Progress of the South Carolina Department of Social Services

MICHELLE H., et al. v. MCMASTER AND ALFORD
MONITORING PERIOD IV
April 1, 2018 – September 30, 2018

Co-Monitors:
Judith Meltzer
Paul Vincent

Co-Monitor Staff:
Rachel Paletta
Elissa Gelber
Gayle Samuels

Center *for the* Study *of* Social Policy
Ideas into Action

Paul Vincent

Michelle H., et al. v. McMaster and Alford
Progress Report for the Period April 1 - September 30, 2018

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

Michelle H., et al. v. McMaster and Alford
Progress Report for the Period April 1 - September 30, 2018

I. INTRODUCTION

This is the fourth six-month report[1] on the progress of the South Carolina Department of Social Services (DSS) in meeting the requirements of the Final Settlement Agreement (FSA) entered in *Michelle H., et al. v. McMaster and Alford*. Approved by the United States District Court on October 4, 2016, the FSA includes requirements governing the care and treatment of the more than 4,500 children in foster care in South Carolina[2] and incorporates provisions that had been ordered in the previous year in a Consent Immediate Interim Relief Order (the Interim Order)[3]. The report covers DSS performance during the period April 1 through September 30, 2018, and has been prepared by court-appointed independent Co-Monitors Paul Vincent and Judith Meltzer, with assistance from monitoring staff Rachel Paletta, Elissa Gelber, Gayle Samuels, and Erika Feinman, and is presented to The Honorable Richard Gergel, U.S. District Court Judge, Parties to the lawsuit (Governor McMaster, DSS, and Plaintiffs), and the public.

The FSA outlines DSS's obligations to significantly improve experiences and outcomes for the children in its care. It was crafted by state leaders and Plaintiffs, who conceived it to include commitments that would guide a multi-year reform effort. The FSA reflects DSS's agreement to address long-standing problems experienced by children in foster care custody and in the operation of South Carolina's child welfare system. It includes a broad range of provisions governing: caseworker caseloads; visits between children in foster care and their caseworkers and family members; investigations of allegations of abuse and neglect of children in foster care; appropriate and timely foster care and therapeutic placements; and access to physical and mental health care for children in DSS custody.

While the FSA includes many specific agreements on policy and practice changes and outcomes to be met, some provisions are more open ended, with agreement by Parties to add greater specificity regarding outcomes, benchmarks, and timelines in collaboration with the Co-Monitors following DSS diagnostic work (including specified assessments and review of baseline information). The FSA thus establishes a structure in which the Co-Monitors work closely with DSS leaders to identify and develop phased implementation plans to guide much of the work ahead.

[1] FSA Section III.D. requires the Co-Monitors to issue reports approximately 120 days after the close of each reporting period, or after the State and/or DSS produces the necessary data to the Co-Monitors. The Co-Monitors did not receive all necessary data for this report covering April through September 2018 performance until March 2019.
[2] The class of children covered by the FSA includes "all children who are involuntarily placed in DSS foster care in the physical or legal custody of DSS now or in the future" (FSA II.A.).
[3] Consent Immediate Interim Relief Order (September 28, 2015).

Included in this report is a summary of the Co-Monitors' general findings, followed by a detailed discussion of DSS's performance this monitoring period with respect to each of the FSA requirements.[4]

II. SUMMARY OF PERFORMANCE

During this monitoring period, DSS simultaneously worked to demonstrate progress on the court-ordered FSA requirements and to develop approvable plans to guide reform in key areas of work in the future. Plan development in the areas of workforce, placement, and health care proved to be more difficult and time consuming than originally envisioned. In February and March 2019, DSS finalized - and obtained Court and Co-Monitor approval of - its Placement, Workforce, and Visitation Implementation Plans, as well as key outstanding components of its Health Care Improvement Plan.[5,6] The completion and approval of these plans is a significant milestone for DSS that came after months of diligent work with internal workgroups, community partners, and consultants to develop and articulate a vision for reform, and to identify strategies and resource commitments to move from vision to action. Together, these plans will serve as a roadmap for an improved South Carolina child welfare system with the potential to better meet the needs of the children and families it is intended to serve.

DSS's Placement Implementation Plan is comprehensive and ambitious. It includes commitments to practices that will keep children in their home communities, with kin, wherever possible, and lays the foundation for a process through which important decisions about children's placements are made purposefully in the context of child and family teams. Significantly, the Plan includes increased compensation for families who open their homes to children in foster care - kin and non-kin alike - and requires that DSS reset its relationship with private providers and engage with them to develop a family-focused placement and placement support system that builds on the assets in the private sector.

DSS's Workforce Implementation Plan includes strategies to address many of the barriers - such as high caseloads and inadequate supervision - identified in the expert consultant report completed early this monitoring period. The Plan creates a new salary schedule for caseworkers and supervisors that substantially increases compensation and retention incentives, and includes a commitment to partnerships with public university departments of social work throughout the state to train and recruit Bachelors and Masters level social work students. In addition, it eliminates the

[4] Pursuant to FSA III.K., "The Co-Monitors shall not express any conclusion as to whether Defendants have reached legal compliance on any provision(s)."
[5] On September 11, 2017, the Co-Monitors approved DSS's Out-of-Home Abuse and Neglect (OHAN) Implementation Plan, and Plaintiffs provide their consent to the Plan on November 7, 2017. On August 23, 2018, the Health Care Implementation Plan, with placeholders for key outstanding components, was approved by the Co-Monitors.
[6] All court-approved Implementation Plans and corresponding documents can be found here: https://dss.sc.gov/child-welfare-reform/

longstanding practice of assigning children's cases to both adoption and foster care caseworkers so that children and families can now have one point of contact for communication and planning.

DSS has now updated, and obtained Co-Monitor approval of, its health care coordination model and the interim benchmarks for performance in key areas related to health care. Completion of these important elements of the Health Care Improvement Plan position DSS and its partners at the South Carolina Department of Health and Human Services (DHHS) and its Medicaid managed care organization (MCO), Select Health, to move forward with implementation. The Plan is based upon a reinvigorated partnership with DHHS and Select Health and includes commitments to adding personnel who will interface with caseworkers, foster caregivers, and children, and to increased access to data and quality monitoring supports to ensure children's health care needs are met.

On March 28, 2019, the Co-Monitors also approved DSS's Visitation Implementation Plan. The Plan outlines a framework not only for improving FSA performance, but also for ensuring that visits are held in a meaningful way that supports the maintenance of family bonds critical to children's well-being, and supports practice improvements in all other implementation plans.

If adequately resourced and implemented with fidelity and the guidance and vision of permanent, committed leadership, DSS's Implementation Plans, combined with its newly developed Case Practice Model, can transform the way in which DSS serves children and families throughout the state. Though there remains much work to be done, the approval of these plans is a real accomplishment for DSS that will hopefully lay the foundation for progress in the months and years ahead.

This reform vision is needed now, more than ever, as DSS struggled this monitoring period in nearly all areas of practice addressed by the FSA. DSS operated without a permanent director for nearly ten months after Susan Alford resigned in July of 2018. The more recent departures of Taron Davis and Holly Pisarik has also meant that the roles of Deputy Director of Child Welfare and Internal *Michelle H.* Monitor have been vacant since the end of March 2019. This has been a strain on an already overtaxed agency, particularly at a time that has required concrete planning for reform.

On March 27, 2019, Governor Henry McMaster announced the nomination of Michael Leach as the next DSS Director, and on April 18, 2019, he was confirmed by the Senate. Mr. Leach has more than ten years of experience serving in Tennessee's Department of Children's Services, most recently as Deputy Director, and has pledged to bring a sense of urgency to the child welfare reform process in South Carolina. It is the Co-Monitor's belief that the appointment of a new leader and, hopefully, the filling of remaining key leadership vacancies, is essential to DSS's ability to

move forward aggressively with the reform, and the Co-Monitors look forward to working with Director Leach and DSS's leadership team.

Below is a summary of performance in key areas of practice.

Investigations of Abuse and Neglect of Children in Out-of-Home Care

DSS's Out-of-Home Abuse and Neglect (OHAN) unit screens referrals alleging abuse and neglect of children in foster care and conducts investigations of those referrals that are accepted. DSS performance improved this period with respect to the appropriateness of investigation decisions to *unfound* allegations of abuse and/or neglect, contact with core witnesses, and timely completion of investigations within 60 days of receiving a report. There were, however, declines in performance, including in DSS's timely initiation of investigations through contact with alleged victim children within 24 hours of the report, and timely completion of investigations within 45 days of initiation.

In accordance with its OHAN Implementation Plan, DSS began implementing additional training and supervision strategies for OHAN staff in late-2018, continuing through early-2019, and additional staff positions have recently been allocated to support this unit. The Co-Monitors have continued to encourage DSS to quickly fill these positions with qualified staff and to frequently evaluate whether more support is needed. On March 18, 2019, nine new staff were hired in the OHAN unit. Six of these staff completed Child Welfare Basic training prior to their hiring, and are scheduled to complete the OHAN investigation training in mid-April 2019. The other three staff have begun required pre-service training and will be prepared to begin accepting investigations in June 2019.

Workforce Recruitment and Retention

Manageable caseloads and adequate supervisory supports are foundational components of a productive and efficient workforce, and are critical to DSS's ability to improve performance and outcomes in all areas of its practice. Despite steps taken by the legislature last year to increase DSS caseworker positions, there are an alarming percentage of caseworkers with caseloads well over the required standard. *As of September 28, 2018, only 15 percent of foster care caseworkers, 16 percent of Intensive Foster Care and Clinical Services (IFCCS) caseworkers, 11 percent of adoption caseworkers, and no OHAN caseworkers had caseloads within the established caseload limits*. The expert consultant who has supported DSS in creating its Workload Implementation Plan concluded that significant progress in hiring and retaining workers will not be possible without addressing fundamental issues such as salary and worker supports. The strategies within the Workload Implementation Plan need to be quickly and ambitiously implemented in order to stabilize and support caseworkers and supervisors in providing for the safety and well-being of children in care.

Placement of Children in Foster Care

DSS has maintained its progress with respect to the placement of children ages 12 and under in congregate care facilities, and the majority of children in DSS care resided in family-based settings at the end of this monitoring period. However, DSS continues to rely heavily on congregate care placements for adolescents and older youth, and too many children spend time in these facilities at some point during their time in foster care. Additionally, many children are placed outside of their home communities, often separated from their siblings. A very small number of children live with kin or other adults with whom they had bonds prior to entering into care. DSS has committed in its Placement Implementation Plan to robust strategies intended to address these significant needs, and it will be critical that DSS move into implementation.

Visits between Children and their Families

The Co-Monitors continue to be very concerned that the vast majority of children in DSS custody do not spend any time with their parents, and that an increasing number do not have contact with their siblings. *In September 2018, only 42 percent of required visits between siblings were held, and a staggering 93 percent of children in foster care did not have the opportunity to visit with their parent(s) twice a month*, as required by DSS policy. Practice in this area must be addressed immediately, guided by DSS's Visitation Implementation Plan.

Health Care

The DSS Health Care Workgroup continued its work this monitoring period with their community and agency partners and outside consultants, under the leadership of the DSS Office of Health and Well-being, to implement aspects of its Health Care Improvement Plan. Despite clear commitment, progress with respect to data development - a key component of the Plan and the foundation of the model envisioned for ensuring children's health needs are met - was slow, evidencing the need for additional DSS resources dedicated to this area of practice. As referenced above, DSS did make significant progress in developing a framework for health care case management and care coordination, in which it committed to, among other things, 16 additional positions in the Office of Child Health and Well-Being,[7] as well as increased resources within a new Select Health Foster Care Unit. These resources will be critical to DSS's ability to carry out, and measure progress with respect to, its Health Care Improvement Plan.

Data Audit and Case Practice Model

In response to concerns raised by the Co-Monitors about the validity and availability of data in DSS's Child and Adult Protective Services System (CAPSS)[8], DSS began work with Chapin Hall at the University of Chicago in January 2018 to assess data validity and improve DSS processes

[7] This includes: five Program Coordinators to monitor and disseminate DSS data and provide TA, training, and coaching; six Clinical Consultants to bring pediatric medical expertise; two Quality and Performance Improvement and Contract Managers to monitor quality, performance, and deliverables by Select Health; and three Data Analysts to perform health care improvements to CAPSS, and monitor daily data feeds and processes for data exchange.

[8] CAPSS is DSS's State Automated Child Welfare Information System (SACWIS).

for reporting, data analysis, and evidence use. This work culminated in December 2018, with the production of a final report in which Chapin Hall concluded that DSS had made substantial progress in validating inaccurate or incomplete data in a range of important areas, and has improved its ability to flag concerns through use of CAPSS data. Chapin Hall also highlighted the strong commitment of the DSS workgroups to the data improvement process, as well as the challenge of leadership transitions, and the need for additional infrastructure to support DSS's data work. The Co-Monitors have urged DSS to act on this recommendation, particularly in light of the number of areas - as discussed throughout this report - in which data remain unavailable.

DSS has also continued its work on the development of a Case Practice Model. As emphasized in prior reports, it is critical that DSS have as the foundation for all of its work a robust and well-articulated model that structures how caseworkers understand and carry out their roles. DSS shared with the Co-Monitors in March 2019 a draft of its Case Practice Model, developed in consultation with Chapin Hall. The near final draft of the Case Practice Model reflects considerable work by DSS and incorporates important principles and understandings about how DSS intends to interact and intervene with children, families, caregivers, and community partners going forward. Finalization of this draft and broad communication about its core elements will be an important step for DSS, and the work of operationalizing the model must now begin. It is critical that the model be universally understood - by DSS leadership at all levels, caseworkers, community providers and stakeholders, foster parents, and families - and that it be implemented in a disciplined and accountable way that builds caseworker and system capacity, ensures fidelity, and ultimately achieves better outcomes for children, youth, and families.

III. MONITORING ACTIVITIES

The Co-Monitors are responsible for factual investigation and verification of data and documentation to compile and issue public reports on performance with respect to the terms of the FSA. In carrying out this responsibility, the Co-Monitors and their staff have worked closely with DSS leadership and staff. The Co-Monitors used multiple methodologies to conduct their work, including verification and analysis of information available through CAPSS; independent review of individual electronic and hardcopy case records; review and validation of data aggregated by DSS; interviews and conversations with DSS leaders and staff; and conversations with external stakeholders, including providers, advocacy, and community organizations. The Co-Monitors have worked with DSS and University of Southern Carolina's Center for Child and Family Studies (USC CCFS) to establish review protocols to gather performance data and assess current practice. Specific data collection and/or validation activities conducted by the Co-Monitors for the current period include the following:

- Review of monthly caseload reports for county, IFCCS, adoption, and OHAN (Out-of-Home Abuse and Neglect) caseworkers and supervisors (FSA IV.A.2.(b)&(c));

- Monthly review of all referrals involving allegations of abuse and neglect of Class Members not accepted for investigation by DSS's OHAN (FSA IV.C.2.);

- Review of all OHAN investigations involving Class Members that were accepted in September 2018 to assess for timely initiation, contact with core witnesses, timely completion, and appropriateness of unfounded decisions (FSA IV.C.3.&4.);

- Review of case files of a statistically valid sample of visits between Class Members and their siblings in foster care in September 2018 to assess whether sibling visits had occurred (FSA IV.J.2.);

- Review of case files of a statistically valid sample of Class Members with a goal of reunification in September 2018 to assess whether visits between children and parents had occurred (FSA IV.J.3.);

- Review of case files of Class Members identified by stakeholders as involved with the South Carolina Department of Juvenile Justice (DJJ) to assess appropriateness of DJJ placement (FSA IV.H.1.);

- Review of case files of children ages six and under who are placed in a congregate care setting (FSA IV.D.2.); and

- Review of all case files of children reported to have remained in a DSS office overnight (FSA IV.D.3.).

In addition to these data collection and reporting functions, the FSA gives the Co-Monitors the responsibility to review and approve Implementation Plans and to set or approve interim benchmarks and outcomes in multiple areas of practice. To assist in the Co-Monitoring responsibilities, as provided for in the FSA[9], and to support DSS in the development of their plans, the Co-Monitors engaged several consultants who bring expertise in specific areas of practice. These consultants have assisted the state in developing the Health Care Improvement Plan, Workload Implementation Plan, and Placement Implementation Plan. The Co-Monitors continued to work closely this reporting period with each of these consultants to gather information and data to inform their analysis, and coordinate and facilitate communication to ensure appropriate sequencing of activities and reduce any potential for overlap of tasks or responsibilities.

[9] FSA III.B. and IV.K.3.

IV. SUMMARY TABLE OF *MICHELLE H., et al. v. McMASTER and ALFORD* FINAL SETTLEMENT AGREEMENT PERFORMANCE

Table 1: Summary Performance on Settlement Agreement Requirements

Final Settlement Agreement (FSA) Requirements	Final Target	October 2017 - March 2018 Performance	April - September 2018 Performance
Workload Limits for Foster Care: A foster care Workload Limit must apply to every Caseworker and to every Caseworker's supervisor. DSS may identify categories of Caseworker or Supervisor or both and set a different Workload Limit for each category. (FSA IV.A.2.(b)&(c))	1a. At least 90% of caseworkers shall have a workload within the applicable Workload Limit. 1b. No caseworker shall have more than 125% of the applicable Workload Limit. ***Interim benchmark requirement - By September 2019, 40%***	OHAN caseworkers: As of March 2018, 17% of OHAN caseworkers had a caseload within the required limit and 67% of caseworkers had caseloads more than 125% of the limit. Monthly range of performance for caseworkers within the required limit: 14 - 17% Monthly range of performance for caseworkers with caseloads more than 125% of the limit: 67 - 83%	OHAN caseworkers:[10] As of September 2018, 0% of OHAN caseworkers had a caseload within the required limit and 80% of caseworkers had caseloads more than 125% of the limit. Monthly range of performance for caseworkers within the required limit: 0 - 33%.[11] Monthly range of performance for caseworkers with caseloads more than 125% of the limit: 50 - 100%.[12]

[10] The Co-Monitors selected a random day in each month this period to measure caseload compliance for each type of caseworker. These random dates are as follows: April, 26; May 15; June 6; July 19; August 3; and September 28, 2018. Performance on this date was compared to one other randomly selected date during the month to ensure limited variability and reported performance is not an anomaly.

[11] Monthly performance for OHAN caseworker caseloads within the required limit are as follows: April, 33%; May, 17%; June, 14%; July, 17%; August, 0%; September, 0%.

[12] Monthly performance for OHAN caseworker caseloads more than 125% over the limit are as follows: April, 50%; May, 67%; June, 86%; July, 83%; August, 100%; September, 100%.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
Approved Caseworker Limits:[13,14] • OHAN investigator: one caseworker: eight investigations • Foster Care caseworker: one caseworker: 15 children • IFCCS caseworker[15]: one caseworker: nine children • Adoption caseworker: one caseworker: 17 children • New caseworker: ½ of the applicable standard for their first six months after completion of Child Welfare Basic Approved Supervisor Limits: • For Foster Care, IFCCS and Adoption supervisors: one supervisor: five caseworkers • OHAN supervisors: one supervisor: six investigators		<u>Foster Care, IFCCS, Adoption caseworkers:</u>[16]	<u>Foster Care caseworkers:</u> As of September 2018, 15% of foster care caseworkers had a caseload within the required limit[17] and 77% of caseworkers had caseloads more than 125% of the limit. Monthly range of performance for caseworkers within the required limit: 14 - 20%[18,19]

[13] These limits were approved by the Co-Monitors on December 6, 2016, after completion of the Workload Study.

[14] Caseload limits and methodologies to calculate performance for caseworkers with mixed caseloads, both Class and Non-Class Members, were approved in December 2017. Non-Class Members include children receiving family preservation services while remaining in the home with their parent or caregiver, Adult Protective Services cases, families involved in child protective service assessments and children placed by ICPC. Performance for foster care caseworkers with mixed caseloads is calculated by adding the total number of foster care children (Class Members) the caseworker serves to the total number of families (cases) of Non-Class Members the caseworker also serves. The total number should not exceed 15 children and cases.

[15] Intensive Foster Care and Clinical Services.

[16] In prior periods, caseload performance was calculated by including supervisors carrying cases in the universe of caseworkers. Through development of the Workload Implementation Plan, and in consultation with the workforce consultant, this methodology has changed and does not include supervisors. Instead, a separate workload standard for instances in which a supervisor is carrying cases in addition to supervising staff will be developed. For example, a supervisor's workload may be 20 percent case carrying and 80 percent supervision of staff. The data collection and analysis process for this standard has not yet been finalized. To ensure appropriate data comparisons and tracking over time, prior performance data which included supervisors are not displayed within this Table.

[17] In addition to caseworkers carrying cases, there were 11 foster care supervisors carrying cases as of this date. If they were included in caseload calculations, performance would be 17%.

[18] Monthly performance for foster care caseworker caseloads (which includes newly hired caseworkers) within the required limit are as follows: April, 20%; May, 14%; June, 14%; July, 17%; August, 15%; September, 15%.

[19] Monthly caseload performance for only newly hired foster care caseworkers are as follows: April, 21%; May, 4%; June, 5%; July, 11%; August, 17%; September, 7%.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
			Monthly range of performance for caseworkers with caseloads more than 125% of the limit: 67 - 77%.[20] <u>IFCCS caseworkers:</u> As of September 2018, 16% of IFCCS caseworkers had a caseload within the required limit[21] and 60% of caseworkers had caseloads more than 125% of the limit. Monthly range of performance for caseworkers within the required limit: 16 - 32%[22,23] Monthly range of performance for caseworkers with caseloads more than 125% of the limit: 41 - 60%.[24]

[20] Monthly performance for foster care caseworker caseloads more than 125% over the limit are as follows: April, 67%; May, 73%; June, 67%; July, 73%; August, 77%; September, 77%.
[21] In addition to caseworkers carrying cases, there were seven IFCCS supervisors carrying cases as of this date. If they were included in caseload calculations, performance would be 20%.
[22] Monthly performance for IFCCS caseworker caseloads (which includes newly hired caseworkers) within the required limit are as follows: April, 22%; May, 22%; June, 32%; July, 19%; August, 24%; September, 16%.
[23] Monthly caseload performance for only newly hired IFCCS caseworkers are as follows: April, 60%; May, 64%; June, 78%; July, 33%; August, 37%; September, 23%.
[24] Monthly performance for IFCCS caseworker caseloads more than 125% over the limit are as follows: April, 54%; May, 49%; June, 41%; July, 54%; August, 58%; September, 60%.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
			<u>Adoption caseworkers:</u> As of September 2018, 11% of adoption caseworkers had a caseload within the required limit[25] and 79% of caseworkers had caseloads more than 125% of the limit. Monthly range of performance for caseworkers within the required limit: 6 - 13%[26,27] Monthly range of performance for caseworkers with caseloads more than 125% of the limit: 67 - 84%[28]

[25] In addition to caseworkers carrying cases, there were four adoption supervisors carrying cases as of this date. If they were included in caseload calculations, performance would be 10%.
[26] Monthly performance for adoption caseworker caseloads (which includes newly hired caseworkers) within the required limit are as follows: April, 13%; May, 10%; June, 7%; July, 6%; August, 6%; September, 11%.
[27] Monthly caseload performance for only newly hired adoption caseworkers are as follows: April, 0%; May, 0%; June, 0%; July, 0%; August, 0%; September, 25%.
[28] Monthly performance for adoption caseworker caseloads more than 125% over the limit are as follows: April, 67%; May, 74%; June, 74%; July, 84%; August, 81%; September, 79%.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
	2a. At least 90% of supervisors shall have a workload within the applicable Workload Limit. 2b. No supervisor shall have more than 125% of the applicable Workload Limit. ***Interim benchmark requirement - By September 2019, 40%***	<u>OHAN Supervisors:</u> As of March 2018, 100% of OHAN supervisors were within the required limit. Monthly range of performance for supervisors within the required limit:100% <u>Foster Care Supervisors:</u> As of March 2018, 42% of foster care supervisors were within the required limit and 36% of supervisors were more than 125% of the limit. Monthly range of performance for foster care supervisors within the required limit: 42 - 45%	<u>OHAN Supervisors:</u> As of September 2018, 50% of OHAN supervisors were within the required limit and none were more than 125% of the limit. Monthly range of performance for supervisors within the required limit: 50 - 100%[29] No OHAN supervisor was responsible for more than 125% of the limit. <u>Foster Care Supervisors:</u> As of September 2018, 30% of foster care supervisors were within the required limit and 48% of supervisors were more than 125% of the limit. Monthly range of performance for foster care supervisors within the required limit: 30 - 45%[30]

[29] Monthly performance for OHAN supervisors within the required limit are as follows: April, 100%; May, 100%; June, 100%; July, 100%; August, 100%; September, 50%.
[30] Monthly performance for foster care supervisors within the required limit are as follows: April, 41%; May, 45%; June, 42%; July, 40%; August, 34%; September, 30%.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
		Monthly range of performance for supervisors more than 125% of the limit: 35 - 38% <u>IFCCS Supervisors:</u> As of March 2018, 57% of IFCCS supervisors were within the required limit and 29% of supervisors were more than 125% of the limit. Monthly range of performance for IFCCS supervisors within the required limit: 47 - 57% Monthly range of performance for supervisors more than 125% of the limit: 29 - 32% <u>Adoption Supervisors:</u> As of March 2018, 38% of adoption supervisors were within the required limit and 19% of supervisors were more than 125% of the limit.	Monthly range of performance for supervisors more than 125% of the limit: 34 - 48%[31] <u>IFCCS Supervisors:</u> As of September 2018, 29% of IFCCS supervisors were within the required limit and 58% of supervisors were more than 125% of the limit. Monthly range of performance for IFCCS supervisors within the required limit: 26 - 29%[32] Monthly range of performance for supervisors more than 125% of the limit: 47 - 59%[33] <u>Adoption Supervisors:</u> As of September 2018, 35% of adoption supervisors were within the required limit and 29% of supervisors were more than 125% of the limit.

[31] Monthly performance for foster care supervisors more than 125% over the limit are as follows: April, 34%; May, 34%; June, 41%; July, 44%; August, 48%; September, 48%.
[32] Monthly performance for IFCCS supervisors within the required limit are as follows: April, 26%; May, 20%; June, 24%; July, 27%; August, 29%; September, 29%.
[33] Monthly performance for IFCCS supervisors more than 125% over the limit are as follows: April, 47%; May, 50%; June, 57%; July, 59%; August, 50%; September, 58%.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
		Monthly range of performance for adoption supervisors within the required limit: 38 - 61% Monthly range of performance for supervisors more than 125% of the limit: 11 - 19%.	Monthly range of performance for adoption supervisors within the required limit: 25 - 44%[34] Monthly range of performance for supervisors more than 125% of the limit: 22 - 29%.[35]
Caseworker-Child Visitation: (FSA IV.B.2.&3.)	3. At least 90% of the total minimum number of face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place.	Unable to determine current performance.	Unable to determine current performance.[36]

[34] Monthly performance for adoption supervisors within the required limit are as follows: April, 25%; May, 35%; June, 35%; July, 44%; August, 35%; September, 35%.
[35] Monthly performance for adoption supervisors more than 125% over the limit are as follows: April, 25%; May, 29%; June, 29%; July, 22%; August, 29%; September, 29%.
[36] The Co-Monitors determined during the last monitoring period that documentation continued to be insufficient to allow for reporting on this measure. Because CAPSS documentation has not been sufficient to allow for a complete review of visit content, the Co-Monitors have been unable to assess whether the visits were done in accordance with DSS policy. In addition, the Co-Monitors were unable to report on DSS performance because DSS and Plaintiffs did not have a common understanding of what constitutes a "visit" under the FSA. As discussed in Section VI, Parties recently agreed upon a definition that will be utilized for measurement purposes going forward.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
	4. At least 50% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place in the residence of the child. ***Dates to reach final target and interim benchmarks to be added once Visitation Implementation Plan is approved.***[37]	Unable to determine current performance.	Unable to determine current performance.[38]
Investigations - Intake: (FSA IV.C.2.)	5. At least 95% of decisions not to investigate a Referral of Institutional Abuse or Neglect about a Class Member must be made in accordance with South Carolina law and DSS policy. ***Interim benchmark requirement - By September 2018, 95%***	Monthly performance for screening decisions not to investigate determined to be appropriate: October 2017: 92% November 2017: 84% December 2017: 93% January 2018: 89% February 2018: 80% March 2018: 81%	Monthly performance for screening decisions not to investigate determined to be appropriate: April 2018: 81% May 2018: 100% June 2018: 100% July 2018: 88% August 2018: 89% September 2018: 86%

[37] As discussed above (see supra. note 36), baseline data have not yet been collected for this measure. Once these data become available, DSS will need to integrate them into their Visitation Implementation Plan so that appropriate interim benchmarks can be calculated.
[38] See supra. note 36.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
Investigations - Case Decisions: (FSA IV.C.3.)	6. At least 95% of decisions to "unfound" investigations of a Referral of Institutional Abuse or Neglect must be based upon DSS ruling out abuse or neglect or DSS determining that an investigation did not produce a preponderance of evidence that a Class Member was abused or neglected. ***Interim benchmark requirement - By September 2018, 55%***	In March 2018, there were 29 applicable investigations with decisions to unfound; 21% (six) of these decisions were determined to be appropriate.	In September 2018, there were 39 applicable investigations with decisions to unfound; 41% (16) of these decisions were determined to be appropriate.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
Investigations - Timely Initiation: (FSA IV.C.4.(a)) *Investigations - Contact with Alleged Child Victim:* (FSA IV.C.4.(b))	7. The investigation of a Referral of Institutional Abuse or Neglect must be initiated within twenty-four (24) hours in accordance with South Carolina law in at least 95% of the investigations. 8. The investigation of a Referral of Institutional Abuse or Neglect must include face-to-face contact with the alleged victim within twenty-four hours in at least 95% of investigations, with exceptions for good faith efforts approved by the Co-Monitors.[39] ***Interim benchmark requirement - By September 2018, 80%***	In March 2018, of the 32 applicable investigations, 66% (21) were timely initiated or had documentation supporting completion of all applicable good faith efforts.	In September 2018, of the 39 applicable investigations, 62% (24) were timely initiated or had documentation supporting completion of all applicable good faith efforts.[40]

[39] The Co-Monitors' interpretation of the FSA requires that investigations be initiated within 24 hours of receipt of the referral by DSS, not within 24 hours of the decision to accept the referral, and that initiation is completed by making face-to-face contact with the alleged victim child(ren). As a result, the performance for both FSA measures IV.C.4.(a) and (b) are measured using the same methodology and timeframes - the time between receipt of referral and face-to-face contact with alleged child(ren) victim must be within 24 hours.

[40] Contact was made with all the alleged victim child(ren) within 24 hours in 22 investigations and in two additional investigations, documentation supported completion of all applicable good faith efforts.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
Investigations - Contact with Core Witnesses: (FSA IV.C.4.(c))	9. Contact with core witnesses must be made in at least 90% of the investigations of a Referral of Institutional Abuse or Neglect, with exceptions approved by the Co-Monitors. Core witnesses will vary from case to case and may or may not include the victim(s), Class Members, alleged perpetrators, reporter (if identified), identified eyewitness(es), other children in the placement, facility staff, treating professionals, and foster parents or caregivers as deemed to be relevant to the investigation. ***Interim benchmark requirement - By September 2018, 45%***	In March 2018, 3% (one) of the 32 applicable investigations included contact with all necessary core witnesses during the investigation.	In September 2018, 21% (eight) of the 39 applicable investigations included contact with all necessary core witnesses during the investigation.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
Investigations - Timely Completion: (FSA IV.C.4.(d-f))	10.a. At least 60% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within forty-five (45) days of initiation of an investigation, unless the DSS Director or DSS Director's designee authorizes an extension of no more than fifteen (15) days upon a showing of good cause.[41] ***Interim benchmark requirement - By September 2018, 75%***	82% of applicable investigations received in March 2018 were appropriately closed within 45 days.	64% of applicable investigations received in September 2018 were appropriately closed within 45 days.[42]

[41] For the purposes of this section, an investigation is not completed if DSS determines the report is unfounded because the deadline to complete the investigation has passed.
[42] The Co-Monitors are currently in conversation with DSS about the methodology used to calculate performance for this measure. Performance reported here utilizes what was understood by reviewers and some DSS staff at the time of the review to collect data. If this methodology is revised, an update will be provided in the next monitoring report.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
	10.b. At least 80% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within sixty (60) days of initiation of the investigation, and all investigations not completed within sixty (60) days shall have authorization of the DSS Director or DSS Director's designee of an extension of no more than thirty (30) days upon a showing of good cause.[43] ***Interim benchmark requirement - By September 2018, 80%***	88% of applicable investigations received in March 2018 were closed within 60 days.	100% of applicable investigations received in September 2018 were closed within 60 days.
	10.c. At least 95% of all investigations of a Referral of Institutional Abuse or Neglect not completed within sixty (60) days shall be completed within ninety (90) days.[44] ***Interim benchmark requirement - By September 2018, 95%***	88% of applicable investigations received in March 2018 were closed within 90 days.	100% of applicable investigations received in September 2018 were closed within 90 days.

[43] Ibid.
[44] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
Family Placements for Children Ages Six and Under: Within sixty (60) days, DSS shall create a plan, subject to the approval of the Co-Monitors, for preventing, with exceptions approved by the Co-Monitors, the placement of any Class Member age six (6) and under in any non-family group placement (including but not limited to group homes, shelters or residential treatment centers). The plan shall include full implementation within sixty (60) days following approval of the Co-Monitors. (FSA IV.D.2.)	11. No child age six and under shall be placed in a congregate care setting except with approved exceptions.	In March 2018, there were eight Class Members ages six and under in DSS custody and residing in a congregate care facility. The circumstances of seven of those children met an agreed upon exception for placement in congregate care and approval was sought prior to the child's placement as per DSS directive. Between October 2017 and March 2018, a total of 16 Class Members ages six and under were placed in congregate care. The circumstances of 12 of these young children met an agreed upon exception.	In September 2018, there were eight Class Members ages six and under in DSS custody and residing in a congregate care facility. The circumstances of all eight (100%) met an agreed upon exception for placement in congregate care and approval was sought prior to the child's placement as per DSS directive, as needed. Between April and September 2018, a total of 19 Class Members ages six and under were placed in congregate care. The circumstances of all but one of these young children met an agreed upon exception.[45,46]

[45] Applicable exceptions for the referenced children include: the child was residing in a treatment facility with their mother; or the child was part of a sibling group of four or more children for whom DSS reports a single, family-based placement could not be located.

[46] In validating data for this measure, the Co-Monitors identified one situation that did not meet an agreed-upon exception. One child was in a congregate care facility with siblings at the time DSS filed with the Court to gain custody of the children and the Court ordered that the child remain in that placement.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
Phasing-Out Use of DSS Offices and Hotels: Within sixty (60) days, DSS shall cease using DSS offices as an overnight placement for Class Members, and shall cease placing or housing any Class Members in hotels, motels and other commercial non-foster care establishments. For any Class Members moved out of such DSS Offices or Hotels, DSS shall provide for their appropriate placement. In the extraordinary event that a child stays overnight in a DSS office, Defendants shall immediately notify the Co-Monitors, who shall provide a report to Parties as appropriate, including whether or not, in their view, the incident should be reported to the Court as a violation which would preclude Defendants' ability to achieve compliance on this provision. (FSA IV.D.3.)	12. No child shall be placed or housed in a DSS office, hotel, motel, or other commercial non-foster care establishment.	Between October 2017 and March 2018, DSS reports two children remained overnight in a DSS office.	Between April and September 2018, DSS reports that two children remained overnight in a DSS office.
Congregate Care Placements: (FSA IV.E.2.)	13. At least 86% of the Class Members shall be placed outside of Congregate Care Placements on the last day of the Reporting Period. ***Interim benchmark requirement - By September 2019, 80%***	As of March 31, 2018, 78% (3,313 of 4,226) of children in foster care were placed outside of a congregate care setting.[47]	As of September 30, 2018, 80% (3,540 of 4,437) of children in foster care were placed outside of a congregate care setting.[48]

[47] Twenty-six children who were hospitalized (11) or in a correctional facility (15) are not included in the universe for this measure.

[48] Fifty children who were hospitalized (24), in a correctional/juvenile justice facility (24), or in college (two) are not included in the universe for this measure. Data reported for the period ending on September 30, 2018 are for Class Members only. Although the Co-Monitors worked with DSS in the prior reporting period to manually correct for identified coding issues, it is possible that for some placement measures a small number of Non-Class Members are included in the data reported. As a result, data for this reporting period may not be comparable to that reported as of March 31, 2018.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
Congregate Care Placements - Children Ages 12 and Under: (FSA IV.E.3.)	14. At least 98% of the Class Members twelve (12) years old and under shall be placed outside of Congregate Care Placements on the last day of the Reporting period unless an exception pre-approved or approved afterwards by the Co-Monitors is documented in the Class Member's case file. ***Interim benchmark requirement - By September 2019, 94%***	As of March 31, 2018, 92% (2,727 of 2,966) of children ages 12 and under in foster care were placed outside of a congregate care setting.[49]	As of September 30, 2018, 94% (2,981 of 3,186) of children ages 12 and under in foster care were placed outside of a congregate care setting.[50,51]

[49] Exceptions have been approved, though not applied during this monitoring period; therefore, actual performance may be higher than reported. DSS will develop a process for exception review and approval in future monitoring periods.
[50] Ibid.
[51] Fourteen children who were hospitalized are not included in the universe for this measure.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
Emergency or Temporary Placements for More than 30 Days: (FSA IV.E.4.)	15. Class Members shall not remain in any Emergency or Temporary Placement for more than thirty (30) days. Under exceptions subject to the Co-Monitors' approval, if a child is initially placed in an Emergency or Temporary Placement that is not a Congregate Care Placement, and that placement is re-designated within thirty (30) days as a long-term foster home or therapeutic foster home, then the child's stay shall not be considered a violation of this provision and the re-designation shall not be considered a placement move under Section IV.F.1 below. ***DSS has not yet proposed Interim Benchmarks and timelines to meet final target.***[52]	Data are not available for this period.	Data are not available for this period.[53]

[52] Pursuant to the Placement Implementation Plan, DSS is required to propose to the Co-Monitors a methodology to measure the use of emergency and temporary placements by June 2019. After approval of the methodology, and by July 2019, DSS is required to propose interim enforceable targets for these measures, which are subject to consent by the Co-Monitors and Plaintiffs.

[53] DSS is unable to provide the data needed to report on this requirement. DSS has identified two primary barriers to collecting and providing these data: (1) there is not a standard, operational definition for "emergency" or "temporary" placements; and (2) due to a lack of a clear operational definition, placement data utilizing these categories are inconsistently entered by staff into CAPSS. DSS has informed the Co-Monitors that after a definition is agreed upon, a code book of definitions describing each level of foster care will be developed and fields will be added to CAPSS to capture and collect necessary information. DSS anticipates reporting on this measure in July 2019.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
Emergency or Temporary Placements for More than Seven Days: (FSA IV.E.5.)	16. Class Members experiencing more than one Emergency or Temporary Placement within twelve (12) months shall not remain in the Emergency or Temporary Placement for more than seven (7) days. Under exceptions subject to the Co-Monitors' approval, if a child's subsequent placement within twelve (12) months in an Emergency or Temporary Placement is not a Congregate Care Placement, and that placement is re-designated within thirty (30) days as a long-term foster home or therapeutic foster home, then the child's stay shall not be considered a violation of this provision and the re-designation shall not be considered a placement move under Section IV.F.1 below. ***DSS has not yet proposed Interim Benchmarks and timelines to meet final target.***[54]	Data are not available for this period.	Data are not available for this period.[55]

[54] Pursuant to the Placement Implementation Plan, DSS is required to propose to the Co-Monitors a methodology to measure the use of emergency and temporary placements by June 2019. After approval of the methodology, and by July 2019, DSS is required to propose interim enforceable targets for these measures, which are subject to consent by the Co-Monitors and Plaintiffs.

[55] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
Placement Instability: (FSA IV.F.1.)	17. For all Class Members in foster care for eight (8) days or more during the 12-month period, Placement Instability shall be less than or equal to 3.37.	For the period October 1, 2016 to September 30, 2017[56], children in foster care for eight (8) days or more experienced instability at a rate of 3.55.	For the period October 1, 2017 to September 30, 2018, children in foster care for eight (8) days or more experienced instability at a rate of 3.92.[57,58]

[56] Data for this measure are reported on an annual basis.
[57] Specifically, there were a total of 6,003 moves and 1,532,961 total applicable days.
[58] It should be noted that performance based on the FSA placement instability measure is not comparable to performance with respect to the federal Round 3 Child and Family Services Review (CFSR) permanency outcome that measures stability of foster care placement. The CFSR outcome is based on the rate of placement per day of *all* children who enter foster care in a 12-month period, which is likely to be significantly higher than the rate of placement for *all* children in foster care during that period of time. See *Data Indicators for the Child and Family Services Review*, available at https://www.acf.hhs.gov/sites/default/files/cb/data_indicators.pdf

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
Sibling Placements: (FSA IV.G.2.&3.)	18. At least 85% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with at least one of their siblings unless one or more of the following exceptions apply: (1) there is a court order prohibiting placing all siblings together; (2) placement is not in the best interest of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3) additional exceptions as approved by the Co-Monitors. ***Interim benchmark requirement - By September 2019, 69%***	63% (547 of 863) of children entering foster care with their siblings or within 30 days of their siblings from October 2017 to March 2018 were placed with at least one of their siblings on March 30, 2018.	60% (594 of 996) of children entering foster care with their siblings or within 30 days of their siblings from April to September 2018 were placed with at least one of their siblings on September 30, 2018.[59,60,61]

[59] Sibling groups were identified utilizing data in CAPSS which defines a sibling group as a set of children with the same CAPSS case identifier.
[60] Exceptions have been approved, though not applied during this monitoring period; therefore, actual performance may be higher than reported. DSS will develop a process for exception review and approval in future monitoring periods.
[61] The methodology utilized to calculate these data is being evaluated by DSS, the Co-Monitors, and Chapin Hall at the University of Chicago, and adjustments may be made in future monitoring periods.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
	19. At least 80% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with all their siblings, unless one or more of the following exceptions apply: (1) there is a court order prohibiting placing all siblings together; (2) placement is not in the best interest of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3) additional exceptions as approved by the Co-Monitors. ***Interim benchmark requirement - By September 2019, 49%***	As of March 30, 2018, 38% (324 of 863) of children entering foster care with their siblings or within thirty (30) days of their siblings from October 2017 to March 2018 were placed with all of their siblings.	As of September 30, 2018, 36% (361 of 996) of children entering foster care with their siblings or within thirty (30) days of their siblings from April to September 2018 were placed with all of their siblings.[62]

[62] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
Youth Exiting the Juvenile Justice System: (FSA IV.H.1.)	20. When Class Members are placed in juvenile justice detention or another Juvenile Justice Placement, DSS shall not recommend to the family court or Department of Juvenile Justice that a youth remain in a Juvenile Justice Placement without a juvenile justice charge pending or beyond the term of their plea or adjudicated sentence for the reason that DSS does not have a foster care placement for the Class Member. DSS shall take immediate legal and physical custody of any Class Member upon the completion of their sentence or plea. DSS shall provide for their appropriate placement.	Unable to determine current performance.	Unable to determine current performance.[63]

[63] DSS does not currently have a system in place for tracking youth involved with both the juvenile justice and child welfare systems. As discussed in Section VIII below, the Co-Monitors reviewed a number of cases - likely representative of many others - in which youth spent time in DJJ facilities due, in part, to DSS's failure to meet their needs.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
Therapeutic Foster Care Placements - Referral for Staffing and/or Assessment: (FSA IV.I.2.)	21. All Class Members that are identified by a Caseworker as in need of interagency staffing and/or in need of diagnostic assessments shall be referred for such staffing and/or assessment to determine eligibility for therapeutic foster care placement and/or services within thirty (30) days of the need being identified. This requirement shall not apply if the Caseworker withdraws the identified need in good faith and in the best interests of the Class Member within thirty (30) days. ***Dates to reach final target and interim benchmarks to be added once approved by the Co-Monitors.***[64]	Data are not available for this period.	Data are not available for this period.[65]

[64] Pursuant to the Placement Implementation Plan, DSS is required to propose to the Co-Monitors a methodology to measure compliance with this requirement by July 2019. After approval of the methodology, DSS is required to propose interim enforceable targets for these measures, subject to consent and approval by the Co-Monitors and Plaintiffs. In addition, Parties have agreed that this measure may need to be revised in light of the newly envisioned placement processes set forth in the Plan, discussed in Section XIII below. In this instance, DSS would have to obtain approval from the Co-Monitors and Plaintiffs on new final targets.

[65] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
Therapeutic Foster Care Placements - Receipt of Recommendations for Services or Placement: (FSA IV.I.3.)	22. All Class Members that are referred for interagency staffing and/or needed diagnostic assessments shall receive recommendations for specific therapeutic foster care placement and/or services within forty-five (45) days of receipt of the completed referral. The recommendation(s) may include diagnostic assessment, community support services, rehabilitative behavioral health services, therapeutic foster care, group care, and psychiatric residential treatment facility. Level of Care Placement recommendations shall utilize the least restrictive care philosophy suitable to the child's needs and seek to place a Class Member in a family setting with a community support system. DSS shall update the assessment at least annually thereafter, upon a placement disruption or upon a material change in the Class Member's needs. In making that determination, DSS may consider the full array of appropriate placement alternatives to meet the needs of the Class Members.	Data are not available for this period.	Data are not available for this period.[67]

[67] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
	Dates to reach final target and interim benchmarks to be added once approved by the Co-Monitors.[66]		
Therapeutic Foster Care Placements - Level of Care Placement: (FSA IV.I.4.&5.)	23.a. Within 60 Days: At least 90% of children assessed as in need of therapeutic foster care placement shall be in the Therapeutic Level of Care and specific placement type that matches the Level of Care for which the child was assessed within sixty (60) days following the date of the first Level of Care Placement recommendation. ***DSS has not yet proposed Interim Benchmarks and timelines to meet final target.***[68]	Data are not available for this period.	Data are not available for this period.[69]

[66] Ibid.
[68] Ibid.
[69] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
	23.b. At least 95% of children assessed as in need of therapeutic foster care placement shall be in the Therapeutic Level of Care and specific placement type that matches the Level of Care for which the child was assessed within ninety (90) days following the date of the first Level of Care Placement recommendation. ***DSS has not yet proposed Interim Benchmarks and timelines to meet final target.***[70]	Data are not available for this period.	Data are not available for this period.[71]

[70] Ibid.
[71] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
Family Visitation - Siblings and Parents: (FSA IV.J.2.&3.)	24. At least 85% of the total minimum number of monthly sibling visits for all siblings not living together shall be completed, with exceptions when (1) there is a court order prohibiting visitation or limiting visitation to less frequently than once every month; (2) visits are not in the best interest of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3) with exceptions approved by the Co-Monitors. ***Interim benchmark requirement - By September 2019, 66%***	In March 2018, 57% of all required visits between siblings occurred for siblings who were not placed together.	In September 2018, 42% of all required visits between siblings occurred for siblings who were not placed together.[72]

[72] Data were collected during a review conducted by USC CCFS and Co-Monitor staff of a statistically valid random sample based on a 95% confidence level and +/- 5% margin of error.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
	25. At least 85% of Class Members with the goal of reunification will have in-person visitation twice each month with the parent(s) with whom reunification is sought, unless (1) there is a court order prohibiting visitation or limiting visitation to less frequently than twice every month; or (2) based on exceptions approved by the Co-Monitors. ***Interim benchmark requirement - By September 2019, 35%.***	In March 2018, 17% of children in foster care with a goal of reunification visited twice with the parent(s) with whom reunification was sought.	In September 2018, 7% of children in foster care with a goal of reunification visited twice with the parent(s) with whom reunification was sought.[73]

[73] Data were collected during a review conducted by USC CCFS and Co-Monitor staff of a statistically valid random sample based on a 95% confidence level and +/- 5% margin of error. Permanency goals were identified utilizing data in the CAPSS field in which caseworkers are expected to update case goals in accordance with the most current determination in legal proceedings.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
Health Care - Immediate Treatment Needs: By the end of ninety (90) days following final court approval of the Final Settlement Agreement (identification period), DSS shall identify Class Members with Immediate Treatment Needs (physical/medical, dental or mental health) for which treatment is overdue. (Immediate Treatment Needs means immediate non-elective physical/medical, dental or mental health treatment needs and documented assessment needs, excluding routine periodic assessments.) (FSA IV.K.4.(b))	26. Within forty-five (45) days of the identification period, DSS shall schedule the necessary treatment for at least 90% of the identified Class Members.	Data for this measure are not available.	Data for this measure are not available.[74]

[74] As reported in prior monitoring periods, DSS does not have a mechanism for assessing performance with respect to the FSA requirement that it "identify Class Members with Immediate Treatment Needs (physical/medical, dental, or mental health) for which treatment is overdue," initially intended to apply to children in DSS custody at the time of entry into the agreement in October 2016 (FSA IV.K.4.(b)). Though DSS reported in its Health Care Improvement Plan that it expected to propose an alternative to this provision based on data available through Select Health, the MCO for the majority of children in DSS foster care, it has not yet done so. The Co-Monitors will monitor progress in this area and report on the status of these data in the next monitoring period.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
Health Care - Initial Medical Screens	27. At least 90% of Class Members will receive an initial medical screen prior to initial placement or within 48 hours of entering care. ***Dates to reach final target and interim benchmarks to be added once approved.***[75]		Data for this measure are not available.[76]
Health Care - Initial Comprehensive Assessments	28. At least 85% of Class Members will receive a comprehensive medical assessment within 30 days of entering care. ***Interim benchmark requirement - By September 2019, 57%***		Data for this measure are not available.[77]

[75] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, DSS will present approvable interim benchmarks to the Co-Monitors by May 31, 2020.
[76] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, these data are to be reported for all children entering DSS custody beginning in monitoring period VII (October 2019 - March 2020).
[77] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
	29. At least 95% of Class Members will receive a comprehensive medical assessment within 60 days of entering care. ***Interim benchmark requirement - By September 2019, 71%***		Data for this measure are not available.[78]
	30. At least 85% of Class Members ages three and above for whom a mental health need is identified during the comprehensive medical assessment will receive a comprehensive mental health assessment within 30 days of the comprehensive medical assessment. ***Interim benchmark requirement - By September 2019, 80%***		Data for this measure are not available.[79]

[78] Ibid.
[79] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
	31. At least 95% of Class Members ages three and above for whom a mental health need is identified during the comprehensive medical assessment will receive a comprehensive mental health assessment within 60 days of the comprehensive medical assessment. ***Dates to reach final target and interim benchmarks to be added once approved.***[80]		Data for this measure are not available.[81]
	32. At least 90% of Class Members under 36 months of age will be referred to the state entity responsible for developmental assessments within 30 days of entering care. ***Interim benchmark requirement - By September 2019, 29%***		Data for this measure are not available.[82]

[80] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, DSS will present approvable interim benchmarks to the Co-Monitors by May 31, 2020.
[81] Ibid.
[82] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, these data are to be reported for all children entering DSS custody beginning in monitoring period VII (October 2019 through March 2020).

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
	33. At least 95% of Class Members under 36 months of age will be referred to the state entity responsible for developmental assessments within 45 days of entering care. ***Interim benchmark requirement - By September 2019, 30%***		Data for this measure are not available.[83]
	34. At least 60% of Class Members ages two and above for whom there is no documented evidence of receiving a dental examination in the six months prior to entering care will receive a dental examination within 60 days of entering care. ***Interim benchmark requirement - By September 2019, 50%***		Data for this measure are not available.[84]

[83] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, these data are to be reported for all children entering DSS custody beginning in monitoring period VI (April through September 2019).
[84] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
	35. At least 90% of Class Members ages two and above for whom there is no documented evidence of receiving a dental examination in the six months prior to entering care will receive a dental examination within 90 days of entering care. ***Interim benchmark requirement - By September 2019, 68%***		Data for this measure are not available.[85]
Health Care - Periodic Preventative Care	36. At least 90% of Class Members under the age of six months in care for one month or more will receive a periodic preventative visit monthly. ***Interim benchmark requirement - By September 2019, 79%***		Data for this measure are not available.[86]

[85] Ibid.
[86] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
	37. At least 90% of Class Members between the ages of six months and 36 months in care for one month or more will receive a periodic preventative visit in accordance with current American Academy of Pediatrics periodicity guidelines. ***Interim benchmark requirement - By September 2019, 77%***		Data for this measure are not available.[87]
	38. At least 98% of Class Members between the ages of six months and 36 months in care for one month or more will receive a periodic preventative visit semi-annually. ***Interim benchmark requirement - By September 2019, 84%***		Data for this measure are not available.[88]

[87] Ibid.
[88] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
	39. At least 90% of Class Members ages three and older in care for six months or more will receive a periodic preventative visit semi-annually. ***Interim benchmark requirement - By September 2019, 50%***		Data for this measure are not available.[89]
	40. At least 98% of Class Members ages three and older in care for six months or more will receive a periodic preventative visit annually. ***Interim benchmark requirement - By September 2019, 83%***		Data for this measure are not available.[90]
	41. At least 75% of Class Members ages two and older in care for six months or longer will receive a dental examination semi-annually. ***Interim benchmark requirement - By September 2019, 75%***		Data for this measure are not available.[91]

[89] Ibid.
[90] Ibid.
[91] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2017 - March 2018 Performance**	**April - September 2018 Performance**
	42. At least 90% of Class Members ages two and older in care for six months or longer will receive a dental examination annually. ***Interim benchmark requirement - By September 2019, 86%***		Data for this measure are not available.[92]
Health Care - Follow-Up Care	43. At least 90% of Class Members will receive timely accessible and appropriate follow-up care and treatment to meet their health needs. ***Dates to reach final target and interim benchmarks to be added once approved.***		Data for this measure are not available.[93]
Health Care - Case Management and Care Coordination	44. By March 1, 2019, DSS must submit to the Co-Monitors a proposed care coordination model, subject to Co-Monitor approval. Related outcome measures will be included at that time.		DSS's Health Care case management and care coordination model (the "Health care Addendum") was approved by the Co-Monitors on February 25, 2019.

[92] Ibid.
[93] Ibid.

V. CASELOADS

A sufficient, qualified, and trained workforce with manageable caseloads is foundational to a well-functioning child welfare system. Caseworkers must have sufficient resources and support to allow them to conduct meaningful visits with children and families, assess for safety and risk, and monitor progress towards individualized case goals, among many other important tasks. Child welfare agencies must ensure that the appropriate level of positions are allocated within each region and county office so that workers have manageable caseloads, and that when vacancies exist, they are quickly filled with as little disruption as possible to families and colleagues.

Unfortunately, the percentage of caseworkers meeting caseload standards was well below required targets and, for most types of caseworkers, declined between April and September 2018. Over the course of the monitoring period, DSS reports the number of children in foster care increased by approximately 400 children, further intensifying the caseload crisis in many parts of the state. The urgency of this issue cannot be understated and the strategies included within the Workload Implementation Plan must be aggressively pursued in order for relief to come and needed changes in practice to occur.

DSS reports of the 223 new positions allocated in the FY2019 budget, as of the writing of this report, 118 positions have been filled, and 105 are vacant. Additionally, of the 2,066 total caseworker and supervisor positions at DSS – which includes foster care, adoptions, IFCCS, child protective services, and caseworker assistants – as of the writing of this report, 1,715 of these positions are filled, and 351 positions are vacant.[94]

A. Workload Implementation Plan

The FSA required that by December 5, 2016, DSS develop an Implementation Plan to achieve the final FSA workload requirements. The Implementation Plan must include "enforceable interim benchmarks with specific timelines, subject to consent by Plaintiffs and approved (sic) by the Co-Monitors, to measure progress in achieving the final targets…" (FSA IV.A.2.(a)).

DSS first submitted a draft of the Workload Implementation Plan on November 30, 2016. After numerous rounds of the Co-Monitors and Plaintiffs providing feedback on the draft Plan and DSS making revisions and submitting new drafts, the Co-Monitors hired an expert consultant, Sue Steib, in June 2018. Ms. Steib has expertise in hiring practices and recruitment, and was tasked with assessing DSS's draft Plan, identifying where DSS planning could be strengthened, and suggesting strategies that would enable DSS to meet their workload obligations. Between July and October 2018, the consultant:

[94] These data have not been independently verified by the Co-Monitors. DSS reports that the number of filled positions does not include the recently filled OHAN investigator and supervisor position.

- Interviewed 57 DSS staff at the direct practice, management, and administrative levels, and three USC employees who provide training to DSS staff;
- Reviewed relevant documents pertaining to the *Michelle H.* action, as well as DSS policies, job descriptions, staffing reports, human resources policies related to pay raises and performance evaluations, and salary scales; and
- Compiled a summary of research on the factors known to impact recruitment, retention, and performance of direct practice child welfare staff.

The consultant worked closely with a workgroup assembled by DSS in developing findings and recommendations. The final report, titled *SC DSS Child Welfare Workforce Assessment, Findings, and Recommendations,* was issued on October 16, 2018, and shared with Parties and the Court. The consultant provided an oral summary of her analysis, findings, and recommendations at the *Michelle H*. status hearing held on December 4, 2018. Among the most important of the findings were:

Strengths

- County and state leaders and managers consistently cited the commitment of their respective staff as a strength.
- Despite changes in leadership and significant resource limitations, DSS has developed a core of professional middle managers, regional leaders, and county directors who are well attuned to the agency's workforce needs.

Challenges

- The level of pay and advancement opportunities are clearly inadequate to attract and retain highly qualified, high performing front line staff.
- There is no formalized relationship with state university schools of social work to promote recruitment of new graduates or continuing education for employees in area of study most closely aligned with child welfare practice.
- Workloads are uneven and unreasonably high in some counties and/or units.
- Many supervisors are themselves carrying caseloads and/or supervising more than five caseworkers.
- The lack of local resources for placement of children in out-of-home care results in case managers assigned to serve these children and their families spending an extraordinary amount of time driving and transporting children for family visits and other activities, thus limiting the time they have available for actual casework with both children and their parents or other permanency resource.

Following finalization of the report in October 2018, DSS requested the consultant provide assistance in revising the draft Workload Implementation Plan to incorporate the findings and recommendations. The revised Plan, which was approved by the Co-Monitors on February 20,

2019[95], includes infrastructure improvements and strategies to improve hiring and retention of caseworkers and supervisors. One of the most fundamental strategies in the Plan is the creation of a new salary schedule for caseworkers and supervisors that substantially increases compensation and retention financial incentives. Specifically, under the current salary schedule, the average caseworker at DSS, who does not have a social work degree, earns $35,541. Under the new salary schedule, the baseline salary for Level 1 caseworkers who do not have a social work degree will be $46,000; the top range of this position - for caseworkers with 10 years of experience and within the Level 3 classification - will be $55,261.33. This salary schedule provides greater parity with caseworker salaries in states with similar demographic characteristics and ensures staff receive a living wage upon hiring or no later than within two to three years of employment. Funding for the new salary schedule - estimated to require a total of approximately $33.6 million in new federal and state funds - will be requested for FY2021 and will be implemented beginning July 2020. In the interim, the state had requested in its pending budget request for the FY2020, beginning July 2019, a five percent salary increase for all staff.

The Plan also includes a commitment to partnerships with public university departments of social work throughout the state to recruit Bachelors and Masters level social work students. In addition, it eliminates the longstanding practice of assigning children's cases to both adoption and foster care caseworkers so that children and families can now have one point of contact for communication and planning. Also, in response to the Workforce Assessment recommendation that DSS consider eliminating specialized IFCCS[96] caseloads, by May 31, 2019, DSS will complete the necessary research to determine the funding and caseload distribution implications of this change and if it is feasible to eliminate IFCCS positions and move all children to generalized foster care caseloads. If DSS does eliminate this workload category, a transition plan will be developed and completed by August 30, 2019.

The interim benchmarks approved in the Plan include timelines that begin as of September 2019, with an anticipated goal of DSS meeting workload standards by March 2021. The interim targets require that no caseworker has a caseload of more than 180 percent of the standard by September 2019, no caseworker has more than 170 percent of the standard by March 2020, and no caseworker has more than 160 percent of the standard by September 2020.

[95] The Workload Implementation Plan is available at: https://dss.sc.gov/media/1948/dss-workload-implementation-plan.pdf

[96] Eligibility for IFCCS (Intensive Foster Care and Clinical Services) is determined following a review of a child's mental health assessment(s) and diagnosis; frequency, intensity and duration of symptoms; multi-system involvement; and exhaustion of alternative services. IFCCS services utilize funding through SC's Interagency System for Caring for Emotionally Disturbed Children (ISCEDC) to pay for treatment costs. ISCEDC funding are pooled dollars from multiple state agencies, including DSS, the Department of Mental Health, the Department of Disabilities and Special Needs, the Department of Juvenile Justice, and the Department of Education.

B. Performance Data[97]

Early in the reform, DSS leadership and the Co-Monitors expressed concern over the inability to accurately track and calculate data for caseworker and supervisory workloads. With assistance from Chapin Hall at the University of Chicago, DSS undertook several activities to better understand the prevalence of potential data inaccuracies, as well as the causes. The assessment found that improvements to CAPSS architecture completed in late-2017 allowed for more accurate tracking of caseworker and supervisor assignments, but that additional efforts were needed to update and validate some caseworker and supervisor information (referred to as "profiles") within CAPSS. In response, DSS has represented that it will consider changing policy to require that caseworker CAPSS profiles can only be completed by county Human Resources staff or other administrative level personnel instead of allowing and relying upon caseworker self-identification of their job titles.

The FSA requires "[a]t least 90% of Workers and Worker supervisors shall have a workload within the applicable Workload Limit" (FSA IV.A.2.(b)) and that "[n]o Worker or Worker's supervisor shall have more than 125% of the applicable Workload Limit" (FSA IV.A.2.(c)). There are different caseload standards dependent upon the types of cases a caseworker manages - specifically foster care, IFCCS, adoption, and investigations of allegations of abuse and neglect of a child in foster care. There are also reduced workload standards specific to newly hired caseworkers within their first six months of completing Child Welfare Basic training.

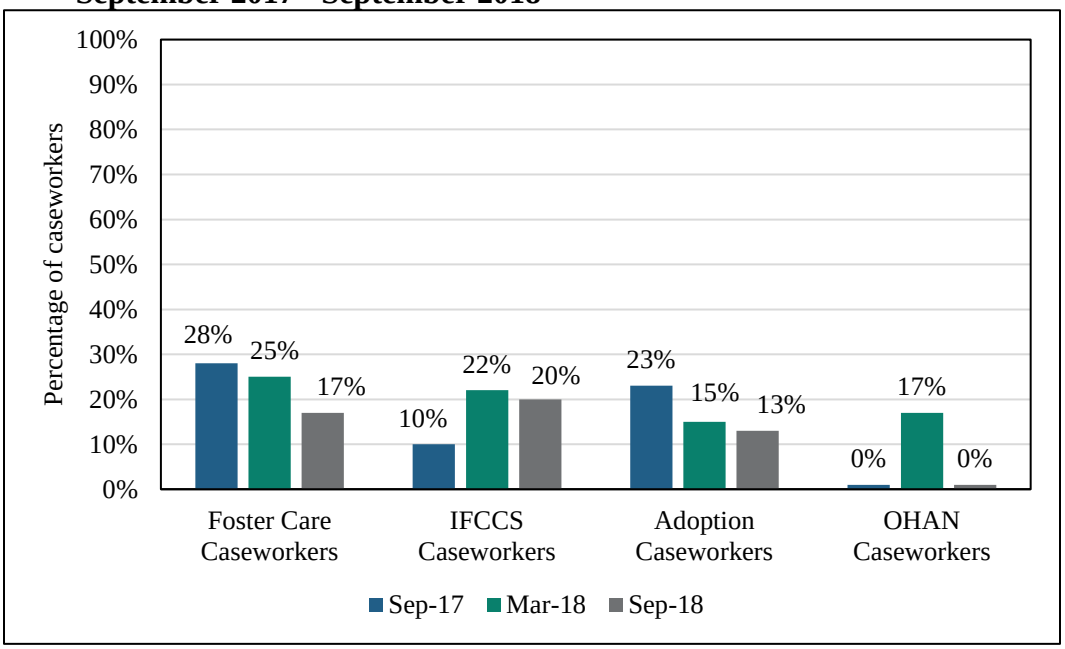
DSS has many staff with mixed caseloads that include both Class and Non-Class Members. On December 21, 2017, the Co-Monitors provisionally approved DSS's proposal to calculate caseloads for caseworkers with mixed caseloads by adding the total number of foster care children (Class Members) they serve to the total number of families (cases) of Non-Class Members they also serve.[98] The following types of cases are counted by family (case): Child Protective Services (CPS) assessment; family preservation; other child welfare services; and those involving a child subject to Interstate Compact on the Placement of Children (ICPC). This methodology is only applied to foster care caseworkers with mixed caseloads and is not applied to caseloads for IFCCS and adoption caseworkers.

[97] The Co-Monitors selected a random day in each month this period to measure caseload compliance for each type of caseworker. These random dates are as follows: April 26, May 15, June 6, July 19, August 3, and September 28, 2018. Performance on this date was compared to one other randomly selected date during the month to ensure limited variability and ensure reported performance is not an anomaly.

[98] In approving this mixed caseload methodology, the Co-Monitors relied upon DSS's commitments to: (1) move forward with plans to move caseworkers to single-type caseloads as feasible and appropriate; (2) change their internal metrics for family preservation cases to use a "family" as opposed to an individual child count; and (3) assess and find a way to address the Co-Monitors' concerns about the potential for unreasonable caseloads that could result from caseworker assignment to several family preservation cases involving families with multiple children. DSS has indicated that managers are continually assessing assignments to caseworkers with mixed caseloads to ensure balanced and manageable workloads. Because approval of this methodology is "provisional," DSS and the Co-Monitors will assess it in practice as it is implemented, reserving the right to modify the standard at any time if it is determined that the best interests of children are not being served.

To assist in assessing progress over time, Figure 1 provides performance data for this measure by caseworker and supervisor type over the past several monitoring periods.

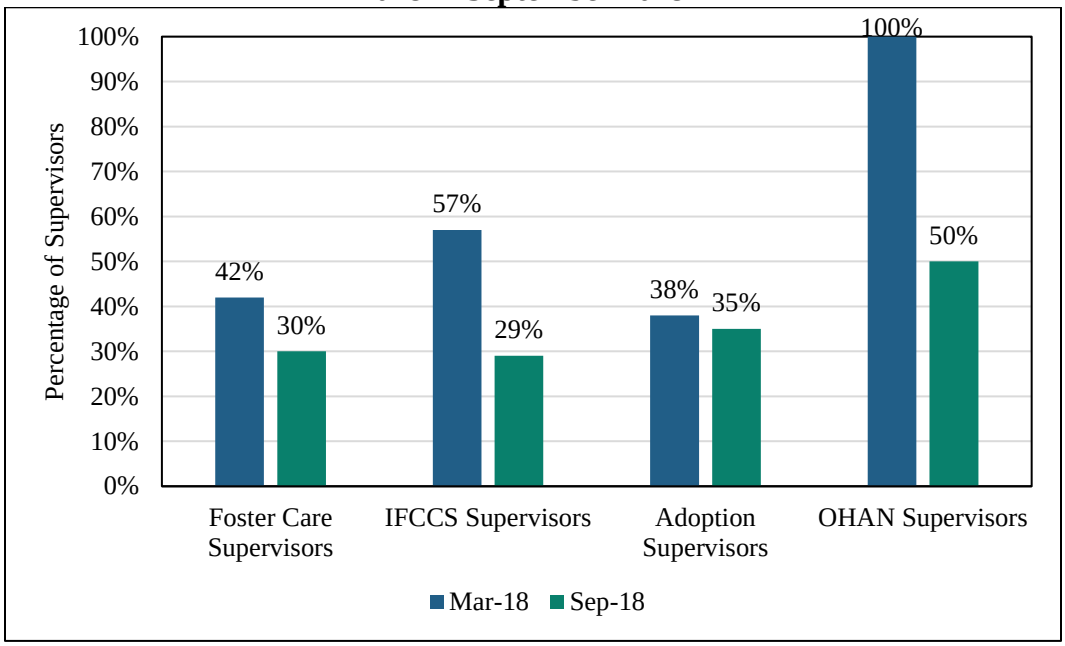
Figure 1: Performance Trends for Percentage of Caseworkers within the Required Caseload Limits, by Caseworker Type September 2017 - September 2018[99,100]



Source: CAPSS data provided by DSS

[99] For comparison purposes, performance data in this Figure are inclusive of supervisors carrying cases. As discussed later, current performance data presented below and in Table 1 of this report do not include supervisors.
[100] Caseload limits are as follows: foster care caseworker, 1:15; IFCCS caseworker, 1:9; adoption caseworker, 1:17; OHAN investigator, 1:8. The final target for this measure is 90%.

Figure 2: Performance Trends for Percentage of Supervisors within the Required Workload Limits, by Supervisor Type March - September 2018[101]



Source: CAPSS data provided by DSS

In prior monitoring periods, and in the Figures above, the Co-Monitors calculated performance for caseworker caseloads by including supervisors who were also directly carrying cases in the universe of caseworkers. Through development of the Workload Implementation Plan, and in consultation with the workforce consultant, this methodology has been adjusted to exclude supervisors from that calculation. Moving forward, a separate workload standard for those instances in which a supervisor is carrying cases in addition to supervising staff will be developed and reported on. For example, a supervisor's workload may be 20 percent case-carrying and 80 percent staff supervision. The data collection and analysis process for this standard has not yet been finalized; however, to ensure appropriate data comparisons and tracking over time, performance data for the current monitoring period discussed below and in future monitoring reports will only include caseworkers carrying cases (not supervisors).

Detailed performance by caseworker and supervisor type is discussed below.

Foster Care Caseworkers

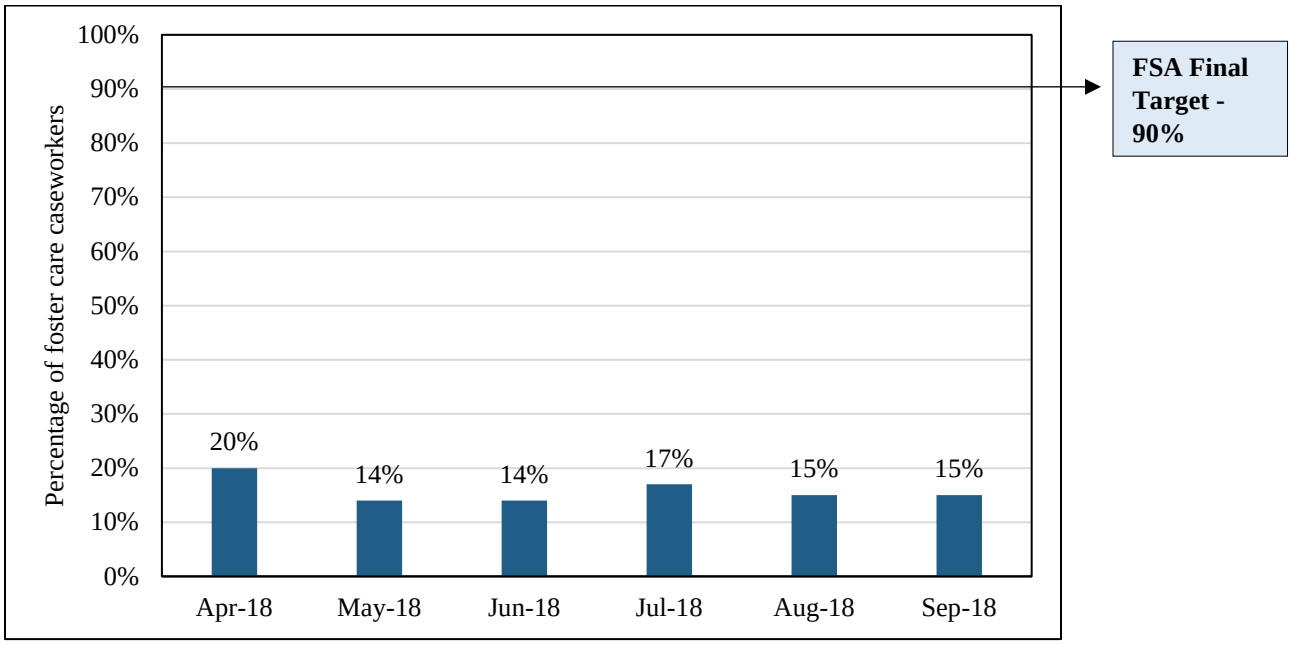
The caseload standard for caseworkers who are responsible for providing case management for foster care cases is one caseworker to 15 children (1:15). Newly hired foster care caseworkers

[101] Workload limits for supervisors are as follows: foster care, IFCCS, and adoption supervisors, one supervisor to five caseworkers; OHAN supervisors, one supervisor to six investigators. The final target for this measure is 90%.

should have no more than eight cases on their caseload for six months after they complete Child Welfare Basic training.

Between April and September 2018, a monthly range of 14 to 20 percent of foster care caseworkers had caseloads within the required limit (Figure 3) [102] and 67 to 77 percent of foster care caseworkers had caseloads more than 125 percent of the caseload limit (Figure 4). Specifically, on September 28, 2018, there were 176 foster care caseworkers[103] with at least one foster care child on their caseload. Of these 176 caseworkers, 27 (15%) foster care caseworkers had caseloads within the required limit.[104] Additionally, 135 (77%) caseworkers' caseloads were more than 125 percent of the caseload limit.

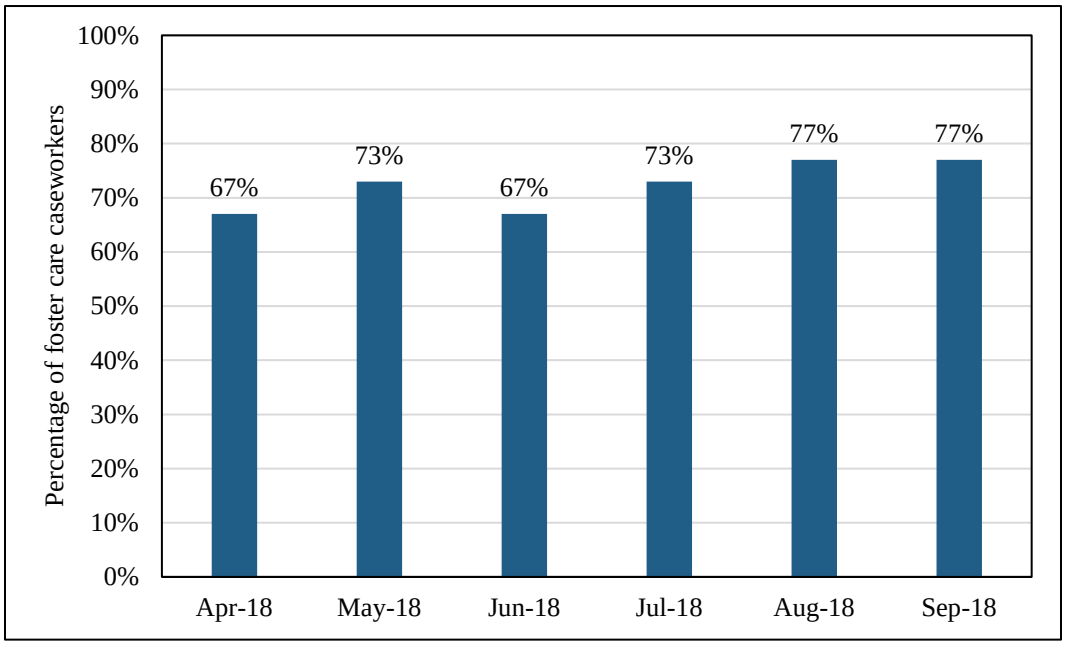
Figure 3: Foster Care Caseworkers within the Required Caseload Limits April - September 2018[105]



Source: CAPSS data provided by DSS

[102] In calculating performance, a standard of eight foster care children or Non-Class families is applied to newly hired caseworkers (half of the applicable caseload standard) and 15 foster care children or Non-Class families is applied to foster care or Adult Protective Services (APS) caseworkers.
[103] This includes eight caseworkers also managing adult protective services cases and 27 newly hired foster care caseworkers.
[104] In addition to caseworkers carrying cases, there were 11 foster care supervisors carrying cases as of this date. If they were included in caseload calculations, performance would be 17%.
[105] The interim benchmark for this measure is 40% by September 2019.

Figure 4: Foster Care Caseworkers over 125% of Required Caseload Limits April - September 2018[106]

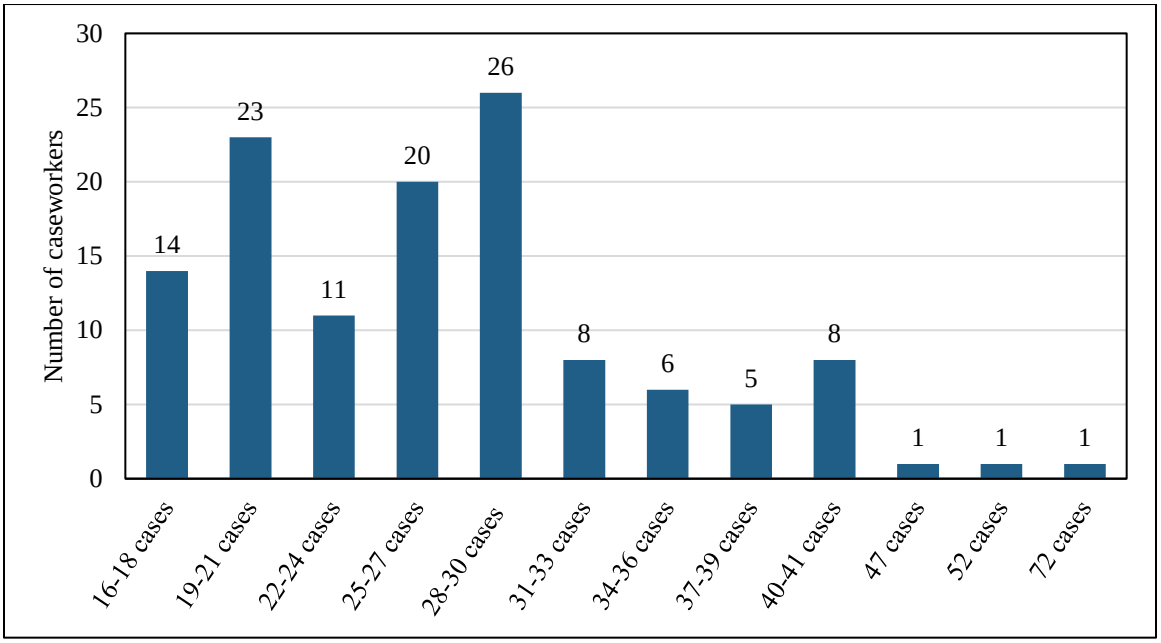


Source: CAPSS data provided by DSS

Figure 5 reflects the number of cases carried by the 124 foster care caseworkers who were not new caseworkers (completed Child Welfare Basic more than six months prior) and had more than 15 cases on their caseload on September 28, 2018.

[106] The interim benchmark for this measure is 40% by September 2019. The final target is 0%.

Figure 5: Number of Foster Care Caseworkers Over the Caseload Limit and their Caseload Size September 28, 2018 N=124



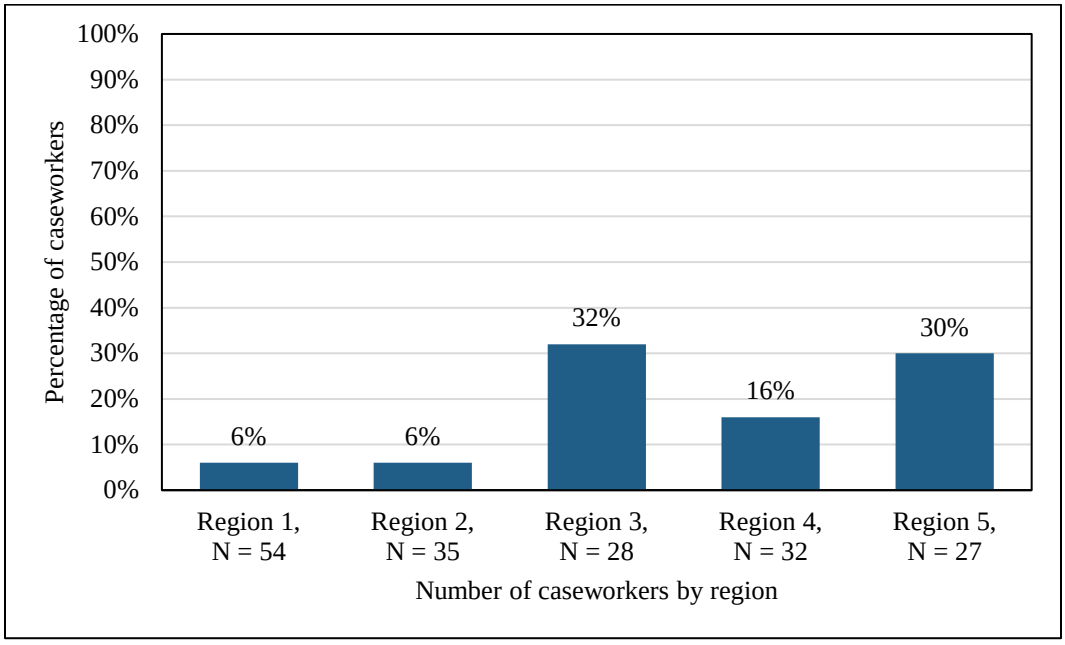
Source: CAPSS data provided by DSS

Although the FSA standard requires that new caseworkers be assigned one half of a full caseload for the first six months after Child Welfare Basic, data for this monitoring period indicate that the majority of new caseworkers (between 79 and 96 percent each month) had caseloads well above the required limits.[107]

There are five regions throughout the state, and each vary in terms of geographical size, the number of children and families served, and the number of caseworkers. Data on foster care caseworker caseloads as of September 28, 2018, shown in Figure 6, reflect that all Regions struggle with high caseloads. In Regions 1 and 2, in particular, only six percent of caseworkers in those two regions have caseloads within the required limits.

[107] Monthly caseload compliance for newly hired foster care caseworkers are as follows: April, 21%; May, 4%; June, 5%; July, 11%; August, 17%; September, 7%.

Figure 6: Foster Care Caseworkers by Region within the Required Caseload Limits September 28, 2018



Source: CAPSS data provided by DSS

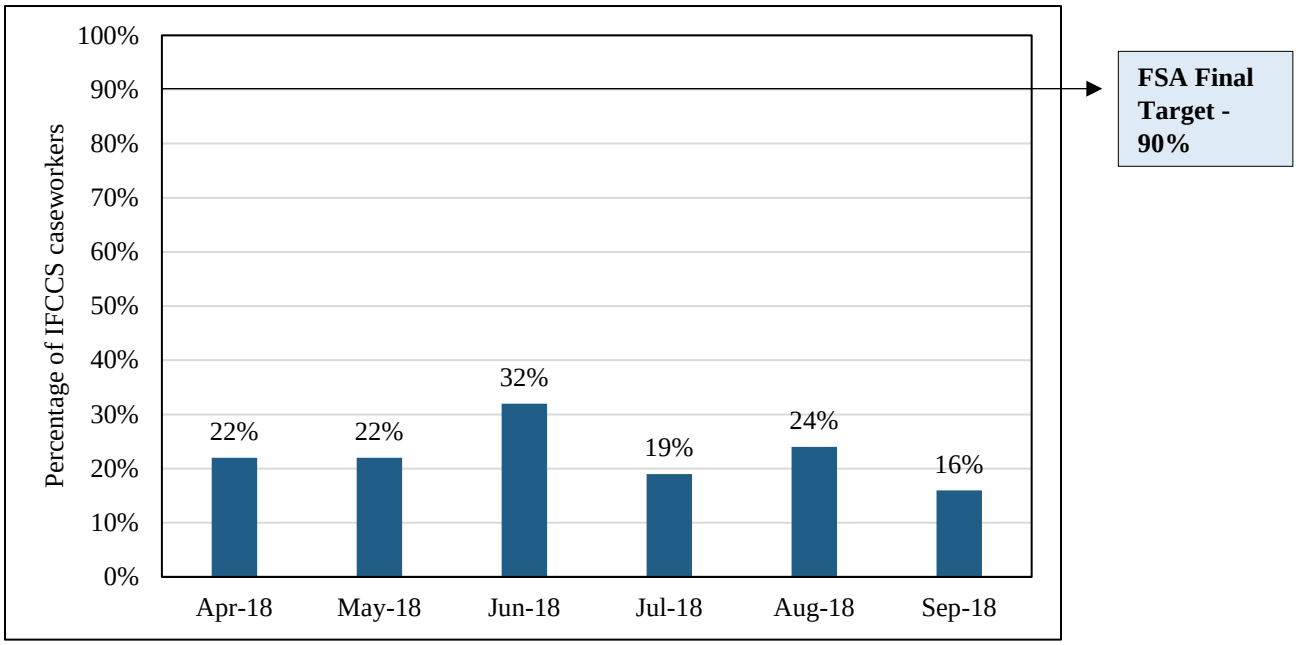
IFCCS Caseworkers

The caseload standard for caseworkers who are responsible for providing case management to children designated as needing IFCCS services is one caseworker to nine children (1:9). Newly hired IFCCS caseworkers should have no more than five children on their caseload for six months after they complete Child Welfare Basic training.

Between April and September 2018, a monthly range of 16 to 32 percent of IFCCS caseworkers were within the required limits and 41 to 60 percent had caseloads that exceeded 125 percent of the caseload limit (Figures 7 and 8). Specifically, on September 28, 2018, there were 101 IFCCS caseworkers[108] serving at least one Class Member and 16 (16%) of these caseworkers were within the required caseload limit[109]. Sixty-one (60%) caseworkers had caseloads more than 125 percent of the caseload limit.

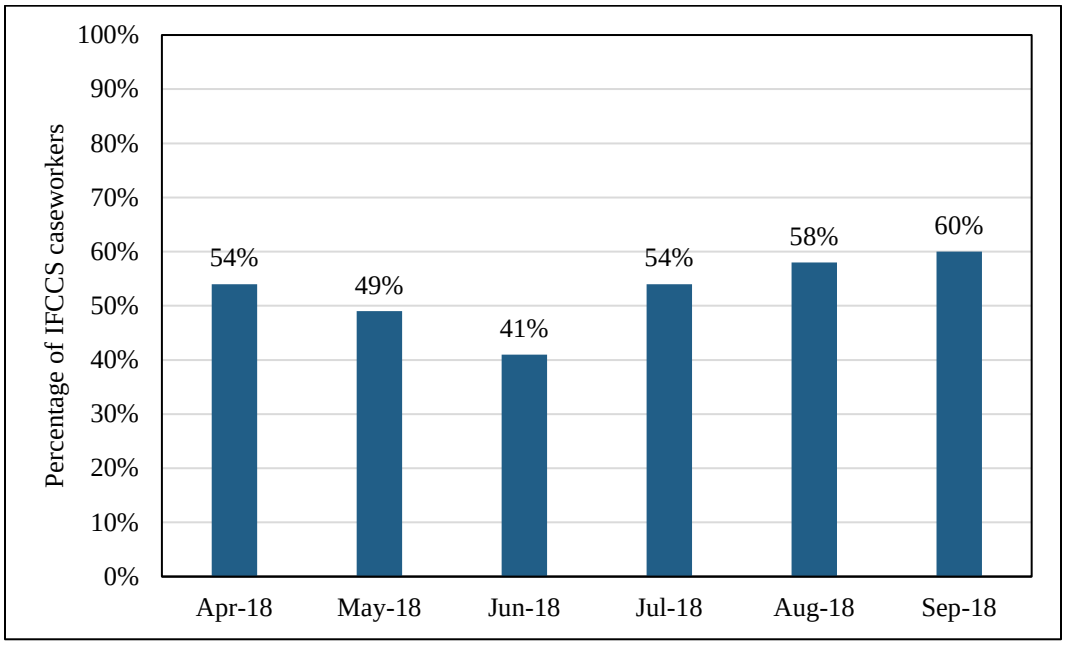
[108] Total includes 30 newly hired IFCCS caseworkers with a caseload standard of five children.
[109] In addition to caseworkers carrying cases, there were seven IFCCS supervisors carrying cases as of this date. If they were included in caseload calculations, performance would be 20%.

Figure 7: IFCCS Caseworkers within the Required Caseload Limits April - September 2018[110]



Source: CAPSS data provided by DSS

Figure 8: IFCCS Caseworkers over 125% of Required Caseload Limits April - September 2018[111]

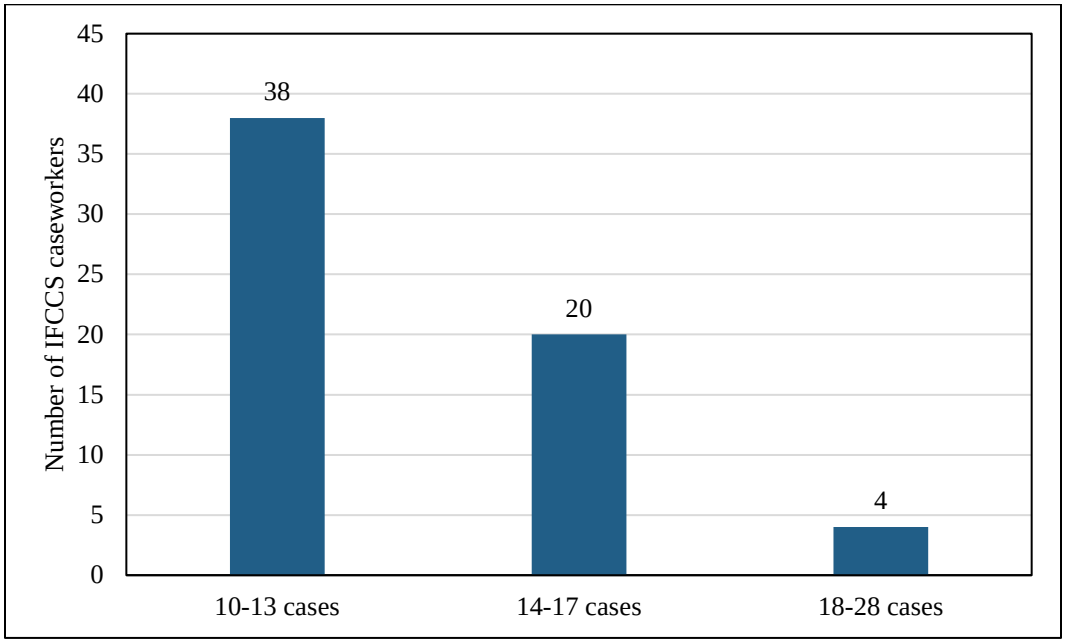


Source: CAPSS data provided by DSS

[110] The interim benchmark for this measure is 40% by September 2019.
[111] The interim benchmark for this measure is 40% by September 2019. The final target is 0%.

As of September 28, 2018, there were 62 IFCCS caseworkers who were not new caseworkers (completed Child Welfare Basic more than six months prior) and had more than nine children on their caseload. Figure 9 reflects the caseload size of these 62 caseworkers.

Figure 9: Number of IFCCS Caseworkers Over the Caseload Limit and their Caseload Size
September 28, 2018
N=62



Source: CAPSS data provided by DSS

In the first three months of the period, a range of 60 to 78 percent of newly hired IFCCS caseworkers had caseloads within the required limit of five children; however, in the remaining three months of the period, this percentage dropped, with only 23 percent of newly hired IFCCS caseworkers within the required limit as of September 28, 2018.[112]

Adoption Caseworkers

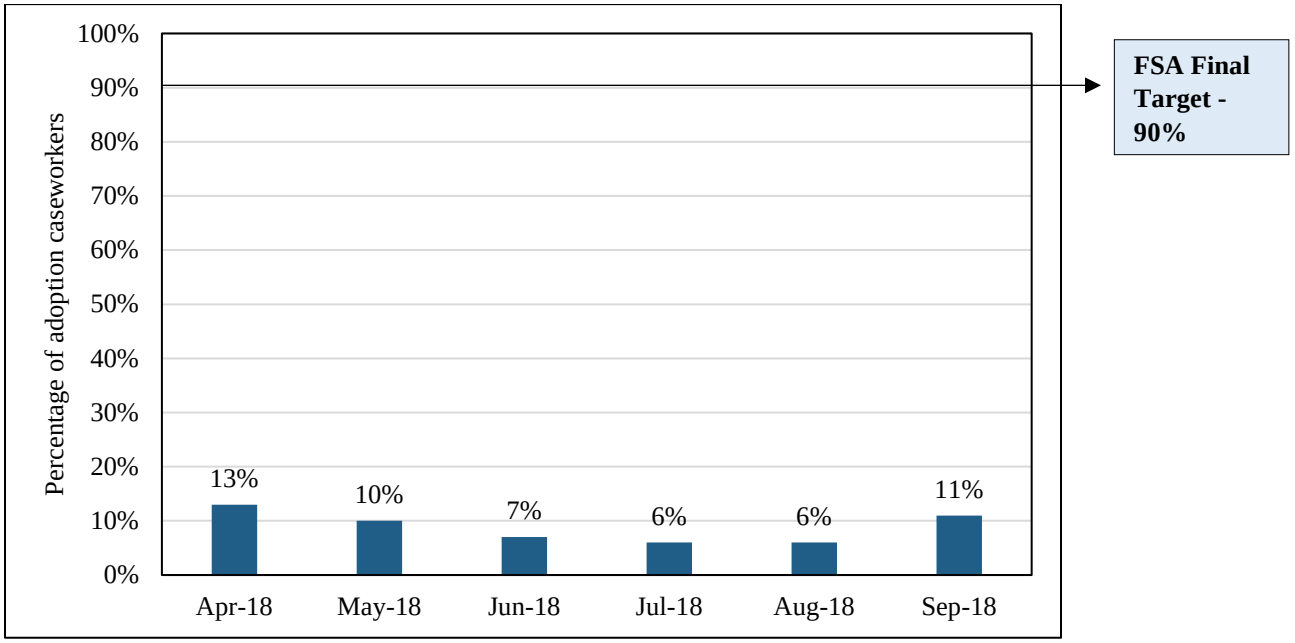
The caseload standard for caseworkers providing adoption support to children with a goal of adoption is one caseworker to 17 children (1:17).[113] Newly hired adoption caseworkers should

[112] Monthly caseload performance for newly hired IFCCS caseworkers are as follows: April, 60%; May, 64%; June, 78%; July, 33%; August, 37%; September, 23%.
[113] In approving these caseload limits, the Co-Monitors noted that although a caseload of 17 children for adoption caseworkers is not within the standard proffered by the Council on Accreditation, as DSS is currently structured, case management responsibilities remain with the foster care caseworker, even when an adoption caseworker is assigned, until a placement agreement is signed. As mentioned earlier in this section, DSS is eliminating the practice of foster care and adoption caseworkers sharing case management responsibility on individual cases. This will result in a modification to the adoption caseload standard in future monitoring periods.

have no more than nine children on their caseload for six months after they complete Child Welfare Basic training.

Between April and September 2018, a monthly range of six to 11 percent of adoption caseworkers had caseloads within the required limit (Figure 10) and 67 to 84 percent had caseloads that exceeded 125 percent of the required limit (Figure 11). On September 28, 2018, there were 71 adoption caseworkers[114] serving at least one Class Member. Of these 71 caseworkers, eight (11%) caseworkers had caseloads within the caseload requirement[115] and 56 (79%) caseworkers had caseloads that exceeded 125 percent of the limit.

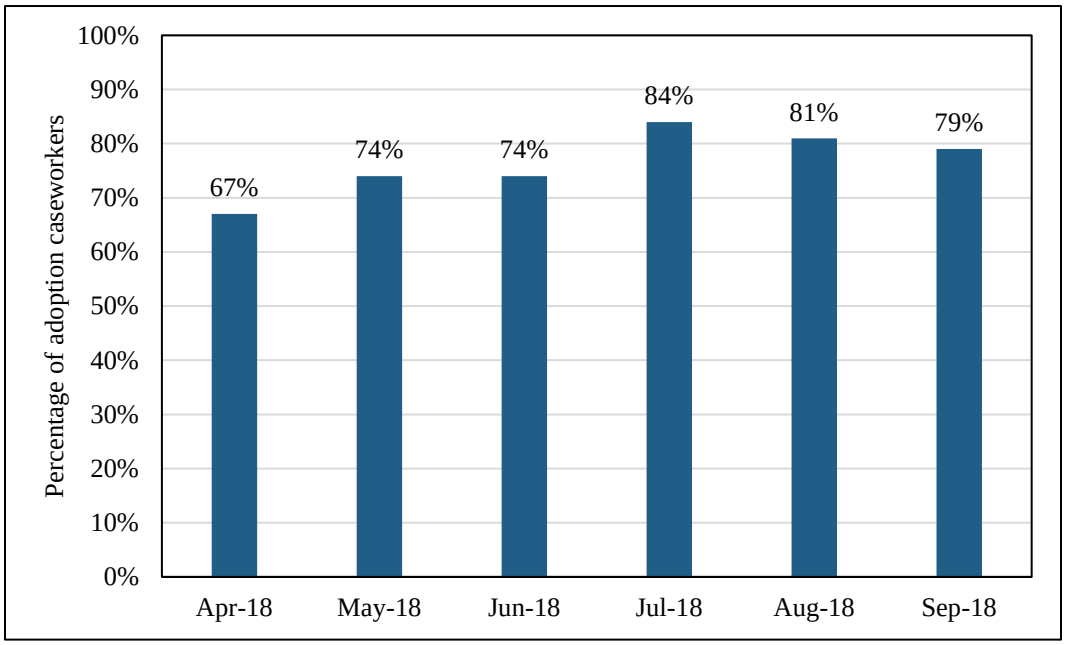
Figure 10: Adoption Caseworkers within the Required Caseload Limits April - September 2018[116]



Source: CAPSS data provided by DSS

[114] Total includes four newly hired adoption caseworkers with a caseload standard of nine children.
[115] In addition to caseworkers carrying cases, there were four adoption supervisors carrying cases as of this date. If they were included in caseload calculations, performance would be 10%.
[116] The interim benchmark for this measure is 40% by September 2019.

Figure 11: Adoption Caseworkers over 125% of Required Caseload Limits April - September 2018[117]



Source: CAPSS data provided by DSS

Nearly every month, all newly hired adoption caseworkers were responsible for more than nine children.[118] On September 28, 2018, of the four adoption caseworkers who had completed Child Welfare Basic training less than six months prior, only one (25%) caseworker had fewer than nine cases.

OHAN Caseworkers

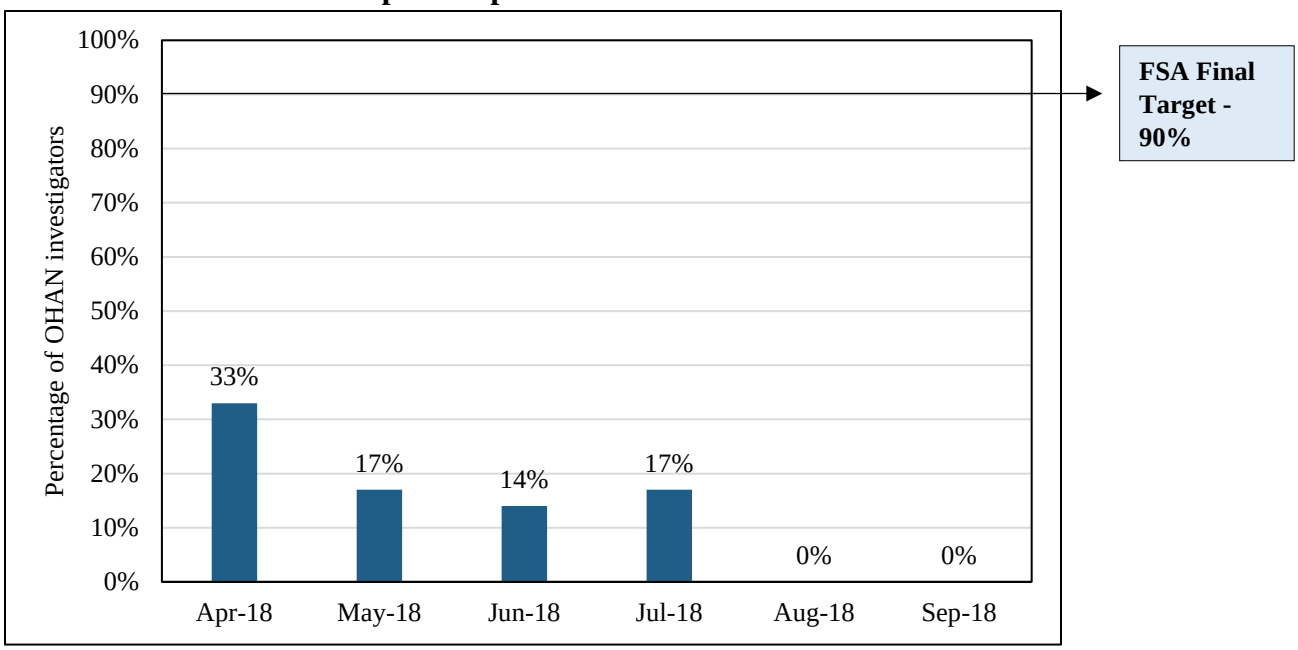
The caseload standard for caseworkers conducting investigations involving allegations of abuse and/or neglect of a child in foster care is one caseworker per eight investigations (1:8). Newly hired OHAN caseworkers should have no more than four children on their caseload for six months after they complete Child Welfare Basic training.

Between April and September 2018, a monthly range of zero to 33 percent of OHAN caseworkers had caseloads within the required limits (Figure 12) and 50 to 100 percent of caseworkers had caseloads that exceeded 125 percent of the required limit each month (Figure 13). Large fluctuations in performance between months is due to the small number of investigators assigned investigations each month.[119] Specifically, on September 28, 2018, of the five OHAN

[117] The interim benchmark for this measure is 40% by September 2019. The final target is 0%.
[118] Monthly caseload performance for only newly hired adoption caseworkers are as follows: April, 0%; May, 0%; June, 0%; July, 0%; August, 0%; September, 25%.
[119] Number of OHAN investigators accepting investigations each month are as follows: April, 5; May, 6; June, 7; July, 6; August, 5; September, 5.

investigators, none (0%) of the investigators had caseloads within the required standard; all five caseworkers (100%) had caseloads over 125 percent of the required limit (Table 2).

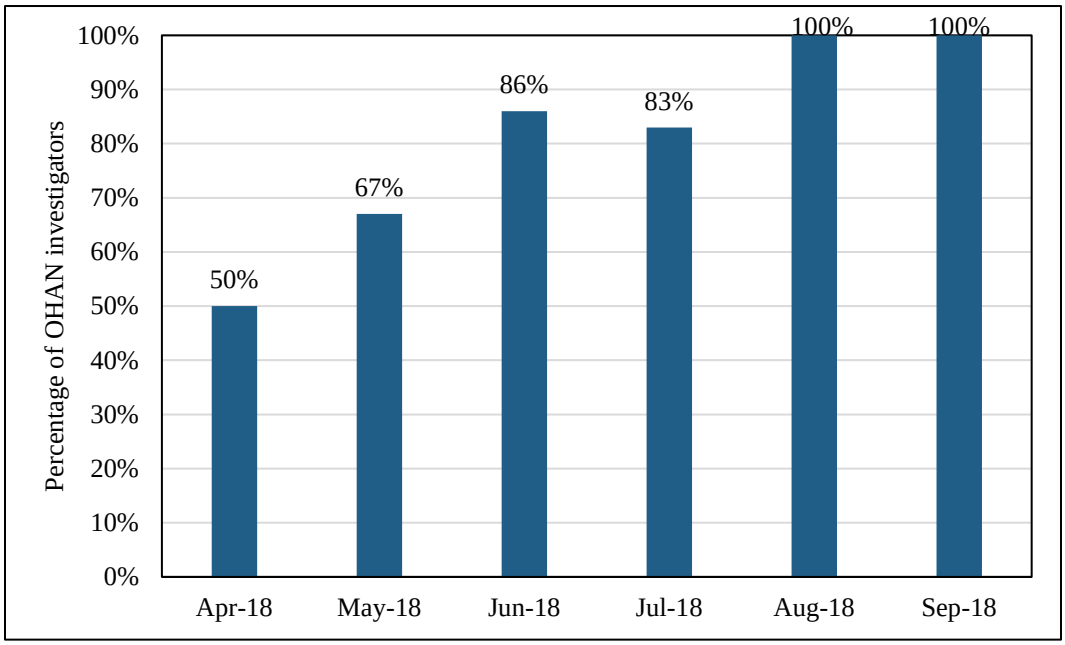
Figure 12: OHAN Investigators within the Required Caseload Limits April - September 2018[120]



Source: CAPSS data provided by DSS

[120] The interim benchmark for this measure is 40% by September 2019.

Figure 13: OHAN Investigators over 125% of Required Caseload Limits
April - September 2018[121]



Source: CAPSS data provided by DSS

Table 2: Caseload Size for OHAN Caseworkers
September 28, 2018
N=5

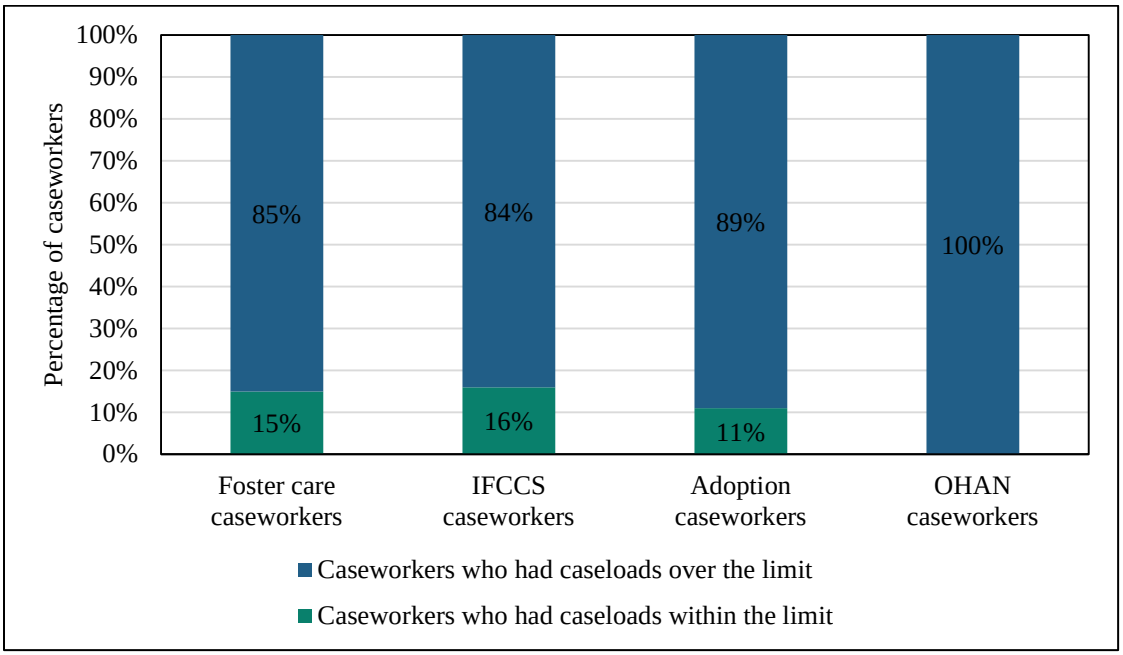
Caseworker	Number of Investigations
Caseworker 1 (new caseworker)	6
Caseworker 2	14
Caseworker 3 (new caseworker)	23
Caseworker 4 (new caseworker)	28
Caseworker 5	34
Total - 5 caseworkers	**Total - 105 investigations**

Source: CAPSS data provided by DSS

In summary, Figure 14 reflects the percentage of foster care, IFCCS, adoption, and OHAN caseworkers within and above the required caseload limits on September 28, 2018.

[121] The interim benchmark for this measure is 40% by September 2019. The final target is 0%.

Figure 14: Foster Care, IFCCS, Adoption, and OHAN Caseworkers that were Over and Within the Required Caseload Limits September 28, 2018



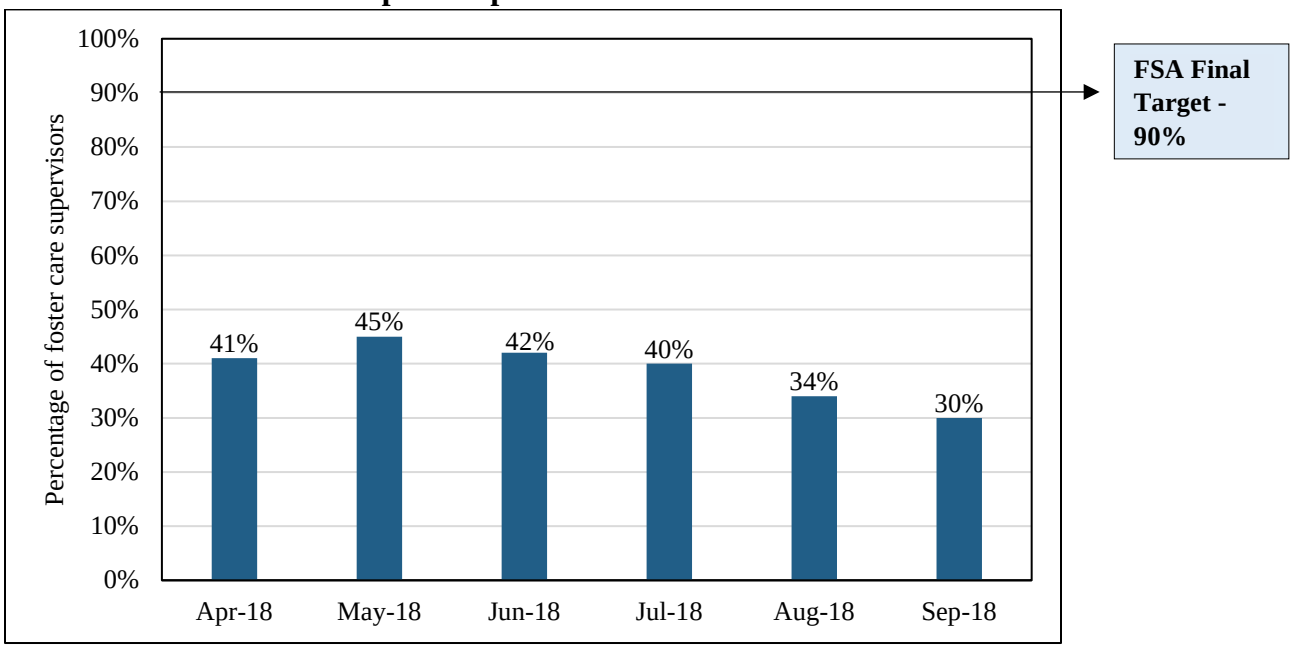
Source: CAPSS data provided by DSS

Foster Care Supervisors

The workload standard for supervisors providing supervision to foster care caseworkers is one supervisor to five caseworkers (1:5).

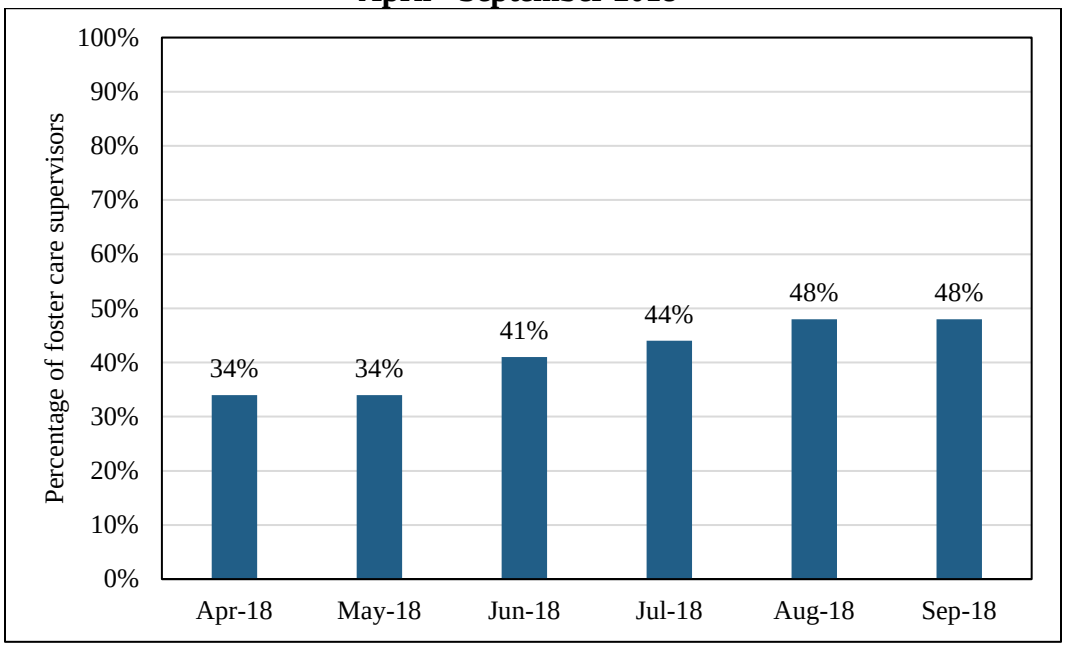
Between April and September 2018, a monthly range of 30 to 45 percent of foster care supervisors supervised five or fewer caseworkers (Figure 15) and 34 to 48 percent of supervisors had workloads of more than 125 percent of the required limit (Figure 16). Specifically, on September 28, 2018, of the 69 supervisors supervising foster care caseworkers, 21 (30%) supervisors supervised five or fewer caseworkers and 33 (48%) supervisors had workloads more than 125 percent over the required limit.

Figure 15: Foster Care Supervisors within the Required Workload Limits
April - September 2018[122]



Source: CAPSS data provided by DSS

Figure 16: Foster Care Supervisors with Workloads More Than 125% Over the Required Limit
April - September 2018[123]



Source: CAPSS data provided by DSS

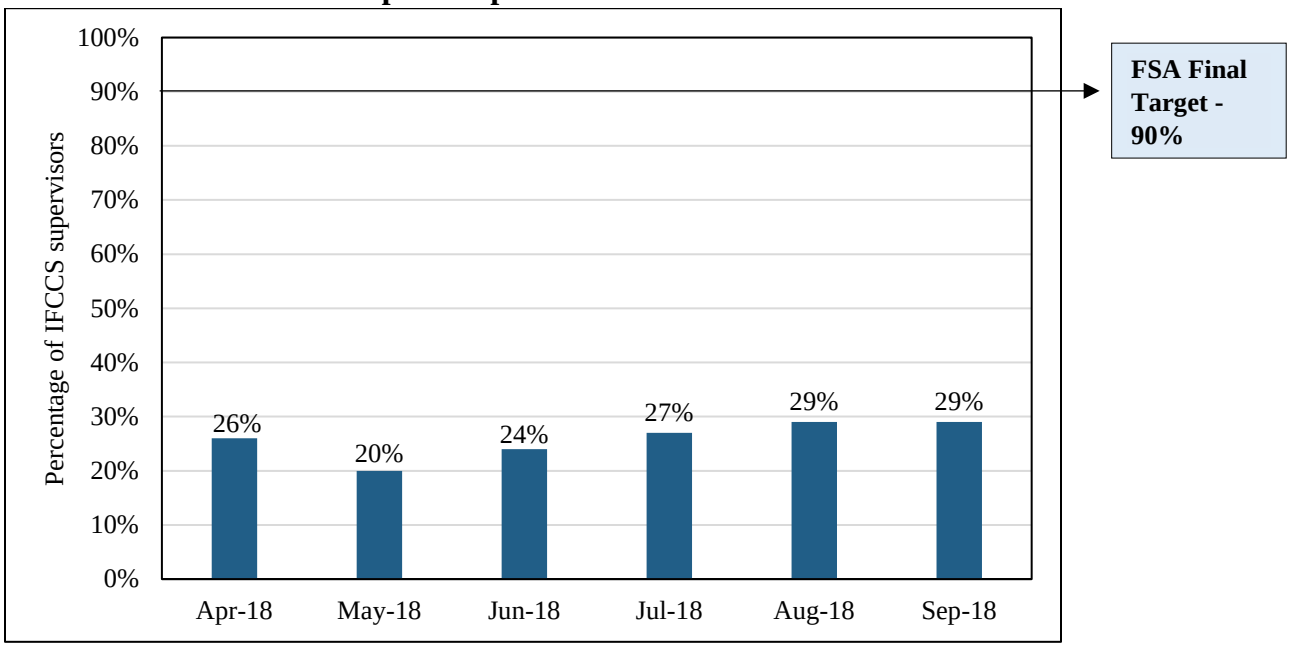
[122] The interim benchmark for this measure is 72% by September 2019.
[123] The interim benchmark for this measure is 20% by September 2019. The final target is 0%.

IFCCS Supervisors

The workload standard for supervisors providing supervision to IFCCS caseworkers is one supervisor to five caseworkers (1:5).

Between April and September 2018, a monthly range of 20 to 29 percent of IFCCS supervisors supervised five or fewer caseworkers (Figure 17) and 47 to 59 percent of supervisors had workloads of more than 125 percent of the required limit (Figure 18). Specifically, on September 28, 2018, of the 24 supervisors supervising IFCCS caseworkers, seven (29%) supervisors supervised five or fewer caseworkers and 14 (58%) supervisors had workloads more than 125 percent over the required limit.

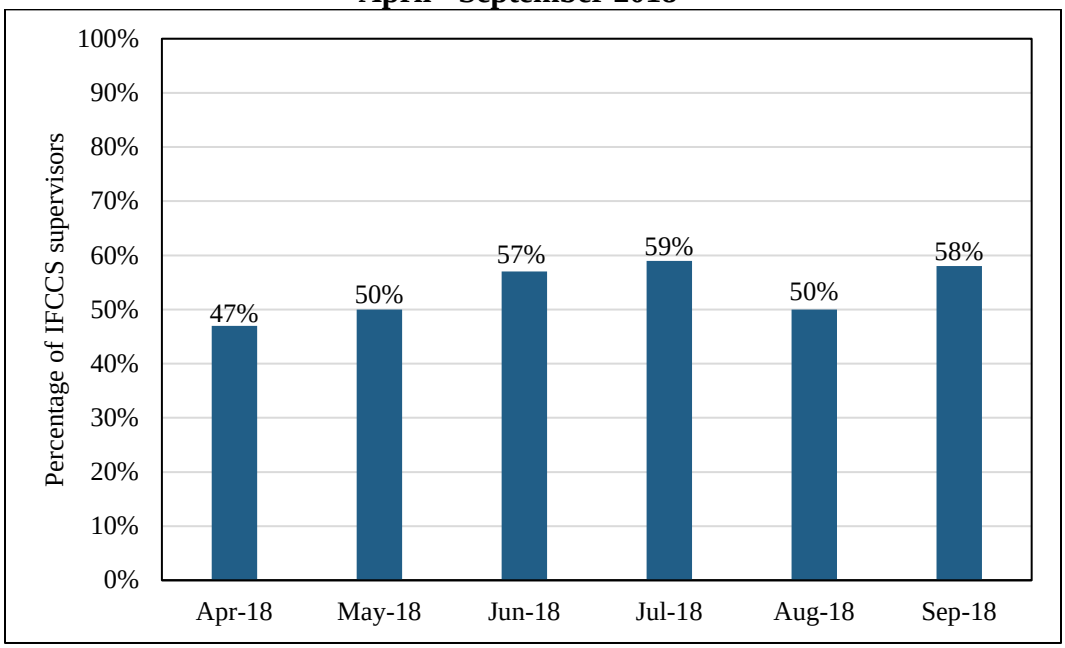
Figure 17: IFCCS Supervisors within the Required Workload Limits
April - September 2018[124]



Source: CAPSS data provided by DSS

[124] The interim benchmark for this measure is 72% by September 2019.

Figure 18: IFCCS Supervisors with Workloads More Than 125% Over the Required Limit April - September 2018[125]



Source: CAPSS data provided by DSS

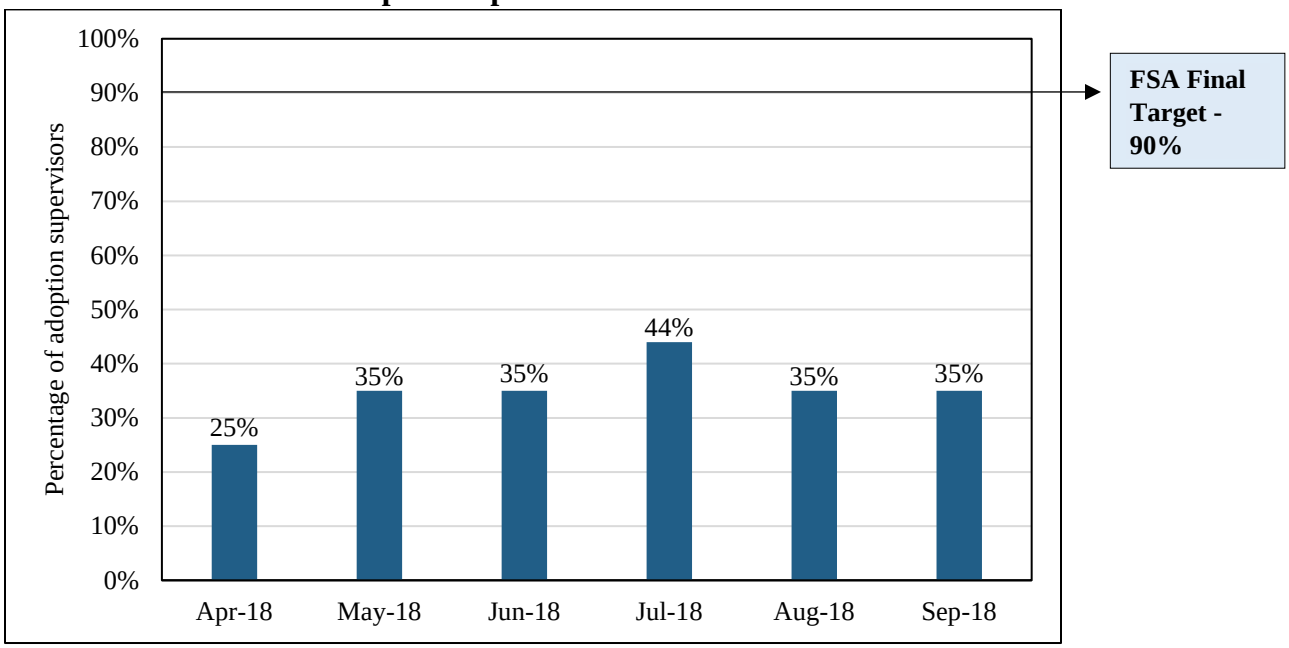
Adoption Supervisors

The workload standard for supervisors providing supervision to adoption caseworkers is one supervisor to five caseworkers (1:5).

Between April and September 2018, a monthly range of 25 to 44 percent of adoption supervisors supervised five or fewer caseworkers (Figure 19) and 22 to 29 percent of supervisors had workloads of more than 125 percent of the required limit (Figure 20). Specifically, on September 28, 2018, of the 17 supervisors supervising adoption caseworkers, six (35%) supervisors supervised five or fewer caseworkers and five (29%) supervisors had workloads more than 125 percent over the required limit.

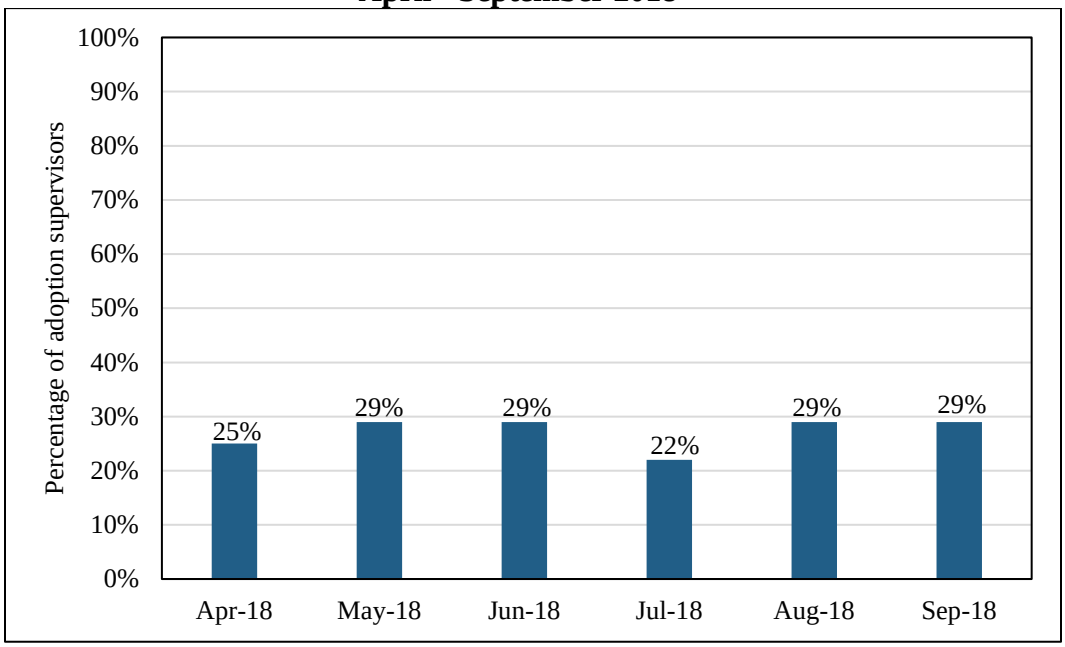
[125] The interim benchmark for this measure is 20% by September 2019. The final target is 0%.

Figure 19: Adoption Supervisors within the Required Workload Limits
April - September 2018[126]



Source: CAPSS data provided by DSS

Figure 20: Adoption Supervisors with Workloads More Than 125% Over the Required Limit
April - September 2018[127]



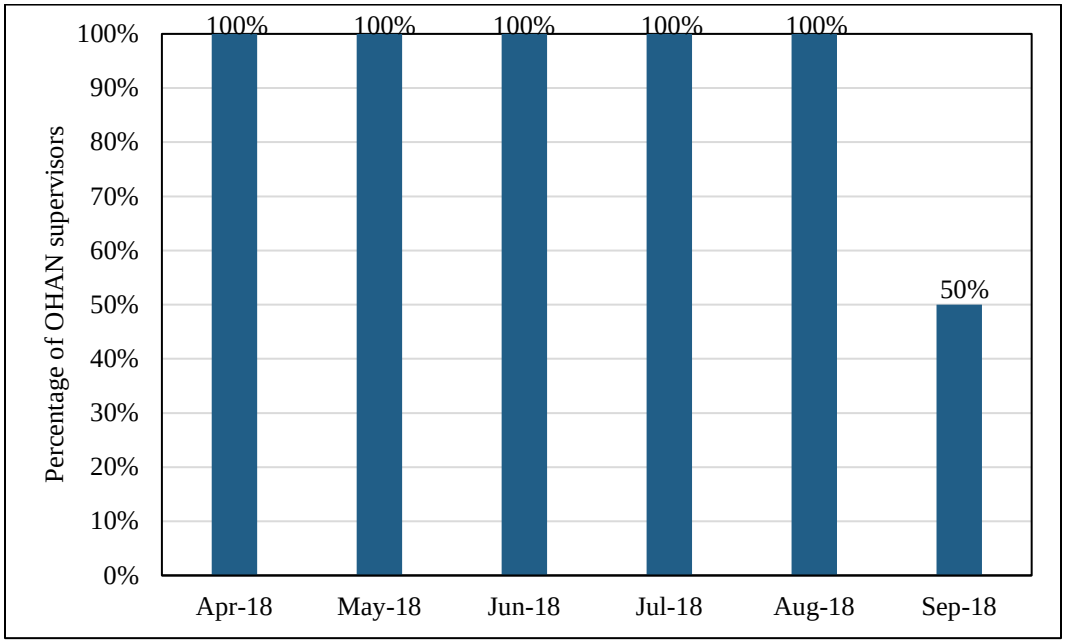
Source: CAPSS data provided by DSS

[126] The interim benchmark for this measure is 72% by September 2019.
[127] The interim benchmark for this measure is 20% by September 2019. The final target is 0%.

OHAN Supervisors

The workload standard for supervisors providing supervision to caseworkers conducting OHAN investigations is one supervisor to six investigators (1:6).[128] In September 2018, there were two OHAN supervisors; one supervisor was responsible for six investigative staff, and the other was responsible for seven staff, thus, performance in September 2018 is 50 percent. Performance during the other months in the period were 100 percent (Figure 21).

Figure 21: OHAN Supervisors within the Required Limits
April - September 2018



Source: CAPSS data provided by DSS

VI. CASEWORKER-CHILD VISITATION

Visits between caseworkers and children in foster care are foundational to a child welfare agency's ability to monitor the safety and well-being of the children in their care. DSS has continued to report that these visits are a core element of their practice and that caseworkers throughout the state visit with children on a monthly basis in nearly all cases. Due to documentation issues identified in prior reporting periods, the Co-Monitors have continued to be unable to validate the occurrence of visits.

The FSA requires "[a]t least 90% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place" (FSA IV.B.2.)

[128] The Co-Monitors approved the higher caseload standard for OHAN supervisors in recognition of the fact that the OHAN caseworkers they supervise will have lower caseloads than other direct service caseworkers.

and that "[a]t least 50% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place in the residence of the child" (FSA IV.B.3.). The FSA further required that by December 5, 2016, DSS was to develop an Implementation Plan with "enforceable interim benchmarks with specific timelines, subject to consent by Plaintiffs and approval by the Co-Monitors" (FSA IV.B.1.) to achieve the final targets related to caseworker visits with children.

DSS reported at the time of entry into the FSA that it was already achieving the final targets related to caseworker-child visits and therefore did not need to develop an Implementation Plan in this area. Although the Co-Monitors have performed validation reviews of CAPSS data at various times, these reviews have been limited because DSS and Plaintiffs held differing views of what is considered compliant under the FSA. On February 27, 2019, Judge Gergel ordered that Parties work to resolve these differences, and on March 13, 2019, Parties agreed that, for the purpose of FSA performance measurement, a visit must include: (1) an interview with the child alone, away from both the caregiver and other children in the home; (2) substantive inquiry[129] as to the child's safety, permanency, and well-being; and (3) appropriate documentation of the visit in CAPSS.[130,131]

On March 13, 2019, DSS re-submitted its draft Visitation Implementation Plan to include strategies for caseworker visits with children in foster care. The final DSS Visitation Implementation Plan was approved by the Co-Monitors on March 28, 2019, and includes strategies to improve both the accuracy of visit documentation and, most significantly, visitation practice to ensure that it aligns with DSS's policy and Case Practice Model.[132] Now that Parties have reached agreement on the components that must be documented for the purposes of FSA compliance, the Co-Monitors will work with DSS to collect baseline data so that interim benchmarks can be established and integrated into DSS's Visitation Implementation Plan. Given the importance of caseworker visits in monitoring the safety, well-being, and permanency of children in foster care, and how critical these visits will be to DSS's ability to meet many of the FSA measures, DSS will need to quickly work to address practice in this area.

[129] For purposes of this definition, "substantive inquiry" means focused on issues pertinent to case planning and service delivery to ensure the safety, permanency and well-being of the child.
[130] This definition was derived from guidance included in Chapter 510.4 of the DSS Human Services Policy and Procedure Manual.
[131] A visit is documented in CAPSS if it includes: (1) the location and circumstances of the interview; (2) a summary of the conversation and assessment of safety, permanency, and well-being; and (3) a statement reflecting any changes in the case plan or service delivery, or acknowledging the continued path of the current case plan and service delivery.
[132] The Visitation Implementation Plan is available at: https://dss.sc.gov/media/1956/3-28-2019-final-dss-visitation-implementation-plan.pdf

VII. INVESTIGATIONS OF ALLEGED ABUSE/NEGLECT IN OUT-OF-HOME CARE

The work of screening and investigating allegations of abuse and/or neglect of children in foster care - completed by DSS's Out-of-Home (OHAN) unit - is another critical function of any child welfare system. This unit must be prepared 24 hours a day, seven days a week to receive reports, appropriately decide which reports should be screened in for investigation and, for those reports that require an investigation, make contact with the alleged victim child(ren) within 24 hours of the report to assess the child's safety and the allegations. Children are in foster care as a result of abuse or neglect by their caregivers, and ensuring their safety and well-being while in state custody is a primary obligation.

Data for the current monitoring period reflect improvements over the prior period in the appropriateness of investigation decisions to *unfound* allegations of abuse and/or neglect, make contact with core witnesses during investigations, and timely completion of investigations within 60 days of receiving a report. Performance data reflect some declines in performance, including in timely initiation of investigations and timely completion within 45 days of initiation.

OHAN staff vacancies and the adequacy of staffing positions allocated to this unit continued to be an issue this monitoring period. Data analysis has determined that a total of between 14 and 16 investigative staff are needed in order to meet the FSA caseload standards for OHAN. From April to September 2018, there were between five to seven OHAN staff a month conducting investigations. As of September 28, 2018, there were only five investigators assigned to the approximately 105 open investigations. DSS reports that new positions have recently been allocated to OHAN, and that nine positions - including newly allocated and current vacancies - were posted for hire in December 2018. DSS reports all nine staff have been hired and those who have already completed Child Welfare Basic training (6 staff) will begin accepting cases no later than April 30, 2019. The remaining three staff will complete required training over the next several months and should begin accepting cases in June 2019.

A. OHAN Implementation Plan

The FSA requires that by December 5, 2016, DSS develop an Implementation Plan for the provisions related to OHAN intake and investigations. The Implementation Plan must have "enforceable interim benchmarks with specific timelines, subject to consent by Plaintiffs and approval by the Co-Monitors, to measure progress in achieving the final targets […]" (FSA IV.C.1.). On September 11, 2017, the Co-Monitors approved DSS's OHAN Implementation Plan and Plaintiffs provided their consent to the Plan on November 7, 2017.[133]

[133] The OHAN Implementation Plan is available at: https://dss.sc.gov/media/1967/michelle-h-2017-approved-ohan-section-of-august-9-implementation-plan-su.pdf

In addition to setting interim benchmarks and timelines, the OHAN Implementation Plan includes strategies developed to improve OHAN practice and achieve the targets required by the FSA. These strategies include: improvement in caseworker time management; implementation of processes to track and monitor timely initiation of investigations and contact with core witnesses; development of checklists and other forms; development and completion of new OHAN training for investigators; coordination between OHAN and licensing staff; and improvements in supervision within OHAN.

Beginning in late-2018, DSS relocated OHAN staff from the central office in Columbia to offices within each region to reduce travel time and increase familiarity with foster parents, congregate care facilities, and local DSS staff. Following an intake training for staff held in September and November 2018, DSS reports that intake caseworkers are showing improvement in collecting information from reporters.[134] A planned investigation training curriculum has now also been finalized, and the first week of the two-week training - which focuses on identifying physical abuse, sexual abuse, and neglect, as well as conducting interviews, and assessing safety - was delivered to three OHAN caseworkers and one supervisor in early January 2019. The second week of the training - which includes legal considerations and regulations, policy and procedures, and critical thinking - was delivered to select OHAN staff in mid-April 2019. DSS reports additional sessions of the two-week training will be scheduled as new staff are hired. Overall, however, implementation of several important OHAN Implementation Plan strategies has been stalled due to lack of staff and resources. Specifically, DSS has not been able to provide complete and relevant training to all of their staff, and use of some new checklists and tools have been hindered by staff workload. Attached as Appendix B are implementation status updates on all strategies within OHAN Implementation Plan as of December 31, 2018.

B. Performance Data

OHAN Intake

Pursuant to South Carolina state statute and DSS protocol, all allegations of abuse or neglect of children in out-of-home settings - including licensed foster homes, residential facilities, and group homes - received by local county offices or regional Intake Hubs must be forwarded to OHAN for screening and, if accepted, for investigation.[135,136,137] OHAN staff make decisions to either accept

[134] The Co-Monitors cannot validate this statement at this time, as data validated for this report reflect performance prior to the training.
[135] SC Code § 63-7-1210; Human Services Policy and Procedural Manual, Chapter 7-721. p.3 (effective date 11/29/2012); SC DSS Directive Memo, April 26, 2016.
[136] Allegations of abuse or neglect by a foster parent of their biological or adopted child are investigated by child protective service caseworkers in local county offices.
[137] In January 2015, DSS began implementation of a regionalized Intake Hub system which provides central locations for receipt of referrals of abuse and/or neglect against children in the state. There are a total of seven Intake Hubs within the five state regions. For the current monitoring period, allegations of abuse and/or neglect against children in foster care or children in day care settings are directed and screened by centralized OHAN staff.

a referral for investigation or take no further action on the referral (screen out) based upon information collected from reporters to determine if the allegations meet the state's statutory definition of abuse or neglect.[138] Reports of licensing violations that do not include allegations of abuse or neglect, are referred to DSS's licensing unit for follow up. DSS policy establishes three main screening criteria for investigations of abuse or neglect of children in out-of-home care: (1) the alleged victim child is younger than 18 years of age; (2) there is an allegation of actual harm that has occurred or is occurring to a child or the caregiver's acts or omissions present a significant risk of harm; and (3) the alleged perpetrator is a person responsible for the child's welfare[139]. OHAN staff are also directed to accept for investigation referrals which identify safety and risk factors to the child in care. All screening decisions are reviewed and approved by a supervisor prior to being finalized.

The FSA requires "[a]t least 95% of decisions not to investigate a Referral of Institutional Abuse or Neglect about a Class Member must be made in accordance with South Carolina law and DSS policy" (FSA IV.C.2.). Table 3 includes the approved OHAN Implementation Plan timeline and interim benchmarks for this measure:

Table 3: Baseline, Timeline, and Interim Benchmark for Appropriateness of Decision Not to Investigate Referral Alleging Institutional Abuse and/or Neglect

Baseline	
August 2016 - January 2017	44%
Timeline	**Interim Benchmark**
September 2017	75%
March 2018	90%
September 2018	**95%**
Final Target	**95%**

Source: OHAN Implementation Plan

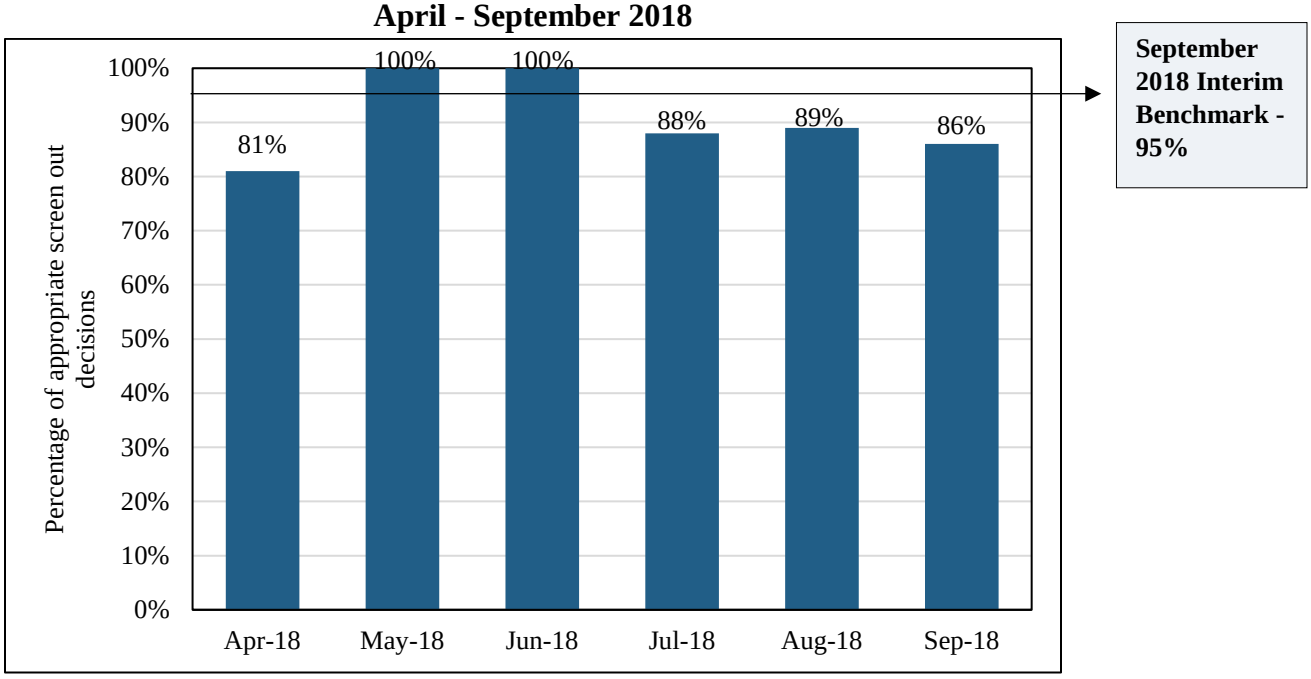
[138] SC Code § 63-7-20.

[139] This includes a foster parent; an employee or caregiver in a public or private residential home, institution, or agency; or an adult who has assumed the role and responsibility of a parent or guardian for the child, but who does not necessarily have legal custody of the child. Human Services Policy and Procedural Manual, Chapter 7-721. p.3 (effective date 11/29/2012).

All applicable referrals[140] of abuse and/or neglect received and not investigated (screened out) by DSS's OHAN unit between April and September 2018 were reviewed by Co-Monitor staff.[141] Performance data were collected and are reported separately for each month.

Between April and September 2018, the Co-Monitors determined a monthly range of 81 to 100 percent of decisions not to investigate a referral of abuse and/or neglect were appropriate (Figure 22). Specifically, in September 2018, 12 (86%) of the 14 applicable screening decisions were deemed appropriate.[142] DSS met the September 2018 interim benchmark in May and June 2018; performance fell below the benchmark in the remaining months in the period.

Figure 22: Appropriateness of Decision Not to Investigate Referral of Institutional Abuse and/or Neglect April - September 2018



Source: Monthly review data, Co-Monitor staff

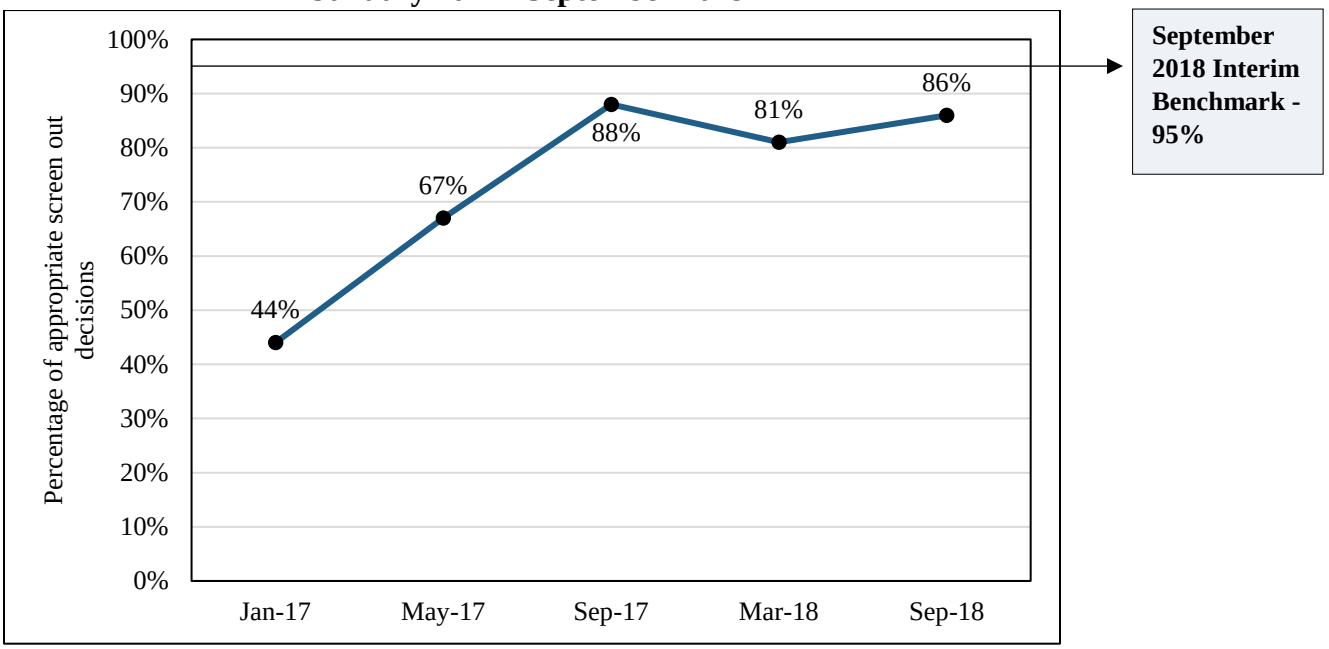
[140] Some referrals were found not to be applicable for review because the alleged victim child was not a Class Member (i.e. the child was voluntarily placed by the legal guardian or through ICPC from another state, or was the biological child of the caregiver). DSS has represented to the Co-Monitors that all referrals of abuse and/or neglect in licensed foster homes, residential facilities, and group homes across the state involving Class Members are received by or forwarded to OHAN for screening and investigation, as appropriate, and screening decisions are not made by local office or Intake Hub staff at this time.

[141] When assessing performance for this measure, reviewers considered three main criteria: (1) the allegation, if true, meets the legal definition of maltreatment; (2) the OHAN caseworker did not collect all information necessary to make an appropriate screening decision; and (3) safety or risk factors were identified within the information shared. If any of these questions were answered in the affirmative, the decision not to investigate the referral was determined to be inappropriate.

[142] Of note, of the 39 referrals that were accepted for investigation in September 2018, Co-Monitor staff assessed that five of the referrals should not have been accepted for investigation as there was no documentation alleging abuse or neglect by a caretaker. Three of these five investigations involved incidents of sexual activity between children and did not indicate the caregiver provided inadequate supervision or responded inappropriately when this was discovered.

Figure 23 includes performance trends for appropriateness of decisions not to investigate referrals between January 2017 and September 2018.

Figure 23: Performance Trends for Appropriateness of Decision Not to Investigate Referral Alleging Institutional Abuse and/or Neglect January 2017 - September 2018



Source: January 2017 performance collected during review of 128 referrals received by DSS between August 1, 2016 and January 31, 2017 and not accepted for investigation. Performance data for May 2017, September 2017, March 2018, and September 2018 reflect findings from monthly reviews completed by Co-Monitor staff.

OHAN Investigations

If a referral is accepted for investigation, the FSA and OHAN policy require face-to-face contact with the alleged victim child(ren) within 24 hours to assess for safety and risk, and the investigation is to be completed within 45 days.[143] OHAN policy also requires that throughout the course of the investigation, the investigator must conduct a safety assessment of the alleged victim child, including a private interview with that child; work with the child's caseworker or law enforcement to make arrangements for medical treatment or examinations, as needed; interview core witnesses to inform the investigation; review documents and records related to the incident; and assess the risk of further maltreatment to all children within that setting.[144] All of these activities are critical components of a quality investigation that results in accurate assessments and findings.

[143] Human Service Policy and Procedural Manual, Chapter 7-721. p. 6, 12 (effective date 11/29/2012).
[144] Human Services Policy and Procedural Manual, Chapter 7-721. p. 7 (effective date 11/29/2012).

There are seven FSA measures pertaining to practice within investigations - timely initiation (two measures)[145], contact with core witnesses (one measure), investigation determination decisions (one measure), and timely completion (three measures). The most recent performance data detailed below were collected during a case record review conducted in December 2018 which examined 39 applicable investigations[146] that were accepted in September 2018.

Timely Initiation

The FSA requires "[t]he investigation of a Referral of Institutional Abuse or Neglect must be initiated within twenty-four (24) hours in accordance with South Carolina law in at least 95% of the investigations" (FSA IV.C.4.(a)). Additionally, FSA Section IV.C.4.(b) requires "[t]he investigation of a Referral of Institutional Abuse or Neglect must include face-to-face contact with the alleged victim within twenty-four hours in at least 95% of investigations, with exceptions for good faith efforts approved by the Co-Monitors." The Co-Monitors measure performance for both FSA IV.C.4.(a) and (b) using the same methodology and timeframes - the time between receipt of referral by OHAN and face-to-face contact with the alleged child victim must be within 24 hours.

The Co-Monitors approved the following efforts listed in Table 4 as "good faith efforts" for timely initiation which must be completed and documented, as applicable, to contact with an alleged victim child(ren) within 24 hours:

Table 4: Good Faith Efforts to Contact Alleged Victim Children within 24 Hours

• Investigator attempted to see child(ren) at school or child care facility • Investigator attempted to see child(ren) at doctor's visit or hospital • For child(ren) moved to an out-of-state location in order to receive specialized treatment, investigator attempted to interview by Skype or other electronic means • Investigator attempted to see child(ren) at the police department • Investigator attempted to attend forensic/CAC interview	• Investigator attempted to see child(ren) at therapist's office • Investigator contacted the assigned foster care caseworker(s) and/or supervisor(s) • Investigator attempted to contact the parent/guardian of the victim child(ren) if the child(ren) has returned home • Investigator attempted to contact the child at all foster care placements where the child may temporarily be placed in the first 24 hours

[145] The Co-Monitors' interpretation of the FSA requires that investigations be initiated within 24 hours of receipt of the referral by DSS, not within 24 hours of the decision to accept the referral, and that initiation is completed by making face-to-face contact with the alleged victim child(ren). As a result, the performance for both FSA measures IV.C.4.(a) and (b) are measured using the same methodology and timeframes - the time between receipt of referral and face-to-face contact with alleged child(ren) victim must be within 24 hours.

[146] A total of 50 reports were accepted for investigation in September 2018, however, 11 reports were determined not appropriate for review as the alleged victim child(ren) was not a Class Member (i.e. the child was voluntarily placed by the legal guardian or was placed through ICPC from another state).

Additionally, the following extraordinary circumstance exceptions to timely initiation (listed in Table 5) were approved by the Co-Monitors:

Table 5: Extraordinary Circumstance Exceptions to Contact with Alleged Victim Children within 24 Hours

• Child was returned to biological family prior to report and family refuses contact • Child is deceased • Law enforcement prohibited contact with child	• Facility restrictions due to child's medical requirements • Natural disaster • Child missing despite efforts to locate (efforts should include all applicable good faith efforts listed above)

Table 6 includes the approved OHAN Implementation Plan timeline and interim benchmarks for this measure.

Table 6: Baseline, Timeline, and Interim Benchmarks for Timely Initiation of Investigations

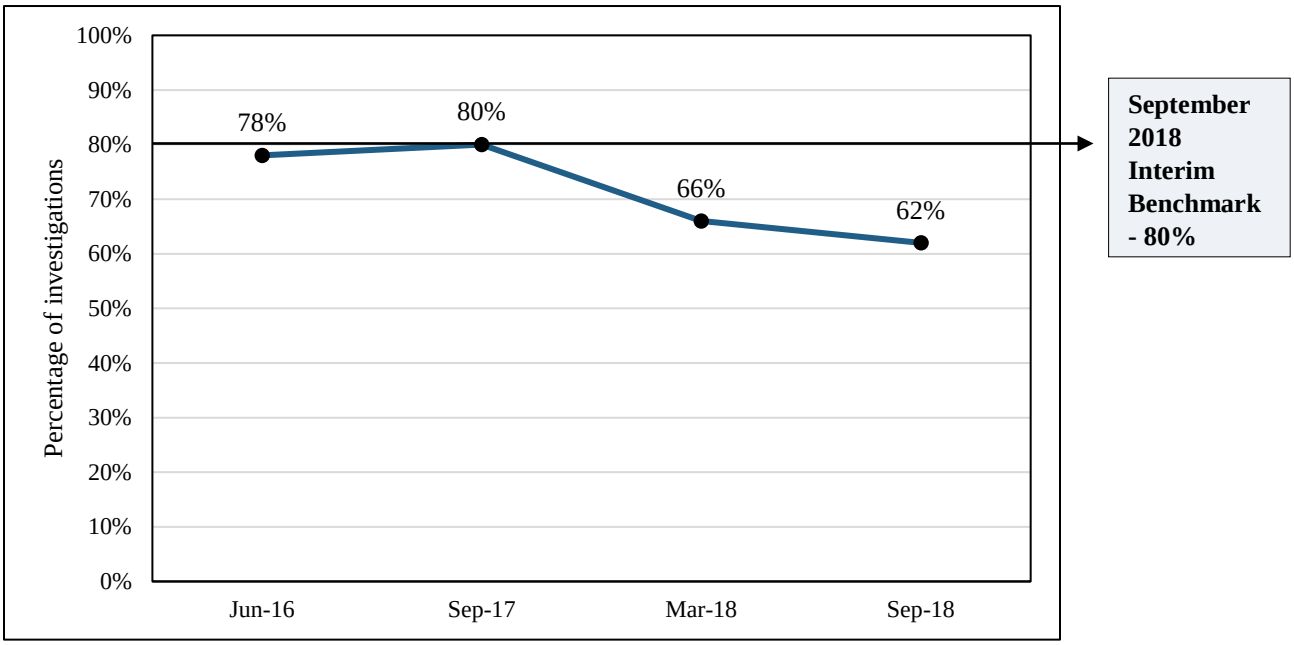
Baseline	
June - November 2016	78%
Implementation Plan Timeline	**Interim Benchmark**
September 2017	78%
March 2018	80%
September 2018	**80%**
March 2019	85%
September 2019	85%
March 2020	90%
September 2020	90%
March 2021	95%
Final Target	**95%**

Source: OHAN Implementation Plan

Performance data for this period were collected during a case record review of investigations accepted in September 2018.[147] Of the 39 applicable investigations, contact was made with all alleged victim child(ren) within 24 hours in 22 (56%) investigations and in two (5%) additional investigations, documentation supported completion of all applicable good faith efforts; total performance for September 2018 is 62 percent, which is below the interim benchmark of 80 percent and a decline from performance during the prior period (Figure 24).

[147] The Co-Monitors have continued to assess that although data for this measure are collected in CAPSS and monthly reports are provided to the Co-Monitors by DSS, the aggregate CAPSS report cannot currently be used for reporting due to the following: the CAPSS report does not distinguish between investigations involving Class and Non-Class Members which is required for reporting performance and the Co-Monitors have found instances in which caseworkers have incorrectly documented the time a child is seen.

Figure 24: Timely Initiation of Investigations
June 2016 - September 2018



Source: Case Record Reviews completed in June 2017, January 2018, June 2018, and December 2018 by USC CCFS and Co-Monitor staff

Contact with Core Witnesses

The FSA requires "[c]ontact with core witnesses must be made in at least 90% of the investigations of a Referral of Institutional Abuse or Neglect, with exceptions approved by the Co-Monitors" (FSA IV.C.4.(c)).

A core witness is defined as an individual who is pertinent to the investigation because they witnessed or have knowledge of the alleged actions and can shed light on the allegations and the actions of the alleged perpetrators. Core witnesses may differ investigation to investigation, but in all cases include: reporter(s), alleged perpetrator(s), alleged child victim(s), child's DSS caseworker, other child(ren) and/or adult(s) in the home and, when involved, law enforcement. If the allegations involve an institutional setting, all other adults and children relevant to the investigation are also considered core witnesses.[148]

Listed in Table 7 are exceptions, approved by the Co-Monitors, to the requirement that the investigator make contact with a core witness during an investigation. In all instances, the exception must be supported by documentation of the exception reason and best efforts to engage the person:

[148] This definition of core witnesses was proposed in DSS's OHAN Implementation Plan, which was approved by the Co-Monitors and consented to by Plaintiffs.

Table 7: Exceptions to Contact with Core Witnesses during Investigations

• Witness refused to cooperate • Witness advised by counsel or law enforcement that interview could not occur (e.g. pending charges, lawsuit) • Witness is deceased	• Unable to locate or identify witness • Medical conditions prevented witness from cooperating

Table 8 includes the approved OHAN Implementation Plan timeline and interim benchmarks for this measure:

Table 8: Baseline, Timeline, and Interim Benchmarks for Contact with All Necessary Core Witnesses during the Investigation

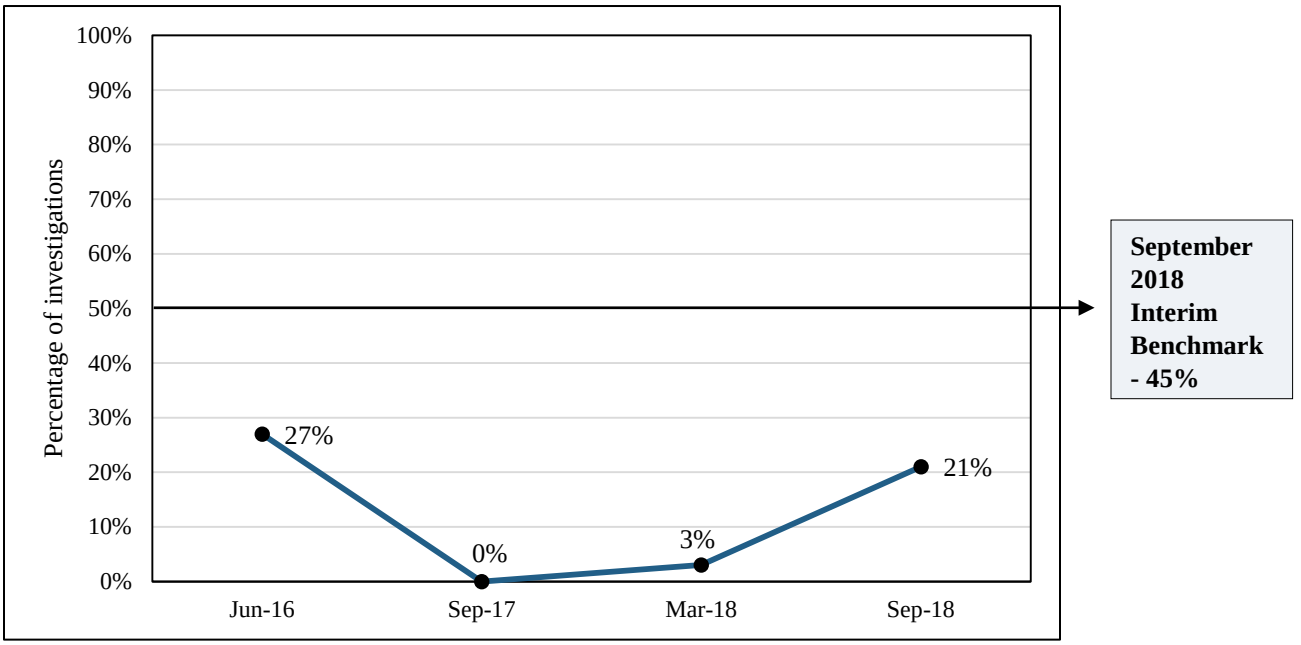
Baseline	
June - November 2016	27%
Implementation Plan Timeline	**Interim Benchmark**
September 2017	35%
March 2018	40%
September 2018	**45%**
March 2019	55%
September 2019	60%
March 2020	70%
September 2020	80%
March 2021	90%
Final Target	**90%**

Source: OHAN Implementation Plan

Performance data for this period were collected during a case record review of investigations accepted in September 2018. Eight (21%) of the 39 applicable investigations reflected contact with all necessary core contacts during the investigation (Figure 25).[149]

[149] In four of the investigations in which reviewers determined not all core contacts were made, the Co-Monitors did not assess that the information provided at intake warranted the reports being accepted and investigated.

Figure 25: Contact with All Necessary Core Witnesses during Investigations June 2016 - September 2018



Source: Case Record Reviews completed in June 2017, January 2018, June 2018, and December 2018 by USC CCFS and Co-Monitor staff

The following data, presented in Table 9, reflects the frequency of OHAN investigator contact with each category of core witness in the 39 investigations reviewed. Improvements since the prior period are noted for all categories of core witnesses.

Table 9: Contact with Necessary Core Witnesses during Investigations by Type of Core Witness
September 2018
N=39

Core Witness	Number of Applicable Investigations	Contact with All	Contact with Some	Contact with None
Alleged Victim Child(ren)	39	34 (85%)	4 (10%)	1 (3%)[150]
Reporter	38[151]	19 (50%)	-	19 (50%)
Alleged Perpetrator(s)	36[152]	35 (97%)[153]	-	1 (3%)
Law Enforcement	7	1 (14%)	-	6 (86%)
Alleged Victim Child(ren)'s Caseworker(s)	39	21 (54%)	1 (3%)	17 (44%)
Other Adults in Home or Facility[154]	27	10 (37%)	4 (15%)	13 (48%)
Other Children in Home or Facility[155]	29	6 (21%)	7 (24%)	16 (55%)
Additional Core Witnesses	22[156]	9 (41%)	5 (23%)	8 (36%)

Source: Case Record Review completed in December 2018 by USC CCFS and Co-Monitor staff
*Totals may not equal 100% due to rounding

Case Decisions

At the conclusion of an investigation, a decision to *indicate* or *unfound* is made based upon the totality of the information collected, with the preponderance of the evidence as standard of proof of the facts.[157]

Section IV.C.3. of the FSA requires "[a]t least 95% of decisions to '*unfound*' investigations of a Referral of Institutional Abuse or Neglect must be based upon DSS ruling out abuse or neglect or DSS determining that an investigation did not produce a preponderance of evidence that a Class Member was abused or neglected."

[150] In one investigation, the alleged victim children were not named at the time of intake. However, information regarding injuries to and actions toward children were specific enough that inquires could have been made by the investigator in attempt to identify the alleged victim children. No children placed at the facility were interviewed during the course of this investigation.
[151] The reporter in one investigation was anonymous.
[152] Exceptions to contact with alleged perpetrator(s) were applicable in three investigations, as the investigator was unable to identify or locate the alleged perpetrator despite efforts.
[153] In one investigation, there were two alleged perpetrators; the investigator interviewed one and the other was deceased.
[154] For investigations involving foster homes, in addition to speaking with the alleged perpetrator(s), the investigator should speak with all other adults in the household. For investigations involving institutions, the investigator should speak with all other adults who were involved in or who have knowledge of the allegations.
[155] For children who are placed in foster homes, in addition to speaking with all alleged victim children, the investigator should speak with all non-victim children in the home to inform the investigation, including other foster children and biological or adopted children in the home. For investigations involving institutions, as most facilities have many children placed there, investigators should speak with all other children who were involved in or who have knowledge of the allegations.
[156] Additional core witnesses identified by reviewers in 22 investigations included family members, school personnel, mental health providers, medical staff, and forensic interviewers.
[157] SC DSS Human Services Policy and Procedural Manual, Chapter 7-721. p. 3 (effective date 11/29/2012).

Table 10 includes the approved OHAN Implementation Plan timeline and interim benchmarks for this measure:

Table 10: Baseline, Timeline, and Interim Benchmarks for Appropriate Case Decisions during Investigations

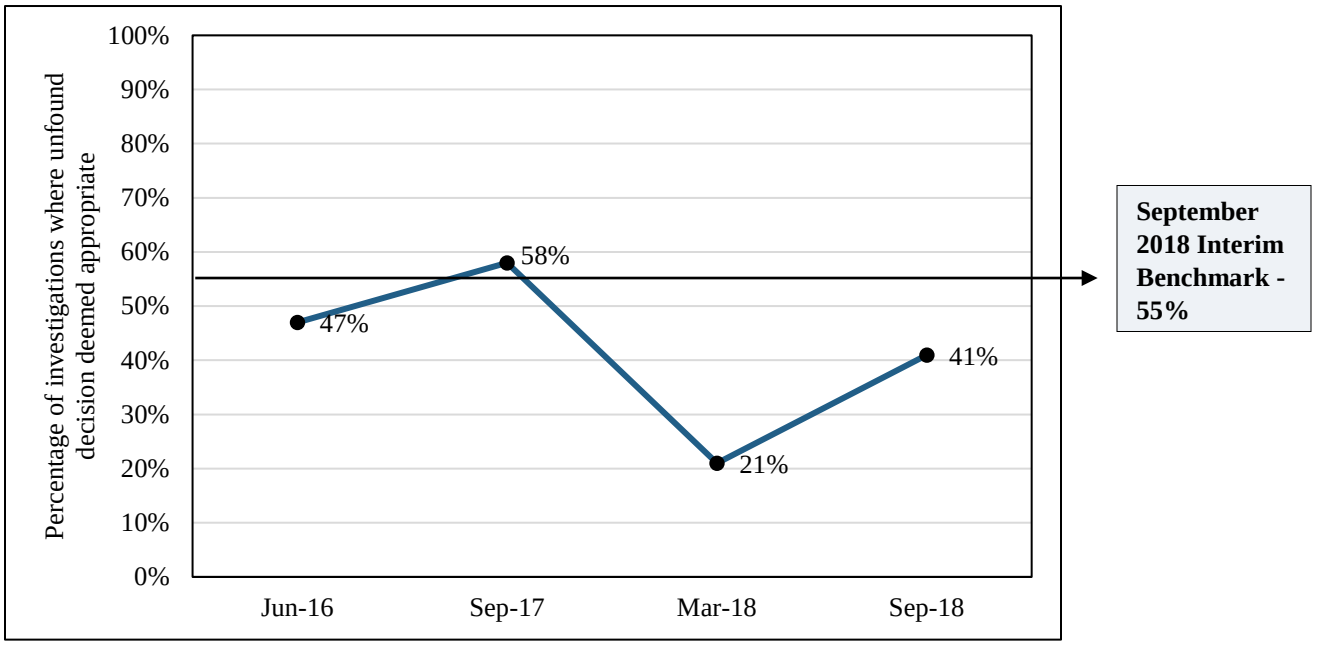
Baseline	
June - November 2016	47%
Implementation Plan Timeline	**Interim Benchmark**
September 2017	48%
March 2018	50%
September 2018	**55%**
March 2019	60%
September 2019	65%
March 2020	75%
September 2020	85%
March 2021	95%
Final Target	**95%**

Source: OHAN Implementation Plan

Performance data for this period were collected during the previously referenced case record review of investigations accepted in September 2018. In all 39 applicable investigations reviewed, the final case decision was to *unfound* the allegations. Reviewers agreed that the case decision to *unfound* the investigation was appropriate in 16 (41%) of the 39 investigations (Figure 26)[158]. Although performance has improved since March 2018, current performance is below the interim benchmark of 55 percent.

[158] In three of the investigations in which reviewers did not agree with the decision to unfound, the Co-Monitors did not assess that the information provided at intake warranted the reports being accepted and investigated.

Figure 26: Decision to Unfound Investigations Deemed Appropriate
June 2016 - September 2018



Source: Case Record Reviews completed in June 2017, January 2018, June 2018, and December 2018 by USC CCFS and Co-Monitor staff

For those investigations in which reviewers disagreed with the unfounded decision, in all but one investigation, the reviewer assessed that the investigator failed to collect sufficient information necessary to make an accurate finding. This was primarily due to the lack of interviews with, and insufficient information collected from, collateral contacts.[159]

Timely Completion

The FSA includes the following three measures for timely completion of investigations, recognizing that some investigations may take longer than 45 days as policy requires:

- "At least 60% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within forty-five (45) days of initiation of an investigation, unless the DSS Director or DSS Director's designee authorizes an extension of no more than fifteen (15) days upon a showing of good cause. For the purposes of this section, an investigation is not completed if DSS determines the Report is unfounded because the deadline to complete the investigation has passed" (FSA IV.C.4.(d)).
- "At least 80% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within sixty (60) days of initiation of the investigation, and all investigations not completed within sixty (60) days shall have authorization of the DSS Director or DSS Director's designee of an extension of no more than thirty (30) days upon a showing of

[159] As part of the Co-Monitors protocol for all case reviews that are conducted, if during the course of a case review a safety concern is identified that was not addressed, DSS is immediately notified for appropriate follow up.

good cause. For the purposes of this section, an investigation is not completed if DSS determines the Report is unfounded because the deadline to complete the investigation has passed" (FSA IV.C.4.(e)).

- "At least 95% of all investigations of a Referral of Institutional Abuse or Neglect not completed within sixty (60) days shall be completed within ninety (90) days. For the purposes of this section, an investigation is not completed if DSS determines the Report is unfounded because the deadline to complete the investigation has passed" (FSA IV.C.4.(f)).

The FSA and OHAN policy provide that the DSS Director or Director's Designee may authorize an extension of up to 15 days for "good cause" or compelling reasons.[160] Good cause means that, through no fault of the investigator, sufficient reason exists for delaying the case decision. Examples of good cause may be one of the following listed in Table 11:

Table 11: Examples of Good Cause Reasons to Extend Investigation Timeframes

• Awaiting critical collateral information (e.g. medical report, x-rays, toxicology, video)	• Critical new information was received from witness that requires follow up
• Awaiting forensic interview/findings	• Awaiting action by law enforcement
• Awaiting critical information from another jurisdiction (e.g. central registry check)	• Child has been too ill or traumatized to speak with investigator

Table 12 includes the approved OHAN Implementation Plan timeline and interim benchmarks for this measure:

[160] SC DSS Human Services Policy and Procedural Manual, Chapter 7-721. p. 12 (effective date 11/29/2012).

Table 12: Baseline, Timeline, and Interim Benchmarks for Timely Completion of Investigations

Baseline	
June - November 2016	45 days - 95%
	60 days - 96%
	90 days - N/A
Implementation Plan Timeline	**Interim Benchmark**
September 2017	45 days - 75%
	60 days - 80%
	90 days - 95%
March 2018	45 days - 75%
	60 days - 80%
	90 days - 95%
September 2018	**45 days - 75%**
	60 days - 80%
	90 days - 95%
March 2019	45 days - 80%
	60 days - 80%
	90 days - 95%
September 2019	45 days - 80%
	60 days - 80%
	90 days - 95%
March 2020	45 days - 90%
	60 days - 90%
	90 days - 95%
September 2020	45 days - 90%
	60 days - 90%
	90 days - 95%
March 2021	45 days - 95%
	60 days - 95%
	90 days - 95%
Final Target	**95%**

Source: OHAN Implementation Plan

Performance data for this section were collected during the case record review of investigations that were accepted in September 2018.[161,162]

Closure within 45 Days

Of the 39 applicable investigations received in September 2018, 25 (64%) investigations were timely closed within 45 days (Figure 27). Reviewers did not find documentation of any extension requests being made in the remaining 14 investigations. Current performance is below the interim benchmark of 75 percent.

Closure within 60 Days

The remaining 14 investigations were closed between 45 and 60 days, resulting in performance of 100 percent on timely completion within 60 days. Performance meets the interim benchmark for closure within 60 days.

Closure within 90 Days

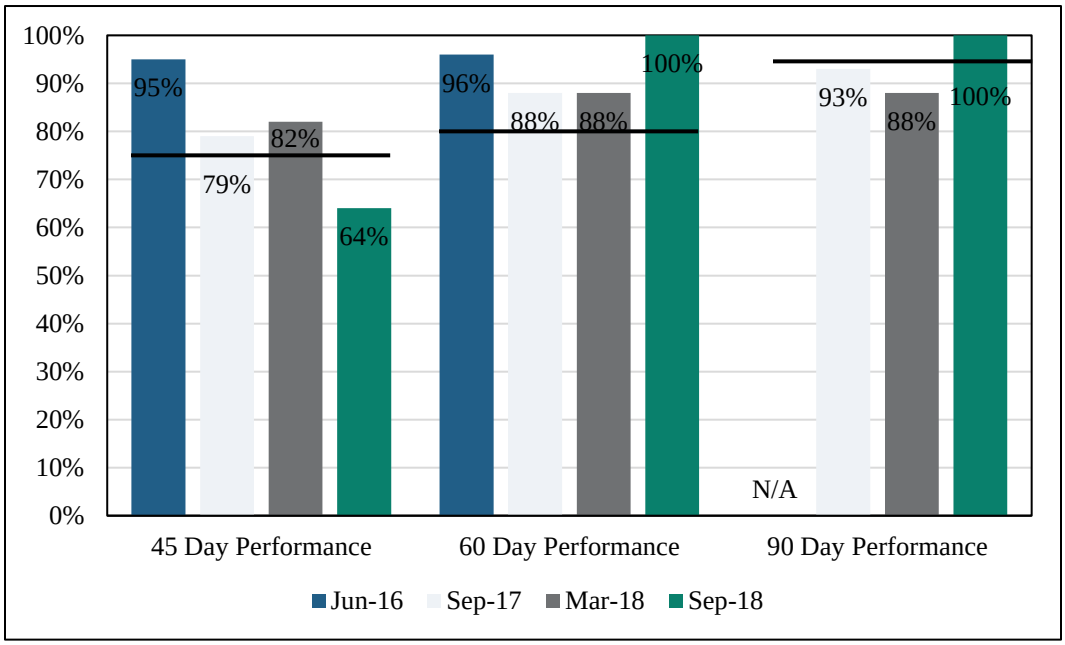
All investigations were closed within 60 days; therefore, performance toward 90 day closure is 100 percent. Performance meets the interim benchmark for closure within 90 days.

Figure 27 reflects performance for timely closure between June 2016 and September 2018.

[161] The Co-Monitors have continued to assess that although data for this measure are collected in CAPSS and monthly reports are provided to the Co-Monitors by DSS, these data cannot currently be used for reporting due to the following: the CAPSS report does not distinguish between investigations involving Class and Non-Class Members which is required for reporting performance and a case record review is required to determine if an investigation is closed prematurely to meet required timeframes.

[162] The Co-Monitors are currently in conversation with DSS about the methodology used to calculate performance for this measure. Performance reported here utilizes what was understood by reviewers and some DSS staff at the time of the review to collect data. If this methodology is revised, an update will be provided in the next monitoring report.

Figure 27: Timely Completion of Investigations
June 2016 - September 2018



Lines represent September 2018 Interim Benchmarks

45 Day Performance: 75%

60 Day Performance: 80%

90 Day Performance: 95%

Source: Case Record Reviews completed in June 2017, January 2018, June 2018, and December 2018 by USC CCFS and Co-Monitor staff

VIII. PLACEMENT

When DSS must take custody of a child, the FSA requires that DSS place the child in the most family-like setting appropriate to meet the child's needs and with siblings, whenever possible. The expectation is that children will experience stability during foster care, not multiple placements. Additionally, supportive caregivers and flexible, individualized interventions must be available and accessible to address the child's safety, health, and well-being.

DSS has maintained its early progress in reducing the number of children ages six and under in congregate care, and has continued to reduce the number of children ages seven to 12 in these placements. The availability of appropriate placements for children throughout the state has, however, continued to be a challenge, with many children placed far from their families and home communities, and separated from their siblings, other family members, and important people in their lives. This problem has been exacerbated by the increasing number of children entering DSS custody, with the number of children in foster care rising from 3,968 on September 30, 2016, to 4,041 children on September 30, 2017, to 4,517 children as of September 30, 2018. As discussed below, the approval of DSS's Placement Implementation Plan in February 2019 was a milestone for DSS, and is intended to establish a strong foundation for significant reform and performance improvement in this area.

A. Placement Needs Assessment

Section IV.D.1. of the FSA required DSS to perform a statewide and regional foster care Placement Needs Assessment to determine the minimally adequate capacity and array of placements for meeting the placement needs of all Class Members. The FSA further required that the Placement Needs Assessment "include specific recommendations addressing all the assessment's findings, including but not limited to recommendations that address the capacity to place Class Members close to their home community, placing Class Members in the least restrictive, most family-like placement, the number and array of therapeutic foster care placements, a system of tracking availability of beds in family foster homes, and matching of Class Members to placements that can meet their needs." DSS produced a Placement Needs Assessment on August 31, 2017 and provided updated data to support the Assessment on March 31, 2018, as requested by the Co-Monitors.

B. Placement Implementation Plan

Within 60 days of completion of a Placement Needs Assessment, DSS was to develop an Implementation Plan to implement the recommendations of the Needs Assessment within 18 months. "The Implementation Plan must have enforceable benchmarks with specific timelines, subject to approval by the Co-Monitors, to measure progress in executing the recommendations of the needs assessment" (FSA IV.D.1.(a)).

DSS submitted draft Placement Implementation Plans to the Co-Monitors on October 31, 2017 and March 31, 2018. As reported in the previous monitoring report (dated September 18, 2018), on July 1, 2018, the Co-Monitors engaged consultants Kent Berkley and Andy Shookhoff to support DSS and the Co-Monitors by: (1) assessing the recommendations, feasibility, resource needs, strategies, and timelines that DSS proposed and identify gaps; (2) incorporating the information they collected to develop an approvable Placement Implementation Plan that meets each of the expectations outlined in the FSA, including a clear Case Practice Model that will be reflected in all aspects of the placement process; and (3) if needed, supporting DSS with Plan implementation.

On February 20, 2019, the Co-Monitors approved DSS's Placement Implementation Plan.[163] The Placement Plan was developed through a months-long participatory and iterative process through which the consultants gained a firsthand understanding of the feasibility of and gaps in previous draft plans submitted by DSS. In addition to gathering information and data from the DSS placement workgroup, the consultants also met with multiple state and county-level DSS staff responsible for aspects of systems related to placement, as well as providers, advocates, foster parents, and youth. These diverse informants aided the consultants in helping DSS to revise the Plan to address key challenges.

[163] The Placement Implementation Plan is available at: https://dss.sc.gov/media/1950/dss-placement-implementation-plan.pdf

The final Plan is comprehensive and ambitious. It reflects a new reliance on children's kin or fictive kin, and a strong preference for maintaining children, with appropriate supports, in family-based settings in their own communities. The Plan includes commitments to identify, engage, and support kin and fictive kin as placement and supportive resources for children, as well as to improve the recruitment and retention of foster parents. It also includes a commitment to restructured case planning and placement processes driven by well-constituted child and family teams, engaged in collaborative decision-making.

In the Plan, DSS has committed to a closer strategic partnership with private providers to foster and support the development of a placement and service array to meet the needs of children in custody. These are enormous and necessary undertakings, which will require re-orientation of the workforce and deep engagement with key partners, such as foster parents and service providers. For initial implementation, it will also require the use of technical assistance. If well implemented and adequately resourced, the Plan has the potential to drive a transformation in placement practices that can vastly improve the experiences of South Carolina's children and families. DSS plans to pilot aspects of the Placement Implementation Plan in select counties, prior to taking some strategies to scale statewide.

The Placement Implementation Plan incorporates findings from a special review of 14 congregate care facilities throughout the state[164], performed by consultants Marci White and George Taylor, and which was completed on December 21, 2018. The consultants' report included recommendations that DSS design and implement more robust monitoring and quality assurance practices for congregate facilities to include observations of programming and facilities, interviews with children and staff, and review of records. Strategies for implementation of these recommendations are included in the Placement Implementation Plan.

C. Performance Data

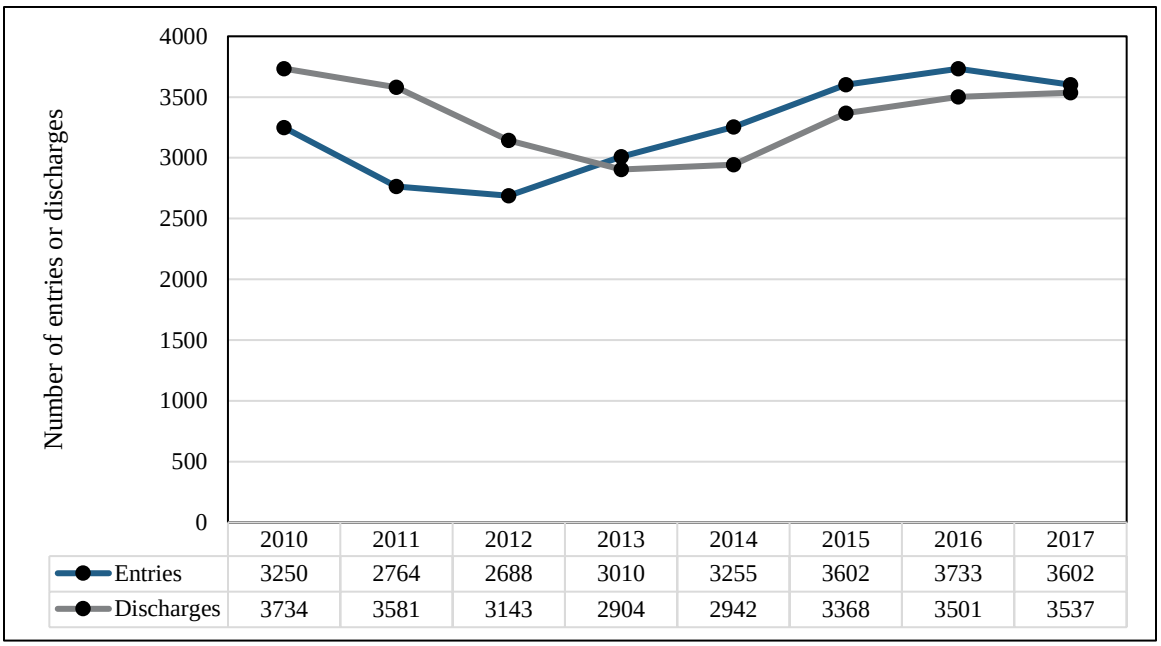
Foster Care Entries and Exits

The increase in the number of children in DSS custody has meant that DSS needs more placements for children and youth at a time when it is already struggling with its ability to place children in appropriate placements, within and near their home communities. DSS data show that foster care entries declined from calendar year 2010 to 2012, but have risen since 2012 (Figure 28). Discharges from foster care have not risen at the same rate and this has led to an increase of children in care over the last five years. Additional data as of June 2018 show that foster care

[164] Facilities were located within each of the five DSS regions and ranged from small, single site buildings to large, multisite providers operating congregate care facilities and community-based foster homes.

entries continue to rise and exceeded entries for the same time period in 2017 by 368 children (1,754 to 2,122).

Figure 28: Foster Care Entries and Exits
CY2010 - 2017



	2010	2011	2012	2013	2014	2015	2016	2017
Entries	3250	2764	2688	3010	3255	3602	3733	3602
Discharges	3734	3581	3143	2904	2942	3368	3501	3537

Source: DSS report utilizing data analyzed by Chapin Hall

Placement of Children in Congregate Care

There are multiple requirements in the FSA related to placing children in the most family-like, least restrictive environments and, where possible, with their siblings. The FSA requires that at least 86 percent of Class Members be placed outside of congregate care placements on the last day of the reporting period (FSA IV.E.2.).

DSS data show that on September 30, 2018, 80 percent (3,540 of 4,437) of Class Members in foster care were placed outside of a congregate care placement (including residential treatment and emergency shelters; see Table 13).[165]

[165] Fifty children who were hospitalized (24), in a correctional/juvenile justice facility (24), or in college (two) are not included in the universe for this measure.

Table 13: Types of Placements for Children as of September 30, 2018

Children in Foster Care	
4,437* (100%)	
Types of Placement for Children in Foster Care	**Number (Percentage) of Children**
Family-Based Setting	3,540 (80%)
Congregate Care, Emergency Shelter, or Residential Treatment Facility	897 (20%)
Breakdown by Type of Group Care Facility	
Congregate Care	826 (19%)
Emergency Shelter	2 (<1%)
Residential Treatment Facility	69 (2%)

Source: CAPSS data provided by DSS
*Excludes 50 children - 24 who were hospitalized; 17 in juvenile justice facility; seven in a correctional facility; and two in college.

It is important to note that these data reflect the percentage of children in each type of placement at a single point in time. They do not capture all children's experiences while in care, or changes that occur over time. DSS has been working with Chapin Hall to develop data sets that show the percentage of children who experience a congregate care placement at any time while in foster care. Initial reports show that a far greater number of children (particularly adolescents and older youth) reside in a congregate care facility at some point while in foster care.

Children Ages 12 and Under

The FSA also includes placement standards specific to certain age groups of children, and requires that "[a]t least 98% of the Class Members twelve (12) years old and under shall be placed outside of Congregate Care Placements on the last day of the Reporting Period unless an exception pre-approved or approved afterwards by the Co-Monitors is documented in the Class Member's case file" (FSA IV.E.3.).

The Co-Monitors have approved the following exceptions for placing children ages seven to 12 in a congregate care facility, as outlined in Table 14:

Table 14: Exceptions for Placement of Children Ages 12 and Under in Non-Family-Based Placements

- The child has clinical and medical needs that can **only** be met in a congregate care setting and cannot be provided in a family-like setting, and the placement is a facility that has the capacity and specialized treatment to meet those needs. The determination of clinical need must be based upon a decision issued by a Licensed Practitioner of the Healing Arts (LPHA) within the scope of their practice under SC State Law and not an employee of DSS. A determination of medical need must be made by a physician.
- The child is part of a sibling group of four or more.
- The child has been removed and is in the legal custody of the SCDSS and is placed with a parent who is not in SCDSS care, but who is temporarily in a residential group setting for treatment.

As reflected in Table 15, as of September 30, 2018, 94 percent (2,981 of 3,186) of Class Members ages 12 and under in foster care were residing in a family-based setting.[166,167] These data reflect an increase from March 31, 2018, when 92 percent of younger children were residing in a family-based setting.

Table 15: Types of Placements for Children Ages 12 and Under as of September 30, 2018

All Children in Foster Care Ages 12 and Under	
3,186***** (100%)	
Types of Placement	**Number (Percentage) of Children**
Family-Based Setting	2,981 (94%)
Congregate Care, Emergency Shelter, or Residential Treatment Facility	205 (6%)
Breakdown of Type of Facility	
Congregate Care	179 (6%)
Emergency Shelter	2 (<1%)
Residential Treatment Facility	24 (<1%)

Source: CAPSS data provided by DSS
*Excludes 14 hospitalized children.

[166] Fourteen children who were hospitalized are not included in the universe for this measure.
[167] Exceptions have been approved, though not applied during this monitoring period; therefore, actual performance may be higher than reported. DSS will develop a process for review and approval of applicable exceptions.

Children Ages Six and Under

The Interim Order, entered September 28, 2015, included provisions to immediately address the placement of children ages six and under in congregate care, requiring that by November 28, 2015, DSS "create a plan, subject to the approval of the Co-Monitors, for preventing, with exceptions approved by the Co-Monitors, the placement of any Class Member age six (6) and under in any non-family group placement (including but not limited to group homes, shelters or residential treatment centers)" (IO II.3.(a) & FSA IV.D.2.). The plan was to include "full implementation within sixty (60) days following approval of the Co-Monitors."

On March 15, 2016, the Co-Monitors approved DSS's plan, including acceptable exceptions (listed in Table 16), and DSS issued a directive outlining the procedure to be used by local and regional office staff to ensure the appropriate placement of children ages six and under in family placements (IO II.3.(a) & FSA IV.D.2.). The procedure currently requires prior approval from the applicable Regional Director before DSS places any child ages six and under in a non-family-based setting.

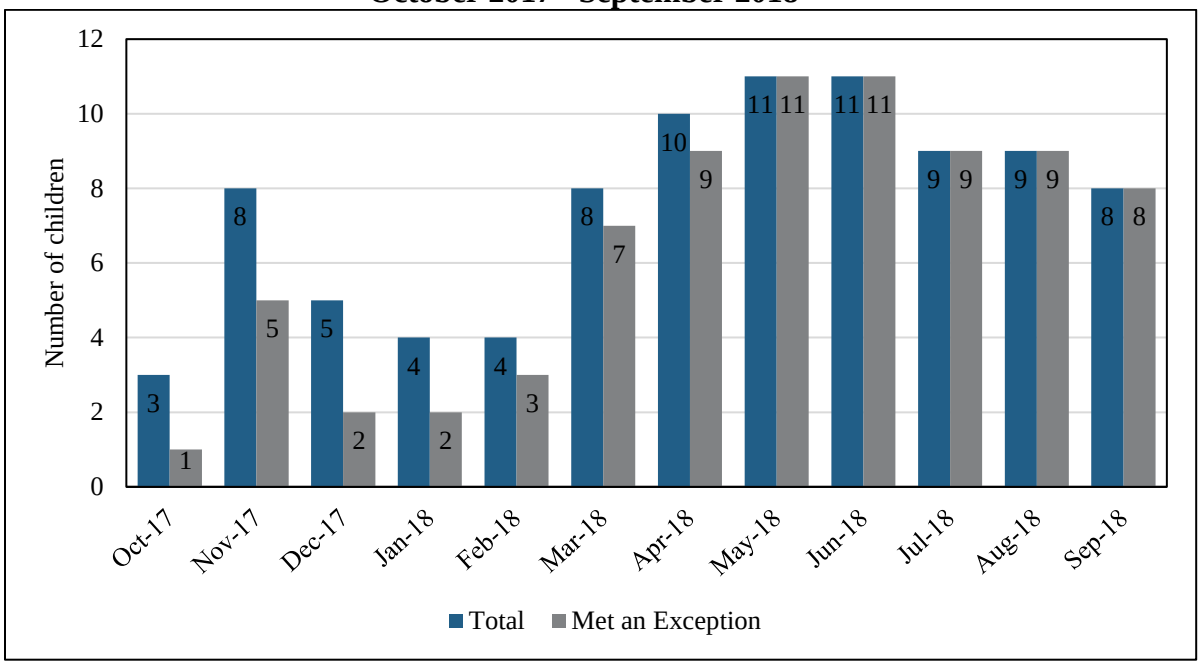
Table 16: Exceptions for Placement of Children Ages Six and Under in Non-Family-Based Placements

- The child requires a degree of clinical and/or medical support that can only be provided in a group care setting and cannot be provided in a family like setting, and the placement is a facility that has the capacity and specialized treatment to meet those needs.
- The child is the son or daughter of another child placed in a group care setting.
- The child coming into care is in a sibling group of four or larger and all efforts to secure foster home and Therapeutic Foster home placements have been completed and have not produced a home. In that instance, placement in a facility that can accommodate the sibling group together and maintain daily contact between siblings is an allowable exception. This exception is time-limited for up to 90 days and can be extended for time-limited increments after considering and documenting the best interests of the children and pursuing and documenting intensive efforts to identify and support an appropriate placement or placements.
- The child comes into care and is placed in congregate care with his or/her biological parent who is not in DSS care but who is receiving treatment at a facility.
- Children who are voluntarily placed by their parent or caregiver are not subject to this requirement.

DSS provided data on all children ages six and under who were placed in congregate care during this monitoring period. These data include child-specific information regarding approved exceptions each month, with the reasons for the approval.

As illustrated in Figure 29, DSS reported that the number of Class Members in congregate care placements ranged from eight to 11 children during each month of this monitoring period. All but one child met an agreed upon exception for placement in congregate care. Most of these children were residing in a treatment facility with their mother or were part of a sibling group of four or more children for whom DSS reports a single, family-based placement could not be located.[168]

Figure 29: Children Ages Six and Under in Congregate Care
October 2017 - September 2018[169]



Source: CAPSS data provided by DSS

Placement in DSS Offices and Hotels

The FSA requires that by November 28, 2015, "DSS shall cease using DSS offices as an overnight placement for Class Members, and shall cease placing or housing any Class Members in hotels, motels and other commercial non-foster care establishments. For any Class Members moved out of such DSS Offices or Hotels, DSS shall provide for their appropriate placement. In the extraordinary event that a child stays overnight in a DSS office, Defendants shall immediately notify the Co-Monitors, who shall provide a report to Parties as appropriate, including whether or not, in their view, the incident should be reported to the court as a violation which would preclude Defendants' ability to achieve compliance on this provision" (FSA IV.D.3.).

[168] In validating data for this measure, the Co-Monitors identified one situation that did not meet an agreed-upon exception. One child was in a congregate care facility with siblings at the time DSS filed with the Court to gain custody of the children and the Court ordered that the child remain in that placement.
[169] Monthly totals are not discrete; one child may be represented across several months.

During this monitoring period, the Co-Monitors were notified of two instances of children staying overnight at a DSS office in violation of this provision. DSS reports that in May 2018, a 12-year old child spent the night in a DSS office while staff were seeking placement. Law enforcement had taken the child from a therapeutic foster home to a hospital for assessment after an incident in the foster home, and DSS began a search for a new placement for the child after the foster parent refused to allow the child to return. DSS initiated the search just after midnight, but did not locate another therapeutic foster home until late morning. DSS promptly reported the overnight stay to the Co-Monitors and provided supporting documentation. The second instance involved a 17-year old youth who stayed overnight in a DSS office in September 2018, after the youth returned from runaway status and requested placement. This youth had previously been placed by DSS in a treatment facility after being identified as a victim of sex trafficking. DSS reported this overnight stay to the Co-Monitors in November 2018.

Emergency or Temporary Placements

The FSA requires that "Class Members shall not remain in any Emergency or Temporary Placement for more than thirty (30) days. Under exceptions approved by the Co-Monitors, if a child is initially placed in an Emergency or Temporary Placement that is not a Congregate Care Placement, and that placement is re-designated within thirty (30) days as a long-term foster home or therapeutic foster home, then the child's stay shall not be considered a violation of this provision and the re-designation shall not be considered a placement move…" (FSA IV.E.4.). Exceptions to this standard have not yet been proposed by DSS.

The FSA also requires that "Class Members experiencing more than one Emergency or Temporary Placement within twelve (12) months shall not remain in the Emergency or Temporary Placement for more than seven (7) days. Under exceptions subject to the Co-Monitors' approval, if a child's subsequent placement within twelve (12) months in an Emergency or Temporary Placement is not a Congregate Care Placement, and that placement is re-designated within thirty (30) days as a long-term foster home or therapeutic foster home, then the child's stay shall not be considered a violation of this provision and the re-designation shall not be considered a placement move…" (FSA IV.E.5.).

DSS is not yet able to reliably measure the use of emergency or temporary placements. Beginning in February 2018, DSS and Chapin Hall conducted a data audit and identified several issues with data related to placement type, stability, and temporary placements, and DSS subsequently made a number of CAPSS updates to allow for documentation of "temporary events," such as an emergency placement. It also clarified who is to be alerted of such events and when. These events - including respite placement, hospitalization, or summer camp - occur for various reasons but are expected to be short-term, not exceeding 30 days. DSS anticipates proposing a methodology for measuring the use of emergency and temporary placements to the Co-Monitors by June 2019, and

by July 2019, proposing interim enforceable targets for these measures, subject to consent by the Co-Monitors and Plaintiffs. DSS has committed to report these data beginning in July 2019.

As set out in DSS's Placement Implementation Plan, DSS plans to utilize child and family teams to make more informed individualized placement decisions for children and provide tailored services to meet children's needs. DSS anticipates that this new approach will reduce reliance on emergency and temporary placements for children. When an emergency placement does occur, DSS has reported that it intends to limit the number of days a child remains in an emergency or temporary placement to 30 days for the first occurrence and seven days for a subsequent occurrence within 12 months of the first, consistent with the FSA.[170]

Juvenile Justice Placements

The FSA, incorporating an Interim Order provision, requires "[w]hen Class Members are placed in juvenile justice detention or another Juvenile Justice Placement, DSS shall not recommend to the family court or Department of Juvenile Justice that a youth remain in a Juvenile Justice Placement without a juvenile justice charge pending or beyond the term of their pleas or adjudicated sentence for the reason that DSS does not have a foster care placement for the Class Member…" (FSA IV.H.1.).

As reported in prior monitoring periods, DSS still does not have a system in place for identifying youth involved with both the juvenile justice and child welfare systems. This is a significant barrier in understanding the extent to which DSS involvement may be serving as a pipeline into juvenile justice (or vice versa) so that underlying systems issues can begin to be identified and addressed, and youth can be appropriately engaged and supported. Combined with a lack of suitable placements and services for youth, the lack of a systemic process to identify these youth has complicated the already difficult transition from juvenile justice to foster care placement for youth exiting DJJ without a home to which they can return.

No violations of the FSA were reported to the Co-Monitors by DSS again this monitoring period, although the Co-Monitors think this is due to the lack of a system to identify the involved youth. Stakeholders throughout the state continue to make credible reports to the Co-Monitors that youth are sometimes held in detention or secure evaluation facilities because there are no appropriate DSS placements available, and describe attempts by DSS to transfer responsibility to DJJ for youth with significant behavioral needs or who require a higher level of care. For example, in September 2018, the Co-Monitors received a report that DSS informed DJJ that it did not have a placement available for a 17-year old youth at the time of a planned release from a DJJ facility. After a court ordered that the youth be placed by DSS, DSS expressed concern about needing to find placement for a youth so close to the time the youth would be aging out of care.

[170] FSA IV.E.4.&5.

The Co-Monitors also remain concerned about continued reports of instances in which inappropriate placements contribute to behavioral issues that ultimately lead to a youth's involvement, or re-involvement, with DJJ. For example, when a 16-year old youth was picked up by police in March 2018 after running away from a temporary foster care placement, the youth was placed at a group home whose director stated that they did not have space and could not handle the youth's complex behavioral and mental health needs. The youth quickly ran away again, and when found almost three months later, was arrested on runaway charges, and placed at a DJJ facility where the youth remained for months.

DSS has continued to represent that it is addressing these issues through implementation of their September 2017 Memorandum of Understanding (MOU) with the DJJ. The MOU requires, among other things, the identification of DSS and DJJ liaisons in each county to serve as first points of contact to identify youth involved in each system, provide relevant caseworker contact information, and share limited records. The MOU also requires that Interagency Staffings - meetings between DSS and DJJ caseworkers involved with a youth's case - be held within 30 days of "identification," as well as anytime a youth is detained, on "runaway," "offends in placement," or is otherwise at "risk of reoffending"; and allows for the sharing of case information. Evidence from stakeholders suggest that there is variable understanding and implementation around the state of these MOU provisions.

DSS began implementing the MOU during the last monitoring period in partnership with regional attorneys and county DJJ and child welfare staff. DSS has reported that regional attorneys from the Office of General Counsel have continued meeting with legal staff and solicitors throughout the state to communicate MOU requirements, and that designated DSS county liaisons have been providing DJJ with relevant contact information and participating in monthly interagency staffings. DSS has also reported that it has developed a test version of a DJJ portal, demonstrated to DSS leadership in June 2018, which will allow designated DJJ staff to access portions of the DSS CAPSS records of children in foster care. As of this monitoring period, however, the portal was not yet in use, and DSS was still unable to even generate a list of the youth in its custody who are placed in DJJ facilities, or whom have pending charges or are on probation.

The Co-Monitors believe that the deeply troubling reports they have been receiving about dually involved youth are likely representative of many others, and remain very concerned that youth are continuing to spend time in DJJ facilities because DSS cannot provide the placements and supports needed to keep them safely in their communities. This is an urgent need that is in many ways tied to DSS's challenges at both the case and systems levels. It is critical that it be addressed in a concrete, meaningful way, and that DSS quickly demonstrate progress in solving these problems.

Placement Instability

The FSA requires that for all Class Members in foster care for eight days or more during the 12-month period, the placement instability rate shall be less than or equal to 3.37 (FSA IV.F.1.). Placement instability is defined as the rate of placement moves per 1,000 days of foster care among Class Members (FSA II.O.) and placement moves are changes in foster care placements.

DSS reports that for the period of October 1, 2017 to September 30, 2018, Class Members experienced placement changes at a rate of 3.92, higher than the FSA requirement.[171] This is a higher rate than in the prior period, from October 1, 2016 to September 30, 2017, when children experienced placement changes at a rate of 3.55.

Sibling Placement

The FSA recognizes the importance of the relationship among siblings and requires that at least 80 percent of children who enter care with or within 30 days of their siblings be placed with their siblings (FSA IV.G.2. & 3.). The FSA allows for exceptions to this requirement, including when there is a court order prohibiting such placement or if the placement is determined not to be in the best interest of one or more siblings. The FSA sets two targets - one for placement with *at least one* of a child's siblings (85% target) and the other for placement with *all* siblings (80% target).

DSS provided data for 996 children who entered foster care between April 1 and September 30, 2018 with a sibling or within 30 days of their sibling's entry to placement and were still in care on September 30, 2018.[172] As of September 30, 2018, for this cohort, 36 percent (361 of 996) of children were placed with all of their siblings and 60 percent (594 of 996) of children were placed with at least one of their siblings[173,174] (Table 17).

[171] Specifically, there were a total of 6,003 moves and 1,532,961 total applicable days.
[172] An additional 515 children in siblings groups entered foster care during this six month period, however, they were no longer in care as of September 30, 2018, and are therefore not included in this analysis.
[173] Exceptions have been approved, though not applied during this monitoring period; therefore, actual performance may be higher than reported. DSS will develop a process for review and approval of exceptions.
[174] The methodology utilized to calculate these data is being evaluated by DSS, the Co-Monitors, and Chapin Hall at the University of Chicago, and adjustments may be made in future monitoring periods.

Table 17: Sibling Placements for Children Entering Placement between April and September 2018
N=996

Sibling Placement Status	Number (Percentage) of Children	FSA Final Target
Total Number of Children Entering Placement from April to September 2018 Who Have a Sibling Entering Placement With or Within 30 Days	996	
Children placed with **all siblings**	361 (36%)	80%
Children placed with **at least one sibling**	594 (60%)	85%
Children **not placed with any sibling**	402 (40%)	

Source: CAPSS data provided by DSS

IX. FAMILY VISITATION

Children who have been removed from their homes due to abuse or neglect need to spend time with family members while in foster care. Time together with family is essential to permanency planning, and fundamental to child and family well-being. The FSA includes requirements related to visits between children in foster care and their siblings and parents. DSS performance with respect to both requirements declined further during this reporting period. The Co-Monitors continue to be very concerned that the vast majority of children in DSS custody do not spend time with their parent(s), and that an increasing number are also not visiting with their siblings.

A. Visitation Implementation Plan

The FSA requires "[w]ithin 60 days of the entry of the Order approving the Settlement Agreement, Defendants shall develop an Implementation Plan to implement the achievement of the final targets in this subsection. The Implementation Plan shall have enforceable interim benchmarks with specific timelines, subject to consent by Plaintiffs and approval by the Co-Monitors, to measure progress in achieving the final targets in this subsection. Plaintiffs will not unreasonably withhold consent, and if the Co-Monitors approve and Plaintiffs do not consent, Plaintiffs will describe with sufficient detail, rationale, and recommendations that will lead to consent" (FSA IV.J.1.).

DSS initiated a process for developing the Visitation Implementation Plan in October 2016 with the convening of an internal Visitation Workgroup, and submitted an initial draft Plan to the Co-Monitors on November 30, 2016. Since that time, there have been several rounds of revisions and modifications, and a long delay while DSS developed a system for reliably collecting baseline data with respect to the number of children in foster care with reunification goals. DSS submitted an updated draft Visitation Implementation Plan on January 14, 2019, to which the Co-Monitors

provided feedback. DSS subsequently decided that it would await final approval of the Workforce and Placement Implementation Plans before modifying the Visitation Implementation Plan so that visitation strategies could be appropriately linked to those key areas of practice. DSS re-submitted their Plan on March 13, 2019, and, after several rounds of feedback, the Co-Monitors approved the Plan on March 28, 2019.[175]

The DSS Visitation Plan sets forth a framework for guiding family visitation practice. Among other strategies, the Plan includes commitments to developing a visitation model that is aligned with the DSS Case Practice Model, and to training DSS supervisors and caseworkers, as well as foster parents, providers, and other stakeholders on the goals and importance of quality time with family. The Plan also includes strategies to provide transportation support for caseworkers and families, and for quality assurance and oversight on meeting the expectations of the visitation policy.

B. Performance Data

Sibling Visits

Section IV.J.2 of the FSA requires "[a]t least 85% of the total minimum number of monthly sibling visits for all sibling visits shall be completed." The FSA also allows for exceptions if there is a court order prohibiting or limiting visitation, if "visits are not in the best interest of one or more of the siblings and the facts supporting the determination are documented in the case file," or with exceptions approved by the Co-Monitors (FSA IV.J.2.). The Co-Monitors have approved the appropriate exceptions to sibling visits as listed in Table 18:

Table 18: Exceptions to Sibling Visitation Requirement

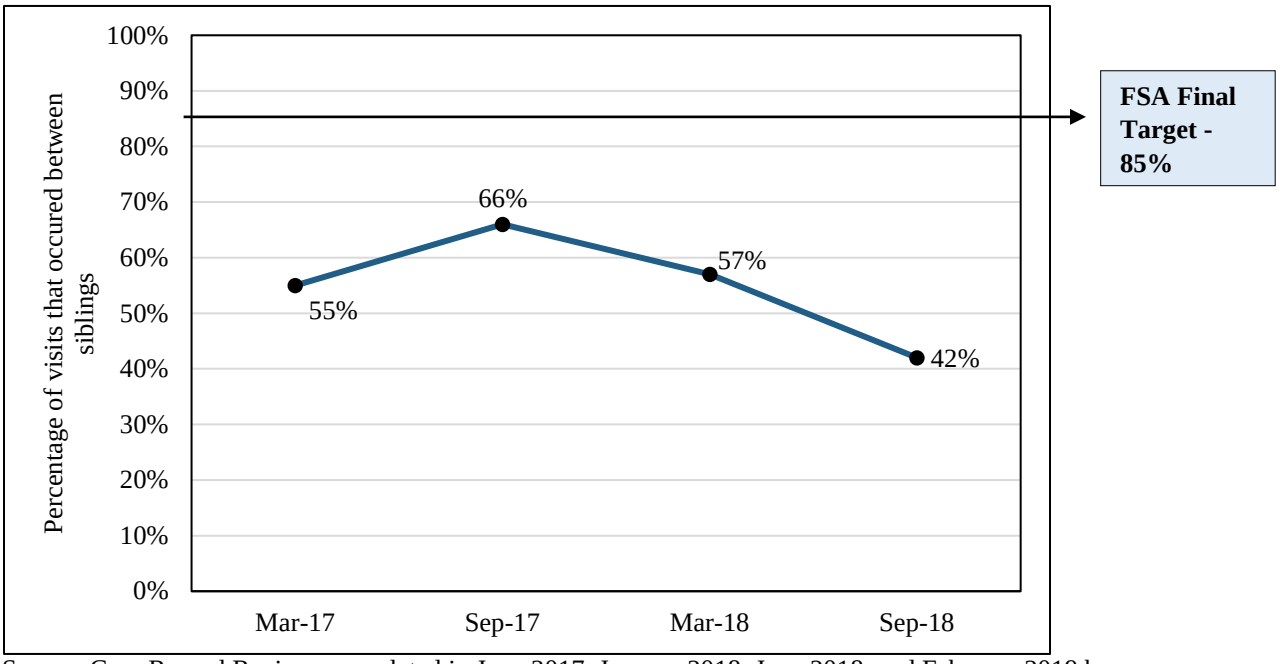
- Court order prohibits or limits sibling visitation.
- Child or sibling is on runaway during a calendar month with best efforts to locate.
- Child or sibling is incarcerated in or in a facility that does not allow visitation despite efforts.
- Child or sibling refuses to participate in the visit where age appropriate.
- Sibling visit is infeasible due to geographic distance with efforts to provide alternative forms of contact. Geographic distance will only be allowed as an exception upon individual review of the applicable case by the Co-Monitors.
- County Director approval with legal consultation for determination that a visit poses immediate safety concerns for the child or sibling. If an immediate safety incident or concern occurs prior to or during a visit, the caseworker is to remove the child from the visit and notify the County Director afterward.
- Supervisory approval for determination that visitation would be psychologically harmful to the child.[176]

[175] The Visitation Implementation Plan is available at: https://dss.sc.gov/media/1956/3-28-2019-final-dss-visitation-implementation-plan.pdf

[176] A DSS supervisor must confirm the determination that visitation would be psychologically harmful to the child based upon written documentation of a clinical decision issued by a Licensed Practitioner of the Healing Arts (LPHA) within the scope of their

In February 2019, USC CCFS and Co-Monitor staff conducted a review utilizing a structured instrument to collect data on the occurrence of visits between children in foster care and their siblings during this monitoring period. By policy and in accordance with the FSA, children are expected to visit with each of their siblings at least monthly. In order to assess performance, reviewers examined a sample of 313 required visits in September 2018.[177] Reviewers determined that only 130 of the applicable 312[178] visits occurred, resulting in performance of 42 percent, as shown in Figure 30. This performance represents a significant decline in performance from the last two monitoring periods.

Figure 30: Visits that Occurred between Siblings
March 2017 - September 2018



Source: Case Record Reviews completed in June 2017, January 2018, June 2018, and February 2019 by USC CCFS and Co-Monitor staff

Parent Visits

The FSA requires "[a]t least 85% of Class Members with the goal of reunification will have in-person visitation twice each month with the parent(s) with whom reunification is sought…" (FSA IV.J.3.). The FSA also allows for exceptions if there is a court order prohibiting or limiting visitation or with exceptions approved by the Co-Monitors listed in Table 19.

practice under SC State Law and who is not an employee of DSS. The LPHA's name, professional title, signature, and date must be listed on the document to confirm the clinical decision.

[177] As of September 30, 2018, there were 1,666 visits required between siblings who had been in foster care for at least one month. A statistically valid random sample of 313 cases was reviewed based on a 95% confidence level and +/- 5% margin of error.

[178] One case was removed from the universe because visitation was prohibited by a court order.

Table 19: Exceptions to Parent and Child Visitation Requirement

• Court order prohibits or limits parent visitation.
• Parent is missing or child is on runaway during a calendar month with best efforts to locate.
• Parent or child is incarcerated in or in a facility that does not allow visitation in the calendar month despite best efforts.
• Parent refused to participate.
• Parent did not show up to visit despite attempts to successfully arrange and conduct the visit.
• Parental rights were terminated in that month.
• Parent visit is infeasible due to geographic distance, with efforts to provide alternative forms of contact. Geographic distance will only be allowed as an exception upon individual review of the applicable case by the Co-Monitors.
• County Director approval with legal consultation for determination that a visit poses immediate safety concerns for the child. In addition, if an immediate safety incident or concern occurs prior to or during a visit, the caseworker is to remove the child from the visit and notify the county director afterward.
• Supervisory approval for determination that visitation would be psychologically harmful to the child.[179]

In January 2019, USC CCFS and Co-Monitor staff utilized a structured instrument to collect data on the occurrence of visits between children in foster care and their parents with whom reunification is sought during this monitoring period. By policy and in accordance with the FSA, children are expected to visit with their parents at least twice per month. In order to assess performance, reviewers examined a sample of 331 cases for which visits between children and parents were required in September 2018.[180,181] Reviewers determined that only 23 of the applicable 329[182] children visited twice during the month with all parent(s) with whom reunification was sought, resulting in performance of seven percent, as shown in Figure 31. The majority of children (196; 60%) had no documented visit with whom reunification was sought in the month of September 2018.

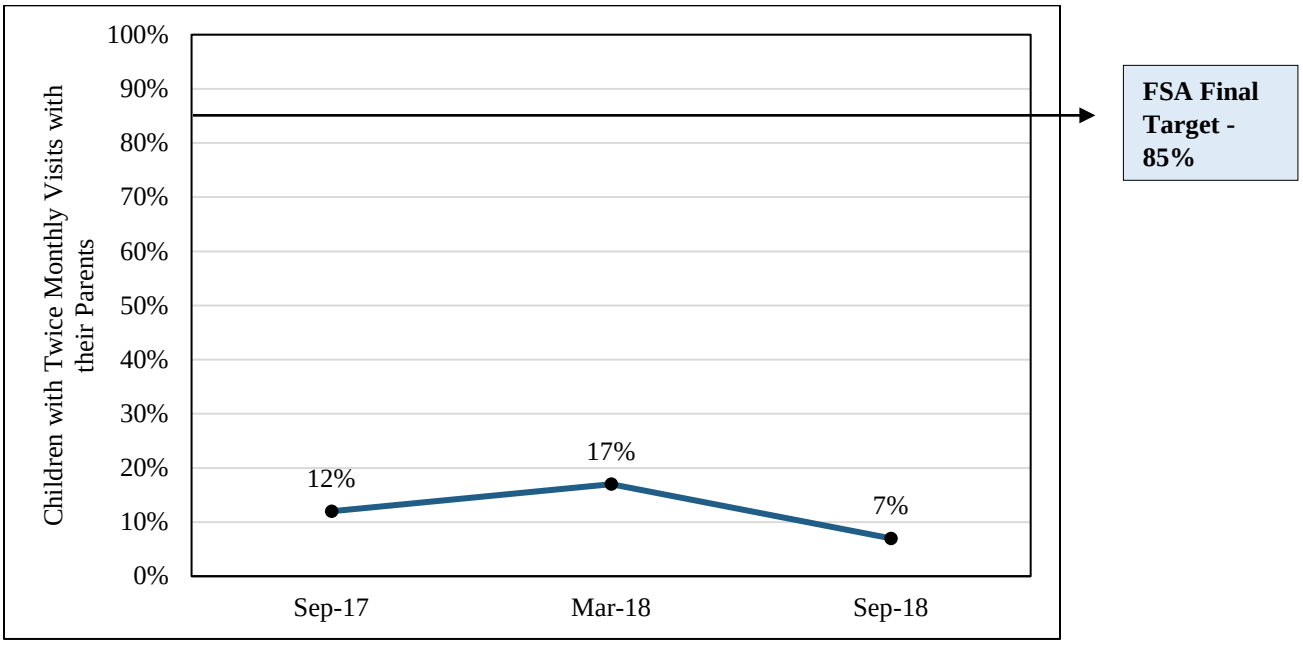
[179] A DSS supervisor must confirm the determination that visitation would be psychologically harmful to the child based upon written documentation of clinical decision issued by a Licensed Practitioner of the Healing Arts (LPHA) within the scope of their practice under SC State Law and who is not an employee of DSS. The LPHA's name, professional title, signature, and date must be listed on the document to confirm the clinical decision.

[180] As of September 30, 2018, there were 2,119 children who had been in foster care for at least one month with a goal of "return to home" or "not yet established." A statistically valid random sample of 331 cases was reviewed based on a 95% confidence level and +/- 5% margin of error.

[181] Permanency goals were identified utilizing data in the CAPSS field in which caseworkers are expected to update case goals in accordance with the most current determination in legal proceedings.

[182] One case was removed from the universe because visitation was prohibited by a court order and one case was removed because the parent cancelled visitation despite efforts by the caseworker to facilitate the visit.

Figure 31: Children with Twice Monthly Visits with their Parents
September 2017 - September 2018



Source: Case Record Reviews completed in January 2018, June 2018, and January 2019 by USC CCFS and Co-Monitor staff

X. HEALTH CARE

Child welfare systems, acting as temporary guardians for children, provide children in foster care with the supports and services they need to be healthy. This requires the ability to quickly identify children's physical and behavioral health needs, to provide high quality preventative and acute care, and to maintain a system for tracking care delivery and communicating key health care information. As of February 2019, DSS has in place a final approved Health Care Improvement Plan, which includes a framework for health care case management and care coordination, as well as agreed upon final outcome measures and interim benchmarks by which progress in this area will be measured.[183] Though data regarding children's health status are not available for this reporting period, DSS expects that the finalization of its Health Care Improvement Plan will enable it to move forward quickly in analyzing and utilizing the Medicaid and Select Health data sources to which it has access, laying the foundation for measuring progress as it implements the Plan in the coming months.

[183] All components of the Health Care Improvement Plan are available at: https://dss.sc.gov/child-welfare-reform/

A. Health Care Improvement Plan

Health Care Improvement Plan Approval

The FSA required that by April 3, 2017, DSS "with prior input and subject to approval by the Co-Monitors, shall develop a Health Care Improvement Plan with enforceable dates and targets for phased implementation concerning initial screening services, periodic screening 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. The Plan shall 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 baselines and interim percentage targets for performance improvement in coordinating screens and treatment services" (FSA IV.K.1.(a-c)).

After receiving an extension for preparation of the Health Care Improvement Plan, DSS submitted a draft Plan to the Co-Monitors on September 29, 2017. Though it set out a general vision for the delivery of health care services to children in foster care, the draft Plan did not address many of the complexities that the Co-Monitors believed to be essential to effective implementation. In light of this, in November 2017, the Co-Monitors engaged consultants with specific expertise in child welfare health care reform - Kathleen Noonan and Gail Nayowith - to assess the sufficiency of the Plan, pursuant to FSA IV.K.3. The consultants' recommendations - based on the results of validation activities and interviews with key DSS, Department of Mental Health (DMH), DHHS, Select Health (the State's designated and contracted MCO for the vast majority of children in foster care), and community provider staff - were submitted in a Findings and Recommendations Report on February 12, 2018[184]. The Report concluded that DSS's draft Health Care Improvement Plan contained important contextual and structural elements, but did not yet include the operational framework needed for implementation. After the release of the Findings and Recommendations Report, DSS worked extensively with support from the consultants to revise its Plan. On August 23, 2018, after review and incorporating additional input from the Co-Monitors and Plaintiffs, DSS obtained Co-Monitor approval for its Health Care Improvement Plan.

In granting Plan approval, the Co-Monitors indicated that DSS would need to update it to include two critical components it was not yet prepared to submit: (1) baselines and interim percentage

[184] This report was Appendix C to the Co-Monitors *Michelle H., et al. v. McMaster and Alford Monitoring Period II,* which can be found here: https://cssp.org/resource/michelle-h-v-mcmaster-monitoring-report-for-april-2017-sept-2017/

targets (FSA IV.K.1.(c)); and (2) a proposed model of health care case management and care coordination, with updated associated budget projections. Both of these additional components were also subject to Co-Monitor approval, and are discussed in more detail below.

The Health Care Improvement Plan is broad in scope and includes a comprehensive vision for the delivery of health care to children in foster care through collaboration with DHHS and Select Health, including mechanisms for sharing and utilizing critical health care data. It also incorporates the six "priority action items" that the health care consultants had included in their February 12, 2018 Findings and Recommendations Report. Updates with respect to each of these are included below.[185]

Priority Action Item Progress

In addition to recommending that DSS complete its Health Care Improvement Plan, the health care consultants' Findings and Recommendations Report indicated that DSS should take immediate action with respect to: identifying a health care director and convening a leadership team; obtaining a gap-in-care report[186]; mitigating the 30-day gap for enrollment for foster children in Select Health; and addressing children's immediate treatment needs.

DSS Health Care Leadership: Gwynne Goodlett has continued to serve as the Director of the DSS Office of Child Health and Well-Being and DSS has continued its collaboration with DHHS and Select Health, meeting weekly to discuss issues related to the development and implementation of the Health Care Improvement Plan, including protocols for data sharing, production of management reports, and coordination of health care case management. This team approach has proven essential to Plan development and will continue to play a critical role as implementation proceeds. In addition, the reconvened Foster Care Health Advisory Committee - a cross-agency and provider workgroup, charged with addressing issues related to the provision of physical and mental health services to children in foster care statewide - is scheduled to meet on a monthly basis to address issues of concern with respect to the health care needs of children in foster care throughout the state.

Obtain Gap-in-Care Reports from DHHS and its MCO: DSS has continued to work in close collaboration with Select Health and DHHS on the development of protocols for sharing and analyzing health data with respect to the children in DSS care. As reported in the last monitoring period, this included the procurement of reports from Select Health that identify children in foster care who have not received required screenings, assessments, and follow-up ("gap-in-care reports"). Since obtaining the first of these reports in May 2018, progress towards utilizing data has been slow. DSS has reported that the work to translate these data into a usable format has been more complex than anticipated, and that after utilizing a dedicated data analyst at DHHS to attempt

[185] For an update on DSS progress with respect to strategies and commitments set out in the Health Care Improvement Plan, see Appendix C.

[186] Gap-in-care reports identify children in foster care who have not received required screenings, assessments, and follow-up.

to produce a comprehensive management report that uses these data, they have shifted focus to Medicaid claims data instead of the Select Health gap-in-care reports. Although DSS has begun sharing ("cadencing") DHHS data with caseworkers with respect to missing initial health assessments and, as of February 2019, the use of multiple psychotropic medications and developmental assessments, it is imperative that the work to access and utilize data that relates to ongoing health needs be quickly deciphered and integrated into this process.

Data Workaround to mitigate the 30-day Enrollment Gap: Although nearly all children in foster care in South Carolina[187] are enrolled in one MCO, Select Health, enrollment is not immediate. The monthly contracting arrangement DHHS has with Select Health has meant that there can be up to a 30-day enrollment lag. In acknowledgement of the challenges this poses to DSS in its efforts to track health claims data for children from the time they enter DSS custody, the health care consultants recommended that DSS develop and implement a data workaround until DSS puts a longer term solution in place. DSS and DHHS have been working to resolve this issue, initially expected to be completed in January 2019, and reports that a temporary, manual solution has now been put in place while implementation of a longer term automated process is explored.

Initiate Short-Term Plan to Address Immediate Treatment Needs: Given DSS's lack of reliable data on provision of follow-up care identified in prior reporting periods, the health care consultants recommended that DSS quickly develop a process by which DHHS data could be utilized to identify children who did not receive needed screenings, assessments, or follow-up care. DSS began work on this recommendation in September 2018, and, as described above, has reported that it has made progress in accessing Medicaid claims information as a means of identifying children's health care needs.[188]

Health Care Case Management and Care Coordination Model

Pursuant to the Health Care Improvement Plan and a January 15, 2019 Court Order, DSS was required to submit a detailed model for health care case management and care coordination for Co-Monitor approval by February 21, 2019. The proposal was to detail 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 DSS to meet the health care needs of all children in foster care." The plan was also to delineate

[187]As of May 31, 2018, there were 65 children in a DHHS Medicaid waiver who were not eligible for Select Health. In addition, 30 children were ineligible for enrollment based on their immigration status. DSS has committed in their Health Care Addendum to performing the health care coordination function for these children through DSS Office of Child Health and Well-Being nurse and program coordinator staff.

[188] DSS still does not have a mechanism for assessing performance with respect to the FSA requirement that it "identify Class Members with Immediate Treatment Needs (physical/medical, dental, or mental health) for which treatment is overdue," initially intended to apply to children in DSS custody at the time of entry into the agreement in October 2016 (FSA IV.K.4.(b)). Though DSS reported in its Health Care Improvement Plan that it expected to propose an alternative to this provision based on data available through Select Health, it has not yet done so. The Co-Monitors will monitor progress in this area and report on the status of these data in the next monitoring period.

necessary changes in policies, guidance, and procedures at DSS and Select Health, and to include "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."

After weeks of work with the DSS Health Care Workgroup, the health care consultants, and DSS partners, DSS submitted a proposed model (the "Health Care Addendum") on January 27, 2019. The Co-Monitors and Plaintiffs shared feedback, including concerns that the model required a clearer delineation of roles, and a more robust resource commitment. After exchanging revised drafts, the Health Care Addendum was approved by the Co-Monitors on February 25, 2019. [189] The Addendum sets out a framework for meeting the health care needs of the children in DSS's care through enhanced and strengthened partnerships with the DHHS and Select Health. DSS and its partners believe that when fully developed, this model will be capable of identifying children's physical and behavioral health needs, promptly linking them with appropriate services, and tracking whether needs have been met and outcomes achieved. Given the newness of this model, DSS and the Co-Monitors have agreed to assess the efficacy and adequacy of the model in meeting the health care needs of children in foster care after each implementation year to see if it requires any additions or changes.

Final FSA Health Care Outcomes

The FSA required that within 120 days of the completion of the Health Care Improvement Plan, the Co-Monitors, with input from Parties, "identify the final health care outcome measures related to initial screening services, periodic screening services, documentation, treatment and other corrective services, which the parties agree will be final and binding" (FSA IV.K.5). After consulting with Parties and the health care consultants, the Co-Monitors submitted final health care outcomes to the Court on December 21, 2018. These outcomes are intended to guide health care implementation, and to serve as measures of DSS's progress in meeting the physical health, mental health, and dental needs of the children in their care.

In accordance with FSA K.1.(c), the Co-Monitors requested on December 21, 2018, that DSS update its Health Care Improvement Plan to include baselines and interim percentage targets for meeting the final health care outcomes. On February 1, 2019, DSS submitted draft interim targets to the Co-Monitors including, where available, baseline data. After many rounds of feedback and revision by DSS, the Co-Monitors approved DSS's targets on February 25, 2019.[190]

B. Performance Data

DSS has continued to make progress in building protocols to access health care data housed at DHHS and Select Health, and has reported that it put systems in place during this and prior

[189] The Health Care Addendum is available at: https://dss.sc.gov/media/1962/2-25-2019-approved-health-plan-addendum.pdf
[190] The Health Care Targets are available at: https://dss.sc.gov/media/1958/appendix-b-final-health-care-targets.pdf

monitoring periods that will serve as a foundation for ongoing data sharing, analysis, and dissemination, and that it has been receiving regular "data dumps" from DHHS. DSS was primarily focused during this monitoring period on the development of methodologies and data sources that will be utilized to report on progress in this area going forward, and has not yet produced data with respect to children who were in DSS custody during this monitoring period. This includes foundational data on basic health screens and assessments, as well as data that shows whether DSS provided appropriate care to meet children's identified needs.[191,192]

Given the importance of data to ensuring that children's health care needs are met - and the extent to which DSS has relied upon the availability of robust, reliable data in building out its care coordination framework - the Co-Monitors believe it is essential that DSS produce health care data going forward in accordance with its commitments in the Health Care Improvement Plan and Addendum.

[191] As in the prior monitoring period, DSS produced to the Co-Monitors data reflecting the percentage of children who entered DSS foster care between April 1 and September 30, 2018 who received initial medical visits of some kind. Because these data do not align with the definitions that have now been established for each of the FSA Health Care Outcomes, and were produced in a way that did not allow for Co-Monitor validation, they have not been included herein.

[192] As reported in prior monitoring periods, DSS does not have a mechanism for assessing performance with respect to the FSA requirement that it "identify Class Members with Immediate Treatment Needs (physical/medical, dental, or mental health) for which treatment is overdue," initially intended to apply to children in DSS custody at the time of entry into the agreement in October 2016 (FSA IV.K.4.(b)). DSS has reported that it expects to propose an alternative to this provision, based upon available data sources, but has not yet done so.

APPENDIX A - Glossary of Acronyms

CAPSS: Child and Adult Protective Services System
CFSR: Child and Family Services Review
DHHS: Department of Health and Human Services
DJJ: Department of Juvenile Justice
DMH: Department of Mental Health
DSS: Department of Social Services
FSA: Final Settlement Agreement
ICPC: Interstate Compact on the Placement of Children
IFCCS: Intensive Foster Care and Clinical Services
IO: Interim Order
MCO: Managed Care Organization
MOU: Memorandum of Understanding
OHAN: Out-of-Home Abuse and Neglect Unit
PIP: Performance Improvement Plan
SC: South Carolina
USC CCFS: University of South Carolina's Center for Child and Family Studies

Appendix B - OHAN Implementation Plan Strategy Updates
as of December 31, 2018

Strategies towards Achieving Targets:

The Department identified a number of strategies to achieving the OHAN targets:

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of December 31, 2018[193]
Intake and Investigations			
a. Institute investigative caseworker office day for case management activities	Complete by September 2017	Plan identified that action could be completed with existing internal resources	Due to staffing deficiencies, DSS has not implemented this strategy. DSS reports that implementation began in February 2019 and work is underway to update the schedule to include the new staff members who started in March 2019.
b. Develop a user-friendly report to track and monitor face-to-face contact and case initiation within 24 hours	To be determined after Data Workgroup prioritizes CAPSS and data work (See Core Foundational and Capacity Building Section Above - 3.b). Some development has already occurred.	Plan identified that action could be completed with existing internal resources	DSS reports requests have been made to CAPSS IT to develop two reports. The first report will track timely initiation and the second will capture timely initiation only for Class Members. A timeframe for report development is not yet available.
c. Revise the intake referral sheet to gather updated placement and caseworker information	Complete by March 2017	Plan identified that action could be completed with existing internal resources	DSS reports that staff are using the revised intake referral sheet and the Co-Monitors have observed instances of improvement in collected and documenting information.

[193] In some instances, information in this Table reflects the status of actions after December 31, 2018.

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of December 31, 2018[193]
d. Revise existing checklist to expand core witness list	Complete by April 2017	Plan identified that action could be completed with existing internal resources	DSS has revised the list of core witnesses and reports improvements in this area. Co-Monitor staff have observed inconsistencies in its use; sometimes the form is used appropriately, and at other times it is not. DSS attributes this to staff workload.
e. Develop tracking system for documenting core witness contacts and provide additional guidance and training to caseworkers on identifying core witnesses	Complete by December 2017	Plan identified that action could be completed with existing internal resources	DSS reports that updates to CAPSS to track core witnesses have been delayed due to a lack of resources and the volume of work within OHAN. CAPSS updates are scheduled to occur in late February, early March 2019. Once the updates are entered, testing will occur, and a demonstration to staff will be scheduled. DSS did not provide a date by which the updates will go live.
f. Research and adopt a screening and assessment tool to help guide decision-making for OHAN intake	Complete by May 2017	Plan identified that action could be completed with existing internal resources	DSS has begun the process for utilizing Structured Decision-Making ® (SDM)[194] in the Intake Hubs. With the assistance of NCCD, this new tool will incorporate the necessary information to screen OHAN intakes as well. Inter-rater reliability testing was completed on April 3, 2019, and next steps include finalizing the tool, training staff, and completing the CAPSS interface. DSS anticipates full implementation of SDM will begin on July 1, 2019. At that time, OHAN intakes will shift to the Intake Hubs.

[194] For more information on Structured Decision Making, see https://www.nccdglobal.org/assessment/sdm-structured-decision-making-systems/child-welfare

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of December 31, 2018[193]
g. Develop and conduct specialized OHAN training to include findings from OHAN baseline reviews (including clarifying practice standards around "collateral" contact prior to making a hotline decision), CAPSS documentation training, interview and investigative techniques, restraint training, assessing for safety and risk, and critical decision-making	OHAN basic intake training to occur for existing caseworkers and supervisors beginning September 2017. OHAN basic investigative training to occur for existing caseworkers and supervisors by December 2017. All new caseworkers and supervisors will be required to complete training going forward	Plan identified that action could be completed with existing internal resources and USC Training Staff	Trainings on a newly developed intake training curriculum were conducted in September and November 2017. Training on this curriculum will be provided to new staff in July 2019. The investigation training curriculum has been finalized, and the first of the two week training - which focuses on identifying physical abuse, sexual abuse, and neglect, as well as conducting interviews and assessing safety – was initially delivered to three OHAN caseworkers and one supervisor in early January 2019. The second week of the training - which will include legal considerations and regulations, policy and procedures, and critical thinking – is scheduled for April 15 through 19, 2019. DSS reports additional sessions will be scheduled as new staff are hired.
h. Develop a Provider History report in CAPSS to provide an easy to access and consistent history on providers for use by OHAN caseworkers, supervisors, and reviewers - Preliminary report is currently being tested - Once finalized, report will be automated in CAPSS. - OHAN intake caseworkers will be trained to access, read, and summarize the previous allegations for the past two years and consider the previous history as a factor in determining preponderance of evidence for case	Work has begun. Preliminary report has been created and is being pretested with staff, supervisors, and reviewers. Based on feedback, report will be finalized and automated in CAPSS. Until automation, adhoc reports will continue to be extracted. Work complete by September 2017.	Plan identified that action could be completed with existing internal resources	DSS reports a provider history report has been developed and was incorporated into standard practice in September 2017. The report includes the past five years of OHAN intakes and investigations, allowing caseworkers to identify possible trends.

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of December 31, 2018[193]
i. Develop a coordinated process with Licensing that may include the following: - Create a new policy to establish clear guidelines for revocation of foster home and facility licenses for multiple allegations of policy violations that do not constitute abuse or neglect but that are detrimental to child well-being	Development of policies to be completed by July 2017. Implementation of policies and training of existing staff on new policies completed by November 2017 by Licensing and OHAN	Plan identified that action could be completed with existing internal resources	DSS reports that OHAN policy has been updated, to include a provision that a foster parent's license may be revoked if a provider is found to have violated the signed discipline agreement, including the prohibition against corporal punishment. DSS reports that updated policy will be submitted for final approval and publication by April 30, 2019.
Supervisor Review			
a. Determine ways to increase guided supervision staffing, critical thinking, monitoring-accountability system by supervisor			
- Revise the Guided Supervision Tool to be specific to OHAN performance measures and for case reviews and system for utilization in practice. After implementation, this tool will be used at every supervisory review to guide the critical thinking of staff in investigatory work.	Complete by May 2017	Plan identified that action could be completed with existing internal resources	DSS reports the Guided Supervision Tool was finalized in May 2017 and is currently in use. As mentioned earlier, the workload of staff have resulted in inconsistent quality in these staffings.
- Train OHAN Supervisors on use of the Guided Supervision tool (See above for additional training of supervisors on information from OHAN baseline reviews)	Complete by June 2017	Plan identified that action could be completed with existing internal resources	

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of December 31, 2018[193]
- Implement Guided Supervision in OHAN by training staff on the expectations and begin use of the Guided Supervision process	Complete by June 2017	Plan identified that action could be completed with existing internal resources	
b. Implement standardized supervisory case review prior to case decision	Complete by April 2017	Plan identified that action could be completed with existing internal resources	During recent reviews of closed OHAN investigations, Co-Monitor staff have found that these reviews routinely occur.
c. Refine case closure supervisory review to include CAPSS and paper file (thorough review)	Complete by April 2017	Plan identified that action could be completed with existing internal resources	During recent reviews of closed OHAN investigations, Co-Monitor staff have found evidence in the paper file of case closure supervisory review, however, many times these occur after the investigation has already been closed.
d. Develop methodology for caseload distribution	Complete by September 2017	Plan identified that action could be completed with existing internal resources	Beginning in late-2018, new OHAN staff are being allocated to and physically located in the DSS regions to assist in travel responsibilities and increase familiarity with foster parents, congregate care facilities, and local DSS staff. Caseload data from September 2018 reflect inconsistencies in the number of investigations assigned to each caseworker.

Appendix C - Health Care Implementation Plan Strategy Updates as of December 31, 2018

Strategies towards Achieving Targets:

The Department identified a number of strategies to achieving the health care targets:

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of December 31, 2018[195]
Child Health Goal 1: Each Child in Foster Care is Linked to a Care Coordinator Matched to the Child's Needs			
Weekly meetings with Select Health on care coordination practice, processes and protocol.	Weekly, beginning from October 2018 - Present		Ongoing. Meetings have been occurring on a weekly basis, and moved from an early focus on data to planning for a model of care coordination and health care case management.
Weekly meetings with DHHS on data-sharing and refining gaps in care prototype and other reports.	Weekly, October 2018 - Present		Ongoing. Meetings have been occurring on a weekly basis, and moved from an early focus on data to planning for a model of care coordination and health care case management.
Choose validated assessment tool, train DSS staff, and roll out standardized assessment tool in accordance with the processes developed in the Placement Implementation Plan.	February 2019 - March 2019		Not yet due.
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.	February 2019 - March 2019		Not yet due.

[195] In some instances, information in this Table reflects the status of actions after December 31, 2018.

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of December 31, 2018[195]
Connect health/behavioral health initial assessments and comprehensive assessments to placement decision-making processes, informing the Placement Implementation Plan.	February 2019		Not yet due.
Institute weekly cadence call to staff cases, review progress made and resolve immediate needs beginning August 2018.	Weekly, August 2018 - Present		Ongoing, in part: DSS has moved forward on the implementation of these calls and has reported that they are useful in pushing out data in re: health care needs of children. The calls have focused primarily on initial health assessments - unanticipated complexities in data analysis in re: other important markers (periodic assessments, gaps in care) has meant that this work has been delayed.
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.	February 2019		Not yet due.
Produce a comprehensive care coordination and health care case management framework subject to approval of the Co-Monitors.	March 2019		Completed. The DSS Health Care Addendum was approved by the Co-Monitors on February 25, 2019.

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of December 31, 2018[195]
Child Health Goal 2: Each Child in Foster Care has a Primary Care Provider and Receives Timely Screening, Assessment, and Follow-Up Care - 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.	February 2019		Not yet due.
DSS will collaborate and explore with DMH the designation of its CMHCs as preferred outpatient behavioral health providers, given child psychiatry staffing and regional locations around the state.			Ongoing.
DSS will collaborate and explore with DMH the designation of its CMHCs as preferred outpatient behavioral health providers, given child psychiatry staffing and regional locations around the state.	February 2019		Not yet due.

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of December 31, 2018[195]
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.	February 2019		Not yet due.
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.	February 2019		Not yet due.
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.	2020		Not yet due.
Child Health Goal 2: Each Child in Foster Care has a Primary Care Provider and Receives Timely Screening, Assessment, and Follow-Up Care - Eligibility and Enrollment			
Build out and pilot test the rostering, tracking and follow-up mechanism for initial assessments, comprehensive assessments and timely follow-up.	September 2018 - February 2019		Completed.

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of December 31, 2018[195]
Fix 30-day enrollment lag by January 2019, and in interim, develop and use an 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.	August 2018 - January 2019		Not yet due.
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.	February 2019		Not yet due.
Child Health Goal 2: Each Child in Foster Care has a Primary Care Provider and Receives Timely Screening, Assessment, and Follow-Up Care - Screening and Assessment			
DSS, DHHS and Select will collaborate on the development of a no-lag enrollment protocol by January 2019.	January 2019		Not yet due.
DSS and DHHS have already developed and signed a data-sharing agreement.	December 2018		Completed.
DSS, DHHS and Select Health will develop an implementation timeframe for producing regular monthly gaps in care reports.	February 2019		Not yet due.

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of December 31, 2018[195]
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.	August 2018 - February 2019		Not yet due.
Caseworker training will include new expectations for documentation and follow-up and refresher training on DSS practice standards.	February 2019		Not yet due.
Child Health Goal 2: Each Child in Foster Care has a Primary Care Provider and Receives Timely Screening, Assessment, and Follow-Up Care - 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.	November 2018		Not yet completed.
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.	August 2018 - Present		Ongoing.

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of December 31, 2018[195]
Child Health Goal 2: Each Child in Foster Care has a Primary Care Provider and Receives Timely Screening, Assessment, and Follow-Up Care - 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.	August 2018 - Present		Ongoing.
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.	August 2018 - Present		Not yet completed.
Child Health Goal 3: Each Child in Foster Care has Timely Access to Quality Health, Behavioral Health, and Dental Services - 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.	June 2019		Not yet due.
DSS will contract with USC to conduct targeted annual topical studies, with recommendations, as needed.	June 2019		Not yet due.

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of December 31, 2018[195]
Child Health Goal 3: Each Child in Foster Care has Timely Access to Quality Health, Behavioral Health, and Dental Services - CFSR Case Record Review and PIP			
DSS will continue its focus on health and behavioral health services in CFSR case record reviews.	August 2018 - December 2018		Ongoing.
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).			USC Center for Child and Family Studies is preparing an analysis of these cases.

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of December 31, 2018[195]
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.			USC Center for Child and Family Studies is preparing an analysis of these cases.
Child Health Goal 3: Each Child in Foster Care has Timely Access to Quality Health, Behavioral Health, and Dental Services - 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.	June 2019		Not yet due.
DSS, DHHS and Select Health will meet once a year to review provider and network adequacy and capacity issues.	June 2019		Not yet due.

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of December 31, 2018[195]
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.	June 2019		Not yet due.
Child Health Goal 3: Each Child in Foster Care has Timely Access to Quality Health, Behavioral Health, and Dental Services - 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.	December 2018		DSS reports that, as of December 2018, an improved process has been implemented for payment of medical, mental health, and dental bills for children who are not eligible for Medicaid. A plan is in place to communicate this process via informational memo and policy changes.
DSS will identify the appropriate role for DSS caseworker where out-of-network services are necessary and train caseworkers accordingly.	December 2018		Not yet completed. DSS reports that it has determined more work is needed, in collaboration with DHHS and Select Health, to define expectations with respect to service array adequacy and in- and out-of-network services.

DSS Proposed Strategies to Achieve Targets	DSS Reported Timeline	Resources Identified as Needed in Plan	DSS Implementation Update as of December 31, 2018[195]
Child Health Goal 4: Each Child in Foster Care Has Improved Health Outcomes			
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).	December 2018		Completed. FSA Health Care Outcomes were approved by the Co-Monitors and submitted to the Court on December 21, 2018.
Convene FCHAC in facilitated working sessions to review proposed benchmarks and targets.	Spring and Fall annually, beginning April 2019		Not yet due.
Finalize benchmarks and targets.	December 2018		Completed. FSA Health Care Outcomes were approved by the Co-Monitors and submitted to the Court on December 21, 2018.
Convene FCHAC in facilitated working sessions to review proposed benchmarks and targets.	Spring and Fall annually, beginning April 2019		Not yet due.
Review/refine annually.	Spring and Fall annually, beginning April 2019		Not yet due.
Interim benchmarks incorporated into plan.	March 1, 2018		Completed. Interim benchmarks were approved by the Co-Monitors for inclusion in the Health Care Improvement Plan on February 25, 2019.