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

Paul Vincent

Michelle H., *et al.* v. McMaster

PROGRESS REPORT: SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES

April 1 - September 30, 2022

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I. Introduction

This report covers the progress of the South Carolina Department of Social Services (DSS) in meeting the requirements of the Final Settlement Agreement (FSA)[1] entered in *Michelle H., et al. v. McMaster and Leach*, for the period April 1 through September 30, 2022.[2] Approved by the United States District Court on October 4, 2016, the FSA includes requirements for the care and treatment of the approximately 4,000 children in foster care in South Carolina and incorporates provisions ordered in a September 2015 Consent Immediate Interim Relief Order (the Interim Order or IO).[3,4] The FSA outlines South Carolina's obligations to significantly improve the experiences of and outcomes for children removed from the care of their parent(s) or guardian(s) and placed in DSS's custody, and reflects an agreement by the State to address long-standing problems in the operation of its child welfare system. The report has been prepared by court-appointed independent Co-Monitors Paul Vincent and Judith Meltzer, with assistance from Elissa Gelber, Ali Jawetz, Sarah Esposito, and Gayle Samuels. It 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 was crafted by state leaders and Plaintiffs to guide a multi-year reform effort on behalf of children in DSS's custody and includes specific provisions governing: the workloads of case managers and supervisors; visits between children in foster care and their case managers; family time, or visits between children in foster care and their parents and siblings; investigations of allegations of abuse and/or neglect of children in foster care by a caregiver; appropriate placements; and access to timely physical and mental health care. Within this structure, the Co-Monitors worked closely with DSS and Plaintiffs between 2017 and 2019, leading to

[1] Final Settlement Agreement (October 4, 2016, Dkt.32-1)
[2] 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.
[3] 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.).
[4] Consent Immediate Interim Relief Order (September 28, 2015, Dkt. 29)

the development of Implementation Plans approved and ordered by the Court.[5] The intention was that these Plans – the implementation of which are tracked by the Co-Monitors – would provide blueprints and accountability for the reform work ahead.

The Co-Monitors and their staff utilized a range of sources and activities to collect data and information for inclusion in this report, and to inform the overall assessment of the State's progress. These include, among other things, review of records in DSS's Child and Adult Protective Service System (CAPSS);[6] analysis and validation of data provided by DSS and collected by DSS and Co-Monitor staff through structured reviews; discussions with case managers and other DSS staff, private providers, and stakeholders; meetings with DSS leaders; and discussions with Plaintiffs' counsel. Appendix B includes a list of specific activities used to assess DSS's progress during the monitoring period.

Included in this report is a summary of the Co-Monitors' general findings, followed by a discussion of DSS's performance with respect to the FSA requirements, as well as updates on the implementation of strategies contained in each of the court-ordered Implementation Plans.[7] In order to make the report as useful as possible to the Court, Parties, and public, the Co-Monitors have also included information about developments beyond September 30, 2022 (the end of the monitoring period), where applicable.

[5] See court orders approving Workload, Placement, and Health Care Plans (February 27, 2019, Dkt. 109) and Visitation Plan (April 3, 2019, Dkt. 115). To see all Implementation Plans and Addendums for the *Michelle H.* Final Settlement Agreement, go to: https://dss.sc.gov/child-welfare-reform/

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

[7] 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)."

II. Summary

This report covers DSS's performance between April 1 and September 30, 2022, a period of transition for DSS. In July 2022, after years of being woefully under-resourced and grappling with the challenges caused by the COVID-19 pandemic, DSS received an influx of an additional $39 million in funding from the South Carolina General Assembly, signaling new confidence in the leadership provided by DSS Director Michael Leach. Two months later, Director Leach appointed Emily Medere Deputy Director for Child Welfare. Together, these changes have translated into a renewed energy for the Department. The crisis orientation that has defined DSS for years has begun to give way to a more purposeful focus on building infrastructure and improving practice with families, as will be necessary to meet the requirements of this lawsuit.

DSS performance has continued to improve in some key areas. This monitoring period again saw a reduction in the number of children brought into foster care; lower staff turnover; continued placement of children with kin and outside of congregate care; and improved compliance with supervisor and Foster Care case manager caseload limits (towards the end of the monitoring period). There were also improvements in Out-of-Home Abuse and Neglect (OHAN) investigative practices with respect to contact with core witnesses and appropriate decisions to unfound investigations. As previously reported, the Co-Monitors have identified five FSA measures that may be eligible for "Maintenance of Effort" designation.[8,9]

The coming months will be crucial for DSS, as it continues to fill newly allocated positions and more fully implement important strategies and obligations that have long been sidelined. Perhaps most importantly, DSS will need to continue the work it has begun to translate the values and principles embodied by state leadership into real practice change at all levels, and with all system partners – changing the way children and families are treated; how they experience the DSS child welfare system; and the safety, permanency, and well-being outcomes that result. In addition, though the General Assembly has provided badly needed additional resources, leadership, including from the Governor's office, DSS, the South Carolina Department of Health

[8] These measures are: Timely Completion of Investigations within 45, 60, and 90 days (FSA IV.C.4.(d), (e), and (f)); and Congregate Care Placements for all Class Members and Class Members 12 years old and under on the last day of the Reporting Period (FSA IV.E.2&3).
[9] FSA V.E.3 provides the Co-Monitors "will identify which provisions may be eligible for the Maintenance of Effort designation," indicating that Defendants may have achieved compliance for the specific obligations. Designations of Maintenance of Effort status are made by the Court pursuant to FSA V.E.1.

and Human Services (DHHS), and other state agencies will need to continue to work together to secure additional support for community-based services that remain in short supply. These services will be essential for the state to fulfill the requirements of the FSA.

Both the Co-Monitors and DSS will be closely tracking progress over the next monitoring period – the first full period to be assessed after the deployment of Fiscal Year (FY) 2022-2023 funding. With new leadership, energy, focus, and additional resources now in place, it is a shared expectation that these changes will begin to take hold and be reflected in performance data and outcomes.

Areas of promise

Foster Care Census

There has been a continued decrease in the number of children in foster care; there were 3,794 Class Members as of September 2022, compared to 3,973 Class Members at the end of March 2022. This is a positive trend and DSS leadership reports the decrease reflects ongoing work to reduce family separations, support children and families within their homes, and expedite reunification when possible. The allocation of a significant number of newly funded positions in the FY2022-2023 budget to child welfare functions for Non-Class Members (the "front end" of the child protection system), such as Child Protective Services and Family Preservation, has the potential to increase supports for families and reduce family separations further.

Turnover and Retention

There was an increased emphasis on staff hiring towards the end of this monitoring period, as DSS worked to fill the vacancies created by staff turnover and the many new positions allocated in the FY2022-2023 budget. As of September 2022, there was a vacancy rate of 22 percent for Class Member program areas (Foster Care, Adoptions, and OHAN).[10] DSS reports continued improvement since and that, as of the end of January 2023, the vacancy rate had fallen to 16 percent, with 106 out of 652 positions vacant.[11] DSS has put particular focus on filling supervisory positions, so that appropriate supports are in place for case managers.

Within the context of a difficult hiring environment, there has been some progress in filling long vacant and newly funded nurse and health care support positions. As of

[10] October 20, 2022, Updated DSS Data Packet from Michael Montgomery, (Dkt. 260, p.26)
[11] These data include staff who were hired but had not started yet; DSS reports that many of the open positions were in the final stage of interviewing and conducting background checks.

March 2023, seven of 10 nurse positions statewide were filled, as were two new state-level quality improvement positions who will act as liaisons with Select Health, the Managed Care Organization (MCO) for children in foster care.

Responding to the continued challenges of staff turnover, DSS is in the process of rolling out many of the strategies that have long been overdue under the court-approved Workforce Implementation Plan. DSS is building out a competency-based model for interviewing and hiring applicants for child welfare positions, bolstering its certification training programs, and considering a range of additional retention strategies utilized effectively in other jurisdictions.

Data Capacity

DSS has made significant progress over the last few months in building its internal capacity to measure performance. DSS child welfare leadership recently developed a data dashboard to regularly track key performance indicators. DSS reports it is currently using the dashboard to regularly track seven measures – including measures that relate to children's time spent with family members (through visits) and provision of health care to children – and that monthly reports are distributed to all staff for management purposes. DSS is also beginning to utilize SafeMeasures®, a nationally recognized web-based system for data aggregation, reporting, and analysis.[12]

DSS's ability to monitor its performance has also been strengthened by the transition of its quality assurance (QA) capacity from an outsourced function at the University of South Carolina (U of SC) to a team within DSS that is familiar with the day-to-day functions, policies, and practices of the Department. The internalization of the QA team has allowed DSS to develop regular reviews, including peer reviews of OHAN investigations, and provide feedback in real time to managers and to the field.

DSS has also been working in close partnership with the Co-Monitors to develop ways of assessing performance with respect to FSA measures it has historically been unable to track.[13] Department leadership has communicated its commitment to revising and developing methods for data collection that will yield not only quantitative data, but meaningful qualitative information that can be used for system improvement. In addition, DSS worked with a national data consultant hired by the Co-Monitors between September and December 2022 to review its placement

[12] More information about SafeMeasures can be found at: https://evidentchange.org/analytics/safemeasures/

[13] These measures include: Youth Exiting the Juvenile Justice System (FSA IV.H.1); Therapeutic Foster Care Placements (FSA IV.I.2 – 5); Immediate Treatment Needs (FSA IV.K.4.(b); Initial Medical Screens; Initial Mental Health Assessments; and Follow-Up Care.

instability data.[14] After receiving a report largely validating its methodology, DSS has moved forward to integrate the consultant's feedback and recommendations that will further increase the likelihood of data validity in this area.

Kin Placement

The placement of children with kin (relatives or other familiar people) has continued to be an important priority for DSS, and the percentage of children who are placed with kin after being removed from their homes has further improved.[15] As of the end of this reporting period, nearly one quarter of children (23%) in DSS custody were residing with their kin (up from 21% at the end of the prior period and 11% in March 2020 when this metric was first evaluated). Towards the end of the monitoring period, DSS began collaborating with private providers throughout the state to implement an initiative that will enable kin to become therapeutic foster care providers,[16] allowing them to access more services and supports to care for and stabilize the children in their homes. DSS estimates rollout of this initiative to begin in early summer 2023.

Congregate Care

DSS has continued to decrease its use of congregate care facilities for the placement of children in its custody. As of September 30, 2022, 12 percent of children were placed in non-family-based settings, down from 13 percent in the prior period, and 22 percent in March 2017, just after entry into the FSA. This was largely accomplished through an initial focus on decreasing the use of these placements for younger children, and more recently through the gradual decrease in placement of children ages 13 through 17 in congregate care. On September 30, 2022, 34 percent of children ages 13 to 17 years old were placed in congregate care as compared to 36 percent on March 31, 2022. Although placement of older youth in congregate care remains high, DSS has now met the FSA performance standard for children in family-based placements for three monitoring periods, an important accomplishment.[17]

[14] In August 2022, the Co-Monitors engaged Action Research, a national research and technical assistance provider, for the purpose of evaluating the validity of DSS's methodology for collecting data on placement instability after DSS reported identifying inconsistencies in these data in the prior monitoring period. More information about Action Research can be found at https://www.actionresearch.io/

[15] FSA IV.E.2&3.

[16] As in many systems across the country, some private organizations throughout South Carolina are licensed as Child Placing Agencies (CPAs). These agencies receive funding to provide foster care placement and monitoring through group facilities or by recruiting, training, and licensing foster parents. Approximately 34% of children in DSS custody were placed through CPAs at the end of the monitoring period.

[17] FSA IV.E.2.

Out-of-Home Abuse and Neglect

Though challenges remain in the DSS unit which investigates allegations of abuse and/or neglect of children in DSS custody by a foster parent or staff of a facility, there has been significant improvement with respect to the requirement that investigators interview all core witnesses during an investigation.[18] A review of 51 investigations from September 2022 showed that all applicable core witnesses were interviewed in 67 percent of investigations, an increase from the finding of 51 percent in March 2022. The September 2022 records also highlighted an improvement in practice around investigative decisions.[19] Of the 51 investigations reviewed, the final decision in 44 investigations was to *unfound* the allegations; reviewers agreed that the decision to *unfound* the investigation was appropriate in 86 percent (38 of 44), an increase from 72 percent in March 2022.

Supervisor and Case Manager Caseloads

DSS's focus on filling vacant supervisory positions has led to reduced caseloads for supervisors across program areas.[20] For the first time, as of September 30, 2022, 90 percent of supervisors' caseloads, of all types – Foster Care, OHAN, and Adoptions – were within required limits.[21] The infusion of resources for hiring in July 2022 also resulted in some improvements towards the end of the period in case manager caseloads in some areas and is expected to translate into further improvement over the coming months. At the end of September 2022, 51 percent of Foster Care case managers had caseloads within the required limit, up from 42 percent in March 2022.[22] As of the end of September 2022, no OHAN investigators had caseloads that exceeded 125 percent of the caseload standard (an improvement from March 2022, when seven of 19 OHAN investigators had caseloads that were more than 125 percent of the standard).[23]

[18] FSA IV.C.4.(c))
[19] FSA IV.C.3.
[20] DSS reports that as of March 3, 2023, 96% of all supervisor positions, 94% of Foster Care case manager positions, and 100% of Adoption case manager positions have been filled.
[21] FSA IV.A.2.(b))
[22] As discussed in more detail in Section V. *Staffing and Caseloads*, DSS data shows an increase in supervisors directly responsible for carrying Foster Care cases. For example, the Co-Monitors found that in two small counties, Beaufort and Dillion, all four Foster Care managers had caseloads within the standard, but their two supervisors carried 9 and 13 cases, respectively.
[23] At the end of September 2022, 15 of 20 OHAN investigators had caseloads within the required limit, up from seven of 19 OHAN investigators within the required limit in March 2022.

Areas of challenge

Health Care

Despite much attention in this area over the past several years, the percentage of children receiving their medical and dental visits according to prescribed timelines has not improved. According to DSS's internal data, 60 percent of children in its custody were up-to-date on their well-child visits as of November 21, 2022.[24] Sixty four percent of children in care at the end of September 2022 were up-to-date on their dental exams as of November 21, 2022. As for the requirement in the Health Care Improvement Plan, as well as state and professional practice standards, that children receive an initial comprehensive medical exam when they enter foster care, only 35 percent of children who entered care between March and August 2022 received a comprehensive medical assessment within 30 days; 45 percent of children who entered care during this period received a dental visit within 60 days, as required.

DSS's small team of nurses and data coordinators continued to work to the limits of their capacity to manage and document the health care needs of children in foster care this monitoring period. DSS was granted long-awaiting funding for three additional nursing positions, as well as additional support positions, in the FY2022-2023 budget, but a nationwide nurse shortage has made it difficult for the team to fill open positions as quickly as hoped.

The responsibility of delivering health care to children in foster care in South Carolina does not rest with DSS alone. It is critical that DSS work with its state agency partners like DHHS and the South Carolina Department of Mental Health (DMH), community partners, and its private MCO partner (Select Health) to implement the Health Care Improvement Plan entered by the Court more than four years ago to improve performance in this area.

Assessment and Teaming

DSS has taken several important steps towards improving its practice with and outcomes for families by undertaking efforts to strengthen its understanding of children's needs and implementing a Child and Family Teaming (CFT) process. Staff

[24] Health care data reporting timelines were adjusted this period to accommodate delays in access to Medicaid administrative data. To provide the most up-to-date information, some data points are reported for more recent months than others. For example, data reflecting periodic well-child and dental visits are reported as of November 21, 2022. Data that relate to initial comprehensive medical and dental visits are reported for all children who entered care between March and August 2022. All data throughout are labeled accordingly.

are being trained in the use of the Child Assessment of Needs and Strengths (CANS) assessment tool, as well as in teaming. Coaches are mentoring front-line staff and DSS leadership is promoting the practices through multiple communication strategies.

Despite these efforts, CFTs are not yet occurring as frequently as they should be, and data are not widely available on the quality of the meetings and their results.[25] Though a CFT is to be held for each child upon entry into foster care and at key times throughout their case – for example, every time a child changes placement or is at risk of disruption – only 665 CFTs of any kind were held during the monitoring period, when 1,437 children entered foster care. The teaming process is most frequently used as an opportunity for assessment and planning related to placement. While DSS does convene CFTs for children experiencing emergency placements, these meetings have been used to search for housing, rather than as forums for exploring children's needs and crafting strategies that will provide ongoing stability and progress toward permanency.

DSS agrees that the time is ripe to refine its assessment and teaming process, and orient it, as designed, to be family-driven and focused on meaningful case planning and assessment in collaboration with families' informal and formal supports. Assessment of child and family needs must go beyond focusing on behavioral symptoms that make it challenging to find a placement to learning what underlies children's behavior. Once identified, those underlying needs must be met with highly individualized services. CFTs should begin at the time of first contact with families and continue throughout the family's involvement with the child welfare system, a goal to which DSS is committed. Intensive training and coaching of case management staff will be required to teach front-line staff to facilitate team meetings with adequate fidelity and achieve the desired results. A robust quality assurance process is needed to ensure that assessment and team meetings are faithful to the model, and to identify where staff need additional support.

Placement Instability

The lack of adequate resources in South Carolina has made the maintenance of an appropriate number and array of placements and supports for children in foster care throughout the state a challenge for DSS since the inception of this lawsuit. The

[25] DSS reports that it has begun distributing surveys to CFT participants and that for CY2022, 1,223 CFT participants (including 258 parents, 365 extended family members and other kin, 27 clinicians, 154 Guardian Ad Litems [GALs], 231 DSS staff, 76 foster parents, and others) completed surveys, including for cases with Non-Class Members.

severity of these barriers came into stark relief beginning in 2021 as large numbers of children began staying overnight in DSS offices. DSS's implementation of the Overnight Stay Plan, jointly agreed upon with Plaintiffs on March 23, 2022,[26] initially led to a sharp decrease in the number of children sleeping in DSS offices. Between April 1 and September 30, 2022, 28 children slept overnight in DSS offices, compared to 108 children in the prior monitoring period. Following the end of the monitoring period, the number of notifications of overnight stays remained low until February 2023, when there was another spike in the number of children sleeping overnight in DSS offices. From October 1, 2022 to March 20, 2023, 47 children experienced a combined total of 65 nights spent in a DSS office; most of these stays occurred in February (19 overnight stays) and March (28 overnight stays in 20 days) alone.

Children in foster care, on average, experienced the highest degree of placement instability between October 2021 and September 2022 than in any period reviewed since the inception of this lawsuit. Children are frequently placed in short-term placements that are not equipped to meet their needs, leading, only, to the need for further moves.

Though DSS data collection on emergency placements has been inconsistent,[27,28] currently available data indicate that between April 1 and September 30, 2022, 515 children experienced 1,295 emergency placements over the course of 4,915 nights. Over a third of these children, 185 of 515 (36%), experienced more than seven non-consecutive nights of emergency placement during the prior 12 months, and 40 children (8%) experienced more than 30 nights of emergency placements since October 2021. One child experienced 129 nights of emergency placements in the past year. At times, children without long-term placements spend daytime hours in DSS offices or other holding places and nights moving between foster homes or congregate care facilities that are unfamiliar to them.[29]

[26] Overnight Stay Plan (March 23, 2022, Dkt. 236)
[27] DSS defines an emergency placement as a short-term placement that is only utilized after all efforts have been made to identify a permanent long-term placement and those efforts were unsuccessful (SC DSS Child Welfare Policies and Procedures Manual, Chapter 5:510 (effective July 22, 2020)).
[28] As discussed in more detail in Section VIII. *Placements*, DSS reports inconsistent entry of emergency placements into CAPSS between October 2021 and March 2022, and that the technological process continues to be enhanced, so these data may be updated in subsequent reports. DSS reports having made several process refinements during this monitoring period to improve the accuracy and consistency of data entry.
[29] See Order Notifying Parties and Co-Monitors of Information Relayed to the Court (February 22, 2023, DKt.271): "DSS reports few children in its custody sleep overnight in DSS office; however, children in DSS custody remain in DSS offices until late in the evening and are driven by a DSS worker to a temporary foster placement across counties that are sometimes located several hours away. The children remain at the temporary foster home throughout the night – only for a few hours – before a DSS worker picks the child up in the early morning."

Even children who remain in placements for longer periods of time are frequently placed far from their communities. As of September 1, 2022, only 35 percent of children were placed within their home counties.[30] This makes it difficult or impossible for children to maintain long-term relationships, visit with family, attend school consistently, engage in treatment and supportive services, or experience continuity of any kind.

Family Time

Since the start of the lawsuit, DSS has woefully underperformed with respect to the maintenance and support of connections between children in foster care and their family members. Due to a lack of available data, DSS, University of South Carolina's Center for Child and Family Studies (U of SC CCFS), and Co-Monitor staff have historically conducted twice-yearly reviews of a statistically valid sample of children's records to determine performance on DSS's minimum twice-monthly standard for children's contacts with their parents and minimum once-monthly standard for contact between siblings in foster care and living apart.[31] Results from these reviews showed performance far below policy and practice expectations. Across four years and 10 reviews, DSS and the Co-Monitors learned that on average, only half of records contained documentation that a child had seen their sibling during a selected month. On average, only 13 percent of records showed documentation of children having twice monthly contact with their parents with whom they were to be reunified.

Upon agreement of all Parties, and given poor performance on these measures and lack of substantial progress, and after reviewing and reporting performance for September 2021, the Co-Monitors suspended the review of a statistically valid sample of records and reporting on this measure for at least four monitoring periods, or until DSS reports that its corrective strategies have begun to produce a substantial increase in performance. DSS does not believe there has yet been significant improvement. With implementation of SafeMeasures®, expected to begin in May 2023, DSS plans to produce reliable data reports on children's visits with their siblings and parents and eliminate the need for a review of case records. The Co-Monitors and DSS have discussed utilizing SafeMeasures® reports, along with the results of a review of records to the Court and Parties on performance for the period ending September 30, 2023, in order to inform an ongoing plan for measuring performance in this area.

[30] As discussed in Section III. *Background Information*, the state is organized into four DSS regions. DSS reports that 75% of children were placed in their region of origin as of September 1, 2022.
[31] Data from the last day of the months of March and September are used to measure and report performance.

DSS leadership recognizes the importance of maintaining family connections to children's well-being and to progress in all other areas. DSS reports it is focusing on this area of practice as a key priority and expects improvements to take hold as case manager vacancies are filled, caseloads are reduced, placements are made closer to children's home communities, and data tracking capacity increases. Full implementation of the DSS Guiding Principles and Standards (GPS) Case Practice Model and strengthened engagement with children and their families will be vital.[32]

Community-Based Supports and Services for Families

There continues to be a shortage of quality services to support children and families in the community. As DSS leadership acknowledges and has been consistently reported in all prior monitoring reports, placement decisions are most often made based on availability of beds, rather than on the unique needs of children and their families. In addition, the lack of community-based services and other supports further hamper children's ability to remain with kin and in family-based placements.

Now that DSS is in a forward-thinking posture, it will be imperative that leadership focus on developing wraparound, crisis intervention, and other community-based services particularly for kin caregivers; maximizing the use of Medicaid-funded mental health services to fill gaps in the current service array; and recruiting and retaining more foster parents, particularly kin caregivers to better address placement needs of Class Members.[33] DSS's ability to access federal and state resources, and commitment to aligning the core strategies included in its Placement Plan with the key strategies of the reform effort overall, will be essential to improving the experiences and outcomes of the children in its care.

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[32] DSS's GPS practice model was designed in recognition of the need for a culture that 'engage[s], encourage[s], honor[s], and support[s] families.' To see the GPS practice model, go to: https://dss.sc.gov/media/2746/gps-practice-model-final.pdf

[33] As discussed in prior reports, many jurisdictions throughout the country have been successful in leveraging Medicaid funding to support children, youth, and families involved with the child welfare system. This can involve the use of the Medicaid benefits plan and/or Waivers to provide or increase the provision of key home- and community-based- services including intensive care coordination and high-fidelity Wraparound, Mobile Crisis Response and Stabilization, different types of Therapeutic Foster Care, mentoring, and family peer support, among other services. For more information see https://www.casey.org/medicaid-funded-services/; https://www.casey.org/media/20.07-KM-LFOF-Medicaid-waiver-authorities.pdf. In addition, on January 4, 2023 the Centers for Medicare and Medicaid Services (CMS) issued guidance offering states the option of utilizing Medicaid managed care programs to reduce health disparities and address unmet health-related social needs (HRSNs), such as housing instability and nutrition insecurity, using supports offered "in lieu" of a service or setting (ILOS) covered under the Medicaid state plan. South Carolina has begun exercising this option. For more information go to:
https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf

The report sections that follow include analysis related to demographic information, the state's budget, and each area of practice specifically addressed in the FSA. These include staffing and caseloads; visits between case managers and children; investigations of alleged maltreatment of children while in foster care; placements; time siblings spend with each other; time children who are to return home spend with their parents; and health care. To the extent available, policy, practice, and strategic updates, and relevant performance data are also included.

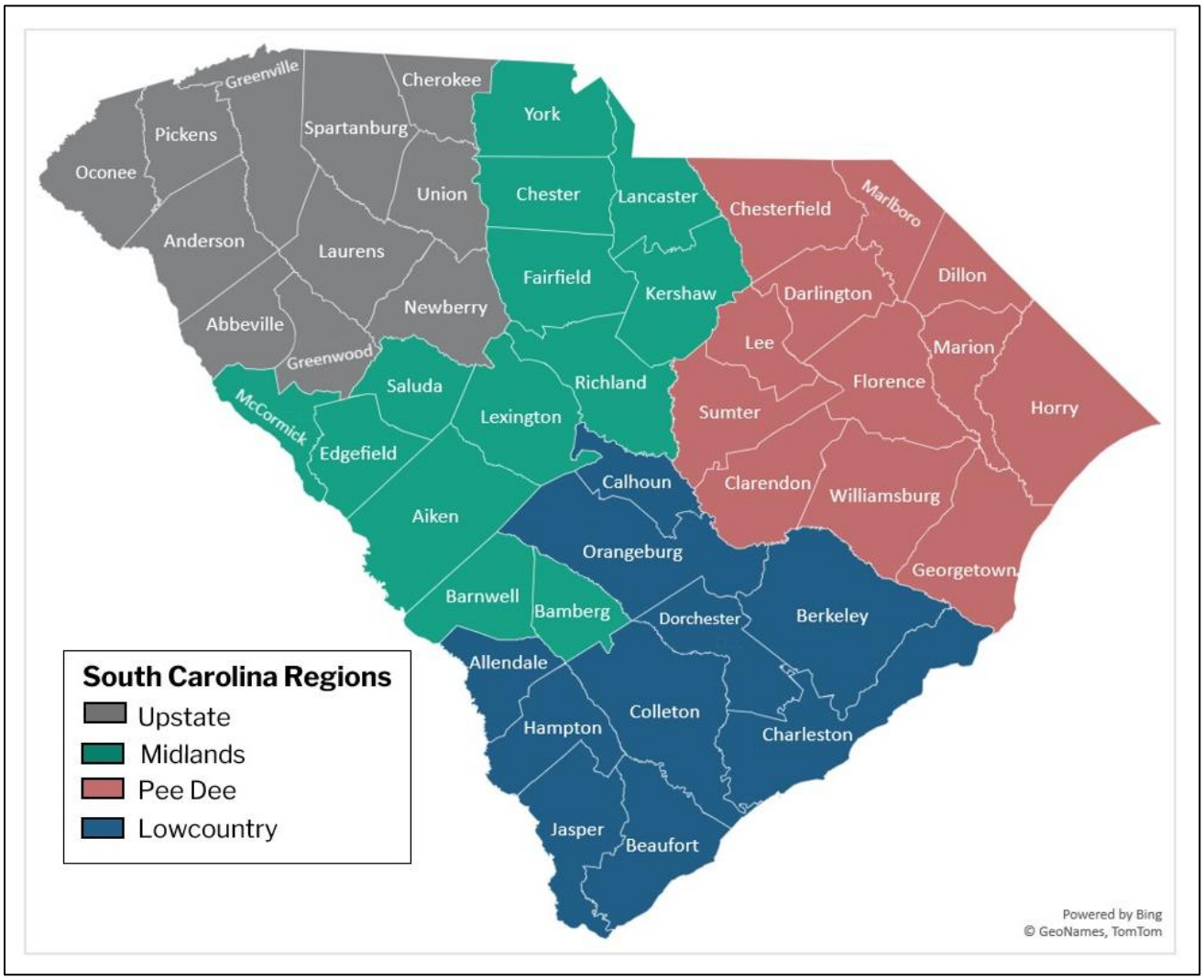
III. Background Information

South Carolina Department of Social Services: Structure and Mission

DSS is a cabinet-level agency charged with "promoting the safety, permanency, and well-being of children and vulnerable adults, helping individuals achieve stability and strengthening families."[34] The agency, directed by Michael Leach, oversees investigations of alleged child abuse and/or neglect by parents, guardians, foster parents, and staff of daycare centers and facilities where children reside; preventative services for families; foster care; adoptions; childcare; child support; Adult Protective Services (APS); and economic assistance programs such as Temporary Assistance for Needy Families (TANF), which provides financial assistance to families experiencing poverty, and programs to support employment, and the Supplemental Nutrition Assistance Program (SNAP), which provides nutrition benefits to families earning low wages to purchase food. DSS is structured to deliver services through regional and county offices; the state's 46 counties are divided into four regions – Midlands, Upstate, Pee Dee, and Lowcountry (see Figure 1).

[34] To see DSS's mission, visit: https://dss.sc.gov/about/

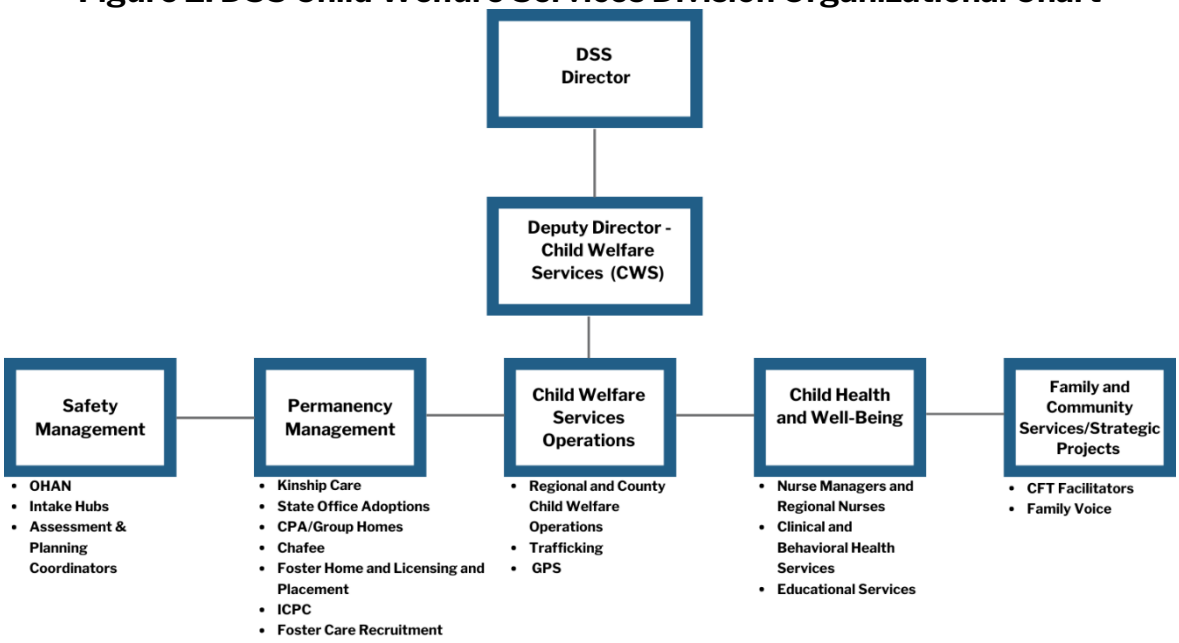
Figure 1: South Carolina Counties by Region



The FSA pertains to children who have been involuntarily removed from the custody of their parents or guardians due to a finding of abuse or neglect and taken into the custody of DSS. These children reside in foster care or "out-of-home" care. DSS is responsible for caring for children on a temporary basis, preferably while the children remain with their siblings and reside with family members or someone else known to their family, and working to ensure children can return home to their parents or guardians (referred to as reunification). When reunification is not possible, DSS must pursue another permanent, long-term plan, such as guardianship or adoption.

DSS's foster care work is part of its Child Welfare Services Division, overseen by Deputy Director of Child Welfare, Emily Medere.[35] The Child Welfare Services Division is now organized into five primary areas of focus: Safety Management; Permanency Management; Child Welfare Services Operations; Child Health and Well-Being; and Family and Community Services and Strategic Projects. Figure 2 depicts this structure, and the general responsibilities encompassed in each area of work.

Figure 2: DSS Child Welfare Services Division Organizational Chart



Source: Graphic provided by DSS, as of 12/16/2022

Foster Care Budget and Financing

Federal law establishes legal mandates and provides financial support to child welfare systems through several sources and has shown "long-standing interest in helping states improve their services to children and families."[36] Specifically, the federal Children's Bureau, within the Administration for Children and Families, distributes funds to states through mandatory spending programs authorized through the Social Security Act. The largest of these programs is authorized under

[35] Karen Bryant served in this role until July 2022. Emily Medere transitioned to the Deputy Director of Child Welfare position in August 2022.
[36] Stoltzfus, Emilie (July 30, 2018). Child Welfare Funding in FY2018. Congressional Research Service. https://fas.org/sgp/crs/misc/R45270.pdf

Title IV-E of the Social Security Act and operates as an "open-ended" matching fund source, meaning states are entitled to receive reimbursement for a portion of every dollar spent on behalf of an "eligible" child.[37] The child's eligibility depends on the income level of the parent(s) from whose custody the child was removed. Even if a child's case is found to be eligible for reimbursement pursuant to Title IV-E, reimbursement is only allowed for specific portions of certain eligible expenses. For example, states receive 50 percent reimbursement for eligible administrative costs, 75 percent reimbursement for eligible training costs, and reimbursement at the Medicaid matching rate (see below) for payments to foster parents to help cover the costs of caring for children in their homes.[38] The maximization of federal reimbursement available through Title IV-E has continued to be a priority under Director Leach's tenure.[39] Approximately 46 percent of children in foster care meet Title IV-E eligibility requirements (referred to as the state's Title IV-E penetration rate).[40]

Nearly all children in foster care are eligible for medical insurance through Medicaid, another important source of revenue for state child welfare systems. States paying for Medicaid services included in federally approved state plans and waiver programs receive federal matching funds for state expenditures at a state's Federal Medical Assistance Percentage (FMAP) rate. In South Carolina, this rate for Federal FY2022-2023 is 70.58 percent.[41] The Families First Coronavirus Response Act (FFCRA)

[37] The Title IV-E program was established by HR. 3434 Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272).
[38] Section 474(a)(3)(A),(B),(C),(D), and (E) of the Social Security Act
[39] See, *supra* note 33.
[40] In February 2018, the federal Family First Prevention Services Act (FFPSA) was passed to promote placement of children in family foster care settings as opposed to congregate care settings, and to allow states to use federal IV-E funding to provide evidence-based prevention services in the community to reduce the need for out-of-home placement. FFPSA prevents federal reimbursement of congregate care facilities that do not meet the new criteria for a Qualified Residential Treatment Program (QRTP), which include: a trauma-informed treatment model, on-site registered or licensed nursing and clinical staff, inclusivity of family members in treatment planning, offering aftercare support 6 months post-discharge, and accreditation by a select group of bodies. (Family First Prevention Services Act, Publ. L. No. 115-123, H.R.253. (2017)). In February 2022, the Children's Bureau approved South Carolina's 5-year Family First Prevention Services plans. If statutory requirements are met, this will enable the state to access to federal funding to help families stay together and prevent entry into foster care. DSS has been working with community and agency partners on developing implementation strategies. The agency has not yet begun to make IV-E claims under the Family First Prevention Services Act (FFPSA), as it is currently using 100% federal funding received through the Family First Transition Act (FFTA) grant. To see South Carolina's Family First Prevention Services plan, go to: https://dss.sc.gov/media/3284/south-carolina-dss-title-iv-e-prevention-plan.pdf
[41] Kaiser Family Foundation. State Health Facts. Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier.https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Multiplier%22,%22sort%22:%22desc%22%7D

authorizes temporarily increased federal funding to states through a higher FMAP.[42] The increased support is slated to remain at 6.2 percentage points above a state's regular FMAP through March 31, 2023, be phased down in each subsequent fiscal quarter, and end entirely as of January 1, 2024.[43] This means that for every dollar South Carolina spends on a Medicaid-reimbursable service for a child or eligible family member, the federal government reimburses the state almost 77 cents through March 31, 2023. This is both a considerably higher rate than the reimbursement rate for most expenditures under Title IV-E and one that can be applied broadly to *all* children in foster care, as the Medicaid reimbursement is not limited to services for children who meet the Title IV-E eligibility requirement. States that have responsibly maximized the use of federal Medicaid matching dollars have been able to increase – sometimes vastly – funding available for the support of children in foster care.[44] Medicaid can be used to cover non-direct health care services, such as mental health services, and services as part of therapeutic foster care.

State funding for foster care in South Carolina is allocated annually through the General Assembly agency appropriation process. The state fiscal year in South Carolina is from July to June, spanning two calendar years.[45] South Carolina's budget process begins in July or August of the year preceding the start of the new fiscal year when the Governor sends budget instructions to state agencies. State agencies generally submit budget requests to the Governor between September and November, detailing every new and recurring dollar they plan to spend in the following year, and those items that will require state funding. Agencies are also required to estimate anticipated federal funding and other considerations. In November, upon instruction from the Governor, the state Board of Economic Advisors issues an initial forecast of economic conditions to give the Governor and lawmakers a sense of how much revenue will be available for expenditure in the coming year. In early January, the Governor submits the Executive Budget to the General Assembly. Both houses of the state legislature review the budget, initially in committee (the House Ways and Means and Senate Finance Committee), and ultimately pass budgets through full floor votes. If the House and Senate versions of

[42]Section 6008 of P.L. 116-127. For more information, go to: https://www.congress.gov/bill/116th-congress/house-bill/6201.
[43] Section 5131 of P.L. 117-328. For more information, go to: https://www.fns.usda.gov/pl-117-328.
[44] To compare state-by-state Child Welfare financing using the National Council of State Legislatures' tool, go to: https://www.ncsl.org/research/human-services/child-welfare-financing-101.aspx#/
[45] Throughout this report and in accordance with state practice, fiscal year (FY) designations reference the July year in which funding is allocated, and the June year in which the fiscal period ends. For example, FY2022-2023 references the period from July 2022 through June 2023.

the budget do not match, a conference committee consisting of both House and Senate members is assembled to reconcile differences. The legislature must pass a budget with a simple majority by the beginning of the fiscal year, July 1. The Governor may exercise line-item veto power on the enacted budget. Details regarding DSS's budget request for FY2023-2024 are included in Section IV. *Fiscal Resources*.

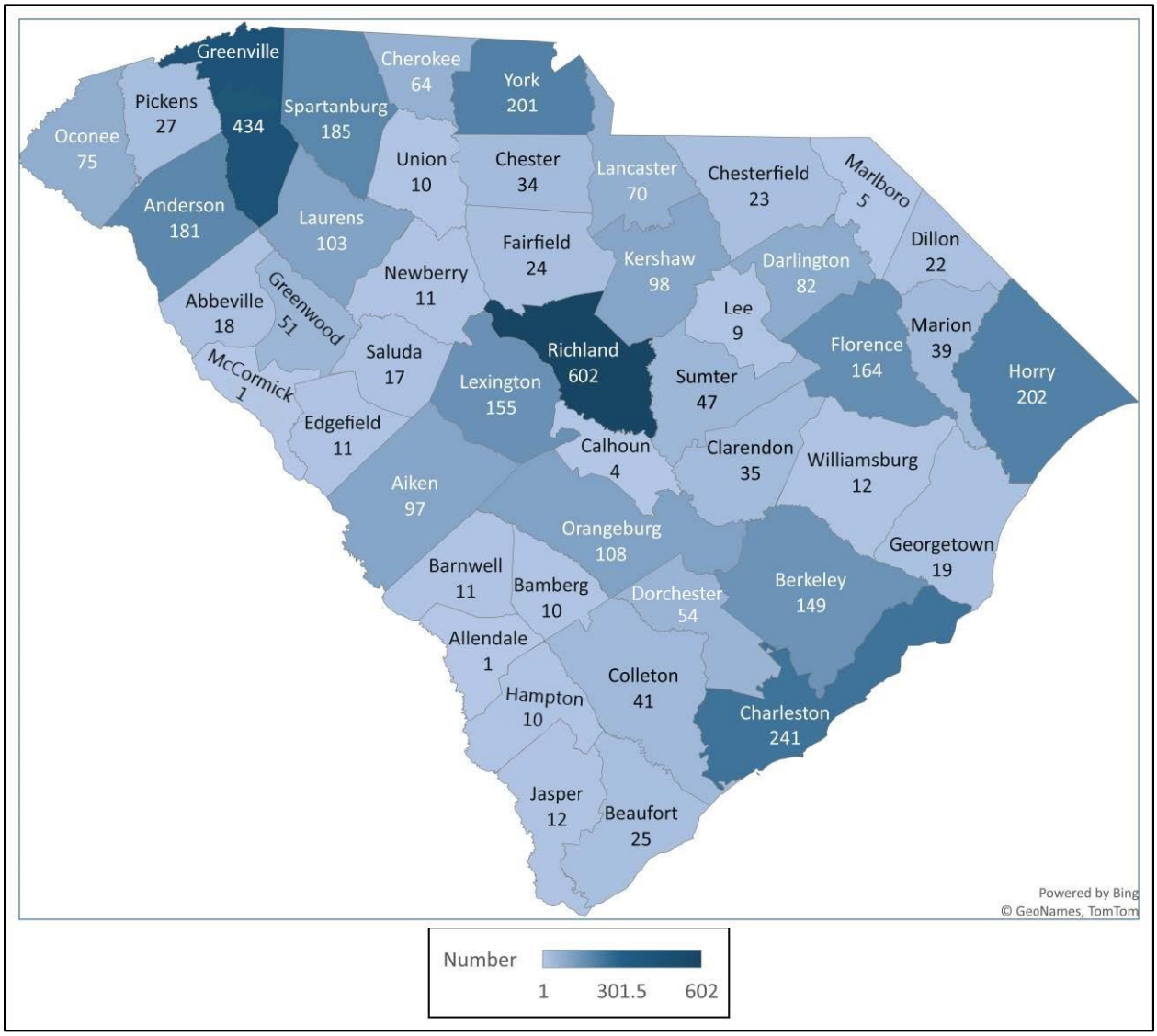
Population and Demographics of Children in Foster Care

During the monitoring period, 5,412 children were in foster care at some point. DSS regularly publishes real-time data about children in out-of-home care on its public website.[46] Demographic data on age, race, and gender are available, as well as information about where children are placed and how long they have been in out-of-home care.

The map in Figure 3 shows the number of children from each county in foster care on the last day of the monitoring period, September 30, 2022, ranging from none to 602. Differences among counties contribute to a variation in accessibility of services and programs, and distances that case managers, families, and children in placement must travel to spend time in person with one another, receive treatment, or attend appointments.

[46] To see DSS's data dashboard, go to: https://dss.sc.gov/about/data-and-resources/foster-care-dashboard/

Figure 3: Number of Children in DSS Custody by County as of September 30,2022[47] N=3,794



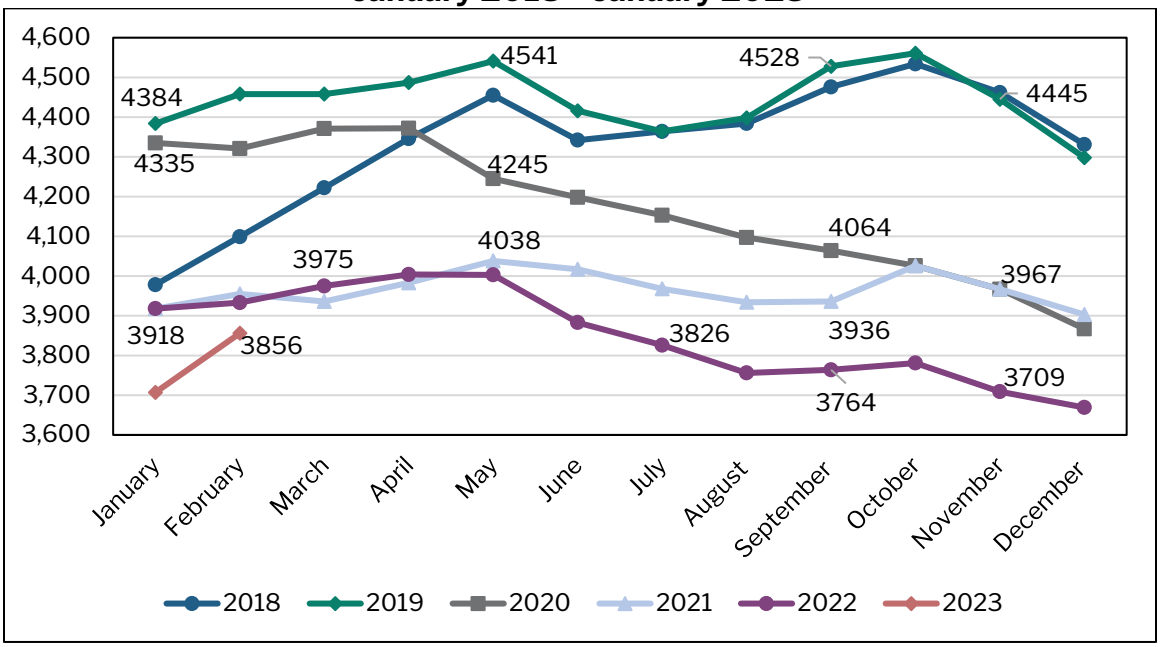
Source: CAPSS data provided by DSS

On September 30, 2022, the last day of the monitoring period, there were 3,794 Class Members in foster care. The foster care population decreased from the end of the prior monitoring period (on March 31, 2022, there were 3,973 Class Members in

[47] To see this map with current data, go to: http://reports.dss.sc.gov/SSRSReportServer/Pages/ReportViewer.aspx?/Foster+Care

foster care). This decrease is reflective of an overall trend of a decreasing foster care population, as depicted in Figure 4.[48]

Figure 4: Population of Children in DSS Custody
January 2018 – January 2023



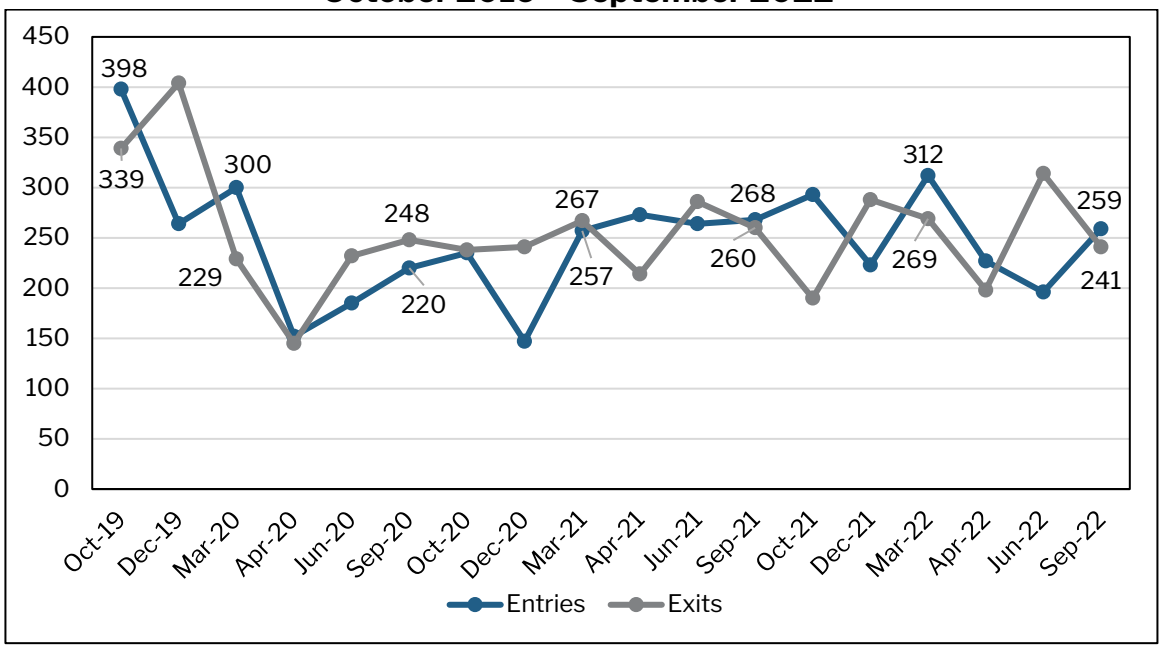
Source: Data from DSS data dashboard, 2/9/23

Figure 5 shows how the foster care population decreased during this monitoring period, because 1,437 children entered foster care and 1,630 children exited foster care.[49] DSS leadership reports that this is the result of its ongoing strategy to reduce family separations and expedite reunification when it is determined that children need to be removed from their families and brought into foster care.

[48] Foster care population data included herein is sourced from DSS's data dashboard and includes some children who are not Class Members. More information can be found at https://reports.dss.sc.gov/ReportServer/Pages/ReportViewer.aspx?/Foster+Care

[49] These data may include children in foster care who do not fall within the definition of Class Members as per the FSA.

Figure 5: Foster Care Entries and Exits
October 2019 – September 2022



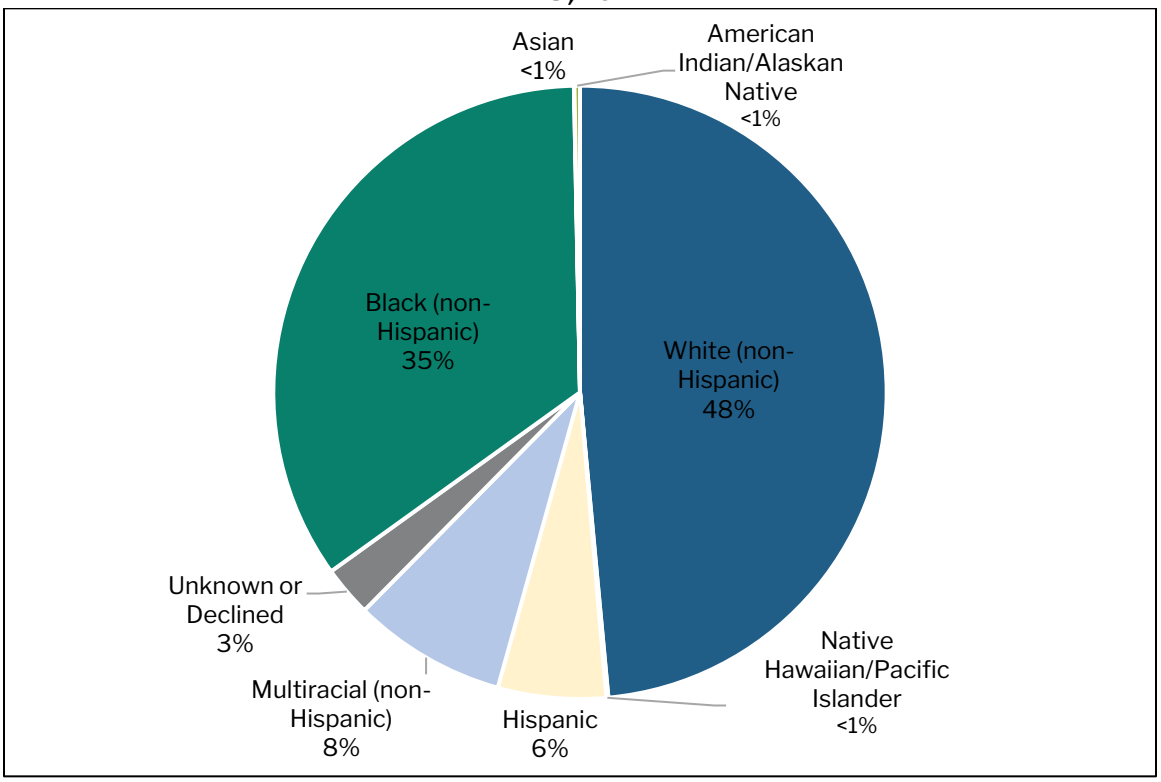
Source: CAPSS data provided by DSS

As shown in Figure 6, 48 percent of children in foster care are identified as White and 35 percent of children in foster care are identified as Black. Though Hispanic is an ethnicity and not a race, to be inclusive of this population in analysis of race data, the Co-Monitors calculated the Hispanic category as those children who were marked as a "Yes" for Hispanic ethnicity, which make up six percent of children in foster care.[50,51]

[50] Following federal guidelines, DSS does not record Hispanic or Latinx as a category in race data published on its public dashboard but does capture Hispanic ethnicity as a category in placement data. To be inclusive of this population in analysis of race data, the Co-Monitors calculated the Hispanic category as those children who were marked as a "Yes" for Hispanic ethnicity, including 13 children who were indicated as both Black and Hispanic, 14 children who were indicated as both Multiracial and Hispanic, and 131 children who were indicated as both White and Hispanic.

[51] To see DSS's current race data, go to:http://reports.dss.sc.gov/SSRSReportServer/Pages/ReportViewer.aspx?/Foster+Care

Figure 6: Population of Children in DSS Custody by Race as of September 30,2022 N= 3,794[52]

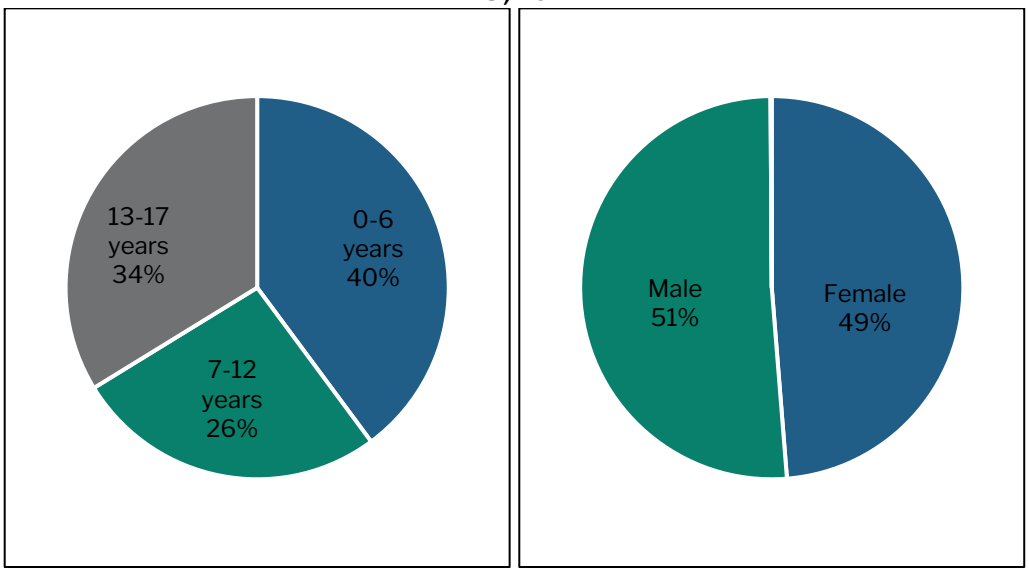


Source: CAPSS data provided by DSS

In terms of age and gender, Figure 7 reflects that about one-third (34%) of children in the foster care population are adolescents (ages 13 to 17), 27 percent of children in the foster care population are between the ages of seven to 12, and 39 percent of children are ages six and under. Slightly less than half of children in foster care are reported to be female (49%). DSS does not collect data on children who identify as gender neutral or non-binary.[53,54]

[52] This includes 22 children who resided in other institutional settings on September 30,2022 and may not match the data in Section VIII. *Placement*.
[53] CAPSS data provided by DSS indicate that on September 30, 2022, the gender identity of 4 children (<.01%) in foster care was unknown.
[54] DSS reports that on September 26, 2022, the Department introduced additional categories to CAPSS to more accurately capture information regarding gender identity and sexual orientation.

Figure 7: Children in DSS Custody by Age and Reported Gender as of September 30,2022
N= 3,794[55]



Source: CAPSS data provided by DSS

[55] This includes 22 children who resided in other institutional settings on September 30,2022 and may not match the data in Section VIII. *Placement*.

IV. Fiscal Resources

The General Assembly passed the Fiscal Year (FY) 2022-2023 budget in June 2022, allocating $39.2 million in new state funds to DSS for child welfare programs. The appropriation provided long-sought-after funding to support the changes the Department has been obligated to make, including funding for hiring new staff, supporting the implementation of the DSS Placement Plan and Health Care Improvement Plan, development of community-based services and supports for families, and the Kinship Navigator Programming.[56]

Funding obligations associated with the *Michelle H.* lawsuit, agreed-upon by Parties and ordered to be funded by the Court, have been approved and appropriated by the General Assembly over the last six fiscal years. DSS has submitted its budget request for state fiscal year 2023-2024, which begins July 1, 2023 and the Department included additional requests for continuing its child welfare reform efforts.

[56] For a more in-depth discussion of the FY2022-2023 budget, please refer to the Michelle H. et al. V. McMasters Progress Report for October 1, 2021 – March 31, 2022, Section IV. *Fiscal Resources*, available at: https://cssp.org/wp-content/uploads/2022/10/10-5-2022-MP11-Progress-Report.pdf.

V. Staffing and Caseloads

A sufficient, qualified, and trained workforce is vital to ensuring case managers have the capacity to serve families well. Case managers must have the skills, resources, and supports needed to engage families and providers in creating meaningful plans towards individualized case goals, among many other important tasks.[57] Child welfare systems must ensure that the appropriate number and types of positions – including case managers, supervisors, and support staff – are allocated within each region and county office so that caseloads are manageable, and that when vacancies exist, they are quickly filled by qualified workers with as little disruption as possible to families and other staff. Case managers also need training and supervision to ensure they have the knowledge and skills required to effectively carry out their roles, and must be compensated with sufficient salaries and benefits so they can invest in and pursue their work as a career.

High caseloads for case managers continued to be a challenge for DSS during this monitoring period, though the infusion of resources for hiring that went into effect in July 2022 resulted in some important accomplishments. For the first time this period, workloads for 90 percent of supervisors across all program areas – Foster Care, Adoptions, and OHAN – were within caseload limits, the result of a purposeful strategy to focus first on filling all supervisory vacancies.[58] Although overall performance for all case manager types was well below the final target of 90 percent compliance with caseload standards, improvements in some areas began to take hold, particularly towards the end of the monitoring period. At the end of September 2022, 51 percent of Foster Care case managers had caseloads within the required limit, up from 42 percent in March 2022.[59] Also at the end of September 2022, no OHAN investigators had caseloads that exceeded 125 percent of the caseload standard (seven of 19 OHAN investigators had caseloads that were more than 125 percent of the standard in March 2022).[60]

[57] The FSA utilizes the term "caseworker" to refer to DSS case-carrying staff. As part of its Guiding Principles and Standards (GPS) Case Practice Model development and work to define enhanced job expectations, DSS now utilizes the term "case manager." Where appropriate and for consistency with practice, this report will utilize the term case manager.

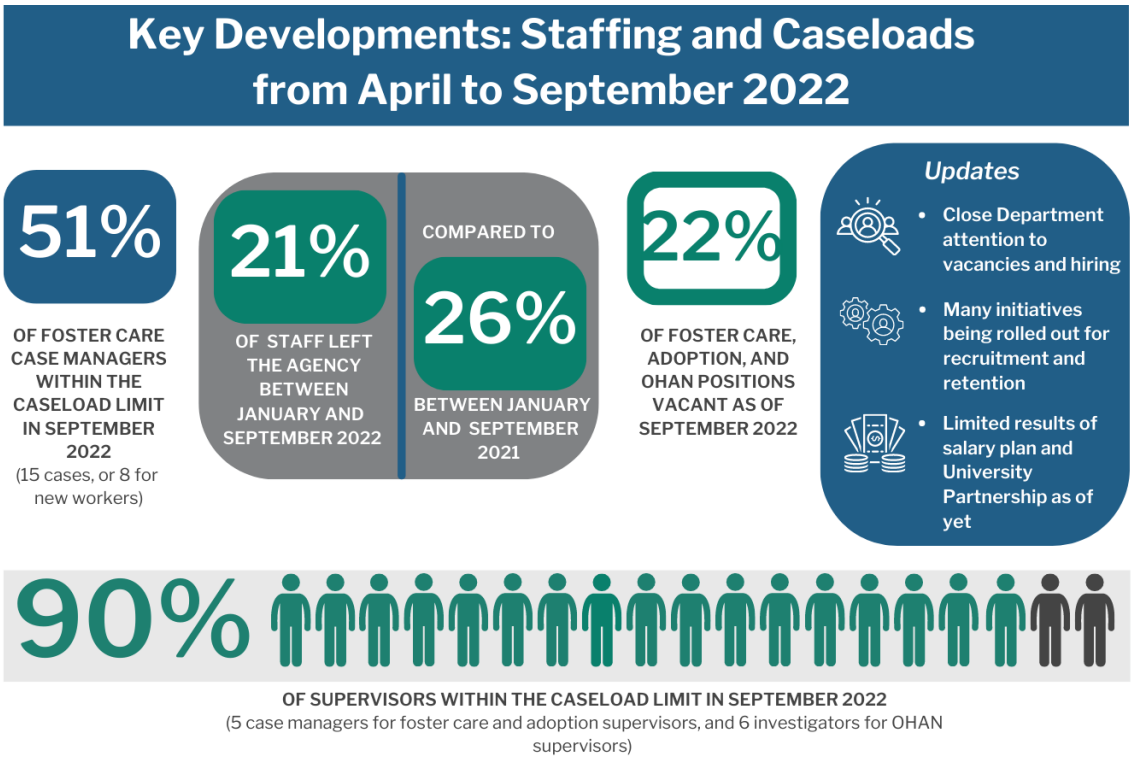
[58] DSS reports that as of March 3, 2023, 96% of all supervisor positions, 94% of Foster Care case manager positions, and 100% of Adoption case manager positions have been filled.

[59] As discussed in more detail in below, DSS data shows an increase in supervisors directly responsible for carrying Foster Care cases. For example, the Co-Monitors found that in two small counties, Beaufort and Dillon, all four Foster Care managers had caseloads within the standard, but their two supervisors carried 9 and 13 cases, respectively.

[60] At the end of September 2022, 15 of 20 OHAN investigators had caseloads within the required limit, up from seven of 19 OHAN investigators in March 2022.

In addition, though the impact cannot be seen as immediately, the allocation and hiring of a significant number of newly funded positions in the FY2022-2023 budget to child welfare functions for Non-Class Members (the "front end" of its system), such as Child Protective Services and Family Preservation, are intended to support continued reductions in the number of children separated from their families and taken into foster care.

In the months since receiving the budget allocation, DSS has focused on increasing recruitment and retention efforts. As of September 2022, there was a vacancy rate of 22 percent.[61] DSS reports continued improvement since and that as of the end of January 2023, the vacancy rate had fallen to 16 percent, with 106 out of 652 positions vacant.[62]



[61] October 20, 2022, Updated DSS Data Packet from Michael Montgomery, (Dkt. 260, p.26)
[62] This number includes staff who were hired but had not started yet; DSS reports that many of the open positions were in the final stage of interviewing and conducting background checks.

Workforce Progress and Implementation Updates

The FSA required that by December 5, 2016, DSS develop an Implementation Plan to achieve the final FSA workload requirements. The Implementation Plan was to 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)).

The Workforce Implementation Plan was approved by the Co-Monitors on February 20, 2019, and by the Court on February 27, 2019.[63] The Plan's strategies primarily focus on improvements to infrastructure; hiring, training, and retention of case managers and supervisors; and increasing case manager and supervisor salaries. The discussion below includes implementation updates for select Implementation Plan, the July 22, 2019 Joint Report of Plaintiffs and Defendants to the Honorable Judge Gergel (hereafter "Joint Report"),[64] and Mediation Agreement strategies during this period.

Hiring and Recruitment Strategies

For its FY2022-2023 budget request, DSS included funding for 286 staff positions specifically: 120 case managers, 15 OHAN investigators, 25 case manager assistants, 24 case manager supervisors, three OHAN investigator supervisors, and a 15 percent over-hire. The General Assembly approved this request, and the new positions became available as of July 1, 2022. As of January 23, 2022, DSS reports a total of 652 positions were allocated to Foster Care, Adoptions, and OHAN, and 106 (16%) positions were vacant.

DSS leaders are tracking efforts to fill vacancies, and regional directors are now reporting vacancy updates to the Child Welfare Operations Director during weekly meetings. The Child Welfare Operations team is working with Human Resources to identify barriers to filling vacancies and adjust hiring processes as needed.

DSS has been engaged in intensified hiring efforts and job fairs, and has increased advertising and promotion of open positions. DSS's Human Resources has

[63] The Workforce Implementation Plan is available at: https://dss.sc.gov/media/1948/dss-workload-implementation-plan.pdf
[64] Joint Report of Plaintiffs and Defendants to the Honorable Richard Gergel (July 22, 2019, Dkt. 145)

completed 12 "hiring blitzes" since July 2022, at which qualified candidates can receive job offers on the spot, with finger printing scheduled that day.

University Partnership Program

DSS reports that interviews of prospective candidates for the Child Welfare Bachelor's Degree in Social Work (BSW) Scholars Tuition Assistance Program occurred in fall 2022, and seven BSW scholars were chosen for the Spring 2023 semester cohort. The selected candidates – from South Carolina State, U of SC, and Winthrop University – will receive tuition reimbursement and stipends of $5,000 for their final three semesters of social work coursework. In exchange, the seven students will complete their internships with DSS and commit to two years of working for DSS upon graduation. The selected candidates will complete the Child Welfare Academy Pre-Service Certification Training during their internship, so they can begin managing cases immediately upon being hired. Nineteen additional universities with majors or concentrations in social or human services work have been identified as potential hiring pipelines. DSS plans to advertise internships and career opportunities within these sites. In the 2021-2022 academic year, DSS hosted 57 student interns. To date in the 2022-2023 academic year, DSS has hosted 46 student interns, 16 in the Fall 2022 semester, and 30 interns currently in the Spring semester.

Increased Salaries for Case Managers and Supervisors

The approved Workforce Implementation Plan includes an updated salary schedule for case managers and supervisors that raises entry level salaries, and provides for structured increases based on education, training, and longevity. The salary schedule provides greater parity with case manager salaries in states with similar demographic characteristics, and when it was developed in 2018, ensured staff received a living wage upon hiring or no later than within two to three years of employment.[65] The updated salaries are included in the recruitment messaging and advertisements in order to ensure transparency.

The General Assembly appropriated the necessary funds ($24.7 million) to implement the updated salary schedule in its FY2021-2022 budget. In the first phase of the salary adjustment, which began on July 1, 2021, the increased salary schedule

[65] The living wage was calculated using Massachusetts Institute of Technology's (MIT) Living Wage Calculator. The Workforce Implementation Plan's salary schedule was based upon the calculated living wage in South Carolina at the time the Plan was developed in 2018. As of the writing of this report, the living wage has increased significantly, and is now $65, 167 for a household with 1 adult and 1 child in South Carolina. The salary schedule as implemented now does not offer a living wage for any position at any level or years of experience. For more information, see: https://livingwage.mit.edu/.

was applied to case managers and supervisors, with different ranges based upon the type of degree staff hold (e.g., BSW or Master's Degree in Social Work [MSW]), and their length of service with DSS (from less than one year up to 10 years). In addition, the new salary schedule provides supervisors with a 10 percent higher starting salary than the baseline salary for case managers, as shown in Table 1. Staff will automatically receive increases for years of service on a quarterly basis, based on the anniversary date for individual staff. All salaries were increased by an additional three percent as of July 2, 2022, as reflected in Table 1.

Table 1: SCDSS Salary Schedule for Case Managers and Supervisors

Position and Degree	Average Salary in 2019	Phase 1 (beginning July 1, 2021)		Phase 2 (staff were eligible on May 1, 2022, with salary increases effective July 1, 2022)	
		Starting Salary for <1 year of Service[66]	**Salary Range for Level 1** (varies based upon years of service)	**Salary Range for Level 2** (varies based upon years of service)	**Salary Range for Level 3** (varies based upon years of service)
Case Manager - Degree Other than BSW/MSW	$35,541	$41,200	$47,380 - $49,803	$48,808 - $53,379	$50,528 - $56,919
Case Manager - BSW	$35,885	$42,230	$48,564 - $51,048	$50,027 - $54,714	$51,790 - $58,342
Case Manager - MSW	$35,417	$43,260	$49,749 - $51,439	$51,171 - $55,965	$52,974 - $59,675
Supervisor	$40,709	$45,320	$50,600 - $53,188	$52,124 - $57,008	$53,962 - $60,760

Source: DSS Workforce Implementation Plan, dated February 2019, and FY2022-2023 Salary Plan

In April 2022, DSS began implementing the second phase of the salary plan which allows case managers and supervisors to advance in their career path based upon a showing of specific competencies. The process for advancement requires completion of training and certifications, a competency self-assessment, a

[66] This also applies to case managers who have not yet completed Child Welfare Services Certification.

competency assessment completed by the staff's supervisor,[67] field observation,[68] case review,[69] and data analysis.[70]

As of January 2023, no case managers had been approved for advancement to Level 2, and one supervisor was approved. Fewer than 10 staff have applied for advancement. While DSS has provided feedback to the staff who were not approved, the Department is also in the process of evaluating the standards being applied for advancement to determine if they are realistic and feasible with current workloads, and is promoting the opportunity more broadly to increase the number of staff who apply for and receive these enhanced salaries.

Turnover and Retention Strategies

Between January and September 2022, DSS had an average of 1,840 case managers, supervisors, and caseworker assistants across all program areas (Adoptions, Family Preservation, Foster Care, Intake, Investigations, Licensing, and OHAN). During that same time period, 377 (21%) staff left their positions.[71] This represents a decrease in turnover from the prior year; between January and September 2021, 470 (26%) staff left their positions. The turnover from January to September 2022 within areas that are focused specifically on Class Members - Foster Care, Adoptions, and OHAN - was higher, at 24 percent - and DSS estimates it to be 31 percent for the full CY 2022, using preliminary Q4 data.

Staff turnover within Foster Care, Adoptions, and OHAN decreased slightly between Q1 and Q2 in CY2022 (8% in Q1 to 7% in Q2); increased to nine percent in Q3 (July to September 2021) and returned to seven percent in Q4 (October to December 2022), as reflected in the table below.

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[67] The competency assessments evaluate staff's comprehension and application of the 10 baseline competencies, including: sense of mission and motivation; communication; adaptability; decision-making and problem-solving; collaboration and teaming; conflict management; planning and organizing; professional development; cultural responsiveness; and coaching. There are 4 additional competencies for supervisor positions, including: guiding and developing staff; strategic focus; trauma-informed practice; and team leadership.
[68] Commonly referred to as a "ride-along", the field observation allows for assessment of the staff's performance, practice, and utilization of GPS Case Practice Model core practice skills while working with children, families, colleagues, and/or external stakeholders.
[69] The case review is an assessment of the quality of a staff's documentation within a case record.
[70] Data analysis is a review of a staff's performance over the last 6 months toward identified data indicators – established quantitative metrics specific to the job tasks of a staff's position. Staff are expected to consistently meet or exceed the data indicators required for their level. For example, data indicators for an investigation case manager at level 2 include 85% of investigations are initiated within 24 hours, and 85% of investigations have timely case determinations.
[71] This includes 18 staff who remained employed within DSS but accepted new roles.

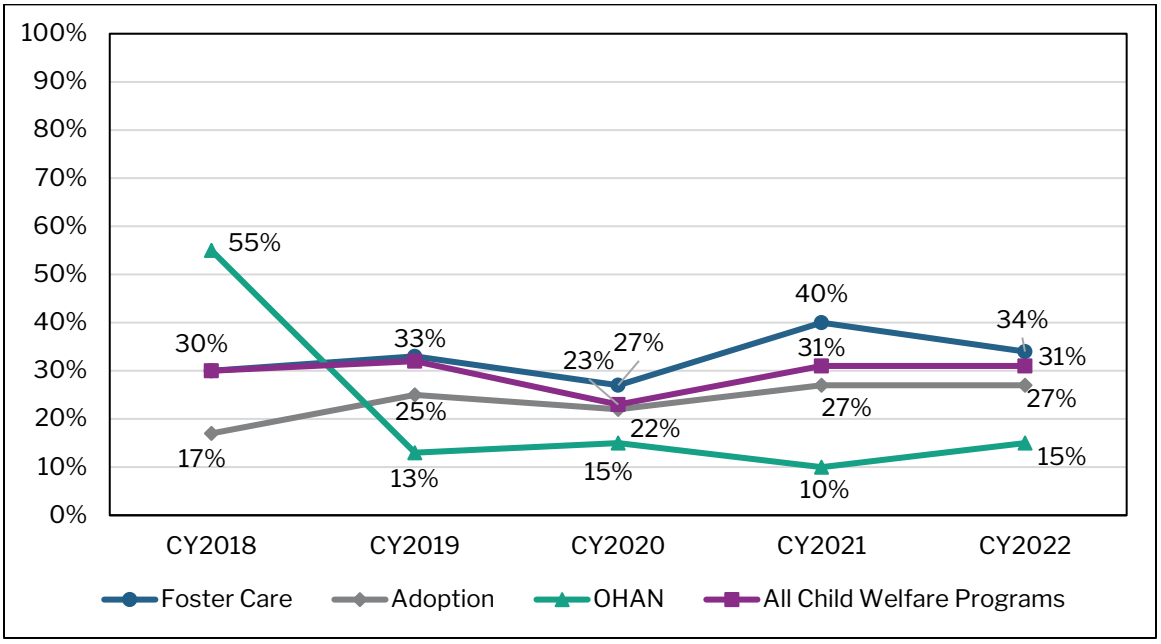
Table 2: Quarterly Turnover within Foster Care, Adoptions, OHAN, and All Child Welfare Programs Q4CY2021 – Q4 CY2022

Practice Area	Q4 2021 (Oct – Dec 2021)	Q1 2022 (Jan – Mar 2022)	Q2 2022 (Apr – June 2022)	Q3 2022 (July – Sept 2022)	Q4 2022 (Oct – Dec 2022)[72]
Foster Care	9%	9%	8%	9%	8.5%
Adoptions	5%	6%	4.5%	11%	5.5%
OHAN	4%	4%	7.5%	4%	0%
All Child Welfare Programs	**5%**	**8%**	**7%**	**9%**	**7%**

Source: Data provided by DSS, Annual Turnover Rate by Program Area and January 20, 2023 submission to Judge Gergel

While turnover seems to have slowed slightly based on the preliminary Q4 data, rates remain significant, particularly for foster care staff.

Figure 8: Annual Turnover within Foster Care, Adoptions, OHAN, and All Child Welfare Programs CY2018 – 2022[73]



Source: Data provided by DSS, Annual Turnover Rate by Program Area and January 20, 2023 submission to Judge Gergel

[72] Data for Quarter 4 of CY2022 is preliminary and may be adjusted in the following monitoring report.
[73] Ibid.

Programs to Address Staff Attrition

The Workforce Implementation Plan required DSS to design or adopt a competency-based model for interviewing and hiring applicants for child welfare positions, and to train personnel involved with hiring on this new process by July 31, 2020.[74] DSS adopted *Staying Power* – a toolkit developed by University of North Carolina (UNC)-Chapel Hill School of Social Work – and made adaptations to align with DSS's GPS Practice Model.[75] DSS now refers to this adaptation as *Destination Retention: Hiring for the Long Haul*, which was in a testing phase between October and December 2022, and rolled out to all counties as of February 28, 2023. DSS anticipates that implementation of the hiring process based on the *Destination Retention* model will occur by April 2023.

Regional Support Teams

DSS has begun to hire regional teams that can be deployed to counties experiencing spikes in staff turnover or caseloads. These staff could support case managers in completing necessary tasks such as visiting children in their foster care placements, facilitating children's time with their families, searching for family members for children to be placed with kin, or transporting children to appointments. As of March 2, 2023, three of four supervisory positions had been filled, and one of five case manager assistant positions have been filled. Two of 20 case manager positions for these case management teams have been filled. DSS is aiming to complete hiring for these positions by July 2023 and anticipates that the teams will promote staff retention by helping to balance case manager workloads.

Pre-Service Certification Training Redesign and Supervisory Training

Statewide roll out of the new Child Welfare Academy Pre-Service Certification Training began in December 2021, initially in the Upstate region, followed by the Pee Dee, Midlands, and Lowcountry regions. The training includes 18 days of virtual instructor-led training (ILT) and 25 days of on-the-job training (OJT) after which there is a final assessment of the core practice skills, including a skill demonstration.[76] A score of 85 percent is needed for the new case manager to proceed to post-service

[74] The approved Implementation Plan deadline for this strategy was January 2020, which was amended by the Joint Report and Mediation Agreement to July 31, 2020.

[75] DSS's GPS Case Practice Model outlines the values, principles, and practice skills DSS seeks to promote. For more information and to view the full model see: https://dss.sc.gov/gps-practice-model/.

[76] DSS reports the OJT component of training incorporates the use of the learning support team, which includes the learner, the learner's supervisor, a mentor/host coworker, and a performance coach. The support team works with the learner to enhance knowledge obtained from ILT and build skills. Also included are opportunities for the learner to work with their peers and begin building a network of support. OJT includes shadowing the mentor or host coworker, and gradually taking on more casework responsibilities. Included in ILT is the AWAKEN: Addressing Trauma training, which also includes components about addressing bias and its impact on families.

training and begin receiving cases.[77] As of January 20, 2023, 306 new case managers and nine supervisors completed the certification training.

For supervisors, DSS has adopted the Coach Approach to Adaptive Leadership (CAAP) model, which focuses on coaching competencies like building trust, demonstrating empathy, and creating a positive feedback environment. As of January 20, 2023, 348 leaders from 36 counties have completed this training. Soon to be available for supervisors is the new Supervisor Certification Training Program, a 15-week learning experience that launched its first pilot in May 2022. The program is designed to improve the capacity of supervisors to lead staff in understanding and demonstrating quality practice. The second pilot finished in November 2022, and a total of 50 participants have participated thus far. DSS anticipates implementing the training statewide in March 2023.[78]

Mentoring Program

One of the longer-term strategies within the Workforce Implementation Plan (to be implemented between July 2020 and 2023) is for DSS to establish a mentoring program that pairs senior case managers with new case managers, develop policies and procedures for implementing such a program, establish a process for monitoring and continuous quality improvement for a mentoring program, and provide training to supervisors and senior case managers on mentoring. DSS reports that it has implemented the first phase of its mentoring program, which provides peer support from an experienced case manager during certification training. DSS plans to roll out the second phase of the program, which will involve peer support from a Performance Coach for three months post-certification – by the end of July 2023.

[77] Pursuant to the Workplan Implementation Plan (February 27, 2019, DLT109 p.7 -8), new case managers may only carry half caseloads for the first six months after completion of training: new Foster Care case managers and Adoption case managers are to have no more than 8 children on their caseloads; new OHAN case managers are to have no more than 4 children on their caseloads. The Workforce Implementation Plan is available at: https://dss.sc.gov/media/1948/dss-workload-implementation-plan.pdf

[78] The Co-Monitoring team will be reviewing the training program in the coming months.

Performance Data

The FSA requires that *"[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)). The Workforce Implementation Plan set the final target to be reached by DSS in March 2021.

There are caseload standards depending upon the types of cases a case manager manages – specifically Foster Care and Adoptions, and investigations of allegations of abuse and neglect of children in foster care (OHAN).[79] The approved caseload standards are included in Table 3.

[79] DSS has many staff with "mixed" caseloads that include different case types and both Class and Non-Class Members. On December 21, 2017, the Co-Monitors provisionally approved DSS's proposal to calculate caseloads for foster care case managers 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 also served. In approving this mixed caseload methodology, the Co-Monitors relied upon DSS's commitments to: (1) move forward with plans to transition case managers to single-type caseloads as feasible and appropriate; (2) change its 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 case manager assignment to several family preservation cases involving families with multiple children. DSS has indicated that supervisors and office managers are continually assessing assignments to case managers 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. The following types of cases are counted by family (case): Child Protective Services (CPS) investigations; family preservation; other child welfare services; and those involving a child subject to the Interstate Compact on the Placement of Children (ICPC). This methodology is only applied to foster care case managers with mixed caseloads and is not applied to Adoptions case managers.

Table 3: Caseload Standards by Worker Type

Worker Type	Caseload Standard	Caseload Standard for New Workers*	More than 125% of Standard	More than 160% of Standard	More than 170% of Standard	More than 180% of Standard
Case Managers						
Foster Care Case Manager	One case manager to 15 children (1:15)	No more than eight children (1:8)	More than 18 children or Non-Class cases	More than 24 children or Non-Class cases	More than 25 children or Non-Class cases	More than 27 children or Non-Class cases
Adoptions Case Manager[80]	One case manager to 15 children (1:15)	No more than eight children (1:8)	More than 18 children	More than 24 children	More than 25 children	More than 27 children
OHAN Investigator	One investigator per eight investigations (1:8)	No more than four investigations (1:4)	More than 10 investigations	More than 12 investigations	More than 13 investigations	More than 14 investigations
Supervisors						
Foster Care Supervisor	One supervisor to five case managers (1:5)	N/A	More than six case managers			
Adoptions Supervisor	One supervisor to five case managers (1:5)	N/A	More than six case managers			
OHAN Supervisor	One supervisor to six investigators (1:6)[81]	N/A	More than seven investigators			

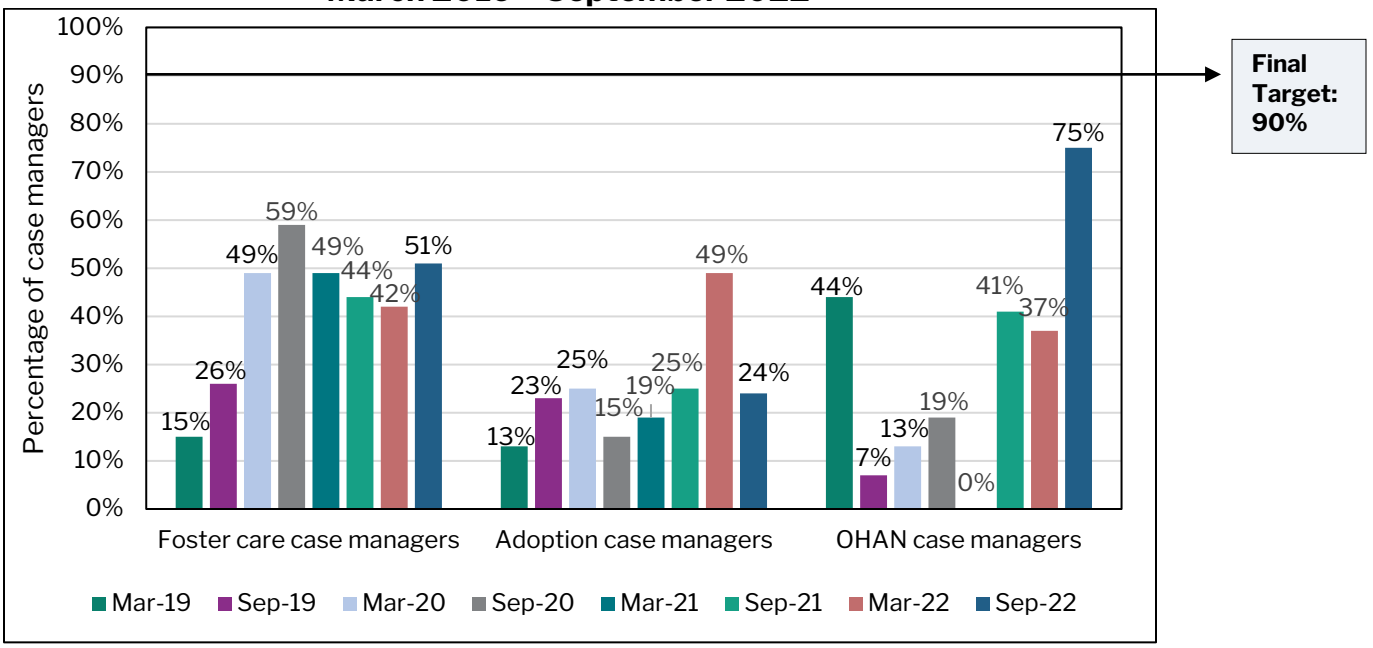
Source: Approved DSS Workforce Implementation Plan (February 2019)
* Employed less than 6 Months since completing Child Welfare Pre-Service Certification Training

To assist in assessing progress over time, Figure 9 shows performance data on caseloads by case manager type for prior and current monitoring periods. As of September 30, 2022, compared to six months prior, the percentage of workers with caseloads within required limits has improved for foster care and OHAN, and declined

[80] Prior to 2019, DSS's workforce was structured so that case management responsibilities remained with the Foster Care case manager, even when an Adoptions case manager was assigned, until a placement agreement was signed. As a result, the approved caseload standard for Adoptions case manager was 1:17. In 2019, DSS began transitioning case management responsibility to Adoptions case manager once children became legally eligible for adoption. This transition was complete in January 2020; thus, Adoptions case manager caseload performance is assessed at a standard of 1:15, the same standard applied to Foster Care case managers.
[81] The Co-Monitors approved the higher caseload standard for OHAN supervisors in recognition of the fact that the OHAN investigators they supervise will have lower caseload standards than other direct service case managers.

for Adoptions case managers. Though performance for all case manager types remained significantly below the final target of 90 percent, the percentage of Foster Care case managers with caseloads within required limits increased by the end of the monitoring period. The percentage of Adoptions case managers with caseloads within required limits declined at the end of the period (by the end of September 2022, the number of Adoptions case managers in compliance was half what it was at the start of the period). Caseload compliance for OHAN investigators increased over the course of the monitoring period.

Figure 9: Percentage of Case Managers with Caseloads Within the Required Limits, by Case Manager Type March 2019 – September 2022[82]

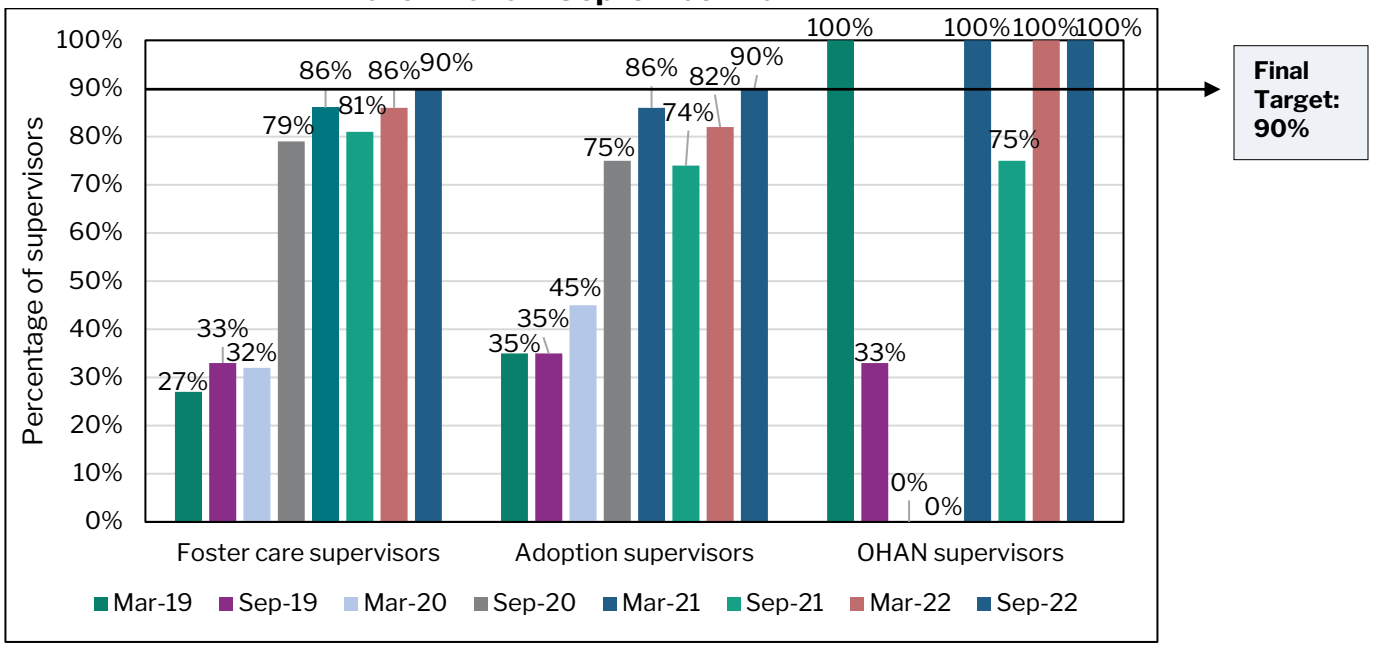


Source: CAPSS data provided by DSS

As shown in Figure 10, for the first time, 90 percent of supervisors' caseloads were within required limits in September 2022. This is the result of focused efforts to prioritize filling all supervisor vacancies so that appropriate supports are in place for case managers. However, as discussed below, in some cases, supervisors are continuing – at an increasing rate this period – to be directly responsible for cases to relieve case managers with unmanageable caseloads. Supervisory workloads may be higher than reflected. Nevertheless, this is an important accomplishment.

[82] Adoptions case manager performance in March 2019 and September 2019 was assessed at a standard of 1:17, which changed to 1:15 beginning in January 2020.

Figure 10: Percentage of Supervisors with Workloads Within the Required Limits, by Supervisor Type March 2019 – September 2022



Source: CAPSS data provided by DSS

The table below includes performance data for each month during the monitoring period and reflects the number and percentage of case managers and supervisors – by type – who had caseloads within required limits, and more than 125 percent, 160 percent, 170 percent, and 180 percent of the caseload standard. Cells highlighted in green met the final target.

Table 4: Caseload Compliance by Worker Type
April 2021 – September 2022

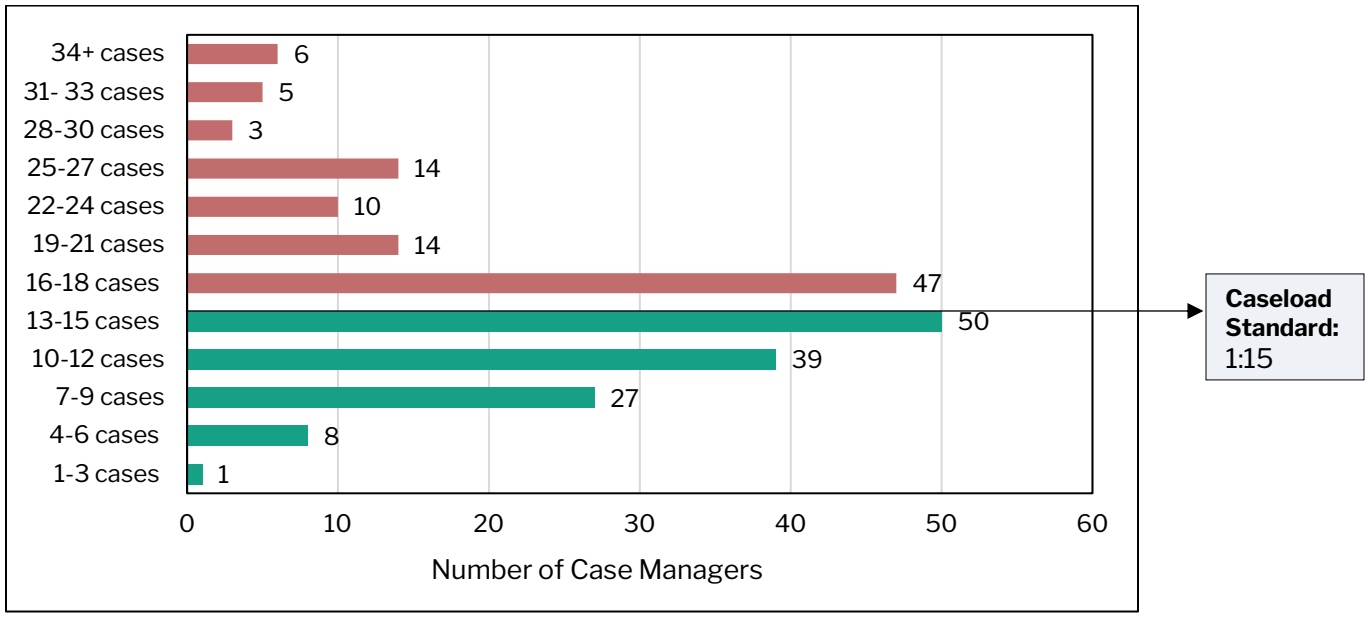
	April 2022	May 2022	June 2022	July 2022	August 2022	September 2022	Final Target
Case Managers							
#/% of Foster Care Case Managers Compliant	**113/43%**	**116/44%**	**111/46%**	**120/50%**	**121/50%**	**132/51%**	**90%**
#/% of Foster Care Case Managers >125% of standard	100/38%	99/38%	84/35%	81/34%	80/33%	74/29%	**0%**
#/% of Foster Care Case Managers							**0%**
>160%	51/19%	51/19%	51/21%	50/21%	48/20%	46/18%	
>170%	44/17%	39/15%	45/19%	47/20%	39/16%	39/15%	
>180%	27/10%	24/9%	30/12%	33/14%	29/12%	27/11%	
#/% of Adoption Case Managers Compliant	**38/47%**	**40/49%**	**33/40%**	**35/42%**	**20/25%**	**19/24%**	**90%**
#/% of Adoption Case Managers >125% of standard	27/33%	29/35%	30/37%	32/38%	34/43%	29/37%	**0%**
#/% of Adoption Case Managers							**0%**
>160%	13/16%	16/20%	13/16%	15/18%	15/19%	12/15%	
>170%	12/15%	13/16%	12/15%	14/17%	12/15%	12/15%	
>180%	8/10%	9/11%	7/9%	8/10%	10/13%	9/11%	
#/% of OHAN Case Managers Compliant	**9/41%**	**7/32%**	**6/29%**	**17/81%**	**19/95%**	**15/75%**	**90%**
#/% of OHAN Case Managers >125% of standard	7/32%	6/27%	7/35%	2/10%	1/5%	-	**0%**
#/% of OHAN Case Managers							**0%**
>160%	2/9%	2/9%	3/14%	2/10%	-	-	
>170%	1/5%	2/9%	2/10%	2/10%	-	-	
>180%	-	2/9%	1/5%	1/5%	-	-	
Supervisors							
#/% of Foster Care Supervisors Compliant	**92/89%**	**96/86%**	**94/90%**	**89/87%**	**95/91%**	**103/90%**	**90%**
#/% of Foster Care Supervisors >125% of standard	3/3%	5/5%	5/5%	4/4%	3/3%	5/4%	**0%**
#/% of Adoption Supervisors Compliant	**19/86%**	**24/96%**	**21/88%**	**22/88%**	**18/86%**	**19/90%**	**90%**
#/% of Adoption Supervisors >125% of standard	2/9%	1/4%	-	1/4%	1/5%	-	**0%**
#/% of OHAN Supervisors Compliant	**4/100%**	**4/100%**	**4/100%**	**4/100%**	**4/100%**	**4/100%**	**90%**
#/% of OHAN Supervisors >125% of standard	-	-	-	-	-	-	**0%**

Source: CAPSS data provided by DSS

Foster Care Case Managers

The data presented above reflect a compilation of all Foster Care case managers – those newly hired as well as those hired more than six months prior to completing training. Figure 11 reflects the number of cases assigned only to the 224 foster care case managers on September 30, 2022 who had completed Child Welfare Pre-Service Certification Training more than six months prior (not including new workers). The Figure shows the distribution of cases for the 125 workers within the caseload standard and the 99 workers above the caseload standard. At the end of the monitoring period, 11 case managers were responsible for more than 30 cases (double the caseload standard). In the prior monitoring period, only six case managers had caseloads this large.

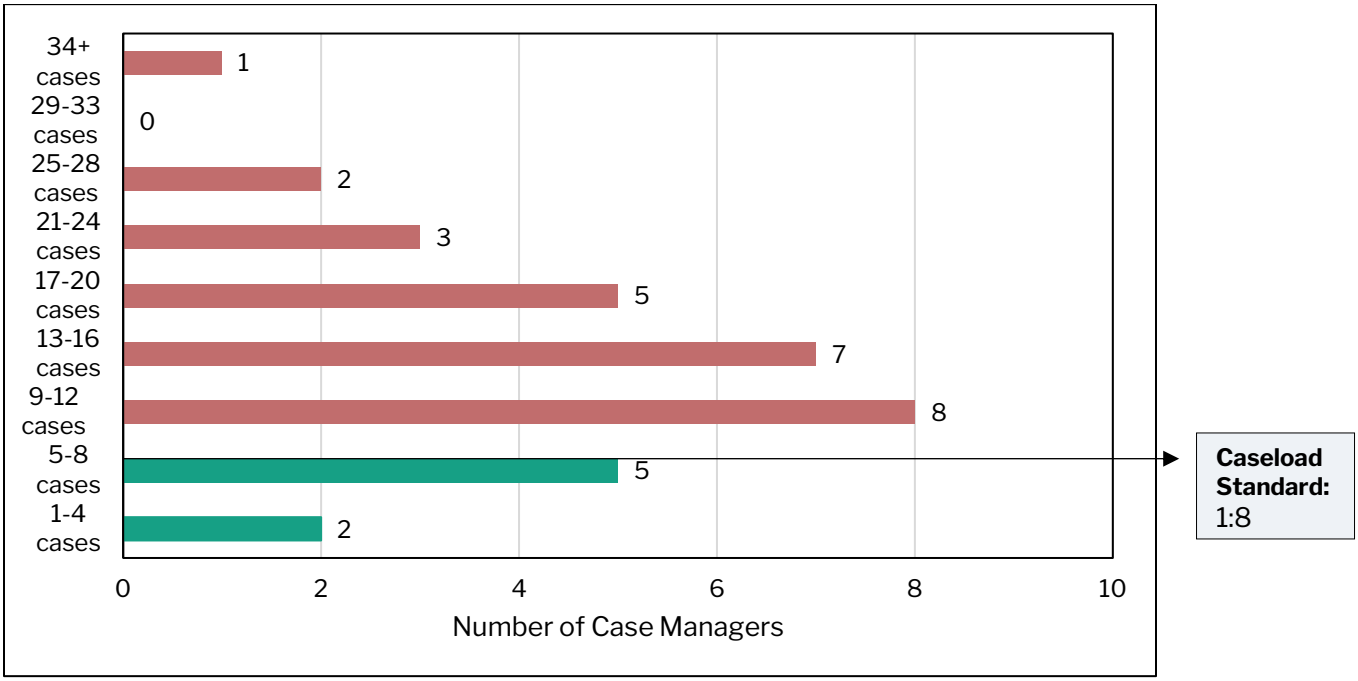
Figure 11: Number of Cases Assigned to Foster Care Case Managers Who Have Completed Certification Training More than Six Months Ago September 2022 N = 224



Source: CAPSS data provided by DSS

Figure 12 reflects the number of cases assigned to the 33 new foster care case managers on September 30, 2022 who had not completed certification training more than six months prior. Only seven new workers had caseloads within the standard. As of this date, one-third (33%, or 11 of 33) of new case managers were responsible for 17 or more cases (approximately double the caseload standard). Graduated caseload standards are an important retention strategy and necessary to allow new staff the time to develop their skills.

Figure 12: Number of Cases Assigned to New Foster Care Case Managers
September 2022
N = 33



Source: CAPSS data provided by DSS

Data on foster care case manager caseloads by region as of September 30, 2022 are shown in Table 5. DSS offices are divided among four regions, which differ in terms of geographical size, the number of children and families served, and the number of assigned and onboarded case managers. Performance has improved in most regions as compared to 12 months prior but declined within the Midlands region.

Table 5: Foster Care Case Managers with Caseloads Within the Required Limit by Region
September 30, 2021 – September 30, 2022

Region	Foster Care Caseloads within Required Limit on September 30, 2021	Foster Care Caseloads within Required Limit on March 31, 2022	Foster Care Caseloads within Required Limit on September 30, 2022
Lowcountry	38% N=18/48	37% N=22/60	50% N=22/44
Midlands	34% N=28/83	24% N=20/82	27% N=21/78
Pee Dee	51% N=24/47	56% N=30/54	67% N=35/52
Upstate	53% N=53/100	55% N=49/89	65% N=54/83

Source: CAPSS data provided by DSS

Supervisors Carrying Cases

DSS has identified situations in which supervisors may be directly responsible for a case(s) for a short period of time.[83] Data for April 1 through September 30, 2022 reflect that the number of supervisors responsible for cases for longer than five days ranged between 18 to 28 supervisors each month. On September 30, 2022, 175 cases were managed or carried by supervisors. A vast majority (137, or 78%) of the cases were Foster Care cases. This is an increase from the previous period, when on March 31, 2022 there were 100 cases managed by supervisors and 58 percent were Foster Care cases.

[83] These include circumstances in which a case manager is promoted to supervisor and may temporarily retain case management for up to 45 days if a case is nearing closure; there are complexities regarding the case that need to be addressed; or an important legal event will occur within the timeframe. While the supervisor is directly managing, or "carrying" a case, they are responsible for all required case duties, including visits with the child: monitoring the child's safety, placement, well-being, case plan, and service delivery; ensuring the child is visiting with their siblings and/or parent, as applicable; and other activities, as necessary. When cases are being transferred from one case manager, office, unit, or program area to another, the case may be temporarily assigned to the receiving supervisor for up to 5 days until the supervisor assigns the case to the receiving case manager. After reviewing data on supervisors carrying cases for several monitoring periods, DSS has identified additional circumstances which result in supervisors carrying cases. These include when a case manager leaves the agency and creates a vacancy that takes some time to fill (including onboarding new staff with required training and limiting their caseload to half the required limit during the first 6 months after completing training), or when case managers are on extended leave. DSS has assigned cases to supervisors in these circumstances due to their familiarity with the child and family, and to prevent overburdening other case managers within their unit. The Co-Monitors have reviewed and discussed data with DSS reflecting these situations, and in March 2021, DSS proposed a process to closely monitor these situations. The process requires Regional Director approval for supervisors to carry cases for greater than 5 days; documentation will be shared with staff within Accountability, Data, and Research (ADR) and must describe the cases the supervisor will carry, the circumstances leading to the supervisor carrying cases, and a specific plan and timeline to address the issue. The Co-Monitors approved this process in April 2021, and DSS began tracking and reporting these data in May 2021.

VI. Case Manager Visits with Children

DSS case managers are responsible for maintaining contact with children in foster care and their caregivers. DSS policy and the FSA require case managers to have face-to-face visits with children in foster care and their caregivers at least once a month.[84] At least 50 percent of those visits must be in the child's placement.[85] The expectation, in policy and practice, is that the case manager make opportunities to meet with children privately as developmentally appropriate; discuss the child's status and progress, including in the areas of safety, emotional well-being, physical well-being, and permanency with both the child and caregiver; continuously track the impact of any services being provided; and provide documentation of these contacts in the agency record (CAPSS).

The FSA requirement that at least 90 percent of required visits face-to-face visits between case managers and children in a 12-month period take place can be reported with quantitative data collected in CAPSS. DSS reports performing at a rate of 97 percent for this federal requirement in 2019 and 2020. Between September 2021 and September 2022, CAPSS data show case managers made monthly contact with children in 95 percent of cases.

However, historically, Co-Monitor staff found it difficult to verify reported quantitative data upon review of documentation to assess the content of the visit. At times, the same documentation was repeated over several months or was too minimal to establish that there was indeed contact consistent with policy expectations. Therefore, Parties agreed that under the FSA a case manager's documentation of a contact with a child in CAPSS should reflect each of DSS's policy and practice expectations for a visit and that such documentation would be assessed to determine that a visit has been held for monitoring and reporting performance. DSS continues to assert that the qualitative nature of the agreement between Parties is onerous, subjective, goes beyond the federal standard for visits by a case manager, and has asked that this approach for assessing visits be reconsidered. The Co-Monitors do not support this proposal and the agreement remains in place at this time. Performance benchmarks as required by the Visitation Implementation Plan for this measure have not yet been set.

[84] FSA IV.B.2.
[85] FSA IV.B.3.

Documentation from five statistically valid samples of DSS records for children in foster care between 2019 and 2021 shows that case managers had contact with the overwhelming majority, if not all, of the children in the sample, and that these contacts predominantly occurred where the child resides. Documentation of what occurred during these contacts improved over time; most records contained a summary of the case manager's contacts, identified who was seen, where they were seen, and the content of conversations and/or observations. Some records were also reflective of DSS's policy expectations for these visits and contained information about the child's environment and interaction with adults and other children with whom they live. Additionally, some contained information related to contacts with parents and other family members; how the child is doing at school; and physical health and/or mental health care and status. However, across two years and five case record reviews conducted by DSS, U of SC CCFS, and Co-Monitor staff, results showed only an average of one-third of records contained documentation of all required elements of a visit between a child/youth and their case manager required by DSS policy.

Upon agreement of Parties in May 2022, given current performance and lack of substantial progress, the Co-Monitors suspended review of a statistically valid sample of records and reporting on this measure for at least four monitoring periods, or until DSS reports that their strategic improvement efforts, as confirmed by their internal quality assurance, has established a substantial increase in performance.[86] At that time, the Co-Monitors will work with DSS to resume review of performance on this measure. The Co-Monitors agreed to, in the interim, report on DSS's actions towards improvements in this area, including overall results of internal efforts.

DSS reports prioritizing addressing and improving outcomes for family visits (time spent between parents and their children, and siblings in foster care not residing together) at this time. Training is offered to staff on an ongoing basis to improve documentation of practice during visits in CAPSS, as well as practice expectations of the GPS Practice Model are sources for improving performance on case manager visits with children.

DSS shared data gathered its federal Child and Family Services Review (CFSR) which, similar to DSS data reports and to data from prior case record reviews, confirm the high frequency of case manager contacts with children. The results also reflect concerns about the quality of those visits in addressing key child welfare functions,

[86] Currently, the Co-Monitors plan for a review of performance as of March 2024.

as reflected in the findings of the case record reviews performed in prior monitoring periods by DSS and the Co-Monitors.[87] DSS's internal QA team conducted reviews of 142 Foster Care cases in 26 counties across the state between January 1, 2022 and December 31, 2022, in accordance with CFSR methodology. DSS reports that in 128 (90%) of the 142 cases reviewed, the *frequency* of contact between the case manager and child was sufficient to address issues pertaining to the safety, permanency, and well-being of the children, and promote achievement of case goals. Further, the Department reports that in 93 (65%) of 142 cases reviewers determined that the *quality* of contacts between case managers and children was sufficient to address issues pertaining to the safety, permanency, and well-being of the children and to promote achievement of case goals.[88]

Visits Between Case Managers and Children: Progress and Implementation Updates

DSS's Visitation Implementation Plan was approved by the Co-Monitors on March 28, 2019, and by the Court on April 3, 2019.[89] The Plan includes strategies to clarify the role and function of case manager contacts with children through:

- GPS Case Practice Model implementation;
- Increasing the quality of contacts by developing and delivering training;
- Improving the quality of documentation of visits; and
- Implementing quality improvement processes.

DSS has continued to deliver training and issue written communication to staff on the importance of visits and documentation.

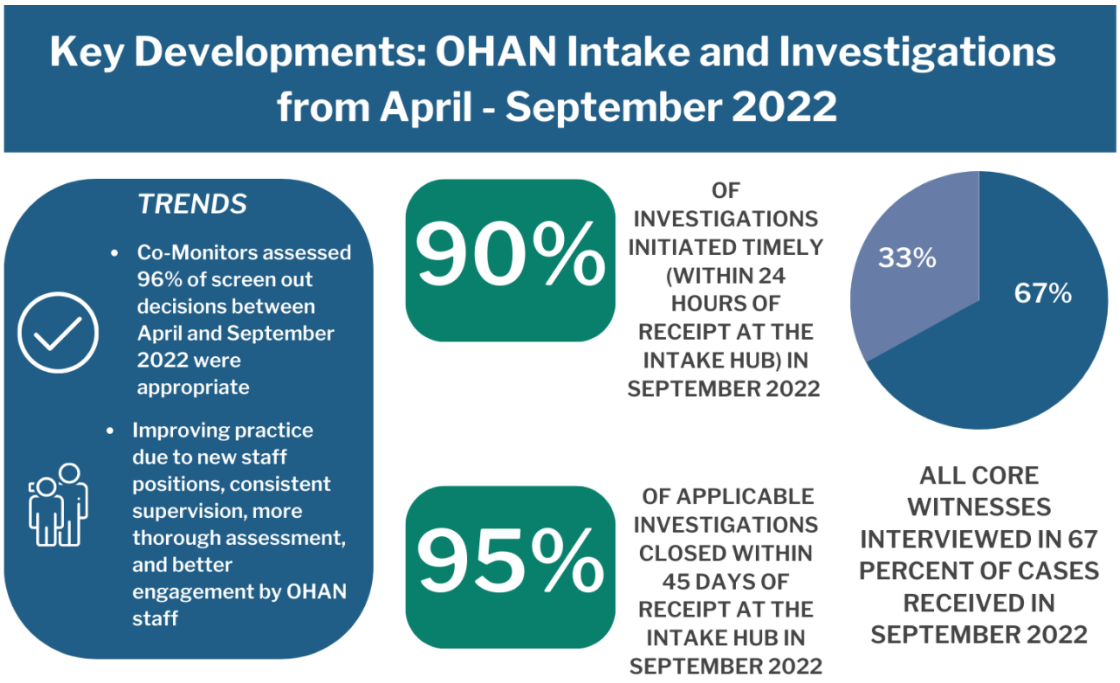
[87] The CFSR is a periodic assessment by the Children's Bureau of a state's performance of child welfare goals. CFSR Item 14 pertains to Caseworker Visits with Child.
[88] These data have not been validated by the Co-Monitors.
[89] The Visitation Implementation Plan is available at: https://dss.sc.gov/media/1956/3-28-2019-final-dss-visitation-implementation-plan.pdf

VII. Intakes and Investigations of Alleged Abuse/Neglect in Out-of-Home Care

Children are separated from their families by the State based upon a determination that they are not safe with their families. Ensuring children's physical and emotional safety while in DSS custody is a primary obligation of the State. Through Intake Hubs,[90] DSS screens allegations of abuse and/or neglect of children in foster care. DSS's Out-of-Home Abuse and Neglect (OHAN) unit conducts investigations of allegations deemed by Intake Hub staff to warrant investigation. OHAN unit staff must have the capacity, tools, skills, and supervision necessary to complete investigation tasks with required quality and timeliness.

Beginning in 2017 and through a dozen reviews of either a statistically significant sample of investigations or all investigations initiated during one month of each six-month monitoring period, Co-Monitor staff continue to observe improvements in the overall quality of OHAN practice. Increased staff positions, more consistent supervision, improved information gathering and assessments, and improved engagement by OHAN staff with children and other core witnesses during investigations are important contributors.

[90] Intake Hubs are regionally-based call centers responsible for: receiving reports of alleged abuse and/or neglect of children and vulnerable adults, conducting phone interviews, assessing the risk of harm, and collecting relevant information from callers in order to make screening decisions as to whether or not the information provided meets South Carolina's criteria, per state law and DSS policy, for what is defined as abuse or neglect of a child or vulnerable adult.



Out-of-Home Abuse and Neglect: Progress and Implementation Updates

The FSA required 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 on November 7, 2017.[91]

In addition to setting interim benchmarks and timelines, the OHAN Implementation Plan contains strategies to improve OHAN practice and achieve the targets required by the FSA, including: improvement in case manager 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 training for investigators; coordination between

[91]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

OHAN and licensing staff; and improvements in supervision. All strategies were initially scheduled for implementation beginning in December 2017, and ongoing. DSS has adjusted some strategies, as reflected in the Joint Report.[92]

Staffing

Sufficiently filled staff positions – investigators, supervisors, and administrative staff – allow for manageable caseloads and support to complete all required tasks on time and with quality is necessary. DSS allocated new positions to OHAN and prioritized filling these positions and new vacancies as they arise. The approved FY2022-2023 DSS budget includes funding for the requested 15 new OHAN investigators, and three new OHAN supervisors, which DSS had estimated were necessary to meet caseload standards. As of January 20, 2023, the OHAN unit was allocated a total of 33 investigator positions, five supervisor positions, and two program assistant positions. Seven investigator positions,[93] and one supervisor position were vacant and posted for hiring on that date.

Training

Child Welfare Pre-service Certification Training is required for all child welfare staff. All Intake Hub staff have completed an intake certification process which includes a module specific to OHAN reports, according to DSS. Effective November 2022, Intake staff may contact and consult with OHAN staff regarding allegations received but are no longer required to contact an OHAN supervisor or designee to confirm all screen out decisions. Additionally, OHAN staff, like county staff, may request reconsideration of a report accepted for investigation if they believe the allegation or information does not meet the criteria for an investigative response.

All OHAN staff are expected to complete new investigator training within two weeks after completing Child Welfare Pre-Service Certification Training. DSS reports that certified employees who transfer to OHAN from other areas of the Department typically receive this training within their first week. The new investigator training includes OHAN policy, practice, and procedural expectations, two days of shadowing an investigator; and one day of OHAN-specific CAPSS training. If a new investigator still needs additional assistance, their supervisor may arrange for additional peer support and shadowing and increase supervisory support. As of January 20, 2023, 22 investigators had successfully completed new investigator training.

[92] Joint Report of Plaintiffs and Defendants to the Honorable Richard Gergel (July 22, 2019, Dkt. 145)
[93] Three vacancies are from positions newly allocated in the FY2022-2023 budget, 4 are existing vacancies, 1 created by the promotion of an investigator. This does not include 2 investigators with anticipated start dates.

Performance Data

OHAN Intake

Since November 2019, DSS's Intake Hubs have been responsible for screening all reports alleging abuse and neglect of children, including allegations involving children in foster care placed in foster homes and congregate settings.[94] Screening decisions are made utilizing a Structured Decision Making(SDM)® intake tool.[95] Decisions to either accept a report for investigation or take no further action on the report ("screen out") are based upon information received by the Intake Hub to determine if the allegations would, if substantiated, meet the state's statutory definition of abuse or neglect.[96] 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.[97] All screening decisions are reviewed and approved by a supervisor prior to being finalized.

The FSA requires that *"[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.). DSS committed to achieving these targets by March 2021.

[94] In addition to the Intake Hub call center, DSS maintains a child abuse and neglect online reporting system accessible through their website. Guidance provided on the site indicates that it is designed to receive non-emergency reports of suspected abuse and/or neglect of a child or adult, and that it should not be used to report suspected abuse and/or neglect against a child in foster care. After reporting that some reports regarding children in foster care were submitted through this website, which has a 48-hour timeframe for processing, and that procedures for web report are being reviewed and modified to meet the FSA requirements for a 24-hour response, DSS states designated Intake supervisors are responsible for checking DSS's online portal every two hours for reports.

[95] For more information on SDM, see https://evidentchange.org/assessment/structured-decision-making-sdm-model/child-welfare/ (retrieved Jan. 26, 2023)

[96] SC Code § 63-7-20.

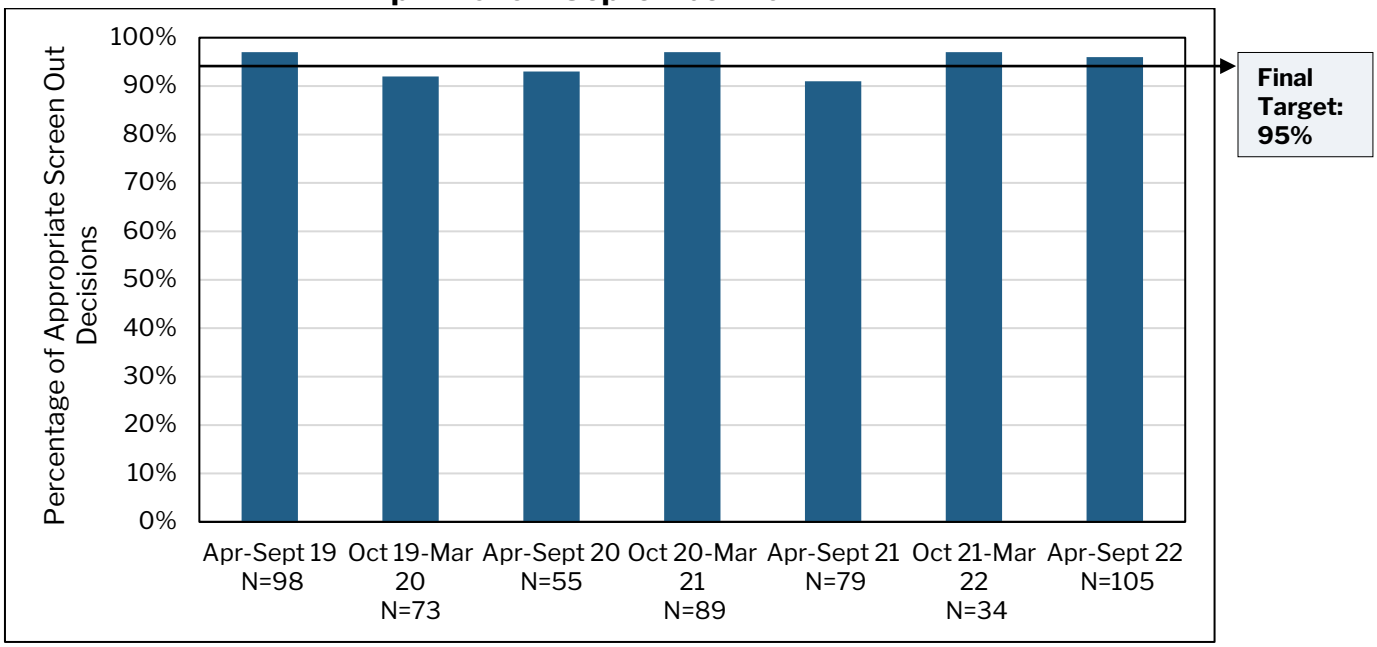
[97] This includes a foster parent; a kinship foster parent; an employee or caregiver in a public or private residential home, institution, or agency; or an adult who has assumed the role and responsibility of a parent or guardian for the child, but who does not necessarily have legal custody of the child. SC DSS Child Welfare Policy and Procedures Manual, Chapter 16: Special Topics: Out of Home Abuse and Neglect (effective May 19, 2022).

Reports of abuse and/or neglect involving a foster child received and not approved for investigation by DSS's Intake Hub staff from April 1, 2022 to September 30, 2022 were reviewed by Co-Monitor staff, in collaboration with DSS, to determine the appropriateness of the screening decision.[98,99,100,101] During this timeframe, DSS determined an investigation was not warranted for 105 applicable reports.[102] Upon review, Co-Monitor staff, in collaboration with DSS, determined that for 101 of 105 reports (96%), the decision to not investigate was appropriate. For four reports (4%) the decision to not investigate was not appropriate.

As reflected in Figure 13, performance on this measure is above the final target of 95 percent for the second consecutive monitoring period.

[98] This review includes examining information entered into CAPSS, and listening to recordings of reports, when available.
[99] Some reports 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 in the congregate care setting or through ICPC from another state, or was the biological or adopted child of the caregiver), or the report was screened out as a duplicate to a prior report that was under investigation or had previously been investigated.
[100] When assessing performance for this measure, 2 main criteria are considered: (1) the allegation, if true, meets the legal definition of maltreatment; and (2) the Intake Hub staff did not collect all information necessary to make an appropriate screening decision. If either of these questions were answered in the affirmative, the decision not to investigate the report was determined to be inappropriate.
[101] Co-Monitor staff identified a number of reports to the Intake Hub that were processed, screened, and coded as abuse or neglect allegations, however, the information shared did not include an allegation of abuse or neglect against a foster parent or caregiver. These include reports of children running away from placement when the foster parent or facility staff acted appropriately in response to the child's actions, or reports of critical incidents that occurred within a foster home or facility setting that required notice to DSS as the child was in foster care but did not allege abuse or neglect by a caretaker. Beginning in June 2021, DSS and Co-Monitor staff agreed these reports were appropriately screened out and could be identified as such by DSS in a preliminary review so that Co-Monitor staff could focus their review on the remaining reports.
[102] Due to fluctuations in the number of applicable screening decisions each month, the Co-Monitors assess performance aggregated across the monitoring period.

Figure 13: Appropriateness of Decision Not to Investigate Report of Institutional Abuse and/or Neglect April 2019 – September 2022



Source: Monthly review data, Co-Monitor and DSS staff

OHAN Investigations

Allegations of abuse or neglect of children in DSS custody – in settings including licensed foster homes, residential facilities, and group homes – screened by DSS's Intake Hub as appropriate for investigation are assigned to OHAN staff.[103,104] The FSA and OHAN policy require face-to-face contact with the alleged victim child(ren) within 24 hours of the report to Intake to assess for safety and risk, and the investigation is to be completed within 45 days.[105] OHAN policy requires that throughout the investigation, the investigator must conduct a safety assessment of the child, including a private interview; collaboration with the child's case manager or law enforcement to make arrangements for medical treatment or examinations, as needed; interviews with core witnesses to inform the investigation; review of documents and records related to the incident; and an assessment of the risk of

[103] SC Code § 63-7-1210; SC DSS Child Welfare Policies and Procedures Manual, Chapter 16: Special Topics: Out of Home Abuse and Neglect (effective May 19, 2022).
[104] Allegations of abuse or neglect by a foster parent of their biological or adopted child are investigated by child protective service case managers/investigative staff in local county offices.
[105] SC DSS Child Welfare Policies and Procedures Manual, Chapter 16: Special Topics: Out of Home Abuse and Neglect (effective May 19, 2022).

further maltreatment to all children within that setting.[106] These activities are critical components of a thorough OHAN investigation.

There are seven FSA measures that relate to OHAN investigations – timely initiation (two measures),[107] 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 by DSS and Co-Monitor staff in December 2022 which examined 51 investigations involving Class Members that were accepted for investigation in September 2022.

The Co-Monitors have reported observations of reports screened in for investigation by OHAN staff that do not meet the criteria for a screened in report. The frequency of this practice has significantly decreased from prior reviews (when, for example, reports of a youth leaving a placement without permission and with no allegations of inappropriate supervision by staff were investigated). These inappropriate assignments for investigation result in expenditure of DSS and other staff time and other resources to complete all required investigative tasks. Training of Intake staff and increased communication between Intake and OHAN staff have improved screening decisions made by Intake Hub staff. This allows OHAN investigators to focus on reports which justify a special response.

Timely Initiation of Investigations

The FSA requires that *"[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)). FSA Section IV.C.4.(b) requires that *"[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."*[108] The Co-Monitors measure performance for both

[106] Ibid.

[107] The Co-Monitors' interpretation of the FSA requires that investigations be initiated within 24 hours of receipt of the report by DSS, not within 24 hours of the decision to accept the report, 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/report and face-to-face contact with alleged child(ren) victim must be within 24 hours.

[108] The Co-Monitors approved the following efforts 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: 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,

FSA IV.C.4.(a) and (b) using the same methodology and timeframes – the time between receipt of a report by the Intake Hub and face-to-face contact with the alleged child victim must be within 24 hours. DSS committed to achieving these targets by March 2021.

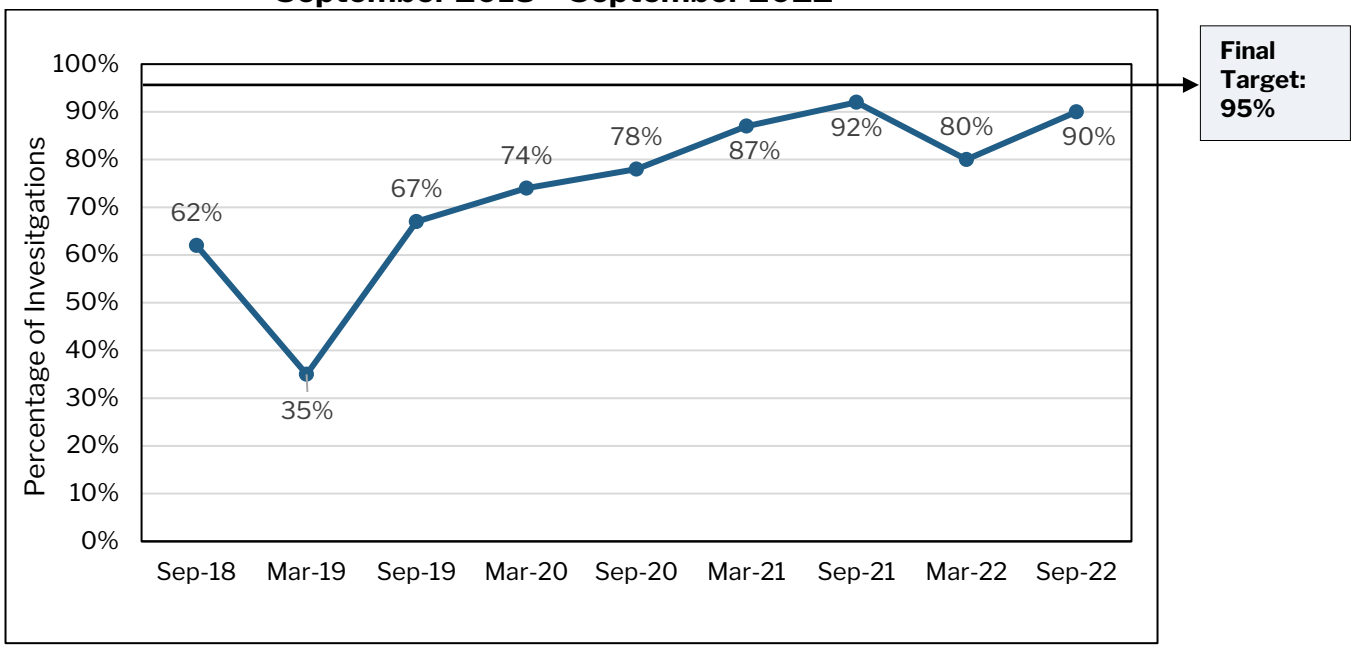
Of the 51 applicable OHAN investigations in September 2022, contact was made with all alleged victim children within 24 hours in 42 (82%) investigations and in an additional four (8%) investigations, all applicable good faith efforts were made to contact each of the alleged victim children;[109] a total of 90 percent of investigations were initiated in a timely manner. In five investigations, there was no documented reason why all alleged victim children were not seen by the OHAN investigator within 24 hours of receipt of the report at the Intake Hub. An ongoing challenge for OHAN staff contacting children within 24 hours remains a lack of readily available information about the location of alleged victim children within the intake documentation or in CAPSS. A child may have moved to another foster home or facility or returned home.

Current performance shows an increase from the prior period and does not meet the final target of 95 percent (see Figure 14).

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/Child Advocacy Center (CAC) interview; investigator attempted to see child(ren) at therapist's office; investigator contacted the assigned foster care case manager(s) and/or supervisor(s); investigator attempted to contact the parent/guardian of the victim child(ren) if the child(ren) has returned home; and investigator attempted to contact the child at all foster care placements where the child may temporarily be placed in the first 24 hours. Additionally, the following extraordinary circumstance exceptions to timely initiation were approved by the Co-Monitors: child was returned to biological family prior to report and family refuses contact; child is deceased; law enforcement prohibited contact with child(ren); facility restrictions due to child's medical requirements; natural disaster; and child missing despite efforts to locate (efforts should include all applicable good faith efforts).

[109] There were instances of children considered to be on "runaway" status and a child who had returned home with a closed case and could not be found to participate in the investigation.

Figure 14: Timely Initiation of OHAN Investigations
September 2018 – September 2022



Source: Case Record Reviews completed by U of SC CCFS (up to Sep-21), DSS, and Co-Monitor staff

Contact with Core Witnesses during Investigations

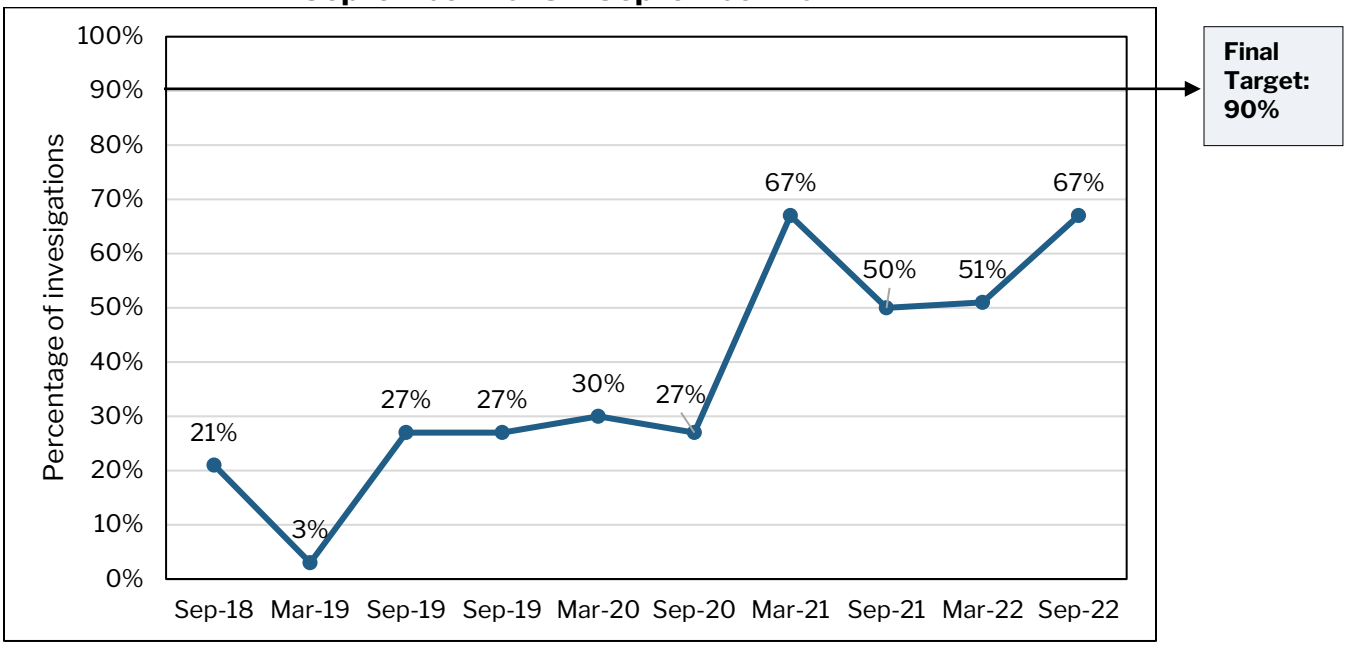
The FSA requires that *"[c]ontact with core witnesses must be made in at least 90% of the investigations of a Referral of Institutional Abuse or Neglect, with exceptions approved by the Co-Monitors"* (FSA IV.C.4.(c)).[110] DSS committed to achieving these targets by March 2021.

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 from investigation to investigation, but in all cases include: reporter(s), alleged perpetrator(s), alleged child victim(s), child's DSS case manager, 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.[111]

[110] The following are exceptions, approved by the Co-Monitors, to the requirement that the investigator contact a core witness during an investigation: witness refused to cooperate; witness advised by counsel or law enforcement that interview could not occur (e.g., due to pending charges, lawsuit); witness is deceased; unable to locate or identify witness; and medical conditions prevented witness from cooperating. In all instances, the exception must be supported by documentation of the exception reason and best efforts to engage the witness.
[111] 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.

Of the 51 applicable reports involving Class Members accepted in September 2022, 34 (67%) reflected contact with all necessary core contacts during the investigation. Current performance is an increase from the past two periods and remains below the final target of 90 percent (see Figure 15).

Figure 15: Contact with All Necessary Core Witnesses During OHAN Investigations September 2018 – September 2022



Source: Case Record Reviews completed by U of SC CCFS (up to Sep-21), DSS, and Co-Monitor staff

Data presented in Table 6 shows the frequency of OHAN investigator contact with each type of core witness in the 51 investigations reviewed.

Table 6: Interviews with Necessary Core Witnesses During OHAN Investigations by Type of Core Witness September 2022 N=51

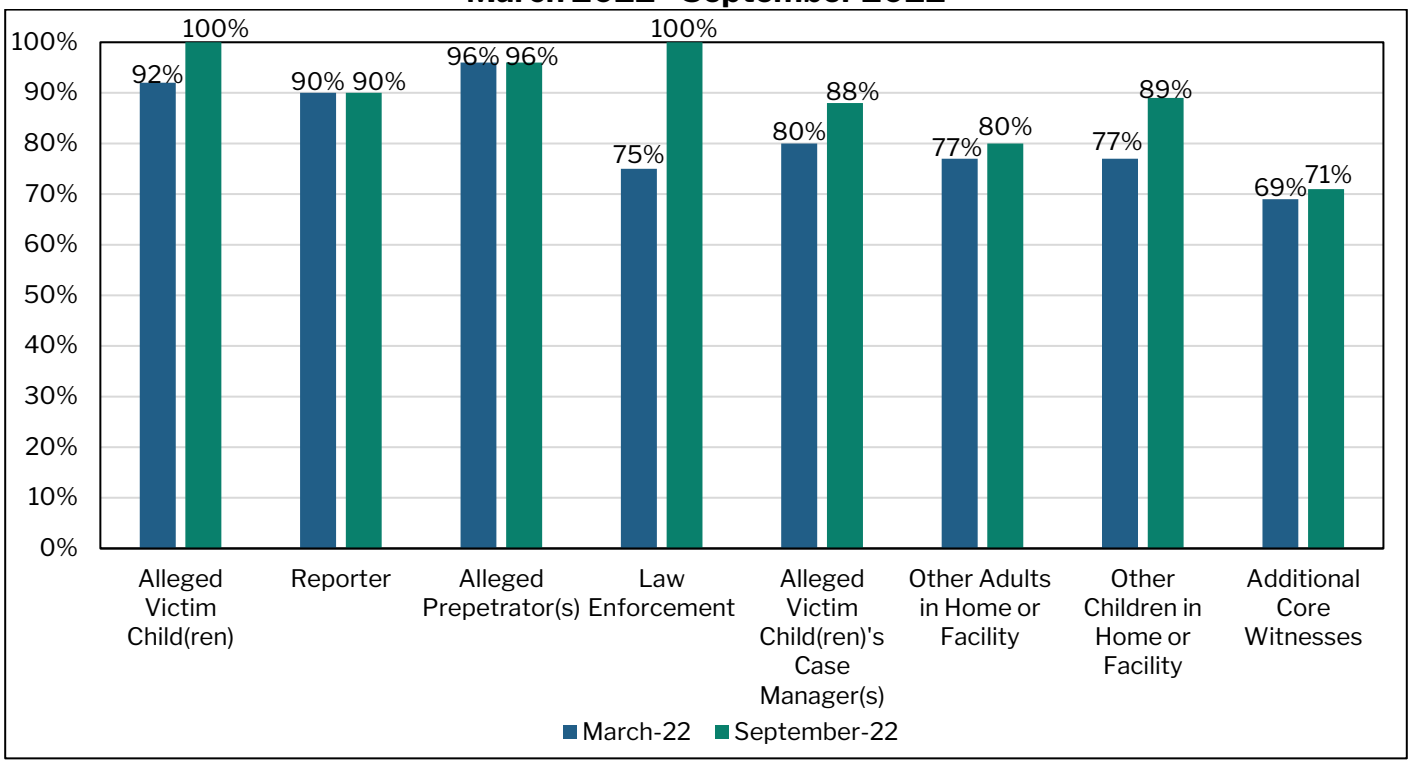
Core Witness	Applicable Investigations	Contact/Interview with All	Contact/Interview with Some	Contact/Interview with None
Alleged Victim Child(ren)	50[112]	50 (100%)	-	-
Reporter	42[113]	38 (90%)	-	4 (10%)
Alleged Perpetrator(s)	51	49 (96%)	1 (2%)	1 (2%)
Law Enforcement	15	15 (100%)	-	-
Alleged Victim Child(ren)'s Case Manager(s)	51	45 (88%)	2 (4%)	4 (8%)
Other Adults in Home or Facility[114]	25	20 (80%)	4 (16%)	1 (4%)
Other Children in Home or Facility[115]	28	25 (89%)	2 (7%)	1 (4%)
Additional Core Witnesses	48[116]	34 (71%)	12 (25%)	2 (4%)

Source: Case Record Review completed in December 2022 by DSS and Co-Monitor staff

Data in Figure 16 show the frequency of contact within all categories of core witnesses in September 2022 as compared to the prior review in March 2022. Improvements are noted in the frequency of contact with most core witness types, including case managers, law enforcement, and other children in the foster home or facility.

[112] The investigator was unable to locate the child, whose status was considered "runaway".
[113] In 7 investigations, the reporter was anonymous; in 1 investigation, the reporter refused to be interviewed, despite efforts; and in 1 investigation, the investigator was unable to locate the reporter despite efforts.
[114] 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.
[115] 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 children in foster care and biological or adopted children in the home. For investigations involving institutions, as facilities can have many children placed within them, investigators should speak with all other children who were involved in or who have knowledge of the allegations.
[116] Additional core witnesses identified by reviewers in 48 investigations included: DSS licensing staff, medical and behavioral health providers, school or daycare personnel, and Guardian Ad Litem (GAL).

Figure 16: Contact with Necessary Core Witnesses During OHAN Investigations March 2022 - September 2022



Source: Case Record Reviews completed by U of SC CCFS (up to Sep-21), DSS, and Co-Monitor staff

Investigation 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.[117]

Section IV.C.3. of the FSA requires that *"[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."* DSS committed to achieving these targets by March 2021.

Of the 51 investigations reviewed, the final decision was to *unfound* the allegations in 44 investigations. Reviewers agreed that the decision to *unfound* the investigation was appropriate in 38 (86%) of the investigations.[118] In all investigations in which the

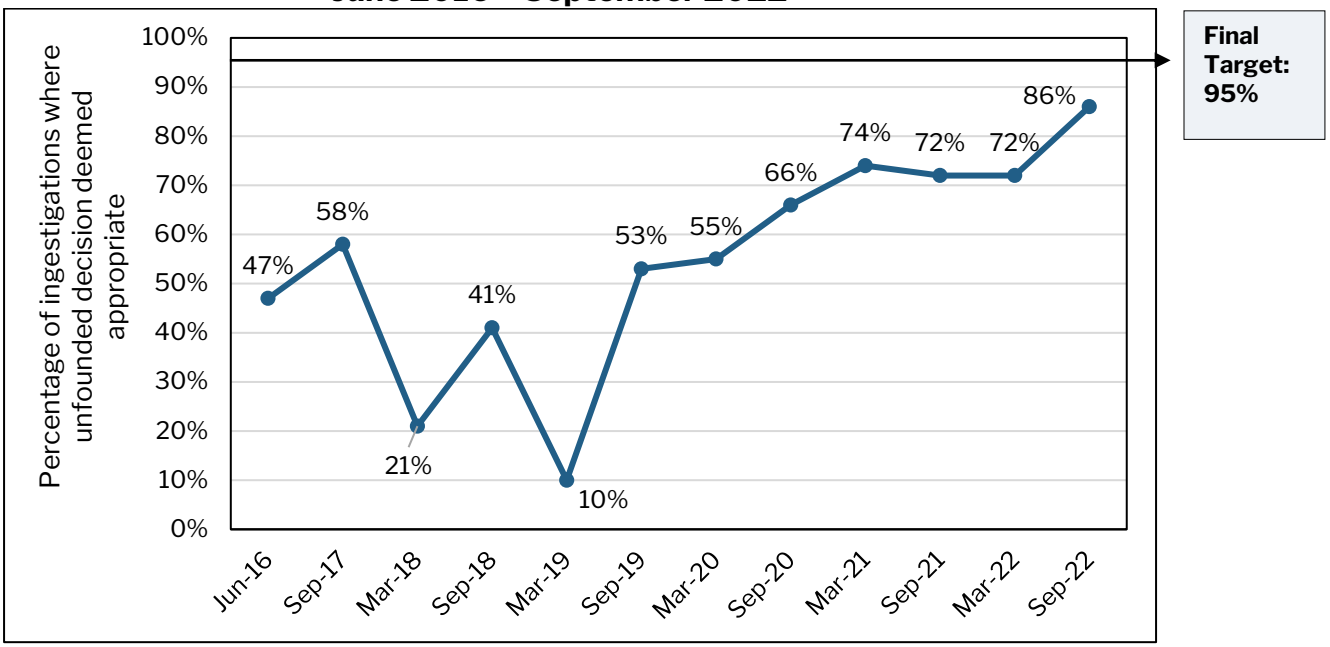
[117] SC DSS Child Welfare Policies and Procedures Manual, Chapter 16: Special Topics: Out of Home Abuse and Neglect (effective May 19, 2022).

[118] As part of the Co-Monitors protocol for all case reviews that are conducted, if a safety concern is identified and documentation does not reflect it was addressed, DSS is immediately notified for appropriate follow-up.

reviewer did not agree with the decision to *unfound*, the disagreement was due to the reviewer determining that the investigator did not collect all critical information necessary to make an accurate finding in the investigation, including, for example, not interviewing a witness with relevant information, or not clarifying conflicting information gathered during the investigation.

Performance in this area has increased from the prior period, and is the highest observed since reviews began in 2016. However, performance remains below the final target of 95 percent.

Figure 17: Decision to Unfound OHAN Investigations Deemed Appropriate June 2016 – September 2022



Source: Case Record Reviews completed by U of SC CCFS (up to Sep-21), DSS, and Co-Monitor staff

Timely Investigation 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)). The March 2021 final benchmark for this measure is 95 percent, which is higher than the FSA final target.

- *"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. 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)). The March 2021 final benchmark for this measure is 95 percent, which is higher than the FSA final target.
- *"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)). DSS committed to achieving these targets by March 2021.

The FSA and OHAN policy provide that the OHAN Director or Director's Designee may authorize an extension of up to 15 days for "good cause" or compelling reasons.[119] Good cause means that, through no fault of the investigator, sufficient reason exists for delaying the investigation decision.[120]

Completed within 45 Days

In nine of the 51 investigations reviewed, the investigator requested and received an extension for an additional 15 days to complete necessary investigative tasks. Of the remaining 42 investigations, two were not closed within 45 days and did not have an approved extension. Thus, of the 42 investigations assessed for the 45-day closure measure, 40 (95%) investigations were timely completed within 45 days (see Figure 17). Current performance meets the final target for this measure.

[119] SC DSS Child Welfare Policies and Procedures Manual, Chapter 16: Special Topics: Out of Home Abuse and Neglect effective (May 19, 2022).

[120] Examples of good cause may be one of the following: awaiting critical collateral information (e.g. medical report, x-rays, toxicology, video); awaiting forensic interview/findings; awaiting critical information from another jurisdiction (e.g. central registry check); critical new information was received from witness that requires follow-up; awaiting action by law enforcement; or child has been too ill or traumatized to speak with investigator.

Completed within 60 Days

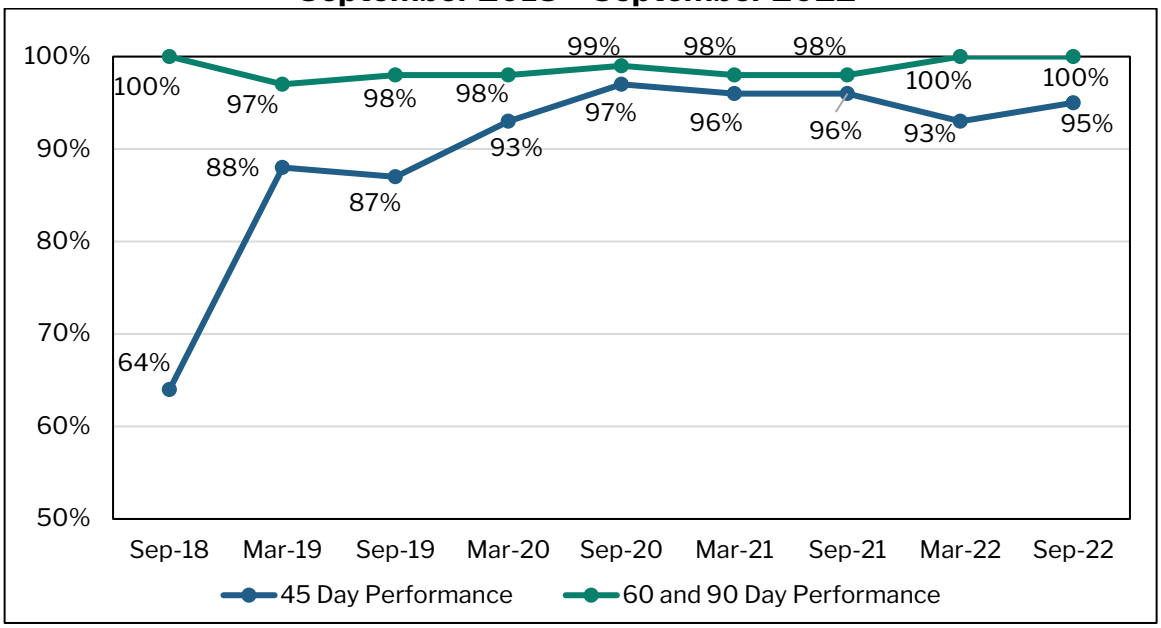
All (100%) of the 51 investigations were completed within 60 days of opening. Performance meets the final target for closure within 60 days.

Completed within 90 Days

Since all investigations were closed within 60 days, performance toward 90-day closure is also 100 percent, and performance meets the final target for this measure.

Figure 18 reflects performance for timely closure of investigations from September 2018 to September 2022.

Figure 18: Timely Completion of OHAN Investigations September 2018 – September 2022



Source: Case Record Reviews completed by U of SC CCFS (up to Sep-21), DSS, and Co-Monitor staff

DSS has met and maintained the required final target levels for all three measures assessing timely completion of OHAN investigations since September 2018. Pursuant to FSA Section V.E., the Co-Monitors have identified these measures as eligible for Maintenance of Effort status.[121]

[121] Pursuant to FSA V.E.1-3, the Co-Monitors identify these provisions may be eligible for "Maintenance of Effort" designation by the Court. Defendants have previously achieved compliance with the obligations set forth in FSA IV.C.4.(d), (e), and (f), as reflected in monitoring reports from 2019 to present.

VIII. Placements

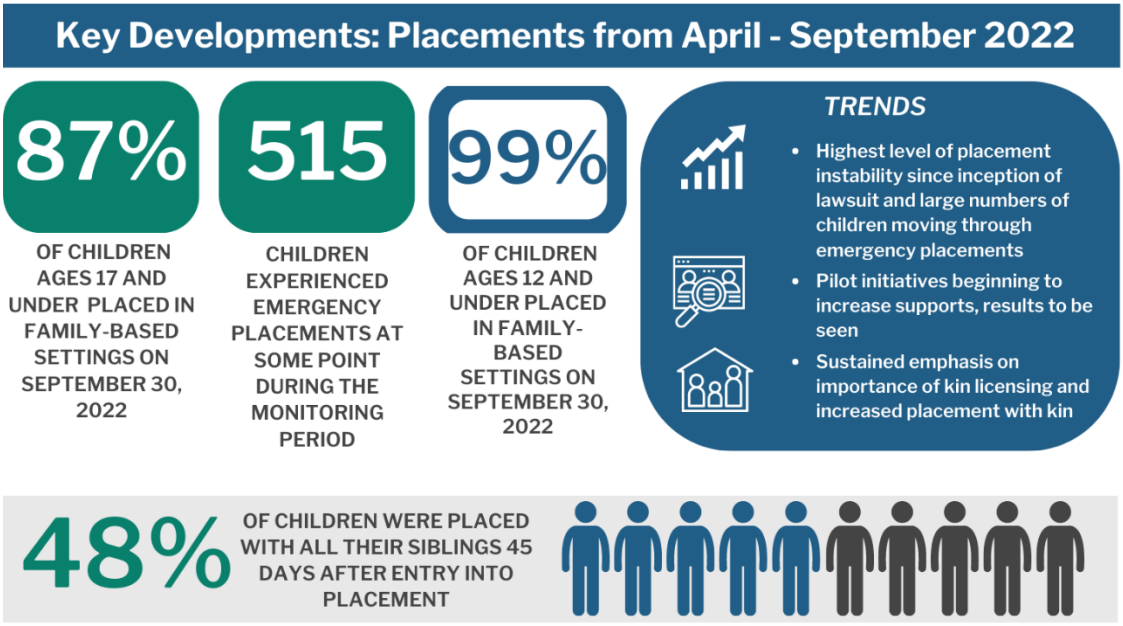
When children are removed from their homes, it is imperative that they be placed in settings in which they are safe and supported. This means ensuring that children are in family-like environments, with kin and siblings, and in or close to their home communities whenever possible. This policy and practice expectation requires that child welfare systems identify and support kin and family-based caregivers and provide flexible, accessible, and individualized supports and services in the community to meet children's needs. This allows children to avoid institutional placement, maintain connections to their families, and experience continuity of care when they return home.

The lack of adequate resources in South Carolina has made the maintenance of an appropriate number and array of placements and supports for children in foster care throughout the state a challenge for DSS since the inception of this lawsuit. Children in foster care, on average, experienced the highest degree of placement instability between October 2021 and September 2022 than in any period reviewed since the inception of this lawsuit. A lack of quality supports and services throughout the state, and still nascent structures around assessment and teaming, has meant that children are frequently placed in short-term placements that are not equipped to meet their needs.

At times, children without long-term placements spend daytime hours in DSS offices or other holding places and nights moving between foster homes or congregate care facilities that are unfamiliar to them.[122] Even for children who remain in placements for longer periods of time, they are frequently placed far from their communities. As of September 1, 2022, only 35 percent of children were placed within their home county.[123] This makes it difficult or impossible for children to maintain long-term relationships, visit with family, consistently attend school, engage in supportive services, or experience stability of any kind.

[122] See Order Notifying Parties and Co-Monitors of Information Relayed to the Court (February 22, 2023, DKt.271): "DSS reports few children in its custody sleep overnight in DSS office; however, children in DSS custody remain in DSS offices until late in the evening and are driven by a DSS worker to a temporary foster placement across counties that are sometimes located several hours away. The children remain at the temporary foster home throughout the night – only for a few hours – before a DSS worker picks the child up in the early morning."
[123] As discussed in Section III. *Background Information*, the state is organized into four DSS regions. DSS reports that 75% of children were placed in their region of origin as of September 1, 2022.

The infusion of desperately needed fiscal resources in the FY2022-2023 budget and the Department's recent focus on more fully engaging placement and service providers in its reform planning are both essential to addressing this placement crisis. With the help of new funding and a more transparent relationship with private providers, DSS leadership has expressed renewed energy in implementing core aspects of the Placement Implementation Plan,[124] and reports that it expects to begin seeing shifts in outcomes by the April - September 2023 monitoring period.



Placements: Progress and Implementation Updates

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)).

[124] The Placement Implementation Plan was entered by the Court on February 28, 2019 in response to FSA IV.D.1.(a). Placement Implementation Plan (February 27, 2019, Dkt. 109). The Placement Implementation Plan is available at: https://dss.sc.gov/media/1950/dss-placementimplementation-plan.pdf

On February 20, 2019, DSS obtained Co-Monitor approval of its Placement Implementation Plan, and on February 27, 2019, the Plan was approved by the Court.[125] The Plan incorporates Placement Needs Assessment recommendations and reflects a reliance on children's parents and a strong preference for keeping children, with appropriate supports, in family-based settings in their own communities, and with kin or fictive kin whenever possible.[126] The Plan also includes commitments to restructured case planning and placement processes driven by well-constituted child and family teams engaged in collaborative assessment and decision-making, commitments to closer strategic partnerships with private providers to develop a placement and service array to meet the needs of children and families, and commitments to developing crisis intervention services especially for kin caregivers. These require both significant resources and a re-orientation of the workforce and extensive engagement with key partners, such as foster parents, family members, and placement and service providers.

Placement Resources and Supports

Community-Based Supports and Services

Although DSS has continued to emphasize the importance of reducing congregate placements and increasing reliance on kin caregivers, and has made progress in this area, the shortage of quality services to support children and families in the community remains. As DSS leadership acknowledges and has been consistently reported in all prior monitoring reports, placement decisions are often made based on availability, rather than on the unique needs of children and their families. In addition, the lack of community-based services and other supports places further pressure on the ability for children to remain with kin and in family-based placements.

It will be imperative that leadership focus on developing wraparound, crisis intervention, and other community-based services particularly for kin caregivers; maximizing the use of Medicaid-funded mental health services to fill gaps in the current service array;[127] and recruiting and retaining more foster parents, particularly kin caregivers to better address placement needs of Class Members.[128] DSS's ability to access federal and state resources, and to align the core strategies included in this

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

[126] Fictive kin refers to individuals who are not related to a child by birth, adoption, or marriage, but have emotionally significant relationships with the child.

[127] See, *supra* note 33.

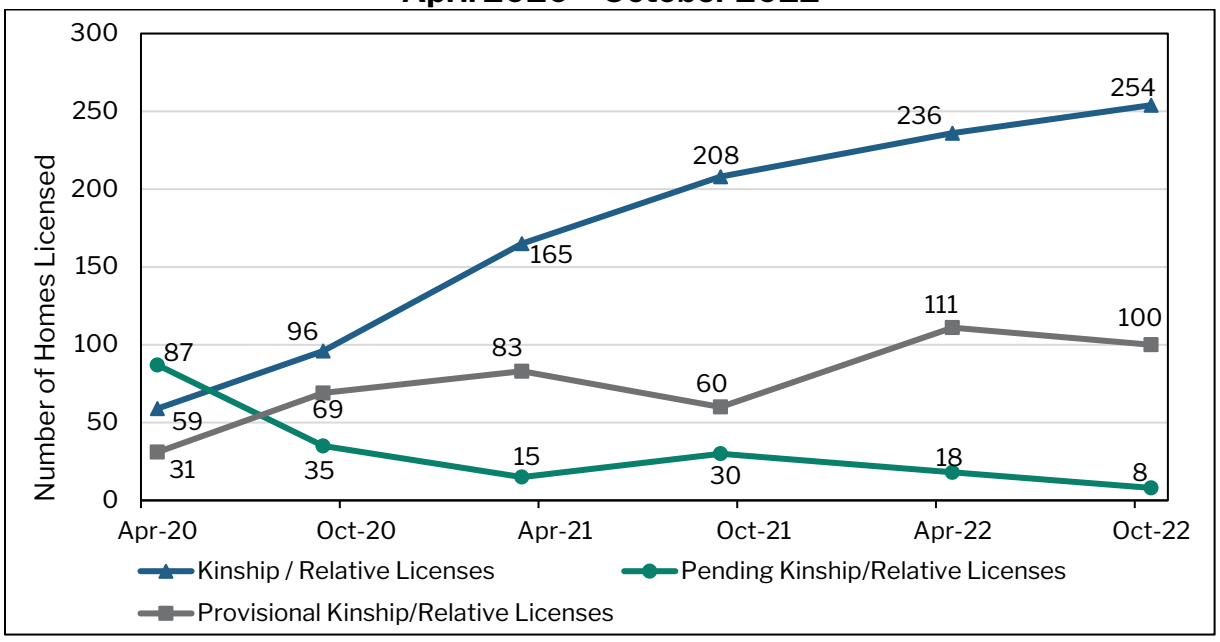
[128] DSS has developed and submitted to Children's Bureau a diligent recruitment and retention plan that includes targets for 2020-2024 and outlines a range of actions that are in various stages of planning.

Plan with the key strategies of the reform effort overall, will be essential to improving the experience and outcomes of the children in its care.

Kin Placement and Licensure

Since the infusion of FY2022-2023 budget funding in July 2022, DSS has begun to focus on some of its long outstanding Placement Implementation Plan commitments. DSS has continued to partner with the private provider community to increase available supports, including therapeutic services, for children. As described in further detail in the Performance Data section below, there has been continued focus on placing children with kin when they are separated from their families, and DSS has gradually increased the number of kin caregivers applying to be licensed foster placements, allowing those caregivers to access financial stipends if they wish to do so.[129] Figure 19 shows the number of licensed kin homes was 254 as of October 31, 2022, an increase of 18 homes since April 2022. There were 100 active provisional kinship home licenses as of October 2022.[130] The figure shows the increase in kin licensing since April 2020. DSS reports that it offers licensing as an option to all kin caregivers, and shares the benefits of licensure, including eligibility for full foster care maintenance payments.

Figure 19: Kinship Licensing Trends
April 2020 – October 2022



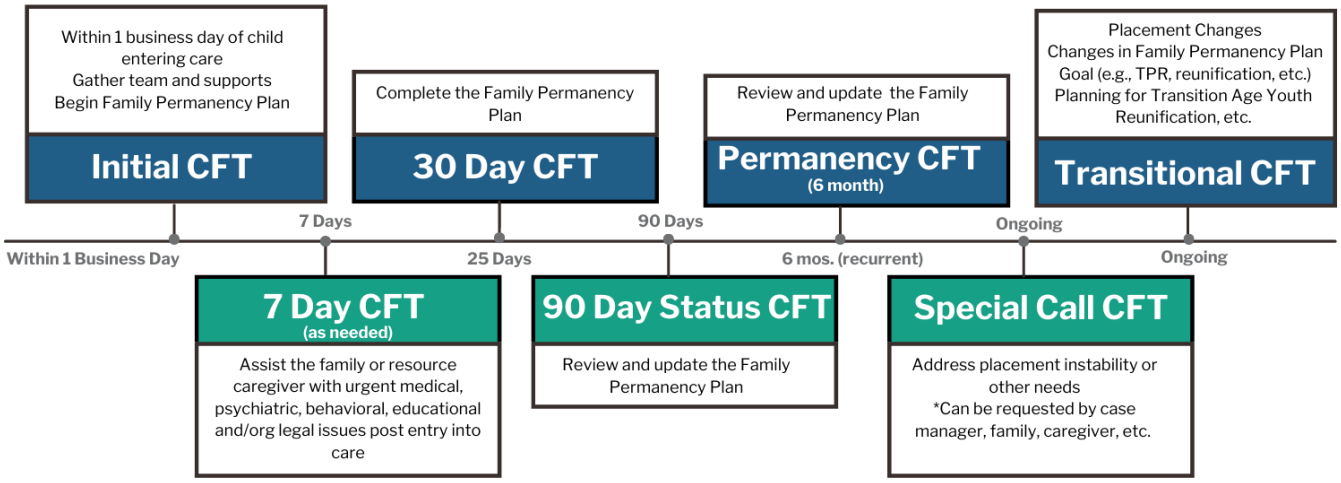
Source: Data provided by DSS

[129] Since July 2020, all potential non-kin foster home providers have been referred to CPAs for licensing. This has enabled DSS to utilize internal resources for licensure of kin homes.
[130] Provisional licensure allows a child to be placed in the kin home before the full foster parent licensure process has been completed.

Individualized, Team-Based Planning

Child and Family Teaming (CFTs) have been formally rolled out throughout the state. The CFT team consists of several facilitators and regional coaches, who support staff in leading CFTs throughout the life of a case. CFTs are required to occur within 24 hours of a child entering foster care, within 30 days of foster care entry, at six months, and before any placement changes or changes in the family permanency plan. Case managers can facilitate additional CFTs at 7 days and 90 days, as shown in Figure 20. DSS acknowledges that far fewer are happening than are required, and that the delay in receiving sufficient funding and training has meant that the meetings are often not yet integrated as an essential part of case practice. As DSS leadership focuses on translating culture and practice changes to the local level over the coming months, it will be essential that these meetings include the right partners, be utilized to identify underlying needs and to drive case planning, and be centered around the voices of children and their family members at all times.

Figure 20: Child and Family Teaming Foster Care Timeline[131]



Source: Graphic provided by DSS

During the monitoring period, 665 total CFTs were documented, though 1,437 children entered foster care during the monitoring period.[132] For comparison, last

[131] CFTs indicated in blue (above the line) are required to be facilitated by a Family Engagement Specialist (FES) Facilitator, while CFTs indicated in green (below the line) could be facilitated by case managers or case manager supervisors.

[132] DSS reports that it has begun distributing surveys to CFT participants and that for CY2022, 1,223 CFT participants (including 258 parents, 365 extended family members and other kin, 27 clinicians, 154 Guardian Ad Litems [GALs], 231 DSS staff, 76 foster parents, and others) completed surveys, including for cases with Non-Class Members.

year, from April to September 2021, 732 CFTs were completed statewide. This year's count does not include 449 Placement CFTs, which can be triggered by a private provider request, and are typically facilitated by a case manager or supervisor rather than a CFT facilitator. DSS plans to continue advertising this option to private providers and provide training on CFTs so that potential placement disruptions can be addressed before they occur or as quickly as possible.

DSS reports that it has continued to use the Family Advocacy and Support Tool (FAST) and the Child and Adolescent Needs and Strengths (CANS) tools statewide to assess children's needs, inform placement decisions, and develop case plans, which will then be discussed and updated via CFTs.[133] The purpose of FAST is to identify existing needs and behaviors to inform placement matching when a child first enters care.[134] CANS is used to guide discussion around treatment needs and make decisions about what care and services will be helpful to both the child and the child's parents and caregivers. If implemented with fidelity and used to inform the work of CFTs, these can be useful tools to help guide case planning. Overall, it is essential that DSS staff continue to strengthen processes and skills for understanding children and family's underlying needs.

Placement Pilots

The Placement Implementation Plan contains a requirement that DSS conduct a placement pilot in particular counties to test strategies for "reducing out-of-region placement and finding more appropriate placements for children who are currently placed out-of-region or at risk for out-of-region placement."[135] The Plan also includes multiple guidelines for how a pilot program with flexible funds, reduced caseloads, and waived procedural requirements could be successful.[136] The infusion of new resources and energy to the Department has led to a renewed commitment to this

[133] For more information on FAST and CANS see: https://praedfoundation.org/tcom/tcom-tools/the-child-and-adolescent-needs-and-strengths-cans/ (retrieved Feb. 7, 2023)
[134] DSS reports that initial statewide roll-out of the FAST and CANS was completed in October 2021, and that since that time DSS has provided monthly refresher trainings, coaching sessions, and skills labs to support the field in effectively utilizing these tools when assessing the needs and strengths of children and families. New staff receive FAST/CANS training in two sessions during certification training.
[135] DSS Placement Implementation Plan, II (e), pp.51-54
[136] Key elements of the pilot were required to include: data supporting the need for change based on the number of children in foster care and the percentage of children placed separate from their siblings or in a placement inappropriate to their needs; presence of private providers willing to engage with DSS on transformation; interest of foster parents in changing ways of working; agreement of local leadership about the needs for change; commitment in pilot counties to expand access to community-based treatment services to keep kids in family placements; access to technical support in pilot planning; access to a pot of flexible funds to seed transportation; allocation of DSS staff positions to pilot counties as needed; and agreement by DSS leaders to waive existing procedures as new ideas are developed and implemented.

work. In the coming months, DSS will be implementing "tests of change" in three counties in the state: Spartanburg, Anderson, and Greenville. The goal is to develop a prevention system that not only addresses out-of-region and out-of-county placements, but also more effectively addresses the needs of adolescents and improves outcomes for the population experiencing significant placement instability. Relevant data has been collected for the three identified counties, and findings will be presented to stakeholders in March 2023. An update on this work will be included in the following monitoring report.

In December 2022, DSS finalized the scope of work for an "Exceptional Needs Pilot," through which private Child Placing Agencies (CPAs) will be given an enhanced rate to develop specialized foster homes for high-needs youth based in a comprehensive treatment approach. The homes will have access to an expanded service array including, intensive counseling, 24/7 crisis management, short-term respite, full mental health evaluations, among other things.[137] Five CPAs have signed the contract to provide "Exceptional Needs Foster Care," and are expected to formally do so beginning in May 2023.

DSS will also continue its collaboration with Thompson Child and Family Focus in the Upstate region, aimed at increasing placement stability by connecting adolescents with trained mentors with lived experience in foster care and a team therapist.

Performance Data

Placement of Children in Family-Based Settings

The FSA contains several provisions related to the placement of children in the most family-like, least restrictive environments necessary to meet their needs. Overall, the FSA requires that *"at least 86 percent of Class Members be placed outside of congregate care on the last day of the reporting period"* (FSA IV.E.2.). DSS committed to achieving these targets by March 2021.

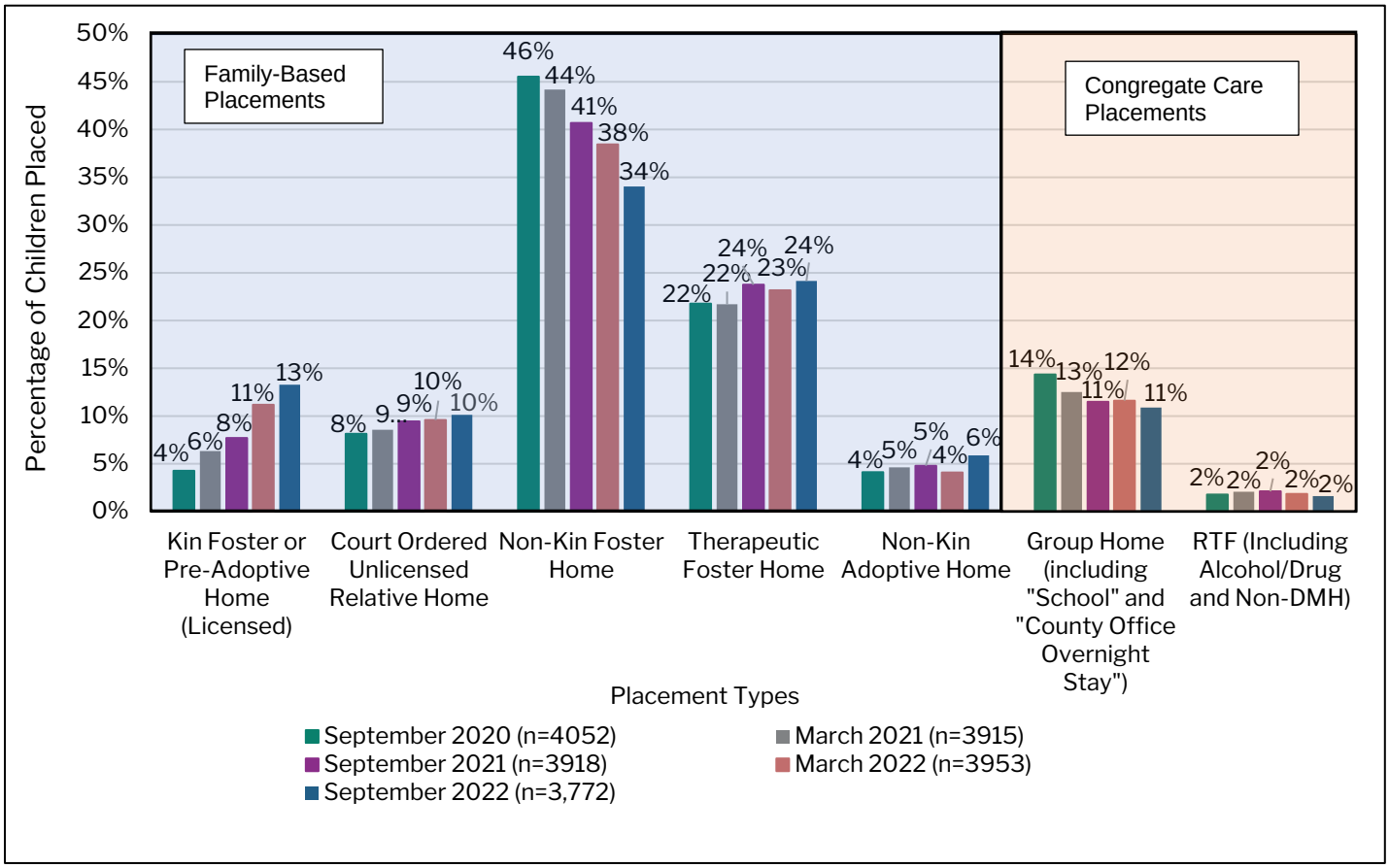
[137] Overnight Stay Plan, pp. 9(6A & B)(March 23, 2022, Dkt. 236)

On September 30, 2022, 87 percent (3,300 of 3,772) of Class Members were placed outside of a congregate care placement and in family-based settings.[138] This represents continued improvement and performance continues to meet the final FSA target for children residing in family-based placements.[139] Figure 21 depicts the breakdown of placements for all children in foster care, both family-based and congregate care, on the last day of the monitoring period between September 2020 and September 2022.

On September 30, 2022, 13 percent (501 of 3,772) of children resided in licensed relative foster homes, a continued improvement from the prior period. As reflected in the figure, when combined with court-ordered unlicensed relative placements, this means almost a quarter of children (23%, or 883 of 3,772) are placed with relatives. As of September 30, 2022, 64 percent of children were placed in foster or adoptive homes with non-relatives, including: 1,284 children (34%) placed in non-kin foster homes, 911 children (24%) placed in therapeutic foster homes, and 222 (6%) placed in non-kin adoptive homes. Most children in congregate care placements continue to reside in group homes (411 children, or 11%),[140] while 61 children (2%) are in residential treatment facilities.

[138] 22 children resided in other institutional settings and were removed from the universe. Specifically, DSS reports that 12 children were incarcerated in correctional or juvenile detention facilities, 9 children were hospitalized, and 1 child was in a Department of Disability and Special Needs (DDSN) Residential Facility.
[139] Pursuant to FSA V.E.1-3, the Co-Monitors identify this provision may be eligible for "Maintenance of Effort" designation by the Court. Defendants have achieved compliance with the obligations set forth in FSA IV.E.3., as reflected in the March 23, 2022 and October 3, 2022 monitoring reports.
[140] This includes 3 children placed in boarding schools and 2 children who slept overnight in a DSS county office on the last day of the monitoring period.

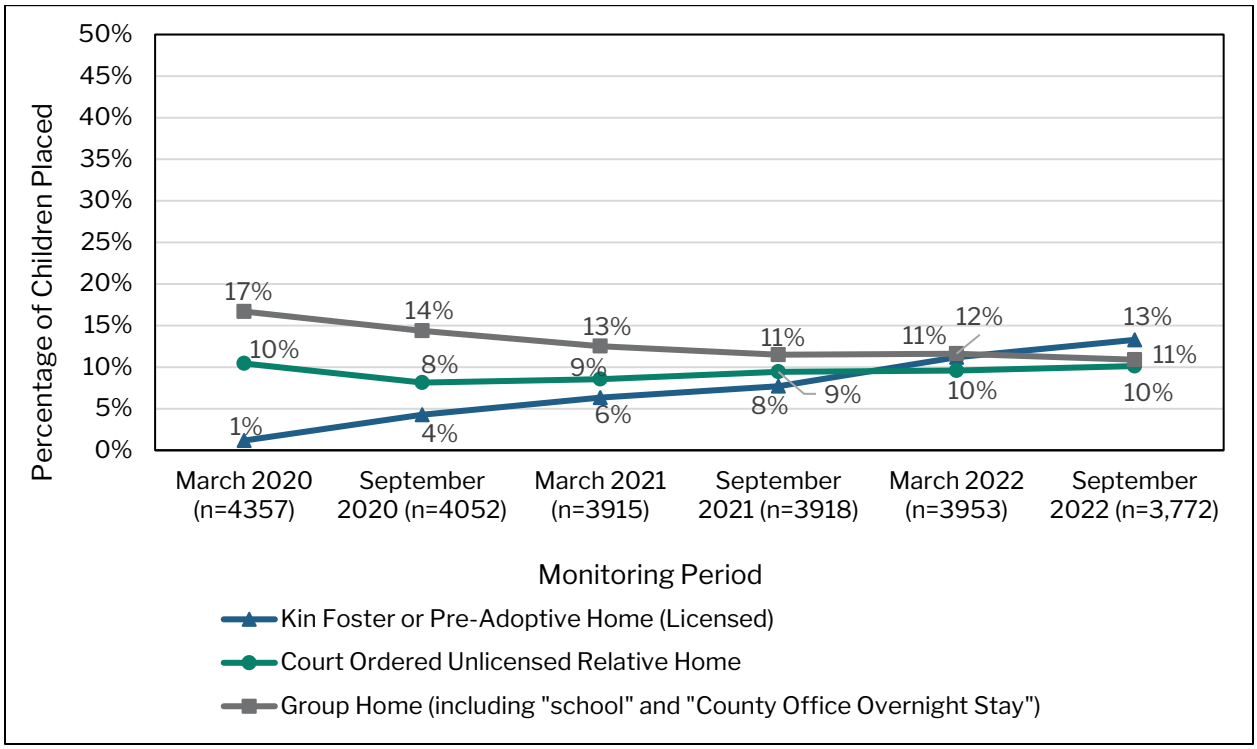
Figure 21: Percentage of Children in Family-Based and Congregate Care Placements, September 2020 – September 2022



Source: DSS Data

To examine these data further, Figure 22 shows the breakdown of three placement types between March 2020 and September 2022. Data show that the percentage of children placed in licensed kin homes has increased while the percentage of children placed in group homes has decreased. This continues to be a positive trend, and reflects DSS's efforts to place children outside of congregate care and with kin whenever possible.

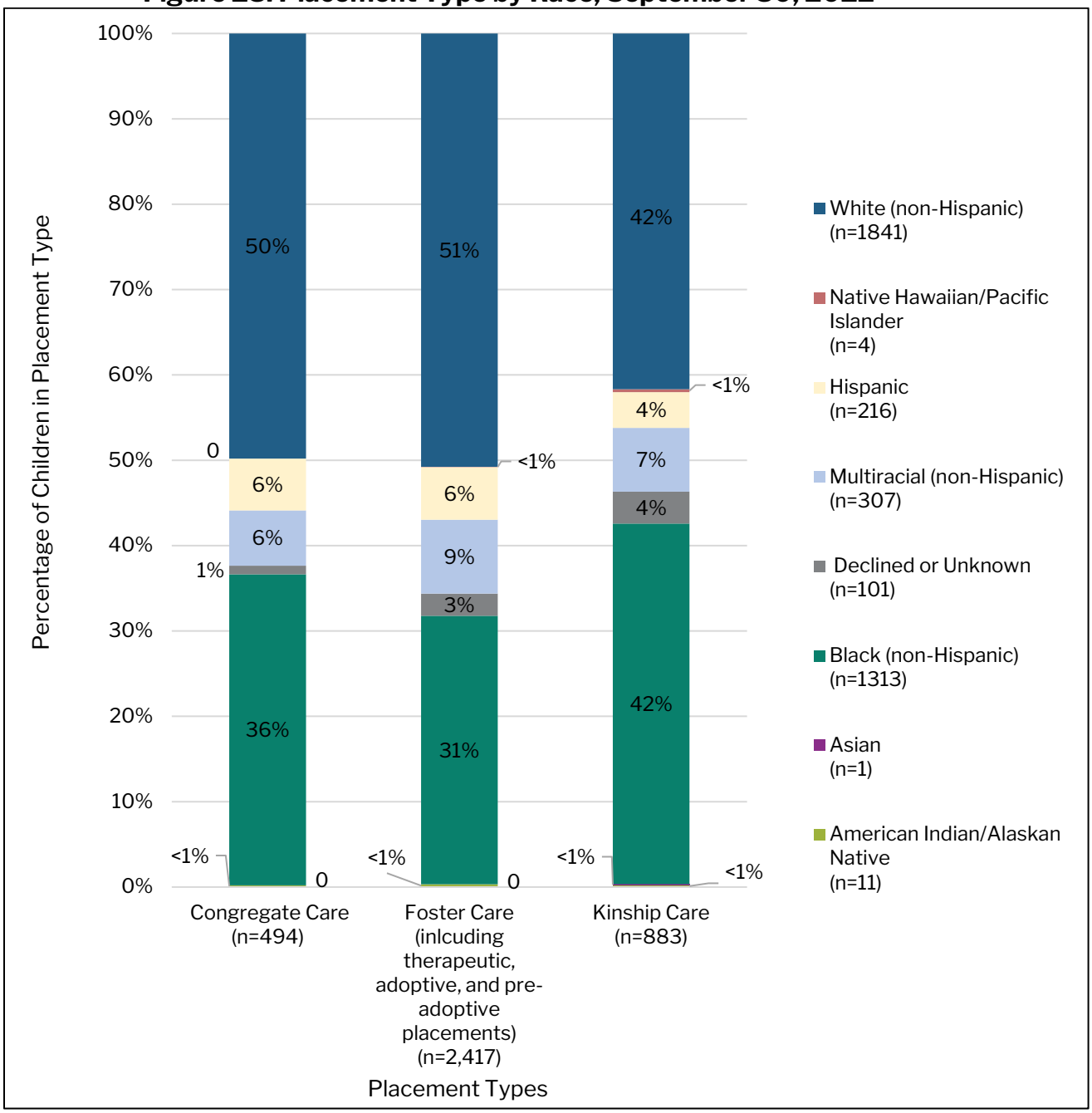
Figure 22: Percentage of Children Placed in Licensed Relative Homes, Unlicensed Relative Homes, and Group Homes March 2020 – September 2022



Source: DSS Data

DSS also provided placement data by race for the last day of the monitoring period. Though there are difficulties in many child welfare systems across the country to attain valid data on race and ethnicity that reflect how people within the system self-identify, these data in Figure 23 provide a baseline understanding for racial groups within different placement categories.

Figure 23: Placement Type by Race, September 30, 2022[141]



Source: DSS data

[141] Following federal guidelines, DSS does not record Hispanic or Latinx as a category in race data published on its public dashboard but does capture Hispanic ethnicity as a category in placement data. To be inclusive of this population in analysis of race data, the Co-Monitors calculated the Hispanic category as those children who were marked as a "Yes" for Hispanic ethnicity, including 13 children who were indicated as both Black and Hispanic, 14 children who were indicated as both Multiracial and Hispanic, and 131 children who were indicated as both White and Hispanic.

Placement of Children in Congregate Care Settings

Children Ages 12 and Under

The FSA 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.). DSS committed to achieving these targets by March 2021.

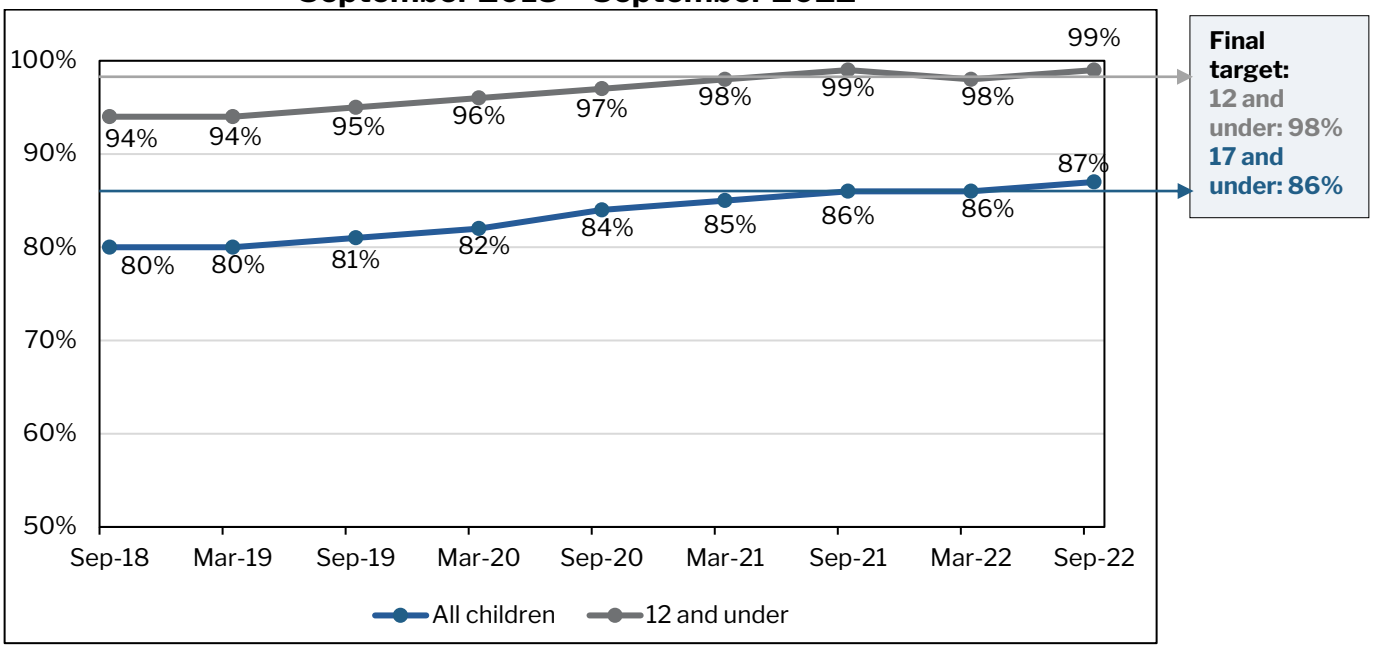
As reflected in Figure 24, as of September 30, 2022, 2,464 of 2,508 Class Members ages 12 and under resided outside of a congregate care placement, in a family-based setting. Eight children ages six and under and four children ages seven to 12 resided in congregate care pursuant to a valid exception,[142] resulting in performance of 99 percent.[143] This is a significant achievement. As shown in the figure, performance on this measure continues to meet the final target.[144]

[142] The Co-Monitors have approved exceptions for placing children ages 7 to 12 in a congregate care facility. DSS submitted four exceptions for children placed between April and September 2022 because they required 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. For this monitoring period, the Co-Monitors excluded four cases from the congregate care calculation. In all four of these cases, the children resided in residential treatment facilities on the last day of the monitoring period. The Co-Monitors and DSS will work to further define a process for documenting these exceptions in the next monitoring period.

[143] Five additional children ages 12 and under were hospitalized on the last day of the monitoring period and are excluded from the calculations.

[144] Pursuant to FSA V.E.1-3, the Co-Monitors identify this provision may be eligible for "Maintenance of Effort" designation by the Court. Defendants have achieved compliance with the obligations set forth in FSA IV.E.3., as reflected in the October 6, 2021, March 23, 2022, and October 3, 2022 monitoring reports.

Figure 24: Trends in Placement of Children Outside of Congregate Care September 2018 – September 2022



Source: CAPSS data provided by DSS

The data in Figure 24 do not capture children's experiences over the entirety of their time in foster care and do not include children who resided in other institutional settings, such as hospitals or correctional facilities.

Children Ages 13 to 17

Children ages 13 to 17 are more likely than younger children to spend time in congregate care, though DSS has worked to reduce this number. On September 30, 2022, 428 (34%) of 1,264 children ages 13 to 17 resided in congregate care. This is slightly less than the prior monitoring period, when the amount was 36 percent, but represents a significant reduction over time (in September 2020, for example, 42 percent of children ages 13 to 17 resided in congregate care).

Slightly less than half (45%, or 841 of 1,889) of children ages 13 to 17 in foster care at any time between April 1 and September 30, 2022 were placed in a congregate care setting at some point during the period. This is the same percentage as the prior period.

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, and required 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."*[145]

On March 15, 2016, the Co-Monitors approved DSS's plan, including acceptable exceptions (due to medical necessity, placement with parents, or placement with siblings),[146] and DSS issued a directive outlining the procedure to be used by staff to reduce the placement of young children in congregate care, and ensure the appropriate placement of children ages six and under in family placements (IO II.3.(a) & FSA IV.D.2.). The procedure requires approval of a Regional Director prior to the placement of any child under the age of seven in a non-family-based setting.

Of the 16 children ages birth to six who resided in congregate care facilities during the monitoring period, all were placed there pursuant to an agreed upon exception. All 16 children resided in a treatment facility or group care setting with their mothers.

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.

[145] On March 15, 2016, the Co-Monitors approved DSS's plan, including acceptable exceptions (due to medical necessity, placement with parents, or placement with siblings),[145] and DSS issued a directive outlining the procedure to be used by staff to reduce the placement of young children in congregate care, and ensure the appropriate placement of children ages 6 and under in family placements (IO II.3.(a) & FSA IV.D.2.). The procedure requires approval of a Regional Director prior to the placement of any child under the age of 7 in a non-family-based setting.

[146] The following are exceptions, approved by the Co-Monitors, to the requirement that children ages 6 and under be placed outside of congregate care: 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; or the child coming into care is in a large sibling group and all efforts to secure foster home and Therapeutic Foster home placements have been completed and have not produced a home. In that the last 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.

After errors in producing data for this measure were identified by DSS last year, the Co-Monitors engaged a consultant to examine the process and methodology used to calculate placement instability.[147] Although the consultant made some recommendations, they found DSS's current methodology to be sound. Included herein are the corrected data for the 12-month period from October 1, 2020 to September 30, 2021, along with newly produced data for the most recent 12-month period from October 1, 2021 to September 20, 2022.

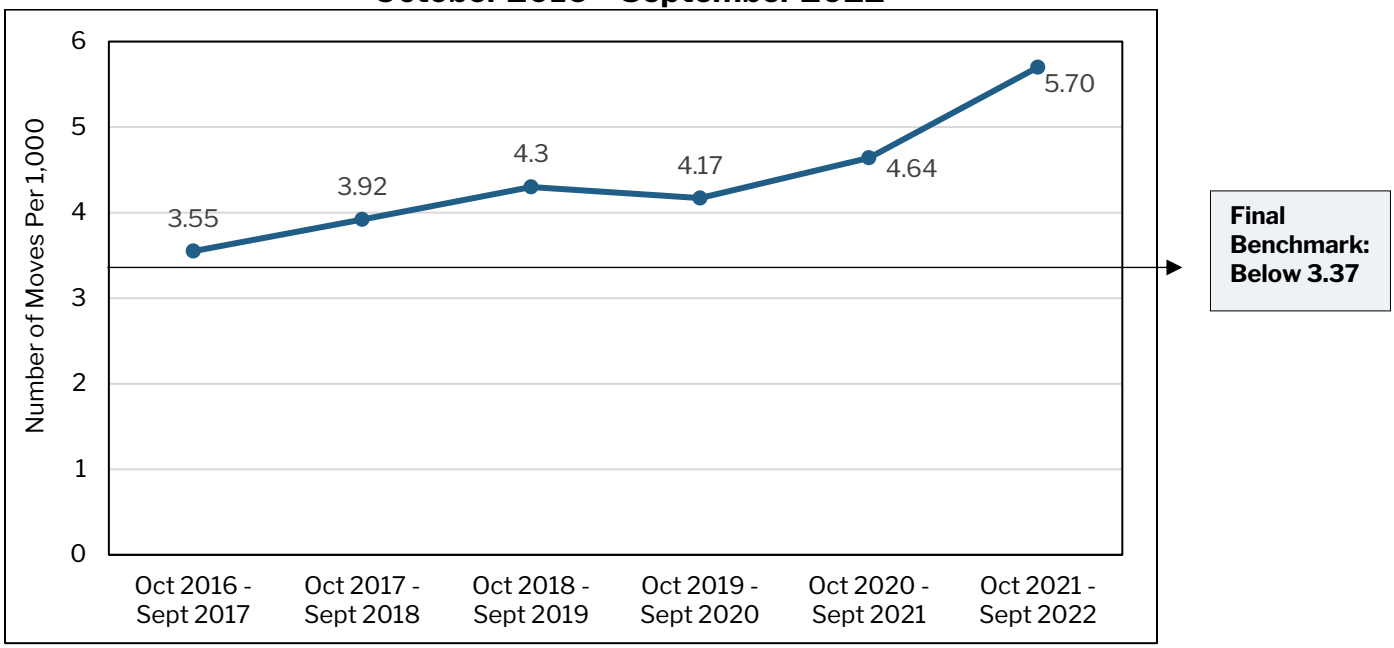
DSS reports that for the period October 1, 2020 to September 30, 2021, Class Members experienced placement changes at a rate of 4.64, meaning there were 4.64 moves per 1,000 days in care, across all children in foster care.[148] For the period October 1, 2021 to September 30, 2022, Class Members experienced placement changes at an even higher rate of 5.70, meaning there were 5.70 moves per 1,000 days in care, across all children in foster care.[149] Performance for neither period meets the benchmark of 3.37 or fewer moves per 1,000 days in care. As shown in Figure 25, the level of placement instability reported for this most recent period is the highest it has been since the inception of the lawsuit.

[147] In August 2022, the Co-Monitors engaged Action Research, a national research and technical assistance provider, for the purpose of evaluating the validity of DSS's methodology for collecting data on placement instability after it reported identifying inconsistencies in these data in the prior monitoring period. More information about Action Research can be found at https://www.actionresearch.io/

[148] Children are counted as experiencing a placement move if the move was not temporary (they did not return to the original placement), the move was not the original removal episode, and the length of stay in foster care was greater than 7 days. Moves between residence buildings at the same congregate care facility were excluded from these data.

[149] Specifically, there were 8,136 moves across 1,426,906 kid-days.

Figure 25: Rate of Placement Moves
October 2016 – September 2022



Source: DSS data

These data reflect placement moves that occurred over a 12-month period, an arbitrary designation for a child, and may build upon a history of frequent placement moves in prior years. Some children who were moved through emergency placements, or slept in DSS offices, experienced anywhere from two to 35 placements within the prior 12 months, and significantly more placements during their years spent in foster care. All available research indicates the profound negative consequences of such instability on children's well-being.

Placement in DSS Offices and Hotels

The FSA required 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.).

Beginning in the spring of 2021, DSS saw a surge in the number of children sleeping overnight in DSS offices. Between October 1, 2021, and March 31, 2022, 107 unique children stayed overnight in DSS offices for a combined total of 273 nights. One year prior, between October 1, 2020, and March 31, 2021, the Co-Monitors had only been notified of five instances of violations of this FSA provision. Alarmed by the sharp and rapid increase in the number of children staying overnight in offices, DSS and Plaintiffs developed an Overnight Stay Plan,[121] jointly entered on March 23, 2022. DSS worked diligently to implement the strategies in the plan, resulting, initially, in a substantial decrease in children staying overnight in offices. Between April 1 and September 2022, data provided by DSS reflects 28 unique children stayed overnight in DSS offices for a combined total of 53 nights, the majority of which occurred during the first month of the period, April (18 unique children spent 42 nights in DSS offices before April 30,2022.

The number of children staying overnight in DSS offices remained low for the first three months directly following the monitoring period. However, as of February 2023, overnight stay notifications have dramatically increased, reaching crisis levels again. From October 1, 2022, to March 20, 2023, 47 children experienced a combined total of 65 stays in a DSS office; most of these stays occurred in February (19 nights) and March (28 nights) alone.

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.).

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 defines an emergency placement as a short-term placement that is only utilized after all efforts have been made to identify a permanent long-term placement and those efforts were unsuccessful.[150] In comparison, DSS defines a *temporary* placement as a move triggered by a specific event, of limited duration. In a temporary placement, such as respite care, hospitalizations for less than 30 days, and transitional visits with caregivers, when the triggering event ends, the child returns to the previous long-term placement, and the placement does not count as a placement move.

As DSS has acknowledged, the designation of emergency placement is often tied to a case manager's intent at the time of placement and, as such, has been difficult to measure accurately. In prior periods, the Co-Monitors have reported on instances in which foster parents or group homes were given "incentive" payments by DSS to care for children on a short-term basis, understanding that these data did not include all emergency placements. DSS reports that it recently developed the capacity, through the introduction of an automated process, to more broadly track children who have spent time in emergency placements and the length of time they have spent there. These data have not been validated by the Co-Monitors, and DSS reports that more internal analysis is required to better understand how staff are using the designation within CAPSS. Preliminary data have been included below.

The FSA measures refer to children who stay in a single emergency placement for more than a designated period of time (no more than 30 days; no more than 7 days for a subsequent placement. Though DSS data collection has been inconsistent,[151] DSS reports that between April 1 and September 30, 2022, 515 unique children experienced at least one of the 1,295 emergency placements over the course of 4,915 nights. This is a significant increase from 390 unique children who experienced at least one of 844 emergency placements in the prior monitoring period. DSS reports that six of the 515 youth had at least one emergency placement that started and ended during the monitoring period that lasted longer than 30 days.

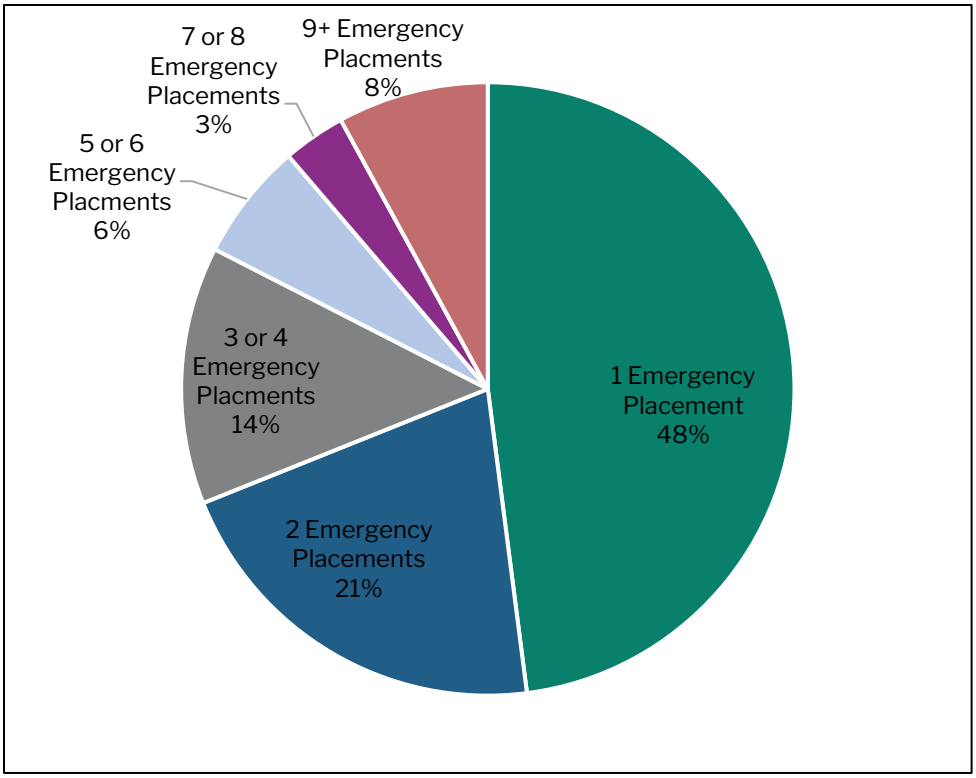
[150] SC DSS Child Welfare Policies and Procedures Manual, Chapter 5:510 (effective July 22, 2020).
[151] DSS reports inconsistent entry of emergency placements into CAPSS between October 2021 and March 2022. As technological processes continue to be enhanced, data may be updated in subsequent reports. DSS reports having made several process refinements during this monitoring period to improve the accuracy and consistency of data entry.

Regarding the FSA's requirement that subsequent emergency placements last no more than seven days, the only month for which DSS could provide data is September 2022, due to limitations in the validity of data prior to October 2021. DSS reports that, of the 112 unique children who experienced emergency placements in September 2022, 67 (60%) of them had additional emergency placements within the prior 12 months. Of those, 20 (30%) children had at least one subsequent emergency placement that lasted more than seven days.

While the FSA focuses on the length of time children spend in a particular emergency placement, children experience even more instability when they are moved *between* multiple emergency placements and DSS offices or other holding places. Thus, DSS also provides data on the total number of emergency placements through which children are moved.

Over a third (36%, or 185) of these 515 children experienced more than seven nights of emergency placement since October 2021, and eight percent (40 children) experienced more than 30 nights of emergency placements in the same period. Eleven children experienced more than 50 nights in emergency placements since October 2021. One child alone experienced 129 nights of emergency placements. Figure 26 shows the distribution of emergency placements those 515 children experienced during the monitoring period.

Figure 26: Number of Emergency Placements Experienced by Class Members
April - September 2022
N= 515



Source: CAPSS data provided by DSS

Delving into this new data capacity will be important for DSS to better understand trends in emergency placements and to identify individual children who are experiencing significant instability. The Co-Monitors and DSS have reviewed several cases where, as a result of this type of instability, children's behavior worsens, contributing to a feedback loop of further instability. It is necessary, in the Co-Monitors' view, to delve deeply into the history and experiences of these youth to understand underlying needs that were missed or not addressed and to develop an individualized plan to prevent further trauma and instability going forward.

Juvenile Justice Placements

The FSA requires that *"[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. 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" (FSA IV.H.1.).

The limited quantitative data available in this area has made tracking performance in this area a challenge, and the Co-Monitors have historically had to rely significantly on anecdotal reports by stakeholders to assess performance. In November 2022, the Co-Monitors and DSS, with the Department of Juvenile Justice's (DJJ) permission and collaboration, published a report of findings from their joint comprehensive review of the experiences of children dually involved with both DSS and DJJ.[152] The key review findings are as follows:

- *As to the experiences of children dually involved with both DSS and DJJ, they are greatly impacted by a lack of community-based supports and limited opportunities for contact with family members.* They linger for long periods of time without their basic need for connection and support being met, leading to cycles of instability. DSS too often focuses on "accountability" for presenting behavior, rather than on normative development and the effects of trauma, leading to increased risk of detention.
- *As to DSS's and DJJ's processes for assessing and understanding these children and their parents, there are many opportunities for information sharing between the agencies. However, there is much work to be done by DSS surrounding the use of a quality functional assessment that examines underlying needs and occurs in collaboration with parents.* The usefulness of the current assessments is limited by a lack of integration into a team-based, family-centered approach, often leaving behavior unaddressed and families feeling unsupported.
- *As to the collaboration between DSS, DJJ and other agencies, there have been extensive efforts to support children who are dually involved by improving coordination between multiple systems.* A significant number of structures exist to guide collaboration between DSS and DJJ, but a lack of clarity around specific responsibilities and purpose undermines the impact of those efforts. Decisions are made by a large and often changing number of individuals and agencies, often without input or knowledge of children and their family members.

[152] More information on the joint findings about children dually involved with DSS and DJJ can be found at: https://cssp.org/wp-content/uploads/2022/10/FINAL-Children-Concurrently-Involved-with-SC-DJJ-and-DSS-Joint-Review-Findings-002.pdf

- *As to the challenges and system barriers impacting the ability to meet children's placement and service needs, there is a fundamental misunderstanding about the distinct purposes, missions, and responsibilities of DSS and DJJ.* A severe lack of quality supports and services available across the state is also a key issue. Finally, a lack of problem-solving orientation, often caused by the effort to adhere to the perceived roles and boundaries of each agency, creates internal rigidity and prevents creative solutions.
- *As to whether practices or procedures of DSS and DJJ contribute to unnecessary DJJ involvement, the frequency of engaging law enforcement and advocating for children to be held "accountable" for their presenting behaviors heightens the risk of deepened DJJ involvement for children in foster care.* The behaviors that lead to DJJ involvement are at times an expression of the failures by multiple systems to provide children and their families with needed supports and honor their strengths and histories. Instead, children's DJJ involvement is sometimes perceived as an opportunity for DSS to shift case management and placement responsibility to DJJ (just as DSS sometimes perceives DJJ as shifting responsibility for placement).

This review and the report which followed has been an important collaboration, and a key step in identifying some of the barriers to meeting the needs of many of the children in DSS's care who present with high levels of need. In February 2023, DSS and the Co-Monitors staff, with the support of DJJ, hosted a symposium to present the report findings and begin discussing next steps. The symposium was attended by over 100 individuals representing DSS, Parties, DJJ, other state agency partners, community members, and individuals with lived experience. DSS will be working with the Co-Monitors, DJJ, and its system partners to develop and test practices that address these findings in the coming months, as part of the Small Test of Change efforts underway in Spartanburg, Anderson, and Greenville counties. The Co-Monitors will also be working with DSS, in light of review findings, on ways to improve tracking and performance with respect to the specific FSA requirement in this area. Updates will be included in upcoming monitoring reports.

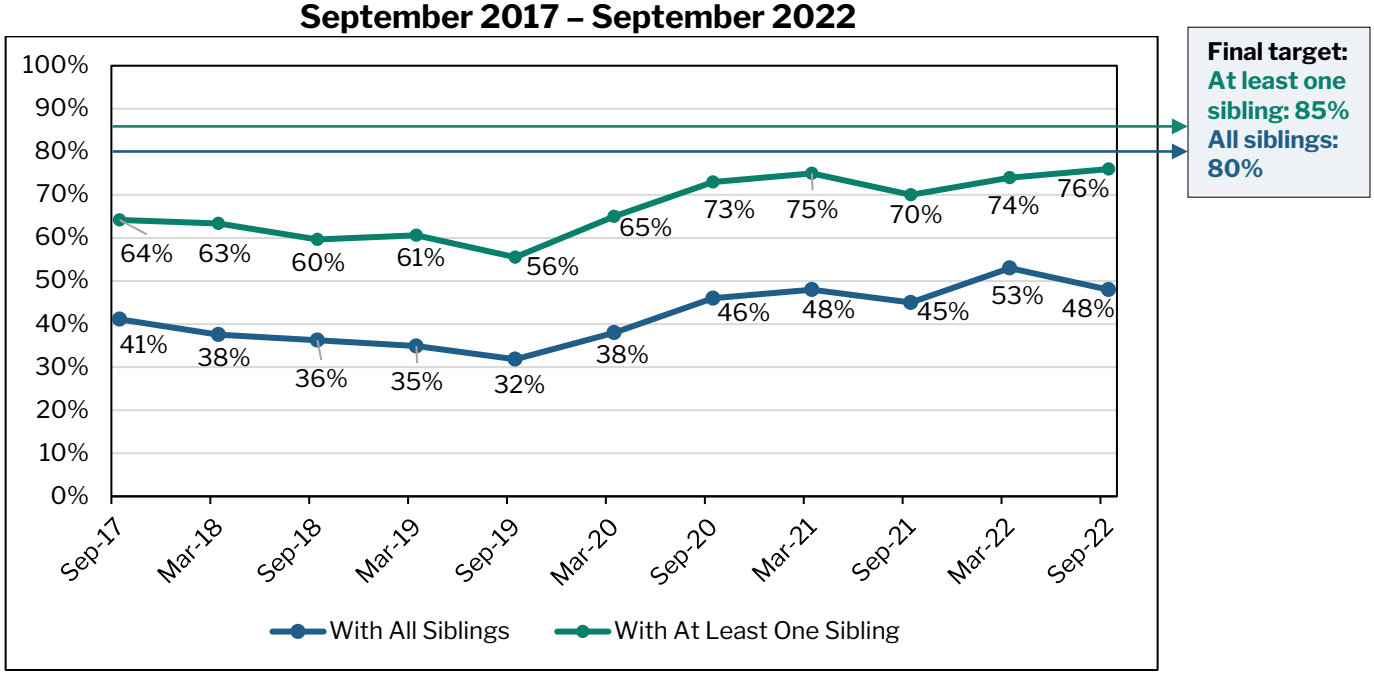
Sibling Placements

The FSA recognizes the importance of the lifelong and supportive relationships between children and their 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 includes 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).[153] DSS committed to achieving these targets by March 2021.

DSS provided data for 638 children who entered foster care between April 1 and September 30, 2022, with a sibling or within 30 days of a sibling's entry into foster care. For this cohort, 76 percent (486 of 638) of children were placed with at least *one* of their siblings, and 48 percent (308 of 638) of children were placed with *all* of their siblings 45 days after entry into care. As shown in Figure 27, this represents a slight increase in the percentage of children placed with at least *one* of their siblings and a decrease in the percentage of children placed with *all* siblings 45 days after entry into care from the prior monitoring period. Performance does not meet the final targets.

Figure 27: Sibling Placements for Children Entering Placement September 2017 – September 2022



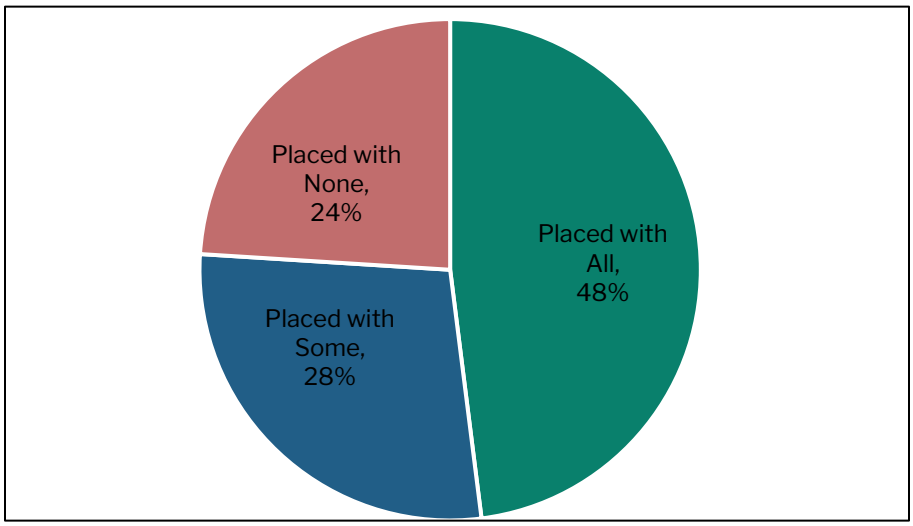
Source: CAPSS data provided by DSS

Figure 28 further shows the breakdown of sibling placements during this monitoring period. Twenty-four percent of all children entering care with siblings were not placed with *any* siblings 45 days after entry, which is a slight decline in performance from the

[153]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 1 or more siblings. Exceptions to placement of children with their siblings 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 in a future monitoring period.

prior monitoring period, when 26 percent of children were not placed with *any* siblings.

Figure 28: Sibling Placements for Children Entering Placement
April – September 2022
N=638



Source: CAPSS data provided by DSS

Therapeutic Placements

The FSA includes the following requirements with respect to the assessment of children's need for therapeutic supports and placement:

All Class Members that are identified by a Worker 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 Worker withdraws the identified need in good faith and in the best interests of the Class Member within thirty (30) days (FSA IV.B.I.3).

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 (FSA IV.B.I.4).

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 (FSA IV.B.I.5).

The FSA also includes a requirement that DSS identify "*enforceable interim benchmarks with specific timelines, subject to consent by the Plaintiffs and approval by the Co-Monitors, to measure progress,*" with respect to the placement of children in therapeutic placements when determined to be needed (FSA IV.B.I.2.).[154] These benchmarks and timelines were to be established as part of the Placement Implementation Plan (FSA IV.B.I.2.).

At the time of finalization of the Placement Implementation Plan, the Co-Monitors and Parties determined that, because the process of assessing and identifying the need for more intensive supports and placements would likely be modified as DSS began to implement its Placement Implementation Plan and develop new assessment, decision-making, and placement processes, DSS would wait to propose benchmarks and timelines until implementation began. DSS and the Co-Monitors anticipated there might be a need for the initial FSA requirements regarding placement to be amended, and expected that any proposed updates, benchmarks, and timelines would be submitted by no later than July 2019. DSS has not yet submitted such a proposal, and has committed to working with the Co-Monitors to address this measure in the coming months.

For this monitoring period, DSS produced initial data related to the FSA requirements. DSS and the Co-Monitors are in the process of analyzing these data and discussing ways to collect data in this area. DSS has expressed an interest in adopting a method of data collection that will allow for a more comprehensive understanding of how

[154] "Therapeutic Level of Care" refers to the leveling system used by DSS within the therapeutic placement and services array, including but not limited to Level 1, 2, 3 foster care placements and Psychiatric Residential Treatment Facilities (PRTFs), as described in the Human Services Policy and Procedures Manual and The State of South Carolina, Fixed Price Bid No. 5400002885 (FSA II.S.).

children's underlying needs are assessed and how the provision of supports and services to meet these needs are measured. Determining how to evaluate progress in this area, which interplays significantly with other focus areas such as assessment, teaming, placement in the appropriate level and type of placement to match the assessed need, and follow-up on health care needs, will be a priority in the coming months.

IX. Family Time: Visits with Parents and Siblings

Ongoing, supportive relationships with family members are essential to children's well-being, more so for children who have experienced separation from all that is familiar to them. According to DSS records, far too many children in foster care lose regular access to their parents, their extended family, and their sibling(s) who are also in DSS custody.[155]

Case managers report that children see their parents and other family members at DSS offices; local parks and indoor play spaces; churches; homes of kin foster parents; and restaurants. Most children, however, are not spending even the *minimum* time required by DSS policy and the FSA with their family, based on documentation in case records. DSS, U of SC CCFS, and Co-Monitor staff have historically conducted twice-yearly case record reviews to determine performance on DSS's minimum twice-monthly standard for children's contacts with their parents and minimum once-monthly contact between siblings in foster care and living apart.[156] Results from these reviews showed performance far below policy and practice expectations. Across four years and ten reviews, the Co-Monitors learned that on average, only half of records contained documentation that a child had seen their sibling during a selected month, and only 13 percent of records showed documentation of children having twice monthly contact with parents with whom they are to be reunified.[157]

The priority for visits or family time has been communicated by DSS leadership through policy, training, practice resources, and the development of monthly management data reports to be used for tracking and improving outcomes. Additionally, DSS has begun to hire regional staff teams that can assist with casework when geographic areas experience vacancies, including assisting with driving to out-of-county visits.[158] These efforts aim to address some of the barriers to timely visits including high caseloads and far distances between children's placements and their home communities.

Upon agreement of all Parties, given poor performance on these measures and lack of substantial progress, the Co-Monitors suspended the review of a statistically valid

[155] DSS reports that as of September 30, 2022, almost 900 Class Members are residing with a family member or family friend.
[156] Data from the last day of the months of March and September are used to measure and report performance.
[157] DSS expects there will be some improvement in this area as legal information is updated in the DSS record.
[158] As of January 16, 2023, two of four supervisory positions had been filled and one of five case manager assistant positions have been filled. All 20 case manager positions for these case management teams remain open.

sample of records and reporting on this measure for at least four monitoring periods, or until DSS reports that there has been a substantial increase in performance.[159] At that time, the Co-Monitors will work with DSS to review performance on this measure. In the interim, the Co-Monitors will report on DSS's actions towards improvements in this area.

Family Time: Progress and Implementation Updates

The FSA required *"[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).

Data

DSS reports it has prioritized various Continuous Quality Improvement (CQI) strategies to improve performance and data collection on visits between children and their families. During this monitoring period, the Office of Accountability, Data, and Research (ADR) developed reports on parent-child and sibling visits that are shared monthly with DSS staff and leadership on the Child Welfare Services Dashboard. The monthly reports closely follow the FSA but do not include all agreed-upon exceptions, such as changes in a child's permanency plan within a month, and are not yet robust enough to track if visits were sought with particular family members but not others. DSS has shared these reports across the agency, including as part of a training at the end of September 2022 delivered to all frontline supervisors and county leadership.

Additions and modifications to CAPSS to capture data on visits and a new Visitation Plan document are not yet in uniform use by staff. DSS reports continuing efforts to gain feedback and amend CAPSS to make it more user-friendly for data entry, including through the regular practice of holding visitation skills labs and surveys.[160]

[159] A review of performance as of March 2024 is expected.

[160] DSS reports that it will be holding their next series of visitation skills labs in March 2023. These skills labs will focus on the use of the visitation tab, how to document special circumstances, and how to utilize available data reports for management purposes.

In August 2022, DSS Child Welfare Operations leadership met with county and regional leaders to discuss the necessity for changing practice around visitation and learn about the strengths and challenges of entering visitation data into CAPSS. Additionally, on December 16, 2022, DSS surveyed frontline Foster Care and Adoption staff regarding how they utilize the Visitation Tab in CAPSS. DSS intends to use responses to determine additional training needs and inform future technological updates. DSS reports that members of its CQI team will meet with front-line staff in April 2023 to discuss barriers and ideas for practice improvement in this area.[161]

DSS has continued to encourage foster parents and providers to utilize the Child and Adult Information Portal (CAIP) to document the visits with which they are aware and/or facilitate. Effective January 2023, the Non-Therapeutic Foster Home and Therapeutic Foster Home (CPA) contracts will require CPA staff to ensure their foster families enter data on visitation. Entries by providers and foster parents via CAIP will be incorporated into the CAPSS visitation reports and provide DSS with a more holistic picture of contact between children and their families.

Evident Change, a research and technical assistance provider, is working with DSS to create easy-to-use, web-based trend reports for performance on the requirements that children visit with their family members using SafeMeasures®.[162] Frontline staff will be able to view individualized reports of data captured from CAPSS relevant to their workload. Once the web-based trend reports are ready for use and have been validated, CAPSS and ADR reports will be phased out. DSS anticipates these reports will be available for use by the field by May 2023. The Co-Monitors anticipate using SafeMeasures® reports for updates on DSS performance with visits after validating data of performance during March 2024.

Training and Coaching

DSS's Internal Monitoring team has conducted internal reviews of parent-child visits and partnered with 10 county leaders to provide supervisory-level coaching. These coaching sessions have focused on proper documentation of visits, utilizing CAPSS and ADR reports for daily management, addressing barriers to timely documentation, and establishing continuous monitoring and improvement methods. In addition to the coaching by DSS's Internal Monitoring Team, DSS has enlisted performance coaches to offer and deliver county trainings on using the Visitation tab in CAPSS and to

[161] Survey results from the March 2023 visitation skills labs will inform these CQI Meetings.
[162] To read more about Evident Change and the development of SafeMeasures®, go to: https://www.evidentchange.org/analytics/safemeasures

emphasize the value of facilitating contact between children and their family members. To ensure cross-county and regional consistency in data interpretation, meetings with counties of comparable size have been held to review data reports and discuss the implementation of practice improvements. DSS also reports that Quality Visitation Tips were distributed to staff on December 15, 2022.

During the monitoring period, DSS finished developing Quality Visitation training and began testing it in October 2022. DSS began implementing the training on February 1, 2023.

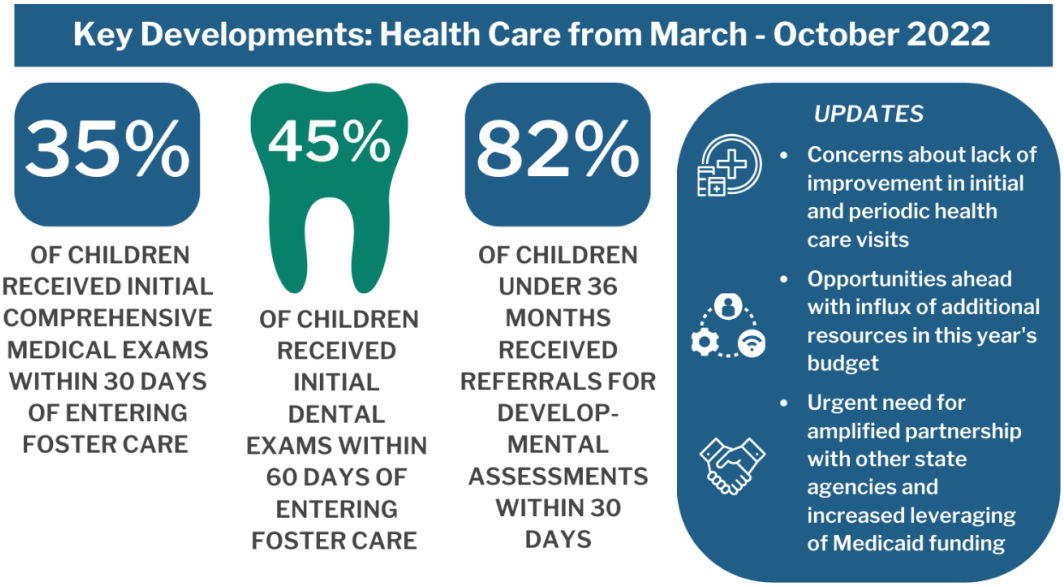
Visitation Awareness training continues to be offered on a quarterly basis to case managers, supervisors, and foster parents and, along with documentation training, is required for all new child welfare staff within one year of employment. From April to September 2022, an additional 36 case managers, four supervisors, and 40 foster parents participated in Visitation Awareness Training.

X. Health Care

Child welfare systems must be able to quickly identify children's physical, mental, and behavioral health needs, provide high-quality preventative and acute care, track care delivery, and communicate health care information to families, caregivers, and partner agencies. Despite a lot of attention in this area over the past several years, the percentage of children receiving their medical and dental visits according to prescribed timelines has not improved.

DSS's small team of nurses and data coordinators continued to work to capacity to manage and document the health care needs of children in foster care this monitoring period. DSS was granted long-awaiting funding for three additional nursing positions (as well as additional support positions) in the FY2022-2023 budget, but a nationwide nurse shortage has made it difficult for the team to fill open positions as quickly as hoped.

The responsibility of delivering health care to children in foster care does not rest with DSS alone. It continues to be critical that DSS work with its state agency partners like the Department of Health and Human Services (DHHS) and the Department of Mental Health (DMH), community partners, and its private MCO partner (Select Health) to implement the Health Care Improvement Plan entered by the Court in 2018, and to develop robust, accessible, community-based services and supports across the state for children and families, including intensive in-home supports.



Health Care: Progress and Implementation Updates

The FSA required that by April 3, 2017, DSS *"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)).

On August 23, 2018, the Co-Monitors approved DSS's Health Care Improvement Plan.[163] A Plan addendum (the "Health Care Addendum") was approved by the Co-Monitors on February 25, 2019, establishing commitments by Select Health, the MCO for the majority of children in foster care, and DHHS to a framework for care coordination involving distinct, interrelated roles for the DSS Office of Health and Well-Being, DSS case managers, Select Health Care Coordinators, and foster and biological families.[164] The Plan was approved with the understanding that additional detail would be determined during implementation, and the efficacy and adequacy of the model would be assessed each year to see if it requires changes or additions.

Internal Capacity Building

Timothy Nix, former Lead Clinical Specialist, formally transitioned into the leadership role of the Office of Child Health and Well-Being in August 2022. An infusion of funds

[163] To see the Health Care Improvement Plan, go to: https://dss.sc.gov/media/1980/8-23-2018-final-approved-dss-health-care-implementation-plan.pdf
[164] To see the Health Care Addendum, go to: https://dss.sc.gov/media/1962/2-25-2019-approved-health-plan-addendum.pdf

in the FY2023 budget allowed for the hiring of three additional nurses, for a total of ten nurses, five new program coordinator positions (one in each region, though Midlands will have two), three new data and statistical analysis support positions, and two new liaison support positions who will work with Select Health and DHHS. These positions are in the process of being filled. The team continues to have four health care data coordinators, one on each of the regional Well-Being Teams. Of these positions, vacancies remain for two program coordinators, one data support position, and three nurses as of March 2, 2023.

Data and CQI

DSS holds weekly staffing calls to explore solutions around improving completion of well-child and dental visits, and is using regular data management reports to track progress with the field. DSS continues to train providers on using the CAIP to allow providers to enter notification of medical appointments for youth in foster care, which should auto-populate into CAPSS. There is also currently a CAPSS build in place to notify the nursing team of the results of the initial medical screen captured in the CANS tool, which is intended to identify immediate health needs, as well as needs that have arisen within the prior 30 days.

Cross-Agency Partnership

As is the case in all states, and as explicitly designed and reflected in DSS's Health Care Improvement Plan, DSS must work with its state agency partners, including DHHS, to provide for children's health and behavioral health care needs, especially through the use of Medicaid and other federal funding streams.

DSS reports continued productive work with the DHHS leadership team, led by Director Robbie Kerr, who was confirmed in April 2021. Given the need to improve access to quality services for all South Carolina children, particularly those in foster care, it is essential that DSS continue to foster this collaboration and accountability with DHHS as its leadership team sets priorities, and that the agencies actively pursue ways to maximize federal Medicaid funding to meet the needs of children in foster care throughout the state.[165]

Select Health (MCO) Partnership

South Carolina's system for health care delivery to children and families that utilize Medicaid gives a significant role to private MCOs. Select Health is the designated MCO for nearly all children in foster care in the state, which means that it is

[165] See, *supra* note 33.

contractually obligated to ensure children's health care needs are being met. It is also charged with approving or denying payment for medical and behavioral health services. In so doing, Select Health plays many roles: it is a point of contact, a collector of essential data, a resource in identifying providers, a determiner of allowable services, and a payor of claims. To define a cohesive system of care delivery for children in care, DSS's Health Care Plan and Addendum formalized expectations for health care case management and care coordination for children in foster care. These expectations relied, in large measure, on the capacity and responsibilities that already rested with Select Health as MCO. In so doing, Select Health became an important partner in an innovative model for health care delivery for children in foster care.

Select Health has 19 staff in its Foster Care Unit (including eight clinical nurses, two social workers, and one Foster Care Liaison), along with a medical director. It has continued to partner with DSS on a weekly Foster Care Grand Rounds process through which cases of concern are discussed. DSS reports that it has continued to engage Select Health as a partner in devising real-time solutions as health care challenges have arisen for children in foster care.

There remains significant work to be done in operationalizing Select Health's role in the day-to-day management of children's health care, beyond denying or approving claims and offering a roster of in-network providers. There continues to be a lack of clarity around many of the role definition issues that were to be resolved in early implementation of the Health Care Improvement Plan and Addendum, which has meant, all too often, that DSS has been left with the tasks of managing children's health care, but without a sufficient infrastructure to do so. This is not a sustainable model, nor is it consistent with the one conceptualized during development of the Plan and Addendum. Given the resources provided by the state to Select Health for the management of children's health care, and the lack of real improvement in ensuring that children's health care needs are being met, these issues must be addressed immediately.

Performance Data

As noted in previous monitoring reports, the Co-Monitors and DSS have been engaged in discussions about re-assessing the approved data methodologies for health care measures given the shared goal of efficiently and effectively producing understandable, timely performance data that can be used both for public and court

accountability purposes, and for day-to-day management and quality improvement. In some areas, as indicated, the data included for this monitoring period were collected by DSS's Regional Nurses from several sources and have not been independently validated by the Co-Monitors. DSS does not have the capacity to produce aggregate health care data related to initial health screens, mental health assessments (following a screening which identified a need for such an assessment),[166] and follow-up care.[167,168]

Health care data reporting timelines were adjusted this period to accommodate delays in access to Medicaid administrative data. In order to provide the most up-to-date information, some data points are reported for more recent months than others. For example, data on periodic well-child and dental visits are reported as of November 21, 2022. Data on initial comprehensive medical and dental visits are reported for all children who entered care between March and August 2022. All data throughout are labeled accordingly.

Comprehensive Medical Assessments

In accordance with American Academy of Pediatrics (AAP) guidelines for health care delivery to children in foster care, comprehensive medical assessments are to be performed for the purpose of "reviewing all available data and medical history about the child or adolescent;" identifying medical, developmental, and mental health conditions requiring immediate attention; and developing an "individualized treatment plan."[169]

In the DSS Health Care Outcomes, approved by the Co-Monitors on December 21, 2018, based on AAP guidelines, DSS committed that *"at least 85% of Class Members*

[166] DSS has provided data on the *total* number of children who receive mental health assessments, but those assessments are not tied to an identified need for a mental health assessment from a comprehensive medical assessment. DSS is not yet able to report data on the number of children receiving mental health assessments after the *need* for such an assessment has been identified. As a result, the Co-Monitors have not reported these data.

[167] DSS has proposed a methodology for measuring follow-up care through a qualitative review process and has taken steps to pull initial related information upon request by the Co-Monitors. An update on the review methodology and any resulting data will be reported in the following monitoring report.

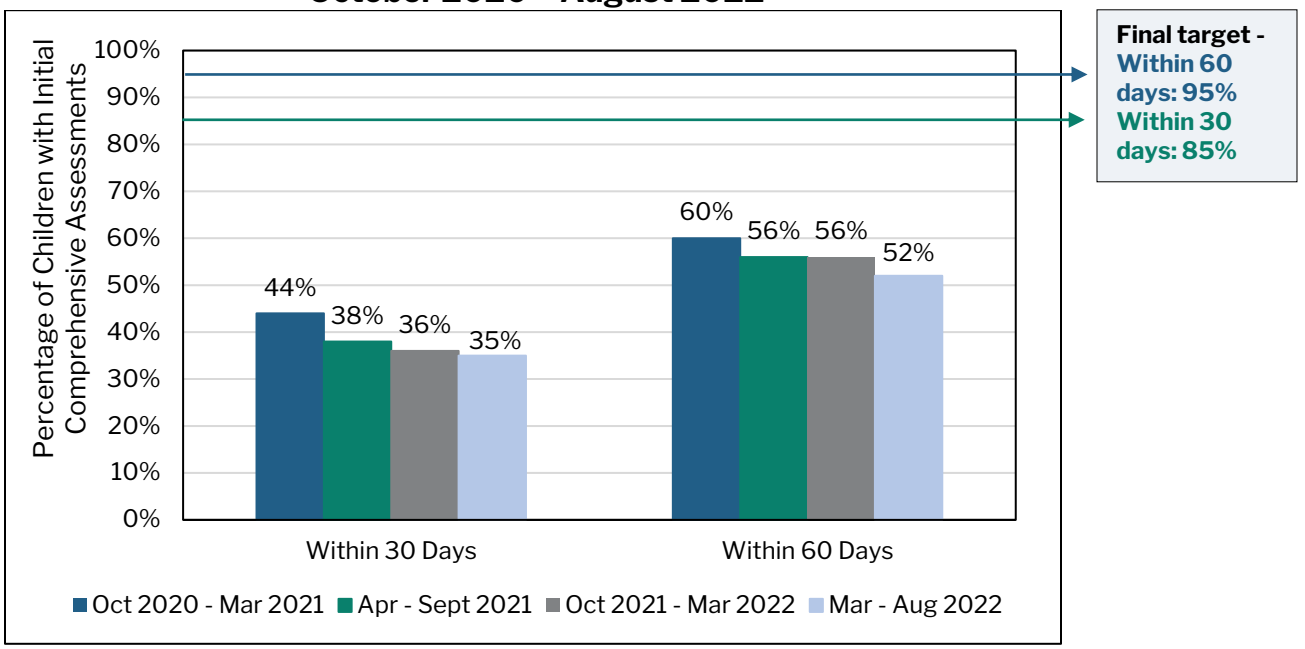
[168] DSS reports that a medical module, added to the FAST as of November 10, 2022, serves as an initial health screening tool for children entering foster care. DSS ADR is currently teaming with CAPSS IT to extract necessary data collected from the completion of this tool to begin analyzing beginning in the April-September 2023 monitoring period. Further, DSS has proposed collecting additional qualitative information using a case review process to measure follow-up care, based on the instrument used for the CFSR, and is currently discussing review design with the Co-Monitors

[169] *Fostering Health: Health Care for Children and Adolescents in Foster Care*, 2d. ed (16-17). American Academy of Pediatrics (2003)), p. 22.

will receive a comprehensive medical assessment within 30 days of entering care; at least 95% will receive a comprehensive medical assessment within 60 days of entering care."[170] DSS committed to achieving these targets by March 2021.[171]

DSS reports that 35 percent (363 of 1,030) of children who entered foster care between March 1 and August 31, 2022, and were in foster care for at least 30 days received an initial comprehensive medical assessment within 30 days, and 52 percent (380 of 738) of children who entered foster care this period and were in foster care for at least 60 days received an initial comprehensive medical assessment within 60 days (see Figure 29). This performance is slightly lower than the prior monitoring period when performance was 36 percent within 30 days and 56 percent within 60 days. Performance remains significantly below the final targets of 85 percent of children receiving an initial exam within 30 days, and 95 percent of children receiving an initial exam within 60 days. The Co-Monitors and DSS are closely tracking performance in this area.

Figure 29: Initial Comprehensive Medical Assessments within 30 and 60 Days October 2020 – August 2022



Source: Medicaid claims data provided by DSS

[170] The Health Care Outcomes are available at: https://dss.sc.gov/media/1958/appendix-b-final-health-care-targets.pdf

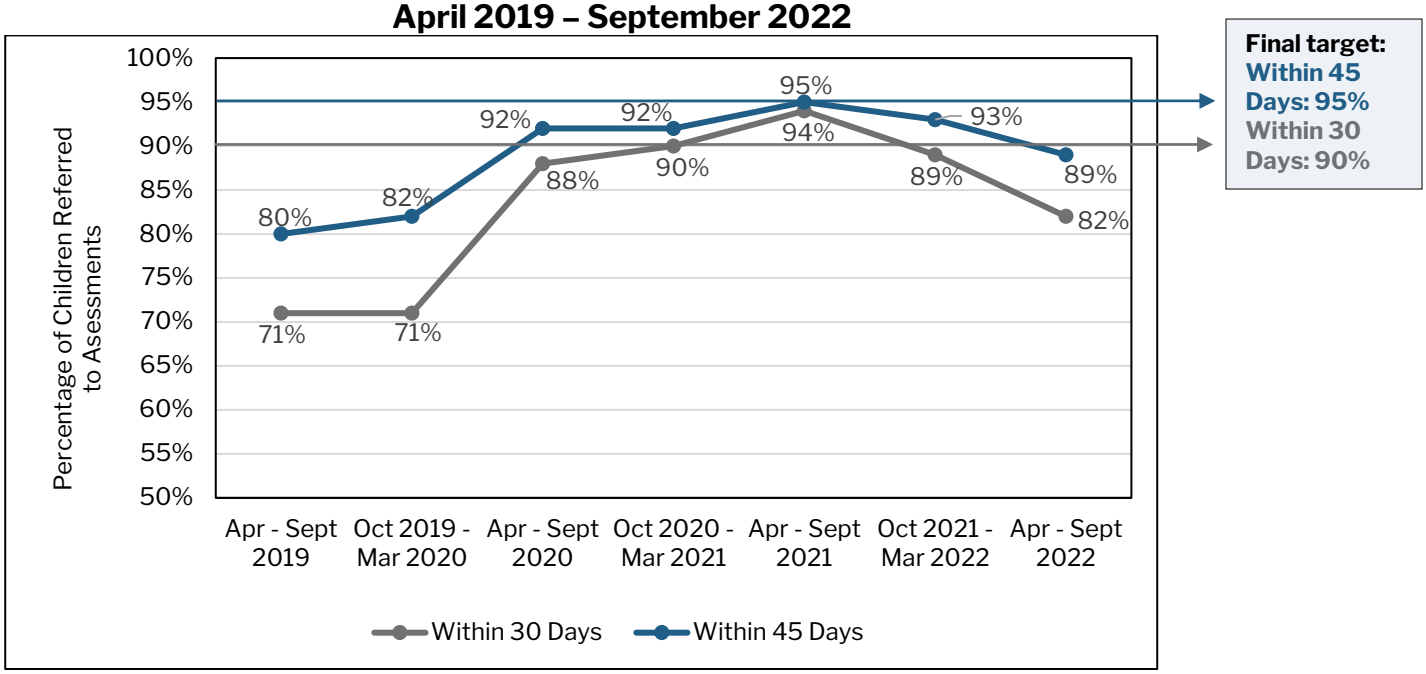
[171] The baseline performance data that were used to determine the benchmarks were in some cases extracted based upon methodologies that were different from those later approved by the Co-Monitors.

Developmental Assessments

In the DSS Health Care Outcomes, DSS committed that "*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; at least 95% shall be referred within 45 days.*" DSS committed to achieving these targets by March 2021.

DSS reports that 82 percent (262 of 319) of children under 36 months of age who entered care between April 1 and September 30, 2022 and were in care for at least 30 days were referred to BabyNet – the state entity responsible for developmental assessments – within 30 days of their entry into care; and 89 percent (270 of 302) of children who were in care for at least 45 days were referred to BabyNet within 45 days. Current performance represents a decrease from the prior monitoring period and a significant decline from the previous year when the final targets for this measure were met for the first time (see Figure 30). These data only measure whether a child was referred for a developmental assessment and do not capture whether an assessment occurred.

Figure 30: Referrals for Developmental Assessments within 30 and 45 Days April 2019 – September 2022



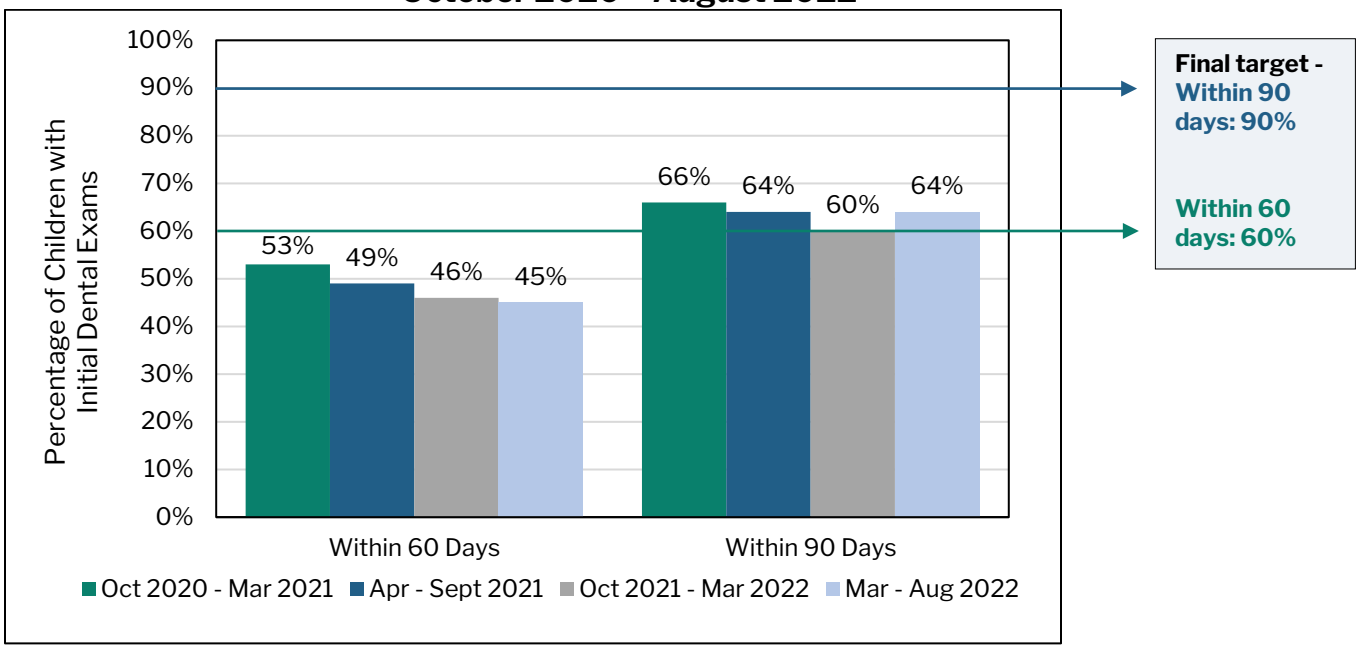
Source: CAPSS data provided by DSS

Initial Dental Examinations

In the DSS Health Care Outcomes, approved by the Co-Monitors on December 21, 2018, DSS committed that *"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; at least 90% will receive a dental examination within 90 days of entering care*." DSS committed to achieving these targets by March 2021.[172]

DSS reports that 45 percent (239 of 526) of children ages two and older who entered foster care between March 1 and August 31, 2022, and were in foster care for at least 60 days had a dental exam within 60 days, and 64 percent (255 of 401) of children ages two and older who remained in care for at least 90 days had a dental exam within 90 days.[173] This performance is comparable to the prior monitoring period, with a slight improvement in the 90-day figure, but does not meet the target for either requirement, as shown in Figure 31.

Figure 31: Initial Dental Exams within 60 and 90 Days
October 2020 – August 2022



Source: Medicaid claims data provided by DSS

[172] The baseline performance data that was used to determine the benchmarks were in some cases extracted based upon methodologies that were different from those later approved by the Co-Monitors.
[173] This excludes children who had a visit within 3 months of entering care.

Periodic Well-Child Visits

In accordance with AAP guidelines for ongoing health care delivery for children in foster care, periodic preventative well-child visits should be performed for the purpose of promoting "overall wellness by fostering healthy growth and development," as well as "regularly assess[ing] for success of foster care placement," and "identify[ing] significant medical, behavioral, emotional, developmental, and school problems through periodic history, physical examination, and screenings."[174] AAP guidelines for health care delivery for children in foster care recognize the increased needs of these children and youth as compared with the general population. Based on these guidelines, DSS committed in its Health Care Outcomes that, *"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. 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;[175] at least 98% will receive a periodic preventative visit semi-annually. 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; at least 98% will receive a periodic preventative visit annually."[176]* DSS committed to achieving these targets by March 2021.

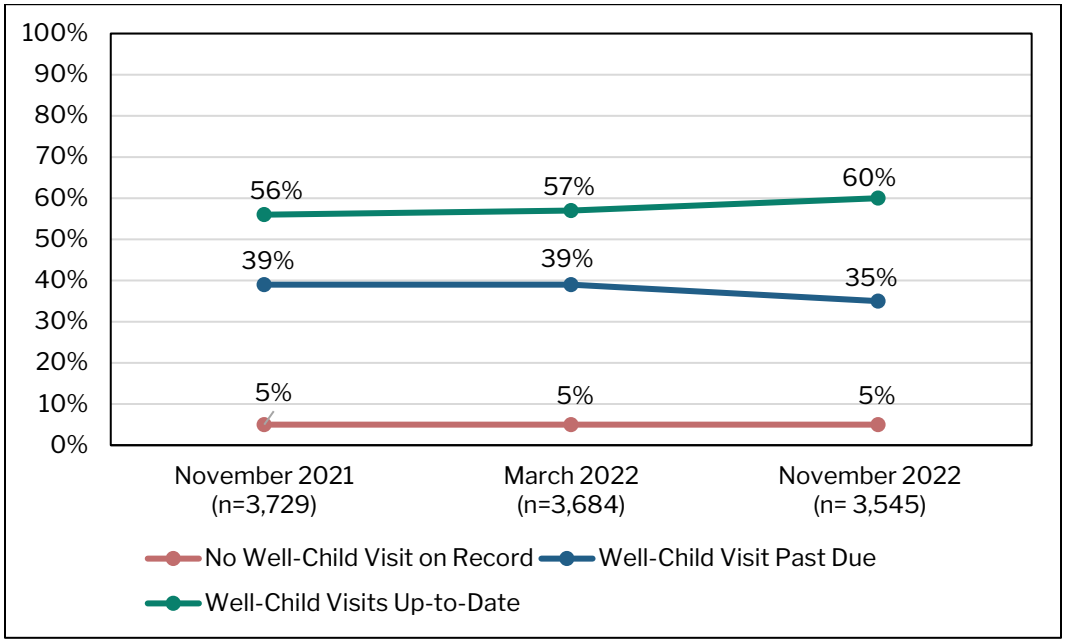
The Co-Monitors have continued to work with DSS to understand the best methods to efficiently and effectively produce understandable, timely performance data on periodic preventative well-child visits that can be used both for public and court accountability purposes, and for day-to-day management and quality improvement. The data used for day-to-day management by DSS is validated by DSS nurses who review CAPSS for encounters entered by case managers and after-visit summaries completed by doctors. Data are also cross-checked with administrative data from DHHS and Select Health. DSS's ADR reviews encounters to see whether they are verified by more than one source.

DSS reports that of all children under 18 years of age who were in foster care for at least 30 days as of September 30, 2022, 60 percent (2,112 of 3,545) were up-to-date

[174] *Fostering Health: Health Care for Children and Adolescents in Foster Care*, 2d. ed (16-17). American Academy of Pediatrics (2003), p. 30.
[175] See AAP Recommendations for Preventative Pediatric Health Care, which can be found at https://www.aap.org/enus/Documents/periodicity_schedule.pdf
[176] These guidelines are based on AAP's recommendations for children in foster care as described in *Fostering Health: Health Care for Children and Adolescents in Foster Care*, 2d. ed (16-17). American Academy of Pediatrics (2003).

on their well-child visits as of November 21, 2022, an improvement from the prior period, when 57 percent of children were up-to-date. Of the remaining children, 190 (5%) children did not have a well-child visit on record. As depicted in Figure 32, 35 percent (1,243 of 3,545) of children were past due on their well-child visits.

Figure 32: Well-Child Visits
November 2021 – November 2022



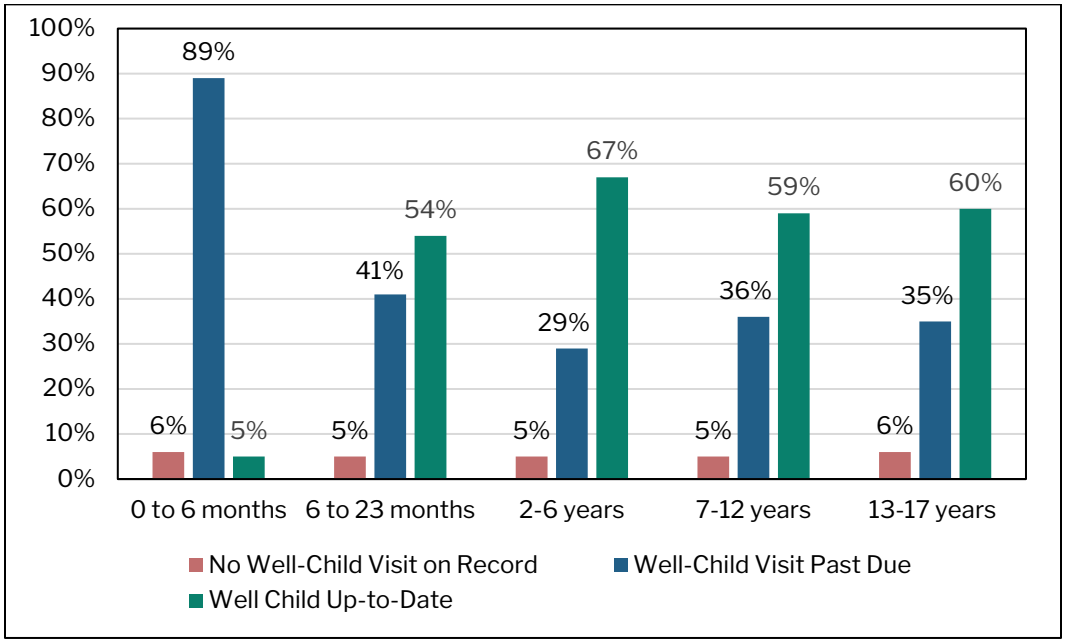
Source: CAPSS, DHHS, and Select Health data provided by DSS

These data are also reported to the Co-Monitors by age group. As of November 2022, only five percent of children birth to six months old were up-to-date on their well-child visits, a decline from 21 percent in March 2022, as seen in Figure 33. There was also a higher number of children birth to six months old with no well-child visits on record, from one percent (1 of 75 children) in March 2022 to six percent (5 of 79 children) in November 2022. This performance is of significant concern to the Co-Monitors.

Compared to the prior monitoring period, a greater percentage of children older than six months were up-to-date on their well-child visits. The percentage of children ages six to 23 months who were up-to-date on well-child visits increased from 44 percent in March 2022 to 54 percent in November 2022. For children ages two to six years old, the percentage of those who were up-to-date on well-child visits increased from 62 percent in March 2022 to 67 percent in November 2022. For children ages seven to 12 years old, performance improved from 56 percent to 59 percent, and for ages

13 to 17 years old, there was a slight increase in up-to-date visits from 58 percent to 60 percent.

Figure 33: Well-Child Visits by Age as of November 21, 2022
N=3,545



Source: CAPSS, DHHS, and Select Health data provided by DSS

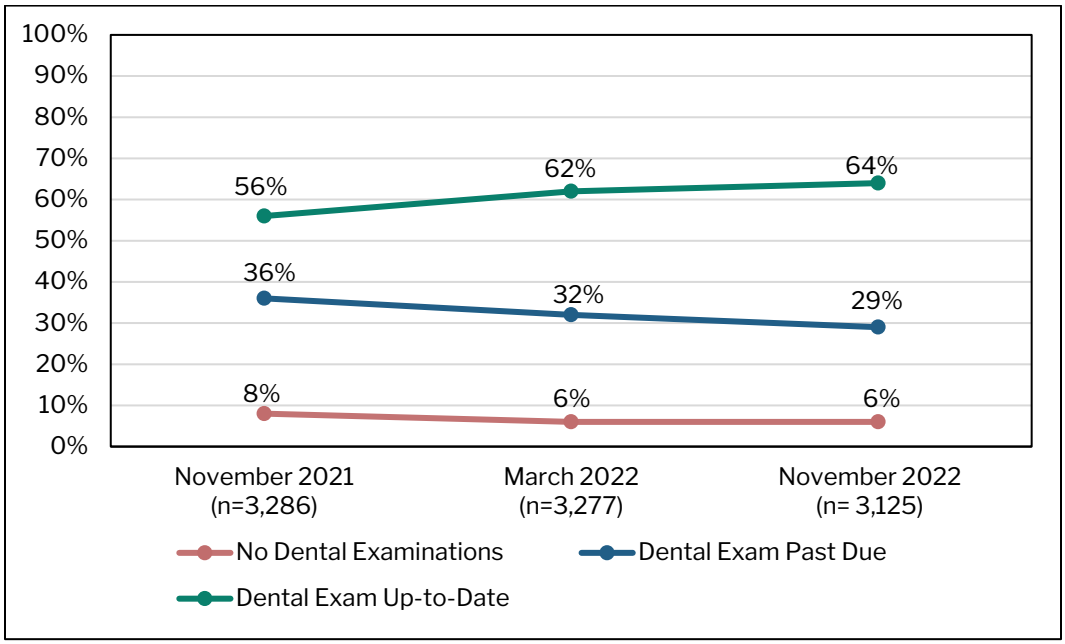
Periodic Dental Examinations

In the DSS Health Care Outcomes, DSS also committed that "*at least 75% of Class Members ages two and older in care for six months or longer will receive a dental examination semi-annually; at least 90% will receive a dental examination annually.*" DSS committed to achieving these outcomes by March 2021.

DSS reports that of the children between two and 17-years-old who were in care for at least 30 days, 64 percent (2,015 of 3,125) were up-to-date on their semi-annual dental examination as of November 21, 2022. As shown in Figure 34, 29 percent (913 of 3,125) were past due for their dental exam and six percent of children (197 of 3,125) had no dental examination on record.[177] This is slightly improved performance from the prior monitoring period, when 62 percent of children were up-to-date on their semi-annual dental examinations.

[177] These data were collected and analyzed by DSS staff for internal management purposes and have not been validated by the Co-Monitors.

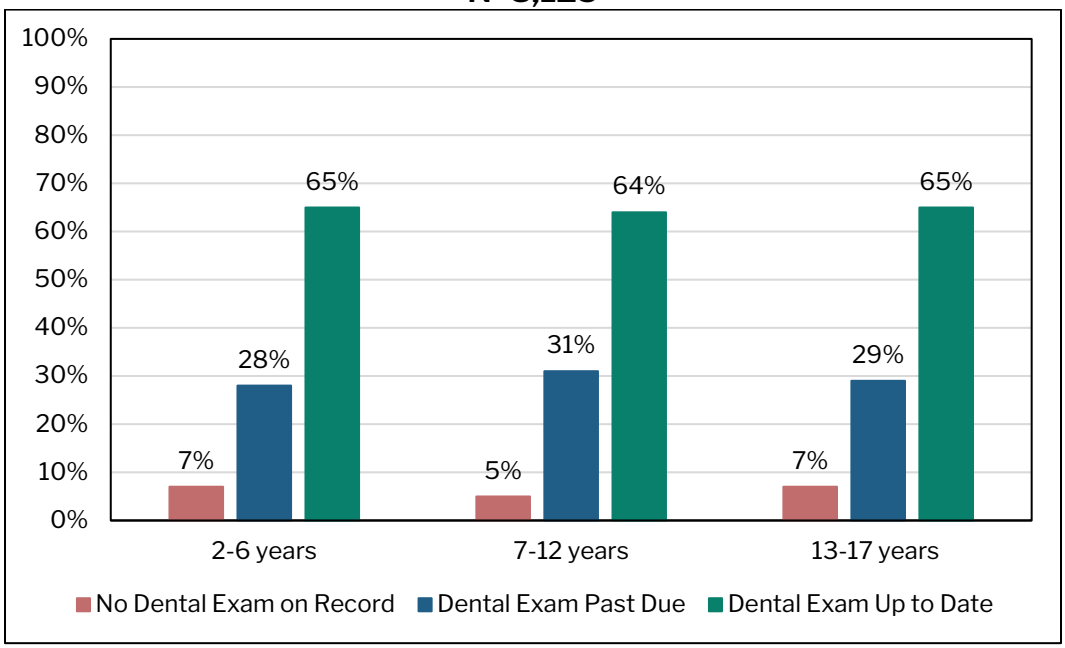
Figure 34: Periodic Dental Examinations
November 2021 – November 2022



Source: CAPSS, DHHS, and Select Health data provided by DSS

DSS also provided their internal management data for dental examinations by age group, as seen in Figure 35. These data did not show much disparity by age – about 65 percent of children in each age group are up-to-date on their dental examinations, and between 28 and 31 percent of children in all age groups are past due on their dental exams. Performance for children ages seven to 12 years is comparable to the prior monitoring period, but the youngest children (ages two to seven years old) and the oldest children (13 to 17 years old) showed some improvement in having dental exams up-to-date, up from 60 percent in March 2022.

Figure 35: Periodic Dental Examinations by Age as of November 21, 2022
N=3,125



Source: CAPSS, DHHS, and Select Health data provided by DSS

Appendix A – Glossary of Acronyms

AAP: American Academy of Pediatrics
ADR: The Office of Accountability, Data, and Research
APS: Adult Protective Services
BSW: Bachelor's Degree in Social Work
CAAP: Coach Approach to Adaptive Leadership Model
CAC: Child Advocacy Center
CAIP: Child and Adult Information Portal
CAPSS: Child and Adult Protective Services System
CANS: Child Assessment of Needs and Strengths
CFT: Child and Family Teaming
CFSR: Child and Family Services Review
CMS: Centers for Medicare and Medicaid Services
CPA: Child Placing Agency
CPS: Child Protective Services
CQI: Continuous Quality Improvement
CWS: Child Welfare Services
CY: Calendar Year
DDSN: Department of Disability and Special Needs
DHHS: Department of Health and Human Services
DMH: Department of Mental Health
DJJ: Department of Juvenile Justice
DSS: Department of Social Services
FAST: Family Advocacy and Support Tool
FES: Family Engagement Specialist
FFCRA: Families First Coronavirus Response Act
FFPSA: Family First Prevention Services Act
FFTA: Family First Transition Act
FMAP: Federal Medical Assistance Percentage
FSA: Final Settlement Agreement
FY: Fiscal Year
GAL: Guardian Ad Litem
GPS: Guiding Principles and Standards Case Practice Model
HRSN: Health-Related Social Needs
ICPC: Interstate Compact on the Placement of Children
ILOS: In Lieu of Services and Settings
ILT: Instructor-Led Training
IO: Interim Order

MCO: Managed Care Organization
MIT: Massachusetts Institute of Technology
MSW: Master's Degree in Social Work
OHAN: Out-of-Home Abuse and Neglect Unit
OJT: On-the-Job Training
PMA: Office of Performance Management and Accountability
PRTF: Psychiatric Residential Treatment Facility
QA: Quality Assurance
QRTP: Qualified Residential Treatment Program
SACWIS: State Automated Child Welfare Information System
SDM: Structured Decision Making
SNAP: Supplemental Nutrition Assistance Program
TANF: Temporary Assistance for Needy Families
TPR: Termination of Parental Rights
UNC: University of North Carolina
U of SC: University of South Carolina
U of SC CCFS: University of South Carolina's Center for Child and Family Studies

Appendix B – Monitoring Activities

The Co-Monitors are responsible for independent validation 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 use multiple methodologies to conduct their work, including verification and analysis of information available through CAPSS; review of individual electronic case records of Class Members; review and validation of data aggregated by DSS; interviews and conversations with DSS leaders and staff; and conversations with external stakeholders, including providers, advocates, and community organizations. The Co-Monitors worked with DSS to establish review protocols to gather performance data and assess current practice for some measures. The Co-Monitors engaged in video interviews with case managers, supervisors, county directors, other DSS staff, and a range of stakeholders throughout the monitoring period.

Other 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, adoption, and Out-of-Home Abuse and Neglect (OHAN) case managers 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 Intake Hub and OHAN (FSA IV.C.2.);

- Review of all OHAN investigation case records in CAPSS involving Class Members as an alleged victim accepted in September 2022, 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 Class Members identified by both DSS and stakeholders as involved with the South Carolina Department of Juvenile Justice (DJJ) to assess whether DJJ placement was in violation of the FSA (FSA IV.H.1.);

- Review of case files of Class Members ages six and under who were placed in a congregate care setting from April 1 to September 30, 2022 (FSA IV.D.2.);

- Review of case files of Class Members reported to have remained in a DSS office overnight from April 1 to September 30, 2022 (FSA IV.D.3.);

- Engagement in joint review of Class Members concurrently involved in both DSS and DJJ;[178]

- On-site visit to SC DSS for meetings with leadership and staff.

[178] To see the Joint Review of Children Concurrently Involved with South Carolina Department of Juvenile Justice and Department of Social Services, go to: https://cssp.org/wp-content/uploads/2022/10/FINAL-Children-Concurrently-Involved-with-SC-DJJ-and-DSS-Joint-Review-Findings-002.pdf

Appendix C – Summary Table of Michelle H., et al. v. McMaster and Leach Final Settlement Agreement Performance

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Workload Limits for Foster Care: 1a. At least 90% of caseworkers[179] shall have a workload within the applicable Workload Limit. 1b. No caseworker shall have more than 125% of the applicable Workload Limit. (FSA IV.A.2.(b)&(c))	OHAN investigators: 0% within required limit. (September 2017) 100% had more than 125% of the limit. (September 2017) Foster Care case managers: 28% within the required limit. (September 2017)	OHAN investigators: 41% within the required limit Monthly range within the required limit: 8 – 41% 35% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 35 – 86% Foster Care case managers: 44% within the required limit	OHAN investigators: 37% within the required limit Monthly range within the required limit: 24 – 47% 37% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 24 – 53% Foster Care case managers: 42% within the required limit	OHAN investigators:[184] 75% within the required limit Monthly range within the required limit: 29 – 95% 0% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 0 – 35% Foster Care case managers: 51% within the required limit

[179] The FSA utilizes the term "caseworker" to refer to DSS case carrying staff. As part of its Case Practice Model development and outlining enhanced job expectations, DSS now utilizes the term "case manager." Where appropriate and for consistency with practice, this report will utilize the term case manager.

[184] The Co-Monitors selected a random day in each month this period to measure caseload compliance for each type of case manager and supervisor. These random dates are as follows: April 30, 2022; May 13, 2022; June 22, 2022; July 8, 2022; August 16, 2022; September 30, 2022.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Approved Workload Limits:[180,181] • *OHAN worker* - 8 investigations • *Foster care worker* – 15 children • *Adoption worker* – 15 children[182] • *New caseworker* – ½ of the applicable standard for first six months after completion of Child Welfare Pre-Service Certification Training	59% had more than 125% of the limit. (September 2017) IFCCS case managers:[183] 10% within the required limit. (September 2017) 77% had more than 125% of the limit. (September 2017)	Monthly range within the required limit: 44 – 54% 37% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 31 – 37%	Monthly range within the required limit: 40 – 48% 35% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 33 – 41%	Monthly range within the required limit: 43 – 51% 29% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 29 – 38%

[180] These limits were approved by the Co-Monitors on December 6, 2016, after completion of the Workload Study.
[181] Caseload limits and methodologies to calculate performance for case managers 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, APS cases, families involved in child protective service assessments, and children placed by ICPC. Performance for foster care case managers with mixed caseloads is calculated by adding the total number of foster care children (Class Members) the case manager serves to the total number of families (cases) of Non-Class Members the case manager also serves; the total number should not exceed 15 children and cases.
[182] Prior to 2019, DSS's workforce was structured so that case management responsibilities remained with the foster care case manager, even when an adoption case manager was assigned, until a placement agreement was signed. As a result, the approved caseload standard for adoption workers was 1:17. In 2019, DSS began transitioning case management responsibility to adoption workers once children became legally eligible for adoption. This transition was complete in January 2020; thus, adoption case manager caseload performance is assessed at a standard of 1:15, the same standard applied to foster care case managers.
[183] The IFCCS case manager and supervisor positions were eliminated as of January 2020, with staff positions and cases transferred to county foster care case manager and supervisor positions and caseloads in December 2019.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
	Adoption case managers: 23% within the required limit. (September 2017) 62% had more than 125% of limit. (September 2017)	Adoption case managers: 25% within the required limit Monthly range within the required limit: 14 – 25% 62% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 61 – 65%	Adoption case managers: 49% within the required limit Monthly range within the required limit: 21 – 49% 34% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 34 – 62%	Adoption case managers: 24% within the required limit Monthly range within the required limit: 24 – 49% 37% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 33 – 43%
Workload Limits for Foster Care: 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. (FSA IV.A.2.(b)&(c))	OHAN Supervisors: 100% within the required limit. (March 2018) None were more than 125% of the limit. (March 2018)	OHAN Supervisors: 75% within the required limit Monthly range within required limit: 67 – 100% 0% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 0 - 33%	OHAN Supervisors: 100% within the required limit each month this period 0% had more than 125% of the limit.	OHAN Supervisors: 100% within the required limit each month this period 0% had more than 125% of the limit.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Approved Supervisor Limits: • *OHAN supervisors* – 6 investigators • *Foster Care*, *IFCCS*,[185] and *Adoption* supervisors – 5 case managers	Foster Care Supervisors: 42% within the required limit. (March 2018) 36% had more than 125% of the limit. (March 2018) Adoption Supervisors: 38% within the required limit. (March 2018) 19% had more than 125% of the limit. (March 2018) IFCCS Supervisors:[186] 57% within required limit. (March 2018) 29% had more than 125% of the limit. (March 2018)	Foster Care Supervisors: 81% within the required limit Monthly range within the required limit: 81 – 83% 8% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 7 – 11% Adoption Supervisors: 74% within the required limit Monthly range within the required limit: 73 – 91% 9% had more than 125% of the limit.	Foster Care Supervisors: 86% within the required limit 4% had more than 125% of the limit. Adoption Supervisors: 82% within the required limit 9% had more than 125% of the limit.	Foster Care Supervisors: 90% within the required limit. Monthly range within the required limit: 86 – 91% 4% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 3 – 5% Adoption Supervisors: 90% within the required limit Monthly range within the required limit: 88 – 96% 0% had more than 125% of the limit.

[185] The IFCCS case manager position has been eliminated as of January 2020, with staff positions and cases transferred to county foster care case manager and supervisor positions and caseloads between September and December 2019.
[186] The IFCCS case manager and supervisor positions were eliminated as of January 2020, with staff positions and cases transferred to county foster care case manager and supervisor positions and caseloads in December 2019.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
		Monthly range supervising more than 125% of the limit: 5 – 9%		Monthly range supervising more than 125% of the limit: 0 – 9%
Visits Between Case Managers and Children: 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. (FSA IV.B.2.)	24% of cases reviewed had all agreed-upon elements of a visit. (September 2019)	34% of cases reviewed had documentation of all agreed-upon elements of a visit.[187,188]	Upon agreement of all Parties, the Co-Monitors suspended a review of a statistically valid sample of records and reporting on this measure for at least four monitoring periods, or until DSS reports there has been substantial increase in performance.	Upon agreement of all Parties, the Co-Monitors suspended a review of a statistically valid sample of records and reporting on this measure for at least four monitoring periods, or until DSS reports there has been substantial increase in performance.

[187] DSS, U of SC CCFS, and the Co-Monitors worked together to develop an instrument and reviewed a statistically valid sample of records for which there was indication in CAPSS that a case manager had face-to-face contact with a Class Member in the month of September 2021. Reviewers assessed documentation reflecting the elements which define a visit, as reflected in DSS policy and guidance on documentation, in the CAPSS dictation of the face-to-face contact. The goal for reporting on this measure is reliable, aggregate CAPSS data which reflect practices with children.

[188] A sample of 345 records, designed to produce results at a 95% confidence level with a +/- 5% margin of error was reviewed. Documentation from a statistically valid sample of DSS records from September 2021 shows contact between case managers and the focus child for all (345 of 345, or 100%) of the children reviewed.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Visits Between Case Managers and Children: 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. (FSA IV.B.3.)	22% of documented face-to-face contacts with children had all agreed upon elements of a visit and took place in the child's residence. (September 2019) 92% of face-to-face contacts took place in the child's residence. (September 2019)	26% of documented face-to-face contacts with children had all agreed upon elements of a visit and took place in the child's residence.[189,190] 80% of face-to-face contacts took place while the child was in their own residence or placement.	Upon agreement of all Parties, the Co-Monitors suspended a review of a statistically valid sample of records and reporting on this measure for at least four monitoring periods, or until DSS reports there has been substantial increase in performance.	Upon agreement of all Parties, the Co-Monitors suspended a review of a statistically valid sample of records and reporting on this measure for at least four monitoring periods, or until DSS reports there has been substantial increase in performance.

[189] DSS, U of SC CCFS, and the Co-Monitors reviewed a statistically valid sample of records for which there was indication in CAPSS that a case manager had face-to-face contact with a Class Member in the month of September 2021. Reviewers assessed documentation for the elements which define a visit.
[190] A sample of 345 records, designed to produce results at a 95% confidence level with a +/- 5% margin of error, was reviewed. Documentation from a statistically valid sample of DSS records from September 2021 shows contact between case managers and the focus child for all (345 of 345, or 100%) of the children reviewed.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Investigations - Intake: 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. (FSA IV.C.2.)	44% of screening decisions to not investigate were determined to be appropriate. (March 2017)	Between April and September 2021, 91% of screening decisions not to investigate were determined to be appropriate.	Between October 2021 and March 2022, 97% of screening decisions not to investigate were determined to be appropriate.	Between April and September 2022, 96% of screening decisions not to investigate were determined to be appropriate.
Investigations - Case Decisions: 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. (FSA IV.C.3.)	47% of applicable investigation decisions to unfound were determined to be appropriate. (March 2017)	72% (36) of 50 applicable investigation decisions to unfound were determined to be appropriate.	72% (36) of 50 applicable investigation decisions to unfound were determined to be appropriate.	86% (38) of 44 applicable investigation decisions to unfound were determined to be appropriate.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Investigations - Timely Initiation: 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. *Investigations - Contact with Alleged Child Victim:* 8. The investigation of a Referral of Institutional Abuse or Neglect must include face-to-face contact with the alleged victim within twenty-four (24) hours in at least 95% of investigations, with exceptions for good faith efforts approved by the Co-Monitors.[191] (FSA IV.C.4.((a)&(b))	78% of applicable investigations were timely initiated. (March 2017)	92% (49) of 53 applicable investigations were timely initiated.	80% (41) of 51 applicable investigations were timely initiated.	90% (46) of 51 applicable investigations were timely initiated.

[191] 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.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Investigations - Contact with Core Witnesses: 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. (FSA IV.C.4.(c))	27% of applicable investigations included contact with all necessary core witnesses. (March 2017)	50% (27) of 54 applicable investigations included contact with all necessary core witnesses.	51% (26) of 51 applicable investigations included contact with all necessary core witnesses.	67% (34) of 51 applicable investigations included contact with all necessary core witnesses.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Investigations - Timely Completion: 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.[192] (FSA IV.C.4.(d)) ***Final target by March 2021: 95% closure in 45 days***	95% of applicable investigations reviewed were appropriately closed within 45 days. (March 2017)	96% of investigations reviewed were appropriately closed within 45 days.	93% of investigations reviewed were appropriately closed within 45 days.	95% of investigations reviewed were appropriately closed within 45 days.

[192] For the purposes of this measure, an investigation is not completed if DSS determines the report is unfounded because the deadline to complete the investigation has passed.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Investigations - Timely Completion: 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.[193] (FSA IV.C.4.(e)) ***Final target by March 2021: 95% closure in 60 days***	96% of investigations reviewed were closed within 60 days. (March 2017)	98% of investigations reviewed were closed within 60 days.	100% of investigations reviewed were closed within 60 days.	100% of investigations reviewed were closed within 60 days.

[193] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Investigations - Timely Completion: 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.[194] (FSA IV.C.4.(f))	93% of investigations reviewed were closed within 90 days. (September 2017)	98% of investigations reviewed were closed within 90 days.	100% of investigations reviewed were closed within 90 days.	100% of investigations reviewed were closed within 90 days.
Family Placements for Children Ages Six and Under: 11. No child age six and under shall be placed in a congregate care setting except with approved exceptions. (FSA IV.D.2.)	Baseline data for this measure are not available.	The circumstances of all but 4 children met an agreed upon exception. A total of 25 Class Members ages six and under were placed in congregate care.	The circumstances of all but 4 children met an agreed upon exception. A total of 16 Class Members ages six and under were placed in congregate care.	The circumstances of all children met an agreed upon exception. A total of 16 Class Members ages six and under were placed in congregate care.

[194] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Phasing-Out Use of DSS Offices and Hotels: 12. No child shall be placed or housed in a DSS office, hotel, motel, or other commercial non-foster care establishment.	Baseline data for this measure are not available.	DSS reports there were 68 overnight placements in a DSS office (for 34 unique children).	DSS reports there were 273 overnight placements in a DSS office (for 107 unique children).	DSS reports there were 53 overnight placements in a DSS office (for 28 unique children).
Congregate Care Placements: 13. At least 86% of the Class Members shall be placed outside of Congregate Care Placements on the last day of the Reporting Period. (FSA IV.E.2.)	78% of children in foster care were placed outside of a congregate care setting. (March 2018)	86% of children in foster care were placed outside of a congregate care setting.	86% of children in foster care were placed outside of a congregate care setting.	87% of children in foster care were placed outside of a congregate care setting.[195]

[195] This does not include 22 children who were hospitalized (9), in a correctional/juvenile justice facility (12), or in a DDSN Residential Facility (1).

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Congregate Care Placements - Children Ages 12 and Under: 14. At least 98% of the Class Members 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.)	92% of children ages 12 and under in foster care were placed outside of a congregate care setting. (March 2018)	99% of children ages 12 and under in foster care were placed outside of a congregate care setting.	98% of children ages 12 and under in foster care were placed outside of a congregate care setting.	99%[196] of children ages 12 and under in foster care were placed outside of a congregate care setting.[197]
Emergency or Temporary Placements for More than 30 Days: 15. Class Members shall not	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	6 children remained in an Emergency or Temporary Placement for more than thirty (30) days.[198]

[196] This includes eight children ages 6 and under and four children ages 7 to 12 who resided in congregate care placements on the last day of the monitoring period pursuant to a valid exception.
[197] This does not include five children who were hospitalized on the last day of the monitoring period.
[198] DSS reports inconsistent entry of emergency placements into CAPSS between October 2021 and March 2022. As technological processes continue to be enhanced, data may be updated in subsequent reports.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
remain in any Emergency or Temporary Placement for more than thirty (30) days. (FSA IV.E.4.) ***Dates to reach final target and interim benchmarks to be added once approved.***				
<u>*Emergency or Temporary Placements for More than Seven Days:*</u> 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. (FSA IV.E.5.) ***Dates to reach final target and interim benchmarks to be added once approved***.	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	Of the 67 children who experienced an Emergency or Temporary Placement in the month of September and had experienced an additional Emergency or Temporary Placement in the prior 12 months, 20 children experienced a subsequent Emergency or Temporary Placement for more than seven (7) days.[199]

[199] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Placement Instability: 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. (FSA IV.F.1.)	3.55 moves per 1,000 days. (October 1, 2016 to September 30, 2017).	4.64 moves per 1,000 days. (October 1,2020 to September 30,2022).	Data for this measure are produced on an annual basis.	5.70 moves per 1,000 days. (October 1, 2021 to September 30, 2022).
Sibling Placements: 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 an exception applies (FSA IV.G.2.&3.)	63% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry. (March 2018)	70% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry.	74% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry.	76% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry.[200]

[200] 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 in a future monitoring period.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Sibling Placements: 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 an exception applies.	38% of children entering foster care with siblings were placed with all their sibling on the 45th day after entry. (March 2018)	45% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry.	53% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry.	48% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry.[201]
Youth Exiting the Juvenile Justice System: 20. When Class Members are placed in juvenile justice detention or another Juvenile Justice Placement, DSS shall not	Baseline data for this measure are not available.	Data are not available for this period	Data are not available for this period.	Data are not available for this period.[202]

[201] Ibid.

[202] As discussed in Section VIII. *Placements,* the limited quantitative data available has made tracking performance in this area a challenge, and the Co-Monitors have historically had to rely significantly on anecdotal reports by stakeholders to assess performance. In November 2022, the Co-Monitors and DSS, with DJJ's permission and collaboration, published a report of findings from their joint comprehensive review of the experiences of children dually involved with both DSS and DJJ, accessible here: https://cssp.org/wp-content/uploads/2022/10/FINAL-Children-Concurrently-Involved-with-SC-DJJ-and-DSS-Joint-Review-Findings-002.pdf). This review and report have been an important collaboration, and a key step in identifying some of the barriers to meeting the needs of many of the children in DSS care who present with high levels of need. DSS will be working with the Co-Monitors, DJJ, and its system partners to develop and test practices that address these findings in the coming months. The Co-Monitors will also be working with DSS, in light of review findings, on ways to improve tracking and performance with respect to the specific FSA requirement in this area. Updates will be included in upcoming monitoring reports.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
recommend to the family court or DJJ 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. (FSA IV.H.1.)				

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Therapeutic Foster Care Placements - Referral for Staffing and/or Assessment: 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. (FSA IV.I.2.) ***Dates to reach final target and interim benchmarks to be added once approved***.	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	Data are not available for this period.[203]

[203] At the time of finalization of the Placement Implementation Plan, the Co-Monitors and Parties determined that, because the process of assessing and identifying the need for more intensive supports and placements would likely be modified as DSS began to implement its Placement Implementation Plan, DSS would wait to propose benchmarks and timelines until implementation began. As discussed in Section VIII. *Placements*, DSS produced initial data related to the FSA requirements for the first time this monitoring period. DSS and the Co-Monitors are in the process of analyzing these data and discussing alternative ways of measuring performance in future periods to allow for a more comprehensive understanding of how children's underlying needs are assessed, and the extent to which supports and services to meet these needs are provided.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Therapeutic Foster Care Placements - Receipt of Recommendations for Services or Placement: 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. (FSA IV.I.3.) ***Dates to reach final target and interim benchmarks to be added once approved***.	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	Data are not available for this period.[204]

[204] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Therapeutic Foster Care Placements - Level of Care Placement: 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. (FSA IV.I.4.) ***Dates to reach final target and interim benchmarks to be added once approved***.	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	Data are not available for this period.[205]

[205] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Therapeutic Foster Care Placements - Level of Care Placement: 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. (FSA IV.I.5.) ***Dates to reach final target and interim benchmarks to be added once approved***.	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	Data are not available for this period.[206]

[206] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Family Visitation - Siblings 24. At least 85% of the total minimum number of monthly sibling visits for all siblings not living together shall be completed, unless an exception applies. (FSA IV.J.2.)	66% of all required visits between siblings occurred for those who were not placed together. (March 2018)	50% of all required visits between siblings occurred for those who were not placed together.[207]	Upon agreement of all Parties, the Co-Monitors suspended a review of a statistically valid sample of records and reporting on this measure for at least four monitoring periods, or until DSS reports there has been a substantial increase in performance.	Upon agreement of all Parties, the Co-Monitors suspended a review of a statistically valid sample of records and reporting on this measure for at least four monitoring periods, or until DSS reports there has been a substantial increase in performance.[208]

[207] Data are from a CAPSS record review conducted by USC CCFS, Co-Monitor, and DSS staff of a statistically valid sample designed to produce results at a 95% confidence level with a +/- 5% margin of error.

[208] DSS is working with staff on multiple levels to improve performance in this area and does not believe there has yet been significant improvement. With implementation of SafeMeasures®, expected to begin in April 2023, DSS expects to produce reliable data reports on children's visits with their siblings and parents and eliminate the need for a review of case records. The Co-Monitors and DSS have discussed utilizing SafeMeasures® reports, along with the results of a review of records to the Court and Parties on performance for the period ending September 30, 2023, in order to inform an ongoing plan for measuring performance in this area.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Family Visitation - Parents: 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 an exception applies. (FSA IV.J.3.)	12% of children with a permanency goal of reunification visited twice with the parent(s) with whom reunification was sought. (March 2018)	17% of children with a permanency goal of reunification visited twice with the parent(s) with whom reunification was sought.[209]	Upon agreement of all Parties, the Co-Monitors suspended a review of a statistically valid sample of records and reporting on this measure for at least four monitoring periods, or until DSS reports there has been a substantial increase in performance.	Upon agreement of all Parties, the Co-Monitors suspended a review of a statistically valid sample of records and reporting on this measure for at least four monitoring periods, or until DSS reports there has been a substantial increase in performance.[210]

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

[210] DSS is working with staff on multiple levels to improve performance in this area and does not believe there has yet been significant improvement. With implementation of SafeMeasures®, expected to begin in April 2023, DSS expects to produce reliable data reports on children's visits with their siblings and parents and eliminate the need for a review of case records. The Co-Monitors and DSS have discussed utilizing SafeMeasures® reports, along with the results of a review of records to the Court and Parties on performance for the period ending September 30, 2023, in order to inform an ongoing plan for measuring performance in this area.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Health Care - Immediate Treatment Needs: 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 with Immediate Treatment Needs (physical/medical, dental, or mental health) for which treatment is overdue. (FSA IV.K.4.(b))	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.[211]

[211] FSA IV.K.4.(b)). required that by August 31, 2016, DSS "identify Class Members with Immediate Treatment Needs (physical/medical, dental, or mental health) for which treatment is overdue." Though initially intended to apply to children in DSS custody at the time of entry into the agreement in October 2016, DSS has lacked a mechanism for measuring performance with respect to this requirement. On October 28, 2019, DSS and Plaintiffs entered into the Joint Agreement on the Immediate Treatment Needs of Class Members (Dkt. 162) which set out a timeline for specific action steps DSS would take to comply with, and ultimately measure performance with respect to, a new set of standards that would replace the initial FSA IV.K.4(b) requirements.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 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.***[212]	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.[213]

[212] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, DSS was to present approvable interim benchmarks for Initial Medical Screens and Initial Mental Health Assessments to the Co-Monitors by May 31, 2020. Given the delay in production of baseline data, benchmarks have not yet been proposed.

[213] DSS reports that it will be able to reliably collect and report these data once data from the new Medical Module in the FAST/CANS has been collected, analyzed and successfully tested for the measure.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Health Care - Initial Comprehensive Assessments 28. At least 85% of Class Members will receive a comprehensive medical assessment within 30 days of entering care.	36% of children received a comprehensive medical assessment within 30 days. (March 2019)	38% of children received a comprehensive medical assessment within 30 days.	36% of children received a comprehensive medical assessment within 30 days.	35% of children received a comprehensive medical assessment within 30 days.[214]
Health Care - Initial Comprehensive Assessments 29. At least 95% of Class Members will receive a comprehensive medical assessment within 60 days of entering care.	52% of children received a comprehensive medical assessment within 60 days. (March 2019)	56% of children received a comprehensive medical assessment within 60 days.	56% of children received a comprehensive medical assessment within 60 days.	52% of children received a comprehensive medical assessment within 60 days.[215]

[214] As discussed in Section X. *Health Care*, these data are based on Medicaid claims and have not been independently validated by the Co-Monitors.
[215] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Health Care - Initial Mental Health Assessments 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. ***Dates to reach final target and interim benchmarks to be added once approved.***	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.[216]

[216] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, these data were to be reported for all children entering DSS custody between October 2019 and March 2020. DSS has provided data on the *total* number of children who receive mental health assessments, but those assessments are not tied to an identified need for a mental health assessment. DSS is not yet able to report data on the number of children receiving mental health assessments after the *need* for such an assessment has been identified. As a result, the Co-Monitors have not reported these data.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Health Care - Initial Mental Health Assessments 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.***	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.[217]

[217] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Health Care –Referral to Developmental Assessments 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.	19% of children under 36 months of age were referred within 30 days. (July-December 2017)	94% of children under 36 months of age were referred within 30 days.	89% of children under 36 months of age were referred within 30 days.	82% of children under 36 months of age were referred within 30 days.
Health Care –Referral to Developmental Assessments 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.	20% of children under 36 months of age were referred within 45 days. (July to December 2017)	95% of children under 36 months of age were referred within 45 days.	93% of children under 36 months of age were referred within 45 days.	89% of children under 36 months of age were referred within 45 days.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Health Care – Initial Dental Examinations 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.	35% of children age one and above received a dental exam within 60 days. (March 2018)	49% of children ages two and above received a dental exam within 60 days.	46% of children ages two and above received a dental exam within 60 days.	45% of children ages two and above received a dental exam within 60 days.[218]
Health Care – Initial Dental Examinations 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.	48% of applicable children age one and above received a dental exam within 90 days. (March 2018)	64% of applicable children ages two and above received a dental exam within 90 days.	60% of applicable children ages two and above received a dental exam within 90 days.	64% of applicable children ages two and above received a dental exam within 90 days.[219]

[218] As discussed in Section X. *Health Care*, these data are based on Medicaid claims and have not been independently validated by the Co-Monitors.
[219] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Health Care – Periodic Preventative Care (Well visits) 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.	49% (40) of 82 children under the age of six months received a periodic preventative visit monthly. (March 2019) 30% (42) of 137 children under the age of six months who entered care between October 1, 2018 and March 31, 2019 received a periodic preventative visit monthly.	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*
Health Care - Periodic Preventative Care (Well visits) 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 (AAP) periodicity guidelines.	38% of children between the ages of six and 36 months received periodic preventative visits in accordance with the periodicity schedule. (March 2019)	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Health Care – Periodic Preventative Care (Well visits) 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.	62% of children between the ages of six and 36 months received a periodic preventative visit semi-annually. (March 2019)	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*
Health Care – Periodic Preventative Care (Well visits) 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.	12% of children ages three years and older received a periodic preventative visit semi-annually. (March 2019)	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
Health Care – Periodic Preventative Care (Well visits) 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.	58% of children ages three years and older received an annual preventative visit. (March 2019)	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*
Health Care – Periodic Dental Care 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.	54% of children ages two years or older received a dental exam semi-annually. (March 2019)	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2021 Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**
<u>*Health Care – Periodic Dental Care*</u> 42. At least 90% of Class Members ages two and older in care for six months or longer will receive a dental examination annually.	81% of children ages two years or older received an annual dental examination. (March 2019)	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*
<u>*Health Care - Follow-Up Care*</u> 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.***[220]	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.[221]

[220] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, DSS was to present approvable interim benchmarks to the Co-Monitors by November 30, 2019.
[221] DSS has proposed a methodology for measuring follow-up care through a qualitative review process and has taken steps to pull initial related information upon request by the Co-Monitors. An update on review methodology and any resulting data will be reported in the next monitoring report.