Progress of the South Carolina Department of Social Services

MICHELLE H., et al. v. MCMASTER AND LEACH
MONITORING PERIOD
April – September 2019
February 28, 2020

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I. INTRODUCTION

This is the sixth six-month report[1] on the progress of the South Carolina Department of Social Services (DSS) in meeting the requirements of the Final Settlement Agreement (FSA) entered in *Michelle H., et al. v. McMaster and Leach*. Approved by the United States District Court on October 4, 2016, the FSA includes requirements governing the care and treatment of the more than 4,500 children in foster care in South Carolina (SC)[2] and incorporates provisions that had been ordered in a September 2015 Consent Immediate Interim Relief Order (the Interim Order or IO).[3,4] This report covers DSS performance during the period April 1 through September 30, 2019, and has been prepared by court-appointed independent Co-Monitors Paul Vincent and Judith Meltzer, with assistance from monitoring staff Rachel Paletta, Elissa Gelber, Gayle Samuels, Ali Jawetz, and E Feinman, and is presented to The Honorable Richard Gergel, U.S. District Court Judge, Parties to the lawsuit (Governor McMaster, DSS, and Plaintiffs), and the public.

The FSA outlines the State's obligations to significantly improve the experiences and outcomes of the abused and neglected children in its care, and reflects DSS's agreement to address long-standing problems in the operation of its child welfare system. It was crafted by state leaders and Plaintiffs, who conceived it to include commitments that would guide a multi-year reform effort. The FSA includes a broad range of provisions governing: case manager and supervisor caseloads; visits between children in foster care and their case managers and family members; investigations of allegations of abuse and neglect of children in foster care; appropriate foster care and therapeutic placements; and access to physical and mental health care for children in DSS custody. It also includes a number of provisions that are more open-ended, which require DSS to complete assessment work before designating outcomes, benchmarks, and timelines. The FSA thus establishes a structure in which the Co-Monitors have worked closely with DSS leaders to identify and develop phased Implementation Plans to guide much of the needed reform work.

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

[1] FSA Section III.D. requires the Co-Monitors to issue reports approximately 120 days after the close of each reporting period, or after the State and/or DSS produces the necessary data to the Co-Monitors.
[2] The class of children covered by the FSA includes "all children who are involuntarily placed in DSS foster care in the physical or legal custody of DSS now or in the future" (FSA II.A.).
[3] Consent Immediate Interim Relief Order (September 28, 2015, Dkt. 29). Civil Action No.: 2:15-cv-00134-RMG.
[4] Where relevant, included herein is discussion of DSS performance with respect to Court Orders entered subsequent to the entry of the FSA. This includes the Joint Report of Plaintiffs and Defendants to the Honorable Richard Mark Gergel (July 22, 2019, Dkt. 145). Civil Action No.: 2:15-cv-00134-RMG.

requirements.[5] In order to make this report as useful as possible to the Court, Parties, and public, the Co-Monitors have also included information about any key developments and strategy implementation beyond September 30, 2019 (the end of the current monitoring period).

II. SUMMARY OF PERFORMANCE

This six-month monitoring period began with the confirmation by the General Assembly of a new DSS Director, Michael Leach, in April 2019. Selected by Governor McMaster following a national search, Director Leach has experience working in the Tennessee child welfare system, most recently as its Deputy Commissioner for Child Programs. Director Leach has brought fresh energy to this work at a critical time, combining the need to listen and learn from those working on the ground in South Carolina with his own ideas, experiences, and direction for change. He has spent considerable time assessing the Department's challenges and opportunities through discussions with state legislative and administrative leaders, private providers, advocates, children and families, and DSS employees across the state, strengthening relationships and fostering a new sense of possibility. Director Leach has also both built up DSS's leadership team – including through the addition of a Chief of Staff and the hiring of a new Deputy Director of Child Welfare – and empowered new and existing managers in key areas to take action. And most recently, Director Leach and his staff have begun to engage with a host of child welfare experts from around the country who have been enlisted to support South Carolina's reform efforts.

The last few months have been productive and promising for DSS, as it has moved to implement its FSA commitments to the extent possible given the significant resource constraints presented by historic budget deficiencies and its FY2019-2020[6] budget allocation. In July 2019, DSS identified a number of limited action items on which it could move forward without the resources it had requested from the legislature, as memorialized in a July 22, 2019 Joint Report (the "Joint Report").[7] As discussed in more detail below, the Department has followed through on many of these commitments, and has worked to do as much as possible to position itself to quickly proceed with more comprehensive reform in hopes that it will receive the funding it needs and has requested in the FY2020-2021 budget. Over just the last few months, DSS has transitioned to a new staffing structure, moving certain staff from regional to county offices and ensuring that all children have a single case manager; begun to put in place kinship licensing workers to assist with critical efforts to place children with family members; begun to build internal capacity to implement Child and Family Teaming (CFT) statewide; bolstered critical relationships with private providers throughout the state; strengthened partnerships with health care partners; built an understanding of

[5] Pursuant to FSA III.K., "The Co-Monitors shall not express any conclusion as to whether Defendants have reached legal compliance on any provision(s)."

[6] The state fiscal year in South Carolina runs from July to June, spanning two calendar years. Throughout this report and in accordance with state practice, fiscal year designations reference the July year in which funding is allocated, and the June year in which the fiscal period ends. For example, FY2019-2020 references the period from July 2019 through June 2020.

[7] Joint Report of Plaintiffs and Defendants to the Honorable Richard Mark Gergel (July 22, 2019, Dkt. 145). Civil Action No.: 2:15-cv-00134-RMG.

key health care data; staffed the Office of Child Health and Well-Being with clinical nursing staff; put in place important team structures with the Department of Health and Human Services (DHHS) and Select Health[8] to collaboratively meet children's health care needs; and continued its work on federal revenue enhancement strategies.

Despite these significant accomplishments in laying the groundwork for change, performance has either declined or remained relatively flat in many areas covered by the FSA, and too few of the families engaged with DSS have experienced a change in their interaction with the system. Though caseloads in some areas have fallen, as of September 2019, nearly three-quarters of foster care case managers throughout the state still had caseloads in excess of FSA standards, making it impossible to meet practice expectations. There have been improvements in Out-of-Home Abuse and Neglect (OHAN) investigations as the unit added positions and integrated lessons learned from prior case reviews, but high caseloads continue to hamper the important work of investigating allegations of abuse or neglect by institutions and foster parents. Placements of children in congregate care have fallen slightly, but children are experiencing even more placement moves than before and are less likely to be placed with their siblings, and children and families continue to be subject to long periods of time without contact. And while DSS's work to meet children's health care needs has recently gotten real traction, many children and youth remain in placements unmatched to their clinical needs (or, at times, in Department of Juvenile Justice (DJJ) facilities) due to a lack of robust, appropriate community-based services. In the Co-Monitors' view, this is testament to the reality that DSS's lack of resources has been crippling and will take time to reverse, severely limiting the ability of this new energetic, thoughtful leadership team to put its plans into action. As emphasized by Judge Gergel in his Order of August 15, 2019, reiterating DSS's absolute obligation to comply with the FSA, a "profound lack of staff and resources" has made it "essentially impossible to competently and professionally carry out the mission of the agency to provide care and support for the State's foster children."[9]

Of course, meaningful and sustainable change requires more than the dedication of financial resources. Perhaps most importantly, it demands a vision and framework for living out DSS's stated values – of being family-centered, trauma-informed, strengths-based, and culturally responsive – and for defining DSS's role and purpose in the lives of South Carolina's children, youth, and families. DSS reports that it has continued to work on its "Guiding Principles and Standards" (GPS) Case Practice Model, and now has eight work groups in place to help begin implementation, though the model has yet to be rolled out. The Co-Monitors continue to believe that this work is critical, and have urged DSS to prioritize it in the coming months to ensure that it is understood and applied by DSS staff at all levels, as well as stakeholders and community and agency partners, and that it drives DSS policy and practice across the board.

[8] As discussed in Section X. *Health Care*, of this report, Select Health is the Managed Care Organization (MCO) that serves the majority of children in foster care in South Carolina.
[9] Order of the Honorable Richard Mark Gergel (August 15, 2019, Dkt. 152). Civil Action No.: 2:15-cv-00134-RMG.

Director Leach's commitment and leadership, and his team's hard work to lay the groundwork for change over the last few months is commendable. Combined with a clear willingness to openly share information and engage in a transparent problem-solving process with stakeholders, advisors, the Co-Monitors, and Parties to this action, there is, possibly for the first time since entry into the FSA, a well-founded, shared sense of optimism. Of course, DSS's most profound challenge, and one that cannot wait, is how to translate these efforts into meaningful improvement in the outcomes and experiences of children and families, many of whom still live every day with the realities born from an agency that has for too long failed to deliver on its promises. As noted by Judge Gergel, "the time for performance by the State of South Carolina has now arrived."[10]

Director Leach has publicly expressed his strong desire to take on this challenge, and he and the Co-Monitors have confidence that, with necessary resources, the coming months and years can bring positive change and a renewed sense of purpose to an agency that remains deeply in need of reform.

III. 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 used multiple methodologies to conduct their work, including verification and analysis of information available through CAPSS;[11] review of individual electronic and hardcopy 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, judges, advocates, and community organizations. The Co-Monitors have worked with DSS and the University of South Carolina's Center for Child and Family Studies (USC CCFS) to establish review protocols to gather performance data and assess current practice for some measures. Specific data collection and/or validation activities conducted by the Co-Monitors for the current period include the following:

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

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

[10] Ibid.
[11] CAPSS, Child and Adult Protective Services System, is DSS's State Automated Child Welfare Information System (SACWIS).

- Review of a statistically valid sample of OHAN investigations involving Class Members as an alleged victim accepted in September 2019, to assess for timely initiation, contact with core witnesses, timely completion, and appropriateness of unfounded decisions (FSA IV.C.3.&4.);

- Review of a statistically valid sample of case records in CAPSS for Class Members in foster care 30 days or more on September 30, 2019, to assess whether dictation/documentation of a case manager's face-to-face contact with a child in September 2019 addressed each of the agreed upon expected practices or elements which collectively meet the definition of a visit (FSA IV.B.2&3.);

- Review of a statistically valid sample of case records in CAPSS for Class Members in foster care for 30 days or more on September 30, 2019 and living apart from a sibling also in foster care, to assess whether a sibling visit had occurred in September 2019 (FSA IV.J.2.);

- Review of a statistically valid sample of case records in CAPSS for Class Members with a permanency goal of reunification, or with a permanency goal which had not yet been established in Family Court, and in foster care for 30 days or more on September 30, 2019, to assess whether the child had visited with the parent(s) with whom reunification was sought during September 2019 (FSA IV.J.3.);

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

- Review of case files of Class Members ages six and under who were placed in a congregate care setting from April to September 2019 (FSA IV.D.2.);

- Review of case files of Class Members reported to have remained in a DSS office overnight from April to September 2019 (FSA IV.D.3.);

- Participation in regular meetings between DSS and its health care partners to review data and plan for implementation; and

- Observation of Visitation Awareness Training delivered to case managers, supervisors, and casework assistants in August 2019.

Although the Co-Monitors have engaged in activities to validate data produced by DSS for many measures, data have been included in some areas that have not yet been independently verified. Where applicable, this is noted with explanations, and where possible, plans for future validation are identified.

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

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
<u>*Workload Limits for Foster Care:*</u> A foster care Workload Limit must apply to every Caseworker and to every Caseworker's supervisor. DSS may identify categories of Caseworker or Supervisor or both and set a different Workload Limit for each category.[12] (FSA IV.A.2.(b)&(c))	1a. At least 90% of caseworkers shall have a workload within the applicable Workload Limit. 1b. No caseworker shall have more than 125% of the applicable Workload Limit. ***Interim benchmark requirement - By September 2019, 40%***	<u>OHAN case managers</u>: As of March 2019, 44% of OHAN case managers had a caseload within the required limit and 56% of case managers had caseloads more than 125% of the limit. Monthly range of performance for case managers within the required limit: 0 - 44% Monthly range of performance for case managers with caseloads more than 125% of the limit: 56 - 86%	<u>OHAN case managers</u>:[13] As of September 2019, 7% of OHAN case managers had a caseload within the required limit and 93% of case managers had caseloads more than 125% of the limit. Monthly range of performance for case managers within the required limit: 0 - 50%[14] Monthly range of performance for case managers with caseloads more than 125% of the limit: 50 - 100%[15]

[12] The FSA utilizes the term "caseworker" to refer to DSS case-carrying staff. As part of its GPS Case Practice Model development and work to define enhanced job expectations, DSS now utilizes the term "case manager." Where appropriate and for consistency with practice, this report utilizes the term case manager.
[13] The Co-Monitors selected a random day in each month this period to measure caseload compliance for each type of case manager. These random dates are as follows: April 8; May 23; June 10; July 18; August 2; and September 30, 2019.
[14] Monthly performance for OHAN case manager caseloads within the required limit are as follows: April 2019, 50%; May 2019, 0%; June 2019, 0%; July 2019, 21%; August 2019, 20%; September 2019, 7%.
[15] Monthly performance for OHAN case manager caseloads more than 125% over the limit are as follows: April 2019, 50%; May 2019, 100%; June 2019, 100%; July 2019, 64%; August 2019, 67%; September 2019, 93%.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
Approved Caseworker Limits:[16,17] • OHAN investigator - one caseworker: eight investigations • Foster Care caseworker - one caseworker: 15 children • IFCCS caseworker[18] - one caseworker: nine children[19] • Adoption caseworker - one caseworker: 17 children[20] • New caseworker - ½ of the applicable standard for their first six months after completion of Child Welfare Certification training		<u>Foster Care case managers:</u> As of March 2019, 15% of foster care case managers had a caseload within the required limit and 76% of case managers had caseloads more than 125% of the limit. Monthly range of performance for case managers within the required limit: 14 - 20%	<u>Foster Care case managers:</u> As of September 2019, 26% of foster care case managers had a caseload within the required limit and 57% of case managers had caseloads more than 125% of the limit. Monthly range of performance for case managers within the required limit: 15 - 26%[21]

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

[17] 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 cases, families involved in child protective service assessments, and children placed by Interstate Compact on the Placement of Children (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.

[18] Intensive Foster Care and Clinical Services.

[19] DSS is in the process of eliminating the IFCCS casework position, with staff positions and cases transferred to county foster care case manager positions and caseloads between September and December 2019. Beginning January 2020, the caseload standard for case managers with children categorized as IFCCS on their caseload will be 1:15. Performance data reported in the next monitoring report will reflect these changes.

[20] In approving these caseload limits, the Co-Monitors noted that although a caseload of 17 children for adoption case managers is not within the standard proffered by the Council on Accreditation, as DSS was structured at that time, case management responsibilities remained with the foster care case manager, even when an adoption case manager is assigned, until a placement agreement is signed. As described further in Section V. *Caseloads* of this report, DSS is in the process of eliminating the practice of foster care and adoption case managers sharing case management responsibility on individual cases. This will result in a modification to the adoption caseload standard beginning January 2020 to 1:15, the same standard applied to foster care case managers. Performance data reported in the next monitoring report will reflect these changes.

[21] Monthly performance for foster care case manager caseloads (which includes newly hired case managers) within the required limit are as follows: April 2019, 15%; May 2019, 16%; June 2019, 15%; July 2019, 18%; August 2019, 22%; September 2019, 26%.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
		Monthly range of performance for case managers with caseloads more than 125% of the limit: 67 - 76% <u>IFCCS case managers:</u> As of March 2019, 36% of IFCCS case managers had a caseload within the required limit and 44% of case managers had caseloads more than 125% of the limit. Monthly range of performance for case managers within the required limit: 15 - 36% Monthly range of performance for case managers with caseloads more than 125% of the limit: 44 - 65%	Monthly range of performance for case managers with caseloads more than 125% of the limit: 57 - 75%[22] <u>IFCCS case managers:</u>[23] As of September 2019, 6% of IFCCS case managers had a caseload within the required limit and 78% of case managers had caseloads more than 125% of the limit. Monthly range of performance for case managers within the required limit: 6 - 32%[24] Monthly range of performance for case managers with caseloads more than 125% of the limit: 45 - 78%[25]

[22] Monthly performance for foster care case manager caseloads more than 125% over the limit are as follows: April 2019, 75%; May 2019, 71%; June 2019, 73%; July 2019, 63%; August 2019, 59%; September 2019, 57%.
[23] As described further in Section V. *Caseloads* of this report, the IFCCS case manager position is being eliminated, with staff positions and cases transferred to county foster care case manager and supervisor positions and caseloads between September and December 2019.
[24] Monthly performance for IFCCS case manager caseloads (which includes newly hired case managers) within the required limit are as follows: April 2019, 32%; May 2019, 19%; June 2019, 18%; July 2019, 13%; August 2019, 8%; September 2019, 6%.
[25] Monthly performance for IFCCS case manager caseloads more than 125% over the limit are as follows: April 2019, 51%; May 2019, 45%; June 2019, 52%; July 2019, 63%; August 2019, 73%; September 2019, 78%.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
		<u>Adoption case managers:</u> As of March 2019, 13% of adoption case managers had a caseload within the required limit and 75% of case managers had caseloads more than 125% of the limit. Monthly range of performance for case managers within the required limit: 10 - 14% Monthly range of performance for case managers with caseloads more than 125% of the limit: 75 - 83%	<u>Adoption case managers:</u> As of September 2019, 23% of adoption case managers had a caseload within the required limit and 69% of case managers had caseloads more than 125% of the limit. Monthly range of performance for case managers within the required limit: 10 - 23%[26] Monthly range of performance for case managers with caseloads more than 125% of the limit: 66 - 71%[27]

[26] Monthly performance for adoption case manager caseloads (which includes newly hired case managers) within the required limit are as follows: April 2019, 15%; May 2019, 14%; June 2019, 16%; July 2019, 10%; August 2019, 13%; September 2019, 23%.
[27] Monthly performance for adoption case manager caseloads more than 125% over the limit are as follows: April 2019, 69%; May 2019, 69%; June 2019, 66%; July 2019, 69%; August 2019, 71%; September 2019, 69%.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
Approved Supervisor Limits: • OHAN supervisors - one supervisor: six investigators • For Foster Care, IFCCS, and Adoption supervisors - one supervisor: five caseworkers	2a. At least 90% of supervisors shall have a workload within the applicable Workload Limit. 2b. No supervisor shall have more than 125% of the applicable Workload Limit. ***Interim benchmark requirement - By September 2019, 72% meet the requirement, and no more than 20% have more than 125% of the required limit***	OHAN Supervisors: As of March 2019, 100% of OHAN supervisors were within the required limit and none were more than 125% of the limit. Performance for supervisors within the required limit was 100% each month. No OHAN supervisor was responsible for more than 125% of the limit. Foster Care Supervisors: As of March 2019, 27% of foster care supervisors were within the required limit and 63% of supervisors were more than 125% of the limit. Monthly range of performance for foster care supervisors within the required limit: 22 - 35%	OHAN Supervisors: As of September 2019, 33% of OHAN supervisors were within the required limit and 33% were more than 125% of the limit. Monthly range of performance for OHAN supervisors within the required limit: 33 - 67%[28] Performance for OHAN supervisors more than 125% of the limit was 33% each month. Foster Care Supervisors: As of September 2019, 33% of foster care supervisors were within the required limit and 50% of supervisors were more than 125% of the limit. Monthly range of performance for foster care supervisors within the required limit: 33 - 42%[29]

[28] Monthly performance for OHAN supervisors within the required limit are as follows: April 2019, 67%; May 2019, 67%; June 2019, 67%; July 2019, 67%; August 2019, 33%; September 2019, 33%.
[29] Monthly performance for foster care supervisors within the required limit are as follows: April 2019, 42%; May 2019, 37%; June 2019, 38%; July 2019, 35%; August 2019, 34%; September 2019, 33%.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
		Monthly range of performance for foster care supervisors more than 125% of the limit: 49 - 64% <u>IFCCS Supervisors:</u> As of March 2019, 22% of IFCCS supervisors were within the required limit and 63% of supervisors were more than 125% of the limit. Monthly range of performance for IFCCS supervisors within the required limit: 22 - 30% Monthly range of performance for IFCCS supervisors more than 125% of the limit: 59 - 63%	Monthly range of performance for foster care supervisors more than 125% of the limit: 45 - 53%[30] <u>IFCCS Supervisors:</u>[31] As of September 2019, 42% of IFCCS supervisors were within the required limit and 42% of supervisors were more than 125% of the limit. Monthly range of performance for IFCCS supervisors within the required limit: 37 - 46%[32] Monthly range of performance for IFCCS supervisors more than 125% of the limit: 37 - 42%[33]

[30] Monthly performance for foster care supervisors more than 125% over the limit are as follows: April 2019, 45%; May 2019, 48%; June 2019, 46%; July 2019, 52%; August 2019, 53%; September 2019, 50%.

[31] As described further in Section V. *Caseloads* of this report, the IFCCS supervisor position is being eliminated, with staff positions and cases transferred to county foster care case manager and supervisor positions and caseloads between September and December 2019.

[32] Monthly performance for IFCCS supervisors within the required limit are as follows: April 2019, 37%; May 2019, 46%; June 2019, 46%; July 2019, 46%; August 2019, 42%; September 2019, 42%.

[33] Monthly performance for IFCCS supervisors more than 125% over the limit are as follows: April 2019, 37%; May 2019, 42%; June 2019, 42%; July 2019, 42%; August 2019, 42%; September 2019, 42%.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
		Adoption Supervisors: As of March 2019, 35% of adoption supervisors were within the required limit and 20% of supervisors were more than 125% of the limit. Monthly range of performance for adoption supervisors within the required limit: 21 - 35% Monthly range of performance for adoption supervisors more than 125% of the limit: 14 - 41%	Adoption Supervisors: As of September 2019, 35% of adoption supervisors were within the required limit and 26% of supervisors were more than 125% of the limit. Monthly range of performance for adoption supervisors within the required limit: 35 - 55%[34] Monthly range of performance for adoption supervisors more than 125% of the limit: 0 - 31%[35]

[34] Monthly performance for adoption supervisors within the required limit are as follows: April 2019, 55%; May 2019, 53%; June 2019, 44%; July 2019, 35%; August 2019, 35%; September 2019, 35%.
[35] Monthly performance for adoption supervisors more than 125% over the limit are as follows: April 2019, 0%; May 2019, 16%; June 2019, 22%; July 2019, 31%; August 2019, 31%; September 2019, 26%

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
Visits Between Case Managers and Children: (FSA IV.B.2.&3.)	3. At least 90% of the total minimum number of face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place.	Data are not available for this period.	In September 2019, there was documentation of a case manager's face-to-face contact with a child that included all agreed-upon elements of a visit in 24% of cases reviewed.[36,37]
	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.	Data are not available for this period.	In September 2019, there was documentation of a case manager's face-to-face contact with a child that included all agree-upon elements of a visit and took place in the residence of the child in 22% of the cases reviewed.[38,39] Of the cases reviewed, 92% of face-to-face contacts took place in the child's residence.

[36] DSS, USC CCFS, and the Co-Monitors worked together to develop an instrument and reviewed a statistically valid sample of records for which there was indication in CAPSS that a case manager had face-to-face contact with a Class Member in the month of September 2019. Reviewers assessed documentation reflecting the elements which define a visit, as reflected in DSS policy and guidance on documentation, in the CAPSS dictation of the face-to-face contact. The goal for reporting on this measure is reliable, aggregate CAPSS data which reflect practices with children.

[37] A sample of 338 records, designed to produce results at a 95% confidence level with a +/- 5% margin of error was reviewed.

[38] DSS, USC CCFS, and the Co-Monitors worked together to develop an instrument and reviewed a statistically valid sample of records for which there was indication in CAPSS that a case manager had face-to-face contact with a Class Member in the month of September 2019. Reviewers assessed documentation reflecting the elements which define a visit, as reflected in DSS policy and guidance on documentation, in the CAPSS dictation of the face-to-face contact. The goal for reporting on this measure is reliable, aggregate CAPSS data which reflect practices with children.

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Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
Investigations - Intake: (FSA IV.C.2.)	5. At least 95% of decisions not to investigate a Referral of Institutional Abuse or Neglect about a Class Member must be made in accordance with South Carolina law and DSS policy. ***Final Target -*** ***By September 2018, 95%***[40]	Monthly performance for screening decisions not to investigate determined to be appropriate: October 2018: 94% November 2018: 94% December 2018: 100% January 2019: 100% February 2019: 88% March 2019: 84%	Monthly performance for screening decisions not to investigate determined to be appropriate: April 2019: 87% May 2019: 100% June 2019: 93% July 2019: 100% August 2019: 100% September 2019: 100%
Investigations - Case Decisions: (FSA IV.C.3.)	6. At least 95% of decisions to "unfound" investigations of a Referral of Institutional Abuse or Neglect must be based upon DSS ruling out abuse or neglect or DSS determining that an investigation did not produce a preponderance of evidence that a Class Member was abused or neglected. ***Interim benchmark requirement -*** ***By September 2019, 65%***	In March 2019, there were 31 applicable investigations with decisions to unfound; 10% (3) of these decisions were determined to be appropriate.	Of the 63 investigations reviewed in September 2019,[41] there were 59 investigations with decisions to unfound; 53% (31) of these decisions were determined to be appropriate.

[40] DSS anticipated meeting the final target of 95% by September 2018.
[41] A total of 74 reports involving Class Members were accepted for investigation in September 2019. Data were collected during a review conducted by USC CCFS, DSS, and Co-Monitor staff of a statistically valid sample designed to produce results at a 95% confidence level with a +/- 5% margin of error.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
Investigations - Timely Initiation: (FSA IV.C.4.(a)) *Investigations - Contact with Alleged Child Victim:* (FSA IV.C.4.(b))	7. The investigation of a Referral of Institutional Abuse or Neglect must be initiated within twenty-four (24) hours in accordance with South Carolina law in at least 95% of the investigations. 8. The investigation of a Referral of Institutional Abuse or Neglect must include face-to-face contact with the alleged victim within twenty-four hours in at least 95% of investigations, with exceptions for good faith efforts approved by the Co-Monitors.[42] ***Interim benchmark requirement - By September 2019, 85%***	In March 2019, of the 34 applicable investigations, 35% (12) were timely initiated.	In September 2019, of the 63 investigations reviewed, 67% (42) were timely initiated.[43]

[42] 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.
[43] For the remaining 21 investigations, documentation did not support that all applicable good faith efforts were made.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
Investigations - Contact with Core Witnesses: (FSA IV.C.4.(c))	9. Contact with core witnesses must be made in at least 90% of the investigations of a Referral of Institutional Abuse or Neglect, with exceptions approved by the Co-Monitors. Core witnesses will vary from case to case and may or may not include the victim(s), Class Members, alleged perpetrators, reporter (if identified), identified eyewitness(es), other children in the placement, facility staff, treating professionals, and foster parents or caregivers as deemed to be relevant to the investigation. ***Interim benchmark requirement - By September 2019, 60%***	In March 2019, 3% (1) of the 34 applicable investigations included contact with all necessary core witnesses during the investigation.	In September 2019, 27% (17) of the 63 investigations reviewed included contact with all necessary core witnesses during the investigation.[44]

[44] Completion of contact with core witnesses by type, as applicable, for the 63 investigations reviewed is as follows: alleged victim child(ren), 94%; reporter, 80%; alleged perpetrator(s), 92%; law enforcement, 41%; alleged victim child(ren)'s case manager, 76%; other adults in home or facility, 38%; other children in home or facility, 36%; and additional core witnesses as identified for the investigation, 58%.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
Investigations - Timely Completion: (FSA IV.C.4.(d-f))	10.a. At least 60% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within forty-five (45) days of initiation of an investigation, unless the DSS Director or DSS Director's designee authorizes an extension of no more than fifteen (15) days upon a showing of good cause.[45] ***Interim benchmark requirement - By September 2019, 80%***	88% of applicable investigations received in March 2019 were appropriately closed within 45 days.	87% of investigations reviewed in September 2019 were appropriately closed within 45 days.[46]
	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.[47] ***Interim benchmark requirement - By September 2019, 80%***	97% of applicable investigations received in March 2019 were closed within 60 days.	98% of investigations reviewed in September 2019 were closed within 60 days.

[45] 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.
[46] Reviewers determined that 1 of the investigations that was closed within 45 days was closed prematurely in an effort to meet the 45-day requirement, which is not considered compliant under the FSA. This investigation was closed prior to OHAN staff scheduling a forensic interview as had been recommended. Although closed in DSS's system, this investigation is not included in the numerator as compliant for any of the timely closure measures.
[47] 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.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
	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.[48] ***Interim benchmark requirement - By September 2019, 95%***	97% of applicable investigations received in March 2019 were closed within 90 days.	98% of investigations reviewed in September 2019 were closed within 90 days.
Family Placements for Children Ages Six and Under: Within sixty (60) days, DSS shall create a plan, subject to the approval of the Co-Monitors, for preventing, with exceptions approved by the Co-Monitors, the placement of any Class Member age six (6) and under in any non-family group placement (including but not limited to group homes, shelters or residential treatment centers). The plan shall include full implementation within sixty (60) days following approval of the Co-Monitors. (FSA IV.D.2.)	11. No child age six and under shall be placed in a congregate care setting except with approved exceptions.	Between October 2018 and March 2019, the circumstances of all but three children ages six and under placed in congregate care met an agreed upon exception. A total of 19 Class Members ages six and under were placed in congregate care.	Between April and September 2019, the circumstances of all but two children ages six and under placed in congregate care met an agreed upon exception.[49] A total of 32 Class Members ages six and under were placed in congregate care.[50]

[48] Ibid.

[49] In validating data for this measure, the Co-Monitors identified 2 situations that did not meet an agreed-upon exception. One instance involved a child that was placed in congregate care with siblings in accordance with an agreed-upon exception, but remained there for longer than 90 days without sufficient efforts by DSS to continue to try to find a more family-like setting in which the children could reside together. The other instance involved a 6-year old who was placed in a group home without evidence that the placement setting was necessary to meet the child's specific needs.

[50] Although the number of children under the ages 6 and under in congregate care has increased, this is largely due to the fact that DSS has successfully placed a greater number of children with their families who are residing in these facilities. Of the 32 children, 24 were residing in a treatment facility or group care with their mothers; six were part of a sibling group of four or more children for whom DSS reported a single, family-based placement could not be located; and 2 required a degree of clinical or medical support that could only be provided in a group care setting.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
Phasing-Out Use of DSS Offices and Hotels: Within sixty (60) days, DSS shall cease using DSS offices as an overnight placement for Class Members, and shall cease placing or housing any Class Members in hotels, motels and other commercial non-foster care establishments. For any Class Members moved out of such DSS Offices or Hotels, DSS shall provide for their appropriate placement. In the extraordinary event that a child stays overnight in a DSS office, Defendants shall immediately notify the Co-Monitors, who shall provide a report to Parties as appropriate, including whether or not, in their view, the incident should be reported to the Court as a violation which would preclude Defendants' ability to achieve compliance on this provision. (FSA IV.D.3.)	12. No child shall be placed or housed in a DSS office, hotel, motel, or other commercial non-foster care establishment.	Between October 2018 and March 2019, DSS reports that there were six overnight placements in a DSS office (four of which related to the same child).	Between April and September 2019, DSS reports that there were four overnight placements in a DSS office.
Congregate Care Placements: (FSA IV.E.2.)	13. At least 86% of the Class Members shall be placed outside of Congregate Care Placements on the last day of the Reporting Period. ***Interim benchmark requirement - By September 2019, 80%***	As of March 31, 2019, 80% (3,548 of 4,426) of children in foster care were placed outside of a congregate care setting.	As of September 30, 2019, 81% (3,637 of 4,500) of children in foster care were placed outside of a congregate care setting.[51]

[51] This does not include 33 children who were hospitalized (6), or in a correctional/juvenile justice facility (27).

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
Congregate Care Placements - Children Ages 12 and Under: (FSA IV.E.3.)	14. At least 98% of the Class Members twelve (12) years old and under shall be placed outside of Congregate Care Placements on the last day of the Reporting period unless an exception pre-approved or approved afterwards by the Co-Monitors is documented in the Class Member's case file. ***Interim benchmark requirement - By September 2019, 94%***	As of March 31, 2019, 94% (2,949 of 3,148) of children ages 12 and under in foster care were placed outside of a congregate care setting.	As of September 30, 2019, 95% (3,022[52] of 3,171) of children ages 12 and under in foster care were placed outside of a congregate care setting.[53,54]

[52] This includes 19 children ages 6 and under who resided in a congregate care placement pursuant to a valid exception.
[53] Exceptions have been approved, though not applied during this monitoring period for children ages 7 to 12; therefore, actual performance may be higher than reported. DSS will develop a process for exception review and approval in future monitoring periods.
[54] Five children who were hospitalized on the last day of the monitoring period are not included in the universe for this measure.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
Emergency or Temporary Placements for More than 30 Days: (FSA IV.E.4.)	15. Class Members shall not remain in any Emergency or Temporary Placement for more than thirty (30) days. Under exceptions subject to the Co-Monitors' approval, if a child is initially placed in an Emergency or Temporary Placement that is not a Congregate Care Placement, and that placement is re-designated within thirty (30) days as a long-term foster home or therapeutic foster home, then the child's stay shall not be considered a violation of this provision and the re-designation shall not be considered a placement move under Section IV.F.1 below. ***DSS has not yet proposed Interim Benchmarks and timelines to meet final target.***[55]	Data are not available for this period.	Data are not available for this period.[56,57]

[55] Pursuant to the Placement Implementation Plan, DSS was to propose a methodology for measuring the use of emergency placements to the Co-Monitors by June 2019. Both DSS and the Co-Monitors recognize that the setting of an appropriate methodology is dependent upon a number of Placement Plan implementation issues that have yet to be resolved.
[56] As discussed in more detail in Section VIII. *Placements*, DSS produced data with respect to temporary placements for the first time this period, but data was provided for only a 2-month timeframe and have not been included herein. The Co-Monitors expect to include data for this measure in the next monitoring report.
[57] Although DSS does not formally track the use of emergency placements, DSS continues to provide the Co-Monitors with data regarding emergency "incentive" payments made to providers to accept placement of a child overnight. In Section VIII. *Placements*, the Co-Monitors report that 226 children were subject to this practice. Although these constitute emergency placements for the purpose of measuring FSA performance, neither DSS nor the Co-Monitors believe that all emergency placements are reflected in this enhanced rate payment data. The Co-Monitors will report data for this measure when a more consistent process for tracking emergency placements has been developed.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
Emergency or Temporary Placements for More than Seven Days: (FSA IV.E.5.)	16. Class Members experiencing more than one Emergency or Temporary Placement within twelve (12) months shall not remain in the Emergency or Temporary Placement for more than seven (7) days. Under exceptions subject to the Co-Monitors' approval, if a child's subsequent placement within twelve (12) months in an Emergency or Temporary Placement is not a Congregate Care Placement, and that placement is re-designated within thirty (30) days as a long-term foster home or therapeutic foster home, then the child's stay shall not be considered a violation of this provision and the re-designation shall not be considered a placement move under Section IV.F.1 below. ***DSS has not yet proposed Interim Benchmarks and timelines to meet final target.*** [58]	Data are not available for this period.	Data are not available for this period.[59,60]

[58] Pursuant to the Placement Implementation Plan, DSS was to propose a methodology for measuring the use of emergency placements to the Co-Monitors by June 2019. Both DSS and the Co-Monitors recognize that the setting of an appropriate methodology is dependent upon a number of Placement Plan implementation issues that have yet to be resolved.
[59] As discussed in more detail in Section VIII. *Placements*, DSS produced data with respect to temporary placements for the first time this period, but data were provided for only a 2-month timeframe and have not been included here. The Co-Monitors expect to include data for this measure in the next monitoring report.
[60] Although DSS does not formally track the use of emergency placements, DSS continues to provide the Co-Monitors with data regarding emergency "incentive" payments made to providers to accept placement of a child overnight. In Section VIII. *Placements*, the Co-Monitors report that 226 children were subject to this practice. Although these constitute emergency placements for the purpose of measuring FSA performance, neither DSS nor the Co-Monitors believe that all emergency placements are reflected in this enhanced rate payment data. The Co-Monitors will report data for this measure when a more consistent process for tracking emergency placements has been developed.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
Placement Instability: (FSA IV.F.1.)	17. For all Class Members in foster care for eight (8) days or more during the 12-month period, Placement Instability shall be less than or equal to 3.37.	For the period October 1, 2017 to September 30, 2018,[61] children in foster care for eight (8) days or more experienced instability at a rate of 3.92.	For the period October 1, 2018 to September 30, 2019, children in foster care for eight (8) days or more experienced instability at a rate of 4.30.[62]
Sibling Placements: (FSA IV.G.2.&3.)	18. At least 85% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with at least one of their siblings unless one or more of the following exceptions apply: (1) there is a court order prohibiting placing all siblings together; (2) placement is not in the best interest of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3) additional exceptions as approved by the Co-Monitors. ***Interim benchmark requirement - By September 2019, 69%***	61% (596 of 983) of children entering foster care with their siblings or within 30 days of their siblings from October 2018 to March 2019 were placed with at least one of their siblings on the 45th day after entry into care.	56% (492 of 886) of children entering foster care with their siblings or within 30 days of their siblings from April to September 2019 were placed with at least one of their siblings on the 45th day after entry into care.[63]

[61] Data for this measure are reported on an annual basis and calculates the rate of placement moves per 1,000 days of foster care among Class Members. See FSA II.O. for further description of methodology.
[62] Specifically, there were a total of 6,936 moves across 1,614,117 days. For further explanation of the placement instability measure, see Section VIII. *Placements*.
[63] Exceptions have been approved, though not applied during this monitoring period; therefore, actual performance may be higher than reported. DSS will develop a process for exception review and approval in future monitoring periods.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
	19. At least 80% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with all their siblings, unless one or more of the following exceptions apply: (1) there is a court order prohibiting placing all siblings together; (2) placement is not in the best interest of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3) additional exceptions as approved by the Co-Monitors. ***Interim benchmark requirement - By September 2019, 49%***	35% (343 of 983) of children entering foster care with their siblings or within 30 days of their siblings from October 2018 to March 2019 were placed with all of their siblings on the 45th day after entry into care.	32% (282 of 886) of children entering foster care with their siblings within 30 days of their siblings from April to September 2019 were placed with all of their siblings on the 45th day after entry into care.[64]

[64] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
Youth Exiting the Juvenile Justice System: (FSA IV.H.1.)	20. When Class Members are placed in juvenile justice detention or another Juvenile Justice Placement, DSS shall not recommend to the family court or Department of Juvenile Justice that a youth remain in a Juvenile Justice Placement without a juvenile justice charge pending or beyond the term of their plea or adjudicated sentence for the reason that DSS does not have a foster care placement for the Class Member. DSS shall take immediate legal and physical custody of any Class Member upon the completion of their sentence or plea. DSS shall provide for their appropriate placement.	Data are not available for this period.	Data are not available for this period.[65]

[65] As discussed in Section VIII. *Placements,* DSS is in the process of developing a real-time system for tracking youth involved with both the juvenile justice and child welfare systems. The Co-Monitors reviewed a number of cases reported by stakeholders in which youth spent time in DJJ facilities due, in part, to DSS's failure to appropriately meet their needs. In accordance with its obligations, DSS also self-reported 2 violations of this provision during this monitoring period.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
Therapeutic Foster Care Placements - Referral for Staffing and/or Assessment: (FSA IV.I.2.)	21. All Class Members that are identified by a Caseworker as in need of interagency staffing and/or in need of diagnostic assessments shall be referred for such staffing and/or assessment to determine eligibility for therapeutic foster care placement and/or services within thirty (30) days of the need being identified. This requirement shall not apply if the Caseworker withdraws the identified need in good faith and in the best interests of the Class Member within thirty (30) days. ***DSS has not yet proposed Interim Benchmarks and timelines to meet final target.***[66]	Data are not available for this period.	Data are not available for this period.[67]

[66] Pursuant to the Placement Implementation Plan, DSS was to propose a methodology for measuring compliance with this requirement by July 2019. Both DSS and the Co-Monitors recognize that the setting of an appropriate methodology is dependent upon a number of Placement Plan implementation issues that have yet to be resolved.
[67] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
Therapeutic Foster Care Placements - Receipt of Recommendations for Services or Placement: (FSA IV.I.3.)	22. All Class Members that are referred for interagency staffing and/or needed diagnostic assessments shall receive recommendations for specific therapeutic foster care placement and/or services within forty-five (45) days of receipt of the completed referral. The recommendation(s) may include diagnostic assessment, community support services, rehabilitative behavioral health services, therapeutic foster care, group care, and psychiatric residential treatment facility. Level of Care Placement recommendations shall utilize the least restrictive care philosophy suitable to the child's needs and seek to place a Class Member in a family setting with a community support system. DSS shall update the assessment at least annually thereafter, upon a placement disruption or upon a material change in the Class Member's needs. In making that determination, DSS may consider the full array of appropriate placement alternatives to meet the needs of the Class Members.	Data are not available for this period.	Data are not available for this period.[69]

[69] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
	DSS has not yet proposed Interim Benchmarks and timelines to meet final target.[68]		
Therapeutic Foster Care Placements - Level of Care Placement: (FSA IV.I.4.&5.)	23.a. Within 60 Days: At least 90% of children assessed as in need of therapeutic foster care placement shall be in the Therapeutic Level of Care and specific placement type that matches the Level of Care for which the child was assessed within sixty (60) days following the date of the first Level of Care Placement recommendation. ***DSS has not yet proposed Interim Benchmarks and timelines to meet final target.***[70]	Data are not available for this period.	Data are not available for this period.[71]

[68] Ibid.
[70] Ibid.
[71] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
	23.b. At least 95% of children assessed as in need of therapeutic foster care placement shall be in the Therapeutic Level of Care and specific placement type that matches the Level of Care for which the child was assessed within ninety (90) days following the date of the first Level of Care Placement recommendation. ***DSS has not yet proposed Interim Benchmarks and timelines to meet final target.***[72]	Data are not available for this period.	Data are not available for this period.[73]

[72] Ibid.
[73] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
Family Visitation - Siblings and Parents: (FSA IV.J.2.&3.)	24. At least 85% of the total minimum number of monthly sibling visits for all siblings not living together shall be completed, with exceptions when (1) there is a court order prohibiting visitation or limiting visitation to less frequently than once every month; (2) visits are not in the best interest of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3) with exceptions approved by the Co-Monitors. ***Interim benchmark requirement - By September 2019, 66%***	In March 2019, 48% of all required visits between siblings occurred for siblings who were not placed together.	In September 2019, 59% of all required visits between siblings occurred for siblings who were not placed together.[74]

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

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
	25. At least 85% of Class Members with the goal of reunification will have in-person visitation twice each month with the parent(s) with whom reunification is sought, unless (1) there is a court order prohibiting visitation or limiting visitation to less frequently than twice every month; or (2) based on exceptions approved by the Co-Monitors. ***Interim benchmark requirement - By September 2019, 35%***	In March 2019, 12% of Class Members with a permanency goal of reunification visited twice with the parent(s) with whom reunification was sought.	In September 2019, 13% of Class Members with a permanency goal of reunification visited twice with the parent(s) with whom reunification was sought.[75]

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

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
Health Care - Immediate Treatment Needs: By the end of ninety (90) days following final court approval of the Final Settlement Agreement (identification period), DSS shall identify Class Members with Immediate Treatment Needs (physical/medical, dental or mental health) for which treatment is overdue. (Immediate Treatment Needs means immediate non-elective physical/medical, dental or mental health treatment needs and documented assessment needs, excluding routine periodic assessments.) (FSA IV.K.4.(b))	26. Within forty-five (45) days of the identification period, DSS shall schedule the necessary treatment for at least 90% of the identified Class Members.	Data for this measure are not available.	Data for this measure are not available.[76]

[76] FSA IV.K.4.(b)). required that by August 31, 2016, DSS "identify Class Members with Immediate Treatment Needs (physical/medical, dental, or mental health) for which treatment is overdue." Though initially intended to apply to children in DSS custody at the time of entry into the agreement in October 2016, DSS has lacked a mechanism for measuring performance with respect to this requirement. On October 28, 2019, DSS and Plaintiffs entered into a *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. The Co-Monitors and Parties believe this applies the intent of the original provision to a more current cohort of Class Members. Progress with respect to these new commitments is assessed and discussed in Section X. *Health Care*.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 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.***[77]	Data for this measure are not available.	Data for this measure are not available.[78]
Health Care - Initial Comprehensive Assessments	28. At least 85% of Class Members will receive a comprehensive medical assessment within 30 days of entering care. ***Interim benchmark requirement - By September 2019, 57%***	36% (483 of 1,341) of children who entered care between October 2018 and March 2019 received a comprehensive medical assessment within 30 days.	32% (553 of 1,746) of children who entered care between April and September 2019 received a comprehensive medical assessment within 30 days.[79]

[77] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, DSS is to present approvable interim benchmarks to the Co-Monitors by May 31, 2020.
[78] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, these data are to be reported for all children entering DSS custody beginning in monitoring period VII (October 2019 - March 2020).
[79] These and other health care data included herein were extracted by DSS and DHHS from Medicaid administrative claims data and other data sources. Though in some instances the Co-Monitors made adjustments to the data to address miscalculations or reflect agreed-upon methodologies, these data were not independently validated by the Co-Monitors.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
	29. At least 95% of Class Members will receive a comprehensive medical assessment within 60 days of entering care. ***Interim benchmark requirement - By September 2019, 71%***	52% (455 of 884) of children who entered care between October 2018 and March 2019 received a comprehensive medical assessment within 60 days.	47% (702 of 1,488) of children who entered care between April and September 2019 received a comprehensive medical assessment within 60 days.
	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.***[80]	Data for this measure are not available.	Data for this measure are not available.[81]

[80] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, DSS will present approvable interim benchmarks to the Co-Monitors by May 31, 2020.

[81] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, DSS is to begin producing these data for children entering DSS custody in monitoring period VII (October 2019 - March 2020). DSS has continued to produce data regarding the *total* number of children who receive mental health assessments during a specific period, but given the lack of ability to match these assessments with identified needs at this time, these data have not been included herein.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
	31. At least 95% of Class Members ages three and above for whom a mental health need is identified during the comprehensive medical assessment will receive a comprehensive mental health assessment within 60 days of the comprehensive medical assessment. ***Dates to reach final target and interim benchmarks to be added once approved.***[82]	Data for this measure are not available.	Data for this measure are not available.[83]
	32. At least 90% of Class Members under 36 months of age will be referred to the state entity responsible for developmental assessments within 30 days of entering care. ***Interim benchmark requirement - By September 2019, 29%***	40% (171 of 428) of children under 36 months of age who entered care between October 2018 and March 2019 were referred to the state entity responsible for developmental assessments within 30 days.	71% (325 of 470) of children under 36 months of age who entered care between April and September 2019 were referred to the state entity responsible for developmental assessments within 30 days.

[82] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, DSS will present approvable interim benchmarks to the Co-Monitors by May 31, 2020.

[83] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, DSS is to begin producing these data for children entering DSS custody in monitoring period VII (October 2019 - March 2020). DSS has continued to produce data regarding the *total* number of children who receive mental health assessments during a given period, but given the lack of ability to match these assessments with identified needs at this time, these data have not been included herein.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
	33. At least 95% of Class Members under 36 months of age will be referred to the state entity responsible for developmental assessments within 45 days of entering care. ***Interim benchmark requirement - By September 2019, 30%***	49% (190 of 390) of children under 36 months of age who entered care between October 2018 and March 2019 were referred to the state entity responsible for developmental assessments within 45 days.	80% (334 of 416) of children under 36 months of age who entered care between April and September 2019 were referred to the state entity responsible for developmental assessments within 45 days.
	34. At least 60% of Class Members ages two and above for whom there is no documented evidence of receiving a dental examination in the six months prior to entering care will receive a dental examination within 60 days of entering care. ***Interim benchmark requirement - By September 2019, 50%***	56% (348 of 619) of applicable children ages two and above who entered care between October 2018 and March 2019 received a dental examination within 60 days.	47% (449 of 958) of applicable children ages two and above who entered care between April and September 2019 received a dental examination within 60 days.
	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.	67% (280 of 415) of applicable children ages two and above who entered care between October 2018 and March 2019 received a dental examination within 90 days.	59% (402 of 683) of applicable children ages two and above who entered care between April and September 2019 received a dental examination within 90 days.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
	Interim benchmark requirement - By September 2019, 68%		
Health Care - Periodic Preventative Care	36. At least 90% of Class Members under the age of six months in care for one month or more will receive a periodic preventative visit monthly. ***Interim benchmark requirement - By September 2019, 79%***	Data for this measure are not available.	49% (40 of 82) of children under the age of six months who were in care on March 31, 2019 received a periodic preventative visit monthly.[84,85] 30% (42 of 137) of children under the age of six months who entered care between October 1, 2018 and March 31, 2019 received a periodic preventative visit monthly.
	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.	Data for this measure are not available.	38% (275 of 726) of children between the ages of six and 36 months who were in care on March 31, 2019 received periodic preventative visits in

[84] DSS has re-assessed its methodology for extracting these data, in partnership with DHHS, and worked to recalculate performance on periodic preventative visits initially submitted for the period October 1, 2018 to March 31, 2019. DSS has not yet produced data for the monitoring period under review.
[85] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, DSS agreed to utilize 2 methodologies to capture the occurrence of required monthly medical visits for children under the age of 6 months: the first applies to children under the age of 6 months who are *in care on the last day of the reporting period*, and the second to children under the age of 6 months *entering care* in a given period.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
	Interim benchmark requirement - By September 2019, 77%		accordance with current AAP guidelines.[86]
	38. At least 98% of Class Members between the ages of six months and 36 months in care for one month or more will receive a periodic preventative visit semi-annually. ***Interim benchmark requirement - By September 2019, 84%***	Data for this measure are not available.	62% (347 of 564) of children between the ages of six and 36 months who were in care on March 31, 2019 received a periodic preventative visit semi-annually.[87]
	39. At least 90% of Class Members ages three and older in care for six months or more will receive a periodic preventative visit semi-annually. ***Interim benchmark requirement - By September 2019, 50%***	Data for this measure are not available.	12% (212 of 1,828) of children ages three years and older who were in care on March 31, 2019 received a periodic preventative visit semi-annually.[88]

[86] DSS has re-assessed its methodology for extracting these data, in partnership with DHHS, and worked to recalculate performance on periodic preventative visits initially submitted for the period October 1, 2018 to March 31, 2019. DSS has not yet produced data for the monitoring period under review. Given the manner in which the dates of periodic preventative visits were extracted and reproduced by DSS during this monitoring period, the analysis for this measure covers a 12-month period, from April 2018 to March 2019.
[87] Ibid.
[88] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 Performance**
	40. At least 98% of Class Members ages three and older in care for six months or more will receive a periodic preventative visit annually. ***Interim benchmark requirement - By September 2019, 83%***	Data for this measure are not available.	58% (1,057 of 1,828) of children ages three years and older who were in care on March 31, 2019 received an annual preventative visit.[89]
	41. At least 75% of Class Members ages two and older in care for six months or longer will receive a dental examination semi-annually. ***Interim benchmark requirement - By September 2019, 75%***	Data for this measure are not available.	54% (1,427 of 2,623) of children ages two years or older on March 31, 2019 received a dental visit semi-annually.[90]
	42. At least 90% of Class Members ages two and older in care for six months or longer will receive a dental examination annually. ***Interim benchmark requirement - By September 2019, 86%***	Data for this measure are not available.	81% (1,563 of 1,919) of children ages two years or older on March 31, 2019 received an annual dental examination.[91]

[89] Ibid.
[90] DSS has re-assessed its methodology for extracting these data, in partnership with DHHS, and worked to recalculate performance on periodic dental examinations initially submitted for the period October 1, 2018 to March 31, 2019. DSS has not yet produced data for the monitoring period under review.
[91] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements			
Final Settlement Agreement (FSA) Requirements	**Final Target**	**October 2018 - March 2019 Performance**	**April - September 2019 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.***[92]	Data for this measure are not available.	Data for this measure are not available.[93]

[92] 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. Due to data limitations and priorities set for Plan implementation, DSS has not yet been able to propose these benchmarks. Benchmarks will be set once there is a reliable mechanism in place for measuring baseline performance in this area.

[93] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, DSS produced data utilizing a Center for Healthcare Strategies (CHCS) process for calculating the delivery of follow-up care. Of the 3,070 children included who had an identified "abnormality" finding during a medical assessment, 1,751 (57%) had a subsequent medical visit within 90 days. Given the lack of specificity in matching the care delivered to the identified need, and DSS's plan to complete a more comprehensive review of follow-up care, the Co-Monitors will report on this measure in the next monitoring report.

V. CASELOADS

A sufficient, qualified, and trained workforce with manageable caseloads is foundational to a well-functioning child welfare system. Case managers[94] must have the resources and support to allow them to conduct meaningful visits with children and families, assess for safety and risk, and monitor progress towards individualized case goals, among many other important tasks. Child welfare agencies must ensure that the appropriate number and types of positions – including case managers, supervisors, and support staff – are allocated within each region and county office so that caseloads are manageable, and that when vacancies exist, they are quickly filled with as little disruption as possible to families and colleagues. Case managers also need salaries and benefits that equate to a professional living wage and allow them to pursue this work as a career.

DSS reports that 186 of the 223 case manager and supervisor positions allocated in the FY2018-2019 budget were filled by the end of September 2019. As of September 30, 2019, DSS reports the following vacancies: 46 foster care case managers; 14 adoption positions; two OHAN (Out of Home Abuse and Neglect) positions; and 24 IFCCS positions that were being reallocated to the counties based upon need.[95] In addition to case managers, the following supervisor positions were also vacant: 10 foster care supervisors, two adoption supervisors, and one IFCCS supervisor. DSS reports the average length of time these positions have been vacant is 5.3 months, suggesting another challenge in ensuring appropriate caseloads.

DSS has provided turnover rate data for CY2018 and the first six months of CY2019. In CY2018, for the average number of employees within adoptions, family preservation, foster care, IFCCS, intake, investigations, licensing, and OHAN, the turnover rate was 34 percent (455 of 1,346). This means that more than one-third of workers left the agency within a 12-month period. Between January and June 2019, the turnover rate for the same programs was 14 percent (232 of 1,666), which is relatively on pace with the same time period in CY2018. The programs with the highest turnover are IFCCS (18%),[96] investigations (16%), foster care (15%), family preservation (13%), and adoptions (12%).

Current performance data show improvements in caseload compliance for foster care and adoption case managers, and declines in compliance for OHAN and IFCCS case managers. Additionally, improvements are noted for workloads of foster care and IFCCS supervisors.

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

[95] As described later in this section, DSS is in the process of eliminating all IFCCS case manager and supervisor positions and is transferring these positions and associated cases to county foster care staff positions and caseloads between September and December 2019. In anticipation of this transition, DSS delayed filling vacant IFCCS positions, which negatively impacted how long vacancies remained.

[96] DSS reports increased turnover in IFCCS positions following the decision to eliminate this position category and transition these roles into foster care case managers and supervisors.

A. Performance Data[97]

The FSA requires *"[a]t least 90% of Workers and Worker supervisors shall have a workload within the applicable Workload Limit"* (FSA IV.A.2.(b)) and that *"[n]o Worker or Worker's supervisor shall have more than 125% of the applicable Workload Limit"* (FSA IV.A.2.(c)).

Tables 2 and 3 include the approved Workload Implementation Plan timelines and interim benchmarks for this measure:

Table 2: Baseline, Timeline, and Interim Benchmarks for Case Manager Caseloads Within the Required Limits

Baseline	
September 2017	23%
Timeline	**Interim Benchmark**
September 2019	**40%**
March 2020	65%
September 2020	80%
Final Target - March 2021	**90%**

Source: Workload Implementation Plan

Table 3: Baseline, Timeline, and Interim Benchmarks for Case Manager Caseloads More Than 125% of the Required Limit

Baseline	
September 2017	64%
Timeline	**Interim Benchmark**
September 2019	**40%**
March 2020	25%
September 2020	15%
Final Target - March 2021	**0%**

Source: Workload Implementation Plan

[97] The Co-Monitors selected a random day in each month this period to measure caseload compliance for each type of case manager. These random dates are as follows: April 8; May 23; June 10; July 18; August 2; and September 30, 2019.

The interim targets also require that no case manager has a caseload of more than 180 percent of the standard by September 2019, no case manager has more than 170 percent of the standard by March 2020, and no case manager has more than 160 percent of the standard by September 2020.

There are different caseload standards dependent upon the types of cases a case manager manages – specifically foster care, IFCCS, adoption, and investigations of allegations of abuse and neglect of a child in foster care (OHAN).[98] There are also reduced workload standards specific to newly hired case managers within their first six months of completing Child Welfare Certification training.[99]

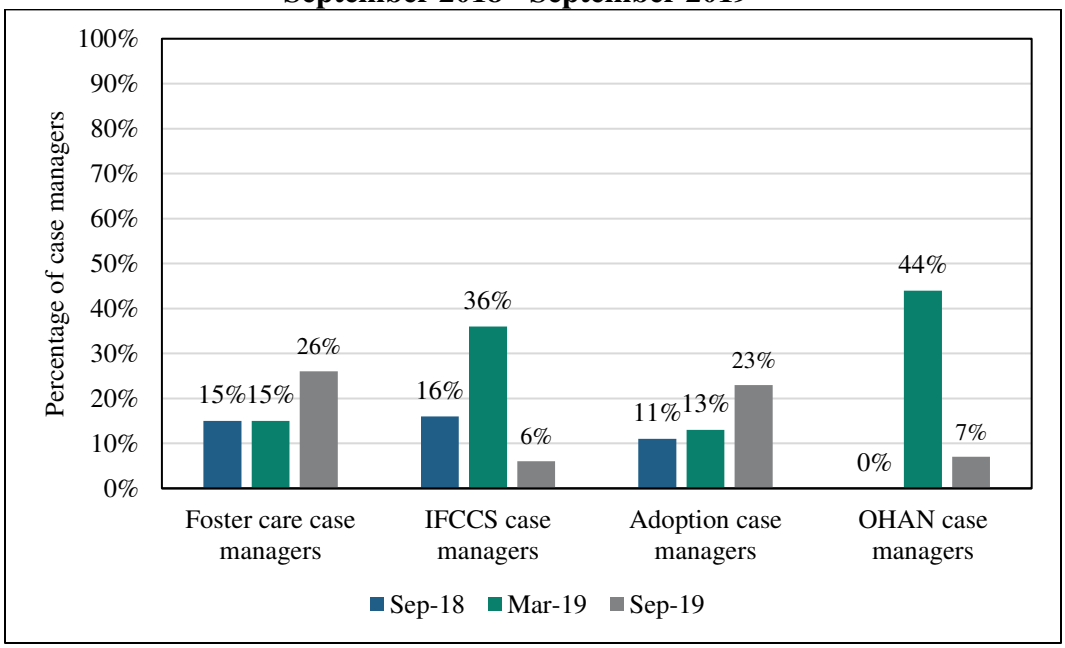
DSS has identified occasional situations in which supervisors may carry a case for a short period of time. These include when a case manager is promoted to supervisor and may temporarily retain case management for up to 45 days if a case is about to close, if there are complexities regarding the case that need to be addressed, or if an important legal event will occur within the timeframe. While the supervisor is carrying a case, they are responsible for all required case duties including visiting with the child; monitoring the child's safety, placement, well-being, case plan, and service delivery; ensuring the child is visiting with their siblings and/or parent, as applicable; and other activities as necessary. When cases are being transferred from one case manager, office, unit, or program area to another, the case may be temporarily assigned to the receiving supervisor for up to five days until the supervisor assigns the case to the receiving case manager.

To assist in assessing progress over time, Figures 1 and 2 provide performance data on caseloads by case manager and supervisor type for prior and current monitoring periods.

[98] DSS has many staff with "mixed" caseloads that include different kinds of case types and both Class and Non-Class Members. On December 21, 2017, the Co-Monitors provisionally approved DSS's proposal to calculate caseloads for foster care case managers with mixed caseloads by adding the total number of foster care children (Class Members) it serves to the total number of families (cases) of Non-Class Members it also serves. In approving this mixed caseload methodology, the Co-Monitors relied upon DSS's commitments to: (1) move forward with plans to move case managers to single-type caseloads as feasible and appropriate; (2) change their internal metrics for family preservation cases to use a "family" as opposed to an individual child count; and (3) assess and find a way to address the Co-Monitors' concerns about the potential for unreasonable caseloads that could result from case manager assignment to several family preservation cases involving families with multiple children. DSS has indicated that supervisors and office managers are continually assessing assignments to case managers with mixed caseloads to ensure balanced and manageable workloads. Because approval of this methodology is "provisional," DSS and the Co-Monitors will assess it in practice as it is implemented, reserving the right to modify the standard at any time if it is determined that the best interests of children are not being served. The following types of cases are counted by family (case): Child Protective Services (CPS) assessment; family preservation; other child welfare services; and those involving a child subject to ICPC. This methodology is only applied to foster care case managers with mixed caseloads and is not applied to caseloads for IFCCS and adoption case managers.

[99] Following the transition of increased case management responsibility to adoption case managers and the elimination of IFCCS positions, in January 2020, the caseload standard for all foster care and adoption case managers will be 1:15. OHAN case managers will continue to maintain the caseload of 1:8.

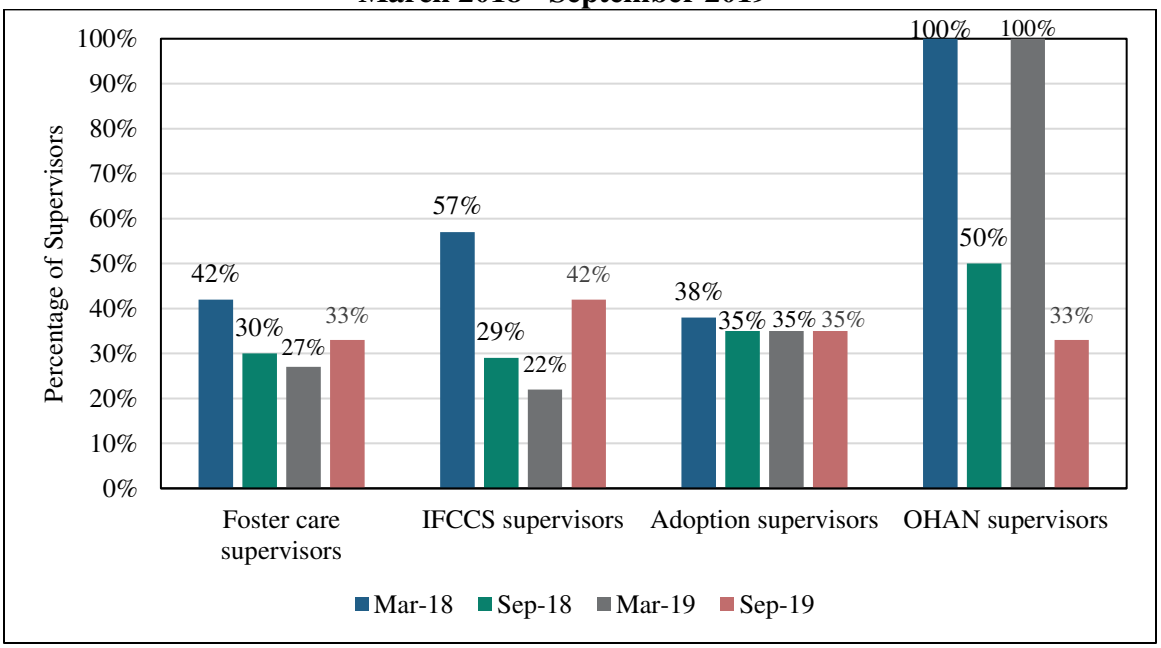
Figure 1: Performance Trends for Percentage of Case Managers Within the Required Caseload Limits, by Case Manager Type September 2018 - September 2019[100]



Source: CAPSS data provided by DSS

[100] Caseload limits are as follows: foster care case manager, 1:15; IFCCS case manager, 1:9; adoption case manager, 1:17; and OHAN investigator, 1:8. The final target for this measure is 90%.

Figure 2: Performance Trends for Percentage of Supervisors Within the Required Workload Limits, by Supervisor Type March 2018 - September 2019[101]



Source: CAPSS data provided by DSS

Detailed caseload data by case manager and supervisor type are discussed below.

Foster Care Case Managers

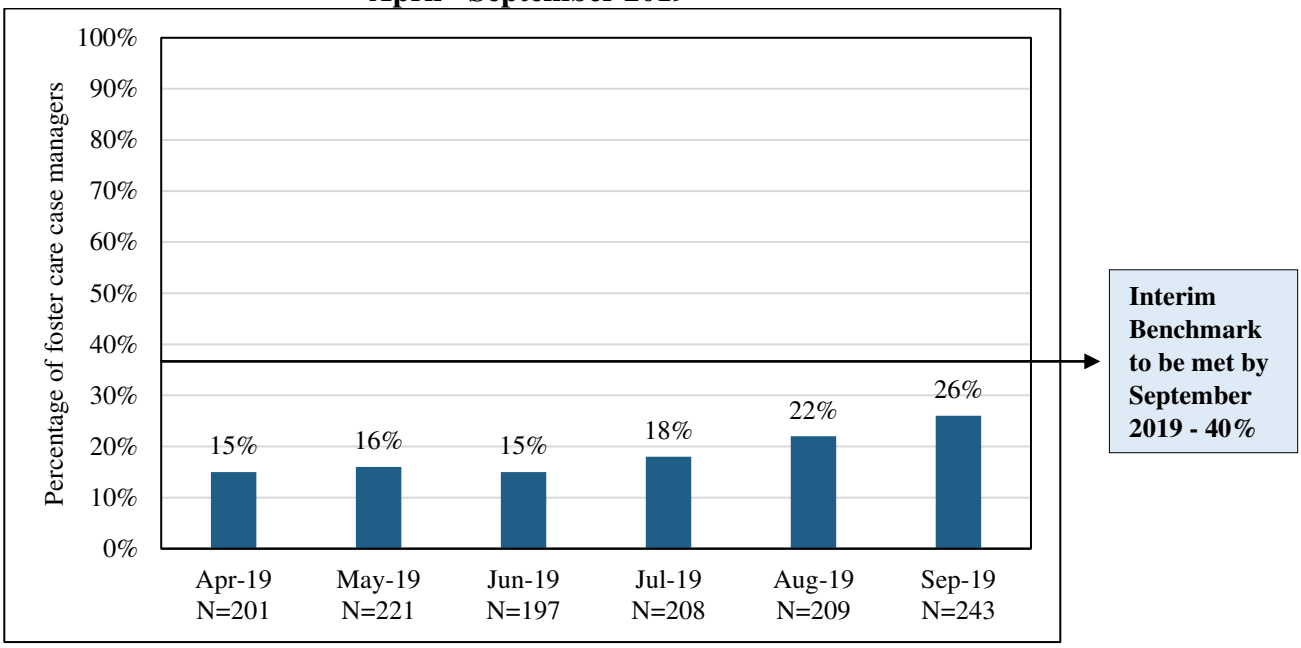
The caseload standard for case managers who are responsible for providing case management for foster care cases is one case manager to 15 children (1:15). Newly hired foster care case managers are expected to have reduced caseloads as they build skills for this work in the field, and should have no more than eight (1:8) cases on their caseload for six months after they complete Child Welfare Certification training. The September 2019 interim benchmark for this measure is 40 percent and also requires that no case manager has a caseload of more than 180 percent of the standard by September 2019.

During this monitoring period, the number of foster care case managers increased, from 201 case managers in April 2019 to 243 case managers in September 2019. This is due both to the transition of IFCCS case managers into county foster care positions beginning in September 2019, and the hiring of new workers (in April 2019, there were 51 new foster care case managers, and in September 2019, there were 76 new foster care case managers).

[101] Workload limits for supervisors are as follows: foster care, IFCCS, and adoption supervisors, 1 supervisor to 5 case managers; OHAN supervisors, 1 supervisor to 6 investigators. The final target for this measure is 90%.

Between April and September 2019, a monthly range of 15 to 26 percent of foster care case managers had caseloads within the required limit (Figure 3), and 57 to 75 percent of foster care case managers had caseloads that were more than 125 percent of the caseload limit (Figure 4).[102] Specifically, on September 30, 2019, there were 243 foster care case managers[103] with at least one foster care child on their caseload. Of these 243 case managers, 64 (26%) foster care case managers had caseloads within the required limit, and 139 (57%) case managers' caseloads were more than 125 percent of the caseload limit. Additionally, as of September 2019, 43 foster care case managers (18%) had a caseload of more than 180 percent of the standard.

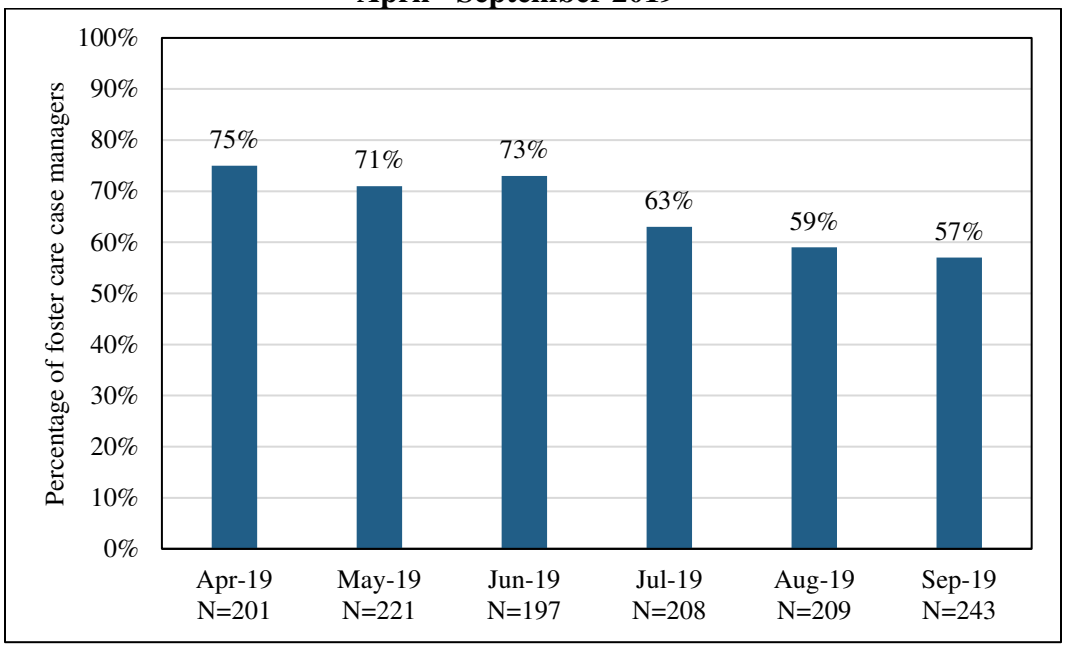
Figure 3: Foster Care Case Managers Within the Required Caseload Limits April - September 2019



Source: CAPSS data provided by DSS

[102] In calculating performance, a standard of 8 foster care children or Non-Class Member families is applied to newly hired case managers (half of the applicable caseload standard) and 15 foster care children or Non-Class Member families is applied to foster care or Adult Protective Services (APS) case managers.
[103] This includes 5 case managers also managing adult protective services cases and 76 newly hired foster care case managers.

Figure 4: Foster Care Case Managers over 125% of Required Caseload Limits April - September 2019[104]

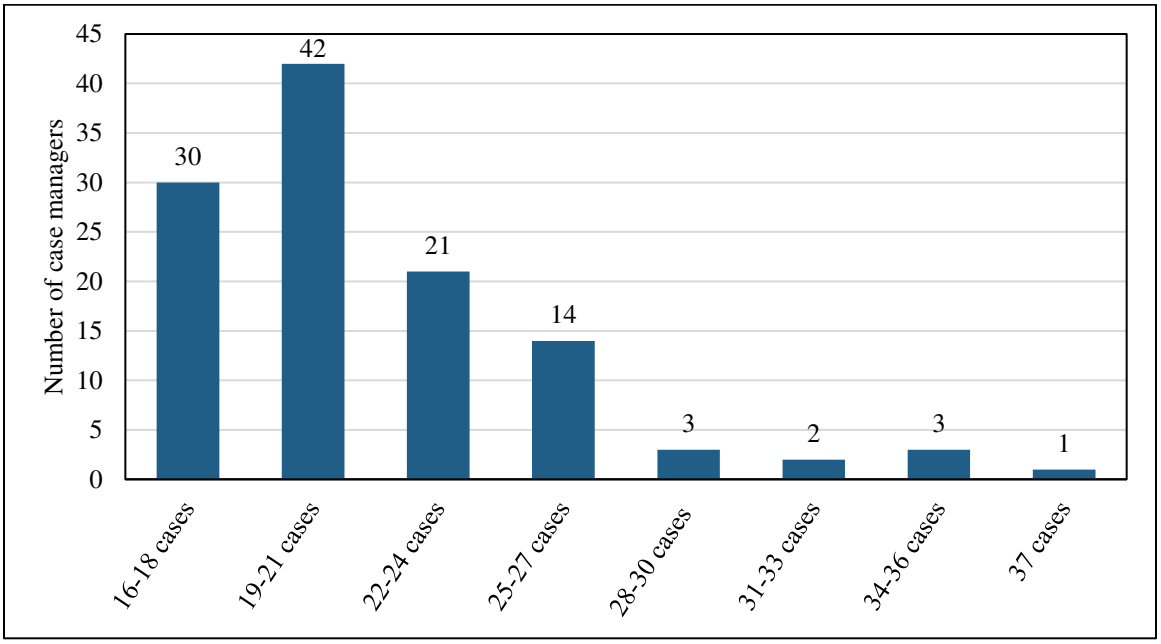


Source: CAPSS data provided by DSS

Figures 3 and 4 merge data for all foster care case managers – those newly hired as well as those hired more than six months prior. Figure 5 looks specifically at the number of cases carried by the 116 foster care case managers who were not new case managers (all had completed Child Welfare Certification more than six months prior), and had more than 15 cases on their caseload on September 30, 2019.

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

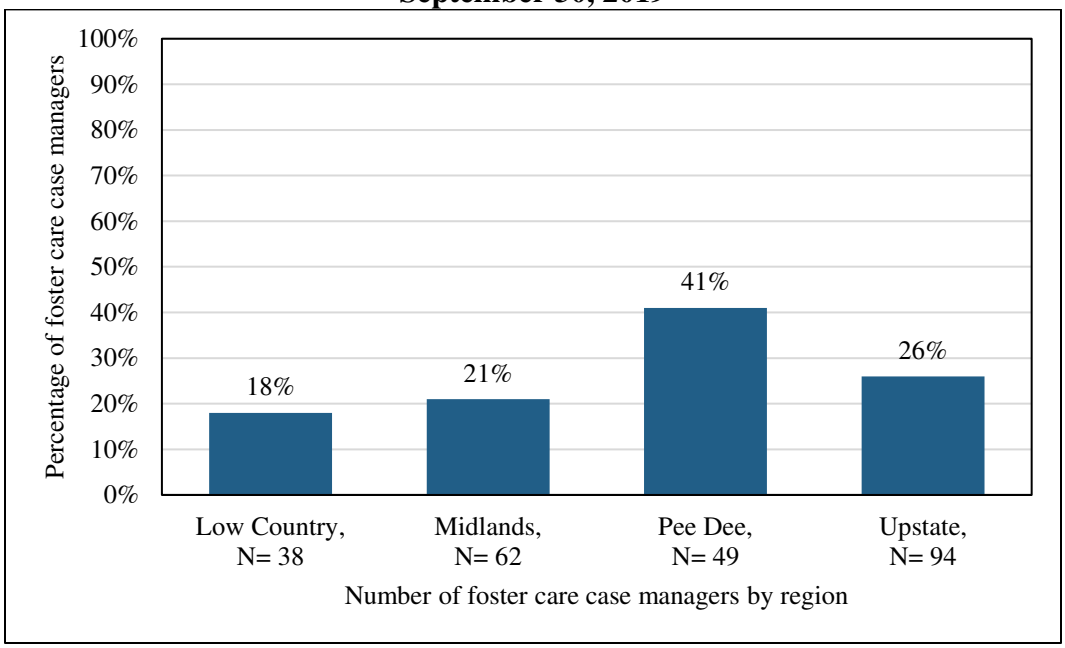
Figure 5: Number of Foster Care Case Managers Who Have Completed Certification Training More than Six Months Ago and are Over the Caseload Limit
September 30, 2019
N=167



Source: CAPSS data provided by DSS

DSS offices are divided among four regions, and each differ in terms of geographical size, the number of children and families served, and the number of assigned and onboarded case managers. Data on foster care case manager caseloads by region as of September 30, 2019, are shown in Figure 6.

Figure 6: Foster Care Case Managers by Region Within the Required Caseload Limits September 30, 2019



Source: CAPSS data provided by DSS

IFCCS Case Managers[105]

In September 2019, DSS began the transition of eliminating IFCCS as a separate caseload category, thus converting IFCCS case manager and supervisor positions into county foster care positions. The transition is scheduled to be complete by January 1, 2020. However, for the current reporting period, IFCCS positions continued to exist, and were required to maintain previously agreed upon caseload standards. As of September 2019, the number of IFCCS case managers was 79, a decline from 90 IFCCS case managers in August 2019, and 106 IFCCS case managers in April 2019. As discussed earlier in this section, the decline is attributable to the transition of positions to foster care units, as well as turnover in staff once the transition was announced. DSS worked to facilitate a smooth transition of staff, however, the performance data discussed below may have been impacted by shifts in staffing.

The caseload standard for case managers who are responsible for providing case management to children designated as needing IFCCS services is one case manager to nine children (1:9).[106]

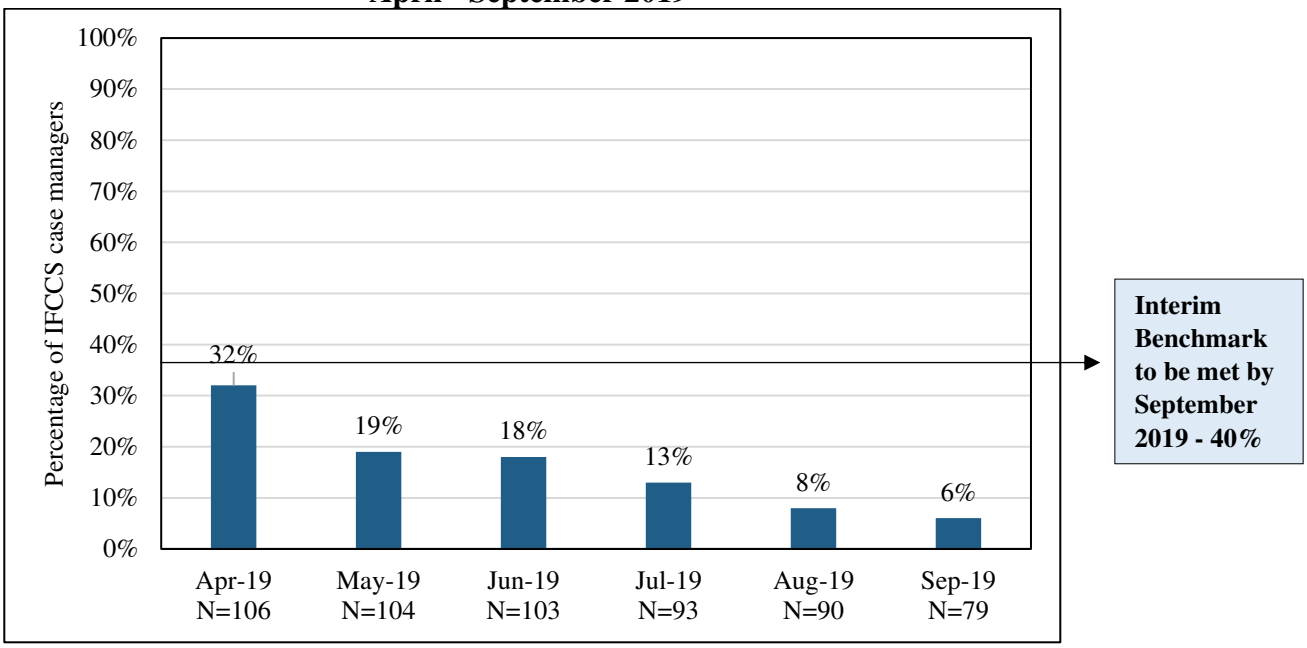
[105] Eligibility for IFCCS is determined following a review of a child's mental health assessment(s) and diagnosis; frequency, intensity, and duration of symptoms; multi-system involvement; and exhaustion of alternative services. IFCCS services utilize funding through SC's Interagency System for Caring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

[106] Following elimination of the IFCCS position, beginning January 2020, the caseload standard for case managers with children categorized as IFCCS on their caseload will be 1:15.

Newly hired IFCCS case managers should have no more than five children on their caseload for six months after they complete Child Welfare Certification training. The September 2019 interim benchmark for this measure is 40 percent and also requires that no case manager has a caseload of more than 180 percent of the standard by September 2019.

Between April and September 2019, a monthly range of six to 32 percent of IFCCS case managers had caseloads within the required limits (Figure 7), and 45 to 78 percent had caseloads that exceeded 125 percent of the caseload limit (Figure 8). Specifically, on September 30, 2019, there were 79 IFCCS case managers[107] serving at least one Class Member; five (6%) of these case managers were within the required caseload limit, and 62 (78%) case managers had caseloads more than 125 percent of the caseload limit. In September 2019, five (6%) case managers had a caseload of more than 180 percent of the standard.

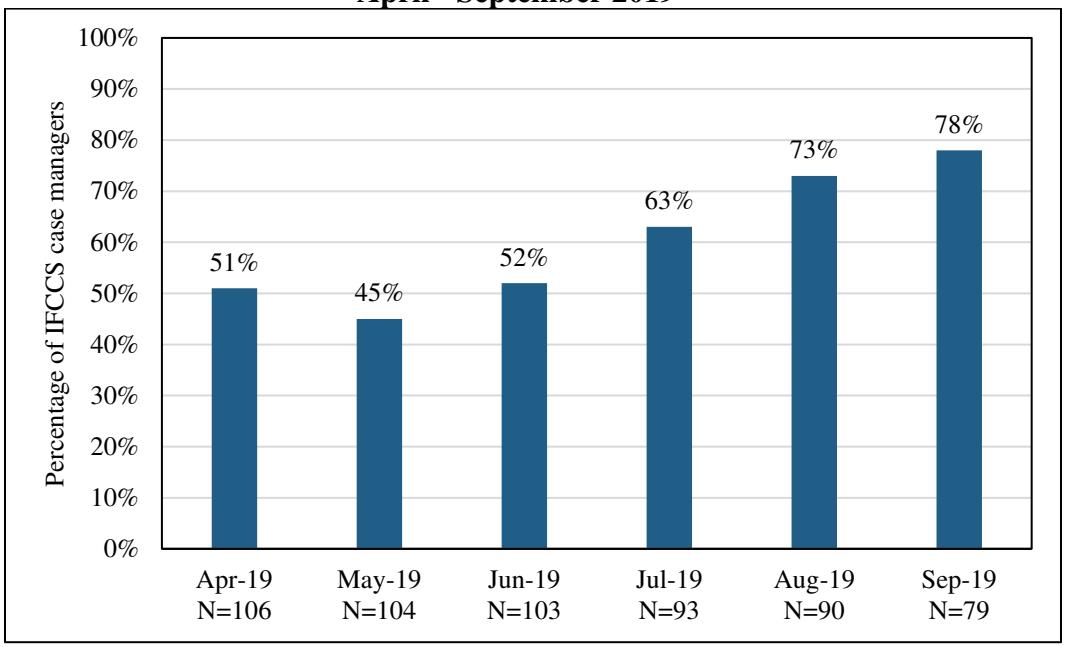
Figure 7: IFCCS Case Managers Within the Required Caseload Limits April - September 2019



Source: CAPSS data provided by DSS

[107] Total includes 7 newly hired IFCCS case managers with a caseload standard of 5 children.

Figure 8: IFCCS Case Managers over 125% of Required Caseload Limits April - September 2019[108]

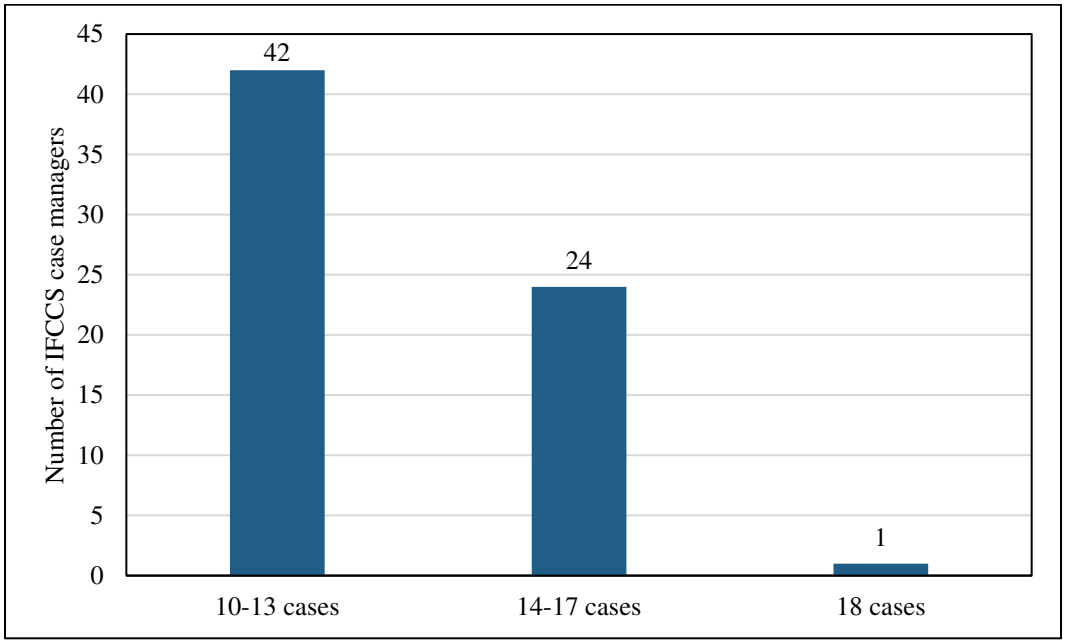


Source: CAPSS data provided by DSS

As of September 30, 2019, there were 67 IFCCS case managers who were not new case managers (completed Child Welfare Certification more than six months prior) and had more than nine children on their caseload. Figure 9 reflects the caseload size of these 67 case managers.

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

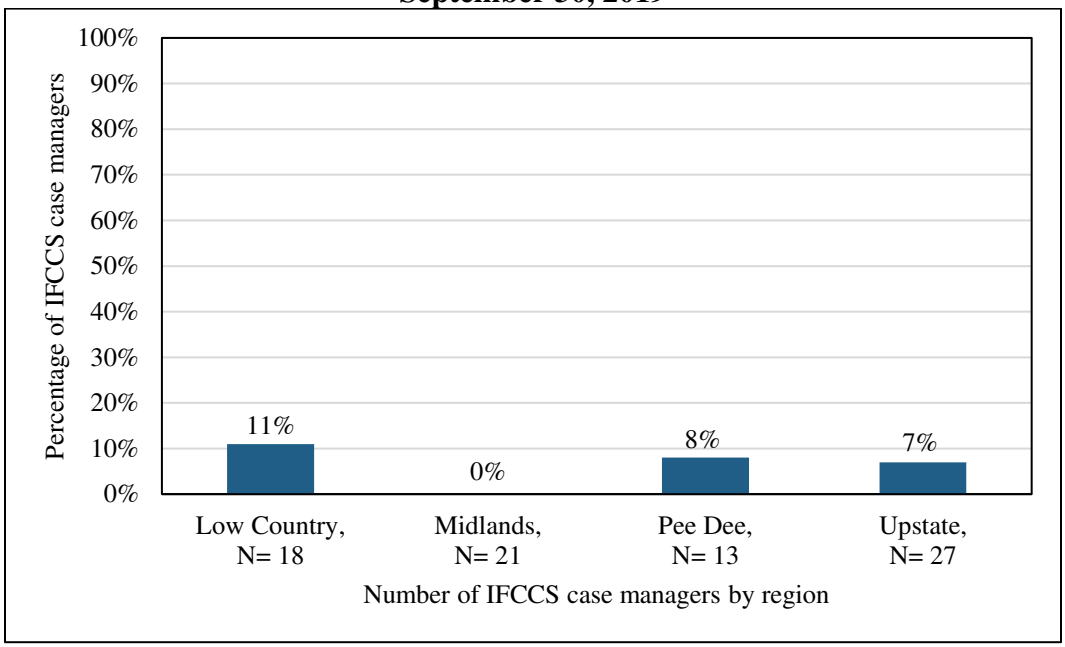
Figure 9: Number of IFCCS Case Managers Who Have Completed Certification Training More than Six Months Ago and are Over the Caseload Limit
September 30, 2019
N=67



Source: CAPSS data provided by DSS

Data on IFCCS case manager caseloads as of September 30, 2019, shown in Figure 10, reflect caseload compliance by region.

Figure 10: IFCCS Case Managers by Region Within the Required Caseload Limits September 30, 2019



Source: CAPSS data provided by DSS

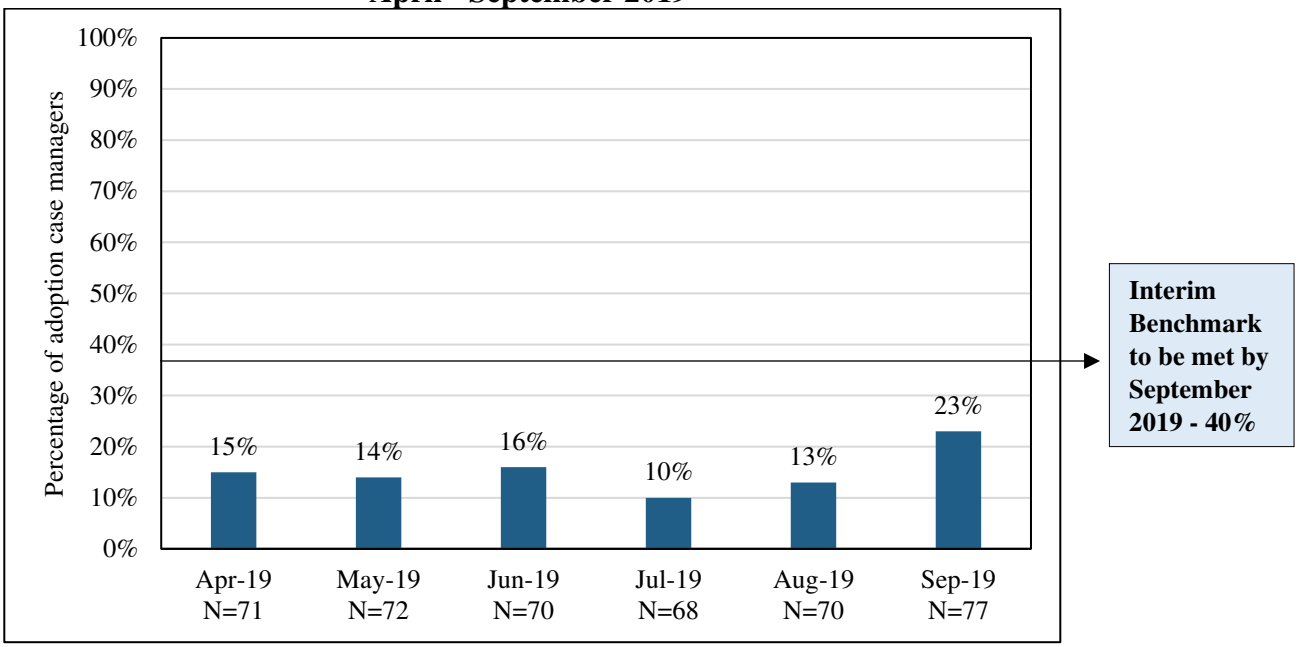
Adoption Case Managers

The caseload standard for case managers providing adoption support to children with a goal of adoption is one case manager to 17 children (1:17).[109] Newly hired adoption case managers should have no more than nine children on their caseload for six months after they complete Child Welfare Certification training. The September 2019 interim benchmark for this measure is 40 percent and also requires that no case manager has a caseload of more than 180 percent of the standard by September 2019.

Between April and September 2019, a monthly range of 10 to 23 percent of adoption case managers had caseloads within the required limit (Figure 11), and 66 to 71 percent had caseloads that exceeded 125 percent of the required limit (Figure 12). On September 30, 2019, there were 77 adoption case managers[110] serving at least one Class Member. Of these 77 case managers, 18 (23%) case managers had caseloads within the caseload requirement, and 53 (69%) case managers had caseloads that exceeded 125 percent of the limit. Additionally, 22 (29%) adoption case managers had a caseload of more than 180 percent of the standard.

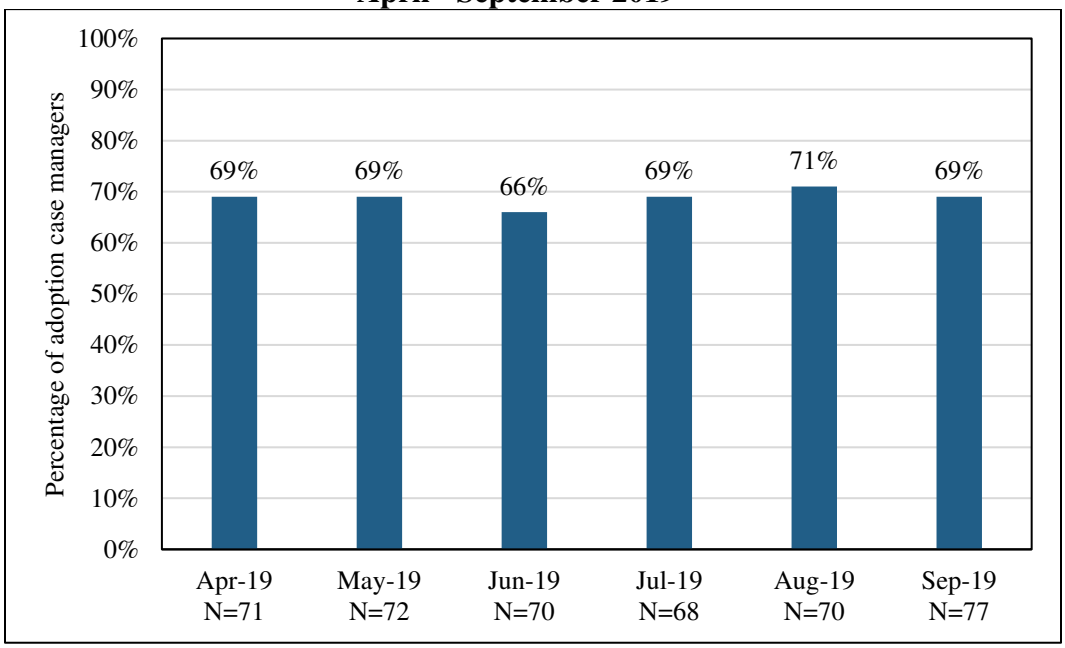
[109] In approving these caseload limits, the Co-Monitors noted that although a caseload of 17 children for adoption case managers is not within the standard proffered by the Council on Accreditation, as DSS was structured at that time, case management responsibilities remained with the foster care case manager, even when an adoption case manager is assigned, until a placement agreement is signed. As discussed later in this section, DSS is in the process of eliminating the practice of foster care and adoption case managers sharing case management responsibility on individual cases. This will result in a modification to the adoption caseload standard beginning January 2020 to 1:15, the same standard applied to foster care case managers.
[110] Total includes 19 newly hired adoption case managers with a caseload standard of 9 children.

Figure 11: Adoption Case Managers Within the Required Caseload Limits April - September 2019



Source: CAPSS data provided by DSS

Figure 12: Adoption Case Managers over 125% of Required Caseload Limits April - September 2019[111]



Source: CAPSS data provided by DSS

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

Out of Home Abuse and Neglect (OHAN) Case Managers

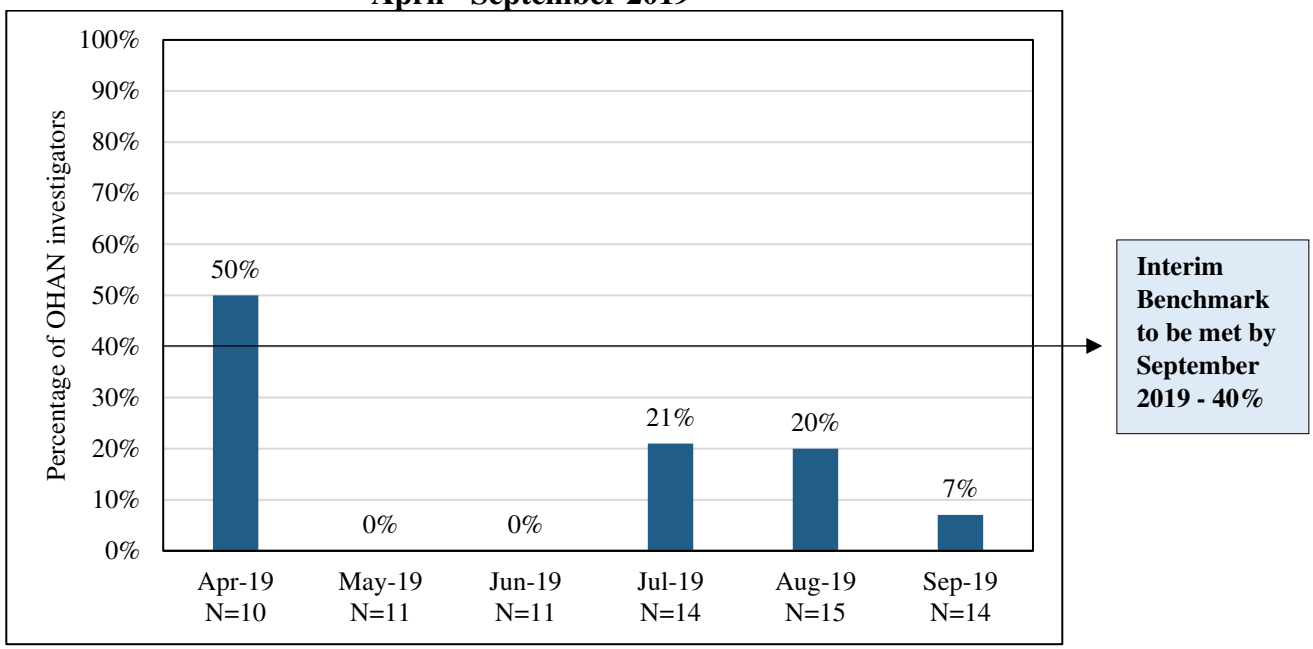
The caseload standard for case managers conducting investigations involving allegations of abuse and/or neglect of a child in foster care is one case manager per eight investigations (1:8). Newly hired OHAN case managers should have no more than four children on their caseload for six months after they complete Child Welfare Certification training. The September 2019 interim benchmark for this measure is 40 percent and also requires that no case manager has a caseload of more than 180 percent of the standard by September 2019.

Although DSS has added new OHAN case managers carrying cases between April and September 2019, the number of investigations has increased over 40 percent within the same timeframe – from 158 investigations in April 2019 to 231 investigations in September 2019. DSS has not determined a cause for this increase, and it is unclear what this may mean for determining the requisite number of staff for the OHAN unit.

Between April and September 2019, a monthly range of zero to 50 percent of OHAN case managers had caseloads within the required limits (Figure 13), and 50 to 100 percent of case managers had caseloads that exceeded 125 percent of the required limit each month (Figure 14). Large fluctuations in performance between months is due to the small number of investigators assigned investigations each month.[112] Specifically, on September 30, 2019, of the 14 OHAN investigators, one (7%) of the investigators had a caseload within the required standard, and 13 (93%) investigators had caseloads over 125 percent of the required limit. Additionally, 10 (71%) OHAN investigators had caseloads of more than 180 percent of the standard.

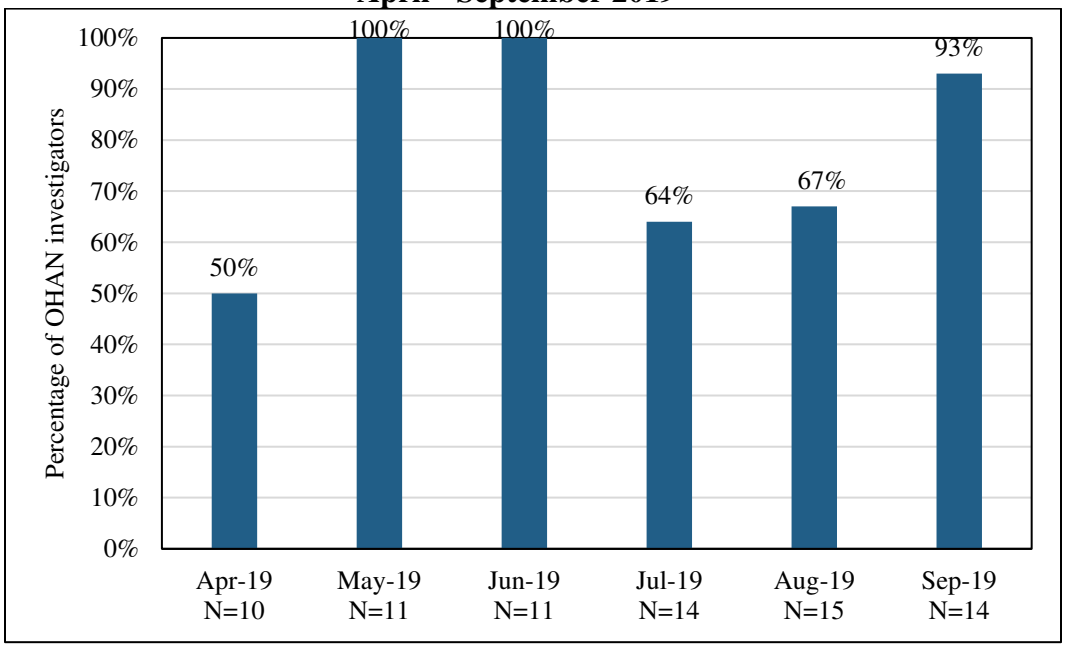
[112] Number of OHAN investigators accepting investigations each month are as follows: April 2019, 10 workers; May 2019, 11 workers; June 2019, 11 workers; July 2019, 14 workers; August 2019, 15 workers; and September 2019, 14 workers.

Figure 13: OHAN Investigators Within the Required Caseload Limits
April - September 2019



Source: CAPSS data provided by DSS

Figure 14: OHAN Investigators over 125% of Required Caseload Limits
April - September 2019[113]



Source: CAPSS data provided by DSS

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

Table 4 includes the specific caseload size of each OHAN investigator on September 30, 2019. As reflected below, the distribution of caseload size across workers is uneven, with some worker's caseloads triple the size of others. DSS reports that this is primarily due to assignment of workers and cases by regions. For example, if more investigations are received in one region, the investigators within that region are assigned more cases than others. DSS reports leadership assesses case distribution and staffing on an ongoing basis, and supervisors review caseloads weekly to assess for balance across investigators. DSS may place newly hired staff to areas where the number of investigations are high, and may distribute investigations within one region to staff assigned to another region for balance.

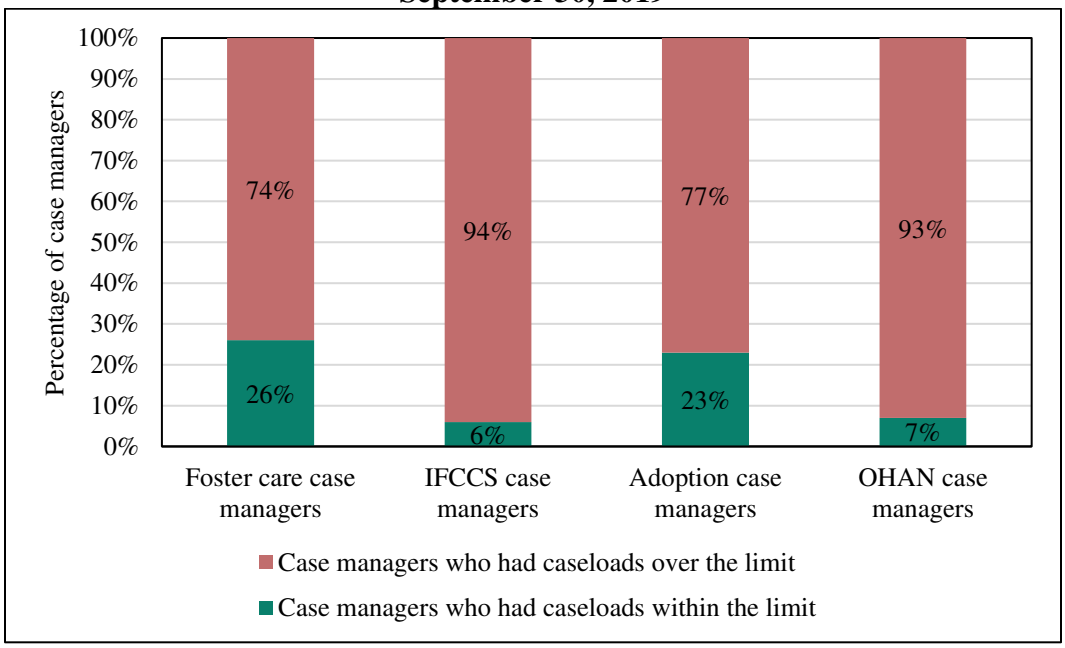
Table 4: Caseload Size for OHAN Case Managers
September 30, 2019

Case manager	Number of Investigations
Case manager 1	7
Case manager 2 (new worker)	11
Case manager 3	11
Case manager 4 (new worker)	13
Case manager 5	13
Case manager 6	14
Case manager 7	16
Case manager 8	17
Case manager 9	18
Case manager 10	20
Case manager 11	20
Case manager 12	22
Case manager 13	24
Case manager 14	25
Total - 14 case managers	**Total - 231 investigations**

Source: CAPSS data provided by DSS

In summary, Figure 15 reflects the percentage of foster care, IFCCS, adoption, and OHAN case managers within and over the required caseload limits on September 30, 2019.

Figure 15: Foster Care, IFCCS, Adoption, and OHAN Case Managers that were Within and Over the Required Caseload Limits September 30, 2019



Source: CAPSS data provided by DSS

The Workforce Implementation Plan includes interim targets that require that no case manager has a caseload of more than 180 percent of the caseload standard by September 2019, no case manager has more than 170 percent of the standard by March 2020, and no case manager has more than 160 percent of the standard by September 2020. Table 5 reflects the percentage of case managers, by type, who had more than 180 percent, 170 percent, and 160 percent of the caseload standard as of September 30, 2019.

Table 5: Percentage of Workers with Caseloads More than 180%, 170%, and 160% of the Required Caseload Standard September 30, 2019

Worker Type	More than 180% (to be eliminated by September 2019)	More than 170% (to be eliminated by March 2020)	More than 160% (to be eliminated by September 2020)
Foster Care Case Managers N=243	18%	23%	28%
IFCCS Case Managers N=79	6%	11%	24%
Adoption Case Managers N=77	29%	35%	38%
OHAN Case Managers N= 14	71%	79%	86%

Source: CAPSS data provided by DSS

Supervisor Workloads

The Workload Implementation Plan includes separate timelines and interim benchmarks for supervisors. The first interim benchmark begins September 2019, with a goal of reaching final target levels by September 2020 (Tables 6 and 7).

Table 6: Baseline, Timeline, and Interim Benchmarks for Supervisors Within the Required Workload Limits

Baseline	
March 2018	45%
Timeline	**Interim Benchmark**
September 2019	**72%**
March 2020	80%
Final Target - September 2020	**90%**

Source: Workload Implementation Plan

Table 7: Baseline, Timeline, and Interim Benchmarks for Supervisor Workload More than 125% of the Required Limit

Baseline	
March 2018	31%
Timeline	**Interim Benchmark**
September 2019	**20%**
March 2020	10%
Final Target - September 2020	**0%**

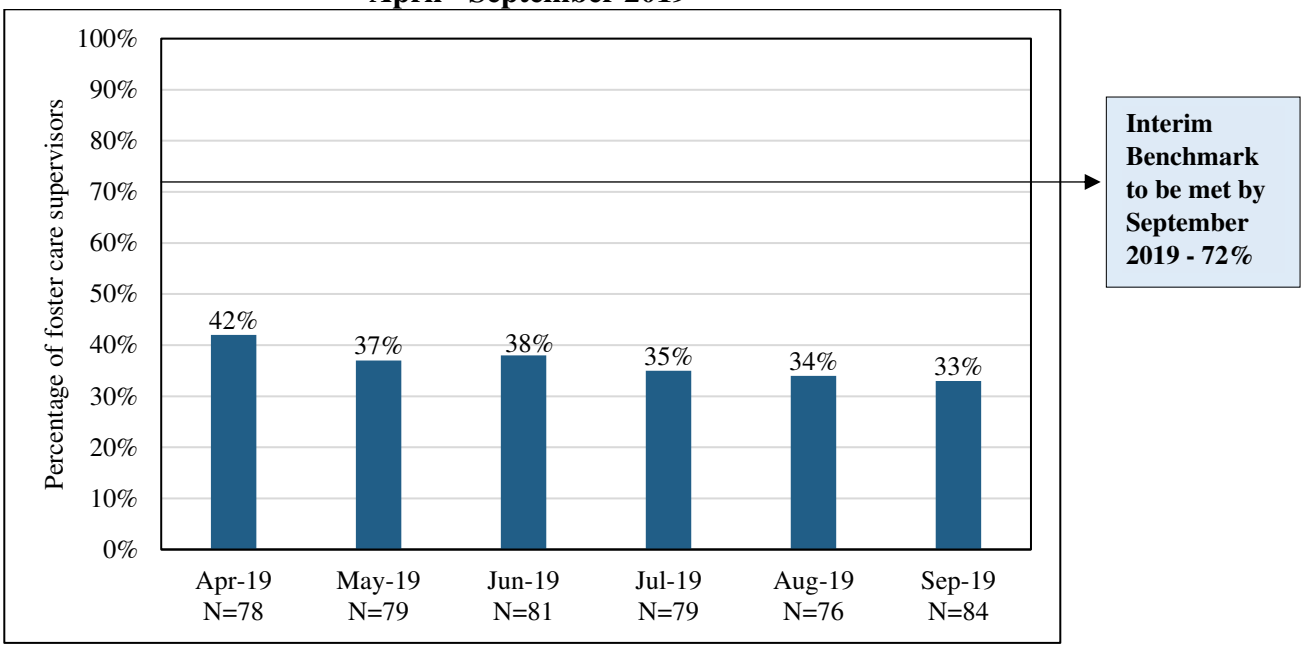
Source: Workload Implementation Plan

Foster Care Supervisors

The workload standard for supervisors providing supervision to foster care case managers is one supervisor to five case managers (1:5). The September 2019 interim benchmark for this measure is 72 percent of supervisors meet the workload requirement, and no more than 20 percent of supervisors have more than 125 percent of the required limit.

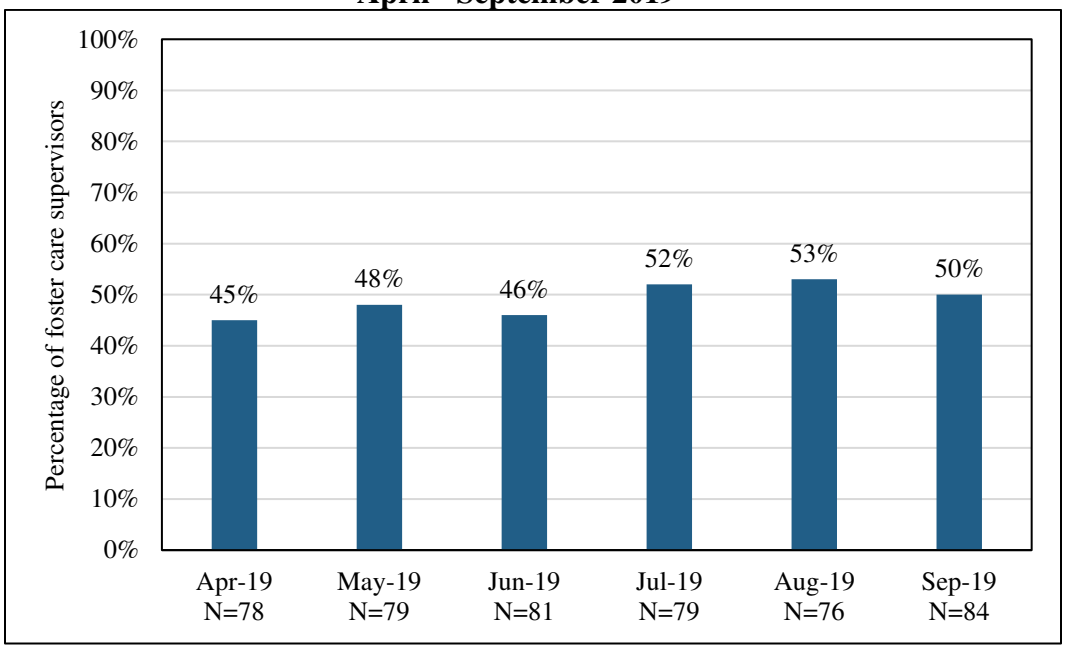
Between April and September 2019, a monthly range of 33 to 42 percent of foster care supervisors supervised five or fewer case managers (Figure 16), and 45 to 53 percent of supervisors had workloads more than 125 percent of the required limit (Figure 17). Specifically, on September 30, 2019, of the 84 supervisors supervising foster care case managers, 28 (33%) supervised five or fewer case managers, and 42 (50%) supervisors had workloads more than 125 percent of the required limit.

Figure 16: Foster Care Supervisors Within the Required Workload Limits April - September 2019



Source: CAPSS data provided by DSS

Figure 17: Foster Care Supervisors with Workloads More Than 125% of the Required Limit April - September 2019[114]



Source: CAPSS data provided by DSS

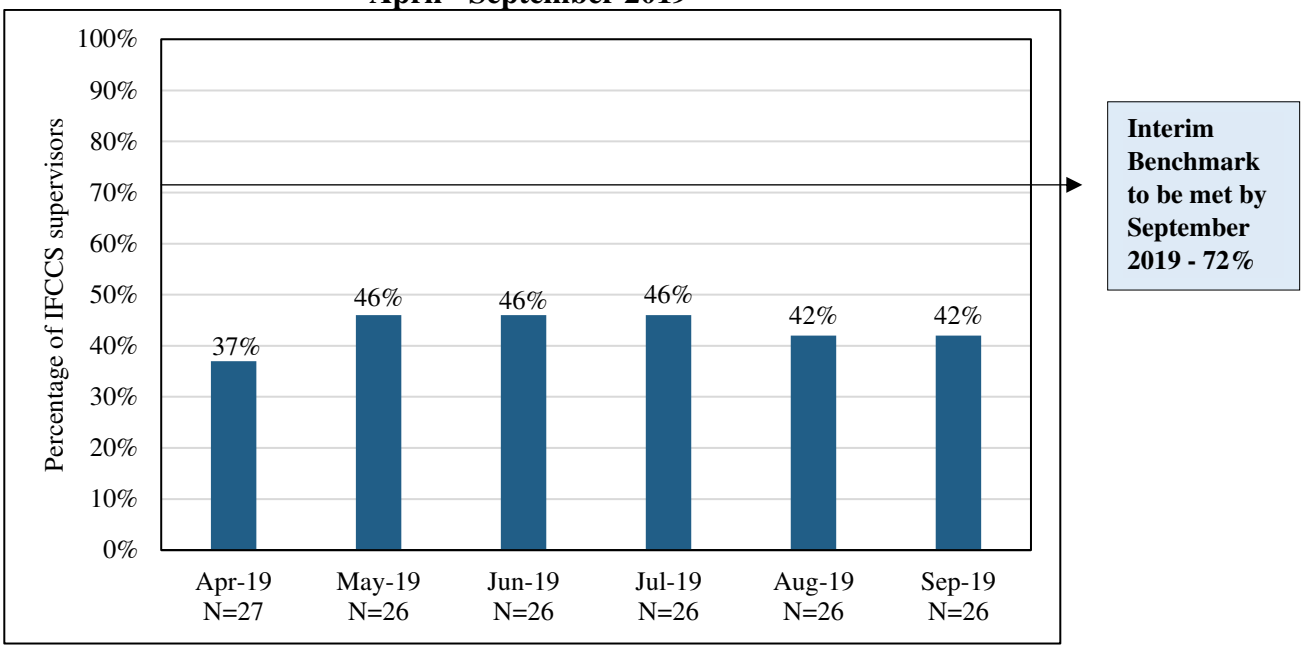
IFCCS Supervisors[115]

The workload standard for supervisors providing supervision to IFCCS case managers is one supervisor to five case managers (1:5). The September 2019 interim benchmark for this measure is 72 percent of supervisors meet the workload requirement, and no more than 20 percent of supervisors have more than 125 percent of the required limit.

Between April and September 2019, a monthly range of 37 to 46 percent of IFCCS supervisors supervised five or fewer case managers (Figure 18), and 37 to 42 percent of supervisors had workloads of more than 125 percent of the required limit (Figure 19). Specifically, on September 30, 2019, of the 26 supervisors supervising IFCCS case managers, 11 (42%) supervisors supervised five or fewer case managers, and 11 (42%) supervisors had workloads more than 125 percent over the required limit.

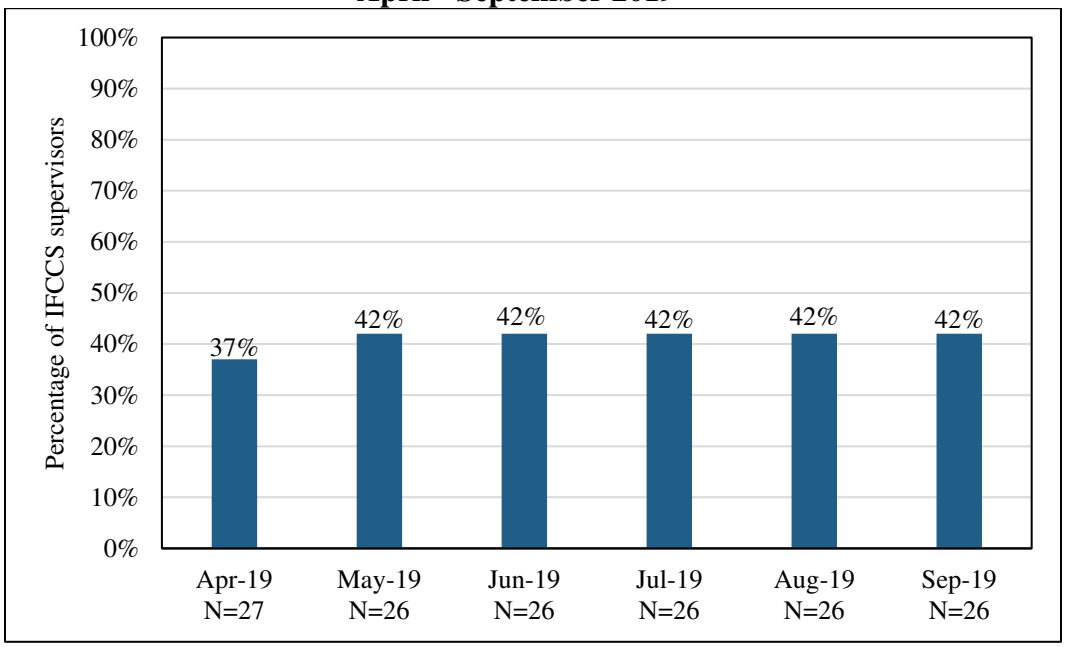
[114] The interim benchmark for this measure is 20% by September 2019. The final target is 0%.
[115] As described further in this section, IFCCS case manager and supervisor positions are being eliminated, with staff positions and cases transferred to county foster care staff and caseloads between September and December 2019.

Figure 18: IFCCS Supervisors Within the Required Workload Limits
April - September 2019



Source: CAPSS data provided by DSS

Figure 19: IFCCS Supervisors with Workloads More Than 125% Over the Required Limit
April - September 2019[116]



Source: CAPSS data provided by DSS

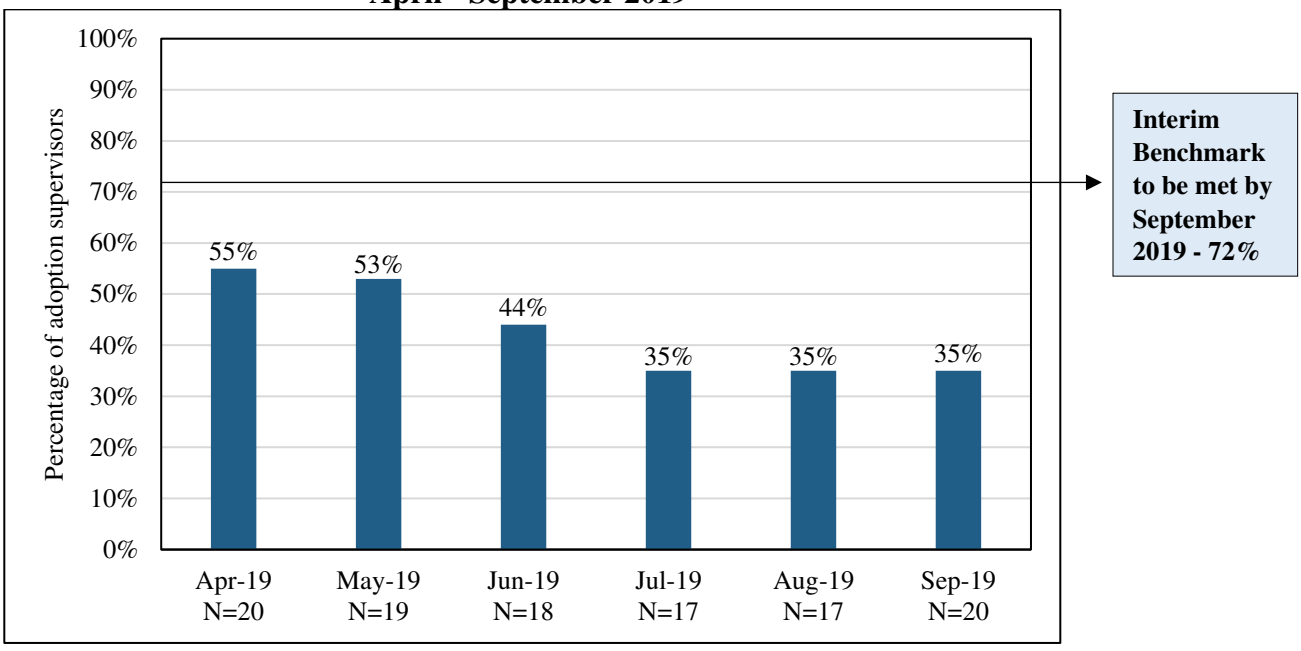
[116] The interim benchmark for this measure is 20% by September 2019. The final target is 0%.

Adoption Supervisors

The workload standard for supervisors providing supervision to adoption case managers is one supervisor to five case managers (1:5). The September 2019 interim benchmark for this measure is 72 percent of supervisors meet the workload requirement, and no more than 20 percent of supervisors have more than 125 percent of the required limit.

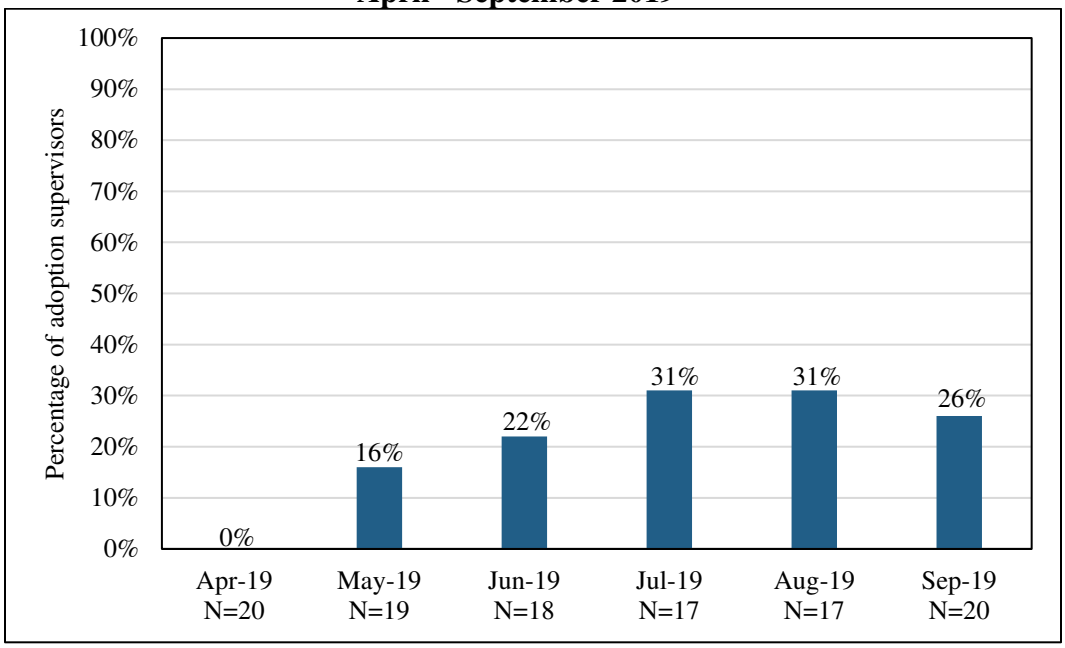
Between April and September 2019, a monthly range of 35 to 55 percent of adoption supervisors supervised five or fewer case managers (Figure 20), and zero to 31 percent of supervisors had workloads of more than 125 percent of the required limit (Figure 21). Specifically, on September 30, 2019, of the 20 supervisors supervising adoption case managers, seven (35%) supervisors supervised five or fewer case managers, and five (26%) supervisors had workloads more than 125 percent over the required limit.

Figure 20: Adoption Supervisors within the Required Workload Limits April - September 2019



Source: CAPSS data provided by DSS

Figure 21: Adoption Supervisors with Workloads More Than 125% Over the Required Limit April - September 2019[117]



Source: CAPSS data provided by DSS

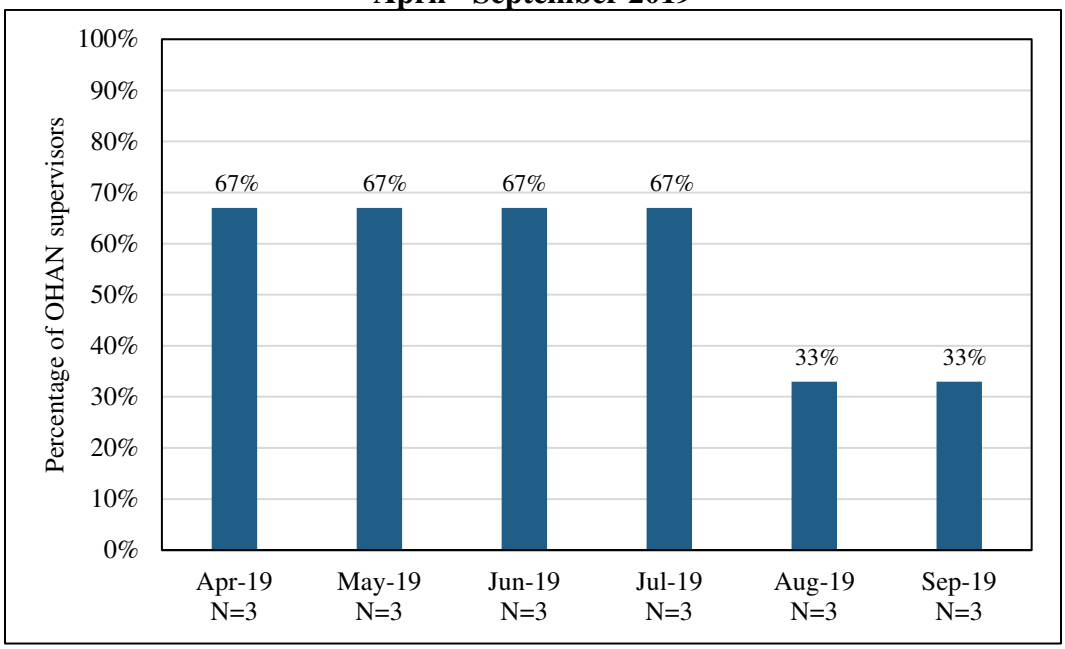
OHAN Supervisors

The workload standard for supervisors providing supervision to case managers conducting OHAN investigations is one supervisor to six investigators (1:6).[118] The September 2019 interim benchmark for this measure is 72 percent of supervisors meet the workload requirement, and no more than 20 percent of supervisors have more than 125 percent of the required limit.

Between April and September 2019, a monthly range of 33 to 67 percent of OHAN supervisors supervised six or fewer case managers (Figure 22),[119] and each month, one (33%) supervisor had a workload of more than 125 percent of the required limit (Figure 21). In September 2019, there were three OHAN supervisors, and one (33%) supervisor was responsible for six or fewer case managers.

[117] The interim benchmark for this measure is 20% by September 2019. The final target is 0%.
[118] The Co-Monitors approved the higher caseload standard for OHAN supervisors in recognition of the fact that the OHAN case managers they supervise will have lower caseloads than other direct service case managers.
[119] Large fluctuations in performance are due to the small number of supervisors each month.

Figure 22: OHAN Supervisors Within the Required Workload Limits
April - September 2019



Source: CAPSS data provided by DSS

B. Workload Implementation Plan

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

The Workload Implementation Plan was approved by the Co-Monitors on February 20, 2019, and approved by the Court on February 27, 2019.[120] The strategies within the Plan focus primarily on improvements to infrastructure and hiring, training, and retention of case managers and supervisors. The strategies are sequenced for short-term implementation (due January 2019 through January 2020), intermediate term implementation (due July 2019 through July 2020), and longer term implementation (due July 2020 through 2023). The discussion below includes implementation updates of short-term and some intermediate strategies due during this monitoring period. Appendix B of this report includes a list of all strategies due this period.

Case Assignment and Worker Categories

As discussed previously, DSS has historically organized its case carrying workers for Class Members into several types: (1) foster care case managers who are located and supervised through

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

county offices; (2) adoption case managers who are frequently secondary case managers for children in foster care with permanency goals of adoption but who are not yet legally free for adoption; and (3) IFCCS case managers who are assigned to children with significant mental or behavioral health needs, and are located and supervised through one of the state's four regional DSS offices.

In an effort to streamline case assignment and practice, the Workload Implementation Plan requires DSS to eliminate duplication in case assignment and more fully utilize adoption case managers by discontinuing the practice of assigning children's cases to both adoption and foster care case managers, and assuring that children and families have one point of contact for communication and planning. This transition is occurring in five phases. The first phase began in February 2019, and involved the assignment of children's cases solely to an adoption case manager if a child's permanency goal is adoption, the child is legally free to be adopted and is placed with a family that has signed an adoption agreement or a pre-adoption agreement. The second phase, which was also underway in February 2019, ensured that the siblings of the children identified in the first phase were also assigned to an adoption worker. The third phase, which DSS projected to begin in July 2019, transferred children with a permanency plan of adoption, who were free for adoption but did not have an identified adoptive resource, from county case managers to the sole case management of an adoption worker. The fourth phase transferred children who were being managed by IFCCS case managers, and who have a permanency plan of adoption, are free for adoption, are siblings of children case managed by an adoption worker, but who do not have an identified adoptive resource, to the sole management of adoption workers. The fifth phase transfers all other children who are free for adoption and managed by IFCCS case managers to the sole management of adoption case managers.[121] DSS reports that work is underway, but not yet complete, for all five transition phases, however, vacancies within the adoption offices have slowed progress.

On May 31, 2019, DSS decided to eliminate IFCCS as a separate workload and staffing category. This change was recommended following the assessment of an expert workforce consultant who determined that, in most instances, IFCCS staff did not possess a higher level of training or skill than other foster care case managers, and that assigning case management solely based on the needs of the child as determined at one point in time diminishes the focus on case and permanency planning with families. In September 2019, DSS developed a transition plan with the following schedule.[122]

- By September 31, 2019, DSS will conduct regional informational meetings regarding the restructure.

[121] See Appendix B for a more detailed explanation of each phase and timeline for transfers.
[122] The Implementation Plan requires DSS to develop a transition plan by August 30, 2019. The Joint Report modified this Implementation Plan strategy, and requires DSS to finalize the transition plan for phasing out IFCCS case managers and determine staffing and fiscal impact by September 30, 2019.

- By October 30, 2019, Human Resources will update position descriptions, location changes, and supervisor changes, as needed. Additionally, DSS will coordinate staffings within county offices to shift siblings who are currently being managed by two case managers to one case manager.
- By November 30, 2019, DSS will conduct regional training on SC's Interagency System for Caring for Emotionally Disturbed Children (ISCEDC) process,[123] and new Well-Being Team members will receive training on new job tasks.
- By December 1, 2019, DSS will complete realignment of Well-Being Team job tasks.
- By December 31, 2019, DSS will complete the transfer of FCCS case managers and supervisors to the county structure, and transfer cases as needed.

DSS reports that all IFCCS staff were transitioned into foster care units by the end of December 2019.

In response to specific concerns about the caseloads of case managers responsible for investigating allegations of abuse or neglect against children in foster care – DSS's OHAN unit – the Workload Implementation Plan requires DSS to hire nine new OHAN investigators, and make offers of employment to identified candidates by March 17, 2019. These offers were made by the required date, and all candidates accepted. Most of the new hires had previously completed Child Welfare Certification training, and completed the newly developed investigation training curriculum shortly after hire. The newly hired staff who had not completed Child Welfare Certification training were enrolled and completed the training in mid-June 2019. As of October 2019, OHAN had 16 investigator positions; 14 positions were filled and there were two vacancies. One of the vacancies was filled in mid-November 2019. OHAN has three supervisor positions, and although all were filled in August 2019, by December 2019, one position became vacant, and a second supervisor went out on leave for several months. Reports indicate there was some delay in posting the case manager and supervisor positions once they became vacant in late 2019, and early 2020. DSS reports interviews for both positions are being conducted in February 2020.

By September 30, 2019, DSS was required to assess OHAN caseloads and determine how many additional staff may be needed to bring staff to the required caseload standards, and begin the process for allocation of additional positions. DSS's FY2020-2021 budget request includes 11 new positions for OHAN.

As required by the Joint Report, DSS reports prioritizing filling vacancies as they occur, and developing retention strategies to maintain current OHAN staff, including alignment of caseloads

[123] Children are determined to be eligible for ISCEDC funding for payment of treatment costs following a review of the child's mental health assessment(s) and diagnosis; frequency, intensity, and duration of symptoms; multi-system involvement; and exhaustion of alternative services. ISCEDC funding are pooled dollars from multiple state agencies, including DSS, the Department of Mental Health, the Department of Disabilities and Special Needs, the Department of Juvenile Justice, and the Department of Education.

with the FSA standards, and providing recognition awards on a quarterly basis in the following categories – best investigator dictation, investigations that include contact with all core witnesses, and notification to parties of post-case decision.

Implementation of Stay Interviews (due June 30, 2019)
DSS developed a new process for gathering retention information from DSS staff, which was presented to County Directors on August 27, 2019. The process consists of interviews (using a structured tool) with new staff at 30 days and six months after employment begins. In addition to in-person interviews, DSS utilizes a survey to collect feedback from new staff. The survey includes questions about job satisfaction and working conditions, and is sent to staff at three months, nine months, and 12 months after their date of hire.

In October 2019, 40 surveys were sent to new case carrying staff, and by the end of November 2019, 18 surveys had been completed and returned. DSS reports that survey results are sent to County Directors, and interviews are scheduled with the staff and their supervisor to follow up.

Engagement of South Carolina public university departments of social work in developing a partnership using provisions for federal funding available under Title IV-E of the Social Security Act (due June 30, 2019)
The goal of this strategy is to develop a partnership with SC university schools of social work to support the training and professional development of social workers who can then be hired by the Department to perform child welfare work. To assist in implementation of this strategy, in addition to other strategies within the Plan, DSS committed to hiring a Child Welfare Workforce Developer within 90 days of Plan finalization.[124] DSS reports the new Workforce Developer started employment on November 4, 2019, and since her hire, has made contact with child welfare staff in Tennessee, Louisiana, and New Jersey to explore their use of university partnerships.

On December 11, 2019, DSS convened a meeting with representatives from USC (Columbia and Upstate Campuses), Winthrop, and SC State to learn more about their social work programs and determine interest in forming a training partnership. A draft MOU which establishes the work of the "University Partnership Planning Team" has been drafted and finalized with input from universities. As of the writing of this report, DSS was awaiting signatures from university partners. DSS reports the Team will convene within 30 days of the MOUs being executed. DSS has targeted spring 2021 for student participation, pending resources requested in the FY2020-2021 budget.

Increased Salaries for Staff with BSW and MSW Degrees
One of the foundational strategies in the Workload Implementation Plan is the adoption of a new salary schedule for case managers and supervisors that will raise entry level salaries significantly,

[124] The Joint Report amended the date for hire of a Child Welfare Workforce Developer from June 30, 2019 to October 31, 2019.

and provide for structured increases based on education, training, and longevity.[125] The salary schedule in the approved Plan provides greater parity with case manager salaries in states with similar demographic characteristics, and ensures staff receive a living wage upon hiring or no later than within two to three years of employment. To implement this strategy, DSS included a request for the necessary funds within its FY2020-2021 budget, for implementation to begin in July 2020.

Review of current procedures for approving requests for authorizations of salary above the minimum and for salary increases within pay band and make any changes needed to ensure that they are based upon clear, objective, and consistently applied criteria (DSS communication of procedures and criteria in writing to all staff by June 30, 2019).
DSS reports a draft communique was distributed to staff on October 14, 2019. DSS anticipates finalizing a policy with procedures for approving salary requests by February 2020.

VI. VISITS BETWEEN CASE MANAGERS AND CHILDREN

It is essential that case managers have regular, face-to-face contact with children in foster care. Beyond simply seeing a child, visits allow case managers to build relationships with children and caregivers, to assess for safety and underlying needs, and to ensure children are healthy and supported. Visits should occur at least monthly, and in a child's residence whenever possible.

Since entry into the FSA, DSS has reported that monthly contact between case managers and children in foster care has been occurring in nearly all cases. However, these contacts have not been consistently documented or held in a manner that aligns with practice expectations. For the first time this period, DSS can report reliable data from a review of a statistically valid sample of case records assessing documentation of case manager contacts with children. Data collected reflect that in more than three-quarters of cases, children did not visit with their case manager in a manner that accords with practice expectations. This is a serious concern.

The steps DSS has taken to memorialize practice expectations and measure progress in meeting those expectations are important ones. Continued attention to system and practice improvements and implementation of the Visitation Implementation Plan – combined with manageable caseloads, integration of a model of case practice, and placement of children closer to home – can begin to improve performance in this critical area.

[125] Under the current salary schedule, the average case manager at DSS, who does not have a social work degree, earns $35,541. Under the new salary schedule, the baseline salary for Level 1 case managers who do not have a social work degree will be $46,000; the top range of this position - for case managers with 10 years of experience and within the Level 3 classification - will be $55,261.33.

A. Performance Data

The FSA requires "*at least 90% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place,"* and "*at least 50% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place in the residence of the child"* (FSA IV.B.2.&3.). The total minimum number of monthly visits between children and a case manager refers to a federal requirement of a minimum of one visit per month.

To determine baseline performance, the Co-Monitors, DSS, and USC staff developed a review instrument and process for evaluating the extent to which documentation of a face-to-face contact between a case manager and child align with practice expectations.[126] A sample of 338 records[127] were reviewed, to gather data on whether the record reflected that the child was seen alone; there was a summary of the conversation; there were assessments of safety, permanency, and well-being; there was discussion of the status of services being delivered; and there was a discussion of the status of the case plan. As discussed later in this section, these activities are outlined as requirements in the Foster Care Visitation section of DSS Policy and Procedure.

Reviewers confirmed documentation of a face-to-face contact between the case manager and child in September 2019 in nearly all (99%/335 of 338)[128,129] cases. Reviewers also confirmed that during September 2019, there was documentation supporting case managers made almost all (92%/312 of 338) of those face-to-face contacts in the child's residence. This result supports CAPSS data are reliable for whether a face-to-face contact occurred, and the location of that contact.

However, further assessment shows that only 24 percent (80 of 338) of records reflected documentation of practice consistent with each required component of a visit. Twenty-two percent (73 of 338) of records reflected practice consistent with each required component of a visit, and that the child was seen at their residence. This performance is well below the performance standard of 90 percent. It reflects both the need for improved documentation and practices with children.

[126] DSS, USC CCFS, and the Co-Monitors worked together to develop an instrument and reviewed a statistically valid sample of case records for which there was indication in CAPSS that a case manager had face-to-face contact with a Class Member in the month of September 2019. Reviewers assessed documentation reflecting the elements which define a visit, as reflected in DSS policy and guidance on documentation, in the CAPSS dictation of the face-to-face contact. The goal for reporting on this measure is reliable, aggregate CAPSS data which reflect practices with children.

[127] The sample size of 338 was determined for the universe of 2,755 (Class Members in foster care on November 4, 2019 who had been in care for 30 or more days for which there was indication in CAPSS that a case manager had face-to-face contact with a Class Member in the month of September 2019) using a +/-5% margin of error and 95% confidence level.

[128] Three cases were removed from the sample because the Class Member resided in another state. Those cases were replaced from an oversample list. DSS will remove cases of children residing in another state from the universe for this review and will conduct a special review of the cases of those children in the future.

[129] In 1 record, there was no documentation of a face-to-face contact with the child during September 2019. In 4 remaining cases, the reviewer determined documentation for September 2019 was identical to previous months, not reflecting a unique contact. The reviewer could not determine, based on the documentation, whether the child was indeed seen in September 2019.

The Co-Monitors will work with DSS to develop interim benchmarks for case manager visits with children.

When assessing documentation, reviewers found the following:

- 80 percent (270 of 338) of the cases demonstrated a summary of conversations and observations;
- 60 percent (202 of 338) of the cases demonstrated that the case manager saw the child alone;[130]
- 11 percent (36 of 338) of the cases demonstrated clear documentation that someone else was present when the case manager spoke with the child;[131]
- 28 percent (96 of 338) of the cases were not clear whether someone else was present when the case manager spoke with the child;[132]
- 77 percent (260 of 338) of the cases demonstrated that the case manager discussed the topics of well-being with the child;
- 66 percent (256 of 338) of the cases demonstrated that the case manager discussed the status of services being delivered with the child; and
- 57 percent (192 of 338) of the cases demonstrated that the case manager discussed the status of a case plan with the child.

B. Visitation Implementation Plan

The Co-Monitors approved DSS's Visitation Implementation Plan on March 28, 2019.[133] Pursuant to the Plan, Parties agreed, for purposes of measuring compliance with the FSA, that a case manager's visit with a child must include the following elements as set out in DSS Policy and Procedure (Chapter 5, Foster Care Visitation, effective June 1, 2019):[134]

- An interview with the child alone, away from both the caregiver and other children in the home;

[130] Reviewers applied the requirement that children be seen alone as developmentally appropriate. In general, the expectation is that infants, toddlers, and children under the age of 4 could be seen in the presence of a caregiver.
[131] This may have affected the reviewer's determination of whether a safety assessment was conducted. The expectation is that a verbal child is given the opportunity to speak with their case manager in private.
[132] This may have affected the reviewer's determination of whether a safety assessment was conducted. The expectation is that a verbal child is given the opportunity to speak with their case manager in private.
[133] The Visitation Implementation Plan is available at: https://dss.sc.gov/media/1956/3-28-2019-final-dss-visitation-implementation-plan.pdf
[134] Human Services Policy and Procedural Manual, Chapter 5, Section 510.7.300 can be accessed at https://dss.sc.gov/media/2070/additionalupdatedpolicy_2019-06-07.pdf

- Substantive inquiry as to the child's safety, permanency, and well-being. "Substantive inquiry" means focused on issues pertinent to case planning and service delivery to ensure the safety, permanency, and well-being of the child; and

- Appropriate documentation of the visit in CAPSS. CAPSS documentation must include the location and circumstances of the interview; a summary of the conversation and assessment of safety, permanency, and well-being; and a statement reflecting any changes in the case plan or service delivery or acknowledging the continued path of the current case plan and service delivery.

DSS has streamlined the CAPSS data entry process for documentation of visits so that case managers and supervisors can appropriately reflect their work, and as of August 2019, utilizes a new field developed in CAPSS to capture data. DSS has also offered training and a guidance document to facilitate understanding of practice expectations.

As was anticipated in the Visitation Implementation Plan, DSS reports that it has begun to integrate aspects of the Quality Matters toolkit, designed by the Capacity Building Center for the States to support public child welfare agencies and contracted service providers in building capacity for conducting quality contacts. The toolkit offers resources to assist with the development of training, policy, procedures, practice guidance, and tips. Going forward, it will be essential that DSS works to embed its GPS Case Practice Model in all aspects of this work, building a workforce of case managers with the values and skills to utilize visits as opportunities to listen, learn, meaningfully engage, and plan with the children and families with whom they work.

Attached in Appendix C are implementation status updates on specific strategies within the Visitation Implementation Plan.

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

The work of screening and investigating allegations of abuse and/or neglect of children in foster care – completed by DSS's OHAN unit – is another critical function of any child welfare system. This unit must be prepared 24 hours a day, seven days a week to receive reports, appropriately decide which reports should be screened in for investigation[135] and, for those reports that require an investigation, make contact with the alleged victim child(ren) within 24 hours of the report to assess the child's safety and the allegations. Children are in foster care as a result of abuse or

[135] In November 2019, DSS's Intake Hubs began screening all referrals alleging abuse and neglect against children, including allegations against Class Members in foster homes and institutions. Screening decisions are made utilizing the SDM® intake tool. The Intake Hubs are not yet functioning 24 hours a day; OHAN staff will continue to receive intakes on nights, weekends, and holidays, until the Hubs provide full hourly coverage, which is projected for March 2020. Further discussion of this change will be included in the next monitoring report.

neglect by their caregivers, and ensuring their safety and well-being while in state custody is a primary obligation.

Performance data for the current monitoring period reflect considerable improvements for nearly all measures, and by September 2019, had met the required final targets or interim benchmarks for appropriateness of screening decisions (100%), and timely closure of investigations.

Allocation of staff positions and hiring within OHAN has been identified as an issue impacting the quality and consistency of its work, and strategies were developed within the Workload Implementation Plan to address this. As of September 2019, OHAN had 16 investigative positions, with 14 positions available for assignment of investigations (two positions were vacant). During this monitoring period, OHAN filled one new supervisor position, bringing the total number of supervisors to three. As discussed in the Workload section of this report, although DSS has added new OHAN investigators between April and September 2019, the number of investigations has increased over 40 percent within the same timeframe, making it difficult to stabilize and maintain caseloads within required limits (on September 30, 2019, only one OHAN investigator had fewer than eight investigations). DSS has not determined a cause for this increase, and it is unclear what this may mean for determining the requisite number of staff for the OHAN unit. The Joint Report included action steps for DSS to assess and evaluate OHAN's staffing needs and resources, and to request additional staffing and funding as needed. DSS's FY2020-2021 budget request includes resources for 11 new OHAN staff.

A. Performance Data

OHAN Intake

Pursuant to South Carolina state statute and DSS protocol, during the period under review, all allegations of abuse or neglect of children in out-of-home settings – including licensed foster homes, residential facilities, and group homes – received by local county offices or regional Intake Hubs are forwarded to OHAN for screening and, if accepted, for investigation.[136,137] OHAN staff make decisions to either accept a referral for investigation or take no further action on the referral ("screen out") based upon information collected from reporters to determine if the allegations meet the State's statutory definition of abuse or neglect.[138] Reports of licensing violations that do not include allegations of abuse or neglect are expected to be referred to DSS's licensing unit for follow up, though DSS reports inconsistencies in practice around this requirement. DSS policy establishes three main screening criteria for investigations of abuse or neglect of children in out-

[136] SC Code § 63-7-1210; Human Services Policy and Procedural Manual, Chapter 7-721. p.3 (effective date 11/29/2012); SC DSS Directive Memo, April 26, 2016.
[137] Allegations of abuse or neglect by a foster parent of their biological or adopted child are investigated by child protective service case managers in local county offices.
[138] SC Code § 63-7-20.

of-home care: (1) the alleged victim child is younger than 18 years of age; (2) there is an allegation of actual harm that has occurred or is occurring to a child, or the caregiver's acts or omissions present a significant risk of harm; and (3) the alleged perpetrator is a person responsible for the child's welfare.[139] All screening decisions are reviewed and approved by a supervisor prior to being finalized.

The FSA requires *"[a]t least 95% of decisions not to investigate a Referral of Institutional Abuse or Neglect about a Class Member must be made in accordance with South Carolina law and DSS policy"* (FSA IV.C.2.). Table 8 includes the approved OHAN Implementation Plan timeline and interim benchmarks for this measure:

Table 8: Baseline, Timeline, and Interim Benchmarks for Appropriateness of Decision Not to Investigate Referral Alleging Institutional Abuse and/or Neglect

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

Source: OHAN Implementation Plan

All applicable referrals[140] of abuse and/or neglect received and not investigated by DSS's OHAN unit between April and September 2019 were reviewed by Co-Monitor staff to determine appropriateness of screening decision.[141] Performance data were collected and are reported separately for each month.

Between April and September 2019, the Co-Monitors determined a monthly range of 87 to 100 percent of decisions not to investigate a referral of abuse and/or neglect were appropriate (Figure

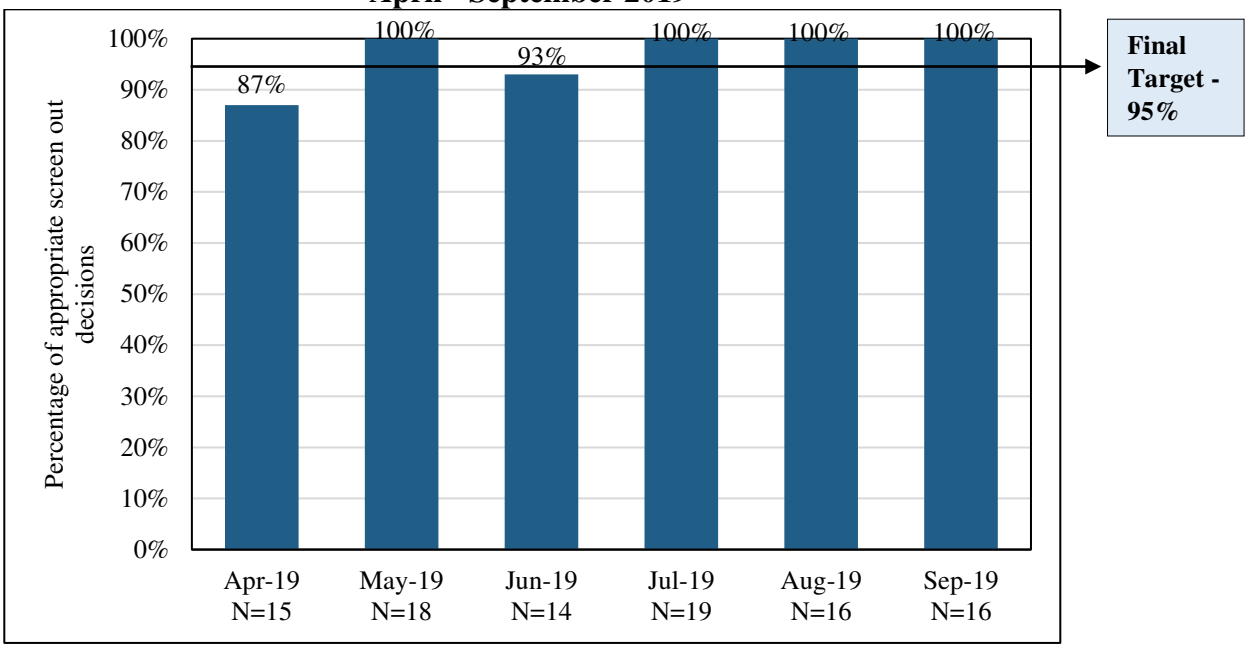
[139] This includes a foster parent; an employee or caregiver in a public or private residential home, institution, or agency; or an adult who has assumed the role and responsibility of a parent or guardian for the child, but who does not necessarily have legal custody of the child. Human Services Policy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

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

[141] When assessing performance for this measure, 2 main criteria are considered: (1) the allegation, if true, meets the legal definition of maltreatment; and (2) the OHAN intake worker did not collect all information necessary to make an appropriate screening decision. If either of these questions were answered in the affirmative, the decision not to investigate the referral was determined to be inappropriate.

23). Specifically, in September 2019, all 16 (100%) of the applicable screening decisions were deemed appropriate. DSS met the final target of 95 percent during most months this period.

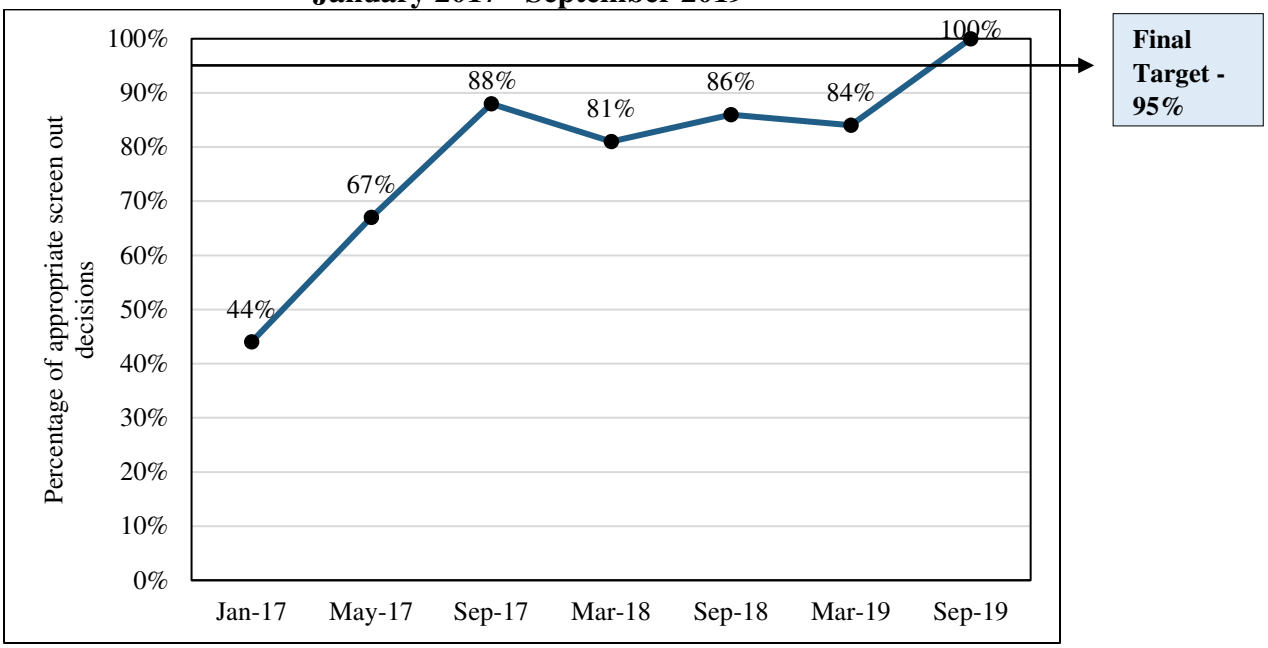
Figure 23: Appropriateness of Decision Not to Investigate Referral of Institutional Abuse and/or Neglect April - September 2019



Source: Monthly review data, Co-Monitor staff

Figure 24 includes performance trends for appropriateness of decisions not to investigate referrals between January 2017 and September 2019.

Figure 24: Performance Trends for Appropriateness of Decision Not to Investigate Referral Alleging Institutional Abuse and/or Neglect January 2017 - September 2019



Source: January 2017 performance collected during review of 128 referrals received by DSS between August 1, 2016 and January 31, 2017 and not accepted for investigation. Performance data for May 2017, September 2017, March 2018, September 2018, March 2019, and September 2019 reflect findings from monthly reviews completed by Co-Monitor staff.

OHAN Investigations

If a referral is accepted for investigation, the FSA and OHAN policy require face-to-face contact with the alleged victim child(ren) within 24 hours to assess for safety and risk, and the investigation is to be completed within 45 days.[142] OHAN policy also requires that throughout the course of the investigation, the investigator must conduct a safety assessment of the alleged victim child, including a private interview with that child; work with the child's 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.[143] All of these activities are critical components of a quality investigation that results in accurate assessments and findings.

There are seven FSA measures that relate to investigations – timely initiation (two measures),[144] contact with core witnesses (one measure), investigation determination decisions (one measure),

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

and timely completion (three measures). The most recent performance data detailed below were collected during a case record review conducted in December 2019 which examined a sample of 63 investigations that were accepted in September 2019.[145]

Timely Initiation of Investigations

The FSA requires *"[t]he investigation of a Referral of Institutional Abuse or Neglect must be initiated within twenty-four (24) hours in accordance with South Carolina law in at least 95% of the investigations"* (FSA IV.C.4.(a)). Additionally, FSA Section IV.C.4.(b) requires *"[t]he investigation of a Referral of Institutional Abuse or Neglect must include face-to-face contact with the alleged victim within twenty-four hours in at least 95% of investigations, with exceptions for good faith efforts approved by the Co-Monitors."* The Co-Monitors measure performance for both FSA IV.C.4.(a) and (b) using the same methodology and timeframes – the time between receipt of referral by OHAN and face-to-face contact with the alleged child victim must be within 24 hours.[146]

Table 9 includes the approved OHAN Implementation Plan timeline and interim benchmarks for this measure.

methodology and timeframes - the time between receipt of referral and face-to-face contact with alleged child(ren) victim must be within 24 hours.

[145] A total of 74 reports involving Class Members were accepted for investigation in September 2019. Sampling is based upon a 95% confidence level with +/- 5% margin of error.

[146] The Co-Monitors approved the following efforts as "good faith efforts" for timely initiation which must be completed and documented, as applicable, to contact with an alleged victim child(ren) within 24 hours: investigator attempted to see child(ren) at school or child care facility; investigator attempted to see child(ren) at doctor's visit or hospital; for child(ren) moved to an out-of-state location in order to receive specialized treatment, investigator attempted to interview by Skype or other electronic means; investigator attempted to see child(ren) at the police department; investigator attempted to attend forensic/CAC interview; investigator attempted to see child(ren) at therapist's office; investigator contacted the assigned foster care case manager(s) and/or supervisor(s); investigator attempted to contact the parent/guardian of the victim child(ren) if the child(ren) has returned home; and investigator attempted to contact the child at all foster care placements where the child may temporarily be placed in the first 24 hours. Additionally, the following extraordinary circumstance exceptions to timely initiation were approved by the Co-Monitors: child was returned to biological family prior to report and family refuses contact; child is deceased; law enforcement prohibited contact with child; 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).

Table 9: Baseline, Timeline, and Interim Benchmarks for Timely Initiation of Investigations

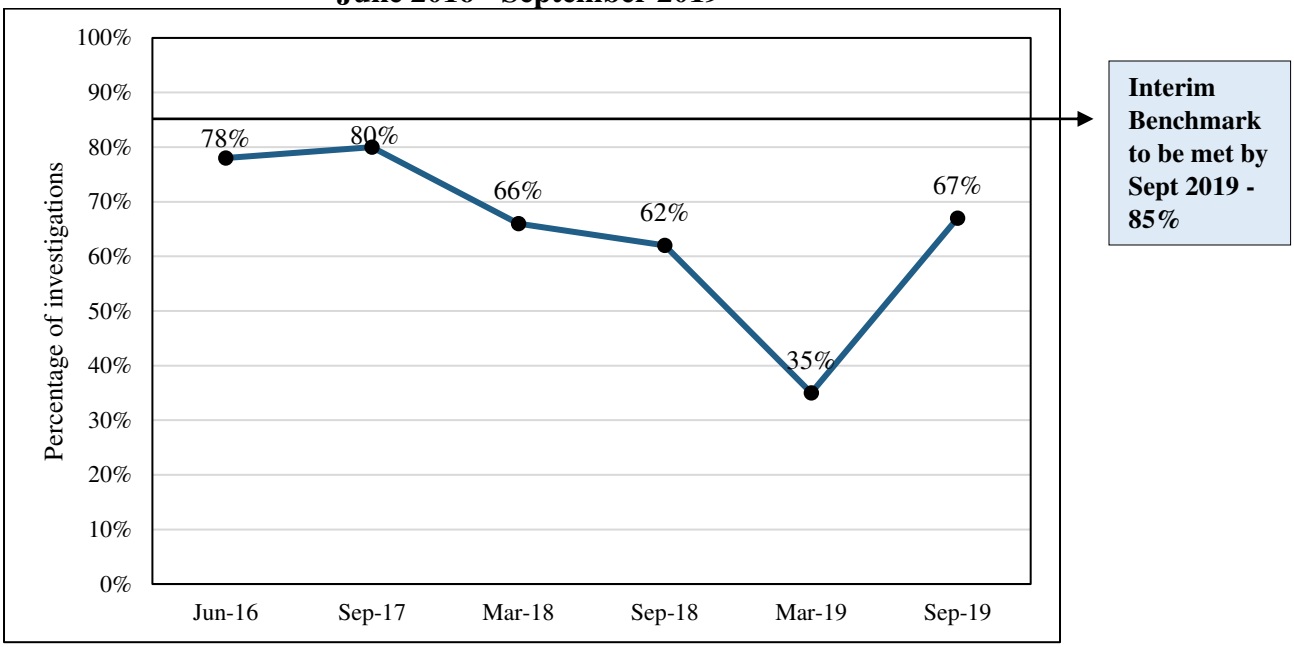
Baseline	
June - November 2016	78%
Implementation Plan Timeline	**Interim Benchmark**
September 2017	78%
March 2018	80%
September 2018	80%
March 2019	85%
September 2019	**85%**
March 2020	90%
September 2020	90%
Final Target - March 2021	**95%**

Source: OHAN Implementation Plan

Performance data for this period were collected during a case record review of a sample of investigations accepted in September 2019. Of the 63 investigations, contact was made with all alleged victim child(ren) within 24 hours in 40 (63%) investigations, and all applicable good faith efforts to contact the alleged victim child(ren) was made in an additional two (3%) investigations, for a total of 67 percent of investigations timely initiated. Current performance has improved, however is below the interim benchmark of 85 percent (Figure 25).

DSS staff attribute improved performance to the relocation of staff into regional offices, which allows for faster response times within a smaller geographic area. At times there are challenges to timely contacting alleged victim children when a child is moved following a report alleging abuse or neglect and the OHAN worker is unable to confirm their new location.

Figure 25: Timely Initiation of Investigations
June 2016 - September 2019



Source: Case Record Reviews conducted by USC CCFS and Co-Monitor staff

Contact with Core Witnesses during Investigation

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

A core witness is defined as an individual who is pertinent to the investigation because they witnessed or have knowledge of the alleged actions and can shed light on the allegations and the actions of the alleged perpetrators. Core witnesses may differ investigation to investigation, but in all cases include: reporter(s), alleged perpetrator(s), alleged child victim(s), child's DSS 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.[147,148]

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

[147] 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.

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

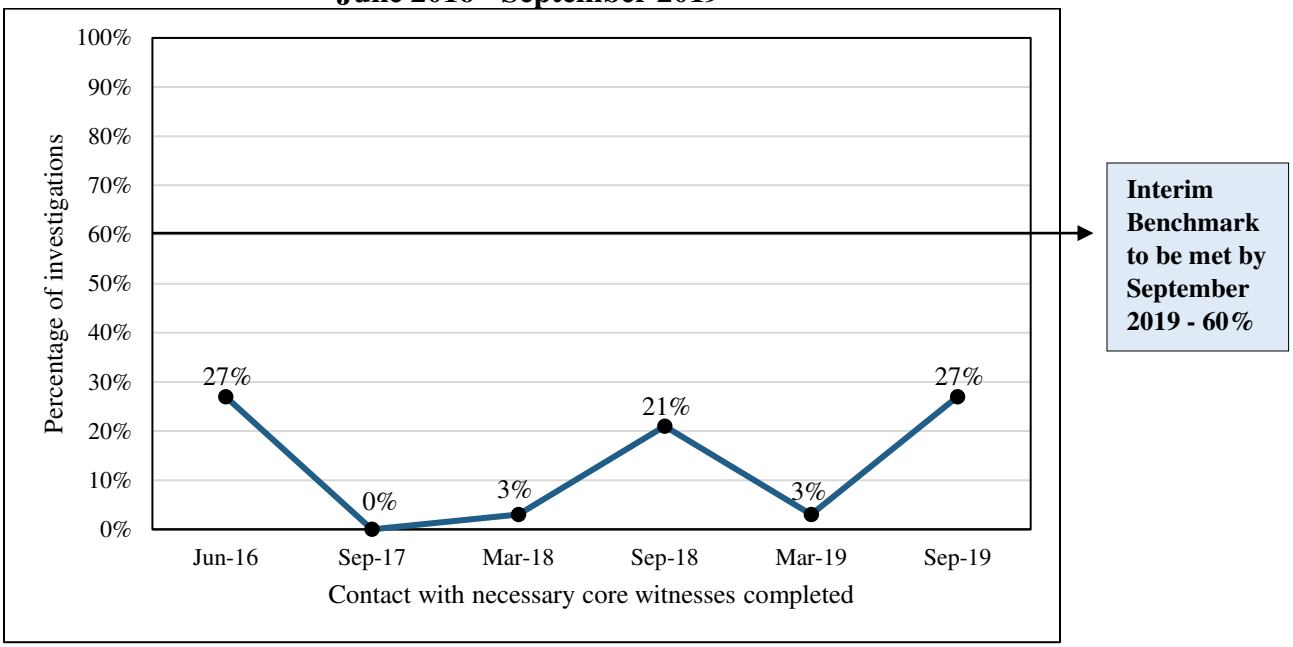
Table 10: **Baseline, Timeline, and Interim Benchmarks for Contact with All Necessary Core Witnesses during the Investigation**

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

Source: OHAN Implementation Plan

Performance data for this period were collected during a case record review of a sample of investigations accepted in September 2019. Seventeen (27%) of the 63 applicable investigations reflected contact with all necessary core contacts during the investigation. Current performance reflects improvements over prior periods, however is below the interim benchmark of 60 percent (Figure 26).

Figure 26: Contact with All Necessary Core Witnesses during Investigations June 2016 - September 2019



Source: Case Record Reviews conducted by USC CCFS and Co-Monitor staff

The following data, presented in Table 11, reflect the frequency of OHAN investigator contact with each category of core witness in the 63 investigations reviewed. Current performance data reflect that since the review for the prior period, investigators are more consistently interviewing all alleged victim children, alleged perpetrators, reporters, and alleged victim children's case managers, but continue to struggle with consistently interviewing law enforcement, other adults in the home or facility, and other children in the home or facility.

Table 11: Contact with Necessary Core Witnesses during Investigations by Type of Core Witness September 2019 N=63

Core Witness	Number of Applicable Investigations	Contact with All	Contact with Some	Contact with None
Alleged Victim Child(ren)	63	59 (94%)[149]	3 (5%)	1 (2%)[150]
Reporter	61[151]	49 (80%)	-	12 (20%)
Alleged Perpetrator(s)	62[152]	57 (92%)	2 (3%)	3 (5%)
Law Enforcement	22	9 (41%)	-	13 (59%)[153]
Alleged Victim Child(ren)'s Case Manager(s)	63	48 (76%)	7 (11%)	8 (13%)
Other Adults in Home or Facility[154]	40	15 (38%)	16 (40%)	9 (23%)
Other Children in Home or Facility[155]	45[156]	16 (36%)	9 (20%)	20 (44%)
Additional Core Witnesses	48[157]	28 (58%)	9 (19%)	11 (23%)

Source: Case Record Review completed in December 2019 by USC CCFS, DSS, and Co-Monitor staff
*Totals may not equal 100% due to rounding

[149] In 1 investigation, the investigator attempted to interview the alleged victim child twice, but was unable to engage him. Due to the nature of the allegations, a forensic interview was conducted.
[150] The only alleged victim child in this investigation ran away from his foster home and was believed to be in a different state with his biological mother. The investigator made multiple attempts to contact him via phone, FaceTime, and text, but was unsuccessful.
[151] The reporter in 2 investigations was anonymous.
[152] Exceptions to contact with alleged perpetrator(s) was applicable in 1 investigation, as the alleged perpetrator refused to cooperate despite efforts.
[153] In 2 investigations, the investigator received a police or incident report, but did not speak with or interview law enforcement involved.
[154] For investigations involving foster homes, in addition to speaking with the alleged perpetrator(s), the investigator should speak with all other adults in the household. For investigations involving institutions, the investigator should speak with all other adults who were involved in or who have knowledge of the allegations.
[155] For children who are placed in foster homes, in addition to speaking with all alleged victim children, the investigator should speak with all non-victim children in the home to inform the investigation, including other foster children and biological or adopted children in the home. For investigations involving institutions, as most facilities have many children placed there, investigators should speak with all other children who were involved in or who have knowledge of the allegations.
[156] Exceptions to contact with other children in home or facility was applicable to 1 investigation, as 1 of the children who may have had information about the incident refused to cooperate despite efforts.
[157] Additional core witnesses identified by reviewers in 48 investigations included family members, school or day care personnel, mental health or medical providers, church members, neighbors or other adults who observed the incident, foster home licensing workers, GALs, in-home care providers, adoptions specialist, approved alternative caregivers, supervisors, physical therapist, speech therapist, youth mentor, director and workers of day care program, previous placement personnel, and forensic interviewers.

Investigation Case Decisions

At the conclusion of an investigation, a decision to *indicate* or *unfound* is made based upon the totality of the information collected, with the preponderance of the evidence as standard of proof of the facts.[158]

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

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

Table 12: Baseline, Timeline, and Interim Benchmarks for Appropriate Case Decisions during Investigations

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

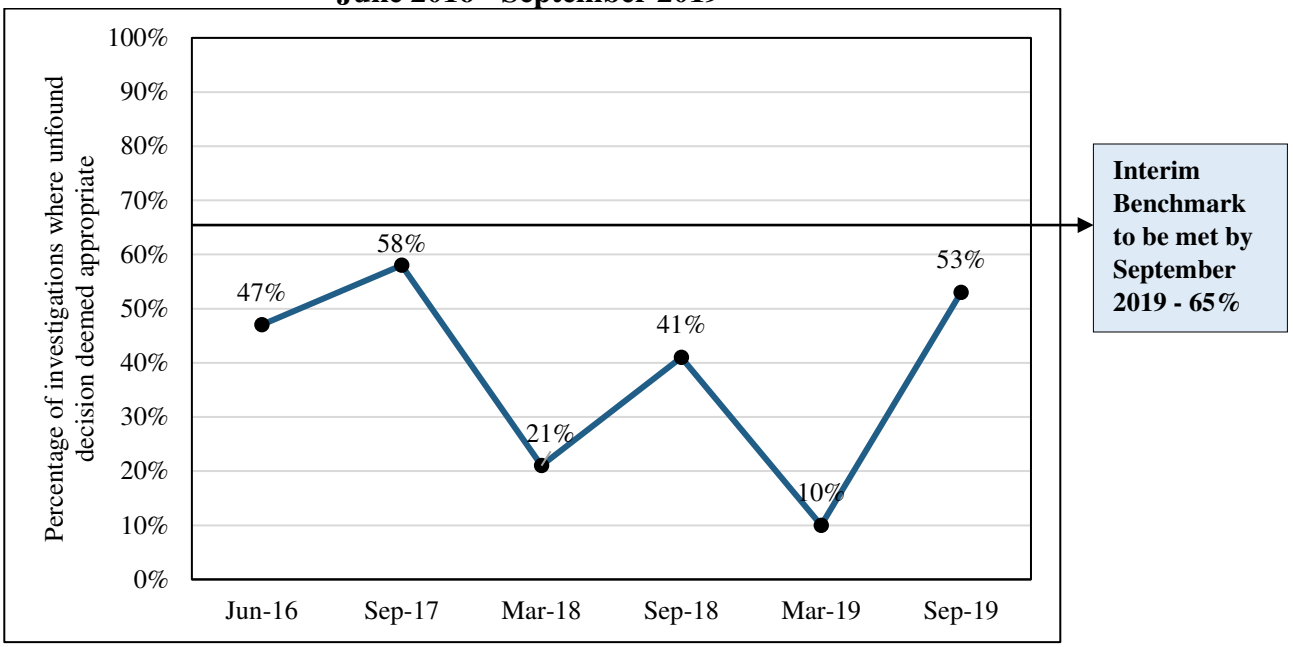
Source: OHAN Implementation Plan

Performance data for this period were collected during the previously referenced case record review of a sample of investigations accepted in September 2019. Of the 63 applicable investigations reviewed, the final case decision was to *unfound* the allegations in 59 investigations. Reviewers agreed that the case decision to *unfound* the investigation was appropriate in 31 (53%)

[158] SC DSS Human Services Policy and Procedural Manual, Chapter 7-721. p. 3 (effective date 11/29/2012).

of the 59 investigations (Figure 27).[159] Current performance has improved over the prior period, but is below the interim benchmark of 65 percent.

Figure 27: Decision to Unfound Investigations Deemed Appropriate
June 2016 - September 2019



Source: Case Record Reviews conducted by USC CCFS and Co-Monitor staff

Timely Investigation Completion

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

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

- *"At least 80% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within sixty (60) days of initiation of the investigation, and all investigations not completed within sixty (60) days shall have authorization of the DSS Director or DSS Director's designee of an extension of no more than thirty (30) days upon a showing of good cause. For the purposes of this section, an investigation is not completed if DSS*

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

determines the Report is unfounded because the deadline to complete the investigation has passed" (FSA IV.C.4.(e)).

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

The FSA and OHAN policy provide that the DSS Director or Director's Designee may authorize an extension of up to 15 days for "good cause" or compelling reasons.[160] Good cause means that, through no fault of the investigator, sufficient reason exists for delaying the case decision.[161]

Table 13 includes the approved OHAN Implementation Plan timeline and interim benchmarks for this measure.

[160] SC DSS Human Services Policy and Procedural Manual, Chapter 7-721. p. 12 (effective date 11/29/2012).
[161] Examples of good cause may be 1 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; and child has been too ill or traumatized to speak with investigator.

Table 13: Baseline, Timeline, and Interim Benchmarks for Timely Completion of Investigations

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

Source: OHAN Implementation Plan

Performance data for this section were collected during the case record review of a sample of investigations that were accepted in September 2019.

Completed within 45 Days

Of the 63 investigations reviewed, 56 investigations were completed within 45 days, however, reviewers determined that one of these investigations was prematurely closed as unfounded in an

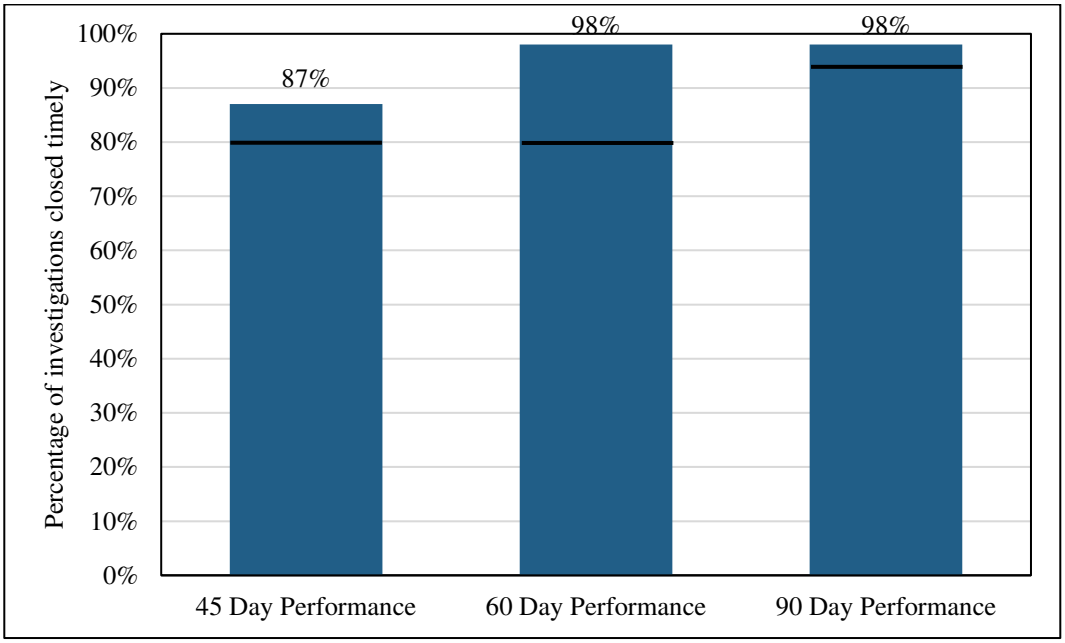
effort to meet the 45 day requirement, which is not considered compliant under the FSA.[162] Therefore, the review determined that 55 (87%) investigations were timely completed within 45 days (Figure 28). Reviewers did not find documentation of any extension requests being made in the remaining seven investigations. Current performance meets the interim benchmark of 80 percent.

Completed within 60 Days
Sixty-two (98%) of the 63 investigations were completed within 60 days of opening. Performance exceeds the interim benchmark and final target for closure within 60 days.[163]

Completed within 90 Days
All investigations were closed within 60 days; therefore, performance toward 90 day closure is also 98 percent.

Figure 28 reflects performance for timely closure in September 2019.

Figure 28: Timely Completion of Investigations
September 2019
N=63



Source: Case Record Review completed in December 2019 by USC CCFS, DSS, and Co-Monitor staff

[162] This investigation was closed within 45 days and prior to OHAN staff scheduling a forensic interview as had been recommended.
[163] This does not include the 1 investigation that was assessed as closed prematurely to meet the required timeframe.

B. OHAN Implementation Plan

The FSA required that by December 5, 2016, DSS develop an Implementation Plan for the provisions related to OHAN intake and investigations. The Implementation Plan must have *"enforceable interim benchmarks with specific timelines, subject to consent by Plaintiffs and approval by the Co-Monitors, to measure progress in achieving the final targets […]"* (FSA IV.C.1.). On September 11, 2017, the Co-Monitors approved DSS's OHAN Implementation Plan and Plaintiffs provided their consent to the Plan on November 7, 2017.[164]

In addition to setting interim benchmarks and timelines, the OHAN Implementation Plan includes strategies developed to improve OHAN practice and achieve the targets required by the FSA. These strategies include improvement in case manager time management; implementation of processes to track and monitor timely initiation of investigations and contact with core witnesses; development of checklists and other forms; development and completion of new OHAN training for investigators; coordination between OHAN and licensing staff; and improvements in supervision within OHAN. All of the strategies have been implemented by this monitoring period, although, high caseloads and the recent deficiency in supervisor staff have impacted their effectiveness.

Attached in Appendix D are implementation status updates on all strategies within the OHAN Implementation Plan, as well as most OHAN strategies within the Joint Report as of October 31, 2019.[165]

VIII. PLACEMENTS

Children who are removed from their homes must be placed in settings in which they feel safe and supported. This means placing children in the most family-like setting possible, with family and siblings and close to their home communities whenever possible. This policy and practice expectation is based in considerable research highlighting the importance of family connections, and requires that child welfare systems identify and support family caregivers and provide flexible, accessible, individualized interventions to address children's safety, health, and well-being.

While DSS has maintained its early progress in reducing the number of very young children in congregate care, the availability of appropriate, stable placements for children throughout the state continues to be a significant challenge. As DSS acknowledges, placement decisions are often made based on availability, rather than on the unique needs of children, youth, and families. Many children are still placed far from their families and home communities, and separated from their siblings, other family members, and important people in their lives. Although there is a shared

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

[165] Some Joint Report strategies that impact both Workload and OHAN are included in the Workload section of this report.

understanding that congregate placement should be reduced, the lack of appropriate alternatives for children – both in terms of family foster homes and quality, community-based supports – has meant that instability has increased, with large numbers of children experiencing multiple placement moves. In addition, there are increasing numbers of children who are separated from their siblings shortly after entering care, and there is a reported increased reliance on emergency and temporary placements. For children and families served by DSS, this can result in turbulent periods of fear, uncertainty, and isolation at a time when what is needed most are opportunities for healing and support that will allow children and families to thrive.

DSS's Placement Implementation Plan, approved by the Co-Monitors in February 2019, presents a roadmap for fundamentally shifting the way the needs of children in foster care are identified and met. Through a focus on building the supports and services necessary to keep children in their communities and with family members whenever possible, and on decision-making in the context of well-formulated child and family teams, the Plan reflects DSS's commitment to a renewed set of values it hopes will underlie all its work with children and families. As DSS has acknowledged, a lack of funding has prevented it from moving forward quickly with many Plan strategies that are critical for establishing the foundation for reform.

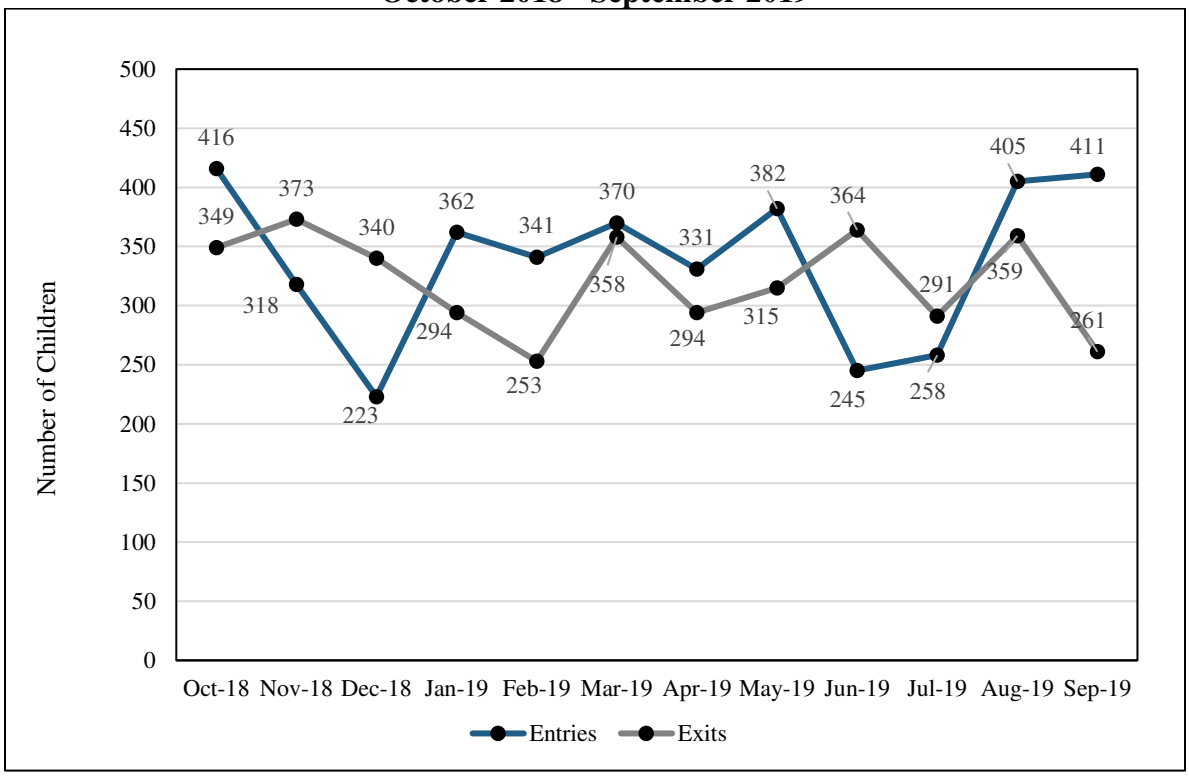
A. Performance Data

Foster Care Entries and Exits

As depicted in Figure 29 and Table 14, the number of children entering foster care during this monitoring period exceeded the number of children exiting foster care in eight of the last 12 months, resulting in an increased number of children in foster care as of September 30, 2019.[166]

[166] Though these data suggest a continuation of the trend reporting in prior monitoring reports of a continually increasing number of children in DSS's custody over the last 5 years, the data are not directly comparable to data reported in prior monitoring periods due to the fact that they were extracted from different data sources.

Figure 29: Foster Care Entries and Exits
October 2018 - September 2019



Source: CAPSS data provided by DSS (extract from February 1, 2020)

Table 14: Foster Care Entries and Exits
April - September 2019[167]

Category	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Children Served	4,757	4,876	4,794	4,682	4,782	4,822
Entries into Care	335	384	248	258	407	412
Exits from Care	265	330	370	307	371	274
Children in Care on Last Day of Period	4,492	4,546	4,424	4,375	4,411	4,548

Source: CAPSS data provided by DSS (extract from December 1, 2019)

DSS now regularly publishes data on its public website about children in out-of-home care, providing users with the ability to compare state demographics of children in foster care with that of any county. Demographic data on age, race, and gender are available, as well as placement type

[167] A small number of non-Class Members, such as those placed in DSS custody voluntarily, are included in these data, resulting in some differences between these data and performance data on the FSA measures related to placement reported throughout this section.

and length of time in care. These data, reportedly updated on a daily basis, will hopefully allow for more transparency and accountability, as well as the opportunity to recognize differences in geographical areas of the state.[168]

Placement of Children in Congregate Care

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.). Table 15 includes the approved Placement Implementation Plan timeline and interim benchmarks for this measure:

Table 15: Baseline, Timeline, and Interim Benchmarks for Placing Class Members Outside of Congregate Care Placements

Baseline	
March 31, 2018	78%
Timeline	**Interim Benchmark**
September 2019	**80%**
March 2020	82%
September 2020	84%
Final Target - March 2021	**86%**

Source: Placement Implementation Plan

DSS data show that on September 30, 2019, 81 percent (3,637 of 4,500) of Class Members were placed outside of a congregate care placement (see Table 16). Thirty-three children resided in other institutional settings on the last day of the monitoring period.[169] This performance meets the September 2019 interim benchmark.

[168] For example, data as of January 13, 2020, indicate that 28% of children in foster care are reported to have been in care for at least 24 months. In Greenville County, the county with the highest number of children in out-of-home placement, 44% of children have been in care for at least 24 months. For more information, see https://dss.sc.gov/about/data-and-resources/foster-care-dashboard/

[169] Specifically, DSS reports that 27 youth were incarcerated in correctional or juvenile justice detention facilities, and 6 youth were hospitalized.

Table 16: Types of Placements for Children
September 30, 2019

Children in Foster Care	
4,500 (100%)	
Types of Placement for Children in Foster Care	**Number (Percentage) of Children**
Family-Based Setting	3,637 (81%)[170]
Congregate Care	863 (19%)[171]
Breakdown by Type of Congregate Care	
Group Home	794 (18%)
Residential Treatment Facility	67 (1%)[172]
Emergency Shelter	2 (<1%)

Source: CAPSS data provided by DSS

As shown in Table 16, the vast majority (92%) of children in congregate care are placed in group homes. These facilities are categorized and funded based on the level of support they are expected to provide (either Level 1, 2, or 3 group homes), and are intended to serve children whose needs cannot be met in a more family-like setting. The facilities vary a great deal in terms of supportiveness, programming, and level of restriction, though none offer formal clinical services onsite. As reported by placement consultants engaged by the Co-Monitors in 2018, the best of these facilities have capable, committed leadership actively engaged in developing resources beyond those currently paid for by DSS, and have established relationships with other agencies in their communities to provide services.[173] Some, however, offer restrictive environments with inflexible rules that can be arbitrary and punitive, with "little indication of individualization of assessment and case planning, cramped interpersonal settings, often contained in locked or fenced settings, excessive reliance on seclusion and restraint,"[174] and lack of connection with their friends and family.

[170] This includes 1 youth who was in a Department of Disability and Special Needs (DDSN) Community Training home, and 1 youth residing at a university.
[171] As discussed above, this does not include 33 youth who resided in other institutional settings on the last day of the monitoring period.
[172] This includes 5 youth in an alcohol or drug treatment facility, 1 youth in a DDSN residential facility, and 2 youth in a non-Department of Mental Health (DMH) psychiatric facility.
[173] Taylor, George, and White, Marci. (December 21, 2018). Review of South Carolina Residential Treatment Facilities and Group Homes Utilized by DSS. *Technical Assistance to the Michelle H. vs. McMaster Co-Monitors*.
[174] Ibid.

It is important to note that, pursuant to the FSA, the data discussed above reflect the percentage of children in each type of placement at a single point in time – the last day of this monitoring period. They do not capture children's experiences over the entirety of their time in care. In an effort to capture more comprehensive data, DSS worked with Chapin Hall at the University of Chicago to develop data sets that reflect the percentage of children who experience congregate care placements at *any time* while in foster care. These data show a significantly greater incidence of congregate care placements, particularly amongst older youth. Data show about one-fourth (1,485 of 6,283) of all Class Members who were in care during this monitoring period were placed in a congregate care setting at some point between April 1 and September 30, 2019.[175] The incidence of congregate care placement for older youth between ages 13 and 17 is the largest of any age group – two-thirds (1,149 of 1,804) of these youth were placed in a congregate care setting at some point during this time period.

Children Ages 12 and Under

The FSA includes placement standards specific to certain age groups of children, and requires that *"[a]t least 98% of the Class Members twelve (12) years old and under shall be placed outside of Congregate Care Placements on the last day of the Reporting Period unless an exception pre-approved or approved afterwards by the Co-Monitors is documented in the Class Member's case file"* (FSA IV.E.3.). Table 17 includes the approved Placement Implementation Plan timeline and interim benchmarks for this measure:

Table 17: Baseline, Timeline, and Interim Benchmarks for Placing Class Members Ages 12 and Under Outside of Congregate Care Placements

Baseline	
March 31, 2018	92%
Timeline	**Interim Benchmark**
September 2019	**94%**
March 2020	95%
September 2020	97%
Final Target - March 2021	**98%**

Source: Placement Implementation Plan

[175] These data do not include children who were placed in other institutional settings at some point during the monitoring period, such as children and youth who were incarcerated in correctional or juvenile justice detention facilities or who were hospitalized. The Co-Monitors have not independently validated these categorizations.

As reflected in Table 18, as of September 30, 2019, 3,003 of 3,171 Class Members ages 12 and under in foster care were placed outside of a congregate care placement, and 19 children ages six and under resided in congregate care pursuant to a valid exception, resulting in performance of 95 percent. These data do not include five children who were hospitalized on the last day of the monitoring period. Performance in this area has improved by one percent since the last monitoring period, and meets the September 2019 interim benchmark.[176]

Table 18: Types of Placements for Children Ages 12 and Under September 30, 2019

All Children in Foster Care Ages 12 and Under	
3,171 (100%)	
Types of Placement	**Number (Percentage) of Children**
Family-Based Setting	3,022 (95%)[177]
Congregate Care	149 (5%)[178]
Breakdown of Type of Congregate Care	
Group Home	130 (4%)
Residential Treatment Facility	19 (1%)[179]

Source: CAPSS data provided by DSS

Similar to the data discussed earlier, these data reflect the percentage of children in each type of placement on the last day of the monitoring period (pursuant to the FSA), and the majority of children in congregate care are in group homes. Data show that eight percent (336 of 4,479) of Class Members ages 12 and under who were in care at any point during this monitoring period were placed in congregate care at some point between April 1 and September 30, 2019.[180]

When focused specifically on the population of children ages seven to 12, as of September 30, 2019, 89 percent (1,173 of 1,320) were placed outside of a congregate care placement, as shown in Table 19. This seems to reflect an improvement from the prior monitoring period, when 85 percent of children ages seven to 12 were placed outside of a congregate care setting on the last

[176] The Co-Monitors have approved, but not applied, exceptions for placing children ages 7 to 12 in a congregate care facility, which mirror the exceptions for children ages 6 and under placed in a congregate care facility. DSS has not yet developed the capacity to track the use of these exceptions on a regular basis, so performance may be higher than reported. DSS will develop a process for review and approval of applicable exceptions in future monitoring periods.
[177] This includes 19 children ages 6 and under who resided in congregate care placements pursuant to a valid exception, as described in Table 20.
[178] This does not include 5 children who were hospitalized on the last day of the monitoring period.
[179] This includes 2 children in an alcohol or drug treatment facility and 1 youth in a DDSN residential facility.
[180] This percentage does not include children who were placed in other institutional settings at some point during the monitoring period, such as children who were hospitalized. The Co-Monitors have not independently validated these categorizations.

day of the period. However, the incidence of congregate care placement at some point over the course of the monitoring period remained nearly the same as last period. Over the course of the monitoring period, 16 percent (298 of 1,822) of Class Members between the ages of seven and 12 were placed in a congregate care setting at some point, compared to 17 percent in the prior monitoring period.[181]

Table 19: Types of Placements for Children Ages Seven to 12
September 30, 2019

All Children in Foster Care Ages Seven to 12	
1,320 (100%)	
Types of Placement	**Number (Percentage) of Children**
Family-Based Setting	1,173 (89%)
Congregate Care	147 (11%)[182]
Breakdown of Type of Congregate Care	
Group Home	130 (10%)
Residential Treatment Facility	16 (1%)
DDSN Residential Facility	1 (<1%)

Source: CAPSS data provided by DSS

Children Ages Six and Under

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

On March 15, 2016, the Co-Monitors approved DSS's plan, including acceptable exceptions (listed in Table 20), and DSS issued a directive outlining the procedure to be used by local and regional office staff to ensure the appropriate placement of children ages six and under in family placements (IO II.3.(a) & FSA IV.D.2.). The procedure currently requires prior approval from the applicable Regional Director before DSS places any child ages six and under in a non-family-based setting.

[181] Ibid.
[182] This does not include 1 child who was hospitalized on the last day of the monitoring period.

Table 20: Exceptions for Placement of Children Ages Six and Under in Non-Family-Based Placements

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

All but two of the children ages six and under who resided in congregate care placements at some point during the monitoring period met an agreed upon exception for placement in congregate care.[183] DSS reports that there were 32 Class Members ages six and under who resided in congregate care placements at some point during the period. Although the number of children under the age of six in congregate care has increased, this is largely due to the fact that DSS has successfully placed a greater number of children with their families who are residing in these facilities. Of the 32 children, 24 were residing in a treatment facility or group care with their mothers, and six were part of a sibling group of four or more children for whom DSS reported a single, family-based placement could not be located.

[183] In validating data for this measure, the Co-Monitors identified 2 situations that did not meet an agreed-upon exception. One instance involved a sibling group that was initially placed in congregate care in accordance with an agreed-upon exception, but remained there for longer than 90 days without sufficient efforts by DSS to continue to try to find a more family-like setting in which the children could be together. The other instance involved a 6-year old who was placed in a group home without evidence that the setting was necessary to meet the child's specific needs.

Placement in DSS Offices and Hotels

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

During this monitoring period, the Co-Monitors were notified of four instances of children staying overnight at a DSS office in violation of this provision. Three of these instances occurred in the Aiken County DSS office. In April 2019, a 15-year old slept overnight in the office after the group home where the youth was residing requested that the youth leave; DSS had been searching for placement for one week, and only temporary placements had been identified. A therapeutic foster home was found the following day, where the youth remained for two weeks before being moved to a temporary placement at a group home. In June 2019, another 15-year old spent the night at the office after being found, after four months missing from placement, sleeping in a park; the youth ran away the next day and was not located again until the following month, at which point they were placed in a group home. In August 2019, a 14-year old spent the night in the DSS office after the youth's adoptive parent called law enforcement and EMS was dispatched, and the youth was taken to and then discharged from the ER. This youth was moved to a group home the following afternoon. The fourth instance occurred in Richland County, where in July 2019, law enforcement was called after a 15-year old left from a foster parent's car; the foster parent refused to take the youth back into the home. Another foster home placement was identified the next morning, and the youth was moved again to a group home the following week.

Emergency or Temporary Placements

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

The FSA also requires that *"Class Members experiencing more than one Emergency or Temporary Placement within twelve (12) months shall not remain in the Emergency or Temporary Placement for more than seven (7) days. Under exceptions subject to the Co-Monitors' approval, if a child's*

subsequent placement within twelve (12) months in an Emergency or Temporary Placement is not a Congregate Care Placement, and that placement is re-designated within thirty (30) days as a long-term foster home or therapeutic foster home, then the child's stay shall not be considered a violation of this provision and the re-designation shall not be considered a placement move […]" (FSA IV.E.5.).

"Temporary placements" are intended to reflect instances in which a child is moved with the intention to return after a short time to the placement from which they came. In many situations, these moves are important and well-supported by best practice. For example, at times, a child may need to be hospitalized for acute medical care, or a foster parent may benefit from the opportunity to temporarily get "respite" in caring for a child so that they can travel, deal with an emergent family need, or have the chance to refuel.

As discussed in earlier reports, DSS has historically been unable to track the use of temporary placements. DSS completed its work during this monitoring period, under the guidance of Chapin Hall, to improve its tracking mechanisms, and was able to begin producing data in August 2019. These data reflect that in the months of August and September 2019, 72 youth spent some time in a temporary placement.[184,185] Sixteen of these children (22%) were hospitalized (for an average of seven days), and 37 children (51%) were in respite placements (for an average of 11 days). Seventeen (24%) of the 72 youth experiencing a temporary placement in this time period (all between the ages of 13 and 17) were on "runaway" status, meaning they were not in a placement at all. One of these youth was on "runaway" status for 77 days, and the average number of days in this "placement type" was 21.

DSS is not yet able to produce data on placements that are made on an emergency basis, in part because of the definitional issues that need to be resolved as it moves to restructure its placement system through implementation of the Placement Implementation Plan. DSS has, however, continued the practice of paying providers an "enhanced rate" to accept children overnight when no appropriate longer-term placement is available, often just for the nighttime hours, returning to await placement in a DSS office the next day. Between April and September 2019, 226 children were subject to this practice (approximately five percent of the children in out-of-home placement during the monitoring period). Of the 226, 68 children experienced more than one emergency placement during the monitoring period, and 19 children experienced between three and eight

[184] Pursuant to the Placement Implementation Plan, "A temporary placement/event occurs in 1 of the following categories: 1) AWOL, 2) Kidnapped, 3) Respite, 4) Medical Hospital, 5) Psychiatric Acute Care Hospital, 6) Transitional visit with parent/relative/fictive kin, 7) Transitional visit with a future foster parent, 8) Transitional visit with potential Adoptive resource, 9) Summer camp."

[185] Three of these youth were placed in a temporary placement more than once in this 2-month time period.

emergency placements.[186] The Co-Monitors believe this is a serious problem requiring immediate attention.

DSS has committed in its Placement Implementation Plan to utilizing child and family teams to make more informed individualized placement decisions for children, and develop and provide quality services and supports to meet children's needs. If effectively implemented, this approach has the potential to reduce reliance on emergency and temporary placements. This remains a critical need.

Juvenile Justice Placements

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

The Co-Monitors continue to be very concerned about Class Members who are also involved with the South Carolina Department of Juvenile Justice (DJJ). Co-Monitors receive regular reports of youth in DSS custody throughout South Carolina, who also have involvement with DJJ (and, in many cases, other state agencies) with needs that are not being met. In many ways, these cases reflect how the lack of quality, strengths-based engagement and assessment, and deficiencies in the array of available community supports and services, translates into poor outcomes for youth.

Class Members become involved with or placed through DJJ for a number of reasons, including, all too often, because of offenses that involve little or no harm to others such as truancy, "incorrigibility," or, in many cases, running away from a DSS placement (or, in some cases, from a DSS office while awaiting placement) if the youth is on probation. DJJ involvement sometimes leads to pre-adjudication detention, a prescribed amount of time at one of the state's secure evaluation centers, and/or post-adjudication placement at a secure facility or one of many group homes with restrictive rules. While the FSA provision regarding "overstay" of a DJJ "sentence" references a discrete point in time, in practice, youth often move with frequency and fluidity between the two systems, with decisions made, at least in part, based on the availability of placement resources, services, supports, and the willingness of a caregiver (DSS or otherwise) to maintain the youth in the community.

[186] Although these placements constitute emergency placements for the purpose of measuring FSA performance, neither DSS nor the Co-Monitors believe that all emergency placements are reflected in this enhanced rate payment data. The Co-Monitors will report data for this measure when a more consistent process for tracking emergency placements has been developed.

Two violations of the specific FSA prohibition against overstays of sentences were reported to the Co-Monitors by DSS this monitoring period. In one case, in early April 2019, a 17-year old in Richland County was held at an adult correctional facility after being arrested for fighting with a friend. The youth was returned home to their birth mother shortly thereafter, and the DSS case was closed. In the second case, a 15-year old in Oconee County was arrested by law enforcement in late April 2019 for running away from a DSS placement (the youth had been missing for nearly two months), and placed in a secure facility for six days. In the five months immediately following this incident, this youth was moved 18 more times, frequently leaving placements in an effort to see their mother. The Co-Monitors believe that these cases are just a small subset of more frequent circumstances in which youth are unnecessarily placed or held in detention, secure evaluation facilities, or DJJ group homes because of inadequacies in the supports and services available through DSS.

The Co-Monitors have continued to share many cases of concern with DSS during this monitoring period, and have encouraged DSS leadership to review, understand, and address the factors that drive DJJ involvement, or prolonged involvement, for Class Members. Amongst these was a report in August 2019 of a 13-year old in Oconee County with special needs who was arrested after a behavioral escalation at the hospital and then remained in a DJJ placement for five months before being returned home. Despite the length of time this youth was detained, and the mother's concerns about the need for more support, the youth was eventually returned home without a discharge plan in place. In the same month, the Co-Monitors received a report of a 16-year old in Greenville County who was moved 13 times in August alone. When this youth was informed of the plan for placement in another group home and that access to their mother would not be allowed, the youth became physical with the DSS case manager, was arrested, and placed through Greenville DJJ while a hospital placement was sought. The youth has since been moved to a residential treatment facility out of state.

The Co-Monitors also received multiple reports from stakeholders about youth who were being held in Psychiatric Residential Treatment Facility (PRTF) placements beyond the length of time deemed clinically necessary, due to a lack of appropriate and less restrictive placement options.[187] Though these youth were not held in DJJ facilities, they were held in more restrictive settings than were required. Stakeholders report that such youth tend to deteriorate if they remain longer than necessary in crisis stabilization settings, but it sometimes takes multiple days to even get in touch with DSS case managers to discuss a discharge plan. In June 2019, the Co-Monitors reported two such cases to DSS; the first was a 13-year old in Spartanburg County who had been in 13 placements before being placed at a residential treatment facility, where the youth remained for six months after the therapist reported that they should have been discharged. The second case was

[187] Medical necessity determinations for placement in a PRTF are made by Select Health, the MCO serving the majority of children in foster care in South Carolina. DSS reports that approvals or denials are not always aligned with DSS recommendations. This is an important issue that DSS is addressing through its Health Care Improvement Plan implementation work, discussed in more detail in Section X. *Health Care*.

a 16-year old in Greenville County for whom DSS did not identify alternative placement by the discharge date, did not come to pick up the youth for several days without communication with facility staff, and ultimately requested an extension for said youth to remain at the PRTF.

As previously reported, DSS has been in the process, formalized in a renewed MOU, of developing systems for sharing information with DJJ to enable both agencies to better track dual involvement of youth. As of December 2019, a portal has been in place to allow designated liaisons at both DSS and DJJ to confirm whether a youth that they serve is currently also being served by, or has been engaged with, the other agency. Though the rollout of this portal comes after two years of planning, it currently offers limited information. A liaison accessing the portal, for example, cannot discern the nature of a youth's involvement with DJJ, or extract even limited information about case status or assigned workers. It is DSS's hope that the portal will, however, serve as a starting point for collaboration between the agencies, giving the ability to quickly identify dually involved youth. DJJ can also use the portal to report violations of the FSA. DSS continued its practice this monitoring period of requesting a match list of children and youth currently in its care to assess the extent of dual system involvement in its foster care population. According to the June 30, 2019 analysis, 480 children (24% of foster youth ages 10 to 17) in foster care had either past or present DJJ involvement. As of October 31, 2019, this number was 457 children (22% of foster youth ages 10 to 17).

While DSS's progress in tracking some information about the population of dually involved youth is notable, the Co-Monitors and DSS agree that even when fully implemented, any technological or data-based solution is unlikely to sufficiently address the significant practice issues apparent in the cases of youth involved with both DSS and DJJ. As discussed in prior reports, the MOU also requires Interagency Staffings – meetings between DSS and DJJ case managers involved with a youth's case – be held within 30 days of "identification," as well as anytime a youth is detained, on "runaway," "offends in placement," or is otherwise at "risk of reoffending." The Co-Monitors continue to receive reports from stakeholders that there is still inconsistent understanding and implementation of the goals of these Interagency Staffings in terms of joint case planning and mutual support to address youth's underlying needs, and the purported shared value of keeping youth out of restrictive settings whenever possible.

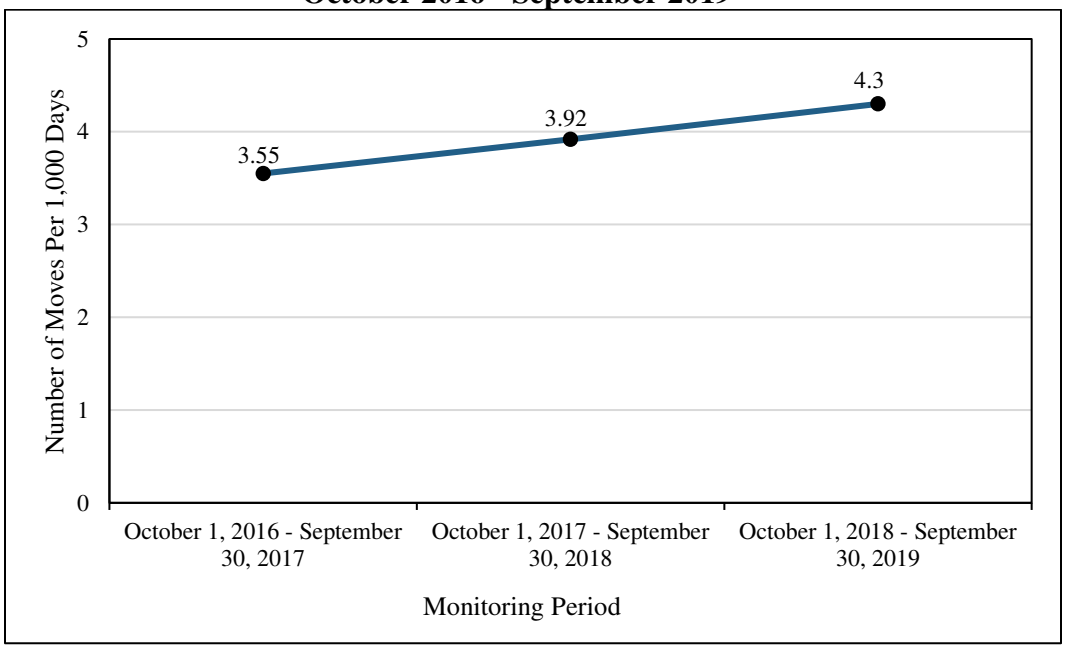
The needs of dually involved youth cannot be met without meaningful engagement, assessment, and planning that is rooted in mutual respect, and access to an array of quality, community-based supports and services to address (at times, profound) underlying needs. This will require that both DSS's GPS Case Practice Model, and its Placement Implementation Plan be implemented expeditiously and with fidelity. These youth cannot continue to wait.

Placement Instability

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

DSS reports that for the period of October 1, 2018 to September 30, 2019, Class Members experienced placement changes at a rate of 4.3, meaning there were 4.3 moves per 1,000 days in care, across all foster children.[188] There were 3,469 children to whom this measure applied;[189] each of whom experienced an average of three placements within the 12 month period. As shown in Figure 30, this rate reflects a continued increase from the two years prior and indicates a trend in the wrong direction; the placement instability rate from October 1, 2017 to September 30, 2018 was 3.92, and in the prior year, the rate was 3.55. This performance does not meet the FSA standard of less than or equal to 3.37.

Figure 30: Rate of Placement Moves
October 2016 - September 2019[190]



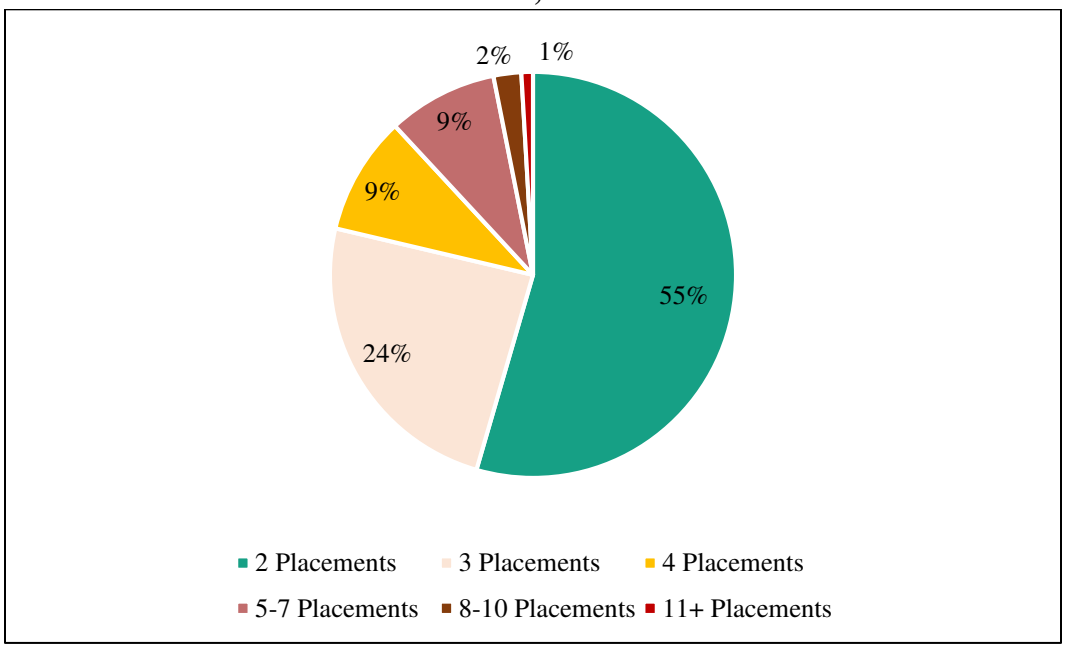
Source: DSS data

Of the 3,469 children to whom this measure applied, 1,568 (45 percent) children experienced two or more placement *moves*, indicating three or more total *placements*, within 12 months. This means

[188] Specifically, there were a total of 6,936 moves across 1,614,117 days.
[189] Children are counted as experiencing a placement move if the move was not temporary (they did not return to the original placement), the move was not the original removal episode, and the length of stay in foster care was greater than 7 days. Moves between residence buildings at the same congregate care facility were excluded from these data.
[190] The final target requires the placement instability rate to be less than or equal to 3.37.

that 55 percent of children experienced two or fewer placements in this time period, represented in green in Figure 31. As shown in the three red segments of the figure, 12 percent of all children experienced five or more placements during this 12-month period. Fifty-one youth experienced at least nine placements, and 32 youth experienced at least 11 placements. Two youth were subject to 20 placements in the 12-month period.

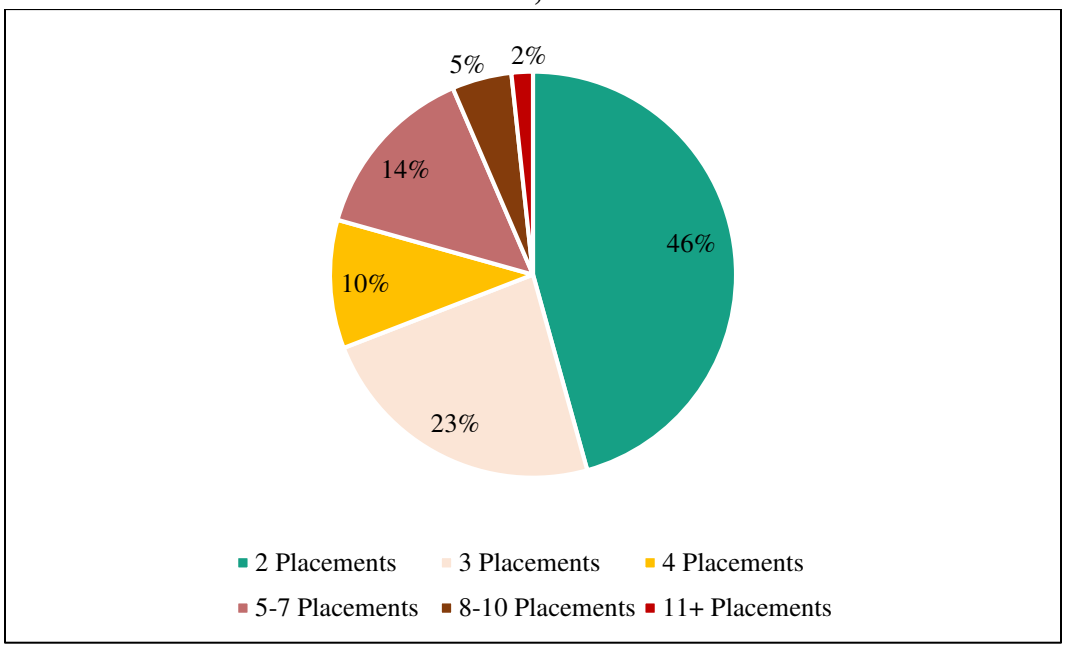
Figure 31: Number of Placements for Children Who Experienced Two or More Placements Within 12 Months October 2018 - September 2019 N=3,469



Source: CAPSS data provided by DSS

For the population of youth ages 13 to 17, the number of placements experienced was even starker. Of the 1,118 youth ages 13 to 17 to whom this measure applied, 604 (54 percent) youth experienced two or more placement *moves*, indicating three or more total placements, within 12 months. This percentage is broken down further in Figure 32. As shown in the figure, almost one-third (341 of 1,118) of youth in this age group experienced four or more placements, and 20 percent (225 of 1,118) – identifed by the three red segments in the figure – experienced five or more placements in the 12-month period.

Figure 32: Number of Placements for Youth Ages 13-17 Who Experienced Two or More Placements Within 12 Months October 2018 - September 2019 N=1,118



Source: CAPSS data provided by DSS

It is important to note that these data reflect placement moves that occurred over a 12-month period, an arbitrary designation for a child, and may build upon a history of frequent placement moves in prior years. For example, one 15-year old in Aiken County (who has been in foster care five times) has been moved through 10 placements since December 2017, including five group homes, two residential treatment facilities, one DJJ facility, and one psychiatric hospital (this youth also stayed overnight at a DSS office and in an emergency overnight placement in a foster home). Another 15-year old in Aiken County (who has been in foster care four times, experiencing between six and 14 placements each time) has been moved through 42 placements during seven years in foster care. A 13-year old in Spartanburg County has been in at least four placements per year for the five years they have spent in foster care, resulting in a total of 15 placements. Similarly, between September 2018 and September 2019, a 16-year old in Horry County was moved through four placements, and has been through a total of 15 placements in the youth's four years in DSS custody. All research available indicates the profound negative consequences of this level of placement instability for a child's current and future health and well-being.

Though placement instability is particularly pervasive among older youth, young children are also subject to frequent moves between homes and institutions. One six-year old in Charleston County has been in 11 placements since January 2019, when the child was taken into DSS custody along with two siblings due to their mother's homelessness. After just one month in foster care, this child had already been moved to four foster homes, reportedly due to "difficult to manage behaviors."

This child's two-year old sibling has also been moved four times since entering care, nearly always to different foster homes than the siblings. This constant cycle of removal and re-placement undercuts children's feelings of safety and stability, and disrupts continuity of any kind in educational settings, social connections, and service and community engagement at a time when children are already experiencing the trauma of removal from their homes and separation from parents and other loved ones.

It is the Co-Monitors belief that while the instability experienced by children in DSS's care may be due, in part, to an insufficient number of placement options, a lack of flexible, intensive home and community-based resources to support children and foster and kinship providers throughout the state is a major reason why children are being moved so frequently. Until this issue is addressed, it will be difficult for DSS to make much progress in this area.

Sibling Placement

The FSA recognizes the importance of the relationship 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 sets two targets – one for placement with *at least one* of a child's siblings (85% target) and the other for placement with *all* siblings (80% target). The FSA allows for exceptions to this requirement, including when there is a court order prohibiting such placement or if the placement is determined not to be in the best interest of one or more siblings. Table 21 includes the approved Placement Implementation Plan timeline and interim benchmarks for placement with at least one of the child's siblings and for placement with all the child's siblings:

Table 21: Baseline, Timeline, and Interim Benchmarks for Placing Class Members With At Least One of Their Siblings

Baseline	**With At Least One Sibling**	**With All Siblings**
March 31, 2018	63%	38%
Timeline	**Interim Benchmark**	
September 2019	**69%**	**49%**
March 2020	74%	59%
September 2020	80%	70%
Final Target - March 2021	**85%**	**80%**

Source: Placement Implementation Plan

DSS provided data for 886 children who entered foster care between April 1 and September 30, 2019 with a sibling or within 30 days of their sibling's entry to placement and were still in care 45 days later. For this cohort, 56 percent (492 of 886) of children were placed with at least *one* of their siblings, and 32 percent (282 of 886) of children were placed with *all* of their siblings 45 days after entry into care (Table 22).[191,192] This is a decline in performance from the prior monitoring period, and falls significantly short of the September 2019 interim benchmarks. Performance with respect to the percentage of children not placed with *any* siblings also worsened, with the percentage of children placed with no siblings rising from 39 percent in March 2019 to 44 percent, in September 2019.

Table 22: Sibling Placements for Children Entering Placement
April - September 2019
N=886

Sibling Placement Status	Number (Percentage) of Children
Total Number of Children Entering Placement from April to September 2019 With a Sibling, or Who Have a Sibling Entering Placement Within 30 Days	886 (100%)
Children placed with **all siblings**	282 (32%)
Children placed with **at least one sibling**	492 (56%)
Children **not placed with any sibling**	394 (44%)

Source: CAPSS data provided by DSS

B. Placement Implementation Plan

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

[191] Exceptions have been approved, though not applied during this monitoring period; therefore, actual performance may be higher than reported. DSS will develop a process for review and approval of exceptions in future monitoring periods.
[192] The methodology utilized to calculate these data was evaluated by DSS, the Co-Monitors, and Chapin Hall, and adjustments were made in calculating performance for this monitoring period. As a result of this assessment, DSS shifted its methodology to one that evaluated placement on the 45th day after siblings entered care, to account for the fact that it often takes some time for DSS to locate a placement that can accommodate sibling groups. Calculations that are based on a different methodology – including, for example, one that assesses togetherness of all sibling groups in care on a specific date – may yield different performance data or data trends.

On February 20, 2019, after many months of work on a draft plan and the engagement of expert consultants, DSS obtained approval of its Placement Implementation Plan.[193] As previously reported, the Plan is comprehensive and ambitious, and aimed at addressing the root causes of the troubling performance reported above. It reflects a new reliance on children's family members, and a strong preference for keeping children, with appropriate supports, in family-based settings in their own communities. The Plan includes commitments to identify, engage, and support kin and fictive kin as placement and supportive resources for families, as well as to improve the recruitment and retention of foster parents. It also includes important commitments to restructured case planning and placement processes driven by well-constituted child and family teams engaged in collaborative assessment and decision-making; and to closer strategic partnerships with private providers to develop a placement and service array to meet the needs of children in custody. These are tremendous undertakings, which require not only significant resources, but re-orientation of the workforce and extensive engagement with key partners, such as foster parents and service providers. As contemplated in the Plan, initial implementation requires the use of technical assistance.

The transition in agency leadership and lack of funding in the FY2019-2020 budget has led to significant delays in DSS's implementation of the Placement Implementation Plan and, in many areas, key deadlines have passed without meaningful progress. Over the last few months, DSS leadership has focused on advocating for much-needed funding for this work in the FY2020-2021 budget, has assessed agency capacity vis-à-vis Plan requirements, and has taken some important steps towards establishing a foundation for roll out. Most notably, there has been a real attempt to engage the private provider community in strategic discussions, creating a working partnership that will be critical moving forward. As discussed below, DSS has also moved forward with the establishment of an internal structure that it believes will be sufficient for supporting the rollout of child and family teaming statewide.

Though these are significant steps, and the Co-Monitors commend the problem-solving approach DSS has taken in light of its financial and resource limitations, much more will be needed – in terms of both internal capacity and external expertise and community resources – to translate the vision that underlies DSS's Placement Implementation Plan into practice across the state. As the Co-Monitors have consistently reported, the strength of this Plan lies in its ambitious and comprehensive approach to addressing the root causes of the placement inadequacies that are preventing meaningful change – and at times causing more harm – for children and families. This requires not only the dedication of new staff and the influx of resources, but a true re-orienting of the values and principles that drive practice, a shift in thinking about how placement decisions are

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

made, and a new focus away from placements and towards community-based services and supports as a way of meeting the needs of children and families.[194]

Child and Family Teaming

DSS has worked over the past few months on the development of a structure for implementing the Child and Family Teaming (CFT) model envisioned in the Placement Implementation Plan. After years of delivering "family engagement programming" through a contracted provider, DSS leadership made the decision to build internal capacity to engage families and community partners. As of January 2020, DSS will have in place a newly designated Family Engagement Program Manager who will oversee 34 regional staff responsible for facilitating and supporting CFTs. Four of these staff will serve as family engagement "coaches," to train facilitators and ensure that team meetings are being held in a manner consistent with DSS's goals and values. Though the Placement Implementation Plan envisioned initial CFT rollout in two to three "pilot" counties, DSS reports that it plans to begin implementing the CFT model in the 10 counties that have been selected for its federal Program Improvement Plan (PIP) in April 2020, with the goal of full implementation statewide by February 2021.[195,196]

The shift from conceptualizing family engagement as a purchased service to understanding it to be a bedrock principle central to DSS's mission and work is an important one, and it will be a critical foundation for practice in partnership with families and communities. If integrated and understood at all levels of the Department, it will set the context in which the CFT model can be rolled out, allowing for assessment, planning, and decision-making through well constituted, collaborative Child and Family Teams. It is clear to the Co-Monitors that DSS will need significant ongoing support in carrying out this new vision, including through the type of on-site technical assistance envisioned in the Placement Implementation Plan. DSS reports that it is in the process of engaging a consultant in this capacity, and the Co-Monitors will closely track the development of this work.

In addition, as discussed with DSS leadership, it is the Co-Monitors' view that the success of this new model will ultimately depend not only on the capacity of a new team of dedicated family engagement staff, but on the ability of *all* DSS case managers to facilitate CFT meetings and practice in a way that is consistent with these values. Case managers are the primary means of connection with families. Without an ability of these staff to genuinely engage with, consistently assess, and work in a collaborative way to support the dynamic needs of families, the Co-Monitors

[194] Given the delays in implementation of the Placement Implementation Plan caused by resource constraints, there is a shared understanding that many of the timelines included in the Plan could not be met and may need to shift. DSS leadership, in collaboration with the Co-Monitors, is in the process of re-assessing the sequencing and timing for rollout of Plan commitments. The Co-Monitors have, therefore, not included a detailed implementation appendix tracking compliance with the original Plan commitments and timelines in this report.

[195] South Carolina Child and Family Services Review Round 3 Program Improvement Plan (PIP). Approved September 19, 2019. Revised October 28, 2019.

[196] The 10 "innovation counties" chosen for implementation of South Carolina's Program Improvement Plan (PIP) are: Greenville, Pickens, Aiken, Newberry, York, Fairfield, Chesterfield, Horry, Berkeley, and Jasper.

do not have confidence that meaningful improvements in practice will be possible. Building this capacity in a stable workforce will require significant resources, and purposeful, ongoing training, coaching, and follow through.

Quality and Safety Response

The Placement Implementation Plan required DSS to engage technical assistance by June 30, 2019, to assist with a plan for oversight of congregate care facilities to ensure children are safe and programming is appropriate. DSS reports that this work, which was initially delayed due to lack of funding, is now moving forward with assistance from outside consultants, and a focus on improved collaboration and communication between OHAN, Contract Monitoring, Licensing, and Regional Clinical staff, all of whom have roles in provider oversight. To focus the work more broadly and proactively, DSS is now referring to this area of work (referenced in Court documents as "Safety Monitoring") as "Quality and Safety Response," and reports that it will be overseen by a Quality and Safety Response Coordinator, a position for which hiring is in process.

DSS reports that it has also moved forward on permanency staffings for children ages 12 and under in congregate care, and that while these have been effective in drawing the attention of key DSS staff to the gaps in supports and services for some children in group placements, DSS has been limited in its ability to respond in a meaningful way due to the lack of a robust array of high quality services, supports, and alternative placements. Though the Placement Implementation Plan includes a goal of moving towards a Continuum Care model through which providers under performance-based contracts will garner community-based resources to support the families with whom they work, DSS has not moved forward in implementing strategies to support this goal.

Kin Placement

DSS reports that it is continuing to build an understanding among DSS staff, community partners, and court officials of its new approach to kinship foster care, including through the monthly convening of a relative caregiver and kinship foster care policy and practice advisory group. The Kinship Advisory Panel includes five kin caregivers, the kinship care manager, six kinship coordinators, and two representatives from advocacy groups. DSS reports that the group is currently working on revising a "What to Expect" guide for kinship caregivers, devising a draft survey for kin, and supporting Kinship Care Day at the state capitol. Though DSS has seen a small increase in the number of kin caregivers applying to be licensed foster parents, the lack of capacity to quickly process these applications – even with DSS's policy amendments that allow for waiver of some licensing requirements that do not relate to safety – has limited DSS's ability to enhance the number of provisionally or fully licensed kinship homes in any significant way. DSS reports that as of February 2020, there are 42 licensed kinship homes in the state and 82 pending applications. DSS is in the process of onboarding eight additional licensing workers to assist with processing these applications (as of January 2020, there were 74 applications pending), but it does not expect this to be anywhere near the capacity it needs to transition to a significant reliance on

kin caregivers. DSS has requested funding for this purpose in the FY2020-2021 budget, and is hopeful that it will allow for a full rollout of its Plan commitments around kinship licensing, payment, and support.

As discussed in the prior monitoring report, an emergency regulation was put in place through legislative action to allow for provisional licensure of kin caregivers, which became effective as of September 21, 2019. Though this has afforded DSS some flexibility in licensing kin foster parents, it has been utilized in only four instances as of February 2020. DSS continues to report that even with this provisional option in place, it is essential that it build capacity to fully license caregivers expeditiously, and that this remains its primary goal.

DSS also reports that it is in the process of developing a Request for Proposals for a statewide kinship navigator program with the support of a national child welfare organization. As outlined in the Placement Implementation Plan, the program is an essential support for kin caregivers throughout the state. Upon receiving funding for the initiative, DSS will work through an identified partner agency to provide a range of supports and connections to community resources, including concrete supports, peer support groups, assistance with benefit applications and legal issues, and guidance with licensure. DSS plans to replicate successful programming in the pilot site to three other regions throughout the state in FY2021-2022 to provide support to as many families as possible. DSS is also in the process of contracting with a provider for a training curriculum that is tailored specifically to the needs of family members who serve as placement resources.

Supports for Foster Parents

The Placement Implementation Plan required DSS to provide an initial increase in foster care board rates, effective July 1, 2019, to be followed by a more significant increase in July 2020.[197] In May 2019, the General Assembly approved a proviso allowing for this incremental increase, which is currently being paid to all foster parents licensed directly through DSS or through private Child Placing Agencies (CPAs). DSS has also committed to another increase that will go into effect on July 1, 2020, to more fully account for the costs of caring for a child in foster care and bring the rate of payment closer in line with other southern states. DSS has requested funding for this increase in the FY2020-2021 budget.

The DSS Placement Implementation Plan and the values embedded therein have the potential to drive a transformation in placement practices that can vastly improve the experiences of South Carolina's children and families. It is the Co-Monitors' hope that DSS is successful in advocating for and securing the funding and other resources needed to proceed with this critical aspect of reform.

[197] In accordance with the Court's May 15, 2019 Order reflecting Placement Implementation Plan commitments, rates were increased from a range of $13.47 to $17.84 per day to a range of $16.70 to $19.63 per day on July 1, 2019, and are to be increased in July 2020 to a range of $20.03 to $24.72 per day.

IX. FAMILY VISITATION

It is essential for children in foster care to have meaningful contact with their parent(s), siblings, and other relatives to maintain bonds, facilitate reunification, and instill a sense of stability and connection. Family visits help maintain connections, give children a sense of belonging, ease the trauma of separation, and help both parents and children remain hopeful for reunification. Time together should be frequent and in natural, comfortable settings whenever possible. DSS made progress this period in emphasizing, through worker training and communications with the family court, more normalized visits by permitting a move away from only allowing visits when supervised by a clinician or case manager (often in a visitation room at a DSS office). However, the majority of children in DSS custody with a permanency goal of reunification still do not visit with their parent(s), and many children do not spend time with their siblings who are also in foster care.

A. Performance Data

Sibling Visits

Section IV.J.2. of the FSA requires *"[a]t least 85% of the total minimum number of monthly sibling visits for all sibling visits shall be completed."*[198] Table 23 includes the approved Visitation Implementation Plan timeline and interim benchmarks for sibling visits:

[198] The FSA also allows for exceptions if there is a court order prohibiting or limiting visitation, if *"visits are not in the best interest of one or more of the siblings and the facts supporting the determination are documented in the case file,"* or with exceptions approved by the Co-Monitors (FSA IV.J.2.). The following are exceptions, approved by the Co-Monitors, to the sibling visitation requirement: court order prohibits or limits sibling visitation; child or sibling is on runaway during a calendar month with best efforts to locate; child or sibling is incarcerated or in a facility that does not allow visitation despite efforts; child or sibling refuses to participate in the visit, where age appropriate; sibling visit is infeasible due to geographic distance with efforts to provide alternative forms of contact (geographic distance will only be allowed as an exception upon individual review of the applicable case by the Co-Monitors); County Director approval with legal consultation for determination that a visit poses immediate safety concerns for the child or sibling (if an immediate safety incident or concern occurs prior to or during a visit, the case manager is to remove the child from the visit and notify the County Director afterward); and supervisory approval for determination that visitation would be psychologically harmful for the child. A DSS supervisor must confirm the determination that visitation would be psychologically harmful to the child based upon written documentation of a clinical decision issued by a Licensed Practitioner of the Healing Arts (LPHA) within the scope of their practice under SC State Law and who is not an employee of DSS. The LPHA's name, professional title, signature, and date must be listed on the document to confirm the clinical decision. In all instances listed above, the exception must be supported by documentation of the exception reason and best efforts to foster time with sibling(s).

Table 23: Baseline, Timeline, and Interim Benchmarks for Sibling Visits

Baseline	
November 30, 2017	66%
Timeline	**Interim Benchmark**
September 2019	**66%**
March 2020	70%
September 2020	76%
March 2021	85%
Final Target	**85%**

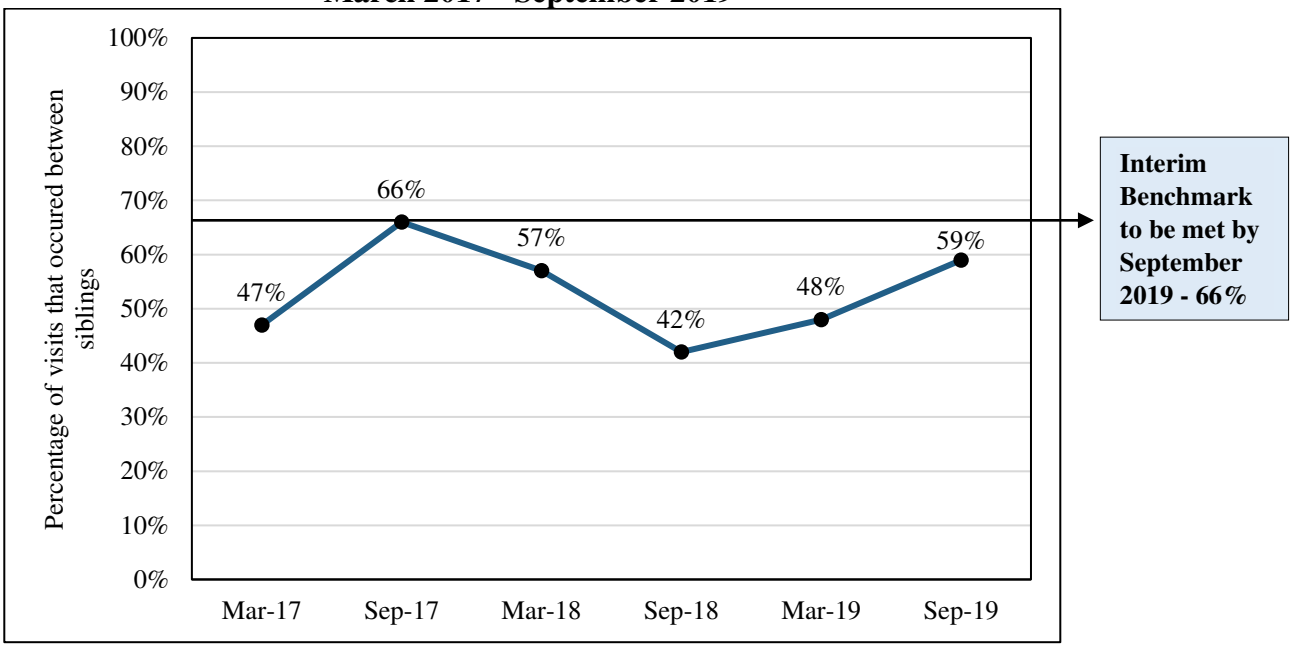
Source: Visitation Implementation Plan

When siblings in foster care reside separately, DSS policy requires face-to-face contact be coordinated monthly, at a minimum, and more frequently when possible. Unless one of the approved exceptions is met and documented in CAPSS, the expectation is that the case manager and caregivers arrange for ongoing, frequent interaction between siblings. These interactions are focused on face-to-face visits, and other types of contacts are encouraged including participation in extracurricular activities, video chats, phone calls, text messaging, photo exchanges, and letters.

Since August 2019, CAPSS contains new visitation screens for data entry, which should increase the validity of CAPSS management data on frequency of visits between separated siblings in foster care. DSS is planning to implement a quality assurance process of generating data reports and verifying data accuracy.[199] To obtain performance data for this monitoring period, however, USC and Co-Monitor staff conducted a case record review using a structured instrument to collect data on visits between children in foster care and living apart from a sibling who is also in foster care. Reviewers examined a sample of 315 records for required sibling visits in September 2019.[200] In five of the 315 records there was an applicable exception to a sibling visit.[201] Of the remaining 310 records, 182 (59%) had documentation reflecting a sibling visit occurred. This represents an improvement in performance from March 2019, as shown in Figure 33, but does not meet the September 2019 interim benchmark of 66 percent.

[199] The Joint Report requires by July 26, 2019 and monthly until automated, DSS conduct case reviews and collect spreadsheets from the field on parent and sibling visitation.
[200] During September 2019, there were 1,717 visits required between siblings who had been in foster care for at least 30 days and living apart. A statistically valid sample of 315 cases was reviewed based on a 95% confidence level and +/- 5% margin of error.
[201] Five cases were removed from the sample because case circumstances reflected a valid exception to the visit requirement: in 4 of these cases, a child or sibling refused to participate in a visit, and in 1 of these cases, it was determined that visitation would be psychologically harmful for the child.

Figure 33: Visits that Occurred between Siblings Placed Apart
March 2017 - September 2019



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

Parent-Child Visits

The FSA requires *"[a]t least 85% of Class Members with the goal of reunification will have in-person visitation twice each month with the parent(s) with whom reunification is sought […]"* (FSA IV.J.3.).[202] Table 24 includes the approved Visitation Implementation Plan timeline and interim benchmarks for this measure:

[202] The following are exceptions, approved by the Co-Monitors, to the parent-child visitation requirement: court order prohibits or limits parent visitation; parent is missing or child is on runaway during a calendar month with best efforts to locate; parent or child is incarcerated or in a facility that does not allow visitation in the calendar month despite best efforts; parent refused to participate; parent did not show up to visit despite attempts to successfully arrange and conduct the visit; parental rights were terminated in that month; parent visit is infeasible due to geographic distance, with efforts to provide alternative forms of contact (geographic distance will only be allowed as an exception upon individual review of the applicable case by the Co-Monitors); County director approval with legal consultation for determination that a visit poses immediate safety concerns for the child. In addition, if an immediate safety incident or concern occurs prior to or during a visit, the case manager is to remove the child from the visit and notify the county director afterward; and supervisory approval for determination that visitation would be psychologically harmful to the child. A DSS supervisor must confirm the determination that visitation would be psychologically harmful to the child based upon written documentation of clinical decision issued by a Licensed Practitioner of the Healing Arts (LPHA) within the scope of their practice under SC State Law and who is not an employee of DSS. The LPHA's name, professional title, signature, and date must be listed on the document to confirm the clinical decision. In all instances, the exception must be supported by documentation of the exception reason and best efforts to foster time between the parent and child.

Table 24: Baseline, Timeline, and Interim Benchmarks for Parent-Child Visits

Baseline	
November 30, 2017	12%
Timeline	**Interim Benchmark**
September 2019	**35%**
March 2020	60%
September 2020	75%
Final Target - March 2021	**85%**

Source: Visitation Implementation Plan

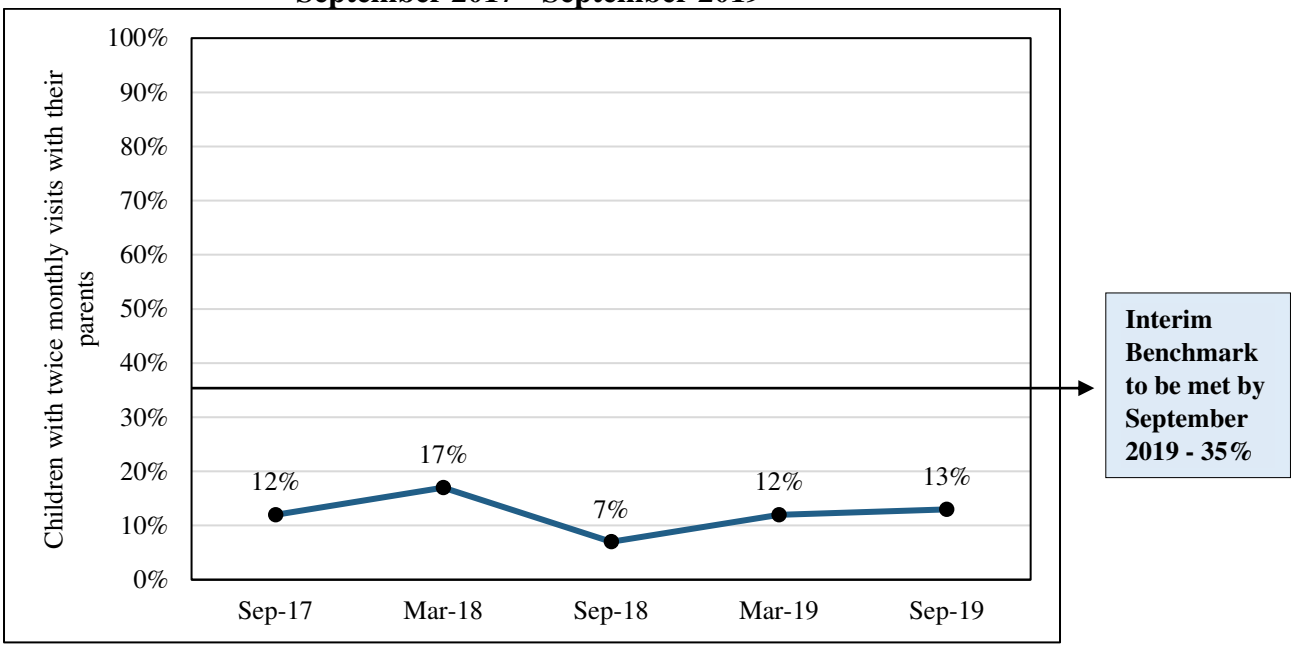
A child's case manager is expected to arrange for parents to visit with their child within one week of the child entering foster care, unless such contact is prohibited by court order.[203] Within 30 days of a child entering foster care, the case manager must create a plan for visits with input from the child, the parents/guardians, other significant persons, foster parent or congregate care provider, the guardian ad litem, and, if applicable, the child's therapist or mental health provider.[204] According to DSS policy, DSS may not recommend visits with parents less than two times per month, unless limited by a court order. Similar to guidance about forms of communication between siblings, DSS has communicated the importance of contacts between children and their parents outside of visits, to include video and phone calls, text messages, and emails, unless contrary to the child's safety or well-being, as determined by a clinician or court order. DSS policy also states that neither DSS staff nor placement providers can limit or prohibit family contact as a disciplinary measure.

Management data on frequency of parent-child visits are not available through CAPSS.[205] To obtain valid performance data, USC and Co-Monitor staff utilized a structured instrument to collect data on visits between children in foster care and the parent(s) with whom reunification is sought. Reviewers examined a sample of 334 records for visits between a child and their parent(s) were required in September 2019.[206, 207] In nine of the 334 records, there was documentation of an applicable exception to this requirement.[208] Of the remaining 325 records, forty-four percent (144

[203] Human Services Policy and Procedural Manual, Chapter 5, Section 510.7.300.
[204] Ibid.
[205] The Joint Report requires by July 26, 2019, and monthly until automated, DSS conduct case reviews and collect spreadsheets from the field on parent and sibling visitation.
[206] As of September 30, 2019, there were 2,568 children who had been in foster care for at least 30 days with a goal of "return to home" or "not yet established." A statistically valid sample of 334 cases was reviewed based on a 95% confidence level and +/- 5% margin of error.
[207] Permanency goals were identified utilizing data in the CAPSS field in which case managers are expected to update case goals in accordance with the most current determination in legal proceedings.
[208] Nine cases were removed from the sample because case circumstances reflected a valid exception to the visit requirement. In 5 of these cases, the parent was missing with best efforts to locate; in 1 case the parent refused to participate; in 1 case, the visit was

of 325) of children had one visit with each parent with whom reunification was sought and in eight additional records, there was documentation that the child visited twice with one of two parents, not both, with whom the child is to reunify. Only 43 (13%) records had documentation of a child visiting with all parent(s) with whom the child is to reunify during September 2019. This is far below the September 2019 performance benchmark of 35 percent. Figure 34 shows performance has remained steady since 2017 when it was 12 percent.

Figure 34: Children with Twice Monthly Visits with Their Parents
September 2017 - September 2019



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

B. Visitation Implementation Plan

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

DSS's Visitation Implementation Plan, approved by the Co-Monitors on March 28, 2019, includes strategies to strengthen practice with respect to time spent with and communication between

infeasible due to geographic distance; in 1 case, it was determined that visitation would be psychologically harmful for the child; and in 1 case, the parent did not visit despite attempts to arrange and conduct a visit.

children in foster care and their family members. It includes strategies related to the cultivation of a shared understanding of the purpose and critical function of family visits, increasing the frequency of family visits, and increasing the quality of data and documentation of parent-child and sibling visits. DSS made some progress towards these goals over the last few months, as described below. Status updates on Plan commitments as of October 31, 2019 are included in Appendix C.

To establish a shared understanding of the importance of parent-child and sibling visits, DSS implemented "Visitation Awareness Training" for staff throughout the state.[209] DSS reports the training focused largely on improving documentation with respect to visits. Visitation Awareness Training is now in the training plan for all new case managers, and the training is available on a quarterly basis throughout the state. New fields have been added to the Learning Management System, the platform used for training registration, which will allow DSS to more accurately track training participation. Also integrated into CAPSS is a new Visitation Plan document, which is expected to be completed by a child's case manager with information regarding who will participate in visits, where the visits will occur, activities to occur during visits, circumstances under which a visit may end, and the levels of supervision required for a visit.[210] DSS has memorialized its expectations in a document entitled "Elements of a Visitation Plan," which has been distributed to all DSS staff.

DSS reports continued work with the SC Foster Parent Association and CPAs to define the role of private agency staff in planning for and supporting effective visits with family members. In November and December 2019, DSS worked with the SC Foster Parent Association to build the Association's capacity to deliver Visitation Awareness and Shared Parenting training. DSS expects that by June 2020, foster parents and group home providers will be fully able to document visits directly in the "Child and Adult Information Portal," which should be available in March 2020. Providers will be given guidance and expected to document the practice of each element of visits and "any structure that was created during the visit to encourage/teach positive interactions and/or parenting skills; and a description of efforts to develop community connections for the youth and/or family."[211]

Given the essential purpose of time children in foster care spend with family members and the significant number of children who are spending little, if any, time with family, it is critical that DSS move expeditiously towards improving the frequency and quality of time family members spend together, as well as encouraging and supporting other forms of maintaining contact.

[209] DSS reports that 732 staff, including 132 supervisors, have now participated in a Visitation Awareness training session. Fifteen County attorneys (25% of attorneys in this role statewide) have also participated.
[210] Level of supervision of visits include: Therapeutic - supervised by a licensed clinician; Supervised - a monitor is present at all times with the child(ren) and adults who are visiting each other; Monitored - a monitor is in the same location, facility or home during the visit between the child(ren) and adults who are visiting each other; and Unsupervised - no monitor is present.
[211] SC DSS Form 30263 (April 13), Foster Parent Documentation – Visitation, Maintaining Family Connections (planned for Child and Adult Information Portal).

X. HEALTH CARE

States must provide children in foster care with the supports and services they need to be healthy. This requires the ability to quickly identify children's physical and behavioral health needs, to provide high quality preventative and acute care, and to maintain a system for tracking care delivery and communicating key health care information. After many periods without significant progress in this area, DSS re-focused its efforts in recent months, purposefully and intensively addressing several important structural issues and establishing a clearer direction to guide the work ahead. This comes at a critical time as – more than three years after entry into the FSA and 18 months since finalization of the Health Care Improvement Plan – data show that many children are not receiving required medical visits, and there remains a need throughout the state for quality community-based services and supports to meet children's needs. It is the Co-Monitors' hope that this will enable DSS to accelerate the pace of implementation in the coming months so that much needed reform in this fundamental area of practice can take hold.

A. Performance Data

Since finalization of the Health Care Improvement Plan (discussed in more detail below), DSS has worked with the South Carolina Department of Health and Human Services (DHHS) and Select Health, the Managed Care Organization (MCO) for the vast majority children in foster care, to put systems in place for the sharing, analysis, and dissemination of data. Although this opened up access to large quantities of information, DSS has struggled to understand how to utilize these data. Over the last few months, through the focused efforts of a team of dedicated staff, DSS has deepened its understanding of how these data can be effectively utilized to track the health care status of the children in its care. Though there is a long way to go before these data are readily available to regional and county staff for use at the case level – and, even, in some areas, before they can be translated into an aggregate data report – this is a significant step forward.

Unless otherwise noted, data included herein were extracted from DHHS's Medicaid claims records and processed by DSS to align with FSA measures. Though in some instances the Co-Monitors adjusted the data to address miscalculations or reflect agreed-upon methodologies, these data have not been independently validated.[212]

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

[212] DSS believes that data for many measures included herein understate actual performance because they are extracted from a single data source – in most instances, Medicaid claims data – which does not capture all instances in which children receive medical visits. For example, visits for children who did not have Medicaid IDs at the time of the data pull, or who were seen by non-Medicaid providers, would not be included.

"reviewing all available data and medical history about the child or adolescent;" identifying medical, developmental, and mental health conditions requiring immediate attention; and developing an "individualized treatment plan."[213]

In the DSS Health Care Outcomes, approved by the Co-Monitors on December 21, 2018, DSS committed, based on AAP guidelines, 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*."[214] On May 3, 2019, the Co-Monitors approved the following interim performance benchmarks, based on initial data available at the time:[215]

Table 25: Interim Benchmarks Timeline for Comprehensive Medical Assessments

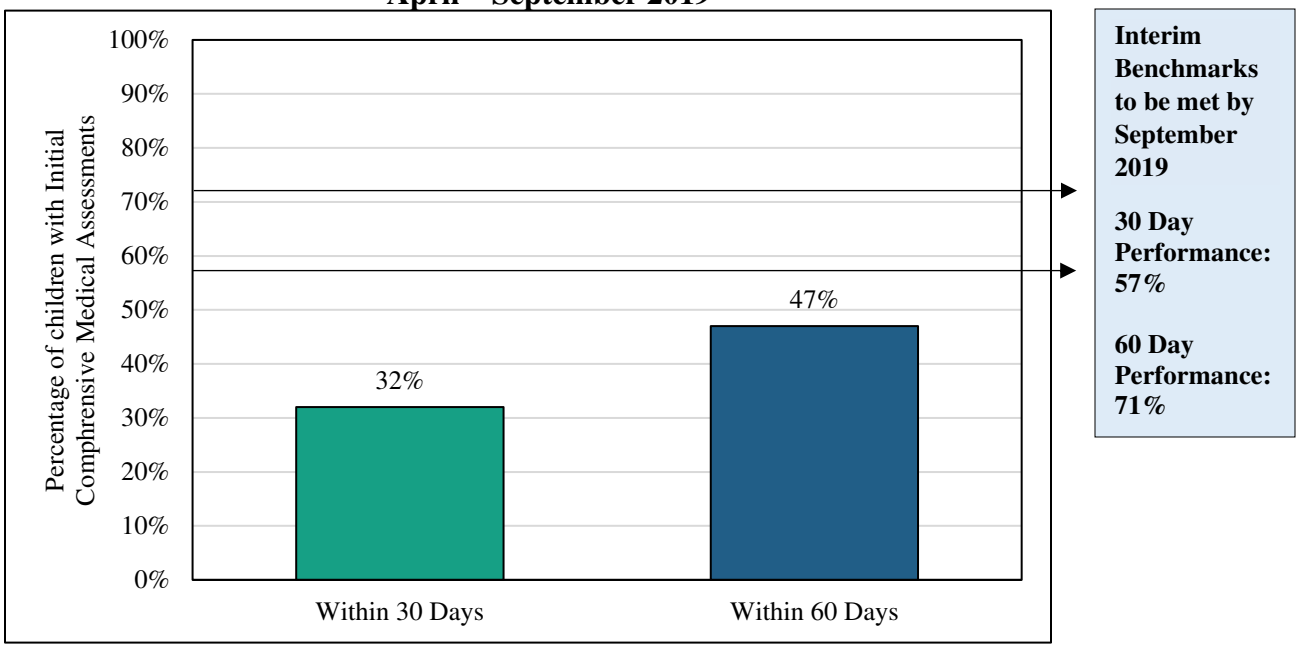
Interim Benchmark Timeline	Within 30 Days	Within 60 Days
September 2019	**57%**	**71%**
March 2020	76%	90%
September 2020	80%	92%
Final Target - March 2021	**85%**	**95%**

Source: Health Care Improvement Plan Baseline Data and Interim Benchmarks

DSS reports that 32 percent (553 of 1,746) of children who entered care between April and September 2019 and were in care for at least 30 days received an initial comprehensive medical assessment within 30 days, and 47 percent (702 of 1,488) of children received an initial comprehensive medical assessment within 60 days (see Figure 35). This performance is significantly below the September 2019 interim benchmarks.[216]

[213] *Fostering Health: Health Care for Children and Adolescents in Foster Care*, 2d. ed (16-17). American Academy of Pediatrics (2003)), p. 22.
[214] The Health Care Outcomes are available at: https://dss.sc.gov/media/1958/appendix-b-final-health-care-targets.pdf
[215] Baseline performance data for this and other health care measures discussed in this section were determined in 2018 by DSS, in coordination with DHHS and external health care consultants. The data were not independently validated by the Co-Monitors, and, in some instances, were extracted based upon methodologies that are different from those that have since been approved by the Co-Monitors. As a result, initial baseline data are no longer comparable to data reported in this and future monitoring periods and have not been included in this report.
[216] This performance is also below that reported for the period October 2018 through March 2019, which was 36 and 52 percent respectively. Due to adjustments made by the Co-Monitors in reviewing the data for the current period, these data may not be directly comparable to those for the prior period.

Figure 35: Initial Comprehensive Assessments in 30 and 60 Days
April – September 2019



Source: Medicaid claims data provided by DSS

Periodic Well-Child Visits

In accordance with AAP guidelines for health care delivery for children in foster care, periodic preventative well-child visits are to 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."[217] Based on these guidelines, DSS committed in its Healthcare Outcomes that, "*At least 90% of Class Members under the age of six months in care for one month or more will receive a periodic preventative visit monthly. At least 90% of Class Members between the ages of six months and 36 months in care for one month or more will receive a periodic preventative visit in accordance with current American Academy of Pediatrics periodicity guidelines;*[218]*at least 98% will receive a periodic preventative visit semi-annually. At least 90% of Class Members ages three and older in care for six months or more will receive a periodic preventative visit semi-annually; at least 98% will receive a periodic preventative visit annually."*[219]

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

On May 3, 2019, the Co-Monitors approved the following interim performance benchmarks, based on initial data available at the time:[220]

Table 26: Interim Benchmarks Timeline for Periodic Preventative Visits

Interim Benchmark Timeline	Monthly Visit for Class Members Ages Birth-6 Months	Periodic Visit for Class Members Ages 6-36 Months	Semi-Annual Visit for Class Members Ages 6-36 Months	Semi-Annual Visit for Class Members Ages 3+ Years	Annual Visit for Class Members Ages 3+ Years
September 2019	**79%**	**77%**	**84%**	**50%**	**83%**
March 2020	83%	81%	88%	63%	88%
September 2020	86%	86%	93%	77%	93%
Final Target - March 2021	**90%**	**90%**	**98%**	**90%**	**98%**

Source: Health Care Improvement Plan Baseline Data and Interim Benchmarks

DSS has been unable to produce data for this measure in prior monitoring periods. Over the last few months, it has re-assessed its methodology for extracting these data, in partnership with DHHS, and worked to recalculate performance data initially submitted for the period October 1, 2018 to March 31, 2019. Because DSS has not yet produced data for the monitoring period under review, updated data for the prior period are included here.

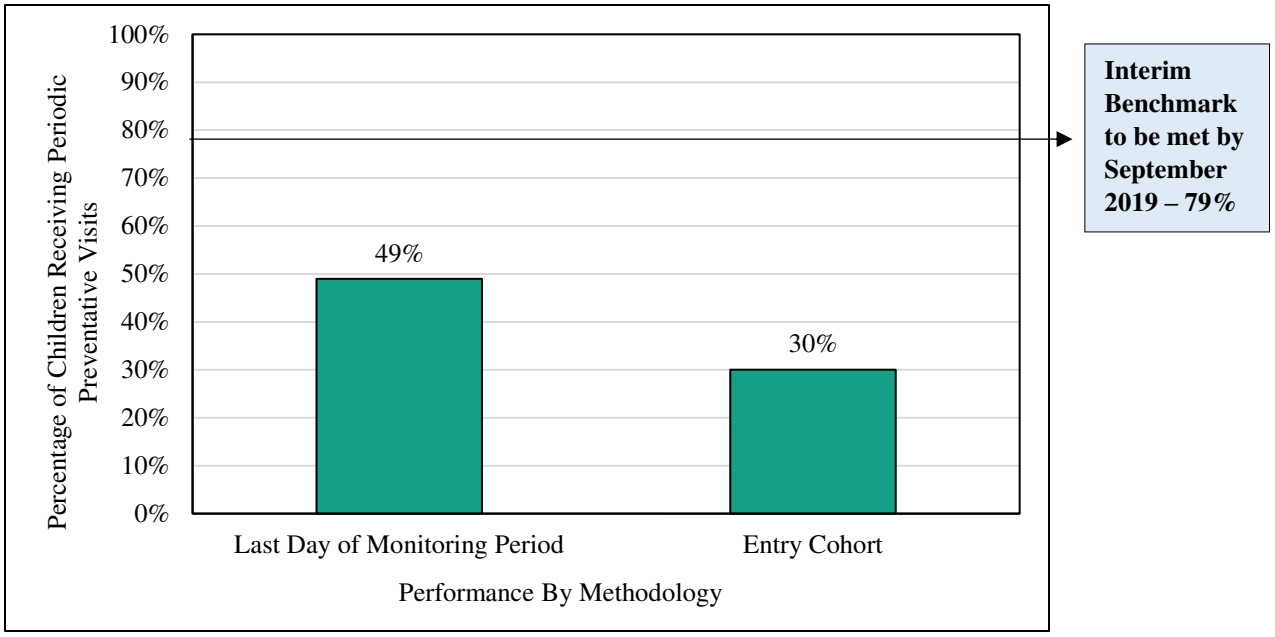
Children Under the Age of Six Months

Given the number of children who leave DSS custody within six months, and the health risks that very young children face, DSS utilizes two methodologies to capture the required monthly medical visits for children under the age of six months: one applies to all children under the age of six months *entering care* in a given period, and the other to children under the age of six months who are *in care on the last day of the reporting period*.

According to either methodology, performance is significantly below the September 2019 benchmark of 79 percent. Data reflect that of all children under the age of the six months who entered foster care from October 1, 2018 to March 31, 2019 and who have been in care for at least 30 days, 30 percent (41 of 137) received at least a monthly well visit as required. Of children under six months of age in care on the last day of the monitoring period (March 31, 2019), 49 percent (40 of 82) received at least one monthly well visit as required (see Figure 36).

[220] Baseline performance data for this and other health care measures discussed in this section were determined in 2018 by DSS, in coordination with DHHS and external health care consultants. The data were not independently validated by the Co-Monitors, and, in some instances, were extracted based upon methodologies that are different from those that have since been approved by the Co-Monitors. As a result, initial baseline data are no longer comparable to data reported in this and future monitoring periods and have not been included in this report.

Figure 36: Periodic Preventative Visits for Children Under 6 Months of Age October 2018-March 2019



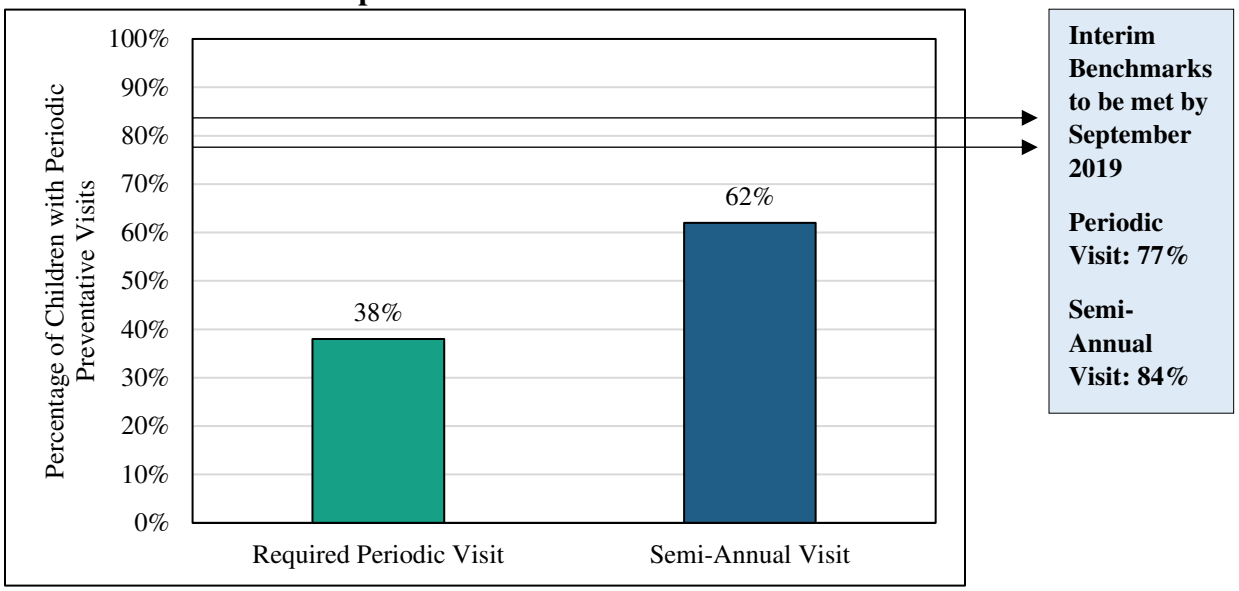
Source: Medicaid claims data provided by DSS

Children Ages Six to 36 Months

For children between the ages of six and 36 months, the AAP recommends that children receive well visits at six, nine, 12, 15, 18, 24, 30, and 36 months. Of all children who were between the ages of six and 36 months and who had been in care for at least 30 days on March 31, 2019, 38 percent (275 of 726) received periodic well visits as required.[221] Of those in this age group who had been in care for at least six months on March 31, 2019, 62 percent (347 of 564) of children received semiannual periodic well visits (see Figure 37). This performance is significantly below the September 2019 targets of 77 percent and 84 percent, respectively.

[221] Given the manner in which the dates of periodic preventative visits were extracted and reproduced by DSS during this monitoring period, the analysis for this measure covers a 12-month period, from April 2018 to March 2019.

Figure 37: Periodic Preventative Visits for Children Ages 6 to 36 Months
April 2018-March 2019

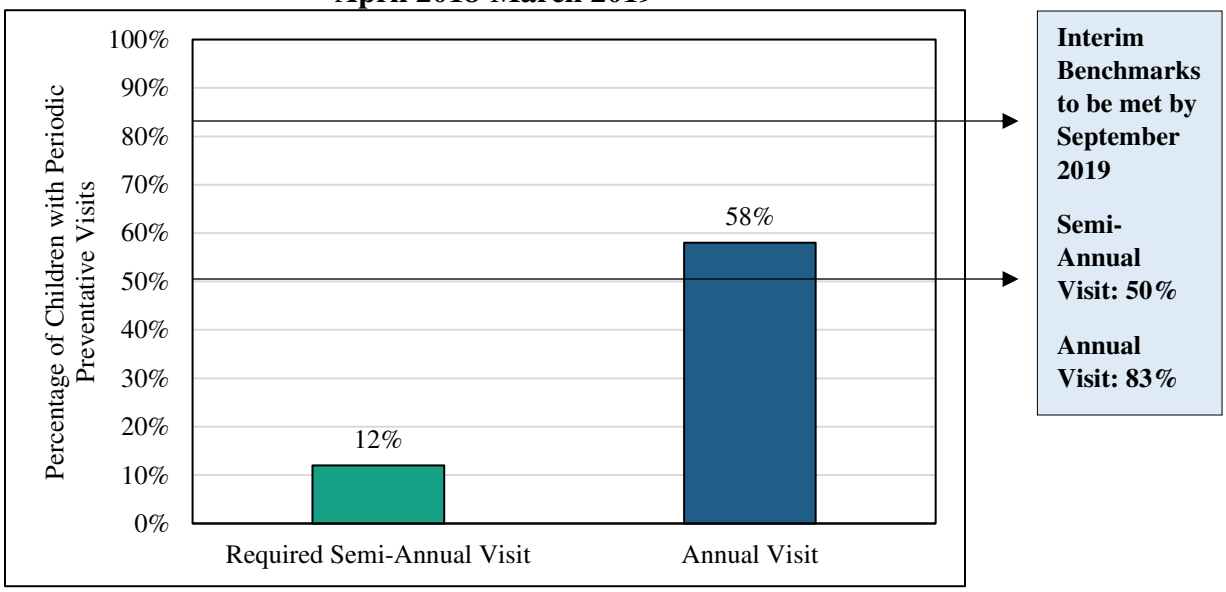


Source: Medicaid claims data provided by DSS

Children Ages Three and Above

For children ages three years and older who had been in care for 12 months or more on March 31, 2019, 12 percent (212 of 1,828) of children had semi-annual well visits as required. Fifty-eight percent (1,057 of 1,828) of children in care for 12 months or more had at least an annual periodic well visit between April 1, 2018 and March 31, 2019 (see Figure 38).[222]

Figure 38: Periodic Preventative Visits for Children Ages 3 Years and Older
April 2018-March 2019



Source: Medicaid claims data provided by DSS

[222] Ibid.

Developmental Assessments

In the DSS Health Care Outcomes, approved by the Co-Monitors on December 21, 2018, 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."* The Co-Monitors approved the following interim performance benchmarks:

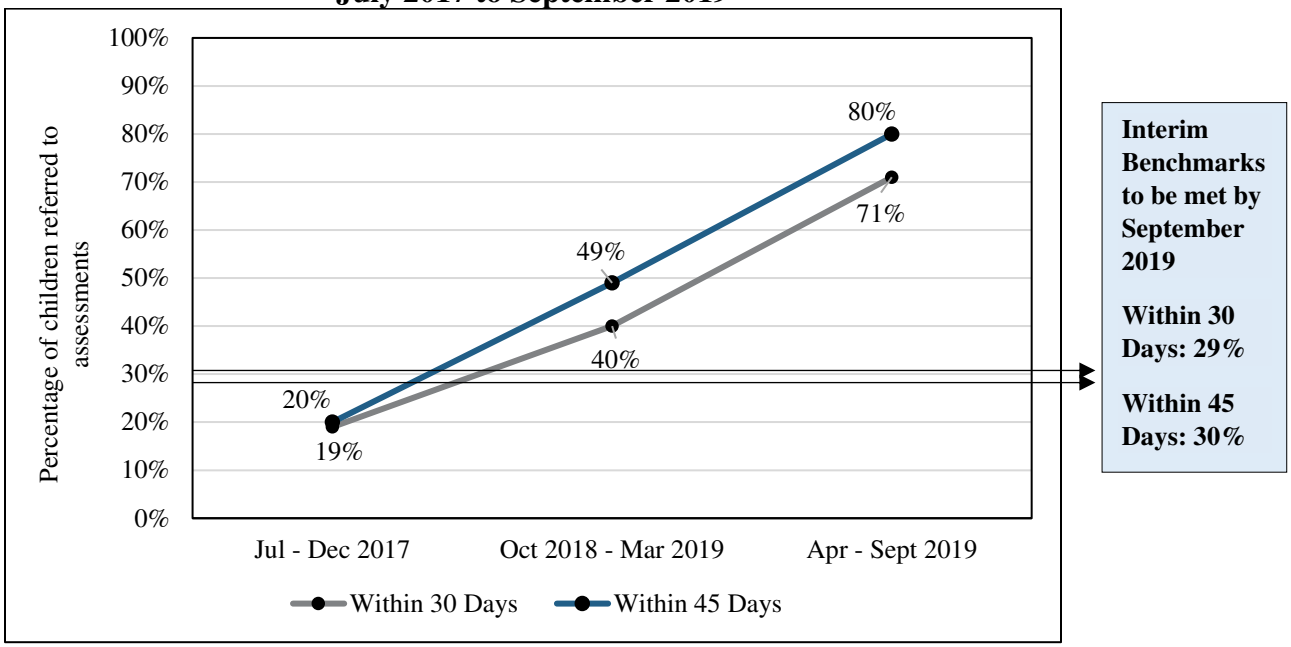
Table 27: Interim Benchmarks Timeline for Developmental Assessments

Interim Benchmarks Timeline	Within 30 Days	Within 45 Days
September 2019	**29%**	**30%**
March 2020	39%	40%
September 2020	64%	67%
Final Target - March 2021	**90%**	**95%**

Source: Health Care Improvement Plan Baseline Data and Interim Benchmarks

DSS put a particular focus this reporting period on ensuring that all children under 36 months of age are referred for developmental assessments to determine if early intervention services are needed, and made significant progress both in documenting referrals that had been made and making new referrals where needed. DSS reports that 71 percent (325 of 460) of children under 36 months of age who entered care between April and September 2019 were referred to BabyNet – the state entity responsible for developmental assessments – within 30 days. Eighty percent (334 of 416) of children were referred within 45 days. These data significantly exceed DSS baseline performance of 19 percent and 20 percent, as well as performance of 40 and 49 percent in the last monitoring period (see Figure 39). This performance also surpasses September 2019, March 2020, and September 2020 interim benchmarks, and marks a significant accomplishment for DSS. It is important to note that these data only measure that a child was *referred* for a developmental assessment and do not capture whether or not an assessment occurred. DSS reports that it is also working to improve its system for tracking completion of these assessments and any recommended follow-up care. This will be essential work.

Figure 39: Developmental Assessments within 30 and 45 Days
July 2017 to September 2019



Source: CAPSS data provided by DSS

Initial Dental Examinations

In the DSS Health Care Outcomes, 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*." The Co-Monitors approved the following interim performance benchmarks:

Table 28: Interim Benchmarks Timeline for Initial Dental Examinations

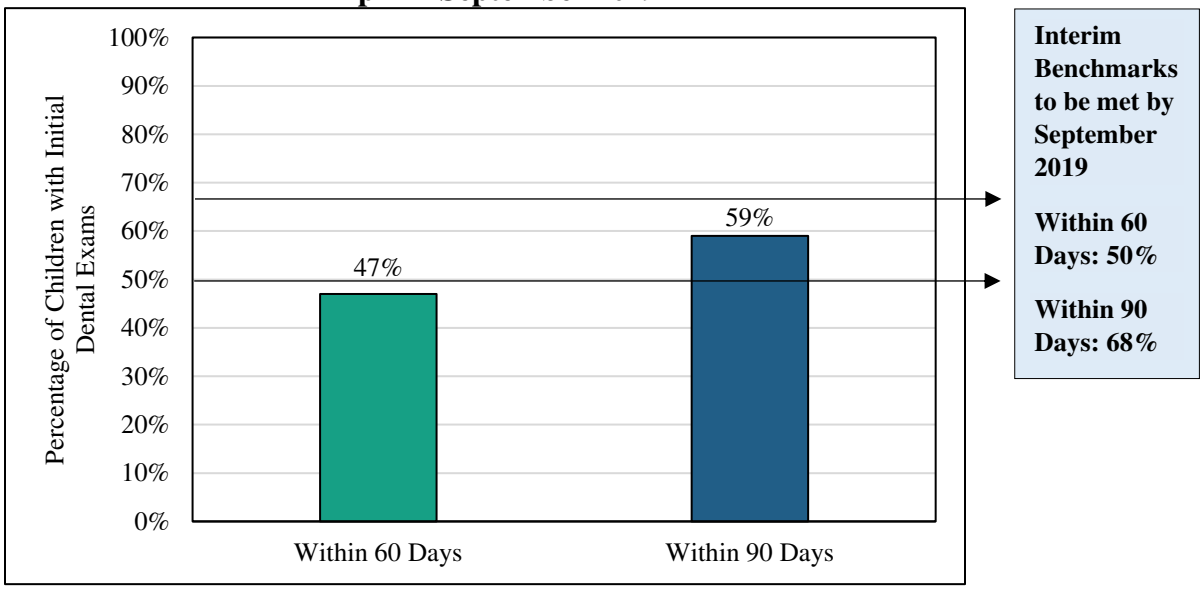
Interim Benchmarks Timeline	Within 60 Days	Within 90 Days
September 2019	**50%**	**68%**
March 2020	54%	75%
September 2020	60%	83%
Final Target - March 2021	**60%**	**90%**

Source: Health Care Improvement Plan Baseline Data and Interim Benchmarks

DSS reports that 47 percent (449 of 958) of children ages two years and older who entered care between April and September 2019 received an initial dental exam within 60 days, and that 59 percent (402 of 683) received a dental exam within 90 days of entering care (see Figure 40). This

excludes children who had a visit within three months before entering care. Performance remains below the September 2019 interim benchmark.

Figure 40: Initial Dental Exams within 60 and 90 Days
April – September 2019



Source: Medicaid claims data provided by DSS

Periodic Dental Exams

In the DSS 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."* The Co-Monitors approved the following interim performance benchmarks:

Table 29: Interim Benchmarks Timeline for Periodic Dental Exams

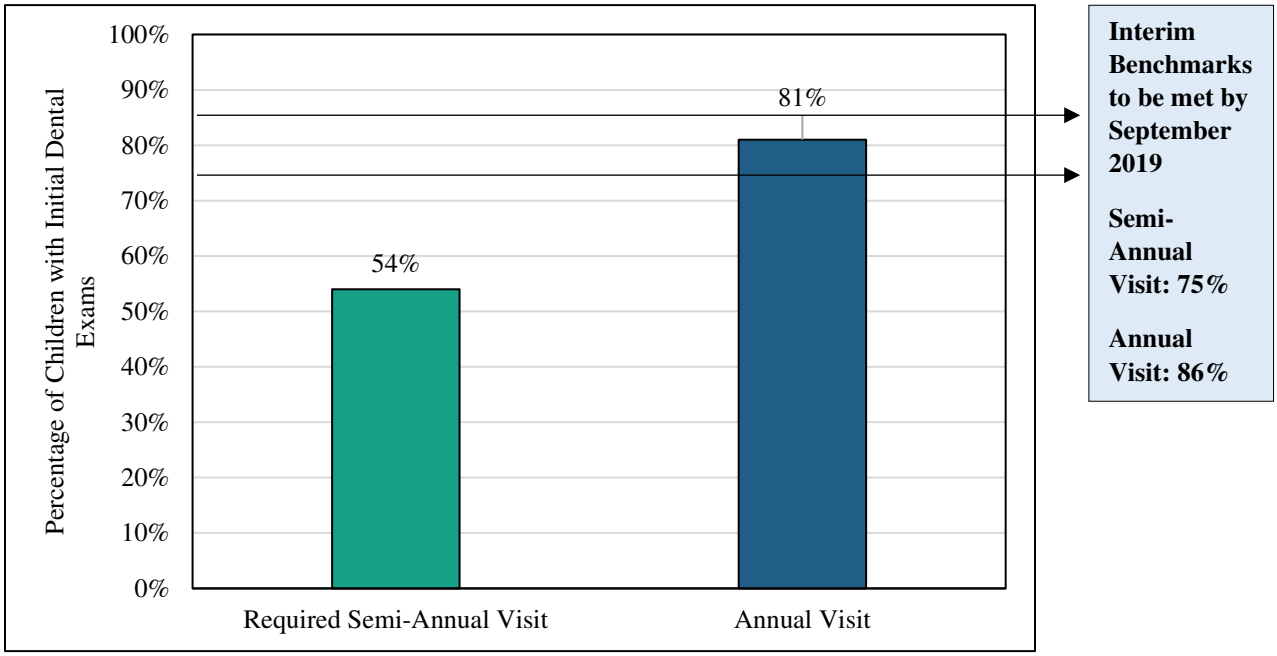
Interim Benchmarks Timeline	Semi-Annual Visit for Class Members 2+ Years	Annual Visit for Class Members 2+ Years
September 2019	**75%**	**86%**
March 2020	75%	87%
September 2020	75%	89%
Final Target - March 2021	**75%**	**90%**

Source: Health Care Improvement Plan Baseline Data and Interim Benchmarks

To measure performance on periodic preventative dental visits, DSS reported data to the Co-Monitors for the period of October 1, 2018 to March 31, 2019. DSS reports that 54 percent (1,427

of 2,623) of children ages two years or older on the last day of the monitoring period received a semi-annual dental visit as required, and that 81 percent (1,563 of 1,919) received an annual visit (see Figure 41). This performance does not meet the September 2019 interim benchmark.

Figure 41: Periodic Dental Exams
October 2018 – March 2019



Source: Medicaid claims data provided by DSS

B. Health Care Improvement Plan

DSS Health Care Improvement Plan and Addendum Approval

The FSA required that by April 3, 2017, DSS "*with prior input and subject to approval by the Co-Monitors, shall develop a Health Care Improvement Plan with enforceable dates and targets for phased implementation concerning initial screening services, periodic screening services, documentation, and health care treatment services for Class Members in the areas of physical health, immunizations and laboratory tests, mental health, developmental and behavioral health, vision and hearing, and dental health. The Plan shall address:*

(a) *Developing the capacity to track screening and treatment services for individual children and aggregate tracking data, including but not limited to screens that are due and past due;*

(b) *Assessing the accessibility of health care screening and treatment services throughout the State, including the capacity of the existing health care providers to meet the screening and treatment needs of Class Members; and*

(c) *Identifying baselines and interim percentage targets for performance improvement in coordinating screens and treatment services"* (FSA IV.K.1.(a-c)).

On August 23, 2018, after many months of review and input from the Co-Monitors and Plaintiffs, and the support of health care consultants, DSS obtained Co-Monitor approval for its Health Care Improvement Plan. In granting Plan approval, the Co-Monitors indicated that DSS would need to update it to include two critical components it was not yet prepared to submit: (1) baselines and interim percentage targets (FSA IV.K.1.(c)); and (2) a proposed model of health care case management and care coordination, with updated associated budget projections.

The FSA also required that within 120 days of the completion of the Health Care Improvement Plan, the Co-Monitors, with input from Parties, would *"identify the final health care outcome measures related to initial screening services, periodic screening services, documentation, treatment and other corrective services, which Parties agree will be final and binding"* (FSA IV.K.5). After consulting with Parties and the health care consultants, the Co-Monitors submitted final health care outcomes to the Court on December 21, 2018. These outcomes are intended to guide health care implementation, and to serve as measures of DSS's progress in meeting the physical health, mental health, and dental needs of the children in their care. In accordance with FSA K.1.(c), DSS updated its Health Care Improvement Plan to include baselines and interim percentage targets for meeting these final health care outcomes.[223]

Pursuant to the Health Care Improvement Plan and a January 15, 2019 Court Order,[224] DSS was required to submit a detailed model for health care case management and care coordination for Co-Monitor approval by February 21, 2019. After significant work with the DSS Health Care Workgroup, the health care consultants, and DSS partners, the Health Care Addendum was approved by the Co-Monitors on February 25, 2019, establishing 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, and foster and biological families. [225] Though a rough delineation of roles were included in the Addendum, it was approved with the understanding that additional detail would need to be determined through implementation, and the efficacy and adequacy of the model would be assessed after each implementation year to see if it requires any changes or additions.

DSS Health Care Improvement Plan and Addendum Implementation

Under the leadership of Gwynne Goodlett, Director of the DSS Office of Child Health and Well-Being, and in collaboration with DHHS and Select Health, DSS made significant strides this period in implementing its Health Care Improvement Plan and Addendum. This was largely the result of the team's transition to a real problem-solving approach, with deliberate focus on the structural

[223] The Health Care Outcomes are available at: https://dss.sc.gov/media/1958/appendix-b-final-health-care-targets.pdf
[224] Court Order (January 15, 2019, Dkt. 105). Civil Action No.: 2:15-cv-00134-RMG.
[225] The Health Care Addendum is available at: https://dss.sc.gov/media/1962/2-25-2019-approved-health-plan-addendum.pdf

elements of the Plan that will be essential to implementation. These include: data development; internal capacity building; defining and operationalizing DSS's partnership with Select Health; and building an understanding of funding mechanisms that will support and sustain this work. Status updates on Plan commitments as of October 31, 2019 are included in Appendix E of this report.

Data Development

Although DSS had been receiving data from both DHHS and Select Health for the last year, it has struggled to analyze and utilize it. Inconsistencies in data sets, lags in report production, and lack of capacity for interpreting and disseminating the data led to concerns, as previously reported by the Co-Monitors, that DSS had over-relied on these administrative data sets in developing its Plan. While some of these concerns are founded – DSS has, for example, learned that, for various reasons, these retrospective data can only be used in combination with real-time, reliable case manager documentation. DSS has now begun to develop (largely during this monitoring period) a much more complex understanding of how these data can be used to enhance its understanding of children's health care needs moving forward.

Of equal importance are DSS's efforts during this monitoring period to review the case files of the children in its care to discern the date of children's last well-child visit with a medical provider. Over a period of three months, and with the help of 40 trained reviewers, DSS was able to extract this information for *every one of the 5,160 children* in its foster care custody during the period between October 1 and December 31, 2019. This process not only provided data that is useful for DSS's management purposes, but brought case records up to date, paving the way for DSS's new Child Health and Well-Being Staff (discussed below) to work prospectively on tracking health care delivery.[226] This review also helped quell concerns, in the absence of other reliable data sources, that DSS might be unaware of children lingering in foster care without contact of any kind with a health care provider.[227]

[226] 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 this was initially intended to apply to children in DSS custody at the time of entry into the agreement in October 2016, DSS has lacked a mechanism for measuring performance with respect to this requirement. On October 28, 2019, DSS and Plaintiffs entered into a *Joint Agreement on the Immediate Treatment Needs of Class Members*. This agreement was formally entered by the Court on November 4, 2019 (Dkt. 162). The Joint Agreement sets 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, applying the intent of this provision to a more current cohort of Class Members. Included in this agreement is the commitment that by December 31, 2019, DSS would have the date of the last well-child visit entered into the CAPSS record of every Class Member, and that by February 1, 2020, it would produce a report (updated monthly thereafter) indicating the date by which each child in foster care is due to have their next well-child visit, as well as children identified as requiring follow-up care for an immediate treatment need, and whether the necessary visits have been scheduled and attended.

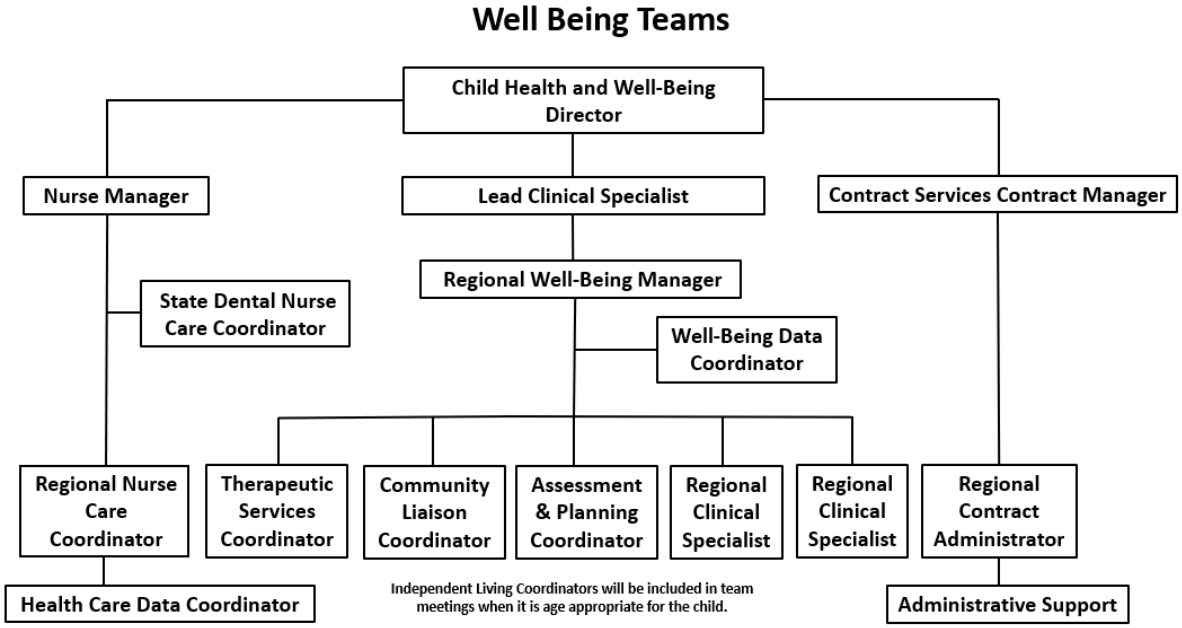
[227] DSS determined that in 79% of the cases reviewed, the child had a visit with a medical provider within the prior 12 months; in 43%, the child had been seen by a provider in the prior 6 months; and in 90%, the child had been to a provider in the prior 18 months. It is important to note that though the collection of these data represents a significant accomplishment for DSS, the data are not intended to indicate the extent to which a child has received *all* needed medical visits. Many children reviewed were, for example, required to have more than 1 visit with a provider in the designated time period (in accordance with *Fostering Health* guidelines and FSA commitments).

Internal Capacity Building

DSS made significant progress in building its internal capacity to track children's health care needs during this period. Notably, it hired and onboarded four of the six nurses who will staff the Office of Child Health and Well-Being. As of January 2020, there is one Regional Nurse Coordinator in place for three of DSS's four regions. DSS reports that a dental nurse will be in place to oversee the delivery of dental care to children in foster care by March 2020. Together, with the support of administrative staff, DSS believes this team of nurses will provide medical expertise and the ability to track health care visits and needs for all children in care.

DSS also moved forward this period to establish regional Well-Being Teams (shown in Figure 42), that will be overseen by Regional Well-Being Managers, and staffed by Regional Nurse Care Coordinators, Regional Clinical Specialists, and other members – including a Therapeutic Services Coordinator, a Community Liaison, an Assessment and Planning Coordinator, a Well-Being Data Coordinator and Healthcare Data Coordinator – who were formerly part of the IFCCS structure. Based on a model utilized effectively in Tennessee, the Well-Being Teams will operate in coordination with state Office of Child Health and Well-Being staff, and will help to assess and manage the well-being needs of children in foster care. The decision to transfer existing IFCCS staff to these roles, as discussed in Section V. *Caseloads* of this report, is an innovation that DSS's leadership team believes will allow it to enhance the framework envisioned in the Health Care Improvement Plan by embedding a dedicated group of staff with specific expertise in each region to focus more specifically on addressing the needs of children in DSS custody. DSS reports that the teams have been in place as of February 2020.

Figure 42: DSS Regional Child Well-Being Team Structure



As previously reported and discussed with DSS, it is not clear to the Co-Monitors that six nurses will be sufficient to manage the significant task of ensuring that the health care needs of all children in care are adequately addressed, particularly given the complexity of, and attention required by, each individual child. As DSS and the Co-Monitors have discussed, ensuring that all children, including those with more complex clinical needs or chronic medical issues, are getting consistent, high quality care, ultimately requires more than a data-tracking solution. The hiring of nurses and the development of a regional structure to support them is a significant step in this direction, particularly in light of DSS's current financial constraints. The Co-Monitors will continue to closely track progress and assess capacity going forward.

Defining a Managed Care Organization Partnership

South Carolina's system for health care delivery to children and families on Medicaid gives a significant role to private MCOs. Select Health is the designated MCO for many children and families on Medicaid and for nearly all children in foster care in the state, which means that it is contractually obligated to ensure children's health care needs are being met, and is charged with approving or denying payment for medical and behavioral health services. In so doing, Select Health plays many roles: it is a point of contact, a collector of essential data, a resource in identifying providers, a decider of allowable services, and a payor of claims. DSS's Health Care Plan and Addendum deepen DSS's reliance on Select Health by also making them partners in an integrated model of health care case management and care coordination for the foster children it serves. This is a complex arrangement, and one that DSS is still in the process of defining and creating. As DSS's ability to articulate its own vision for child well-being deepened over the last few months, so too has its ability to articulate to Select Health what it needs and expects from the MCO that serves children in foster care. This has meant that after many months of slow progress, change has begun to take hold. As of the writing of this report, Select Health has now hired all 19 staff it committed to a new Foster Care Unit, as well as two additional nurses; has established DSS access to parts of its provider portal (NaviNet); and has agreed to a new weekly Foster Care Rounds process through which particular cases of concern will be chosen for intensive review together with DSS.

There is, of course, much work that remains ahead. More than one year after the approval of the Health Care Addendum, there is not, for example, clarity as to the role of Select Health Foster Care Unit staff. Some information still remains out of reach for DSS based in part on what Select Health understands to be the proprietary nature of many of its tools and business practices. There are, too, more questions that will need to be answered about the process by which decisions about authorizations or denials are made, and about how data reflecting these decisions will be shared in an efficient manner that allows for a prompt appeals process, which affords children in foster care their due process rights and protections. Select Health continues to meet with DSS and DHHS staff regularly to work through these challenges, and all are hopeful that the work will continue to move forward in the coming months.

Addressing Funding Mechanisms

DSS worked closely with the provider community and DHHS leadership and staff in recent months to better understand the mechanisms in place for accessing funding for clinical and non-clinical services for children who require different levels of care. This includes deepening its understanding of PRTF approval and denial determinations, of the platform for funding services provided in therapeutic foster placements, and of the historical shift away from group homes that offer onsite clinical services. These are important steps. DSS is now working in collaboration with DHHS to develop and implement solutions to some of the funding barriers to the service array.

It is critical that DSS, in partnership with DHHS, continue to explore ways of maximizing federal Medicaid funding as DSS works towards improving access to quality services for all South Carolina children, particularly those in foster care. Of importance will be efforts to assess the availability of and funding for an array of robust, community-based services, including intensive in-home services, so that children will no longer be subject to frequent moves to higher or lower level placement settings to get their needs met. As referenced in Section VIII. *Placements* above, the Co-Monitors have received multiple reports from stakeholders about children who are held at PRTF placements beyond the length of time deemed clinically necessary, or who are constantly moved between congregate care and foster home placements without access to the services that are essential to their well-being. Meeting this need is no small endeavor and is one that demands the attention and effort of DSS, DHHS, MCO partners, and community stakeholders.

Appendix A - Glossary of Acronyms

AAP: American Academy of Pediatrics
APS: Adult Protective Services
CAPSS: Child and Adult Protective Services System
CFT: Child and Family Teaming
CPA: Child Placing Agency
CPS: Child Protective Services
DHHS: Department of Health and Human Services
DJJ: Department of Juvenile Justice
DMH: Department of Mental Health
DSS: Department of Social Services
FSA: Final Settlement Agreement
FTE: Full-Time Equivalent
GPS: Guiding Principles and Standards Case Practice Model
ICPC: Interstate Compact on the Placement of Children
ISCEDC: Interagency System for Caring for Emotionally Disturbed Children
IFCCS: Intensive Foster Care and Clinical Services
IO: Interim Order
MCO: Managed Care Organization
MOU: Memorandum of Understanding
OHAN: Out of Home Abuse and Neglect Unit
PCG: Public Consulting Group
PIP: Performance Improvement Plan
SC: South Carolina
USC CCFS: University of South Carolina's Center for Child and Family Studies

Appendix B - Workload Implementation Plan Strategy Updates[228] as of October 31, 2019

Strategies towards Achieving Targets:

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

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[229]
Short-Term Strategies (January 2019 - January 2020)		
1. The Agency will make updated projection of the number of additional caseworkers needed to achieve caseload compliance.	June 30, 2019; date amended by the Joint Report to August 30, 2019	Completed. As part of its FY2020-2021 budgeting process, using a standard of 12 children to one case manager, DSS estimated a need for 213 additional case manager and 43 supervisor positions. The agency requested the requisite resources to fund these positions.
2. More fully use caseworkers assigned to the custody programs by eliminating the current practice of assigning two caseworkers, one in the foster care program and one in adoptions, to children who are legally free for adoption.	End of January 2020	This work is underway and is being implemented in 5 phases. DSS reports that vacancies within the adoption offices have slowed progress.

[228] Not all strategies included and required in the Workload Implementation Plan are included in this Table. Strategies identified as intermediate or long-term were not yet due during this period, and will be included and discussed in future monitoring reports.

[229] In some instances, information in this Table reflects the status of actions after October 31, 2019.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[229]
2.a. Phase 1: Cases of all children with a permanency plan of adoption who are free for adoption and are placed with a family that intends to adopt and has signed an adoption agreement or a pre-adoption agreement will be assigned solely to an adoption worker.	Implementing as of February 2019	DSS reports that work is underway for all five phases, however, vacancies within the adoption offices have slowed progress
2.b. Phase 2: Cases of children with a permanency plan of adoption who are free for adoption, and who are siblings of children case managed by Adoptions pursuant to Phase 1 but are not placed with a family that intends to adopt will be assigned solely to an adoption worker.	Implementing as of February 2019	
2.c. Phase 3: Cases of children case managed by county DSS foster care case managers who have a permanency plan of adoption and are free for adoption, but do not have an identified adoptive resource will be assigned solely to an adoption worker.	DSS will begin implementation by July 2019	
2.d. Phase 4: Cases of children case managed by IFCCS service coordinators who have a permanency plan of adoption and are free for adoption, and who are siblings of children case managed by Adoptions pursuant to Phase 3, but do not have an identified adoptive resource will be assigned solely to an adoption worker.	DSS will begin implementation by September 2019	
2.e. Phase 5: Cases of all other children who have a permanency plan of adoption, are free for adoption and case managed by IFCCS service coordinators, but do not have an identified adoptive resource will be assigned solely to an adoption worker.	DSS will begin implementation by November 2019	

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[229]
3. By May 31, 2019, the Department will complete the necessary research and decide whether to move forward or not with eliminating IFCCS as a separate caseload category. If IFCCS is eliminated as a workload category, a transition plan will be completed by August 30, 2019.	DSS will make decision by May 31, 2019, and develop transition plan by August 30, 2019; date amended by the Joint Report to September 30, 2019	Completed. On May 31, 2019, DSS decided to eliminate IFCCS as a separate workload and staffing category.[230] In September 2019,[231] DSS developed a transition plan with the following schedule: - By September 31, 2019, DSS will conduct regional informational meetings regarding the restructure - By October 30, 2019, Human Resources will update position descriptions, location changes, and supervisor changes, as needed. Additionally, DSS will coordinate staffings within county offices to shift siblings that are currently being managed by two case managers to one case manager. - By November 30, 2019, DSS will conduct regional training on the ISCEDC process, and new Well-Being Team members will receive training on new job tasks. - By December 1, 2019, DSS will complete realignment of Well-Being Team job tasks. - By December 31, 2019, DSS will transfer IFCCS case managers and supervisors to the county structure, and transfer cases as needed. - The transition plan was completed on schedule.
4. Implement "Stay" interviews conducted by managers for staff at regular intervals (e.g., 60, 90, 180, 260 days) through their first year of work and develop and implement a process for follow up on needs expressed by interviewees. The process also includes county office Directors' documentation of individual follow-up with interviewed caseworkers to address more immediate non-systemic needs.	A formal process to record and aggregate results of "Stay" interviews is being developed and will be implemented by June 30, 2019.	Delayed, subsequently completed, and implementation ongoing. DSS reports that an interview tool has been developed and the new process was presented to County Directors on August 27, 2019. In October 2019, 40 "stay" surveys were sent to front line staff, and by November 2019, 18 surveys had been completed and returned. DSS reports that survey results are sent to County Directors and interviews are scheduled with the staff and their supervisor to follow up.

[230] This change was recommended following the assessment of an expert workforce consultant who determined that, in most instances, IFCCS staff did not possess a higher level of training or skill than other foster care case managers, and that assigning case management solely on the needs of the child diminishes the focus on case and permanency planning with families.

[231] The Implementation Plan requires DSS to develop a transition plan by August 30, 2019. The Joint Report modified this Implementation Plan strategy, and requires DSS to finalize the transition plan for phasing out IFCCS case managers and determine staffing and fiscal impact by September 30, 2019.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[229]
5. Increase salaries for staff having BSW or MSW degrees and revise caseworker and supervisor job descriptions to indicate a clear preference for social work degrees as per the attached salary plan.	End of January 2020	Not yet due. Necessary funding is included in DSS's FY2020-2021 budget request.
6. Engage South Carolina public university departments of social work in developing a partnership using provisions for federal funding available under Title IV-E of the Social Security Act. This partnership will be directed toward recruitment of BSW students who, in return for tuition support and DSS-based internship opportunities, will commit to at least two years of work for DSS upon graduation. Ideally, this partnership will also be developed to include at least two courses with specific child welfare content that will lead, along with the agency internship, to allowing these students to become qualified as caseworkers without having to go through the pre-service training currently required of all new hires. The focus of student education should be direct practice rather than administrative.	End of January 2020	Updates discussed below.
6.a. Within 90 days of plan finalization, hire a Child Welfare Workforce Developer. Once this person is in place, he/she will be responsible for implementing items b - d below by June 30, 2019.	June 30, 2019; date amended by the Joint Report to October 31, 2019	Completed. DSS reports that a Workforce Developer was hired and started employment on November 4, 2019.
6.b. Contact the Georgia Department of Family and Children's Services agency-university consortium, and possibly with those in other states (e.g., Louisiana, New Jersey, Pennsylvania, etc.) known to have long standing, successful agency-university partnerships, to obtain information about design and other key considerations in establishing and supporting agency-university agreements.	June 30, 2019; date amended by the Joint Report to November 30, 2019	On June 17, 2019, DSS staff spoke with university consortium contacts in Georgia's Division of Family and Children's Services (DFCS) to learn more about the opportunities and challenges in implementing this strategy. The Joint Report requires DSS to contact other states such as Louisiana, New Jersey, and Pennsylvania regarding their university partnership programs by November 30, 2019. DSS reports that since her hire, the new Workforce Developer has contacted child welfare staff in Tennessee, Louisiana, and New Jersey.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[229]
6.c. Conduct outreach to South Carolina universities to ascertain interest and establish a planning group.	June 30, 2019	Delayed, implementation ongoing. On December 11, 2019, DSS convened a meeting with representatives from USC (Columbia and Upstate Campuses), Winthrop, and SC State to learn more about their social work programs and determine interest in forming partnerships. A draft MOU which establishes the work of the "University Partnership Planning Team" has been drafted and finalized with input from universities. As of the writing of this report, DSS was awaiting signatures from university partners. DSS reports the Team will convene within 30 days of the MOUs being executed. DSS has targeted spring 2021 for student participation, pending resources requested in the FY2020-2021 budget.
6.d. Consult with Public Consulting Group, the Region 4 office of the federal Administration for Children, Youth, and Families, and/or other technical assistance resource(s) to explore opportunities for accessing IV-E funding to support a university partnership or multi-university consortium.	June 30, 2019	DSS reports an initial conversation was held with Public Consulting Group (PCG) to explore opportunities for IV-E funding in June 2019. DSS has identified that one of the university partners has experience with IV-E funding from working in another state, and they are hoping to utilize her expertise in this work. Additionally, DSS is sending select staff to a IV-E training conference in May 2020. Finally, DSS plans to identify additional technical assistance to move this work forward, as needed.
7. Advance the proposal already initiated to provide repayment of student loans for staff employed for at least one year who have degrees in social work and, possibly, in very closely related fields. Work to assess the cost of this strategy will be completed during the current fiscal year to allow for this to be included in the agency's budget request for 2020-21 which will be made in September 2019. Once approved, payment can be made retroactively to staff who qualify.	September 2019	Completed. DSS included in its FY2020-2021 budget request funding for a Title-IV E Stipend Training Program.
8. Create a realistic job preview video or a virtual reality demonstration or, alternatively, enter into an agreement with an existing jurisdiction to adapt an existing one, for posting on the state human resources website with required viewing by those wishing to submit an online application for a child welfare caseworker position.	August 2019	Delayed, implementation ongoing. DSS has been working with USC to develop a job preview video similar to the one utilized by Georgia's child welfare system. DSS reports that staff were selected to participate in the video, and production was scheduled for the end of November 2019. The video was provided to DSS on February 13, 2020. DSS plans to post the

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[229]
		video on the state Human Resources website, as well as short clips of the video on DSS's website, Facebook page, and Twitter page.
9. With the Office of Human Resources, review current procedures for approving requests for authorizations of salary above the minimum and for salary increases within pay band and make any changes needed to ensure that they are based upon clear, objective, and consistently applied criteria.	DSS communication of procedures and criteria in writing to all staff by June 30, 2019.	Delayed, implementation ongoing. DSS reports a draft communique was distributed to staff on October 14, 2019. DSS anticipates finalizing a policy with procedures for approving salary requests by February 2020.
10. DSS will make offers of employment for the nine new OHAN investigative positions to begin by March 17, 2019. The staff that accept an offer of employment and who have completed child welfare certification will be trained utilizing the new OHAN Investigation Training curriculum and accepting cases no later than April 30, 2019. The staff that accept an offer of employment and who have not completed child welfare certification will complete child welfare certification, will be trained utilizing the new OHAN Investigation Training and will be accepting cases no later than July 15, 2019. By September 30, 2019, DSS will determine how many additional staff are needed to bring OHAN staff to the required caseload standards and begin the process for allocation of additional positions.	Make offers of employment by March 17, 2019. Ensure all staff are trained and accepting cases no later than July 15, 2019. By September 30, 2019, DSS will determine how many additional staff are needed; date amended by the Joint Report to August 30, 2019 for DSS to identify (assess and evaluate) staffing needs and resources based on current workload and trend analysis, and identify future resources as indicated.	Completed. Offers of employment were made to nine new OHAN investigative candidates by March 27, 2019 and all candidates accepted. Most of the new hires had already completed Child Welfare Certification training, and completed the newly developed Investigation training curriculum shortly after hire. The newly hired staffed who had not completed Child Welfare Certification training were enrolled and completed the training in mid-June 2019. As of October 2019, OHAN had 16 investigator positions; 14 positions were filled and there were two vacancies. One of the vacancies was filled in mid-November 2019. OHAN had three supervisor positions, and although all were filled in August 2019, by December 2019, one position became vacant, and a second supervisor went out on leave for several months. As of the writing of this report, the second supervisor returned from leave, and interviews for the vacant supervisor and investigator position are scheduled for late February 2020.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[229]
Short-Term Strategies (July 2019 - July 2020)[232]		
11. DSS will seek funding in September 2019 to raise the salaries of all child welfare frontline staff (i.e., caseworkers and supervisors) consistent with the salary plan. Where such raises for caseworkers and supervisors result in caseworkers being paid more or within 10% less than child welfare supervisors or managers to whom they report, budget shall also be requested to raise salaries of those positions to the next highest step consistent with the salary plan so that salaries are higher than those in the highest subordinate position level.	September 2019	Completed. DSS included in its FY2020-2021 budget request funding to implement the new salary plan to bring case manager and supervisor salaries to the SC living wage amount.

[232] This list is not exhaustive of all intermediate strategies; it only includes those strategies due between July and September 2019.

Appendix C - Visitation Implementation Plan Strategy Updates[233] as of October 31, 2019

Strategies towards Achieving Targets:

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

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[234]
Parent-Child & Sibling Visitation: Data Collection and Interim Benchmarks		
1. Baseline data for parent-child and sibling visitation requirements (J.2 and J.3) will be determined using case reviews with a confidence level of 95% and a confidence interval of 5%. These case reviews will be contracted out to the University of SC who will build, test, and use two instruments to capture the data.		Baseline data were collected (see discussion in Section IX. *Family Visitation* of this report).
2. Interim benchmarks to be determined following analysis and aggregation of baseline data. Benchmarks will be monitored for compliance through case review samples until ongoing reports for compliance have been developed, validated and methodologies approved.		Interim benchmarks have been approved (see discussion in Section IX. *Family Visitation* of this report).

[233] Not all strategies included and required in the Visitation Implementation Plan are included in this Table. Strategies identified as not yet due during this period will be included and discussed in future monitoring reports.

[234] In some instances, information in this Table reflects the status of actions after October 31, 2019.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[234]
Parent-Child & Sibling Visitation: Increase the Quality of Parent-Child Visitation		
3. Seek technical assistance for defining quality parent-child visitation and develop a model that is in line with the agency's practice model.	March 2019	Delayed. The selected consultant (Capacity Building Center for the States) has not been able to provide a model for parent-child visitation. The developing Quality Matters training series is focused solely on worker-child visits and the Capacity Building Center has not found a viable way to adapt the model to parent-child visits. DSS has asked consultants (New Allies) to assist with moving this work forward.
Parent-Child & Sibling Visitation: Cultivate a Shared Understanding of the Importance and Critical Function of Parent-Child and Sibling Visitation, and an Understanding of Related Policy, Procedures, and Responsibilities		
4. Develop and implement a consistent and comprehensive visitation policy that is aligned with the agency practice model and incorporates the core practice skills of engagement, teaming, assessment, planning, intervening, tracking and adapting. Additional policy enhancements will be made once the practice model is finalized and the quality visitation model is developed.	April 2019	Delayed. DSS released policy and procedures on children's visits and other contact with their siblings and parents, effective June 1, 2019. Additional policy enhancements are expected to align with DSS's practice model and quality visitation model.
5. Develop and deliver a visitation awareness training to casework assistants, caseworkers, supervisors, and Program Coordinators that is integrated with the practice model framework. Training will address the importance of visitation, how to engage the family in visitation planning and integrating visitation into the case plan; new policy to include roles and responsibilities; and CAPSS changes. This training will be an introductory step to build on as the quality visitation model is developed.	May 2019	Delayed, subsequently completed. DSS delivered Visitation Awareness training sessions regionally between July 11 and August 9, 2019, provided make-up sessions, and plans to hold quarterly sessions beginning in January 2020. DSS reports 732 staff (case managers, supervisors, support staff) participated in Visitation Awareness training through November 2019.
6. Develop and disseminate practice tips to casework assistants, caseworkers, supervisors, and program coordinators.	June 2019	Delayed, subsequently completed, and implementation ongoing. Practice tips were distributed to staff at the end of September 2019 and in November 2019. There is a plan to develop and deliver additional practice tips quarterly.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[234]
7. Invite legal staff to visitation training to begin aligning legal practices with visitation best practices.	May 2019	Delayed, subsequently completed. Legal staff were invited to Visitation Awareness training sessions. Fifteen County attorneys, representing 25% of County attorneys, participated in September/October 2019 training.
8. Incorporate initial training and refreshers into staff training plans.	May 2019 & ongoing.	Delayed, subsequently completed, and implementation ongoing. DSS reports since September 2019, initial training is included in each staff person's training plan and DSS supervisors have been tasked with ensuring that staff participate in both initial and refresher training.
Parent-Child & Sibling Visitation: Increase the Frequency of Parent-Child and Sibling Visitation		
9. Engage the leadership of provider organizations (Foster Parent Association Palmetto Association for Children and Families and Child Placing Agencies) in defining their role and setting the expectations for foster care providers.	April 2019	DSS reports holding a session regarding barriers to visitation and possible solutions during an April 2019 meeting with providers, and forming a provider visitation work group in July 2019. The group has discussed what a quality visit should look like; shared the updated visitation policy; shared "visitation matters" newsletter; reviewed the visitation plan from the CAPSS visitation tab; reviewed the updated Universal Application; and discussed additional supports needed to enable providers to assist the Department with facilitating parent/child and sibling visits.
10. Develop and deliver Foster Care provider training on the importance and function of parent-child and sibling visitation and their role in visitation.	June 2019	Delayed, subsequently completed, and implementation ongoing. DSS's Training Division offered "train the trainer" sessions to provider organizations at the end of October 2019. Training for foster parents began in November 2019.
11. Reinforce expectations through contract monitoring. Specifically, monitor compliance with the regulation prohibiting the deprival of family visits as a form of punishment.	Ongoing	DSS reports that since August 2019, Contract Monitoring and Licensing staff have been interviewing children during site visits to determine whether facilities are complying. Issues are to be addressed as they arise, including immediately meeting with the provider.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[234]
12. Develop and implement a process for ongoing budget request for state fleet vehicles that accounts for additional allocated casework assistant positions as proposed in the Caseload Implementation Plan.	Ongoing	Under development: DSS reports that counties will assess vehicle needs based on number of staff and current fleet utilization and will make requests accordingly. DSS funding for additional vehicles was included in the request for additional positions in the FY2020-2021 budget request.
13. DSS will fill all (10) current vacancies for transportation aides and make deliberate efforts to keep those positions filled.	June 30, 2019	Delayed, implementation in procress. DSS's casework assistants to help with transportation, five case manager assistant positions remain open with a request to fund for 36 additional positions in the FY2020-2021 budget.
14. Develop and implement a Foster Care Provider Portal for Foster Parents and Group home providers to directly input visitation information into CAPSS.	May 2019	Delayed. USC and DSS are developing a portal for foster parents to input children's health and education information in partnership with DSS. The capacity to document visitation information will be added to this portal. The provider portal is on track for completion in March 2020, and training on the use of the portal will follow. Estimated implementation is now May 2020.
15. Provide supervisor training on responsibilities and procedures for monitoring the frequency and quality of family visits	June 2019	Delayed, subsequently completed. Supervisor-specific training started on October 22, 2019 and ended November 15, 2019.
16. Develop user-friendly, actionable management reports in CAPSS.	June 2019	Delayed. New data entry screens were created in CAPSS, reports are being developed and tested through early March 2020.
17. Provide training on management reports.	June 2019 & ongoing	Delayed. Once reports are selected and generated, training for management will begin.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[234]
18. Determine a ratio of allocation of support staff positions to foster care caseloads using current data on workload, miles traveled by caseworkers, and number of children placed farther than 30 miles away. Based on ratio, determine the number of new support positions needed statewide and by county. In addition, determine a base number of support positions for each county to meet transportation needs as Placement Implementation Plan efforts to reduce the number of children placed out of county. The agency currently has 62 support positions statewide. Consider position need by county as a basis for adjusting current assignments and requesting budget in September 2019 for additional allocations in FY2020-2021.	September 2019	Completed. DSS reports assessing the number of support staff currently in each county office, and determined the number of additional positions needed based on the size of the county and their Class Member population. DSS reports currently having 78 casework assistant positions, and requesting an additional 36 positions in the FY2020-2021 budget.
Parent-Child & Sibling Visitation: Increase the Quality of Data and Documentation of Parent-Child and Sibling Visits		
19. Develop and implement CAPSS enhancements to increase the capacity for documenting parent-child and sibling visitation information.	March 2019; amended by the Joint Report to August 15, 2019	Completed. CAPSS enhancement took effect at the end of August 2019.
20. Provide training on CAPSS enhancements.	May 2019	Delayed, subsequently completed. Webinars were held in September 2019. A manual for CAPSS visitation instruction is available to staff.
21. Develop user-friendly, actionable management reports in CAPSS.	June 2019	Delayed, subsequently completed, and implementation ongoing. New data entry screens were created in CAPSS. In late-August 2019, DSS planned to begin identifying reports needed.
22. Provide training on management reports.	June 2019	Delayed. Once reports are selected and generated (see #21 above), training will be provided.
23. Develop and implement standards for quality documentation.	June 2019	Delayed. This work is scheduled to be done with support from the Capacity Building Center for States.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[234]
Case Manager-Child Visitation: Clarify the Role and Function of Case Manager-Child Contacts		
24. Practice Model Implementation: • Utilization of practice guidance related to caseworker-child contacts • Supervision, modeling and coaching related to caseworker-child contacts	May 2019	The GPS Case Practice Model was completed in July 2019. A video of Director Leach and staff announcing the roll-out, along with a booklet, infographic, and practice profiles were sent to staff. DSS is working to contract with Chapin Hall to assist with full GPS implementation over the next 18 months. DSS is also working with the Capacity Building Center for States on the adaptation of Quality Matters for case manager-child contacts and has selected a training outline from TN upon which to build. The next step if curriculum development. Relevant dates have not yet been set.
25. Visitation Awareness Training delivered to Casework Assistants, caseworkers, supervisors, and Program Coordinators.	April 2019	Delayed. Current Visitation Awareness Training does not address case manager-child visitation. DSS is working with the Capacity Building Center for States on this commitment as described above (#24) and below (#26).
26. Draft and implement policy revisions that align caseworker-child contact policy and procedure with the agency practice model.	June 2019	Delayed. DSS worked with the Capacity Building Center for States to draft policy which is expected to be finalized in April 2020.
27. Develop and disseminate practice tips to casework assistants, caseworkers, supervisors, and program coordinators that reinforce practice model values, guiding principles and practice skills related to caseworker-child visits.	June 2019	Delayed, subsequently completed, and implementation ongoing. One of the Practice Profiles distributed to staff as part of GPS in July 2019 contains practice tips on visits. Practice Profiles were also distributed in August and November 2019 DSS plans to distribute additional tips through quarterly newsletters.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[234]
Case Manager-Child Visitation: Increase the Quality of Case Manager-Child Contacts		
28. Adopt and adapt quality contact training developed by the Capacity Building Center for States.	May 2019	Delayed. DSS began work on this with the Capacity Building Center for States in August 2019 and reports that documentation training is being finalized for roll out in March 2020.
Case Manager-Child Visitation: Improve the Quality of the Dictation Capturing the Case Manager-Child Visit		
29. Deliver training to casework assistants, caseworkers, supervisors, and program coordinators.	June 2019	Delayed. To be rolled out in March 2020 with assistance from the Capacity Building Center for States.
30. Develop and implement standards for visitation and quality documentation.	June 2019	Delayed. Development of standards and quality documentation is underway in collaboration with the Capacity Building Center for States with implementation expected in March 2020.

Appendix D - OHAN Implementation Plan Strategy Updates[235] as of October 31, 2019

Strategies towards Achieving Targets:

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

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[236]
Intake and Investigations		
1. Institute investigative caseworker office day for case management activities	Complete by September 2017	Delayed, subsequently completed, and implementation ongoing. DSS reports that implementation began in February 2019.
2. Develop a user-friendly report to track and monitor face-to-face contact and case initiation within 24 hours	To be determined after Data Workgroup prioritizes CAPSS and data work (see Core Foundational and Capacity Building Section Above - 3.b). Some development has already occurred.	Delayed, subsequently completed. The Joint Report required by August 31, 2019, DSS rebuild the timeliness reports using queries to remove Non-Class Members. In August 2019, DSS reports CAPSS IT finished development of a report to track timely initiation of investigations involving only Class Members. The Co-Monitors are validating this information, and will provide feedback to DSS, as needed.

[235] Not all strategies included and required in the OHAN Implementation Plan are included in this Table. Strategies identified as intermediate or long-term were not yet due during this period, and will be included and discussed in future monitoring reports.

[236] In some instances, information in this Table reflects the status of actions after October 31, 2019.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[236]
3. Revise the intake referral sheet to gather updated placement and caseworker information	Complete by March 2017	Completed. DSS reports that staff are using the revised intake referral sheet. Beginning in November 2019, the intake process was revised as DSS's Intake Hubs began screening all referrals alleging abuse and neglect against children, including allegations against Class Members in foster homes and institutions. Screening decisions are made utilizing a Structured Decision-Making® (SDM)[237] intake tool. The Intake Hubs are not yet functioning 24 hours a day; OHAN staff will continue to receive intakes on nights, weekends, and holidays, until the Hubs provide full hourly coverage, which is projected for March 2020.
4. Revise existing checklist to expand core witness list	Complete by April 2017	Completed. DSS has revised the list of core witnesses checklist. Reviews conducted Co-Monitor staff have identified instances in which the checklists are not fully utilized.

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

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[236]
5. Develop tracking system for documenting core witness contacts and provide additional guidance and training to caseworkers on identifying core witnesses	Complete by December 2017	Delayed. DSS reports that updates to CAPSS to track core witnesses were delayed due to a lack of resources and the volume of work within OHAN. The Joint Report required by July 29, 2019, DSS to identify core witnesses for each case during supervision using the core witness checklist and when cases are completed, utilize the checklist to determine whether all identified core witnesses were contacted. The Joint Report also required by August 15, 2019, the new core witness screens in CAPSS should be completed and reports should begin to be generated; additionally, DSS was to implement a quality assurance process to verify that entered data are complete and accurate. The CAPSS updates were completed, and the new screens were launched on August 15, 2019. DSS reports that CAPSS reports have been developed and are being refined to capture necessary data. DSS plans to continue case reviews over the next several months to compare findings to these reports to verify complete and accurate data are being collected. OHAN leadership has routinely been reviewing closed investigations to determine if core witnesses were appropriately identified and interviewed, and has provided its findings to the Court during monthly status hearings held during the monitoring period. Co-Monitor staff had a meeting with OHAN and DSS staff in January 2020 to discuss findings from recent reviews.
a. Research and adopt a screening and assessment tool to help guide decision-making for OHAN intake	Complete by May 2017	Delayed, subsequently completed. During this monitoring period, with the assistance of NCCD,[238] DSS completed the process of developing a SDM process and instrument for use at the Intake Hubs. Implementation began in November 2019.

[238] For more information on NCCD, see https://www.nccdglobal.org/

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[236]
6. Develop and conduct specialized OHAN training to include findings from OHAN baseline reviews (including clarifying practice standards around "collateral" contact prior to making a hotline decision), CAPSS documentation training, interview and investigative techniques, restraint training, assessing for safety and risk, and critical decision-making	OHAN basic intake training to occur for existing case managers and supervisors beginning September 2017. OHAN basic investigative training to occur for existing case managers and supervisors by December 2017. All new case managers and supervisors will be required to complete training going forward.	Completed. Training sessions on a newly developed intake training curriculum were conducted in September and November 2017. Delayed, subsequently completed, and implementation ongoing. The investigation training curriculum has been finalized, and the first of the two week training – which focuses on identifying physical abuse, sexual abuse, and neglect, as well as conducting interviews and assessing safety – was initially delivered to three OHAN case managers and one supervisor in early January 2019. The second week of the training – which includes legal considerations and regulations, policy and procedures, and critical thinking – was held in mid-April 2019. Newly hired staff completed investigation training in July 2019.
7. Develop a Provider History report in CAPSS to provide an easy to access and consistent history on providers for use by OHAN caseworkers, supervisors, and reviewers - Preliminary report is currently being tested - Once finalized, report will be automated in CAPSS. - OHAN intake caseworkers will be trained to access, read, and summarize the previous allegations for the past two years and consider the previous history as a factor in determining preponderance of evidence for case	Work has begun. Preliminary report has been created and is being pretested with staff, supervisors, and reviewers. Based on feedback, report will be finalized and automated in CAPSS. Until automation, ad hoc reports will continue to be extracted. Work complete by September 2017.	Completed. DSS reports a provider history report has been developed in CAPSS and was incorporated into standard practice in September 2017. The report includes the past five years of OHAN intakes and investigations, allowing case managers to identify possible trends.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[236]
8. Develop a coordinated process with Licensing that may include the following: - Create a new policy to establish clear guidelines for revocation of foster home and facility licenses for multiple allegations of policy violations that do not constitute abuse or neglect but that are detrimental to child well-being	Development of policies to be completed by July 2017. Implementation of policies and training of existing staff on new policies completed by November 2017 by Licensing and OHAN.	Delayed, subsequently completed. DSS reports that OHAN policy has been updated, to include a provision that a foster parent's license may be revoked if a provider is found to have violated the signed discipline agreement, including the prohibition against corporal punishment. The policy was published on May 31, 2019.
Supervisor Review		
9. Determine ways to increase guided supervision staffing, critical thinking, monitoring-accountability system by supervisor		DSS reports the Guided Supervision Tool was finalized in May 2017 and is currently in use. During the review in December 2019 of closed OHAN investigations, Co-Monitor staff observed documentation that reflects inconsistent quality in these staffings. OHAN added a third supervisor position in June 2019, which was filled in August 2019. In December 2019, one position became vacant, and a second supervisor went out on leave for several months. This deficiency in staffing will likely adversely impact continued implementation of these supervisory strategies.
10. Revise the Guided Supervision Tool to be specific to OHAN performance measures and for case reviews and system for utilization in practice. After implementation, this tool will be used at every supervisory review to guide the critical thinking of staff in investigatory work.	Complete by May 2017	
11. Train OHAN Supervisors on use of the Guided Supervision tool (see above for additional training of supervisors on information from OHAN baseline reviews)	Complete by June 2017	
12. Implement Guided Supervision in OHAN by training staff on the expectations and begin use of the Guided Supervision process	Complete by June 2017	

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[236]
13. Implement standardized supervisory case review prior to case decision	Complete by April 2017	DSS reports this strategy is being implemented, and during recent reviews of closed OHAN investigations, Co-Monitor staff have found documentation that these reviews routinely occur.
14. Refine case closure supervisory review to include CAPSS and paper file (thorough review)	Complete by April 2017	DSS reports this strategy is being implemented, and during recent reviews of closed OHAN investigations, Co-Monitor staff have found evidence in the paper file of case closure supervisory review, however, these may occur after the case decision has been made.
15. Develop methodology for caseload distribution	Complete by September 2017	Delayed, subsequently completed, and implementation ongoing. Beginning in late-2018, OHAN staff are allocated to and physically located in the DSS regions to assist in travel responsibilities and increase familiarity with foster parents, congregate care facilities, and local DSS staff. Cases are distributed based on geographic location. DSS reports a review of the distribution methodology was scheduled to occur in November 2019.

Appendix E - Health Care Improvement Plan Strategy Updates as of October 31, 2019[239,240]

Strategies towards Achieving Targets:

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

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[241]
Structures for Coordination with Health Care Partners		
1. Weekly meetings with Select Health on data sharing and other key practices, processes, and protocols.	October 2018 - Present	Ongoing. Meetings have been occurring on a weekly basis, and moved from an early focus on access to data to planning for implementation of the model of care coordination and health care case management outlined in the DSS Health Care Addendum.
2. Weekly meetings with DHHS on data-sharing and other key practices, processes, and protocols.	October 2018 - Present	Ongoing. Meetings have been occurring on a weekly basis, and moved from an early focus on access to data to planning for implementation of the model of care coordination and health care case management outlined in the DSS Health Care Addendum.

[239] Not all strategies included and required in the Health Care Improvement Plan are included in this Table. Strategies identified as not yet due during this period will be included and discussed in future monitoring reports.

[240] Commitments included herein are based upon the Health Care Improvement Plan (August 23, 2018, Dkt. 120), the Health Care Addendum (February 22, 2019, Dkt..120-1), the Joint Report (October 30, 2019, Dkt. 145), and the Joint Report on Immediate Treatment Needs of Class Members (November 4, 2019, Dkt. 162).

[241] In some instances, information in this Table reflects the status of actions after October 31, 2019.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[241]
3. Weekly cadence call to staff cases, review progress made and resolve immediate needs.	August 2018 - Present	Ongoing, in part. DSS began regularly holding "cadence calls" in September 2018, in which Office of Child Health and Well-Being staff discuss performance data with identified reginal liaisons. Though the structure of the discussions is aligned with this requirement, limitations on access to reliable, real-time data limited the ability of participants to identify and track current, or recent, health care needs. The *Joint Agreement on the Immediate Treatment Needs of Class Members* includes additional commitments to address these issues, and DSS has completed all items required as of December 31, 2019.
4. Continue convening Foster Care Health Advisory Committee (FCHAC), a collaboration of DSS, DHHS, and providers and community partners throughout the state.	January 2018 - Present	Completed, implementation ongoing. The Foster Care Health Advisory Committee (FCHAC) continues to meet on a monthly basis and has been a key body in vetting, developing, and improving plans for implementation of health care work for children in foster care.
Selection and Development of Tools for Assessment and Planning		
5. Explore with DHHS, Select Health, QTIP providers and the AAP (American Academy of Pediatrics SC Branch), DSS's plan to use a standard, system-wide screening and assessment tool and ways to integrate the use of this tool and other best practice guidance on delivering health and behavioral health care to children in foster care.	February 2019	Delayed, implementation ongoing. DSS has developed a draft initial health screening tool for DSS case managers to use to identify needs, and for primary care providers to receive at the first appointment. DSS reports that the integration of the tool into CAPSS and the Health and Education Passport is expected to be completed by May 2020.
6. Choose validated assessment tool, train DSS staff, and roll out standardized assessment tool in accordance with the processes developed in the Placement Implementation Plan.	Tool selection by August 31, 2019; request for funding by September 2019.	Ongoing. In consultation with community partners, DSS has committed to implementation of the Child Assessment of Needs and Strengths (CANS) tool. DSS has requested grant funding that would allow for TA to begin in 2019. DSS has also requested funding for this work in its FY2020-2021 budget request.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[241]
7. Adapt Universal Application (UA) to include health and behavioral clinical and functional assessment questions as recommended by child welfare leadership and the Foster Care Health Advisory Committee.	Tool selection by August 31, 2019; request for funding by September 2019.	Ongoing. DSS reports that the Universal Application has been updated based on the recommendations of its workgroup and the FCHAC. DSS reports that the integration of the tool into CAPSS and the Health and Education Passport is expected to be completed by May 2020.
8. Connect health/behavioral health initial assessments and comprehensive assessments to placement decision-making processes, informing the Placement Implementation Plan.	August 31, 2019	Delayed, implementation ongoing. DSS reports the workgroup responsible for reviewing and recommending changes to the Universal Application has been focusing on connections between medical and behavioral health assessments and placement decision-making processes, and that there has been ongoing planning with respect to the use and rollout of the CANS. Delays in the implementation of the Placement Implementation Plan, including the Child and Family Teaming (CFT) process, have also delayed the timeline for this work.
Care Coordination Model Development and Staffing		
9. Develop aligned timeframes for initial assessments, comprehensive assessments and follow-up that track AAP standards for children in foster care. Those timeframes will be clarified and operationalized for data tracking purposes.	February 2019	Completed. DSS developed a set of health care process requirements and outcomes, approved by the Co-Monitors, that align with the FSA and best practice for children in foster care.[242] These requirements have been shared with DHHS and Select Health, and Select Health is in the process of updating its internal reporting processes to reflect the timeframes included therein.
10. Produce a comprehensive care coordination and health care case management framework subject to approval of the Co-Monitors.	March 2019	Ongoing. The DSS Health Care Addendum was approved by the Co-Monitors on February 25, 2019, with the understanding that it would be reviewed on an annual basis. DSS and Select Health are continuing to build out the details of this model, including through a process mapping meeting scheduled for February 2020.

[242] *Fostering Health: Health Care for Children and Adolescents in Foster Care*. American Academy of Pediatrics (2003).

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[241]
11. Select Health will build a new Foster Care Unit through the addition of 19 new positions (6 RN Complex Care Managers; 8 Care Connectors; .5 RN Manager; 1 RN Supervisor; 2 Licensed Social Worker Care Managers; .5 Medical Director; and 1 Quality Improvement Specialist).	July 2019 and ongoing	Completed. Select Health reports that all 19 staff have been hired for its Foster Care Unit, as well as two pediatric nurses for a total of eight nurses, for a total of 21 staff.
12. DSS will hire, on board and train selected candidates for Office of Child Health and Well-Being Nurse Care Manager and Nurse Care Coordinator Positions. 12.a. DSS will hire, on board, and train selected candidates for 4 remaining Office of Child Health and Well-Being Nurse Care Coordinator Positions. 12.b. Request funding for 5 Program Coordinators, 2 Quality Improvement and Contract Managers, and 3 Data Analytics and Reporting staff for Office of Child Health and Well-Being.	October 31, 2019 January 31, 2020 September 2019	Ongoing. Three of four Nurse Care Coordinators have been onboarded since November 2019. The position of Nurse Care Manager was filled in November 2019, but the position needed to be reposted after the candidate rescinded. The Upstate Nurse Care Coordinator was promoted to Nurse Manager in December 2019, and DSS expects the new Upstate Nurse Care Coordinator to start in March 2020. The dental nurse starts in February 2020. DSS also transitioned former IFCCS data coordinators to positions in regional Well-Being Teams from which they will support Regional Nurse Care Coordinators, in place as of December 2019. DSS has requested funding to meet this commitment in the FY2020-2021 budget.
13. DSS will determine processes and requirements for funding the Medicaid portion of new Office of Child Health and Well-Being positions.	September 2019	Completed. DSS reports that it is using Medicaid Administrative Activities contracting and that Office of Child Health and Well-Being nurses are keeping monthly time sheets.
Data Development		
14. Develop proposed set of child health outcome benchmarks and targets similar to those in the Center for Health Care Strategies' report "Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit" (Allen, 2012).	December 2018	Completed. FSA Health Care Outcomes were approved by the Co-Monitors and submitted to the Court on December 21, 2018.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[241]
15. Convene FCHAC in facilitated working sessions to review proposed benchmarks and targets.	Spring and Fall annually, beginning April 2019	Completed. The FCHAC reviewed proposed FSA Health Care Outcomes prior to finalization in December 2018, and have participated in ongoing discussions of how to operationalize these measures.
16. Finalize benchmarks and targets.	December 2018	Completed. FSA Health Care Outcomes were approved by the Co-Monitors and submitted to the Court on December 21, 2018. For those measures for which data were not and are not yet available, timeframes were included for the production of baseline data and the establishment of interim benchmarks.
17. Review/refine annually.	Spring and Fall annually, beginning April 2019	Next due in 2020.
18. Interim benchmarks incorporated into plan.	March 1, 2019	Completed. Interim benchmarks were approved by the Co-Monitors for inclusion in the Health Care Improvement Plan on February 25, 2019. For those measures for which data were not yet available, timeframes were included for the production of baseline data and the establishment of interim benchmarks.
19. Use gaps in care and other red flag reports, cadence calls and performance tracking and develop a protocol based on experience beginning in August 2018.	August 2018 - Present	Completed. DSS began regularly holding "cadence calls" in September 2018, in which Office of Child Health and Well-Being staff discuss performance data with identified reginal liaisons. As DSS has developed its plan and structures for tracking the delivery of health care services to children in foster care, this mechanism will become part of the Well-Being Team responsibilities
20. DSS will work with USC to conduct health care case reviews to build an understanding of available data and means of storing and accessing it through CAPSS.	November 30, 2019, with results to Plaintiffs and Co-Monitors by December 31, 2019.	Completed. In October and November 2019, DSS worked with internal staff and staff at USC CCFS to perform a review of the process for entering and storing health data in CAPSS. DSS reports that the review has been used to inform changes to CAPSS and guidance to case managers and Office of Child Health and Well-Being staff.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[241]
21. DSS will perform a "data cleanup" to ensure the most recent identified well child visit date is entered as an encounter in CAPSS for every Class Member as of December 1, 2019.	December 31, 2019	Completed as of December 31, 2019.
21.a. DSS will produce a report, updated monthly, that indicates the date by which each Class Member is due for their next well child visit.	February 1, 2020	Not yet due.
22. Caseworker training will include new expectations for documentation and follow-up and refresher training on DSS practice standards.	February 2019	Ongoing. Case manager training will be updated further when the health screening tool is finalized and implemented after the screening and assessment tool and Universal Application are integrated into CAPSS in May 2020
23. DSS will collaborate with DHHS to create a report and roster that tracks services delivered to children in foster care who are either ineligible for Medicaid or utilize services that are not covered by Select Health's per member/per month rate including dental services, Medicaid waiver services and specialty care for medically fragile children among other out-of-network services provided to children in foster care. DSS and DHHS will use the report to recommend changes or improvements needed.	December 2018	Delayed, implementation ongoing. DSS reports that it has had an improved process in place for payment of medical, mental health, and dental bills for children who are not eligible for Medicaid since December 2018. DSS reports that CAPSS can produce a report of children in care who are not eligible for Medicaid. Policy changes have been developed and are awaiting approval so that full implementation can begin when nurse care coordinators are hired.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[241]
Select Health Enrollment, Policy and Practice Development Tailored to Needs of Children in Foster Care		
24. Fix 30-day enrollment lag by January 2019, and in interim, develop and use an administrative work-around so that children in foster care receive necessary initial assessment, comprehensive assessment and follow up, and the data tracks them as such.	August 2018 - January 2019	Ongoing. DSS continues to work with Select Health to resolve enrollment barriers, and reports that the average time between entry into foster care and formal enrollment is now approximately three days. In a decreasing number of cases, however, enrollment has taken longer – at times more than a month. DSS, Select Health, and DHHS now have in place a process for weekly communication regarding children not yet enrolled and are continuing to monitor children who experience a longer than expected wait time.
25. DSS and Select Health will work together to update the Select Health Policy and Procedure Manual to ensure guidance is specific to children in foster care.	March 2019	Delayed, implementation ongoing. DSS and Select Health met in October 2019 to review each section of the current manual to determine how, if at all, adjustments need to be made to accommodate children in foster care. DSS reports that updates to the manual will be completed by April 2020.
Availability of Quality Health Care Services for Children in Foster Care		
26. DSS will collaborate with DHHS to develop a protocol to identify dental providers available to children in foster care.	August 2018	Delayed, implementation ongoing. DSS reports that it is working with the DHHS dental provider manager to develop a relevant protocol. DHHS has discussed giving DSS staff access to the DentaQuest provider database. This function will be transferred to the dental nurse.
27. DSS will plan a behavioral health and dental services capacity study to be conducted every two years by USC using Medicaid administrative data, qualitative surveys from foster parents, birth families and youth in care and DSS regional office staff.	June 2019	Delayed. DSS reports that initial planning work has begun with USC to conduct a capacity study.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[241]
28. DSS will collaborate with DHHS, Select Health and the Foster Care Health Advisory Committee to establish a preferred provider designation based on HEDIS parameters and provider agreement to participate in cohort learning collaboratives that meet two times a year.	June 2019	Delayed, implementation ongoing. The FCHAC supported DSS in the development of recommendations for both primary care and behavioral health providers. DSS reports that it is currently exploring mechanisms for possible Medicaid reimbursement for primary care providers for care coordination activities for children in foster care. DSS has continued to work with Medical University of South Carolina (MUSC) on the development of a process that will allow providers to identify children in foster care through data, and to develop trainings for providers who serve children in foster care.
29. DSS will collaborate and explore with DMH the designation of its CMHCs as preferred outpatient behavioral health providers, given child psychiatry staffing and regional locations around the state.	February 2019	Delayed.
30. DSS, DHHS and Select Health will collaborate to establish a protocol to assign children to a patient-centered medical home, QTIP-like or FQHC preferred provider and caregivers will have the opportunity to opt-out and exercise freedom of choice.	February 2019	Delayed. DSS reports that it has identified patient-centered medical homes that may be willing to accept children in foster care into their practices.
31. DSS will work with DHHS and the AAP to build out a learning cohort of pediatric practices who wish to work with the foster care population.	February 2019	Delayed, implementation ongoing. DSS has completed a contract for the establishment of learning collaboratives under the guidance of the MUSC. The TA center has planned two webinars in March and May 2020.
32. DSS will contract with USC to conduct targeted annual topical studies, with recommendations, as needed.	June 2019	Delayed. DSS reports that initial planning work has begun with USC to conduct a capacity study.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of October 31, 2019[241]
33. DSS will review the annual External Quality Review Reports for Select Health to determine adequacy of the provider network and quality improvement plans to improve access.	June 2019	Completed, in part. DSS reports that it reviewed the most recent EQR report, Select Health baseline assessment and supplementary report from 2018, and the 2019 provider network accountability assessment, but has determined that additional information is needed to assess provider adequacy.
34. DSS, DHHS and Select Health will meet once a year to review provider and network adequacy and capacity issues.	June 2019	Ongoing. DSS reports that the function of capturing systemic monthly data will be transferred to Well-Being Teams. DSS will meet with DHHS and Select Health to present findings after trends are determined.
35. DSS will collaborate with DHHS and Select Health to determine network sufficiency, and implement mitigation plans for areas where service or provider capacity is limited.	June 2019; date amended by the Joint Report to August 31, 2019 and ongoing for DSS to collaborate with DHHS and Select Health to identify and determine network sufficiency for Class Members and implement mitigation plans for areas where service or provider capacity is limited.	Ongoing. DSS reports that the function of capturing systemic monthly data will be transferred to Well-Being Teams. DSS will meet with DHHS and Select Health to present findings after trends are determined.
36. DSS will identify the appropriate role for DSS caseworker where out-of-network services are necessary and train caseworkers accordingly.	December 2018	Delayed. DSS reports that it has determined more work is needed, in collaboration with DHHS and Select Health, to define expectations with respect to service array adequacy and in- and out-of-network services. These cases are staffed in weekly Foster Care rounds.