L. J. v. Dallas Independent Verification Agent CERTIFICATION REPORT FOR DEFENDANTS' 52nd SIX-MONTH COMPLIANCE REPORT

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L.J. V. DALLAS INDEPENDENT VERIFICATION AGENT CERTIFICATION REPORT FOR DEFENDANTS' 52nd SIX-MONTH COMPLIANCE REPORT

This is the ninth IVA Certification Report under the Modified Consent Decree (MCD), entered by the Court on October 9, 2009.[1] This is the seventh report under this IVA.[2]

The release of the 52nd report to the IVA has coincided with Interim Director David Thompson's departure from Baltimore City Department of Social Services (BCDSS), and Molly McGrath Tierney's return to her position as Director of BCDSS. Because the IVA received the 52nd Report in mid-December, 2014, the data from that report is, in some cases, now a year old, and because the 53rd Report will be issued soon, this IVA report will be brief and will address only a limited number of issues raised by Defendants.

[1] For an explanation of the IVA's functions under the Modified Consent Decree (MCD) and the structure of the MCD's Exit Standards and Internal Success Measures, see this IVA's previous reports, filed with Defendants' 46th, 47th, 48th and 49th Six-Month Compliance Reports.

[2] While not required by the MCD, the IVA shares a draft of the IVA Certification Reports with the BCDSS Director. Because of the timing of the delivery of this report to the IVA, the IVA was unable to share a draft with Interim Director Thompson but did provide a draft to Director McGrath and the other parties.

Accomplishments of Interim Director Thompson's Administration

Although his time as Interim Director was brief, David Thompson made an important mark upon the progress of the agency. He initiated important projects and reorganization efforts that this IVA recommends that the agency continue. A brief description of each follows:

Quality Service Reviews

Under Interim Director Thompson, BCDSS furthered their commitment to the Quality Service Review (QSR) process. As discussed in the IVA's last report, former Director Tierney put in place the necessary structure – including a Program Manager and 6 full-time QSR reviewers – to implement fully a QSR review process. Under Interim Director Thompson, staff received intensive training and mentoring in the use of the QSR protocol. This QSR process strives to meet two main goals. The first and most important goal is to inform practice – to let the agency know how the children in its care are doing; what agency and caseworker practices are working well and which are not; and then to spur action to improve the children's care through improving agency and caseworker practice. The second goal is the use of QSR to meet the requirements of a number of the L.J. measures.

In 2014, eighty-four cases were reviewed to provide data for practice assessment and improvement. An experienced Program Manager and licensed social work clinician was selected Program Manager, and oversight of the program was moved to the Director of Practice and Policy in line with meeting the first goal of the program. More information about the results of the 2014 reviews will be provided in the IVA's response to the 53rd Report.

Office of Educational Opportunity and Academic Achievement

Building on a concept developed by Director Tierney during her earlier administration, Interim Director Thompson created the Office of Educational Opportunity and Academic Achievement, led by a former CINA attorney and recent OHP Program Manager, to focus on the many educational needs of children and youth in foster care. The agenda of this office includes ensuring school stability (a goal which will require significant planning and agreement with multiple school jurisdictions); full implementation of appropriate special education services for children who qualify; development of robust educational plans and monitoring of educational progress by caseworkers; and attention to meeting such needs as tutoring for children who are performing below grade level and return to school or robust GED programs of youth who have dropped out to school in order to increase the likelihood of successful attainment of a high school diploma or GED for all youth in foster care. As part of meeting this agenda, one goal is to develop the agency's own tutoring program with the support of community volunteers.

Director of Practice and Policy

Interim Director Thompson created the new position of Director of Practice and Policy. Such a position is critical to development of a trauma-informed case practice model which can guide case workers and supervisors in better serving children and families. It had become clear that without such a position, where the appointee is permitted to focus on building new practice, such development would not occur. Other executive staff, who might otherwise be in a position to focus on practice development, simply face too many daily demands to respond to individual case needs. Rena Mohamed, who has many years of experiencing in developing and implementing programs and practice throughout Maryland and Washington, D.C. was hired in the summer of 2014 to fill this newly created position. She also brings with her an expertise in

early childhood development and education, an area critical to BCDSS where the largest number of entrants into foster care is children under the age of 6. Ms. Mohamed has been given a large supervisory portfolio, including the MATCH program, the new Office of Educational Opportunity and Academic Achievement, and the QSR program.

Trauma-Informed Practice

BCDSS is currently in the planning stages of implementing trauma-informed practice across child welfare. This effort is directly tied into the Title IV-E Waiver recently awarded to Maryland, as well as the recognition among child welfare experts of the critical need to develop trauma-informed practices to mitigate the impact to and to promote recovery for families who have experienced trauma. The Director of Practice and Policy is leading this effort.

Fatality Reviews

Interim Director Thompson shifted responsibility for the fatality reviews to the QSR Unit under the Director of Practice and Policy. The IVA believes this to be an appropriate move due to the importance of ensuring that any lessons to be learned from the review and recommendations that arise from it, be implemented and responded to by changes in agency practice.

Restructuring of the MATCH Program

During Interim Director Thompson's tenure, the MATCH program began an ambitious restructuring. Led by Dr. Rachel Dodge, Medical Director, and Director of Practice and Policy Mohamed, MATCH has continued to reassess its program and respond with changes that are anticipated to improve health outcomes for children and youth in foster care, program functioning and staff retention rates. MATCH has been reorganized to create special teams of

medical case managers (nurses, social workers or care coordinators) and their supervisors with a particular set of skills to meet the needs of the children monitored by their teams. It is believed that this reorganization will allow MATCH staff to better utilize their knowledge and skills, to better engage them in their client's cases and to establish relationships with many of the most frequently used medical, mental health, dental and placement providers. In addition, Director of Practice and Policy Mohamed is using her expertise in the mental health services field to improve mental health assessments and services to children and youth.

Initial Health Assessments

Initial health assessments are essential to the early identification of the needs of children and youth entering foster care. During the Thompson administration, the decision was made, with the support of the IVA, to try to have most of the initial health assessments completed by medical staff at Baltimore Child Abuse Center (BCAC) rather than by the child's primary care physician. This collaboration between the MATCH program and BCAC provides an opportunity for timely, consistent reports on the health status of the child at the time of entry into foster care done by medical staff expert in the assessment of child abuse and neglect. It also removes the pressure for the primary care physician to do a comprehensive health assessment during a last-minute appointment and before, for younger children, substitute caregivers have had an opportunity to observe behaviors and developmental milestones so important to be reported in full physicals for young children.

Family Visitation Center

Research has shown that frequent and meaningful visitation between parents and children is critical to successful timely reunification. The current supervised visitation

arrangement for children in foster care in Baltimore City is unacceptable. Visitation takes place in one of a few small rooms with the caseworker sitting just outside an open door. Furthermore, the rooms are right inside the main entrance to the building, meaning that many of the caseworkers and anyone coming to visit them must pass by the rooms. There is no privacy and really no place for a parent to engage in meaningful activity with a child.

Under Interim Director Thompson, BCDSS began the process of renovating the third floor of 2520 Pennsylvania Avenue for use as a visitation center. The visitation center will have separate visitation rooms that are fully equipped as living spaces with separate observation rooms for staff. The visitation center will also have meeting rooms for staff and families to meet pre and/or post visit, as well as a training room. The plan is for the visitation center to be staffed by a center manager, two clinical social workers, and a family support worker. Training on evaluating parent-child interaction to support workers in observing supervised visits is planned. Training for staff will occur closer to the opening of the visitation center. The projected opening by Summer 2015.

Adoption Services Expansion

Exposure for children in need of an adoptive resource is being maximized by integrating Digital Me videos onto the Adopt US Kids site. The Adoptions unit is expanding its work to provide essential pre- and post- adoption services through a partnership with Adoptions Together. These expansion efforts are critical to identifying adoptive resources and ensuring successful adoptions. Disrupted adoptions are devastating to children and their families alike. Resources must be readily available to prevent such disruptions whenever possible.

Family Find

The Family Find program, which focuses on using internet and other resources to find family for children and youth in care, has been moved under the supervision of the Program Manager for Adoptions, Guardianships and CPRU (central placement unit) which places it closer to the Out-of-Home Placement staff and opens up the program to look for family for all children and youth, not just older youth. The program needs to be expanded to better address the needs of all children and youth who are in foster care.

Provisional Licensing for Kin Providers

As permitted by Maryland regulations, BCDSS has begun provisional licensing of kin providers. Kin providers often have greater financial needs than can be met through Temporary Cash Assistance (TCA) benefits on which they have had to rely until completing the licensing process. (Kin providers not within the narrow range of relatives that can receive TCA on behalf of a child have no cash assistance available.) Maryland regulations permit the agency to provisionally license kin providers, which provides them with the full foster home stipend for up to 120 days while working to become fully licensed. Provisional licensing encourages kin to become fully licensed and assists families in meeting children's needs from the time they enter care. It also reduces the amount of flex funds expenditures for children in kin homes and increases the important training to which providers are exposed.

FIM Implementation Review/Evaluation

In line with the agency's shift to best practices, it is crucial that Family Involvement Meetings (FIMs) become more meaningful in content and participation. As part of this effort, the FIM units have been combined into one unit. Additional training and coaching for the

more recently appointed FIM staff and for others, such as OHP supervisors, who lead FIMs, is needed to ensure that FIMS become a more effective tool in child welfare practice.

The 52nd Reporting Period

Defendants' 52nd Report covers the January 1, 2014 through June 30, 2014, reporting period. Defendants claim compliance with twelve Exit Standards - 3, 39, 52, 65, 68, 79, 82, 93, 106, 115, 116, and 121. The IVA continues to find and certify compliance with Exit Standards 68 and 121. The IVA continues not to be able to certify compliance with Exit Standards 3[3], 39, 52, 65, 93, 115 and 116 for the reasons set out in the chart that follows. For the first time, during the 52nd reporting period, the Defendants claims compliance for measures 79, 82 and 106. These three Exit Standards are discussed below. The remaining measures will be addressed in chart form. First, however, the IVA will address her serious concerns with the reporting for Exit Standard 65.

Exit Standard 65

The safety of children in foster care is paramount. Exit Standard 65 requires that 99.68 percent of children in OHP were not maltreated in their placement, as defined in federal law. Even though this Exit Standard has been discussed in detail in prior IVA reports, it is being repeated here again because of the importance of the measure – maltreatment of children in foster care – and the IVA's concern that Defendant DHR continues to maintain its erroneous position as to which cases it is and is not required to report as maltreatment in care for both LJ and the federal government. This is an Exit Standard over which BCDSS does not have control for reporting purposes. It is DHR which needs to make the necessary corrections.

[3] Defendants last claimed compliance with Measure 3 in the 47th Report. The IVA's reasons for non-certification remain the same as they did in the IVA's Response to the 47th Report, p.18. Essentially, compliance cannot be certified because a qualitative review, such as the QSR, is required. The specific reasons are summarized on the chart, below.

In the MCD, this measure contains the following footnote:

> The measurement for maltreatment in foster care in this Decree is the measurement used by the United States Department of Health and Human Services in Child and Family Services Reviews, which means the percentage of children who were found to be victims of indicated maltreatment by perpetrators who are relative foster parents, non-relative foster parents, and group home or residential facility staff. **"Relative foster parents" include unlicensed kinship care providers with whom BCDSS placed children in OHP.** (emphasis added)

Defendants' calculation and report of a compliance rate of 99.74% in the 52nd Report is neither valid nor accurate because it omits from the calculation an entire category of children- those abused or neglected by unlicensed kinship care providers with whom they were placed by BCDSS – as well as an entire category of cases - those in which the report of abuse or neglect occurred before the relevant reporting period even though the disposition was made during the relevant reporting period.[4] The MCD and federal law requires that those children and those cases be included in the calculation. The IVA incorporates here the discussion on pages 17-19 of the IVA's Certification Report for the 46th Report. See also *National Child Abuse and Neglect Data System (NCANDS) Child File, FFY 2012 …User's Guide and Codebook*[5] at p.17 (Element 3 "Submission Year" (". . . Reports received in a prior year but whose disposition was made within the reporting year, should be included in the NCANDS data submission."), and p. 30 (Element 63 "Foster Care Services" ("A foster parent is an individual who provides a home for … children under the placement, care or supervision of the State. The individual may be a

[4] It appears that some of the cases not reported were actually for children who were abused or neglected by foster parents or congregate care staff but the maltreator had been inaccurately coded in CHESSIE, e.g., a foster mother coded as "other," resulting in their exclusion from the reported cases.

[5] http://www.ndacan.cornell.edu/datasets/pdfs_user_guides/178-NCANDS-child2012v1-User-Guide-and-Codebook.pdf (site last visited April 1, 2015).

relative or non-relative and need not be licensed by the State agency to be considered a foster parent.").

As with prior reports, DHR provided a summary report to BCDSS for a six month period - in this case, September 1, 2013 through February 28, 2014.[6] DHR also provided a corresponding excel spreadsheet with child-specific information that DHR submitted to the federal government as part of a required report. Defendants' 52nd Report for this Measure is based upon a finding of two cases of unsubstantiated[7] neglect and four cases of unsubstantiated abuse by a foster parent or group home caregiver for a total population of 2,300 children in foster care for that six month period which results in a maltreatment rate of .26% or, put in the language of the Measure, a 99.74% non-maltreatment rate.

The IVA reviewed this data and found that at least eight additional cases of unsubstantiated or indicated maltreatment during this time period were not included in the calculation even though the children were found to be victims of unsubstantiated or indicated maltreatment by caregivers while in foster care. With the addition of these eight cases to the six cases included, the maltreatment rate would change to .60% or a rate of 99.40% of children in OHP not maltreated. This number is well below 99.68% - that required by both the federal government and LJ for compliance. Furthermore, the addition of these eight cases also brings the total reported maltreatment rate for Maryland to .60% or a rate of 99.40 children in OHP not maltreated.

[6] DHR uses a different time period from the LJ report for reporting maltreatment to the federal government. For the purpose of the 47th LJ report, the time period used is March 1, 2011 through August 31, 2011. The IVA believes it would be much simpler and more accurate to use the same time frame used for federal reporting for LJ reporting and recommends that the parties discuss this matter in the near future.

[7] Defendant DHR reports both "unsubstantiated" and "indicated" cases as meeting the federal definition of "indicated."

Therefore, the reported level of compliance with Measure 65 cannot be certified as accurate.

The IVA will be able to certify this Measure as accurate only when the reported compliance rate includes the two sets of currently excluded cases – those where the report and disposition did not both occur in the time period under review, and those where the perpetrator was an unlicensed kinship caregiver. In addition, because of the finding that some of the non-reported cases appear to have not been reported because of coding errors, DHR needs to establish some type of verification system in order to ensure the accuracy of reporting of such important statistics.

Exit Standard 79

Exit Standard 79 requires that 90 percent of new entrants into OHP received a comprehensive health assessment within sixty days of placement. The following definitions from the MCD at pp. 29-30 apply:

> (1) "Comprehensive Health Assessment" means a thorough age-appropriate examination of a child by a qualified practitioner in each of the following domains: medical, dental, and mental health (including psychological, behavioral and developmental). The mental health portions of the comprehensive assessment must be conducted by a licensed mental health professional who is not responsible for the direct care of the child. In addition to assessing the child's health in the above domains, the assessment also shall address the child's educational status and needs based on the available information. Prior to the performance of the Comprehensive Health Assessment, the child's complete and up-to-date health, mental health, dental, and educational records from the time prior to the child's entry into care, plus the initial health screen, shall be obtained, if reasonably available, and provided to the assessing staff.
>
> (2) Before finalizing the health plan, BCDSS shall hold a team meeting to discuss results of the comprehensive assessment and

> obtain further information about the child. Following the team meeting, the assessment results shall be integrated into a single document, which will constitute the comprehensive assessment and be used to inform permanency planning. For every child in OHP, BCDSS shall develop and implement a health plan that is updated at least annually and more frequently when the child's health status changes materially.
>
> (3) Copies of the comprehensive assessment and health plan shall be provided within ten business days to the child's attorney and child's health care providers. Further distribution shall be at the discretion of BCDSS, subject to the child's clinical needs, applicable confidentiality laws, and decisions by the team meeting.
>
> (4) All provisions of the Standards[8] that address the comprehensive assessment are incorporated by reference into this definition.

Through the MATCH program, BCDSS has made significant strides in timely scheduling and completion of the three examinations required for the comprehensive assessment – medical, dental and mental health. In addition, the mental health assessments are completed by a small group of qualified practitioners from Catholic Charities who are not responsible for the care of the child. Furthermore, as per the "MATCH Program Practice Guidelines," (hereinafter "guidelines") dated 06/07/2013[9] (Copy attached as Att. 1). MATCH staff now must complete an initial "Health Care Plan," also entitled "BCDSS Health Passport," within sixty days of entry into care. (Examples attached as Atts. 2a and 2b). The Health Care Plan provides information about health care providers, diagnoses, medication, allergies, appointment dates, and requires a narrative "Health Assessment and Plan Summary (Include recommendations to meet health needs)."

[8] Under the MCD, "'Standards' means standards that are specific to the needs of children in OHP which will be developed within the first year of the BCDSS Health Care Initiative by the medical director. In developing the Standards, the medical director shall apply and adapt the Child Welfare League of America/American Association of Pediatrics standards for health care for children in OHP to the specific needs of children in BCDSS OHP." MCD, Part II.Section III.C.2 (pp. 28-29 of signed MCD order).

[9] So far as the IVA is aware, this is the most current version of the guidelines; they are in the process of being revised.

However, there is no documentation that four other requirements of this portion of the MCD are met:

> (1) In addition to assessing the child's health in the above domains, the assessment also shall address the child's educational status and needs based on the available information.
>
> (2) Prior to the performance of the Comprehensive Health Assessment, the child's complete and up-to-date health, mental health, dental, and educational records from the time prior to the child's entry into care, plus the initial health screen, shall be obtained, if reasonably available, and provided to the assessing staff.
>
> (3) Before finalizing the health plan, BCDSS shall hold a team meeting to discuss results of the comprehensive assessment and obtain further information about the child. Following the team meeting, the assessment results shall be integrated into a single document, which will constitute the comprehensive assessment and be used to inform permanency planning. (emphasis added).
>
> (4) Copies of the comprehensive assessment and health plan shall be provided within ten business days to the child's attorney and child's health care providers.

Furthermore, the Guidelines leave to non-medical staff the responsibility of reviewing the "documentation to assure age appropriate exams and assessments are completed in accordance with EPSDT/Maryland Schedule of Preventive Health Care." (Guidelines, p. 4) The Guidelines at p. 7, provide that "The RN and SW [Medical Case Manager]'s are available to review all medical documentation and mental health evaluations received by the [Case Coordinators]." However, all of the RNs and social workers either have their own caseloads or are already supervising other RNs and social workers. The non-medical staff is not supervised directly by medical staff.

Finally, and perhaps of greatest concern, non-medical staff are expected to "develop a Comprehensive Health Plan that meets EPSDT and AAP standards and that incorporates

recommendations from the comprehensive health assessments (medical, dental and mental health)" and to give each child "health status" and "mental health status" scores based on the documents received and whether "all health care needs" are being met. In order to consider certifying this measure, the IVA will need to verify that the non-medically trained care coordinators and social workers are sufficiently trained and supervised to complete these tasks ably.

The latter would be of less concern if MATCH had sufficient medical staff who could review all – or an appropriate sample – of the children's comprehensive assessments – particularly those done by care coordinators - and the supporting documentation to ensure that the plans being developed and the Health Status scores being assigned are accurate. The importance of the Health Status scores is that it controls to which type of MATCH staff – nurse, social worker or care coordinator - the case is assigned and how frequently the case is scheduled for review.

In large part because no such auditing has been occurring, the IVA also would not certify this measure until MATCH implements a quality assurance program and until the IVA has had the chance to do her own sampling of comprehensive assessments to assure the quality, not just the timeliness of the Health Care Plans and whether or not it meets the requirements of the comprehensive assessment.

Exit Standard 82

Exit Standard 82 requires that 90 percent of children entering OHP received timely periodic EPSDT examinations and all other appropriate preventive health assessments and examinations, including examinations and care targeted for adolescents and teen parents.

The IVA is unable to certify this measure for the following reasons:

(1) As with the comprehensive assessment, MATCH reports summary data without any verification by QA, i.e., there is no "QSR" of MATCH reporting and no supervisory review of scoring.

(2) It is unclear to the IVA how this measure is being assessed for compliance. The use of health needs scores is not reflected in the current guidelines that were effective 6/7/2013. Based on the information provided to the IVA, it is unknown when a health needs score is given, who determines the score and where it is documented in the MATCH database, ETO.

(3) There is limited discussion in the current MATCH guidelines concerning care targeted for adolescents and teen parents. According to the guidelines, pregnant and parenting teens' cases are reviewed quarterly but there is no indication what information is sought. The care for these youth should improve markedly under the MATCH restructuring in which a team of medical case managers supervised by the Nurse Supervisor is assigned all pregnant and parenting foster youth.

(4) As discussed above, the review of documentation for most children and youth to ensure that the exams comply with EPSDT standards is done by Care Coordinators and social workers who may lack the medical background or training to determine if the exam meets the standards.

Again, because no such auditing has been occurring, the IVA also would not certify this measure until MATCH implements a quality assurance program and until the IVA has had the chance to do her own sampling.

Exit Standard 106

Exit Standard 106 requires that, "For 90 percent of children, BCDSS had monitored the child's educational progress monthly. According to the MCD at pp. 35-36,

> (7) "Monitoring" the child's educational progress means that the child's caseworker shall:
>
> (a) Review the child's educational progress through discussion with the caregiver, teacher and child;
>
> (b) Review the child's report cards, progress reports and attendance records; and
>
> (c) Take reasonable steps to support the child's educational progress and achievement.

Compliance with this Measure is determined through the File Review process. The file review tool looks only at whether or not "the contact notes reference" certain education terms, such as "learning, education, class" rather than requiring actual evidence of monitoring.

The IVA is unable to certify compliance with Exit Standard 106 for the following reasons:

(1) The review needs to but does not include children who are out-of-state or in correctional facilities.

(2) The review does not monitor progress at all - just whether the case notes "reference" the listed education-related terms.

(3) The review does not meet MCD definition of "monitoring" (pp. 35-36) that includes discussion with caregiver, teacher and child as well as review of the child's report card and attendance record and taking reasonable steps to support the child's educational progress and achievement.

It has been agreed by the parties that compliance with Exit Standard 106 will require a qualitative review, and the parties are in the process of developing a QSR indicator to measure agency practice in meeting the educational needs of children and youth in BCDSS care.

Exit Standard Certification Decisions and Reasons

Exit Standard	Defts' 52nd Report	IVA	Reason for IVA Decision	What is Needed for Compliance/Notes
3 - 90 percent of children and families in family preservation had a case plan.	91.5%	No	Failure to require that the Service (Case) Plan: 1. Reflect that the case-worker and family identified the problems and needs which could lead to removal of a child if not resolved. 2. Contain objectives appropriate to resolving the problems and needs identified. 3. Contain tasks and services reasonably related to meeting the objectives of the Plan.	Qualitative case review such as the BCDSS Quality Service Review (QSR).
39 - The array of current placements matched the recommendation of the biennial needs assessment.	Yes	No	1. Failure to complete a biennial needs assessment. 2. Failure to provide written assessment of placement needs and the specific steps being taken to meet those needs.	Defendants need to articulate in writing : (1) the placement needs for children in BCDSS care, as required by Additional Commitment OHP 1; and, (2) if not all needed placements are available, the steps they are taking to obtain the needed placements.
52 –BCDSS employed a staff of non-case carrying specialists to provide technical assistance to caseworkers and supervisors for cases that required specialized experience and /or knowledge.	Yes	No	1. Non-case carrying specialists not available in all areas required by MCD. 2. Education specialists not fulfilling requirements of position. (See IVA Response to 51st Report, Att.1, Education Specialist Job Description). 3. It does not appear that staff was provided with updated Resource Directories during this report period	Defendants need to: (1) demonstrate the availability of housing specialists to assist staff in helping parents and guardians with a plan of reunification to find appropriate housing; and (2) ensure that education specialists are meeting requirements of positions and acting as a resource to caseworkers. Note: It appears that this requirement may be met

Exit Standard	Defts' 52nd Report	IVA	Reason for IVA Decision	What is Needed for Compliance/Notes
			despite changes in some specialists. Last directory posted on the intranet is dated 8/2013.	during the 53rd Report period with the establishment of the Office of Educational Opportunity and Academic Achievement; (3) ensure that staff has up-to-date contact information on the available resources.
65 – 99.68% of children in OHP were not maltreated in their placement, as defined in federal law. [footnote omitted]	99.74%	No	See pp. 10-13, above	See pp. 10-13, above.
68 – 99.8 percent of children in OHP were not housed outside regular business hours in an office, motel, hotel or other unlicensed facility. [Remainder of standard omitted as not applicable.]	99.94%	Yes	Reports available and reviewed for all but two shifts between January 1 and June 30, 2014. Two children (one 7 and one 20) each spent just over 4 hours at the Extended Hours building ("Gay Street") during this report period. No evidence of children otherwise being housed in office buildings, hotels or motels.	Notes: 1. Sixth Consecutive Certification. 2. Related Measure 67 is <u>not</u> certified as accurate because BCDSS has not provided written instructions for a reliable system to report the actual amount of time that each child spends in the Extended Hours building after regular business hours.
79 – 90% of new entrants into OHP received a comprehensive assessment within sixty days of placement.	91.7%	No	See pp. 13-16, above	See pp. 15-16, above.
82 – 90% of children entering OHP received timely periodic EPSDT examinations and	90.2%	No	See pp. 17-18, above.	See pp. 17-18, above.

Exit Standard	Defts' 52nd Report	IVA	Reason for IVA Decision	What is Needed for Compliance/Notes
all other appropriate preventive health assessments and examinations, including examinations and care targeted for adolescents and teen parents.				
93 – 90% of all new entrants had a complete health passport that was distributed to the children's caregivers promptly.	96.3%	No	Failure to meet MCD requirement to provide caregiver with documentation of child's condition at time of entry into care.	Defendants need to provide to the caregiver documentation of child's condition at time of entry into care. Because there is often little information available immediately, one of the ways to meet this measure would be to send copies of initial health assessments (and any necessary interpretations of doctor's language) along with any critical medical history to the caregiver when they are received. For further documentation of the child's condition at the time of entry into care, the caregiver should be provided with a copy of the comprehensive assessment (the combination of the medical, dental and mental health examinations) as soon as the documentation is available. Under the MCD, the caregiver must also be provided with a copy of the health plan. (MATCH has indicated that the initial health plan (created at about 60 days after entry into care) is now being sent to caregivers.)

106 – For 90% of children, BCDSS had monitored the child's educational process monthly.	89.8%	No	See pp. 18-19, above.	See pp. 18-19, above. Qualitative Case Review required.
115 – 90% of case-carrying staff was at or below the standard for caseload ratios.	99.9%	No	1. Failure to use DHR-established caseload standards in calculating compliance. Using the ratio of 1:12 for OHP caseworkers, 78% of caseworkers were at or below the standard for January – June 2014. 93% of case workers had no more than 13 cases. BCDSS has clearly made exceptional progress in lowering caseloads. It will be critical that sufficient staffing is maintained to maintain the lowered caseloads. 2. Failure to include new applications as cases in calculating caseloads for Resources & Support workers.	1. Defendants need to use caseload ratios of 1:12 for calculating compliance for OHP caseworkers. 2. Defendants need to include new applications assigned to Resources & Support workers as cases for the purpose of calculating caseloads. 3. Defendants need to use caseload ratios of no greater than 1:36 for calculating compliance for Resources & Support caseworkers. [Note: The IVA has not determined what the exact Resources & Support caseload limit should be; presumably, the caseload limit should be somewhere between 1:14 and 1:36 since the Resources & Support workers have both new application cases (for which DHR has set a 1:14 caseload limit) and ongoing cases. The IVA asks that the parties discuss the issue and try to come to an agreement.]
116 – 90% of case-carrying teams were at or below the standard for ratio of supervisor: worker.	99.3%	No	Failure to use DHR-established supervisor to caseworker standards in calculating compliance. Using the 1:5 ratio, only 42% of the supervisors had 5 or fewer caseworkers as of June 30, 2014. However, as of December 31, 2014, 78% of supervisors had 5 or fewer caseworkers under their supervision.	Defendants need to use supervisor to caseworker ratios of 1:5 for calculating compliance.

121 – 95% of case workers met the qualifications for their position title under Maryland State law.	100%	Yes	Procedures are in place to ensure qualifications are met. (No caseworkers hired this period.)	Notes: 1. Seventh Consecutive Certification. 2. Related Internal Success Measures 117 and 118 are also certified as accurately reported.

Additional Commitments

The MCD also requires that Defendants report on their compliance with the Additional Commitments which are set out at the end of each section of Part Two of the MCD. Defendants have failed to do so despite numerous prior requests by the IVA. The IVA again requests that Defendants include such a report with their next Compliance Report and subsequent reports.

One Additional Commitment that has long awaited attention is now poised for implementation – the Education Additional Commitment (MCD, p. 37). With the appointment of a Program Manager for Education and Academic Achievement, the IVA is confident that BCDSS has taken a great leap forward towards compliance with the education requirements of the "Fostering Connections to Success and Increasing Adoptions Act."

Submitted by:
/s/
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L.J. v. Dallas Independent Verification Agent

Copies provided on April 21, 2015, by email to:

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