

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



ARNOLD SCHWARZENEGGER
GOVERNOR

June 9, 2010

Ms. DeAnna Avey-Motikeit, Director
San Bernardino County Children and Family Services
150 South Lena Road
San Bernardino, CA 92415

Dear Ms. Avey-Motikeit:

**SUBJECT: AUTHORIZATION OF THE RESIDENTIALLY BASED SERVICES (RBS)
REFORM PROJECT IN SAN BERNARDINO 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 Bernardino 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 Bernardino 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 Bernardino County RBS Reform Project.

As permitted by W&IC section 18987.72(d)(1) you 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 Bernardino 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.

Ms. DeAnna Avey-Motikeit
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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 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 children's progress. In order to ensure that the costs of implementing the RBS Reform Project for San Bernardino 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

CDSS/San Bernardino County Human Services Administration
MEMORANDUM OF UNDERSTANDING

between

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

and

COUNTY OF SAN BERNARDINO

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 Bernardino, 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

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The term of this Agreement shall be from June 1, 2010 through December 31, 2012 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, pre-discharge, 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. Follow up post discharge 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

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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 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, 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 Bernardino RBS Voluntary Agreement.

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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.

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- 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 Bernardino 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 Bernardino RBS Waiver Request.

E. COUNTY RESPONSIBILITIES

The county:

1. Shall provide children with the services identified as part of their RBS program and outlined in their state approved Voluntary Agreement.
2. Shall follow the state approved San Bernardino 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.

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- 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 withdrawal from the RBS Reform Project and waivers, if the state finds that the county has failed to fully and timely perform the activities described in sub paragraphs 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 records, 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 providers(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 that can be used to implement the RBS Reform Project, where appropriate and feasible,

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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 on the status of any county agreements entered into the RBS Reform Project and on 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 the all the 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 Bernardino RBS Plan. See Attachment I, Exhibits 1, 2, and 3. Reimbursement rates for the county shall be paid as prescribed in the San Bernardino 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,

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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 cost reporting forms 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. Nothing contained in this Agreement or otherwise shall create any contractual relationship between the state and any county providers, and no providers or their 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 providers, 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 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 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

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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 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. San Bernardino County Human Services Contracts - Fiscal Monitoring Unit shall conduct an audit/review of the fiscal operation of the RBS program no later than twenty-four (24) months after the program begins. These audits/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 (Title 2 CFR, part 230 – Cost Principles for Non-Profit Organizations) and Title 2 part 215 - Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals and Other Non-Profit Organizations.
12. If the state determines, based on an audit/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. A copy of the contractor's FAR shall be submitted to County of San Bernardino, HS Admin - Contracts Unit/Fiscal Monitoring by the due date of the report.

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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 Bernardino County Board of Supervisors hereby delegates to the Director or their designee of the San Bernardino County Department of Children's Services 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 Form (Attachment 1, Exhibit 3) or this 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.

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- 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 BERNARDINO

By:

[Signature]
JOHN A. WAGNER, Director

By:

[Signature]
Gary C. Oviatt, Chair, County Board of Supervisors

Date:

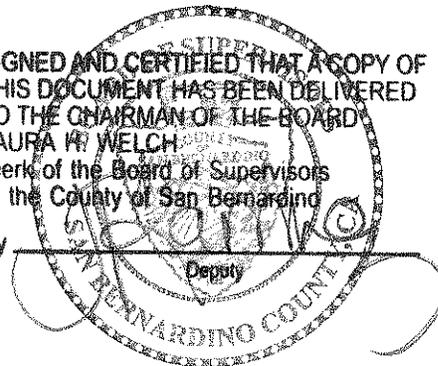
JUN 09 2010

Date:

APR 13 2010

SIGNED AND CERTIFIED THAT A COPY OF THIS DOCUMENT HAS BEEN DELIVERED TO THE CHAIRMAN OF THE BOARD LAURA W. WELCH Clerk of the Board of Supervisors of the County of San Bernardino

By





The RBS Reform Coalition
RECONNECTING CHILDREN, FAMILIES AND COMMUNITIES

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.

Voluntary Agreement

MOU #09-6002
Attachment I, Exhibit 1 – San Bernardino
RBS Voluntary Agreement

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.

Revisions: The following information will serve as a guide in helping you identify the changes that were made to the Voluntary Agreement 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 Voluntary Agreement 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'.

Voluntary Agreement

MOU #09-6002
Attachment I, Exhibit 1 – San Bernardino
RBS Voluntary Agreement

Demo Site: San Bernardino	Date: 12-7-09
Prepared by: Kathy Watkins and Neal Sternberg	Title/Organization: Manager VTC Executive Administrator
E-mail: kwatkins@hss.sbcounty.gov neal@victor.org	Phone: (909) 288-0167 (530) 472-1281

- 1. EXECUTIVE SUMMARY (Previously Question 2 of Program Description) – 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 goal of San Bernardino County's RBS system is to create a community/family reconnection engine for highly disconnected foster youth with significant mental health challenges. Currently, at least 25% of these high-need foster youth in San Bernardino County are being served in RCL-14 programs out-of-state; those that remain in-state are bouncing in and out of psychiatric hospitals and being transferred laterally between RCL 14 placements. The result is that they become disconnected from their families and communities. These youth remain institutionalized for long periods of time; the severe barrier behaviors they display prevent them from being served in the existing options for family-based settings. Our prior outcome data indicates that if we do not change our system of care, most of these youth will either emancipate from group home placement to an adult system of care without any lifelong connections, others will put themselves at risk by running away, by becoming involved in the criminal justice system, or becoming homeless. Our new RBS resource will have two objectives: 1) to help these youth permanently re-establish safe, nurturing family, educational and community connections; 2) to establish a new system of care that will prevent any more youth from reaching this point of disconnection. Our system will have an overall capacity for 30 total enrollments, 12 of which will be in short-term residential placement in the two 6 bed facilities that we will establish. The remainder would be in family (biological or found), kinship or other placements with permanent caregivers. We are expecting that our average enrollment in the system of care will be for 24 months.

Our RBS system of care will consist of the following elements:

Environmental Interventions: We will have two kinds of primary environmental interventions. First, Victor Treatment Centers will acquire two additional 6 bed homes in county dedicated to the RBS system that provide short-term intensive stabilization, life and social skill development, enhanced intensive family connections work, and support in a trauma informed environment while parallel services and supports are being used

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to develop sustainable permanent living options for enrolled youth. In addition, local Foster Family Agency (ies) (FFA) experienced in administering an ITFC program will be selected via a MOU process to recruit an agreed upon number of intensive treatment certified foster homes. The FFAs will work in partnership with the RBS Care Coordination Team to meet the needs of youth who require intensive one on one intervention as they step down to a family setting from group care. Trauma-informed care will be the treatment paradigm used for all intervention.

Currently our RCL 14 beds are primarily used for youth whose group home careers average 32 months and whose average time in foster care exceeds six years. These youth spend an average of a week per year on AWOL, 2 weeks per year in psychiatric hospitals, and have an average of three prior failed placements.

Portable Intensive Treatment Interventions: We will develop an integrated, portable Care Coordination Team (CCT) and service plan for each youth/family that will follow the youth and family through the arc of enrollment. In addition to training to meet the high-level of psychological and psychiatric needs of the youth and families, the team of individuals serving the client and family will be trained to use principles of trauma-informed care. These same treatment principles will be employed continuously by all care providers throughout the arc of enrollment including the residential treatment and community settings. The CCT is designed to identify and respond to the specific unmet needs and clinical issues that are contributing to the ongoing family disruption. CCTs will be available to work with youth and their families regardless of the youth's current living situation so that services and support are consistent and continuous across environments. In addition to the SW or PO and an assigned DBH clinician, the CCT consists of at least a facilitator, the assigned Family Clinician, a parent partner, a peer advocate, the youth, the family (biological or prospective) and assigned staff from the youth's placement settings (group home, FFA). Currently most treatment is placement anchored, so that when a youth's placement changes, so do the treatment providers. With RBS, youth will remain connected with the same treatment team as they move to lower levels of care.

Parallel Community Services: A designated Family Clinician who is assigned at intake and who stays constant throughout enrollment will provide CCT support, case management, natural support development, family therapy, parent support and guidance, family finding engagement and empowerment, and liaison with schools and other services needed to help prepare a place for youth as they move toward permanency. Currently many of these parallel community services are not available for youth in group homes, and those that are available are not sufficiently integrated with the rest of the service and planning process. As a result reconnection opportunities are missed and youth languish in institutions.

Follow-up Aftercare Services: Once youth have returned to or joined the families who will be their permanent primary caregivers, the same CCT members and Family Clinician will continue to provide support as needed while the ups and downs of reunification work themselves out and local community services are developed to provide ongoing support.

Family Involvement: Parent partners who have had children served and have experienced the system will help family members understand the new program, feel comfortable with participation, and share their perspectives, ideas and concerns. These

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parent partners will be part of the CCT. In addition, if available, family members will be invited to participate in enrollment and treatment planning decisions using TDM, IEP meetings and the RBS Screening Meeting where family, residential treatment center staff and county staff will come together prior to placement to confirm that this is the best avenue for treatment. Currently, these decisions are made between county and provider staff and families are informed after the recommendation has been made. CCT meetings will be scheduled around when parents and other important people in the youth's life can attend; their frequency will be tailored to the needs of the family and reset as needed depending on where the youth/family happens to be in the arc of enrollment. Arrangement will also be made so that key members can attend the CCT telephonically.

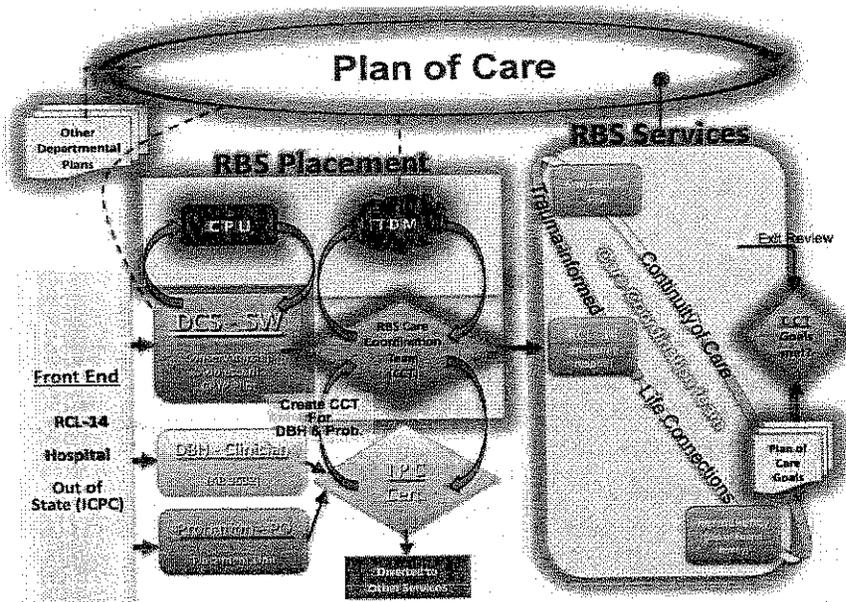
Utilization Management: The RBS Oversight Committee will be created which will meet as often as needed but no less than monthly to review the enrollments and exits from the RBS system of care. Representatives from VTC, VCSS, CFS, DBH, Probation, parent partner and peer advocate will constitute the committee. Currently, each of the county placement systems operates independently with respect to this population. This Committee will liaison with the financial departments throughout the County and provider to monitor payments and lengths of stay.

Funding: Funding for RBS services will integrate MHSA Prevention dollars (Success First Wrap), and AFDC-FC dollars to provide the RBS services with billing to EPSDT as allowed. This integrated funding structure will necessitate the further integration of Victor Treatment Centers' group home service model and Victor Community Support Services division's community-based activities. Additionally, one or more ITFC FFAs are being recruited via a MOU process as a step down placement option for youth who are not ready for family placement or regular FFA homes. The ITFC rate will be established per SB1380 implementation instructions. Other funding streams such as IV-E training, THP, SSI Disability, and Wrap SB 163 will be utilized.

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The following diagram sketches the general design of the RBS System of Care in San Bernardino:



2. PARTICIPANTS & ROLES

2.1 Participants (Previously Question 1 of Program Description): 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. If the private non-profit participants have not yet been selected, identify the process and timeline for selection.

Agency or Department	Contact Person Name & Title	Email Address
Children and Family Services (CFS)	Norm Dollar, Deputy Director	ndollar@hss.sbcounty.gov
Department of Behavioral Health (DBH)	Mike Schertell, Acting Deputy Director	mschertell@dbh.sbcounty.gov
Department of Probation	Tina Mason, PO III	tmason@prob.sbcounty.gov
Victor Treatment Centers, Inc.	Neal Sternberg	neal@victor.org
ITFC FFA*	TBD	TBD

Process and timeline for selecting non-profit agency participants (if this has not already occurred).
* The county is pursuing a MOU process to select one or more FFA's which have experience with ITFC. This process is anticipated to be completed in Spring of 2010.

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2.2 Role of the Placing Agency(ies)¹: Describe the role of the Placing Agency(ies) in the operation of the RBS program.

The role of the three placing agencies will be to insure that the right youth and their families get the right help at the right time and in the right place. Each has agreed to host the RBS Steering Meeting on-site for any of their youth who have been referred to RBS by a worker. The placing agency will provide redacted documentation access to Victor staff and family during that meeting so that a placement decision can be made immediately and the Interagency Placement Committee certification process can be expedited. Individual consent for treatment orders will be obtained per youth from the Juvenile Court prior to the referral to the RBS Steering Committee.. The placing agency will also ensure that their workers assigned to RBS cases are freed up to attend CCT meetings throughout the arc of enrollment either in-person or via teleconference so that they act as full participants in the CCT consensus decision making process and that treatment and transition are not delayed.

Treatment options integrated within the RBS program will include SB 163 wraparound, intensive in-home services, intensive day treatment services, intensive treatment foster care, and group home placement. Enrollment in RBS will be limited to youth who are currently in or needing RCL 14 or higher placements and do not have a viable permanency plan.

Strategically, the impact of RBS is already being felt throughout San Bernardino County. In the Fall of 2008, the County had an RCL-14 provider somewhat unexpectedly close their facility, necessitating the relocation of approximately 40 youth in other appropriate care facilities quickly and with a minimum of disruption and trauma to the children and their families. DCS and DBH adopted the San Bernardino RBS values and team approach and in less than two weeks completed the transition for all youths. The effort went smoothly, exceeding County expectations with such vulnerable children and their families, and was widely recognized throughout the County as a breakthrough in practice. The leadership involved from CFS and DBH attributed much of this success to operating from inside the RBS paradigm.

Following this event and several briefings of senior County leadership regarding RBS progress, inter-departmental cooperation and innovation, the San Bernardino County Children's Network Policy Council adopted the recommendations of the biannual Group Homes Needs Assessment that the RBS principles serve as their long-term working model for out of home care for youth at risk of entering or in residential care and approved a recommendation that the county proceed to enter into the MOU with CDSS to conduct the RBS pilot as described in AB 1453, chaptered 2007. This includes endorsing these principles:

- Adopting the "No handoff, No drop off" paradigm for continuity of RBS care,
- Viewing residential care as a short term treatment and stabilization intervention vs. long-term care ,

¹ Reference 'Role of the Placing Agency' section of the 'Framework' document

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- Providing long-term treatment and care in a family-based setting,
- Providing parallel family services while the youth is in residential treatment so that youth can return to their community and families with needed supports,
- Engaging the community including hospitals, FFA's, the Regional Center, ITFCs, community resources, and schools both earlier in and throughout the youth's trajectory of care, and
- Including family readiness and/or family finding/engagement as a mainline and early component of group care ensuring that each youth have a permanent connection with a caring, committed adult.

2.3 Role of the Provider Agency(ies)²: Describe the role of the Provider Agency(ies) in the operation of the RBS program.

Two divisions of one provider agency have been selected to form the hub of the San Bernardino County RBS system: Victor Treatment Center (VTC) and Victor Community Support Services (VCSS). VTC will acquire two 6-bed group homes in-county to provide short-term stabilization, life and social skill development, intensive family work, natural support development with possible guest arrangements to accommodate services for extended family visitation, interaction and mentoring. VTC will create a Care Coordination Team for each youth enrolled in RBS which will provide continuity of services across each youth's living situation throughout the arc of care pursuant to an individualized mental health treatment plan and the foster youth's court ordered case plan

Upon the completion of a recruitment process and MOUs with CDSS, San Bernardino County will have the selected qualified FFAs recruit 5 to 10 Intensive Treatment Foster Homes to be integrated in the RBS array of placement options. Care coordination will continue to be provided by the same RBS CCT while an RBS enrollee is in an ITFC home.

In addition, coordination between the existing THP and THPP providers and the RBS system will occur to ensure the transition of appropriate older youth who are close to emancipation to a THPP housing slot with continuing services provided by the VTC CCT.

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

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

We have two levels of collaborative involvement in the RBS system. First, there is the San Bernardino County RBS Steering Committee which includes youth and family and

² Reference 'Role of the Provider Agency' section of the 'Framework' document

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advocate representatives, a representative from County Superintendent of School's Foster Youth Services, a SW representative, VTC/VCSS representatives, a probation officer, a mental health case worker, a Regional Center administrator, a representative from a local FFA, staff from local psychiatric hospitals, staff persons from the Human Services Program Development and Research and Evaluation divisions, an Independent Living Program representative, a representative from the San Bernardino County's California Permanency for Youth Project pilot, and a representative from the San Bernardino County Family to Family Initiative, itself an interagency group of the community's family support agencies. Additional members will be added as needed during implementation such as representatives from the school district in which the RBS facility will operate. This group currently meets on a monthly basis and will meet quarterly during operation of the pilot. This group will 1) review data from the RBS Oversight Committee (below), CMS and C-IV data, and RBS evaluation measures, 2) assess use of the program by the county, and 3) propose solutions to any emergent issues.

Second, we will have the RBS Oversight Committee, a subcommittee of the Steering Committee, which will meet as needed to conduct utilization review and management, ensure eligibility requirements are being met and assess whether there is an appropriate rate of flow of enrollees throughout the arc of care. The Oversight Committee consists of a parent partner (shared responsibility of placing agencies), a peer advocate, key staff from each of the three placing agencies (such as a program manager and a staff analyst) and a representative from Victor.

3. ENROLLMENT CRITERIA³

3.1 Target Population (Previously Question 1 of Voluntary Agreement): 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.

Our initial target population consists of any youth aged 13 to 18 who is currently 1) in an RCL 14 group home placement, 2) in an out-of-state group home and that placement is failing, or 3) has had a history of multiple prior psychiatric hospitalizations and/ or on administrative days in a psychiatric hospital. In addition, the typical RBS candidate is highly disconnected from viable permanency options (family, relatives or another permanent caregiver), has had multiple placement failures and psychiatric hospitalizations, a history of running away, and is likely to remain in institutional care until the age of majority absent RBS intervention. This target population will include seriously emotionally disturbed youth whose significantly disruptive behaviors are such that a highly structured residential setting and intensive mental health services are

³ Reference the 'Placement Criteria' section of the 'Framework' document

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needed to enable the youth to succeed in personal relationships, family relationships, personal care, academic goals, and independent living skills. Although some of these children may meet the criteria for special education definition of SED or Seriously Emotionally Disturbed, this term is being used in a more generally descriptive manner as is common when referring to children facing severe mental health issues, as will be the case with all RBS youth. Special education children who are approved for AB3632 residential services within their Individual Education Program (IEP) would be eligible for enrollment in RBS as a placement option if all other criteria for participation are met. It is expected that 1 or 2 AB3632 minor may be enrolled in RBS. Additionally, the youth enrolled in RBS will participate in identifying adults who are committed to being an on-going natural support for the youth or with the intention of providing permanent placement in the near future.

Youth who have no identified families or non-related extended family members are allowed to participate in the RBS system of care. If a youth does not have identified family, we complete family finding, search, and engagement efforts to try to find family members. It is assumed that every child has someone who is related, either biologically or emotionally (fictive kin, mentors, former teachers, former foster parents, former neighbors). Based on our experience with using models through the California Permanency for Youth Project, CPYP, we believe that locating connections is possible, as we have had some success with finding family members through engagement techniques with children of similar demographics. However, it is not unforeseeable that there may be an occasion when family finding does not produce appropriate biological or emotional connections for these children. In this case the goal will be to assist the child in creating these connections. In order to create connections a CASA (Court Appointed Special Advocate) will be assigned to the youth and other permanency options will be explored such as adoptive placement, and/or emotional permanency with a lifelong caring and committed adult.

At intake it will need to be assessed whether the goals of the youth and family can be met by the age of majority or if during the duration of the pilot, California opts into the federal IV-E expansion of AFDC-FC to age 21, and older youths may be considered.). As we gain experience with operating an RBS system, we hope to expand enrollment to include children of younger ages (within statutory limitations) who are referred for placement to an RCL 14 group home and for whom there is no imminent plan for reunification.

We will begin enrollment by reviewing the situations of the identified children and youth in our initial target population and selecting 6 males and 6 females for enrollment. (Attention will need to be paid to risk mitigation by not mixing a wide range of ages). Enrollment will take into consideration the foster children who are identified as having high utilization of EPSDT in the County's EPSDT Program Improvement Program (PIP) by DBH, so that the placing agencies are coordinating improving outcomes for both the EPSDT and CSFR's PIP's. Selection will be made on the following basis: lack of stability and progress in the current placement, number of prior placements prior to the current placement, presence of interested family members (or lack thereof), relatives or other caring adults who might be willing to become primary caregivers should sufficient

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support be available, identification of a high level of need as determined through administration of VTC's comprehensive assessment, and recommendation through the youth and family's respective team decision making process (TDM, IEP, etc.).

Victor will maintain an additional Level 14 group home in San Bernardino County which can serve those San Bernardino youth who require that level of care when a RBS bed is not available. San Bernardino County recognizes that referring RCL14 youth from the County in addition to the 12 youth served residentially through the RBS pilot maintains the occupancy necessary for financial stability of the pilot beds. Traditionally those youth that qualify for this intense level of care necessitate a Non-Public school to meet their educational needs. VTC's sister Agency North Valley Schools operates a educational environment geared to serve this population and provides the required Mental Health Services often identified to assure these youth obtain an appropriate education. The continuity of the relationships between all of the environments that serve this difficult population, the residential milieu, Mental Health services, and the educational environment play a critical role in the intense treatment environment needed to obtain the success the pilot is seeking.

3.2 Enrollment Criteria: 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 number of youth in our target population exceeds our program capacity, in that over a year's time we have approximately 40 youths placed in RCL 14 homes. Therefore we will apply the criteria noted above in 3.1 to identify children for enrollment. As stabilization and movement to family, relative or intensive treatment foster/FFA certified homes occurs for the initial 12 enrollees, additional referrals will be considered and made by the placing agency until the designed capacity of 30 total enrollments is reached. At that point new enrollments will depend on the rate of exits from RBS, unless additional capacity is added to the program. The RBS Oversight Committee will monitor the rate of referrals and evaluate youth for new enrollments as vacancies arise.

3.3 Assessment and Matching (Previously Question 3 of Voluntary Agreement):

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.

When a Team Decision Meeting (TDM) results in a recommendation that a CFS youth be considered for an RBS placement, the selected youth will typically have had multiple placement failures, psychiatric hospitalizations, and/or a history of running away.

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From the TDM process Victor will be involved with the child, family (when available), and worker(s) to engage in case mining (review of the redacted case record) so as to determine if the youth meets criteria for being placed at Victor. A comprehensive assessment is completed during the screening period on all youth referred. VTC incorporates the use of the Child and Adolescent Needs and Strengths (CANS) for assessing the child/youth. Youth can be denied based on the program capabilities defined in the program statement filed with CCL. Victor's program statement indicates that youth with the following categories cannot be served in a Victor group home: arson / fire setter, non-ambulatory, pregnant, blind / visual impairment, gang membership (affiliation would be considered), severe developmental disability (borderline would be considered), severe / pervasive sexual perpetrator (less severe would be considered when low risk to other youth in the group home). Once youth meet Victor criteria, their case is presented to the Interagency Placement Council (IPC). The target population is youth identified as qualified for RCL-14 care but have needs that go above and beyond the typical RCL-14 youth's needs. The match for RBS in San Bernardino County are those youth qualified by the IPC as appropriate to receive RBS services, who are currently in an out-of-state group home placement that is failing, or who have had a history of multiple prior psychiatric hospitalizations and / or are on administrative days in a psychiatric hospital, or have little or no family connections / natural supports.

The point in which youth are first tracked as part of an RBS cohort and included in the cost neutrality analysis is the point in which the youth is able to be admitted into one of the 12 RBS residential facility beds. The provider will engage in pre-placement services to initiate the Care Coordination Team (CCT) to help the youth transition from the existing placement (e.g., psychiatric hospital) to the residential treatment.

Our primary assessment tool will be the RBS Screening Meeting. (Currently no such meeting exists.) At this meeting, any available assessment results will be added to a complete case review. The RBS Screening Meeting is designed to occur at the placing agency with the youth, any family and the provider present, so that redacted case documentation is present and accessible to the provider enabling a placement decision to be made on the spot. (Currently, the process of case review and assessment results in significant wait-in-queue time for a youth being placed in a RCL 14 group home.)

The Screening Meeting also provides Social Workers and Probation Officers the opportunity to get technical assistance with respect to filling out the documentation for the Interagency Placement Committee (IPC). No formal assessment tool is currently or will be used with this target population at the matching stage. A clinical assessment, which may include case review or prior assessments done on the youth, is provided at this time by the IPC to determine RCL 14 eligibility. During the IPC, qualified mental health professionals recommend appropriateness of the case for either RBS or other options such as Wraparound or ITFC. This will continue to be the case during RBS. Held after the Screening Meeting, the IPC will use the county's interagency Universal Referral Form to confirm RCL-14 certification. Our primary formal tool will be the VTC Comprehensive Assessment which will be completed at admission to the facility. It is a nine page assessment which identifies clinical needs, barrier behaviors and discharge

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goals. Other assessments will be brought to bear by the provider as clinically indicated such as the CANS, (enrollment, every 6 mos. and exit) and the Ansell Casey Life Skills Assessment. The Screening Meeting is coordinated by CFS Group Home Coordinator in collaboration with all involved parties. This meeting is a place where all parties can meet and a determination can be made to see if the youth can be accepted into the Victor Facilities (given their licensing and program statement requirements). This meeting is a place for the Victor staff to meet the youth and family, engage the social worker, and determine appropriate fit. There is no formal format. This is also the place where Victor staff can collect the paperwork they need from the files, as authorized by the court, to ensure they have all the information necessary to determine if the youth will fit the facility, gather family information from the case record for family finding, and assess the youth's feelings about the matter. This meeting includes all parties that have some influence over decisions made on the youth's behalf such as CFS social worker, probation officer, family, youth, DBH clinician, and Victor staff. This meeting does not follow the traditional TDM model, but occurs directly after a Team Decision Making Meeting has been held. This screening meeting is necessary in order for the Victor staff to engage the youth and family outside the structured format of a TDM that does not allow for this type of engagement

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.

During the initial phase of enrollment the existing members of the target population will be assessed using the RBS Screening Meeting process to identify the 6 males and 6 females most likely to benefit from and most in need of RBS intervention. Input into this process will be provided by the Team Decision Making meetings that occur for CFS youth needing a placement change. Enrolled youth will be referred to VTC for the creation of a CCT and for placement in a residential bed. In order to ensure that we are not screening out unnecessarily youths whose families are at a great distance from the provider, the following accommodations will be made:

- When distance is a factor, we will pay for transportation (plane fare, etc.) to bring family to visit or to have the child and treatment staff visit family
- To the degree that licensing permits, a guest house/cottage at the facility, as available, will be used for family visits.
- After stability is achieved in the RBS residential facility, as part of the step down to lower level of care, we will consider the use of ICPC to place youth with families out of state.

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

In all instances the voice of the youth and family members will be paramount. There will be four levels of youth and family involvement. First, the RBS Steering Committee will have youth and family representatives. Second, the RBS Oversight Committee will

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have a parent partner and peer advocate as members. These two levels constitute family participation in an advisory capacity. Third, through the use of TDMs and/or IEP's and the RBS Screening Meeting prior to enrollment each youth and their families and advocates will be equal partners in weighing the options and needs and choosing the best match for achieving progress and positive outcomes. Fourth, the individual youth and family's explicit needs and wishes will be the nexus around which the CCT conducts its case planning and service delivery activities. The latter two levels involve the active participation of an individual youth and family in their own case planning and treatment. With the exception of situations that would create a high risk for the youth, safety concerns for the youth, or directly conflicts with a court order, the youth and families will be granted the maximum voice possible regarding decisions and input. The family and youth are involved in all processes of engagement and are members of the Care Coordination Team.

4. PROGRAM CRITERIA⁴

4.1 Mission (Previously Question 2 of Program Description): 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.*

Working together to safely build and sustain positive, successful family connections and children's futures.

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

The transformed system will provide resources specifically designed to facilitate the ongoing movement of children and youth who have complex emotional and behavioral needs toward more permanent and positive connection or reconnection with their families, schools and communities. The transformed system will create effective partnership and collaboration across systems in the interest of better outcomes for those youth and their families.

4.3 Guiding Principles⁵ (Previously Question 4 of Program Description): 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.*

⁴ Reference the 'Program Criteria' section of the 'Framework' document

⁵ Reference 'Values' in the 'Program Criteria' section of the 'Framework' document

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- *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.*
-

Family-driven, Youth-Guided. Providing for and insuring active and equitable youth and family participation in all phases of intervention and treatment.

Trauma Informed Stabilization. Providing positive and supportive assistance to guide children and youth in replacing the behaviors that require/d residential placement with safe, pro-social alternatives that better express and address their unmet needs.

Permanency Focus. Helping children and youth stabilize in placement so that they can quickly return to and remain safely with their families, schools and communities and connected with a caring and committed adult who will be that youth's lifelong connection.

No Handoff, No Drop Off. Providing for and ensuring that families and children experience continuity of relationships with the same core service providers throughout the arc of enrollment.

Tailored Flexibility. Respect for the culture, individuality and humanity of children, youth and families while building plans of care which are based on the unique strengths, needs and goals of each youth and family member.

Partnership and Integration Across Systems. Recognizing that is the responsibility of the system of care to seamlessly coordinate itself across agencies and providers and not the responsibility of the youth and family.

4.4 Administration⁶:

- 4.4.1 Placing Agency Oversight: 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.**
-

An important difference between the way our County placing agencies have managed traditional group home care and the way they will provide oversight in our RBS System is the shift of emphasis from placement to enrollment. Our RBS Oversight Committee will monitor the overall arc of care delivered by our RBS providers from point of

⁶ Reference 'Administration' in the 'Program Criteria' section of the 'Framework' document

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enrollment through any needed moves in the places where children and youth live while receiving services until a stable and permanent family living arrangement is achieved. CCTs will be primarily accountable to this body. In turn, the RBS Oversight Committee is accountable to the RBS Steering Committee.

The RBS Steering and Oversight Committees will collaborate to oversee an outcome driven system of care. The expectation is that VTC/VCSS will demonstrate ongoing progress in helping enrolled youth and families make progress toward achieving permanency, safety and well-being. While understanding that straight-line improvement is unlikely when youth and families have complex and enduring needs, these bodies nevertheless will use objective measures as well as the qualitative reports of the children, youth and families to track overall movement toward the identified goals of our system of care.

The chief objective measure will be the results of the administration of the CANS at intake, every 6 mos., and exit. Quantitative reports of the youth and family's perception of progress and satisfaction with services will be garnered by the Youth Services Survey (YSS) and the YSS-F for families. Victor will also assess client satisfaction qualitatively using the Victor Client Satisfaction Survey.

In addition, the Oversight Committee will track key events marking progress including reduced ratio of residentially-based treatment to community-based treatment, reduction in out-of-state placement, reduction in hospitalizations, reduction in AWOL incidents and increased permanency as demonstrated by stable family level placement, increased pro-social behavior and more lifelong connections. The Oversight Committee will monitor lengths of stay to ensure the pilot meets the objective of AFDC-FC cost neutrality. The Oversight Committee will coordinate a feedback loop to Victor and to the RBS Steering Committee so that all involved will have a clear sense of what is working and what isn't and appropriate decisions about system adjustment can be made to improve both the delivery of services and the outcomes achieved through those services. CFS will appoint chair of the Oversight Committee.

Besides monitoring implementation of RBS plans of care and the progress being achieved by enrolled children, youth and families via linkage with the Oversight Committee, the RBS Steering Committee will also oversee the funding model, described in detail in our Funding Model proposal, and will report to the directors of the three placing agencies cooperating in forming the San Bernardino County RBS System, the juvenile court, CDSS and the state RBS Advisory Committee.

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.

The San Bernardino County RBS System will use a lead provider structure for the delivery of the comprehensive package of services, supports and interventions included in our RBS System. During the initial phase of the System's development we will use

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two divisions of one lead provider: Victor Community Support Services and Victor Treatment Centers. The lead provider will be responsible for integrating the operations of its two divisions to develop and implement a comprehensive RBS plan of care that coordinates both the needs and services plan supported through AFDC-FC funding and an individual behavioral health services plan that is supported through MHSA and EPSDT for those children and youth who are meeting medical necessity and through MHSA only for those who are not.

Victor Treatment Centers (Victor) has been providing residential services to California's most troubled youth since 1966. Over the past few years the agency has been working diligently to transform their services and culture to improve transition outcomes and reduce the length of stay for children who are placed into their Level 14 Residential Treatment Facilities. For example, they have transitioned away from traditional behavioral level systems and developed treatment models based on effective relationships, values, evidence-based practices and skill building. They are focused on preparing youth to return to family-based care and their communities as quickly as possible and see RBS as a vehicle to create a program to produce such results.

Victor will acquire two in-county 6-bed group homes, one for males and one for females. If feasible within the property market, there will be a separate structure on the same property that will be used for expanding family participation while the youth is in residential treatment. As the lead provider, Victor will also provide overall care coordination for each enrolled youth and his or her family, full clinical and social services assessments, and parallel and follow along community services through the formation of CCTs. In addition, Victor will make arrangements for additional formal and informal assistance, services and supports as appropriate given each youth and family's specific strengths, needs and goals as identified in the RBS plan of care developed by the Care Coordination Team. These services will be supported through subcontracts from the lead provider by direct payment where the youth and family are eligible for those services, by contribution by the family or through their insurance, and by encouraging voluntary community assistance and natural connections wherever possible.

Another provider type will be recruited via a competitive procurement process to join RBS provider group. One or more Foster Family Agencies with experience using the ITFC model will be selected to develop 5 to 10 Intensive Treatment Foster Care certified homes to provide bridge care (step down) for children and youth for whom a regular FFA placement does not meet their needs for one on one intervention with a caregiver while a living situation with their family, relatives or other primary permanent caregivers is being developed,. The Care Coordination Team will assess the appropriateness of such a placement option on a case-by-case basis.

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.

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Victor will include a parent partner and peer advocate on the management team supervising their RBS program in addition to working with the CCTs. In addition, several formal and informal techniques will be used for obtaining family and youth feedback including focus groups, confidential interviews conducted by non-threatening interviewers and mid-service and exit satisfaction surveys.

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.

Victor has been involved in seeking a new database system that could be used for all programs and services VTC provides. Victor has been using a "home-designed" database for years that we continue to develop and enhance as we seek on a parallel track to acquire and implement the use of new software with more robust capabilities. The existing database is fairly sophisticated, but the new software would be much more robust and be easier to modify.

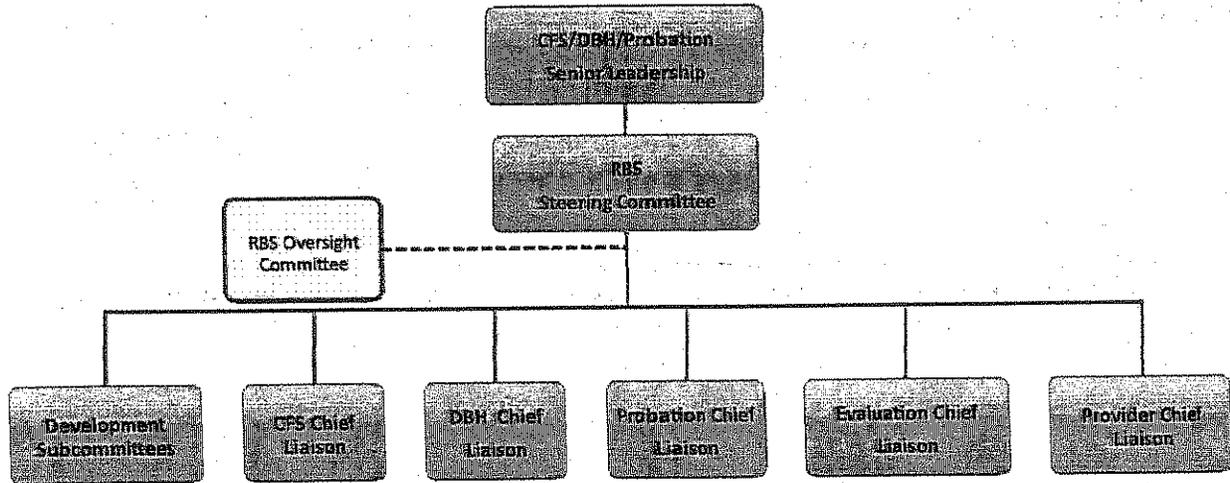
Victor has been engaged for several months in a data mapping process which should be finished in July 2010. The outcomes of this exercise will help Victor determine next steps in terms of, when, and what kind of new database software we might purchase and implement.

4.5 Management:⁷

4.5.1 Management Roles & Responsibilities (Previously Question 7 of Voluntary Agreement): Please identify key managers of the Placing Agency(ies) and each Provider Agency(ies), and their roles and responsibilities for the implementation and operation of your program (If a Provider Agency has not yet been selected for your project, simply describe the roles and responsibilities that they will be expected to fulfill upon selection). *If available attach organizational chart that displays positions by job title/ classification.

SEE FOLLOWING PAGES FOR DIAGRAM AND TABLE

⁷ Reference 'Management' in the 'Program Criteria' section of the 'Framework' document



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Agency	Manager	Role & Responsibility
SB Probation	Tina Mason (Chief Liaison)	Ms. Mason will serve as a member of the RBS Oversight Committee as one of the most experienced placement officers to manage the youth and families referred to RBS. She will set up an internal review process within juvenile probation to insure that all workers understand the purpose of RBS and can make referrals when appropriate.
	Holly Benton	Ms. Benton is an executive champion who will serve as Probation's representative on the RBS Steering Committee.
SB Child Welfare	Christa Banton (Chief Liaison)	Ms. Banton will serve as a member of the RBS Oversight Committee as one of the most experienced placement supervisors to manage the children, youth and families referred to RBS. She will set up an internal review process within CFS to insure that all workers understand the purpose of RBS and can make referrals when appropriate.
	Norman Dollar	Mr. Dollar is an executive champion who will serve as DCS's representative on and co-chair of the RBS Steering Committee. Mr. Dollar will also oversee the development of the ITFC Resource with CFS manager Hernaldo Sequeira
SB Behavioral Health	Anjali Barse (Chief Liaison)	Ms. Barse will serve as a member of the RBS Oversight Committee as a lead clinician to supervise the assessment process for referrals and to participate on all teams pursuant to 26.5 (AB3632) when RBS may be an appropriate option. She will also assign one of her most experienced case managers to oversee the development of individual mental health treatment plans for children and youth who are referred to RBS.
	Michael Schertell	Mr. Schertell is an executive champion who will serve as DBH's representative on and co-chair of the RBS Steering Committee. Tim Hougen serves as a delegate for Mr. Schertell
VTC	Doug House (Chief Liaison)	Mr. House will serve on the RBS Oversight Committee and will designate an experienced unit supervisor to oversee the day to day operations of the RBS unit, and participate with Mr. Cook (below) in the hiring and training of the VCSS staff, family support staff and CCT members for getting the unit up and running.
	Neal Sternberg	Mr. Sternberg is an executive champion who will serve as VTC's representative on the RBS Steering Committee.
VCSS	Charles Cook (VCSS Liaison)	Mr. Cook will serve as an experienced coordination team supervisor and act as a liaison to the day to day operations of CCTs, and participate with Mr. House in the hiring and training of the VCSS staff, family support staff and CCT members for getting the program up and running.

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	Doug Scott	Mr. Scott will be invited to be an executive champion who will serve as VCSS' representative on the RBS Steering Committee.
FFA/ITFC	TBD (Chief Liaison)	The FFA will designate a foster care lead worker to liaison with the intensive treatment foster homes that will be made available to provide bridge care RBS services, train the ITFC foster parents on the elements of the RBS values and system, and supervise all RBS bridge care placements.
	TBD	The FFA Executive Director will serve on the RBS Steering Committee.
Evaluation	Kelly Cross (Chief Liaison)	Ms. Cross from the HS Legislative and Research department will serve as the key RBS Evaluation staff integrating data from all participating organizations, managing CWS/CMS and C-IV data extraction. She will also serve as the liaison to the larger RBS Evaluation Subcommittee.
	Kathy Watkins	Ms. Watkins is an executive champion who will serve as SB County HS Administration's representative on the RBS Steering Committee. She will serve as the Evaluation representative on the RBS Steering Committee.

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.

We will use the RBS Oversight Committee and the RBS Steering Committee as our two primary forums for communication. Information will feed into these groups from the Victor's care management system and the family observations, concerns and satisfaction feedback system. The RBS Steering Committee will include representatives from the advocacy community, the schools, the courts, and the broader service network and will thus be able to gather information from those perspectives. By combining operational and CCT data from Victor with the qualitative data from the family feedback system, and administrative data tracking of youth outcomes the RBS Oversight Committee will be able to continually adjust the structure, operations and services of the RBS demonstration to better meet youth and family needs.

4.6 Staffing:⁸

4.6.1 Staff Roles & Responsibilities: What changes will the Placing Agency(ies) and each Provider Agency 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

⁸ Reference 'Staffing' in the 'Program Criteria' section of the 'Framework' document

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responsibilities, qualifications, experiences, and education necessary.

The placing agencies will be designating and training selected skilled placement workers to case manage RBS enrollments. This will be within the normal scope of the duties of these workers and will not constitute a change in the staffing model. The provider agencies will be making significant changes in their staffing models.

VTC will establish two new program components for the transformed RBS residential treatment milieu and the RBS CCT. The residential treatment unit will have three main staffing functions: 1) the core CCT staff consisting of a facilitator, parent partner, peer advocate, and clinician, 2) the residential milieu staff who will maintain the milieu in the two new 6-bed RBS facilities, and 3) individual staff members chosen by the child and family to follow them across treatment settings.

The selected ITFC FFAs will provide 5 to 10 intensive treatment foster care certified homes which will become part of the San Bernardino County RBS System and will offer the bridge care as needed for enrolled children and youth who can't otherwise be stepped down to a regular FFA or lower levels of care..

4.6.2 Provider Staff Capacity Plan: 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.

Both VTC and VCSS all have proactive, ongoing and highly targeted recruitment and retention plans. Victor will use a human resources system which emphasizes consistent, strength-based and goal focused hiring and retention from the job announcement, through applicant interviews, job descriptions and orientation training, through the ongoing supervision and career advancement process. In addition to their in-house training programs, staff from all three providers will take part in the cooperative RBS training sequence, along with staff from the San Bernardino County placing agencies.

We currently project that experienced workers who have expressed eagerness to transition to this new form of service and support will fill about 80% of the RBS staff positions at Victor. New hires from the group of applicants currently being considered by the two agencies will fill the remainder of the positions. The selected ITFC FFA will be expected to recruit and train experienced treatment foster parents who have demonstrated strong abilities to work with children and youth who have challenging behaviors and have been able to form positive and active partnerships with family members from a wide variety of backgrounds.

4.6.3 Placing Agency & Provider Agency Staff Training Plan (Previously Question 10 of Voluntary Agreement): Please describe your plan for training the Placing Agency(ies) and each Provider Agency(ies) staff

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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.

San Bernardino County will establish a cooperative RBS training sequence that will be hosted by Victor Treatment Centers. Staff who are working in one or more components of the RBS System will complete an initial training containing the core elements of the sequence, which includes the following topics: RBS principles overview, description of the SB County RBS System (including the roles and responsibilities of the participating public and private agencies and of the staff working in those agencies), RBS practices overview (family search and engagement, intensive treatment interventions (to include Risking Connections/Trauma Informed Care and Ansell Casey), parallel community services, Pre- Residential services, follow-up aftercare services, utilization management, and funding), and introduction to the RBS plan of care development process. The County plans to work with VTC to purchase from and/or contract with VTC to provide coordinated cross agency training using the enhanced Title IV-E training funds.

Depending on the role that the staff person will play in the RBS system, they will then complete the role-specific training elements. These will vary in length and focus based on the staff person's duties. We are preparing training elements for county placing workers from the three placing agencies (CFS, Probation DBH) for the Victor service delivery team, for milieu staff at the Victor Treatment Centers, for clinical assessment and treatment staff from all public and private agencies, for the members of the Care Coordination Teams, for the family engagement and empowerment staff at Victor Treatment Centers, and for the intensive treatment or FFA certified foster parents (who will provide bridge care).

Throughout the year, Victor will internally focus on a set of ten foundational values focused on, that all staff will be expected to exhibit: Diversity, Health, Responsibility, Learning, Respect, Trust, Fairness, Safety, Citizenship, and Caring. Each of the foundational values has an associated description, a rationale for its development, a set of practices for developing the values in the youth we serve and indicates the activities, groups, outings that expose the value to the youth.

In addition we also have identified a set of task specific skills for the various roles that staff will be filling. The initial group of public and private staff assigned to the RBS System will complete the sequence together. The training department at Victor Treatment Center will then review the initial training materials and sequence with the participants and prepare a revised version of the training elements. We will offer the foundation training as needed via e-learning modules. We are developing on-line training modules for many of the role-specific training elements to insure ready access. In addition, we will offer quarterly half-day in-service programs, some of which will be all-staff, and some role-specific.

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Training areas/topics will include:

- Initial implementation training for all stakeholders; Public and Private staff to review and prepare for the development and coordination of the RBS System of Care (includes RBS philosophy, values and milestones)
- Initial implementation training for the Public and Private staff to review and prepare for the development and coordination of the Family Driven, Youth Guided model to include details about the function and membership of the Care Coordination Team (CCT).
- Initial implementation training for the Public and Private staff to review and prepare for the development and coordination of the Trauma Informed Care model “Risking Connection” (includes residential milieu training)
- Implementation of training for Agency clinical staff on “Family Search and Engagement” including the Family Inclusion Model which involves on-site participation of families in treatment via overnight stays, joint field trips with staff and extended visits.
- Initial implementation training for the public and private staff to review and prepare for the development and coordination of the Ansell Casey assessment tool and independent living skills curriculum.
- Documentation training to complete comprehensive consolidated plans and weekly summaries that identify services provided and progress on goals.

4.7 Quality Assurance (Previously Question 9 of Voluntary Agreement):⁹

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]
Group Home Monitoring (CFS)	<ul style="list-style-type: none"> • How Placing Agency needs are met 	<ul style="list-style-type: none"> • Group Home Needs Assessment 	<ul style="list-style-type: none"> • Every 3 yrs 	<ul style="list-style-type: none"> • Kelly Cross (HS-LRU)
	<ul style="list-style-type: none"> • Impact of GH on community • Assisting and strengthening GH programs 	<ul style="list-style-type: none"> • Compliance re: special incidents • Abuse in out-of-home care reports • Site visits • Review of records 	<ul style="list-style-type: none"> • Quarterly • Monthly • Continuous • Continuous 	<ul style="list-style-type: none"> • Kelly Cross (HS-LRU) • Jeany Zepeda (CFS)
Contract Monitoring (DBH)	<ul style="list-style-type: none"> • Appropriate application of MHSA and EPSDT funded programming 	<ul style="list-style-type: none"> • Data Collection and Reporting (DCR) system • Site visits • Review of 	<ul style="list-style-type: none"> • Annually • Annually • Annually 	<ul style="list-style-type: none"> • Tim Hougen (DBH)

⁹ Reference 'Quality Assurance' in the 'Program Criteria' section of the 'Framework' document

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		charts		
MOU Monitoring (HS Admin)	<ul style="list-style-type: none"> • Appropriate application of AFDC-FC funds 	<ul style="list-style-type: none"> • Fiscal audit to OMB standards 	<ul style="list-style-type: none"> • Twice a year 	<ul style="list-style-type: none"> • Maury Sharfiri
Contact Monitoring (CFS SB163)	<ul style="list-style-type: none"> • Assisting and strengthening Wrap programs 	<ul style="list-style-type: none"> • Site visits • Records review 	<ul style="list-style-type: none"> • Minimum quarterly and more frequently as needed 	<ul style="list-style-type: none"> • Regina Dorman (HS-PDD)
Steering/Oversight Committee	<ul style="list-style-type: none"> • Utilization review and management 	<ul style="list-style-type: none"> • Status Reports from the Oversight committee on utilization review at Steering Committee Mtgs. • Fiscal reviews of AFDC-FC cost neutrality 	<ul style="list-style-type: none"> • Quarterly data reviews 	<ul style="list-style-type: none"> • Kathy Watkins (HS LRU) • Norm Dollar (CFS) • Mike Schertell (DBH) • Holly Benton (Prob)
IPC	<ul style="list-style-type: none"> • Appropriate use of RBS Placement 	<ul style="list-style-type: none"> • Status Reports at Steering Committee Mtgs. 	<ul style="list-style-type: none"> • Monthly data reviews (will be quarterly as program matures) 	<ul style="list-style-type: none"> • Merida Saracho • Tim Hougen
Provider Internal Surveillance	<ul style="list-style-type: none"> • Appropriate Service Planning • Quality of Care • Client Satisfaction 	<ul style="list-style-type: none"> • CANS • Victor Outcome Measurement database • YSS, YSS-F • Victor Client Satisfaction Survey 	<ul style="list-style-type: none"> • Quarterly 	<ul style="list-style-type: none"> • Doug House, VTC • CJ Cook, VCSS

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.

San Bernardino County's Departments of Children and Family Services and Probation completed its C-CSFR County Self Assessment in the Fall of 2008. This collaborative, community driven process is built on the themes from the first SIP, which focused on the needs of transitional aged youths. While this population remains a priority, the CSA's review of performance of the new federal measures lead to an expanded focus on needing to improve performance for adolescent foster youths in long term care. Specifically in the new 2009 to 2011 SIP, the County has committed to improving outcomes in placement stability for youths in care more than 24 months, C4.3, in exits to permanency C3.1, and youths in care 3 or more years aging out of care, C3.3. These selected SIP goals align with the required improvements in the State's PIP.

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The RBS pilot is a critical SIP strategy for improvement in these measures for older youths in care and as such is programmatically integrated with other SIP strategies, such as Wraparound Services expansion, increasing TDM's throughout the life of the PP case, increasing Family Finding and Engagements efforts, cross training staff with the provider community on grief and loss issues and building community partner capacity to mentor families and youths. The RBS pilot will operate concurrently with the new 3 year SIP. Measuring progress in implementation, monitoring individual and aggregate youth outcomes, tracking trends in impact to the C-CSFR measures using the UCB CSSR's composite measures planner, and reviewing lessons learned will be analyzed in the annual SIP updates.

5. SERVICE CRITERIA¹⁰

5.1 Engagement

5.1.1 Engagement Processes: 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.

The engagement process begins at the TDM whenever placement into the RBS treatment program is considered. The Victor Client Service Coordinator (CSC) and Family Clinician would be invited to the TDM to provide information about RBS. With the exception of situations that would create a high risk for the youth, safety concerns for the youth, or directly conflicts with a court order, the youth and families will be granted the maximum voice possible regarding decisions and input. The family and youth are involved in all processes of engagement and are members of the Care Coordination Team

The TDM occurs just prior to the Screening Meeting and only discusses placement options under the formal, applied format of the Family to Family model. For both meetings, we have off site capacity with community partners so the setting is convenient and comfortable for the family in their neighborhood. We can arrange as needed travel out of state or video conferencing or alternative arrangements as the need arises. When planning for these meetings, the most important consideration is that the location is portable and the design allows for the maximum involvement of the family and the youth.

Immediately following a TDM in which RBS is recommended, the Victor CSC and Family Clinician will begin building relationships with the youth and family through the interview process in the RBS Steering Meeting; the court consented case mining process pursuant to current CFS policy is initiated to gather historical, family, clinical, education, medical and other relevant information about the youth. The Victor CSC and Family Clinician develop a safety plan with the assistance of the youth and family

¹⁰ Reference the 'Service Criteria' section of the 'Framework' document

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members based on historical safety issues that will be used to guide responses to emergency situations in which the child's safety is at risk. The youth's connection map is created to depict their possible family / community connections and is the basis for work conducted by the Family Clinician for family engagement and finding.

- Case mining continues as the IPC reviews the youth's case to determine if they will grant the youth RCL-14 certification. Upon certification by IPC, Victor coordinates and facilitates the initial Care Coordination Team meeting during which the team begins development of the RBS plan of care. This is a strength-based, needs-driven plan with a targeted focus on helping the youth and family achieve and maintain the goals that are most important to them.
- When a bed is available for RBS residential treatment the youth is brought to a RBS Victor group home. The first week at a group home is often very difficult. Victor wants to welcome all new youth as warmly and respectfully as possible. The welcoming of the new youth will be an all-house effort and will include, but not be limited to:
 - A room that is ready, clean and welcoming
 - A pleasant meal planned (if possible the new youth should choose the meal).
 - Welcoming gifts – hygiene supplies, posters, magazines, and games.
 - A house buddy (peer) will be assigned to the youth to help teach the house rules, spend time hanging out, and help with chores.
 - A copy of the house program is provided.
- Victor staff will be trained in Risking Connections, a trauma-informed approach to care in residential treatment in which they seek to understand the trauma linked to the youth's behaviors and how that information guides the relationships built between the staff and youth. Key to the effective use of this process is the recognition that persistent behaviors that appear challenging, dangerous and ineffective are usually driven by critical unmet needs, and that the development of effective alternatives requires not only understanding the nature of those needs, but also identifying core individual strengths of the youth and family members as well as shared strengths of the family as a whole on which to build more effective adaptive responses to those needs.
- The motivation for the hard work that it takes for children or youth and their families to make this shift to more effective adaptive behaviors can't be imposed externally if being told to do things differently was going to work, things would have turned around long before a referral to the RBS system became necessary. Instead it must come from within. For that reason, the plan is based on the youth and family's own sense of mission or goals. They must have a sense of what it would be like to be doing okay on their own terms, and a hope and belief that with work it will be possible to make their dream a reality.

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

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program's nature and processes and have adequate and effective voice and participation?

- The San Bernardino RBS System will have five primary components that will operate directly to insure a family-supportive environment. First, Victor will assign a parent partner who has been a primary caregiver or close family member of a youth with severe emotional disabilities placed out of the home in high level care for extended periods of time. Second, Victor will assign a peer advocate who has experienced the foster care system and will join the CCT team. Third, Victor will have a Family Clinician dedicated to family engagement and finding for the purpose of providing opportunities for the youth to develop lasting relationships with relatives that will extend beyond the RBS system of care. Fourth, the RBS plan of care development and implementation process is client and family-driven with transition beginning at intake. Fifth, a Parent Partner and Peer Advocate will serve on the Oversight Committee so that there is a family and youth voice present in utilization review and management. Each of the components (engagement, planning, implementation and transition) requires active youth and family involvement.
- Strengths can only be identified in the context of the youth and family's stories of ways that they have coped with big challenges in the past; critical unmet needs only emerge through a dialogue with the youth and family members in which potential unmet needs are posited, tested and honed, until the point of focus becomes clear to both them and their Care Coordination Team. Goals have to flow directly from the youth and family's own vision of what it would be like to be doing okay. Without clearly identified strengths, needs and goals, there is no plan. Family involvement isn't just a good idea, it's essential for progress.
- In general VTC's Family Inclusion Model will ensure family members and youth have choice to participate in:
 - selecting members of their Care Coordination Team.
 - selecting providers and services, whenever possible.
 - selecting Family Partners and Youth Advocates (from the community and from within the residential provider organization).
 - selecting providers they deem respectful of and responsive to their cultural and linguistic preferences.

The model also calls for:

- Field trips that include Parents, Family members or Relatives (PFR) as a common practice
- PFR dinner nights participating in cooking a special favorite meal at the group home combined with cultural specialties
- PFR attendance at all special events (Softball, Basketball, Talent shows, Tournaments)
- PFR involvement in regularly scheduled Advisory council

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- PFR opportunities to volunteer mentor new PFR of new clients
- PFR employed as Parent Partners
- PFR attendance at regularly scheduled trainings, all staff meetings, global training opportunities
- PFR training to support transitioning home.
- PFR involved in interviewing possible lower level placement options when youth is not ready to transition home
- PFR involved in making decision regarding rewards, consequences, celebrations
- PFR inclusion in camping, kayaking and other recreational activities
- PFR participating in our strategic priorities process; more specifically, parents interviewing other parents according to an appreciative inquiry protocol that is developed with parents.
- Youth interviewing other youth in our programs according to an appreciative inquiry protocol that is developed with the youth.
- PFR as part of the expected school-wide learning results development
- PFR attending Holiday caroling at each residential house
- PFR attending Back to School night
- PFR attend the case conference meeting for the portion that applies to their youth
- PFR participate in quarterly treatment meeting
- PFR participate in summit meetings
- PFR who are willing and able can present their experiences relative to having a youth in placement in all-staff meetings
- PFR invited to participate in craft fair with their children (or other special events), family night baseball, etc.
- PFR invited to local VTC site support group meeting

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?

Engagement consistency is supported by the core skills that all staff will be trained in Risking Connections (trauma informed care).

The engagement steps will be expressed in ways which take the unique needs of the youth into account as well as the family's situation, preferences, culture and needs. In order for the process to be used consistently and effectively, training is only the first step. That training is reinforced by the documentation required to complete the RBS plan of care, by the ongoing quality assurance and improvement feedback that is provided through peer to peer and supervisory consultation, and through the results of client and family satisfaction surveys. From the moment a youth has been accepted into RBS and placed in the RBS residential placement, the biological family or other significant person in the child/youth's life (fictive kin, mentor, former foster parent, former neighbors, etc.) is invited to participate as a member of the Care Coordination Team (CCT). The engagement of the family is emphasized and monitored throughout

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the RBS trajectory of care to include RBS residential placement, transition stage, and the post-residential follow-up care stage.

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

- selecting members of their CCT.
- selecting providers and services, whenever possible.
- selecting Family and/or community supports and Youth Advocates (from the community and from within the residential provider organization).
- selecting providers they deem respectful of and responsive to their cultural and linguistic preferences

The primary vehicle for consistent engagement with the family members is the CCT. CCTs are held at the convenience of the youth and family for a duration and frequency determined by the members of the CCT. In the event that families begin to disengage, the members of the CCT work with the family members to help them re-engage and continue to participate in the process.

The families we support often have developed trust issues with service providers within what they think of as "the system." Therefore, Residential Based Services (RBS) staff utilizes a nonjudgmental, empathic, and **strength-based** approach to re-establishing trust in community service providers. Engagement is a key intervention that enables us to introduce other supportive interventions. Without successful engagement with a family, wherein a mutually respectful working relationship is developed, subsequent interventions in all phases of the process are ineffective and family progress staggers or fails altogether.

The following engagement interventions are specific for the initial stages of the Residential Based Services process. However, it is important to note that engagement is not limited to the initial stages of service provision. RBS staff must continually assess for the quality of the RBS program's relationship with the family. RBS staff may have to utilize engagement interventions several times throughout the course of treatment as the family deals with painful or stressful situations.

Listed below are the engagement tools used in the CCT to gain child and family buy into the process:

*** Hearing the family's story utilizing an empathic stance:** It's not that our families have never shared their story with service providers before; in fact, they may have done that several times over the months or years leading up to beginning Residential Based Services. Therefore, they may not be enthusiastic about having to share it again.

However, for the most part, their story has been used to conduct a mental health assessment and/or to make a diagnosis of their "problems." Utilizing a **strength-based** empathic stance, we listen to the family's story with the goal of seeking first to

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understand them within the context of that story. In so doing, we begin aligning with the family. As a Residential Based Services team member you will be coached and trained in the art of delineating empathy with a family from pity for them. Pity, feeling sorry for the family, is disempowering to them. Conversely, empathy fosters connection to another's experiences. Residential Based Services operates on the belief that through a successful engagement process, a supportive connection occurs between the team and the families -- a connection which cannot be rushed or forced. Engagement comes from a demonstration of our understanding of the family and our commitment to their success rather than through our pity for, or our judgment of them.

* **Natural Supports Discovery via the Connection Map:** At the core of strength-based approach lies the ability to acknowledge and believe that our families have all the tools necessary to overcome obstacles and accomplish their goals. Often these tools involve natural supports. The process of creating a Connection Map allows for a nonjudgmental way of discovering not only available natural supports but also an opportunity for the family to identify the connections associated with each support.

* **Strength Assessments:** Residential Based Services team members work diligently to assist families in discovering their strengths because we believe that therein lies the core strategy to addressing many of their unmet needs. Thus it becomes just as vital that our families discover their strengths via the Residential Based Services Strength Assessment. This early and vital activity encourages family members to begin identifying, acknowledging and supporting each other's strengths. Each person identifies his or her areas of interest, expertise and excitement/passion, which, if utilized properly, can quickly become resources. For example, a next-door neighbor/family friend who joins the CCT to be helpful and is also an avid bowler. He suggests the child might like joining him at the lanes when he practices on Saturday mornings. From there, the child may decide that bowling is pretty fun and suddenly the neighbor is helping to sign him up for a youth bowling league. Opportunities like this arise all the time if you take the time to learn about people. Therefore, each time a new member joins the CCT, his or her strengths are identified as well so that they might be utilized in the Child and Family Plan created by the team.

* **The Safety Plan:** Every family/child has some sort of a safety plan. What do we plan to do in case of a fire? What should a child do if he or she gets lost? Which friend, relative or neighbor gets called in an emergency if a parent is not available? Such situations and the plans families make to address them are, in fact, a safety plan whether or not the strategies are ever written down for quick reference. Residential Based Services utilizes a formal, written Safety Plan under the assumption that the majority of our families struggle in times of crisis.

The Safety Plan promotes the use of the family's natural supports. While creating the plan, the CCT anticipates potential crises. Utilizing CCT members and their identified strengths, interventions are developed that the family and their natural support system can initiate as needed. Residential Based Services team members act as adjunct supports as needed during crises. The long-term goal of this intervention is for our

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families to develop safe strategies for dealing with crises on their own, utilizing their network of natural supports to replace those offered by Residential Based Services.

* **Development of a CCT (Care Coordination Team):** CCT's are a highly successful way of promoting a family's ability to become self-sufficient. They coach the family to identify their strengths and to utilize both informal and formal supports to make decisions, solve problems, and celebrate each other's successes. An effective CCT requires the active participation of the children, caregivers, informal supports and **natural supports** and Residential Based Services. **Collaboration** among all team members is essential. Residential Based Services recommends that **natural supports** outnumber service providers in order to encourage **family voice and choice** decision-making, the sharing of tasks and moving toward self-sufficiency. It is important to remember that a CCT is an intervention and should be monitored and adjusted just as any other intervention to fully maximize its potential.

5.2 Service Planning

5.2.1 **Individualized Service Planning (Previously Question 6 of Voluntary Agreement): 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.**

The RBS plan of care will anchor services in the RBS System. The RBS plan of care, which includes a Strengths Assessment and a Safety Plan, is developed and implemented through a specific set of planning steps (engagement, planning, implementation and transition) that will be used by all care coordinators in the system. Documentation will be managed through the selected software system. The plan will interact with other plans needed for the treatment of the youth and family including the mental health coordinated care plan and IEP (if applicable).

Both the TDM and the IEP processes facilitate family and youth input to the maximum level possible, but each have unique characteristics. The TDM process allows for maximum voice that the child and family can have considering all factors that allow the Care Coordination Team to ensure safety, judicial order compliance, legal issues, and minimization of risk. The family and youth are involved in all processes of engagement and are members of the Care Coordination Team. Educational decisions made at an IEP, including those relating to placement and mental health, are made as a team and legally require guardian/parental collaboration and agreement prior to any implementation of agreed upon services.

A care coordinator (CCT Facilitator) from VTC will meet with the youth, and, if available, the family for the first time at the RBS Screening Meeting. If there is no identifiable family available to participate in the process then the youth can decide whom they want to participate as support. A Peer Family Advocate will be included as well as a Parent Partner to ensure some advocacy for the youth.

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If the youth has immediate needs that have to be addressed to insure safety and stability, the care coordinator will arrange for the milieu staff and/or the CCT facilitator to provide temporary assistance. Based on these meetings, the care coordinator will craft an initial inventory of strengths, needs and goals, and identify potential members of a CCT. Bringing this group together, the care coordinator will work with them to craft a plan of care to address the unmet needs and help the family begin to achieve some of their goals and move toward connection or reconnection.

If a youth's family relationships have been extremely disconnected, the care coordinator will begin to use family finding technology, in coordination with placing agency, to work with the youth to identify potential family members who can be appropriately invited into a circle of care, or if necessary, work with the assigned placing worker to develop an effective concurrent permanency plan. At a minimum, the care coordinator will help the youth to identify at least one adult who knows and cares about the youth and is willing to make a commitment to be an ongoing part of the youth's life, even if providing a permanent home for the youth is not possible.

One of the purposes of the RBS plan of care is to insure that the effort to address the youth's immediate need for a place to live does not undermine, but instead supports the broader goals of helping the youth achieve permanency, safety and well-being.

The RBS plan of care references, but does not control two other important aspects of the youth's service array: education and behavioral health. Because both of these service systems have their own requirements for documentation, eligibility, service delivery and funding, they will continue to require their own plans: the individual education plan for school, and the individual treatment plan for behavioral health services. These two plans are developed in parallel with the RBS plan of care. One of the tasks of the care coordinator is to insure that effective communication is maintained between the school and the RBS Care Coordination Team, including having a school representative on the team whenever possible. Pursuant to a contract with the San Bernardino County Department of Mental Health, the individual behavioral health plan for each enrolled youth is developed by clinical staff at Victor and may be implemented by the CCT, by individual therapists or counselors from Victor, or by referral for outside services when appropriate.

The RBS plan of care reflects activities that will be carried out by VCSS/VTC staff, by the youth and family, by community-service agencies, and by informal, voluntary sources of support and assistance. Each activity is tied to strength and a need, and the performance and effect of the activity will be tracked to identify progress toward the youth and family's goals.

The plan of care will include a policy of paid bed holds for up to 14 calendar days per month for enrolled CFS youth who AWOL from residential care, are placed in psychiatric hospitals for treatment, or otherwise are temporarily absent from the residential facility. Under this policy we can provide CCT engagement with family members to help locate and re-engage the AWOL or CCT services to hospitalized youth

and thereby ensure continuity of care when the youth is ready to return. Title IV-E permits payment of the AFDC-FC placement costs for up to 14 days per calendar month. If a youth is not returned to residential during this bed hold time period, the CCT will make a case-by-case decision to determine if that youth should remain enrolled in RBS.

When interventions help, they can be continued or increased. When certain options don't result in improvement, the team can use this information to identify better forms of intervention and assistance. As progress continues, the team must begin to develop a plan for transition out of RBS which includes having family, school and community representatives on the CCT as early as possible. This starts with aftercare and follow-up services and eventually leads to RBS disenrollment and transition to ongoing sources of support and treatment as necessary to maintain permanency, safety and well-being.

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

In most cases, the major exception being Probation, a referral to RBS will begin with a TDM or IEP that already has active youth and family participation. Upon enrollment a care coordinator and parent partner will meet with the family if they are available, or work with the family engagement unit to find and link with parents and extended family members as appropriate, in order to begin the planning process.

The planning process itself is based on youth and family voice. No CCT meetings will be held at times inconvenient to the youth and family. Accommodations will be made to ensure that transportation and child care are not barriers to youth or family attendance. Whenever possible, decisions will not be made without the presence or prior notification of the youth and family; the same courtesy currently provided for placing agency workers and provider clinicians.

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.

As noted above, the RBS care-planning process is specifically designed to start with the identification of strengths and needs and goals from the perspective of the youth and family as a foundation for services, interventions and support. We use a dynamic interactive process to ferret out the key unmet needs that are the hidden drivers behind the patterns of harmful and self-defeating behaviors that have led to the RBS intervention in the first place. Trauma-informed care will be the interview and treatment approach used by county and provider staff involved in the CCT and by the residential milieu staff. Trauma-informed care is predicated on the assumption that many of the problematic behaviors displayed by the target population are a result of unmet needs; if

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the need can be uncovered and more adaptive ways to get it met are learned, the problem behaviors are replaced with more adaptive ones. Additional intensive treatment will be planned out based on a diagnostic assessment. Trauma informed care is a philosophical orientation that all interactions and services provided, including those within a milieu structure of a residence, will be informed by a holistic understanding of the impact of trauma upon the child and youth. This impact includes an understanding of neurological, biological, psychological, and social sequelae of trauma. Trauma informed care can be offered to youth when staff members have been trained to understand the impact that trauma has on the child and how that impact correlates with the behaviors being observed in the milieu. Staff must also be in touch with the fact that they will experience vicarious trauma while working with the RBS youth. Trauma informed care allows the staff members involved in the care and treatment of the youth to see beyond what the youth presents on the surface and engage with the youth in a way that takes the impact trauma has had on the youth into consideration. The emphasis with trauma informed care is on the healing that comes through relationships.

Trauma informed care as proposed in the SB County RBS pilot represents an approach to working with abused children, their offending caregivers and other family members that acknowledges the serious and lasting effect of traumatic events. This approach addresses the multiple physical and psychological traumas and losses typically experienced by at-risk children prior to foster care placement. A detailed discussion of the principles, modalities, and specific, evidence based techniques can be found on the National Child Traumatic Stress Initiative website on the Intervention Summary, NCTSNET.org.

The RBS approach to care recognizes that trauma and loss events have a persistent effect on development, emotions, behavior and ability to form enduring relationships; and specifically identifies the linkage of the traumatic history to collateral symptoms of depression, anxiety, anger, and external locus of control. These disruptions in normal functioning are viewed in the context of the child's heightened feelings of vulnerability and helplessness that typically persist after trauma.

The RBS approach has dual goals: to restore normal developmental progression and function and to equip the youth and family with skills for engaging in healthy, enduring relationships. In pursuit of these goals the RBS trauma informed approach integrates conceptual foundation from several theoretical perspectives including: psycho-dynamic, family centered, attachment, cognitive-behavioral, complexity theory and social learning approaches to social work and residential treatment.

Trauma-Focused model has both clinical and milieu applications in treating posttraumatic stress and related emotional and behavioral problems in children, adolescents. Components of the treatment approach typically include individual, parallel and increasingly conjoint work with the individual youth and family members. In the milieu there is a strong focus by all staff members on reducing the youth's distress by assisting them in processing their abusive experiences and developing adaptive coping skills. Victor residential has trained all staff in a trauma informed model that promotes a

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common language for staff and residents to use when discussing the impact of trauma events.

In the clinical and casework aspects of the RBS pilot there is emphasis on use of trauma sensitive interventions with elements of cognitive-behavioral therapy as well as a strong psycho-educational focus on skill building to address the unique needs of children with Post-Traumatic Stress Disorder and other problems related to traumatic life experiences. Typical skill building focus areas will include: affect expression and regulation skills, relaxation skills, altering faulty beliefs, anger control strategies, cognitive coping skills and processing, trauma narrative and life books and family mapping and geno-gram exploration. As treatment progresses there is an increasing focus on dyadic approaches to therapy including conjoint parent-child sessions, family, community teams and extended family team oriented sessions and for the parent and guardians parenting skills classes prescriptively designed to address the family's or prospective guardian's ability to promote pro-social behaviors and to discourage the use of coercive and aggressive behaviors at both the individual and family level. For those youth not able to return to family of origin there will be a treatment goal of equipping the youth with relationship skills necessary to build and engage with a "permanency team" of formal and informal helpers committed to an enduring relationship with the youth.

Other objectives included in the RBS pilot include increasing children's connectedness to positive others and building internal objects that support future growth, to develop effective social, affect management, and cognitive skills, to develop and implement safety plans for children in their homes and at the residential treatment center, and to reduce PTSD symptoms including aggressive and dangerous behaviors that necessitated residential placement.

The CCT functions as the primary vehicle for coordinating services while a child is in the residential component of RBS; however, a Wraparound Child and Family Team, CFT cannot coordinate services in the group home as group care is a disenrollment reason for Wraparound. The RBS CCT can also provide services across systems of care with no hand-off. RBS services are offered and delivered through one provider, which is not the case in a Wraparound model. Wraparound often lacks the cohesive structure to hold the multiple services from different providers together, while RBS provides the services in the context of a single integrated system of care.

The traditional wraparound services are different than the services that are proposed in this design. In the RBS design the Care Coordination Team (CCT) is created and remains the coordinating body throughout the child's involvement in the system of care regardless of placement type. The Care Coordination Team also functions under the primary principles of "no hand-off, no drop-off". Therefore when youth begin to act out behaviorally, the CCT looks for the reasoning behind the behavior and they make adjustments to the plan of care as appropriate and until the plan becomes effective, the child is not discharged. In the current wraparound model if the youth begins to act out and behavior does not change, then the recommendation could be to disenroll the youth

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for placement in a higher level of care. Disenrollment and disengagement are not concepts that are consistent with the RBS program design.

Currently in this county there are multiple wraparound vendors with multiple organizational cultures. In this RBS design there is a single vendor with a single organizational culture that is in line with the cultural values and philosophy of the RBS system of care model; a single integrated philosophy of vision. This model strongly advocates, initiates, encourages, and engages family, youth, and agency involvement in all decisions about the child's care and not just on the child's identified problem. The goal of the RBS is to see the child through to permanence; the goal of wraparound is to stabilize the child's placement so they do not go into a residential setting or higher level of care. RBS also recognizes that relapse of behaviors is paramount towards recovery whereas wraparound views relapse as program failure.

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.

RBS plans of care are multi-modal and multi-environmental. At the same time as environmental interventions are being provided to a youth living in the RBS unit or a treatment foster home to help the youth understand and replace the habitual behaviors that have contributed to (or been generated by) prior disruptions, the CCT will be working with the family and community in parallel to help them prepare a landing pad that will effectively accommodate the youth. The CCT will reflect and reinforce the helping strategies that are being developed in the residential treatment center by the milieu and family engagement staff. If the youth's biological family is not a viable permanent placement, family finding options will be discussed as early as the screening meeting and will begin in earnest the day the youth is enrolled/placed in residential treatment. Furthermore, family finding efforts will identify multiple connections for the youth so that if the primary option ceases to be viable at any point during the arc of care the efforts move to the next option and very little time to reunification/adoption is lost. Targeted life and social skills development is critical to the long term success of the youth and skill development will be embedded in all aspects of the youths care.

When the youth has transitioned to the community placement in the ITFC or FFA or relative care, the family will have access to an emergency response system created by VTC and VCSS and driven by the CCT, so that a staff member with whom the family is already familiar responds. There will be accommodations made in the staffing model so that the shift vacated by a VTC staff member responding in the community can be back-filled temporarily by additional staff. The CCT is the primary vehicle for recommending and coordinating the transition. As the youth moves closer to transition, the community-based support and services begin to participate in the CCT meetings. As these additions to the team begin to support the youth, formal supports begin to become peripheral or secondary and become less involved. This will look different for every child

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and family as each brings his or her own unique strengths and timelines for the process. We anticipate that a few months before the transition occurs, a TBS worker will begin to support the youth and will follow that youth as the transition occurs and the family moves to more informal community-based services. Home visits will increase in frequency as the transition begins allowing the family and youth to practice their new skills with support. It will be imperative that the CCT begin linking the family to community services and supports to set the stage for informal supports to play a more active role in the family's growth and wellness.

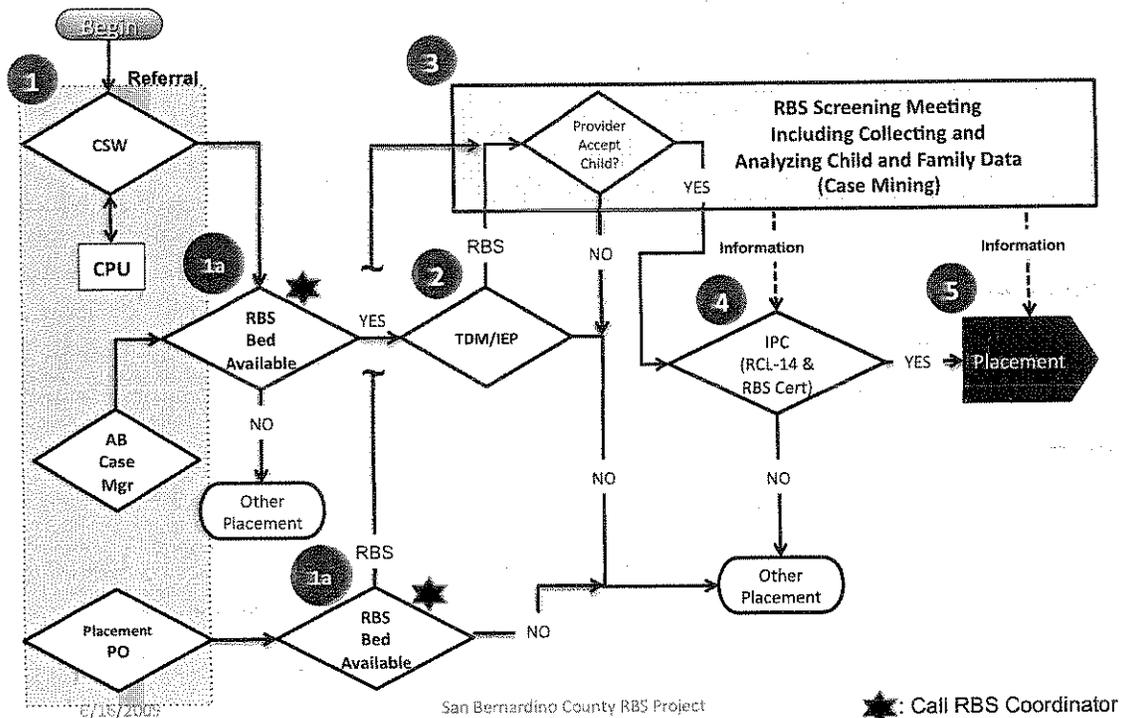
Family finding technology and practices that will be used during the trajectory of care would offer informal supports that exist in the community. The enhanced relationships with these supports are seen as resources that would be available to the youth and family as a periodic crisis occurs. A strong and tested safety plan for the youth and family combined with these informal supports will increase the likelihood that formal supports would not be needed to manage a crisis. Linkages to community-based services that replace the formal service offered by Victor would be relied upon to manage any crisis that arises. At such time a client is experiencing a crisis and would otherwise be referred back to the RBS bed, and none are available, at the direction of the CCT, RBS outpatient services will work to surround the client with a variety of service supports. Those supports would be billed as EPSDT as appropriate and/or MHSA funds. If necessary those supports can be offered in any alternative placement willing to collaborate with RBS personnel. We can anticipate times that the client will need to be placed in non-RBS affiliated programs due to bed capacities, and other unanticipated circumstances. This population warrants that concurrent planning be completed within the process of the Care Coordination Team (CCT) as the primary decision making body for RBS children. The CCT will also be responsible to make concurrent plans for a need for crisis stabilization such that alternatives, such as family, fictive kin, ITFC, and other resources are arranged and in place prior to the crisis occurring. In this way there will be no reactionary response to crisis, but a proactive planned response. At all time the care of each child is monitored by the CCT as well as the Oversight Committee that will review progress on each case. It is estimated that the frequency in which this situation may occur will be highly minimized given a proactive ideology regarding crisis and relapse as a means towards recovery.

If psychiatric hospitalization is required during residential treatment or post discharge, the CCT facilitator will be the primary point of contact to ensure continuity of treatment and smooth re-integration into the RBS treatment setting post-hospitalization. The new MHSA funding allows for care coordination to continue while a youth is in the hospital, something that is currently not possible under the SB163 Wrap model. Arrangements have been made with the local psychiatric hospitals (Loma Linda University Medical Center and Canyon Ridge) to design a way for hospital staff to know that a patient is part of the RBS pilot and that there is a CCT driving the treatment for that youth as opposed to the traditional group home treatment team. Once the hospital deems the child fit for return to the community, it is expected that close collaboration between hospital staff and CCT will prevent children from remaining in the hospital on administration days. Administration days are days which a minor, who had been

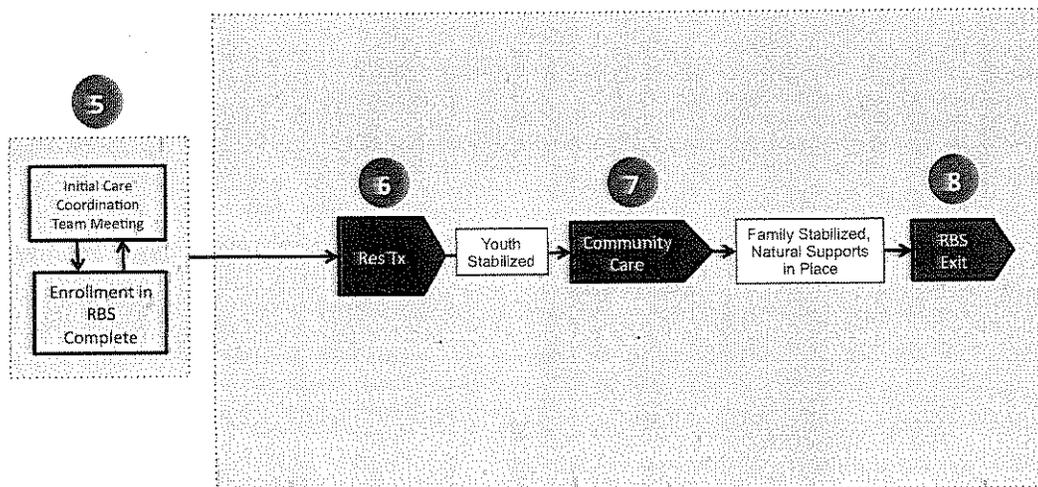
admitted to a hospital in crisis, is now stable, but continues to be in the hospital due to inability to locate an appropriate placement.

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.

Referral and Enrollment



Placement



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5.3 Service Implementation

5.3.1 Services Baseline (Previously Question 7 of Program Description): 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
Group home placement	Placement in an RCL or 14 group home	32 months or more, in aggregate	San Bernardino County, other counties, out-of-state.
Day Treatment Intensive	Intensive behavioral health services offered in conjunction with an alternative school setting	24 months plus in aggregate for all children and youth in target population	Provided in conjunction with group home placement.
Therapeutic Behavioral Services	One-on-one intensive behavioral intervention to identify a specific challenging behavior and replace with more effective, pro-social alternative; pre & post GH transition support services	Aggregate average of 18 months per episode; used at least once by 80%, multiple times by 25%.	Provided by VCSS or other local DBH contracted organizations in any setting where the child is living. Done by other TBS providers in the respective county for out-of-county placements.
Foster Care	Foster family homes with or without the services of an additional private agency social worker depending on the needs of youth.	Aggregate average of 6 months or more; used by 10%	Licensed foster homes or foster family agencies in SB County or neighboring counties.
Kinship care	Placement with a relative	Aggregate average of 6 months; used by 10%	Approved kinship care provider.
Individual, group and family therapy	Various types of mental health treatment	Aggregate average of 3 years; used by 100%	Licensed clinician either on-site or in an outpatient office of the current provider through Value Options.
Psychiatric consultation and medication support services	See the psychiatrist, get prescription, take medication, observe results, change if necessary	Aggregate average of 3 years, used by 90%	Either in tx setting or outpatient by VCSS or other local DBH contracted organizations. Done by other MH providers in the respective county for out-of-county placements.
Psychiatric hospitalization including administrative days.	Admitted voluntarily or involuntarily based on an acute crisis caused by an underlying psychiatric disturbance.	Aggregate average of 6 weeks, used by 80%.	Loma Linda or Canyon Ridge (SB County) or out of state hospitals.
Non Public School (NPS) – Specialized school services	If a youth has an IEP for a learning disability or severe emotional disturbance and cannot be maintained in a public school setting.	Aggregate average of 18 months, used by 80 %.	NPS associated with the out of state group home provider.

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5.3.2 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-Discharge, Community-Based Interventions, (D) = Follow-Up, Post-Discharge 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	Stabilization, assessment and possible respite, life and social skill development, connection building (trauma-informed approach)	Highly intensive, 24/7 care	Average aggregate of 12 months or less, used by 85%.	VTC SB County	X	
A	Intensive treatment foster care/FFA	Bridge care provided in a treatment foster home (trauma-informed approach)	Moderately intensive, offered throughout the day as needed	Average aggregate of 6 months used by 25% in ITFC and by 75% in regular FFA	SB County (ITFC provider to be selected)	X	
B	Care Coordination Team (CCT)	Mobile intensive services and treatment driven by the RBS plan of care and mental health plan of care	Moderately intensive, up to 10 hrs per week	Average aggregate of 18 months, used by 100%	VCSS SB County	X	
B	Intensive Day Treatment	Campus based educational and experiential services	Highly intensive, no less than 4 hours per day	Aggregate average of 12 months, used by 85%	VTC SB County/North Valley Schools		X
B	Individual and family counseling and treatment	Evidence-based treatments (trauma-informed approach)	Moderately intensive, up to 10 hours per week	Aggregate average of 12 months, used by 100%	VCSS clinical staff on campus or in community		X
C	Family engagement and empowerment	Family finding, support and engagement to prepare for youth's arrival	Moderately intensive, up to 5 hours per week	Aggregate average of 12 months, used by 100%	On location with families by VTC Family Clinician	X	
C	Intensive In-home services	TBS and CCT provide integration with behavior management and crisis management techniques from residential treatment.	Moderately intensive, up to 5 hours per week	Aggregate average of 18 months, used by 100%	On location with families by VTC Family Clinician	X	
D	Follow-up post discharge services	Family support for re-integration and crisis management after youth has returned home	Low intensity, up to 3 hours per week	Aggregate average of 12 months, used by 100%	On location with families by VCSS	X	
D	Support & Response team	Expedited response to in-home crisis post-discharge by staff from VTC/VCSS with whom family is familiar.	Moderately intensive, up to 1 hours per week	Aggregate average of 12 months used by 80%	On location with families by VCSS and VTC in collaboration	X	

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Parallel services include:

Family Engagement and Empowerment – a clinical pool that includes the Family Clinician and two house clinicians will engage in this service with the families. The family clinician is primarily responsible for engaging in family finding activities and family therapy and works in conjunction with the two house clinicians. The house staff will play an important role with the family engagement process as families spend time in the residential milieu. Family inclusion activities will be emphasized and will be viewed as routine opportunities for all families to interact with the youth and staff at the group home.

Intensive In-Home Services - The CCT is organized and facilitated by the CCT Facilitator. The CCT facilitator leads the CCT meetings, schedules the CCT meeting times and locations, invites and communicates with CCT members, and operates as the liaison with the Residential Services Supervisor (RSS) and the other members of the clinical team. TBS services will be provided by the TBS worker for the RBS program. The two MHRS / Life Coaches will provide rehab services for the youth that can occur in the home while the youth is having home visits. The family clinician and the two house clinicians will work together to continue to support the family as the youth transitions back home and provide services in the home as defined by the CCT meetings for each individual youth.

5.3.3 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.

From day one of RBS enrollment to permanent placement, the CCT will provide care coordination and arrange for intensive-in home treatment and in-residential treatment for the youth and family to help reduce the impact of youth's behavioral, emotional and mental health issues that have been a part of the family disruption, in the context of the family system. The CCT will drive service delivery by creating an integrated, transparent Plan of Care with input from the youth and family, the residential treatment center, mental health service providers and education providers. The CCT will ensure that the Plan of Care integrates with the mental health CCCP and IEP (when applicable).

The Family Clinician from VTC will engage with existing parents and families whenever possible using a variety of informal and formal types of assistance, guidance and instruction to help them acquire the knowledge, skills and understanding needed to increase their resiliency to a level that will empower them to provide a safe, stable and nurturing environment for the youth in question while the youth and the family system as a whole continues the process of recovery from the situation, events and interactions that contributed to the need for RBS enrollment. The Family Clinician will work closely with the Residential Treatment Clinician and the CCT facilitator to ensure integrated treatment and communication with the family and County. All parties will attend all CCT meetings and communicate how both the youth and the family are progressing in respective treatment settings.

In situations in which county placing agency is pursuing concurrent planning by developing potential alternative permanent placements, the CCT will work in both settings to help keep communication and options open.

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.

Victor's Fostering Connections model (family find, family inclusion, Risking Connections) includes not only family finding / identification, but the search, engagement, preparation, skill building, modeling, and supporting of those individuals committed to the youth in order to increase the likelihood that connections are sustained post RBS. We plan to not only find biological family, but other potential connections as described above (fictive kin, CASA, mentors, teachers, foster parents, etc.) that may not result in permanent placement but in lifelong connections (emotional permanency). The establishment of relationships that provide emotional permanency for the RBS youth will

have just as much impact as those relationships that might be able to provide placement permanency. Other strategies will include linkages to parallel services and aftercare, CPYP, and Families for Life.

When used correctly, family finding technologies provide a list of family and NREFM connections for any youth so that if the first option does not materialize as a permanent placement, the youth does not feel as though all is lost. If reconnection with current family is not possible, potential adoptive or kin or NREFM guardianship families will be identified. If adoption or guardianship is not possible, particularly if the youth will enter an adult system of care, the CCT will ensure that at least one lifelong adult connection or mentor has been identified and a visitation plan has been established.

Support for reconnection will be provided by creating opportunities for safe and appropriate interactions between children or youth and their families in places and activities that fit well with youth/ family culture and preferences.

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

A representative from the county's primary Post Adoptive Services program will sit on the RBS Steering Committee. When Post Adoptive Services are part of an adopted youth's range of services at the time of enrollment, or when the benefit of using those services arises during enrollment, the care coordinator will invite a Post Adoption Services representative from to join the CCT, and will insure that the youth's Post Adoptive Services plan of care is well matched with the overall RBS plan of care.

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, aging out, etc.

Although our goal is to have every youth in a permanent family home, or living environment at the end of their enrollment in RBS, we recognize that no system will be perfect and that alternative options must be available. First, we will use family finding and engagement technology to enhance the likelihood that each enrolled youth has appropriate and ongoing family connections, even if those connections do not lead to placement opportunities. Second, we will work to link youth who are emancipating from care with the THPP/THP Plus program in the community where they can live as young adults upon leaving our care systems. For those youth who are not able to enter THPP or THP Plus, services will be offered that provide the youth with training through the county Independent Living Program and VTC's Skill Building Program well in advance of their turning 18. We will also recruit and support the participation of volunteer mentors to join the Care Coordination Teams and then to provide any support needed to help that relationship continue on past graduation from the RBS System. For disabled youth who qualify for SSI benefits, we will work with Regional Centers and adult mental health systems of care to transition the youth to the appropriate service milieu.

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For older youth, an assessment will occur at intake to determine whether the youth and family's goals can be met before the age of majority. For children who are risk of 'aging out of the system," consideration for getting the appropriate approvals from CCL will be made to extend the youth's enrollment in RBS.

5.5 Evaluation and Quality Improvement

5.5.1 Data Baseline (Previously Question 9 of Program Description): 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
CWS/CMS	Case management activities	Process & outcome
C-IV	Payments for CFS, Probation and DBH foster care placements	Process Outcome
Wrap database	CANS, YSS, YSS-F, demographics	Process & outcome
SAS/MS Access	Queries against CWS/CMS	Process & outcome
Business Objects	Queries against CWS/CMS	

5.5.2 Evaluation (Previously Question 11 of Voluntary Agreement): Please indicate the means by which you will gather the information required for the annual evaluation report required by AB 1453 and who will be 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
<ul style="list-style-type: none"> • compiling VTC satisfaction surveys • collecting YSS, YSS-F survey data • collecting CANS assessment data • compiling CANS assessment data • outcome transition data 	<ul style="list-style-type: none"> • Doug House, VTC • Charles Cook, VCSS 	<ul style="list-style-type: none"> • Information will be gathered at enrollment, every 6 months and at exit for the YSS, YSS-F, and CANS data. • The outcome summary will be compiled and sent to the county twice a year.. • The outcome transition data will be submitted when the youth

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<ul style="list-style-type: none"> • Outcome Summary 		<ul style="list-style-type: none"> leaves the residential portion of RBS.
<ul style="list-style-type: none"> • compile and synthesize RBS data from provider for submission to State (CANS, YSS, YSS-F) • measure utilization • querying C-IV and CWS/CMS databases 	<ul style="list-style-type: none"> • Kelly Cross, SB County HSS 	<ul style="list-style-type: none"> • The RBS data on CANS, YSS and YSS-F will be analyzed twice a year, depending on the number of clients enrolled in the first year. • Analysis of client tracking will be done monthly and outcome measures will be done on a bi-annual basis.

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 Harder + Company Community Research and the Evaluation Subcommittee. By checking this box and signing this Voluntary Agreement you are agreeing to the terms and research method criteria of Harder + Company Community Research.

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
SB County HS	Kelly Cross	kcross@hss.sbcounty.gov
SB County HS	Kathy Watkins	kwatkins@hss.sbcounty.gov
Victor	Rogene Becklund	rbecklund@victor.org
SB County Probation	Trina West	twest@prob.sbcounty.gov

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.

There are three levels of feedback for SB County's RBS program. First, the CCT for an individual youth will examine program utilization and effectiveness on an individual case level and provide trouble shooting and solutions. Second, the RBS Oversight Committee will regularly examine the process and outcomes of the CCTs and integration with residential treatment, community treatment and mental health services. Third, the RBS Steering Committee will receive data about and provide solutions for problems with the RBS Operations in the County to ensure that RBS is an integrated and well-utilized service option within SB County's child welfare, probation and mental health systems of care.

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- 6. IMPLEMENTATION PLAN (Previously Question 10 of Program Description) –**
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	Person/Agency Responsible	Timeline
Contracting	Norm Dollar, CFS Kathy Watkins, HS Mike Schertell, DBH Neal Sternberg, Victor	<ul style="list-style-type: none"> • Begin RBS plan/MOU development in March 2009 • Amend RBS plan/MOU development for alternate funding model by Dec, 2009 • MOU to BOS by Jan., 2010 • MOU approved by DSS Feb, 2010 • Provider-DBH Contract by Mar 2010
Fiscal Monitoring	Steve Adams, CFS Doris Melara, DBH	<ul style="list-style-type: none"> • Beginning at MOU signature and ongoing after that
Training	Julie Pasaak, Victor	<ul style="list-style-type: none"> • Begin subcommittee mtgs in Feb 2009 • Develop social marketing materials by Apr 2009 • Develop curricula by Jan 2010 • Funding in place by March 2010 • Complete joint training program by Apr 2010
Facilities	Neal Sternberg, Victor	<ul style="list-style-type: none"> • Begin search in Feb 2009 • Acquire facility by Jan 2010 • Submit program statement to CCL by Jan 2010

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		<ul style="list-style-type: none"> • Facility licensed by Feb 2010
Program Implementation	Christa Banton, CFS Doug House, VTC Charles Cook, VCSS Tina Mason, Probation Anjali Barse, DBH	Finalization of program design Dec 2009 Conversion to Oversight Committee Mar 2010
Evaluation	Kelly Cross, HS Kathy Watkins, HS	First evaluation review in Oct 2010 and every 6 months thereafter
Policy Development	Angela Ukiru, HS Merida Saracho, DBH Tina Mason, Probation	<ul style="list-style-type: none"> • Draft policy created by June 2009 • Final policy approved Feb 2010 • Joint Training on policy begins in Mar 2010
Documentation	Angela Ukiru HS Christa Banton, DCS Doug House, Victor	<ul style="list-style-type: none"> • Crosswalk documentation needs of program design in Dec 2009 • Evaluate current documentation in use and modify as needed by Jan 2010 • Training on documentation begins Feb 2010
FFA/ITFC	Norm Dollar, CFS Hernaldo Sequeira, CFS	<ul style="list-style-type: none"> • Release LOI by Sept 2009 • LOI Responses due Dec. 2009 • Selections made Jan 2010 • MOU's signed Feb. 2010 • Acculturation complete Apr 2010

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

[SEE FOLLOWING PAGE]

AAP	Adoption Assistance Program
AB 3632	Mental Health Services for Special Education Pupils
AWOL	Absent Without Leave
CANS	Child and Adolescent Needs and Strengths Assessment
CCL	Community Care Licensing
C-CSFR	California Child and Family Services Review
CCT	Care Coordination Team
CDSS	California Department of Social Services
CPU	Central Placement Unit
CWS/CMS	Child Welfare Services Case Management System
DBH	Department of Behavioral Health
DCR	Data Collection and Reporting
DCS	Department of Children's Services
FFA	Foster Family Agency
GH	Group Home
HS	Human Services Administration
ICPC	Interstate Compact on the Placement of Children
IEP	Individual Education Plan
IPC	Interagency Placement Committee
ITFC	Intensive Treatment Foster Care

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LRU	Legislative and Research Unit
MHSA	Mental Health and Substance Abuse
NPS	Non-Public School
NREFM	Nonrelated Extended Family Member
PDD	Policy Development Division
PFR	Parent, Family Members or Relatives
PIP	Program Improvement Plan
PO	Probation Officer
RBS	Residentially-Based Services
RCL	Residential Classification Level
Res Tx	Residential Treatment
SIP	System Improvement Plan
SW	Social Worker
TBS	Therapeutic Behavioral Services
TDM	Team Decision Making
THP	Transitional Housing Program
THPP	Transitional Housing Placement Program
UCB CSSR	UC Berkley Center for Social Services Research
VCSS	Victor Community Support Services
VTC	Victor Treatment Center
YSS/ YSS-F	Youth Satisfaction Survey / Family

Residentially Based Services Reform Project

Voluntary Agreement

RBS Program Approval – Signatures of Authorizing Collaborative Participants

-Add as many signatory lines as necessary-

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 AB 1453), and on the experience and information acquired from the implementation and the ongoing operation of the program.

***County Social Services Agency**

Name:

Title:

Agency:


Signature

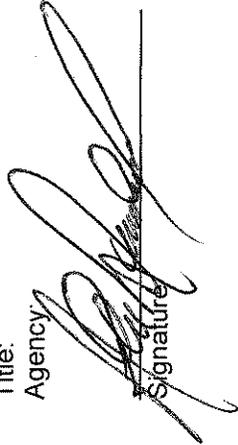
9/3/09
Date

***County Mental Health Agency**

Name:

Title:

Agency:


Signature

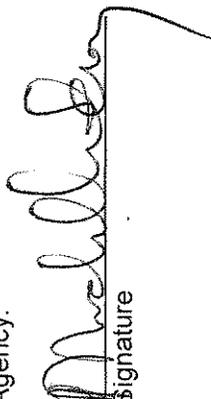
9/3/09
Date

***County Probation Agency**

Name:

Title:

Agency:


Signature

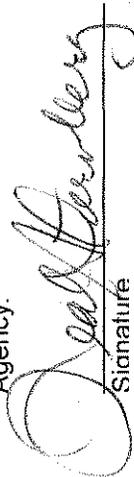
9-3-09
Date

***Provider Agency(ies) – Victor Treatment Centers**

Name: Neal Sternberg

Title: Executive Administrator

Agency:


Signature

9/3/09
Date

* Signature required before submittal to CDSS

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Active Participation in the Development of the RBS Program

Agency/Department	Level of Involvement Required: High, Medium, Low
Department of Children and Family Services	High
Department of Behavioral Health	High
Department of Probation	Medium
Victor Treatment Centers	High
Victor Community Support Services	High
Loma Linda Hospital	Low
Inland Regional Centers	Low
San Bernardino Schools	Medium



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-discharge community-based interventions for families, and follow-up post-discharge 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.

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(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-discharge support and post-discharge 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.

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(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'.

Funding Model

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RBS Funding Model.

Demo Site: San Bernardino County	Date: 3-15-10
Prepared by: Kathy Watkins and Neal Sternberg	Title/Organization: Manager Executive Administrator VTC
E-mail: kwatkins@hss.sbcounty.gov neal@victor.org	Phone: 909-388-0167 530-472-1281

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.

Currently, at least 25% of the high-need foster youth of the target population in San Bernardino County are being served in RCL-14s out-of-state and those that remain in-state are bouncing in and out of psychiatric hospitals and being transferred laterally between RCL-14 placements. The result is that they become disconnected from their families and communities. These youth remain institutionalized for long periods of time, and the severe barrier behaviors they display prevent them from being served within the existing in-county options for family-based settings. San Bernardino County's RBS Demonstration Project is targeting this population which consists of approximately 35-40 youth over an average year.

Using RBS principles, the San Bernardino County will contract with our sole current in county RCL-14 provider Victor Treatment Centers (VTC) and Victor Community Services (VCSS) to test out a new RBS service option with 12 residential beds (6 male and 6 female beds) with a total of 30 slots over each 24 month period of the pilot. There are three key program innovations:

1) Transforming the milieu of the RCL-14 residential facility into a short-term intensive stabilization and treatment facility, which is permeable to and concurrently aligned with family finding, engagement and support efforts as well as concurrent school-based and community-based interventions. Currently, an RCL-14 facility functions as a self-contained, long-term placement for high-needs youth where youths are maintained until emancipation. Our goal is to transform residential care so that each youth is reconnected with options for family-based permanency. Our target population has a history of frequent runaway behaviors and it is key to the success of the pilot to reduce AWOL episodes through the family engagement strategies. In order to implement our value of "no hand-offs no drop-offs", we will utilize the Title IV-E standard for the definition of temporary absence of 14 days per calendar month and pay for bed holds for CFS youth for that IV-E duration of time to ensure continuity of care and services.

2) Establishing a Youth and Family Care Coordination Team (CCT) as the primary vehicle to provide unified treatment direction, transition recommendations, case

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management, and family reconnection/finding/engagement services for RBS eligible youth. A pool of resources, including, but not necessarily limited to AFDC-FC Maintenance, EPSDT, Title IV-E Training Funds and possibly IV-E Administrative funds as experience dictates, MHSA Success First Wraparound and subsequently SB 163 Wraparound, will fund these innovations. The CFS has a strong AB1331 SSI Advocacy program which will be used to offset AFDC-FC costs for all non-federally eligible youths and for federal youths once in relative/parental homes. This has required service integration of service delivery and administration of CFS, Probation and DBH, and leads to the third innovation: The CCT will have the flexibility to transition the youth between the residential milieu and the family/community and support the reconnections to family, and support stabilization and permanency at lower levels of care.

3) A alternate funding model which supports the transformation of the residential and community service models, by increasing the AFDC-FC residential rate to an amount closer to actual care and supervision costs and by using MHSA Prevention and Intervention dollars (Success First Wraparound) to augment costs for residential and community based services not included in the alternate RBSAFDC-FC rate are funds for the activities of the Youth and Family Care Coordination Team. Additionally, Intensive Treatment Foster Care (ITFC) is being considered to create a 'specialized foster care' placement option for youth who need more intensive supervision than a FFA placement in the initial step down from group care. This feature should be available to RBS via a Letter of Interest process and CFS hopes to have qualified providers selected by early Spring, 2010. Several qualified and experienced FFA providers have expressed interest in expanding their ITFC program to San Bernardino and working in concert with the RBS Pilot. We expect to have available ITFC beds in place prior to the first RBS youth being stepped down from residential care. Should an appropriate ITFC bed not be available, the CCT will determine the appropriate step-down placement for that youth. Note: for purposes of calculating AFDC-FC cost containment in Attachment A, we are using a 60% estimate for the federal eligibility rate for ITFC.

The model assumes an average of 12 months in the RBS residential care facility, followed by an average of 6 months in step-down care in either an ITFC (25% of youths) or an FFA (75% of youths), followed by an average of 6 months in family based settings (75% of youths with relative care with the SCI and 25% with parents. For the first 18 months, the applicable AFDC-FC rates will be supplemented by up to \$3,897 per month per child of MHSA funds for the CCT and family engagement efforts. For months 19 to 24, these activities as well as any family-based placement cost will be funded by SB163 Wraparound funds for youths in family based settings. Each youth's path to the lowest level of appropriate care within the 24 month model will be unique and based on that youth's progress and the decisions of the CCT, which are driven by youth and family voice and choice. We anticipate that MHSA will fund the first 18 months of the CCT directed services. The last 6 months while the youth is returned to the parental home or placed in relative care, the CCT and family engagement services will be funded by SB163 Wrap. We have amended our SB163 Wrap contract with Victor Community Services to accommodate additional RBS slots. Our SB163 Wrap program is not limited

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by a cap on slot requests. We are managing the SB163 budget so we do not hit the budget ceiling.

At this time, all funding, allocations, costing, claiming and payment mechanisms required to operate the RBS pilot are currently in place, with possible need for some local adaptation. We will not alter the fully compliant nature of these systems. We are requesting to implement an alternate funding model to accommodate frontloading the RBS residential care rate for the first 12 months to ensure the improved outcomes of placement stability, reconnection to family and community and permanency are fully integrated into the residential milieu.

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.

Historically, Victor Treatment Centers, Inc (Victor) has charged a supplemental daily rate above and beyond the AFDC-FC RCL-14 rate in its residential program. This rate has paid for Medi-Cal billable services and for unfunded Title-IV-E expenses; the additional amount did not cover services crucial to reunification and permanency. These services include family finding, support and engagement, peer advocacy, parent support, or intensive community-based treatment to prepare these settings to receive these high-needs youth. RBS will underwrite a treatment model transformation, which will allow VTC to provide a new residential treatment model using an alternate RBS AFDC-FC rate that maximizes Federal participation and further covering any reasonable allowable Title IV-E expenses and benefits using a fair share agreement with each County Department responsible for services with their funding streams.

The historic rate did not allow for paying of the actual reasonable AFDC-FC Title-IV-E costs. The Pilot alternate RBS rate of \$8835 allows for those expenses within the rate and resulting in 96% IV-E allowable under the Federal definition, We have established a 96% IV-E allowability percentage of cost on line 1b of Attachment A.

The alternate RBS AFDC-FC rate is based upon historical reasonable and prudent expenses Victor has had serving arguably the most challenged residing in California's Group care system The additional reasonable allowable Title IV-E dollars allow for the RBS rate to free up MHSA dollars that were otherwise not covered by the historical Level 14 rate., and enhances targeted services for long term sustainable gains and permanency with possible earlier reunification. This will be accomplished by the alternate RBS AFDC-FC rate for residential care, and concurrently enrolling each child in an MHSA-funded Full Service Partnership slot, which will anticipate additional revenue per each of the 30 slots paid monthly. These funds will be pooled such that they are not capitated for each child, allowing for maximum flexibility in meeting the needs of enrolled children. The MHSA and associated EPSDT funding will adequately fund those services and additional supports crucial to providing a high-needs child with a permanent non-institutional home. There is a commitment to ensure sustained funding through MHSA and EPSDT for RBS beyond the 24 month pilot; however, this

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commitment is not a guarantee as the fiscal climate of the State of California may impact funding availability beyond local control. We have estimated those costs on the spreadsheet attached. We understand these total dollars are settled to cost at the end of the fiscal year. Monthly claiming for all payments (AFDC-FC, EPSDT, and MHSA) will use existing formats. VTC and the County will insure appropriate records are maintained to track all RBS funds including AFDC-FC funds to support the residential portion of the rate.

A portion of the non Medi-Cal billable services in this project are planned to be paid for with MHSA (Success First) funds. Victor also plans on paying for a full-time Client Coordination Team Facilitator, a half-time Peer advocate with MHSA funds, and a full-time Parent Partner with MHSA funds.

Victor also plans to charge a portion of shared Program Support costs of the residential program to MHSA funds. These costs represent a share of direct program support consisting of Director, Assistant Director, Human Resources, Intake, Maintenance, Computer and Clerical support. In addition, certain costs for hiring, transportation, direct assistance to children & families and indirect cost are budgeted to be paid with MHSA funds

The attached budget spreadsheet presents the entire annual residential budget. The MHSA funding is identified in the shaded column and identifies all of the costs discussed above. The budget for the pilot is based upon projected estimates and is capitated to the maximum allowable in the County and provider contracts.

Community/Family Based Care Months 13 to 24:

Although San Bernardino County does not currently have an ITFC program, the CFS is actively pursuing a procurement process with FFA providers and intends to apply for the normal state approval process for the FFA ITFC rate pursuant to ACL-09-16, dated June 3, 2009, to implement SB1380, chaptered in 2008. For purposes of estimating costs, in ATT A we used the highest ITFC rate based upon ACL 08-01, dated Jan. 17, 2008, reduced by the 10% cut effective October 1, 2009. We estimate up to 25% of youths will need this intensive one-on-one caregiver treatment model for up to 6 months of step-down care. Up to 75% of the youth are expected to be placed in regular FFA settings for months 13 to 18. In both the ITFC and FFA, the same MHSA funded CCT and family engagement services from the RBS provider will seamlessly follow the youth to support transitions to lower levels of care and reconnect the youth to family.

In months 19 to 24, while the CCT members remain the same for each youth, the funding shifts to SB163 Wraparound Services, assuming the youth will be in a family setting, either returned to the parental home, or placed with a relative or NREFM who will be the youth's committed lifelong connection. We are using the RCL 13 Wrap rate in ACIN 1-91-08, adjusted by the 10% cut effective October 1, 2009, for \$2,832. We assume that 75% of youths will be with relatives/NREFM's and needing the higher specialized care increments that our county schedule permits, which combined with the

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applicable basic rate, would assume an average placement cost of \$1300, leaving the remainder of the applicable Wrap rate for CCT/family engagement services. The remaining 25% will be in parental homes, eligible for the full Wrap rate, if federally eligible. If the youth is not federally eligible, we will use the full SB163 Wrap RCL 13 rate of \$5665. For the federally eligible youth, we will use the non-federal share of the RCL 13 rate of \$2,757 (computed using the current FMAP of 56.2%). We applied the \$5665 rate to the 28% of youths who are not federally eligible and the \$2757 rate for the 72% of the youths who are federally eligible for a weighted average of \$3,571. We use this \$3,571 weighted rate in Attachment A. Assuming that \$1,300 of the \$3571 rate will be used for Post-discharge Relative Care for the federal title IV-E allowable foster care payments, we determine that 36.4% of that \$3751 payment would be federally eligible. We have modified Attachment accordingly. We do acknowledge that during the federal ARRA period that ends December 31, 2010, the increased FMAP reduces the SB163 rate for federal children to \$2481 and we will pay that rate accordingly. We will not backfill that rate. When the ARRA period is complete, we will go back to the \$2832 rate for the federally eligible youth. It appears FMAP will be extended another 6 months.

While residential treatment provides a vital role in the continuum of services for kids, Victor Family of Services (VFOS) has continued to look for ways to keep youth with their families in the community. While this is not always possible or advisable, in circumstances where it is, that is where SB163 Wraparound, Success First, Therapeutic Behavioral Services (TBS) and Transitional Age Youth (TAY) enter the picture. It is these services as deemed appropriate for each client follow the youth into the community following transition from the residential environment.

TBS is one-to-one contact between a mental health provider and a beneficiary for a specified short period of time, to prevent placement in a group home of RCL rating 12 – 14 or a locked facility for the treatment of mental health needs, including acute care; or to enable a transition from any of those levels to a lower level of residential treatment, by reducing or eliminating maladaptive target behaviors and achieving short-term treatment goals. TBS can provide support to youth currently placed in a rate of classification level 12 or above group home; and or a locked treatment facility for the treatment of mental health needs.

A youth who is preparing to transition from Victor Treatment Centers (VTC) Residential Based Services (RBS) would initially be referred to TBS. TBS would be utilized to stabilize behaviors in the residential setting that have prevented the youth from transitioning to a lower level of care. Once youth has been stabilized and a suitable home has been located, i.e. FFA Foster home, ITFC, Relative/NREFM, legal guardian etc, the youth can transition home and services would follow for stabilization.

Another possible step down support that could be offered to a youth leaving the residential setting could be Wraparound (SB163). The youth must either be at risk of being placed outside of the home in a Level 10 or higher placement (high level group home, juvenile hall/juvenile camp, out of state program, mental hospital) or is already at such a program and is wanting to return home, hence youth transitioning from the

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residential setting. In either case, the family (a willing care provider such as a FFA/ITFC certified foster home, relative/NREFM, legal guardian, bio parent, etc) participates in the extensive process that is SB 163 Wraparound. Youth transitioning at this point would be considered not to be an undue safety risk to themselves, their families or the community at large in order to qualify.

Projected community based services offered in months 13-24 are funded by a sequence of Success First MHSA Wraparound and then SB163 Wraparound and is a program whose mission is to provide family-centered, strengths-based, needs-driven services to maintain at-risk youth in family settings, in schools and in their communities. The program is focused on achieving the stabilization of youth and building the parenting capacity of their families to achieve the successful transition to community-based resources and/or other VCSS mental health programs for on-going progress and support. Transitional Age Youth Centers (TAY) will provide integrated services to those youth (age 16-25) in the Pilot that necessitate additional services. VCSS operates a TAY Center in the High Desert Region and DBH operates a TAY center in San Bernardino city area.

In order to promote continuity of care and to avoid unnecessary program disenrollments, the federal definition of temporary absence for foster care of up to 14 days per calendar month will be utilized on a case-by-case basis to authorize the payments for having the youth's bed held during that temporary absence. Thus if a youth needs hospitalization or has run away, or otherwise has a planned or unexpected disruption from his placement, the CCT will determine the appropriateness of holding bed for the youth's return based on the 14 day rule. In that many if not all of these youths have serious emotional disorders, many youths will qualify for SSI Disability, including those IV-E eligible. Under the mandates of both AB1663 and AB1331, the CFS will actively pursue SSI applications to both offset AFDC-FC costs and to provide a secure source of income for youths transitioning out of care either to the parental home or to the adult systems of care as further described in the response to Question 6.

Throughout the entire length of RBS enrollment, there is always a chance that an enrollee will go into crisis requiring additional support. The primary means of crisis stabilization will be to work with the child in their current residence to facilitate resolution of the crisis while maintaining safety; however, in some instances psychiatric hospitalization is required to maintain the child's safety. When hospitalized, the CCT services will continue and the goal will be to return the child to their current residence as soon as possible. Should the hospitalization occur after the child has left residential care and returning to the current residence (e.g., ITFC) is not feasible even with additional support, then the most appropriate placement will be facilitated. Hopefully, this will be into the RBS home; however, should there not be an available bed, then the most appropriate placement will be facilitated. For example, a child could be temporarily placed at another ITFC or RCL 14 group home until stabilized to the point of being able to return to either the RBS home or the residence at time of hospitalization. If temporarily placed at a non-RBS ITFC or RCL 14, then RBS staff would maintain daily contact with the child until placement at an RBS ITFC or group home is possible. MHSA

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and EPSDT funding will continue throughout this period of time. (For additional explanation, see p.38 of Voluntary Agreement).

Hospitalization stays which last longer than 14 days during one calendar month are expected to be very unlikely. The average hospital stay for a minor is 2-3 days, and extended stays past 14 days are generally related to difficulties in locating an appropriate placement. When a child, who was admitted to the hospital in crisis and is now stable, is required to stay at the hospital due to not being able to locate an appropriate placement they are on "Administration Days." Given the multiple placement options through RBS, this is not expected to happen frequently; however, should a hospitalization stay approach 14 days, then the CCT team will evaluate the expected date of discharge and anticipated participation the child can have with RBS.

In addition see Attachment A.

- 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.**
-

See item #2 above and Attachment B.

- 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.**
-

CFS, DBH and Probation already have an existing system that monitors and manages RCL-14 and Wraparound placements, which will be applied to RBS. The existing Wraparound payment and claiming process can be replicated for RBS payment and claiming purposes, with an additional special project code added for RBS youths in the CMS-CWS automated system. San Bernardino County Human Services (HS) Administration is charged with tracking, integrating and reporting of key data and measures to insure AFDC-FC cost-neutrality and to comply with all tracking and reporting requirements as agreed to for evaluation purposes and for completing the annual report. The county has the capacity and experience to ensure that all requirements for the evaluation will be met. The county's C-IV assistance payment automated system can track for all AFDC-FC payments and the Human Services LRU has sophisticated ad hoc querying capabilities to run reports on expenditures. These queries will be also used to ensure that no more than 14 days of temporary absence bed holds will be paid per calendar month in accordance with IV-E rules.

HS Administration's Program Development Division has a contract unit that will perform semiannual on-site program monitoring jointly with the Administrative Support Division's Contract Monitoring unit that performs fiscal audits. This monitoring is explained in greater detail in the Waiver Request, Question 6.

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DBH has an EPSDT contract monitor who will be assigned to monitor EPSDT expenditures for RBS services and supports. At this time, no significant changes are planned in the oversight and management that ensure accountability, efficiency and accuracy in access to and disbursement of the targeted funding streams. In addition, the three placing agencies will utilize existing fiscal monitoring practices to oversee the funding streams associated with the transformed treatment model and will provide the administrative support required to pay for RBS services in a compliant and timely manner.

The HS Administration's LRU will be the central collection point for gathering data on EPSDT and MHSA expenditures from the provider and DBH as well as the AFDC-FC payments for the annual evaluation report.

Each placing agency will have a representative who sits on the RBS Oversight Committee that tracks utilization, enrollment, disenrollment activity, lengths of stay, monitors and analyzes RBS payments made to providers, adjusts for outliers and communicates child specific data regularly with HS Fiscal and Auditing divisions for payments and claiming.

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.

All costing, claiming and allocations for MHSA, EPSDT, SB 163 Wraparound, and AFDC-FC will initially be performed through County and provider systems currently in place and compliant with County, State and Federal requirements. The County will adhere to and utilize the Manual Claim form and the Child Cost Tracking Sheet as stipulated in the RBS MOU.

See the Voluntary Agreement and Attachment A herein for the various services and their funding.

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?

Our alternate funding model establishes a RBS AFDC-FC residential rate of \$8835 and will maximize federal financial participation in the following ways:

1. Draw down an appropriate share of federal IV-E participation for care and supervision allowable costs in the AFDC-FC rate By utilizing MHSA to cover the non IV-E costs for the Social Work activities, CCT and family engagement services, we can increase the percent of IV-E allowable costs from the historic RCL 14 percent of 93.5% to an RBS percent of 96% as explained in item #2.

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2. Utilize IV-E eligible training funds at the enhanced rate to provide training with an array of curricula that ranges from orientation to practice interventions for all public and private agency staff, community partners and key stakeholders, including enrolled youth and families
3. Utilize a system of documenting and reporting the use of Title XIX EPSDT that ensures full reimbursement for appropriate activities.
4. Utilize the existing SSI Advocacy contractor to file and pursue SSI disability claims on all non-federally eligible youths upon RBS enrollment and on all federally eligible youths at the point they are placed in relative/NREFM care.

As further explanation of the impact of the SSI Advocacy program, we employ the guideline as described in AB1663 and AB1331 for foster youth. For non-federally eligible foster youth, we will screen these youths to apply for SSI on behalf of youths who meet the disability criteria. The county acts as the youth's representative payee, and pursuant to Social Security Administration regulations, will apply that appropriate portion of the youth's monthly benefits to reduce the state-funded AFDC-FC placement costs. For the federally eligible youth, federal regulations do not permit the receipt of two federal funding streams, IV-E and SSI, so any applicable SSI benefits will be held in suspense until the youth ages out of foster care, or, if the youth is in family based foster care that has a rate less than the SSI Non-medically Board and Care rate, the county as the rep payee, SSI will be used to pay the youth's placement costs so that no AFDC-FC funds are used.

We will continue to use existing quality assurance processes that focus on improving the county's federal to state AFDC-FC penetration rate for the CFS and Probation placements in group care. DBH AB 3632 placements are only state AFDC-FC funded. Based upon placement rates, it is expected that one or two AB3632 minors are expected to participate in RBS. HS Administration has a full time Federal Maximizer position that reviews all newly awarded state foster care cases for application of the Preponderance of the Evidence Model (P.O.E.M.) and as appropriate, converts the case to federal IV-E payments, thereby increasing the penetration rate. During the pilot, there will be an increased effort to apply P.O.E.M. to group care cases. We have determined the current penetration rate of youths placed in RCL 14 homes to be 72%. This is slightly lower than the quarterly penetration rate for the overall population of 76.5% used in our submission. We will adjust the penetration rate of the IV-E eligible youths in Attachment A to the 72% to more accurately reflect the target population. (25 youths currently in RCL 14 homes, of which 18 are federal and 7 are nonfederal).

Involvement of the parents and family as part of the CCT may provide missing data on family income and circumstances that can assist in the P.O.E.M. process. Because we are using MHSA monies for the family engagement and CCT efforts for the first 18 months, there is no fiscal disincentive to enrolling federally eligible youths in RBS, unlike the SB163 Wraparound program. We do not anticipate a significant loss in the federal penetration rate during the life of the pilot in that the target population is the seriously mentally/emotionally disturbed youths placed in RCL14. While we expect to achieve AFDC-FC savings due to reduced lengths of stay in high end group care, many youths will continue to need a stepped down out of home placement for some period of time,

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such as transitioning to an ITFC or FFA and then to relative or guardian care with a specialized care increment. During their trajectory of care the youths will remain federally eligible with a consistent impact on the penetration rate. As this county is not in the IV-E Waiver, once the youth is returned and stabilized in the parental home, we recognize that IV-E funded placement ends for that child. However that is the desired outcome of both the pilot and of the IV-E program.

- 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.**

The table below shows the baseline data and desired outcomes for the target population:

Key Measures	Baseline Data	RBS Goal
Reduced Length of Stay (group care)	2 yrs, 8 months (32 months)	12 months
Reduced Reliance on Out of State Placements	6 eligible youth currently out of state	60% reduction
Reduced Hospitalizations Note: Administration days are days that a minor, who had been admitted to a hospital in crisis, is now stable, but continues to be in the hospital due to inability to locate an appropriate placement.	3.1 episodes 41 days total* *some are admin days	0 admin days
Reduced AWOL Incidents	3.2 episodes 28 days total	50% reduction following first 90 days of care
Improved Permanency: Increased placement stability in family care	(6.2 years in foster care) 3 placements	- 80% of youth remain in RBS until goals met

The above goals set treatment baselines for financial analysis including cost for services and AFDC-FC cost neutrality for both the State and the County.

The county Human Services Administration's LRU used data from the statewide CWS/CMS automated system to establish a baseline of all child welfare youths who had at least one placement in a RCL 14 or out of state equivalent group home in calendar year 2006. The results and demographics of that analysis are provided:

Population: All youths who had at least one RCL 14 or out of state group home placement in 2006.

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Time frame: To determined baseline length of stay, we limited the group home placements from start of their current placement episode to Dec 31, 2006. Placements made after were censured from the analysis.

There were 41 foster youth, with an average time in group care of 2.67 years (32 months) with a range of 1.4 months to 8.7 years. Note this is a cumulative length of stay – for total group home days in the current placement episode.

Demographics of the 41 foster youth:

Average age on Dec 31, 2006 was 15 with a range of 11 to 18:

There were 25 females and 16 males.

Ethnicity	# Of Foster Youths
American Indian	1
Black	13
Hispanic	11
White	16
Total 2006 Cohort Youths	41

Active or last placement by the end of Dec 31, 2006:

Placement Type	# Of Foster Youth
Court Specified Home	1
FFA Certified Home	2
Foster Family Home	1
Group Home	33
Relative/NREFM Home	4
Total 2006 Cohort Youths	41

Average length of stay in foster care (based on current placement episode) up to Dec 31, 2006: 3.6 years with a range of 4.5 months to 10 years.

Average length of stay in current or last group home placement made in 2006: average of 10.7 months with a range of 6 days to 3.6 years.

Average length of total group home days (any group home placement from current placement removal to Dec 31,2006) was 2.8 years with a range of 5.2 months to 9.4 years.

	Average Days GH Career	Average Years GH Career	GH Career Range	# of GH Youths
2006 GH Youths	1,031.51	2.8 years	45 days to 3,203 days (1.4 months to 8.7 years)	41

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The 2.8 years (32 months) in group care is a conservative estimate that we used to establish the baseline average length of stay in group care for the funding model. The subsequent analysis is for a cohort of youths who had a two year time period to be an RCL 14 group home while the baseline cohort youths had a one year time period for selection. In addition, the two year cohort had a longer time period in care than our baseline youths. We are using the more conservative estimate of 2.8 years rather than the 4.17 years because we think RBS will significantly shorten the youth's time in group care

Subsequent Analysis using a 2 year cohort:

Career Length of Stay in Foster Care (current foster care placement episode)

- Calculating current placement episode for all youths who were eligible for RBS (aka in a RCL 14 group home) any time during 7/1/2007 to 2/28/2009.

Table 1:

Age Range	Age as of Feb 09*	PE Averages Days	PE Min Days	PE Max Days	PE Average Years
0 to 5	0	n/a	n/a	n/a	n/a
6 to 10	0	n/a	n/a	n/a	n/a
11 to 15	16	1,750.93	103	3,568	4.79
16 to 18	31	2,245.77	153	5,826	6.15
19 or older	3	2624	1,198	4,445	7.18
Total youths	50	2,110.12	103	5,826	5.78

*Note some youth had exited foster care prior to Feb 2009, and hence were not in care at age 19 or older.

Career Group Home Stays in Current Foster Care Episode (All types of group homes)

- Calculating all group home placements (any type of RCL) during their current placement episode. For any child who was eligible for RBS (aka in a RCL 14 group home) any time during 7/1/2007 to 2/28/2009.

Table 2:

Age Range	Age as of Feb 09*	Average Time in GH Days	GH Min Days	GH Max Days	Average Time in GH Years
0 to 5	0	0	n/a	n/a	n/a
6 to 10	0	0	n/a	n/a	n/a
11 to 15	16	1,512.18	437	2,546	4.14
16 to 18	31	1,474.35	18	3,081	4.04
19 or older	3	2,090	1514	2,580	5.72
Total youths	50	1,523.4	18	3,081	4.17

*Note some youth had exited foster care prior to Feb 2009, and hence were not in care at age 19 or older

The costs below are the costs for the current population:

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Type of Service	Funding Source	Average annual cost per client
• Level 14 Residential Placement	• AFDC-FC	\$80,328 effective October 1, 2009, \$72,300
• Level 14 Residential Day Rate	• MH Realignment Funds	\$26,280
• Day Treatment Intensive	• EPSDT	\$39,600
• Med Support Services	• EPSDT	\$2,000
• Specialized School Services	• PL 94-142	\$30,660 (\$146/day for 210 days)

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

The current design of RBS was intentionally created to avoid the complications of implementing new payment systems, so that the treatment and care innovations for the most impacted children in the system could be the entire focus of the demonstration. The key integration points for payment needed to facilitate residential stabilization and care in a community setting using a Care Coordination Team facilitating a Trauma Informed treatment model are already in place.

The fact that San Bernardino County has shown that RBS can be implemented using allowable Title IV-E costs, EPSDT, and MHSA funds and an alternate model for insuring a standard of care equal or greater than the existing point system. represents a major breakthrough by DBH and CFS in integrating their care and management systems. This has produced the flexibility and integration sought within the scope of existing State mandates, regulations and systems; thus, creating for both the State and the County potentially hundreds of millions of dollars cost avoidance to retool existing systems and practices.

The alternate funding model allows a greater portion of the MHSA funds for transportation to support family and youth visits. Transportation costs are a significant challenge for this County which is geographically the largest in the 49 states, excluding Alaska. In addition many of the target population are currently placed in our of state group homes and initial enrollment activities necessitate the CCT members traveling to the youth's placement to arrange the transition to RBS. This increased investment in transportation is crucial in reconnecting youths with extended family members, achieving permanent connections and shortening residential care.

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

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The payment system in the county's RBS pilot is designed to support cost neutrality in AFDC-FC payments by achieving reduced lengths of stay in RBS group care from our average of 2.8 years (32 months), reduced out of state placements in group care, reduced psychiatric hospitalizations, and promote placement stability in family care. Through collaboration with our county mental health partners, the pilot will benefit from accessing MHSA monies, a new source of revenue focused on increasing family engagement and ensuring the case plan is driven by the youth and family's goals and needs. The design of the county pilot is embedded in and fully aligned with the context of the federal and state safety, permanency and child well-being outcomes. Monitoring of the progress of the target population in achieving the desired outcomes is within existing duties and functions of the HS Administration LRU which tracks the AB636 measures and will not result in new costs. The RBS pilot is one of the strategies in the county's Self Improvement Program to increase exits to permanency and reduce multiple placements for older youth.

Attachment C represents the Standard of Care for the San Bernardino RBS Pilot.

Also see items #1, 4, 5 and 8 above. (Existing systems and practices are to be used.)

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 alternate funding model is based on the assumption that with the provision of individualized, intensive, youth and family driven services that are seamlessly and continuously provided throughout a planned step-down milieu of residential and community based care, the length of group home care and associated costs will be shortened for the target population. Since our average overall group home stay for our target population is 2.8 years (32 months), we can assume savings if these youths average 12 months or less in group care. Because our target population consists of the most challenging youths in group care, we have been conservative in our estimates on the trajectory of care. If each enrolled youth stays 12 months in group care, 6 months in an ITFC or FFA and 6 months with a relative using SB163 Wrap services, we will still realize savings. We expect that some youths will average 9 months in residential care and some youths will be able to go directly to relative/parental care and therefore bypassing the ITFC/FFA stay.

It is also understood that some youths will exceed the 12 months of residential care. The RBS Oversight Committee will carefully manage the average lengths of stay and identify those outliers whose extended stays pose fiscal risk to overall cost neutrality. These youths will be accounted for in the 24 month cost neutrality calculations; as well as for determining lengths of stay or average costs per youth. All enrolled youth will be included in the evaluation, in fiscal reports and for any cost neutrality calculations. Early discharge, such as unplanned moves out of the area, ICT's, incarcerations,

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extended AWOL's, will be tracked to determine if there are programmatic or operational gaps in services that contribute to unplanned discharges.

The following considerations have been addressed to manage risk:

- The RBS Oversight Committee will monitor monthly expenditures and lengths of stay per youth and report to management with recommendations for program and operational adjustments as needed. We will measure AFDC-FC cost neutrality in increments of 24 months for the duration of the pilot. If a youth has not attained stable family or alternate lower level of placement by month 24, it will require RBS Steering Committee approval to remain enrolled.
- The County will assume the risk of not meeting SGF cost neutrality for AFDC-FC funds, but will also realize the savings to its county share of costs for reduced lengths of stay and reinvest those county savings in its Wrap Reinvestment Fund. This is not a shared risk model and, the provider will not be penalized for youth whose care exceeds the goal of 12 mos. The county assumes the fiscal risk to repay the state if SGF cost neutrality for AFDC_FC payments is not achieved.
- Joint utilization reviews will occur at regular intervals to assess if lengths of stay are regularly exceeding expectations and programmatic modifications (provider and/or County) will be made to improve outcomes as identified.

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?

The payment rate for the subsequent years past the 24 month Pilot period years will be based on these cost reports, and will take in account any program changes mutually agreed upon by the provider and the county which would increase or decrease provider costs in the next year. The county will examine actual costs in relation to the rates proposed in this Funding Model and would make any needed adjustments accordingly. The county recognizes that any rate adjustments will need to be reflected in an amended Funding Model, and in considering any such amendment, the State will be constrained by state budget requirements.

In anticipation of providing more intensive and effective care in a reduced time, the County's MHSa plan was modified to address the enhanced services and no risk to EPSDT funding is anticipated. Since the County and the provider are employing existing systems and practices, there is high degree of experience and knowledge embedded in the delivery and oversight of all services, including EPSDT. This ensures that any variances, should they occur (and they are not anticipated), will be handled quickly before serious concerns might arise over EPSDT funding.

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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.

Based on the projection of average length of stay in the Pilot as identified in Attachment A., we anticipate no increase in costs to the State General Fund over the 24 month period. HS Administration will provide tracking and reporting of all AFDC-FC payments with respect to the target population via the existing automated C-IV payment system. In addition, the RBS program will be a unique cost center and AFDC-FC costs will be reported to CDSS, and a manual claiming system to be developed by the State will be used for RBS. DBH will do the same for all mental health related costs (EPSDT and MHSA) and reported as required to CDMH. (See items #1, 4, 5 and 8 above.)

Further, the baseline data for the target population (youth currently in RCL-14 care or equivalent out of state care) indicates that the typical RCL-14 stays averaged 2.8 years (32 months). The planned residential component for RBS care is a total of 12 months with transition to intensive treatment foster care (ITFC), regular FFA, followed by relative care and/or in-home care as the CCT sees fit. Our alternate funding model incorporates the necessary additional services and resources designed to ensure reduced lengths of stay and thereby result in SGF cost neutrality.

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.

San Bernardino County and its partners in RBS are using time proven and tested financial systems, practices and documentation that have been used effectively throughout the State of California for many years. One of the primary innovations that this demonstration brings to the State for consideration, is what inter-departmental cooperation, forward thinking leadership and a broad community willingness can accomplish when putting the needs of the child and family first inside the "current envelope."

The enhanced service model targets those services most likely to result in shorter lengths of stay, with the additional supports youth will have when visiting family members or potential foster placements. In addition the piloting a professional youth advocate, to support, guide and counsel youth in difficult choices throughout the care.

This primary innovation tests the power of collaboration between county mental health departments and probation and child welfare placing agencies bringing the flexibility and creativity of MHSA dollars into the residential based services model.

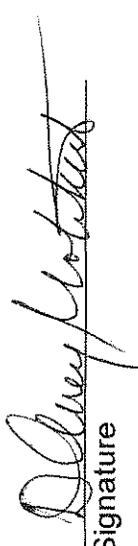
Residentially Based Services Reform Project Funding Model

BS 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.

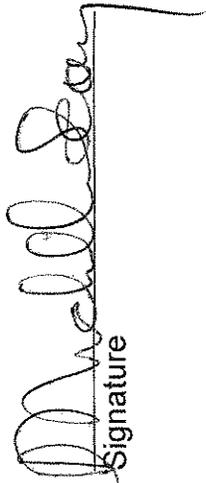
*County Social Services Agency

Name:
Title:
Agency:


Signature
Date: 9/3/09

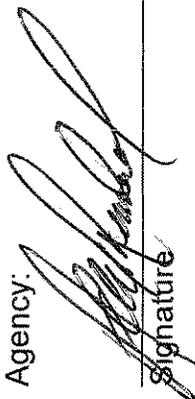
*County Probation Agency

Name:
Title:
Agency:


Signature
Date: 9-3-09

*County Mental Health Agency

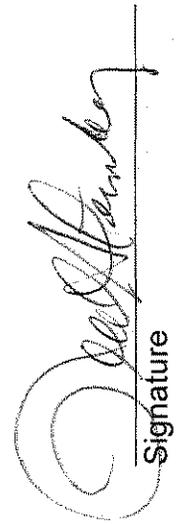
Name:
Title:
Agency:


Signature
Date: 9/3/09

Provider Agency(ies) – Victor Treatment Centers

Name: Neal Sternberg
Title: Executive Administrator

Agency: Victor Treatment Centers


Signature
Date: 9/3/09
~~6-11-2009~~

* Signature required before submittal to CDSS

ATTACHMENT A: RBS Funding Model Deliverable: San Bernardino County (3-17-10)

SECTION 1: ESTIMATING COSTS OF RBS PROGRAM

This example uses an AFDC-Foster Care rate for current traditional group home placements that reflects the full 76.25% increase in the CNI since 1990, based on the final Judgment issued by the Federal District Court for the Northern District of California on February 24, 2010.

The figures in RED are assumptions, which can be changed, about estimated RBS costs, 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							
RBS Program Components	12	Months of RBS Group Care,	6 Months of Some Type of Supportive Bridge Care in an ITFC or FFA, and				6 Months of Relative Care or In-Home Aftercare Services		Federal Medical Assistance Percentage (FMAP)
			A.	B.	C.	D.	E.	F.	
			Average Unit Costs (per month)	Percentage of Costs which are Eligible as Federal IV-E Maintenance Payments	Average Duration of Service (in months)	Average Utilization (percentage of children/families receiving the service)	TOTAL COSTS (per child) A x C x D	Costs which are Eligible as Federal IV-E Maintenance Payments (per child) B x E	
1	Residential (Group) Foster Care* and Parallel Family Services								
	a.	TOTAL costs	\$12,732						
	b.	NET costs after \$3,897 per month MHSA offset	\$ 8,835	96.0%	12	100%	\$106,020	\$101,779	
2	a.	ITFC (Level A)	\$ 4,028	60.0%	6	25%	\$6,042	\$3,625	
	b.	FFA (15+ years old)	\$ 1,679	70.6%	6	75%	\$7,556	\$5,336	
3	a.	Post-discharge Relative Care, including \$1,532 for services to the child and family, which are not federally allowable, and \$1,300 for board and care payments (\$627 basic and \$673 SCI) which are 100% federally allowable, making 36.4% of the total \$3,571.	\$ 3,571	36.4%	6	75%	\$16,071	\$5,850	
	b.	Post-discharge Aftercare after the child has been reunified with family (or another family setting not involving an AFDC-FC payment)	\$ 3,571	0.0%	6	25%	\$5,357	\$0	
Average Total Costs of an RBS Placement for					24	Months	\$141,045	\$116,590	
Total Costs NOT Eligible as Federal Title IV-E foster care maintenance payments									\$24,455
72.0%	Percentage of Children Federal Title IV-E Eligible			Total Federal IV-E foster care maintenance payment funding available:			\$47,177	33.4%	of total RBS costs
Net State/County Costs after Title IV-E Reimbursement							\$93,868	66.6%	of total RBS costs

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

SECTION 2: ESTIMATING CURRENT COSTS OF TRADITIONAL GROUP HOME PLACEMENTS

AFDC-FC Group Home Rates [per month] under the final Judgment issued by the Federal District Court on February 24, 2010		Federally-Allowable Portion of AFDC-FC Rate	Costs: Per Child Per Month					
			Federal Share @ 56%	State Share @ 40% of Nonfederal Share	County Share @ 60% of Nonfederal Share	Combined State and County Share		
RCL 14	Federally- Eligible Children	93.50%	\$ 4,643	\$ 1,677	\$ 2,515	\$ 4,192	47.5% of total costs	
	NON-Federally- Eligible Children	0.00%	\$ -	\$ 3,534	\$ 5,301	\$ 8,835	100.0% of total costs	
	Composite of Federal and Non-Federally- Eligible Children		\$ 3,343	\$ 2,197	\$ 3,295	\$ 5,492	62.2% of total costs	
Period (in Months) over which Cost-Neutrality will be Evaluated		24	Percentage of Children Eligible for Federal Title IV-E Payments			72.0%		
Current Total Costs for an Average Group Home Placement		Federally-Allowable Portion of AFDC-FC Rate	Current Costs for an Average Group Home Placement				New Costs/ (Savings) with RBS Program [per child]	Current Distribution of the RBS Target Population among the RCLs
			Federal Share @ 56%	State Share @ 40% of Nonfederal Share	County Share @ 60% of Nonfederal Share	Combined State and County Share		
RCL 14	\$ 212,040	0.00%	\$ 80,223	\$ 52,727	\$ 79,090	\$ 131,817	\$ (37,949)	100% (37,949)
RCL-Weighted Average Costs/(Savings) per child:							\$ (37,949)	

Note: The impact of the Federal Stimulus package (ARRA) is included in this analysis, which uses the federal financial participation rate of 56.2% for allowable costs for federally eligible children, rather than the "normal" 50%.

Victor Treatment Centers, Inc.
San Bernardino County Behavioral Health
RBS Residential Annual Budget 12 slots
As of March 12, 2010

D E S C R I P T I O N	FTE	Estimated Mental Health Services				TOTAL
		Residential	MH TOTAL	EPSDT	TBS	
New RBS Services Staff						
Transition/Family Clinician	1.00		\$53,000	\$53,000		\$53,000
MHRS/Life Coach Mentor	2.00		\$76,000	\$76,000		\$76,000
Behavioral Support Staff I	1.00		\$0	\$0	\$27,000	\$27,000
Behavioral Support Staff II	2.00		\$70,600	\$70,600	\$70,600	\$70,600
Program Analyst/Quality Assurance	0.50		\$27,000	\$27,000	\$27,000	\$27,000
Peer Advocate	0.50		\$14,000	\$14,000	\$14,000	\$14,000
Office Support	1.00		\$27,000	\$0	\$27,000	\$27,000
TBS Worker	1.00		\$33,000	\$33,000		\$33,000
CCT Facilitator	1.00		\$70,000	\$70,000	\$70,000	\$70,000
Parent Partner	1.00		\$28,500	\$28,500	\$28,500	\$28,500
Subtotal RBS	11.00	\$0	\$426,100	\$129,000	\$33,000	\$426,100
Day Treatment Intensive Program						
DT Coordinator	0.40		\$27,444	\$27,444		\$27,444
Clinicians	2.00		\$104,200	\$104,200		\$104,200
MHRS	1.00		\$38,000	\$38,000		\$38,000
Nurse	0.40		\$26,662	\$26,662		\$26,662
Support	0.40		\$11,511	\$11,511		\$11,511
Subtotal Day Treatment	4.20	\$0	\$207,817	\$207,817	\$0	\$207,817
Residential Group Care						
Total Child Care & Supervision	22.00	\$546,315	\$51,475	\$0	\$0	\$597,790
Shared Program Support						
Total Shared Program Support	4.00	\$104,945	\$52,650	\$52,650	\$0	\$157,595
Total Salaries & Wages	41.20	\$651,260	\$738,042	\$389,467	\$33,000	\$1,389,302
Taxes & Benefits	40.00%	\$260,505	\$295,213	\$155,783	\$13,200	\$555,718
Total Personnel Cost		\$911,765	\$1,033,255	\$545,250	\$46,200	\$1,945,020

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DESCRIPTION	FTE	Residential	Estimated Mental Health Services				TOTAL
			MH TOTAL	EPSDT	TBS	MHSA	
Operating Expenses RBS Residential							
Hiring Cost @ \$1,000/FTE			\$11,000	\$6,000	\$1,000	\$4,000	\$11,000
Training Cost (To Be Determined (TBD) with Title IV-E offset)			TBD			TBD	TBD
Professional Fees		\$12,000	\$31,000	\$31,000			\$43,000
Supplies		\$43,200	\$2,640	\$2,640			\$45,840
Telephone & Postage		\$14,900	\$1,200	\$1,200			\$16,100
Occupancy		\$65,200	\$21,200	\$21,200			\$86,400
Equip Lease & Maint		\$10,065	\$4,000	\$4,000			\$14,065
Transportation		\$31,720	\$55,565	\$17,960		\$37,605	\$87,285
Conferences & Meetings		\$3,000	\$2,000	\$2,000			\$5,000
Direct Assistance to Children & Families		\$30,360	\$57,750	\$29,040	\$8,710	\$20,000	\$88,110
Liability Insurance		\$4,800	\$3,000	\$3,000			\$7,800
Miscellaneous		\$14,700	\$3,000	\$3,000			\$17,700
Total RBS Res & DT Operating Expense		\$229,945	\$192,355	\$121,040	\$9,710	\$61,605	\$422,300
Total Direct Cost		\$1,141,710	\$1,225,610	\$666,290	\$55,910	\$503,410	\$2,367,320
Indirect Cost		\$79,640	\$86,365	\$46,640	\$4,475	\$35,250	\$166,005
Total Program Cost		\$1,221,350	\$1,311,975	\$712,930	\$60,385	\$538,660	\$2,533,325
EVENUES							
AFDC (\$8,835 x 12 clients x 12 months x 96% Occup)		\$1,221,350					\$1,221,350
EPSDT @ \$2.60/min, 3 hrs/wk 12 kids, 47 wks, 96%			\$252,866	\$252,866			\$252,866
DT @ \$202/d + Med Support @ \$4.82/m Title IV-E Training offset			\$460,064	\$460,064			\$460,064
TBS @ \$2.60/min, 0.75 hrs/wk 12 kids, 42 wks, 96%			\$60,385		\$60,385		\$60,385
MHSA Funds Parent Partner			\$39,900			\$39,900	\$39,900
MHSA Funds			\$498,760			\$498,760	\$498,760
Miscellaneous			\$0			\$0	\$0
Total Program Revenue		\$1,221,350	\$1,311,975	\$712,930	\$60,385	\$538,660	\$2,533,325
Net Revenue Over Expense		\$0	\$0	\$0	\$0	\$0	\$0
Average cost per child per month AFDC		\$8,835					

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DESCRIPTION	FTE	Estimated Mental Health Services				TOTAL
		Residential	MH TOTAL	EPSDT	TBS	

Estimated MHSA Fund Costs:			
1) RBS CCT Facilitator		\$98,000	18.19%
2) Behavioral Support Staff		\$136,640	25.37%
3) Program Analyst/Qual Assurance		\$37,800	7.02%
4) Parent Partner & Peer Advocate		\$59,500	11.05%
5) Residential Staff Costs		\$72,065	13.38%
6) Support Staff Costs		\$37,800	7.02%
7) Transportation + Specific Asst + Indirect		\$96,855	17.98%
8) Match for Title IV-E Training costs		TBD	
Total MHSA Funds		\$538,660	100.00%

ASPECTS OF STANDARDS OF CARE IMPLIED BY WAIVER REQUEST

- Our understanding of the mechanisms that promote permanency, and especially family reconnection for the older youth who typically have languished in group care, have grown enormously over the past decade, in part due to the principles and innovations such as flex funding pioneered through Wraparound and other new technologies like the relative search engines made possible by the internet and the protocols developed for case mining and team decision making.
- a new rate and coordinated funding streams provide resources to allow a Care Coordination Team to focus on community-based treatment, family finding, engagement, preparation, and support, and flexible funds
- the amount of supports a child and family need to be successful will be supplied but in a more customizable way so that safe return to family settings can also be ensured
- enriched staff in model allows us to provide “one-to-one” supervision when a child needs it either in the residential setting, community, school or family home....and the most intense supervision is not just restricted to the residential setting
- assessment, planning, interventions and services follow a child regardless of placement setting
- fluid program design
 - three main staff roles:
 - CCT-related staff, who will provide facilitated planning, family engagement/empowerment services and coordinate the development and implementation of the plan of care.
 - The portable staff who may or may not be regular members of the CCT and will bridge the facility treatment and community treatment by providing clinical services and/or behavioral interventions in the portable therapeutic milieu which includes the home, school and community.
 - The residential facility staff who will primarily maintain the care environment in the units, but be capable of joining youth on visits and pre-placement visit opportunities.
- staffing minimum experience guidelines:
 - CCT Facilitator Preferably Bachelors plus 4 years experience
 - Parent Partner Preferably one with DSS involvement experience, ideally residential treatment related
 - Clinician ‘Qualified mental health professional’ as defined by DMH
 - Family Finder Preferably Bachelors plus 2 years experience
 - Residential Svcs Sup. Preferably Bachelors plus 2 years supervisory experience
 - Behavioral Support staff Preferably Bachelors plus 2 years experience
 - Child Care Worker Preferably High School plus two years experience
 - Peer Advocate Preferably successful graduate of Foster Care system
 - Awake Overnight Staff Preferably High School plus two years experience

Residentially Based Services Reform Project Funding Model – Attachment C

MOU #09-6002

Attachment I, Exhibit 2, Attachment C
San Bernardino RBS Funding Model

- Peer Advocate assisting in empowering the youth who is a former client of both the child welfare and mental health systems, and has experience in residential treatment
- Both the CANS and CAFAS Tools and Progress Summary Report will be reviewed monthly to track the youth's progress in RBS. CCT usage and youth and family involvement will be reviewed quarterly.

Staffing:

- A new Care Coordinator Team Facilitator plays a critical role in the overall management of the RBS services and key residential and community-based staff, who all participate in the trajectory of care for each client assigned. The Care Coordinator Team Facilitator will coordinate and facilitate the CCT Meetings. Newly hired mental health and RBS staff will coordinate the development of the RBS plan of care and will provide the clinical services offered during the facility based and community based portions of the program.
- The Parent Partner, Peer Advocate, RBS Family Clinician, and the RBS treatment team will engage the youth's family and encourage and support their active involvement in the development of the care plan and throughout the delivery of RBS services.
- The Parent Partner will have the experience consumer of mental health services or have a child member who is or was a consumer of children and family mental health services. The Pilot will seek a Peer Advocate who has been a former resident of the Foster Care system program, was discharged from Probation and emancipated successfully.
- The RBS team will consist of Residential Counselors, Behavioral Specialists, the RBS Care Coordination Team Facilitator, and Facility Managers, Individual and Family Therapists, Community based qualified staffs who are assigned with treatment responsibilities for each youth.
- As outlined above, the Pilot will utilize specialists whose job it will be to work with the RBS youth in the residential treatment program, in the family home, or elsewhere in the community. "Bridge" specialists, such as the individual and family therapist, case manager, TBS staff, and Care Coordination Team Facilitator, will work in both facility based and community based care components of RBS and work with the youth and family discharge from RBS.
- Under the direction and supervision of the Clinician, the residential treatment and care staff will maintain the care environment in the new RBS program. This will be similar to their current duties, but at a higher staff to youth ratio.
- RBS residential staff will include direct care RBS child care staff, an RBS Residential Services Supervisor for each home, Behavioral Support Staff, Mental Health Rehabilitation Specialist/Life Coach, TBS staff, Residential Clinician, and Family Clinician. The direct residential staff members preferably will have a BA level of related education, along with considerable group home work experience. The VTC nurse will provide medical oversight and on-site services and oversee medication management. Staff include a Registered Nurse, and contract Child Psychiatrist (Board Certified MD).
- Qualified individuals for the Family Support Counselors will possess a bachelor's degree in a behavioral science, several years of working with youth and families in a

Residentially Based Services Reform Project Funding Model – Attachment C

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Attachment I, Exhibit 2, Attachment C
San Bernardino RBS Funding Model

residential and/or community setting, good communication skills, a high degree of comfort working in residential and community environments, the ability to teach, model and give feedback on Family Interaction assignments, and the ability to establish a therapeutic and supportive relationship with families and youth.

- Family Clinicians will be licensed or licensed eligible, MFT, or LCSW, will be trained in family engagement protocols, strategies, and intensive relative searches, will have good communication skills, and be able to positively reinforce families for their initial, ongoing, and community based support of all youth.
- RBS Clinicians will deliver the individual, group and therapies that will be utilized to support youth and families. Therapists will possess a master's degree, be licensed or a registered intern for LMFT or LCSW licensure, and will participate as a member of the CCT. Therapists will be trained in Evidence Based practices that support the needs of the youth and families enrolled in RBS.
- The training plan for those staff involved in direct service provision will entail as much as 40 hrs. over an extended period of time, and may include "refresher" training, whereas, a community stakeholder, may only receive an Orientation to RBS which could range from 2-6 hours depending on their role and needs

Family Engagement:

- The Family Clinician, Parent Partner and Client Services Coordinator meet with the youth and family prior to and at the point of entry to the RBS program to explain the nature and processes of the program
- A Parent Partner who has been a primary caregiver or close family member of a youth with severe emotional disabilities experiencing high level out of home placement. The Parent Partner will be a resource for the Family to teach them about the program and how to be involved with and express their wishes for plan of care for their child. The Parent Partner would also be the primary trainer of the EES curriculum supplied by the United Advocates for Children and Families – an education program that teaches parents about the mental health, probation, education, and child welfare systems, as well as, gives parents valuable information about several common mental health diagnoses for youth and medication information.
- Peer Advocate, who has been a youth that has experienced high level out of home placement, can educate other youth about the program, and who can teach youth how to appropriately advocate for themselves.
- Family Therapy will be utilized by the therapist on a weekly basis to prepare the family for the return home of their youth, develop skills for active and consistent communication and listening between family members, address past issues that have been barriers for good communication and to coordinate support for the youth and family.
- Family Support Groups will be utilized by the therapist and Parent Partner to encourage support from one family to another, discuss successes and challenges throughout the RBS pilot process, address crisis issues, and facilitate training on agency specific issues for family members. The Family support group would also be a forum for evaluation and re-evaluation of the RBS program where the Care Coordinator Team Facilitators and other Administrators could meet with parents to

Residentially Based Services Reform Project Funding Model – Attachment C

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Attachment I, Exhibit 2, Attachment C
San Bernardino RBS Funding Model

discuss their opinions and experiences while receiving RBS services. Family support groups may also include participation of the Family Support Counselors.

- TBS Staff will be utilized to supervise interactions between family and youth during residential placement, assist with therapeutic family interaction assignments, discuss, encourage, model, and give feedback in the development of positive interaction skills that meet the needs of the family and youth and prepare both family and youth for success in the community. TBS staff will start their work with the family and youth in the residential facility and will be an integral part of the transfer of services out into the community with the family.
- RBS MHRS staff and assigned Child Care staff will work with youth who will be “aging out of the system,” to prepare them for successful adulthood by helping by providing the following services;
 - Educational supports and opportunities in partnership with the local County Office of Education to facilitate obtaining a GED or high school diploma and enrollment in college or vocational training according to interest
 - Independent living skills training opportunities, i.e., job skill prep, household mgt., skills, etc. through the Ansel Casey Life Skills program and, supplemented by independent living opportunities
 - Linkage to transitional living programs
 - Utilize family finding and engagement technology to insure that each enrolled child or youth has appropriate and ongoing family connections, even if those connections do not lead to placement opportunities
 - Work with San Bernardino County, other Private providers, and The John Burton Foundation to link youth who are emancipating from alternative care with the THP Plus program in the community where they hope to live as they become adults and leave our care systems
 - Recruit and support the participation of volunteer mentors to join the child and family teams, and then to provide any support needed to help that relationship continue on post graduation from the RBS System.
 - Locating living arrangements through existing community housing programs such as VA and THP-Plus
 - Providing educational supports and/or opportunities
 - Facilitating the development of job skills and other independent living skills such as, establish savings accounts, learning about transportation, household management, etc.
- following QA tools that will be utilized for quality assurance purposes to track the effectiveness of the San Bernardino County RBS Demonstration Project:
 - YSS, YSS-F Data Report
 - CAFAS
 - CANS Results Report
 - Child and Family Team Use Report
 - RBS Contract Monitoring
 - EPSDT Contact Monitoring

**Residentially Based Services Reform Project
Funding Model – Attachment C**

MOU #09-6002

Attachment I, Exhibit 2, Attachment C
San Bernardino RBS Funding Model

Position	RBS FTE	Hours to RBS Program / Week	Component	Funding Source	Hours / RBS Client / Week
CCT Facilitator	1.00	40.00	combined		
Executive Director	0.33	13.33	combined	All	1.11
Peer Advocate	0.50	20.00	combined	MHSA	1.67
Family Clinician	1.00	40.00	combined	EPSDT	3.33
Clinician	2.00	80.00	Residential	EPSDT	6.67
Office Direct Support	1.00	40.00	Residential	EPSDT	3.33
Facility Manager/RSS	2.00	80.00	Residential	AFDC	6.67
TBS Worker	1.00	40	Combined	EPSDT	3.33
MHRS/Life Coach	2.00	80.00	Residential	EPSDT	6.67
Care and Supervision	16	640.00	Residential	AFDC	53.33
Care and Supervision (non-AFDC-FC)	7	280.00	combined	EPSDT/MHSA	23.33
Clinical Supervisor	0.25	10.00	Combined	EPSDT	0.83
Parent Partner	1.00	40.00	Combined	TANF/ECF	3.33
Program Analyst/Quality Assurance	0.50	20.00	Combined	MHSA	1.67
Day Treatment Support Staff (B)	2.25	90.00	DayTx	EPSDT	7.5
Psychiatrist		1.67	Combined	EPSDT	0.14
Shared Program Support (A)	3.10	124.00	Combined	All	10.33
Total FTE	40.93				
Total Hours Per Week Per RBS Client					133.24

Waiver Request Form

MOU #09-6002

Attachment I, Exhibit 3 – San Bernardino
RBS Waiver Request



The RBS Reform Coalition

RECONNECTING CHILDREN, FAMILIES AND COMMUNITIES

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'.

Waiver Request Form

MOU #09-6002
Attachment I, Exhibit 3 – San Bernardino
RBS Waiver Request

Demo Site: San Bernardino	Date: Revised 3/17/10
Prepared by: Kathy Watkins and Neal Sternberg	Title/Organization: Manager VTC Executive Administrator
E-mail: kwatkins@hss.sbcounty.gov neal@victor.org	Phone: (909) 388-0167 (530) 472-1281

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

The RBS Voluntary Agreement and Funding Model submissions constitute our request and plan to use alternative methods and procedures.

San Bernardino 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 with the rate further modified through negotiation as proposed in San Bernardino County's RBS Voluntary Agreement and Funding Model, as approved by San Bernardino County, Victor Treatment Center and the San Bernardino 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.

Waiver Request Form

MOU #09-6002

Attachment I, Exhibit 3 – San Bernardino
RBS Waiver Request

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

Waiver Request Form

MOU #09-6002

Attachment I, Exhibit 3 – San Bernardino
RBS Waiver Request

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.

The RCL system imposes a barrier for the effective, efficient and timely implementation of the San Bernardino RBS pilot in the following way:

Existing RCL regulations require that the costs be allowable and reasonable in order to obtain Federal funding, and that the State must cover that cost. The term “foster care maintenance payments” (HR 6893) means payments to cover 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.

When the original rates were set in 1990, the RCL system was itself based on cost studies in which group home program service providers participated. However, those cost studies only accounted for provision of “reasonable and allowable” services directly to the child. The cost studies did not account for the additional community-based services and family finding, engagement, preparation, and support services that we now know are required to reunify a child permanently with a family and community. The historic rate did not allow for paying of the actual reasonable AFDC-FC Title-IV-E costs. The Pilot rate of \$8835 allows for those expenses within the rate to be 96% allowable under the Federal definition, yet still falling short of all of the total AFDC-FC allowable costs that VTC has historically charged counties: the full cost of the allowable AFDC-FC expenses, totaling in VTC's last rate package over \$8,400.00 per month. VTC does not include Medi-cal billable services in the 100% percentage since these expenses are covered under EPSDT. It would be appropriate for the full reasonable allowable Title IV-E to be covered in the RBS rate, but the cost share from the County was not feasible. We have established a 96% IV-E allowability percentage of cost on line 1b of Attachment A.

Our understanding of the mechanisms that promote permanency, and especially family reconnection for the older youth who typically have languished in group care, have grown enormously over the past decade, in part due to the principles and innovations such as flex funding pioneered through Wraparound and other new technologies like the relative search engines made possible by the internet and the protocols developed for case mining and team decision making.

As San Bernardino County began to understand these factors, the RBS pilot program design was conceived to test strategies to reduce the length of residential stays to produce better outcomes on safety, permanency and well-being measures.

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

The intention of the RCL system is to ensure safety and stability in a residential treatment facility employs the correct types of staff members and provides the adequate level of treatment and supervision to safely and ethically serve the clients it admits. It does not allow for the services necessary to achieve rapid transition to a lower level of care on their journey to permanency.

SB RBS is requesting the ability to create a new treatment, supervision and staffing model, one that views youth who would otherwise be placed in a RCL 14 program as a high needs population with similar treatment and permanency needs, particularly the need for individualized, customizable and portable treatment for the youth and family. This will be achieved by providing a standardized qualified staff to client ratio matrix providing the safety and stability intended. The new RBS rate for Residential (Group) Foster Care and Parallel Family Services is based on the Title IV-E reasonable allowable costs, with costs which are not Title IV-E allowable being paid for with MHSA funds. The staffing patterns are designed to maximize treatment to obtain the shortest possible stays in group care through blending the variety of funding streams in a fair share matrix, assuring the appropriate stream of funding covers the allowable cost within that funding stream's criteria. The staffing pattern includes the full range of professional and para-professional staff, insuring the client benefits from the range of qualified professionals to meet the client's full needs. The overall costs rates are designed to allow for the resources to allow a Child and Family Team to focus on safety and supervision within the group care setting, community-based treatment, family finding, engagement, preparation, and support, and flexible funds. The goal of this approach is to ensure that reunification (or placement in a new family) occurs safely, quickly and endures.

In the past we have dealt with increased safety needs associated with these children through providing a higher level of adult supervision (otherwise said as a lower child to staff ratio), specialized treatment interventions and, at times, one-to-one supervision. The decision to place in a RCL 14 specifically relates to the child to staff ratio with RCL 14 having more intense supervision and more intense clinical interventions. In the SB RBS model, the amount of supports a child and family need to be successful will be supplied but in a more customizable way so that safe return to family settings can also be ensured. A good analogy is the HMO model where there are high, medium, and low utilizers, but each individual gets a treatment plan based on the unmet needs of that specific child and family. For example, the enriched staff of the SB RBS model allows us to provide "one-to-one" supervision when a child needs it either in the residential setting, community, school or family home. The most intense supervision is not just restricted to the residential setting which is what the current RCL system dictates. In SB RBS, assessment, planning, interventions and services follow a child regardless of placement setting, unlike under the current system. This is why we have conceptualized the new RBS case rate as sufficient on average to cover the needs of youth who previously would have

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been categorized as RCL 14, since these high needs youth can be better served by a more fluid, program design.

The waiver of the RCL system would allow this portable and individualized treatment across a broadened therapeutic milieu, which now would include the residential treatment facility and community-based settings, in the interest of accelerating and sustaining permanency. The Voluntary Agreement describes the proposed staffing and qualifications for SB RBS. The Provider Cost Spreadsheet attached to the Funding Model details projected typical provider costs for the staffing, activities and services outlined in the Voluntary Agreement. Note Standard of Care Attachment C. to the Funding Model

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

Essentially, SB RBS reflects a paradigm shift by redefining the parameters of a therapeutic milieu. The RCL system restrictively defines the therapeutic milieu as that occurring inside a residential treatment facility. SB RBS redefines the therapeutic milieu as the entire community surrounding the youth and their family including, but not limited to, the residential treatment facility, foster homes, churches the family attends, local community-based organizations, school and home. We believe that this concept of the open therapeutic community captures the very essence of AB 1453 and the RBS framework document, which describes RBS as a "reconnection engine." We also believe that the SB RBS Project offers an affordable design that brings a current, evidence-based, cutting-edge treatment technology to do what it really takes to quickly, safely and sustainably bring a high-needs foster child home.

In San Bernardino the intent is to reduce the aggregate length of stay in group care through the enhanced staffing model, targeted training, and seamless coordinated care model that is consistent through the trajectory of care. The model facilitates supporting alternative family-based settings, creates a trauma informed therapeutic community milieu, works with families to provide intensive support and services, and maintains the relationships and builds lifelong connections with the youth. It is our vision that youth who need residential treatment under limited circumstances, when their behaviors pose a threat to themselves or others in the community and can best be stabilized in such a structured setting, are provided the supports necessary to build and maintain lifelong connections, will obtain life and social skills necessary to sustain the gains made during the residential stay. The SB RBS Project is another step toward reducing the amount of time foster youth in San Bernardino spend in group care, sustain the gains they make there, and achieve the RBS goals of active child and family involvement, collaborative decision making, and permanence.

The SB RBS Project is planned as a 24 month demonstration project beginning in 2009. By late 2011, after 24 months, an evaluation will be done and depending on the results and outcomes, revisions as necessary would be made. The program is expected to be extended for an additional 12 months with modifications to size or

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scope, or discontinued. The evaluation results will provide the information necessary to judge whether this test was successful.

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 SB RBS Project's programming will be monitored as described in Section 4.7.1. of the Voluntary Agreement. All County and Private Provider partners will participate in the SB RBS Work Group and Roundtables (See Section #4.5: Management, in the Voluntary Agreement) along with a wide range of community representatives, including those from the schools, child and family representatives, community-based service agencies, and county government. The Workgroup will provide direct feedback on the quality of the services and outcomes being achieved and will make suggestions for system and service improvement to the Steering committee.

The fiscal and contracting monitoring will be handled as follows:

1. As noted in the Funding Model, the design of the County Demonstration is fully aligned with Federal and State safety, permanency, child well-being and financial guidelines. To ensure these guidelines are met as reflected in the SB RBS outcomes and program design discussed in the Voluntary Agreement, monitoring of the progress of the target population in achieving the SB RBS outcomes has been placed in the scope of the duties and functions of the SB RBS Steering committee, and supported by the appropriate County fiscal organizations, County Auditor Controller, and the SB RBS Evaluation Subcommittee.
2. As noted in the Funding Model, various strategies and actions are planned to manage financial risk. Below is a summary of the pertinent SB RBS Demonstration Project features to manage financial risk :
 - a. Payment reconciliation will be held to ensure that all payments are allowable and properly accounted to insure cost neutrality per child to be paid for all SB RBS related AFDC-FC costs incurred by the providers for the 24-month period of the Demonstration.
 - b. Steering Committee oversight of SB RBS utilization will occur at regular intervals to assess overall SB RBS utilization effectiveness.
 - c. The County and the providers will perform internal reviews and audits of the SB RBS Demonstration. The Auditor Controller performs the Single Audit of a randomly selected number of programs each year. The Auditor Controller does not have a major role in the fiscal monitoring of contracts/MOUs. All payments are made through the Auditor Controller's office and payments are recorded in the County's Financial Accounting System (FAS). The AC reviews all payment documentation on a flow basis and certifies the accuracy of assistance claims and payments. For HS Administration, its two divisions, Program Development Division (PDD) and Administration Support Division (ASD) perform joint and coordinated program and fiscal monitoring of all HS contracts and MOUs. The fiscal monitoring is conducted in

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compliance with the Code of Federal Regulations (CFR). The ASD's fiscal monitoring unit has access to FAS and tests the accuracy of payments to the provider comparing the FAS records with the monthly invoices submitted by the provider. Monthly invoices are reviewed by the ASD staff prior to submitting them to the Auditor Controller for payment. ASD in coordination with the PDD staff monitors random samples of expenditures, and payroll verification. At least once a year the ASD and PDD staff perform an on-site review monitoring compliance to the terms and conditions of the contract/MOU. The first visit is conducted 3 to 5 months after the start of the contract/MOU. The goal of monitoring is to provide technical assistance to the provider to ensure 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 follow-up visit will be conducted within a reasonable time of 3 to 4 months to ensure compliance with the recommendations indicated in the monitoring report. The provider has the responsibility to hire an independent auditor (CPA) to perform the agency's annual audit in accordance with OMB-133. 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.

**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.

***County Social Services Agency - DCFS**

Name:
Title:
Agency:


Signature _____
Date 9/3/09

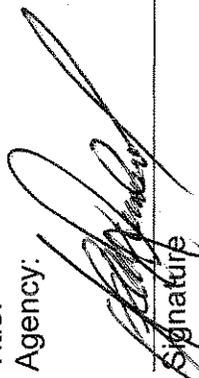
***Provider Agency(ies)**

Name: Neal Sternberg
Title: Executive Administrative Director
Agency: Victor Treatment Centers Inc.


Signature _____
Date 9/3/09

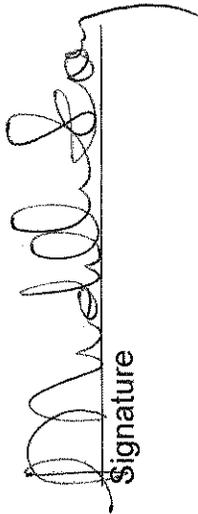
***County Mental Health Agency - DMH**

Name:
Title:
Agency:


Signature _____
Date 9/3/09

***County Probation Agency**

Name:
Title:
Agency:


Signature _____
Date 9-3-09

*Signature required before submittal to CDSS