DSS SOUTH CAROLINA
DEPARTMENT of SOCIAL SERVICES

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Frequently Asked Questions for South Carolina Providers

1. **What is the preferred evidence-based model for family engagement services that the Agency would like for group care providers to adopt?**

   The Department does not currently have a "preferred" evidence-based model for family engagement services that the Department would like for group care providers to adopt. Federal guidelines for the QRTP notes the following: "…to extent appropriate, and in accordance with the child's best interest, facilitates participation of family members in the child's treatment program; facilitates outreach to the family members of the child, including siblings, documents how the outreach is made (including contact information), and maintains contact information for any known biological family and fictive kin of the child; documents how family members are integrated into the treatment process for the child, including post-discharge, and how sibling connections are maintained."
   Please refer to the California Evidence-Based Clearinghouse for various topics and models that are considered to be Well-Supported, Supported, and Promising. For additional information or reference information please refer to: https://www.cebc4cw.org/.

2. **What requirements will SCDSS invoke upon group homes regarding family engagement services?**

   SCDSS will enforce federal QRTP guidelines surrounding family engagement. Federal guidelines for the QRTP note the following: "…to the extent appropriate, and in accordance with the child's best interest, facilitates participation of family members in the child's treatment program; facilitates outreach to the family members of the child, including siblings, documents how the outreach is made (including contact information), and maintains contact information for any known biological family and fictive kin of the child; documents how family members are integrated into the treatment process for the child, including post-discharge, and how sibling connections are maintained.

3. **Where does the department see the role of group homes in the next five years?**

   Children who require a congregate care setting based on their level of needs will be placed into one of the following specified settings:
   a. "A qualified residential treatment program (QRTP);

b. A setting that specializing in providing prenatal, post-partum, or parenting supports for youth;
c. In the case of a youth who has attained 18 years of age, a supervised setting in which the youth is living independently;
d. A setting providing high-quality residential care and supportive services to children and youth who have been found to be, or are at risk of becoming, sex trafficking victims; or
e. A licensed residential family-based treatment facility for substance abuse.

4. Can the licensed nursing staff be an LPN?

Yes. A Licensed Practical Nurse (LPN) is an acceptable nurse as long as the nurse provides care within the scope of their practice as defined by state/tribal law, or on-site according to the treatment model, and are available 24 hours a day and 7 days a week.

5. If we do not have therapist, what are the expectations for implementing trauma-informed model of care?

Per federal guidelines, a trauma informed treatment model must be utilized that is designed to address the needs, including clinical needs as appropriate, of children with serious emotional or behavioral disorders or disturbances. Please refer to SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. This guide provides guidance in relation to implementing a trauma-informed model: https://store.samhsa.gov/system/files/sma14-4884.pdf.

6. We serve a specialized population (autism/ID) will there be different guidelines?

Based on federal guidelines, approved congregate care settings include:
a. A qualified residential treatment program (QRTP);
b. A setting that specializing in providing prenatal, post-partum, or parenting supports for youth;
c. In the case of a youth who has attained 18 years of age, a supervised setting in which the youth is living independently;
d. A setting providing high-quality residential care and supportive services to children and youth who have been found to be, or are at risk of becoming, sex trafficking victims; or
e. A licensed residential family-based treatment facility for substance abuse.

There will not be different guidelines for providers who serve youth with Autism or Intellectual Disability (ID). Ultimately, you will have to comply with QRTP guidelines and can continue to serve this special population.

7. **How many QRTP beds does DSS anticipate it will need in SC?**

   Currently, there are approximately 634 children placed in group care and 665 children placed in therapeutic foster care homes. The levels of care for children based on the utilization of the CANS will be the true determinate of how many children will require a QRTP level placement.

8. **How will a QRTP be different from a PRTF?**

   The difference between a QRTP and PRTF is that a QRTP placement is based on assessed need and a PRTF placement is based on medical necessity. Levels of care will be defined based on children's needs utilizing the CANS. Algorithms embedded in the CANS will ultimately support a child's placement based a child's assessed needs.

9. **Will the rules change to allow us to provide Medicaid billable services to youth who are living in our care?**

   The South Carolina Department of Social Services is currently having ongoing conversations with the South Carolina Department of Health and Human services regarding Medicaid, billing, services, and a statewide structure in relation to out of home care. More updates will be provided soon.

10. **Is there a transition plan for implementing FFPSA standards related to residential group care? If so, when will providers be able to see the plan?**

    A QRTP Implementation Plan will be developed by August 2020. Providers will be able to see the plan upon its release.

11. **When will the DSS prevention plan be released?**

    The Title IV-E prevention plan will be tentatively drafted and submitted to our federal partners by winter 2020. Upon approval from our federal partners, the plan will be published. This the timeframe for approval by the federal government has varied. Updates on components of the prevention plan are actively shared

with the FFPSA Prevention workgroup and on the Open Calls held every other Friday from 2-3pm.

12. What is the best way to be notified of changes, updates, contracts?

There is a FFPSA call that is scheduled biweekly on Fridays from 2pm to 3pm. A flyer is sent out with call in information. This call is designed to provide updates to stakeholders statewide to include providers, advocacy groups, community members, etc. In addition, a FFPSA email has been created to allow for open communication with the Department and stakeholders that have specific questions related to FFPSA. The email address is: familyfirstpsainfo@dss.sc.gov

13. Will programs providing services to families recently reunified be eligible for reimbursement given the risk of re-entry associated with reunification?

After care services are a now required component of the new QRTP model. For FFPSA prevention services, the Department is strongly considering Homebuilders which is an in-home based prevention program for children who are high-risk of entering foster care. This model can also be utilized to assist children and families with reunification and stabilization.

14. Will economic mobility services be eligible for family first funding?

Job training programs are not one of the prevention funded programs; however, this type of service can couple or enhance other approved services.

15. Besides the specific populations mentioned in the FFPSA will SC recognize other special populations such as the IDD and Autistic population which are very much in need of a full continuum of services and are often the most difficult to find residential or community-based services for?

Providers that serve these special populations are strongly encouraged to continue to carve out approved services to these groups within the guidelines set forth by FFPSA and build and enhance the continuum of services delivered to targeted populations.

16. **Medically complex youth who also have co-occurring disorders are another special population that needs direct services and funding streams at both a residential and community level e.g. violent ID youth with a trach who will tear out the tube if unsupervised.**

    Providers that serve these special populations are strongly encouraged to continue to carve out approved services to these groups within the guidelines set forth by FFPSA and build and enhance the continuum of services delivered to targeted populations.

17. **Do we anticipate that there will be solicitations put out for non-residential array of services or in what manner will service providers be made aware of what agency needs are in demand?**

    The Department is currently working on a scope of work to develop a qualified provider listing for community-based services. Once the Department finalizes this scope, information will be provided through the South Carolina Business Opportunities. Please monitor scbo.sc.gov for FFPSA related partnerships, information will be, advertised on SBO as the Department moves toward implementation.

18. **Will other child serving agencies be involved in defining needs for an array of residential and non-residential?**

    Yes, other child-serving agencies have been invited and currently participate in determining service needs of children and families based on current data that is captured on clients. DMH, DHHS, DAODAS, BHSA, SC Fist Steps, Children's Trust, and others have been a part of the ongoing service array work.

19. **Will there be stricter regulations for kinship placements? Meaning so many kinship placements fail and this could be prevented if there is a more diligent information gathering, home studies, checks, etc.**

    The Department plans to adopt the federal model licensing home standards; which encompass all the necessary components to license a family foster home, are flexible enough to respond to individual circumstances, but most importantly make sure that children are placed in a safe and stable family like setting. In regards to kinship families, case managers and supervisors are coached and trained on engaging with kinship families. Brochures and specific kinship foster care training have been developed so that kinship families understand the licensing process. The Department has acknowledged that identifying kin and

doing a thorough assessment of kinship families on the front-end are important on the longevity of a kinship placement.

20. Will DSS be more forthcoming with families on information to become a licensed kinship caregiver?

Yes, currently case managers provide kinship caregivers with a form that explains to them the option of becoming a licensed kinship placement on the front-end and explains what services are provided to kinship families if they become licensed or if they choose not to become a licensed a kinship home. The Department has also revised the kinship care booklet that is shared with all kinship caregivers regarding their role and involvement with the Department.

21. If we are going to push for kinship placements, will we be providing them with the support and resources they need? If not, we are only delaying the inevitable, entry into foster care.

Yes, the Department is currently in the process of continuing to enhance the kinship navigation services for all kinship caregivers statewide. The Administration of Children and Families has provided the agency with Kinship Navigator Grant funds; which the Department has contracted with private providers to provide support groups, training and other support services for our kinship families. Kinship families who become licensed kinship homes shall receive the same support and resources as foster homes. Kinship homes can be licensed with non-safety waivers as well.

22. Will there be a designated number of beds?

Currently, there are approximately 634 children placed in group care and 665 children placed in therapeutic foster care homes. The levels of care for children based on the utilization of the CANS will be the true determinate of how many children will require a QRTP level placement and the number and level of needed placement.

23. Will providers have assistance from DSS in rolling out QRTP?

The Family First Transition Act (FFTA) was approved by the Department of Health and Human Services and the proposal has been submitted to the Children's Bureau. South Carolina has been allotted approximately $8.6 million dollars to assist providers with capacity building and implementation related to FFPSA. Providers who plan to implement the QRTP model will be eligible for

funding under the FFTA. Upon receipt of the funds, the Department will receive more specific guidance in how the funds can utilized by providers.

24. What will the daily rate be for the QRTP?

The Department has been working closely with the Palmetto Association for Children and Families (PAFCAF) and a small group of its members to develop a QRTP framework. Once the framework is fully developed, this will be coupled with the funding structure for children placed in a QRTP.

25. What are the qualifications for the therapist and direct care staff?

The QRTP must have licensed clinical staff who provide care within the scope of their practice as defined by state law and are onsite according to the treatment model. This requirement shall not be construed as requiring a program to acquire behavioral health staff solely through the means of a direct employer/employee relationship. State law and regulations allow for individuals who work under the supervision of a licensed or registered health professional to provide certain forms of care within the scope of their practice.

Another requirement for the QRTP is that the program utilizes a trauma-informed treatment model that is designed to address all clinical and other needs of children with serious emotional and behavioral disorders. With that, training and workforce development for all staff, to include direct care staff, shall be a part of this model along with basic state licensing requirements for all group care settings. For further information on the SAMHSA Concept of Trauma and Guidance for a Trauma-Informed Approach please see the following link: **https://store.samhsa.gov/system/files/sma14-4884.pdf.**

26. Who will be the licensing entity?

The South Carolina Department of Social Services will be the licensing entity at this time.

27. What will the time frame be for implementation of the QRTP?

South Carolina is required to implement all FFPSA related requirements by October 1, 2021.

28. What will happen to group homes if they decide not to become a QRTP?

Upon implementation of Family First in South Carolina, as of 10/1/2021, Title IV-E funds can only be claimed for the following congregate care settings:

- Placement settings for pregnant or parenting youth;
- Supervised independent living for youth ages 18-21;
- Specialized placements for children who are at-risk of being or are identified victims of sex trafficking;
- Family-based residential treatment facilities for substance use disorders or;
- Qualified Residential Treatment Programs (QRTP) for youth with treatment needs.

29. When will we be told what the transition plan will look like?

The Title IV-E prevention plan will be tentatively drafted and submitted to our federal partners by winter 2020. Upon approval from our federal partners, the plan will be published. This the timeframe for approval by the federal government has varied.

Updates on components of the prevention plan are actively shared with the FFPSA Prevention workgroup and on the Open Calls held every other Friday from 2-3pm.

30. Will there be contracts for CPAs to license kinship homes?

At this time the Department has not made the decision to procure contracts for CPAs to license kinship homes. The Department will continue evaluating Kinship Licensing and will notify providers if this is determined as a need in the future.

To date, the Department has hired regional kinship licensing coordinators to focus solely on licensing kinship homes and providing support to these kinship families.

31. How will prevention services connect to out of home care? Despite the best prevention services available, some children are going to require out of home placement. Will there be FFPSA services available to these children?

FFPSA is designed to enhance prevention services to prevent children from entering foster care but also serve children who require out of home care.

Ultimately, there will be a continuum of service array available for children and families with all levels of need within the system. The Department will determine utilization of Title IV-E funds to provide optimal service delivery to families however they come involved with the Department.

32. Funding? How are services going to be funded? Will additional funds be requested in the DSS budget or will only federal funds be used to fund services?

Services will be funded through FFTA grant funding, through IV-E claiming based upon the final approved SC FFPSA Prevention Plan and based on requested funds through the Department's fiscal year budget request. The Department is also evaluating current contracts and funding streams to leverage all available resources to help ensure sustainability of an enhanced service array.

33. I would like to provide more services to biological families to prevent the need for out of home care and for transitional and reunification purposes from TFC. Will transitional funds be accessible for providers that are currently providing well supported services soon? Is a contract allowable?

Yes, based on the Department's FFPSA Prevention Plan and the identified services within the plan, funds may be available to providers that provide services deemed as "Well-Supported." The Department is currently working on developing guidelines and protocols for providers to access these funds.

34. When will decisions be made and providers involved to assist in the implementation? What is the timeframe expected or is it all waiting until October 2021? Will RBHS services menu change to reflect EBP or will it be based on contracts/proposals/ RFPs?

The Department currently partners with providers, community stakeholders, advocates, and other state agencies to assist in development and implementation of its IV-E plan. The Department has and will continue to communicate which interventions it is evaluating for inclusion in its IV-E prevention plan and how it will assist in statewide capacity building efforts, as well as plans for pilot implementation prior to full FFPSA implementation in October 2021. There have been no discussions about modifying the RBHS state plan at this time. It should be noted that when interventions are medically necessary with a Medicaid beneficiary and are included in the SC Medicaid State Plan, the IV-E prevention program shall be the payor of last resort.

Please continue to monitor the Department's FFPSA Bi-Weekly Open Call for updates.

35. Has SC developed a list (or started making a list) of programs/models for which a waiver might be requested (i.e. those that are not approved-or not yet approved-by the Clearinghouse?

At this time, the Department is not seeking to pursue a waiver for any unrated services. The Department has narrowed its list of interventions based on relevant data, survey of the landscape of evidence-based practices across the state, and through partnerships with its providers and community stakeholders. A final list will be published in the near future. Please continue to monitor the Department's FFPSA Bi-Weekly Open Call for updates.

36. Does DSS have anywhere on the website or another website for information for FFPSA in SC can be accessed?

To obtain updated FFPSA information on the public website: dss.sc.gov, scroll to the bottom of the page to Child Welfare Reform. Click on the button: Family First Prevention Services Act. Updates and information will be readily available there.

37. Who is the primary contact person at DSS for FFPSA? Secondary?

The primary contact for FFPSA is:

Steven Ferrufino
Assistant Director, Office of Child Health and Well-Being
(803) 898-0956
steven.ferrufino@dss.sc.gov

The secondary contact related to out of home care is:

La Toya Faulkner-Clayton
Private Provider Manager, Division of Permanency Management
(803) 898-7327
latoya.faulkner@dss.sc.gov

38. Is DSS going to do a needs assessment to gather information on what services are needed in the state to be included in the FFPSA array of services?

A survey developed by the Institute for Families has been disseminated statewide to the continuum of providers to assess needs and services for children and families statewide that will guide the development of a Qualified Provider List (QPL) which will serve as a FFPSA pilot program.

39. When might it be reasonable for providers to start planning to develop programs for DSS as right now, without funding in place, it is too big of a risk to start something that might not be included in SC's plan or might not have a funding option outside of the plan?

The FFPSA Prevention Plan will be tentatively drafted and submitted to our federal partners by winter 2020. Upon approval from our federal partners, the plan will be published. The timeframe for approval by the federal government has varied state to state.

The Department will provide a formalized declaration of intent to pursue certain interventions in the early summer. Following this announcement, the state will determine how best to build capacity for targeted interventions.

Please continue to monitor the Department's FFPSA Bi-Weekly Open Call for updates.

40. Would like a listing of the models of care that will be approved by FFPSA in South Carolina.

For models of care for foster care that include a trauma-informed component, please refer to the California Evidence-Based Clearinghouse: https://www.cebc4cw.org/. Here, providers can access models of care that have undergone a qualitative review process and have been rated as Well-Supported, Supported, Promising, and Not Rated.

The Department will also be hosting two presentations in June 2020 on some available models of care; The CARE model and the Teaching Family Model. Electronic flyers will be sent out to providers statewide for participation.

41. How is DSS going to address the various levels of care needed regarding QRTP? Someone needs to publically address that just as there is a leveled system currently, there must be QRTP levels therapeutic (severe) and non-therapeutic.

Upon implementation of FFPSA, the following settings will be approved in South Carolina:

- Placement settings for pregnant, post-partum, or parenting youth;
- Supervised independent living for youth ages 18-21;
- Specialized high-quality placements for children who are at-risk of being or are identified victims of sex trafficking;
- Family-based residential treatment facilities for substance use disorders or;
- Qualified Residential Treatment Programs (QRTP) for youth with treatment needs.

For QRTPs, the Department is currently considering a two-tier QRTP framework for youth with moderate and high-level needs and a payment structure to match the levels. This framework is currently in the stage of development.

42. What are the needs of SCDSS? Mothers and babies, sex trafficking, independent living? It is difficult to know which program to develop when currently we are asked to take ANY child.

As of April 22, 2020 these are the most recent statewide numbers of the special populations noted above:

- Youth ages 18-21 in a supervised independent living setting: 429
- Confirmed victims/survivors of sex trafficking: 46 (10 males and 36 females)
- Teen pregnant, parenting, post-partum mothers: 24

43. Will the state offer funds to help group homes transition to other needed programs and services, whether in child welfare or another sector?

Based on state funds and the FFTA funding provided to the state, the Department is considering providing funding for group homes to facilitate transition into QRTP settings.

44. How does DSS see group homes meeting programming needs for 18 to 21 year olds?

The Department is currently developing draft form legislation that will enhance services for youth ages 18-21, also known as Non-Minor Dependents. Upon passing of the legislation, the Department will be able to draw down Title IV-E funds to assist with the placement needs of this population.

Under FFPSA one of the approved IV-E settings include Supervised Independent Living Services for youth ages 18-21.

45. How will DSS define at risk for sex trafficking, and what details can you provide about residential programming opportunities for children so classified?

The Department will use the DSS Form, Child Trafficking Tool, to help define at-risk youth. This tool will be completed on all suspected trafficking victims and the results will determine next steps for the youth. Once completed, if the youth scores "at-risk" of becoming a victim of sex trafficking, the case manager will consult with their local Child Advocacy Center (CAC) to determine if a forensic interview is necessary to further assist the youth and determine follow up services such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). The case manager will staff the case with Supervisor. They will continually monitor the youth's status monthly and if the concerns escalate to High Risk or Confirmed, they will staff the case with the Regional Clinical Specialist and Supervisor. Currently, there is only one licensed and contracted group home in our state that offers housing to this population. The Department is currently considering other options and has applied through the Office for Victims of Crime for a grant that will assist with housing and other services for this population. Additionally, the Department continues to explore other housing options for this special population that includes collaborating with Child Placing Agencies.

46. How will the State do more to support kinship care?

The state is focusing on being a kin first state. The agency has requested in the DSS budget to include state funding for kinship navigation services as well. As stated before, the federal government is also supporting the state with funding to partner with other agencies and to provide comprehensive kinship navigation services to kinship families throughout the state. We've also included in our Guiding Principles and Standards Practice Model that our principles and values are providing family-centered practice and identifying and engaging with kinship

families because we know that children thrive and are stable when they are connected to their families and communities.

47. What impact will it (Kinship Care) have on CPAs?

Kinship care will impact CPAs by CPAs may having the opportunity to support kinship caregivers by partnering to provide kinship navigation services. We're in the process of exploring ways to contract with providers to support kinship caregivers. Additionally, even in a child welfare system where kin are prioritized there is still a need for regular and therapeutic foster home placements.

48. Has it been determined definitively if there will be a cap on the number of children served in each location?

Per the language noted by the ACF the following information is noted: Per 45 Code of Federal Regulations (CFR) § 1355.20, "Child care institution means a private child care institution, or a public child care institution which accommodates no more than 25 children and is licensed by the licensing authority responsible for licensing or approval of institutions of this type as meeting the standards established for such licensing. "The licensing authority must be a state authority in the state in which the child care institution is located, a tribal authority with respect to a child care institution on or near an Indian reservation, or a tribal authority of a tribal title IV-E agency with respect to a child care institution in the tribal title IV-E agency's service area. This definition must not include detention facilities, forestry camps, training schools or any other facility operated primarily for the detention of children who are determined to be delinquent." The 25-bed limitation applies to public child care institutions.

49. Can providers serve multiple referral sources in the same program/building, i.e. DSS, DDSN, DMH, and DJJ?

Yes. Providers can serve youth from multiple child-serving agencies. Staffing, supervision, and bed assignments shall be adhered to based on established licensing regulations, monitored, and adjusted based on children served within each milieu.

50. Will QRTPs be required to use a trauma model approved by the designated Clearinghouse?

The IV-E Clearinghouse is required for prevention services. This does not apply to group care settings. For potential models for out of home care, please refer to: https://www.cebc4cw.org/. In addition, a document with trauma-informed models

of care that are on the California Evidence-Based Clearinghouse will be made available to providers. Upcoming presenters in June will also talk on trauma-informed models that can be implemented and the process.

51. Will QRTPs have an age range for children?

Per the ACF, tracking is required for the following circumstances: "If a title IV-E agency places a child in a QRTP for more than 12 consecutive months, or 18 nonconsecutive months, or, in the case of a child who has not attained age 13, for more than six consecutive or nonconsecutive months, the title IV-E agency must submit to HHS:

- The most recent versions of the evidence and documentation submitted for the most recent status review or permanency hearing; and
- The signed approval of the head of the title IV-E agency for the continued placement of the child in that setting (section 475A(c)(5) of the Act).

Age is taking into consideration reform established by Michelle H coupled with federal tracking requirements.

52. What type of concrete activities can providers begin to do to prepare to be a provider for preventative services?

One major component embedded within the FFPSA is business providers diversifying their business practices to support better outcomes with children and families that interface with the child welfare system on the continuum.

As the Department develops a service array with guidance from the Children's Bureau and stakeholders, providers can remain informed with prevention measures and plan accordingly.