County of Ventura
COUNTY EXECUTIVE OFFICE
MEMORANDUM

DATE: September 1, 2005

TO: Thomas W. Womack, Chief Deputy Executive Officer

FROM: David Stoll, CEO Management Analyst

SUBJECT: Response to 2004-05 Grand Jury Report No. 07 entitled, **"Mental Health Crisis Team: Behavioral Health Management"** on behalf of the Board of Supervisors

R-01: Establish administrative controls to ensure that policies and procedures have integrity and effective dates. Develop controls that would prevent one individual from manipulating the system.

Response: The Board concurs and believes the revised Procedure Number 1A completed by Behavioral Health management has addressed the concerns stated by the Grand Jury.

R-02. Provide separation of duties or checks and balances. Separate policy and procedure approval authority from the documentation and execution function.

Response: The Board concurs and believes the revised Procedure Number 1A completed by Behavioral Health management has addressed the concerns stated by the Grand Jury.

DS

County of Ventura
COUNTY EXECUTIVE OFFICE
MEMORANDUM

DATE: September 21, 2005

TO: Members, Board of Supervisors

FROM: John F. Johnston, CEO

SUBJECT: Response to 2004-05 Grand Jury Report No. 07 entitled, **"Mental Health Crisis Team: Behavioral Health Management"**

R-01: Establish administrative controls to ensure that policies and procedures have integrity and effective dates. Develop controls that would prevent one individual from manipulating the system.

Response: Policy A--1 has been revised to establish greater administrative control. (See Attachment G).

R-02. Provide separation of duties or checks and balances. Separate policy and procedure approval authority from the documentation and execution function.

Response: The revised Policy A--1 addresses the concerns raised by the Grand Jury according to the Health Care Agency Director. The HCA Compliance Officer will continue to follow-up to verify that the necessary changes are implemented.

JFJ

Attachment G

VENTURA COUNTY BEHAVIORAL HEALTH POLICIES AND PROCEDURES

POLICY:	SCOPE AND DEVELOPMENT OF POLICIES AND PROCEDURES	PROCEDURE NO: A1	Page 1 of 3
DEPARTMENT:	ADMINISTRATION	ORIGINAL EFFECTIVE DATE: 8/11/00	REVISION DATES: 12/15/00; 2/10/04; 9/12/05
AFFECTS:	ALL DEPARTMENTS		REVIEW DATES:

APPROVED BY:

Linda Shulman
Behavioral Health Director

Behavioral Health Medical Director

POLICY:

It is the policy of Ventura County Behavioral Health (VCBH), which encompasses Mental Health Services, Alcohol and Drug Services, Proposition 36 and Drinking Driver Program, to develop and maintain one integrated policy and procedure manual. This manual will provide general guidelines for the effective and efficient management of VCBH, will be available to staff, on the Intranet, and will serve as the sole and comprehensive reference for all policies and procedures for the department.

PROCEDURE:

A. All policies in this manual are consistent with, and incorporate by reference, those set forth in the Ventura County Administrative Manual, the Ventura County Medical Center (VCMC) Compliance Manual, and the policy and procedures of VCMC.

B. Unless otherwise noted, policies and procedures in this manual apply to all VCBH organizational units and offices.

C. The office of the Behavioral Health Director shall be responsible for coordinating development and implementation of the policies and procedures included in this manual. The Managers of each division will be responsible for:

1. Review of all proposed policies and procedures for incorporation into the department manual;
2. Reviewing the manual on an annual basis;
3. Developing policies and procedures as appropriate;

The MA III in Administration will be responsible for:

1. Assigning numbers, formatting, and editing each policy and procedure;

2. Forwarding the policies and procedures to the Health Care Agency Information Technology Services (HCA ITS) Department to post on the Intranet, and maintaining the official hard copy of the manual;
    a. The HCA ITS Department will be responsible for posting the policy to the Intranet and forwarding notification to staff of policy updates.

D. VCBH policies and procedures will follow a standard format as follows:

1. All policies and procedures will be typed on the official VCBH policy and procedure template (Attachment A).

2. The Original Policy Effective Date is established when a new policy is implemented. This date never changes.

3. The Review Date is noted each time a policy is reviewed for accuracy, but no changes are made.

4. A Revision Date is noted any time revisions are made to a policy.

5. All attachments and accompanying text will be stamped with the policy and procedure number, and will be kept current.

E. Generally, all VCBH services are responsible for developing policies and procedures for their area of expertise, and all staff members are encouraged to participate in this process.

F. The procedure for submitting proposed new or revised policies and procedures, securing the required approvals, and getting new or revised policies and procedures disseminated is as follows:
    1. The author of the new or revised policy submits it to the Management Assistant (MA) in Administration. In the case of proposed revisions to existing policies, the author will submit the old policy with the proposed revisions attached.
    2. The author compares the proposed policy to existing policies of VCMC, Ventura County Administration, and the Office of Compliance to ensure consistency and conformity.
    3. If necessary, the author modifies the proposed policy to ensure such consistency and conformity.
    4. The author must identify areas that are impacted by the new or revised policy so that the MA can forward the proposed policy to the Managers in these areas for review and comment (Attachment B).
    5. The reviews by the Managers will be logged (Attachment C) and forwarded to the author who will incorporate any comments and finalize the procedure.
    6. The author will produce a memo (Attachment D) describing the approved policy, the training that will be required for the effective implementation of that policy, including the date that the training will occur, and the implementation date of the policy. This memo and the final draft of the policy are then forwarded to the MA.

7. The MA will forward the policy to the Behavioral Health Director and Medical Director for final approval and signature.
8. The approved policy and the memo from the Manager will go to affected areas and training as needed, will occur. Staff are required to sign the memo indicating they have received the appropriate training.
9. An annual audit of training logs/receipts are maintained by Program Administrators
10. The approved policy will be forwarded by the MA to the Health Care Agency Information Technology Services (HCA ITS) in Adobe PDF format via e-mail with the date of implementation one week prior to the effective date of the policy and procedure (Attachment E).
    a. Within one week HCA ITS will insert the new or revised document in the VCBH policy and procedure website, and delete any prior policy or procedure as applicable.
    b. Immediately after completing the step above, HCA ITS will send an e-mail out to all VCBH staff, notifying them that the Intranet Policies and Procedures Website has been updated.

ATTACHMENTS:

A. Policy and Procedure Template
B. Memo to Managers Template
C. Policy and Procedure Review Log Template
D. Memo to Managers to Provide Training to Staff Template
E. Memo to HCA ITS Template

VENTURA COUNTY
HEALTH CARE AGENCY
2323 Knoll Drive, #412, Ventura, Ca 93003
Phone: 677-5110 Fax: 677-5116

M E M O R A N D U M

DATE: September 27, 2005

TO: JOHN F. JOHNSTON
COUNTY EXECUTIVE OFFICER

FROM: PIERRE DURAND, DPA
HCA DIRECTOR/VCMC ADMINISTRATOR

SUBJECT: RESPONSE TO GRAND JURY REPORT: CRISIS TEAM & BEHAVIORAL HEALTH MANAGEMENT

I have reviewed and concur with the Behavioral Health Department's response to the Grand Jury Report on the Crisis Team & Behavioral Health Management.

VCBH

Ventura County
Behavioral Health
Department

Linda Shulman, M.F.T.
Behavioral Health Director

Michael Ferguson, M.D.
Behavioral Health Medical Director

"Best Science, Best Service, Best Outcomes"

A Division of Ventura County Health Care Agency

August 4, 2005

TO: John Johnston
Chief Executive Officer

FR: Linda Shulman
Director, Behavioral Health Department

Cc: Pierre Durand
Director, Health Care Agency

RE: Response to Grand Jury Report: Crisis Team and Behavioral Health Management

Attached is the response from the Department regarding the above title Grand Jury Report.

If you have any questions, or need further information, please let me know.

300 Hillmont Avenue • Ventura, CA • 93003 • (805) 652-6737 • FAX: (805) 652-6160
www.vchca.org

Findings:

Background:

(F 01 – 04) – Concur

(F 05) The Department does not concur with this statement.
During the preparation of the 04-05 Budget, the Department was asked to eliminate approximately $7 million from its operations Budget. In determining how to accomplish this reduction, the number one priority was maintaining service. The Department proposed contracting out for Crisis Team Services and in this proposal would have maintained full service capacity for crisis response in the Community. The department did not plan the downsizing of the Crisis Team. The Department first presented the idea of proposed contracting out of services at the Board's Budget Study Session in May 2004. Additionally, in the preliminary Budget Book the restoration list request for the 04-05 Budget contained the following item: "Crisis Team – Restore $827,077 with 17.8 FTE. Allows county to continue to provide 24 hours a day, 7 days a week phone and field based crisis team services through county employees rather than possible contract for services." Just prior to Budget hearings, concern by the Union about contracting out services was voiced. It was not until Budget Hearings held on June 22, 2004 that the Board of Supervisors asked the Department to configure a way to provide mandated services and enter into negotiations with the Union. It was at this time that the configuration of the Crisis Team was determined. The Department entered into meet and confer sessions with the Union to determine what could be agreed upon – with the priority being restoration of service. It is during this time, when the crisis team was in a constant state of flux and the department was unsure of the final outcome of the negotiations that the policies referred to in most of this report are related to.

(F 06) – While the statements are accurate – adding the statement "Well documented and well maintained procedures help a hospital or health care agency avoid problems such as misidentification of patients, wrong site surgeries, improper billings, caregiver and medication mix ups" is misleading – as it may imply to some readers that such errors have occurred with the Crisis Team. The department is not aware of any documentation or report that the Crisis Team had any of the above problems during this transition period or any time after.

(F 07) – Again, this statement is a part of the Agency Code of Conduct – but its relevance to this study is not clear.

(F 08-09) Intranet versions of Policies and Procedures are common place. VCMC has their policies and procedures on the Intranet. The movement to Intranet policies is to ensure that all employees have access to the most current policy. Under a manual system – when a policy is changed or updated – a written version of this policy must be sent out to all clinics. Then – staff at the clinic must remove the old policy and replace it with the new one. The Behavioral Health Department has at least 20 locations of service and three years ago, when preparing for a Joint Commission Survey, it was

determined that these hard copy manuals had not been kept up and at that time, it was determined to move to Intranet versions, so that all employees could have access to accurate policies.

How to access, and use the Intranet policy and procedures is a part of annual compliance training to ensure that all BHD employees are aware of this process.

(F – 11) Policy A-1 – does refer to a policy and procedure committee. This committee had been established by the previous Director and this committee was disbanded by the previous director as well. The Current Director had moved the function of this committee to the Executive Management team. Most of Policy A-1 had been rewritten to reflect that it was the Executive Management Team that wrote and reviewed policies and to reflect that there was not a Policy and Procedure Committee. However the committee is still mistakenly named in Item # C of this policy. All other areas of the policy refer to the Executive Management group – (See Item F – 4 and 5 in the policy).

Additionally, it is important to clarify the role of the Director in development and approval of policies. Item C of Policy A1 states *" It is the Office of the Behavioral Health Director that is responsible for coordinating development and implementation of the policies and procedures included in this manual."* No where is it stated that the Director is personally responsible for this function. Policies are the responsibility of the Supervisors of each program area – and then the responsibility of the Managers of each division to ensure that they are accurate. (See Item E of this policy). The Medical Director and Behavioral Health Director sign off on all policies to ensure conformity to Department standards. The Director is not involved in the day to day management of policies and procedures. This oversight, is more typically handled by the Chief Operating Officer – a position that due to budget cuts has remained unfilled within the Department for almost a year. As this response will demonstrate, there were consequences to the infrastructure of the Department that had lost one third of its positions and several key management positions. The focus of all managers and supervisors was on service, staff communication and morale and determining the best ways to reorganize programs within the department that had been through these losses. The department is proud of how it has responded, though admittedly, some items, like policies on the Intranet did not get attended to during this time.

(F – 12) The Department concurs and the revised version is attached.

(F – 13) The MA is responsible for the clerical work of taking changes to policies presented by staff or managers, typing them into the policy format, routing them for approvals, and once approved – posting them to the Intranet.

Crisis Team Policies and Procedures:

(F – 17 - 19) Concur

(F – 20) The Supervisor of the Crisis Team in July 2004 reports to this writer that at the time the department was in negotiations with the Union and had implemented the "mandated version" of crisis team services DRAFT versions of new policies that indicated to them how to proceed were provided to the staff. In addition, Attachment A was provided to staff and there were regular staff meetings and discussions to keep them abreast of a very changing environment. Attachment B is a copy of a memo that was provided to the Crisis Team in February 2004 prior to their restructure in March of that year, and this memo states " we will use this time to provide an overview of the new crisis team structure and discuss and review our Policy and Procedures. " The Supervisor reports that many of these meetings continued to occur and that at no time during this transition or the transition in July did the Crisis Team express concern of not knowing how to proceed or operate and that all policies were reviewed with them. However, she indicates that it was thought that this gap version of service would be temporary and it was not known when the final determination of crisis team operations would be concluded and therefore, the Supervisor reports that there was not an attempt to finalize new procedures and place them on the Intranet. Rather, it was prioritized to communicate regularly with the Crisis Team members and ensure that they were aware of what to do. To further support that this Supervisor's statement of trying to ensure accurate communication to crisis team members and those impacted by this transition occurred, I have also provided, Attachment C, D and E, communications that went out to Emergency Rooms and the Police to communicate to them the current structure and status of the crisis team. The Grand Jury acknowledges in F 30 – that there is indication that some of the new procedures had been communicated verbally to the Team over the past year. The Supervisor of the Crisis Team during this time and referenced in this response was not interviewed or contacted by the Grand Jury and therefore, this information was not included in their review.

The policies that were placed on the Intranet in April, were therefore, not believed to be new to the Crisis Team and the effort of updating them on the Intranet was in response to information learned from the Grand Jury that the Intranet versions of the policies were inaccurate. Additionally, the Grand Jury had asked that we sign confidentiality statements and not discuss anything that had been discussed during their interview with anyone. The Director was aware that Crisis Team members and current Supervisors were being interviewed as well and therefore, caution was taken to ensure that no one would construe that communications about policies during this time would appear to be an attempt to intervene in the Grand Jury investigation.

(F – 22) The department does not believe this statement is accurate. As explained in previous responses the Supervisor of the Crisis Team had reviewed or revised policies in July 2004 and this date accurately reflects the time that the Supervisor of the Crisis Team had presented them to the Crisis Team. The only thing that did not occur was final templating of the policies and posting of them to the Intranet. The Director only

became aware that there was a problem with the policies when first interviewed by the Grand Jury. At that time, the Director asked the MA to provide all current versions of the policies and any new or revised versions that had been provided by the Supervisor. The Director reviewed the policies only in a manner to ensure that they were accurate to the current operations of the Crisis Team and some minor updates were made. The July 04 review/revision date was the last date provided by the Supervisor – and therefore, that is the date the MA used on the Policy Template. There was no intent to back date or to make policies appear as if they had been on the Intranet. In fact it was acknowledged to the Grand Jury that they were not accurately on the Intranet.

(F – 23) There are some inconsistencies on the documents. The original policies have effective dates consistent with the Table provided by the Grand Jury in F 17. The policies provided to the Director to review and then post (Response F 22) had different effective dates. According to the MA, when asked to provide current policies to the Director (see F 22), she printed out policies from her desktop and not from the Intranet believing that her desktop versions were the same as the ones on the Intranet (They were in a folder on her desktop marked completed policies) As the Grand Jury points out, this MA began in October of 2004. As she did not create these it turned out she was not correct in this assumption. It appears that the templates for the policies on the MA's desktop had mistakenly had effective dates copied from one policy and carried over to all of the policies, thus, they all have an effective date of 12/12/03. Prior to the current MA being responsible for this work, the Director had 2 other MA's and 2 temporary staff working and it is unknown how or when this error occurred. When the Director reviewed the policies provided and then performed the functions described in the response to F 22, no review of the dates was performed. Actually, while an oversight, the lack of attention to effective dates is further demonstration that the department was not attempting to misrepresent the dates of these policies. The content of the policy and the accuracy of the procedures is what was focused on. There was no review of effective dates. As to the statement that explanations introduced additional inconsistencies, it is not known whose explanations or specifically what is being referred to here. The Director was interviewed by the Grand Jury on March 30 and on April 6. Other staff who provided information to the Grand Jury were interviewed after this time. The Director was not provided an opportunity by the Grand Jury to review any of these inconsistencies or to provide further explanation to clarify any confusion they may have had. Had the Director been given the opportunity to meet with the Grand Jury and asked to review their concerns, I am quite confident that any sense of inconsistency or misinformation could have been eliminated. As we have reviewed the policies and the information that we have access to that was provided to the Grand Jury we were able to immediately see the inconsistencies in the effective dates, however, these inconsistencies are the result of many staff changes and time lapses between staff responsible for the maintaining of the policies and in no way were due to any purposeful attempt on anyone's part to deceive or misrepresent.

(F – 25) The response to F 23 explains the reason for the inconsistent dates. The information provided to the Grand Jury regarding duplicate websites was accurate and was part of the explanation as to how inaccurate policies were posted on the Intranet.

(F – 26) Do not concur. Please see response to F 20.

(F – 27) If the Team staff asked for these updates they did not ask the Director and no other current manager or lead of the Crisis Team communicated that there were questions regarding policies. The Director only got involved in the correction of the policies and procedures because she became aware of the problem when the Grand Jury inquired. The Director contacted County Counsel and specifically asked if it was o.k. to correct something that the Grand Jury had pointed out was in error and was advised it would be o.k. to do so as long as we informed the Grand Jury that corrections were being made. This was done.

(F – 28) See responses to F 22 and 23 for the explanation regarding effective dates. In light of this a 100% review of all policies is in process and the department is working diligently to ensure that all dates and information of the Policies on the Intranet are accurate.

(F – 29) The Director did not write this policy. The Supervisor of the Crisis Team (the one not interviewed by the Grand Jury) did. The original version of this policy is attached. (Attachment F). This policy was written when the Crisis Team was moving from the Inpatient Unit in March of 2004. Again, the Supervisor states that copies of this policy were provided to Crisis Team members.

(F – 30) As stated in Response F 22 and 23 no new policies were written. Only policies provided by the Supervisor were posted to the Intranet and again, she reports that they were communicated to the Crisis Team.

(F-31) Again, the Supervisor at the time of the two restructures of the Crisis Team states that policies were reviewed and updated. It is true that they were not updated on the Intranet.

(F 32) See responses to F 22 and 23.

(F 33) While this has never occurred, the Department recognizes the potential for this to appear to be true and therefore, the Revised Policy A1 institutes some new procedures to correct any potential confusions in the future.

Responses:

(R 01) No one manipulated the system – however, the revision to Policy A1 does establish greater administrative controls.

(R 02) The revision of Policy A1 addresses these concerns.

Attachment A

Just to go over our restructure for you again. Please take a look at this and let's make sure it makes as much sense as it can at this point. We will begin services as of Tuesday July 6. We will all start our rotations out of the Ralston office. We will do this until we 'settle in'. Please get in touch with me with questions, or if some of this is glaringly wrong.

Access Line Support Services:

We will provide:

Telephone Crisis Intervention
Information
Referrals
Crisis Assessment
Coordinate and assist between facilities, ER's and PD when Appropriate
A Shoulder To Cry On

When urgent crisis services are identified, the caller is to be directed to call 911 or proceed to the nearest ER. If there is a responsible party in the house, an attempt should be made to speak with them while assessing the most appropriate course of action. When it is not possible for the individual to make contact with 911 or secure appropriate transport, Telephone Access support should coordinate the response.

We will continue to have ER's and hospital floors contact us for service. It is up to us to contact the Assessment Specialist in the field and keep them updated on facility needs. It is also important to consult with and advise the facilities when requested to do so. Remind them of the schedule of regional availability and our attempts to have someone respond to their facility sooner if possible. When possible, we may be requested to assist in securing or advising a facility about bed availability and/or potential beds.

Providing chart and POR information to the field team will continue to be important. Our job will include dispatch coordination.

The logbook remains an important component to our work. Please log all calls received.

Assessment Specialist Support Services:

Please refer to the revised Regional Schedule. During the first week or two of our new structure, we should plan on visiting all ER's during each shift. Make sure to contact our Access Support when you begin your shift and intermittently during your schedule for updates, status, etc.. It may become necessary during a shift to adjust to the 'real' community needs at hand. In other words, if you are available and outside of a requesting region, you can respond if the situation warrants and it will be many hours before the next team responds. In addition, there may be requests from the PD for assistance in the field. If this is the case and you are available, please do all you can to respond. The police would remain at the scene with you.

Calls will be received from ER's as well as facility 'floors'. Most of the floor calls will be coming through our Access Support Lines. However, when you are in a facility, or calling to assess need, please be sure to be transferred to the floors and ascertain their needs. It is our responsibility to provide assessment to the entire facility.

In regard to what you do on your "down" time. I don't expect anyone to hang out in the field, or OD on Starbucks. If you are in the West County and there are no calls pending, supporting the Access Support Staff would be great. When in the East County, remember we have the office at the Sheriff's station. You can use that to complete paperwork, access POR or.....

We also have 'our' office at 300 Hillmont. It will be our "home' space. However, during these first weeks we may use the parking lot and facilities at Ralston.

Let's play all of this by ear. We will know more about how this actually 'looks' in a week or two.

Plan on beginning your new rotation Tuesday July 6 out of the Ralston office. That is where keys, vehicles, etc. will be located.

Please refer to the prior outline (attached) for the 'how to's" regarding 5150's, securing beds, medical clearance and how long someone can be detained (the "8 Hour Rule") and how it applies to us.

Attachment B

VENTURA COUNTY
BEHAVIORAL HEALTH DEPARTMENT
HEALTHCARE AGENCY

M E M O R A N D U M

Date: February 18, 2004

To: L. Brady, T. Barrett, V. Lee, R. Carpenter, S. Luckey, P. Oveido, E. Alviz, J. Kelsch, L. Barth, F. Dominguez, D. Hewlett, L. Savino, C. Rydjord, T. Pizano, P. Dudley, J. Ames, M. Yeto

From: Susan Kelly

RE: Crisis Team Re-Organization Update and Training

There will be a **mandatory** meeting of all above staff on Monday, February 23, 2004. This meeting will take place in the Community Room, downstairs 300 Hillmont. The meeting will be from 1:00pm until 3:00pm.

We will use this time to provide an overview of the new crisis team structure and discuss and review our Policy and Procedures. It is a time to ask questions, raise concerns and together begin to create answers and solutions to our new endeavor.

If you have any questions or concerns, please give me a call.

Attachment C

BEHAVIORAL HEALTH CRISIS TEAM
HOSPITAL REFERRAL LIST

WHEN IT HAS BEEN DETERMINED SOMEONE IN YOUR FACILITY REQUIRES PSYCHIATRIC HOSPITALIZATION AN ACCEPTING FACILITY MUST BE IDENTIFIED BEFORE A W&I CODE 5150 IS WRITTEN.

HOW TO USE THIS LIST:

AN ATTEMPT SHOULD ALWAYS BE MADE TO SECURE ADMISSION IN A FACILITY WITHIN THE COUNTY THE PATIENT LIVES IN. WHEN THIS IS NOT POSSIBLE, THIS LIST MAY BE USED TO FIND ALTERNATIVE PLACEMENT.

WHAT WILL BE EXPECTED OF YOU:

-REQUEST TO SPEAK WITH THE PSYCHIATRIC ADMISSIONS TEAM
-PROVIDE:

- -NAME - DOB - SOCIAL SECURITY NUMBER
- -INSURANCE INFORMATION
- -LEGAL STATUS (CONSERVATORSHIP/5150/MINOR, ETC)
- -BRIEF DESCRIPTION OF PSYCHIATRIC CONDITION
- -BRIEF DESCRIPTION OF MEDICAL CONDITION
- -TRANSPORTATION UPON ACCEPTANCE
- -PAPERWORK TO TRANSFER WITH THE CLIENT SHOULD INCLUDE:
  - -ORIGINAL W&I CODE 5150
  - -MEDICAL RECORDS AND CLEARANCE
  - -PSYCHIATRIC ASSESSMENT

QUESTIONS OR CONCERNS?
PLEASE CALL THE CRISIS TEAM
652-6767

Attachment D

CRISIS TEAM FACT SHEET
EMERGENCY ROOM

WHO – WHAT – WHERE – WHEN - WHY

805 - 652-6727

WHEN TO CALL: ANYTIME YOU HAVE A PATIENT YOU BELIEVE MAY HAVE A MENTAL HEALTH CONDITION THAT REQUIRES IMMEDIATE ASSESSMENT. THIS WOULD INCLUDE THE CLIENT:

- -EXPRESSING THOUGHTS OF SUICIDE
- -THREATENING TO HARM OTHERS
- -OVERDOSING ON ANY TYPE OF MEDICATION
- -APPEARING NOT ABLE T TAKE CARE OF THEMSELVES

WHAT THE CRISIS TEAM WILL NEED FROM YOU:

- -A BRIEF DESCRIPTION OF THE PROBLEM
- -NAME AND IDENTIFYING DATA ON THE PATIENT IF AVAILABLE (DOB, ADDRESS, FAMILY)
- -CURRENT MEDICAL CONDITION
- -APPROXIMATE TIME OF MEDICAL CLEARANCE
- -FINANCIAL INFORMATION

WHAT THE EMERGENCY ROOM CAN EXPECT FROM US:

- -TELEPHONE INFORMATION, RECOMMENDATIONS AND REFERRALS
- -APPROXIMATE TIME OF ARRIVAL TO YOUR FACILITY
- -CHILD AND ADOLESCENT SPECIALIST WHEN APPROPRIATE
- -ASSESSMENT OF PATIENT
- -W&I CODE 5150 APPLICATION COMPLETED IF APPROPRIATE
- -W&I CODE 5150 ORIGINAL AND COPIES OF ALL SUPPORTING DOCUMENTATION PROVIDED
- -RECOMMENDATION AND REFERRAL SUGGESTIONS FOR PATIENT

OUTCOME: AFTER OUR ASSESSMENT HAS BEEN COMPLETED IF HOSPITALIZATION IS RECOMMENDED AND A 5150 IS WRITTEN, YOUR FACILITY WILL NEED TO:

- -ARRANGE ADMISSION TO AN LPS FACILITY
- -ARRANGE TRANSPORTATION TO THE FACILITY

IF CLIENT WOULD BENEFIT FROM HOSPITALIZATION, BUT DOES NOT MEET CRITERIA FOR A W&I CODE 5150 AND WILLGO VOLUNTARILY FOR TREATMEN YOU MAY PROVIDE REFERRALS

IF THE CLIENT IS A MINOR THE CRISIS TEAM WILL SEND SPECIALISITS TO ASSESS AND ASSIST YOU IN SECURING A FACILITY FOR ADMISSION.

Attachment E

Ventura County
Behavioral Health Department
Alcohol & Drug Programs
Mental Health Services

A Division of Ventura County Health Care Agency

Linda Shulman, M.F.T.
Acting Behavioral Health Director

Michael Ferguson, M.D.
Behavioral Health Medical Director

June 24, 2004

To All Ventura County Chiefs of Police:

As each of you are aware, the County Behavioral Health Crisis Team is to be reorganized as of July 1, 2004. Our commitment and continual support to the community will be provided through our 24 Hour Access Line Support Services. This assessment and referral will focus on community based services available to each individual. In addition, we will provide 24 hour W&I Code 5150 assessment services to all County medical facilities.

I am aware that this reorganization will impact each law enforcement agency. Please know that the Behavioral Health Department remains committed to working with and supporting you as you contact the mentally ill within our community.

There has been concern expressed regarding the Behavioral Health Department's on-going commitment and active support of the Crisis Intervention Team training. I want to assure each of you that the Department commitment to this very successful program remains strong. We intend to continue to support the program, provide the much necessary training of all officers, and continue to be available for on-going consultation. The continued success of the Interagency Case Management Council (AICMC) is, we believe, dependent upon our mutual cooperation and communication. Linda Shulman, our Behavioral Health Care Director has made clear to each Manager, her continued commitment to this program.

I hope you will feel free to contact me, or Linda Shulman at any time you have questions or concerns regarding the changes within our Crisis Services, or regarding our continued support of the Crisis Intervention Team.

Sincerely,

Susan Kelly, MFT
Supervisor

Attachment F

Crisis Team Dispatch Tracking of Mobile Teams

POLICY:

Dispatch will have documented knowledge of where each mobile team is at any given time. This information will be logged in the Main Log Book, located at the Downtown Oxnard Regional site. This information will include date, time of mobile team dispatch, location, client name, presentation and time call completed. Also noted will be calls made to dispatch during the call regarding transferring to facility, etc..

PROCEDURE:

When call is received by dispatch, receiver will log call in Log Book noting time call received, location, name and presenting problem. When dispatch contacts mobile team and sends them on a call, this time will be noted in the Log Book. When the call has been completed, the mobile team will immediately contact dispatch to inform them of the completion of the call. Dispatch will then note time in the Log Book, along with the disposition of the case. If the mobile team determines it necessary to transport client to another location (facility, home, etc.), mobile team will call dispatch as they are leaving first location to transport. This will be logged by dispatch, along with time as well.

Attachment G

VENTURA COUNTY BEHAVIORAL HEALTH POLICIES AND PROCEDURES

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AFFECTS:	ALL DEPARTMENTS		REVIEW DATES:

APPROVED BY:

Linda Shulman
Behavioral Health Director

Behavioral Health Medical Director

POLICY:

It is the policy of Ventura County Behavioral Health (VCBH), which encompasses Mental Health Services, Alcohol and Drug Services, Proposition 36 and Drinking Driver Program, to develop and maintain one integrated policy and procedure manual. This manual will provide general guidelines for the effective and efficient management of VCBH, will be available to staff, on the Intranet, and will serve as the sole and comprehensive reference for all policies and procedures for the department.

PROCEDURE:

A. All policies in this manual are consistent with, and incorporate by reference, those set forth in the Ventura County Administrative Manual, the Ventura County Medical Center (VCMC) Compliance Manual, and the policy and procedures of VCMC.

B. Unless otherwise noted, policies and procedures in this manual apply to all VCBH organizational units and offices.

C. The office of the Behavioral Health Director shall be responsible for coordinating development and implementation of the policies and procedures included in this manual. The Managers of each division will be responsible for:

1. Review of all proposed policies and procedures for incorporation into the department manual;
2. Reviewing the manual on an annual basis;
3. Developing policies and procedures as appropriate;

The MA III in Administration will be responsible for:

1. Assigning numbers, formatting, and editing each policy and procedure;

2. Forwarding the policies and procedures to the Health Care Agency Information Technology Services (HCA ITS) Department to post on the Intranet, and maintaining the official hard copy of the manual;
    a. The HCA ITS Department will be responsible for posting the policy to the Intranet and forwarding notification to staff of policy updates.

D. VCBH policies and procedures will follow a standard format as follows:

1. All policies and procedures will be typed on the official VCBH policy and procedure template (Attachment A).

2. The Original Policy Effective Date is established when a new policy is implemented. This date never changes.

3. The Review Date is noted each time a policy is reviewed for accuracy, but no changes are made.

4. A Revision Date is noted any time revisions are made to a policy.

5. All attachments and accompanying text will be stamped with the policy and procedure number, and will be kept current.

E. Generally, all VCBH services are responsible for developing policies and procedures for their area of expertise, and all staff members are encouraged to participate in this process.

F. The procedure for submitting proposed new or revised policies and procedures, securing the required approvals, and getting new or revised policies and procedures disseminated is as follows:
    1. The author of the new or revised policy submits it to the Management Assistant (MA) in Administration. In the case of proposed revisions to existing policies, the author will submit the old policy with the proposed revisions attached.
    2. The author compares the proposed policy to existing policies of VCMC, Ventura County Administration, and the Office of Compliance to ensure consistency and conformity.
    3. If necessary, the author modifies the proposed policy to ensure such consistency and conformity.
    4. The author must identify areas that are impacted by the new or revised policy so that the MA can forward the proposed policy to the Managers in these areas for review and comment (Attachment B).
    5. The reviews by the Managers will be logged (Attachment C) and forwarded to the author who will incorporate any comments and finalize the procedure.
    6. The author will produce a memo (Attachment D) describing the approved policy, the training that will be required for the effective implementation of that policy, including the date that the training will occur, and the implementation date of the policy. This memo and the final draft of the policy are then forwarded to the MA.

7. The MA will forward the policy to the Behavioral Health Director and Medical Director for final approval and signature.
8. The approved policy and the memo from the Manager will go to affected areas and training as needed, will occur. Staff are required to sign the memo indicating they have received the appropriate training.
9. An annual audit of training logs/receipts are maintained by Program Administrators
10. The approved policy will be forwarded by the MA to the Health Care Agency Information Technology Services (HCA ITS) in Adobe PDF format via e-mail with the date of implementation one week prior to the effective date of the policy and procedure (Attachment E).
    a. Within one week HCA ITS will insert the new or revised document in the VCBH policy and procedure website, and delete any prior policy or procedure as applicable.
    b. Immediately after completing the step above, HCA ITS will send an e-mail out to all VCBH staff, notifying them that the Intranet Policies and Procedures Website has been updated.

ATTACHMENTS:

A. Policy and Procedure Template
B. Memo to Managers Template
C. Policy and Procedure Review Log Template
D. Memo to Managers to Provide Training to Staff Template
E. Memo to HCA ITS Template

VENTURA COUNTY BEHAVIORAL HEALTH POLICIES AND PROCEDURES

POLICY:	PROCEDURE NO:	Page of
DEPARTMENT: AFFECTS:	ORIGINAL EFFECTIVE DATE:	REVISION DATES: REVIEW DATES:

APPROVED BY:

Behavioral Health Director

Behavioral Health Medical Director

A1 Attachment A

VENTURA COUNTY
BEHAVIORAL HEALTH DEPARTMENT
HEALTHCARE AGENCY

POLICY & PROCEDURES MEMORANDUM

Date:

To: **(Affected Program Managers)**

From: **Carolyn Cawiezell, MA**

RE:

Attached is a copy of proposed (new / revised) Policy and Procedure for your review and comment.

Please review the Policy and Procedure and note your comments and/or suggested additions/changes. It would be appreciated if you would please sign this memo and return to me, together with the reviewed Policy and Procedure, no later than _____.

Thank you for your timely attention to this.

A1 Attachment B

Policy and Procedure Review Log

Policy Title	Procedure Number	New Policy	Revision to existing policy	Author	Programs / Areas affected by new or revised policy	Date Distributed for Review	Reviewed by:	Review Date	Signature

VENTURA COUNTY
BEHAVIORAL HEALTH DEPARTMENT
HEALTHCARE AGENCY

POLICY & PROCEDURES MEMORANDUM

Date:

To: **(Managers of affected areas of New or Revised Policy & Procedure)**

From: **(Author of Policy)**

RE:

The attached approved Policy and Procedure Number will go into effect thirty (30) days from today ( ).

Please assure that all staff under your supervision have been trained on this new/revised policy no later than the effective date.

Please have this memo signed by all staff indicating that they received training. Please retain a copy of the memos for future reference and forward original to me.

Thank you.

I have received the training for the above noted Policy Number _____.

_____	_____ ***Date***
_____	_____ ***Date***
_____	_____ ***Date***
_____	_____ ***Date***
_____	_____ ***Date***
_____	_____ ***Date***
_____	_____ ***Date***
_____	_____ ***Date***
_____	_____ ***Date***

VENTURA COUNTY
BEHAVIORAL HEALTH DEPARTMENT
HEALTHCARE AGENCY

POLICY & PROCEDURES MEMORANDUM

Date:

To: **Health Care Agency Agency Information Technology Services**

From: **Carolyn Cawiezell, MA III**

RE: **Revised Policy and Procedure Number _____**

Attached is the Adobe PDF format of revised Policy and Procedure . Please post this policy to the Ventura County Behavioral Health Policy and Procedure Intranet website on the effective date of _____.

Once posted to the Intranet, please inform all VCBH staff notifying them that the Intranet Policies and Procedures Website has been updated.

Should you have any questions, please do not hesitate to contact me.

A1 Attachment E

Mental Health Crisis Team and Behavioral Health Management

Summary

In response to a citizen complaint, the Ventura County 2004-2005 Grand Jury has found that the Mental Health Crisis Team (Team) is a valuable public health resource that was downsized due to shrinking public funds, but should be restored to full capabilities when funding is available.

The Team reports to the Ventura County Behavioral Health Department, a part of the Health Care Agency. In reviewing the internal procedures and communications, the Grand Jury found that policies and procedures within the Behavioral Health Department (BHD) lack proper controls.

The Grand Jury found that Ms. Linda Shulman, the Director of BHD, had given employees verbal instructions that did not agree with documented policies and procedures. The Grand Jury also found Ms. Shulman placed, or directed to be placed, altered and un-reviewed Team policies and procedures on the county employee Intranet.

Background

The Grand Jury received a citizen complaint that the BHD had taken actions to downsize the Mental Health Crisis Team. The complaint stated that the county was losing a valuable public service.

The complaint also alleged that management of BHD had been giving the Team verbal instructions in direct contradiction to their approved and published policies and procedures. The verbal instructions were said to restrict the Team's usefulness to the public with the result being that staff felt demoralized by the lack of management support.

Methodology

The Grand Jury interviewed complainants and reviewed numerous supporting documents. In addition, Team staff and supervisors were interviewed. Sworn testimony was obtained regarding supervisory practices, policies and procedures, and verbal directions to employees.

When investigating the management decisions that led to downsizing of the Team, the Grand Jury was confronted by inexplicably inconsistent information with regard to internal policies and procedures.

Much of the investigation was involved in reconciling discrepancies between management's assertions and staff claims. To this end, copies of policies and procedures were sought from the BHD to compare with the documents in the possession of the staff. Policy and Procedure documents were obtained from the Ventura County government employee's Intranet, and backup copies of prior policies and procedures were obtained

(for several previous months) from the county's Information Systems Department in order to analyze for changes and discrepancies.

Testimony and documentation from all sources was compared extensively and the findings in this report are determinations of the Grand Jury after deliberating on the evidence. As required by Penal Code section 916, all findings in this report are supported by documented evidence.

Findings

Background

F-01. In 1996 there were 20 full-time Team members. Teams were available 24 hours a day on 12-hour shifts. The teams would respond to community requests for assistance and they would be called by police when mentally ill persons were encountered.

F-02. Since July 1, 2004, the Team has been funded for 10 staff members. They no longer evaluate people in their homes or respond to the police when assistance is requested.

F-03. The Team has a working supervisor. Three levels of supervision currently exist between the Team and the BHD; however, two of those supervisors have little knowledge of, or involvement with, the Team.

F-04. Crisis Team staff demonstrate a high degree of responsibility to the clients within the community.

F-05. In planning the Team's downsizing, management had a responsibility to adhere to budgets and cost controls to the detriment of provided services.

F-06. The *Code of Conduct* for the Ventura County Medical Center states, "Employees and agents deserve clear instructions about what is expected of them."[1] Well-documented and well-maintained procedures help a hospital or health care agency avoid problems such as misidentification of patients, wrong-site surgeries, improper billing, caregiver and medication mix-ups, etc.

F-07. The *Code of Conduct* further states, "Employees and agents shall promptly report all suspected violations of the *Code of Conduct*, Compliance Guidelines, operational policies, laws, or regulations to their manager or supervisor, through the Confidential Compliance Line or to the Compliance Officer."

F-08. The Department requires that all Policies and Procedures (P&P) be maintained on the Intranet so they will be accessible by all employees at all times.

[1] Code of Conduct No. 1, "Ventura County Medical Center Code of Conduct & Confidential Disclosure Program"

F-09. Hardcopy (paper) P&Ps have not been distributed to staff in the past two to three years, since at least June of 2002. If staff members require hardcopies of P&P documents, they must print their own from the Intranet website.[2]

F-10. There was a hardcopy P&P notebook available to the Team at one time, estimates ranging from two to four years ago. There has been no official hardcopy P&P notebook available to Team staff since before March 2004.

F-11. There is an approved P&P, identified as procedure number "A1" (Procedure A1, see Attachment 1) describing the single, integrated master P&P manual. Procedure A1, located on the department Intranet, states that the Behavioral Health Director is "responsible for coordinating development and implementation of policies and procedures."[3] It also explains the function of the Policy and Procedure Committee, the use of an "approvals sheet" to record approvals, and the dissemination of a memo and training information.

F-12. Currently, Procedure A1 is outdated and in need of revision. There is no "approvals sheet" or Policy and Procedure Committee.

F-13. A Management Assistant (MA) is responsible for coordinating changes to P&Ps throughout the department, performing this function since October of 2004 and revising over 50 of the department's P&Ps to date. A P&P is considered in effect at the moment the MA places it on the Intranet.

F-14. When a new or revised P&P document is placed on the Intranet, an authorized copy is signed by the BHD's Director and the Medical Director. The signed paper copy is then placed in the master manual (notebooks) stored at the MA's desk.

F-15. When a new or revised P&P document is placed on the Intranet, it is the MA's responsibility to send an email to supervisors and staff to inform them that an update has taken place.

Crisis Team Policies and Procedures

F-16. Team duties reportedly changed twice in 2004. One change was a result of reorganization in March of 2004. The second change was the result of downsizing the Team in July 2004.

F-17. A review of an ISD web site backup of March 26, 2005, showed that P&P documents on the Intranet on that date did not correspond to the new Team duties as of March or July of 2004. Documents on the web site on and before March 26, 2005, confirmed Team members' assertions that P&Ps had not been updated. There were 13 P&P documents on the web site prior to March 26, 2005. These documents are listed in Table 1.

F-18. The Director of BHD was asked to provide and did provide to the Grand Jury copies of the 14 current P&P documents, all showing an effective date of 12/12/03 and a last review date of 7/01/04. These documents are listed in Table 2.

---

[2] The Ventura County Behavioral Health Intranet web site address is http://vcweb/hca/vcbh This address is internal to Ventura County government and is not publicly accessible from the Internet.
[3] Ibid.

Proc. #	Policy Name	Effective Date
CT1	Domestic Violence Screening	04/16/01
CT2	Screening and Treatment Decision Protocol for Patients Presenting to Hillmont Psychiatric Care Center Crisis	09/24/01
CT3	Transportation of Clients	01/16/02
CT4	Crisis Team Admission Concerns	07/31/98
CT5	Referrals – Crisis Team	01/18/93
CT6	Patient Alert Forms	07/31/98
CT7	Crisis Team – Off Site Services and Physician Oversight	07/99
CT8	Crisis Team – Attending Physician	12/01/01
CT9	Crisis Team – Progress Note	07/99
CT10	Crisis Team Assessment	02/18/93
CT11	Crisis Team – Brief Services Assessment	01/18/93
CT12	Crisis Team Records Assembly	01/16/02
CT49	Client Personal Property Inventory and Search	11/19/03

Table 1. Crisis Team Policies and Procedures as of March 26, 2005

Proc. #	Policy Name	Effective Date
CT3	Transportation Arranged by Crisis Team	12/12/03
CT5	Referrals – Crisis Team	12/12/03
CT6	Patient Alert Forms	12/12/03
CT11	Crisis Team – Brief Services Assessment	12/12/03
CT13	VCBH Crisis Team Telephone Triage	12/12/03
CT17	Initiating a Welfare and Institutions Code Section 5150 Application	12/12/03
CT23	Crisis Team HIPPA Standards	12/12/03
CT26	Crisis Telephone Management – Staff Shortage	12/12/03
CT27	Crisis Team Procedure for Using Greyhound Bus Ticket Purchase Authorization	12/12/03
CT30	Crisis Team Dispatch Tracking of Mobile Teams	12/12/03
CT32	Crisis Team Charting and Billing	12/12/03
CT33	Log Book Documentation	12/12/03
CT44	Maintenance of Crisis Team Vans	12/12/03
CT48	Medical Necessity Taking Precedence Over W&I Code 5150 Upon Admission to Non-LPS Designated Facility	12/12/03

Table 2. Crisis Team Policies and Procedures as of April 19, 2005

F-19. The documents provided by the Director of BHD did correspond to new Team duties; however, these documents were not on the Intranet and accessible to the employees until April of 2005, nearly 16 months after the recorded effective date of every document.

F-20. Neither the Team members nor their supervisors had been informed that procedures were being reviewed or that new P&P documents had been placed on the Intranet in April of 2005. There was no email received by any staff announcing these policy changes.

F-21. For instance, the procedure CT1, titled "Domestic Violence Screening," is a function that Team members believe they are required to perform. However, that function has been removed from the Intranet web site by the Director of BHD without informing the Team staff.

F-22. The new P&P documents were back-dated to appear that they had been on the Intranet since at least July 2004, coincident with the downsizing of the Team.

F-23. The documents showed inconsistencies and the explanations introduced additional inconsistencies.

F-24. Recovered backup files from the Intranet server, provided by ISD, confirmed that the documents now on the Intranet, showing Effective Dates of 12/12/03 and Revision/Review Date of 07/01/04, were actually created by the MA around April 19, 2005.

F-25. Multiple backups from ISD were analyzed and there was a consistency in the older version of policies and procedures between December 2003 and April 2005. The explanation of website confusion and duplicate websites was ruled out as a reason for the inconsistent document dates.

F-26. Before March 26, 2005, P&Ps for the Mental Health Crisis Team had not been reviewed, updated, or revised for at least a year.

F-27. Although the Team staff reportedly asked for updates to the information, it was only after the Grand Jury asked for copies of the policies and procedures that the Director of BHD initiated action to update the files.

F-28. The effective dates and review dates of documents are chronologically inconsistent with documents found on backup tapes of Intranet records. The P&P effective dates are also chronologically inconsistent with the events, such as budget cutbacks, that supposedly caused those policy changes.

F-29. Of particular significance is a P&P identified as CT30, "Crisis Team Dispatch Tracking of Mobile Teams" (see Attachment 2). This procedure refers to service calls "received by dispatch." There never was a function known as "Dispatch" within the Team. This procedure was reportedly written by the Director of BHD when it was anticipated that the 24-hour crisis telephone service would be contracted. This documented procedure, as well, was originally effective on 12/12/03, months before the Director reported the effort to contract the Team's functions.

F-30. While there is indication that some of the new procedures had been communicated verbally to the Team over the past year, there are new procedures since April 2005 that were never communicated. Those new procedures also show an effective date of 12/12/03.

F-31. It was found that all policies and procedures for the Team were not reviewed or revised in the two years prior to April of 2005.

F-32. All policies and procedures for the Team were reviewed and revised as of April 19, 2005. In spite of this review and revisions process, none of the Crisis Team P&P documents shows a review or revision date later than 7/1/04.

F-33. All Intranet P&P documents in BHD can be changed at will by BHD management. Documents can be backdated with no verifications or management controls.

Conclusions

C-01. The Team provides a valuable community service, but funding problems in the County required that it be downsized to perform mandated services only. (F-01, F-02, F-05)

C-02. The Director of BHD is more directly involved with the Team policies and procedures than the two mid-level supervisors. (F-03)

C-03. BHD does not follow its own procedures for maintaining, reviewing, and updating policies and procedures. (F-08, F-09, F-11 thru F-15, F-20, F-21)

C-04. There is no document integrity to the policies and procedures on the Intranet, and there is no reliable verification mechanism to ensure that the procedures being followed have been adequately reviewed and appropriately controlled. (F-17 thru F-19, F-24 thru F-26, F-32, F-33)

C-05. Employees do not get clear instructions about what is expected of them. There is no well-documented or well-maintained procedure for providing services to clients. (F-16, F-17, F-20, F-21, F-27, F-29, F-30)

C-06. There is an inconsistent and contradictory flow of information from the Director of BHD to the employees in the department. (F-20, F-22, F-23, F-25, F-29, F-30)

C-07. The Director of BHD was less than candid and often contradictory when interviewed multiple times by the Grand Jury. Two of the interviews were under oath. (F-23, F-25, F-28 thru F-31)

Recommendations

R-01. Establish administrative controls to ensure that policies and procedures have integrity and effective dates. Develop controls that would prevent one individual from manipulating the system.

R-02. Provide separation of duties or checks and balances. Separate policy and procedure approval authority from the documentation and execution function.

Responses

Responses Required From:

Board of Supervisors (R-01, R-02)
County Executive Officer (R-01, R-02)
Health Care Agency (R-01, R-02)

Attachments

Attachment 1. "Scope and Development of Policies and Procedures," Ventura County Behavioral Health Policies and Procedures, Procedure No. A1, August 11, 2000.
Attachment 2. "Crisis Team Dispatch Tracking of Mobile Teams," Ventura County Behavioral Health Policies and Procedures, Procedure No. C30, December 12, 2003.

VENTURA COUNTY BEHAVIORAL HEALTH POLICIES AND PROCEDURES

POLICY:	SCOPE AND DEVELOPMENT OF POLICIES AND PROCEDURES	PROCEDURE NO: A1	Page 1 of 2
DEPARTMENT:	ADMINISTRATION	EFFECTIVE DATE: 8/11/00	ORIGINAL POLICY DATE: 8/11/00
AFFECTS:	ALL DEPARTMENTS		REVISION/REVIEW DATES: 12/15/00; 2/13/04
APPROVED BY:	Behavioral Health Director		Behavioral Health Medical Director

POLICY:

It is the policy of Ventura County Behavioral Health (VCBH), which encompasses both Mental Health Services and Alcohol and Drug Services, to develop and maintain one integrated policy and procedure manual. This manual will provide general guidelines for the effective and efficient management of VCBH, will be available to staff, and will serve as the sole and comprehensive reference for all policies and procedures for the department.

PROCEDURE:

A. All policies in this manual are consistent with, and incorporate by reference, those set forth in the Ventura County Administrative Manual, the Ventura County Medical Center (VCMC) Compliance Manual, and the policy and procedures of VCMC.

B. Unless otherwise noted, policies and procedures in this manual apply to all VCBH organizational units and offices.

C. The office of the Behavioral Health Director shall be responsible for coordinating development and implementation of the policies and procedures included in this manual. To this end, the Behavioral Health Director has established a Policy and Procedure Committee to carry out this function and to do the following:

1. Reviewing all proposed policies and procedures for incorporation into the department manual;
2. Assigning numbers, formatting, and editing each policy and procedure;
3. Reproducing and distributing policies and procedures for the manual;
4. Reviewing the manual on an annual basis;
5. Developing policies and procedures as appropriate;
6. Posting the policies and procedures on the Intranet, and maintaining the official hard copy of the manual.

Page 1 of 2 A1

Attachment 1. Procedure A1: "Scope and Development of Policies and Procedures"

VENTURA COUNTY BEHAVIORAL HEALTH POLICIES AND PROCEDURES

D. VCBH policies and procedures will follow a standard format as follows:

1. All policies and procedures will be typed on the official VCBH policy and procedure template;
2. All attachments and accompanying text will be stamped with the policy and procedure number, and will be kept current.

E. Generally, all VCBH services are responsible for developing policies and procedures for their area of expertise, and all staff members are encouraged to participate in this process.

F. The procedure for submitting proposed new or revised policies and procedures, securing the required approvals, and getting new or revised policies and procedures disseminated is as follows:

1. The author of the new or revised policy submits it to the Administrative Management Assistant.
2. The author compares the proposed policy to existing policies of VCMC, Ventura County Administration, and the Office of Compliance to ensure consistency and conformity;
3. If necessary, the author modifies the proposed policy to ensure such consistency and conformity;
4. The author forwards the proposed policy to the executive management group and other impacted departments, attaching a timeline that will not exceed ten (10) working days, and a corresponding approvals sheet;
5. Once all modifications are made and approved by the executive management group, the policy is returned to the Administrative Management Assistant with the fully completed approvals sheet;
6. The Administrative Management Assistant will assign a number to the approved policy and forward it to the Medical Director and the Behavioral Health Director for approval;
7. Once approved, the Administrative Management Assistant will incorporate it into the Policy and Procedure Manual and post it to the Intranet;
8. The author will produce a memo describing the approved policy; the training that will be required for the effective implementation of that policy, including the date that the training will occur; and the implementation date of the policy.

G. In the case of proposed revisions to existing policies, the author will submit the old policy with the proposed revisions attached, and will follow the same procedure delineated in number 6 above.

Page 2 of 2 A1

Attachment 1. Procedure A1: "Scope and Development of Policies and Procedures"

VENTURA COUNTY BEHAVIORAL HEALTH POLICIES AND PROCEDURES

POLICY:	CRISIS TEAM DISPATCH TRACKING OF MOBILE TEAMS	PROCEDURE NO: CT30	Page 1of 1
DEPARTMENT:	SUPPORT SERVICES	EFFECTIVE DATE: 12/12/03	ORIGINAL POLICY DATE: 12/8/03
AFFECTS:	CRISIS TEAM		REVISION/REVIEW DATES: 1/01/04

APPROVED BY:

Linda Shulman
Behavioral Health Director

Behavioral Health Medical Director

POLICY:

Dispatch will have documented knowledge of where each mobile team is at any given time. This information will be logged in the Main Log Book. This information will include date, time of mobile team dispatch, location, client name, presentation and time call completed. Also noted will be calls made to dispatch during the call regarding transferring facility, etc.

PROCEDURE:

When call is received by dispatch, receiver will log call in Log Book noting time call received, location, name and presenting problem. When dispatch contacts mobile team and sends them on a call, this time will be noted in the Log Book. Mobile team will notify dispatch when they arrive at service location. When the call has been completed, the mobile team will immediately contact dispatch to inform them of the completion of the call. Dispatch will then note time in the Log Book, along with the disposition of the case.

Page 1 of 1 CT30

Attachment 2. Procedure CT30: "Crisis Team Dispatch Tracking of Mobile Teams"