TULARE COUNTY AGREEMENT NO. 28746

COUNTY OF TULARE
HEALTH & HUMAN SERVICES AGENCY
SERVICES AGREEMENT

THIS AGREEMENT ("Agreement") is entered into as of July 1, 2018 between the **COUNTY OF TULARE**, a political subdivision of the State of California ("COUNTY"), and **VICTOR TREATMENT CENTERS, INC.**, a California Corporation ("CONTRACTOR"). COUNTY and CONTRACTOR are each a "Party" and together are the "Parties" to this Agreement, which is made with reference to the following:

A. COUNTY wishes to retain the services of CONTRACTOR for the purpose of providing Intensive Day Treatment (full day) and Specialty Mental Health services, to include Medication Support, Case Management, and Crisis Intervention for Medi-Cal eligible foster children placed in their facility by COUNTY'S Child Welfare Program and Probation. CONTRACTOR's services also include a Residential Treatment Program, which provides a highly structured therapeutic milieus and predictable environment to help support and enable the youth to focus on their improving mental health.

B. CONTRACTOR has the experience and qualifications to provide the services COUNTY requires pertaining to the COUNTY'S Mental Health Program; and

C. CONTRACTOR is willing to enter into this Agreement with COUNTY upon the terms and conditions set forth herein.

THE PARTIES AGREE AS FOLLOWS:

1. **TERM:** This Agreement becomes effective as of July 1, 2018, and expires at 11:59 PM on June 30, 2019, unless earlier terminated as provided below, or unless the Parties extend the term by a written amendment to this Agreement.

2. **SERVICES:** See attached **Exhibits A, A-1, B-1**

3. **PAYMENT FOR SERVICES:** See attached **Exhibit B.**

4. **INSURANCE:** Before approval of this Agreement by COUNTY, CONTRACTOR must file with the Clerk of the Board of Supervisors evidence of the required insurance as set forth in the attached **Exhibit C**.

5. **GENERAL AGREEMENT TERMS AND CONDITIONS:** COUNTY'S "General Agreement Terms and Conditions" are hereby incorporated by reference and made a part of this Agreement as if fully set forth herein. COUNTY'S "General Agreement Terms and Conditions" can be viewed at http://tularecountycounsel.org/default/index.cfm/public-information/

6. **ADDITIONAL EXHIBITS:** CONTRACTOR shall comply with the terms and conditions of the Exhibits listed below and identified with a checked box, which are by this reference made a part of this Agreement. Complete Exhibits D, E, F, G, G-1, and H can be viewed at http://tularecountycounsel.org/default/index.cfm/public-information/

COUNTY OF TULARE
HEALTH & HUMAN SERVICES AGENCY
SERVICES AGREEMENT

☒	**Exhibit D**	Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreement
☒	**Exhibit E**	Cultural Competence and Diversity
☒	**Exhibit F**	Information Confidentiality and Security Requirements
☒	**Exhibit G**	Contract Provider Disclosures (Must be completed by Contractor and submitted to County prior to approval of agreement.)
☒	**Exhibit G1**	National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
☐	**Exhibit H**	Additional terms and conditions for federally-funded contracts
☐	**Exhibit**	

7. NOTICES: (a) Except as may be otherwise required by law, any notice to be given must be written and must be either personally delivered, sent by facsimile transmission or sent by first class mail, postage prepaid and addressed as follows:

COUNTY:

CONTRACT UNIT
TULARE COUNTY HEALTH & HUMAN SERVICES AGENCY
5957 S. Mooney Boulevard
Visalia, CA 93277
Phone No.: 559-624-8000
Fax No.: 559-737-4059

With a Copy to:

COUNTY ADMINISTRATIVE OFFICER
2800 W. Burrel Ave.
Visalia, CA 93291
Phone No.: 559-636-5005
Fax No.: 559- 733-6318

CONTRACTOR:

VICTOR TREATMENT CENTERS, INC.
1360 East Lassen Ave.
Chico, CA 95973
Phone No.: 530-893-0758
Fax No.:530-839-0502

(b) Notice personally delivered is effective when delivered. Notice sent by facsimile transmission is deemed to be received upon successful transmission. Notice sent by first class mail will be deemed received on the fifth calendar day after the date of mailing. Either Party may change the above address by giving written notice under this section.

8. AUTHORITY: CONTRACTOR represents and warrants to COUNTY that the individual(s) signing this Agreement on its behalf are duly authorized and have legal capacity to sign this Agreement and bind CONTRACTOR to its terms. CONTRACTOR acknowledges that COUNTY has relied upon this representation and warranty in entering into this Agreement.

COUNTY OF TULARE
HEALTH & HUMAN SERVICES AGENCY
SERVICES AGREEMENT

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9. COUNTERPARTS: The Parties may sign this Agreement in counterparts, each of which is an original and all of which taken together form one single document.

THE PARTIES, having read and considered the above provisions, indicate their agreement by their authorized signatures below.

VICTOR TREATMENT CENTERS, INC.

Date: 6/18/18

By _____

Print Name EDWARD HACKETT

Title CFO

Date: 6/19/18

By _____

Print Name Douglas Scott

Title CEO

(Pursuant to Corporations Code section 313, County policy requires that contracts with a **Corporation** be signed by both (1) the chairman of the Board of Directors, the president or any vice-president (or another officer having general, operational responsibilities), and (2) the secretary, any assistant secretary, the chief financial officer, or any assistant treasurer (or another officer having recordkeeping or financial responsibilities), unless the contract is accompanied by a certified copy of a resolution of the corporation's Board of Directors authorizing the execution of the contract. Similarly, pursuant to California Corporations Code section 17703.01, County policy requires that contracts with a **Limited Liability Company** be signed by at least two managers, unless the contract is accompanied by a certified copy of the articles of organization stating that the LLC is managed by only one manager.)

COUNTY OF TULARE

Date: July 17, 2018

By _____
Chairman, Board of Supervisors

ATTEST: MICHAEL C. SPATA
County Administrative Officer/Clerk of the Board of Supervisors of the County of Tulare

By _____
Deputy Clerk

Approved as to Form
County Counsel

By _____ 7/2/18
Deputy

Matter # 2018725

EXHIBIT A

Victor Treatment Centers

STRTP Program Statement

1. Population to be Served

Contractor, Victor Treatment Centers, Inc. (VTC) serves severely emotionally disturbed youth (male and female) who range in age from 8-18 and Non-Minor Dependents (NMD) based upon the initial assessment and the appropriate placement availability at each site. Youth sharing a home with a NMD youth will be less than five years younger. Each site and each home at the sites place youth with similar needs and levels of functioning together. All NMD youth placed must agree to the Shared Living Agreement signed at placement in order to maintain placement. Due to the complexity of the placement assessment and matching with openings, VTC does take emergency placements but only in extreme cases of need with local placing counties.

VTC serves children and youth with histories of abuse and neglect, delinquency, sexual adjustment and functioning, drug and alcohol use, and harm to self and/or others. Youth with physical or developmental disabilities will be evaluated on a case by case basis to ensure that our program could effectively meet their needs.

We also serve LGBTQIA youth. To better support transgender youth, he/she is placed based on their chosen gender not his/her biological gender. Our agency also receives annual training on LGBTQIA and commercially sexually exploited children to support their unique needs.

VTC utilizes Trauma focused Cognitive Behavioral Therapy, Risking Connections and Motivational Interviewing to serve youth and families placed in our care. These modalities are easily tailored to address the differing needs of all youth and families. VTC is able to collaborate with community partners to address needs of specific populations.

VTC's Residential Treatment Program aims to create highly structured therapeutic milieus to help support all youth. The Residential Program focuses on providing consistent daily schedules and routines, positive staff engagement and community involvement. The goal of the Residential Program is to provide a predictable environment so youth can focus on his/her mental health issues.

VTC engages in continuous performance improvement to ensure program effectiveness. On a monthly basis through the CFT process, the program's supports are evaluated to determine their effectiveness. Different measurement tools, including the CANS, may be utilized to measure youth's progress towards their treatment goals. Treatment plans will be modified to meet the needs of the youth and families determined by data outcomes.

VTC serves youth who have a propensity for behaviors that result in harm to self or others. Intervention plans are included in the initial Needs & Services plan to address these high risk behaviors including identifying triggers, indicators of potential harm to self or others, effective past intervention and youth directed safety plans. As the needs of the youth change, the agency will utilize Clinical Intervention Safety Plans to identify

interventions to support the youth. Interventions may also include increasing a youth supervision level in order to keep him/her or others safe. Law enforcement and emergency psychiatric services may be utilized in instances when all other interventions have failed.

VTC engages community based organizations and community based providers are needed to address the needs of a specific youth or a sub set of youth. We have reached out to providers that specialize in gender transitioning youth, substance abuse providers and community based organizations that specialize in LGBTQIA services. We don't annually contract with any of these providers as we reach out to them on a case by case basis. We have also worked with community providers around our CSEC population. Shasta County provides resources for CSEC services for our youth and training for our staff. Any specific needs are discussed as part of the CFT meetings and responsibility is assigned to a member of the CFT to follow up on any specialized needs that are needed for the youth. We reach out to community members through phone calls and emails. We have also worked with community members in the youth's or family's home county to coordinate any services that are not available in the greater Redding area. These services have also included keeping families and youth with preferred providers including psychiatric, family therapists and LGBTQIA providers.

2. Emergency Response Services

VTC utilizes an Emergency On-Call system to provide emergency services outside of normal business hours. The On-Call system is comprised of Residential Services Supervisors, Residential Counselor IIs, clinical staff and the site leadership team. A member of the On-call team is able to respond to emergencies in a timely manner to help support youth and staff. In case of a natural disaster, staff will follow the Emergency Evacuation Plan. The On-call/Emergency reporting system will be in effect to ensure notifications of authorized representatives for all youth. Please refer to facility sketches for site specific evacuation plans.

Daily preplanning takes place to ensure the needs of youth are being meet through additional supports. Preplanning meeting take place at each shift change throughout the day, ANC to RCAM, RCAM to RCPM, RCPM to ANC. On-call should be the lead in these meetings to ensure staffing ratios needed to support youth. Youth with identified support needs shall be discussed to ensure coverage. Additional needs include but not limited to youth that have been in a restraint in the last 24 hours, high risk of AWOL, unusual behavior over repeated days or for extended period of time (more than four hours), and CSEC. VTC has the ability to provide flexible staffing to ensure that we can meet the needs of youth and staff through the use of on-call and floaters. In the case that more staff are needed due to call out, on call will call off duty staff to cover needed ratio at house to ensure floaters are still available for crisis and emergencies.

3. Transportation Arrangements

Transportation is provided to youth and non-minor dependents as needed for school, activities, medical appointments and home visits per agency home visit transportation schedule. Agency schedules are developed to include the necessary staff to cover

youth transportation. The agency also provides transportation for youth when AWOL and need to be picked up. Staff shall utilize on-call or floaters to ensure that the agency is capable of picking up youth regardless of the time of day or distance from agency. Floaters are regularly schedule to help in crisis and emergencies, including transportation needs. VTC also has several staff that are transportation specialist, in that they are scheduled to take all youth for home passes on the weekends. Once a youth has notified the VTC that they need transport, staff call on-call to set up transportation. Staff are usually able to pick up youth within 30 minutes after notification. VTC may utilize law enforcement or community partners to assist in transportation needs when youth are in dangerous situation and need assistance with transportation. Law enforcement shall only be utilized when the youth feels that they are in a dangerous situation. Staff will help youth to decide if law enforcement shall be called to help with transportation. It is not an expectation that law enforcement would transport youth home but rather help ensure their safety until VTC staff arrive. Staff will help problem solve with the youth to help them get to a safe place or increase their safety while waiting for transport. VTC has extra vehicles both vans and cars in order to support the transportation needs of the youth/NMD. Staff members often coordinate transportation needs between houses as to cut down on the need for individual transports. Any special transportation needs are assessed at intake and included in the needs and services plan to ensure VTC is able to accommodate the needed services. Transportation needs are addressed in the monthly CFT to address any concerns or new transportation needs. VTC has floaters and on-call staff available as needed to help transport youth as needed.

Non-minor dependents are permitted, unless otherwise stated in his/her Transitional Living Plan, to arrange for his/her own transportation. If the licensee provides transportation to a non-minor dependent at the request of him/her then the licensee shall ensure that the persons who transport a non-minor dependent use vehicles that are in safe operating condition. Non-minor dependents that possess a driver's license are permitted to possess/operate their own vehicle if it contains all required safety equipment (seatbelts), is in safe operating condition and is properly registered and insured. Non-minor dependents will coordinate the parking arrangements for their vehicle with program staff. Staff will facilitate activities related to transportation for non-minor dependents, including training on public transportation, and driver education and safety.

No smoking is allowed at any time in any company vehicles. This includes when youth may need to be transported in staff's personal vehicles.

4. Core Services and Supports

Core services and supports are individualized, specialized and intensive, to support the goal of six month tenure in the VTC STRTP. Core services, then, are put into place according to the needs of the child and family. They include, but are not limited to:

1) Behavioral and mental health services provided by a clinician.
2) Adjunctive mental health services provided by Mental Health Rehabilitation Specialists and/or Family Support Counselors.

3) Medical/medication support services.
4) Educational support services.
5) Facilitation services for CFT's (description to follow).
6) Life and social support.
7) Natural (bio) and resource (professional) family supports.
8) Permanency-related services.
9) Services for non-minor dependents.
10) Transition support services at discharge.
11) Linkage to community services and supports.
12) Linkage to substance abuse treatment, as indicated.

For a youth/NMD in residential treatment, from the time s/he wakes up until s/he goes to sleep, all of his or her interactions with Victor Residential or North Valley School (NVS) staff are part of treatment. Training in these Core Services, therefore, happen at all levels of staffing, as appropriate for the role. For example, while the Clinician is trained to provide formal TFCBT treatment, Residential Counselors, Instructional Aids and Teachers learn about this treatment approach in order to support the child's therapy from within their particular role.

(a) Specialty Mental Health Services

The availability of a broad array of mental health services is essential to the comprehensive support of the children and youth placed in VTC. The majority of the youth placed in our program have experienced trauma that can have long-term negative impacts to the youth's developmental, social, emotional and physical health. Thus, our VTC Specialty Mental Health Services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program are provided for all youth placed in our program up to age 21 who meet Medical Necessity and have full scope Medi-Cal. Further, these mental health services include the Core Practice Model (Katie A. lawsuit), calling for the provision of these comprehensive services delivered in a coordinated manner and tailored to meet the needs of individual children and families. These services include the provision of Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) in alignment with the Core Practice Model and in conjunction with the full array of Specialty Mental Health Services.

Prior to authorization for placement in VTC, a universal assessment process identifies the needed services and supports, and facilitates the development of plans to meet the needs of the child, youth and their families. From the placing agency, a Child and Family Team (CFT) approves the placement and assists in the development of the needs and service plan that ensures participation from the youth, family, caregiver, and professionals, including county mental health partners. The youth who receive services from VTC have a severe mental disorder which causes functional impairment in multiple areas of their life and interfere with their development of life, social, and emotional skills. Furthermore, the symptoms and impairments that result from their disorders require each youth to learn adaptive skills for their healthy development and transition to

less intensive community based support and a family setting. During the enrollment period a VTC Comprehensive Assessment is completed. The assessment identifies clinical needs, barrier behaviors, and discharge goals. Other assessments completed include the Child and Adolescent Needs and Strengths (CANS).

The intensive mental health services consist of four phases, specifically:

1) **Engagement** – Identifying strengths and needs, assessing and identifying functional impairments/reasons for referral (e.g. self-harm, aggressive behavior, etc.), and enhancing and empowering the Child and Family Team to develop connection map, discharge plan, etc.

2) **Planning** – Developing a mental health treatment plan that covers all milieus with incremental steps, short term goals and time frames and providing intensive clinical and rehabilitative services that focus on the major functional impairments/reason for referral which typically includes individual therapy twice weekly, group therapy, rehabilitation services daily in all milieus (STRTP, school, family home) focusing on skill development related to functional impairment, and family therapy/family connection/family finding.

3) **Implementation and Maintenance** – Implementing and adapting the treatment plan as needed, focusing skill development on practicing skills in the milieu and community, family work and visits to Family Visitation continues, and celebrate successes.

4) **Maintenance and Transition** – Focusing individual treatment on maintaining gains and translating them into other environments, adopting related skills learned and transition them to home and/or community environment, family therapy continues and transfers if appropriate into the home/foster/Family Visitation Center, and transition mental health services are available for up to 30 days after discharge.

Throughout a youth's stay at VTC Child and Family Teams meet regularly to create child and family driven individualized service plans. These plans include elements from and are consistent with the mental health treatment plan.

Parent partners who have had children served by and have experienced the system help family members understand the new program, feel comfortable with participation, and share their perspectives, ideas, and concerns. These parent partners are part of the CFT. In addition, if available, family members are invited to participate in the enrollment decision at the VTC enrollment meeting where family, residential program staff and county staff come together prior to placement to confirm that this is the best avenue for treatment. After enrollment, family members will participate in subsequent treatment planning decisions through a client and family driven team meeting approach (CFT meetings), and Individual Education Plan meetings. CFT meetings are scheduled when parents and other important people in the youth's life can attend; their frequency is tailored to the needs of the family and reset as needed depending on where the youth/family happens to be in the trajectory of care. Arrangements are made so that key members can attend the CFT telephonically. In addition, provisions are made for parents to be with their youth in the facility when residential treatment is needed.

A designated Family Clinician who is assigned at enrollment provides the following throughout the trajectory of care: CFT support, case management, natural support development, family therapy, parent support and guidance, family finding engagement and empowerment, and liaison with schools and other services needed to help prepare a place for youth as they move toward permanency. VTC utilizes each youth's comprehensive bio-psychosocial assessment as the basis to identify the skills to be targeted that will ameliorate their condition.

Medication Support Services

Medication Support Services include assessing the need and benefit of medication and if warranted, prescribing, administering, dispensing and monitoring of psychiatric medications that are necessary to alleviate the symptoms of mental illness. VTC's Psychiatrists evaluate the need for medication; its clinical effectiveness, side effects, instruction in the use, risks and benefits of, and alternatives for medication. Medication support services include collateral and plan development related to the delivery of the service and/or assessment of the child, prescribing, administering, dispensing and monitoring of psychiatric medications and medication education. A supportive nursing staffing system is employed to enhance the level of support offered to our youth. These supportive measures include general health need follow-ups, connectivity to appropriate community based resources and client education on medications being prescribed.

(b) Transition Services

VTCs provides Transitional planning upon intake. This planning includes connection mapping and ongoing concurrent planning during the course of treatment at every CFT. VTC then provides Support Services upon discharge from the residential program. These include follow-up services in varying degrees of intensity and duration to stabilize and maintain the return to the home-based family care setting, school and community. Once youth have returned to or are joined with the families who will be their permanent primary caregivers, the same CFT members and Family Clinician who have participated in treatment at the residential placement continue to monitor and support, on an as needed basis, the services provided by established local community supports while the ups and downs of reunification inevitably occur. Transition Plans for on-going after-care support are developed and activities include but are not limited to: Connection Map Utilization, Infusion of Natural Supports, Child and Family Team meetings with integrated Safety Plans, Clinical Services, and Medication Support Services.

(c) Education, Physical, Behavioral, Mental Health, Extracurricular Supports

The VTC residential program includes educational, physical, behavioral, and mental health supports fully integrated with a myriad of extracurricular and social supports.

VTC values education and understands it is a critical component to a youth/NMD's success. VTC supports and admits youth that attend both public and non-public schools. During the intake process, the client services facilitators work with the IPC to identify the youth's educational needs to ensure that our agency can provide the needed services. VTC continues towork closely with the educational rights holder during the youth's placement to review and evaluate that the youth's educational needs are being met. The youth's educational needs and services are reviewed at every CFT,

every 30 days, to ensure continual alignment with the Needs and Services Plan and to help with transition planning. VTC operates a non-public school in which youth/NMDs may be placed if he/she is unable to attend public school. This determination is made by our local school districts in partnership with SELPA. If a youth/NMD is placed at public school, VTC's client services facilitators are responsible for collaborating with public school representatives. VTC provides transportation for youth/NMD to and from school when bussing is not available. The client services facilitators attend all IEPs to support youth's educational needs. Public school representatives are encouraged to participate in the youth's CFTs. VTC works with all youth/NMDs to ensure that he/she has all necessary tools complete their school work and/or participate in school activities. Members of the VTC leadership team meet with school districts on a regular basis to help align agency and school services to better support youth placed at VTC.

VTC is a residential milieu program that is specifically designed to teach social skills, values, enhance community involvement, develop personal health and safety education; develop leisure skills training and independent living skills. VTC's highly trained interdisciplinary team of psychiatrists, licensed clinical staff, and residential counselors follow an individualized treatment plan to assure each youth an opportunity to have a successful and fully integrated experience.

Individual, group and family therapy is made available within the structure of the residential program and Specialty Mental Health Services are offered as authorized by the placing county. VTC embraces a team driven care model, and seeks to include the family and/or family support people in every aspect of each youth's care.

Assessments are made at intake to determine social needs, and eligibility for specialty Mental Health Services. A psychiatric evaluation is completed to assess the current need for psychotropic medication. An educational assessment is completed within the school environment to assess the special education needs. When necessary a psychological evaluation is completed. As a result of these assessments and evaluations a comprehensive treatment plan is developed. The treatment plan is reviewed, evaluated, and renewed at least every 90 days, and youth are reassessed quarterly. This review is completed by an interdisciplinary team consisting of the residential staff, clinical staff, education staff, parents and placement officials, and most importantly, the youth.

VTC's Family Inclusion Model is intended to ensure family members and youth have choice to participate in:

- Selecting members of their Child and Family Team.
- Selecting providers and services, whenever possible.
- Selecting Family and/or community supports and Mentors *(from the community and from within the residential provider organization).*
- Selecting providers they deem respectful of and responsive to their cultural and linguistic preferences.

Examples of Extracurricular and Social Support with full family inclusion are:

- Educational and/or Entertainment Field trips that include family, significant others.
- Dinner nights participating in cooking a special favorite meal at the STRTP combined with cultural specialties.
- Family attendance at all special events (Softball, Basketball, Talent shows, etc.).
- Family opportunities to volunteer mentor new family members of new clients.
- Family employed as Parent Partners.
- Family attendance at regularly scheduled trainings, staff meetings, global training opportunities, and training to support transitioning home.
- Family involved in interviewing possible lower level placement options when youth is not ready to transition home.
- Family involved in making decisions regarding rewards, consequences, and celebrations.
- Family inclusion in camping, kayaking and other recreational activities.
- Family participating in our strategic priorities process; more specifically, parents interviewing other parents according to an appreciative inquiry protocol.
- Youth interviewing other youth in our programs according to an appreciative inquiry protocol that is developed with the youth.
- Family as part of the expected school-wide learning results development.
- Family attending Holiday caroling at each residential house.
- Family attending Back to School night.
- Family attending case conference meeting for the portion applicable to their youth.
- Family participating in quarterly treatment meetings.
- Family participating in summit meetings.
- Family who are willing and able can present their experiences relative to having a youth in placement in all-staff meetings.
- Family invited to local VTC site support group meeting.

(d) Transition to Adulthood Services/Transition Age Youth (NMD)

On a case by case situation, VTCs serves foster youth over the age of 18 (non-minor dependents) as defined by the Welfare and Institutions Code. These youth are enrolled in school and meet the qualification requirements specified in Welfare and Institutions Code section 1605.1. These youth are expected to honor the rules of the household and sign a Shared Living Agreement at placement. However, his/her support structure focuses on developing responsible independence. Due to the fact that the youth are legally adults, he/she is expected to be compliant with his/her treatment plans. No

physical interventions are utilized when working with the youth over the age of 18. There is no tolerance for dangerous behavior that is directed towards other youth placed in the program or the staff providing support and guidance. The treatment plan for non-minor dependents is uniquely designed to focus on his/her goal of a successful transition from residential treatment into the broader community.

VTC Transition to Adulthood Services includes interactive life skills training, lifelong connections support, access to education support, employment support, case management, permanency support services, and access to public services. Specific Evidence Based Practices utilized include:

Independent Living Program (ILP)

VTC utilizes an Independent living curriculum with a goal to promote independence by providing youth opportunities to gain valuable life skills to balance their transition to freedom with responsibility.

This program is designed to support youth who are at least 15 ½ years old and have identified a need to develop independent living Skills. Youth will increase their knowledge of community resources and how to utilize them to meet their own needs, while gaining the skills needed to manage their own lives successfully and effectively. All subjects can be taught individually by staff at any site, such as home, office or public locations. Other sites for groups can be but are not limited to local community centers, libraries and local churches.

The curriculum consists of four modules or areas of life that pertain to gaining valuable independent living skills and promoting independence. These areas include:

- Financial: Teenagers need to see how money works in the real world, including where it comes from and where it all seems to go. This module can cover topics such as banking, budgeting, credit, and finding employment.
- Personal: As teens transition into adulthood they become aware of community and public roles and responsibility. With a positive beginning, teens can develop life-long values that will protect and aid them. This module can include such topics as etiquette, values, choices, and safety.
- Social: It is important to teach teens the social and life skills they need to negotiate through their increasingly more complicated world. Teens that are equipped with these skills will experience greater success in their family, social, and academic lives. This module covers things like communication, recreation, and transportation.
- Physical: Eating poorly, sleeping too little, and running on empty may lead to serious health consequences. It is important to teach teens simple steps to maintaining good physical health. This module can include topics such as medical insurance, basic first aid, hygiene, and exercise.

Incentives: Each participant can be rewarded for attending the weekly groups by either gift card or other site specific guidelines regarding funds for youth or earn points toward a larger reward. Rewards can be privileges, things or activities with parents as well.

Community Involvement: The curriculum can be incorporated in the community by teaching groups at local community centers or other venues and by including local professionals that can present first-hand knowledge to the participants regarding the specific topics in the ILP curriculum.

Job Skill Search/Development/Coaching

Workability is a training program for special education students ages 16-22 at North Valley Schools. It is designed to promote career awareness and exploration while students complete their secondary education program. The mission of Workability is to promote the involvement of key stakeholders including students, families, educators, employers and other agencies in planning and implementing an array of services that will culminate in successful student transition to employment, lifelong learning, and quality of life. VTC provides youth with opportunities for job shadowing, paid and non-paid work experience and ongoing support and guidance.

(e) Native American Indian Child Services

VTC STRTP services are provided and VTC child and family assessments reflect cultural awareness and sensitivity and consider the specific cultural background of each youth placed in the residential program. VTC services incorporate and embrace the unique cultural characteristics of clients from diverse backgrounds, including Native American Indian children. All efforts will be made to ensure Native American Indian children remain connected with their tribe and placed back within their tribe whenever possible. Services are tailored to account for child and family diversity and always include the child and family perspective. The Family Inclusion Approach within the VTC service delivery system ensures the services appropriately fit the child and family needs.

5. Trauma Informed Intervention and Treatment Practices

VTC is committed to having all staff trauma informed trained to be respectful, informed, connected, and hopeful for youth/NMD regarding her own experience with trauma. The agency understands the interrelationship between trauma and symptoms of trauma including, but not limited to, substance abuse, eating disorders, depression, and anxiety. The agency works in a collaborative way with a youth/NMD, her family and friends, and human services agencies in a manner that will empower the child/NMD. Trauma informed intervention shall be included in the needs and services plan and shall be reviewed at every CFT to determine if new interventions need to be utilized to better support the youth/NMD. Trauma informed interventions shall be in alignment with case plans, transitional independent living plans, needs and services plan and child and family team. These plans shall be reviewed as part of intake and discuss at every CFT meeting to ensure consistency with the trauma informed interventions.

When a child depends on an adult for nurturance, safety, and love, he or she should not be taking a risk. After betrayal, making connections requires risking disappointment at minimum, if not shame, loss, and further trauma. Traumatized children become skilled at pushing away relationships to avoid more disappointment. In adulthood, many of the youth served at VTC continue to find it risky to connect with others as well as make connections between their past and their present, their thoughts and feelings.

To heal, a traumatized youth must risk connecting with caring adults who are different (enough) from those of his or her past. Yet, there are many reasons why youth would not take that chance. Over time, however, through the experience of RICH® relationships—those that demonstrate Respect, Information, Connection, and Hope—youth can learn to trust in caring adults and move beyond the wounds of the past.

The STRTP staff are trained to know they are role models to youth/NMD and all youth/NMD are to be treated with dignity and respect. The agency will not tolerate any victimization of youth/NMD. The trauma informed training integrates trauma informed consequences to reduce any potential to re-traumatize youth/NMD. STRTP team members are trained and expected to comprehensively integrate their knowledge of the trauma training into every aspect of our service delivery process including implementation of our policies and procedures which will be experienced by our families as promoting the necessary healing to support a smooth transition process post-treatment. This training is scheduled throughout the year and new employees receive training at the earliest point possible. Training is provided by Risking Connections certified trainers, Vicki Sheckles, Bethany Bilyeu, Mike Smith and Bill Deshais. Our new employee orientation (Bi-monthly or monthly dependent upon the level of hiring) introduces the trauma informed environment expectation and is followed up on in subsequent initial orientation trainings for our residential treatment and mental health provider team members to assist them in initiating services. They will build on those services throughout the year.

VTC's promotes physical and psychological safety for youth/NMD and families. VTC enhances the well-being and resilience of youth/NMD and families. The trauma informed training VTC mandates, focuses on creating essential elements of informed care which include creating and establishing an environment that is physically safe and work with the youth to learn what it will take to create psychological safety in the STRTP. The training offers suggestions and techniques to help children and adolescents understand the links between their thoughts, feelings and behaviors (the cognitive triangle) and to take control of their behavioral responses. The trauma informed training also focus on thoughts of why if a certain incident or event occurred what is being triggered and causing the child to have anxiety or reject physical or redirecting contact with the care giver. Focusing on feelings of experiencing the past trauma that has caused hurt or anger; Focusing on behaviors that have assisted the child with getting through the trauma, which can keep the child from forming positive relationships with their care giver, and use negative behaviors to sabotage the relationships. Our ongoing goal is to assist the family system to strengthen through this improved connection and learning (understanding). Research supports the outcomes that include increased feelings of empowerment, stability and well-being that act as building blocks to promote sustainable positive change (Permanency). With increased understanding of the trauma they have experienced, and the fact that there are healthy alternatives that are doable, this allows the family to begin to heal and to move forward.

VTC also promotes physical health through safety planning and psychoeducation with youth/NMD and their identified families. VTC staff help youth/NMD develop safety plans to be utilized while in care at the facility. Once transition plans are finalized, VTC staff

help the youth and family develop safety plans based in their new community. Safety plans are developed and reviewed during CFT meetings. VTC is promotes a healthy lifestyle by incorporating physical activities into the daily schedule as well as providing healthy meals for youth/MND. Clinical staff also work with parents to help them develop similar plans and guidelines that they can follow at their home. VTC often has physical fitness challenges for both staff and youth/NMD to help encourage participation in physical activity. Rewards are provided to those youth completing the challenges.

VTC contributes to youth/NMD and families' well-being and resiliency through trauma informed interventions with the focus on developing positive relationship, regulating emotions, psychoeducation and safety planning. This work in completed in all milieus and in all modes of treatment including individual and family therapy, individual and group rehabilitation, and group therapy. As youth/NMD and families start to develop positive social skills, emotional regulation skills and skills related to safety, they gain a greater sense of well-being and resiliency as these newly acquired skills help them manage any future issues related to trauma, mental illness, or safety. These skills also transfer to other areas of their lives even though they may not be the main focus of treatment. Youth and families build resiliency by successfully managing stressful situation. VTC staff work to help youth and families develop coping skills to better manage and deal with stressful situation. Debriefing stressful events is also an important component to building resiliency as it helps youth and families redefine their own capabilities to manage stressful events on their own.

VTC STRTP employs Risking Connections training program.

Risking Connection

Risking Connection® is a foundational trauma training program, rooted in relational and attachment theory. It provides a framework for understanding the wide array of trauma-based symptoms and behaviors that cause people to surface for help in various mental health and addictions settings. Because it is foundational, Risking Connection® training complements and enhances treatment techniques used with traumatized clients, such as Dialectical Behavior Therapy (Linehan), EMDR (Shapiro), Exposure (Foa), and Trauma-Focused Cognitive Behavior Therapy (Cohen, Deblinger, and Mannarino).

Risking Connection® was commissioned by the states of Maine and New York to train public mental health system staff at all levels to provide trauma-informed treatment to clients. Since its inception, the program has been implemented in independent living programs, psychiatric hospitals, residential treatment, criminal justice settings, outpatient mental health, among other settings.

Risking Connection® is unique in several respects:

- It is a philosophy of treatment rather than a treatment technique.
- It is for staff at all levels of training and creates a common language among staff to speak about trauma within treatment settings.
- It stresses the direct link past traumatized attachment and current relationships with treatment staff. In essence, since youth have been hurt in

relationships, supportive nurturing relationships are critical to healing. Therefore, every person who has contact with youth in a treatment setting is doing "trauma treatment."

- It asserts that treating traumatized people also poses risks to those providing treatment, namely the risk of vicarious traumatization. In this model, respect for, and care of, both youth and clinician or counselor are viewed as vital.
- It acknowledges that strong feelings are inevitable in clinician or counselor working with traumatized youth. Thus the program helps clinician or counselor learn how to use those feelings to promote healing.

STRTP staff members (Clinicians and Residential Milieu staff) are trained in Risking Connections, in which they seek to understand the trauma linked to the youth's behaviors and how that information guides the relationships built between the staff and youth. Key to the effective use of this process is the recognition that persistent behaviors that appear challenging, dangerous, and ineffective are usually driven by critical unmet needs, and that the development of effective alternatives requires not only understanding the nature of those needs, but also identifying core individual strengths of the youth and family members as well as shared strengths of the family as a whole on which to build more effective adaptive responses to those needs. The Initial training is 24 hours conducted by certified Risking Connections trainers (Executive Director, Clinical Supervisor and Clinical and Residential team members that have been certified). Clinical staff is trained throughout the year in trauma focused treatment methodology and service implementation and in scheduled trainings to keep their knowledge base associated with our EBP implementation current. This training is provided by certified trainers and scheduled throughout the year as these sessions are scheduled.

The appropriate trauma focused intervention is identified after the completion of a detailed Mental Health assessment process that is drafted by the assigned agency clinician for the assigned client. This is a detailed process that includes several meetings with the client and their family or identified and available point of post treatment transition. Clarity and efficiency in the completion of this process is an ongoing priority as the service intensity and short term goal remain an area of focus. All assessments are reviewed by the Clinical Supervisor assigned to the Clinician and advance the completion of the Treatment Plan. This plan will outline behaviors and need areas that will be addressed in treatment and monitored for improvements or increases in behaviors. We will use the CANS (Dr. John Lyons - Child and Adolescent Needs and Strengths) tool as a tool to assess improvements in the client's response to treatment. This information will be shared with the client and the family to increase their understanding of the progress being made. Trauma informed intervention methods will also include the family members and significant contacts that are a part of the client's supportive network. Family therapy sessions will be regularly scheduled to promote familiarity and comfort for the family as they work with our clinical team toward a successful transition process.

Cognitive Behavior Therapy (CBT)

VTC endeavors to maintain appropriate levels of fully trained staff in the appropriate disciplines to support the implementation of a trauma informed treatment process. As a result, the recruitment of CBT trained clinicians in addition to the provision of ongoing training for our mental health practitioners to increase their knowledge base will remain a critical facet of our employment and staff retention structure.

Cognitive Behavior Therapy and its focus on short term, present focused skill development aligns well with our short term, intensive treatment services structure. Services will be provided in the treatment home, in private. MFTI, MSW, LPCC or PhD clinicians not licensed will be supervised by a licensed supervisor who is also trained in Cognitive Behavioral Therapy. Clinical staff will be supervised a minimum of once per week for one hour of individual supervision or a two hour group supervision (in accordance with the California Department of Consumer Affairs Board of Behavioral Sciences or Board of Psychology. During observation and supervision the Clinical Supervisor will ensure fidelity to the model. The Clinical Assessment and Client Treatment Plan will be utilized to ensure individualized trauma informed services are provided.

Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

All clinical staff (MFTI, MSW, LPCC, PhD) are trained in Trauma Focused Cognitive Behavioral Therapy. Trauma Focused Cognitive Behavior Therapy (TF-CBT) has been rated by the CEBC in the area of Trauma Treatment for Children. TF-CBT is a conjoint youth and parent psychotherapy model for youth who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles. Trauma Focused Cognitive Behavioral Therapy is a child-centered treatment intervention designed to help children and adolescents work through (on an individual basis) their traumatic past (and significant stressors experienced during childhood) with a trained psychotherapist. The essential components of the TF-CBT include: skill building, psycho-education, affective expression and modulation, cognitive coping, trauma narrative development and processing, in-vivo exposure, conjoint parent-child training/sessions and enhancing safety.

Aggression Replacement Training (ART)

VTC endeavors to maintain appropriate levels of fully trained staff in the appropriate disciplines to support the implementation of a trauma informed treatment process. As a result, our existing and future residential milieu team members will participate in ongoing ART training sessions designed to promote their capacity to better support the needs of the adolescents and families we serve.

Aggression Replacement Training® (ART®) is a multimodal psycho educational intervention designed to alter the behavior of chronically aggressive adolescents and young children. The goal of ART® is to improve social skill competence, anger control,

and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger-control training, and training in moral reasoning. *Skill-streaming* uses modeling, role-playing, performance feedback, and transfer training to teach pro-social skills. In *anger-control training,* participating youths must bring to each session one or more descriptions of recent anger-arousing experiences (hassles), and over the duration of the program they are trained in how to respond to their hassles. *Training in moral reasoning* is designed to enhance youths' sense of fairness and justice regarding the needs and rights of others and to train youths to imagine the perspectives of others when they confront various moral problem situations.

The program consists of a 10-week, 30-hour intervention administered to groups of 8 to 12 students three times a week. The 10-week sequence is the "core" curriculum, though the ART® curriculum has been offered in a variety of lengths. During these 10 weeks, participating youths typically attend three 1-hour sessions per week, one session each of skill-streaming, anger-control training, and training in moral reasoning. The program relies on repetitive learning techniques to teach participants to control impulsiveness and anger and use more appropriate behaviors. In addition, guided group discussion is used to correct antisocial thinking.

Family Systems Approach

The family systems theory is a theory that suggests individuals cannot be understood in isolation from one another, but rather as a part of their family, as the family is an emotional unit. Families are systems of interconnected and interdependent individuals, none of whom can be understood in isolation from the system. Further, the family is always changing, self-organizing, and adapting to its members and the outside environment. At VTC we take a Family Systems Approach to our work with children and families and visualize youth as a member of a system and treat and work with not only the youth but the family (as the youth defines it) and the community connected to that youth.

Values Development

CHARACTER COUNTS! is an ethical program designed for the purpose of bringing together, into a public setting, a common ethical language. It touches youth, the home, the community, and city at large. It creates a moral awareness in the development of character, producing a community sensitive to transcendent values. This ethical ideal is based on qualities, highly regarded in all communities of the world, from the past to the present, and is the foundation upon which a credible democracy is based. The ethical values used in the CHARACTER COUNTS! Program at VTC focuses on the qualities of trustworthiness, respect, responsibility, fairness, caring, and good citizenship.

Equine Therapy

The mission of the Horse Program is to take advantage of the healing power of nature and the kinesthetic metaphor presented by human-animal interaction in order to restore trust, balance, self-esteem, and build confidence.

There are two separate components to the Horse Program. Horse group is offered during school hours with a combination of community students and residential students. Horse Club is then offered after school to the residential youth only. Horse

Club is offered three afternoons a week to residents of three houses at a time. Both components deal with therapeutic issues and referrals are made by the youths' therapists.

Clinicians who provide Equine Assisted Psychotherapy are trained through the Equine Assisted Growth and Learning Association (EAGALA) which is the international standard-setting and training organization for Equine Assisted Psychotherapy.

Training Resources to Maintain EBP's Knowledge Base

We utilize the following options to train our Mental Health practitioners:

Medical University of South Carolina Webinar

- TF-CBT (Initial Training)

Alison Hendricks, LMFT

Alison Hendricks is a licensed Marriage and Family Therapist trained by Drs. Anthony Mannarino, Esther Deblinger, and Judy Cohen, the developers of Trauma Focused Cognitive Behavioral Therapy (TF-CBT), to provide training and supervision to therapists in TF-CBT as a Trainer of Trainers. She has been working with traumatized children and their families for 13 years, and has been training for the last 5 years. Her expertise in the areas of domestic violence, sexual abuse, physical abuse and neglect inform the depth of her capacity to understand the complexities of childhood trauma.

- TF-CBT (2 day training, 14-16 Consultation Calls)

All direct care staff receive trauma focused cognitive behavioral training provided by Adriana Niculescu, LMFT. This training is provided throughout the year to ensure that all staff are able to support the clinical work by using similar techniques. This training is a two part four hour training. All direct care staff also receive training on Collaborative Problem Solving and the Neurosequential Model which outlines the effects of trauma on the brain and effective interventions to support youth where they are at in their trauma process. This training is a four part four hour training provided by Bethany Bilyeu, Psy.D., LCPC, throughout the year.

Program Evaluations and Outcomes Focus:

Our VTC Program Evaluations and Outcomes structure includes a Program Analyst tasked with reviewing service outcome levels and overall effectiveness. This information is reviewed monthly with the Regional Director and the Director of Residential Services to assess trends and make the necessary improvements to service delivery. VTC will analyze data related to high risk behaviors (harm to self/others, AWOL, property damage, etc.) to determine effectiveness of interventions.

The integrity and effectiveness of our Trauma Informed Service Environment will be evaluated in a number of ways:

- Tracking of the reduction of the challenging behavior patterns and the implementation of positive replacement behaviors that will be shared with the

child and family team to better support the continuation of these practices. This information will help the family to increase their confidence level in remaining committed to these new behaviors and communication structure.

- The utilization of the CANS to assess the improvement in client needs and the development of strengths as a tool to illustrate the development levels being achieved by the client. Will create a common language for discussion of progress in CFT.

- Tracking of STRTP team interventions that are proving to be helpful to the client and family to ensure clarity as the intensive treatment process advances.

Frequency of high risk behaviors will be evaluated to determine the effectiveness of the trauma informed practices. High risks behaviors include but not limited to harm to self and/or others, property damage, run away behaviors, sexualized behaviors, and aggression. High risk behaviors should decrease in frequency as treatment increases in effectiveness. Please refer to the Program Evaluation and Outcomes (PEO) Matrix.

6. Development of the Needs and Services Plans

VTC works collaboratively with placing agencies to ensure successful transitions. Before a youth is placed with VTC, client services facilitators complete an intake assessment to determine the needs and services for each youth. This assessment is completed through interviews with youth, authorized representatives and others as needed to develop a comprehensive assessment. The completed assessment is reviewed with the Clinical Supervisor to ensure that we have the needed services in place to best serve the youth at time of placement. Part of the initial assessment is to determine length of stay or treatment. The facilitators gather information including but not limited to; placement history, county case plan, status of family reunification, potential identified placements, history of trauma, history high risk behaviors, utilization of coping skills, response to treatment and any family finding to determine length of stay.

Given the information gathered during the assessment, facilitators work with the CFT and IPC to help estimate the duration of treatment. The transition plan is developed upon intake and reviewed at every CFT (every 30 days) to evaluate the transition plan appropriateness. The IPC will utilize the CFT process to determine placement. The provider team would join at the point that the youth is accepted into our services. After placement at any point that there is a need to convene to review case planning, an emergent need or a change in case status the facilitators will schedule a CFT. All plans and assessments are completed within the overarching framework of the team process which is driven in the CFT meetings.

Every youth is assessed every 30 days, as part of the CFT, to determine readiness for transition. VTC utilizes the CANS, frequency of high risk behaviors, and engagement of mental health services as assessment measures to help determine readiness for transition. All core services are reviewed at every CFT to determine if they are being met or if changes need to be made to better support the youth. This review process

happens at the CFT, every 30 days, to create alignment and consistency on services and transition plans.

VTC will use the reasonable parent standard when developing the Needs and Services Plan to help determine the most appropriate services for a youth. The client services facilitators will work to gather all necessary information during the intake process to help inform prudent parent standard decisions. Most decisions regarding the youth/NMD are made during the CFT to help support the prudent parent standard. Decisions are made as a team to ensure appropriate supports are in place for the youth and family.

Facilitators shall obtain the information specified in Section 84070, and shall develop an individual Needs and Services Plan for the youth which meets the following requirements:

1) Reason for placement.
2) Education – including the method for determining needs if they are not specified.
3) Training.
4) Personal Care and grooming.
5) His/her ability to manage their own money, including the maximum amount of money the youth shall be permitted to have in his/her possession at any one time.
6) Visitation, including the frequency of and any other limitation on, visits to the family residence and other visits inside and outside of the VTC.
7) Other specific services including services to parents/guardians.

The Needs and Services Plan shall include the following information regarding services necessary to meet the youth's needs:

1) Types of services necessary.
2) The program's ability to provide the services based upon the following:
    a. Purpose, program methods and goals of VTCs.
    b. Admission policies and procedures.
    c. Services provided by the facility in cooperation with community resources.
3) Planned length of placement including the discharge plan.
4) Financial arrangements for the provision of services.

The youth, the parent/caregiver, and the youth's authorized representative are involved in the development of the Needs and Services Plan. The Needs and Services Plan is updated through the CFT process which occurs every 30 days.

Needs and Services Plan for non-minor dependents:

1) The Needs and Services Plan for non-minor dependents will be consistent with the Transitional Independent Living Plan which is also developed if there is not one that accompanies the placement.
2) The non-minor dependent shall participate in the development of the Needs and Services Plan.
3) The Needs and Services Plan shall contain the following:
    a. Planned length of placement including the discharge plan for the non-minor dependent.
    b. The information specified in the Needs and Services Plan as specified above in the Youth's plan.
    c. The information required by the Welfare and Institutions Code section 16501.1:
        i. Consideration of the full range of placement options and specify why admission to, or continuation in a STRTP placement is the best choice at the time to meet the needs of the non-minor dependent.
        ii. Explanation of how the placement will contribute to the non-minor dependent's transition to independent living.
        iii. Specification of treatment strategies that will be used to prepare the non-minor dependent for discharge to a less restrictive setting, including a target date.
        iv. Review of the placement regularly to ensure that the placement in the STRTP remains in the best interest of the non-minor dependent and that progress is being made toward the independent living goals.
4) Needs and Services Plans shall be signed by the non-minor dependent, the Clinician, and the person or agency responsible for placement.

7. Planned Activities/Use of Community Resources

VTC encourages all youth to participate in a variety of planned activities including but not limited to extracurricular, enrichment, cultural, social, LGBTQIA and educational. These activities alignment with the core services and are individualized for each youth. All youth/NMD are involved in the development of their activities during the CFT meetings. While decisions regarding appropriateness of activities may be determined in the CFT, any staff can be responsible for supporting the youth/NMD's participation in the activity. The responsibility and follow up of the youth/NMD participation and response to their activities are assigned and reviewed at each CFT, every 30 days. VTC will utilize the prudent parent standard when determining appropriateness of activities. The client services facilitators will be responsible for gathering all necessary information during intake and ongoing to ensure that all decisions are well informed.

All youth are expected to participate in mental health service as part of their treatment. Mental Health activities are individualized and driven by the assessment and outlined in

the needs and services plan. These activities include but not limited to individual therapy, group therapy, family therapy, and individual and group rehabilitation. These activities are scheduled throughout a youth/NMDs week and occur across different as needed to best support the youth/NMD's treatment. Mental Health Services are viewed as the priority when scheduling a youth/NMD's time. Intensive services are needed to shorten lengths of stay and need to be prioritized as such to ensure successful treatment.

All youth are encouraged and expected to participate in activities as long as they are displaying safe behaviors. VTC has a variety of activities that take place on agency owned properties to help facilitate more youth participating in the activities. Most youth are able to use the onsite activities as a way to developed necessary skills to ensure safe behavior at offsite activities. It can be viewed as a stair step approach but not all youth/NMDs need to be stair stepped. Each youth/NMD's plan is individualized to meet their needs and services. Each youth is involved in social and recreational activities as an integral part of the treatment program. The mental health treatment program integrates process groups, adjunctive groups, and individual psychotherapy. All of the youth/MNDs are provided with individual and group rehabilitation services that are individualized and focus on skill development including but not limited to personal self-care, money management, independent living skills, and emotional regulation skills. The youth/NMDs activities are based on their assessment and outlined in their Needs and Services Plan.

Youth/NMD are encouraged to participate in religious/spiritual activities if it is of interest to them. VTC has several churches within the community that youth/NMD have attended. We schedule staff to be able to support a diverse interest in different religions or spiritualty.

After school activities include recreation and leisure time activities such as team sports, individual sports, table games and community outings. Community resources are utilized including informal recreation programs, libraries, and church youth groups. Outings include camping, backpacking, and out-of-town excursions, etc. All youth are expected and highly encouraged to participate in at least 30 minutes of daily exercise.

Off-site recreation and socialization activities, including LGBTQIA activities are geared for the specific population. Each youth is assessed for their ability to control their own impulses and follow staff direction to determine eligibility for involvement. Safety plans are developed for all youth/NMDs who participate in offsite activities to better support their success with specialized plans for CSEC youth. VTC hosts several enrichment, cultural and social activities throughout the month. All youth/NMD are encouraged to participate. LGBTQIA youth are encouraged to participate in outside activities and support groups geared towards their special needs. There are weekly LGBTQIA support groups that youth attend and are encouraged to attend social events that are hosted throughout the region as there are not a lot of specialized services in Redding.

Many youth referred to VTC have been previously assessed for Special Education. When students experience problems in their school setting, and do not currently have an IEP, a request for an assessment by the school study team may be made. It is anticipated that students determined to be eligible for special education services at a

non-public school will be enrolled in a local non-public school, to benefit from the level of intense integration between the school, the residence and the treatment program. The final determination for school attendance lies with the IEP team. All students are considered, on an ongoing basis, for mainstreaming to the public education system. VTC works closely with schools to determine any unaddressed educational needs and utilizes the schools resources to address those needs.

According the abilities and interests, a non-minor dependent shall be entitled to select and participate in activities of their choosing. All staff will work to encourage NMDs to engage in a variety of activities to better support the NMD into adulthood.

Throughout the daily schedule youth/NMD have time have independent activities as well as group activities. Individual and group activates may range from homework time, craft projects, journaling, listening to music, watching movies, playing video games, or a variety of physical activities running, walking, weight lifting, etc. VTC creates individual plans for all youth as to ensure the best support for their needs. Every day all youth/NMD are encouraged to participate in 30 minutes of physical activity. Youth are provided several different options to help ensure participation from all youth. During the intake process, all youth are encouraged to participate in leisure activities which are outlined in their NSP.

8. Services During Placement and Post-Permanency

During the CFT process, any additional needs requested or identified by the team shall be provided or arranged for to support the youth and family either during services or post-permanency. The facilitators will be responsible to ensure that these services that been offered. The child and family team determine who will be involved in post-permanency services. Placement and post-permanency roles and responsibilities for all CFT members will be determined during the CFT meetings. These services will be discussed throughout the youth's stay and up to 30 days post transition.

Therapeutic Behavioral Services

Therapeutic Behavioral Services (TBS) is an intensive, individualized, one-to-one, short-term service for those qualified youth who are experiencing a stressful transition or life crisis and need additional short-term specific support services to accomplish outcomes specified in their written treatment plan. For our youth to be eligible for TBS, the placing county and the VTC treatment team must find either that it is highly likely that without the additional short-term support of TBS, the youth will need placement in an acute psychiatric hospital inpatient service, psychiatric health facility service, or crisis residential treatment service, or the youth needs the additional support of TBS to enable a transition to a lower level.

9. Plan for participation in the Child and Family Team

The VTC residential service model is built on the foundation of Wraparound principles, including a fully integrated *teaming process.* The VTC Child and Family Team model has been developed over years of experience in both the Wraparound and Katie A. Core Practice Model (CPM) and includes phases of treatment. VTC will advocate through the CFT process to ensure cultural sensitivity which includes but is not limited to a youth's lesbian, gay, bisexual, transgender, queer/questioning and religion. In

addition VTC will advocate through the CFT process to ensure commercially sexually exploited children will not be re-victimized. The VTC Child and Family Team Model operates in four phases which may unfold linearly for a given child and family while for others, the phases may require some repeating or reinforcement. The Client Services Facilitators will be responsible for engaging all members of the CFT. This is done through several different modes of communication, email, phone, mail or fax. VTC documents all attempts to engage stakeholders in CFT meetings. The placing county and family are integral members of the CFT and as such will be invited to all CFT meetings. Even if the family is not the identified transition placement, they are still invited to CFT meetings as appropriate. Once an identified family or placement is determined, they are also invited to participate in CFT meetings to help support a successful transition. The county's responsibility in CFT meetings is to engage and complete any and all assigned tasks which could include updates to case plans, transition or placement identification, transition services (WRAP, etc.) and working to get approvals from courts. All plans and assessments are completed within the overarching framework of the team process and VTC Phases of Treatment:

Phase One is Engagement. It is a truism that the heart of successful treatment is based upon the positive and trusting relationship between providers and client. A successful engagement phase entails the providers in all aspects of our program establishing and maintaining meaningful and trusting relationships with clients and their families. In the engagement phase, the child is assessed for proper placement, brought into the program, introduced to residential and school staff and started along the path to a successful discharge. What follows are the responsibilities of VTC staff during this phase. The placing county continues to be a core member of the CFT. Some counties may continue to hold their own CFT meetings while the youth/NMD is at the facility. The placing county will continue to be lead to help determine transition planning and placement.

The Intake Coordinator/Client Services facilitator:

1) Prescreens the child for appropriateness of placement;
2) Coordinates educational needs and plans with the appropriate SELPA;
3) Introduces the child and family to the program, provides a tour of the facilities and answers any questions the child and family may have prior to placement;
4) Oversees the successful transition of the child into school and residential placement;
5) Works with the CFT to determine the needs and services.

The Facilitator:

Facilitation services are the glue that binds the three treatment areas of the child's life: residential, mental health/behavioral and educational. In residential treatment, it is said that discharge planning starts at intake and assessment ends at discharge. Therefore, the Facilitator:

1) Monitors the progress being made in the three areas where unmet needs are identified;

2) Facilitates, assigns and coordinates the efforts of the CFT members to keep the focus of the treatment on the child's overall program goals;

3) Begins the coordination of discharge planning to ensure a seamless "warm handover" of the child and family to the services to be accessed upon transition to the home or next level of care.

The Residential Services Supervisor (RSS) is responsible for maintaining the child's residential placement and the program services delivered within it. S/he ensures a consistent behavioral management approach by training and supervising all direct child care staff (Residential Counselor 1's and 2's). While a residential staff cannot ever replace the child's family, they can create and maintain a consistent and nurturing environment where the child can learn and practice the interpersonal skills necessary to function safely in a less restrictive environment, leading to a successful transition to his or her home or to a less restrictive level of care.

During the Engagement phase the Facilitator creates the first Connection Map with the child in order to identify the important people in his or her life who might be willing to contribute substantively to his or her progress through participation in the Child and Family Team (CFT). The CFT begins to take shape during the Engagement phase and includes many, if not all, of the placing Child and Family Team (CFT) members. Basically, the CFT is an expansion of the CFT to include VTC staff and other important individuals discovered through the connection mapping process.

The Clinician establishes medical necessity according to the dictates of EPSDT creates the initial CANS in collaboration with the CFT and begins the formal Mental Health Assessment leading to the creation of the Treatment Plan. His or her clinical efforts are enhanced by the work of the Mental Health Rehabilitation Specialists (MHRS) who reinforce the child's clinical progress through the teaching and practicing of clinical skills consistent with the treatment approach.

Phase Two: Planning

The Planning phase focuses on setting up services to address issues relating to Progress Goals in the behavioral, residential and educational domains. In this phase:

1) The clinical team (Clinician and MHRS) completes the assessment and works with the child and family to establish mental health goals for the formal Mental Health Treatment Plan; in the CFT and with the assistance of the Facilitator, residential/behavioral goals are established.

    a. The CANS is updated every three months or sooner as needed.

    b. The Connection Map is updated as more resources are identified and engaged in the CFT process.

2) The teacher(s) and school administration establish educational goals aimed at preparing the child to mainstream into public school, as indicated and/or appropriate.

3) The Residential team in collaboration with the CFT establishes individualized goals for the child at the residence that are incorporated into the treatment plan.

4) The CFT, beginning with the end in mind, facilitates the establishment of short and long term placement goals.

Phase Three: Implementation

The aforementioned plans are put into practice. The CFT uses the CFT format to monitor the child and family's progress in all domains: residential, educational and mental health.

In this Implementation process, the need for mid-course corrections may be identified, requiring, at times, a temporary return to the Planning or even the Engagement phase, depending on the needs of the child and family. This is not a sign of failure but instead a source of useful information for creating plans more likely to deliver desired outcomes.

The CANS continues to serve as a barometer for identifying specific unmet needs which are then integrated into the goals of the appropriate domain for further focus.

Phase Four: Transition

In this phase, the family receives the benefits of three of VTC'S core beliefs:

1) Begin with the end in mind/discharge planning begins at Intake;
2) Assessment (of unmet needs) ends at discharge;
3) Connection Maps provide the family with natural supports which outlast formal services.

A successful outcome is defined by a cogent and CFT agreed upon aftercare plan:

1) Attainment of goals in the three areas of focus (residential/behavioral, educational and mental health);
2) A transition to home/next placement plan that includes:
    a. Appropriate school placement at next residential setting.
    b. "Warm hand-off" for Clinical and Med support services.
    c. Family utilization of natural supports.

10. Identification of Home based services

The VTC program supports ongoing youth permanency through the provision of the full array of services, including Intensive Care Coordination, Intensive Home Based Services, clinical and therapeutic services and educational supports to improve permanency outcomes. As well, VTC in collaboration with the placement worker, practices family finding, connectivity mapping, and engagement by using formal and informal resources to locate and learn about family members and other supportive relationships, which are prepared and engaged to be available for placement and/or social support. VTC will utilize releases of information and provide services in private locations to ensure confidentiality of services. Services will be documented in VTC's electronic health record, TIER. For all of the children and youth in need of these services, our program assists youth in maintaining, establishing, or re-establishing life-long permanent relationships that are reliable and consistent and for which the youth feels connected. VTC offers a family visitation center in which families are able to stay

for a few days while visiting and engaging in the team process. Further, VTC services include support for sibling relationships as appropriate, including but not limited to information, education and visitation supports. Our specific approach includes the following practice:

Life-Long Connections

Life-Long Connections is a program in which a search is done to find family and friends from the youth's past which are willing to provide some sort of life long connection for the youth. Historically, many of VTC's youth do not have anyone to connect to once they leave treatment. It is VTC's commitment through this program that youth involved will have people they know and love as a support system (no matter how big or small) to be a support person throughout their lives. Through the CFT process, in collaboration with the county social worker, the youth involved learn about their families including family history, family trees, and even discovering family members they never knew existed.

11. Complaints and Grievances

Grievance Procedures shall be presented to be signed by the youth and authorized representative at the time of intake. A copy shall be maintained in the youth file. A copy of the grievance procedure shall be posted in a prominent location within the facility.

Procedures

Client Grievance Procedure

Policy Statement:

A grievance is a complaint any client may have about rules, consequences, policies, treatment, etc., at VTCs. It is anticipated that conflict and its resolution are part of the therapeutic process and most conflicts will be resolved within the milieu or in therapy with the clinician. The VTC policy is to find equitable solutions to the problems that cannot be resolved through the usual therapeutic process as expeditiously as possible and at the lowest supervisorial level. If there are any questions as to the policy of the grievance procedures please contact the Human Resources Director who is the corporate civil rights coordinator at (530) 893-0758.

Procedure:

The client has the right to file a complaint with CCLD or the Ombudsman's office at any time. The grievance process is posted at each residence in plain sight and reviewed during program admission.

1) A client will first take the grievance to his/her advocate for resolution.
2) If the client's advocate is unable to resolve the problem with the client and Agency's satisfaction, the client shall take the grievance to the Residential Services Supervisor of the house.
3) If the grievance is still not resolved after it has been reviewed at the Residential Services Supervisor, the client shall make an appointment to

discuss the matter with the Clinician.

4) If the Clinician is unable to resolve the problem, then the client will be referred to the Director.
5) The grievance procedure should not exceed twenty (20) working days.

Documentation:

1) Records will be initiated at each level that the grievance is received. The records shall include, at a minimum, the following information:
    a. Client's name
    b. Date
    c. Summary of grievance
    d. Applicable client services policy or operating procedure
    e. Action initiated by supervisor, or reason(s) no action was deemed
    f. Supervisor's signature
    g. Client's signature
2) One copy of the record will be forwarded to the client's appropriate Social Worker, Probation Officer or designated representative.
3) One copy will be given to the client.

Once copy will be put in the client's file.

12. Participation and Assistance in Initiatives to Improve the Child Welfare System

Professional Training Opportunities

For over fifty years, VTC has provided children, youth, and their families with the individualized and comprehensive care they need to maximize their potential and lead healthy, productive lives. Members of our leadership team are engaged in various statewide initiatives to improve services to children and families, such as participation in California Wraparound Curriculum and Training, the Core Practice Model, and Child and Family Teaming. Several members in the agency, including Family Partners, are certified in Triple P, Positive Parenting, PCIT, and Nurturing Parenting.

VTC Training Services' highly-trained and experienced professionals bring this same commitment and comprehensive approach to advanced training courses. VTC's specialty designed courses provide highly flexible, individualized training that is focused on the development and advancement of behavioral health professionals. These training courses have been developed by VTC to advance professional skills, giving participants the tools and knowledge to ensure the highest level of service to adults, children, and families. VTS provides relevant, up-to-date courses in the areas of Management Development, Advanced Behavioral Health, Wraparound Philosophy and Services, Evidence Based Practices and Promising Practices, and Behavioral

Healthcare Organization. All VTS course participants earn continuing education units (CEUs) as specified by the California Board of Behavioral Sciences (BBS), and the California Department of Social Services Community Care Licensing Division (CCLD).

13. Family Visitation

VTCs believes that family involvement in the treatment process is critical to positive long-term success of the youth and their families. Coordination of family contact and visitation is a significant treatment plan goal. Family contact is coordinated with VTC staff, the authorized representative and the family. Visits are coordinated, by treatment team, on an individual basis with the family. If needed, family visits may begin on the grounds of the program with agency staff in attendance and gradually work toward overnight home visits. This progression is individualized for each youth. Our goal is to enhance, maintain, and establish life-long connections for the youth we serve through family therapy, visitation, seeking family support members and eventual transition. Timelines and appropriateness for visits from family, friends, and others is determined in CFT meetings, however visits will not be denied unless restricted by a court order, authorized representative or staff applying the prudent parent standard with good cause. The discussion of visits is to be reviewed during CFT meetings with the goal of building lifelong connections. Home visits are also to be discussed and scheduled during CFT meetings to ensure that they are safe and clinically appropriate. Special consideration should be used with CSEC youth to ensure safety. Safety and support plans shall be created before home visits to support successful visits for both the youth/NMD and their families.

Visiting hours are available each evening and are generally scheduled in advance. However, unannounced visits are allowed but schedule visits are encouraged in order to provide support to youth and families. For the LGBTQ residents, VTC will make every effort to link them with family, or mentors, who can affirm their sexual orientation, gender identity or gender expression.

During the visit, our Residential Counselors are periodically checking in with the visitors and youth to ensure the visit is progressing in a positive manner. This step is designed to prevent a youth from being treated poorly or rejected in some way by their visitor. Family Therapy sessions are also scheduled on the dates of visitation and can act as an additional support to youth if issues related to their treatment needs, sexual orientation, trauma history or ultimate transition plan surfaces during a visit. Family Therapy also is the place where the more sensitive aspects related to acceptance of the youth by their family is discussed and support systems and opportunities for learning developed. This can include signing family members up for classes in their community or connection to a support group so they can increase their knowledge and understanding of their family member's experience. After every visit, Residential Counselors will check in with the residents to verify that the visit went well and to confirm the resident was safe and cared for throughout the visit. If a safety concern is mentioned, the staff will contact the on call house supervisor for instruction.

Visits with other relatives and friends are encouraged and supported. VTC will provide training and education to families and identified persons in order to better support our youth's cultural diversity including sexual orientation, gender identity, etc. If youth are being rejected by visitors and education and training are not working, agency facilitators will coordinate with the youth's authorized representatives to request supervised visits or court restrict visits until such a time that the visits can be supportive of the youth's culture and sexual orientation.

When a commercially sexually exploited child is accepted, VTC will work with the youth's authorized representative to create a needs and services plan that outlines the steps to be taken to ensure the youth's safety. The plan shall outline the precautions to be taken by agency staff and visiting persons including but not limited protocol to be followed in case of suspected danger. An example of one step to ensure the youth's safety would be to restrict the use of personal cell phones during visits. VTC shall inquire about any court ordered restrictions or special instructions from the authorized representative for visitations during the intake process.

Staff shall apply the prudent parent standard for all other visits and visitors. This includes but not limited to peer relationships from school, community, church and sports. It is important for residents to have friends outside of the agency and as such VTC shall encourage and not hinder the process for such visits.

Visitation allowances and limitations shall be designated in the needs and services plan. Visitations or denial of visitations shall not infringe on any youth/NMD's personal rights.

Visitation for non-minor dependents is permitted and privacy is allowed for them to visit with those they choose, as long as the safety of all youth in the residence is not compromised.

In addition, VTC offers a family visitation center in which families are able to stay for a few days while visiting and engaging in the team process.

14. Personal Rights

Personal Rights shall be reviewed and acknowledgement of receipt of personal rights shall be signed during the intake process. Personal rights shall be reviewed at the first CFT meeting and quarterly thereafter or as needed to ensure youth and families are informed of their personal rights and how file a complaint. Personal rights shall be posted outside the office wall in an area that is always fully visible and unobstructed.

VTC's Intake Staff is responsible for reviewing Personal Rights with the resident and authorized representative upon intake. Acknowledgement of receipt of personal rights shall be signed during the intake process and kept in the resident's file. Personal rights shall be reviewed at the first CFT meeting and quarterly thereafter or on an as needed basis to ensure residents and their families are informed of their personal rights and how to file a complaint. Personal rights shall be posted at all program sites in an area that is always fully visible and unobstructed. The following steps identified below represent the process to insure that at all times, our resident youth are aware of their rights:

1. Upon Intake, the Intake Coordinator/Client Services Facilitator reviews the Personal Rights form with the authorized representative and the resident. A copy of the personal rights is given to family/authorized representatives at the time of intake. This process includes going through each right individually and responding to questions or concerns raised by the resident to ensure clarity and understanding.
2. Personal Rights are posted in each living unit and copies are available to residents for their own documentation process.
3. Periodic reviews of the Personal Rights form are conducted by the Residential House Supervisor to ensure clarity or in response to questions from residents. This occurs annually or sooner as needed during weekly house meetings with residents and staff.
4. Personal rights are also reviewed with family members during Family Therapy and prior to approved home visits to ensure resident safety.
5. Non-Minor Dependents are also presented with a Personal Rights Form for review and to discuss questions prior to signing. They will receive a copy for their own future reference and will be reviewed periodically with their Residential House Supervisor to ensure clarity and understanding.

All residents, NMD and family members are oriented to the Personal Rights procedures in addition to how to file complaints which is clarified in Section 11: Complaints and Grievances.

15. House Rules

All residents have the right to be treated with dignity and respect at all times. This includes resident, staff, and all visitors. Personal Rights are reviewed with all residents at the time of admission. All staff are trained on the reasonable and prudent parent standard which shall be applied as needed to best support youth.

In addition to honoring the personal rights of each resident, the following house rules are expected to be honored. The following behaviors are not acceptable and will not be tolerated:

1) Violent behavior towards yourself, others or property.
2) Drugs, alcohol, and contraband possession.
3) The use of tobacco products in any form.
4) Sexual activity between residents of the house and staff and/or visitors.
5) Disrespect towards one's culture, religion, or nationality.
6) Use of abusive or threatening language.
7) Being in possession of knives, razor blades, any sharp object having the potential to cause injury, lighters, matches, lighter fluid, aerosol cans, paint, glue or any other potentially dangerous items.
8) Discrimination based on sexual orientation, gender identity or expression

Personal rights of resident and non-minor dependents include the right to acquire, possess, maintain, and use adequate personal items. These shall include, but are not limited to the non-minor dependent's own:

- Clothing.

- Toiletries and personal hygiene products.
- Furnishings, equipment, supplies for his/her personal living space in accordance with his/her interests, needs and tastes (as long as no items present a danger to the other resident living in the residence).Food of his/her own choosing.
- Medical, dental, vision and mental health care and related services at his/her discretion.

If developmentally appropriate for and upon the request of a non-minor dependent, the licensee shall assist the non-minor dependent in obtaining his/her own records. A complete and up to date file however is the responsibility of the licensee.

In ensuring the rights of a non-minor dependent, the licensee is not required to permit or take action that would infringe on the rights of the other residents or impair the health and safety of the non-minor dependent or others in the facility

Smoking Policy
Smoking is not allowed. We utilize a variety of teaching aids and formal presentations to encourage smoking cessation and prevention. When applicable, community support programs are also utilized

Dating Other Resident in Placement
There are times when residents within placement develop a caring relationship. These relationships are discussed in treatment regarding the appropriateness of the relationship and the impact the relationship is having on the resident's treatment progress. In addition, the resident's Clinician and House Supervisor may also discuss with the resident, what an appropriate relationship entails during individual therapy sessions or individual meetings. These meetings also occur with residents involved in relationships outside of VTC.

Resident involved in relationships within VTC may be permitted to attend activities together depending on both residents' progress toward their treatment plan. All activities which involve the residents are supervised by staff. Any inappropriate touching, contact or sexual behaviors is prohibited and is redirected by staff. Residents involved in relationships with community peers are allowed to have visits and engage in social activities as deemed appropriate. Staff shall apply prudent parent standards when assessing the appropriateness of activities.

In service training for staff relating to competency and sensitivity when providing care for LGBTQ resident will occur throughout the calendar year. VTC is dedicated to providing a non-discriminatory environment in which LGBTQ rights are not violated.

Completion of Homework
All residents are expected to complete all homework assignments provided by the school the resident attends. During the weekdays, study time and homework is scheduled each day. Staff is available to assist the resident in completing their assigned homework. School progress is obtained and provided to the resident's

treatment team. Any concerns regarding the completion of homework assignments is not only discussed individually with the resident, but is also discussed in the resident's treatment team meeting. VTC also works with their office of education to provide tutoring services for those residents who may need extra educational support.

Use of Entertainment Equipment

Each resident is allowed to have items they use for entertainment. These items may include, but are not limited to: IPods, MP3 players, personal DVD/video players, boom boxes/stereos, cell phones and laptops. Some of these items may also be limited to use depending on the recommendation of a resident's CFT or treatment team. In the circumstance that the resident is limited to usage, the equipment may need to be secured in the staff office and signed in and out. All residents will be provided with their own personal storage area within the staff office to store their items. All personal items will played at a level as not to disturb their peers or neighbors in the community.

VTC may also provide a television, a computer, internet services, a DVD player, a basketball hoop, books and board games. These items may be used during designated times based on the schedule for the day.

Curfew Hours

Curfew is based on several factors including but not limited to:

- Compliance in the milieu
- Attendance at school
- Compliance with house rules
- Participation in treatment
- Appropriate social interactions on and off residence

Curfew or time to be present back at the residential program for youth not currently employed or participating in community activities is 10pm. However, youth that work or have an approved activity (Prom, Sporting Events, Family Event, etc.) will have an extended curfew. Non-minor dependent residents will have an extended curfew time dependent on the need and activity but not to exceed 10:30pm. Staff may apply the prudent parent standard to alter curfew as they deem appropriate to meet the needs of the youth.

Bedtimes

Bedtimes shall be posted in the house for all to see. Staff may use the prudent parent standard to adjust of youth's bed time as needed to support the youth.

Each house may set bedtimes that meet the needs of the youth in the house as long as the bedtimes fall within the listed guidelines and are between the hours of 7pm and 9pm on school days and 7pm to 10 pm on non-school days.

Resident Dress Code

It is the standard that while residing at VTC, residents are to be dressed appropriately at all times. Appearances that may identify as gang related, drug related, etc. are not

allowed.

Upon interviewing for placement, residents are explained that VTC has a dress code and clothing policy. Residents sign an acknowledgement form upon intake. It is explained to residents that if they are dressed inappropriately they will be instructed to change their clothes. .

The following is a list of our standards that must be followed by our residents. These standards will be updated as needed. To help prevent misunderstandings, this policy will be reviewed at intake with the residents, parent, placing party and with staff at the time of admittance.

Dress Code Standards:

1. No clothing or accessories advertising items such as beer, drugs, violence, or racial statements.
2. No white ribbed tank tops ("wife-beaters") unless worn only as an undershirt. No tank tops that reveal undergarments or chest.
3. Staff reserve the right to identify and confiscate clothing and apparel that may be indicative of gang membership or support.
4. Regular T-shirts and tank tops may be worn if they are an appropriate size (no bare midriff or excessive cleavage) and with an acceptable design.
5. Face jewelry shall not be permitted including tongue piercings or ear gauges.
6. No clothing or accessories that may cause injury shall be permitted (spiked bracelets, chains, hoop earrings, steel-toed boots, etc.
7. Pants must fit properly No sagging
8. Appropriate make-up required (no war paint type or gang affiliated makeup)
9. Wear appropriately fitting clothing (Follow staff direction regarding appropriateness)
10. Pajamas shall be worn at the house and appropriate sleepwear must be worn to bed. Excessively short shorts or low cut tops are prohibited
11. Items that are transparent are not allowed unless undergarments are worn under.
12. No excessively long belts.

All counselors are made aware of the clothing expectation for our residents while in the care of VTC. If counselors encounter a resident who is not abiding to the dress code the counselor will complete the following:

1. The resident will be instructed to change their clothing to clothing more appropriate.

2. If the resident is noncompliant to change her clothing, the resident will be counseled and informed of the logical consequences.

3. The resident will be held back from any outings with the organization while dressed inappropriately.

Resident Cell Phone Policy

The possession and use of a personal cell phone is a privilege that residents can earn upon achieving and maintaining appropriate and compliant behavior within the milieu. Once the privilege is earned, it will be written into their needs and services plan residents are then expected to maintain their compliant behavior. At the time of intake clients will be informed of the cell phone policy and turn in any cell phones to the Intake Staff.

Residents will be responsible to monitor their phones, use the phone appropriately, and turn in the cell phone at the designated times. If residents are non-compliant with the cell phone rules, they may lose the privileges. To reinstate the cell phone privilege the resident must obtain the approval of the house supervisor or CFT.

Housekeeping

Residents are expected to complete household chores commensurate with their age and ability. Chores are completed daily and assigned by rotation. Chores may include making their bed, maintaining their bedroom, and community living quarters in an orderly fashion, vacuuming, sweeping, mopping, dusting, washing dishes and other general household tasks. Participation in chores not only teaches them important skills regarding community living, the residents' are also provided with opportunities to learn essential life skills.

Resident Council

Resident Council meetings will be held on a monthly basis. The council meeting will be facilitated by a member of the supervising team and will discuss various areas of concerns brought to attention by the residents. Council members will consist of volunteer representatives from each house; these representatives will have the responsibility of bringing forth complaint/grievances/concerns of the peers in their house. Council members will also be responsible for communicating the outcome/decisions of the meeting to their peers and housemates after the meeting.

Meeting agendas will always contain the following items:

- House Concerns
- Activity/recreation requests and feedback
- Menu preferences
- Issues pertaining to staff

Agendas will also consist of any items brought to the meeting by the Council members. The outcome of the meeting will be presented at the next supervisor's meeting following the council meeting to review the residents' concerns. The supervising team will address all items and make any provisions, within reason and that follows our program statement, to assist in improving the quality of care provided to the residents.

House Meeting

Each week the house will hold an all house meeting. The meeting should be scheduled to include as many members as possible to attend. It is an expectation that both residents and staff attend the meeting to address any issues. This meeting is viewed as a mechanism for change. Residents and staff should be encouraged to respectfully

address concerns within the house. The meeting should take place onsite or off site as deemed appropriate to meet the needs of the youth.

16. Positive Discipline

Positive Feedback

VTC believes in providing youth with frequent positive feedback. Positive feedback should be giving freely and often to all youth who reside with VTC. Each day staff should provide at least three positive feedback statement to each youth they work with in that day. It is important that even when youth are struggling when need to provide them with positive feedback. In fact it might be even more important when youth are struggling to provide them with positive feedback. Positive feedback should be sincere, truthful and immediate. Positive feedback can be a simple acknowledgement of a youth's success. An example is "Hey Larry. I noticed that you are sitting quietly working on your homework. I appreciate it." In this example, you are acknowledging that the youth is following the expectations and you see it and recognized the youth for it. These simple positive statements can help shape a youth's experience of themselves into a positive one.

Disciplinary Actions

Agency disciplinary actions should be natural or logical in nature when at all possible. For any action, staff should be able to explain the very good reason for action taken which should be in proportion to the infraction and should closely relate to the positive behavior that is being taught so it can be replicated in the future. They are not used as a form of punishment or retaliation by staff. After a problem has been resolved and a plan has been developed and implemented, appropriate natural or logical disciplinary actions are discussed with the resident. The actions will be related to the problem, for example, a resident who is arguing about the TV, may lose TV privileges for a short reasonable amount of time. Privileges should not be restricted for more than 24 hours and may be reinstated quicker if an appropriate restorative plan is developed. The exception to this is noted below under AWOLs and Assaults. Property damage should be handled in a logical manner (e.g., if you break something, make amends and do something to help support it being in place again for use). It is not possible to list every possible appropriate consequence; instead the following guidelines should be used in relation to consequences:

1. Logical actions (Discipline) helps resident learn to cooperate. It helps them learn self-control.
2. The Keys to effective positive disciplinary actions are:
    - Make it a collaborative process
    - Expect the resident to cooperate
    - Explore several concurrent options
    - Provide choices
    - Apply consequences
    - Avoid power struggles
    - Remember RICH (Respect, Information, Connection, Hope)

- Avoid measures that recapitulate the resident's experience with trauma
- Carry out measures that generate opportunities to learn values for the future
- Do not forget the importance of empowering residents

3. Goal is to set limits and provide choices to residents instead of dictating actions (orders). Limits and choices provide residents with the opportunity to experience self –control.
4. Disciplinary actions are ways of teaching the setting of limits and creating choices:
    - Show respect for you and the resident.
    - Fit the misbehavior.
    - Are for bad choices not bad resident.
    - Are about now - not the past.
    - Are firm and friendly.
    - Are for the benefit of the resident and not to show staff power or control over the resident.
5. To use disciplinary actions to give choices. Then follow through by letting the resident act on the choice.
6. Some guidelines for using disciplinary actions are:
    - Be both firm and kind
    - Listen
    - Talk less, act more
    - Don't power struggle
    - Use respectful words
    - Respect, negotiation, and choice
    - Make it clear when there is not a choice
    - Let all resident be responsible for their choices
    - Don't worry about what others think
    - Stay calm
    - Look for opportunities to empower resident
7. Be patient with the resident and yourself.

Time Away

Staff will usually ask a resident to take time away when prompts and other interventions don't seem to be working, the resident's behavior is disruptive, or the resident seems to be becoming agitated and is likely to lose control. This is intended to be a supportive intervention allowing resident an opportunity to make positive choices. Time away, is an opportunity for the resident to walk away and compose themselves before staff needs to take control by using consequences. Resident choosing to accept time away will be allowed to follow their personal safety plan, which will designate choices available. The resident will decide how long they need to compose themselves and what they will be doing while they are away from the group (within reason). When the resident rejoins the group they will be expected to have pulled themselves together and be ready to participate.

Staff Redirection Plan

Structured time is another opportunity for a resident to regain control of their behavior.

Staff will usually give the resident an opportunity to take time away independently before giving structure time. When the resident is not willing or able to take time away, staff will structure an activity for her. Staff will decide what the resident will be doing and for what length of time before returning to the group. The activity and length of time should be reasonable and be supportive of the resident. A few examples are:
A very energetic disruptive resident may be asked to burn off their energy with exercise. An "anxious" hostile resident may be asked to go to her room and listen to some mellow music. A worried upset resident may be asked to call a relative and check in with them (if that has been helpful before). Very often an appropriate activity will be found on the resident's safety plan. The goal is to help the resident make positive choices and turn her behavior around. Once structure time is assigned the resident must complete it before returning to the current activities.

Grounded

Grounding is defined as the limitation of access to certain community based activities. Activities excluding from the grounding are any activities that are therapeutic (any therapy, rehabilitation, and physical exercise). Employment or other activities (sports leagues, community service, etc.) that are deemed a responsibility of the youth are also excluded from grounding. Grounded youth are encouraged to participate in home based activities as appropriate. When youth are grounded, they are still encouraged to be a part of the milieu; they should not be excluded to their rooms.
When residents have negative behavior that affects the community and the resident does not respond to other interventions, then staff may decide to also ground them for a short period of time (1 to 24 hours).
Resident may be grounded 24 to 72 hours for serious misbehavior such as:

- Assaulting others
- AWOL
- Property damage
- Stealing
- Drugs/Alcohol/Tobacco/Weapons/Paraphernalia
- Interfering in crisis
- Threats within proximity
- Refusal to follow directions in the van
- Racial slurs
- Breaking confidentiality
- Bullying
- Disruptiveness that affects neighbors or community members
- Sexualized behavior/ Harassment
- Instigation

Resident must complete the following to regain privileges:

1. Complete a Life Space Interview (LSI) with staff and develop a plan of action to make amends.
2. Do something as stated above to make amends for their behavior.
3. Complete 1 to 3 days of being grounded.

The goal of this is to provide extra structure to help residents get back on track and to teach the residents how to make amends.

Property Destruction

Residents will be responsible for repairing or "paying (community service)" back for the property that they break including house property and personal property. When property destruction occurs:

- Staff will contact the maintenance department and repair costs will be assessed.
- The youth will provide community service for the facility at the same rate as minimum wage to cover the cost of repairs.
- Allowance will not be withheld for property damage.
- No money will be exchanged for the property damage.

Suggested Consequences that may apply:

- No paid outings or fun activities until responsibilities are completed
- Loss of a specific outing
- Outing Restriction 1 to 3 days
- Paying for property destruction
- Early bedtime
- Letters of apology
- Apologizing to the group
- Writing a report about a subject (racism, smoking, effects of drugs)
- TV restriction
- Select a task related to one of the ten Values or a life/social skill to be practiced
- Personal Entertainment Device Restriction

Restoring Relationships

The purpose of making amends is to give the residents every opportunity to learn from the mistakes they have made and to restore the relationship(s) that have been damaged through their negative behavior.

The **learning** component should be based on these key questions:

- What was happening with me?
- How do others handle this?
- What patterns can I notice? What skills can I develop? What skill can I practice?
- What do I need to do to be forgiven?

This process can be facilitated through the LSI by an adult involved in the incident or by the resident's advocate.

Accountability should be based on these key questions:

- Who was affected/hurt?
- How can I come to understand how my actions affected others?
- What can I do to make it up to them and why should I want to?

"Accepting Responsibility" is as simple as acknowledging that a mistake was made and to take responsibility to correct it. While the idea of accepting responsibility is simple, many situations are complex and may involve several individuals making mistakes. Everyone needs to accept responsibility for "his or her part" of the situation. *No one can control how other people will behave; you can only control what you will do.*

"Doing something to correct the mistake" involves making a plan to try and make things right. Here are some examples:

- If you break something, then fix it or pay for it to be fixed.
- If you hurt someone, then apologize.
- Actions speak louder than words; show the offended person that you hurt that you feel bad by doing something nice for them; for example, pick up their chore, let her have your turn, spend time hanging out, participate in a conflict resolution and make some agreements.
- Ask for forgiveness
- If you hurt yourself then, make a plan to take better care of yourself, exercise, eat right, dress nicely, speak well of yourself, and/or find someone or something to help you when you are in distress.
- If you affected the community as a whole, then acknowledge your mistake by apologizing to the group and asking them what you can do to correct it.

The above list is only examples; the resident and the staff will have to decide what is appropriate for the given situation. Some other factors to consider are:

- Apologizing or asking for forgiveness is good but often it is not sufficient in itself. People want to see actions. Good deeds say more than a simple apology.
- If the incident was a repeated offense, then there may be nothing that the offending person can do to make things right. When this is the case, then the transgressor has no other alternative but to take action to improve himself or herself as a person. Does the mistake reflect a need to relearn a value? A behavioral plan needs to be made to revisit these values related to their behavior.

If a **non-minor dependent** does not comply with reasonable behavioral expectations while living at VTC he/she shall be subject to reasonable and temporary positive disciplinary actions as discussed by the Facility Staff and the non-minor dependent.

1) Review the reason and need for the facility staff to impose positive disciplinary actions on the non-minor dependent and provide him/her with an opportunity to participate in determining the appropriate disciplinary action.

2) Develop a plan that includes the time limit of the positive disciplinary action with the non-minor dependent.

3) Document the decision regarding the disciplinary actions and steps taken to support the non-minor completion of her chosen plan.

VTC categorically prohibits the use any type of physical punishment, nor deny family visitation as means of discipline. Deprivation of food is not permitted and staff cannot withhold allowances. Violation of a resident's personal rights as a means of discipline is also prohibited.

Resident's will not receive disciplinary action related to:

1. Resident sexual orientation, gender identity, gender identity or gender expression. Facility staff is trained to respond appropriately and in a supportive manner as our youth respond to treatment and support services while at VTC.
2. Positive disciplinary actions take into consideration the trauma suffered by our youth including sexual exploitation/commercial sexual trafficking and special care is taken to ensure that these actions do not re-traumatize our residents.

17. Medical/Dental

Each program has a professional relationship with medical and dental professionals in the community. Each program has one staff available that is responsible for assuring initial and follow-up appointments are scheduled and coordinating transportation to those appointments. Medical and dental needs are assessed upon intake by our nurse to determine timelines for initial appointments. All youth/NMDs should be seen at least yearly for well child exams and every six months for dental screenings. Given the information provided in the intake paperwork regarding the medical and dental needs of the youth, VTC will ensure that a youth is seen by the appropriate medical professionals within 30 days of intake. If during the intake process it is determined that the youth may suffer physical harm from restraints (any form of restraints), the nurse will schedule an appointment with the appropriate health professionals to determine if restraints should be avoided. Until a determination can be made, no restraints shall be used with the client. All follow up appointments are scheduled as needed from professional recommendations. All appointments and follow up appointments are entered into our electronic health record and track to ensure all youth/NMD medical and dental needs are being met. VTC staff, in collaboration with youth/NMD's identified supports, provide transportation for appointments. All youth/NMD are referred to our psychiatrist for initial assessment to evaluate appropriateness for psychotropic medications. If youth/NMD is prescribed psychotropic medications then they will be seen by the psychiatrist every six weeks, if not prescribed psychotropic medications then they will be consult with the psychiatrist every 90 days.

Youth/NMD are assisted in the self-administration of medication. All staff persons are trained in the administering of medication.

Each youth has consent for medical treatment in their case file signed by their authorized representative. This includes a current JV220 and JV221, or parent consent for psychotropic medications to be filed in their electronic health record.

Each facility has posted in a prominent place the name and telephones number of the emergency medical care and dental care provider.

Psychiatric emergencies are handled through local contract and/or agreement.

For non-minor dependents with a health condition that requires prescription or non-prescription medication facility staff shall assist the non-minor dependent with the self-administration of medication and injections if permitted by his/her physician. Documentation of the administration of the medications will be maintained by the Licensee. The program staff will ensure that the non-minor dependent stores medication in a manner that ensures the safety of others in the facility.

VTC will work with local agencies to meet the medical needs of all youth including transgender youth. Any medical needs will be addressed at the youth's CFT and if needed the youth will be referred to medical professionals who specialize in treatment for transgender youth. Specialized medical decisions regarding transgender youth will be made by the youth and his/her medical professional not the agency treatment team including but not limited to hormone treatment.

VTC will work with commercially sexually exploited youth to ensure they are not re-victimized during medical exams. VTC will provide education to local providers as needed to help support the specialized needs of these youth. Agency staff will work with the youth to prep for medical exams by reviewing the steps to be taken by the medical staff and provided coaching and mental health support during those medical appointments when possible. When possible, the appointment preparation could include meeting the medical staff to provide the youth with an opportunity to ask questions before the appointment. If youth refuses or in unable to access medical care due to inability to be examined then the agency will notify the youth's authorized representative and community care licensing.

Section 18. Storage of Medication

HANDLING OF MEDICATION

CENTRALLY STORED

1. **Medication shall be centrally stored under the following circumstances:**

   a) Preservation of the medication requires refrigeration. Small refrigerators will be provided for use in the staff office for this purpose.

   b) Any medication determined by the physician to be hazardous if kept in the personal possession of the client for whom it was prescribed.

   c) Because of physical arrangements and the condition or the habits of persons in the facility, the medications are determined by either the administrator or by the licensing agency to be a safety hazard.

2. **The following requirements shall apply to medications which are centrally stored:**

   a) Medication shall be kept in a safe and locked place that is not accessible to persons other than employees responsible for the supervision of the centrally stored medication.

   b) Each container shall identify the items specified in **(g) (1-8)** below.

   c) All medication shall be labeled and maintained in compliance with label instructions and state and federal law.

   d) No person other than the dispensing pharmacist shall alter a prescription label.

   e) Each client's medication shall be stored in its originally received container.

f) No medication shall be transferred between containers.

g) The licensee shall ensure the maintenance, for each client, of a record of centrally stored prescription medications which is retained for at least one year and includes the following:
   1. The name of the client for whom prescribed.
   2. The name of the prescribing physician.
   3. The drug name, strength and quantity.
   4. The date filled.
   5. The prescription number and the name of the issuing pharmacy.
   6. Expiration date.
   7. Number of refills.
   8. Instructions, if any, regarding control and custody of the medication.

CHECKING MEDICATION INTO A HOUSE

Picking Up Medication (**Pick medication up prior to picking up the clients from school.)**

When picking up a medication (blister packet, bottles) before leaving the Pharmacy or Nurse's Office:

1. Check to see that the medication(s) is for one of your clients.

2. Check to see that the correct number of days are filled.

3. Check to see that each bubble contain the same number and type of medication.

4. Check to see that you have a START sheet-Green, or a D/C sheet-Red, or CHANGE sheet-Orange (**Medication Information / Change Form**) if needed.

5. Place medication into a locked box and transport to the house.

Once At the House

1. Take locked box into the office and let your co-workers know that you are going to check in medications.

2. Lock yourself in the office

3. Pull out the Med-Book and open the lock box and medication cabinet up.

4. Take out the green red or orange MARS sheet from the lock box and the blister packets for one client.

5. Compare labels in Med-Book with labels on new blister packet. If label is not in Med-Book or they do not match go to **New Medications, D/C Medication or Label Change Procedures**.

6. If all labels match look in medication cabinet for old blister packets and remove them following the **Medication Disposal Procedure**.

7. Place new blister packets in appropriate time slots in medication binders.

8. MARS Sheets identified for each time period are indicated as follows:

8:00am	YELLOW Sheet
12:00pm	RED Sheet
4:00pm	PURPLE Sheet
8:00pm	BLUE Sheet
PRN	GREEN Sheet

NEW MEDICATIONS, D/C MEDICATION OR LABEL CHANGES

1. Follow steps 1- 4 from Checking Medications in (**Once at the house**).

2. Compare blister packet label to green, red, or orange MAR sheet.(**Medication Information / Change Form**)

3. Using a Yellow highlighter Only – highlight all boxes on the **Face Sheet, Medication Chart** and **Medication Pill Count Form** where the medication that is being changed is written.

4. In highlighted area write the date, your initials and **D/C** if medication has been discontinued or **Label** if it is the label that has changed (i.e. different prescription number).

5. Add new medication name and number to the **Face Sheet**.

6. In one of the blank squares on the far left of the **Medication Chart** write in the new label information. Top of **Medication Chart** needs to have the Clients full name, the month that it is circled and the year written in the appropriate places.

7. Write in the times to be given in the box marked Time (i.e. 8am, 12n, 4pm, 8pm)

8. Line out days prior to start date, to identify date and time medication was actually started.

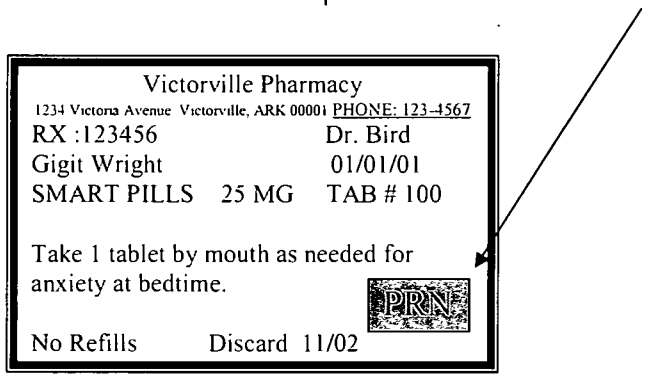
9. Repeat steps 7- 9 on a **Medication Pill Count Form** if needed.

10. Count medication that is in bottles and record the number of pills on the **Medication Pill Count Form** under the correct date and time.

11. Place blister packets / bottles for that medication in the appropriate time slots in the medication cabinet. Remember to remove the old blister packets / bottles for that medication following the **Medication Disposal Procedure.**

12. Go to the next medication for that client and repeat the procedure for each medication. One client at a time and one medication at a time.

13. PRN's should be identify on the **Face Sheet**, **Medication Chart** and **Medication Pill Count Form** by the boxes indicated for the time to given highlighted with Pink Only and PRN written in this space.



TEMPORARILY DISCONTINUED MEDICATIONS/MEDICATION HOLD

1. Upon receiving the Medication Information Change form, check to see when the medication is to be discontinued.

2. Go to the Medication Charts and clearly line out the dates that the medication will no longer be given.

3. Clearly label the Medication package with a sticky dot over the bubbles of when the medication is not to be given.

4. Log in the General log the changes that have been ordered and that you have followed orders and discontinued according to procedure.

5. Sign the Medication Information Change form that you have completed the Medication Intake procedures.

MEDICATION ORDERING

1. All medication ordering will be coordinated by the Nurse. Medication will be ordered once a month and delivered to the office. The client's medications will be packaged in blister packs/ bottles and each house will be given a week's supply at a time. The used blister packs / bottles shall be turned in when staff pick up the next weeks supply from the Nurse.

Cycle Medications

Are medications that are automatically reordered every month and delivered to us prior to the 7th of the month. Exception: If a client is to begin a new medication we will be given enough medication to get us through until the 7th of the month at which point the next blister pack will start on the 7th to be in cycle with all the rest. Cycle will start on Thursday of each week.

Non Cycle Medications (Medication As Needed, New Clients, Triplicate Medications, Medications that require Lab Testing prior to reordering.)

Are medications that staff must request to be re-ordered. They could be PRN's, Antibiotics, Allergy, Sleep aides etc... These medications will be identified by the Medical Department with a tag or hand written **NON CYCLE** label or by email.

It is the responsibility of **all** staff to ensure that the client does not run out of medication prior to the next order being delivered. This means that if on Sunday, there are not enough medications in the med cabinet to get you through the next 7 days (for each client), they need to be reordered. Please put the requests into the Medical Departments mailbox by Monday. This gives the Medical Department several days to contact the pharmacy, order the medications, and check them in prior to a staff member picking them up by Thursday.

2. If staff return a blister pack with medications left over, other than the extras provided for, it must be documented on the med chart and the blister pack as to why there were medications left over (**i.e. AWOL, discontinued etc...**).

3. If at any time the house runs out or is about to run out of medication over the weekend, notify Clinical On –Call.

MEDICATION PRESCRIPTION PROCEDURES

Scheduled Doctors' Appointments

When taking a client to a scheduled Doctors Appointment staff shall wait for the Physician to fill out the Medical Appointment form and return it and any other paperwork to the Medical Department. Copies may be made for the house.

Physicians are to call in the prescription to Owens Pharmacy so that we can pick it up. The medication may also be delivered by Owens Pharmacy directly to Med. Office. If you are given a Prescription, turn it into the Medical Department that day so that they can have it filled immediately. **Do Not Wait For The Next Day!**

Emergency Room Appointments

When taking a client to an Emergency Room Appointment staff shall wait for the Physician to fill out the Medical Appointment form and return it and any other paperwork to the Medical Department. Copies may be made for the house.

If you are given a Prescription Script turn it into the Medical Department that day so that they can have it filled immediately. **Do Not Wait For The Next Day!**

If it is after business hours request from the Physician at the Emergency Room enough medication to get you through 24 hours. If they will not, ask them if the medication can be started the next day.

Filling Prescriptions

If a prescription needs to be filled the following Pharmacies have agreed to assist us when Owens Pharmacy is closed. Please use one of the following;

Walgreen's Pharmacy

On the corner of Churn Creek and Cypress is open **24 hours** a day, they will run Medi-cal from a copy and will bill Medi-cal for primary insurance co-pays.

If a client has Private Insurance (Kaiser Etc...) ask if they will honor the Insurance, if not **make arrangements** with Administrative On-Call for consult.

If the Pharmacy cannot fill the prescription (doesn't have the item and no substitutions can be made), contact the Medical Department for procedure to manage this. If the Medical Department is not open then contact On Call for instructions. At no time shall a client go without medication that has been prescribed, unless the Physician has given permission or the Nurse has given you that instruction directly.

Make sure the Medical Department has a copy of the prescription label by the next working day.

PRNS

These are medications prescribed by a doctor to be used on an as needed basis. They are pain, stomach, cough, asthma, allergy, psychotropic medications **(mood altering, hallucinations etc...)** and side effect medications. Staff are to know what each medication is intended to be used for. If you are not sure, find out from the Nurse.

When a PRN of psychotropic or side effect medications is requested by the client, staff must administer it according to the instructions listed on the label from the doctor after seeking permission from the Administrative on–call person.

PRN medication for pain, if it states give one (1) or two (2) tablets as needed attempt to give one. If one tablet does not work then give the second tablet not exceeding the recommended two (2) tablets of that time period. Take into consideration the fact that the clients may be going to school and it is difficult to get the medication to them.

All PRN medication given must be documented on the morning report form as well as on the medication chart with the time given and by whom.

When a PRN is given at the house prior to coming to school, this must be documented on the PRN/OTC sheet and delivered to the medical office first thing in the morning. Likewise, if a PRN is given at the school, it will be documented on the PRN/OTC sheet and placed in the house box for pick up with the clients.

COUGH SYRUP

Over the Counter cough **Syrup** is **not** allowed in the houses unless noted on the approved OTC sheet provided for each individual client. It is not on the approved Over the Counter medication list signed by the prescribing Psychiatrist for VTC, Redding.

If a client is prescribed Cough Medication by a Physician it may be administered according to the **labeling instruction** on the bottle. It may be used for only the **time period prescribed** by the physical and for the **duration of the current illness**.

PILL COUNT PROCEDURES

1. Distribute Medication according to program procedures and labeling instructions.
2. Put on clean latex gloves.
3. Pour the contents of only 1 bottle of medication on the tray. Count the number of tablets remaining and document this on the pill count form under the correct date and time. Place the tablets back into the original container, close the container and return it to the medication lock up.
4. When more than 1 bottle of medication is required to be counted, you shall wipe the tray clean with soap/water and dry with a clean paper towel between the different medication counts.
5. When the pill counting procedure has been completed, clean the pill count tray one last time and place it in a clean dry plastic (zip lock) bag.

HOW TO CHECK LEVEL OF AN INHALER CARTRIDGE

Shaking the cartridge will **NOT** give you a good estimate of how much inhalant is left. A simple method is shown in the diagram below.

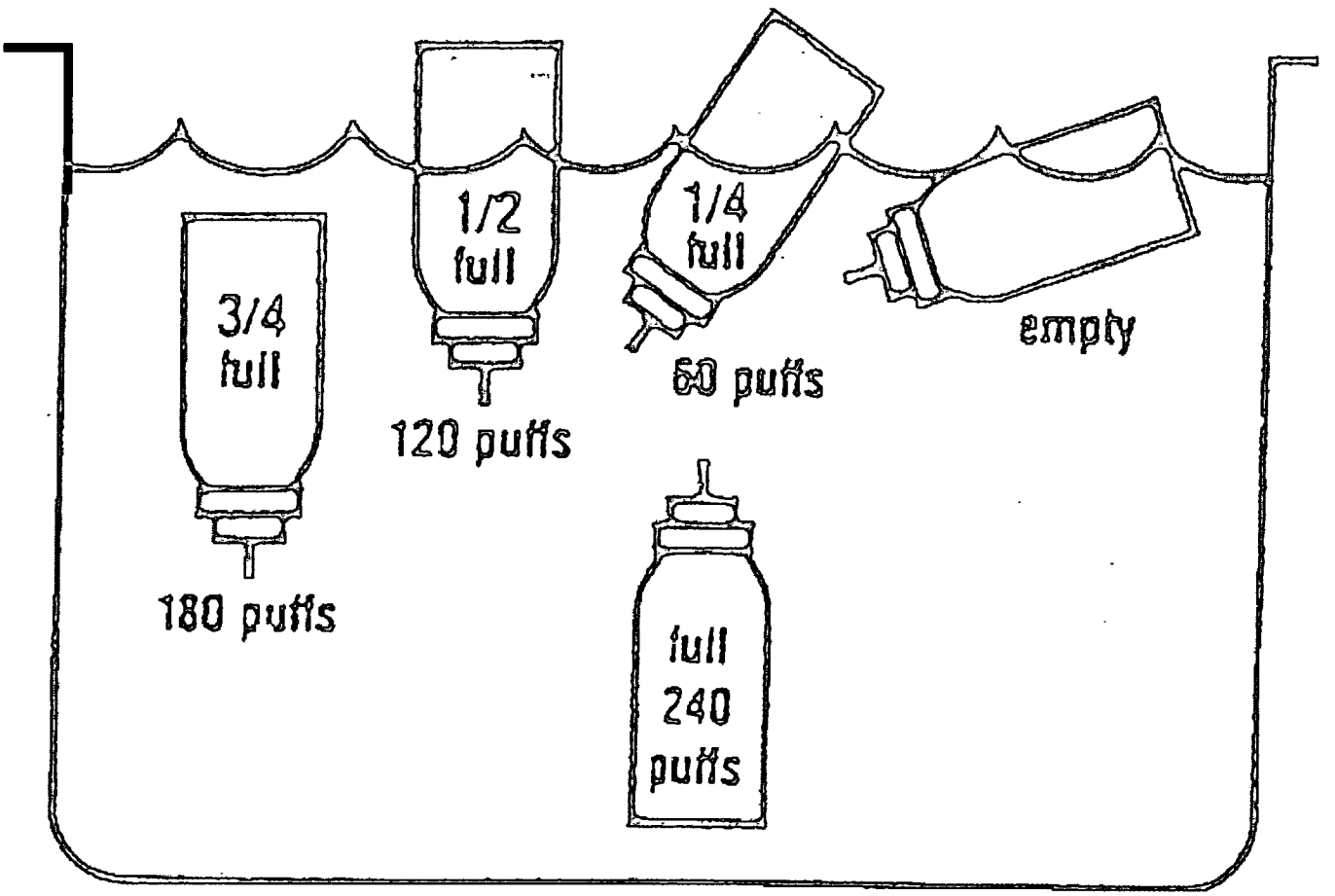
1. Float the cartridge in enough cold water to cover it when it is standing up, and note what position it takes. When empty, the cartridge will float horizontally on the surface. (See diagram.)

2. When the cartridge is almost empty, contact the Nurse and fill out a **Medication Refill(s) Request Form.**

3. Recommendation is to check the cartridge once a week.

4. Check "Number counter" on the back of the inhaler.

PROCEDURE REGARDING MEDICATION AND HOMEPASSES/SCHOOL TRIPS



1. HOUSE STAFF will inform the medical office no later than 4 business days prior to the client leaving the facility.

2. House Staff will bring all the medication for that client to Owens Pharmacy or the medical office.

3. HOUSE STAFF must know exactly the days and times of the home pass/trips. They are to have a prepared packet of copied medication charts so that the medications can be signed off. The medication and charts shall be returned at the end of the home pass/trip. The charts will be attached to the originals and submitted to the office for filing at the end of the month.

4. OUR AGENCY NURSE OR THE PHARMACY is the only personnel to transfer medication from blister packs to vials.

5. If staff is transporting...Staff will hand all medication to the responsible party on home pass/trips, review the label instruction for giving medications and have the person sign the **Medication Transfer Sheet**. When picking the client up staff must again document and sign the **Medication Transfer Sheet** with the responsible party.

6. If client is to ride the bus or airplane (AT NO TIME MAY CLIENT CARRY MEDICATIONS ON THE BUS OR AIRPLANE WITH THEM.) Staff is required to inform the responsible party from home pass that meds were over-nighted to them the day before the client leaves. A phone call to the responsible party ahead of time is critical. The same applies to return bus or airplane trips.

7. Overnight Fed Express is also an option. Medications must be at the office no later than 9 am the day prior to leaving, along with a confirmed street address and responsible party.

8. At times there may be occasions that a client leaves on an unplanned trip (death in the family etc...). There will not be sufficient time to get medications transferred, so we will send what we have with the client. We will follow the same procedures as in # 5 above, hand delivering the medications when possible and utilizing the **Medication Transfer Sheets**.

9. Turn in Medication Transfer Sheets at the end of the month with the Medication Charts to be filed in the clients file.

Any Questions Ask Agency Nurse, Clinical Supervisor, Assistant Executive Director Or Executive

Director.

MEDICATION DISPOSAL PROCEDURE

When medication for our clients are changed or discontinued, they shall be returned to the Nurse within **1 working day**. The medication shall be accompanied by a completed **"Returned Medication Sheet"**.

At the end of the week all returned medications from the Group Homes shall be recounted and destroyed by administrative process. A record shall be maintained for one year, which lists the following:

1. Name of client
2. The prescription number and the name of pharmacy
3. The drug name, strength and quantity destroyed.
4. The date of destruction

A log of what has been returned and destroyed shall be maintained in the office.

MEDICATION ERRORS

In an effort to provide better documentation of medications for the clients in our care, please read the following carefully:

It seems at times that we have more medication errors than at other times and it is important that we learn from each error we make. It appears that many errors occur because of incomplete communication, lack of communication, plus a variety of other problems. In order to get a handle on this problem and determine exactly where our system is breaking down, please follow the guidelines listed below.

1. Notify your RSS, On-Call and Administrative On-Call immediately, if a med error occurs.

2. Document the med error by writing an incident report on any and all medication errors.
   a) Be sure to put in the Client/Staff Involved section which staff member made the medication error.

TYPE I

- Giving the wrong dose or wrong medication to a resident, wrong dose of medication given, or discontinued medication given.
- Failure to dispense medication, giving PRN of psychotropic nature to client w/o prescribing doctors/on-call verbal ok.

TYPE II

- Late on medication.
- Failure to record medication given.
- Failure to record in the correct space/date medication given.
- Unclear log entries regarding the dispensing of medication.
- Bottled medication not counted daily.Medication not logged into the house or not following procedure for dispensing medication.

3. Turn in incident report to the office as soon as possible.
4. Notify Nurse as soon as possible.

MEDICATION FORMS

1. **MEDICATION INFORMATION/CHANGE FORM**

New medications do require an information change form from the Nurse. The original script fromthe doctor will be used to fill the order.

The **Medication Information Change** form will be used to inform the group homes of medication changes for clients. **A change should NOT be made unless it comes with written orders from the doctor on the Medication Information Change form.** The Nurse will send the change form to the houses on all changes, discontinued meds and RX # changes. If you have any questions, please see the Nurse.

Absolutely NO medication will be started, discontinued, or changed in any way until you have a

Medication Information/Change Form ("Orange Sheet") in the house with the medication.

If a medication must be started after hours, weekends, or holidays per a doctor's written order, it must be reported to the Buffer. Staff will give the original paperwork to the Medical Department by the next Business Day.

The Nurse must be made aware of any medication change by both house staff and the Buffer by the following working day. At which time a **MEDICATION INFORMATION / CHANGE FORM ("Red Sheet")** must be filled out, taken to the house and recorded on all medications forms if it has not already been done.

This procedure will be **strictly followed** and it will be the responsibility of each staff to make sure it is
followed.

The medication change form needs to be placed behind the appropriate clients face sheet in your medication binder. Once the medication has been discontinued, the change form and medications shall be turned into the Nurse within **1 working day**.

Any empty medication bottles shall be turned in to the Nurse when the medication is completed or
discontinued. We will attempt to have very few bottled medications.

2. MEDICATION REFILL REQUEST FORM

This form is used to reorder non-cycle medication. It shall be filled out at least 7 days in advance **(no more than 10 days in advance)** to running out of medication to ensure timely replacement. If you become aware of a need for reordering medication and there are less than 7 days of medications available at the house still reorder with this form. Document that you have reordered medication by keeping a copy of the form in the medication log until all the medication has arrived at the house. Once that has occurred this form shall be placed in the Shredding Bin at the Office for disposal of "Confidential" materials.

3. **MEDICATION FACE SHEET**

This form is the first form in the medication dispensing binder. It is a quick reference form to identify what medications the client is on, how much to they take, who prescribed them and at what times does the client take them. At the end of the month, all old face sheets should be turned into the office.

4. MEDICATION CHART

This form is used to document the date and time that a medication was given during a months' time period. If you should initial on this form, your printed name should be at the bottom of the sheet with your initials. Medication errors can be recorded on the back of this sheet. All **PRN** medication are on the green MARS. This form should be turned in weekly to the Med. office. **Remember, when filling out the med chart staff's initials are required in the time slot. This means if you gave it, initial that you gave it. If the school gave it or they were on home pass, you initial that you were the person recording the information on the chart. When you give a PRN, you put the time and your initials. In the event of a med error or that another code needs to be put in the med slot, you initial that as well.**

5. **SYRINGE CHART**

This form is to tract the usage of syringes by insulin dependent clients. (This is an extremely important issue surround the accountability of hypodermic needles and must be tract accurately.)

6. **NON-PRESCRIPTION MEDICATION SHEET**

This form is used to document all non-prescription medications that a client takes in a months' time. If you should initial on this form, your name should be printed at the bottom of the sheet with your initials. When you give a client a non-prescription medication you should write the time given, what was given, and your initials in the most appropriate box for that time period. This chart should be turned in on the **first day of every month** to the office.

7. **RETURNED MEDICATION FORM**

This form is used by staff to document what, how much and whose medications are being returned to the office for disposal. All discontinued medications shall be returned with this form completed to the Nurse within **1 working day** of being discontinued.

8. **PILL COUNT FORM**

This form is to be used by staff to inventory all medications that are in bottles. This form is to be completed daily by staff. **All bottled medication shall be counted after each time that it is administered. This means if it is given 3 times a day it shall be counted 3 times a day and documented on the Pill Count form. In addition, all bottled PRN medication and other medication that is given on an as needed basis shall be counted on a daily basis and recorded on the pill count sheet. This should be put on each MAR.**

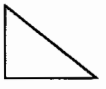
9. **APPROVED OTC LIST**

This form is authorization for the listed over the counter medications to be distributed upon request of the client, nurse or physician. Only those medications marked with a yes may be given as designated on the label or by physicians' orders.

10. **MEDICATION TRANSFER SHEET**

This form is to be used to transfer medication between program staff and those who will be dispensing medication and supervising clients while they are not at the program. This form shall be filed with the Home pass Planning Forms upon completion.

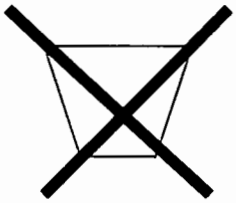
DON'T LIST



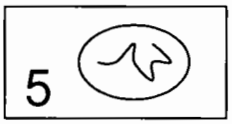
Do Not Cut pills in half, only the pharmacist, parent or Nurse may.

Do Not Break open or crush medication.

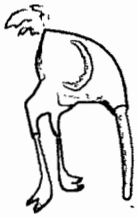
Do Not add it to food or a drink, unless you have written instructions from a physician and the client is made aware prior to doing it.



Do Not Transfer medication from its originally received container to a cup or anything else. Note: Medication coming with a measuring device or liquid medication will require a transfer for administration.



Do Not Punch out empty blister pack bubbles for fun.



Do Not Ignore or Hide medication errors. They must be reported immediately to the Buffer and an Incident Report Written.
Do Not allow others to cover up medication errors. We must always keep the best interest of the clients in mind and let that be our guide.

Do Not take medication to a Pharmacy for request of travel packs on medications that are not filled by the pharmacy on the label. Only the pharmacy the medication was filled at locally can transfer the medication. If the medication was filled out of town and sent to us then take it to the Nurse 4 days prior to travel date.

Medication Filled At:
Longs Drugs

~~Medication Transferred At:
Enterprise Pharmacy~~

Medication Transferred At:
Longs Drugs

ADMINISTERING MEDICATIONS

1. One staff shall be designated to distribute medications on a weekly basis on each end of the week. All staff shall be trained to transport, distribute, intake and discontinue medications at the site.

2. **One staff should be stationed in the hallway while medications are being administered.**

3. **REMEMBER to only do one client at a time. Other clients should be in their rooms engaging in a quiet activity, with no talking, while medications are being administered. Each client will be called to the office to receive their medications.**

4. Note the time. Medication may only be given if it falls within the range of 1hour before or 1 hour after the designated medication time on the medication chart. If it is other than the 1 hour range either direction, a call must be made to the Administrative On-Call.

5. Lock yourself in the staff office. Medications should never be out of the med lock up with clients present in the staff office. Staff should not be coming in and out of the office while you are working with medications. There will be no answering of phone calls or making phone calls during medication distribution time frames.

6. Pull out the medication charts, open to the first client. Check to see which meds are to be given at this time. See that they have not already been given by checking to see if another staff member has signed them off.

7. Pull out all of the medications needed to be administered at that time period for the client you are about to give medication to. Make sure the medication cabinet is closed and has the lock through it, so that in an emergency the cabinet may be locked quickly.

8. Compare the med chart label with the label on the med bottle or blister pack. Everything should be exactly the same on both labels, if they are not do not give the medication, call Administrative On-Call.

9. Read the instructions on the label to insure that you are administering the medication properly.

10. Call the client to the office door and make sure that they have water to drink. Must have Dr. written permission to use any other liquids.

11. Punch the medication directly into the clients hand from its originally received container and observe closely during the process of them taking the medication. **(Without you touching the meds)** or into a paper cup.

12. Have the client show you the pills on their tongue prior to drinking anything. Check the drinking cup for hidden medications and to see if they were taken. Have the client fill their checks fully with air and blow hard. Then have them open their mouth and check thoroughly that they have taken the medications. Some clients may need to drink lots of fluids to prevent them from cheeking and others it may be required that they do a finger sweep of their own mouth to prove that they have not cheeked.

13. **Initial the med chart that you have given the medication. Staff giving the medication will then switch out with the staff in the hallway so they can immediately verify that the medications where given and documented correctly. Once they have been verified, the medications will be secured in the medication cabinet and the house may go about their usual business.**

14. Medications must be kept in an orderly manner. Please keep the medication cabinet **NEAT & CLEAN**. This includes the Pill Counting Equipment and Medication Transportation Boxes, which shall also be kept clean and in good repair.

CLIENT REFUSAL TO ACCEPT MEDICATION PROCEDURE

1. **Should a client refuse medication, follow the listed guidelines:**

   a) Advise the client of the need to take medication at the allotted time. Immediate withdrawal of medication can cause side effects, i.e., lethargy, dry mouth, sleepiness, nausea, etc...
   b) Advise the client that you are required to follow the doctor's orders and cannot change the medication. Offer to speak with the clinician to arrange an appointment with the psychiatrist the next time he/she is in. Explore with the client what issues are going on.
   c) Allow the client the time to make the decision to accept the medication.
   d) If the client refuses, document appropriately.

2. **If the client does not take the medication within 1 hour, notify Administrative On- Call. He/she will approve accordingly. Staff is not to take any action without consulting Administrative On- Call first.**

3. Client will be placed on AE to monitor possible side effect and withdrawal from medication.

EPS SYMPTOMS (COMMON SIDE EFFECTS ASSOCIATED WITH PSYCHO-TROPIC MEDICATIONS)

ANTI-PSYCHOTIC MEDICATIONS:

1. Sedation (especially with low potency drugs)
2. Extra-Pyramidal Symptoms (especially in high potency drugs)
   a) Parkinson's-Like Symptoms: muscular rigidity, shuffling gait, pill-rolling tremors, mask like faces, lethargy
   b) Dystonia: spasms in neck and other muscle groups, oculogyric crisis.
   c) Akathisia: sense of inner restlessness, fidgeting.
   d) Tardive Dyskinesia: slow rhythmical automatic repetitive movements usually of the mouth, tongue or lips.
3. Autonomic Side Effects
   a) Acute Hypotension (low blood pressure)
   b) Anti-Cholinergic Side Effects (especially in low potency drugs): dry mouth, slight blurring of vision, constipation, urinary retention.
4. Occasional Impotence or Retrograde Ejaculation with Mellaril.
5. Heat intolerance and Photosensitivity (sensitivity to sunlight).

ANTI-DEPRESSANT MEDICATION:

1. High Cardio-Toxicity with many anti-depressants.
2. May lower seizure thresholds in epileptic clients.
3. Sedation (especially in Elavil, Doxepin, Ludiomil and Tofranil).
4. Anti-Cholinergic Side Effects: Same as outlined above under Anti-Psychotic Medications.

5. Hypertensive crisis with MAO (monoamine oxidase) Inhibitors.
6. Occasional weight gain.

ANTI-MANIC MEDICATIONS (Lithium Carbonate):

1. Fine hand tremor
2. Sedation
3. Muscular weakness/in coordination
4. Dry mouth
5. Nausea

ANTI-ANXIETY MEDICATION:

1. Sedation
2. Dependence (physiological and psychological)

ANTI-HYPERKINETIC MEDICATIONS (Psych-Stimulants):

1. Anorexia
2. Sleep disturbance
3. Mild abdominal distress
4. Lethargy
5. Suppression of height growth (rare)

MEDICAL TERMS & ABBREVIATIONS

PASSING MEDICATION

Importance of being cautious

The clients deserve and have a right to effective medication monitoring and management by the employees of this corporation. Mistakes in the distribution and handling of medication can have serious effects on the health and safety of the clients that we serve. We may through our actions, put a client in a potentially life threatening medical emergency. ***Safety precautions to take prior to passing medication to a client;***

Double Lock System

The Double lock system means that the medication is locked in a cabinet or refrigerator and locked in the staff office or otherwise designated room. This is to ensure that access by clients is restricted to potential dangerous prescribed medications over the counter medications and vitamins.

California Sunshine & Medications

The following medication causes **Photo-Sensitivity**. Meaning that clients' taking the listed medications will **Sunburn Easily**.

Bactrim (Co-trimoxazole)	Phenergan (Promethazine)
Compazine (Prochlorperazine)	Povan (Pyrvinium Pamoate)
Dilantin (Phenytoin Sodium)	Prolixin (Fluphenazine)
Elavil (Amitriptyline)	Septra (Co-trimoxazole)
HCTZ (Hydrochlorothiazide)	Serentil (Mesoridazine Besylate)
Mellaril (Thioridazine Hydrochoride)	Stelazine (Trilfluperazine Hydrochoride)
Minocin (Minocycline Hydrochoride)	Tetracycline (Tetracycline Hydrochoride)
Navane (Thiothixene Hydrochoride)	Thorazine (Clorpromazine Hydrochoride)
Negram (Nalidixic Acid)	Tofranil (Imipramine)
Oral Contraceptives	Trilafon (Perphenazine)
Periactin (Cyproheptadine)	

Any client taking Thyroid replacement such as Synthroid, Levlthroid, Levoid, Eltrozin or Noroxine will experience heat intolerance (i.e., if you fell warm, they will feel hot.) In our warm (real hot) summer, clients may expereince dizziness, nausea, and dehydration. If advanced they will have tremors, pallor and fainting. Keep the clients cool and well hydrated (lots of water).

Special attention must be given regarding hydration for all clients during warm weather. If you are thirsty, so are they.

Special Note on Sun Block 15

Using sun block will only extend the amount of time clients may be exposed to the sun without burning. It does **NOT** provide full protection over an extended period of time. If the client will burn in one hour without the sun block, they will burn in two or more hours **with sun block**. Remember, it will wash off with water or perspiration. If skin is becoming pink or red, additional applications of sun block is **NOT** effective. The skin areas should be covered with a shirt, pants, socks, hat, etc.

Psychotropic Medication

Medication commonly prescribed with an effect on psychic (mental) function, behavior or experience.

Neuoleptics - antipsychotics, ataractics and major traquilizers
Anxiolytic Sedatives - minor tranquilizers, psycholeptics and anti-anxiety agents
Anti-manic Agents - lithium
Anti-depressants - psychic energizers and thrymoleptics
Psycho-stimulants -stimulants

Stimulant Medication

Medication commonly prescribed to reduce and provide some relief to the effects of hyperactivity, impulsivity and inattentiveness. It increases the level of alertness and / or motivation. Used primarily with children who have been diagnosed with Attention Deficit Hyperactive Disorder.

Anti-psychotic (Neuroleptic) Medication

Medication commonly prescribed to reduce and provide some relief to the effects of psychotic symptoms in clients. They have been referred to also as neuroleptics or major tranquilizers. The effects include reduction in hallucinations, delusions, un-cooperativeness, thought disorder, agitation, and aggressive, self-injurious behaviors.

Anti-depressant Medication

Medication commonly prescribed to reduce and provide some relief to the effects of depression on the client and therefore increase the client's ability to function more normally. It is not intended to be a cure, but one of several interventions implemented in the treatment process for working with depressed clients. It is an important tool intervention used with clients whom are at risk of being a danger to themselves.

Side Effects

Common and Occasional effects that the medication may produce when taken. This is especially important for all workers to be aware of. Side effects may at times produce serious impairments to clients functioning and comfort. At times they may produce life-threatening conditions that require immediate medical attention.

Tardive Dyskinesia

Slow, rhythmical, automatic, stereotyped movements in a single muscle group or more universally; occurring as an undesirable side effect in some patients treated with medication (especially phenothiazines and neuroleptics). It is characterized by repetitive involuntary movements of the tongue, lips and mouth, particularly in younger patient's movements in the trunk and limbs may also occur.

PRN

A term used to identify medication that is taken on an as needed basis. This means that the medication is prescribe for a client and will be given intermittently, either upon request of the client or as a clinical intervention approved by the prescribing physician in this program. It is used to reduce and / or provide short-term relief to symptoms the client is experiencing therefore assisting the treatment process.

PDR

Physicians' Desk Reference, book used to identify and describe the medications that are typically used with the clients we serve. It shows what the medication looks like, describes what it is used for and typical side effects among other information.

Side Effects Symptoms Checklist

Information that can be obtained from the Medication Information for Informed Consent which identifies the uses, potential side effects and additional information necessary regarding particular medications. This is a good reference for medications and concerns to review for the medications being administered to the clients in the house. This information assists workers in understanding why a client is taking a specific medication and what to look out for with regards to side effects so that the information may be reported to the Nurse immediately. The reporting of this information is important in that some medications when given can produce life threatening side effects and the workers are the first link in protecting the client from harm.

When a new medication is prescribed by the Doctor, the Nurse will send a copy of information to the house which will assist staff in understanding the benefits, purpose and potential side effects of it. Staff may at any time request information on any medication for clients from the Nurse.

Medical Terms & Abbreviations

STAT	Immediately
A.C.	Before Meals
P.C.	After Meals
AD LIB	As Desired
PRN	As Necessary
PO	By Mouth
HS	Bedtime
Q	Every
Qam	Every Morning
QH	Every __ Hours
Q1	Every 1 Hour
Q4	Every 4 Hours
Q6	Every 6 Hours
QOD	Every Other Day
BID	2 Times a Day
TID	3 Times a Day
GTTS	Drops
D/C'd	Discontinued
QID	4 Times a Day
↑	Increase
↓	Decrease
Δ	Change
3	On Half
C	With
S	Without
P	After

Metric & Apthecary Conversions:

1000 mg	1 Gram
60 mg	1 Grain
1 TBSP.	15 cc's
1 tsp.	5 cc's
1 Ounce	30 cc's
98F	36.6
1 cc	1 ml
1000 cc's	1 Liter
1 ounce	2.5 cm
2.2 lbs.	1 Kilogram

19. Accreditation

We hold a COA accreditation since 2000. We received our renewal in 2017.

20. Mental Health Program Approval

VTC maintains current Medi-Cal Certification from contracting county Mental Health Plans (MHP) to directly deliver the services those children and youth need, as authorized by the county MHP and in accordance with medical necessity criteria under the Medi-Cal EPSDT program.

The availability of a broad array of mental health services is essential to the comprehensive support of the children and youth placed in VTC. The majority of the youth placed in our program have experienced trauma that can have long-term negative impacts to the youth's developmental, social, emotional and physical health. Thus, our VTC Specialty Mental Health Services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program are provided for all youth placed in our program up to age 21 who meet Medical Necessity and have full scope Medi-Cal. Further, these mental health services include the Core Practice Model (Katie A. lawsuit), calling for the provision of these comprehensive services delivered in a coordinated manner and tailored to meet the needs of individual children and families. These services include the provision of Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) in alignment with the Core Practice Model and in conjunction with the full array of Specialty Mental Health Services.

Assessment

A service activity designed to evaluate the current status of a youth's mental, emotional, or behavioral health. Assessment includes but is not limited to one or more of the following; mental status determination; analysis of the youth's relevant clinical history; analysis of relevant cultural issues and history; diagnosis; and use of testing procedures.

Plan Development

A service activity that consists of development of client plans, approval of client plans,

and/or monitoring of a youth's progress.

Targeted Case Management

Case Management/Brokerage is a service that assists a youth to access needed medical, educational, social, prevocational, vocational, and rehabilitative or other community services. The service may include, but are not limited to: communication, coordination, and referral; monitoring service delivery to ensure youth access to service and the service delivery system; monitoring a youth's progress; placement services; and plan development.

Individual, Family or Group Therapy or Rehabilitation

Mental health services are individual or group therapy and intervention services designed to provide reduction of mental disability and restoration, improvement or maintenance of functioning consistent with the goals of learning, development, independent living and enhanced self-sufficiency. Services may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.

Collateral

A service to a significant support person in a youth's life for the purpose of meeting the needs of the youth in terms of achieving the goals of the youth's client plan. Collateral may include but not limited to consultation and training of the significant support person to assist in better utilization of specialty mental health services by the youth, consultation and training of the significant support person to assist in better understanding of mental illness, and family counseling with the significant support person. The youth may or may not be present for this service.

Medication Support Services

Medication Support Services include assessing the need and benefit of medication and if warranted, prescribing, administering, dispensing and monitoring of psychiatric medications that are necessary to alleviate the symptoms of mental illness. VTC's Psychiatrists evaluate the need for medication; its clinical effectiveness, side effects, instruction in the use, risks and benefits of, and alternatives for medication. Medication support services include collateral and plan development related to the delivery of the service and/or assessment of the child, prescribing, administering, dispensing and monitoring of psychiatric medications and medication education. A supportive nursing staffing system is employed to enhance the level of support offered to our youth. These supportive measures include general health need follow-ups, connectivity to appropriate community based resources and client education on medications being prescribed.

Therapeutic Behavioral Services

Therapeutic Behavioral Services (TBS) is an intensive, individualized, one-to-one, short-term service for those qualified youth who are experiencing a stressful transition or life crisis and need additional short-term specific support services to accomplish outcomes specified in their written treatment plan. For our youth to be eligible for TBS, the placing county and the VTC treatment team must find either that it is highly likely that without the additional short-term support of TBS, the youth will need placement in an acute psychiatric hospital inpatient service, psychiatric health facility service, or crisis

residential treatment service, or the youth needs the additional support of TBS to enable a transition to a lower level.

21. Food and Nutritional Plan/Sample Menus/Clothing & Incidentals

Menus are written one week in advance and copies of the menus as served are kept on file for at least 30 days. Menus are utilized on a rotation basis and are repeated monthly. Modified menus are available as medical necessity dictates. We consult with Elise Hawkins, NTP#001927- she is a licensed Nutritional Therapy Practitioner.

Breakfast will be served between 6:30am-9:30am, lunch will be served between 11:30am-1:30pm, and dinner will be served between 4:30pm-7:30pm. No youth/NMD shall have meals times that exceed 15 hours in a 24 hour period. Meals time windows are large to ensure flexibility to accommodate youth/NMD's schedules. Snacks are served in between meal times to accommodate growing youth/NMD's nutritional needs.

The program provides or ensures three nutritious meals per day, and snacks as needed and that meet the dietary needs documented in each youth's Needs and Services Plan.

The quantity and quality of food available in the facility shall be equally available to all youth including non-minor dependents in placement. The non-minor dependent shall be invited to participate in all meals.

For non-minor dependents, to the extent of his/her ability and as agreed upon with the administrator, a non-minor dependent shall have the opportunity to plan meals, grocery shop, and store and prepare food. Food storage must meet all licensing regulatory requirements. A non-minor dependent shall have access to all meal preparation areas, appliances, and utensils for meal preparation. A non-minor dependent shall have the opportunity to participate with the administrator in the menu planning, and meal preparation, but shall not be required to prepare meals for others.

Clothing and Incidentals: VTCs ensures residents are supplied with and maintain an adequate amount of clothing. When a resident is placed at VTC a clothing inventory is completed and clothing is purchased for the youth as needed. Requests for clothing are all approved by the Executive Director or Assistant Executive Director. Upon approval, funds are issued to the house staff for the resident. After the clothing has been purchased, the youth initials the store receipt for the clothing, indicating he/she received the clothes and house staff persons enter the new clothing descriptions on the resident's clothing log (which is kept in their file). All youth/NMDs are able to participate in the purchase of their clothing. Refer to advocate policy for minimum requirements for youth clothing.

VTC ensures residents are supplied with personal hygiene items, such as shampoo and deodorant. Each facility is budgeted for hygiene items, which are purchased by house staff as needed. For non-minor dependents, they are permitted to purchase items they choose, as determined in their Transitional Independent Living Plan.

22. Emergency Intervention Plan (Runaway Plan)

Early intervention is the key to successfully engaging youth/NMD in avoiding emergency situations or successfully navigating one with a youth/NMD. At the first sign of escalation, anxiety or other unusual behaviors from a youth staff should encourage the youth to use their coping skills/tools which have been outlined in their crisis safety plan. Only if staff feel that a coping tool would further escalate a youth would a staff deter the youth/NMD for utilizing it in the moment. For example, a youth is making statements about self-harm; we wouldn't necessarily allow them to take a walk by themselves. We would want to stay in close proximity to intervene if needed. Most coping tools are designed to be able to be used in most all crisis situations, listening to music, taking space, and calling support people. Early intervention tools include engagement with youth/NMD, process out any problems or concerns, readily available coping tools and occupational tools.

At this time, staff should also notify on-call of the potential for needed support. The staff not actively engaged with the youth/NMD should be the one making the notification to on-call. At this time, additional staff should be requested if needed to help manage the situation. It is important to make the initial notification to request staff if needed to ensure additional staff are onsite if an emergency intervention is used.

A runaway is defined by a resident walking off the premises without staff permission and/or is out of staff supervision for any amount of time. At the time of runaway, VTC counselors will shadow the resident and counsel with them in an attempt to return them to the facility. If the counselor is unable to redirect the resident back to the facility, a Missing Person Report will be filed and all appropriate parties will be notified.

At the time a runaway occurs:

1. Staff will make every effort to shadow/follow the resident and redirect/counsel them back to the facility.
2. Staff is to contact on-call to update on current behaviors of the resident and inform that they are following the resident, including information concerning the direction they are walking.
3. If staff is unable to maintain visual contact of the resident while shadowing/following, the staff is to exert all means to locate the resident, this may include, but not limited to, driving around the nearby areas in the community or drive to any possible location within the community where the resident may go.
4. If the staff is unable to locate the resident, the following is to occur:
    a. Contact on-call, updating on the last seen location of the resident and efforts made to locate the resident.
    b. Staff will contact local law enforcement to file a Missing Person Report.
    c. Staff will complete a Missing Person Report for the officers prior to their arrival to the house.
    d. Upon arrival of the officer, the staff is responsible to be at the house and will provide the officer with the completed Missing Person Report along with a copy of the resident's Face Sheet.
    e. Staff MUST obtain the REPORT # and officer's name (that is it be reported on a Special Incident Report).

f. On-call will notify appropriate parties (Parents, CSW, DPO, etc.) via telephone (a message will be left if there is no answer).

5. The reporting staff is to complete an SIR (Special Incident Report) the same day, prior to leaving their shift.
6. The runaway incident will be included in the Communication Log so all staff are aware of the absence.
7. After seven days, a staff member shall inventory the resident's belongings, labeling it as a runaway inventory, and box/bag the belongings. Packing the resident's belongings occurs on the same day of the runaway.
8. Youth/NMD's items will be shipped to the appropriate authorized representative once the bed has closed.

Upon intake, the runaway plan will be reviewed with the resident and their authorized representative. If the new intake has a history of running away, an individual plan to prevent and discourage runaway behavior will be developed by the Child and Family Team (Runaway Prevention Plan). This plan is especially important when working with resident's who have been commercially sexually exploited.

Runaway Return Procedures

Upon return from runaway, the resident will be debriefed by the first available residential team member. At the time of return, staff will try to assess if there is a need for a medical intervention. If it is determined that the youth needs a medical intervention, then the residential staff will notify on call that will coordinate the medical intervention. VTC provides flexible staffing to ensure the needs of the youth are met. If there is good cause or it is outlined in the youth/NMD's Needs and Services Plan then the youth/NMD shall be searched for contraband. This check is to ensure the safety of all residents in our care.

Threatening to Runaway

Staff are encouraged to verbally dialogue with youth if they mention that they intended to run away. The staff with the best relationship should be the point person for the conversation. Staff should encourage the youth to use coping to manage their desire to run away. Interventions that focus on the youth's success and ability to make a positive choice in the moment are useful. Pro and cons, harm reduction conversations are also useful in trying to convince a youth to stay in the program. It may also help to support the youth to try to distract them with a preferred activity.

Emergency Intervention Plan

The Emergency Intervention Plan will be used to prevent a resident who exhibits assaultive behaviors from injuring or endangering themselves or others.
Staff may be justified in using emergency interventions, which include restraint if:

1. The restraint is reasonably applied to prevent a resident exhibiting assaultive behavior from exposure to immediate injury or danger to themselves or others.

2. The force used does not exceed that reasonably necessary to avert the injury or danger.
3. The danger of the force applied does not exceed the danger being averted.
4. The duration of the restraint ceases as soon as the danger or harm had been averted.
5. The resident receiving restraint has no known medical or physical condition due to which there is reason to believe that the use of restraint would endanger the resident's health and safety or exacerbate the medical condition
6. The staff using the restraint has been trained to use the emergency interventions.
7. The staff conforms with all requirements pertaining to the use of restraints

All staff working directly with residents will receive the emergency intervention plan training.

We use a continuum of interventions techniques, which start with the least restrictive intervention (use of non-physical interventions). We move to a more restrictive intervention if the less restrictive intervention technique attempts are not effective and the resident continues to present as imminent danger of injuring or endangering themselves or others. The continuums of crisis intervention are as follows (range from the least restrictive too more restrictive). The time frames in the following interventions will vary depending on the cooperation of the resident.

1. Oral Counseling – Residential Counselor redirecting the resident to self-correct their inappropriate behaviors.
2. Evasion- principles taught in Pro Act (Professional Assault Crisis Training) which is designed to provide early interventions to avoid an assaultive situation.
3. Manual Restraint- these intervention principles are used as a last resort to stop a resident from harming themselves or others after all other non-physical interventions have failed.

Whenever an emergency intervention technique is used it is to stabilize the resident so they can return to working toward their goals to complete their program here at VTC.

The following emergency intervention techniques will *NOT* be used on a resident at any time:

1. Mechanical Restraints, except postural supports as specified in section 80072 (a) (8).
2. Placing blankets, pillows, clothing, or other items over the resident's face or head

3. Any restraint or containment technique that can exacerbate a resident's medical or physical condition
4. Any restraint technique that places a resident in a prone position with their hands behind their back
5. Any restraint technique as an extended procedure
6. Averse behavior modification interventions including, but not limited to, spanking, body shaking, water spray, slapping, pinching, ammonia vapors, sensory deprivation and electric shock.
7. Intentionally producing pain to limit the resident's movement, including but not limited to, arm twisting, finger bending, joint extension, and headlocks.
8. Methods of restricting the resident's breathing or circulation.
9. Corporal punishment
10. Placing blankets, pillows, clothing or other items over residents face or head; body wraps with sheets or blankets.
11. The use of psychotherapeutic or behavior modifying drugs as punishment for the convenience of facility personnel to control a resident who is exhibiting assaultive behavior.
12. Techniques that can be reasonably expected to cause serious injuries to the resident that require medical treatment provided by a health practitioner, licensed under Division 2 of the Business and Professions Code, a health practitioner would include a physician, surgeon, osteopath, dentist, licensed nurse, optometrist, etc.
13. Verbal abuse or physical threats by facility personnel.
14. The isolation if a resident in a room which is locked by means of: key lock; deadbolt; security chain; flush; edge; or surface bolt; or similar hardware which is inoperable by the resident in the room.
15. Manual restraints for more than 15 consecutive minutes in a 24-hour period, unless as specified in Section 87095.22 of the licensing regulations.
16. Manual restraints for more than four (4) cumulative hours in a 24-hour period.

In addition to techniques specified in section 87095.01 (a), any emergency intervention technique not approved for use, as part of the license's emergency intervention plan must not be used at any time.

Manual restraints must never be used for the following purposes:

1. Punishment or discipline
2. Replacement for on duty direct care staff
3. Convenience of staff
4. As a substitute for, or as part of a treatment program
5. As a substitute for, or as part of a behavior modification program
6. Harassment or humiliation
7. To prevent a resident from leaving the facility unless otherwise stated in their Needs and Services Plan.

84300.1 (c) Emergency Intervention Prohibition

Manual restraints must not be used when a resident's medical assessment, as specified in section 80069, documents that they have a medical condition that would contraindicate the use of manual restraints; and when the resident's current condition contraindicate the use of manual restraints.

The potential use of our emergency intervention plan may include, but not limited to, the following behaviors and circumstances.

1. A resident leaving the premises without permission, only if outlined in their Needs and Services Plan.
2. A resident destroying property to the point of causing harm to self or others.
3. A resident causing harm to themselves or others.

If more than one resident require the use of emergency intervention at the same time, the staff have been trained to communicate among themselves to decide who will handle which resident. The staff will also, decide among themselves who will maintain care and supervision of residents not involved in the crisis. There are two staff on call and floaters available in the agency to provide support if needed. This call should be made at the first sign of escalation of a youth/NMD. The staff is instructed to work with the resident until they can stabilize the resident and reintegrate them back into the stable environment. Staff debrief the incident with the youth and quickly tries to get them back into their program as to help the youth move on from the incident. When the youth is calm and able to better process the incident, youth/NMD complete a life space interview as a way to avoid restraints in the future. Staff utilize the Life Space Interview as a way to tailor their interventions to better support the youth/NMD.

There shall be three staff present to enact a manual restraint. Staff are trained to notify on-call of youth/NMD's escalated behaviors to ensure that the needed staff are present and available if a restraint is needed. Floaters and agency support staff are able to respond within 20 minutes and/or sooner depending on the locations of the incident. Agency staffing patterns, typically schedule three and sometimes more staff in order to help support youth. On-call is able to move extra support staff around the agency as needed to provide additional support to a youth that may be displaying escalated behaviors. VTC provides flexible staffing as needed to support youth and staff. There are two on call staff at all times that are able to respond to crisis or emergencies.

Staff conduct shift change meetings throughout the day to ensure that we have staff to cover the needs of the youth. This includes having additional staff at houses were youth might be struggling or have a high risk of AWOLS or danger to self or others.

The staff is instructed to keep in constant communication with the house supervisor or on-call so direction can be given to change or terminate the emergency intervention technique being used at that time. If a resident is not responding to the numerous

emergency intervention techniques being used to encourage compliance with the agency's policies and rules, and the resident continues to demonstrate negative behaviors, the treatment team will have to meet to determine if we have the adequate resources to serve the resident.

VTC does not encourage the use of manual restraints, but all direct care staff are required to be certified in Pro-ACT (Professional Assault Crisis Training) for handling residents who exhibit behaviors that can cause injury to self or others. A daily all staff debrief/planning meeting helps to assign needed support to both staff and youth/NMD. During this meeting, staff discuss any challenging youth/NMDs behaviors, review any restraints from the previous day, and discuss staff related issues including but not limited to burnout, emotional regulation, and self-care plans.

If determined that a manual restraint is to be used, the following procedures are in place to ensure that the resident is safe, the amount of time is limited to the time the resident is presenting an immediate danger to self or others, and the restraint will not cause injury to the resident:

(A) A resident does not remain in a manual restraint for more than 15 consecutive minutes, unless written approval to continue the restraint after the initial 15 minutes is obtained from the administrator's designee.
1. The individual who approves the continuation of the restraint must be a person other than the individuals who are involved in the manual restraint.
2. The individual who visually checks the resident after 15 minutes to ensure the resident is not injured and that the resident's personal needs, such as access to the toilet facilities, are met, must be a person other than the individuals restraining the resident
3. After the initial 15 minutes, the individual who approves the continuation of the manual restraint observes the resident's behavior while the resident is being restrained to determine whether continued use of the manual restraint is justified.
4. Written approval to continue a manual restraint beyond 15 consecutive minutes must be documented in the resident's file.

(B) A resident does not remain in a Manual restraint for more than 30 consecutive minutes in a 24-hour period unless the resident is still presenting as a danger to self or others and written approval to continue the restraint after the 30 minutes is obtained from the administrator or the administrator designee and a social work staff. If facility Social work staff is not onsite to provide written approval, the facility may obtain verbal approval. Written approval must be obtained within 24 hours of the verbal approval.
1. The individual who approves the continuation of the restraint must be a person other than the individuals who are involved in the manual restraint.
2. The resident is visually checked after the initial 30 minutes, by a person other than the individual who are involved in the restraint, to ensure the

resident is not injured and that the resident's personal needs, such as access to the toilet facilities, are met.

3. After the initial 30 minutes, the individual who approves the continuation of the manual restraint observes the resident's behavior while the resident is being restrained to determine whether continued use of the manual restraint is justified.
4. Written approval to continue the use of the manual restraint must be documented in the resident's file.

(C) After the initial 30 minutes, a resident who is placed in a manual restraint must be visually checked every 15 minutes until the manual restraint is terminated, to ensure the resident is not injured, that personal needs are being met, and the continued use of the manual restraint is justified.

1. This visual check must be documented in the resident's file.
2. The person conducting the check must not be one of the individuals who restrained the resident.

(D) After the initial 30 minutes and at 30 minutes intervals if the resident is still presenting a danger to herself or others, the administrator or administrator's designee and the facility social work staff must evaluate whether the facility has adequate resources to meet the resident's needs.

(E) Manual restraints used in excess of 60 consecutive minutes must be approved every 30 minutes, in writing by the administrator or administrator's designee, facility social work staff and the resident's authorized representative. If the resident's authorized representative is not available to provide written approval, the facility may obtain a verbal approval. Written approval must be obtained within 24 hours of the verbal approval. The continued use of a manual restraint shall be documented in the resident's file.

(F) Within 48 hours of the manual restraint of 60 cumulative minutes or longer, in a 24 hour period, the resident's Needs and Service plan must be reviewed by the facility administrator or the administrator's designee, facility social worker and the resident's authorized representative, and modified if needed.

(G) Manual restraints must not exceed four (4) cumulative hours in a 24 hour period

1. If the resident continues to present an immediate danger to self or others, the facility must inform the resident's authorized representative and contact community emergency services to determine whether or not the resident should be removed from the facility.

(H) If a manual restraint exceeds two (2) hours, at regular intervals not exceeding two (2) hours, the resident must be allowed to access liquids, meal, toilet facilities, and a range of motion exercises.

(l) Staff must make provisions for responding promptly and appropriately to a resident's request for services and assistance and repositioning the resident when appropriate.

All direct care staff are trained in our emergency intervention plan. The Pro ACT (Professional Assault Crisis Training) training consists of the following:

1. 20 hours of training held regularly
2. The staff are trained in the following areas:
    a. Principles of group and individual behavior management, including, but not limited to, crisis prevention, factors leading to assaultive behavior and crisis intervention.
    b. Methods of de-escalating volatile situations, including non-physical intervention principles, such as crisis communication, evasive principles and alternative behavior.
    c. Alternative methods of handling aggressive and assaultive behavior.
    d. The physical principles of applying manual restraints in a safe and effective manner ranging from the least to most restrictive type(s) of restraint including, but not limited to, a standing restraint, escort, seating restraint, wall assisted restraint and floor assisted restraint.
    e. Principles for returning the resident to the planned activity following the completion of the emergency intervention.
    f. A written and hands-on competency test.

Once hired, all new staff members are required to attend Pro ACT trainings. All staff must complete the emergency intervention plan training prior to the use of intervention techniques on a resident. All staff members must be re-certified in Pro ACT training every year. Pro ACT is provided by using certified Pro Act Trainers employed by VTC.

Documentation of staff training is kept in their personnel file located in the Administration Building. The documentation consists of the date, hours and description of the training, the instructor's name and training certification and certificate of successful completion of the training.

Each time a Manual restraint is used it must be reported in the following manner:

1. The use of a manual restraint must be reported immediately to the administrator on-call.
2. The staff members involved in the manual restraint must complete a detailed incident report no later than the end of the working shift.
3. The Department and the resident's authorized representative must be informed of the incident by telephone the next working day.
4. A detailed written incident report must be submitted to the Department within 1 business day.
5. A copy of the report must be maintained in the resident's file.

We will maintain a separate monthly log of each use of a manual restraint. The following information will be included in the log:

1. Name of each child.
2. Date and time of the intervention.
3. Duration of the intervention.
4. Names of staff members who participated in the manual restraint.
5. Description of the intervention used.
6. Result of the agency review.
7. Other past reported incidents.
8. Facility Plan.
9. How resident was re-integrated back into the stable environment.

The administrator of the administrator's designee will discuss/investigate the use of a manual restraint with staff members involved no later than the next working day following the incident. During this meeting the administrator or the administrator's designee will determine if the emergency intervention action taken by the staff members were consistent with the emergency intervention plan. All findings will be documented in the monthly log. The manual restraint review must evaluate the following:

1. Did the staff members attempt to de-escalate the situation?
2. What were the possible triggers?
3. What interventions were used?
4. Did the staff member attempt at least two non-physical interventions (if the staff members/techniques used caused the resident to escalate during the crisis, we must evaluate the effectiveness of the staff/technique).
5. Was the resident restrained for the minimum amount of time, limited to when the resident was presenting an immediate danger to herself or others?
6. The administrator, authorized representative or parent will make an assessment whether it is necessary to amend the resident's needs and service's plan.
7. Any different strategies?

The administrator or the administrator's designee will contact the resident's authorized representative the next working day to inform them of the incident and if necessary, schedule a meeting to discuss/review the use of manual restraint on the resident. The call as well as the outcome of this meeting will be documented. The administrator or the administrator's designee will be responsible for obtaining a medical examination for the resident during or after the incident if it is determined the resident has a physical/suspected injury. The determination for the examination will be made after the administrator or the administrator's designee has seen/talked with the resident. If there is no need for an examination, this must be documented in the report. And post injury/suspected injury or any complaint must be investigated, documented and reported to the administrator and the resident's authorized representative.

VTC reviews the emergency intervention plan on a quarterly basis with other agencies, site leadership team and our PEO department. VTC reviews the use of emergency interventions to recognize patterns and to make adjustments to the plan. The site

leadership team also conducts a restraint reduction meeting on a monthly basis to identify needed support, program evaluation and needed trainings.

The emergency intervention plan is reviewed and approved by the board. The use of the emergency intervention plan will be implemented into our admission agreement, program statement and it will be reviewed with the resident and her authorized representative during the time of admission. VTC consulted with Cari Stilwell, BCBA on the emergency intervention plan. She has extensive experience working with at risk youth and experience working with youth in residential treatment. Currently, she is the behavioral management trainer for Shasta County SELPA.

For non-minor dependents, if they become dangerous to themselves or others, physical interventions such as restraints or escorts will be utilized, and law enforcement may be contacted. If law enforcement must be contacted then a review of the appropriateness of the placement will take place as soon as possible.

For a non-minor dependent, an incident report will be written and submitted to the responsible parties. Any incident that threatens the physical or emotional health or safety of the non-minor dependent or another resident in care will also be reported according to licensing regulatory requirements.

VTC doesn't use exclusion as an emergency intervention technique.

23. Neighborhood Complaint/Community Engagement

Policy and Procedure

ADMINISTRATIVE SERVICES POLICY

SUBJECT: Good Neighbor

POLICY STATEMENT:

The Victor Agency expects all personnel to be good neighbors in the community and take all complaints seriously making it a priority to respond to complainants as soon as possible.

Each Program shall develop, maintain and implement written procedures that meet or exceed the following standards.

STANDARDS:

Employee Conduct

Employees shall:

1) Observe all vehicle safety and driving laws at all times.
2) Show respect for neighbors when transporting clients.

3) Be aware of parking around the group home/school; don't park in a manner that may cause concern to the neighbors.
4) Be sure that the clients are properly supervised in the community.
5) The attitude of the employee sets the tone for the behavior of the clients. If the employee responds to neighbors in a defensive or aggressive manner when complaints or questions are raised about the facility, developing a congenial relationship will be unlikely. Employees and clients should adopt the position that they are a part of the community.
6) Be an overall good neighbor. Take walks around the block. See the neighbors and let them see you. Build relationships on a personal level as much as your time allows.

Neighborhood Complaints

1) The Executive Director (ED) shall act as the spokesperson for each facility or may appoint the duty to the Principal or Assistant Executive Director (AED).
2) The following shall occur in the instance of a complaint:
    a) The employee that receives the complaint shall act respectfully to the complainant and let the person know that it is the Agency's policy to try to address and/or correct all complaints/concerns in a timely manner. The employee shall then give the complainant the appropriate contact phone number along with the ED or Principal's name so that the ED or Principal can return the complainant's call. The employee shall also collect the name and phone number of the complainant so that the ED or Principal may follow up.
    b) The employee that receives the complaint shall then notify the ED/ through the On-call/Emergency Reporting System (VTC-CS-05)
    c) The ED/AED/Principal shall contact the complainant and address or correct the problem. The ED/AED/Principal shall document that conversation.
    d) The ED/AED shall report the incident to the VTC Administrative office and CEO and remark on the incident in the Weekly Risk Management Report.

Law Enforcement

1) Get to know the local police and fire department before they may be called to the facility. Invite them to become familiar with the group home.
2) All facility employees understand and follow policies and procedures in order to minimize reliance on law enforcement in crisis situations.

3) Establish an agreement with the local law enforcement agency so there is understanding of the AWOL process VTC must adhere to and when law enforcement will be contacted.

Community Relations

1) Acquaint your neighbors with the Agency and present the name and phone number of the Administrative office, the ED and/or Agency representative.

Community Partnerships

The creation of positive and sustainable community partnerships are an important aspect of our residential therapeutic services structure. VTC team members partner with our local law enforcement stakeholders to increase collaboration and awareness of our service structure, client base and program goals.

Outreach to our local city government, legislative and community partners is an ongoing practice. This practice promotes an increased awareness of our services in our community and supports our participation in service development stakeholder workgroups designed to inform service structure and client goal attainment.

EXHIBIT A-1

TRANSLATION SERVICES

CONTRACTOR agrees to provide translation services such as, but not limited to, interpreting and sign language to consumers for the provision of services under this Agreement at CONTRACTOR'S sole cost.

Services provided may include:

- AT&T Language Line
- American Sign Language Translation Services, including TTY/TDD California Relay Services
- Orchid Interpreting
- Other interpreting services as deemed necessary to provide the consumer with linguistically and culturally appropriate services

CONTRACTOR will not be allowed to use COUNTY'S language and translation services' providers' accounts. Separate accounts will need to be arranged at CONTRACTOR'S discretion.

If COUNTY at any given time receives charges for CONTRACTOR'S language and translation services, CONTRACTOR will receive an invoice for such charge(s).

Exhibit B
Compensation
Fiscal Year 2018/2019

1. COMPENSATION

a. COUNTY agrees to compensate CONTRACTOR for allowed cost incurred as detailed in **Exhibit A**, subject to any maximums and annual cost report reconciliation
b. The maximum contract amount shall not exceed One Hundred and Ten Thousand Dollars ($110,000.00) per year, and shall consist of County, State, and Federal funds. Notwithstanding any other provision of this Agreement, in no event shall COUNTY pay CONTRACTOR more than this Maximum Contract Amount for CONTRACTOR's performance hereunder without a properly executed amendment. Notwithstanding any other provisions of this Agreement, in no event may CONTRACTOR request a rate that exceeds the County Maximum Allowance (CMA) or request a rate that exceeds CONTRACTOR'S published charge(s) to the general public except if the CONTRACTOR is a Nominal Charge Provider.
c. If the CONTRACTOR is going to exceed the Maximum contract amount due to additional expenses or services, it is the responsibility of the CONTRACTOR to request the amendment and provide all supporting documentation that substantiates the increase. No amendments can be requested after April 1, 2019.
d. CONTRACTOR agrees to comply with Medi-Cal requirements and be approved to provide Medi-Cal services based on Medi-Cal site certification.
e. CONTRACTOR shall be responsible for verifying the Consumer's Medi-Cal eligibility status and will take steps to reactivate or establish eligibility where none exists.
f. CONTRACTOR shall certify that all Units of Service (UOS) entered/submitted by CONTRACTOR into AVATAR for any payor sources covered by this Agreement are true and accurate to the best of the CONTRACTOR'S knowledge.
g. CONTRACTOR shall use funds provided by COUNTY exclusively for the purposes of performing the services described in **Exhibit A** of this Agreement.
h. CONTRACTOR shall permit authorized COUNTY, State and/or Federal agencies, through any authorized representative, the right to inspect or otherwise evaluate the work performed hereunder including subcontract support activities and the premises, which it is being performed. The CONTRACTOR shall provide all reasonable assistance for the safety and convenience of the authorized representative in the performance of their duties. All inspections and evaluations shall be made in a manner that will not unduly delay the work.
i. In the event the state or federal government denies any or all claims submitted by COUNTY on behalf of the CONTRACTOR, COUNTY will not be responsible for any payment obligation and, accordingly, CONTRACTOR shall not seek payment from COUNTY and shall indemnify and hold harmless COUNTY from any and all liabilities for payment of any or all denied claims, including those claims that were submitted outside the period of time specified in this Agreement.

2. ACCOUNTING FOR REVENUES

CONTRACTOR shall comply with all County, State, and Federal requirements and procedures, as described in Welfare Institutions Code Sections 5709, 5710 and 14710, relating to: (1) the determination and collection of patient/client fees for services hereunder based on Uniform Method for Determining Ability to Pay (UMDAP) (2) the eligibility of patients/clients for

Medi-Cal , Medicare, private insurance, or other third party revenue, and (3) the collection, reporting, and deduction of all patient/client and other revenue for patients/clients receiving services hereunder. Grants, and other revenue, interest and return resulting from services/activities and/or funds paid by COUNTY to CONTRACTOR shall also be accounted for in the Operating Budget.
CONTRACTOR shall maintain internal financial controls, which adequately ensure proper billing and collection procedures. CONTRACTOR shall pursue payment from all potential sources in sequential order, with Medi-Cal as payor of last resort. All fees paid by or on behalf of the consumer receiving services under this Agreement shall be utilized by CONTRACTOR only for the delivery of mental health service units as specified in this Agreement.

3. INVOICING

a. CONTRACTOR shall submit monthly invoices to Tulare County Mental Health Department, Managed Care, 5957 S. Mooney Blvd, Visalia, Ca 93277, no later than fifteen (15) days after the end of the month in which those expenditures were incurred. The invoice must be supported by a system generated report that validates services indicated on the invoice.
b. Invoices shall be in the format approved by the Tulare County Health & Human Services Agency. All payments made under this Agreement shall be made within thirty (30) days of submission of all required documentation and in accordance with the COUNTY'S payment cycle.
C. 12 month billing limit: Unless otherwise determined by State or Federal regulations (e.g. medi-medi cross-over) all original (or initial) claims for eligible individual persons under this Agreement must be received by COUNTY within twelve (12) months from the month of service to avoid denial for late billing.

4. COST REPORT:

a. Within sixty (60) days after the close of the fiscal year covered by this Agreement, CONTRACTOR shall provide COUNTY with an accurate and complete Annual Cost Report with a statement of expenses and revenue for the prior fiscal year. The Annual Cost Report shall be prepared by CONTRACTOR in accordance with all applicable Federal, State, and County requirements and generally accepted accounting principles. CONTRACTOR shall allocate direct and indirect costs to and between programs, cost centers, services, and funding sources in accordance with such requirements and consistent with prudent business practice. All revenues received by CONTRACTOR shall be reported in its Annual Cost Report, and shall be used to offset gross cost. CONTRACTOR shall maintain source documentation to support the claimed costs, revenues, and allocations, which shall be available at any time to Designee upon reasonable notice.
b. The Cost Report shall be the final financial and statistical report submitted by CONTRACTOR to COUNTY, and shall serve as the basis for final settlement to CONTRACTOR. CONTRACTOR shall document that costs are reasonable, allowable, and directly or indirectly related to the services to be provided hereunder.

5. RECONCILIATION AND SETTLEMENT:

a. COUNTY will reconcile the Annual Cost Report and settlement based on the lower of cost or County Maximum Allowance (CMA). Upon initiation and instruction by the State, COUNTY will perform the Short-Doyle/Medi-Cal Reconciliation with CONTRACTOR.

b. COUNTY will perform settlement upon receipt of State Reconciliation Settlement to the COUNTY. Such reconciliation and settlement will be subject to the terms and conditions of this Agreement and any other applicable State and/or federal statutes, regulations, policies, procedures and/or other requirements pertaining to cost reporting and settlements for Title XIX Short-Doyle/Medi-Cal.

6. REPAYMENT OR REIMBURSEMENT TO STATE OR OTHERS:

a. CONTRACTOR agrees that any repayment or reimbursement that must be made by COUNTY to the State of California or others as a result of an audit or conduct by CONTRACTOR, its agents, officers or employees of the programs or services provided under this Agreement shall be paid by CONTRACTOR, out of its own funds, within thirty (30) days after the parties are notified that repayment or reimbursement is due. For purposes of this provision, it is agreed that offsets made by the state are included within the phrase "repayment or reimbursement."
b. It is understood that if the State Department of Health Care Services disallows Medi-Cal claims, CONTRACTOR shall reimburse COUNTY for any and all State and Federal Medi-Cal funds for those disallowed claims, regardless of the fiscal year of the disallowance within sixty (60) days of the State disallowing claims.

Exhibit B-1
Interim Reimbursement Rate Schedule
Fiscal Year 2018/2019

County of Tulare County
Mental Health Agreement

Service Function	Mode of Service Code	Service Function Code	Time Basis	County Maximum Rates
OUTPATIENT SERVICES	15			
Case Management (including ICC)		01-09	Staff Minute	$2.08
Mental Health Services - Collateral		10-19	Staff Minute	$2.83
Mental Health Services		30-57, 59	Staff Minute	$2.83
Medication Support		60-69	Staff Minute	$4.80
Crisis Intervention		70-79	Staff Minute	$3.73
Therapeutic Behavioral Services		58	Staff Minute	$2.83

EXHIBIT C

PROFESSIONAL SERVICES CONTRACTS

INSURANCE REQUIREMENTS

CONTRACTOR shall provide and maintain insurance for the duration of this Agreement against claims for injuries to persons and damage to property which may arise from, or in connection with, performance under the Agreement by the CONTRACTOR, his agents, representatives, employees and subcontractors, if applicable.

A. Minimum Scope & Limits of Insurance

1. Coverage at least as broad as Commercial General Liability, insurance Services Office Commercial General Liability coverage occurrence form GC 00 01, with limits no less than $1,000,000 per occurrence including products and completed operations, property damage, bodily injury and personal & advertising injury. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this project/location (ISO CG 25 03 or 25 04) or the general aggregate limit shall be twice the required occurrence limit.

2. Insurance Services Office Form Number CA 00 01 covering Automobile Liability of $1,000,000 per occurrence including any auto or, if the CONTRACTOR has no owned autos, hired and non-owned auto coverage. If an annual aggregate applies it must be no less than $2,000,000.

3. Workers' Compensation insurance as required by the State of California, with Statutory Limits, and Employer's Liability Insurance with limit of no less than $1,000,000 per accident for bodily injury or disease.

4. Professional Liability (Errors and Omissions) insurance appropriate to the CONTRACTOR's profession, with limit no less than $1,000,000 per occurrence or claim, $2,000,000 aggregate.

B. Specific Provisions of the Certificate

1. If the required insurance is written on a claims made form, the retroactive date must be before the date of the contract or the beginning of the contract work and must be maintained and evidence of insurance must be provided for at least three (3) years after completion of the contract work.

2. CONTRACTOR must submit endorsements to the General Liability reflecting the following provisions:

   a *The COUNTY, its officers, agents, officials, employees and volunteers are to be covered as additional insureds as respects; liability arising out of work or operations performed by or on behalf of the CONTRACTOR including material, parts, or equipment furnished in connection with such work or operations.*

   b. *For any claims related to this project, the CONTRACTOR's insurance coverage shall be primary insurance as respects the COUNTY, its officers, agents, officials, employees and volunteers. Any insurance or self-insurance maintained by the COUNTY, its officers, agents, officials, employees or volunteers shall be excess of the CONTRACTOR's insurance and shall not contribute with it*

   c *CONTRACTOR hereby grants to COUNTY a waiver of any right to subrogation which any insurer of CONTRACTPR may acquire against the county by virtue of the payment of any loss under such insurance. CONTRACTOR agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the COUNTY has received a waiver of subrogation endorsement from the insurer.*

d. Each insurance policy required by this agreement shall be endorsed to state that coverage shall not be canceled by either party, except after written notice has been provided to the County.

3. The Workers' Compensation policy shall be endorsed with a waiver of subrogation in favor of the COUNTY for all work performed by the CONTRACTOR, its employees, agents and subcontractors. CONTRACTOR waives all rights against the COUNTY and its officers, agents, officials, employees and volunteers for recovery of damages to the extent these damages are covered by the workers compensation and employers liability.

C. Deductibles and Self-Insured Retentions

Self-insured retentions must be declared and the COUNTY Risk Manager must approve any deductible or self-insured retention that exceeds $100,000.

D. Acceptability of Insurance

Insurance must be placed with insurers with a current rating given by A.M. Best and Company of no less than A-:VII and a Standard & Poor's Rating (if rated) of at least BBB and from a company approved by the Department of Insurance to conduct business in California. Any waiver of these standards is subject to approval by the County Risk Manager.

E. Verification of Coverage

Prior to approval of this Agreement by the COUNTY, the CONTRACTOR shall file with the submitting department, certificates of insurance with original endorsements effecting coverage in a form acceptable to the COUNTY. Endorsements must be signed by persons authorized to bind coverage on behalf of the insurer. The COUNTY reserves the right to require certified copies of all required insurance policies at any time.