A Framework for Integration of

Congregate Care Reform Efforts in California

Submitted by the Congregate Care Reform Integration Committee
Membership includes:

County Welfare Directors Association
Chief Probation Officers of California
County Mental Health Directors Association
California Alliance of Children and Family Services
Youth Law Center
California Youth Connection
California Institute of Mental Health
California Legislature
California Judicial Council
California Department of Social Services
California Department of Mental Health
California Department of Alcohol and Drug Programs
University of California, Berkeley
University of California, Davis
Casey Family Programs
Sierra Health Foundation

Developed under the auspices of Casey Family Programs
in partnership with Sierra Health Foundation

January 21, 2011

Acknowledgements

The Executive Committee of the Congregate Care Reform Integration Project thanks the following individuals for their contributions to this report through participation in "strategic thinking" sessions, workgroup meetings and reviewing drafts of the framework. Their respective organizational affiliations are listed for informational purposes only; the document was not submitted for formal approval.

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The Executive Committee extends special thanks to the 14 former foster youth who shared their experiences in focus group sessions. Their combined wisdom served as a constant reminder of the importance and urgency of congregate care reform. The Executive Committee also thanks the project staff for capturing the essence of the deliberations and preparation of this report: Sylvia Pizzini, Project Facilitator, Michael Wright, Managing Partner of The Results Group; Isha Leinow, Organizational Development Intern; and Jenny Ventura, Social Work Intern.

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The Congregate Care Reform Integration Project

In late 2010, the Congregate Care Reform Integration Project (CCRIP) reviewed 13 current initiatives that are interconnected with the reform of residentially-based services for children and youth who:

- Are being served by California's child welfare, probation and/or disabled students systems, and
- Require a high level of mental health behavioral or therapeutic interventions, alcohol and drug treatment and/or special education services.

The CCRIP Committee consisted of representatives from the 13 initiatives and the programs listed above (see Appendix A for a description of the CCRIP process). As the Integration Project progressed, it quickly became evident that these initiatives have many principles and practices in common. Because the Residentially Based Services (RBS) project incorporates many of the principles and practices of the new philosophy for residential care, the Committee used that project's work as a foundation, and incorporated additional elements from the other reform efforts into the Integration Framework presented on the following pages. The goals were to outline how the 13 initiatives can work together to achieve the vision of a new system of care for children and families and to provide the California Department of Social Services and its partners with a roadmap for congregate care reform that builds on and leverages existing efforts.

The Integration Framework for Congregate Care Reform

The Integrated Framework is intended to guide the evolution of the array of services for children and families served by child welfare, probation and special education programs in the coming years. Some of the principles and practices are already being implemented, at least in parts of the state, but many are visionary and will require fundamental change in statutes, regulations, funding mechanisms, program practices, and organizational cultures at the state, county and provider levels. The Integration Framework consists of the following elements:

1. A **vision** for a system of care, in which congregate care is part of a continuum of services.

2. A set of **outcomes** for the system of care.

3. **Principles and guidelines** for program practices, evaluation and continuous improvement.

4. Recommended **system of care; funding and rates/costs; data collection and evaluation; and leadership and structure** to improve the system of care.

5. An **implementation roadmap** describing how the various reform initiatives interconnect and provide initial guidelines for implementation.

6. An **action plan** for congregate care reform.

Items one through five are presented in this document. The sixth item, a detailed action plan with responsibilities assigned to specific individuals is to be developed under the leadership of the California Department of Social Services in partnership with other state agencies, county agencies, provider organizations and consumers as a separate document.

1. Vision

The System of Care

The system of care, of which congregate care is one part, operates with full collaboration and shared accountability among public and private service providers of all disciplines. It is continually informed by data that measure outcomes and support continuous quality improvement, and appropriate funding is provided to achieve positive outcomes.

Congregate Care in the Continuum of Services

> "Group homes should offer more extracurricular activities for youth on a voluntary basis. We need more experiences out in the community so that we can learn what is 'normal.'" - Former Foster Youth

Congregate care is a short-term, high quality intervention that is part of a continuum of care. It is used only for children and youth whose very challenging needs cannot be met in a family-based setting, and is one component of a plan of services and support to achieve permanency, safety and well-being. Youth who enter congregate care after age 17 may opt to remain in that setting while developing a network of caring adults who will provide guidance and emotional support upon emancipation.

2. Outcomes

Outcomes for children and families:

- ***Permanency*** – Children and youth achieve reunification with their birth families or lifelong parenting connections to family and other persons who are important to them; they have support systems in place to maintain these connections after they leave the residential setting.

- ***Well-being and Safety*** – Children and youth are safe; their educational, mental health, social and medical needs are met during their time in care; and support systems are in place to maintain their safety and well-being after they leave the residential setting.

- ***Satisfaction*** – Children, youth, families, and caseworkers in the aggregate describe the services they receive as helpful and state that the voices of children, youth and families are heard.

> "Some foster children are blessed with a good home; we *all* should have one."
> - Former Foster Youth

Outcomes for the System of Care:

- Services are coordinated across agencies and providers at the state and local levels and are seamless from the perspective of children and families.
- Decisions are data-driven at the policy, program, and individual child and family levels.
- Continuous improvement is an integral part of the system of care, supported by state policy, availability of relevant data, and appropriate and adequate funding.
- Funding is aligned with desired program outcomes.
- All funding streams are appropriately maximized (including federal financial participation).
- Accountability and oversight supports the measurement of desired outcomes and ensures the appropriate use of resources.

3. Principles and Guidelines

System of Care Principles

The system of care will fully address the needs of children and families who are being served by the child welfare, probation and disabled student systems, and whose needs include mental health services, alcohol and drug treatment, and/or special education services. To do so, organizations placing or serving these children and youth will:

- Coordinate with other public or private agencies including child welfare, probation, mental health, alcohol and drug programs, education, special education and nonprofit service providers so that the child and family receive an integrated, comprehensive set of services that meet their needs.
- Fully involve the child and family in the assessment and planning processes initially, and also at key decision points throughout the evolution of the child's path to permanency.
- Consider a range of options including community-based family alternatives that may preclude the need for residentially based services, such as Wraparound Services, Intensive Treatment Foster Care (ITFC), Multidimensional Treatment Foster Care (MTFC), and, with appropriate services and support, treatment foster care, foster family home, relative home and birth parent home.

> "Treatment is more effective when youth are clued into what staff are thinking and are involved in developing the treatment plan."
> - Former Foster Youth

- Utilize congregate care as a short-term residentially-based setting for services when children cannot be safely treated in family settings. Residentially-based programs focus on permanency and prepare children and youth to return to the community, continually assessing their readiness to transition to the most appropriate family-home alternative for each individual child. The extension of foster care up to age 21 will additionally challenge congregate care to support youths' continuing participation in school, higher education or vocational training.
- Coordinate and maximize the use of funding streams across programs so that children who meet eligibility criteria have these resources available in a timely and streamlined manner. County and state agencies responsible for dispensing these funds collaborate to effectively integrate, blend or braid funding when submitting claims to their respective funding sources (for example, Medi-Cal Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Mental Health Services Act (MHSA), Alcohol/Drug treatment and Special Education funds).

Program Practice Guidelines

The process for assessing and meeting the needs of the above-described children and families will include:

- County interagency placement councils (child welfare, probation, mental health, alcohol and drug, education and nonprofit providers) jointly consider referrals for service and what services are needed and the setting where these services can most effectively be delivered.
- Family Team Decision-making meetings are conducted by the responsible placement agency and bring together the child, family members and representatives from other agencies involved in the child's life to discuss the needs of the child and family, identify strengths and challenges and identify placement options.
- Once the child has been referred and accepted for services, the service provider convenes a child and family team to further assess the strengths and needs of the individual child and family,

> "Group Homes should help youth transition from group home living to a family home. I had difficulties when I went to live with my sister because I didn't know how to do basic things like using cell phones and taking the bus."
> - Former Foster Youth

such as mental health status, alcohol and drug issues physical health challenges, educational progress and any juvenile justice involvement. A comprehensive assessment is conducted utilizing the best assessment tools appropriate to the situation and determine the specific plan of treatment and services that will be provided. The child and family are fully involved in the assessment and planning processes. All assessment results for an individual child and family are made available to everyone on the team, including the child and family members, in a format or with the appropriate supports in place that the meaning of the results can be understood by the family. The provider and the placement agency agree upon the case plan for each child and family which they believe will achieve the outcomes described above – safety, permanency and well-being.

- The plan of services includes who is responsible for what pieces of the plan. Implementation of the plan will often require problem-solving to remove barriers to services. Youth and family voice, trauma-informed services, caregiver training and a constant focus on permanency are important elements of success. A system of checks and balances should be in place with the community service providers responsible for day-to-day coordination and delivery of services, and the county placing agencies responsible for ensuring progress toward each individual child and family's goal and the quality of services they receive (in collaboration with quality assurance by the county and state agencies).
- The Family Team Decision-making meetings are the setting for the exploration and development of recommendations for the best setting for individualized care, looking at all options including birth parents, relatives, fictive kin, county foster family, certified treatment foster care parent, intensive treatment foster care parent, multidisciplinary treatment foster care parent, congregate care group homes, and, in the four counties testing RBS, residentially-based treatment centers.

Evaluation and Continuous Quality Improvement (CQI) Guidelines

Evaluation and CQI take place at both the system level and program level:

- Evaluation of the system of care as a whole should be required to determine how the system supports program and individual achievements and where it needs to be streamlined or changed. State, county and provider leadership should engage children, families, direct service staff and management staff in system evaluations, generate improvement plans and guide ongoing progress in their implementation. The existing county-level System Improvement Plans and state-level Program Improvement Plan, which are required by the federal government as a part of California's Child and Family Services Review, could serve as the means to conduct this work.

> "Length of stay in group homes will not be reduced unless there are families who can care for youth with mental health challenges."
> - Former Foster Youth

- Evaluations of programs operated by nonprofit agencies, by both the agencies themselves and by county and state oversight agencies, can provide essential information regarding what practices work and what practices should be changed to more effectively achieve positive outcomes for children and families. Evaluations should minimally include review of policy and program manuals that reflect evidence-based or evidence-informed practices, training curricula, program audits, data regarding outcomes and information on child and family satisfaction. For program models that are shared between providers or jurisdictions, assessments of program fidelity or model adherence should also be included. Child and family teams should be empowered to be part of the program evaluation process. Evaluations should address the effectiveness of crisis stabilization, interventions addressing behavioral issues, aftercare component and planned re-entry for intensive support as long as the child is consistently moving toward permanency with a family.

4. Recommendations: System of Care; Funding and Rates/Costs; Data Collection and Evaluation; Leadership and Structure

System of Care Recommendations

State and county polices and funding strategies should be developed or revised to:

1. Reflect the new vision, outcomes, principles and guidelines for congregate care into the larger system of care:
   - From: currently functioning as placements of either convenience or last resort, with children who are placed in them almost always remaining there until emancipation.
   - To: short-term, permanency-focused treatment interventions for children who need intensive services and cannot safely receive them while living with families in the community, but then transition to family-based settings as quickly as possible.
2. Drive a system-wide commitment to youth and family "voice and choice," including participation in assessment; strategies for that child to achieve safety, permanency, well-being; development of treatment plans; decisions regarding what services will be provided in what settings; and preparing the child to successfully transition to adulthood.
3. Promote individualized care based on a comprehensive assessment of the needs of each child and family's strengths and needs.
4. Fund and implement (a) prevention/early intervention strategies such as Family Finding Engagement and Support (FFES) to secure safe, permanent family homes for children so that they do not need congregate care and, (b) sustainability strategies such as aftercare services to support children in permanent family homes after they have received treatment in congregate care.
5. Address the recent legislative changes expanding the age of youth in the child welfare system to age 21, including the establishment of appropriate education and employment policies for these youth; further, emphasize that in conjunction with permanency preparation for successful adulthood must be a priority beginning at least by age 15, and that there is an expectation that many youth will be able to leave foster care with permanency before age 18, and certainly by age 21.
6. For those children who need to remain in congregate care because of a health or mental health condition, support efforts to establish permanent connections and facilitate the transition from the children's system of care to young adult residential services prior to age 21.
7. Determine whether children now in congregate care could better be served in family-based alternatives. In order to be consistent with the RBS and CCRIP Committee's philosophy that congregate care is a short-term, permanency-focused treatment service for children whose challenging needs cannot be met in a family setting, as part of the ongoing assessment and planning process, each child in congregate care should be tested against this criterion. In order to offer more appropriate family settings available for children who do not need congregate care, concerted efforts should be made to develop family resources, such as expanded FFES, using permanency strategies developed under the federal grant project, training current county and Foster Family Agency (FFA) certified foster parents to be ITFC or MTFC parents and school-based foster family recruitment.
8. Indentify all current and potential funding sources that are available to support the CCRIP vision and outcomes, e.g., Foster Youth Services in the schools can be a great resource for recruitment of foster families. In addition, Foster Youth Services funding can be used as match for child welfare funding.

Funding and Rates/Costs Recommendations

9. Provide state-level leadership and guidance to develop a coherent, systematic funding approach which effectively utilizes funding from a variety of sources including child welfare and mental health.
10. As fully as possible, coordinate child welfare, mental health, alcohol and drug, juvenile justice, and special education services to allow an more efficient and seamless continuum of services for children and families; to promote effective use of funding across programs and funding streams; to minimize the need for multiple case managers from different agencies; and to eliminate competing or non-coordinated goals.
11. Build congregate care rates on the RBS program model and fund both cost of care and cost of therapeutic, FFES and individualized services that are in each child's service plan. Funding should be flexible and maximize available federal resources from Aid to Families with Dependent Children Foster Care (AFDC-FC) Maintenance funds, AFDC-FC Administrative funds, Medi-Cal EPSDT funds. Medi-Cal Drug funds, Substance Abuse Treatment funds, Minor Consent funds and Drug Dependency Court funds, as appropriate.
12. Incorporate program effectiveness, as measured by outcomes achieved, into new rate-setting policies and procedures for residential services.

Data Collection and Evaluation Recommendations

13. Create a checklist of the guidelines and principles outlined above as the roadmap for developing the capacity of the entire system of care so that family-based alternatives are more readily available and the need for congregated care is reduced. Collect and analyze data for accountability purposes and monitor outcome, building on data systems that are already in place. Congregate care providers and county child welfare, probation, mental health, alcohol and drug, and special education agencies will need to measure performance for many purposes, including continuous improvement, performance-based contracting, and rate-setting. County staff should monitor outcomes for individual children. The provider should collect outcome data related to and have limited access to Child Welfare Services/Case Management System (CWS/CMS) in order to collect relevant data and prepare program evaluations for County funders. Continuous quality improvement measures related to outcomes that are based on evaluations should be developed, implemented and re-assessed on an ongoing basis.

Leadership and Structure Recommendations

14. Build leadership necessary for the establishment and maintenance of the systems of care into the roles and responsibilities of the California Child Welfare Council. The Council is ideally suited to address the challenges and barriers to a smoothly operating system of care, particularly in systemically and effectively utilizing all relevant funding sources and sharing information across agencies at the state and county levels. (Each of its four Committees – Early Intervention and Prevention; Permanency; Child Development and Successful Transitions; and Data Linkage and Information Sharing – are already dealing with issues related to cross-system coordination and collaboration.) It is a logical next step to include within the Council's purview the establishment of an explicit overarching system of care for children and families, with a review of current membership to ensure all stakeholders are at the table (for example, county mental health is not represented now).
15. Continue developing ways to strengthen the system of care as a key item on the agenda of the State Interagency Team. While this body is informal, the membership is well positioned to create the relationships needed for cross-system coordination and collaboration, including braided or blended

funding and information sharing among state agencies. The State Interagency Team agencies could look at funding opportunities that would support the continuum of care and advocate for financial reforms that support the Congregate Care Reform outcomes related to safety, permanency, well-being and child and family satisfaction.

16. Assign oversight responsibilities related to program outcomes, funding mechanisms and interagency collaboration to staff from the California Department of Social Services working in the child welfare, rate setting and audits and licensing programs; staff from the California Department of Mental Health working in the Early and Periodic Screening, Diagnosis and Treatment and Mental Health Services Act programs; staff from the California Department of Alcohol and Drug Programs; and staff from the Department of Education working in special education programs.

Implementation of Recommendations

Implementation of the above recommendations will provide more clarity about the challenges of children who require congregate care (and other high levels of care such as ITFC and MTFC), the outcomes achieved, the lessons learned and the costs associated with the services provided, including state, county and provider costs. In addition, there should be greater transparency regarding how the system of care works both programmatically and fiscally.

To begin the implementation process, a workgroup comprised of state, county and provider representatives of the Committee developed a "parallel track roadmap," presented in Section 5, page 11. The workgroup members realized that there were two major challenges to moving forward: (1) ensuring that policymakers have the latest information regarding what is known from other congregate care reform efforts both nationally and internationally, and (2) applying the lessons learned during the multi-year RBS development effort to the benefit of clients served by congregate care programs beyond the programs in the four test sites taking advantage of evaluation data as soon as it is available. The roadmap addresses both these challenges by including the first challenge in the duties of a combined Rate Setting/RBS Workgroup and by allowing the second challenge to be addressed through interim measures over the next six months to two years that build on what is already known and what is learned over time from RBS experiences.

In order to make the roadmap truly actionable, the California Department of Social Services will lead the development and implementation of a detailed action plan and timetable – in partnership with other state agencies, county agencies, provider organizations and consumers – with responsibilities assigned to specific individuals.

5. Parallel Track Roadmap for Implementing Recommendations
Combined Group Home Rate-Setting and RBS Committee
Timeframe for completion: Six Months to Two Years

Fact finding and analyses: **Prerequisites to inform an improved rate-setting system**	**Building RBS features into existing programs based on what works:** **Interim measure to build on knowledge developed by RBS Workgroup**
➔ Gather, analyze and make recommendations based on what is already known in the broader congregate care field: ▪ Business Model (UC Davis). ▪ Performance-based Contracting (UC Berkeley). ▪ RBS data from four Counties testing the model (RBS Project). ▪ Data from other states. ▪ "Specialty" residential services, e.g. substance abuse programs and programs for children who are developmentally disabled. ▪ Congregate care alternative programs, e.g. ITFC, MTFC, Wraparound. ▪ Funding "template," i.e., description of how congregate care and alternatives are funded. ➔ Examine, analyze and make recommendations regarding organizational issues: ▪ Administrative structure of state oversight responsibilities. ▪ Child Welfare/Probation and Mental Health coordination and collaboration strategies at the state and local levels. ➔ Lead cultural change that is required at all levels – state, counties and providers.	➔ Evaluate outcomes of current congregate care programs ▪ Identify key variables ▪ Seek information from CWS/CMS; Community Care Licensing Division; Audits and Rates Branch; and pilot projects ➔ Examine ways to incrementally allow group homes to incorporate desired program elements such as aftercare and transitional services, e.g., allow "points" under the rate-setting criteria for these services and interpret current regulations more expansively. ➔ Gather information from group home providers regarding their ideas for implementing RBS elements, including how to overcome licensing and other barriers that may prevent moving in this direction; current RBS providers will be a key resource. ➔ Consider using the waiver authority so that group homes can begin testing RBS components. ➔ Make information regarding current congregate care programs more transparent, e.g., post information on the web regarding accreditation status; licensing violations; last licensing visit; consumer satisfaction (using tools such as the Youth Satisfaction Form); and CWS/CMS web site information.

A detailed action plan with explicit timelines and responsibilities assigned to specific managers is to be developed under the leadership of the California Department of Social Services in partnership with other state agencies, county agencies, provider organizations and consumers as a separate document.

Appendix A: About the Congregate Care Reform Integration Project

Project Purpose and Initiatives

In October 2010 Casey Family Programs, in partnership with Sierra Health Foundation, provided funding for a short-term "Congregate Care Reform Integration Project" (CCRIP) consisting of strategic thinking sessions, focus groups and interviews with child welfare stakeholders. The purpose was to reach agreement regarding how to best integrate and leverage the work of the 13 congregate care projects or activities now underway, planned, or being considered (please see Appendix B for a summary of the initiatives and Appendix C for a summary of the policy and funding changes of the initiatives) and to provide a roadmap for proceeding with the congregate care reform efforts. The goal was to have a written Integration Framework by December 31, 2010, including a plan of approach for moving forward with congregate care reform in California so that all the projects will be interconnected and coordinated. The Framework must also recommend the optimal sequencing and timing for each of the recommendations and identify key participants to be included in the development and implementation of reform. Specifically, it must include recommendations regarding the following key elements of reform:

- Rate Classification Level restructuring, including desired outcomes, monitoring, data collection and accountability processes.
- Roles and responsibilities, internal structures and functions of existing governmental activities such as licensing, rate setting and auditing
- Integration of RBS Reform with the broader congregate reform project and how the broader changes envisioned can inform and enhance RBS
- Business models of group home care
- Fiscal models that include braided and/or blended funding streams
- Enhancing transparency and information sharing

The CCRIP Committee

The California Department of Social Services Deputy Director for Children and Family Services appointed a CCRIP facilitator and established a CCRIP Committee comprised of a total of 51 representatives from the following public and nonprofit agencies:

County Welfare Directors Association
Chief Probation Officers of California
County Mental Health Directors Association
California Alliance of Children and Family Services
Youth Law Center
California Youth Connection
California Institute of Mental Health
California Legislature
California Judicial Council
California Department of Social Services
California Department of Mental Health
California Department of Alcohol and Drug Programs
University of California, Berkeley
University of California, Davis
Casey Family Programs
Sierra Health Foundation

The CCRIP Committee facilitator conducted pre-meeting interviews with nine stakeholders including a former foster youth, child and family advocates, a researcher, a foster care ombudsman, and representatives from a county social services association, a county probation association, a nonprofit provider association, and state social services and alcohol and drug programs. (See Attachment I for themes that emerged from these interviews). The facilitator then convened the CCRIP Committee for four strategic thinking sessions focused on the development and integration of various congregate care reform projects underway or planned (see Attachment II for a description of projects). At its first meeting, the

Committee agreed that all of the reform initiatives under consideration focus on changes to one or more of the following: vision, policies, program practices, outcomes, and funding. These topics formed the agenda for the first three meetings (see Attachment III for meeting notes in these subject areas). At its final strategic thinking session on December 10, 2010, the Committee revisited the content related to all elements of the Integration Framework, and agreed upon a draft to be finalized off-line by the due date of December 31, 2010.

Presentations of Foundational Information

During the first three meetings, Committee members presented an overview of each of the initiatives and their associated program, policy, and funding innovations. In addition, several presenters provided relevant information to inform the discussion. After an initial presentation by University of California Berkeley staff of publicly available data (http://cssr/berkekey.edu/ucb_childwelfare), a presentation using these data showed that the total foster care caseload declined from 111,757 children in January 1998 to 63,493 in April 2010. (These numbers include children in all types of foster care placements, e.g., foster family homes, relatives, foster family agencies, group homes, guardians, shelters and both Child Welfare and Probation cases.) Over the same twelve-year period, group home placements have declined at approximately the same pace as total foster care placements. Group home placements started at 10,854 in January 1998, rose to 11,329 in April 2003, but then declined steadily to 6,703 in April 2010. The percentage of the total foster care population in group homes is approximately the same now (10.6% in April 2010) as it was in January 1998 (9.7%). Excluding the Probation population, the percentage of the total child welfare Foster Care population in group homes is almost exactly the same same now (6.46% in April 2010) as it was in January 1998 (6.55%). If one starts the comparison of total foster care placements and group home placements in April 2003, then the decline in group home placements is much faster than the decline in total foster care placements. It was noted that this reduction in group home placements is remarkable when one considers three key factors that have changed since 1998:

1. State hospital beds for children with mental health issues have been completely eliminated since 1998; many of the several hundred children who would have been placed in State hospitals in 1998 are now placed in group homes in California or in out-of-state facilities.
2. The number of delinquent youth placed at the State level, with what was called the California Youth Authority and is now the Division of Juvenile Justice, has dropped dramatically, from over 8,000 youth in CYA facilities in 1998 down to less than 1,500 in April 2010. Many delinquent youth who would have been sent to CYA in the past are dealt with at the county level, where group home placement is one of several alternative services.
3. The number of children 0 to 18 years of age increased from 9,691,602 in 1998 to 10,613,742 in 2010, an increase of 922,147 or 9.5%.

In looking at the future of congregate care, we need to recognize the success of the partnership among the state, the counties, and the private nonprofit providers to develop group home programs with shorter lengths of stay; to develop family-based alternatives to group homes in Intensive Treatment Foster Care (ITFC) and Multidimensional Treatment Foster Care (MTFC); and to provide effective support services through Wraparound which permit children safely to remain at home or to be placed with relatives or guardians. There is still a great deal that can and should be done to improve the quality of congregate care and services and the outcomes for the children placed in them, and to develop new and expand existing alternative family-based placement alternatives. At the same time we should recognize what we have accomplished so far so that we can build upon it.

A presentation from a researcher at the University of California, Davis, focused on congregate care business models. While this study is still in process, the researcher presented initial findings, noting that our current system is based on a static value proposition described as “caring for youth that are not able

to live in a family home foster care setting." This contrasts with the value proposition that drives most of the reform initiatives, which, as stated by the RBS counties, is "Providing youth with educational and therapeutic services that enable them to return to families and communities and less restrictive environments." The consultant also emphasized the need that the public oversight agency has regulations in place and capacity for oversight necessary to prevent fiscal and programmatic abuse.

The California Foster Care Ombudsman is in the process of evaluating group homes across the state by looking at system of care issues such as staff, living environment, program focus, program services, education, outcome data and perspectives of youth placed in the group homes. While the evaluation is still underway, the Ombudsman has drafted seven preliminary recommendations which the group reviewed, targeting the following areas: accreditation; Community Care Licensing oversight; staff training and certification requirements; research and evidence-based practices; oversight of quality services and youth outcomes; rate reimbursement model that includes premiums for the severity of problems and incentives for finding permanent families.

Drawing from Current Efforts

Representatives from each of the congregate care reform initiatives provided essential information that became part of the Integration Framework. For example, the Committee found that the RBS reform project had developed material that could be utilized as a foundation for our work. In 2006, after a year of intensive deliberation, the RBS project members established the RBS Framework, *representing a level of consensus never before achievable across stakeholders regarding the purpose and intended outcomes of congregate care and the processes that must be in place to achieve them.* Next, RBS project members worked out the essential elements of program design and funding mechanisms, as well as defining roles and responsibilities of the placing agency and community providers. Four counties are now testing the RBS model. We eagerly await information on successes and lessons learned as they serve children who require short-term residential care and their families.

Also, the Committee observed that the California Child Welfare Council and State Interagency Team support cross-system efforts. The Council is a statutorily-formed advisory body co-chaired by the Secretary of Health and Human Services and a State Supreme Court Justice; it considers recommendations to improve child and youth outcomes through increased collaboration and coordination among programs, services and processes administered by agencies and courts involved in the child welfare system. The Interagency Team is an informal body comprised of representatives from multiple state agencies whose purpose is to provide leadership and guidance to facilitate full county implementation of improved systems that benefit communities and their common population of children, youth and families. The Team promotes shared responsibility and accountability for the welfare of children, youth and families by ensuring that planning, funding and policy are aligned across state departments to accomplish the following goals: (1) build community capacity to promote positive outcomes for vulnerable families and children; (2) maximize funds for our shared populations, programs and services; (3) remove systemic and regulatory barriers to optimum delivery of services; (4) ensure policies, accountability systems and planning are outcome-based; (5) promote practice that engages and builds on the strengths of families, youth and children; and (6) share information and data.

In 2007 the Research and Training Center for Children's Mental Health published an Issue Brief with advice based on case studies conducted over a five year period; it offered the following recommendations to achieve effective community-based systems of care:

1. Create an early and consistent focus on values and beliefs which will, in turn, provide a significant anchor for system development regardless of the challenges faced.

2. Translate shared beliefs into shared responsibilities and shared action; most importantly share a commitment that things really can be done differently and that stakeholders can be empowered to make change.
3. Recognize that opportunities for action are not linear; take advantage of opportunities to leverage systems change when and where they occur.
4. Know that being concrete does not mean being static; being concrete about values and strategic about action allows stakeholders to be flexible in system response and proactive in system development.
5. Be aware that structural change, without a solid anchor in values and beliefs, rarely has the sustained positive impact that system of care implementers seek.
6. Remember that the system emerges from the choices and actions of stakeholders throughout the system, including family members, front-line staff and community partners.

Roadmap Development Workgroup

Once the Committee completed its review and analysis of current and planned Congregate Care Reform initiatives, a small workgroup comprised of representatives from state, county and provider agencies met to determine the best way to move forward on the recommendations. The workgroup determined that rate-setting reform and program reform must go hand-in-hand, and therefore created a roadmap in which the rate-setting and RBS development would be combined into one committee. Further, the workgroup wanted practices that benefit children and youth to be available sooner than the multi-year testing period for RBS, and therefore included development of interim measures to be implemented based on RBS knowledge gathered to date and to be learned over time through the evaluation process. The items on the roadmap (page 11) are targeted to be implemented over the next six months to two years.

Next Step – Detailed Action Plan

While the roadmap serves as a guide, a detailed action plan with explicit timelines and responsibilities assigned to specific managers is needed to achieve the outcomes desired through implementation of the recommendations. The California Department of Social Services in partnership with other state agencies, county agencies, provider organizations and consumers will lead this effort and produce the plan as a separate document.

Appendix B – Current and Planned Congregate Care Reform Efforts in California

Project/Activity	Description
Residentially Based Services Reform Project (RBS)	California's Residentially-based Services Reform initiative seeks to transform the state's group homes, currently providing long-term congregate care and treatment, to permanency-focused interventions combining short-term residential stabilization and treatment with follow along community-based services to reconnect youth to their families, schools and communities. Guided by the RBS Framework and designed to enhance services and expedite permanent family placement for youth needing some time in a residential setting, RBS reforms and evaluates the way group homes are utilized in California, the range of services they offer and how they are reimbursed for these services. RBS partners include the California Department of Social Services, the counties of Los Angeles, Sacramento, San Bernardino and San Francisco, the California Alliance of Child and Family Services and its member agencies, Casey Family Programs, Sierra Health Foundation and the Child and Family Policy Institute of California.
Congregate Care Reform	Developed in response to the cost-of-care lawsuit, a workgroup comprised CDSS and county staff developed several short-term and longer-term strategies to reduce usage of congregate care, and increase opportunities for foster children to receive services within home-based settings; the ongoing workgroup is to be expanded to include additional participants,
California Partnership to Reduce Long Term Care	5 year federally-funded pilot project targeting African/Native-American youth. Led by CDSS, includes: 14 counties, California Child Welfare Co-Investment Partnership, CWDA, Child and Family Policy Institute of California, Administrative Office of the Courts, UC Berkeley, California Youth Connection, Center for the Study of Social Policy. Goal: an integrated casework practice model (FFE, TDM's, Integrated Mental & Behavioral Health, Innovative Family-Caregiver-Child Engagement Strategies, Post Permanency Supports).
Family Finding and Engagement	The Family Finding model, developed by Kevin Campbell offers methods and strategies to locate and engage relatives of children living in out of home care. The goal of family finding is to provide each child with the lifelong connections that only a family can offer.
ITFC and MTFC	Intensive Treatment Foster Care (ITFC) serves children with serious behavioral problems who would otherwise require group home Rate Classification Level 9-11. Multidimensional Treatment Foster Care (MTFC) is an evidence-based service that may be offered by ITFC parent. Only Foster Family Agencies (FFAs) are authorized to provide ITFC and MTFC.
IFPS	A recent study by the National Family Preservation Network demonstrated that Intensive Family Preservation Services (ITFS) is an effective way to prevent long term foster care in youth of all ages, especially older. The study refuted the belief that these services are effective only for younger children.
Group Home Rates Work Group	Per Trailer Bill. Workgroup of legislative policy/budget staff and stakeholders (foster youth, providers, children's advocates, and counties) consider the larger context for how the system can better incorporate a spectrum of placements and services.
Title IV-E Waiver Capped Allocation	A federal waiver demonstration project in Alameda and LA counties (Child Welfare and Probation Departments) in which these counties received a capped allocation of federal Title IV-E funds and were given flexibility in the use of federal and state foster care maintenance and administrative funds.
Wraparound Services	Enacted in 1997 by SB 163 "to provide children with service alternatives to group home care through the development of expanded family-based services programs." The program permits flexible use of state foster care/group home funding for this purpose.
Boys Republic Waiver	Enacted in 2007, CDSS is waiving the RCL regulations and point values for formal post-graduate education in setting the rate level for Boys Republic, which contracts with eight counties to serve delinquent boys in its residential facility and is reimbursing them at the RCL 10 rather than the RCL 5 level that it otherwise would have received. Boys Republic and participating counties must track and report on standard performance outcome measures to determine if experience and training to serve this population can be equally or more effective.
AB 12 CA Fostering Connections Act	New statute (9-30-10) that includes a number of improvements to the Kin-GAP program and extends foster care to age 21. There is a need to ensure that the availability of foster care beyond age 18 does not reduce efforts to achieve permanency for foster children as soon as possible.
CA Child Welfare Council	The CWC, a State advisory body, will consider recommendations to improve CWS outcomes through increased collaboration among programs, services and processes administered by agencies and courts in 4 focus areas: Prevention/Early Intervention; Permanency; Child Development/Successful Youth Transitions; and Data Linkage and Information Sharing.
State Interagency Team for CYF	SIT provides leadership to align planning, funding and policy across state departments and ensure full county implementation of improved systems. Members: HHSA management; Judicial Council, CDSS, DHCS, DMH, Corrections, and Education Department.

Appendix C: Cross-Referencing the Initiatives' Policy and Funding Changes

Policy Changes

The Committee compared the fundamental policy exceptions and changes that were made as part of each congregate care reform initiative. To promote a system of care, all policies were considered from the perspectives of child welfare, community care licensing, mental health, alcohol and drug, and probation services. The following summarizes the policy exceptions and changes for each reform initiative.

RBS Reform Project **proved to be the guiding force that we should use for all congregate care reform initiatives.** RBS changes existing policy and practices to evolve group homes from "placements of last resort and then the end of a process for children who are placed in them" to "short-term treatment programs for children who need intensive services and cannot safely receive them while living with families in the community." The RBS Framework is referenced in the statute authorizing the four RBS pilots (located in San Bernardino, Los Angeles, Sacramento and San Francisco Counties). RBS incorporates substantial policy, funding, program and practice changes that should be used to inform all congregate care reform efforts.

The Congregate Care Reform Workgroup, comprised of county, state and a nonprofit providers association, meets informally as needed to work out issues related to congregate care reform efforts before proposing formal policy or procedural changes.

The ***California Partnership*** is funded by a federal grant focusing on disparate treatment and outcomes for African American and Native American foster youth, including youth in group homes where the disparities are higher than in the foster care program as a whole. The Partnership pilot counties are exploring ways to prevent foster care placement ("front end" services) and sustain permanence with aftercare services ("back end" services), two essential components of a system of care that complement the RBS component.

Family Finding and Engagement and Support (FFES) policies are essential to support the safety, permanency and well-being goals of the Congregate Care Reform Initiatives. Policies around child and family engagement and support need to be strengthened; "finding" family members is not enough; helping them connect or reconnect with youth and other family members so that they can support the youth in working through past traumas and in progressing on their individual Child and Family Team Plans is essential. The RBS philosophy of integrating and retaining a focus on outcomes will inform a system of care business model for effective FFES. We need defined roles of county agencies, nonprofit service providers, other community agencies and family members. Issues of confidentiality related to FFES policies have been addressed in briefs issued by the Child Welfare Council and Administrative Office of the Courts. One important role for county agencies is to begin FFES as soon as a child enters the system so that a natural system of support can be in place for the child while under the county agency's jurisdiction and after the case is closed. Nonprofit provider agencies, including the congregate care reform initiatives, should then build on these initial FFES efforts for the children and families they respectively serve.

Intensive Treatment Foster Care (ITFC) and Multidimensional Treatment Foster Care (MTFC) provide highly individualized care, and usually operate most effectively when there is only one child in the home. Policies that provide for mental health services to be offered to children placed with ITFC/MTFC parents are essential for the success of treatment. While policies are in place regarding the training requirements for parents to become certified ITFC/MTFC providers, they should be strengthened to include documentation that learning objectives were achieved.

Intensive Family Preservation Services policies allocate special funds to support parents and other caregivers upon reunification with their children in the 16 pilot counties. This "aftercare" opportunity is found in other initiatives as well and is believed to be an essential part of sustaining success.

The Title IV-E Waiver policies emphasize assessment of the child and family needs and strengths, and provide the ability to utilize federal Title IV-E funding flexibly to achieve the best outcomes for children and families because cost-savings from program innovation may be reinvested in prevention, family finding, and other efforts to reduce congregate care and achieve permanency, and to provide post-permanency support. Team decision-making structures, including public agency and nonprofit service providers and the child and family, are in place to guide planning and monitor progress, and the policies allow flexibility to operate a true system of care.

Wraparound Services policy calls for youth and family "voice and choice" as a key program philosophy and provides for highly individualized, community-based care. The Child and Family Team create a strength-based case plan that is transparent to everyone. At the same time the a medically-based mental health treatment plan developed to access Medi-Cal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) funding is a separate process and includes an assessment of mental health functioning, a diagnosis or diagnoses, a treatment plan and, when wraparound services are ending, a discharge summary. Often the youth and family do not have access to the mental health treatment plan which may compromise the "voice and choice" philosophy. Policies should be developed to support more coordination across child welfare, mental health, juvenile justice and education systems and/or seamlessly integrated services and effective systemic utilization of funding.

The Boys Republic Waiver has implication for rate-setting policies and the opportunity to re-look at the logic behind the current rate setting system. Based on evaluations to date, the hypothesis that longevity of staff is positively correlated with good outcomes appears to be holding true. As group home rate setting policies change, there is still a need to look at staffing, costs, programs, and accountability.

AB 12 represents a practice shift to serving young adults in addition to youth, and policies need to be developed that focus on education and employment for the young adults in foster care who are not seriously disabled while at the same time ensuring that the availability of foster care services beyond age 18 does not reduce the effort to achieve permanency for foster children as soon as possible and thereby reducing the number of children who emancipate from foster care. There is also a need to develop policy for serving disabled young adults and adults in foster care, including licensing and program standards for those who require residential care. We need to build programs to meet the needs of those children who remain in congregate care because of a health or mental health condition, including transitioning from congregate care to young adult services prior to age 21. Planning and preparations should begin with youth before they reach age 18.

The Child Welfare Council, in addition to promoting a robust system of care, is working on policies for data and information sharing; for leveraged reinvestment of savings achieved through specialized youth permanency services; and Medi-Cal policies for youth living out-of-county, including role of providers. The Council is also looking at the issues of aftercare for foster youth living out-of-county and how to include Mental Health and Probation in the system of care.

Performance Based Contracting was discussed by the Committee including the merits of statewide policies that would require Performance Based Contracting for congregate care services. These types of contracts are now at individual county discretion. The example of the Los Angeles County Scorecard for Group Home and Wraparound Services was shared with the Committee, and it has these features:

- Based on federal measures for safety, permanency and well-being.

- Monitors for contractual, programmatic, practice and fiscal compliance.
- Benefits include the fact that everyone is on notice regarding what the county is watching.
- It is in the county's best interest to support the provider, and it is in the provider's best interest to meet outcome objectives.
- Looks at individual child level, e.g., tutoring and environmental level, e.g., landscaping.

Funding Changes

Similar to the process used to look at policy implications of the various Congregate Care Reform initiatives, the Committee compiled the fundamental funding exceptions that were part of each congregate care reform initiative and identified funding strategies to be included in the CCRIP Framework. To promote a system of care, all funding sources from child welfare, community care licensing, mental health, alcohol and drug programs and probation services were considered.

RBS Reform Project payments include cost of care as well as the cost of working with families, thus requiring a waiver from statute and regulations related to the current Rate Classification Level rate-setting system which funds care and supervision costs as allowed by the federal Title IV-E rules. Beyond funding for the time in care, there is a need to fund aftercare services based on studies regarding the effectiveness of these services for sustaining family reunification and permanency. The funding for RBS is based on projected costs of staffing patterns which is the highest cost item for congregate care programs. The costs include estimates for recruiting and retaining qualified staff. The payment models incentivized shorter residential stays and permanency while balancing risk (with the providers bearing the most risk in terms of costs); and put a cap on "savings" (Los Angeles County). Uncertainties prevented the use of more performance-based incentives initially.

The funding for RBS included those activities that can be time-studied as Title IV-E allowable. Providers are now completing time studies and documenting the costs for the first time. Existing mental health funding is coordinated with RBS. RBS counties find that looking at "cost of outcomes" is different than looking at "cost of points" as dictated by the current RCL system although they are constrained by the necessity for cost neutrality.

To work smoothly, the collaboration between the county and provider partners must have transparency and engender trust. There were a number of reasons behind the design of the current RCL system, such as inequities across counties and administrative difficulties. At that time (20 years ago) the need for transparency was not a goal of the rate design system, and it is now seen as essential to success.

The Congregate Care Reform Workgroup has examined issues such as how to improve efficiencies in accessing both child welfare and mental health resources. The forthcoming Katie A settlement will address what is billable under Early Periodic Screening Diagnosis and Treatment (EPSDT) and may facilitate this effort.

The ***California Partnership*** includes federal funding for five years which will cover the costs of developing and implementing strategies to reduce long-term foster care for the African American and Native American populations. Consistent with a system of care philosophy, the grant will allow for testing an integrated casework practice model including family finding and engagement, team decision making and permanency teaming, integrated mental and behavioral assessment and treatment, innovative family, caregiver and child engagement strategies and post-permanency supports.

Family Finding, Engagement and Support is currently paid for from existing foster care allocations and should be integrated with child welfare as fundamental to best practices. It is important to emphasize

that funding needs to be available for engagement and support; finding family members is not enough. In counties providing wraparound services and in the Title IV-E waiver counties, the costs of FFE may be funded by Medi-Cal EPSDT using the state and county foster care funds that become available after children are living with families as matching dollars. As we gather data to support that FFE works as an evidence-based practice, we can make the case for this use of flexible funding.

Intensive Treatment Foster Care/Multidimensional Treatment Foster Care provides a funding model for children needing a high level of care. In ITFC there is flexibility for providers and counties to design the programs needed at the local level; the downsides to this flexibility are an inconsistency in the design and practices and the fact that it is not an evidence-based practice. MTFC is an evidence-based program which does not offer flexibility but does promote practices that result in permanency for those children and families that meet the criteria for admission. It is possible that Title IV-E training funds could be used to ensure consistency in design, services and outcomes for both these models of care. Again, we need more efficient access to mental health funding to make the program work. The MTFC program reportedly has high start-up costs and requires lots of structural support; the ITFC rates have not been updated since this program was established in statute 20 years ago. Some Counties are using MHSA funding to fill the gaps. In addition to funding challenges, there is a shortage of families who want to be ITFC or MTFC parents. The requirement in MTFC to place only one child per home may compromise the fiscal viability of the program for foster parents. Another factor that may discourage families from wanting to be ITFC or MTFC parents is the fact that the AFDC-FC rates for these programs have not received regular cost of living adjustments since the original payment levels were established in 1993. Further, these rates were reduced by 10% on October 1, 2009. According to the California Alliance, the purchasing power of ITFC and MTFC rates no longer cover the costs of care because they represent only 70% of their original levels. The original minimum payment level for the ITFC-certified parents of $1,200 per month has never been raised, and, if adjusted for inflation, it would now be approximately $2,000 per month.

Intensive Family Preservation Services is funded by the federal Promoting Safe and Stable Families (PSSF) and is used to cover costs of aftercare services. Analysis of the fiscal viability of the funding to achieve desired outcomes is pending.

Title IV-E Waiver is basically a funding strategy that allows flexibility in the use of the federal and state shares of foster care funding in exchange for acceptance of a capped allocation of dollars with some provisions for increases. Under the waiver, the participating counties of Alameda and Los Angeles may reinvest foster care funds realized from the reduction of the number of children in foster care in support services to children living with permanent families. The waiver expires in June 2012; CDSS has obtained a ten month “bridge extension” and plans to request a longer term extension and also to consider expansion to include additional counties. The waiver is one of a number of strategies under discussion as part of the national dialogue regarding comprehensive child welfare finance reform.

The Wraparound Services Program Forty-seven counties have been approved or are in the process of being approved for Wraparound Services. The foster care funding allotted to each enrolled child is based on whether the child otherwise would be placed in a level 10 -11 (level 10.5) or level 12-14 (level 13) group home program. The foster care funds that otherwise would have been used for a group home payment are instead used to provide intensive services to the child and family in the community. Because Wraparound is not an option under the federal AFDC-FC program, the federal share of the rate is not available for federally eligible children. The funds may be used flexibly and any surplus may be reinvested to develop new programs and to pay for specific services needed by individual youth and families. EPSDT funding is also accessed to pay for mental health services for Wraparound clients. Some counties negotiate a standard “Wrap Rate” rather than a client-by-client rate based on federal/nonfederal eligibility in which case the county bears the risk if the level of federally eligible children increases.

The Boys Republic Waiver pilot began in 2007 in order to test a different weighting system for rate development using staff experience over staff education levels. Under the standard weighting, Boys Republic qualified for an RCL 5, when rebalanced using staff experience, it qualified for an RCL 10. Under this waiver, the "longevity" point system replaces the education point system. Based on an evaluation of the relationship of experience (longevity) to positive outcomes, this waiver will inform the deliberations of the upcoming Group Home Rate Setting Workgroup.

AB 12 funding for most young adults in foster care will support services to transition them to independent living. Workforce preparation, work experience and education will be emphasized. It is anticipated that very few of these young adults will need congregate care which will be limited to those young adults who have serious medical or mental health challenges. In addition to foster youth who become young adults while in care, the state will receive federal financial participation for youth in the Kinship Guardian Assistance Program (KinGAP) for services provided under the provisions of AB 12.