Volume 1, Issue 1

October 20, 2016

Continuum of Care Reform (CCR)

Los Angeles County
Department of Mental Health
Children's Countywide Services Division

Continuum of Care Reform (CCR) Newsletter Series

The January 1, 2017 CCR start date is quickly approaching and there have been many questions about what is to come. This monthly newsletter series will serve as an information source, highlighting and providing updates on CCR.

CCR Overview

Assembly Bill (AB) 403, also known as Continuum of Care Reform (CCR), is a comprehensive transformation to the foster care system to ensure that youth and families receive necessary services and supports. CCR was signed into law in October 2015 as a result of years of effort and extensive engagement with a broad range of stakeholders (youth, parents, child welfare, probation, education, and mental health). Continuum of care refers to the spectrum of placement settings for foster or probation youth; from the least restrictive (foster homes or relative care) to most restrictive (group homes/residential treatment). Department of Mental Health (DMH), Department of Children and Family Services (DCFS) and Probation are expected to collaborate to ensure foster youth have the opportunity to grow up in permanent supportive homes and to become self-sufficient and successful adults.

Vision: To ensure all children and youth have an opportunity to live with a committed, permanent, and nurturing family.

Goal: To maintain the family setting by offering tailored services and supports to meet the need of the individual youth.

CCR Timeline

July 2012: **Senate Bill 1013 signed into law**

California Department of Social Services (CDSS) was required to establish a Workgroup to develop recommended revisions to current rate-setting services, programs serving children and families in the continuum of Aid to Families with Dependent Children-Foster Care (AFDCFC), and to reduce reliance on congregate care.

Sept 2012: **CDSS launches CCR Workgroup**

More than 300 individuals participate over 2 years.

Jan 2015: **CDSS submits CCR recommendations to California Legislature**

The CDSS report outlined a comprehensive approach to improving the experience and outcomes of children and youth in foster care. The report also included recommendations based on collaboration with county partners and stakeholders, with inter-dependent recommendations:

- to improve the assessments of children and families to make more informed and appropriate initial placement decisions;
- emphasize home-based family care placements; appropriately support placements,
- change the goals for congregate care placements, and
- increase transparency and accountability of child outcomes.

Feb 2015: **Assemblymember Mark Stone introduced Assembly Bill (AB) 403**

Oct 2015: **AB 403 signed into law**

Jan 2016: **CCR Implementation Advisory Committee Kick-Off Meeting**

CCR Implementation set to begin on January 1, 2017.

CDSS launched the Stakeholder Implementation Advisory Committee and introduced stakeholders to the Workgroups that would convene through 2016 to develop the policies and protocols for CCR implementation. Workgroups include:

- State/County Implementation Workgroup
- Stakeholder Implementation Advisory Workgroup
- Foster Family Agency (FFA)/Short-Term Residential Treatment Program (STRTP) Workgroup
- Therapeutic Foster Care sub-workgroup

CCR Timeline Overview *continued*...

- Mental Health Workgroup
    - Child and Family Team sub-workgroup; and Medical Necessity sub-workgroup
- Performance and Oversight Workgroup
    - Client Satisfaction sub-workgroup

Feb 2016:	AB 1997 introduced by Assemblymember Mark Stone (AB 403 clean-up bill)
Aug 2016:	AB 403 passed in Assembly and Senate
Sept 2016:	AB 403 enrolled and presented to California Governor Jerry Brown

Dr. Robert Byrd's Perspective on CCR

Dr. Robert Byrd, Mental Health Clinical District Chief, Children's Countywide Services Division, has championed the efforts to implement CCR in Los Angeles County, Department of Mental Health and can be considered a "guru" on this reform. He has travelled to Sacramento extensively during the past several months to collaborate with CDSS and Department of Health Care Services (DHCS) in CCR strategic planning, and to participate in implementation meetings and workgroups. One of his major accomplishments has been developing and enhancing partnerships with DCFS, Probation, stakeholders, state representatives and neighboring counties. He explained that the key to successful implementation will be building upon relationships. As such, Dr. Byrd is currently involved in 18 different local and state workgroups partnering with stakeholders at various levels, who he states have a common mission "to help youth succeed". Dr. Byrd was interviewed to obtain his valued perspective on CCR and what DMH should anticipate.

Q:What can DMH expect from CCR?

R: CCR will impact all Service Areas and Bureaus in various ways. For example, we are working with Program Support Bureau to develop trainings for documentation and claiming, and to assist with Medi-Cal Certification; Finance Service Bureau will develop a plan to fund this mandate; Chief Information Office Bureau (CIOB) will ensure new agencies get on-boarded into Integrated Behavioral Health Information System (IBHIS); Administrative Support Bureau (ASB) will assist with addressing space issues related to staffing increases; and Transition Age Youth (TAY) Division will be significantly involved as CCR includes youth up to age 21, who will transition into independent living.

Q:How will CCR improve service delivery for children and youth?

R: CCR builds on prior initiatives to expand the provision of a comprehensive continuum of services for probation and foster youth regardless of the placement. The Child and Family Team (CFT) process will inform the youth's placement, mental health services, and support services and will be conducted as frequently as needed. Utilizing the Shared Core Practice Model lens to identify strengths, underlying needs, empower youth to be an active participant, and include the child and family's voice and choice in treatment planning and placement decisions are key enhancements in service delivery. An additional mandate is to develop resources and extensively train staff in order to tailor services to the needs of specialized populations (i.e. LGBTQ youth and Commercial Sexual Exploitation of Children and Youth). "If I need heart surgery I do not want to go to a Generalist, but a Cardiologist", which is the same for these specialized populations that require "Specialist" to address their needs.

Q: What are some of the advantages to collaborating with DCFS and Probation?

R: "The people I am working with are fun, which makes the work easier. They are equally committed to this process". It is evident that DMH, Probation, and DCFS have a shared vision and all three departments are committed to improving outcomes for youth. Collaborations have provided a better understanding of each system. Partnering has also involved dialogue regarding the different assessments conducted by each department (DCFS placement assessment, Probation assessment, and DMH mental health assessment) and understanding the purpose of each. This has allowed DMH to shed light on the meaning of medical necessity and eligibility for specialty mental health services.

Q:How have you addressed the major changes that CCR will bring to DMH?

R: Staying informed by conducting detailed analyses of Group Home spending, administering surveys to providers, and "a lot of research, planning and reading" have significantly contributed to the implementation decision-making process. As I receive new information, I disseminate acquired knowledge via meetings and presentations to Executive Management, District Chiefs, my staff, contract providers, DCFS, and Probation in order to keep all informed. To add, in January 2016 I initiated small workgroups with providers to obtain their input on what is working and areas that can be improved in residential and foster care; as a result vital partnerships have been established.

Q: Why do you think CCR is the solution?

R: "CCR is a mandate". The "spirit of the law" in directing DCFS, DMH and Probation to regularly re-assess, discuss how to improve outcomes, and to transition youth into community based placements is beneficial. The three departments now have a similar language and philosophy, since CCR is utilizing the lens of the Shared Core Practice Model.

Q: What advice can you give DMH as we embark on this exciting new change?

R: "We have a strong workforce with a lot of talent and skill, who are well poised to make the transitions that CCR requires". However, I encourage everyone to remain flexible as CCR is a process and not an event.