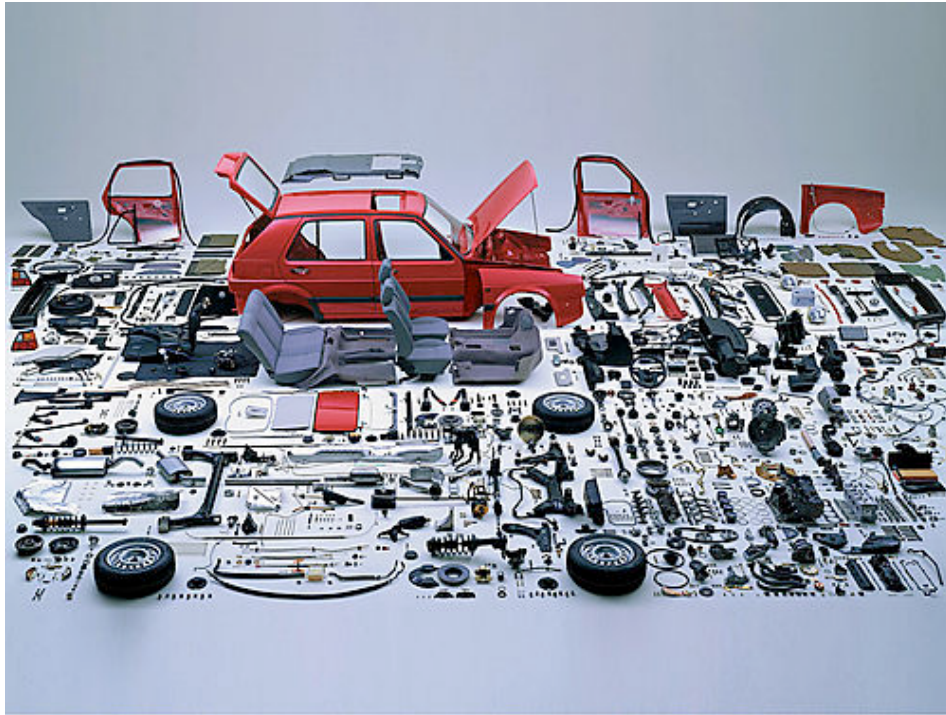


Some Assembly Required

A Workbook for Local Residentially Based Services
Reform Implementation Teams



A Resource Prepared by the California RBS Reform
Implementation Support Team

Version 1, May 16, 2008



Some Assembly Required

A Workbook for RBS Implementation Teams

Introduction

Congratulations, you have been selected as an RBS demonstration site!

... Now what?

How will you translate your vision of a better way to reconnect children and youth with their families, schools and communities into reality?

Each of the selected sites have presented a preliminary design for their new RBS system, but all acknowledge that a lot of work is needed to flesh out their designs and create a functional funding system to support their operation.

This workbook offers a series of exercises for the Local Implementation Teams in each county or consortium to use as they develop their models and prepare for implementation. Each set of questions is designed to help team members share perspectives, build better lines of communication and understanding, visualize a common design for the project, craft the components needed to carry the design forward, generate a management structure, data system, budget and implementation plan to support their operation. The steps are presented serially, but feel free to bounce around, filling in the portions where you have answers, and marking some to come back to as additional information is obtained.

Step One- Who Do You Want To Help? This section focuses on identifying and clarifying the characteristics of your target population, and generating the baseline data that will be needed to demonstrate program effectiveness and to calculate cost neutrality¹ under AB 1453's evaluation requirements.

¹ The California Department of Social Services (CDSS) is charged with determining cost neutrality for the AB 1453 demonstration. The statute does not define the precise terms for this determination and at the time this workbook was prepared CDSS had not yet established the criteria it will provide. Therefore we are offering suggestions for capturing a range of data that can be used for this calculation when the criteria are chosen. The new criteria will be shared with the demonstration sites as soon as it becomes available.

Step Two – How Do You Want To Help Them? This section is intended to help your team clarify its mission, vision, values and goals for the RBS demonstration. It looks at how care will be offered, the services that will be included, how children and families will experience your new way of doing business, the underlying assumptions about the improved impact the use of these services will have, and the outcomes that you hope to achieve.

Step Three- Who Will Be Providing The Help? This section addresses the participants and structures you will assemble to support the RBS project and the program, process and organizational changes on both the public agency and private provider sides that will be needed to deliver the care you described in Step Two.

Step Four – How Will You Pay for It? This section helps you decide how to pay for the array of services you have just put together.

Step Five – How Will You Make It Happen? This section helps you develop a strategic plan for implementation.²

Using the Workbook

Although AB 1453 provides the conceptual foundation for building an RBS system of care, it does not impose a one-size-fits-all mandate or provide an easy to follow blueprint. The intent is for each demonstration site to create its own version of RBS. Thanks to the generosity of Casey Family Programs, each county and consortium will have a project coordinator to facilitate the public agencies, providers, and youth and family representatives who will be members of each county or consortium's Implementation Team and manage the details of getting the project up and running. Each county or consortium will also have access to consultation services for assistance with programmatic or fiscal issues. Finally, through regular meetings, informal communication and postings to the RBS website, the projects will be able to share insights and solutions with one another.

This workbook is a tool to help build a common language to support this collaborative exchange. Answering the questions that form the basis for each of the four steps will help clarify the who, what and how of each project and make it easier to compare and contrast ideas and blend perspectives.

Each site will take its own path for design and implementation, but one way to use this workbook would be to hold a series of Implementation Team half- or full-day mini-retreats to develop their project design. Using the steps in the workbook should help the teams produce the four deliverables that demonstration sites are expected to submit before the end of the planning year:

² Special thanks is due to the Los Angeles County RBS workgroup who have been dealing with many of the issues discussed in this workbook and have been kind enough to share their insights with us.

1. The **Project Description**, including the participants, mission, vision, guiding principles, outcomes, strategic plan, target population baseline, fiscal baseline, data baseline, and contractual baseline of your program's design.
2. The **Voluntary Agreement**, which is the formal agreement among the project participants about how you will work together to put the design into action.
3. The **Alternative Funding Model** that you will use to support the project.
4. Any **Regulatory Waivers** that you will need to implement your project design and funding model.

This is not a product that can be used straight from the box. Some assembly is required. We hope this workbook will help with that process.

Step One

Who do you want to help?

The point of RBS reform is to help those children and youth who have the most complex and enduring emotional and behavioral needs spend less time in congregative care settings and more time building positive connections with their families, schools and communities.

Understanding who is being helped is critical to insuring that the help offered will match well with the needs presented. Each of the demonstration sites has provided a preliminary definition of their proposed target population in their Letter of Intent. For the implementation phase these definitions will have to be tightened so that it is clear who will be enrolled and the type of needs they will present, and also so we can document the impact of the assistance they receive.

A variety of attributes can be used to define the target population. Some relate to placement history and situation. Others describe the developmental, behavioral and emotional characteristics of the children and youth. And some deal with status and history of their family relationships and attachments. All have advantages and disadvantages. The Implementation Team may want to generate a definition that draws elements from each type of attribute in order to improve the functionality of the project's entry criteria.

Placement History and Situation.

The most succinct definition of the RBS target population is children and youth who are in high level group home placements and have a history of repeated and extended periods of placement; but this definition doesn't tell us much about the children or youth themselves. The population served in high-end group care tends to be diverse in both their strengths

and their needs. They could be young or old, male or female, have severe neurobiological disorders or be healthy, be the victims of abuse or neglect or have received good care at home, have suffered severe traumas or have had relatively positive life experiences, be involved in the juvenile justice system or have no history of criminal offenses, have serious educational impairments or be good learners, be abandoned by their families or have strong family ties. What they have in common is that none of the help that they and their families have received has been sufficient to resolve the concerns that led to system involvement.

The advantage of defining your RBS demonstration project's target population by placement history and situation is that it reflects the diversity that most communities' systems of care experience at the far end of their levels of care. The disadvantage is that the more emphasis that a project puts on placement as the basis for enrollment, the wider the range of resources it will have to incorporate in order to address the many different constellations of strengths and needs the children, youth and families entering the project are likely to present.

Emotional, Behavioral and Developmental Characteristics

Another aspect of the children and youth who experience extended placements in high-level group homes is that they tend to act in ways that their families and other caregivers have difficulty managing. The nature of these behaviors can vary: they may run away repeatedly, hurt themselves or others, damage or destroy the places where they are living, feel deeply sad and lost, or angry and defiant. The explanations for the way these children and youth behave also may vary: many will have had multiple diagnoses and received many different treatments based on those diagnoses; some will have suffered traumas that make it hard for them to cope with even moderate stressors; some will have neurodevelopmental challenges that require unique adaptations and accommodations in care; some will have co-occurring disorders that require collaborations between service disciplines that may have difficulty working together.

The advantage of using diagnostic or descriptive characteristics to define the target population is that it may help focus the range of services that the RBS system will have to include in order to meet their needs. The disadvantage is that some children and youth may have accumulated contradictory diagnoses, so it's hard to know which one to go by – unless the inability to form a diagnosis that results in successful treatment is itself a definitional criterion. A disadvantage of using bad behavior as a guideline for selecting the target population is that different unmet needs can be expressed in similar actions. What helps one child or youth turn things around may exacerbate another's problems.

Family History, Relationships, and Status

Some children and youth who have been in placement a long time have little or no contact with their parents and other family members. Some may have been neglected or abused by

their parents or caregivers or have other unresolved family conflicts. Some may struggle relating to their parents or caregivers because of attachment issues. In other cases, advocacy by deeply involved and committed parents and guardians may have led to a placement in residential care because that was the only place the family felt that the child or youth could get the help that they needed.

The advantage of using family history and relationships as element in defining the target population is that family connection and reconnection is a fundamental goal of RBS reform. The disadvantage is that it may be difficult to identify specific aspects of family history that will serve as useful discriminators for identifying the members of the target group.

Other Factors

Other factors that may influence a Local Implementation Team's definition of a target population will be the size of the group to be included in the demonstration project, the most pressing unmet needs in the community, the resources available from the participants in the project, and the results of efforts that have already been undertaken to reduce the county or consortium's reliance on long-term out of home care.

Multiple Target Populations

Some of the RBS projects are considering multiple target populations. That way they can bring a tighter focus of resources and processes to the response they make to each of the groups. The exercises that follow can be used in either case. When the Implementation Team is developing multiple target populations they should, however, take into consideration whether different resource pools will be used for each group, and if so how potential enrollments will be screened and guided into the correct response pathway.

Step One Exercises

1. Describe your target population(s) as objectively as possible in terms of the criteria you will use to define eligibility for enrollment in your project. Craft a definition that will allow the staff managing the selection and intake process to reliably distinguish between those referred children and youth who are members of the proposed target group(s) and those who are not. Use the following table to record your results:

- To provide baseline data to help in determining cost neutrality, estimate the current average annual per child state general fund share of the foster care payments expended on behalf of the members of the target population. One way to calculate this baseline is to select a representative sample of children and youth from the target population and use a historical chart review process to calculate the total number of months spent in placement during a representative two year period of their time in care, and multiply that by the per month rate for the placements. Multiply this by the percentage of the foster care payment supported by state general fund revenues and divide by 24 and the number of children or youth included in the chart review process.³ .

For the purpose of establishing the cost neutrality baseline, do not include other payments for that were used to fund the total service package for the child or youth and family during the sample time period, such as EPSDT, Mental Health Services Act, S.B. 163 wraparound or additional county revenues. (Total cost baselines for budgeting purposes will be developed in the exercise following this one.)

The following table can be used to guide the development of the cost neutrality baseline.

Calculating the per child per month cost neutrality baseline figure		
Step One: Calculate the total spent on group home board and care for each child or youth		
For each member of the sample population	Identify the months spent in placement at RCL level 10 or higher during the representative 2 year period	Multiply by the monthly rate for each level of care
Child or Youth	Months at RCL 10	
	Months at RCL 12	
	Months at RCL 14	
	Months at CTF level	
Total spent on group home placement during the two year period for this child		

³ An annualized 24-month window is suggested because it captures a more accurate reflection of the service history of children and youth who bounce among placements and are in care for long periods of time. It will be necessary to keep track of the percentage of children who are federally eligible for IV-E reimbursement, and how many are state only.

Step Two: Aggregate the total spent on all members of the group and complete the calculation	
Total spent on group home placement during the representative two year period for all children and youth in the sample	
Multiplied by the percentage of the state general fund used for these payments	
Divided by 24 months	
Divided by the number of children and youth in the sample provides the per child, per month baseline figure	

4. While the above calculation should be helpful for the AB 1453 evaluation process, measured in isolation the federal IV-E and state general fund foster care expenditures for the members of the sample group will not provide enough information to develop a complete budget for the demonstration project, since it will include a broader service array. In fact, the members of the sample group and their families may have received many more services than those funded through the IV-E board and care rate, such as behavioral health interventions, family preservation and family support assistance, and services to the child or youth's parents or caregivers that were directly related to helping the child or youth remain in or return home, such as substance abuse treatment, parent education, and expenditures to help the family retain their dwelling place. A variety of funding streams managed by different public agencies may have supported these additional services.

The Implementation Team may wish to take advantage of the chart review process to form a more complete retrospective of the sample group's service experience. By looking at the services that were purchased to enhance the care provided to the child or youth and family beyond that covered by the group home board and care rate, who paid for these services, how they were used, and the impact that they had, the team will learn a lot about what the target population is likely to need, options that may be helpful in meeting these needs, and the ways in which these options might be funded. Also, by looking at what was tried, the team may be inspired to create new options that address the gaps that remained.

This review of the enhancement services does not require statistical precision. The point is to develop a better sense of what services were used and how they were provided and paid for. The following tables offer one way to keep track of the team's observations about the patterns of care provided to the children, youth and families in the retrospective sample.

Lessons learned that can be applied to the new RBS system

Ideas for new options for funding the RBS spectrum of services.

6. Because these will be multi-year demonstration projects, calculating the size of the target population that will be enrolled requires an estimate of the rates of both entry and exit. Traditional group home care often involves many years of placement in various facilities. RBS will use shorter and more intermittent stays, but will also provide parallel and aftercare community support. Children, youth and families leaving RBS may still transition to ongoing services provided through other venues, but to provide a foundation for estimating total capacity for the demonstration project, the team may want to note the entry and exit characteristics of the children and youth in the retrospective sample.

Over the course of the time period captured in the sample, on average how many children or youth meeting your criteria for the target population entered high level group home placement each month? How many left group home placement per month during that time span? What were some of their reasons for exiting? How many exits were due to decreased needs and/or reconnection with their families or primary caregivers?

Record your results in the following table:

Average number entering the target population per month	Average number leaving the target population	Reasons for exiting	Percentage leaving for because of positive outcomes
What is your team’s initial estimate of the number of children and youth who would be able to receive facility based care at any given point in time when the project reaches capacity?⁴			
What is your estimate of the number who would be supported in community based care?⁵			
What are you proposing as your average time of enrollment⁶			

Step Two

How do you want to help them?

What is your team’s vision of a better way to help the children, youth and families in your target population? What will be different about the kind of help you offer them and the way it is provided? When a child or youth and his or her family are enrolled in the new system, what will it feel like for them? How will it be different from their prior service experiences? What values will underlie the structure and operations of your new system? Why do you believe that doing it this new way will help the children or youth and their

⁴ Note: some projects are also considering distinguishing between the beds to be allocated for initial facility based care, i.e. entry beds, and those that will be used for intermittent care for services such as stabilization and respite.

⁵ Under RBS, community based care is a constant and includes both parallel services provided while the child or youth is in placement as well as follow-up and aftercare services offered when the child or youth is at home or in another family-like community-based option. Thus this number should reflect estimated total enrollment at capacity. The team may want to distinguish between those receiving community-based care plus facility-based services, and those receiving community-based care only.

⁶ The average time of enrollment will help you estimate the number leaving the project during the demonstration period, and any new enrollments that may occur during that time.

families achieve and sustain better outcomes? What will these improved outcomes be and how will you know if they are being achieved?

In this step, your Implementation Team begins the process of turning its members' separate dreams into a common reality.

The first element of this process is developing a shared mission, vision and values. Although everyone on the team may agree that better options are needed for the children and youth who are now spending extended periods of time in group home placement, they may not be of one mind about what those options should be.

The team's mission should be a succinct statement of what your team will commit itself to accomplishing through RBS reform. The vision is a description of how that mission will be carried out, a picture of how the new approach will work. The values provide the project with a sense of direction to start with and reminders for correction along the way.

The power of a mission statement is not in the words the statement contains, but the passion that informs those words. One way to develop a mission statement is to give each member of the team a chance to talk about his or her personal role and goal in RBS reform. After everyone has spoken, see if a common phrase or expression captures the essence of your combined effort. In the business world, the most famous and shortest mission statement was Pepsi's: "Beat Coke". Yours might be a bit longer, but however it is phrased it should serve as the touchstone for your ongoing efforts. Every time the team has to choose among options, the question should be, "Will doing this help us ... [*insert the action verb and object from your mission statement here*]?"

The function of a vision statement is the same as an architect's rendering of a new house, and it differs from the implementation plan in the same way that a picture of the house differs from the blueprints that will be used to build it. One way to generate a shared vision for your new RBS system might be to imagine how it will look from the perspective of a child or youth and family that is participating in it. Put yourselves in their place and imagine the services response you would want to experience. What values and guiding principles flow naturally from looking at the project in this light?

The next element of the design process is articulating a theory of change to explain why you believe your new way of helping will be more effective. A theory of change puts into words the mechanism through which your team believes your new approach to providing care will produce better outcomes for the target population, and specifically identifies the measurable outcomes that will indicate whether the theory behind the new model is accurate.

The final element of the design process is to assemble the various pieces into an integrated service array that will be made available through your new model and the processes that will be used for accessing and delivering those services.

Mission and Vision

What is your team hoping to accomplish? After listening to each team member’s personal expression of his or her mission or goals, test a number of brief statements that capture the team’s shared passion for change, then choose one that captures the heart of your effort.

Our Team’s Mission Statement

To help clarify your team’s vision of a new RBS system, start by exploring the type of experience you would like to have if you or your child was a member of the target population.

Describe how children and families will experience the process of moving through recovery and reconnection in your new RBS system?

Now translate that internal experience into a short description of what your new system will look like. This is your marketing statement for selling RBS to your community’s stakeholders. It has to be sufficiently short and straightforward to allow someone who is not closely involved with group homes and social services to not only understand what you are going to build, but also see why you are building it.

Our Team’s Vision Statement

Values

This is an opportunity to instill your core values in the guiding principles of your new design. For values to become guiding principles they must not only be implemented but also produce results. Use the table below to list critical values your team wants to see expressed in the new RBS system, explain how those values will be implemented, and describe the impact that implementing those values will have.

Transforming Values into Guiding Principles		
Value	Implementation	Impact

Theory of Change

Why does your team think that this new model will help children, youth and families in the target population achieve better outcomes? And what are the outcomes that will demonstrate the effectiveness of your new model? This is a chance to explore the logic behind your approach.

A theory of change has four components:

- A. For a group of people with these characteristics >>>
- B. If we provide these services >>>
- C. Then we should see these results >>>
- D. For these reasons >>>

Your team has already completed the first two components. Part A is your definition of the target population. Part B is your vision statement. Now pin down the changes or outcomes that you hope to help the children, youth and families in your project accomplish. Try to formulate your goal statements in a way that builds on what you learned about the outcomes that were being achieved by the children, youth and families in the representative sample that you used to generate the baselines for your target population. Also try to make your statements as measureable as possible, either in quantitative or

qualitative terms. The three basic categories for outcomes are safety, permanency and well-being. What are the characteristics your team wants to measure to demonstrate improved performance in your new model? What changes in those characteristics do you hope to achieve compared with those reflected in the retrospective sample?

Basic Outcome Categories	Specific Outcome Elements for each Category	Baseline Outcome Measures from the Sample Group	Outcome Targets for the New RBS System
Safety			
Permanency			
Well-being			

To finish off the theory of change, your team should explain why doing things differently in your new model would produce these improved outcomes. Given the strengths and needs of the target population, how will your new service inputs connect to better outcomes? The purpose of the RBS demonstrations is to prove that our new approach actually works. We have to articulate the reasons behind our choice of actions if we are going to determine whether those choices are effective.

Imagine that a dispassionate observer asks you the simple question, “So why are you doing it this way?” Your response, which technically is called an operational hypothesis, should capture the kernel of the reasoning behind the design of your model.

The operational hypothesis assumes that certain things you do, or certain ways in which you do them (your inputs) will result in certain changes in the knowledge, skills, understanding, relationships and resiliency of the children, youth and families who are in your system and the people who are helping them (your outputs) and that these changes will manifest themselves in improved results that can be observed in the lives of these children, youth and families (your outcomes).

The following table is offered to help your team put the operational hypothesis underlying your theory of change into words.

Articulating the Operational Hypothesis (I.e. the reasoning behind your service model)		
These service inputs:	Should produce these outputs (i.e. effects or changes):	Which should result in these improved outcomes:

Service Array and Access

Although a wide variety of service options are likely to be a part of each site's RBS system, the available options can be arranged in the following categories:

- **Comprehensive care coordination services** including facilitating child or youth and family teams and preparing and guiding the implementation of plans of care.
- **Family engagement and empowerment services** such as parent partners, family finding and family engagement.
- **Intensive short-term residential stabilization and assessment services** that can be accessed at the outset of enrollment and from time to time as needed during the course of care.
- **Intensive family preservation services** that would occur while the child or youth is receiving facility-based services to form a basis for reconnection or connection and continue afterward to assist in the transition back to home, school and community.
- **Ongoing family support services** following the period of intense family intervention to maintain the connections that have been made, assist in addressing ongoing issues, and forestall removal from the new home setting, including in-home services and respite opportunities.
- **Educational engagement and enrichment services** to improve the ability of children and youth to re-enter and prosper in their local school systems.
- **Individualized child, youth and family behavioral health services**, including but not limited to:

- Psychiatric, psychological, developmental, behavioral and substance abuse assessments and treatment
- Therapeutic Behavioral Services
- Family-focused interventions and treatment, such as Multi-Systemic Therapy, Functional Family Therapy and Family Effectiveness Training.
- Individual-focused interventions and treatments, such as Dialectical Behavior Therapy and Trauma-Focused Cognitive Behavioral Therapy.
- Community-based treatment options such as Intensive Treatment Foster Care and Therapeutic Day Treatment.
- Individualized skill development and behavioral support services
- Mobile crisis intervention services
- Recovery-oriented substance abuse treatment
- **Non-traditional support and assistance services** unique to each child, youth or family situation, strengths and needs, including helping the child or youth and family bring together an informal support network appropriate to their culture, preferences and needs.
- **Other innovative options and approaches** that one or more of the sites may develop locally or that emerge in the national literature as the project continues.

Given your vision of a new approach to care, what service options do you want to include in your RBS system? How will children, youth and families participate in these services? How will the array of services be coordinated?

1. Describe the primary service options you will include in your RBS system. How will they be developed or adapted to respond to the range of unmet needs your target population’s children, youth and families are likely to present?

Type of service option	How will it be developed or adapted?

2. How will children, youth and families participate in the decision to be included in the system, in the development of the plan of care, in the choices about the type of services that will be included and the places where those services will be provided? What kinds of help will be available, how will the help be provided, who will be providing it, and what will it feel like to receive this help? What do you estimate that the average length of participation in your RBS system will be?

How will children or youth and families participate in the decision to enroll in the RBS demonstration and in their plan’s development and implementation?

Types of help to be available	Who will provide it?	How will it be accessed?

How long are you projecting the average length of involvement in your RBS system to be, what range in length of involvement are you expecting to see? And what are you estimating your rate of entry and exit to be? Expected total daily enrollment at full capacity? Percentage of time in facility based care?

Average total length of involvement	
Range in total lengths of involvement	
Rate of entry	
Rate of exit	
Total daily enrollment at capacity	
Expected percentage of time children and youth will spend in facility-based care versus community based care on an annual basis	
Estimated average percentage children or youth who will be in facility-based care versus those in community based care, when capacity is reached	

- Describe the process steps that children or youth and their families will follow in your RBS system from the point at which potential enrollees are identified until enrolled children or youth and their families complete their involvement. What will

happen at each step? Who will be responsible for carrying out each step? What criteria will they apply for key decisions along the process?

Process step	What will happen?	Who will do it?	What criteria will be used?

- Given the array of service options that will be included in your system, how will they be coordinated or integrated to provide the contiguity, consistency and continuity of care that is required for the RBS demonstration projects? (Contiguity means preservation of the primary care relationships across service environments; consistency means preservation of basic service tenor and approach across modalities; and continuity means preservation of the plan of care across stages and environments of care.)

Strategies for coordination or integration of service elements across stages and environments of care	Rationale for how these strategies will insure contiguity, consistency and continuity of care?

- Finally, it is important to put the operation of the demonstration project in context with the larger system of care. The public and private agency staff who are a part of the project will be working side by side with staff who are delivering care as usual (or may be asked to work in both systems), and some families may also be split between existing service modalities and the new system. Your proposed strategies should address both potential conflicts and opportunities for positive interactions.

Strategies for managing the interactions between the existing system and the demonstration project		
Areas of Concern and Interest		Strategies for managing the interactions
Potential Conflicts		
Potential Opportunities		

Step Three

Who will be providing the help?

Once you have clarified the target population and the process and type of services you will use to help the children or youth and families in this population, the next step is to tie down the details of who will be doing what and how they will be organized.

Although there were some variations in the organizational structures that were proposed in the Letters of Intent, the basic format was that in each demonstration site there would be one or more primary providers who would offer the majority of the services used by each enrolled child or youth and family, including both facility and community-based elements, with some additional community-based services offered by other agencies.⁷

The exercises in this step will guide your team through a more detailed description of the organizational structures and processes that you will use in the demonstration project. The description you create will ultimately translate into the interagency agreement or memorandum of understanding that the public agency partners use to join forces in the reform effort and the contracts or contract addenda that will engage the providers who will deliver the various service elements you have described in Step Two, above.

The county partners in some of the demonstration sites have already selected the service partners who will be a part of the project, others will have to wait until the system is developed and then follow county contracting procedures for engaging the service providers. The exercises are set up so they can be completed in either situation. If the services providers are already known, you can enter the specific agencies that will be fulfilling various roles. If they have not been selected, you can identify the type and number of agencies to be used in each role, with a note about how they will be selected as the project proceeds.

RBS reform involves a partnership between public and private agencies. The public agencies will form the framework for the reform effort by managing the process of referring and assessing children and youth, deciding whether enrollment in the RBS project

⁷ Besides the lead agency approach, communities have used two other models for structuring their integrated systems of care. One uses an alliance formed by the public agencies to jointly staff and operate a resource that provides some or all of the service elements. The other uses a network of providers and one or more care coordination agencies to generate plans of care for each enrolled child or youth and family that draws the service elements from the various members of the provider network. However, since the Letters of Intent submitted for the RBS demonstration phase all proposed systems that used contracts with lead agencies as the primary structure for their RBS systems, the alliance and network models won't be explored in this workbook. Instead the focus will be on whether to use a single lead agency or multiple agencies, and deciding what additional services will be accessed through collateral service providers.

2. What structures and processes will your public agencies use to select children or youth and their families for enrollment in the demonstration process and manage their ongoing participation? Which staff from the public agencies will carry out the direct care aspects of this process? How will the relationships of the various public agencies participating in the demonstration be coordinated?⁸

Operational responsibility	Agency or agencies responsible	Staff or units who will do the work	How they will carry out the work
Selection of enrollees			
Oversight of provision of care			
Coordination of service operations			
Management of fiscal operations			
Interagency collaboration plan			

3. How many lead agencies will you use and will these agencies have different emphases in the nature of the care they provide? If you have different subsets in your target population, will different lead agencies take primary responsibility for each subset? Will the lead agencies serve different geographic areas? If a lead agency is primarily a residential provider, will they also be providing community-based services? If so, how will those services be added? In general, which of the services in the array you have selected in Step Two will the lead agencies offer and which will be provided by other community partners? If the specific lead agencies have not been selected, how will that selection process take place? How will the public agencies contract with them for RBS services?

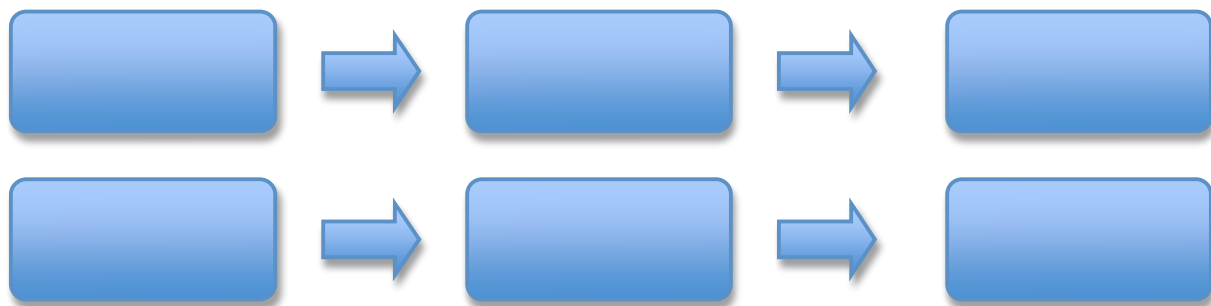
⁸ Counties should define each of these operational responsibility terms for themselves to establish clear boundaries for what functional role and tasks are expected for each area of responsibility. This will answer the question implicit in this table, which is, “What is the work within this area of operational responsibility?”

Lead agency expectations	Implementation choices
How many lead agencies will your project use during the demonstration phase?	
How will roles and responsibilities be divided up among lead agencies, if more than one will be used?	
What facility-based services will the lead agencies provide?	
What community-based services will the lead agencies provide?	
If the lead agencies will not be delivering certain community-based services, how will those services be included in each child or youth and family's plan of care?	
If the lead agency or agencies have not been selected, how will the selection process take place?	
How will the public agencies contract with the lead agencies for RBS services?	

4. What additional agencies will be used to provide community-based services? What services will they provide? How will their services be included in each child or youth and family's plan of care? If these agencies have not yet been selected, how will they be chosen? Use the following table to resolve some of these questions.

Additional agency expectations	Implementation choices
How many additional agencies will your project use during the demonstration phase to provide community-based services?	
How will roles and responsibilities be divided up among these additional agencies?	
What community-based services will the additional agencies provide?	
How will those services provided by the additional agencies be included in each child or youth and family's plan of care?	
If the additional agencies have not been selected, how will the selection process take place	
How will the public agencies contract with the additional agencies for community-based services?	

5. Create a flow chart that describes the process steps that your system will follow from initial referral through enrollment, service planning, delivery, review and modification to the point of transition.



Step Four

How will you pay for the help?

Five key questions in funding RBS are: how much to pay for the services, where to get the money, what method to use for paying providers, how to manage the various funding streams used to support the project, and how to address the risk of unexpectedly high or fluctuating costs of care. All of these factors are interrelated, but for purposes of analysis and planning, we'll start with the source, then address the method, then look at managing the funding streams, next deal with setting the amount, and finally look at risk.

Source

In Step One, you identified the various funding sources that are being used to support the services currently being provided to the members of the target population. The primary funding streams are federal IV-E and state general fund foster care dollars, which are used to pay for the residential care component of group home placement, and Medi-Cal, which can be used to pay for behavioral health services for eligible clients when those services are determined to be medically necessary. You may also have noted a variety of secondary streams, including the Mental Health Services Act, additional child welfare, juvenile justice or special education resources, and funding through adult services, welfare to work, and resources for children or adults with developmental disabilities. Remember that various indirect funding channels are also likely to be used to pay for the time of public agency employees who provide assistance to the members of the target population.

Now your task is to decide how to tap into those funding streams to support the service model you envisioned in Step Two. Step Three helped you decide who was going to be involved, and the exercises you will complete in the next section of this step will help you choose the method you will use to pay for the provision of care. But first comes the task of deciding what funding streams can and should be used.

Money for human services always comes with strings attached. Usually those strings are connected to the particular type of need that the system supplying the money was set up to address. Funding for mixed and complex needs like those being addressed through RBS is relatively rare, but California does have two funding systems set up to directly assist children, youth and families who have complex and enduring needs spanning multiple service domains. SB 163 wraparound allows redirection of the state share of group home costs into an array of community-based services. The limitations on the use of this resource for the RBS system are that the number of SB 163 slots are capped for each county, and that there are limited options for funding parallel community services when a child or youth is in a high level group home placement. California's Mental Health Services Act also provides a significant level of flexibility for strength-based behavioral health services, to the extent that funds through the act are available in a particular county and fit with that county's plan for using them.

Method

When developing a funding system method you have to decide whom you are paying and how you are paying them.

Whom: As discussed in Step Three, the implementation team has to decide whether to contract with a single lead agency, or multiple agencies, and how extensive a group of providers will provide additional community-based services beyond those offered by the lead agencies.

How: There are four options for paying these providers. Option one is to use a case rate, option two is to use a fee for service approach, option three is cost-reimbursement and option four is a combination of the first three options.

In a **case rate system**, providers and payers make their best estimate of what it will cost to provide the identified services and then enter into a contract that defines how much of the service the providers will deliver for how long for a negotiated amount. This often is reflected in a standard per-child per-month fee, even though the services any particular child receives in any given month will vary. In a pure case rate system, the lead agencies will be expected to subcontract with community partners for any additional needed services using a portion of the monthly payments that they receive.

In a **fee for service system** the contract indicates the amount that will be paid for a certain service but each provider (whether a lead agency or an additional community partner agency) is only paid when that service is used.

In a **cost-reimbursement system**, lead agencies and additional providers use an open accounting system to show what it actually costs to provide the services and are paid accordingly (usually within certain parameters) following the delivery of services.

A compromise between case rate, cost-reimbursement and fee for service can be created in which a certain amount is paid each month based on a negotiated case rate, additional billing can occur for certain specific services as they are provided on a fee for service basis, and then a cost-reimbursement reconciliation (up or down) is made at the end of a period of time based on the providers actual cost experience. Usually this is done by holding back a portion of the available funding until the reconciliation is carried out. In a mixed payment system, some of the contracts (often those for additional services) will be purely on a fee for service basis. Those with the lead agencies are more likely to have a combination of payment strategies.

Four factors affect the decision of how to go about paying for any service, including RBS.

1. The nature of the service: how clearly is its nature and extent defined and understood? The closer a service is to being a readily reproducible and standardized activity, the more likely that it can be paid for on a fee for service basis. The more the elements of the service vary from one client to the next, the more likely it will be paid for either on a negotiated case rate or through cost reimbursement.

2. The nature of the funding sources: some funding streams require payment to be made in a certain way. For example, absent a waiver, Medi-Cal requires that TBS (therapeutic behavioral services) be paid on a fee or service basis – a certain rate is paid for each unit of service provided.
3. The nature of the organization making the payments: an agency may have an accounting system that can only accommodate a certain approach to billing and reimbursement, or be operating in a political environment that restricts the options for payment structure.
4. The goals of the help to be provided: people tend to produce what is measured. Therefore, to the greatest extent possible, the funding system should reinforce the values and objectives of the service system.

Use the table below to help determine which funding system makes the most sense for your demonstration project:

Factors favoring a case rate system	Factors favoring a fee - for - service system	Factors favoring cost-reimbursement	Factors favoring a mixed system
Given a comparison of the above factors, what funding system makes the most sense for your project?			

Funding stream management

Now think about how you want to bring these streams together to support your funding strategy. Funding stream management can vary from approaches that are blended to those that are braided to those that are distributed. In blended models funding from multiple sources flows into a common operational fund¹⁰ that can be used to pay for any of the full array of services. In braiding the funding streams stay tied to their original sources, but flow in parallel contracts that are interlinked. Distributed funding is just that, a separate funding stream and billing process support each service.

¹⁰ This operating fund is often referred to as a risk pool. Risk pools will be discussed in more detail below in the closing section of this Step.

The type of stream management you will use depends on the nature of the partnership between the public agencies that are collaborating in the RBS reform effort, the nature of the contracts with your lead agencies and additional service providers, and any available waivers in the strings associated with the various funding streams.

Blending

Blending funding is a challenge in human services because of the different requirements of each funding source. Federal agencies often demand high degrees of collaboration among child welfare, juvenile justice, mental health, substance abuse and special education providers at the state level, while at the same time expecting them to maintain separate systems for managing the various funding streams. This separateness is often echoed in the state level agencies that pass these resources on to counties and school districts, and may even be continued at the county level.

Various types of waivers are used to overcome these restrictions. For example, Los Angeles and Alameda Counties have federal waivers of some of the limitations in federal IV-E funding that will allow them to blend those funds and use them more flexibly. In the past, communities were able to obtain waivers of some of the restrictions on medical assistance funding that allowed more flexible use of the funding for children's mental health services. SB 163 wraparound is a waiver of state group home funding that allows counties to pool those funds and use them for community-based services. Under AB 1453 counties will be able to apply for individually designed waivers of some of the state regulations.

Capitation is the usual mechanism for blending. A fixed amount flows into an operating fund for each child or youth that enters the program. This is usually set up as a per-child per-month rate of inflow. Providers then generate comprehensive plans of care designed to respond to the individual needs of each child or youth and family and draw money from the fund to cover the cost of those plans.

HMOs are the most common example of funding systems that use capitation. Each person enrolled in an HMO results in a fixed inflow from either a private health insurance company or medical assistance. Then outflows are drawn every time one of the enrolled members accesses some form of covered health care. As anyone who participates in an HMO knows, the outflows are usually tightly managed. Each medical service must be either pre-approved so that it can be automatically accessed, or the proposed service plan must be submitted and receive prior approval before the service can be delivered.

The outflow in a capitated system can still be by case rate, fee for service, or cost reimbursement. That is a decision made between the entity that is managing the operating fund and the providers.

To accomplish blending in RBS reform the county agencies who currently use extended stays in high-level group homes must form some kind of shared system to manage the enrollment of children, youth and families in the RBS system, approving plans of care, and disbursing funding from the operating fund where the inflow funding is collected.

For example, if your team's design for the RBS system is a small group of lead agencies combined with other community providers who offer additional services, and you want to blend the group home, Medi-Cal and other funding streams to create a common operating fund for this system, you will have to design a managing entity that has the authority to receive or combine funding from those sources and enter into and manage contracts with the lead agencies and additional providers while still insuring upstream and down stream accountability. Payments from the fiscal management entity can still be through case rates, fee for service, cost reimbursement or a mix of all three.¹¹ The advantage of blending is its support for creative and flexible responses to individual child, youth and family needs. The disadvantage is its legal and administrative complexity.

Braiding

Given the challenges of creating a blended system, most systems of care attempt to gain some degree of fiscal integration through braiding. Braided streams maintain the direct connection between each funding source and the provider. Board and care costs for facility placements stay on one track, mental health service costs on another, and so forth. But an intermediary system is used to tie the various streams together and jointly manage their operations.

For example, a county may establish an interagency committee with child welfare, juvenile justice, mental health, substance abuse, and special education representatives. Each agency remains responsible for its own funding streams, but the group agrees to jointly contract with providers so that children, youth and families can access multiple service options through a single provider relationship. Many of the SB 163 implementations use some degree of braiding in their operations.

Public agencies developing braided systems can improve the efficiency of billing by providers who deliver an integrated combination of services by looking carefully at the documentation, billing and claiming methods they use in each of their systems and designing new forms and protocols that offer more consistency and alignment.

The advantage of braided systems is that they can support a significant level of service integration without the administrative upheavals required to achieve blending. The disadvantage is that the alliance of public agencies that are cooperating in the braiding effort can be fragile, and if the relationships between those agencies break down, the braiding can quickly unravel.

Distributed systems

In a distributed approach for managing funding streams, the provider is expected to directly bill each funding source for each type of service provided. Generally the way these

¹¹ At the time this workbook is being prepared, the child welfare and mental health departments in Los Angeles County are developing a plan to form a shared entity to manage partially blended funding for both their RBS services and for mental health services for children and youth in out of home care in the child welfare system.

are set up is that a primary funder will enter into a contract with a provider to deliver the bulk of the designated services, but the agreement will be contingent on the provider also making arrangements with the agencies managing the other relevant funding streams to be able to bill for the remainder of the services expected to be included in the full array.

A number of counties use a distributed funding approach for SB 163 wraparound. The child welfare department contracts with a lead agency to provide the primary wraparound services, but to gain that contract the provider must also have a separate contract with the mental health department that allows the provider to bill Medi-Cal for mental health services provided to eligible children, youth and families. The provider maintains separate books for each funding stream.

The advantage of the distributed approach is its simplicity for the public agencies. Extensive collaboration is difficult because each one operates under such different legal and fiscal mandates, and this allows each agency to operate its shop its own way. In essence it is a bureaucratic application of Robert Frost’s admonition that good fences make good neighbors. The disadvantages are that it limits flexibility in service response for some of the children, youth and families who are served by lead agencies and it increases the administrative overhead for the providers who must use multiple service tracking and billing systems.

Mixed models

Mixed funding management strategies are also possible. Mixed strategies may blend some funding streams, braid others, and use direct billing in still others.

Given your project design, your funding methods and your funding sources, what are the advantages and disadvantages of using a blended, braided, distributed or mixed funding stream management system? Given these advantages and disadvantages, what type of management system are you going to use?

Funding stream management option	Advantages for your project’s design	Disadvantages
Blended		
Braided		
Distributed		
Mixed		
Given these advantages and disadvantages what system will you use to manage your project’s funding streams?		

Amount

Answers to the question of how much to spend for the care of children, youth and families who have complex, intense and enduring needs like those who will be served through the RBS system generally range from “as little as possible” to “whatever it takes” depending on who is answering the question.

In the case of the AB 1453 demonstration there is a little more guidance. While the total amount spent to support each child or youth and family’s plan of care while they are enrolled in the RBS system is not capped, there can be no increase in the amount drawn from the state’s general fund for foster care services. That draw can be used more flexibly, and other fiscal services can be used to fund the overall cost of the plans of care, but the project as a whole has to remain cost neutral with regard to the average per child utilization of state foster care funds as compared to what would have been spent on group home placements for the children and youth if they weren’t enrolled in RBS.

In Step One you calculated an average annual per child foster care cost figure using a representative sample from your target population. Your task in this step is to start with that amount and build an overall payment schedule that reflects the sources, method and funding stream management strategies you have decided to use and takes into account the expected cost and price of the elements you are including in your system.

It is important to take both cost and price into consideration when building your payment schedule. In this context *price* represents the providers’ best estimate of the funding needed to deliver the requested services. *Cost* refers to the public agencies’ best estimate of what they will be able to pay to obtain those services.

The goal is to generate anchor points for funding the package of services you put together in Step Two that reflects the perspectives of the funding sources, the children, youth and families to be served, the private agencies that will be asked to provide these services, and the public agencies that will be asked to administer them.

The worksheets that follow are designed more to inspire conversations than to be the basis for detailed calculations. Once the general shape of the fiscal environment is defined a more precise methodology should be used to generate the actual sums to go into budgets and contracts.¹² The worksheets that follow use case rates, because that is the simplest option for illustration purposes. But the same approach can be used to estimate funding amounts in a fee for service or cost reimbursement environment by breaking the service elements down into their constituent categories. The first worksheet builds a cost estimate starting with the baseline figures from the representative sample of the target population

¹² Two financial modeling tools based on Excel spreadsheets have been developed by fiscally astute people in the demonstration sites to help in setting various cost parameters. They allow planning teams to input various values and see how the funding elements work out. The tools can be downloaded from the RBS Reform website: www.rbsreform.org.

you looked at in Step One. The second worksheet generates a price estimate based on what providers would be spending to deliver the services included in the RBS system you designed in Steps Two and Three.

1. Developing a budget using a cost analysis perspective. (Remember that we are using *cost* to refer to the county's perspective of the payment structure.)

Start by generating a baseline that describes the county's total cost experience for supporting children, youth and families in the target population that identifies both the state general funds that were used, as well as all other funding sources. For example, let's say that using the exercises in Step One you determined that the overall average state general fund contribution for foster care services for representative members of the target population was \$5,000 per-month, per-child. (All of the numbers in this example are made up for illustration purposes only, designed primarily to make calculation easy.) Now look at the proportion of time that the children and youth in the representative sample spent in placement. Let's say that overall the children and youth in the target population averaged 5/6ths of each year in placement, or 10 out of every 12 months. That would mean that the average annual per-child state general fund draw for group home care for this group was \$50,000.

To expand the estimate, let's say that in your Step One analysis you determined that the total per-child, per-month cost of care for the children, youth and families in the target population was \$10,000 per month, or \$120,000 per year. Subtracting the \$50,000 paid for by state general fund foster care funds leaves \$70,000 per-child, per-year costs that were funded by federal IV-E, Medi-Cal, Mental Health Services Act, county tax levy and other sources.

If your goal is to cut the average time spent in facility-based care in half that would mean the budget should only allow for an average of 5 months per child of facility-based care per 12 months of enrollment. This sounds like it would produce a huge savings, but two things are important to remember: first, to make this change, facility-based care is probably going to be more expensive, because its going to be more intensive; and second, community-based care is also going to be more costly because it will be going on both while the child or youth is in the facility and also when he or she is in the community, even though its intensity is likely to decrease during the aftercare phase.

The next step is to build a budget that will spend no more than what was already being spent, but does so in a way that is designed to produce better child, youth and family outcomes. Doing so from the county's perspective requires two targets. The gross target is the overall average per child annual cost care. (\$120,000 in our example.) The second is the state general fund average annual per child expenditure for group home placement. (\$50,000 in our example.)

If your team estimates that the average per-child monthly cost of community-based

care in the new RBS system will be \$5,000 (you might use your SB 163 budgets plus the EPSDT expenditures as a guide to generate a real number to use for your site) that would make the annual cost for that component \$60,000 per-child per-year, leaving up to \$60,000 to pay for the facility-based cost of care, minus system overhead and any amounts retained to build the risk pool.

If \$20,000 per year per child is retained for system overhead, training, flexible funding and building the operating fund/risk pool, that would leave \$40,000, which would work out to \$8,000 per month for facility-based care, if the total amount of time in the facility per-year per-child averaged 5 months or less. This calculation takes none of the strings for either the facility- or community-based care into account, but it may help your team start thinking about how these factors interrelate, and will provide the basis for your AB 1453 waiver request.

To maintain cost neutrality with regard to the state general fund contributions toward the total cost of care, the budget would have to insure that no more than the pre-determined baseline (\$50,000 average per-child annual cost) was being drawn down by the project. Since the average per-child, per-year time in facility-based care is only projected to be 5 months the county is either going to have to use its waiver to draw and apply those funds across the total course of care (including both facility and community-based services) or find increased sources of revenue to support the greater reliance on community-based care. In the example, if \$50,000 per-child per-year could still be drawn from the state general fund, \$10,000 could be allocated to other aspects of the RBS system. Sample numbers from the example used above are included in the worksheet below as guides, but you should replace them with your own figures.

Estimating costs and targets by working back from your baseline figures	
Average per-child annual expenditure of state general funds used to support group home placements for representative members of the target population	\$50,000
Average additional annual per child expenditures for representative members of the target population and their families	\$70,000
Total average annual per child baseline expenditures for representative members of the target population	\$120,000
Average per-child time spent by children in the representative sample in group home placement on an annual basis in months	10 months
Target for average per-child months to be spent in facility-based care on an annual basis for the demonstration project	5 months
Estimated average per child annual cost for community-based care for members enrolled in the demonstration project	\$5,000 per mo x 12 = \$60,000
Projected per-child annual hold-back for system costs, training, flexible funding and building the risk pool	\$20,000
Portion of baseline figure remaining to fund facility-based care on a per-child annual basis	\$120,00 - \$80,000 = \$40,000
Potential monthly funding available for facility-based care if target is met	\$40,000/5 = \$8,000

2. Now generate a price estimate by looking at what it will take to provide the elements in your RBS system design.

Imagine a child or youth and family who are entering this new model who represent a level of need at the midline of the target group. From the provider's perspective, estimate the services this child and his or her family are likely to consume during their span of enrollment on an annualized basis.

If your projected total time of enrollment in RBS before transitioning to a less-intensive form of care is 24 months, you might start by estimating that your imaginary midline consumer will spend a total of 5 months in facility-based care in the first 12 months and perhaps 3 more months total during the second 12 months, for an average of 4 months per year. (Stays may be intermittent, for stabilization, assessment and respite as the process of recovery and reconnection plays itself out.)

Now visualize your team's expectations for what facility-based care will look like in the context of an ongoing foundation of community-based care. What will be happening in the facility, who will be doing it, how often will it occur? How will it be connected with what is going on in the community? Some aspects of facility-based care in an RBS system will be different from stand-alone group home services. With shorter, intermittent stays for purposes of stabilization, assessment and respite, a higher staff to client ratio may be needed, and the staff may need to have more training and specific qualifications. There could also be increased overhead for insuring extensive family involvement.

Other aspects will be similar: the therapeutic milieu will have to be maintained, children and youth will need places to sleep, food to eat, appropriate access to medical and educational resources, opportunities for play and study, etc. Some aspects of facility-based care in an RBS system may result in reduced costs attributed to the facility since some functions, such as care coordination, may be covered in the ongoing community-based care line (even if they are being carried out by staff from the agency that operates the facility). This conversation should result in an estimate of the daily or monthly expenses for the facility-based component of a comprehensive RBS service plan.

Because the range of community-based services that each enrolled child or youth and family will use is likely to vary significantly, the process for constructing this estimate will be different from that used for the facility component. On the community side, RBS creates a resource array that each enrolled child or youth and family will draw from differently. Your RBS implementation team may wish to look at the cost experience with SB 163 wraparound for youth with this level of need. Another option for visualizing potential utilization would be to start with some members of the representative sample youth and families from the target population and imagine what a comprehensive plan of community care for them would include, drawing from the resource options listed in Step Two. Through

processes like these a monthly average rate for all community-based care, including care coordination should be generated.

Taken together the cost-perspective and price-perspective calculations for the facility-based and community-based elements of the RBS system of care should provide you with a starting point for building and negotiating a budget for implementing the project. The estimates at this point just describe a break-even figure where the project's annualized costs are equivalent to what is currently being spent for services as usual for members of the target population. If less facility-based care is used, or if the cost of community-based care is lower, then measurable savings will occur. These can be captured in the risk pool, described in the next section.

The worksheet that follows can be used to generate a price-perspective budget and compare it with the cost-perspective estimates from the last worksheet. Through this comparison your team should be able to generate a budget estimate for the new model that balances both perspectives. As you produce these estimates, don't forget to make note of any other assumptions you are making that may affect these amounts.

One important assumption to keep in mind is that as the project proceeds over time, the number of children, youth and families receiving community-based care will continue to increase, while the number of beds that have been allocated for this demonstration will stay at a fixed level. For example, a demonstration project may have 60 beds that will be used for facility-based care. To make the example easier to present, we'll assume that at the start of the project all of these beds are full. (Some projects are planning to convert existing group home placements into RBS enrollments, others are going to start with empty beds and fill them over the opening months of the project.)

If we assume an average length of initial facility-based care of 6 months, and that 15 of the 60 beds will be held back for intermittent respite and stabilization for already enrolled children and youth, that means that 45 new facility-based referrals can be enrolled every 6 months. If the average length of enrollment is two years, by the time the first cohort of 60 children and youth are graduating, 135 additional children and youth will have been enrolled. (45 each at 6, 12 and 18 months.) From that point the ongoing capacity of the project will be about 135 with 45 entering and leaving every 6 months.

Estimating the price of facility-based care		Estimating the price of community-based care	
Basic site operational expenses		Estimated per child per month care coordination expenses	
Specialized care augmentation expenses		Estimated average family intensive care expenses	
Family involvement augmentation expenses		Estimated specialized behavioral health service expenses	
Other cost factors unique to operating in an RBS context		Estimated family supportive care services expenses	
Total estimated per child per month facility-based service expenses		Total estimated per child & family per month community care expenses	
High-low range for estimate		High-low range for estimate	
Best estimate using a price-perspective			
Per month facility-based rate:			
Per month aggregate community-based care rate:			
Comparison with the cost-perspective estimate:			
Per month facility-based rate:			
Per month aggregate community-based care rate:			
Working budget estimates to use for building the funding system:			
Per month facility-based care rate:			
Per month community-based care rate			
Key assumptions used to set these costs:			

- As noted above, this process just helps set ballpark numbers. Now you have to move things closer to reality by bringing in the specific funding sources with their strings. Using the break out of funding sources for the care the target population has been receiving, see how many of the existing funding lines can be matched to the components in your new model. Some links are likely to be more reliable than others. Some components may not have any funding lines that will readily connect. This analysis will help you decide how to manage the funding and where you may need to seek the waivers permitted under AB1453.

consistent and sustainable reconnection with home, school and community – will actually work in practice.

- The second is whether the public and private agency staff will be able to acquire the knowledge, skills and understanding needed to implement the RBS model in a reasonable period of time.
- The third is whether the constellation of resources chosen to support the facility and community based elements of the model are sufficiently well-matched with the needs of the target population, or whether additional alternatives will have to be purchased on the run.
- The fourth is whether the amount of services purchased will be sufficient for the level, scope and intensity of the needs of the target population.
- The fifth is whether as the project reaches its enrollment capacity more outliers with high cost needs emerge than were planned for.

The impact of some of these risks will reveal themselves early in the project's existence. Others will take a while to be tested. It won't take long to see whether the staff and agencies are able to implement the practice model. Once the model is in place, six months should show whether it is having the expected initial impact (although long-term results such as stability will require more time to emerge). As the number of enrolled children, youth and families begins to reach the proposed enrollment capacity, the adequacy of the service mix, and the quantity and quality of the service array will be tested. As the project moves through its second year of operation, a better sense of the incidence of outliers (those whose enrollments extend longer than expected or include more facility-based care than expected) will be gained.

Besides covering unexpected costs, a risk pool can also provide an incentive for providers and administering agencies to meet the project's goals. If the project's cost experience for producing the expected outcomes meets certain expectations, draws from the risk pool can be used as a source for positive rewards. For providers this might mean a percentage bonus based on exceeding performance goals, or the creation of a flexible source for program enhancements that don't match with any of the funding lines, such as improvements in the environments of care, or coverage of extraordinary expenses for helping certain families reunify or stay together. For the administering agencies, a positive balance in the risk pool may provide the ability to enroll children and families who might not otherwise be eligible for the program, and could cover the cost of bringing on staff who can help insure more effective program operations.

Questions to consider when creating your risk pool include:

- How much to put into it,
- Where the money in the risk pool should come from,
- How the money should be added,
- Who should manage the risk pool, and
- How draws from the risk pool should be made.

How much to put into it? The size of your risk pool should be based in part on the size of your demonstration project (how many children, youth and families will be enrolled at its

capacity) plus your estimate of the highs and lows for community-care costs, plus your estimate of how much facility-based care children and youth will actually use, plus how much revenue the project has to draw from. With this many variables, it is clear that the size of the risk pool is a subjective determination that the implementation team must make based on its best judgment and prior experience. It's like an insurance policy: how much you buy depends on how risky you think the situation is and how much of that risk you can manage without the backup account.

However, one additional factor must also be addressed – adding money to the risk pool may affect your ability to demonstrate cost neutrality if those contributions show up as expenses at the time they are made.

Factors to consider when estimating the size of your risk pool

How many children, youth and families will be enrolled at capacity?	
What will your rate of enrollment be?	
What will your average per-child, per-month payment be for each enrollee?	
Based on your review of the costs for care in the representative sample, what is a reasonable rate of variation from this average?	
At capacity what do you expect your ratio of children in facility-based care to those only in community-based care to be?	
If the RBS system meets its performance targets, how much savings against the baseline will be achieved, as expressed in an average per-child, per-month figure?	
How much short-term loss can your selected providers manage without kicking in a stop-loss payment?	
Will you be using the risk pool solely to manage unexpected losses, or will it also be used as an incentive for achieving and exceeding performance goals?	
If the risk pool will be used to support incentives for reaching performance goals, how much do you want to invest in the incentive program?	

Where should the money come from? Essentially there are three ways to fund the risk pool. One is to build it incrementally by holding back a certain percentage of the per-child, per-month billing (from whatever method you have decided to use for payment). The other is to use an existing account to prefund the pool. If the methods are combined, the money used to prefund the pool can be treated as a loan to cover early risk while the pool grows and then withdrawn or used to expand the project if the results of the demonstration project are successful. Finding a source for prefunding the pool is likely to be difficult for agencies that have little flexibility in their annual budgets. Recourse in that situation might be to seek support from a private foundation.

A third option for funding the risk pool is available in projects that use some form of blending to manage their RBS funding streams. If you are combining funding streams in an operating account, the risk pool will be a reserve maintained in that account. All of the per-child, per-month billing flows into the operating account. Then the entity managing the

system pays out costs of care to the providers using whatever method (case rate, fee for service, actual cost or a combination) the system’s designers have chosen. The risk pool’s growth is then based on the difference between the capitation received and the cost of services provided. Front loading will probably be necessary in this situation to address early risk that the cost of services will exceed the capitation.

In systems that are using braided or distributed funding stream management systems, the risk pool will have to be generated either by holding back some of the payments (in which case the risk pool will be an account managed at the county level) or by having the providers set aside some of the funding they receive that is not expended in service delivery (in which case the risk pool is maintained in accounts managed by the providers). It is also possible for both the providers and the county to establish an independent account that is managed by a committee with county, provider and consumer representatives.

How will you be creating your risk pool?		
Methods to consider	Pluses	Minuses
As a component of the operating fund in a blended funding system		
As an account maintained by the county with funds held back from payments to the providers		
As an account maintained by providers built through the surplus in what they are receiving		
As an independent account maintained by a collaborative entity and funded by both county and provider contributions		
Best option based on your situation		

How should the money be added? There are four ways of accruing funds in the risk pool. First, a flat percentage can be retained or held back from every month’s allocation to each provider agency. Second, to account for early risk, a higher hold back can be used at the beginning that then declines as the pool matures and the project has enough service experience to improve its risk estimates. Third, to account for later risk of having more outliers as the enrolled population increases, and to give providers a break during their startup phase, a smaller amount can be held back early on, with an increasing percentage as the project matures and the providers get their programs up and running. Fourth, a variable amount can be added at certain reconciliation points based on the difference between actual costs and the funds allocated. If more enrollees are served for less than was budgeted in a given quarter, more can be allocated to the risk pool.

As noted above, depending on the fiscal model your system uses, the rate of accrual in the risk pool can affect cost neutrality.

How will you add money to your risk pool?		
Method	Pluses	Minuses
Flat contribution on a per-child, per-month basis		
Higher early contributions, decreasing over time		
Lower early contributions, increasing over time		
Percentage contribution based on savings per reconciliation period		
Best option based on your situation		

Who should manage the risk pool? In a blended funding model, the operating fund managers control the reins of the system. In addition to managing the normal inflow of funds from primary sources and the outflow to providers, they would also control the risk pool account and administer it according to the terms of the contracts that established that community’s funding stream management plan.

In braided and distributive systems, where the risk pool acts as a back up to the system, rather than the core operational fund, and is accumulated in an accounts that are either held by the county, by the providers or by a separately created collaborative entity, rules and mechanisms are still needed for deciding when and how to access the risk pool funds. The most formal third party strategy is for the public and private agencies in the RBS system to form a nonprofit corporation that has a board with representatives from the agencies, community stakeholders and consumers to manage the fund. If the risk pool is in a protected account at one of the public agencies that holds the fund, they might establish a representative committee through an interagency agreement to make recommendations about payouts. If one or more of the private agencies participating in the system can hold the risk pool in a reserve account, a representative committee again could manage its disbursements.

All three approaches have their pluses and minuses. Establishing an administrative services entity to manage a blended fund is a complex undertaking. Creating the nonprofit corporation to manage holdbacks from a braided or distributive system can also be a lot of work for a small project. Public and private agencies may have limitations on their ability to hold reserve accounts that are managed by committees that are separate from the standard governance systems of those agencies. The agencies may also have difficulty accounting for these held over reserves in their annual books. Finally, there is always a question about how protected a protected account really is. When times are tight, both private agency boards and public agency governments will look anywhere they can to make up deficits.

How will you manage your risk pool?		
Method	Pluses	Minuses
As a part of the operating fund in a blended funding system		
As a backup fund, managed by a new non-profit corporation		
Protected account at one of the public administering agencies		
Protected account at one or more of the provider agencies		
Best option based on your situation		

How should draws from the risk pool be made? The criteria for managing the account and making decisions about when to withdraw money, how to disperse it, and how much should be dispersed should be part of the interagency agreement that forms the risk pool and chooses or creates the entity that manages it. The three main reasons for draws are to cover unexpected costs, to respond to extraordinary child and family needs, and as incentives for reaching or exceeding performance goals. The interagency agreement should include criteria for managing these payouts, including:

- The percentage of the fund that can be used to support any of these payouts,
- The percentage of loss that a provider will be expected absorb before the stop-loss provisions of the risk pool kick in,
- The factors to be considered when reviewing applications for addressing extraordinary needs,
- The targets that will cue incentive-based payouts,
- The percentage of the fund that can be used to support these payouts, and
- The form in which incentive payouts may be made (i.e. direct payments or reimbursement for approved program enhancements).

What criteria will you use to manage dispersals from your risk pool		
Criteria for covering unexpected provider costs	Criteria for covering extraordinary enrollees needs	Criteria for incentive payments

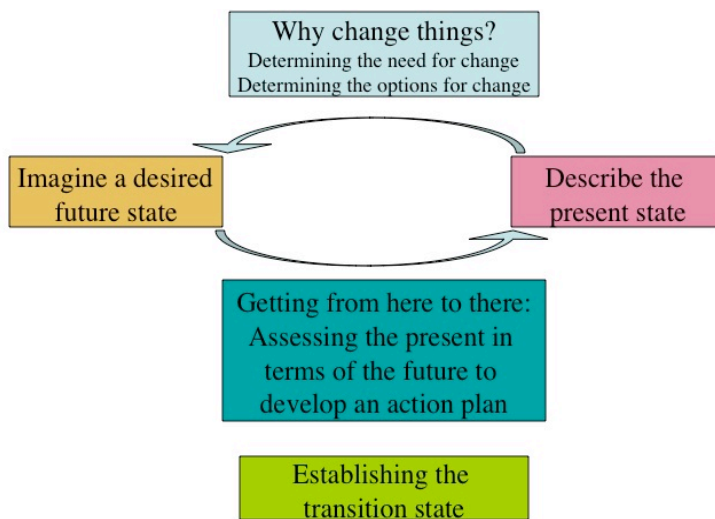
Step Five

How will you make it happen?

Strategic planning is the art of managing the transition. Getting from where we are to where we want to be always involves complications, confusion and unexpected changes in plans and participants. Similes like “herding cats across the freeway” and “building the plane while we’re flying it” are frequently applied to the task of implementing an organizational change process.

Edgar Schein’s model for organizational change illustrates this complexity. The first stage is making it clear why change is urgently needed and examining at the options for change. The second stage is a conversation in which the participants evaluate the present state of the organization, while at the same time envisioning the future state that they would like the organization to achieve. The third stage is creating an action plan that builds on the foundation of the present to reach the future. The fourth stage is to implement the plan and enter into a transition phase where elements of both the baseline state and the future state are active.¹³

The following chart illustrates this process:



The limited outcomes that are being reported for youth who are leaving long-term, high-level group care generated the urgency for change that led to the enactment of AB 1453. The exercises in Step One helped to describe the present state, and those in Two, Three and Four produced the elements of the future state.

¹³ Schein, Edgar (1999). *The Corporate Culture Survival Guide*. San Francisco: Jossey Bass.

By comparing your models of the present and future states, your team can begin putting an action plan together. The plan doesn't have to be complicated. Good action plans only need six parts:

1. What needs to be done?
2. Who is going to do it?
3. How are they going to do it?
4. When is it going to happen?
5. How will you know if it has happened?
6. How will you know if it has helped?

On the county side, some of the key tasks will be:

- Setting up the referral, assessment and enrollment system, including the criteria that will be applied, the processes that will be used, the staff who will carry it out, and the timeframe for the process steps.
- Designing the case management process to follow children, youth and families as they enter, participate in, and exit the RBS system, including who will do it, what their roles and responsibilities will be, and how they will interact with to the county agencies and private providers.
- Creating, implementing and operating the funding system designed in Step Four, including the degree to which it will participate in the existing system, who will manage it, where the funding will come from, how it will be dispersed, and how accountability and accuracy will be assured.
- Developing a system for selecting, contracting with and managing the contracts of the lead agencies and the agencies providing additional services in a way that assures quality and effectiveness.

On the provider side, for lead agencies some of the key tasks will be:

- Designing a methodology for providing facility and community-based care that takes into account the geographic, cultural and need variations among the children, youth and families that will be assigned for care, including facility operations, community outposts, staffing patterns, management, supervisory, clinical, case coordination, educational and support staff roles, documentation, billing, and evaluation.
- Training staff at all levels for the transition to the RBS methodology.
- Developing effective communication systems with county staff, stakeholders, clients, community service providers and parent and youth consumer advisors.

- Helping to develop and execute contracts that preserve the guiding principles of RBS reform and that provide adequate support for the sustainability of the project.
- Creating partnerships with the community agencies that will be providing additional services to support the plans of care, insuring that their staff understand and are able to carry out their assigned roles, and working with the county agencies to establish a fair and equitable system for reimbursing them for the services they provide.
- Implementing an evaluation and feedback system that tracks service performance and client outcomes and satisfaction and that supports ongoing project improvement.

Use the tables like the ones that follow to record the action plans that your team develops during its design meetings or retreats and as reference points during implementation to see what’s been done, what remains, and what needs to be adjusted.

County Agency Action Plan				
	Task 1	Task 2	Task 3	Task 4
Activities involved				
Actors involved				
Implementation Methods				
Timing				
Implementation Check				
Implementation Evaluation				
Key concerns and opportunities				

Provider Agency Action Plan				
	Task 1	Task 2	Task 3	Task 4
Activities involved				
Actors involved				
Implementation Methods				
Timing				
Implementation Check				
Implementation Evaluation				
Key concerns and opportunities				

Conclusion

RBS is designed to begin the process of reforming California's longstanding group home system. Therefore RBS systems will not be built from scratch. They will combine some existing services, processes and programs, the transformation of others, and the creation of new components. Figuring out how to get all these parts to fit together and keep them working together will be an ongoing challenge for the implementation team. The energy to keep moving forward has to come from our passion for better lives for children, youth and families and our commitment to a vision of a better way of helping. The members of the RBS implementation support team wish to convey our heartfelt thanks to each of the RBS demonstration sites for their willingness to take on this effort. We hope you find this workbook useful. Please know that we are available as needed to assist you in the planning, implementation and operation of your projects.

For more information about RBS reform and to contact any of the consultants involved in the project, please visit the website at www.rbsreform.org.