 1 JA 00345–46, JA 00351–53), and *crisis residential services*, which are for individuals who are experiencing an acute psychiatric crisis and could benefit from short-term (usually less than seven days) 24/7 medical and treatment supports, (see 1 JA 00346, JA00355–57). The County does not appear to operate either of

these forms of care. (See 1 JA 00352, 356.) In particular, the annual External Quality Review Report from 2022–2023 found that the County Medi-Cal Mental Health Plan's "adult hospitalization rate in CY 2021 was less than half that of the state, and its average inpatient units was half that of the state. The [County's] MHP does not have a Crisis Stabilization Unit or psychiatric emergency services and crisis stabilization was a fraction of the statewide rate, as most of these services happen out of the county." (Cal. Dept. Health Care Services, FY 2022–23 Medi-Cal Specialty Behavioral Health External Quality Review, Siskiyou Final Report (May 17, 2023) p. 28.)

The County is not too small to operate these or other crisis-level behavioral health services: at least three California counties smaller than Siskiyou (Del Norte, Inyo, and Trinity) each operate or have operated, crisis stabilization units, for example. (1 JA 00263; 00460–61.) Further, counties are authorized to act jointly for the delivery of the specialty mental health services they administer (Cal. Welf. & Instit. Code, § 14702), so the County could collaborate with neighboring counties to expand access to crisis stabilization, crisis residential, and inpatient psychiatric services to ensure patients in the region who are experiencing a psychiatric crisis have timely access to these levels of care.

These sorts of crisis services, as well as intermediate psychiatric facilities, have demonstrably reduced ED boarding times for 5150 patients. Other innovative models have been used and evaluated over the years to reduce ED boarding times, including one studied in 2013 wherein law enforcement initiating

§ 5150 holds did not transport 5150 patients to an ED directly, but instead called for an ambulance and had paramedics assess medical stability in the field. (See Zeller, Calma & Stone, *Effects of a Dedicated Regional Psychiatric Emergency Service on Boarding of Psychiatric Patients in Area Emergency Departments*, *supra*, at p. 3.) If patients were medically stable (which, in the referenced study, was the case for approximately 60 percent of patients), they were transported directly to a dedicated psychiatric emergency services ("PES") unit, which is a stand-alone ED specifically for psychiatric patients. (*Id.* at 2–3.) Those patients who were medically unstable were taken to an ED, and once they were medically cleared, were immediately transferred to the dedicated PES unit. (*Id.* at 3.) This model demonstrated reductions in the average ED boarding time by 80 percent: reducing stays from an average of over 10 hours (reflected in another study of California hospitals) to one hour and 48 minutes. (*Id.* at 4–5.)

II. THE COUNTY'S INTERPRETATION OF ITS LPS ACT OBLIGATIONS IS CONTRARY TO LAW AND POLICY

Notwithstanding the harms of ED boarding, the County argues that it is not responsible for transferring 5150 patients out of Fairchild's ED because Fairchild itself is a facility designated to provide treatment for 5150 patients. The County reads the LPS Act to authorize a county to *unilaterally* determine a general acute care hospital is a "county-designated" facility for the purposes of the LPS Act if the County brings 5150 patients to the hospital's ED, without any approval from the State and even

though Fairchild does not provide mental health services or have the ability to detain 5150 patients. (See County Respondent's Brief at 31–37.) Fairchild, in return, argues that the plain-text, logical, and common-sense interpretation of the LPS Act identifies hospitals as *eligible* to be designated by a county to serve LPS functions, rather than necessarily designated to do so, and that the Act must be read to also require DHCS approval to designate hospitals carrying out any component of § 5150 designated functions. (See Appellant's Reply Brief ("ARB") at 15–23.)

For all the reasons outlined in Fairchild's briefs (AOB at 29–43; ARB at 15–23), Fairchild has the better reading of the statute. Further, the County's position is unprecedented in the state, does not comport with the clearly evidenced intent of the California legislature, and introduces constitutional concerns.

A. The County's Extraordinary Position that it May Unilaterally Designate Acute Care Hospitals as LPS Act Designated and Approved Facilities Has No Precedent in Any Other County

The County's reading—that the LPS Act allows it to unilaterally designate a hospital—is unprecedented. CHA is not aware of *any other county* that has designated a general acute care hospital under § 5150 without the hospital's knowledge or consent. (See 1 JA 00264 ¶ 18.)

Moreover, while CHA understands that counties have implemented various processes and policies with respect to how and whether they designate particular health facilities under § 5150, CHA is not aware of any other county that deems a facility to be designated if it does not have the capacity to provide

appropriate levels of mental health treatment to 5150 patients, nor if the designation is not approved by the State. Indeed, several counties would not even *allow* such a facility to be LPS designated. For instance, Los Angeles County requires that a designated facility be able to provide "evaluation *and treatment*," have "24 hour a day, seven day a week *mental health* admission, evaluation, referral, *and treatment capabilities*" and "*provide[] whatever mental health treatment and care* involuntarily detained persons require for the full period they are held."[4] Los Angeles County specifies that it recommends a facility for LPS Designation to DHCS, which confirms final approval.[5] San Francisco County similarly defines an LPS designated facility as "*a mental health treatment facility* designated by the Board of Supervisors for evaluation *and treatment, approved by the State Department of Health Care Services. . . .* "[6]

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[4] (Los Angeles County Dep.t. of Mental Health Office of Chief Medical Officer, Clinical Quality of Care – Practice Parameters: Lanterman-Petris-Short Authorization and Designation (May 2023), § I.B.6, available at: https://secure4.compliancebridge.com/lacdmh/public/index.php?fuseaction=print.preview&docID=4123 [citing Welf. & Inst. Code, § 5152] [emphases added].)

[5] (*Id.* at § III.A.8.)

[6] (City and County of San Francisco Dept. of Public Health, Policy/Procedure Regarding: Authority for Involuntary Detention for 72-Hour Evaluation and Treatment, Manual No. 3.07-02 (2023), § I.A, available at: https://www.sf.gov/sites/default/files/2024-04/3.07-02%20Authority%20for%20Involuntary%20Detention%20for%2072-Hour%20Evaluation%20and%20Treatment%202023-04-27.pdf [emphasis added].)

For its part, DHCS does not list Fairchild as a county designated LPS facility. (See JA00082; [DHCS directory of county LPS designated 24-hour facilities listing no facility as designated for Siskiyou County].) And as a party in this appeal, DHCS's appellate brief did not dispute Fairchild's evidence or arguments that it is not designated. To require Fairchild to nonetheless take on the full scope of responsibilities imposed on LPS Act designated facilities (see ARB at 17–18) without hospital consent, state approval, or the capacity to actually provide mental health treatment would represent a fundamental sea change in California's behavioral health care scheme.

B. Fairchild's Superior Statutory Reading is Further Supported by Legislative Intent

The LPS Act itself does not support the County's position. Nothing in the LPS Act can or should be read to require a facility to serve as a county designated LPS facility simply because a county has brought a § 5150 hold to the ED. That a general acute hospital *may* be a county-designated LPS facility does not mean they *must* be designated, especially not without hospital consent, state approval, or the ability to provide the full scope of necessary mental health treatment.[7]

The County relies on the language of § 5008 as in effect throughout the pendency of this case, which defines a designated

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[7] Of note, the County (at 38–39) contends that it has discretion to determine how to designate *professionals* under the LPS Act. The question of the County's discretion to designate *professionals* is entirely separate from the question of whether the County has sole discretion to designate a *facility* for the purposes of § 5150. The answer to the latter is a resounding "no".

facility to be either, at the highest level, "a facility that is licensed or certified as a mental health treatment facility or hospital, as defined in subdivision (a) or (b) of Section 1250 of the Health and Safety Code." (Cal. Welf. & Instit. Code, § 5008, subd. (n).) Because a general acute care hospital is included in the definition of a "hospital" in Health and Safety Code, § 1250, subdivision (a), the County concludes Fairchild "clearly fits the definition of a designated facility." (County Respondent's Brief at 31–32.) But the definition continues, explaining that a designated facility "may include, but is not limited to, a licensed psychiatric hospital, a licensed psychiatric health facility, and a certified crisis stabilization unit." In light of both these specific references to facilities that can provide the care 5150 patients require and the overall intent of the LPS Act, it would be extraordinary to interpret this provision to *necessarily require* a hospital that cannot provide psychiatric care to be an LPS Designated facility. (See *In re Corrine W.* (2009) 45 Cal.4th 522, 531 [A list of particular items enumerated in a statute define the broader term of "care and supervision," such that a sought expenditure "does not fit comfortably" into the definition of "care and supervision" as shaped by the specific items. This cannon of interpretation, *ejusdem generis* "instructs that when a statute contains a list or catalogue of items, a court should determine the meaning of each by reference to the others, giving preference to an interpretation that uniformly treats items similar in nature and scope"] [internal quotations omitted].)

Pieces of recent behavioral healthcare legislation further bolster Fairchild's interpretation. In California Assembly Bill ("AB") No. 2275 (2021–2022 Reg. Sess.), which became effective on January 1, 2023, the state legislature amended the LPS Act to address a dearth of procedures available to individuals that remained involuntarily held pursuant to § 5150 past the initial 72 hours but who were not yet certified under § 5250 for further intensive treatment. As relevant here, the amended law specifies procedures owed to 5150 patients who are not at a designated facility. (See Welf. & Inst. Code, § 5256, subd. (b) ["The professional person in charge of the facility designated by the county for evaluation and treatment, *or an individual designated by the county if the person is not in a designated facility*, shall inform the detained person of their rights with respond to [a] hearing . . ."] [emphasis added].) The legislature has also codified other provisions delineating requirements related to certain immunities for "licensed general acute care hospital[s] . . . that [are] not [] county-designated facilit[ies] pursuant to Section 5150." (See Cal. Health & Saf. Code, § 1799.111.)

In these legislative acts, the California legislature evidenced their understanding that some hospitals are *not* designated but may nonetheless provide care for 5150 patients for some period of time. This understanding is plainly antithetical to the County's interpretation of the LPS Act, which would render *all* licensed hospitals that receive a 5150 patient as County-designated. This Court should not adopt the County's interpretation of the LPS Act, which would render the LPS Act's

references to non-designated facilities superfluous. (See *Tuolumne Jobs & Small Business Alliance v. Superior Court* (2014) 59 Cal.4th 1029, 1038–39 ["It is a maxim of statutory interpretation that courts should give meaning to every word of a statute and should avoid constructions that would render any word or provision surplusage. An interpretation that renders statutory language a nullity is obviously to be avoided."] [internal citations and quotations omitted].)

The California legislature's newly passed Senate Bill ("SB") No. 1238 (2023–2024 Reg. Sess.) (see ARB at 19–20) equally supports Fairchild's reading. First, SB 1238's text and analysis evidences the Legislature's understanding that state approval of LPS designated facilities is necessary under current and future law. As the Legislative Digest of SB 1283 law states, a 5150 patient is placed "in a facility designated by the county for evaluation and treatment and *approved by the State Department of Health Care Services*." (Legis. Counsel's Dig., Sen. Bill No. 1238 (2023–2024 Reg. Sess.) [emphasis added].) The bill also amends Welf. & Inst. Code § 5404 (in newly-added subsection (b)) to reinforce that "[t]he State Department of Health Care Services shall approve county designation of facilities" to provide involuntary treatment, including pursuant to § 5150. (Sen. Bill No. 1238 § 7 [amending Cal. Wel. & Inst. Code § 5404].) (See also Cal. Code Regs. Tit. 9, § 821 ["Any facility designated by the board of supervisors of a county for evaluation and treatment pursuant to [LPS Act Chapter 2, Articles 1 and 2, §§ 5150–5213] is subject to approval of the Department."].)

C. A Narrower Reading of the LPS Act's Designated Facilities Minimizes Constitutional Concerns

Fairchild was also correct (see ARB at 18–19) to note constitutional complications with the County's theory. Again, a federal court has already held a state's ED boarding practice (albeit under a different statutory scheme)—namely, boarding psychiatric patients in the hospitals' EDs "without the permission of the hospitals"—to constitute an unreasonable (and thus unconstitutional) seizure of the hospitals' EDs. (*Commissioner, N.H. Dept. of Health and Human Services*, *supra*, at p. 217–18.) The County's read of the LPS Act would give it unfettered discretion to impose on any facility the burdens and costs of carrying out the broad range of LPS obligations, without the consent of the facility or oversight from the state. (See ARB at 17–18 [outlining the scope of responsibilities and duties imposed on facilities deemed to be designated pursuant to the LPS Act].) This is both constitutionally unsound and practically unworkable, especially for small, rural hospitals like Fairchild.

III. THE TRIAL COURT FAILS TO RECOGNIZE THE SEPARATE AND INDEPENDENT OBLIGATIONS UNDER THE LPS ACT, ON ONE HAND, AND EMTALA, ON THE OTHER

Finally, in addition to their misconceptions regarding facility designation under the LPS Act, the trial court here, as well as Defendants, appear to also be operating under a misconception of Fairchild's EMTALA's obligations. As a starting point, both fail to understand that a hospital's compliance with EMTALA is separate and apart from any state-law involuntary hold scheme, such as the LPS Act. Neither the EMTALA statute

nor the regulations recognize the concept of an involuntary hold. And, in fact, the statute provides that it does "not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section." (42 U.S.C. § 1395dd(f).)

Importantly, not every involuntary hold placed pursuant to § 5150 involves an emergency medical condition, and the majority of emergency medical conditions would not meet the criteria for a § 5150 hold. There may be cases that qualify under both, but it is not correct to assume that patients on involuntary holds represent a subset of patients with emergency medical conditions. This is the case because EMTALA and the LPS Act are independent statutory frameworks with their own, separately defined, concepts. In particular, there are three important differences between these two frameworks and how they might apply to a particular individual that presents at a hospital emergency department such as Fairchild's: (1) *what* in particular is being assessed; (2) *how* an individual is being assessed; and (3) *who* is permitted under the relevant statute to assess the individual.

First, there is a vast difference in *what* is being assessed under the two frameworks: on the one hand, whether someone has an "emergency medical condition" and whether it is stabilized (EMTALA), and, on the other, a determination that someone is a danger to themselves or others or is gravely disabled as a result of a mental disorder (LPS Act). As relevant here, an emergency medical condition means:

> a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual … in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part . . .

(42 U.S.C. § 13955dd(e)(1).)[8] Stabilization means "with respect to an emergency medical condition . . . that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility . . . ." (*Id.*, § 13955dd(e)(3)(B).) Unlike the medical conditions and status being assessed under EMTALA, § 5150 requires a finding that a person is "as a result of a mental health disorder, . . . a danger to others, or to themselves, or gravely disabled." These are independent assessments, aimed at determining different end points. Again, while there may be cases that qualify under both definitions, not every § 5150 hold involves an emergency medical condition that is not stabilized.[9]

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[8] The EMTALA statute also contemplates that a hospital's obligations would end upon a refusal to consent to treatment or transfer (see 42 U.S.C. § 1395dd(b)(2), (3)), raising the question of whether a hospital's EMTALA's obligations would expire for any individuals on involuntary holds and refusing to consent for any further examination, treatment, and/or transfer.

[9] The County argues that "*As a matter of law*, 'a 5150 patient is not stabilized until he is no longer a danger to himself or others[,]'" while citing only to sub-regulatory guidance, the

Second, there is a vast difference between the medical judgment necessary to determine whether an individual has an emergency medical condition and if that condition is stabilized, and the ability to make an initial probable cause determination that an individual meets statutory criteria for a 5150 hold. Specifically, the determination that an individual has (or does not have) an emergency medical condition, as defined by EMTALA, necessarily includes the professional judgment of a physician or other qualified medical professional. (See 42 U.S.C. § 1395dd(a) [". . . the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition . . . ."], (e)(1); 42 C.F.R. § 489.24(a)(1)(i).) Similarly, medical judgment is necessary for the hospital's determination that a particular individual's emergency medical condition is stabilized. The definition of "stabilized" under EMTALA necessarily includes a medical determination: ". . . no material deterioration of the [emergency medical] condition is likely, *within reasonable medical probability*, to result from or occur during the transfer of the

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Centers for Medicare and Medicaid Services' ("CMS") EMTALA Interpretative Guidelines. (County Respondent's Brief at 72 [emphasis added].) CHA notes further that the interpretations expressed in that guidance, as well as the regulations, have not been addressed by a post-*Loper Bright Enterprises v. Raimondo* (2024) 144 S.Ct. 2244 court.

individual from a facility . . . ." (42 U.S.C. § 13955dd(e)(3).)[10] Upon a determination by the hospital that an individual's emergency medical condition is stabilized, even if the underlying medical condition remains, the physician may discharge the individual home with referrals for follow-up care, admit them to the hospital, or transfer the individual to another facility, depending on their clinical condition. (See 42 U.S.C. § 13955dd(c)(1) [restricting transfers for individuals with *unstabilized* emergency medical conditions]; see also *id.*, § 13955dd(e)(4) ["The term 'transfer' means the movement (including the discharge) of an individual outside a hospital's facilities . . ."].) Similar to the need for inpatient admission or post-acute care after stabilization of an acute emergency medical condition such as a heart attack, patients on an involuntary hold that have been determined to have *stabilized* emergency medical conditions may still require further care and treatment for the underlying behavioral health condition. However, such care is not governed by EMTALA.

On the other hand, a determination that an individual meets the statutory criteria to be taken into custody pursuant to § 5150 is based on a probable cause standard, not a determination based on medical judgment. (See Cal. Welf. & Instit. Code, § 5150, subd. (a) [permitting certain designated

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[10] California law uses the same definition of "stabilized" as EMTALA, except that California law states that a finding that an emergency condition is "stabilized" must be made by a physician or other appropriate licensed person acting with the scope of licensure under the supervision of a physician. (Cal. Health & Saf. Code, § 1317.1, subd. (j).)

individuals "*upon probable cause*, [to] take, or cause to be taken, the person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment and approved by [DHCS]"] [emphasis added].) That a § 5150 probable cause determination does not involve medical judgment is confirmed by the LPS Act's designation of "peace officers"—who are not necessarily medical professionals—as individuals authorized to make this determination and to take individuals into custody when the statutory criteria are met.

Third, *who* is doing the assessing under each statutory scheme differs. As noted above, the EMTALA statute is clear that the hospital and its physicians are responsible for determining both whether an individual has an emergency medical condition and if that condition is stabilized. (See 42 U.S.C. § 1395dd(a), (e)(1), (e)(3); see also 42 C.F.R. § 489.24(a)(1)(i).) A hospital, and its emergency physicians or other qualified medical professionals, do not have a duty to accept the judgment of a peace officer or other designated individual in conducting a medical screening examination and determining whether or not an emergency medical condition is present for a particular individual. And any such deference could be contrary to a physician's scope of licensure. (Cf. Cal. Bus. & Prof. Code, § 2052, subd. (b) [discussing the prohibition on aiding and abetting the unlicensed practice of medicine].)

Under § 5150, a number of individuals may, upon probable

cause, take or cause to be taken, a person into custody, including: "a peace officer, professional person in charge of a [designated] facility . . . , member of the attending staff . . . of a [designated] facility . . . , designated members of a mobile crisis team, or professional person designated by the county . . ." (Cal. Welf. & Instit. Code, § 5150, subd. (a).) While there can be overlap between these two groups (for example, in an LPS-designated psychiatric hospital that has an emergency department), EMTALA would not permit medical screening examinations or stabilization determinations to be conducted by County personnel here. Instead, EMTALA requires the hospital to make each of these determinations. (See 42 U.S.C. § 1395dd(a), (e)(1), (e)(3); see also 42 C.F.R. § 489.24(a)(1)(i).)

Although the County here simply has no role under EMTALA, the trial court incorrectly stated that only the *County* could determine when a patient is stabilized. (See 3 JA 1597 ["Petitioner's obligation under EMTALA continues until the patient is stabilized or transferred. By its own allegations, Petitioner lacks the expertise to determine if a patient has stabilized and *must rely on County to make that assessment*."] [emphasis added]; 3 JA 1611 ["In the present case Petitioner *is obligated* to provide services pursuant to EMTALA until the patient has stabilized and is no longer a danger to himself or others. Respondent County's § 17000 obligation does not arise *until that assessment of danger is completed by County* and the patient is either released to [sic] transferred to another facility."] [second emphasis added].) As noted above, this is not the case.

The hospital determines medical stabilization, independent of any involuntary hold or assessment done by another party.[11]

These basic misunderstandings underlie both Defendants' arguments and the trial court's reasoning and decisions. However, based on a correct reading of these two statutes, ensuring 5150 patients receive appropriate treatment and evaluation without a visit to or prolonged stay at Fairchild's ED does not need to conflict with Fairchild's EMTALA obligations.

The California legislature, in the LPS Act and other state laws, has designed a process to ensure patients experiencing mental health crises receive appropriate and ethical care. Nothing in EMTALA undercuts the state-law imposed obligations of the County or DHCS to provide this behavioral health treatment, and it is appropriate for this Court to ensure the County and DHCS carry out their obligations, rather than rely on small hospitals without psychiatric care capabilities to do so for them.

CONCLUSION

For the reasons stated herein and those articulated in Fairchild's Opening and Reply Briefs, the Court should reverse the judgments of the trial court.

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[11] California State Association of Counties ("CSAC") seeks leave from this Court to file an *amicus curiae* brief in support of Markedly, CSAC's proposed *amicus brief* does not provide any legal support for its assertion that the County determines whether a patient's psychiatric emergency is stabilized under EMTALA. (See CSAC Brief at 14.) Instead, CSAC glides past EMTALA's plain text, mischaracterizes this as a factual issue, and erroneously suggests that this court should defer to the trial court's factual findings at the demurrer stage.

Respectfully submitted,

DATED: October 8, 2024

By: 

JACQUELYN J. GARMAN
Attorney for Amicus Curiae
CALIFORNIA HOSPITAL
ASSOCIATION

CERTIFICATE OF COMPLIANCE

Pursuant to California Rules of Court, rule 8.204(c), I hereby certify that this brief contains 7,533 words using 13-point Century Schoolbook font, including footnotes, which is less than the total words permitted by the California Rules of Court. In making this certification, I have relied on the word count of the computer program used to prepare the brief.

DATED: October 8, 2024

By: 

JACQUELYN J. GARMAN
Attorney for Amicus Curiae
CALIFORNIA HOSPITAL
ASSOCIATION

PROOF OF SERVICE

I am a citizen of the United States and employed in Sacramento County, California. I am over the age of 18 and not a party to the within action. My business address is 1215 K. Street, Suite 700, Sacramento, California 95814.

On October 8, 2024, I served on the interested parties the document described as **[PROPOSED] BRIEF OF THE CALIFORNIA HOSPITAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PLAINTIFF AND APPELLANT FAIRCHILD MEDICAL CENTER** by transmitting a true and correct copy thereof as follows:

Long X. Do Athene Law 5432 Geary Blvd., Ste. 200 San Francisco, CA 94121 ***Attorneys for Appellant, Siskiyou Hospital, Inc.***	Ricardo Enriquez Office of the Attorney General 1300 I St., Ste. 125 P.O. Box 944255 Sacramento, CA 94244-2550 ***Attorneys for Respondent, Department of Health Care Services et al.***
Margaret R. Prinzing Olson Remcho 1901 Harrison St., Ste. 1550 Oakland, CA 94612 ***Attorneys for Respondent, County of Siskiyou et al.***	

BY ELECTRONIC SERVICE: I electronically filed the document(s) with the Clerk of the Court by using the TrueFiling system. Participants in the case who are registered users will be served by the TrueFiling system. Participants in the case who are not registered users will be served by mail or by other means permitted by the court rules.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Executed October 8, 2024, at Sacramento, California.

Lisa Geraty

PROOF OF SERVICE

I am a citizen of the United States and employed in Sacramento County, California. I am over the age of 18 and not a party to the within action. My business address is 1215 K. Street, Suite 700, Sacramento, California 95814.

On October 8, 2024, I served on the interested parties the document described as **[PROPOSED] BRIEF OF THE CALIFORNIA HOSPITAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PLAINTIFF AND APPELLANT FAIRCHILD MEDICAL CENTER** by transmitting a true and correct copy thereof as follows:

Clerk, Siskiyou County Superior Court
c/o The Honorable Karen L. Dixon
411 Fourth Street
Yreka, CA 96097

BY MAIL: I enclosed the document(s) in a sealed envelope or package addressed to the persons at the addresses listed in the Service List and placed the envelope for collection and mailing, following our ordinary business practices. I am readily familiar with California Hospital Association's practice for collecting and processing correspondence for mailing. On the same day that correspondence is placed for collection and mailing, it is deposited in the ordinary course of business with the United States Postal Service, in a sealed envelope with postage fully prepaid. I am a resident or employed in the county where the mailing occurred. The envelope was placed in the mail at Sacramento, California.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Executed October 8, 2024, at Sacramento, California.

Lisa Geraty