

## Residentially Based Services (RBS) Reform Project

### County Annual Report

Demonstration Site:  SAN BERNARDINO COUNTY	Reporting Period:  Calendar Year 2010
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Instructions: The County Annual Report is to be prepared and submitted by each pilot county in collaboration with its participating private nonprofit agency(ies). The report is prepared for each calendar year in which the RBS Reform Project is in operation and submitted to the California Department of Social Services (CDSS) by March 1 of the following year. Narrative responses must be provided to Sections A through H, below. Additional information may be attached as necessary.

**Section A - Client Outcomes: This section provides analysis of the outcomes for children and youth, including achievement of permanency, average length of stay, and rates of entry and reentry into group care.**

- 1. Describe the demographics and characteristics of the target population served in this reporting period.**
- 2. Provide a qualitative analysis of the Child Welfare Services/ Case Management System (CWS/CMS) outcome data provided by Walter R. McDonald & Associates (WRMA). Include in this analysis a discussion of the reasons for disenrollment during the reporting period and discussion of the experience of the children/youth that stepped down to lower levels of care and/or achieved permanency during the reporting period.**
- 3. Describe the proportion of children/youth that spent some period of time in temporary group home stays for purposes of crisis stabilization? What were the reasons for the returns to group home care? From the county perspective, what steps will be used to improve the effectiveness of crisis stabilization?**

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#### **Describe the demographics and characteristics of the target population served in this reporting period.**

San Bernardino County's RBS program has deviated from the model in that they have served and will only be serving Probation and CFS youths due to legislative changes to the AB3632 program. However, the program will accept Special Education Placement referrals from the four SELPA in San Bernardino County. As of Dec 31, 2010, the RBS program has served 2 probation youths and 12 CFS youths for a total of 14 youth. Currently we have served the same amount of youths 50% (7 youths) and 50% were males (7 youths). The average age on Dec 31, 2010 was 16.0 years old with a range of 13 to 17 years old. The primary language for all youths was English, and the ethnic breakdown is 6 African American youths (2 from probation), and 8 white youths.

#### **Provide a qualitative analysis of the Child Welfare Services/ Case Management System (CWS/CMS) outcome data provided by Walter R. McDonald & Associates (WRMA). Include in this analysis a discussion of the reasons for disenrollment during the reporting period and discussion of the experience of the children/youth that stepped down to lower levels of care and/or achieved permanency during the reporting period.**

As of Dec 31, 2010, the RBS program in San Bernardino County's has run for approximately 6 months. Child welfare outcomes: No youth have achieved permanency in the first six months of the program. There was only one child welfare youth who had a placement episode termination because he was incarcerated in Juvenile hall. The average days in group home for the child welfare RBS youth is 120 days or 4.0 months with a range of 21 days to 186 days (6.1 months). Re-entry into group/foster care: Currently no youth has stepped down to a lower level of care and only one probation youth has exited foster care to incarceration in juvenile hall. As for child safety, there have been no substantiated allegations for youths in foster care or out of foster care at this time. Child well-being: 92.3% of the CFS youth have not had additional foster care placement (12 out of 13 youths) beyond the transfer to the RBS group home and 7.7% (1 youth) has had three additional lateral placement changes (from group home to group home) due to the youth runaway from placements. (State provided data: Number of Placement in RBS program: There were 5 child welfare youth who had a lateral placement change from one group home to another group home. Average number of placements during RBS: on average the RBS youths had 1 placement in 2010 with a range of 1 to 4 placements. )

One youth has been disenrolled in CY 2010. The placing agency for this youth was the Probation Department and the disenrollment was prior to Probation given access to CWS/CMS.

During this reporting period, the calendar year, 2010 no youth has stepped down to

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a lower level of care and/or achieved permanency.

**Describe the proportion of children/youth that spent some period of time in temporary group home stays for purposes of crisis stabilization? What were the reasons for the returns to group home care? From the county perspective, what steps will be used to improve the effectiveness of crisis stabilization?**

There have been no youth who have transitioned to the community based portion of our Residentially Based Services program in 2010 and therefore crisis stabilization has not been utilized.

**Section B - Client Involvement: This section addresses the involvement of children or youth and their families.**

- 1. Provide a qualitative analysis of the Child and Adolescence Needs and Strengths (CANS), Youth Services Survey for Youth (YSS) and Youth Services Survey for Families (YSS-F) data provided by WRMA. (Do not duplicate the analysis required in Section C 1.)**
- 2. What proportion of youth actively participated in the child/family team meetings? If youth did not participate, why not?**
- 3. What proportion of youth had at least one supportive adult routinely participating in child/family team meetings?**
- 4. Discuss any best practices/lessons learned with regard to family search and engagement, enhancing family relations, etc.**

**Provide a qualitative analysis of the Child and Adolescence Needs and Strengths (CANS), Youth Services Survey for Youth (YSS) and Youth Services Survey for Families (YSS-F) data provided by WRMA. (Do not duplicate the analysis required in Section C 1.)**

There were 12 CFS youth and 2 probation youth enrolled in RBS, and of those youth 9 CFS youth had approved CANS and 5 youth had the 6 month follow up CAN. In comparing the initial CANS to the follow up CANS: the RBS youths improved on Functional Status, Mental Health, Child Strengths, made no changes in Risk Behaviors, Family/Caregiver Needs and Strengths, Child Safety and had a negative progress on the Educational Progress section. The CANS areas that had not progress are not surprising, as the RBS provider only had at most 6 months to work with the youths.

Overall, the youths and relative/caregivers were satisfied with the RBS program based on the YSS and YSS-F surveys, more detailed information will be provided in Section C -1.

**What proportion of youth actively participated in the child/family team**

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#### **meetings? If youth did not participate, why not?**

The majority of youth, 86% served in this review period actively participated in the CCT meetings. Two (2) youth did not actively participate; one youth ran away from her public school two weeks into being at RBS and never had a CCT prior to running away, the second youth had two opportunities to participate in a CCT, but flat out refused to participate. A total of 13 youth in RBS have actively participated in the CCT meetings out of 14 eligible youth.

#### **What proportion of youth had at least one supportive adult routinely participating in child/family team meetings?**

46% of youth served during the reporting period had at least one (1) supportive adult (not a provider or agency employee) participating in CCT meetings

#### **Discuss any best practices/lessons learned with regard to family search and engagement, enhancing family relations, etc.**

Family involvement has a significant impact upon the youth's morale and ability to re-engage with other family members, community, peers, and partner agency staff. It is critically important to participate in early engagement in family finding with youth and partner agencies. This requires efforts beyond the use of simple tools or structures that have come to define family finding; it involves an active outreach with the family and being creative in the reconnection with individuals that the youth may not have seen for many years. Family finding efforts include activities such as: providing a means of reengagement that is safe for both the youth and the family members, preparing the youth and family for the reconnection, providing family therapy to address unspoken or unresolved issues, seeking out members who fall out of the RBS team, and providing collateral support services to identify family members. This also involves handling the grief and loss issues that start to reemerge upon the reintroduction of family back into the youth's life

As a program we learned that family participation is essential for success; however, some family members who had been inconsistently involved are not always enthusiastic for increasing this involvement and may lapse in their participation. This created a need to reengage and to practice some methods to track down family members who fall out of the RBS team. The staff's extensive efforts to reconnect were minimally effective due to several factors such as: lack of information provided by the placing agency, lack of participation in the coordination of care (CCT) by the placing agency workers, lack of enthusiasm for the reconnection by the youth and/or the family members, insufficient training in the methodologies used for family search and engagement, and lack of

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communication between service providers that hindered the process. In addition, the program expectations of the family members were not always realistic for specific members and the expectations for the family needed to be more in line with what that individual was capable, willing, and able to do for the youth as opposed to what the RBS team wanted. In addition, what the family perceives as being positive or negative events are not always in agreement with the assessment made by the RBS team. However, it is apparent that servicing youth at this level of care did bring a wide range of individual dynamics that sometimes hindered the ability to keep family engaged with the youth or to allow for alternative planning that the family may/or may not have agreed with. In addition, it was found that RBS cannot reach the goals and aspirations of the program design without family engagement for every youth being a primary focus.

**From the provider:** The concept of family find is an important additional service that can benefit our youth; however, the level of grief and loss issues that accompany this process can be overwhelming for youth and can cause significant increase in behaviors and decreased interest in follow through when expectations do not fit with reality.

It is critical that this part of the RBS process / services begins during the early engagement phase of the program.

**Section C - Client Satisfaction:** This section addresses the satisfaction of client children or youth and their families with the RBS Reform Project services they have received.

- 1. Provide a qualitative analysis of YSS and YSS-F data provided by WRMA, specifically address satisfaction measured in Items 1-15 of the YSS and YSS-F and outcomes measured in Items 16-22 of the YSS and YSS-F.**
- 2. Discuss any best practices/lessons learned in ways to enhance client satisfaction.**

**Provide a qualitative analysis of YSS and YSS-F data provided by WRMA, specifically address satisfaction measured in Items 1-15 of the YSS and YSS-F and outcomes measured in Items 16-22 of the YSS and YSS-F.**

There were 9 CFS youth who completed the YSS and 3 youth with family who completed the YSS-F in Nov 2010. The two CFS youths who did not complete the YSS because neither one of them was physically in the RBS group home in Nov 2010 (one was in Juvenile hall and the other youth was in a different group home).

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Overall, the youths were satisfied with the RBS program. The 9 youth were satisfied with satisfaction of the services domains (median 4.0) and well being domains (median 4.0), they were slightly satisfied with the child and family voice and choice domain (median 3.7). The YSS domains range from 1 strongly dissatisfied to 5 strongly satisfied, any score above 3.5 is considered satisfied by the creators of the YSS.

An aunt, an unidentified relative and a foster father completed the YSS-F for the RBS youths. Overall, the relatives were more positive than the foster parent for the YSS-F responses. They were most satisfied with the services (median 4.9) and Well-being domains (median 4.3) but slightly more dissatisfied with the child's voice and choice (median 2.7). The RBS provider has had some challenges in obtaining the most appropriate staff for the Family Clinician. This may have had some impact on the satisfaction of the caregivers/family members who are participating in the RBS program. We expect to see an improvement in the next annual report in this domain.

#### **Discuss any best practices/lessons learned in ways to enhance client satisfaction.**

It is very important to emphasize and validate the "voice & choice" to the youth. The RBS program gives the youth "voice & choice" to help create for the youth individualized services and allows the youth to hold the program accountable when the individual services (enrichment activities) are not met. This voice & choice philosophy provides evidence and experiences to the youth that the agencies are not only interested in controlling them but also to facilitate and support their hopes and dreams. The CCTs have had to honor decision made by the youth and/or families while occasionally having to express opposition to the said choices. The process of the youth expressing their voice & choice has a positive impact on the youth's perception and ability to function better with others, as they learn to express their opinions better. By implementing the voice & choice it has helped several youth with history of non-engagement and pattern of running away to connect and engage in the program.

Keeping the family engaged in the process, even when difficult, has made for better outcomes for the youth. It is very important to include the family perceptions in decision making process. Finally, active family involvement facilitated youth developing hope for their future, as they experience other invested in their future.

Finally, allowing the youth voice and choice and the family to have decisions has been a cultural shift for the agencies (CFS and Probation).

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**Section D – County Use of RBS Program:** This section includes discussion of the use of the RBS Reform Project by the county.

- 1. Discuss how the county has put into operation the concepts contained in the approved plan.**
- 2. Discuss the quality assurance activities performed during this reporting period to ensure program fidelity to the approved plan.**
- 3. How has the operation of the program changed from the original concept proposed in the approved plan? When did this change occur? How was the required change identified and implemented? How has the program been adapted to improve the effectiveness of the project?**
- 4. How did the county manage program utilization and administer resources in the RBS project?**
- 5. Discuss how each county agency (e.g., Child Welfare Services, Mental Health, Probation, Regional Center) participated in the RBS program. Were there any significant differences from the roles and responsibilities described in the approved plan? If so, when and how were the differences identified?**
- 6. Describe the interactions among and between the county agencies, providers and community partners (e.g., collaborative efforts towards placements, exits, services planning, etc.).**
- 7. Describe any lessons learned/best practices.**

**Discuss how the county has put into operation the concepts contained in the approved plan.**

Upon implementation of the RBS program in San Bernardino County an Oversight Committee was created out of the program subcommittee that was responsible for the design of the RBS program. Members of the Oversight Committee were chosen from each partner agency. The purpose of the Oversight Committee is to monitor fidelity to the RBS model while ensuring the progress made by youth is tracked and to create a venue for problem solving and conflict resolution. Then youth were identified as potential RBS participants from the existing Victor Group Home population, youth who were in a psychiatric facility, and those that were placed out of state (out of state population has decreased significantly). A few youth were returned from out of state to participate in RBS and to return to their communities.

Environmental Interventions:

Two homes were opened within San Bernardino County that where specifically

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designated as RBS homes. One home is for (6) female residents and the other for (6) male residents. Both homes have opened and were renovated in hopes of facilitating the provision of RBS. We are serving the appropriate high need, multi-difficulty, youth and have succeeded in returning youth to the local community from out-of-state or out-of-county. Children and Family Services has developed working relationships with four local ITFC/FFA providers and is with working with DSS in order to modify the business model to make ITFC financially viable (The county on the advice of other California county needed to modify the ITFC model to expand the number of foster children placed in the ITFC home beyond the current ITFC model of one child only). However, an MOU currently exists with these four ITFC/FFA providers for ITFC homes to be used as a step down or transitional placement.

#### Portable Intensive Treatment Interventions:

The Care Coordination Team, including youth, meets at least monthly, in an emergency, or as needed depending upon the circumstances of the youth. The Trauma Informed Care Model is being utilized as the RBS provider, partner agencies, and consultants have conducted county-wide trainings for staff from multiple agencies. All staffs involved in RBS have been trained in the RBS model, risking connections, and grief and loss and follow-up trainings have been provided when necessary. Training of staff not directly involved with RBS has also been provided, as trauma informed model training is facilitating paradigm shift for all agency staff. Agency staff and structure of the program is established to allow for a youth to stay engaged in a consistent treatment team during transitions to the community. This has occurred once in 2010, when the youth had a trial visit out of county to stay with fictive-kin.

#### Parallel Community Services

A family clinician has been brought on board and this position is still in development. The responsibilities are being expanded in order to include more thorough family finding, increase the provision of family therapy in the community, provide more collateral support for guardians, and extensive involvement in the transition planning.

#### Follow-Up Services

Agency staff and structure of the program is ready to provide follow-up services; however, there has not been an opportunity to provide this during 2010.

#### Family Involvement

Almost every child has experienced an increase in family involvement and family connections while enrolled in the RBS program. In addition, family members are a core member of the CCT to the extent that they choose; family members report feeling empowered through the 'voice & choice' element of RBS. Emotional connections with family, friends, prior caregivers, mentors, CASA workers, and agency workers have been cultivated more fully and retained throughout the program. Furthermore, family members and others have been involved in holiday

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visits and exploration of post discharge placement is occurring at a much higher rate than typical for this population. The Service Provider has also facilitated family member participation through atypical support (e.g., Thanksgiving Gift Basket, transportation, reengagement of family who fall out of the CCT). These interventions have significantly lowered the long term AWOL rate as only one youth has officially AWOL' d from the program for a significant amount of time.

#### Utilization Management:

The program design committee was successfully transitioned into an RBS Oversight Committee and members were identified from each partner agency. The RBS Oversight Committee has been successfully operated since the start of the program and has adjusted meeting time and day to accommodate the needs of the members and youth. These modifications were needed to meet the needs of the program and youth more consistently (e.g., changed from monthly to weekly meetings). Modifications included no longer tasking the Oversight Committee with the responsibility of liaising with the financial departments and transferring those responsibilities to Human Services Contract Monitoring unit. Policy Development has also been reviewed and will be modified to facilitate the work flow within RBS.

#### Funding

The integration of multiple funding sources has been successful to date, but some of the funding sources were not needed in 2010 as youth are not in all phases of the program (e.g., enrolled in SB163 Wraparound).

#### **Discuss the quality assurance activities performed during this reporting period to ensure program fidelity to the approved plan.**

The Oversight Committee is a multi-agency committee with all partner agencies actively participating. This committee meets on a weekly basis and monitors the following: service delivery, placement, resolution of conflicts or issues that arise, progress of every youth is reviewed twice a month using a review of 5 domains: education, activities, mental health/behaviors, family connections, and participation in Independent Living Program (ILP), and insurance of fidelity to the model through revisiting the core values. The Oversight Committee has been episodically expanded to include youth to make recommendations for admissions to ensure adherence to the target population.

**How has the operation of the program changed from the original concept proposed in the approved plan? When did this change occur? How was the required change identified and implemented? How has the program been adapted to improve the effectiveness of the project?**

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It was apparent early on that some changes were necessary to ensure service was provided to youth in a manner that reinforced our RBS mission, vision, and values and fidelity to the model design. Therefore, adaptations needed to be made for a variety of reasons including the following: it took longer than hoped to have certain components of the program up and running, especially line worker participation and support of the specific core components of the model: 1) family engagement, 2) family finding, 3) individualized activities, 4) community activities, 5) care coordination team, and 6) urgent problem solving and conflict resolution. In addition, there needed to be policy revisions as some issues that we faced were not anticipated in the design.

There were issues that were different from our early expectations in that we were unable to incorporate AB3632 youth due to cuts in funding that did not allow for utilization of this program within RBS. The pathway of the youth in the program were not in line with our predictions and our planning and therefore we had to take a more individualized response to youth than to assume they were going to follow our trajectory of care model. In addition, some youth transitioned earlier than expected and the youth's measure of success was different than the RBS measure of success. There was also a need for the paradigm shift to be made for all those involved in the RBS system of care and this was difficult and still presents a challenge as partner agencies have struggled internally with line staff to assist them in understanding what RBS is and what RBS is not.

Many of these changes were identified between the months of July 2010 and December 2010 as we started the program these changes become necessary to ensure that the program could maintain and sustain its mission, vision, and values. Many of these issues were identified within the weekly Oversight Committee meetings as a general function of the meeting to resolve conflict and situations as they arise with each youth. The Oversight Committee responded to these identified issues and problem solved as need with the idea that the focus is to adapt the program to fit the youth, not force the youth to change to fit the program. The Oversight Committee actively engaged, promptly resolved, and maintained the needed flexibility to restructure and address these issues.

Some adaptations that have been made to the program have entailed a deeper understanding of these youth and the needs and dynamics of their behaviors in response to interventions and the reintroduction of family. This has also included increased communication between all partner agencies, additional trainings with outside consultants such as Darla Henry, and demonstratively responding to input and suggestions from the RBS youth, RBS provider, assigned CFS social workers, probation officers, Inland Regional Center representative, and DBH/CFS administration.

**How did the county manage program utilization and administer resources in**

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#### **the RBS project?**

When RBS began the goal was to bring any youth placed in an out of state group home back to San Bernardino County, to identify all RCL 14 youths and to find youth in psychiatric hospitalizations. Since the RBS program took several years to implement there were some necessary changes that occurred for the program to function: 1) the department had to adjust the social marketing to CFS social workers to refer their youth, and 2) the CWS/CMS data was mined to identify any potential RBS youth. To make the program run smoother: the Department of Mental Health assigned one Clinical Case Manager to oversee all the RBS youth and the Children and Family Services department assigned a Social Worker liaison to participate in all of the RBS services requiring a social worker presence.

Finally, the very rapid implementation of the youth enrolled in RBS created some difficulties within the placement home. Some youth exhibited more violent behavior than anticipated, which made it difficult to have the home completely filled. There was too much movement in the beginning with youth being placed in the home too quickly, which destabilized the RBS homes. In addition, there has been a more rapid discharge of youth being enrolled in RBS (e.g. youth exiting the RBS program before the planned 6 month period) resulting in the need for more youth to be identified to utilize the program to capacity.

At the beginning of the program there were youth who needed a high level placement quickly due to a variety of issues and thus were placed without the TDM or proper screening. This destabilized the home environment by introducing youth who were not received through the designed method of admission into RBS into a home milieu that was designed to avoid rapid admission and proper introduction into the RBS home.

**Discuss how each county agency (e.g., Child Welfare Services, Mental Health, Probation, Regional Center) participated in the RBS program. Were there any significant differences from the roles and responsibilities described in the approved plan? If so, when and how were the differences identified?**

**CFS:** The majority of youth placed in the RBS program are from Children and Family Services (CFS) and thus participation within the RBS program has been substantial. This participation also included chairing the Oversight Committee meetings weekly, co-chairing the RBS Steering Committee monthly, and being actively engaged in the RBS system and specific dynamics of each youth. It became apparent that with the exclusion of the AB3632 youth that there would need to be an increase in CFS youth that participated in the RBS program. There were no

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significant changes in the roles and responsibilities of CFS within the RBS model; however, CFS staff have had to take a more active role in the weekly functioning of the youth, making adjustments to RBS forms and county policy as needed, addressing conflict and seeking resolution, engaging county line staff to increase participation in RBS activities including the CCT, assigning one RBS coordinator who actively attends as a CFS representative on all CCT meetings, tracking all incident reports, addressing line staff lack of understanding and the departmental paradigm shift. These additional needs were identified within the Oversight Committee meeting. As a general function of this meeting changes are made to ensure compliance and fidelity to the RBS model.

**IRC:** Inland Regional Center (IRC) has yet to find a youth ideal for placement/participation in the RBS pilot project. At present one adolescent who is currently residing in an RBS home is being evaluated for IRC eligibility. IRC's role has primarily been to collaborate with other stakeholder agencies, attend meetings, offer input and represent the Developmentally Disabled community within our county. IRC has a designee who sits on both the Oversight and the Steering committees. While little doubt remains of the appropriateness of the RBS model for some RC clients, IRC looks forward in anticipation with a positive sense of enthusiasm when the first IRC client resides/participates in the RBS program. The administration at IRC remains committed to the success of the RBS project and is poised to offer tangible support when the opportunity arises. Since its inception there have been no substantive differences in IRC's role/responsibility as described in the original plan.

**DBH:** There are two primary roles for DBH in the approved plan: (1) Provide clinical case management services to all youth enrolled in RBS {including all multidepartment collaboration}, and (2) Facilitate AB 2726 (3632) placements that were appropriate for RBS. The roles and responsibilities of being a partner in this process and serving the youth enrolled in RBS has not changed significantly from the approved plan. However, on October 8, 2010 then Governor Schwarzenegger suspended AB3632 and DBH no longer has a role or responsibility in the residential placement of special education students. This means that the portions of the plan that incorporated the Individualized Education Program (IEP) as a formal treatment authorizing meeting do not apply.

**Probation:** The Department of Probation is an active member of the RBS demonstration in San Bernardino County. There is a single Probation Officer assigned to work with the RBS program's daily functioning and to participate in the Care Coordination Team meetings as well as the weekly Oversight Committee meetings. This Probation Officer shares input and best practices as it applies to the Probation youth currently enrolled in RBS. There were no significant changes from the approved plan. However, Probation did reassign RBS to a different Probation

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Officer than the one originally involved in the RBS implementation and it did take some time to bring that individual into the RBS model. Probation continues to place youth in RBS and shares in the vision of better care for these high level needs youth.

**Describe the interactions among and between the county agencies, providers and community partners (e.g., collaborative efforts towards placements, exits, services planning, etc.).**

All RBS partner agencies are actively engaged in the RBS Steering Committee meetings as well as the weekly Oversight Committee meeting. This meeting is the hub of RBS activity and this is where changes to plans, follow-up, problem solving, and communication exists among and between the committee members. In addition, each RBS CCT is scheduled to meet at least weekly and these are attended by participants that represent the interests of the youth (RBS provider agency, placing agency, community, school, therapist, family, youth). Emergency (ER) CCT's are called when emergent changes need to be made, issues present themselves, or someone has a concern about the youth or the direction of the youth within the RBS system of care. These ER CCT's are attended by the CCT team in addition to the Oversight Committee members. The Oversight Committee members act as experts on the RBS model, design, mission, vision and values.

**Describe any lessons learned/best practices.**

(Within our RBS program model we have learned many things that have enhanced our ability to service our population of youth. We learned early on that communication between partner agencies is essential for problem solving and conflict resolution. This has served to be an achievement for our county in that prior to RBS there was little collaboration of care for these identified youth. This has also been liberating for these youth as prior to RBS no one really asked them for their opinions or perspectives on their needs. In addition, it is crucial that the plans for youth at this level of care be reviewed frequently and for there to be oversight to monitor the successes and challenges of every youth so youth do not languish in the group home system.

One lesson that has proven to challenge us is that every partner agency has their own philosophy about youth and that to create a shift in those ideas one must consistently challenge, engage, and counter those ideas until a new paradigm and level of understanding has been achieved. This has not been easy and we continue to work on this issue. Another lesson we learned is that success to our youth may not mirror the RBS definition of success and if we believe in the right of youth to make some decisions for themselves we must also believe in the right for these

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same youth to define their own life path, goals, and successes. This has not been easy for us as traditionally child welfare in general has applied a sense of control over youth upon youth. There are two examples: One youth decided to leave the system of RBS care upon his 18<sup>th</sup> birthday and was discharged and dismissed at that time. At the CCT the team tried to assist the youth to leave in a way that was planned as opposed to leaving without proper support. Youth was not willing to stay in the residential treatment even though he had stated at prior CCT's that he wanted to stay until he was 19. Youth was assisted with airline ticket to Bay area to be with relatives and was given referrals to local community providers in that area to continue care. Youth made the choice and we honored his right to choose to leave the child welfare system at 18.

Second youth was sent to an extended visit with a NREFM in San Diego in December 2010. CFS Social worker decided to make that extended visit a placement in January 2011 even though the RBS team felt that youth should transition a little slower to ensure services were in place prior to move. CFS social worker decided against this and placed anyway, community services were set up after the fact and were difficult to access due to a change in county based Medi-Cal.

We value youth 'voice and choice' even if it is not what we would want for that youth. Another lesson that we learned is that we are not going to be successful for every youth and some youth will need more than what RBS can provide them. In addition, we learned how very valuable it is to retain RBS model fidelity and that this fidelity can sometimes impede the goals of partner agency staff.

**Section E – Operation by Nonprofit Agency(ies): This section includes discussion of the operation of the RBS Reform Project by the private nonprofit agency(ies).**

- 1. Discuss how the provider(s) has put into operation the concepts proposed in the approved plan.**
- 2. How has the operation of the program changed from the original concept proposed in the approved plan? When and how was the change identified? How has the program been adapted to improve the effectiveness of the project?**
- 3. How did the provider(s) manage program utilization and administer resources in the RBS project?**
- 4. Describe the interaction between the county and provider(s).**
- 5. Describe how crisis stabilization was provided. From the provider perspective, what steps will be used to improve its effectiveness?**

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#### 6. Discuss any lessons learned/best practices.

##### **Discuss how the provider(s) has put into operation the concepts proposed in the approved plan.**

Victor Treatment Center is the sole provider associated with the San Bernardino RBS Pilot project.

##### Environmental Interventions

Victor had one group home already licensed and physically located in San Bernardino County within the approved County Supervisorial District for use in the RBS pilot project. Victor stopped using that group home in November 2009 to prepare it in anticipation of it being used for the RBS program; use of this home for RBS began in mid July 2010. This house has the capacity of 6 beds maximum.

In order to meet the vision of serving both boys and girls in the RBS program a second home needed to be purchased within the approved County Supervisorial District. Victor was able to purchase a home in Rialto, CA after an extensive search lasting over 18 months. The home required some moderate modification before seeking the facility to be licensed by Community Care Licensing (CCL), but once the work was completed we received significant and sustained support from our local CCL office and particularly our CCL analyst, Deborah Mullen as we pursued getting the facility licensed. Victor was successful with acquiring licensure for our Rialto facility in late May 2010; this facility began working with our first female clients on June 28, 2010.

This facility was previously licensed as a 10 bed facility; however, upon purchase Victor attempted to transfer the Conditional Use Permit (CUP) with the City of Rialto but there was no record of a CUP since 1965 when it had been established as a 5 bed facility. This changed our approach for use of the facility to move forward with a license for only 6 beds. The original plan was to have 6 regular RBS beds, and two respite / crisis stabilization beds (a total of 8 beds); the crisis beds could be used for youth who were struggling in the community based phase of RBS where they would come back to the residential milieu to spend a short amount of time until stabilized and then sent back out to the community. Victor intends to move forward at some point with acquiring the CUP from the city to allow this option to come to fruition.

##### Portable Intensive Treatment Interventions

The Care Coordination Team (CCT) is designed to be the vehicle through which the decisions are made by the team. The team usually consists of the child, family members, county worker, Victor clinical and residential staff, a DBH representative (at every CCT), and a CFS representative at every CCT. The CCTs have been

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conducted in various locations based on the needs of the team members but with particular interest on encouraging the family to be involved and what is in the best interest of the youth (i.e. minimizing pulling youth out of school, pulling youth out of treatment, etc.)

The most significant hurdle around the effective implementation of the CCT meetings has been the inconsistent involvement of the case carrying County Worker. Without the consistent participation of the County Worker in the CCT meetings, there is little that can effectively move forward for the RBS youth. This paradigm shift has been more challenging than anticipated.

Trauma informed Care (Risking Connection) - All of the RBS staff and several of our partners have been trained in Risking Connection, a trauma informed model that allows the youth's traumatic life experiences to be taken into context when working with the youth. There is still a need to have this training provided to some of the County Agency personnel working with the RBS program.

There are two significant members of the RBS team who are critical to the effective implementation of the portable intensive treatment interventions for youth experiencing the RBS model:

The Family Clinician is an additional resource not usually offered as part of the intervention plan for youth. The Family Clinician's role is to be a part of the early engagement of the youth through participation in the Team Decision Making process prior to the change of placement where RBS is first considered for a youth. The Family Clinician also implements a Connection Map process for the youth prior to entering the RBS program to kick start the family finding and engagement process. This work often occurs in the community with the families, but can really be provided wherever it makes sense for the family and youth. The Family Clinician works closely with the Parent Partner to ensure the families' needs are addressed to further assist them in supporting the RBS youth. One initial setback for the program was the difficulty with recruiting and hiring the Family Clinician for RBS. It was mid August when we were finally able to bring the Family Clinician on board the Victor RBS clinical team. Most of the youth currently in the program had already entered the program and the youth and families' connections with the Family Clinician were slower established than originally designed.

The Life Coach is also an additional resource that is not typically offered outside of the RBS program. The Life Coach begins working with the youth by performing an Ansell Casey Life Skills Assessment with the youth upon enrollment into RBS to determine what life skill deficits the youth might have. Once a client plan has been established where measurable goals have been defined, the Life Coach begins working with the youth on a 1:1 basis attempting to increase their skills in the defined areas. This work helps the youth begin to build the necessary skills to navigate the

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RBS process and move toward transition into the community based phase of RBS.

#### Parallel Community Services

As mentioned above, the Family Find and Engagement process assists youth with reconnecting them to family or friends who can play a supportive role in the youth's life. This process allows the youth to begin building relationships in the community and prepare for a transition to the community based portion of the RBS program. While connecting youth back with family has been important to the process of RBS, it has not come without its struggles. Sometimes when families are not yet prepared to commit to levels of participation in the youth's life that meets the expectation of the youth grief and loss issues arise and youth may have a tendency to revert to old behavioral patterns. This will likely continue to be an area where significant learning can be gleaned.

Also as mentioned above, the role of the Family Clinician and Life Coach are critical components of the community services that occur while youth progress through the residential phase of RBS. The youth have often required significant preparation to be able to properly participate in the community services. An emphasis has been placed on providing enrichment activities for each youth based on individualized personal interest (i.e. dance class, food preparation / cooking class, sports / athletic activities)

Victor staff and structure of the program is ready to provide follow-up services for youth as they transition into the community based service phase of the RBS program; however, there has not been an opportunity to provide this in 2010.

#### Family Involvement

Almost every child has experienced an increase in family involvement and family connections while enrolled in the RBS program. In addition, family members are a core member of the CCT to the extent that they choose; family members report feeling empowered through the 'voice & choice' element of RBS. Emotional connections with family, friends, prior caregivers, mentors, CASA workers, and agency workers have been cultivated more fully and retained throughout the program. Furthermore, family members and others have been involved in holiday visits and exploration of post discharge placement is occurring at a much higher rate than typical for this population. Victor has also facilitated family member participation through atypical support (e.g., Thanksgiving Gift Basket, transportation, reengagement of family who fall out of the CCT).

#### Utilization Management

The RBS Program Manager / CCT Facilitator has played a crucial role in the

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Utilization Management of the RBS program. While many of the agreements have and can be made within the CCT structure, the real work happens outside of those CCT meetings. The CCT facilitator role helps to ensure that tasks or activities have the proper follow through to ensure there is focus on progressing youth closer to goals that need to be reached to allow for transition into the community based phase of the RBS program.

Both the Victor Director and the RBS Program Manager sit on the Oversight Committee which meets on a weekly basis to review the progress made by youth and to influence the process by injecting ideas and accountability into the RBS program. One of the most important things we have learned about the Oversight Committee is that its effectiveness is dictated by the level of consistent and effective communication about the program. The Oversight Committee has gone through its own continuous quality improvement (CQI) process and has progressed in terms of streamlining the tools for communication used to provide information about the program to the Committee members as well as streamlining the method in which meetings are conducted.

Victor also has its own system for utilization management which includes weekly RBS Team meetings. The weekly team meetings include clinical and residential milieu staff who discuss each RBS youth and the targeted actions their teams must take to properly support each RBS youth.

#### Funding

The integration of multiple funding sources has been successful to date, but some of the funding sources were not needed in 2010 as youth are not in all phases of the program (e.g., enrolled in SB163 Wraparound).

Victor has spent significant time with our sister programs creating the infrastructure and systems to streamline the integration of service lines provided to RBS youth through our collaborative multi-entity teams

VCSS San Bernardino - is subcontracted to provide TBS services to our RBS youth.

VCSS Victorville – holds a WRAP 163 and Success First (MHSA) contract that can be utilized for qualified youth transitioning into the community based services phase of RBS.

A significant factor with the implementation of the RBS program to date has been and continues to be the lack of occupancy in the program. The occupancy issue creates significant fiscal issues as discussed in section G.2 and G.4 of this report.

**How has the operation of the program changed from the original concept**

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**proposed in the approved plan? When and how was the change identified? How has the program been adapted to improve the effectiveness of the project?**

Originally, we planned to have a CCT on the first day the child arrived in the RBS program. In our first attempt at conducting the program on June 28, 2010 we quickly realized that this would not be an effective approach. The youth had never really experienced the CCT process and they were overwhelmed to the point of complete disengagement in the CCT. Most every youth entering RBS required some preparation provided by the clinical team before they were able to reconcile the foreign concept of a group of supports where their voice was emphasized (the format of the CCT). The adaptation was to push back the first CCT until after proper relationships had been cultivated to ensure the best chance of the CCT meeting process to be successful for youth.

Along the same vein, the structure and documentation of the CCT meetings have changed as we have learned more about what is consistently important to be addressing with each youth as they progress through the program.

Operational definitions are being created around several program critical issues such as criteria for youth transitioning into the Community Based phase of RBS and criteria for disenrollment of youth from the RBS program.

**How did the provider(s) manage program utilization and administer resources in the RBS project?**

As described above resources and program utilization were managed by participating in the weekly Oversight Committee and the weekly RBS team meetings. Additionally, Victor created an internal steering committee that has met at least on a monthly basis to develop, monitor, and guide the internal infrastructure and systems needed to implement and operate the RBS program with our County partners.

**Describe the interaction between the county and provider(s).**

Things started out well as we began to serve youth in the RBS program. There was a high level of commitment by all involved for a successful roll out of the RBS program. Additionally, there was a commitment to working through any conflict that might arise as we partnered to get things rolling. The monthly Steering Committee and weekly Oversight committee have been two very important vehicles for accomplishing our RBS mission. There were efforts for combined training between

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Victor staff hired for RBS and the County Workers who would become partners on the case level of the RBS program. These trainings proved extremely helpful with building relationships that would be important as we moved forward.

As we move further away from the core county champions for RBS, the paradigm shift required to allow RBS to be successful became more important and less evident that the shift had effectively occurred. Participation in the CCTs by case carrying County Workers was minimal in the beginning, although it appears to be increasing slightly as of late.

In several situations the County Workers lacked the understanding of the process for resolving conflict or concerns that arise with the RBS program which resulted in high level guidance by County Agency leaders to inform lower level County employees that RBS would not be business as usual; rather, workers would not have the ability to make unilateral decisions, nor would the provider. We would need to work together to ensure things would succeed.

The process of identifying youth for RBS has been an interesting journey. The RBS model emphasized early engagement of the youth to encourage relationship building between the youth and provider. There have been times where the emergent placement needs for a youth have come into direct conflict with the designed process for engaging and enrolling youth into RBS. The RBS admission design for CFS called for at least a 7 day process and the youth have needed placement at a much quicker rate than 7 days which has caused some rush in the process. This has caused us to think of ways to rush through the admissions as opposed to allowing for proper screening and assessment prior to placement. In addition, the acceptance in the program is usually a team approach there have been times when one party or RBS member agency has opposed the placement while another has accepted. Usually we resolve these issues in a way that is respectful and in line with our goals for RBS.

There are still paradigms around engaging and enrolling youth that will need to change in order for RBS to function as it was designed; there has not been enough of a shift from the historical emergent placement of youth mentality, where “we need this youth placed yesterday”, towards a well thought out and relationship based referral, engagement, and RBS enrollment process.

**Describe how crisis stabilization was provided. From the provider perspective, what steps will be used to improve its effectiveness?**

Crisis Stabilization had not occurred yet during this reporting period as there had been no youth who moved into the Community Based Services phase of the RBS program.

**Discuss any lessons learned/best practices.**

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It is critical for the successful implementation of the RBS model for County Workers to regularly attend the Care Coordination Team (CCT) Meetings.

It is important to spend significant time as partners defining the different components of the RBS program in terms of concrete operational definitions to ensure all participants share an understanding of the who, what, where, when, how, and why's of RBS so movement towards RBS program objectives can occur in a collaborative manner.

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**Section F – County Payments to Nonprofit Agency(ies):** This section addresses the payments made to the private nonprofit agency(ies) by the county.

1. Report the total payments from all fund sources paid to the provider(s) for RBS during the period the report covers under each of the following:
  - Aid to Families with Dependent Children – Foster Care (AFDC-FC):
  - Early Periodic Screening, Diagnosis and Treatment (EDSDT):
  - Mental Health Services Act (MHSA):
  - Grants, loans, other:
2. Provide the following for all RBS enrolled children/youth in group home care during the reporting period:
  - Average months of stay in group care:
  - Average monthly cost per child/youth:
  - Average monthly amount of AFDC-FC paid (both total AFDC-FC and State General Fund):
3. Provide the following for all RBS enrolled children/youth receiving community services (not in group home) during the reporting period:
  - Average months of services provided per child/youth: N/A
  - Average monthly cost per child: N/A
  - Average monthly amount of AFDC-FC paid (both total AFDC-FC and State General Fund): N/A
4. Discuss how the county and provider(s) managed any payment shortfalls/overages, incentives, refunds during the reporting period.
5. Describe any changes that have been made or are being considered in the funding system for the program and explain why they are necessary.
  - a. Exploring access & utilization of MHSA funds

**Report the total payments from all fund sources paid to the provider(s) for RBS during the period the report covers under each of the following:**

- Aid to Families with Dependent Children – Foster Care (AFDC-FC): \$260,785
- Early Periodic Screening, Diagnosis and Treatment (EDSDT): \$48,239
- Mental Health Services Act (MHSA): \$96,135
- Grants, loans, other: \$28,296

**Provide the following for all RBS enrolled children/youth in group home care during the reporting period:**

- Average months of stay in group care: 4.0 months or 120 days with a range of 21 to 186 days)
- Average monthly cost per child/youth: \$11,625
- Average monthly amount of AFDC-FC paid (both total AFDC-FC and State General Fund): \$8,492

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**Provide the following for all RBS enrolled children/youth receiving community services (not in group home) during the reporting period:**

We have not experienced any need to fund additional community services. The three youth which were transitioned out of RBS were served through means which did not require community services at this time.

- **Average months of services provided per child/youth: N/A**
- **Average monthly cost per child: N/A**
- **Average monthly amount of AFDC-FC paid (both total AFDC-FC and State General Fund): N/A**

**Discuss how the county and provider(s) managed any payment shortfalls/overages, incentives, refunds during the reporting period.**

Victor Treatment Centers, Inc. (Victor) and San Bernardino County (County) have addressed the issue of startup costs during this initial reporting period. Significant costs were incurred by Victor to open twelve (12) RBS beds in the County. County and Victor partnered and found two funding streams to help pay for these costs. A grant was acquired from the Casey Foundation and paid \$28,296 for building renovation and staff training costs. In addition, the County Department of Behavioral Health (DBH) provided MHSA dollars in its fiscal 2009-10 budget and paid the remaining startup costs.

**Describe any changes that have been made or are being considered in the funding system for the program and explain why they are necessary.**  
**Exploring access & utilization of MHSA funds**

At November 30, 2010 this RBS pilot program has been in operation for five (5) months. County and Victor are considering two changes in the funding system.

First, County and Victor are considering shifting some of the AFDC-FC funding to the front end of the placement and reducing funding at the back end of the placement. The need for this shift in funding is to better match revenues against costs incurred. Experience shows that children coming into the RBS program are in greater need of services. Those same children benefitting from the program need fewer services towards the end of placement. Discussions are continuing.

Second, average occupancy in the twelve (12) beds is lower than anticipated to date. This has resulted in operating losses in the program amounting to \$225,000+ at November 30, 2010. County and Victor are exploring revenue sources to offset these losses and ways to reduce cost (See further discussion at Section G.4)

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**Section G – Actual Costs of Nonprofit Agency(ies):** This section addresses the actual costs incurred by the nonprofit agency(ies) for the operation of the program.

1. If the county has performed the fiscal audit required by the Memorandum Of Understanding (MOU), describe any problems/issues with the provider's operations or implementation of the Funding Model that were disclosed by the fiscal audit performed. If the fiscal audit has not been conducted, when will that occur?
2. Were the expectations for operating the Funding Model met or were there issues that had to be addressed to make the Funding Model work?
3. Provide an analysis of the actual costs compared to the proposed budget. Comment on any changes made by the provider(s) in operating the program within the funding framework. Discuss why those changes were necessary, when they were made, and how effective they were.
4. Provide an analysis of total RBS provider expenditures and total RBS provider revenues. Address whether the rates paid under the Funding Model for the RBS residential and community components were greater than, equal to, or less than the actual expenditures for each component. If not equal to, discuss the degree to which the rates either exceeded or fell short of actual expenditures.
5. Discuss any extraordinary costs associated with any particular child/youth (i.e., outliers), providing the amount of the cost and what it purchased.
6. If after 24 months of operating the RBS project, has an analysis of the current approved RBS rates versus RBS expenditures been performed in the reporting period and will the RBS rates for continued operation of the program be increased, decreased, or remain the same? If not proposed to remain the same, by how much will they be proposed to increase or decrease and why? If such an analysis has not been performed, when will that analysis be completed?

**If the county has performed the fiscal audit required by the Memorandum Of Understanding (MOU), describe any problems/issues with the provider's operations or implementation of the Funding Model that were disclosed by the fiscal audit performed. If the fiscal audit has not been conducted, when will that occur?**

A fiscal audit by County is scheduled in March or April, 2011, approximately nine (9) months after operations started.

**Were the expectations for operating the Funding Model met or were there issues that had to be addressed to make the Funding Model work?**

The Funding Model operated for five (5) months during this initial reporting period.

Anticipated challenges were met and resolved. Two areas continue to be addressed:

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occupancy and residents not being available to receive EPSDT services.

First, occupancy over the five months has averaged 64% versus 96% budgeted. The first three months reflected the expected phase-in of residents with new placements occurring as current residents settled in and the program was ready to absorb more residents. November occupancy was 85%. County and Victor are working on increasing occupancy.

Second, four (4) of the current residents attend public school (versus the program related non-public school) and are not present and able to receive EPSDT services provided in the non-public school. This is an impediment to the child's progress in the program and has resulted in lost days of service being billed resulting in losses in the EPSDT component of the program. County and Victor began shifting its available services in order to serve these public school children. The process to shift and add services took longer than anticipated and services began being delivered in January. Moving forward, this issue is resolved. The deficit incurred through December is being discussed between County and Victor.

**Provide an analysis of the actual costs compared to the proposed budget. Comment on any changes made by the provider(s) in operating the program within the funding framework. Discuss why those changes were necessary, when they were made, and how effective they were.**

Attached is Schedule B which is an analysis of the RBS program's staffing through November 30, 2010. Most positions are filled now with some salary savings in certain positions attributable to delayed hiring during the phase-in period.

**Provide an analysis of total RBS provider expenditures and total RBS provider revenues. Address whether the rates paid under the Funding Model for the RBS residential and community components were greater than, equal to, or less than the actual expenditures for each component. If not equal to, discuss the degree to which the rates either exceeded or fell short of actual expenditures.**

Attached is Schedule A which is an analysis of total RBS expenditures and revenues for the reporting period versus budget. The expenditures and revenues are separated into three distinct components: Residential (AFDC), EPSDT (Medi-Cal) and MHSA (DBH).

Residential:

Personnel Costs are 87% of budget

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Operating Costs are 97% of budget

Total Expenditures are 90% of budget

Total Revenues are 68% of budget

Total expenditures are 10% below budget, mostly in personnel costs, and reflect some salary savings during phase-in and a few open positions to date. Total revenues are 32% below budget and are attributable to low occupancy.

#### EPSDT (Medi-Cal):

Personnel Costs are 76% of budget

Operating Costs are 41% of budget

Total Expenditures are 71% of budget

Total Revenues are 32% of budget

Total expenditures have been reduced to 31% below budget to adjust expenses to services delivered as much as possible. Total revenues are 68% below budget and are attributable to low occupancy in the day treatment program and a temporary inability to provide other EPSDT services while certifications and staff training were completed. County and Victor are working to revise its budget and discuss use of MHSA funds for costs related to helping youth maintain their placement, which will offset these losses.

#### MHSA (DBH):

Personnel Costs are 71% of budget

Operating Costs are 8% of budget

Total Expenditures are 63% of budget

Total Revenues are 63% of budget

MHSA funding is cost reimbursement. These dollars fund several specific positions, tasked with helping youth maintain placement, improve their functioning, and facilitate transition to a lower level of care. Many of these activities are not reimbursable by AFDC or Medi-Cal. MHSA also funds certain travel and family related costs if

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necessary and not covered by AFDC or Medi-Cal budgets. To date minimal operating costs have been incurred under this MHSA contract. DBH has committed verbally to use MHSA funds from this contract to cover the costs related to helping youth maintain their placement which will offset losses in other program components. Discussions are ongoing.

**Discuss any extraordinary costs associated with any particular child/youth (i.e., outliers), providing the amount of the cost and what it purchased.**

To date there are no extraordinary costs associated with any particular child/youth.

**If after 24 months of operating the RBS project, has an analysis of the current approved RBS rates versus RBS expenditures been performed in the reporting period and will the RBS rates for continued operation of the program be increased, decreased, or remain the same? If not proposed to remain the same, by how much will they be proposed to increase or decrease and why? If such an analysis has not been performed, when will that analysis be completed?**

This question is not applicable in that this RBS program is not post 24 months of operation.

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**Section H – Impact on AFDC-FC Costs:** This section analyzes the impact of the RBS Reform Project on state and county AFCD-FC program costs for all children served by RBS, and for those children who have entered and exited RBS in 24 months.

- Using the RBS claim fiscal tracking sheets, please complete the information below for all children served by RBS from the start of the project to the end of the reporting period:

**RBS Payments for All Children Enrolled in RBS during the Reporting Period:**

<b>Total Children Served In RBS:</b>	<b>Total: 13</b>	<b>Federal: 56.2%</b>	<b>State: 40%</b>	<b>County: 60%</b>
<b>Federal Payments:</b>				
<b>Residential:</b>	\$247,562.00	\$ 135,757.84	\$42,321.66	\$ 63,482.49
<b>Community:</b>	\$n/a	\$n/a	\$n/a	\$n/a
<b>Post-discharge:</b>	\$n/a	\$n/a	\$n/a	\$n/a
<b>Total Federal Payments:</b>	\$135,757.84			
<b>Non-federal Payments:</b>				
<b>Residential:</b>	\$181,090	\$0	\$72,436	\$108,654
<b>Community:</b>	\$n/a	\$n/a	\$n/a	\$n/a
<b>Post-discharge:</b>	\$	\$n/a	\$n/a	\$n/a
<b>Total Non-federal Payments:</b>	\$181,900			
<b>Total RBS Payments</b>	\$422,652			

**Note 14 youths were enrolled in RBS during the time period, but because of the county’s policy of paying in arrears and the payment information is from July to Nov 2010, only 13 youths payment information has been included. One youth enrolled in RBS in Dec 2010.**

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2. Of the children reported in H1 above, please complete the information below for all children who entered and exited RBS in 24 months:

Note: In the initial report, no children may have completed an RBS program cycle. If so, enter zero.

RBS Payments for Children Entering and Exiting RBS in the 24 month Period:				
<b>Total Children Completing RBS:</b>	<b>Total: 0</b>	<b>Federal: 0</b>	<b>State: 0</b>	<b>County: 0</b>
<b>Federal Payments:</b>				
Residential:	\$ 0	\$ 0	\$ 0	\$ 0
Community:	\$ 0	\$ 0	\$ 0	\$ 0
Post-discharge:	\$ 0	\$ 0	\$ 0	\$ 0
<b>Total Federal Payments:</b>	\$ 0			
<b>Non-federal Payments:</b>				
Residential:	\$ 0	\$ 0	\$ 0	\$ 0
Community:	\$ 0	\$ 0	\$ 0	\$ 0
Post-discharge:	\$ 0	\$ 0	\$ 0	\$ 0
<b>Total Non-federal Payments:</b>	\$ 0			
<b>Total RBS Payments:</b>	\$ 0			

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3. Using the approved Attachment A from the Funding Model, please complete the information below regarding the expected base Foster Care costs for RBS target population children that otherwise would have been served in Foster Care:

Note: If zero have completed, enter zero for this reporting period comparison.

<b>AFDC Base for Comparison:</b>				
	<b>Approved Base Rate Per Child:</b>	<b>\$ 8,974.00</b>		
	<b>Number of Children Completing RBS:</b>	<b>0</b>	(from H2, above)	
	<b>Approved Base Months in Regular Foster Care:</b>	<b>24</b>		
	<b>Applicable Federal Funds Rate:</b>	<b>56.2%</b>		
	<b>Total</b>	<b>Federal</b>	<b>State</b>	<b>County</b>
<b>Base Payment for Target Group:</b>	<b>\$ 0</b>	<b>\$ 0</b>	<b>\$ 0</b>	<b>\$ 0</b>

4. For those children who have completed the RBS program, using the information from H2 and H3 above, subtract H3 from H2 and complete the following information:

	<b>Total</b>	<b>Federal</b>	<b>State</b>	<b>County</b>
<b>RBS Incremental Cost/(Savings)Based On Program Completion:</b>	<b>\$ 0</b>	<b>\$ 0</b>	<b>\$ 0</b>	<b>\$ 0</b>

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Please provide narrative responses to H5 through H7 in the space provided after H7.

5. In viewing the results of Question 4, what aspects of operating RBS contributed to the positive fiscal impact or negative fiscal impact compared to regular Foster Care?
6. Discuss if/how the pattern of usage in EPSDT has changed when compared with the typical usage by similar children/youth in traditional foster care.
7. Discuss if/how the pattern of usage in MHSA has changed when compared with the typical usage by similar children/youth in traditional foster care.

**In viewing the results of Question 4, what aspects of operating RBS contributed to the positive fiscal impact or negative fiscal impact compared to regular Foster Care?**

N/A no youth successfully exited RBS, The probation youth who exited RBS when to juvenile hall and will remain there until she reaches age of majority.

**Discuss if/how the pattern of usage in EPSDT has changed when compared with the typical usage by similar children/youth in traditional foster care.**

There has been no change in the county's usage of EPSDT services. The RBS youth are at such a high level of severity requiring extensive mental health services and the provider has provided similar services under RBS as they would through other programs. There are no significant changes in the provisions of EPSDT for these youth.

**Discuss if/how the pattern of usage in MHSA has changed when compared with the typical usage by similar children/youth in traditional foster care.**

Children or youth in traditional foster care access MHSA programs through a spectrum of different programs depending upon need. For foster youth with more severe needs the MHSA programs typically focus on improving daily functioning, preventing hospitalizations, ensuring a sustained residence or educational placement, engaging in community activities, and transitioning to a lower level of care as appropriate. These points of focus remain valid for RBS youth, and in that manner there is not a difference between typical usage of foster youth with a similar level of difficulties. However, at least during this start-up year, there is a different pattern of usage in that more funds are being directed at ensuring a sustained residence. This different pattern appears to be due, in part, to the vacancies within the residential program and need to still support a full and broad program to help these youth maintain a residence at the RBS home.

**Victor Treatment Centers Inc**  
**RBS Program**  
**Statement of Expenditures & Revenues**  
**June 28, 2010 to November 30, 2010**

Attachment A

	Residential (AFDC)			EPSDT (Medi-Cal)			MHSA (County DBH)		
	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
Staff Compensation	201,011	227,631	26,620	102,722	136,411	33,689	100,106	131,490	31,384
Taxes & Benefits	76,260	91,053	14,793	48,683	63,092	14,409	30,091	52,596	22,505
<b>PERSONNEL COST</b>	<b>277,271</b>	<b>318,684</b>	<b>41,413</b>	<b>151,405</b>	<b>199,503</b>	<b>48,098</b>	<b>130,197</b>	<b>184,085</b>	<b>53,888</b>
Professional Fees	4,113	5,000	887	5,488	14,985	9,497	545	1,667	1,122
Supplies	16,051	18,000	1,949	687	1,069	382	18	0	(18)
Tel & Postage	2,862	6,208	3,346	0	486	486	0	0	0
Occupancy	30,331	27,167	(3,164)	9,618	8,586	(1,032)	0	0	0
Equip Rental & Maint	6,725	4,194	(2,531)	624	1,620	996	174	0	(174)
Transportation	21,146	13,217	(7,929)	2,207	7,274	5,067	1,233	15,669	14,436
Confer & Meetings	1,407	1,250	(157)	0	810	810	0	0	0
Direct Asst to Children & Families	8,277	12,650	4,373	936	11,761	10,825	0	8,333	8,333
Liability Insurance Exp	1,015	2,000	985	496	1,215	719	0	0	0
Misc	1,239	6,125	4,886	0	1,215	1,215	0	0	0
<b>TOTAL OPER EXPENSE</b>	<b>93,166</b>	<b>95,810</b>	<b>2,644</b>	<b>20,056</b>	<b>49,021</b>	<b>28,965</b>	<b>1,970</b>	<b>25,669</b>	<b>23,699</b>
<b>SUBTOTAL DIRECT COSTS</b>	<b>370,437</b>	<b>414,495</b>	<b>44,058</b>	<b>171,461</b>	<b>248,524</b>	<b>77,063</b>	<b>132,167</b>	<b>209,754</b>	<b>77,587</b>
<b>SHARED PROGRAM SUPPORT</b>	<b>59,256</b>	<b>61,218</b>	<b>1,962</b>	<b>22,318</b>	<b>21,323</b>	<b>(995)</b>			<b>0</b>
<b>TOTAL DIRECT COSTS</b>	<b>429,693</b>	<b>475,713</b>	<b>46,020</b>	<b>193,779</b>	<b>269,847</b>	<b>76,068</b>	<b>132,167</b>	<b>209,754</b>	<b>77,587</b>
<b>INDIRECT COST</b>	<b>28,556</b>	<b>33,183</b>	<b>4,627</b>	<b>11,097</b>	<b>18,889</b>	<b>7,792</b>	<b>8,833</b>	<b>14,688</b>	<b>5,855</b>
<b>TOTAL EXPENSE</b>	<b>458,249</b>	<b>508,896</b>	<b>50,647</b>	<b>204,876</b>	<b>288,737</b>	<b>83,861</b>	<b>141,000</b>	<b>224,442</b>	<b>83,442</b>
AFDC Revenue	347,073	508,896	161,823						
MHSA Revenue									
EPSDT									
Day Treatment + Med Support				0	102,411	102,411	139,690	224,442	84,752
				91,950	186,326	94,376			
<b>TOTAL REVENUE</b>	<b>347,073</b>	<b>508,896</b>	<b>161,823</b>	<b>91,950</b>	<b>288,737</b>	<b>(196,786)</b>	<b>139,690</b>	<b>224,442</b>	<b>84,752</b>
<b>TOTAL REV OVER EXP</b>	<b>(\$111,176)</b>	<b>\$0</b>	<b>(\$111,176)</b>	<b>(\$112,926)</b>	<b>\$0</b>	<b>(\$112,926)</b>	<b>(\$1,310)</b>	<b>\$0</b>	<b>(\$1,310)</b>

Victor Treatment Centers Inc  
RBS Program  
Staffing Detail  
June 28, 2010 to November 30, 2010

Attachment B

	Residential (AFDC)			EPSDT (Medi-Cal)			MHSA (County DBH)		
	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
Staff Compensation	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Transition/Family Clinician	\$0	\$0	\$0	\$14,752	\$21,465	\$6,713	\$0	\$0	\$0
MHRS/Life Coach Mentor	\$0	\$0	\$0	\$33,072	\$30,780	(\$2,292)	\$0	\$0	\$0
Behavioral Support Staff	\$0	\$0	\$0	\$0	\$0	\$0	\$24,986	\$40,667	\$15,681
Progr Analyst/Qual Assur	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$11,250	\$11,250
Peer Advocate	\$0	\$0	\$0	\$0	\$0	\$0	\$2,803	\$5,833	\$3,030
Office Support	\$0	\$0	\$0	\$0	\$0	\$0	\$8,977	\$11,250	\$2,273
TBS Worker	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
CCT Facilitator	\$0	\$0	\$0	\$0	\$0	\$0	\$30,746	\$29,167	(\$1,579)
Parent Partner	\$0	\$0	\$0	\$0	\$0	\$0	\$7,879	\$11,875	\$3,996
DT Coordinator	\$0	\$0	\$0	\$5,638	\$11,115	\$5,477	\$0	\$0	\$0
Clinicians	\$0	\$0	\$0	\$31,896	\$42,201	\$10,305	\$0	\$0	\$0
MHRS/Life Coach Mentor	\$0	\$0	\$0	\$12,714	\$15,390	\$2,676	\$0	\$0	\$0
Nurse	\$0	\$0	\$0	\$4,650	\$10,798	\$6,148	\$0	\$0	\$0
Support	\$0	\$0	\$0	\$0	\$4,662	\$4,662	\$0	\$0	\$0
RSS	\$33,288	\$37,696	\$4,408	\$0	\$0	\$0	\$0	\$0	\$0
Safety Officer	\$25,318	\$28,671	\$3,353	\$0	\$0	\$0	\$0	\$0	\$0
Residential Counselors	\$142,405	\$161,264	\$18,859	\$0	\$0	\$0	\$24,715	\$21,448	(\$3,267)
<b>Total Staff Compensation</b>	<b>\$201,011</b>	<b>\$227,631</b>	<b>\$26,620</b>	<b>\$102,722</b>	<b>\$136,411</b>	<b>\$33,689</b>	<b>\$100,106</b>	<b>\$131,490</b>	<b>\$31,384</b>
Taxes and Benefits	\$76,260	\$91,053	\$14,793	\$48,683	\$63,092	\$14,409	\$30,091	\$52,596	\$22,505
<b>PERSONNEL COST</b>	<b>\$277,271</b>	<b>\$318,684</b>	<b>\$41,413</b>	<b>\$151,405</b>	<b>\$199,503</b>	<b>\$48,098</b>	<b>\$130,197</b>	<b>\$184,086</b>	<b>\$53,889</b>