

EXHIBIT A

**THE TECHNICAL ASSISTANCE
COMMITTEE**

IN THE CASE OF

BRIAN A. v. HASLAM

**SUPPLEMENT TO THE
JULY 31, 2015 MONITORING REPORT**

September 29, 2015

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INTRODUCTION

Under Section XVIII.C of the Settlement Agreement, the parties, following the issuance of the monitoring report, are to meet with the Technical Assistance Committee (TAC) and attempt to agree upon which provisions in the agreement should be identified MAINTENANCE; if, following that attempt, any provisions remain in dispute, the parties are to “refer the decision on such identification to the TAC, which shall issue its determination within (30) days of the referral.” The Settlement Agreement further provides that the TAC’s decision is “final, binding, and unappealable by the parties.”

Following the filing of the July 2015 Monitoring Report, and in preparation for the meeting contemplated by XVIII.C.1, the parties, through both written communication and conference calls, shared their views on MAINTENANCE with each other and the TAC. In advance of the face-to-face meeting, which was held on September 9, 2015, and subsequent to that meeting, the TAC engaged in a number of conversations with the parties, both separately and together, to understand fully the basis for each party’s view about which provisions warranted a MAINTENANCE designation.

During the course of those discussions, the TAC, in response to questions and requests of the parties, produced additional data analysis, conducted additional in-depth reviews of cases that appeared to be non-compliant, and clarified certain aspects of everyday practice and procedure. Following the September 9 meeting, the TAC continued to provide the parties with additional information to support efforts to reach consensus.

In some instances, the additional information provided by the TAC has allowed the parties to reach agreement. In others it has not; however, even in those instances, the effort has ensured that the TAC had the benefit of both the additional information generated and a full airing of the parties’ respective positions before deciding how to resolve those matters that remained in dispute.

This Supplemental Report includes the additional information that the TAC has generated and provided the parties in the course of maintenance discussions and, for those sections about which the parties were unable to agree, this report includes the TAC’s determination, based on both this supplemental information and the information presented in the July 2015 Monitoring Report, about whether current performance warrants a maintenance designation.

The TAC’s Approach to Making the Maintenance Determination

Given that this is the first time in several years that the parties have not been able to reach agreement on all of the MAINTENANCE designations, the TAC thought it useful to describe the factors that the TAC considers in determining whether a provision should be moved into (or remain in) maintenance.

First, the TAC looks to see whether Department policy is consistent with the requirements of the Settlement Agreement provision.

Second, the TAC analyzes the data related to performance, including the “compliance percentage” (where aggregate reporting or case reviews provide such a percentage) and makes a judgment as to whether the level of performance is what one would expect to see in a well-functioning child welfare system. In instances in which there is no compliance number or percentage in the Settlement Agreement, the TAC may consider relevant standards, such as those established by the Department of Health and Human Services or the Council on Accreditation, as a point of reference in evaluating the sufficiency of the level of performance.

In instances in which the Settlement Agreement provision specifies a particular manner of measurement and compliance percentage, the TAC uses that as a reference point. However, in cases in which the aggregate data show performance below a designated measure, the TAC may also look at other relevant measures and consider that additional data in determining whether or not the Department is performing well enough to warrant a maintenance designation, consistent with the intent of the provision and the goals of the Settlement Agreement. The TAC believes that this approach is particularly important in circumstances in which the child welfare field has developed better and more reliable measures of system performance than those included in the Settlement Agreement.

Third, the TAC reviews non-compliant cases and the processes that the Department has in place to identify, understand, learn from and respond to those cases. As the TAC has observed in various contexts in previous monitoring reports, cases can be technically “non-compliant” with a specific provision of the Settlement Agreement but still reflect appropriate individualized case practice. And with the complexity and multiplicity of case practice requirements, even in the best run child welfare systems there will always be some percentage of cases in which some aspect of performance will fall short. A certain amount of shortfall in performance should not be a matter of significant concern, as long as there are processes in place that are designed and carried out to prevent individual cases from “slipping through the cracks” and as long as the CQI processes are in place to identify and respond to systemic issues impeding appropriate practice.

Fourth, the TAC considers the overall intent and purposes of the Settlement Agreement provision and whether the Department’s performance addresses the underlying concerns that the provision was designed to address. Notwithstanding some of the modifications in the Settlement Agreement agreed to in 2010, much of the language in the current Settlement Agreement dates back to the original Settlement Agreement entered 15 years ago, which was responsive to the systemic problems that existed at that time. No matter how prescient the negotiators of the original Settlement Agreement were 15 years ago (or even five years ago when some modifications were agreed to), a particular phrase or sentence or detail that may have been relevant or significant at the time that language was originally drafted, may have diminished relevance or significance in the context of current practice and other processes and improvements that the Department of Children’s Services has put in place. For this reason, the TAC, in determining whether a section of the Settlement Agreement should be identified MAINTENANCE ordinarily analyzes the section as a whole and determines whether the evidence supports a finding that the Department’s performance substantially complies with the overall requirements of the provision.

The Settlement Sections Addressed in this Supplement

The parties agreed that those sections of the Settlement Agreement currently designated MAINTENANCE should continue to be so identified. However, at the plaintiffs' request, the TAC has included supplemental information on one of those sections (VI.A.1.b).

The parties agreed that the following sections not previously designated MAINTENANCE should now be so identified: III.B; IV.A; V.L; VI.A.1.d; VI.A.2; VI.A.3; VI.H (except provisions related to private time and joint visits); VII.C; VII.D; VII.E; VII.F; VII.J; VIII.C.3; IX.D; XI.E.1; XII.E; XVI.A.6; XVI.B.3.

The TAC, pursuant to XVIII.C.2, has determined that Section III.A should also be designated MAINTENANCE.

There are a small number of provisions (Sections VI.D, VII.B, VII.M, XVI.A.1 and two elements of Section VI.H) for which the Department presented their reasons for asserting that current performance warrants a maintenance designation. Notwithstanding their position, the Department has agreed to the TAC's request for additional time to validate the Department's position and to postpone the decision on MAINTENANCE with respect to those provisions until after the issuance of the next monitoring report, scheduled for early 2016.

SECTION THREE

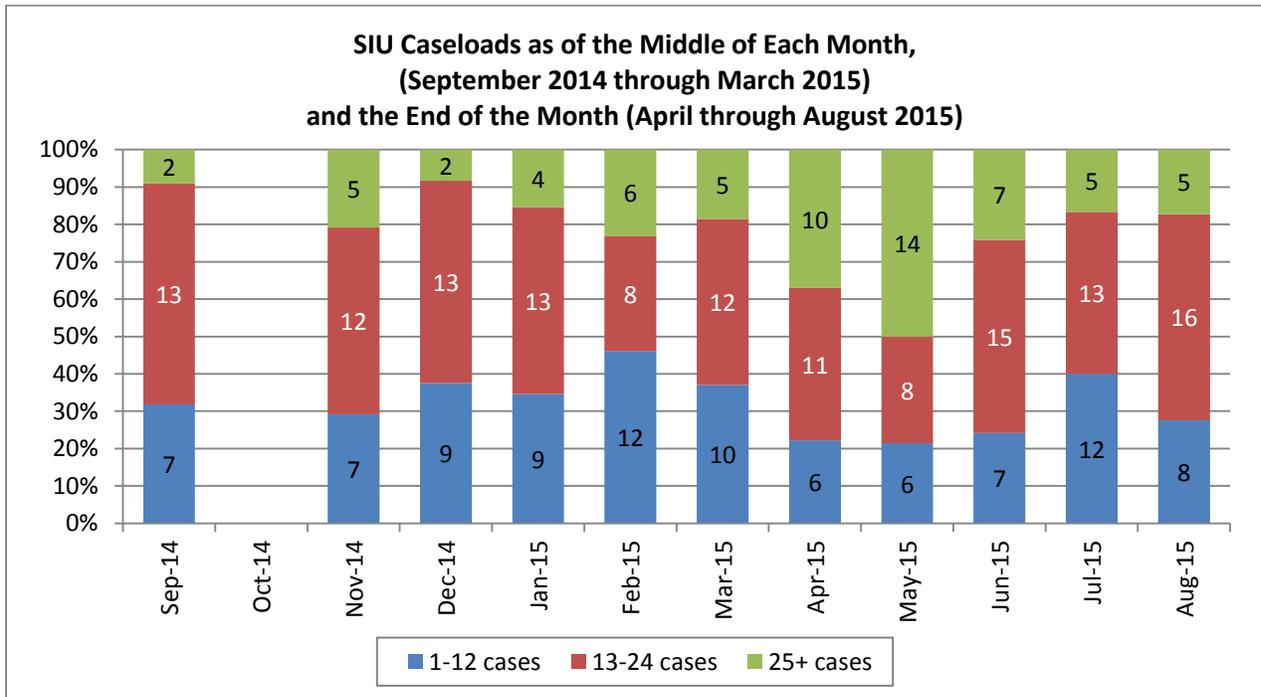
III.A

The plaintiffs requested that the TAC provide updated data regarding SIU caseloads, priority response, and open cases by case age in this Supplement. As reflected in the data, there was a spike in caseloads and overdue cases in May and June 2015.¹ However, the Department responded to that spike (using the mechanisms described in detail in the July 2015 Monitoring Report), and by August 2015, performance had returned to previous levels.

The following figure presents SIU caseloads according to SIU’s manual compilation of caseloads as of the middle of each month from September 2014 through March 2015² and according to the TFACTS Case Manager Activity Reports for April 2015 through August 2015.

The following is a list of the specific caseloads of 25 or more during June, July, and August 2015:

- For June: 7 workers with caseloads of 27, 28, 31, 33, 36, 39, 45
- For July: 5 workers with caseloads of 27, 31, 31, 33, 39
- For August: 4 workers with caseloads of 25, 25, 28, 29, 32

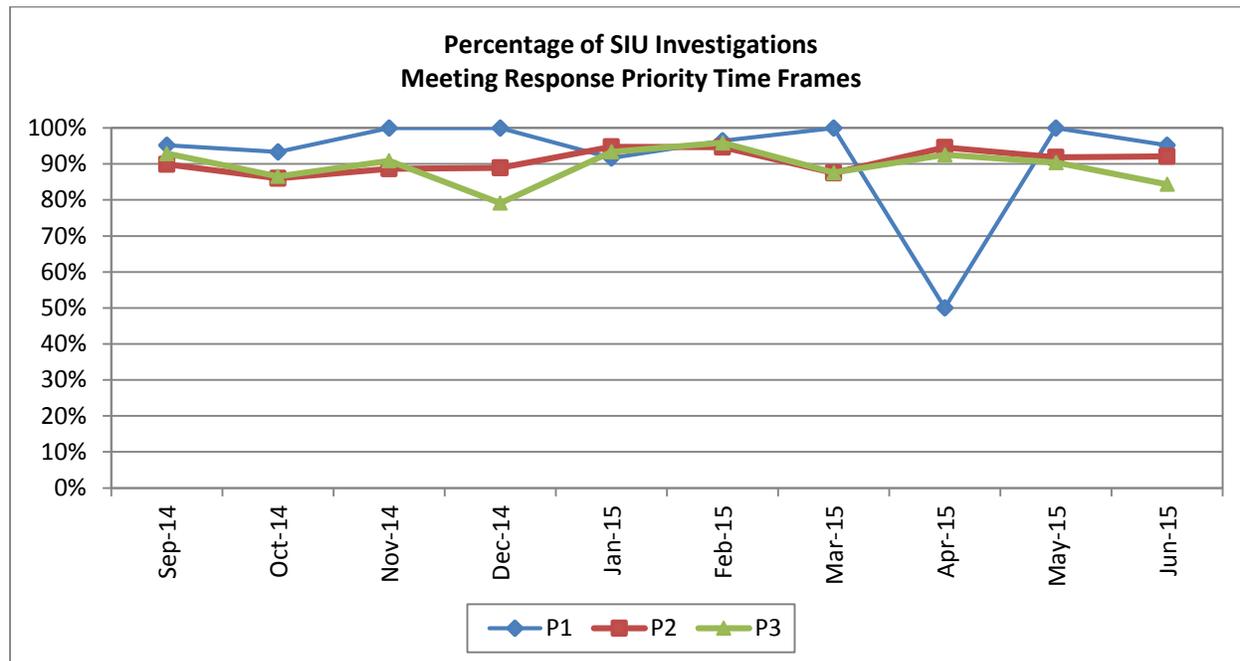


Source: SIU’s manual caseload tracking from September 2014 through March 2015; TFACTS Case Manager Activity Reports from April 2015 through August 2015.

¹ Because the TFACTS priority response reports are delayed by two months to allow sufficient time for SIU investigators to document their responses in TFACTS, data on priority response during July and August 2015 are not yet available.

² As discussed in the July 2015 Monitoring Report, SIU did not produce manual counts for October.

The following figure presents performance on priority response for SIU (including, but not limited to, *Brian A.* class members) according to TFACTS reporting.³



Source: TFACTS CPS Referral Response by Priority, Investigations reports for September 2014 through June 2015.

The following figures present the number and percentage, respectively, of open SIU investigations by case age as of the middle of each month from January 2015 through August 2015.

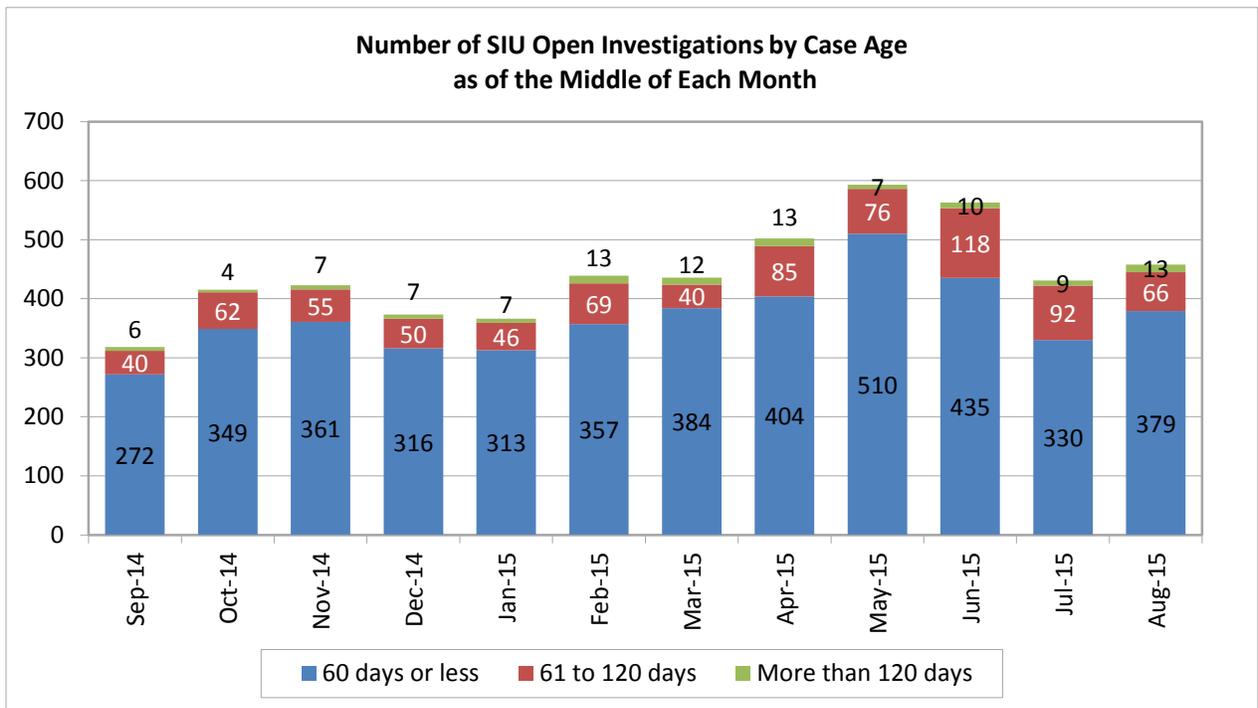
³ The data shown in this figure are pulled from recently “refreshed” reports run several months after the reporting period to allow additional time for data entry.

In April 2015, the P1 response time was met for 11 of 22 alleged child victims (50%). There were 11 alleged child victims (three total cases—only one of which involved *Brian A.* class members or placements) for whom the response time was not met.

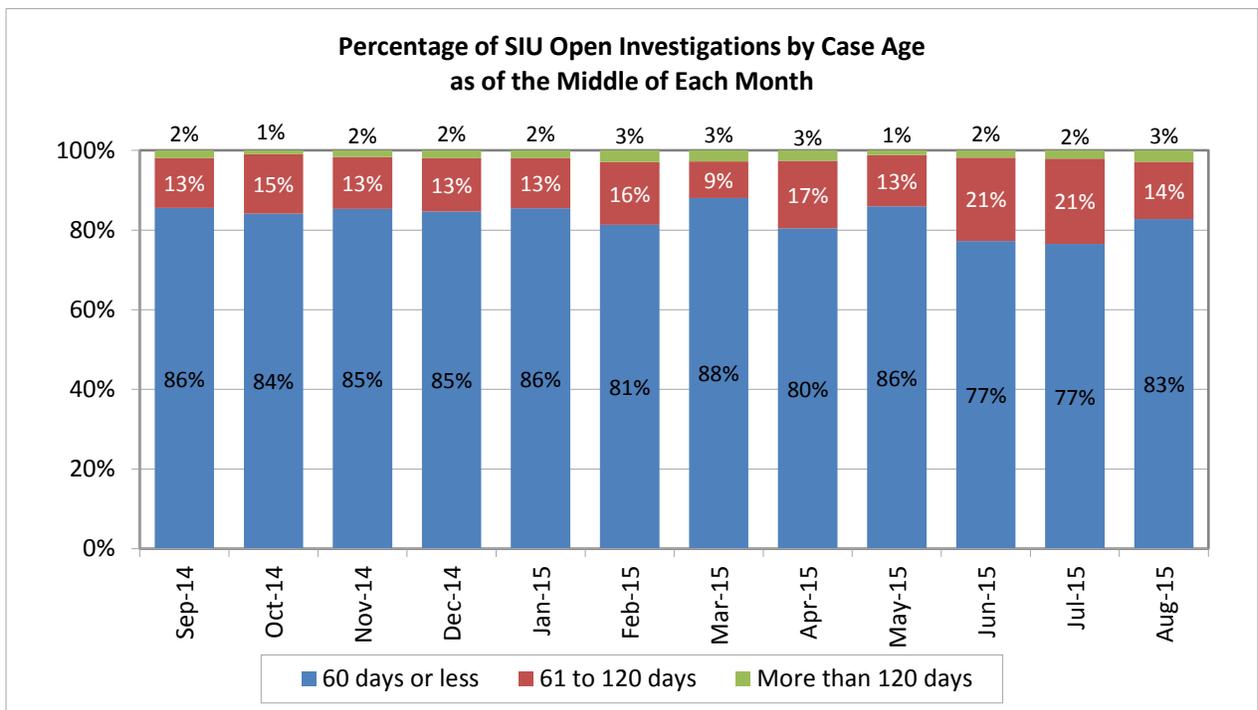
The first case involved six alleged child victims at an in-home daycare. None of the alleged child victims were in custody, and the alleged perpetrators had not previously been involved with the Department in any way. The allegations were about environmental neglect and failure to meet the Department of Human Services’ licensing standards. The investigator made contact with the alleged perpetrators within the response time and noted that the home was clean and there were no safety concerns. However, the alleged child victims were no longer at the daycare at the time the response was made, and the alleged perpetrators refused to provide addresses for the children. The investigator did not document a second good faith effort to see the alleged child victims within the response time, which is required in order to receive credit for making good faith efforts to meet priority response.

The second case involved allegations of sexual and physical abuse of two non-custody children at two respite facilities with which the Department does not contract. The response was not met because the alleged child victims were physically located far from each other and the investigator on the date the response was due, but they were not placed at the respite facilities any longer (they had disclosed these allegations of previous abuse during therapy), so the alleged perpetrator no longer had access to them.

The third case involved allegations of drug-exposed child, physical abuse, and sexual abuse of an adoptive daughter and three foster children in a foster home. The case was initially assigned to regional CPS, but when the assigned investigator met the response with the adoptive daughter and learned that the parents were foster parents for the Department, the case was reassigned to SIU. The reassignment resulted in a delay in making response with the three foster children, which occurred the day after it was due.



Source: TFACTS CPS Open Investigations by Case Age reports as of the middle of each month from September 2014 through August 2015.



Source: TFACTS CPS Open Investigations by Case Age reports as of the middle of each month from September 2014 through August 2015.

Fluctuations in SIU caseloads are to be expected and the Department has demonstrated its capacity to quickly respond to those fluctuations. The Department has continued to maintain

acceptable overall performance on both priority response times and investigation completion. The Department is appropriately attentive to ensuring adequate allocation of staff positions to SIU and this attentiveness, combined with the mechanisms for providing short-term supplemental staffing in response to spikes in caseload, support the TAC's finding that SIU is adequately staffed.

The parties have requested that the TAC comment further on the quality of SIU investigations. The TAC continues to be very impressed by the SIU director and by the supervisory and QA processes in place to help ensure the quality of SIU investigations. As discussed in the July 2015 Monitoring Report, the director has identified opportunities for continuous quality improvements, including in the area of casework documentation; however, while the director is appropriately focused on SIU practice improvement, the TAC is satisfied (based on the TAC monitoring staff's observations and participation in case review related activities of SIU and based on the TAC's review of the case quality review process and completed case quality review forms) that SIU investigations are being responsibly conducted and that to the extent that case practice in an individual case (or case practice of an individual investigator) falls short of expectations, the current supervisory processes are adequately identifying and responding to those situations.

III.B

The TAC has been asked to comment specifically on whether, in the TAC's view, reports of abuse and neglect of children while in DCS custody are being reviewed in a timely manner by the DCS units responsible for quality assurance and provider oversight, and whether the processes in place, including the tracking processes implemented by the Quality Control (QC) Division, reasonably ensure both that appropriate corrective action is taken, and that any patterns of abuse or neglect are identified and addressed. The TAC has also been asked to specifically address the requirement that results of the reviews be incorporated into performance based contracting.

In a well operating child welfare system, there should be little opportunity for a pattern of abuse or neglect to develop. In Tennessee, a single report of a child being abused or neglected in a resource home results in an immediate freeze of admissions to that home pending the completion of the investigation; and a substantiation of abuse or neglect against a resource parent, unless there were unusual mitigating circumstances, would generally result in the closing of the home.

In a congregate care facility, a substantiation of abuse and neglect against a staff member would invariably result in the termination of that staff member, and heightened scrutiny of the facility.⁴

As discussed in the July 2015 Monitoring Report, the SIU investigation process itself includes mechanisms for ensuring that any immediate safety concerns about the resource home or

⁴ The provider oversight staff not only scrutinize specific allegations against staff members, but also recognize that, in congregate care settings, incidents that do not specifically allege staff misconduct—for example, incidents of physical assaults by children on other children, or incidents of children running away—may be indications of inadequate supervision by facility staff.

congregate care placement identified during the course of an investigation are promptly addressed. If the investigator has concerns about the child's immediate safety or the safety of other children in the placement, such that removal of that child or others is necessary to protect their safety, the investigator works with the case manager, Team Leader, or regional management to coordinate the removal of the child from the placement while the investigation is being conducted. If the identified risks or concerns do not warrant removal, the investigator may implement a safety plan to address those risks. If the allegation concerns a staff member at a congregate care facility who poses a continuing threat to the safety of children in that facility, the SIU investigator is responsible for ensuring that the facility has taken appropriate steps to restrict contact between the staff member and the alleged child victim (or any other children deemed by the investigator to be at risk) pending the conclusion of the investigation.

The QC Division has implemented a tracking system that uses three logs: one to ensure that resource homes are placed on freeze at the beginning of any SIU investigation (and to ensure that the freeze is lifted at the appropriate time following the completion of the SIU investigation and the Resource Home Quality Team review); a second log to track the status of the Resource Home Quality Team review for those homes requiring a review; and a third log, the most recently implemented, which tracks both initial notifications and closing notifications involving congregate care facilities to ensure that all such cases are subject to review, and that cases raising concerns are referred to the Provider Quality Team for further review. The TAC monitoring staff have worked closely with the Department staff in the development and implementation of the QC review processes, and have observed and actively participated in those processes. They are familiar with the tracking logs and with the way those logs are conscientiously maintained by QC staff. In combination, those three tracking logs ensure that reports of abuse and neglect of children while in resource homes or congregate care settings are referred to and reviewed by the units and staff with relevant quality assurance and placement and provider oversight responsibility.

With respect to the timeliness of the reviews, the data presented in the July 2015 Monitoring Report reflected that QC reviews were occurring within 15 days of receipt by QC of the closing notifications reporting the results of the SIU investigation, with the vast majority of notifications reviewed by QC the same day they were received. However, there are often delays between the completion of the SIU investigation and the date on which the closing notification is sent to QC staff for review. As a result, for the three-month period discussed in the July 2015 Monitoring Report, 75% of the closing notifications were reviewed within 90 days of the closure of the investigation.

The Department is currently implementing changes to the process for sending closing notifications that both the Department and the TAC expect will reduce the delays between the completion of the SIU investigation and the forwarding of the closing notification to the QC Division. In any event, these delays take on less significance, since information generated in the course of the SIU review that would raise significant health or safety concerns is being shared in a timely manner, so that any action necessary to protect affected or potentially affected children can be taken in advance of the completion of the formal review process. The TAC is satisfied that the regular communication and close working relationship between SIU, QC and the various DCS staff with provider oversight responsibility, and the improvements in the PQT process,

sufficiently ensure that any concerning information about placements or providers is being shared and reviewed in a timely manner.

Finally, with respect to the requirement that the results of the reviews conducted by the quality assurance unit of the reports of abuse or neglect of children in foster care “be incorporated into the performance based contracting provided by DCS,” the Department’s contracts for placements are performance based contracts, and to be eligible to contract with the Department every agency must have the capacity to provide safe and healthy placements for children. The Department therefore considers the results of the Section III.B reviews (as well as other relevant health and safety data generated by various provider oversight processes) in determining whether to continue contracting with an agency. In the TACs view, this is the appropriate way to incorporate the results of these reviews into the performance based contracting process.⁵

⁵ In the time since the original Settlement Agreement was entered, the Department has significantly raised the standards that private providers are required to meet, expanded and made more demanding the contract requirements (including the provisions in the Provider Manual), implemented performance based contracting, and dramatically improved provider oversight. As a result, the Department has reduced the number of different agencies that it works with from over 90 at the time the original consent decree to less than 30 today. The improved oversight combined with the reduction in the number of agencies with which the Department contracts means that the Department has much more frequent contact and much more extensive knowledge of each of those providers.

SECTION FOUR

IV.A

The TAC was asked to provide additional information regarding the services provided to the families in Figure 4.2 of the July 2015 Monitoring Report for whom a need had initially been identified for services in one or more categories.

The Department, in collaboration with TAC monitoring staff, conducted an analysis of the review data to determine whether, as of the review date, services had been provided to address the families' needs in each category that was initially identified as a need for each family. For each of these cases, the further review found that either (a) the services had been provided, or, (b) in cases in which a service had not yet been provided to meet a family member's identified need, there were case circumstances that provided a reasonable explanation for not providing the service at that point in the case.

Those circumstances fell into three categories:

1. Parents who disappeared or avoided the Department after the removal of the child (including two cases of infants who were abandoned at the hospital at birth);
2. Parents who had multiple needs identified and the Department was focusing on the primary needs first (so that services provided for secondary needs could be more effective); and
3. One case in which a mother refused to complete the aftercare program recommended by her intensive outpatient substance abuse program, which would have provided assistance with her housing and employment needs.

The following is the breakdown of the number of families initially identified as having needs in each category who had received at least one service in that category as of the review:

- Substance abuse services were provided to 34 of 39 families;
- Mental health services were provided to all nine families;
- Housing services were provided to three of five families;
- Parenting education services were provided to 28 of 50 families; and
- Domestic violence services were provided to three of four families.

As stated in the July 2015 Monitoring Report, TAC monitoring staff also conducted case-specific follow-up on the children included in the sample for the IV.A Review who, as of the time that the review was conducted, remained in care and were not on THV or in full guardianship (a) to identify the obstacles that were preventing the return of the child to the family and, (b) to determine, to the extent that there were any IV.A services that were relevant to overcoming those obstacles, whether those services had been offered or provided to the family. This follow-up review was conducted during the first two weeks of August and involved the 38 children from the original sample who, as of that time, remained in care and were not on THV or in full guardianship.

TAC monitoring staff found significant evidence of a full range of community-based services to support and preserve families of foster children in state custody, as suggested by the other sources of data regarding such services presented in the July 2015 Monitoring Report.

TAC monitoring staff found several examples of provision of individualized services to families and of the Department's ability to arrange for payment when parents were uninsured, their insurance denied coverage, or there was a long waitlist. For example, in one case, the Department arranged for the mother to receive intensive outpatient substance abuse treatment in her home because her multiple sclerosis made it difficult for her to get out of her house; the Department also paid for homemaker services even though the services were covered by her insurance because the waitlist for the provider in her insurance network was too long.

In those cases in which relevant services were not provided, it was not the lack of services, but rather the parent's failure to take advantage of available services, that accounted for the failure of the parents to receive services: in some cases the parents were uninvolved, were avoiding contact with DCS, or otherwise could not be located; in others, the family failed to follow through when services were made available.

TAC monitoring staff were only able to identify one instance in which a problem with access to a service was an obstacle to case progress. In that case, the father's permanency plan required him to complete an alcohol and drug assessment, and he sought to get that assessment through his health insurance coverage. He was unable to do so and was under the impression that his insurance would not cover the cost of an assessment. However, when he was asked to obtain a letter of denial from the insurance company (the documentation required for the Department to cover the cost of the assessment), the father learned that the insurance company had not, in fact, denied the request, but was requiring him to pay for the cost of the assessment himself and then file with the company for reimbursement. As of the time of the review, the Department was working to resolve the situation.

The additional information generated by these two additional follow-up activities further support the TAC's conclusion that the range of services available to families of children in DCS custody meets the requirements of Section IV.A.

SECTION FIVE

V.L

In conducting the targeted review of case transfers, the results of which were reported in the July 2015 Monitoring Report, the TAC neglected to gather specific information on the extent to which the cases covered by the review had been “reassigned within one business day” and therefore met the requirements that no case be “uncovered at any time.” Plaintiffs requested that the TAC provide that additional information. Plaintiffs also requested that the TAC comment specifically on the Department’s performance on the requirement that the departing case manager make “every effort to introduce the receiving case manager, in person, to the child and the child’s parents.”

The TAC monitoring staff checked the TFACTS assignment history for all 82 cases that were transferred during March and April 2015 because the case manager carrying the case left the agency to determine whether there was a gap in assignment when the case transferred from the departing worker to the new worker and whether the reassignment occurred within one business day of the date that the departing worker left the agency.

Of the 82 cases, TFACTS assignment history reflects reassignment within one business day for 81 cases (99%).⁶ The one case not reassigned within one business day was reassigned during the second business day after the departure of the case manager. This transfer occurred during a period of severe winter storms that necessitated the closing of State offices on the day before the case manager left.

One of the factors contributing to this high level of performance on new case manager assignment is that the Department’s Human Resources Division is responsible for promptly disabling a case manager’s TFACTS account upon that case manager’s termination. Because TFACTS does not permit a case manager’s account to be disabled unless all of the cases assigned to that case manager have been reassigned, the HR processes act as a “fail safe” to ensure that all cases are promptly reassigned.

The TFACTS assignment history for these 82 cases did not reflect any gaps in assignment at the time that the case manager left the agency.⁷

The data reflecting the promptness of case reassignment confirms that cases are not going “uncovered.” In addition, supervisors also have responsibility for the cases of the case managers that they supervise and for necessary casework if the case manager is absent at any time for any reason.

⁶ This includes 14 cases in which there was an intervening weekend or holiday between the first business day and the second business day and the reassignment occurred over the weekend or holiday prior to the second business day.

⁷ In one case, the new worker was given an incorrect assignment role (“Permanency Specialist” instead of “SS Custody Worker”), but this incorrect assignment role would not have impacted her ability to perform the necessary case management functions for the case in TFACTS.

The Settlement Agreement requirement includes that efforts be made by the departing case manager to introduce the new case manager to the family. This requirement is intended to ensure some continuity for the family when a case manager changes. In situations in which a case is transferred within the departing case manager's team, the case remains under the same supervisor, and the family's familiarity with that supervisor also provides continuity. Similarly, if the case is a private provider case managed case, when the DCS case manager assigned to that case departs, the private provider case manager provides continuity for the family.

As reported in the July 2015 Monitoring Report, there were 35 cases in which there was no documentation that the departing worker introduced the new worker to the child and/or family. However, of those 35 cases, 29 (or 83%) were transferred within the departing case manager's team and therefore maintained consistent supervision throughout the transition, and in a number of these cases, the transfer was made to a case manager on the team who had had some previous contact with the family, thus providing additional continuity.

In 19 (or 54%) of the 35 cases, the children were placed in private provider placements and therefore maintained consistent case management through their private provider case manager throughout the transition.

While the reason that an introduction did not occur was not documented in every case, the review did demonstrate that successful efforts were being made in many cases and provided some examples of the reasonable obstacles to accomplishing an introduction prior to the case manager's departure. In some cases the case manager either left unexpectedly or took maternity or medical leave and then did not return to work. In other cases, a combination of the limited amount of time prior to the case manager's departure; the Department's difficulties, despite efforts, in making this happen when workers are terminated; and the competing demands on that case manager's time between notice and leaving prevented an in-person introduction. In one case, the plan was to accomplish the introduction at a child and family team meeting, but the parent did not attend the CFTM.

Based on the review of the data and the analysis of the cases, the TAC is satisfied that the Department is meeting the overall requirements of Section V.L and that the interests of continuity are sufficiently served by the current levels of performance.

SECTION SIX

VI.A.1.b

The TAC was asked to provide some further comments and clarification related to this provision, which is currently in maintenance.

While the Department no longer uses shelter placements, the Department does use Primary Treatment Center (PTC) programs for a small number of children for an assessment period in order to gain information to match the child with the appropriate treatment and/or placement, such as Sexual Offender or Alcohol and Drug Treatment. As reflected in Figure 1.11 and 1.12 in the June 2015 Monitoring Report, for the period from 2004 through 2014, 2% to 4% of class members entering out of home care for the first time had this type of congregate care placement as their initial placement and less than 2% had this type of placement as their predominant placement while in care. In addition, a completion of a PTC stay does not always result in a physical move, as some children remain in the facility where they were placed during their assessment but enter the correct contract and treatment program after the completion of the assessment.

The Department has several processes in place to ensure that children in PTC placements receive special oversight. Children in PTC placements are monitored by the Network Development Division staff in Central Office, who look at cases to ensure that necessary assessments are done timely and to help secure appropriate placement for the youth when the assessments are complete. In the regional offices, a Placement Exception request (PER) is required when a child remains over 30 days in a PTC placement. Regional Administrator approval is required, documented on a PER form that is uploaded in the child's file, and the child is logged on the PER spreadsheet shared with the Quality Control Division. In addition, the QC division does further analysis on the children remaining over 30 days, utilizing information that includes both of the sources listed above, to ensure appropriate action is taken in each case and to look for any patterns or systemic issues.

The TAC continues to find that children who go into PTC placements typically have extraordinary treatment and placement needs and that when a child remains in a PTC placement for more than 30 days it is generally reflective of appropriate practice. And the TAC continues to be impressed by the diligence of the Network Development Division in monitoring PTC placements and working with the PTCs to ensure timely completion of necessary assessments and thoughtful matching of these children with placements that can meet their challenging needs.

VI.A.1.d

As discussed in the July 2015 Monitoring Report, TAC monitoring staff and Department staff jointly completed a review of placements made during the last quarter of 2014 that resulted in (1) more than three foster children, (2) more than six total children, or (3) more than three children under age three in a resource home. The TAC was asked to provide data reflecting the

percentage of class members experiencing one or more of these three placement exceptions for a relevant “point in time” during the monitoring period.

The TAC has the ability to provide these data for two of the three categories using readily available spreadsheet reports from TFACTS: more than three foster children and more than six total children in a resource home. As of December 15, 2014, 12% of class members (879 of 7,117) were in a resource home with more than three foster children (including homes appropriately serving only a sibling group of custodial children that is larger than three).⁸

On that same date, 62 custodial children, representing less than 1% of class members, were in a resource home with more than six total children in it.⁹

Data on the third category, more than three children under age three in a resource home, are not available from TFACTS spreadsheets, because there is no regularly produced report at this time that lists the *ages* of non-foster children (birth and adopted children) in resource homes. The TAC therefore drew on the validated PERs data for the third quarter of 2014 (included in Appendix H of the July 2015 Monitoring Report), to provide data on the percentage of class members placed in a foster home that had more than three children under the age of three in the home.

The TAC was also asked to provide information on the percentage of resource homes that are overcrowded at any given time. A recent review of open resource homes¹⁰ found that 4% of resource homes were serving more than three foster children and 2% had more than six total children.

Finally, the TAC was asked to comment specifically on whether the percentages of homes that are overcrowded at any given time or the percentages of class members placed in those homes is excessive. Every review of overcrowded homes that the TAC has conducted, including the most recent one reported in the July 2015 Monitoring Report, has found those homes overall to be safe and appropriate placements for the children in the homes, notwithstanding the over-crowding. The TAC has consistently found, with few exceptions, that the decision to place a child in a home that exceeds placement limits has been done thoughtfully. In the vast majority of cases, the resource parents accepting these children have demonstrated their capacity to effectively and appropriately serve larger groups of children and are willing and able to do so.¹¹ Based on the findings of the targeted reviews, the TAC is satisfied that the current level of placements in

⁸ This includes 585 class members who were in homes with a total of four foster children; 208 who were in homes with a total of five foster children; 72 children who were in homes with a total of six foster children; and 14 who were in homes with a total of seven foster children.

⁹ The resource home TFACTS report, which provides the number of birth and adopted children in each home, provides the number of custodial children but does not provide information on the adjudication of those children. Therefore, some youth with delinquent adjudications may be included in this number.

¹⁰ To be considered an open resource home for purposes of this review, the home not only had to be “open” as of the August 2015 review date, but it also had to have served at least one child at some point during 2015.

¹¹ Child welfare systems have traditionally used emergency shelters—congregate care facilities that serve as temporary placements for children until a bed opens up in a foster home—as a way of avoiding “overcrowding” of resource homes. Tennessee appropriately eliminated these congregate care facilities, recognizing that, if done thoughtfully, and if the resource homes are well-supported, children are better off in resource homes, even if for a period a home is overcrowded, than in emergency shelters.

excess of capacity limits is reasonable and that the Department's performance meets the requirements of VI.A.1.d.

VI.A.2

As reported in the June 2014 Monitoring Report, the QC Division has been working with the regions to tighten up the process for ensuring both that PER approval is being obtained before any exceptional placement is made and that those approvals are being documented on the regional spreadsheets. The presence of the child's name on the spreadsheet indicates that the Regional Administrator (RA) approved the placement, and that a PER form was filled out documenting the reason for the exception and the approval of the RA. On a monthly basis at the beginning of each month, the QC division checks the regional spreadsheets against TFACTS data for the placement exception categories b, e, f and g, and (as discussed above) for two of the three overcrowded home exceptions of d, in order to share with the regions information about any cases from the preceding month that were missed.¹² In addition, information on VI.A.1.a and c, while not produced monthly, is available from TFACTS reports, but there is a lag time of months before the reports are released.¹³ The QC division periodically checks these categories to determine the extent to which PERs are being filed; however, they are not a part of the regular monthly CQI work done by the QC division and are not subject to the same level of follow-up and data clean-up.¹⁴

VI.A.3

The parties have asked the TAC to provide more information on the compiled PER data that QC shares throughout the Department and with the TAC. The Excel workbook contains tables, charts, and detailed information by PER category, region, and reason for placement. The first tab or worksheet contains a table listing the number of exceptions in each category for each region during the time period, and the reason given for the exception. There is also a separate tab or worksheet for each exception category. Each of these tabs contains a graph or chart that has built in filters or "slicers" which give the user the ability to see the exceptions and reasons for their own region, their own county, or their own cluster (a set of counties). These graphs also provide a visual display of the data contained in the tables. A final tab includes the detailed list

¹² These are the exceptions for which monthly data is readily available from regular TFACTS reporting.

¹³ As discussed in Section One of the July 2015 Monitoring Report, 75 mile reporting is available quarterly provided by Vanderbilt. Separation of sibling data is available using the sibling visits report, also discussed in Section One of the July 2015 Monitoring Report, but visit reports are delayed to allow ample time for staff to enter documentation of visits.

¹⁴ The most recent check conducted for separation of siblings—a review of a randomly selected sample of class members for whom a PER should have been filed for sibling separation during fiscal year 2014-15—found that 93% (98 of 105) were listed on the regional spreadsheets when checked by QC. The most recent check conducted of PERs for placement outside of region or 75 miles found that 80% of class members (102 of 128) requiring such a PER in February of 2015 were listed on the regional spreadsheets when checked by QC. Based on the experience of the monthly CQI follow-up that there are ordinarily in any given month a number of cases in which a PER was filed, but inadvertently omitted from the regional spreadsheet, as well as cases in which placement appeared to require a PER but on further examination actually did not, the TAC believes that the PER performance on placements outside of 75 miles/out of region is likely higher than the percentage indicated by the recent QC check.

of all PERs during the time period, including: the date the PER was incurred, the date of RA approval, Region, County, basic information about the child (such as name and TFACTS ID), provider name (if applicable), placement information, and information about the PER (category and reason).

The PERs process itself is designed to ensure that appropriate action is taken when a placement does not meet the placement standards. The focus of the CQI work done by Central Office has been to ensure that the PER process is functioning properly and that the RAs review and approval role is being exercised appropriately, including noting any further action required as a condition of the RA approval.

The results of periodic case reviews of specific categories of cases, including reviews of separated siblings, overcrowded resource homes, PTC placements, and detention center placements, discussed in the TAC's monitoring reports have all generally reflected appropriate practice in these categories of cases. Aggregate data are also available to track and report on the frequency of exceptional placements.

The TAC is satisfied that the QC Division is currently sufficiently meeting its responsibilities for tracking, reporting, and ensuring appropriate action is being taken with respect to placements that do not comply with the placement standards in Section VI.A 1.

VI.H.1; VI.H.2

Frequency of Case Manager Face-to-Face Contact with Children

The July 2015 Monitoring Report presented aggregate data on the frequency with which children are receiving face-to-face visits from their DCS case managers. The Settlement Agreement requires six visits in the first two months of custody and two visits per month thereafter for children in DCS placements; and at least one visit per month by the DCS case manager for children in private provider case managed placements. The parties agreed that the Department's performance on the frequency of visits by DCS case managers to be sufficient to warrant maintenance on those specific requirements of the Settlement Agreement.

With respect to the frequency of face-to-face contacts by private provider case managers in private provider case managed cases, the level of performance reflected in TFACTS aggregate reporting is significantly lower than performance by DCS case managers. However, the TAC is persuaded that this reflects the data entry challenges created by the current federal SACWIS requirements that prohibit the Department of Children's Services from importing face-to-face contact data that private agencies maintain in their own electronic data bases into TFACTS. Private providers are therefore required to have staff re-enter information about private provider contacts into TFACTS that the private provider case managers have already entered into the private provider case files

While the providers have been working with the Department to improve their face-to-face documentation (and while the Department has been working to persuade the U.S. Department of

Health and Human Services to allow the import of data from private provider systems), the private providers understandably have a much greater stake in the accuracy and completeness of their own agency files, not only because they rely on them for their own management purposes, but because it is those files that are subject to external audits, by licensing agencies, contract monitors, TennCare, or the Council on Accreditation (COA) accreditation process.

For this reason, the TAC believes that the Program Accountability Review (PAR) audits of the private provider files for documentation of face-to-face visits provide a more reliable measure of the frequency of private provider case manager face-to-face visits with children in private provider placements than the aggregate data in TFACTS that is dependent on redundant data entry by provider staff.

The PAR reviews that are conducted of private agencies include in their case file audits a specific inquiry as to whether “the private provider case manager has conducted face-to-face visits with the child at the frequency required by policy: six visits in the first two months of placement in a resource home or facility; two visits per month thereafter.” Of the 235 case files reviewed during the 2014-15 review year, 216 (92%) were designated as “no evidence of a need to improve” indicating documentation of compliance with the frequency requirements; 10 (4%) were designated as “evidence of need to improve” and nine (4%) were designated as “significant evidence of need to improve.”¹⁵ The TAC is satisfied that this level of performance is sufficient to warrant a finding of maintenance with respect to the frequency of private provider visits.¹⁶

Frequency with Which Face-to-Face Contacts Take Place at the Child’s Placement

The July 2015 Monitoring Report also provided monthly data reflecting the extent to which at least one face-to-face case manager contact each month takes place at the child’s placement. (According to TFACTS aggregate reports, this requirement was met in 83% to 87% of the cases each month during 2014.¹⁷) However the TAC inadvertently neglected to include data on the extent to which children were receiving the required three case manager visits at their placement during the first 60 days of custody. Of the 4,020 children who entered custody during 2014 and remained in care for at least 60 days, 2,429 (61%) were visited at least three times at their placement during those first 60 days, 824 (21%) were visited twice and 524 (13%) were visited once. In the TAC’s view, this level of performance is sufficient to warrant a maintenance

¹⁵ Eight of the nine findings of “significant evidence of a need to improve” involved one particular provider. In response, the provider committed to ensuring that case managers in their residential settings would enter at least one case recording a week documenting their face-to-face visits.

¹⁶ The TAC also received and reviewed spreadsheets from two agencies containing data on face-to-face contacts to both understand how they maintain their face-to-face contact data in their data systems and to specifically examine their face-to-face contact data for August of 2015 to determine the frequency of face-to-face contact with DCS children served during that month. For one agency, 89% of the children had received two or more contacts during that month, and for the other, 98% of the children had received two or more contacts. (Because neither data set was sortable by adjudication, these percentages include, but are not limited to, class members served by the agencies).

¹⁷ The 2014-15 PAR reviews reflect a higher percentage of contacts in the child’s placement. Of the 235 private provider case files reviewed by PAR, 210 (89%) met the standard of at least one visit at the child’s placement per month. In 15 cases (6%), the reviewers found “evidence of a need to improve”, and in 10 cases (4%) the reviewers found “significant evidence of need to improve.”

designation on the provisions regarding the frequency of case manager contacts at the child's placement.

Remaining Requirements

There were two requirements of Section VI.H. for which the TAC did not provide specific data in its July 2015 Monitoring Report: (1) that the case manager spend private time with the child during each required face-to-face contact; and (2) that there be joint DCS/private provider case manager face-to-face contact once every three months in private agency managed cases. The Department believes that their performance meets these requirements and the TAC is in the process of gathering and verifying data on those two requirements in order to make a determination.

SECTION SEVEN

VII.C

The July 2015 Monitoring Report included data from both aggregate Child and Family Team Meeting (CFTM) reporting and the Child and Family Team (CFT) Process Review that established that Initial CFTMs are occurring within the time frames required by the Settlement Agreement: prior to a child entering custody when that is possible, but within seven days of the child coming into custody in circumstances, such as emergency removals, when that is not practical. The TAC was asked to provide a breakdown reflecting the portion of the Initial CFTMs that occurred prior to a child coming into DCS custody and those that occurred following the child's entry into custody, and to comment on the extent to which the Department is seeking to convene CFTMs in advance of a child entering custody.

Of the 89 Initial CFTMs held in the cases in the CFT Process Review, 30 were held prior to the child entering DCS custody and an additional 16 were held on the day that the child came into custody. A spot check of cases in which CFTMs were held after the child entered custody confirmed that these were circumstances that made a pre-custodial Initial CFTM impractical. They involved not only emergency removals (35 cases), but also children placed in DCS custody through "bench orders" (11 cases) not sought by the Department (including three instances of placement ordered by a juvenile court pursuant to a petition filed by a parent).

The TAC is satisfied that the Department's Child and Family Team practice currently meets the requirements of Section VII.C, including the requirement that Initial CFTMs be convened prior to a child's entering state custody, except in cases of an emergency removal.

VII.D

The TAC was asked to provide additional comment on three of the requirements related to the Initial Permanency Planning CFTM: the requirement that, when parents cannot be located or refuse to meet with the case manager, the case manager document all efforts made to locate the parent; the requirement that the plan be presented to the Court within 60 days; and the requirement that the parents have a meaningful opportunity to review and sign the plan, before the plan is submitted to the Court.

As described in the July 2015 Monitoring Report, the results of the targeted case review found that of the 92 cases reviewed, at least one parent signed the permanency plan in 69 cases, and in an additional 13 cases, a parent who was present for the Initial Permanency Planning CFTM elected not to sign the plan. In an additional four cases, the parents' whereabouts were unknown at the time of the Initial Permanency Planning CFTM, or they were not involved in the child's life at the time of removal.

Thus, in 82 (93%) of the 88 cases in which parents were available to participate and were involved in the child's life, at least one parent was present at the Initial Permanency Planning CFTM and/or signed the initial permanency plan.¹⁸

The targeted review also evaluated the degree to which plans were presented to court within 60 days of a child's entering custody. As the parties and the TAC have discussed, the Department's ability to submit a plan to the Court within 60 days often varies from county to county based on the manner in which a local juvenile court prefers to receive and review permanency plans. Some courts allow plans to be filed at any time; however, other courts require that plans be presented in the context of a hearing with all parties present. Scheduling these hearings, accommodating all parties and attorneys, often leads to delays in presenting completed plans to courts.

The results of the targeted review are consistent with the variation in local court practice and procedure. Of the 90 cases,¹⁹ 56 (62%) were presented to the court within 60 days of a child's entering custody; 68 (76%) were presented to court within 75 days; and 76 (84%) were presented within 90 days.

In the TAC's view, this level of performance is sufficient to meet the requirements of VII.D.

VII.F

The TAC has been asked to express its view of the level of supervisor participation in the Discharge Planning CFTMs (71%), as well as the extent to which supervisors are participating in a family's CFTM at least once every six months (70%).

¹⁸ There were 10 cases in which neither parent attended the Initial Permanency Plan CFTM and did not sign the plan.

- The whereabouts of both parents were unknown in two cases. In one of these, the parents had absconded with the children at the time of custody until after the meeting. In another, diligent search efforts were ongoing.
- In one case the father's whereabouts were unknown. The mother and her attorney had notice of the meeting, but she was hospitalized at the time of the meeting.
- In another three cases it was documented that there was attempted contact/parents were invited to the meetings. In one of these, the mother was incarcerated and father was in a rehabilitation center. In another case, there was no response from the parents regarding the meeting. The father lived in Chicago, and it was later documented that he did not want to be involved. In the third case, the meeting was scheduled around the parents' work schedules, but they failed to show up for the meeting.
- In one case the father did not attend due to work, but the step-mother did attend. The child had been removed from the father and step-mother.
- In two cases the parents had not been involved with the children since before they entered custody. In one of these cases, the parents lived in Indiana.
- In the last case, the father was in prison for the abuse which led to the youth's custody episode. There is documentation that the youth was concerned that the mother was not in good enough health to protect her from the father. The youth did not want contact with either parent and chose to receive Extension of Foster Care services.

¹⁹ The targeted review included 92 cases, but as of the time of the review, two permanency plans had not yet been submitted to the court.

In the TAC's view, the overall level of attendance of supervisors at CFTMs, including Discharge CFTMs, is acceptable, as is the level of performance on the requirement that a supervisor attend at least one CFTM every six months.

The adoption of the Child and Family Team process as the core of the Department's practice model represented a significant shift in policy and practice for the Department; it required then existing staff to abandon a case planning process that they were used to—one that planned for children and families largely without their input—to a family conferencing model that required case managers to actively engage and plan with children and families.

In order to ensure that this new approach to case planning would be effectively implemented, the active participation and support (and “buy in”) of supervisors was critical. At the inception of the CFT process, it therefore made sense to require supervisors to actively participate in CFTMs, and it is in this context that the Settlement Agreement specified that supervisors both attend certain types of CFTMs and attend CFTMs with a certain frequency.

Now, years later, the CFT Process is well-established in Tennessee and broadly embraced at all levels of the Department. Rather than being a new approach requiring a change in the way staff have been used to working, it is for most of the front-line case managers the only approach to case planning that they have known. In this current context, it makes good sense that supervisors be accorded some flexibility in deciding which CFTMs to attend based on their judgements about the complexity of the case and/or the skill level of their worker and in balancing the amount of time they spend attending CFTMs against the other important and competing demands on their time (many of which relate to other requirements of the Settlement Agreement).

The current level of performance, in the TAC's view, reflects appropriate allocations of supervisor time and constitutes appropriate levels of supervisory participation and support of the CFT process.

VII.J

The TAC was asked specifically to comment on the extent to which the 2014-15 Quality Service Review (QSR) scores for Child and Family Planning Process (75% acceptable), Plan Implementation (78% acceptable), and Informal and Community Supports (76% acceptable) are sufficient to support a finding of maintenance.

As the TAC observed in the Executive Summary of the July 2015 Monitoring Report, the current QSR scores “have reached levels that are generally viewed as reflective of a reasonably well-functioning child welfare system.”

In discussing the Department's performance on Section VII.J in the July 2015 Monitoring Report, the TAC therefore referenced the system performance indicators relevant to the provisions of VII.J, all of which were above 70%, as reflecting positively on the Department's performance.

It is important to remember that the QSR measures are more demanding in a number of respects than the requirements of the Settlement Agreement. For this reason, cases that score unacceptable for the Child and Family Planning Process, Plan Implementation, or Informal Community Supports, may nevertheless meet the related requirements of VII.J.

To illustrate this point, the TAC monitoring staff reviewed 40 cases from the 2014-15 review that scored “marginally unacceptable” (a score of 3) for either Child and Family Planning Process, Plan Implementation, or Informal and Community Supports (but not less than three on any of those indicators) to determine whether the unacceptable score was based on a failure to meet one or more of the requirements of Section VII.J. In 32 of those 40 cases, notwithstanding the fact that the case scored “unacceptable” using the more demanding QSR standard, each case nevertheless met the requirements of Section VII.J; and in an additional six cases, the failure to meet one or more of the requirements of Section VII.J was a reflection of appropriate case practice²⁰ and was reasonable given the particular posture of the case. In the remaining two cases, only some of the requirements of VII.J appeared to have been met.²¹ In the TAC’s view the Department’s performance is meeting the requirements of VII.J.

²⁰ In three of the five cases, the children had only been in care for short periods of time. Two of the three children were facing some mental health issues that their teams were attempting to address as the first, most pressing, needs for planning. It was understandable that once these needs were assessed and beginning to be addressed, the team would move toward the more comprehensive planning contemplated by the DCS practice model and the requirements in VII.J. The other child came from the hospital into care after extreme physical abuse. The team was beginning to understand the child’s extensive needs, and the parents’ responsibility for the child’s injuries, as well as their own abilities and needs.

In two other cases, the teams had shifted permanency planning to a goal of adoption and were therefore no longer focused on the parents’ meeting their responsibilities specified in earlier plans or in their progress toward earlier planning goals.

In the fifth case, the child’s parents were both in jail, so the team was doing what they could to assess the parents’ needs and plan with them for life upon their release, acknowledging that case planning would be limited until that time.

²¹ In one case, the child had been struggling with intense behaviors and was stepping down from a level 3 residential treatment facility at the time of the QSR. His mother was slow in working through her pieces of the plan, so some important planning steps had been taken, while others seemed stalled. In the other case, the child and family had a long history with the Department, and while some of their challenges seem to have been identified and plans made to address those challenges, further attention needed to be given to the mother and child’s mental health needs.

SECTION EIGHT

VIII.C.3

The parties have asked the TAC to comment specifically on whether, in the TAC's view, the results of the targeted case review support a finding that the nine-month attorney reviews are occurring as required by the Section VIII.C.3.

As discussed in the July 2015 Monitoring Report, VIII.C.3 is in essence a requirement for a "legal consultation" about the status of the case to make sure that, from the DCS attorney's perspective, the case is moving in a sensible direction, that the permanency goal or goals make sense, that the barriers to permanency have been identified, and that reasonable efforts are being made to address those barriers.

The Settlement Agreement language presents two possible outcomes of this nine-month review: (1) if the child is to return home or be placed in the custody of a relative, establishment of a timetable for unsupervised visits, trial home visits, and hearings to be returned to the parent/relative; (2) if the child is not returning home, establishment of a timetable for providing documentation and information to the DCS attorney in order to file a TPR.²² The targeted review conducted by the TAC therefore looked to see whether these timelines had been established.

However, as the parties and the TAC have discussed, in a fair number of cases at the nine-month mark, it may well be appropriate to continue to work toward return to parent or relative and not file TPR, but still not be appropriate to set a timetable for reunification or initiating a THV. For this reason, the targeted review also examined the circumstances of those cases in which these timetables were not set at the nine-month review, to determine whether there appeared to be a reasonable basis for not doing so.

The findings of the targeted review, which were presented with considerable case detail in the July 2015 Monitoring Report, can be summarized as follows:

- Nine-month attorney reviews were documented in 68 of the 69 cases reviewed.²³
- In 42 cases, specific time tables for either reunification or TPR had been established.
- In six cases the case conference notes reflected some exigent circumstances that arose around the time of the nine-month review that were impeding reunification and that were also preventing timetables from being established for unsupervised visits and trial home visits. In each of those cases the case conference notes reflected actions that were being

²² As discussed in the July 2015 Monitoring Report, because, under the Child and Family Team Process embraced in the Settlement Agreement, establishing timetables for unsupervised visits, trial home visits and hearings for children who are to be reunited with their parents is the responsibility of the Child and Family Team, the role of the attorney in the nine-month review is not to usurp the responsibility of the Child and Family Team, but rather to ensure that the Child and Family Team has addressed or is addressing those issues responsibly.

²³ The one child who did not receive a nine-month attorney review was a 15-year-old who was on a THV at the time that the nine-month review would have been expected to be scheduled. As a result of discussions during the Discharge CFTM for this child, the team concluded that there were safety concerns that warranted terminating the THV and the child was placed in a Level III resource home.

taken or would be taken to address these circumstances and those actions appeared to be appropriate.

- In five cases, notwithstanding the absence of explicit timetables in the case conference notes, the child within a relatively short period following the nine-month review began THV (three cases), was discharged to a relative (one case), or entered full guardianship (one child, through a surrender).
- In the remaining 15 cases, based on a combination of the nine-month review case conference notes and the follow-up conducted by TAC monitoring staff, the TAC concluded that there was a reasonable basis for not establishing timetables for reunification or TPR at the time of the nine-month review.²⁴

Based on the results of the targeted review, the TAC is satisfied that the Department's practice with respect to the nine-month attorney reviews adequately meets the requirements of VIII.C.3.

²⁴ The TAC has continued to follow up on those 15 cases. Three cases are moving toward adoption, with all three children currently in pre-adoptive homes.

Ten cases appear to be moving toward reunification or relative placement: three children are currently placed with relatives; five children are having unsupervised visits with their parents or are on THV; in the two remaining cases, the Department is exploring relative placements (and in one of those cases, the mother, who is on probation in another state, is seeking permission to move back to Tennessee and is maintaining telephone contact with the child).

There is less certainty regarding the trajectories of the remaining two cases. In one case, the permanency plan has been changed to add adoption as a concurrent goal, in the second case, there appears to be little progress toward reunification with the mother and a request for an ICPC placement with the out of state father was denied.

SECTION NINE

IX.D

The parties requested that the TAC provide additional information on the process that the Department uses to ensure that private provider resource parents caring for special needs children are receiving the required specialized training.

As discussed in the July 2015 Monitoring Report, the DCS Program Accountability Review (PAR) Unit is responsible for ensuring that private providers are complying with specific DCS policies and contract requirements, including compliance with policies related to resource parent training. The DCS Provider Policy Manual, Section Two provides that, in addition to the training required for Standard Foster Care, resource parents caring for special needs children—those providing “medically fragile foster care” and “therapeutic foster care”—complete an additional 15 hours of special training.

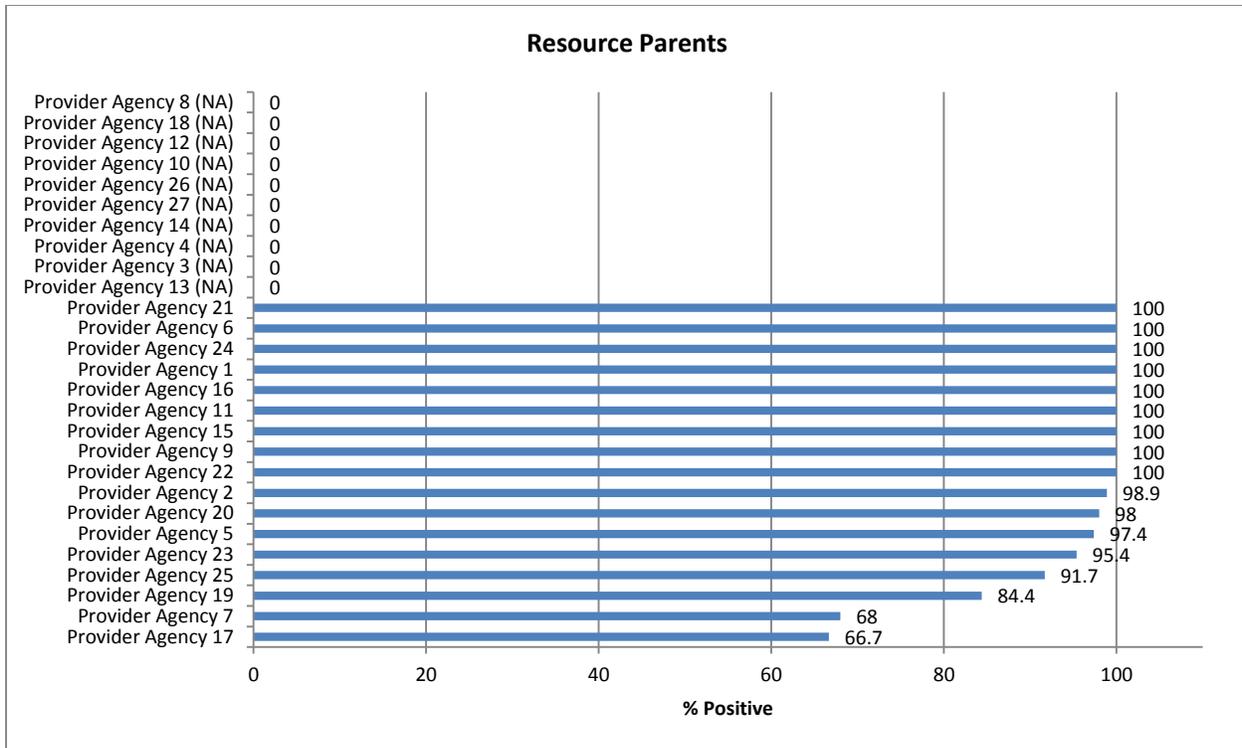
Resource parents caring for medically fragile children are required to receive medically-oriented specialized training necessary to competently care for the greater needs of these children. The Department policies identify relevant training topics including: growth and development; nutrition; medical disabilities; orientation to assistive technology; and seizure management. However, the choice of topics should be tailored to the specific types of children served; and in the case of medically fragile children, the training must also include specialized training on the specific special medical needs of the child being placed.

Resource parents providing “therapeutic foster care” are required to receive specialized training that is “therapeutic in nature to meet the needs of the children/youth the parents will be working with.” Recommended topics for inclusion in a “therapeutic curriculum” include: child trauma; crisis intervention/de-escalation; targeted child specific mental health diagnosis and treatment strategies; working with sexually reactive youth; child development; advanced medication administration; grief and loss associated with entering foster care.

The PAR Unit reviews include an examination of a sample of private provider resource parent files for compliance with contract requirements and requirements outlined in the *Private Provider Manual* regarding resource parent training, including both the specific required courses and the number of training hours. PAR, in collaboration with the Vanderbilt Center of Excellence, issues an annual report, presenting a compilation of private provider performance on monitored items, included as an appendix to the June 2015 Monitoring Report. Private providers are expected to respond to and correct any PAR findings as a part of their exit conference after their review.

The following table shows the results of the resource parent training findings for the 2013-14 fiscal year.²⁵

²⁵ The lowest performing provider agency serves delinquent clients and does not serve class members.



Source: Program Accountability Review Annual Report of Annual Report of Performance Based Contracts
 *NA indicates a residential facility that does not have resource parents

Specifically when reviewing the file of a resource parent who serves medically fragile children, PAR looks for evidence that the resource parent was trained in medical conditions and specific care needs of the child in their care. PAR reviewed seven such files during fiscal year 2013-14 and found evidence in six of the files. As a part of the exit conference for the provider of the remaining home, the provider agency committed to having their recruiter supervisor audit their files quarterly to ensure that resource parent training hours are documented in the files.

The annual report for fiscal year 2014-15 has not been released yet. However the TAC reviewed the data on resource parent files collected during the year and found that PAR reviewed 10 resource parent files for parents serving medically fragile children and all 10 contained evidence of training for medical conditions and care of the specific child.

The TAC is satisfied that the PAR process adequately ensures that resource parents serving children with special needs are receiving the specialized training envisioned by Section IX.D.

SECTION ELEVEN

XI.E.1

Section XI.E.1 provides that the QA division, utilizing aggregate data and case reviews as appropriate, is responsible for tracking, reporting and ensuring that appropriate action is taken with respect to children who have experienced three different placements, excluding a return home, within the preceding 12 months.

For the past several years, the Department has used a sophisticated analysis of aggregate data compiled by Chapin Hall to both understand issues related to placement stability and to develop, implement, and track the impact of strategies to improve placement stability generally. The Department is now supplementing that information with a periodic case file review of children experiencing three or more different placements within a 12-month period. The first of these reviews was conducted in the spring of 2015 and the results were reported in the July 2015 Monitoring Report; the Commissioner has indicated that a similar review will be conducted at least annually.

As discussed in the July 2015 Monitoring Report, the QC Division had initially proposed developing a monthly report to identify any child who changed placements during that month for whom that move resulted in the child's third placement in a 12-month period and to use the monthly report to review those cases more frequently. However, based on the results of the recently completed case file review (which found that in two-thirds of the cases the most recent placement move was a positive step toward permanency, toward a less restrictive placement setting, or to a setting better suited to meet the treatment needs of the child) and based on the Child and Family Team Process Review (which found that Placement Stability CFTMs were being regularly convened to address placement disruptions), the Commissioner determined that the Department now has review processes in place that provide sufficient assurance that "appropriate action is being taken" for this group of children.

The TAC agrees with the Commissioner's approach. This particular provision of the Settlement Agreement was created before the full implementation of the Placement Stability CFTM process. In the TAC's view, because the CFTM process is functioning as designed and the Placement Stability CFTMs (as reflected in the CFT Process Review) are being convened regularly when there is a placement disruption, an annual case review of children experiencing multiple moves is sufficient to meet the requirements of XI.E.1.

SECTION TWELVE

XII.E

In the July 2015 Monitoring Report, the TAC reported that: “The TAC monitoring staff have received and reviewed the unannounced visit reports documenting each of the unannounced visits conducted by the PAR and Licensing Units for fiscal year 2014-15. Reports have been posted for each of the 81 facilities for which unannounced visits were required.²⁶”

Plaintiffs have requested that the TAC specifically comment on the extent to which the Department has addressed the issues identified in the May 2014 Monitoring Report. In that report, the TAC commented that “the Department does not yet appear to have a process for tracking and documenting these visits that would allow the TAC to verify at this point that the Department is meeting this requirement of the Settlement Agreement. The Department was able to produce for the TAC more unannounced visit reports this year than in any of the previous fiscal year periods; however, in some of the visit reports it is not clear that the reviewer toured all of the group homes, cottages, or units on the campus of each facility.”

However the TAC concluded by expressing confidence that “as a part of the work being done by the Department on the provider oversight process, the expectations around unannounced visits will be clarified and supporting documentation will be ensured.” As the TAC anticipated, the issues identified in the May 2014 Monitoring Report have now been fully addressed.

The Department ensured that all 81 facilities received the required unannounced visit and that each of those visits were documented in a facility specific report. TAC monitoring staff read each of those reports and in each case found the expected documentation of the unannounced visit, including evidence of touring all group homes, cottages or units on campuses and the extent to which those facilities met licensing and DCS policy requirements. TAC monitoring staff worked closely with the Department, facilitating a QA role that is now ingrained in the PQT work of the Department. In addition, the Department set up a process for increased ongoing communication and information sharing around facilities and unannounced visits.

The Department maintains sufficient staffing for appropriate monitoring and oversight of private providers. The oversight practices of the Licensing, PAR and other units and the collaboration of those units through the Provider Quality Team are sufficient to determine agency compliance with DCS requirements, including those of the Settlement Agreement.

²⁶ The reports are posted on a shared drive accessible to all members of the Provider Quality Team.

SECTION SIXTEEN²⁷

XVI.B.3

The 2014 Sibling Visits Review, the results of which are presented on pages 42-47 of the July 2015 Monitoring Report, approached the data gathering on sibling visits separately for each month of the review period using five categories:

1. Siblings visited more than once during the month.
2. Siblings visited once during the month.
3. Siblings did not visit at least once during the month; however, the case circumstances during that month met one or more of the sibling visit exceptions allowed under the Settlement Agreement: court order prohibiting sibling visits; sibling does not want to visit; sibling is in an ICPC placement; and sibling visits are not in the best interest of one or more siblings.
4. Siblings did not visit at least once during the month; however, there was a therapeutic concern that, in the TAC's view, presented a reasonable basis for visits not occurring.
5. There was no evidence of any visits during the month in either TFACTS documentation or in follow-up information provided, and case circumstances did not warrant inclusion in either of the exception categories described above.

In subsequent conversations with the parties about the circumstances of those cases in which the TAC found "therapeutic concerns," the TAC was persuaded that these cases could reasonably be considered as falling within the "visits not in the best interest of one or more siblings" category. The parties requested that the TAC (a) revise the data related to the "best interest" category to include those cases in which the TAC found "therapeutic concerns" justifying the failure to visit; and (b) present the "allowable exception" data for each month covered by the review broken down among the specific allowable exceptions of the Settlement Agreement.

The following figures provide a revised analysis of the data, providing the breakdown among permissible exceptions: court order; wishes of sibling(s); ICPC; and best interest (which includes those cases previously categorized as "therapeutic concerns").²⁸

²⁷ In the July 2015 Monitoring Report, performance on the Section XVI measures of the Settlement Agreement is contained in Section One: Data and Outcome Measures Overview.

²⁸ The TAC's analysis assessed the circumstances of each case during each month of the review period separately, so that a case in which circumstances warranted an exception to sibling visits during one month of the review period but not during the remaining two months would be counted as such in the data.

