Proposed Continuum of Care Reform (CCR)
Concept Paper
10/16/13

Introduction & Executive Summary

The purpose of this paper is to offer a potential framework to inform and guide the Continuum of Care Reform (CCR) efforts. The primary objective of this document is to describe the transformation of group homes and foster family agencies from placement agencies into programs that support the overarching goals of the child welfare system – safety, permanency and well-being of children – and which are aligned with most current research and practices to support positive outcomes for children and their families

The proposed model would allow private agencies to restructure their service offerings in order to collaborate with public and other private agencies to create a continuum of care, services and treatment for children, youth and their families known to the child welfare system. It would replace the current system in which children and youth are often rotated between programs and provider organizations in order to obtain needed services and treatment as their living situations change.

This framework document:

- Provides a brief description of current group home and foster family agency structures and services;
- Describes the proposed model for transforming group home and foster family agencies into Residentially-Based Services and Child, Youth and Family Service Agencies;
- Describes the process for assessing a child and family's strengths and needs and how that informs both where the child is placed, and the provision and payment of services; and
- Explains how performance and accountability can be achieved under this framework.

This document was developed jointly by the Alliance of Child and Family Services and the County Welfare Directors Association of California (CWDA) and is intended to be a working document for further discussion with California's child welfare stakeholders engaged in the CCR process.

<u>This proposal includes the following:</u>

1. Embraces the Vision of the CCR Steering Committee with respect to promoting permanent family connections, supporting individualized services for children, youth

and families and transforming group home care into short-term, intensive treatment options.

2. Expands the Residentially-Based Services (RBS) program model statewide and makes RBS the replacement to group home care.

3. Changes the program design and rate setting system for Foster Family Agencies (FFAs) into Child, Youth and Family Agencies (CYFAs) to provide services and supports that are individually-tailored to meet the strengths and needs of those served.

4. Assures children and youth can receive the care, services and treatment they need regardless of where and with whom they live, and that caregivers – including kin and NREFMs – can receive the services and support necessary for them to successfully care for and meet the needs of children and youth.

5. Creates an assessment process to standardize placement decisions by county child welfare/probation with input from a child and family team when possible. This assessment process will identify the supports and services to be provided to children, youth and families, and determine the appropriate payment levels, for children specifically to be served by the CYFA.

6. Identifies the tools, resources, and strategies to improve accountability and performance of RBS and CYFAs, and the respective roles of these agencies, counties and the State. It requires that all RBS and CYFAs become accredited through a recognized national accrediting body.

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Description of Current Continuum of Care Structure

Group Homes: California uses the term "group home" to cover a wide variety of congregate care settings. According to Title 22, a group home is "any facility of any capacity which provides 24-hour care and supervision to children in a structured environment, with such services provided at least in part by staff employed by the licensee." Some group home programs consist of a single six-bed facility; others consist of multiple six-bed facilities; some consist of a single campus with multiple "cottages;" and others are a combination of a central campus plus smaller facilities located in the community.

With the exception of those in Los Angeles County, the vast majority of group homes accept children referred from multiple counties. Since 1993, group homes receiving AFDC-Foster Care payments have been required by State law to be operated by private nonprofit organizations. Group homes are funded using the Rate Classification Level (RCL) system which pays providers a pro-rated monthly fee for the room, board, care and supervision of children placed with them. Developed in the late 1980s and implemented in 1990-91, the RCL system is made up of 14 levels each with its own foster care rate based on points earned for the number, education, training, and experience of direct care and social work staff, and reflects the average cost to care for a youth in a program with that level of staffing. The RCL system was designed during a period when the primary consideration for most youth was stability of placement through intensity of supervision and behavior management; as a result, the RCL rate includes no funding for family engagement and support, permanency focused services, aftercare, or mental health treatment.

Group homes are used by County child welfare and juvenile probation agencies primarily for foster youth with very serious emotional and/or behavioral issues (including substance abuse). Since 1995, average lengths of stays in group homes have decreased from 18 to 24 months to 9 to 15 months. The Residentially-Based Services (RBS) reform project, which is discussed in this paper, was begun in 2005 in an attempt to modify State rate-setting, licensing, and other administrative system to support the evolving role of group homes as short-term intensive treatment programs. About 10% of youth in foster care reside in group homes.

Foster Family Agencies (FFAs): FFAs are funded to recruit, screen, train, certify and support 'certified' foster families, to provide board, care and supervision for children placed with those families, social work services for the child and foster family, and to provide various other supports as required or requested by the placing agency. Public entities such as county child welfare agencies and nonprofit private organizations may operate FFAs.

FFAs were established and their rate system designed and first implemented in the mid-1980s. During that period and for 10 years or more thereafter, long-term foster care was considered a desirable permanency option for children not reunified with their families. Accordingly, FFAs were originally designed to provide mid-to-long-term foster family-based care and, as with group homes for which FFAs were seen as a less restrictive option, stability of placement was a primary consideration. FFA rates were

designed to reflect that understanding. The five levels of FFA rates are based on the ages of children and youth served and include four components: a Basic Rate and a Child Increment paid by the FFA to the foster family to cover the costs of caring for the child, a Social Work component for foster parent support and care coordination, and a component to cover the costs of recruitment, training, and certification of foster parents, to pay for additional costs of care not covered by the other three components, and to cover the costs of administration of the program. Like group home rates, FFA rates do not include funding for family engagement and support, prevention, permanency focused services, aftercare, or mental health treatment.

Some private organizations with FFAs are also licensed as Adoption Agencies (AAs) to recruit and certify prospective adoptive families and complete necessary steps for adoption of children from the foster care system. Others provide other child welfare related services including family resource centers, differential response, family preservation, SB 163 Wraparound, Intensive Treatment Foster Care (ITFC), Transitional Housing (THPP, THP-Plus, and THP-+ FC), and group home services, as well as EPSDT funded mental health services, all funded separately. Rarely are organizations authorized, funded and able to provide combinations of these activities in an integrated, goal-directed fashion for any given child or family. Currently, 28% of foster children are residing in FFA certified homes.

Foster Care and Kin: County child welfare agencies are given express authority under current law to conduct reviews and approvals of relative (kin) and non-related extended family members (NREFMs) for living arrangements for children and youth. In addition, individuals may become licensed foster families through either Community Care Licensing (CCL) or the county licensing office (through contract with CCL). Licensed foster homes, relatives and NREFMs receive a basic foster care payment plus any specialized care increment paid by the county; however, for relatives caring for foster children not Title IV-E eligible, those relatives may only receive a CalWORKs cash grant. Any additional services to support the child and the caregiver come directly from the county child welfare agency.

Context of the Proposed Changes

Stakeholders in the CCR workgroups have affirmed that children/youth served by the child welfare and probation systems should have access to culturally-relevant services and supports based on their individual strengths and needs, regardless of where or with whom they live. Specifically, children should not have to be moved from one living situation to another in order to secure necessary services and supports, as moves from one living arrangement to another are destabilizing for the child and can lead to further trauma.

In addition, there is a need to leverage resources to improve services to children in care, especially mental health and education services. The Settlement Agreement in the *Katie A. v. Bonta* lawsuit (*Katie. A.*) and pending changes to the Foster Youth Services Program (i.e., the Local Control Funding Formula recently signed into state law[1]) may offer such opportunity.

Vision: The CCR Steering Committee has adopted the proposed Vision for the CCR:

- All children live with a committed, permanent, and nurturing family.

[1] AB 97, Chapter 97, Statutes of 2013.

- Services and supports are tailored to meet the needs of the individual child and family being served with the ultimate goal of maintaining the child with his/her family, transitioning to a caring, permanent family and/or preparation for a successful transition into adulthood.
- Congregate care is a short-term, high quality, intensive intervention that is part of a continuum of care for children, youth and young adults.
- There is a demonstrated commitment to support the cultural needs of the child and family, tribal affiliation and the child's sexual orientation, gender identity and expression.

Proposed Structure

Residentially-Based Services (RBS):

Existing group homes will be transitioned over time into short-term, high quality, intensive interventions used for the minority of children who cannot be safely served in their own homes or other home and community-based settings. These shall be known as "Residentially-Based Services" or RBS providers. RBS program designs will be state-approved with some local flexibility allowed in terms of the foster children to be served and services tailored to meet local needs. Providers will be licensed and regulated by DSS and CCL and utilized by county child welfare agencies to provide services and supports.[2] Since the intent is to serve children with significant behavioral or mental health needs, RBS providers will need to be subcontractors of County Mental Health Plans (or AOD for substance abuse services) to ensure the RBS provider can offer specialty mental health services to youth who meet medical necessity criteria. RBS providers must be able to effectively implement evidence-supported interventions for children in care and for youth transitioning to home and community-based care (e.g., Alternatives for Families: A Cognitive-Behavioral Therapy [AF-CBT], Functional Family Therapy [FFT], Aggression Replacement Therapy [ART], Managing and Adapting Practice [MAP], etc.)

All RBS providers will be required to have capacity to step-down children into family-based settings. This may be done in a number of ways, including through an RBS-Wraparound program or therapeutic foster care, and it may be provided by the RBS provider organization or through MOU with a separate Child, Youth and Family Agency (CYFA, see below). In addition, per the *Katie A.* Documentation Manual, RBS programs may provide Intensive Care Coordination (ICC) for up to 30 days to enable the transition to home and community based care. Once a child is placed with a family, the RBS provider may continue to support the transition through provision of ICC and Intensive Home Based Services (IHBS) as a Wraparound provider. RBS providers will be required to work with county child welfare and mental health[3] agencies in "Child and Family Teams" (CFTs)[4] to develop and implement individual care plans for the child and family that incorporates youth and family voice and choice.

[2] The RBS pilot counties contract with RBS providers, but this may not be necessary as RBS expands statewide. For example, MOU's between county agencies and RBS providers are also options. Additional discussion is needed through the CCR – RBS workgroup.

[3] The RBS provider will be a subcontractor of the County Mental Health Plan (MHP) and will have staff clinicians participating on the CFTs. Reference to "county mental health" is intended to be general to align with the *Katie A*. Core Practice Model.

[4] Child and Family Team is defined in the *Katie A.* Practice Guide as a team comprised of the youth and family and all of the ancillary individuals who are working with them toward their successful transition out of the child welfare

Specific services to be provided or accessed through RBS programs will include[5]:

1. Comprehensive care coordination
2. Family engagement and empowerment
3. Intensive short-term residential stabilization and assessment
4. Intensive interventions focused on achieving permanency
5. Ongoing family support
6. Educational engagement and enrichment
7. Individualized child, youth and behavioral health
8. Non-traditional support and assistance

RBS will be required to submit plans of operation to include a description of the resources, supports and capacity of the RBS program to transition foster children and youth into home and community-based, permanent homes. The plans must be developed with input and support from the local child welfare agency and county mental health plan and may include options such as having Wraparound services (IHBS and ICC) housed under RBS, contracting with other providers for Wraparound or Therapeutic Foster Care (TFC, including Multi-dimensional Treatment Foster Care [MTFC], Intensive Treatment Foster Care [ITFC], etc.) and/or contracts with CYFAs (see below).

Referral into RBS: RBS programs will coordinate with county agencies to identify and intake youth who are appropriate for this program. These decisions will be guided by the assessment process described below, with input from the child, youth and family and based on any additional criteria or process developed by county agencies and RBS providers.

***Financing*:** Rates will be funded using both Title IV-E and Medi-Cal/EPSDT (separate funding streams) with local match from county realignment funds, in a manner and at levels yet to be determined.[6] Other possible sources of funding include Wrap Reinvestment savings and MHSA; however these funding sources can vary across counties. DSS and DHCS should consider financing strategies for RBS, ICC/IHBS (Wraparound) and TFC that can maximize federal funding for the services needed by all children, youth and families. Performance incentives or allowance for performance incentives should also be built into this model.

Child, Youth and Family Agencies (CYFAs):

CYFAs would replace FFAs and would provide and support a broad spectrum of family-based and foster family-based care, including support for kin caregivers and NREFMS, and serving children with lower level of needs to those with high level needs that may require Therapeutic Foster Care, RBS or Wraparound (IHBS & ICC) care. Under this model, both private non-profit organizations as well as county child welfare agencies could operate CYFAs.[7] All CYFAs will be licensed/certified by CCL.[8] CDSS

system. It includes a facilitator which may be a mental health provider, social worker or probation officer. It also includes service providers.

[5] See attached for expanded information regarding these services.

[6] Other funding sources may also be identified, such as Alcohol and Drug Services, etc.

[7] This would be a local county choice to operate as a CYFA just as it is now as counties may operate FFA's.

Audits and Rates Division will continue to review rate applications and perform audits of CYFA providers. In addition, CYFAs would be required to submit program statements to CDSS that must have the input and approval of the county child welfare agency where the CYFA is headquartered.

In order to support a true "continuum" of care and address the need to improve supports to county licensed foster homes and relative/NREFMs, it is strongly encouraged that CDSS and counties determine how to incentivize county child welfare agencies to also become licensed/certified as CYFAs, or to contract with private CYFAs, so that the new rate methodology can support all foster children in care regardless of their living situation. It is widely recognized that foster children who are cared for by county-licensed foster parents, relatives and NREFMs would benefit from additional supports and services [9]

As a condition of licensure/certification, the CYFA must identify the program and service categories it intends to deliver in one or more of the following areas:

1. *Early Intervention Services (Differential Response, Kinship Support Services, Family Preservation, and Family Resource Centers):* These agencies specialize in providing supports and services to children and families who are at risk of abuse and neglect. Funding and support are largely from Title IV-B, Prevention and Early Intervention (PEI) funds, local realignment, etc. Program statements should include, at minimum, a description of the prevention and early intervention strategies that are grounded in the five protective factors known to help prevent abuse and neglect, which is based on the Strengthening Families framework. Providers of these services would have to be certified to provide the services utilizing a process not yet developed.

2. *Transition and Assessment*: These programs would provide temporary emergency living situations upon a child or youth's entry into protective custody or between living situations while the child, youth and his/her family members are being assessed for needs and strengths to determine needed living situation specialization, supports and services and treatment and therapies. These programs w provide care and supervision during this short-term transition period.

3. *Transition to Adulthood (may include THPP, THP+ FC):* May be individual home-based or group settings where youth are provided supports and services geared towards transition to independent living in a supported and supervised environment. These will serve as alternatives to group homes for youth who prefer living situations that are not family-based. In these settings, concerted efforts must be made to help youth develop lifelong connections with caring adults who can commit to supporting youth into adulthood.

[8] FFA's currently certify foster parents. CYFAs will continue to certify foster parents; however, discussions are underway with respect to potential changes to the certification and training requirements of foster parents under the CYFA model, as well as oversight and enforcement.

[9] Three scenarios are possible under this proposed framework and would be options available to counties to choose from: Option 1: "Status quo" in that foster families/relatives are licensed/approved by the county and receive the basic foster care payment plus any SCI. Option 2: Status quo and in addition, the county could refer the foster parent/relative to the CYFA for services (which requires an additional payment based on assessed strengths and needs) and Option 3: County could become a CYFA and "certify" FFH/relatives, thus providing both payments and services directly. Counties get to decide what option to pursue.

4. *Permanency Services:* The majority of CYFAs will fall under this category which is intended to serve children who cannot live with the primary caregiver from whom they were removed and placed in protective custody. These agencies will provide care & supervision, permanency-focused services & supports, and post-permanency services in a family or foster family-based setting. This includes children with lower level of needs to those with high level needs that may require Therapeutic Foster Care, RBS, Wraparound (IHBS & ICC) care or children with special health care needs or who are medically fragile who may need intensive support and supervision.

Although the aforementioned categories are distinct, CYFAs must demonstrate the internal capacity, or through collaboration and/or formal agreements with other CYFAs and community-based organizations that have the capacity, to offer services across all domains in support of the continuum of care for children, youth and families.

Mental Health Services though CYFAs: Efforts must be made to increase access to mental health services for all foster children including children, youth and families served through CYFAs. There are several options that should be considered to accomplish this, and locally, county child welfare and county mental health plans should be required to jointly[10] determine which option to implement as appropriate to local needs:

1. CYFAs can become contractors of County Mental Health Plans (MHP) and thus CYFAs can bill directly to deliver specialty mental health services.
2. CYFAs can become certified by MHPs as a pre-requisite to contracting with MHPs. Although certification isn't a subcontract, it can expedite access to EPSDT services specifically for foster youth who are placed out-of-county with a CYFA.[11]
3. County child welfare and mental health departments can establish local agreements for serving children placed in CYFAs, consistent with local *Katie A.* Joint Management Protocols. For example, in San Diego County, the MHP operates a single contract that serves all children placed into their local foster family agencies.

CYFA Financing: Additional discussion is needed to determine the specific components of the rate to be paid per child served by the CYFA, including roles and responsibilities of CYFA staff and certified foster parents. Generally, the CYFA rates will be comprised of:

- CYFA Administrative and Social Worker Staff costs, including overhead
- Board, care and supervision (paid to the foster parent to cover the costs of the child or youth's living situation)
- Services and Supports (through the agency)
- Mental health services (paid for through EPSDT or other mental health funding sources)

[10] Consistent with the *Katie A* Settlement Agreement which requires county child welfare and county mental health to implement a core practice model for ALL children in foster care with mental health needs.

[11] It does so by streamlining the process so that the jurisdiction county MH agency can quickly contract with the host CYFA for EPSDT services as needed.

Assessment Process

County child welfare and probation agencies are statutorily responsible for decisions regarding living arrangements, case planning, and implementing case plans to promote the child's safety, permanency and well-being. The process of properly identifying the child, youth and family strengths and needs is therefore critical in making these life-altering decisions. This section of the document describes the recommended process to identify strengths and needs, the appropriate living situation and needed services for foster children, youth and families, including services provided by RBS and CYFAs. In addition, this section identifies how the assessment process can be linked to payment levels in RBS and CYFAs.

A team-based approach is desired as it improves information for case planning and brings others to the table to support the implementation of the case plan, which ultimately can improve outcomes for children, youth and families. All children and families served by the child welfare system should be assessed for their specific child and family strengths and needs with input from a child and family team. The goal is to assess as early as possible upon initial contact with the child welfare system to inform decisions on living arrangements and service planning and at frequent intervals throughout the child's stay in care. However, a comprehensive, team-based assessment may not always be possible (eg. Emergency placements, etc.). In these situations, the child welfare/probation agency should obtain as much information as possible to inform its decision on living arrangements and services to best meet the needs of the child/youth and family, with additional follow up from child and family team members later. In addition, the assessment should be guided by a standardized tool or set of tools that are used by county agencies and other team members.

The assessment tools and process should be used to guide the county child welfare/probation agency in determining living arrangement (e.g. relative, county-licensed home, CYFA, RBS, etc.), the supports and services to be provided by the RBS, CYFA or other agency, amount of care and supervision needed from foster caregivers, and any need for specialized, treatment services (e.g. Mental health, AOD, etc.).

The goals of the assessment process described above are to:

- Identify the most appropriate living situation for the child;
- Identify the strengths/needs of the child, youth and family for services and support to inform case planning,
- Identify the child or youth's level of need for mental health or other treatment services; and
- Determine payment levels for CYFAs to deliver needed services.

Specific components of the assessment should include:

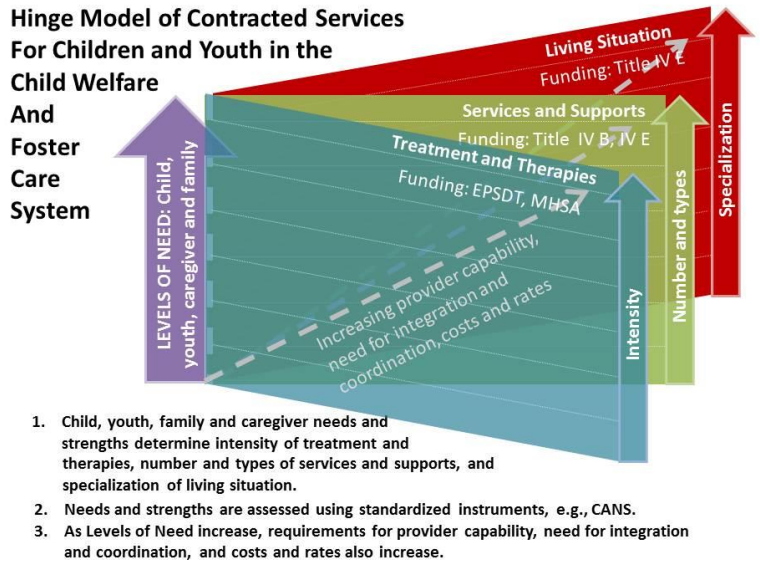
a. *Living Situation:* Determine the level of specialization in living situation needed to meet the child's physical, behavioral, and emotional needs. Determine, first, if a child or youth may remain in his/her home; if not, if the child or youth can live with a relative or non-related extended family member (NREFM), how the child or youth may live with siblings, and options that keep the child in close proximity to school and community. Information from parents,

caregivers, and medical staff (i.e., diagnosis of medical conditions) would inform this portion of the assessment. May also factor in additional supervision for emergency/crisis care when protection and safety of the child or youth is an immediate need. In addition, the basic costs of board and care will vary by age of the child.

b. *Supports and Services:* This portion of the assessment would identify the needs of the child and family to meet case plan goals, such as family reunification, or transition to permanency or independent living, and may include services and supports such as transportation for medical appointments, visitation support, coaching and support from agency staff in the home (beyond the monthly visits from the county case worker), youth skills development, etc. For many youth in care, this will also include family finding and engagement activities and linking youth to a permanent, caring adult.

c. *Treatment and Therapies:* This portion of the assessment identifies needs for trauma and mental health treatment, substance use treatment, behavioral intervention (as well as educational and developmental needs) of children entering care as well as for children while in care to measure their progress and changes over time. Mental health screening and assessment, which is a requirement under the *Katie A.* Settlement Agreement, will be performed using research-based and recognized screening and assessment tools administered by county child welfare, county mental health, or care providers based on local practices (per the *Katie A*. Core Practice Model).

Rates Based on Assessments of Needs and Strengths: Living situation, services and supports should be determined based on the combination of the assessments noted above. However, the best interest of the child and current mandates to place first with relatives/NREFM's, with siblings, etc., as noted in (a) above will always be the first priority. The results of the assessment could then be translated into Levels of Board and Care, Services and Support, and Treatment and Therapies that define payments to CYFAs.



Using the adjacent "Hinge Model," children, youth and their families can be assessed to determine their strengths and levels of need for specialization of living situation, numbers of supports and services, and intensity of mental health treatments and therapies. Foster care rates would reflect this assessment of Living Situation, and Services and Support, while EPSDT services and payments would be based on the level of need for Treatment and Therapies.[12] These levels may be tiered (e.g. 1-5) and

[12] Unless living situation for a non-federally eligible child is with a relative caregiver, in which case the payment will be a CalWORKs rate. This may change based on further discussions with stakeholders.

corresponding rates developed per tier.

For children with mental health treatment needs, mental health services would be funded through a separate EPSDT payment to the provider. An important goal of the CCR effort is that all RBS providers, and most CYFAs, should be able to contract with the county Mental Health Plan to either directly provide, or subcontract for, mental health services for children who are assessed and found to have mental health needs can receive services.

Higher need, however, does not necessarily translate to a more specialized living situation. Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Behavioral Services (TBS) are intensive services designed for children and youth with significant mental health needs and may be offered in home and community-based settings such as in CYFAs.

As stated previously, referral into RBS programs will be driven by a number of factors that include the results of the assessment (including MH assessment), input from the Child and Family Team that includes youth and families, and any other locally-determined process. Child safety based on high acuity of mental health needs which cannot be met at the lowest level should be a primary factor when placing children into more restrictive care settings.

Accountability and Performance

Transition to statewide RBS and CYFA models will be a major undertaking for the state, county agencies, foster families and community service providers. Stakeholders will need to identify the state, county and agency staffing needs to support these major changes.

State, county and service-providers will all have important roles to play to ensure successful implementation of the reform recommendations:

State:

- CCL will continue to license and review RBS and CYFAs to ensure facilities are safe and meet CCL Health and Safety Code requirements. CCL will also monitor for complaints and coordinate with DSS Program Staff and County CWS and MH staff to resolve complaints though a joint process that will need to be developed.
- DSS Program staff, with input from stakeholders, will set training, education and experience requirements for local RBS and CYFA program staff, and will review and update licensing and certification standards for foster families that align with expected outcomes.
- DSS Program staff will review program statements, issue rate letters, perform periodic audits, prepare and make available to the public performance outcomes[13], and provide technical assistance to county agencies and service providers.
- DSS will identify and meet training needs (with County agencies, private providers and stakeholders) on a continuous basis to support quality improvement.

[13] Note that specific performance outcome measures are not described in this paper as they are being discussed in the CCR Outcomes and Accountability Workgroup.

- DSS will coordinate with DHCS to facilitate access to mental health services for children in foster care and to address any issues that arise impeding access to mental health services.
- DSS Program Staff will monitor performance and will develop a process that will base contract renewals on meeting accreditation[14] and performance outcomes.
- DSS, in collaboration with county agencies, will identify the automation needs in the CWS case management system to support implementation of these recommendations and will work with counties to implement those changes.

County Agencies[15]:

- CWS (and possibly mental health) will work with local providers to inform RBS and CYFA program plans that are submitted to the State.
- County agencies will include service providers whenever feasible in local training on practices in serving youth in care, in support of the child and family team activities and improving service delivery.
- CWS and MH will monitor performance outcomes of RBS and CYFA providers and use that information locally to inform decisions. County agencies will be encouraged to meet with local providers periodically to discuss barriers to improving performance.
- CWS should work with service providers to support their efforts to achieve accreditation status, including but not limited to, providing technical assistance, participating in exit reviews, etc.[16]

Service Providers:

- RBS and CYFAs will become accredited through an approved national accrediting body. Licensure will be contingent on acquisition and maintenance of national accreditation. This process should start first with RBS programs, and expand eventually to CYFAs, but the timing should be determined based on further discussions with CDSS and stakeholders.
- RBS and CYFA administrators will commit to continuous quality improvement by linking staff to training and engaging with county agencies with respect to performance monitoring, service planning and other practice implementation.
- RBS and CYFAs will monitor performance outcomes and participate in regular meetings with county staff to address barriers to improved performance. If performance standards are not being met, the RBS and CYFAs will prepare plans to improve performance that will be required for licensing renewal.
- RBS and CYFAs will include county partners in training on practice implementation, in support of the child and family team activities and improving service delivery.

Fiscal Considerations

The CCR effort is intended to reduce use of residential care, and reform the use of FFAs, at minimum. This proposal embraces the Legislature's intent, and the vision and goals of the CCR Stakeholders, to

[14] This proposal supports accreditation but defers to the CCR Workgroup to determine if this should be required for licensure.

[15] This framework currently discusses only CWS agencies; Probation agencies will need to be consulted and factored into this framework.

[16] The county role will need to be defined and counties may need training on how to support this process.

increase quality of care and improve child, youth and family outcomes. These goals cannot be accomplished without an up-front investment of funding.

The CCR Reform effort will undoubtedly result in changes to services and staffing for RBS and CYFAs. Given that this proposal improves services to children, youth and families served by these agencies, and increases oversight and training, these critical changes are likely to increase overall costs incurred by counties for foster care programs and services. However, on an individual basis, the per-child rate may increase, decrease or have no change, as the rates will be based on the specific needs of children, youth and families and costs will reflect the number of children served and the duration of services.

In addition, we anticipate new costs due to the increased demand on county staff resources, specifically with respect to social workers' added time to complete placement assessments using standardized tools, matching children with placements, identifying and leveraging services, and working with agencies in child and family teams.

These up-front investments will be critical in achieving the goals of the CCR and improving outcomes for children, youth and families. This investment will likely yield savings in the future for the child welfare system, and in other systems including criminal justice, welfare, public health, and education.

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Attachment A - Required Elements of RBS Providers: this is the "what," it's up to the Providers to determine the "how"

1. Comprehensive Care Coordination	2. Family Engagement & Empowerment	3. Intensive Short-term Res. Stabilization & Assessment	4. Intensive Permanency
Identify a person responsible for CCC Participate in ETDM Develop and monitor an individualized plan of care by facilitating a CFT process at intake and at every 90 days until discharge with child, youth, and family specific staffing where appropriate Unifies all elements of child, youth & family care and service such as school, ILP, care plan, clinical care, reinitiation, ACP, meds Address linkages with other special care systems that may be involved with the child, youth and families including developmental/physical disabilities, substance abuse, etc. Provide or arrange for aftercare follow-up after graduation from RBS for evaluation	Identify a person responsible for providing family finding Identify a person or agency responsible for family engagement Identify a family/youth advocate Offer EES training Support and ensure family involvement in services/interventions and therapeutic service activities Incorporate Family-to-Family strategies for appropriate support and engagement	Maintain safe and supportive residential milieu through adequate and well-trained staff Identify trained individual(s) responsible for behavioral, medical, emotional stabilization Identify trained individual(s) responsible for conducting thorough evaluation & assessment in all needed areas and prepare a report summarizing the results and sharing them via CCC Implement a plan based on these Provide needed medical support Provide emergency intervention services Transportation services necessary for community integration and family involvement	Ensure that staff are trained and competent in permanency practice Provide alternative family finding Identify a resource for time limited bridge care pending permanency when short-term residential is no longer needed Provide/ensure availability of parent and family education to prepare for permanency Have flex funds available
5. Ongoing Family Support	**6. Educational Engagement & Enrichment**	**7. Individualized Child, Youth, & Family Behavioral Health**	**8. Non-traditional Support & Assistance**
Provide or arrange for support groups for parents and in-home or other respite Provide or arrange for peer-to-peer family education and support Provide or arrange for social and recreational activities for families and children to reengage and learn to enjoy living together Provide or arrange for parent training for parents of SED youth Provide or arrange for support for sibling relationships 24/7 phone and mobile crisis support available post-discharge Available respite beds for crisis situations Provide or arrange for community- specific resource development and access to support family reunification and well-being Provide or arrange for family respite as needed in the location that best meets individual child, youth, and family needs	Identify a person responsible for provider-school liaison services to ensure effective assessment and transition to community school Ensure availability of ILP services and provide support for participation Ensure access to community resources such as youth groups, sports, volunteer work and support for participation as part of the treatment plan Provide or arrange for tutoring via youth mentors Plan or arrange for family partners to assist with educational advocacy	Plan or arrange for family therapy via a LPHA Plan or arrange for EBP or promising practices for treatment designed to address the specific needs of the child, youth and family Plan or arrange for a referral for psychiatric services Provide or arrange for substance abuse and co-occurring disorders securing assessment and treatment Complete referral and fax to Access Team for TBS when needed Provide or arrange for screening, assessment and delivery of individualized mental health services Ability to provide 1:1 staffing and monitoring when appropriate	Transportation Holistic care (complimentary medicine) Provide flexible hours for service provision Accommodate special and unique personal characteristics, culture, and preferences of child, youth and family Incorporate child, youth, and family spirituality, customs, sexuality and nutritional choices into plan of care Provide LGBTQ training for staff Provide or arrange for age appropriate sex education as needed pursuant to the individualized plan