ECP Program Models and Eligibility

In the **E-STRTP model**, agencies utilize a staff-based placement and service model under an STRTP license. These programs provide intensive behavioral health services, funded by EPSDT contracts, while engaging in care and supervision activities funded by an enhanced STRTP placement rate established collaboratively by the county and provider. Youth are placed alone or with one other youth in a licensed STRTP facility operating with a significantly higher staff to client ratio than standard STRTPs. All E-STRTP placements must be approved by the county Interagency Placement Committee and recommended by the Qualified Individual (QI), unless the youth is placed on an emergency basis.

In the **E-ISFC model**, youth are placed in a family setting with a Specialized Resource Parent who has received the additional training, coaching, and supervision that enables them to respond in a therapeutic manner to very challenging behaviors The Specialized Resource Parent is funded by an enhanced payment rate for both the agency and the resource parent, which must be negotiated and may not exceed the standard STRTP placement rate. Youth are typically placed alone in an E-ISFC family and program staff are available to support the youth and family in the home 24 hours per day/7 days per week. Youth also receive intensive behavioral health services funded through EPSDT contracts. E-ISFC placements may be with a family member or other natural support whenever possible, provided that all preconditions of the ISFC license are met and the family member or natural support is approved as a Resource Parent through a Foster Family Agency (FFA) that is able to administer an E-ISFC program. ISFC families can be relatives or fictive kin of the youth identified by the provider and county partners.

Program	Description	License	Primary Funding Options	Staffing
Enhanced ISFC	Foster home with a Specialized Resource Parent (including qualified family members, kin, or natural supports), that also includes intensive staffing to focus on stabilization and permanency needs	FFA, RFA home with ISFC levels of training	- Funded up to traditional STRTP rate - Wrap w/ reinvestment - Specialty Mental Health Services - TFC	- Resource parent (with no other job or competing responsibility) - Intensive staffing individualized to meet the most urgent needs
Enhanced STRTP	STRTP level placement with 24/7 staffing to serve one to two youth at a time, with the whole program customized to that/those youth	STRTP	- Enhanced STRTP rate - Wrap w/ reinvestment - Specialty Mental Health Services	- 24/7 staffing, flexibly designed to offer the individualized structure - Mental health services provided multiple hours per day

While enrolled in either an E-STRTP or E-ISFC program, youth receive comprehensive assessment, treatment planning, therapy, rehabilitation, collateral, intensive home-based services, intensive care coordination and case management services from registered or licensed clinicians and experienced skills counselors. Medication and nursing support will be provided or arranged for, as needed. Interventions are trauma-informed, highly innovative and individually designed to target the behaviors or symptoms that most significantly inhibit the youth's ability to progress in traditional behavioral health and/or placement programs. In collaboration with the placing county and the Child and Family Team (CFT), ECPs also provide guidance and/or support to the youth's permanency planning process, including family search, engagement and permanency support activities as appropriate and necessary.

ECPs serve minor children and nonminor dependents. Programs accepting youth with unmet complex needs will review youth symptoms, risks and behaviors, fit with any other individuals in the home/program, available staff resources and the ability of less restrictive or intensive settings to serve the youth. If the program is utilizing an STRTP license model, state requirements regarding alignment with the Qualified Individual Assessment justifying the need for an STRTP level of care would be considered.

Eligibility Criteria

CANS reflects significant needs across a variety of domains, particularly related to Behavioral/Emotional Needs, Life Functioning and Risk Behaviors

And two or more of the following:

- Self-harm with or without imminent risk of suicide
- Aggression with or without imminent risk of homicide
- Fire setting with or without imminent risk of arson
- Psychosis that is dangerous or disabling; places youth or others at risk of harm
- Risk of wandering or absences from care arising from a mental health condition
- Significant sexualized behaviors putting youth or others at risk, including commercial sexualized exploitation
- Substance use or abuse
- Frequent impulsive, high-risk behaviors
- Psychotic episodes that are not presenting in an acute stage
- Serious deterioration in ability to manage activities of daily living
- Repeated removal from placements and/or a history of placement instability
- Challenges with engagement in mental health services
- Co-occurring Mental Health, Substance Use and/or Developmental Delay diagnoses
- Delinquent behaviors resulting from behavioral health challenges
- History of psychiatric hospitalizations/5150s with continued significant safety concerns
- Serious physical health concerns with or without imminent risk of hospitalization
- Other behavioral problems that are not able to be treated in other treatment settings

County Partnerships

ECPs are focused on the provision of services to treat youth's behavioral and emotional health needs and not on trying to match a youth without placement to an open bed. This focus requires partnerships between providers and county agencies to ensure agencies have the resources necessary to meet the needs of the most complex youth in the county. All relevant county agencies and associated system partners should be

included in these partnerships, including but not limited to child welfare, probation, behavioral health, education and regional centers.

Critical features of partnership for ECPs include building strong team communication between the provider and all involved county departments, intense coordination of care, integrated funding models utilizing Behavioral Health and Child Welfare/Probation funds, inclusion of educational system and regional center partners and development of shared risk structures. Counties should work toward alignment with AB 2083 and Children and Youth System of Care memorandums of understanding. State agency partnership is necessary for counties with providers to navigate the licensing standards as programs launch.

In Celia's case, the placing county's social services agency was ready and willing to pay for the entire cost of the placement and therapeutic supports, even without the involvement of behavioral health.

Recognizing the importance of leveraging Medi-Cal EPSDT to access federal revenue and support the provision of mental health services to which youth are entitled, Caring Change(CC) began persistently reaching out, including sending emails every day to the placing county's behavioral health department to reiterate that CC could not move forward with the placement without a behavioral health contract in place. The social services department began doing the same, reiterating the importance of establishing a behavioral health contract with CC that addressed the myriad needs Celia had, including provisions for Specialty Mental Health Services, Therapeutic Behavioral Services, Therapeutic Foster Care, Medication Management and step-down Wraparound services.

Within two weeks, there was an agreement that a behavioral health contract was possible and CC was able to begin providing all the required documentation to establish a contract. As a result, CC was able to provide a comprehensive array of behavioral health services to support Celia's transition to a lower level of home-based care.

As a team, all involved partners should not only have a voice in the considerations of the youth's needs, but also have a responsibility to help fully fund those services in an integrated way within their scope and regulations. For example, if a youth is in an individualized placement setting, requiring 24/7 staffing, the design needs to ensure that this level of service is supported in the staffing and budget within the program, rather than relying on a variety of outside providers to push services into the program. Certainly, if the youth is already connected to and has a relationship with another provider, that partner should become part of the broader team, but behavioral health services provided by the staff in the program must be fully funded and flexibly applied. This means that funding for ECPs must be a braid of both placement rates and behavioral health funding. Not only is this the best scenario for youth, but this ensures programs are leveraging as much Federal Financial Participation as possible, bringing down the overall cost to the county. Additionally, funding for family finding and engagement activities must be part of the menu of services provided through an ECP.

It can take quite some time to create the kind of placement that will help youth stabilize when time is of the essence. Providers need time to secure a site, hire the staff, recruit Specialized Parents if home-based placement will be utilized, train and on-board staff and ensure they are working as a strong and integrated team. This takes time and resources – resources that agencies aren't able to invest without a partnership with a county and a commitment to fully fund and support the program during start-up and over time.

Shared Risk

Protecting and preserving the safety of youth with unmet complex needs is the highest priority of providers and creating programs that promise a no eject/no reject approach can present significant risk that was historically assumed to be held 100% by the provider. Thus, when critical incidents or high-profile accidents occurred, blame was often placed wholly on the provider. Yet it is known that no incident or program challenge occurs in a vacuum, without other driving factors. Sometimes those factors can look like pressure to take a youth quickly,

with inadequate funding and siloed, uncoordinated services. In each of these situations, responsibility – and thus risk – is shared not only with the provider, but also the placing agency and entire system of care.

ECPs will operate with a high degree of attunement to issues related to trauma-informed care and cultural responsiveness, mitigating the disparities in service and the impact of racial bias and racism on youth in treatment. Program staff and county partners are expected to reflect both internally and as a team to ensure that concerns about youth admissions to the program and/or remaining in treatment are discussed in ways that address the systemic challenges that youth of color face and the frequency with which they are deemed "too challenging" or "unsuccessful" due to behaviors that white youth could exhibit without fear of losing placement.

Enhanced Care Program providers and their county partners work diligently within the CFT context to design solutions to challenging issues so that youth can stay in their placement and program, even when doing so requires extraordinary interventions developed by and with the CFT members. All treatment discussion and decisions will occur within the Child and Family Team context, ensuring that all efforts are made to identify areas of challenge or concern and to preserve placement. Removal from an Enhanced Care Program occurs as a result of a CFT decision that a placement change is in the youth's best interest or that a youth no longer needs enhanced services. If disruption does occur, youth should be given immediate access to support to help them exit in order to mitigate potentially devastating effects on their' well-being.

Licensing

In order to provide services within an Enhanced Care Program, agencies operating under an STRTP framework will need to update and/or create a new Plan of Operations and Program Statements for Community Care Licensing (CCL) review and approval. Depending on the content of their existing Plan of Operations, FFA based programs may need to update these documents for CCL as well to achieve the flexibility needed for this program. These updates will enable programs to operate under adjusted structures and providing clarity to licensing departments about the ways in which the structure, services and supports available within ECPs are distinctly different from "standard" ISFC or STRTP programming. If not already in place, ECPs using an STRTP licensure model will also need to work with the Department of Health Care Services (DHCS) to ensure Mental Health Program Approval of any new program sites. Providers can anticipate the need to work with the local CCL liaison, as well as CDSS leadership and state-level CCL staff in order to address barriers within existing STRTP or ISFC regulations and to discuss area where exceptions may be necessary in order to best serve the youth identified for treatment within an ECP.

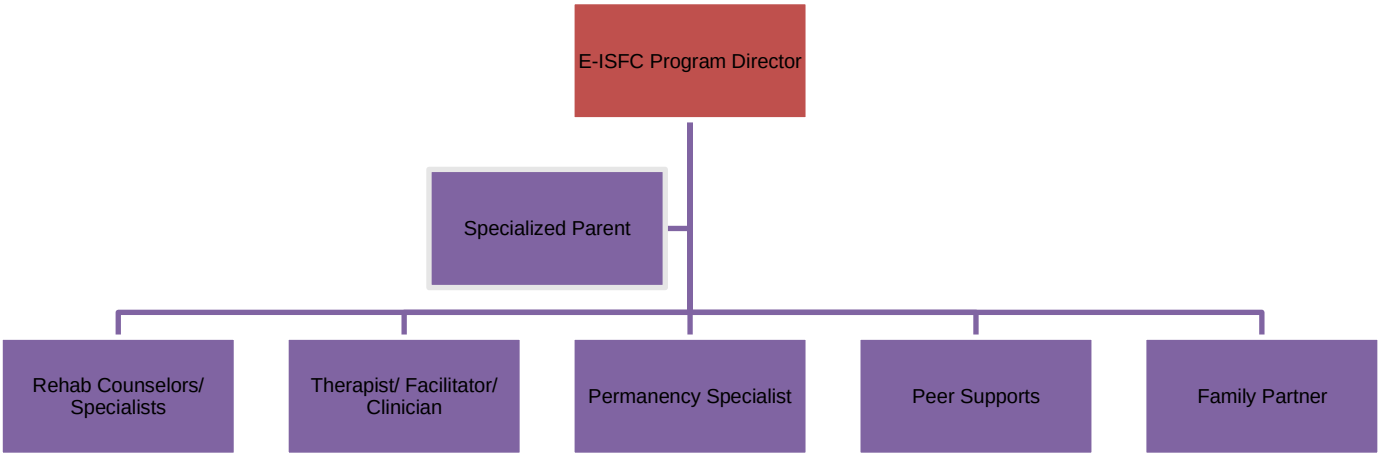
Staffing Models

E-ISFC Staffing

Enhanced Care Program staffing is determined by the license under which the program will be operating. The Enhanced ISFC model builds on a traditional ISFC home through the addition of a dedicated Specialized Parent. Specialized Parents differ from traditional ISFC resource parents in several key ways, including:

- experience in a helping profession, or prior experience working with youth with unmet complex needs;
- capacity for 24/7 availability to respond to youth needs, with at least one parent acting full-time as a Specialized Parent and not working outside the home;
- a commitment to providing unconditional care for the youth regardless of any behavioral challenges that emerge, with a no eject, no reject policy; and
- successful completion of rigorous supplemental training and continuing education.

Enhanced Care Program staff are available to provide in-person support in the home 24 hours per day, seven days per week, further enhancing the level of support and therapeutic intervention available. This support, provided by therapists, rehab counselors and permanency specialists, may include scheduled meetings, additional check-ins during challenging periods or responding to crises in the home as they arise. In some programs, family partners and/or peer support also provide key services to increase engagement and the therapeutic impact of services. Designed to be short-term treatment options, Specialized Parent homes support youth stabilization and the creation of a sustainable legal and/or emotional/relational permanency plans. ECPs are intended to be linked directly with supportive community-based services such as Wraparound and Mobile Crisis Response to support placement preservation. Wraparound services can also assist with family finding and support step-down into traditional ISFC or Foster Family Agency (FFA) homes or with natural supports.



E-ISFC Staff Training

Because the E-ISFC program serves youth with highly complex behavioral health needs, the staff training plan is more comprehensive than traditional ISFC staff training and is aligned with training provided for staff working in an STRTP. In some cases, E-ISFC staff training meets or exceeds the licensing regulations for STRTPs. Training for E-ISFC staff ranges from 80-120 hours of initial training that includes both new hire orientation and

in-program training. Additionally, E-ISFC staff also complete ongoing annual training commensurate with agency and Interim Licensing Standards. Please see Appendix C for an example staff training plans.

Enhanced Care Program staff will receive training and technical assistance to increase cultural responsiveness.

Specialized Parent Training

At the core of the E-ISFC model are the Specialized Parents, who are specifically recruited, assessed, trained and approved by the FFA to meet the individualized needs of youth with unmet complex needs. Specialized Parents often have previous professional experience in the helping professions and/or in working with high needs youth. Regardless of prior experience, all caregivers are highly trained to the E-ISFC model and receive additional training as compared to standard ISFC resource parent training.

To ensure that all caregivers are prepared to meet the unique challenges of the youth in their home, the FFA provides at least 40 hours of intensive pre-approval training, in alignment with both Intensive Services Foster Care (ISFC) standards and TFC requirements, followed by additional training and coaching specific to the youth they will care for. Please see Appendix C for an example list of Specialized Parent trainings.

In addition to the intensive pre-approval training, Celia's identified Specialized Parent, Laurel, received training in managing insulin dependency from Celia's hospital staff. Laurel was also trained in Medication Policies and Procedures, as well as multiple trainings on building resilience and supporting attachment with foster youth who have experienced complex trauma.

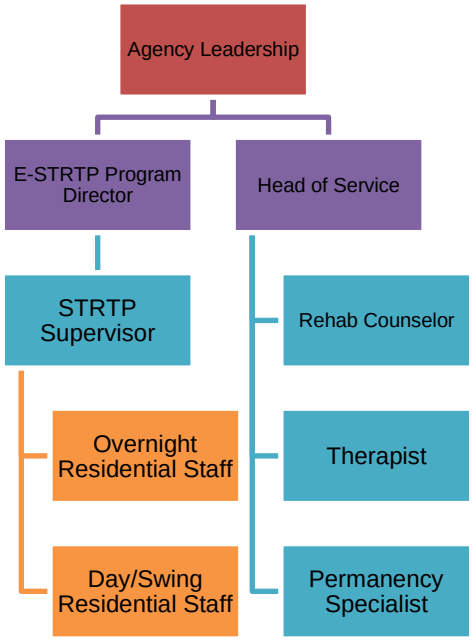
To best support Celia with her history of trauma and substance use disorder, Celia's staff team received additional training on the Seeking Safety model of treatment. Once Celia began to feel a sense of safety with Laurel and her Caring Change (CC) team, she was able to participate in CC's weekly Seeking Safety group therapy sessions, which also provided her with an opportunity to build some relationships with her peers, outside of situations involving her substance use. Finally, Celia's team was trained in DBT training and DBT skills groups, to support Celia's healing.

The FFA conducts a thorough assessment of the parents' skills, experience and capacity to be trauma-informed and develops goals with caregivers for continuous learning. Each caregiver receives youth-specific support from the treatment team, families are invited to attend monthly caregiver group meetings offering support and training. Caregivers must also engage in ongoing training tailored to their specific needs and the population of youth for whom they are caring. This training is offered in group classes, as deemed appropriate, and in the private weekly coaching meetings component of the support they receive while providing Therapeutic Foster Care.

Enhanced-STRTP Staffing

E-STRTP staffing structures are more robust than the minimum direct care and mental health program staff to youth ratios outlined by licensing and DHCS regulations for licensed STRTPs. E-STRTP programs must be able to increase staffing to address any anticipated high needs and to responsively meet such needs when they arise. E-STRTPs should typically assume at least a 1:1 milieu staff to client ratio 24 hours a day; however, it is not uncommon, particularly early in treatment, to have two milieu staff available on site at all times.

Additionally, a rehab counselor and therapist are available and participating in the milieu to enhance therapeutic activities on a daily basis. This staffing model allows for the 1:1 support of youth while balancing care and supervision with therapeutic interventions. Therapeutic supports are provided by staff on the floor throughout the day through planned skill-building interventions and ready response to crisis behavioral needs. For youth with substance use issues, staff will be trained in interventions to address substance use.



E-STRTP Staff Training

E-STRTP staff have access to a dedicated training team to support the rigorous and comprehensive field, classroom and experiential learning required to serve their target population. The team should have considerable experience with residential treatment and developing relevant curriculum and course work. This is particularly critical in assisting staff in balancing their responsibility to act in a trauma-informed manner, while intervening on challenging behaviors.

E-STRTP training is centered on the premise that everything we do and how we do it has the potential to either cue safety and stability or contribute to further dysregulation, disengagement and unsafe coping mechanisms that may compromise safety and security. E-STRTPs must make every effort to translate trauma-informed research into practical and realistic practice for youth and staff.

Training experiences should emphasize the essential elements on trauma-informed care within each training provided to staff:

- Explaining the benefits of trauma-informed approaches
    - Promoting healing and resilience, increasing youth functioning and overall well-being
    - Minimizing retraumatization, reducing the number of critical incidents and crisis services, fewer placement changes

    - Management: enhancing staff resilience and improving job satisfaction, reducing turnover and burnout
- Presenting basic information on trauma
    - What trauma is and how it affects the brain and body
    - Trauma related adaptations, symptoms and behaviors
    - Gender and culturally specific issues, including coping mechanisms,
    - Facilitating youth safety and stability
- Demonstrating effective skills
    - Effective response to youth experiencing challenges with program expectations
    - Responding to youth disclosures of trauma respectfully and effectively
- Sufficient skill practice and rehearsal
    - Using role plays
    - Practicing de-escalation techniques
    - Practicing how to identify boundary issues and maintain professional boundaries
- Reinforcing and building upon strategies that have been used successfully in the past

E-STRTP staff are required to complete orientation training, including up to 80 hours of in-person and online training and at least 8 hours of field training/job shadowing, prior to any work directly with youth. Additionally, E-STRTP staff are required to receive at least 52 hours of training annually. Please see Appendix C for an example list of E-STRTP trainings.

ECP Funding

Designing an effective and individualized program is dependent on integrated funding from child welfare and behavioral health to provide all the necessary services and supports. Delivering the individualized services needed to effectively meet the needs of youth who require complex care necessitates creativity, collaboration, partnership and an unconditional commitment to do whatever it takes to achieve success. These innovative services can be funded through a comprehensive mix of placement and service dollars, utilizing state investments in complex care funding made available through AB153 as outlined in the existing All County Letter (ACL-21-119) with available county allocations described in the recent County Fiscal Letter (CFL 21-22-35) and forthcoming guidance from CDSS. Further detail on each of the below funding streams, as well as additional funding information, can be found in Appendix E.

Complex Care Funding		
Behavioral Health		
Medi-Cal: Specialty Mental Health services	Leverage federal, state EPSDT and local funding. Per-minute reimbursement for services documented in progress notes including assessment, plan development, rehabilitation, IHBS, collateral, therapy, case management, ICC, crisis, medication management	Provisional service rates determined based on provider costs and projected units of services during contract negotiation with county MHP
Medi-Cal Therapeutic Foster Care	Leverage federal, state and local funding to reimburse resource parent therapeutic work. Daily rate based on services and a progress note	Provisional service rate determined based on provider costs and projected units of services during contract negotiation with county MHP

MHSA	Programmatic funding based on county MHSA plan	Based on MHSA fund availability
AB153 Child Specific Funding	Option to apply for child specific AB153 funding for increased anticipated EPSDT local match costs.	Amount based on proposal/request submitted to CDSS. See ACL 21-119 for submission details.
DMC-ODS	Substance Use funding may be available through the Behavioral Health Department	Provisional service rate determined based on provider costs and projected units of services during contract negotiation with county MHP
General Fund	Additional funding needed for cost reimbursement or other expenses that may not be covered through Medi-Cal, social services or other payers.	Reimbursement of costs
Social Services		
Enhanced STRTP or Enhanced ISFC rate individualized rate (through AB2944)	Monthly rate, prorated, for the provision of intensive services negotiated with CDSS	ISFC rate up to $14,035/mo. STRTP rate at least $14,035 per month. Rates set in collaboration with CDSS.
AB153 Child Specific Funding	Option to apply for child specific AB153 funding for increased anticipated county costs.	Amount based on proposal/request submitted to CDSS. See ACL 21-119 for submission details.
Wraparound	Monthly rate, prorated, for the provision of intensive services	Up to $14,035/mo., prorated. For lower rates, funding may be available in reinvestment options
Wraparound reinvestment	County-allocated funds for foster youth via Wraparound and County funding allocations; unused funding received for eligible Wraparound services and funding can be used for alternative approaches	Range of adjunct funding
Grants and Allocations, Community funds; 2011 realignment	Block Grants and other county-specific dollars may be used for pro-social services and activities	Range of adjunct funding
Juvenile Probation		
Enhanced STRTP or Enhanced ISFC rate individualized rate (through AB2944)	Monthly rate, prorated, for the provision of intensive services negotiated with CDSS	ISFC rate up to $14,035/mo. STRTP rate at least $14,035 per month. Rates set in collaboration with CDSS.
AB153 Child Specific Funding	Option to apply for child specific AB153 funding for increased anticipated county costs.	Amount based on proposal/request submitted to CDSS. See ACL 21-119 for submission details.
Wraparound	Monthly rate, prorated, for the provision of intensive services	Up to $14,035/mo., prorated. For lower rates, funding may be available in reinvestment options
Wraparound reinvestment	Similar to social services, probation may share the oversight of these funds	Range of adjunct funding

Grants and Allocations	Block Grants and other county-specific awards may be used for pro-social services and activities	Range of adjunct funding
Regional Center		
Individual Program Plan (IPP)	Services are determined by the Individualized Program Plan (IPP) team to support persons with developmental disabilities and their families to build their capacities and capabilities. Services are coordinated and provided for by the regional center through generic resource coordination or the regional center network of providers or vendors. Services coordinated by the regional center may not fund ECPs, unless the provider is vendored by their local regional center to provide specific services according to their vendorization. Regional center services designated by the IPP can be layered and integrated into the ECP programing, per the IPP.	"Vendor" and "provider" are the words used to describe the community of professionals who provide direct services to people with developmental disabilities through contracts with California's network of 21 community-based, non-profit regional centers. Before providers can provide and be reimbursed for services, they must go through an approval and contracting process with their local regional center(s). Vendorization is the process for identification, selection, and utilization of service providers based on the qualifications and other requirements necessary in order to provide services to consumers. The vendorization process allows regional centers to verify, prior to the provision of services to consumers, that an applicant meets all of the requirements and standards specified in regulations. Applicants who meet the specified requirements and standards are assigned a unique vendor identification number and service code.
Education		
Individualized Education Plan (IEP)	Through the IEP, services may be approved and paid for by the education system for special education and related services. Special Education Dept has to review and the IEP must include specific language about how services are related to youth obtaining a Free Appropriate Public Education. Funds will not be used for programs, but may fund specific services provided by programs.	Funding determined by IEP team
Local Control Funding Formula (LCFF)	District funds are available to provide some direct services, including academic instruction, to students who are in foster care that meet the LCFF definition.	Funding determined by School District
Foster Youth Services Coordinating Program	Can provide direct services to foster youth through AB 130 at the COE level. This requires that the COE FYSCP apply for funds. See this link for more information	Funding determined by FYSCP

	https://fyscptap.scoe.net/resources/additional-direct-service-funds-ab-130	

Start-up and operational costs are part of funding considerations. Start-up costs may be inclusive of funding for recruitment of Specialized Parents (E-ISFC); hiring, training/ramp up for staff; and facilities costs (rental, purchase, renovation or other for offices and/or facility for E-STRTP). Because of these complexities and to guarantee availability of the program as urgent youth needs arise, it is strongly recommended that counties develop cost-reimbursement contracts that fully fund both start-up and operational costs in an ongoing manner. AB 153 provides for funding for these costs through a proposal process to build capacity within counties, though precise guidance on applying for these funds is forthcoming. Please see Appendix D for example Enhanced Care Program budgets.

Funding can also be viewed through the lens of the core program elements. The example below reflects the potential costs of each element of service within an E-ISFC model. The blended funding can cover all or portions of each service, such as social services funding paying for the Specialized Parent, flex funds paying for some of the family finding and stabilization and behavioral health paying for some of the family engagement activities and all of the behavioral health services.

E-ISFC Cost Breakdown Example			
Service	**Rationale**	**Example Monthly Cost per Youth**	**Example Annual Cost**
Specialized Parent	To support high cost of living and incentivize giving their time and energy to the youth: ● Tiered payment approach ● Stipend/housing as available ● Medical benefits ● Matrix of specialty homes ● Type of household/personality for the different youth personalities/behaviors	$ 8000	$96,000
Family Engagement/ Finding	● Family Finding staff time ● Rapid Response Family Finding for youth with no permanency plan ● Rapid engagement for families + youth with a plan. Involves resourcing, parent prep/training, time together with coaching ● 16 hours/week of family search/finding ● Flex funds; travel costs	$5000	$60,000
Clinical Care Team (stabilization, service provision and oversight/ supervision)	● Child and Family Team (CFT) ● Therapeutic Interventions and EBPs ● Community linkage ● Independent Living Skills ● 24/7 Rapid Response ● Flex funds ● Program Staffing (portion of FTE funded per youth): ○ 1 Clinical Program Manager ○ 1 CADAC ○ 2 Clinician II ○ 1 Family Finding Supervisor ○ 6 Family Specialists ○ 1 Family Partner	$12,000	$144,000

	○ 1 Family Finding Specialist ○ 1 Administrative Assistant ● Stabilization up to 24/7, titrating down to 10 hrs./wk.; 40 hrs./wk. average; 10 staff		
	Total	**$25,000**	**$300,000**

Enhanced programs provide significant long-term fiscal savings to future health systems by comprehensively addressing unmet complex needs to reduce crisis and urgent medical services. This link describes these benefits in more detail.

Questions to Consider for Counties

1. What is the current continuum of care in the county and what might be missing?
2. What are the highest levels of care available in your county (Wraparound, Emergency Response, STRTP, Other)?
3. Does the county regularly have placement gaps, frequent placement changes or absences from care with some youth with complex unmet needs in the foster care or probation system?
4. Are there youth that have intensive needs that require more services than Wraparound or currently available community-based services?
5. Are there youth that struggle in congregate care, regularly leave placement without permission or refuse to go to identified placements?
6. Are there periods of time youth in the foster care system with complex unmet needs are at higher risk of engaging in higher risk behaviors and need more intensive individualized supports than can be offered?
7. Approximately how many youth in the county require more intensive, individualized and time-limited programs to stabilize and step down to a lower level of care?