BUTTE COUNTY GRAND JURY REPORT 2008/2009
BUTTE COUNTY DEPARTMENT OF BEHAVIORAL HEALTH

SUMMARY

The 2008/2009 Grand Jury chose to visit the Department of Behavioral Health (BCDBH) since it had not been investigated for seven years, nor reviewed for five. Upon the first two visits of BCDBH clinics, it became evident that there were problems of malcontent within the Department. Simultaneously, the media began to report that the Department was financially upside down and $5 million had to be cut from the BCDBH budget. The Board of Supervisors granted the Department a "loan" plus interest, to subsidize them during their financial crisis. The fiscal predicament was partly due to state funding problems and their purported "oversight" which created a three year funding delay, and partly due to failure on the former Director's end to report financial difficulties or discrepancies. The Director left his position abruptly.

After learning of the financial crisis, the Board of Supervisors publicly voiced their concerns about the operation of BCDBH, summing up the situation by saying there were "too many Chiefs and not enough Indians." At this time an outside auditor was brought in to conduct an audit of the BCDBH business office and help explain the budget at a public workshop held by the Board of Supervisors on September 8, 2008.

Voluntary information and stories from the past eight years to present began pouring out during routine visits to local Behavioral Health Clinics and Counseling Centers. Generally, the Grand Jury does not become involved with personnel issues; however, repetitive testimony from all levels of staffing, reporting the same inefficiencies, led the panel to be concerned for the overall well-being of the entire Department. Thus, the Grand Jury began an investigation and the process of interviewing numerous witnesses. Eighty eight percent of those witnesses independently corroborated much of the same detailed information during personal interviews.

Medical, clinical, and line staffs within the individual divisions of BCDBH were suffering from low morale, mistrust, and fear of losing their jobs. In some cases, entire clinics and counseling centers were in danger of being closed and programs in jeopardy of being cut. The closing of the clinics/counseling centers did not occur, as it became clear to those calling for the drastic measures that it would be illegal to take such action according to precluding rules set forth by Government Code, the County Charter, and County personnel.

Behavioral Health is one of the few self-supporting Departments in the County that is capable of supporting their programs through patient billing for reimbursement through Medi-Cal, Medicare, CMSP, EPSDT, grant funding, and state and federal funding.

The importance of retaining first-rate medical and clinical staff that generates revenue for the Department is essential. Achieving higher productivity standards, re-organizing the structure of management, and maintaining an honest and transparent administration are imperative in preserving quality patient care and the future wellbeing of BCDBH. The focus of the Department should on patient care rather than administration.

GLOSSARY

ACCESS – a single point of assessment and entry to the inpatient Psychiatric Health Facility

AVATAR – an information system comprised of software specific to medical records, reporting, and billing

Butte County Behavioral Health Board – an Advisory Board to BCDBH, comprised of ten members, and four staff representatives

BCDBH – Butte County Department of Behavioral Health

CMSP – County Medical Services Program; provides health services for low-income indigent adults in 34 rural CA counties

Crisis Stabilization Unit - a facility capable of assessing, evaluating, holding, and treating four adults and two youth patients in crisis, for up to 24 hours

Dashboard Report – an abbreviated real-time, at-a-glance report that shows cost to revenue data

EPSDT – Early Periodic Screening Diagnostic Training Program, funded by Medi-Cal dollars

HERE – Homeless Emergency Runaway Effort

HOPE Cottage – a care home for youth in crisis

HR Dept. – Human Resources Department

IT – Information Technology

MHSA Funding – Mental Health Services Act; a streaming fund from the millionaire's tax (Prop. 63) designed to implement new programs in conjunction with existing programs, inviting community input

MOUs – Memorandum of Understanding describing a bilateral or multilateral agreement between two parties

PHF – Psychiatric Health Facility; a 16 bed facility that can hold and treat patients up to five days

RFQs – Request for Quote or quotation from competitively bidding contractors

BACKGROUND

The mission statement of BCDBH: The mission of Butte County Department of Behavioral Health is to establish a wide spectrum of health promotion and treatment services for individuals and families at-risk of, or currently suffering from, acute psychological and/or serious mental illness, as well as substance abuse. This will be accomplished through collaborative programs and partnerships with key segments of our community.

BCDBH provides a comprehensive continuum of services meeting vital community needs related to mental health and substance abuse problems. Services provided by BCDBH may be placed in the following general categories: administrative services, community education and prevention services, client intake and access services, residential treatment services, day treatment services, and psychiatric inpatient and outpatient treatment services. Approximately twenty five percent of the Department's budget is used to contract for treatment services. The remainder of the services is provided by Departmental staff or through inter-departmental collaborations, and with several local non-county entities.

Background Chronicle 2000-2008:

a. Previous Director takes over BCDBH with a $2 million surplus

b. Unit rates (cost based unit of billable time) are reduced below costs.

c. Budgeting is taken from transparent (when management and staff participated), to a behind-closed-doors secretive process.

d. Vacant positions are frozen midyear and eliminated prior to budget approval by the Board of Supervisors.

e. An assistant administrator is given authority to make budget cuts at will, taking away the rights of assistant directors and program managers, to manage their own budgets.

f. Budget decisions are questioned by medical/clinical staff.

g. Clerical, HERE/ACCESS, HR, and Contracts, are all centralized under the former Director, causing lost revenue and inefficiency as far as decision making, hires, contracts, MOUs, RFQs, etc.

h. Cost effective programs are cut, staff is transferred to non-direct client services as monitors, quality assurance, and compliance officers.

i. Eight youth service staff are moved to non-billable positions, resulting in loss of revenue and staff morale.

j. Adolescent day treatment programs are eliminated at a loss of $500,000 a year in revenue profit.

k. Attempts by medical/clinical staff to advise against cutting clinical positions, resulting in cutting patient services, are disregarded.

l. Psychiatrists and psychologists are reclassified to a salary below market rates, while administrators receive large pay raises. Clinicians, counselors, MRTs (medical records technicians) get little or no increases.

m. Staff becomes restricted from Department data necessary to make informed decisions on patient care, i.e., out-of-home placement, hospital data, expenditures, costs, and clinical outcomes.

n. Medical staff feels their clinical concerns regarding patient care are being ignored and voice their opinions to the Board of Supervisors.

o. Shortly after it becomes evident that the Department is in financial trouble, the former Director abruptly leaves his position.

p. An outside audit is called for and a standing-room-only crowd attends a public workshop held by the board of Supervisors for the purpose of explaining the BCDBH budget.

In light of the *background chronicle*, the Department of Behavioral Health was left in an emotional and financial turmoil following the sudden resignation of the former Director who had served in that position for eight years. An Interim Director was subsequently hired to come in and pick up the pieces. Because of mistrust and lack of leadership under the former Administrator, staff was plagued with low morale, grievances from the past, and job insecurities. In addition to the aforementioned problems, the Interim Director was faced with mopping up from the financial backlash of unreported difficulties. A three year funding oversight on the State's end and the fact that the former Director was not "minding the store," literally put the BCDBH into debt. The 2007/2008 budget was $48 million and yet the Board of Supervisors had to authorize a "loan" for an additional $5 million. The new Interim had little choice but to reduce the budget by enforcing immediate cuts in staffing, shifting/relocating staff, proposing the closing of clinics, counseling centers, and the cutting of programs, in order to regain financial stability.

It is important that financial information be clear and understandable when presented to persons making decisions for the health and welfare of others. It has been difficult to obtain current, easy to understand, financial data and reports upon request by medical/clinical staff and supervisors. Several witnesses said they gave up and quit asking the business office for information. The business office, or fiscal operation of Behavioral Health, has the reputation of being run by a small group of people who make important decisions indirectly affecting patient care based solely on financial considerations, without input from the entire leadership team, or representation from medical and clinical staff. The leadership team is currently comprised of eight people: the Interim Director, assistant directors, program managers, and an analyst.

The Interim Director inherited the problems left behind by the former Department head. Coming to the end of his first year, the Interim has been successful in regaining some of the lost trust within the Department. He is reportedly a good listener, and is well liked and respected by all levels of Department personnel. However, because the Director continues to have an interim

status with no contracted or agreed upon time limits, there remains an atmosphere of uncertainty until a permanent Director is appointed. The consensus of witness testimony is that things aren't changing fast enough, and some of the same issues that existed under old leadership have not changed nor been resolved.

APPROACH

- The Grand Jury approached this investigation by conducting numerous personal interviews. Thirty four people were interviewed over the course of seven months. Some witnesses were called upon multiple times to testify.

- Visits were conducted at seven of the BCDBH clinics and facilities located in the Oroville, Paradise, and Chico areas.

- Administrators, supervisors, program managers, physicians, clinicians, and financial experts were questioned by the Grand Jury in order to gain insight into the workings of BCDBH.

- Financial data and reports were received from the business office of Behavioral Health. Current information was difficult to obtain.

- Information gathered from interviews and documentation was corroborated and cross-referenced to establish priority areas of concern existing within the BCDBH.

- The Grand Jury followed the proceedings of the Board of Supervisor's meetings and public hearings.

DISCUSSION

Emotional Healing

The intent of this report is to focus on reorganization, restructuring, and emotional healing of this Department so that it may function to the full intent of its sole purpose: to treat the mentally and emotionally ill who would otherwise go untreated, harm themselves or others, be removed from their families, end up on the streets, or be mistakenly incarcerated in prisons.

If it weren't for the dedication of the Department's psychiatrists, therapists, clinicians, and social workers who devote their lives and careers to each of these less fortunate individuals, many would not be integrated back into their families, neighborhoods, schools, or workplaces. These dedicated professionals do much more than provide the latest medical treatments and counseling for their patients. They provide hope and improved quality of life to those suffering lifelong mental illnesses.

The Department appears to be healing slowly; however, the consensus of witness testimony reveals a continuing lack of transparency, fear of retaliation for speaking out, and decision making that continues to be made by a small group of people at the top.

Permanent Director
The Department is in need of a highly qualified permanent Director who will continue the task of re-organizing the Department so that it may operate at maximum efficiency and support itself financially. A Director who is willing to work in collaboration with a medical director, medical, clinical, and line staff is imperative in establishing continuity, permanency, trust, and a healthier Department environment. According to the bylaws of the Behavioral Health Board, they, along with the Board of Supervisors, are required to interview each candidate for the position of Director of BCDBH.

Medical Director
All witnesses interviewed support the need for a Medical Director physician who would be in charge of medical services, oversee and direct physicians and clinicians, and represent them in administrative decision making. The high cost of hiring a psychiatrist to fill the Medical Director position could be offset by Medi-Cal reimbursement for direct services, providing the psychiatrist sees patients a percentage of the work week. The administrative portion of his/her work schedule could be billed for reimbursement as a "claim-for-management" cost.

Transparency
"Transparency promotes accountability and provides information for citizens about what their Government is doing. My Administration will take appropriate action, consistent with law and policy, to disclose information rapidly in forms that the public can readily find and use. Executive departments and agencies should harness new technologies to put information about their operations and decisions online and readily available to the public. Executive departments and agencies should also solicit public feedback to identify information of greatest use to the public. Executive departments and agencies should use innovative tools, methods, and systems to cooperate among themselves, across all levels of Government, and with nonprofit organizations, businesses, and individuals in the private sector. Executive departments and agencies should solicit public feedback to assess and improve their level of collaboration and to identify new opportunities for cooperation." (Quoted excerpts from a portion of Barack Obama's 2009 transparency memorandum directive)

According to eighty eight percent of witnesses, transparency is non-existent in the BCDBH. The line of communication between medical/clinical staff and the business/administrative office of Behavioral Health appears to be the weak link within the Department. Information is not readily available, and sometimes never forthcoming upon request by program managers and medical/clinical staff. Witnesses who have tried to obtain statistical and budgetary information from the business office have been "stonewalled" and given up. The majority of witnesses believe that major decisions for the entire Department of BCDBH continue to be made by a small group of people in the business office.

BCDBH should follow government transparency guidelines as mentioned above. Financial reporting and data should be understandable and readily accessible upon request. The at-a-glance, "Dashboard Report," currently in development, should be implemented as soon as possible to provide on-demand information.

Communication
Historical barriers of communication need to be broken down in order to regain trust and cooperation across the Department. While some problems of the past continue to linger, efforts are being made to raise morale. "Focus Groups" have recently been formed to work with line staff, inviting them to participate in policy decisions regarding patient/client care. The groups will then compile a report addressing the self-disclosed issues or input derived from line staff. From this information, a draft report is produced and sent to line staff. Administration should continue to foster open avenues of communication such as this example.

Leadership Training
Several witnesses felt there was inadequate training available to them when transitioning into leadership roles, for example, moving up to supervisor or manager positions. Comprehensive leadership training should be provided by the HR Department to produce strong leaders.

Contracts
The monitoring and administering of contracts is reported to be poor considering the increase of contracts issued. In the past four years, spending for contract providers has increased from $2,051,000 to $6,379,000. This dramatic increase needs to be clarified, and a better balance between county services and contract providers should be reached.

Productivity
Productivity is measured by the number of billable hours for direct patient services versus non-billable hours. In some cases clinicians are producing at fifty to sixty percent while others may be producing at eighteen percent. Overall productivity in BCDBH outpatient clinics is about fifty percent. Productivity statistics are affected by the high number of non-productive supervisors and program managers (non-productive meaning, they do not see patients). Productivity levels should be analyzed, determined, and maintained for the highest level of efficiency, which in turn generates revenue.

Youth Residential Facilities
There is a need for additional youth residential facilities in Butte County to reduce costly out-of-county transportation, hospitalization and placement expenditures of approximately fifty youth and children each year. Contracting for additional local residential facilities would allow BCDBH psychiatrists to treat children and youth close to home, school, and family. Unfortunately, the state makes credentialing and licensing very difficult, hampering the development of new residential facilities such as Hope Cottage, a newly opened care home for youth in crisis. The facility is now fully licensed in compliance with state mandated licensing requirements and is operational at this time.

Adult Residential Facilities
Additional residential facilities are needed to reduce out-of-county hospitalizations and long-term placements for adults as in the same situation mentioned under Youth. A new adult twelve bed facility will be opening in Paradise that will allow a six to twelve month stay. It is currently awaiting Paradise City Council, and state licensing approvals.

Partnering
Partnering agreements with local hospitals and facilities, equipped and staffed to hospitalize and treat mentally ill patients, would save additional County dollars that presently finance transportation, treatment, and hospitalization for those sent outside of the County. The annual cost of placing patients in out-of-county institutional care is approximately $1,800,000. Meetings are being held to foster partnerships.

Systems Performance
The Department is becoming more data driven, and under close scrutiny by state and federal governments. The addition of a trained Systems Performance Evaluation Coordinator is important. Funding of this position could be supported by various grant revenues and the administrative portion could be funded by Medi-Cal reimbursement. The Coordinator would be responsible for the integration of IT data along with AVATAR's reporting system, including mental health outcomes and research slated for development. Line staff would be additionally served as well by the Coordinator's focus on overall systems performance and fulfillment of mandates, including MHSA funding and state and federal grants.

Overhead
When the newly appointed Interim Director took over his duties, he was faced with the immediate challenge of reducing an astronomical forty percent overhead. The state allows for a fifteen percent overhead to qualify for reimbursement. The Interim Director has been successful in his efforts to lower overhead operating expenses by reducing office and other supply expenditures, bottled water dispensers, closing excessive office suites, eliminating vacant positions, and cutting staff.

Board of Supervisors
The Grand Jury had the opportunity to address three members of the Board of Supervisors. When asked questions regarding BCDBH issues, they knew very little about the financial affairs or administrative workings, which was shocking in the light of the Department's recent history and subsequent bailout loan in the fall of 2008.

Psychiatric Health Facility
Also known as the PHF, the Psychiatric Health Facility is a sixteen bed unit which can hold and treat patients for up to five days. When visited, the facility was at full capacity, extremely clean, quiet, and staffed by caring, dedicated professionals. The facility has a large backyard where patients can visit or garden with the help of staff. Vegetable and flowering plants are donated by a local non-profit nursery in the spring.

Crisis Stabilization Unit
The Crisis Stabilization Unit has the capacity to hold four adult and two youth patients in crisis. Patients cannot be held for more than a twenty four hour period. They are assessed, evaluated, treated, and moved on to appropriate modes of treatment or facilities, or released to family. The early opening of the unit was fraught with problems that ranged from seldom being fully staffed, to the program manager not being a licensed mental health care worker, slowing the facilities' licensing process. Now fully staffed twenty four-seven, the unit is officially licensed and up and running as of March 7, 2009. The Crisis Stabilization Unit is one hundred percent funded by MHSA monies.

Caseloads
Caseloads have doubled, tripled, and even quadrupled, at some of the mental health outpatient facilities visited. One clinic for instance, has the same number of staff that they had five years ago, upon startup; however, their caseload has increased from seventy to four hundred. According to one program manager, caseloads that used to be thirty are now fifty. Psychiatric technicians who monitor medications for patients often have caseloads of 250-300.

Representative Payee Program
The Representative Payee Program is set up to manage money for adults, 18 or older, with mental impairments, who cannot manage their own funds. To be eligible for the program, patients must be referred by their case manager. The program ensures that daily living needs are met, and the patient's well being and independence are maintained. Some patients who qualify for the Representative Payee Program have transitioned from a conservatorship. The next transition would be to encourage independence when appropriate.

The duty of the representative, an employee of the County, is to help the consumer with finances, write rent checks, pay utilities, allocate an allowance, etc., at no cost to the patient. The program is supported by realignment funds.

Two outside businesses offer representative payee services for thirty seven dollars per month. A low monthly fee of thirty seven dollars can even be too expensive for some of those in need of the service, and it may be too difficult for them to navigate the logistics of getting to, and negotiating with, a business on their own. Landlords may refuse to rent to the mentally ill without them being enrolled in the Representative Payee Program.

Representative Payee Program was slated to be discontinued but following protest from medical and clinical staff, the program is presently fully maintained. Grant monies that supported the program in the past have now been diverted to a homeless program.

County Medical Services Program
It was proposed by administration to limit service to CMSP patients. The majority of CMSP patients are low-income, indigent and oftentimes mentally ill. Twenty five percent of patients at one BCDBH facility alone are CMSP patients. There is a behavioral health effort to enlist the Welfare Department in helping switch CMSP card holders over to Medi-Cal for two reasons. One being for better reimbursement, and two being for better patient care. Very few physicians will see CMSP patients as reimbursement is too little and too late.

FINDINGS

F1. There is no plan in place to hire a permanent Director who will reorganize and stabilize BCDBH.

F2. There is no Medical Director in BCDBH for the overall management of medical/ clinical staff, nor a spokesperson to advocate for the medical/clinical staff in administrative decision making.

F3. There is a lack of a transparent, financial, and statistical data reporting system.

F4. There is a lack of productive communication, trust, and cooperation within the various divisions that comprise BCDBH.

F5. There is a lack of effective leadership, due to lack of leadership training.

F6. There is a lack of monitoring and administering of the increased number of contracts.

F7. Productivity levels appear lower than the standard in some areas of BCDBH.

F8. There is a lack of contracted residential facilities for youth in crisis in Butte County.

F9. There is a lack of contracted residential facilities for adults in crisis in Butte County.

F10. There has been a lack of local partnering with a hospital or facility that can hospitalize and treat patients locally. Meetings are being held to foster partnerships.

F11. There was a lack of a Systems Performance Evaluation Coordinator in the past. This position has just been assigned and is in the process of classification.

F12. Overhead costs that were too high in relation to the budget have been reduced to qualify for state reimbursement.

F13. The Grand Jury found the Butte County Board of Supervisors to be surprisingly uninformed, and un-involved in overseeing and monitoring the Department of Behavioral Health's fiscal affairs, structure of management, and administrative decisions made for the Department. When questioned they were unable to answer most of the Grand Jury's inquiries about the Department.

F14. The PHF was visited and found to be well staffed, extremely clean, and full to its sixteen bed capacity.

F15. The Crisis Stabilization Unit is now fully staffed 24-7 and is in compliance with state mandates as of March 7, 2009.

F16. Caseload ratios in the clinics and counseling centers need to be studied and adjusted accordingly.

F17. Representative Payee Program was slated to be discontinued but following protest from medical and clinical staff, the program is presently fully maintained. Grant monies that supported the program in the past have now been diverted to a homeless program. The Representative Payee Program is currently being supported by realignment funds.

F18. The outside audit report done in August-September, 2008 has not been received to date.

RECOMMENDATIONS

R1. The Board of Supervisors needs to prioritize recruitment for a Permanent Director of BCDBH with the medical staff and Behavioral Health Board strongly involved in the process of interviewing every single applicant.

R2. A Medical Director should be actively recruited. The cost of doing so could be offset by reimbursement through Medi-Cal billing for direct services and billing for administrative claim-for-management time. It is recommended that the Medical Director see patients a percentage of his/her workday, as well as represent and direct the medical and clinical staff.

R3. BCDBH should follow government transparency guidelines. Financial reporting and data should be understandable and readily accessible upon request. The at-a-glance, "Dashboard Report," currently in development, should be implemented as soon as possible to provide on-demand information.

R4. Communication, cooperation, and trust need to be fostered by administration.

R5. HR should provide appropriate leadership training to promote effective leaders within BCDBH.

R6. A plan and process for monitoring contracts should be developed.

R7. Productivity levels need to be established and enforced. Qualified medical and clinical supervisors should interface with patients a percentage of the time.

R8. Additional residential facilities that meet state mandated requirements and licensing qualifications should be encouraged for the purpose of treating and housing youth locally. This would be advantageous to the families involved and save the County a great deal of money.

R9. Additional residential facilities that meet state mandate requirements and licensing qualifications should be developed for treating and housing adults needing long-term placement locally, again saving out-of-county costs.

R10. Partnerships with local hospitals in the County need to be developed for the collaborative treatment and care of severely mentally ill patients.

R11. The classification process and position allocation for the Systems Performance Evaluation Coordinator should be completed and accepted by the Board of Supervisors as soon as possible.

R12. Overhead operating costs should continue to be monitored and kept at or below the state requirement level of fifteen percent to qualify for state reimbursement.

R13. The Board of Supervisors should become more regularly informed and more involved with the fiscal affairs and administrative structure of BCDBH.

R14. The Psychiatric Health Facility should retain full coverage staffing in order to continue to operate at full capacity.

R15. The Crisis Stabilization Unit should retain full coverage staffing in order to continue to operate at full capacity.

R16. Clinics and counseling center's caseload ratios should be studied and reassessed.

R17. The Representative Payee Program should be continued in its full capacity and should not be outsourced.

R18. The Board of supervisors should pursue receipt of the outside audit done in August-September, 2008.

REQUEST FOR RESPONSES

Pursuant to Penal Code Section 933.05, the Grand Jury requests responses as follows:

Butte County Behavioral Health Interim Director

Butte County Chief Administrative Officer

Butte County Board of Supervisors

The governing bodies indicated above should be aware that the comment or response of the governing body must be conducted subject to the notice, agenda and open meeting requirements of the Brown Act.

Reports issued by the Civil Grand Jury do not identify individuals interviewed. Penal Code Section 929 requires that reports of the Grand Jury not contain the name of any person, or facts leading to the identity of any person who provides information to the Civil Grand Jury. The California State Legislature has stated that it intends the provisions of Penal Code Section 929 prohibiting disclosure of witness identities to encourage full candor in testimony in Civil Grand Jury investigations by protecting the privacy and confidentiality of those who participate in any Civil Grand Jury investigation.

Disclaimer:
This report was issued by the 2008/2009 Grand Jury with the exception of one member of the panel who is a contracted employee of the Butte County Department of Behavioral Health. This juror was excluded from all parts of the investigation including voting rights, deliberation, and composition and acceptance of this report.