CDSS
WILL LIGHTBOURNE
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • *www.cdss.ca.gov*

EDMUND G. BROWN JR.
GOVERNOR

November 20, 2012

Ms. Debby Jeter, Deputy Director
Family and Children's Services
San Francisco County Human Services Agency
P.O. Box 7988
San Francisco, CA 94120

Dear Ms. Jeter:

SUBJECT: APPROVAL TO AMEND MEMORANDUM OF UNDERSTANDING (MOU) NO. 10-6082 BETWEEN THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES (CDSS) AND SAN FRANCISCO COUNTY REGARDING THE RESIDENTIALLY BASED SERVICES (RBS) REFORM PROJECT

This letter is in response to the request from San Francisco to amend the MOU No. 10-6082 between CDSS and San Francisco County regarding the operation of the county's RBS pilot project. San Francisco County requests the following amendments to the MOU:

- MOU No. 10-6082 Attachment I, Exhibit 1 – Section 3.2 Enrollment Criteria: Amend to increase the total number of youth served by each provider to six youth annually for a total of 18 additional youth served by RBS annually through 2016.

- MOU No. 10-6082– Section C: Extend the term of this MOU to be effective March 4, 2011 through July 1, 2016.

The CDSS approved the amendment as described above. All other terms and conditions of MOU No. 10-6082 remain the same. This amendment is hereby incorporated into MOU No. 10-6082 by inclusion of this letter and its enclosures as Attachment I, Exhibit 5.

Should you have any questions regarding the RBS Reform Project or MOU No. 10-6082, please contact me at (916) 657-2598 or Gregory E. Rose, Deputy Director of the Children and Family Services Division, at (916) 657-2614.

Sincerely,

WILL LIGHTBOURNE
Director

Enclosures

CDSS
JOHN A. WAGNER
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • *www.cdss.ca.gov*

EDMUND G. BROWN JR.
GOVERNOR

March 4, 2011

Ms. Debby Jeter, Deputy Director
Family and Children Services Division
San Francisco Human Services Agency
P.O. Box 7988
San Francisco, California 94120

Dear Ms. Jeter:

SUBJECT: AUTHORIZATION OF THE RESIDENTIALLY BASED SERVICES (RBS) REFORM PROJECT IN SAN FRANCISCO COUNTY

Pursuant to Welfare and Institutions Code (W&IC) section 18987.7 et al (Chapter 466, Statutes of 2007, Assembly Bill 1453), this letter grants approval from the California Department of Social Services (CDSS) to San Francisco County to pursue a pilot demonstration of RBS Reform. In approving this pilot, the determination has been made that the design and operation of the RBS Reform Project for San Francisco County, as described in the enclosed Memorandum of Understanding (MOU), will ensure the health and safety of the children and youth to be served and provides fair and equitable services.

In order to operate this pilot, a waiver is hereby granted of CDSS regulations governing the group home rate setting process contained in Division 11, Manual of Policies and Procedures, sections 11-402.1 through 11-402.4 and section 11-402.9. This waiver and instructions provided in the enclosed MOU shall have force and effect only with respect to the San Francisco County RBS Reform Project.

As permitted by W&IC section 18987.72(d)(1), a county may request approval of waivers, notwithstanding the requirements set forth in subdivision (c) of W&IC section 16501, at any point during the demonstration period. In addition, W&IC section 18987.72(4) permits amendments, modifications, and extensions to the agreement to be made, with the mutual consent of both parties and with approval from CDSS. The CDSS has authority to waive California child welfare law and regulations. Therefore, all federal rules and regulations will remain unchanged unless otherwise informed by the United States Department of Health and Human Services.

For purposes of operating the RBS Reform Project in San Francisco County, please reference the RBS Pilot Rate Notification Letter for specifics on the RBS provider program number, rates, audit provisions, and conditions for rate termination.

All licensed providers participating in the RBS Reform Project shall implement and comply with all state laws, regulations, and policy pertaining to the license of group homes pursuant to Division 6, Chapter 1 and 5 of the California Code of Regulations, Title 22 and must request a waiver or exception from the CDSS Community Care Licensing Division prior to implementing any variation.

Additional information regarding the RBS Reform Project will be provided through numbered RBS letters and other letters of instruction issued by CDSS that will contain pertinent information and instructions on the policies and procedures of the project. The RBS letters can be found on the CDSS website at http://www.childsworld.ca.gov/PG2119.htm.

The RBS Reform Project offers an extraordinary opportunity to test alternative program designs and funding models that can inform state policy makers as they determine the future direction of foster care services. Your willingness to operate this pilot and to participate in its full evaluation is essential to ensuring that credible, informative data is available from which conclusions may be drawn. The CDSS would like to remind you that under the terms of the MOU, after 18 months of the project have been completed, CDSS will be conducting a review of the childrens' progress. To ensure that the costs of implementing the RBS Reform Project for San Francisco County stay within the parameters of your Funding Model, CDSS will be reviewing whether or not children are moving through the residential component in the timeframes contained in your program design, so that a decision can be made if the project should be continued.

Thank you for your commitment to improving the delivery of foster care services to vulnerable children and youth. The CDSS looks forward to working with you, your staff, and other project partners on this exciting pilot demonstration project. In the course of the project, if you should encounter any problems or barriers, please bring them to CDSS' attention as quickly as possible. In the meantime, should you have any questions, please contact Gregory E. Rose, Deputy Director of the Children and Family Services Division, at (916) 657-2614 or Karen Gunderson, Chief of the Child and Youth Permanency Branch, at (916) 651-7464.

Sincerely,

JOHN A. WAGNER
Director

Enclosure

MEMORANDUM OF UNDERSTANDING

between

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

and

COUNTY OF SAN FRANCISCO

This Memorandum of Understanding, hereinafter referred to as Agreement, is entered into by and between the California Department of Social Services, hereinafter referred to as the state, and the County of San Francisco, hereinafter referred to as the county, for the purpose of implementing a pilot demonstration under the Residentially Based Services (RBS) Reform Project.

A. BACKGROUND

The RBS Reform Project is established pursuant to Assembly Bill (AB) 1453, Chapter 12.87 (commencing with Section 18987.7) Part 6 of Division 9 of the Welfare and Institutions Code (W&IC), relating to foster care. This legislation allows for a pilot demonstration project aimed at transforming the current system of group care, currently providing long-term congregate care and treatment, to RBS programs, which combine short-term residential stabilization and treatment with follow along community-based services to reconnect youth to their families, schools and communities.

B. PURPOSE

The purpose of this Agreement is to:

1. Make available to the county, the state share of Aid to Families with Dependent Children – Foster Care (AFDC-FC) funds, in order to allow the county to provide RBS program alternatives;

2. Enable the county to access all possible sources of federal funds for the purpose of developing RBS program alternatives;

3. Specify mechanisms/procedures to be used for tracking, claiming, reporting, and evaluating the number of children served, and the amount of funds requested for reimbursement; and

4. Specify the roles and responsibilities of all parties.

C. TERM

The term of this Agreement shall be from March 1, 2011 through December 31, 2014 and may be extended upon written mutual consent of both parties.

D. DEFINITIONS

For purposes of this Agreement:

1. "Residentially Based Services" means behavioral or therapeutic interventions delivered in nondetention group care settings in which multiple children or youth live in the same housing unit and receive care and supervision from paid staff. Residentially Based Services are most effectively used as intensive, short-term interventions when children have unmet needs that create conditions that render them or those around them unsafe, or that prevent the effective delivery of needed services and supports provided in the children's own homes or in other family settings, such as with a relative, guardian, foster family, or adoptive family. Residentially Based Services shall include the following interventions and services:

    a. Environmental interventions that establish a safe, stable, and structured living situation in which children or youth can receive the comfort, attention, structure, and guidance needed to help them reduce the intensity of conditions that led to their placement in the program, so that their caregivers can identify and address the factors creating those conditions.

    b. Intensive treatment interventions that facilitate the rapid movement of children or youth toward connection or reconnection with appropriate and natural home, school, and community ecologies, by helping them and their families find ways to mitigate the conditions that led to their placement in the program with positive and productive alternatives.

    c. Parallel, predischarge, community-based interventions that help family members and other people in the social ecologies that children and youth will be joining or rejoining, to prepare for connection or reconnection. These preparations should be initiated upon placement and proceed apace with the environmental interventions being provided within the residential setting.

d. Followup postdischarge support and services, consistent with the child's case plan, provided as needed after children or youth have exited the residential component and returned to their own family or to another family living situation, in order to ensure the stability and success of the connection or reconnection with home, school, and community.

2. "Voluntary Agreement" means an agreement entered into by the county and RBS provider(s) and shall satisfy the following requirements:

a. Incorporate and address all of the components and elements for RBS described in the "Framework for a New System for Residentially Based Services in California".

b. Reflect active collaboration among the RBS provider(s) operating RBS programs and county departments of social services, mental health, or juvenile justice, alcohol and drug programs, county offices of education, or other public entities, as appropriate, to ensure that children, youth, and families receive the services and support necessary to meet their needs.

c. Require a written evaluation report to be prepared annually and jointly by county and the RBS provider(s). The evaluation report shall include analyses of the factors set forth in W&IC Section 18987.72 (b) (3) which specify that the county shall send a copy of each annual evaluation report to the Director of the California Department of Social Services, hereinafter referred to as the Director, and the Director shall make these reports available to the Legislature upon request.

d. Provide that the failure to timely prepare a written evaluation as set forth in paragraph c above may result in termination of this Agreement, resulting in the withdrawal from the RBS Reform Project and approval of related waivers.

e. Permit amendments, modifications, and extensions of the agreement to be made in writing, with the mutual written consent of both parties and with approval of the state, based on the evaluation described above, and on the experience and information acquired from the implementation and the ongoing operation of the program.

f. Be consistent with the county's system improvement plan developed pursuant to the California Child Welfare Outcomes and Accountability System.

The Voluntary Agreement is one of three deliverables developed by the county in conjunction with RBS provider(s) and submitted to the state for approval. The Voluntary Agreement includes all elements and components specified above and in W&IC Section 18987.72 (c)(1-5). See Attachment I, Exhibit 1 – San Francisco RBS Voluntary Agreement.

3. "Funding Model" allows the Director to approve the use of up to a total of five alternative funding models for determining the method and level of payments that will be made under the AFDC-FC program to RBS provider(s) operating RBS programs in lieu of using the rate classification levels and schedule of standard rates provided for in W&IC Section 11462. These funding models may include, but shall not be limited to, the use of cost reimbursement, case rates, per diem or monthly rates, or a combination thereof. A funding model shall do all of the following:

   a. Support the values and goals for RBS, including active child and family involvement, permanence, collaborative decision-making, and outcome measurement.

   b. Ensure that quality care and effective services are delivered to appropriate children or youth at a reasonable cost to the public.

   c. Ensure that payment levels are sufficient to permit the RBS provider(s) operating RBS programs to provide care and supervision, social work activities, parallel predischarge support and services for children and their families, including the cost of hiring and retaining qualified staff.

   d. Facilitate compliance with state requirements and the attainment of federal and state performance objectives.

   e. Control overall program costs by providing incentives for the RBS provider(s) to use the most cost-effective approaches for achieving positive outcomes for the children or youth and their families.

   f. Facilitate the ability of the RBS provider(s) to access other available public sources of funding and services to meet the needs of the children or youth placed in their RBS programs, and the needs of their families.

   g. Enable the combination of various funding streams necessary to meet the full range of services needed by foster children or youth in RBS programs, with particular reference to funding for mental health treatment services through the Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment program.

h. Maximize federal financial participation, and mitigate the loss of federal funds, while ensuring the effective delivery of services to children or youth and families, and the achievement of positive outcomes.

i. Provide for effective administrative oversight and enforcement mechanisms in order to ensure programmatic and fiscal accountability.

The Funding Model is one of three deliverables developed by the county in conjunction with RBS provider(s) and submitted to the state for approval. The Funding Model includes all elements and components specified above and in W&IC Section 18987.72 (d)(2)(A-I). See Attachment I, Exhibit 2 – San Francisco RBS Funding Model.

4. "Waiver Request" is developed by the counties and RBS provider(s) to waive child welfare regulations regarding the role of counties in conjunction with RBS provider(s) operating RBS programs to enhance the development and implementation of case plans and the delivery of services in order to enable a county and RBS provider(s) to implement the program description described in the Voluntary Agreement. The Waiver Request is one of three deliverables developed by the county in conjunction with RBS provider(s) and submitted to the state for approval. The Waiver Request must address all components as specified above and in W&IC Section 18987.72 (d)(1). See Attachment I, Exhibit 3 – San Francisco RBS Waiver Request.

E. COUNTY RESPONSIBILITIES

The county:

1. Shall provide children with the services indentified as part of their RBS program and outlined in their state approved Voluntary Agreement.

2. Shall follow the state approved San Francisco RBS Plan, as prescribed in Attachment I, Exhibits 1, 2 and 3, for the RBS Reform Project. These approved deliverables will address the system, process, and financing capacities identified in providing RBS program services.

3. Shall monitor the RBS Reform Project provided in accordance with the above RBS deliverables.

4. Agrees to comply with all language of AB 1453 Sections 18987.7, et seq.

5. Shall allow state access to statistics, records, and other documents required to carry out its responsibilities.

   a. Shall ensure that the evaluation of the RBS Reform Project is

conducted in accordance to 18987.72(c)(3).

b. Agrees to maintain all documentation necessary to track expenditures for the children participating in the RBS Reform Project.

c. Agrees to submit an annual report to the state in accordance with 18989.72(c)(3).

d. Agrees to the termination of this Agreement, and the withdrawal from the RBS Reform Project and waivers, if the state finds that the county failed to fully and timely perform the activities described in subparagraphs a, b, and c of paragraph 5.

e. Agrees to maintain all records associated with RBS, and cause to be maintained by any contracted RBS provider all records, including financial, case documentation and other support for all costs claimed for RBS for a period not less than three years from the last claim submitted for RBS. Any record related to litigation or any federal or state audit, exception(s), disallowance(s) or deferral(s) shall be retained until notified by the state.

f. Agrees to track in a manner prescribed by the state all payments to RBS provider(s), regardless of fund source and maintain total costs to RBS provider(s) for the purposes of reporting.

6. Agrees to participate in any state RBS Reform Project meetings and site visits conducted by the state or its designee.

7. Shall implement a project in a manner that will ensure that any services being provided to a child or family member at the time the RBS Reform Project ends will be completed and/or case plans for children and their families are adjusted, if necessary, for the post-demonstration project period.

8. Prior to entering into the agreement with the provider(s), the county shall verify that the provider(s), their principals or affiliates or any sub-providers used under this agreement are not debarred or suspended from federal financial assistance programs and activities nor proposed for debarment, declared ineligible, or voluntarily excluded from participation in covered transactions by any federal department or agency, per Executive Order 12549, Debarment and Suspension.

F. STATE RESPONSIBILITIES

The state:

1. Will, at the request of the county submitted in the form of the Waiver Request deliverable, consider a state waiver of specific regulations under the waiver authority granted in W&IC Section 18987.7. In addition, technical assistance will be provided to the county to identify opportunities within existing law and regulation to implement the RBS Reform Project and where appropriate and feasible, pursue other waiver authority to remove barriers to implementation.

2. Shall process RBS Invoice Quarterly Claims for reimbursement in a timely manner.

3. Shall report during the legislative budget hearings the status of any county agreements entered into the RBS Reform Project and the development of statewide RBS programs.

G. JOINT RESPONSIBILITIES

1. Both parties agree to establish mutually satisfactory methods for the exchange of information, as may be necessary, in order that each party may perform its duties, functions, and appropriate procedures under this Agreement.

2. Both parties agree to comply with the provisions of W&IC Section 10850 and W&IC Sections 827, 827.1, and 830 to ensure that all information concerning children and families in RBS shall be kept confidential in accordance with federal and state laws and policies.

3. Both parties agree to comply with all elements and components of the state approved RBS deliverables. Any amendments, modifications, and extensions of the deliverables are to be made in writing, with the mutual consent of all parties and with approval of the state.

H. FISCAL PROVISIONS

1. Both the state and county understand that there are no new or additional sources of funds provided for the RBS Reform Project. For the purposes of ensuring there are no increased costs to the General Fund, if the state determines that additional upfront costs for this project are necessary, these upfront costs must be offset by other program savings identified by the state to ensure that there are no net General Fund costs in each fiscal year associated with this project.

2. The county shall pay the reimbursement rates to the RBS provider(s) as prescribed in the San Francisco RBS Plan. See Attachment I, Exhibits 1,

2, and 3. Reimbursement rates for the county shall be paid as prescribed in the San Francisco RBS Plan. See Attachment I, Exhibits 1, 2, and 3. The Title IV-E allowable portion of these rates may be modified by the state to ensure conformity with federal requirements and to maximize federal financial participation.

3. The state shall reimburse the county, for the purpose of providing RBS program services up to 100 percent of the state share of non-federal funds, to be matched by the county's share of cost as established by law, and to the extent permitted by federal law, up to 100 percent of the federal funds allocated for group home placements of eligible children at the authorized rate. The federal funds reimbursement rate will be based on the applicable federal medical assistance percentage (FMAP) rate during the RBS Project period.

4. The county shall claim reimbursement of costs quarterly for federally eligible and non-federally eligible children on the RBS Invoice Quarterly Claims – RBS FC (Fed and Non Fed) - Summary Report of Assistance Expenditures, RBS FC 1 (Fed, Non Fed, and SB 163 Fed) - Foster Care Facility Report, and RBS CERT - Expenditure Certification for RBS Assistance Claim Expenditures. RBS Invoice Quarterly Claims shall be submitted thirty (30) calendar days after the end of the claiming quarter. The county shall submit the required RBS Fiscal Tracking Sheets to the state using the same quarterly schedule.

5. Contingent upon the county's timely submission of required state fiscal reports, the state may issue a monthly advance payment to the county based on county need and spending trends. If the state issues an advance payment, it will do so by the last business day of the month the advance is for.

6. All AFDC-FC expenditures associated with RBS claiming shall be subject to audit to ensure federal funds have been appropriately claimed.

7. The RBS Reform Project shall be subject to review under the county's single audit.

8. The state foster care funds and, to the extent permitted by federal law, federal foster care funds shall remain within the administrative authority of the county welfare department, which may enter into an interagency agreement to transfer those funds, and shall be used to provide RBS program services. Expenditures of excess funds shall be consistent with federal and state law. The county shall submit to the state copies of all contracts for RBS services entered into with the RBS provider(s). Nothing contained in this Agreement or otherwise shall create any contractual relationship between the state and any county sub-providers, and no sub-providers shall relieve the county of its responsibilities and obligations

hereunder. The county agrees to be fully responsible to the state for the acts and omissions of its sub-providers and of persons either directly or indirectly employed by any of them as it is for the acts and omissions of persons directly employed by the county. The county's obligation to pay its sub-providers is an independent obligation from the obligation of the state to make payments to the county. As a result, the state shall have no obligation to pay or to enforce the payment of any monies to any sub-provider.

9. Any federal or state audit exception(s), disallowance(s), or deferral(s) resulting from a federal or state review or audit of two or more participating counties' RBS programs shall be based on the individual county's percentage of total costs claimed during the time period in question. In the event that any federal or state audit exception(s), disallowance(s), or deferral(s) are taken against an individual county, the county is not liable for any audit exception(s), disallowance(s), or deferral(s) resulting from a federal or state review or audit of any other county's RBS program; or any liability, claims or costs resulting from any other county's implementation of any duty owed the state.

10. In the event a federal or state review or audit results in an exception, disallowance, or deferral, the state and county shall participate in the repayment of the exception, disallowance, or deferral in accordance with W&IC Section 15200. In no case shall the state assume financial liability for the county share of federal or state review or audit exception(s), disallowance(s), or deferral(s).

    a. In the event an audit finding determines a cost to be allowable but not eligible for federal funding the county shall repay the ineligible federal portion and the state shall participate in the repayment of the state's portion pursuant to WIC Section 15200.

    b. In the event an audit finding determines a cost is not allowable for claiming, the county shall be responsible for refunding the federal and state share.

11. The San Francisco County Human Services Agency shall conduct an audit or review of the fiscal operation of the RBS program no sooner than twelve (12) months and no later than twenty-four (24) months after the program begins. These audits or reviews shall be conducted using the applicable standards in accordance with federal, state, and county regulations and guidelines, including federal Office of Management and Budgets Circular A-122, Cost Principles.

12. If the state determines, based on an audit or review, that an RBS provider has misused Title IV-E funds, as defined in the Manual of Policies and Procedures (MPP) 11-400(m)(6), the county shall collect from the RBS provider an amount equal to the total amount of misused funds.

13. All RBS providers shall submit a Financial Audit Report (FAR) to the state in accordance with the W&IC Section 11466.21. The FAR submitted by the RBS provider(s) shall separately identify all revenues and expenditures attributable to the RBS program. Failure to submit a FAR in accordance with law will result in termination of the RBS rate.

14. The county shall ensure that each RBS provider participating in the operations of the RBS Reform Project shall conduct time studies of activities performed by the RBS provider staff in a manner prescribed by the state.

I. GENERAL PROVISIONS

1. This Agreement may be amended only by written agreement of both parties.

2. This Agreement is subject to any additional restriction, limitations, or conditions enacted by the state Legislature that may affect the provisions, terms or funding of the RBS Reform Project. This Agreement shall be modified as necessary due to changes in state or federal law that impact its provisions.

3. The San Francisco County Board of Supervisors hereby delegates to the Director or their designee of the San Francisco County Human Services Agency the authority to enter into such written amendments with the state on behalf of the county.

4. The state's signing of this Agreement does not constitute a waiver of state laws or regulations, other than as specifically described in the Waiver Request (Attachment I, Exhibit 3) or the Agreement, pages one (1) through eleven (11).

J. TERMINATION

1. Either party shall have the right to terminate this Agreement for cause upon sixty (60) calendar days prior written notice to the other party.

2. The county may elect to terminate their participation in the RBS Reform Project subject to the following provisions:

   a. The county must consult with the state prior to exercising the opt-out election to terminate their participation in the RBS Reform Project and must provide written notification to the state of the county election to opt-out.

   b. The state must be in receipt of the written notification of the county opt-out election sixty (60) calendar days prior to the first day of the

month in which the county intends to terminate its participation in the RBS Reform Project.

c. The county must be able to implement a phase-down strategy to ensure that case plans for children and their families are adjusted, if necessary, for the post-RBS Reform Project period.

3. The state may terminate this Agreement in any of the following circumstances:

a. If the county fails to comply with Section E.

b. If the state determines, based on its review of the county's RBS program conducted no sooner than 18 months after the first child is enrolled, that the county is not achieving timely movement from RBS group residential care facilities into lower levels of care or exits from foster care to permanent families with associated savings. In this event, the state shall provide 60 days advance notice of termination to the county.

c. If the state determines that pursuant to Section H (1) upfront costs for this project are necessary but funds are not available.

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES	COUNTY OF SAN FRANCISCO
By: _____	By: _____
JOHN A. WAGNER, Director	Trent Rhorer Executive Director Human Service Agency
Date: 3/4/11	Date: 2-23-11

The RBS Reform Coalition

Residential Based Services Reform Project

Deliverable Template – VOLUNTARY AGREEMENT

Introduction: AB 1453 directs the counties and providers in each demonstration site who are cooperating to develop an RBS alternative to traditional group home care to describe their new program model in a document called the "Voluntary Agreement."

The California Department of Social Services is instructed to review each site's Voluntary Agreement according to criteria set out in the statute. If the proposal meets those criteria, the statute enables the director of CDSS to waive child welfare regulations regarding the role of counties in conjunction with private non-profit agencies operating residentially based services programs to enhance the development and implementation of care plans and the delivery of services as described in the Voluntary Agreement.

The AB 1453 statute states that Voluntary Agreements shall satisfy the following requirements:

1. Incorporate and address all of the components and elements for residentially based services described in the "Framework for a New System for Residentially Based Services in California."
2. Reflect active collaboration among the private non-profit agency that will operate the residentially based services program and county departments of social services, mental health or juvenile justice, alcohol and drug programs, county offices of education, or other public entities as appropriate, to ensure that children, youth and families receive the services and support necessary to meet their needs.
3. Provide for an annual evaluation report, to be prepared jointly by the county and the private nonprofit agency. The evaluation report shall include analyses of the outcomes for children and youth, including the achievement of permanency, average lengths of stay, and rates of reentry into group care. The evaluation report shall also include analyses of the involvement of children or youth and their families, client satisfaction, the use of the program by the county, the operation of the program by the private nonprofit agency, payments made to the private nonprofit agency by the county, actual costs incurred by the nonprofit agency for the operation of the program, and the impact of the program on state and county AFDC-FC program costs. The county shall send a copy of each annual evaluation report to the director, and the director shall make these reports available to the Legislature upon request.
4. Permit amendments, modifications and extensions of the agreement to be made, with the mutual consent of both parties and with approval of the department, based on the evaluations described in paragraph 3, and on the experience and information acquired from the implementation and the ongoing operation of the program.

5. Be consistent with the county's system improvement plan developed pursuant to the California Child Welfare Outcomes and Accountability System.

The 'Framework for a New System of Residentially-Based Services in California' defines the 4 services elements of RBS, identifies the role of the placing agency and the provider agency, establishes criteria for placement, defines the qualities necessary for programs to deliver residentially-based services and the elements of the services themselves, defines the outcome criteria that programs should be designed to achieve, and sets out a model for implementing the Framework.

Functionally, the Voluntary Agreement constitutes a memorandum of understanding among the public and private agencies who are working together to transform group home care in a given demonstration site that describes the structure and operation of the system they have designed and reflects their commitment to make that system a reality, should approval be granted by CDSS.

The purpose of this template is to provide a consistent format for these agreements that includes each of the provisions required by the statute. This version of the template is based upon a preliminary draft that each site completed and incorporates the questions from that draft, plus the questions from a second preliminary template, the Program Description, and also addresses some of the more detailed elements from the Framework that were omitted from the initial version that can now be completed because each site's program design is more fully developed.
The Voluntary Agreement and the Alternative Funding Model Templates are companion documents, and share some inquiries in common, such as the description of the services to be offered. This may require some duplication of answers in the two documents.

Instructions
When answering the questions in the Voluntary Agreement, please be as descriptive as possible and provide all necessary information, attachments, flow charts, diagrams, etc.

If your Voluntary Agreement includes multiple Provider Agencies, please be sure to clearly answer each element of the question for each Provider involved in RBS.

Reference Material: Please be sure to reference the AB 1453 enacted legislation, and the 'Framework for a New System of Residentially-Based Services in California'.

Voluntary Agreement

Demo Site:	SAN FRANCISCO	Date:	6/02/10
Prepared by:	The San Francisco RBS Implementation Committee Lead Contact: Mark Lane	Title/Organization:	SF RBS LOCAL IMPLEMENTATION COORDINATOR
E-mail:	Marklane49@aol.com	Phone:	831-227-9997

1. **EXECUTIVE SUMMARY – In 1 page, summarize the alternative program and funding model you are proposing. Include a comparison between the specific service and funding model innovations in your RBS program and the services and funding that is currently in place. Please use Attachment A to list the active participation between all parties in the development of the RBS program.**

The City and County of San Francisco and 3 providers, Edgewood Center for Children and Families, Seneca Center, and St. Vincent's School for Boys and the San Francisco Boy's and Girls Homes, have joined together to create a new program model to serve families with children who up until now have required extended placements in high level group homes using a methodology that fundamentally transforms the nature of traditional residential services. These three providers will be using a single program design and budget.

This new approach, called a Family Connections Program (FCP), breaks down the traditional barriers between residential treatment and intensive in-home services and replaces them with an integrated, family-based intervention that delivers continuity of care in whatever environment a child or youth might temporarily be living.

The goal of the Family Connections Program is to act as a re-connection engine with a focus on permanency within 24 months, or sooner. The Family Connections Program (FCP) assumes that each enrollee will spend an average of 5 months in residential services and 19 months in community based services. These community based services can support youth as they return home to family or kin, or during short stays in intensive treatment foster care, other FFA or County foster placement.
This model is designed to test the feasibility of creating a new, integrated and replicable treatment option for children or youth who traditionally have been served through extended group home placements, and their families. The model brings three core services together in one continuous, coordinated and strength-based program: residential treatment, family support and intensive behavioral health services. In combination, this service package should help children, youth and families who otherwise might have permanently disrupted relationships achieve permanency, safety and well-being.

FCPs are designed to complement the community-based resources that make up San Francisco's system of care, including family resource centers, outpatient mental health services, intensive in-home treatment and support, kinship care, wrap-around, and intensive treatment foster care. FCPs share the same values of active family involvement, strength-based, needs-directed, and outcome-driven service planning, cultural competency, and individualized support and intervention with all of the other system of care options. However, within that array FCPs are intended to meet the needs of that small percentage of children and youth and their families who cannot, at least for the moment, be served through less restrictive options because of the level of risk presented by a continuing pattern of behaviors being expressed by the child or youth.

An FCP is a place where children, youth and families who have experienced both significant and sustained disruptions in their relationships as well as highly challenging child or youth behaviors can work together with a multi-disciplinary support and treatment team to fashion a comprehensive strategy for:

- Understanding the driving forces behind the disruptions and the behaviors associated with those disruptions,
- Developing and implementing actions and interventions to address those driving forces,
- Making the adjustments in their lives that are necessary to achieve permanency, safety and well-being, and
- Accessing and establishing the habits, supports, services and resources needed to adhere to and sustain the improvements that have been achieved

FCPs differ from conventional group homes in three fundamental ways. First, while FCPs have a small residential component where children and youth can stay for a while, they are not second homes. Children and youth are not expected to adapt to living long-term in a congregative care setting. Instead, it is a place for children and youth to get away from a chaotic pattern of living, acquire some stability, initial insights and coping behaviors, and begin the process of working with their families and primary caregivers to find answers to the problems that have so dramatically undermined their relationships.

Second, even while a child or youth is staying in the residential component of an FCP, family involvement is a critical part of the plan of care. Applying a family systems perspective, family members are invited onto the campus for several hours each week to work together with the child or youth and the treatment team on deconstructing the patterns of behavior and interactions that have disrupted the family relationships and building more effective and positive life strategies. The 3 FCPs will have a family connections center that has sufficient space for families and children to work together to identify and practice more productive interaction patterns in a safe environment. Then the treatment team and the family will go out to the natural settings where these interactions will be occurring to test the new ways of getting along together, sort out the kinks and

continue to practice them until they become beneficial new habits that the child or youth and family can sustain on their own.

Third, the residential component of an FCP is only one aspect of a coherent array of directly provided and linked services and supports that can be selectively and individually adapted to meet the specific needs of each child or youth and her or his family. The treatment team working with the child or youth and family will stay with them across environments when the child moves back home or transitions to an intensive treatment foster home as a step toward returning home. The plan of care developed by the family and treatment team will be consistent across environments, as will the people helping the child or youth and family carry out the plan's elements from initial engagement, from the phase of family-based residential care that will include both onsite and parallel community care, through any stops in treatment foster care that will also include onsite and parallel services, through placement with the family with intensive follow-along services, and concluding with an aftercare phase when sufficient support is provided to make sure the new family relationships and the placement will be sustained over time. The model takes into account the fact that some children and youth may achieve permanency through placement with extended family members with kinship care support, or with an adoptive family with appropriate assistance through that system.

The FCP consists of three care components:

- A Residential Care Center, for a maximum of 6 RBS youth, anchored by milieu staff, and primarily funded through federal, state and county IV-E case rates. The Residential Care Center will also serve as a short term Crisis Stabilization for RBS youth and children, that may have transitioned back to the community, but who are in need of a brief intensive intervention in order to stabilize them, so they can successfully return to family.
- A Community Care Component serving up to 14 children or youth and their families in both the residential center and in the community, anchored by youth and family support staff, care coordinators and family partners, funded in part through state and county IV-E case rates and in part through EPSDT fee for service billing.
- A Clinical Care Component, also serving all 14 children or youth, and anchored by youth and family clinicians and mental health rehabilitation specialists, and funded primarily through EPSDT fee for service billing.

The four required program elements of RBS/FCP; environmentally based interventions, intensive treatment and interventions, parallel services, and follow-up and transitional support, are noted in section 5.2.4 of the Voluntary Agreement.

Voluntary Agreement

The FCP Arc of Care

Keeping in mind that this will be the first phase demonstration of a new service concept integrating residential, clinical and community-based care that may evolve significantly as it is implemented, here's a summary of the steps proposed for the FCP arc of care:

1. Initial screening by the county placing agencies (child welfare, and mental health)
2. Decisions will be made at the supervisory level about which youth and families are appropriate for enrollment, and will be presented at a team decision meeting.
3. MAST committee in San Francisco will review recommendations, authorize enrollments and choose a provider in coordination with the San Francisco FCP Project Coordinator.
4. Care Coordinator and Family Partner from the selected provider contact youth and family, within 72 hours, and begin enrollment intake process
5. Enrollment intake process is completed and Care Coordinator and Family Partner work with youth and family to begin developing the Family Support Team
6. If needed, the milieu staff in the residential unit help youth manage any immediate and dangerous out of control behaviors, supported by youth and family clinicians, youth and family behavior specialists as needed
7. Youth's individual education plan (IEP) is addressed or updated as needed and educational services are initiated or continued
8. Youth and family clinician works with youth and family to develop a behavioral health plan of care to address emotional and behavioral needs and implementation of the plan begins, supported by the youth and family clinician, behavioral health specialists, and therapeutic behavioral health specialists (if needed) Family support team develops initial strength-based comprehensive care plan and begins implementation
9. Youth and family with support team practice using the new interactive skills during home visits
10. Youth and support team work with school or other potential community sites to prepare for reconnection
11. Family support team expands as needed to include both informal supports and formal community care providers
12. Youth begins making extended visits with family
13. Youth leaves the residential facility, after an average of 5 months, and moves either to the family home, to another potential permanent placement, or to a foster home and youth and family or other primary care providers continue work with team on long term life skills
14. Youth may return to the residential site for short-term crisis stabilization.
15. If youth was in an interim community placement, youth moves to a permanent placement; youth and family continue intensive therapeutic work at that site as needed

16. Youth and family reconnection becomes relatively stable and youth and family shift from intensive therapeutic services to maintenance and transitional support from team, usually by months 18-21.
17. Family support team develops plan for transitioning out of FCP, by month 21.
18. Youth and family continue receiving any needed support through local service providers and informal sources of support as arranged through the transition plan
19. Enrollment is completed, by month 24, or sooner.

See attachment for complete protocol for dis-enrollment from FCP.

The San Francisco RBS Implementation Team has also developed a more integrated funding model to support the new program. It differs from existing funding by allowing for reasonable costs for care in the residential component that will maximize the appropriate draw-down of federal AFDC IV-E funds, while explicitly aligning the costs for Title XIX funded treatment services that will be offered throughout the course of enrollment with the flexible use of the county and state AFDC IV-E funds authorized by AB 1453 to support the achievement and maintenance of permanency for each enrolled child or youth.

Through a difficult and painstaking process, the public and private members of the Implementation Team have created a new way of helping children and families with highly complex needs that can serve as a template for implementing this model throughout the state of California.

2. PARTICIPANTS & ROLES

2.1 Participants: In the table below, please list the public and private non-profit agencies that will be involved in the operation of your program. For each participating agency or department identify a key contact person and their email address.

Agency or Department	Contact Name & Title	Email Address
San Francisco County HSA	Liz Crudo	Liz.crudo@sfgov.org
Edgewood	Heather Nelson Brame	HeatherN@edgewood.org
Seneca	Katherine West	katherine_west@senecacenter.org
St Vincent's	Dan Gallagher	dgallagher@cccyo.org
San Francisco CBHS	Alison Lustbader	Alison.lustbader@sfdph.org

All three providers have agreed to operate one comprehensive program with each provider receiving 14 enrollees. HSA will be the only placing agency for this pilot program.

2.2 Role of the Placing Agencies: Describe the role of the Placing Agencies in the operation of the RBS program.

The San Francisco placing agencies will implement the following process for identifying children and youth and their families who will benefit from enrollment in a Family Connections Program (FCP), and for accomplishing, supervising and funding the enrollment:

1. Case carrying workers in the child welfare system will be trained to recognize the key characteristics that identify children or youth and their families as members of the target population as described in the responses to questions 3.1 and 3.2 below.
2. If a worker believes that a child or youth and their family appear to be eligible for enrollment in an FCP, the worker will confer with her or his supervisor and if the supervisor agrees, confer with the family, if available or other person responsible for making decisions on behalf of the child or youth, and arrange for a Family Team Meeting (FTM). The purpose of FTM is to review a variety of placement or enrollment options, using a family-centered placement decision process. (In some places in California this meeting is called a Team Decision Meeting.)
3. If the recommendation of the Family Team Meeting is to pursue an enrollment in an FCP, the case carrying worker or her or his supervisor will present this recommendation at the MAST (Multi-Agency Services Team) meeting, which functions as San Francisco's Interagency Placement Approval Committee (IAPC).
4. In deciding whether to recommend (on the part of the FTM) or authorize (on the part of the MAST) enrollment in an FCP both the FTM and the MAST meeting will consider the following criteria:
    a. First, that this option provides the most effective, appropriate and safest environment in which to address the needs that are the driving force behind the behaviors that are the focus of concern
    b. Second, that the specific program chosen for enrollment has flexibility, structures, interventions, services and location that are well-matched with the strengths and needs of the child or youth and family, and
    c. Third, that there is no available community-based service arrangement that would adequately address the needs of the child and family without placement in the residential component of the FCP.
5. If the interagency placement approval team accepts the recommendation that was generated from the FTM process, a referral to one of the FCPs will be authorized.
6. The choice of which of the FCPs with openings provides the best match for a particular child or youth and her or his family will be based on the particular service focus of the FCP, its location, the connections that it has with local community service resources, and the input of the child or youth and family. The matching process may

include meetings with representatives of one or more of the FCPs to help inform this decision.

7. When a match is made, and authorization for enrollment is granted by MAST, the case carrying worker, or a worker from the placement unit in that worker's agency will complete the necessary paperwork to accomplish the enrollment, and the FCP will become responsible for the care of the child or youth, and for providing support and services for the child or youth's family if they are known at that time, or for initiating the family finding and engagement process as quickly as possible. Preparation for enrollment for children and youth who are under court order will also require the completion of the steps needed to obtain or amend an appropriate disposition order that includes authorization of the initiation of RBS services and any placements that are known to be likely to occur during the enrollment.

   As the enrollment proceeds, the worker assigned to participate in and monitor the enrollment will serve on the Family Support Team that each FCP will use to coordinate the care provided to children, youth and their families, and will serve as the ongoing liaison with the court, where appropriate, and with the placing agency in order to:

   - Insure accurate sharing of information;
   - Collaborate in the development, implementation and revision of the plan for meeting the needs of the child or youth and her or his family, including the parallel, community-based components;
   - Assist in monitoring and recognizing progress;
   - Help facilitate an effective transition to a family-based living setting; and,
   - Help insure that effective follow up supports are in place.

8. Direct oversight of each enrollment will be the responsibility of the placing agency. Information about the status of all current enrollments will be reviewed on a monthly basis by the MAST team.

9. As children or youth and their families complete their individual course of care, the assigned worker from the placing agency will assist the Family Support Team as needed in the design and implementation of a transition plan out of the FCP. Post-FCP involvement may require ongoing formal services, but may also be accomplished through the development of informal and natural local supports and services in the community where the child or youth and her or his family are living. Transition out of the FCP may also involve informing the court and obtaining necessary court approval for the modification or termination of applicable court orders.

   - The San Francisco juvenile court makes general placement orders. This includes out-of-home placement orders for children placed in foster or relative care.

- San Francisco Family and Children's Services has been working with the court to advise them of the FCP development.
- The body of the court report will identify the FCP as the general placement, and describe the services provided.
- Movement from out-of-home care to relative care, or re-unification with the birth parent, requires specific court approval. Thus, step-down from the FCP to a relative home, or to the parent, requires a change in placement order.
- Any decision to return a child or youth to their home will require court approval.
- The County social worker will include in their 6 month report to the court an update on the progress the youth has made in the FCP. This will be incorporated into the comprehensive care plan.
- The child welfare worker must notify the minor's attorney upon any change in placement.

10. Special projects codes will be entered into the CWS/CMS system identifying each FCP placement. This data will be captured separately and analyzed independently of the other placements in the system. Since the federal PIP and the state/county SIP look at placement stability as an indicator of success this data will be reviewed from that same perspective. This data is also being analyzed as part of the over-all evaluation plan.
11. Most children and youth enrolled in an FCP will access behavioral health services as well as family connection and support services. If enrollment is through either the child welfare or the juvenile justice systems, then a contract for behavioral health services between the FCP and the appropriate county behavioral health department must also be in place, and the relevant elements of the overall plan of care monitored by that department as provided in that contract. If the enrollment is through the San Francisco behavioral health agency, that agency will monitor all aspects of the enrollment.

2.3 <u>Role of the Provider Agencies:</u> Describe the role of the Provider Agencies in the operation of the RBS program.

Each of the provider agencies named in section 2.1 will establish FCPs that will offer the full sequence of RBS services: intensive, short-term residential treatment and family connection services, intensive behavioral health services, parallel community services, and follow-along and aftercare services as described in detail in section 5.3, below.

All three providers have dedicated 6 bed residential facilities dedicated to serve rbs youth exclusively. St. Vincents has a separate residential facility they are setting up with a total

capacity of 6 beds, all of which are designated for rbs. Edgewood has a 12 bed residential facility, and are planning on utilizing only 6 beds of this total capacity, in order to serve rbs youth exclusively. Seneca Center has a separate group home with a 6 bed total capacity, and those beds will be designated for rbs youth exclusively as well.

Children and families enrolled in an FCP can expect that the provider will:

1. Address any immediate needs for safety structure, services or assistance that the child or youth may present.
2. Assign a staff member to reach out to and engage the child or youth and her or his primary family members and caregivers, hear their stories and develop a sufficiently trusting relationship that they will be able to share their understanding of what works, what doesn't work, what they need and what they believe the child or youth and family needs in order to achieve permanency, safety and well-being.
3. If the child or youth has highly disrupted family arrangements, an initial element of family discovery will be initiated that will be followed by the process of reaching out and engagement.

After a child or youth has been enrolled in an FCP, a care coordinator and parent partner will begin the process of engagement with the child and family (as described in more detail in section 5.1, below), then work with the child or youth and their family to form a Family Support Team (FST) that includes the child or youth and family members, people that the child or youth and family choose to have join them to provide support, primary treatment and service staff from the FCP, educational and other community service providers who are assisting the family, and other people whose presence will enhance the circle of support the child or youth and family will need to accomplish their goals.

The FST will provide the framework for consistency in planning, coordination, support and communication throughout the child or youth and family's enrollment by utilizing the following components:

- They will use a strength-based and family-centered collaborative planning process to bring together all of the relevant information and points of view necessary to address the key unmet needs of the child or youth and family across multiple life domains and help the child or youth and family achieve their goals. Where necessary and appropriate the FCP will provide or have available a full range of assessment and diagnostic resources to help the child or youth and family better understand any underlying emotional, behavioral, or developmental factors that may be contributing to the challenges they are experiencing.

1. The FST will prepare a comprehensive care plan that incorporates family and community support, emotional and behavioral health services, living arrangements, educational programming, and other formal and informal services and supports that will be assembled, including both those that are directly offered by the FCP, those that will be provided by local community based organizations through arrangement

with the FCP, as well as formal, informal and natural services and supports that are available through the child or youth and family's own network of support.

2. Resources will be arranged and coordinated through the operation of the FST and will be offered in a complementary, coordinated and consistent manner across whatever locations children or youth happen to be during the course of care. When children are staying in locations other than their permanent family home, parallel community supports and services will be available to help the child or youth's family prepare for reunification. After reunification occurs and prior to transition, follow-up and aftercare support and services will also be offered.

3. Through the FST, staff from the FCP will coordinate with the community resources, services and supports necessary to achieve the goals developed in the comprehensive care plan and to sustain those successes following transition out of the FCP. The FCP will assume fiscal responsibility for the course of care during enrollment, except where billing from external insurance options is available and appropriate, and put in place mechanisms for assuring the appropriate use of resources within the funding model and for measuring and documenting the outcomes achieved by the children, youth and families served by the FCP.

4. The FST will track progress that the child or youth and family are making towards the accomplishment of their goals through formal means including the quarterly administration of the CANS, and through informal means such as asking the child or youth and family members to describe their satisfaction with the process and services and supports that are being arranged through the FST process, and their sense of the degree to which the key unmet needs standing in the way of achieving their goals are being addressed.

5. As the child or youth and family achieve a more stable and sustained permanent living arrangement and have acquired the resiliency and natural and informal sources of ongoing support necessary to sustain this arrangement, the FST will work with the family to prepare a transition plan for accomplishing graduation from FCP enrollment.

6. When FCP clients are living in the community and need short term crisis stabilization, each provider will have the capacity to provide additional residential beds for this purpose as needed. A typical crisis stabilization stay would be 1-14 days. Every effort will be made during this time to stabilize the youth and support the family so that they are able to return back to the community as soon as possible. Supports that could enable an earlier return to the community might include: in-home supports; and therapeutic, psychotropic, and psychiatric services. If there is need for further time in the residential care component, the youth or child may shift from a crisis stabilization status to a short term return to residential status, as available, appropriate, and approved, until a permanency plan is worked out.

Typical behavior that might result in the need for crisis stabilization would be danger to self or others; or other special circumstances that can't be managed safely in the community.

7. San Francisco County acknowledges the exception CDSS granted in its October 6, 2010 correspondence to permit comingling for crisis stabilization. This comingling would only occur until a bed in the RBS unit is available, or until the youth is ready to return to the community care component. Immediate notice would be provided to CDSS. It is anticipated that the need for this exception would rarely occur after the first cohort of RBS-enrolled youth transition out into the community care component because providers plan to leave some RBS group home beds available for such a circumstance. In order to be in compliance, the following conditions must be met: 1) The RBS provider will initiate a Family Team Meeting within 72 hours of an RBS youth's occupancy of a non-RBS bed to ensure that key RBS services are not disrupted and that the case plan is modified to address the services needed to stabilize the youth. 2) San Francisco County must immediately notify the CDSS Community Care Licensing Division of the change in placement for the RBS youth. 3) Prior to placement of an RBS youth into a non-RBS unti, the provider staff working in the non-RBS unit must be fully trained in RBS principles and practices. 4) The RBS youth will be moved to an RBS bed immediately when an RBS bed vacancy occurs. 5) Should an RBS youth require multiple period of crisis stabilization in a non-RBS bed, the RBS rate the provider will be paid for this youth will convert to the appropriate Rate Classification Level of the program. 6) The RBS provider will not accept new intakes into the RBS pilot if an RBS youth is occupying a non-RBS bed. San Francisco County agrees to comply with these requirements.

2.4 <u>Role of Other Collaborators</u>: Describe the active collaboration among the following participants in the operation of the RBS program:

- ***Other private non-profit service providers***
- ***Other public agencies/departments: mental health, alcohol and drug programs, education, juvenile justice, courts, tribes, etc.***
- ***Children, youth and families***

The provider agencies that are developing FCPs for the San Francisco RBS System have created an extensive network of connections with other community based service providers throughout the Bay Area. These connections will be used to insure an effective continuation of support and services for children, youth and families during the follow-along and aftercare phases, and following the completion of enrollment in the FCP. Some examples of these connections include:

- Seneca has MOU's with over 25 community-based organizations that currently support youth and families enrolled in their San Francisco Wraparound Program.

They have also established a wide range of informal relationships and partnerships with community based providers and resources.

- Edgewood has created numerous partnerships with nonprofit organizations and public agencies in San Francisco and San Mateo counties, including 20 school sites.
- St. Vincent's and the San Francisco Boys' and Girls' Home maintains relationships and collaborations with over 20 Community Based Organizations in San Francisco and Marin Counties

Other public agencies will be linked with the San Francisco RBS System's efforts through the operation of the MAST. As described in more detail in 4.4 below, MAST is a true interagency and community collaborative with public agency, provider and family advocate representation.

Family and youth involvement will occur at two levels. At the Interagency level, youth and family representatives will be a part of the MAST. At the program level, each FCP will have Parent Partners who will team with the Care Coordinators to assist families, children and youth with engagement, access, voice and ownership of the comprehensive plans of care that are developed through the FST process.

3. ENROLLMENT CRITERIA

3.1 <u>Target Population:</u> Describe the criteria that your RBS program will use to select the children, youth and families who will potentially be enrolled during the demonstration period. These criteria may include factors such as age; gender; current placement situation; emotional, behavioral and interpersonal characteristics; legal status, etc. Include a description of any phased or staggered enrollment into the RBS Program.

The focus for this project is best understood by the criteria used to define its overall target population, the factors that will be used to select specific children, youth and families from this general set for enrollment in the program, and the capacity that the program is designed to achieve during its test phase. The criteria that will be used to define the target population are:

- Between the ages of 6 and 16, and gender is not a criteria.
- Currently in placement in an RCL level 12 or higher group home, or at risk of or pending placement in an RCL level 12 or high group home, as determined by MAST, no minimum number of placements is required, and

- Placement or pending placement in such an RCL due to a combination of family disruption, abuse and or dangerous behaviors that cannot be managed in other settings, and
- Have an available family/kin or anyone else who can provide a permanent home as determined by MAST, and is willing to participate in the program. This family may be identified before enrollment in FCP, or family finding will be done after enrollment to identify family, or other permanent home in the community.
- Although the child or youth has a parent or primary caregiver who is connected with and willing to work towards permanency, a permanency plan is unlikely to be accomplished within 6 months unless intensive work takes place to resolve difficulties in attachment between the child or youth and his or her parents or other primary caregiver, and/or to address the challenges to reunification caused by the child or youth's persistent dangerous and disruptive actions that at present cannot be managed in the community.
- An average of 5 months is being used to allow for those clients who will need both more, or less time, in the residential component based on their individual needs. The average range would be 4-7 months, and while there is no cap on the amount of time in residential, this placement would be reviewed at MAST if they are approaching the upper end of this range.

3.2 <u>Enrollment Criteria</u>: When the number of youth from the target population exceeds your RBS capacity, what selection criteria and process will be used to determine which youth from your target population will be enrolled in RBS:

The selection factors that the MAST will apply in choosing the subset of the target population who will become the initial cohorts to be served through the programs will include the following:

- The nature and extent of the child or youth's family or primary adult caregivers' involvement in the child or youth's life, and their willingness to participate actively in an intense program to find and implement solutions to the forces that have disrupted the family's relationships;
- The age and gender of the child or youth;
- The strengths, needs, interests and goals of the child or youth and family;

- The extent and nature of the disruption in the relationship between the child or youth and her or his family;
- The history, nature and extent of any violence, trauma or criminal activity that has impacted the relationships within the family and between family members and the child or youth;
- The geographic location of the family's household, and their ability and willingness to participate in the FCP;
- The child or youth's legal status and the nature and directives of any outstanding court orders applicable to the child or youth and family;
- The child or youth's psychiatric status, and any indications or contra-indications that this status may have for the use of an FCP as the primary care intervention;
- The child or youth's current educational placement, and any needs to continue, modify or change that placement;
- The current openings for enrollment in the 3 Family Connections Programs;
- Specific resources, services and treatment options available from a given FCP or through community-based service agencies that work in partnership with an FCP; and,
- The history of any prior services and placements that the child or youth and family have received or experienced, and consideration by the child, youth, family, the FTM and the MAST concerning which options have been most helpful, and which have had a negative impact.

The proposed operating capacity for the program will be about 42 children or youth and their families at any given time, with up to 14 enrolled in each FCP. The 3 FCPs will begin by enrolling 6 children or youth and their families into their residential components. As those children and families move on to community-based phases of treatment, additional children, youth and families will be enrolled until the ongoing capacity of 14 is reached in each FCP. Then additional enrollments will occur as children, youth and families complete their enrollments and transition to natural and informal services and supports or leave the programs for other reasons. The goal is for each of the FCPs to reach the ongoing capacity of 14 children or youth and their families within 12 to 18 months, with an average of 5 months in residential, and the remainder in the community.

In order to provide crisis stabilization beds each provider will develop some ITFC capacity, will share crisis stabilization beds across sites, and as a last resort will use the crisis stabilization/co-mingling waiver when an rbs bed is not available in any of the three provider facilities.

Once the first cohort of FCP clients step down into the community, the MAST team will review any and all referrals to determine eligibility for FCP. In addition to the eligibility criteria listed above, children and youth will be screened in order to determine priority for placement, and a wait list will be created if necessary.

3.3 Assessment and Matching:

Please describe the approach your program will take to ensure that only the children and youth who are best served via Residentially-Based Services are appropriately matched for this level of care by answering the following questions:

3.3.1 Indicate the tools your program will use to assess/identify the needs and strengths of the children, youth and families who are referred for enrollment.

The primary diagnostic tool will be the CANS, the Child and Adolescent Needs and Services assessment tool developed by Dr. John Lyons. However, additional diagnostic tools specific to the characteristics and situations of particular children or youth and their families will be used by the clinical care staff in each FCP to explore needs and strengths in more detail. When a child or youth and family is being considered for the use of either an RCL level 12 or higher placement, or a referral to an FCP the case carrying worker and her or his supervisor will schedule a Family Team Meeting to consider the available alternatives and make a decision about which option is the most likely to produce positive outcomes.

The placing agency, through MAST, will determine the appropriate matching of a youth with an FCP provider by looking at family preference, geographical location, availability of placement, and any factors unique to that provider that may better meet the needs of that youth and family.

3.3.2 Describe the process/procedures that will be used to decide who will be enrolled and how matching enrolled children, youth and families with an RBS provider will occur.

The primary procedure prior to enrollment will be Family Team Meetings (FTMs). As described in more detail in section 2.2 above, FTMs are independently facilitated events that are designed specifically to help families make informed decisions about whether and what type of placement or other service intervention to use. In addition to the child or youth and immediate family and primary adult caregivers, all relevant stakeholders are

invited to attend, including extended family members, current or recent service providers, case managers and probation officers, and members of the child or youth and family's natural support network. Combining the insights, perspectives and commitment of all of these people helps to improve the accuracy and appropriateness of the screening and decision-making progress. FCPs will be added as one of the options that can be selected through the FTM process, if the criteria for enrollment are met.

The MAST meeting will then review the recommendation for enrollment in an FCP by the members of an FTM. That group will have the authority to authorize the enrollment in a specific FCP.

3.3.3. Explain how children, youth and families will be involved in the assessment and matching decision-making processes.

The use of the FTM process maximizes the participation of children or youth and their families in the decision-making process. A staff person from the county placing agency helps them prepare for the meeting in advance, and the facilitator insures that their voices and perspectives are dominant elements of the conversation during the meeting. In addition, the CANS is an instrument that draws from the insights of the family as well as the person administering it, and is a potent tool for generating productive conversations among the members of the Family Support Team about differences in perceptions regarding the strengths and needs of the child or youth and his or her family.

4. PROGRAM CRITERIA

4.1 Mission: What is the mission that you hope to accomplish through the implementation of your program? At a minimum, the mission should:

- ***Ensure that all children/youth who receive services are ultimately able to connect or reconnect with family, school and community following placement and***
- ***Provide for active family involvement, behavioral stabilization, intensive treatment, parallel community services and follow-up support to help achieve the mission.***

The *mission* of the FCP model is to interrupt at the outset of involvement the multiple placements and serially disrupted attachments that characterize the lives of those children and youth in our child welfare, juvenile justice and mental health systems whose behaviors and family situations have up until now kept them from achieving successful outcomes and permanency through participation in community-based resources such as SB 163 Wraparound, Therapeutic Behavioral Services (TBS) and Intensive Treatment Foster Care (ITFC).

4.2 <u>Vision (*Previously Question 3 of Program Description):*</u> Describe your vision of how your program will go about accomplishing the mission you have chosen:

The *vision* of the San Francisco RBS System is that through the use of FCPs children and youth with complex needs and situations will no longer have to experience one placement failure after another in the search for a match that works, but instead that they and their families will get the help they need, when they need it, and in the places most likely to help them achieve and sustain positive outcomes.

4.3 <u>Guiding Principles:</u> What are the value-based principles that will guide you in the development and operation of your program? These principles should support a program service environment that reflects the following values from the Framework:

- ***Respect for the culture, individuality and humanity of children, youth & families.***
- ***Maintaining a focus and building plans of care on the individual strengths, needs and goals of each child, youth & family member.***
- ***Providing for and insuring active and equitable family participation in all phases of intervention & treatment.***
- ***Helping children, youth develop and sustain positive connections with family, school & community.***
- ***Understanding and supporting the emotional, behavioral, intellectual and physical development of children, youth.***
- ***Providing positive and supportive assistance to guide children, youth in replacing the behaviors that require residential placement with pro-social alternatives that better express and address their unmet needs.***
- ***Helping children, youth in placement quickly return to and remain safely with their families, schools & communities.***

The *guiding principles* that the San Francisco RBS System will apply in setting up and operating the FCP model will include:

- All children and youth deserve a home, a family, a community, and a voice in their care – we cannot give up until each child and youth achieves permanency, stability and well-being.
- The job of an FCP is not to be a "placement" but to be a part of a process to return youth to their families and communities as quickly as possible in order to avoid the negative effects that long-term disruption can sometimes have on child and youth behavior and development;
- Families and kin in the broadest sense are the backbone of every child and youth's life, and family must be the foundation upon which our interventions are constructed.
- FCPs are not the family for their enrolled children and youth. No matter how well intentioned treatment is, this never changes. No matter what their file may say,

every child and youth has a family. The job of the program is to find, engage, and empower positive family relationships;

- Children, youth and families must have access to the development of, voice in choosing the components included in, and ownership for the accomplishment of their plans of care.
- Interventions must be strength-based, family-centered, individualized and culturally competent;
- Continuity and consistency of care, caring relationships and the locations of care are critical to sustaining long-term positive outcomes;
- Residential interventions, when used, must be short-term strategies designed to help children, youth and families make progress on their road to permanency, safety and well-being;
- To be effective, programs must operate in partnership with children and youth and their families, as well as other supportive adults and agencies and organizations in the community;
- To support long term success, programs must insure that each young person and family establishes a network of supportive individuals and activities in the communities where they will be living;
- The purpose of an FCP is not to fix a broken child or youth so they can return to their families and communities. The challenges these children and youth face are systemic in nature; overcoming those challenges requires a broader focus that includes all the domains of a child or youth and family's life;
- Neither is the purpose of an FCP to raise or contain a child or youth and keep them out of the community. Programs must be flexible and dynamic, not static. They must get into the community, collaborate with families and their local service providers and support systems, and in partnership with them solve the complex issues that are the driving forces behind the continuing disruptions in the relationships between these children and youth and their families;
- FCPs must not impose cultural values on a child or youth and family, but instead support them to understand better and celebrate more fully who they are and to reconnect with their cultures and communities;
- FCPs must be flexible in offering a horizontal continuum of services that can be accessed at any point or time by enrolled children, youth and families.

- Throughout the service delivery process, young people and their families must experience themselves as drivers of the service planning process and be treated as experts on their own strengths and needs;
- The concept of milieu in FCPs must be broadened. The program should not establish one milieu to which all children and youth in residence must adapt. Every child/youth comes from and will be returning to a different environment. The FCP's task is to learn about each child or youth and family's natural milieu and partner with them to make it safer, healthier and more permanent and effective;
- Accountability for achieving progress and effective outcomes should become a key element of further system development; and,
- One child – one system: The RBS system must develop a single, integrated, flexible and transparent system focused on insuring continuity and resolution to cross-system barriers.

4.4 Administration:

4.4.1 <u>Placing Agency Oversight</u>: Describe how the Placing Agency will ensure that each Providers' administration, management and staff will provide high quality, cost-effective care and facilities for youth and families enrolled in the RBS program. Also, include specific parties/units who will be responsible for carrying out this approach.

Interagency oversight of the San Francisco RBS System will take place through the MAST. The MAST meeting is a collaborative interagency review process that provides assessment, service, and placement recommendations for emotionally disturbed children at risk of or being considered for out-of-home placement in a high level of care, including residential treatment Levels 13-14, RBS, and the Community Treatment Facility (CTF). By working in partnership with the Family and Children's Services (FCS) division of the San Francisco Department of Human Services, the Community Behavioral Health Services (CBHS) division of the Department of Public Health, and the Juvenile Probation Department (JPD,) as well as with identified service providers, MAST promotes solution-focused recommendations that assure least restrictive and appropriate levels of care.

MAST replaces San Francisco's previous Wraparound and Interagency Placement Committee (IAPC) meetings in an effort to provide more efficient, effective and expedient service delivery and support. Members will review and approve referrals for the following:

- Out of state facilities
- Step-down from RCL 13-14 facilities or the Community Treatment Facility (CTF)
- Referral to RCL 13-14
- Referral to the CTF
- Referral to SB 163 Wraparound/Seneca Connections

- Complex cases requiring interagency consultation (i.e. high-risk behaviors, hospitalization, placement disruptions, etc.)
- Referrals for enrollment in the RBS Family Connections Programs.

MAST will also be the meeting where required authorizations by CBHS for managing EPSDT (Early Periodic Screening, Diagnosis and Treatment) slots will be made, to better align the oversight required by the behavioral health system with that provided by the child welfare and juvenile justice systems.

MAST is a comprehensive system for decision-making that operates at 3 levels but applies the same criteria at all levels. The three levels are:

- Level I will consist of the decision-making processes that takes place within each of the three placing agencies (HSA, CBHS & JPD) that sometimes result in a request for higher-end services, but most often connect children, youth and families with home and community-based resources. Some decisions at Level I can be made by workers with the approval of their supervisors, and some need to be approved by internal review meetings held by each of the three agencies.
- Level II will be an interdepartmental meeting that occurs every Wednesday morning from 9 to 11 at which direct service workers who are requesting approval for the high-end resources listed above make individual case presentations.
- Level III will be a meeting that follows immediately after the Level II presentations where managers from the 3 placement agencies and from designated service providers make final decisions about authorization of new services or reauthorization of existing services based up on the information presented during the Level II meeting.

At the Program level each child or youth and family enrolled in an FCP will have care and services coordinated through the FST process. The FST will integrate care management in several dimensions. Family Support Teams will consist of placement workers from the placing agency so that a consistent approach to the management of FCP enrollments will be maintained. Second, once a child/youth and family are enrolled, their FST will stay involved with them regardless of the particular place in which care is being provided. While understanding that straight-line improvement is unlikely when children, youth and families have complex and enduring needs, the Family Support Team will monitor and track the progress of a child or youth and their families and across all providers who may be involved with the family in addition to the FCP staff. The data accumulated regarding that progress will be aggregated, analyzed and compared at the meetings of the MAST and through the evaluations process.

MAST oversees an outcome-driven system of care. The expectation is that FCPs will demonstrate ongoing progress in helping enrolled children, youth and families to achieve permanency, safety and well-being. MAST includes representatives who will provide

feedback to fiscal management units of both the AFDC-FC billing and the mental health services billing departments of the member counties responsible for managing the contracts with the FCPs.

The MAST will assign an evaluation subcommittee to track outcomes for children, youth and families enrolled in the 3 FCPs through the use of several tools and measures. The chief objective measure will be the results of the quarterly administration of the Child and Adolescent Needs and Services assessment tool (CANS). Qualitative reports of the child or youth and family's perception of progress and satisfaction with services will be garnered through focus groups, interviews conducted by parent partners and by completion of the Youth Services Survey (YSS) and the YSS for families. In addition, each FST will track child and youth school performance, progress towards achieving permanency, improvements in emotional and behavioral health, and justice system involvement.

All of the providers establishing FCPs have school-based programs and some have non public schools at their facilities. Additionally, some have satellite classrooms in public schools. An educational representative serves on MAST, and FSTs and FTMs will also invite educational liaisons to participate relative to each individual enrolled child or youth. The San Francisco office of education has a foster youth liaison who will help coordinate communication at the agency and individual levels.

MAST will review the reports from the FCPs on the progress being achieved by enrolled children, youth and families and will pass this information on to the courts and the city and county's board of supervisors.

Also sitting on MAST is the FCP Project Coordinator, who works closely with the three providers, HSA, CBHS, and the FCP MAST RBS Sub-Committee. The project coordinator's duties and responsibilities involve working with management, administration, and staff to provide high quality, cost effective care. The FCP MAST RBS Sub-Committee will provide oversight by reviewing cases on a quarterly basis. The project coordinator will also be preparing a yearly report and reviewing evaluations. All staff will be trained on the practice guide, and the QA managers for each provider will also be assuring high quality effective service delivery.

4.4.2 Provider(s) Resource Capacity: For each Provider involved, describe the capacity for supplying adequate fiscal, material and personnel resources to carry out their role in the RBS program.

All providers have the fiscal, material and personnel resources to develop and operate Family Connections Programs. During both the planning and implementation stages of the San Francisco RBS system, the participating providers have explored and will continue to explore the sharing and/or pooling of administrative functions and service resources such as information technology and data collection/analysis, training, therapeutic foster family

care, kinship care, adoption services, etc. This will contribute to the achievement of fiscal neutrality for the system's operations.

Each of the providers has developed a variety of other innovative programs and will use that expertise to start up and operate its Family Connections Project. The following paragraphs provide a brief overview of the experience and resources that the 3 providers bring to this project.

Edgewood, St. Vincent's, and Seneca provide residential, community-based and school-based services for thousands of children and families in their homes, neighborhoods, and schools located throughout the Bay Area. All three agencies have Medi-Cal contracts with the San Francisco Department of Public Health.

Edgewood employs 405 staff members and serves approximately 5,000 children, youth and families each year. Seneca employs a staff of 760 and serves approximately 2,500 children, youth and families each year. St. Vincent's has a staff of about 150 and serves about 200 children and youth each year.

Through their wraparound programs Edgewood, and Seneca agencies have focused on supporting young people and their families to rely increasingly upon informal resources in their neighborhoods and communities. These informal supports include family members and fictive kin identified through the family finding process, public school teachers, coaches, instructors in dance, music and the arts, individuals affiliated with faith-based organizations, friends, and neighbors.

All 3 providers began as residential treatment programs with non-public school services. Over time, through client feedback, evaluation of outcomes, and research, they have made the boundaries between residential setting and community more porous, and now view their residential programs as one intervention among a continuum of early intervention and intensive support services.

In 1993, Edgewood partnered with kinship caregivers to create the *Kinship Support Network* (KSN) that transformed Edgewood into a community-based organization rooted in family/caregiver support and collaboration. Since then, it has integrated Family Conferencing across all programs, established a Research Institute, and became a learning organization for which outcome evaluation is woven into program design, implementation, and administration.

While Seneca diversified into intensive treatment foster care in 1991 and wraparound and public school-based mental health services in the mid-nineties, the most prominent example of its transformation is the recent conversion of the Oak Grove Community Treatment Facility (CTF) to the Oak Grove Center for Family Connections. Oak Grove's RBS philosophy centers on (1) implementing practices/interventions driven by the recognition that no young person exists or thrives in isolation, and (2) supporting the young person to feel safe, healthy, and permanently connected in lifelong relationships with his/her family.

Edgewood and Seneca also have experience operating as members of a collaborative services network. Seneca is a founding member of the Contra Costa Collaborative

Continuum of Care (C^5) that provides integrated residential and community services in that county. Edgewood has developed a collaborative family and child treatment program with Youth and Family Enrichment Services, as well as housing and educational collaborative for transitional youth in San Mateo. All agencies are members of the Bay Area Intensive Services collaborative.

Each agency also has extensive experience serving the children, youth and families in the FCP target population. Seneca serves the younger children in its latency-age residential treatment program, older youth in the Oak Grove RBS program and in the San Francisco CTF, and all ages in its wraparound, school-based, mobile crisis response, and TBS programs. Edgewood also serves the full age range in their residential programs and throughout all school and community-based services.

St. Vincent's has a budget of approximately $10 million and partners with Timothy Murphy School (budget of $3 million), a non-public school, in providing educational services for the residents of St. Vincent's and Marin County. St. Vincent's has the administrative capacity to insure that all children, youth and families enrolled in its programs receive high quality, cost effective care.

In 2008, St. Vincent provided services for 200 children. St. Vincent's also oversees a Foster Family Agency with an ITFC component, of approximately twenty (20) clients. The residential and foster family programs work closely together, share staff and form a continuum of care for those clients who can transition to foster families. The approximately 150 FTE's employed by Vincent's reflects the cultural makeup of the clients and is culturally competent in providing services.

St. Vincent's has a 40-year history of providing: community school placement; school attendance monitoring, mentoring and tutoring; medical, dental, recreational program and mental health referrals; support for parents; domestic violence prevention support: and substance abuse prevention support and prevention. Professional treatment services at SFBGH consist of counseling, psychotherapy, family therapy and case management services, educational services, medical referrals, community outreach services and a myriad of comprehensive social services. Special programs include family reunification, pre-placement services, emancipation, and partnering with other community based organizations (CBO's) in meeting the needs of its clients.

Services offered at St. Vincent's that contribute to the mission and the visions of the RBS pilot are:

- Residential services that support environmentally based interventions
- Mental Health services and case management services that support intensive treatment interventions.
- Residential and mental health services designed to support parallel, pre-dis-enrollment community-based interventions
- Foster Family services, including ITFC services, and Mental Health aftercare services

that support follow-up, post-dis-enrollment to insure the stability and success of the connection with home, school and community.

St. Vincent's serves boys between the ages of 7 and 18 years of age and can maintain them in placement until age 19 if they are graduating from high school. San Francisco is the host county for the agency and the surrounding Bay Area counties provide the most frequent referrals, although there are at least 12 counties using the services regularly. Child Welfare departments of San Francisco, Contra Costa, Sonoma, Santa Clara, and Alameda counties are the biggest sources of referrals. Three quarters of the referrals are court dependent children. The remaining quarter are referred through their school districts and local mental health departments.

St. Vincent's School for Boys/San Francisco Boys' and Girls' Home has a sixty (60)-bed residential treatment facility licensed by the California Department of Social Services as a Medi-Cal provider for mental health and day treatment services through San Francisco Department of Public Health and Community Behavioral Health Services. Located on an 850-acre campus, the program shares the campus with Timothy Murphy School, which provides educational services for the residents of St. Vincent's as a non-public school (NPS). The San Francisco Boys' and Girls' Home has 16 Level 12 beds in two homes which provide mental health and behavioral health services. SFBGH also provides mental health and behavioral health services in partnership with the Youth Education and Treatment Center at the Principal Center Collaborative

4.4.3 Provider(s) Consumer Input Capacity: For each Provider involved, describe how the administrative structure will include opportunities for ongoing input by representative family members and service consumers.

In all of their projects, both during startup and in ongoing operations, the three providers rely on a variety of tools for obtaining and responding to input by the children, youth and families they are serving. These open feedback loops will be particularly critical in the establishment and operation of the Family Connections Programs because of the unique aspects of family-based residential treatment. The FCPs will want to learn from the family members how best to transform the core principles and values of the program model into practical structures and process that encourage family engagement, support both family members and youth during the high-stress interactions that often accompany child and family re-connection, model, teach and reinforce coping strategies that can be effectively used in the home environment, and foster the understanding, bonding and mutual trust that the children, youth and families will need to maintain and continue to improve on the gains that are made during program enrollment.

The tools that the FCPs will use to support this learning process will include: inclusion of a parent partner in each FST, convening focus groups of families in each FCP to provide

insights about what is working and what isn't working about the program and suggestions for improving it, completing both independent and facilitated satisfaction surveys, having the lead parent partner serve on the management team for the program, and conducting exit interviews with all children, youth and families leaving or graduating from the program.

Consumer feedback gathered by individual programs will be shared with the MAST RBS Oversight Subcommittee to insure that the observations, insights and suggestions are available to all of the programs. This information will be added to the data provided through the formal project evaluation and the input from the family and youth advocates on the MAST and will form the basis for decisions about ongoing program improvement and refinement.

4.4.4 Provider(s) Data Capacity: For each Provider involved, describe the capacity for having a well-structured and reliable system for data management that accurately reflects its operations, costs, service delivery and outcomes.

All three providers are large, multi-service agencies that have had to develop and implement extensive and reliable systems for managing the operations, accounting, service delivery and outcomes of a wide variety of projects and programs. These systems will provide the capacity to manage the information flow that will be generated by establishing and operating their FCPs.

Edgewood and Seneca each utilize an electronic system for data collection and billing related to client children and families. In order to maximize efficiencies for the Bay RBS pilot project, the providers are exploring the sharing or pooling of this and other administrative functions, as well as service resources such as therapeutic foster family care and adoption services.

Seneca's data management and reporting system is considered one of the finest of its kind and has been praised by County agencies and by program staff who use the on-line system for its effectiveness and the quality of the reports it produces. Edgewood has an electronic medical record, outcome and billing system developed and individualized for services and built to facilitate efficiency, both internally and externally. St. Vincent's quality assurance department currently operates a client and fiscal database to record all residential and mental health activities, including services, outcomes, and billing for its clients. This data base records child and family plans of care, documents services, generates billing, tracks child and family progress and outcomes and prepares reports for the placing agencies and the courts. This system is stable and secure and contains data fields that are compatible with the multi-modal, multi-environmental nature of the FCP.

The San Francisco Boys' and Girls' Home has 16 Level 12 beds in two homes which provide mental health and behavioral health services. SFBGH also provides mental health and

behavioral health services in partnership with the Youth Education and Treatment Center at the Principal Center Collaborative.

4.5 Management:

4.5.1 <u>Management Roles & Responsibilities</u>: Please identify key managers of the Placing Agencies and Provider Agencies, and their roles and responsibilities for the implementation and operation of your program

Public Agency Managers

Participating Public Agency	Managing Staff Person	Role and Responsibility
San Francisco County HSA	Liz Crudo	Oversight of child welfare referrals to and supervision of and enrollments in FCPs, organizing and coordinating data collection, contract monitoring and program evaluation; Participation on MAST.
San Francisco County Mental Health	Sai-Ling Chan-Sew	Participation on MAST; coordinating/monitoring mental health contracts with FCPs; program evaluation, data collection.
SF County Juvenile Probation Department	A delegate will be named by the Chief Deputy Probation Officer	Participation on the MAST

Provider Agency Managers

Participating Private Provider Agencies	Managing Staff Person	Roles and Responsibilities
Seneca	Katherine West	Coordinate the development, staffing and implementation of an FCP within their agency; Participate on MAST; negotiate the necessary child welfare and mental health contracts with the corresponding county departments; respond to referrals and arrange for enrollments; Provide oversight for ongoing services to enrolled children, youth and families; collect and report on operational data and program outcomes; Provide oversight of quality assurance operations and program evaluation.
Edgewood	Matt Madaus	
St. Vincent's	Dan Gallagher	

4.5.2 Communication Network: Describe how your management team will have a communication network sufficient to insure that accurate information about issues and challenges regarding program operation or child, youth and family needs are noted and responded to in a timely and effective manner.

Communication in San Francisco RBS system starts at the direct service level. Each enrolled child or youth and family has a Family Support Team that includes a parent partner whose primary task is to insure that child or youth and family voice is heard and addressed.

At the system level, the San Francisco MAST system was designed specifically to comply with a directive by the Board of Supervisors that the San Francisco Human Services Agency establish an effective and efficient communication network to gather and assesses information and make decisions across departments and up and down through the management levels. Because its members oversee all services for children and youth with severe emotional challenges and their families, RBS will be addressed as an integral part of the continuum of care. However, the MAST group will use an RBS Oversight Subcommittee to provide close observation during the rollout and early years of operation. MAST also uses an oversight subcommittee to track the use of SB 163 services, and the RBS subcommittee will operate in a similar manner, meeting weekly and providing a summary of its results at the full MAST meeting.

In this way, San Francisco will have nearly continuous dynamic, face-to-face communications about the use of RBS across disciplines, agencies, management levels and perspectives on a weekly basis. Issues that arise both with regard to individual services as well as system operations can be addressed immediately and directly.

As noted earlier, the MAST includes youth and family advocates, and representatives from the courts, educational systems, and from local community service agencies. This will facilitate communication about the implementation of RBS model among a wider audience, provide additional perspectives and help resolve larger systemic challenges to successful project implementation.

By combining feedback and observations received from the Family Support Teams and the input from the RBS subcommittee, the MAST will be able to continually adjust the structure, operations and services of the RBS system to better meet the needs of children, youth and families in the target population.

4.6 Staffing:

4.6.1 <u>Staff Roles & Responsibilities</u>: What changes will the Placing and Provider Agencies be making in the staffing model in order to transform their existing group home programs into the new RBS program. Include information on the role and responsibilities, qualifications, experiences, and education necessary.

The San Francisco placing agencies will not be making any changes in their staffing models. However, existing case managers with placement responsibilities will be trained in the nature and use of the new FCPs, so that they can make appropriate suggestions for possible referrals for FCP enrollment, and so that they can participate effectively on the Family Support Teams for any of their clients who may be enrolled in an FCP.

The 3 provider agencies of the RBS system will each establish a new service unit called a Family Connections Program that will implement the principles of RBS. These FCPs will deliver family-centered residential treatment designed to help children, youth and families with relationships that are severely disrupted and accompanied by a continuing pattern of challenging behaviors by the child or youth that stands in the way of providing intensive treatment services in a community setting.

Each FCP will have a residential component with room for up to six children or youth who are there for extended stays during the first phases of the family-based treatment process, plus room for other children or youth who are primarily living at home or in the community, but who need to return for brief stays while certain acute care and supervision issues are resolved. Near the residential component will be a space designated as a family connections center where children and youth and their families can work together with program staff to understand the driving forces leading to their disrupted relationships and the accompanying challenging behavior patterns of the child or youth, identify techniques for addressing those driving forces, and develop coping strategies for maintaining positive relationships and managing the challenging behaviors that can be used in the community. Additionally, the FCP will have a multi-environmental treatment team that will provide direct support both in the residential component and at home and in the community. When fully operational each FCP will be staffed to support up to 14 children or youth and their families.

When capacity of 14 clients (6 in residential and 8 in the community) for each provider is reached, each of the FCPs will be staffed as follows:

Position	FTE	Roles and Responsibilities	Qualifications
Senior Level Director (Regional/Division Director/Assistant Executive Director)	.30 or less	Oversight for programs across the agency, including but not limited to the FCP, and provides direct supervision of all program directors.	Masters level position, with 5+ years upper level management experience.

Voluntary Agreement

RBS Program Director	.5	Manage the development, implementation and operation of the FCP	Masters level or above., at least 5years experience, at least two as a supervisor or manager
Lead Clinician/Clinical Supervisor	.5	Supervise all behavioral health service plans, assessments and provide liaison with community mental health services	Masters level or above, 3 years of experience, License preferred
RBS Supervisor/Milieu trainer	1	Supervise the family specialists across environments. Will also provide oversight of the residential component and coordinate program management with the program director and lead clinician. They will also provide the training for establishing and maintaining the therapeutic milieu in the residential and community environments.	Bachelors level or above, at least 5 years experience, at least 2 as a supervisor or manager
Family Specialists	12-15 (depending upon need)	Help to implement the behavioral health elements of the Comprehensive Care Plans in the residential component and in the community, support develop and use of improved family interaction and coping skills, participate in the Family Support Team meetings. Maintain the residential milieu, provide support, nurturance and structure for the residents, help them manage their challenging behaviors	Bachelor's level or equivalent experience at least 1 year experience working with children or youth and families
Clinical Care Coordinators	2	Facilitate the engagement process, strengths, needs and goals discovery, and the Family Support Team process. Document the Comprehensive Care Plan developed by the FST, and coordinate its implementation. With the FST track service delivery the progress being made by children, youth and families	Master's level, trained in facilitating strength-based, family-centered plan development and coordination of service activities across multiple domains.
Facilitator	1	Facilitate child and family team meetings, take notes, and track progress on meeting objectives.	Master's level, trained in facilitation, experience working with children and families preferred.

Voluntary Agreement

Family Partner	1	Provide engagement and support for family members and youth, help them understand the nature of the program and insure that they have access, voice and ownership in the process of developing and implementing the Comprehensive Care Plan, and help with facilitating accurate and effective child, youth and family input in the evaluation and continuing improvement of program services and operations.	Prior experience as a parent, family member or primary adult caregiver of a child or youth with serious emotional and behavioral needs who received services through 1 or more of the county systems of care, including child welfare, mental health and juvenile justice.
Administrative Assistant/ Scheduler	1	Provide assistance with internal record maintenance, scheduling, obtaining needed external records, provide quality assurance oversight of treatment records. They will also be responsible for scheduling family specialists in the community.	Bachelor's level or equivalent experience, at least 1 year of prior administrative support experience.
Consulting Psychiatrist (contracted services)	.25	Assist with assessment and evaluation of children and youth's needs as requested, consult with lead clinician and staff on intervention strategies, manage any medication issues that children and youth may have if they do not have their own community-based prescribing psychiatrists.	M.D., board certified child psychiatrist, at least 1 year experience working with children and youth with severe emotional and behavioral needs
Family Finder/Foster Home Recruiter	.25	Duties include foster home recruitment for the two providers with FFA's, and will do family finding primarily for the provider who does not run an FFA.	Bachelor's level, or equivalent experience.
Quality Assurance Personnel	.5	Maintain files, support all QA functions	Bachelor's level or above.
Nurse	10 hours or less/week	Provide direct patient care services to clients and assist in actual caring for sick children in the residential cottage.	Registered nurse with a current license issued by the California Board of Registered Nursing
Facility Maintenance	10 hours or less/week	This position is responsible for handling all repairs and maintenance at all agency facilities.	One year minimum experience in related skills

On-call crisis response	Stipend position/duties will be rotated amongst FCP mental health staff.	The responsibility for being on-call and responding to crises by phone, or in person, as needed will be carried by all FCP who provide mental health services, on a rotating basis.	See existing qualifications listed under each of the FCP staff positions that are providing mental health services (clinical care coordinator, family specialist, lead clinician/clinical supervisor)

See attachment for all job duty statements.

4.6.2 <u>Provider Staff Capacity Plan</u>: Describe how the RBS program will recruit and retain skilled and effective staff, maintain adequate and consistent staffing levels, and ensure that staff understand and are able to put into action the mission and values of the program.

Each of the provider agencies is planning to use experienced staff members to fill the majority of the positions in the new FCP. All 3 have a variety of existing programs from which to recruit these individuals. The plan will be to bring a core team together that will start the program with the first group of enrolled children and youth and their families, and then gradually add staff corresponding with new enrollments as the initial enrollees complete the early phases of their programs and begin receiving care primarily in the community. The core team staff will be selected for their interest in and willingness to undertake a new approach to serving children, youth and families and their demonstration of creativity and flexibility in providing services in the past.

The core team will establish the foundation values and culture of the program and transmit it to new staff who are added as enrollments increase. This of course will take place along with the training program that is outlined in the next section; but equally important with training are the day-to-day interactions through which organizational culture is also transmitted.

The providers all have the extensive human resource and training programs necessary to recruit, train, and retain sufficient numbers of qualified staff for program implementation. In addition, these agencies recruit program staff from the neighborhoods where RBS-enrolled children and families are likely to reside in order to support diversity and cultural competency.

The agencies' human resources recruitment model is designed to support the mission and vision of RBS in that there is a focus on searching for new personnel who are interested in delivering strength-based, family-centered and outcome-oriented services.

The agencies have achieved excellent records for staff retention through several strategies. First, they do this by selecting new staff that have the energy, skill and commitment to build a successful career in child and family services. Second, they provide a variety of opportunities for personal development and career advancement. (Being able to apply to become a member of the FCP start-up team is one example of an opportunity for advancement that can be offered.) Third, they offer reasonable compensation within the context of the always under-funded field of human services. Fourth, they provide staff support and guidance to address the challenges of burn-out and shared trauma that are an inescapable element of working with children, youth and families who have had harrowing life experiences.

All 3 agencies use a comprehensive recruitment, hiring and staff preparation process that matches new hires with the position and location best suited to their qualifications, experience, schedule, career goals and geographic location. Applicants are also screened at their proposed locations by the individuals who would be supervising them, should they be hired. Once hired, all new staff members participate in a pre-service training program that introduces them to the roles and expectations for working in the agency and for providing effective care for the children, youth and families that the agencies serve. Following this universal pre-service training, each agency also has specialized training for staff going into specific service roles.

In the case of staff who will be working in Family Connections Programs at the 3 agencies, this specialized training program will also include participating in the cross-agency training program that is described in the next section. One of the benefits of this cross-agency training is that FCP staff will be able to join in informal learning communities with their colleagues in the other agencies who are performing similar roles. A learning community is a "right-sized" group of identified members from a set of sites who are in contact with each other regularly for the purpose exchanging ideas to improve their RBS implementation skills.

Through efforts such as these, the 3 provider agencies will develop a skillful and committed cadre of caring professionals dedicated to the effective implementation of the new model for family-based residential care as a means for helping children, youth and families achieve and sustain permanency, safety and well-being despite the challenges that led to the disruption of their relationships in the past and any obstacles that they continue to face in the present.

4.6.3 <u>Placing Agency & Provider Agency Staff Training Plan</u>: Please describe your plan for training the Placing and Provider Agency staff who will be implementing your program and also describe how ongoing (continued) training will be provided. Include the positions that will require training, the training topics essential to implement your RBS program, and the general skill development you are seeking to improve.

The San Francisco RBS implementation team has created a Training Subcommittee to develop a specialized training model. This group includes representatives from all providers as well as county agency representatives and a representative from the Bay Area Training Academy. This training group meets frequently to prepare a training plan for the RBS system, identify current capacity for training and forecast future training needs. Since the RBS project is an ongoing, developmental model, training details will emerge throughout implementation of the RBS process.

Principles guiding the training plan include:

- **Integration**: The San Francisco RBS system is committed to creating and implementing an integrated training capacity rather than a stand-alone model. There may be a need to develop a method to communicate core RBS concepts but the training group is not planning to create a series of unique RBS training events but instead, is working to integrate RBS core values, practices and principles into existing training events.
- **Cross-Organizational Resource Management**: In bringing everyone together, the training group found that training resources could be shared to enhance everyone's work. This enhances partnership and keeps cost down.
- **Build on What's There:** The Bay Area already has multiple trainings that are compatible with the intent of RBS. The training group is planning to enhance what is there and then fill in gaps rather than creating specialty-training services.
- **Youth and family members Involvement:** All training programs will be developed with significant input from youth and family members who have experience with residential care

San Francisco RBS Training Structure

Structure for Delivery of Values, Skills and Knowledge	Details
Needs Assessment by Program, Partner or Individual	Training will be tailored to the unique needs of each program, partner or individual involved in the RBS community. Part of what the training committee is committed to is avoiding duplication and integrating RBS training within existing structures. Training Directors in each public and private will complete an individual

Structure for Delivery of Values, Skills and Knowledge	Details
	assessment of their agency's situation so that training is tailored to the needs of individuals, programs and partners. Children and families who are participating in the RBS system will play an integral part in developing a training curriculum.
Individualized Plans by Programs/Persons includes: Tracking Methods "Passport." The Passport will be issued to all employees and families associated with RBS implementation and will outline core concepts and competencies and encourage learners to seek out trainings that help to build those core competencies. The Training Passport will be portable in that it travels with the individual as they move from provider to provider or employer to employer.	The RBS training committee has also committed to creating tracking methods to assure that participants, no matter where they are housed or what their title is, will have assurance that they are participating in baseline values, knowledge and skill activities. The Training Committee will not only track progress and delivery of training but will come together periodically to review training delivery to determine whether any gaps exist. If so, then training resources will be integrated across organizations to fill discovered gaps as they emerge.
On-site Training • Orientation to RBS (e-learning module) • Supervision • Program Specific Orientation	Recognizing that there is a difference between attending training and actually learning things that can be applied, the Bay Area RBS Training model involves training and skills development within a hands-on context. This means that supervision within RBS will be seen as an integral part of training to insure that people are able to put learning in context and to immediate use. Training will be delivered within the context of programming and supervision will be a critical part of reinforcing and assuring ongoing staff learning.
Cross Training Opportunities	Each of the county agency and provider partners in the San Francisco RBS system are committing to open up cross system/cross agency training opportunities. Increasing access to staff development opportunities for FCP staff, partners within the community and youth and families will allow the project to build on what's available and create consistency across system, community and family sectors.

Training recipients

Placement agency workers and provider agency workers will be the recipients and target audience for this training plan. Training will be open to everyone needed to implement the model and/or participate in Family Team Meetings where enrollment in an FCP may be discussed, and serve on Family Support Teams for enrolled children or

youth and their families, including in-house support and mental health staff, supervisors and managers, community partners, parents and community members. All employees will receive training at new hire and moving forward RBS reform core competencies training will be integrated into both new hire and on-going training plans. Utilization of the passport will keep team members current on the training needed and completed.

Quality management
Individual agency & county training programs management structures will manage the passport requirements of their agency staff. The Subcommittee will continue meeting quarterly and review the training plan effectiveness, content, & consistency with RBS reform goals. Evaluation reports will be generated for all training to ensure the feedback is integrated into improving the training plan and meets the criteria for the core competencies in the training plan.

Plan for new and continuing staff as the program develops and evolves
In collaboration with the RBS oversight subcommittee and MAST, the training subcommittee will reassess the training plan regularly. This sub-committee values on-going skill based training and this value will be incorporated in to the RBS-reform training plan.

See attached training plan for more details.

4.7 Quality Assurance

4.7.1 Describe the tools and/or methods your program will use to insure accuracy and accountability in service delivery and the persons responsible for managing quality assurance.

QA Tools	Intent/Purpose: What aspect of the program is this tool measuring?	QA Methods	Frequency	Person/s responsible: Title and Duties
Parent Empowerment Tool	Measures parents' degree of involvement with FCP services.	Survey/focus groups	Monthly	FST or Provider Lead
Client satisfaction survey	Measures children, youth and families level of satisfaction with FCP services.	YSS and/or YSS-F as noted in the Evaluation Plan	Quarterly	FCP staff
Random Case Review	Will determine if FCP process and protocols	Peer Quality Review	Bi-annual	RBS Oversight Subcommittee

	are being uniformly followed.			members
Practice/policy change Review	To determine if policy change is needed to facilitate culture change	Internal agency communication tools – focus group/staff meetings	Quarterly	MAST
Monitor and evaluate providers to ensure that services are adequately provided for each child	To assure consistency and continuity in practice and service delivery.	Status reports audits, site visits from providers on child/youth and	Quarterly	RBS Oversight Subcommittee members and MAST
Identify and track problems with providers to ensure improvement or resolution	FCP problem resolution and system adjustment.	Review of performance and outcome data, input from youth and families, onsite observation	Monthly	RBS Oversight Subcommittee members and MAST

4.7.2 Explain how each Provider is linking its quality assurance system and goals with those of the broader community, including the county SIP and state PIP.

The quality assurance systems and goals of each provider agency are already linked to the county SIP and state PIP, as those broader community goals are taken into account when designing, implementing, and evaluating agency programs. In addition, the providers will participate in the RBS oversight subcommittee and MAST meetings along with placing agency representatives and child/family advocates. These groups will provide direct feedback on the quality of the services and outcomes being achieved and will make suggestions for system and service improvement.

The FCP model that the San Francisco RBS Implementation Team has developed to implement the principles of RBS is well-matched with the goals of the county and state child welfare SIPs and PIP, as well as the state mental health PIP because FCPs are designed to help children, youth and families who are at present most likely to experience extended, if not permanent disruptions in their relationships and placements, even with out best, current community-based service options. Helping this small, but important subset of the county and state service population achieve permanency, safety and well-being will result in a significant advance towards accomplishing the SIP and PIP goals.

The congruence with the SIP and PIP goals can be seen by a review of the Outcome Measures that will be applied to the implementation of the FCPs in San Francisco:

RBS Program Outcome Measures:

Service Activity Measures	Child and Family Outcome Measures
1. Be aligned with the Child Welfare Services Accountability and Outcomes System that is implemented under AB 636. 2. Be incorporated in the contracts of providers through which placements are made, and reimbursed, and the format used to document the plans of care generated through those placements. 3. Be designed to ensure that group home placement is used judiciously, appropriately and effectively in order to obtain specific, affirmative outcomes that cannot be reached using services provided while a child lives in a family setting in the community. 4. Families, including children, will experience themselves as decision makers in all service planning activities.	1. Reduced lengths of stay in group care. 2. Increased % of youth dis-enrolled to permanency (reunification with immediate family, adoption, legal guardianship with a relative or fictive kin, or living independently within a supportive community. 3. Increase children's proximity to their home and community. 4. Improved placement stability for youth in group care. 5. Decreased % of youth re-entering after dis-enrollment from group care; 6. Families will have greatly expanded contact with their children while in the group home setting. 7. Enhanced wellness and health as measured by normed measures agreed upon by the evaluation subcommittee, e.g. CANS, YSS and YSS-F. 8. Participating youth are enrolled and actively participating in educational or vocational program and/or employed at six months after dis-enrollment from RBS-including community based aftercare services. 9. CFSR Outcomes will continue to be utilized for outcome measures.

5. SERVICE CRITERIA

5.1 Engagement

5.1.1 <u>Engagement Processes</u>: Do staff have explicit processes for engaging the children, youth and families who are referred for care, and accurately determining their strengths, needs, and goals? Explain.

To insure that children, youth and families are fully engaged in the effort to build and sustain strong family connections, programs will have processes that support meaningful involvement, a service delivery environment that is supportive to family participation, and

specific methods for maintaining consistent engagement throughout the period of enrollment in the program.

Once a child or youth and family have been referred for enrollment with a particular FCP, staff from that facility will begin an engagement process to help them understand and participate in the program's operations. Engagement has both emotional and informational components. A two-person team consisting of a parent partner from the FCP and the individual who will be facilitating the Family Support Team process will lead the outreach and engagement process. The purpose of the Family Support Team is to develop and implement a unified plan of care that will address the critical unmet needs of the child or youth and family that are standing in the way of a positive and sustainable reconnection.

The FST facilitator (who may also be called a care coordinator in some of the FCPs) and the parent partner will begin the engagement process at the pre-enrollment interview, and will provide an introduction to the mission, vision and guiding principles of the FCP, a tour of the facility, a review of the process that the program follows and an overview of the types of resources that children, youth and families can access through the comprehensive plan of care.

All FCP staff members will be trained to openly engage children, youth and families through active listening and focused and reflective responses to child, youth and family questions. The purpose of outreach and engagement is to:

- Engage youth and their families, restore hope and build momentum by presenting the FCP as an innovation different from previous services and placements, and by fully inviting children, youth and families into the decision making from the very beginning;
- Orient the family to the FST approach so they can be active and effective participants;
- When the family indicates that they understand how the FCP will operate and is willing to participate, obtain all necessary consents and gather any available assessments and baseline data to help the child or youth and family make well-informed decisions;
- Explore the child and family's strengths, needs, culture and vision for the future; and,
- Identify individuals who can be brought together in a team to help the child and family reach their goals. Particular attention will be paid to invite people to join the team who reflect the cultural, linguistic and service preferences of the family.

Upon enrollment, the Family Support Team process will begin. This is a 4 step, family-centered process that starts by helping the child or youth and family identify their functional strengths and coping skills, the critical unmet needs that are the driving forces behind the disruptions that have occurred in their family relationships, and the specific

outcomes that the child or youth and family want to accomplish through their participation in the FCP. With that foundation, the process moves on to create an outcome driven plan that addresses key unmet needs using strategies that are based on the child or youth and families strengths, coping skills and preferences. Next the plan is implemented and modified as needed based on the family and team's observations about what is working and what isn't. Finally, the fourth step of the process is to assist the child or youth and family as they transition to more natural and informal sources of support and prepare for graduation from the program.

This process supports meaningful child, youth and family participation because the focus, parameters and strategies of the plan of care have to be based on the input and decisions of the child or youth and family. Without their ownership the actions become things that are done to, rather than with the family, and are far less likely to be successful.

5.1.2 Family Supportive Environment: List and describe the supports, such as the use of parent partners and peer advocates, provided to insure that children, youth and family members understand the program's nature and processes and have adequate and effective voice and participation?

Each FCP's physical service environment will be designed to be supportive of child, youth and family involvement and investment. Ample opportunities and support will be provided to open the campus to extended family visits and participation. Each site will contain a family connections center, where children, youth and families can together practice the skills and approaches they will use to adjust their interactions at home in the community. They will be able to test new options in the family connections center, then go into the community try them out in the environments where they will be used, then return to the center for more practice or adjustments as needed.

In addition, as noted in section 5.1.1 above, FCPs will provide active interpersonal support for families. Every family will meet a parent partner as part of the engagement process to insure that children, youth and family members understand the program's nature and processes and have adequate and effective voice and participation.

5.1.3 Engagement Consistency: Describe how the engagement process will be used consistently and effectively with each child or youth who is referred for services and with his or her family members?

Family member engagement will be consistently and effectively continued throughout the period of enrollment through the mechanism of the Family Support Team. During the 4 phases of Engagement, Planning, Implementation and Modification, and

Transition, supported by the team facilitator, the FST will continue to meet, tracking progress and problems, documenting new skills and accomplishments, and updating the plan of care based on the evolving needs, strengths and choices of each child or youth and his or her family. Meetings for updating and modifying the plan of care will occur regularly. However, the family will also have the opportunity to call a meeting at any time they feel that additional support or problem solving is needed. The parent partner will be checking in regularly with the family to make sure that they feel the rest of the team is still in tune with their perspective and needs.

5.2 Service Planning

5.2.1 Individualized Service Planning: Describe the process your program will use to develop and document the individual service plan that will guide intervention and assistance for each enrolled child or youth and his or her family.

A consistent template and process for developing Comprehensive Care Plans (CCP) will be used by the FSTs in each of the Family Connections Programs. These plans will define and coordinate each child or youth and family's individual array of services and supports. The CCP is best understood through the process that is used to develop and maintain the plan and the content it contains, through the way in which it is designed to coordinate services planning in relation to the specific unmet needs of the child or youth and family, and by the strategies that are used to involve children, youth and families in developing their plans of care.

The Family Support Team will carry out the *process* through which plans of care will be developed. The team will be anchored by a facilitator or care coordinator and a parent partner and will include key stakeholders whose help will be needed by the child or youth and family to achieve their desired outcomes. Besides the child or youth and family, the FST will have a balance of formal and informal members. Examples of formal members include the child or youth's case carrying worker from the child welfare, juvenile justice or mental health systems, mental health professionals assisting the child or youth and parents or adult caregivers, and school staff. Informal members would include extended family members and members of the child or youth and family's natural circles of support, ranging from ministers to next door neighbors, to best friends.

The FST will start by recognizing the functional strengths that the child or youth and family frequently use to deal with challenging situations that had been identified through the conversations with the care coordinator and parent partner during the engagement phase. Then the team will look at the critical events that seem to produce the events and conditions that have led to the disruptions that resulted in the referral to the FCP. From an examination of those events and interactions the FST will then work with the child or youth and family to extract the key unmet needs that appear to be the driving forces behind the continued repetition of these events and interactions. The FST will then listen carefully to

clearly understand the child or youth and family's vision of how they want things to be different in their lives. Based on that vision, the FST will listen for the family's mission and goals – what they want to accomplish through their involvement with the FCP.

The FST will then map out the steps that will have to be taken to help the child or youth and family accomplish their mission and develop an action plan for carrying out those steps that builds upon the strengths and preferences of the child or youth and family.

The *content* of the plan will identify each action step, the need it is designed to address, who will carry it out, how and when it will be carried out, how the team will know whether or not the action has taken place, and how the team will measure whether and to what degree it has helped the child or youth and family move closer to their goals.

Plans will be domain-based, arranging action steps by the areas of the lives of the child or youth and family where the action of that step will be focused, including domains such as:

- A place to live
- Getting along as a family
- Doing well in school
- Making a living
- Taking care of physical health needs
- Taking care of emotional health needs
- Participating in the family's cultural and spiritual traditions
- Being a part of the community
- Making and keeping friends
- Having fun
- Helping others

Arranging the plan by domains allows all of the team members to see the inter-relationship among the various actions so that the *overall effort can be coordinated* to address specific unmet needs. Laying all of the actions and timelines out in the same document allows for synergy and prevents counter-productive scheduling and other conflicts. Because most primary actors involved with the child or youth and family will be members of the FST, they will have a better understanding of one another's roles and responsibilities in achieving the overarching goals in the plan of care.

5.2.2 Active Family/Youth Participation: Describe how the service planning process includes active and equitable participation by children, youth and families.

Strategies to insure child or youth and family involvement in the ongoing development and implementation of the plan include tying all of the actions in the plan to outcomes that the child or youth and family have selected for themselves, building in opportunities for early success so that the child or youth and family can feel a sense of accomplishment and increased self-confidence, and choosing activities that capture the energy and enthusiasm of the child or youth and family.

Since the child or youth and family are central members of the FST, they will not only be involved in every step of developing the plan of care, but will also be responsible for carrying out many of the elements of the plan. Over time, as the resiliency of the family increases, and the arc of care nears the time to transition out of the FCP, the majority of the activities will be carried out by the child or youth, family, or formal and informal members of their local support network.

5.2.3 Child-Specific Planning: Describe how this process will adapt the RBS program's general services interventions, treatment and support options to address each child or youth's specific unmet needs and those of his or her family.

The planning process described in section 5.2.1 will adapt the FCP's general program services to address each child or youth and family's specific unmet needs by building services from needs out, rather than services in. To put it another way, all of the service options that are available through the FCP and any other partner agencies with which it is aligned are possible but not necessary elements of a given child or youth and family's comprehensive care plan. To build from needs out the FST will brainstorm with the family "What are all the possible ways for helping you, in the context of your particular strengths, culture, preferences and circumstances, address this particular critical unmet need?" Looking at the range of options thus generated, the FST with the guidance and input of the family will select the strategy that is best aligned with the family's profile, and that appears to have the greatest likelihood for success. Then the FST will decide whether an existing resource in the FCP can be used as is to implement the chosen strategy. If not, the question becomes whether an existing resource can be adapted to fit the need. If that also is not possible, then the FST may use the flexible funds available through the AB 1453 re-allocation of state and county IV-E dollars to assemble the needed service option.

5.2.4 Parallel & Follow-Up Services: Describe how the plans will identify strategies for providing or obtaining parallel services in the home and community to prepare for the return of the child or youth and for delivering follow-up services to maintain the community placement once it occurs.

Each FCP will provide directly or subcontract for the coordinated and coherent delivery of a full array of services and supports designed to help children or youth and their families understand, address, adjust to and recover from the driving forces that have resulted in the ongoing disruptions in their relationships. These services will include environmentally based interventions, intensive therapeutic interventions, parallel services provided in the community while the child or youth is still staying in the residential component of the program, and follow-along and aftercare support provided after the child or youth has returned to live with her or his family. An equally important part of the service array are the efforts needed to insure coordination between the assistance provided on campus in the residential component and the family connections center, and in the community.

Details about the various aspects of these services will be provided in this section and in the sections that follow, but it is important to note, as was pointed out in the previous section, that the FCP will provide highly individualized services. Children, youth and families will not all proceed through the same treatments and services. So this description should be seen as the foundation and not the total package.

Although not mentioned in the question introducing this section, it is important to see the parallel and follow-along services in the context of the family-based approach FCPs will take to meeting the needs of enrolled clients.

Environmentally based interventions

The environmentally based interventions in the residential component of each FCP will be designed to provide the short-term, high-impact behavioral stabilization, assessment, and support required to help children and youth who are repeatedly using problematic behaviors to reflect the underlying conflicts, fears, trauma, loss, loneliness and turmoil in their lives.

Often, working through difficult family issues can initially escalate rather than diminish the behaviors that children and youth use to show how they are feeling. By creating a safe and supportive environment with high levels of staffing, the residential component can help children, youth and their families deal with the stress they will experience during these times without further exacerbating family conflict or risking additional changes in placement.

The balanced and comforting milieu of the residential component will also provide a neutral baseline environment that will help the program's clinical staff more accurately

assess the components of the child or youth's internal model of the world, especially as it applies to relationships and attachments with peers, adults and family members.

Intensive treatment and interventions

The therapeutic component of each FCP will provide an array of intensive treatment and interventions designed to help the child or youth and family understand and address the psychosocial and neurobiological drivers that may be contributing to (or resulting from) the disruptions that the family has experienced and is experiencing. Each child or youth and family's circumstances and needs are different, but frequently having a thorough assessment in the context of an ongoing series of thoughtful interactions and a carefully assembled history of the child or youth and family's long-term ups and downs will provide insights that were obscured previously by the turmoil that characterized the family's life together and apart. When an assessment and analysis has been developed that makes sense to the child or youth and family, a treatment plan will be established to address their concerns and help them move toward resolution or management of the issues underlying their ongoing pattern of disruptions.

The treatment offered will be coordinated with and included in the comprehensive plan of care, and might include elements such as individual therapy, family therapy, psychiatric services, medication, day treatment, and Therapeutic Behavioral Services.

Parallel services

The FCP begins its relationship with the child or youth and family in the residential unit and the family connections center on campus, but as quickly as possible begins to transition the locus of support and services to the environment where the child or youth will be living upon completion of enrollment. So that the child or youth and family can receive effective parallel, pre-reunification, community-based services and supports a service team from the FCP will frequently travel with the child or youth and family to the family's home to try out the skills that were being taught and practiced in the family connections center, such as having meals together at home, completing chores, going shopping, engaging in recreational activities, etc. In addition, the service team may also spend time with the child or youth at the school that he or she currently attends or will be attending upon reunification, and at other community sites the child or youth and family may be using, including family resource centers, shopping malls, recreation facilities, etc.

The interface between the residential component and the home and community is semi-permeable. Since achieving a safe and sustainable return to family and community is the goal and purpose of the FCP, it makes sense to get out to those locations as soon as possible. That way the child or youth and family and the entire FST can begin sorting through the issues that have undermined earlier attempts to deal with the problems and disruptions that have overwhelmed the family. But by testing new options for getting along more effectively while the security and support of the residential component of the

FCP is still available, there is a safety net in case things go wrong. In that way if difficult events do occur, they are simply learning experiences, and don't require another disruption of the child or youth's living arrangements.

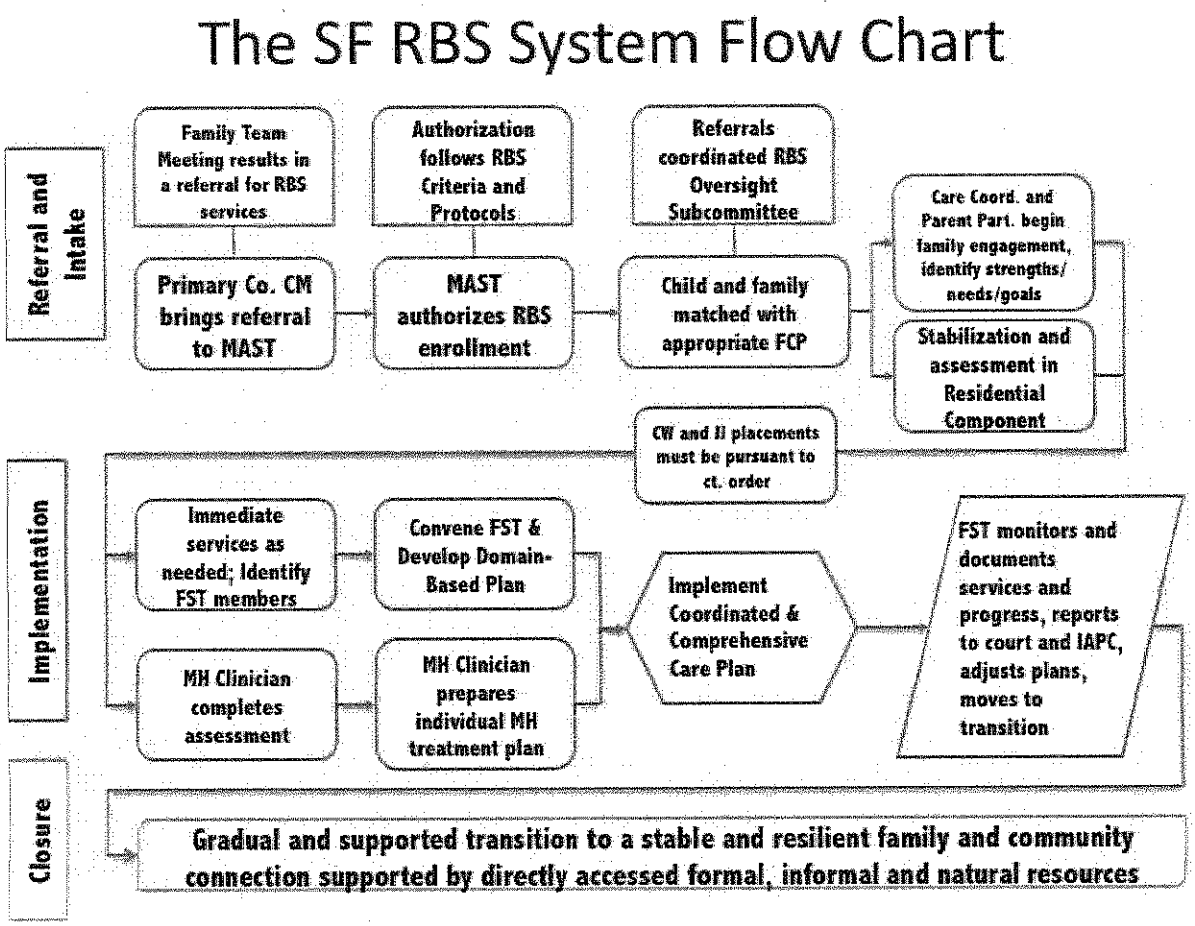
Follow-up and Transitional Support

After the first layer of driving forces have been addressed sufficiently for the child or youth to move back with the family, the work of the FST doesn't stop. If anything it accelerates because ongoing follow-up, post-reunification support and services provided during the first few months following the child or youth's return home are a critical element in helping children or youth and their families lock in and adhere to the new ways of interacting with one another that have been developed and practiced while the child or youth was staying in the residential component.

Even overnight and weekend visits offer only a limited foreshadowing of what it will take for children or youth and families that have suffered big disruptions on a repeated basis to settle down and make a life together. Moving back in is the only way to really see what is going to happen. The in-home service team from the FCP will be there to provide ongoing treatment and instruction, and to offer both onsite and phone support during times of crisis, depending on what is needed.

As the child or youth and family adjust to their new way of life together, the FCP can gradually begin to reduce the level of service involvement – always based on the action plans and modifications developed through the FST. A period of transitional support will be made available for all families as they approach the end of their enrollment to insure a smooth transition to local formal and informal supports and services.

5.2.5 Flow Diagram: Please provide a diagram or flow chart that clearly illustrates the flow or movement of a particular child through the RBS program.



5.3 Service Implementation

5.3.1 Services Baseline: Please indicate the service arrangements that are currently being used to meet the needs of the members of your target population that will form the baseline against which you will measure the changes in system and service design that you will be implementing through your project. This should include the type of services, the service description, the approximate average duration of service involvement, and the locations where these services are being provided.

Type of Service	Service Description	Average Service Duration	Service Location
Residential treatment center	RCL 12 and 14 group care.	Although these children are 16 years of age and under, most have already been placed outside their homes for more than 3 years.	They are placed in group homes throughout the Bay Area and beyond.
Day treatment Intensive	Group based intensive mental health services delivered in a NPS or in the group home setting.	24 months plus	In conjunction with group homes but can also be used with community-based treatment.
Day treatment rehab	Group based mental health services with larger ratio than DTI.	24 months plus	As above.
Intensive treatment foster care	Foster family home with additional services such as crisis stabilization, mentorship, shadowing, parent partners.	12-36 months	In several Bay Area counties near the FCP
Therapeutic behavioral services	1:1 intensive behavioral intervention aimed at helping child develop a replacement behavior for a maladaptive behavior, which puts his placement at risk.	3-13 months	Group homes, foster homes, community.
Foster family homes	Certified, extensively trained families.	12-48 months	In several Bay Area counties.
Individual and family therapy	Mental health interventions designed at ameliorating suffering, managing symptoms, improving quality of life.	12-48 months	At the FCP, in the community or in private offices.
Medication support	Evaluation and medication oversight by a licensed psychiatrist.	12-48 months	At the FCP, in the community or in private offices.

Kinship services	Support Services for relative caregivers and their children including, support groups, crisis stabilization, tutoring, case management, and mental health services.	12-48 months	In the community as well as FCP facilities.

Residentially Based Services Reform Project

Voluntary Agreement

RBS Program Services: Please provide a detailed description of the services that will be provided for the following Service Categories: (A) = Environmental Interventions, (B) = Intensive Treatment Interventions, (C) = Parallel, Pre-Dis-enrollment, Community-Based Interventions, (D) = Follow-Up, Post-Dis-enrollment Support & Services. Be sure to indicate whether or not the services are currently being provided.

Service Category	Type of Service	Service Description	Range of Service Intensity	Expected Service Duration	Service Location	New	Current
A	Residential treatment interventions	Assessment, stabilization, crisis stabilization, rehabilitation care	High, 24/7 care	Average of 4 to 7 months	FCP		X
A	Family-Based Res. Care	Working with children or youth and families in the family connection center on campus to develop shared coping strategies to use in the community and at home	High, approx. 6 hours per week, but varying with families and needs	Average of 4 to 7 months	FCP	X	
B, C, D	Mental Health Services	Individual therapy, family therapy, collateral mental health services, begun onsite in the FCP, continued in the community	High, up to 10 hours a week	1 to 18 months (simultaneous)	FCP/Family Community		X
A, C	Day Treatment	Intensive group based mental health treatment aimed at building social skills, ameliorating suffering, managing symptoms, acquiring new coping mechanisms, accessed as needed	Highly intensive, 20 plus hours a week, varies with need	12-24 months (simultaneous)	Community		X
A, C	Family finding and linkage	Using an intensive family finding process through the enrollment to make sure all family connections are explored	Moderate	6-12 months (simultaneous)	FCP/Family Community		X
A,C,D	Therapeutic Behavioral Services	Foster family as a bridge to family placement or as a final placement with involvement with family	Moderately intensive, as needed	3-12 months (simultaneous)	FCP/ Community		X

Residentially Based Services Reform Project

Voluntary Agreement

A.C	Community Capacity Building	Establish/Build rapport in community and transfer learning to families and CBO's	Low to Moderate	12- 18 months (simultaneous)	FST/Staff/ Community	X	
C	Parallel Family Support	Spending time in the community with child or youth and family to transfer coping skills and life strategies developed in the family connections center to the natural settings where they will be used	High	4-24 months (simultaneous)	FST/Treatment team/community	X	
D	Follow-up	Continuity of Care once children are reunited with their families, including family support, ongoing skill-building, crisis assistance, FST planning and coordination, and mental health services	Varying from High to Low as the placement stabilizes	5 to 12 months (sequential)	FST/Treatment Team/ Community	X	
D	Transitional Support	As families prepare to complete enrollment and transfer to local formal and informal support service, aftercare contact will continue to insure an effective bridge and to maintain stability of the placement	Low	1 – 3 months (sequential)	FST / Community	X	

Coordination between Facility-Based and Community-Based Services: Describe the coordinating mechanisms that will ensure collaboration between facility-based and community-based services and resources.

Several elements will insure effective coordination between facility-based and community-based services offered by the FCPs. First, both sets of activities will be laid out in the comprehensive plan of care. Second, many of the same service staff will be working with the child or youth and family in both settings. Third, the child or youth and family will be active participants in both environments, moving with the service team to one location or another depending on where they are in the steps outlined in the plan of care.

All services and supports, both formal and informal, that a child or youth and family will receive from an FCP will be identified and coordinated in the comprehensive care plan developed by the FST. Even activities over which the FCP may have little or no influence, such as special education programs, will be reflected in the plan of care, so everyone knows what is going on, children or youth and their families are not being double scheduled, and so the team can take advantage of building on one another's efforts.

The treatment plan for mental health services will be developed in compliance with the applicable federal and state regulations, and the results reflected in and coordinated with the comprehensive plan of care developed by the FST. Similarly, court ordered activities, such as the conditions of probation or required parent activities will be identified in the comprehensive care plan, even though the court sets the terms for those activities. The third separately developed plan that may be coordinated through the FST's comprehensive care plan will be the child or youth's Individual Educational Plan (IEP) prepared in accordance with the applicable regulations if the child or youth is in a special educational program.

5.4 Permanency

5.4.1 Describe how the RBS program will include services and strategies for reinforcing, re-establishing or establishing positive and lifelong connections between the child and his/her family, if possible, or with a caring adult in a familial relationship if reconnection within the family cannot be accomplished.

The FCP is designed to serve as a safe, but intensive site for beginning family permanency efforts. The mechanisms included in the model to help children and youth and their families achieve permanency, safety and well being include:

Family Outreach and Engagement Activities: from the beginning care coordinator and parent partners will reach out to families to insure access, voice and ownership in the process, to understand as much as possible the driving forces that have been undermining positive family relationships, and to learn from the children, youth and families their honest goals for having a better life together

The Family Support Team: Following engagement, the care coordinator and parent partner will bring together Family Support Teams, who, with the active participation of the children, youth and families, will develop Comprehensive Care Plans specifically designed to help children, youth and families achieve their goals for permanency, safety and well-being.

The Family Connections Center: Each FCP will have on-site a comfortable space where children, youth and families can work closely and intensively with staff to develop the coping strategies, life skills, and interaction techniques they will need to live together safely and successfully.

Intensive Therapeutic Services: Each child and youth will have a thorough, strength-based assessment to identify any psychosocial or neurobiological needs that will have to be addressed in order to reduce any negative behaviors that are standing in the way of reunification and life in the community, and a detailed treatment plan will be established using empirically supported services and interventions to address those needs and mitigate the identified behaviors.

Parallel Community Services: As children and youth and their families begin developing repertoires for positive interactions in the Family Connections Center, staff will accompany them to the community and family home to practice their skills and insights in the kinds of normal family activities that in the past have resulted in dangerous and disruptive events. Based on what is learned through these parallel activities, additional

Follow-up Support and Services: The key to permanency is ongoing support following reunification of the child or youth with their family. The FCPs will each have active and frequent support to families when the child or youth returns to live in their home. This will include a continuation of any behavioral health services that have not yet reached their outcome goals, mobile support to help families avoid, reduce or manage crises, opportunities for crisis stabilization, and the option for refresher stays in the residential component when that will help the child or youth and family develop additional skills for managing newly emerging challenging behaviors or interpersonal conflicts. The goal of the follow-up services will also be to connect children or youth and families with local community-based organizations that can provide ongoing support as needed following graduation from the program.

Transitional support : Following active involvement with the FCP in both the residential and home-based phases, transitional support will be available for 1-3 months on an as-needed basis. Program staff will check in by phone or in person, depending on the child or youth and family's needs, provide temporary assistance if needed, or help with making additional community service options.

5.4.2 Describe the role and involvement of adoption agencies in your RBS program.

In some situations, Adoption Assistance Program (AAP) services will be part of a child or youth's range of options at the time of enrollment. If that is the case, when the benefit of

using services arises during enrollment, the FST Facilitator, in conjunction with the child's placing agency worker, will invite a representative from the appropriate AAP provider to join the Family Support Team, and will insure that the child or youth's AAP plan of care is well matched with the overall RBS plan of care.

In addition, the San Francisco RBS system will include at least one agency that offers foster-adoption services, which will be one of the options available to the family support teams for enrolled children and youth. Concurrent planning and recruitment of Fost-Adopt homes through FFA/ Adoption services and collaborations would also support those children for whom adoption is viable.

5.4.3 Describe how you will serve those children and youth who will be unsuccessful at reaching permanency due to lack of family connections, behavioral problems, ageing out, etc.

In situations in which permanency and life long connection between a child or youth and his parents or the adult who was the primary caregiver prior to placement out of the home, will not be possible, the FCP will have adequate and appropriate mechanisms to secure alternative life long connections.

The FCPs will use all available options to help children and youth and their families of origin rebuild the disrupted relationships that have resulted in the enrollment in the FCP. However, in those situations in which either by the choice of the family or the order of the court it is determined that those relationships are not likely to be restored, the FST will immediately begin an aggressive process to identify extended family members who would be able to enter into a life-long connection with the child or youth. This will be followed by a warm welcoming and engagement process, and, as the relationship between the child or youth and the extended family members develops, the provision of support and services to begin a kinship care arrangement.

In the rare situation in which a kinship care arrangement cannot be established, the FCP in cooperation with the county case carrying worker and the appropriate county adoption assistance program, will assist in the pursuit of an adoptive family and provide ongoing services to nurture and sustain the developing relationship and with the AAP explore local community-based service options that can provide ongoing help following graduation from the FCP. In some instances an ITFC, or other foster care, placement may need to made. These placements may result in permanency for the youth, or they may be needed until a more permanent placement is secured. The FCP will work closely with S.F. county MAST team to determine the most appropriate, and permanent option for each youth, depending upon their individual circumstances.

In the rare situations where youth will not have a permanent connection prior to aging out of the system at disenrollment, FCP will support the transition by assisting youth in the following ways:

- Locating living arrangements through existing community housing programs such as THP-Plus
- Providing educational supports and/or opportunities
- Facilitating the development of job skills and other independent living skills, including partnering with San Francisco County Independent Living Program services to ensure maximum opportunity for independent living skill development.

5.5 Evaluation and Quality Improvement

5.5.1 <u>Data Baseline:</u> Describe the current tools and methods that are available for acquiring, analyzing and reporting information about the needs of the children, youth and families in the target population. This will provide the baseline against which you will measure changes in your program's target population.

Data Acquisition Tools	Items Measured	Process or Outcome Indicators
CANS	Measure the child or youth's current level of unmet needs in the context of his or her range of strengths and family support.	Are children and youth making progress toward permanency, safety and well being, staying out of trouble with the law, and presenting greater strengths and more pro social behavior?
Intra-departmental data systems in child welfare, juvenile justice and mental health—CWS/CMS	Placement history, court involvement, prior abuse or neglect, law violations, service plans, etc.	Is the child or youth in a more stable placement, safe, and avoiding further court involvement?
Educational records	Report cards, IEPs, Team reports, attendance reports, Educational Passport	Is the child making reasonable progress from grade to grade, and are her or his special educational needs being addressed?

5.5.2 <u>Evaluation (*Previously Question 11 of Voluntary Agreement*)</u>: Please indicate the means by which you will gather the information required for the annual evaluation report required by AB 1453 and who will responsible for compiling this information and submitting the report. Please include the names and job titles of these individuals.

Info Gathering Process	Person/Agency Responsible	Timeline
Case Reviews—CWS/CMS	Liz Crudo, San Francisco County Program Manager	Quarterly
CANS	Providers, FST Care Coordinators	Quarterly
YSS, and YSS-F	FST Care Coordinators	Quarterly

5.5.3 **[X] Check this box if both the Provider Agency and Placing Agency will be involved in the development of the terms and conditions of the evaluation plan developed by Walter R. McDonald and the Evaluation Subcommittee. By checking this box and signing this Voluntary Agreement you are agreeing to the terms and research method criteria of Walter R. McDonald.**

5.5.4 **Please provide the name and title of the individual(s) who are participants of the Evaluation Subcommittee:**

Agency or Department	Name/Title	Email
Consultant	Mark Lane	MarkLane49@aol.com
San Francisco County Dept. of Children and Family Services	Liz Crudo	Liz.crudo@sfgov.org
San Francisco Department of Children and Family Services	Adam Nguyen	Adam.Nguyen@sfgov.org
Edgewood	Don Cohon	cohond@peds.ucsf.edu
San Francisco Public Health Department	Nathaniel Israel	Nathaniel.israeli@sfpdh.org
San Francisco Department of Children and Family Services	Debby Jeter	Debby.jeter@sfgov.org

5.5.5 **Quality Improvement: Please describe both the Placing Agency and Provider Agency feedback loops that will be in place to keep staff informed about what is working and not working both with individual families and also at a program level that assists them in developing more effective alternatives.**

At the direct service level, Family Support Team meetings, which will be held at least weekly during any residential stays for enrolled children and youth, biweekly during the first phase of community-based care, and monthly during the follow-along and aftercare phases, will provide a continuous and frequent feedback loop to keep FCP program staff and placing agency staff informed about what is working and not working with individual families. At the program level, FCP Program and Clinical Directors will monitor child and family observations, suggestions and outcomes in order to provide or facilitate needed supervision and training for FCP staff, as well as changes in the array of services offered to enrolled children and their families.

At the inter-agency level, MAST and the RBS Oversight Subcommittee will be actively monitoring quantitative and qualitative information from the county agencies and providers, and through the efforts of the Evaluation Subcommittee, be providing regular updates on progress, problems, insights and needs. The MAST members will then use this input to adjust, improve and refine program design and operations to improve child, youth and family engagement, satisfaction, progress and outcomes.

Child, youth and family involvement will occur at the practice, program and system levels. At the practice level children, youth and families will be active participants in the FST process. At the program level, the lead parent partner will participate in the program effectiveness reviews with the program and clinical directors. At the system level, the family and youth advocate members will be active participants in the review activities conducted by MAST.

Data from these meetings can be fed to training staff and administrative staff so that there is a constant awareness and attention to effective strategies, training needs, staffing needs and family satisfaction.

The CANS and other FCP specific rating forms will be used and reviewed on a consistent basis either on a quarterly basis so that it is possible to look at objective data regarding targeted behaviors as well as the subjective input from family satisfaction surveys and focus groups.

6. IMPLEMENTATION PLAN

Please summarize your plan for implementing your program by listing the key implementation activities, the persons or agency responsible for carrying out these activities, and the timeline for accomplishing them. Be sure to address key implementation areas such as policy & procedures, training, communications, provider conversion, quality assurance, etc.

Implementation Activity	Resource	Timeline
Develop an agreed upon model for the Family Connections Programs that the 3 providers will develop and capture the terms of the model in a program description	Facilitated by the Local Implementation Coordinator and agreed to by the county child welfare and mental health and provider leads on the program subcommittee	Program descriptions prepared and agreed to by all participants by May 28, 2010 Practice guide to be completed by 12/15/10
Develop an agreed upon model for funding the FCPs	Facilitated by the Local Implementation Coordinator and agreed to by the county child welfare and mental health and provider leads on the fiscal subcommittee	Funding model prepared and agreed to by all participants by May 28, 2010. New version with revisions will be re-submitted by

Voluntary Agreement

		December 7th , 2010
Complete an updated Voluntary Agreement, Funding Model and Waiver Request and submit them to CDSS	Facilitated by the Local Implementation Coordinator and carried out by the county child welfare and mental health and provider leads on the program, fiscal, training, evaluation and waiver subcommittees	Final versions prepared and submitted by June 25, 2010 New version will be submitted with revisions by December 7th , 2010
Obtain approval of the new VA, FM and WR from CDSS	CDSS review team	December 21, 2010
Develop MOUs between San Francisco and CDSS and begin the process for MOU approval	Joint CDSS/County Agency team	December 31,2010
Establish policies and procedures for county and provider participants to follow in establishing, operating and using the FCPs	MAST	December 15,, 2010
Identify FCP Program Directors in each of the 3 provider agencies, begin plan for developing and staffing the programs	Provider Executive Directors	November 1 , 2010
Train county and provider staff in RBS principles and FCP program design and operation	SF RBS Training Subcommittee, UC Davis, Bay Area Training Academy	October–January, 2011
Establish systems for data collection, analysis and reporting	Evaluation subcommittee	November 30,, 2010
Establish system for screening, referrals and enrollment	Program subcommittee	October 31, 2010
Establish system for billing, claiming and payment	Fiscal subcommittee	December31, 2010
Complete the signature and approval process for the State/County MOUs	CDSS staff, SF Department Directors	January 31,, 2011
Complete final structural and staffing preparations for opening the new FCPs	FCP Program Directors and core team	January 31, 2010
Begin screening for FCP enrollment	County placing agency staff	December 31 2010
Enroll and begin serving initial cohort of children, youth and families	County placing agency staff/ Provider FCP staff	February 15, 2011

7. GLOSSARY OF TERMS – Please provide a list of definition of terms and acronyms that may not be known to the general public.

Term/Acronym	Definition
Family Connections Program (FCP)	A new program model for delivering family-based care that is integrated and continuous across residential and community environments. Each of the 3 providers in the SF RBS system will establish FCPs. Each FCP will have a residential component as well as support and treatment staff who can provide continuity of care in both the residential component and in the community.
Family Support Team (FST)	A Family Support Team (FST) comprised of the child or youth, family members, friends or neighbors, fictive kin, the Team Facilitator or Care Coordinator, the child's therapist, the Parent Partner, a representative from the county placing agency and any other people invested in the child's success (teacher, school district representative, coach, etc) will focus throughout the FCP enrollment period on providing consistent, continuous support to the child and family in developing, implementing and monitoring a comprehensive plan of care that addresses unmet needs in order to facilitate achievement of a stable, permanent family connection for the child or youth.
Family Team Meeting (FTM)	Before enrollment in the FCP, a Family Team Meeting (FTM) will be held by the county placing agency that will include current service providers, family members and others who are responsible for the identification of the most viable permanency option available to the child or youth. Participants at the FTM will review placement or enrollment options, including FCP, using a family-centered placement decision meeting process to best meet the needs of the child or youth and their family.
MAST	The San Francisco Multi-Agency Services Team, which functions as the Interagency Placement Committee, but also is part of a larger system for coordinating information and decision-making relative to services for children and youth with severe emotional challenges and their families across the child welfare, juvenile justice and behavioral health systems. MAST will coordinate access to and utilization of RBS services.

Residentially Based Services Reform Project

Voluntary Agreement

RBS Program Approval – Signatures of Authorizing Collaborative Participants

By signing this Voluntary Agreement, you agree to the design and operation of the alternative program and funding model as described in this document. This Voluntary Agreement permits amendments, modifications, and extensions of the agreement to be made, with the mutual consent of all parties and with approval of CDSS, based on the evaluations (described in paragraph (3) of AB1453), and on the experience and information acquired from the implementation and the ongoing operation of the program.

Provider Agency
Name:
Title:
Agency: Edgewood

Signature — Date: 4/1/10

Provider Agency
Name: Kent Engelson
Title: Executive Director
Agency: St. Vincent's

Signature — Date: 4-1-10

Provider Agency
Name: Ken Berrick
Title: CEO / President
Agency: Seneca

Signature — Date: 4/1/10

County Mental Health Agency
Name:
Title:
Agency: San Francisco County

Signature — Date: 6/15/10

County Social Services Agency
Name:
Title:
Agency: San Francisco County

Signature — Date:

Residentially Based Services Reform Project

Voluntary Agreement

Active participation in the development of the San Francisco RBS System

Agency/Department	Level of Involvement: High, Medium, Low
Edgewood	High
St. Vincent's School for Boys/San Francisco Boys' and Girls' Home	High
Seneca	High
San Francisco County	High

BAY AREA FAMILY CONNECTIONS PROGRAM (RBS) CORE TRAINING MENU

Training Topic	Competencies Overview	Target Audience	Length, Frequency, Modality	Trainer	Budget Narrative	When?	Budget
RBS Orientation & FCP overview - Foundations Training	1. What is Residential Based Services (Hx, Research, Outcomes) 2.Brief review of RBS history, goals, target population(s), site program model(s), referral/access, evaluation and future implications 3.The RBS Arc of Care 4.Who are the partners in RBS? defining the roles of in our partnership 5. Review of the fiscal structure 6. Why is RBS important? 7. What is different about RBS? Cultural Shift for counties and providers 8. Which children & families will be assisted through RBS? (Target populations) – who is eligible? 9. How will children & families be assisted through RBS? Importance of family involvement./Use of the CPP 10. Testimonial/Example of families participation in RBS (video) *Use of Stakeholders Powerpoint	General Public County & Agency providers - managers, supervisors Parents/Caregivers Community partners (i.e FFA's, juveniile justice etc.)	2-4 hours Train-the-trainer model taped?	Pat Miles - Program staff -	Collaboration with Center For Family Focused Practice (UCD) Title IV E billable for training hours	12/7/2010	$0.00

Tracking Methods "Passport": trainees of FCP will receive a copy of the recommended competencies as well as a certificate of completion after each training for their records

Training Topic	Competencies Overview	Target Audience	Length, Frequency, Modality	Trainer	Budget Narrative	When?	Budget
Family Support Team Decision Making Meetings-Family Conferencing	Facilitation & coordination techniques that are family centered and strength-based currently used at Edgewod	County & Providers who are facilitating and coordinating these meetings (shorter knowledge building orientations to the process available)	12 hours (skill building)	Edgewood - Family Conferencing	Curriculum development at $185 for 10 hours. Title IV E billable for training hours	For programs who need a FST model	$1,850.00
Comprehensive Care Planning (CPP)	1. Explain the purpose and importance of a comprehensive care coordination (CCC)process for RBS 2. Define the three primary components of the CCC process & their interrelationship 3. Define the purpose & key characteristics of the Family Support Team (FST) 4.Explain the steps in strengths-based planning 5. Describe the process for developing the FST 6. Explain the key components of an effective FST & roles of FST members 7. Describe the role of the Comprehensive Care Coordinator 8. Explain the purpose and components of the CCP 9. Describe the steps in the development & implementation of the CCP & its relation to the FST (including Attachment A) 10. Explain the components of proactive & reactive planning, & the role of a Plan B 11. Demonstrate the development of the CCP 12. Demonstrate development of the Crisis Prevention & Care plan 14. Explain the importance & methodology of crisis plan reviews 15. Describe the purpose & structure of the Care Review (CR) Team 16. Explain how CR can assist FSTs 17. Define the role of the CC Coordinator in the CR process 18. Describe the role of CR in the promotion of successful implementation of RBS 19. Explain the CR process 20. Describe the roles of CR Team members & the logistics of CR Team meetings	County & Providers who are facilitating and coordinating these meetings (shorter knowledge building orientations to the process available)	12 hours (skill building)	Martha Kaufmann	50 hours @ $125 includes the guide and 2 days of training Providers will work with Martha to ensure our team meeting structures incorporate the CCP	12/7-8/2010	$6,250.00

BAY AREA FAMILY CONNECTIONS PROGRAM (RBS) CORE TRAINING MENU

Training Topic	Competencies Overview	Target Audience	Length, Frequency, Modality	Trainer	Budget Narrative	When?	Budget
Cultural Awareness/Humility	Cultural Implications of FCP - Understanding oppression/poverty cycles and exploring biases and developing nonjudgmental practice **Other relevant trainings** 1.Ethnographic interviewing 2. Engaging fathers 3. Undoing racism; examining white privilege 4. Generational differences	County & Agency providers	4-6 hours on-going	BAA/Edgewood and Seneca also recommend trainers Include Parent Partners as trainers when possible	$500 half day $1000 full day Title IV E billable for training hours	second quarter	$0.00

Tracking Methods "Passport": trainees of FCP will receive a copy of the recommended competencies as well as a certificate of completion after each training for their records

Training Topic	Competencies Overview	Target Audience	Length, Frequency, Modality	Trainer	Budget Narrative	When?	Budget
Introduction to WRAP	Participants will gain theory and understanding of the model - not a skill building workshop	County & Agency providers Parents/Caregivers	3 hours	Seneca's Wraparound Trainers		December	$0.00
WRAP: Ensuring Child & Family Voice & Ownership	1. The power of family in achieving permanency 2. The importance of youth & family in reaching goals & objectives 3. Understanding key elements of family voice and choice (families are engaged in the decision making process & are seen as experts) 4. Family-centered practice & building relationships 5. Family finding & engagement & empowerment 6. The importance of culture (Family & Youth) 7. Effective communication and support (Active Listening) 8. Family reconnection & healing (Need for Repair) 9. Child & family voice/participation critical in RBS teams 10. Redefining the inclusion of "child and family" to equal "family"	County & Agency providers Parents/Caregivers * (*parents/caregivers may need their own orientation)	6 hours	Seneca's Wraparound Trainers Include Parent Partners as trainers when possible	Curriculum development at $185/hour plus consultation from the Center on Family Focused Practice-Wrap Institute /UCD for 25 hours. Title IV E billable for training hours Train-the- trainer model	December	$4,625.00
WRAP: Effective Environmental and Treatment Interventions in Short Term Residential Care	1. Strategies for a safe and stable environment during times when children and youth have challenging behaviors that cannot be managed safely in less restrictive settings 2. Purpose of & rationale for environmental interventions in RBS 3. Understanding the difference between group care and RBS response 4. Structuring the environment and activities/time 5. Effective team (including family) communication about RBS interventions 6. Understanding developmental and mental health impact on the youth & families systems (cultural awareness/humility) 7. Family systems awareness building 8. Linking interventions to outcomes 9. Intensive treatment interventions examples 10. Ongoing modification of treatment interventions based on reassessment of youth needs 11. Planning for permanency (legal and emotional) 12. Planning for discharge from the beginning	Overview: Family, County, Schools, Providers County & Agency providers Parents/Caregivers * (*parents/caregivers may need their own orientation)	6 hours	Seneca and BAA Include Parent Partners as trainers when possible	Adjunct curriculums available: Understanding child and youth Recognizing sabotaging behaviors (BAA) Understanding loss and grief (brain science) (BAA) Train-the- trainer model	December	$0.00

BAY AREA FAMILY CONNECTIONS PROGRAM (RBS) CORE TRAINING MENU

Training Topic	Competencies Overview	Target Audience	Length, Frequency, Modality	Trainer	Budget Narrative	When?	Budget
WRAP: Effective Parallel Community Interventions & Supports	1. Purpose of & rationale for parallel community interventions & supports 2. Understanding the child & family's sense of community 3. Community activities are linked to family/youth goals 4. Building awareness of & connections with the range of community activities specialized needs i.e. developmental disabilities & Network of care 5. Cultural & developmental issues in identifying appropriate community activities 6. Ensuring child & family voice in community activity participation 7. identifying and advocating for community resources 8. Planning for permanency (legal and emotional) 9. How to provide parents/caregivers with strategies	Community, Providers, County, Schools, Direct Care Staff Parents/Caregivers (*parents may need their own orientation)	6 hours	Seneca's Wraparound Trainers Include Parent Partners as trainers when possible	Train-the- trainer model	December	$0.00
WRAP: Effective After-Care Interventions & Supports	1. Purpose of & rationale for follow-up & post-discharge support 2. Understanding the difference between disruption & failure (Planning for relapse) 3. Community engagement & advocacy 4. On-the-Ground elements to promote successful outcomes -Effective & timely support -Assessment of & communication of risk issues to others -De-escalation of crisis/ prevention -Effective crisis planning & implementation -Continuity of care -Field Safety– respect, entering homes, cultural issues 5. On-going effective team (including family) communication about RBS interventions	County & Agency providers Parents/Caregivers (*parents may need their own orientation)	3 hours	Seneca's Wraparound Trainers Include Parent Partners as trainers when possible	Train-the- trainer model	December	$0.00
Training Topic	**Competencies Overview**	**Target Audience**	**Length, Frequency, Modality**	**Trainer**	**Budget Narrative**	**When?**	**Budget**

Tracking Methods "Passport": trainees of FCP will receive a copy of the recommended competencies as well as a certificate of completion after each training for their records

Training Topic	Competencies Overview	Target Audience	Length, Frequency, Modality	Trainer	Budget Narrative	When?	Budget
Attachment Family Therapy (empirically supported practice)	1. Overview of Family Treatment 2. Introduction to PACE (Playfulness, Acceptance, Curiosity and Empathy as central therapeutic stance 3. Fostering Affective/reflective dialog 4. Meeting with Parents/Caregivers 5. Being with Children 6. Managing Shame, Breaks and Repairs 7. Exploring and resolving child and [illegible]	County & Agency providers - clinical focus	6-8 hour	Daniel Hughes/BAA	Daniel Hughes = $5000	Third quarter	$0.00
Trauma Informed Treatment (empirically supported practice)	1. assessment of trauma and complex trauma 2. mindfulness interventions 3. environmental interventions for trauma treatment 4. teaching parents and collaterals trauma treatment interventions 5. the collaborative problem solving approach as applied to trauma	County & Agency providers - clinical focus	6 hour	Matt Madeus/BAA and St. Vincent's		Second quarter	$0.00
Family Search & Engagement	Overview: 1. Identify key factors that lead to youth remaining in care 2. Understand the research findings that demonstrate the negative outcomes for youth who remain in long term care 3. Identify how to increase the number of caring adults available as life-long connections for the youth 4. Ability to utilize tools to meaningfully engage family at the earliest opportunity 5. Understand the importance of setting in motion a plan for successful family responsibility 6. Begin the process of building a collaborative relationship with other stakeholders Series: 1. The ability to adequately prepare yourself, family and youth in the permanency planning process 2. Lead a youth/family centered meeting (such as blended perspective meeting) that results in one plan with at least 3. supportive measures that result in permanency for children/youth 4. Meaningfully engage maternal and paternal family members to develop a network of relatives and other healthy relationships 5. Lead family discussions of youth's connections via mobility or connectedness mapping 6. Understand how to transition from state responsibility to a family shared-responsibly model, including community supports for sustainability		1-2 day overview 6 part series January 3, Jan 24-25, or week of Jan 31	Seneca (If trained by Kevin Campbell the cost is higher than if Seneca staff train)	$3-4,000 $9-12,000	One training per month January-June	

BAY AREA FAMILY CONNECTIONS PROGRAM (RBS) CORE TRAINING MENU

Training Topic	Competencies Overview	Target Audience	Length, Frequency, Modality	Trainer	Budget Narrative	When?	Budget
Evaluation, Quality Assurance & Improvement	1. Overview of RBS evaluation plan & our role in it 2. Universal evaluative standards and systems -CANS (Child & Adolescent Needs and Strengths) -YSS (Youth Services Survey) -YSSF (Youth Services Survey for Families) 3. Promoting child & family voice in program improvements 4. Effective use of data for program improvements	County & Agency providers	1. 1-2 hours Evaluative and systems training depends on current staff needs	Website** Casey reps		10/28/2010	$0.00
Funding & Waivers in RBS	1. Overview of categorical funding streams relevant to RBS & cost neutrality commitment 2. How RBS funding works 3. Flexible funding 4. Utilizing and maximizing funds in individual Care Plans 5. Monitoring utilization of funds 6. Overview of Waivers in RBS	County & Agency providers	1 hour Integrated into foundations ?	RBS Committee			$0.00

Tracking Methods "Passport": trainees of FCP will receive a copy of the recommended competencies as well as a certificate of completion after each training for their records

Training Topic	Competencies Overview	Target Audience	Length, Frequency, Modality	Trainer	Budget Narrative	When?	Budget
Parent/Caregiver Training	1.Understanding child and youth behavior (what is the range of normal?) 2. Addressing Behaviors (understanding symptoms of suicide, crisis intervention, positive discipline) 3. Integrating the youth with special needs back into the family (work with the siblings) and creating & maintaining a plan for structuring time and activities 4. Understanding emotions and effects of trauma, loss and grief (brain science) **Other relevant Trainings** 1. Understanding how residential care is run 2. Family dynamics 3. Accessing and advocating for resources (e.g. school)	Parents/caregivers	8-10 hours (2 hour modules) On-going	Seneca, BAA and Edgewood will work on a curriculum based in their areas of expertise Include Parent Partners as trainers when possible	Curriculum development at $185 for 16 hours. Training at $185 for 10 hours Childcare/Food/Stipends (will need additional support from program budgets)	Third quarter	$2,960.00 $1,850.00
					Training Supplies (Food, refreshments etc.)		$2,465.00
					TOTAL		**$20,000.00**

Attachment A1

RBS Service Component Rate Calculation Worksheet

Worksheet Narrative

Overview: The attached Rate Calculation Worksheet represents the projected costs of service options within the San Francisco RBS continuum. These are point in time projections, and reflect costs associated with a typical program type, assuming an annual capacity as shown in the header of each service option. Not all program types will necessarily be operational at the same time within each agency, depending upon the flow of referrals and the individual needs of the clients that are referred. The rates for each service option will be invoiced to reflect the specific type of service in which each RBS youth is enrolled. This is not a projected budget for the entire period, as the actual expenditures will vary according to the needs of the youth and family, and the placement of the youth within the range of service options. The numbers of full time equivalent positions will vary depending upon the overall enrollment in each agency at any point in time, both in terms of the numbers of youth, and the placement of each specific youth within the service continuum. There will be periodic reconciliations between actual costs and the funds received to ensure fiscal viability and sustainability of the project.

Adjustments to Attachment A: In response to the state feedback, the following changes/corrections have been made to the Attachment A1. Please note:

- Each agency will have their RBS Director report to the appropriate administrator (Senior Level Director), depending upon the service mix provided to the enrolled RBS youth. This administrator is not a new hire, and an allocation of this position is built into the rate for each service.

- The Program Director is title is now shown as the RBS Director. A job duty statement is included. The time will be allocated to each service component as appropriate, depending upon utilization of the service by enrolled RBS youth.

- Given the current size of the program, the responsibilities of the supervisors are now embedded within the Clinical Supervisor and Residential Milieu/Trainer position. There are job duty statements included for these positions. The allocation of time to each of the service components will be dependent upon the utilization of the service by enrolled RBS youth.

- Family Specialists: Family Connections Program Counselors are now all referred to as Family Specialists. These staff will provide the direct care and supervision when an RBS youth is enrolled in the residential service component. Therefore, all of the time allocated to this activity is a IVE allowable cost.

- The Administrative Assistant Position has been expanded to include the responsibilities of scheduling and clerical support. There is a job duty statement included.

- Nurse and Facility Maintenance positions reflect an allocation of cost as needed. These positions currently exist, and job duty statements have been included.

- On-Call/Beeper/Crisis Response: These services will be provided as needed from the roster of RBS staff included in the rate calculation work sheet. These hours will be paid on a stipend basis.

Most all Clinical and Family Specialist positions will move with a child and family to provide the appropriate level of services needed. This will ensure that key relationships remain in place, as clients move through the program.

The suggestions made through the state review process relative to IVE allowable costs have been incorporated into the attachment. In addition, a fraction of the Division Director's time (1%) reflects time spent performing appropriate IVE activities. In Column 7, includes all projected FFA, county foster parent, relative, and NREFM maintenance costs, projected at 79% IVE allowable. This percentage is based upon the average utilization and length of service in these placement types as seen in Attachment A lines 3a-3c, which have a combed IVE allowability percentage of 23.77%. In addition, the IVE allowable payroll allocations in column 7 also reflect RBS time spent performing appropriate IVE activities when children are in out of home care.

RBS Service Options / *Service Component Rate Calcultion Work Sheet*		Residential Service Option - Projected Cost Detail and IV-E Allowable Costs										ITFC Service Option			Community Serv.			IVE Allowable	Mental Health Funds
		Column 1			Column 2			Column 3		Column 4		Column 5			Column 6			Column 7	Column 8
		12 clients	Residential Support Services	IV-E Allow. Cost	12 clients	Residential RBS Parallel Services	IV-E Allow. Cost	12 clients	Total Residential Services	12 clients	Total Residential IV-E Allowable Costs	10 client program	ITFC Foster Care Services	IV-E Allow. 60%	28 clients	Step Down Community Support Services	IV-E Allow. Cost	Placmts in Community IV-E Allowable Costs (FFA/FH/RelNREFM Placmts)	Mental Health Support Services All Service Options
Expenses	Avg. Annual																		MH
Payroll	Salary	FTE			FTE			FTE				FTE			FTE				FTE
Senior Level Director	100,000				0.125	12,500	10%	0.125	12,500	0.01	1,250	0.125	12,500		0.75	75,000			0.50 50,000
RBS Program Director	80,000	1.00	80,000	100%				1.00	80,000	1.00	80,000	0.20	16,000		1.00	80,000	10%	0.10 8,000	- -
Clinical Supervisor/Lead Clinician	75,000										-								1.00 75,000
Clinicial Care Coordinator	50,000										-								4.00 200,000
Facilitator	50,000										-								4.00 200,000
Nurse	75,000	0.25	18,750	0%				0.25	18,750		-								
RBS Supervisor/Milieu Trainer	72,000	0.50	36,000	100%	0.50	36,000	20%	1.00	72,000	0.60	43,200								
Family Specialist	35,776	15.00	534,200	100%	1.00	45,000	20%	16.00	579,200	15.20	543,200	2.50	89,060		6.50	251,480	7%	0.45 17,320	10.00 332,800
Parent/Family Partner	35,776				1.00	35,776	20%	1.00	35,776	0.20	7,155	-	-		1.00	35,776			
Family Finder/Foster Home Recruitor	45,000										-	0.50	22,500						
Quality Assurance/Billing Spec.	37,440										-								2.00 74,880
Administrative Assistant/Scheduler	37,440	0.25	9,360	100%	0.75	28,080	50%	1.00	37,440	0.40	14,976	0.50	19,360		1.00	38,720	15%	0.15 5,616	0.25 10,000
Facility Maintenance	40,000	0.25	10,000	80%	-	-	0%	0.25	10,000	0.20	8,000								
On-Call/Beeper/Crisis Response	Stipend Position					10,000			10,000		-		5,000			5,000			
Total Direct Payroll		17.25	688,310		3.38	167,356		20.63	855,666	17.81	697,781	3.83	164,420		10.25	485,976		0.70 30,936	21.75 942,680
Benefits @	0.30		206,493			50,207			256,700		209,334		49,326			145,793		9,281	282,804
Total Direct Salary Costs			**894,803**			**217,563**			**1,112,366**		**907,116**		**213,746**			**631,769**		**40,217**	**1,225,484**
																		5.37%	
Operations																			
Contract Services																			
Psychiatric																			31,200
Total Contract Services																			**31,200**
Direct Program Support																			
Office Supplies			3,000	100%					3,000		3,000		3,000			3,000			3,000
Telephone			10,000	100%		2,675			12,675		10,000		2,295			6,150			13,050
Mileage Reimbursement			10,985	100%		10,985			21,970		10,985		4,973			13,325			28,275
Staff Recruitment			3,000	100%					3,000		3,000		3,000			3,000			3,000
Training and Conference			3,000	100%					3,000		3,000		3,000			3,000			3,000
Outcomes/QA																			
Total Direct Program Support			**29,985**			**13,660**			**43,645**		**29,985**		**16,268**			**28,475**		-	**50,325**
Direct Facility Costs																			
Lease			54,000	100%					54,000		54,000		12,000			36,000			
Utilities			12,000	100%					12,000		12,000		2,400			6,000			
Building Maintenance			48,000	100%					48,000		48,000		3,000			10,000			
Expendable Equipment			30,000	100%					30,000		30,000		3,000			6,000			
Depreciation																			
Total Direct Facility Costs			**144,000**			-			**144,000**		**144,000**		**20,400**			**58,000**		-	-
Direct Vehicle Costs																			
Lease																			
Depreciation			12,000	100%					12,000		12,000		6,000			18,000			
Vehicle Operations			4,800	100%					4,800		4,800		2,400			7,200			
Total Direct Vehicle Costs			**16,800**			-			**16,800**		**16,800**		**8,400**			**25,200**		-	-
Direct Client Care Costs																			
Food			72,000	100%					72,000		72,000		5,000			8,000			
House Supplies			7,200	100%					7,200		7,200								
Transportation (Mileage Reimb.)			3,000	100%					3,000		3,000		1,000			3,000			
Personal Needs			2,000	100%					2,000		2,000		2,000			2,000			
Medication			1,000						1,000		1,000		1,000			1,000			
Family Support Fund						5,000			5,000		-		3,500			35,000			5,000
Incentive/Reward Program									-		-								
Special Events									-		5,000		3,000			4,000			
Family Maintenance Payments/Family Support									-		-		156,000			269,993	79%	213,294	
Respite									-		-								
Recreation Activities/Supplies			5,000						5,000		-								
Total Direct Client Care Costs			**90,200**			**5,000**			**95,200**		**90,200**		**171,500**			**322,993**		**213,294**	**5,000**
Total Operations			280,985			18,660			299,645		280,985		216,568			434,668		213,294	86,525
Total Payroll (Including Benefits)			894,803			217,563			1,112,366		907,116		213,746			631,769		40,217	1,225,484
Total Direct Expense			1,175,788			236,223			1,412,011		1,188,101		430,314			1,066,437		253,511	1,312,009
Allocable Overhead @ 12%			141,095			28,347			169,441		142,572		51,638			127,972		30,421	157,441
Total Cost			**1,316,883**			**264,570**			**1,581,452**		**1,330,673**		**481,951**			**1,194,409**		**283,932**	**1,469,450**
Daily Cost Per RBS Client Per Service Option			$301			$60			$361		$304		$132			$117			$169
Monthly Cost Per RBS Client Per Service Option			$9,043			$1,842			$11,012		$9,264		$4,028			$3,556			$5,116
Annual Cost RBS Per Client Per Service Option			$109,740			$22,047			$131,788		$110,689		$48,195			$42,657			$61,227
											84.14%		60% Per State Formula					20.77%	

FCP Disenrollment Protocol

Overview

Each child or youth and family's Family Support Team is responsible for developing and implementing the Comprehensive Care Plan for FCP services and support, which includes the Disenrollment Plan, tracking progress in accomplishing the plan, and updating and modifying the plan as needed. The San Francisco County FCP MAST RBS Sub-Committee is responsible for reviewing the plans prepared by the family support teams, monitoring utilization and working with the MAST team, who are responsible for authorizing changes in the placement status of enrolled children and youth, and the implementation of the disenrollment plan.

Reasons for Disenrollment from FCP

Disenrollments may be carried out for the following reasons:

- The successful completion of the full course of care through an FCP enrollment at the end of a period of transitional support and the implementation of a transition plan for any needed ongoing support and assistance through natural, informal and community-based resources;
- Even though a full course of care through the FCP program has not been completed, the transfer of the child or youth and family for care, treatment or services through another program or agency when it has been determined that this transfer will better meet their continuing needs;
- Even though a full course of care through the FCP program has not been completed, the parent or guardian has decided to withdraw their consent for a child or youth to participate in the program;
- The movement of the parent or guardian to a community sufficiently distant from the San Francisco region such that continuity of care in the FCP program cannot be reasonably continued as determined by the MAST RBS Sub-Committee and the child or youth's parent or guardian; every effort will be made to identify resources in the new community and shall assist youth/family in obtaining needed services prior to disenrollment from FCP.
- A decision by a court with jurisdiction over the child or youth to transfer the child or youth to a placement that is incompatible with continuing participation in the FCP program;
- A sustained absence of the child or youth from the program without permission of the program, the court or the child or youth's parents or guardians with no contact for at least 30 days, and a determination by the MAST RBS Sub-Committee that

continued participation in FCP upon the child or youth's return would not meet the needs of the child or youth and family;

- The child or youth and family have been enrolled in the FCP program for an extended period of time, and although they have not completely achieved their goals and outcomes, the Family Support Team does not believe that continued enrollment in the FCP program will result in significant additional benefit and that obtaining services and support through other resource options would be more appropriate; and,
- A determination by the MAST RBS Sub-Committee that the needs of a given child or youth and family are more severe than were identified during the intake process and are at a level that cannot be appropriately or safely addressed through the FCP program (such as a situation that requires intensive psychiatric care, or because of repeated and dangerous criminal behavior that requires care and supervision in a more secure setting) and a decision by the MAST RBS Sub-Committee to recommend discontinuation of FCP enrollment and provision of care in an alternative setting.

Disenrollment planning

- The care coordinator is responsible for facilitating the development of the disenrollment plan.
- Planning for disenrollment shall involve the child or youth and their families, all members of the Family Support Team and any independent or community-based service providers who are assisting the child or youth and her or his family.
- The initial disenrollment plan shall be incorporated in the Comprehensive Care Plan and shall identify the goals and outcomes toward which the child or youth, family and Family Support Team have agreed to work and the criteria they will use for measuring progress toward reaching those goals and outcomes.
- The initial disenrollment plan may be modified at any time during the course of care as the child or youth and family's strengths, needs and goals are better understood.
- When a child or youth and family are approaching accomplishment of their outcomes and goals and the completion of their enrollment is likely to occur within 3 months or less, or when a disenrollment prior to accomplishment of those goals occurs for any of the other reasons listed above, a final disenrollment plan shall be prepared.
- Final disenrollment plans shall identify:
    - The membership of the Family Support Team;
    - The mission, goals and outcomes toward which the child or youth and family were working;

- The progress that has been made toward accomplishing the mission and goals and outcomes;
- The skills and strengths that the child or youth and family have demonstrated in making progress and examples of successes they have achieved;
- The natural or informal circle of support that the child or youth and family have developed during the course of care;
- Assistance and interventions that have been provided to the child or youth and family that have helped support progress, as well as assistance and interventions that were tried but found to be ineffective or detrimental, and what was learned about assistance and intervention that has been or is most likely to be helpful;
- An ongoing safety plan that the child or youth and family will use to help sustain the successes they have achieved that includes potential risk factors or situations, proactive strategies to avoid those factors or situations, as well options and interventions to get back on track should those factors or situations occur, and contacts the child or youth and family can use to obtain help if needed to remain safe;
- Any needs for continuing care and assistance that the children or youth and families may have, and any arrangements that have been to obtain those services and supports through either formal or informal means;

- If the disenrollment is occurring for any of the reasons listed above other than for accomplishment of the child or youth and family's goals and outcomes, the final disenrollment plan shall also state:
  - the reasons for the disenrollment;
  - any alternatives to disenrollment that were considered;
  - any anticipated need for continued, care, treatment and services that are likely to occur; and
  - potential options for obtaining or arranging for those services.

Disenrollment procedures

- When a Family Support Team is recommending that a child or youth and family are approaching the completion of their enrollment in the FCP program, they shall prepare a proposed final disenrollment plan and submit it to the MAST RBS Sub-Committee and then to MAST for authorization.

- When a Family Support Team learns that disenrollment from the FCP program will be required because of any of the other reasons listed above, they shall prepare a report to the MAST RBS Sub-Committee describing the reasons that disenrollment will be required and accompany it with a disenrollment plan designed to provide as much ongoing information as possible to help the child or youth and family continue to make progress toward their goals in whatever situation they will now be in, and to coordinate as appropriate with any individuals or agencies that will be providing ongoing care following disenrollment.

- Upon receipt of a recommendation for successful disenrollment because the child or youth and family is approaching the successful completion of their course of care, the MAST RBS Sub-Committee, and MAST team, shall review the submission by the Family Support Team.

    - If it appears appropriate and complete, the MAST RBS Sub-Committee will authorize disenrollment in the time frame proposed by the Family Support Team.

    - If the MAST RBS Sub-Committee feels that changes in the plan may help improve the sustainability of the disenrollment plan, or if the MAST RBS Sub-Committee has suggestions for additional post-enrollment assistance or support, they shall share those recommendations with the Family Support Team, who shall submit an amended disenrollment plan for final approval and authorization by the MAST team.

- Upon receipt of a report that a disenrollment prior to successful completion of the Comprehensive Care Plan may be necessary because of any of the other reasons listed above, the MAST RBS Sub-Committee, and MAST team, shall review the report and accompanying proposed disenrollment plan, and may take either or both of the following actions:

    - Accept the report and authorize the disenrollment according to the proposed plan;

    - Suggest alternatives to the unplanned disenrollment and/or, if appropriate, pursue system level advocacy to achieve consensus with the family and FST, as well as provide continuity of care for the child or youth and family either within the FCP system or elsewhere.

Disenrollment support

- When a child or youth and family are disenrollmentd, the care coordinator and parent partner shall insure that they have been informed of and understand:

    - The reason they are being disenrollmentd;

  - Any anticipated need for continued care, treatment and services that are likely to occur after disenrollment;
  - When indicated, that the child and family understand how to obtain continuing care, treatment and services following disenrollment that may be required to assist with any remaining unmet needs; and
  - Any assistance that may be available from the Family Support Team or through other sources to help the child's parent, guardian or legal custodian arrange for services needed to meet the child and family's needs after disenrollment.

- Disenrollment plans shall be prepared and presented in a form that the child and family can understand and implement. A copy of the disenrollment plan shall be given to the child and family and with appropriate releases and authorizations to any persons or agencies that will be responsible for providing continuing care following disenrollment.
- When children or youth and their families are disenrollment in order to receive services by a transfer of care to other agencies or organizations, appropriate information related to their care, treatment and services shall be exchanged with these other service providers, as long as all necessary releases have been completed.

The RBS Reform Coalition
RECONNECTING CHILDREN, FAMILIES AND COMMUNITIES

Residential Based Services Reform Project

Deliverable Template – FUNDING MODEL

Instructions: The Funding Model lays out the demonstration sites' plan to fund the RBS Program. The primary purpose of the Funding Model Template is to guide demonstration sites in presenting the needed information about their Funding Model in a succinct and organized manner so that CDSS staff can fairly and accurately judge whether the proposed Funding Model meets the basic requirements of Assembly Bill (AB) 1453. An additional purpose is to help the local implementation teams in the sites better understand what the elements of a Funding Model are, so that it is easier for them to construct one to support their approach to implementing RBS.

Nine of the requirements for the Funding Model in AB 1453 are in section 18987.71 d. 2 (A) – (I). (Key points are underlined):

2. …the director may also approve the use of up to a total of five alternative funding models for determining the method and level of payments that will be made under the AFDC-FC program to private nonprofit agencies operating residentially based services programs in lieu of using the rate classification levels and schedule of standard rates provided for in Section 11462. These alternative funding models may include, but shall not be limited to, the use of cost reimbursement, case rates, per diem or monthly rates, or a combination thereof. An alternative funding model shall do all of the following:

(A) Support the values and goals for residentially based services, including active child and family involvement, permanence, collaborative decision-making, and outcome measurement.

(B) Ensure that quality care and effective services are delivered to appropriate children or youth at a reasonable cost to the public.

(C) Ensure that payment levels are sufficient to permit the private nonprofit agencies operating residentially based services programs to provide care and supervision, social work activities, parallel pre-disenrollment community-based interventions for families, and follow-up post-disenrollment support and services for children and their families, including the cost of hiring and retaining qualified staff.

(D) Facilitate compliance with state requirements and the attainment of federal and state performance objectives.

(E) Control overall program costs by providing incentives for the private nonprofit agencies to use the most cost-effective approaches for achieving positive outcomes for the children or youth and their families.

(F) Facilitate the ability of the private nonprofit agencies to access other available public sources of funding and services to meet the needs of the children or youth placed in their residentially based services programs, and the needs of their families.

(G) Enable the combination of various funding streams necessary to meet the full range of services needed by foster children or youth in residentially based services programs, with particular reference to funding for mental health treatment services through the Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment program.

(H) Maximize federal financial participation, and mitigate the loss of federal funds, while ensuring the

effective delivery of services to children or youth and families, and the achievement of positive outcomes.

(I) Provide for effective administrative oversight and enforcement mechanisms in order to ensure programmatic and fiscal accountability.

The final requirement is in section d. 3. (D) of the statute:

(D) Neither the waiver nor the alternative funding model will result in an increase in the costs to the General Fund for payments under the AFDC-FC program, measured on an annual basis. This would permit higher AFDC-FC payments to be made when children or youth are initially placed in a residentially based services program, with savings to offset these higher costs being achieved through shorter lengths of stay in foster care, or a reduction of re-entries into foster care, as the result of providing pre-disenrollment support and post-disenrollment services to the children or youth and their families.

Beyond the statutory requirements regarding cost neutrality for state AFDC-FC, there is also an understanding that the RBS demonstration sites will apply equally thoughtful stewardship in the use of EPSDT funds. Essentially, AB 1453 is inviting the demonstration sites to find an innovative approach that will provide improved outcomes for the same or less cost. The design of the Funding Model has five elements or stages:

1. Specify the Program Model: Development of an innovative approach to meeting the needs of children who are now being cared for using long term high level group home placements and their families that is likely to produce better outcomes for the same or less cost.

2. Estimate the Provider Bid: Creation by the providers of a cost estimate for delivering the services that will be included in the RBS package that is based on the new approach (see paragraph 2 (C) above).

3. Prepare the County Budget: Preparation by the county child welfare, mental health and probation departments of a preliminary operational budget for their RBS system that reflects the fiscal realities of the departments and that insures the balanced and equitable utilization required under paragraph 2 (G).

4. Demonstrate Cost Neutrality: Calculation by the local implementation team of a rationale for demonstrating the cost neutrality required by Section 3 (D), above.

5. Agree on a Rate and Payment Protocol: Integration of all these inputs by the local implementation teams into a rate and payment protocol for the RBS system that addresses the various requirements in the statute.

In order for the CDSS reviewers to fairly and accurately assess the funding models that will be submitted, the template will need to reflect all five of these elements in a way that ties them to the AB 1453 requirements.

Revisions: The following information will serve as a guide in helping you identify the changes that were made to the Funding Model Deliverable Template:

Blue Font –the blue font represents new questions &/or sections that have been added to the template.

(Items in Parenthesis) –the items in parenthesis provide a reference back to the specific question in the preliminary Program Description and Voluntary Agreement templates.

Signatory Page – A signatory page was added to the end of the Funding Model and should be signed by a representative from the county social service agency, mental health agency and the private non-profit agencies.

Reference Material: Please be sure to reference the AB 1453 enacted legislation, and the 'Framework for a New System of Residentially-Based Services in California'.

Residentially Based Services Reform Project

Funding Model

Demo Site: The San Francisco RBS Project		Date: 12/6/10
Prepared by: Mark Lane	Title/Organization:	Local Implementation Coord. San Francisco RBS Project
E-mail: Marklane49@aol.com		Phone: (831) 227-9997 (mobile)

1. **Briefly summarize the intervention, services, and support strategies your program model will use to help children or youth and their families enrolled in your RBS system achieve and sustain positive life outcomes.**

The San Francisco RBS Project has created a well-defined and replicable model for implementing the values, principles, structures and services that together make up the RBS complex. Our model, the Family Connections Program (FCP), integrates family inclusion, residential stabilization, community care, clinical care and transitional support through a strength-based system of care coordination and team cooperation that insures continuity of relationships and services across environments and stages of change. We believe that putting all of these elements together will result in shorter lengths of stay, increased family bonding, lower negative behaviors, increased indicators of positive functioning, increased likelihood to achieve permanency or a lifelong connection with a family, and lower rates of recidivism.

As described in more detail in the Voluntary Agreement, each Family Connections Program will include six main elements:

- A residential care component designed to serve children or youth, at any point in time, when their behaviors and needs are such that they require 24/7 supervision and care for their own safety and the safety of those around them. Residential care is the first placement for all children entering RBS, and it is where assessment and intervention plans are developed for the child and where intervention services are initiated. The residential service component will also offer capacity as needed when children or youth have been placed in the community care component and are placed with a family but their behavior or circumstances require 24/7 care and supervision or crisis stabilization in the residential setting. The planned and anticipated average length of stay in RBS Residential, inclusive of crisis stabilization time, is five months with a range of four to seven months. There is no minimum or maximum. Members of the residential team that work with the youth and family will remain on the child and family team throughout the term of enrollment.

- Community care components may include supporting the youth and family placed in Intensive Treatment Foster Care or Foster Family Agency foster homes as well

as in relative, foster, non-related extended family member, or their birth homes. Follow-up services will provide the ability to extend continuity of the care and support regimen to the home, school and neighborhood environments where the child or youth and family will be living and interacting. Transitional support will help the child and family prepare for disenrollment from the RBS program and will take place in the final one to three months that children are enrolled in RBS and while they are in the Community component. The planned and anticipated average length of stay in a RBS Community placement setting is nineteen months with a range of seventeen to twenty months.

- Within the community care components listed above: Intensive Treatment Foster Care options for those children or youth who do not need the staffed 24/7 care and supervision of the residential component, but whose behavior or family system is not yet at a point where reunification can be completed.

- A family inclusion component is embedded in each of the FCP service options. The involvement of family during an initial residential stay will allow the family system as a whole to work together to develop more effective interactive and coping strategies. Gains made during this time, along with the relationship developed with the treatment team, will work to reduce and ultimately eliminate the need for future out-of-home placement.

- Clinical care components to insure that each child or youth and family receives consistent, well-matched and effective therapeutic care regardless of whether the child or youth is staying in the residential component, a treatment foster home, or in her or his family home.

- Comprehensive care coordination to provide integrity, continuity and compatibility of all of the service and support elements, and to insure effective voice and choice for children and youth and their families.

2. **Describe the calculations used by the providers to estimate the reasonable costs of delivering the package of services that will be incorporated in your RBS system. Please fill out Attachment A – Provider Cost Matrix.**

The providers have elected to submit one Service Component Rate Calculation worksheet (Attachment A1) representing projected program costs associated with RBS implementation. The providers are committed to the creation and implementation of one program model, with the attached worksheet capturing projected costs for all providers. This attached rate calculation worksheet represents a point in time, with costs that justify the rates that will be charged for the residential and community service options. The community options include both ITFC services, (with its own rate structure) and other community services which may include standard FFA, county foster home, relative/NREFM care, or biological family support services. Any foster care maintenance payments paid directly to a non RBS provider will be deducted from the

community service rate paid to the RBS provider. To calculate the cost of operating RBS, the providers carefully estimated the staffing requirements for both residential and community service components, both in terms of number and qualifications, which would be needed to appropriately serve the proposed population at the enrollment capacities identified in the Voluntary agreement. Cost projections include overhead costs associated with each of the primary components of care.

These estimates were then translated into a cost base that is laid out in detail in the Attachment A1, Service Component Rate Calculation worksheet, accompanying this document. The columns for each type of service reflect the costs associated with the specific treatment environment. It is important to remember that the core treatment staff will move with enrolled children and youth through each environment of care, as needed, so a given staff position's time will be apportioned to reflect this flexibility. Several of the positions listed, including Nurse, Facility Maintenance, and on-call represent an allocation of projected expense that will be quite small when pro-rated for 14 clients, and will be provided as needed across the service components. Either the Senior Level Director time and/or the RBS Program Director time are allocated to each program component, and may change at any point in time, depending upon program need and size. Records will be maintained to track the appropriate expense to the appropriate service to ensure accurate cost and data reporting. The rate calculation for each service component reflects an allocation of all costs encountered to support the youth and family in that environment, but there is no duplication of costs. A description of adjustments to Attachment A1 in response to CDSS feedback received on October 29, 2010 is available in Attachment A1 Narrative, which is a new document.

The two primary service environments are:

Residential Support Services

The attached provider cost projections detail both the residential care and supervision program costs (column 1) and the parallel RBS services embedded within the residential component (column 2). The total residential costs are reflected in column 3. The mental health services that will support all youth and families regardless of the treatment environment are shown in the last column. The projected costs are based upon a sample 12 client program, however at any point in time an individual provider may have as many as six youth in residential care, or as few as zero youth in the residential component. The columns show the costs and staffing ratios which justify the rate charged for each day of residential services. Initially, each child will be referred into, or may be currently enrolled, in a residential program. Treatment services for each youth enrolled in RBS will begin in the residential treatment component. The length of stay may range, depending upon the needs of each child and family. The average length of stay in residential care is anticipated to be five months, with an average range of 4-7 months. Each provider will have the capacity to serve up to six residential clients at one point in time.

As indicated, the residential care and supervision costs include costs that are IV-E allowable for federally eligible youth. While the RBS supplemental services that are IV-

E allowable are indicated, there are some costs that may not be appropriate to claim to IV-E. As required, each agency will keep accurate time studies reflecting the nature of specific tasks that are performed. These costs will be accurately collected and reported as required. The county and providers have agreed to review fiscal data on a quarterly basis to review both fiscal and program performance. The attached rate calculation worksheet reflects that 84.14% of the Residential component rate is IV-E allowable for IV-E eligible children. Please note that there are no social work costs that are duplicative of county agency staff activities or clinical/social work costs allocated to either component of the RBS program. All appropriate clinical will be reimbursed through EPSDT and are listed separately. The providers are committed to maximizing the level of FFP reimbursement that may be appropriately claimed.

Cost projections were calculated based upon the collective historical experience of the providers. The rate calculation worksheet reflects (1) the annual salary, by position, (2) the likely full time equivalent (fte) each staff person will spend in the residential care service component, and (3) all operational costs associated with this service option. Individual staff members may work across the service options as they continue to work with youth while in transition from the residential setting into family homes in the community. These residential care projections capture the cost of maintaining the physical environment and the nature, number, qualifications, salaries and benefits of the staff required to deliver residential services, as needed throughout a length of stay in the residential component of a Family Connections Program.

The residential rate calculations based on these estimates were reviewed by the San Francisco Human Services Agency fiscal office and found to be a reasonable estimate of the costs of providing the care and services needed to operate the proposed programs. The rate paid to the provider for these RBS residential services will be $11,000 per month per enrolled child or youth.

Community Services

Intensive Treatment Foster Care

The ITFC community service component will be provide a family environment for those youth in Family Connections Programs that are in need of significant supervision and treatment services, but are able to thrive in and benefit from a family setting. This opportunity may provide a long term family connection for a child, or a stable environment from which a child may continue to transition to biological or fictive kin family. This service is one placement type within the community service structure. The county will pay the ITFC rate of $4028 per month per client directly to the ITFC provider to cover the ITFC costs. As the ITFC rate exceeds the RBS community service rate of $3500 per month per client, there will be no RBS rate paid to the provider. All of the San Francisco RBS providers have an ITFC program or can contract for slots as needed. Clinical and mental health costs, as appropriate, will be reimbursed through an EPSDT service contract.

Funding Model

The attached provider cost projections are detailed in Column 5 of the Attachment A1. The rate calculation reflects (1) the annual salary, by position, (2) the likely full time equivalent (fte) each staff person will spend in ITFC, and (3) all operational costs associated with this service option. All clinical and mental health services will be provided through EPSDT, as appropriate and authorized. These costs are reflected in the last Mental Health Funded column of the provider cost rate calculation worksheet and include, for example, the care coordinators for each child's Family Support Team.

As indicated, the ITFC care and supervision include costs that are IV-E allowable for federally eligible youth. Family service costs (also known as family maintenance payments) are IVE allowable, as this represents the payment to the foster family for care and supervision of the child. Providers will keep accurate time studies as required, so the county may accurately claim the appropriate levels of IVE funds. Please note that there are no social work or clinical costs allocated to the ITFC program. The attached rate calculation reflects the 60% federal allowability requested by the state for federally-eligible children. The providers are committed to maximizing the level of FFP reimbursement that may be appropriately claimed.

These projections were calculated based upon the collective historical experience of the providers. ITFC projections capture the cost of supporting the foster family and the nature, number, qualifications, salaries and benefits of the staff required to deliver ITFC services, as needed throughout a length of stay in the ITFC component of a Family Connections Program.

The FCP ITFC program rate is projected at the current state approved Level A rate of $4,028 per child per month. The service costs, in conjunction with the appropriate clinical/treatment costs allocated to EPSDT, were reviewed by the San Francisco fiscal office and found to be a reasonable estimate of the costs of providing the care and services needed to operate the ITFC service component.

Less Intensive Community Service Options

This service component will also support youth living with families in community settings. This may include youth living with biological families, relative or non-related extended family member families (NREFM), county foster families, and treatment foster families (FFA). The cost structure includes payment of the state approved family maintenance rate payments for foster, relative, or NREFM families in addition to support as needed for biological families. The costs paid directly to a family or non RBS agency for FFA services will be deducted from the RBS payment made to the RBS provider.

The attached provider cost projections are detailed in Column 6 and Column 7 of the Exhibit A. The rate calculation reflects (1) the annual salary, by position, (2) the likely full time equivalent (fte) each staff person will spend in the Community Support Service component, and (3) all operational costs associated with this service option. The mental health services that will support all youth and families regardless of the treatment environment are shown in the last column.

Funding Model

Within the community service component cost structure, foster care maintenance payments are included as IV-E allowable costs for federally eligible youth. Placement costs in an FFA foster home are estimated to be $1679 per month (prorated) of which an estimated 70.64% is IV-E allowable. Placement costs with relatives, non-related extended family members and county foster homes are estimated to be $627 per month (prorated) and they are 100% IV-E allowable. These costs will be claimed as appropriate to ensure that all federal funds are maximized to support the pilot project. In addition, a small percentage, 6.37%, of RBS provider staff time will be spent performing activities that are IV-E allowable per RBS Letter 05-10 such as scheduling meetings and visiting the child in placement. This percentage is the total Community personnel costs estimated to be IV-E allowable (in column 7) divided by total staff costs (in column 6). Community Based Services provided to support biological and fictive families do not include any IV-E eligible costs unless we are informed otherwise by CDSS. These costs will be funded through county and state funds that represent the county and state shares of cost that would otherwise support those youth in traditional out-of-home placements. As required, each agency will keep accurate time studies reflecting the nature of specific tasks that are performed. The Service Component Rate Calculation worksheet as well as Attachment A reflect these factors, and across all the possible placement options, on average 20.61% of the Community Support component rate is IV-E allowable for IV-E eligible children.

Consistent across all RBS service options, there are no social work/clinical costs allocated to AFDC-FC for the Community Support Services program. Clinical and mental health costs, as appropriate, will be reimbursed through an EPSDT service contract.

These projections were calculated based upon the collective historical experience of the providers. Projections capture the cost of supporting the youth and families and the nature, number, qualifications, salaries and benefits of the staff required to deliver community support services, as needed throughout a length of stay in a Family Connections Program.

The Community Support Services program rate is projected at $3500 per child per month. The service costs, in conjunction with the appropriate clinical/treatment costs allocated to EPSDT, were reviewed by San Francisco and found to be a reasonable estimate of the costs of providing the community support services.

Payment: Providers will be paid the projected rates for each service component described above. Payment to the provider will depend upon the number of youth enrolled in each different service component. Providers will have the flexibility to average costs within each service component, so that on average, each child will cost no more than the rates that have been paid. For example, there may be one child in the residential program that requires an extremely rich treatment program to meet the goals identified in her treatment plan; while another child may require less intensive services than most. This flexibility within each service component will allow the three programs

to deliver the appropriate level of care for each child and family in each service component.

These costs were then translated into a standard fee structure that the San Francisco Human Services Agency has agreed to pay for enrollment in an FCP, based on the location in which a child or youth is living while receiving care:

- While in the residential component the fee will be a fixed rate $11,000 per month per child or youth and family. The percentage of the rate that is IV-E allowable for IV-E eligible youth is estimated to be 84.14%. The county will receive IV-E reimbursement for the residential rates paid based on this percentage as well as the appropriate Federal Medicaid Assistance Percentage (FMAP) for a minimum of the first 24 months of the program (see Question 4, Cost Report). The projected average length of stay in residential services is five months, with a possible range of a four to seven month length of stay.
- While in an Intensive Treatment Foster Care (ITFC) placement, the fee will be $4,028 per month per month, per child or youth and family. This is the current CDSS-approved rate for ITFC Level A. While the SF RBS Implementation Team believes that the costs may exceed the state projected IV-E allowable rate of 60% for federally eligible youth, we have adjusted our projections to reflect this requirement. The length of stay in the component will be dependent upon each child's family situation, but we would estimate an average ITFC length of stay to be approximately 14.4 months.
- While in the family home or in another permanent placement, the fee will be $3,500 per month, per child or youth and family. $3,500 is inclusive of any foster care maintenance costs paid by the county to a placement caregiver. For example, if a youth is placed with a relative who receives $700 per month as a foster care maintenance payment, the county will send the relative $700 per month and will send the RBS provider $2,800 per month to provide community based services. However, if a youth is placed with his or her biological parents, the county will send the RBS provider $3,500 per month. Maintenance costs for federally eligible youth are 100% federally allowable for foster home, relative, and non-extended family member placements, and on average 70.64% allowable for treatment foster family agency placements. San Francisco will receive IV-E reimbursement for the residential rates paid based on these percentages as well as any IV-E allowable activities performed by RBS provider staff that are documented in the timestudy process and using the appropriate FMAP for a minimum of the first 24 months of the program (see Question 4, Cost Report). The average length of stay in these community service components will average 19 months (inclusive of months treated in an ITFC Home), We anticipate the average length of stay in a community FFA to average 11 months, and approximately a 13 month average length of stay in either of the parent or kinship homes. All inclusive, there may be a range of 14-21 months of care in any on the community service options. Considering average utilization and durations of service as is also demonstrated in Attachment A, the percentage of the total

$3500 Community rate that is IV-E allowable for IV-E eligible youth is estimated to be 20.61% on average.

- Given the anticipated lengths of stay and utilization of RBS Residential and Community component placement options, it is anticipated that the average payment per client will be no more than $122,500 for a 24 month course of treatment in RBS. This figure is also the agreed upon negotiated maximum average payment between the County and each of the three providers over the 24-month RBS program. As also described under Question 4, if the total county AFDC-FC payments over the 24-month period exceeds $122,500 times the number of clients served by the RBS provider, the provider will submit to the county the difference between the amount they received in AFDC-FC payments and $122,500 times the number of clients served. This process will be included in a contract between the County and each provider. It is anticipated that with the projected utilization and RBS placement rates, San Francisco will be able to maximize federal funding and achieve cost neutrality for the state and county over a two-year period. The 24 months of payments will be compared to the Funding Baseline which does incorporate rates described in ACL 10-38, and which increases the possibility of generating additional savings as well as cost neutrality for the state and county.

3. **Identify the activities and associated funding streams that the county departments that are in collaboration with your RBS system will use to support the service elements that you have included in your package of services. Please fill out Attachment B – Activity Allowability Inventory Worksheet.**

The activities included when a child or youth is in the residential component will be:

- Behavioral stabilization, modeling and reinforcement of positive behaviors, and ordinary care, discipline and supervision provided by residential childcare and milieu staff. These activities are associated with the federal IV-E, state and county foster care maintenance payment funding streams.
- Family inclusion and support provided by staff in the family connections center and parent partners. These activities are associated with the state and county foster care maintenance funding streams and certain activities may also be associated with the federal IV-E, state, and county foster care maintenance payment funding stream.
- Therapeutic diagnosis and treatment provided by clinical care staff. These activities are associated with the Medi-Cal EPSDT funding stream.
- Parallel community services with family and other community partners provided by the community care staff. These activities are associated in part with the state and county foster care maintenance payment funding streams and in part with the EPSDT funding stream. Certain activities such as transporting and providing supervision during extended visits with parents may also be associated with the federal IV-E, state, and county foster care maintenance payment funding stream.

- Care coordination and facilitation of the family team process by the care coordinator and parent partner. These activities are primarily associated with the EPSDT funding stream.
- Costs to provide nursing services will not be claimed as a IVE allowable cost. Whenever possible, counseling staff will be responsible to assist clients with the administration of their medications.

Activities included when a child is in the Intensive Treatment Foster Care component are:

- Behavioral stabilization, modeling and reinforcement of positive behaviors, and ordinary care, discipline and supervision provided by the treatment foster parents. These activities are associated with the federal IV-E, state and county foster care maintenance payment funding streams.
- Onsite crisis response services provided by community care staff. These activities are associated in part with the state and county foster care maintenance payment funding streams and in part with the EPSDT funding stream. As appropriate and allowable, all eligible crisis response services will be billed to EPSDT.
- Family inclusion and support provided by staff in the family connections center and parent partners. These activities are associated with the state and county foster care maintenance funding streams.
- Therapeutic diagnosis and treatment provided by clinical care staff. These activities are with the EPSDT funding stream.
- Parallel community services with family and other community partners provided by the community care staff. These activities are associated in part with the state and county foster care maintenance payment funding streams and in part with the EPSDT funding stream.
- Care coordination and facilitation of the family team process by the care coordinator is associated with the EPSDT funding stream.
- Caregiver maintenance payments will be claimed as an allowable IVE cost. These are payments to the foster families for care and supervision of children in their homes.

Activities included when the child or youth is living at home with her or his family or other permanent caregiver will include:

- Onsite crisis response services provided by the community care staff. These activities are associated in part with the federal IV-E (as documented in timestudies per RBS Letter 05-10) as well as state and county foster care maintenance payment funding streams, and in part with the EPSDT funding stream. As appropriate and allowable, all eligible crisis response services will be billed to EPSDT.
- Residential behavioral stabilization services provided through stays of less than 14 days in the residential component. These activities are associated with the federal, state and county foster care maintenance payment funding streams.

- Family inclusion and support provided by staff in the family connections center and parent partners. These activities are associated with the state and county foster care maintenance payment funding streams.
- Therapeutic diagnosis and treatment provided by clinical care staff. These activities are associated with the EPSDT funding stream.
- Community services with family and other community partners provided by the community care staff. These activities are associated in part with the federal IV-E (as documented in timestudies per RBS Letter 05-10) as well as state and county foster care maintenance payment funding streams, and in part with the EPSDT funding stream.
- Care coordination and facilitation of the family team process by the care coordinator. These activities are associated with the EPSDT funding stream.
- Disenrollment planning and activities to enable children and youth to successfully transition out of the RBS program. These activities are associated in part with the state and county foster care maintenance payment funding streams and in part with the EPSDT funding stream.

Attachment B- the "Activity Allowability Inventory" follows this narrative and provides a detailed breakdown of the program component activities with the associated funding streams. Each provider will maintain time studies to facilitate accurate and appropriate claiming of IV-E allowable costs by San Francisco County

4. Indicate how the participating county departments will work together to provide effective administrative oversight to insure accountability, efficiency and accuracy in the access and disbursement of these funding streams.

The San Francisco Human Services Agency and three providers are committed to carefully overseeing the RBS program to promote expected progress and gains in child/youth and family functioning as well as to avoid incurring more state or county costs than would have been incurred if RBS were not an available resource.

To provide effective administrative oversight and to insure accountability, efficiency and accuracy in the access and disbursement of these funding streams, centralized utilization management will be carried out by the RBS Subcommittee of the San Francisco Multi-Agency Services Team (MAST), described in more detail in the Voluntary Agreement, which is responsible for ongoing administrative and program oversight of the Family Connections Programs. The Family Connections Program (FCP) Project Coordinator, acting on behalf of the MAST RBS Subcommittee will track all enrollments, locations of care, and care coordination plans.

On a monthly basis, members of the RBS Subcommittee and/or the FCP Project Coordinator will track the number of enrollees by provider and by the three service components (Residential, Community-ITFC, or Community-Other) for the most recently ended month.

Residentially Based Services Reform Project

Funding Model

On a quarterly basis, members of the RBS Subcommittee will review providers' drafts of actual revenues and costs, as well as projected fiscal year revenues and costs. Members will bring information about red flags and/or costly trends to MAST.

On an annual basis, members of the RBS Subcommittee will review:

- Providers' actual costs, by service component, for the first 12 months of the RBS program.
- The County's RBS AFDC-FC and EPSDT payments to providers by service component, and associated claimed state and federal revenues.
- A comparison of both of the above to the CDSS-approved Funding Model and internal county projections by fiscal year.
    - Based on the results, the RBS Subcommittee may recommend that providers try to adjust their actual costs by Component of Care.
- This information will be included in the annual written evaluation of the RBS project to CDSS per the MOU between the county and CDSS.

After the end of the second year of RBS implementation, the RBS Subcommittee or its designee will consider information from both the first and second year of the program to

1. Develop and review a **Cost Report** of provider costs and County payments for the non-ITFC Community Components of care for each provider.
    - Should costs exceed the payments made by the county, there will be no additional payments to providers, as that is considered the providers' risk.
    - Should costs reflect a savings, that is providers' costs are less than the revenue they receive, there will be no refund or payment to the county.
        - Savings must be reinvested in services for children and families in activities that are recommended by the RBS Subcommittee and approved by MAST.
    - Additionally, the County will ask providers to share copies of the Cost Reports that they will have prepared for CDSS for their RBS Residential component and ITFC rate. If CDSS has not required such cost reports, providers will prepare cost reports for those components analogous to the cost reports for the Community component.

2. Review the County's payments and estimated state and federal revenues and compare them to the CDSS-approved Funding Model and County projections by fiscal year.
    - Should costs reflect that the projected amount of federal dollars were not actually possible due to the actual placement history of enrolled youth, there is no refund or payment due to the County from the providers, as that risk is assumed by the County.

3. Information from these cost reports will be used to adjust RBS rates to providers, as well as adjust assumptions about the IV-E allowability of costs inside of those rates, for the future months of the RBS Project. Any RBS rate adjustments will need to be

reflected in an amended Funding Model and, in considering such amendments, the State will be constrained by budget requirements.

Beginning after the 30th month of the RBS Project, the County will carry out a **Payment Reconciliation** process with each provider for each cohort of RBS participants placed by the County with that provider who have completed 24 months of care. This Payment Reconciliation process will be included in contracts between the County and each RBS provider. A cohort of RBS participants is defined as all children who were enrolled in RBS within a six-month period. The reconciliation will start after the first 30 months of the project because at that point the first cohort of participants will have completed 24 months of care. The next reconciliation will start after the 36th month, and the next will start after the 42nd, etc. The reconciliation process will involve the following steps:

- If the total county AFDC-FC payments over the 24 month period exceed $122,500 times the number of clients served by the RBS provider, the provider will submit to the county the difference between the amount they received and $122,500 times the number of clients served. Any such reconciliation payments submitted to the county by a provider under this process will be treated as a credit in the RBS claiming process.
- Should the payments be equal to or less than $122,500 the county will have met its full obligation.

To claim RBS costs to the CDSS, the County shall claim payments per state instruction for federally eligible and non-federally eligible children..

The three providers have or will have contracts with the San Francisco Department of Public Health – Community Behavioral Health Services and these contracts will be modified to reflect the providers' responsibility to provide billable mental health services for enrolled children, youth and their families. The providers will submit invoices for these services using existing procedures and at existing rates.

Quality assurance for EPSDT billing will be the joint responsibility of the quality assurance clinician employed by each provider and by the behavioral health utilization management system. Representatives from the behavioral health department will sit on the RBS Subcommittee and MAST to insure that reporting and billing for those services are consistent with the overall enrollment and location of services data.

As described in the Voluntary Agreement, the MAST will review the reports by the RBS Subcommittee on progress being achieved by enrolled children, youth and families and will pass this information on to the courts and the County's Board of Supervisors.

Funding Model

5. **Describe how providers will be paid in your system. Indicate the rate or rates they will receive, the method for billing, making payments and the documentation that will support billing and payment.**

The County will use the same billing methodologies currently used for regular foster care. The providers will be paid RBS rates on a per-child, per-month basis that is prorated for the time that the child is placed in any given RBS placement setting. Adapting a process that San Francisco has employed for its Wraparound program to further ensure accurate payments, providers shall submit monthly invoices to SF Human Services Agency that will indicate each child or youth that has been served by the RBS program during that month, the dates of enrollment, and the setting(s) where that child or youth was living. If the child or youth moved during the month invoiced, the dates that the child or youth lived in each location will be included. Children that are no longer enrolled in RBS will not be included on the RBS invoice, nor will the County make an RBS payment for them. Following existing procedures, County Foster Care Eligibility staff will cross check invoices against their records before executing payments.

For children or youth served by an RBS provider and living at an RBS Residential site, the County will pay that provider a rate of $11,000 per month, prorated by the fraction of the month in which the child or youth was in that setting. The provider will be paid this rate as long as the child remains with the provider in that setting.

For children whose placement is a family home but due to their behavior or in order to stabilize the home the child needs to stay temporarily in an RBS residential setting for crisis stabilization, for those days that the children or youth reside in the RBS residential setting the stays will be invoiced to the County, paid by the County, and claimed to the state at the RBS residential rate of $11,000 on a pro-rated basis. If it is in the best interest of the child and family and if the provider agrees, the provider may pay the family homes a bed-hold rate but only if the family home was receiving a maintenance payment from the County when the children or youth resided there. The County will not pay the provider any additional funds for bed-hold rates nor will they pay the family home any placement rate. The provider will earmark those bed-hold costs a non IV-E allowable and account for them as such in their Cost Report to CDSS.

The anticipated average length of stay for children in an RBS residential setting, inclusive of time spent there for crisis stabilization, is five months. Each case will be considered individually, but the anticipated range of days per RBS residential placement for crisis stabilization is between one and fourteen.

For children or youth served by an RBS provider in the Community component and living in an Intensive Treatment Foster Care home during the month, the County will pay that provider a rate of $4,028 per calendar month, prorated by the fraction of the month in which the child or youth was in the ITFC foster home. The provider will be paid this rate as long as the child remains with the provider in that setting. Each San Francisco RBS providers either has or can contract for ITFC foster homes.

Funding Model

For children or youth served by an RBS provider in the Community component and living in the home of an FFA foster parent, a county-licensed foster parent, a relative, a non-related extended family member, or a biological parent, the County will pay that provider based on a rate of $3,500 per month, prorated by the fraction of the month in which the child or youth was in that home. The provider will be paid this rate as long as the child remains with the provider in that setting. As described above in Question 2, $3,500 shall be decreased by any foster care maintenance payments paid by the County to a placement caregiver.

RBS invoices will detail, by child, the number of enrolled days in each service component. From that data, an invoice will be generated, reflecting the established rate for each RBS program component times the number of days per client for each service. Because the ITFC rate exceeds the community service rate, no RBS payment will be issued to the RBS provider. An ITFC payment will be made directly to the agency providing the ITFC service.

The anticipated average length of stay for children in an RBS Community setting is nineteen months.

In addition, each provider will submit invoices for payment to SF Community Behavioral Health Services based on actual behavioral services provided pursuant to appropriately completed assessments and plans of care for each referred child or youth at the standard rates for the services indicated. Upon review of the submission for accuracy, the SF Community Behavioral Health Services will execute payment for those services.

6. **How will your model maximize federal participation and mitigate the loss of federal participation that will occur as a result of decreased length of stay in residential care?**

The Family Connections Program model for RBS services maximizes federal participation in the following ways:

- Paying rates by component of care based on where the children or youth are placed at any given time.
- Developing the rates for each component of care that represent the actual anticipated costs for the specific services to be included in that component. This also allows the County and CDSS to anticipate which of those specific supervision, case management, and administration activities and services are likely to be IV-E allowable for federally eligible children or youth.
- Because youth are placed by the County in the FCP Residential foster care setting and because several of the activities in both the "typical" residential support services as well as the enhanced, parallel services meet or are anticipated to meet the definition of IV-E allowable supervision, case

- The ITFC rate utilized in the SF RBS program is the rate that is currently approved by CDSS for Level A services, $4,028. All youth utilizing the ITFC component of care for RBS will meet the existing requirements for Level A ITFC services. Should CDSS adjust this rate, the SF RBS program would likewise adjust the ITFC rate paid to FCP providers for ITFC placements. As indicated in Attachment A, 60% of all ITFC AFDC-FC payments are IV-E allowable for IV-E eligible children or youth.

- During their time in the Community component, any maintenance payments to FFA or county foster homes, relatives, or non-related extended family members will also remain federally allowable for federally eligible youth. Also, per RBS Letter 05-10, some activities that are not duplicative of County staff activities such as scheduling meetings and visiting the child in placement, are also IV-E allowable. As indicated in Attachment A, we anticipate that on average 20.61% of all non-ITFC Community component AFDC-FC payments are IV-E allowable for IV-E eligible children or youth.

- Although placements with biological parents during the Community component are not federally-allowable, enabling children and youth to live with their families, and to leave residential settings earlier, than they would have without the FCP program is an important goal of California's RBS pilot.

7. **Funding Baseline** ***(Previously Question 8 of Program Description):*** **Please estimate the cost of care for the members of the target population under the current service arrangements. This will form the baseline against which you will measure changes in funding under your RBS program. For each type of service, indicate the funding source and estimate the average annual per person cost of care.**

In order to calculate the funding baseline, the County gathered group home placement information for cases that represent the San Francisco RBS target population. There were 97 youth who fit the criteria. Their stays in group home began as long ago as 1996 and ended as long ago as 2000, although the vast majority of cases had group home stays begin after 2000. The average age at placement in a group home was 12.3 with a range of 6.4 to 16 years old. The average total length of time in group home care for these youth was 31 months, with a range of just over 3 months to 119 months. Of note, the target population typically experienced multiple group home placement changes that should be avoided when youth are enrolled in RBS. The most recent

group episode was 17 months long on average with a range of three-quarters of a month to 119 months.

Taking into consideration that the RBS project must be cost neutral over a 24-month period, and so it is not appropriate to include savings incurred in months after the 24th months of a youth's group home stay in the cost neutrality estimate, the average total length of time in group home care was then re-calculated so that all cases with total stays over 24 months were capped at 24 months. Following this methodology we found the new average stay in total group home care to be 19 months (with a range of just over 3 months to 24 months).

Using this methodology, as well as the group home rates for FY10-11 as described in ACL 10-38, the average cost of group home care for these youth was found to be $156,316 over a 24-month period. The estimated annual costs are $78,158. These costs do not include any other AFDC-FC costs, such as foster home maintenance payments or SB163 Wraparound costs that the youth likely also incurred within the 24-month period.

Of the average of 19 months that these youth spent in group home care, 41% of the time was spent in an RCL 14 level facility and 49% of the time was spent in an RCL 12 facility. The remaining time in group home care was comprised of short stays in RCL 7, 8, 9, and 11 facilities. 75.3% of youth were eligible for IV-E AFDC-FC. Based on these factors, of the total $156,316 in group home care costs, $54,831 would be federal IV-E funds, $40,594 would be state funds, and $60,891 would be county funds.

The San Francisco RBS Implementation Team estimates that the monthly EPSDT costs for children and youth placed in RCL 12 and 14 group homes is about $5,000. For planning purposes, the group believes that this amount will be about the same for children and youth being served through a Family Connections Program, since each child or youth's behavioral health care plan is based on an individual assessment or her or his needs, and those needs are going to be similar regardless of the locus of service delivery. These services will be delivered as appropriate and consistent with the county and state guidelines relative to compliance to applicable regulations.

8. **How will your payment system help to support the values and goals of the RBS system?**

The San Francisco RBS funding model supports the values and goals of the California RBS system because under the system we have proposed, the County will be purchasing an integrated package of services for children, youth and families that brings together residential, family inclusion, community care, clinical services, care coordination and transitional support.

The SF RBS funding model also ensures that funding levels to providers are sufficient to cover the cost of care, by utilizing placement-based rates approved by the providers and the County which are designed to cover the costs of implementing each care

component. As described under Question 5, the County will pay an RBS residential, Community-ITFC, or Community-other rate to the providers based upon where the youth is living while they are enrolled in the RBS program.

The funding model's Payment Reconciliation process also provides incentives to RBS providers to serve the youth in a way that will speed their transition to family settings. As described under Question 4, this process states that a provider must pay the County back if the County paid the provider more than $122,500 on average per child or youth for each 24-month cohort of children served by that provider. Because RBS residential rates are $11,000, youth with longer stays in RBS residential will drive up a provider's average received payments, making them more likely to have to make a reconciliation payment to the County.

According to the research that provided the underpinning for the RBS Framework, the biggest drivers for positive outcomes for children and youth in the target population are family involvement, continuity of care, evidence-based therapeutics, and reliable transitional support. The San Francisco RBS funding model supports the delivery of all of these elements through the monthly RBS billing rate combined with the continuing availability of EPSDT funded clinical services.

9. How will your payment system facilitate compliance with state requirements and attainment of federal and state performance objectives?

As described in Section 4.7.2 of the Voluntary Agreement, the Family Connections Program model supports the goals of the county and state child welfare SIPs and PIP, as well as the state mental health PIP because it is designed to help children, youth and families who are at present most likely to experience extended, if not permanent disruptions in their relationships and placements, even with our best, current community-based service options. Helping this small, but important subset of the county and state service population achieve permanency, safety and well-being will result in a significant advance towards accomplishing the SIP and PIP goals.

The SF RBS payment system links with compliance with state requirements and federal and state performance objectives through the following:

1. Explicitly identifying the full range of services and supports needed to achieve the performance objectives of permanency, safety and well-being
2. Paying the actual cost of delivering those services
3. Establishing a collaborative public/private utilization management system to insure that actual service delivery occurs
4. Using an operational model that can potentially be replicated across the state to improve outcomes.

Through this innovative program design, children and youth with the most complex emotional and behavioral challenges will receive the needed resources to break the cycle of repetitive placements, separation and accelerating behaviors. This will

decrease long term utilization of high end group home placements and increase placement and successful permanency in community and family settings.

10. **Describe how your program will manage fiscal risk. Indicate your methods for providing coverage for exceptional costs due to outlier expenses and for gathering, managing and distributing any temporary surpluses that may be generated through program operations.**

The SF RBS funding model has several tools for risk management. The following table lists these tools, and describes their benefits to the County and the State, and also to providers.

Risk Management Tool	Benefits to County and State	Benefits to Providers	
1)	Comprehensive referral, approval, and assignment processes	Limits the risk of enrolling youth that would not be well-served by the RBS program and would likely require much more than 5 months time in a residential setting	Limits the risk of enrolling youth that would not be well-served by the RBS program and would likely require much more than 5 months time in a residential setting
2)	Rates per service component are based upon actual projected costs	Sufficient funds should be available to meet enrollee's needs	Sufficient funds should be available to meet the costs of enrollees' needs
3)	Pooling actual savings and costs compared to rates received from counties by provider	Lower administrative burden than if payments were made on a cost reimbursement basis	The actual costs of services, particularly in the Community component of care, will vary from youth to so providers shall pool "savings" from youth whose services cost less to use for youth whose services cost more.
4)	Rates per service component are paid based on placement.	Maximizes federal financial participation	Sufficient funds should be available to meet the costs of enrollees' needs as those needs arise
5)	Quarterly MAST RBS Subcommittee meetings and staffing by the Project Coordinator reviews of provider revenues and costs	Centralized review of enrollees by component of care, invoices and payments, etc that will allow the Committee to be quickly see red flags and costly trends to point out to MAST.	Centralized review of enrollees by component of care, invoices and payments, etc that will allow the Committee to be quickly see red flags and costly trends to point out to MAST.

Residentially Based Services Reform Project

Funding Model

6)	Payment Reconciliation so that a provider must repay the county if they received more than $122,500 on average per youth per a contract that will be developed with each provider. (Note, this process does not include EPSDT billing)	Limits the risk of state and county costs that could exceed the cost neutrality baseline, given that the Community service component has limited ability to draw federal funds and yet it is anticipated to be the most utilized component over the course of an enrollee's time in RBS	$122,500 is a sufficient amount of funds to provide for an average of 5 months in the RBS residential component (inclusive of any days that a youth may step up to residential after having already been living with a family) and a variety of different placement options for the remaining 19 months.
7)	Pooling payments in the Payment Reconciliation Process	Lower administrative burden than if payments were reconciled on a per youth basis	A provider may receive rates for any individual child or youth that total more than $122,500 and still not have to pay back the difference as long as they also served other children or youth for whom they received a lower total of rates such that the average total payments was still $122,500 or less.
8)	"By provider" approach to reconciliations	Lower administrative burden than if payments were reconciled on a per youth basis	Providers can manage their own risk by managing their actual expenditures without concern about how other providers are faring financially.
9)	Cost Reports shall compare rates received from providers to their actual costs	If costs are lower on average than were payments, this information provides the basis for adjusting future rates to meet projected future costs. Any savings from the Community component of care (per the description of the Cost Report in answer to Question 4) must be reinvested in activities that are approved by the MAST and that serve children and families.	If costs are higher on average than were payments, this information provides the basis for adjusting future rates to meet projected future costs. Providers have the opportunity to learn from each others' experiences how best to manage expenditures for similar types of services and youth.
10)	Data collection on outcomes	Information will be available about how the RBS pilot program is serving children, youth, and families	Information will be available about how the RBS pilot program is serving children, youth, and families

Another way to manage risk is to consider disenrolling children and youth and their families who present a level of need beyond what the service was meant to address. (For example, this might occur if a child or youth were to develop a severe Axis I disorder that required intensive psychiatric care, or if a child or youth were to engage in repeated and dangerous criminal behavior.) However, the position of the SF RBS Project is to avoid disenrolling anyone from the program if at all possible, as long as an adaptation can be developed to meet the needs of the child or youth and family, and the

child welfare and financial staff and the provider clinical and financial staff are in agreement that the anticipated placements under that the adapted case plan are likely to be effective and will result in costs that can be managed by both the provider or the County. Disenrollment from the program will be a last resort, and may only occur if the entire MAST group agrees.

The following strategy will be used to prevent as many disenrollments of these types of children as possible:

Generally, should it become apparent that a youth and family's needs exceed the program parameters of RBS, there will be a collaborative review of the child's needs and fiscal resources to determine the best approach at that point in time. Should disenrollment become the best option for the child, the MAST RBS Subcommittee will review the proposed final disenrollment plan submitted by the Family Support Team. The Committee may recommend specific provisions for services that can be provided through other means that will present a better likelihood for success. Each member of the SF RBS Project is committed to developing program and fiscal alternatives to ensure that each child and family is given every possible opportunity to succeed.

Besides youth whose needs exceed the capabilities of the program's design, there will be other children, youth and families who leave the program prior to successful disenrollment for other reasons, such as the family moving to a new jurisdiction, extended runaway, a decision by a family to pursue other avenues of treatment, and changes in service plans ordered by the courts. The RBS Subcommittee will track early disenrollment of youth by provider to determine if there are programmatic or operational gaps that are leading to unplanned exits from the program. All youth that are enrolled, regardless of when they disenroll, will be included in the RBS evaluation process.

11. **How will your system insure the appropriate use of EPDST funded mental health services while avoiding significant cost increases above that which would have been expended using traditional group home based services for enrolled children?**

RBS client EPSDT charts, including detailed billing information, will be subject to current internal and external Utilization Review per San Francisco County Quality Management Policy and Procedures. Ongoing monitoring of EPSDT services will be conducted by the Contract Monitor from the Behavioral Health Department to ensure that the scope of services being provided meet Medi-Cal guidelines for reimbursement and are within the scope and intensity outlined in the RBS EPSDT contract.

Residentially Based Services Reform Project

Funding Model

12. Provide the rationale and calculations you used to insure that your funding model would not result in an increase in the costs to the General Fund for payments under the AFDC-FC program.

The San Francisco RBS Funding Model assumes that youth that have had lengthy stays in high-level residential care under other existing approaches will have significantly shorter stays in RBS residential care if they are supported by parallel services, clinical care, follow-up care and transitional supports throughout their expected 24 months of enrollment in the RBS program. Shortening stays in residential placements and maximizing IV-E funding through appropriate claiming and time study practices will free up county and state dollars to fund services in the Community component of care. Setting an upper limit on the total amount of RBS payments per enrolled child or youth and family of $122,500 over a two year period also incentivizes shorter placements in a residential setting.

Some of the services provided to children and families in the Community component and particularly when children are placed with their biological parents will not be eligible for federal IV-E reimbursement. Also, even with a high federally-allowable rate in the RBS residential component, a rate that is higher than current CDSS-approved rates also increases the need for county and state funds. However, the SF RBS Funding Model strongly mitigates that risk because the $122,500 cap on net average payments to providers is less than the total of actual anticipated expenditures, as well as the state and county shares of such expenditures, if RBS-eligible youth were not enrolled in RBS.

San Francisco's Funding Model is built on an anticipated average length of stay of five months in the RBS Residential component and nineteen months in the Community component. Within the Community component there are different RBS payment rate and IV-E allowability factors.

Attachment A displays the average unit costs, IV-E allowability, durations of service and utilizations that taken all together result in a total average cost for the RBS program of approximately $122,327. Of that, the model calculates that $65,155 is IV-E allowable, $57,172 is not, and that the net state and county costs are $97,810. The average durations of service and utilizations are compilations of various potential placement scenarios that represent reasonable possibilities, given the program design described in the Voluntary Agreement and the individual needs of children and families.

Attachment A then compares the federal, state, and county funds projected to be required to run the Family Connections Program and compares it to the Funding Baseline described previously in answer to Question 7. Since the average length of stay in total group home care over 24 months was calculated to be 19, a "Wrap/FH/Bio Home" line was added to allow us to represent the 5 months out of 24 that were spent in other types of placements. Although that time is represented, any AFDC-FC costs such as foster home maintenance payments or SB163 Wrap costs likely incurred in that time period are not represented.

Funding Model

As demonstrated on Attachment A, even without including non-group home care costs, the SF RBS Project anticipates cost neutrality in state and county shares of AFDC-FC payment funds over the course of all 24 months of a child's enrollment. It is important to note that the RBS pilot may require more county and state funds in the first 12 months of the project compared to the cost neutrality baseline, however this will be balanced out by decreased need for county and state funds in the later months of the project.

13. Please include any other information you believe is relevant about your site's funding model that will help us understand how its design meets the requirements in AB 1453.

The SF RBS funding model will, once the cost estimates have been tested and either verified or adjusted and the outcomes obtained through the delivery of the integrated package of services in the Family Connections Program model have been measured, provide a straightforward and replicable approach to the large scale revision of California's current approach to providing high level residential treatment for children and youth with severe emotional and behavioral challenges and their families.

Other providers will have a clear blueprint for developing similar programs, and the state and counties will have a reliable benchmark on which to base their payment levels and utilization management systems.

This replicability and direct adherence to the components in the RBS Framework helps the Family Connections Program model meet not only the requirements, but more importantly the spirit of AB 1453.

RBS Program Approval – Signatures of Authorizing Collaborative Participants

-Add as many signatory lines as necessary-

By signing this Funding Model, you agree to the design and operation of the alternative funding model as described in this document. This Funding Model permits amendments, modifications, and extensions of the agreement to be made, with the mutual consent of all parties and with approval of CDSS, based on the evaluations (described in paragraph (3) of AB 1453), and on the experience and information acquired from the implementation and the ongoing operation of the program.

County Departments

San Francisco City and County Human Services Agency
Name: _____
Title: _____
_____ _____
Signature Date

San Francisco City and County Department of Behavioral Health
Name: Barbara A. Garcia
Title: Deputy Director of Health
_____ 6/9/10
Signature Date

Provider Agencies

***Edgewood**
Name: [illegible]
Title: CFO
_____ _____
Signature Date

St. Vincent's
Name: Kent Engfer
Title: Executive Director
_____ 4-1-10
Signature Date

Seneca
Name: Ken Berrick
Title: CEO / President
_____ 4/1/10
Signature Date

San Francisco RBS Funding Model Attachment A

ESTIMATING COSTS OF RESIDENTIALLY-BASED SERVICES PROGRAMS

The figures in RED are assumptions, which can be changed, about estimated RBS costs (16 items), current estimated average length of stay in group homes for the target population, and percentage of the target population which is Federal Title IV-E eligible.

The figures in BLUE are computed using these assumptions and will be recomputed automatically if the assumptions are changed.

24	Month RBS Program Model, with				
5.0	Months of RBS Group Care	and	19.0	Months of Various Types of RBS Post-Group Care Discharge Aftercare Services	

RBS Program Components

		A. Average Unit Costs (per month)	B. Percentage of Costs which are Eligible as Federal IV-E Maintenance Payments	C. Average Duration of Service (in months)	D. Average Utilization (percentage of children/ families receiving the service)	E. TOTAL COSTS (per child) A x C x D	F. Costs which are Eligible as Federal IV-E Maintenance A x B x C x D
1	Residential (Group) Foster Care and Parallel Family Services, including Crisis Stabilization	$ 11,000	84.14%	5.0	100.00%	$54,890	$46,184
Community Family Support Component, comprised of 2 and 3 below				19.0	100.00%		
2	Community Family Support - ITFC Family Foster Care and Post-Residential Family Support Services	$ 4,028	60.00%	14.4	14.00%	$8,120	$4,872
3	Community Family Support Services, less intensive, comprised of 3a-3c below	$ 3,500	20.61%	16.9	86.00%	$59,316	$12,222
	a FFA Family Foster Care and Post-Residential Family Support Services	$ 3,500	40.26%	11.5	31.50%	$12,678	$5,104
	b Relative Care/Foster Care and Post-Residential Family Support Services	$ 3,500	24.26%	13.4	62.50%	$29,313	$7,118
	c Post-Residential Family Services with Biological Parents	$ 3,500	0.00%	19.2	37.50%	$17,325	$0
Average Total Costs of an RBS Placement for				24	Months	$122,327	$63,279

Combined IV-E Allowability for 2b, 2c & 2d
20.61%

Total Costs NOT Eligible as Federal Title IV-E foster care maintenance payments				$59,048
75.3%	Percentage of Children Federal Title IV-E Eligible	Total Federal IV-E foster care maintenance payment funding available:	$23,811	34.4%
Net State/County Costs after Title IV-E Reimbursement			$98,515	80.5%

X — Cost Components eligible for federal Title IV-E funding as "foster care maintenance payments." Some of the other costs of services may be eligible for federal Title IV-E reimbursement as "case management" under Title IV-E Administration. Title IV-E Administration case management does NOT include direct services, such as individual or group counseling.

* Occupancy level (as well as actual operational costs) will significantly affect per diem costs for group care.

** The per diem costs of Bridge Residential Care will depend on the mixture of non-group home residential care that are utilized. For example, the costs of ITFC "bridge" placements would be much more expensive than "bridge" placements with a relative or foster parent.

ESTIMATING CURRENT COSTS OF TRADITIONAL GROUP HOME PLACEMENTS

Current 2010-11 AFDC-FC Group Home Rates [per month]		Federally-Allowable Portion of AFDC-FC Rate	Costs: Per Child Per Month — Federal Share @ 50%	State Share @ 40% of Nonfederal Share	County Share @ 60% of Nonfederal Share	Combined State and County Share for Federally-Eligible Youth	
Wrap/FH/Bio Home	$ 0	100.00%	$ 0	$ 0	$ 0	$ 0	50.0%
RCL 7	$ 5,281	93.98%	$ 2,482	$ 1,120	$ 1,680	$ 2,799	53.0%
RCL 8	$ 5,809	93.98%	$ 2,730	$ 1,232	$ 1,848	$ 3,079	53.0%
RCL 9	$ 6,335	92.16%	$ 2,919	$ 1,366	$ 2,049	$ 3,416	53.9%
RCL 10	$ 6,863	92.16%	$ 3,162	$ 1,480	$ 2,220	$ 3,701	53.9%
RCL 11	$ 7,388	92.16%	$ 3,404	$ 1,593	$ 2,390	$ 3,984	53.9%
RCL 12	$ 7,917	92.16%	$ 3,648	$ 1,708	$ 2,561	$ 4,269	53.9%
RCL 13	$ 8,450	94.53%	$ 3,994	$ 1,782	$ 2,674	$ 4,456	52.7%
RCL 14	$ 8,974	94.53%	$ 4,242	$ 1,893	$ 2,839	$ 4,732	52.7%

Period (in Months) over which Cost-Neutrality will be Evaluated	24.0	Percentage of Children Eligible for Federal Title IV-E Payments	75.3%	New Costs/ (Savings) with RBS Program [per child]	Current Distribution of the RBS Target Population among the RCLs		

Current Total Costs for an Average Group Home Placement		Federally-Allowable Portion of AFDC-FC Rate	Current Costs for an Average Group Home Placement — Federal Share @ 50%	State Share @ 40% of Nonfederal Share	County Share @ 60% of Nonfederal Share	Combined State and County Share				
Wrap/FH/Bio Home	$ 0	100.00%	$ 0	$ 0	$ 0	$ 0	$ 98,515	20.92%	20,610	months not in GH care
RCL 7	$ 126,744	93.98%	$ 44,821	$ 32,769	$ 49,154	$ 81,923	$ 16,593	0.13%	22	
RCL 8	$ 139,416	93.98%	$ 49,303	$ 36,045	$ 54,068	$ 90,113	$ 8,402	0.02%	2	
RCL 9	$ 152,040	92.16%	$ 52,726	$ 39,726	$ 59,589	$ 99,314	$ (799)	1.18%	(9)	
RCL 10	$ 164,712	92.16%	$ 57,120	$ 43,037	$ 64,555	$ 107,592	$ (9,076)	5.74%	(521)	of time in GH care, % of time spent by RCL
RCL 11	$ 177,312	92.16%	$ 61,490	$ 46,329	$ 69,493	$ 115,822	$ (17,307)	1.12%	(193)	
RCL 12	$ 190,008	92.16%	$ 65,892	$ 49,646	$ 74,469	$ 124,116	$ (25,600)	38.56%	(9,872)	
RCL 13	$ 202,800	94.53%	$ 72,137	$ 52,265	$ 78,398	$ 130,663	$ (32,147)	0.00%	-	
RCL 14	$ 215,376	94.53%	$ 76,610	$ 55,506	$ 83,259	$ 138,766	$ (40,250)	32.32%	(13,008)	
MEDIAN Costs of Current Traditional Group Home Placements for the RBS Target Population	$ 156,316		$ 54,831	$ 40,594	$ 60,891	$ 101,485	$ (2,970)	100.00%	(2,970)	100.00%

RCL-Weighted Average Costs/(Savings) per child: $ (2,970)

MOU #10-6082
Attachment I, Exhibit 2, Attachment B
San Francisco RBS Activity Allowability Inventory

RBS Activity Allowability Inventory	RBS Demonstration Site: San Francisco Prepared by: Katherine West and Heather Davis				Phone: 510-317-1446	Email: katherine@senecacenter.org
TITLE IV-E ACTIVITIES:						
Please list all activities eligible for only Federal Title IV-E reimbursement	New Activity (Yes/No)	Performed In or Out of the RBS Facility	Individual Performing the Activity			
			Title[1]	Agency[2]		
Title IV-E Maintenance Activities:						
- Daily Supervision and Care activities in RBS residential setting	Yes	Both	Support Counselor, Supervisor, Milieu Director, and Nursing Svcs	Provider		
- Arranging for and providing transportation to visits and appointments	NO	Both	Support Counselor, (Primarily)	Provider		
- Maintenance costs for placement in ITFC or other FFA Homes	No	Out	Parent Support Fees as indicated on Cost Projections	Provider		
- Maintenance costs for placement in county foster homes or with relatives or nrefms	No	Out	Parent Support Fees as indicated on Cost Projections	County		
- Recruitment of ITFC and other FFA foster homes	No	Out	Foster Care Family Recruiter	Provider		
Title IV-E Administrative Activities:						
- Participation in TDMs, service referral, and service enrollment process	No	Out	Child Welfare Worker, CWW Supervisor	County		
- Contribute to the Family Support Teams (FSTs)	Yes	Both	Child Welfare Worker, CWW Supervisor	County		
- Contribute to FSTs regarding transition plans to exit youth from Family Connections Program	Yes	Both	Child Welfare Worker, CWW Supervisor	County		
- Include relevant information about Family Connections Program in updates to the Court	No	Out	Child Welfare Worker, CWW Supervisor	County		
- Program oversight and supervision	No	Both	FCS Administration in BAC Coordinating Committee	County		
STATE AFDC-FC ACTIVITIES:						
Please list all activities/services eligible for only State AFDC-FC reimbursement	New Activity (Yes/No)	Performed In or Out of the RBS Facility	Individual Performing the Activity			
			Title[1]	Agency[2]		
State AFDC-FC Maintenance Activities:						
- Family Engagement and Empowerment Services	Yes	Both	Parent/Family Support Partner; Support Counselor; Assoc. Supr.	Provider		
- Youth Engagement and Empowerment Services	Yes	Both	Parent/Family Support Partner; Support Counselor; Assoc. Supr.	Provider		
- Family skills and resiliency building	Yes	Both	Parent/Family Support Partner; Support Counselor; Assoc. Supr.	Provider		
- Supporting Family and youth extended visits and interactions	Yes	Both	Parent/Family Support Partner; Support Counselor; Assoc. Supr.	Provider		
- Supporting Family and youth with educational transitions, educational curriculum, and Advocacy	Yes	Both	Parent/Family Support Partner; Support Counselor; Assoc. Supr.	Provider		
- Parallel community services to support reconnection	Yes	Both	Parent/Family Support Partner; Support Counselor; Assoc. Supr.	Provider		
- Aftercare and follow-along services to maintain reconnection	Yes	Out	Parent/Family Support Partner; Support Counselor; Assoc. Supr.	Provider		
- Contracting for community-based support services	Yes	Both	Supervisor	Provider		
- Making contact with and arranging for sharing information with schools and community agencies	Yes	Both	Parent/Family Support Partner; Support Counselor; Assoc. Supr.	Provider		
- Providing flexible funds to address unique child and family needs	Yes	Both	Approval by Provider/County Administrators	Collaborative		
- Supervision of the Community Based Services	Yes	Both	Program Director/Program Supervisor	Provider		
- Administrative support for and operational costs of the Community Based Services	Yes	Both	Direct Program Clerical Support/CEO, HR, IT, QA thru Allocable	Provider		
State AFDC-FC Administrative Activities:						
Not aware of any activities that fall in this category						
TITLE XIX - EPSDT ACTIVITIES:						
Please list all activities/services eligible for only Title XIX-EPSDT reimbursement	New Activity (Yes/No)	Performed In or Out of the RBS Facility	Individual Performing the Activity			
			Title[1]	Agency[2]		
Mental Health Services						
- Facilitation of Child and Family Team Meetings (Plan Development).	Yes	Both	Facilitator	Provider		
- Conduct clinical assessment	Yes	Both	Clinician	Provider		
- Develop Individualized treatment plan	Yes	Both	Clinician	Provider		
- Individual and Family Therapy, as needed	Yes	Both	Clinician	Provider		
- Individual Rehabilitation Services	Yes	Both	Clinician/Support Counselor/Family Support Partner	Provider		
- Intensive Case Management Services	Yes	Both	Clinician	Provider		
- Family Engagement and Empowerment Services	Yes	Both	Clinician/Support Counselor/Family Support Partner	Provider		
- Family skills and resiliency building	Yes	Both	Clinician/Support Counselor/Family Support Partner	Provider		
- Parallel community services to support reconnection	Yes	Both	Clinician/Support Counselor/Family Support Partner	Provider		
- Youth Engagement and Empowerment Services	Yes	Both	Clinician/Support Counselor/Family Support Partner	Provider		
- Referral for specialized evidence-based treatment	Yes	Both	Clinician	Provider		
- Crisis stabilization and support	Yes	Both	Clinician/Support Counselor/Family Support Partner/Psychiatric	Provider		
- Provide specific services, support and treatment based on behavioral health services plan	Yes	Both	Clinician/Support Counselor/Family Support Partner	Provider		
- Aftercare and follow-along services to maintain reconnection	Yes	Out	Clinician/Support Counselor/Family Support Partner	Provider		
- Psychiatric assessment and consultation	Yes	Both	Psychiatrist	Provider		
BRAIDED[4] FUNDING ACTIVITIES:						
Please list all activities/services eligible for Braided Funding reimbursement	New Activity (Yes/No)	Performed In or Out of the RBS Facility	Individual Performing the Activity			Percent of each Funding Stream[3]
Please note: your demonstration site may not have any activities with braided funding			Title[1]	Agency[2]		*EPSDT, IV-E, State AFDC-FC, MHSA*
This model has no braiding						none
TRAINING:						
Please list training activities that may be eligible for reimbursement. In addition, please list the target audience and subject matter of the training.	New Activity (Yes/No)	Performed In or Out of the RBS Facility	Individual Performing the Activity			Percent of each Funding Stream[3]
			Title[1]	Agency[2]		*EPSDT, IV-E, State AFDC-FC, MHSA*
- Providing ongoing training for milieu staff on strategies for effective care and structure	Yes	In	All RBS Staff/County Staff - as appropriate	TBD (Collaborative Process)		IV-E Training
- Providing introductory and role specific training for public and private agency staff on RBS	Yes	Both	All RBS Staff/County Staff - as appropriate	TBD (Collaborative Process)		IV-E Training

[1] Title - this represents the classification of the individual performing the activities. Examples: CWS Social Worker, SPMP, County Mental Health Worker, Parent Partner, etc.

[2] Agency - this should represent the agency that the individual performing the represents. Examples: County Mental Health Agency, School, Provider.

[3] Percent of each Funding Stream - this should indicate the percentage of each funding stream that will pay for each of these specific activities. Example: 50% EPSDT, 50% State AFDC-FC.

[4] Braided funding is when two or more funding streams pay for one activity. Braided streams maintain the direct connection between each funding source.

The RBS Reform Coalition

Residential Based Services Reform Project

Deliverable Template – WAIVER REQUEST

Instructions: The WAIVER REQUEST allows the demonstration sites to submit a request to have a particular statute or regulation waived under the authority of the California Department of Social Services as described in Assembly Bill (AB) 1453.

When answering the questions in the WAIVER REQUEST, please be as descriptive as possible and provide all necessary information, attachments, flow charts, diagrams, etc.

Revisions: The following information will serve as a guide in helping you identify the changes that were made to the WAIVER REQUEST Deliverable Template.

Blue Font –the blue font represents new questions &/or sections that have been added to the template.

Signatory Page – A signatory page was added to the end of the Waiver Request and should be signed by a representative from the county social service agency, mental health agency and the private non-profit agencies.

Reference Material: Please be sure to reference the AB 1453 enacted legislation, and the 'Framework for a New System of Residentially-Based Services in California'.

Residentially Based Services Reform Project

Waiver Request Form

Demo Site:	SAN FRANCISCO	Date:	12/28/10
Prepared by:	Liz Crudo-	Title/ Organization:	Program Manager San Francisco Human Services Agency
E-mail:	liz.crudo@sfgov.org	Phone:	415-557-6502

1. What is the specific regulation for which you are requesting a waiver? Please include title, code section, paragraph #, etc.

San Francisco County is requesting to waive CDSS regulations governing the group home rate setting process (Division 11, Manual of Policies and Procedures, Sections 11-402.1 through 11-402.4 and Section 11-402.9)
In lieu of the rate classification level (RCL) system, the county will implement the "Cost based" rate system in San Francisco County's Voluntary Agreement and Funding Model, as approved by San Francisco County Dept. of Children and Family Services, San Francisco County Department of Probation, Seneca Center, Edgewood Center for Children and Families, St. Vincent's School for Boys and the San Francisco County Board of Supervisors.

2. Describe the overall intent behind the existing regulation? Examples: safety, quality services, adequate training

The intent of the existing regulations is to establish a system for making and for ensuring accountability for, AFDC-FC payments which cover the average necessary and reasonable costs of private nonprofit agencies to deliver a specified set of services associated with traditional group care.

The current regulations attempt to fulfill this intent by establishing a single methodology for categorizing all of the many diverse group home programs which serve a large number of children with a wide range of challenges, into a finite group of 14 levels of care with the same AFDC-FC standard rate for all programs in the same RCL., The 14 different levels are distinguished by "point ranges" from under 60 to 420 and up. Each RCL covers a 30 point range. Under these regulations, the level of care and services is defined using a point system which measures the number of hours of child care, social work and mental health treatment services provided on a per child per month basis, weighted to take into account the formal education, prior experience and ongoing training of the child care workers and the professional qualifications of the social workers and mental health providers. The overall intent of these ranges is to distinguish the intensity of services and level of professional expertise in a facility and reimburse higher levels with higher rates.

Safety (or supervision), quality of services and adequate training are addressed in the RCL system through measuring the presence of various levels of staff and translating that into points, regardless of any individual child's particular identified needs. The RCL point system measures the number of "paid-awake" hours worked per month by a program's child care and social work staff and their first line supervisors. The point system also counts the number of hours of mental health treatment services received by the children in the program, although these services do not have to be paid for by the provider. These hours are then weighted to reflect the experience, formal education, and on-going training of the child care staff and the qualifications of the social work and mental health professionals. These "weighted hours" are then divided by 90% of the program's licensed capacity to compute the program's RCL points, which are used in the determination of the monthly rate the program receives for the care of a child.

The regulations are based on the assumption that group home programs which provide a higher level of care, as defined and measured by the RCL point system, will be able to ensure the safety of, and deliver needed services to, children with more difficult presenting problems. However, the regulations do NOT assume that group homes at the higher RCLs are safer, or provide higher quality care and services, than those at the lower RCLs. It is assumed that safe and high quality programs can be operated at any of the RCL categories, as long as county social workers and probation officers place children in group homes which provide the appropriate level of care and services needed by the children.

The regulations are also based on the assumption that group homes providing a higher level of care and services will have higher costs for foster care "allowable" activities. At the most basic level, it is assumed that group homes which provide more hours, per child per month, of child care or social work services will have to spend more money to pay for their staff for those hours of work. At a more detailed level, the use of the RCL "weightings" is based on the assumption that group homes with child care workers who have higher levels of formal education and/or more years of experience, and/or more ongoing training (and with social workers with higher professional qualifications) will have to spent more money to recruit and retain them than group homes with child care workers with less education, experience, and training (or social workers with lower professional qualifications). The RCL point system uses an indirect method for measuring and comparing the overall costs of group home programs and setting standard payment rates for programs providing similar levels of care and services, as measured by the RCL point system.

The RCL standard rates were intended to reflect the current average and reasonable costs of providing the level of care and services (as measured by the RCL point system) associated with each RCL. These costs included not only the costs of the wages, payroll taxes, and employer-paid for the child care workers and social workers, whose time and qualifications are measured directly by the RCL point system. They also included the other foster care "allowable" costs of operating a group home program (e.g. food, clothing, shelter, transportation, personal incidentals, and administration) which are not measured by the RCL point system.

3. Discuss why the existing regulation or the AFDC-FC payment requirements, or both, impose a barrier for the effective, efficient and timely implementation of the RBS program.

First, definition of "allowable" costs under California's AFDC-FC program is limited to those activities covered under the federal Title IV-E definition of "foster care maintenance payments" and to State-funded social work activities. The current federal definition of "foster care maintenance payments" includes only:

> the cost of (and the cost of providing) food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, reasonable travel to the child's home for visitation, and reasonable travel for the child to remain in the school in which the child is enrolled at the time of placement. In the case of institutional care, such term shall include the reasonable costs of administration and operation of such institution as are necessarily required to provide the items described in the preceding sentence.

The current AFDC-FC payments received by group homes do not include any funding for providing "parallel family services" to the family while the child is in group care or any other out-of-home setting. Further, if a group home used funds received as part of its AFDC-FC rate payment in order to provide services to the family, such expenditures would be considered to be "unallowable" and the group home would be subject to an overpayment assessment.
Second, the AFDC-FC payments now made to group homes do not include any funds to provide services to the child, or to provide services and support to the child's caregivers, after the child has left group care to live at home, with another permanent family (through adoption or guardianship), or with a relative or foster parent in another foster care setting. Once again, if a group home used funds received as part of its AFDC-FC rate payment in order to provide aftercare services to the child and his/her family or caregivers, such expenditures would be considered to be "unallowable" and the group home would be subject to an overpayment assessment.

Third, the AFDC-FC payment level for a group home program tied to its placement into one of 14 Rate Classification Levels (RCLs) using a point system which measures the number of hours of child care, social work, and mental health treatment services provided on a per child per month basis, weighted to take into consideration the education, experience, training, and professional qualifications of staff. The RCL point system does not support the RBS program in a number of ways.

For example:

- RBS requires the use of other staff (such as parent partners, team facilitators, and family finders) who may not fall into one of the three "pointable" activities.

- RBS also requires some child care and social work staff to spend some time working with the child and his/her parents (or other caregivers) outside of the group home setting, which may also be "non-pointable" for RCL purposes.
- The "weightings" used in the RCL point system for education, experience, training, and professional qualifications were not designed to reflect and reward the factors that are the most relevant for effective RBS staff, e.g. prior experience working in residential care.
- The RCL "weightings" do not reflect the current relative value of the factors being measured in either clinical/program terms or in terms of their economic value; e.g. RCL weightings for experience are limited to only four years; the RCL weightings for experience and education do not reflect the current labor market costs of hiring and retaining staff with higher levels of education and experience.

It is anticipated that the total costs of the RBS program over a child's entire episode in foster care will be the same or lower that the current costs to the State and counties of making ADFC-FC payments to traditional group home programs. However, the initial few months of child's enrollment in the RBS program will cost significantly more than the AFDC-FC payments that are now being made to traditional group homes under the RCL system. These higher up-front costs will be offset by reducing the average length of stay in group care.

4. How do you propose to otherwise meet the intention of the regulation?

The intent of the RCL system is to provide safety and stability in residential treatment facilities by making sure that these facilities are adequately staffed. The Family Connections Program Model created by the San Francisco RBS Oversight Committee starts with a specific identification of the numbers and type of staff who will be needed to implement the residential component of the program, but goes well beyond the scope of the RCL system by laying out a complete staffing pattern for not only residential services, but also family inclusion, community care, care coordination and therapeutic services and establishing protocols for insuring that all of these elements work together in a family-centered, strength-based, outcome-oriented and evidence-based continuum. The Funding Model that accompanies the Program Model reflects the estimated actual cost for the delivery of this integrated package of services in three modes (while the child or youth is living in the residential component, while the child or youth is living in a treatment foster home, and while the child is living in the community with her or his family or other permanent caregiver). The Funding Model also provides for the confirmation of those estimated costs after the first year of implementation and the implementation of any needed changes in the rates after two years of implementation.

5. Describe how the waiver request will offer a worthwhile test of the development, implementation and on-going operation of an RBS program?

RBS can be viewed as a complex experiment. The hypothesis is that creating a program that integrates family inclusion, residential stabilization, community care,

clinical care and aftercare through a strength-based system of care coordination and team cooperation that insures continuity of relationships and services across environments and stages of change will result in shorter lengths of stay, increased family bonding, lower negative behaviors, increased indicators of positive functioning and lower recidivism.

Protecting the independent variable, which in this case has multiple sub-variables, requires restructuring the environment in which the program is offered and re-training the staff who are providing the services. Thus, the only way to test the RBS concept to see if it really does make a difference is establish an alternative funding model that insures that all of the elements of RBS are present and being offered to each enrolled child or youth and her or his family. Unless the current RCL regulations are waived, and an alternative set of requirements and funding are put in place that is explicitly aligned with the delivery of the integrated package of multi-disciplinary and multi-environmental RBS services, the likelihood of the independent variable in this experiment being maintained is lessened.

If the requested waiver is granted, the RBS and EPSDT contracts with the providers who are developing the SF RBS Family Connections Programs can address the overall package of care these programs are designed to contain, and the provider can invoice the county for an integrated combination of services that accurately reflects all of the components of the RBS Framework.

6. Explain how the agreement will be monitored for compliance with the terms of the waiver or the alternative funding model or both. Provide information regarding the agency for monitoring frequency.

The County and the providers will perform internal reviews and audits of the SF RBS Demonstration. The County will perform a Single Audit of a randomly selected number of programs each year. We would rely on the RBS provider's single audit report. In addition, we would monitor and/or perform a fiscal monitoring site visit on an annual or as needed basis.

The Contract Manager reviews payment documentation on a flow basis and certifies the accuracy of assistance claims and payments. For SFHSA, its two divisions, Contracts and Family & Children's Services, perform joint and coordinated program and fiscal monitoring of designated SFHSA contracts and MOUs. The fiscal monitoring is conducted in compliance with the Code of Federal Regulations (CFR), OMB standards A-122 and OMB A-133. Contracts/Fiscal monitoring unit has access to FAS (Fiscal Accounting System) and/or CalWIN and confirms the accuracy of payments to the provider comparing the FAS and/or CalWIN records with the monthly invoices submitted by the provider. Monthly invoices are reviewed by Foster Care Eligibility staff prior to authorizing the payment in CalWIN and submitting them to SFHSA fiscal staff for payment. Contracts and Fiscal staff perform an annual on-site review monitoring compliance to the terms and conditions of the contract/MOU. The goal of monitoring is to provide technical assistance to the provider ensuring compliance with the federal regulations and specific laws that apply to the program. The provider will receive a copy

of the monitoring report. If serious deficiencies are noted in the report, a full audit by the county controllers office will be conducted to access overall compliance of the Agency with corrective action recommendations. The provider has the responsibility to hire an independent auditor (CPA) to perform the agency's annual single audit in accordance with OMB-133/OMB A-122. The county obtains a copy of the audit report and reviews the report for both the accuracy of the reported expenditures and to follow-up on any internal control/fiscal finding noted on the audit report. In addition to our standard procedures outlined above, we will require our RBS partners to submit on a quarterly basis all documentation that supports expenses outsourced by the RBS partner in connection with these services. The Contract managers whom all have advanced degrees in Business and Finance Administration will review and audit these quarterly documents for accuracy and adherence to our RBS plan. The County Controller's Office designates the Department of Human Services to conduct initial audit of all contracted services within the Department. We will further compile these reports into an annual report per child and keep said documentation on file.

Residentially Based Services Reform Project

Waiver Request Form

RBS Program Approval – Signatures of Authorizing Collaborative Participants

-Add as many signatory lines as necessary-

By signing this Waiver Request, you agree to the request for a waiver in the alternative program and/or funding models. This Waiver Request permits amendments, modifications, and extensions to be made, with the mutual consent of all parties and with approval of CDSS, based on the evaluations (described in paragraph (3) of AB 1453), and on the experience and information acquired from the implementation and the ongoing operation of the program.

***San Francisco City and County Human Services Agency**
Name: _____
Title: _____
Signature _____ Date _____

***San Francisco City and County Department of Behavioral Health**
Name: Barbara A. Garcia
Title: Deputy Director of Health
Signature _____ Date 6/18/10

***Edgewood**
Name: NANCY REBLOW
Title: CEO
Signature _____ Date _____

Provider Agency
Name: Kent Eastman
Title: Executive Director
Agency: St. Vincents
Signature _____ Date 4-1-10

***Seneca**
Name: Ken Berrick
Title: CEO & President
Signature _____ Date 4/1/10