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

Paul Vincent

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

PROGRESS REPORT: SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES

April 1 - September 30, 2023

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Published March 25, 2024

Michelle H., et al. v. McMaster and Leach Progress Report for the Period April 1, 2023 – September 30, 2023

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Michelle H., et al. v. McMaster and Leach
Progress Report for the Period
April 1, 2023 – September 30, 2023

I. Introduction

This report covers the progress of the South Carolina Department of Social Services (DSS) in meeting the requirements of the Final Settlement Agreement (FSA)[1] entered in *Michelle H., et al. v. McMaster and Leach*, for the period April 1, 2023, through September 30, 2023.[2] Approved by the United States District Court on October 4, 2016, the FSA includes requirements for the care and treatment of the approximately 3,700 children in foster care in South Carolina and incorporates provisions ordered in a September 2015 Consent Immediate Interim Relief Order (the Interim Order or IO).[3,4] The FSA outlines South Carolina's obligations to significantly improve the experiences of and outcomes for children removed from the care of their parent(s) or guardian(s) and placed in DSS's custody, and reflects an agreement by the state to address long-standing problems in the operation of its child welfare system. The report has been prepared by court-appointed independent Co-Monitors Paul Vincent and Judith Meltzer, with assistance from Elissa Gelber, Sarah Esposito, Gayle Samuels, and Lisa Mishraky-Javier. It is presented to the Honorable Richard Gergel, U.S. District Court Judge; Parties to the lawsuit (Governor McMaster, DSS, and Plaintiffs); and the public.

The FSA was crafted by state leaders and Plaintiffs to guide a multi-year reform effort on behalf of children in DSS's custody and includes specific provisions governing: the workloads of case managers and Team Leaders;[5] visits between children in the Department's custody and their case managers; family time, or 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 utilized 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 used to assess DSS's progress.

In order to make this report as useful as possible to the Court, Parties, and public, the Co-Monitors have also included information about developments beyond September 30, 2023 (the end of the monitoring period), as well as references to data DSS provided directly to the Court on December 8, 2023 (DSS's Data Submission to the Court),[8] where applicable.

[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] Letter from J. Michael Montgomery Providing Update on Information Required Pursuant to 8/3/23 Order (December 8, 2023, Dkt. 295)

II. Areas of Improvement and Areas of Challenge

DSS continued to make progress in some key areas during this monitoring period (April 1, 2023 to September 30, 2023) and in the months since. The Department's focus on becoming a "kin first" state has resulted in an ongoing decline in the number of children being brought into its custody. DSS has emphasized the need to further reduce family separations by building out community supports and assessing removal practices and continues to communicate the importance of keeping families together.

For children who are separated from their parent(s) or guardian(s), DSS has continued to prioritize placement with family members ("kin") or other important people in children's lives ("fictive kin"). Twenty-seven percent of all children in DSS custody were placed with kin at the end of September 2023 – the highest percentage since this lawsuit began. DSS has eagerly planned for the implementation 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]

Collaboration between state agencies and other key partners improved this monitoring period, with the support of the Governor's office. The South Carolina Department of Health and Human Services (DHHS) began addressing the urgency of meeting the needs of children and their families by lifting the long-standing Rehabilitative Behavioral Health Services (RBHS) and Targeted Case Management (TCM) provider moratoriums; beginning roll-out of evidence-based, prevention-focused Homebuilders and Multi-Systemic Therapy (MST) services; and planning for the addition of much-needed crisis stabilization capacity in hospitals throughout the state. In addition, an October 2023 convening of agency partners and stakeholders aimed at addressing DSS's placement instability crisis has begun to generate new ideas and plans for further collaboration through 2024 and beyond.

[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

In terms of staffing, DSS made further progress in hiring Team Leaders and case managers, and in filling staff vacancies in Foster Care, Adoptions, and OHAN. DSS reports a decrease in the vacancy rate in these areas from 22.4 percent on November 30, 2022, to 16.9 percent on October 31, 2023. DSS also reports further reductions in staff turnover. Preliminary data for July to September 2023 show a significant decrease in turnover from a year prior for all Foster Care, Adoptions, and OHAN staff, from 9.2 percent for July to September 2022 to 6.9 percent for July to September 2023.

DSS leadership has continued to emphasize the importance of data-driven management. Although there are areas in which reliable data are still needed, the Department's data capacity has improved greatly. DSS's Office of Accountability, Data, and Research (ADR) has significantly helped the Department develop more refined approaches to data utilization that can benefit staff and the children and families DSS serves. For example, DSS has been able to use data generated by ADR to better understand the importance of early kin placement and to identify where family separation can be avoided through cross-agency collaboration and the development of supportive services.

Additionally, DSS sustained its progress during the monitoring period on the Out-of-Home Abuse and Neglect (OHAN) unit measures for which it was granted "Maintenance of Effort" status in August 2023 - timely initiation and completion of OHAN investigations (FSA IV.C.4(d), (e), and (f)), as well as appropriateness of decisions not to investigate referrals of abuse or neglect (FSA IV.C.2).[10,11]

Despite these successes, the placement instability crisis has reached new extremes, causing further harm to many children and families. Between September 2022 and October 2023, children in DSS's custody were moved an average of 6.07 times per 1,000 days in foster care, the highest instability experienced by Class Members since the inception of this lawsuit.

[10] August 3, 2023 Order (Dkt. 290)

[11] FSA IV.E.1-5 allows specific obligations to be designated for Maintenance of Effort status when Defendants have achieved substantial compliance as reflected in monitoring reports, and entails that the Co-Monitors shall "reduce the level of monitoring over that item to a level sufficient to identify any significant deterioration of performance."

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.[12] In the months since, children in DSS custody were moved between placements, DSS offices, and emergency settings at exponentially higher rates. In the five years between April 2018 and March 2023, children slept overnight in DSS offices for a total of 506 nights. However, in this six-month monitoring period alone (April to September 2023), children spent an alarming 1,012 nights in DSS offices. For this same period, DSS reports that 555 unique children spent 8,991 nights in emergency placements. This is an increase from the prior monitoring period, October 1, 2022, to March 31, 2023, when 489 unique children spent 7,400 nights in emergency placements. Despite efforts by DSS, this crisis is growing and shows no signs of abating. DSS reports that in the three months since the end of the monitoring period (October 1 to December 31, 2023), 166 children spent 860 nights at DSS offices.

Placement instability is caused by many factors including the need across the state for quality assessment and community-based services to support and meet the unique health and mental health needs of children and families. A lack of sufficient supports and services combined with broad statutory authority for law enforcement officers to remove children from their homes,[13] among other factors, has resulted in extremely high numbers of children being brought into DSS custody for very short periods of time. Nearly one third (27 percent, or 393 of 1,482) of children who were taken into DSS custody during the monitoring period (April 1, 2023, to September 30, 2023) exited DSS custody within 60 days of entry. 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.

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 DHHS and other DSS partners in recent months to begin to address service gaps are encouraging. However, the Department and the Co-Monitors acknowledge

[12] *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.
[13] See SC Code § 63-7-20 (12a&b).

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 supportive care for South Carolina's children and families.

Now is also the time for DSS to shift the way it works with families by moving forward its Guiding Principles and Standards (GPS) Case Practice Model.[14] This work must move beyond messaging to more robust implementation across the state, as children and families are continuing to be harmed as they wait for change. Many of the practice changes needed to engage more responsively with families were not possible when caseloads were extraordinarily high, and training and data capacity was nascent. The additional resources provided by the General Assembly, and the strides DSS has made in these important areas – the result of sustained effort and steadfast leadership – are significant and, in many ways, have laid the necessary foundation for reform.

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.

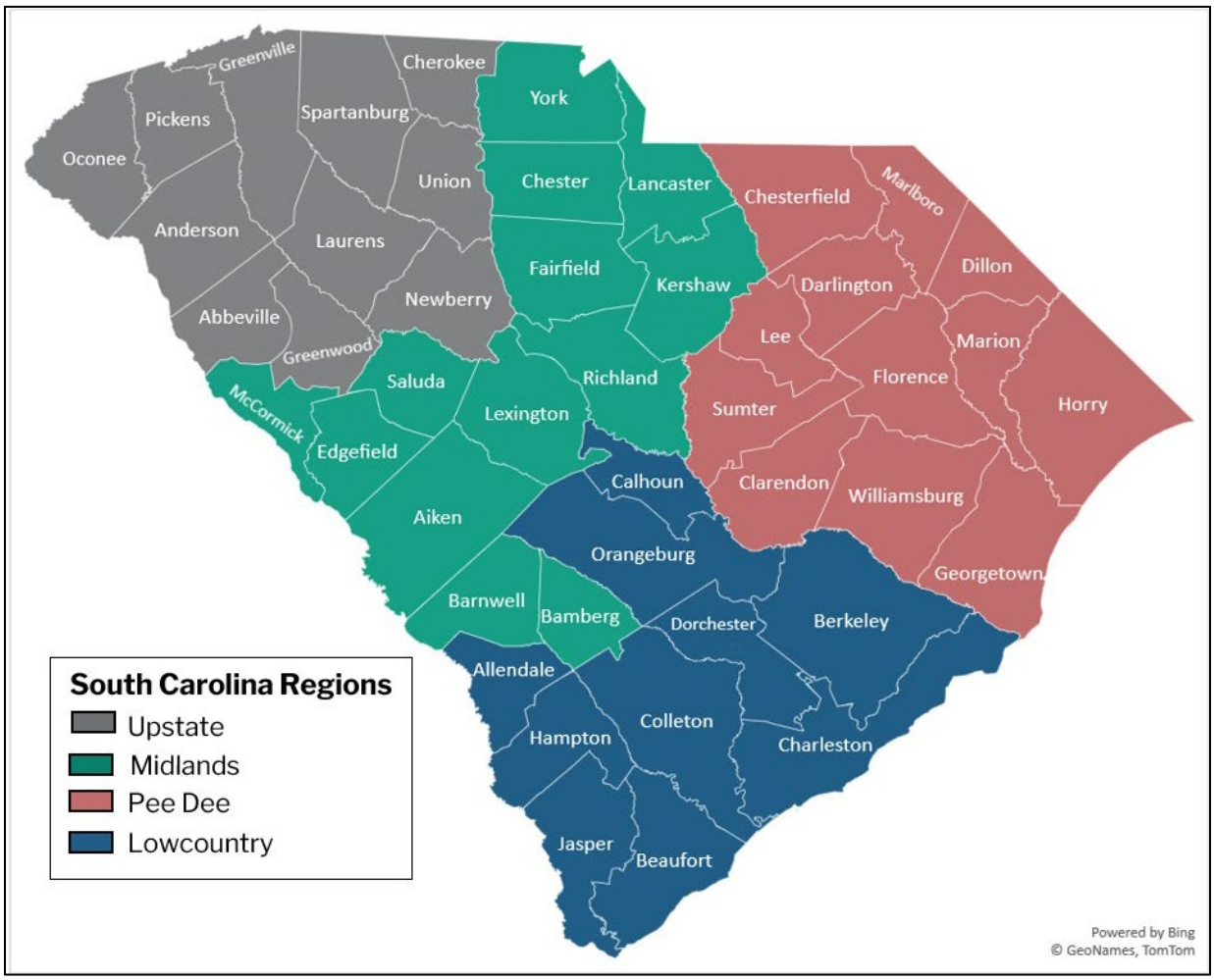
[14] DSS's GPS Case Practice Model was designed in recognition of the need for a culture that 'engage[s], encourage[s], honor[s], and support[s] families.' To see the GPS Case Practice Model, go to: https://dss.sc.gov/media/2746/gps-practice-model-final.pdf

III. Background Information

DSS is a cabinet-level agency that reports directly to the Governor. A detailed summary of its structure and mission can be found in prior monitoring reports, available here. 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 ("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 (see Figure 1). Some DSS functions are located regionally, including Adoptions offices, Child Health and Well Being Teams, and Child Placement Teams.

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 five primary areas of focus: Safety Management; Permanency Management; Child Welfare Services Operations; Child Health and Well-Being; and Family and Community Services and Strategic Projects. Figure 2 depicts this structure, and the general responsibilities encompassed in each area of work.

Figure 2: DSS Child Welfare Services Division Organizational Chart

Source: Graphic updated by DSS, as of 3/1/2024

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.[15] 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.[16] Approximately 45 percent of children in foster care in South Carolina

[15] The Title IV-E program was established by HR. 3434 Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272).
[16] 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).[17]

Nearly all children in foster care are eligible for medical insurance through Medicaid, another important source of federal revenue for state child welfare systems.[18] 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.[19,20] 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 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 health care

[17] 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 that do not meet the new criteria for a Qualified Residential Treatment Program (QRTP), which include: a trauma-informed treatment model, on-site registered or licensed nursing and clinical staff, inclusivity of family members in treatment planning, offering aftercare support 6 months post-discharge, and accreditation by a select group of bodies. (Family First Prevention Services Act, Publ. L. No. 115-123, H.R.253. (2017)). In February 2022, the Children's Bureau approved South Carolina's 5-year Family First Prevention Services plans. If statutory requirements are met, this will enable the state access to federal funding to help families stay together and prevent entry into foster care. DSS has been working with community and agency partners on developing implementation strategies. The agency has not yet begun to make IV-E claims under the Family First Prevention Services Act (FFPSA) 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

[18] DSS reports that as of February 26, 2024, there were 44 children in its custody who were ineligible for full Medicaid due to their immigration status.

[19] 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

[20] 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).

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.[21]

Details regarding DSS's budget for FY2024-2025 are included in Section IV. *Fiscal Resources*. 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

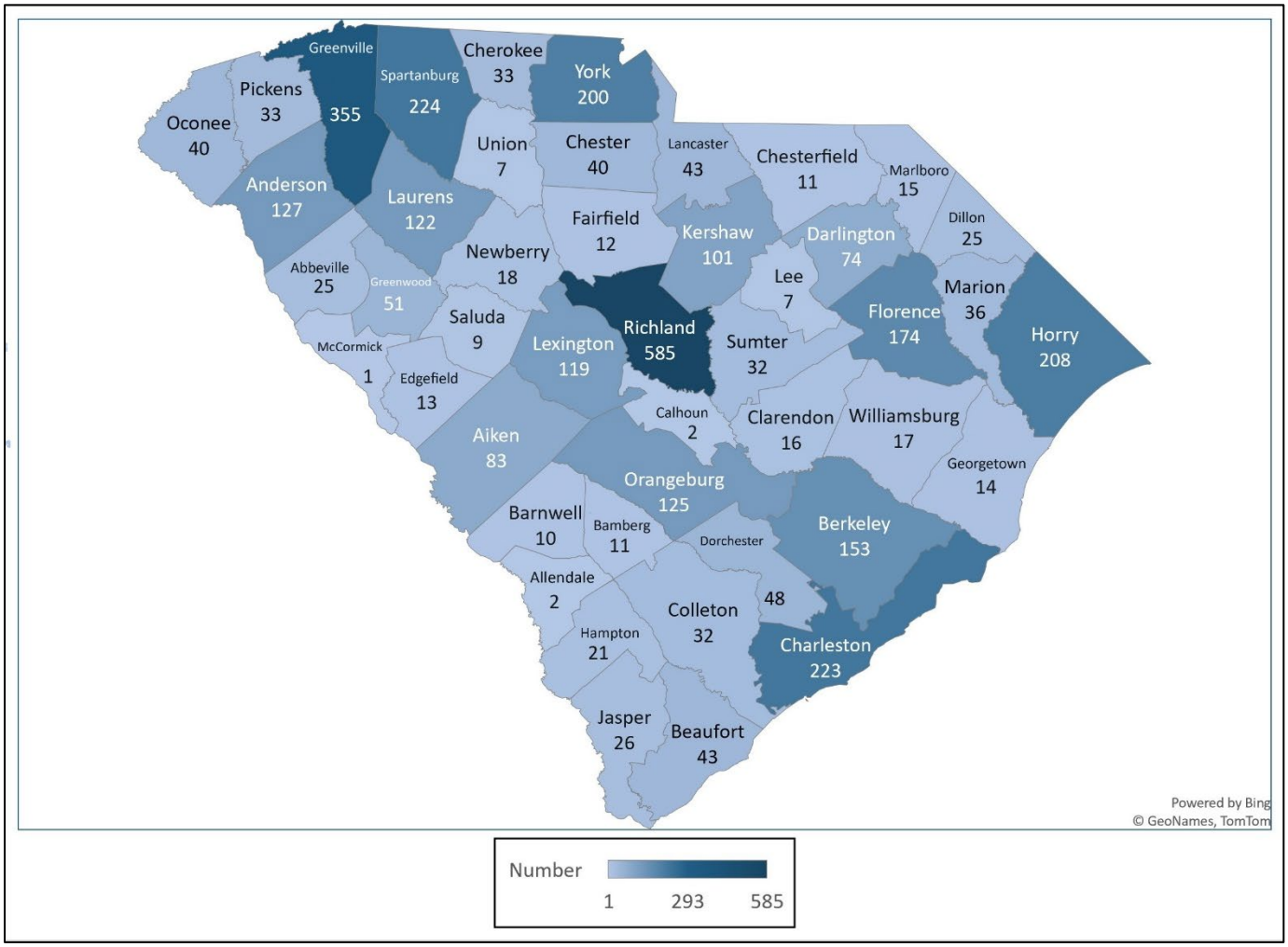
Population and Demographics of Children in Foster Care

Between April 1, 2023, and September 30, 2023, 5,127children were in foster care at some point. On September 30, 2023, the last day of the monitoring period, there were 3,566 children in foster care across the state.[22] The map in Figure 3 shows the number of children from each county in the Department's custody on that day.

[21] 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.

[22] This includes 18 children who resided in other institutional settings on September 30, 2023, and may not match the data in Section VIII. *Placement*.

Figure 3: Number of Children in DSS Custody by County as of September 30,2023[23] N=3,566 Children[24]



Source: CAPSS data provided by DSS

As shown in Figure 4,[25] the population of children in DSS custody has sharply declined since the filing of this lawsuit and has continued to decrease, consistent with national

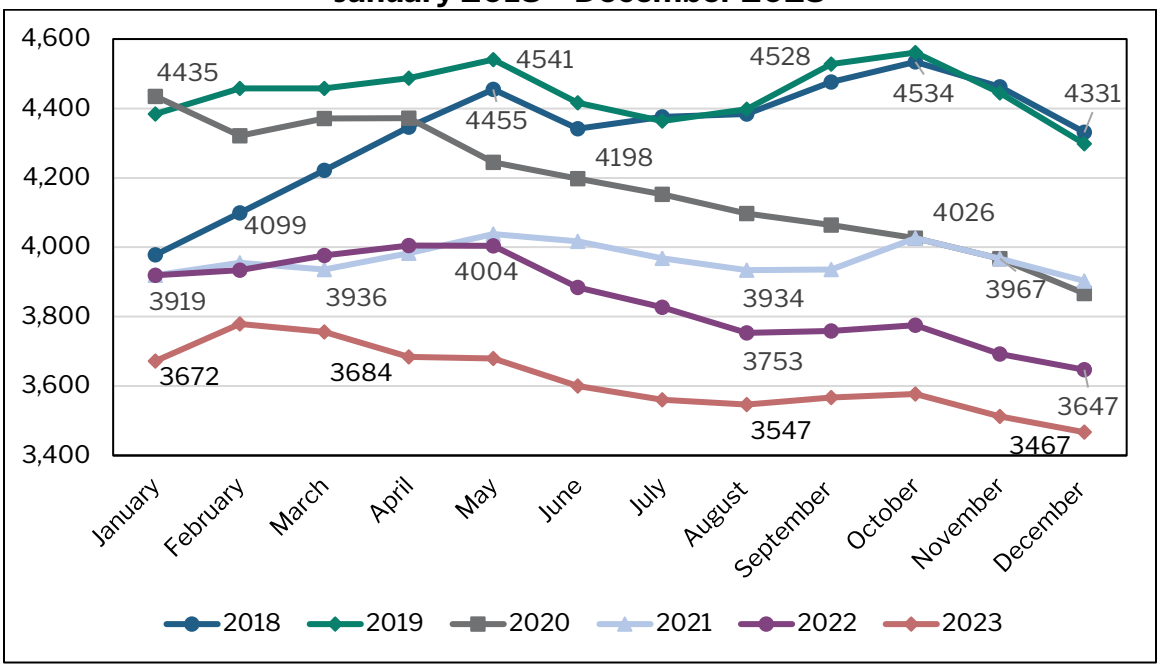
[23] To see this map with current data, go to: https://reports.dss.sc.gov/ReportServer/Pages/ReportViewer.aspx?/Foster+Care

[24] This includes 18 children who resided in other institutional settings on September 30, 2023, and may not match the data in Section VIII. *Placement*.

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

trends.[26] For example, in December 2018, there were 4,331 children in foster care. Five years later, in December 2023, there were 3,467 children in foster care. The Department has reported that the decrease in family separations has been a result of DSS's efforts to prioritize prevention services and reunify children with 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, could also positively impact DSS's ability to further decrease its foster care population by reunifying families more rapidly.

Figure 4: Population of Children in Foster Care
January 2018 – December 2023



Source: DSS data dashboard, 01/10/24[27,28]

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

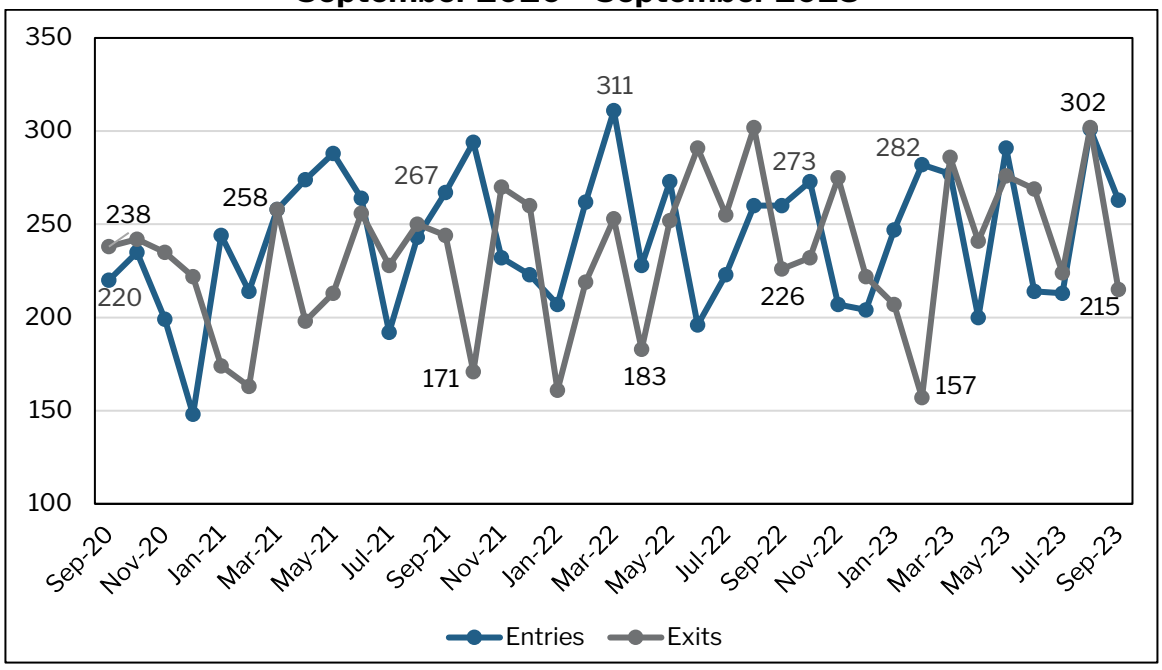
[27] DSS regularly publishes real-time data about children in out-of-home care on its public website. Demographic data on age, race, and gender are available, as well as information about where children are placed and how long they have been in out-of-home care.
To see DSS's data dashboard, go to: https://dss.sc.gov/about/data-and-resources/foster-care-dashboard/

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

Children Entering and Exiting Foster Care

Between April 1, 2023, and September 30, 2023, the number of children who exited foster care (1,527) was greater than the number of children who were brought into foster care (1,482).[29] As a result, the number of children in DSS custody further declined.

Figure 5: Foster Care Entries and Exits
September 2020 – September 2023



Source: CAPSS data provided by DSS

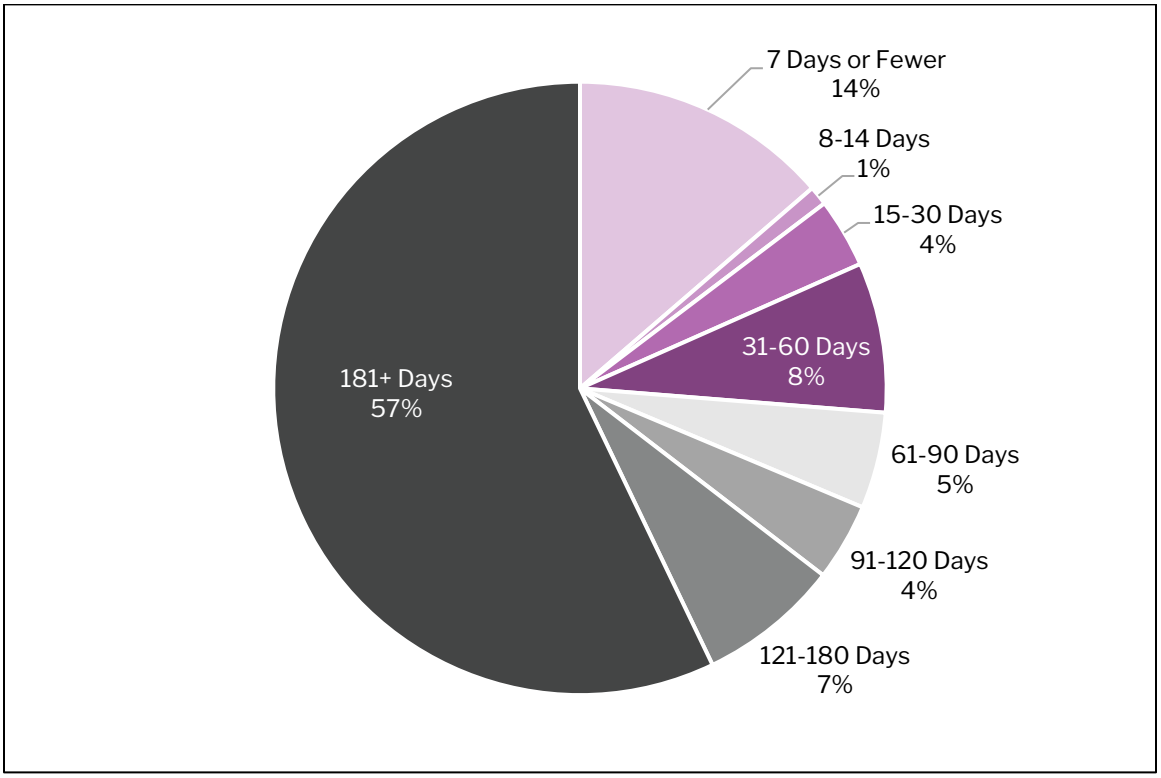
To better identify when family separation can be avoided through cross-agency collaboration and the development of supportive services, ADR has begun refining its analysis of data on the amount of time children spend in foster care, with a particular emphasis on children who remain in foster care for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

DSS reported data this monitoring period for all children who exited foster care from November 1, 2022, to November 30, 2023. As shown in Figure 6, of these 3,057 children, 26 percent (803) of these children exited within 60 days. This includes 18 percent (561) of children who exited within 30 days; 15 percent (449) of children who

[29] Foster care population data included herein is sourced from DSS's data that includes some children who are not Class Members.

exited within 14 days; and 14 percent (418) who exited within only seven days. 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 6: Length of Stay in Foster Care
November 1, 2022 – November 30, 2023
N=3,057 Children

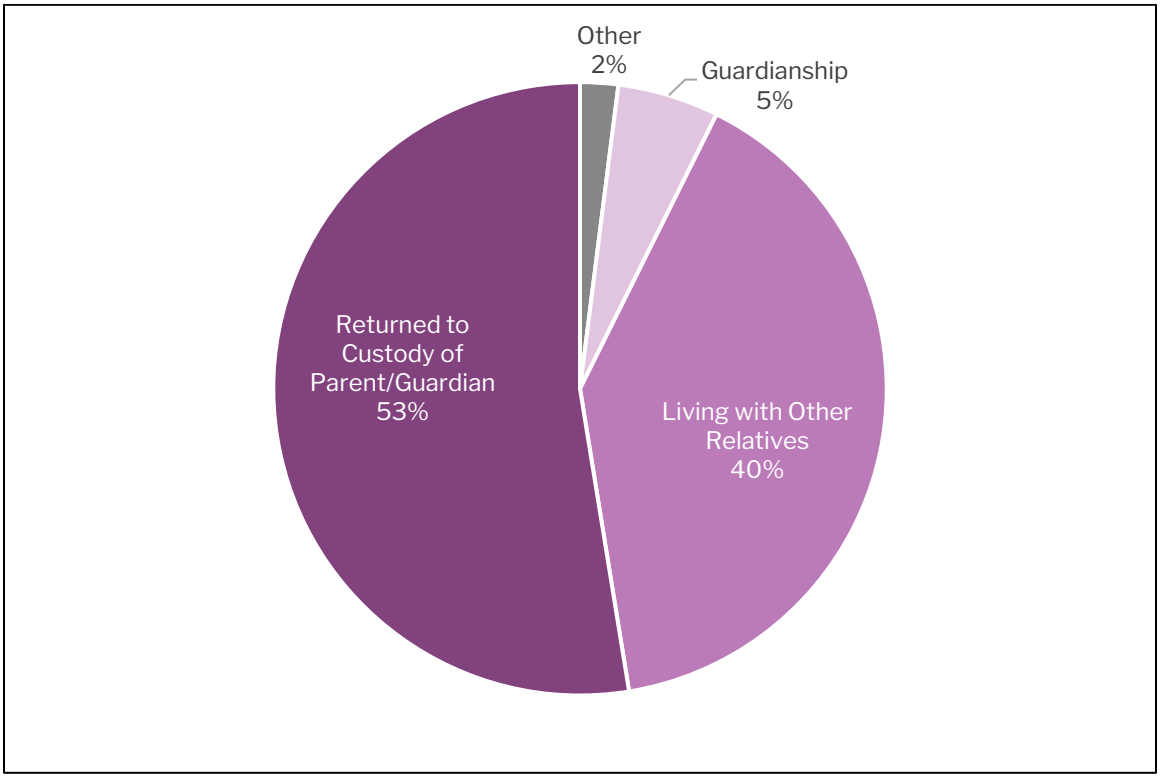


Source: DSS Data

Figure 7 shows the exit reasons for the 449 children who exited foster care within 14 days between November 1, 2022, and November 30, 2023. As depicted, more than half of these children (236 of 449, or 53%) were returned to the custody of their parents or guardians. Forty-five percent (204 of 449) of these children exited to live with other relatives (180) or guardians (24). Of the 236 children who were reunified with parents within 14 days of entering foster care, only 15 children (6%) experienced a subsequent entry into care during the 13-month period.[30]

[30] Three of the 15 children who had a subsequent foster care episode after being returned to their parent(s) were in care for fewer than 15 days. Two were returned to their parent(s) or guardian(s).

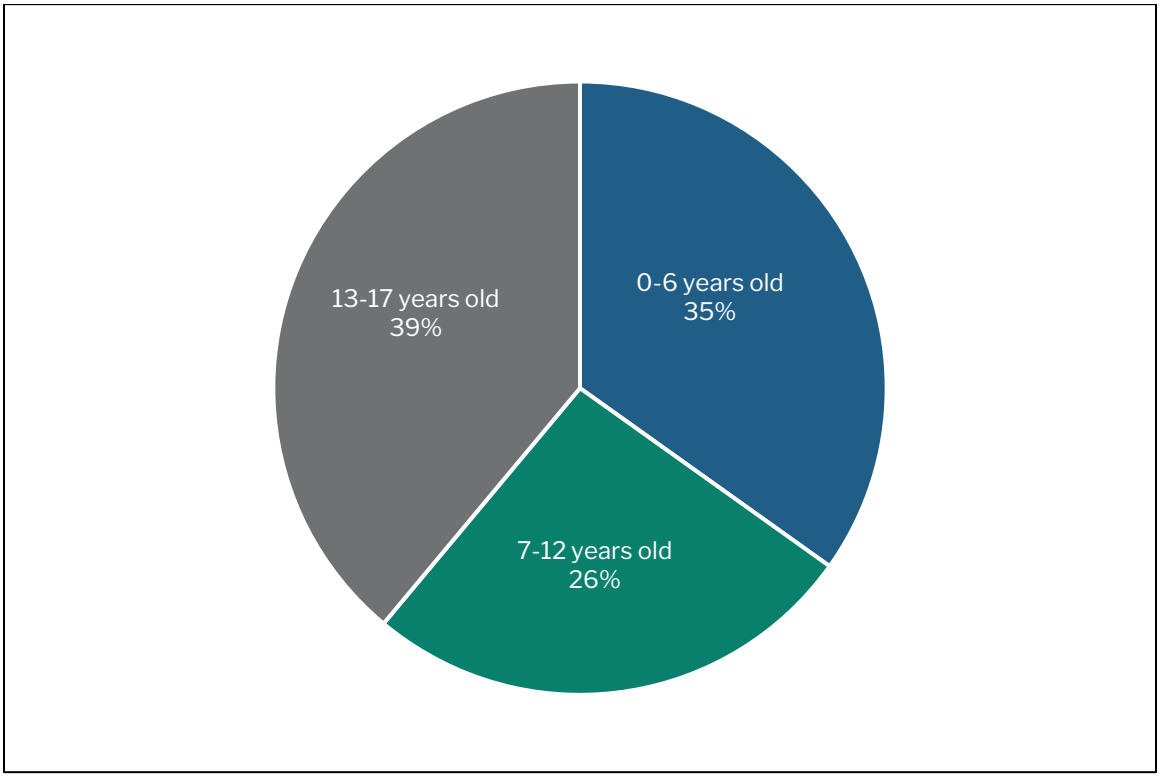
Figure 7: Exit Reason for Children in Care 14 Days or Less
November 1, 2022 – November 30, 2023
N=449 Children



Source: DSS Data

When measured as a percentage of children who entered care during the monitoring period (between April 1, 2023, and September 30, 2023), 27 percent (393 of 1,482) of children remained in care for short periods ranging from one to 60 days. Figure 8 shows the age ranges of these children. Thirty-nine percent of these children were 13 to 17 years old; 35 percent were birth to six years old; 26 percent were seven to 12 years old.

Figure 8: Ages of Children who Entered Foster Care Between April and September 2023 and Exited within 60 Days of Entry
N=393 Children



Source: DSS Data

Further, according to DSS data, 15 percent (223 of 1,482) of children who entered foster care during the monitoring period (April 1, 2023, to September 30, 2023) remained in care for *seven days* or less.

Unilateral emergency removals by law enforcement officers significantly contribute to this pattern of "short stays" in foster care in South Carolina, among other factors. 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]

[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.

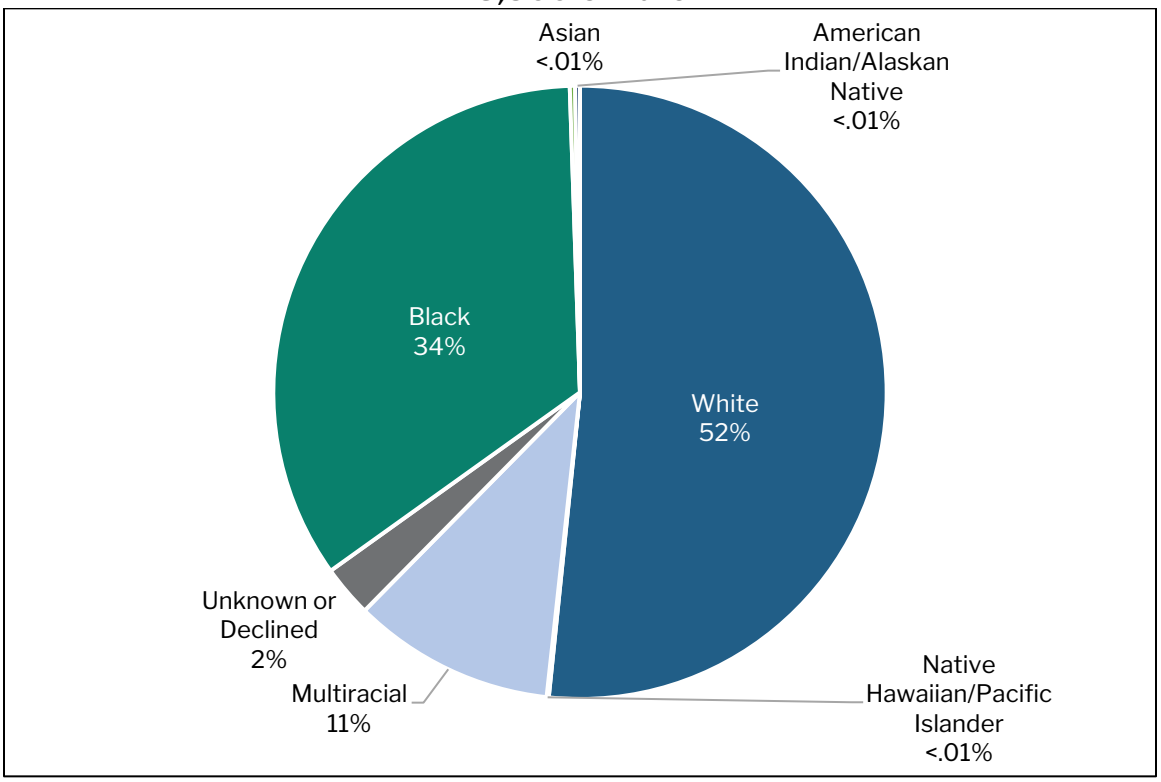
DSS has expressed a commitment to deepening its understanding of practices around child removal in an effort to reduce unnecessary family separations. This has been identified as a priority in the Small Test of Change (STOC) counties (Anderson, Greenville, and Spartanburg), discussed in Section VIII. *Placements*, and should be a priority statewide in the coming period.

Demographics of Children in DSS Custody

As shown in Figure 9, of the children in DSS's custody on September 30, 2023, 52 percent were identified as White, 34 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. DSS does capture Hispanic ethnicity as a category in placement data. DSS reports that six percent (277 out of 3,566 children in DSS custody on September 30, 2023) 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] These data include 18 children who resided in other institutional settings on September 30, 2023, and may not match the data in Section VIII. *Placements*.

Figure 9: Population of Children in DSS Custody by Race as of September 30,2023 N= 3,566 Children[34]

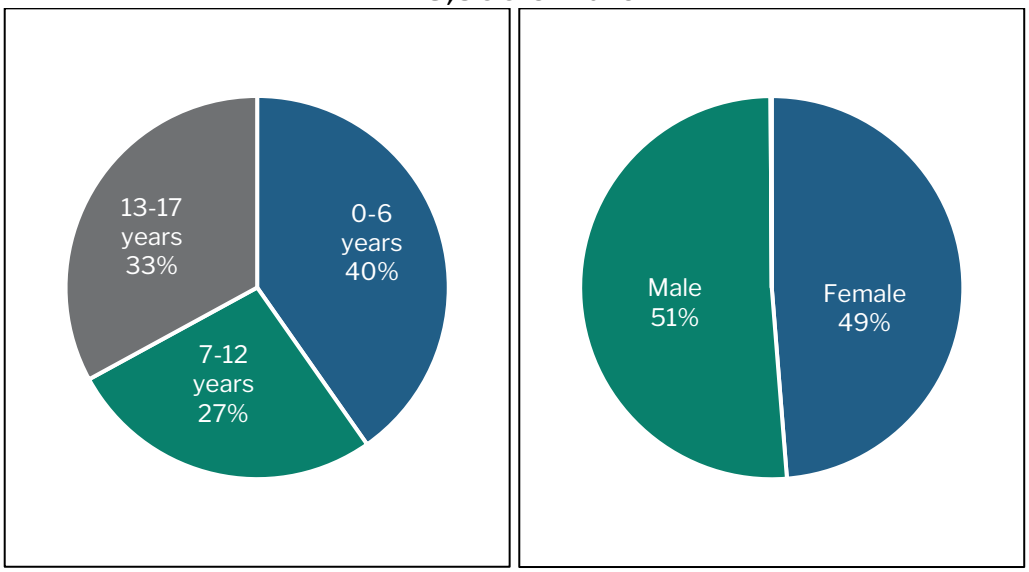


Source: CAPSS data provided by DSS

Figure 10 shows that of all children in DSS custody on September 30, 2023, about one-third (33%) were adolescents (ages 13 to 17); 27 percent were between the ages of seven and 12, and 40 percent were ages six and under. Slightly fewer than half of children in DSS custody on September 30, 2023, were reported to be female (49%).[35,36] These demographics have remained consistent for multiple monitoring periods.

[34] Percentages do not add to 100 percent due to rounding.
[35] Data provided by DSS on placements on the last day of the monitoring period indicate that on September 30, 2023, the gender identity of 3 children (<.01%) in foster care was unknown.
[36] DSS now 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 working with staff to increase reliable data entry in this area.

Figure 10: Children in DSS Custody by Age and Reported Gender as of September 30,2023
N= 3,566 Children



Source: CAPSS data provided by DSS

IV. Fiscal Resources

Funding obligations associated with the *Michelle H.* lawsuit have been appropriated by the General Assembly over the last six fiscal years. In June 2022, the General Assembly passed the FY2022-2023 budget, allocating $39.2 million in new state funds to DSS for child welfare programs. The appropriation provided long-sought-after funding to support the hiring of new staff; strategies for the implementation of the DSS Placement Plan and Health Care Improvement Plan; development of community-based services and supports for families; and Kinship Navigator Programming.[37] For FY2023-2024, DSS was appropriated funding to continue its child welfare reform efforts. This includes $13.7 million in state general funds to increase provider rates and support KinGAP, a guardianship assistance program that provides a path for children to exit the foster care system into subsidized legal guardianship with their kinship caregiver.[38,39]

DSS's FY2024-2025 budget request includes $14.4 million in additional state general funds for child welfare services.[40] This includes, among other items, $590,000 for foster family home rate increases; $3.9 million for a group home cost of care adjustment; $2 million for a residential crisis assessment and stabilization center; $1.7 million for additional placement staffing; and $3.2 million for staffing for additional state-level strategic and Child Health and Well-Being data support positions.[41] These items are included in the January 8, 2023, Executive Budget.[42]

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

[38] To see the full FY2023-2024 General Assembly Appropriation, go to: https://www.scstatehouse.gov/sess125_2023-2024/appropriations2023/ta23ndx.php

[39] For more information on the Kinship Guardianship Assistance Program (KinGAP), go to: https://dss.sc.gov/news/governor-henry-mcmaster-signs-legislation-to-establish-a-kinship-guardianship-program-in-south-carolina/

[40] 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

[41] To see the full FY2024-2025 Agency Budget Plans of all state agencies, go to: https://www.admin.sc.gov/services/budget/building-budget/agency-budget-plans

[42] To see the full FY2024-2025 Executive Budget, go to: https://www.admin.sc.gov/sites/admin/files/Documents/Budget/FY25%20Executive%20Budget%20Book%20-%20Web%20Layout%20-%2001092024.pdf

DHHS and the South Carolina Department of Mental Health (DMH) have also requested funding for FY2024-2025 for important services and supports that will be utilized, in part, for children in foster care. This includes a $931,000 request by DHHS to cover the state's contribution to new evidence-based intensive in-home services for families (MST and Homebuilders); and a $2.6 million request by DMH for new Child and Adolescent Precrisis Intervention Support Teams, to be deployed in the way that many states utilize Mobile Response and Stabilization Services (MRSS) – to help families de-escalate, support, and stabilize and avoid the need for law enforcement involvement.

The FY2024-2025 budget is currently under consideration by the South Carolina Legislature.

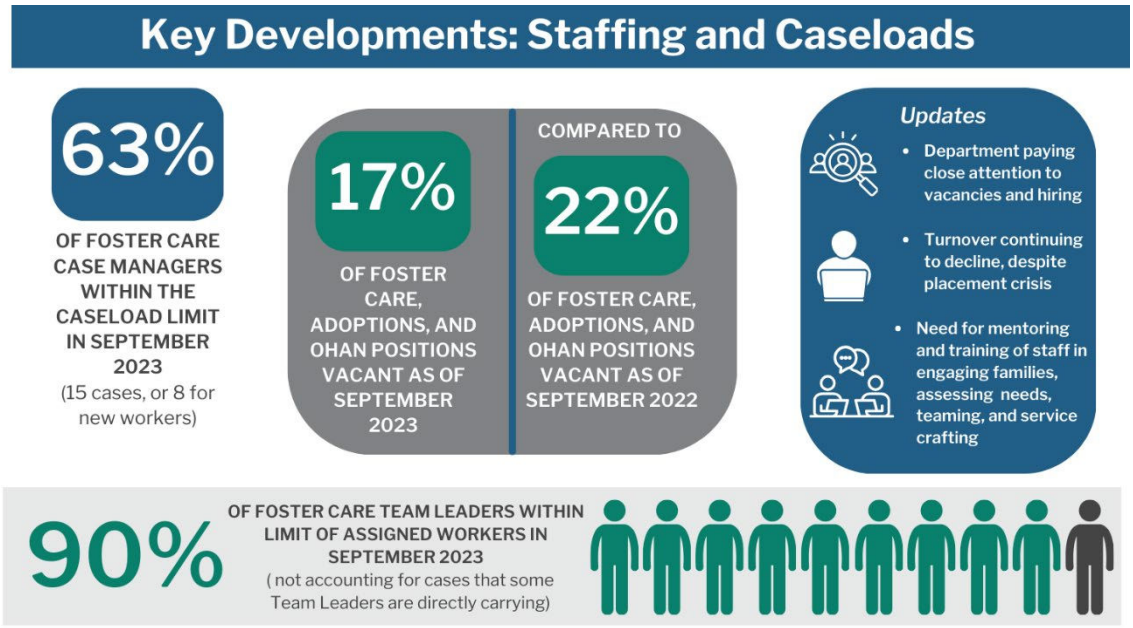
V. Staffing and Caseloads

The focused attention of DSS leadership on staffing, combined with the declining number of children in DSS custody, has resulted in a continued reduction in case manager caseloads. At the end of September 2023, 63 percent of Foster Care case managers had caseloads within the required limit, up from 58 percent in March 2023; 44 percent of Adoptions case managers had caseloads within the required limit, up from only 26 percent in March 2023. Ninety percent of Foster Care Team Leaders[43] 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).[44]

The allocation and hiring of a significant number of newly funded positions in the FY2022-2023 budget to child welfare functions for Non-Class Members (the "front end" of its system), such as Child Protective Services (CPS) and Family Preservation, has promoted continued reductions in the number of children separated from their families and taken into foster care. This important investment is also likely to contribute to further reductions in caseloads for Class Members over time.

The hiring of additional staff is intended to allow case managers the time and capacity to better serve children and families. As discussed throughout this report, the growing placement instability crisis has increased the demands on case managers throughout the state. Despite these pressures, staff turnover has continued to decline from its peak in 2022. Nevertheless, as the placement instability crisis has continued, and harms to children and families have increased, the need for mentoring and training of staff in engaging families, assessing children's underlying needs, working as a team with family members and others who support them, and tailoring interventions has become clearer than ever.

[43] 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.
[44] Throughout the monitoring period (April 1, 2023 to September 30, 2023), some Team Leaders continued to carry direct cases in addition to supervising staff.



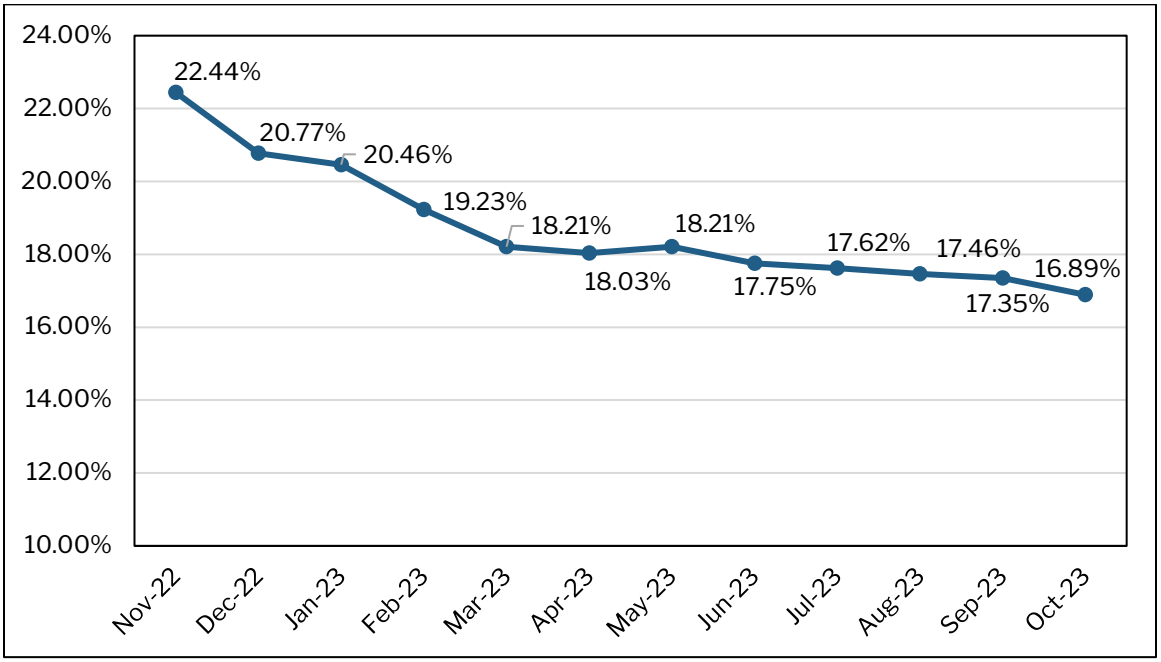
Staffing and Caseload Updates

In DSS's most recent 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.[45] As reflected therein, staff turnover has continued to steadily decline, from 9.2 percent in Quarter 3 of 2022 (from July to September) to 7.2 percent in Quarter 2 of 2023 (from April to June), with a predicted drop to 6.9 percent in Quarter 3 of 2023 (from July to September) according to preliminary data. DSS continues to track staff turnover carefully.

The vacancy rate for Foster Care, Adoptions, and OHAN case managers and Team Leaders has `also continued to gradually decline, to 16.89 percent for October 2023. As shown in Figure 11 below, this is an improvement over prior years.

[45] DSS reports that newly certified case managers now receive 90 days of mentoring from the Regional Performance Coach who was on their support team during Pre-Service Certification training.

Figure 11: Vacancy Rate for Foster Care, Adoptions, and OHAN Case Managers and Team Leaders
November 2022 - October 2023



Source: DSS's Data Submission to the Court (December 8, 2023, 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 investigations of allegations of abuse and neglect of children in foster care (OHAN).[46] Approved caseload standards are included in Table 1.

[46] 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 1: 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[47]	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 supervisor to five case managers (1:5)	N/A	More than six case managers			
Adoptions Team Leader	One supervisor to five case managers (1:5)	N/A	More than six case managers			
OHAN Team Leader	One supervisor to six investigators (1:6)[48]	N/A	More than seven investigators			

Source: Approved DSS Workforce Implementation Plan (February 2019)

* Employed less than 6 Months since completing Child Welfare Pre-Service Certification training

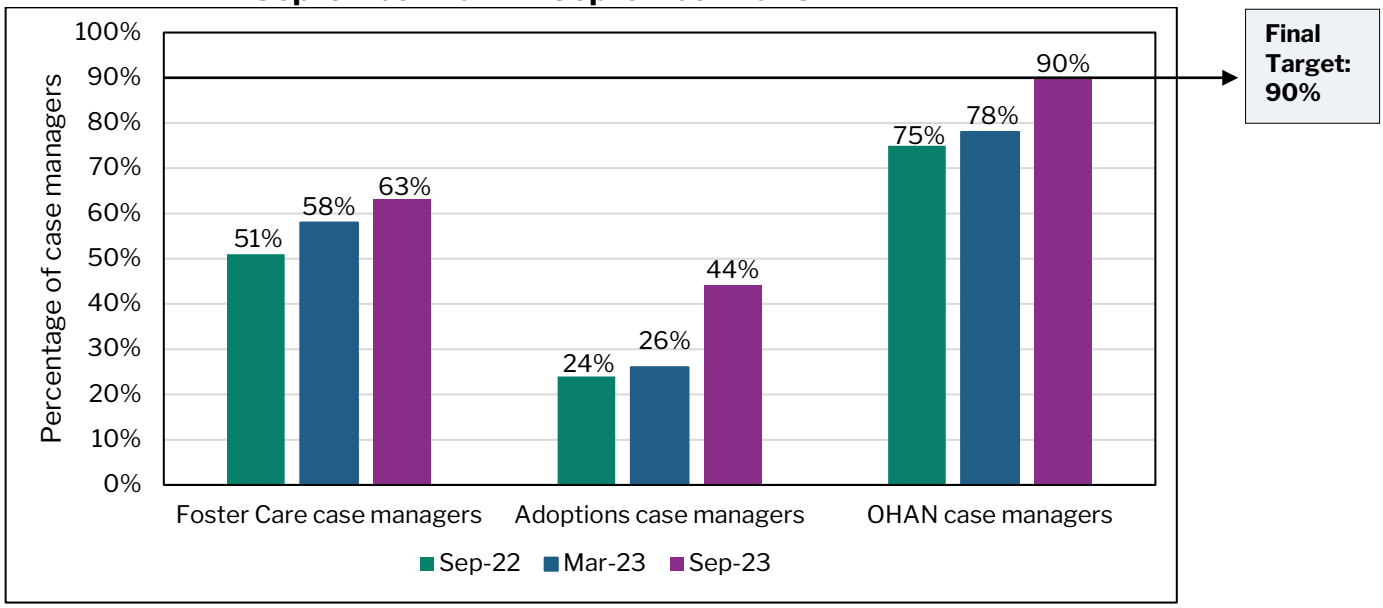
applied to Foster Care case managers with mixed caseloads and is not applied to Adoptions case managers.

[47] 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.

[48] 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 12 shows performance data on caseloads by case manager type for the two prior and the current monitoring periods. As of September 30, 2023, compared to six months prior, the percentage of workers with caseloads within required limits has improved for all three case manager types.

Figure 12: Percentage of Case Managers with Caseloads Within the Required Limits, by Case Manager Type September 2022 – September 2023

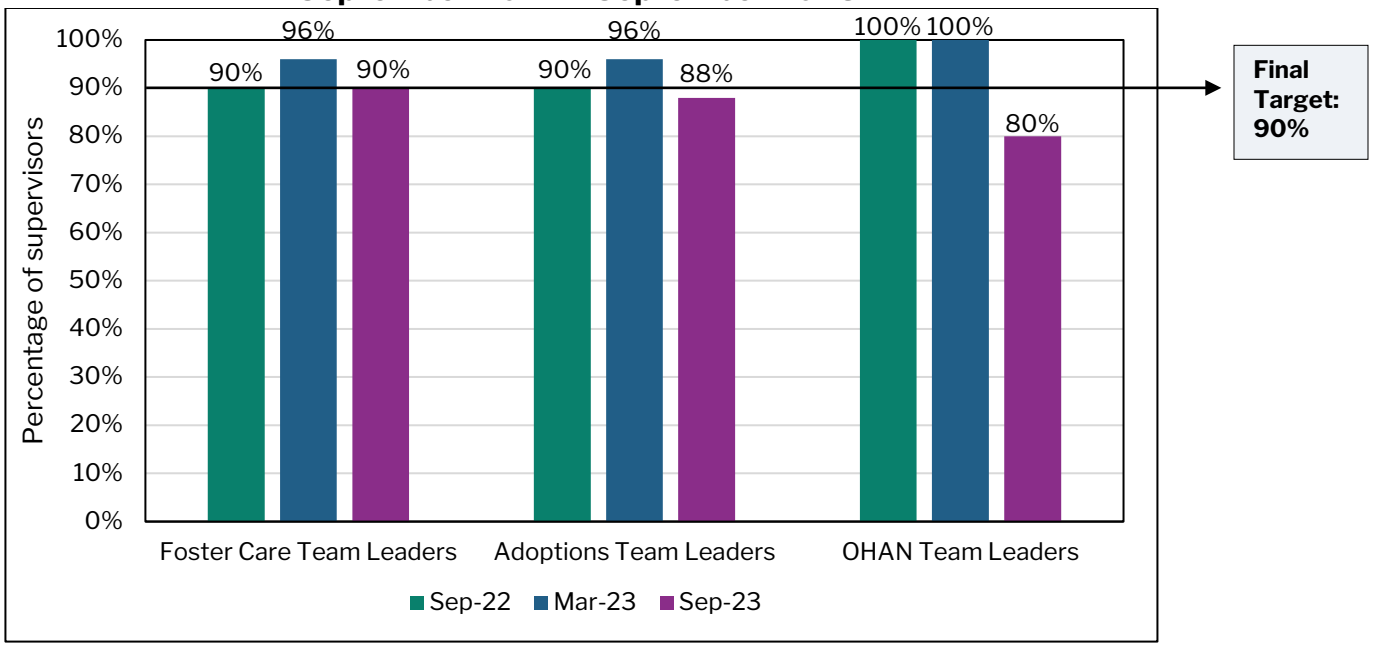


Source: CAPSS data provided by DSS

As shown in Figure 13, performance for all Team Leaders for September 2023 fell slightly in comparison to March 2023. Team Leaders' workloads may be higher than is reflected in the data, as initial data submitted by DSS show that some Team Leaders are continuing to be directly responsible for cases.[49]

[49] 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

Figure 13: Percentage of Team Leaders with Assigned Workers Within the Required Limits, by Supervisor Type September 2022 – September 2023



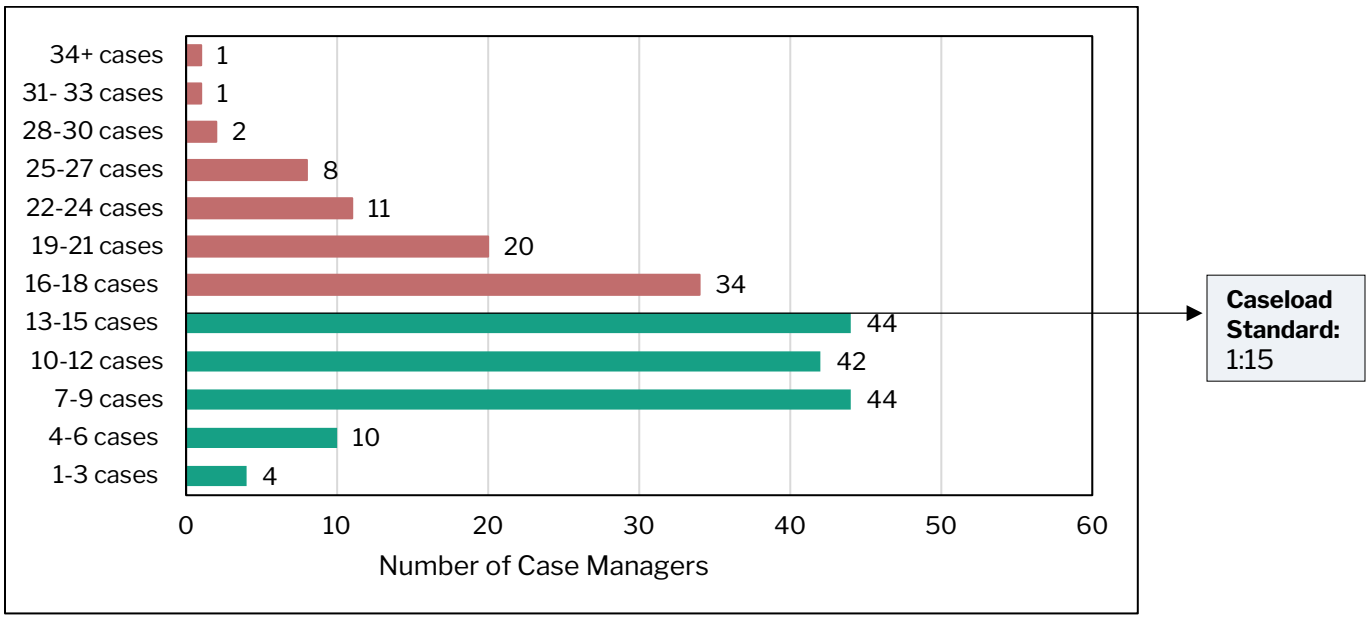
Source: CAPSS data provided by DSS

Foster Care Case Managers

Figure 14 shows the number of cases assigned on September 30, 2023, to the 221 Foster Care case managers who had completed Child Welfare Pre-Service Certification training more than six months prior (classified as "case managers who are not new"). Figure 14 shows the distribution of cases for the 144 case managers with caseloads within the standard and the 77 case managers with caseloads above the standard. As shown in the Figure 14, as of September 30, 2023, two case managers who were not new were responsible for more than 30 cases each (double the caseload standard). This is an improvement from the period six-months prior, when on March 31, 2023, six case managers who were not new were responsible for more than 30 cases each.

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 Accountability, Data, and Research (ADR); 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.

Figure 14: Number of Cases Assigned to Not New Foster Care Case Managers
September 2023
N= 221 Not New Foster Care Case Managers



Source: CAPSS data provided by DSS

Graduated caseload standards are an important worker retention strategy and are necessary to allow new staff the time to develop their skills. Figure 15 reflects the number of cases assigned to the 55 new Foster Care case managers on September 30, 2023, who had not completed certification training more than six months prior (classified as "new case managers"). Over half (53%, or 29 of 55) of new case managers had caseloads within the standard. As of this date, 13 percent (7 of 55) of new case managers were responsible for 17 or more cases (approximately double the caseload standard).

Figure 15: Number of Cases Assigned to New Foster Care Case Managers
September 2023
N = 55 New Foster Care Case Managers

Source: CAPSS data provided by DSS

Data on Foster Care case managers caseloads by region as of September 30, 2023, are shown in Table 2. 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. Compared to 12 months prior (September 30, 2022), performance improved in the Midlands and Upstate region, was maintained at the same level in the Pee Dee region, and declined in the Lowcountry region. Compared to 6 months prior (March 31, 2023), there was significant improvement in caseloads in the Midlands region, which went from 30 percent of Foster Care case managers with assignments at or below the requirement on March 31, 2023, to 50 percent on September 30, 2023. The Lowcountry and Pee Dee regions maintained approximately the same caseloads, and performance declined in the Upstate region.

Table 2: Foster Care Case Managers with Caseloads Within the Required Limit by Region September 30, 2022 –September 30, 2023

Region	Foster Care Caseloads within Required Limit on September 30, 2022	Foster Care Caseloads within Required Limit on March 31, 2023	Foster Care Caseloads within Required Limit on September 30, 2023
Lowcountry	50% N=22/44	40% N=17/42	41% N=14/34
Midlands	27% N=21/78	30% N=23/77	50% N=46/92
Pee Dee	67% N=35/52	67% N=39/60	67% N=40/60
Upstate	65% N=54/83	87% N=73/84	81% N=73/90

Source: CAPSS data provided by DSS

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

After years of consistently low performance on 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,[50] the Co-Monitors suspended reviews and reporting on these measures beginning in October 2021. Parties agreed that these reviews would be paused for at least four monitoring periods, or until DSS's internal data suggest there has been substantial increase in performance.[51]

DSS has continued its efforts to train staff on the importance of time children in its custody spend with their families. These efforts have included attempts to increase the competencies of Team Leaders who serve as coaches for staff by incorporating DSS's Guiding Principles and Standards (GPS) Case Practice Model, which focuses on family engagement.[52] DSS reports that performance with respect to family time (visits between children and their parents, and children and their siblings) has begun to improve.

Currently, DSS and the Co-Monitors are planning a review of March 2024 performance on family time. Findings from this review will be included in the Co-Monitors' report for the October 1, 2023, to March 31, 2024, monitoring period.

[50] 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.

[51] For more information on the agreement to pause reviews related to visitation, refer to *Michelle H.,et al. v. McMaster and Leach* Progress Report for the Period October 1, 2021 – March 31, 2022, Sections VI. *Case Manager Visits with Children* and IX. *Family Time: Visits with Parents and Siblings,* located here.

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

Case Manager Visits Updates

At this time, data on whether a monthly face-to-face visit by case managers occurred can only be reported with quantitative data from CAPSS. These data are reflected in DSS's most recent Data Submission to the Court. To assess FSA compliance, Parties agreed that a case manager's documentation in CAPSS of a contact with a child should reflect each of the Department's policy and practice expectations for a visit and that CAPSS documentation would be assessed qualitatively to determine that a visit conforms to these expectations.

Family Time: Visits with Parents and Siblings Updates

DSS's most recent Data Submission to the Court included results from monthly internal reports on the number of visits between children and their parents and children and their siblings, as well as updates on training and coaching of staff regarding expectations for visits. The Data Submission details DSS's efforts to increase direct documentation by foster parents and providers of visits in the Child and Adult Information Portal (CAIP) for visits of which they are aware and/or facilitate.

Though it is DSS's goal to provide real-time data in a dashboard format for tracking and improving practice in this area through SafeMeasures®,[53] there have been delays in implementing the system, and rollout is now anticipated in April 2024. An introduction to SafeMeasures® has been included in Team Leader certification training in anticipation of its rollout.

DSS has also reported utilizing Regional Support Teams to improve practice around visitation.[54] Regional case management team members are expected to support case manager activities: support case manager contacts with children, help increase

[53] SafeMeasures® is a nationally recognized web-based system for data aggregation, reporting, and analysis developed by Evident Change. To read more about Evident Change, go to: https://evidentchange.org/analytics/safemeasures/

[54] There is currently 1 Regional Support Team per region staffed with a Team Leader, 4 case managers, and a case manager assistant. These teams were created to increase staff retention by balancing workloads of county case managers and are generally deployed to counties experiencing spikes in turnover and/or caseloads.

time children spend with family members, conduct family search and engagement activities, and provide help with transportation.[55]

State leadership has been reaching out to County and Regional Directors responsible for counties which have not shown improvement in recent months, or that consistently perform below the state average, to identify barriers and develop strategies for improvement.

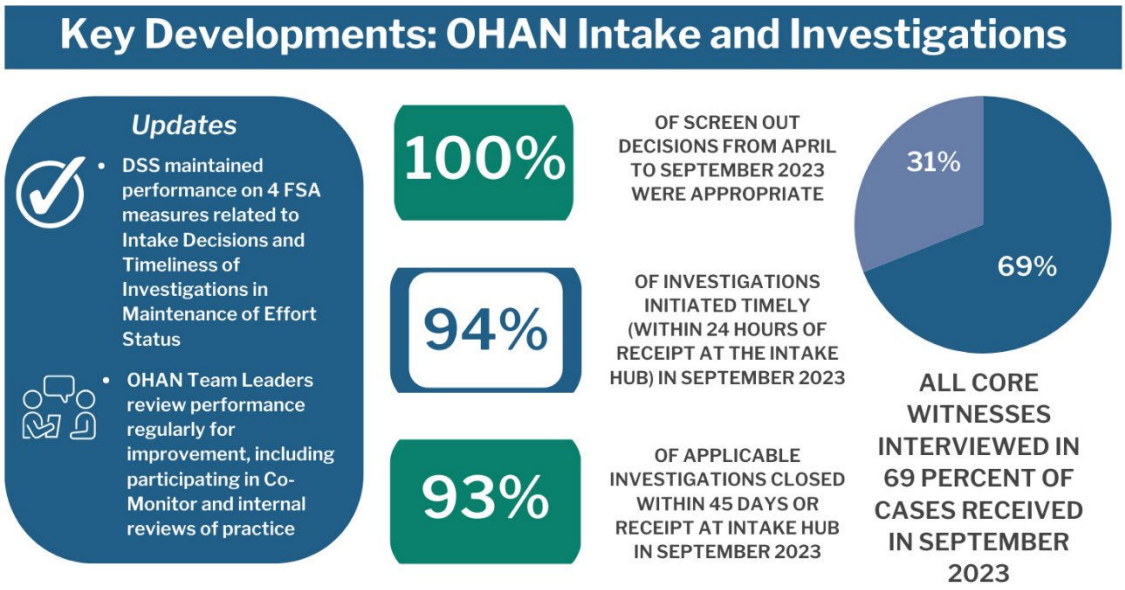
[55] DSS reports that internal data indicate that approximately 50% of Regional Support Team requests are for assistance with case manager visits with children.

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. There were some ongoing improvements in the overall quality of documentation and practices within OHAN during this monitoring period. DSS maintained its performance on all four FSA OHAN subsections for which it was granted Maintenance of Efforts status on August 3, 2023:[56] Intake – Decision Not to Investigate; Timely Completion of Investigation Within Forty-five (45) Days of Initiation; Timely Completion of Investigation Within Sixty (60) Days of Initiation; and Timely Completion of Investigation Within Ninety (90) Days of Initiation. An increased number of OHAN investigator and Team Leader positions, focused and consistent supervision, and improved information gathering and assessments are important contributors to these continued successes.

DSS performance with respect to other OHAN FSA measures – timely initiation of investigations, investigation decisions, and contact with core witnesses during investigations – fell this monitoring period following improvements in the prior monitoring period. Data suggest newly onboarded staff can benefit from increased supervision and support. DSS reports implementing several new processes and tools, including providing all OHAN investigators additional support in investigations involving multiple children or alleged perpetrators, utilizing the Family Advocacy and Support Tool (FAST), and improving collaboration with alleged victim children's Foster Care case managers and Team Leaders. It is DSS's expectation that the implementation of these new practices, along with the appointment of a new Director of the Office of Safety Management (Josie Jones), will help improve OHAN performance in the months ahead.

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



OHAN Performance Data

OHAN Intake

Since November 2019, DSS's Intake Hubs have been responsible for screening all reports alleging abuse and/or neglect of children, including allegations involving children in foster care settings.[57] Screening decisions are made utilizing a Structured Decision Making (SDM)® intake tool.[58]

Decision Not To Investigate

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

[57] 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 2 hours for reports.

[58] For more information on SDM, see https://evidentchange.org/assessment/structured-decision-making-sdm-model/child-welfare/ (retrieved Feb. 08, 2024)

determine whether the allegations would meet the state's statutory definition of abuse or neglect.[59] All screening decisions are reviewed and approved by a Team Leader before being finalized.

The FSA requires that *"[a]t least 95% of decisions not to investigate a Referral of Institutional Abuse or Neglect about a Class Member must be made in accordance with South Carolina law and DSS policy"* (FSA IV.C.2.).

DSS met the agreed upon target for this measure. The Co-Monitors reviewed data provided by DSS which shows DSS has maintained performance on this measure for the April through September 2023 monitoring period. DSS's Internal Monitoring Team agreed with the decision to screen out each of 32 (100%) applicable reports with an allegation of maltreatment.[60]

OHAN Investigations

Allegations of abuse or neglect of children in DSS custody screened by DSS's Intake Hubs as appropriate for investigation are assigned to OHAN staff.[61,62] The FSA and OHAN policy require face-to-face contact with 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.[63] OHAN policy requires that the investigator conduct a safety assessment of the child, including a private interview; 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.[64]

[59] SC Code § 63-7-20.
[60] This review includes examining information entered into CAPSS, and listening to recordings of reports, when available.
[61] 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).
[62] 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.
[63] SC DSS Child Welfare Policies and Procedures Manual, Chapter 16: Special Topics: Out of Home Abuse and Neglect (effective May 19, 2022).
[64] Ibid.

FSA measures that relate to OHAN investigations include: timely initiation (two measures);[65] contact with core witnesses (one measure); investigation determination decisions (one measure); and timely completion (DSS met and has maintained these three requirements).

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."* [66] The Co-Monitors measure performance for both FSA IV.C.4.(a) and (b) using the same methodology and timeframes – the time between receipt of a report by the Intake Hub and face-to-face contact with the alleged child victim which must be within 24 hours.

Of the 52 applicable OHAN investigations which began in September 2023, investigators made contact with all alleged victim children within 24 hours in 47

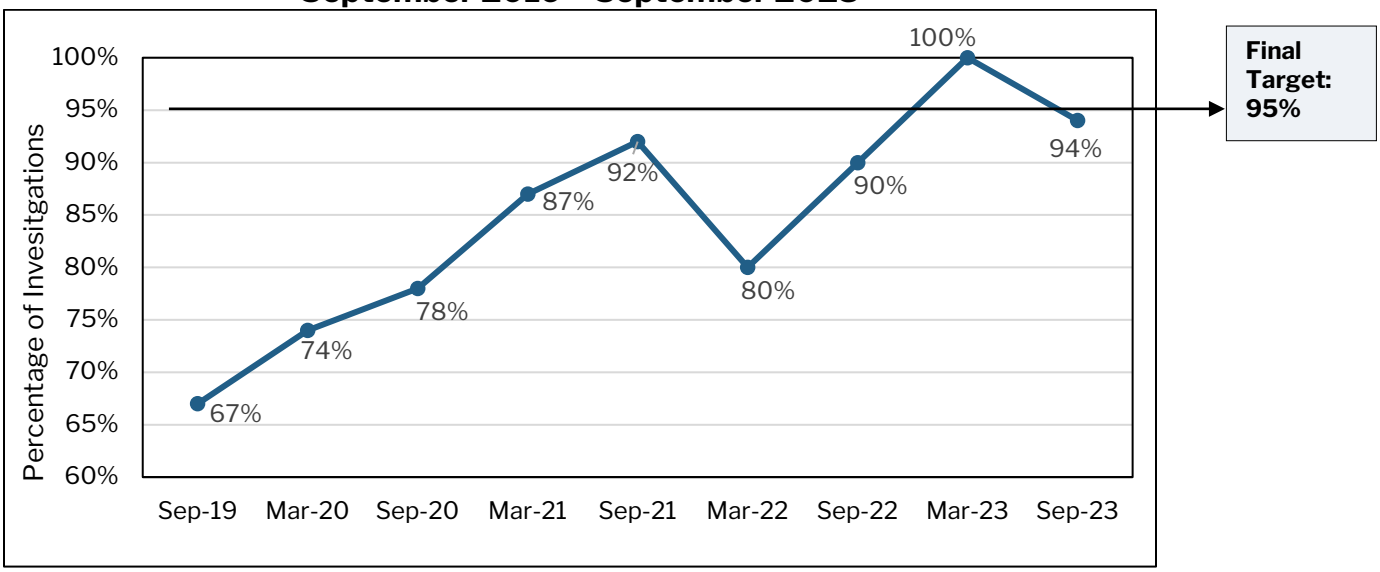
[65] The Co-Monitors' interpretation of the FSA requires that investigations be initiated within 24 hours of receipt of a report by DSS, not within 24 hours of the decision to accept the report, and that initiation is completed by making face-to-face contact with the alleged victim child(ren). As a result, 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.

[66] 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).

(90%) investigations. In an additional two (4%) investigations, all applicable good faith efforts were made to contact each of the alleged victim children.[67] Thus, 94 percent of investigations were initiated in a timely manner.

Current performance shows a decrease from the prior period (see Figure 16) and falls just below the final target.

Figure 16: Timely Initiation of OHAN Investigations
September 2019 – September 2023



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

Contact with Core Witnesses during Investigations

The FSA requires that *"[c]ontact with core witnesses must be made in at least 90% of the investigations of a Referral of Institutional Abuse or Neglect, with exceptions approved by the Co-Monitors"* (FSA IV.C.4.(c)).[68]

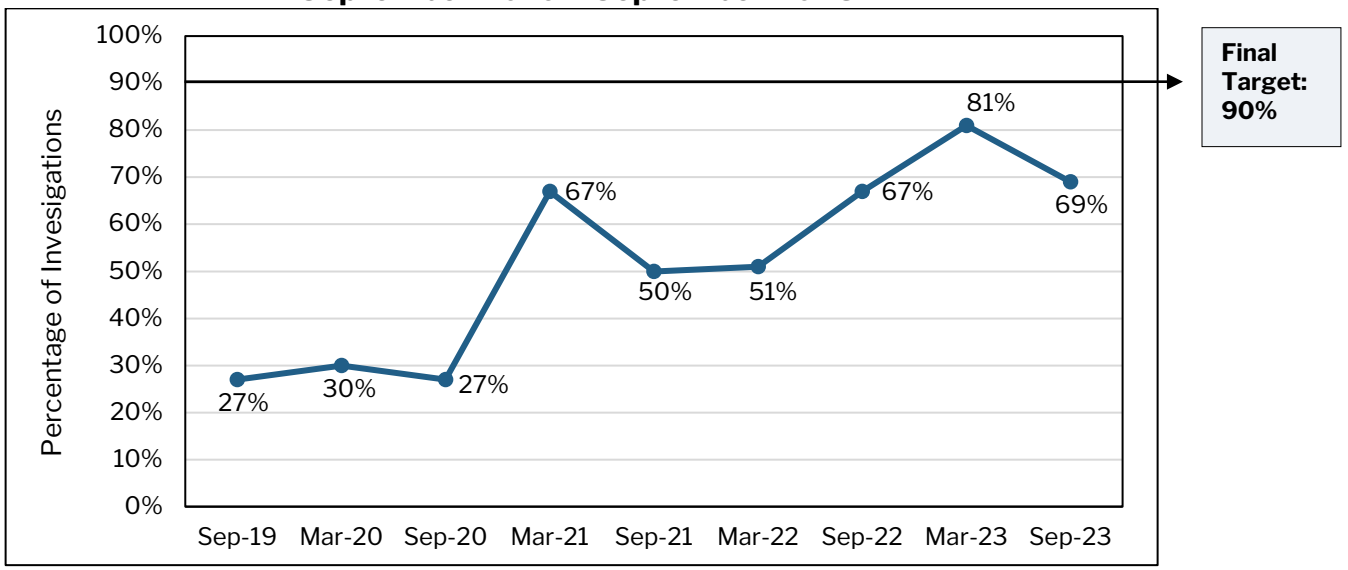
[67] There were 2 instances of children considered to be on "runaway" status and a child who had returned home with a closed case and could not be found to participate in the investigation.
[68] The following are exceptions, approved by the Co-Monitors, to the requirement that the investigator contact 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.

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.[69]

Of the 52 applicable reports involving Class Members accepted in September 2023, 36 (69%) reflected contact with all necessary core witnesses during the investigation. Current performance, at 69 percent, is a significant decrease in performance from the prior period, when 81 percent of reports in March 2023 reflected contact with all necessary core witnesses during an investigation. Current performance is comparable to a year prior (September 2022) when OHAN investigators made contact with all necessary core witnesses in 67% of cases). Performance for September 2023 remains below the final target of 90 percent (see Figure 17).

[69] 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 17: Contact with All Necessary Core Witnesses During OHAN Investigations September 2019 – September 2023



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

Data presented in Table 3 shows the frequency of OHAN investigator contact with each type of core witness in the 52 investigations reviewed.

Table 3: Interviews with Necessary Core Witnesses During OHAN Investigations by Type of Core Witness September 2023 N=52

Core Witness	Applicable Investigations	Contact/Interview with All
Alleged Victim Child(ren)	52	49 (94%)
Reporter	47[70]	44 (94%)
Alleged Perpetrator(s)	52	51 (98%)
Law Enforcement	14	12 (86%)
Alleged Victim Child(ren)'s Case Manager(s)	52	46 (88%)
Other Adults in Home or Facility[71]	21	18 (86%)
Other Children in Home or Facility[72]	36	29 (81%)
Additional Core Witnesses	48	39 (81%)

Source: Case Record Review completed in December 2023 by DSS and Co-Monitor staff

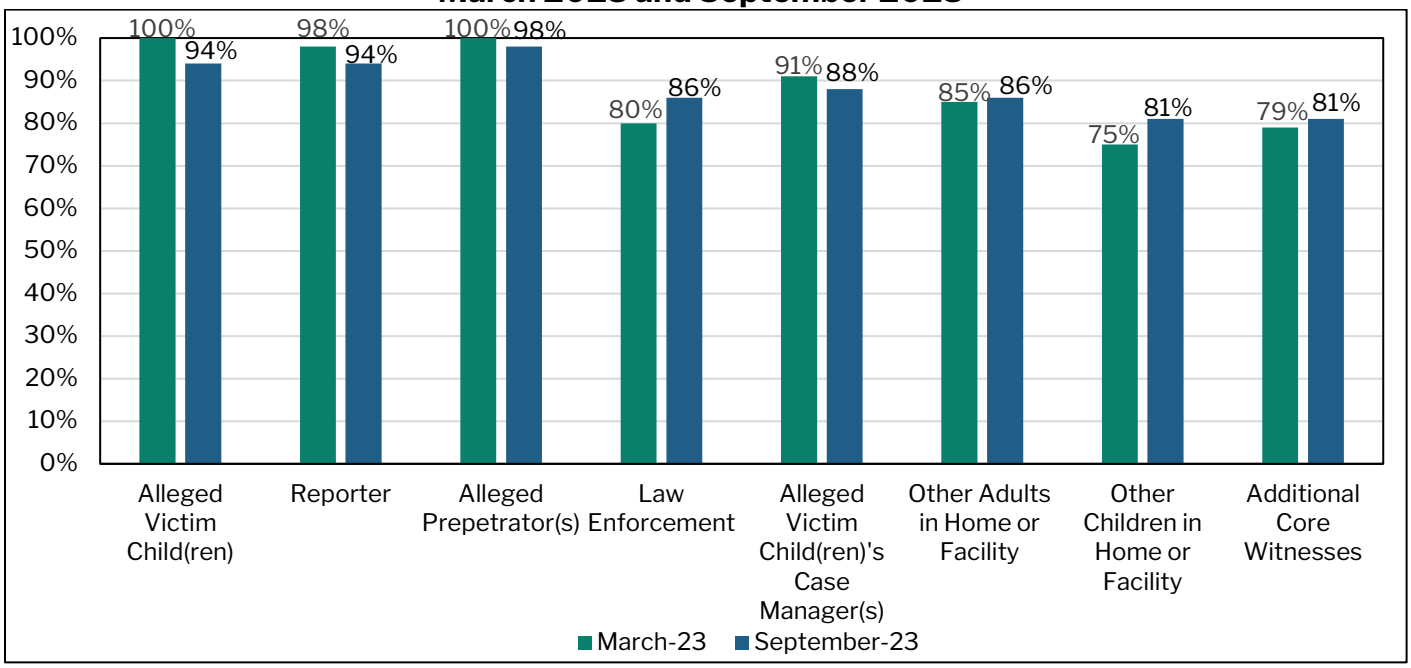
Data in Figure 18 show the frequency of contact within all categories of core witnesses for investigations opened in September 2023 compared to the prior review of investigations opened in March 2023. Improvements are noted in the frequency of contact with law enforcement and other children in the home or facility.

[70] In 5 investigations, the reporter was anonymous.

[71] 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.

[72] 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 18: Contact with Necessary Core Witnesses During OHAN Investigations March 2023 and September 2023



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.[73]

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."*

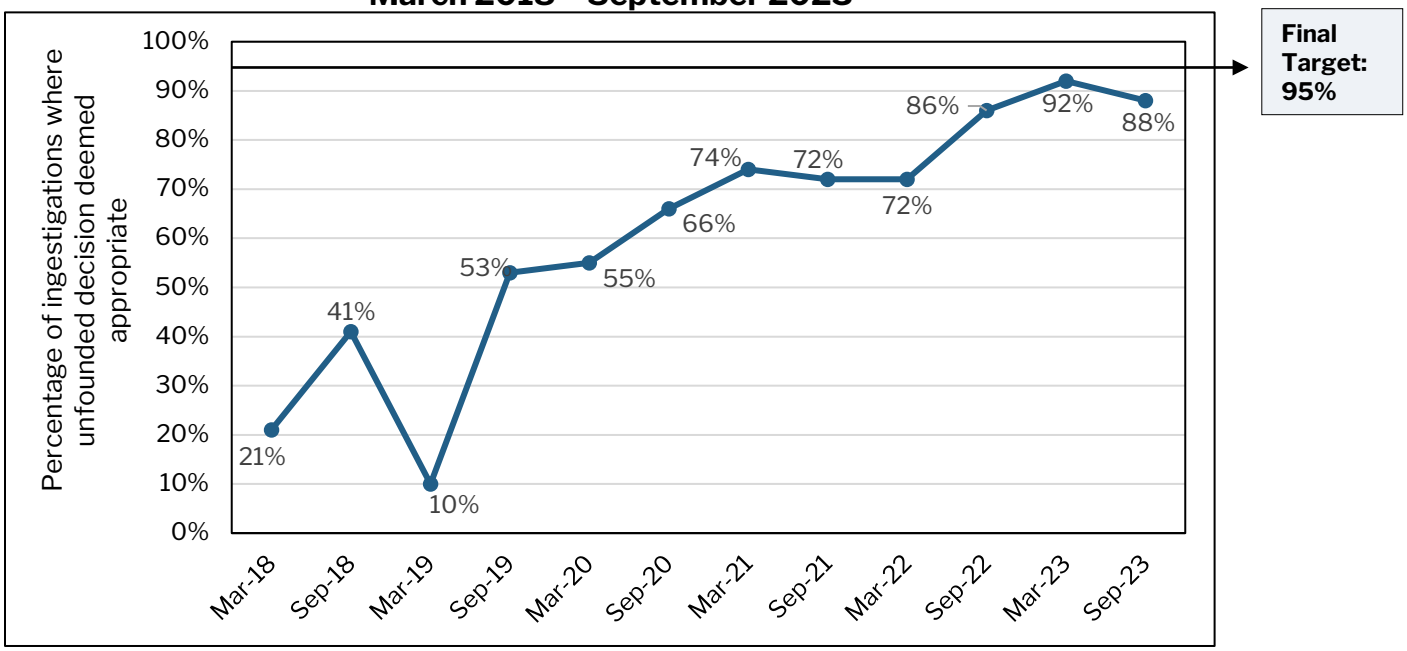
Of the 52 investigations reviewed, the final decision was to *unfound* the allegations in 48 investigations. Reviewers agreed that the decision to *unfound* the investigation was appropriate in 42 (88%) of the investigations.[74] In each investigation in which the

[73] SC DSS Child Welfare Policies and Procedures Manual, Chapter 16: Special Topics: Out of Home Abuse and Neglect (effective May 19, 2022).
[74] As part of the Co-Monitors protocol for all case reviews that are conducted, if a safety concern is identified and documentation does not reflect it was addressed, DSS is immediately notified for appropriate follow-up.

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

Performance in this area remains below the final target of 95 percent.

Figure 19: Decision to Unfound OHAN Investigations Deemed Appropriate March 2018 – September 2023



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.[75] Good cause means that, through no fault of the investigator,

[75] 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.[76] 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 will be tracked twice yearly by the Co-Monitors through case record reviews.

Completed within 45 Days

In three of the 52 (6%) investigations reviewed, the investigator requested and received an extension for an additional 15 days to complete necessary investigative tasks. Forty-five (87%) of investigations were completed within 45 days. Current performance at 93% exceeds the final target for this measure.

Completed within 60 Days

All (100%) of the 52 investigations were completed within 60 days of opening. Performance exceeds the final target for closure within 60 days.

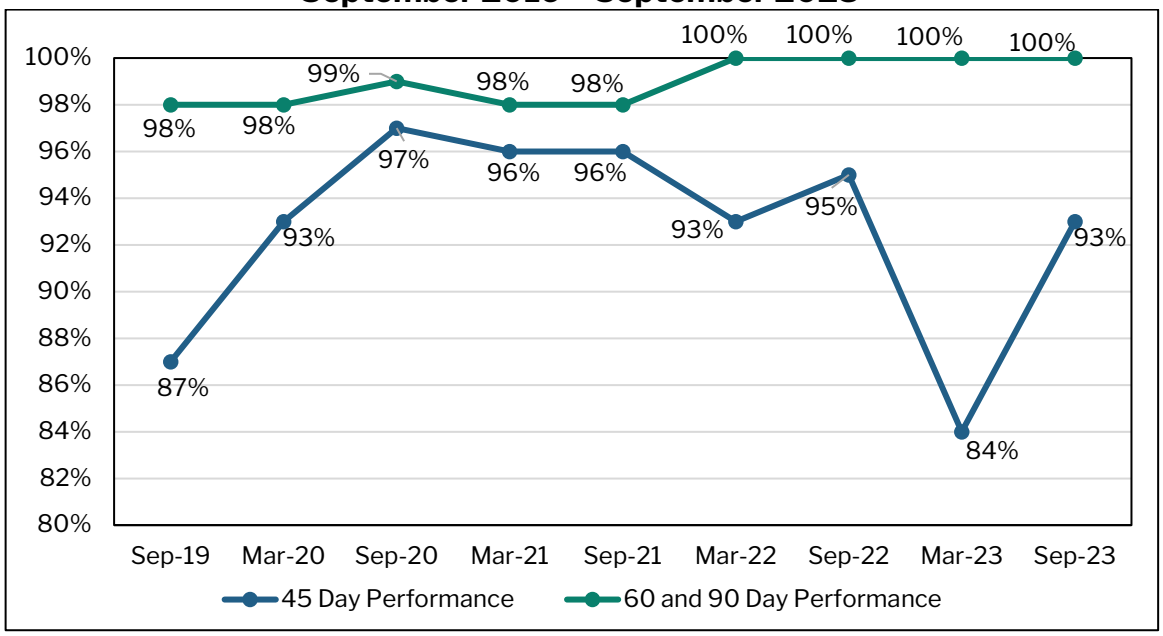
Completed within 90 Days

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 20 shows performance for timely closure of investigations from September 2019 to September 2023.

[76] 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 20: Timely Completion of OHAN Investigations
September 2019 – September 2023



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 important people in children's lives ("fictive kin"), and to work towards becoming a "kin first" state. Twenty-seven percent of all children in DSS custody were placed with kin at the end of September 2023 – the highest percentage since the inception of this lawsuit.

Despite these successes, the placement instability crisis reached new extremes during the monitoring period. The Co-Monitors' Supplemental Report, issued in August 2023, described the urgent concerns about the impact of the placement crisis on children, families, kin, foster parents, group home staff, private providers, and DSS frontline staff and leaders.[77] In the months since, children in DSS custody continue to be moved between placements, DSS offices, and emergency settings at exponentially higher rates.

From September 2022 through October 2023, children in DSS custody were moved an average of 6.07 times per 1,000 days in foster care, surpassing all previous counts. Children spent 1,012 nights in DSS offices in just the most recent six-month monitoring period (April 1, 2023, to September 30, 2023), compared to the 506 nights children spent sleeping in offices in all of the five years between April 2018 and March 2023. During the most recent six-month period, 555 unique children spent 8,991 nights in emergency placements.[78] In the prior monitoring period, October 1, 2022, to March 31, 2023, 489 unique children spent 7,400 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*

[77] *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.

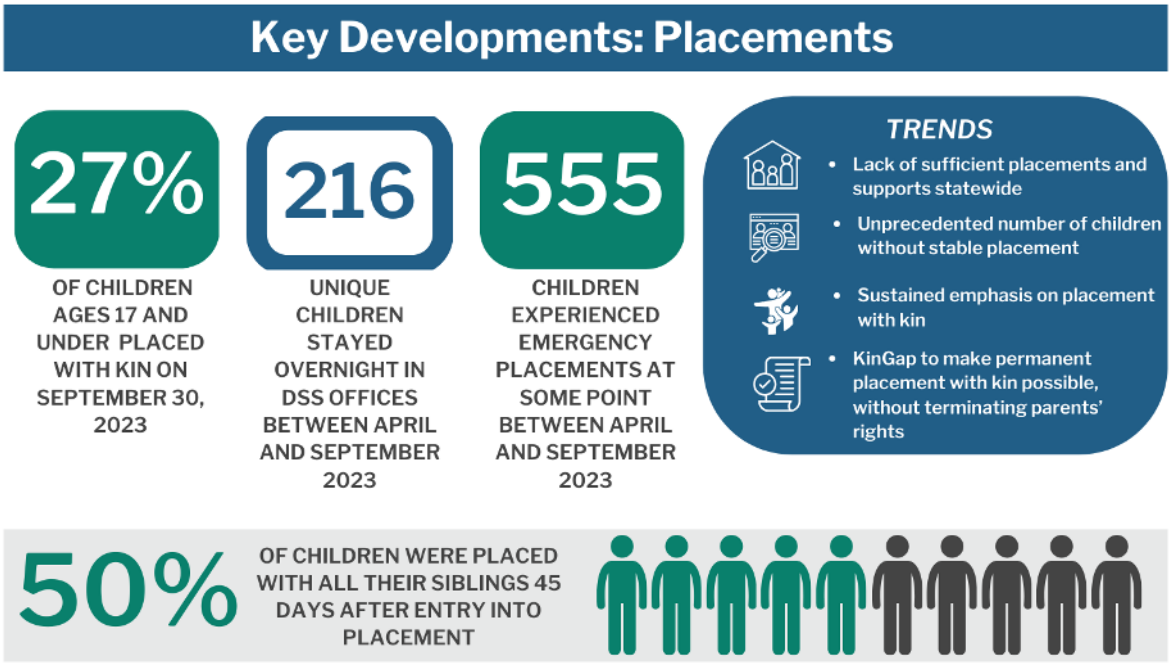
[78] In DSS's most recent Data Submission to the Court, DSS initially reported that 556 children spent 9,081 nights in emergency placements between April 1, 2023, and September 30, 2023. These data have since been corrected and updated data are included herein.

phone (and only lifeline) would be dysregulating to any adult, no less children looking for a sense of control and stability."[79]

This crisis shows no signs of abating. DSS reports that in the three months since the end of the monitoring period (October 1 to December 31, 2023), 166 children spent 860 nights in a DSS office. Five children spent a total of five nights in a DSS office in December 2022. One year later, in December 2023, 77 children slept a total of 326 nights in a DSS office.

This placement instability is largely a symptom of the severe shortage of services and supports for children and families throughout South Carolina, and the limited ability of staff to identify and act to address children's underlying needs. DSS cannot effectively succeed in its mission of supporting children's safety, permanency, and well-being, and strengthening families, without more readily available supports and treatment services for children and their families. This work must be done in conjunction with other state agencies, such as 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) – as well as private providers.

[79] *Michelle H.* Co-Monitors' Supplemental Report Regarding South Carolina's Placement Crisis (August 1, 2023, Dkt. 288-1), p.16.



Placement Updates

Expansion of Home- and Community-Based Services Through Medicaid

DSS has made progress since the last monitoring period in moving forward with some of the recommendations included in the Co-Monitors' Supplemental Report.[80] Collaboration between agencies and other key partners improved, with the support of the Governor's office. DHHS has committed to addressing some urgent service needs, including the lifting of the long-standing Rehabilitative Behavioral Health Services (RBHS) and Targeted Case Management (TCM) provider moratoriums; 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.

As discussed in prior reports, Medicaid is critically important and extensively used in jurisdictions throughout the country to provide intensive in-home and community-based services. Though the services currently being rolled out in South Carolina are

[80] 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

an important start, the selected interventions are narrowly focused, and limited in their reach and could be expanded. Medicaid allows states flexibility in tailoring services or coverage for specific populations and has been essential in the development of services and supports for children in foster care for decades.[81]

There are some services that are foundational to any family-serving system that can be financed through Medicaid, including: intensive care coordination (ICC) and high-fidelity wraparound;[82] intensive in-home mental health treatment services;[83] therapeutic foster care; and peer mentoring; among others.[84]

[81] For examples of how other states have utilized Medicaid waivers see, *Michelle H.* Co-Monitors' Supplemental Report Regarding South Carolina's Placement Crisis (August 1, 2023, Dkt. 288-1), p.27(FN60),https://cssp.org/wp-content/uploads/2023/10/Supplemental-Report-re-South-Carolinas-Placement-Crisis.pdf

[82] ICC is "a robust, comprehensive form of case management services, designed specifically for children and youth with significant mental health needs," and should include: assessment and service planning; help with access to and coordination with services, including crisis services, support for meeting basic needs, family advocacy, and progress monitoring. (Lav, Jennifer and Lewis, Kim *Children's Mental Health Services: The Right to Community-Based Care* (April 1, 2018) (citing Joint Centers for Medicare and Medicaid Services (CMS) and Substance Abuse and Mental Health Services Administration (SAMHSA) Informational Bulletin, Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions (May 7, 2013), https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf).) ICC is often provided through a "wraparound" model, which is a structured approach to individualized family- and youth-driven care coordination. (Center for Health Care Strategies, *Intensive Care Coordination Using High-Quality Wraparound for Children with Serious Behavioral Health Needs: State and Community Profiles 5 (*July 2014*),* https://www.chcs.org/media/ICC-Wraparound-State-and-Community-Profiles1.pdf; *see* Jennifer Schurer Coldiron et al., *A Comprehensive Review of Wraparound Care Coordination Research*, 1986-2014, 26(5) Journal for Child and Family Studies 1245 (2017).)

[83] Intensive in-home mental health treatment services are comprehensive, collaborative interventions provided to improve child, youth, and family functioning and to prevent the need for out-of-home placement, placement disruption, inpatient hospitalization, or residential treatment. Multisystemic Therapy, Intensive Family Preservation Services, Homebuilders, Functional Family Therapy are examples of such interventions, amongst many others. (Barbot, B., Bick, J., Bentley, M.J., Balestracci, K., Woolston, J., Adnopoz, J.A., & Grigorenko, E. (2016) *Changes in mental health outcomes with the Intensive In-Home Child and Adolescent Psychiatric Service: A multi-informant, latent consensus approach.* International Journal of Methods in Psychiatric Research*.; see* Stroul, B, et al. *The Evolution of the System of Care Approach*. University of Maryland Institute for Innovation and Implementation.https://www.cmhnetwork.org/wp-content/uploads/2021/05/The-Evolution-of-the-SOC-Approach-FINAL-5-27-20211.pdf)

[84] Center for Health Care Strategies. *Lessons From Other Fields: What are Promising Practices for Using Medicaid State Plan Amendments and Waivers to Address the Needs of Children and Youth in Foster Care?* Casey Family Programs. Retrieved from: https://www.casey.org/media/20.07-KM-LFOF-Medicaid-waiver-authorities_fnl.pdf

The state acknowledges that changes currently made or in planning and development are only beginning steps in what will need to be a comprehensive and long-term effort to build a robust system of care and supports for South Carolina's children and families. In addition to ongoing collaboration with Medicaid and other state agency partners to expand the scope and reach of these services, it will be essential that DSS designate someone to lead the effort to develop community-based services aligned with DSS's assessment of needs. It will take significant time for these services to become available to families, even if this work moves forward expeditiously.

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

DSS leadership and staff report that the practice of convening a CFTM prior to a child's placement into foster care has been effective at keeping families together and identifying kin and other family resources, as has been the case in jurisdictions throughout the country that are implementing CFTMs. The Co-Monitors recommended in the Supplemental Report that these CFTMs be mandated before or upon placement, with regularity and in accordance with the GPS Case Practice Model,[85] and 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] Until CFTMs are regularly used by DSS and its partners to engage, assess, and support children and families when they initially enter DSS's custody and throughout their involvement with DSS, CFTMs will remain as mainly a crisis response and their full potential will not be realized.

DSS has identified the increased use of pre-removal CFTMs as a core strategy in the Small Test of Change (STOC) and is in the process of rolling out pre-removal CFTMs in three counties in the state: Spartanburg, Anderson, and Greenville. The goal of CFTMs for children in placement are to work with community partners to develop

[85] 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

[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.

strategies to increase the percentage of children placed in or near their home communities and improve outcomes for older youth, who are currently experiencing significant placement instability in South Carolina. The Co-Monitors encourage the Department to move forward on this work as quickly as possible, and to dedicate resources to rollout as needed.[87] This includes ample flexible funding that can be quickly accessed by teams working with children and their families and creatively utilized to support safety, stability, permanency, and well-being.

Practice Development to Assess Underlying Needs and Craft Individualized Services

The Co-Monitors have long recommended that DSS embrace a different approach to identifying and understanding children's 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 in Greenville, Richland, and Spartanburg counties. These consultations are geared towards assessing underlying needs, identifying innovative problem-solving strategies with children and families, and supporting and developing DSS staff to do the same. This is a beginning step toward integrating the GPS practice model throughout the system.

Stakeholder and Private Provider Partnerships

The Department has continued to engage private providers as partners in developing and implementing change strategies. Since the outset of this lawsuit, the provider community has expressed 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 meaningful partnerships with providers.

[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.

On October 9 and 10, 2023, DSS convened a strategic session with providers and other stakeholders to discuss the placement instability crisis and follow-up actions. The convening resulted in a shared understanding by many of the deeper underlying causes of the acute issues DSS is now facing, the severity of the placement instability crisis, and harms currently being caused to children and families. The resulting next steps from the convening were to establish and/or further develop topic-focused workgroups to develop potential solutions on four priority topics:

(1) design a youth-centered process for gathering strengths and needs to inform the placement process;
(2) shift the system to become truly kin-first;
(3) enhance and expand Child and Family Team Meetings;
(4) develop and leverage informal and formal services that are easily accessible and tailored to the needs of young people, parents and caregivers; and

DSS reports that it has now convened new workgroups to align with these priorities, each of which includes representatives from DSS, provider entities, and partner organizations, and will incorporate input from those with lived experience.

Although the promise of the workgroup effort and the focus on root causes and underlying needs is essential and important, the Co-Monitors have expressed their recommendation that more immediate action continues to be needed. This need is underscored by the alarming rate at which children continue to be moved through offices and placements. The lifelong deleterious effects on children and families of family separation and instability highlight the urgency of developing immediate workable solutions.

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.).

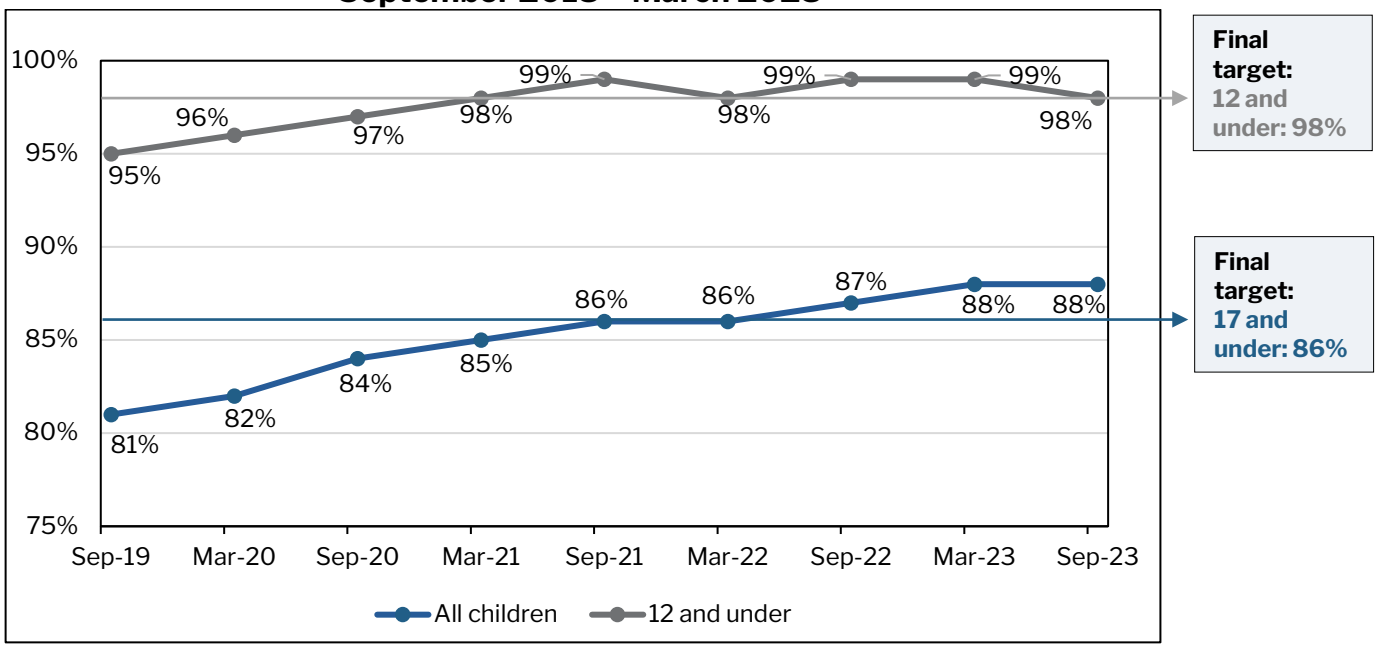
On September 30, 2023, 88 percent (3,111 of 3,548) of Class Members were placed outside of a congregate placement and in family-based settings.[88] Performance continues to meet the final FSA target for children residing in family-based placements.[89]

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 21, as of September 30, 2023, 2,349 of 2,385 Class Members ages 12 and under resided outside of a congregate placement, in a family-based setting, resulting in performance of 98 percent.[90,91] As shown in the figure, performance on this measure continues to meet the final target.[92]

[88] Eighteen children resided in other institutional settings and were removed from the universe. Specifically, DSS reports that 11 children were incarcerated in correctional or juvenile detention facilities and 7 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 placement.
[90] This includes 5 children under the age of 6 who resided with their parent in a residential facility.
[91] Six additional children ages 12 and under were hospitalized on the last day of the monitoring period and are excluded from the calculations.
[92] 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, 2023, October 3, 2022, March 23, 2022, and October 26, 2023 monitoring reports.

Figure 21: Trends in Placement of Children Outside of Congregate Care September 2018 – March 2023



Source: CAPSS data provided by DSS

These data do not capture children's experiences over the *entirety* of their time in foster care and do not include children who resided in other institutional settings, such as hospitals or correctional facilities. Approximately 17 percent of all children and three 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.).[93,94]

[93] 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 6 and under in family placements (IO II.3.(a) & FSA IV.D.2.). The procedure requires approval of a Regional Director prior to the placement of any child under the age of 7 in a non-family-based setting.

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

Of the 17 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.[95]

Children ages 13-17 are still far more likely than younger children to be placed in congregate settings. On September 30, 2023, 34 percent (396 of 1,163) of children ages 13-17 resided in a congregate facility. This is comparable to the end of the prior monitoring period (March 31, 2023) when 33 percent of children ages 13 to 17 resided in congregate facilities. Forty-six percent (756 of 1,656) of children ages 13 to 17 in DSS custody at any time between April 1, 2023, and September 30, 2023 were placed in a congregate setting at some point during the period. This is a slight increase over the prior monitoring period when 44 percent of children ages 13 to 17 were placed in congregate facilities at some point during the period.

Distribution of Placement Types

Figure 22 shows the breakdown for all placement types for children in DSS custody on the last day of the monitoring period. On September 30, 2023, 14 percent (502 of 3,548) of children resided in licensed relative foster homes. As reflected in the figure, when combined with court-ordered unlicensed relative placements, this means that 27 percent (966 of 3,548) of children were placed with relatives. As of September 30, 2023, 60 percent (2,145 of 3,548) of children were placed in foster or adoptive homes with non-relatives,[96] including: 1,103 children (31%) placed in non-kin foster

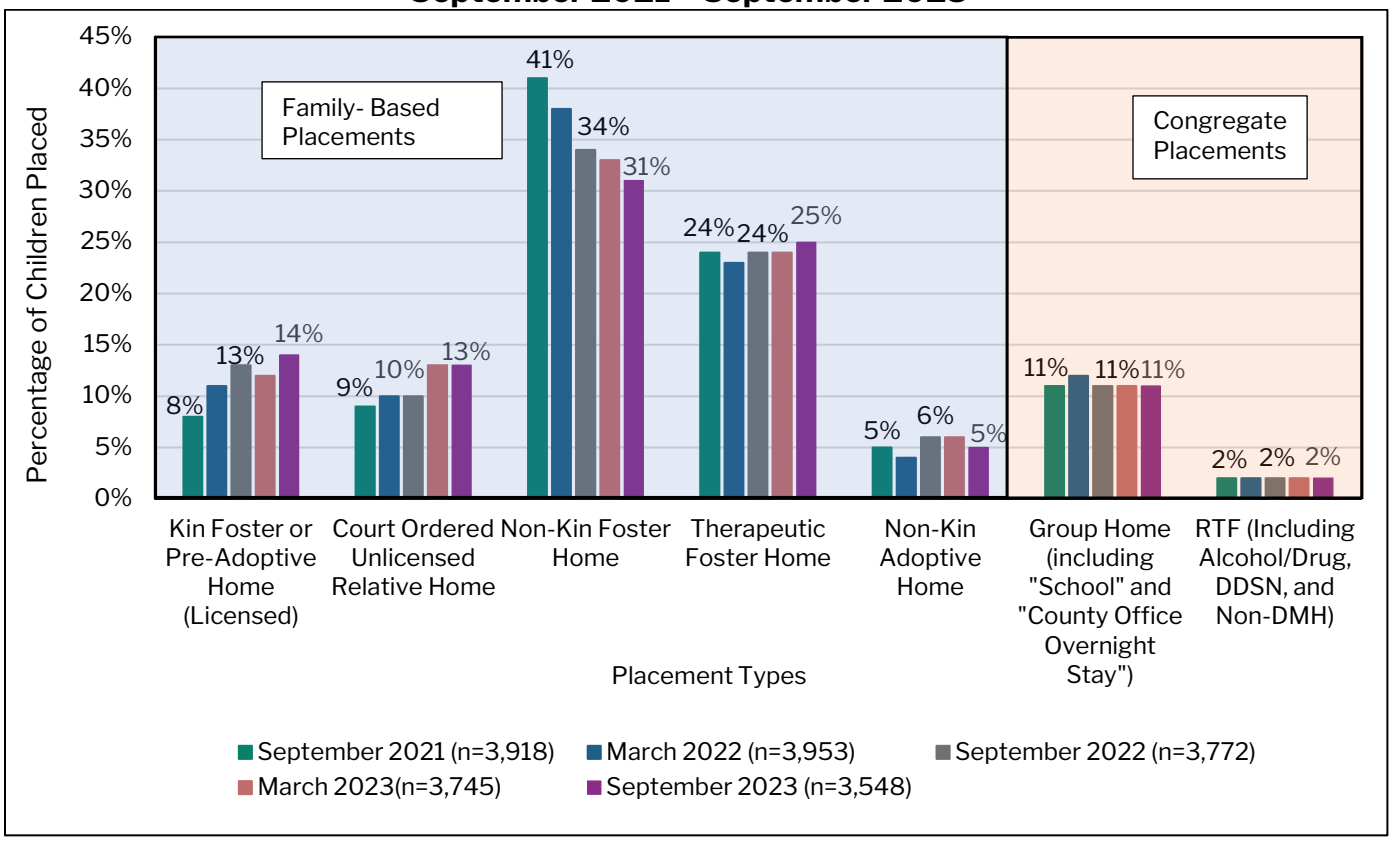
: the child requires a degree of clinical and/or medical support that can only be provided in a group care setting and cannot be provided in a family-like setting, and the placement is a facility that has the capacity and specialized treatment to meet those needs; the child is the son or daughter of 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.

[95] Of the 17 children, 15 were placed in a treatment facility or group care setting with their parent; 1 was placed with siblings for less than 90 days, and 1 was placed in a psychiatric hospital for which a clinical need was identified.

[96] 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, September 30, 2023, 37% of children in DSS custody were in a CPA placement.

homes, 875 children (25%) placed in therapeutic foster homes, and 167 (5%) placed in non-kin adoptive homes. Most children in congregate placements continue to reside in group homes (378 children, or 11%),[97] while 59 children (2%) are in residential treatment facilities.

Figure 22: Percentage of Children in Family-Based and Congregate Placements, September 2021 – September 2023



Source: DSS Data

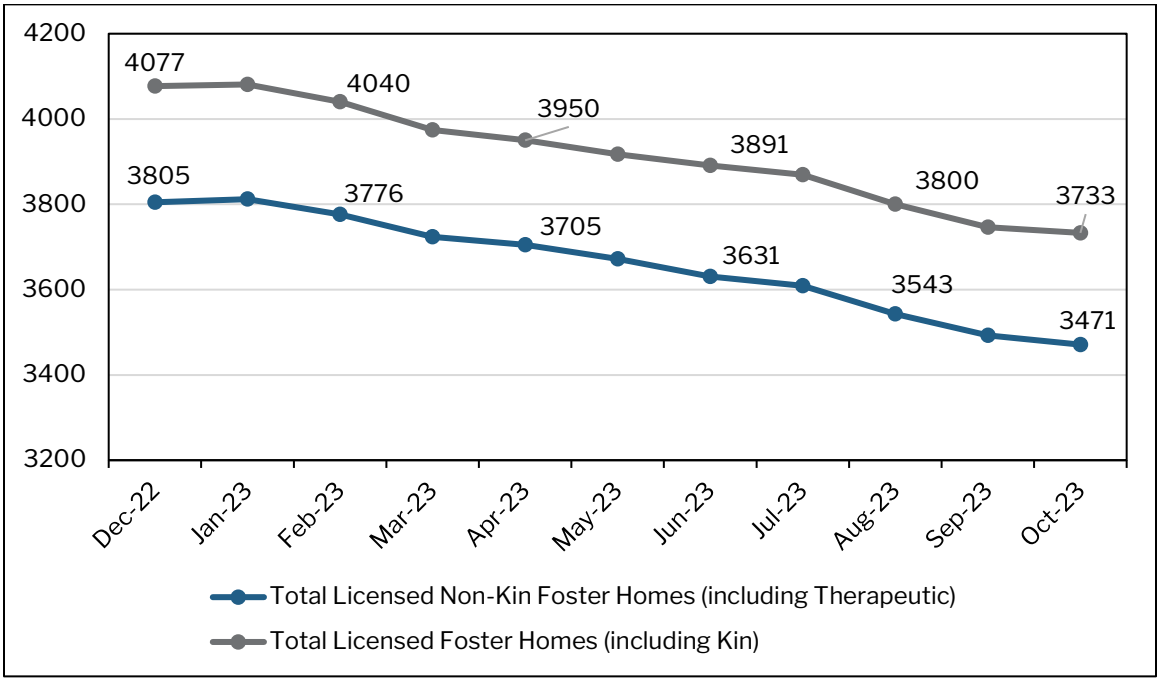
Kin Placement and Licensure

After shifting its focus exclusively to the licensing of kin homes in July 2020, in May 2023, DSS re-initiated direct licensing of foster homes for adolescents, youth who identify as LGBTQ+, and large sibling groups. DSS continues to dedicate staff to recruiting and licensing kin, and to prioritize the placement of children with kin. As seen in Figure 23, the number of total licensed kin homes had declined slightly as of

[97] This includes 4 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.

October 1, 2023, at a time when there also has been a reduction in the number of overall licensed foster homes.

Figure 23: Availability of Kin and Non-Kin Foster Homes December 2022 – October 2023



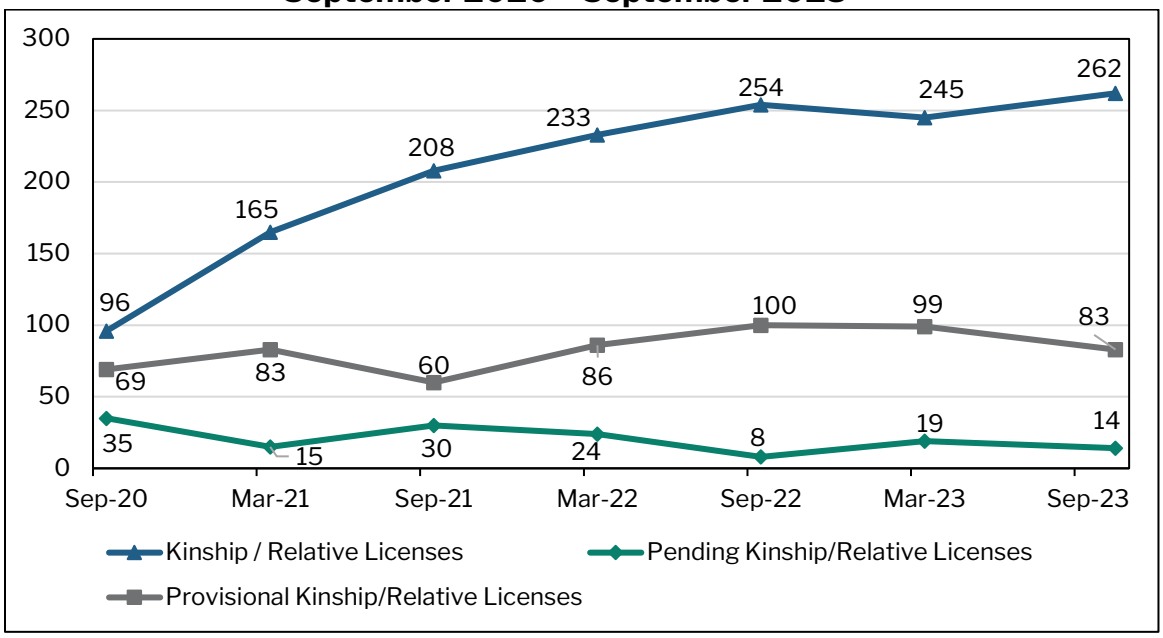
Source: DSS's Data Submission to the Court (December 8, 2023, Dkt.295)

Figure 24 shows the number of newly licensed kin homes from September 2020 to October 2023. According to DSS's most recent Data Submission to the Court, the number of provisional kin licenses ranged from 79 to 114 for each month between December 1, 2022, and October 1, 2023.[98] 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.[99]

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

[99] In recognition of the importance of kinship support in improving outcomes for children and families, on September 28, 2023, the U.S. 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. DSS reports that it is currently considering implementation strategies with respect to this new rule, with the goal of increasing equity for and maximizing payments to kinship providers. This will be essential in further expanding the array of kin providers throughout the state. 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

Figure 24: Kinship Licensing Trends
September 2020 – September 2023[100]



Source: Data provided by DSS

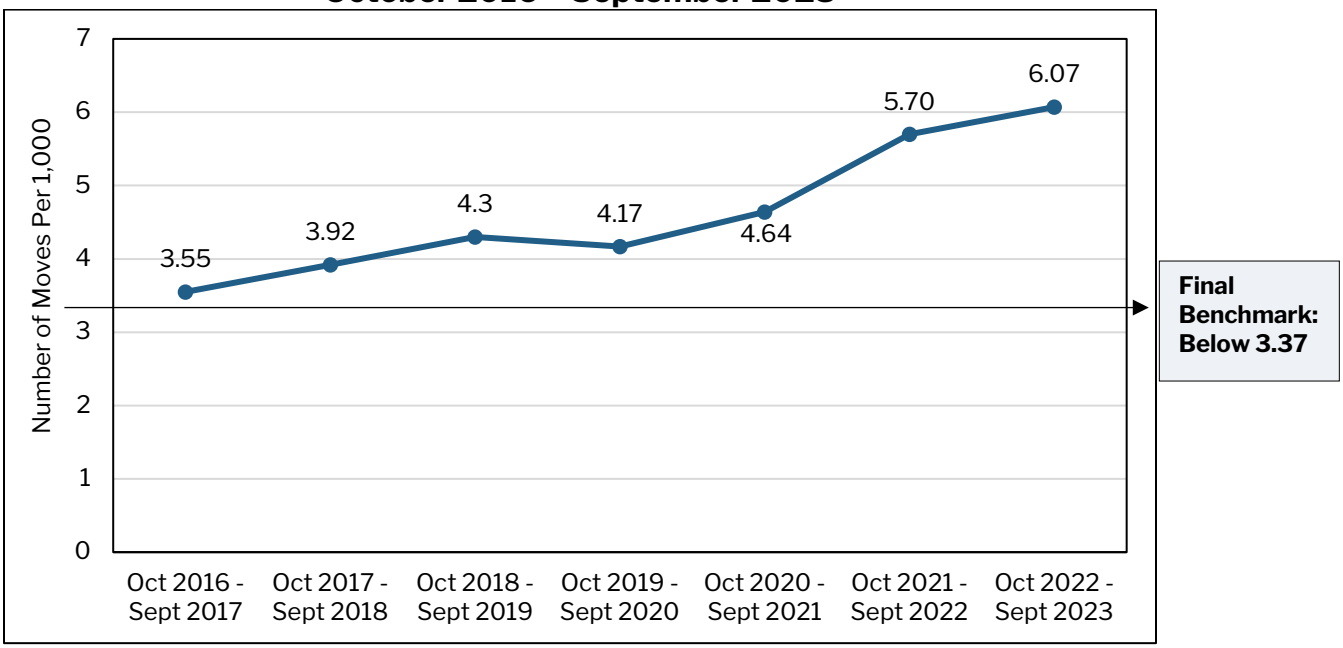
Placement Instability

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

DSS reports that for the period October 1, 2022, to September 30, 2023, Class Members were moved an average of 6.07 times per 1,000 days in care.[101] As shown in Figure 25, this level of placement instability is significantly higher than for the prior year, and the highest it has been since this lawsuit began.

[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 September 2023 were reported by DSS as of October 1, 2023 (instead of September 30, 2023, as previously reported).
[101] For the purpose of this measure, a placement change is considered as a move if it was not temporary (the child did not return to the original placement), the move was not the original removal episode, and the child's length of stay in foster care was greater than 7 days.

Figure 25: Rate of Placement Moves
October 2016 – September 2023



Source: DSS data

As shown in Table 4, children across the state experienced high levels of placement instability during the monitoring period. Approximately 20 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 (three or more placements) in the six-months between April 1, 2023, and September 30, 2023.

Table 4: Number of Placement Moves for Children in DSS's Custody by Region

Number of Moves	Lowcountry		Midlands		Pee Dee		Upstate		Statewide	
0 Moves	486	49%	1048	60%	494	54%	835	56%	2863	56%
1 Move	299	30%	358	20%	244	27%	401	27%	1302	25%
2-3 Moves	151	15%	211	12%	124	14%	135	9%	621	12%
4-5 Moves	24	2%	47	3%	24	3%	43	3%	138	3%
6-10 Moves	19	2%	42	2%	11	1%	48	3%	120	2%
>10 Moves	8	1%	41	2%	15	2%	19	1%	83	2%
Grand Total	987	100%	1747	100%	912	100%	1481	100%	**5127**	100%

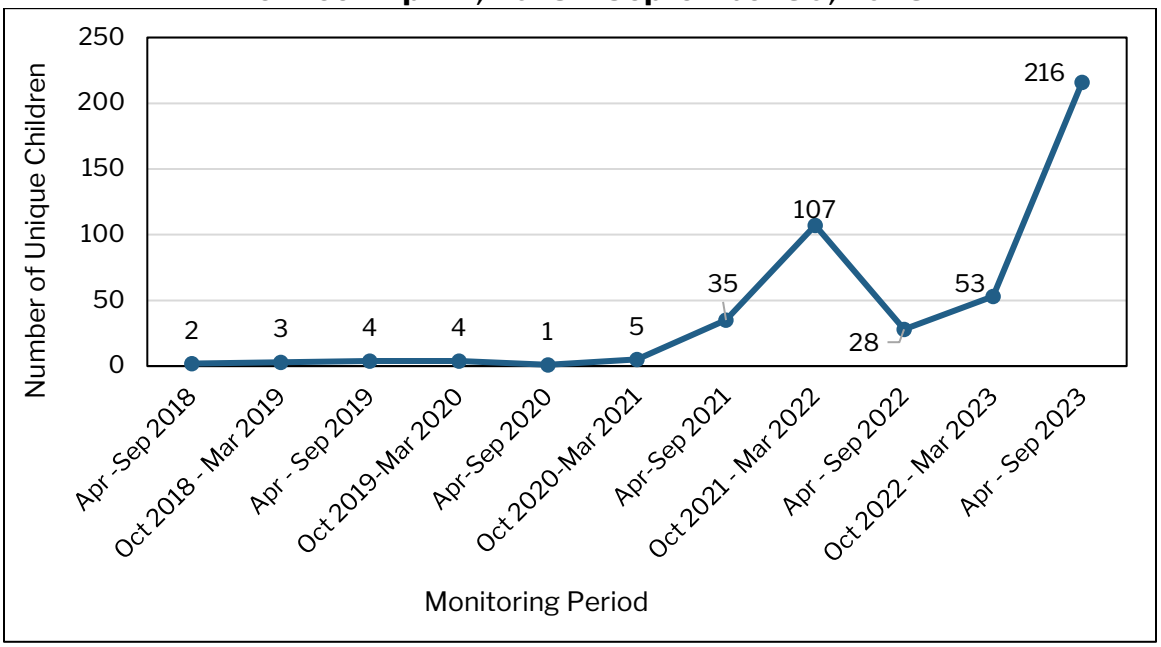
Source: DSS Data

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 April 1, 2023, and September 30, 2023, 216 unique children stayed overnight in a DSS office (see Figure 26), an alarming increase over all prior periods.

Figure 26: Number of Unique Children who Stayed Overnight in a DSS Office Between April 1, 2018 – September 30, 2023

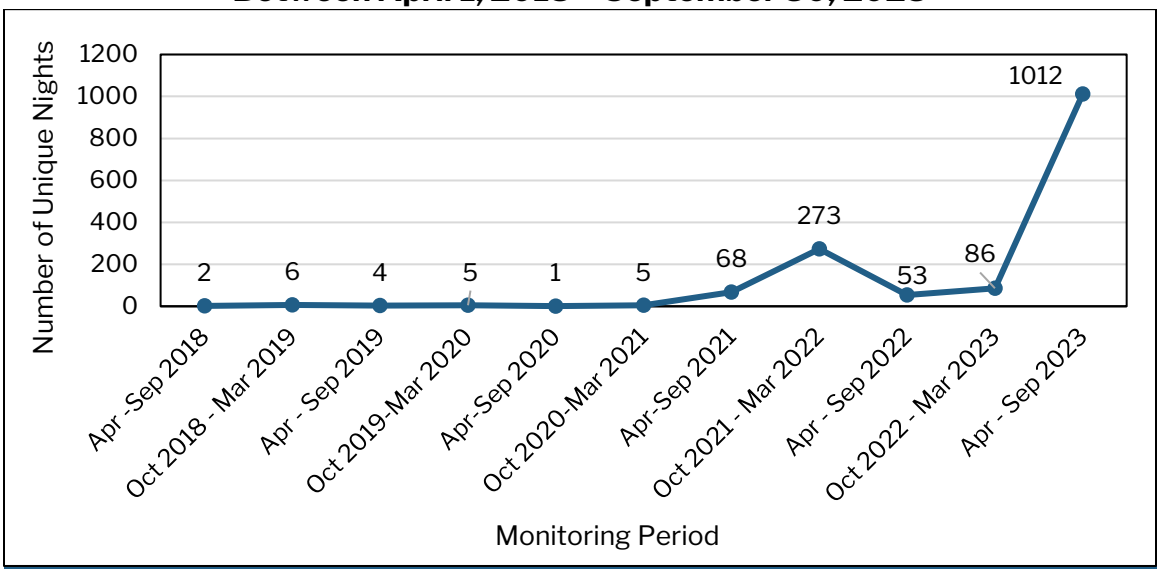


Source: DSS Data

Measured in terms of the number of *nights,* as opposed to children, this increase is even more staggering. As shown in Figure 27, in the five years between April 2018 and March 2023, Class Members slept overnight in DSS offices for a total of 506

nights (the highest number of overnights during this timeframe was between October 2021 and March 2022, when children had to spend 273 nights in DSS offices); by comparison, Class Members spent ***1,012*** **nights in DSS offices** in just the most recent six-month monitoring period alone (April 1, 2023 to September 30, 2023).

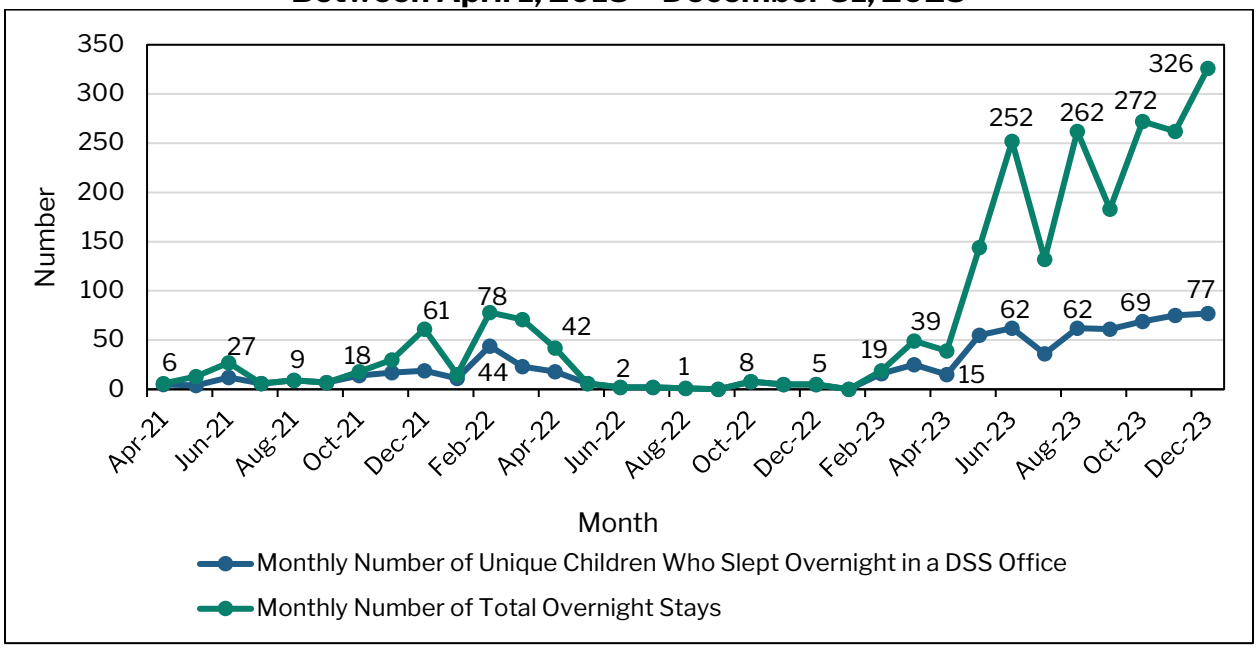
Figure 27: Number of Overnight Stays in a DSS Office Between April 1, 2018 – September 30, 2023



Source: DSS Data

As shown in Figure 28, the number of children sleeping in offices continued to surge since September 30, 2023. DSS reports that for the three-month period after the most recent monitoring period ended, October 1, 2023, to December 31, 2023, 166 unique children spent a combined total of ***860*** **nights in DSS offices**.

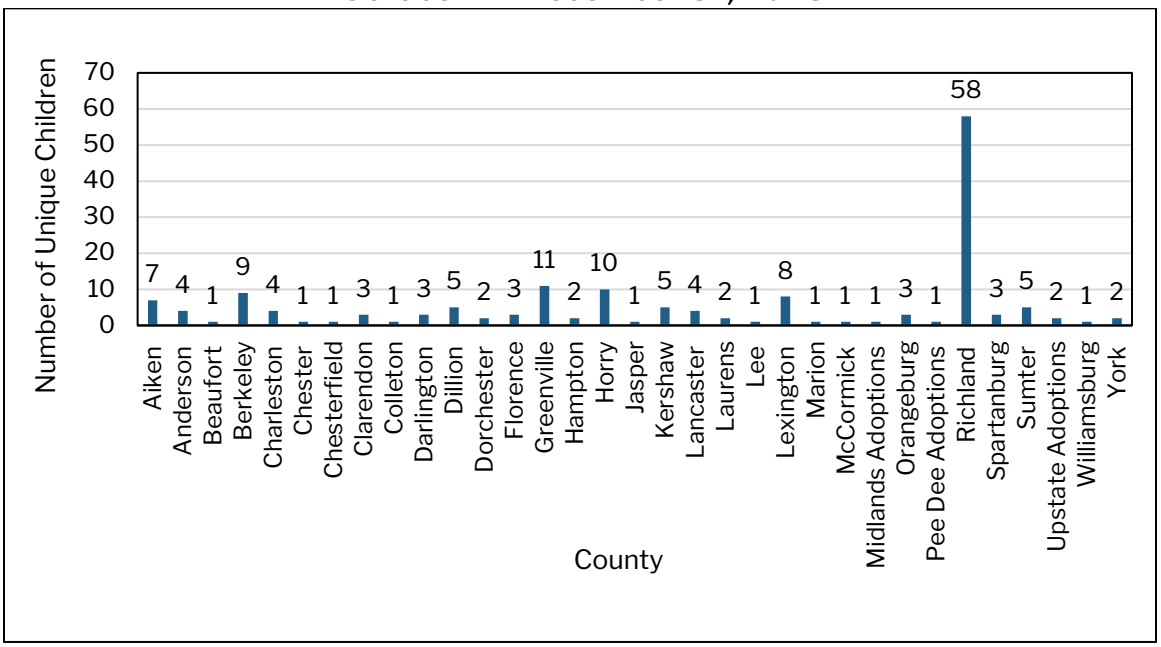
Figure 28: Children's Overnight Stays in a DSS Office Between April 1, 2018 – December 31, 2023



Source: DSS Data

When assessed by county of origin, of the 166 unique children who slept overnight in a DSS office between October 1, 2023, and December 31, 2023, more than one-third (58 children) were from Richland County.

Figure 29: Number of Unique Children Staying Overnight in DSS Offices by County October 1 – December 31, 2023



Source: DSS Data

Although the number of children in DSS custody in Richland County accounts for only 16 percent of the total foster care population, from October 1, 2023, to December 31, 2023, almost half of the overnight stays across the state occurred in Richland County (48%, or 412 of 860). These data are shown in Figure 29 and Table 5 and suggest an urgent need to develop and activate specific strategies in Richland County as DSS also pursues statewide initiatives.

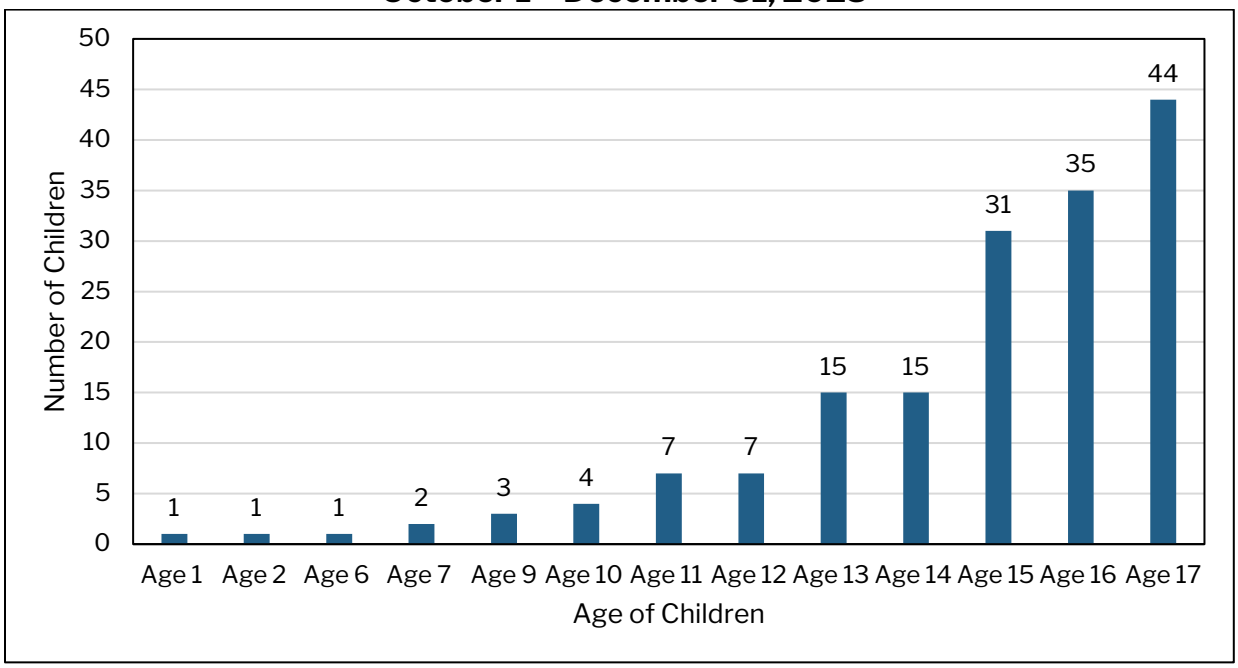
Table 5: Representation of Children's Overnight Stays in DSS's Largest Counties October 1 – December 31, 2023

	Percentage of Overnights (Between October 1 – December 31, 2023)	Percentage of all Children in Care
Richland County	48% (N=412/860)	16% (N=552/3471)
Greenville County	12% (N=103/860)	10% (N=364/3471)
Horry County	4% (N=33/860)	5% (N=187/3471)
Florence County	3% (n=22/860)	5% (N=181/3471)
Charleston County	1% (N=11/860)	6% (N=199/3471)
Spartanburg County	1% (N=5/860)	6% (N=203/3471)
York County	<1% (N=3/860)	6% (N=199/3471)

Source: Data from DSS Dashboard (1/5/2024) and DSS Data

While the greatest number of the children sleeping overnight in DSS offices were between 15 and 17 years old, many younger children also stayed overnight in DSS offices. As shown in Figure 30, two children under three years old spent at least one night in a DSS office between October 1, 2023, and December 31, 2023, and 54 children between the ages of six and 14 spent at least one night in a DSS office.

Figure 30: Number of Children Staying Overnight in DSS Offices by Age
October 1 – December 31, 2023

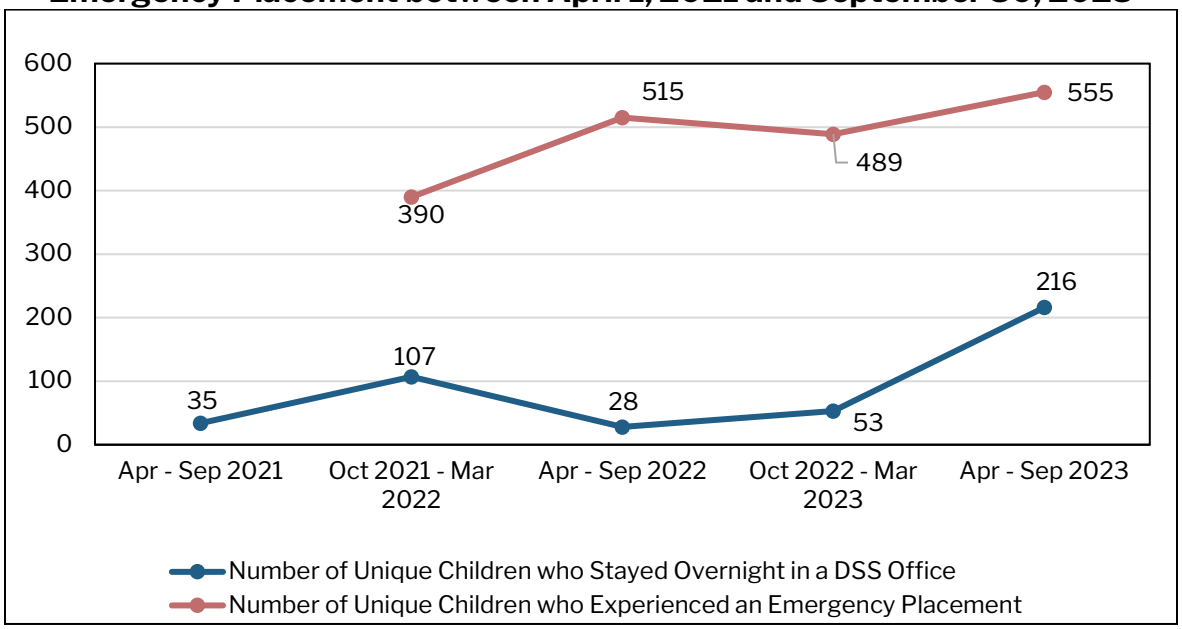


Source: DSS Data

In December 2023 alone, 77 children spent at least one night sleeping in a DSS office. Most of these children (52 or 68%) had already been in DSS custody for at least 30 days. Twenty-five children had newly entered DSS custody. Eight of these 25 children (32%) had previously been in the custody of DSS.

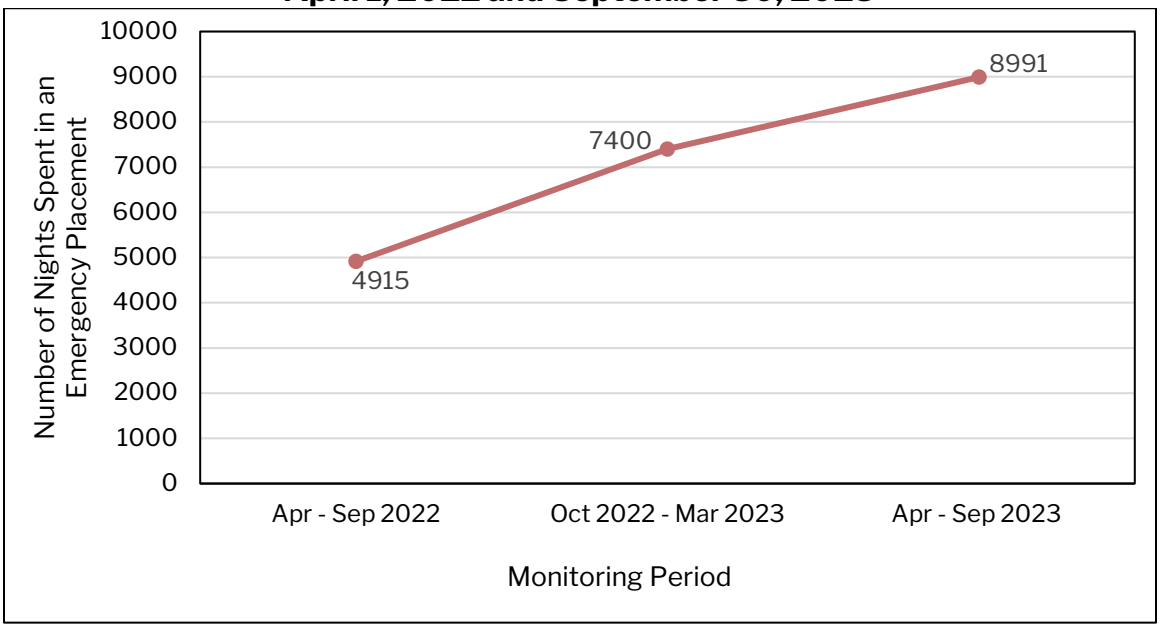
The high levels of instability experienced by children during and since the end of the monitoring period is also reflective of DSS's practice of moving children between short-term emergency placements while staff search for and children await appropriate placement. Since March 31, 2023 (the end of the prior monitoring period), the number of nights that children spent in emergency placements has also significantly increased. As shown in Figures 31 and 32, between April 1, 2023, and September 30, 2023, DSS reports that 555 unique children spent ***8,991*** **nights in emergency placements.**

Figure 31: Children who Experienced an Overnight Stay at a DSS Office or an Emergency Placement between April 1, 2021 and September 30, 2023



Source: DSS Data

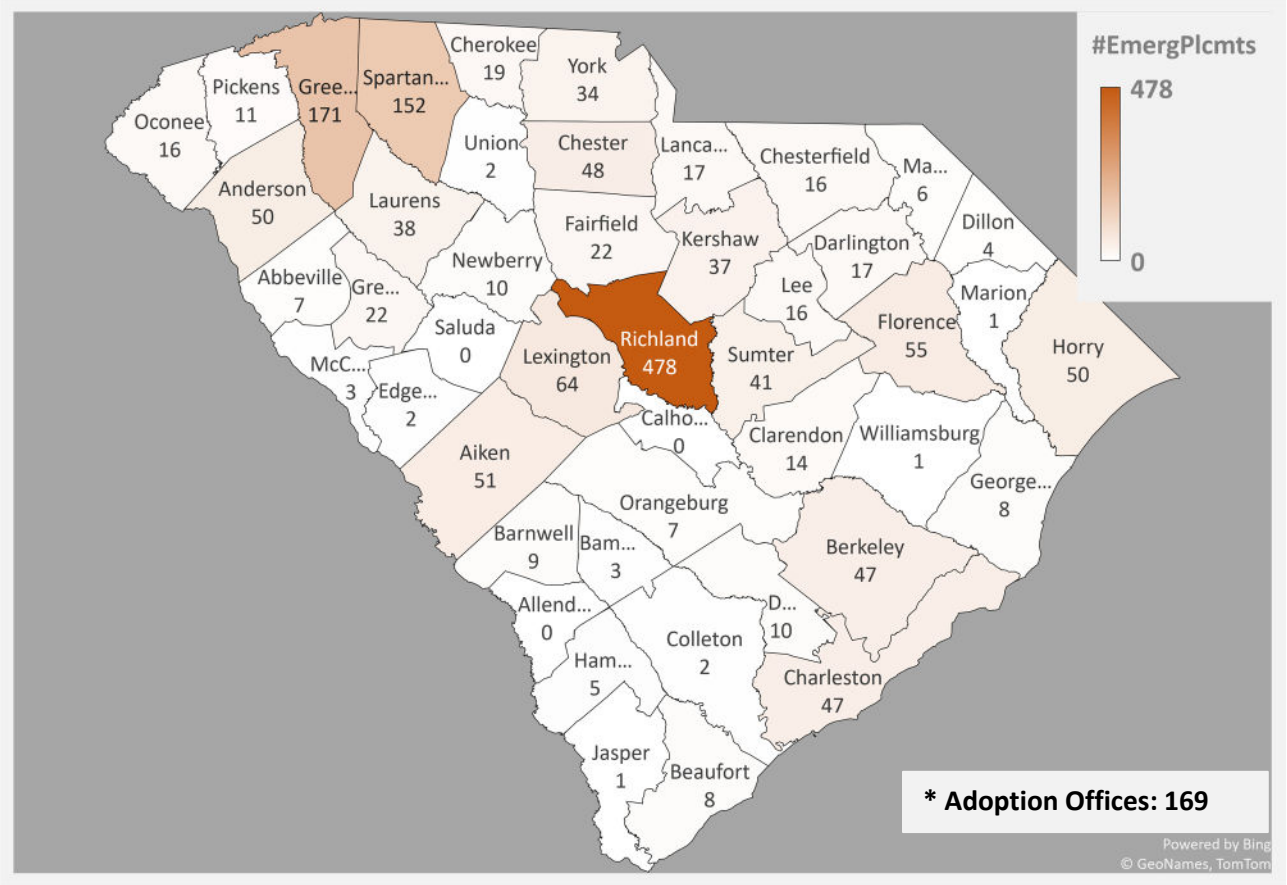
Figure 32: Number of Nights Spent in an Emergency Placement between April 1, 2022 and September 30, 2023



Source: DSS Data

Figure 33 shows the number of emergency placements that occurred between April 1, 2023, and September 30, 2023, by county of origin. As depicted, 27 percent (478 out of 1,791) of emergency placements during this time were for children from Richland County.

Figure 33: Emergency Placements by Counties
April 1 – September 30, 2023
N= 1,791 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.

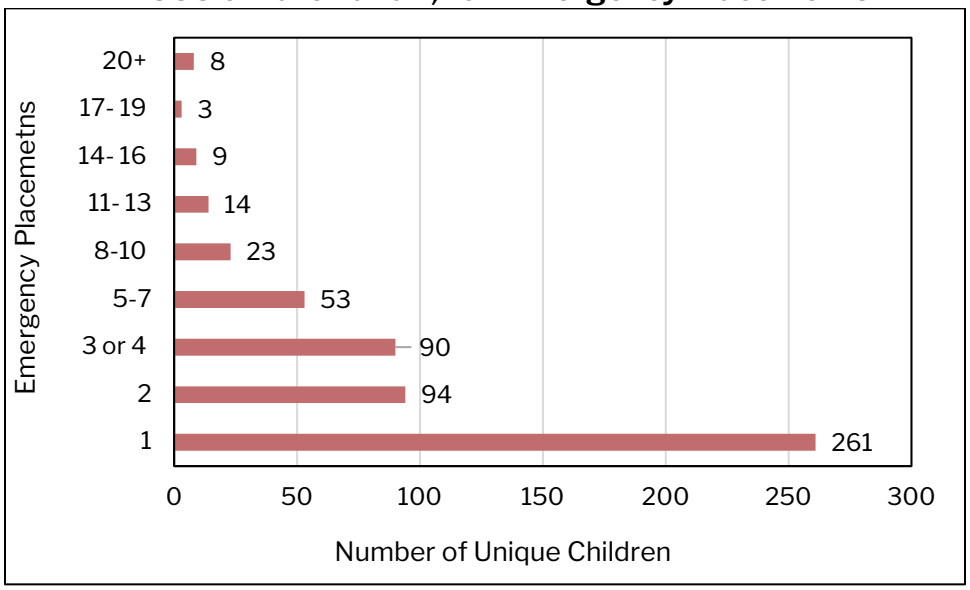
As required by the FSA, DSS reports that 24 of the 555 children who experienced an emergency placement between April 1, 2023, and September 30, 2023, had at least one emergency placement that lasted longer than 30 days.[102] The Department also reports that of the 320 unique children who had already experienced at least one emergency placement within the prior 12 months, 158 (49%) had at least one subsequent emergency placement during the monitoring period that lasted more than seven days.

DSS also collects data on the total number of nights spent in emergency placements across multiple placements. Half (50%, or 280) of the 555 children who experienced emergency placements remained in emergency placements for more than seven total nights. Eighty-five children (15%) experienced more than 30 nights of emergency placements. Forty-two children (8%) experienced more than 50 nights in emergency placements. Sixteen children (3%) experienced more than 75 nights in emergency placements, including 10 children who experienced 90 or more nights in emergency placements and six children who experienced more than 100 nights in emergency placements.

Figure 34 shows the distribution of the number of emergency placements that the 555 children experienced between April 1, 2023, and September 30, 2023.

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

Figure 34: Number of Emergency Placements Experienced by Class Members
April 1 – September 30, 2023
N= 555 children and 1,791 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.[103] The full report, including key findings and recommendations can be found here.

The review was a key step in identifying some of the barriers to meeting the needs of many of the children in DSS's care who present with high levels of need. DSS will be working with the Co-Monitors, DJJ, and its system partners to develop and test practices that address these findings in the coming months, as part of the Small Test of Change (STOC) efforts underway in Spartanburg, Anderson, and Greenville counties. The Co-Monitors will report on the progress of this work in the next monitoring report.

Sibling Placements

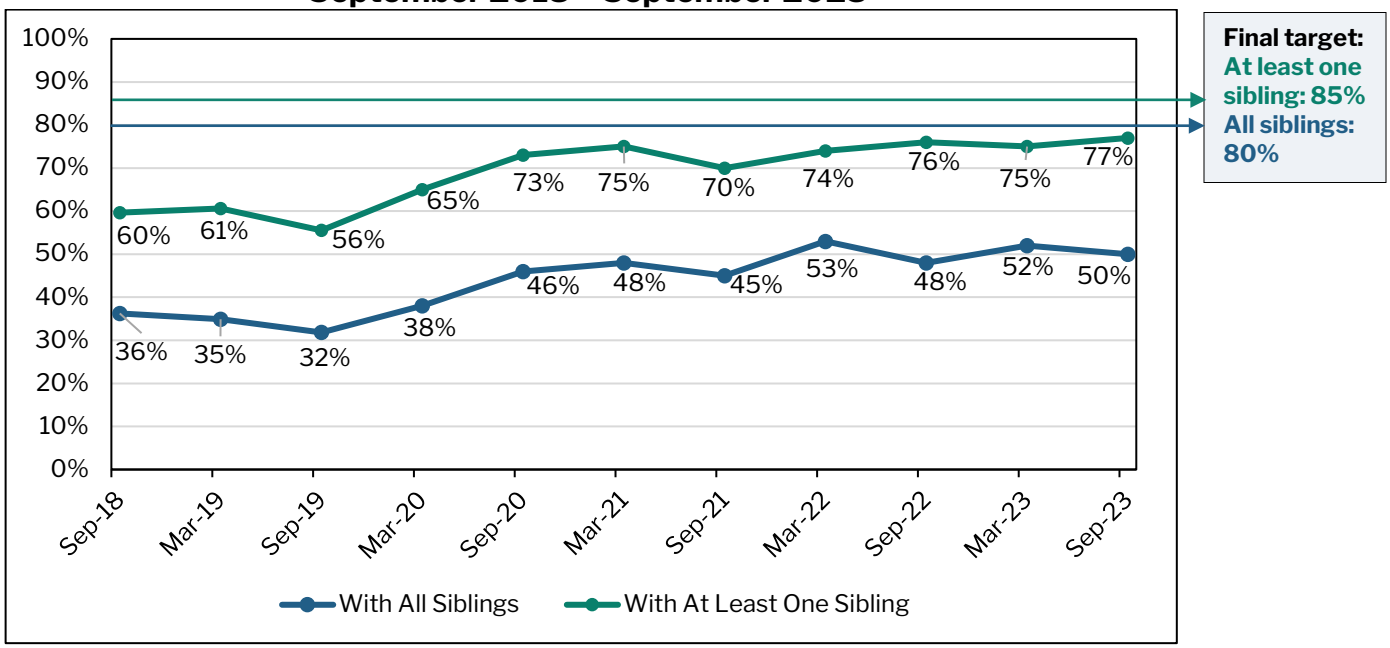
The FSA recognizes the importance of the lifelong and supportive relationships between children and their siblings and requires that *"at least 80 percent of children who enter care with or within 30 days of their siblings be placed with their siblings"* (FSA IV.G.2. & 3.). The FSA includes two targets – one for placement with *at least one* of a child's siblings (85% target) and the other for placement with *all* siblings (80% target).[104] DSS committed to achieving these targets by March 2021.

DSS provided data for 699 children who entered foster care between April 1, 2023, and September 30, 2023, with a sibling or within 30 days of a sibling's entry into foster care. For this cohort, 77 percent (537 of 699) of children were placed with at least *one* of their siblings, and 50 percent (351 of 699) of children were placed with *all* of their siblings by 45 days after entry into care. As shown in Figure 35, this performance is roughly comparable to performance from the prior three monitoring periods. Performance does not meet the final targets.

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

[104] 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.

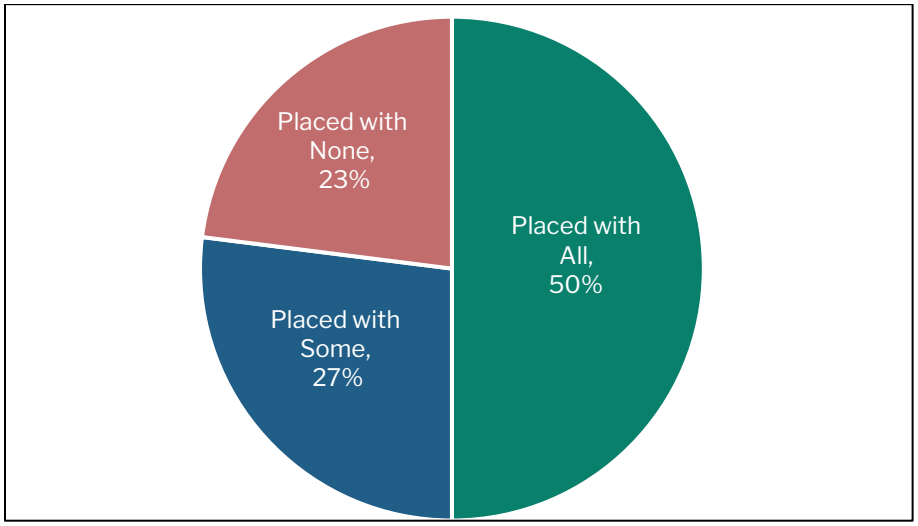
Figure 35: Sibling Placements for Children Entering Placement September 2018 – September 2023



Source: CAPSS data provided by DSS

Figure 36 further shows the breakdown of sibling placements during this monitoring period. Twenty-three percent (162 of 699) of all children entering care with siblings were not placed with *any* siblings 45 days after entry. This result is also roughly comparable with the prior three monitoring periods.

Figure 36: Sibling Placements for Children Entering Placement
April 1 – September 2023
N=699



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 particular time period of the receipt of the recommendations.

The FSA also includes a requirement that DSS identify "*enforceable interim benchmarks with specific timelines, subject to consent by the Plaintiffs and approval by the Co-Monitors, to measure progress,*" with respect to the placement of children in therapeutic placements when determined to be needed (FSA IV.B.I.2.).[105] These requirements have been delayed for years as DSS has considered ways to align measurement with its placement leveling system. In the Supplemental Report, the Co-Monitors recommended that DSS consider alternatives to the current leveling

[105] "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.).

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 recommend 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. It is essential that DSS move forward in the very near future in grappling with the issues foundational to these FSA requirements.[106]

[106] 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.

IX. Health Care

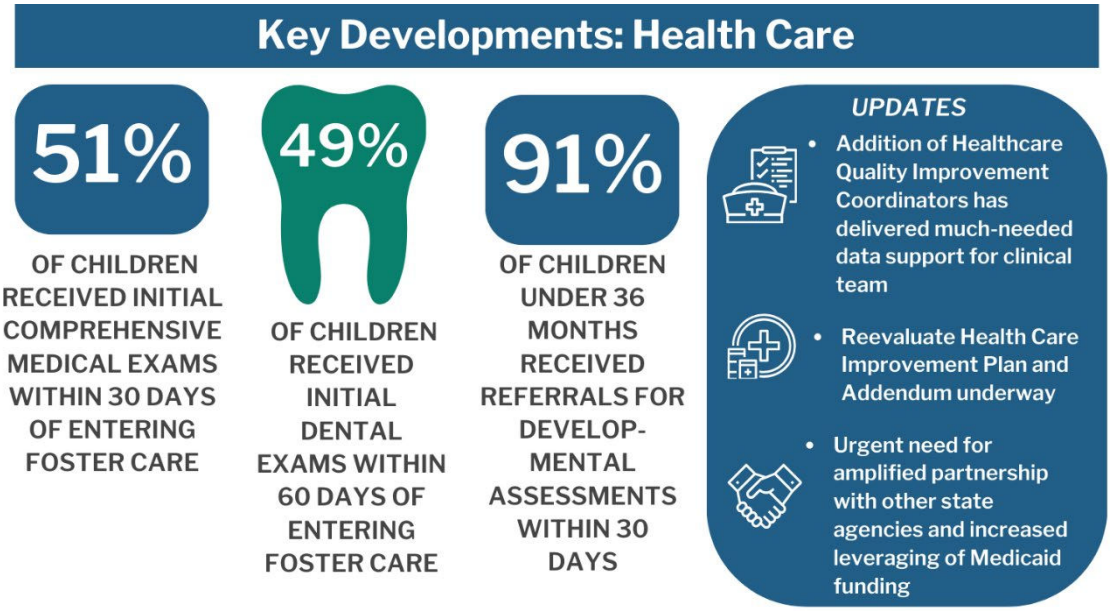
DSS's efforts to meet the health care needs of the children in its care were accelerated by the hiring of additional nurses and staff to support data collection (Healthcare Quality Improvement Coordinators, or HQICs) included and provided for in the FY2022-2023 budget. However, despite these efforts, 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.[107] 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.[108] 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 intensive in-home supports.

The Health Care Improvement Plan[109] and care coordination addendum (the "Health Care Addendum"), approved 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, the state's MCO for these children.[110] The Plan also 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 the

[107] 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B); 1396d(r)
[108] 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
[109] 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
[110] To see the Health Care Addendum, go to: https://dss.sc.gov/media/1962/2-25-2019-approved-health-plan-addendum.pdf

coming months, work will be underway to modify the Health Care Improvement Plan, and related Health Care Addendum as needed for improved performance.



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 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.

Despite the important addition of new positions at DSS to support data collection (HQICs), there remain systemic barriers to ensuring that children receive the health care to which they are entitled. Over four years after the Health Care Addendum was agreed upon (five years into the implementation of the Health Care Improvement Plan), there are ongoing challenges in defining care coordination roles and ensuring the performance of key strategies, such as assessing and ensuring network adequacy with agency partners like Select Health and DHHS. The Co-Monitors will be

working with DSS to re-assess the Plan and Addendum in the coming months and to recommend and reach agreement with Parties on needed modifications.

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, more 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 November 2023. Data on initial comprehensive medical and dental visits are reported for all children who entered care between March and August 2023. 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,[111] mental health assessments (following a screening which identified a need for such an assessment),[112] and follow-up care.[113]

Comprehensive Medical Assessments

In accordance with American Academy of Pediatrics (AAP) guidelines for health care delivery to children in foster care, comprehensive medical assessments are to be performed for the purpose of "reviewing all available data and medical history about the child or adolescent;" identifying medical, developmental, and mental health

[111] 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.
[112] 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.
[113] 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 design with the Co-Monitors.

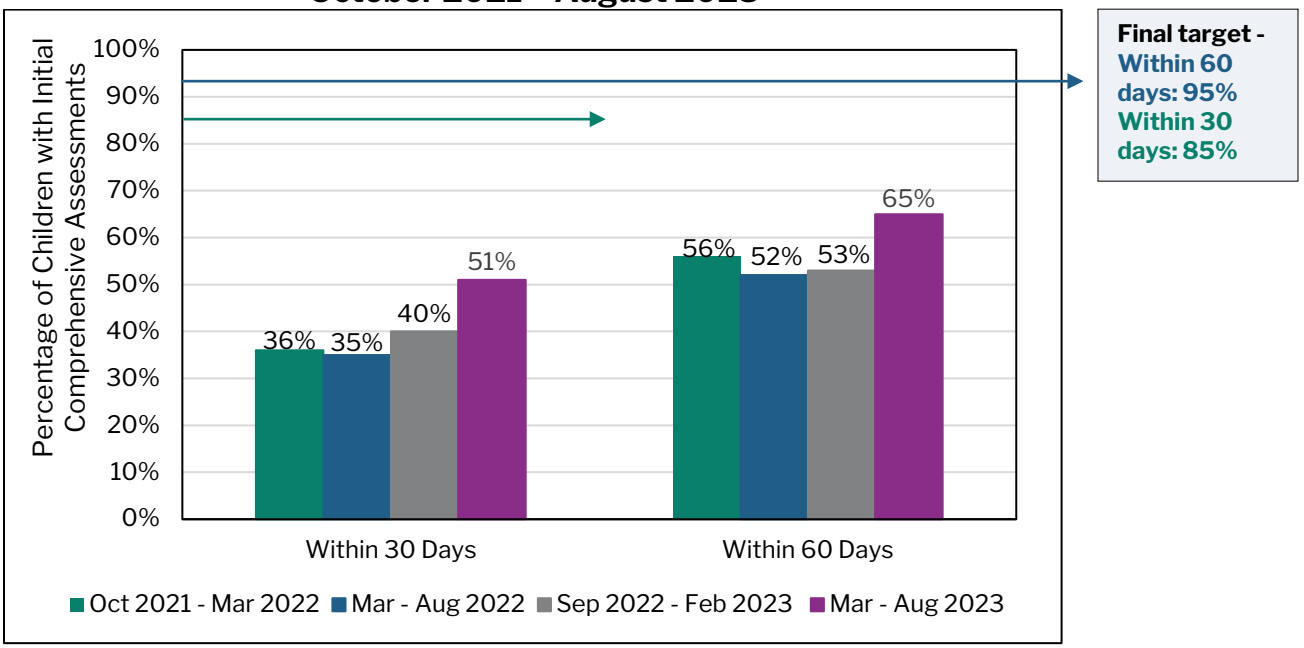
conditions requiring immediate attention; and developing an "individualized treatment plan."[114]

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*."[115] DSS committed to achieving these targets by March 2021.[116]

DSS reports that 51 percent (497 of 982) of children who entered foster care between March 1, 2023, and August 31, 2023, and were in foster care for at least 30 days, received an initial comprehensive medical assessment within 30 days; Sixty-five percent (471 of 721) of children who entered foster care this period and were in foster care for at least 60 days received an initial comprehensive medical assessment within 60 days (see Figure 37). This represents an improvement from February 2023 when performance was 40 percent and 53 percent, respectively. Performance remains 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.

[114] *Fostering Health: Health Care for Children and Adolescents in Foster Care*, 2d. ed (16-17). American Academy of Pediatrics (2003), p. 22.
[115] The Health Care Outcomes are available at: https://dss.sc.gov/media/1958/appendix-b-final-health-care-targets.pdf
[116] 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 37: Initial Comprehensive Medical Assessments within 30 and 60 Days October 2021 – August 2023



Source: Medicaid claims data provided by DSS

Developmental Assessments

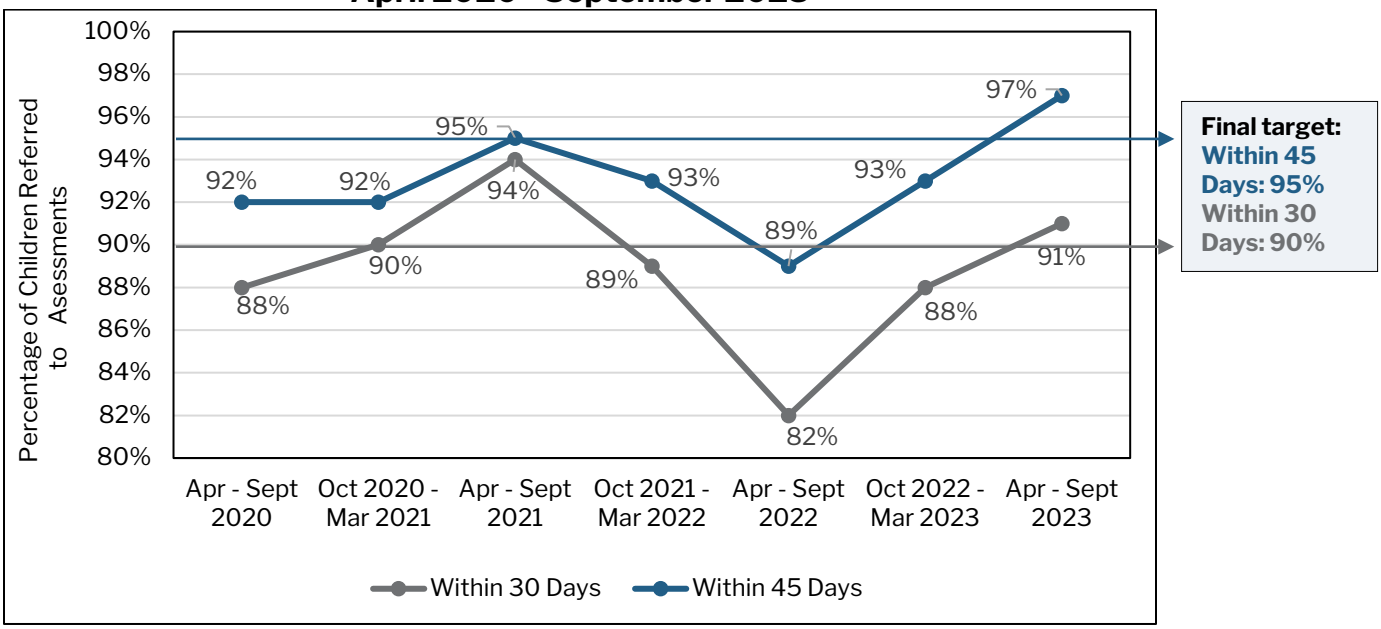
In DSS's Health Care Outcomes, DSS committed that "*at least 90% of Class Members under 36 months of age will be referred to the state entity responsible for developmental assessments within 30 days of entering care; at least 95% shall be referred within 45 days.*" DSS committed to achieving these targets by March 2021.

DSS reports that 91 percent (286 of 314) of children under 36 months of age who entered care between April 1, 2023, and September 30, 2023, 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 (293 of 301) 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 38).[117] These data only measure whether a child was referred for a developmental

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

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 receives a timely assessment.

Figure 38: Referrals for Developmental Assessments within 30 and 45 Days April 2020– September 2023



Source: CAPSS data provided by DSS

Initial Dental Examinations

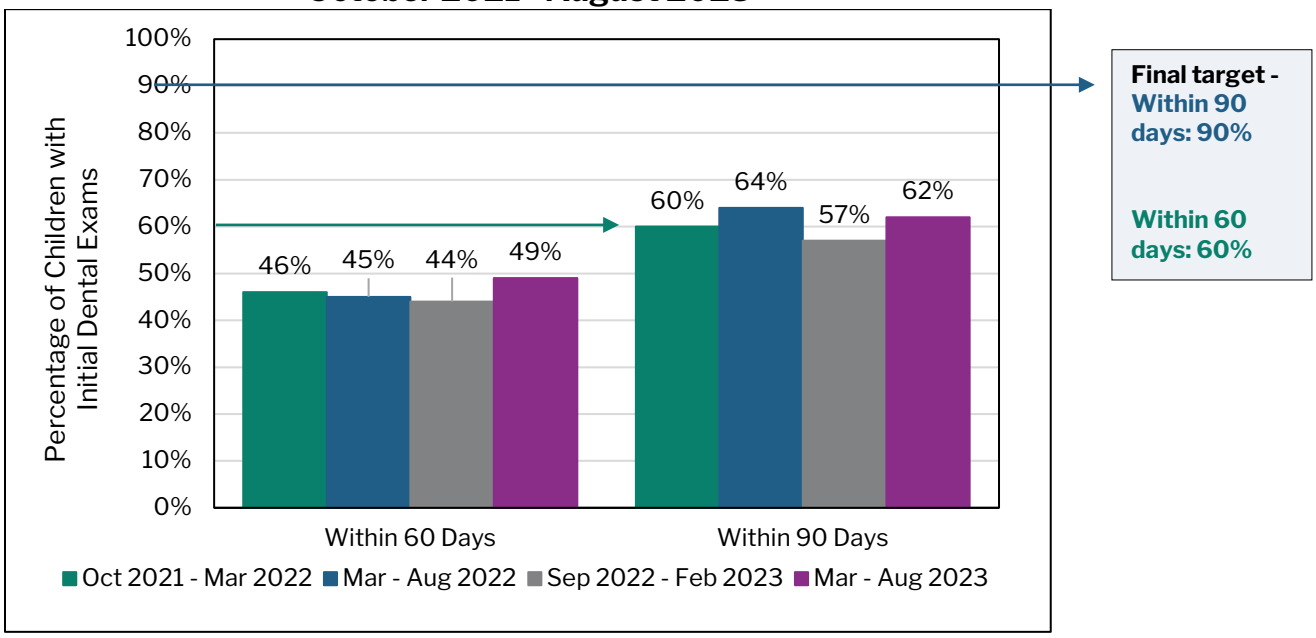
In DSS's Health Care Outcomes, approved by the Co-Monitors on December 21, 2018, DSS committed that *"at least 60% of Class Members ages two and above for whom there is no documented evidence of receiving a dental examination in the six months prior to entering care will receive a dental examination within 60 days of entering care; at least 90% will receive a dental examination within 90 days of entering care*." DSS committed to achieving these targets by March 2021.[118]

DSS reports that 49 percent (245 of 498) of children ages two and older who entered foster care between March 1, 2023, and August 31, 2023, and were in foster care for

[118] 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.

at least 60 days had a dental exam within 60 days, and 62 percent (223 of 361) of children ages two and older who remained in care for at least 90 days had a dental exam within 90 days.[119] This performance represents an improvement from the prior period, in which performance had declined. Performance does not meet the target for either requirement, as shown in Figure 39.

Figure 39: Initial Dental Exams within 60 and 90 Days
October 2021– August 2023



Source: Medicaid claims data provided by DSS

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."[120] AAP guidelines for health care delivery for children in foster care recognize the

[119] This excludes children who had a visit within 3 months of entering care.
[120] *Fostering Health: Health Care for Children and Adolescents in Foster Care*, 2d. ed (16-17). American Academy of Pediatrics (2003), p. 30.

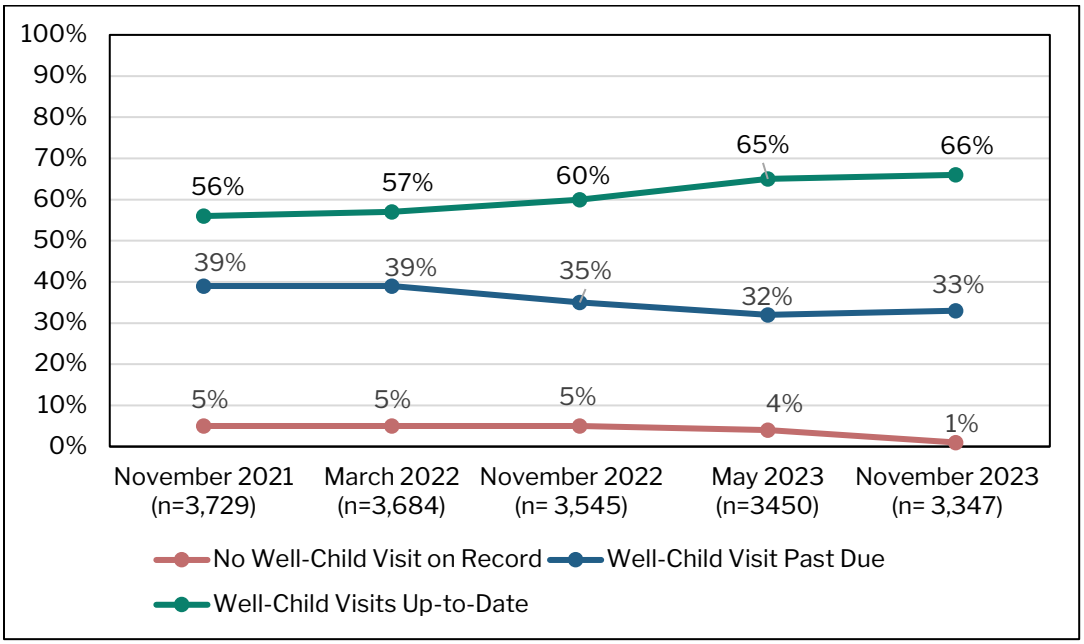
increased needs of these children and youth as compared with the general population.

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.[121,122] 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 (2,211 of 3,347) were up to date on their well-child visits as of November 20, 2023, an improvement from May 2023, when 65 percent of children were up to date. Of the remaining children, 36 (1%) children did not have a well-child visit on record. As depicted in Figure 40, 33 percent (1,100 of 3,347) of children were past due for their well-child visits.[123]

[121] Bright Futures/American Academy of Pediatrics. Recommendations for Preventative Pediatric Health Care. Accessed at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf
[122] 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
[123] Percentages do not add to 100 percent due to rounding.

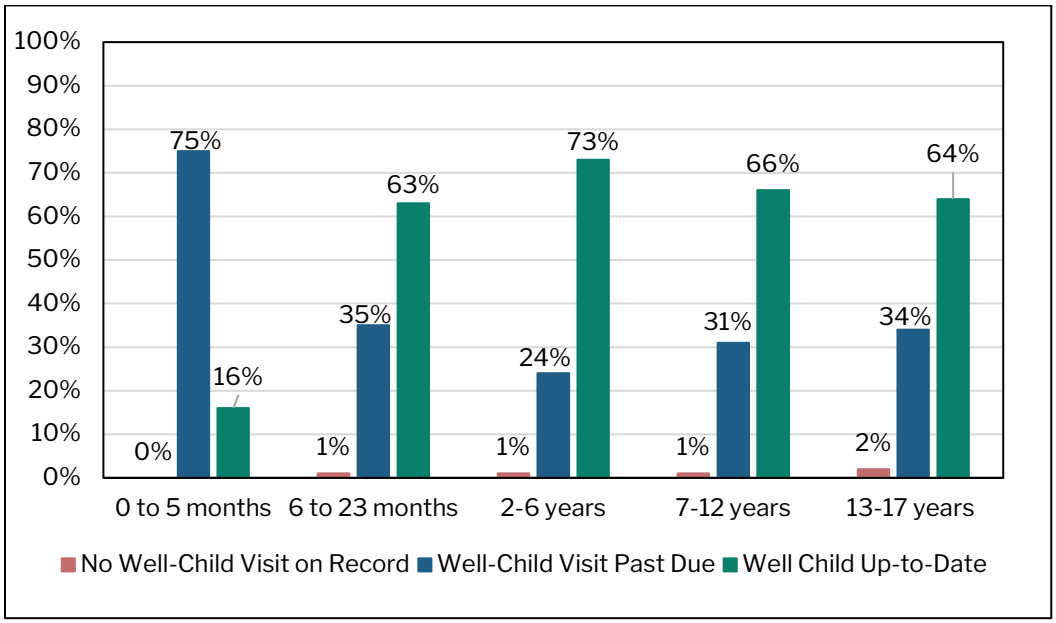
Figure 40: Well-Child Visits
November 2021 – November 2023



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

These data are also reported to the Co-Monitors by age group, as shown in Figure 41. As determined by DSS, 16 percent of children under age six months were up to date on their well-child visits as of November 2023. This is a decline in performance from May 2023, when 19 percent of children were determined to be up to date. For all other age groups, the percentage of children determined by DSS to be up-to-date increased slightly: from 61 percent in May 2023 to 63 percent in November 2023 for children ages six to 23 months; 72 percent to 73 percent for children ages two to six; 65 percent to 66 percent for children ages seven to 12 years old; and 62 percent to 64 percent for children ages 13 to 17 years old.

Figure 41: Well-Child Visits by Age as of November 20, 2023
N=3,347



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

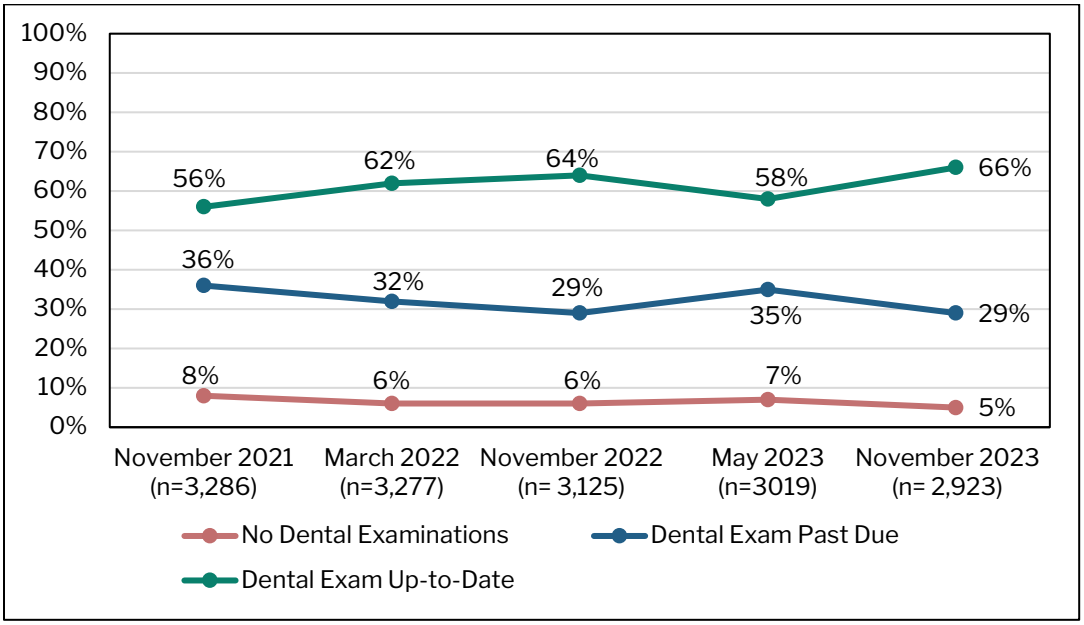
Periodic Dental Examinations

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, 66 percent (1,927 of 2,923) were up to date on their semi-annual dental examination as of November 20, 2023. This represents an improvement from May 2023, when DSS reported that performance had fallen to 58 percent of children. As shown in Figure 42, 29 percent (836 of 2,923) of children were past due for their dental exam and five percent of children (160 of 2,923) 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.

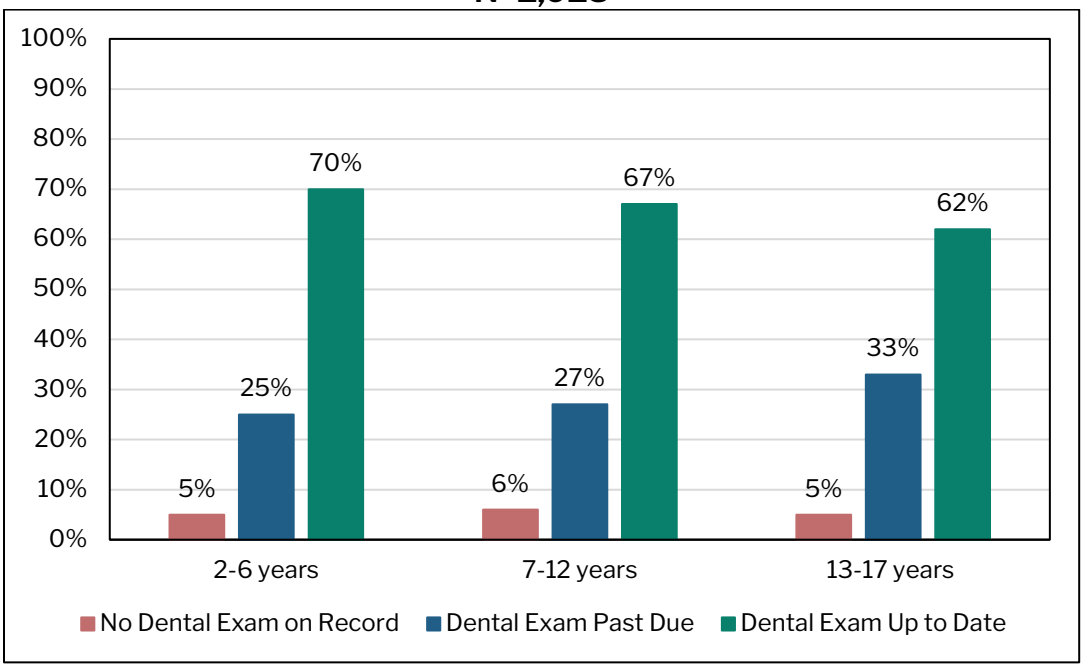
Figure 42: Periodic Dental Examinations
November 2021 – November 2023



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 43. These data show improvements from prior performance levels for all age groups: DSS reports that 70 percent of children ages two to six years old were up to date on their dental exams; 67 percent of children ages seven to 12 years old were up to date; and 62 percent of children ages 13 to 17 years old were up to date.

Figure 43: Periodic Dental Examinations by Age as of November 20, 2023
N=2,923



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

Appendix A – Glossary of Acronyms

AAP: American Academy of Pediatrics
ACF: U.S. Administration for Children and Families
ADR: The Office of Accountability, Data, and Research
APS: Adult Protective Services
CAAP: Coach Approach to Adaptive Leadership Model
CAC: Child Advocacy Center
CAIP: Child and Adult Information Portal
CAPSS: Child and Adult Protective Services System
CANS: Child Assessment of Needs and Strengths
CFTM: Child and Family Team Meeting
CFSR: Child and Family Services Review
CMS: Centers for Medicare and Medicaid Services
CPA: Child Placing Agency
CPS: Child Protective Service
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
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

ICC: Intensive Care Coordination
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
MRSS: Mobile Response and Stabilization Services
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
SAMSHA: Substance Abuse and Mental Health Services Administration
SDM: Structured Decision Making
STOC: Small Test of Change
TA: Technical Assistance
TCM: Targeted Case Management
TPR: Termination of Parental Rights
U of SC CCFS: University of South Carolina's Center for Child and Family Studies

Appendix B – Monitoring Activities

The Co-Monitors are responsible for independent validation of data and documentation to compile and issue public reports on performance with respect to the terms of the FSA. In carrying out this responsibility, the Co-Monitors and their staff have worked closely with DSS leadership and staff. The Co-Monitors use multiple methodologies to conduct their work, including verification and analysis of information available through CAPSS; review of individual electronic case records of Class Members; review and validation of data aggregated by DSS; interviews and conversations with DSS leaders and staff; and conversations with external stakeholders, including providers, advocates, and community organizations. The Co-Monitors worked with DSS to establish review protocols to gather performance data and assess current practice for some measures. The Co-Monitors engaged in in-person site visits at which they visited county offices, attended convenings, and 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 September 2023, 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 April 1, 2023, to September 30, 2023 (FSA IV.D.2.);

- 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 April 1, 2023, to December 31, 2023 (FSA IV.D.3);

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

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

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 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: 0% within required limit. (September 2017) 100% had more than 125% of the limit. (September 2017)	OHAN investigators: 75% within the required limit Monthly range within the required limit: 29 – 95% 0% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 0 – 35%	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:[130] 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%

[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: April 4, 2023; May 6, 2023; June 25, 2023; July 18, 2023; August 20, 2023; September 30, 2023.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 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) 77% had more than 125% of the 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% of the limit: 29 – 38%	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% of the limit: 27 – 32%	Foster Care case managers: 63% within the required limit Monthly range within the required limit: 56 – 65% 22% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 22 – 31%

[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**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
	Adoptions case managers: 23% within the required limit. (September 2017) 62% had more than 125% of limit. (September 2017)	Adoptions case managers: 24% within the required limit Monthly range within the required limit: 24 – 49% 37% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 33 – 43%	Adoptions case managers: 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%	Adoptions case managers: 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%
Workload Limits for Foster Care: 2a. At least 90% of supervisors shall have a workload within the applicable Workload Limit. 2b. No supervisor shall have more than 125% of the applicable Workload Limit. (FSA IV.A.2.(b)&(c))	OHAN Team Leaders: 100% within the required limit. (March 2018) None were more than 125% of the limit. (March 2018)	OHAN Team Leaders: 100% within the required limit each month this period 0% had more than 125% of the limit.	OHAN Team Leaders: 100% within the required limit each month this period 0% had more than 125% of the limit.	OHAN Team Leaders:[133] 80% within the required limit each month this period Monthly range within the required limit: 60 – 83%

[133] Team Leaders' workloads may be higher than is reflected in the data, as initial data submitted by DSS show that some Team Leaders continued to carry direct cases in addition to supervising staff during the monitoring period.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
Approved Supervisor Limits: • *OHAN supervisors* – 6 investigators • *Foster Care*, *IFCCS*,[131] 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:[132] 57% within required limit. (March 2018) 29% had more than 125% of the limit. (March 2018)	Foster Care Team Leaders: 90% within the required limit Monthly range within the required limit: 86 – 91% 4% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 3 – 5% Adoptions Team Leaders: 90% within the required limit Monthly range within the required limit: 88 – 96%	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. Monthly range supervising more than 125% of the limit: 0 -20% 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%

[131] The IFCCS case manager position has been eliminated as of January 2020, with staff positions and cases transferred to county Foster Care case manager and supervisor positions and caseloads between September and December 2019.
[132] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
		0% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 0 – 9%	0% had more than 125% of the limit.	Adoptions Team Leaders: 88% within the required limit Monthly range within the required limit: 88 – 96% 0% had more than 125% of the limit.
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.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 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 to investigate a Referral of Institutional Abuse or Neglect about a Class Member must be made in accordance with South Carolina law and DSS policy. (FSA IV.C.2.)	44% of screening decisions to not investigate were determined to be appropriate. (March 2017)	Between April and September 2022, 96% of screening decisions not to investigate were determined to be appropriate.	Between October 2022l and March 2023, 100% of screening decisions not to investigate were determined to be appropriate.	Between April and September 2023, 100% of screening decisions not to investigate were determined to be appropriate.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
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)	86% (38) of 44 applicable investigation decisions to unfound were determined to be appropriate.	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.
Investigations - Timely Initiation: 7. The investigation of a Referral of Institutional Abuse or Neglect must be initiated within twenty-four (24) hours in accordance with South Carolina law in at least 95% of the investigations.	78% of applicable investigations were timely initiated. (March 2017)	90% (46) of 51 applicable investigations were timely initiated.	100% (43) of 43 applicable investigations were timely initiated.	94% (49) of 52 applicable investigations were timely initiated.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
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)				

[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**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
Investigations - Contact with Core Witnesses: 9. Contact with core witnesses must be made in at least 90% of the investigations of a Referral of Institutional Abuse or Neglect, with exceptions approved by the Co-Monitors. (FSA IV.C.4.(c)	27% of applicable investigations included contact with all necessary core witnesses. (March 2017)	67% (34) of 51 applicable investigations included contact with all necessary core witnesses.	81% (35) of 43 applicable investigations included contact with all necessary core witnesses.	69% (36) of 52 applicable investigations included contact with all necessary core witnesses.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
Investigations - Timely Completion: 10.a. At least 60% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within forty-five (45) days of initiation of an investigation, unless the DSS Director or DSS Director's designee authorizes an extension of no more than fifteen (15) days upon a showing of good cause.[135] (FSA IV.C.4.(d)) ***Final target by March 2021: 95% closure in 45 days***	95% of applicable investigations reviewed were appropriately closed within 45 days. (March 2017)	95% of investigations reviewed were appropriately closed within 45 days.	84% of investigations reviewed were appropriately closed within 45 days.	93% 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**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
Investigations - Timely Completion: 10.b. At least 80% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within sixty (60) days of initiation of the investigation, and all investigations not completed within sixty (60) days shall have authorization of the DSS Director or DSS Director's designee of an extension of no more than thirty (30) days upon a showing of good cause.[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**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 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 16 Class Members ages six and under were placed in congregate care.	The circumstances of all children met an agreed upon exception. A total of 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.

[137] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
Phasing-Out Use of DSS Offices and Hotels: 12. No child shall be placed or housed in a DSS office, hotel, motel, or other commercial non-foster care establishment.	Baseline data for this measure are not available.	DSS reports there were 53 overnight placements in a DSS office (for 28 unique children).	DSS reports there were 86 overnight placements in a DSS office (for 53 unique children).	DSS reports there were 1,012 overnight placements in a DSS office (for 216 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)	87% 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]

[138] This does not include 18 children who were hospitalized (7), or in a correctional/juvenile justice facility (11).

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
Congregate Care Placements - Children Ages 12 and Under: 14. At least 98% of the Class Members 12 years old and under shall be placed outside of Congregate Care Placements on the last day of the Reporting period unless an exception pre-approved or approved afterwards by the Co-Monitors is documented in the Class Member's case file. (FSA IV.E.3.)	92% of children ages 12 and under in foster care were placed outside of a congregate care setting. (March 2018)	99% of children ages 12 and under in foster care were placed outside of a congregate care setting.	99% of children ages 12 and under in foster care were placed outside of a congregate care setting.	98%[139] of children ages 12 and under in foster care were placed outside of a congregate care setting.[140]

[139] This includes 5 children ages 6 and under who resided in congregate placements on the last day of the monitoring period pursuant to a valid exception.
[140] This does not include 6 children ages 12 and under who were hospitalized on the last day of the monitoring period.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
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.	6 children remained in an initial Emergency or Temporary Placement for more than thirty (30) days.	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.
Emergency or Temporary Placements for More than Seven Days: 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.	Baseline data for this measure are not available.	Of the 67 children who experienced an Emergency or Temporary Placement in the month of September and had experienced an additional Emergency or Temporary Placement in the prior 12 months, 20 children experienced a subsequent Emergency or Temporary Placement for more than seven (7) days.	Of the 286 children who experienced more than one Emergency or Temporary Placement in a 12-month period, 153 (53%) children experienced at least one subsequent Emergency or Temporary Placement for more than seven (7) days.	Of the 320 children who experienced more than one Emergency or Temporary Placement in a 12-month period, 158 (49%) children experienced at least one subsequent Emergency or Temporary Placement for more than seven (7) days.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
(FSA IV.E.5.) ***Dates to reach final target and interim benchmarks to be added once approved***.				
Placement Instability: 17. For all Class Members in foster care for eight (8) days or more during the 12-month period, Placement Instability shall be less than or equal to 3.37. (FSA IV.F.1.)	3.55 moves per 1,000 days. (October 1, 2016, to September 30, 2017).	5.70 moves per 1,000 days. (October 1, 2021, to September 30, 2022).	Data for this measure are produced on an annual basis.	6.07 moves per 1,000 days. (October 1, 2022, to September 30, 2023).

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
Sibling Placements: 18. At least 85% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with at least one of their siblings unless an exception applies (FSA IV.G.2.&3.)	63% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry. (March 2018)	76% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry.	75% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry.	77% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry. [141]
Sibling Placements: 19. At least 80% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with all their siblings, unless an exception applies.	38% of children entering foster care with siblings were placed with all their sibling on the 45th day after entry. (March 2018)	48% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry.	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.[142]

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

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
<u>*Youth Exiting the Juvenile Justice System:*</u> 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	Baseline data for this measure are not available.	See Section VIII. *Placements*.	See Section VIII. *Placements*.	See Section VIII. *Placements*.[143]

[143] 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). This review and report have been an important collaboration, and a key step in identifying some of the barriers to meeting the needs of many of the children in DSS's care who present with high levels of need.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
their sentence or plea. DSS shall 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	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] 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**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
placement and/or services within thirty (30) days of the need being identified. (FSA IV.I.2.) ***Dates to reach final target and interim benchmarks to be added once approved***.				
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.	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**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
(FSA IV.I.3.) ***Dates to reach final target and 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.)	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]

[146] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
Dates to reach final target and interim benchmarks to be added once approved.				
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.	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.[147]

[147] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
(FSA IV.I.5.) ***Dates to reach final target and interim benchmarks to be added once approved***.				
Family Visitation - Siblings 24. At least 85% of the total minimum number of monthly sibling visits for all siblings not living together shall be completed, unless an exception applies. (FSA IV.J.2.)	66% of all required visits between siblings occurred for those who were not placed together. (March 2018)	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.	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.[148]

[148] The Co-Monitors plan to work with DSS to conduct a review of performance in this area in the spring of 2024. Findings from this review will be included in the Co-Monitors' report for the October 2023 to March 2024 monitoring period.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
Family Visitation - Parents: 25. At least 85% of Class Members with the goal of reunification will have in-person visitation twice each month with the parent(s) with whom reunification is sought, unless an exception applies. (FSA IV.J.3.)	12% of children with a permanency goal of reunification visited twice with the parent(s) with whom reunification was sought. (March 2018)	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.	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.[149]

[149] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
Health Care - Immediate Treatment Needs: 26. Within forty-five (45) days of the identification period, DSS shall schedule the necessary treatment for at least 90% of the identified Class Members with Immediate Treatment Needs (physical/medical, dental, or mental health) for which treatment is overdue. (FSA IV.K.4.(b))	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.[150]

[150] 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.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
Health Care - Initial Medical Screens 27. At least 90% of Class Members will receive an initial medical screen prior to initial placement or within 48 hours of entering care. ***Dates to reach final target and interim benchmarks to be added once approved.***[151]	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.[152]

[151] 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] 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**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
Health Care - Initial Comprehensive Assessments 28. At least 85% of Class Members will receive a comprehensive medical assessment within 30 days of entering care.	36% of children received a comprehensive medical assessment within 30 days. (March 2019)	35% of children received a comprehensive medical assessment within 30 days.	40% of children received a comprehensive medical assessment within 30 days.	51% of children received a comprehensive medical assessment within 30 days.[153]
Health Care - Initial Comprehensive Assessments 29. At least 95% of Class Members will receive a comprehensive medical assessment within 60 days of entering care.	52% of children received a comprehensive medical assessment within 60 days. (March 2019)	52% of children received a comprehensive medical assessment within 60 days.	53% of children received a comprehensive medical assessment within 60 days.	65% of children received a comprehensive medical assessment within 60 days.[154]

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

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
Health Care - Initial Mental Health Assessments 30. At least 85% of Class Members ages three and above for whom a mental health need is identified during the comprehensive medical assessment will receive a comprehensive mental health assessment within 30 days of the comprehensive medical assessment. ***Dates to reach final target and interim benchmarks to be added once approved.***	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.[155]

[155] 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**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
Health Care - Initial Mental Health Assessments 31. At least 95% of Class Members ages three and above for whom a mental health need is identified during the comprehensive medical assessment will receive a comprehensive mental health assessment within 60 days of the comprehensive medical assessment. ***Dates to reach final target and interim benchmarks to be added once approved.***	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.[156]

[156] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
Health Care –Referral to Developmental Assessments 32. At least 90% of Class Members under 36 months of age will be referred to the state entity responsible for developmental assessments within 30 days of entering care.	19% of children under 36 months of age were referred within 30 days. (July-December 2017)	82% of children under 36 months of age were referred within 30 days.	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.
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)	89% of children under 36 months of age were referred within 45 days.	93% of children under 36 months of age were referred within 45 days.	97% of children under 36 months of age were referred within 45 days.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
Health Care – Initial Dental Examinations 34. At least 60% of Class Members ages two and above for whom there is no documented evidence of receiving a dental examination in the six months prior to entering care will receive a dental examination within 60 days of entering care.	35% of children ages one and above received a dental exam within 60 days. (March 2018)	45% of children ages two and above received a dental exam within 60 days.	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.[157]
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)	64% of applicable children ages two and above received a dental exam within 90 days.	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.[158]

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

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
Health Care – Periodic Preventative Care (Well visits) 36. At least 90% of Class Members under the age of six months in care for one month or more will receive a periodic preventative visit monthly.	49% (40) of 82 children under the age of six months received a periodic preventative visit monthly. (March 2019) 30% (42) of 137 children under the age of six months who entered care between October 1, 2018, and March 31, 2019, received a periodic preventative visit monthly.	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*
Health Care - Periodic Preventative Care (Well visits) 37. At least 90% of Class Members between the ages of six months and 36 months in care for one month or more will receive a periodic preventative visit in accordance with current American Academy of Pediatrics (AAP) periodicity guidelines.	38% of children between the ages of six and 36 months received periodic preventative visits in accordance with the periodicity schedule. (March 2019)	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
Health Care – Periodic Preventative Care (Well visits) 38. At least 98% of Class Members between the ages of six months and 36 months in care for one month or more will receive a periodic preventative visit semi-annually.	62% of children between the ages of six and 36 months received a periodic preventative visit semi-annually. (March 2019)	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*
Health Care – Periodic Preventative Care (Well visits) 39. At least 90% of Class Members ages three and older in care for six months or more will receive a periodic preventative visit semi-annually.	12% of children ages three years and older received a periodic preventative visit semi-annually. (March 2019)	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*
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*

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
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*
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*

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**	**April – September 2023 Performance**
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.***[159]	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.[160]

[159] 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.

[160] 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.