CONSEJO ASESOR DE SALUD CONDUCTUAL

Junta General

Lunes, 15 de marzode 202 10:00 a 15:00

REUNIÓN VIRTUAL A TRAVÉS DE ZOOM

Ampliar la participación

La siguiente información a la que se hace referencia a continuación y al final del orden del día se le proporciona en apoyo de su asistencia a la próxima Junta General de BHAB a través de Zoom:

Únase a la reunión de Zoom de la siguiente manera:

Unirse a la reunión de zoom:
https://us02web.zoom.us/j/83332714732?pwd=bE43OUJqRHhHa0ExSlR5L1VLMWMyQT09
Identificación de la reunión: 833 3271 4732
Contraseña: 149553
Dial-In: 669-900-9128

Agenda

I. Llamada al orden

II. Roll Call

III. Bienvenida e introducciones

IV. Aprobación del orden del día – **ACCIÓN** (Roll Call)

V. Aprobación del 22de febrerode 2021 Minutos – **ACCIÓN** (Roll Call)

VI. Comentarios públicos (3 min. por orador)

VII. Presentacións
   A. Actualización trimestral del Comité Asesor de Gestión de Calidad (QMAC) – Sloane Burt, Gerente de Salud Conductual de VCBH, Mejora de la Calidad (15 min.)
   B. Resumen de directivas anticipadas psiquiátricas – Elizabeth R. Stone, MiembroBHAB (15 min.)

VIII. Observaciones de la Presidencia (5 min.)

IX. Informe del Director – Dr. Sevet Johnson (15 min.)

X. Comentarios y anuncios de los miembros de la Junta (10 min.)

XI. Informe de Secretary – Mary Haffner (5 min.)

XII. Informes del Comité BHAB (5 min. cada uno)
   A. Comité de Servicios para Adultos – Nancy Borchard, Copresidenta / Gane Brooking, Copresidenta
   B. Comité de Prevención – Janis Gardner, Presidenta
   C. Comité de Juventud en edad de transición (TAY) – Elizabeth R. Stone, Presidenta
   D. Comité de Servicios a la Juventud y la Familia – Kevin Clerici, Presidente

XIII. Viejo negocio
   A. Disparidades Reducción de Grupo de Trabajo Actualización – Gane Brooking y Marlen Torres (10 min.)
   B. Actualización del grupo de trabajo del especialista del mismo nivel – Elizabeth R. Stone (10 min.)
   C. Ombudsman/Peer Advocate Hiring Update – Dr. Sevet Johnson (5 min.)
   D. Respuesta del VCBH a las lagunas identificadas en el servicio – Discusión continuada (20 min.)

XIV. Nuevo negocio
   A. Seguimiento de VCBH sobre el proceso de comentarios públicos – Dr. Sevet Johnson (10 min.)

Los miembros del público que realizan presentaciones orales a la Junta en relación con uno o varios puntos del orden del día o no del orden del día en una sola reunión se limitan a un tiempo total acumulado para no exceder (5) minutos para todas sus presentaciones orales en dicha reunión a menos que se disponga lo contrario. Las observaciones públicas sobre los puntos del orden del día deben hacerse antes de las deliberaciones de los miembros de la junta sobre los puntos del orden del día. Todo el período de comentarios públicos está limitado a no más de (20) minutos en total para todos los oradores. NOTA: El Presidente puede limitar el número o la duración de los oradores sobre un asunto. Yon cumplimiento de la Ley de Estadounidenses con Discapacidades, si necesita asistencia especial para participar en esta reunión, comuníquese con la Administración de Salud Conductual al (805) 981-6830. La notificación previa razonable de la necesidad de adaptación antes de la reunión (48 horas de antelación es preferible) nos permitirá hacer arreglos razonables para garantizar la accesibilidad a esta reunión.

B. Abierto 30 días período de comentarios públicos sobre el proyecto de innovación salud mental móvil – Hilary Carson, administradora de innovaciones de MHSA - **ACCIÓN** (roll call) (10 min.)

C. Actualización anual del informe del año fiscal 2019-20 (5 min.)

D. Informe de seguimiento del Programa de Tratamiento Ambulatorio Asistido (ASSIST) – Dr. John Schipper (10 min.)

E. Actualización de la unidad de gestión de reclusos terapéuticos – Jerry Harris - (5 min.)

F. Solicitudes de presentación

G. Recomendaciones de premios de reconocimiento

XV. Contratos

A. Acuerdos aprobados por la Junta de Supervisores – 2 de febrero de 2021

1. Año fiscal (ejercicio fiscal) 2020-21 Quinta Enmienda del Acuerdo con tradiciones para los servicios psiquiátricos
2. Año Fiscal 2020-21 y Año Fiscal 21-22 Acuerdo con Tradiciones para servicios psiquiátricos

B. Acuerdos aprobados por la Junta de Supervisores – 9 de febrero de 2021

1. Año Fiscal 2020-21 Pshhc Memorándum de Entendimiento para la Prestación de Servicios de Apoyo en el Hotel El Patio

C. Consejo de Supervisores Acuerdos Aprobados – 23 de febrero de 2021

1. Año Fiscal 2020-21 al año fiscal 2024-25 Acuerdo con Evalcorp for Mental Health Student Services Act (MHSSA) Grant Evaluation Services
2. Año Fiscal 2020-21 y ejercicio fiscal 2021-22 Acuerdo con Turning Point Foundation for Augmented Board and Care Services

XVI. Comentarios públicos (3 min. por orador)

XVII. Aplazar

Próxima reunión: Lunes 19 de abril de 2021

Tenga en cuenta la siguiente información importante relacionada con el apoyo a su participación en la próxima reunión:

1. El zoom comenzará inicialmente con una **"sala de espera",** se le "admitirá" en la sala de reuniones cuando comience la reunión.
2. La reunión está grabada.
3. Todos los participantes se silencian al entrar para minimizar cualquier interrupción involuntaria de los sonidos de fondo. Por favor, manténgase mudo a menos que esté hablando.
4. Tenga en cuenta lo siguiente con respecto a las partes de comentarios públicos del orden del día:
   a. Los comentarios públicos se hacen **"levantando la mano"** de una de las siguientes maneras:
      i. Si se une a la reunión a través de vídeo/audio, se une a la cola de comentarios de las siguientes maneras:
         1. Si está ejecutando una versión anterior de Zoom, puede "levantar la mano" haciendo clic en la ventana del participante en la parte inferior de la pantalla Zoom y luego hacer clic en la función **"levantar la mano"** en esa ventana del participante.
         2. Si está ejecutando la versión más actual de Zoom (5.4.9 y superior) puede "levantar la mano" haciendo clic en el botón Reacciones y luego haciendo clic en la función "levantar la mano". Su mano aparecerá en la esquina superior izquierda de su ventana de Zoom individual, así como la ventana del participante.
         3. Tenga en cuenta que su mano levantada aparecerá al anfitrión en el orden en que fue recibida.
      ii. Si se une a la reunión solo por teléfono, puede unirse a la cola de comentarios pulsando ***9**. Cuando sea tu turno de hacer tu comentario, presiona ***6** para desactivar y luego de nuevo para silenciarte.
   b. Los comentarios se toman en el orden en que se reciben en la ventana de cola/participante.
   c. Cuando sea tu turno de hacer un comentario, se te pedirá que te desmutes.
   d. Los comentarios públicos pueden ser de hasta 3 minutos durante los períodos de comentarios públicos, o antes de un punto del orden del día, con un tiempo total acumulado que no exceda de 5 minutos.
   e. El cronometrador asignado realizará un seguimiento de cada tiempo de comentario público, así como del tiempo total por altavoz. Cuando termine su tiempo, el cronometrador interrumpirá para hacerle saber que ha alcanzado el máximo de 3 minutos, así como cuando haya alcanzado su tiempo total asignado.
   f. Al final de los tres minutos y/o el tiempo asignado, el micrófono se abrirá a la siguiente persona en la cola de comentarios.

Los miembros del público que realizan presentaciones orales a la Junta en relación con uno o varios puntos del orden del día o no del orden del día en una sola reunión se limitan a un tiempo total acumulado para no exceder (5) minutos para todas sus presentaciones orales en dicha reunión a menos que se disponga lo contrario. Las observaciones públicas sobre los puntos del orden del día deben hacerse antes de las deliberaciones de los miembros de la junta sobre los puntos del orden del día. Todo el período de comentarios públicos está limitado a no más de (20) minutos en total para todos los oradores. NOTA: El Presidente puede limitar el número o la duración de los oradores sobre un asunto. Yon cumplimiento de la Ley de Estadounidenses con Discapacidades, si necesita asistencia especial para participar en esta reunión, comuníquese con la Administración de Salud Conductual al (805) 981-6830. La notificación previa razonable de la necesidad de adaptación antes de la reunión (48 horas de antelación es preferible) nos permitirá hacer arreglos razonables para garantizar la accesibilidad a esta reunión.

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Healthcare Agency

March 15, 2021

VCBH QUALITY MANAGEMENT ACTION COMMITTEE (QMAC)

To Review the Quality of Specialty Mental Health and Substance Use Services and Advise on Improvement Efforts

Presentation to the Behavioral Health Advisory Board

Role of the QMAC

- Per DHCS, a quality improvement committee, locally named the Quality Management Action Committee (QMAC), shall review the quality of specialty mental health & substance use services provided to beneficiaries

- QMAC activities may include:
  - Policy recommendations.
  - Review and evaluation of QI activities, including performance improvement projects (PIPs).
  - Recommend QI actions.
  - Ensure follow-up of QI processes.
  - Documentation of QI committee meeting minutes regarding decisions and actions taken.

(MHP Contract, Ex. A, Att. 5)

Quality Focus Areas

Advanced Prevention & Awareness	Service Utilization and Level of Care	Access and Timeliness	Health Equity & Cultural Competency
Client Satisfaction & Grievances	Provider Appeals & Grievances	Service Delivery Effectiveness/ Clinical Outcomes	Network Adequacy & Service Distribution
Patient Safety & Medication Practices	Coordination and Continuity of Care	Documentation Review	Staff/ Provider Satisfaction & Development

VENTURA COUNTY BEHAVIORAL HEALTH

QMAC Structure

- Committee includes:
  - Behavioral Health staff
  - Partner Agency representatives
  - Consumers and Family Members
- General QMAC meetings held 3 times a year
- Every 3 years a SWOT analyses will be conducted
- Ad hoc committees will be convened to address special topics

- In FY 2018-19 SWOT analyses were conducted by 4 subcommittees:
  - Adult, Youth, Substance Use, and Cultural Equity.
  - Results have informed meeting content and information shared since then.

Key Findings from 18-19 SWOT Analyses

	Substance Use Services	Adults	Youth and Family	Health Equity
Increase Awareness	Roadmap to Services	Roadmap to Services	Roadmap to Services	Roadmap to Services
Partnerships	Increase Partnerships (Child & Family Services and Jails)	Peer Service Model	Standardize Caseload Assignment	Improve Communication and Partnerships (SUTS, MH, System Partners)
Balance	Workforce Solutions (Partnership with Local Universities)		Improve No Show rate	Improve Access

VENTURA COUNTY BEHAVIORAL HEALTH

FY 2019-20 & FY 2020-21 Meetings

Information Shared:

- Audits & Reviews
- Employee Engagement Survey
- Quality Assessment Performance Improvement Plan (QAPI)
- Performance Improvement Projects (PIPs)
- New Technology: Policy Stat & MD-Staff
- Impact of COVID-19

Special Topic Input Sessions:

- Timeliness
- Road Map to Services
- Grievances & Appeals
- Cultural & Linguistic Competence, especially in the times of COVID-19
- Beneficiary Outcomes and Satisfaction with Services

2020 QMAC Results and Action Updates

June & September 2020 Committee Feedback

Enhance Cultural and Linguistic Competency
"Studies show Latinos use their cell phones for most internet access"

VCBH Website Revamp
"Community resource listing being added under the Cultural Competency webpage for Health Equity"

Grievances and Appeals
"Consider bicultural/bilingual staff involved to assist in the process. Bicultural peer advocates to help guide them through the grievance process, help the process be less intimidating, help answer questions"

Group Discussion
"How can clinics and providers ensure clients feel they are being treated sensitively, empathetically, and feel heard?"

Group Discussion
"What would culturally competent linguistic services look like in times like these?"

2020-21 QMAC Committee New Membership Cycle

Completed Action Items

Office of Health Equity have many efforts to improve services via enhanced cultural and linguistic competency communication. Multimedia campaign via What's App, Facebook.

Navigation
- Breadcrumbs
- Search
- Landing pages

Access
- Contact Info
- Clinic location
- Resources

Content
- Expanded program information
- New pages

Roadmap to Services
- Continuum of Care

Developed new procedure for Grievances and Appeals. Updates to the policy includes education about the grievance and appeals process during the intake orientation (CA-60 and SUS-19).

Proposal of a study to identify the community through population data such as preferences of the LGBTQ+ and other communities.
iPads have been purchased to be used to get more real time data from the TPS to assess adult consumer satisfaction.

Development of process for concurrent communication sent in our threshold languages- English, Spanish and Indigenous language. New distribution plans for resource guidance.

QMAC membership recruitment - QI sent out notices to current QMAC members and recruited new members. Identified new members for a balanced representation.

VENTURA COUNTY BEHAVIORAL HEALTH

MH Performance Improvement Projects

Enhanced Access PIP (August 2018 through July 2020)

- Goal: Improve timely access from an initial request for service (RFS) to first kept service.
- Began in Santa Paula, expanded to Oxnard Clinics
- Interventions included allowing for “walk-in” requests, bringing assessment process to local clinics through staff increases and/or expanded duties, and conducting group orientation session (N. Oxnard) to expedite intake process
- Overall results: Steady increase in the number of consumers who received a first service within the 10-day DHCS standard

MH Performance Improvement Project

Post-Hospitalization PIP (July 2020-present)

- Goal: Enhance the services provided to consumers discharged from an inpatient psychiatric unit (IPU) to decrease the 7 and 30-day readmission rates
  - Project started with a targeted population of clients at Vista Del Mar with a 30-day readmission
- Interventions currently include enhanced care coordination with more timely notifications and document sharing to support coordination between the hospital and outpatient clinic staff
  - Additional and expanded interventions forthcoming
  - Grant-funded post-hospitalization care coordination team being created to broaden the scope of the PIP
- Initial data analysis underway

MH Performance Improvement Project

Client Progress Summary PIP (August 2020 – present)

- Goal: To enhance client engagement through the development and implementation of a “client progress summary” tool which will display various mental health outcome measure(s) data and other client information that can be used for collaborative service planning and treatment goal setting.
- Initial Steps: Surveyed providers about current use of data/information to guide service planning and to gather their input on ways data/information could be made presentable and useful to clients.
- Next Steps: Design “client progress summary” tool then pilot test; study the use of the tool and its impact on enhancing client engagement and involvement in services

SUS Performance Improvement Project

Clinical PIP: Study of care coordination post- discharge (April 2019 to April 2021)

- Goal: to help clients leaving residential care stay engaged in the ASAM treatment continuum by following up with admission to a lower level of care. Clients who stay in treatment longer have better chances of recovery.
- Intervention: members of a care coordination team help client with case management/discharge planning as the client prepares to exit residential treatment.
- Findings: percentage of clients admitted to outpatient care within 7 days of a residential discharge improved from baseline[1] of 4.7% to 10.4% after the intervention[2], which exceeds the statewide average. Both staff and client feedback indicate a high level of satisfaction with the care coordination process.

[1] 1/1/19 – 9/30/19

[2] 10/1/19 – 1/31/21

VENTURA COUNTY BEHAVIORAL HEALTH

SUS Performance Improvement Project

Non-clinical PIP: Study of timeliness from first contact to assessment (April 2019 to April 2021)

- Goal: to decrease time to service for clients' first clinical appointment after an initial service request.
- Intervention: more systematic entry of no-show/cancellation notes and weekly monitoring of this process by clinic administrators which 1) improves data completeness, 2) helps clinicians conduct more frequent client outreach after missed appointments, and 3) improves efficiency and accountability for clinician documentation time.
- Findings: The median number of days from first service request to first clinical appointment decreased from 14 days at baseline[1] to 7 days after the intervention[2], which is well within the 10-day state standard. Other timeliness process improvements were identified and carried out as well, as a result of increased data monitoring around this PIP.

[1] 1/1/19 – 7/31/20

[2] 8/1/20 – 1/31/21

VENTURA COUNTY BEHAVIORAL HEALTH

Thank you!

Questions or comments can be directed to
vcbh.quality@ventura.org

VENTURA COUNTY
BEHAVIORAL HEALTH

Advance Health Care Directive of _____

(Your name)

Instructions Included in My Directive

Put a check mark in the left-hand column for each section you have completed.

#	**PART I** **Appointment of an Agent for Healthcare**
1 ☐	Designation of Health Care Agent Designation of Alternate Health Care Agent
2 ☐	Authority Granted to My Agent
3 ☐	My choice as to a Court Appointed Conservator
#	**PART II(a)** **Statement of Individual Mental Health Care Instructions**
4 ☐	Who, In Addition to My Health Care Agent, Should Be Notified Immediately of My Admission To a Psychiatric Facility?
5 ☐	My Choice of Treatment Facility and Choices for Alternatives to Hospitalization If 24-Hour Care is Deemed Medically Necessary for My Safety and Well-being
6 ☐	My Primary Physician who is to Have Primary Responsibility for my Mental Health Care is:
7 ☐	My Choices about primary Physicians Who Will Treat Me if I Am Hospitalized and my Primary Physician is Unavailable
8 ☐	My Choices Regarding Methods for Avoiding Emergency Situations
9 ☐	My Choices Regarding Emergency Interventions
9(a) ☐	My Choices Regarding **Routine** Medications for Psychiatric Treatment
9(b) ☐	My Choices Regarding **Emergency** Psychiatric Medication
10 ☐	My Choices Regarding Electroconvulsive Therapy
11 ☐	The Following People Are to be Prohibited from Visiting Me
12 ☐	Other Instructions About Mental Health Care

#	**PART II(b)** **Individual Physical Health Care Instructions**
13 ☐	My Primary Physician who is to Have Primary Responsibility for my Physical Health Care is:
14 ☐	Statement of Desires, Special Provisions and Limitations
15 ☐	My Choices Regarding Experimental Studies and Drug Trials
16 ☐	My Instructions Regarding Life Sustaining Treatment
17 ☐	My Choices Regarding Contribution of Anatomical Gift
18 ☐	My Instructions Regarding Autopsy
19 ☐	Choices Regarding Disposition of My Remains

Advance Health Care Directive of _____

(Your name)

PART I
APPOINTMENT OF AN AGENT FOR HEALTH CARE

****MAKE SURE YOU GIVE YOUR AGENT**
A COPY OF ALL SECTIONS OF THIS DOCUMENT**

If no agent is designated under the Power of Attorney for Health Care section of this document, or if the agent cannot be located, health care providers must still follow any Individual Health Care Instructions contained in this document. Cal. Probate Code Sections 4670, 4671. An agent has priority over any other person in making health care decisions for the patients. Cal. Probate Code Section 4685.

STATEMENT OF INTENT TO APPOINT AN AGENT:

I, (*your name*) _____, being of sound mind, authorize a health care agent to make certain decisions of my behalf regarding my health treatment when I am incompetent to do so unless I mark this box ☐, in which case my agent's authority to make health care decisions for me takes effect immediately. I intend that those decisions should be made in accordance with my expressed wishes as set forth in this document. If I have not expressed a choice in this document, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

1. Designation of Health Care Agent

A. I hereby designate and appoint the following person as my agent to make health care decisions for me as authorized in this document. This person is to be notified immediately of my admission to a psychiatric facility.

Name: _____

Address: _____

City, State, Zip Code: _____

Day Phone: _____ Evening Phone: _____

Pager: _____ Cell Phone: _____

Designation of Alternate Health Care Agent

If the person named above is unavailable, unable or unwilling to serve as my agent, I hereby appoint and desire immediate notification of my alternative agent as follows:

Name: _____

Address: _____

City, State, Zip Code: _____

Day Phone: _____ Evening Phone: _____

Pager: _____ Cell Phone: _____

2. Authority Granted to My Agent

If I become incapable of giving informed consent to health care treatment, or if I marked the box under "Statement of Intent to Appoint an Agent" causing my agent's authority to make decisions for me to immediately become effective, I hereby grant to my agent full power and authority to make health care decisions for me, including the right to consent, refuse consent, or withdraw consent to any health care, treatment, service or procedure, consistent with any instructions and/or limitations I have set forth in this advance directive EXCEPT as I state here. If I have not expressed a choice in this advance directive, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

_____

_____

_____

_____

_____

_____

3. My Choice as to a Court-Appointed Conservator

In the event a court decides to appoint a conservator who will make decisions regarding my health treatment, I desire the following person to be appointed:

Name: _____ Relationship:_____

Address: _____

City, State, Zip Code: _____

Day Phone: _____ Evening Phone: _____

Pager: _____ Cell Phone: _____

The appointment of a conservator or other decision maker shall not give the conservator or decision maker the power to revoke, suspend, or terminate my individual health care instructions or the powers of my agent.

****MAKE SURE YOU GIVE YOUR AGENT AND ALTERNATE AGENT A COPY OF ALL SECTIONS OF THIS DOCUMENT****

Advance Health Care Directive of _____

(Your name)

PART II(a)
STATEMENT OF INDIVIDUAL
MENTAL HEALTH CARE INSTRUCTIONS

In this part, you state how you wish to be treated (such as which hospital you wish to be taken to, which medications you prefer) if you become incapacitated or unable to express your own wishes. If you want a paragraph to apply, put your initials before the paragraph letter. If you do not want the paragraph to apply to you, leave the line blank.

NO INDIVIDUAL MENTAL OR PHYSICAL HEALTH CARE INSTRUCTION CONTAINED IN THIS DOCUMENT MAY BE CARRIED OUT AGAINST MY WISHES.

4. Who, In Addition to My Health Care Agent, Should Be Notified Immediately of My Admission To a Psychiatric Facility? *Be sure to include the agent and any alternate agent you designate in your Durable Power of Attorney, if you have one.*

Name: _____

Address: _____

City, State, Zip Code: _____

Day Phone: _____ Evening Phone: _____

Pager: _____ Cell Phone: _____

Name: _____

Address: _____

City, State, Zip Code: _____

Day Phone: _____ Evening Phone: _____

Pager: _____ Cell Phone: _____

Name: _____

Address: _____

City, State, Zip Code: _____

Day Phone: _____ Evening Phone: _____

Pager: _____ Cell Phone: _____

Name: _____

Address: _____

City, State, Zip Code: _____

Day Phone: _____ Evening Phone: _____

Pager: _____ Cell Phone: _____

5. My Choice of Treatment Facility and Choices for Alternatives to Hospitalization If 24-Hour Care is Deemed Medically Necessary for My Safety and Well-being

☐ A. In the event my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I would prefer to receive this care at the following programs/facilities instead of psychiatric hospitalization.

Facility's Name: _____

Reason: _____

Facility's Name: _____

Reason: _____

Facility's Name: _____

Reason: _____

☐ B. In the event I am to be admitted to a hospital for 24-hour care, I would prefer to receive care at the following hospitals:

Facility's Name: _____

Reason: _____

Facility's Name: _____

Reason: _____

Facility's Name: _____

Reason: _____

☐ C. I do not wish to be admitted to the following hospitals or programs/facilities for psychiatric care for the reasons I have listed:

Facility's Name: _____

Reason: _____

Facility's Name: _____

Reason: _____

Facility's Name: _____

Reason: _____

6. My Primary Physician who is to Have Primary Responsibility for my Mental Health Care is:

Dr. _____ Phone _____

Address _____ Pager _____

City, State, Zip _____ _____

7. My Choices about the Physicians Who Will Treat Me if I Am Hospitalized and my Primary Physician is Unavailable

Put your initials before the letter and complete if you wish either or both paragraphs to apply.

____ A. My choice of treating physician if the above physician is unavailable is:

Dr._____ Phone _____

Address _____

OR if neither is available

Dr._____ Phone _____

OR if none of the above is available

Dr._____ Phone _____

____B. I do not wish to be treated by the following, for the reasons stated:

Dr._____ Reason:_____

OR _____

Dr._____ Reason:_____

OR _____

Dr._____ Reason:_____

_____

8. My Choices Regarding Methods for Avoiding Emergency Situations

If during my admission or commitment to a mental health treatment facility it is determined that I am engaging in behavior that **may** make emergency intervention necessary, I prefer the following choices to help me regain control:

Fill in numbers, giving 1 to your first choice, 2 to your second, and so on until each has a number. If your choice is not listed, write it in after "other" and give it a number as well.

- ❑ Provide a quiet private place
- ❑ Have a staff member of my choice talk with me one-on-one
- ❑ Allow me to engage in physical exercise
- ❑ Offer me recreational activities
- ❑ Assist me with telephoning a friend or family member
- ❑ Offer me the opportunity to take a warm bath
- ❑ Offer me medication
- ❑ Offer me a cigarette
- ❑ Allow me to go outside
- ❑ Provide me with materials to journal or do artwork
- ❑ Offer me assistance with breathing or calming exercises
- ❑ Provide me with a radio to listen to
- ❑ Other: _____

_____

_____

_____

9. My Choices Regarding Emergency Interventions

If, during an admission or commitment to a mental health treatment facility, it is determined that I am engaging in behavior that requires an emergency intervention (e.g., seclusion and/or physical restraint and/or medication), my wishes regarding which form of emergency interventions should be made as follows. I prefer these interventions in the following order:

Fill in numbers, giving 1 to your first choice, 2 to your second, and so on until each has a number. If an intervention you prefer is not listed, write it in after "other" and give it a number as well. If you do not want a listed intervention ever used, cross it out and explain why under "Reasons for my choices."

	Reasons for my choices
❑ Seclusion	_____
❑ Physical restraints	_____
❑ Seclusion and physical restraint (combined)	_____
❑ Medication by injection	_____
❑ Medication in pill form	_____
❑ Liquid medication	_____
❑ During seclusion and/or restraint, I prefer to be checked by **female** staff	_____
❑ During seclusion and/or restraint, I prefer to be checked by **male** staff	_____
❑ Other:_____	_____
_____	_____
See Section 9(b) for choices regarding emergency medication	_____

I expect the choice of medication in an emergency situation to reflect any choices I have expressed in this section and in Section 9(b). **The choices I express in this section and Section 9(b) regarding medication in emergency situations do not constitute consent to use of the medication for non-emergency treatment**.

9(a). My Choice Regarding *Routine* Medications for Psychiatric Treatment

In this section, you may choose any of the paragraphs A-G that you wish to apply. Be sure to initial those you choose.

If it is determined that I am not legally competent to consent to or to refuse medications relating to my mental health treatment, my wishes are as follows:

____ A. I consent to the medications agreed to by my agent, after consultation with my treating physician and any other individuals my agent may think appropriate, with the reservations, if any, described in (D) below.

____ B. I consent to and authorize my agent to consent to the administration of:

Medication Name or Medication Type	**Not to exceed the following dosage/day**	**OR**	**In such dosage(s) as determined by**
_____	_____		Dr. _____
_____	_____		
_____	_____		Or if unavailable, then by
_____	_____		
_____	_____		Dr. _____
_____	_____		
_____	_____		
_____	_____		

____ C. I consent to the medications deemed appropriate by Dr. _____ , whose address and phone number are: _____

_____

9(a) Continued

____D. I specifically do not consent and I do not authorize my agent to consent to the administration of the following medications or their respective brand name, trade name, or generic equivalents:

Name of Drug	**Reason for Refusal**
_____	_____
	_____
_____	_____
	_____
_____	_____
	_____
_____	_____
	_____

____ E. I am willing to take the medications excluded in (D) above if my only reason for excluding them is their side effects and the dosage can be adjusted to eliminate those side effects.

____ F. I am concerned about the side effects of medications and do ***not*** consent or authorize my agent to consent to any medication that has any of the side effects I have checked below at 1% or greater level of incidence (*check all that apply)*.

- ❑ Tardive dyskinesia
- ❑ Loss of Sensation
- ❑ Motor Restlessness
- ❑ Seizures
- ❑ Muscle/skeletal rigidity
- ❑ Tremors
- ❑ Nausea/vomiting
- ❑ Neuroleptic Malignant Syndrome
- ❑ Other _____
  _____
  _____

____ G. I have the following other choices about psychiatric medications:

_____

_____

9(b) My Choices Regarding *Emergency* Psychiatric Medication

If during my admission or commitment to a mental health facility, it is determined that I am engaging in behavior that requires emergency psychiatric medication, I prefer the following medication:

Medication Name or Medication Type	Not to exceed the following dosage/day	OR	In such dosage(s) as determined by
_____	_____		Dr. _____
_____	_____		
_____	_____		Or if unavailable, then by
_____	_____		
_____	_____		Dr. _____
_____	_____		
_____	_____		
_____	_____		

The choices expressed in this section regarding medication in emergency situations do not constitute consent to use of the medication for non-emergency treatment.

10. My Choices Regarding Electroconvulsive Therapy

☐ A. I **do not** consent to administration of electroconvulsive therapy.

B. Under California law, this Directive **cannot** be used to consent for electroconvulsive therapy. However, if I am administered electroconvulsive therapy, I have the following choices:

☐ I will be administered no more than the following number of treatments _____ .

☐ I will be administered the number of treatments deemed appropriate by Dr. _____, whose phone number and address is:

_____.

11. The Following People Are to be Prohibited from Visiting Me:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

12. Other Instructions About Mental Health Care

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must sign and date EACH of the additional pages at the same time you sign and date this document.)

Advance Health Care Directive of _____

(Your name)

PART II(b)
INDIVIDUAL PHYSICAL HEALTH CARE INSTRUCTIONS

NO INDIVIDUAL MENTAL OR PHYSICAL HEALTH CARE INSTRUCTION CONTAINED IN THIS DOCUMENT MAY BE CARRIED OUT AGAINST MY WISHES

13. My Primary Physician who is to have primary responsibility for my physical health care is:

Dr._____ Phone _____

Address _____ Pager_____

City, State, Zip Code: _____

OR if the above physician is unavailable, then I request:

Dr._____ Phone _____

Address: _____

City, State, Zip Code: _____

OR if neither of the above is available, then I request:

Dr._____ Phone _____

Address: _____

City, State, Zip Code: _____

I specifically do not want to be treated by the following physicians:

Dr._____ Reason:_____

OR _____

Dr._____ Reason:_____

OR _____

Dr._____ Reason:_____

_____

14. Statement of Desires, Special Provisions and Limitations

☐ A. I specifically express the following desires concerning these health care decisions:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

☐ B. And I specifically limit this Advance Directive as follows:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must sign and date EACH of the additional pages at the same time you sign and date this document.)

15. My Choices Regarding Experimental Studies and Drug Trials

☐ I **will not** participate in experimental studies or drug trials.

Under recent changes to California law, a health care agent, if one has been appointed, a conservator, a family member, or domestic partner may consent to participation in a medical experiment on behalf of a person who is unable to consent under very specific circumstances. See Health and Safety Code, section 24178 for a list of these specific circumstances.

Complete this section **only** if you do not consent to participation in medical experiments under any circumstances.

16. My Instructions Regarding Life Sustaining Treatment

☐ A. I **do not** want my life to be prolonged and I **do not** want life-sustaining treatment to be provided or continued: (1) if I am in an irreversible coma or persistent vegetative state; or (2) if I am terminally ill and the application of life sustaining procedures would serve only to artificially delay the moment of my death; or (3) under any other circumstances where the burdens of treatment outweigh the expected benefits. I want the relief of suffering and the quality as well as the possible extension of my life considered in making decisions concerning life-sustaining treatment.

OR

☐ B. I want my life to be prolonged and I want life sustaining treatment to be provided **unless I am in a coma or vegetative state** which my doctor reasonably believes to be irreversible. Once my doctor has reasonably concluded that I will remain unconscious for the rest of my life, I **do not** want life-sustaining treatment to be provided or continued.

OR

☐ C. I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery or the cost of procedures.

AND/OR

☐ D. I specifically express the following desires concerning life-sustaining treatment.

_____

_____

_____

_____

_____

17. My Choices Regarding Contribution of Anatomical Gift

If either statement reflects your desires, sign the line next to the statement. You do not have to sign either statement. If you do not wish to sign either statement, your agent (if you have one) and your family will have the authority to make a gift of all or part of your body under the Uniform Anatomical Gift Act.

☐ I **do** want to make a gift under the Uniform Anatomical Gift Act, effective upon my death, of:

☐ Any needed organs or parts; or

☐ The parts or organs listed:

_____

_____

_____

_____
(Signature)

☐ I **do not** want to make a gift under the Uniform Anatomical Gift Act, nor do I want my agent or family to do so.

_____
(Signature)

18. My Instructions Regarding Autopsy

If either statement reflects your desires, sign the line next to the statement. You **do not** *have to sign either statement. If you do not sign either statement, your agent (if you have one) and your family will be able to authorize an autopsy.*

☐ I **do** authorize an examination of my body after death to determine the cause of my death.

_____
(Signature)

☐ I **do not** authorize an examination of my body after death to determine the cause of my death.

_____
(Signature)

19. Choices Regarding Disposition of my Remains

If either statement reflects your desires, sign the line beneath the statement. You do not have to sign either statement. If you do not sign either statement, your agent (if you have one) and your family will be able to direct the disposition of your remains.

☐ I **do** authorize

_____ _____

(name) (phone)

_____

(address/city/state/zip)

to direct the disposition of my remains by the following method:

☐ Burial

☐ Cremation

_____

(signature)

OR

☐ I have described the way I want my remains disposed of in:

☐ A written contract for funeral services with:

_____

(name and phone of mortuary/cemetery)

_____

(address/city/state/zip)

☐ My will.

☐ Other:_____

_____

(signature)

By signing below, I am executing this advance directive for health care and, by so doing, am revoking any prior durable power of attorney for health care.

EFFECT OF COPY: A copy of this form has the same effect as the original.

SIGNATURE: Sign and date the form here in the presence of your witnesses/notary.

_____	_____
(date)	*(signature)*
_____	_____
(address)	*(print your name)*
_____	
(city) *(state)*	

STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First Witness	Second Witness
_____	_____
(print name)	*(print name)*
_____	_____
(address)	*(address)*
_____	_____
(city) *(state)*	*(city)* *(state)*
_____	_____
(signature of witness)	*(signature of witness)*
_____	_____
(date)	*(date)*

ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California, that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

_____	_____
(signature of witness)	*(signature of witness)*

SPECIAL WITNESS REQUIREMENT: The following statement is required only if you are a patient in a skilled nursing facility – a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

_____	_____
(date)	*(signature)*
_____	_____
(address)	*(print your name)*
_____	
(city) *(state)*	

ACKNOWLEDGEMENT OF NOTARY PUBLIC

State of California)

County of _____)

On _____, before me, _____(here insert name and title of the officer), personally appeared _____ personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same.

WITNESS my hand and official seal.

Signature: _____ (Seal)

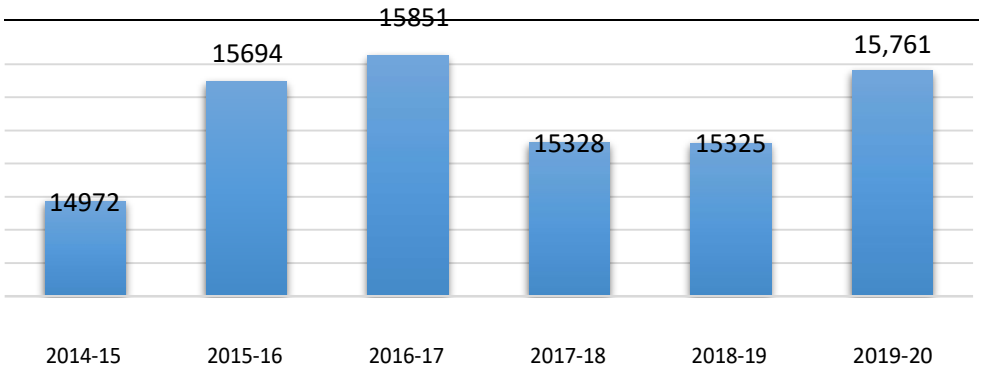
This document is valid only if signed by two witnesses OR acknowledged before a notary public.

Sumisión Número	BRECHA EN EL ELEMENTO DE SERVICIO	FRECUENCIA DE ENVÍO	RESPUESTA DE DIVISIÓN DE ADULTOS	RESPUESTA DE DIVISIÓN JUVENIL Y FAMILIAR
9	Camas para pacientes hospitalizados psiquiátricos adicionales	7	Las camas HPC adicionales están programadas ara entrar en línea 1/4/21. También participó en discusiones muy tempranas sobre el desarrollo de un Centro de Salud Psiquiátrico a través de una asociación público-privada. VCBH ise asocia con Alvarado Parkway Institute para abrir un CRT en Santa aula con la capacidad de tomar admisiones directas y voluntarias de la communitv.	Currently para jóvenes (12-17), Vista del Mar tiene hasta 17camas en un momento dado-esto fue un aumento ya que con el paso de los años siguientes al Thomas Fire. Ha habido algunos de las Ubicaciones del Condado basadas en necesidades específicas de edad (menores de12 años) que Vista no puede proporcionar a veces.
8	Sillas/Slots adicionales de la CSU	5	Se está programado que las sillas adicionales de la CSU del condado vengan enla línea 1/4/21. VCBH se asocia con Dignity/St. John's abrirá una CSU de 8 sillas en Oxnard y con Alvarado Parkway Institute para abrir un CRT en Santa Paula con la capacidad de tomar admisiones directas y voluntarias de la comunidad.	Se ha establecido una CSU juvenil durante más de 3 años y está respondiendo a la necesidad. La CSU de Y&F tiene una capacidad de cuatro camas y es raro tener que desviarse de ella debido a que está en el máximo censo.
22	Mantenga a las personas con enfermedades mentales graves fuera de la cárcel	5	RISE y Assist (y el equipo de crisis en algunos casos) con su enfoque en involucrar a clientes con enfermedades mentales graves, que no suelen estar involucrados en el tratamiento, indirectamente buscan reducir la probabilidad de arresto. Tribunal de Salud Mental y la desviación de salud mental proporcionan la oportunidad de tratamiento psiquiátrico como alternativa al encarcelamiento. VCBH contrata con Telecare para proporcionar tratamiento de salud mental al ser liberado de la cárcel a través del programa VISTA en un esfuerzo por reducir la reincidencia. Del mismo modo, VCBH contrata con Telecare para proporcionar tratamiento de salud mental a las derivaciones de libertad condicional AB109 a través del programa VOICE en un esfuerzo por reducir la reincidencia.	
2	Puntualidad en la prestación de servicios	3	VCBH ha contratado con Behavioral Assessment Inc. realizar una evaluación del proceso STAR (pre-COVID); puntualidad entre las cuestiones objeto de examen. Adaptaciones a las restricciones COVID han provocado evaluaciones remotas / virtuales que parecen haber creado gran facilidad de acceso y mejorado timeliness.	Al llamar a la clínicade la Juventud y la Familia, una nueva cita está programada dentro de los 10 días. Si el caso se hubiera cerrado el año en que se reabrió el caso, y se programa una ingesta en un plazo de 10 días.

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Consumidores de VCBH atendidos en el año

Recuento de clientes noplicado



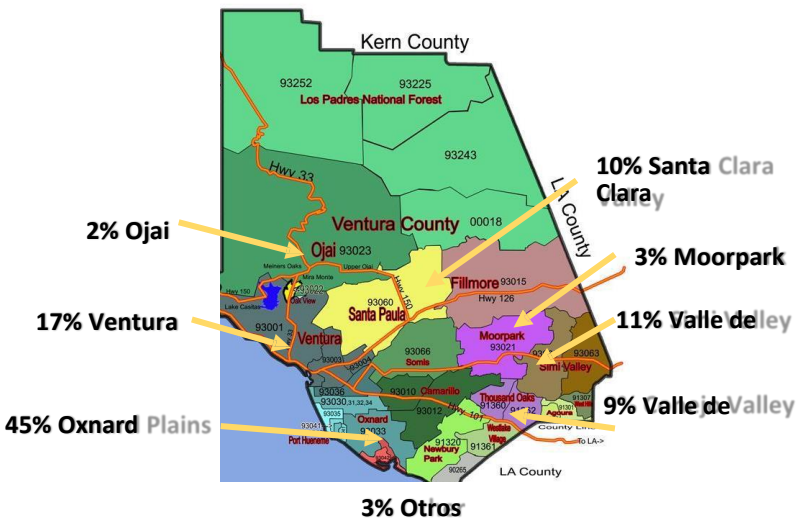
Sinduplicar Cliente Contar Incluye Clientes Con Medi-Cal, Da.A del Sur. Y Otro Pagador Fuentes

Raza / Etnicidad

- 45% latino el hispano
- 32% Blanco
- 15% desconocido
- 3% Afroamericano
- 3% Carrera Múltiple el

Edad

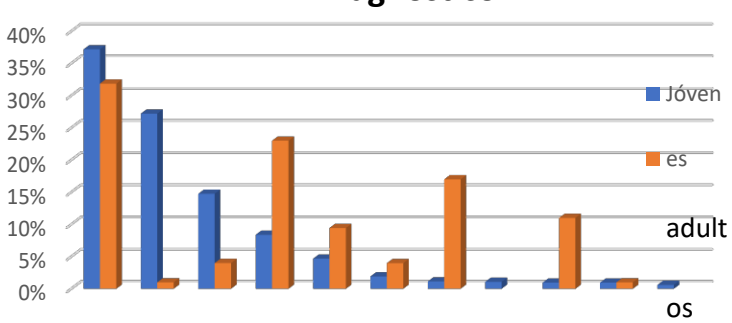
• 0-5	5%
•6-17	33%
•18-25	13%
•25-64	45%
•65+	5%

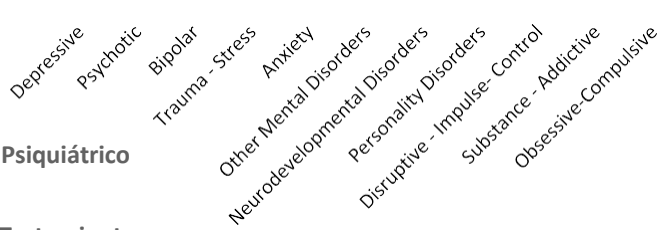


Género

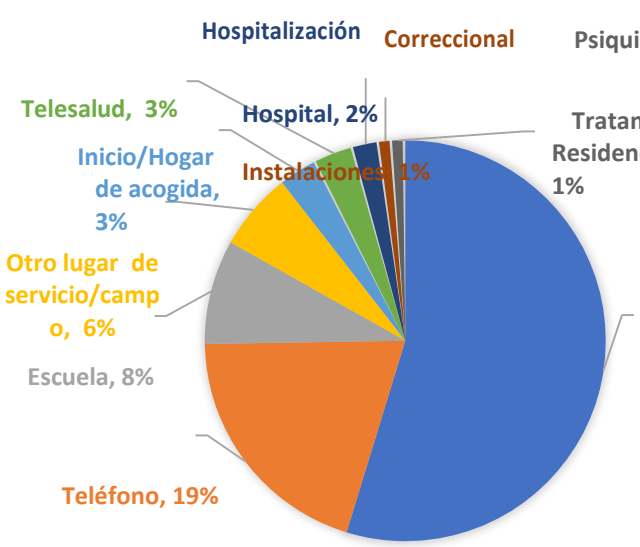
- 51% Femenino
- 49% masculino

Diagnóstico





Ubicación del servicio



Servicios proporcionados

Adulto vcbh	45%
VCBH Juventud y Familia	34%
ESTRELLA VCBH	19%
Crisis de adultos	19%
Jóvenes y contratistas	12%
Adulto Csu	5%
Uip	5%
Contratistas adultos	4%
Sin datos	3%

El número de clientes atendidos en 19-20 fue ligeramente mayor que en los últimos años. Aún así, los

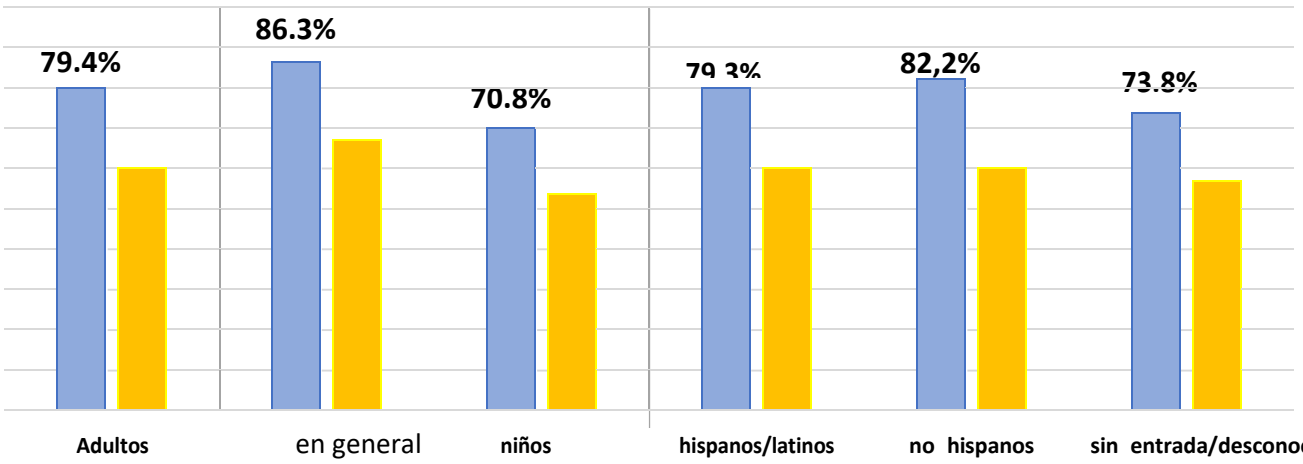
det

el

Fuente de datos: Resumen de VCBH de clientes atendidos desde Electronic Health Record

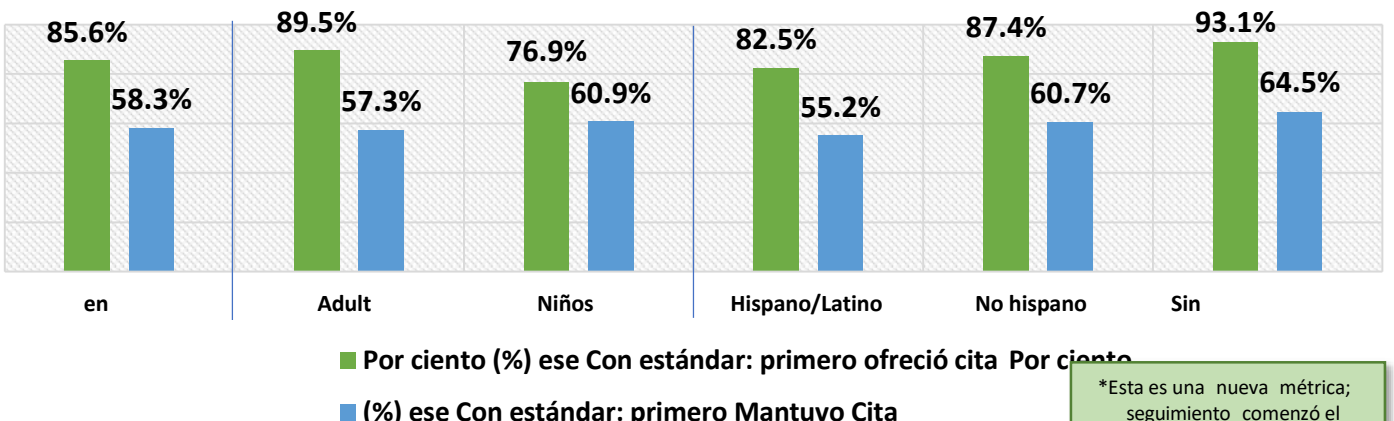
https://vcbh.org

Tiempo desde **la solicitud inicial** hasta la **primera** cita **ofrecida** y **solicitud** inicial para **mantener primero** la cita. Estándar: 10 días hábiles.



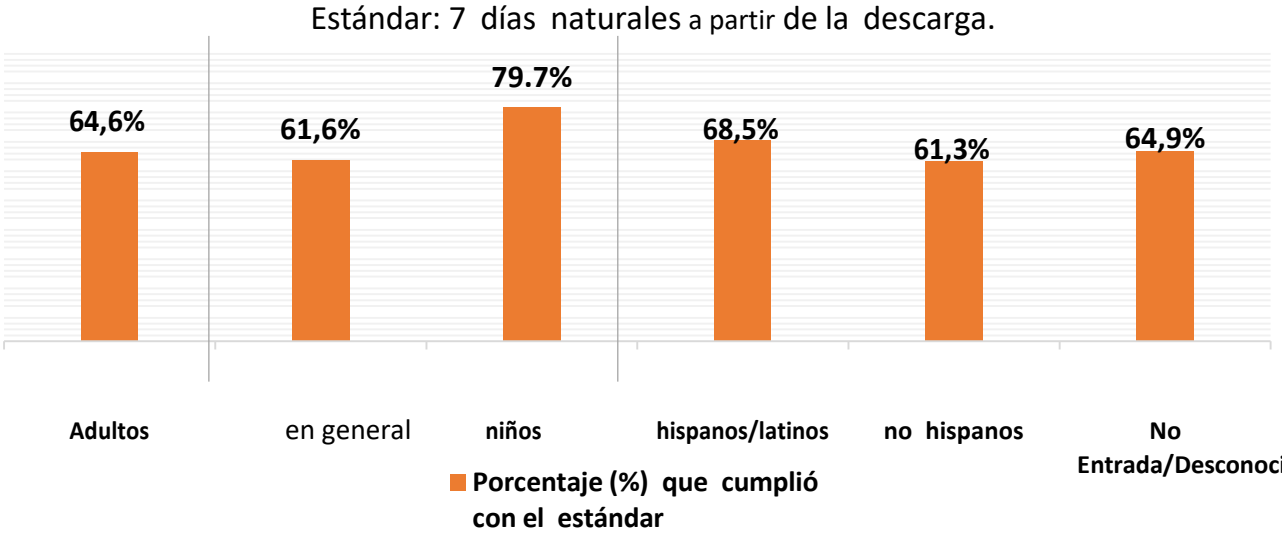
Los proyectos específicos recientes él ayudado Un mejorar estas medidas de puntualidad. En comparación, en general en el ejercicio fiscal 18-19, el **57,4%** de las solicitudes cumplieron con el estándar para la primera oferta y el **42,6%** lo cumplieron para la primera cita real.

Tiempo desde la **solicitud inicial** hasta **la primera cita psiquiátrica*** y la **solicitud inicial** de **mantener primero** la cita **psiquiátrica.** Estándar: 15 días hábiles



*Esta es una nueva métrica; seguimiento comenzó el

Puntualidad de las citas de seguimiento después del alta hospitalaria psiquiátrica. Estándar: 7 días naturales a partir de la descarga.



En el año fiscal 18-19, el **47%** de las citas cumplieron con el estándar de seguimiento de 7 días. VCBH actualmente tiene Un proyecto de mejora y financiación de subvenciones para mejorar los apoyos para los clientes en el período de alta hospitalaria post-psiquiátrico. Los objetivos suyos aumentar la coordinación asistencial y reducir las tasas de re-hospitalización, que actualmente están en el 19% en general.

Acceso oportuno

Datos Fuente: Servicio Datos De Electrónico Grabado

https://vcbh.org

El Departamento de Servicios de Atención Médica establece normas de acceso oportunos para garantizarme ntal HeAlth serVices Unre PrOvided en una oportuna Manár. Tély Unre examined yTemprano DuReng el proceso de revisión externa. Algunas medidas clave de acceso oportuno se destacan a Siguientes y se presentan para todos *los clientes. para*

Salud conductual del condado de Ventura

de la Junta Resumen de contratos para febrero de 2021

Board Date	Contractor	Amount	Term	Description
2/2/2021	Psychology Group, Inc., dba Traditions Behavioral Health (Tradiciones)	$8,771,111	July 1, 2020 to January 31, 2021	**Fiscal (ejercicio fiscal) 2020-21 Quinta Enmienda del Acuerdo con Tradiciones para los Servicios Psiquiátricos.** Traditions proporciona servicios médicos psiquiátricos en varios sitios de clínicas/programas en todo el sistema de Salud Conductual del Condado de Ventura (VCBH). La Quinta Enmienda del Acuerdo de Servicios Psiquiátricos con Tradiciones revisa los términos de compensación y el plazo del acuerdo para tener en cuenta un período de siete (7) meses, en lugar de un período de doce (12) meses. El acuerdo existente finalizará el 31 de enero de 2021 y será sustituido por un nuevo acuerdo que abarcará el período comprendido entre el 1 de febrero de 2021 y el 30 de junio de 2022.
2/2/2021	Tradiciones	$21,740,821	February 1, 2021 through June 30, 2022	**Año Fiscal 2020-21 y Año Fiscal 21-22 Acuerdo con Tradiciones para Servicios Psiquiátricos.** Traditions proporciona servicios médicos psiquiátricos en varios sitios de clínicas/programas en todo el sistema VCBH. El nuevo acuerdo con Traditions incorpora los siguientes cambios en los términos del acuerdo del acuerdo anterior: (1) agrega el Código de Conducta de los Servicios de Consumo de Sustancias (SUS) de VCBH y los requisitos al acuerdo según lo requerido por el Departamento de Servicios de Atención Médica (DHCS), (2) agrega un profesional de enfermería equivalente a tiempo completo (FTE) de la División SUS al acuerdo para llevar a cabo tareas de subvención de integración de salud conductual (BHI), (3) añade un médico o enfermero de Integración de Atención Primaria de .60 FTE al acuerdo para completar las tareas de concesión del BHI para la atención ambulatoria, (4) revisa el alcance del trabajo para agregar las funciones específicas requeridas por el DIRECTOR MÉDICO del DHCS, (5) revisa el alcance del trabajo para incluir un servicio de atención directa al cliente mínimo para médicos y profesionales de enfermería que mejorará la prestación de servicios , y (6) revisa las condiciones de compensación para agregar financiación adicional para los 1,60 puestos de FTE añadidos al acuerdo y ajusta la forma en que los médicos/profesionales de enfermería son compensados en virtud del acuerdo. El número total de médicos y enfermeros está aumentando de 33,25 a 34,85 FTE. Para el período del 1 de febrero, De 2021 al 30 de junio de 2021, el monto máximo del acuerdo será de $6,394,359 y para el período del 1 de julio de 2021 al 30 de junio de 2022, el monto máximo del acuerdo será de $15,346,462 (un aumento de $310,271 con respecto al acuerdo del año anterior).
2/9/2021	Corporación de Vivienda de Autoayuda popular (PSHHC)	$0	February 9, 2021 through June 30, 2021	**Año Fiscal 2020-21 Pshhc Memorando de Entendimiento para la Prestación de Servicios de Apoyo en el Hotel El Patio.** La misión de PSHHC es construir viviendas permanentes y de apoyo con servicios basados en sitios que ofrezcan oportunidades para cambiar vidas y fortalecer comunidades. Bajo este memorando de entendimiento, PSHHC continuará siendo propietario y administrar el Hotel El Patio, un edificio de apartamentos convertido, compuesto por cuarenta y dos (42) apartamentos de ocupación de habitaciones individuales o alquiler de estudio ubicados en 167 South Palm, Ventura, California, para personas de muy bajos ingresos. De estas unidades, 16 unidades están reservadas para personas de muy bajos ingresos que tienen una discapacidad psiquiátrica. VCBH se compromete a proporcionar servicios de apoyo a aquellas personas con discapacidad psiquiátrica de muy bajos ingresos que residen en el Hotel El Patio. Estos servicios de apoyo pueden incluir: a) gestión de casos, b) asistencia de promoción de beneficios y apoyo a los ingresos, como ingreso suplementario de seguridad (SSI), asistencia temporal para familias necesitadas, asistencia general, CalFresh (anteriormente cupones de alimentos) c) que organizan servicios de gestión/pago de dinero, d) gestión/monitoreo de medicamentos, y e) asistencia para obtener otros recursos y apoyo basados en la comunidad, como cuidado infantil, transporte, educación, capacitación laboral y empleo.

2/23/2021	Evalcorp	$200,000	February 23, 2021 through June 30, 2025	**Año Fiscal 2020-21 al Año Fiscal 2024-25 Acuerdo con Evalcorp for Mental Health Student Services Act (MHSSA) servicios de evaluación de subvenciones.** A través de mhssa Grant de la Comisión de Supervisión y Rendición de Cuentas de Servicios de Salud Mental (MHSOAC, por sus hijos) de VCBH, VCBH está colaborando con la Oficina de Educación del Condado de Ventura (VCOE) para utilizar los fondos de subvenciones mhssa para establecer y administrar centros de bienestar in situ en campus específicos de escuelas secundarias para aumentar el acceso a los servicios de salud mental en lugares que son fácilmente accesibles para los estudiantes y sus familias. VCBH está contratando con Evalcorp para proporcionar los servicios de evaluación necesarios requeridos en virtud del acuerdo de subvención de MHSSA con el MHSOAC. En concreto, Evalcorp se contratará para: a) trabajar en colaboración con VCBH y VCOE para desarrollar infraestructura de evaluación y capacidad de evaluación, b) colaborar con VCBH para revisar las herramientas de recopilación de datos según sea necesario y/o crear nuevas herramientas de evaluación para garantizar la recopilación continua de datos de evaluación de alta calidad, c) llevar a cabo la entrada de datos requerida para los proveedores según sea necesario para informar informes trimestrales y de fin de año, d) crear planes de análisis de datos y realizar análisis estadísticos univariados y multivariantes de alta calidad, e) elaborar un informe de evaluación anual, y f) prepararse y facilitar reuniones mensuales de evaluación con VCBH y VCOE. El plazo del contrato se extenderá durante un período de cinco años para alinearse con el plazo de concesión y conceder los requisitos de presentación de información. El monto inicial del contrato para el primer año del acuerdo (año fiscal 2020-21) será de $25,000. Los montos del contrato para el año fiscal 2021-22, el año fiscal 2022-23 y el año fiscal 2023-24 serán de $50,000 por cada año fiscal. El monto del contrato para el último año del acuerdo (año fiscal 2024-25) será de $25,000.
2/23/2021	Fundación Punto de Inflexión	$486,911	March 1, 2021 through June 30, 2022	**Año Fiscal 2020-21 y año fiscal 2021-22 Acuerdo con Turning Point Foundation for Augmented Board and Care Services.** El acuerdo con Turning Point Foundation garantiza un mínimo de 20 camas para clientes de VCBH. El acuerdo incluye un presupuesto inicial de $95,411 que permitirá a Turning Point Foundation contratar personal, proporcionar la instalación y comprar los materiales y suministros necesarios para prepararse para Thompson Place para aceptar clientes a partir del 1 de abril de 2021. VCBH también pagará a Turning Point Foundation una tarifa por cliente/mes de $1,305 por servicios de pensión y cuidado aumentados. Esta tarifa se suma a los beneficios mensuales de SSI que los clientes asignarán a Turning Point Foundation para servicios básicos de junta y atención. Si un cliente no tiene beneficios SSI, VCBH proporcionará fondos temporales para cubrir la junta básica y los servicios de atención hasta que el cliente reciba beneficios de SSI. Para el período del 1 de marzo de 2021 al 30 de junio de 2021, el monto máximo del acuerdo será de $173,711 y para el período del 1 de julio de 2021 al 30 de junio de 2022, el monto máximo del acuerdo será de $313,200.