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

October 1, 2023 - March 31, 2024

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Published October 2, 2024

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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 October 1, 2023 through March 31, 2024.[2] Approved by the United States District Court on October 4, 2016, the FSA includes requirements for the care and treatment of the approximately 3,500 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 Lisa Mishraky-Javier, Gayle Samuels, Rachel Paletta, and Arthur Argomaniz. It is presented to the Honorable Richard Gergel, U.S. District Court Judge; the 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 Team Leaders;[5] visits between children in the Department's custody and their case managers; family time (visits

[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).
[5] The FSA utilizes the term "supervisor" to refer to DSS staff who oversee 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 "Team Leader" for this role, effective May 2023.

between children in DSS custody and their parents and siblings); investigations of allegations of abuse and/or neglect of children in the state's custody by a caregiver; appropriate placements; and access to timely physical and mental health care. Since the development of the FSA, Implementation Plans for key bodies of work – which are also tracked by the Co-Monitors – have been approved and ordered by the Court.[6]

The Co-Monitors and their staff utilize a range of sources and activities to collect 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);[7] 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 and other state leaders; and discussions with Plaintiffs' counsel. Appendix B includes a list of specific activities the Co-Monitors used to assess DSS's progress.

In order to make this report as useful as possible to the Court, Parties, and the public, the Co-Monitors have also included information about developments beyond March 31, 2024 (the end of the monitoring period), as well as references to data DSS provided directly to the Court on April 26, 2024, and July 11, 2024 (DSS's Data Submission to the Court),[8] where applicable. The Co-Monitors will be filing a supplemental letter along with this monitoring report, with observations and recommendations stemming from a September 2024 site visit to the Richland County office.

[6] 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/
[7] CAPSS is DSS's State Automated Child Welfare Information System (SACWIS).
[8] Letters from J. Michael Montgomery Providing Update on Information Required Pursuant to 1/12/24 and 3/22/22 Orders (April 26, 2024, Dkt. 308 and July 11, 2024, Dkt. 238).

II. Areas of Improvement and Areas of Challenge

During the period under review (October 1, 2023, to March 31, 2024), DSS continued to make progress in certain key areas. There was a continued reduction in the number of children brought into DSS's custody; increased placement of children with kin and outside of congregate care settings; and improvements in Out-of-Home Abuse and Neglect (OHAN) investigative practice with respect to contact with core witnesses and appropriateness of decisions to unfound investigations. Staff turnover also declined, and there was improved performance regarding meeting caseload limits for Foster Care, Adoption, and OHAN case managers.

The Department continues to focus its messaging and efforts on becoming a "kin first" system and preventing unnecessary family separation by building out community supports and assessing removal practices, while also communicating the importance of keeping families together. For children who are separated from their parent(s) or guardian(s), DSS continued to prioritize placement with family members ("kin") including other important people in children's lives. Twenty-nine percent of all children in DSS custody were placed with kin at the end of March 2024 – the highest percentage since this lawsuit began and a slight increase from 27 percent during the last monitoring period (September 2023). DSS is implementing strategies with the goal of increasing equity and for maximizing payments to kinship caregivers as 57 percent are unlicensed as of March 2024. On February 1, 2024, DSS implemented Subsidized Legal Guardianship (SLG), as part of the state's new KinGAP legislation, providing a path for children to exit the foster care system into subsidized legal guardianship with their kinship caregivers, without the termination of their parents' rights.[9] Since that time, DSS finalized SLG for 17 families and is currently supporting 18 additional families through the final stages of the process. Additionally, DSS drafted proposed regulations for the licensure of kinship caregivers allowing for a less burdensome application and approval standards.[10]

[9] On May 16, 2023, Governor McMaster signed S0380 (Rat #32, Act #25) into law, which amended the definition of "legal guardian" to establish a program by which kin legal guardians can receive equivalent benefits to adoption subsidies if DSS demonstrates that termination of parental rights (TPR) is not in the child's best interest or adoption is otherwise not appropriate. For more information, go to: https://www.scstatehouse.gov/billsearch.php?billnumbers=380&session=125

[10] DSS's proposed regulations for the licensure of kinship caregivers were published in the State Register on August 23, 2024 (Document No. 5296). For more information, go to: https://www.scstatehouse.gov/state_register.php

During the monitoring period, DSS leadership continued to emphasize the importance of data-driven management. Although there remain areas in which reliable data are still needed, the Department's data capacity has improved significantly since the start of the lawsuit. DSS's Office of Accountability, Data, and Research (ADR) has continued to develop more refined approaches to data utilization that can benefit staff and the children and families DSS serves. For example, DSS now uses data generated by ADR to better document and understand the placement instability crisis and to identify county specific strategies for improved performance in multiple areas.

The Department made further progress in its workforce development strategies that has resulted in a more stable workforce. Staff turnover has continued to decline, from 25.4 percent in CY 2022 to 22.7 percent in CY 2023. DSS also reports a further modest reduction in the staff vacancy rate for Foster Care, Adoptions, and OHAN case managers and Team Leaders from 18 percent in April 2023 to 17 percent in March 2024.

Despite these successes, the placement instability crisis has reached new extremes, causing harm to many children, families and staff. Placement instability is caused by many factors including the need across the state for quality assessments and community-based services to support and meet the unique physical and mental health needs of children and families. South Carolina continues to lack sufficient supports and community-based services for children and families. These deficits combined with broad statutory authority for law enforcement officers to remove children from their homes, among other factors, has resulted in extremely high numbers of children being brought into DSS custody by law enforcement for very short periods of time. Slightly over one-quarter (27 percent, or 353 of 1,322) of children who were taken into DSS custody between October 1, 2023, and March 31, 2024, exited DSS custody within 60 days of entry. Eighty-one percent (286 of 353) of children who were brought into DSS custody for 60 days or less were emergency removals conducted by law enforcement officers. In addition to diverting system resources, the separation of children from their families, even for a short time, is highly traumatizing and can have long-lasting negative consequences for children, families, and communities.

The Co-Monitors' Supplemental Report, issued in August 2023, described the growing concerns about the impact of the placement instability crisis on children,

families, kin, foster parents, group home staff, private providers, and DSS frontline staff and leaders.[11] In the months since, children in DSS custody were moved between placements, DSS offices, and emergency settings at exponentially higher rates. Specifically, between October 1, 2023, and March 31, 2024, 587 unique children spent an alarming 9,280 nights in emergency placements, reflecting an increase from the prior monitoring period, when 555 unique children spent 8,991 nights in emergency placements. Despite multiple efforts by DSS, this crisis is growing and shows no signs of abating. In some parts of the State, the placement crisis has created untenable and unsafe conditions for children and DSS staff, threatening the many other improvements that DSS has been making to increase and stabilize its workforce and improve the quality of care of children in its custody.

Addressing the placement instability crisis requires immediate action by all of South Carolina's state agencies responsible for serving children and families. The steps taken by Department of Health and Human Services (DHHS) and other DSS partners in recent months to begin to address placement instability are encouraging. However, the Department and the Co-Monitors acknowledge that these efforts are only beginning steps in what will need to be a comprehensive, collaborative, and longer-term effort to build a robust system of community-based supportive care for South Carolina's children and families. Additionally, much work remains to be done in building relationships with law enforcement and schools to prevent the unnecessary separation of families and with Medicaid and the behavioral health system to expand the availability of and access to services.

The placement instability crisis is intensified by slow progress in changing the agency's culture and practice to more fully engage children and families; conduct comprehensive assessments to identify strengths and underlying needs; and to provide individualized services that address both concrete and underlying needs. DSS must intensively and urgently shift the way it works with children and families by more aggressively requiring that case practice be based on its Guiding Principles and Standards (GPS) of family-centered, trauma-informed, individualized and strengths based, and culturally responsive practice. This work must move beyond messaging

[11] *Michelle H.* Co-Monitors' Supplemental Report Regarding South Carolina's Placement Crisis (August 1, 2023, Dkt. 288-1) To see the full report, go to: https://cssp.org/wpcontent/uploads/2023/10/Supplemental-Report-re-South-Carolinas-Placement-Crisis.pdf.
13 See SC Code § 63-7-20 (12a&b).

to more robust implementation across the state, focused on meaningful changes as children and families are continuing to be harmed as they wait for change.

The Co-Monitors urge DSS to prioritize employing various Continuous Quality Improvement (CQI) strategies to monitor and improve performance with regards to its implementation of its case practice model including building its capacity to collect and analyze qualitative data. Relying primarily on quantitative data limits DSS's ability to gather information from a variety of sources that can help to assess and track quality of practice and services delivered and their impact on the experiences and outcomes of children and families. The Co-Monitors look forward to working closely with the Governor's office, South Carolina state agencies, and other stakeholders to support DSS in its efforts over the coming months.

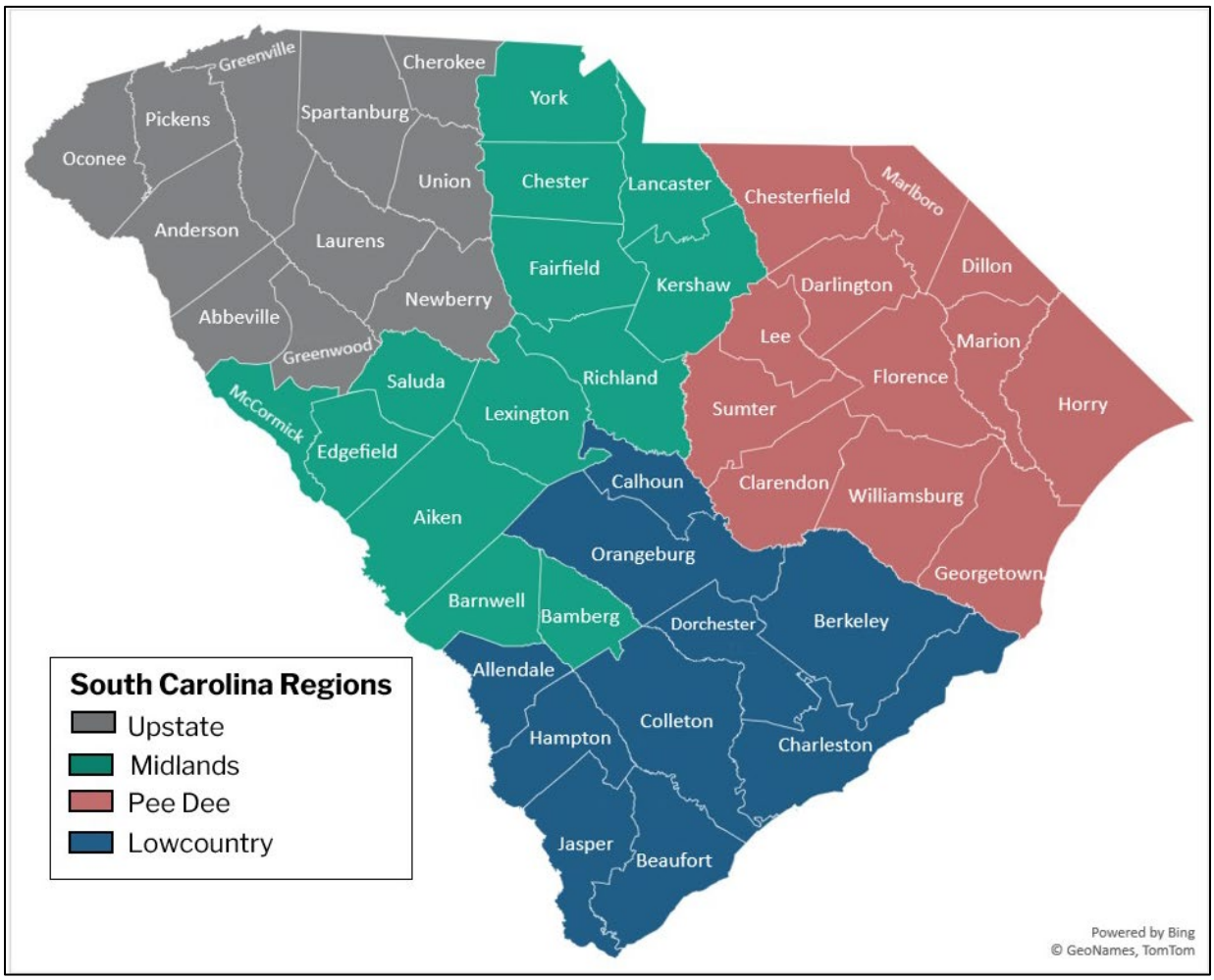
III. Background Information

DSS is a cabinet-level agency that reports directly to the South Carolina Governor. A detailed summary of its structure and mission can be found in prior monitoring reports, available here.[12] The FSA pertains to children who have been involuntarily removed from their parent(s) or guardian(s) due to a finding of abuse and/or neglect and taken into the custody of DSS. When this occurs, 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 the family. During this time, DSS must ensure children remain in contact with their families and engage and support parents and guardians as needed so that children can be returned home quickly ("reunified"). When reunification is deemed not possible, DSS must pursue another permanent, long-term plan, such as guardianship or adoption.

DSS is structured to deliver services through regional and county offices. As shown in Figure 1, the state's 46 counties are divided into four regions – Midlands, Upstate, Pee Dee, and Lowcountry. Some DSS functions are located regionally, including Adoptions offices, Child Health and Well Being Teams, and Child Placement Teams.

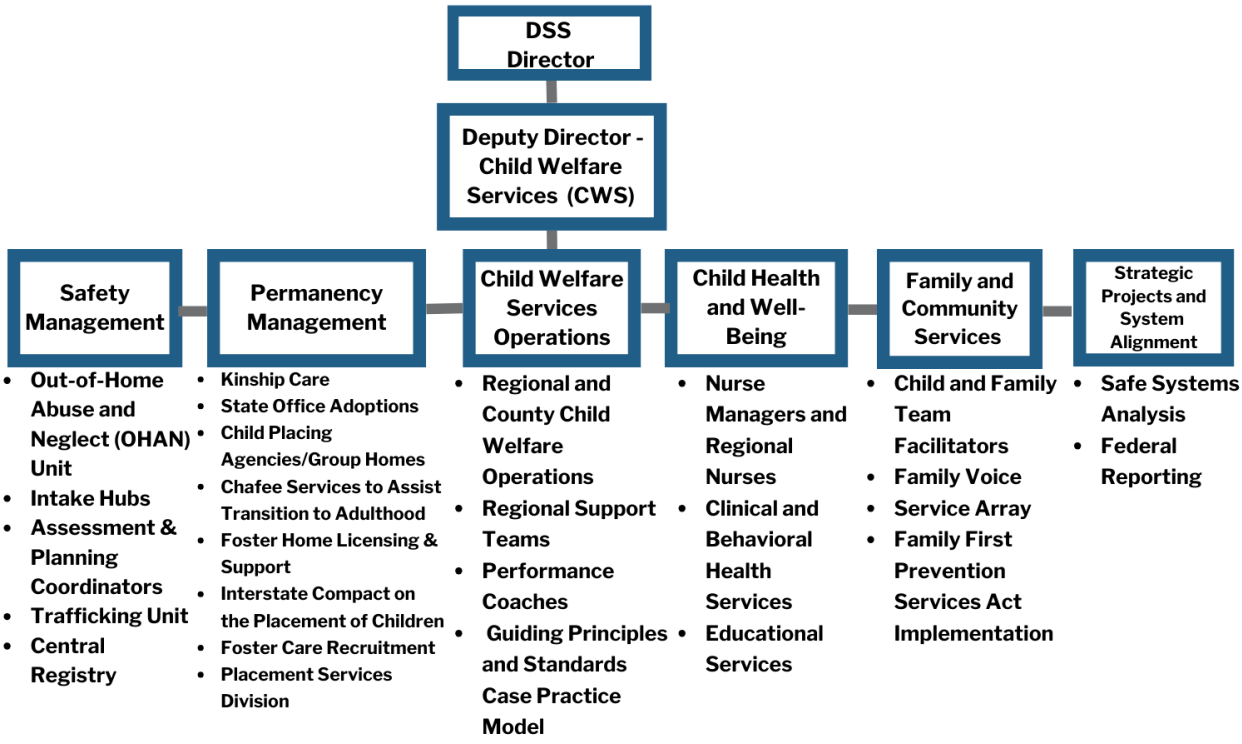
[12] https://cssp.org/our-work/project/child-welfare-reform-through-class-action-litigation/#south-carolina-s-department-of-social-services

Figure 1: South Carolina Counties by Region



DSS foster care is part of its Child Welfare Services Division, overseen by Deputy Director of Child Welfare, Emily Medere. The Child Welfare Services Division is organized into six primary areas of focus: Safety Management; Permanency Management; Child Welfare Services Operations; Child Health and Well-Being; Family and Community Services; and Strategic Projects and System Alignment. 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 updated by DSS, as of 8/28/2024

Foster Care Budget and Financing

The federal Children's Bureau, within the Administration for Children and Families, distributes funds to states for defined child welfare functions and services through mandatory spending programs. The largest of these programs is authorized under 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 a defined service on behalf of an "eligible" child.[13] The child's eligibility depends on the income level of the parent(s) from whose custody the child was removed. Even when 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.[14] Approximately 45 percent of children in foster care in South Carolina

[13] The Title IV-E program was established by HR. 3434 Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272).
[14] Section 474(a)(3)(A),(B),(C),(D), and (E) of the Social Security Act.

currently meet Title IV-E eligibility requirements (referred to as the state's Title IV-E penetration rate).[15]

Nearly all children in foster care are eligible for health insurance through Medicaid, another important source of federal revenue for state child welfare systems.[16] States authorizing payment for Medicaid services included in their 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 Fiscal Year (FY) 2024 is 69.53 percent.[17,18] This means that for each dollar South Carolina spends on a Medicaid-reimbursable service for a child or eligible family member in the current fiscal year, the federal government reimburses the state almost 70 cents. This is both a higher rate than the reimbursement received under Title IV-E and one that can be applied broadly, 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

[15] 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 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 facilities beyond 14 days that do not meet the 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 six 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)). Since the 14-day claiming limitation went into effect in October 2021, approximately $12M in foster care maintenance payments made on behalf of children placed in a congregate care setting that would have previously been funded via Federal Title IV-E funds were no longer eligible for that funding due to the FFPSA restrictions. In February 2022, the Children's Bureau approved South Carolina's 5-year Family First Prevention Services plan. If statutory requirements are met, this will enable the state to access 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 FFPSA and 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

[16] DSS reports that as of August 27, 2024, there were 25 children in its custody who were ineligible for full Medicaid due to their immigration status.

[17] 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

[18] The Families First Coronavirus Response Act (FFCRA) authorized temporarily increased federal funding to states through a higher FMAP, increasing the rate for recent years to almost 77% (Section 6008 of P.L. 116-127). The increased support was phased down in each subsequent fiscal quarter after March 31, 2023, and ended entirely as of January 1, 2024 (Section 5131 of P.L. 117-328).

have been able to increase – sometimes vastly – funding available for the support of children in foster care. Medicaid can be used to cover non-direct medical care expenses, such as mental health services and services as part of therapeutic foster care. Medicaid can now also be used to address social determinants of health or associated health-related social needs (HRSNs), including housing, nutrition, and transportation.[19]

Details regarding DSS's budget that includes both federal revenue and state general fund revenue for FY2024-2025 are included in Section IV. *Fiscal Resources* of this report. Details on the general process for budget allocation through the General Assembly can be found in prior monitoring reports.

Population of Children in Foster Care

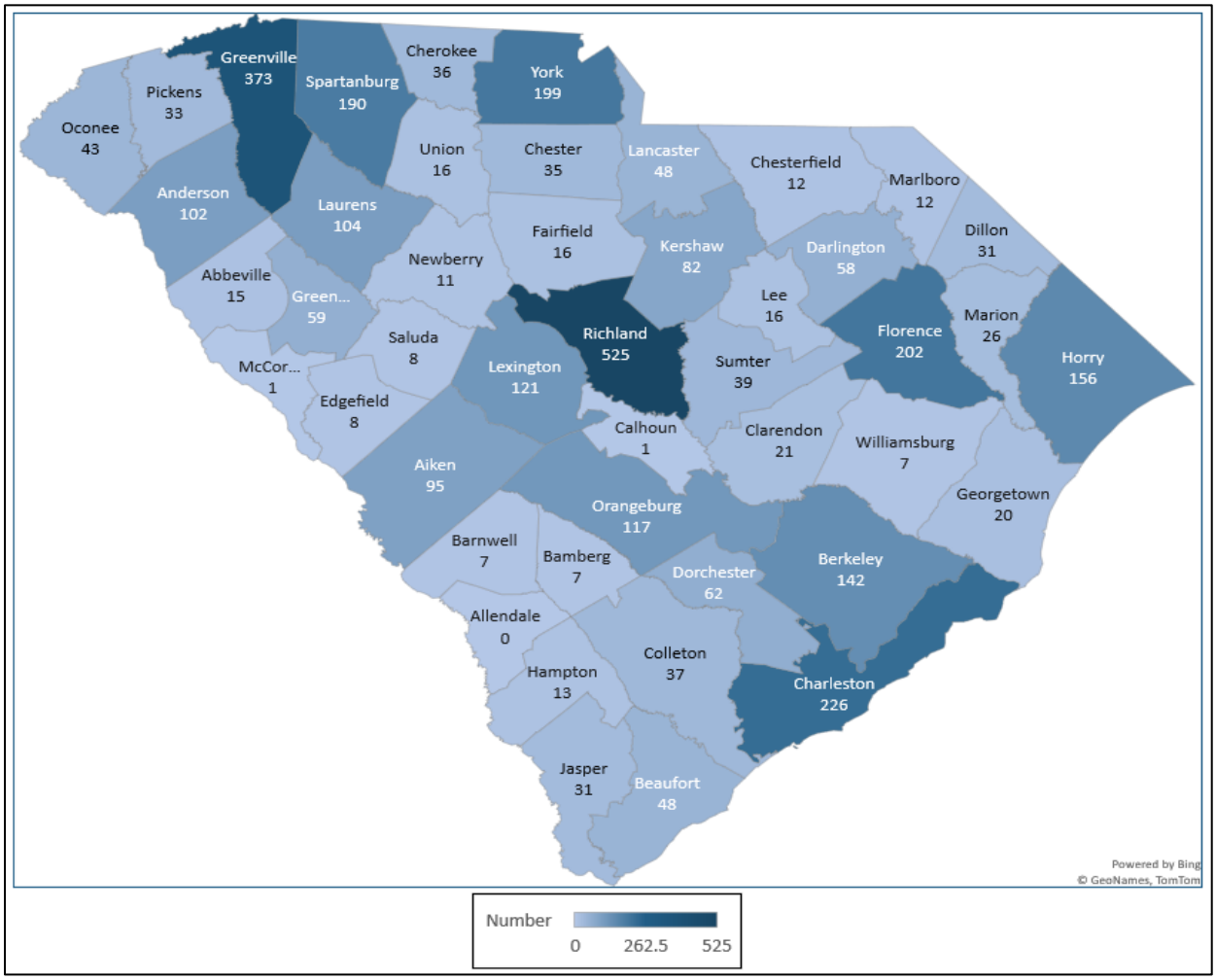
Population and Demographics of Children in Foster Care

Between October 1, 2023, and March 31, 2024, 4,792 children were in DSS custody at some point. On March 31, 2024, there were 3,411 children in DSS custody across the state.[20] The map in Figure 3 shows the number of children from each county in the Department's custody on that day.

[19] For more information on Medicaid funding for HRSNs, go to: https://www.chcs.org/media/Understanding-New-Federal-Guidance-on-Medicaid-Coverage-of-Health-Related-Social-Needs.pdf. For example, Oregon was recently granted a 1115 waiver to, among other things, address social determinants of health using non-medical services, with children in foster care as one target population. North Carolina has used a 1115 waiver to implement evidence-based interventions to address social determinants of health through its "Healthy Opportunities Pilots" program, which focuses on housing instability, transportation insecurity, interpersonal violence, and toxic stress for a limited number of managed care enrollees who meet needs-based criteria. New York recently received approval for an 1115 waiver to fund its expansive Health Equity Reform, which includes a significant expansion of the state's Medicaid program to address HRSNs through social care networks and health equity organizations. See https://www.health.ny.gov/health_care/medicaid/redesign/sdh/index.htm.

[20] This includes 22 children who resided in other institutional settings (e.g. Department of Juvenile Justice Facility, hospitalized for 30 days or more) on March 31, 2024, and may not match the data in Section VIII. *Placement*.

Figure 3: Number of Children in DSS Custody by County as of March 31, 2024[21] N= 3,411 Children[22]



Source: CAPSS data provided by DSS

As shown in Figures 4 and 5[23], the population of children in DSS custody has sharply declined since the filing of this lawsuit and has continued to decrease, consistent with the State's policy priorities and national trends.[24] For example, in January 2019, there

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

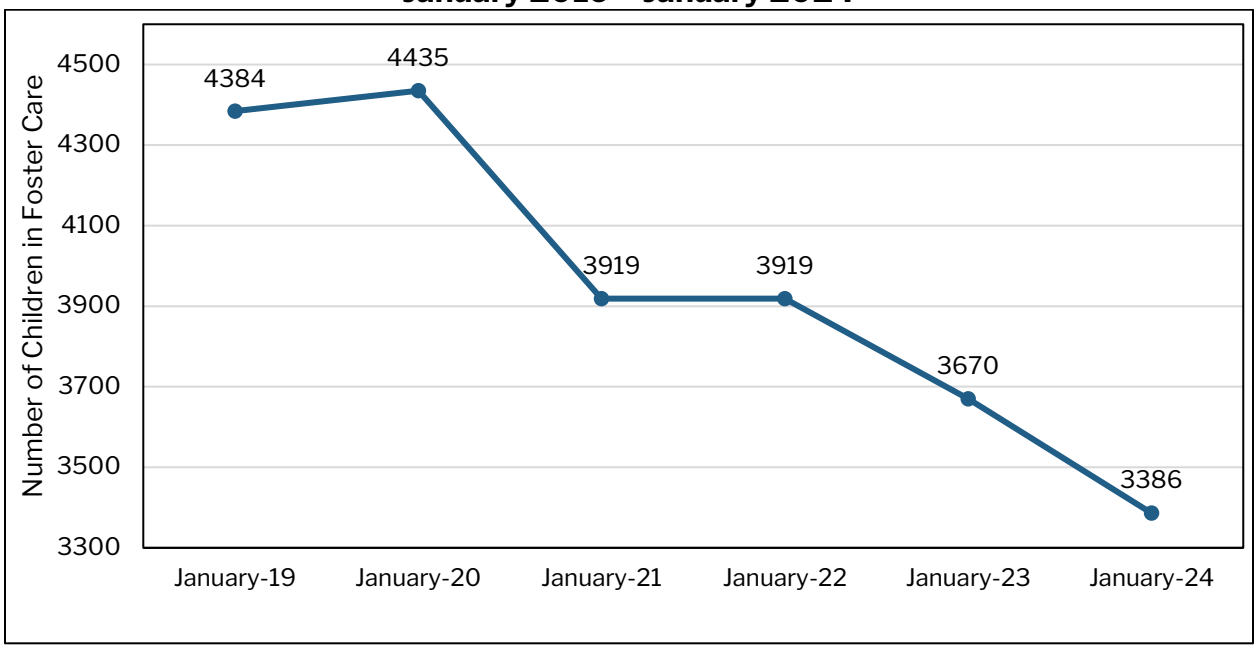
[22] This includes 22 children who resided in other institutional settings on March 31, 2024, and may not match the data in Section VIII. *Placement*.

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

[24] U.S. Administration for Children and Families, (2022). "With a Focus on Prevention and Kinship Care, Number of Children Entering Foster Care Decreases for the Fourth Consecutive Year"

were 4,384 children in foster care; five years later, in January 2024, there were 3,386 children in foster care – a 23 percent decrease. The Department has reported that the decrease in family separations has been a result of DSS's efforts to prioritize prevention services and wherever possible, reunify children quickly with their families. Additional improvements in the amount and quality of time children in foster care spend with their parents and siblings from whom they are separated can also positively impact DSS's ability to further decrease its foster care population by increasing the timeliness and frequency of family reunification.

Figure 4: Population of Children in Foster Care
January 2019 – January 2024



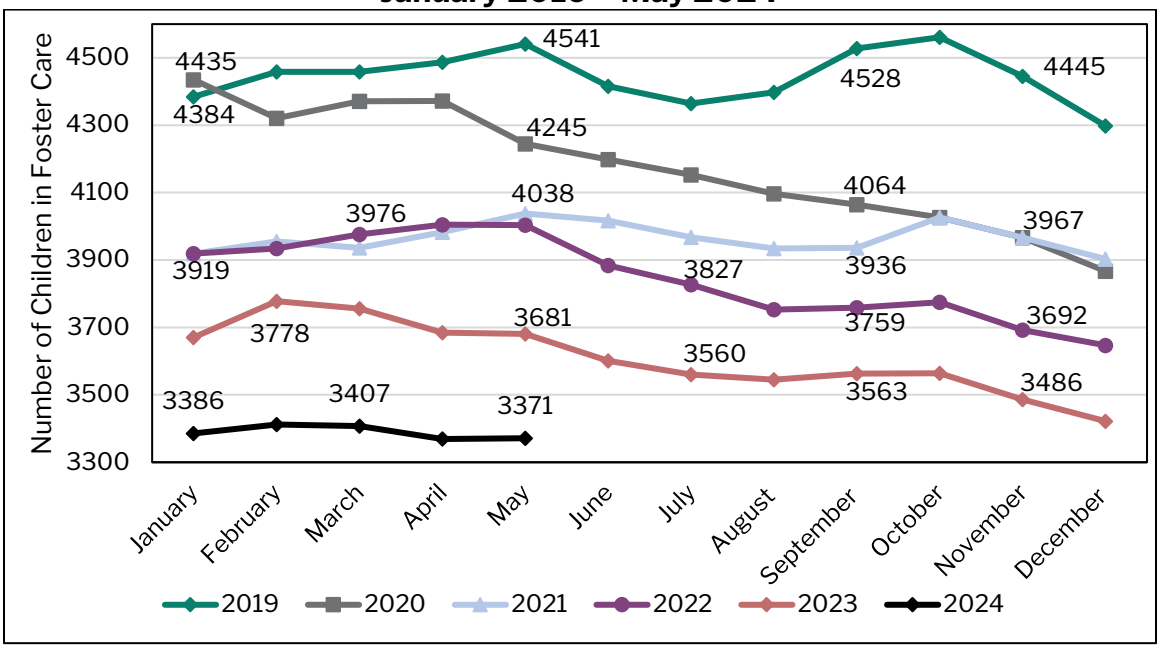
Source: DSS data dashboard, 06/12/24[25,26]

https://www.acf.hhs.gov/media/press/2022/focus-prevention-and-kinship-care-number-children-entering-foster-care-decreases

[25] DSS regularly publishes real-time data about children in out-of-home care on its public website. 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. To see DSS's data dashboard, go to: https://dss.sc.gov/about/data-and-resources/foster-care-dashboard/

[26] Data from DSS's data dashboard includes children in foster care who do not fall within the definition of Class Members under the FSA.

Figure 5: Population of Children in Foster Care
January 2019 – May 2024



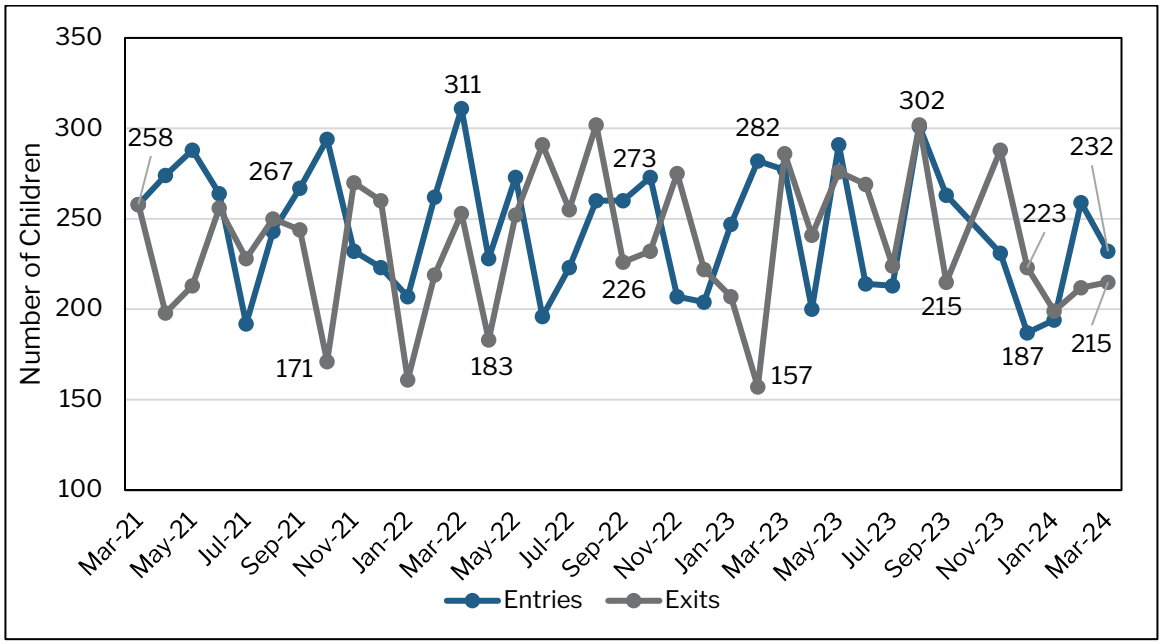
Source: DSS data dashboard, 06/12/24[27,28]

Children Entering and Exiting Foster Care

Between October 1, 2023, and March 31, 2024, the number of children who exited foster care (1,338) was slightly greater than the number of children who were brought into foster care (1,322).[29]

[27] Ibid.
[28] Ibid.
[29] Ibid.

Figure 6: Foster Care Entries and Exits by Month
March 2021 – March 2024

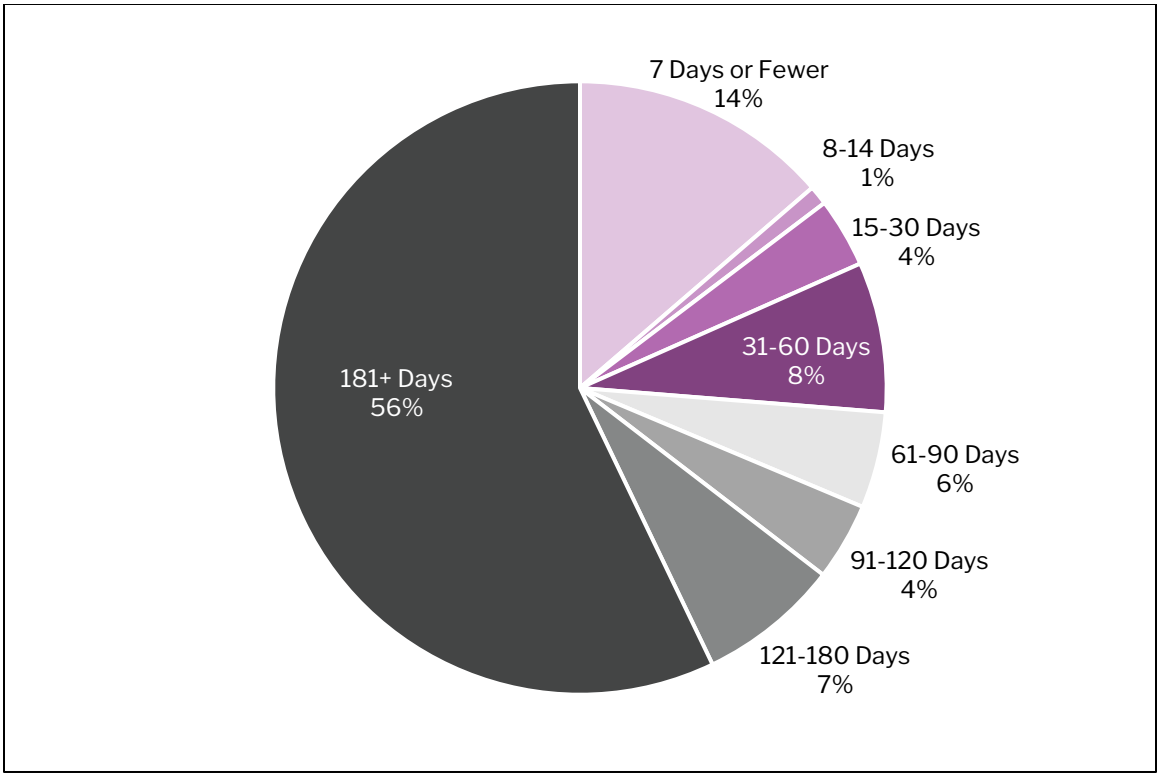


Source: CAPSS data provided by DSS

To better identify when family separation can be avoided through cross-agency collaboration and the development of supportive services, ADR has begun refining its analysis on the amount of time children spend in foster care, with a particular emphasis on children who remain in foster care for less than six months.

During the period of April 1, 2023, to April 30, 2024, DSS reports that 3,073 children exited care. As shown in Figure 7, of these 3,073 children, 27 percent (844) exited within 60 days. This includes 19 percent (597) of children who exited within 30 days; 16 percent (481) of children who exited within 14 days; and 14 percent (439) who exited within seven days of entry. These data show that there are a significant number of children who are separated from their families and brought into DSS's custody for very short periods of time.

Figure 7: Length of Stay in Foster Care for Children who Exited Between April 1, 2023 – April 30, 2024
N= 3,073 Children

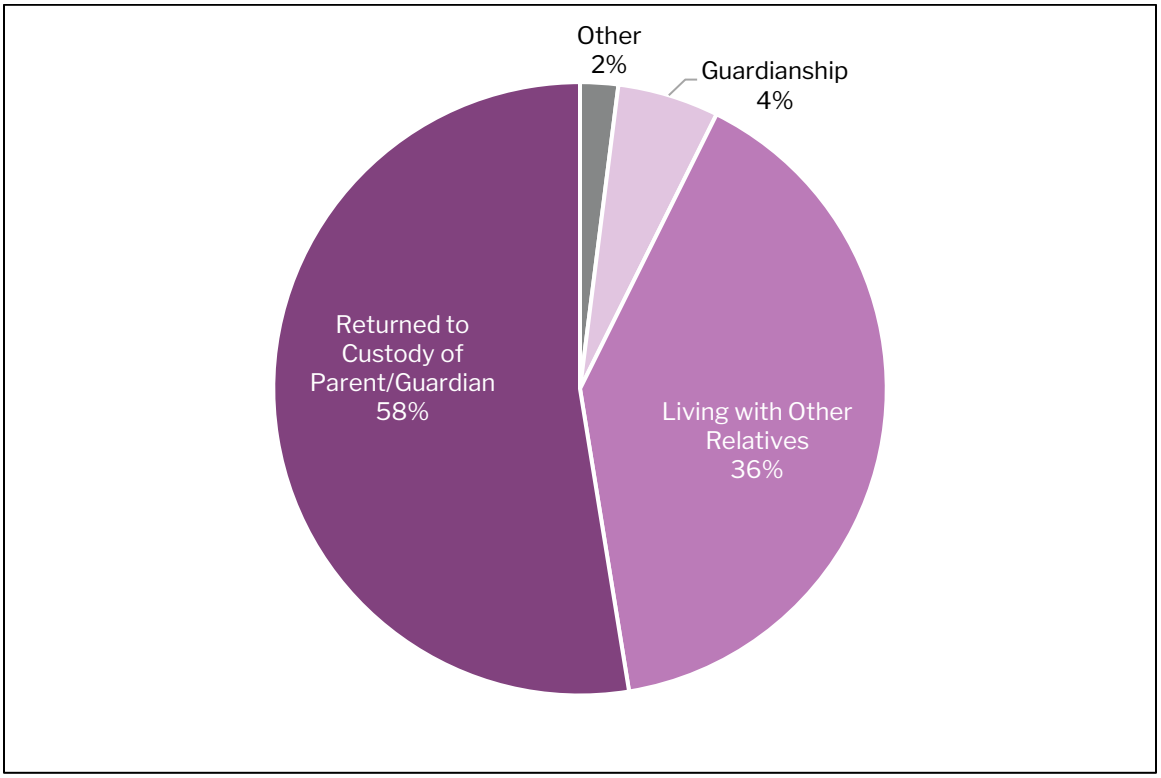


Source: DSS Data

Figure 8 shows the exit reasons for the 481 children who exited foster care within 14 days between April 1, 2023, and April 30, 2024. As depicted, more than half of these children (281 of 481, or 58%) were returned to the custody of their parents or guardians, and 39 percent (189 of 481) of these children exited to live with other relatives (172) or guardians (17). Of the 281 children who were reunified with their parents within 14 days of entering foster care, only 14 (5%) children experienced a subsequent entry into care during the 13-month period.[30]

[30] Four of the 14 children who had a subsequent foster care episode after being returned to their parent(s) were in care for fewer than 15 days during their subsequent entry. Three of those four children were returned to their parent(s) or relative(s).

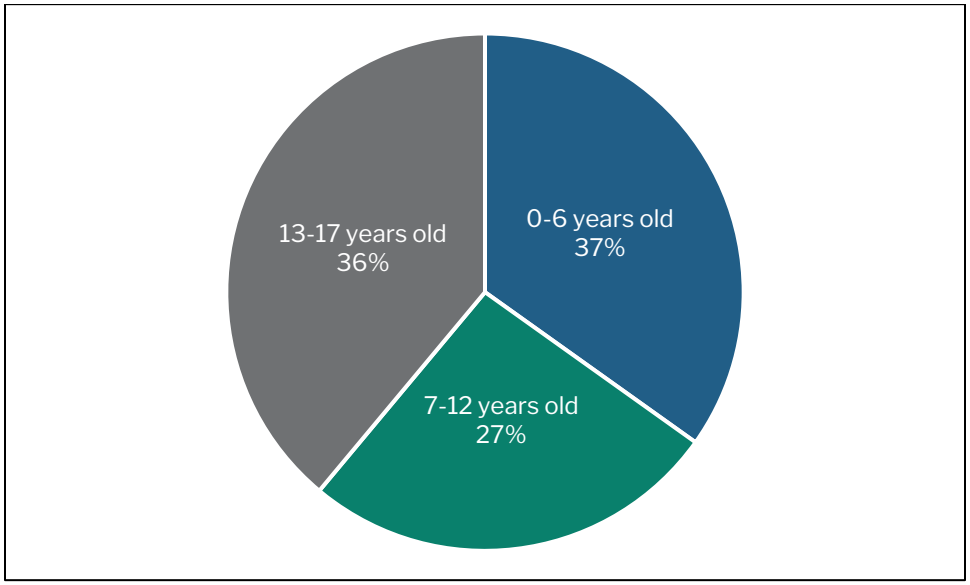
Figure 8: Exit Reason for Children in Care 14 Days or Less Between April 1, 2023 – April 30, 2024
N= 481 Children



Source: DSS Data

Data for the monitoring period (0october 1, 2023 to March 31, 2024) show similar patterns. Twenty-seven percent (353 of 1,322) of children who entered care between the six-month period remained in care for short periods ranging from one to 60 days. Specifically, according to DSS data, 14 percent (189 of 1,322) of children who entered foster care during the monitoring period remained in care for seven days or less. This is unchanged from the last monitoring period. Figure 9 shows the age ranges of these children. Thirty-seven percent of these children were six years old and younger; 36 percent were 13 to 17 years old; and 27 percent were seven to 12 years old.

Figure 9: Ages of Children who Entered Foster Care Between October 1, 2023 and March 31, 2024 and Exited within 60 Days of Entry
N= 353 Children



Source: DSS Data

In South Carolina, law enforcement has the authority to unilaterally remove children from their homes and place them in Emergency Protective Custody (EPC). These emergency removals by law enforcement officers significantly contribute to this pattern of "short stays" in foster care. Of the 189 children who entered foster care during the monitoring period (October 1, 2023, to March 31, 2024) and remained in care for seven days or less, 85 percent (161) entered care due to a unilateral emergency removal by law enforcement. To further analyze the issue of short stays in foster care, the Co-Monitors reviewed 13 months of data (from April 1, 2023, to April 30, 2024) and found that 87 percent (382 of 439) of children who remained in foster care for only seven days or less entered foster care due to a unilateral emergency removal by law enforcement. Research affirms the harm and trauma inflicted on children and families who are separated by law enforcement removals and child welfare systems, even for very short periods of time.[31]

As shown in Table 1, high numbers of children are being brought into DSS custody by law enforcement for very short periods of time across all four regions of the state.

[31] See, e.g.: Sankaran, V., Church, C., & Mitchell, M. (2019). A Cure Worse than the Disease? The Impact of Removal on Children and their Families. University of Michigan Law School Scholarship Repository,102(4). and Getz Z., Simmel C., Zhang L., Greenfield B. (2022). "Short-stayers" in child welfare: Characteristics and system experiences. Children and Youth Services Review, 138, 106531.

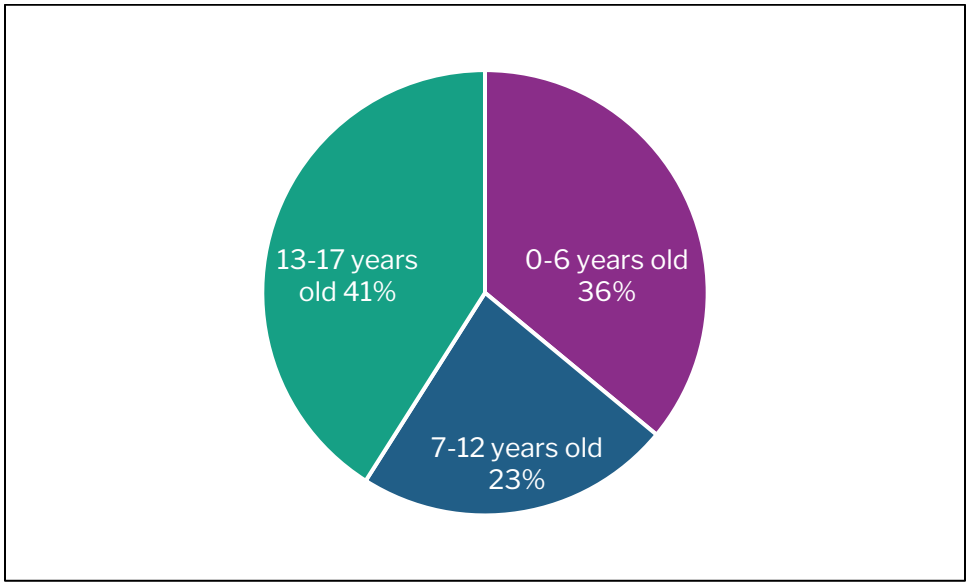
Figure 10 shows the age ranges of these children. Forty-one percent of these children were 13 to 17 years old; 36 percent were six years old and younger; and 23 percent were seven to 12 years old. Children who identify as Black represent 35 percent of the foster care population in South Carolina. Data in Figure 11 show the disproportionate percentage (41%) of Black children who are separated from their families by law enforcement removals for very short periods of time.

Table 1: Number of Children who Entered Through EPC and Stayed in Care for Seven Days or Less, by Region
April 1, 2023 – April 30, 2024

Region	Number of Children in Care for 7 Days or Fewer	Percent that Entered through EPC
Lowcountry	120	82% N= 98/120
Midlands	121	90% N= 109/121
Pee Dee	72	94% N= 68/72
Upstate	126	85% N= 107/126

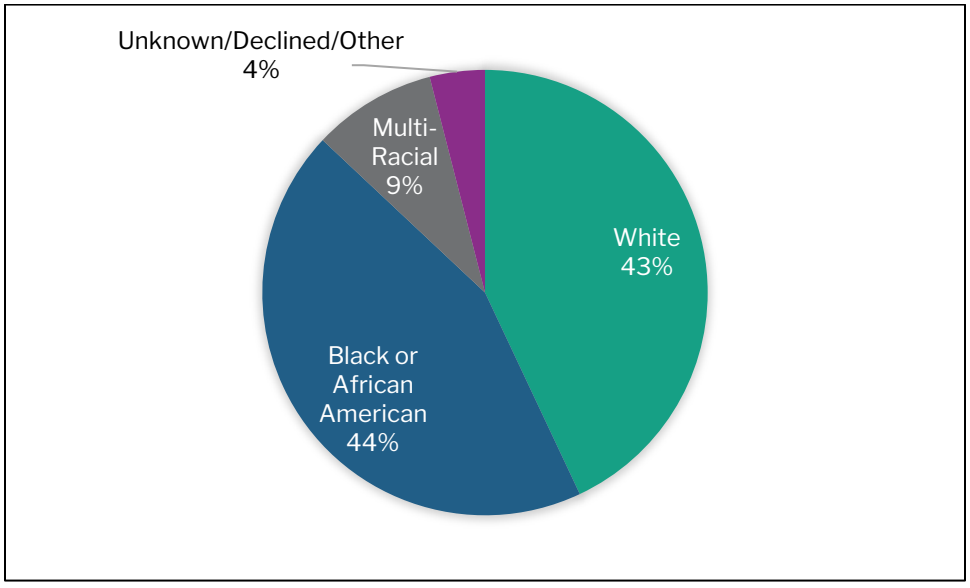
Source: DSS Data

Figure 10: Ages of Children who Entered Through EPC and Stayed in Care for Seven Days or Less
April 1, 2023 – April 30, 2024
N= 382



Source: DSS Data

Figure 11: Race of Children who Entered Through EPC and Stayed in Care for Seven Days or Less
April 1, 2023 – April 30, 2024



Source: DSS Data

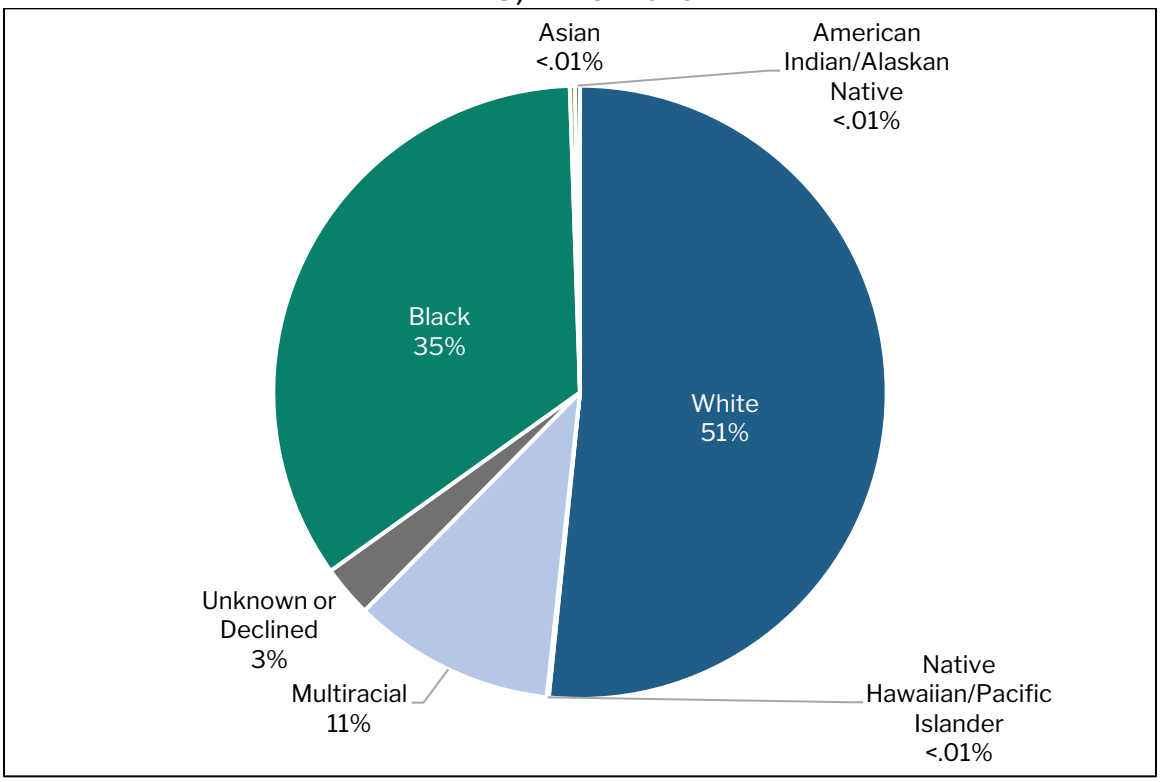
To reduce unnecessary family separation, DSS has expressed a renewed commitment to examining and changing the practices leading to removing children from their homes and working collaboratively with law enforcement to limit unnecessary emergency removals. This has been identified as a priority in the Small Test of Change (STOC) counties (Richland, Anderson, Greenville, and Spartanburg), discussed in Section VIII, *Placements*, and should be an urgent priority statewide.

Demographics of Children in DSS Custody

As shown in Figure 12, of the children in DSS's custody on March 31, 2024, 51 percent were identified as White, 35 percent were identified as Black, and 11 percent were identified as Multiracial.[32,33] In accordance with federal guidelines, DSS does not record Hispanic or Latinx ethnicity as a category in demographic data published on its public dashboard. However, DSS captures Hispanic ethnicity as a category in placement data and reports that six percent (217 of 3,411) of children in DSS custody on March 31, 2024, were identified as being of Hispanic ethnicity.

[32] Data included herein were provided by DSS and have not been independently validated by the Co-Monitors.
[33] According to South Carolina's 2021 Kids Count Data, 54 percent of children 18 years and under identify as White, 29 percent identify as Black, and 10 percent identify as Hispanic.

Figure 12: Population of Children in DSS Custody, by Race as of March 31, 2024 N= 3,411 Children

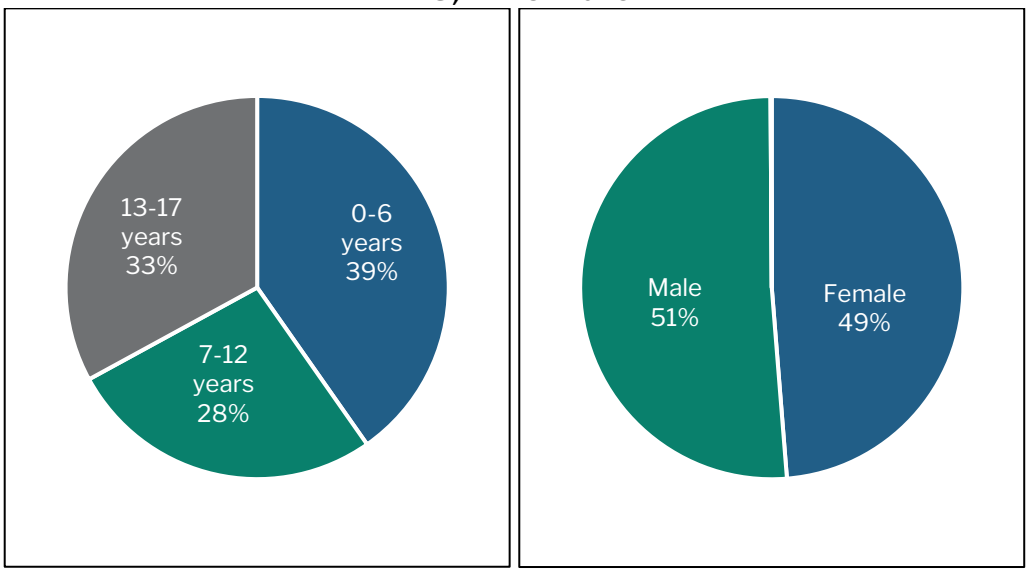


Source: CAPSS data provided by DSS

Figure 13 shows that of all children in DSS custody on March 31, 2024, about one-third (33%) were adolescents (ages 13 to 17), 28 percent were between the ages of seven and 12, and 39 percent were ages six and under. Slightly fewer than half (49%) of children in DSS custody on March 31, 2024, were reported to be female .[34,35] These demographics have remained consistent for multiple monitoring periods.

[34] Data provided by DSS on placements on the last day of the monitoring period indicate that on March 31, 2024, the gender identity of one child (<.01%) in foster care was unknown.
[35] DSS has the capacity in CAPSS to collect information on children who identify as gender neutral or non-binary, as well as information on children's pronouns. DSS leadership reports that they are closely monitoring the usage of the fields and continue to work with staff to increase reliable data entry in this area. According to DSS data for July 2024, the use of the field for gender identify for Class Members was 64 % and 68% for the field for pronouns.

Figure 13: Children in DSS Custody by Age and Reported Gender as of March 31, 2024
N= 3,411 Children



Source: CAPSS data provided by DSS

IV. Fiscal Resources

Over the last three fiscal years, the General Assembly has provided $59.2 million in new state general revenue funds to support reform and improvement efforts, including for hiring many new staff. In FY 2023-2024, the additional state funds made possible the launch of KinGAP, an important guardianship assistance program that provides a path for children to exit the foster care system into subsidized legal guardianship with their kinship caregiver.[36]

For the FY 2024-2025 appropriation process and the budget year which began July 1, 2024, DSS requested $19.66 million in new funding for Child Welfare Services. The requested amount included $14.4 million in new state recurring general funds and $5.3 million in additional authority to spend federal and other funds.[37] The request for new recurring funds included $590,000 (amounting to $864,000 in total state/federal funding) to increase family foster care board rates consistent with meeting the United States Department of Agriculture (USDA) guidelines for the costs of raising a child in the Southeast region as required under the FSA. The budget request also included $3.9 million in recurring state funds (amounting to $5.2 million in total state/federal and other funding) to increase rates paid to group home providers; $2 million (amounting to $2.1 million in total state/federal and other funding) for short-term residential crisis assessment and stabilization centers; $1.7 million (amounting to $2.5 million in total state/federal and other funding) for additional staff to facilitate Child and Family Team Meetings (CFTMs); and $6.2 million (amounting to $8.9 million in total state/federal and other funds) for staffing additional state-level strategic and Child Health and Well-Being data support positions.

These items were included in the Governor's Executive Budget issued on January 5, 2024. The House and Senate considered the budget requests over many months, and in the final approved FY 2024-2025 Appropriations Act,[38] allocated far less than

[36] On May 16, 2023, Governor McMaster signed S0380 (Rat #32, Act #25) into law, which amended the definition of "legal guardian" to establish a program by which kin legal guardians can receive equivalent benefits to adoption subsidies if DSS demonstrates that termination of parental rights (TPR) is not in the child's best interest or adoption is otherwise not appropriate. For more information, go to: https://www.scstatehouse.gov/billsearch.php?billnumbers=380&session=125

[37] To see DSS's full FY2024-2025 Agency Budget Plan, go to: https://www.admin.sc.gov/sites/admin/files/Documents/Budget/FY25%20L040%20-%20DSS.pdf

[38] To see the full FY2024-2025 General Assembly Appropriation, go to: https://www.scstatehouse.gov/sess125_2023-2024/appropriations2024/gab5100.php

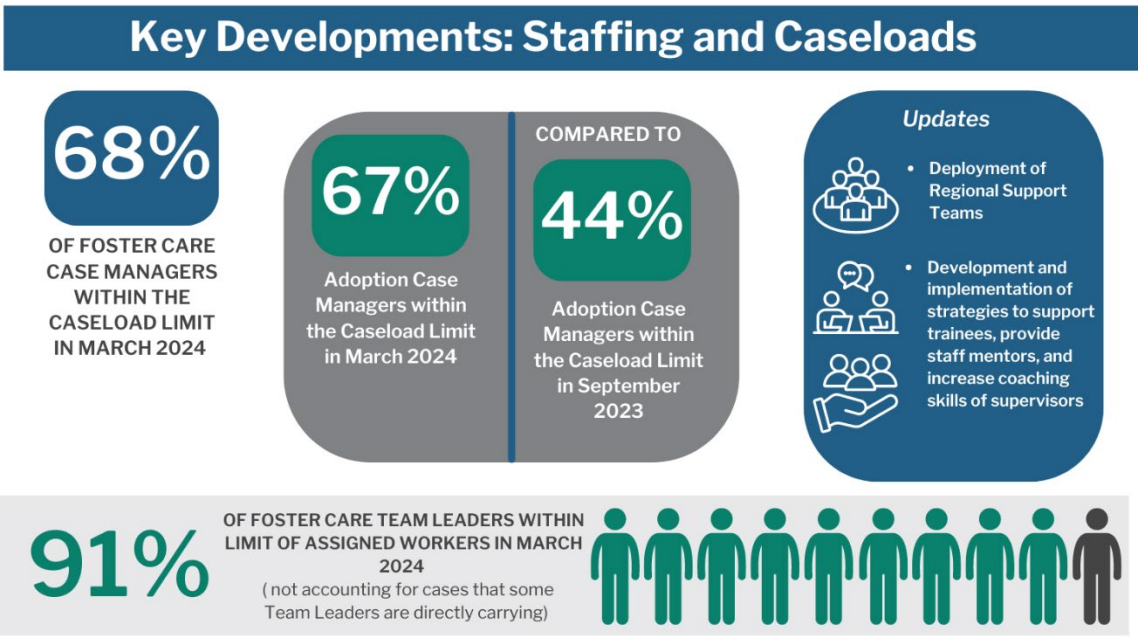
what DSS and the Governor requested. The approved budget added only $5 million in state recurring funds of the $14.4 million requested in the DSS budget for Child Welfare Services. DSS reports that the $5 million increase will cover the increases in foster parent board rates, group care rates, a portion of the short-term residential crisis assessment and stabilization center, and salary increases for case manager assistants.

DSS also reports that the FY 2024-2025 Appropriations Act includes provision for modest salary increases and provision to cover the increase in health premiums for all state employees . DSS's total budget for Child Welfare Services for FY 2024-2025 including state, federal, and other funds is $347 million. Total Child Welfare Services expenditures for the prior fiscal year (FY 2023-2024), including state, federal, and other funds was $359 million.

DHHS and the South Carolina Department of Mental Health (DMH) also requested funding for FY 2024-2025 for important services and supports that were to be utilized, in part, for children in foster care. DMH received $4 million in new funds for contracted community beds. DHHS received their full requests totaling approximately $103 million in new state general fund revenue. The Co-Monitors have asked for additional information to determine whether this amount of state funding to DHHS will provide sufficient dollars for the state share (or matching funds) for the planned enhancements to Medicaid funded community-based services for children, youth, and families. DHS is likely to ask the legislature for additional state revenue for matching funds in the next fiscal year as its work to expand behavioral health and community-based services across the state moves forward.

V. Staffing and Caseloads

The focused attention of DSS leadership on workforce (specifically, recruitment, staffing, training and retention efforts), combined with the declining number of children in DSS custody, has resulted in a continued reduction in case manager caseloads. At the end of March 2024, 68 percent of Foster Care case managers had caseloads within the required limit, up from 63 percent in September 2023; 67 percent of Adoptions case managers had caseloads within the required limit, up from 44 percent in September 2023; and all (100%) OHAN case managers had caseloads within the required limit. Ninety-one percent of Foster Care Team Leaders[39] and all (100%) of Adoption Team Leaders were within required limits in terms of the number of case managers they supervised (not accounting for the cases some Team Leaders were directly carrying).[40]



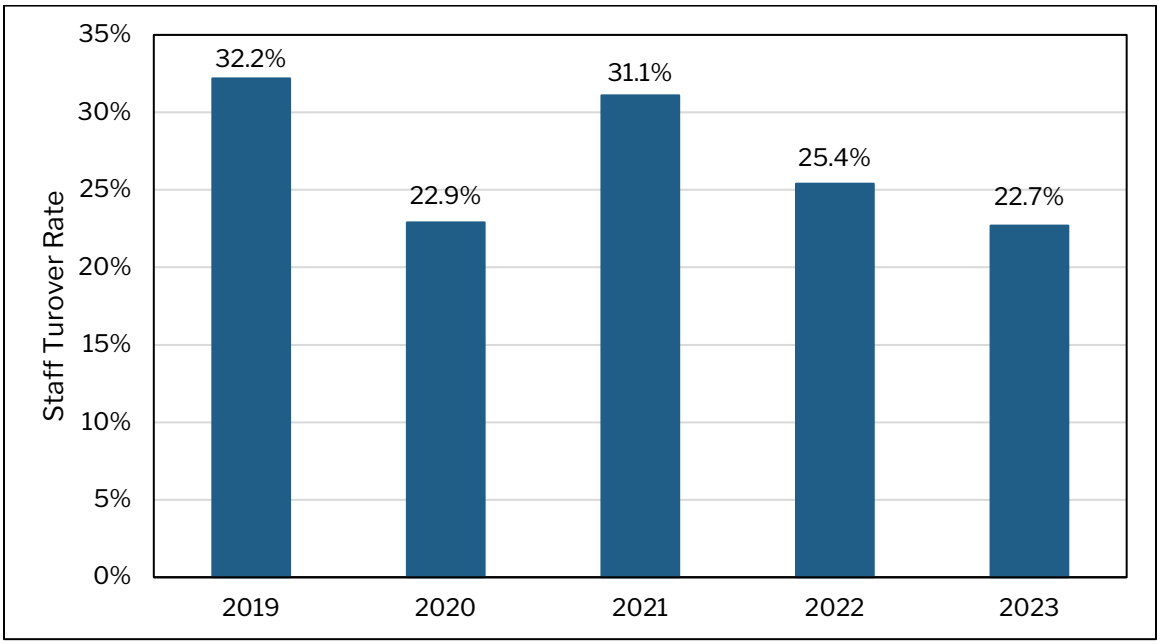
[39] The FSA utilizes the term "supervisor" to refer to DSS staff who oversee case-carrying staff. As part of its Guiding Principles and Standards (GPS) Case Practice Model development and work to define enhanced job expectations, DSS now utilizes the term "Team Leader" for this role, effective May 2023.
[40] Throughout the monitoring period (October 2023 through March 2024), some Team Leaders continued to carry direct cases in addition to supervising staff.

Staffing and Caseload Updates

In DSS's April 2024 Data Submission to the Court, the Department provided updates on hiring, recruitment, staff turnover, and retention strategies; merit-based pay; and training curriculum rollout for Team Leaders. The turnover rate for Foster Care, Adoptions, and OHAN case managers and Team Leaders has continued to decline, from eight percent in Quarter 3 of 2023 (from July to September) to seven percent in Quarter 4 of 2023 (from October to December), with a drop to six percent in Quarter 1 of 2024 (from January to March) according to preliminary data. As shown in Figure 14, annual turnover data for CY2023 was 22.7 percent, down from 25.4 percent in CY2022. DSS continues to carefully track staff turnover.

As discussed throughout this report, growing placement instability has increased the demands on case managers throughout the state, who must handle the increased stress and workload involved with children who do not have stable placements. These include the addition of multiple shifts to regular work hours where staff must respond to children without placement and/or with night-to-night emergency placements which often put undue burden on staff and place children in harm's way. Despite these pressures, staff turnover has declined from its peak in 2019. There's an urgent need for increasing access to community-based and therapeutic services in addition to focused implementation of DSS's GPS Case Practice Model including mentoring and training staff in engaging families, assessing underlying needs, working as a team with family members and others who support them, and tailoring interventions to align with families' needs.

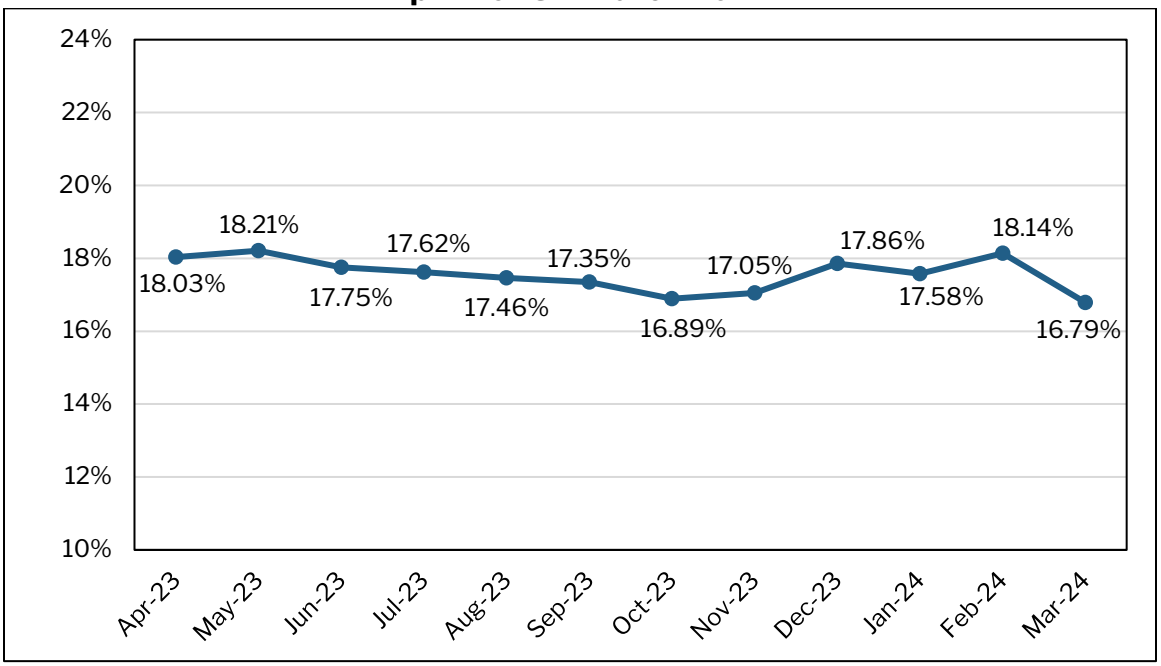
Figure 14: Annual Staff Turnover Rate
CY2019 - 2023



Source: DSS's Data Submission to the Court (April 26, 2024, Dkt.295)

As shown in Figure 15, the vacancy rate for Foster Care, Adoptions, and OHAN case managers and Team Leaders has fluctuated over the last 12-month period, though ultimately declining in the final month – from 18.03 percent in April 2023 to 16.79 percent in March 2024.

Figure 15: Vacancy Rate for Foster Care, Adoptions, and OHAN Case Managers and Team Leaders
April 2023 – March 2024



Source: DSS's Data Submission to the Court (April 26, 2024, Dkt.295)

Staffing and Caseloads 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. Caseload standards differ by case manager type – specifically Foster Care and Adoptions and investigators of allegations of abuse and neglect of children in foster care (OHAN).[41] Approved caseload standards are included in Table 2.

[41] 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 children in foster care (Class Members) they serve to the total number of families (cases) of Non-Class Members also served. The following types of cases are currently counted by family (case): 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

Table 2: 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[42]	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
Team Leaders						
Foster Care Team Leader	One team leader to five case managers (1:5)	N/A	More than six case managers			
Adoptions Team Leader	One team leader to five case managers (1:5)	N/A	More than six case managers			
OHAN Team Leader	One team leader to six investigators (1:6)[43]	N/A	More than seven investigators			

Source: Approved DSS Workforce Implementation Plan (February 2019)

* Employed less than six Months since completing Child Welfare Pre-Service Certification training

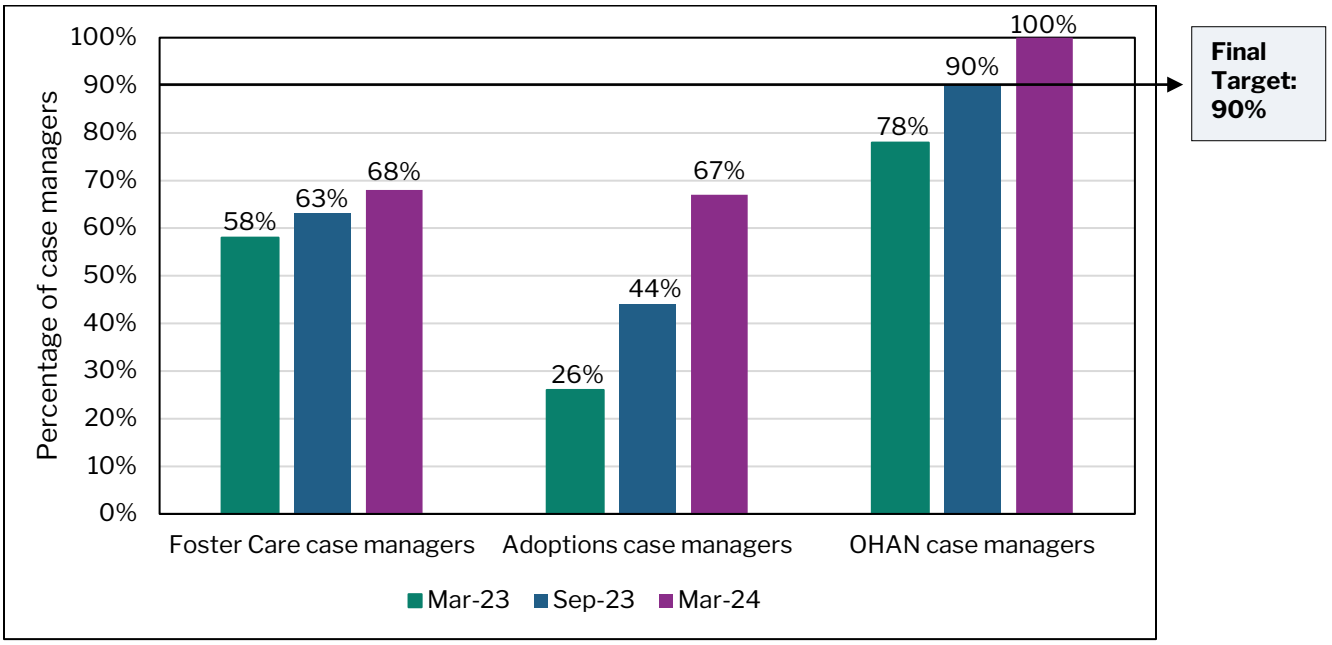
applied to Foster Care case managers with mixed caseloads and is not applied to Adoptions case managers.

[42] 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 managers was 1:17. In 2019, DSS began transitioning case management responsibility to Adoptions case manager once children became legally eligible for adoption. This was completed in January 2020; thus, Adoptions case manager caseload performance is assessed at a standard of 1:15.

[43] The Co-Monitors approved a higher caseload standard for OHAN Team Leaders in recognition of the fact that the OHAN investigators they supervise have lower caseload standards than other direct service case managers.

Figure 16 shows performance data on caseloads by case manager type for the two prior and the current monitoring periods. As of March 31, 2024, compared to six months prior, the percentage of case managers with caseloads within required limits has improved for all three case manager types.

Figure 16: Percentage of Case Managers with Caseloads Within the Required Limits, by Case Manager Type March 2023 – March 2024

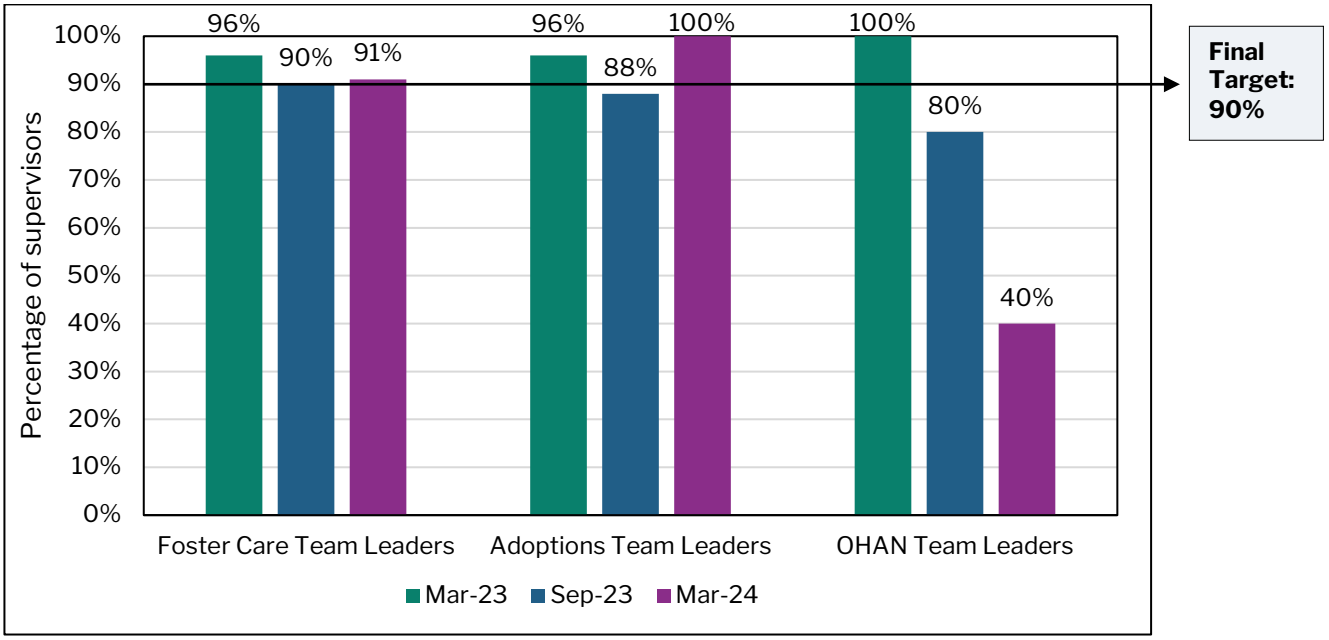


Source: CAPSS data provided by DSS

As shown in Figure 17, performance as of March 2024 for both Foster Care and Adoption Team Leaders has improved since September 2023. The percentage of OHAN Team Leaders within caseload compliance declined in March 2024 as a new Team Leader started in the role and was only assigned one case manager, shifting the remaining case manager assignments to three other Team Leaders who each managed seven case managers that month (one more than the standard of 1:6).

Team Leaders' workloads may be higher than is reflected in the data, as data submitted by DSS show that some Team Leaders are continuing to be directly responsible for cases.[44]

Figure 17: Percentage of Team Leaders with Assigned Workers Within the Required Limits, by Supervisor Type March 2023 – March 2024



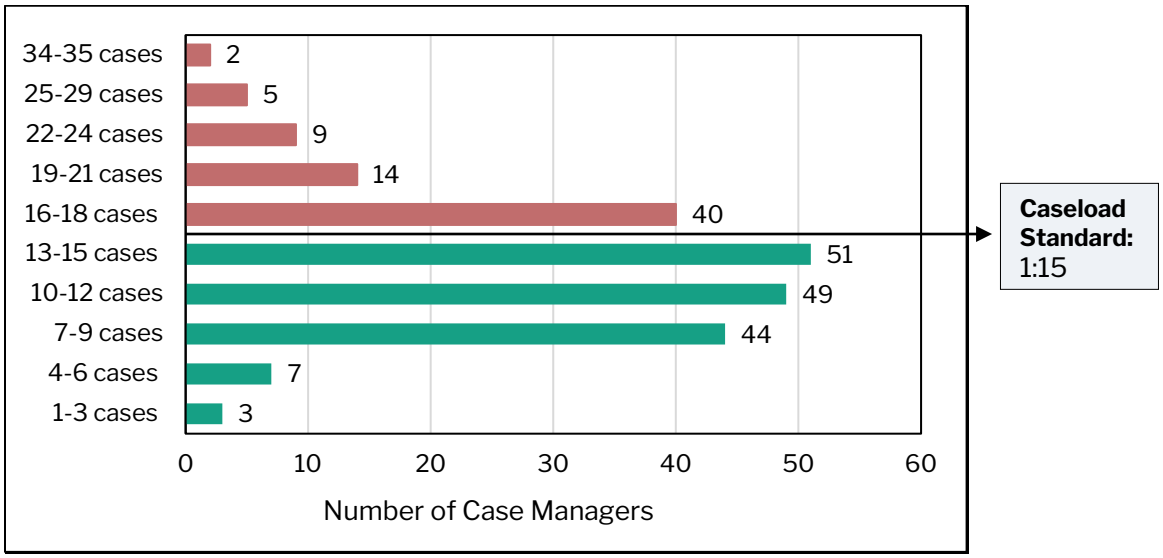
Source: CAPSS data provided by DSS

[44] DSS has identified situations in which it may be necessary for Team Leaders to be directly responsible for carrying cases for short periods of time. These include circumstances in which a case manager is promoted to Team Leader and may temporarily retain case management responsibilities 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. 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 Team Leader for up to 5 days until the Team Leader assigns the case to the receiving case manager. DSS has also identified that Team Leaders sometimes carry cases when a case manager leaves the agency and creates a vacancy that takes some time to fill or when case managers are on extended leave. While the Team Leader 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(s); and other activities as necessary. For these circumstances, DSS requires Regional Director approval for Team Leaders to carry cases for more than 5 days; documentation be shared with DSS's Accountability, Data, and Research (ADR) unit; and a description of the case(s) the Team Leader will carry, the circumstances leading to the Team Leader carrying cases, and a specific plan and timeline be created to address the issue.

Foster Care Case Managers

Figure 18 shows the number of cases assigned on March 31, 2024 to the 224 Foster Care case managers who had completed Child Welfare Pre-Service Certification training more than six months prior (classified as "not new case managers"). The Figure shows the distribution of cases for the 154 case managers with caseloads within the standard and the 70 case managers with caseloads above the standard. As shown in the Figure 18, as of March 31, 2024, two case managers who were not new were responsible for more than 30 cases each (double the caseload standard).[45]

Figure 18: Number of Cases Assigned to Not New Foster Care Case Managers
March 31, 2024
N= 224 Existing (Not New) Foster Care Case Managers



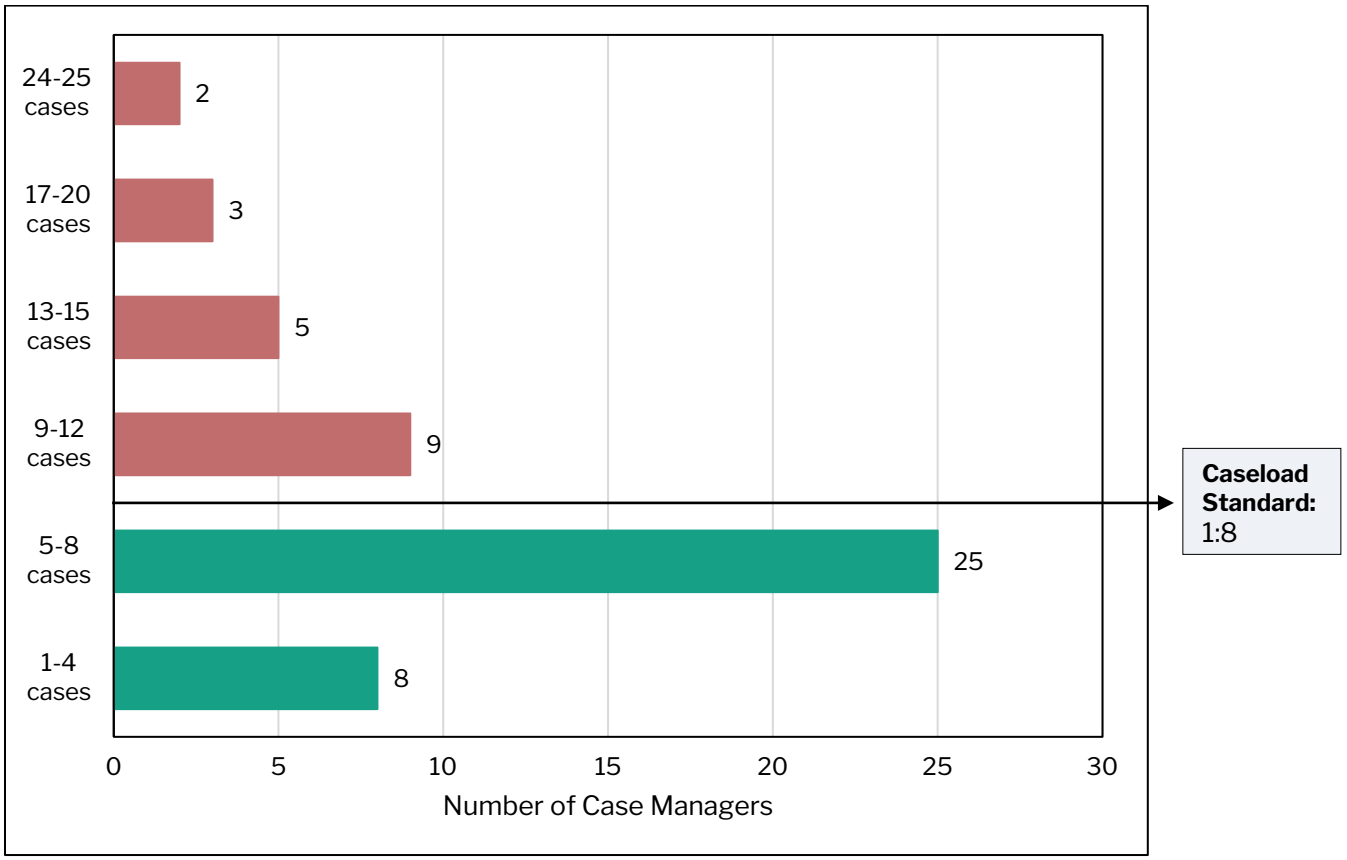
Source: CAPSS data provided by DSS
*Green bars indicate caseloads at or below the required standard; red bars indicate caseloads higher than the required standard.

Apart from allowing workers sufficient time to engage with children and families and meet best practice expectations, graduated caseload standards are an important worker retention strategy and allow new staff the time to develop their skills. Figure 19 shows the number of cases assigned on March 31, 2024 to the 52 new Foster Care case managers who had not completed certification training more than six months prior (classified as "new case managers"). Sixty-three percent (33 of 52) of new

[45] The Foster Care case manager with 34 cases was in Laurens County, and the Foster Care case manager with 35 cases was in Charleston County.

Foster Care case managers had caseloads within the standard. As of March 31, 20204, 10 percent (5 of 52) of new Foster Care case managers were responsible for 17 or more cases (approximately double the graduated caseload standard).

Figure 19: Number of Cases Assigned to New Foster Care Case Managers
March 2024
N= 52 New Foster Care Case Managers



Source: CAPSS data provided by DSS
*Green bars indicate caseloads at or below the required standard; red bars indicate caseloads higher than the required standard.

Data on Foster Care case managers' caseloads by region as of March 31, 2024, are shown in Table 3. 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. Over the last 12 months, performance improved in the Midlands and Pee Dee regions, and declined in the Lowcountry and Upstate regions.

Table 3: Foster Care Case Managers with Caseloads Within the Required Limit, by Region March 31, 2023 – March 31, 2024

Region	Foster Care Caseloads within Required Limit on March 31, 2023	Foster Care Caseloads within Required Limit on September 30, 2023	Foster Care Caseloads within Required Limit on March 31, 2024
Lowcountry	40% N= 17/42	41% N= 14/34	36% N= 15/42
Midlands	30% N= 23/77	50% N= 46/92	63% N= 58/92
Pee Dee	67% N= 39/60	67% N= 40/60	88% N= 53/60
Upstate	87% N= 73/84	81% N= 73/90	75% N= 61/81

Source: CAPSS data provided by DSS

VI. Contacts with Children: Case Manager Visits with Children Family Time - Children's Visits with Their Parents and Siblings

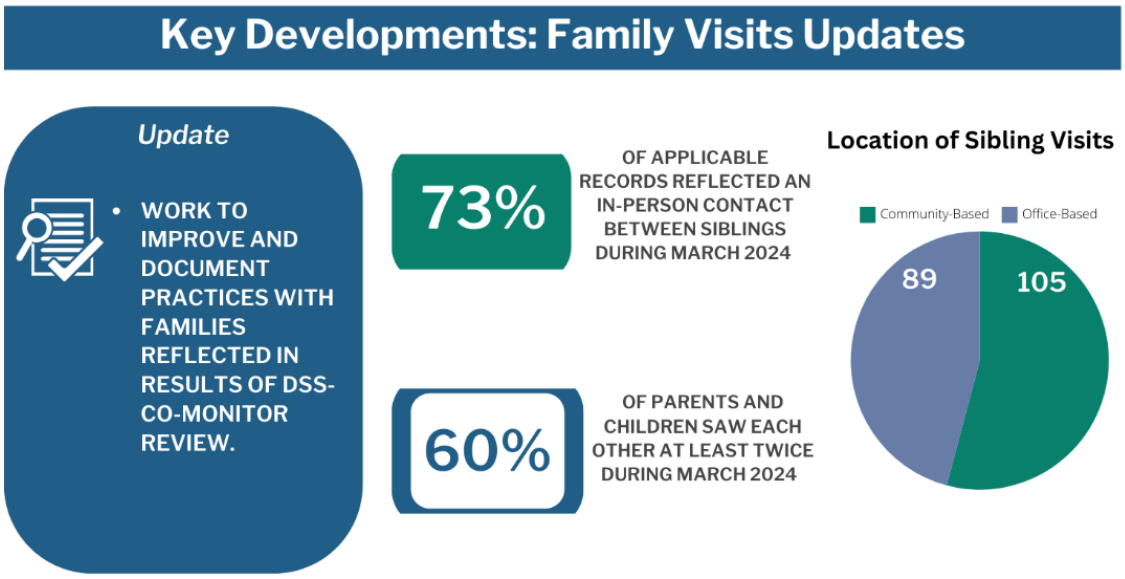
In October 2021, after years of consistently low performance on essential visits between case managers and children (FSA IV.B.3) and time children spend with their parents, family members, (FSA IV.J.2), and siblings who are also in foster care and placed separately (FSA IV.J.3), and upon agreement of all Parties,[46] the Co-Monitors suspended case record reviews and reporting on these measures. Reviews of statistically valid samples of records in September 2021, conducted by the Co-Monitors, found 34 percent of case manager visits met FSA requirements, 17 percent of children spent time with their parents with whom they were to be reunified, and 50 percent of children spent time with a sibling who was also in foster care and from who they were separated. Parties agreed that reviews would be paused for at least four monitoring periods, or until DSS's internal data indicate there has been substantial increase in performance.[47]

In 2023, DSS reported improvements in the rate of children's visits with their parents, or reunification resource, and children's visits with their siblings, two requirements on which the agency concentrated efforts since 2021. In addition to an increased focus with staff on the importance of in-person and other forms of contacts between parents and children as well as the importance of documenting those contacts, DSS reports working with staff on multiple levels to identify barriers and develop strategies for improving practice in this area. DSS's strategies include training staff, increasing the competencies of Team Leaders who serve as coaches for staff, and a particular focus on how staff incorporate DSS's Guiding Principles and Standards (GPS) Case Practice Model into practice. DSS also made updates to CAPSS to capture data; however, additional CAPSS updates are needed to account for all allowable exceptions to visits. Currently, exceptions not in CAPSS must be assessed through a review of case record documentation.

For this monitoring period, the Co-Monitors and DSS reviewed a statistically valid sample of case records to assess performance on family time between children and

[46] For more information on DSS's performance on the FSA measures related to visits between case managers and children, and time children spend with their parents and other family members, refer to *Michelle H.,et al. v. McMaster and Leach* Progress Report for the Period April 1 – September 30, 2021, Sections VI. *Case Manager Visits with Children (p. 46)* and IX. *Family Time: Visits with Parents and Siblings (p. 98),* located here.
[47] Ibid.

their parents and siblings in March 2024. The review found that while performance on frequency of family time has improved, it remains below the FSA final targets.



Family Time: Visits with Parents and Siblings

Parent-Child Visits

The FSA requires that "*[a]t least 85% of Class Members with the goal of reunification will have in-person visitation twice each month with the parent(s) with whom reunification is sought […]*" (FSA IV.J.3.).[48] DSS committed to achieving this target by March 2021.

[48] The following are exceptions approved by the Co-Monitors to the parent-child visitation requirement: court order prohibits or limits parent visitation; parent is missing or child is on runaway during a calendar month with best efforts to locate; parent or child is incarcerated or in a facility that does not allow visitation in the calendar month despite best efforts; parent refused to participate; parent did not show up to visit despite attempts to successfully arrange and conduct the visit; parental rights were terminated in that month; parent visit is infeasible due to geographic distance, with efforts to provide alternative forms of contact (geographic distance will only be allowed as an exception upon individual review of the applicable case by the Co-Monitors); County Director approval with legal consultation for determination that a visit poses immediate safety concerns for the child (if an immediate safety incident or concern occurs prior to or during a visit, the case manager is to remove

Results from a review of a statistically valid sample of 306 applicable records in March 2024 show documentation of an approved exception to the requirement for visits between a child and their parent(s) in 98 records.[49,50] Of the remaining 208 records, 83 (40%) had no documentation visits between children and parent(s).

Sixty percent (125 of 208) of children in DSS custody with a goal of reunification visited their parents or reunification resource twice during March 2024. Current performance shows improvement from the September 2021 review at 17 percent but continues to fall below the final target of 85 percent.

Sibling Visits

Section IV.J.2. of the FSA requires that "*[a]t least 85% of the total minimum number of monthly sibling visits for all sibling visits shall be completed.*"[51] DSS committed to achieving this target by March 2021.

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the child from the visit and notify the County Director afterward); and Team Leader approval for determination that visitation would be psychologically harmful for the child. A DSS Team Leader must confirm the determination that visitation would be psychologically harmful to the child based upon written documentation of clinical decision issued by a Licensed Practitioner of the Healing Arts (LPHA) within the scope of their practice under SC State Law and who is not an employee of DSS. The LPHA's name, professional title, signature, and date must be listed on the document to confirm the clinical decision. In all instances, the exception must be supported by documentation of the exception reason and best efforts to foster time between the parent and child.

[49] As of March 31, 2024, there were 1,579 children who had been in foster care for at least 30 days with a permanency goal of "return to home" or "not yet established." A statistically valid sample of 306 cases was reviewed based on a 95% confidence level and +/- 5% margin of error.

[50] These exceptions include that the parent did not visit despite attempts to arrange and conduct a visit; a court order prohibited visits; and the child refused to participate in a visit.

[51] The following are exceptions approved by the Co-Monitors to the sibling visitation requirement: court order prohibits or limits sibling visitation; child or sibling is on runaway during a calendar month with best efforts to locate; child or sibling is incarcerated or in a facility that does not allow visitation despite efforts; child or sibling refuses to participate in the visit, where age appropriate; sibling visit is infeasible due to geographic distance with efforts to provide alternative forms of contact (geographic distance will only be allowed as an exception upon individual review of the applicable case by the Co-Monitors); County Director approval with legal consultation for determination that a visit poses immediate safety concerns for the child or sibling (if an immediate safety incident or concern occurs prior to or during a visit, the case manager is to remove the child from the visit and notify the County Director afterward); and Team Leader approval for determination that visitation would be psychologically harmful for the child. A DSS Team Leader must confirm the determination that visitation would be psychologically harmful to the child based upon written documentation of a clinical decision issued by a Licensed Practitioner of the Healing Arts (LPHA) within the scope of their practice under SC State Law and who is not an employee of DSS. The LPHA's name, professional title, signature, and date must be listed on the document to confirm the clinical decision. In all instances

Results from a review of a statistically valid sample of 285 applicable records in March 2024 show documentation of an agreed-upon exception to the requirements that siblings visit each other at least once a month in 21 records. [52,53,54] Of the remaining 264 records, 70 (27%) had no documentation of siblings spending time together.

Seventy-three percent (194 of 264) of the total minimum number of monthly sibling visits for all sibling visits were completed in March 2024 . Current performance shows improvement from the September 2021 review at 50 percent but continues to fall below the final target of 85 percent.

Of the sibling visits that occurred in March 2024, a majority (54% or 105 of 194) took place in a community-based setting with a case manager or caregiver present. A small number (6% or 11 of 194) of siblings spent time wholly unsupervised. Others (45% or 89 of 194) spent time with each other in a DSS office during a supervised visit with a parent. [55]

Case Manager Visits

The FSA requires that "*at least 90% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place,*" and "*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.2.&3.). The total minimum number of monthly visits between children and a case manager refers to a federal requirement of a minimum of one visit per month.

listed above, the exception must be supported by documentation of the exception reason and best efforts to foster time with sibling(s).

[52] The universe applied to the requirement for monthly sibling visits includes siblings in foster care and living apart for the entirety of March 2024. It is further narrowed to siblings placed in foster care at the same time or within one year of each other to better reflect siblings who "lived together before their placement," one of the elements of the definition of a sibling, as reflected on page 2 of the court ordered Visitation Plan (April 3, 2019, Dkt. 115).

[53] A statistically valid sample of 285 cases was reviewed from a universe of 1,099, based on a 95% confidence level and +/- 5% margin of error.

[54] Exceptions included siblings refusing to visit and court orders prohibiting a visit.

[55] This includes three siblings whose time was facilitated by a therapist.

To assess FSA compliance, the Parties agreed that a case manager's documentation in CAPSS of a contact with a child should reflect DSS policy and practice and that CAPSS documentation would be assessed qualitatively. [56] DSS has not reported improvements in case manager visits with children. Therefore, the Co-Monitors have not resumed case record reviews to determine performance on this measure.

[56] 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

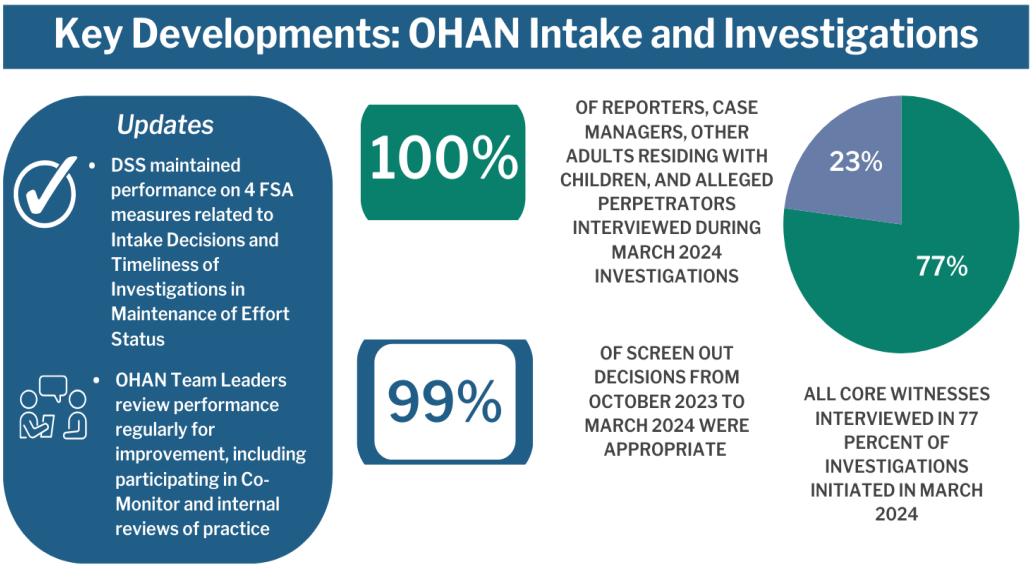
The Out-of-Home Abuse and Neglect (OHAN) unit conducts investigations of allegations of abuse and/or neglect of children in foster care screened by Intake Hub staff and deemed to warrant investigation. On August 3, 2023, based on DSS achieving and demonstrating performance, the Court granted *Maintenance of Effor*ts status for four FSA OHAN commitments[57] 1)Intake – Decision Not to Investigate; 2)Timely Completion of Investigation Within Forty-five (45) Days of Initiation; 3)Timely Completion of Investigation Within Sixty (60) Days of Initiation; and 4)Timely Completion of Investigation Within Ninety (90) Days of Initiation.

DSS has maintained performance levels in each of these areas. The Co-Monitors continue to note improvements in the quality of documentation and practices within OHAN. The increased number of OHAN staff; regional assignment to investigations; consistent supervision and management; and dedication to improvement are important contributors to this continued success.

Overall, performance with respect to other OHAN FSA measures – timely initiation of investigations, investigation decisions, and contact with core witnesses during investigations – improved. DSS's implementation of new processes and practice tools positively influenced performance in several areas, including seeing children in a timely manner and gathering needed information from core contacts. An ongoing issue is that some reports to the Intake Hub of incidents that do not meet the criteria for alleged abuse or neglect could be screened out and better managed by the child and family's team or by licensing workers instead of to OHAN for investigation.[58]

[57] Court Order approving Maintenance of Effort for FSA IV.C.2 and FSA IV.C4(d), (e), and (f). (August 3, 2023, Dkt.290)

[58] Examples 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 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.



OHAN Performance Data

OHAN Intake

DSS's Intake Hub screens all reports alleging abuse and/or neglect of children, including allegations involving children in foster care settings.[59] Decisions on whether to accept a report for investigations are made using a Structured Decision Making (SDM)® intake tool.[60]

[59] In addition to the Intake Hub call center, DSS maintains a child abuse and neglect online reporting system accessible through its 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 determining that some reports regarding children in foster care were improperly submitted through this website, which has a longer 48-hour timeframe for processing, DSS reviewed its procedures for web-based reports with the goal of modifying them to meet the FSA requirements for a 24-hour response. DSS reports it has designated Intake Team Leaders to be responsible for checking DSS's online portal every two hours for reports.

[60] For more information on SDM, see https://evidentchange.org/assessment/structured-decision-making/child-welfare/

Decision Not to Investigate

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.).

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 whether the allegations would meet the state's statutory definition of abuse or neglect.[61] A Team Leader reviews and approves each screening decision.

DSS met the agreed upon target for this measure. The Co-Monitors reviewed data collected by DSS's Internal Monitoring Team which show DSS has maintained performance on this measure between October 2023 through March 2024. DSS's Internal Monitoring Team agreed with the decision to screen out 55 of 56 (98%) applicable reports.[62]

OHAN Investigations

Allegations of abuse or neglect of children in DSS custody screened by DSS's Intake Hub as appropriate for investigation are assigned to OHAN staff.[63,64] The FSA and OHAN policy require face-to-face contact with each of the alleged victim child(ren) within 24 hours of a report to Intake to assess for safety and risk, and the investigation is to be completed within 45 days.[65] OHAN policy requires that the investigator conduct a safety assessment, including a private interview with the child; collaborate with the child's case manager or law enforcement to make arrangements for medical treatment or examinations, as needed; interview core witnesses to inform the investigation; review documents and records related to the incident; and assess the risk of further maltreatment to all children within that setting.[66]

[61] SC Code § 63-7-20.
[62] This review includes examining information entered in CAPSS, and listening to recordings of reports, when available.
[63] 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).
[64] Allegations of abuse and/or neglect by a foster parent of their biological or adopted child(ren) are investigated by child protective service case managers/investigative staff in local county offices.
[65] SC DSS Child Welfare Policies and Procedures Manual, Chapter 16: Special Topics: Out of Home Abuse and Neglect (effective May 19, 2022).
[66] Ibid.

FSA measures that relate to OHAN investigations include timely initiation of the investigation (two measures);[67] contact with core witnesses (one measure); investigation determination decisions (one measure); and timely completion (three requirements which DSS has met and maintained). The Co-Monitors and DSS staff review all investigations initiated in March and September of each year to report on performance. In March 2024, OHAN initiated 48 investigations; 30 of the investigations involved Class Members and were applicable for review.

Timely Initiation of Investigations

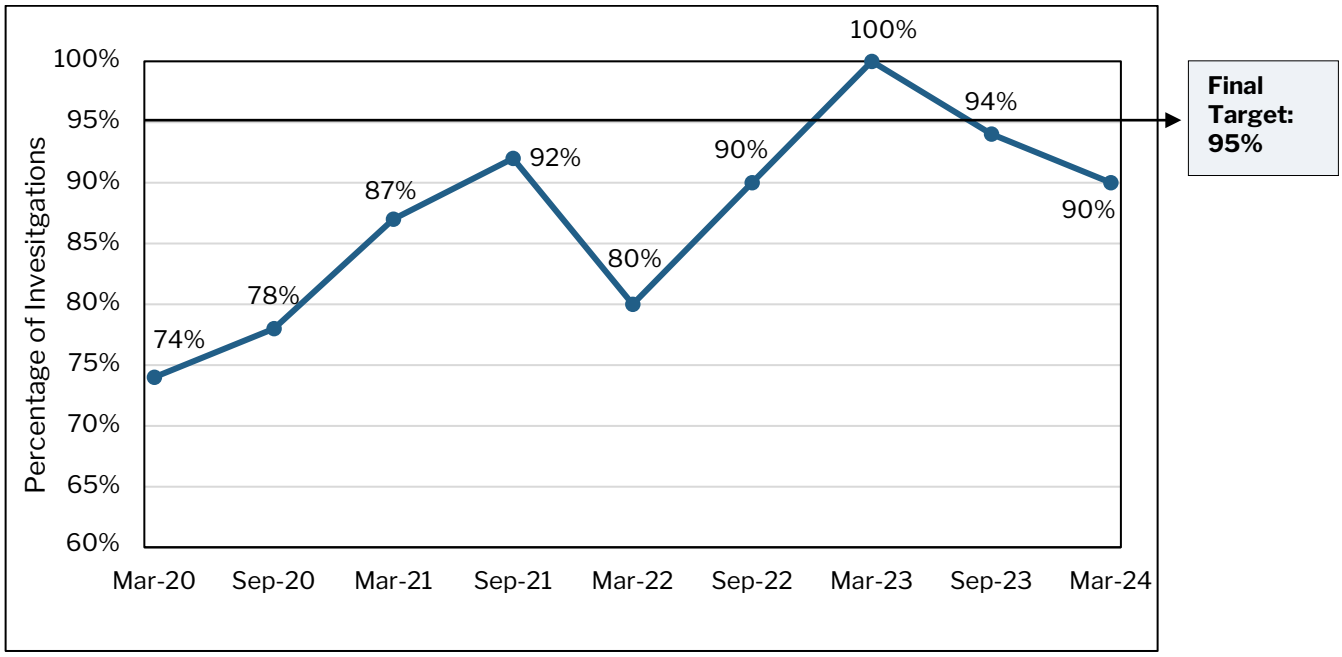
The FSA requires that *"[t]he investigation of a Referral of Institutional Abuse or Neglect must be initiated within twenty-four (24) hours in accordance with South Carolina law in at least 95% of the investigations"* (FSA IV.C.4.(a)). FSA Section IV.C.4.(b) requires that *"[t]he investigation of a Referral 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."* [68] The Co-Monitors measure performance for both FSA IV.C.4.(a) and (b) using the same methodology and timeframes, requiring face-to-face contact with the alleged child victim within 24 hours of a report by the Intake Hub.

[67] The Co-Monitors' interpretation of the FSA requires that investigations be initiated within 24 hours of receipt of a 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.

[68] The Co-Monitors approved the following efforts as "good faith efforts" for timely initiation which must be completed and documented, as applicable, to make 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, 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 Team Leader(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).

Of the 30 applicable OHAN investigations which began in March 2024, investigators met with all alleged victim children within 24 hours in 26 (87%) investigations. In one (3%) additional investigation, all applicable good faith efforts were made to contact each of the alleged victim children.[69] Therefore, 90 percent of investigations were initiated in a timely manner. Current (see Figure 20) falls slightly below the final target of 95 percent.

Figure 20: Percentage of OHAN Investigations with Timely Initiation March 2020 – March 2024



Source: Case Record Reviews completed by University of South Carolina Center for Child and Family Studies (U of SC CCFS) (up to Sep-21), DSS, and Co-Monitor staff

Contact with Core Witnesses during Investigations

[69] One case involved a youth considered to be on "runaway" status who could not be located during the investigation.

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)).[70]

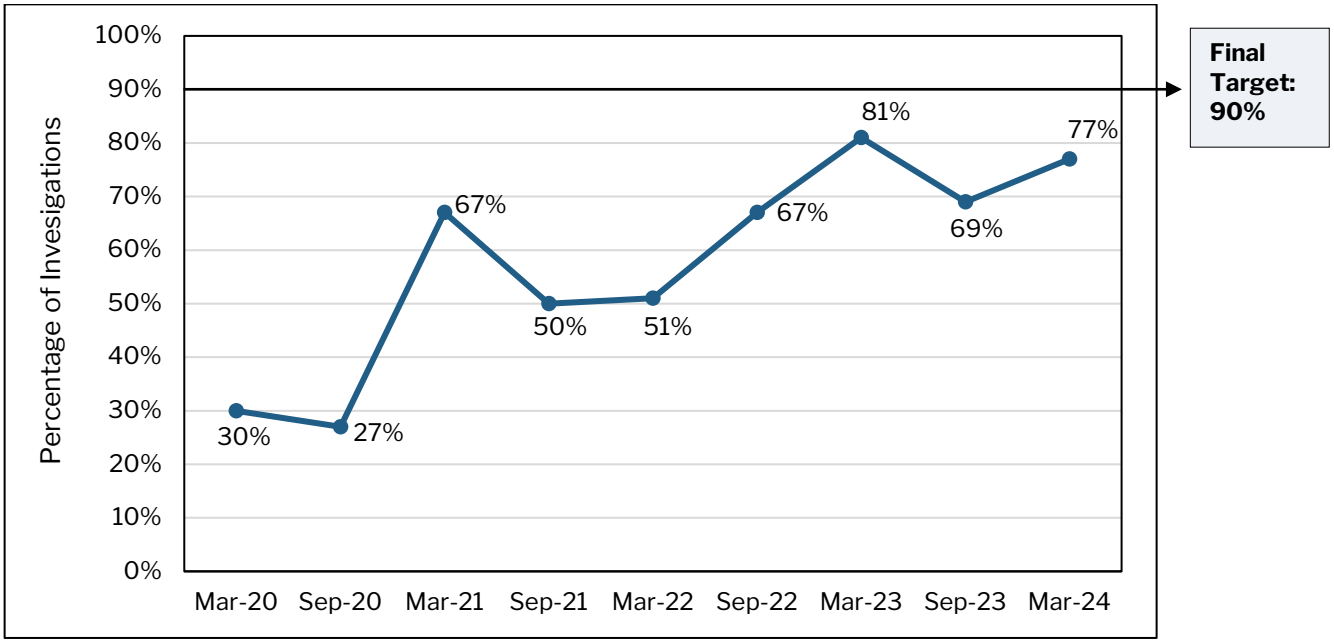
A core witness is defined as an individual who is pertinent to the investigation because they witnessed or have knowledge of the alleged actions and can shed light on the allegations and the actions of the alleged perpetrators. Core witnesses may differ from investigation to investigation, but in all 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.[71]

Of the 30 applicable investigations which began in March 2024, 23 (77%) documented contact with all necessary core witnesses during the investigation. This performance reflects an increase from the previous monitoring period (69%) but remains below the final target of 90 percent (see Figure 21).

[70] 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 and best efforts to engage the witness.

[71] 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.

Figure 21: Percentage of OHAN Investigations with Contact with All Necessary Core Witnesses
March 2020 – March 2024



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

Data presented in Table 4 show the frequency of OHAN investigator contact with each type of core witness in the 30 investigations reviewed.

Table 4: Percentage of OHAN Investigations with Necessary Core Witnesses by Type of Core Witness
March 2024
N= 30

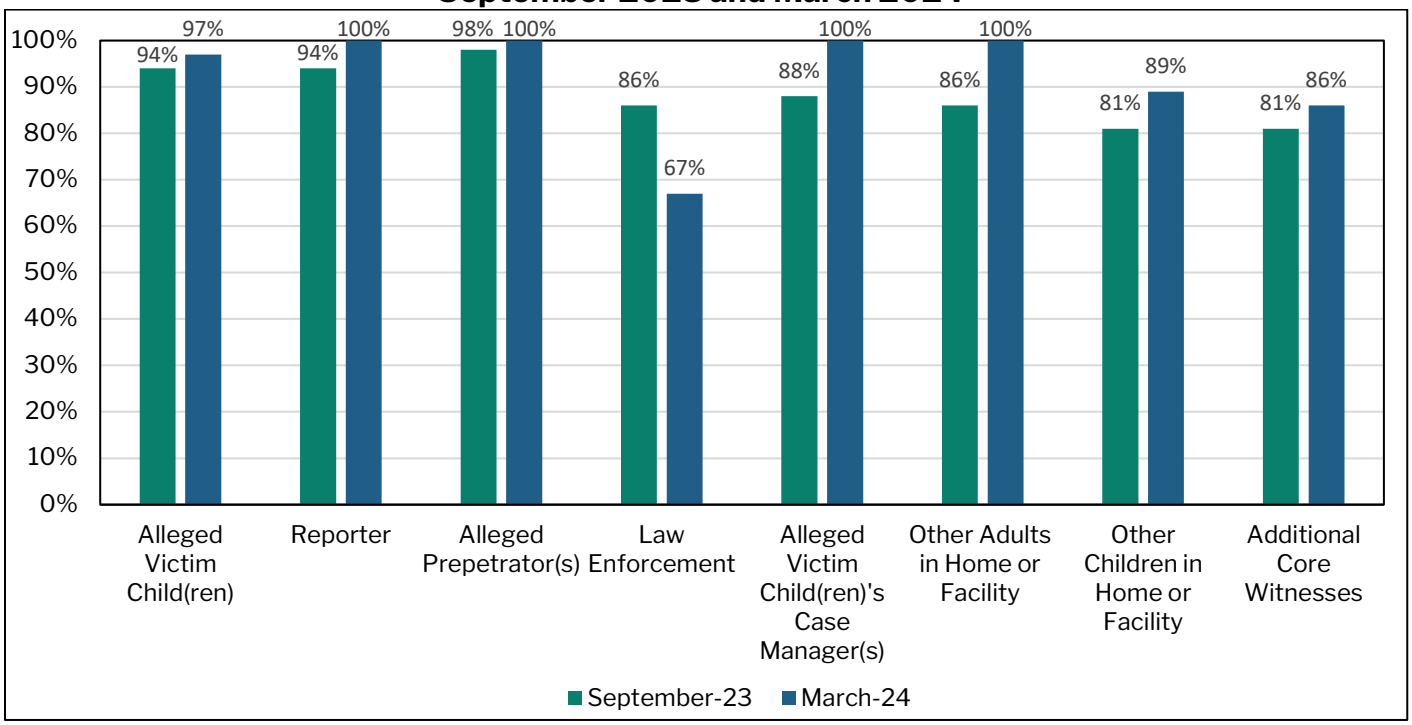
Core Witness	Applicable Investigations	Interview with All
Alleged Victim Child(ren)	30	29 (97%)[72]
Reporter	29[73]	29 (100%)
Alleged Perpetrator(s)	30	30 (100%)
Law Enforcement	9	6 (67%)
Alleged Victim Child(ren)'s Case Manager(s)	30	30 (100%)
Other Adults in Home or Facility[74]	10	10 (100%)
Other Children in Home or Facility[75]	19	17 (89%)
Additional Core Witnesses	28	24 (86%)

Source: Case Record Review completed in June 2024 by DSS and Co-Monitor staff

Data in Figure 22 show the frequency of contact within all categories of core witnesses for investigations opened in March 2024 compared to the prior review of investigations in September 2023. There are improvements in each area, except with the frequency of contact with law enforcement, where performance declined.

[72] For each investigation, the investigator interviewed and/or observed each alleged victim child, as age appropriate. In one investigation, a child needed an interpreter for a full interview, and one was not provided.
[73] In one investigation, the reporter was anonymous.
[74] 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.
[75] 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 there, investigators should speak with all other children who were involved in or who have knowledge of the allegations.

Figure 22: Contact with Necessary Core Witnesses During OHAN Investigations September 2023 and March 2024



Source: Case Record Reviews completed by DSS and Co-Monitor staff

Investigation Decisions

According to DSS policy, 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.[76]

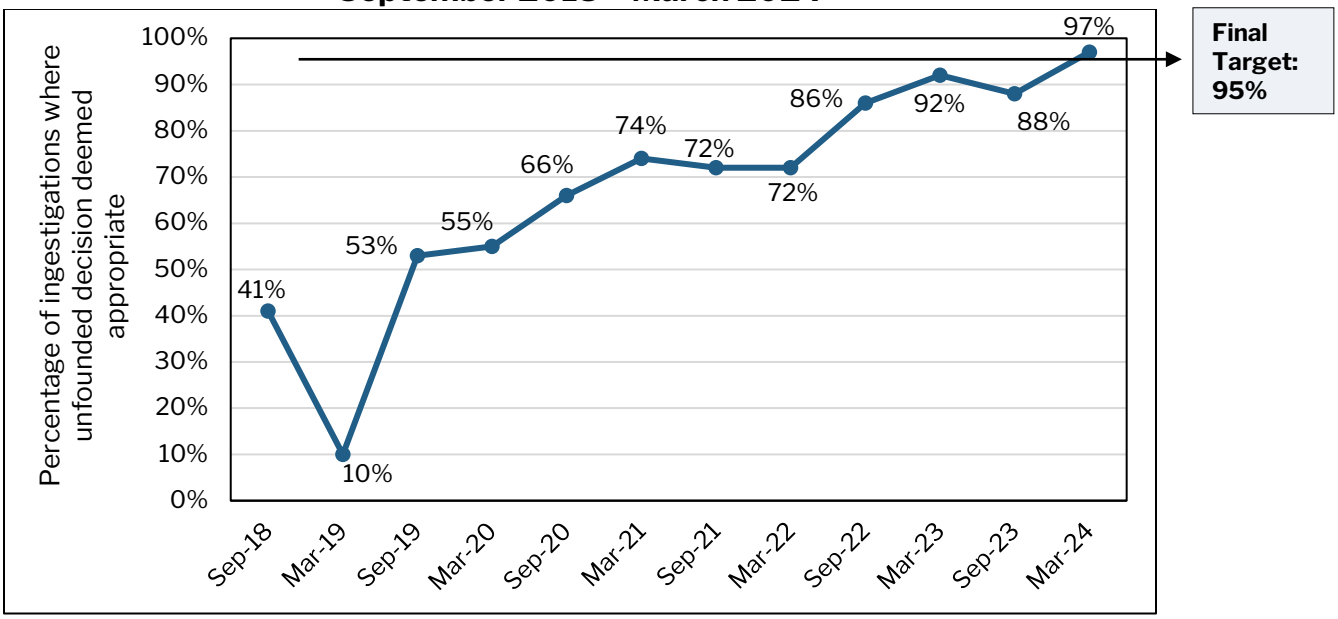
Section IV.C.3. of the FSA requires that *"[a]t least 95% of decisions to 'unfound' investigations of a Referral of Institutional Abuse or Neglect must be based upon DSS ruling out abuse or neglect or DSS determining that an investigation did not produce a preponderance of evidence that a Class Member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

In each of the 30 investigations reviewed, the final decision was to *unfound* the allegations. Reviewers agreed that the decision to *unfound* the investigation was

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

appropriate in all but one (97%) of the investigations.[77,78] For the first time since the inception of this lawsuit, performance in this area exceeds the final target of 95 percent.

Figure 23: Decision to Unfound OHAN Investigations Deemed Appropriate September 2018 – March 2024



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 three measures for timely completion of investigations (FSA IV.C.4(d),(e)&(f)), recognizing that some investigations may take longer than 45 days as policy requires. 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.[79] Good cause means that, through no fault of the investigator,

[77] For the investigation in which the reviewer did not agree with the decision to *unfound*, the reviewer determined there was not sufficient documentation of the information necessary to make an accurate finding in the investigation.
[78] As part of the Co-Monitors protocol for all case reviews, if a safety concern is identified and documentation does not reflect it was addressed, DSS is immediately notified for appropriate follow-up.
[79] SC DSS Child Welfare Policies and Procedures Manual, Chapter 16: Special Topics: Out of Home Abuse and Neglect effective (May 19, 2022).

sufficient reason exists for delaying the investigation decision.[80] DSS has met and maintained the required final target levels for each measure assessing timely completion of OHAN investigations since September 2018. These measures are in Maintenance of Effort status and are tracked twice yearly by the Co-Monitors through case record reviews.

Completed within 45 Days

Twenty-four (80%) of the 30 investigations reviewed were completed within 45 days. The six (20%) remaining investigations reviewed, included approval for an additional 15 days to complete necessary investigative tasks and were closed within the extended timeframe. Current performance at 100 percent exceeds the final target for this measure.

Completed within 60 Days

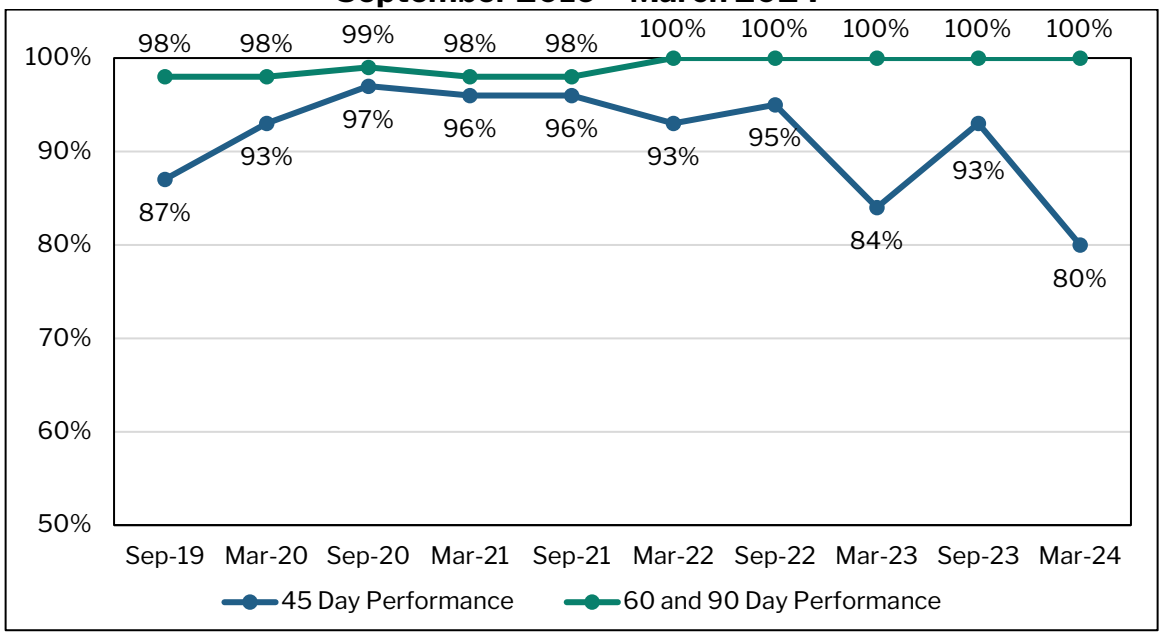
All (100%) of the 30 investigations reviewed were completed within 60 days of opening. Performance exceeds the final target for closure within 60 days.

Completed within 90 Days

Since all investigations were closed within 60 days, performance on 90-day closure is also 100 percent, and performance exceeds the final target for this measure. Figure 24 shows performance for timely closure of investigations from March 2020 to March 2024.

[80] 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.

Figure 24: Timely Completion of OHAN Investigations
September 2019 – March 2024



FSA Final Targets:
45 Day – 60%
60 Day – 80%
90 Day – 95%

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

VIII. Placements

For children who are separated from their families, DSS has continued to prioritize placement with family members ("kin") or other people who are important in children's lives ("fictive kin"). Consistent with what is now considered best practice by the federal government and many states, DSS is actively working towards becoming a "kin first" state and increasing the number of children successfully placed with kin and fictive kin. Twenty-nine percent of all children in DSS custody were placed with kin at the end of March 2024 – the highest percentage since the inception of the *Michelle H.* lawsuit, and an increase from 27 percent during the last monitoring period.

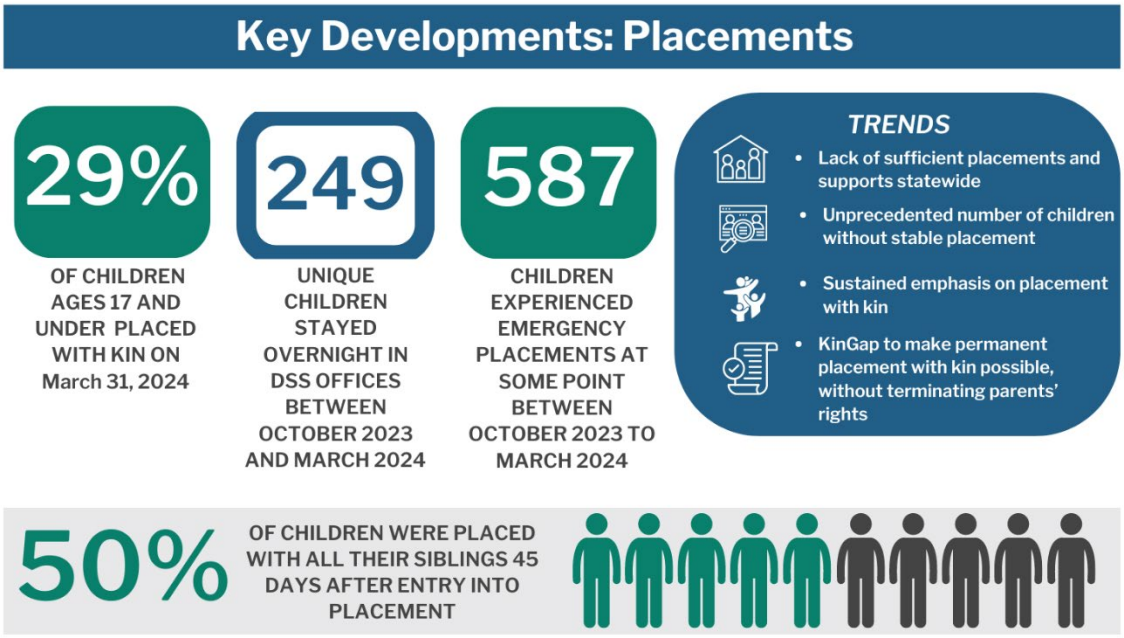
Overall, however, the placement instability crisis shows no signs of abating and continues to require immediate attention. The Co-Monitors' Supplemental Report, issued in August 2023, described the urgent concerns with the impact of the placement crisis on children, families, kin, foster parents, group home staff, private providers, and DSS frontline staff and leaders.[81] In the months since, children in DSS custody continue to be moved between placements, DSS offices, and emergency settings at exponentially higher rates.

During the most recent six-month monitoring period (October 1, 2023, to March 31, 2024), ***587 unique children spent 9,280 nights in emergency placements*** reflecting an increase from the prior monitoring period, when 555 unique children spent 8,991 nights in emergency placements. As noted in the Co-Monitors' Supplemental Report, "*For children who come to DSS after forced separation from everything they know – family, friends, communities – instability and uncertainty can be devastating. Being moved day after day through offices and strangers' homes, having to bathe in public places, losing access to one's phone (and only lifeline) would be dysregulating to any adult, no less children looking for a sense of control and stability.*"[82]

There are many interrelated factors that contribute to placement instability for children removed from their families. In South Carolina, key contributors are the severe shortage of community-based services and supports, including crisis intervention services and trauma-based treatments; an insufficient array of

[81] *Michelle H.* Co-Monitors' Supplemental Report Regarding South Carolina's Placement Crisis (August 1, 2023, Dkt. 288-1) To see the full report, go to: https://cssp.org/wp-content/uploads/2023/10/Supplemental-Report-re-South-Carolinas-Placement-Crisis.pdf
[82] *Ibid. at* p.16.

placement resources, especially those with caregivers trained and supported to work with children with complex needs; and the limited ability of staff to identify, assess, and respond to children's underlying needs. DSS cannot solve this problem by themselves. They need more effective partnerships with private providers and transparent collaboration with and accountability between other state agencies, most importantly the Department of Health and Human Services (DHHS), the Department of Mental Health (DMH), the Department of Juvenile Justice (DJJ), the Department of Disability and Special Needs (DDSN), the Department of Education (DE), and the Department of Children's Advocacy (DCA) to develop the services and supports that children and youth need. Medicaid and its contractor, Select Health, as the principal funders of needed service expansions must be fully engaged and committed. Further, DSS will be unable to fully succeed in its mission of supporting children's safety, permanency, and well-being and strengthening families, without additional work to integrate its Guiding Principles and Standards (GPS) case practice model[83] into its practice with children and families.



[83] DSS's GPS case 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 case practice model, go to: https://dss.sc.gov/media/2746/gps-practice-model-final.pdf

Placement Updates

Practice Development to Assess Underlying Needs and Craft Individualized Services

The Co-Monitors have long recommended that DSS demonstrate a different approach to identifying and understanding children and families' underlying needs. During this monitoring period, DSS continued to work with a consulting psychologist who is providing technical assistance on a small number of complex cases involving youth in Greenville, Richland, and Spartanburg counties. These consultations are geared towards assessing children and families' underlying needs, identifying innovative problem-solving strategies, and supporting and developing DSS staff expertise in crafting individualized service plans. This is an initial strategy intended to build capacity and skills of DSS workers to integrate the GPS practice model into their work with children and families.

Stakeholder and Private Provider Partnerships

Since the start of the lawsuit, the Department's efforts to engage private providers as partners in developing and implementing change strategies have grown. Since the outset, many members of the provider community have shared that they are ready and willing to contribute and adapt as needed to assist DSS in its efforts to better support children and families. The effectiveness of many of the recommendations included herein, as well as initiatives in which DSS is currently engaged, depend not only on collaboration with other state agencies, but on consistent and meaningful partnerships with providers.

On October 9th and 10th, 2023, DSS convened a strategy session with providers and other stakeholders to examine together the root causes of the placement instability crisis and to consider and develop follow-up actions. The convening resulted in the formation of three workgroups: one focused on embedding a kin-first culture, the second on strategies to improve placement stability and the redesign of CFTMs, and the third was charged with embedding youth-centered approaches into case practice. Each workgroup consists of representatives from DSS, providers, and partner organizations, and will incorporate input from participants with lived experience. The Co-Monitors participate with some of the workgroups.

Although the promise of the workgroup effort and the focus on root causes and the underlying needs of children and families is essential and important, the outputs from the workgroups have been slow. Parallel to that work, the Co-Monitors continue to believe that more immediate actions are needed in response to the alarming rate at which children experience multiple moves and continue to be housed in DSS offices. The known lifelong deleterious effects on children and families of family separation compounded by placement instability highlight the urgency of developing immediate workable solutions.

Expansion of Home- and Community-Based Services Through Medicaid

DSS and its partner agencies continued to move forward this monitoring period with some of the recommendations included in the Co-Monitors' Supplemental Report.[84] With the support of the Governor's office, there appears to be increased collaboration between agencies and other key partners. Planning continues for the initial roll-out of evidence-based, prevention-focused Homebuilders and Multi-Systemic Therapy (MST) services; and the planned addition of much-needed crisis stabilization capacity in hospitals throughout the state. The Co-Monitors will continue to closely track and report on the implementation of MST, Homebuilders, and the addition of hospital based crisis stabilization services. It is important to note that while MST and Homebuilders are valuable resources, both models have eligibility requirements that limit services to a modest number of children and families.

The Co-Monitors encourage DSS and its partner agencies to proceed expeditiously in developing a robust system of care and supports for South Carolina's children and families that is available at scale and across the state.

Expansion and Use of Pre-Removal Child and Family Team Meetings (CFTMs) and Risk-of-Placement-Disruption CFTMs

DSS leadership and staff report that convening a CFTM prior to a child's placement into foster care has been an effective practice for keeping families together and identifying kin and other family resources should a child need to enter placement. The use of CFTMs as part of efforts to prevent family separation has proved to be an

[84] A full list of Co-Monitor recommendations for addressing the placement crisis can be found in the Supplemental Report pp. 19-29, https://cssp.org/wp-content/uploads/2023/10/Supplemental-Report-re-South-Carolinas-Placement-Crisis.pdf

effective practice in many jurisdictions throughout the country. In its Supplemental Report, the Co-Monitors recommended that CFTMs be mandated to routinely occur before or upon placement, and in accordance with the GPS Case Practice Model.[85] The Co-Monitors also recommended that "DSS engage technical assistance support in the form of external expert consultation around the assessment of underlying needs and innovative problem-solving strategies with families, including use of flexible funds that could meet the needs of families to avoid family separation."[86] The regular and consistent use of CFTMs by DSS and its partners remains a goal and a work in progress. Until CFTMs become an expected part of practice and are consistently used to engage, assess, and support children and families when children initially enter DSS's custody and throughout their involvement with DSS, the potential of CFTMs to be more than a crisis response will not be fully realized.

DSS identified its desire to use pre-removal CFTMs as a core strategy in counties involved with their Small Test of Change (STOC) work. As part of that work, they began rolling out pre-removal CFTMs focused on young people ages 13 to 17 who are at risk of entering foster care in four counties in the state: Richland, Spartanburg, Anderson, and Greenville. The goal of pre-removal CFTMs is to prevent the unnecessary separation of youth and families and to work with community partners to develop strategies to improve service planning and outcomes for older youth. The Co-Monitors encourage the Department to move forward on this work as quickly as possible, and to dedicate sufficient resources to support statewide rollout as needed.[87] This includes access to ample flexible funding that can be quickly accessed by teams working with children and their families and creatively utilized to support

[85] To see the GPS Case Practice Model, go to: https://dss.sc.gov/media/2746/gps-practice-model-final.pdf

[86] *Michelle H.* Co-Monitors' Supplemental Report Regarding South Carolina's Placement Crisis (August 1, 2023, Dkt. 288-1), p.22. To see the full report, go to: https://cssp.org/wp-content/uploads/2023/10/Supplemental-Report-re-South-Carolinas-Placement-Crisis.pdf

[87] As identified in the Supplemental Report, successful implementation will require flexible funds to be available to CFTMs, without unnecessary layers of approval. These funds should be easily accessible to staff, and available for concrete supports and non-traditional interventions that are not currently funded through other state and federally funded programs to meet needs identified by children and their families. This need for flexible funds was identified as a high priority in the planning work underway in the STOC counties (Greenville, Anderson, and Spartanburg). *Michelle H.* Co-Monitors' Supplemental Report Regarding South Carolina's Placement Crisis (August 1, 2023, Dkt. 288-1), p.23. DSS reports that it has dedicated $500,000 in flexible funds to be used by these counties to prevent entry into foster care for youth at risk of system involvement.

child specific efforts to ensure safety, stability, permanency, and well-being.

Placement 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.).

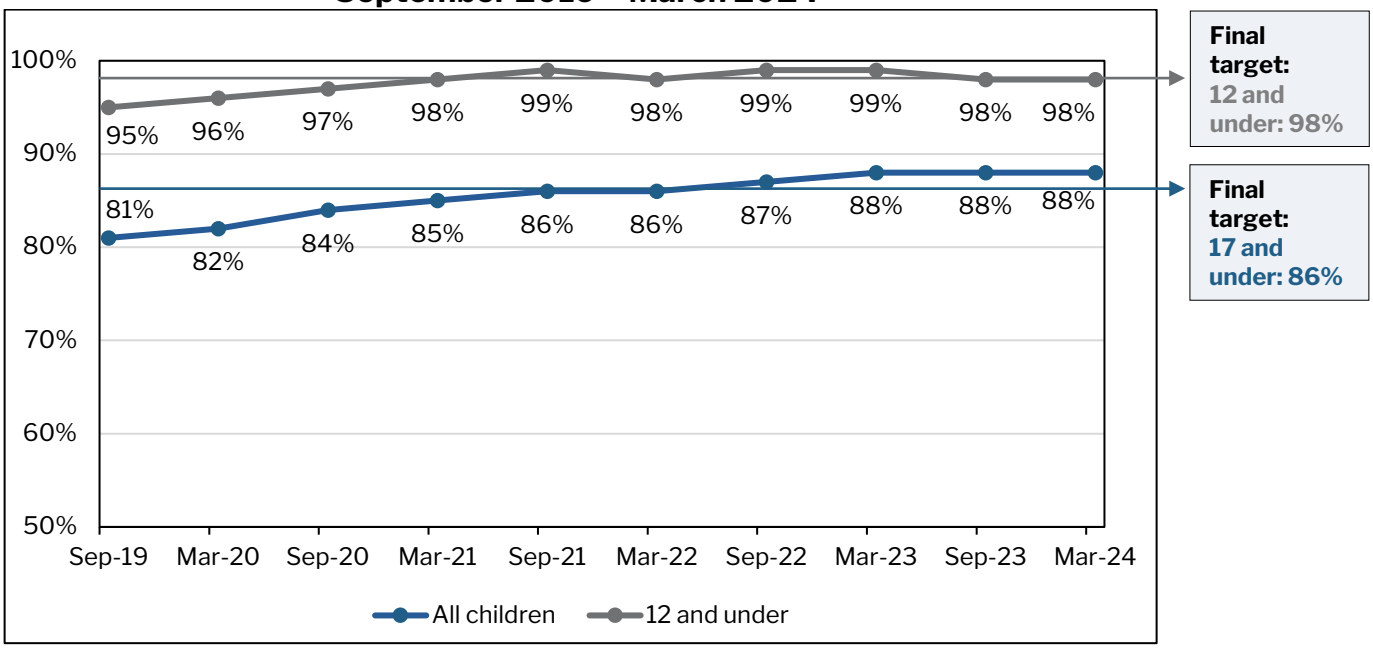
On March 31, 2024, 88 percent (2,966 of 3,389) of Class Members were placed in family-based settings and outside of a congregate placements.[88] Performance continues to meet the final FSA target for children residing in family-based placements.[89]

The FSA also includes placement standards specific to certain age groups of children, requiring 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.).

As reflected in Figure 25, as of March 31, 2024, 98 percent (2,231 of 2,272) of Class Members ages 12 and under resided in a family–based setting and outside of a congregate placement.[90] As shown in Figure 25, performance on this measure continues to meet the final target.[91]

[88] Twenty-two children resided in other institutional settings and were removed from the universe. Specifically, DSS reports that 16 children were incarcerated in correctional or juvenile detention facilities and six children were hospitalized.
[89] This measure captures strictly the type of setting in which children are placed at a given point in time and does not reflect stability or the long-term nature of that placement. Children without long-term placement who are being shuffled through emergency placements are included in this calculation as residing in family-based placements.
[90] This includes three children under the age of six who resided with their parent in a residential facility.
[91] 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 30, 2022, October 3, 2022, March 23, 2023, October 26, 2023, and March 25, 2024 monitoring reports.

Figure 25: Trends in Placement of Children Outside of Congregate Care
September 2019 – March 2024



Source: CAPSS data provided by DSS

The overall placement of children across the state in family-based settings is an important accomplishment. However, there is still more work to be done. The data do not capture the experiences of children over their time in foster care or include children who resided in other institutional settings, such as hospitals or correctional facilities. Approximately 16 percent of all children and two percent of children ages 12 and under in foster care experienced placement in a congregate facility *at some point* during the monitoring period.

DSS is also required to prevent, 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.).[92,93]

Of the nine children ages birth to six who resided in congregate facilities during the monitoring period, all were placed in those settings pursuant to an agreed upon exception.[94]

Children ages 13 to 17 are far more likely than younger children to be placed in congregate settings and do so at consistently high rates. On March 31, 2024, 34 percent (382 of 1,117) of children ages 13 to 17 resided in a congregate facility; this is the same performance as the prior monitoring period. Forty-three percent (701 of 1,613) of children ages 13 to 17 in DSS custody were placed in a congregate setting at some point between October 1, 2023, and March 31, 2024. This is a slight decrease from the April 1, 2023 to September 30, 2023 monitoring period, when close to half (46%) of children ages 13 to 17 were placed in congregate facilities at some point during the period.

Distribution of Placement Types

Figure 26 shows the breakdown for all placement types of children in DSS custody on the last day of the monitoring period. On March 31, 2024, 15 percent (497 of 3,389) of children resided in licensed kin foster homes. As shown in the Figure 26, when combined with court-ordered unlicensed relative placements, 29 percent (971 of 3,389) of children were placed with relatives. As of March 31, 2024, 59 percent (1,995

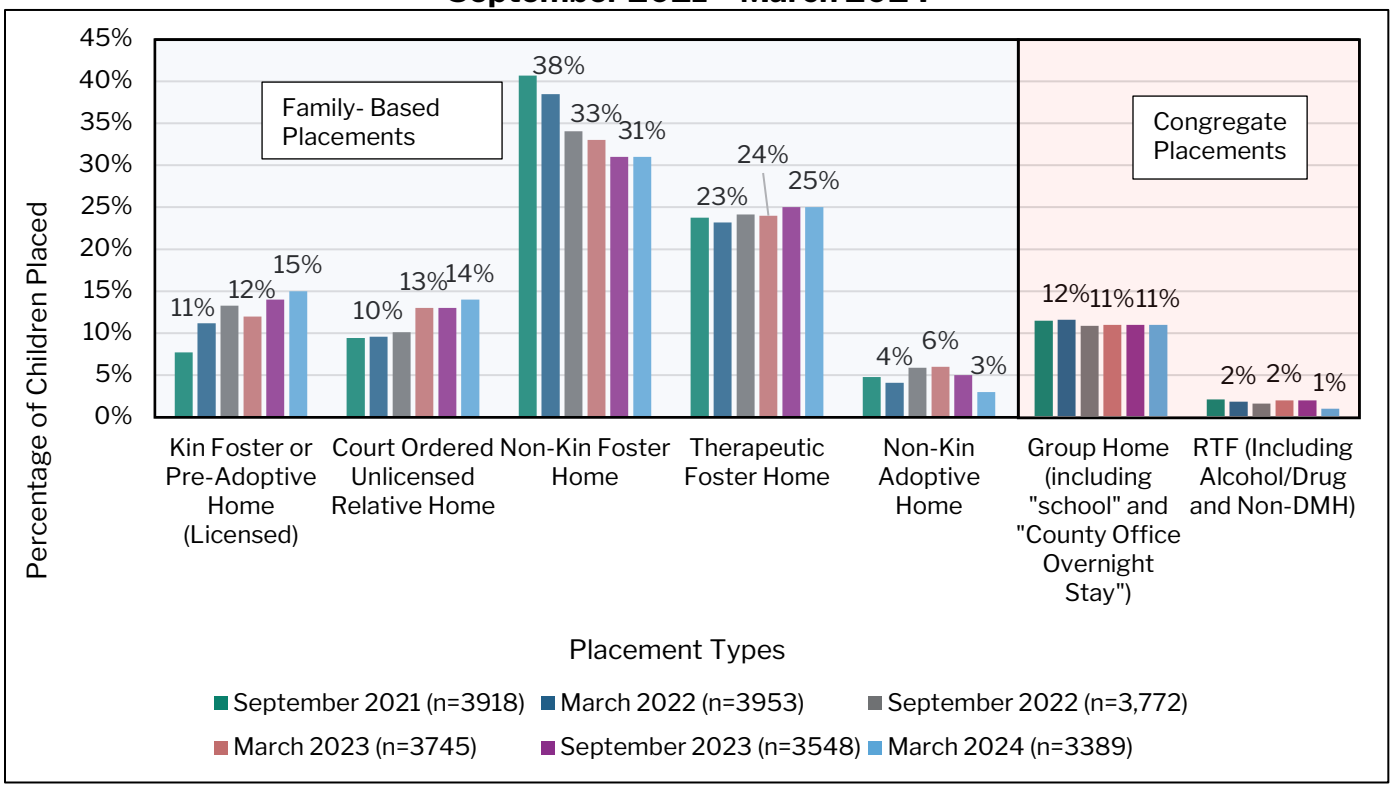
[92] On March 15, 2016, the Co-Monitors approved DSS's plan, including acceptable exceptions (due to medical necessity, placement with parents, or placement with siblings), and DSS issued a directive outlining the procedure to be used by staff to reduce the placement of young children in congregate care, 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.

[93] The following are exceptions approved by the Co-Monitors to the requirement that children ages 6 and under be placed outside of 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 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.

[94] Of the nine children, eight were placed in a treatment facility or group care setting with their parent; and one was placed with siblings for more than 90 days.

of 3,389) of children were placed in foster or adoptive homes with non-kin,[95] including: 1,039 children (31%) placed in non-kin foster homes, 853 children (25%) placed in therapeutic foster homes, and 103 (3%) placed in non-kin adoptive homes. Consistent with previous monitoring periods, most children in congregate placements resided in group homes (378 children, or 11%),[96] while 45 children (1%) were in residential treatment facilities.

Figure 26: Percentage of Children in Family-Based and Congregate Placements September 2021 – March 2024



Source: DSS Data

[95] As in many systems across the country, in South Carolina some private organizations 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. Many children in non-kin foster or therapeutic foster homes are placed through CPAs. On the last day of the period, March 31, 2024, 38 percent of children in DSS custody were in a CPA placement.

[96] This includes nine children who slept overnight in a DSS county office on the last day of the monitoring period. These are not licensed or appropriate foster care placements.

Kin Placement and Licensure

In July 2020, as part of the state's efforts to license kin homes, they reoriented DSS staff to complete kin licensing and shifted the licensing of non-kin foster homes to private agencies under contract. In May 2023, in recognition of the need for additional capacity, DSS re-initiated direct licensing of foster homes for adolescents, youth who identify as LGBTQ+ and large sibling groups. DSS continues to also dedicate staff to recruiting and licensing kin, and to prioritize the placement of children with kin.

There has been a slow but steady increase in licensed kin homes, both those with provisional and with full licenses.[97] Figure 27 shows the number of newly licensed kin homes between September 2020 and March 2024. According to DSS's April 2024 Data Submission to the Court, the number of provisional kin licenses ranged from 83 to 114 for each month between April 1, 2023 and March 1, 2024. DSS reports that it offers licensing as an option to all kin caregivers, and that staff share with potential kin caregivers the benefits of licensure, including eligibility for full foster care maintenance payments.

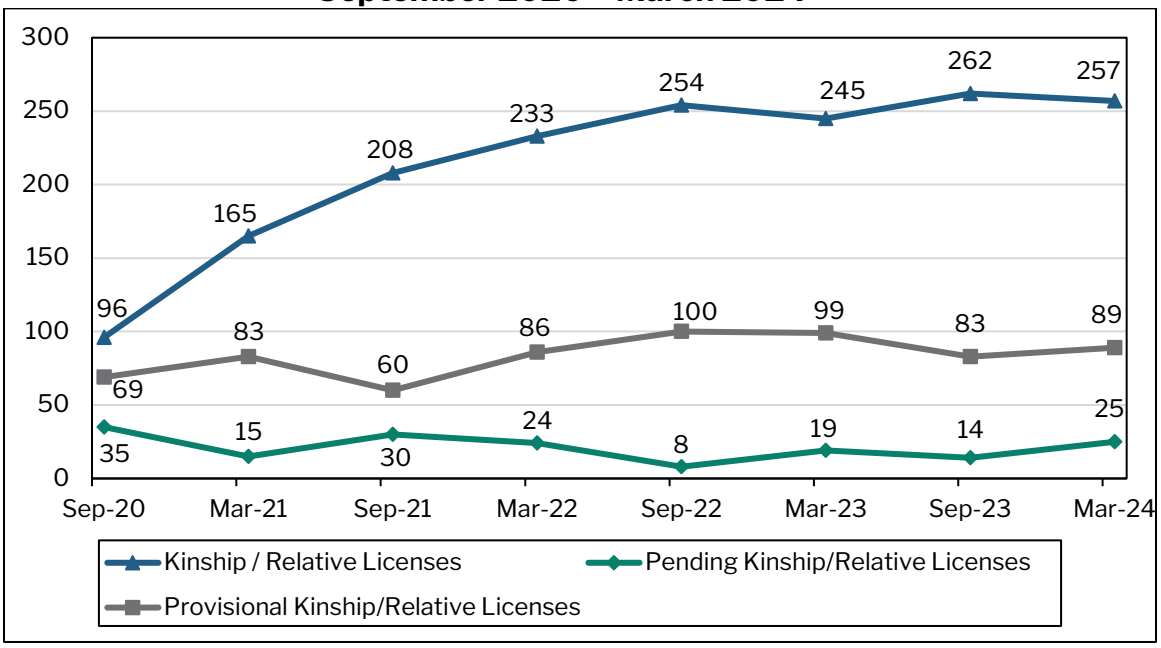
In accordance with new federal regulations[98] urging states to provide the same maintenance payments to all caregivers, including approved kin caregivers and those with provisional licenses. DSS reports that it pays kinship caregivers who are licensed and those who are provisionally licensed the same rate as non-related foster family homes. As 57 percent of kin caregivers are unlicensed as of March 2024, DSS is working to develop and implement strategies with the goal of increasing equity and for maximizing payments to all kinship caregivers. This will be essential if DSS is to be successful in further expanding the array of kin providers throughout the state. Additionally, DSS drafted proposed regulations for the licensure of kinship caregivers

[97] Provisional licensure allows a child to be placed in the kin home before the full foster parent licensure process has been completed.

[98] In recognition of the importance of kinship support in improving outcomes for children and families, on September 28, 2023, the Administration for Children and Families (ACF) published a new rule allowing Title IV-E agencies to utilize separate licensing and approval standards for kinship placements. For more information, see: https://www.federalregister.gov/documents/2023/09/28/2023-21081/separate-licensing-or-approval-standards-for-relative-or-kinship-foster-family-homes

allowing for a less burdensome application and approval standards which were published in the State Register on August 23, 2024.[99]

Figure 27: Kinship Licensing Trends
September 2020 – March 2024[100]



Source: DSS's Data Submission to the Court (April 26, 2024, Dkt.295)

Placement Instability

As shown in Table 5, children across the state experienced high levels of placement instability during the monitoring period. Eighteen percent of children in the Lowcountry, Midlands, and Pee Dee regions, and 16 percent of children in the Upstate region experienced two or more placement moves in the six-months between October 1, 2023, and March 31, 2024.

[99] DSS's proposed regulations for the licensure of kinship caregivers were published in the State Register on August 23, 2024 (Document No. 5296). For more information, go to: https://www.scstatehouse.gov/state_register.php

[100] Due to shifts in DSS data collection and reporting timelines, beginning in September 2023, data included herein are as of the first day of the following month. For example, data for March 2024 were reported by DSS as of April 1, 2024 (instead of March 31, 2024, as previously reported).

Table 5: Number of Placement Moves for Children in DSS's Custody by Region October 1, 2023 – March 31, 2024[101]

Number of Moves	Lowcountry		Midlands		Pee Dee		Upstate		Statewide	
0 Moves	546	55%	953	60%	494	54%	769	57%	2736	57%
1 Move	275	28%	351	22%	244	28%	354	26%	1220	25%
2-3 Moves	119	12%	156	10%	124	11%	141	10%	514	11%
4-5 Moves	30	3%	43	3%	24	2%	40	3%	134	3%
6-10 Moves	17	2%	38	2%	11	2%	24	2%	94	2%
>10 Moves	7	1%	48	3%	15	3%	17	1%	94	2%
Grand Total	994	100%	1589	100%	912	100%	1345	100%	4792	100%

Source: DSS Data

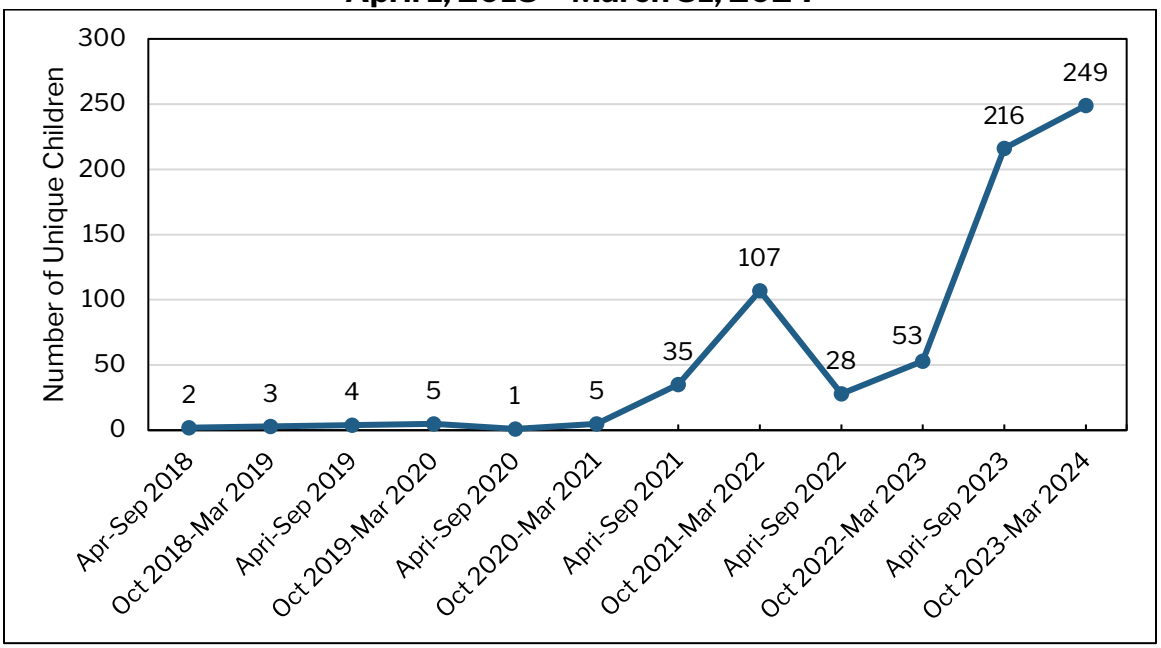
Emergency Placements and Overnight Stays in DSS Offices and Hotels

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

Between October 1, 2023, and March 31, 2024, 249 unique children stayed overnight in a DSS office (see Figure 28), a disturbing increase over all prior periods. Children staying overnight in DSS offices is unacceptable and leads to escalating problems and harm to children, families and DSS staff.

[101]Ibid.

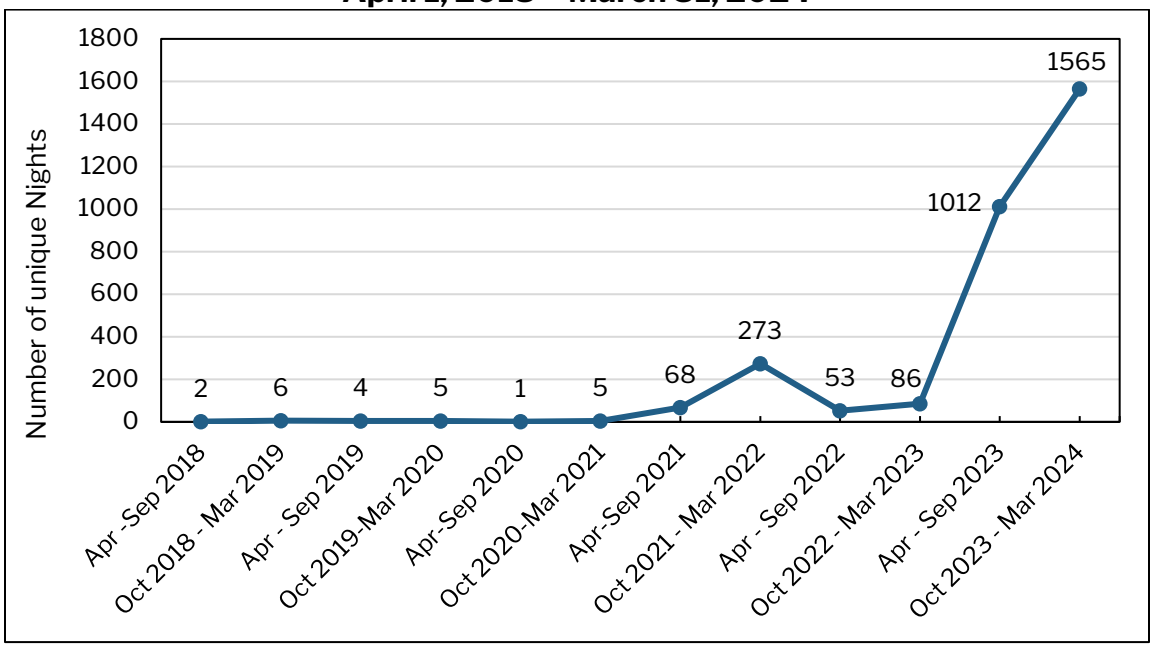
Figure 28: Number of Unique Children who Stayed Overnight in a DSS Office April 1, 2018 – March 31, 2024



Source: DSS Data

Measured in terms of the number of *nights,* as opposed to children, this increase is even more staggering. As shown in Figure 29, Class Members spent ***1,565* nights in DSS offices** in the most recent six-month monitoring period alone (October 1, 2023 to March 31, 2024), an increase of 553 nights from the prior monitoring period.

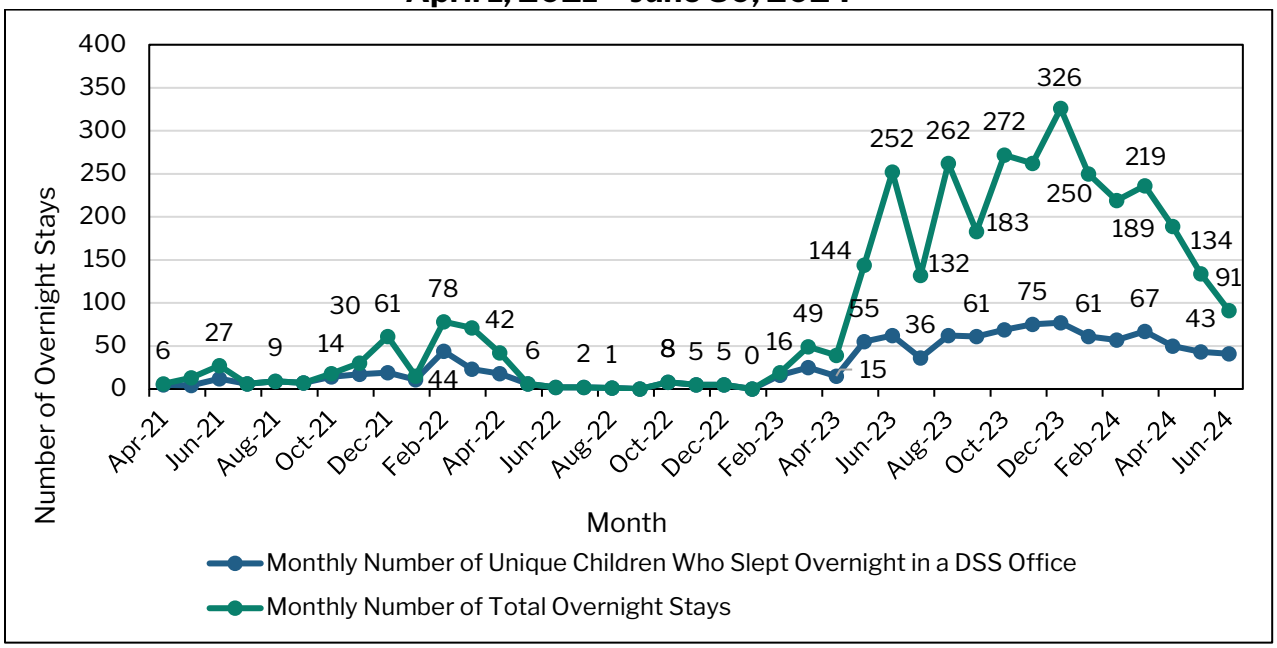
Figure 29: Number Nights Children Stayed a DSS Office
April 1, 2018 – March 31, 2024



Source: DSS Data

Since the end of the monitoring period, DSS reports a decline in the number of children sleeping in offices, as shown in Figure 30, data reported by DSS shows that for the three-month period between April 1 and June 30, 2024, 106 unique children spent a combined total of 414 nights in DSS offices.

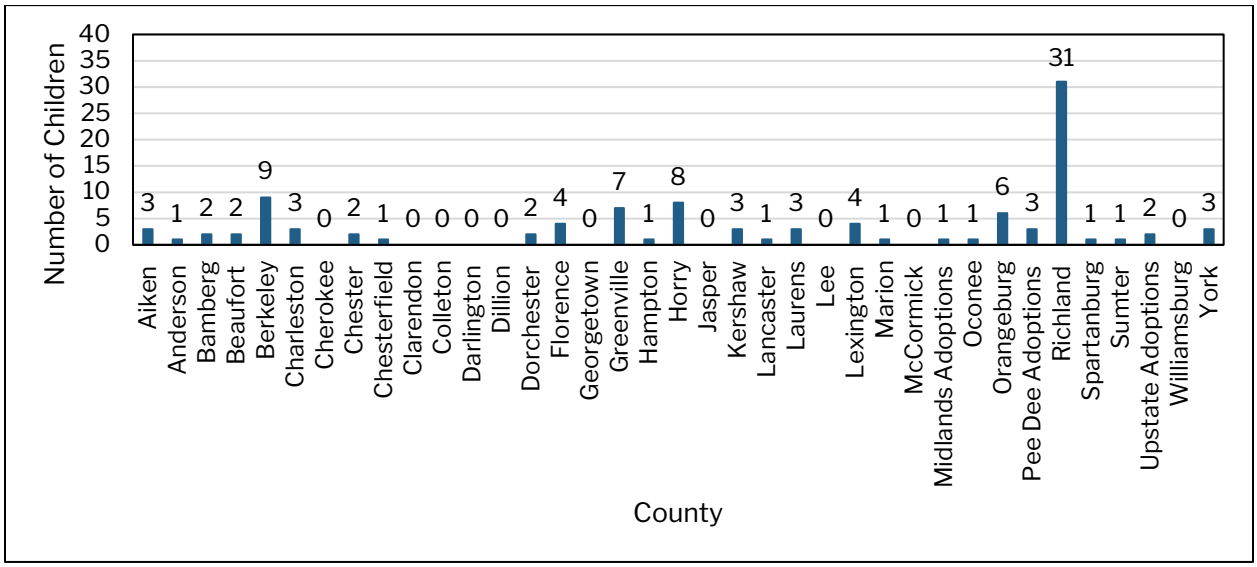
Figure 30: Number of Children's Overnight Stays in DSS Offices
April 1, 2021 – June 30, 2024



Source: DSS Data

When assessed by county, of the 106 unique children who slept overnight in a DSS office between April 1 and June 30, 2024, 29 percent (31 children) were from Richland County (see Figure 31).

Figure 31: Number of Unique Children Staying Overnight in DSS Offices by County April 1 – June 30, 2024 N= 106



Source: DSS Data

As shown in Table 6, although the number of children in DSS custody in Richland County accounts for 15 percent of the total foster care population, from April 1 to June 30, 2024, half of the overnight stays across the state occurred in Richland County (50%, or 205 of 414). These data are consistent with findings during the period of October 1 to December 31, 2024. The data shown in Figure 31 and Table 6 suggest a continuing urgent need to develop and activate specific strategies in Richland County as DSS also pursues statewide initiatives.

Table 6: Representation of Children's Overnight Stays in DSS's Largest Counties April 1 – June 30, 2024[102]

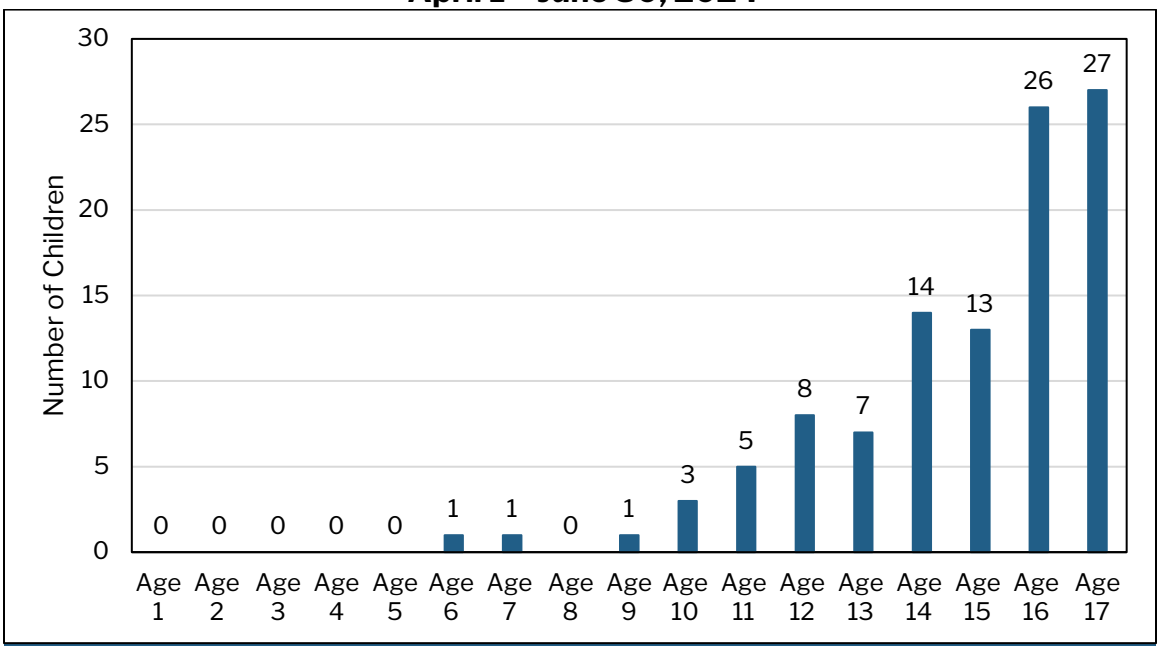
	Percentage (Number) of Overnight Stays N= 414	Percentage (Number) of all Children in Care N= 3336
Richland County	50% (205)	15% (507)
Greenville County	4% (15)	12% (399)
Horry County	6% (23)	5% (174)
Florence County	4% (16)	6% (190)
Charleston County	<1% (3)	7% (217)
Spartanburg County	<1% (1)	5% (177)
York County	1% (5)	6% (191)

Source: Data from DSS Dashboard (7/11/2024) and DSS Data

While the greatest number of the children sleeping overnight in DSS offices were between 16 and 17 years old, many younger children also stayed overnight in DSS offices. As shown in Figure 32, 53 children between the ages of six and 15 spent at least one night in a DSS office during the period of April 1and June 30, 2024.

[102] Data in this figure represents the total number of overnights experiences by children in DSS custody which includes multiple overnights experienced by one child.

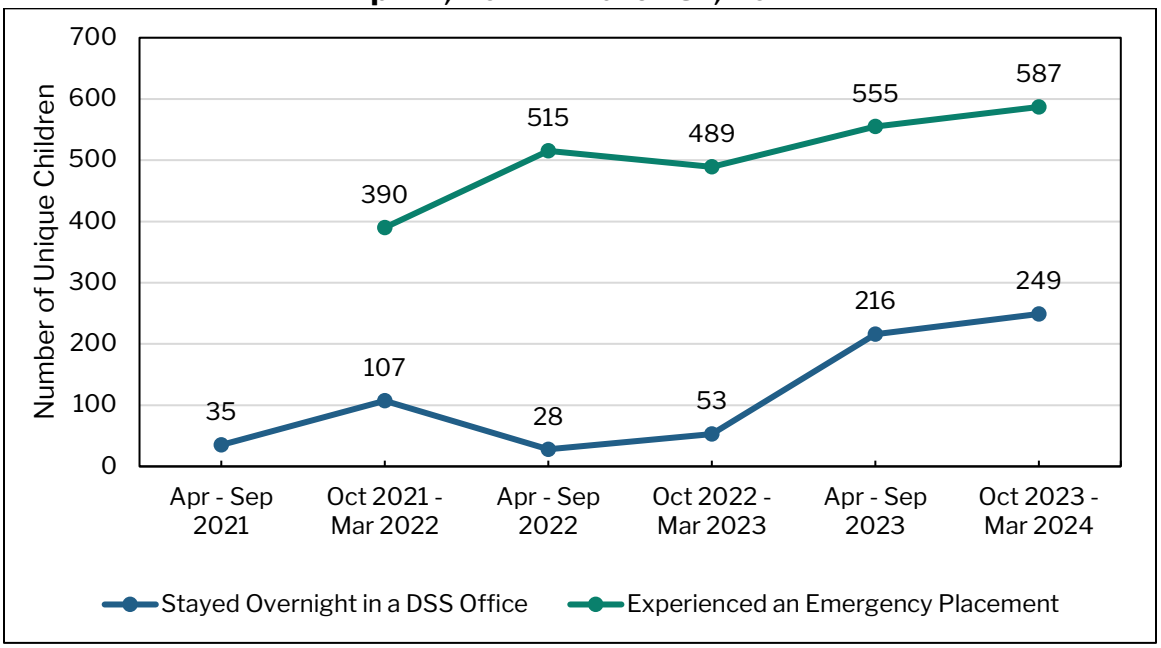
Figure 32: Number of Children Staying Overnight in DSS Offices by Age
April 1 – June 30, 2024



Source: DSS Data

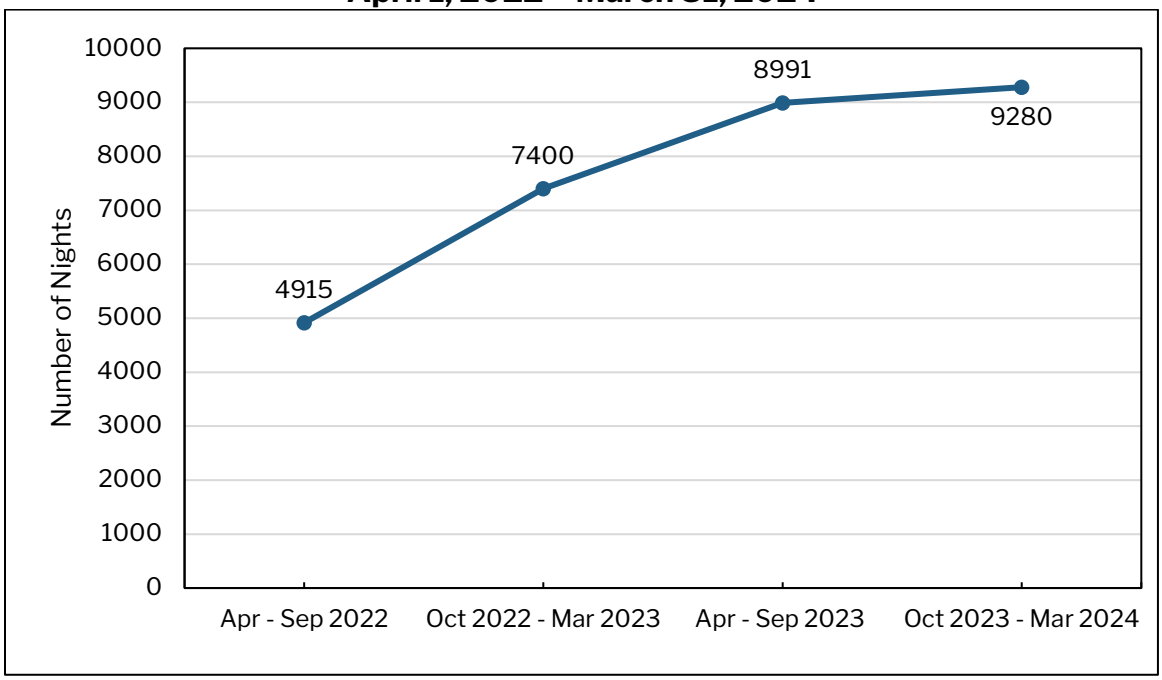
The high levels of instability experienced by children during and since the end of the monitoring period is also reflective of DSS's practice of moving children between short-term emergency placements while staff search for, and children await, appropriate and stable placement. Since September 30, 2023 (the end of the prior monitoring period), the number of nights that children spent in emergency placements has also increased. As shown in Figures 33 and 34, between October 1, 2023, and March 31, 2024, DSS reports that **587 unique children spent *9,280* nights in emergency placements.** This is an untenable situation for children whose lives have already been disrupted by entry into foster care. The moves from short term emergency placement to emergency placement disrupt family and community connections, school enrollment and participation, services, and can communicate to children that they are unwanted.

Figure 33: Children who Experienced an Overnight Stay at a DSS Office or an Emergency Placement
April 1, 2021 – March 31, 2024



Source: DSS Data

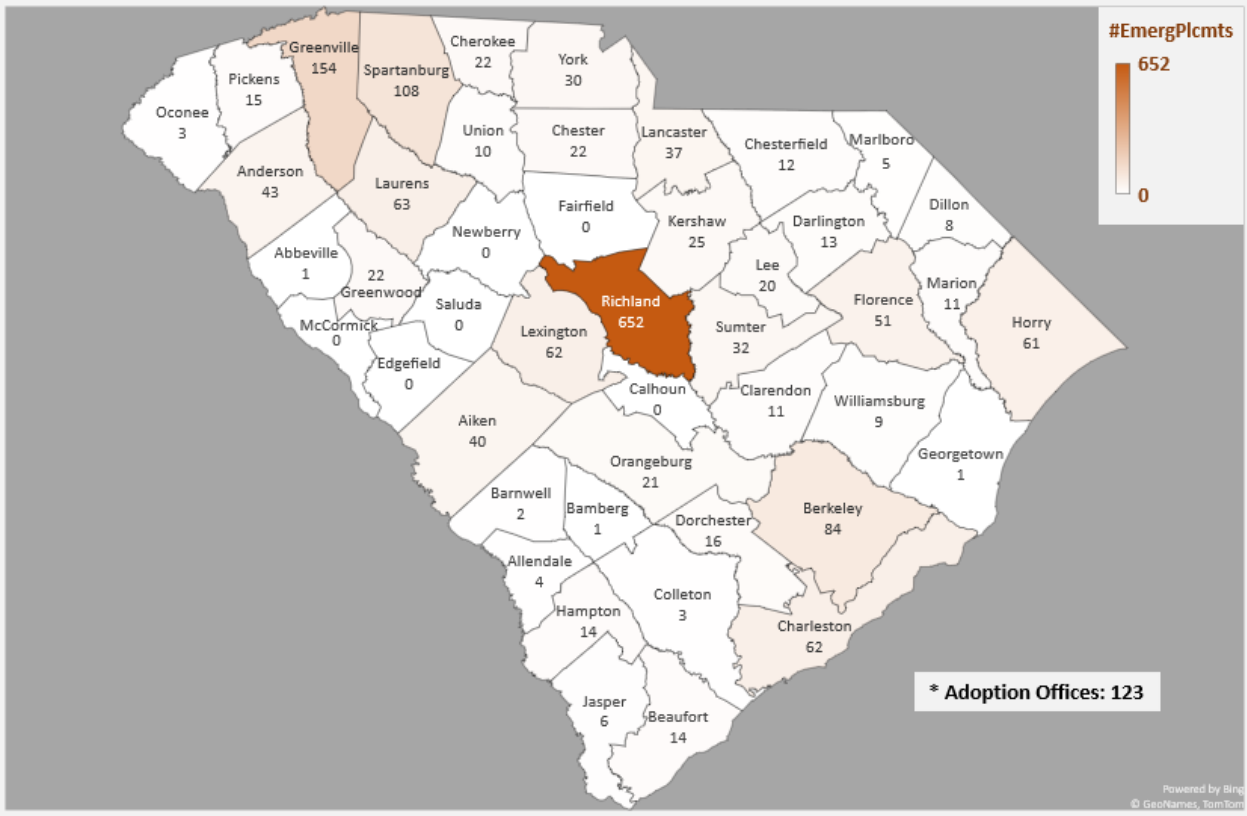
Figure 34: Number of Nights Spent in an Emergency Placement
April 1, 2022 – March 31, 2024



Source: DSS Data

Figure 35 shows the number of emergency placements that occurred between October 1, 2023, and March 31, 2024, by county. Notably, 34 percent (652 out of 1,894) of emergency placements during this time were for children from Richland County, an increase from 27 percent during the previous monitoring period.

Figure 35: Emergency Placements by Counties
October 1, 2023 – March 31, 2024
N= 1,894 Emergency Placements



Source: DSS Data

The FSA requires that children should not remain in an initial emergency placement for longer than 30 days (FSA IV.E.4.), and if they experience an additional emergency placement within 12 months, the subsequent emergency placement should not last more than seven days (FSA IV.E.5.). These FSA requirements are of limited value in capturing the experiences of South Carolina's children, as children experiencing instability are more commonly moved between emergency placements rather than remaining in a single emergency placement for a long period of time.

As required by the FSA, DSS reports that 25 of the 587 children who experienced an emergency placement between October 1, 2023 and March 31, 2024, had at least one emergency placement that lasted longer than 30 days.[103] The Department also reports that of the 323 unique children who had already experienced at least one

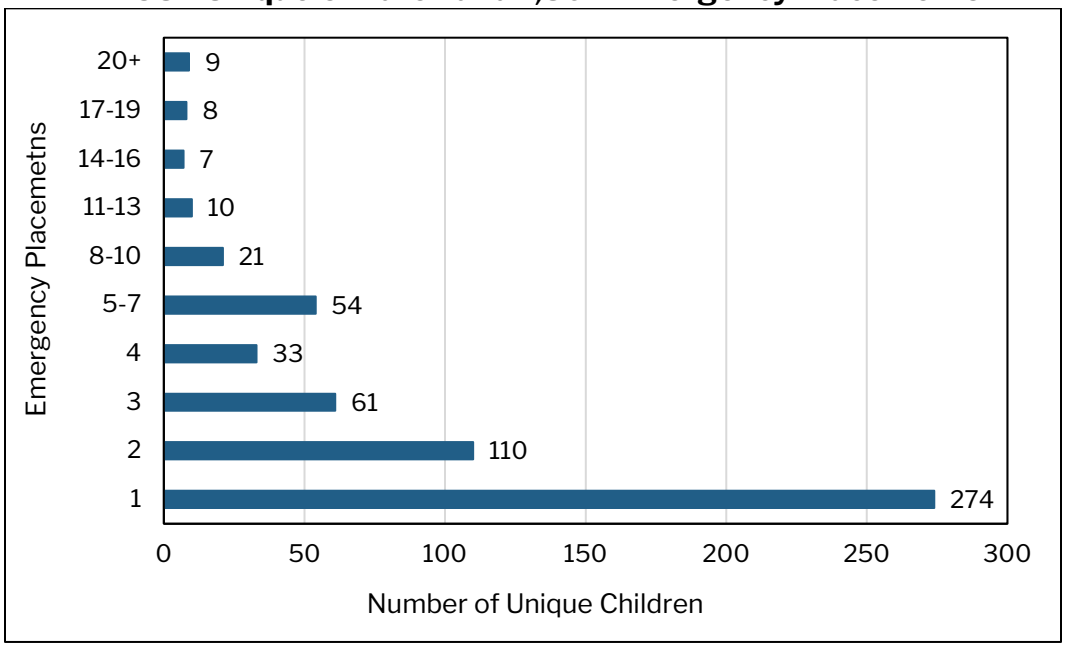
[103] When emergency placements last longer than 30 days, CAPSS triggers a redesignation for that placement to a long-term placement rather than emergency placement.

emergency placement within the prior 12 months, 170 (53%) had at least one subsequent emergency placement during the monitoring period that lasted more than seven days.

DSS collects data on the total number of nights spent in emergency placements across multiple placements. Slightly more than half (54% or 316) of the 587 children who experienced emergency placements remained in emergency placements for more than seven total nights. One-hundred-and-one children (17%) experienced more than 30 nights of emergency placements; 42 children (7%) experienced more than 50 nights in emergency placements; and 15 children (3%) experienced more than 75 nights in emergency placements, including seven children who experienced more than 100 nights in emergency placements.

Figure 36 shows the distribution of the number of emergency placements that the 587 children experienced between October 1, 2023, and March 31, 2024.

Figure 36: Number of Emergency Placements Experienced by Class Members
October 1, 2023 – March 31, 2024
N= 587 Unique Children and 1,894 Emergency Placements



Source: CAPSS data provided by DSS

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.)

Due to the complexities of tracking data in this area, the Co-Monitors have historically had to rely significantly on reports and discussions with stakeholders and DSS to assess performance. In November 2022, the Co-Monitors and DSS, with the South Carolina Department of Juvenile Justice's (DJJ) permission and collaboration,

published a report of findings from their joint comprehensive review of the experiences of children involved with both DSS and DJJ.[104]

During this monitoring period, DSS continued planning for the Small Test of Change (STOC) efforts underway in Spartanburg, Richland, Anderson, and Greenville counties that have focused on addressing some of the key recommendations from the joint review. As part of that work, they have begun implementing CFTMs for youth who are DJJ involved and are at risk of coming into DSS custody. Since the implementation phase of this work is just beginning, the Co-Monitors will report on the progress of this work in the next monitoring report.

Sibling Placements

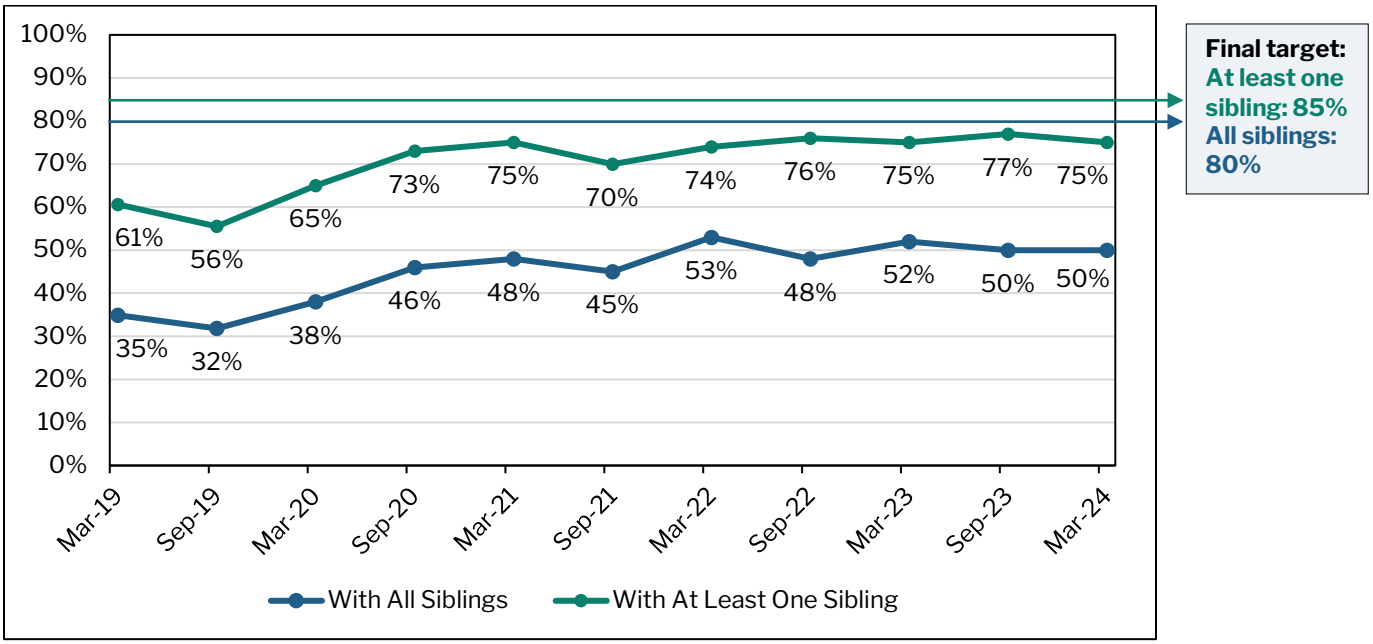
The FSA recognizes the importance of the lifelong and supportive relationships between children and their siblings and requires that *"at least 80 percent of children who enter care with or within 30 days of their siblings be placed with their siblings"* (FSA IV.G.2. & 3.). The FSA includes two targets – one for placement with *at least one* of a child's siblings (85% target) and the other for placement with *all* siblings (80% target).[105] DSS committed to achieving these targets by March 2021.

DSS provided data for 644 children who entered foster care between October 1, 2023 and March 31, 2024 with a sibling or within 30 days of a sibling's entry into foster care. That data show DSS placed 75 percent (480 of 644) of applicable children with at least *one* of their siblings, and 50 percent (323 of 644) of applicable children with *all* of their siblings by 45 days after entry into care. As shown in Figure 37, this performance is roughly comparable to performance from the prior three monitoring periods. Performance does not meet the final FSA targets.

[104] The full report, including key findings and recommendations 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

[105] 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.

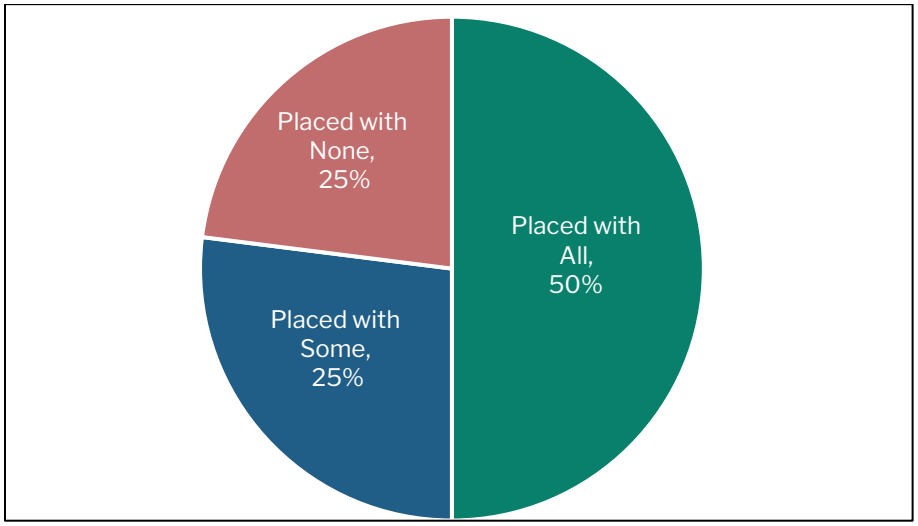
Figure 37: Sibling Placements for Children Entering Placement March 2019 – March 2024



Source: CAPSS data provided by DSS

Figure 38 further shows the breakdown of sibling placements during this monitoring period. Twenty-five percent (164 of 644) of all children entering care with siblings were not placed with *any* siblings 45 days after entry into care. This is roughly comparable to the prior three monitoring periods.

Figure 38: Sibling Placements for Children Entering Placement
October 1, 2023 – March 31, 2024
N= 644



Source: CAPSS data provided by DSS

Therapeutic Placements

The FSA includes requirements with respect to the assessment of children's need for therapeutic supports and placement, requiring that Class Members identified as needing diagnostic assessments for a higher level of care are referred timely for a staffing; that the recommendations for appropriate placements and services will be provided within a particular time period of the staffing; that the level of care in which a child is placed matches the recommendations, and that placement occurs within a designated time period of the receipt of the recommendations.

The FSA 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.).[106] These requirements have been delayed since the start of the FSA as DSS has considered ways to align measurement of the timely response to therapeutic needs and placements with its placement leveling system and its assessment protocols and

[106] "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, and 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.).

practices. In the Supplemental Report Regarding South Carolina's Placement Crisis, the Co-Monitors recommended that DSS consider alternatives to the current leveling approach, which is frequently based only on placement availability and a child's current behavior, rather than the child's underlying needs. The Co-Monitors also recommended that the current Interagency System for Caring for Emotionally Disturbed Children (ISCEDC) clinical assessment and eligibility process be assessed and, potentially, modified with input from private providers who utilize the results of these assessments. There has been no real progress in making changes in response to these recommendations during this monitoring period although the Co-Monitors and DSS have been in productive discussion about ways to both modify the FSA and implement these requirements in ways that get to the timely assessment of children's needs and the provision of services and placements that respond to the assessed needs. It is essential that DSS move forward in the very near future in grappling with the issues foundational to these FSA requirements.[107]

[107] As Parties have long discussed, this will likely involve redefining the FSA requirements in this area so that a baseline can be established and work towards improving performance is aligned and measurable. Discussions with Plaintiffs and the Co-Monitors have begun but have not yet concluded.

IX. Health Care

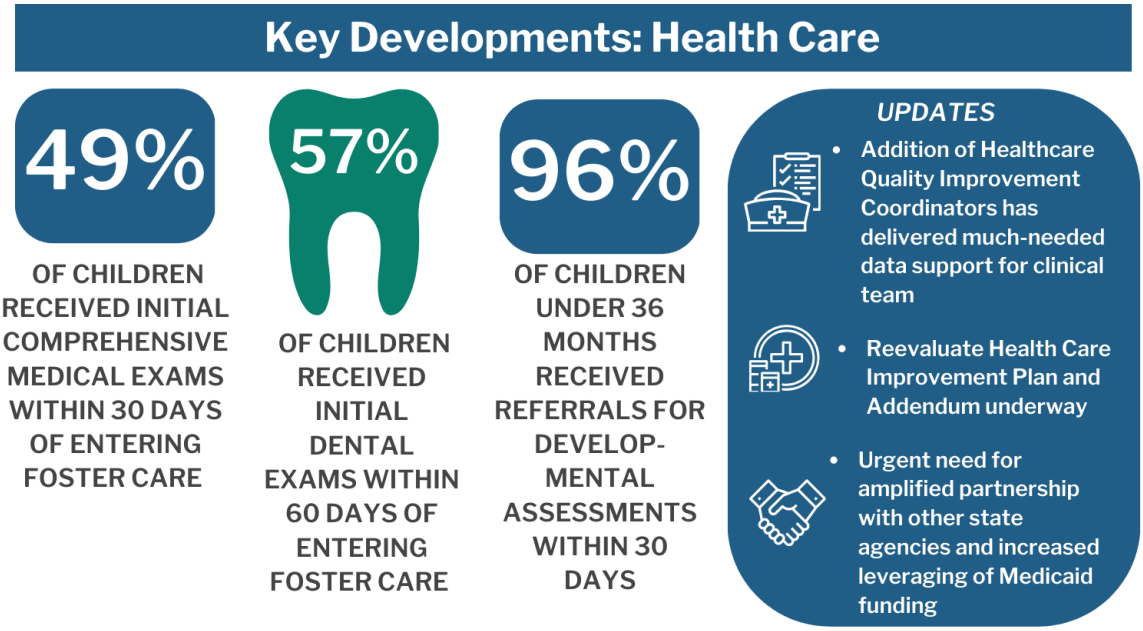
DSS has continued its efforts to meet the health care needs of the children in its care. However, despite multiple actions, health care outcomes for children in foster care have yet to significantly improve, particularly for initial comprehensive medical assessments and initial dental exams upon entering foster care.

The responsibility of delivering health care to children in foster care does not rest with DSS alone. It is inherently a legal responsibility of the state in accordance with federal Medicaid mandates for Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) for all children who are eligible for Medicaid, which includes children in foster care.[108] The affirmative obligation to children to provide treatment to meet their physical, mental, and behavioral health needs is what makes EPSDT different from Medicaid for adults.[109] It continues to be critical that DSS work with its state agency partners like DHHS, DMH, and DDSN; community partners; and its private managed care organization (MCO) partner, Select Health to develop robust, accessible, community-based services and supports across the state for children and families, including strategies for assessing and meeting basic health care needs as well as needs for intensive in-home supports and therapeutic interventions.

The Health Care Improvement Plan[110] and care coordination addendum (the "Health Care Addendum"), approved by the Co-Monitors and the Court on August 23, 2018, and February 25, 2019, respectively, vested considerable responsibility for meeting the health care needs of children in state custody with Select Health.[111] The Plan envisioned strong collaboration by the MCO and other state agencies in delivering services, developing the service array needed, and collecting and tracking performance data. Progress in meeting the Plan's requirements for service expansion and care coordination has not kept pace with these expectations. In this monitoring period, work began to explore needed modifications to the Health Care

[108] 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B); 1396d(r).
[109] U.S. Department of Health and Human Services, EPSDT: A Guide for States. (June 2014) p. 6 https://www.hhs.gov/guidance/document/epsdt-guide-states-coverage-medicaid-benefit-children-and-adolescents
[110] 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
[111] To see the Health Care Addendum, go to: https://dss.sc.gov/media/1962/2-25-2019-approved-health-plan-addendum.pdf

Improvement Plan, and related Health Care Addendum for improved performance. This work has been slow but will hopefully accelerate in the coming months.



Health Care Updates

The Health Care Improvement Plan and Health Care Addendum established commitments by Select Health 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, foster parents, and families. The Plan and Addendum were approved and ordered by the Court in 2018 with the understanding that additional details would be determined during implementation, and the efficacy and adequacy of the model would be assessed on an ongoing basis to determine what changes or additions are needed.

DSS added positions including 10 regional nurses and six Healthcare Quality Improvement Coordinators (HQIC) to support data collection and emphasize with case managers the importance of health care visits. However, there remain systemic barriers to ensuring that children receive the health care to which they are entitled. Over five years after the Health Care Addendum was agreed upon (six years into the

implementation of the Health Care Improvement Plan), there is still lack of clarity about care coordination roles and responsibilities. Work remains in the performance of key strategies, such as assessing and ensuring network adequacy with agency partners like Select Health and DHHS. The Co-Monitors, in collaboration with DSS, are reassessing the Plan and Addendum with the goal of reaching agreement with Parties on needed modifications and additional strategies in the next few months.

Health Care Performance Data

Health care data reporting timelines were adjusted again this period to accommodate delays in access to Medicaid administrative data. To provide the most up-to-date information, the most recent data are included in the areas in which they were available. For example, data on periodic well-child and dental visits are reported as of March 2024, and data on initial comprehensive medical and dental visits are reported for all children who entered care between September 2023 and February 2024. All data throughout are labeled accordingly.

In some areas, as indicated, the data included 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,[112] mental health assessments (following a screening which identified a need for such an assessment),[113] and follow-up care.[114]

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

[112] DSS ADR is currently working with CAPSS IT to extract data collected from the completion of the FAST medical module to potentially utilize for this purpose.
[113] DSS has provided data on the *total* number of children who receive mental health assessments, but those assessments are not necessarily 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.
[114] DSS has proposed collecting additional qualitative information using a case review process to measure follow-up care, based on the instrument used for the Child and Family Services Review (CFSR), and is discussing potential approaches and review methodology with the Co-Monitors.

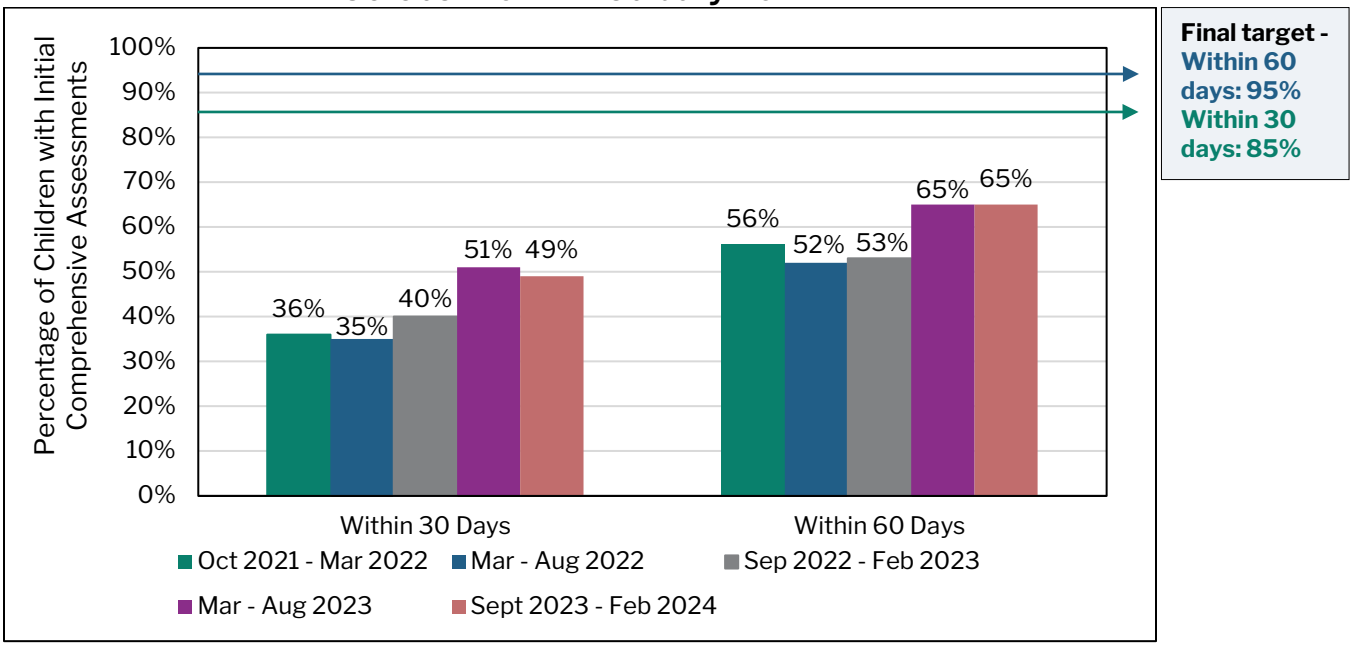
the child or adolescent;" identifying medical, developmental, and mental health conditions requiring immediate attention; and developing an "individualized treatment plan."[115]

In DSS's 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 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*."[116] DSS committed to achieving these targets by March 2021.[117]

DSS reports that 49 percent (438 of 893) of children who entered foster care between September 1, 2023 and February 29, 2024, and were in foster care for at least 30 days received an initial comprehensive medical assessment within 30 days; and 65 percent (429 of 655) of children who entered foster care during the months cited and were in foster care for at least 60 days received an initial comprehensive medical assessment within 60 days (see Figure 39). Performance remains substantially 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.

[115] *Fostering Health: Health Care for Children and Adolescents in Foster Care*, 2d. ed (16-17). American Academy of Pediatrics (2003), p. 22.
[116] The Health Care Outcomes are available at: https://dss.sc.gov/media/1958/appendix-b-final-health-care-targets.pdf
[117] 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.

Figure 39: Initial Comprehensive Medical Assessments within 30 and 60 Days October 2021 – February 2024



Source: Medicaid claims data provided by DSS

Developmental Assessments

In DSS's 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.

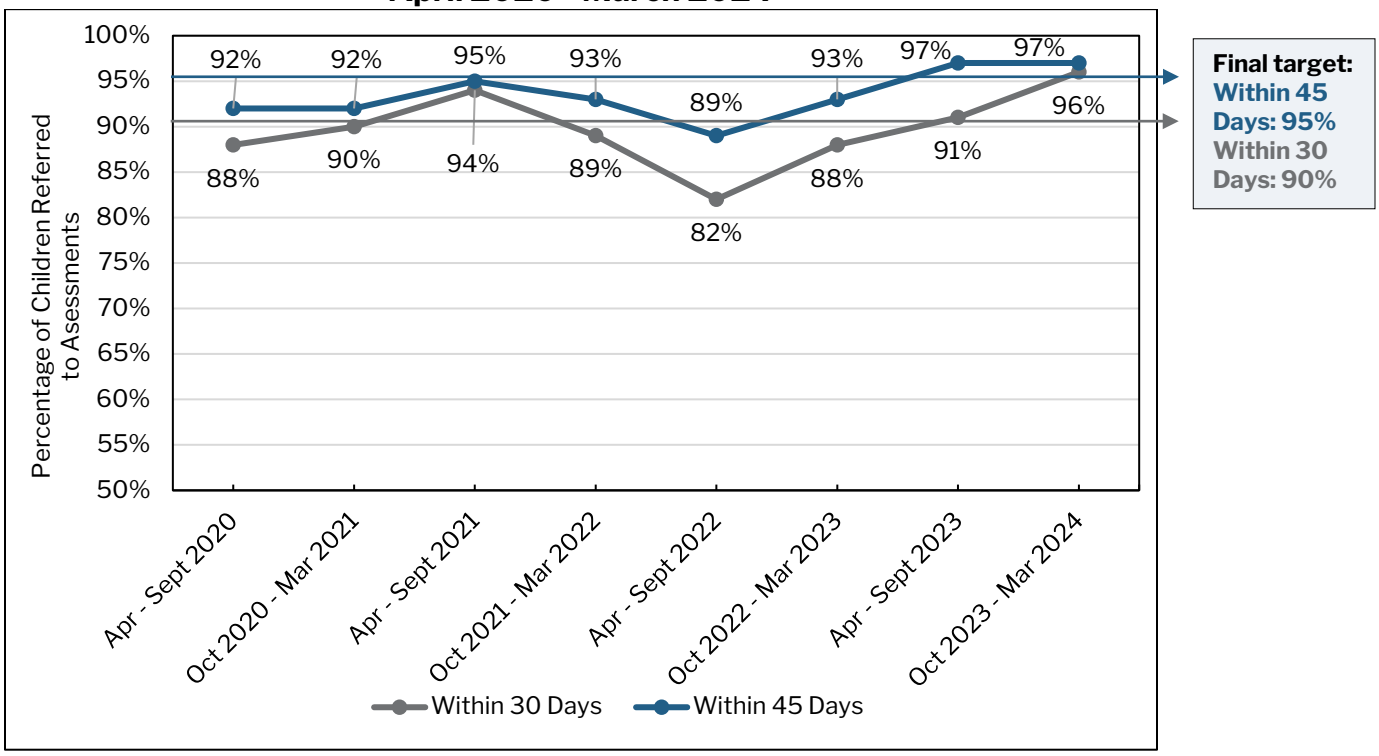
DSS reports that 96 percent (265 of 277) of children under 36 months of age who entered care between October 1, 2023 and March 31, 2024, and were in care for at least 30 days were referred to BabyNet – the state entity responsible for developmental assessments – within 30 days of their entry into care; and 97 percent (253 of 260) of children who were in care for at least 45 days were referred to BabyNet within 45 days.

Current performance represents an increase from the preceding monitoring period and meets the final targets for this measure (see Figure 40).[118] These data only

[118] Pursuant to FSA V.E.1-3, the Co-Monitors identify these provisions may be eligible for "Maintenance of Effort" designation by the Court. These obligations are set forth in the DSS Addendum to the Health

measure whether a child was referred for a developmental assessment and do not capture whether an assessment occurred. Although not an FSA commitment, DSS reports that the Office of Child Health and Well-Being is currently developing a process for tracking not only the referral to BabyNet, but whether or not the child received a timely assessment.

Figure 40: Referrals for Developmental Assessments within 30 and 45 Days April 2020– March 2024



Source: CAPSS data provided by DSS

Initial Dental Examinations

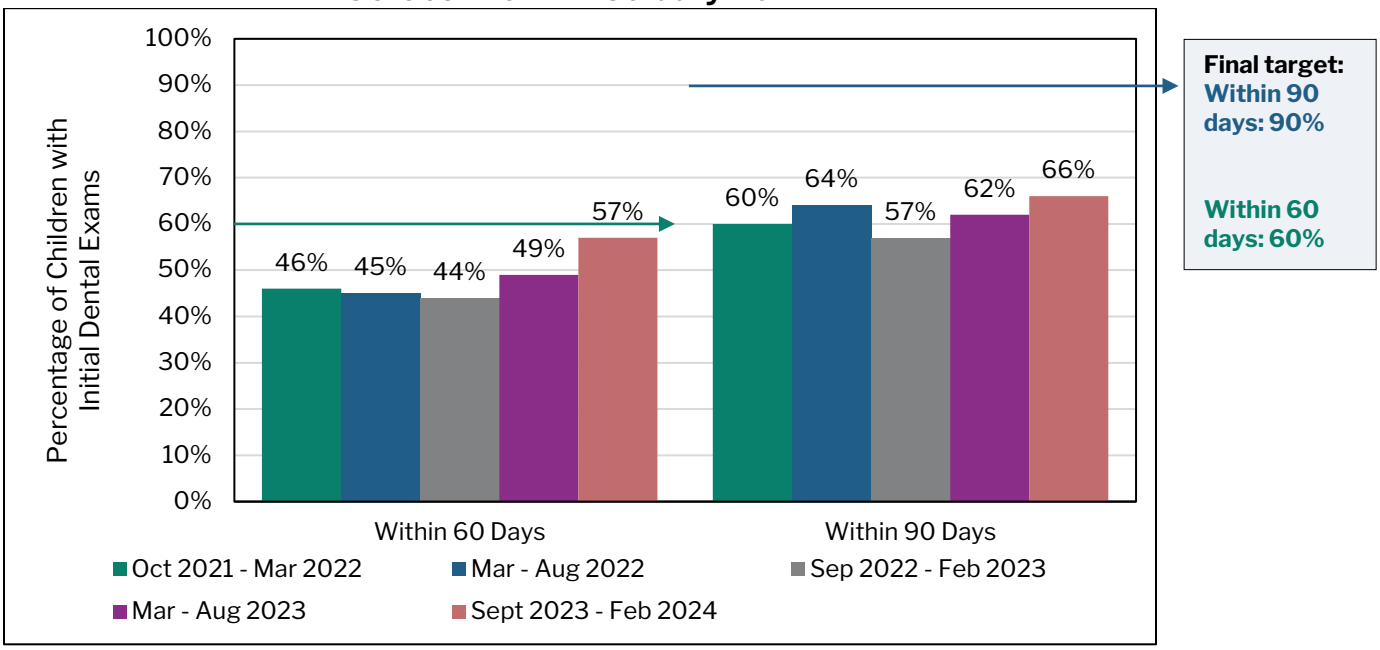
In DSS's Health Care Outcomes, approved by the Co-Monitors on December 21, 2018, DSS committed that *"at least 60% of Class Members ages two and above for whom there is no documented evidence of receiving a dental examination in the six months prior to entering care will receive a dental examination within 60 days of entering*

Care Improvement Plan, Appendix B- Health Care Targets available at: https://dss.sc.gov/child-welfare-transformation/

care; at least 90% will receive a dental examination within 90 days of entering care." DSS committed to achieving these targets by March 2021.[119]

DSS reports that 57 percent (263 of 460) of children ages two and older who entered foster care between September 1, 2023, and February 29, 2024, and were in foster care for at least 60 days had a dental exam within 60 days, and 66 percent (230 of 348) of children ages two and older who remained in care for at least 90 days had a dental exam within 90 days.[120] This performance represents improvement from the prior period. However, performance does not meet the target for either requirement, as shown in Figure 41.

Figure 41: Initial Dental Exams within 60 and 90 Days
October 2021– February 2024



Source: Medicaid claims data provided by DSS

[119] 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.
[120] This excludes children who had a visit within three months of entering care.

Periodic Well-Child Visits

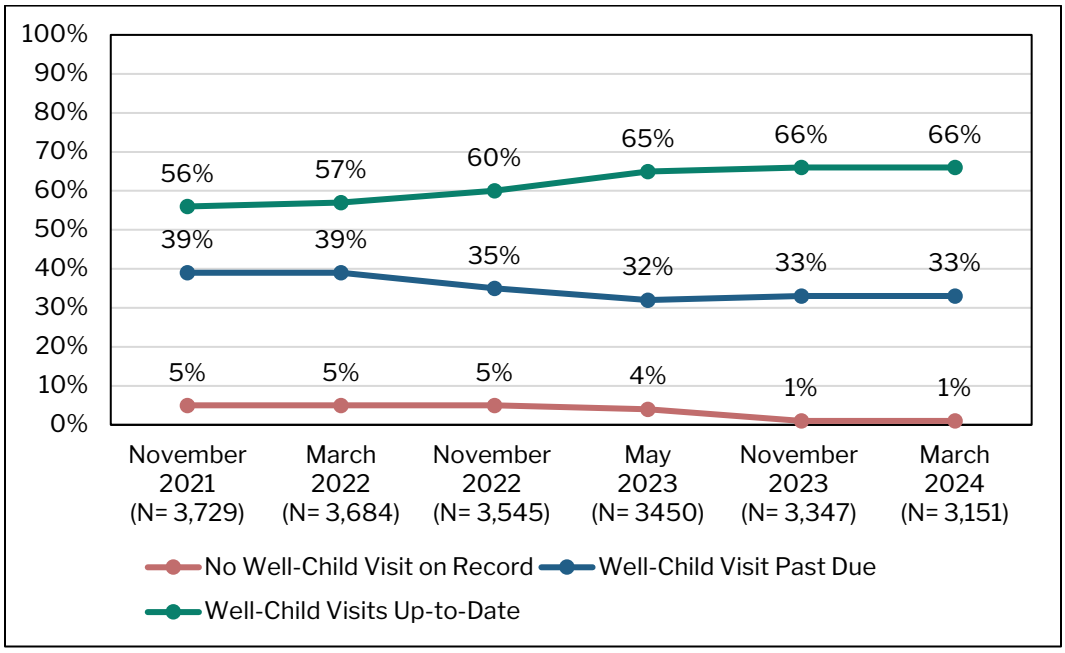
In accordance with AAP guidelines for ongoing health care delivery for children in foster care, periodic preventative well-child visits should be performed for the purpose of promoting "overall wellness by fostering healthy growth and development," as well as "regularly assess[ing] for success of foster care placement," and "identify[ing] significant medical, behavioral, emotional, developmental, and school problems through periodic history, physical examination, and screenings."[121] 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.

DSS committed to several Health Care Outcomes based on the periodicity schedule required of different age groups pursuant to AAP guidelines for children in foster care.[122,123] Although DSS has consistently provided data in accordance with the agreed-upon methodology for calculating compliance with the periodicity schedule, DSS and the Co-Monitors have both determined that this methodology does not sufficiently reflect performance. As a result, the Co-Monitors have been reporting the health care data that DSS uses for day-to-day management and quality improvement. These data are validated by DSS Regional 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 reports that of all children under 18 years of age who were in foster care for at least 30 days, 66 percent (2,066 of 3,151) were up-to-date on their well-child visits as of March 2024. As depicted in Figure 42, of the remaining children, 33 percent (1,041) were past due for their well-child visits, and 44 (1%) children did not have a well-child visit on record.

[121] *Fostering Health: Health Care for Children and Adolescents in Foster Care*, 2d. ed (16-17). American Academy of Pediatrics (2003), p. 30.
[122] Bright Futures/American Academy of Pediatrics. Recommendations for Preventative Pediatric Health Care. Accessed at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf
[123] As of April 1, 2018, SC DHHS amended South Carolina's Title XIX state plan to update the medical and dental periodicity schedule to align with nationally recognized guidelines. To see the press release, go to: https://www.scdhhs.gov/communications/public-notice-final-actions-update-periodicity-schedules

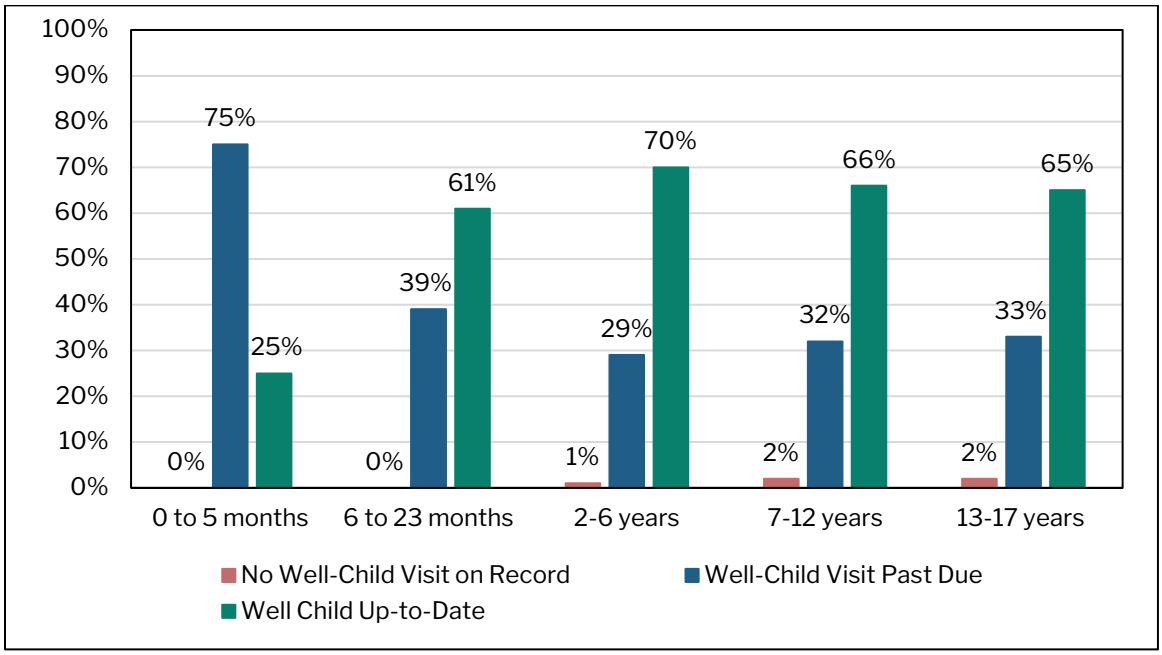
Figure 42: Well-Child Visits
November 2021 – March 2024



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

These data are also reported to the Co-Monitors by ages of the children, as shown in Figure 43. As determined by DSS, 25 percent of children under age six months were up-to-date on their well-child visits as of March 2024. This is an improvement in performance from November 2023, when 16 percent of children were determined to be up-to-date. For the age groups of six to 23 months, there was a slight decline in the percentage of children determined by DSS to be up-to-date: from 63 percent in November 2023 to 61 percent in March 2024.And for children ages two to six years, performance also declined from 73 percent in November 2023 to 70 percent In March 2024. The percentage of children determined to be up-to-date remained the same as in the previous monitoring period at 66 percent for children ages seven to 12 years old, and slightly increased from 64 percent to 65 percent for children ages 13 to 17 years old.

Figure 43: Well-Child Visits by Age as of March 2024
N= 3,151



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

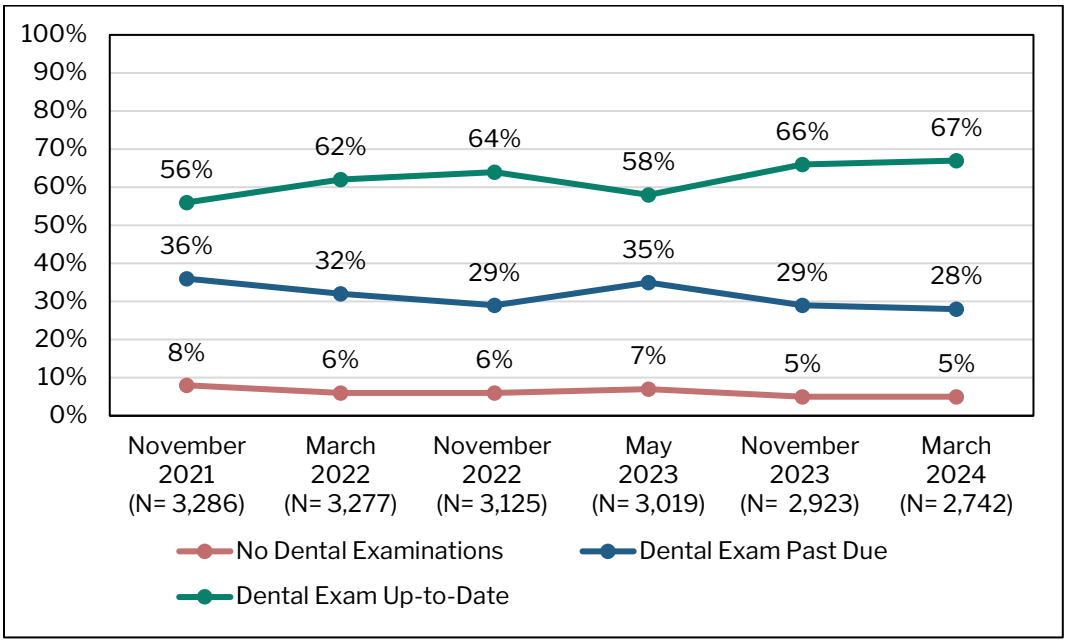
Periodic Dental Examinations

In DSS's Health Care Outcomes, DSS 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 children between two and 17 years old who were in care for at least 30 days, 67 percent (1,839 of 2,742) were up-to-date on their semi-annual dental examination as of March 2024. As shown in Figure 44, 28 percent (767 of 2,742) of children were past due for their dental exam, and five percent of children (136 of 2,742) had no dental examination on record.[124]

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

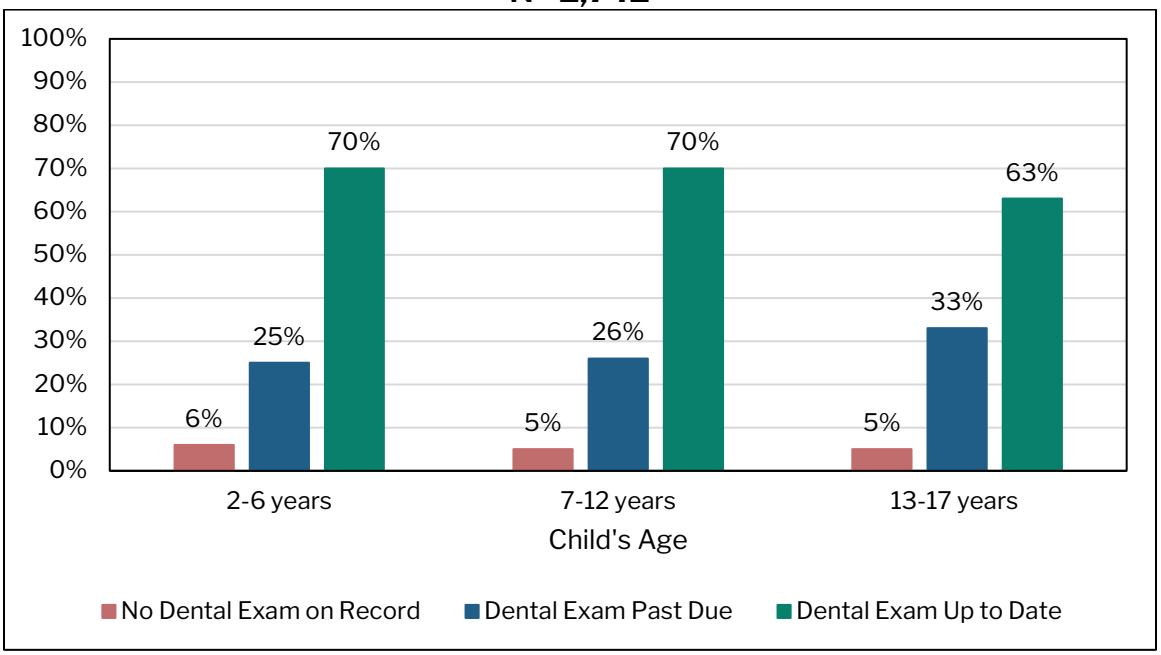
Figure 44: Periodic Dental Examinations
November 2021 – March 2024



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

DSS also provided its internal management data for dental examinations by age group, as seen in Figure 45. As compared to the last monitoring period, performance remained the same for the age group of children two to six years old with 70 percent up-to-date on their dental exams. Performance slightly increased from 67 percent in November 2023 to 70 percent in March 2024 for children ages seven to 12 years old who were up-to-date; and from 62 percent to 63 percent of children ages 13 to 17 years old who were up-to-date.

Figure 45: Periodic Dental Examinations by Age as of March 2024
N= 2,742



Source: CAPSS, DHHS, and Select Health data provided by DSS
* Totals may not equal 100% due to rounding

Appendix A – 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 conducted in-person site visits to county DSS offices where they met with DSS leadership and staff. The Co-Monitors also met with 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 Foster Care, Adoptions, and Out-of-Home Abuse and Neglect (OHAN) case managers and Team Leaders (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 March 2024, 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 setting between October 1, 2023, to March 31, 2024 (FSA IV.D.2.);

- Review of a statistically valid sample of case records in CAPSS for Class Members in foster care for 30 days or more on March 31, 2024 and living apart from a sibling also in foster care, to assess whether a sibling visit occurred in March 2024 (FSA IV.J.2.);

- Review of a statistically valid sample of case records in CAPSS for Class Members with a permanency goal of reunification, or with a permanency goal which had not yet been established in family court, and in foster care for 30 days or more on March 31, 2024, to assess whether the child had visited with the parent(s) with whom reunification was sought during March 2024 (FSA IV.J.3.);

- Review of overnight stay notices, Universal Applications, and a sample of case files of Class Members reported to have remained in a DSS office overnight between January 1 ,2024 to June 30, 2024 (FSA IV.D.3);

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

Appendix B – 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**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
Workload Limits for Foster Care:[125] 1a. At least 90% of caseworkers shall have a workload within the applicable Workload Limit. 1b. No caseworker shall have more than 125% of the applicable Workload Limit. (FSA IV.A.2.(b)&(c))	OHAN investigators: None within required limit. (September 2017) 100% had more than 125% of the limit. (September 2017)	OHAN investigators: 78% within the required limit Monthly range within the required limit: 77 – 89% 4% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 0 – 5%	OHAN investigators: 90% within the required limit Monthly range within the required limit: 68 – 96% 0% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 0 – 8%	OHAN investigators:[130] 100% within the required limit Monthly range within the required limit: 71 – 100%[131] 0% had more than 125% of the limit Monthly range with caseloads more than 125% of the limit: 0 – 4%

[125] The FSA utilizes the term "caseworker" to refer to DSS case-carrying staff and "supervisor" to refer to DSS staff who oversee case-carrying staff. As part of its GPS Case Practice Model development and outlining enhanced job expectations, DSS now utilizes the terms "case manager" and "Team Leader," respectively. Where appropriate and for consistency with practice, this report utilizes the terms case manager and Team Leader.

[130] The Co-Monitors selected a random day in each month this period to measure caseload compliance for each type of case manager and Team Leaders. These random dates are as follows: October 19, 2023; November 13, 2023; December 9, 2023; January 18, 2024; February 23, 2024; March 31, 2024.

[131] In November 2023, one supervisor was responsible for one investigation for seven days after an investigator left the agency.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
Approved Workload Limits:[126,127] • *OHAN worker* - 8 investigations • *Foster Care worker* – 15 children • *Adoptions worker* – 15 children[128] • *New caseworker* – ½ of the applicable standard for first six months after completion of Child Welfare Certification training	Foster Care case managers: 28% within the required limit. (September 2017) 59% had more than 125% of the limit. (September 2017) IFCCS case managers:[129] 10% within the required limit. (September 2017)	Foster Care case managers: 51% within the required limit Monthly range within the required limit: 43 – 51% 29% had more than 125% of the limit. Monthly range with caseloads more than 125%	Foster Care case managers: 58% within the required limit Monthly range within the required limit: 53 – 58% 31% had more than 125% of the limit. Monthly range with caseloads more than 125%	Foster Care case managers: 68% within the required limit Monthly range within the required limit: 60 – 68% 16% had more than 125% of the limit. Monthly range with caseloads more than 125%

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

[127] 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, Adult Protective Services (APS) cases, families involved in CPS 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.

[128] 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 workers was 1:17. In 2019, DSS began transitioning case management responsibility to Adoptions workers 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.

[129] 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 Team Leaders positions and caseloads in December 2019.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
	77% had more than 125% of the limit. (September 2017) <u>Adoptions case managers:</u> 23% within the required limit. (September 2017) 62% had more than 125% of limit. (September 2017)	of the limit: 27 – 32% <u>Adoptions case managers:</u> 26% within the required limit Monthly range within the required limit: 26 – 46% 38% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 35 – 38%	of the limit: 22 – 31% <u>Adoptions case managers:</u> 44% within the required limit Monthly range within the required limit: 27 – 44% 34% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 34 – 49%	of the limit: 16 – 26% <u>Adoptions case managers:</u> 67% within the required limit Monthly range within the required limit: 37 – 67% 22% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 21 – 35%
<u>Workload Limits for Foster Care</u>: 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))	<u>OHAN Team Leaders</u>: 100% within the required limit. (March 2018) None were more than 125% of the limit. (March 2018)	<u>OHAN Team Leaders:</u> 100% within the required limit each month this period 0% had more than 125% of the limit.	<u>OHAN Team Leaders:</u> 80% within the required limit each month this period Monthly range within the required limit: 60 – 83% 0% had more than 125% of the limit.	<u>OHAN Team Leaders:</u> 40% within the required limit each month this period Monthly range within the required limit: 40 – 100% 0% had more than 125% of the limit each month this period.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
Approved Supervisor Limits: • *OHAN supervisors* – 6 investigators • *Foster Care*, *IFCCS*,[132] and *Adoptions* supervisors – 5 case managers	Foster Care Team Leaders: 42% within the required limit. (March 2018) 36% had more than 125% of the limit. (March 2018) Adoptions Team Leaders 38% within the required limit. (March 2018) 19% had more than 125% of the limit. (March 2018) IFCCS Supervisors:[133] 57% within required limit. (March 2018) 29% had more than 125% of the limit. (March 2018)	Foster Care Team Leaders: 96% within the required limit. Monthly range within the required limit: 90 – 97% 1% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 0 – 4% Adoptions Team Leaders: 96% within the required limit Monthly range within the required limit: 90 – 100% 0% had more than 125% of the limit.	Foster Care Team Leaders: 90% within the required limit. Monthly range within the required limit: 90 – 97% 2% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 1 – 2% Adoptions Team Leaders: 88% within the required limit Monthly range within the required limit: 88 – 96% 0% had more than 125% of the limit.	Foster Care Team Leaders: 91% within the required limit. Monthly range within the required limit: 91 – 92% 1% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 1– 4% Adoptions Team Leaders: 100% within the required limit Monthly range within the required limit: 93 – 100% 0% had more than 125% of the limit each month this period.

[132] Ibid.
[133] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
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)	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.	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.
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)	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.	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.
Investigations - Intake: 5. At least 95% of decisions not	44% of screening decisions to not investigate were determined to be	100% of screening decisions not to investigate were determined to be	100% of screening decisions not to investigate were determined to be	99% of screening decisions not to investigate were determined to be

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
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.)	appropriate. (March 2017)	appropriate.	appropriate.	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)	92% (35) of 38 applicable investigation decisions to unfound were determined to be appropriate.	88% (42) of 48 applicable investigation decisions to unfound were determined to be appropriate.	97% (29) of 30 applicable investigation decisions to unfound were determined to be appropriate.
Investigations - Timely Initiation: 7. The investigation of a Referral of Institutional Abuse or Neglect	78% of applicable investigations were timely initiated. (March 2017)	100% (43) of 43 applicable investigations were timely initiated.	94% (49) of 52 applicable investigations were timely initiated.	90% (27) of 30 applicable investigations were timely initiated.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
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.[134] (FSA IV.C.4.((a)&(b)				
Investigations - Contact with Core Witnesses: 9. Contact with core witnesses	27% of applicable investigations included contact with all necessary	81% (35) of 43 applicable investigations included contact with all necessary	69% (36) of 52 applicable investigations included contact with all necessary	77% (23) of 30 applicable investigations included contact with all necessary

[134] 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**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
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)	core witnesses. (March 2017)	core witnesses.	core witnesses.	core witnesses.
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.[135] (FSA IV.C.4.(d))	95% of applicable investigations reviewed were appropriately closed within 45 days. (March 2017)	84% of investigations reviewed were appropriately closed within 45 days.	93% of investigations reviewed were appropriately closed within 45 days.	100% of investigations reviewed were appropriately closed within 45 days.

[135] 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**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
Final target by March 2021: 95% closure in 45 days				
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.[136] (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)	100% 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.

[136] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 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.[137] (FSA IV.C.4.(f))	93% of investigations reviewed were closed within 90 days. (September 2017)	100% of investigations reviewed were closed within 60 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 children met an agreed upon exception. A total of 26 Class Members ages six and under were placed in congregate care.	The circumstances of all children met an agreed upon exception. A total of 17 Class Members ages six and under were placed in congregate care.	The circumstances of all children met an agreed upon exception. A total of 9 Class Members ages six and under were placed in congregate care.
Phasing-Out Use of DSS Offices and Hotels:	Baseline data for this measure are not available.	DSS reports there were 86 overnight placements in a DSS office (for 53 unique	DSS reports there were 1,012 overnight placements in a DSS office (for 216	DSS reports there were 1,565 overnight placements in a DSS office

[137] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
12. No child shall be placed or housed in a DSS office, hotel, motel, or other commercial non-foster care establishment.		children).	unique children).	(for 249 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)	88% of children in foster care were placed outside of a congregate care setting.	88% of children in foster care were placed outside of a congregate care setting.	88% of children in foster care were placed outside of a congregate care setting.[138]
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	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.	98%of children ages 12 and under in foster care were placed outside of congregate care setting. [139]

[138] This does not include 22 children who were hospitalized (6), or in a correctional/juvenile justice facility (16).
[139] This includes nine children ages six and under who resided in congregate placements on the last day of the monitoring period pursuant to a valid exception.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
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.)				
Emergency or Temporary Placements for More than 30 Days: 15. Class Members shall not 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.***	Baseline data for this measure are not available.	19 children remained in an initial Emergency or Temporary Placement for more than thirty (30) days.	24 children remained in an initial Emergency or Temporary Placement for more than thirty (30) days.	25 children remained in an initial Emergency or Temporary Placement for more than thirty (30) days.
Emergency or Temporary Placements for More than Seven Days:	Baseline data for this measure are not available.	Of the 286 children who experienced more than one Emergency or Temporary Placement in a 12-month	Of the 320 children who experienced more than one Emergency or Temporary Placement in a 12-month	Of the 323 children who experienced more than one Emergency or Temporary Placement in a 12-month

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
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***.		period, 153 (53%) children experienced at least one subsequent Emergency or Temporary Placement for more than seven (7) days.	period, 158 (49%) children experienced at least one subsequent Emergency or Temporary Placement for more than seven (7) days.	period, 170 (53%) children experienced at least one subsequent Emergency or Temporary Placement for more than seven (7) days.
<u>*Placement Instability:*</u> 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).	Data for this measure are produced on an annual basis.	6.07 moves per 1,000 days. (October 1, 2022, to September 30, 2023).	Data for this measure are produced on an annual basis.
<u>*Sibling Placements:*</u> 18. At least 85% of Class	63% of children entering foster care with siblings were placed with at least	75% of children entering foster care with siblings were placed with at least	77% of children entering foster care with siblings were placed with at least	75% of children entering foster care with siblings were placed with at least

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
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.)	one of their siblings on the 45th day after entry. (March 2018)	one of their siblings on the 45th day after entry.	one of their siblings on the 45th day after entry.	one of their siblings on the 45th day after entry. [140]
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. (FSA IV.G.3.)	38% of children entering foster care with siblings were placed with all their sibling on the 45th day after entry. (March 2018)	52% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry.	50% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry.	50% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry.[141]

[140] Exceptions have been approved, though not applied during this monitoring period; therefore, actual performance may be higher than reported.
[141] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
Youth Exiting the Juvenile Justice System: 20. When Class Members are placed in juvenile justice detention or another Juvenile Justice Placement, DSS shall not 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	Baseline data for this measure are not available.	See Section VIII. *Placements*.	See Section VIII. *Placements*.	See Section VIII. *Placements*.[142]

[142] As discussed in Section VIII. *Placements,* the complexities of tracking performance in this area have meant that the Co-Monitors have historically had to rely significantly on reports by DSS and 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 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).

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
provide for their appropriate placement. (FSA IV.H.1.)				
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	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.[143]

[143] 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 implementation, DSS would wait to propose benchmarks and timelines. These modifications have not yet occurred. As discussed in Section VIII. *Placements*, the Co-Monitors have made recommendations that DSS consider alternatives to the current leveling approach, which is frequently based only on placement availability and a child's current behavior, rather than on the child's underlying needs. Parties have expressed a commitment to redefining the FSA requirements in this area so that a baseline can be established and work towards improved performance is aligned and measurable.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
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***.				
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***	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.[144]

[144] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
interim benchmarks to be added once approved.				
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.[145]

[145] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 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.[146]
Family Visitation - Siblings 24. At least 85% of the total	66% of all required visits between siblings occurred for those who were not	Upon agreement of all Parties, the Co-Monitors suspended a review of a	Upon agreement of all Parties, the Co-Monitors suspended a review of a	73% of siblings in foster care and living apart visited each other (including

[146] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
minimum number of monthly sibling visits for all siblings not living together shall be completed, unless an exception applies. (FSA IV.J.2.)	placed together. (March 2018)	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.	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.	exceptions).[147]
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)	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.	60% of children with a permanency goal of reunification visited twice with the parent(s) with whom reunification was sought (including exceptions).[148]
Health Care - Immediate Treatment Needs:	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

[147] Data are from a CAPSS record review conducted by 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.
[148] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
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))				not available.[149]
Health Care - Initial Medical Screens 27. At least 90% of Class Members will receive an initial medical screen prior to initial	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.[151]

[149] 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 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.

[151] DSS ADR is currently working with CAPSS IT to extract data collected from the completion of the FAST medical module to potentially utilize for this purpose.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
placement or within 48 hours of entering care. ***Dates to reach final target and interim benchmarks to be added once approved.***[150]				
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)	40% of children received a comprehensive medical assessment within 30 days.	51% of children received a comprehensive medical assessment within 30 days.	49% of children received a comprehensive medical assessment within 30 days.[152]
Health Care - Initial Comprehensive Assessments 29. At least 95% of Class	52% of children received a comprehensive medical assessment within 60 days. (March 2019)	53% of children received a comprehensive medical assessment within 60 days.	65% of children received a comprehensive medical assessment within 60 days.	65% of children received a comprehensive medical assessment within 60 days.[153]

[150] 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.
[152] As discussed in Section IX. *Health Care*, these data are based on Medicaid claims and have not been independently validated by the Co-Monitors.
[153] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
Members will receive a comprehensive medical assessment within 60 days of entering care.				
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***	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.[154]

[154] 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 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.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
once approved.				
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.[155]
Health Care –Referral to Developmental Assessments 32. At least 90% of Class Members under 36 months of	19% of children under 36 months of age were referred within 30 days. (July-December 2017)	88% of children under 36 months of age were referred within 30 days.	91% of children under 36 months of age were referred within 30 days.	96% of children under 36 months of age were referred within 30 days.

[155] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
age will be referred to the state entity responsible for developmental assessments within 30 days of entering care.				
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)	93% of children under 36 months of age were referred within 45 days.	97% of children under 36 months of age were referred within 45 days.	97% of children under 36 months of age were referred within 45 days.
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	35% of children ages one and above received a dental exam within 60 days. (March 2018)	44% of children ages two and above received a dental exam within 60 days.	49% of children ages two and above received a dental exam within 60 days.	57% of children ages two and above received a dental exam within 60 days.[156]

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

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
a dental examination within 60 days of entering care.				
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 ages one and above received a dental exam within 90 days. (March 2018)	57% of applicable children ages two and above received a dental exam within 90 days.	62% of applicable children ages two and above received a dental exam within 90 days.	66% of applicable children ages two and above received a dental exam within 90 days.[157]
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,	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*

[157] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
	and March 31, 2019, received a periodic preventative visit monthly.			
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*
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*

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
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*
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**	**October 2022 – March 2023 Performance**	**April –September 2023 Performance**	**October 2023– March 2024 Performance**
Health Care – Periodic Dental Care 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*
Health Care - Follow-Up Care 43. At least 90% of Class Members will receive timely accessible and appropriate follow-up care and treatment to meet their health needs. ***Dates to reach final target and interim benchmarks to be added once approved.***[158]	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.[159]

[158] 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.

[159] 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 discussing potential approaches and review design with the Co-Monitors.

Appendix C – Glossary of Acronyms

AAP: American Academy of Pediatrics
ACF: U.S. Administration for Children and Families
ADR: Office of Accountability, Data, and Research
APS: Adult Protective Services
CAC: Child Advocacy Center
CAPSS: Child and Adult Protective Services System
CFTM: Child and Family Team Meeting
CFSR: Child and Family Services Review
CPA: Child Placing Agency
CPS: Child Protective Service
CQI: Continuous Quality Improvement
CWS: Child Welfare Services
DCA: Department of Children's Advocacy
DDSN: Department of Disability and Special Needs
DE: Department of Education
DHHS: Department of Health and Human Services
DMH: Department of Mental Health
DJJ: Department of Juvenile Justice
DSS: Department of Social Services
EPC: Emergency Protective Custody
EPSDT: Early, Periodic, Screening, Diagnosis and Treatment
FAST: Family Advocacy and Support Tool
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
GPS: Guiding Principles and Standards Case Practice Model
HQIC: Healthcare Quality Improvement Coordinator
HRSN: Health-Related Social Need
ICPC: Interstate Compact on the Placement of Children
IO: Interim Order
ISCEDC: Interagency System for Caring for Emotionally Disturbed Children
KinGAP: Kinship Guardianship Assistance Program

MCO: Managed Care Organization
MST: Multi-Systemic Therapy
OHAN: Out-of-Home Abuse and Neglect Unit
PRTF: Psychiatric Residential Treatment Facility
QRTP: Qualified Residential Treatment Program
RBHS: Rehabilitative Behavioral Health Services
RTF: Residential Treatment Facility
SACWIS: State Automated Child Welfare Information System
SDM: Structured Decision Making
SLG: Subsidized Legal Guardianship
STOC: Small Test of Change
TA: Technical Assistance
TPR: Termination of Parental Rights
U of SC CCFS: University of South Carolina's Center for Child and Family Studies
USDA: United States Department of Agriculture