BEHAVIORAL HEALTH ADVISORY BOARD
General Meeting
Monday, March 15, 2021, 1:00 – 3:30 PM
VIRTUAL MEETING VIA ZOOM

Zoom Participation

The following information referenced below and at the end of the agenda is provided to you in support of your attending the upcoming BHAB General Meeting via Zoom:

Join the Zoom meeting in the following way:

Join Zoom Meeting: https://us02web.zoom.us/j/83332714732?pwd=bE43OUJqRHhHa0ExSlR5L1VLMWMyQT09
Meeting ID: 833 3271 4732
Password: 149553
Dial-In: 669-900-9128

AGENDA

I. Call to Order

II. Roll Call

III. Welcome and Introductions

IV. Approval of the Agenda – **ACTION** (Roll Call)

V. Approval of the February 22, 2021 Minutes – **ACTION** (Roll Call)

VI. Public Comments (3 min. per speaker)

VII. Presentations

A. Quality Management Advisory Committee (QMAC) Quarterly Update – Sloane Burt, VCBH Behavioral Health Manager, Quality Improvement (15 min.)

B. Psychiatric Advance Directives Overview – Elizabeth R. Stone, BHAB Member (15 min.)

VIII. Chair Comments (5 min.)

IX. Director's Report – Dr. Sevet Johnson (15 min.)

X. Board Member Comments and Announcements (10 min.)

XI. Secretary's Report – Mary Haffner (5 min.)

XII. BHAB Committee Reports (5 min. each)

A. Adult Services Committee – Nancy Borchard, Co-Chair / Gane Brooking, Co-Chair
B. Prevention Committee – Janis Gardner, Chair
C. Transitional Age Youth (TAY) Committee – Elizabeth R. Stone, Chair
D. Youth & Family Services Committee – Kevin Clerici, Chair

XIII. Old Business

A. Disparities Reduction Workgroup Update – Gane Brooking and Marlen Torres (10 min.)
B. Peer Specialist Workgroup Update – Elizabeth R. Stone (10 min.)
C. Ombudsman/Peer Advocate Hiring Update – Dr. Sevet Johnson (5 min.)
D. VCBH Response to the Identified Gaps in Service – Continued Discussion (20 min.)

XIV. New Business

A. VCBH Follow-Up on Public Comments Process – Dr. Sevet Johnson (10 min.)

Members of the public making oral presentations to the Board in connection with one or more agenda or non-agenda items at a single meeting are limited to a cumulative total time not to exceed (5) minutes for all of their oral presentations at such meeting unless otherwise provided. Public comments on agenda items must be made prior to board member deliberations of agenda items. The entire public comment period is limited to no more than (20) minutes total for all speakers. NOTE: The Chair may limit the number or duration of speakers on a matter. In compliance with the Americans With Disabilities Act, if you need special assistance to participate in this meeting, please contact Behavioral Health Administration at (805) 981-6830. Reasonable advance notification of the need for accommodation prior to the meeting (48 hours advance notice is preferable) will enable us to make reasonable arrangements to ensure accessibility to this meeting.

B. Open 30-day Public Comment Period on Innovation Project Mobile Mental Health – Hilary Carson, MHSA Innovations Administrator - **ACTION** (Roll Call) (10 min.)

C. FY2019-20 Annual Report Update (5 min.)

D. Assisted Outpatient Treatment Program (ASSIST) Follow-Up Report – Dr. John Schipper (10 min.)

E. Therapeutic Inmate Management Unit Update – Jerry Harris - (5 min.)

F. Presentation Requests

G. Recognition Award Recommendations

XV. Contracts

A. Board of Supervisors Approved Agreements – February 2, 2021

1. Fiscal Year (FY) 2020-21 Fifth Amendment to the Agreement with Traditions for Psychiatric Services
2. FY 2020-21 and FY 21-22 Agreement with Traditions for Psychiatric Services

B. Board of Supervisors Approved Agreements – February 9, 2021

1. FY 2020-21 PSHHC Memorandum of Understanding for the Provision of Supportive Services at the El Patio Hotel

C. Board of Supervisors Approved Agreements – February 23, 2021

1. FY 2020-21 to FY 2024-25 Agreement with Evalcorp for Mental Health Student Services Act (MHSSA) Grant Evaluation Services
2. FY 2020-21 and FY 2021-22 Agreement with Turning Point Foundation for Augmented Board and Care Services

XVI. Public Comments (3 min. per speaker)

XVII. Adjourn

Next Meeting: Monday, April 19, 2021

Please note the following important information related to supporting your participation in the upcoming meeting:

1. Zoom will initially start with a "**waiting room**"—you will be "admitted" into the meeting room when the meeting starts.
2. The meeting is recorded.
3. All participants are muted upon entry to minimize any unintended disruption of background sounds. Please keep yourself on mute unless you are speaking.
4. Note the following regarding the public comment portions of the agenda:
   a. Public comments are made by **"raising your hand"** in one of the following ways:
      i. If you are joining the meeting via video/audio, you join the comment queue in the following ways:
         1. If you are running an older version of Zoom, you can "raise your hand" by clicking on the participant window at the bottom of the Zoom screen and then click on the **"raise hand"** feature in that participant window.
         2. If you are running the most current version of Zoom (5.4.9 and above) you can "raise your hand" by clicking on the Reactions button and then clicking on "raise hand" feature. Your hand will appear in the upper left-hand corner of your individual Zoom window as well as the participant window.
         3. Note that your raised hand will appear TO THE HOST in the order it was received.
      ii. If you are joining the meeting by telephone only, you can join the comment queue by pressing ***9**. When it is your turn to make your comment, press ***6** to unmute and then again to mute yourself.
   b. Comments are taken in the order they are received in the queue/participant window.
   c. When it is your turn to make a comment, you will be asked to unmute yourself.
   d. Public comments may be up to 3 minutes during the public comment periods, or before an agenda item, with a cumulative total time not to exceed 5 minutes.
   e. The assigned timekeeper will track each public comment time as well as the total time per speaker. When your time is up, the timekeeper will interrupt to let you know that you have reached the 3-minute maximum as well as when you have reached your total allotted time.
   f. At the end of the three minutes and/or allotted time, the mic will be opened to the next person in the comment queue.

Members of the public making oral presentations to the Board in connection with one or more agenda or non-agenda items at a single meeting are limited to a cumulative total time not to exceed (5) minutes for all of their oral presentations at such meeting unless otherwise provided. Public comments on agenda items must be made prior to board member deliberations of agenda items. The entire public comment period is limited to no more than (20) minutes total for all speakers. NOTE: The Chair may limit the number or duration of speakers on a matter. In compliance with the Americans With Disabilities Act, if you need special assistance to participate in this meeting, please contact Behavioral Health Administration at (805) 981-6830. Reasonable advance notification of the need for accommodation prior to the meeting (48 hours advance notice is preferable) will enable us to make reasonable arrangements to ensure accessibility to this meeting.

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)

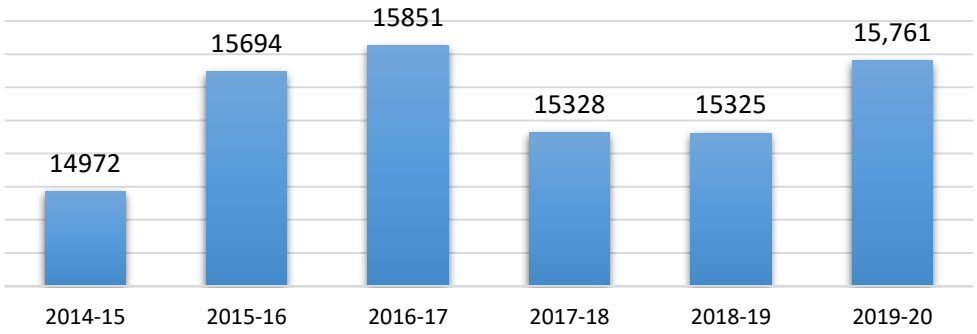
This document is valid only if signed by two witnesses OR acknowledged before a notary public.

SUBMISSION NUMBER	GAP IN SERVICE ITEM	SUBMISSION FREQUENCY	RESPONSE FROM ADULTS DIVISION	RESPONSE FROM YOUTH AND FAMILY DIVISION
9	Additional Psychiatric Inpatient Beds	7	Additional HPC beds are scheduled to come online 1/4/21. Also engaged in very early discussions about the development of a Psychiatric Health Facility through a public/private partnership. VCBH is partnering with Alvarado Parkway Institute to open a CRT in Santa Paula with the capacity to take direct, voluntary admits from the community.	Currently for youth (12-17), Vista del Mar has up to 17 beds at any given time—this was an increase since over the years following the Thomas Fire. There have been some out of County Placements based on age specific needs (below age 12) that Vista is not at times able to provide.
8	Additional CSU Chairs/Slots	5	Additional County CSU chairs are scheduled to come online 1/4/21. VCBH is partnering with Dignity/St. John's to open a 8-chair CSU in Oxnard and with Alvarado Parkway Institute to open a CRT in Santa Paula with the capacity to take direct, voluntary admits from the community.	A youth CSU has been established for over 3 years and is responding to the need. The Y&F CSU has a four bed capacity and it is rare to need to divert from it due to it being at maximum census.
22	Keep People with Serious Mental Illness Out of Jail	5	RISE and Assist (and the Crisis Team in some instances) with their focus on engaging clients with serious mental illnesses, who are not typically engaged in treatment, indirectly seek to reduced the likelihood of arrest. Mental Health Court and Mental Health Diversion provide the opportunity for psychiatric treatment as an alternative to incarceration. VCBH contracts with Telecare to provide mental health treatment upon release from jail via the VISTA program in an effort to reduce recidivism. Similarly, VCBH contracts with Telecare to provide mental health treatment to AB109 Probation referrals via the VOICE program in an effort to reduce recidivism.	
2	Timeliness in Service Delivery	3	VCBH has contracted with Behavioral Assessment Inc. to conduct an evaluation of the (pre-COVID) STAR process; timeliness being among the issues under review. Adaptations to COVID restrictions have prompted remote/virtual assessments which seem to have created greater ease of access and improved timeliness.	Upon calling the Youth & Family clinic, a new appointment is scheduled within 10 days. If the case had been closed w/n the year the case is re-opened, and an intake is scheduled within 10 days.

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

VCBH Consumers Served FY 2019-20

Unduplicated Client Count



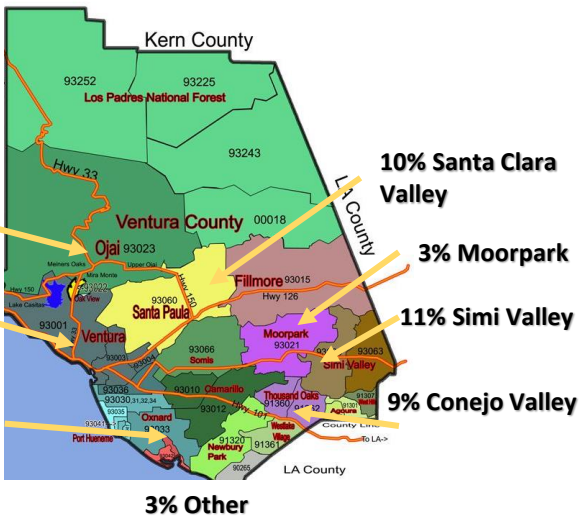
Unduplicated Client Count includes clients with Medi-Cal and other payor sources

Race / Ethnicity

- 45% Latino or Hispanic
- 32% White
- 15% Unknown
- 3% African American
- 3% Multiple Race or Filipino

Age

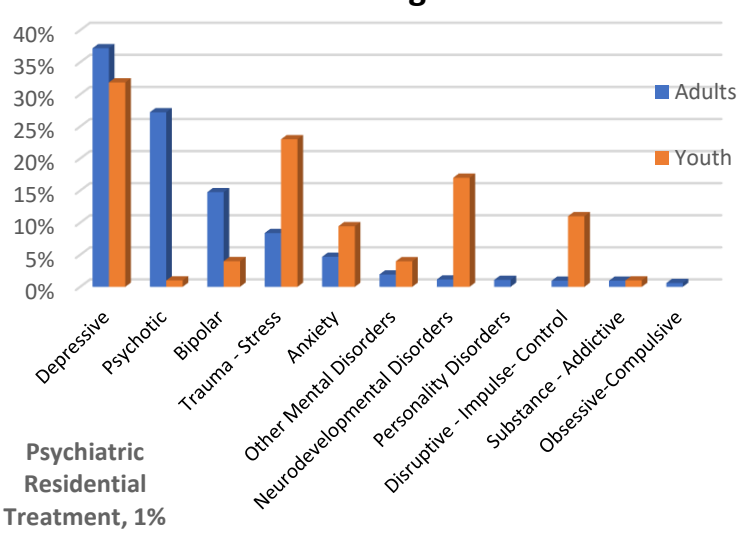
• 0-5	5%
•6-17	33%
•18-25	13%
•25-64	45%
•65+	5%



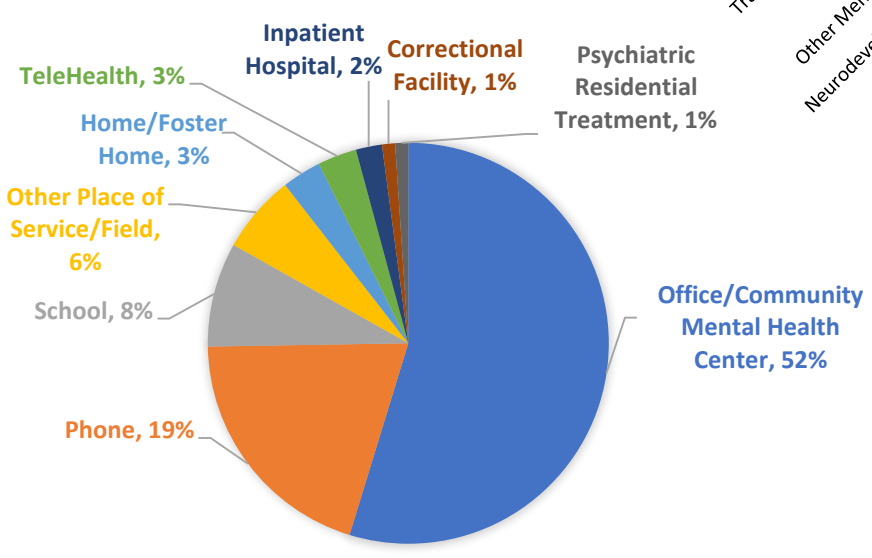
Gender

- 51% Female
- 49% Male

Diagnosis



Service Location



Services Provided By	
VCBH Adult	45%
VCBH Youth and Family	34%
VCBH STAR	19%
Adult Crisis	19%
Youth & Family Contractors	12%
CSU Adult	5%
IPU	5%
Adult Contractors	4%
No Data	3%

The number of clients served in 19-20 was slightly greater than in the last few years. Still, the client details, as described for 19-20, have remained proportionally similar over the last few years. A key difference this year is the increase in services provided by "phone" as a result of COVID-19.

Data source: VCBH summary of clients served from Electronic Health Record

https://vcbh.org

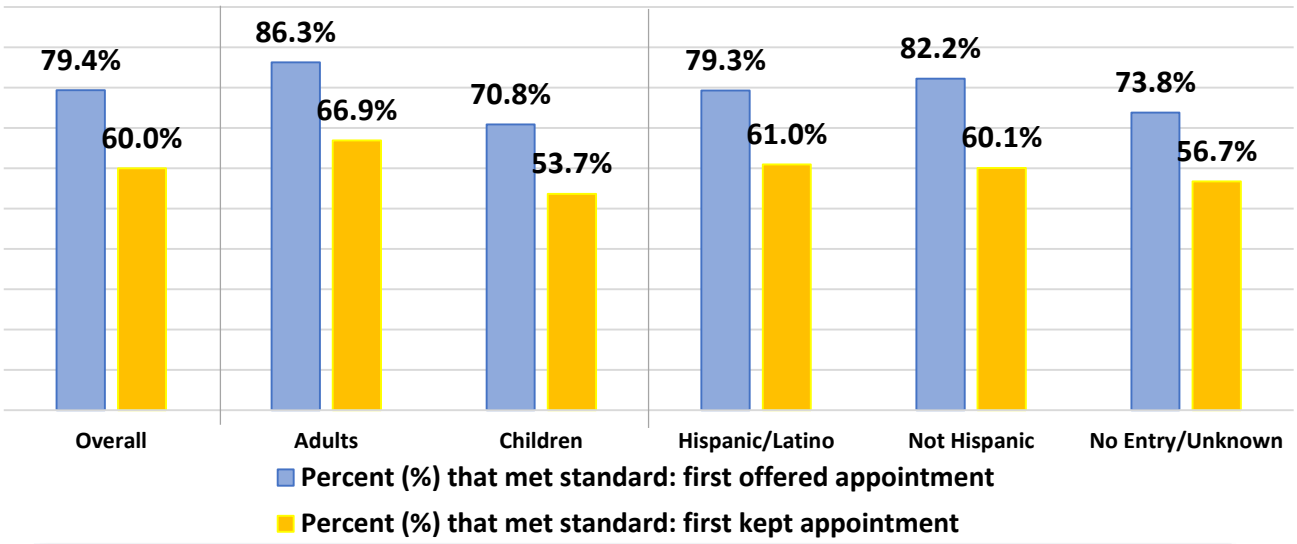
VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

VCBH Consumers Served FY 2019-2020: Timely Access

Timely access standards are established by the Department of Health Care Services to ensure mental health services are provided in a timely manner. They are examined yearly during the external review process. Some key timely access measures are highlighted to follow and are presented for *all clients, for adults & children,* and *by ethnicity*.

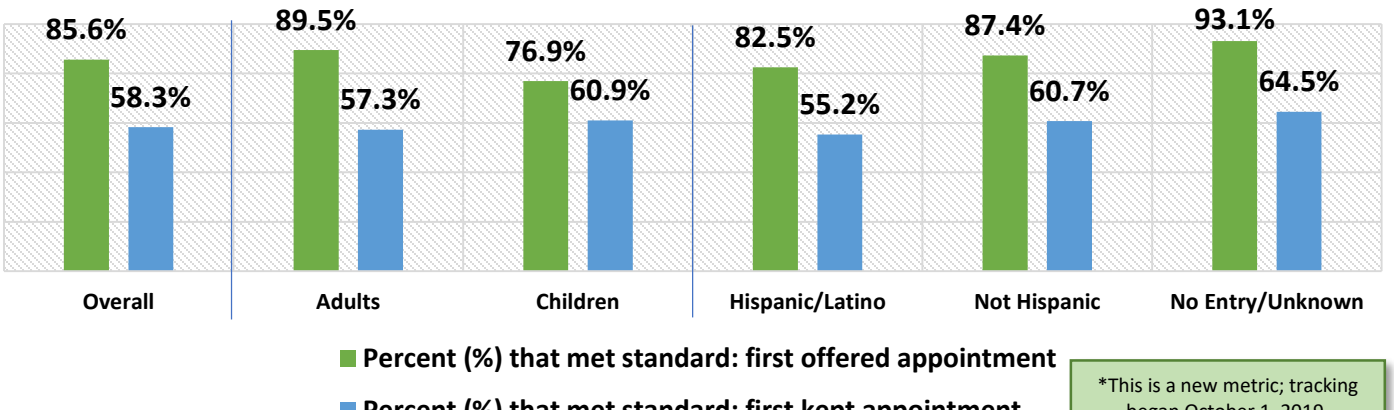
Note: Ethnicity data is self-reported and in some cases is not provided, here shown as no entry/unknown

Time from **initial request** to **first offered** appointment & **initial request** to **first kept** appointment. Standard: 10 business days.



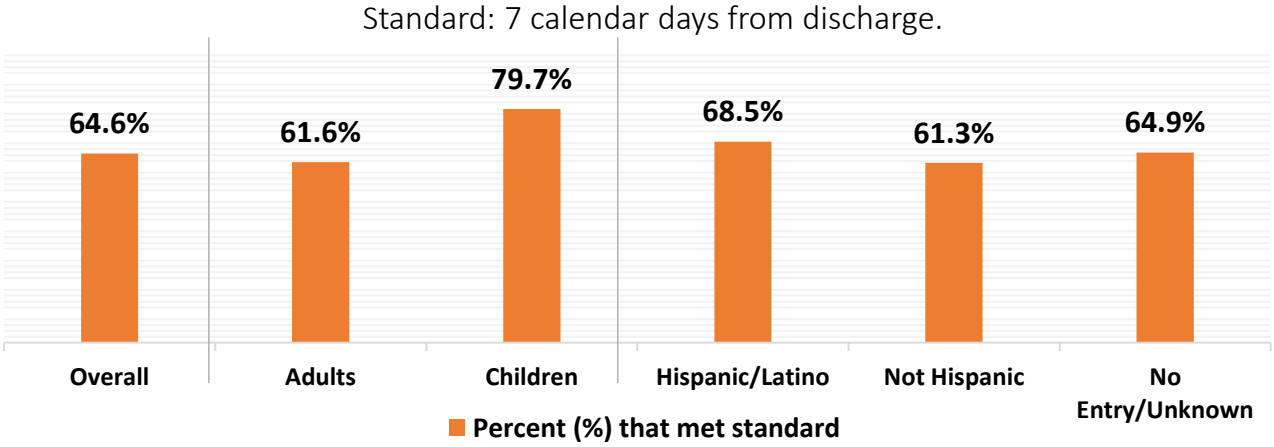
Recent targeted projects have helped to improve these timeliness measures. For comparison, overall in FY 18-19, **57.4%** of requests met the standard for first offered and **42.6%** met it for first actual appointment.

Time from **initial request** to **first offered psychiatric*** appointment & **initial request** to **first kept psychiatric** appointment. Standard: 15 business days



*This is a new metric; tracking began October 1, 2019.

Timeliness of **follow-up appointments** post-psychiatric inpatient discharge. Standard: 7 calendar days from discharge.



In FY 18-19, **47%** of appointments met the 7-day follow-up standard.
VCBH currently has an improvement project and grant funding to enhance supports for clients in the post-psychiatric inpatient discharge period. The goals are to increase care coordination and reduce re-hospitalization rates, which are currently at 19% overall.

Data source: Service Data from Electronic Health Record

https://vcbh.org

Ventura County Behavioral Health

Board Letter Summary of Contracts for February 2021

Board Date	Contractor	Amount	Term	Description
2/2/2021	Traditions Psychology Group, Inc., dba Traditions Behavioral Health (Traditions)	$8,771,111	July 1, 2020 to January 31, 2021	**Fiscal Year (FY) 2020-21 Fifth Amendment to the Agreement with Traditions for Psychiatric Services.** Traditions provides medical psychiatric physician services at various clinic/program sites throughout the Ventura County Behavioral Health (VCBH) system. The Fifth Amendment to the Agreement for Psychiatric Services with Traditions revises the compensation terms and agreement term to account for a seven (7) month period, instead of a twelve (12) month period. The existing agreement will end January 31, 2021 and be replaced with a new agreement that will cover the period of February 1, 2021 to June 30, 2022.
2/2/2021	Traditions	$21,740,821	February 1, 2021 through June 30, 2022	**FY 2020-21 and FY 21-22 Agreement with Traditions for Psychiatric Services.** Traditions provides medical psychiatric physician services at various clinic/program sites throughout the VCBH system. The new agreement with Traditions incorporates the following changes to the agreement terms from the prior agreement: (1) adds the VCBH Substance Use Services (SUS) Code of Conduct and requirements to the agreement as required by the Department of Health Care Services (DHCS), (2) adds a 1.0 full time equivalent (FTE) SUS Division nurse practitioner to the agreement to conduct Behavioral Health Integration (BHI) grant duties, (3) adds a .60 FTE Primary Care Integration physician or nurse practitioner to the agreement to complete BHI grant duties for ambulatory care, (4) revises the scope of work to add specific DHCS required SUS Medical Director service and supervision duties, (5) revises the scope of work to include a direct client care service minimum for physicians and nurse practitioners that will improve service delivery, and (6) revises the compensation terms to add additional funding for the 1.60 FTE positions added to the agreement and adjusts the manner in which physicians/nurse practitioners are compensated under the agreement. The total number of physician and nurse practitioners is increasing from 33.25 to 34.85 FTE. For the term of February 1, 2021 through June 30, 2021, the maximum agreement amount will be $6,394,359 and for the period of July 1, 2021 through June 30, 2022, the maximum agreement amount will be $15,346,462 (an increase of $310,271 over the prior year agreement).
2/9/2021	People's Self-Help Housing Corporation (PSHHC)	$0	February 9, 2021 through June 30, 2021	**FY 2020-21 PSHHC Memorandum of Understanding for the Provision of Supportive Services at the El Patio Hotel**. The mission of PSHHC is to build permanent, supportive housing with site-based services that offer opportunities to change lives and strengthen communities. Under this MOU, PSHHC will continue to own and manage the El Patio Hotel, a converted apartment building, comprised of forty-two (42) single room occupancy or studio rental apartments located at 167 South Palm, Ventura, California, for very low-income persons. Of these units, 16 units are set aside for very low-income persons who have a psychiatric disability. VCBH agrees to provide supportive services to those very low-income psychiatrically disabled persons residing at El Patio Hotel. These supportive services may include: a) case management, b) benefits advocacy and income support assistance such as Supplemental Security Income (SSI), Temporary Assistance for Needy Families, General Assistance, CalFresh (formerly food stamps) c) arranging for money management/payee services, d) medication management/monitoring, and e) assistance in obtaining other community-based resources and support such as child care, transportation, education, job training and employment.

2/23/2021	Evalcorp	$200,000	February 23, 2021 through June 30, 2025	**FY 2020-21 to FY 2024-25 Agreement with Evalcorp for Mental Health Student Services Act (MHSSA) grant evaluation services.** Through VCBH's Mental Health Services Oversight and Accountability Commission (MHSOAC) MHSSA Grant, VCBH is collaborating with Ventura County Office of Education (VCOE) to utilize the MHSSA grant funds to establish and manage on-site Wellness Centers on specific high school campuses to increase access to mental health services in locations that are easily accessible to students and their families. VCBH is contracting with Evalcorp to provide the necessary evaluation services required under the MHSSA grant agreement with the MHSOAC. Specifically, Evalcorp will be contracted to: a) work in collaboration with VCBH and VCOE to develop evaluation infrastructure and evaluation capacity, b) collaborate with VCBH to revise data collection tools as needed and/or create new evaluation tools to ensure high quality ongoing evaluation data collection, c) conduct required data entry for providers as needed to inform quarterly and year-end reporting, d) create data analysis plans and conduct requisite univariate and multivariate statistical analyses, e) develop an annual evaluation report, and f) prepare for and facilitate monthly evaluation meetings with VCBH and VCOE. The contract term will extend over a five-year period to align to the grant term and grant information submittal requirements. The initial contract amount for the first year of the agreement (FY 2020-21) will be $25,000. The contract amounts for FY 2021-22, FY 2022-23, and FY 2023-24 will be $50,000 for each fiscal year. The contract amount for the final year of the agreement (FY 2024-25) will be $25,000.
2/23/2021	Turning Point Foundation	$486,911	March 1, 2021 through June 30, 2022	**FY 2020-21 and FY 2021-22 Agreement with Turning Point Foundation for Augmented Board and Care Services.** The agreement with Turning Point Foundation guarantees a minimum of 20 beds for VCBH clients. The agreement includes a startup budget of $95,411 that will allow Turning Point Foundation to hire staff, furnish the facility, and purchase materials and supplies needed to prepare for Thompson Place to accept clients beginning April 1, 2021. VCBH will also pay Turning Point Foundation a rate per client/per month of $1,305 for augmented board and care services. This rate is in addition to the monthly SSI benefits that clients will assign to Turning Point Foundation for basic board and care services. If a client does not have SSI benefits, VCBH will provide temporary funding to cover basic board and care services until the client receives SSI benefits. For the term of March 1, 2021 to June 30, 2021, the maximum agreement amount will be $173,711 and for the period of July 1, 2021 to June 30, 2022, the maximum agreement amount will be $313,200.