

SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES
PLACEMENT IMPLEMENTATION PLAN¹

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¹ This Placement Implementation Plan is developed to meet the requirements of the *Michelle H. v. McMaster* FSA sections IV.D.1.(a) (Placement Implementation Plan), E.1. (Congregate Care Placements and Emergency or Temporary Placements), G.1. (Sibling Placements), and I.1. (Therapeutic Foster Care Placements).

I. Introduction

DSS leadership is committed to reforming its child welfare system to provide in-home, trauma-informed, evidence-based prevention services to children and families to prevent removal into foster care² and better serve children when removal to foster care is necessary. Fundamental to this reform work is ensuring that the system has the placement and service array to meet the needs of children and their families. The service array (kinship, foster family and residential placements, in-home and community based treatment and supportive services) will support family centered casework practices that leverage naturally occurring family, community and cultural resources to help children in foster care thrive and families to become stable and functional. Child and Family Teams will play a central role in identifying the services and supports that complement the family's unique strengths, needs, challenges and goals. Children in foster care must remain close to their home community, with their siblings and in the least restrictive, most family-like placement. The placement array DSS will develop will be heavily weighted in favor of placing children in family foster homes (preferably kinship foster homes) as the first placement option, but will also include, in reduced numbers, a range of congregate care settings for children whose clinical care or behavioral health needs cannot be met in a robustly supported family or community living environment. A service network will be developed to support children in foster family settings and will provide access to a range of prevention³, in-home (including crisis intervention and stabilization), health, educational, mental health, substance-abuse treatment and family support services. These services can be described broadly as programs that will enhance placement stability, prevent repeat maltreatment, expedite permanency, promote pro-social community engagement, and increase child well-being.

² Preventive services to avert a stay in foster care, while not part of the Michelle H. matter, will assume a larger role in early supports to families, as DSS moves into the planning and implementation of new federal legislation. On February 9, 2018, the Family First Prevention Services Act was signed into law which will dramatically change the way child welfare systems across the country are funded. One of the major areas this legislation seeks to change is the way Title IV-E funds can be spent by states. Title IV-E funds previously could be used only to help with the costs of foster care maintenance for eligible children; administrative expenses to manage the program; and training for staff, foster parents, and certain private agency staff; adoption assistance; and kinship guardianship assistance. Now states, territories, and tribes with an approved Title IV-E plan have the option to use these funds for prevention services that would allow "candidates for foster care" to stay with their parents or relatives. States will be reimbursed for prevention services for up to 12 months. A written, trauma-informed prevention plan must be created, and services will need to be evidence-based.

³ DSS will begin to deliver more in-home prevention services to children to prevent removal into foster care. With this shift, many of the reforms outlined in this Placement Plan will apply to family preservation cases. For instance, the Child and Family Teaming structure will be used to create a plan for the family. And, if at some point during the in-home case, it appears that a child may come into care, much of the work such as assessments and placement decision making will be done prior to entry into care. However, because this Plan is written pursuant to the Michelle H. FSA, which applies only to "all children who are involuntarily placed in DSS foster care in the physical or legal custody of DSS either now or in the future," this shift for family preservation, or in-home cases, is not specifically mentioned throughout the Plan.

Currently, DSS's placement system has a number of serious issues with its placement system, including overreliance on congregate care;⁴ lack of services to meet the needs of children placed in congregate care; lack of a meaningful system to match children's needs to services and placement; multiple, duplicative or sometimes inconsistent case plans for children; lack of meaningful youth and family engagement in placement decision-making; underutilization of kinship care placements; insufficient foster and therapeutic foster homes; a lack of community-based services to meet the needs of children in foster care; and inadequate training and supports for kinship and foster parents. All of these issues make it difficult for DSS to place children close to their home community and with their siblings in the least restrictive, most family-like placement, and to accurately estimate the projected number of new family home resources that need to be developed in geographic areas of the state.

To improve the quality of case planning and decision-making, DSS will develop and implement a child and family teaming process that assures that the team will follow the family to meet their goals throughout their experience in the system. Case planning and placement decisions will be driven by the child and family team, based on an assessment of child and family strengths and needs made by the team, drawing on the collective knowledge of the child and family and other team members and other relevant information from other sources, including formal assessments.⁵

To address deficiencies in the current placement and service array, DSS will build a robust kinship foster care and relative caregiver support program, improve foster parent training, services and supports, expand the role of private providers in the recruitment and support of foster homes, and develop and implement performance based continuum contracting so that providers have increased flexibility, responsibility, financial incentives and accountability for working with children and their families, ensuring child well-being, and helping children achieve timely permanency.

⁴ Prior to entry of the *Michelle H.* Final Settlement Agreement, this was particularly true for children 0-6; however, DSS has done a significant amount of work over the last two years to dramatically reduce the number of children 0-6 placed in congregate care.

⁵ The term "assessment of strengths and needs" as it is used in the context of Child and Family Team decision-making, includes the kinds of formal assessments typically associated with the health care system, focused on diagnosis and treatment. The information generated by those assessments helps the team ensure that health care needs are identified and addressed in the plan; and those assessments also help determine which of the health related needs are eligible for Medicaid coverage. However, in case planning and placement decision making, the Child and Family Team is focused not just on physical and behavioral health needs of the child, but on needs and strengths related to education, recreation, social development, and on assessing the child's situation to ensure that a child in foster care has access to the same kinds of age appropriate opportunities and experiences that are associated with healthy child and adolescent development and successful transition to adulthood. And, of course, central to the case planning of the child and family team is the assessment of family functioning.

Intersection of Planning and Work Products Related to Practice Model, Congregate Care Study, Health Plan, Workload Analysis, and Budget and Finance

The development of this Placement Implementation Plan is just one of a number of concurrent planning activities that DSS has undertaken as part of its multifaceted system improvement effort.⁶ This concurrent work includes a range of planning activities related and unrelated to the *Michelle H. Final Settlement Agreement (FSA)*: developing and implementing a new practice model; recruiting and retaining a capable and committed workforce and caseload ratios; ensuring the quality and appropriate use of congregate care; meeting the physical, mental health and dental needs of children in care; building out its data analytics and performance reporting capabilities, re-envisioning training, partnership relationship management and ensuring, through a combination of state dollars and federal reimbursement, that there are sufficient funds to support the reform.

The DSS Placement Implementation Plan has been informed by the work products generated from these other planning activities. When those planning activities have already resulted in the endorsement or approval of particular goals or principles or in specific findings and recommendations, the Placement Plan includes strategies that are consistent with those goals, principles, findings and recommendations. The Placement Plan also contains placeholders related to work underway by the other DSS work groups that will impact placement policies and practices once that work is completed and implemented. In some instances, the Placement Plan anticipates forthcoming developments in policy and practice based on the announced intentions of work group decision makers or on logical inferences drawn from decisions already made by DSS work groups.

This Plan was also informed by the Placement Needs Assessment, completed by the University of South Carolina in August 2017. The short summary of findings, attached as Appendix A, include quantitative data with respect to children's placement settings and location as of March 31, 2017. Some major takeaways from those findings include:

- Of the 4,114 children in care, the greatest number (36%; 1,492) were from Region 1, followed by Region 2 (22%; 903).

⁶ The Placement Plan also took into account the results of Round 3 of the CFSR in South Carolina which found that DSS was not in substantial conformity with any of the safety, permanency or well-being outcomes. DSS is required by the Children's Bureau to develop a Program Improvement Plan (PIP) to address the areas in which it was not found to be in substantial conformity and safe, timely, and appropriate entry and placement in foster care are key components of safety, permanence, and wellbeing. Practice trends identified by the Children's Bureau based upon CFSR case reviews include: lack of quality assessments; the need to focus on engaging parents, youth and caregivers; unstable and multiple placements for children; and lack of access to services. The Placement Plan includes strategies and action steps that are relevant to each of these practice trends.

- Approximately 66 percent of children in foster care were placed either out of the county of origin or out of state; 25 percent were placed out of their home region or out of state. Specifically, 26 percent of children who came from Region 1 were placed out of the region, and 45 percent of children from Region 5 were placed out of their home region.
- Statewide, approximately 78 percent of children were placed in a family home setting⁷; 22 percent were in a group setting⁸; and less than 1 percent were placed in other settings⁹.
- Of children in family settings, slightly over half (55%) were placed in a foster home and 34 percent were in a therapeutic foster home.
- The majority of children in foster care were White (55%), followed by African American (37%). Only seven percent of the children in foster care were Hispanic.
- Approximately 32 percent of the children in foster care were between the ages of seven and 13; 43 percent were in the birth to six age group; and 25 percent were between 14 and 17 years of age.
- Statewide, 30 percent of foster children were placed in a high level of care¹⁰. Most of these children were older, between 14 and 17 years of age (47%), male (59%), White (51%), and non-Hispanic (93%). Seventy-three percent of these children were placed in a family home environment; however 82 percent were placed out of their county of origin, and 49 percent were placed out of their Region of origin.

II. Placement Plan Elements, Strategies and Action Steps

The Placement Implementation Plan is intended to be a dynamic document with some strategies that will be implemented simultaneously on a statewide basis and others that will be phased-in or piloted in particular regions or counties. DSS expects that work on pilot projects will be refined based on lessons learned, progress in meeting designated outcomes, and evolving reform work underway by other DSS work groups. The timetables for implementing the strategies are included below and are intended to reflect both the need for urgent and quick action and reasonable time to develop and support the range of partnerships and processes that will be needed for success. Implementation timeframes for strategies are shown within three phases or time periods: Short-term/phase 1 (to begin immediately and to be significantly accomplished within 6 months); Intermediate/phase 2 (to begin within 6

⁷ A Family home setting includes the following type of placements: Adoptive Home (Foster Parent), Adoptive Home (Relative), Foster Home, Foster Home (Relative), Pre-Adoptive Home, Other Adoptive Home, Therapeutic Foster Home, Court Ordered Parent, Court Ordered Unlicensed Non-Relative, and Court Ordered Unlicensed Relative.

⁸ Group Home setting includes Group Home - DJJ, SIL, Child Caring Institution, Residential Treatment Facility, and Emergency Shelter.

⁹ Type of placements defined as "Other setting" includes Alcohol/Drug Treatment Facility, Correctional Facility (Non-DJJ), DJJ Facility, Hospital (Non-Temporary - 30+days), DMH Psychiatric, and School/College.

¹⁰ A high level of care is defined in CAPSS as a High Management, Moderate Management or Therapeutic Foster Care Level I, II, or III.

months and be significantly accomplished within 18 months) and Long-term/phase 3 (to begin within 18 months and be significantly accomplished within 36 months). For strategies that need to be field-tested prior to issuing statewide policy, the Department will use administrative issuances to communicate the policy direction to the field. Once the strategy is tested and proven effective, it will be considered for statewide implementation, and the Department will adopt and revise and train all staff on new policy accordingly.

This Plan identifies five major strategy areas and there is work that will begin in each of these areas immediately. To the extent feasible and in order to be responsive to the Court's request, the Plan provides specific information about costs and timelines. Special attention has been given to identifying those activities that will be completed within the next six months, particularly with respect to kinship care. For those activities where the immediate actions constitute pilot testing in select counties as first steps in implementing the broader strategies, the cost estimates and timelines are less precise and will need to be informed by the pilot processes. For this reason, it is anticipated that the intermediate timelines (6 to 18 months) or longer term timelines (18 months to 36 months) will be revisited and adjusted periodically, in consultation with the Plaintiffs and with the approval of the Co-Monitors and the Court.

The strategies are grouped around five key thematic operational goals: These goals, subsections A-E below, address:

- A. Case Planning and Placement Processes;
- B. Restructuring the Partnership between DSS and Private Providers;
- C. Utilization and Support of kin and fictive kin as kinship foster care providers;
- D. Recruitment, Retention and Utilization of Non-Relative Foster Parents;
- E. Conducting a Placement Pilot.

A. Restructure the case planning and placement process to be driven by a well-constituted child and family team and collaborative decision-making

DSS has a vision for practice which is captured in the working draft of its practice model. The practice model emphasizes the following core practice elements: Building trusting relationships and engaging children and families in the assessment, placement, case planning and implementation process; convening a team that includes the family and those working with the family and gathering information, including formal assessments, from other sources to help assess the strengths and needs of the child and family; developing a plan that builds on those strengths and addresses those needs and that responds to the concerns that brought the child and family to the attention of DSS; making placement decisions driven by the child and family team; implementing the plan by delivering the needed

services, supports and interventions called for by the plan; and tracking progress under the plan and making adjustments in the services, supports and interventions or in the plan itself based on the progress being made.

DSS currently has established a family group conferencing structure for engaging families and convening teams, utilizing specially trained facilitators. However, as discussed below, the structure is being used for very limited purposes, and is largely disconnected from (and often viewed by families, case managers, and private providers as irrelevant to) the variety of other case planning and implementation activities that impact the experience of children in care and their families. The “family plan” (the term used for the plan that is developed through this family conferencing process) is only one of a number of plans that are developed and it often has very little impact on those plans or on the trajectory of a case.

The Department believes that by building upon and strengthening the current team conferencing structure, a child and family teaming process can be created that more authentically engages children and families and results in integrated case management that enables the case manager and the Child and Family Team to access necessary information and identify placement resources based on the individualized needs of the child and family. It also includes the development of a single master plan for the child and family that addresses child safety, well-being and permanency in a way that makes sense both to the families and to the service providers and case managers working with them. Having a single plan, developed collaboratively with the family and key service providers, will help ensure that delivery of services and supports to the child and family will be better coordinated, and will increase the likelihood that the goals of safety, well-being, and permanency will be achieved. While family teaming has been used up until this point as a specific activity, the ultimate goal of DSS is that teaming is also a practice approach and principle that workers use with families, each other, outside partners, etc.

1. *Strategy A.1 – Expand the purpose of the current family team meetings and family group conferences (for ease of reference hereinafter referred to using the generic term Child and Family Teaming (“CFT”) to encompass and align with the core practice elements of the practice model.*

DSS has a structure for engaging families and convening teams that relies on a contract provider (and subcontractors) to coordinate and manage the four key components of family engagement spelled out in the contract. The assigned coordinator is responsible for

conducting Family Finding (FF), convening and facilitating Family Team Meetings (FTM) and Family Group Conferences (FGC)¹¹ and completing Unlicensed Relative Assessments (URA).

The family engagement structure is currently being used more narrowly than the design allows and is largely disconnected from (and often viewed by families, case managers, and private providers as irrelevant to) the variety of other case planning and implementation activities that impact the experience of children in care and their families. With some modification of the current family team meeting approach and expansion of its purpose, the Child and Family Team process will better support collaborative decision making, seamless delivery of service provision and more family-centered case plans that empower families to be active and helpful participants in the process.¹²

The DSS practice model (currently in final stages of development) highlights the use of the Child and Family Team Meeting (CFT) for making critical decisions and developing meaningful case plans. This is based on the belief that the best way to aid and protect children over time is to strengthen and support families in understanding and carrying out their responsibilities. The intent of the CFT process is to ensure the long-term well-being of children through the provision of services and supports that complement the family unit's unique strengths, challenges, and goals. The process is grounded in an understanding that family members are most knowledgeable about the events that brought them to the attention of DSS; the underlying conditions and causes of their behavior and the strengths they have in developing solutions. It also creates an opportunity to identify and share information about the child's medical or mental health history, education and other needs.

The CFT model provides family-focused teams with the discretion and the power to locate and use placement resources, including kin and fictive kin and in home and in community supports, and create placement, service and treatment plans that meet the needs of children and their families. The individualized focus of the process, coupled with the continuous and supportive relationships

¹¹ Pursuant to the terms of the contract, the FTM is to be held the next business day after a child enters foster care (but no later than 3 days of the child's entry). The first meeting (FTM) is described in Departmental documents as "an agency driven, addressing safety and outlining assessments needed for more thorough planning." The second of these meetings, FGC, is to occur within 25 days after the child entry to foster care and is to be "guided by the family for the purpose of identifying the family's needs and the services, supports and resources that will help them meet those needs." The FGC is an evidence-based approach that produces a Family Plan developed in partnership with the family group and DSS. By South Carolina statute, the family team meeting must occur within 24-hours of the child coming into care and the family group conference must be held within 30 days of the child coming into care. As part of initial implementation, DSS will confer with the Co-Monitors and a TA provider, as described below, to address the use and integration of these various types of team meetings, with the goal of utilizing a framework that is coordinated and that creates continuity for families.

¹² See Appendix B for an initial conceptualizing of core principles and approaches to which a new Child and Family Teaming process will need to align.

developed between the child, family, case manager and the other members of the Child and Family Team, assures that children and families receive the best placements and most appropriate services and supports to promote helpful change and achieve permanency.

In order to build on the best aspects of DSS's family engagement approach, DSS will make structural changes to the current family team conferencing process. Highlights of the structural and practice changes include:

- In consultation with the Co-Monitors, the Department will identify and engage a technical assistance provider with expertise in training, coaching and implementing the family group conferencing approach envisioned in the DSS practice model, in order to assist the Department in implementing its CFT model.
- DSS will restructure the focus, purpose and protocols of the Child and Family Teaming process to include: adopting the more generic single term, Child and Family Teaming, to align with the case practice model; preparing and orienting families to the process; holding the meetings at critical junctures of the case and as needed; using strengths-based approaches and conducting ongoing assessments that identify the child and family's underlying needs; matching service to needs; and maintaining and sustaining the CFT throughout the life of the case.
- DSS will develop a protocol, guidance and timeframes for the field about the new Child and Family Teaming model (including Administrative Issuances to pilot the approach), assessment tool(s), availability of case-specific information from DSS partners and administrative data, the frequency of child and family team meetings and family group conferences, documentation requirements in CAPSS and other documentation requirements.
- DSS will determine whether contract modifications are necessary to the Family Engagement contract and, if necessary, make contract modifications to align with the Placement Plan.
- The Department's Family Engagement Liaisons, DSS staff who have been responsible for training the contract Engagement Coordinators on team meeting facilitation, will provide training on the new CFT approaches and protocols, including training and coaching DSS staff in CFTM facilitation (see strategy A.4). Family Engagement Liaisons will be deployed in the immediate term to work with DSS staff to develop a CFT schedule for existing foster care cases for children that have been in care for at least 9 months and have not had a CFT in the last 6 months.

Milestones, Timing, Resources & Oversight

Milestones of Progress	Timing¹³	Projected Implementation Date¹⁴	Resource Commitments
Communicate restructured CFT process to staff, providers, lawyers and judges	Short term	March 1, 2019	
With TA assistance, DSS will develop a protocol and guidance and timeframes for the field about the new Child and Family Teaming model (including Administrative Issuances to pilot the approach), assessment tool(s), availability of case-specific information from DSS partners and administrative data, the frequency of child and family team meetings and family group conferences, documentation requirements in CAPSS and other documentation requirements	Short term	June 30, 2019	
DSS will determine whether contract modifications are necessary to FE contract and if necessary, make modifications	Short term	Determine whether contract modifications are needed – June 30, 2019 Make contract modifications, if necessary, if no additional funds are needed – August 30, 2019 Make contract modifications, if necessary, if additional funds are needed – July 1, 2020	FE contract modification to support infrastructure and capacity enhancements
DSS will secure TA provider to work with and coach FE Liaisons in new CFT practices. This will initially occur in the pilot counties and then deployed by region throughout the state.	Short term	Determine cost of TA assistance – March 1, 2019 TA to begin – May 30, 2019 (to account for contracting process)	TA contract
DSS will, with TA assistance as necessary, develop and implement training and coaching plan for CFT process for new and existing caseworkers and will secure a TA provider, if necessary, to shadow FE Liaisons and DSS staff in implementing the new CFT process	Intermediate	Develop training and coaching plan in consultation with the Co-Monitors – August 30, 2019	Possible TA contract

¹³ In Tables throughout this document, this designation indicates the projected start date of implementation. See discussion on p.5, 6.

¹⁴ In Tables throughout this document, the Projected Implementation Date is the anticipated completion date.

		Begin Implementing training and coaching plan –October 30, 2019	
DSS will design and implement: a QA process that regularly assesses the fidelity of CFTs	Intermediate	QA Process to be developed and begin implementation by – December 30, 2019	

2. *Strategy A.2 – Expand the Child and Family Team to include older youth, foster parents, private providers and others who have a supportive relationship with the family and take steps to prepare them to effectively participate in collaborative decision making.*

The CFT is the forum that will be used to call together, on an ongoing basis, a team of committed individuals who will work to strengthen the family and help it craft and monitor an individualized case plan. As mentioned above, CFT mirrors the way in which families generally form natural helping systems or community supports to meet needs and solve problems in times of crisis. The members of the Child and Family Team will bring the best of their skills and resources to bear upon problem-solving, service plan development, and resource utilization. The CFT process will use a strengths-based framework that will elicit child, youth and family insights and experience, recognizing that they are the experts about their own family, and apply it to finding solutions and developing a plan of care. As DSS rolls out its practice changes, it will consider when the CFT process can be used with a family before a child has entered custody (while this process is not part of this court-ordered plan, it represents the direction that DSS wants to move in terms of connecting upfront with families and developing contingency placement plans in the pre-placement period that consider the family’s kin preference if time in foster care becomes necessary).

DSS will seek to authentically engage youth in the process so that they have a voice in planning.¹⁵ By adopting a participatory decision-making process, DSS staff expects to join with children, their families and identified community supports to develop and monitor comprehensive, individualized, strengths-based and culturally appropriate plans.

DSS will promote family engagement in the following ways:

- Identifying family members and resources for the Family Team Meetings.
- The family engagement coordinator will apply the same set of skills and competencies used in effective family finding, genogram construction and eco-mapping to recruit a strong and robust family team to attend in person, by telephone or

¹⁵ “Nothing About Us Without Us” is the teaching mantra for national youth advocacy organizations using evidence informed approaches to youth engagement. Two foster care alumni attending a Region 1 advisory group meeting expressed feeling great frustration, hurt and disappointment in having decisions made about their lives without their input.

by video conferencing the initial and subsequent CFT. Recruitment of family team members will be ongoing and dynamic so that the team composition can change in response to emerging needs.

- Prior to the initial CFT, families and youth will be briefed in person about the CFT process and the opportunities for them to fully participate.
- The family engagement coordinator will attempt to contact any clinicians who have relevant information about the child and/or family, to arrange for their input in person, by telephone or by video conference.
- Develop a youth engagement strategy, in consultation with the Co-Monitors, that includes the identification of resources needed to carry it out.
- DSS, in collaboration with private providers, will create avenues for peer support and training to develop self-advocacy skills.
- Communicate to families and youth in care the importance of attending and participating in the Family Team Meetings.
- DSS will require that caseworkers inform and encourage youth to attend upcoming CFTs. As is current practice, DSS will provide transportation assistance for youth and families to attend CFTs Meetings. CFTs should be scheduled in a manner that makes it easy for parents and older youth to participate, recognizing that a youth can choose not to attend and participate. When the youth doesn't attend, the reasons will be documented in the child's case file.

Milestones, Timing, Resources & Oversight

Milestones of Progress	Implementation Timing	Projected Implementation Date	Resource Commitments
FE Coordinators and DSS, with TA assistance if necessary, will work to develop processes for including clinical input and distance participation in ways that preserve the primacy of the CFT.	Short term	To be done in conjunction with development of protocol and guidance of new CFT model – June 30, 2019	Possible TA Contract
Design YE program, propose draft budget and launch YE program within DSS	Long-term	Design YE program and propose draft budget – September 1, 2019 Launch YE program – July 1, 2020	Funding to implement YE program with funds for all 3 elements described above

3. *Strategy A.3 – Use the child and family team to: make key decisions related to case planning and placement decision-making (utilizing information developed from formal assessments as well as information provided to and by team members, including the family and youth) with the team’s planning and placement decisions having presumptive authority to guide the case; and to consolidate multiple plans into one master plan for the child and family that makes sense to the child and family and to the case managers and service providers working with them.*

The Child and Family Team will be empowered to make key placement and case planning decisions that meet the needs of children and their families. They will have access to key resources to help in the decision-making processes. These resources will include the family’s network of support, the broader neighborhood and community in which the family lives, schools, places of worship, community services agencies, kinship care experts, placement resources specialists, Independent Living specialists, legal representatives, therapeutic treatment staff, institutional staff and other private providers. DSS will develop a placement tracking system so that teams will have accurate, real-time information about available placement options. In making placement decisions, the role of placement resource staff will be to inform caseworkers of placement options to present to the Child and Family Team to enable them to make informed decisions. The team will also have the benefit of available information about the child’s physical and behavioral health, including that generated from formal assessments and assessment tools. In order to maximize the full potential of the CFT process to effectively engage children and families and to achieve desired outcomes, the decisions made by the Child and Family Team must be afforded due deference and respect.

The current family engagement structure promotes uncertainty about the relevance of topics discussed and the weight given to decisions made at team meetings. Families, children, caseworkers and providers report being confused by the proliferation of plans that are developed and used in different contexts to define goals, expectations, responsibilities and measures of success for families, children, providers and DSS. For example, the plan that is developed at the initial FTM is largely disconnected from (and often viewed by families, case managers, and private providers as irrelevant to) the variety of other case planning and implementation activities that impact the experience of children in care and their families. The “family plan” (the term used for the plan that is developed through this family conferencing process) is only one of a number of plans that are developed, and it often has very little impact on those plans or on the trajectory of a case. The Family Plan is supposed to be incorporated into the Placement Plan and presented to the family court “as part of the agency’s reasonable efforts.” In practice, it is unclear what role the family plan has in presenting information to the court since some DSS attorneys responsible for presenting the Placement Plan to the court have been largely

unaware of the FGC process or that there were Family Plans that the lawyers were supposed to be sure to incorporate into the Placement Plan.¹⁶

As a remedy to the confusion caused by multiple plans, DSS will apply its practice model principles and information from the ad hoc workgroup to distill and synthesize key information from the many plans that affect the child and family and develop a “master plan” for the child and family.

Another advantage of designating CFT as the “family group headquarters” for planning and setting priorities is that it will remove ambiguities about which plans are merely helpful advice and aspirational as compared to plans that are considered enforceable and prerequisites to case advancement. In order to provide clarity around expectations, the collaboratively derived decisions by the Child and Family Team should have presumptive authority in guiding the case and should only be superseded by court orders.

DSS will take the following steps to ensure decision-making is respected and plans are consolidated into one clear master plan:

- DSS will integrate the work of the *ad hoc plan consolidation work group* and develop protocols to guide CFT facilitators in using the CFT process to develop one dynamic master plan that captures the key elements of all the other planning efforts. DSS has demonstrated that it can effectively articulate clear parameters for family engagement coordinators about expectations for meeting processes, agendas and results. Using those same skills DSS will develop guidelines for inclusion of plan consolidation as an agenda item at each CFT.
- DSS will provide training to attorneys on how to use information from FGCs and incorporate information from Family Plans into the Placement Plan which is presented to the family court as part of the agency’s reasonable efforts.

¹⁶ DSS has an ad hoc work group that is looking at ways to consolidate planning efforts. Families and children are impacted by a half a dozen or more plans that affect the child’s experience in foster care and the child’s permanency pathway. During a planning exercise, several members of the Region 1 advisory group stated that there are so many plans it would be difficult to describe them all. They mentioned a list of plans that should be examined and considered for consolidation into a master plan which included: the CFASP (Child and Family Assessment and Service Plan), Private Provider Comprehensive Care Plan (created separately and independent of DSS plans) for the child, the permanency plan (with visitation schedules), the preliminary family service plan from the initial FTM, the family plan developed at the FGC which contains service and treatment expectations, education plans (504, IEP, best interests plan for possible change of schools), the transition plan for moving from private provider care, and transition plan created in advance of exiting or aging out of care (Fostering Connections and Increasing Adoptions Act).

- DSS will streamline and coordinate the documentation and reports required in the first 30 days of placement and will train DSS staff, foster care provider and foster parent support organizations, and other partners on the new integrated planning process. The training will cover the new placement process, new approach to CFT Meetings, planning documents and reports, roles and responsibilities as participants in CFT.
- Develop protocols to reconcile court orders and plans developed in the CFT process when incongruence occurs from normal plan adjustments that occur as information is obtained and circumstances change. DSS will make sure that when significant adjustments to the plan occur that the adjustments are discussed and made part of the master plan in a CFT; presented to the court for modification of court orders if necessary; and timely entered into CAPSS.

Milestones, Timing, Resources & Oversight

Milestones of Progress	Timing	Projected Implementation Date	Resource Commitments
DSS will present findings of case plan work group to key leaders at DSS	Short term	4-30-19	
DSS will train supervisors, case managers, placement staff, private providers and attorneys on consolidated planning process, products and use	Intermediate	10-31-19	Training team with dedicated days to plan consolidation training project
DSS attorneys systematically inform judges on new processes	Short term	10-31-19	

4. *Strategy A.4 – Utilize the Department’s family engagement liaisons and internal training staff to serve as trainers and coaches to DSS case managers so they can facilitate ongoing CFTs.*

DSS has established a structure for engaging families and convening teams that relies on a contract provider (and subcontractors) to coordinate and manage the four key components of family engagement spelled out in the contract. The assigned coordinator is responsible for conducting Family Finding (FF), convening and facilitating Family Team Meetings (FTM) and Family Group Conferences (FGC) and completing Unlicensed Relative Assessments (URA). The Coordinators have been able to handle a relatively large volume of cases with some degree of consistency in setting agendas, collecting data and producing reports. However, giving these Coordinators special responsibility for family engagement may have had the inadvertent effect of de-emphasizing the importance of case managers’ role and responsibility to engage family members. Family engagement is not a component of casework practice that DSS should

outsource. And while it is helpful to have a cadre of external engagement coordinators available to facilitate the initial meetings and complex meetings, it is also important for DSS case managers to develop skills around family engagement and to become comfortable convening and facilitating a team meeting to address issues that arise. As discussed in Strategy A.1 above, DSS intends to utilize the DSS Family Engagement Liaisons, the DSS staff who currently train the Engagement Coordinators who facilitate team meetings under the current contract, to train, coach and mentor DSS case managers in facilitating CFTs.

DSS will take the following steps to strengthen Family Engagement Liaisons and use them to train, coach and mentor DSS supervisors and case managers so DSS can acquire internal capacity to engage family group teams and facilitate CFTs:

- DSS will use Family Engagement Liaisons to develop a training and coaching plan for supervisors and case managers within regions that will pilot the new approach.
- DSS will use Family Engagement Liaisons to train remaining staff.
- After training, supervisors and case managers, with the assistance of Family Engagement Liaisons as coaches, will facilitate CFT held for the purpose of collaborative decision making in the course of the case.
- DSS will work to ensure that the pre-service training required for newly hired case managers and staff will include skill development to enhance family engagement and facilitation of CFT.
- With assistance from the TA provider referenced in Strategy A.1 above, DSS will assess the capacity of the Family Engagement Liaisons to deliver the above described training and coaching, explore opportunities to enhance that capacity, and will work collaboratively with the Co-Monitors to develop a schedule for delivery of that training.

Milestones, Resources, Timing & Oversight

Milestones of Progress	Implementation Timing	Projected Implementation Date	Resource Commitments
Develop coaching and training plan for DSS case managers and supervisors	Short-term	Develop training and coaching plan – August 30, 2019	
Family Engagement Liaisons to provide training to supervisors and case managers in pilot counties	Short-term	Implement training and coaching plan in pilot counties by September 30, 2019	

Family Engagement Liaison to provide training to supervisors and case managers in other areas of the state; training will be rolled out by region	Intermediate	Start training March, 2020 and complete by 5-30-2020	
Include CFT facilitation into DSS pre-service training curriculum	Intermediate	3-30-20	

5. *Strategy A.5 – Design and implement an integrated assessment process that links initial and ongoing safety, risk and functional family assessments as well as any available medical or mental/behavioral health assessments; produces a coherent family story to inform the development of individualized plans; and includes input from children and families.*

The purpose of the assessment process is to collect and analyze relevant information to inform planning to address safety, risk, family functioning, strengths and needs, and health and behavioral health issues. The process is ongoing, involves both formal and informal assessments and in some instances involves using a series of tools to aid in the collection and analysis of relevant information.

Casework and permanency planning on behalf of a child and family will be linked to the safety concerns and risk of future harm that brought them to the attention of DSS. Assessments are used to help identify needs and inform plans for providing services and supports to meet those needs. Information from the various formal and informal assessments help the child and family team understand the best way to provide the most appropriate services to children and families, at the right time, and in the right setting.

DSS understands that placements and services are different but related concepts. The DSS practice model suggests that in all but the most extreme cases, services should be wrapped around the child and provided in the least restrictive and most family like setting possible. Just as most children in an intact family can receive physical and behavioral health services without moving that child from her home, children in foster care should receive needed services in a foster family setting without being placed or moved to a more restrictive setting, unless that is absolutely necessary.

DSS will take the following steps to design and implement an integrated assessment process:

- DSS will establish protocols providing that each child will receive an assessment of strengths and needs to use to inform decision-making about matching the child with the most appropriate least restrictive placement and services;
- DSS will select an evidence informed assessment tool, such as the CANS, to capture assessment information for children in care and will train workers on the use of the tool¹⁷;

¹⁷ Action steps for selection of an evidence-based assessment tool are also included in the Health Care Improvement Plan.

- DSS will train case managers in how to authentically engage families and work collaboratively with them to conduct functional assessments that help tell the family’s story and provide information that will help undertaking functional assessments as described in the DSS practice model;

Milestones, Timing, Resources & Oversight

Milestones of Progress	Implementation Timing	Projected Implementation Date	Resource Commitments
<p>Select evidence-informed assessment tool to capture assessment information for pre-placement and point-in-placement and service planning decisions and will train workers on their use</p> <p>Make budget request and engage in procurement process for new assessment tool</p>	Short term	<p>Deadline of 8-30-19 for selecting the assessment tool</p> <p>Deadline of 9-30-19 to make budget request or to conform with budget cycle</p>	Budget request for tool and/or training for tool
Implement recommendations in the Health Plan regarding health care coordination and management	As outlined in the Health Plan addendum	Timelines to conform to those in Health Plan addendum, once approved by Co-Monitors.	
Develop roll-out plan for training, certification and use of the revised Universal Application (UA) as standardized assessment tool pending procurement of new evidence-informed assessment tool	Intermediate	<p>Deadline of 8-30-19 to modify the UA</p> <p>Implement modified UA – November 15, 2019</p> <p>Implementation completed for new evidence-informed assessment tool by December, 2020</p>	
Continue implementation of Health Plan activities and other deliverables related to service capacity, access and availability	Intermediate and Long-term	To conform with timeframes in healthcare plan	

B. Restructuring the partnership between DSS and the private foster care providers to foster and support the development of a placement and service array to meet the needs of children coming into state custody

The Department recognizes that each region has a group of private providers that are capable and willing to play a role in broadening and strengthening the placement and service array. By building on the collective strengths of private providers in each region and utilizing their existing assets and their untapped service potential, DSS believes that it can redesign the current placement and services array to conform with its new vision for family-based foster care and access to a robust service array that can support most children in family settings.

DSS believes to successfully shift away from congregate care to family-based care, as required by both the Settlement Agreement and the Family First Prevention Services Act, and to improve both well-being and permanency outcomes, the Department needs to partner with the provider community to develop and implement performance based continuum contracting. Restructuring the relationship with private providers to more effectively collaborate with providers is a necessary first step toward developing contracts that incentivize serving children in family settings and measure and reward providers based on performance measures and outcomes that matter in the lives of children and families. The process for developing and implementing performance-based continuum contracting will necessarily involve, among other things, an expansion of responsibilities for agencies who provide placements for children, a revision of the rate structure and, related to that, changes to the way in which level of care is determined and shared understanding of the outcomes to be achieved for children and families. It will also require a very different process for quality assurance and provider oversight. Fortunately, technical assistance is available from those who have successfully implemented PBCC in other states to facilitate the development and implementation of PBCC in South Carolina.

- 1. Strategy B.1 – Design and implement an approach to performance-based continuum contracts that incentivizes providers to develop services for children and families that are delivered in the least restrictive setting, that improve placement stability, and that ensure timely the movement toward permanency.*

DSS intends to develop and implement performance based continuum contracting that allows providers flexibility in designing services for children and families, the ability to facilitate rapid movement of children through the service system toward permanency, and the ability to customize the delivery of services to children and families in the least restrictive setting, including after the child returns home.¹⁸ Providers will be able to develop, deliver or link to a service network that includes a continuum of treatment models,

¹⁸ DSS is looking at several continuum contract models that share similar features. For example, the Department of Children’s Services in Tennessee, who has provided DSS with peer to peer consultation during the exploratory stage, maintains a network of “Continuum Contracts” with private agencies providing out-of-home care and services to children

interventions and supports services for children with moderate to complex mental health, behavioral, and medical needs that go beyond the scope of services offered through the state managed care plan. Foster care agencies will be able to access or deliver services necessary for maintaining the stability of the child/youth and if the agency is unable to provide a particular service to a child/youth directly, the continuum will procure the service from an appropriately credentialed entity.¹⁹

DSS will contract with technical assistance to explore the various performance-based continuum contracting models and, in consultation with the Co-Monitors, adopt a model for implementation in South Carolina. To inform selection and development of this model, DSS will designate staff to work with its private providers and other entities/sources of information, as necessary, to identify and estimate the current number of children in need of therapeutic services, regional service and placement gaps, or specialized services (e.g. for dual jurisdiction with juvenile justice, pregnant and parenting teens, large sibling groups, sex trafficked youth), and to specifically explore whether specialized services should be built into the continuum with special financial incentives or possibly as a stand-alone special service, and other information that will be necessary to inform the development of the model.

DSS will take the following actions to build a performance-based continuum contracting model:

- In consultation with the Co-Monitors, the Department will engage a TA provider with experience designing and implementing performance based continuum contracting in other jurisdictions and the private provider community in developing and implementing performance based continuum contracts.
- With appropriate support from the TA provider, DSS will host information exchange and planning meetings with congregate care and family foster care providers to: provide an orientation of the performance based continuum contracting concept to providers; to discuss and inform DSS's plans for transitioning to performance based continuum contracts; to solicit input for implementation; and to encourage interested providers to actively collaborate with the Department in the development and implementation of PBCC.
- DSS will designate staff to work in close collaboration with its private providers and other entities/sources of information, as necessary, to identify and estimate the current number of children in need of therapeutic services, regional service and

in the custody of the Department and services to their families. A Tennessee Continuum provider is responsible for delivering all services necessary for maintaining the stability of the child and family. That service may be delivered in a variety of treatment settings: a Residential Treatment Center, a Group Home, and a Resource Home or in the youth's home receiving In-Home Continuum Services. If an agency is unable to provide a particular service to a child directly (the agency's per-diem rate for the child covers some services), the provider must procure the service from an appropriately credentialed entity. Children cannot be disrupted from their recommended level of care based on an unavailability of services. It is the responsibility of the continuum contractor to coordinate these therapeutic services but it is not an expectation that the contracting agency will be responsible for payment. These community-accessed services therapeutic services may be billed to their designated Managed Care Organization.

¹⁹ This is not to suggest that foster care agencies will have the authority to procure services separately that are offered through the state managed care plan.

placement gaps, or specialized services (e.g. for dual jurisdiction with juvenile justice, pregnant and parenting teens, large sibling groups, sex trafficked youth) and will specifically explore whether specialized services for difficult to place youth should be built into the continuum with special financial incentives or possibly as a stand-alone special service.

- In consultation with the Co-Monitors, DSS will select a performance-based continuum contracting model.
- In consultation with the Co-Monitors, DSS will develop a plan for rolling out PBCC across the state.
- DSS will provide transition funds and assistance to help congregate care providers develop the capacity to deliver and support family foster care and family foster care support services and help family foster care provider organizations that seek to develop more therapeutic and kinship family settings.

Milestones, Resources, Timing & Oversight

Milestones of Progress	Implementation Timing	Projected Implementation Date	Resource Commitments
Step #2: Work with internal and external stakeholders, including, private providers to gather information to support development of the care continuum model	Short-term	By 6-30-19	
Step #1: Retain TA to develop care continuum model	Short-term for retaining TA, intermediate for adopting model	April 2019	Resources necessary to hire TA
Offer incentives for care continuum transition resource development	Short-term	July, 2019	Resources necessary for financial incentives; make budget requests September, 2019
Hold regular information exchange meetings	Short term	By 8-30-19 and ongoing	
Begin testing continuum in first roll out counties	Long-term	July, 2020	

2. *Strategy B.2: Design and enhance DSS capacity to do quality and performance management, monitoring and improvement tracking including tracking administrative (staff qualifications, background checks, financial practices) and direct care activities (-conditions of care, incidents, child-specific goals (movement to permanency, provision of services, repeat maltreatment) and other critical functions required by contracts with family foster care and congregate care providers.*

DSS recognizes that while collaboration with providers is essential to developing the placement and service array required to appropriately serve children in foster care, the Department also has a responsibility to provide effective private provider oversight. The recently issued Congregate Care Assessment Report identifies the key elements of a comprehensive approach to congregate provider oversight. Although that Report focused on oversight of congregate care placements, those same key elements apply to effective oversight of foster homes, including private provider homes and DSS directly-operated foster homes.

The Congregate Care Assessment Report raises concerns about the fragmentation of the current DSS oversight processes and the risk that concerning information may not lead to prompt, appropriate corrective action. DSS will build on its own and the experiences of other state child welfare systems to establish a process for developing a quality improvement and performance management tracking system and protocols, processes, regular reports on the status of foster family and congregate care provider services and assist with provider relationship management and technical assistance.

DSS will design and implement a congregate care and foster home placement oversight and quality assurance system that includes:

- Prompt investigation and response to significant incidents and allegations of maltreatment of a child while in a congregate care or foster home placement;
- Implementation of policies and procedures for the administration of psychotropic drugs that meet or exceed national best practice professional standards; and monitoring of the private providers and foster parents to ensure that they are complying with those policies and procedures;
- Implementation of updated policies and procedures for the use of restraints and seclusion that meet or exceed national best practice professional standards; and monitoring of the private providers and foster parents to ensure that they are complying with those policies and procedures;
- Establishing a process for receiving, reviewing and responding to reports of “critical incidents” both to ensure that providers and foster parents are documenting and responding appropriately to those incidents and that systemic issues that might emerge from a single incident or a combination or pattern of incidents are identified by the Department and appropriate corrective action is taken:
- Establishing a mechanism for receiving, reviewing and responding appropriately to complaints or concerns raised by children, parents, case managers or others about conditions or practices at a particular congregate care placement or foster home including concerns identified by DSS staff in the course of an investigation of abuse and neglect, irrespective of whether the concerns are related to the allegations of abuse and neglect; and
- Establishing a structure for ensuring communication and coordination among the various units and divisions with one or more responsibilities for private provider or foster home oversight, so that information is shared in a way that allows the

Department’s oversight to benefit from the collective wisdom of the various DSS staff involved in the various oversight activities.

Milestones, Timing, Resources & Oversight

Milestones of Progress	Implementation Timing	Projected Implementation Date	Resource Commitments
Develop a “stop-gap” safety monitoring plan for congregate care placements, including but not limited to, developing policy and practice updates and reminders to caseworkers on what should occur during visits with children and refresher training to caseworkers on how to assess children’s safety at every visit and explore issues which have already been identified at congregate care facilities (and other placements)	Short term	Work is underway; timelines to be established separately in “stop gap” safety monitoring plan	
Identify and select technical assistance provider, in consultation with the Co-Monitors, possessing expertise in maltreatment, protection from harm issues (e.g. isolation/restraints, behavior management, psychotropics) and continuous quality improvement	Short term	Deadline of 6-30-19 to contract with TA	TA contract
Work with TA provider to design a congregate care and foster home placement oversight and quality assurance approach that addresses all 6 bullet points above	Intermediate	Deadline of 1-30-20 with understanding that TA may require additional time	
Working with TA provider, develop training module related to placement oversight and quality assurance to include in preservice and ongoing training of DSS staff and require through contracting process that provider agencies incorporate these elements into their training plans	Intermediate	Begin implementation July 1, 2020	

3. *Strategy B.3: Develop a system that tracks, manages and reports placement data in real time and that specifically includes elements that define, track, and provide data necessary for the Department to limit the use of emergency and temporary placements.*

Current placement practices are ineffectual in part because decision makers lack ready access to vital information about the characteristics, location and appropriateness of potential placement settings and about the accessibility, mechanisms and timing for providing needed services. This information deficit has hindered placement staff and case managers involved in placement decisions under the current placement model and, if unaddressed, will continue to create challenges for child and family teams making placement decisions under the new practice model. DSS will take immediate steps to develop within its data management system the ability to track, manage and report placement data necessary for identifying potential placement settings, making appropriate placement matches and providing wrap around and other services and supports to children in care. In addition, DSS will pursue a data exchange agreement with CPAs and group home providers to obtain placement data daily for both DSS and non-DSS children.

In the revised placement process, DSS will use the child and family teaming process to make a more informed placement decision for children, provide tailored services to meet the individual child's needs, and ideally move the child to permanency from his/her first foster care placement. This new approach will reduce DSS's current reliance upon emergency and temporary placements for children. Where still necessary, DSS will limit the number of days a child remains in an emergency or temporary placement to 30 days for the first occurrence and 7 days for a subsequent occurrence within 12 months of the first.²⁰

In its current structure²¹, an emergency placement occurs when DSS must pay an incentive payment to foster families pursuant to an Informational Memo dated September 15, 2015 (Subject – Incentive for Emergency Placements with Resources Families), or Change Order #5 to the licensed therapeutic foster homes and residential providers contract (See Informational Memo dated October 16, 2015; Subject – Emergency Placement Procedures). Incentive payments are offered for these emergency placements for one of the following reasons:

1. When the county desires to place a child or children in a home-like setting but extenuating circumstances make the placement difficult. Extenuating circumstances include, but are not limited to, a child coming into care after hours or weekends, needing to move a child with short notice, or keeping sibling groups together; or
2. A child/youth entering foster care or being discharged from a foster family home, therapeutic foster home or group home within 24-48 hours or a child/youth needs a secure placement that has the staffing, supervision, and structural environment to ensure safety and well-being, and DSS has exhausted its placement referral alternatives; or

²⁰ See FSA Section IV.E(4) and (5)

²¹ Once DSS creates and implements a care continuum model, it will likely phase out use of these incentive payments and revisit the definition of an emergency placement.

3. A child and/or youth has an unscheduled discharge or release from a foster home, therapeutic foster home or group home, DSS has exhausted its placement referral alternatives, and no placements are available or immediately available to meet the needs of the child/youth.

A temporary placement/event occurs in one of the following categories: 1) AWOL, 2) Kidnapped, 3) Respite, 4) Medical Hospital, 5) Psychiatric Acute Care Hospital, 6) Transitional visit with parent/relative/fictive kin, 7) Transitional visit with a future foster parent, 8) Transitional visit with potential Adoptive resource, 9) Summer camp.

Pursuant to the FSA, DSS will begin identifying, tracking, measuring, and reporting the use of emergency and temporary placements by July 2019.

4. *Strategy B.4: Identify and track youth dually involved with the SC Department of Juvenile Justice and the SC Department of Social Services²² and continue to strengthen communication and collaboration with the SC Department of Juvenile Justice for the benefit of the children served by both agencies.*

In recent months, DSS has made efforts to increase its ability to identify, track and plan for placements for Class Members as they exit the juvenile justice system. DSS has entered into a Memorandum of Understanding with the Department of Juvenile Justice (DJJ) concerning its dually-involved population of children/youth. Liaisons have been identified in each DJJ and DSS county office, and pursuant to the MOU, the liaisons are to work together to identify, staff, and coordinate placements for children who are involved with both DSS and DJJ. In addition, work is underway to modify DSS's CAPPS system to identify and report placement information for dually involved youth. CAPSS data regarding dually involved youth will be available for reporting in July 2019.

The Department recognizes that promptly re-placing youth leaving a juvenile justice placement into an appropriate placement matched to meet their needs is a specific challenge in the DSS system. The Department commits to taking actions to more specifically quantify the size of this population and their placement needs, building an appropriate placement array for this population, and targeting casework and service supports to best plan for placement before and after the youth leaves a juvenile justice facility, including trauma informed services and supports.

²² As defined in the DSS/DJJ MOU protocol.

C. Develop a plan to incentivize the development of additional licensed kinship placements and restructure processes used to identify, utilize, engage and support kin and fictive kin as placements and family group support resources

In addition to the planned conversion of congregate care beds to foster family opportunities to support the goal of family-first foster care placements, DSS seeks to increase the number of children who are placed with relatives (kinship foster homes). Increasing the use of kinship foster care is not only an effective way of increasing foster home capacity, but it is also a better way of serving individual children. As studies cited by “Thirty Days to Family” (an innovative kinship foster home recruitment and support program) reflect, foster children living with relatives:

- Experience fewer placement changes
- Are more likely to live with their siblings
- Are less likely to run away
- Are less likely to change schools
- Have fewer behavioral problems
- Are more likely to report that they “always felt loved”
- Are less likely to re-enter foster care), and
- Are more likely to report liking those with whom they live.

Generally, placement with relatives helps children maintain family connections, is less traumatic, promotes normalcy, and supports resiliency. DSS is committed to expanding its utilization and support of relative placements and to implementing a robust kinship foster home program.

In South Carolina, kinship care takes different forms. Sometimes the arrangement is informal and occurs when the parents and relative caregivers reach a private arrangement for the relatives to provide primary care for the parent’s child or children. In other situations, DSS is involved in the placement of children with relative caregivers. The Department handles these cases in one of two ways. In some but relatively few cases, DSS takes legal custody and places the child with the relative caregiver as a foster care placement. In other cases, DSS facilitates the placement with kin or fictive kin and does not take legal custody of the child (family preservation case). The degree of involvement by DSS and the amount of support received by the children and kinship caregivers varies greatly depending on which track the case is on.

Until recently, South Carolina’s approach has been similar to other states that have been slow to embrace an expansion of kinship foster care. These states rely heavily on “informal” kinship placement (where children go to live with relatives as the way of “resolving”

a neglect referral) or on relatives taking custody (often because they are told by the child welfare agency staff that otherwise the children will be taken away and placed with strangers) as a way of diverting children from the system. Frequently the family members stepping forward are grandparents on fixed incomes, or aunts, uncles, or cousins, for whom taking on responsibility for their grandchild, niece, nephew or cousin, without any additional services or supports, is extremely challenging; however, when faced with the alternative of the child going into state custody and being placed with strangers and the added trauma that would involve, they cannot say no. Too often, they are led to believe that services and supports will be available, but those services and supports do not materialize. Too often, they are led to believe that they will only be taking on the responsibility for a matter of days or weeks, but that turns into months or years.

Systems that have maximized the effective use of relative resources have taken four important steps to do so. First, they have vastly improved their approaches to identifying and engaging relatives. Second, they have developed a range of “placement status options” (from informal arrangements to kinship foster care and subsidized permanent guardianship) for relatives who are willing and able to serve as a relative placement for a child and a range of readily accessible services and supports for each placement status. Third, they have created a process for ensuring that the relatives understand the range of options and are able to make a well-informed choice from among those options. And fourth, they have expanded the pool of relatives who can qualify for IV-E reimbursable kinship foster home status and subsidized permanent guardianship by narrowing the exclusionary criteria for qualifying as a kinship foster home, expanding the authority of the agency, on a case by case basis and guided by the best interests of the child, to waive specific foster care licensing requirements and to “correct” or “remediate” any requirements that can be corrected and remediated through reasonable expenditure of funds.

- 1. Strategy C.1: Establish a diligent search process that begins at the first contact with a child and family and continues throughout the life of the case to identify family resources, including but not limited to kin and fictive kin willing to serve as a placement resource and that includes supervisory review before placement of a child in a non-family placement can be made.*

The Department is committed to improving the identification of and engagement with kin and fictive kin, both those who might consider being a placement for a child and those who might consider playing another supporting role for the child and family.

The Department will:

- Inventory and review current regional diligent search processes;
- Continue to require its own staff to seek to identify and engage relatives and fictive kin;

- Continue to utilize the Seneca Search, “family finding” genogram, and ecomap functions performed by NYAP team meeting coordinators;
- Enhance and expand the family finding and family engagement efforts by involving kinship coordinators as support to the field in how to successfully engage and inform kin about the process for becoming a placement resource. The coordinators will provide education, coaching and other identified supports to the regions.
- Whenever possible, require a supervisory review and approval of diligent search efforts before placement of a child in a non-family placement can be made; and when prior supervisory review and approval is not possible, require supervisory review and approval within 24 hours after the placement.

Milestones, Timing, Resources & Oversight

Milestones of Progress	Implementation Timing	Projected Implementation Date	Resource Commitments
Inventory and review current regional diligent search processes	Short term	May 2019	
Develop new protocols for kinship care coordinators to support the field in engaging kin as a placement resource	Short term	August 2019	
Develop supervisory review waiver process and documentation protocol for a placement with a foster parent/provider unknown to the child	Short term	July 2019	
Publish an administrative issuance and begin implementation of supervisory waiver process for placements with a foster parent/provider unknown to the child	Short term	August 2019	

2. *Strategy C.2: Work with the Governor’s Office and General Assembly to amend state law and Department policies to give the Department the maximum flexibility allowed under federal law and regulation, to lift certain licensing requirements and draw down IV-funding for kinship care and permanent guardianship.*

Both the Department’s current policies and the kinship care law enacted last legislative session do not take full advantage of the flexibility that federal law and regulation allow and that other jurisdictions have used successfully to expand their utilization of kinship

foster care. In addition, the absence of a subsidized guardianship permanency option creates an unnecessary conflict for relatives who are willing to provide a permanent home for children unable to return to their parents but do not see the value (and see potential harm) in terminating parental rights. The Department will look to other states for model legislation and model kinship foster care policies (including waiver policies) that provide maximum flexibility to waive non-safety licensing requirements and policies that maximize the ability to utilize fictive kin as well as biological relatives.

The Department will:

- Convene a relative caregiver and kinship foster care policy and practice advisory group that includes relative caregivers and kinship foster parents, advocates for relative caregivers, and private agency and technical assistance providers, selected in consultation with the Co-Monitors, with special expertise in relative caregiver engagement and support to provide input and feedback on policies and practices related to utilization of kinship caregivers.
- With support from an appropriate technical assistance provider selected in consultation with the Co-Monitors, review relevant legislation and policies from other jurisdictions that have been successful in increasing the utilization of kinship placements and develop kinship care legislation and policies using those states as a model.
- Create an expedited placement process (involving a criminal background check, a child abuse and neglect record check, and a home inspection check) that allows a child to be immediately placed in the home of a relative caregiver who expresses an interest in becoming a licensed foster home and to enable the Department to provide financial assistance to that caregiver while the full foster care licensing process is completed. (As noted above, while pre-placement activities are not part of this court-ordered plan, training both preventive and CPS workers to think pre-emptively with families about natural supports should mean potential kinship providers are identified before a decision to place a child is made.)
- Identify the resources and develop a process to remediate any reasonably remediable building code or other dwelling need that might otherwise create a disqualifying safety problem (smoke detectors, lead paint remediation, etc.)
- Develop Memoranda of Understanding with other governmental agencies that have a role in the licensing process to ensure that the licensing process functions are expedited in kinship cases (e.g., the required fire inspections from the Fire Marshal).
- Provide financial and in-kind support following expedited placement and do so in a way that maximizes the opportunity to receive IV-E reimbursement back to the date the child was physically placed in the home, in the event that the home is ultimately licensed.
- Create kinship foster parent training options (both pre-service and in-service) that are specially designed for kinship foster parents.
- Provide access to wraparound and crisis intervention services to support and stabilize relative care giver placements.

- Provide access to day care and before and after school care for children.

To address problems that have been identified in the Department’s current approach to kinship foster home licensing, the policies that the Department develops should:

- Create a presumption that, unless there is clear evidence that it is in the child’s best interest for the relative caregiver and the child to forego the supports and services associated with placement of a child in a licensed foster home, the relative caregiver will be encouraged to become a licensed foster home.
- Make clear to a relative who receives a Class Member in their home that for a period of up to 4 months the child will remain in the legal custody of the Department and that they will remain eligible to become a licensed foster home and will not be asked or allowed to sign any waiver of that eligibility²³.

In order to ensure that new kinship care policies are effectively communicated to families and those who work with them, including DSS and community agency staff, the Department will:

- Develop protocols and scripts for informing and discussing with families the relative caregiver options.
- Develop and make available written materials that clearly communicate those options in ways that families and those working with them can understand.
- Provide training to all relevant DSS staff so that they understand the new approach to kinship foster care.

²³ Although the class of children subject to the FSA includes only children in DSS custody, the Department recognizes that some actions taken or not taken with respect to relative caregivers and fictive kin prior to a child coming into DSS custody can inadvertently prevent relatives from later becoming a Title IV-E eligible kinship foster home. While not subject to *Michelle H.* tracking, reporting, monitoring, or enforcement, the Department has indicated its commitment to communicating clearly with relatives and fictive kin in those situations so that, if the relative or fictive kin would like to seek to become a kinship foster home in an emergency and/or if the placement becomes longer term, the Department is able to take action to bring the child into its legal custody to preserve IV-E eligibility. The Department also recognizes that when temporary placement with a relative or fictive kin is used as part of a safety plan to prevent a child from coming into DSS custody, the relative or fictive kin needs to be provided sufficient information to consider whether the best option for the child and family would be for DSS to seek a court order granting DSS legal custody of the child and for the child to be placed with the relative or fictive kin as a “provisional” or “expedited” kinship foster home placement. Although not subject to *Michelle H.* compliance tracking, reporting, monitoring or enforcement, the Department is committed to supporting that choice and insuring that relative caregivers understand that the sole choice is not between their accepting the child as a non-custodial placement or placement of the child in foster care with strangers.

Milestones, Timing, Resources & Oversight

Milestones of Progress	Implementation Timing	Projected Implementation Date	Resource Commitments
Establish and convene relative caregiver and kinship foster care policy and practice advisory group	Short term	May 2019	
Engage TA to help DSS conduct policy (and legislation) review	Short term	July 2019	TA contract
DSS will explore possibility of promulgating an emergency regulation to allow for a provisional license. Also, Senate Bill S.191 currently pending before the Legislature would, if passed, make some of these changes.	Short-term	August 2019	
DSS will review model legislation developed by national kinship technical assistance and advocacy organizations and in consultation with the Co-Monitors will draft proposed legislation for South Carolina that would provide the maximum flexibility permitted under federal law for using relatives and fictive kin for placement under the broadest circumstances allowable.	Intermediate	December 2019	
Host meeting and solicit input from relative caregiver and kinship foster care policy and practice advisory group on policy assessment	Short term	August 2019	
Create an expedited placement process for immediate placement as described above (see bullet above)	Intermediate/Long-term depending on extent of statutory and regulatory amendment needed	July 2020	
Identify resources and develop a process for home remediation and policy for their use	Intermediate	July 2020	
Develop change order to current contract for expedited inspections for kinship care providers	Short term	July 2019	
In conjunction with service array development action steps referenced throughout, develop wraparound and crisis intervention services for kin placements and resources for day care and before/after school care	Long term	July 2020	

Engage fiscal consultant to develop and implement process for providing financial and in-kind support to maximize the opportunity to receive backdated IV-E reimbursement in appropriate cases	Intermediate	April 2019	
Develop and implement administrative issuance/policies (see above) for presumptive case plan that relative caregiver will become a licensed foster home; four months relative caregiver retains right to seek to become licensed or unlicensed foster home; safety plan of prevention case for 6 months;	Short term	May 2019	
Develop protocols and scripts and outreach materials for informing and discussing with families the relative caregiver options, and develop and make available written materials that clearly communicate those options in ways that families and those working with them can understand	Short term	April 2019	
Develop and deliver training to all relevant DSS staff and community partners and judges so that they understand the new approach to kinship foster care	Short term	May 2019 and ongoing	

3. *Strategy C.3: Establish in each region a well-resourced kinship navigator program that links kinship families to: financial assistance for food and health care; support groups and professional care; enhanced case management; community volunteer and donation programs (e.g. school supplies, holiday gifts, respite, summer camps); and legal assistance to help kinship parents get court orders for legal guardianship.*

The Family First Prevention Services Act passed in 2018 encourages states to implement Kinship Navigator programs by providing federal matching funds to states to support those programs. In order to receive federal funding, these programs must:

- Be coordinated with other state or local agencies that promote service coordination or provide information and referral services, including entities that provide 2-1-1 information systems where available.
- Be planned and operated in consultation with kinship caregivers and organizations representing them, youth raised by kinship caregivers, relevant government agencies, and relevant community-based or faith-based organizations.

- Establish information and referral systems that link (via toll-free access) kinship caregivers, kinship support group facilitators, and kinship service providers to: each other; eligibility and enrollment information for federal, state, and local benefits; relevant training to assist kinship caregivers in caregiving and in obtaining benefits and services; relevant legal assistance and help in obtaining legal services; provide outreach to kinship care families, including by establishing, distributing, and updating a kinship care website, or other relevant guides or outreach materials; and promote partnerships between public and private agencies, including schools, community-based or faith-based organizations, and relevant government agencies, to increase their knowledge of the needs of kinship care families to promote better services for those families.

Under the current circumstances and given the clear benefits of getting kinship navigator programs up and running as quickly as possible, the most realistic approach to implementing this strategy is through a partnership between DSS and the provider community. The Department will contract and work in partnership with a private agency with demonstrated expertise in relative caregiver engagement and kinship support, with that agency to be responsible to develop (either on its own or through collaboration with other private providers or some combination thereof) a robust statewide kinship navigator program that has at least one kinship navigator physically present in each large county and additional navigators available to serve smaller counties or combinations of counties. The kinship navigator program will be in addition to the kinship coordinator positions for each region that already exist with responsibility for kinship care. These kinship coordinators will serve as the Department's liaisons to the kinship navigator program.

The kinship navigator program will meet all of the requirements of the federal legislation. The services provided by the navigator program will include: face to face meetings with any family referred to them (whether by DSS, the NYAP facilitator, another community partner or self-referred) to provide information to help them make an informed decision about how they can best be involved as a placement or placement support for the child; participation as a resource (in person or by phone) in every initial CFT; intensive family finding and engagement (using the 30 days to Family model) for any child for whom a viable relative or fictive kin placement has not been identified and engaged by the family group conference; facilitating the development of support services for kinship families through outreach to other community agencies; helping relative caregivers connect with available services, including assistance in signing up for and obtaining ABC vouchers and other financial assistance (particularly for those relative caregivers who do not become licensed foster homes).

Prior to the fully developed kinship navigator program, DSS will utilize funds from a small kinship navigator grant received in 2018 and requested again in 2019 as described below.

The Department will:

- DSS received and is applying for additional kinship navigator grant funds. The grant will be piloted in the Midlands and Low country area for now. The Kinship Navigator program will include the following:
 1. Support groups for kinship caregivers
 2. Arc Training for kinship caregivers
 3. An evaluation of the Arc Training
 4. Media awareness of services, etc.
 5. A position to manage the Kinship Navigator Grant

The plan is to request additional funds of \$342,151. The plan is to expand this pilot statewide to include support to develop a more comprehensive navigator program that is similar to the promising practice models described in the program instructions from the ACF. This request for funds is due March 15, 2019.

- Develop an RFP, with assistance from experienced providers and/or TA as necessary, and contract for the establishment of a statewide kinship navigator program.
- Convene the relative caregiver and kinship foster care policy and practice advisory group (described in strategy 1 above) to work with DSS and the private providers in developing the specifications for the kinship navigator program.
- Enter into a contract with a Kinship Navigator contractor(s) possessing demonstrated experience in effectively engaging and supporting kinship and relative caregivers.
- Establish practice protocols to ensure that relatives can effectively access the services of the Kinship Navigator Program by adopting the following practices: (i) for any child subject to a DSS investigation or referral, for which, pending resolution, DSS is requiring, assenting to or recommending that a child be placed in the physical care of kin or fictive kin (whether as part of a safety plan or as an alternative to an emergency removal) DSS will refer the relative to a kinship navigator who will reach out to and discuss with the relative or fictive kin the full range of placement arrangements, including the option of kinship foster care, and the range of supports and services available for each arrangement; (ii) any orders entered, placement plans developed, and safety plans or other documents signed shall state the supports and services that the relative will receive and that the child will receive. In these cases, DSS shall ensure that a referral is made to the kinship navigator to follow up with the relative. As discussed above, if the relative opts for a placement arrangement that does not involve the child coming into DSS custody, the relative shall not be required to waive the opportunity to become a licensed or unlicensed foster home; and (iii) before DSS can seek to close, either administratively or through a juvenile court process,

a case in which a child has been placed with a relative, the kinship navigator must seek to meet with the relative and make sure the relative understands the consequences of the case closure, including any benefits (e.g., ABC vouchers) that will be terminated as a result of the case closure.

- All relatives who are potential resources will be provided information about the availability of kinship navigator services. When a child is placed with a relative, regardless of the status of that placement, a referral will be made to the kinship navigator program.
- DSS will include in its Kinship Navigator work-scope and contract the following activities: Develop a desk guide for DSS caseworkers; and develop a welcome packet for kinship families.
- The desk guide and welcome packet will include, in language that relative caregivers can understand, information for each placement status that shows the rights and responsibilities associated with each status, the services and supports available to those with that status, and the requirements to be approved for that status.

Milestones, Timing, Resources & Oversight

Milestones of Progress	Implementation Timing	Projected Implementation Date	Resource Commitments
Implement kinship care grant	Immediate	December 2019	\$370,324 currently and applying for \$342,151 additional
Contract for the establishment of a statewide kinship navigator program (see above)	Intermediate	July 2020	\$2.5 million for kinship navigator contract /program
Establish scope of work to ensure that relatives can effectively access the services of the Kinship Navigator Program (see above)	Intermediate	June 2019	
Convene meetings with relative caregiver and kinship foster care policy and practice advisory group to advise on programming and to later meet with kinship navigator contractor to establish ongoing advice and support role to program	Short term	May 2019 and ongoing	

4. *Strategy C.4: Establish an expedited kinship foster home licensing process that allows children to be placed with potential relative caregivers while the relative caregivers go through the licensing process, provides resources to support the placement pending licensing, and that tailors the requirements of the licensing process to the special circumstances of relative caregivers.*

A robust kinship foster care program requires the ability to move quickly to place children with relative caregivers and expedite the licensing process. Because of the inherently special status of kinship caregivers, child welfare systems have the legal flexibility to make certain accommodations to kinship caregivers that would not be appropriate in the licensing of non-kin foster parents. This includes not only the ability to waive non-safety related requirements, but also the ability to place children with kin while they go through the licensing process, tailor both the content and the delivery of training to the needs and circumstances of relative caregivers. Further, if Class Members are placed with kin or fictive kin, those kin are entitled to equal services and supports upon licensure or provisional licensure by DSS, including equal foster care maintenance payments.

DSS will take the following steps to expedite kinship foster home placement and licensing:

- The Department will develop criteria for the screening and approval of kinship foster homes that provides maximum flexibility to the Department to waive, in appropriate cases, any non-safety licensing requirements. To the extent that legislative changes are required to allow waiver certain current South Carolina licensing requirements that are waivable in states that have implemented successful kinship foster care programs, the Department will immediately seek to introduce those legislative changes.
- The Department will develop for potential relative caregivers and DSS staff and others working with them an easy to understand “tip sheet” listing those licensing requirements that can be waived and shall update that “tip sheet” once any legislative changes are made that affect the waiver process.
- The Department will develop an expedited placement process for any child entering or in DSS custody that allows expedited placement within 72 hours (pending completion of the expedited licensing process approval), requiring only a basic criminal background check, a DSS child abuse perpetrator check, and a home inspection. (Again, DSS will also be working with CPS workers outside the requirements of this plan, to think in the pre-placement period about kinship supports to avoid emergency placements whenever possible as kin are identified before a child is taken into custody).
- Develop a menu of immediate supports and services available following expedited approval—including in kind supports, cash assistance, and corrective services to remediate safety issues. To the extent that this requires the use of financial resources, establish a process for expedited access to these funds and develop a “tip sheet” explaining the availability of funds, giving examples of what can be funded, and explaining the process for accessing such funds.

- Currently, there are 28 sites/locations throughout the state for individuals to be fingerprinted. Additional locations will be available soon. The turnaround time for processing fingerprints after submitting to Identogo (contracted agency) is generally up to two days, unless there is a criminal charge that requires additional research.
- Structure the expedited placement process to allow IV-E claiming back to the date of placement, if the placement is subsequently approved as a licensed foster home.
- Develop specific training for kinship foster homes that can be delivered quickly, including opportunities for individualized “classes” to expedite completion of the training.
- If it is necessary to infuse additional resources into the process to accomplish this expedited placement and licensing process, contract with private providers (who receive special training related the Department’s new policies and practices related to kinship foster care) to assist with completion of the expedited placement process and licensing application process including kinship foster parent training.

Milestones, Timing, Resources & Oversight

Milestones of Progress	Implementation Timing	Projected Implementation Date	Resource Commitments
Develop new criteria for the screening and approval of kinship foster homes	Short term	July, 2019	
Develop “tip sheet” and protocols for use and updating	Short term	July, 2019	
Develop and implement expedited placement process	Short term	July, 2019	n/a
Develop a menu of immediate supports and services available following expedited approval	Intermediate	July, 2020	
Develop and provide specific training for kinship foster homes that can be delivered quickly, including opportunities for individualized “classes” to expedite completion of the training	Intermediate	December, 2019	
Hire additional staff or contract with providers if necessary, to have capacity to complete expedited approval within timelines	Short term	Hire licensing staff or contract to ensure sufficient staff available to handle work of expedited kin licensing.	

D. Improve the recruitment, retention and utilization of foster parents

The Department's preference whenever possible is to place children with relatives and fictive kin (non-relatives with a family-like relationship with a child) who are able to provide a safe and appropriate home for them. However, placement with kin is not always possible and the Department also needs expanded capacity to match children with foster families not previously known to the children. Because of the current shortage of well-matched foster families, children frequently now bounce from placement to placement and often end up in group homes and other congregate care settings that are less safe and more expensive.

Foster parents play a critical role in supporting children in foster care, ensuring their well-being while in care, and helping them achieve permanency. In many child welfare systems, the foster family is encouraged to work with the biological parent to engage in functional co-parenting unless safety issues prevent this. No matter the particular circumstances, foster parents need to be valued members of the child and family team and actively involved in developing permanency and life plans for children placed with them.

Foster parents spend more time interacting with children in their care than teachers, mental health professionals and case workers. Foster parents are expected to provide prudent parenting to children who have experienced trauma, and who often have behavioral challenges and are managing strong emotions associated with identity formation. Foster parenting is difficult but can be extremely rewarding when foster parents receive the training and support that they need. On the other hand, foster parenting can be frustrating and unfulfilling to foster parents when they are poorly trained and inadequately supported.

The following strategies address the shortage of foster homes, the utilization of kinship and non-relative foster homes and improvements in casework practice that will provide greater stability to the foster home placements.

1. *Strategy D.1: – Increase foster care board payments for DSS foster parents to meet the USDA guidelines for the southeast region and make it a contract requirement that private providers caring for children in DSS custody also pay their foster parents board payments that meet the USDA guidelines.*

Foster parents are responsible for directly providing the shelter, food, clothing, supervision, educational necessities, and other personal incidentals required to promote the safety, permanency, and well-being of children in their care. States have considerable discretion in designing and administering their foster care payment systems. DSS pays foster parents at the low end of the payment scale when compared to other states. It is not uncommon for foster parents to spend personal assets above what is paid or reimbursed in order to provide basic care to foster children in their homes. The table below comparing the foster care board payments in South Carolina to nearby states shows the significant gap in financial support.

State	Basic Rate	Other family foster care rates
South Carolina	\$13.47—\$17.84	Therapeutic Foster Care: \$48.49 – Level 1 \$68.16 – Level 2 \$89.51 – Level 3
North Carolina	\$15.62 - \$20.84 (Public Agency) \$47.11 - \$53.85 (Private Agency <i>Maintenance + Administrative</i>)	Therapeutic Foster Care: Basic maintenance + \$88 Specialized: County discretion
Kentucky	\$22.70 - \$24.70	Basic Advanced: \$24.90 - \$26.90 Care Plus (Therapeutic): Basic: \$40.00 Care Plus (Therapeutic): Advanced: \$45.00 Medically Fragile: Basic: \$40.00 Medically Fragile: Advanced: \$45.00 Medically Fragile: Degreed: \$48.00 Specialized Medically Fragile: Advanced: \$56.40 Specialized Medically Fragile: Degreed: \$91.55
Tennessee	\$23.26 - \$27.28	Special Circumstances: \$25.59 - \$30.01 Extraordinary: \$45.00

Source: FAMILY FOSTER CARE REIMBURSEMENT RATES IN THE U.S. A REPORT FROM A 2012 NATIONAL SURVEY OF FAMILY FOSTER CARE PROVIDER CLASSIFICATIONS AND RATES.

DSS realizes that for the vast majority of cases the cost of care in a foster home is substantially less than the cost to provide services in a congregate care or in-patient facilities. This will continue to be true even when the board rate for family foster homes in South Carolina is substantially increased.

In order to promote greater success in foster family recruitment and retention DSS will take the following steps:

- The agency will request a proviso change to be effective July 1, 2019, to increase foster care board rates. DSS is currently working with the Governor’s Office and General Assembly to explore opportunities to request funds to support a foster board rate increase during this fiscal year for foster parents to \$16.65 for youth 0-5, \$17.42 for youth 6-12, and \$19.64 for youth 13+ as projected in the 5-year budget submitted to the Court. If DSS does not receive additional funds to support

the increased rates in its FY 2019-2020 allocation, it will use existing resources to support such an increase, provided that the proviso is changed to support the increase. Going forward, DSS will engage technical assistance to develop a rate setting methodology, a component of which will be how frequently rates should be examined and an adjustment made if the review shows an increase is necessary. Once the process is developed, DSS will review and adjust rates in accordance with the methodology. Although the methodology is still to be determined, DSS anticipates that this methodology will include, at a minimum, an annual review of USDA data.

- DSS will assemble a DSS work group to conduct a review of the cost estimate for raising a child in South Carolina {using data from the United States Department of Agriculture (USDA) and other sources} and will assess shortfalls within the existing structure (factoring in allowances for incidentals) and reset the board rate structure to reflect the actual cost of caring for a child in South Carolina.
- Establish a foster home board rate that is set and adjusted annually to meet or exceed the USDA guidelines.

Milestones, Timing, Resources & Oversight

Milestones of Progress	Implementation Timing	Projected Implementation Date	Resource Commitments
DSS will conduct review to establish child care costs in South Carolina	Short term	May 30, 2019	
DSS will request funds to support an adjusted foster home board rate applicable to licensed kinship, private provider and DSS approved foster homes, adjusted on an established periodic basis, that meets or exceeds USDA guidelines and develop a process for periodically reviewing these rates	Intermediate/ongoing	Request in Fall, 2019 with anticipated funding in July, 2020 and ongoing	
DSS will increase foster care board rates	Short term	July, 2019, provided proviso is updated	

2. *Strategy D.2: – Expand the role of private agencies in foster parent recruitment, training and support and integrate targeted private sector recruitment plans into DSS’ overarching regional recruitment plans.*

DSS recognizes that it needs to work more collaboratively and partner more extensively with private providers if it is going to provide the enhanced placement and service array required to meet the needs of children in its care. The Department has generally handled recruitment of “regular” foster homes internally and relied on the private provider network to provide therapeutic foster care and deliver clinical services, but has handled recruitment and support of “non-therapeutic” or “regular” foster homes internally. Given the shortage of “non-therapeutic” foster homes the Department recognizes that value of contracting with private providers to recruit and support regular foster homes as well. Private providers have strong ties to the communities in which they are located and that they serve, and they may well be able to recruit foster homes that are not as likely to become licensed through DSS thereby increasing the overall pool of foster homes.

The Department will collaborate and communicate with providers in developing the contracts for non-therapeutic foster home recruitment and support. The Department’s recent experience with an RFP for regular foster homes that had to be withdrawn shortly after its issuance underscored for the Department the importance of working more effectively and collaboratively with the providers in the development of and in advance of issuing any RFP.

DSS will take the following steps to collaborate with private providers in foster parent recruitment, training and support:

- By no later than March 31, 2019, DSS will utilize an emergency procurement to expeditiously contract to provide support to private providers who can recruit family foster homes and provide family foster care services. Subsequently, DSS will begin work on an RFP to procure these services. DSS will engage technical assistance to set rates that are fair and attractive to encourage a positive response to the RFP from CPAs.
- Prior to issuing the RFP, DSS will meet with private providers to gain their input and suggestions to have private providers recruit family foster homes and provide family foster care services. A number of the congregate care programs are licensed as Child Placing Agencies and are poised to expand their agencies’ missions to develop and provide family foster care for DSS children, along with other home and community-based services. Some have invested their own dollars from their endowment funds, parent organization investment as “start-up,” and separate private foundation funding to underwrite the cost of recruiting, training and supporting family foster care and expanding therapeutic foster care. It is not financially sustainable for CPAs to develop family foster care without DSS funding to support recruitment, training, licensing and ongoing support for foster homes. DSS will share and receive information about scope of services and costs prior to issuing an RFP.

- DSS will develop regional recruitment plans for DSS homes and will incorporate the private agency recruitment plans from agencies in their region into an overarching regional recruitment plan that has both broad recruitment strategies and targeted recruitment strategies that consider the unique needs of the children and youth in need of foster and adoptive homes.
- DSS will solicit input from foster parents on developing and implementing the regional recruitment plans and will support events and outreach of local foster parent associations.
- DSS will gather data to measure the effectiveness of recruitment efforts, including success rate from special public relations recruiting events.
- Regional recruitment plans will include targeted recruitment strategies to find homes that will be a good match for children that have historically been difficult to place. These targeted plans will include strategies to find homes for children who are part of sibling groups, dually involved in juvenile justice and child welfare, parenting teens and victims of sex trafficking.
- DSS will encourage regions to incorporate youth engagement strategies into the regional recruitment plans. Youth who show an interest in advocacy and have been trained and properly prepared are effective recruiters of foster families.

Milestones, Timing, Resources & Oversight

Milestones of Progress	Implementation Timing	Projected Implementation Date	Resource Commitments
Hold information and planning meetings with providers regarding private provider regular foster home RFP	Short term	June 2019	
Issue contracts expeditiously	Short term	Timeline developed in consultation with TA assistance for development of continuum model	
Complete regional recruitment plans	Short term	By 7-30-19	
Implement collection data plan to track recruitment success rate for different types of efforts and events	Intermediate	By 12-30-19	

3. *Strategy D.3: Provide high-quality, trauma-informed pre-service training to foster parents, adoptive parents and dually licensed parents and expand in-service training opportunities to include topics of expressed interest by foster parents (including trauma informed in service training) and by leveraging training capacity within the foster parent and private provider networks.*

Both DSS and private agency foster parents must have a clear understanding of the goals of foster care and their roles and responsibilities in meeting those goals. One factor in making sure foster parents are able to support the foster care goals and help a child in achieving timely permanency is to provide the foster parents with quality training and relevant professional development resources.

A foster parent in South Carolina currently must have fourteen (14) hours of pre-service training to be issued a DSS foster parenting license. Many of the private providers have their own standards which are more demanding. For example, one of the larger private agencies requires a minimum of forty-six (46) hours of training for foster parents and some foster parents in specialized training groups are required to complete 60 hours prior to licensure. A foster parent is required to have 28 hours of in-service over two years to get relicensed.

Historically, the current state-mandated pre-service curriculum for foster care and therapeutic foster care is provided by a single state-level contractor that uses a curriculum created for South Carolina rather than an evidence-based nationally recognized curriculum. The state contractor's training manual states:

“The approach to foster care has evolved as we’ve learned how important it is— and how much better it makes the child’s life in most cases—to remain closely in touch with the birth parents. Now foster parents are considered resource families, or caregivers who serve as part of a team that focuses on preserving the birth family (including the child as a part of it) unless dire circumstances make that impossible. Resource families work with the birth family, the agency, and the child as just that— a resource providing safe temporary care. This can help both the birth parents and the child to a safer, smoother reunification.”

In practice, it does not appear that the resource parent philosophy embraced by the training manual is reflected by actual practice in the regions. It is rare encounter foster parents who are encouraged or empowered to take on the co-parenting role. This fundamental shift in the role of foster parenting needs greater attention during pre-service training.

DSS is in the process of completing a review of training content, delivery and approach to ensure that the pre-service training required for foster parents is relevant, useful and skills-oriented and that ongoing training is responsive to what foster parents indicate they need. The report of the congregate care consultants indicated that private providers believe the preservice curriculum does not

address the minimal training needs for new foster parents. DSS intends to adopt a national training model that focuses more on trauma informed approaches for in-service training. DSS recently began plans to pilot ARC Reflections (a rigorous trauma informed in-service training) in Region 2.

DSS will take the following steps to improve foster parent training:

- DSS will adopt and begin using an evidence informed and trauma informed preservice training model to meet the needs of foster parents, such as PRIDE or TIPS/MAPP.
- DSS will approve substitute nationally certified curricula used and being credited toward training hours by private providers.
- DSS will evaluate foster parent satisfaction with the content and delivery of the preservice training through the use of exit surveys of all foster parents completing the training.
- DSS will collaborate with private providers who already offer pre-service and in-service training that is approved by the state as an acceptable substitute for the required foster parent training currently offered by DSS, to allow prospective and current DSS foster parents to participate in those trainings (with appropriate compensation provided to the providers). CPAs have the capacity to provide pre-service training that is responsive to new and ongoing foster parent training needs and DSS will leverage this capacity to provide a greater range of training offerings to a larger pool of foster parents.
- DSS will support the development and maintenance of an on line “training calendar” for postings of in-service trainings offered by DSS and by private providers. DSS will provide incentives for providers to open up in-service training options to DSS foster parents and foster parents employed by other private agencies.

Milestones, Timing, Resources & Oversight

Milestones of Progress	Implementation Timing	Projected Implementation Date	Resource Commitments
DSS will develop and begin utilizing a foster parent exit survey	Short term	July 2019	
DSS will select an evidence and trauma informed training model for preservice foster parent training	Short term	Select model by 8-30-19	
DSS will develop a process to review and certify any curricula used by private agencies	Intermediate	July 2020	
DSS will develop new schedule using new model	Intermediate	July 2020	Budget request to purchase and implement new model

DSS will engage and contract with private providers to enhance the training offerings and access	Short term	July 2019 and ongoing	
DSS will build and launch online training calendar	Short term	March 30, 2019	

4. *Strategy D.4 – Accelerate and streamline the process in which foster parents apply and become licensed foster and adoptive parents.*

DSS recognizes that foster, adoptive and kinship families are cherished resources and invaluable to the work of serving children and families. Because the process for becoming a licensed foster home is necessarily complicated, DSS will do everything in its power to value and support foster and adoptive parents at every stage of the process, beginning at the point of first inquiry, and will be attentive to their needs at each stage through licensing and beyond. The Department is promoting a practice model shift that views foster parents as essential members of the child and family team and as a resource that needs to be sought out, supported, valued and retained.

DSS is interested in learning from innovative recruitment approaches in other states. One such innovative approach is the Resource Family Retreat experiment in Rhode Island. The RI Department of Children, Youth & Families conducted a weekend-long Resource Family Retreat for prospective foster families. The goal was to condense most of the training from 10 weeks to just one weekend. Their goal was to have the families in attendance complete most of the requirements to become a licensed foster parent during the weekend event. The retreat was a crash course in expedited licensing and addressed on the spot issues that typically delay the process such as including fingerprinting and physical exams. Schedules were made for families to have follow-up interviews and home inspections.

DSS, based on some of the lessons learned from the Rhode Island experience, will expedite the licensing process by doing the following:

- DSS will develop Memoranda of Understanding, or change order to existing contract, with other governmental agencies that have a role in the licensing process to ensure that licensing process functions are not unduly delayed by workload issues involving other areas of work performed by these agencies (e.g. Fire Marshal).
- DSS will allocate, hire and bring on board additional staff as necessary in the licensing unit to expedite the home study and approval process (in addition to addressing the licensing protocols for group homes to align with recommendations in the congregate care report) to eliminate bottlenecks cause by DSS staff shortages.

- After reviewing some “screen out” decisions for potential foster parents for calendar year 2018, DSS will consider pulling back the screen in/screen out function currently performed by the state level preservice training contractor and bring that function in-house using staff from the licensing unit. DSS licensing staff will assume responsibility for screening decision making of applicants who participate in training.
- DSS will require that contractors involved in the licensing and training process keep and report tracking data to determine the time from intake to application to licensing and all relevant milestones in between. DSS will track the attrition rate of foster parent candidates and the reasons that candidates drop out of the process and use that information to improve their processes and results.
- DSS will explore hosting a high intensity and time-compressed foster parent recruitment event for parents who are in the application process for licensure that may use of the features of the Rhode Island Resource Family Retreat in order to widen the recruitment net and shorten the time to licensing and placement.

Milestones, Timing, Resources & Oversight

Milestones of Progress	Implementation Timing	Projected Implementation Date	Resource Commitments
Develop and obtain signed MOU or a change order to current contract	Short term	July, 2019	
Hire additional staff in licensing unit	Pilot region – short-term and Ongoing	July 2019 for pilot region and July, 2020 for ongoing	
Review some calendar year 2018 “screen out” decisions and make decision about whether to implement new screening in/out protocols with licensing staff	Short term	6-30-19	
DSS will communicate with training providers new data collection requirements	Short term	3-30-19	
Host high intensity and time compressed recruitment	Pilot region – Short term; Other regions – Intermediate	Pilot – October 2019; Anticipate beginning regionally by 12-30-2020	

5. *Strategy D.5 – Improve information gathering and sharing to improve matching during placement decisions so that a child’s characteristics can be matched with the characteristics of available foster homes and so placement stabilization supports can be provided to assist the resource family.*

The current placement process does not allow for a matching of children’s needs to the skills of foster parents. As reported in the Placement Needs Assessment and restated in findings by the consultant groups working with the Department, most placements are made based solely on bed availability. Collecting, storing and using data vital to matching has been a challenge. DSS has for the past few months made it a point of emphasis to enter data into CAPSS (licensing screen menu) about foster home characteristics that are essential to making better placement matches and to being able to analyze why so many licensed homes have no children. For example, during a recent data pull it appeared that nearly 50% of the licensed foster homes in Region 1 were empty even as placement staff in Region 1 reported to be in crisis because they did not have enough foster homes for children. One possible explanation is that these empty homes are people who became foster parents in the hopes of adopting an infant and were not interested in fostering beyond that. If that is the case with a significant portion of that 50%, it may suggest some problem with the recruitment and approval process. However, it is also possible that some of these families had never been presented with the need and the opportunities to foster older children and that a special outreach effort, including outreach from foster parents who can talk about the rewards of fostering older children, could result in some of these foster parents opening their home to older children.

The recruitment and licensing process, including the pre-services training, should ensure that foster parents are prepared to receive a child into their home and should provide those involved with the placement process with information on the characteristics and special strengths of the foster home that will help in making a good match. However, each child brings unique strengths and challenges and the success and stability of any foster home placement not only depends on thoughtful matching at the time of placement, but also depends on the ability of the foster family and the child to access appropriate services and supports, especially when circumstances arise that, if not addressed, may lead to placement disruption.

DSS will take the following approaches to improving matches and placement stabilization supports:

- Foster and kin families will be provided with services, supports and the necessary tools to increase and/or sustain their capacity to be effective in caring for the children in their home and in minimizing placement disruptions. Supportive services will be provided to foster parents and children in their home and will include: wraparound and crisis intervention services (mobile crisis response); day care subsidies to foster parents; respite care to support and stabilize foster home placements home. DSS will build the array of supportive services into future contracting.

- DSS will require that individualized treatment and service plans identify risks for placement disruption and identify services and rapid response strategies that will be taken to minimize or eliminate the risk.
- DSS will standardize and provide foster parents with a comprehensive handbook of information pertaining to frequently asked questions and how to access the help desk and link with the peer to peer resource parent support group.
- DSS will review data and feedback about the revised Universal Application to assess if it provides resource families with all necessary information at the time of placement to promote placement stability and will explore alternative approaches to determine if better tools are available.
- DSS will assemble a workgroup to investigate data management tools such as Binti that specialize in managing information for recruiting and approving foster families and finding the best placement match for children. If determined to be a good idea, DSS will move forward with piloting the selected system.
- DSS will conduct a foster home utilization assessment and completion of study which will: identify foster homes that have been licensed for at least six months and have not taken a child into their home in the last three months to conduct outreach to those families and get a clear understanding of why they have not received a child and, if they continue to appear to be an appropriate placement for children, what could be done to appropriately utilize them as a foster home. Foster homes not interested in continuing to receive children will be removed from the database.

Milestones, Timing, Resources & Oversight

Milestones of Progress	Implementation Timing	Projected Implementation Date	Resource Commitments
Build the array of supportive services and integrate into future contracting	Long term	July 2020	Significant investment is contemplated and will be requested in future years
Build disruption risk into planning process	Short term	October 31, 2019	
Develop foster parent handbook and distribution plan	Short term	Start process in Spring, 2019 with anticipated distribution by 12-30-19	Handbook development costs
Assemble software research group for foster home recruitment and matching data	Intermediate	July, 2020	Piloting costs (including staff)

Conduct foster home utilization assessment and completion of study	Intermediate	This process has begun and is ongoing. A memo was issued in July, 2018 regarding this. Review for the pilot counties will be complete by July 2019 and statewide by September 2019.	Contract for utilization study
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6. *Strategy D.6: Develop infrastructure to support foster parents through peer-to-peer support groups; access to a sufficiently staffed help desk and with opportunities to provide feedback (through surveys and other methods) about their level of satisfaction and ideas they have to improve the foster parenting experience.*

Timely access to relevant information is a valuable asset highly appreciated by foster parents. According to national experts, poor communication is a major, if not the major, contributor to foster parent attrition. Too often, foster parents have been left to their own devices to find information and sort it out. This often leads to foster parents either not finding answers to important questions or obtaining out dated or incorrect information. Foster parents almost universally identify as a priority for system improvement the creation of an efficient and responsive infrastructure for finding and exchanging information and for getting their questions answered quickly. Foster parents place high value on having a structure for peer to peer information sharing and a “help desk” or “ombudsperson” to facilitate getting questions answered or concerns addressed when there has been a breakdown in communication.

Foster parents have also expressed a desire to be seen as valued providers of information as well as consumers of information. The information foster parents have to share is valuable on the systemic level as well as the individual case level. Foster parents appreciate the opportunity to add value by being invited to participate in designing and implementing system improvements efforts.

DSS will take the following steps to promote the helpful exchange of information between foster parents and the DSS and among foster parents from peer to peer:

- Provide, through an appropriately skilled private provider, a foster parent ombudsperson or ombudspersons (either county based or region based or some combination thereof) with responsibilities for organizing and facilitating peer to peer support for foster parents and to serve as a conduit to the Department for resolving “help desk” requests. The peer to peer support is intended to be qualitatively different than is typically provided by foster parent associations. This is intended to

provide a structure for foster parents to regularly meet and provide each other with relational and emotional support on a variety of issues (e.g. challenges with school issue) common to foster parenting and prominent in the lives of foster parents in a particular moment in time. The program can also use web-based forums and other creative approaches to include all foster parents interested in participating.

- DSS, in collaboration with foster parents, will hold foster parent retention events to show appreciation to resource families, assess the state of the foster parenting experience in South Carolina and create opportunities for staff to strengthen partnerships with current resource families. Supports will include readily available respite care and clear protocols for access to respite by foster parents that are publicized to foster parents.
- DSS will regularly survey foster parents to garner their input on a variety of issues. In addition to satisfaction surveys, DSS will solicit input on proposed policy matters that impact children, families and family group teams.
- DSS will make available post placement supports for resource families who experience trauma when a child is removed.

Milestones, Timing, Resources & Oversight

Milestones of Progress	Implementation Timing	Projected Implementation Date	Resource Commitments
Create ombudsperson using internal capacity	Short term	6-30-19	
Develop and publicize regional schedules for foster parent retention events	Short term	6-30-19	
Develop and implement policy for regular foster parent survey input	Short term	7-30-19	
Develop trauma informed policy for supporting foster parents after a child is removed	Intermediate	August 2019	Budget commitment along with Strategy D3

E. Conducting a Placement Pilot

In most cases, when a child has to come into state custody, the child should be placed in the child’s home community, so that the child can maintain family, school and community connections. Placement in the child’s home community can mitigate some of the trauma

and disruption that the child experiences. It also makes it much easier for providers and DSS staff to work with families and support. Keeping children in or near their home communities positively impacts permanency, well-being and educational outcomes

Unfortunately, the current placement process increases the likelihood that children are placed far from their home counties, causing harm to them and their families, and making it more difficult and more time consuming for case managers to meet their casework obligations. It also results in siblings being placed in separate homes and at distance from each other.

Over time, as the Department implements its Placement Plan statewide, the Department expects to build in each region the array of placements and services necessary to meet the needs of the children coming into care from that region. However, in the short run, the Department has identified a number of strategies for reducing out of region placement and finding more appropriate placements for children who are currently placed out of region or at risk for out of region placement.

1. Strategy E.1 – Conducting a Placement Pilot

DSS will implement a placement pilot in three counties²⁴: Greenville County or another county that serves a similar number of children in foster care and two other medium to small sized counties in terms of foster care population to be selected after a review of data and based on an assessment of the following criteria for a successful pilot. Key elements of the pilot will include: data supporting the need for change based on the number of children in foster care and the percentage of children placed out of county, separate from their siblings, or in a placement not appropriate to their needs; presence of one or several private providers willing to engage with the department on transformation; interest of foster parents in developing new ways of work; agreement of regional and/or local leadership about the needs for change; commitment in pilot county to expand access to community-based treatment services to keep kids in family placements; access to technical support in pilot planning and implementation and agreement by DSS leaders to waive existing procedures as new ideas are developed and implemented; access to a pot of flexible funds to seed/support transformation; allocation of DSS staff positions to pilot county as needed to reduce caseloads at least to levels where staff can engage in the transformation work.

²⁴ Selection of the three pilot counties will be made in consultation with the Co-Monitors.

One of the ironies of the Department's current placement process is that it has produced a situation in which a child from Greenville county, for example, may end up being placed in Charleston, because a child from Charleston has been placed in Greenville. The often crisis-based search to find an available bed inevitably ends up creating these kinds of problems. And it is very hard to reverse the use of out of region placements unless the regions are given some ability to hold some regional beds open for children from the region, before making those beds available to other regions. In the short term, as continuum contracts are being developed and while large numbers of children are still being placed inappropriately in more restrictive settings, placement staff and Child and Family Teams will be authorized to place children in foster homes in the child's county of origin that would otherwise be unavailable.

- Pilot counties will be given a 72-hour window of control over foster home openings in their home-county and home region during which time the home county/region has exclusive rights to access that particular foster home.
- Pilot counties will be permitted to use local therapeutic foster homes (TFC homes) for level 1 children when the only other available options are more restrictive congregate care placements or out of region foster homes that are more than 75 miles from the child's home county. While it is not desirable to place a child in a therapeutic foster home when that child has not demonstrated the level of need usually associated with such placements, in the short run, that use of available therapeutic foster homes is worth the benefit of avoiding the harm to children and burdens to case managers and providers currently caused by out of region placements.
- Pilot counties will be granted easier access to an enhanced flexible funds pool for the purpose of locally developing and utilizing community-based treatment services, including non-traditional services and supports that create, bolster, stabilize, and redeem placements for children currently placed out of region or to make available an in-region alternative to an out of region placement.
- Pilot counties will be able to enter into "unique care contracts" to assist in moving children into placement within the region and prevent out of region placements.
- Pilot counties will develop and implement the child and family teaming process and will provide additional resources and flexibility to support those pilot activities, including but not limited to additional staff, CFT training and coaching, flexible funds for tailored services as well as for children returning to their home county.
- Allocation of new case manager positions will be used to reduce caseloads of workers in the pilot counties in 2019.
- As part of the development of the child and family teaming process, pilot counties will engage a private agency with demonstrated expertise in youth and family engagement to facilitate a "placement reconsideration CFT" for any young person who is placed in out of region congregate care. The "placement reconsideration CFT" will be for the purpose of determining whether there are possible alternative placements with kin or fictive kin (previously undiscovered or not

pursued) or with foster homes in-region that are suitable and desired by the youth. No youth will be forced to move from a placement that is meeting their needs and desired by the youth to be the ongoing placement option.

Milestones, Timing, Resources & Oversight

Milestones of Progress	Implementation Timing	Projected Implementation Date	Resource Commitments
DSS will implement and conduct pilot project to test innovate practices as described above.	Short term	July 2020	

2. *Strategy E.2 – Develop enhanced and flexible transportation support services to ensure that children’s health, visitation and normalcy needs are met and that permanency is not unduly delayed because families and case managers can’t address transportation challenges.*

The Department recognizes that until it is able to ensure that children are placed in or near their home counties, there will be a need to provide case managers with some relief from the burdens of transporting children who are placed out of region. However, the Department also recognizes that the interaction between children and DSS staff that occurs naturally during the course of transportation is an important opportunity to engage with the child and assess how the child is doing. The Department therefore believes it is important for those who provide transportation to be more than “taxi” or “uber” drivers.

As reported by the congregate care consultants, DSS currently contracts with external transportation providers and they are reported to be heavily used. Such providers can be a valuable and appropriate resource for adult clients in various DSS programs. Their use for children in out of home care, however, raises serious questions about safety, the provision of emotional support in stressful situations such as trips to court, family visits, or medical and mental health appointments, and continuity of care when a trip for a child may involve the need to communicate important information to or from a service provider. When caseworkers are inexperienced and lack sufficient expert supervision, as appears to often be the case in DSS, the potential for such a resource to be misused in services to children is great.

DSS will take the following actions to provide transportation assistance in pilot counties and then expand statewide, as needed:

- DSS will quickly conduct a performance review of the transportation vendor to determine if they possess the necessary engagement skills to provide the necessary transportation assistance to families and other adults in a therapeutically sufficient manner.
- DSS will compare the programming and performance of the current transportation vendor options against the current utilization of DSS caseworker assistants to provide transportation assistance and make a determination whether to hire additional casework assistants or significantly increase the current transportation contract for pilot counties. If after comparing the two transportation models DSS concludes that transportation assistance services using casework assistants is more aligned with the practice model and preferable, then funds will be provided to hire staff to perform this function.

Milestones, Timing, Resources & Oversight

Milestones of Progress	Implementation Timing	Projected Implementation Date	Resource Commitments
Review transportation models and select chosen approach to use in pilot	Short term	July 2019	
Hire caseworker assistants to assist with transportation and other case manager functions in the pilot	Short term	July 2019	

III. Interim Enforceable Measures

Congregate Care Interim Enforceable Targets

- A. Target E.2:** At least 86% of the Class Members shall be placed outside of Congregate Care Placements on the last day of the Reporting Period.

Baseline: As of March 31, 2018, 78% of children in foster care were placed outside of a congregate care setting.

B. Target E.3: At least 98% of the Class Members twelve (12) years old and under shall be placed outside of Congregate Care Placements on the last day of the Reporting Period unless an exception pre-approved or approved afterwards by the Co-Monitors is documented in the Class Member's case file.

Baseline: As of March 31, 2018, 92% of children ages 12 and under in foster care were placed outside of a congregate care setting.

Exceptions²⁵:

- (1) The child has clinical and medical needs that can only be met in a congregate care setting
- (2) The child is the son or daughter of another child placed in a group care setting
- (3) Sibling group of four or larger
- (4) The child has been removed & is in the legal custody of the department & is placed with a parent who is not in our care, but who is temporarily in a residential group setting for treatment

Current Status of Data Related to these Targets:

DSS has weekly reports on children who are placed in congregate care settings. While these reports are populated weekly by staff from Research, Data, and Accountability, the data are from a “mirrored” image of the production SQL-Server CAPSS “live” database which is populated daily. Those weekly reports served as the foundation for the Michelle H. monthly reports to the monitors. These monthly reports include the following:

- Congregate Care Placements 6 and under, a summary and listing of children: The case, service, and person ids are included along with the name of child in the listing.
- Congregate Care Placements 7-12 years, a summary and listing of children: The case, service, and person ids are included along with the name of child in the listing.
- Percentage of class members placed in congregate care by type of congregate setting, a summary and listing of children: The case, service, and person ids are included along with the name of child in the listings. The data provides the percentage of all

²⁵ The Co-Monitors approved these exceptions on February 9, 2018.

class members under 18 years of age placed outside of congregate care and for class members twelve (12) years old and under placed outside of congregate care.

DSS will use these well-established reports to measure compliance for Michelle H. Targets E.2 and E.3

Interim Benchmarks and Timeline:

The projected interim performance on E.2 and E.3:

Congregate Care Placements:		
	FSA IV.E.2.	FSA IV.E.3.
	At least 86% of the Class Members shall be placed outside of Congregate Care Placements on the last day of the Reporting Period.	At least 98% of the Class Members twelve (12) years old and under shall be placed outside of Congregate Care Placements on the last day of the Reporting period unless an exception pre-approved or approved afterwards by the Co-Monitors is documented in the Class Member’s case file.
Target	86%	98%
Baseline	78%	92%
Sep-19	80%	94%
Mar-20	82%	95%
Sep-20	84%	97%
Mar-21	86%	98%

Emergency or Temporary Placement Interim Enforceable Targets

- A. Target E.4:** Class Members shall not remain in any Emergency or Temporary Placement for more than thirty (30) days. Under exceptions subject to the Co-Monitors' approval, if a child is initially placed in an Emergency or Temporary Placement that is not a Congregate Care Placement, and that placement is re-designated within thirty (30) days as a long term foster home or therapeutic foster home, then the child's stay shall not be considered a violation of this provision and the re-designation shall not be considered a placement move under Section IV.F.1 below.

B. Target E.5: Class Members experiencing more than one Emergency or Temporary Placement within twelve (12) months shall not remain in the Emergency or Temporary Placement for more than seven (7) days. Under exceptions subject to the Co-Monitors' approval, if a child's subsequent placement within twelve (12) months in an Emergency or Temporary Placement is not a Congregate Care Placement, and that placement is re-designated within thirty (30) days as a long term foster home or therapeutic foster home, then the child's stay shall not be considered a violation of this provision and the re-designation shall not be considered a placement move under Section IV.F.I.

Current Status of Data Related to Targets E.4 and E.5:

In its current structure, an emergency placement occurs when DSS must pay an incentive payment to foster families pursuant to an Informational Memo dated September 15, 2015 (Subject – Incentive for Emergency Placements with Resources Families) or Change Order #5 to the licensed therapeutic foster homes and residential providers contract (Informational Memo dated October 16, 2015; Subject – Emergency Placement Procedures).

To measure compliance, the following steps are necessary:

- 1) CAPSS needs to be updated and placement type codes for Emergency shelters need to be deactivated. This update will serve to increase the reliability of the data within CAPSS though it would not necessarily affect the data capture on the incentive payments.

- 2) CAPSS needs to be modified to capture the incentive payment to foster families pursuant to an Informational Memo dated September 15, 2015 (Subject – Incentive for Emergency Placements with Resources Families) or Change Order #5 to the licensed therapeutic foster homes and residential provider's contract. Currently these incentive payments are captured outside of CAPSS. However a recent review of the information revealed insufficient identifiers to link to CAPSS through a secondary analysis with the information from the licensed therapeutic foster homes and residential providers. While the incentive payment to foster families' extracts do have identifiers, a recent review of that data extract and a comparison to CAPSS placement information encountered data quality issues and inconsistencies to CAPSS.

CAPSS IT has created a timeline that includes development, testing including acceptance testing, rolling out to the field new fields and training. Pursuant to the FSA, DSS will begin identifying, tracking, measuring, and reporting the use of emergency and temporary placements. By June 2019, DSS will propose a methodology to measure use of emergency and temporary placements to the Co-

Monitors. After approval of the methodology and by July 2019, DSS will propose interim enforceable targets for these measures, which are subject to consent by the Co-Monitors and Plaintiffs.

Sibling Placement Interim Enforceable Targets

- A. Target G.2:** At least 85% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with at least one of their siblings unless one or more of the following exceptions apply: (1) there is a court order prohibiting placing all siblings together; (2) placement is not in the best interest of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3) additional exceptions as approved by the Co-Monitors.

- B. Target G.3:** At least 80% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with all their siblings, unless one or more of the following exceptions apply: (1) there is a court order prohibiting placing all siblings together; (2) placement is not in the best interest of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3) additional exceptions as approved by the Co-Monitors.

Definition of Sibling: Children in foster care who have one or more parents in common either biologically, through adoption, or through marriage of their parents, and with whom the child lived before his or her foster care placement.

Proposed Exceptions:

Two exceptions are defined in the Settlement Agreement:

- (1) There is a court order prohibiting placing all siblings together;
- (2) Placement is not in the best interest of one or more of the siblings and the facts supporting that determination are documented in the case file;

Additional exceptions can be approved by the Co-Monitors

Current Status of Data Related to these Targets:

DSS has a well-established monthly report for children in foster care and their siblings on placements. This report measures placement of all foster care children and their sibling groups for a point in time. Sibling groups are further defined where two or more children

had an open foster care service for that point in time and had been in foster care for 30 days or more. This report further constructs a measure for siblings who are “with all siblings”, “with no siblings”, and “with at least one sibling”. It also served as the foundation for the newly developed Michelle H. monthly report on sibling placements.

To measure changes in placement proximity of siblings, compliance for Michelle H, and after consultation and review of the settlement agreement; a new report was created to measure entry cohorts into foster care. Specifically the Michelle H settlement agreement for G.2 and G.3 uses the words “Class Members entering foster care during the Reporting Period”. Thus the report was restructured to focus on six month entry cohorts of children and siblings entering care within 30 days during the reporting months. Sibling groups were defined as two or more children from the same case entering foster care during a reporting month or within 30 days. Again, the report constructs a measure for siblings who are “with all siblings”, “with no siblings”, and “with at least one sibling” and also includes a detailed listing with CAPSS identifiers for review.

Baseline for Targets:

Baseline was calculated for children entering foster care with their siblings or within 30 days of their siblings from October 2017 to March 2018 for the following two measures:

G.2 63% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings were placed with at least one of their siblings (Target 85%)

G.3 38% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings were placed with all of their siblings (Target 80%)

Interim Benchmarks and Timeline:

The projected interim performance on G.2 and G.3:

	FSA IV.G.2.	FSA IV.G.3.
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	At least 85% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with at least one of their siblings unless one or more of the following exceptions apply: (1) there is a court order prohibiting placing all siblings together; (2) placement is not in the best interest of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3) additional exceptions as approved by the Co-Monitors.	At least 80% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with all their siblings, unless one or more of the following exceptions apply: (1) there is a court order prohibiting placing all siblings together; (2) placement is not in the best interest of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3) additional exceptions as approved by the Co-Monitors.
Target	85%	80%
Baseline	63%	38%
Sep-19	69%	49%
Mar-20	74%	59%
Sep-20	80%	70%
Mar-21	85%	80%

Therapeutic Foster Care Placements Interim Enforceable Targets

- A. Target I.2** All Class Members that are identified by a Worker as in need of interagency staffing and/or in need of diagnostic assessments shall be referred for such staffing and/or assessment to determine eligibility for therapeutic foster care placement and/or services within thirty (30) days of the need being identified. This requirement shall not apply if the Worker withdraws the identified need in good faith and in the best interests of the Class Member within thirty (30) days.
- B. Target I.3** All Class Members that are referred for interagency staffing and/or needed diagnostic assessments shall receive recommendations for specific therapeutic foster care placement and/or services within forty-five (45) days of receipt of the completed referral. The recommendation(s) may include diagnostic assessment, community support services, rehabilitative behavioral health services, therapeutic foster care, group care, and psychiatric residential treatment facility. Level of Care Placement recommendations shall utilize the least restrictive care philosophy suitable to the child's needs and seek to place a Class Member in a family setting with a community support system. DSS shall update the assessment at least annually

thereafter, upon a placement disruption or upon a material change in the Class Member's needs. In making that determination, DSS may consider the full array of appropriate placement alternatives to meet the needs of the Class Members.

- C. Target I.4** At least 90% of children assessed as in need of therapeutic foster care placement shall be in the Therapeutic Level of Care and specific placement type that matches the Level of Care for which the child was assessed within sixty (60) days following the date of the first Level of Care Placement

- D. Target I.5** At least 95% of children assessed as in need of therapeutic foster care placement shall be in the Therapeutic Level of Care and specific placement type that matches the Level of Care for which the child was assessed within ninety (90) days following the date of the first Level of Care Placement recommendation.

Current Status of Data Related to these Targets:

These targets, as written, do not align with the Placement Plan design. DSS will work with Chapin Hall to develop a revised methodology for capturing data that more closely aligns with the Plan and will present the proposed methodology to the Co-Monitors by no later than July 2019. It will take some time to revise the placement process to then measure it. If it takes DSS longer than July 2019 to develop the revised placement process and propose a revised methodology, it will seek an extension from the Co-Monitors. If the methodology varies from the provisions in the FSA, DSS will need to obtain approval from the Plaintiffs and Co-Monitors. After approval of the methodology, DSS will propose interim enforceable targets, which are subject to consent by the Plaintiffs and the Co-Monitors.

Appendix A

The Placement Needs Assessment completed by the University of Social Carolina, includes quantitative data on children's placement settings and location as of March 31, 2017. Below are some of the general findings for the 4,114 foster children²⁶ in care on that date:

Placement in County of Origin

- The majority of the children in Foster Care were from Region 1 (n = 1492; 36.3%), followed by Region 2 (n = 903; 21.9%). In Region 1, most of the children in care originated from Spartanburg and Greenville counties (30.4% and 28.0%, respectively); while for Region 2, the majority of the children came from Richland County (38.2%). More than half of the kids in Region 3 were from Charleston County. Regarding Region 4, a large proportion of the kids came from Horry County (n = 241; 34%). In Region 5, the counties with more kids coming into foster care were from Aiken, Laurens, and Orangeburg (73.2%).
- About 66% of the children in foster care were placed either out of the county of origin or out of state, however only 25.4% were placed either out of the region or out of state. Twenty-six percent of the children who came from Region 1 were placed out of the region, and 44.9% from Region 5 were placed out of the region.

Placement Settings and Demographics by Placement Type

- Statewide, about 78% of the children were placed in a family home setting²⁷, 21.6% in a group home setting²⁸, and 0.8% in other setting²⁹. Regarding family home settings, 55.1% of the children were placed in a Foster Home and 33.6% in a Therapeutic Foster Home. Approximately 27% of the children placed in a family home setting were white males (n=919). Regarding age of the child, 55% of the children were in the 0-6 age group (n=1758). In a Group Home setting, only 2.4% (n = 21) of the kids were placed in an emergency shelter. Twelve children in the 0-6 age group were placed in a congregate care (1.3%; 12/889). Approximately 28% of

²⁶ Youth 18 years old or older are not considered *Michelle H. Class Members* and were not included in this analysis.

²⁷ A Family home setting includes the following type of placements: Adoptive Home (Foster Parent), Adoptive Home (Relative), Foster Home, Foster Home (Relative), Pre-Adoptive Home, Other Adoptive Home, Therapeutic Foster Home, Court Ordered Parent, Court Ordered Unlicensed Non-Relative, and Court Ordered Unlicensed Relative.

²⁸ Group Home setting includes Group Home - DJJ, SIL, Child Caring Institution, Residential Treatment Facility, and Emergency Shelter.

²⁹ Type of placements defined as Other setting includes Alcohol/Drug Treatment Facility, Correctional Facility (Non-DJJ), DJJ Facility, Hospital (Non-Temporary - 30+days), DMH Psychiatric, and School/College.

the kids in congregate care were white males (n=245). A high proportion of children in other setting category were placed in a DJJ Facility (37.5%; n = 12). More than half of these children were boys between 14 and 17 years of age (n=17).

- About 32% of the children in FC were between the ages of 7 and 13 years; 43.1% were in the 0 to 6 age group, and 24.9% were between 14 and 17 years of age. Regarding race, the majority of children in foster care were White (54.6%), followed by African Americans (36.7%). Only 6.5% of the children in foster care were Hispanics.

Levels of Care

- Statewide, 29.8% of the kids were placed in a high level of care³⁰. Most of these children were older between 14 and 17 years of age (47.2%), male (58.5%), white (50.5%), and non-Hispanic (93.1%). A high proportion of these children were placed in a family home environment (73.4%), however 81.9% were placed out of the county of origin (n=1002) and 48.5% were placed out of the Region of origin (n=594).

³⁰ A high level of care is defined in CAPSS as a High Management, Moderate Management or Therapeutic Foster Care Level I, II, or III.

	Provider Region								
County of Origin Number of kids/ Row Percentage	Region 1	Region 2	Region 3	Region 4	Region 5	Out of State	Total Placed Out of the Region	Total number of kids per Region	Percentage of kids placed out of the region
Region 1	--	134	53	65	104	35	391	1492	26.21%
		34.27	13.55	16.62	26.6	8.95			
Region 2	49	--	34	99	51	20	253	903	28.02%
	19.37		13.44	39.13	20.16	7.91			
Region 3	27	19	--	48	10	20	124	601	20.63%
	21.77	15.32		38.71	8.06	16.13			
Region 4	11	37	22	--	5	19	94	708	13.28%
	11.7	39.36	23.4		5.32	20.21			
Region 5	47	46	25	33	--	33	184	410	44.88%
	25.54	25	13.59	17.93		17.93			
Total	134	236	134	245	170	127	1046	4114	25.43%

Appendix B

Modification of Child and Family Teaming Process

Engaged children and youth actively participate in all aspects of their cases. DSS is committed to practice that promotes the use of engagement skills, strengths-based approaches, and team decision-making. These practices are based on the premise that the best way to aid, protect and nurture children over time is to strengthen and support families within their own homes, communities and cultures. Thoughtful and skilled mobilization and facilitation of their naturally occurring family, community and cultural resources is the most successful intervention for stabilizing and strengthening families. The Child and Family Teams is the best way to marshal resources that support that complement the permanent families' unique strengths, challenges, and goals.

DSS will conduct Child and Family Teaming in a manner consistent with following approaches and principles:

- To avoid confusion and make it easier for families and others to understand the emphasis on family engagement and to signal an expansion of the role of family-focused group problem solving that will be central to all elements of planning and decision making, the DSS will utilize the generic term of Child and Family Teaming and will retain the FTM and FGC labels to distinguish the family team meetings (FTM) and the family group conference (FGC). The Department will use the Family Engagement Liaisons to train, coach and mentor DSS supervisors and case managers to acquire internal capacity to engage family group teams and facilitate family meetings for the purpose of collaborative decision making during critical points in the case (Permanency Planning, placement change, etc.).
- An initial FTM will be held within 24 hours of a child coming into care as per statute. In addition, a follow-up FTM will be held within 7 days of the child entering care to allow additional family members and support persons to participate. The focus of the initial and follow-up FTM will remain as a collaborative meeting, utilizing family and community supports to meet immediate safety, assessment and placement needs. The follow-up FTM will give the facilitator more time to plan the meeting and prepare for youth participation. Under the new structure, DSS envisions that the Initial and follow-up FTM would allow the team to consider whatever issues are important for planning at the particular stage of the case, whether those issues are DSS concerns or family concerns.
- DSS will hold the initial FTM within 24 hours using a family group conferencing format. This first convening will establish that child and family teaming will be the forum used on an ongoing basis to work with the child and family to craft, monitor and adjust the individualized case plan. The agenda for the initial FTM will be to review the safety plan; review the placement

status; schedule any formal assessments; introduce the foster care case manager to the family; provide the family some basic understanding/ overview of the practice model approach that will frame their relationship going forward; establish a schedule for parent-child visits, sibling visits if siblings are separated, and other forms of contact (phone, video chat, etc.) for family and friends, as well as create a communication plan between the family and case managers; and plan for the follow-up FTM. The follow-up FTM will include additional family and supports and provide an opportunity to further discuss the agenda items from the initial FTM. It will also include an introduction to the foster parents (or group home provider representative) whenever possible, a discussion of goals and preparation steps for the 30-day FGC.

- Assign a foster care case manager to the case and require that person's attendance at the initial and follow-up meetings. The case manager (and if present, supervisor) will take steps consistent with the DSS practice model to begin building a trusting and engaging relationship with the family at these meetings. Presently it is not uncommon (at least in Region 1 which is experiencing a severe foster care case manager shortage) for the investigative worker to be the only case manager present at the initial FTM. This causes delays in scheduling and supporting visits and introduces stressors to the foster care worker/family relationship at the outset. If the foster care case manager cannot attend the initial FTM, the case manager supervisor will be present so that someone with responsibility for the ongoing case work is present—and someone with authority to implement the initial visitation plans and set up formal assessments.
- At the initial FTM, DSS in collaboration with the family group team will establish and launch an interim visitation plan (covering parent child visits, sibling visits, and other contact between the child and family members and friends). Visits will begin as soon as they can be safely implemented and any transportation issues that might be obstacles to visits will be addressed. The team will revisit the visitation plan to determine if it can be improved upon at the follow-up FTM and again at the FGC to be held within 30 days of the date the child entered custody.
- The 30-day FGC will be held as soon as possible upon receipt of initial formal assessment information but generally no later than 30 days after the child comes into custody (to ensure it occurs prior to the merits hearing). The work conducted in the 30-day FGC will be grounded in the initial and ongoing assessments of safety, risk and progress toward permanency. Decision making at this meeting will be informed by clinical input as well as the insights, perspectives, and family-specific expertise of the family members attending. If the family has been well oriented to the child and family teaming process at the FTM meetings, and further oriented to the FGC process during the preparation and planning phase of the FGC, the family members should be in a better position to be effective participants at the meeting.
- DSS will conduct child and family teaming as needed and at critical junctures of the case following the FTMs and FGC. Benchmarks that would regularly trigger a meeting would include: prior to making a non-emergency placement move (other than a move that has been planned for at a previous FTM or FGC); promptly after an emergency placement move; when there

is a need to consider making a significant change in the permanency plan, child treatment plan, family treatment plan, education plan or any other plan impacting the case; at regular intervals to review progress related to attainment of the permanency goal; and prior to case closure. Members of the family group should be able to call for a convening of the team to assess the fit of wrap around services or whenever issues arise that significantly impact implementation of the plan or threaten progress toward permanency. Follow Up FGC's are available for situations where relationships may be strained or contentious and an independent FGC Coordinator is needed to facilitate the meeting.