

SOUTH CAROLINA
DEPARTMENT OF SOCIAL
SERVICES FOSTER CARE
HEALTH PLAN



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I. Introduction

The South Carolina Department of Social Services (DSS) is undertaking a comprehensive reform of its child welfare system with a special focus on the health care needs of children in foster care. In partnership with the South Carolina Department of Health and Human Services (DHHS), DSS is redesigning the way health care services are organized and delivered to children in foster care. Our vision is a fundamentally reformed system that can be a model for other child welfare systems around the country.

The South Carolina Department of Social Services submits this Health Plan to represent and satisfy the commitments it made in the *Michelle H. v. McMaster* Final Settlement Agreement (FSA). The plan includes the Department’s goals, system components, activities underway and to be undertaken, timeframes for implementation, deliverables, performance targets and process for quality monitoring and performance review.

II. Priority Actions

Given the expansive scope of the reforms envisioned, DSS is working concurrently on both roll out of the Plan, which will take several years, and on “*priority actions*” that respond to pressing child health issues. Work on these six *priority actions* started in Winter of 2018, before the final Health Plan was complete. The below identifies the six priority actions, and the status of them at the time of writing this Plan.

	Priority Actions	Status as of August 1, 2018
1.	Produce a Revised Health Plan	In process. Target for Completion in mid-August, 2018. Working with DHHS and Select Health to accomplish. Other new developments: Child health and system goals have been developed. DSS will move to use a validated assessment tool to determine level of care and level of need. Among other things, the Plan will cover initial assessment, comprehensive assessment and follow-up; immediate needs; care coordination and care management; health-related case practice; network adequacy; data and reporting; quality improvement and performance. DSS holds weekly planning meetings with the consultants.
2.	Identify an <i>Interim</i> Director of DSS Office of Health and Well-Being	Completed. Identified a <i>PERMANENT</i> Director ¹ who began on April 27 th . Work is underway to align staffing and new plan functions, reconfigure the FCHAC (Foster Care Health Advisory Committee) and manage all aspects of the revised Health Plan.

¹ Position Description in Appendix, Section 5.

3.	Identify and convene a Cross-Agency SWAT Team.	Completed. Consultants ² recommended that DSS meet weekly with DHHS and Select Health. DSS and DHHS now have standing weekly meetings. In March, DSS, DHHS and Select Health began meeting weekly on data sharing; development of a coordinated health care management model; development of child-specific rosters and aggregate data tracking reports, etc. The consultants attend these ongoing weekly meetings as needed.
4.	Obtain Gaps in Care Reports from DHHS and Select Health	Completed & an ongoing process. Consultants found that retrospective verification of health history, initial and comprehensive assessments by caseworkers were duplicative, delayed and less reliable than the same information collected and tracked by Select Health. Data sharing, report development and testing, a data dictionary and other elements of a data system are being built now in consultation with consultants. Two reports have been produced using this new data-sharing approach and they show that many more children are getting assessed than were originally identified from third-hand data inputs collected by caseworkers. Contemporaneous collection of information by caseworkers, which now occurs, will continue but be verified by administrative reviews and select case reviews. See no. 6 in this table for more information.
5.	Initiate Short-Term Data Work Around to Mitigate 30-day Enrollment Gap	Ongoing. Resolution by Jan 2019. The DHHS- Select Health contract is negotiated annually in January of each year. DSS and DHHS will collaborate to create a separate administrative contract to include the development of a weekly notification system for new entrants into (and exits from) foster care. DSS currently uploads rosters to DHHS nightly to identify new entrants into and exits from foster care. DHHS will produce monthly a rostered gaps in care/utilization report capturing initial assessments, assessments or follow-up services provided to new entrants. DSS and DHHS are working to resolve the enrollment issue with an expected date of completion in January 2019 and the eligibility gap after the existing process is automated with an expected completion date in June 2019.
6.	Initiate Short-Term Plan to Address Immediate Needs	Process in development. Once the data reports begin to run regularly and the new processes are in place in August 2018, the backlog of children on the immediate needs roster will be reduced. In the short run, to catch up and reach all children on the roster, DSS developed a new process for addressing immediate needs that will roll-out beginning in August 2018: DSS caseworkers will follow

² Consultants Gail Nayowith and Kathleen Noonan were identified by the Co-Monitors under the FSA to work with DSS on health care issues.

		<p>up on needed assessments from the DHHS/SH reports and document into the CAPSS (Child and Adult Protective Services System, DSS’s Statewide Automated Child Welfare Information System SACWIS) foster care case record any actions taken. After implementation of the practice model, caseworkers will also be expected to enter into case notes, any follow up care needed, including confirmation with foster parents or other caregivers that follow-up visits have occurred. Caseworkers will also be expected to ensure that birth/natural parents are included in health care planning, and apprised of any/all appointments, etc. To assist with verification and to see that that care needs are met, DSS will review the roster of children with high need/risk diagnoses against 30-60-90-day gaps in care/utilization reports, in collaboration with DHHS and Select Health. DSS will also undertake a review of select case records, consistent with CFSR PIP, to ensure that children and youth are getting services they need. These multiple layers of tracking and review, at the individual case level and population level, allow children and youth who might have missed initial assessments, comprehensive assessment or follow up care to be identified and staffed until they receive the care they need.</p>
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The following sets forth DSS’s health care plan for children and youth in foster care. Section III summarizes the commitments made by DSS related to health care in the Final Settlement Agreement (FSA). Sections IV and V are the core components of the Plan. Section IV identifies the Plan’s four child health goals, and Section V identifies the Plan’s three system goals. Each goal identifies a task Lead; key activities and deliverables; and a timeframe. Additional materials are included in the appendices.

III. Health Care and Related Placement Commitments in the Final Settlement Agreement

In the final Settlement Agreement (FSA) in *Michelle H. v. McMaster* (FSA), DSS committed to develop and implement a Healthcare Improvement Plan (the “Plan”). In addition, DSS agreed that the Plan would include enforceable dates and targets for phased implementation related to initial assessment services, periodic assessment services, documentation, and health care treatment services for Class Members in the areas of physical health, immunizations and laboratory tests, mental health, developmental and behavioral health, vision and hearing, and dental health. Pursuant to the FSA, the Plan will address:

- (a) Developing the capacity to track screening and treatment services for individual children and aggregate tracking data, including but not limited to screens that are due and past due;
- (b) Assessing the accessibility of health care screening and treatment services throughout the state, including the capacity of the existing health care providers to meet the screening and treatment needs of Class Members; and
- (c) Identifying the baselines and interim percentage targets for performance improvement in coordinating screens and treatment services.

DSS understands that the commitments it made to health care in the FSA must work in concert with other commitments, including those related to placements for children in foster care. Under the FSA, DSS envisioned that decision-making about placement and services would be based on assessment of strengths and needs. Moreover, under the FSA, DSS committed to a child welfare system in which family-based placements are the presumption over institutional or congregate placements, especially for young children. Special placement resources like residential treatment or therapeutic foster homes (TFCs) are accessed by referral for inter-agency staffings. Currently, this process involves assessing for eligibility for the Interagency System of Caring for Emotionally Disturbed Children (ISCEDC).

Given the overlap between the health and placement components of the FSA, synchronizing planning and implementation in these areas is critical to the reform envisioned by DSS. For example, the health and behavioral health care initial assessments and comprehensive assessments used when a child enters foster care should inform decisions about higher level of care placements and services for eligible children. For example, DSS is currently able to verbally authorize a provisional 35-day eligibility for ISCEDC inter-agency staffing in cases where the presumption is that a child needs a higher level of care and where corroborating information can be obtained to substantiate the child's ISCEDC eligibility. If used, this presumptive eligibility function could prevent multiple placements and reduce the wait time for a "least restrictive, most appropriate" higher level placement or authorize community-based services and supports to stabilize placements. These details are discussed in this Plan.

The Placement Implementation Plan under development by DSS will make explicit the articulation between level of care (LOC) placement decisions and level of need (LON) services, and will further define the process and assessment tools to be used as part of determining appropriate placements and services for children and youth. Among other things, the Placement Implementation Plan will focus on a teaming model, caregiver and youth engagement and other key supports in the assessment and placement process. To the extent

possible, DSS would prefer that children in foster care receive their health, behavioral health and dental services in community settings that also serve children who are not in care. This promotes continuity of care when children are in foster care and access to the same services when they leave care.

In addition to the necessary integration of health care and placement work, DSS's health plan implementation activities will also be important as DSS begins planning for the implementation of new federal legislation - *The Family First Prevention Services Act*. Importantly, the new legislation requires states to move away from non-clinical group residential settings to family foster care and community-based preventive services. DSS has asked the health care consultants for assistance in building out the level of need/level of care assessment process design outlined in the Health Plan to best match a child's service needs with community-based services and a suitable placement. The health assessment features of this process will dovetail with work to strengthen the placement process to be fleshed out in the DSS Placement Implementation Plan. In addition, the new federal law requires child welfare group homes and congregate care to meet new licensing and accreditation standards that were historically more common in PRTFs and other clinically-oriented health care settings and residential treatment programs. The go-live date for certain parts of the federal statute may be as early as October 2019, and DSS wants to be ready for implementation.

DSS began development of the Health Plan in 2017, and submitted a draft to the Co-Monitors on September 29, 2017. The Co-Monitors provided feedback to the draft Plan on October 31, 2017, advising DSS that they would retain consultants to assist the Co-Monitors and staff with validating components identified in the Health Care Plan and identifying additional infrastructure and operational enhancements that may be needed.

The consultants reviewed and considered the elements of the proposed Health Care Plan, including its nine infrastructure components, seven innovation areas and select targets, and developed a validation framework to guide their assessment. They examined reports, data, policies and practices already in place and visited with DSS and its partners for three days in January 2018. The consultants' review culminated in a report which included identification of six priority actions for immediate implementation and their findings and assessment of whether each Plan element should remain in the plan, remain in the Plan with revisions, or be removed from the Plan. As an overall finding, the consultants found that the draft Health Care Plan included important conceptual and structural elements on which to build a robust health system for children in foster care. Since issuance of their report, DSS and the consultants have worked together through two sets of multi-day onsite meetings and weekly check-in calls on implementation of the six priority action items, framing elements of the Plan and on revisions to the Plan. DSS is committed to plan and implement concurrently and is actively engaged in

planning and operational improvement activities simultaneously. To this end, DSS has engaged the health care consultants in both aspects of their work.

IV. The Proposed Health Care Pilot and Process Review

DSS proposes a health care pilot and process review that will test, refine and scale the operational elements of the Health Plan. The Health Care Pilot and Process Review will run from October 2018 through February 2019 with system-wide implementation beginning in March 2019 and continuing through the end of the year. It is the view of the healthcare consultants, that the scope of the system redesign envisioned by the Plan, which includes new external partners and new processes, protocols and capacities internal to the Department, warrants careful testing and process refinement before full statewide implementation. The Health Care Pilot and Process Review will identify, follow, and review the health-related processes and care experience of 20 children entering or re-entering foster care. The sample of children will be selected to represent three types of conditions: children who are typically developing with no serious health or behavioral health conditions; children who have a chronic condition that warrants regular follow-up; and, children with complex medical or serious behavioral health care needs. The goals of the Health Care Pilot and Process Review include process review, testing and refinement in the following areas:

- 1) Assessing and matching child health and/or behavioral health needs and level of care decisions at the point of placement;
- 2) Assignment of a single DSS caseworker (county-based or regional IFCCS worker), throughout the child's stay in foster care, informed by the child's health or behavioral health needs;
- 3) Alignment of DSS casework and Select Health care management tiering, care coordination responsibilities, practice and protocols;
- 4) Automation of CAPSS data feeds to reduce the documentation burden on DSS casework and IFCCS staff and to leverage data that is available from Select Health and Medicaid system of record;
- 5) Red flag or high needs rostering of children whose health or behavioral health condition warrants close monitoring (this will include red flags for events like visits to the emergency room); and
- 6) Production and use of gaps in care/utilization reports derived from administrative data (Medicaid encounter and claims data) and dissemination to DSS field staff for follow-up;
- 7) Follow-up tracking of high need, immediate need or other special populations of children based on data and through weekly management meetings at leadership

level and “cadencing” to field level. Just as a squad or military formation uses a regular, disciplined practice to march to the same beat, cadencing is a process that tracks a specific data element statewide. On weekly or bi-weekly conference calls missing or unclear data is followed until the information is provided or the issue is resolved. This continual improvement process aligns management and field staff to achieve the same goal and develop a forum for continual improvement;

- 8) Staff training on new health protocols and use of new health tools and reports;
- 9) Caregiver education and engagement by Select Health; and
- 10) Identification of the necessary service array, availability and access.

DSS will lead the Health Care Pilot and Process Review in collaboration with DHHS and Select Health with support from the health care consultants. The Health Care Pilot and Process Review will be coordinated with and build on other DSS work streams and consultant projects to avoid duplication and to leverage other resources (e.g., Chapin Hall retained by DSS for assistance on a data audit, development of the DSS case practice model and training and placement experts retained by Monitoring team). The Health Care Pilot and Process Review is discussed below in the relevant Child Health Goals and the System Components sections.

V. Health Care Plan: Child Health Goals

DSS translated its commitments in the FSA and the recommendations of the consultants into four child-centered goals and three key system components. The child health goals set forth the key features of DSS’s health care plan for children in foster care.

Child Health Goals

Goal 1.	Each child is linked to a care coordinator matched to the child’s needs.
Goal 2.	Each child in foster care has a primary care provider, preferably a medical home, and receives timely screening, assessment and follow-up.
Goal 3.	Each child in foster care has timely access to quality health, behavioral health and dental services.
Goal 4.	Each child in foster care has improved health outcomes.

The child-centered goals speak to the ways in which DSS and its partners will plan for, provide and monitor health, behavioral health and dental services to children in foster care. Each goal is expressed as a set of policy, practice or management activities to be undertaken, and each activity is assigned to a task lead.

Child Health Goal 1: Each child in foster care is linked to a care coordinator matched to the child's needs

This goal speaks to the efforts underway to assign a single DSS caseworker and a Select Health care manager based on each child's individualized clinical needs. This will involve revisiting and refining DSS caseworker roles and responsibilities and aligning DSS caseworker assignment and Select Health care manager assignment to meet the child's safety, permanency, well-being and health care needs.

Coordinated and effective care management is foundational to success in improving outcomes for children in foster care. Currently, both DSS and Select Health tier their basic case management and intensive care coordination activities. DSS bases its decision about the level of care management on a combination of diagnostic assessments, treatment needs and placement type (level of care). Select Health bases its decision on the severity or complexity of the child's health or behavioral health needs (level of need) and other criteria described below. In addition, the Select Health contract requires it to provide a care management system that conforms to the requirements and industry standards stipulated in the National Committee for Quality Assurance (NCQA) requirements for Complex Case Management and by the Standards of Practice of Case Management released by the Case Management Society of America (CMSA). Today, neither DSS nor Select Health use a standardized assessment tool to determine care coordination level. Under this plan, DSS will collaborate with DHHS and Select Health to explore the use of single severity assessment tool (MCO Contract 5.3.3) to align care management and case assignment.³

DSS has two types of child welfare case management: basic county-based case management and regionally-based IFCCS case management. IFCCS workers are expected to have a smaller caseload (9 children) because of the children's health/behavioral health complexity. While there is agreement that IFCCS workers should focus in greater detail on the health needs of the children on their caseload, the practice requirements for county and regional IFCCS caseworkers are not codified. In other words, heightened case work standards related to a child's health status do not currently exist.

As described above, beginning in October 2018, DSS plans to launch a Health Care Pilot and Process Review to, among other things, review and test the process for collecting and using health information for case management decisions. This includes adaptations to the current

³ South Carolina has a history of Medicaid innovations for adults with complex health care needs and piloted a case severity screening tool that uses weighted medical and psycho-social markers to stratify clients into low, moderate and high-risk categories. The severity screen and assessment is administered by a caseworker during an initial home visit, scored to determine level of need and then assignment is made to a registered nurse case manager (for moderate-high severity cases), caseworker (moderate severity cases) or community caseworker (moderate-low severity cases).³ This innovation was awarded the Robert Wood Johnson Culture of Health prize in 2015. This experience offers useful parallels for the changes envisioned for children in foster care.

Children's Services Application (CSA), also called the Uniform Application, assignment to a county or IFCCS/regional caseworker; to understand and make recommendations to improve how case workers obtain health information and services for children on their caseload and document it in CAPSS; to define case management responsibilities for DSS county, IFCCS regional workers and Select Health care management; to consider modifications to the Select Health care management assignment algorithm to include additional health and behavioral health indicators including conditions, prior service use or prior placement in foster care, among others; and, to understand and make recommendations to strengthen DSS's new practice model.

The Health Plan Pilot will also assist DSS in determining how to align the CSA with the assessment tools used by Select Health providers and with high quality behavioral health and medical providers. DSS will collaborate with DHHS and Select Health to train providers on the new tool chosen by DSS for its child assessments. Other training will include discussion of preferred brief screening tools like SEEK for social determinants of health for young children, the Edinburgh Postnatal Depression Scale for maternal depression, among other options to improve practice quality. Health and behavioral health training content will be folded into the new DSS Training Plan.

DSS will also use the information gathered during the Health Plan Pilot to inform how information about a child's health and well-being can be effectively collected and better utilized as part of the placement decision-making process and family teaming work. In collaboration with the work on the Placement Implementation Plan, DSS will obtain advice from experts, and internal and external stakeholders on whether and how to modify the CSA and/or adopt an alternative standardized assessment protocol. The pilot will review the existing systemic health care processes to also help inform thinking about how to enable children with complex medical or serious behavioral health needs to remain in community-based settings with appropriate supports.

In preparation for the Health Plan Pilot process, DSS is collaborating with Select Health to better understand the Select Health risk stratification and care coordination assignment methodology and seeks to align Select Health care management tiering with DSS caseworker assignment protocols to best meet the special case management needs of children in foster care. Weekly calls have been scheduled and are underway to understand Select Health's three levels of care coordination: 1) integrated health care management, 2) utilization management, and 3) rapid response care management. DSS will collaborate with DHHS and Select Health to introduce additional data elements for consideration in the risk stratification and care coordination assignment methodology and also for use to build out its own caseworker assignment protocols. These criteria include: repeat maltreatment, polypharmacy, dual diagnosis,

significant functional limitations, chronic illness and other relevant indicators of health risk. Concurrently, DSS and the healthcare consultants will develop a matrix (following the lead of other states) defining the role of the county DSS or IFCCS caseworker or the care coordinator from Select Health to be completed by the end of the Health Pilot in February 2019.

The Health Pilot will give DSS an opportunity to look closely at its current case management practice and roles, and those of Select Health. The methodology for the DSS Health Pilot will be developed by September 2018 to make it possible to roll-out the Pilot beginning in October 2018. The pilot methodology includes a process review of 20 child-specific “*use cases*.” The pilot cohort will include both children who are first entering DSS custody, as well as children who are experiencing a placement change, likely to be children who are moving from a lower level of care to a TFC and/or residential placement. These cases will allow DSS to strengthen and develop protocols for case management and Select Health to strengthen care coordination services that can be communicated to all frontline staff. It will also enable a deeper understanding of how this process interacts with the placement process and approach.

DSS intends to define the tiering and caseworker assignment protocols for its own case management practice to best match each child’s needs. The pilot will give DSS an opportunity to do this, and to determine what additional support is available through Select Health care coordination. It is expected that DSS will clarify the responsibilities of county, IFCCS and adoption caseworkers as well as develop new processes for assigning caseworkers to children. Caseload size, deployment and responsibilities of the 110 IFCCS workers will also be reviewed.⁴ The goal is for each child in foster care to have one DSS case manager who is responsible for their health, well-being, safety and permanency planning.

During the pilot, DSS will work with the Health Care Consultants to test the various roles and functions and develop a case management and care coordination framework for DSS caseworkers (county and IFCCS) and Select Health care managers.

To memorialize and implement improvements in care coordination learned from the pilot, DHHS, Select, and DSS will collaborate to create a policy and procedure manual that governs how children in foster care will receive more robust care coordination. The contract governing the relationship between Select Health and DHHS is a common contract for all five Medicaid managed care entities (MCOs) in South Carolina. The MCO contract cannot be altered for just Select Health, because that contract governs all five MCOs and Select is the exclusive MCO for children in foster care. DHHS has offered to collaborate to create a policy and procedure

⁴ This will be coordinated with the workload implementation plan for distributing cases and having a sufficient number of caseworkers that is in development. It’s important to note the explicit intention not to inadvertently increase caseloads for county workers by tightening up the criteria for IFCCS.

manual specific to Select Health for children in foster care. DHHS has also agreed to review the rate for children in foster care, if Select Health has additional requirements for children in foster care. Rates are changed in July annually. The Health Care Pilot and Process Review will inform additional requirements for children in foster care and can be incorporated into a rate review prior to new rates being issued in July 2019.

By March 2019, and subject to the approval of the Co-Monitors, DSS will utilize the information gathered from the pilot to produce a care coordination and health care case management framework that details the following:

- Detailed articulation of the differentiated roles of DSS foster care, DSS IFCCS caseworkers, and Select Health care managers, with a delineation of processes for case assignment, care management tiering based on child's level of need, expectations for communication, and case consultation and coordination between Select Health and SCDSS to meet the health care needs of all children in foster care, including those with complex health needs, disabilities or serious behavioral health needs;
- Development of related policies, and guidance to the field;
- Delineation of changes to DHHS-Select Health policies and procedures to operationalize the care coordination and health care management framework;
- Detailed financial projections and budget commitments for resources needed to fully implement the care management and coordination activities including any new staff, training or resources to support implementation;
- Timeline for statewide rollout.

Child Health Goal 1: Elements of the Work Plan

Task Lead(s): DSS Office of Child Well-Being

Key Activities and Deliverables:

- Weekly meetings with Select Health on care coordination practice, processes and protocol
- Weekly meetings with DHHS on data-sharing and refining gaps in care prototype and other reports
- Choose validated assessment tool, train DSS staff, roll out standardized assessment tool in accordance with the processes developed in the Placement Implementation Plan
- Adapt CSA to include health and behavioral clinical and functional assessment questions as recommended by child welfare leadership and the Foster Care Health Advisory Committee.

- Connect health/behavioral health initial assessments and comprehensive assessments to placement decision making processes, informing the Placement Implementation Plan;
- Institute weekly cadence call to staff cases, review progress made and resolve immediate needs beginning August 2018.
- Explore with DHHS, Select Health, QTIP providers and the AAP (American Academy of Pediatrics SC Branch), DSS's plan to use a standard, system-wide screening and assessment tool and ways to integrate the use of this tool and other best practice guidance on delivering health and behavioral health care to children in foster care.
- Produce a comprehensive care coordination and health care case management framework subject to approval of the Co-Monitors.

Timeframe: Health Care Pilot and Process Review October through February 2019, Implementation March 2019

Child Health Goal 2: Each child in foster care has a primary care provider (preferably, a medical home) and receives timely screening, assessment and follow-up care

This goal is expressed by activities related to eligibility determination, enrollment in a single managed care plan, provider assignment, preferred provider designation, screening, assessment and follow-up and managing the response to immediate needs.

A. A Single Managed Care Organization for all children in foster care: Select Health

In recognition of the fact that children in foster care require a more comprehensive, coordinated healthcare delivery model that promotes better access to health, behavioral health and dental services and improves health outcomes, almost six years ago, in November 2012, DSS and DHHS announced the Foster Care Health Initiative, a collaborative effort to better address healthcare delivery to foster care children. As the legal guardian, DSS determined that it is in the best interest of foster children to be enrolled in coordinated and managed care because these children enter the system at high risk of poor developmental and health outcomes and in need of care related to the effects of the neglect, abuse, and associated trauma that brought them into care. Further, many children entering South Carolina's foster care system enter already enrolled in managed care. As a result of this initiative, all children and youth placed into foster care, with few exceptions, are enrolled in First Choice by Select Health of South Carolina, a Managed Care Organization to meet their medical and behavioral health needs.

Select Health is required to provide foster care child members “medically necessary” care. Specific core benefits and service requirements are set forth in Section 4 of the DHHS and Select Health MCO contract⁵. Select Health receives a capitation payment of \$950.75 per foster child/per month in FY18. This rate incentivizes the expectation that providing health and behavioral health care to children in foster care requires additional time, care coordination and additional specialty services, principally outpatient behavioral health services, over what is needed by the regular Medicaid child population. A comparison of managed care rates for the two populations illustrates this point with a per member/per month rate (PM/PM) for children aged 1-6 set at \$134.00, 7-13 at \$144.48 and ages 14-18 set at between \$156.73-\$185.26 as compared to the PM/PM for all children in foster care set at \$950.75.⁶

With this in mind, DSS will collaborate with DHHS and Select Health to identify, plan and implement and care coordination system that works optimally for children in foster care.

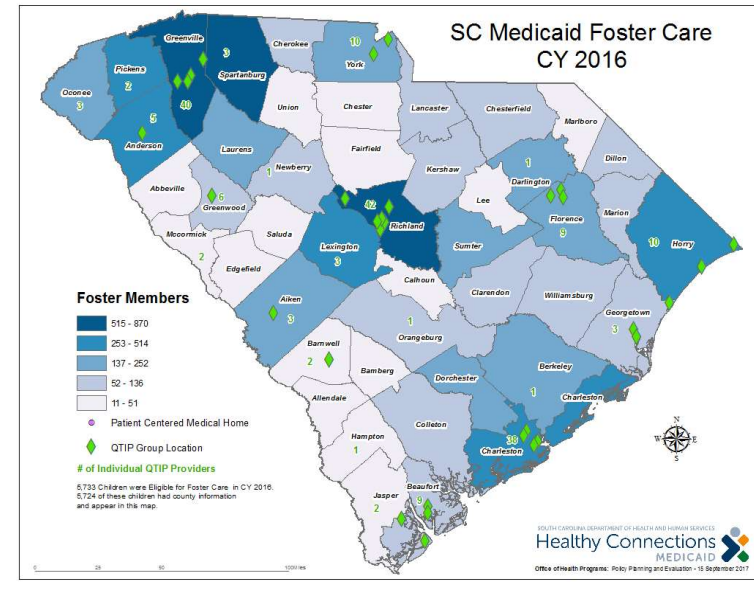
Medical Home/QTIP⁷

While all Medicaid providers are required to meet standards of proficiency and quality, some providers are especially well equipped to provide the highest quality care for foster children. As part of its Plan, DSS, DHHS and Select Health are committed to collaborating so that every child in foster care has a high-quality primary care provider, preferably a “medical home,” which, among other practices, includes providers who adhere to the American Academy of Pediatrics (AAP) “Bright Futures” standards. To achieve this, DSS will build on lessons learned from the Quality through Innovation in Pediatrics (QTIP) program, a DHHS quality improvement initiative in partnership with the AAP that provides direct support to pediatric providers to engage in quality measurement and practice improvement activities and integrates behavioral health and physical health. The QTIP program now includes approximately 30 providers in South Carolina. The graphic below maps the location of QTIP practices and distribution of children in foster care by county.

⁵ DHHS and Select Health Contract in Appendix, Section 4.

⁶ All Select Health primary care, specialty care, behavioral health, pharmacies, hospitals and ancillary providers, must be licensed or credentialed under the NCQA Standards and Guidelines for Accreditation of Medicaid Managed Care Organizations, as described earlier in the Plan.

⁷ Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit February 2012, Center for Health Care Strategies



The QTIP project began as a grant-funded CHIPRA Quality Demonstration (authorized by 401 (d) of the Children's Health Insurance Program Reauthorization Act of 2009). This QTIP project was accomplished through encouraging and assisting with use of clinical quality measures and incorporation of mental health services into a medical home. Based on the success of the demonstration project, DHHS continued most aspects of the QTIP program.

QTIP practices engage in quality improvement work in several ways, including a Learning Collaborative in concert with the South Carolina Chapter of the American Academy of Pediatrics; on-site training and technical assistance in general quality improvement principles and topic-specific clinical focus areas during annual on-site visits; monthly conference calls; and specific attention to the quality of the EPSDT visits and the completeness of recommended screenings. Through this work, QTIP practices have repeatedly demonstrated better performance on a range of quality measures, when compared to similar practices.

DSS will explore and develop with DHHS and the AAP new ways to supplement the on-going training of practices with foster care specific training materials and consider enhancing the capacity of the AAP to establish a QTIP-like Learning Collaborative or cohort training model for other pediatric practices who seek preferred provider status.

DSS, DHHS, and Select Health will collaborate on the development of provider assignment protocols to take into account factors such as whether a child is already being seen by a current Select Health provider, unique needs of the child, preferences expressed by the birth parent, geographic access, and provider availability. DSS will implement these assignment protocols through a new policy that considers auto-assignment to a “preferred provider,” with an opt-

out to preserve foster parent choice, where appropriate. In addition, DHHS and DSS will collaborate with Select Health, and preferred providers to train caseworkers and foster parents in the standardized and comprehensive health and behavioral health assessment tools. One of the significant recommendations of the DSS Foster Care Health Advisory Committee (FCHAC) was to have a standardized protocol for screenings, assessments, and follow-up for all children entering and in foster care. As discussed earlier in the section on Care Coordination, DSS plans include adoption of a validated and standardized assessment protocol for use by its field staff statewide to ensure necessary health and behavioral health information is collected at the time of placement, to inform decisions about placement and services.

Finally, DSS, DHHS and Select Health will collaborate on ways to further incentivize preferred provider participation, increase the number of high quality preferred providers or otherwise enhance QTIP or QTIP-like practices. DHHS is exploring several ways to introduce a special payment for foster child visits, either as a discrete service code or through the use of modifiers. This work will begin 12 months after implementation of the basic reforms outlined in the Health Plan. Currently, Select Health incentivizes its providers for outstanding performance on certain HEDIS measures (HEDIS measures are discussed in detail below) associated with improved health and behavioral health outcomes for members. DSS wants Select Health to benefit from its incentives for outstanding performance on HEDIS measures most relevant to children in foster care. To accomplish this, DHHS, DSS and Select Health will collaborate to develop the preferred provider designation and incentive package for preferred providers beginning in February 2019 so that this work is completed prior to and reflected in the Select Health rate setting process in July 2019.

Of course, not all providers are, or will be QTIP providers. Given this, DSS plans to collaborate with DHHS, Select Health, the AAP South Carolina Branch, and the Foster Care Health Advisory Committee to: 1) review the performance of all health, behavioral health and dental providers currently serving children in foster care, 2) develop criteria and a process for designation of providers as “preferred provider” as well as minimum or baseline criteria for all providers of services to children in foster care, 3) consider designating QTIP, DMH clinics and FQHCs as preferred providers, 4) provide provider training opportunities and other supports, and 5) consider increased or modified rates to incentivize providers to accept and spend sufficient time with foster care children. Taken together, these actions will increase the availability of quality providers and improve health care quality statewide.

B. Eligibility and Covered Services

Children in foster care are eligible for Medicaid the day they enter placement and the vast majority of children in foster care are covered by Medicaid managed care through Select

Health⁸. Select Health provides medical and mental health services and DentaQuest provides dental care. Many children enter foster care already enrolled in Medicaid or Medicaid eligible. The eligibility process for all children in foster care is automatic and each child is assigned a Medicaid number and payment code that allows providers to deliver and bill for services and allows DSS and DHHS to track services rendered, gaps in care/utilization and follow-up needed.

Enrollment Plan	Unique Children in Foster Care as of 5/4/18
FFS Waiver	65
FFS Non-Waiver	305
Select Health	3832
ATC	40
Blue Choice	50
Molina	44
Well Care	19 ⁹

The following services are available to children through the Select Health contract¹⁰: services for emergency medical conditions; inpatient services; post-stabilization care services; specialty services; behavioral health and substance use services; vision and audiology services, referral to out-of-network services; pharmacy and a regularly updated pharmacy formulary of generic and brand medication; EPSDT health and developmental screenings that follow the American Academy of Pediatrics periodicity schedule; second opinion; automated 24/7 toll-free line and staffed call center with information on what to do in case of an emergency and option to talk directly to a nurse or other clinician; and care coordination, among other services.

A small number of children in foster care are not covered by Select Health as shown in the table above. Children who are undocumented are ineligible for Medicaid and receive identical physical, mental and dental benefits paid by 100% state dollars until age 18. Children in any of the nine DHHS fee for service waivers are also not covered by Select Health. As of May 4, 2018, 65 children were in those waivers. Children with complex medical or behavioral health needs may also receive services outside of the Select Health network. DSS tracks health care utilization and outcomes for all children, whether they are in Select Health or in one of the groups that falls outside the MCO contract. DSS will track the care and services for all of these

⁸ Medicaid coverage is provided for all children in foster care through their 18th birthday with the exception of undocumented children whose health care coverage is paid for by the State of South Carolina.

⁹ As of the May 4, 2018 member matched file.

¹⁰ SCDHHS-MCO Contract 7/1/2016.

children, whether covered by the Select Health program or through another Medicaid coverage vehicle such as a waiver program.

The current contract between DHHS and Select Health does not differentiate between the benefit and service package provided to children who are in foster care and those who are not. In fact, there is a single contract between DHHS and the five MCOs that operate in South Carolina. Since children in foster care are enrolled in Select Health, the contract does not contain any specific requirements related to foster care children. However, moving forward, Select Health will be expected to enhance its model to offer unique plan elements relevant to children in foster care including, but not limited to, in electronic and paper form: foster care member handbook, ID card, provider directory, health education materials, guidance on member rights, communication and coordination between Select Health and DSS caseworkers.¹¹ By March 2019, DSS, DHHS and Select Health will collaborate to determine specific requirements and implement policies and procedures for Select Health that will include alignment with DSS timeframes and tools for required initial assessments, standardized assessment, follow-up and identification of immediate treatment needs for and data tracking for all foster care children. These will be memorialized in a DHHS-Select Health Foster Care policy and procedure manual.

As noted above, dental services are not provided through the Select Health contract. Rather, all children in foster care receive their dental services through DentaQuest, including regular screenings and annual dental exams, follow-up for dental caries, orthodontia and other oral health needs. By December 2018, DSS will develop a new report to flag, roster and follow-up on gaps in care and introduce this new report into the process for handling all other gaps in care and cadence call process.

C. Enrollment

Although coverage is guaranteed for all children in foster care, the Medicaid system has a built-in enrollment lag of 30 days. DSS, DHHS and Select Health began to address the 30-day time lag as an **immediate priority** based on the report by the Health consultants to reduce any gaps between entry into foster care placement and enrollment into Select Health.

As noted earlier, the vast majority of children coming into the foster care system are Medicaid eligible and already enrolled in one of the state's MCOs. Children entering foster care are automatically eligible for Medicaid and there is no interruption in any services that they are already receiving; however, enrollment in Select Health does not start automatically the day

¹¹ Contract Between SCDHHS and << Contractor >> for the Purchase and Provision of Medical Services Under the SC Medicaid Managed Care Program, July 1, 2016 (Section 3)

the child enters care. One consequence of this lag is that a child may remain the responsibility of a health plan or provider not affiliated with Select Health making more challenging to make sure that 7-day, 72-hour and 30-day timeframes for initial assessment and comprehensive assessment are completed, that immediate needs are identified and met, and that follow-up is scheduled for all identified health and behavioral health needs.

Children are assigned to and enrolled in Select Health on a monthly basis. Approximately 284 children entered foster care each month in 2017. However, from January to April of 2018, the monthly average of children entering foster care each month was 368 children, indicating a rise in the number of children entering foster care. During this 30-day period, initial assessments, comprehensive assessments and follow-up are paid fee-for-service or by the MCO that the child had prior to coming into care. Lifting this administrative barrier will address key gaps in care.

There are several administrative steps that can be taken quickly to address the enrollment lag. All children coming into care have a Medicaid ID that includes a designation - - called a recipient service program (RSP) that allows the Medicaid system of record to recognize their foster care eligibility status. Although the majority of children enter foster care with an active Medicaid ID#, DSS and DHHS found that approximately 300 children were deemed ineligible based on a coding error in third party software. Work is ongoing to permanently resolve the software issue. Until that time, DHHS staff manually remedy the problem.

The Plan includes the development of a new enrollment and eligibility protocol that will eliminate the 30-day enrollment lag for an estimated 300 children entering foster care each month, which will be in place by January 2019, the annual date under the state's contractual terms with the MCO by which contractual changes can be made. In the interim, the mitigation plan includes the development and use of existing reporting processes that correct any missing or incorrect enrollment data, matches the current roster of children placed in foster care against CAPSS data and other DSS reports, DHHS Medicaid utilization, claims and other data. These matched files are then used to identify missing health, mental health or dental initial assessments, comprehensive assessments and follow-up. This report, called a "gaps in care/utilization report" will be used to flag unmet need in the first 30 days of foster care placement and throughout the duration of placement. The gaps in care report will be used centrally by the DSS Office of Health and Well-Being and in the field by caseworkers, supervisors and directors. The detail on how DSS will manage to and use the report is described on page 43. DSS received its first gaps in care report in April 2018 and its second report in late May 2018.

Currently, there are two categories or "buckets" of data that DSS is analyzing for the Health Plan: 1) Data collected within the first thirty days of a child entering foster care. This includes initial medical, mental, and dental health assessment data. These data come from CAPSS and

are verified through a matching process with DHHS administrative claims data.¹² 2) Data from Select Health, including data on gaps in care. DSS is working to understand how Select Health categorizes and reports gaps in care. To that end, DSS and Select Health are working to understand and clarify data reporting definitions with sources. This will assist DSS in understanding how best to use data that Select Health has at its disposal for children in foster care.

DSS will begin piloting the gaps in care report with the field in August 2018, described in greater detail later in this report. In addition, the Health Care Pilot and Process Review will use the sample of 20 children to develop statewide policies and practice protocols related to care coordination but also to Medicaid enrollment. The enrollment and payment lag described earlier will be addressed by drafting a standalone DHHS-Select Health administrative contract with a go-live date of January 2019. A time-limited enrollment mitigation work around will be used until then, which involves DSS and DHHS manually ensuring that all children that enter foster care are enrolled in Select Health.

D. Screening and Assessment

DSS wants all children in foster care to be appropriately screened and assessed and receive the follow-up services they need. Children can come into foster care with little known or documented about their health history or medical, dental, and mental health needs, and these initial assessments and comprehensive assessments are critical to drive early identification of needs and matching services. Early coordination to track these assessments, identify needs, and procure necessary services, will assist DSS in placing and stabilizing children in the least-restrictive most family-like setting, hopefully making each child's first placement, his/her only placement. For those children where a more restrictive setting is necessary, early coordination of these efforts will assist DSS in developing a plan to step the child down to a less restrictive more family-like setting when the child is ready.

Building on the above, DSS plans for all children to receive the appropriate initial assessments and comprehensive assessments in a number of ways, including: tracking children at the time of placement into the level of care coordination that best fits their level of need; and including in the CSA appropriate questions about child health, behavioral health and well-being so that the care coordination, placement and services decisions made at the time of placement are informed by initial health information about the child. As noted earlier, synchronizing any

¹² Initial Assessment Data in Appendix, Section 10.

health care initial assessments and assessments with placement decision making, staffing and family teaming is critical.

The term “screening” as typically used by primary care providers involves a brief paper and pencil questionnaire given to a parent or other youth to quickly and easily determine if further assessment is needed. Primary care providers may be able to bill separately for these screenings. Examples include the Modified Checklist for Autism in Toddlers (M-CHAT) or the Ages and Stages Questionnaire (ASQ) which can be completed by a parent in a pediatrician’s office during a well-child visit. Depending on the results of the screening, a provider knows whether to refer a child for more thorough assessment, typically performed by another more specialized provider. DSS policy refers to the first medical, mental health, and dental encounters a child has upon entering foster care as “initial assessments”. These initial medical, mental and dental health assessments are more detailed than screens and are intended to be thorough enough to determine what follow-up care should be addressed in the child’s plan of care.

DSS has previously committed to the following timelines related to collecting health information, initial assessments, and comprehensive assessment and includes the timelines below for reference. Health Plan implementation activities related to initial assessments and comprehensive assessments will be undertaken in collaboration with DHHS, Select Health, DMH and other partners to align and refresh policies, timeframes and practice. The activities and timelines are as follows:

- Within 72 hours of the child's entry into foster care the Foster Care/IFCCS Worker shall gather all necessary, educational and healthcare information for completion of the child's Education and Health Passport (DSS Form 30245), which should be updated at least every three months.
- The Foster Care/IFCCS Worker shall schedule the Initial Medical Assessment and Mental Health Assessment within one business day of a child’s removal to foster care. The worker shall schedule a dental health assessment within 14 days of a child’s removal into foster care.
- The worker shall facilitate completion of a Comprehensive Medical Assessment within 30 days of the child's Initial Medical Assessment, if a Comprehensive Medical Assessment was not completed during the Initial Medical Assessment.
- If the Initial Mental Health Assessment recommends further assessment or the provision of Mental Health Services, the worker shall facilitate the completion of a Comprehensive Mental Health Assessment within 30 days of the Initial Mental Health Assessment.

- If a child is under the age of three at the time of his or her removal, the worker shall immediately make a referral to BabyNet, South Carolina's interagency Early Intervention System for infants and toddlers.
- If a child is a suspected or known victim of acute physical abuse or sexual abuse, the worker shall schedule a forensic exam within 24 hours.
- The initial dental assessment will occur within thirty calendar days of coming into care. If the child is less than 1 year of age or has not had a tooth emerge or the provider is unwilling to re-exam the child due to previous encounter within six months, an oral exam during the EPSDT/well child visit is acceptable.

As part of the DSS Health Care Pilot and Process Review as discussed earlier in the Health, DHHS, DSS and Select Health will collaborate to determine whether certain children should be targeted for screenings and assessments with preferred providers. For example, children who initially enter care or children who are being moved to a new placement who meet certain health and/or mental health criteria might be referred for screenings and assessments with preferred providers (e.g., QTIP practices, FQHCs or DMH clinics). This will be particularly important for children that DSS has already determined through the CSA to need heightened care coordination. Children needing intensive care coordination include children with certain medically complex or behavioral health conditions or diagnoses such as bipolar disorder or psychotic disorders, or children who are receiving or being prescribed a psychotropic medication(s) and are age six or less, taking an antipsychotic, or are taking four or more psychotropic medications, or who are medically fragile or have an activity-limiting chronic condition. The state's network of 17 SCDMH community mental health centers, are available and may be better utilized by DSS to do 72-hour trauma assessments and leveraged as preferred providers for children with more complex mental health needs. DSS will collaborate with DMH to assess the timely availability of trauma screenings and CMHC clinic capacity to provide child-focused clinical treatment to children in foster care.

As part of their routine case management responsibilities, DSS caseworkers will verify that all children on their caseload have had required screenings and assessments, and any follow-up care needed. Follow-up care will be tracked through the caseworkers' monthly visitation requirements. DSS will rely on the CAPSS system to capture this information and as a source to extract data for reporting purposes. CAPSS currently has encounter type fields that are designated to allow caseworkers to enter the type of assessment, date of assessment, and provider. In addition, caseworkers can describe through dictation the visits as well as link appropriate medical documents to the case. DSS caseworkers will record notes in CAPSS based on discussions they have with birth parents, foster parents and the children themselves about medical, mental health or dental care assessments and issues requiring follow-up. Where a child has an Intensive Care Coordinator from Select Health, the DSS caseworker will inquire and

solicit information regularly from birth parents, and either the foster parent or contract provider (if the child is placed in congregate care) so that the child's needs are met. DSS and DHHS will collaborate with Select Health to develop a red flag report to notify the assigned DSS caseworker and supervisor and Select Health care manager, if one is assigned, of children who have not received follow-up care, missed a well-child visit, presented at the emergency room, was hospitalized or whose utilization patterns suggest may be the subject of repeat maltreatment in care or need referral to specialty services subject of repeat maltreatment.

DSS recognizes that policies and procedures between DHHS and Select Health and DentaQuest will need revisions to meet the current expectations for casework practice for initial assessments. For instance, based on South Carolina Medicaid MCO access standards, providers are required to make a best effort to do initial assessments within 90 days and have appointment availability within four to six weeks for routine office visits, not within 14 days as DSS policy currently requires. DSS will collaborate with DHHS and Select Health to resolve this discrepancy by June 2019. Once set, DSS will develop a training plan for its caseworkers, supervisors and directors on any new policies developed.

In addition, in conjunction with review and modifications to placement processes, DSS will review its existing "interagency-staffing" process (ISCEDC) for children identified as needing therapeutic family foster care or other higher-levels of care. Where possible, modifications will be made so that the decision around an appropriate placement resource happens more quickly than 45 days, especially for children entering foster care for the first time. The Health Care Pilot and Process Review aims to track how this process currently works to identify the best process for children, and where efficiencies could be gained by better coordination between health care and placement assessment processes.

As noted above, DSS will use the Health Care Pilot and Process Review to gather information about these activities between September and February and will finalize recommendations from the Pilot by March 2019.

E. Immediate Needs

Under the FSA, DSS committed to identify "Class Members" (children) with "Immediate Treatment Needs (IN)." DSS has previously established an operational definition for "Immediate Treatment Needs" as a mechanism for focusing case practice. However, there are two issues with the language and intent of this requirement that may need modification: (1) how IN are identified and tracked for the defined cohort of children in foster care; and (2) how immediate treatment needs are defined. DSS is currently undertaking efforts to meet the

immediate needs of children using this broad definition. See Appendix for DSS Child Health Fact Sheet which contains categories of immediate treatment needs for children.¹³

First, while DSS has had success requiring caseworkers to track whether children on their caseload have had the appropriate initial assessments and comprehensive assessments, tracking immediate treatment needs through the case record is proving to be more difficult. To meet the conditions of the FSA and before development of the DSS Health Plan, the Parties developed a caseworker-dependent workaround to fill in for in the absence of other sources of data to identify immediate treatment needs in the identified cohort of Class members. The health care consultants retained by the co-monitors recommended against this data work-around for any “look back” analysis because the information collected was unreliable and likely to be incomplete. Instead the consultants recommended that DSS use Medicaid encounter, claims and other data of record (MMIS) to identify the treatment needs, services rendered or gaps in care for children in custody.

The consultants recommended that DSS caseworker and supervisory staff resources be devoted instead to making sure that children get to medical appointments and receive the care they currently need, not to track down historical data. The consultants recommended that DSS collaborate with DHHS and Select Health to generate the gaps in care/utilization report for a specified time period for a defined cohort of children in foster care to determine whether their immediate treatment needs were met. The gaps in care reports are based on a list of diagnostic conditions and HEDIS health quality measures used nationally and by many state child welfare systems including New Jersey, Utah, New York and others. In February, DSS requested a gaps in care report from DHHS, which was delivered at the end of April 2018. As noted above, weekly calls between DSS and DHHS to refine and build the report have been ongoing during the months of May and June 2018 and will continue.

DSS expects that once these gaps in care data reports, which will be tested in the Health Care Pilot and Process Review and in weekly cadence calls beginning August, begin to run regularly, the immediate treatment needs roster will be reduced. In the short run, to catch up and reach all children on the immediate treatment needs roster, DSS’s new process for addressing immediate needs is as follows: DSS caseworkers will review each child’s file on the immediate treatment needs roster and determine what action is required. If an appointment or staffing is required, Office of Child Health and Well-Being staff will monitor the child through completion of the staffing or appointment, whichever is later. The caseworker will enter initial assessment and comprehensive assessment data from the DHHS/Select Health reports into the CAPSS foster care case record. Going forward, caseworkers will also be expected to enter into

¹³ DSS Child Health Data Fact Sheet in Appendix, Section 6.

case notes, any follow-up care needed and confirm with foster parents or other caregivers that follow-up visits have occurred. To assist with verification and so that care needs are met, DSS in collaboration with DHHS and Select Health will review the roster of children missing screenings, assessments or follow-up services and those with high need/risk diagnoses against 30-60-90-day utilization reports. DSS will also use external evaluators to review a random sampling of case records through the Child and Family Services Review (CFSR) case review process. The review will determine whether children and youth receive needed health and behavioral health services. Weekly cadence calls will review all cases on the roster, so that cases are staffed as needed and appropriate services are scheduled, if warranted. These reinforcing layers of tracking and review using qualitative and quantitative data, at the individual case level and aggregated at the population level, allows children and youth who might have missed screening, assessment or follow up to be identified and staffed until they receive the care they need.

DSS has been collaborating with DHHS and Select Health to build reporting and analytic capacity and a format for the development of additional gaps in care/utilization reports that can be reviewed on a rolling basis, every 30-60-90 days at the outset, to track that children are receiving the care they need – tracking is for services covered by Select Health as well as those like dental that are covered outside the Select Health contract and the small number of children in foster care who will still be enrolled in the Medicaid fee for service program. DSS uploads a nightly roster of children who come into care that is tracked against the DHHS Medicaid enrollment roster for accuracy. In addition, children with specific diagnoses, including but not limited to diabetes, asthma, sickle cell, and various behavioral health diagnoses, will be tracked and rostered by DSS and Select Health so that they are receiving high quality care and are assigned to a Select Health integrated health care management, if needed. Currently, this care manager assignment from Select Health is time-limited, typically up to six months. DSS will collaborate with DHHS and Select Health to determine if this time limit is appropriate for children in foster care and will work through a protocol for longer duration care management assignment by March 2019. This information will be used by DSS to produce a tracking and red flag report that caseworkers can use to supplement information collected from caregivers and children. Simultaneously, as noted above, DSS caseworkers will incorporate into their monthly visits questions about follow-up medical, mental health and dental care, and make notes of this in the CAPSS electronic case record. DSS envisions a future technology application, to be developed and tested in 2019, that allows verification using DHHS data that will be automatically uploaded into CAPSS. Once this process is complete, existing functionality in CAPSS that gives caseworkers notification prompts for missed follow-up appointments will be more useful in aligning practice to immediate treatment needs.

Second, the health care consultants found that the definition of “immediate treatment needs” as defined in the settlement agreement was overbroad and inconsistent with how the words are used in the health care sector. As part of its Plan, DSS seeks to develop a revised definition that categorizes treatment needs in language that is consistent with the health care field. For example, DMH categorizes needs as either “routine, urgent or emergent” while DHHS defines it as “urgent, non-emergent, routine, and emergent” care. DSS will consult with DHHS, Select Health, DMH and request approval from Co-Monitors and Plaintiffs, for use of a new definition of immediate treatment needs by November 2018. The goal of this exercise is not to reduce DSS’s obligations to provide needed care timely for children in its custody. Rather, it is to see that its treatment needs framework will be adopted, understood and used consistently by its health provider partners. Once this framework is revised, DSS will track services accordingly using real-time data capture by caseworkers in CAPSS and quarterly retrospective look-backs using administrative data.

F. Follow Up

DSS is developing a two-part solution for follow-up visits and services. This process will include a practice solution and a data solution. For the practice solution, DSS caseworkers will continue to engage birth parents, foster parents and youth in reporting the status of health care follow-up and identification of any outstanding needs at monthly visits. These case notes, referred to as “dictation” by DSS, and any discharge summary provided by the health/behavioral health provider will be uploaded into CAPSS. Children identified as having unmet follow-up care needs will be rostered with staff assigned to complete follow-up activities and tracked on the DSS weekly cadence call. The weekly roster will be transmitted from DSS to the Select Health Care Coordination Department for tracking, verification and follow-up scheduling assistance for needed appointments, medication management or medical equipment, eyeglasses or other assistive devices needed. This practice solution will be tested in the Health Care Pilot and Process Review that will be completed by February 2019 and new drop-down fields will be created in CAPSS to enable CAPSS to generate weekly and monthly “*needing follow-up*” rosters. This process will identify individual children in need, and will also surface counties and regions where community-based services are harder to access or altogether unavailable.

A retrospective review of the 30-60-90-day gaps in care/utilization report for children identified as needing follow-up will provide another level of validation. This data solution will require new fields to be added to the report. DSS will be able to use the “*needing follow-up*” roster to ascertain whether children received services in the 30-60-90-day period following the identification of unmet follow-up care needs. Again, this will surface access and availability patterns related to health and other community-based supports.

Child Health Goal 2: Elements of the Work Plan

Task Lead(s): DSS Office of Child Well-Being and Office of Data, Research and Accountability

Key Activities and Deliverables:

Medical Home

- DSS will collaborate with DHHS, Select Health and the Foster Care Health Advisory Committee to establish a preferred provider designation based on HEDIS parameters and provider agreement to participate in cohort learning collaboratives that meet two times a year
- DSS will collaborate and explore with DMH the designation of its CMHCs as preferred outpatient behavioral health providers, given their child psychiatry staffing and regional locations around the state
- DSS, DHHS and Select Health will collaborate to establish a protocol to assign children to a patient-centered medical home, QTIP-like or FQHC preferred provider and caregivers will have the opportunity to opt-out and exercise freedom of choice
- DSS will work with DHHS and the AAP to build out a learning cohort of pediatric practices who wish to work with the foster care population
- DSS will collaborate with DHHS and Select Health to create a manual for policies and procedures specific to children in foster care by 2020 to include incentives for medical homes/preferred providers, timeframes for assessments, etc.

Eligibility and Enrollment

- Build out and pilot test the rostering, tracking and follow-up mechanism for initial assessments, comprehensive assessments and timely follow-up.
- Fix 30-day enrollment lag by January 2019, and in interim, use developed administrative work-around so that children in foster care receive necessary initial assessment, comprehensive assessment and follow up, and the data tracks them as such.

Screening and Assessment

- DSS has already developed aligned timeframes for initial assessments, comprehensive assessments and follow-up that track AAP standards for children in foster care. Those timeframes will be clarified and operationalized for data tracking purposes.
- DSS will develop timeframes that align with FSA requirements, and coordination with placement and re-placement decision-making assessments.

- DSS, DHHS and Select will collaborate on the development of a no-lag enrollment protocol by January 2019.
- DSS and DHHS have already developed and signed a data-sharing agreement.
- DSS, DHHS and Select Health will develop an implementation timeframe for producing regular monthly gaps in care reports.
- DSS will field-test the use of gaps in care reports, cadence calls, and monthly tracking and develop practice guidelines beginning in August 2018 and running through February 2019.
- DSS will include a targeted focus on health and behavioral health in its CFSR PIP and will develop a process for integrating case record review findings into the weekly/monthly cadence calls.
- Caseworker training will include new expectations for documentation and follow-up and refresher training on DSS practice standards.

Immediate Needs

- DSS will propose a revised definition of Immediate Needs to more closely match language and conditions that are customarily used in the health care industry by November 2018.
- Use gaps in care and other red flag reports, cadence calls and performance tracking and develop a protocol based on experience beginning in August 2018.

Follow-Up Services

- Develop and pilot practice and data solutions to ensure the regular flow of information to caseworkers and between DSS and DHHS beginning in August 2018.
- DSS will collaborate with DHHS to develop a protocol to identify dental providers and develop a roster of children needing dental care follow-up beginning in August 2018.

Timeframe: Current through February 2019, Draft Select Health Policy and Procedure Manual, May 2019

Child Health Goal 3: Each child in foster care has timely access to quality health, behavioral health and dental services

DSS will accomplish this goal by assessing provider capacity to accept and serve children in foster care, coordinating the annual network adequacy assessments conducted by Select Health and validated by DHHS and use data to develop a process to address capacity gaps. To improve the availability of high-quality, community-based health and behavioral health services, DSS will collaborate with DHHS and Select Health to develop a process for an annual

review of network capacity and access to services at the local, regional and state level. In addition, DSS has developed a monthly report to track, flag and prompt timely completion of health, dental and behavioral health initial assessments. DSS will also develop a protocol for a monthly report and assessments, referrals and follow-up needed and to identify immediate needs and gaps in care as discussed in detail earlier in the Health Plan.

DSS is actively exploring ways to align its own network adequacy assessments with those required by DHHS for Select Health. The network adequacy features envisioned for the new health system for children in foster care are detailed below.

A. DSS sponsored USC Study

In April 2017, the DSS Healthcare Improvement Workgroup, in partnership with the University of South Carolina's Center for Child and Family Studies (USC), undertook a healthcare needs assessment specifically focused on the initial and ongoing health assessments for the physical, mental health, dental, and trauma needs of children in care. Members of the Healthcare Improvement Workgroup, along with USC team members, designed and tested an instrument to be deployed through Survey Monkey. Each county director through their Regional leadership was asked to submit one answer that best represented the circumstances of that county. The instrument was deployed with a 100% response rate. Data was unduplicated where necessary and, in some instances, recoded to be easily summarized for patterns. The survey established baseline capacity needs and gaps and provided useful information to inform DSS's annual discussion of network adequacy with DHHS and Select Health. DSS has a current contract with USC to conduct the needs and capacity survey bi-annually. The survey findings will be used to inform DSS's resource development.

DHHS's network adequacy requirements in the Select Health contract also offer DSS another source for actionable information on community-based service and provider capacity. DHHS and Select Health will revisit the need to supplement this analysis and will develop a process for monitoring and addressing issues of local and regional service availability, access and timeliness and reporting back to DSS about plans to fill service gaps.

Some key findings from the USC study related to the availability of services included:

- Generally, counties felt that they did have sufficient providers to meet their medical needs though some have issues with access within their counties. Those counties who appeared to have issues with access were often rural, with Florence one notable exception. Some counties were more specific in their accessibility barriers. These barriers included a lack of providers in some parts of a given county, limited mental

health providers who would see children under 6 years of age, dentists who sometimes did not want to see young children, and not all providers being trained in trauma or otherwise qualified to serve the specialized needs of children in care.

- Over a third of the counties experienced timeliness issues for three or more of the initial assessments.
- Counties experienced a number of barriers to completing their assessments that fell into several “buckets”. The first bucket of barriers was related to the lack of placements within a child’s home county. Because of the lack of placements in a given county, a child may need to be placed in a county far away from their home county. This led to caseworkers who were not familiar with providers in distant counties and caseworkers having to spend time traveling. They also noted the hardships placed on the child who sometimes had to miss school. A second bucket included wait times and a lack of late or alternative times for appointments. Finally, the third bucket was Medicaid data issues such as inaccurate data in the system or missing Medicaid numbers and/or Medicaid eligibility issues.

B. Case Record Reviews

DSS CFSR case reviews will review questions related to health and behavioral health services. Questions and data collection will focus on the identification of gaps in care, timeliness of care and ease of access. Other sources of information such as case notes in CAPSS, gaps in care/utilization reports and Select Health network adequacy data will also provide feedback to DHHS about the need for additional capacity or a different regional service mix. This will include CFSR Item 12 assessing needs of families and children and providing those services; CFSR Item 13 including parents and children in case planning; CFSR Item 14 frequency and quality of visits between caseworkers and child, CFSR Item 15 frequency and quality of visits between caseworkers and mothers and fathers, CFSR Item 16 educational needs, CFSR Item 17 physical health needs, and CFSR Item 18 behavioral health needs. The information in the case record reviews will further inform DHHS and Select Health’s analyses described below so that DSS has a comprehensive view of both community-based services and supports.

C. DHHS and Select Health Network Analyses

DHHS requires Select Health to have a network of providers sufficient to deliver adequate access to services for all children in care, including prevention services, primary and specialty care. The contract also requires Select Health to develop mechanisms to monitor compliance by providers and take corrective action for failure to comply. The DHHS-Select Health contract details minimum provider network adequacy requirements informed by:

- Utilization estimates based on the characteristics and health care needs of the population served
- A geographic service area which in the case of children in foster care requires Select Health to plan for geo-mapped statewide geographic distribution
- Estimates of the number and types of credentialed providers needed who are primary care and specialty care providers, hospitals and other health care providers.
- Estimates of credentialed providers with capacity to accept new patients
- Sufficient credentialed providers who can provide a second opinion
- Distance, travel time, typical means of transportation; physical access
- Meet standards for timely access and respond to urgent care needs
- Standard hours of operation
- 24/7 service access for medically necessary services
- Routine visits within 4-6 weeks
- Wait times that do not exceed 45 minutes for routine schedule appointments
- Urgent care within 48 hours
- Capacity to handle walk-ins

In addition to the network adequacy requirements covered under contract, Select Health must also manage utilization review and prior authorization for services. The “utilization management (UM) function” as it is known by MCOs is not to be confused with the care coordination function. The UM function monitors the child’s patterns of service use and pays particular attention to overutilization, underutilization, hospitalization and emergency room use, medication adherence, medical necessity and prior authorization of certain in or out of network services. Network adequacy information will be shared annually by Select Health in a performance improvement meeting with DHHS and DSS. UM data will be provided by DHHS to DSS quarterly to inform casework follow-up with the child and family.

D. Out-of-Network Services

DSS will collaborate with DHHS to review the eligibility and enrollment protocols for the nine waiver programs and other specialty services for high needs children currently operating in South Carolina and refresh its referral protocols. DSS will also collaborate with DHHS and Select Health to develop a notification process so DSS caseworkers and Select Health care managers know which children are receiving out-of-network services. DSS will also collaborate with DHHS to track utilization of dental, waiver and other out-of-network services for children who receive services outside of the Select Health provider network. Review of these programs will include the identification of access and availability of community-based services necessary to meet the health care needs of children in care.

Child Health Goal 3: Elements of a Work Plan

Task Lead(s): DSS Office of Child Health and Well-Being

Key Activities/Deliverables:

USC Study

- DSS to plan a behavioral health and dental services capacity study to be conducted every two years by USC using Medicaid administrative data, qualitative surveys from foster parents, birth families and youth in care and DSS regional office staff
- DSS will contract with USC to conduct targeted annual topical studies, with recommendations, as needed

CFSR Case Record Review and PIP

- DSS will continue its focus on health and behavioral health services in CFSR case record reviews.
- Using the CFSR quality assurance process, which reviews each of the state's 46 counties every three years, DSS will analyze CFSR review data from the 23 counties in the 2017 cycle. Of the 450 cases for this time period, approximately half were foster care cases. The review included questions from the federal CFSR tool related to physical health including dental (item 17) and mental/behavioral health (item 18).
- DSS will develop corrective action plans and PIPs to address issues that relate well-being outcomes 1, 2 and 3 which include CFSR Item 12 assessing needs of families and children and providing those services, CFSR Item 13 including parents and children in case planning, CFSR Item 14 frequency and quality of visits between caseworkers and child, CFSR Item 15 frequency and quality of visits between caseworkers and mothers and fathers, CFSR Item 16 educational needs, CFSR Item 17 physical health needs, and CFSR Item 18 behavioral health needs.

Select Health Network Adequacy Review

- DSS will review the annual External Quality Review Reports for Select Health to determine adequacy of the provider network and quality improvement plans to improve access
- DSS, DHHS and Select Health will meet once a year to review provider and network adequacy and capacity issues

- DSS will collaborate with DHHS and Select Health to determine network sufficiency, and implement mitigation plans for areas where service or provider capacity is limited

Out-of-Network Services

- DSS will collaborate with DHHS to create a report and roster that tracks services delivered to children in foster care who are either ineligible for Medicaid or utilize services that are not covered by Select Health's per member/per month rate including dental services, Medicaid waiver services and specialty care for medically fragile children among other out-of-network services provided to children in foster care. DSS and DHHS will use the report to recommend changes or improvements needed.
- DSS will identify the appropriate role for DSS caseworker where out-of-network services are necessary and train caseworkers accordingly.

Timeframe: Current through December 2018 to establish basic understanding of methodologies used with annual review thereafter, Network Sufficiency and Topical Studies planned through June 2019

Child Health Goal 4: Each child in foster care has improved health outcomes

DSS is committed to improving the health outcomes for children in its custody. Under the FSA, DSS committed to targets related to initial assessments, comprehensive assessments, and timely follow-up care. DSS also intends to track the health outcomes of the children and youth in its custody. Specifically, DSS will collaborate with its Foster Care Health Advisory Committee (FCHAC) experts, DHHS and Select Health, to determine key outcomes it should track, including those identified by the Academy of Pediatrics Bright Futures program. The targets will include outcomes such as percent % completed medical, mental health and dental initial assessments within X days, % completed assessments within X days, % follow-up visits completed within X weeks, % completed immunizations, % vision and hearing screenings conducted, etc. DSS and Select Health performance will also be benchmarked against HEDIS targets and compared to children served by Select Health who are not placed in foster care. DSS will refresh its measures and targets, collect baseline data and produce an annual report showing work underway and over time to improve from baseline.

Child Health Goal 4: Elements of a Work Plan

Task Lead(s): DSS Office of Child Health and Well-Being and the Office of Data, Reporting and Accountability

Key Activities/Deliverables:

- Develop proposed set of child health outcome benchmarks and targets similar to those in the Center for Health Care Strategies’ report “Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit” (Allen, 2012).
- Convene FCHAC in facilitated working sessions to review proposed benchmarks and targets
- Finalize benchmarks and targets
- Review/refine annually
- Publish annual report on health status of children and youth in foster care

Timeframe: FCHAC will convene each year in Spring and Fall to review annual performance against benchmarks and targets. The initial review will begin by April 2019.

VI. Child Health Plan: System Components

DSS also translated its commitments in the FSA and the recommendations of the consultants into three key system components. The key system goals speak to the core operating elements of an effective health care system for children in foster care.

Component 1.	Establish the Office of Health and Well-Being and define Internal and External Roles and Responsibilities and build into a sustainable governance structure that provides direction and oversight of initial Health Plan implementation and thereafter ongoing review.
Component 2.	Build out the capacity to collect, analyze, disseminate and use administrative data to drive child health outcomes (including central and field-facing quality improvement processes, incident review and adverse event monitoring and monitoring of network adequacy).
Component 3.	Develop practice guidance, policies and training for the field, birth families, foster parents and contract, placement and treatment providers.

System Component 1. Establish the Office of Health and Well-Being and define internal and external roles and responsibilities developing a sustainable governance structure that provides direction and oversight of Health Plan implementation and ongoing review.

A. Establish the Office of Health and Well-Being

DSS is principally responsible for implementation and oversight of the Plan through the recently created Office of Health and Well-Being within the Division of Child Welfare. The Office is responsible for child and adolescent health, child and adolescent clinical and behavioral health through the IFCCS, therapeutic foster care, specialized treatment services, oversight and monitoring of psychotropic medication, child and adolescent education services and provide support for the Foster Care Health Advisory Committee (FCHAC). This office will develop health and behavioral health policies, procedures, protocols, and practices designed to achieve safety, permanency, and well-being outcomes for children and families. It is also responsible for developing, with internal and external partners, health, behavioral health and other well-being measures and performance targets. This Office has primary responsibility for implementation of this Plan.

The Office is currently staffed with a Director hired in April 2018¹⁴, a Consultant Psychiatrist, Lead Clinical Specialist, and Intensive Foster Care and Clinical Services Administrator. The Director is responsible for building out, refreshing and rolling out all DSS health and behavioral health policies and practice protocols, data reporting and quality assurance and the operation of this new office at DSS. The scope of the reforms underway in foster care will require the Director to provide health and behavioral health leadership and support to related Department activities including guidance on the health and behavioral health components of the case practice model being developed by Chapin Hall, implementation of the CSFR PIP, and the development of the Foster Care Placement Plan. In this capacity, the Director serves as the liaison to DHHS, DMH, Select Health and other external Health Plan implementation partners and stakeholders, is a member of the DSS Foster Care Leadership Team and sets strategy, goals and performance targets for health and behavioral health services for children in foster care, attends the Joint Council on Children and Adolescents, leads in the development of department health and behavioral health priorities, policies and practice and leads on the implementation management of the Health Plan. The Director also sets the agenda for the Foster Care Health Advisory Committee, interfaces with USC and internal partners on the bi-annual capacity and network adequacy survey, coordinates the DSS response to the well-being quality improvement components of the CSFR PIP (Program Improvement Plan), which includes physical and behavioral health of children in foster care.

The Child Psychiatrist's responsibilities include psychotropic medication oversight, clinical consultation for regional clinical specialists and other field staff, tracking and follow-up on high

¹⁴ Position Description in Appendix, Section 5.

need cases (children receiving psychotropic medication, polypharmacy and children < 6), development of protocols for informed consent, enhanced clinical health care and psychopharmacology and behavioral health basic training for DSS and IFCCS casework staff and supervisors.

The Lead Clinical Specialist's duties include providing guidance or specialized clinical assistance to field staff serving children with significant behavioral health needs, oversight of the psychotropic medication management process for youth in psychiatric residential treatment facilities, project management for the implementation of the health and education passport, managing the roster of high needs/immediate needs children and cadence calls to staff cases for follow-up, and provision of field training to DSS caseworkers and supervisors on health and behavioral health policy and practice.

The Intensive Foster Care and Clinical Services Administrator (IFCCS) develops policies procedures and practices to enable the 110 IFCCS caseworkers achieve safety, permanency, and well-being outcomes for children in need of intensive foster care and clinical services, coordinates the rostering, staffing and follow-up for complex behavioral health cases, participates in community, governmental, and educational activities representing the Child Welfare Services Program, provides input on program related issues, and provides content for IFCCS worker Basic Orientation Training.

Given the significant expansion of duties in DSS's new Office of Health and Well-Being, and the need for deep engagement of other state agencies, stakeholders and partners tied to successful implementation of the Health Plan, DSS will evaluate the need for additional staffing and the phase-in of any additional staff, including additional clinical staff. Detailed information regarding the plan for additional staff will be included in the care coordination and healthcare case management framework discussed above, to be completed by March 2019. One area of consideration will be the addition of up to three Clinical Specialists, including pediatric nurses, who could serve under the supervision of the Lead Clinical Specialist and Chief Medical Officer to enhance training, support and consultation to DSS and IFCCS caseworkers and supervisors, interface with health care providers and support the rostering, tracking and follow-up work needed by high-needs and medically complex children. Another functional consideration will be for up to three staff to build out the team responsible for data analytics, rostering and monitoring and quality and performance improvement, support PIP implementation and quality improvement activities. The preliminary budget model was prepared for submission to the Co-Monitors in May 2018 and is currently under review.

The DSS Office of Health and Well-Being has a lateral relationship with the DSS Director of

County Operations to whom all regional and county foster care operations report and the Director of Data, Accountability and Research who produces and analyzes data for DSS. The Office will have functional authority over all policies and procedures related to healthcare and will also serve as clinical advisor to the entire Division of Child Welfare. County and regional operations will be expected to coordinate efforts with the Office of Health and Well-Being to implement the elements in this Plan.

B. Define External Roles and Responsibilities

For the Health Plan to be successful, DSS must collaborate closely and in partnership with multiple state agencies including DHHS, DMH, and Select Health, the MCO that serves children in foster care. DSS and DHHS are lead agencies for the purpose of Health Plan activities. Weekly planning and implementation meetings began in April 2018. SCDMH serves in both a key provider and partner role. Select Health is central to the provision of health and behavioral health services to children in foster care and DSS has reset its relationship with DHHS and Select Health and the three entities are meeting, planning, problem-solving together.

DHHS

The South Carolina Department of Health and Human Services (DHHS) operates, among other activities, the state's Medicaid program and is an essential partner with DSS in ensuring that the health care needs of children in foster care are met. DHHS manages Medicaid eligibility and enrollment; determines covered services; pays for covered services; holds the contract with the managed care organization (MCO) that serves these children and provides fee-for-service payment for medical, behavioral or dental care to a small number of children in foster care with complex needs. DHHS is the state agency that is responsible for federal Medicaid requirements, including implementation of the state Medicaid plan, Home and Community-Based (HCBS) waiver services.

SCDMH

The South Carolina Department of Mental Health (SCDMH) has 17 community mental health centers operating over 60 clinics, with at least one clinical location in every County. The agency operates two psychiatric hospitals, Bryan Psychiatric Hospital in Columbia and Harris Psychiatric Hospital in Anderson, as well as a specialty hospital for substance use disorders, Morris Village, in Columbia. The Department's Bryan Psychiatric Hospital includes the William S. Hall Psychiatric Institute, which consists of three separate hospital units for children and adolescents:

- a latency age hospital unit for patients ages 4 to 12;
- an adolescent unit for patients age 13 to 18; and
- a substance use disorder unit for adolescents age 13-18.

DMH Community Mental Health Centers provide outpatient mental health services, including when needed psychiatric services and medication management. Staff are trained and practice trauma-informed care, and SCDMH Mental Health Centers offer a number of other evidence-based interventions, such as school mental health services. In the 2017–18 school year, SCDMH Mental Health Center therapists provided clinical services in over 600 schools across South Carolina.

Select Health

In recognition of the fact that foster care children require a more comprehensive, coordinated healthcare delivery model that promotes better access and improves health outcomes, in November 2012, DSS and DHHS announced the Foster Care Health Initiative, a collaborative effort to better address healthcare delivery to foster care children. As the legal custodian of children in foster care, DSS determined that it is in the best interest of foster children to be enrolled in a single MCO that could coordinate their care in both their routine health care needs and the special needs that arise for children who have been abused, neglected and placed in state custody. As a result of this initiative, all foster youth, with few exceptions, are enrolled in First Choice by Select Health of South Carolina, a Managed Care Organization. Specific core benefits and service requirements are set forth in Section 4 of the DHHS and Select Health MCO contract. Select Health is paid through a capitation rate, a “per member/per month” fee of \$950.75 for each child in foster care. The rate has been adjusted to meet the special needs of children in foster care. In addition to screening, assessment, treatment and follow up, Select Health is also required to provide care management that meets national standards.¹⁵

C. Develop Governance Structures and Routines

Development and implementation of the Plan will require a tiered governance structure led by DSS with DHHS to keep the lines of communication open, to resolve issues that may arise and to establish accountability mechanisms for DSS internal; cross-agency; and external partners. The governance structure being utilized by DSS to develop and implement the FSA and the Plan are described in the table below. The structures include both internal decision-making groups, and external advisory groups. As part of its priority actions, DSS has recently created a cross-agency SWAT team that meets weekly on implementation issues. This group has proven critical to gaining traction on important cross-agency issues, particularly as it relates to DHHS’ role as

¹⁵ Detailed contractual requirements for Select Health in Appendix, Section 4.

contract manager to Select Health.

But more than a SWAT team, this plan requires the establishment of, and routine meetings by, a set of new governance bodies, as described below, as well as the continued convening of an outside advisory group. The table below identifies the set of governance groups DSS is convening to implement the Plan. Over time, groups like the SWAT team will be converted to routine governing bodies that meet on a regular basis to oversee and monitor the ongoing health functions described in this Plan.

The table below sets forth the governance structures (including internal “cadence” structure) that DSS will utilize to design, track and implement the Health Plan.

Governance Level/ Group Name	Members*	Responsibilities	Meeting Frequency
Internal/ Cadence Team	<ul style="list-style-type: none"> • Office of Child Health and Well-Being • DSS Division of CW (includes program support, IT, etc.) • Regional and County Operations 	Operations group of Executive Team and Regional Directors for day-to-day management, system and operations planning and system-wide health-related oversight.	Weekly
Internal/Regional	<ul style="list-style-type: none"> • Regional Directors • County Directors • Performance Coaches 	Regional directors share data, identify outliers, and gaps.	Weekly
Internal/ Supervisors	<ul style="list-style-type: none"> • County supervisors • Caseworkers 	Discuss data, identify outliers in unit cases; flag cases for staffing and follow up.	Weekly
Cross-Agency/ SWAT Team	<ul style="list-style-type: none"> • DSS • DHHS • Select Health 	Operations group to coordinate, track and trouble-shoot all aspects of data and analytics to support health care for children in foster care. Develop outlier reports and flags for higher needs children. Develop and track system performance and quality reports.	Weekly

External/Foster Care Health Advisory Committee¹⁶	<ul style="list-style-type: none"> • DSS • DHHS • Foster Care Health Advisory Committee • Select Health • SCDMH • Health and Behavioral Health providers, practitioners and organizations, including QTIP and Federally Qualified Health Clinic representatives 	Advisory group co-Lead by DSS and DHHS; provides consultation on issues as needing; for example, Access to Care; trauma-informed Care; Medical Assessment.	Quarterly
*Governance group lead in red			

Although successful implementation of this Plan will be a collaborative effort, DSS is principally responsible for its oversight. Three other entities will play a major role in implementation of this Plan: DHHS, Select Health, and the South Carolina Department of Mental Health. Key leads from DSS, DHHS, and Select Health have convened weekly meetings, which will continue throughout the implementation of this Plan. The purpose of these meetings is to develop and revise this Plan, where necessary, monitor implementation, troubleshoot and resolve issues and conflicts that arise.

External partners and stakeholders will serve in an advisory capacity related to implementation issues. The Foster Care Health Advisory Committee (FCHAC) will be instrumental in implementing and monitoring fidelity to the Healthcare Plan. This is an existing committee charged with helping children in foster care have effective and coordinated medical and mental health services and is comprised of a broad representation from the medical and behavioral healthcare fields statewide, including nurses and pediatricians from various clinics, Select Health representatives, Child Advocacy Centers, Department of Mental Health (SCDMH), private community-based Licensed Independent Professionals (LIPs), Palmetto Association for

¹⁶ The FCHAC is comprised of representatives from the medical and behavioral healthcare fields statewide, including nurses and pediatricians from various clinics, Select Health representatives, Child Advocacy Centers, Department of Mental Health (DMH), private community-based Licensed Independent Professionals (LIPs), Palmetto Association for Children and Families, Therapeutic Foster Care agencies, Group Care and Rehabilitative Behavioral Health Services (RBHS) providers, and Foster Parent support agencies.

Children and Families, Therapeutic Foster Care agencies, Group Care and Rehabilitative Behavioral Health Services (RBHS) providers, and Foster Parent support agencies.¹⁷ DSS and DHHS will partner together to lead the quarterly FCHAC meetings. DSS expects to reorganize the FCHAC to focus more directly on achieving the healthcare targets set forth in this Plan. The FCHAC has reviewed the draft Plan and discussed it at its June 26, 2018 meeting.

System Component 1: Elements of a Work Plan

Task Lead(s): DSS Office of Child Health and Well-Being

Key Activities and Deliverables

- DSS will develop a working protocol for its internal governance activities including guidance to the field: health data report production and dissemination, cadence calls, follow-up and oversight tracking
- DSS will collaborate with DHHS to develop a data-sharing agreement and schedule for reports
- DSS, DHHS and SH will collaborate to develop a process for data sharing
- DSS, DHHS and SH will collaborate to develop a protocol for resolution of child or provider specific issues
- The Office of Health and Well-Being will work with the Office of Data, Research and Accountability to develop health data management reports and guidance to the field, data analytics, technology solutions through CAPSS

Timeframe: Work has already begun on establishing structures. Governance protocols complete by December 2018; Health Data Management Reports January 2019

System Component 2: Build out the capacity to collect, analyze, disseminate and use administrative data to drive child health outcomes

The Plan's success rests on DSS capacity to collect, analyze, disseminate and use administrative and case data to improve health care services to children in foster care, improve field operations and see that children in foster care receive quality care. While DSS is ultimately accountable for meeting the health needs of children in their care, it depends on a strong partnership and collaboration with DHHS and Select Health to meet its obligations to children.

¹⁷List of FCHAC Members in Appendix, Section 7.

Key components of the Plan Are built on a data-sharing agreement to be developed between DSS, DHHS and Select Health to:

- Program automatic uploads and facilitate completion of CAPSS records for each child
- Flag, roster, track and follow-up on children identified with immediate needs
- Provide timely screening and assessment
- Identify children in need of IFCCS or Select Health Intensive Care Coordination
- Allow for a targeted focus on the health and behavioral health care needs and follow-up of children in foster care
- Formalize channels of reporting and accountability

As described earlier, DSS and DHHS are collaborating to develop a system-wide database and report that captures health and behavioral health measures for each child in foster care and can be aggregated by region, county, supervisor and caseworker. Work is also underway to formalize this data-sharing agreement by December 2018. The data agreement will cover sharing data needed to populate CAPSS, data access permissions and restrictions and will include a data dictionary, list of monthly, quarterly, annual or more frequent population health reports (more than one medication, immediate needs, etc.) and other elements.

The Plan contemplates three components of its data and quality improvement system, including a component related to continuous case- and management-level data; immediate need (IN) data as defined in the FSA; and quality improvement. They are described below.

A. Strengthening Use of Case-Level Data and Management-Level Data

DSS and DHHS have begun to link their data to create a synchronized roster of eligible children and are working now to move any remaining children who are not coded as “foster care” into that status. Medicaid claims, service and utilization data from the DHHS system of record and Select Health should populate, along with other ancillary information, the official CAPSS health record for all children in foster care. This is not only important for children while they are in foster care but will provide critical medical history that can follow children once they transition out of foster care. While we understand that setting up a data-sharing exchange will take time and the patience of all involved, it presents an opportunity for South Carolina to be a national model with respect to the health of children in foster care. Given the importance of data to the Plan, DSS is developing a clinically and analytically-oriented data team tasked to work with DHHS and Select Health, related departments at DSS and other affiliated entities. This team will work with other DSS departments to develop dashboards, report templates, inform the quality improvement process and assist with implementation of the DSS CSFR PIP.

Continuous case-level data will mean that a child's case record will be up-to-date as far as whether a child has received appropriate screening and assessments, and any routine, urgent or emergent follow-up care. To accomplish this, DSS county and IFCCS workers will continue to populate CAPSS with information on screenings, assessments and follow-up care as they are currently doing. In the short-term, follow-up care will be documented monthly in case notes. Over the long-term and beginning in March 2019, DSS will collaborate with DHHS and Select Health to determine which data from providers' electronic health record or Medicaid data can auto-populate the DSS CAPSS record. Additionally, DSS will collaborate with DHHS and Select Health to review utilization data to determine which health episodes, if any, for example a trip to the emergency room, should trigger immediate provider contact with Select Health, followed by immediate notification to DSS. Notification of emergency room visits, or injuries identified during a routine health visit can serve as a proxy for identifying maltreatment in care and so should likely be an important immediate notification flag. Over time and as needed, other immediate notifications or red flag reports will be developed between DSS, DHHS and Select Health.

Continuous management-level data will mean that DSS county, regional and central leaders will have regular data reports on key practice and child health indicators, such as percent of children with timely screenings and assessments or utilization of behavioral health services by children placed in congregate care. These reports will identify certain gaps in care reports that DSS, DHHS and Select Health will use to routinely monitor child health outcomes and field-level performance.

Missing Initial Assessment A missed initial medical, dental or behavioral health assessment becomes an immediate treatment need. DSS began tracking these missed initial assessments in June 2017. Immediate need reports are pulled weekly and reviewed with child welfare leadership Fridays and cadenced with regional health care liaisons on Mondays. The process for staffing immediate needs cases, follow-up activities and monitoring completion of follow-up activities are outlined on page 48 of the Plan.

DSS has begun receiving Medicaid claims and encounter data and tests it against CAPSS data for accuracy and reliability. Using the initial cohort defined in the FSA, DSS is testing a process to cross-reference the two data sets, identify nuances in the data that may require further clarification (medically fragile children who may be unable to participate in a behavioral health initial assessment, healthcare providers who do not bill Medicaid for services provided or batch claims, and claims that may have a lag time), and where it appears certain that a health, behavioral health or dental initial assessment should have been scheduled and was not, provide instruction to the field to immediately schedule the missed initial assessment. Once DSS has refined and streamlined the new gaps in care/utilization report and cadence process, it will

begin using it for the FSA cohort--all children who entered care during CY 2017 and are still in care which is a shift in the definition outlined in the FSA. DSS has developed a standardized reporting format that will enable the caseworkers to report back to the Regional Health Care Coordination Liaisons and for the regional liaisons to report back to the Office of Health and Well-Being in weekly calls. DSS will use its cadence governance process and the gaps in care report to routinely monitor and follow-up on initial assessments, missing assessments and other immediate needs.

Gaps in Care/Utilization

The definition of immediate treatment needs includes, '[a]ny diagnosis that requires follow-up with a medical, mental health, and dental provider outside of the child's normal routine periodic assessments.' To better identify and address unmet need, DSS has asked DHHS and Select Health to prepare gaps in care/utilization reports based on HEDIS (Healthcare Effectiveness Data and Information Set) measures. HEDIS measures are a widely used set of performance measures in the managed care industry developed by the National Committee for Quality Assurance (NCQA). Generally, HEDIS measures address a broad range of important health issues and represent nationally agreed upon practices to improve healthcare quality. Select Health routinely distributes these gaps in care reports to its network providers to identify members or providers who failed to meet a particular HEDIS measure.

In April 2018, DSS compiled a list of the most common diagnoses and conditions for children in foster care and sent this list to DHHS. From that list, DHHS and Select Health selected HEDIS measures that aligned most closely with the identified diagnoses and conditions deemed important. This list was further refined and expanded with the assistance of a HEDIS expert at DHHS and Select Health's current and former medical director and corporate quality assurance director. The current list includes the HEDIS measures below.

The gaps in care/utilization reports serve as a roster and based on the HEDIS measures tracked, will identify children who require follow up, as required by the immediate treatment need definition; those who are and those who fall below an established HEDIS parameter. The report will also identify lack of access to more preventative health care services such as immunizations, well-child visits, and weight assessment. The gaps in care data can also be queried and organized to produce focused reports on utilization or access challenges by region, by placement type (TFC or congregate care), by diagnosis and by provider, among others. The data can be queried to identify providers who are not adhering to DSS, DHHS or Select Health prescribing standards. DSS and DHHS anticipate producing the first set of gaps in care reports in August 2018.

HEDIS Measures to be Included in Monthly Gaps in Care Report		
Abbreviation/Measure	Measure Description	Notes
CDC—Comprehensive Diabetes Care	Used to determine if patients age 18-75 with Type I or Type II diabetes received proper testing and care for diabetes during the measurement year.	This diabetes measure will be reported for all children in foster care with age restriction removed (blood pressure <140/90, HbA1c<9, dilated eye exam, and nephropathy screening). Note this measure is dependent on record review.
AMR—Asthma Medication Ratio	Paid pharmacy claims are used to determine if the patient is filling more rescue medication compared to total asthma medication. An AMR less than .5 is a strong indicator that a patient may benefit from a discussion about current medication usage.	This will be reported with actual ratio for each child.
FUH—Follow-Up After Hospitalization for Mental Illness	Used to determine if patients age 6 and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, and intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Treatment is measured after a psychiatric hospitalization—7 days, best practice and 30 days to pass the measure.	
ADD—Follow-Up Care for Children Prescribed ADHD Medication	Pharmacy claims data is used to determine if newly prescribed (or restarted with sufficient break) ADHD for 6-12-year olds had at least three follow-up care visits within a 10-month period,	This will be reported with the age restriction removed.

	with the first visit being within 30 days of when first ADHD medication was dispensed. Best practice is to get all three visits.	
AMM—Antidepressant Medication Management	Used to determine if patients 18 years or older with a diagnosis of major depression who were newly treated with an antidepressant remained on the antidepressant medication for 84 days for the acute phase and 180 days for the continuation phase. Uses pharmacy claims data.	This will be reported with the age restriction removed.
CIS—Child immunization Status: Combo 10	Used to determine if children received immunizations. Includes 4 DTAP, 1 MMR, 3 HepB, 4 PCV, 2 or 3RV, 3 IPV, 3 HIB, 1 VZV, 1 HepA, 2 Influenza. PCPs also document vaccines in the SC immunization registry	
APM—Metabolic Monitoring for Children on Antipsychotics	Used to determine whether children 1-17 years old who are on an antipsychotic also had metabolic monitoring.	
APP—Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Used to determine if children 1-17 years old have psychosocial treatments prior to being prescribed antipsychotic medication. Antipsychotics are recommended as a second-line treatment option only after psychosocial interventions have been tried and symptoms are severe and persistent.	Measure only focuses on first appointment, not ongoing appointments. Later consider matching to DHHS claims data to determine if other psychosocial interventions being utilized.

APC—Use of Multiple Concurrent Antipsychotics in Children and Adolescents	Used to determine % of patients 1-17 on two or more antipsychotics concurrently in a 90-day period. Lower % is better.	Fine as is
IET—Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Used to determine % of patients ages 13 and older with a new episode of alcohol or other drug dependence who received initiation of AOD treatment (admission, outpatient visit, intensive outpatient, or partial hospitalization) within 14 days of diagnosis and engagement of AOD treatment after initiation with two or more services within 30 days of initiation visit.	
IMA—Immunizations for Adolescents	Used to determine if males and females turning 13 during the measurement year completed immunizations on or before their 13 th birthday: 1 MCV (on or between 11 th and 13 th birthday), 1Tdap (on or between 10 th and 13 th birthdays), and 3 HPV (on or between 9 th and 13 th birthdays) PCPs also document vaccines in the SC immunization registry	
W15—Well-Child Visits in the First 15 Months of Life	Used to determine if babies turning 15 months old completed six or more well-child visits before reaching 15 months of age In order to count, documentation must include evidence of: health history, physical developmental	

	history, mental developmental history, physical exam, and health education/anticipatory guidance	
W34—Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Used to determine children ages 3-6 who had at least one well-care visit with a PCP during the measurement year. In order to count, documentation must include evidence of: health history, physical developmental history, mental developmental history, physical exam, and health education/anticipatory guidance	
AWC—Adolescent Well-Care Visits	Used to determine if patients age 12-21 had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year	This will be reported with the age restriction removed.
WCC—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Used to determine if children age 3-17 completed a body mass index percentile, counseling for nutrition and counseling for physical activity. To pass, BMI percentile, height, and weight must be documented.	Note this measure is dependent on record review.

DSS acknowledges that tracking missed initial assessments in the gaps in care reports are the first step in addressing the FSA issue of immediate needs. It is also clear that tracking missed initial assessments is a first step. This leaves unaddressed the following portion of the agreed upon treatment need definition, “Additionally, should the required initial assessments or any routine periodic assessment identify a diagnosis, symptom, or condition resulting in an additional follow-up referral or treatment need, this is considered an immediate treatment need.”

The immediate treatment needs report will ultimately be a combination of multiple data elements that will be tracked in an enhanced gaps in care report. It will include HEDIS measures, diagnoses, AAP data standards, and other national child welfare health, behavioral health, and dental measures. To this end, DSS will develop additional reports, request additional more specific claims data, and conduct case reviews with some regularity in the first year of Plan implementation. However, no combination of DSS and Medicaid data alone will be sufficient to address this portion of the definition. DSS will develop, pilot, and implement a robust care management and coordination process to distribute the data, follow-up with providers, caseworkers, birth families and foster parents, and to see that follow-up care is identified and provided. DSS has developed a new protocol internally to identify and address missing initial assessments, comprehensive assessments and follow-up, outlined on page 48.

DSS is collaborating closely with DHHS and Select Health, to build out this data and tracking system, define specific roles and responsibilities for each entity, identify existing resources such as a staff person on loan from DHHS to assist DSS with Medicaid data management and analytics and evaluate the need for additional resources for consideration in a future budget request.

Going forward, DSS anticipates producing or receiving, at a minimum the following data from DHHS, Select Health or DMH on a routine basis, every 30-60-90 days:

- Claims and encounter data related to medical, dental, and mental health initial assessments for all Class Members
- Psychotropic medication red flag data for all Class Members
- Gaps in Care/utilization reports for all Class Members; rosters of all Class Members with Immediate Needs or needing follow-up services (discussed in detail below)
- Weekly cadence and completed follow-up notification reports that flag and roster children with no or partial initial assessments, assessment and follow-up on immediate and other needs

B. Build Data Capacity Related to Immediate Treatment Needs as Defined in the FSA

In the FSA, DSS committed to submit information on the status of initial medical, dental, and mental health assessments for Class Members in an identified cohort. In addition, DSS committed to submitting data related to the immediate treatment needs of Class Members in the same cohort. Accomplishing this required a significant amount of capacity building. Initially, DSS did a significant amount of CAPSS development to build fields for this data, caseworker training to capture this data, and data input. Ultimately, DSS, with the assistance of the healthcare consultants, determined that this method was too burdensome on the

caseworkers and not the most reliable method. Instead, DSS began collaborating with DHHS and Select Health to capture this information through claims data.

Recently, DSS received its first initial health assessments report from DHHS for calendar year 2017 for all children in the original FSA cohort and those who entered care in 2017. And, as noted in earlier in Section IV, DSS received its first batch of gaps in care reports in April 2018 which was designed to show the children that need some type of follow-up care. DSS, DHHS, and Select Health continue to refine the methodology for capturing this data, and upon agreement to the best approach, DSS will begin receiving these data on a monthly basis.

Additionally, DSS is developing a protocol for distribution and follow-up on this data as described below. Now, with this new, more reliable method of tracking initial health assessments and other health care utilization, DSS will be better equipped to meet the healthcare needs of children.

The development of management structures and practices is the key to leveraging the value of this data. Building on the governance processes described in the Plan, DSS has built out an Immediate Treatment Need/gaps in care follow-up process to link data reports with follow-up care management. The timing, work flows and management hierarchy will be implemented in August 2018 and is described below:

1) Leadership Cadence Calls--Fridays

- DSS Leadership holds “cadence calls” Friday mornings.
- Friday calls are with child welfare services leadership: Deputy Director Child Welfare Services, Regional and County Operations Director, Safety Management Director, Permanency Management Director, Child Health and Well-Being Director, Performance Management and Accountability Director, Director of Data, Reporting and Accountability, and Regional Directors.
- Data is presented at the state and regional level. Staff present percent and number of missed initial assessments by type—medical, mental health, and dental.

2) Individual child level cadence calls--Mondays

- Regional Healthcare Liaisons for each region have “cadence calls” each Monday with Child Well-Being Staff. These liaisons may be performance coaches, data coordinators, or other staff chosen by the Regional Director. Two are chosen for each region.

- Office of Child Well-Being Staff send spreadsheet lists to liaisons monthly. The liaisons break down the regional list and email individualized lists to each foster care case manager who has a child on the list. The county director, supervisor, and program coordinators are copied on the email.
- Foster care case managers review case files and determine if documentation, follow-up appointments, or case staffing is needed. Foster care case managers report that information back to liaisons.
- During the Monday cadence call, questions and common themes are discussed. Office of Child Well-Being staff gather lessons learned and address systemic barriers. The group works together to continually improve the process.
- Liaisons report back to Office of Child Well-Being staff on a standard spreadsheet on what was found during the file review:
 - Appointment occurred, documentation found in case file: If only a date was entered, the case manager reports any documentation located in the case file. This documentation may include an uploaded linked file or dictation.
 - Appointment occurred, documentation not in case file: If a date was entered, but no documentation is in the case file, foster care case managers can get documentation (such as a discharge summary, patient plan or after visit summary) from the provider. Until documentation is provided, liaisons report on the status of getting documentation in CAPSS.
 - Appointment needed: If there is no evidence that an appointment occurred, then the foster care case manager schedules an appointment and lets the liaison know the date of the appointment. Once an appointment date is scheduled, the appointment is entered in CAPSS for follow up and monitoring.
 - Staffing needed: In cases where a decision needs to be made such as a psychotropic red flag issue, a staffing may need to be scheduled. Each child is followed until the staffing has occurred and a decision has been made.
- For physical health care issues, each child is tracked until documentation is provided in CAPSS that a staffing or a follow-up appointment occurred, whichever is later.
- For psychotropic medication issues, each child is tracked until documentation is provided in CAPSS that a satisfactory staffing occurred with a Regional Clinical Specialist and/or DSS Psychiatrist or a follow up referral appointment occurred with a specialist such as a psychiatrist, whichever is later. For example, a child

on multiple psychotropic medications may be staffed and need an appointment with a psychiatrist. The child would be followed until the appointment with the psychiatrist was complete.

DSS is hopeful that the above processes will allow it to use the data available on children in its care for the benefit of better health care access and outcomes.

C. Strengthen Continuous System-level Quality and Performance Improvement Capacity

At the same time that DSS caseworkers and managers are creating routine access to health care data and that DSS is meeting its commitments related to immediate treatment needs under the FSA, DSS is also collaborating with DHHS and Select Health to coordinate and enhance its continuous system-level quality and performance improvement capacity. This enhanced capacity will track system-wide care quality, investigate adverse events, and review case records among other continuous quality improvement (CQI) activities and use this information to improve policies, practice and staff and foster parent/caregiver/birth family training. The elements of a broad quality improvement system will include several elements:

1. Regular Reporting

- A. Quarterly review of DSS/DHHS/Select Health initial assessment and comprehensive assessment data** derived from the standard assessment tool that DSS, DHHS and Select Health will identify and use for children and youth in foster care. The use of a standardized tool should allow DSS to develop a comprehensive understanding of the needs of children and youth in its care. These reports will be generated by county and region and will compare quarter-over-quarter performance. DSS will establish performance targets and develop and monitor corrective action plans.
- B. Annual Child Health Data Measures Review** (HEDIS and others) will be conducted annually to monitor statewide, regional and county improvements in child health outcomes and to monitor adverse events. This will roll up into an annual report on the health of children in foster care.

2. Performance Monitoring and Review

- A. Ongoing Select Health Data Reports and Processes.** Select Health produces a number of daily, weekly, monthly, quarterly, annually and ad hoc reports for DHHS. These reports run the gamut from claims verification, encounters (services

provided, by date), member and provider characteristics to claim payments. DHHS uses the data from Select Health to evaluate access to care, availability of services and quality of care. DHHS also uses this data to assess the cost-effectiveness of Select Health and its performance by validating actual service utilization and determining whether federal Medicaid reporting requirements have been met. Encounter validation is done by comparing utilization data against health records and reviewing data from other sources. DHHS conducts a minimum of one site visit to Select Health annually and conducts independent audits every three years.

By contract, Select Health must comply with Quality Assessment and Performance Improvement (QAPI) standards established by DHHS and must meet NCQA (National Committee for Quality Assurance) health plan accreditation requirements. In order to meet these robust state and federal mandates, Select Health must have an approved continuous quality improvement program, called a QAPI. Central to the terms of the QAPI, Select Health must operate a Quality Assurance Committee that meets at least quarterly and is comprised of the Chief Medical Officer, quality improvement staff, representative health professionals, network providers with a primary care emphasis and pediatricians. The Select Health QAPI Plan also requires a significant amount of data tracking, health outcomes and performance review and the development of corrective action for any problems identified. Data tracking includes specific statewide and regional utilization and quality and access measures such as over/underutilization, and care quality and appropriateness for all members specifically, members with special health care needs.

The CQI process in place between DHHS and Select Health includes quarterly performance review meetings and the development of Performance Improvement Plans (PIPs) focused on clinical and non-clinical areas of operation when warranted. Progress on PIPs is reported to DHHS annually. In addition to the QAPI Plan and CQI process, Select Health is also subject to a HEDIS compliance audit and regular reporting on Child Core Quality Measures. Select Health is held to a high standard of performance and is subject to fines, established by DHHS if they fail to meet quality and contract requirements.

Select Health also conducts an annual member satisfaction survey of all members using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) from the US Agency for Healthcare research and Quality (AHRQ), CAHPS Health Plan Survey required by NCQA for accreditation annually by July 1st. Significant levels of member dissatisfaction triggers CAPs (corrective action plans). DSS in conjunction

with DHHS and Select Health will meet annually to review provider quality and performance.

B. Annual Services Review will review the availability, utilization and types of follow-up or specialty services received by children and youth in foster care, episodes of service for children in foster care compared to other South Carolina children enrolled in the Medicaid or CHIP programs. This report will be informed by the network capacity study conducted DHHS/Select Health and by USC, if appropriate. This review will also include a review of grievances and appeals to Select Health and DHHS that reflect adverse incidents or service decisions.

C. Annual Topical Reports will be special reports identified and developed annually by DSS, DHHS and SH to examine key child health issues, such as the use of psychotropics medications by children in foster care; or the prevalence of depression for children in foster care; teen pregnancy; substance misuse or early childhood development. The point of these reports will be for the purposes of developing better system knowledge and capacity related to key child health issues.

3. Case Record Review

Beginning in July 2018, as noted above, DSS will use the case record review component of the CFSR to identify strengths and limitations in its practice around the health and behavioral care for children in foster care. The Office of Health and Well-Being will be responsible for implementing the health and behavioral health components of the PIP including ongoing CQI efforts and monitoring the health-related elements of the case record review. The review will be used as a way to verify administrative data but also to identify more qualitative issues that are not as easily discerned from aggregate data sets. The case reviews, done in tandem with family and child satisfaction surveys, and potentially child and family interviews, will provide a comprehensive view of health care for children in foster care.

4. Annual Family and Child Satisfaction Survey

Conducted by Select Health, the survey will be anonymized, aggregated and shared with DHHS and DSS to ascertain feedback on service access and effectiveness. Consideration will be given to oversampling foster families and youth in care to ensure a strong response rate and generate more useful data.

5. Development of Workplan, Measures and Targets

DSS will develop an implementation workplan with timeframes and task assignments incorporating all Plan implementation activities by late August 2018. The workplan will

include the development of a process to select, track and report out performance and quality measures tied to established benchmarks and improvement targets by November 2018.

System Component 2: Elements of a Work Plan

Task Lead(s): DSS Office of Child Health and Well-Being and Office of Data, Reporting and Accountability

Key Activities & Deliverables

- Include capacity in the DSS budget to increase capacity to manage and analyze data (e.g., Medicaid claims data, CAPSS data; Select Health gap in care reports, etc.) and produce actionable dashboards and reports that can be disseminated to caseworkers, supervisors and Regional Directors. DSS will need analysts who are familiar and comfortable working with large administrative data sets
- Produce new reports and annual studies that highlight emerging capacity, quality, access and coordination issues
- Establish a process for DSS and DHHS to review Select Health quality and performance annually
- Develop a process for DSS to assess the performance of its casework staff in securing necessary health care information for children on their caseloads
- DSS to get aggregate member satisfaction data from Select Health annually and develop corrective action plans and mitigation actions to address issues that arise

Timeframes: Quality and performance improvement data, dashboards and reports to be issued monthly, quarterly and annually beginning November 2018.

System Component 3: Develop practice guidance, policies and training for the field, birth families, foster parents and contract, placement and treatment providers.

Implementation of the Plan will require developing new practice guidance for the field, as well as accompanying policies and training. Although the Plan is focused on the health of children and youth in foster care, the case practice contemplated by the Plan focuses on the state's responsibilities related to safety and permanency, and also on the state's capacity to improve

child and family well-being. Through a lens of improved child and family well-being, the Plan envisions child welfare case practice that considers the strengths and needs of children, youth and their families from the first-time contact is made with them. In other words, from the moment of contact, caseworkers consider not only what is needed to promote child safety, but how the child welfare system, if it stays involved with the family, can support improved family well-being while simultaneously helping children stay connected to their family and maintain placement stability, if a child is taken into care. With this as a goal, the Plan sets forth below the following approach to the development of system components related to health practice guidance, policies and training.

A. Development of DSS Health Practice Guidance

Under the FSA, DSS committed to a vastly improved child welfare system built on a number of core system and practice components, including focusing on the use and development of family-based placement resources rather than institutions, especially for young children; and on the importance of caseload sizes that allow for family visitation that supports both sibling connections and reunification. DSS is keenly aware that research has shown that children do better growing up with their own families or with substitute, permanent families; and that children and parents that visit more while a child is in foster care are more likely to be reunified.

The Plan described in this document is built on the promise of these (and other) critical practice system building blocks—better family-based placement resources and caseload sizes that support robust family visitation. The health care practices identified in this Plan will be integrated within the context of these improved core practice components being developed by the Department in conjunction with Chapin Hall. Specifically, to complement the child health goals described earlier, DSS will develop health practice guidance for the field that:

- County caseworkers collect information on child health and well-being from initial contact with a family and include it in the child’s case record; this is especially important for cases where children are not immediately removed but the caseworker believes they will substantiate abuse or neglect (in other words, cases where there is a chance that the child(ren) will be removed to foster care at a later date);
- County caseworkers include information about child health and well-being in the CSA, including use of the standardized assessment that DSS chooses to use to accompany placement resource requests;

- County caseworkers understand and know how to connect with either DHHS or Select Health for children if there is a likelihood that a child will need a higher level of care management from the start of a case (e.g., caseworkers will have practice guidance that helps them connect with DHHS or SH resources if they need help understanding a child's health at the start of an investigation and/or they need help developing the CSA);
- Regional Placement Units understand and know how to match children to placements that can support their health needs, including seeing that children placed in congregate care settings (group homes and residential facilities) have the health and behavioral health services and treatments that a child needs. This function will be revisited in the DSS Placement Plan and will build on important system practices like family team meetings and other ways to incorporate family voice and choice;
- Regional Placement Units work with county and IFCCS caseworkers to match children to the appropriate level of DSS and Select Health case management and care coordination;
- IFCCS and county caseworkers understand and know how to incorporate their ongoing assessment and monitoring of child health and well-being in visits with children, placement resources (e.g., foster parents, group home child care staff) and birth families, including updating the child's case record on both routine child health matters (e.g., well visits) and any issues that require follow up;
- IFCCS and county caseworkers understand and know how to coordinate and collaborate with Select Health care coordinators, as well as DHHS for children who remain in the fee-for-service Medicaid program; and
- Regional and county leaders understand and know how to supervise as related to health care and well-being issues so that initial assessments and comprehensive assessments are completed timely and use data to manage case practice goals.

As discussed above, DSS will detail additional practice guidance and changes in its care coordination and health care case management framework to be prepared upon completion of the DSS Health Care Pilot and Process Review.

B. Development of Health-Related Policies

DSS will develop health-related policies that reflect the new practice guidelines identified above. Given that the Plan anticipates a pilot phase upon which many of the new practices associated with child health goals will be developed, the formalization of new policies will not occur until early to mid-2019. Policies already in place related to initial assessments and assessment requirements, as well as responsibilities of caseworker staff to track and monitor health and well-being will remain in effect as the pilot rolls out. New policies will build on current requirements with a focus of improving collaboration between DSS, DHHS and Select Health, as well as considering a child's health needs and incorporating them in the context of all placement decisions. DSS will also review, modify and, as needed, develop policies related to consent for treatment and the informed consent process. As discussed above, DSS will detail additional policy changes in the care coordination and health care case management framework to be prepared upon completion of the DSS Health Care Pilot and Process Review.

C. Training and Supervision

Training and supervision are foundational to the effective casework practice and improved operations that lead to improved health for children and youth in foster care. A complete overhaul of DSS's caseworker and supervisor health-related training, will not happen immediately. Rather, DSS will phase its review and modifications to training focusing initially on what will result in the most immediate results for improved child health. In this regard, collaboration with the Chapin Hall consultants developing the Department's case practice model and Training Plan and the Foster Care Health Advisory Committee (FCHAC), as well as the American Academy of Pediatrics (AAP), statewide QTIP network and foster parent association will be leveraged for more rapid feedback. In particular, DSS will engage these groups to determine what health-related training is essential for workers, birth families, foster parents and other placement resources and health and behavioral health providers. Because DSS will be simultaneously implementing and building an improved health care practice lead by the Office of Health and Well-Being and contemplated in the Chapin Hall practice model under development, its training will be organized into two buckets: short-term essentials, and longer-term system training components. The short-term health and behavioral essentials for DSS caseworkers and supervisors will focus on what needs to be done for children and youth to be timely initially assessed, assessed, and receive follow-up services so that any gaps in care are staffed and addressed timely. Longer term health training components will consider including additional modifications to new worker child welfare basic training; IFCCS worker Orientation Training; supervisory training; foster parent training; working with families; Select Health and DHHS training; and data and monitoring training.

Select Health is required by contract to provide educational information and materials for all enrollees. These materials can be used to inform DSS caseworkers, foster families and other caregivers about how Select Health serves its members and the responsibilities of SH providers and provider networks.

System Component 3: Elements of a Work Plan

Task Lead(s):

Office of Child Health and Well-Being

Key Activities and Deliverables

- Develop practice guidance consistent with the Health Care Plan, including clarity for case workers related to their own obligations to meet children’s health care needs; coordination with birth families, foster parents and placement providers on child health; and collaboration with Select Health care coordination on child health;
- Develop policies consistent with Health Care Plan; the policies will be informed by the Health Care Pilot and Process Review
- Develop/adapt training for caseworkers and supervisors related to new case management/care coordination processes and roles based on Health Care Pilot and Process Review (20 prototype cases)

Timeframes: Health training essentials will be identified by December 2018 and incorporated into the newly developed child welfare basic and IFCSS case manager trainings beginning in February 2019. Additional health-related training components will be identified by fall 2018 and rolled out by end of 2020. Health practice guidance and health policies will be developed following the Health Care Pilot and Process Review with initial roll-out to occur March 2019.

VII. Resource Needs

The South Carolina Department of Social Services (SCDSS) submitted a comprehensive, five-year budget plan (2019 – 2023) to the Court in May 2018 that includes the financial, staffing and other support the agency anticipates will be necessary to meet the performance targets required by the Settlement Agreement. The budget identifies estimated funding requirements for new positions, training, technology, rates, and services needed to facilitate the Implementation Plans associated with meeting Health Care Improvement requirements of the Settlement Agreement and to address budget requirements for each of the performance

targets. It is important to note the budget plan only includes new or increased costs to be incurred each year. It is expected that once costs are appropriated for a specific line item, those appropriations will be recurring in subsequent years.

To address the performance targets as part of the health plan, SCDSS anticipates the following costs in the fiscal years outlined below. SCDSS anticipates that many of the costs required as part of the healthcare and mental health plan will be absorbed through the South Carolina Department of Health and Human Services (DHHS) budget and DHHS’s managed care contract (MCO) for children in foster care. Determining the appropriate budget for Health Plan activities is an evolving and ongoing process. As specific costs are identified, the following budget will be updated.

Design of an Infrastructure for Tracking and Delivery of Health and Mental Health Services for Children in Foster Care		
Purpose	Amount	Budget Year
Contracts —Consultants to provide agency with support during plan implementation	\$90,000	2019
Training --Contract for standardized level of care assessment tool	\$30,000	2020
Training —Contract for continuing training for new staff on standardized level of care assessment tool	\$3,000 ¹⁸	2021
Staff —Office of Well-Being Staff, clinical specialists, and staff to monitor monthly initial assessment reports, psychotropic medication reports and gaps in care. Staff will also identify service array issues, and communicate those gaps to Select Health, develop standards for preferred providers, educate providers on best practices for children in foster care, identify paid and unpaid resources for families and children, and recruit providers when those providers are outside of Select Health’s network development goals.	\$2,360,582	2020
Staff —Salary increase for staff hired in 2020	\$73,031	2021
Staff —Salary increase for all recurring staff	\$76,757	2023

VIII. Appendix

1. **FSA Michelle H. Settlement Agreement—See attachment**
2. **Consultant Validation Report—See attachment**
3. **Placement Needs Assessment Baseline Study Final Report—See attachment**
4. **Select Health Scope of Work and DHHS Managed Care Contract—Selections below and full contract found here**
<https://www.scdhhs.gov/Portals/0/GI/g/h/g/hn/Lore%20h%20Ghi%20ham>
5. **Position Description for Director of Child Health and Well-Being—See attachment**

¹⁸ These costs will be adjusted to reflect actual costs of implementation, training and fidelity monitoring of a new assessment tool once the pilot is complete and a full care coordination plan has been developed.

- 6. DSS Child Health Fact Sheet—See Attachment**
- 7. South Carolina DSS Five-Year Comprehensive Budget Narrative—See attachment**
- 8. Foster Care Health Advisory Committee Members—See attachment**
- 9. DHHS and DSS Data Sharing Memorandum of Agreement**
- 10. Initial Assessment Data—See attachment**

1. FSA Michelle H. Settlement Agreement – Submitted as separate attachment

2. Consultant Validation Report – submitted as separate attachment

**3. Placement Needs Assessment Baseline Study Final Report – submitted
as separate attachment**

4. Select Health Contracted Scope of Work and MCO Contract

Memorandum of Understanding /
Letter of Intent

In particular, Select Health's care management system must do the following for all of its members:

- Develop programmatic-level policies and procedures for Care Management and Coordination of services.
- Use Care Management and Coordination as a continuous process for:
- The assessment of a Member's physical health, behavioral health and social support service and assistance needs,
- The identification of physical health services, behavioral health services and other social support services and assistance necessary to meet identified needs, and
- The assurance of timely access to and provision, coordination and monitoring of the identified services associated with physical health, behavioral health, and social support service and assistance to help the member maintain or improve his or her health status.

In addition, Select Health is required to develop a system for complex case management. In particular, Select Health must do the following as a part of its complex case management:

- Develop a detailed Program description for Complex Case Management
- Have policies and procedures for the assessment of characteristics and needs of its Member population (including children/adolescents, individuals with disabilities and individuals with Serious and Persistent Mental Illness (SPMI), and/or Serious Emotional Disorders (SED)).
- Have a Case Management System based on sound evidence.
- Have a systematic process for identifying Members with complex conditions and referring them for case management services.
- Determine the need for enhanced services that may be necessary for the member.

- Have a mechanism in place to allow a member direct access to a specialist as appropriate for the member's condition and needs.
- Have automated systems to support the case management staff.
- Have a Case Management System that provides appropriate documentation and follow up.
- Have a Case Management System with processes for initial assessment and ongoing management of members.
- Measure its performance and member satisfaction.
- Have procedures to improve performance when necessary.
- Have a process to review and revise care planning and case management at least once every twelve (12) months or when the members' circumstances or needs change significantly or at the request of the member.

In accordance with its contract and 42 CFR § 438.206, Select Health must possess a network of providers sufficient to provide adequate access to all services covered under its Contract.

- This section should describe the service array as exists now, and will need to exist.
- Describe Select Health's contractual requirements to provide a sufficient network.
- Include description of SH provider networks, role for SCDMH clinics, dental services, access to specialty care.
- USC Placement Needs Assessment Baseline study summarized and dropped into an Appendix.
- Should define how DSS will collaborate with DHHS and SH to improve network adequacy, access to services, particularly services for any immediate treatment needs.
- How will you use data to help identify service gaps and how will DSS collaborate with DHHS and SH to close gaps.

Select Health has a wide network of providers in all 46 counties of South Carolina as well as bordering counties in North Carolina and Georgia.

**5. Position Description for Director of Child Health and Well-Being –
submitted as separate attachment**

6. DSS Child Health Fact Sheet – submitted as separate attachment

**7. Department of Social Services Five-Year Comprehensive Budget
Narrative, May 2018 -- submitted as separate attachment**

**8. Foster Care Health Advisory Committee Members – submitted as
separate attachment**

9. DHHS and DSS Data Sharing Memorandum of Agreement – submitted as separate attachment

10. Initial Assessment Data – submitted as separate attachment