

**THE TECHNICAL ASSISTANCE
COMMITTEE**

IN THE CASE OF

BRIAN A. v. HASLAM

**SUPPLEMENT TO THE
FEBRUARY 8, 2016 MONITORING REPORT**

April 4, 2016

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INTRODUCTION

This Supplemental Report contains additional information which the Technical Assistance Committee (TAC) has provided to the parties on a number of provisions covered in the February 2016 Monitoring Report to help inform the “maintenance discussions.”

VI.D Requirements Related to the Administration of Psychotropic Medications

The overall goal of the requirements of Section VI.D of the Settlement Agreement is to ensure that psychotropic medications are being responsibly prescribed and administered to treat appropriately diagnosed mental health conditions in accordance with professional medical standards, including the requirements of informed consent.

At the request of the parties, the TAC has been asked to indicate the level of confidence that it has in the processes in place to ensure that psychotropic medications are being appropriately prescribed for children in DCS custody and that informed consent is obtained before any child in DCS custody is administered psychotropic medications. The TAC has also been asked to provide some further discussion of the findings of the targeted review regarding documentation of informed consent for children prescribed medications after they entered DCS custody.

A. The Recommendations of the American Academy of Child and Adolescent Psychiatry as a Frame of Reference

In assessing the Department's performance related to Section VI.D, the TAC has used as a frame of reference the recently published best practice recommendations of the American Academy of Child and Adolescent Psychiatry (AACAP).¹ Ten of the AACAP recommendations (recommendations eight through 17) are specifically relevant to psychotropic medication monitoring and oversight responsibilities of child welfare agencies.² The TAC therefore begins this supplemental discussion with a review of those 10 recommendations and a brief summary of the extent to which the Department's approach to medication monitoring and oversight is consistent with each recommendation.

8. Non-physician professionals working with youth should have knowledge of the guidelines in AACAP publications and other relevant resource documents relevant to the use of psychotropic medication with youth. As discussed in previous monitoring reports, the Department has developed and broadly distributed best practice guidelines, policies, and forms, provided relevant training to DCS staff, private provider staff, foster parents, and mental health agency staff, and has provided ongoing outreach and consultation services through both its own DCS staff (DCS health unit nurses, regional mental health consultants, Psychology Director, and Medical Director) and through the Centers of Excellence.

9. Mental health agencies, child welfare, Medicaid agencies, and managed care organizations should collaborate to create systems to monitor, review, and inform practice patterns with psychotropic medications. This recommendation specifically refers to "infrastructure elements" including "the capacity to share data; common practice expectations; common monitoring standards; methods for data review; identification of red flag criteria triggering external reviews; criteria for prior authorization; and methods for timely feedback to prescribers." As discussed in

¹ AACAP, *Recommendations about the Use of Psychotropic Medications for Children and Adolescents Involved in Child-Serving Systems* (hereinafter referred to as the "AACAP Recommendations") (2015).

² AACAP Recommendations at pp. 2-3, 29-32.

the February 2016 Monitoring Report, the Department of Children's Services, with additional support from the Vanderbilt Center of Excellence, has worked with TennCare (the state Medicaid agency) and Magellan (the TennCare pharmacy benefits manager) to be able to access and analyze pharmacy claims data in monitoring and overseeing the use of psychotropic medications for children in DCS custody. The "red flag" criteria that the Department has long used as triggers for special review by the Medical Director are included among the "red flag" criteria that TennCare uses in its oversight of prescription practices and its criteria for prior authorization (discussed in more detail below). The Department's practice expectations, reflected in the Department's guidelines and policies, are consistent with TennCare policy; and those expectations are reinforced by the guidelines and monitoring standards used by TennCare Select in its oversight activities of prescribers.

10. State and county agencies serving children in foster care should use the Best Principle Guideline in the 2005 AACAP Position Statement as the framework for developing formal monitoring and oversight programs. The guideline calls for the agency to develop, in consultation with child and adolescent psychiatrists: (1) policies and procedures to guide the psychotropic medication management of youth in state custody and (2) effective oversight procedures. The Department's policies and practice guidelines were developed through a year-long process that involved extensive consultation with state and national experts in child and adolescent psychiatry; and those policies and practice guidelines have been reviewed and refined periodically, always in consultation with leading experts in the field. The Department's oversight processes have also been designed in consultation with national and state experts in the field of child psychiatry and pharmacology. The guideline also contemplates the development of a "consultation program administered by child and adolescent psychiatrists," a function served by the Centers of Excellence.³

11. Consultation programs should involve child and adolescent psychiatrists, who can offer technical assistance, second opinions and case review when indicated. This particular recommendation was motivated by the increase in psychotropic medication prescribing by primary care physicians for children and adolescents. Through the Centers of Excellence, the Department has ensured that technical assistance, second opinions and case review services are available throughout the state, to provide consulting support to non-psychiatric physicians, and to DCS and private provider staff working with children who have mental health needs. The Centers of Excellence provide the range of consultation services, from chart reviews, to telephone conversations, to face-to-face assessments called for by the guideline.

12. Monitoring methods should entail a combination of approaches that includes review of aggregate data on prescribing patterns, chart audits, and tracking of specific red flag markers. As described further below, both the Department and TennCare use aggregate data, record reviews, and tracking of red flag markers in monitoring psychotropic medication use.

³ The guideline also includes "development of a website to create ready access for clinicians, foster parents, and other caregivers to relevant policies and procedures, specific forms, educational information, data and links." The DCS website, which is accessible to those identified groups, provides access to all of the relevant DCS policies, procedures and documents. In addition, <http://www.kidcentraltn.gov/>, supported by DCS and other child-serving agencies, provides a host of relevant information, links and resources.

13. *Child and adolescent psychiatrists should participate in the development of monitoring and oversight standards in their state and community, and involved systems should actively support their involvement.* This recommendation encompasses the recommendation of the 2005 guideline discussed above, and includes monitoring and oversight responsibilities beyond those of the child welfare agency.

14. *Psychotropic medication monitoring and oversight efforts should involve ongoing collaboration among state and county agencies as well as managed care organizations.* As discussed above, the Department's ongoing collaboration with TennCare, TennCare Select, and the Vanderbilt Centers of Excellence exemplifies the efforts called for by this recommendation.

15. *Systemic oversight of psychotropic medication prescribing should be pursued in a collegial manner that promotes the use of evidence informed practice.* The collegial approach to system oversight has long been embraced by those who have served as the Department's Medical Director over the years and continues today, from the ongoing outreach work of the regional health unit nurses to build good working relationships with mental health providers and primary care physician prescribers in the regions, to the work of the Centers of Excellence in providing peer consultation.

16. *Systems for medication review and for the approval or denial of psychotropic medication requests should be streamlined and efficient, to avoid unnecessary treatment delay or provider burden.* This recommendation acknowledges the importance of ensuring that oversight mechanisms do not interfere with the need to get children and adolescents "the pharmacological treatment they need in a timely manner." As discussed further below, the Department's oversight approach, including its approach to informed consent, has been implemented in a balanced way that promotes best practice, including parent engagement, without placing undue burdens on prescribers or unnecessarily delaying treatment.

17. *All stakeholders and child-serving systems responsible for youth with complex mental health needs should advocate for increased availability of evidence-based psychosocial interventions by qualified staff.* This final AACAP recommendation related to oversight and monitoring of psychotropic medications emphasizes that youth with severe trauma or other complex behavioral health needs should have access to effective psychosocial interventions, not just psychotropic medication. In keeping with this recommendation, the Department's review processes, from the reviews conducted by the health unit nurses and regional mental health consultants to those provided by the Centers of Excellence, evaluate prescribing practices in the context of the child's overall treatment.

B. The Three Levels of Medication Oversight

The Department currently relies on three levels of oversight to ensure that psychotropic medications are appropriately prescribed.

The first level of oversight is that provided by the case managers, who have received the training for non-physician professionals discussed above, and who are regularly monitoring the well-

being of the children on their caseloads. These cases managers are supported by both the regional health unit nurses and the regional mental health consultants, and they have access, both directly and through the regional nurses and mental health consultants, to additional consultation services from the Centers of Excellence. This first level of oversight allows questions and concerns about mental health issues, including medication issues, to be raised and addressed.

There are a number of quality assurance processes in place to ensure that this first level of oversight is ensuring appropriate medication practice. This includes case file reviews focused on documentation (including regularly conducted Case Process Reviews and Program Accountability Reviews (PAR), as well as the special, targeted reviews discussed in the February 2016 Monitoring Report). This also includes the Quality Service Reviews which assess, among other things, emotional and behavioral well-being, and includes specific inquiry, for children taking psychotropic medications, as to whether the effectiveness of the medication is being monitored regularly.

The quality assurance activities at this first level of oversight also include the monitoring that the health unit nurses do of “red flag” prescriptions and the ongoing work that they do with prescribers, both proactively to ensure that they are up-to-date on DCS policy related to psychotropic medications and in response to situations in which a prescriber’s performance fell short of policy expectations.

The second level of oversight is that provided by the Centers of Excellence, both through the technical assistance and case consultation they provide in specific cases, which includes review of the appropriateness of medications in specific cases, but also through their review and analysis of aggregate data to identify and respond to potentially problematic prescribing practices.

The third level of oversight is that provided by TennCare, Magellan (the TennCare pharmacy benefits manager), and TennCare Select (the managed care provider for children in state custody).

TennCare, through Magellan, has implemented three levels of point-of-sale controls that help ensure responsible prescribing behavior: prior approval requirements; Prospective Drug Utilization Review (PDUR); and Retrospective Drug Utilization Review (RDUR). Prior authorization is required for prescriptions of specific psychotropic medications with higher risk profiles. PDUR uses TennCare’s electronic monitoring system to screen prescription drug claims to identify problems such as therapeutic duplication, drug-disease contraindications, incorrect dosage or duration of treatment, drug allergy, and clinical misuse or abuse. RDUR involves ongoing and periodic examination of claims data to identify patterns of fraud, abuse, gross overuse, or medically unnecessary care and implements corrective action when needed. The results of this review are used by TennCare to inform policy development and provider education and to improve point-of-sale controls.

TennCare Select conducts regular audits of clinicians’ patient files to ensure that statutory and regulatory Medicaid requirements are met, including, among other things, that there is an appropriate diagnosis and treatment plan documented to support any psychotropic medication

prescribed and that there is documentation of informed consent prior to commencement of any treatment (including prescription of psychotropic medications).

Through these three levels of oversight, Tennessee has implemented a system that is well-designed to promote appropriate mental health treatment of children in DCS custody, including appropriate use of psychotropic medication.

C. The Informed Consent Requirements of Section VI.D

Section VI. D of the Settlement Agreement requires that “when possible, parental consent shall be obtained for the use of medically necessary psychotropic medication,” that if a parent is unavailable “the regional health unit nurse shall review and consent,” and that regional nurses shall ensure “that each of their consents is appropriately recorded.”

While many child welfare systems have opted for the ease and administrative convenience of simply authorizing case managers to provide informed consent, Tennessee, as reflected in the Settlement Agreement, has appropriately embraced what is considered best practice: that parents and older children should be actively engaged in the informed consent process, that only when parents are unavailable and children are not old enough to consent for themselves, should state agency staff be authorized to provide informed consent, and that only state agency staff with relevant mental health expertise should have that authority. As discussed in the February 2016 Monitoring Report, the TAC’s review of 85 medications for which informed consent was documented, found that informed consent was given by the parent or other guardian for 32 (38%) of those medications and informed consent was given by the youth (age 16 or older) for 22 (26%). For 31 (36%) medications, consent was given by the health unit nurse, and in the vast majority of those cases reviewers found documentation that the parents were unavailable despite efforts made to engage them.

The priority that the Department places on trying to engage the parents in the informed consent process adds a level of complexity to the informed consent process. Ordinarily, when a child comes to a prescriber’s office, the child is accompanied by the child’s parent—the person who has the authority and responsibility for giving informed consent. With children in DCS custody, the child is ordinarily accompanied by a foster parent or case manager who does not have that authority and responsibility. Sometimes the parent will be available to attend the appointment or be available by phone, but sometimes the informed consent conversation with the parent (or the conversation with the health unit nurse if the parent is unavailable) will not take place until after the child’s appointment. The Department fully expects that psychotropic medication not be administered unless informed consent has been obtained, but the Department recognizes that in some cases the informed consent process will not be completed until after the appointment.

It is, of course, the responsibility of the prescribing physician to obtain informed consent from the person authorized to give it—in the case of children in DCS custody, the parent, youth age 16 or older, or health unit nurse—and to document informed consent in the prescriber’s patient files, whether through case notes, a signed form, or a check box. Once that consent has been obtained by the provider, the Department, as part of its own oversight processes, seeks to have prescribers

furnish separate documentation confirming for the Department that informed consent has been obtained, using either the Department's own informed consent form or a form with comparable information. As part of assuring that informed consent has been obtained before medication is administered, the Department policy requires that the child's file (the TFACTS file for children in DCS placements and the private provider file for those children in private provider placements) has documentation of informed consent for every psychotropic medication that the child is currently taking.

As discussed in the February 2016 Monitoring Report, the Department generally finds that once prescribers understand the Department's need for this separate documentation, they are generally good about providing it. However, with children coming in and out of custody, with children in custody moving and changing placements and prescribers, and with the natural turnover in prescribers, there is a certain amount of slippage that occurs, resulting in delay in receiving documentation in some cases, and failure to receive documentation in others.⁴ It is also not unexpected that, when balancing the competing demands on their time, prescribers might reasonably place a higher priority on the maintenance of timely documentation that TennCare requires for the prescriber's patient files and for billing, than on the secondary documentation that the Department of Children's Services needs for its files.

D. PAR Reviews

As discussed in the February 2016 Monitoring Report, the Program Accountability Reviews (PAR) include, as part of the case reviews, a determination of whether there is an informed consent form in the child's agency case file for every psychotropic medication that the child is taking and whether the consent form was signed prior to the administration of the medication. The PAR reviewers compare prescription dates with medication administration logs and informed consent documentation maintained by the private providers. A negative PAR finding is made if there is insufficient documentation that informed consent was given prior to the administration of the medication; in addition, a negative finding is made if there was an unreasonable delay between the issuance of the prescription and the administration of the medication because of a delay in obtaining documentation of informed consent.

For the 2014-15 PAR reviews, a total of 155 files were reviewed for documentation of informed consent, and 140 (90%) of those files had the required timely documentation for every psychotropic medication that the child was taking. This is consistent with PAR findings from previous years: 88% (77/88) in 2011-12; 93% (150/162) in 2012-13; and 92% (132/144) in 2013-14).

Whenever PAR makes a finding that a child's agency case file did not have a signed informed consent form for one or more medications that the child was taking, PAR requires as a corrective action that the agency either obtain a copy of the informed consent form from the prescriber or

⁴ The Department on occasion finds that a prescriber mistakenly obtains informed consent from someone the prescriber believed had authority to grant it, but in fact does not. The Department therefore does outreach to prescribers to make sure they understand that if a child is in DCS custody only the parent, the youth (if age 16 or older), or the health unit nurse can give informed consent for psychotropic medications.

other source (if the prescriber or other source has an executed form) or that the agency obtain a new informed consent form, signed by the parent, youth age 16 or older, or regional health unit nurse, as appropriate.

E. The Results of the TAC's Targeted Review

The TAC's targeted review looked for two kinds of documentation related to informed consent. For those psychotropic medications that the child was already taking when the child entered care, the TAC looked for documentation of approval of continued administration of those medications.⁵ For those psychotropic medications that were newly prescribed after the child entered DCS custody, the TAC looked for timely secondary documentation that informed consent had been obtained. Applying the general requirement that case file documentation should occur within 30 days of the date of the activity being recorded, the TAC considered this secondary documentation to be timely if the documentation was dated within 30 days of the date of the prescription of the medication.

For those 38 children (a total of 78 medications) in the targeted review sample who were taking previously prescribed medications when they entered custody, the TAC found documentation of approval for continued administration of those medications for 37 of the 38 children (97%), and 77 of the 78 (99%) prescribed medications.

For the 46 children (a total of 105 medications) in the targeted review sample who were prescribed at least one psychotropic medication after entering custody, the TAC found documentation of consent within 30 days of the prescription date for 76 medications (72%), and for 30 of the 46 children (65%), the TAC found documentation of timely consent for *all* medications prescribed.

The TAC did some follow-up on the 16 children for whom documentation was either not timely or was not found for one or more newly prescribed medications (a total of 29 medications). The following is a brief description of the nature of the insufficiency of the documentation in those 16 cases.

- For five of these children (accounting for a total of eight medications for which documentation of consent was not found), upon follow-up the Department found no evidence that the child had actually taken the medication while in DCS custody.
- For four other children (accounting for a total of six medications for which documentation of consent was not found), consent was documented during the period covered by the review, but either the documentation was not within 30 days or the reviewer was unable to determine the timeliness of the secondary documentation because the reviewer could not determine the medication start date.

⁵ While informed consent is required when a medication is initially prescribed, a new informed consent is generally not required for the continuation of the medication. The Department's requirement that there be "approval" for the administration of medication that a child is already taking when the child enters custody is something beyond what the medical profession's "informed consent" process requires.

- In another case, a combination of these two factors account for all four medications for which documentation of consent was not found. There is a consent form signed by a legal guardian, but with no date, for three of four of the medications, and for the other medication, upon follow-up the Department found no evidence that the child had actually taken the medication.
- For an additional three youth (prescribed a total of eight medications, three of which lacked secondary documentation of informed consent), it appeared that for each child, the medication for which timely documentation was lacking had been prescribed during a short period of psychiatric hospitalization.
- There was one additional youth (four medications) who appears to have refused and never took three medications, but who took the fourth medication for a few weeks before refusing it because of the taste. Documentation of consent was not found for this last medication.
- In the remaining two cases (involving a total of five medications, three of which lacked documentation of informed consent), one of the medications for which documentation was missing had been discontinued by the time it came to the attention of the health unit nurse, and therefore no secondary documentation was entered in the file; and in the other, secondary documentation was entered, but this occurred subsequent to the period covered by the review.

The TAC found the results of this follow-up to be reassuring.

If one excludes from the review results those medications that were prescribed but never taken (and for which informed consent was therefore not required or, perhaps to put it another way, the right to refuse to consent was exercised), then 35 (76%) of the 46 children reviewed had timely documentation of informed consent for every medication they were prescribed.

If one were also to include in the review results, all prescriptions for which the TAC found documentation of informed consent, including those cases in which the consent was documented more than 30 days after the date of the prescription (and including those cases in which, because of a missing date, the TAC was unable to determine time between the date of the prescription and the date of documentation), then 41 (89%) of the 46 children had documentation of informed consent for every medication they were prescribed; and for 88 (95%) of the 93 medications that were both prescribed and taken, there was documentation of informed consent.

The Department, of course, needs to continue to work with the prescribers to ensure that they are providing documentation of informed consent in a timely manner and that the documentation includes the date on which the informed consent was obtained if different than

the date that the form was signed or submitted.⁶ However, the delays and lapses in documentation identified in the TAC's targeted review do not undermine the TAC's overall confidence in the Department's oversight and monitoring of psychotropic medication use. The TAC is satisfied that through the processes described above, the Department is meeting its responsibilities under Section VI.D.

⁶ Toward this end, the Department, in consultation with the TAC and with additional guidance from a highly respected expert consultant, is working to develop a follow-up process in connection with its Case Process Review to specifically address timeliness of informed consent. The Department expects to be able to use the information generated by the Case Process Review to further refine the informed consent documentation process.

VI.H Case Manager Contacts with Children

As discussed in the February 2016 Monitoring Report, the TAC considers the primary and most important components of the VI.H requirements to be the provisions related to the frequency of face-to-face visits by case managers with children on their caseload, provisions which have already been designated “maintenance” based on data presented in a prior monitoring report.⁷ The February 2016 Monitoring Report presented data on the two remaining elements of Section VI.H: (1) that the case manager spend time with the child outside the presence of the caretaker (“OPC time”) during each required face-to-face contact; and (2) that in cases managed by private providers, there be joint a DCS-private provider case manager face-to-face contact with the child and the resource parent or other caretaker at least once every three months.

However, the targeted review that the TAC conducted to generate the data presented in the February report was not designed to look specifically at OPC time spent with children during their first two months that a child is in custody, a period during which the Settlement Agreement contemplates more frequent face-to-face contacts (a total of six), rather than the twice a month visits required after the first two months. To address this oversight, the TAC has conducted a supplemental targeted review.

The review was of a sample of 59 children, stratified by region and drawn from the 145 children who entered custody during the second half of September 2015 (between the 16th and the 30th) according to the October 5, 2015 Mega Report and who remained in custody for at least two months.⁸

Table 6.1 presents the number and percentage of face-to-face contacts documented by DCS, and if applicable, the private provider case manager during the first two months in custody, without regard for documentation of OPC time. In 93% (55) of the 59 cases, the number of face-to-face contacts met or exceeded the requirement of six face-to-face visits during the first two months in custody.

⁷ This included maintenance on the provisions specifying the required frequency of visits at the child’s placement.

⁸ This sample size provides a confidence level of 95% and a confidence interval of plus/minus 10.

Table 6.1: Face-to-Face Contacts by the DCS and/or Private Provider Case Manager during the First Two Months in Custody		
Number of Visits with Documented OPC Time	Number of Cases	Percentage of Cases
11+	36	61%
6-10	19	32%
3-5	3	5%
2	0	0%
1	1	2%
0	0	0%
TOTAL	59	100%

Source: March 2016 review of OPC time during the first two months in custody.

Table 6.2 presents the number and percentage of face-to-face contacts presented in Table 6.1 above for which OPC time was documented.⁹ In 49% (29) of the 59 cases, the child received at least six face-to-face contacts during the first two months in custody for which OPC time was documented. In an additional 21 cases (36%), the child had documented OPC time for between three and five contacts.

Table 6.2: OPC Time Documented by the DCS and/or Provider Case Manager during the First Two Months in Custody		
Number of Visits with Documented OPC Time	Number of Cases	Percentage of Cases
11+	9	15%
6-10	20	34%
3-5	21	36%
2	7	12%
1	1	2%
0	1	2%
TOTAL	59	100%

Source: March 2016 review of OPC time during the first two months in custody.

For reasons that the TAC has alluded to in the February 2016 Monitoring Report and discussed at greater length with the parties, case managers understand from their training and from their ongoing supervision that a routine element of a face-to-face visit is to spend OPC time with a child. They are therefore understandably not motivated to separately document OPC time in their case narrative unless there is something notable about it,¹⁰ and while OPC time can

⁹ The reviewers determined OPC time using the guidelines discussed in the February 2015 Monitoring Report at pages 33-34.

¹⁰ The importance of OPC time has long been a part of the DCS training on “quality visitation” as well as an emphasis of routine case supervision.

sometimes reasonably be inferred from the documentation of the location or context of the visit, this is simply one aspect of case practice for which case file review results will inevitably understate system performance. The TAC therefore is well satisfied with the level of performance documented by this review: that in 85% of the cases in this supplemental review, reviewers were able to find documentation of OPC time in three or more visits (at least half of the six visits required in the first two months); and that in 96% of the cases, at least two visits during those first two months.

The TAC is also reassured by other data reflecting that the overall purposes that the OPC visit requirements are intended to serve are in fact being met. The OPC visit requirements of Section VI.H are intended to ensure that the child has an opportunity to voice concerns and desires on his or her own behalf to the case manager so that those concerns and desires are taken into account. In all cases, OPC time serves to promote effective engagement; in cases in which the concerns or desires relate to potentially or actually harmful circumstances, the OPC time helps ensure safety. The Department's performance on the "Voice and Choice" Quality Service Review (QSR) indicator suggests that children generally do feel that their voices are being heard by their case managers and that their concerns and desires are taken into account. The statewide Voice and Choice scores for the child for the two years for which that indicator has been included in the QSR were acceptable in 87% of the cases in the 2013-14 QSR and in 88% of the cases in the 2014-15 QSR.

The Department's performance on the QSR Safety indicator, as well as other data related to the safety of children in placement regularly reported in the TAC's monitoring reports, reflects that safety related oversight activities, including case manager visits with children in their placements and OPC time with children during visits, are occurring sufficiently to ensure the safety of children in placement.

VII.B Participation in Child and Family Team Meetings

As discussed in the February 2016 Monitoring Report, the Department's General Counsel, with the assistance of the Administrative Office of the Courts (AOC), contacted every attorney who accepts appointments in dependency neglect cases, affirming the importance of attorney and guardian *ad litem* (GAL) participation in Child and Family Team Meetings (CFTMs), and inviting attorneys to contact him to share any "issues and/or suggestions on how DCS can assist you in attending CFTMs." The TAC has been asked to provide some additional detail on the responses received and the work being done with regional staff based on those responses.

The TAC has also been asked to provide some additional information on participation of parents and other family members in CFTMs by indicating the extent to which either a parent or relative caregiver was present at the Placement Stability or Discharge Planning CFTMs subject to the CFTM review. That information is presented in Appendix VII.B.

A. Responses to the General Counsel's Letter

The letter from the DCS General Counsel was distributed by the Administrative Office of the Courts by e-mail to the approximately 2,000 attorneys across the state.¹¹ The DCS General Counsel received 38 responses to this communication. According to the data compiled by the General Counsel:

- Fourteen of the attorneys who responded did not report any problems with the process by which CFTMs were scheduled: five commented positively about their experiences with the notice and CFTM scheduling process, and nine others had no specific comments about the notice and scheduling process but shared other concerns or suggestions for improvement, unrelated to CFTM scheduling.
- The remaining 24 attorneys who responded identified challenges related to consistency of advance notice to them by DCS of scheduled CFTMs. Most of these attorneys noted that it is very difficult to coordinate schedules among all team members and that lack of timely notice is most common with newer workers or in instances in which the timeline requirements for CFTM completion leave insufficient flexibility for selecting meeting dates that match their schedules.

B. CFTM Scheduling Pilot Protocols

Almost half (18 of 38) of the responses came from attorneys practicing in either Davidson or Shelby county. The most significant finding from attorney responses in those counties was that attorneys felt that their schedules were not being considered in scheduling CFTMs. While the Department is clear that the first priority in scheduling is availability and convenience for the

¹¹ The AOC mailing list used included, but was not limited to, the attorneys who receive compensation from the AOC for representing parents and children in neglect and abuse hearings.

family members and their supports, in response to the concerns raised by the responses from these 18 GALs, the Department is piloting new CFTM scheduling protocols in Shelby and Davidson counties. The new protocols instruct case managers to identify multiple potential dates when families are available to meet and then to provide all of those dates to the team before scheduling. The team is then given an opportunity to respond with their availability for each of the provided dates, and the meeting is scheduled on the date most convenient for the largest number of team members.

The regional staff overseeing the pilots have collected and compiled tracking data from the two pilot sites to help the Department evaluate the impact of the new scheduling pilot project on attendance at CFTMs by both GALs and Court Appointed Special Advocate (CASA) volunteers. During the period from December 22, 2015 through March 9, 2016, there were 102 CFTMs subject to the scheduling pilot project. GALs had been appointed in time to participate in the scheduling process for 91 of those CFTMs. GALs responded to the scheduling notice for 54 CFTMs and GALs attended 46 CFTMs. During that same period, there were 21 CFTMs for which CASAs had been appointed in time to be included in the scheduling process. CASAs responded to the scheduling notice for 18 CFTMs and CASAs attended 14 CFTMs.

C. Regional General Counsel Letters to Attorneys on Court Appointment Lists

The data from the pilot projects reflect that even with notice and an opportunity for input into the scheduling of the CFTM, GALs may not attend CFTMs as regularly as one would hope. Nevertheless, to reaffirm and underscore the substance of the Deputy General Counsel's letter, the Department has asked the juvenile courts to provide to each attorney currently on the guardian *ad litem* appointment lists, and to going forward to provide any attorney who is newly added to the appointment lists, a letter from the regional general counsel. The letter furnished by the Department includes the name, e-mail address, and phone number of the DCS legal team serving the relevant county, as well as the address of the program staff office serving the county and the main phone number of that office. The letter then states the following:

“If your case includes a child in foster care, you should expect to be invited to a couple of Child & Family Team Meetings (CFTMs) within the first months and to additional CFTMs as the case moves along to review progress, revise the permanency plan, and address specific issues as they arise. We know that you may not be able to attend every meeting, but we do expect that you will receive timely notice. If that is not happening, please contact me, a member of our legal team, or the Regional Administrator, [RA] at [RA phone number].”

The Regional General Counsels (RGCs), in most cases with the assistance and cooperation of the juvenile court and in some through direct mailing to those attorneys that the RGCs are aware accept court appointments, have ensured that the vast majority of attorneys currently serving as GALs have been provided this letter.

D. Relevant Quality Service Review Results Related to Teamwork and Coordination

As discussed in the February 2016 Monitoring Report, there are three Quality Service Review (QSR) indicators, Voice and Choice for the Child and Family, Engagement, and Teamwork and Coordination, which in combination, measure both the extent to which teams are being formed with the right membership and the extent to which those members are actively involved in the Child and Family Team process, including participation in CFTMs. The Voice and Choice for the Child and Family and the Engagement indicators are specifically focused on active involvement of the child and family in the CFT process and the QSR scores for those indicators, in combination with the other data related to child and family participation presented in the February 2016 Monitoring Report, demonstrate the Department's strong performance.

The Teamwork and Coordination indicator measures team member participation more broadly, and provides a relevant context for assessing levels of CFTM attendance by GALs and CASA volunteers. As discussed above, the data generated by the scheduling pilot projects in the Shelby and Davidson regions reflects that even with improved scheduling procedures, it is likely that CFTM attendance rates by GALs and CASAs will continue to fall far short of the rates of participation by older children and engaged parents and family members (whose schedules are appropriately given priority by the Department). The QSR Teamwork and Coordination indicator appropriately recognizes the realities of scheduling challenges that will make it difficult for some team members to regularly attend CFTMs; cases can score acceptable for Teamwork and Coordination even when team members cannot attend meetings, as long as team members, through communication that occurs between meetings, have an opportunity to have input into the decisions of the team.

While the Department appropriately continues to look for ways to increase the attendance of GALs and CASA volunteers at CFTMs, as long as there is generally good communication, teamwork and coordination among team members, including the GAL and CASA volunteer, there is less reason for concern if the GAL or CASA is unable to attend a given CFTM.¹² The Department's current QSR performance on Teamwork and Coordination is therefore reassuring. As reflected in the figures presented in the February 2016 Monitoring Report, the percentage of cases receiving an acceptable score for this indicator reflects substantial improvement over the course of the last three review periods, from 53% in 2012-13, to 73% in 2013-14, and 82% in 2014-15. (As discussed in previous monitoring reports, acceptable system performance scores in 70% or more of the cases reviewed are considered indicative of a reasonably well-functioning child welfare system.)

This level of QSR performance, combined with the actions that the Department has taken to ensure that GALs and CASAs are receiving notice and to improve CFTM scheduling processes in an effort to improve attendance, are sufficient to address the concerns that the TAC might otherwise have had about the level of attendance of GALs and CASAs at CFTMs.

¹² In fact, a number of those who commented positively in response to the General Counsel's letter specifically noted that when they are unable to attend CFTMs they may provide input by talking to the DCS worker in advance of the CFTM, and they may follow up with the DCS worker after the CFTM.

Most importantly, in assessing the Department's overall performance on the requirements of Section VII.B as a whole, the QSR results on all three relevant indicators, combined with the other data presented in the February 2016 Monitoring Report, provide ample support for bringing this provision into maintenance.

VIII.C.1 Diligent Searches and Case Review Timelines

As referenced in the February 2016 Monitoring Report,¹³ “diligent search” has been added as a case activity type option in the TFACTS case file, allowing case managers to more easily document diligent search activities in their case recordings and facilitating tracking and reporting related to diligent search. In response to the request of the parties, the TAC has included in Appendix VIII.C.1 of this supplemental report, a screen shot of the drop down box in TFACTS that the case managers now use to quickly indicate the specific category of diligent search activity performed.

¹³ The data presented in the February 2016 Monitoring Report (in Figure 8.1 and related discussion) tracks the percentage of children who had timely diligent search activity at three, six, nine, and twelve months after entrance into custody. The review that the TAC monitoring staff conducted (also detailed in the February 2016 Monitoring Report) looked at diligent search activity in the first 30 days in custody.

XVI.A.1 Permanency Outcome Measures

A. Section XVI.A.1 Timeliness of Permanency

The current Section XVI.A.1 permanency outcome measures track the federal Child and Family Service Review (CFSR) measures which were in effect at the time the original Settlement Agreement was entered. As discussed in the February 2016 Monitoring Report, the Federal Government has since recognized that those measures were developed using a seriously flawed methodology and could not reasonably be considered valid indicators of a state's permanency performance. The federal government has therefore abandoned those measures and adopted new measures for assessing timeliness of permanency.

The parties and the TAC have agreed that it makes no sense to continue to measure timeliness of permanency using an invalid measure that the Federal Government has abandoned. The parties have therefore agreed that Section XVI.A.1 should be modified to include a measure that tracks the current federal CFSR measure. The parties have also agreed that the Department's performance under the current federal CFSR measure, and further supported by the Chapin Hall data presented in the February 2016 Monitoring Report, warrants a maintenance designation.

B. Sections XVI.A.3 and XVI.A.5 Number of Placements and Reentry into Placement

There are other Section XVI outcome measures, XVI.A.3 (number of placements) and XVI.A.5 (reentry into placement) which also no longer represent the most current methods for assessing performance. Both of these provisions have been and remain in maintenance. However, the TAC believes that it is important to acknowledge the shortcomings of these Section XVI measures and provide supplemental analysis that draws on the more current methods for measuring these two areas of system performance.

1. XVI.A.3 Number of Placements

Section XVI.A.3 of the Settlement Agreement contains two requirements related to the number of placements:

At least 90% of children in care shall have had two or fewer placements within the previous 12 months in custody, not including temporary breaks in placement for children who run away or require hospitalization and return to the same placement.

At least 85% of children in care shall have had two or fewer placements within the previous 24 months in custody, not including temporary breaks in placement for children who run away or require hospitalization and return to the same placement

This approach to measuring performance related to number of placements falls short of more sophisticated measures in several respects. First, the measures fail to account for length of stay

in care and its impact on risk for movement. Second, the measures fail to demonstrate actual number of moves but rather compare children who experience more than two placements over a period of time with those who do not. Finally, the measures fail to provide a sufficient level of detail to allow systems to identify the likelihood that children will experience placement moves at different intervals of their custodial episode.

In order to provide a more useful representation of the Department's performance with regard to this provision, the TAC considered additional sources of evidence. First, the TAC considered the current federal measure for placement stability. This measure tracks placement stability for children entering care in a 12-month period. It assesses total placement moves for children entering care in a 12-month period per number of care days for those children. Specifically, the measure asks:

Of all children who enter foster care in a 12-month period, what is the rate of placement moves per day of foster care?

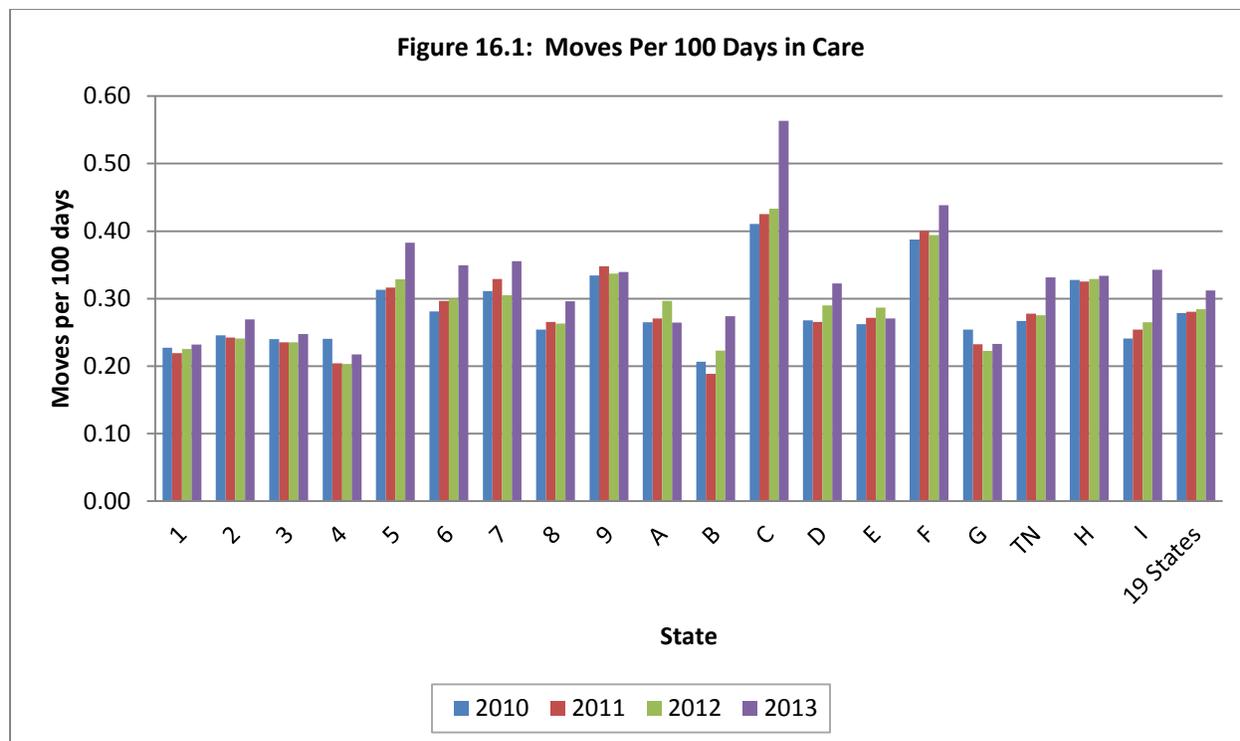
While this measure represents some improvement over the original *Brian A.* measure in that it captures movement within the first year of placement, it fails to account for all children exposed to the risk of experiencing placement moves, particularly those in care longer than 12 months. Additionally, the sample for the federal measure includes children with delinquent adjudications, meaning that the results are impacted by children in Tennessee's system who are not members of the *Brian A.* class.

Notwithstanding the limitations cited above, the TAC has examined Tennessee's performance on the federal measure for purposes of reporting on the Department's performance related to placement moves. The most current published results of the Child and Family Service Review establish a national standard of 4.12 moves per 1,000 days in care, based upon performance for federal fiscal year 2014. Tennessee's observed performance on the measure for the period from October 1, 2013 through September 30, 2014 reflected a rate of 5.31 moves per 1,000 days in care. However, as previously described, this rate of movement includes the effect of children committed to the Department as delinquent youth in addition to *Brian A.* class members, and as a whole, young people committed as delinquent youth experience more placement changes than class members.

In order to address the factors that prevent application of the federal measure to the *Brian A.* class, the TAC also considered the more detailed analysis completed by Chapin Hall. The analysis follows children admitted to care between 2010 and 2014. It relies on five entry cohorts in order to maximize the number of children whose placement experiences contribute to the analysis. Figure 16.1 shows unadjusted, actual number of moves per 100 days in care.¹⁴ The data represent states in Chapin Hall's multistate foster care data archive (FCDA), a collection of placement records used to track the performance of 19 state foster care systems. Chapin Hall

¹⁴ The period measured for each cohort is from the date of admission through the end of 2014. The groups are organized into cohorts based on the date of admission. Moves are counted for children in each cohort until the date of discharge. There is no fixed observation period. The analysis deals with length of the observation window by counting the moves per 100 days in care, so that the values will be larger and more easily interpreted in the figure (in hundredths rather than in thousandths).

receives placement data from each contributing state, harmonizes the data so that the included populations and data elements are as close to identical as the underlying data systems allow. In the case of these analyses, because only *Brian A.* class children are included, the FCDA is the only source of comparative, multistate data currently available.



Source: Chapin Hall's Multistate Foster Care Data Archive.

The results show that Tennessee has an average rate of placement moves—that is, a rate of placement that neither out-performs nor under-performs the multistate group as a whole.¹⁵ When evaluating movement rates across each year separately, the results of this analysis are confirmed—in no year did foster children in Tennessee move more often, on average, than children from the other states as a whole. A table containing the numerical values from which Figure 16.1 was created is attached as Appendix XVI.A.

2. XVI.A.5 Reentry into placement

The Settlement Agreement approach to measuring performance related to reentry into care also suffers from critical methodological failings. Section XVI.A.5 requires that:

¹⁵ A number of states have an elevated rate of movement in the most recent year. This is an artifact of when moves tend to occur. In general, movement rates are much more common in the first year of placement. In the chart that shows movement rates by year and state, results for the more recent cohorts (*e.g.*, 2013) are dominated by the fact that the children in these cohorts are still in the early days of placement, to the extent they have not yet been discharged.

No more than 5% of children who enter care shall reenter within 1 year after a previous discharge.

The provision poorly defines the measure that should be applied, but the approach used for reporting on this performance is the most reasonable interpretation of the language in the Agreement. Reporting on this measure has used an exit cohort to determine what percentage of children exiting custody in a 12-month period return to custody within the 12 months following their discharge. This approach suffers from a number of flaws. First, as previously noted by the TAC, the measure includes children who age out of custody, and thus can never reenter care. Second, the measure relies on an exit cohort that does not account for length of stay. Therefore, it is more difficult to draw conclusions about strength of performance because the sample of children considered includes those in custody a very short time, as well as those with longer lengths of stay. In addition, because the measure is based upon an exit cohort, it is more difficult to understand what the data reflect about system performance. Children who entered care at different times were impacted by different environmental circumstances, different iterations of DCS practice, and legislative changes that affected their movement through the system.

A more valid, reliable approach to evaluating performance related to reentry relies on an entry cohort¹⁶ and follows children who enter care and exit to reunification within a 12-month period. The federal method for assessing performance related to reentry now uses this approach. Specifically, the measure asks:

Of all children who enter foster care in a 12-month period who were discharged within 12 months to reunification, living with a relative, or guardianship, what percentage re-enter foster care within 12 months of their discharge?

While the federal measure for this outcome is more methodologically sound than others discussed, the TAC believes it still fails to precisely measure performance related to class members. Because the federal measure accounts for all children in eligible placements, Tennessee's juvenile justice population skews the overall performance assessment and renders the results inapplicable to measuring compliance with the Settlement Agreement. In other words, the federal measure is instructive but not determinative of the Departments' performance with regard to Section XVI.A.5.

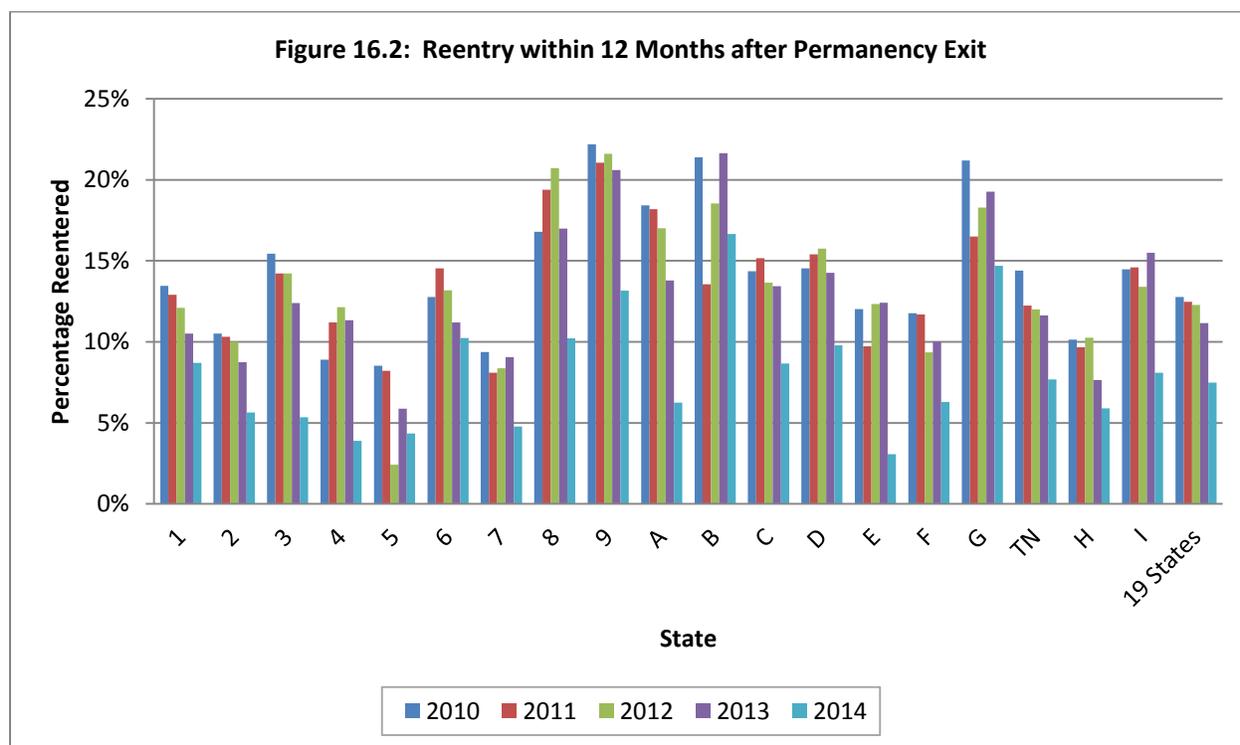
Notwithstanding the challenges of applying this federal measure to the Settlement Agreement provision, the TAC, while acknowledging the limitations, considered the Department's performance on the federal measure for purposes of this reporting. The most current published CFSR results for reentry establish a national standard of 8.3%. Tennessee's observed performance on the measure reflected a reentry rate of 9.1%.¹⁷ The 0.8% difference accounts for eight children, meaning that Tennessee exceeded the national standard by only eight children

¹⁶ See Appendix, A Brief Orientation to the Data: Looking at Children in Foster Care from Three Different Viewpoints, of the February 2016 Monitoring Report for a discussion of the appropriate uses of entry cohort, exit cohort, and "point-in-time" measures.

¹⁷ See the "CFSR Round 3 Statewide Data Indicators Workbook," available online at: http://www.acf.hhs.gov/sites/default/files/cb/cfsr_stateperformanceworkbook.pdf

reentering care and as noted above, the Tennessee data includes the population of children who are adjudicated as delinquent.

In order to address the factors that prevent application of the federal measure to the *Brian A.* class, the TAC also considered the more detailed analysis completed by Chapin Hall. The Chapin Hall data analysis measures reentry to care following a discharge to either reunification or to a relative,¹⁸ provided the return to care happens within one year of discharge. The analysis proceeded in much the same way as placement stability analysis discussed above; it again follows children admitted to care between 2010 and 2014. Five entry cohorts are observed in order to maximize the number of children whose placement experiences contribute to the analysis, and the analysis controls for the year of entry. There are no other adjustments made to the results presented in Figure 16.2.¹⁹



Source: Chapin Hall’s Multistate Foster Care Data Archive.

Figure 16.2 shows the results of the analysis, which compares Tennessee with the same states as the previous analysis. Again, because only *Brian A.* class children are included, the FCDA is the only source of comparative, multistate data currently available. The results presented are the observed, unadjusted reentry rates. Again, these descriptive data indicate that Tennessee’s reentry rate does not differ markedly from the average of all the states. Specifically, the average rate in Tennessee (after taking the year of admission into account) is somewhat lower than the

¹⁸ As is the case with the federal measure, this includes discharge to guardianship.

¹⁹ The period measured for each cohort is from the date of admission through the end of 2014. The groups are organized into cohorts based on the date of admission. The analysis follows children in each cohort until 12 months after the discharge date or until reentry, whichever comes first.

overall average. When Chapin Hall tested this claim using a more advanced statistical model, the results were affirmed. A table containing the numerical values from which Figure 16.2 was created is attached as Appendix XVI.A.

It should be noted that measures like reentry also balance competing priorities. Agencies strive to reunify children both quickly and sustainably. A very low reentry rate may reflect policies that result in unnecessarily long stays in custody. Conversely, a very high reentry rate may reflect policy decisions that lead to returning children quickly but in circumstances that are not sustainable. A moderate rate of reentry, such as Tennessee's, reflects, in the TAC's view, an appropriate, responsible balance of these interests.

Child Death Review (CDR) Process

As noted in previous monitoring reports, the TAC has found the Department's Child Death Review Process (CDR) to be well-designed and appropriately implemented. In the February 2016 Monitoring Report, the TAC reaffirmed, based upon ongoing observation and review of the various stages of the CDR process, that the current protocol is being responsibly carried out, and that timeline and reporting requirements are being met. The TAC has been asked to provide some additional detail and context to supplement the discussion presented in the February 2016 Monitoring Report.

A. A Brief Recap of the Circumstances Giving Rise to the Development and Implementation of the New Child Death Review Process

Prior to implementation of the new Child Death Review Process, the Department did not have clear or well defined decision rules on what counted as a child death subject to Departmental review (particularly with respect to children not in DCS custody at the time of death), who was required to report child deaths, in what time frames and to whom and how that information was to be shared and used by DCS for both immediate actions and review of systemic factors. The former system for reporting relied on over 1,000 staff to enter information disparately into a low-functioning TFACTS system that was difficult to use. This resulted in the lack of a reliable system for the retrieval, aggregation, and reporting of data on child deaths.²⁰ The Department also lacked a defined or systematic process for qualifying deaths for a death review.

In response to these problems, the Department committed in April 2013 to comprehensively revising its Child Death Review process. The revised process, developed with significant input from Department leaders, Vanderbilt's Center of Excellence, plaintiffs, and the TAC, was implemented on August 28, 2013. Since implementation of the current process, the Department has established clear decision rules for counting child deaths and near deaths. The Department has also implemented multiple redundancies to ensure the accuracy of information, including:

- a detailed front-end process (outlined in DCS Policy 20.27) for reporting child deaths and near deaths to the Child Abuse Hotline for investigation, notifying regional and Central Office leadership, and ensuring the safety of any other involved children;

²⁰ Although the former system had the capacity to accurately track deaths of children in custody using the "death of a child" exit type, the process for reviewing child deaths at that time relied on hand-counts of custody deaths rather than the data available from TFACTS. For deaths of children not in DCS custody, because there were no clear or well-defined rules about what qualified as a non-custody death for review, there was no guidance to offer field staff about what specific information needed to be entered into TFACTS so that non-custody child deaths could be aggregated (for example, one case manager may have assumed that entering the date of death for the child was sufficient, while another may have assumed that entering an abuse death allegation was sufficient, and another case manager may have entered a completely different piece of information related to the death). This, in combination with a cumbersome and time-consuming process for entering death information in TFACTS at that time, resulted in a system that contained various pieces of information regarding non-custody child deaths but lacked a way to produce an accurate list of non-custody children who had died.

- a well-functioning TFACTS system that captures child death and near death data in a defined portal;
- a centralized staff person overseeing the child death portal data; and
- a manual redundancy whereby TFACTS data is matched against manual hand counts.

The new process has established clear decision rules that identify child deaths and near deaths that qualify for the Child Death Review Process; increased transparency by creating a system to publish child death and near death information on the DCS website; and created well-defined and articulated policy that supports the documenting, recording, qualifying and public posting of child death and near death information.

B. A Description of the Essential Elements of the Child Death Review Process that the TAC Has Observed and Reviewed and Determined are Functioning Consistent with the Current CDR Protocol

The following is a description of each of the essential elements of the Child Death Review Process. The TAC has observed and reviewed each of the described elements and has found them religiously adhered to and of uniformly high quality.²¹ The TAC has validated all of the reports that both support and document the process. For calendar year 2015, through a combination of reviewing and tracking individual cases and utilizing the validated aggregate data, the TAC found that timelines were met in every case subject to the review process.

The current child death review process includes both a Central Office review and a “systems analysis” review that occurs in the field. The Central Office review occurs within 30 days after a child death or near death is recommended for review by the Office of Child Safety. The Central Office review team identifies any immediate concerns and determines which cases need further review with systems analysis. If recommended for systems analysis, the case receives a systemic review within 90 days. This review includes staff debriefings and a systemic review by a regional multidisciplinary team.

Staff debriefings are facilitated opportunities for staff involved in death or near death cases to share, process, and learn. Debriefing opportunities typically include front-line staff and supervisors, but may include other positions as needed. During debriefings, staff share and process their experiences working the death or near death case and/or historical cases specific to the child or family associated with the death or near death case. Debriefings explore critical decisions and interactions throughout the Department’s history with the subject child or their family (*e.g.*, removal decisions, service provision, teamwork opportunities, record acquisition, etc.) and create a safe environment for staff to identify opportunities for learning and improvement. The debriefing information is provided to the regional systems analysis teams.

²¹ Through participation in many Central Office Child Death Reviews and review of minutes for all 2015 Central Office Reviews, the TAC found no instance of a case warranting a regional review that was not referred. The TAC was equally impressed with the quality of the regional reviews that TAC members and staff observed.

Regional systems analysis teams are comprised of representatives from different disciplines within DCS (*e.g.*, front-line staff, front-line supervisors, health representatives, and regional leadership) and from partner agencies (*e.g.*, law enforcement, Child Advocacy Centers (CACs) and health providers). The team is supported to review the case using a systems analysis model. The systems analysis model challenges team members to analyze cases to identify systemic vulnerabilities (*e.g.*, teamwork, staffing ratios, and service array) and identify any case specific concerns.

The regional safety analyst facilitates both the debriefings and the systems analysis. Safety analysts are child welfare experts trained to have human factors and system safety expertise. Additionally, the safety nurses assist safety analysts. Safety nurses are nursing positions dedicated to the child death review process to support the safety analyst to review any complex medical information associated with death or near death cases.

In 2015, the Department reviewed a total of 123 child death or near death cases. Of those cases, 60 were submitted for Systems Analysis for a more robust evaluation. As part of the Systems Analysis review process, 140 debriefings with staff were conducted. Each debriefing lasts a minimum of one hour; therefore, at least 140 hours of discussion with front-line case managers and supervisors contributed to the Department's evaluation and analysis of practice through the Child Death Review in 2015.

In addition to the direct benefits of an improved system for tracking, reporting, and reviewing child deaths and near deaths, the Child Death Review Process is also a vehicle for identifying and analyzing systems issues and generating improvements. Findings and recommendations from reviews are provided monthly to the Safety Action Group, consisting of the Commissioner, Deputy Commissioner of Child Health, Deputy Commissioner of Child Safety, Deputy Commissioner of Juvenile Justice, Assistant Commissioner of Quality Control, General Counsel, Assistant Commissioner of Finance and Budget, TAC, Director of Policy Continuous Quality Improvement (CQI), and Director of Safety Analysis. This group reviews information generated by the Child Death Review, as well as the Confidential Safety Reporting System and other CQI activities, in order to develop and implement system improvements.

One example of an improvement initiated by the Safety Action Group is increased availability of, and a streamlined process for procuring, safe sleep furniture for families when an unsafe sleeping environment is identified. Through partnership with local health departments and acquisition of a stock of resources for local offices, the Department has increased the timeliness of providing safe sleep resources to families. These changes were prompted by the understanding from the CDR process of the risks to child death posed by the lack of safe sleeping practices for young children and challenges to obtaining safe sleep furniture for at risk families.

Another initiative implemented through the Safety Action Group monthly review is an updated standard for transportation and guidelines for how long and far staff can travel in prescribed time frames. The policy provides for case managers to stay overnight after transporting children or travel with a co-transporter if transportation of a child or travel back to the case manager's home

will require the case manager to remain on the road after reaching the maximum number of work hours.

The Safety Action Group also addressed recurring issues related to acquisition of medical records. The Child Death Review identified challenges case managers faced in obtaining medical records from various facilities. To address this, Safety Analysis and CQI worked with the DCS Legal Division and the Forms Committee to create a request form that explains clearly to medical providers the statutory authority pursuant to which the provider is permitted to provide records to DCS. Prior to development of this request form, some providers were unclear about what records the Department is entitled to obtain in the course of investigating abuse and neglect. This led to inconsistent practice across the state related to obtaining medical records and created challenges for conducting timely, complete investigations when facilities refused to provide records to investigators. Now, case managers have a clear, consistent mechanism for communicating to medical facilities the statutory grounds granting DCS access to certain medical records.

As the final step in the process, as discussed in the February 2016 Monitoring Report, each quarter the Director of Safety Analysis is required to submit to the Commissioner within 30 days of the end of the quarter a report covering the reviews conducted during the quarter, including demographic information for the cases reviewed and findings, recommendations, and Department actions from the reviews. Each year, the Office of Child Health is required to submit to the Commissioner during the first quarter of the following year a report covering the reviews conducted during the year. The report is to include demographic information and cause and manner of death/near death for each case as well as the findings, recommendations, and Department actions from the Child Death Reviews.

TFACTS UPDATE

A. Introduction

Four years ago, two reports—an internal assessment commissioned by the Department of Children’s Services²² and an external audit conducted by the Comptroller’s Office²³—identified significant problems with TFACTS (Tennessee Family and Child Tracking System), the Department’s new Statewide Automated Child Welfare Information System (SACWIS) system. At that time, as a result of flaws in both the development and implementation of TFACTS, field staff had difficulty entering and retrieving data; resource parents experienced delays in receiving board payments; and the department leadership was hampered by the limited ability of the Department’s Office of Information Technology (OIT) to produce timely and accurate data for purposes of management and assessing case progress and performance.

The Department developed a plan to address the challenges identified by the two reports. At the Court’s direction, the TAC conducted its own assessment of TFACTS to determine whether the Department’s plan for improving and maintaining TFACTS was reasonably designed and adequately resourced both to address the deficiencies in TFACTS and to ensure that the Department’s automated information system was sufficiently functional to meet its internal management needs and allow the Department to exit court jurisdiction within a reasonable time. The TAC concluded that the Department’s plan was reasonable and since then the TAC has provided regular updates to the parties and the Court detailing the Department’s progress in implementing that plan.

Over the past four years, the Department has invested significant time and resources, not only to address the specific problems identified in the earlier reports, but to ensure that its OIT has the resources and technical expertise to meet its ongoing information technology (IT) needs. As reflected in the Modified Settlement Agreement entered in April of 2015, this investment and the improvements that resulted from it have led to the Department achieving maintenance on TFACTS related requirements of the Settlement Agreement (Section X). As the Department moves closer to successfully exiting court jurisdiction, the TAC has been asked to provide a brief TFACTS update, explaining the TAC’s ongoing monitoring and validation activities with respect to TFACTS and reflecting on the current experience of field staff with TFACTS functionality, on recent developments in TFACTS reporting, and on prospects for sustaining performance beyond exit.

B. Ongoing TAC Monitoring of TFACTS

In the time since all Section X provisions of the Settlement Agreement were designated as maintenance, the TAC has continued to monitor TFACTS related matters. The TAC chair periodically attends Management Advisory Committee (MAC) meetings and regularly reviews minutes from those meetings, minutes that are posted to the Department’s Intranet website for

²² *DCS TFACTS Assessment*

²³ *Oversight for System Development Projects: A Review of TFACTS Implementation*

distribution to all staff throughout the organization. In addition, TAC monitoring staff participate regularly in System User Network conference calls (discussed below) and in monthly TFACTS Reports Webinars. The monthly reports webinars, open to all Department staff, provide a forum for communication with the field about newly developed reports, existing reports undergoing modification, or reports about which the field has expressed confusion. During the webinars, OIT customer service staff explain the functioning of the reports in detail, and field staff have the opportunity to ask questions. In addition, TAC monitoring staff regularly use TFACTS reports in the course of their monitoring and have found the data to be accurate. Finally, TAC monitoring staff meet periodically with OIT customer service staff to review and discuss the feedback received from the field (including HelpDesk Data and information provided by the regional Field Customer Care Representatives).

TAC monitoring staff continue to monitor developments in TFACTS reporting, reviewing both new *Brian A.* related reports (such as the new diligent search, EPSDT, and CANS tracking reports discussed in the February 2016 Monitoring Report) and modifications of existing reports (such as the CPS Referral Priority Response Report and the Sibling Visits Report). In anticipation of exit, TAC monitoring staff have paid particular attention to the Department's internal processes for report development and validation, processes which have been well designed and conscientiously implemented. Because of the particular interest in caseload reporting and reporting related to child deaths, the TAC monitoring staff continue to closely review the previously validated TFACTS reporting related to both of these areas, to provide additional reassurance about the continued reliability of those reports. (Updated data related to child deaths was presented and discussed in the February 2016 Monitoring Report. Updated caseload data is included in an Appendix to this Supplemental Report, "Caseload and Supervisory Workload Data.")

C. Current Experience of Field Staff

Four years ago, case managers frequently complained about the challenges of using TFACTS in their daily work. The system was slow and cumbersome; it often required multiple and unnecessarily complicated mouse clicks to move through an electronic case file to enter or retrieve data; and in some key areas, information was fragmented or required redundant data entry. Case managers frequently complained of being "kicked out" of the system in the midst of entering data or trying to retrieve information. Field staff had difficulty generating and printing reports and forms from TFACTS. Many staff used computers that were old and slow, and internet connections were insufficiently strong or fast. The system was plagued by frequent problems with the Department's servers.

Staff complained about the insufficiency of the TFACTS training they received, particularly the lack of notice and orientation when changes were made in TFACTS. When new TFACTS applications were rolled out, the change itself was often disruptive, and too often the new application fell short of what the field had hoped for. All too frequently the release was accompanied by glitches and defects that caused a new set of problems and required subsequent fixes.

Most significantly, field staff perceived that their needs as system users were not being sufficiently addressed by OIT and that their complaints were being largely ignored. As a result of poor communication between OIT and the program staff in the field, case managers were largely unaware of the significant infrastructure challenges that OIT was facing, challenges that had to be addressed to stabilize the system, before significant improvements in the end user experience would be possible.

As discussed in previous monitoring reports, the Department was able to successfully address all of the infrastructure problems that had threatened the stability of TFACTS and undermined its functionality.²⁴ Upgrades in the TFACTS supporting infrastructure²⁵ have not only improved TFACTS performance and enhanced its capacity, but have given OIT the ability to deploy TFACTS updates and enhancements into production without taking TFACTS offline, allowing staff to continue to use TFACTS without interruption even as the new features are being deployed. The previous TFACTS production infrastructure relied on six JBOSS application servers that were insufficient to reliably support TFACTS. With the infrastructure upgrades, and the migration of TFACTS to new servers housed in the south data center, TFACTS production now runs on just four JBOSS servers, that are not only reliable but that have sufficient capacity to maintain 50% resource availability during peak usage times.

Old computers have been replaced and more than 2,400 field staff are now benefiting from tablets with specially designed TFACTS interfaces. Issues of connectivity and internet speed have been largely addressed by these and other infrastructure improvements.

Most importantly, with the system stabilized and competently supported by a well-resourced and highly skilled IT division, the bulk of the TFACTS related improvements are now being driven by the needs and priorities of the program staff. This is apparent not only in the priorities established and monitored by the Department's leadership through the monthly MAC meetings (discussed further below), but in the recently implemented "Solutions Development Triage," a weekly OIT meeting designed to ensure an appropriate review of and response to the complaints, requests, and suggestions identified by field staff through the TFACTS Help Desk.

²⁴ Initially there was considerable concern that the Department lacked the technical resources to modify those aspects of TFACTS that had been designed with code that used OptimalJ. As discussed in previous monitoring reports, the Office of Information Technology addressed that concern through strategic hires. The Department's considerable in-house expertise in both OptimalJ and TFACTS is reflected by the fact that since September 2013 all necessary OptimalJ model changes have been done by DCS OIT staff without support or advice from outside vendors.

²⁵ This includes major upgrades in the JBOSS Application Server, Java, and Oracle.

In contrast to the situation four years ago, OIT now actively engages field staff in every stage of the design, development, testing and roll out of TFACTS enhancements.²⁶ As a result, the TFACTS releases are now routinely experienced as welcomed improvements by well-oriented field staff. Additional guardrails and drop-down boxes have helped support accurate and complete data entry, and improved interfaces and strategic shortcuts have made file navigation simpler and more efficient, including restructuring of the case manager’s “workload” screen (showing the list of cases assigned to the worker). It is now the “home” screen viewed when the user logs into TFACTS, eliminating the need for additional clicks to access it. Quick links have been embedded into the list of cases, allowing case managers to go directly to the areas in the case in which they work most often, such as the case recordings module, and a link has been added to the workload page that lists important work items still remaining to be done for each case.

TFACTS improvements deployed in 2015 that support better and more efficient front-line practice while also providing improved tracking and reporting include:

- Modifications of diligent search documentation and reporting, which simplified (and therefore improved) data entry for case managers and captured diligent search activity in ways that allow the kind of tracking and reporting presented in Section VIII.C.1 of the February 2016 Monitoring Report.
- Child Death/Near Death Workflow, which documents, tracks, and reports information related to the deaths of children when there has been an allegation of neglect or abuse, or the child is in the custody of the Department at the time of death.
- Child Abuse Hotline Web Referral and Tracking, a web referral application that allows users to complete a child abuse referral online. Once the referral form is submitted, the information is populated to TFACTS by way of a web service, and an intake ID is returned to the user, allowing the user to track the progress of the investigation resulting from the referral.
- Mandatory Race, an enhancement that requires documentation of Race and Hispanic Origin for children/youth served by the Department, as well as for persons approved as Resource Parents.
- FAST 2.0 Enhancement, which improved the Family Advocacy and Support Tool (FAST) assessment within TFACTS, eliminating the need to use other tools.

²⁶ In a report filed with the Court three years ago, the TAC observed that the Department’s biggest remaining challenges related to TFACTS functionality and reporting were not so much technological challenges, but rather challenges in moving from a “siloed” and “chain of command” approach for identifying and responding to the IT needs of the field to a “teaming” approach. As the TAC wrote, “Many of the problems with TFACTS, whether with the design of a particular TFACTS field or with the quality/utility/accuracy of TFACTS reports, are the result of miscommunication and misunderstanding. Sometimes that is a misunderstanding by the IT staff of the realities of the practice that the application is intended to support, or of the purpose a report is supposed to serve, or of the key questions that the report is intended to answer. Sometimes it is the result of well-intentioned, but insufficiently thought out instructions given by program staff to IT staff. The IT staff need help gaining a good understanding of the field’s needs, helping the field understand the options available to meet those needs, and helping the field prioritize those needs so they can be appropriately sequenced and resourced. This requires a structure that facilitates productive discussion and informed decision making about IT priorities.”

The Department has also responded to concerns about the adequacy of TFACTS training for field staff. In addition to the TFACTS training conducted as part of pre-service training, the Department now holds monthly System User Network meetings (run by TFACTS Field Customer Care Representatives, or FCCRs, in the region and open to all Department staff), which provide a forum to respond to TFACTS related feedback from the regions, to explain changes in TFACTS that have been made in response to policy changes or federal requirements, and to alert the regions to upcoming TFACTS builds. With respect to data that are used for reporting purposes or to respond to certain federal requirements, the Department uses the System User Network meetings to both help staff understand how to enter the data and to help staff understand why timely and accurate entry of that data is so important. And a variety of TFACTS reports are generated to help case managers and supervisors track timeliness and accuracy of data entry and respond appropriately to data entry errors or omissions.²⁷

D. Current TFACTS Reporting

As discussed in the April 2015 Supplement to the January 2015 Monitoring Report, with the successful release of the TFACTS Case Assignment enhancement in December 2014 and the improved caseload tracking and reporting that this enhancement made possible, the Department had available the basic range of aggregate reporting required for responsibly running a child welfare system. Since that time, the Department has continued to refine and add to its regular reporting, including producing additional tracking reports to support and monitor performance related to three of the remaining substantive Settlement provisions not yet designated maintenance: diligent search practice (VIII.C.1), timely completion of CANS and EPSDT assessments (VI.B), and timely convening of quarterly review CFTMs (VII.K).

Particularly noteworthy has been the dramatic streamlining of the approval process and timeline for approval and development of new reports or modifications to existing reports. In the past, an overly bureaucratic and compartmentalized approach to report approval and production resulted in bottlenecks and backlogs in responding to report requests, and impeded, rather than encouraged, communication between report developers and program staff during the report development process, communication that is so important to ensuring that the report meets the needs of the field. Development was driven by a “reports backlog” reflecting all outstanding requests that included report requests that were years old, some of which no longer had any relevance for current practice.

The former process has been discontinued and replaced with a more strategic approach to report prioritization and development. Requests for new reports are sent directly to a representative of the MAC and an OIT liaison who work with the requestor to identify the scope and impact of the request. Report requests are then prioritized, taking into account the amount of time required to develop the report; the number of users who will benefit from its implementation; any impact on litigation, funding, or legislative mandates; and whether a comparable tool exists to meet business needs. When a report is approved for development, OIT staff work directly with program staff with relevant expertise to ensure that the final product is a valuable, effective tool

²⁷ Among others, these include the Diligent Search and CANS/EPSDT tracking discussed in the February 2016 Monitoring Report and the timeliness of permanency planning discussed in the July 2015 Monitoring Report.

for staff. Because of the streamlined approach to managing requests for new reporting or report modifications, the Department is able to strategically deploy resources by combining efforts that implicate similar or overlapping data.

One of the most frustrating aspects of the former system for staff was the lack of communication about what projects would be undertaken and what the timeline for completion would look like. In order to address this issue, a new tool is being utilized to track the progress of a report request from submission through deployment. Authorized users can see where reports have been prioritized, what stage of development reports are in, who is assigned to each phase of work, and any notes from developers about challenges as they arise. This tool has eliminated much of the guesswork about how development resources are being directed by providing program staff with insight into the development process.

E. Sustainability

The improvements in TFACTS functionality and reporting reflect the effectiveness of the MAC in providing ongoing oversight, direction, and support to OIT. The MAC, which is chaired by the DCS Commissioner, and includes all Deputy Commissioners, two regional administrators and other field and program representatives, is responsible for:

- providing IT with strategic decisions and direction;
- establishing IT priorities;
- guiding IT planning;
- participating in IT project oversight;
- providing a forum for all DCS programmatic areas on issues related to IT; and
- ensuring that IT has the resources to meet its responsibilities.

Over the past three years, the MAC has become an extremely effective forum for IT related decision making. The current OIT Director does an excellent job of ensuring that the leadership team has the information they need to understand the relevant opportunities and challenges and to make knowledgeable decisions about priorities and options. The OIT Director has also invested time and effort in understanding the work of program staff so that he and his staff find better ways to support that work.

The MAC meetings, which had been originally scheduled on a quarterly basis, now occur monthly and are among the most well-organized, productive and informative meetings that the TAC has been privileged to observe. All of the key program, fiscal, and IT decision-makers attend and actively participate, allowing issues to be fully discussed and decisions to be made based on those discussions.

In the TAC's view, the MAC structure and process ensures that the Department's IT functions will continue to receive the direction, support, and attention that they need from the Department's leadership. The TAC is confident that this will ensure that the Department will continue to have a well-functioning and well-maintained IT system.

APPENDIX VII.B

For ease of the reference, the entire subsection below is excerpted from the February 2016 Monitoring Report with the supplemental language requested by the parties added in italics in the paragraph following Table 7.1.

A. Participation by Children and Families in the CFTM Process

The table below reflects the frequency with which older children (youth age 12 and older), parents, and family and fictive kin attended Child and Family Team Meetings convened in their cases. For each CFTM type, the table presents two percentages.

The first percentage, presented in **bold type**, is the percentage reflected by the results of the CFT Process Review. The percentages of older youth participating in CFTMs reflect the experiences of the 40 youth in the review sample who were 12 years of age or older during the review period. For purposes of calculating the percentage of parents participating in CFTMs for the 92 children in the sample, parents whose parental rights had been terminated prior to the CFTM and parents who were deceased were excluded.²⁸ In the sample, there were four mothers (two at the time of the Initial and Initial Permanency Planning CFTMs, and two additional at Placement Stability CFTMs) and one father (at the time of the Placement Stability CFTM) whose parental rights had been terminated, and there were three mothers and three fathers who were deceased.²⁹

The second percentage (*italicized* and indicated in parentheses below the CFT Process Review data) is the percentage reflected by the *aggregate CFTM* reporting for 2014.³⁰ As discussed in previous monitoring reports, the TAC has found that the aggregate CFTM reporting generally understates the Department's performance³¹ and therefore the CFT Process Review data would be expected to show higher levels of CFTM member participation than the CFTM aggregate reporting, and that is in fact reflected in Table 7.1 below.

²⁸ The language “*mothers who would have been expected to have participated*” and “*fathers who would have been expected to have participated*” reflects this exclusion.

²⁹ In addition, there was one mother who was alleged to have committed severe abuse; and there was one case in which children had been adopted from Haiti and there was no mention of them having had an adoptive father.

³⁰ For all CFTMs other than the Discharge CFTM, the percentage is based on four quarterly CFTM reports for calendar year 2014. Because of an oversight, the Office of Information Technology did not produce a Discharge CFTM aggregate participant attendance report for the first quarter of 2014. For this reason, the CFTM aggregate reporting percentages for Discharge CFTM participation is based on three quarterly reports rather than four.

³¹ See July 2015 Monitoring Report, footnote 341 at p. 208.

Table 7.1: Child and Family Participation in CFTMs

	Initial CFTM	Initial Permanency Planning CFTM	Placement Stability CFTM	Discharge Planning CFTM
Youth 12 and Older	84% ³² (70%)	100% ³³ (76%)	75% ³⁴ (76%)	95% ³⁵ (86%)
Mother	81% ³⁶ (66%)	83% ³⁷ (65%)	66% ³⁸ (40%)	57% ³⁹ (42%)
Father	37% ⁴⁰ (29%)	38% ⁴¹ (31%)	23% ⁴² (15%)	40% ⁴³ (16%)
Kin	63% ⁴⁴ (42%)	51% (33%)	36% (25%)	45% (27%)

Source: May 2015 Child and Family Team Process Review and Child and Family Team Meeting (CFTM) Summary reports for the four quarters of 2014.

A parent or a present or former relative caregiver was present at 82 (92%) of the 89 Initial CFTMs and at 82 (89%) of the 92 Initial Permanency Plan CFTMs. In 88 (96%) of the cases, a parent or a present or former relative caregiver was present for at least one of those CFTMs. *A parent or a present or former relative caregiver was present at 55 (68%) of the 81 Placement Stability CFTMs and 26 (84%) of the 31 Discharge Planning CFTMs.*

³² Initial CFTMs were held for 38 youth 12 and older: 27 (71%) were physically present and five (13%) participated by telephone.

³³ Initial Permanency Planning CFTMs were held for 40 youth 12 and older: 32 (80%) were physically present and eight (20%) participated by telephone.

³⁴ Placement Stability CFTMs were held for 36 youth 12 and older: 23 (64%) were physically present and four (11%) participated by telephone.

³⁵ Discharge CFTMs were held for 20 youth 12 and older: 18 (90%) were physically present and one (5%) participated by phone.

³⁶ Mothers would have been expected to have participated in 84 of the 89 Initial CFTMs held. The 81% attendance number includes 59 (70%) who were physically present and nine (11%) who participated by phone.

³⁷ Mothers would have been expected to have participated in 87 of the 92 Initial Permanency Plan CFTMs held. The 83% attendance figure includes 62 (71%) who were physically present and 10 (12%) who participated by phone.

³⁸ There were 81 Placement Stability CFTMs held in the 92 cases reviewed (in some cases, one child had a number of Placement Stability CFTMs during the review period). Mothers would have been expected to participate in 70 of those CFTMs. The 66% attendance figure includes 36 (52%) who were physically present and 10 (14%) who participated by phone.

³⁹ Mothers would have been expected to have participated in 28 of the 31 Discharge Planning CFTMs held. The 57% attendance figure includes 15 (54%) who were physically present and one (3%) who participated by phone.

⁴⁰ Fathers would have been expected to have participated in 86 Initial CFTMs. Fathers participated in 32 (37%) of those CFTMs: 26 (30%) were physically present and six (7%) participated by telephone.

⁴¹ Fathers would have been expected to have participated in 89 Initial Permanency Planning CFTMs. Fathers participated in 34 (38%): 28 (31%) were physically present and six (7%) participated by telephone.

⁴² Fathers would have been expected to have participated in 73 Placement Stability CFTMs. Fathers participated in 17 (23%) of those CFTMs: 14 (19%) were physically present and 3 (4%) participated by telephone.

⁴³ Fathers would have been expected to have participated in 30 Discharge CFTMs. Fathers participated in 12 (40%) of those CFTMs: 11 (37%) were physically present and one (3%) participated by telephone.

⁴⁴ At least one kin (relative or friend) was present at 56 (63%) of the Initial CFTMs held, 47 (51%) of the Initial Permanency Plan CFTMs, 29 (36%) of the Placement Stability CFTMs, and 14 (45%) of the Discharge Planning CFTMs.

Appendix VIII.C.1

The following screenshots show the dropdown boxes available in TFACTS to indicate the specific type of diligent search activity completed.

This screenshot shows the 'Contact Type' form in the TFACTS system. The 'Location' dropdown menu is open, displaying the following options: Father, Maternal Grandfather, Maternal Grandmother, Mother, Other Relative, Paternal Grandfather, and Paternal Grandmother. Other visible fields include 'Worker Present?', 'Contact Method:', 'Location Type:', 'Resource:', and 'Copy To Resource Record?'. The 'Purpose' section shows available purposes like 'Permanency', 'Safety - Child/Community', 'Service Planning', and 'Well Being'. The 'Participant' table is empty, and the 'Narrative Details' section is also empty.

This screenshot shows the same 'Contact Type' form, but with the 'Contact Method' dropdown menu open. The options listed are: Attempted Phone Call, Attempted Face To Face, Correspondence, Face To Face, Phone Call, and Records Search. The 'Resource' field now includes 'Resource Search' and 'Clear' buttons. The rest of the form, including the 'Purpose' and 'Participant' sections, remains the same as in the previous screenshot.

APPENDIX XVI.A

This appendix presents tables containing the numerical values from which Figures 16.1 and 16.2 were created.

Table 16.1: Moves Per 100 Days in Care					
State	Cohort Year				
	2010	2011	2012	2013	2014
1	0.23	0.22	0.23	0.23	0.23
2	0.25	0.24	0.24	0.27	0.25
3	0.24	0.24	0.24	0.25	0.24
4	0.24	0.20	0.20	0.22	0.24
5	0.31	0.32	0.33	0.38	0.31
6	0.28	0.30	0.30	0.35	0.28
7	0.31	0.33	0.31	0.36	0.31
8	0.25	0.27	0.26	0.30	0.25
9	0.33	0.35	0.34	0.34	0.33
A	0.26	0.27	0.30	0.26	0.26
B	0.21	0.19	0.22	0.27	0.21
C	0.41	0.43	0.43	0.56	0.41
D	0.27	0.27	0.29	0.32	0.27
E	0.26	0.27	0.29	0.27	0.26
F	0.39	0.40	0.39	0.44	0.39
G	0.25	0.23	0.22	0.23	0.25
TN	0.27	0.28	0.28	0.33	0.27
H	0.33	0.33	0.33	0.33	0.33
I	0.24	0.25	0.26	0.34	0.24
19 States	0.28	0.28	0.28	0.31	0.28

Source: Chapin Hall's Multistate Foster Care Data Archive.

Table 16.2: Reentry within 12 Months after Permanency Exit

State	Cohort Year				
	2010	2011	2012	2013	2014
1	13%	13%	12%	11%	9%
2	11%	10%	10%	9%	6%
3	15%	14%	14%	12%	5%
4	9%	11%	12%	11%	4%
5	9%	8%	2%	6%	4%
6	13%	15%	13%	11%	10%
7	9%	8%	8%	9%	5%
8	17%	19%	21%	17%	10%
9	22%	21%	22%	21%	13%
A	18%	18%	17%	14%	6%
B	21%	14%	19%	22%	17%
C	14%	15%	14%	13%	9%
D	15%	15%	16%	14%	10%
E	12%	10%	12%	12%	3%
F	12%	12%	9%	10%	6%
G	21%	17%	18%	19%	15%
TN	14%	12%	12%	12%	8%
H	10%	10%	10%	8%	6%
I	14%	15%	13%	15%	8%
19 States	13%	12%	12%	11%	7%

Source: Chapin Hall's Multistate Foster Care Data Archive.

APPENDIX: CASELOAD AND SUPERVISORY WORKLOAD DATA

The July 2015 Monitoring Report provided caseload and supervisory workload data for the period from July 2014 through April 2015. This appendix provides caseload and supervisory workload data for the nine-month period from May 2015 through February 2016. All caseload and supervisory workload data is based on TFACTS reporting that the TAC monitoring staff have validated and continue to review and spot check.⁴⁵

A. DCS Case Manager Caseloads

Table 1 below presents the percentage of case managers carrying at least one *Brian A.* case whose caseloads were within the caseload limits established by the Settlement Agreement, statewide and by region, as of the end of each month.

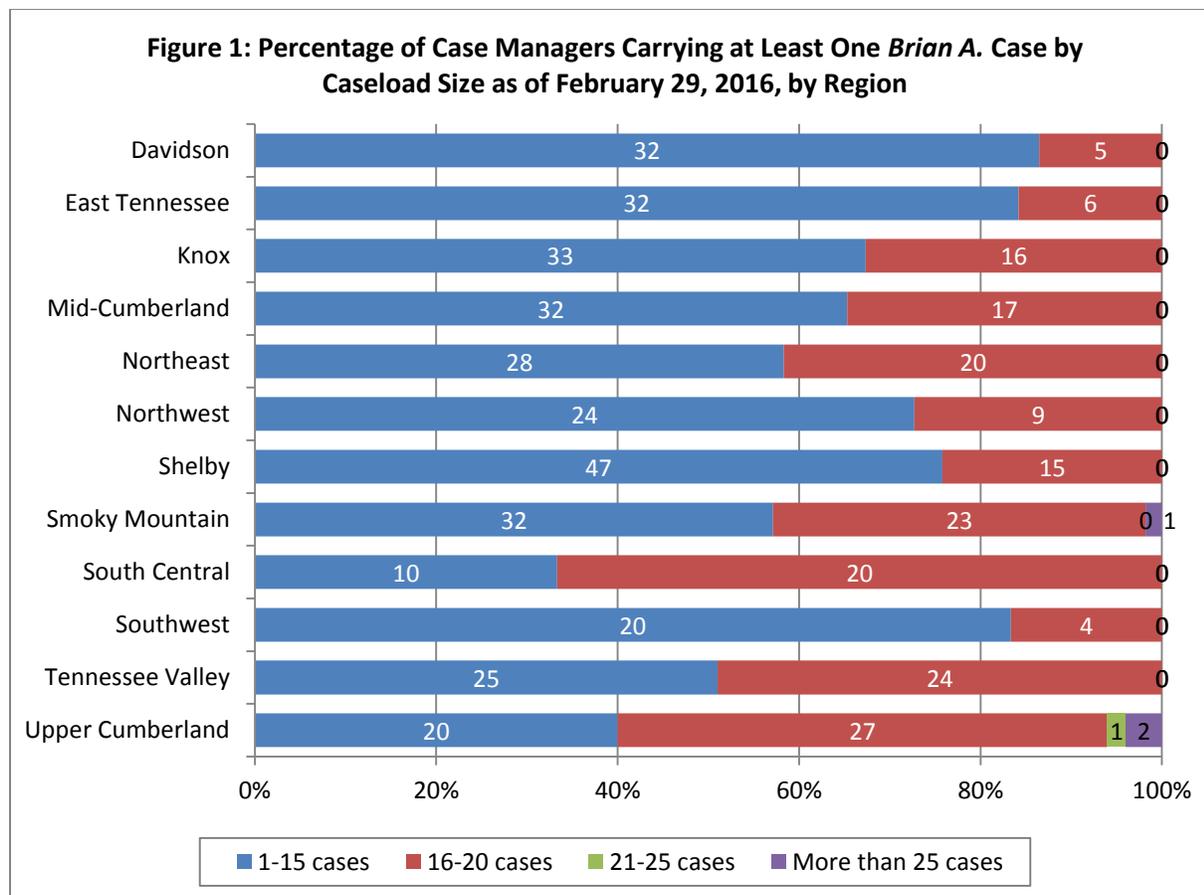
⁴⁵ TAC monitoring staff reviewed each month's summary reports for consistency with previous months' reports (looking for any changes that would warrant further investigation, such as a significant increase or decrease in the total number of case managers or in the compliance percentage) and spot-checked the data for a few case managers and supervisors through comparison to detail reports and to TFACTS. TAC monitoring staff also verified the supervisory structures for every *Brian A.* team for four reports (August 2015, November 2015, January 2016, and February 2016).

**Table 1: Of Case Managers Carrying at Least One *Brian A.* Case,
Percentage Meeting Caseload Requirements as of the Last Day of Each Month**

Region	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Davidson	97%	100%	100%	100%	100%	100%	100%	100%	97%	100%
East	100%	97%	97%	100%	97%	97%	94%	91%	97%	100%
Knox	100%	100%	98%	100%	98%	100%	98%	100%	100%	100%
Mid Cumberland	95%	89%	93%	87%	88%	89%	93%	98%	96%	94%
Northeast	94%	93%	96%	90%	92%	98%	94%	91%	94%	96%
Northwest	90%	86%	87%	84%	88%	91%	86%	92%	94%	96%
Shelby	100%	100%	98%	100%	95%	95%	90%	90%	93%	95%
Smoky Mountain	93%	96%	96%	96%	100%	98%	98%	98%	98%	96%
South Central	100%	100%	100%	100%	100%	97%	97%	97%	97%	97%
Southwest	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Tennessee Valley	98%	98%	96%	93%	96%	98%	98%	96%	93%	94%
Upper Cumberland	94%	94%	89%	83%	83%	92%	91%	94%	89%	90%
Statewide	97% (n=495)	96% (n=488)	96% (n=506)	94% (n=512)	94% (n=517)	96% (n=507)	94% (n=501)	96% (n=518)	96% (n=513)	96% (n=525)

Source: TFACTS Caseload Summary Reports for May 2015 through February 2016.

Figure 1 below presents, for case managers who had at least one *Brian A.* case on their caseloads (without regard for case manager job classification) on February 29, 2016, the percentage of case managers whose caseloads fell within each category (0-15 cases, 16-20 cases, 21-25 cases, and more than 25 cases).⁴⁶



Source: TFACTS *Brian A.* Caseload Threshold Compliance Report as of February 29, 2016.

As of February 29, 2016, the breakdown of compliance with the *Brian A.* caseload standards by case manager position is as follows:

- Case Manager 1: 91% (85/93);
- Case Manager 2: 99% (383/387);
- Case Manager 3: 91% (38/42); and
- Team Leader: 0% (0/3)—three team leaders appear on the report as having a small number of cases assigned, but these assignments reflect the assignment process in TFACTS, whereby the case is briefly assigned to the team leader’s tree in the process of transferring it to the case manager, and are not actual assignments to the team leader to work the case.

⁴⁶ For reasons having to do with the nature of the analysis, the data in Figure 1 do not account for the different caseload caps of case manager 1s, case manager 2s, and case managers 3s in the way that Table 1 above does.

B. DCS Supervisor Workloads

Table 2 below shows the percentage of teams in each region that were in compliance with the supervisory workloads based on the TFACTS Supervisory Caseload Compliance Summaries.

Table 2: Percentage of Supervisory Workloads Meeting Settlement Agreement Requirements for All Teams with at Least One <i>Brian A.</i> Case										
	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Davidson	100%	100%	89%	80%	100%	90%	89%	88%	90%	90%
East	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Knox	100%	100%	100%	100%	93%	100%	100%	100%	100%	100%
Mid Cumberland	94%	100%	88%	93%	94%	100%	100%	100%	100%	100%
Northeast	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Northwest	88%	88%	88%	82%	92%	92%	100%	92%	92%	90%
Shelby	100%	94%	94%	95%	95%	90%	90%	95%	90%	95%
Smoky Mountain	100%	100%	100%	100%	92%	92%	100%	100%	100%	100%
South Central	100%	89%	100%	100%	100%	100%	100%	100%	100%	100%
Southwest	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Tennessee Valley	93%	92%	100%	100%	100%	100%	100%	100%	100%	100%
Upper Cumberland	100%	87%	92%	100%	100%	92%	100%	100%	100%	93%
Statewide	98% (n=157)	96% (n=155)	96% (n=150)	96% (n=155)	97% (n=157)	96% (n=155)	98% (n=155)	98% (n=154)	97% (n=159)	97% (n=159)

Source: TFACTS Supervisory Caseload Compliance Summaries as of the end of each month, May 2015 through February 2016.