

**Residentially Based Services (RBS) Reform Project
County Annual Report (CAR)**

Demonstration Site: <u>San Francisco</u>	Reporting Period: <u>Calendar Year 2011</u>
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Instructions: Pursuant to the legislative requirements for implementing RBS, each county participating in the RBS Reform Project shall prepare and submit an annual report. The report is to be developed in collaboration with the private nonprofit agencies participating in the demonstration project. This County Annual Report (CAR) is to be prepared by the county as a single, comprehensive report for the reporting period. 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, as indicated below and on the following pages. Additional information may be attached as necessary.

Section A - Client Outcomes:

1. Complete the table below on the characteristics of the target population served in this reporting period.

Total Number of Youth:	Average Age of Youth:	Number of Youth who are:	Number of Youth who are:	Number of Youth Placed by:
21	13.1 years	Male: 15 Female: 6	African-American: 15 Caucasian: 1 Hispanic: 3 Other: 1 African American/Samoan 1 African American/Caucasian	Probation: Child Welfare: 21 Mental Health: Other:

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2. **Using the Child Welfare Services/ Case Management System (CWS/CMS) outcome data provided by CDSS, address the following regarding any disenrollments, step downs to lower levels of care and/or achievements to permanency:**

a. Describe any trends indicated by the data.

Disenrollments:

The 3 children who disenrolled were part of the first cohort of youth when the intake process was less clearly defined. Of these, one youth was incarcerated for more than 14 days and one went AWOL more than 14 days. Both of these youth were in the RBS program about 2 months. The third youth was stepped down after nearly 5 months in the RBS residential component to an elderly relative caregiver. Several weeks thereafter, there was a physical altercation in which the relative was injured. The youth returned to the residential for crisis stabilization and was subsequently discharged back to the RCL 12 facility due to escalating aggression and behavioral concerns. Ultimately, this youth was moved to a different treatment facility.

Step-downs to Lower Levels of Care:

7 children were stepped down to family settings and have remained in such settings. San Francisco is fortunate as one of its providers has an ITFC program through which 4 children were stepped down to foster families. One of the youth was even able to move from an NPS to a public school. The RBS staff describe the youth as presenting completely differently in terms of behavior and attitude when they come back on campus. Family finding and engagement has continued for these children as well as for those in other family settings. Two youth transferred to relative or NREFM placements, and another child was placed in an adoptive home, something that was not even on the horizon when the RBS program started. These success stories would likely not have happened in such a relatively short timeframe without the RBS program. When the program is successful, the stories are powerful and inspiring, due in no small part to the tremendous commitment, communication, and dedication of the RBS team.

Step-downs and Return to Residential

Two children were stepped down but then came back into the RBS residential. One was placed in a foster home but psychiatric symptoms escalated and 2 5150s were required. The foster placement disrupted and the youth came back into care. This particular youth has a number of family members involved who have remained in contact with her, although they are not currently placement options. The other child was placed with a NREFM who did not take advantage of the in-home supports from the RBS team, and ultimately gave a 7 day notice, even though the child's behavior was appropriate. That child came back to the RBS residential and is soon to be placed with another NREFM. Although their initial placements were not successful, the

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children were able to come back to a familiar program and people they knew, rather than a strange and unfamiliar placement likely at great distance. The provider has continued to work with the families and various supports to ensure good permanency planning for these children.

Permanency planning requires tremendous dedication as it can be a significant challenge for these high-needs youth. There has been greater success in the number of community placements for the provider with a robust ITFC program. This resource has been very helpful in creating good bridge care options, which is particularly important given how short the residential component is for this site. Travel must also be considered in step-down; many youth are placed at long distances from the RBS provider and staff travel time must be considered in developing good in-home support for community placements. Flexible staff schedules are also a factor to be considered.

	Number	Percent
Total Enrolled in 2011	21	100%
Stepped down/stayed down ¹	7	33%
Did not step down (11) or stepped down but back up again (3)	14	67%
Reunified since enrollment	0	0%

1. "Step downs" are defined as placement changes to lower levels of care that occurred after RBS enrollment, and remained in place through 2011. This group also includes two children who had crisis stabilization activity but ultimately remained "stepped down".

2. Three children in the "Did not step down" group did have placement changes to lower levels of care since RBS enrollment but they stepped back up where they remained through 2011. In addition, three children in this group disenrolled from RBS.

b. Can any conclusions be made from the data? If yes, what are they? If no, why not?

Yes No Explain:

While there are some preliminary results, this site has not been operating long enough to draw any useful conclusions at this time.

In addition, trends should be interpreted with caution because of the small number of

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enrollees. Nevertheless, we observe two preliminary trends:

- 1) RBS children exhibit varying placement histories, ranging from 2 to 24 separate placements prior to enrollment. The average number of placements before enrolling in RBS was 7.4, indicating that the intervention is reaching children well into their placement careers. Among those who successfully stepped down, the average number of placements was somewhat lower – 6.3. Among those who did not yet step down, the average number of prior placements was 8.0. The number of placements, as well as other aspects of children’s placement and maltreatment reporting history prior to the intervention should be considered before drawing conclusions about the impact of RBS.

- 2) There is some variation in RBS exposure to date, and this should be considered when examining the impact of the intervention. The mean number of days in RBS among all 21 enrollees was 205 (by 12/31/11). Among the seven who stepped down, mean duration was higher – 292 days. The remaining children who did not step down had lower exposure times (i.e., enrolled later in the year), at 162 days.

Mean number of placements prior to enrollment	7.4
Among those (7) who stepped down	6.3
Among those (14) who did not step down, or stepped down and back up again	8.0
Mean duration in RBS	205
Among those (7) who stepped down and remained down	292
Among those (14) who did not step down, or stepped down and back up again	162

3. a. **Complete one attached excel document titled, “RBS Days of Care Schedule” for each RBS provider listing information for each youth enrolled in RBS since implementation of the Project. This document captures information on the total days in care in residential, community-based bridge care, after-care and crisis stabilization.**

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b. For youth in crisis stabilization, what were the reasons for the returns to group home care for crisis stabilization?

Five youth have returned for crisis stabilization stays with two of the providers. Two returned for a single night, and were successfully reunified with their caretakers. Two other youth returned for several nights, during which time there were emergency FST meetings and the team was able to return the youth successfully to their caretakers.

The reasons for crisis stabilization in these four situations include: one youth threatening to run away; two others refusing to return home in order to avoid conflict; and the fourth was due to an escalating conflict in the home. In all three cases the team determined that it was important to return to the RBS unit for a brief crisis de-escalation stay. This gave the team time to get a meeting together with the family and to make a plan for a successful return home.

A fifth youth returned for crisis stabilization after an incident with his elderly caregiver, in which she was injured and subsequently decided she could not take him back into her home due to safety issues. This child was later disenrolled from RBS and returned to the RCL unit with the same provider due to: his mental health needs; safety concerns for him and his caregiver; and the need for more time to develop an appropriate permanency plan given the escalating behavior.

In all of these cases the crisis stabilization component of the program resulted in a continuity of care that would not have occurred had they not been enrolled in RBS.

c. From the county perspective, is there a need to improve the effectiveness of crisis stabilization? If yes, how will this be accomplished?

Yes No **Explain:**

There was some lack of clarity about the protocols and procedures, so a policy document was written up and distributed to address this problem. This included discussion about timely communication of the crisis and role of the team, including the provider, caretaker, and child welfare staff, in determining the need for crisis stabilization. It is important that the decision to stabilize the child in the residential treatment is not driven by a single entity.

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Section B - Client Involvement:

1. Using the Child and Adolescence Needs and Strengths (CANS) data provided by Walter R. McDonald & Associates (WRMA), address the following:

- a. Describe any trends indicated by the data.

At the time of this report there was only baseline data available, so there is not sufficient data to establish trends at this time.

- b. Can any conclusions be made from the data? If yes, what are they? If no, why not?

Yes No Explain:

This program is still in an early stage of start-up, so there is not sufficient data from which to draw conclusions.

2. a. Complete the table below on family and youth participation in child/family team meetings.

Total Number of Youth:	Total Number of Youth with at least one Supportive Adult:	Number of Youth Participating in at least 90% of their Child/Family Team Meetings:	Number of Youth with Supportive Adult(s) Participating in at least 90% of that Youth's Child/Family Team Meetings:
21	16	15	15

- b. If youth did not participate, explain why not.

All youth were supported and encouraged to participate in the Family Support Team (FST) meetings, which are typically 1 ½ to 2 hours long. However, five youth had difficulty sitting through the entire FST meetings, or declined to participate in meetings, due to mental health challenges and/or developmental status. In all these cases, the children were encouraged to attend for as much of the meeting as possible, and to take part in their action plan development and review. Having the child in the meeting, and having the parents, minor's attorneys, clinicians, and others speak to the child's interest, has consistently shaped and informed the meetings and related planning.

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Section C- Client Satisfaction:

1. Using the Youth Satisfaction Survey (YSS) and Youth Satisfaction Survey-Families (YSS-F) data provided by WRMA, specifically 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, address the following:

- a. Describe any trends in the data.

There were only baseline surveys completed during the calendar year of 2011, so it is too early to identify any trends in the data.

- b. Can any conclusions be made from the data? If yes, what are they? If no, why not?

Yes No Explain:

See above.

Section D – County and Provider Use of RBS Program:

1. a. Has the operation of the program significantly changed from the original design described in the approved plan? If yes, describe the change.

Yes No Explain:

- b. If yes, how has this adaptation impacted the effectiveness of the project?

N/A

2. Describe the interactions (such as, collaborative efforts towards placements, exits, services planning, etc.) among and between the county agencies (including Child Welfare Services, Mental Health, Probation, Regional Center, etc.), the provider(s), and other community partners.

Child Welfare has been very active in their oversight function from the County lead, to the HSA supervisors and CWW's, who regularly attend the FST meetings at each site. One of the challenges has been to educate the large number of CWWs and their

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supervisors on the RBS program, since there are multiple workers carrying RBS cases. By doing so SFHSA expects that the RBS philosophy will become embedded more quickly through out the agency, rather than being viewed as a more boutique program.

Mental Health's primary point of engagement is at the MAST meetings when referrals and cases are discussed, and in overseeing EPSDT contracts with the providers.

The providers and county staff meet regularly in various forums to review individual cases, develop policy and protocols, and resolve issues that arise. There has also been strong collaboration and partnership between the provider staff. This support has helped strengthen their individual programs, as well as ensure consistency in the model.

- 3. Have there been any significant differences from the roles and responsibilities delineated in the approved plan for the various county agencies and provider(s)? If yes, describe the differences.**

Yes No Explain:

- 4. Were RBS enrollments sufficient during the reporting period? If no, why not?**

Yes No Explain:

One of the providers had a late start-up, while youth in another program needed to stay in residential longer than the estimated time frame, impacting new referrals. This provider also experienced considerable staff turnover which impacted their capacity to serve additional youth.

A challenge for the S.F. site has been in serving a population of youth who have been in the child welfare system for years, and do not have strong family connections. This has necessitated a very robust family finding effort, and recruitment for specific ITFC families to serve as bridge care for many of the youth.

Recent outreach efforts have been made to the broader group home population to try and identify youth who have current family involvement, and as such may be a better fit for RBS. This approach has already brought some success.

- 5. Describe how the county and provider(s) managed RBS staff resources (e.g., filling vacancies, redefining job qualifications, eliminating positions, etc.)**

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Two of the providers have only recently hired family (parent) partners, and one of the providers has experienced significant staff turn-over at all levels, which has impacted their roll-out of RBS. Due to the small numbers of clients, all of the providers have staff fulfilling multiple roles within the RBS program and across programs as well. This has required great flexibility and commitment on the part of staff and agencies in terms of schedules, job duties, and roles.

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Section E –County Payments to Nonprofit Agency(ies):

Note: The payments reported here are from the county records as recorded on a cash basis during the reporting period from January 1 to December 31, for all providers participating in the RBS demonstration project.

1. For Questions a through c, please complete the table below:
 - a. 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:
 - AFDC-FC (The amounts reported here should come from the amount reported under G1, amount claimed per fiscal tracking sheet. They will not be equal because G1 is cumulative for the project and E1 is only for the reporting year.)
 - EPSDT
 - MHSA
 - Grants, loans, other (Itemize any amounts reported by source.)
 - b. Provide the average months of stay for all children/youth in residential (group home) care during the reporting period.
 - c. Provide the average months of stay for all children/youth in community services (not in group home) during the reporting period.

	AFDC	EPSDT	MHSA	Other	Total
Amount Paid for Residential	\$952,285.48	\$ 243,463	\$	\$	\$1,195,748
Amount Paid for Community	\$20,826.70	\$ 42,861	\$	\$	\$ 63,688
Total Amount Paid	\$973,112.18	\$ 286,324	\$	\$	\$1,259,436
Avg Months of Stay in Residential	5.01	5.01	–	–	
Avg Months of Stay in Community	3.76	3.76	–	–	
Avg AFDC Payment Per Youth in Residential	\$9,058.00	\$2,316	–	–	\$ 11,374
Avg AFDC Payment per Youth in Community	\$ 554.00	\$1,140	–	–	\$ 1,694

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2. **Were any changes made to the Funding Model in order to manage payment shortfalls/overages, incentives, refunds during the reporting period? If yes, explain what the changes were and why they were needed.**

Yes No Explain:

No major changes have been made to San Francisco's Funding Model in the reporting period. Some clarifications have been made:

Per RBS Letter 03-11, youth receiving Emergency Assistance Foster Care may also be enrolled in the RBS program, claimed, and included in cost neutrality calculations using their unique federal, state, and county shares of cost.

Crisis stabilization services are paid at the same rate as RBS Residential Services (\$11,000/mo, prorated) but for no more than 14 days. After the fourteenth day the youth must be in a different RBS component (RBS Residential, RBS Community-ITFC, or RBS Community- Other).

If a youth enrolled in RBS is temporarily AWOL, hospitalized, or in Juvenile Hall for 14 days or less, and was in any RBS placement type immediately before and after that absence, then San Francisco shall pay the Community rate of \$3,500/month (including within that, any foster care maintenance payment to a foster home, relative, or non-related extended family member) for those specific days away. After fourteen days a decision about placement and/or RBS enrollment for the youth must be made. This is in line with directions from CDSS.

Any youth who is disenrolled early before graduation from the RBS program shall not be included in San Francisco's Payment Reconciliation process between the county and that RBS provider Youth who graduate early shall be included, and in the divisor these youth shall be counted as one (1). This process mirrors the methodology that CDSS uses in Section G of the County Annual Report where only youth who have successfully completed the RBS program or are still in the program at the 24 month mark are included in the financial comparison for cost neutrality.

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Section F – Actual Costs of Nonprofit Agency(ies):

Note: The amounts reported here should be based on each provider's accounting records for RBS for the period from January 1 through December 31, and be on a basis consistent with the method used to report costs on the annual A-133 Financial Audit Report (FAR) and SR-3 document filed with CDSS.

1. a. For residential costs, complete the table below displaying provider actual costs compared to the RBS proposed budget included in the approved Funding Model. If there is more than one provider in the demonstration project, combine the individual provider data into one table for the project. The wording in the chart below is consistent with the SR-3 financial report. Definitions are listed in the instructions (RBS Letter No. 04-11).

Actual Costs in RBS Residential:

Expenditures:	Proposed Budget for the Period	Actuals for the Period	Over/(Under) Budget
Total Salaries & Benefits	\$ 1,258,777	\$ 1,310,302	\$ 51,524
Total Operating Costs	\$ 250,213	\$ 487,129	\$ 236,916
Total Child Care & Supervision Costs	\$ 660,167	\$ 755,198	\$ 95,031
Total Mental Health Treatment Services Costs	\$ 458,489	\$ 405,112	\$ -53,377
Total Social Work Activity, Treatment & Family Support Costs	\$ 33,937	\$ 40,440	\$ 6,503
Total Indirect Costs	\$ 181,079	\$ 253,156	\$ 72,077
Total Expenditures	\$ 1,690,069	\$ 2,050,586	\$ 360,517

- b. Does the difference between the actual provider costs and the proposed budget exceed 5% on any line item above? If yes, explain what caused the variance and whether this difference is expected to be temporary or permanent.

<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Explain:</p> <p>The budget figures given are extrapolated from the Rate Calculation Worksheet in the Funding Model using the number of days every client has been in the Residential component of RBS, per the Days of Care work sheet. The total days of care in Residential was multiplied by the sum of the daily Residential and Mental Health rates from the Rate Calculation Worksheet. The total expenditures reflect the total of Salaries & Benefits, Operating, and Indirect costs. The lines for Child Care & Supervision, Mental</p>

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Health Treatment Services, and Social Work Treatment and Family Support Costs are costs that are subsets of costs already included in Salaries & Benefits and Operating.

Most of the costs over budget can be attributed to a provider who had a low client census in the Residential component because youth were enrolled over a period of time, and therefore there were few economies of scale. To mitigate this they have begun sharing more of their RBS operational costs with other programs that they operate. Also as their census increases this issue will diminish, although in the future as they have to scale back from 14 clients it could present itself again.

2. a. For community costs, complete the table below displaying provider actual costs compared to the RBS proposed budget included in the approved Funding Model. If there is more than one provider in the demonstration project, combine the individual provider data into one table for the project. This wording in this chart is consistent with the SR-3 financial report. Definitions are listed in the instructions (RBS N Letter No. 04-11).

Actual Costs in RBS Community:

Expenditures:	Proposed Budget for the Period	Actuals for the Period	Over/(Under) Budget
Total Salaries & Benefits	\$ 228,696	\$ 336,029	\$ 107,333
Total Operating Costs	\$ 54,407	\$ 113,100	\$ 58,692
Total Child Care & Supervision Costs	\$ 39,605	\$ 198,118	\$ 158,514
Total Mental Health Treatment Services Costs	\$ 163,971	\$ 105,899	\$ -58,072
Total Social Work Activity, Treatment & Family Support Costs	\$ 5,524	\$ 10,909	\$ 5,385
Total Indirect Costs	\$ 35,784	\$ 51,908	\$ 16,123
Total Expenditures	\$ 318,888	\$ 501,036	\$ 182,149

- b. Does the difference between the actual provider costs and the proposed budget exceed 5% on any line item above? If yes, explain what caused the variance and whether this difference is expected to be temporary or permanent.

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Yes **No** **Explain:**

The budget figures given are extrapolated from the Rate Calculation Worksheet in the Funding Model using the number of days every client has been in the Community component of RBS, per the Days of Care work sheet. The total days of care in Community was multiplied by the sum of the daily Community (average of ITFC and Community, minus family maintenance payments) and Mental Health rates from the Rate Calculation Worksheet. As stated above, the total expenditures reflect the total of Salaries & Benefits, Operating, and Indirect costs. The other three lines are costs that are subsets of costs already included in Salaries & Benefits and Operating.

Since San Francisco started enrolling youth in RBS in March, even the providers who have had youth step down, have had a relatively short amount of time in step-down. That means only a short amount of time has been available to develop staff scheduling and other systems to lower their costs. It also is likely that as youth are stepped down for longer periods of time and are more stabilized in the community, the costs of providing RBS Community services will decline and the average costs throughout the entire period of RBS Community services will be within budget.

- 3. Were there extraordinary costs associated with any particular child/youth (i.e., outliers as defined in the Funding Model)? If yes, provide the amount of the cost and describe what it purchased.**

Yes **No** **Explain:**

- 4. Has the county performed the fiscal audit required by the MOU? If yes, describe any problems/issues with the provider's operations or implementation of the Funding Model that were disclosed by the fiscal audit performed. If no, when will that audit occur?**

Yes **No** **Explain:**

San Francisco has not performed the fiscal audit required by the MOU because we have not yet reached the 12th month of RBS Implementation. We anticipate that audit will be completed in the required time frame between April 2012 and the end of February 2013.

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Section G – Impact on AFDC-FC Costs:

1. This is a cumulative report from the beginning of the project. Amounts reported are based on the amounts included in the claim presented to CDSS. 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 Payment for All Children Enrolled in RBS from the Start of the Project Through the End of the Reporting Period:
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	Total	Federal	State	County
Total Children Served In RBS: _____ 21 _____				
Federal Payments:				
Residential:	\$ 867,675.38	\$ 369,591.00	\$ 199,270.00	\$ 298,904.38
Community:	\$ 20,733.70	\$	\$ 8,293.00	\$ 12,440.70
Total Federal Payments:	\$ 888,499.08	\$ 369,591.00	\$ 207,563.00	\$ 311,345.08
Non-federal Payments:				
Residential:	\$ 63,564.35	\$ 0	\$ 25,427.00	\$ 38,137.35
Community:	\$ 21,049.00	\$ 0	\$ 8,420.00	\$ 12,629.00
Total Non-federal Payments:	\$ 84,613.35	\$ 0	\$ 33,847.00	\$ 50,766.35
Total RBS Payments	\$ 973,112.43	\$ 369,591	\$ 241,410.00	\$ 362,111.43

Note: It is possible to have federal funds used in the Non-federal Payment (i.e., non-federal RBS children) category. These payments would be the federal share of any Emergency Assistance Funding used in the RBS program up to the first 12 months of a child's stay in RBS. The amounts reported would come from the non-federal fiscal tracking sheet, and are based on the instructions provided in RBS Letter No. 03-11.

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2. **Of the children reported in G1 above, please complete the information below for all children who successfully entered and exited RBS in 24 months, or remained in RBS for a full 24 months.**

Note: When completing G2, it is important to understand how G2, G3, and G4. work to form the comparison to regular AFDC costs. Section G4 is a comparison of cost for those children who have completed RBS (From G2) to the cost of regular foster care based on the target group base period (G3). In this context, a child "completing RBS" is one who has either entered the program and then exited after successfully completing his/her RBS program goal, or one who has entered the program and remained in the program longer than the base period (24 months). The comparison in Section G4 is done only for those children who have successfully completed the RBS program goal or are still in the program at the 24 month mark. The count of children for Section G2 and the related costs are only for those children who have completed the RBS program or remained in RBS longer than 24 months. For example, a child entering RBS who remains in the program for only 3 months and then is disenrolled would not be included in G2. A child entering RBS and still in the program at month 26 would be included in G2.

RBS Payments for All Children Entering and Exiting RBS in the 24 Month Period or Remaining in the Program for Longer than 24 Months. (Include all children meeting this condition from the beginning of the project.):

Total Children Completing RBS: <u> 0 </u>	Total	Federal	State	County
Federal Payments:				
Residential:	\$	\$	\$	\$
Community:	\$	\$	\$	\$
Total Federal Payments:	\$			
Non-federal Payments:				
Residential:	\$	\$	\$	\$
Community:	\$	\$	\$	\$
Total Non-federal Payments:	\$			
Total RBS Payments:	\$			

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3. Using the approved Attachment A from the Funding Model and the number of children reported in G2 (above), 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: Since this is used to compare the base AFDC-FC rates had the RBS youth remained in regular foster care, the “Approved Base Rate Per Child” is the weighted average of AFDC-FC payments for RCL 12 and RCL 14 placements as described and approved in the Funding Model. The “Approved Base Months in Regular Foster Care” section is the approved comparison length for the RBS youth had they remained in regular foster care. For all RBS counties, the approved base months in regular foster care is 24 months, based on the demographic for the current length of stay in a group home for the target group. The “Applicable Federal Funds Rate” is the percentage of federal funds rate based on the Federal Medical Assistance Percentage (FMAP) used in the RBS claim. The CAR template has this FMAP funding rate pre-loaded at 50% because all of the RBS Funding Models used the pre-ARRA FMAP rate of 50% for approval purposes. However, because Section G1 of the CAR instructs counties to use financial costs based on the RBS Fiscal Tracking sheets, counties must use the ARRA rate in effect for that month and quarter. For the months through and including December 2010, the ARRA rate is 56.2%. For the months beginning January 2011, the ARRA rate will decline until it reaches 50% beginning July 2011. Details on the ARRA rates used in the RBS claim are in an RBS claim letter. In order to produce a correct comparison of costs between sections G1, G2 and G3, whatever federal funds rate is used in Section G1 should be the same rate used for G2 and G3.

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

AFDC Base for Comparison:				
Approved Base Rate Per Child:		\$		
Number of Children Completing RBS:			(from H2, above)	
Approved Base Months in Regular Foster Care:		24		
Applicable Federal Funds Rate:		50%		
	Total	Federal	State	County
Base Payment for Target Group:	\$	\$	\$	\$

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4. a. For those children who have completed the RBS program, using the information from G2 and G3, subtract G3 from G2 and complete the following information:

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

- b. What aspects of operating RBS contributed to the cost/savings compared to regular Foster Care?

5. Has EPSDT usage changed when compared with the typical usage by similar children/youth in traditional foster care? If yes, explain how it is different.

Yes No Explain:

EPSDT billing has changed in that EPSDT budgets were increased for the RBS providers to allow for billing of individual rehabilitation. The trajectory in the last several years for San Francisco's EPSDT budget overall has been to increase, although last year it stabilized somewhat. While EPSDT expenditures were less than budgeted as reported by the RBS providers, EPSDT expenditures for this program have increased to allow for individual rehabilitation and serving youth and families in community settings.

6. Has MHSA usage changed when compared with the typical usage by similar children/youth in traditional foster care? If yes, explain how it is different.

Yes No Explain:

N/A: MHSA funds are not used in San Francisco's pilot.

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Section H – Lessons Learned:

1. Describe the most significant program lessons learned and best practices applied during the reporting period.

The most significant program lessons learned and related best practices include:

- the importance of appropriate referrals;
- early and aggressive family finding efforts;
- availability of bridge care options such as ITFC homes;
- the importance of having regular FST meetings and involvement of family members early, and often, in the program;
- the importance of parent partners
- good communication and education of CWWs, attorneys, and other stake holders in the RBS model;
- flexible staffing;
- individualized treatment plans and portable interventions.

Providers have needed to be creative in striking a balance between enacting pre-existing, static program structures (schedules, rules, consequences, and privileges), and having enough adaptability/fluidity within the program to meet the differing needs of each of our families and clients. Having a foundational residential structure was helpful for supporting the clients in the absence of family presence and for providing a parenting blueprint for those families that needed more support in the area. And, we found – in attempting to stay true to the charge of creating a program that holds parents and families as integral parts of the process and better preparing youth for the home-settings that they would be stepping down to – that the structure needed to be flexible enough to accommodate varying family expectations on an individual family basis (for example, varying rules around electronics use, differing community activity participation expectations throughout the week, or creating consequences that could realistically be carried out at RBS and in a specific client's home).

As clients began to move more and more into the community component of the program, it also became clear that programs need more flexibility than a traditional residential staffing schedule allows in order to support the needs of all of the clients. To meet the needs of those youth still in the residential portion of the program AND the kids in the community, providers have needed to be creative about freeing Family Support Specialists up to work both residential style shifts (8 hours at a time) in the house and wraparound style shifts that are more action-step oriented (completing a task in the community with a client or doing parent coaching for a couple of hours in a child's home).

While two of our providers began with children already residing in their residential programs, one, Seneca Center, established a new RBS facility and planned to take in youth from their Community Treatment Facility (CTF). For Seneca, it was harder than expected to map the new RBS program on to the preexisting administrative infrastructure at the CTF. This is due to a couple of factors. The RBS program is not housed in the same facility as the CTF program

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and so communication has been more difficult than expected. More was added on to people plates task-wise with the new RBS duties which was hard for the CTF administrative team to balance. As we moved forward, it became clear that RBS is not an appropriate step down all of the young people transitioning out of the CTF, which led to youth entering the Seneca RBS program from other placements. Without a previous relationship to the CTF or Seneca, the expected continuity from the CTF system into the RBS system is not present. The Seneca Care Coordinator Team has been integral in strengthening the cross program connection as they are housed at the CTF but hold all of the RBS clients. This lesson is noteworthy given that the other two providers have begun or will begin taking in children directly into RBS from other placements during the 2nd year of the pilot.

For related discussion, please refer to the site review document “Residentially Based Services (RBS) Reform Project Feedback Report for San Francisco Demonstration Site Review Conducted November 29, 2011,” which further describes best practices and lessons learned for the San Francisco site.

2. Describe the most significant fiscal lessons learned and best practices applied during the reporting period.

One of the most significant lessons learned relates to the mental health funding stream, specifically the importance of increasing contracts with providers to allow for EPSDT dollars needed to support the enhanced mental health services provided by the RBS program. While the goal is to ensure EPSDT cost neutrality overall, the individual providers needed the increased fiscal support to provide mental health services to youth in the community settings as well as the residential settings they had traditionally supported.

There have been significant systems challenges in utilizing CalWIN, the county automated payment system. CalWIN prohibits multiple payments on behalf of the same client for the same period. Consequently, the system will not permit payment for the provider’s claim for services provided to the youth while in the community component of RBS in the same month that the family receives a payment. SFHSA has explored revising the CalWIN system but has been informed that such a fix will take approximately a year and will require expending additional county funds to resolve.

The MediCal automated payment system, Avatar, has also been challenging for providers and the CBHS staff to utilize effectively. While the Avatar issues are not specific to RBS, those challenges compounded with CalWIN issues have impacted San Francisco’s ability to provide timely and complete payments to providers, creating an additional strain on the RBS program. If RBS is to be expanded to multiple counties, there must be resolution with CalWIN to allow for prompt and complete payments.

Economy of scale fiscally impacts the RBS program in various ways. San Francisco’s targeted RBS residential stay of 5 months or less is one example; there is a deliberate fiscal incentive built into the program model to support moving children into the community quickly. However,

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it is important to remember that some children will be ready within a shorter timeframe, and others will need more support and work with the family prior to stepping down to the community setting. Assuming the pilot was to expand and continue for a more extensive period, there would be enough economy of scale in terms of children and families involved to balance the varying needs of different children and related fiscal impact. With the smaller number of children involved in the pilot, there is less opportunity to do so and requires extensive conversation and commitment to ensure best practices and good outcomes for the children and families.

Providers have also struggled with balancing the cost of the residential program with a low client census. This is particularly true for the Seneca site which had a different ramp-up than the other programs. Such struggles occurred for a number of reasons. The Seneca Community Treatment Facility (CTF) program was originally identified as the sole referral source for RBS. As the RBS program developed, we found that the CTF was in fact not a sustainable referral source; step-downs from the CTF were not frequent enough to meet the speed with which we needed clients at RBS and on top of that not every CTF client transitioning out of that program was appropriate for RBS.

We also found that enrolling clients into the program one by one (as opposed to starting the program off with a cohort of 6 kids that would have filled all of the beds on Day 1 meant that the provider had a long period where overhead costs for the residential well outweighed the client revenue. Sharing as many infrastructure costs with the CTF program as possible (nursing support, a clinical team, operations support, etc.) has been essential in making the program financially viable. As the number of clients increases, there will be enough economy of scale to sustain flexible staffing patterns and adjust for overhead expenditures, but as the pilot winds down we will start to see the issue of overhead expense vs. client revenue as providers scale back from the 14 youth targeted for each site.

