BOARD OF SUPERVISORS

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Kevin Goss, Vice Chair 2nd District
Sharon Thrall, 3rd District
Lori Simpson, 4th District
Jon Kennedy, Chair 5th District

AGENDA FOR ADJOURNED REGULAR MEETING OF SEPTEMBER 30, 2014 TO BE HELD AT 10:00 A.M. IN THE BOARD OF SUPERVISORS ROOM 308, COURTHOUSE, QUINCY, CALIFORNIA

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AGENDA

The Board of Supervisors welcomes you to its meetings which are regularly held on the first three Tuesdays of each month, and your interest is encouraged and appreciated.

Any item without a specified time on the agenda may be taken up at any time and in any order. Any member of the public may contact the Clerk of the Board before the meeting to request that any item be addressed as early in the day as possible, and the Board will attempt to accommodate such requests.

Any person desiring to address the Board shall first secure permission of the presiding officer. For noticed public hearings, speaker cards are provided so that individuals can bring to the attention of the presiding officer their desire to speak on a particular agenda item.

Any public comments made during a regular Board meeting will be recorded. The Clerk will not interpret any public comments for inclusion in the written public record. Members of the public may submit their comments in writing to be included in the public record.

CONSENT AGENDA: These matters include routine financial and administrative actions. All items on the consent calendar will be voted on at some time during the meeting under "Consent Agenda." If you wish to have an item removed from the Consent Agenda, you may do so by addressing the Chairperson.

REASONABLE ACCOMMODATIONS: In compliance with the Americans with Disabilities Act, if you need special assistance to participate in this meeting please contact the Clerk of the Board at (530) 283-6170. Notification 72 hours prior to the meeting will enable the County to make reasonable arrangements to ensure accessibility. Auxiliary aids and services are available for people with disabilities.

STANDING ORDERS

10:00 A.M. **CALL TO ORDER/ROLL CALL**

PLEDGE OF ALLEGIANCE

ADDITIONS TO OR DELETIONS FROM THE AGENDA

PUBLIC COMMENT OPPORTUNITY
Matters under the jurisdiction of the Board, and not on the posted agenda, may be addressed by the general public at the beginning of the regular agenda and any off-agenda matters before the Board for consideration. However, California law prohibits the Board from taking action on any matter which is not on the posted agenda unless it is determined to be an urgency item by the Board of Supervisors. Any member of the public wishing to address the Board during the "Public Comment" period will be limited to a maximum of 3 minutes.

DEPARTMENT HEAD ANNOUNCEMENTS/REPORTS
Brief announcements by, or brief reports on their activities by County Department Heads

ACTION AGENDA

1. **BOARD OF SUPERVISORS**
   Adopt **RESOLUTION** adopting the Final Budget for Plumas County and the Dependent Special Districts therein for Fiscal Year 2014-2015 in Accordance with Government Code §29092 and Other Budgetary Administrative Control in Accordance with §29092. **Roll call vote**

2. **KEMPER CONSULTING GROUP** - Lee Kemper
   Presentation of Kemper Consulting Group report, "Plumas County Mental Health Department, A Review of the Current Service Delivery Dynamics, Issues and Considerations". Discussion and possible action

3. **MENTAL HEALTH** – Peter Livingston
   A. Review and accept Mental Health Director's response to the report issued by Kemper Consulting Group regarding the organizational review of Plumas County Mental Health. Discussion and possible action
   B. Presentation by Mike Geiss, Consultant regarding fiscal analysis of Mental Health Services Act (MHSA) Fund Balance. Discussion and possible action

4. **CONSENT AGENDA**

These items are expected to be routine and non-controversial. The Board of Supervisors will act upon them at one time without discussion. Any Board members, staff member or interested party may request that an item be removed from the consent agenda for discussion. Additional budget appropriations and/or allocations from reserves will require a four/fifths roll call vote.

A) **PLUMAS COUNTY COORDINATING COUNCIL**
Consider new directive proposed by the U.S. Forest Service on May 06, 2014 titled "Proposed Directive on Groundwater Resource Management, Forest Service Manual 2560"; approve and authorize the Chair to sign letter to the USDA Forest Service. Discussion and possible action

B) **PUBLIC WORKS**
Solid Waste: Approve and authorize the Chair to sign Memorandum of Understanding between Plumas County and Waste Management regarding Green Waste Disposal in the American Valley area, subject to approval by County Counsel. Discussion and possible action

C) **AUDITOR/CONTROLLER**
Approve and authorize the Chair to sign Amendment to Agreement between Susan Scarlett and the County of Plumas for Budget Consulting services. Approved as to form by County Counsel

5. CLOSED SESSION

ANNOUNCE ITEMS TO BE DISCUSSED IN CLOSED SESSION

A. Conference with Legal Counsel: Existing litigation pursuant to Subdivision (d) (1) of Government Code §54956.9 – High Sierra Rural Alliance v. County of Plumas, Plumas Superior Court Case No. CV14-00009
B. Conference with Legal Counsel: Significant exposure to litigation pursuant to Subdivision (d)(2) of Government Code Section 54956.9
C. Conference with Labor Negotiator regarding employee negotiations: Sheriff's Administrative Unit; Sheriff's Department Employees Association; Operating Engineers Local #3; Confidential Employees Unit

REPORT OF ACTION IN CLOSED SESSION (IF APPLICABLE)

ADJOURNMENT

Adjourn meeting to Tuesday, October 07, 2014, Board of Supervisors Room 308, Courthouse, Quincy, California.

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KEMPER
CONSULTING GROUP

Plumas County Mental Health Department
A Review of the Current Service Delivery Dynamics, Issues and Considerations

Kemper Consulting Group

Marta L. McKenzie
Lee D. Kemper

September 2, 2014

Table of Contents

I. Introduction

The Plumas County Board of Supervisors determined that an independent organizational review of the Plumas County Mental Health Department (PCMH) was appropriate and necessary to better inform the Board's oversight of mental health services provided to residents. Continuing and vocal community and law enforcement concerns about unmet service expectations, several leadership changes over a two-year period, a waiting list for services, a large fund balance, and repeated and numerous staffing and salary changes requested by the Department, were matters of interest that prompted the Board to contract with Kemper Consulting Group to perform a review of PCMH and its operations. This report summarizes the findings of that review, and makes specific recommendations to assist the Board in discharging its responsibility to oversee the mental health services provided by PCMH on behalf of Plumas County residents.

II. Methodology for Review

Kemper Consulting Group used several approaches for gathering information to inform its review of the PCMH. Key informant interviews, direct observation, current PCMH data/report gathering and review, third party evaluation report review (e.g. APS – External Quality Review Organization, FY 2013/14 Grand Jury), and specific data requests were the methods utilized.

Key informant interviews were conducted with key PCMH leadership staff (both current and former), criminal justice system leaders and stakeholders, public health, alcohol and drug, First Five, and social services leaders, as well as local hospital and emergency room representatives. Trends and commonalities among key informants were collated, and when necessary additional data or information gathering was conducted to validate the stakeholders' perspectives. Where appropriate to better illustrate a common point of view, quotations from key informants have been included in the findings or recommendation sections. Key informants interviewed for this report are listed in Appendix #1.

Numerous written documents and reports were analyzed to substantiate key informant perspectives, or obtain factual information about the PCMH and its operations. A complete list is provided in Appendix #2. Among the materials reviewed were the following:

- Past, current and proposed annual PCMH budgets
- FY 2013/14 Grand Jury report (dated June 5, 2014)
- Recently submitted and/or drafted board request items
- Salary survey results and two year's of clinical recruitment history and results
- Mental Health Commission agenda and minutes (July 9, and August 13, 2014 meetings)
- Current Mental Health Commission by-laws
- Summarized information about individuals in the criminal justice system that have been determined in need of mental health evaluation and/or services as part of their sentencing or criminal evaluation
- External quality review of PCMH by a third party contractor of the State Department of Health Care Services released on July 29, 2014.

III. Executive Summary

The Plumas County Mental Health Department (PCMH) has experienced a number of leadership changes over the past two years with four Director changes. PCMH struggles under a fairly widespread stakeholder perception that the Department lacks a collaborative philosophy, is often defensive, and is quick to say no to requests for support. Internal PCMH staff is particularly concerned by this frequently repeated view, as many feel that they are providing significant services on behalf of many clients, including many that are of most concern to their critics. It is clear that a number of stakeholder concerns predate the current leadership and that PCMH has long been regarded as "slow" to collaborate. It will take meaningful effort on the part of the new PCMH leadership to break through the historical perspectives and forge a new experience and view of PCMH in Plumas County.

In general, small county mental health departments face an exceedingly difficult set of circumstances. A plethora of rules associated with running a managed care system, including service requirements and documentation, billing and claiming requirements, audits, and quality improvement responsibilities bring an array of challenges. For small counties, these challenges must be faced by a small staff. Adding to the challenge in smaller counties, like Plumas, are recruitment difficulties and few if any external contractors to help shoulder some of the service responsibilities.

The following findings and recommendations are focused on needed improvements and recommended actions to assist PCMH in becoming a valued, respected provider and partner in the community for addressing the mental health and behavioral health needs of Plumas County residents. At a time when so many other county mental health departments in California are low on cash reserves, and many are relying on realignment transfers from other county departments to make ends meet, PCMH is poised with a fund balance that will allow the Department to make a multi-year strategic investment in the delivery of mental health services in the community, while setting aside a prudent reserve for contingencies. This financial situation, if managed appropriately, offers PCMH and Plumas County an important opportunity to become a strong partner in the provision of mental health services on behalf of County residents.

Despite the downward trend in the number of individuals served over the past few years in Plumas County and statewide, PCMH still ranks as one of the top ten counties in meeting the needs of their Medi-Cal eligible and foster care populations (measured by "penetration rate"). Further, many stakeholders spoke favorably about the youth summer leadership program titled Mountain Visions, and Sierra House which provides residential care to many who might otherwise leave Plumas County but for that local service availability. The PCMH Director has expressed an interest in developing "wellness centers" in four areas of the county with MHSA resources, and PCMH already provides services in several communities in this very rural county.

This review produced thirteen findings. Each finding is explained in the body of the report and followed by one or more recommendations. At the end of the report is a summary of the

recommended actions presented in Appendix #6. This summary is provided to assist PCMH, the Plumas County Board of Supervisors, and community stakeholders in monitoring the actions and follow-through of PCMH and documenting progress.

IV. Summary of Findings

FINDING #1: **Most community stakeholders perceive PCMH to be insular, defensive, and lacking a collaborative orientation.**

FINDING #2: **PCMH maintains a waiting list for services, which has been a long-standing practice. The presence of a waiting list indicates there is insufficient PCMH clinical staffing or contracted service providers to perform key mental health service functions.**

FINDING #3: **While significant Mental Health Services Act (MHSA) resources flow into Plumas County on a monthly basis, MHSA funded programs and services are limited.**

FINDING #4: **Fund Balance Reserves in PCMH exceed what is necessary based on historical expenditures and current projected expenditures and potential financial risk. At the same time, community members and stakeholders report waits for needed services.**

FINDING #5: **Services to children are inconsistent, with some care above expected statewide service standards and other care below expected statewide service standards.**

FINDING #6: **There is little evidence of a clear, effective and collaborative working relationship between PCMH and the Plumas County Alcohol and Drug Department to address the needs of dually diagnosed persons.**

FINDING #7: **A robust quality control/improvement system that promotes effective mental health care delivery by PCMH has not been a priority for many years. Further, baseline State-required performance improvement efforts that demonstrate a commitment to quality improvement are no longer completed, and there is no evidence of planning to restart these activities.**

FINDING #8: **PCMH lacks a formal communications strategy and plan that clearly articulate its role and provide a vehicle for keeping Plumas County residents informed about the services available to them and/or their families.**

FINDING #9: **Numerous required program applications/plans, reporting, procedural, and evaluation activities are not being performed by PCMH, or are being performed substantially after the expected deadline(s).**

FINDING #10: The Mental Health Commission's organizational structure, procedural compliance, and organizational leadership need to be assessed.

FINDING #11: There is a lack of clarity among community emergency service providers about PCMH's role and responsibilities during emergent psychiatric situations.

FINDING #12: As a first-time Director with limited prior management experience, the PCMH Director faces a learning curve in all of the following areas: program administration and management, finance, leadership and training of staff, community relations, and interagency collaboration.

FINDING #13: Some external stakeholders support consideration by the Board of Supervisors of a combined health and human services delivery system as a means to more effectively serve clients, many of whom interact with various different departments.

V. Findings and Recommendations

FINDING #1: Most community stakeholders perceive PCMH to be insular, defensive, and lacking a collaborative orientation.

Discussion

Among key informants interviewed for this review, there was overall agreement that PCMH has historically been an agency that is insular, protective of its resources, defensive in response to requests for support, and not philosophically committed to collaboration. Key informants with the criminal justice system were most vocal in support of this view. While these informants expressed appreciation for the mental health services that are currently performed in the jail, the courts and the alternative sentencing program by PCMH, they see these contributions as limited and nominal when there is such great need. These informants noted that a preponderance of the individuals now involved with the criminal justice system exhibit mental health and/or drug and alcohol issues, yet the services available to the criminal justice population are limited in both amount and duration. Further, these informants note that with the 2011 criminal justice realignment under AB 109, the level of need has become more pronounced. While resources were allocated to Plumas County under AB 109, reportedly approximately $650,000 per year, these resources are modest in consideration of the range of services needed to serve the now expanded population and their multiple needs.

In the context of the county's new responsibility under AB 109, criminal justice system leaders are looking for a "partner" in PCMH that is committed to being a part of the solution. In light of the substantial resources now held by PCMH, justice system leaders are looking to PCHM to contribute some of those resources to serving the criminal justice population, either through PCMH staffing or financial support to other agencies. As stated by one key informant, justice system leaders are looking to PCMH to "embrace" this responsibility as a part of its contribution

to promoting public safety. To date, these leaders have experienced little positive response or willingness to assist from PCMH beyond the existing contribution level.

Some internal PCMH staff interviewed for this review shared similar concerns about the absence of successful collaboration by PCMH. At the same time, nearly every PCMH staff person interviewed for this review expressed concern and frustration about a lack of recognition from criminal justice system leaders for the services PCMH currently provides in justice system settings. Some staff felt that poor collaboration overall may be a significant contributing factor to the lack of recognition of what PCMH is currently providing. On its face, there appears to be a basic disconnect between what criminal justice system leaders see as the need for mental health and substance abuse services and what PCMH perceives as its obligation to those served by the criminal justice system.

Beyond collaboration with the criminal justice system, some PCMH staff members and external stakeholders expressed concern about the lack of progress by PCMH with collaborative programs and service delivery in other areas. Among these, specific concern was raised about the level of services available for veterans, dually diagnosed individuals with mental health and alcohol and drug conditions, and children in the foster care system, as required under the State of California's *Katie A.* legal settlement of 2011, or their parents.

Recommendations

1-1. The PCMH Director and other PCMH leadership staff, as appropriate, should dedicate concerted attention to improving the working relationships with external stakeholders and leaders, particularly those within the criminal justice system, alcohol and drug, and social services. Relationships must be developed over time through trust building, honest dialogue, and reliable follow-through by PCMH on commitments.

1-2. PCMH should work with its criminal justice partners to identify the amount of clinical staff support (particularly those dually trained for mental health and alcohol/drug treatment) needed by the criminal justice system, and identify short-term and longer-term options for providing programmatic and/or financial support to deliver these clinical services. If the service is to be provided by PCMH, the existing Behavioral Health Therapist classification used by PCMH would be a relevant classification for this work. This classification emphasizes the ability to provide treatment for dually diagnosed persons and has been used interchangeably with the Mental Health Therapist in recruitments throughout 2014. In lieu of providing PCMH staff, PCMH could identify a level of financial support that could be directed to carrying out this work through a local contracting organization or under the authority of the appropriate agency within the criminal justice system.

FINDING #2: PCMH maintains a waiting list for services, which has been a long-standing practice. The presence of a waiting list indicates there is insufficient PCMH

clinical staffing or contracted service providers to perform key mental health service functions.

Discussion

In nearly every external key informant interview, the waiting list at PCMH was noted as being a significant problem. In a recently published final report by CaEQRO[1], an external review organization contracted by the State Department of Health Care Services to perform annual reviews of county mental health services, it was stated, "...timeliness for service initiation needs immediate improvement. The mental health department maintains a waitlist for intake assessments, and the waiting periods are not tracked. This practice puts consumers and the system at unnecessary risk."

Presumably, a waiting list would not be necessary if PCMH were staffed at a level sufficient to meet community needs. While difficult financial circumstances frequently put county agencies in the position of limiting services due to a lack of funding, this is not the underlying reason for a lack of sufficient staffing in PCMH. Financial resources are not a current problem, nor do financial limitations appear to have been a significant problem for the past couple of years. Instead, the following dynamics appear to have contributed to the current staffing arrangement and resulting waiting list.

A. PCMH clinical staff salaries are less than those of nearby counties and there is no obvious "career ladder" inside the department that encourages qualified licensed professional staff to stay with the department.

On a per capita basis, PCMH appears to be understaffed in comparison with other small county Mental Health Departments in California[2], and this understaffing hampers the ability of PCMH to meet community expectations about service delivery. The PCMH Director reported that past recruitments have been "underwhelming" and his assessment is that clinical positions go unfilled because of a low salary range. He suggested that the salary range should be benchmarked to the average of counties across the state, based on the argument that PCMH is competing with all other counties in California to attract qualified clinical staff. According to data provided by the Plumas County Human Resources (PCHR), over the last fifteen months of recruitment history, 20 qualified persons applied for either the Mental Health or Behavioral Health Therapist positions, were screened as meeting the minimum qualifications for the open

[1] The State Department of Health Care services monitors the performance of all mental health departments in California through a variety of mechanisms. One of the methods has relied on a contracted provider – APS Healthcare, an External Quality Review Organization (EQRO). Within the California EQRO (CaEQRO) annual review process, a variety of county matrices and data are compared, procedures are reviewed, and mental health staff, consumers and stakeholders are interviewed to validate the data and procedures with 'real world experience'. A draft report is produced and the County has the opportunity to provide additional information before the final report is issued. The most recent review was conducted on May 8, 2014 for the period ending June 30, 2013, and the final report was issued on July 29, 2014.

[2] Budgeted FTE for MH was compared for the four California counties closest in population to Plumas: Glenn, Colusa, Inyo and Mariposa.

job(s), and were referred to PCMH for interviews[3]. It is not clear from this data what job offers transpired with the applicants, the number of offers that were declined, or how many approved applicants accepted a position. On the surface, these data do not indicate a problem with staff recruitment. Further information about what happened with the 20 qualified applicants is needed to better understand why the positions could not be filled with these applicants and vacancies remained.

Three key informants for this review and the Plumas County Grand Jury, in a recent report, suggested that another approach to recruitment and retention would be appropriate. These informants and the Grand Jury suggested that PCMH should consider development of a Therapist III level, which would afford a longer and higher salary "career ladder" for journey level practitioners. This approach is also supported by other county departments, including PCHR, because the new classification would support the retention of journey level clinical staff and reward those who are the most productive and long-term assets of PCMH.

In addition, it would be possible to use this classification to support those clinicians that have developed the capacity to serve both the mental health and alcohol and drug related needs of clients. Further, PCMH could collaborate with other Plumas County departments that may be impacted by this action, such as Social Services and/or Alcohol and Drug, during the development stage to ensure their needs for a Behavioral Health Specialist III position are also met in the process.

Recommendations

2-1. Overall, PCMH staffing levels should be clearly linked to service need in the community, as evidenced by a "waiting list" and a community needs assessment or other similar data on local service needs. In consideration of this information, PCMH staffing levels should then be based upon standards for the volume of unduplicated clients that will be served and assumptions about billable claiming through Medi-Cal and other payers where appropriate. To substantiate the need for specific increases in staffing, PCMH should work to more effectively describe the components of projected need, current staffing, and increases needed to address unmet need.

2-2. PCMH needs to more clearly document current salary levels for licensed personnel and their impact on attracting a strong applicant pool. Toward this end, it would be appropriate for PCMH to compile a ten "comparable county" salary survey to determine the average salary and other compensation for clinical staff positions in the comparable counties. PCHR is supportive of this type of undertaking, and PCMH has already collected the information necessary for this analysis. Within this context, it may also be prudent for PCMH to compare its salary and other compensation with that of neighboring counties to determine how far apart salaries and other compensation may

[3] Data obtained from the PCHR of unduplicated applicants meeting the minimum qualifications for the classification of MH Therapist and/or BH Therapist. Recruitments were conducted from the period March 11, 2013 through June 5, 2014.

be with these nearby counties. Following completion of this analysis, the Board of Supervisors should consider salary range adjustments commensurate with the results. At the most basic level, if PCMH cannot recruit, hire and retain qualified staff, community services needs cannot be met.

2-3. In collaboration with PCHR, PCMH should develop a Behavioral Health Therapist III classification, and move existing staff into this classification as appropriate.

B. There is a heavy reliance on clinical interns, which have typically stayed long enough to complete their training and professional hours and then left for employment options in other counties, resulting in staff turnover and added workload for remaining staff.

Several key informants reported that interns – those that have met academic requirements but are lacking completion of supervised clinical hours – are the most common applicants in the PCMH recruitment pool. After being hired and completing their supervised hours, these interns have typically left the department for employment options outside of Plumas County.

Relying on interns to fill full-time clinical positions appears to be a long-standing PCMH practice. While interns may be preferable to having large unfilled gaps in services, and while interns may bring fresh perspectives, interns also require additional oversight and mentoring that reduces the time of other clinical staff in the department. When interns only stay long enough to fulfill their supervised clinical hour requirement, a churn of hiring, training and supervision then occurs, which is disruptive to the department and undermines continuity in the delivery of services to the community. In essence, this dynamic makes PCMH the training ground or development vehicle for new clinical graduates so that they can take their skills to other counties or providers after they have reached journey level competence. While the Grand Jury recommends in its recent report that interns be actively recruited from northern California universities, reliance on recruitment of interns without a retention strategy to keep these clinicians once they meet journey level competence, will address only the front end of the clinician staffing equation.

Recommendation

2-4. PCMH should consider both of the following approaches:

a. Creating a one-time licensure incentive payment or "licensing/certification bonus" to encourage interns to stay beyond the completion of their supervised clinical hour requirement for a specified period of time, with discretion to PCMH to not retain and reward less than productive/effective intern staff; and/or,
b. Providing for the reclassification of the employee's position upon completion of required clinical hours and licensure with a greater salary variation for licensed staff. A specific variation of "longevity pay" may be a useful means to meet this need.

C. Non-direct service responsibilities placed on clinical staff, along with other service demands, reduce available hours for the provision of direct client services.

From key informant interviews with PCMH employees and external representatives four additional factors were identified as reducing PCMH's ability to meet community service needs. First, the conversion to an electronic medical record (EMR) from a paper-based system has reduced available direct service time of clinical staff. Increasingly expected for providers across the healthcare delivery system, the implementation of electronic records has been challenging in many settings, including PCMH. The system chosen by PCMH, Anasazi, is common in California. Only one other system is more frequently utilized in county mental health departments in the state. However, as described by PCMH employees, activities that used to take an hour in the paper system now take 2-3 hours. This slow down in productivity has reduced the time available for direct patient services and reduced the level of service provided across the department.

Second, there is the appearance to some PCMH employees and external representatives of differences in productivity of PCMH clinical staff. "Productivity" in the mental health context is typically characterized by measurement of the number of billable hours a clinical staff person completes in a workday, proportional to the total paid workday hours. Certain variations, such as those in paid travel time, training, supervision, administrative workload, duty assignment, and paid leave time, are all appropriate and reasonable variables that are taken into consideration in applying a productivity standard to individual staff members. It was suggested by some key informants that development of productivity standards for PCMH would help equalize work output and bring lower performing staff members into compliance. The PCMH Director recently announced his intention to proceed with performance standards for clinical staff. However, the announcement was greeted with skepticism and concern from some PCMH clinical staff because they did not believe they had received a sufficient explanation concerning the use of the standards, variations in measurement and application, and the consequences of under-performance, as represented by the productivity standards.

Third, the availability of clinical staff for delivery of direct services has recently been reduced by personnel changes within PCMH. Specifically, the appointment of one clinician to serve as PCMH Director and the promotion of two clinicians to serve in Program Chief positions, have reduced the amount of total time available for direct service delivery. Departments must establish plans for the orderly succession of employees from the direct service level into management and have mechanisms in place to provide for the timely appointment of new staff to take on direct service responsibilities. It does not appear that PCMH has established such a plan, but instead moved positions into a new structure without a clearly defined service backfill strategy. Within this context, it must be noted that the recent resignation of one of the two Program Chiefs will result in a further diminishment of service capacity in the near term.

Finally, PCMH clinical staff has responsibility for providing crisis services on a rotating basis. Eight staff (now seven with a recent resignation) share the 24/7 "Clinician of the Day" (COD) responsibility. This responsibility is worked a week at a time with added on-call pay, with the

full COD responsibility necessary once every 8 weeks – for the full week. PCMH clinicians are generally expected to maintain their regular daytime responsibilities while carrying the COD responsibility. In some circumstances, this added responsibility may impact a clinician's delivery of direct services to other non-crisis clients when they are also serving as COD.

Recommendations

2-5. In order to better determine current clinician staffing levels and the "direct service time" available for delivery of mental health services by these clinicians, all of the following need to be documented: loss of clinician service hours due to EHR conversion and associated medical record documentation; estimated under-performance by staff and estimated loss of direct service hours; estimated loss of direct service hours resulting from the assignment of clinical staff to new administrative or supervisory duties; estimated loss of direct service hours attributed to recent clinical staff departures; and estimated impact on daily services hours associated with COD, if any.

2-6. Intensive additional training on Anasazi needs to be continued to develop competence. Clinicians that have difficulty with typing or with software navigation should be offered remediation, and/or voice to text software support to assist in meeting this need. Support staff that act as scribes could also help optimize clinical staffing availability.

2-7 Consideration of "productivity" standards should be deferred until PCMH staffing is stable, fully trained and competent in Anasazi. Individual staff persons with apparent under-performance, based on lower client service hours, should be advised regarding their subpar performance, monitored, and where necessary individual performance improvement plans with low producers should be implemented. Productivity standards should be implemented only after clinicians are afforded an opportunity to assist in the development of the methodology for productivity measurement and all staff subject to the standards have been fully trained and are clear about the implications of under performance.

2-8. At the time of this review, duty statements for the two new Program Chiefs had not been developed. Duty statements for both of these positions should be collaboratively developed to guide day-to-day responsibilities, and identify expected time to be dedicated to management duties and direct client services, if any.

2-9. With the input of clinical staff, the advantages and disadvantages of in-house COD responsibility should be reviewed. The review should include the number of calls in a week's time, the expectations for productive hours during the on-call week, and the perceived burden versus added clinical value for professional staff. If warranted, the PCMH should explore contracting some or all of the 24/7 COD responsibility to another entity in an effort to reduce this "extra" duty among existing professional staff.

D. There are very few, if any, non-county mental health service providers in the community that provide services under contract, which results in PCMH having to address all service needs with county-hired mental health staff.

The majority of mental health departments in California rely on external contactors to help meet the mental health treatment needs of their clients. The range of providers under contract in California includes private individual practitioners; provider groups with various clinical staff, including some with psychiatry; and, federally qualified health centers (FQHC) or rural health clinics (RHC) that have, or are able to expand to have, clinical mental health services incorporated into their service delivery systems. In addition, many county mental health departments in California are working diligently to improve their collaboration with physical healthcare service providers to meet mutual client needs. As a result, improvements in information sharing, cooperative or collaborative financing arrangements, and direct contracting have been occurring in many counties. Several key informants suggested that PCMH consider contracting with outside mental health providers to help expand the availability of treatment options for the patient population in Plumas County.

PCMH has a long history of emphasizing internal PCMH staff recruitment instead of seeking and/or developing external community resources. Adherence to this approach has perpetuated a dynamic where the only place to get mental health services in Plumas County is through PCMH. While this dynamic is more common in smaller county mental health departments that have access to fewer external contract options, the result is continued community dependence for services solely on the county mental health department.

Recommendations

2-10. PCMH should encourage the development of additional mental health resources through recruitment of external mental health providers to assist in meeting the community's needs and relieve the pressure on PCMH to address all mental health needs across the community.

2-11. PCMH should promote opportunities for community *medical* providers already serving seriously mentally ill clients to develop expanded mental health treatment capacity. For example, FQHC/RHC and other medical care providers should be encouraged to hire licensed mental health clinicians in their systems and PCMH should collaborate with them to recruit licensed professional staff to the community. PCMH should consider assisting this effort with MHSA resources as occurs in other north state jurisdictions.

2-12. PCMH should work to develop additional mental health provider resources in the community as a strategy in the upcoming three-year MHSA plan. This effort would help develop more mental health care options in the community and could contribute to the development of a "system of care" for those with less serious mental illness.

2-13. PCMH should work with Medi-Cal managed care health plans (Anthem Blue Cross and California Health and Wellness) to identify, secure, and support other Medi-Cal providers for non-serious mental health therapeutic and medication support services. Further, PCMH should contact all network providers with these plans to determine potential interest in contracting with PCMH to provide care to more seriously mentally ill Medi-Cal or other clients.

E. Other recruitment and retention issues hamper the ability of PCMH to quickly recruit, hire, train and bring onboard new mental health staff.

Several PCMH staff informants expressed concern about the current training allotment of $500/year. In consideration of the travel time and distance required to attend statewide or regional training, these informants suggested this level of support was insufficient. For licensed professionals that deliver services in more rural and remote areas, there is typically less regular interaction with teaching institutions or with mental health professionals in other areas to share best-practice models. Importantly, licensed clinical personnel must participate in continuing education to maintain their licensure. While completing these hours could be considered the responsibility of the employee, the benefit of continued training and continued licensure of clinical staff inevitably accrues to the department and is foundational to the department carrying out its service responsibilities. Supporting the clinical training and support needs of licensed personnel enhances the quality of the service provided by department staff, provides evidence to employees of the department's commitment to their professionalism, and may assist with clinician recruitment and retention.

Some PCMH and external key informants identified the process for filling vacant PCMH positions as one that adds time to periods of PCMH understaffing. It was reported that under existing practice each time a staff vacancy occurs PCMH must submit a request to the Board of Supervisors at a regular meeting of the Board to seek approval for recruitment and hiring. The necessity of this extra step is unclear. However, the impact of adding this step is that additional weeks may be added to the hiring process. For each day of understaffing, services are not provided to a range of clients, and "billable" reimbursements are not achieved. Such reimbursements support both the cost of the individual employees and a portion of department overhead.

Recommendations

2-14. PCMH should make every effort to support the appropriate training needs of staff through a stronger investment in training. One approach would be to increase the annual training allocation for clinical staff. A second approach would be to allow a rollover of training funds not used by a clinician in one year to be added to training funds in the following year. A third would be a combination of both approaches. Under the Workforce Education and Training (WET) component of the Mental Health Services Act (MHSA), there is funding to support professional and paraprofessionals working in public mental health service systems. PCMH has an opportunity to make a more robust

investment in training for clinicians using MHSA funds than the department has exercised in the past.

2-15. The Board of Supervisors should provide authorization to PCMH to proceed with recruitment of open positions already approved in the PCMH budget and allocated to PCMH without returning to the Board for individual position-by-position approval. As a part of this authority, the Board of Supervisors should require PCMH to periodically report on staff vacancies and associated recruitments.

2-16. The Board of Supervisors should routinely receive an update from PCMH on the status of any client waiting list, including the elimination of such a list or its reinstatement. Among other considerations, the Board should require that any proposal from PCMH about proposed staffing, including changes to the compensation for licensed personnel, be linked to addressing any waiting list and preventing a waiting list from being re-established.

FINDING #3: While significant Mental Health Services Act (MHSA) resources flow into Plumas County on a monthly basis, MHSA funded programs and services are limited.

Discussion

The Mental Health Services Act (MHSA) was passed by the voters of California in 2004 and levied a tax on millionaires to support and enhance the mental health care delivery system. With this additional funding came a number of new requirements and responsibilities for county mental health departments. One of the hallmarks of MHSA implementation is a well-defined and robust stakeholder process that must be followed before a local plan is submitted to the State. The requirement is intended to ensure that plans are responsive to local needs and service gaps, and inclusive of input from a broad range of constituents.

A. The MHSA annual update has not been completed for FY 2013/14 and the FY 2014/17 three-year plan due for the current period has not been initiated, nor has it been considered and approved by the Plumas County Mental Health Commission and the Board of Supervisors and submitted to the State's MHSA Oversight and Accountability Commission (MHSOAC).

While PCMH has not completed the required planning effort to submit its MHSA plan for the period that began July 1, 2014 and the annual update for the fiscal year period 2013/14 is yet to be completed, PCMH has continued to expend MHSA funds without approved plans in place. The county's performance agreement with the State Department of Health Care Services states:

> *"All expenditures for County mental health programs shall be consistent with an approved three year program and expenditure plan or annual update pursuant to W&I Section 5847."*

Further, Welfare and Institutions Code Section 5847 states:

> *"Each county mental health program shall prepare and submit a three-year program and expenditure plan, and annual updates, adopted by the county board of supervisors, to the Mental Health Services Oversight and Accountability Commission within 30 days after adoption."*

It is unclear if PCMH's MHSA expenditures are appropriate without the submission/approval of an annual update or three-year plan. Further, PCMH's continued delay in the initiation of a MHSA stakeholder process, and/or notification of the State and MHSOAC about the delay(s) and a timeline for expected completion, may jeopardize future distributions of Plumas's share of MHSA funds or cause their redistribution to other counties.

Recommendations

3-1. PCMH should immediately initiate a MHSA planning process that assures appropriate stakeholder involvement and public awareness. Toward this end, PCMH should contract with a MHSA plan expert to facilitate development of the MHSA Plan. Additionally, to enhance the local planning effort, PCMH could request the involvement of professional staff with the Plumas County Public Health Department that have expertise in community health planning and development of a needs-based plan. PCMH should establish a firm schedule for MHSA plan completion and assure the timeline is met.

3-2. PCMH should immediately notify the Mental Health Services Oversight and Accountability Commission and the State Department of Health Care Services, of PCMH's intention to initiate a MHSA planning process and the anticipated timing for completion. As a part of this notification, PCMH should request retroactive approval of its MHSA expenditures for FY 2013/14 and its expected expenditures for FY 2014/15 in anticipation of the completion of the MHSA Plan by a specified future date.

3-3. PCMH should request Board of Supervisors approval for establishment of a new position, MHSA Coordinator, and pending such approval, recruit for this position so that the individual can work alongside the MHSA consultant on the MHSA Plan. This will help build internal PCMH staff capacity for future MHSA planning and support the development of a local contact for MHSA efforts in the county that will grow with MHSA competence.

PCMH may want to consider a non-clinician for the role of MHSA Coordinator in order to avoid taking away current licensed professional hours from direct client services. While clinical staff may be preferable for some MHSA functions, many counties have assigned this work to health educators, service coordinators, and associate social workers. Regardless of the background of MHSA Coordinator, this PCMH staff person needs to be able to organize planning efforts, complete reports, facilitate groups, and collaborate

with internal clinical and fiscal staff, outside contractors, providers and external stakeholders to perform the many aspects of MHSA coordination on behalf of PCMH.

B. A significant MHSA fund balance exists that is greater than necessary to assure a "prudent and operating reserve" as described in statute. At the same time, gaps in mental health services delivery exist, as evidenced in part by a waiting list. Community stakeholders are frustrated.

Numerous key informants vocalized a greater need for services for specified populations, including those involved with the criminal justice system, veterans, and parents of children in the foster care system. Key informants associated with the criminal justice system pointed to a need for additional staffing for all of the following: conducting mental health assessments and providing additional services in the jail; developing a mental health court and/or incorporate mental health staffing in the drug court; and, participating in the alternative sentencing program. Resources to support the development of programming for these specialized population groups would be appropriate components of a future MHSA expenditure plan and could be incorporated through the MSHA Plan development process.

Recommendation

3-4. As a part of the overall MHSA planning effort, PCMH should work with its contracted fiscal consultant(s) to assist in the development of a plan for maintaining a prudent MHSA Reserve while dedicating surplus resources to meeting community needs. This Reserve should be realistic, and established within the context of an overall MHSA expenditure plan. Further, the multi-year reserve expenditure plan should allow for a distribution of resources so that programming and services can be maintained over a sustained period of time.

C. MHSA planning should include relevant longer-term issues that are expected to impact County based mental health services delivery in the future.

There are many "horizon" issues in the field of mental health and changes to health care delivery systems that should be considered as a part of future MHSA planning. Notably, the larger health care and mental health care delivery context has changed. Beginning in 2014, Medi-Cal was expanded to cover low-income adults, which include most of those formerly served by the County Medical Services Program (CMSP). With this expansion of Medi-Cal coverage, more individuals will be eligible for Medi-Cal and some of these may need and seek services from PCMH. Also beginning in 2014, Medi-Cal benefit coverage for mental health services was expanded and Medi-Cal health plans were delegated responsibility for providing these benefits. Under this expansion, services to address "mild to moderate" mental health conditions became the responsibility of Medi-Cal health plans while services to address "serious and persistent" mental health conditions was retained by counties. The two Medi-Cal health plans serving Medi-Cal members in Plumas County – Anthem Blue Cross and California Health and Wellness – have contracted with separate panels of mental health providers to deliver

these new mental health services. PCMH does not contract with either health plan to deliver these services to Plumas County Medi-Cal members.

In the near term, there are two areas of needed interaction and partnering between PCMH and the Medi-Cal health plans providing mental health services. The first is to develop and implement Memorandums of Understanding (MOU) with each health plan that assure appropriate interaction between each health plan and PCMH for Medi-Cal members served by both systems. These MOUs are essential to assuring appropriate continuity of care for individual Medi-Cal members and establishing a clear delineation of responsibilities by each health plan and PCMH.

Second, with the expanded role of Medi-Cal health plans for mental health benefit coverage, and the increasing recognition of the significant reduction in life expectancy for seriously mentally ill individuals, it is clear that there is a need for better overall coordination between mental health service providers and primary care practitioners. Accordingly, investments in strategies that enhance care coordination, including assisting willing primary care providers to develop greater capacity to serve seriously mentally ill individuals, will be needed going forward. Several provider key informants interviewed for this review expressed a desire to work collaboratively with the PCMH to develop strategies that enhance care coordination between the health care and mental health care provider systems.

Recommendation

3-5. MHSA deliberations and planning should include topics, like those identified above, so that strategic investments of MHSA resources can be considered with an eye toward developing a more coordinated delivery of care between the health and mental health service systems.

D. Despite receipt of significant MHSA resources over the past several years, no increase in the number of Plumas County residents receiving services has been achieved by PCMH. The annual unduplicated count of clients receiving services is down overall.

The number of unduplicated clients served during a year is one measure of mental health service delivery and access to mental health services. According to the most recent final CaEQRO report, there was a decline in the number of individual clients served within the five-year period from FY 2008/09 through FY 2012/13. During this time, PCMH experienced a 10% or greater decline in the total clients served in a year (a high of 367 clients served in FY 2009/10, with 320 clients served in FY 2012/13).

Another measure of mental health service delivery is the quantity of services provided to each client. While the PCMH served fewer persons in FY 2012/13 than in any of the previous four years, the number of services provided to each person (as evidenced by the Medi-Cal claims submitted) increased during the same time period. The approved claims-per-beneficiary was highest in FY 2012/13 and was roughly equivalent to the statewide average. Among small rural

counties, it was 33% higher than the average. Unfortunately, there appears to have been no utilization review or utilization management system in place that could provide data for PCMH to determine if a greater number of services were received by some individuals at the expense of serving a greater number of Plumas County residents.

From discussion with key informants and a review of the recent CaEQRO report, there appears to be a lack of necessary monitoring by PCMH of key data to help track system performance. Some of these data points could be considered "quality management" as they concern patient outcomes following treatment and would assist the county to make system or treatment improvements when trends are revealed. Other measurements would help the county mental health system determine if its overall service to the community is consistent over time or if changes are occurring in service demand or delivery. In general, PCMH appears to lack a systematic approach for utilization management. As a result, data is not collected and utilized by PCMH management to understand care delivery and make proactive changes.

It should be noted that despite a decline in the number of clients served within the five-year period between FY 2008/09 and 2012/13, PCMH ranked 10th among California counties in the proportion of unduplicated clients served. The measurement is called "penetration" and is calculated based on the number of Medi-Cal clients served divided by the total number of Medi-Cal eligible persons in the county. Additionally, PCMH's penetration rate for clients served was 13% higher than that of other small rural counties. It is also noteworthy to point out that significant improvements in penetration *have not* been achieved statewide with the passage of MHSA. Rather, as reflected in the PCMH CaEQRO report, statewide penetration fell by about 4% during the time period PCMH's penetration dropped by 20%.

Recommendation

3-6. PCMH should implement a system of "utilization management" to document service delivery and inform PCMH about service utilization trends, and use this information to inform changes in service delivery that will increase services to more eligible clients. This recommendation is consistent with the CaEQRO recommendation that the "beneficiary's level of care needs and corresponding service intensity should be consistently reviewed and a utilization management system developed."

FINDING #4: Fund Balance Reserves in PCMH exceed what is necessary based on historical expenditures and current projected expenditures and potential financial risk. At the same time, community members and stakeholders report waits for needed services.

Discussion

In nearly every key informant interview, the fund balance "reserve" held by the PCMH was raised. Having significant cash resources available to dedicate to meeting community needs puts PCMH in an enviable position, and one that is not shared by the majority of small county

mental health departments in California. While a measure of credit may be due to former administrators and fiscal officers with PCMH, the extent to which decisions were made to save resources in anticipation of potential future risk resulted in an emphasis on savings over service delivery. The current size of the fund balance, and the protection of it by PCMH, is generally viewed by key informants as a demonstration by PCMH that it is not committed to appropriately utilizing available taxpayer resources to meet the mental health needs of Plumas citizens.

Some of the fund balance reserve has been legitimately held for anticipated cost settlement payments for three years (FY 2009/10; FY 2010/11 and FY 2011/12) that will be due to the State for payments received in excess of cost. Additionally, the somewhat unpredictable costs associated with long-term or emergent care for a county resident placed outside of the county is another financial risk that could draw against reserves. Importantly, CaEQRO tracks the most expensive Medi-Cal clients in all counties and reports the data to assist counties in establishing appropriate levels of reserves. In addition, PCMH can draw upon actual cost experience over the past 3-4 years, and observe any significant trends in expenditures. The current fund balance retained by PCMH exceeds the projected potential expenditures by a significant margin and appears to be excessive.

Additionally, despite a million dollar set aside of the PCMH fund balance by the Board of Supervisors specifically for mental health services on behalf of criminal justice stakeholders, very limited amounts of those set aside funds have been utilized for that purpose, and at the current rate of expenditure, will take more than a decade to expend.

Recommendations

4-1. PCMH should work with its contracted fiscal consultants to develop a 5-year expenditure plan that links mental health service expansion to identified community mental health needs. This 5-year plan should also establish the methodology for determining the reserves that should be retained in anticipation of unforeseen financial obligations in each fiscal year. Toward this end, the methodology should include thorough estimates of the cost settlement payments likely to be due to the State; the maximum annual risk for unpredicted psychiatric hospitalization and long term care; the expected cost of care for the most expensive clients; and, the current and projected claiming and cost(s) to provide billable services. These areas of financial risk as well as any others recommended by the fiscal consultants, should be identified and quantified using actual experience from prior years. This approach would offer a planned, methodical strategy for expanding services in the community while at the same time assuring a reasonable, prudent reserve.

4-2. PCMH should link the 5-year expenditure plan to the MHSA expenditure plan to ensure services are funded from the most appropriate source, and any limitations in funding source, reserving, or loss of future allocation are minimized. PCMH should seek guidance from the MHSOAC or the State about the amount of MHSA fund reserve that

will need to be expended within the three year plan period, and if possible lengthen those expenditures to sync with the non-MHSA reserve five year reserve expenditure plan.

FINDING #5: Services to children are inconsistent, with some care above expected statewide service standards and other care below expected statewide service standards.

Discussion

Several key informants within PCMH and external stakeholders voiced concerns about aspects of the mental health care provided to children, or on behalf of children being served in the foster care system. Children's mental health care is different from that provided to adults, in that the services are provided under an entitlement in Medi-Cal for children under 21 years of age. For adults, the statute that governs mental health departments is characterized with the inclusion of an "as resources allow" clause. Children that meet the threshold of seriously emotionally disturbed (SED) are *entitled* to receive mental health care that is deemed necessary to support appropriate growth and development. MHSA Prevention and Early Intervention (MHSA – PEI) guidelines extend this eligibility, with greater emphasis on providing services to "at risk" children and their families to prevent the circumstances that can lead to mental impairment.

While several key informants suggested that the child population in Plumas County is down overall and most seriously mentally ill children are served in group homes out of the county, most key informants agreed that many children with mental health needs remain in Plumas County and that these needs could be better met through PCMH support.

The concerns of key informants fell into four areas: 1) Care to the very youngest residents is scarce or non-existent; 2) *Katie A.* implementation is not prioritized within PCMH; 3) parents of children in the foster care system, who are working against a very stringent federal time clock for family reunification efforts, cannot gain access to needed mental health services; and 4) high poverty areas of the county need more regular and consistent mental health presence, particularly for children.

A. Services to the very young (0-5 year old) population are insufficient to meet community need.

Several key informants noted the lack of services for very young children. Increasingly, research suggests that robust attention to families at-risk pays long-term dividends in child abuse reduction, improved child bonding and literacy, school readiness and a host of other measures. As a result, an emphasis on improved services for young families has emerged as a long-term prevention strategy among agencies across the nation. Plumas County Public Health Department and Plumas First Five, among others, are targeting efforts to this population. The FY 2013/14 CaEQRO report shows services to seven (7) individual 0-5 year olds, up from five (5) in the previous year. Despite the slight increase, PCMH lags behind both the state and small

counties in the proportion of young children served, and in the quantity of services provided to this young child population.

Recommendation

5-1. PCMH should engage with others in the community providing supportive services to 0-5 year olds, and seek to assign a portion of a clinician to support assessment and treatment of mental health needs of the at-risk population served. MHSA PEI funding could support this activity as an appropriate prevention effort. This strategy should be included in the upcoming three year MHSA expenditure plan.

B. Despite many years notice of pending settlement of a class action lawsuit, known as *Katie A.*, that would impact all California mental health departments, implementation by PCMH has been limited.

Both PCMH staff and external key informants, as well as the CaEQRO, noted concerns that PCMH has not proceeded with a plan to meet the required *Katie A.* settlement expectations and is far behind other California counties in making this population a priority for services. The *Katie A.* settlement mandates the provision of intensive in-home and community-based mental health services for California children who are in foster care or at imminent risk of removal from their families.

There is little evidence, other than billing codes included by the third party software vendor, that PCMH is ready to implement the *Katie A.* requirements. A very modest level of staff-to-staff interaction between PCMH and Plumas County Social Services (PCSS) and limited training have reportedly occurred, but a more thorough assessment of responsibilities, as well as protocols and procedures have yet to be realized. And with the recent resignation of the PCMH staff member with the most *Katie A.* knowledge, it will be additionally difficult to adhere to the requirements of this settlement. Key informants reported that there has been limited leadership support at PCMH for additional work to meet these obligations. Because the defined population for *Katie A.* services is also within the responsibility of PCSS, this matter presents another example where collaboration between PCMH and another county department is needed. In this area, development of an effective working relationship between PCMH and PCSS is essential to fulfilling the requirements of the *Katie A.* settlement and to protect and serve the affected children.

Recommendation

5-2. The PCMH Director should immediately engage the PCSS Director in discussions about the implementation of *Katie A.* In addition, a PCMH staff person should be designated to work collaboratively with assigned PCSS staff to ensure that protocols and agreements for children meeting *Katie A.* eligibility are promptly identified and services rendered by PCMH or through PCMH financial support.

C. Services to the parents of children placed in foster care are generally insufficient.

Both PCMH and external key informants noted particular concern about the lag in needed mental health services for parents of children placed in the foster care system, particularly the parents of very young children. By federal mandate, children under three years of age must be reunified with their parents or be freed for adoption or long-term placement in a very short time period. The timeline for older children is also strict, but it is longer and thereby easier to meet. While there is allowance for a one-time extension of the timeline, it remains imperative that parents of young foster children deemed to have mental health conditions that impact their ability to parent adequately, gain access to PCMH services at the soonest possible time. External key informants did not feel that PCMH staff fully appreciate the short timeframe for needed action, or if they do, do not prioritize these families for needed services. Importantly, MHSA-PEI funding could likely be utilized to meet this service need as these children and families are clearly enumerated priority populations within those resource guidelines.

Conversely, the CaEQRO describes good penetration of services provided to foster children by PCMH. According to CaEQRO, PCMH provided services to 64.58% of Plumas County's foster children in 2012. This placed PCMH in the top ten counties statewide. The small county average was 47.17%, and the statewide average was 53.34%. However, despite an upward trend from last year, PCMH provided a lower quantity of services per individual foster child when compared to other small counties or the statewide average for this population.

Recommendations

5-3. Work with the PCSS to develop protocols for prioritizing assessment and appropriate services for parents of children, particularly the youngest children, in the foster care system. Support efforts in the MHSA three year plan to identify and fund the service needs of this at-risk population.

5-4. Evaluate the quantity of services provided to the foster care child population for adequacy through the use of a licensed peer professional from another county.

D. Some geographic areas of Plumas County are in need of enhanced mental health services for youth.

While other areas of concern regarding children's services were vocalized by a variety of key informants, a spirited conversation at the County Mental Health Commission meeting on July 9, 2014 about high-risk youth needing services is worth noting.

In areas of the community where at-risk youth are concentrated due to poverty, drug use, criminal behavior or other parameters, mental health presence can be a very powerful and effective tool to allow youth, particularly vulnerable youth, to have an outlet for adult support, counseling and therapeutic services as appropriate. While it is not realistic that every suicidal or other volatile situation can be prevented, the regular presence and access to mental health

professionals can be an important support system for youth experiencing depression and other adjustment difficulties.

At this time, PCMH leadership has plans to develop permanent offices and "wellness centers" in four areas of the county. This is a laudable goal. However, it may not adequately meet the needs of certain children due to transportation and other challenges. Because of transportation challenges for children and youth, several north state counties utilize contracted mental health providers to embed mental health services in school sites.

In discussions with key informants, several raised the tragic and fairly recent suicide of a local teen. While there was no apparent intent to assign blame, there was noted concern about apparent insensitivity to the situation shown by some PCMH staff members. Importantly, the CaEQRO reported noted the absence of a "sentinel event' analysis and planning process by PCMH.

Overall, the concerns expressed by key informants about the aftermath of the tragedy were consistent with the general perspective that PCMH is not perceived as a committed collaborator. Even when the tragic event involved a mental health condition for which MHSA resources are specifically designed, PCMH did not rise to the occasion and improve their engagement with others impacted by the event. At least one key informant understood the inclusion of suicide prevention emphasis in MHSA funding expectations, and vocalized hope for more efforts in the future to help prevent future tragedies.

Recommendations

5-5. PCMH should evaluate existing services to high-risk population areas, particularly for youth. Even if/when full time "wellness centers" can be opened in four areas of the county, PCMH should consider supporting an enhancement of school-based services to better meet the needs of the youth/young adult population in these settings. Further, PCMH should evaluate the development of a 'Request for Information' with other northern California counties' organizational providers to determine if providing services in Plumas county school sites would be possible.

5-6. PCMH should develop a process for sentinel event analysis to determine needed system improvements and use the findings to inform department efforts to better serve and support the community, especially during times of community tragedy or stress.

FINDING #6: There is little evidence of a clear, effective and collaborative working relationship between PCMH and the Plumas County Alcohol and Drug Department to address the needs of dually diagnosed persons.

Discussion

Consistent among key informants, particularly those associated with the criminal justice system, was an expression of the important and unmet need to serve the dual mental health and alcohol and drug problems of Plumas residents more effectively. Because "dual diagnosis" is widely documented and occurs with significant frequency, it is evident to many that enhanced efforts are badly needed. The Plumas Grand Jury noted this finding in its report, and has formulated a recommendation for continued efforts to align services under a Behavioral Health model by the end of 2014. While a "drug court" does operate in Plumas County, key informants recommended that this court would be more effective if it also addressed populations with dual-diagnosis issues.

Many key informants also noted the unsettled history of the Plumas County Alcohol and Drug Department (PCAD) and its slow renewal into a viable service delivery organization. Despite this history and current reality, there was strong support reported for PCAD's current leadership and a strong sense of that Department's commitment to collaborating to meet the community's needs. The Plumas County Grand Jury formulated a series of recommendations for the Alcohol and Drug Department in its recent report.

Recommendations

6-1. A Memorandum of Understanding and protocols need to be developed between PCMH and PCAD for the appropriate treatment of those suffering with dual conditions.

6-2. PCMH should assign a staff member to regularly attend and provide services to drug court to meet the needs of patients with dual conditions. Further, PCMH should collaborate in efforts to consider the development of a mental health court, or to combine efforts with the existing drug court for a behavioral health court.

6-3. Plumas County should assess the opportunity for future integration of alcohol and drug treatment services with mental health services to enable maximum coordination and collaboration in the treatment of dual conditions. It should be noted that 45 of 58 California counties have moved in this direction and that the statewide associations that support county officials in these roles have now joined to form one organization, the County Behavioral Health Directors Association (CBHDA).

FINDING #7: A robust quality control/improvement system that promotes effective mental health care delivery by PCMH has not been a priority for many years. Further, baseline State-required performance improvement efforts that demonstrate a commitment to quality improvement are no longer completed, and there is no evidence of planning to restart these activities.

Discussion

There is an apparent lack of attention to quality of care monitoring through routine chart reviews, data collection, trend monitoring, protocol/procedure revision, and/or reporting. The lack of a utilization management system as noted earlier is but one example. The State requires all local mental health departments to develop two Performance Improvement Plans (PIP), one clinical in nature and one that is administrative. These PIP's are intended to support improvements in clinical services and in administrative systems to support the care received by clients.

Admittedly, the process of forming a PIP, testing the hypothesis, making a change, monitoring the change, etc. for small jurisdictions can be cumbersome. As a result, it is not uncommon for small counties to band together and collectively determine a common PIP and share the writing and development workload. PCMH used to participate in a small county group PIP, but that activity has dropped off and now PCMH is no longer conducting either a clinical or administrative PIP process. Numerous other examples of inattention to quality and systems improvement, that appear to date back several years, were also identified during this review.

The CaEQRO report presents this same conclusion in its FY 2013/14 final report on PCMH. According to CaEQRO, "Minimal data from the information system is utilized on an ongoing basis. Key performance indicators to be incorporated into the Anasazi (Electronic Health Record and billing software) system have yet to be identified." Additionally, the mental health department "does not have a clear system to evaluate and manage its capacity....." One PCMH staff key informant stated that the past PCMH attitude has been "if there isn't an immediate threat by the State to take back funds, there is little interest."

It is unknown if the failure to complete quality improvement PIPs or other quality improvement efforts over time will result in a loss of funding or some other action by the State. Regardless of that risk, the overriding objective of these activities is to promote the highest quality of care received by county residents.

Recommendation

7-1. Before the end of 2014, PCMH should prepare and adopt a multi-year quality improvement plan that is designed to correct major deficiencies in quality improvement functions and demonstrate a commitment to quality care. Random but systematic chart reviews, timeliness standards for performing initial assessments and entry into care, cultural competence for non-English speakers, a robust utilization management process, and formal PIP development, among other strategies, should be included.

FINDING #8: PCMH lacks a formal communications strategy and plan that clearly articulate its role and provides a vehicle for keeping Plumas County residents informed about the services available to them and/or their families.

Discussion

The community needs to understand PCMH's role in the provision of mental health services, particularly in light of the new expanded role for Medi-Cal health plans in the delivery of mental health services to address "mild to moderate" mental health conditions. In addition, concerted efforts are needed to de-stigmatize mental illness and educate the public about the importance of recognizing mental health conditions and seeking treatment. Further, specific types of community-based efforts are also appropriate, including suicide prevention. Many of these communication objectives could be funded from MHSA as they are an expected component of MHSA services. Persons needing access to care should have a clear understanding of how to get access to this care and the process for getting referred for treatment and actual receipt of treatment. PCMH also needs to share good news and positive outcomes associated with mental health service delivery, when appropriate, to validate that recovery is possible.

Recommendation

8-1. PCMH should consider establishing a part-time assignment that is dedicated to public communications. This assignment could be incorporated into the duties of the recommended new MHSA Coordinator, or it could be addressed through a contracted individual or organization. Initial efforts should focus on communicating positive messages of hope and recovery for those who suffer from mental illness, the MHSA stakeholder process, suicide prevention, and de-stigmatizing mental illness. As staffing levels within PCMH are brought to expected levels, messages about self-referral, expectations of the system, and success stories – particularly in collaborative efforts, would be appropriate communication messages.

It is important to note that a communications strategy, by itself, will not change perceptions about PCMH or its ability to effectively serve the community. This will be achieved through a range of positive actions by PCMH, many of which are recommended in this report. Without taking these other actions, PCMH will *not* improve its public image solely through a public communications strategy.

This recommendation is consistent with the Plumas County Grand Jury report which states: "...the Mental Health Department immediately launch a public relations campaign to repair its public image and increase its profile."

FINDING #9: Numerous required program applications/plans, reporting, procedural, and evaluation activities are not being performed by PCMH, or are being performed substantially after the expected deadline(s).

Discussion

Several areas of inadequate initiation and/or lack of completion of required County mental health service delivery components have been identified through this review. In addition, the CaEQRO noted a number of areas of concern in their final FY 2013/14 report. While many of the delayed or absent responsibilities could be considered administrative in nature, like the failure to submit the required annual update and expenditure report for MHSA, or the new three year plan, others reflect a more fundamental lack of organizational support for quality improvement aspects of the delivery system.

The loss of two key administrative staff over the past 12-18 months has had a significant negative impact on the completion of necessary applications and other reporting functions that have an impact on department financing. Among applications and reports not completed is a SAMHSA grant application to fund the drop-in center, and as noted earlier the MHSA annual update and expenditure report for FY 2013/14, and the three-year plan for FY 2014-17. All have been delayed or not completed and each could have serious financial implications for PCMH if not finished and submitted to the appropriate third parties.

Recommendation

9-1. PCMH should establish or repurpose a current administrative position to assist in the completion of required reports, funding applications, and other essential documents. PCMH should work with the PCHR to determine the appropriate classification and fill the position as soon as possible. It is essential for PCMH to rebuild the capacity for these administrative support functions. Even if the PCMH Director were to assume some of these administrative responsibilities, it is critical to the long-term stability of the organization that a second person in the organization understands their importance, completion, and is charged with carrying out these responsibilities.

FINDING #10: The Mental Health Commission's organizational structure, procedural compliance, and organizational leadership need to be assessed.

Discussion

Several key informants noted concerns with the operation of the Mental Health Commission (MHC) in meeting statutory and MHSA review and oversight obligations. This consultant found credence in these concerns through observation of the July 9, 2014 MHC meeting and review of the Commission agenda and minutes provided. The concerns include the following: 1) Brown Act open meeting requirements, such a agenda posting, are not routinely followed; 2) The MHC membership is larger than statutorily required, particularly in small California counties, and this impacts the MHC's ability to regularly achieve a quorum; 3) There is at least the appearance of a potential conflict for the individual serving as MHC Chair because he also serves at the Patient Advocate; 4) MHC agendas do not clearly stipulate anticipated action, nor do they indicate a member of the public's right to speak at the meeting; 5) Annual reporting

and other responsibilities to the Board of Supervisors have reportedly not occurred for some years; 6) transportation or child care reimbursement for Commission members to participate in MHC activities is not evident, despite statutory allowance[4]; 7) PCMH support for routine aspects of MHC business such as minute taking, agenda posting and distribution, etc. is not evident.

The statutory expectations of MHC's are high (see Appendix #3) and some may be unrealistic without allocating significant resources to support their functions. To be most effective, MHC's need to review systems and outcomes, identify mental health service gaps, and provide public opportunities for families, consumer representatives and others to have a forum for discussion of mental health care and involvement in the MHSA planning process. Setting annual goals, and performing the requisite approval of MHSA expenditure plans after conducting the required public hearing process, would be effective ways to sharpen the focus of the MHC to address top priority issues and concerns.

Recommendations

10-1. PCMH should seek the support of the California Institute of Mental Health to review the organizational function of the MHC and provide training to Commission members.

10-2. PCMH should consider providing support to the MHC through an outside contractor. This support could be responsible for agenda distribution and posting, minute taking, materials distribution, including distribution to members who miss a meeting, orientation and background material development, and completion of a draft annual report to the Plumas County Board of Supervisors, etc.

10-3. PCMH should establish an agenda setting meeting between the MHC officers and the PCMH Director two weeks in advance of scheduled meetings. PCMH should be prepared to assist in supporting the desired activities of the MHC (prepare reports or background information) for review and discussion at the upcoming MHC meeting.

10-4. PCMH should work with Plumas County Counsel and a by-law review committee of the MHC to determine if MHC by-law revisions are warranted. Particular attention should be given to the following topics: relieving members of service after unexcused vacancies; term limits for members or officers; size of Commission; and, MHSA responsibilities of the MHC.

10-5. PCMH should consult with the State Office of the Patient Advocate to determine if a conflict of interest exists for the current Chair of the Commission, who also serves as the

[4] California Welfare and Institutions Code Section 5604.3. "The board of supervisors may pay from any available funds the actual and necessary expenses of the members of the mental health board of a community mental health service incurred incident to the performance of their official duties and functions. The expenses may include travel, lodging, child care, and meals for the members of an advisory board while on official business as approved by the director of the local mental health program."

Patient Advocate. Further, PCMH should consider contracting with an independent person or agency to serve as the Patient Advocate and widely publicize the availability of these services to clients and their families.

FINDING #11: There is a lack of clarity among community emergency service providers about PCMH's role and responsibilities during emergent psychiatric situations.

Discussion

The relationship and expectations of emergency service providers and PCMH appears mixed. In the case of one hospital representative, the relationship and mutual expectations were seemingly well understood and the relationship with PCMH was described as good. Despite some very long emergency room stays for those waiting for psychiatric bed placement, there was an expressed empathy for the reality of PCMH's situation in finding an available facility to treat Plumas residents. There was, however, a vocalized need for assistance in some late hour shifts, when very few staff are available hospital-wide, and a volatile person who may exhibiting psychotic behavior, appears in the emergency room.

In other cases however, the roles and responsibilities of PCMH and the seeming inconsistency in response were of concern. In several key informant interviews the difficult and tragic events in a Portola hospital were repeated as an example of inconsistent response from PCMH. One key informant stated, "In some cases PCMH will show up and help deal with the psychotic individual. In other cases, it seems they can't or won't come." This key informant went on to say that it seemed the response was more dependent on which PCMH staff person was on duty at the time of the call, rather than a protocol for this function.

Other key informants spoke to a seeming initial lack of interest from PCMH in working collaboratively on a "Crisis Intervention Training" for local law enforcement. At the time of this writing it appears that PCMH has begun to engage in that effort.

Recommendations

11-1. PCMH should actively work to develop an MOU with local emergency rooms, law enforcement, Alcohol and Drug services and other emergency facilities and personnel to ensure a clear delineation of roles and expectations in crisis or emergent psychiatric situations, or those appearing to be emergent psychiatric situations. PCMH should seek the advice of the County Supervisors Association of California Excess Insurance Authority attorney with this expertise and may want to invite this attorney to Plumas County to help clarify areas of potential dispute. All PCMH staff or contract providers should be trained in the provisions of the MOU to improve consistency in PCMH response.

11-2. PCMH should develop an "After Action" review or "sentinel event" process and/or actively participate in both internal and inter-agency efforts to improve cooperation,

collaboration and protocol/procedure development following a significant community event that has a mental health component.

11-3. PCMH should actively participate in and support efforts for Crisis Intervention Training for local law enforcement officials, and others that play a role in crisis response.

11-4. PCMH should ensure annual training and documentation for all designated 5150 authorized staff to further emphasize and clarify responsibilities, refresh MOU responsibilities, and identify and problem-solve concerns.

FINDING #12: As a first-time Director with limited prior management experience, the PCMH Director faces a learning curve in all of the following areas: program administration and management, finance, leadership and training of staff, community relations, and interagency collaboration.

Discussion

There is little doubt that leading a County mental health department in California, particularly in a small rural county, can be a unique challenge. Mental health departments serve a difficult and sometimes unpredictable population with serious and challenging illnesses. Many factors – many of them external to Plumas County – are driving changes to the health care and mental health care systems. Small counties in particular are challenged to run a mental health managed care delivery system for a relatively small client population, where the opportunity to spread administrative and oversight responsibilities across dozens of staff does not exist. Finally, the regulatory, reporting and audit expectations of a mental health department in California could intimidate the hardiest health care administrator.

The current PCMH Director is the fourth Director in about a two-year period, and it's clear the broader stakeholder community and PCMH have not recovered from the succession of directors. Much of the institutional knowledge in PCMH has been lost. Many key informants interviewed for this review described their problems with PCMH as problems of long-standing. "It's the way they have always done business. Saying 'no' is what they have always done," said one informant, echoing the sentiment of many others. This poor relationship went back to the longest of the four former directors, and that perspective was reported by most key informants to have carried over to the newest Director.

While key informants generally wished the new PCMH Director success with his efforts, most were skeptical about their future relationship with him and PCMH staff. While many suggested he was an effective clinician, they were less optimistic he would bring the collaborative attitude, temperament, and attention to administration needed to work effectively in the community with others. The fact that he had been an employee inside a department long regarded as not collaborative in working jointly with others in the community raised their skepticism that he could or would be different. Several referenced various interactions with

the Director or PCMH in the prior months that indicated a continuing defensiveness and a lack of willingness to collaborate and partner.

It is a major change to move from serving in a clinician role as a peer with other staff to the top administrator that is called upon to make policy and program decisions affecting department operations and the day-to-day activities of former peers. It is also a major change to move from providing direct client services to overseeing program planning and development, budget preparation, staff supervision and oversight, and effectively carry out public responsibilities to the Board of Supervisors, other county leaders and stakeholders, and the community. In all of these areas, the new Director faces a learning curve. His success will depend upon demonstrating a blend of leadership, technical skill, resilience, and equanimity.

Recommendations

12-1. The PCMH Director should seek the support of other California Mental Health Directors, including a contractual relationship with some Emeritus Director(s) for support in carrying out his role as PCMH Director. Further, the PCMH Director should enroll in the California Institute for Mental Health's leadership institute at the next opportunity.

12-2. The PCMH Director should demonstrate his commitment to improving collaboration with the internal PCMH staff and with community leaders and other County officials. He has the opportunity to "model" what it means to collaborate for his department and set the expectation for his staff. Reliable and consistent follow-through on agreements and decisions will also be necessary for PCMH staff and external stakeholders to gain confidence that PCMH is ready for a new paradigm of collaborative community service.

12-3. The Board of Supervisors should routinely and consistently request feedback from the PCMH Director and others to ensure the improvements and recommendations described in this report are occurring. The responsibilities of a California Mental Health Director are listed in Appendix #5. The specific areas for oversight of the recommendations contained in this report are included in Appendix #6.

FINDING #13: Some external stakeholders support consideration by the Board of Supervisors of a combined health and human services delivery system as a means to more effectively serve clients, many of whom interact with various different departments.

Discussion

In the scope of this work, Kemper Consulting Group was not engaged by the Board of Supervisors to investigate options for formation of an integrated health and human services department. Notwithstanding this, several key informants interviewed for this review introduced the concept of an integrated health and human services department during their interviews. These informants identified seeing a more collaborative working relationship

between other health and human service departments in the county than has existed with PCMH and suggested an integrated department offered the opportunity to maximize collaboration through integrated health and human service delivery for clients.

Integrated health and human services departments are a growing phenomenon in California, particularly for mid-size and smaller counties that seek improved economies of scale, elimination of administrative duplication, and integrated services planning. More than 25 California counties now arrange their public health, mental health, alcohol and drug, veteran's services, public guardian, community action, and/or social services departments into various integrated and consolidated combinations to help achieve these goals.

Recommendation

13-1. The Plumas County Board of Supervisors should consider evaluating the benefits and challenges of establishing a health and human service department at some point in the future.

Appendix #1
Key Informants

Bill Abramson, Plumas County Public Defender (contractor)
Joe Edwards, California Highway Patrol Plumas Commander
Michael Gunter, Plumas County Mental Health Department QI/QC Manager
Mimi Hall, Plumas County Health Department Director
Greg Hagwood, Plumas County Sheriff
Bianca Harrison, Plumas County Assistant Auditor/Controller
Shannon Harston, Plumas County Mental Health Department Program Chief (children's)
David Hollister, Plumas County District Attorney
Ira Kaufmann, Plumas County Presiding Judge
Jon Kennedy, Plumas County Board of Supervisors
Peter Livingston, Plumas County Mental Health Director
Jacque Martinez-Blanton, Plumas County Mental Health Department Sierra House/Continuing Care Coordinator
Dan Prince, Acting Chief Probation Officer
Bill Prouty, Plumas County Public Defender (contractor)
Monica Richardson, Plumas County Mental Health Department Chief Fiscal Officer
Mark Satterfield, M.D., Plumas District Hospital (recent past) Emergency Room Director and Board member
Pam Schaffer, LCSW, Plumas County Mental Health Department Program Chief (adult)
Lori Simpson, Plumas County Board of Supervisors
Elliott Smart, Plumas County Social Services Director
Sharon Sousa, Plumas County Mental Health Department Shop Steward
Louise Steenkamp, Plumas County Alcohol and Drug Director
Ellen Vieira, Plumas County First Five Commission, Executive Director
Robert Zernich, Plumas County Public Defender (contractor)

Other Contacts, Activities and Acknowledgements

Discussion with Gayla Trumbo, Plumas County Human Resources Director
Attendance at Mental Health Commission Regular Meeting on July 9, 2014

Kemper Consulting Group gratefully acknowledges the support of Nancy Da Forno, Plumas County Clerk of the Board of Supervisors, for assisting in scheduling key informant interviews, allowing use of work space, and assisting in the location of key documents.

Appendix #2
Documents Reviewed

APS External Quality Review Organization final report for FY 2013/14 dated 7/29/14, and the final report from FY 2012/13

FY 2013/14 Budgets
- MHSA - Community Services and Supports
- MHSA – Workforce Education and Training
- MHSA – Prevention and Early Intervention
- MHSA - Information Technology
- Criminal Justice Set Aside
- General PCMH Budget
- Sierra House
- CalWORKS

PCMH Program Adjustments Overview – 2014
Plumas County Grand Jury FY 2013/14 Final Report
Various Board Request Items (heard/acted by the BOS, and others prepared but not acted upon)
- Geiss Consulting
- Gary Ernst professional services
- Salary Adjustment for Therapists and Psychiatric Nurses
- Salary Premium for BH Therapists
- Allocation Increases for Core MH Services, Criminal Justice, MHSA, Psychiatric Nursing
- Permission to create new job descriptions for MHSA Coordinator and MH Regional Lead Therapist

PCMH Organizational Charts
PCMH California 58 County Salary Survey Results
PCMH Clinical Recruitments for the period 2013-2014
Plumas County Mental Health Commission
- By-laws approved by Plumas County BOS May 13, 2014
- Agenda for July 9, 2014 and August 13, 2014 Meetings
- Minutes for June 11, 2014, July 9, 2014 and August 13, 2014 Meetings

California Welfare and Institutions Code Sections 5607 and 5608: MH Director Requirements and Duties; Code Section 5604: Local Mental Health Board; and Code Section 5848: Oversight of MHSA Planning by the Local Mental Health Board (Appendices #3-5)
Various e-mail correspondence from/to Peter Livingston

Appendix #3
California Welfare and Institutions Code
Local Mental Health Boards

5604. (a) (1) Each community mental health service shall have a mental health board consisting of 10 to 15 members, depending on the preference of the county, appointed by the governing body, except that boards in counties with a population of less than 80,000 may have a minimum of five members. One member of the board shall be a member of the local governing body. Any county with more than five supervisors shall have at least the same number of members as the size of its board of supervisors. Nothing in this section shall be construed to limit the ability of the governing body to increase the number of members above 15. Local mental health boards may recommend appointees to the county supervisors. Counties are encouraged to appoint individuals who have experience and knowledge of the mental health system. The board membership should reflect the ethnic diversity of the client population in the county.

(2) Fifty percent of the board membership shall be consumers or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services. At least 20 percent of the total membership shall be consumers, and at least 20 percent shall be families of consumers.

(3) (A) In counties under 80,000 population, at least one member shall be a consumer, and at least one member shall be a parent, spouse, sibling, or adult child of a consumer, who is receiving, or has received, mental health services.

(B) Notwithstanding subparagraph (A), a board in a county with a population under 80,000 that elects to have the board exceed the five-member minimum permitted under paragraph (1) shall be required to comply with paragraph (2).

(b) The term of each member of the board shall be for three years. The governing body shall equitably stagger the appointments so that approximately one-third of the appointments expire in each year.

(c) If two or more local agencies jointly establish a community mental health service under Article 1 (commencing with Section 6500) of Chapter 5 of Division 7 of Title 1 of the Government Code, the mental health board for the community mental health service shall consist of an additional two members for each additional agency, one of who shall be a consumer or a parent, spouse, sibling, or adult child of a consumer who has received mental health services.

(d) No member of the board or his or her spouse shall be a full-time or part-time county employee of a county mental health service, an employee of the State Department of Health Care Services, or an employee of, or a paid member of the governing body of, a mental health contract agency.

(e) Members of the board shall abstain from voting on any issue in which the member has a financial interest as defined in Section 87103 of the Government Code.

(f) If it is not possible to secure membership as specified from among persons who reside in the county, the governing body may substitute representatives of the public interest in mental health who are not full-time or part-time employees of the county mental health service, the State Department of Health Care Services, or on the staff of, or a paid member of the governing body of, a mental health contract agency.

(g) The mental health board may be established as an advisory board or a commission, depending on the preference of the county.

5604.1. Local mental health advisory boards shall be subject to the provisions of Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code, relating to meetings of local agencies.

5604.2. (a) The local mental health board shall do all of the following:

(1) Review and evaluate the community's mental health needs, services, facilities, and special problems.

(2) Review any county agreements entered into pursuant to Section 5650.

(3) Advise the governing body and the local mental health director as to any aspect of the local mental health program.

(4) Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.

(5) Submit an annual report to the governing body on the needs and performance of the county's mental health system.

(6) Review and make recommendations on applicants for the appointment of a local director of mental health services. The board shall be included in the selection process prior to the vote of the governing body.

(7) Review and comment on the county's performance outcome data and communicate its findings to the California Mental Health Planning Council.

(8) Nothing in this part shall be construed to limit the ability of the governing body to transfer additional duties or authority to a mental health board.

(b) It is the intent of the Legislature that, as part of its duties pursuant to subdivision (a), the board shall assess the impact of the realignment of services from the state to the county, on services delivered to clients and on the local community.

5604.3. The board of supervisors may pay from any available funds the actual and necessary expenses of the members of the mental health board of a community mental health service incurred incident to the performance of their official duties and functions. The expenses may include travel, lodging, childcare, and meals for the members of an advisory board while on official business as approved by the director of the local mental health program.

5604.5. The local mental health board shall develop bylaws to be approved by the governing body, which shall:

(a) Establish the specific number of members on the mental health board, consistent with subdivision (a) of Section 5604.

(b) Ensure that the composition of the mental health board represents the demographics of the county as a whole, to the extent feasible.

(c) Establish that a quorum be one person more than one-half of the appointed members.

(d) Establish that the chairperson of the mental health board be in consultation with the local mental health director.

(e) Establish that there may be an executive committee of the mental health board.

Appendix #4
California Welfare and Institutions Code
Mental Health Services Act Planning and Local Mental Health Board Oversight

5848. (a) Each three-year program and expenditure plan and update shall be developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans.

(b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft three-year program and expenditure plan and annual updates at the close of the 30-day comment period required by subdivision (a). Each adopted three-year program and expenditure plan and update shall include any substantive written recommendations for revisions. The adopted three-year program and expenditure plan or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the county mental health department for revisions.

Appendix #5
California Welfare and Institutions Code
Duties of a Local Mental Health Director

5607. The local mental health services shall be administered by a local director of mental health services to be appointed by the governing body. He or she shall meet such standards of training and experience as the State Department of Health Care Services, by regulation, shall require. Applicants for these positions need not be residents of the city, county, or state, and may be employed on a full or part-time basis. If a county is unable to secure the services of a person who meets the standards of the State Department of Health Care Services, the county may select an alternate administrator.

5608. The local director of mental health services shall have the following powers and duties:

(a) Serve as chief executive officer of the community mental health service responsible to the governing body through administrative channels designated by the governing body.

(b) Exercise general supervision over mental health services provided under this part.

(c) Recommend to the governing body, after consultation with the advisory board, the provision of services, establishment of facilities, contracting for services or facilities and other matters necessary or desirable in accomplishing the purposes of this division.

(d) Submit an annual report to the governing body reporting all activities of the program, including a financial accounting of expenditures and a forecast of anticipated needs for the ensuing year.

(e) Carry on studies appropriate for the discharge of his or her duties, including the control and prevention of mental disorders.

(f) Possess authority to enter into negotiations for contracts or agreements for the purpose of providing mental health services in the county.

Item	Appendix #6 Summary of Report Recommendations	PCMH	BOS
1-1	Key community and County leaders note improvements in PCMH collaboration.		X
1-2	Assignment/recruitment of staff to the criminal justice system, and on-going use of fund reserve for this purpose.	X	X
2-1	Standardized reporting format for linkage of staff FTE to service levels, and quantification of areas of challenge (EHR, caseloads, productivity, new responsibilities).	X	
2-2	Results of 10 county/nearby salary comparison, and resultant salary increase request.	X	
2-3	Request for a Behavioral Health Therapist III, and the reclassification/promotion of existing PCMH staff who meet the qualifications.	X	
2-4	Request for licensure bonus or other means to maintain interns past their required supervised hour completion.	X	
2-5	Quantification of direct service time available for clinical services provision.	X	
2-6	Report on completion of Anasazi training and support for those staff unable to make improvements in EHR conversion.	X	
2-8	Formalized duty assignments for Program Chiefs.	X	
2-9	Summary of in-house COD advantages/disadvantages and resultant decision about a potential contract.	X	
2-10	Progress in contracting for services with external providers.	X	X
2-11	Plans/progress in developing capacity among medical providers to meet MH needs.	X	
2-12	Inclusion of mental health provider enhancement in three year MHSA plan.	X	X
2-13	List of mental health providers authorized in the managed care system, and the results of contacts with those providers.	X	
2-14	Internal PCMH policy for training budget to include allowance for 2- year accumulated expenditure.	X	
2-15	BOS to consider pre-approval for filling open but allocated PCMH positions.		X
2-16	Status of the department's waiting list.	X	X
3-1, 3-3	Initiation of MHSA planning process, including contractor, and request for an internal MHSA coordinator position.	X	X
3-2	Result of letter to State about expended MHSA funds without plan approval.	X	X
3-4	Multi-year MHSA reserve expenditure plan completed.	X	X
3-5	MHSA plan includes efforts to expand care integration, and develop additional MH providers within in Plumas County.	X	X
3-6	Reported numbers of unduplicated clients is increasing, and utilization management process developed.	X	X
4-1	Multi-year general MH fund balance reserve expenditure plan is completed.	X	X
4-2	Multi-year MHSA expenditure plan and MH reserve plans are linked.	X	X
5-1	MHSA plan includes clinician staff for enhanced services to 0-5 year olds and veterans.	X	X
5-2	Protocols/procedures and MOU's are developed for Katie A. implementation.	X	
5-3	Protocol/procedures for prioritization of parents in the foster care system is developed and stakeholders perceive improvement.	X	
5-4	Peer review of services provided to foster children is complete.	X	
5-5	Expansion of services to areas where high-risk youth reside, or the MHSA plan includes this expansion.	X	X
5-6	Sentinel event analysis process is developed and practiced.	X	
6-1	MOU developed between PCMH and PCAD.	X	X
6-2	Regular assignment of staff to drug court.	X	
6-3	Plumas County should assess the integration of Mental Health and Alcohol and Drug Services.		X
7-1	Multi-year quality improvement plan developed and resources assigned.	X	
8-1	Communications staff is deployed and PCMH community messaging is occurring.	X	X
9-1	Request for additional PCMH administrative support staff.	X	
10-1-5	MH Commission improvements are evident, including potential contract provider.	X	
10-5	Report on role of Patient Advocate, and potential contract provider.	X	
11-1	MOU for emergency psychiatric services is developed and roles and expectations are clear to community stakeholders.	X	
11-3	PCMH participates and actively supports CIT training.	X	
11-4	Annual 5150 training is completed and staff has demonstrated competence in role.	X	
12-1	PCMH evaluates MH Director Emeritus contract or enrolls in CIMH Leadership Institute.	X	
13-1	BOS to consider study of Health and Human Services formation.		X

PLUMAS COUNTY MENTAL HEALTH

3A

Peter Livingston, LCSW, Director
270 County Hospital Road, Suite 109 Quincy, CA 95971
(530) 283-6307 FAX (530) 283-6045
plivingston@kingsview.org

MEMO

DATE: SEPTEMBER 22, 2014

TO: HONORABLE BOARD OF SUPERVISORS

FROM: PETER LIVINGSTON, LCSW, DIRECTOR PML

SUBJECT: AGENDA ITEM FOR BOARD MEETING OF SEPTEMBER 30, 2014

REGARDING: DIRECTOR'S RESPONSE TO KEMPER CONSULTING REPORT

IT IS RECOMMENDED THAT THE BOARD OF SUPERVISORS: Receive and accept the Director's response to the report issued by Kemper Consulting regarding the organizational review of Plumas County Mental Health.

GENERAL COMMENTS: The Kemper report identifies many areas that are in need of improvement by the Department. It appears that Kemper Consulting has recorded most of the concerns and complaints about PCMH which have been in the public purview. In addition, some new considerations have been offered. While the Department (and others) take exception to some of the information included in the report for a number of reasons (i.e. inaccurate, partially accurate, lack of specificity, already outdated, anecdotal bias, etc.), there are nonetheless ample observations that will aid in strengthening the Department. The Kemper report does accurately identify a number of areas in which deficiencies exist, and for which corrective actions are needed.

As the report states, the "findings and recommendations are focused on needed improvements...". It is unfortunate that many existing strengths and recent efforts to stabilize the Department are not addressed in a more evident manner. The Department has many dedicated and hard-working staff members, both clinical and administrative, who provide good services to hundreds of existing clients. In addition, crisis services are provided to community members week-in-and-week out, 24 hours a day. Finally, some client-family-and-peer members of the community have expressed concern that their stakeholder constituency was under-represented in the review process.

The 13 Findings and 51 Recommendations offered in the report provide an abundance of information and identify scores of topics for discussion and consideration; more than can easily be addressed in a response. Some of the information offered in the report has already provided an impetus for change. For the purpose of this response, each of the Findings will be addressed in a global manner. The Department is prepared to review the details of the report with external entities, and data is already being utilized as a means of prompting internal change.

There are a number of recurring themes that appear throughout the report. These include: a lack of services; an overabundance of financial resources that have not been adequately deployed in the community; and a lack of collaboration. The Department agrees that these themes are valid. However, the themes are not consistent with the intent of the current administration. A number of crucial changes will enable many of the concerns and complaints to be addressed in a manner that will yield positive results and will be noticeable to the Board of Supervisors, other governmental departments and entities, peer and family stakeholders, local agencies and nonprofits, and the community in general.

The Department suggests that such progress can be made by addressing a few core areas. More staff members are needed in order to provide the desired levels of service. To use a football analogy, PCMH is playing with only half of a team on the field when it comes to therapists. This simple fact explains most of the complaints about lack of services. There are currently 3 allocated and funded therapist positions that are vacant. An additional three therapist positions are needed, along with more case managers who provide supportive services. The Department is dependent upon the Board of Supervisors to authorize this change and has been ready to present a request for additional staff since May of 2014.

Another simple fact: PCMH has experienced chronic difficulties in recruiting and retention of licensed staff. It is believed that the single largest contributor to this obstacle is that the Department pays its licensed therapist staff lower than 54 other counties in the state. A competitive salary should remedy that deficiency and provide the means required to attract needed clinical staff. Multiple requests for a salary adjustment have been made to the Board over recent years. The Board of Supervisors holds the authority to remedy this problem.

PCMH also needs to create a 3-Year MHSA plan. The Department is in the process of doing so. The process will include a "meaningful stakeholder involvement," as is required by law, and which is consistent with a core value of the Director – i.e. grass-roots stakeholder involvement. The MHSA planning process will unleash a substantial amount of funds that have accumulated over previous years. MHSA funds need to be expended for the benefit of the community, and will need to be achieved in conjunction with local resources and service providers. Coincidental with the MHSA process, attention will be given to issues of compliance, fiscal accountability, and quality assurance and improvement.

PCMH has survived many years of instability. If the Department is provided with the support that is needed, continuing efforts to rebuild, adjust, expand, and improve the Department will be noticeable to all, clients and partners alike.

FINDING #1: Most community stakeholders perceive PCMH to be insular, defensive, and lacking a collaborative orientation.

The current administration wishes to alter this long-standing perception amongst stakeholders. The Department has taken steps towards improving collaboration, and has emphasized the nature of "true collaboration" – i.e. working with partners in a mutual manner for the benefit of clients and community. Many stakeholders may not yet perceive this shift due to the fact that no additional services have been provided. The Department holds the potential to unleash additional services for the community, but needs Board action to do so. Until that potential is unleashed, the inability to provide needed services will undoubtedly be perceived as an unwillingness to collaborate.

Finding #2: PCMH maintains a waiting list for services, which has been a long-standing practice. The presence of a waiting list indicates there is insufficient PCMH clinical staffing or contracted service provider to perform key mental health service functions.

Allocation of additional clinical staff positions by the Board of Supervisors, and the establishment of competitive salaries for licensed staff (which will enable the existing and additional positions to actually be filled) should alleviate wait lists. Funds to achieve these changes are available through a variety of sources. No funds from the Plumas County general fund will be needed.

Finding #3: While significant Mental Health Services Act (MHSA) resources flow into Plumas County on a monthly basis, MHSA funded programs and services are limited.

MHSA programs and services must be authorized through establishment of a local plan. The Department is in the process of creating the new 3-Year MHSA Plan. That plan, and the associated budget, is required prior to putting current funds, as well as unexpended funds from previous years, to work. A considerable amount of unexpended MHSA funds will need to be spent this fiscal year in order to prevent the money from being sent back to the state. New programs and support for programs in existing agencies and departments(whose programs are consistent with the goals and constraints of MHSA) will be a part of the increased MHSA services coming to the county. An emphasis will be placed on client-family-peer stakeholder involvement.

Finding #4: Fund Balance Reserves in PCMH exceed what is necessary based on historical expenditures and current projected expenditures and potential financial risk. At the same time, community member and stakeholders report waits for needed services.

The solutions needed to fix the "lack of services" problem have been previously addressed. The effort that will be required to increase core services, and to properly allocate and account for increased MHSA programs and services will keep the Department busy for well over the upcoming year. It should be noted that Plumas County is responsible for the payment of any state hospital beds that are used by county residents – this amount can run about $250,000 per year, per client. There are no other funding sources for such expenses, so four years could cost the county $1,000,000. A healthy reserve in this fund is to the benefit of the county.

Finding #5: Services to children are inconsistent, with some care above expected statewide service standards and other care below expected statewide service standards.

Improvements consistent with most of recommendations in this section will be dependent on PMCH having enough staff to provide the identified services. Other options for improvement (i.e. 0-5 year olds) may be found in contracting with outside agencies through the MHSA plan process. As the Department stabilizes internally, and additional clinical resources are acquired, services to children will improve. As those capacities improve, Departmental priorities will shift to allow for an increased degree of inter-departmental collaboration.

Finding #6: There is little evidence of a clear, effective collaborative working relationship between PCMH and the Plumas County Alcohol and Drug Department to address the needs of dually diagnosed persons.

It is believed that, had line counselors and clients been interviewed by Kemper Consulting, a higher degree of clinically-based working relationships would have been revealed. PCMH already had a therapist assigned to Drug Court at the time of the review, in spite of the recommendation that such a position be created. The Director has indicated to the Board of Supervisors his willingness to be "at-the-table" for discussions about creating a Behavioral Health model. While no previous request for an MOU with AOD had been made, the Department is willing to work collaboratively on the creation of one, addressing both clinical and administrative considerations.

Finding #7: A robust quality control/improvement system that promotes effective mental health care delivery by PCMH has not been a priority for many years. Further, baseline State-required performance improvement efforts that demonstrate a commitment to quality improvement are no longer completed, and there is no evidence of planning to restart these activities.

The Performance Improvement Project that PCMH had been involved in for two previous years had to be discontinued this year due to a failure in the ability of outside community partners to provide the data and participation required to continue. As mentioned in the Department's response to the Grand Jury report, the new focus for the performance improvement efforts will be on the relatively new, and still evolving TelePsych program. Additionally, multiple issues regarding Quality Assurance have been identified as the result of audits, the EQRO report, analysis of previous QA efforts, and now the Kemper review. Components of a cohesive plan have been identified, and with the completion of the Kemper review, the time is right to formalize and implement a plan as recommended in the report.

Finding #8: PCMH lacks a formal communications strategy and plan that clearly articulate its role and provide a vehicle for keeping Plumas County residents informed about the services available to them and/or their families.

The Department is in agreement with this Finding. The completion of the Kemper review and the commencement of the 3-Year MHSA planning process will provide a logical point from which a concerted, comprehensive, and consistent communication strategy will be implemented.

Finding #9: Numerous required program applications/plans, reporting, procedural, and evaluation activities are not being performed by PCMH, or are being performed substantially after the expected deadline(s).

The Department is in agreement with this Finding. The report rightly notes the loss of the 3 previous three key administrators over the span of a few years. The need to rebuild the administrative capacity of the Department is evident, and progress has been made by filling the Fiscal Officer position. To meet the immediate needs of the Department, consultants in 3 key areas have been engaged with the support of the Board. The Kemper review highlighted the need for additional administrative support, which would most likely be achieved by creation of an Assistant Director position. Action will be taken in conjunction with HR to bring this request to the Board.

Finding #10: The Mental Health Commission's organizational structure, procedural compliance, and organizational leadership need to be assessed.

The Department is amenable to playing a more active role in the functioning of the Mental Health Commission. However, issues regarding the autonomy of the Commission, and the fact that it serves at the pleasure of the Board of Supervisors are important considerations and will need to be addressed by the Board of Supervisors and members of the Commission. Future involvement of the Department will most likely be determined in a collaborative manner with involvement from the Board of Supervisors, Commission members, other stakeholders, and possibly County Counsel.

Finding #11: There is a lack of clarity among community emergency service providers about PCMH's role and responsibilities during emergent psychiatric situations.

Under the facilitation of a Board of Supervisors member, the Director has engaged in meetings with members of the criminal justice and law enforcement communities. At one gathering a need was identified to meet with local entities involved in the 5150 process for the purposes of achieving increased clarity about roles, responsibilities, and practices. The Department has agreed to participate in further meetings. The Department is currently cooperating with County Counsel in the creation of an MOU addressing the 5150 process. The Department is also engaged in the CIT training process initiated by the Highway Patrol.

Finding #12: As a first-time Director with limited prior management experience, the PCMH Director faces a learning curve in all of the following areas: program administration and management, finance, leadership and training of staff, community relations, and interagency collaboration.

The Director readily acknowledges this finding. While previous management experience provided some good preparation in certain areas, the multifaceted and wide-ranging nature of the responsibilities associated with the Mental Health Director position are substantial. It should be pointed out that the Director completed his Masters of Social Work project on the topic of inter-agency collaboration in Plumas County. When the Department is empowered with the additional staff resources needed to improve levels of service delivery, and through the upcoming MHSA planning process, it is anticipated that the Department's value on collaboration will become more evident. The Director is actively committed to obtaining education and consultation for himself, as well as other administrative positions. Efforts are also underway to a management approach that values cross-training and creates an expanded knowledge base across a broader range of administrative positions.

Finding #13: Some external stakeholders support consideration by the Board of Supervisors of a combined health and human services delivery system as a means to more effectively serve clients, many of whom interact with various different departments.

Consideration of the creation of a Health and Human Services delivery system is a function of the Board of Supervisors. It is the understanding of the Director that counties across the state are utilizing a number of different structures and models in the provision of mental health, alcohol and drug, and other health and human services. Varying degrees of success and failure seem to exist. As such, any such changes should be well considered and thoughtfully implemented. The Director, as promised when hired, is willing to be at the-table for any such related discussions.

CONCLUSION: The previous year has been dedicated to stabilizing a department that had experienced a significant degree of internal deterioration. As such, there was little time or energy left for proactive levels of collaboration. In addition, service capacity has been extremely limited, so there has been little to no resource deployment potentials to collaborate about. The Director believes that collaboration is more about action and not just talk. If support for the needed increases in service delivery is provided the Department will be in a position to take action in a beneficial manner. A fresh approach to the MHSA planning process will reveal increased levels of collaboration. Increased levels of programs and services will reach clients and stakeholders.

Finally, thanks to Kemper Consulting are extended for the manner in which it approached this engagement. The reviewers were charged with untangling a multitude of forces and factors, some of which go back many years. While some of the information and conclusions offered are clear-cut and immediately actionable, other information will provide a basis for leading to further discussions and clarification. It is hoped that the efforts of Kemper Consulting will lead to the strengthening of PCMH as well as improvements in collaboration between various stakeholders, and ultimately in improved services for clients and the community.

PLUMAS COUNTY MENTAL HEALTH – PROGRAM ADJUSTMENTS NEEDED

Fall 2014

3A

The organizational review of PCMH conducted by Kemper Consulting indicates weaknesses in a number of areas. PCMH is requesting that the following program adjustments be made immediately in order to adequately address areas of deficiency and improve the delivery of mental health services to the community.

LICENSED STAFF - SALARY ADJUSTMENT

(competitive salaries; ability to actually fill positions and provide services)

23.5% Salary Adjustment for Licensed Staff

PERSONNEL NEEDS

1 DEPUTY DIRECTOR (compliance; certification; audits; contracting; HR; etc.)

1 ADMINISTRATIVE ASSISTANT (to serve all Administrative Staff)

1 PROGRAM CHIEF
MHSA Coordinator; Nursing Coordination; Public Relations

0.6 FISCAL TECH (EHR & Request for Services)

4 MHT/BHT LICENSED THERAPIST POSITIONS
Dedicated OnCall therapist (1)
Criminal Justice / ASP
Affordable Care Act increased demand (1)
Electronic Health Records (increased time demands on therpists) (1)

4 Case Manager Positions
1 Children
2 Adults
1 Criminal Justice / ASP

CAPITAL FACILITIES & LEASES

Quincy Office Space and Wellness Center

Greenville (purchase & remodel - currently no ADA space available in town)

MHSA PROGRAMS & SERVICES

New programs and services identified through the MHSA planning process will most certainly result in increased personnel demands. It is suggested that any additional staffing and facilities needs be addressed as part of the MHSA budget process.

FUNDING SOURCES

ONGOING SOURCES: FFP (Federal/MediCal); Realignment (State); Behavioral Health Subaccount (State); MHSA (State).

ONE TIME SOURCES: existing Fund Balances - 70569 (AB 109); 70570 (Mental Health); 70571 (MHSA).

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PLUMAS COUNTY MENTAL HEALTH

Peter Livingston, LCSW, Director
270 County Hospital Road, Suite 109 Quincy, CA 95971
(530) 283-6307 FAX (530) 283-6045
plivingston@kingsview.org

MEMO

DATE: SEPTEMBER 22, 2014

TO: HONORABLE BOARD OF SUPERVISORS

FROM: PETER LIVINGSTON, LCSW, DIRECTOR PML

SUBJECT: AGENDA ITEM FOR BOARD MEETING OF SEPTEMBER 30, 2014

REGARDING: PRESENTATION OF FISCAL ANALYSIS OF MENTAL HEALTH SERVICES ACT FUND BALANCE BY MIKE GEISS, CONSULTANT TO PCMH.

IT IS RECOMMENDED THAT THE BOARD OF SUPERVISORS: Accept and receive a presentation of the findings of an analysis conducted by Mr. Mike Geiss of PCMH's current MHSA Fund Balance.

BACKGROUND AND DISCUSSION:

PCMH has accumulated a considerable amount of unexpended MHSA funds. These funds represent monies that have not been spent over previous years.

State law and rules address the disposition of such funds, including the possibility of reversion. Timelines and categorical guidelines limit the manner in which such funds may be spent.

The Department, the Board of Supervisors, the Auditor, and stakeholders have vested interests in knowing the status of existing MHSA fund balances in order to conduct planning and insure that MHSA funds are expended in a timely manner and for programs and services that benefit the community and are compliant with state guidelines.

Mike Geiss holds expertise regarding fiscal analysis of MHSA and other California Mental Health funding streams. He has consulted for numerous county and state departments (see attached vitae).

Mr. Geiss has conducted an analysis of PCMH's current MHSA fiscal status and is prepared to present the results to the Board via written documentation (see attached), a 15 minute PowerPoint presentation, and will take questions from the Board and public.

Kemper Consulting has conducted an organizational review of PCMH and has indicated that an analysis of MHSA fund balances would be helpful in making decisions going forward. It is requested that Mr. Geiss be allowed the opportunity to present this important information to the Board.

Mental Health Services Act Fund Balance

The Mental Health Services Act (MHSA) was enacted by voters in November, 2004. The MHSA creates a one percent tax on income in excess of $1 million to expand county mental health services. Distributions between counties are primarily driven by population with fairly significant minimum distributions provided to small counties. The MHSA creates different components, or categories, for which the funding needs to be utilized:

- Community Services and Supports (CSS) Programs
- Prevention and Early Intervention (PEI) Programs
- Innovative Programs.

In addition, through FY2007/08, the MHSA specified an amount of funds that were required to be used for Workforce Education and Training (WET) as well as Capital Facilities and Technological Needs (CF/TN) projects. The MHSA requires the establishment of a prudent reserve for use in years in which there is insufficient funding to continue to provide the same level of services. Beginning in FY2008/09, counties could dedicate up to 20 percent of the most recent five year average distributions to WET, CF/TN, and/or the prudent reserve.

The MHSA specifies that funds other than those dedicated to the prudent reserve must be spent for their authorized purpose within three years, or ten years for WET and CF/TN funds, or the funds revert to the state for redistribution to all counties. The State Department of Health Care Services (DHCS) has defined authorized purpose to mean the component or category of funding. DHCS has not developed regulations to clarify and make specific the statutes related to reversion.

To date, DHCS has allowed counties to self-identify reverted funds through the annual MHSA Revenue and Expenditure Report (R&E). Plumas County identified $225,828 of reverted PEI funding on the FY11/12 R&E (there also was some additional funding identified as reverted associated with a statewide program and a small amount of PEI training funds). DHCS has not released the FY12/13 R&E format and so Plumas County has not completed the R&E for FY12/13.

Analysis of Plumas County expenditures indicates that an additional $30,000 of Innovation funding should have been reported as reverting in FY11/12. In FY12/13, approximately $70,000 of PEI funds and $15,000 of Innovation funds should revert. It is not anticipated that any funds will revert in FY13/14.

Plumas County is basically spending MHSA funds that are three years old, so that any significant increase in revenue results in potential reversion. Also, the sustainable level of MHSA programing has increased while the MHSA program expenditures have not. In order to avoid reversion at the end of FY14/15, Plumas County needs to spend approximately $2.25 million on MHSA programs. The anticipated FY14/15 MHSA expenditures are less than $1.7 million. MHSA expenditures then must be $1.8 million in FY15/16 and approximately $2.3 million in FY16/17 to avoid reversion. Some of the funding may be dedicated to the prudent reserve or reclassified to WET and/or CF/TN in order to avoid reversion.

The estimated funding available by component at the end of FY13/14 is shown in the table below. These funds need to be considered during the stakeholder process to develop the FY14/15-16/17 Three Year MHSA Plan.

Plumas County Estimated MHSA Fund Balance by Component

MHSA Component	Estimated Fund Balance June 30, 2014	Estimated Reverted Funds	Estimated Available Fund Balance
CSS	4,091,600	0	4,091,600
PEI	1,081,900	(300,000)	781,900
Innovation	641,100	(45,000)	596,100
WET	179,600	0	179,600
CF/TN	98,000	0	98,000
Prudent Reserve	1,036,911	0	1,036,911
Housing	251,200	0	251,200
Total	7,380,311	(345,000)	7,035,311

Estimated new MHSA component funding available to Plumas County is shown in the table below. These new funds also need to be considered in the development of the FY14/15-16/17 Three Year MHSA Plan.

Plumas County Estimated MHSA Component Funding by Fiscal Year

MHSA Component	Actual	Estimated		
	13/14	14/15	15/16	16/17
CSS	1,327,682	1,755,600	1,520,925	1,636,275
PEI	354,049	468,160	405,580	436,340
Innovation	88,512	117,040	101,395	109,085
Total	1,770,243	2,340,800	2,027,900	2,181,700

Geiss Consulting

Michael R. Geiss

Firm Position

Mr. Geiss has over twenty-six years of experience developing and evaluating state and local government programs. Prior to establishing Geiss Consulting in 2004, he had over nine years management consulting experience with NewPoint Group and over seven years with Ernst & Young. His public sector consulting experience includes assessments at more than 17 different State of California departments, as well as the federal government and multiple local government agencies. His knowledge of government programs encompasses a broad spectrum of organizations, including health and welfare, environment, public works, law enforcement, transportation, and education. His public sector consulting assignments have involved assessment of all of the following areas:

- ❑ Cost allocation and ratesetting
- ❑ Financial and operating performance measures
- ❑ Governing statutes and regulations
- ❑ Organizational structures and reporting relationships
- ❑ Stakeholder/customer needs and requirements
- ❑ Industry trends, benchmarks, and leading practices
- ❑ Process, material, and workflow
- ❑ Workload standards and staffing requirements.

Education

- ❑ University of California, Davis, B.A., Economics, 1987

Relevant Experience

Local Government

- ❑ **San Francisco County Department of Public Health**–Consultant to provide one day of on-site technical assistance to Department staff. Tasks performed included review of the methodology used by San Francisco County to identify MHSA expenditures and off-setting revenues, review of the strategic and fiscal aspects of proposed MHSA plan, and development of estimated MHSA future revenues for each component under different assumptions.
- ❑ **Ventura County Behavioral Health Department** –Consultant on a current engagement to assist the County in developing a five year fiscal strategic plan for the County's mental health programs. Tasks performed to date include identifying actual expenditures by program and using data to develop estimated expenditures over the next five years. The result of this engagement will be a comprehensive five year fiscal plan that incorporates all community mental health program revenues and expenditures.
- ❑ **Los Angeles County Department of Mental Health** — Consultant on a current engagement to assist the Department with implementing Federal Health Care Reform in Los Angeles County. Tasks include assisting the Department with developing a financial model to evaluate the level of resources needed and estimated resources available under Health Care Reform and analysis of alternative contracting mechanisms with contract providers.
- ❑ **Kern County Department of Mental Health** - Consultant on an engagement to assist the County with development of a five year sustainability plan for mental health services delivered in Kern County. Tasks performed to date include review of the mental health service delivery structure and review of revenue and expenditure data.

- **Orange County Healthcare Agency** — Consultant on an engagement to review the County's fiscal implementation of the Mental Health Services Act (MHSA) to ensure compliance with MHSA statutes and regulations. The focus of this technical assistance was to review the fiscal processes implemented by the County for tracking and reporting MHSA expenditures and revenues in order to assess the extent to which the County may be at risk for an audit finding as well as to identify potential improvements that would increase the efficiency and/or effectiveness of the use of MHSA funding.
- **Sacramento County Division of Behavioral Health Services** – Consultant on a current engagement to assist the County with development of an integrated five year fiscal Strategic Plan. Tasks performed to date include development of revenue projections, assistance with MHSA fiscal planning, and presentations to stakeholders on community mental health financing.
- **Santa Barbara County Alcohol, Drug, and Mental Health Services** — Consultant on an engagement to evaluate the County's Medi-Cal Specialty Mental Health Cost Report process, contract management and monitoring process, and other fiscal processes.
- **Siskiyou County Behavioral Health Division** – Consultant on an engagement to conduct a fiscal review of the Behavioral Health Division and develop a long term sustainability plan. Tasks performed to date include determination of outstanding audit liabilities, identification of areas for integration, and identification of fiscal reporting strategies.
- **Tuolumne County Behavioral Health Services**- Consultant on a current engagement to prepare the County's FY2008/09, 2009/10, 2010/11, and 2011/12 Medi-Cal Specialty Mental Health Services cost reports. Project tasks included collecting, compiling, and analyzing fiscal and staffing data from the County to prepare the cost report.
- **Tulare County Health and Human Services** — Consultant on a current engagement to assist the County with integrating their Mental Health Services Act (MHSA) programs into the Short-Doyle/Medi-Cal cost reporting and settlement processes. The focus of this project includes a review of the MHSA fiscal information reported by contractors and the County's cost center and reporting unit structures. To date, this engagement resulted in recommendations to the contractor payment reconciliation process and how to better track MHSA expenditures by component. Future tasks include reviewing the methodologies used to allocate revenues and expenditures on the Medi-Cal Specialty Mental Health Cost Report and the MHSA Revenue and Expenditure Report.
- **County of El Dorado Health & Human Services Agency** - Consultant on a current engagement to assist the County with various fiscal aspects of their behavioral health system. Tasks performed include review of cost allocation methodologies and consultation on various fiscal strategies.
- **Merced County Department of Mental Health** – Consultant to conduct a fiscal system review of Merced County's Department of Mental Health. Tasks performed included review of processes and data used to develop revenue projections, review of processes and data used to prepare the SD/MC cost report, including the process used to settle with contract providers, review of processes used to identify and monitor potential SD/MC audit liabilities, and review of methodologies used to identify MHSA expenditures and off-setting revenues. This project resulted in a letter report with specific findings and recommendations related to identification and allocation of costs, identification of Medi-Cal units of service, and training of staff.
- **Stanislaus County Behavioral Health and Recovery Services** — Consultant on an engagement to assist the County with confirming potential future Short-Doyle/Medi-Cal cost report audit liabilities. The focus of this project included a review of multiple fiscal year SD/MC cost reports to determine whether recent audit findings would apply.

- **Santa Barbara County Alcohol, Drug, and Mental Health Services** — Project manager to provide financial technical assistance to the Santa Barbara County Alcohol, Drug, and Mental Health Services Department. This engagement involved providing services one to two weeks per month over a two year period, and included the following tasks:
  - Educate county and contractor staff on the SD/MC cost report and related processes
  - Provide an overview of the SD/MC reimbursement process (including the claim process, negotiated rate process, and cost report process) to various stakeholders
  - Assist Department staff in preparing the SD/MC cost report, the Medicare Psychiatric Health Facility cost report, and the Alcohol and Drug Program (ADP) cost report
  - Review Department budget estimates
  - Review fiscal provisions of contracts
  - Assist county staff in hiring key positions for the fiscal subdivision
  - Assist the Department in complying with SD/MC requirements related to legal entity reporting
  - Provide general consultation on all fiscal issues.
- **Ventura County Behavioral Health Department** –Project manager to review the County of Ventura's Short-Doyle/Medi-Cal (SD/MC) cost report for the last four years (FY 1999/2000, 2000/2001, 2001/02, and 2002/03) and issue compliance and management letters regarding findings of each review.
- **Fresno County Human Services** — Consultant on an engagement to assist the County with improving their Short-Doyle/Medi-Cal cost reporting and settlement processes. The focus of this project included a review of the process used to prepare the SD/MC cost report, including allocation methodologies, the logic behind management information reports used to generate supporting documentation, and treatment of administrative costs.
- **Butte County Department of Behavioral Health** — Project manager to evaluate psychiatric inpatient alternatives in Butte County. This engagement involved assessing the demand for psychiatric inpatient services in Butte County and in the surrounding counties, identifying alternatives for meeting this demand, evaluating the financial feasibility of each alternative, and developing a recommended alternative.
- **San Diego County Probation Department** — Project manager to provide Medi-Cal technical assistance to the San Diego County Probation Department in implementing Short-Doyle/Medi-Cal (SD/MC) services in several day treatment centers operated by the Probation Department. Specific tasks included determining the estimated cost and potential revenue of the program under SD/MC requirements, assisting the Probation Department in developing a Memo of Understanding with the San Diego County Heartbeat Program (i.e., children's mental health program in San Diego County) including a budget of estimated units of service and costs, and identifying reporting requirements and other requirements necessary to obtain SD/MC reimbursement.
- **Butte County Alcohol, Drug, and Mental Health Services** — Project manager to develop an accounting systems structure. Specific tasks included identifying Alcohol, Drug, and Mental Health Services cost reporting requirements through review of existing cost reports and interviews with county staff; evaluating the feasibility of mapping the accounting system to cost reporting requirements; comparing alternative accounting packages to the current accounting system; and developing a proposed accounting system structure.
- **City of Berkeley Mental Health Department** — Project manager to prepare the City of Berkeley's FY 1998/99, 1999/2000, 2000/01, 2001/02, 2002/03, 2003/04, 2004/05, 2005/06, 2006/07, 2007/08, 2008/09, 2009/10, and 2010/11 Medi-Cal Specialty Mental Health Services

cost reports. Project tasks included collecting, compiling, and analyzing fiscal and staffing data from the City of Berkeley to prepare the cost report.

- **Los Angeles County Department of Mental Health** — Project manager to assist the Department in maximizing Medi-Cal reimbursement for mental health services provided through the County Department of Mental Health. This project required reviewing historical Medi-Cal reimbursement and negotiated rate agreements with contract providers. Also, an assessment prepared by Department staff on alternative indirect cost allocations was reviewed.
- **Sacramento County Department of Health and Human Services** — Lead consultant on an engagement to provide technical assistance to the Department in expanding their mental health Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Tasks performed under this engagement include development of estimated administrative and direct service expenditures, revenue, and number of Medi-Cal eligible individuals to be served under the EPSDT program expansion. Proposals submitted by contract providers also were evaluated. Finally, a presentation to the Board of Supervisors was prepared showing the increases in federal and state revenues expected under the EPSDT program expansion.

State Government - Health & Welfare

- **California Mental Health Directors Association** — Consultant on a current engagement to provide fiscal consulting services to the California Mental Health Directors Association on a variety of projects including:
  - Assistance with development of potential funding strategies under federal 1115 waiver including funding options for the integration of behavioral health services into the overall health care system.
  - Assistance with the development of funding provisions for 2011 Local Realignment Fund.
  - Development of allocation strategies for Mental Health Services Act funding.
  - Review and analysis of proposed state legislation.
  - Assistance with development of Certified Public Expenditure protocol for Medi-Cal services.
  - Review and analysis of proposed Medi-Cal cost report.
  - Development of estimated Community Mental Health Services revenues.
  - Evaluation of the sufficiency of the funding level of the Small County Emergency Risk Pool (SCERP) in terms of providing a risk pool for psychiatric inpatient emergency services for small counties.
- **California Department of Mental Health** — Consultant to provide fiscal consulting services to the California Department of Mental Health on a variety of projects including:
  - Development of a revised Short-Doyle/Medi-Cal cost reporting system and rate setting methodology to meet federal Medicaid and Medicaid standards.
  - Development of distribution strategies for the Mental Health Services Act (MHSA) funds, budget formats for counties to use in requesting MHSA funds, and maintenance of effort and non-supplanting issues related to the Act.
  - Preparation of cost effectiveness demonstration calculations for the Department's two federal Freedom of Choice Waivers.
  - Assisting the Department with preparation of a legislatively mandated analysis of the impact of the Health and Welfare Realignment Program on mental health services and funding.

- Assisting the Department with consolidation of Fee-for-Service/Medi-Cal (FFS/MC) funding and Short-Doyle/Medi-Cal (SD/MC) funding for acute psychiatric inpatient and professional mental health services.
- Development of a new rate setting methodology for non-contract FFS/MC psychiatric hospital inpatient services.
- Evaluation of San Mateo County Mental Health Plan (MHP) pharmacy and laboratory costs under a federal Freedom of Choice Waiver in order to determine (1) whether the risk corridor should apply to historical expenditures and (2) what future year pharmacy and laboratory costs are estimated to be.
- Analysis of the case rate reimbursement system for the San Mateo County Mental Health Field Test Waiver.
- Analysis of rebasing the Statewide Maximum Allowances (SMAs) for Short-Doyle/Medi-Cal (SD/MC) services.
- Development of the rate setting methodology and computation of the Statewide Maximum Allowance (SMA) for Therapeutic Behavioral Services (TBS) including development of a State Plan Amendment.
- Evaluation of Short-Doyle/Medi-Cal (SD/MC) and Fee-for-Service/Medi-Cal (FFS/MC) psychiatric inpatient rates of treatment and payments for the California Department of Mental Health (DMH).

❑ **California Department of Health Services** — Consultant on an engagement to evaluate and modify the capitation rate setting methodology used for establishing Medi-Cal (Medicaid) reimbursement rates for managed care plans. Primary objectives of this engagement were to: (1) determine the normative needs of the Medi-Cal managed care population, (2) determine if there was actuarial equivalence between the managed care population and the fee-for-service population, (3) determine if reimbursement rates were sufficient to insure that the Medi-Cal beneficiaries have adequate access to health care services, and (4) propose and evaluate alternative mechanisms for establishing capitation rates for managed care plans.

4A

PLUMAS COUNTY COORDINATING COUNCIL

AGENDA REQUEST
for the Sept 30, 2014 Meeting of the Plumas County Board of Supervisors

September 22, 2014

To: Honorable Board of Supervisors

From: Robert Perreault, Chair, PCCC

Subject: Consideration of a New Directive, proposed by the US Forest Service on May 6, 2014, titled: "Proposed Directive on Groundwater Resource Management, Forest Service Manual 2560"; discussion and possible action.

Background:

On September 11, 2014, it came to my attention that the USFS had previously published a "Notice" in the Federal Register on May 6, 2014, titled: "Proposed Directive on Groundwater Resource Management, Forest Service Manual 2560"

Comments on the proposed directive were first due on August 4, 2014, but extensions have been issued and the latest due date for comments is now October 3, 2014.

I do not recall any discussion on this topic at any meeting of the Plumas County Coordinating Council since the PCCC meeting conducted on June 5, 2014

The internet link to the Federal Register Notice, beginning on Page 25815, is located at:

http://www.gpo.gov/fdsys/pkg/FR-2014-05-06/pdf/2014-10366.pdf

An information page, dated May 2, 2014, on the proposed directive has been posted by the USFS on the internet at:

http://www.fs.fed.us/geology/groundwater.html

Inasmuch as the next meeting of the Plumas County Coordinating Council is not scheduled until October 2, 2013, and the next regular meeting of the Board of Supervisors is scheduled for October 7, 2014 (which is 4 days after the deadline to submit comments), this matter is requested to be scheduled as part of the Agenda for the Special Meeting scheduled by the Board of Supervisors for September 30, 2014.

There will be no PCCC Meeting scheduled to develop a recommendation for consideration by the Board of Supervisors.

Inasmuch as the Planning Department and the Plumas County Flood Control and Water Conservation District have been extensively involved in the development of IRWM matters, Leah Wills has been requested to prepare a first draft letter, suitable for consideration by the Board of Supervisors on September 30, 2014. Attached is a copy of the latest draft, as of the submission of this Agenda Request on September 22, 2014. Any proposed revisions will be brought to the attention of the Board of Supervisors during their meeting on September 30, 2014.

As a point of information, the Butte County Board of Supervisors have scheduled consideration of this same matter during their Board meeting on September 23, 2014.

Recommendation:

The PCCC Chair respectfully requests the Board of Supervisors to consider the draft response attached to the Agenda Request during their meeting scheduled for September 30, 2014.

Attachment:

Draft Letter, as of September 22, 2014, including attachments

BOARD OF SUPERVISORS LETTERHEAD

September 30, 2014 **D R A F T**

Mr. Rob Harper
WFWARP
Groundwater Directive Comments
USDA Forest Service
201 14th Street SW Washington, DC 20250

RE: US Forest Service Proposed Directive on Groundwater Resources Management, Forest Service Manual 2560

A Local Government perspective on the Directive in Region 5 of the US Forest Service with the enactment on September 16, 2014, of California's landmark groundwater legislation.

(Via electronic transmission)

Dear Mr. Harper:

The Board of Supervisors for the County of Plumas appreciates the opportunity to provide what we expect to be initial comments on the process for incorporating the Proposed Directive on Groundwater Management (Directive) into the Forest Service Manual 2560.

Plumas County supports and incorporates Butte County's comments, dated September 23, 2014, included as an attachment to this letter.

Plumas County attained Coordinating Agency status in 2008, with the adoption of Plumas County Resolution No. 08-7514 on October 21, 2008; copy attached. The Plumas County Coordinating Council is scheduled to meet monthly and includes notice of such meetings to the US Forest Staff from the 3 National Forests located at least partially within Plumas County. The reoccurring practice of the USFS in failing to properly "coordinate" its Notices in the *Federal Register* with the local agencies is a significant flaw in the USFS notification procedures.

Recommendation One: The US Forest Service should withdraw and redraft the Directive to incorporate Federal-County Coordination obligations, as Butte County recommends in the attached letter. All future communication and actions regarding this directive should be shared with Counties with Coordinating Agency status within the US Forest Service.

Although twice the Washington Office of the Forest Service has extended the comment period for the proposed Directive in mid September 2014, the State of California amended the California Water Code to provide more specific legislative direction on groundwater measurement and management in California (USFS Region 5).

- Specifically, Senate Bill No. 1319, Chapter 348 amends sections 10735.2 and 10735.8 of the Water Code relating to groundwater.
- Senate Bill No. 1168, Chapter 346, amends and adds sections to Part 2.74 of Division 6 of the Water Code relating to groundwater, and,
- Assembly Bill 1739, Chapter 347, amends and adds sections to the Government Code and to Part 2.74 of Division 6 of the Water Code.

Recommendation Two: The US Forest Service should issue direction for each Forest Service Region to develop coordination for the Directive that harmonizes with the Federal Agency coordination provisions in the states' groundwater laws in each Forest Service Region.

Recommendation Three: The US Forest Service should consider and incorporate specific provisions of state groundwater law to guide further development of the Directive in US Forest Service Region 5.

For example, Senate Bill 1168, Chapter 346, of California's new groundwater legislation package provides specific direction on California's responsibilities for engagement with local entities, Tribes, and the Federal agencies on management of shared groundwater basins in California.

> *"SEC. 3. Part 2.74 (commencing with Section 10720) is added to Division 6 of the Water Code, to read:*
> *PART 2.74. Sustainable Groundwater Management*
> *CHAPTER 1. General Provisions*
> *10720. This part shall be known, and may be cited, as the "Sustainable Groundwater Management Act."*
>
> *"10720.1. In enacting this part, it is the intent of the Legislature to do all of the following:*
> *(a) To provide for the sustainable management of groundwater basins.*
> *(b) To enhance local management of groundwater consistent with rights to use or store groundwater and Section 2 of Article X of the California Constitution. It is the intent of the Legislature to preserve the security of water rights in the state to the greatest extent possible consistent with the sustainable management of groundwater.*
> *(c) To establish minimum standards for sustainable groundwater management.*
> *(d) To provide local groundwater agencies with the authority and the technical and financial assistance necessary to sustainably manage groundwater.*
> *(e) To avoid or minimize subsidence.*
> *(f) To improve data collection and understanding about groundwater.*
> *(g) To increase groundwater storage and remove impediments to recharge.*
> ***(h) To manage groundwater basins through the actions of local governmental agencies to the greatest extent feasible, while minimizing state intervention to only when necessary to ensure that local agencies manage groundwater in a sustainable manner."*** (Emphasis added)
>
> *"10720.3. (a) This part applies to all groundwater basins in the state.*
> *(b) To the extent authorized under federal or tribal law, this part applies to an Indian tribe and to the federal government, including, but not limited to, the United States Department of Defense.*
> *(c) The federal government or any federally recognized Indian tribe, appreciating the shared interest in assuring the sustainability of groundwater resources, may voluntarily agree to participate in the preparation or administration of a groundwater sustainability plan or groundwater management plan under this part through a joint powers authority or other agreement with local agencies in the basin. A participating tribe shall be eligible to participate fully in planning, financing, and management under this part, including eligibility for grants and technical assistance, if any exercise of regulatory authority, enforcement, or imposition and collection of fees is pursuant to the tribe's independent authority and not pursuant to authority granted to a groundwater sustainability agency under this part.*
> *(d) In an adjudication of rights to the use of groundwater, and in the management of a groundwater basin or subbasin by a groundwater sustainability agency or by the board, federally reserved water rights to groundwater shall be respected in full. In case of conflict between federal and state law in that adjudication or management, federal law shall prevail. The*

voluntary or involuntary participation of a holder of rights in that adjudication or management shall not subject that holder to state law regarding other proceedings or matters not authorized by federal law. This subdivision is declaratory of existing law."

"10720.5. (a) Groundwater management pursuant to this part shall be consistent with Section 2 of Article X of the California Constitution."

"CHAPTER 2. Definitions (g) "Groundwater" means water beneath the surface of the earth within the zone below the water table in which the soil is completely saturated with water, but does not include water that flows in known and definite channels."

"CHAPTER 4. Establishing Groundwater Sustainability Agencies
10723.2. The groundwater sustainability agency shall consider the interests of all beneficial uses and users of groundwater, as well as those responsible for implementing groundwater sustainability plans. These interests include, but are not limited to, all of the following:
(a) Holders of overlying groundwater rights, including:
(1) Agricultural users.
(2) Domestic well owners.
(b) Municipal well operators.
(c) Public water systems.
(d) Local land use planning agencies.
(e) Environmental users of groundwater.
(f) Surface water users, if there is a hydrologic connection between surface and groundwater bodies.
(g) The federal government, including, but not limited to, the military and managers of federal lands.
(h) California Native American tribes.
(i) Disadvantaged communities, including, but not limited to, those served by private domestic wells or small community water systems.
(j) Entities listed in Section 10927 that are monitoring and reporting groundwater elevations in all or a part of a groundwater basin managed by the groundwater sustainability agency."

In conclusion, Plumas County suggests that the US Forest Service utilize the existing mechanisms as set forth in its County Coordination provisions and in state groundwater law in order for the Agency to achieve the goals of the Directive in ways that conform to the "All Lands" coordination vision of the US Forest Service and which support the real potential to achieve tangible progress on shared groundwater planning and management goals as articulated in the US Forest Service publication titled "Key and Common Questions and Answers Proposed Groundwater Directive FSM 2560."

"The Forest Service recognizes that states have specific authorities with respect to the allocation of water use, including groundwater. The Forest Service, as a federal land management agency, has an obligation to ensure its decisions and activities comply with applicable federal and state laws. The proposed directive does not change that relationship, and the phrase "groundwater resource management" as used in the directive does not presume to change any existing authorities or responsibilities. The Forest Service will engage and work with states within this framework to ensure that agency decisions and activities meet the state groundwater resource objectives, as well as achieve Forest Service objectives for management of National Forest System lands."

Specifically in Region 5, Plumas County suggests that the US Forest Service immediately begin utilizing the existing mechanisms as set forth in County Coordination provisions and in state groundwater law for coordinated groundwater planning and management. In SB 1168, Chapter 346 of the September, 2014 California groundwater legislation package, coordinated federal, state and local groundwater management and planning would have the following attributes:

> *"CHAPTER 6. Groundwater Sustainability Plans"*
>
> *10727.2. A groundwater sustainability plan shall include all of the following:*
> *(a) A description of the physical setting and characteristics of the aquifer system underlying the basin that includes the following:*
> *(1) Historical data, to the extent available.*
> *(2) Groundwater levels, groundwater quality, subsidence, and groundwater-surface water interaction.*
> *(3) A general discussion of historical and projected water demands and supplies.*
> *(4) A map that details the area of the basin and the boundaries of the groundwater sustainability agencies that overlie the basin that have or are developing groundwater sustainability plans.*
> *(5) A map identifying existing and potential recharge areas for the basin. The map or maps shall identify the existing recharge areas that substantially contribute to the replenishment of the groundwater basin. The map or maps shall be provided to the appropriate local planning agencies after adoption of the groundwater sustainability plan."*

Thank you for the opportunity to comment.

The courtesy of a written reply to these specific comments will be appreciated.

Sincerely,

Chair
Board of Supervisors
County of Plumas

Attachments

cc: (via electronic communication)

Randy Moore, Regional Forester, Region 5
Doug Teeter, Chair, Butte County Board of Supervisors
Members of the Plumas County Coordinating Council
Forest Supervisor, Plumas National Forest
Forest Supervisor, Lassen National Forest
Forest Supervisor, Tahoe National Forest

BOARD OF SUPERVISORS

ADMINISTRATION CENTER
25 COUNTY CENTER DRIVE, SUITE 200 - OROVILLE, CALIFORNIA 95965
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Fifth District

September 23, 2014 **D R A F T**

Mr. Rob Harper
WFWARP
Groundwater Directive Comments
USDA Forest Service
201 14th Street SW
Washington, DC 20250

RE: U.S. Forest Service Proposed Directive on Groundwater Resources Management, Forest Service Manual 2560

Dear Mr. Harper:

The Butte County Board of Supervisors offers the following comments on the United States Forest Service (USFS) Proposed Directive on Groundwater Resource Management (Directive), Forest Service Manual 2560 79 FR 25815 (May 6, 2014). Although Butte County appreciates the Forest Service's recognition of the importance of groundwater resources, we were unaware of the proposed directive until mid-September. Butte County has Coordinated Agency status, yet the U.S. Forest Service failed to fulfill their obligations to coordinate the development of this directive with us.

In 2010, the Butte County Board of Supervisors gained Coordinated Agency status by establishing the Butte County Coordinating Committee to assure that the federal agencies fulfill their obligation to coordinate with counties under the National Forest Management Act (16 USC 1604, 43, USC 1701, 43 USC 1712). To date, Butte County has not received any notice concerning the proposed directive. Therefore, the U.S. Forest Service failed to fulfill its obligation to consult with Butte County on the proposed directive on groundwater resource management.

The implications of the policy could be far reaching for Butte County. Butte County is the area of origin for a large portion of California's water portfolio. Moreover, groundwater is the foundation of Butte County's economy, communities and environment. Butte County has a high interest in assuring that groundwater is managed to the benefit of the County. The failure to coordinate the development of the groundwater directive gives Butte County an inadequate amount of time to review the proposal and engage local stakeholders. As a result, it is unclear how it will be implemented in a manner consistent with existing state and local programs.

In summation, the Butte County Board of Supervisors recommends the proposed directive on groundwater management be withdrawn and that a coordinated policy directive process be initiated with Coordinated Agencies; specifically, the U.S. Forest Service should initiate coordination with Butte County, as a Coordinated Agency, to draft a groundwater policy directive.

Sincerely,

Doug Teeter, Chair

Cc: Randy Moore
Region 5 Forester
USDA Forest Service
1323 Club Drive
Vallejo, CA 94592

County of Plumas

RESOLUTION 08 - 7514

A resolution adopting and implementing Coordinated Agency Status in accordance with federal and state laws, and notifying Federal and State agencies maintaining jurisdiction over lands and/or resources located within the County of Plumas of the intent and expectation that Federal and State agency actions shall be made consistent with all county land use plans, and other management plans affecting the natural environment, economic stability, or the public health and safety of the citizens of Plumas County, and to otherwise notify and confer with the County.

WHEREAS, the County of Plumas is a legal subdivision of the State of California and may exercise its powers only through the Board of Supervisors or through agents and officers acting under authority of the Board or authority conferred by law; and

WHEREAS, the County of Plumas has various authorities over the use and management of private lands and natural resources within its jurisdiction and is charged with exercising such authorities to protect and enhance natural resources, maintain economic stability, and protect public health and safety; and

WHEREAS, the federal and state governments own a vast majority of the lands in Plumas County and are responsible for managing these lands for parks, recreation, wildlife habitat, and the production and protection of natural resources, including water, timber, minerals, and grasslands; and

WHEREAS, private lands are interspersed with public lands throughout Plumas County, and plans and management actions for public lands and private lands must be coordinated to ensure effective and consistent protection and enhancement of property and natural resources; and

WHEREAS, the citizens of Plumas County have historically earned their livelihoods from activities reliant upon management of natural resources on public lands and the continuation of those activities is critical to the economic health of Plumas County; and

WHEREAS, the County of Plumas desires to assure that federal and state agencies shall inform the Board of Supervisors of all pending or proposed actions affecting management of the environment, local communities and citizens within Plumas County and coordinate with the Board of Supervisors though the Plumas County Coordinating Council in the planning and implementation of those actions; and

WHEREAS, the National Forest Management Act at 16 USC 1604 requires federal agencies to coordinate its planning processes with local government units such as the County of Plumas; and

WHEREAS, the Federal Land Policy and Management Act at 43 USC 1701, and 43 USC 1712 requires coordination of planning and management actions, regarding the coordinated agency status of a county engaging in the land use planning process, and requires that the "Secretary of the Interior [Secretary] shall....coordinate the land use inventory, planning, and management activities....with the land use planning, and management programs of other federal departments and agencies and of the state and local governments within which the lands are located"; and

WHEREAS, the coordination requirements of Section 1712 provide for special involvement by government officials who are engaged in the land use planning process; and

WHEREAS, Section 1712 sets forth the nature of the coordination required with planning efforts by government officials and subsections(f) of Section 1712 sets forth an additional requirement that the Secretary "shall allow an opportunity for public involvement" (including local government without limiting the coordination requirement of Section 1712 allowing land or resource management or regulatory agencies to simply lump local government in with special interest groups of citizens or members of the public in general); and

WHEREAS, Section 1712 also provides that the "Secretary shall.....assist in resolving, to the extent practical, inconsistencies between federal and non-federal government plans" and gives preference to those counties which are engaging in the planning process over the general public, special interest groups of citizens, and even counties not engaging in a land use planning program; and

WHEREAS, the requirement that the Secretary "coordinate" land use inventory, planning, and management activities with local governments, requires the assisting in resolving inconsistencies to mean that the resolution process takes place during the planning cycle instead of at the end of the planning cycle when the draft federal plan or proposed action is released for public review; and

WHEREAS, Section 1712 further requires that the "Secretary shall....provide for meaningful public involvement of state and local government officials... in the development of land use programs, land use regulations, and land use decisions for public lands"; and, when read in light of the "coordinate" requirement of Section 1712, reasonably contemplates "meaningful involvement" as referring to on-going consultations and involvement throughout the planning cycle, not merely at the end of the planning cycle; and

WHEREAS, Section 1712 further provides that the Secretary must assure that the federal agency's land use plan be "consistent with state and local plans" to the maximum extent possible under federal law and the purposes of the Federal Land Policy and Management Act and distinguishes local government officials from members of the general public or special interest groups of citizens; and

WHEREAS, Federal agencies implementing the Endangered Species Act, the Clean Water Act, the Clean Air Act, and the Outdoor Recreation Coordination Act 16 USC 4601-1[c]and[d] are required by Congress to consider local plans and to coordinate and cooperate directly with plans of local government such as Plumas County; and

WHEREAS, the Federal Power Act 16 USC 803 requires that hydroelectric projects licensed by the Federal Energy Regulatory Commission be best adapted to a comprehensive plan for improving a waterway to provide multiple resource benefits and that consideration be given to any comprehensive state or federal plans that may exist for the waterway; and

WHEREAS, the Intergovernmental Cooperation Act and Presidential Executive Order 12372 set forth coordinated planning requirements for the federal, state, and local governments; and

WHEREAS, California Water Code sections 8125 to 8129 give a county Board of Supervisors authority to address flooding caused by non-navigable streams and such flood planning requires coordination with natural resource planning processes of federal and state agencies; and

WHEREAS, California Public Resources Code section 5099.3 requires coordination by the State of California with the County of Plumas in matters involving the planning, development, and maintenance of outdoor recreation resources and facilities; and

WHEREAS, the California Streets and Highways Code §§940-941.2 makes county governments responsible for the general supervision, management, and control of county roads and highways and planning and actions with regard to such roads by any federal or state agency must be coordinated with the county; and

WHEREAS, it is the intent of the Board of Supervisors to promote the consistency of federal and state agency plans and actions with revised and adopted local plans, including as examples:

Plumas County General Plan
Plumas County Community Wildfire Protection Plan
Upper Feather River Integrated Regional Water Management Plan
Feather River Coordinated Resource Management Plan
Feather River Watershed Management Strategy, and the
Herger Feinstein Quincy Library Group Forest Recovery Act-Pilot Project Plan

NOW, THEREFORE, BE IT RESOLVED, by the Board of Supervisors of the County of Plumas, State of California, that:

1. The County of Plumas hereby establishes Coordinated Agency Status with all federal and state agencies maintaining jurisdiction over lands or resources located with Plumas County.

2. The Plumas County Coordinating Council is hereby established and the following Plumas County officials are designated as permanent members of the committee:

Director, Department of Planning and Building Services
Director, Department of Public Works
General Manager, Plumas County Flood Control & Water Conservation District

3. The Board of Supervisors may appoint additional representatives to the Plumas County Coordinating Council from time to time, including themselves. Council members shall serve at the pleasure of the Board of Supervisors and may be removed from the Council at any time by the Board of Supervisors.

4. The Plumas County Coordinating Council shall represent the County of Plumas in coordinating the management plans and actions of federal and state agencies to ensure consistency with local land use plans, and provide a key component of any General Plan revisions which also must consider land outside the County boundaries which bears relation to county planning especially for matters related to fire prevention, watersheds, land use, natural resources and other related issues to ensure consistency.

5. The Plumas County Coordinating Council shall make recommendations to the Board of Supervisor's when appropriate and as needed, or when the Board requests the committee to provide recommendations.

6. The Plumas County Coordinating Council shall have available to them resources approved and allocated by the Board of Supervisors on February 5, 2008 as described in the approved Title III project to expend for the purposes included in the application titled: Fire Prevention and County Planning: Establishing Coordinated Agency Status Provided for Under Federal Land Policy and Management Act, and administered by the Plumas County Board of Supervisors, and any other funds the Council secures through approval of the Board of Supervisor's.

7. The Plumas County Coordinating Council shall adopt and possibly expand on the Herger Feinstein Quincy Library Group Forest Recovery Act- Pilot Project plan as reauthorized and extended in sections of the Consolidated Appropriations Act of 2008, otherwise known as HR-2764, as the baseline county wide forest and fire prevention land management plan for federal lands within Plumas County not withstanding that the Council may recommend and the Board of Supervisors may agree to address fire prevention and protection in coordination with the Quincy Library Group and/or others.

The foregoing Resolution was duly passed and adopted by the Board of Supervisors of the County of Plumas, State of California, at a regular meeting of said board held on the 21st day of October, 2008.

AYES:	**Supervisors**	Powers, Thrall, Meacher, Olsen, Comstock
NOES:	**Supervisors**	None
ABSENT:		None

Chair, Board of Supervisors

ATTEST:

Clerk of the Board

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PLUMAS COUNTY
DEPARTMENT OF PUBLIC WORKS
SOLID WASTE DIVISION

1834 East Main Street • Quincy, CA 95971 • (530) 283-6268
Robert A. Perreault, Jr., P.E. *Director of Public Works*

AGENDA REQUEST
For the September 30, 2014 Meeting of the Board of Supervisors

Date: September 22, 2014

To: Honorable Board of Supervisors

From: Robert Perreault, Director of Public Works

Subject: Plumas County Solid Waste Program – Green Waste Disposal in the American Valley Area - Proposed Memorandum of Understanding between Plumas County and Waste Management; Discussion, possible action and/or direction to staff

BACKGROUND:

This Agenda Request is a follow up to the Public Works proposal that was discussed and voted upon by the Board of Supervisors during its June 3, 2014, 2014 meeting, which created a new program within the American Valley area for the disposal of certain items of green waste.

As of this writing, the single issue that prevents startup of a green waste disposal program is the need to have a fully executed Memorandum of Understanding (MOU) in place.

- On June 24, 2014, a copy of a draft Memorandum of Understanding, between the County of Plumas and Feather River Disposal (a/k/a Waste Management) as prepared by Public Works and reviewed by County Counsel, to enable the use of part of APN Nos. 116-370-25,-26,-27 (along Industrial Way in Quincy) for operation of the green waste disposal operations, was submitted to Feather River Disposal staff for their review and approval. A copy of the submitted draft MOU is attached.

- In conjunction with the executed MOU, Public Works staff will be responsible for revising the existing Storm Water Pollution Prevention Plan (SWPPP) for the FRD site. Coordination with the Regional Water Quality Control Board has been completed by Public Works. Public Works staff awaits the MOU to be finalized in order to formalize the revision to the existing SWPPP.

RECOMMENDATION:

Public Works staff respectfully recommends that the Board of Supervisors adopt the following motion: to authorize the Chair to execute an MOU between Plumas County and Waste Management, subject to approval as to form by County Counsel.

Attachment: Draft MOU

D R A F T (dated June 18, 2014)

Memorandum of Understanding between County of Plumas and Feather River Disposal Pertaining to the Operation of a Green Waste Disposal Program on a Portion of Property Owned by Waste Management, Inc. in Quincy, California

This **Memorandum of Understanding** ("MOU") is entered on this ___ day of June, 2014, by and between the **County of Plumas** a political subdivision of the State of California, c/o Department of Public Works, 1834 East Main Street, Quincy, CA 95971 ("COUNTY") and **USA Waste of California Inc. DBA Waste Management,** 1166 Industrial Way, Quincy, CA 95971 ("WM").

This Memorandum of Understanding is made with reference to the following facts and circumstances:

WHEREAS, COUNTY and WM are parties to an existing Solid Waste Franchise Contract;

WHEREAS, WM is presently a Solid Waste Franchise Contractor for the COUNTY, whose jurisdiction includes the Quincy area and nearby environs;

WHEREAS, COUNTY desires to conduct certain activities of a green waste disposal program as part of its Solid Waste program in the vicinity of Quincy, California;

WHEREAS, WM and Sierra Pacific Industries, Inc. had been providing certain green waste disposal services to the constituents of Plumas County for many years at no cost to the users – until such time that Sierra Pacific Industries, Inc. abruptly and solely discontinued such services during the Fall 2013, thereby leaving the Quincy area constituents without benefit of such cost-free or low-cost green waste disposal services;

WHEREAS, the COUNTY and WM agree that the COUNTY may provide certain green waste disposal services without affecting the existing franchise contract relationship between the COUNTY and WM;

WHEREAS, Waste Management, Inc. (P.O. Box 1450, Chicago, IL 60690-1450), is owner of parcels within Quincy (APN Nos. 116-370-25, 116-370-26 and 116-370-27), having assigned addresses of 1166, 1210 and 1284 Industrial Way, respectively.

NOW, THEREFORE, be it resolved that it is agreed between the COUNTY and WM that:

1. Green Waste Disposal Activities. COUNTY may conduct certain green waste disposal activities on a portion of property of WM, all as generally described in the "Project Description, dated June 5, 2014, copy attached, including "Site Plan," dated June 5, 2014.

2. Permits. COUNTY is responsible for acquiring all permits and approvals associated with the green waste disposal activities, all at no cost to WM. This requirement pertains to any need to amend any existing regulatory permit required of WM, as may be caused by the green waste disposal program.

3. Regulatory Actions. COUNTY shall be liable for all penalties and fines, as may be imposed by any regulatory agency, that are the result of green waste disposal activities conducted by the County, all at no cost to WM.

4. Term. The initial term of this MOU shall commence on the date first stated above and shall end on December 31, 2016. The term shall be automatically extended for 3-year cycles. In the event that either party desires to not automatically extend the terms, that party will give the other party notice in writing at least 9 months before the expiration date.

5. Bin Storage. In the event that the County use of a portion of the WM property results in insufficient space for the storage of metal bins (that are used by WM within Plumas County) during a winter season, then the COUNTY, through its Department of Public Works will provide a metal bin storage area for WM bins in a location within the Quincy/East Quincy area. Said storage shall be at no rental cost to WM.

6. Notices. Any notices, documents, correspondence or other communications concerning this MOU shall be in writing and addressed as set forth below. Such communication shall be deemed served or delivered: a) at the time of delivery if such communication is sent by personal delivery; b) at the time of transmission if such communication is sent by facsimile; and c) 48 hours after deposit in the U.S. Mail as reflected by the official U.S. postmark if such communication is sent through regular United States mail.

IF TO WM:	IF TO COUNTY:
Dennis Simpson, Manager	Robert A. Perreault, Jr., P.E., Director
Waste Management	Plumas County Department of Public Works
1166 Industrial Way	1834 East Main Street
Quincy, CA 95002	Quincy, CA 95971
Tel: (530) 927-6045	Tel: (530) 283-6268
Fax: (530) 283-2331	Fax: (530) 283-6323

For purposes of convenience and efficiency, any communications not affecting the scope of work or the rights of the parties under this agreement may be transmitted via e-mail.

7. Amendments. This MOU may be amended at any time by mutual agreement of the parties, expressed in writing and duly executed by both parties. No alteration of the terms of this MOU shall be valid or binding upon either party unless made in writing and duly executed by both parties.

8. Governing Law. This MOU shall be governed by and construed under the laws of the State of California without giving effect to that body of laws pertaining to conflict of laws. In the event of any legal action to enforce or interpret this Agreement, the parties hereto agree that the sole and exclusive venue shall be a court of competent jurisdiction located in Plumas County, California.

IN WITNESS WHEREOF, the Parties have executed this Memorandum of Understanding as of the date first written above.

CONTRACTOR:

USA Waste of California, Inc.

By:_____
Name: _____
Title: _____
Date signed: _____

By:_____
Name:_____
Title: _____
Date signed:_____

COUNTY:

County of Plumas, a political subdivision of the State of California

By:_____
Name: Jon Kennedy
Title: Chair, Board of Supervisors
Date signed: _____

APPROVED AS TO FORM:

_____
R. Craig Settlemire
Plumas County Counsel