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

Paul Vincent

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

PROGRESS REPORT: SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES

April 1, 2020 - September 30, 2020

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I. Introduction

This is the eighth 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 approximately 4,000 children in foster care in South Carolina (SC)[2] and incorporates provisions 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, 2020, and has been prepared by court-appointed independent Co-Monitors Paul Vincent and Judith Meltzer, with assistance from Co-Monitor staff Elissa Gelber, Rachel Paletta, Gayle Samuels, Ali Jawetz, and Nicole Kim. It is presented to the Honorable Richard Gergel, U.S. District Court Judge; Parties to the lawsuit (Governor McMaster, DSS, and Plaintiffs); and the public.

The FSA outlines South Carolina's obligations to significantly improve the experiences of and outcomes for children removed from the custody of their parent(s) or guardian(s) and placed in DSS's custody. The FSA 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 to guide a multi-year reform effort on behalf of children in DSS's custody. The FSA includes a wide range of specific provisions governing: the workloads of case managers and supervisors; visits between children in foster care and their case managers; family time, or visits between children in foster care and their parents and siblings; investigations of

[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)
[4] Where relevant, included herein is discussion of DSS performance with respect to Court orders entered subsequent to the entry of the FSA. These include the Joint Report of Plaintiffs and Defendants to the Honorable Richard Gergel (July 22, 2019, Dkt. 145) (referenced herein as the "Joint Report"), and the COVID-19 Pandemic Response Mediation Agreement (July 17, 2020, Dkt. 201) (referenced herein as the "Mediation Agreement").

allegations of abuse and/or neglect of children in foster care by a caregiver; appropriate placements; and access to timely physical and behavioral health care. It also includes provisions which required DSS to complete assessments before designating and incorporating specific performance outcomes, benchmarks, and timelines. Within this structure, the Co-Monitors worked closely with DSS and Plaintiffs between 2017 and 2019, leading to the development of Implementation Plans approved and ordered by the Court.[5] The intention was that these Plans – the implementation of which is tracked by the Co-Monitors – would guide reform work ahead.

In addition to the Implementation Plans, the Court has issued multiple subsequent Orders aimed at guiding reform efforts. These include the Joint Report of Plaintiffs and Defendants (Joint Report),[6] entered in July 2019, specifying priority action steps DSS would take in light of shortfalls in the FY2019-2020 budget, while it awaited the FY2020-2021 appropriation from the South Carolina General Assembly. When the COVID-19 pandemic further delayed the budget process and the prospect of an adequate appropriation, the Court entered the COVID-19 Pandemic Response Mediation Agreement (Mediation Agreement)[7] in July 2020 to codify further agreement by the Parties regarding what steps DSS would take before July 2021, including advocacy for additional funding and newly available federal funds.

The Co-Monitors and their staff utilized a range of sources and activities to collect information for inclusion in this report and to inform the overall assessment of progress. These include, among other things, review of records in DSS's Child and Adult Protective Service System (CAPSS);[8] analysis and validation of data collected by DSS and the University of South Carolina's Center for Child and Family Studies (USC CCFS) through structured reviews; group discussions with case managers, private providers, and other stakeholders; and meetings with DSS leaders and staff. Appendix B includes a list of specific activities used to assess DSS's progress during this monitoring period.

Included in this report is a summary of the Co-Monitors' general findings, followed by a detailed discussion of DSS's performance with respect to the FSA requirements, as well as updates on the implementation of strategies contained in each of the court-

[5] *See* Court orders approving Workload, Placement, and Healthcare Plans (February 27, 2019, Dkt. 109) and Visitation Plan (April 3, 2019, Dkt. 115).
[6] *See supra* note 4.
[7] Ibid.
[8] CAPSS, Child and Adult Protective Services System, is DSS's State Automated Child Welfare Information System (SACWIS).

ordered Implementation Plans.[9,10] In light of the COVID-19 pandemic, and in order to make this report as useful as possible to the Court, Parties, and public, the Co-Monitors have also included information about key developments beyond September 30, 2020 (the end of the monitoring period), where applicable.

[9] 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)."

[10] To see all Implementation Plans and Addendums for the Michelle H. Final Settlement Agreement, go to: https://dss.sc.gov/child-welfare-reform/

II. Summary of Performance

This monitoring period was a time of unprecedented challenge for South Carolina and DSS. It began in April 2020, weeks after Governor McMaster declared a state of emergency in South Carolina based on the imminent threat to public health posed by the COVID-19 pandemic.[11] In the months that followed and continuing to today, the pandemic has negatively impacted South Carolina families in countless ways. For some, it has increased the need for many of the supports administered through DSS – including the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) – and has required enormous effort and constant vigilance from DSS leadership, staff, providers, partners, and community members, all of whom have been operating in a state of uncertainty and flux. For families of children in the custody of DSS, the COVID-19 pandemic has meant countless additional hardships as well, including barriers to in-person time with loved ones, less face-to-face contact with case managers, and limited access to educational supports and other needed services.

Leading a social services agency during a pandemic would be no small task even with adequate resources – well-funded state agencies across the nation have struggled to manage their operations during this time. Agencies have had to acquire and deliver personal protective equipment (PPE) to offices; adjust protocols for visits, in-person contact, and case planning; regularly revisit plans for quarantining and testing; ensure access to technology for families and case managers; determine how services can be accessed in new ways; and make accommodations for staff and providers who have fallen ill or have needed to quarantine. But for an agency that was already deeply constrained in its resource capacity, the additional work the pandemic has demanded – coupled with the loss of anticipated additional funds in the FY2020-2021 budget – has prevented the state from fulfilling its obligations to children and families pursuant to this lawsuit.

The capable and committed DSS leadership team has attempted to maintain a focus on its child welfare reform efforts despite a lack of resources – particularly financial – and the competing demands of the COVID-19 pandemic. The DSS leadership team has publicly emphasized ongoing commitment to the Department's long-standing strategic priorities, including the key reforms required by this lawsuit. That work has

[11] To see the Executive Order, go to: https://governor.sc.gov/sites/default/files/Documents/Executive-Orders/2020-03-13%20FILED%20Executive%20Order%20No.%202020-08%20-%20State%20of%20Emergency%20Due%20to%20Coronavirus%20(COVID-19).pdf

proceeded in some areas and is commendable. As detailed in this report, these efforts – combined with a declining number of children in foster care during the COVID-19 pandemic – have translated into modest progress in some areas of practice. These include:

Reduction in Foster Care Caseloads

Although DSS was unable to obtain new positions or raise salaries for staff as required by the Workload Implementation Plan, due to delays in the state's budget, an improvement in worker retention and the reduced number of children in foster care led to lower foster care caseloads during this period. Each month during the pandemic, as fewer children entered care, a greater number of caseloads for county foster care case managers came into compliance with caseload standards. As of September 2020, 59 percent of foster care case managers had caseloads within the required limit of 15 cases (eight cases for new case managers), compared to 49 percent of foster care case managers six months prior.

Reduction in Congregate Care Placements, Increase in Placement with Siblings

The lower number of children in foster care and emphasis on placing children with kin have also enabled a greater percentage of children to be placed in family settings and with their siblings.[12] In some cases, DSS has also been able to accelerate transitions from congregate care by beginning to use an intensive staffing process in limited areas of the state over recent months. As of September 2020, 16 percent (654 of 4,053) of children resided in congregate care placements, compared to 18 percent (778 of 4,357) of children six months prior. Seventy-three percent (349 of 481) of children were placed with at least *one* of their siblings during the monitoring period, compared to 65 percent (530 of 813) in the prior period.

Healthcare Infrastructure Development

Though many more resources are still needed, the work of a small but strong team of nurses has allowed for the continued development of DSS's Child Health and Well-Being infrastructure. DSS staff are now able to access additional, timely data on the health status of children in foster care, and there is greater

[12] "The term "kin" used throughout includes children's relatives, as well as those who are not related by birth, adoption, or marriage to a child, but who have an emotionally significant relationship with the child (sometimes referred to as "fictive kin").

recognition of and focus by case managers on the importance of understanding and meeting children's health care needs.

Despite these improvements, and the barriers DSS has faced, the stark reality remains that far too little has changed for families in the four and a half years since the Department committed to comprehensive reform pursuant to a federal consent decree. After being separated from their families, children are often subject to practices known to be harmful – long periods of time without contact with loved ones, moves from placement to placement, sometimes far from their home communities, and without the supports they need. The following are areas of particular concern, discussed in more detail throughout this report:

Family Time

Even allowing for virtual visits during the COVID-19 pandemic, the vast majority of children in foster care were not afforded the required contacts with family members again during this period. In a review of cases of children with a permanency goal of reunification, or without a permanency goal yet established by the Family Court, in the month of September 2020, there was documentation of the at least twice-monthly required visits with a parent – either in-person, by video, or by telephone – for only 13 percent of children. Over half (60%) of children had no documented contact of any kind with any parent during the month. Similarly, during September 2020, there was documentation of contact – either in-person or virtual – between siblings in foster care who are not residing together for only 36 percent of siblings.

Out-of-Home Abuse and Neglect (OHAN) Investigations

OHAN caseloads continue to be unacceptably high. As of September 30, 2020, only three (19%) of 16 OHAN investigators had caseloads within the required limit of eight investigations, and nine (56%) investigators had caseloads over 125 percent of the required limit (meaning more than 10 investigations). Even while acknowledging that more investigators were needed, the cadre of staff carrying out the investigations of alleged abuse and neglect in out-of-home settings has become even smaller, with three new vacancies reported by December 2020. This is particularly problematic given that right now, OHAN workers are the only staff that consistently attempt to visit in person with children residing in facilities. In September 2020, 27 percent of investigations included contact with all necessary core witnesses, reflecting that practice

improvements to which the Department has committed and wants to achieve are difficult to attain when staff workloads are not manageable.

Adequacy of Placements, Instability, and Placement Oversight
Despite an increased emphasis on kin placement and a reduction in the use of congregate care, many children continue to be moved through numerous placements during their time in foster care. The lack of appropriate and stable placements has continued to mean that children are sometimes moved through a series of "emergency" placements – at times sent only to sleep for a few hours at a foster parent's home before returning to a DSS office early in the morning to await longer-term, stable placement. It has also meant that DSS has had to continue to rely on some placements, particularly congregate placements, that it knows to be inadequate, unsupportive, or unnecessarily punitive. This reliance on inadequate placements, combined with a safety oversight process that is still developing and building its capacity to act decisively and comprehensively to address issues when they arise, too often leaves children in situations that are not necessarily safer or more appropriate than the ones from which they have been removed.

South Carolina's child welfare system remains woefully under-resourced. DSS will not be able to adhere to either its specific FSA obligations or its broader commitments to families in the absence of an adequate allocation of funds. While the impact of the COVID-19 pandemic on the number of children entering foster care has made caseloads and the identification of placements slightly more manageable, the possibility that this trend will shift as the pandemic eases and children return to school and resume contact with other mandated reporters, raises the specter that this will be but a temporary reprieve. Already operating without sufficient capacity, this system is likely poorly positioned to manage an influx in child abuse and neglect reports post-pandemic.

Though budget shortfalls due to the COVID-19 pandemic and its impact on the state's economy have made the prospect of accessing needed resources more difficult, it is imperative that DSS be afforded what it needs to do its work. During a time of much hardship, South Carolina's families are continuing to bear the impact of a system that is overburdened and utterly hamstrung. Families and children cannot wait.

Resources alone will not transform a system, however. DSS's slow progress is rooted not only in the persistent lack of funding for supports and infrastructure, but also in a

long history of working in ways that do not align with its stated goals of being family focused, culturally affirming, and trauma informed. DSS leadership has been messaging throughout the state and with multiple stakeholders the change in practice and cultural values it would like to achieve. Real change in the ways children and families experience the DSS system will require that this messaging translate into a widespread shift in skills and values at the ground level and become embedded in how the system functions. This will necessitate the integration of guiding principles that genuinely prioritize the voices and experiences of families, the purposeful alignment of direct practice with these principles, and the development of a rich array of supports and services available at the community level that meet families where they are in their lives and are truly responsive to their needs. The Department recognizes that many of these supports and services will need to be provided through other state human services agencies such as the Department of Health and Human Services (DHHS), the Department of Mental Health (DMH), the Department of Disabilities and Special Needs (DDSN), and the Department of Juvenile Justice (DJJ).

It continues to be the Co-Monitors' strong belief that there are foundational action steps that DSS can and should undertake right away to establish the conditions for such change. These steps can position DSS to effectively capitalize on an infusion of budgetary resources when it comes. These include:

- **Thorough and intensive training of all staff in DSS's model of case practice:** System transformation requires a shared vision across multiple systems – public, private, and family – of what is expected in practice to meet the safety, well-being, and permanency needs of the children and families. Though DSS has worked to develop a model of case practice – referred to as its Guiding Principles and Standards (GPS) – the implementation of a strategy for helping new and existing staff build the skills needed to practice in accordance with this model and for building structures and supports for family-centered engagement has been too superficial. Staff have been provided with introductory training on GPS, and plans are in place to implement further supervisor and case manager training. Integration into practice across the agency will require robust coaching, mentoring, and ongoing support to build the skills necessary to meaningfully engage families, assess underlying strengths and needs, craft individualized safety and permanency plans, and track and adjust as case plans proceed. GPS training needs to extend to supervisors, foster parents, and providers so that the entire system has the skills and confidence needed to realize the goals and expectations of the

practice model. In addition, GPS principles need to be integrated into quality assurance processes so that they are aligned with and designed to measure fidelity to the model. Though this work was identified as a priority in the Co-Monitors' very first report, and consistently since, and DSS has reported that development and rollout has been underway for the past two years, the Co-Monitors have yet to see the type of robust training needed to translate the model into practice across the agency and have seen limited evidence of a shift in the way families experience the child welfare system. The GPS Case Practice Model is a framework that organizes the values and skills necessary to help change this. Its impact is dependent upon the quality of training and coaching, manageable caseloads, quality supervision, and a diverse array of accessible services.

- **Leveraging private agency partnerships through contractual relationships that foster meaningful collaboration:** Given the constructive relationship between the current leadership team and its private sector partners, there is significant opportunity for work between DSS and private providers that re-directs funding currently devoted to restrictive congregate care placements to a full array of community-based resources and other supports. The Co-Monitors believe DSS needs to expedite work in this area and capitalize on the interest of providers in fully participating in the reform so that children and families can be provided with the supports they need.

- **Working with public agency partners to increase availability of and access to high-quality community-based services:** The success of the GPS Case Practice Model will also depend upon DSS's ability to work closely across agencies to develop more robust and accountable responses to children and families who come to the attention of DSS. This includes DHHS, DMH, DDSN, and DJJ, among others. While DSS is the legal custodian of children in foster care, it is not the whole of South Carolina's child welfare system or intended response to children and families. A key part of this collaboration must be the assessment and enhancement of available community-based services throughout the state, and the building of a shared understanding of the types of underlying needs of families which can be met through partner agencies, without the need for the involvement of the child protection system. There is wide agreement among stakeholders throughout the state that accessibility and availability of services to families must be improved. DSS has reported that it has begun this work as part of its efforts to prevent children from being removed from their parents' custody, in accordance with the federal Family

First Prevention Services Act (FFPSA), and we encourage the Department to continue these efforts, with a focus also on access to services for children in foster care custody.[13]

- **Continuing to focus on building a strong infrastructure:** DSS must continue to shore up and strengthen the infrastructure necessary to support and sustain change. Despite significant improvements since the beginning of this reform in systems for collecting and utilizing data, DSS's data capacity remains limited in some key areas, and additional staff are still needed. There remain areas of the FSA for which reporting capacity is still being developed.[14] As previously reported, the Department continues to need to build robust Continuous Quality Improvement (CQI) processes that are closely tied to agency management and that can easily and routinely provide quantitative and qualitative information for managers, supervisors, and case managers on the effectiveness of their work. These CQI processes should specifically gather information about DSS's fidelity to key practice principles and include face-to-face interviews with children, families, DSS staff, and external stakeholders about their experiences with DSS.

- **Piloting new strategies in particular areas of the state:** The Co-Monitors continue to recommend that DSS consider a phased approach to implementing some of its reform strategies. Such an approach is often most effective because it allows for local innovation, adaptation, and engagement prior to full rollout, and could be particularly effective at a time when the COVID-19 pandemic has created significant barriers to statewide implementation. Intensive work in specific areas of the state – to integrate practice and culture change, and implement ambitious strategies like Child and Family Teaming (CFT) and re-designed partnerships with private providers that allow for more tailored services – can foster examples of what effective

[13] South Carolina has been identified as one of four jurisdictions that will be participating in *Thriving Families, Safer Children: A National Commitment to Well-Being*, a national program being developed by the federal Children's Bureau, Casey Family Programs, the Annie E. Casey Foundation, and Prevent Child Abuse America to "create more just and equitable systems to break harmful multigenerational cycles of trauma and poverty to benefit all children and families." For more information, see: https://cbexpress.acf.hhs.gov/index.cfm?event=website.viewArticles&issueid=219&sectionid=2&articleid=5652.

[14] These measures include: Emergency or Temporary Placements for More than 30 Days (FSA IV.E.4); Emergency or Temporary Placements for More than Seven Days (FSA IV.E.5); Youth Exiting the Juvenile Justice System (FSA IV.H.1); Therapeutic Foster Care Placements – Referral for Staffing and/or Assessment (FSA IV.I.2); Therapeutic Foster Care Placements – Receipt of Recommendations for Services or Placement (FSA IV.I.3); Therapeutic Foster Care Placements – Level of care Placement (FSA IV.I.4&5); Health Care – Initial Medical Screens; Health Care – Initial Mental Health Assessments; and Health Care – Follow Up Care.

change can look like, and allow for the development of local champions. These can be important assets in full implementation.

- **Maximizing the use of all available sources of funding:** We continue to urge DSS to ensure it is making use of all state and federal revenue sources, especially in light of the state revenue shortfalls that will likely result from the COVID-19 pandemic. Though, as previously discussed, adequate funding is not a magic solution for all needed system improvements, securing and sustaining sufficient fiscal resources are key to DSS's ability to implement the critically important actions to which it is committed on behalf of South Carolina's children and families. Given the economic impact the COVID-19 pandemic has had on South Carolina's economy, DSS must work aggressively with the Medicaid agency to identify any possible way to maximize Medicaid resources and ensure that no possible federal money or support is left on the table. Budget realities also demand that DSS scrutinize contracts it has in place to examine performance and ensure funds are deployed effectively and in support of the reform goals and improved outcomes for children, youth, and families.

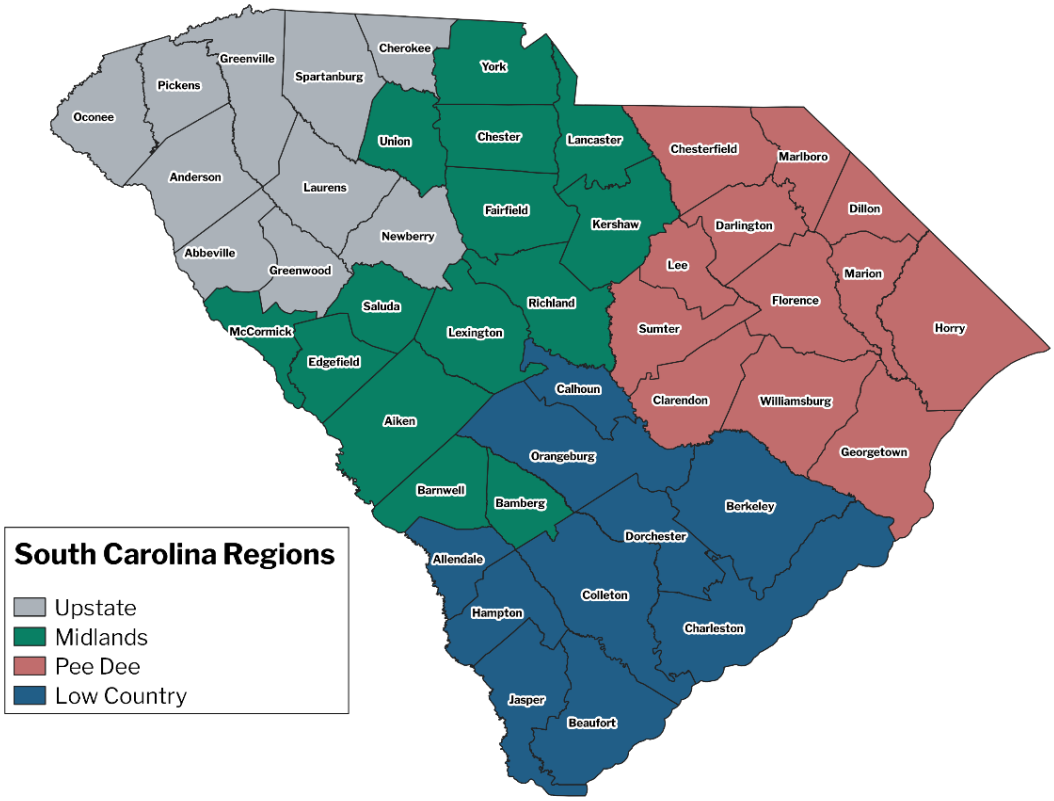
- **Continuing to build a kin-first culture:** The Department has begun the important work of shifting emphasis toward kin caregivers. In the past two years, DSS has updated its placement policies, developed a provisional kin licensure process, expedited a permanent kin licensure process, and increased the number of children placed with kin. DSS staff at all levels are increasingly aware of the preference for placement with kin. We support DSS's work in this area and encourage continued attention on the value of kin placement for children and youth in DSS custody.

III. Background Information

South Carolina Department of Social Services: Structure and Mission

Directed by Michael Leach, DSS is a cabinet level agency aimed at "promoting the safety, permanency, and well-being of children and vulnerable adults, helping individuals achieve stability and strengthening families."[15] The agency oversees investigations of child abuse and/or neglect by parents, guardians, foster parents, and staff of daycare centers and facilities where children reside; preventative services for families; foster care; adoptions; child care; child support; Adult Protective Services (APS); and economic assistance programs such as TANF, which provides financial assistance to families experiencing poverty and programs to support employment, and SNAP, which provides nutrition benefits to families earning low wages to purchase food. DSS is structured to deliver services through regional and county offices; the state's 46 counties are each part of one of four regions – Midlands, Upstate, Pee Dee, and Low Country (see Figure 1).

Figure 1: South Carolina Counties by Region

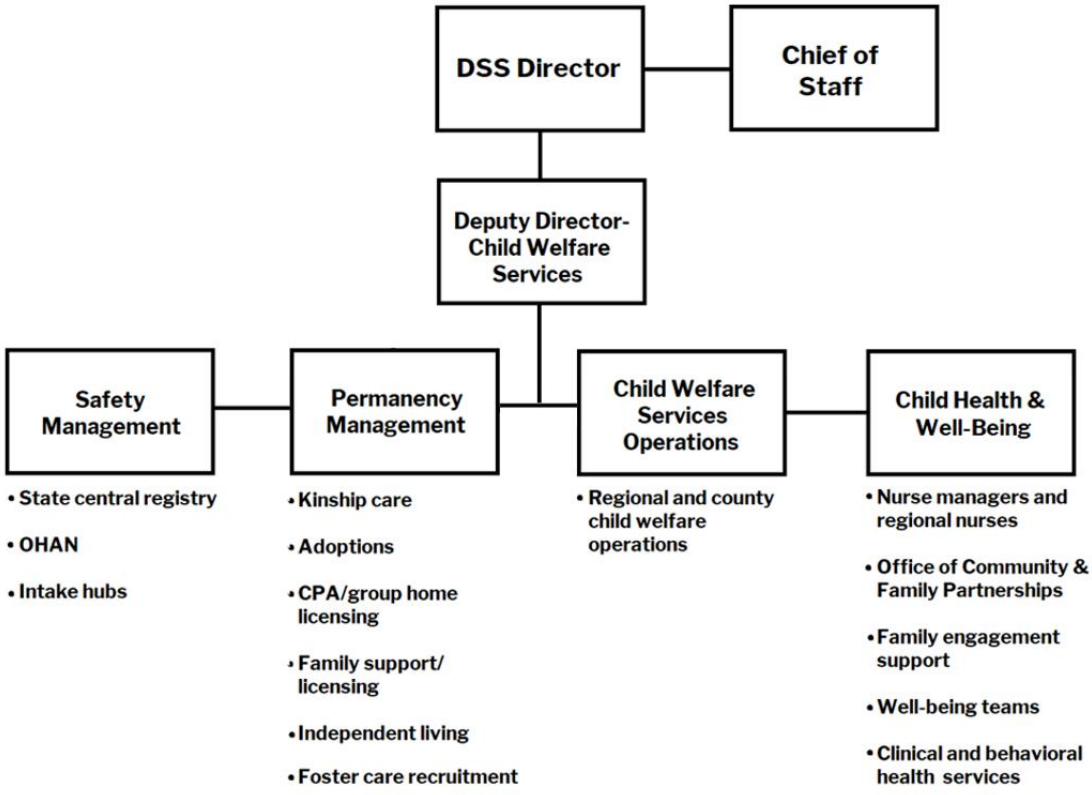


[15] To see DSS's mission, visit: https://dss.sc.gov/about/

The FSA pertains specifically to children who have been involuntarily removed from the custody of their parents or guardians and taken into the custody of DSS. These children reside in "foster care" or "out-of-home care." DSS is responsible for caring for them on a temporary basis, preferably while the children remain with their siblings and reside with a family member or someone known to their family, while working to return them home to their parents or guardians. When reunification is not possible, DSS must work towards another permanent, long-term plan, such as guardianship or adoption.

DSS's foster care work is part of its Child Welfare Services Division, overseen by Deputy Director of Child Welfare, Karen Bryant. The Child Welfare Services Division is organized into four primary areas of focus: Safety Management, Permanency Management, Operations, and Child Health and Well-Being.[16] Figure 2 depicts this structure, and the general responsibilities encompassed in each area of work.

Figure 2: DSS Child Welfare Services Division Organizational Chart



[16] A fifth area of focus – Performance Management and Accountability – was recently moved out of the Child Welfare Services Division. This function has been incorporated into the work of the Department's Policy and Continuous Quality Improvement Division. Additionally, the Child Fatalities and Near Child Fatalities Unit has been moved under Performance Management and Accountability.

Foster Care Budget and Financing

The federal government has shown "long-standing interest in helping states improve their services to children and families," and provides financial support through a number of significant sources.[17] Specifically, the federal Children's Bureau, within the Administration for Children and Families, distributes funds to states through mandatory spending programs authorized through the Social Security Act. The largest of these programs is authorized under Title IV-E of the Social Security Act, and operated on an "open-ended" basis, meaning states are entitled to receive reimbursement for a portion of every dollar spent on behalf of an "eligible" child.[18] Eligibility depends on the income level of the parent(s) from whose custody the child was removed. Even if a child's case is found to be Title IV-E eligible, reimbursement is allowed only for specific portions of certain eligible expenses.[19] In South Carolina, approximately 46 percent of children in foster care meet Title IV-E eligibility requirements (referred to as the state's Title IV-E penetration rate).[20,21]

Because nearly all children in foster care are eligible for Medicaid, this is another important source of revenue for state child welfare systems. States paying for Medicaid services receive funds at a state's Federal Medical Assistance Percentage (FMAP) rate. In South Carolina, this rate is currently 76.8 percent, due in part to an increase resulting from federal COVID-19 legislation.[22] This is both a considerably higher rate than the reimbursement rate for most expenditures under Title IV-E, and one that can be applied broadly to *all* children in foster care. Medicaid reimbursement is not limited to services for children who meet the Title IV-E eligibility requirement.

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[17] Stoltzfus, Emilie (July 30, 2018). Child Welfare Funding in FY2018. Congressional Research Service. https://fas.org/sgp/crs/misc/R45270.pdf

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

[19] For example, states receive 50% reimbursement for eligible administrative costs; 75% for eligible training costs; and reimbursement at the Medicaid matching rate (FMAP rate, see below) for board payments. (Section 474(a)(3)(A),(B),(C),(D), and (E) of the Social Security Act.)

[20] The maximization of federal funding available through Title IV-E has been an immediate priority under Director Leach's leadership, and DSS has been able to increase its penetration rate by approximately 9 percentage points from 38% in February 2019 to nearly 47% in April 2019, resulting in significant additional revenue from this resource (September 9, 2019 Status Conference Hearing). As of January 2021, the penetration rate was 46.4%.

[21] In February 2018, the federal Family First Prevention Services Act (FFPSA) was passed to promote placement of children in family foster care settings as opposed to congregate care settings, and to allow states to use federal IV-E funding to provide evidence-based prevention services in the community to reduce the need for out-of-home placement (Family First Prevention Services Act, Publ. L. No. 115-123, H.R.253. (2017)). DSS has been working with community and agency partners on implementation strategies.

[22] The Families First Coronavirus Response Act (FFCRA), passed by Congress on March 18, 2020, includes a temporary increase to states' Federal Medicaid Assistance Percentage (FMAP) – the federal share for Medicaid health care and health related services. The FFCRA has enabled South Carolina to receive an increase of 6.2% to its FMAP rate, currently set at 70.63%. The FMAP is also used to calculate the federal share of foster care maintenance payments. (Families First Coronavirus Response Act, Publ. L. No. 116-127, H.R.6201. (2020)).

States that have responsibly maximized the use of federal Medicaid matching dollars have been able to increase – sometimes vastly – funding available for the support of children in foster care.[23] Medicaid can be used to cover non-direct health care services, such as behavioral health services, and services as part of therapeutic foster care. Many states have also used Medicaid to support health care case management for children in foster care. South Carolina is largely not currently utilizing the option for reimbursement of these costs for children in foster care. Though they are exploring ways of tapping into this funding, DSS leadership has reported that they believe it will take upwards of 10 years to maximize claiming.

State funding for foster care in South Carolina is allocated on an annual basis through the General Assembly agency appropriation process. The state fiscal year in South Carolina is 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, FY2020-2021 references the period from July 2020 through June 2021. South Carolina's budget process begins in July or August of the year preceding the start of the new fiscal year when the Governor sends budget instructions to state agencies. In typical circumstances (prior to the COVID-19 pandemic), agencies submit their budget requests to the Governor between September and November, detailing every new and recurring dollar they plan to spend in the following year, and the items that will require state funding. Agencies are also required to estimate anticipated federal funding, and other considerations. In November, upon instruction from the Governor, the state Board of Economic Advisors issues an initial forecast of economic conditions to give the Governor and lawmakers a sense of how much revenue will be available for expenditure in the coming year. In early January, the Governor submits the executive budget to the General Assembly. Both houses of the state legislature review the budget, initially in committee (the House Ways and Means and Senate Finance Committee), and ultimately pass budgets through full floor votes. If the House and Senate versions of the budget do not match, a conference committee consisting of both House and Senate members is assembled to reconcile differences. The legislature must pass a budget with a simple majority by the beginning of the fiscal year, July 1. The Governor may exercise line item veto power on the enacted budget.

[23] To compare state-by-state Child Welfare financing using the National Council of State Legislatures' tool, go to: https://www.ncsl.org/research/human-services/child-welfare-financing-101.aspx#/

The regular budget cycle was disrupted in FY2020-2021 due to the COVID-19 pandemic. Because the General Assembly was unable to convene to agree upon a final appropriation, it passed a continuing resolution as a temporary measure. The resolution, passed on May 12, 2020, directed continued funding of the "ordinary" expenses of state government at the levels authorized for FY2019-2020, beginning July 1, 2020.[24] This has been problematic for DSS, as it was hoping for an infusion of funds in the current budget year to meet court-ordered requirements as part of the reform effort. The General Assembly is currently in the process of considering appropriations for FY2021-2022.

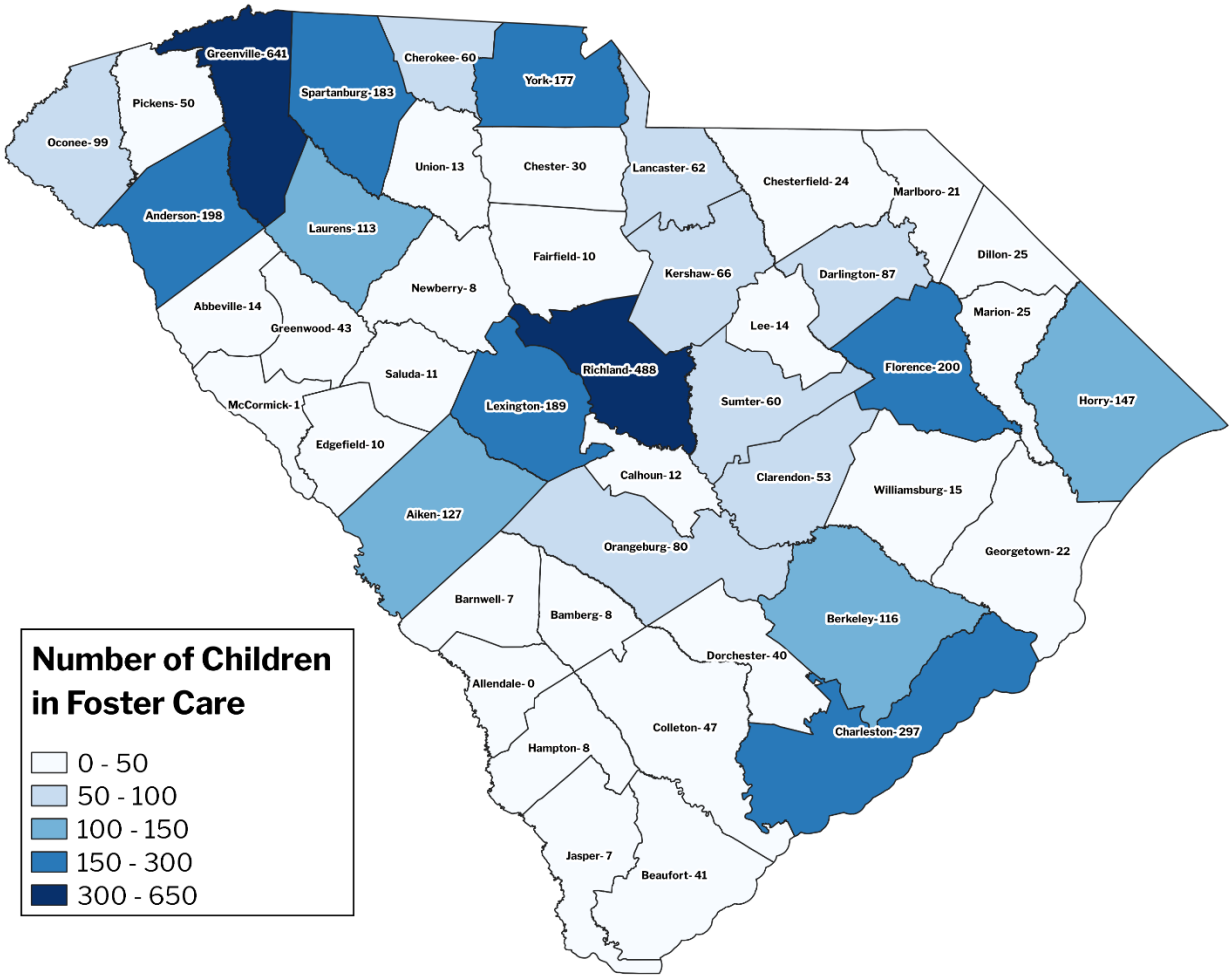
Population and Demographics of Children in Foster Care

Over 1.1 million children under the age of 18 resided in South Carolina; during the monitoring period, 5,360 were placed in foster care at some point.[25,26] In an effort to build accountability and transparency, DSS now regularly publishes real-time data about children in out-of-home care on its public website.[27] Demographic data on age, race, and gender are available, as well as information about where children are placed and how long they have been in out-of-home care. On January 4, 2021, for example, 3,939 children were in DSS's custody, and 1,363 (35%) of these children had been in foster care for 24 months or longer.

The map in Figure 3 shows a varied number of children from each county in foster care as of January 4, 2021 ranging from none to 641. As expected, counties with larger numbers of children in foster care typically correspond to a higher overall population of children within the county. For example, Richland County (total child population 88,924), where Columbia, the state's capital and largest city is based, had the second-highest number of children in foster care in the state, at 488. Allendale County, a primarily rural county and the least populous in the state (total child population 1,655), had no children in foster care on January 4, 2021. Differences among counties contribute to a variation in accessibility of services and programs, and distances that case managers, families, and children in placement must travel to spend time in person with one another, receive treatment, or attend appointments.

[24] To see the bill, go to: https://www.scstatehouse.gov/sess123_2019-2020/bills/3411.htm
[25] To see child population data from Kids Count Data Center, go to: https://datacenter.kidscount.org/data#SC/2/0/char/0
[26] Data provided by DSS.
[27] To see DSS's data dashboard, go to: https://dss.sc.gov/about/data-and-resources/foster-care-dashboard/

Figure 3: Number of Children in DSS Custody by County as of January 4, 2021[28]



Source: Data from DSS, 1/4/21

There has been a sharp decline in the foster care population since March 2020. This is consistent with a national trend, attributed in part to declines in abuse and neglect reporting during the COVID-19 pandemic. As seen in Table 1 and Figure 4, 1,138 children entered foster care and 1,435 children exited foster care during this monitoring period. This means that 788 fewer children entered foster care and 558 fewer children left care over the six-month period between April and September 2020, compared to the last monitoring period (October 2019 to March 2020). Compared to the prior year (April to September 2019), 894 fewer children entered foster care and 449 fewer children left care during this monitoring period. On

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

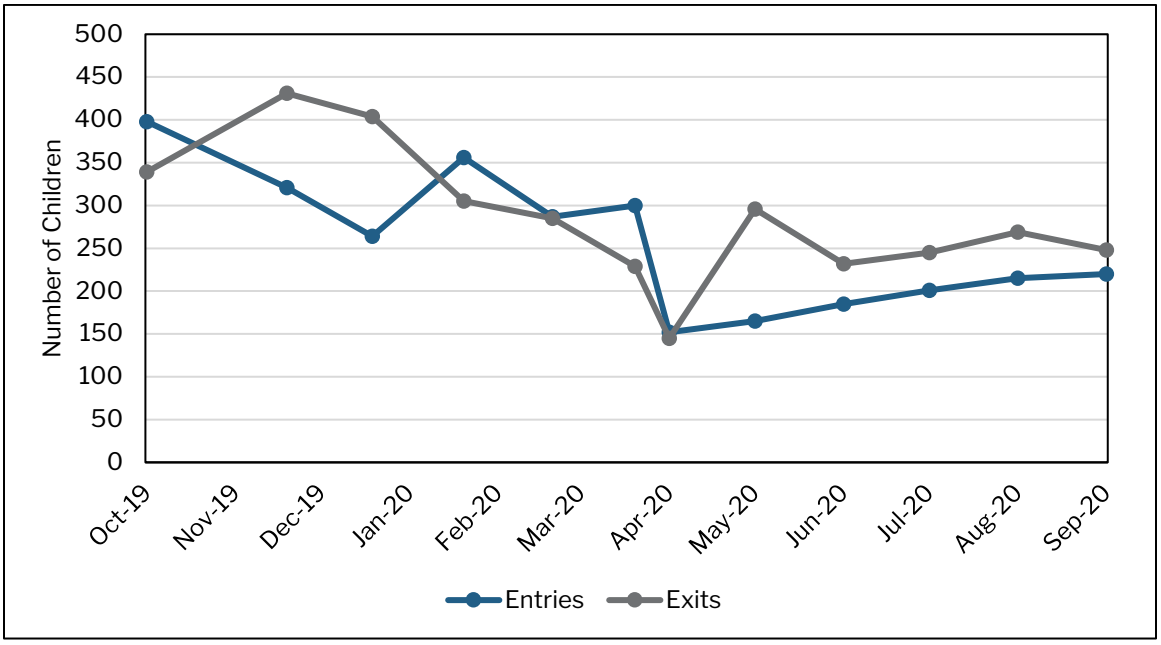
September 30, 2020 – the last day of the monitoring period – there were 4,072 children in foster care, compared with 4,385 children on March 31, 2020, the last day of the prior monitoring period, and 4,545 children a year prior.

Table 1: Foster Care Entries and Exits
April – September 2020

Category	April	May	June	July	August	September
Children Served	4,521	4,541	4,430	4,399	4,369	4,320
Entries into Care	152	165	185	201	215	220
Exits from Care	145	296	232	245	269	248
Children in Care on Last Day of Period	-	-	-	-	-	4,072[29]

Source: CAPSS data provided by DSS

Figure 4: Foster Care Entries and Exits
October 2019 - September 2020

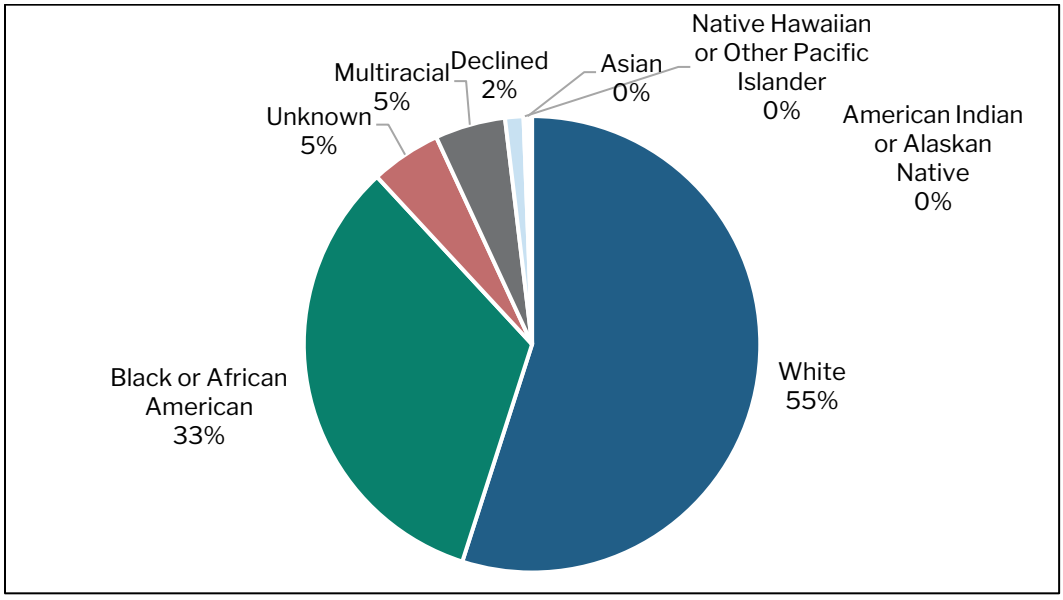


Source: CAPSS data provided by DSS

[29] 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 included later in this report.

The legacy of disproportionate removal of Black children from their families persists in South Carolina, as it does throughout the United States. When comparing race and ethnicity of children in DSS custody, as shown in Figure 5, to that of the total child population in the state, as shown in Figure 30, representation appears slightly disproportionate: 55 percent of children in foster care are identified as White compared to 57 percent of all children in the state; 33 percent of children in foster care are identified as Black compared to 31 percent of all children in the state.[30] As reported in the prior monitoring report, these racial disparities grow when looking at particular counties.[31] In Section VII. *Placements,* Figure 30 also includes information about racial disproportionality in congregate care placement. Section VI. *Intakes and Investigations of Alleged Abuse/Neglect in Out-of-Home Care* includes information on racial distribution across indicated investigations as well.

Figure 5: Population of Children in DSS Custody by Race as of January 4, 2021 N=3,939



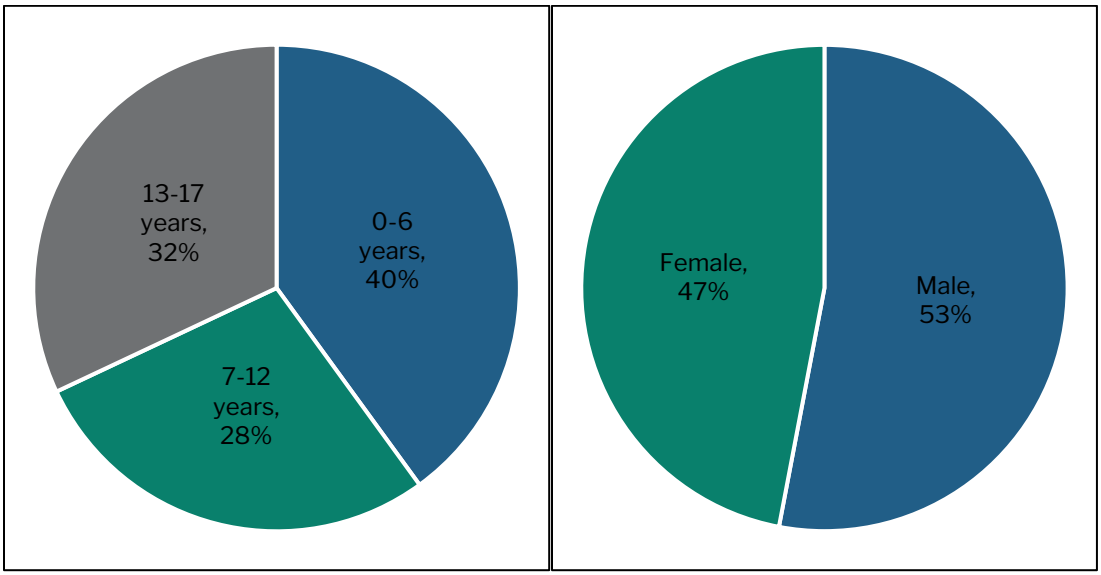
Source: Data from DSS website, 1/4/21[32,33]

[30] Categories included herein reflect data provided by DSS. DSS does not record Hispanic or Latinx as a category in their race data.
[31] *See* Background section from the prior monitoring report, available at: https://cssp.org/wp-content/uploads/2020/10/Michelle-H.-v.-McMaster-October-2019-March-2020-Report.pdf
[32] Data were rounded to whole numbers. The population of Asian, American Indian or Alaskan Native, and Native Hawaiian or Other Pacific Islander children was each 0.1%.
[33] To see DSS's updated race data, go to: http://reports.dss.sc.gov/SSRSReportServer/Pages/ReportViewer.aspx?/Foster+Care

The Department has recognized the need to track data by racial and ethnic groups in order to better target policies, services, and resources. DSS is committed to analyzing what these data indicate about how the state interacts and interfaces with families and communities, and what structures are in place to meet their needs – close to home and with family – as it proceeds with reform.

In terms of age and gender, Figure 6 shows that about one-third of the foster care population are adolescents (ages 13 to 17), and 40 percent are ages six and under. Slightly less than half of children in foster care are reported to be female.[34]

Figure 6: Children in DSS Custody by Age and Reported Gender as of January 4, 2021
N=3,939



Source: Data from DSS Website, 1/4/21

The sections that follow include analysis related to each area of practice specifically addressed in the FSA. These include: caseloads; visits between case managers and children; investigations of alleged maltreatment of children while in foster care, placements; family time with siblings and parents; and health care. To the extent available, policy, practice, and strategic updates, and relevant performance data are also included.

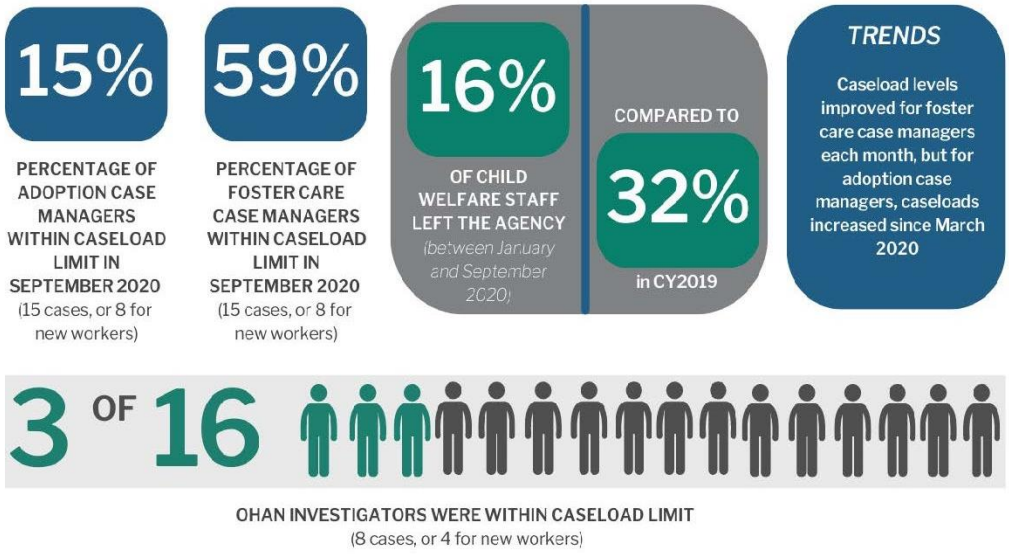
[34] DSS does not collect data on children who identify as gender neutral or non-binary.

IV. Caseloads

A sufficient, qualified, and trained workforce with manageable caseloads is foundational to a well-functioning child welfare system and has been a focus of DSS's reform. Case managers must have the resources and supports needed to engage families and providers in creating meaningful plans and monitor progress towards individualized case goals, among many other important tasks.[35] 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 by qualified staff with as little disruption as possible to families and other staff. Case managers also need training and supervision to ensure they have the skills required to effectively carry out their roles and must be compensated with salaries and benefits that equate to a professional living wage so they can invest in and pursue their work as a career.

As discussed below, DSS experienced a lower rate of staff leaving the agency than in calendar year (CY) 2019 but continued to have challenges filling vacancies. Additionally, the agency was unable to move forward in obtaining new positions or raising salaries for staff – significant components of its Workload Implementation Plan – due to delays in the state's budget.

Key Developments: Staffing and Caseloads, April - September 2020



[35] 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.

Workload Progress and Implementation Updates

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

The Workload Implementation Plan was approved by the Co-Monitors on February 20, 2019, and by the Court on February 27, 2019.[36] The strategies within the Plan primarily focus on improvements to infrastructure and hiring, training, and retention of case managers and supervisors. The discussion below includes implementation updates for select Implementation Plan, and Joint Report, and Mediation Agreement strategies during this period.

Hiring, Training, Onboarding, and Retaining New Case Managers and Supervisors
Obtaining and filling new case manager positions are strategies that can have a significant impact on the current caseload size of staff. Historically, DSS has not had enough case manager positions to ensure caseloads are within the required limits, and even when positions become available, there have been challenges in hiring and retaining staff. Data for the first three quarters of CY2020 reflect improvements in DSS's retention of staff. Between January and September 2020, 16 percent (285 of 1,822) of staff left the agency,[37] compared to 32 percent in CY2019. The adoption staff turnover rate was 14 percent (decrease from 25% in CY2019), and within foster care staff, 18 percent left between January and September 2020 (a decrease from 27% in CY2019). Feedback from case manager exit surveys in 2020 reflect the top personal reasons for leaving are "too stressful/high workload," "further career/financial gain," "burn out," "relocation," "care for family," and "health issues."

As one retention strategy, beginning in September 2019, DSS implemented "stay" interviews or surveys with new staff following their 30-day, 90-day, six-month, and nine-month from hire anniversary dates. DSS reports when issues are identified that require follow-up, they are reported to the County Director, Regional Director, and Human Resources employee relations for follow up.

[36] The Workload Implementation Plan is available at: https://dss.sc.gov/media/1948/dss-workload-implementation-plan.pdf
[37] This includes staff in adoptions, family preservation, foster care, intake, investigations, licensing, and OHAN.

DSS reports as of September 30, 2020, there were 33 vacant foster care case manager, case manager assistant, case manager supervisor, and OHAN investigator positions. These positions had been vacant for an average of 4.22 months, with vacancies the longest within foster care case managers (average of 5.77 months). The most commonly identified barriers to filling vacancies include delay in background checks (impacted by COVID-19 protocols within the agencies conducting fingerprints), lack of appropriate candidates, candidates decline salary offers or do not respond, candidates accept other positions, internal staff fill vacancies and create additional vacancies, and lack of frequent interviews. DSS reports delays in interviews were impacted by a HR process related to automation of applicant lists, that has since been resolved through education of hiring managers on the process.

Using a standard of assigning no more than 12 children to one case manager, DSS estimated a need for 213 additional case manager and 43 supervisor positions in FY2020-2021.[38] The agency sought the requisite resources to fund these positions in its FY2020-2021 budget request however, as discussed earlier, a new budget was not passed by the General Assembly due to the COVID-19 pandemic, and the State has been operating under a continuing resolution maintaining the same funding levels as the FY2019-2020 budget. The agency has again included this request in its FY2021-2022 budget request, currently being deliberated in the General Assembly.

Increased Salaries for Staff with BSW and MSW Degrees

One of the foundational strategies in the Workload Implementation Plan includes steps to stabilize and professionalize the workforce through the adoption of a new salary schedule for case managers and supervisors that will raise entry level salaries significantly, and provide for structured increases based on education, training, and longevity.[39] The salary schedule in the approved Workload Implementation 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 funding in its FY2020-2021 budget. As mentioned above, a new budget was not passed by the General Assembly. The agency has again

[38] This estimate is in addition to previously funded positions that were vacant.

[39] 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.

included this request in its FY2021-2022 budget request, currently being deliberated in the General Assembly.

Increasing the Quality of Supervision
The Workload Implementation Plan includes several measures to support quality supervision as the cornerstone of workforce stability and performance. DSS reports that the requirement for supervisors to be the initial recipients of training in new knowledge and skills has been incorporated into Human Resources policy, and that supervisors will be the first to receive the new certification training that is aligned with the GPS Case Practice Model that is expected to be completed in early 2021 (the original date for completion was mid-2020).

Additionally, DSS has created a Supervisor Advisory Group to provide a forum for supervisors to offer input and feedback to leadership. This group was chartered in August 2020 and meets quarterly. The Advisory Group is comprised of three supervisors per region, and one representative from the offices of Operations, Permanency Management, Child Health and Well-Being, Safety Management, CQI, Staff Development and Training, and HR for a total of 19 members.

Case Assignment and Worker Categories
During the prior monitoring period, DSS phased out use of Intensive Foster Care and Clinical Services (IFCCS) as a separate workload and staffing category, and all IFCCS case managers and supervisors transitioned into foster care units in county offices by December 2019.

The second case assignment change required by the Workload Implementation Plan was the discontinuation of the practice of assigning the cases of children legally eligible for adoption to both adoption and foster care case managers, ensuring instead that children and families have one point of contact for communication and case planning. This transition began in February 2019 with children who were already placed with a family that intended to adopt, and continued through the end of the year for all children who were legally eligible for adoption. As of December 17, 2020, approximately 80 percent of children who were legally eligible with a plan of adoption had been transferred to an adoption worker for case management. Slightly over half (53 of 97) of those children who had not yet transferred are in regular foster care

placements,[40] and approximately one-third (40 of 97) are between the ages of birth and six years.[41]

Finally, in response to specific concerns about the caseloads of those responsible for investigating allegations of abuse and neglect of children in foster care – DSS's Out of Home Abuse and Neglect (OHAN) unit – the Workload Implementation Plan requires that by September 2019, DSS assess OHAN caseloads and determine how many additional staff may be needed to bring staff to the required caseload standards. DSS determined that 11 new positions are necessary to meet the caseload requirements. DSS's FY2020-2021 budget request included funding for these new positions; a new budget has not been passed and they have not been created.

Appendix D of this report includes a list of all workload strategies due this period, as well as Joint Report and Mediation Agreement commitments related to workforce improvement strategies.

Performance Data

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)). The interim benchmark for September 2020 is for at least 80 percent of all case managers to have caseloads within the required limits, and no more than 15 percent of all case managers to have caseloads more than 125 percent of the required limits. The standard also requires that no case manager has a caseload of more than 160 percent of the standard by September 2020. As referenced earlier, there are different caseload standards dependent upon the types of cases a case manager manages – specifically foster care and adoption, and investigations of allegations of abuse and neglect of children in foster care (OHAN).[42]

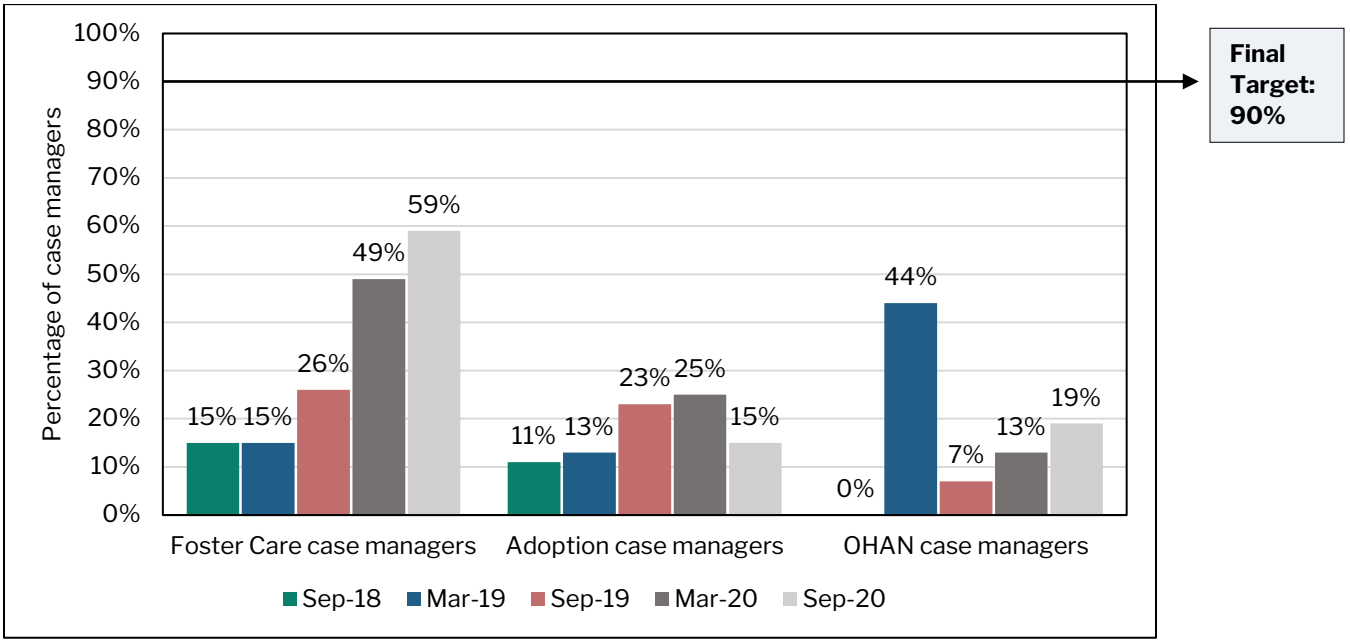
[40] DSS reports that half (27 of 53) of these children have a legally free date of approximately 2 months or less prior to this report. Further, some of the older youth (9 youth are over 17 years old) may not want to be adopted but a permanency planning hearing has not yet occurred to change the legal plan.

[41] DSS reports for children six years and younger, only 18% have a legally free date that would have provided sufficient time for transfer prior to the report being run. These numbers also do not contemplate data errors that indicate children as legally free, but who are not yet legally free due, for example, to appeals. Further, some of the older youth (9 youth are over 17 years old) may not want to be adopted but a permanency planning hearing has not yet occurred to change the legal plan.

[42] DSS has many staff with "mixed" caseloads that include different case types and both Class and Non-Class Members. On December 21, 2017, the Co-Monitors provisionally approved DSS's proposal to calculate caseloads for foster care case managers with mixed caseloads by adding the total number of foster care children (Class

To assist in assessing progress over time, Figure 7 and Figure 8 show performance data on caseloads by case manager and supervisor type for prior and current monitoring periods. As of September 30, 2020, caseload levels had improved since the last period for foster care case managers, but declined for adoption case managers.

Figure 7: Percentage of Case Managers With Caseloads Within the Required Limits, by Case Manager Type September 2018 - September 2020[43]

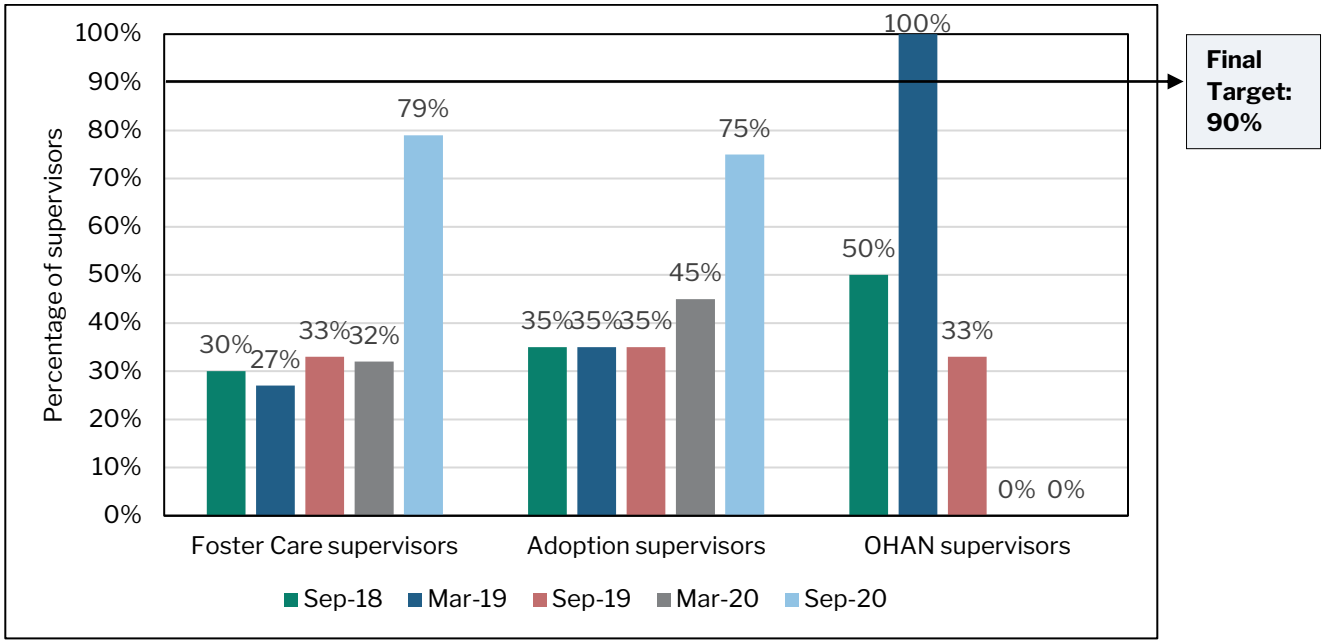


Source: CAPSS data provided by DSS

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

[43] Caseload limits in September 2020 are as follows: foster care case manager, 1:15; adoption case manager, 1:15; and OHAN investigator, 1:8. The final target for this measure is 90%. Adoption case manager performance in September 2018, March 2019, and September 2019 was assessed at a standard of 1:17, which changed to 1:15 beginning in January 2020.

Figure 8: Percentage of Supervisors With Workloads Within the Required Limits, by Supervisor Type September 2018 – September 2020[44]



Source: CAPSS data provided by DSS

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, and should have no more than eight (1:8) cases on their caseload for six months after they complete Child Welfare Certification training.

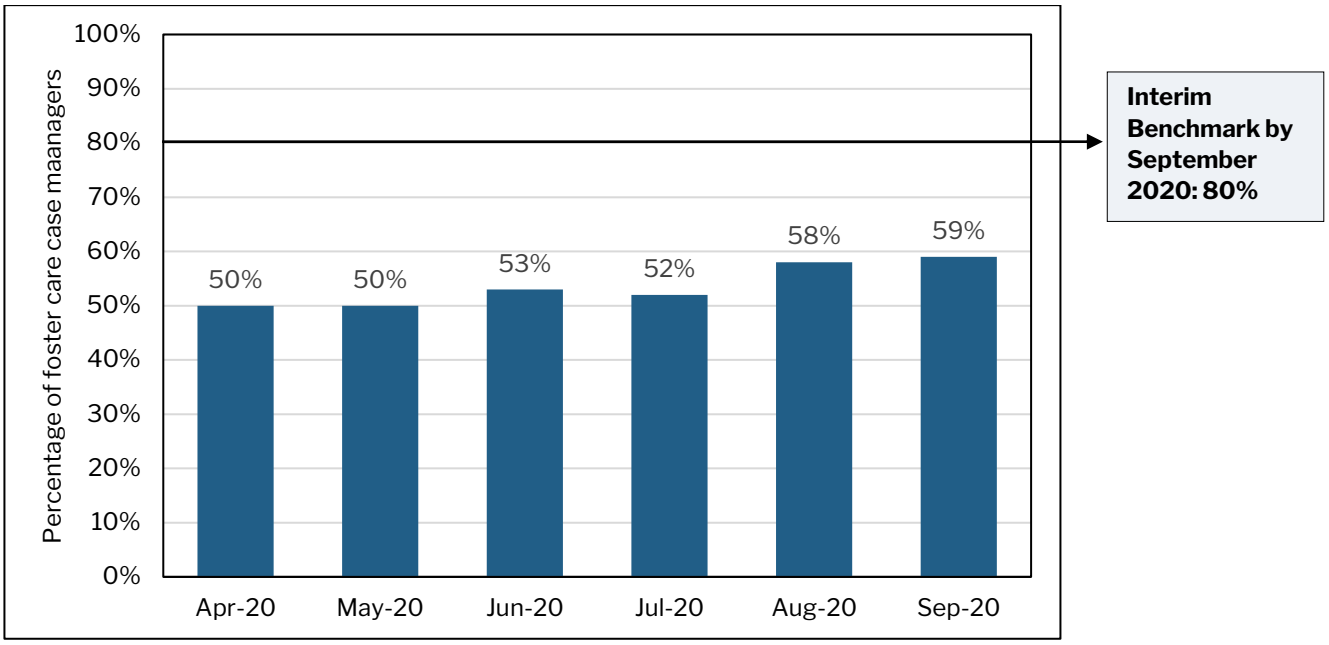
The September 2020 interim benchmark for this measure is 85 percent of case managers will not exceed 15 children on their caseloads, and no more than 15 percent of case managers will have more than 18 cases (125% of the required caseload standard). The standard also requires that no case manager has a caseload of more than 160 percent (no more than 24 cases, or 13 for new case managers) of the standard by September 2020.

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

On September 30, 2020, there were 311 foster care case managers with at least one child in foster care on their caseload.[45] Of these case managers, 59 percent (183) had caseloads within the required limit of 15 cases (eight cases for new case managers), and 26 percent (80) of case managers had caseloads more than 125 percent of the caseload limit, meaning they were responsible for at least 18 cases (at least 10 cases for new case managers). Additionally, as of September 30, 2020, 15 (5%) foster care case managers had caseloads of more than 160 percent of the standard.

Point-in-time data for each month between April and September 2020 show that between 50 and 59 percent of foster care case managers, including new case managers, had caseloads within the required limit (see Figure 9); 26 to 36 percent of foster care case managers had caseloads that were more than 125 percent of the caseload limit; and five to 15 percent had caseloads that were more than 160 percent of the caseload limit (see Figure 10).[46] Performance improved most months this period, but does not meet the interim benchmarks.

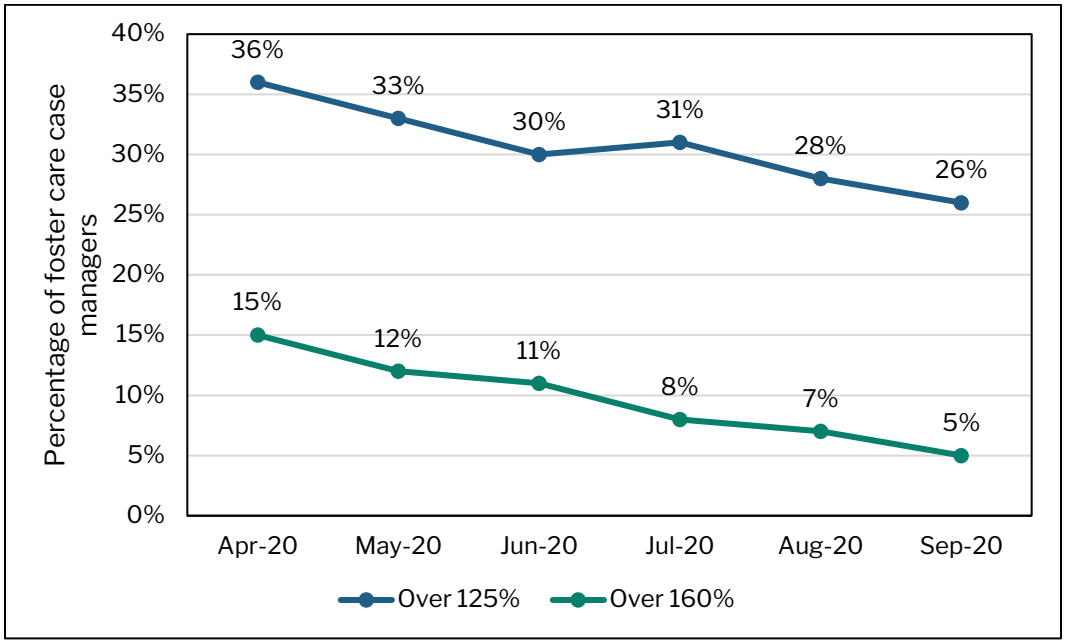
Figure 9: Foster Care Case Managers With Caseloads Within the Required Limits April – September 2020



Source: CAPSS data provided by DSS

[45] This includes 46 newly hired foster care case managers.
[46] In calculating performance, a limit of 8 children in foster care or Non-Class Member families is applied to newly hired case managers (half of the applicable caseload standard), and 15 children in foster care children or Non-Class Member families is applied to foster care or APS case managers.

Figure 10: Foster Care Case Managers With Caseloads over 125% and 160% of Required Limits April – September 2020[47]



125% of standard: 18 cases

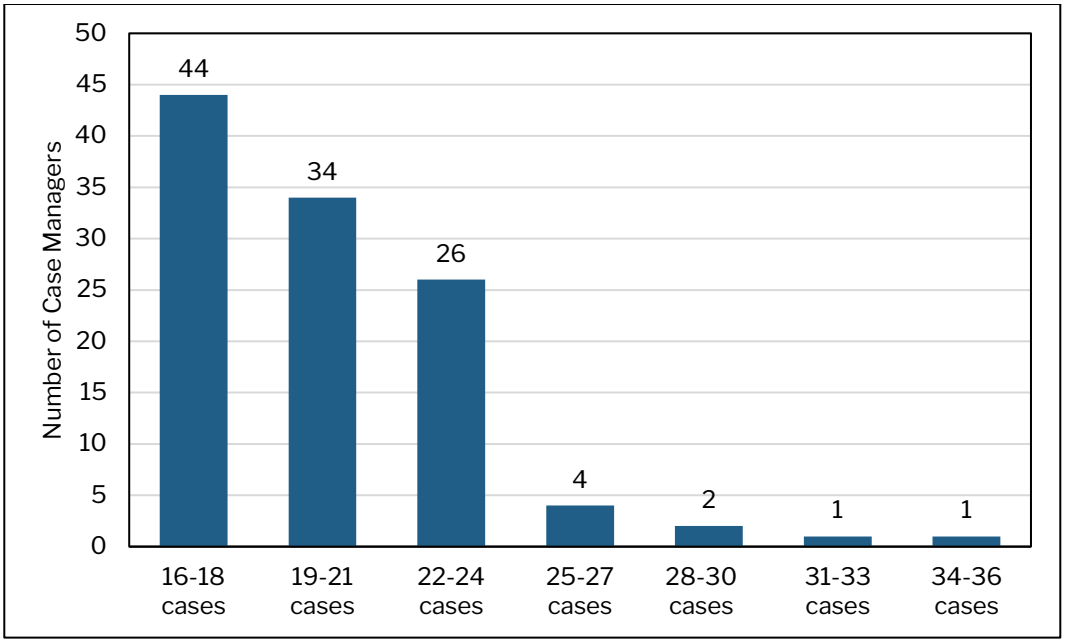
160% of standard: 24 cases

Source: CAPSS data provided by DSS

Figure 9 and Figure 10 merge data for all foster care case managers – those newly hired as well as those hired more than six months prior. Figure 11 reflects the number of cases carried specifically by the 265 foster care case managers who had completed Child Welfare Certification training more than six months prior and had responsibility for more than 15 children on September 30, 2020. Over one-third (39%) of these case managers had caseloads between 16 and 18 cases, and slightly over half (54%) managed caseloads between 19 and 24 cases.

[47] The interim benchmark for case managers with over 125% of the limit is no more than 15% by September 2020. Additionally, by September 2020, no (0%) case manager should have a caseload more than 160% of the limit.

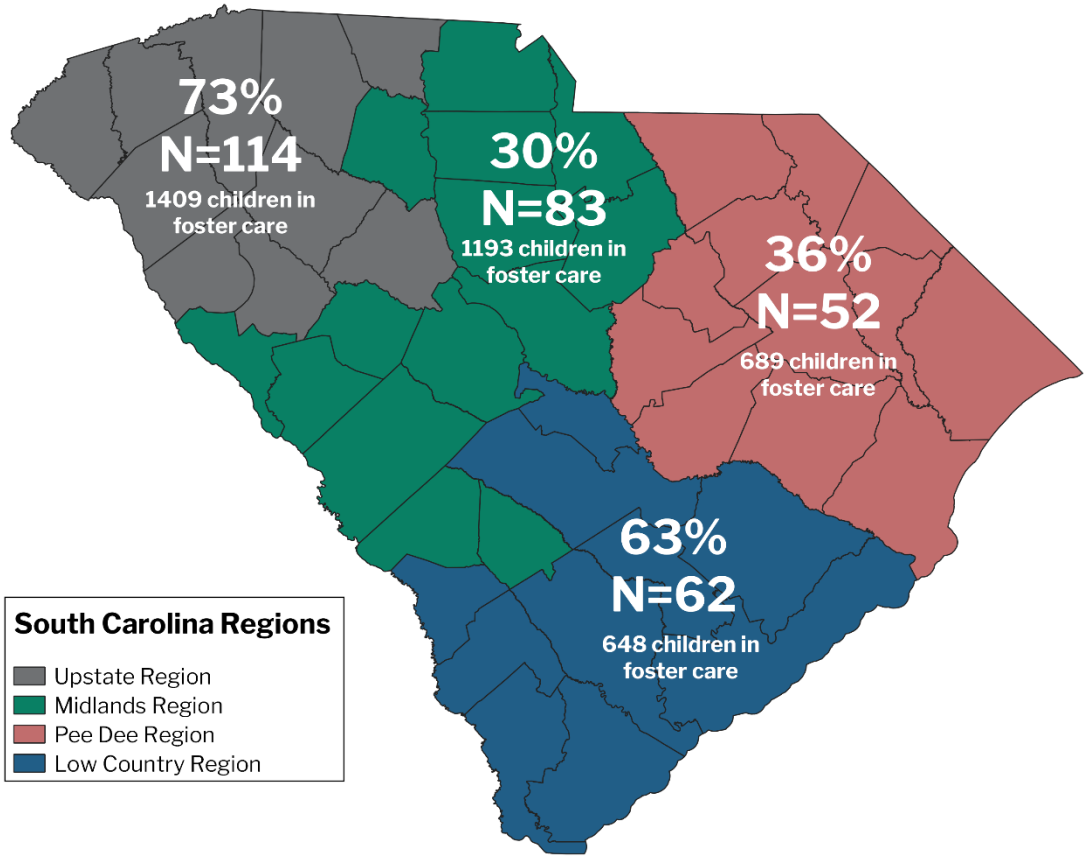
Figure 11: Number of Foster Care Case Managers Who Have Completed Certification Training More than Six Months Ago With Caseloads that Exceeded the Limit September 30, 2020 N=112



Source: CAPSS data provided by DSS

As discussed above, DSS offices are divided among four regions, and each differs 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, 2020 are shown in Figure 12. Although regional performance for foster care case manager caseloads within the standards continues to be lower than the interim benchmark in every region, performance is particularly low in the Midlands (30%), and Pee-Dee (36%) regions.

Figure 12: Percentage of Foster Care Case Managers with Caseloads Within the Required Limit by Region September 30, 2020



Source: CAPSS data provided by DSS; DSS Dashboard data on 1/4/2021.

Adoption Case Managers

The caseload standard for case managers providing adoption support to children with a goal of adoption is one case manager to 15 children (1:15).[48] 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 2020 interim benchmark for this measure is 80 percent of case managers with no

[48] Prior to 2019, DSS's workforce was structured so that case management responsibilities remained with the foster care case manager, even when an adoption case manager was assigned, until a placement agreement was signed. As a result, the approved caseload standard for adoption workers was 1:17. In 2019, DSS began transitioning case management responsibility to adoption workers once children became legally eligible for adoption. This transition was scheduled to be complete in January 2020; thus, adoption case manager caseload performance is assessed at a standard of 1:15, the same standard applied to foster care case managers.

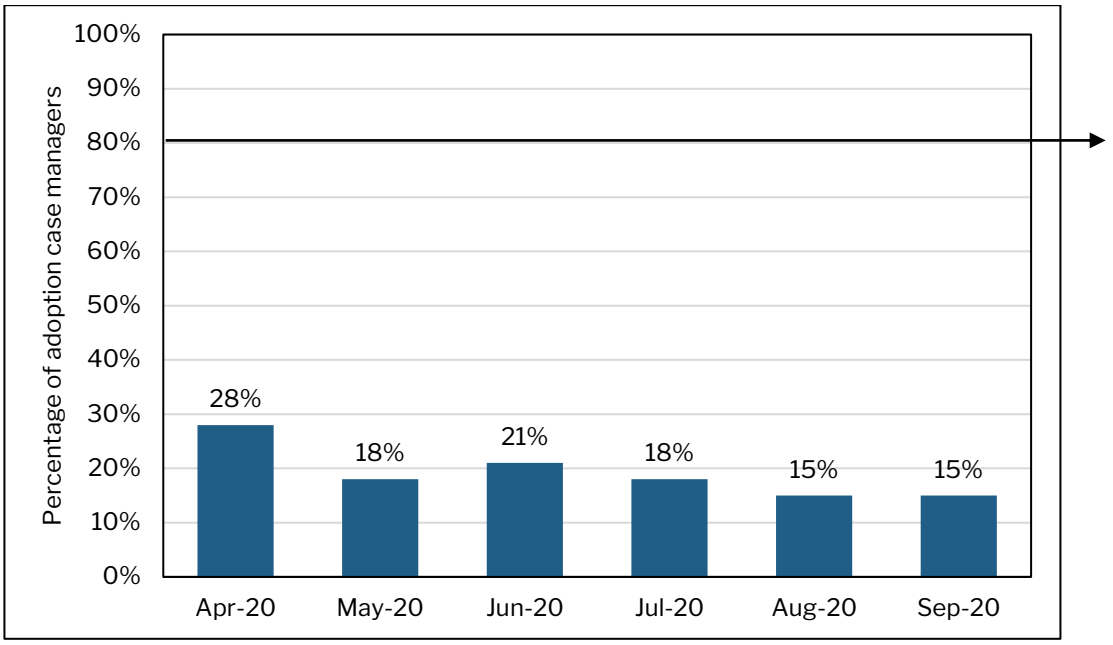
more than 15 cases, no more than 15 percent of case managers with more than 18 cases (125% of the required caseload standard), and also requires that no case manager has a caseload of more than 160 percent (no more than 24 cases, or 13 for new case managers) of the standard by September 2020.

On September 30, 2020, there were 78 adoption case managers serving at least one Class Member.[49] Of these 78 case managers, 12 (15%) case managers had caseloads within the caseload requirement, and 39 (50%) case managers had caseloads that exceeded 125 percent of the limit. Additionally, 13 (17%) adoption case managers had caseloads of more than 160 percent of the standard.

Between April and September 2020, a monthly range of 15 to 28 percent of adoption case managers had caseloads within the required limit (see Figure 13); 50 to 61 percent of adoption case managers had caseloads that exceeded 125 percent of the required limit; and 17 to 24 percent had caseloads over 160 percent of the limit (see Figure 14). Unlike foster care case managers, compliance with the 1:15 caseload standard declined from the start to the end of this period, although there were slight improvements in the percentage of adoption case managers whose caseloads exceeded 160 percent of the standard.

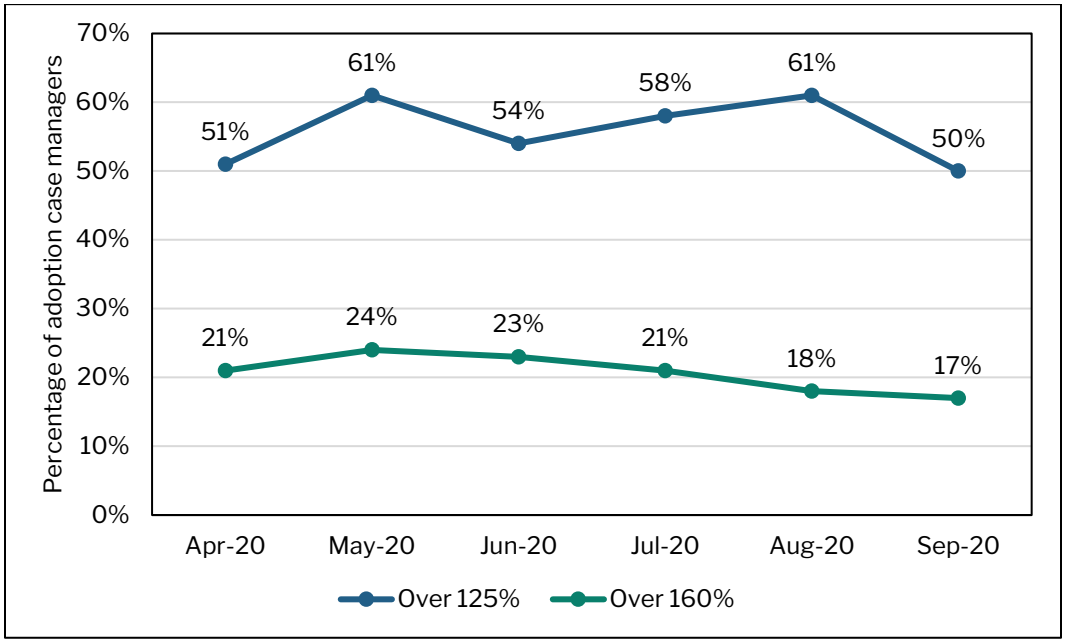
[49] This includes 4 newly hired adoption case managers.

Figure 13: Adoption Case Managers with Caseloads Within the Required Limits
April – September 2020



Source: CAPSS data provided by DSS

Figure 14: Adoption Case Managers with Caseloads over 125% and 160% of Required Limits
April – September 2020[50]



Source: CAPSS data provided by DSS

[50] The interim benchmark for case managers with over 125% of the limit is no more than 15% by September 2020. Additionally, by September 2020, no (0%) case manager should have a caseload more than 160% of the limit.

Out-of-Home Abuse and Neglect Case Managers

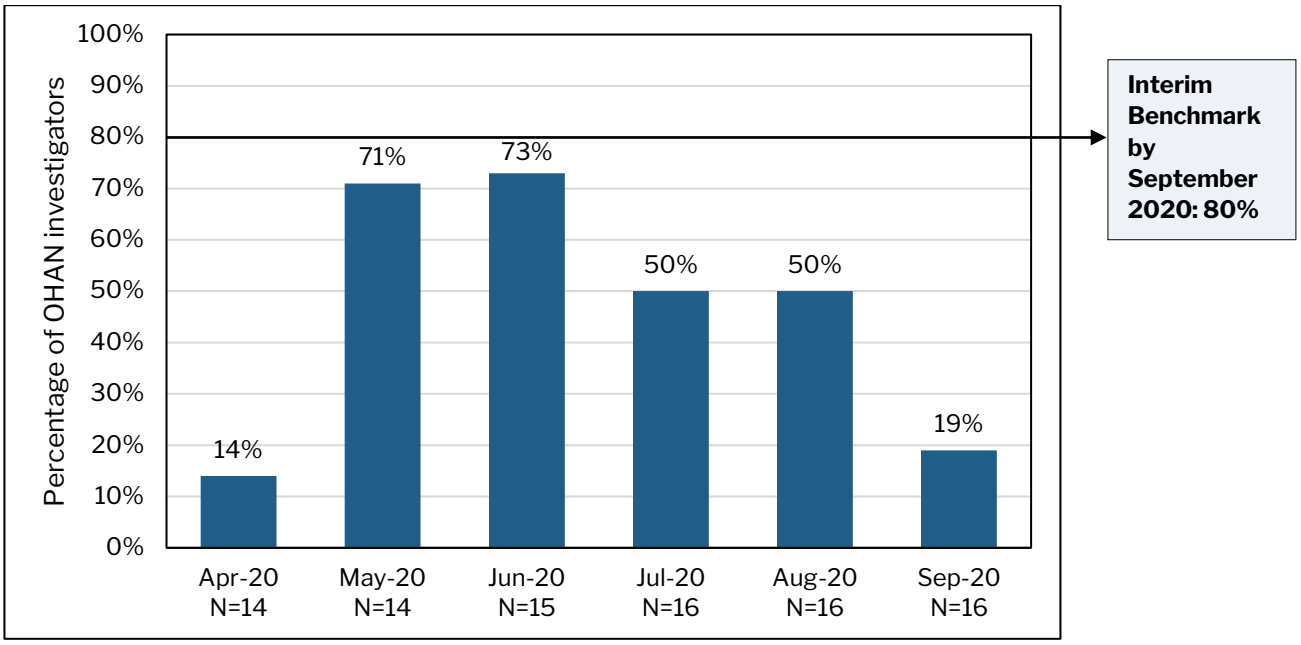
The caseload standard for case managers conducting investigations involving allegations of abuse and/or neglect of a child in foster care is one case manager per eight investigations (1:8). Newly hired OHAN case managers should have no more than four investigations on their caseload for six months after they complete Child Welfare Certification training. The September 2020 interim benchmark for this measure is 80 percent of investigators have a caseload of 1:8, no more than 15 percent of investigators with more than 10 investigations (125% of the required caseload standard), and also requires that no investigator has a caseload of more than 160 percent of the standard (no more than 13 cases or 6 for new investigators) by September 2020.

In September 2020, OHAN had 16 assigned investigators, and all had been employed for longer than six months. On September 30, 2020, of the 16 OHAN investigators, three (19%) investigators had caseloads within the required standard, and nine (56%) investigators had caseloads over 125 percent of the required limit. Five (31%) OHAN investigators had caseloads of more than 160 percent of the standard.

Between April and September 2020, a monthly range of 14 to 71 percent of OHAN case managers had caseloads within the required limits (see Figure 15), and seven to 86 percent of case managers had caseloads that exceeded 125 percent of the required limit each month (see Figure 16).[51]

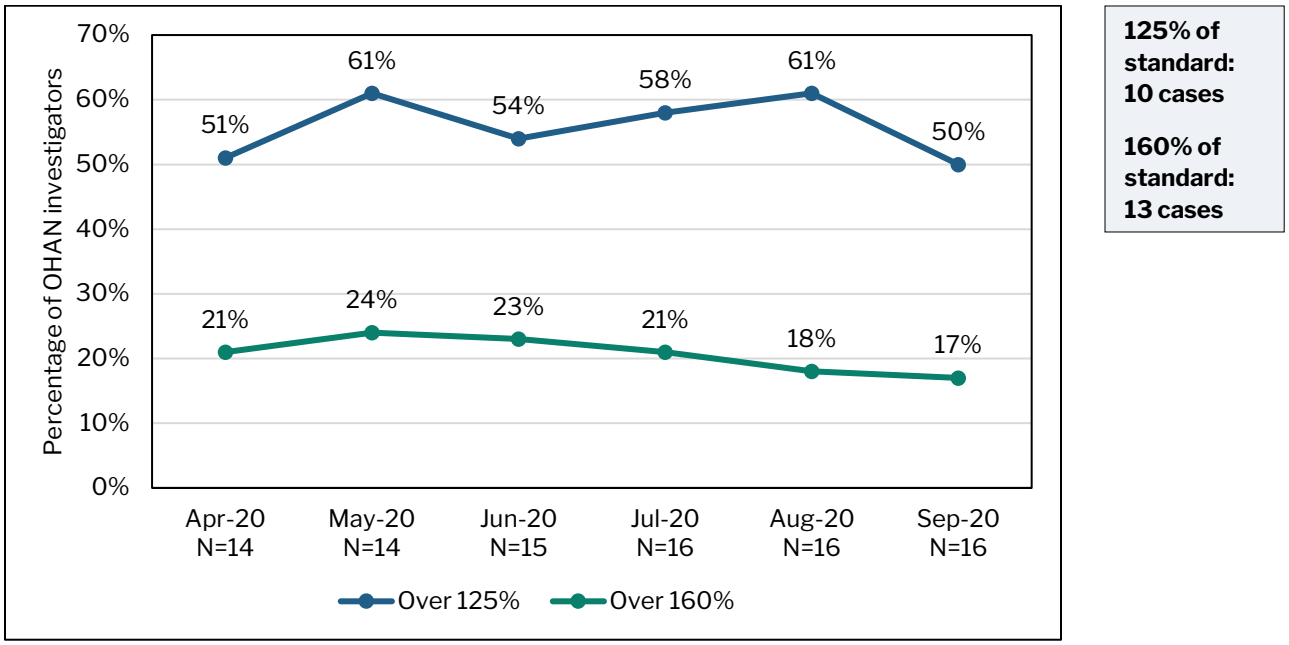
[51] Large fluctuations in performance are due to the small number of OHAN investigators.

Figure 15: OHAN Investigators with Caseloads Within the Required Limits
April – September 2020



Source: CAPSS data provided by DSS

Figure 16: OHAN Investigators with Caseloads over 125% and 160% of Required Limits
April – September 2020[52]

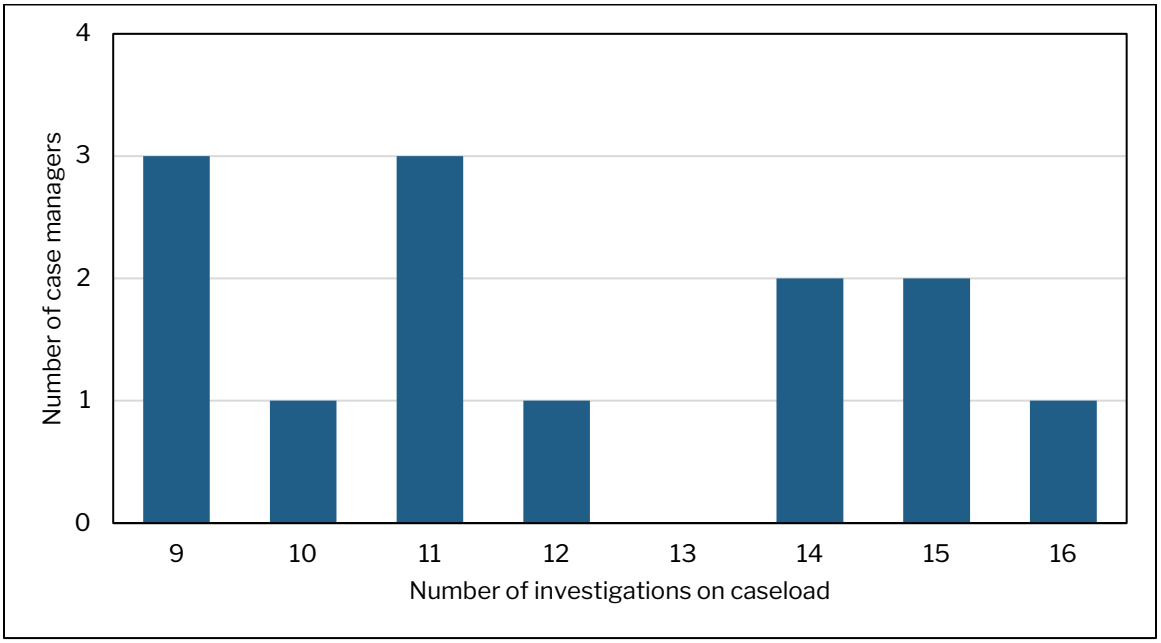


Source: CAPSS data provided by DSS

[52] The interim benchmark for investigators with over 125% of the limit is no more than 15% by September 2020. Additionally, by September 2020, no (0%) investigator should have a caseload more than 160% of the limit.

Figure 17 includes the caseload size of the 13 OHAN investigators who had caseloads exceeding the limit on September 30, 2020. Over one-third (39%) of the case managers had been assigned 14 or more investigations.

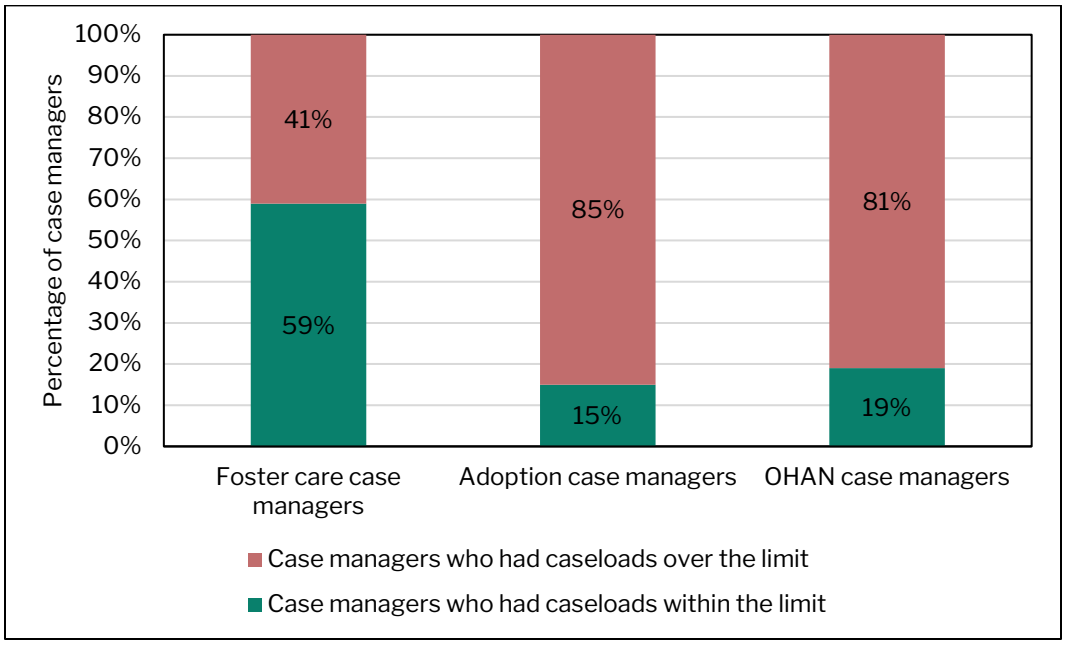
Figure 17: Number of OHAN Investigators with Caseloads that Exceeded the Limit September 30, 2020



Source: CAPSS data provided by DSS

In summary, Figure 18 reflects the percentage of foster care, adoption, and OHAN case managers within and over the required caseload limits on September 30, 2020.

Figure 18: Foster Care, Adoption, and OHAN Case Managers that were Within and Over the Required Caseload Limits September 30, 2020



Source: CAPSS data provided by DSS

Supervisor Workloads

The Workload Implementation Plan includes separate timelines and interim benchmarks for supervisors. The final target is that at least 90 percent of supervisors will supervise the number of case managers within the limit, and no supervisor will be assigned more than 125 percent of the standard (or 7 case managers for foster care and adoption supervisors, and 8 investigators for OHAN supervisors). The approved Workload Implementation Plan anticipates compliance with the final targets by September 2020.

DSS has identified occasional situations in which supervisors may be directly responsible for a case for a short period of time. These include circumstances in which a case manager is promoted to supervisor and may temporarily retain case management for up to 45 days if a case is nearing closure; there are complexities regarding the case that need to be addressed; or an important legal event will occur within the timeframe. While the supervisor is directly managing, or "carrying" a case, they are responsible for all required case duties, including visits with the child: monitoring the child's safety, placement, well-being, case plan, and service delivery;

ensuring the child is visiting with their siblings and/or parent, as applicable; and other activities, as necessary. When cases are being transferred from one case manager, office, unit, or program area to another, the case may be temporarily assigned to the receiving supervisor for up to five days until the supervisor assigns the case to the receiving case manager.

After reviewing data on supervisors carrying cases for the last two monitoring periods, DSS has identified additional circumstances which result in supervisors carrying cases. These include when a case manager leaves the agency and creates a vacancy that takes some time to fill (including onboarding new staff with required training, and limiting their caseload to half the required limit during the first six months after completing training), or when case managers are on extended leave. DSS has assigned cases to supervisors in these circumstances due to their familiarity with the child and family, and to prevent overburdening other case managers within their unit. The Co-Monitors have reviewed and discussed current data with DSS reflecting these situations, and in March 2021, DSS proposed a process to closely monitor these situations. The process will require Regional Director approval for supervisors to carry cases for greater than five days; documentation will be shared with staff within Accountability, Data, and Research (ADR) and must describe the cases the supervisor will carry, the circumstances leading to the supervisor carrying cases, and a specific plan and timeline to address the issue. If this process is approved by the Co-Monitors, it will be reviewed after 12 months to assess its effectiveness and feasibility.

Between April and September 2020, a range of 29 to 32 supervisors were assigned cases each month. The types of cases varied, and included foster care, child protective services, aftercare services, adoption services, or children subject to the Interstate Compact on the Placement of Children because they are placed in South Carolina from a different state. The time commitments and activities required for each type of case varies. Of the 149 cases of all service types assigned to 29 supervisors on September 30, 2020, 66 cases (44%) were classified as foster care services; 32 of these foster care cases (48%) were assigned to four non-foster care and adoption supervisors.

The data reflect that as of September 30, 2020, 11 supervisors were responsible for at least one Class Member on their caseload, and all 11 supervisors were responsible for at least one case for longer than five days. More than half (55%, or 6 of 11) of these supervisors were responsible for one to five cases of any service type, however, five

supervisors (45%) were responsible for directly managing between seven and 19 cases that were open for a median of 59 days (the range of days open were between 25 and 629 days).

Foster Care and Adoption Supervisors

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

Between April and September 2020, a monthly range of 76 to 82 percent of foster care supervisors supervised five or fewer case managers, and five to 15 percent of supervisors supervised seven or more case managers (or 125 percent of the required limit).[53],[54] Specifically, on September 30, 2020, of the 98 supervisors supervising foster care case managers, 77 (79%) supervised five or fewer case managers, and five (5%) supervisors supervised seven or more case managers.

Between April and September 2020, a monthly range of 70 to 81 percent of adoption supervisors supervised five or fewer case managers, and zero to five percent of supervisors supervised seven or more case managers, or 125 percent of the required limit.[55,56] Specifically, on September 30, 2020, of the 20 supervisors supervising adoption case managers, 15 (75%) supervisors supervised five or fewer case managers, and one (5%) supervisor supervised more than six case managers. Current performance is below the interim benchmark and final target of 90 percent.

The workload standard for supervisors providing supervision to case managers conducting OHAN investigations is one supervisor to six investigators (1:6).[57]

Between April and September 2020, OHAN had two supervisors each month responsible for the 14 to 16 investigators who were accepting investigations. Every month, no OHAN supervisor supervised six or fewer case managers, and in the last

[53] Monthly performance for foster care supervisors supervising 5 or fewer case managers are as follows: April, 76%; May, 76%; June, 81%; July, 81%; August, 82%; September, 79%.
[54] Monthly performance for foster care supervisors supervising 7 or more case managers are as follows: April, 15%; May, 10%; June, 8%; July, 8%; August, 6%; September, 5%.
[55] Monthly performance for adoption supervisors supervising 5 or fewer case managers are as follows: April, 81%; May, 76%; June, 75%; July, 70%; August, 75%; September, 75%.
[56] Monthly performance for adoption supervisors supervising 7 or more case managers are as follows: April, 0%; May, 5%; June, 5%; July, 5%; August, 5%; September, 5%.
[57] 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.

four months of the period, one (50%) supervisor supervised eight or more case managers, or 125 percent of the required limit.[58,59]

[58] Large fluctuations in performance are due to the small number of supervisors each month.
[59] Monthly performance for OHAN supervisors supervising 8 or more case managers are as follows: April, 0%; May, 0%; June, 50%; July, 50%; August, 50%; September, 50%,

V. Visits Between Case Managers and Children

DSS case managers are expected to have face-to-face contact with children in foster care and their caregivers at least once a month. At least 50 percent of those contacts must be in the child's residence. Depending upon the needs of the child, the DSS case manager may see children and their caregivers more often. The purposes of these contacts are to assess the child's status in multiple areas including safety, physical and emotional health, and to ensure that the child's needs are being met. Case managers are also expected to assess the status of any services being provided to the child and/or caregiver to meet the child's needs and support placement stability; discuss updates on achieving permanency for the child; and continue to strengthen the relationship with the child and their caregivers during these contacts.

Data from DSS show that monthly contacts of some kind between case managers and children are occurring in nearly all cases. As allowed by DSS leadership during the COVID-19 pandemic, after posing a several questions to screen for risk of exposure to the COVID-19 virus, some case managers had contact with children via video or telephone. According to DSS data, for CY2020, DSS case managers had at least one contact with children in foster care at an average monthly rate of 97 percent. Most of the contacts with children, whether by video, telephone, or in-person, occurred while the child was in their placement. It is commendable that DSS has been able to maintain contacts with this frequency during the pandemic.

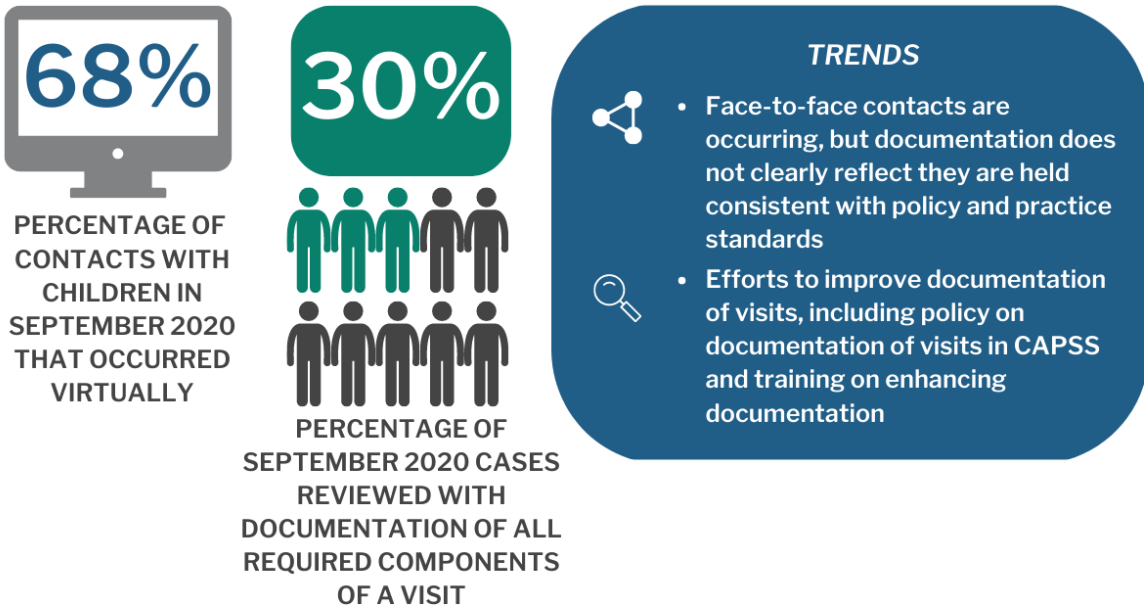
Given the critical nature of case manager visits, the Parties agreed that a case manager's documentation in CAPSS reflecting each of the policy and practice expectations outlined above is needed to determine that a visit has been held. The Co-Monitors and DSS rely on case managers' documentation of the contacts to report on progress in this area and determined again this period that documentation does not reflect that contacts are being made – either in-person, by video, or by telephone – in accordance with these expectations in the majority of cases. As discussed in more detail below, case managers' documentation of contacts with children does not consistently reflect assessments of safety or review of case plan status. Documentation also often does not address the child's progress towards permanency with the child, when old enough, or their caregiver.

The Co-Monitors continue to believe that reduced, manageable caseloads and the placement of children closer to their home communities will allow case managers to spend more time with children, rather than traveling to see them, and allow for

increased and meaningful interaction between children and their case managers. Case managers would also have more time to interact with foster parents and others who reside with the child.

DSS's plan to implement a model of practice that is reflective of the agency's stated values and principles is essential to improving performance in this area. The GPS Case Practice Model places children, their families, and their caregivers at the center of DSS's work and focuses on ongoing assessment and planning with children, their families, and those who care about them to achieve reunification, stability, and other important goals. It also aligns with DSS's expectations of case managers during interactions with children and their caregivers.

Key Developments: Case Manager Contact and Visits with Children, April- September 2020



Visits Between Case Managers and Children: Progress and Implementation Updates

DSS's Visitation Implementation Plan was approved by the Co-Monitors on March 28, 2019, and by the Court on April 3, 2019.[60] The Plan includes strategies to clarify the role and function of case manager contacts with children through:

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

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

While DSS develops training and a coaching plan for statewide implementation of the GPS Case Practice Model, DSS is also delivering training and other information to case managers and supervisors. In April 2020, DSS began offering a combination of online and instructor-led training on the quality of case managers' visits with children and family members. The stated objectives include that case managers and supervisors would:

- Understand the purpose and value the importance of documentation.
    - How documentation impacts safety, permanency, and well-being.
    - How documentation maintains continuity in case management.

- Understand who the audience is for documentation.
    - Identify the many audiences who rely on documentation.
    - Articulate how documentation impacts decision-making and outcomes.

- Gain the ability to write clear objective, descriptive, and relevant documentation.
    - Identify and avoid common writing mistakes that create confusion.
    - Recognize buzzwords and know how to replace them.
    - Describe what is seen and heard.
    - Identify documentation that suggests speculation or bias.

- Gain the ability to thoroughly document (i.e., know what to include in documentation).
    - Identify and document the 5 Ws – What, What, Where, When, Why.
    - Use job aid to check documentation for thoroughness.
    - Determine when information does not need to be included.

- Know strategies to be able to complete documentation within required timeframes.
    - Understand the timeframes required to ensure safety and well-being.
    - Identify workable strategies for writing and entering documentation into CAPSS as soon as possible after every contact.

- Identify alternate strategies so that documentation is completed even when busy.

An additional objective for the training directed towards supervisors is that they gain the ability to coach case managers to improve documentation. The curriculum includes discussion of distinguishing between case consultation and coaching specific to helping case managers build documentation skills.

In October 2020, DSS published a policy on case manager contacts with children and youth as well as a policy on case manager contacts with caregivers.[61] The policy guiding contact with caregivers contains supplemental guidance on preparing for, conducting, and documenting contacts. DSS also implemented a Child Contact Review quality assurance tool for use by County leadership beginning in February 2021. The tool guides the user to respond to questions and provide comments upon the review of documentation of visits. In this effort to improve practice during case manager contacts with children, and subsequent documentation, there is also process for providing feedback to case managers and their supervisor on findings.

Appendix E of this report includes a list of all strategies to address case manager visits due this period, as well as related Joint Report and Mediation Agreement commitments.

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.[62]

As part of DSS's March 2019 Visitation Implementation Plan, Parties agreed that case manager visits with children must include the following elements as set out in

[61] Child Welfare Policies and Procedures, Chapter 5 (effective 2020).
[62] Social Security Act - Section 422(b)(17)

DSS Policy and Procedure (Chapter 5, Foster Care Visitation, effective June 1, 2019),[63] for purposes of compliance with the FSA.

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

A close review of individual case records is required to assess documentation related to the content of contacts between children and their case managers. Reviewers assessed documentation of case manager contacts with children for the agreed-upon elements of a visit, as described above. Specifically, reviewers gather data on whether the record reflects 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 required by DSS policy.

In collaboration with DSS, USC CCFS, and the Co-Monitors, reviewers assessed a statistically valid sample of 348 DSS case records for children in foster care during the entirety of September 2020 to understand the practices of case managers relative to the expectations for the time spent with children.[64] The ability of DSS case managers to see children in-person has been impacted by the COVID-19 pandemic. During September 2020, consistent with practice guidance provided in response to COVID-19, case managers were expected to see children in-person, if possible, and were also encouraged to ask a series of screening questions about possible exposure

[63] 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

[64] The sample was derived from a universe of 3,595 cases active for 30 days or more as of September 30, 2020, with a 95% confidence interval and 5% margin of error.

to COVID-19 and symptoms of the illness, and level of comfort with in-person visits to determine whether to proceed with an in-person contact.[65]

DSS reports that expectations for practice during case manager contacts have not changed to accommodate video or telephone contacts, conducted when children could not be seen in-person as per DSS policy due to COVID-19 pandemic. Case managers are expected to conduct assessments as if the contact were in-person, with assistance from children and their caregivers. This may require multiple contacts during a month and the case manager being shown multiple rooms in a foster home via video.

Reviewers identified documentation of a contact – either in-person or virtual – between a DSS case manager and a child in each of the 348 DSS records. There was documentation that the DSS case managers' contact with 294 (85%) of the children occurred while the child was in their placement. Some contacts between case managers and children also took place while children were at a daycare, a location in the community, or a DSS office.

Most (68%, or 236 of 348) of the contacts case managers had with children were via video calls. Almost one-third (28%, or 93 of 348) of the contacts with children were in-person; nine contacts were by phone; and in 10 instances (3%), documentation was unclear about the case manager's mode of contact with the child.

These data once again support the reliability of CAPSS data as an indication of whether a contact between a case manager and a child occurred. Documentation of practices during these contacts, however, shows that the interactions do not routinely meet the agreed upon standard for a visit. Specifically:

- Reviewers found documented practices consistent with each required component of a visit pursuant to DSS policy and the FSA in only 30 percent (103 of 348) of records.[66]

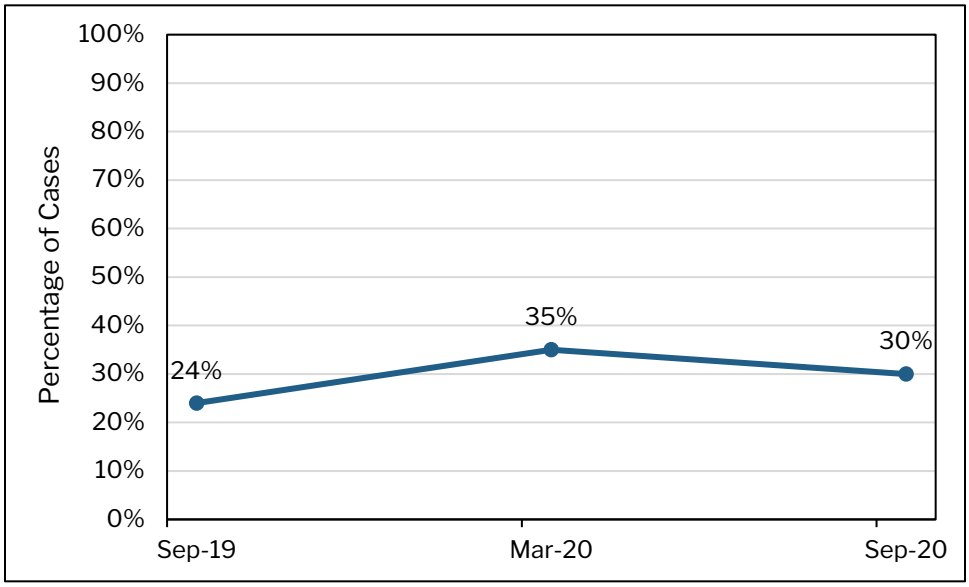
[65] Case managers had virtual contacts with children and their caregivers; 236 contacts were via video; 93 were in-person; and 9 were via telephone. In 10 cases, the reviewer was not able to determine the mode of contact between the child and case manager.
[66] In most (73) of the 103 cases in which documentation reflected all required components of a case manager's visit with a child, the visit was via video; 23 were in-person; and 3 were by phone. For 2 cases, the reviewer was unable to determine the mode of the case manager's visit.

- Reviewers found documentation that case managers were able to speak with the child alone in 303 (87%) cases, though virtual contacts created a challenge to private conversations in some cases.

- In over half of the cases (55% or 192), reviewers determined that the documentation of the contact did not reflect an adequate safety assessment. This is especially true for infants and young children where viewing the home or environment is needed and the ability to engage with and observe the young child as they interact with their caregivers is limited when the contact is by video.

Figure 20 shows results of case record reviews for all components of a case manager's contact with a child during September 2019, March 2020, and September 2020.

Figure 19: Percentage of Reviewed Cases with All Required Components of a Visit Between Case Managers and Children (September 2019-September 2020)



Source: Case Record Review conducted by USC CCFS, DSS, and Co-Monitor staff

Results from the September 2020 review show both the need for improved practices and documentation in CAPSS. Specifically:

- 85 percent (297 of 348) of the records contained a summary of conversations and observations.

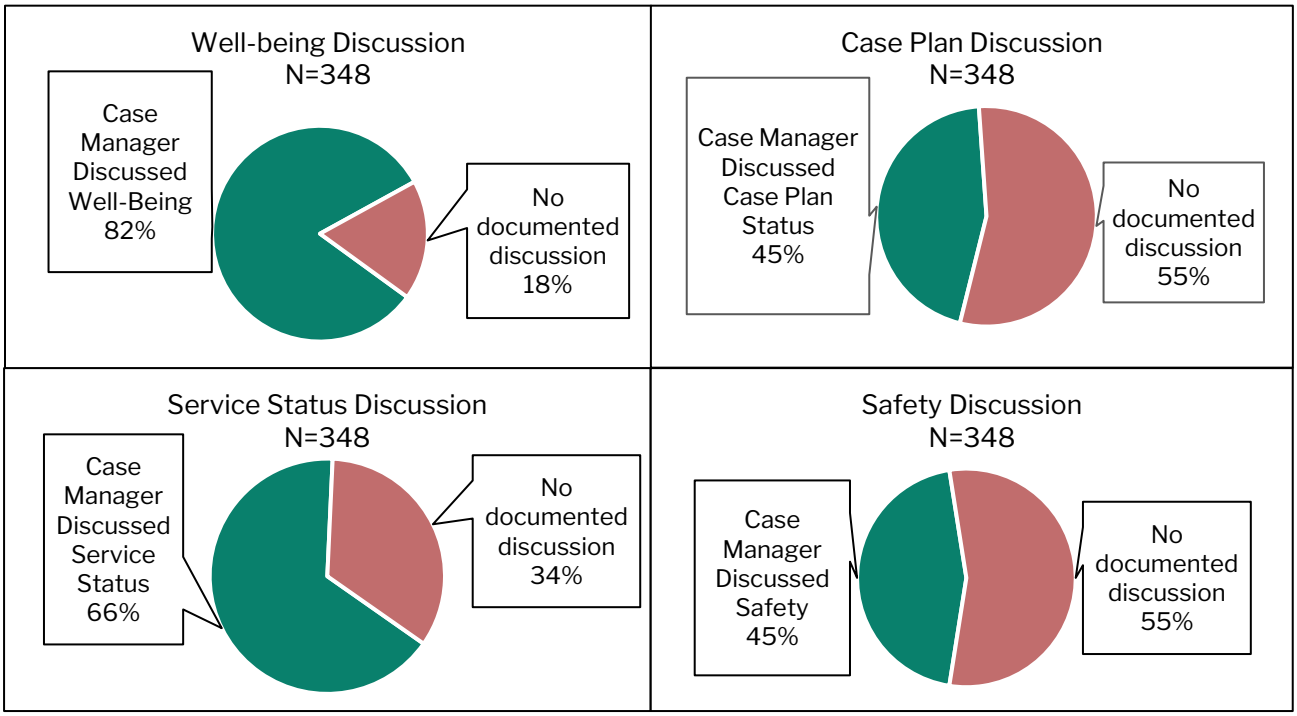
- 45 percent (156 of 348) of the records contained evidence that the case manager assessed the child's safety.[67]

- 82 percent (286 of 348) of the records contained documentation that the case manager discussed the topics of well-being with the child and/or caregiver.

- 66 percent (229 of 348) of the records contained documentation that the case manager discussed the status of services being delivered with the child and/or caregiver.

- 45 percent (156 of 348) of the cases contained documentation that the case manager discussed the status of a case plan with the child and/or caregiver.

Figure 20: Documented Practices during Case Manager Contacts with Children and Caregivers September 2020



Source: Case Record Review conducted by USC CCFS, DSS, and Co-Monitor staff

[67] In reviewing documentation regarding assessment of the child's safety, reviewers also applied the requirement that children be interviewed in private, as developmentally appropriate. In general, the expectation is that infants, toddlers, and children under the age of 4 can be seen in the presence of a caregiver.

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

The work of screening and investigating allegations of abuse and neglect of children in foster care – completed by DSS's Intake Hubs[68] and Out-of-Home Abuse and Neglect (OHAN) unit – is a critical function of any child welfare system. OHAN unit staff must be prepared to quickly respond to all allegations that meet the criteria for possible abuse or neglect in foster homes and group homes; and have the tools, skills, and supervision necessary to complete investigative tasks with quality to determine if abuse or neglect occurred. Children are separated from their families and taken into foster care based on a determination that they have been abused or neglected by their caregivers and are not safe with their families – ensuring their safety and well-being while in state custody is a primary obligation.

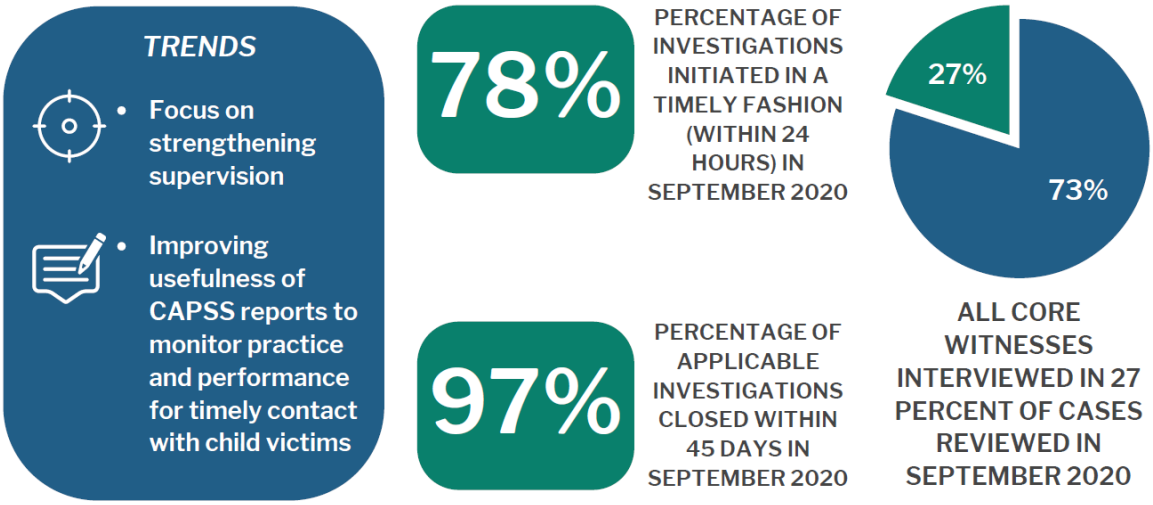
Although the COVID-19 pandemic has caused disruptions and modifications to DSS practice in a number of areas, due to the critical nature of OHAN investigators' work in ensuring the safety of children in foster care, expectations for OHAN investigators have remained largely the same. In response to concerns regarding in-person contact and the potential for COVID-19 exposure to DSS staff and alleged victim children and their households, OHAN leadership allowed for the initial "face-to-face" contact with children to occur over video, if necessary. In limited cases where technology was not available for this purpose within the 24-hour timeframe, a phone interview would occur. Guidance by DSS leadership to staff stressed the importance of continuing to ensure the alleged victim child(ren) was alone, and felt comfortable speaking with DSS staff. DSS's *CPS Investigations Action Plan for COVID-19,* which was distributed to staff on March 27, 2020, requires staff to ask screening questions prior to arriving at a family home or facility in which a child is placed, and to wear PPE and maintain three to six feet distance during interviews. Ultimately, guidance indicated staff should "respond and work cases as usual," and does not prohibit or excuse in-person contact when protective measures are taken.

Performance data for the current monitoring period reflect improvement in timely initiation of investigations, which includes making face-to-face contact with all alleged victim children within 24 hours of the referral; timely closure of investigations;

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

and appropriateness of decisions to unfound the allegations. There has been a slight decline in the percentage of investigations that include contact with all necessary core witnesses during the investigation, although Co-Monitor staff have observed that documentation reflects this has become a focus of supervision with staff. As previously reported, despite best efforts, progress in this area is likely to be limited until DSS has the resources available to add the significant additional staff positions needed to meet OHAN caseload requirements, and to ensure consistent high-quality practice including assessments of children's safety. In September 2020, OHAN had 16 assigned investigators, and only three (19%) of these investigators had caseloads within the required standard of eight investigations.

Key Developments: OHAN Intake and Investigations
April - September 2020



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

The FSA required that by December 5, 2016, DSS develop an Implementation Plan for the provisions related to OHAN intake and investigations. The Implementation Plan must have *'enforceable interim benchmarks with specific timelines, subject to consent by Plaintiffs and approval by the Co-Monitors, to measure progress in achieving the final targets […]"* (FSA IV.C.1.). On September 11, 2017, the Co-Monitors approved DSS's OHAN Implementation Plan on November 7, 2017.[69]

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

In addition to setting interim benchmarks and timelines, the OHAN Implementation Plan includes strategies developed to improve OHAN practice and achieve the targets required by the FSA. These strategies include improvement in case manager time management; implementation of processes to track and monitor timely initiation of investigations and contact with core witnesses; development of checklists and other forms; development and completion of new training for investigators; coordination between OHAN and licensing staff; and improvements in supervision. All strategies were initially scheduled for implementation beginning in December 2017, and ongoing. DSS has adjusted some strategies, as reflected in the Joint Report.

DSS recognizes that more staff are needed to reduce caseloads, and allow investigators the time needed to complete each assigned investigation in accordance with policy and practice expectations. As of September 30, 2020, OHAN had 16 investigator positions filled, as well as three supervisors. There was one vacant investigator position, which DSS reports had been vacant for one month. To meet caseload requirements, DSS has estimated that 11 new OHAN staff positions are necessary. Funding for these positions was included in DSS's FY2020-2021 budget request, which was was not passed by the General Assembly due to the COVID-19 pandemic, and has again included this request in its FY2021-2022 budget, currently being deliberated in the General Assembly.

Work in 2020 has focused on strengthening supervision with staff, and ensuring consistent identification of and contact with all necessary core witnesses during an investigation. DSS reports that updates to CAPSS to track core witnesses were initially delayed from the December 2017 timeline due to a lack of resources and the volume of work within OHAN. However, the CAPSS updates have been completed, and the new screens were launched in August 2019. DSS describes that reports have been developed and are being refined to capture necessary data. During case record reviews of investigations closed in March and September 2020, Co-Monitor staff frequently noted documentation of discussion and identification of core witnesses during periodic reviews between the OHAN supervisor and investigator (for example, 10-day reviews, 20–30-day reviews). Documentation reflects that supervisors routinely identify new core witnesses as the investigation is ongoing and additional information is obtained.

The frequency of staffings with supervisors has increased to accommodate the distance imposed by the COVID-19 pandemic. DSS reports supervisory staffings are

held twice per week via video, Microsoft Teams, and the OHAN Director conducts a daily staff meeting with supervisors.

A new OHAN investigation training curriculum was developed in early 2019, and OHAN staff completed the training in July 2019. DSS reports that the investigation training has not been completed for new hires since that time. New hires currently receive Child Welfare Certification training, and specialized OHAN tools and supports are discussed. DSS reports it is continuing to explore virtual training opportunities for new hires.

Appendix F of this report includes a list of strategies related to OHAN investigation and intake due this period, as well as related Joint Report and Mediation Agreement commitments.

Performance Data

OHAN Intake

Beginning in November 2019, DSS's Intake Hubs were responsible for screening all referrals alleging abuse and neglect of children, including allegations involving children in foster care placed in foster homes and institutions. Screening decisions are made utilizing a Structured Decision Making® (SDM) intake tool.[70] Before this transition, OHAN staff were responsible for screening all referrals involving Class Members, and less structured instrument and guidance were used. On July 27, 2020, the Intake Hubs began providing 24-hour coverage to receive and screen abuse and neglect referrals during weekdays, and OHAN staff continued to receive and screen referrals on weekends. In October 2020, the Intake Hubs were staffed to provide full weekend coverage, and make all referral screening decisions. Thus, intake performance data for this period reflect a combination of Intake Hub and OHAN staff collaborative work and decision-making.

Child welfare agencies across the country have experienced a decline in receipt of abuse and neglect reports during the COVID-19 pandemic. This is primarily caused by fewer children interacting with mandated reporters (i.e., school staff, medical staff) as schools have moved to virtual learning, and some medical offices have delayed

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

routine care appointments during state or county stay-at-home mandates. In reviewing data for referrals that were appropriate for OHAN – both those that involved Class Members and those that do not – there was a decline in referrals during April and May 2020, however, beginning in June 2020, the number of referrals increased to pre-COVID-19 levels.

Decisions to either accept a referral for investigation or take no further action on the referral ("screen out") are based upon information collected from reporters to determine if the allegations meet the state's statutory definition of abuse or neglect.[71] DSS policy establishes three main screening criteria for investigations of abuse or neglect of children in out-of-home care: (1) the alleged victim child is younger than 18 years of age; (2) there is an allegation of actual harm that has occurred or is occurring to a child, or the caregiver's acts or omissions present a significant risk of harm; and (3) the alleged perpetrator is a person responsible for the child's welfare.[72] 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.).

All applicable referrals of abuse and neglect received and not approved for investigation by DSS's Intake Hub and OHAN unit between April and September 2020 were reviewed by Co-Monitor staff[73] to determine appropriateness of the screening decision.[74,75] Due to the small number of applicable screening decisions each month, the Co-Monitors have adjusted the methodology in reporting performance for this measure. Instead of calculating performance based upon

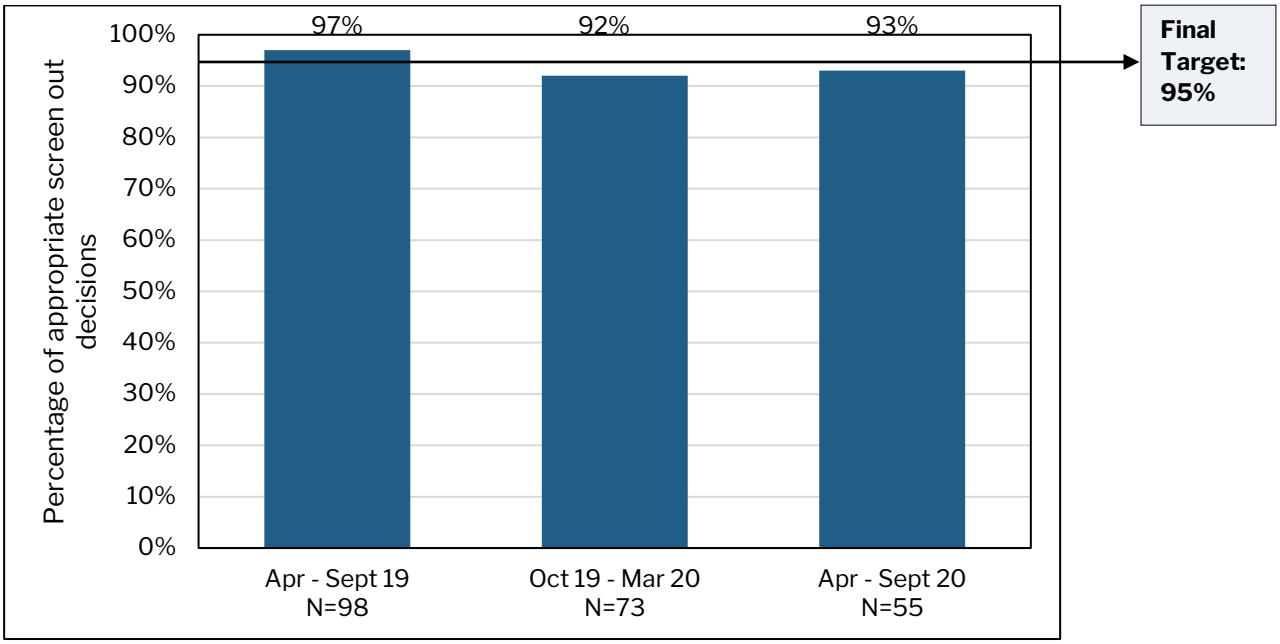
[71] SC Code § 63-7-20.
[72] This includes a foster parent; an employee or caregiver in a public or private residential home, institution, or agency; or an adult who has assumed the role and responsibility of a parent or guardian for the child, but who does not necessarily have legal custody of the child. Child Welfare Policy and Procedures Manual, Chapter 13 (effective 2018).
[73] This review includes examining information entered into CAPSS, and listening to recordings of referrals, when available.
[74] 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 in the congregate care setting or through ICPC from another state, or was the biological or adopted child of the caregiver), or the referral was screened out as a duplicate to a prior report that was under investigation or had previously been investigated.
[75] When assessing performance for this measure, 2 main criteria are considered: (1) the allegation, if true, meets the legal definition of maltreatment; and (2) the Intake Hub or 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.

screening decisions made in each individual month, performance is aggregated to include all screening decisions made during the monitoring period.

Between April and September 2020, a total of 55 referrals alleging abuse or neglect against a child in foster care were received, and a decision was made by DSS staff not to investigate. The Co-Monitors determined that 51 (93%) of these decisions not to investigate were appropriate (see Figure 21).

As reflected in the figure below, performance remains level with the prior period, and DSS is close to meeting the final target of 95 percent.

Figure 21: Appropriateness of Decision Not to Investigate Referral of Institutional Abuse and/or Neglect April 2019 – September 2020



Source: Monthly review data, Co-Monitor staff

In all instances in which the Co-Monitors disagreed with a screening decision, there was insufficient information to make a decision collected and documented by the intake worker. For example, in two intakes for which the Co-Monitors disagreed with the screening decision, the term "verbally abusive" or mental injury were used, but the intake worker did not ask follow-up or clarifying questions to assess how the caregiver's actions were impacting the child, which are necessary to determine if the alleged behavior meets the definitions for these categories of abuse or neglect.

OHAN Investigations

Allegations of abuse or neglect of children in DSS custody – in settings including licensed foster homes, residential facilities, and group homes – screened by DSS's Intake Hub or OHAN unit for investigation are assigned to OHAN staff.[76, 77] 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.[78] 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.[79] All of these activities are critical components of a thorough OHAN investigation that results in accurate assessments and findings.

There are seven FSA measures that relate to investigations – timely initiation (two measures),[80] contact with core witnesses (one measure), investigation determination decisions (one measure), and timely completion (three measures). The most recent performance data detailed below were collected during a case record review conducted by Co-Monitor staff, USC CCFS, and DSS staff in December 2020 which examined 67 investigations involving Class Members that were accepted in September 2020.

Demographics of Alleged Victim Children

Table 2 includes demographic information for the 103 alleged victim children identified in the 67 investigations reviewed. Most investigations (72%) involved one alleged victim child, with nine (13%) investigations including two children, and eight (12%) involving three children.[81] Sixty percent (62) of alleged victim children were

[76] SC Code § 63-7-1210; Child Welfare Policy and Procedures Manual, Chapter 13 (effective 2018); SC DSS Directive Memo, April 26, 2016.
[77] Allegations of abuse or neglect by a foster parent of their biological or adopted child should be investigated by child protective service case managers in local county offices.
[78] Child Welfare Policy and Procedures Manual, Chapter 13 (effective 2018).
[79] Child Welfare Policy and Procedures Manual, Chapter 13 (effective 2018).
[80] 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.
[81] The remaining 2 investigations identified 5 alleged victim children, and 6 alleged victim children, respectively.

between the ages of 10 and 17; and the remaining 40 percent (41) ranged in age from birth to nine years old. All investigations involving children age nine or younger occurred in foster homes. Most investigations involving allegations of abuse or neglect against 14 to 17-year old alleged victims occurred in congregate care settings (82%, or 31 of 38).

Table 2: Demographics of Alleged Victim Children
September 2020
N=103

Number of alleged victim children per investigation	
1 child	72%
2 children	13%
3 children	12%
4 or more children	3%
Age of alleged victim children	
Birth to 2	11%
3 to 4	6%
5 to 9	23%
10 to 13	23%
14 to 17	37%
Placement at time of alleged incident	
Outside home county	81%
Within home county	19%

Source: Case Record Review completed in December 2020 by USC CCFS, DSS, and Co-Monitor staff

Placement Providers

The 67 investigations involved foster homes (60%) more often than group homes or other congregate care facilities (40%). Table 3 reflects the region and county of placement providers who were involved in investigations. Most alleged victim children in the investigations reviewed were placed outside of their home counties, and approximately three-quarters of children were placed outside of their home region. Placement farther from home creates increased logistical challenges in ensuring consistent in-person visits between children and their assigned case manager, as well as with their family members.

Table 3: County and Region of Placement Providers with Investigations, and Percent of Children Placed Within their Home County
September 2020

Region and County	Number of Foster Homes and Facilities with Investigations N=67	Percent of Children Placed Within Home County N=103
Upstate	*13*	*19%*
Greenville	7	0%
Greenwood	2	0%
Laurens	1	0%
Spartanburg	3	66%
Midlands	*19*	*30%*
Aiken	2	0%
Chester	1	0%
Fairfield	3	0%
Kershaw	2	0%
Lancaster	2	0%
Lexington	1	50%
Richland	8	54%
Low Country	*14*	*23%*
Berkeley	2	0%
Charleston	6	56%
Dorchester	3	0%
Orangeburg	3	0%
Pee Dee	*21*	*9%*
Chesterfield	1	0%
Florence	1	0%
Horry	18	10%
Sumter	1	0%

Source: Case Record Review completed in December 2020 by USC CCFS, DSS, and Co-Monitor staff

Three congregate care facilities had multiple investigations accepted in September 2020 (two providers with two investigations, the third provider with 15 investigations), and three foster homes had two investigations. The Co-Monitors assessed that in some instances, there were more than one report received about the same child and caregiver with the same or related allegations, and within a short timeframe. DSS policy requires a separate investigation for each referral, with more documentation requirements for staff, impacting data collection and analysis. Investigations involving the same foster home with related incidents could be linked

and consolidated into one investigation, eliminating the need for duplicative investigation requirements and documentation.

Reporter Type

In approximately half of the investigations reviewed, the identified reporter was DSS staff (51%, or 34 of 67), including the assigned case manager, a supervisor, or an OHAN worker who learned of the alleged abuse or neglect while investigating another matter. This is an increase over the prior period (in March 2020, 37% of reporters for reviewed OHAN investigations were DSS staff), and could reflect the limited interactions other mandated reporters have with children in foster care during the COVID-19 pandemic. Reporters also included school staff (9%) and provider facility staff (6%) who either witnessed alleged abuse or neglect or were informed of an incident that necessitated reporting.

Allegation Type and Finding[82]

Approximately half of the allegations accepted for investigation involving children in foster care in September 2020 included allegations of physical abuse (48%). The most frequent allegation for alleged victim children between the ages of birth and four was physical abuse, and physical neglect. Table 4 reflects the number of allegations by type against alleged victim children by age.

[82] For state statutory definitions of types of abuse and neglect, see SC Code § 63-7-20.

Table 4: Allegation Types against Alleged Victim Children by Age
September 2020

	Age Birth - 2	Age 3 - 4	Age 5 – 9	Age 10 - 13	Age 14 - 17
Physical Abuse	6 (13%)	3 (6%)	13 (27%)	13 (27%)	13 (27%)
Sexual Abuse	1 (13%)	0 (0%)	1 (13%)	3 (38%)	3 (38%)
Mental Injury	2 (8%)	2 (8%)	8 (33%)	7 (29%)	5 (21%)
Physical Neglect	5 (11%)	4 (9%)	12 (26%)	8 (17%)	18 (38%)
Medical Neglect	1 (13%)	0 (0%)	1 (13%)	1 (13%)	5 (63%)
Educational Neglect	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (100%)

Source: Case Record Review completed in December 2020 by USC CCFS, DSS, and Co-Monitor staff

* Investigations can include more than one allegation type

**Totals may not equal 100% due to rounding

The frequency of allegations by placement type are reflected in Table 5. Of the investigations reviewed in September 2020, mental injury was more frequently alleged in foster homes. There were more allegations of both physical abuse and physical neglect in foster homes than in congregate care facilities, but of all the investigations in foster homes, there was an even amount of physical abuse (19) and physical neglect (20) allegations. Similarly, of all investigations in congregate care facilities, there was an even amount of physical abuse (13) and physical neglect (11) allegations.

Table 5: Allegation Types of Victim Children by Placement Type
September 2020

	Foster Home	Congregate Care Facility
Physical Abuse	19	13
Sexual Abuse	3	3
Mental Injury	9	4
Physical Neglect	20	11
Medical Neglect	1	3
Education Neglect	1	0

Source: Case Record Review conducted in December 2020 by USC CCFS, DSS, and Co-Monitor staff

In eight of the 67 investigations, at least one of the allegations was indicated – meaning there was a preponderance of evidence that the victim child (or children) was abused or neglected – and the identified maltreater will be placed on the Child Abuse Registry, unless they successfully appeal and overturn the finding.[83] The eight indicated investigations included 10 allegations – four for physical abuse, two for sexual abuse, two for mental injury, and two for physical neglect.

Half (4) of the indicated investigations involved congregate care facilities, involving five children, and three of these were indications involving the same facility. As this review only assessed investigations in September 2020, the Co-Monitors did not review allegations and investigations from other months involving this facility. However, due to the number of indicated incidents, the Co-Monitors shared with DSS their concerns regarding the care provided to and safety monitoring of children within this facility who are in the state's custody. DSS reports that this facility was reviewed during Safety and Quality Response meetings during the months of September and October 2020, and corrective measures were put in place. Corrective measures cited were increased programming and activities provided to children, and training for staff on use of de-escalation over restraint. In addition to the facility discussed here, at least three other facilities have been identified for concern by DSS's Safety and Quality Response process between September and December 2020.

Finally, although the distribution of race across OHAN investigations roughly reflects the state's foster care population, of the 13 children who were included as victims in those investigations that were indicated, 10 (77%) children were identified as White, two (15%) children as Multiracial, and one (8%) child as Black.[84]

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*

[83] As of January 14, 2021, 4 indications had been appealed by the alleged perpetrator. All had completed an Interim Review by the Deputy Director of Child Welfare, or her designee including the new Director of Safety Management, and all indications had been upheld. Appeal hearings and findings are not yet available, or have not yet occurred as of the writing of this report.

[84] The documented race for alleged victim children within the 67 investigations reviewed were 48% White, 39% Black, 9% Multiracial, 4% unable to determine, and 1% Asian. As of January 2021, data on race of children within the state's foster care population was 55% White, 33% Black, and 5% Multiracial.

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 the Intake Hub and face-to-face contact with the alleged child victim must be within 24 hours.[85] The September 2020 interim benchmark requires that 90 percent of investigations will include face-to-face contact with the alleged victim child(ren) within 24 hours.

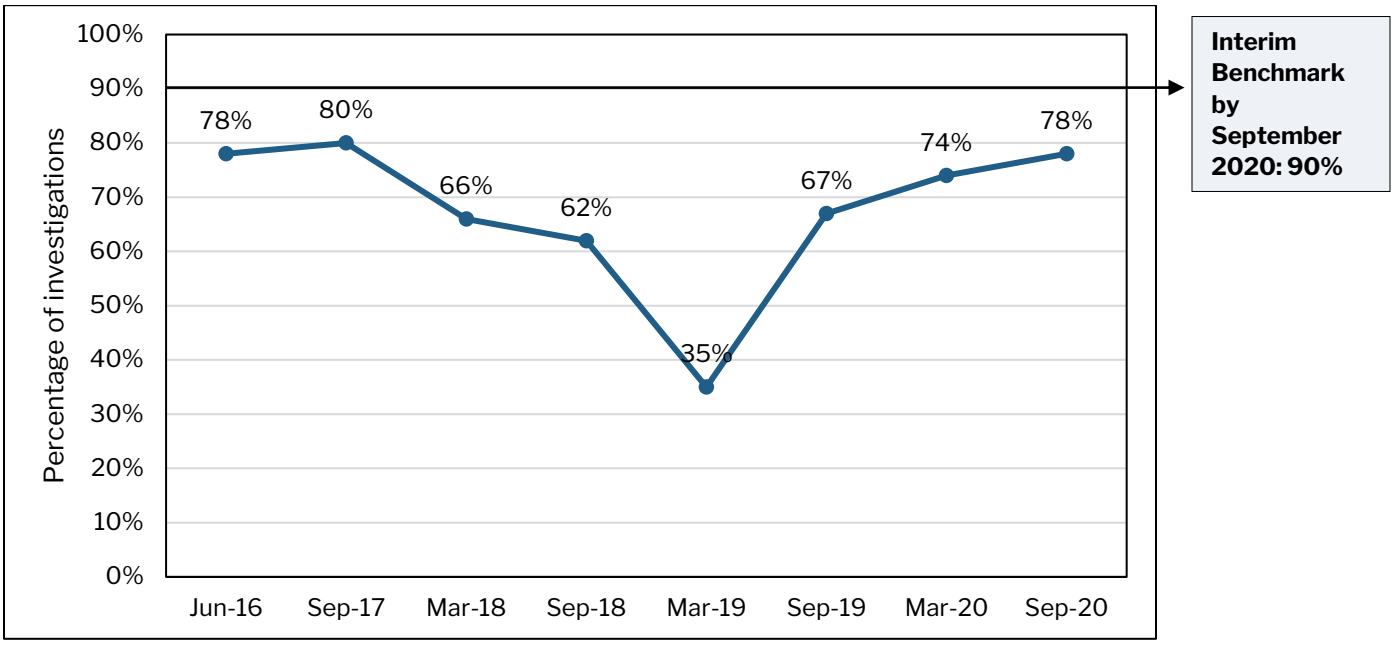
Of the 67 applicable investigations accepted in September 2020, contact – either in-person or video – was made with all alleged victim child(ren) within 24 hours in 52 (78%) investigations.[86] Of the 15 investigations in which DSS did not make contact with all alleged victim children within 24 hours, the investigator made contact with some, but not all, alleged victim children within 24 hours in two investigations. In an additional two investigations, the initial contact with the alleged victim child(ren) was via phone, however, the facility involved in the investigation was allowing visitors during this time, and had technology for electronic video contact which was used in other investigations; thus, it is unclear why contact would have been limited to phone.

Current performance shows continued improvement since September 2019, but it remains below the interim benchmark of 90 percent (see Figure 22).

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

[86] In 11 of these investigations, the initial "face to face" contact was made via electronic video contact.

Figure 22: Timely Initiation of OHAN Investigations
June 2016 – September 2020



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

Data were analyzed by county and region to determine if timely contact was made more frequently in some areas over others. As reflected in Table 6, investigations involving children placed in the Upstate and Low Country were more consistent in ensuring contact within 24 hours of the report.[87]

Table 6: Timely Contact with Alleged Victim Children by Region
September 2020

Region	Contact with all alleged victim children made within 24 hours
Upstate	92%
Midlands	79%
Low Country	93%
Pee Dee	67%

Source: Case Record Review conducted in December 2020 by USC CCFS, DSS, and Co-Monitor staff

The Co-Monitors also reviewed if the time the call was received by the Intake Hub had an impact on timely contact with all alleged victim children. Although fewer of the

[87] In 13 investigations, contact was not made with any alleged victim children within 24 hours; 6 of these investigations involved placements in Horry County.

investigations reviewed were received by the Intake Hub between 5pm and 1am, OHAN staff were more successful in making timely contact (92%) in investigations received during those hours as compared to those investigations that were received between 8am and 5pm (80%).

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)). The September 2020 interim benchmark is 80 percent of investigations include contact with all core witnesses.

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.[88,89]

In reviewing investigative records this period, Co-Monitor staff found documentation reflecting frequent consultations between OHAN investigators and their supervisors to discuss the information collected thus far, and to identify what additional core witnesses should be interviewed prior to case closure. The number of core witnesses interviewed in each investigation, as well as the efforts made by investigators to contact core witnesses who were more difficult to speak with, has greatly improved since prior reviews. Unfortunately, as reflected in the data discussed below, in most investigations reviewed, all necessary core witnesses are not interviewed, and sufficient efforts were not made to attempt to interview those core witnesses who were missed.

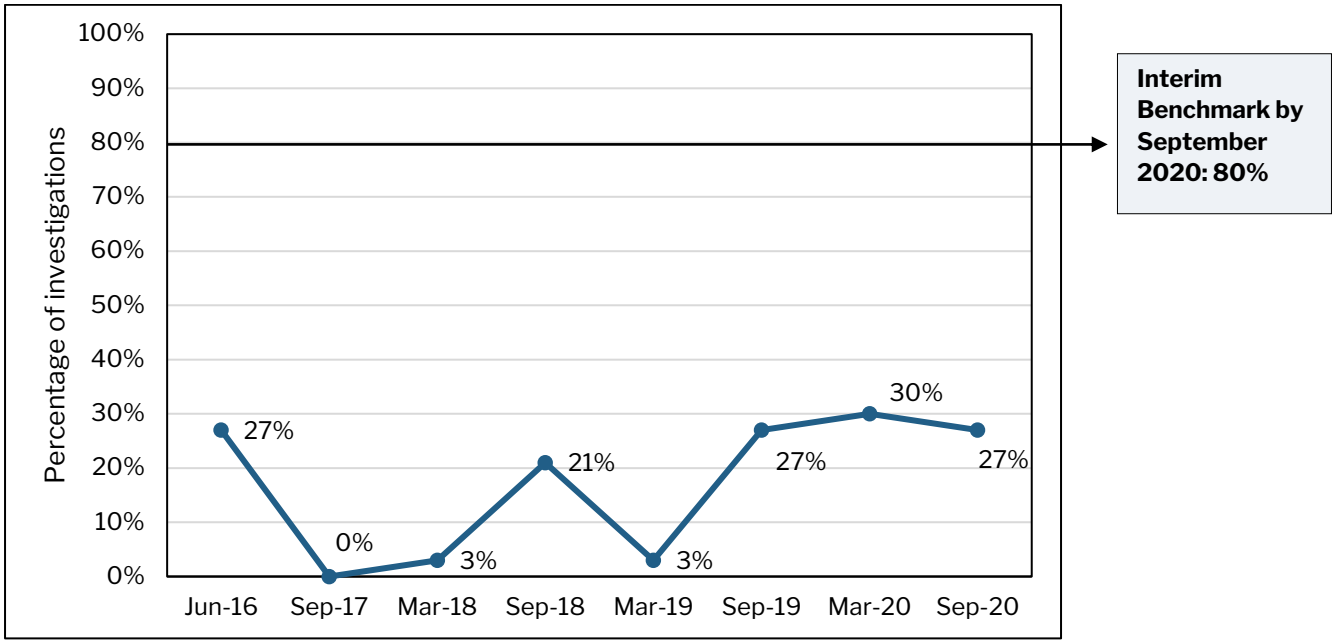
Performance data for this period were collected during the above referenced case record review of investigations involving Class Members accepted in September

[88] 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.

[89] 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.

2020. Eighteen (27%) of the 67 applicable investigations reflected contact with all necessary core contacts during the investigation. Current performance reflects a slight decline since the prior period, and continues to be significantly below the interim benchmark of 80 percent (see Figure 23).

Figure 23: Contact with All Necessary Core Witnesses during OHAN Investigations June 2016 – September 2020



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

Data presented in Table 7 shows the frequency of OHAN investigator contact with each type of core witness in the 67 investigations reviewed.

Table 7: Interviews with Necessary Core Witnesses During OHAN Investigations by Type of Core Witness September 2020 N=67

Core Witness	Number of Applicable Investigations	Contact/Interview with All	Contact/Interview with Some	Contact/Interview with None
Alleged Victim Child(ren)	67	65 (97%)	2 (3%)	-
Reporter	63[90]	50 (79%)	-	13 (21%)
Alleged Perpetrator(s)	62[91]	55 (89%)	6 (10%)	1 (2%)
Law Enforcement	22	13 (59%)	-	9 (41%)
Alleged Victim Child(ren)'s Case Manager(s)	67	53 (79%)	6 (9%)	8 (12%)
Other Adults in Home or Facility[92]	54	30 (56%)	16 (30%)	8 (15%)
Other Children in Home or Facility[93]	55	33 (60%)	11 (20%)	11 (20%)
Additional Core Witnesses	63[94]	23 (37%)	31 (49%)	9 (14%)

Source: Case Record Review completed in December 2020 by USC CCFS, DSS, and Co-Monitor staff
*Totals may not equal 100% due to rounding

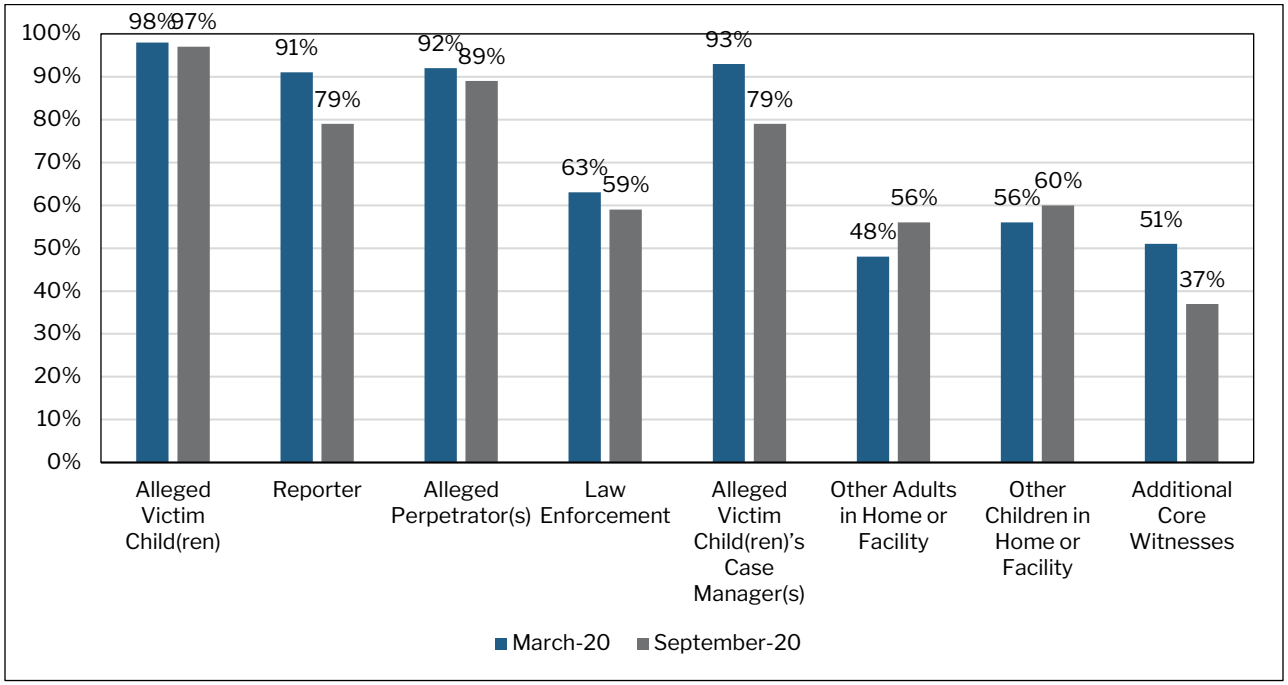
As stated earlier, DSS OHAN practice allowed for video technology to be used to make initial "face to face" contact with alleged victim children within 24 hours. However, DSS guidance to staff conducting child protective services and OHAN investigations was that in-person contact should still occur during the investigation with use of appropriate PPE. In 21 of the investigations reviewed, in- person contact was not made with the alleged victim children during the investigation. There appears

[90] The reporter in 3 investigations was anonymous. In 1 investigation, the investigator was unable to locate or contact the reporter despite attempts.
[91] Exceptions to contact with alleged perpetrator(s) were applicable in 5 investigations, as the alleged perpetrator could not be located or identified despite efforts.
[92] 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.
[93] For children who are placed in foster homes, in addition to speaking with all alleged victim children, the investigator should speak with all non-victim children in the home to inform the investigation, including other children in foster care and biological or adopted children in the home. For investigations involving institutions, as 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.
[94] Additional core witnesses identified by reviewers in 63 investigations included neighbors, family members and friends, medical and mental health providers, school personnel, law enforcement, GALs, current or previous placement providers, foster home licensing workers, other DSS staff, and staff from the Department of Juvenile Justice (DJJ).

to have been a lack of clarity in interpreting guidance to staff, and the Co-Monitors recommend this be clarified for practice moving forward.

Figure 24 reflects primarily declines in contact with select core witness types as compared to performance from the prior review period in March 2020. Frequency of contact with the reporter, alleged child victim's case manager, and additional core witnesses had the steepest downward trend. Slight improvements are noted in contact with other adults and other children in the home or facility.

Figure 24: Contact with Necessary Core Witnesses During OHAN Investigations March 2020 – September 2020



Source: Case Record Review completed in December 2020 by USC CCFS, DSS, and Co-Monitor staff

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.[95]

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*

[95] Child Welfare Policy and Procedures Manual, Chapter 13 (effective 2018).

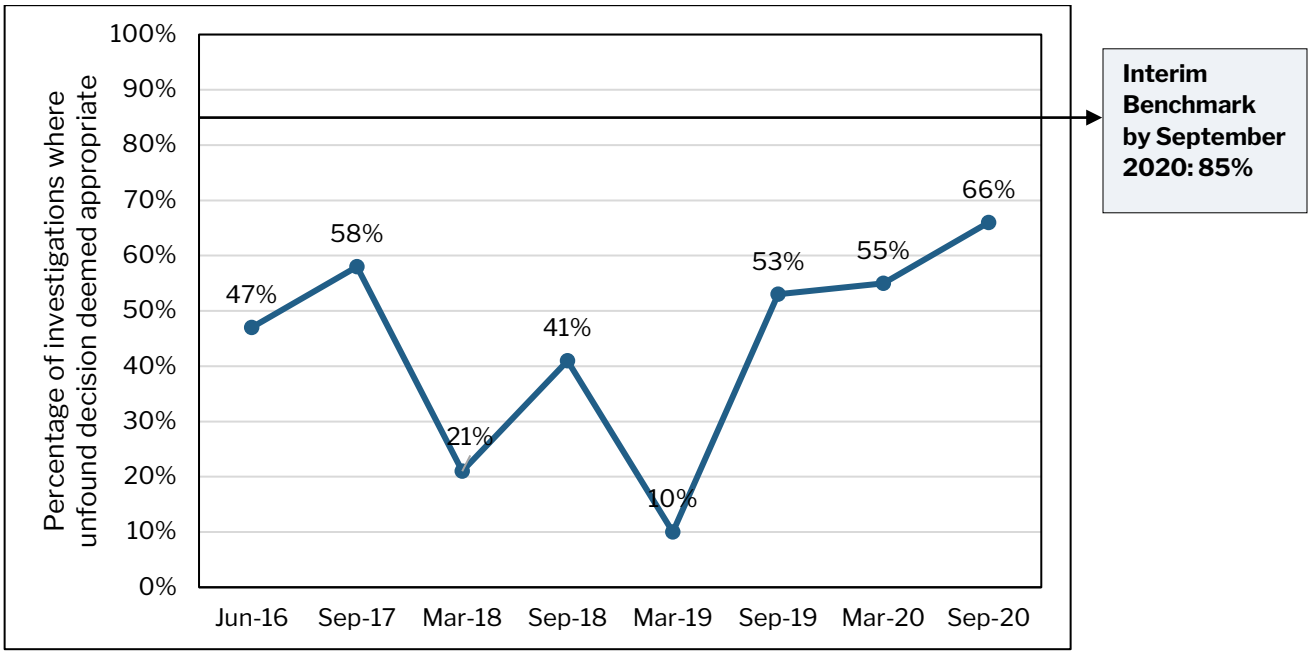
a preponderance of evidence that a Class Member was abused or neglected." The September 2020 interim benchmark is 85 percent of case decisions to unfound determined to be appropriate.

Performance data for this period were collected during the previously referenced case record review of investigations accepted in September 2020. Of the 67 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 39 (66%) of the 59 investigations.[96] In most instances in which a reviewer did not agree with the decision to *unfound*, this was due to the reviewer determining that the investigator did not collect all critical information necessary to make an accurate finding in the case, including, for example, not interviewing a witness with relevant information, not clarifying conflicting information, or not collecting medical/forensic reports. In three investigations in which the reviewer disagreed with the unfounded decision, the reviewer assessed that sufficient information was collected, however, there was some evidence to suggest that the alleged incident – which in each of these cases was inappropriate physical restraint or action by staff against a child within a facility – had in fact occurred.[97]

Current performance has improved since last period, but continues to be below the interim benchmark of 85 percent.

[96] 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.
[97] Co-Monitor staff have shared the specific findings from these investigation reviews with DSS staff.

Figure 25: Decision to Unfound OHAN Investigations Deemed Appropriate June 2016 – September 2020



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

Timely Investigation Completion

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

- *'At least 60% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within forty-five (45) days of initiation of an investigation, unless the DSS Director or DSS Director's designee authorizes an extension of no more than fifteen (15) days upon a showing of good cause. For the purposes of this section, an investigation is not completed if DSS determines the Report is unfounded because the deadline to complete the investigation has passed"* (FSA IV.C.4.(d)). The September 2020 interim benchmark for this measure is 90 percent.
- *'At least 80% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within sixty (60) days of initiation of the investigation, and all investigations not completed within sixty (60) days shall have authorization of the DSS Director or DSS Director's designee of an extension of no more than thirty (30) days upon a showing of good cause. For the purposes of this section, an investigation is not completed if DSS determines the Report is unfounded because the deadline to complete the investigation has passed"* (FSA

IV.C.4.(e)). The September 2020 interim benchmark for this measure is 90 percent.

- *'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 September 2020 interim benchmark for this measure is 95 percent.

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.[98] Good cause means that, through no fault of the investigator, sufficient reason exists for delaying the case decision.[99]

Completed within 45 Days

Of the 67 investigations reviewed, 60 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.[100] All seven investigations that were closed between 46 and 60 days had documentation reflecting the investigator requested an extension beyond 45 days to allow additional time to either receive forensic interview results or collect other critical information; six (86%) of these requests were approved by the OHAN Director. Thus, of the 61 investigations assessed for the 45-day closure measure, 59 (97%) investigations were timely completed within 45 days (see Figure 26). Current performance meets the interim benchmark and final target for this measure.

Completed within 60 Days

Sixty-six (99%) of the 67 investigations were completed within 60 days of opening.[101] Performance meets the interim benchmark and final target for closure within 60 days.

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

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

[100] In this investigation, a supervisory staffing was held on the 30th day of the investigation, and the supervisor instructed the investigator to interview additional contacts, and to obtain medical documents relevant to the allegations. The investigation was closed on the 45th day without these tasks having been completed.

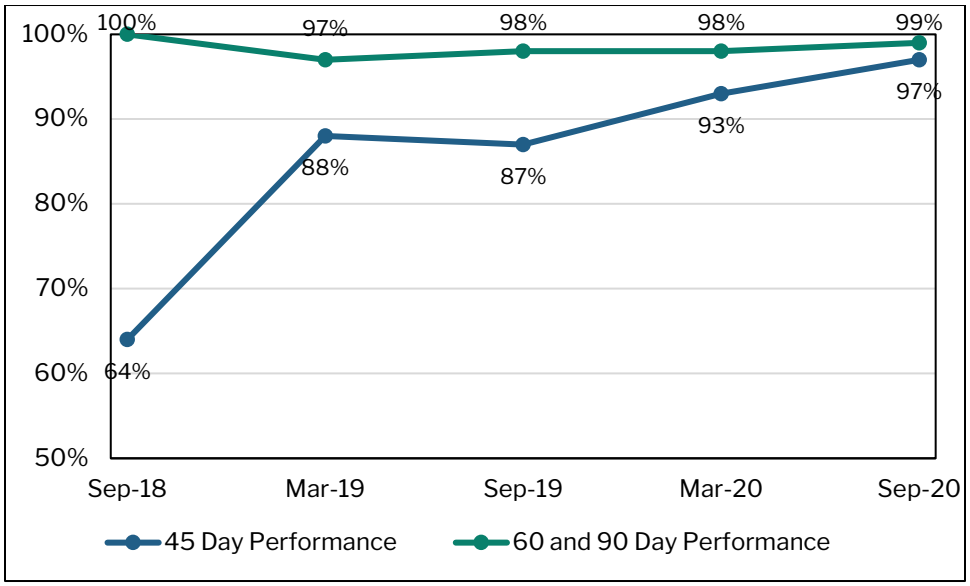
[101] Compliant performance does not include the 1 investigation that was assessed as closed prematurely to meet the required timeframe.

Completed within 90 Days

All investigations were closed within 60 days; therefore, performance toward 90-day closure is also 99 percent, and performance meets the interim benchmark and final target for this measure.

Figure 26 reflects performance for timely closure from September 2018 to September 2020.

Figure 26: Timely Completion of OHAN Investigations
September 2018 - September 2020



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

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

DSS has met the required performance levels for all three measures assessing timely completion of investigations since September 2018. Pursuant to FSA Section V.E., the Co-Monitors have identified these measures as eligible for Maintenance of Efforts status.[102]

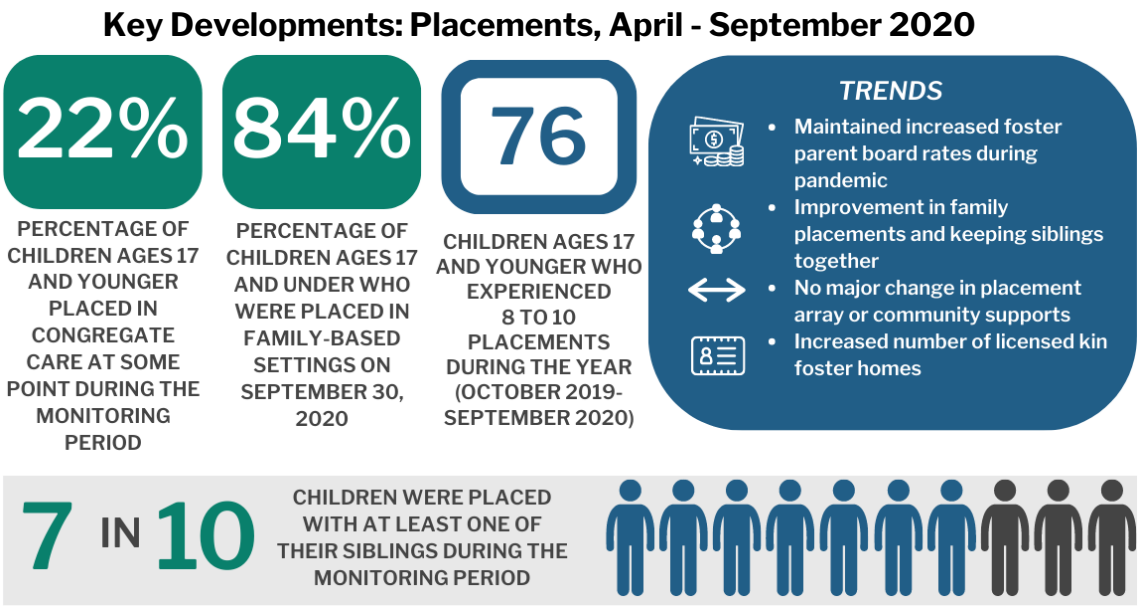
[102] Pursuant to FSA V.E.1-3, the Co-Monitors identify these provisions may be eligible for "Maintenance of Effort" designation by the Court. Defendants have previously achieved compliance with the obligations set forth in FSA IV.C.4.(d), (e), and (f), as reflected in the April 24, 2019, September 16, 2019, February 28, 2020, and October 6, 2020 monitoring reports.

VII. Placements

When children are removed from their homes, it is imperative that they be placed in settings in which they are safe and supported. This means ensuring that children are in family-like environments, with kin and siblings, and in or close to their home communities whenever possible. This policy and practice expectation requires that child welfare systems identify and support kin and family-based caregivers and provide flexible, accessible, individualized interventions to address children's safety, health, and well-being.

The availability of placements and supports for children throughout South Carolina remains a significant challenge for DSS – one that has only been exacerbated by the COVID-19 pandemic. Although DSS has continued to emphasize the importance of reducing congregate placements and increasing reliance on kin caregivers, the shortage of appropriate foster homes and quality services to support children and families in the community has made it difficult to make tangible progress in this area. As DSS acknowledges, placement decisions are often made based on availability, rather than on the unique needs of children and their families, and DSS staff report frequently being met with the reality that they must utilize placements that are far less than ideal. Many children still are moved multiple times during their time in foster care – sometimes through a series of emergency or short-term placements until a more stable setting can be found – and can be placed far from their home communities and schools, and separated from their siblings, family members, and other important people in their lives. This can be very destabilizing for both children and their families who have been separated, at a time when what is needed most is healing, support, and connection.

DSS has endeavored to implement aspects of its Placement Implementation Plan where possible, but a lack of funding and the competing demands of the COVID-19 pandemic have prevented it from moving forward with many strategies that are critical for establishing the foundation for reform. DSS's ability to access resources and recommit to moving forward with the core strategies included in this Plan in the coming months will be essential to improving the experience and outcomes of the children in its care.



Placements: Progress and Implementation Updates

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

On February 20, 2019 DSS obtained Co-Monitor approval of its Placement Implementation Plan, and on February 27, 2019, the Plan was approved by the Court.[103] The Plan incorporates Placement Needs Assessment recommendations and 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, with kin or fictive kin whenever possible. The Plan also includes commitments to restructured case planning and placement processes driven by well-constituted child and family teams engaged in collaborative assessment and decision-making, and to closer strategic partnerships with private providers to develop a placement and service array to meet the needs of children and families. These are tremendous undertakings, which require not only significant resources,

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

but re-orientation of the workforce and extensive engagement with key partners, such as foster parents, family members, and service providers. As contemplated in the Plan, initial implementation requires the use of technical assistance.

DSS has been significantly delayed in implementing its approved Placement Implementation Plan. In many areas, key deadlines have passed without meaningful progress. DSS leadership was focused on advocating for needed funding in the FY2020-2021 budget and was hopeful the Department would be able to proceed with implementation in many areas beginning July 1, 2020. However, the disruption in the budget process caused by the COVID-19 pandemic has made the availability of resources for this work more uncertain, and progress with respect to many Plan strategies elusive.

More than a year ago, DSS leadership shared their desire that some aspects of the Placement Plan be amended to both account for unanticipated delays due to funding inadequacies and to accord with the (then, new) leadership team's reform vision. The Co-Monitors expressed willingness to work with them as they sought to modify the Plan and a completion date for Plan modifications was set at September 30, 2020 in the Mediation Agreement.[104] The Department has not yet submitted proposed Plan modifications to the Co-Monitors, and DSS leadership currently reports that they anticipate submitting an updated proposal by June 2021.[105] The Co-Monitors have continued to emphasize the critical nature of this Plan in addressing so many of the current systemic failures, and the expectation that any acceptable Plan modification must maintain the comprehensiveness and robustness of the approved Plan, and adhere to the FSA directive that it address the issues explored in the Placement Needs Assessment.[106] These include "the capacity to place Class Members close to their home community, placing Class Members in the least restrictive, most family-like placement, the number and array of therapeutic foster care placements, a system of tracking availability of beds in family foster homes, and matching of Class Members to placements that can meet their needs" (FSA IV.D.1).

[104] COVID-19 Pandemic Response Mediation Agreement (July 17, 2020, Dkt. 201)
[105] DSS Letter to Court (February 1, 2021, Dkt. 207, p.15).
[106] To see the Placement Needs Assessment, go to: https://dss.sc.gov/media/1986/appendix-usc-placement-needs-analysis-baseline-study.pdf. After reviewing these initial findings on August 31, 2017, the Co-Monitors shared additional recommendations based on assessment findings and requested additional work be completed on placement projections. Given the delays in completing the Placement Needs Assessment, the decision was made to incorporate these data and recommendations directly into the Placement Implementation Plan instead of producing a final version of the Placement Needs Assessment.

Until a Plan modification is completed, approved, and entered by the Court, the Co-Monitors have continued to monitor progress with respect to the approved Placement Implementation Plan. Included below is a summary of progress in key areas in which DSS attempted to move forward during this period. DSS leadership has expressed its continued commitment to these strategies, both as core elements of the Placement Plan, and as fundamental elements of their vision for the Department.

Child and Family Teaming

DSS has continued its work to establish an internal structure to support the CFT model statewide. After years of delivering "family engagement programming" through a contracted provider, DSS leadership has worked to develop internal capacity to engage families and community partners. As of January 2020, a newly designated Family Engagement Program Manager oversees 38 regional staff responsible for facilitating and supporting CFT meetings.[107] Four of these staff serve as family engagement "coaches," to train facilitators and ensure that team meetings are being held in a manner consistent with DSS's goals, values, and intended processes and timelines for CFTs in the life of a case.

Though the Placement Implementation Plan included initial CFT model rollout in two to three pilot counties to allow for robust training and coaching of facilitators of the meetings, as well as testing and refining of approaches, DSS moved forward, beginning in June 2020, with its plan to introduce the CFT model in the 10 counties that were selected for its federal Program Improvement Plan (PIP), with the goal of roll-out statewide by February 2021.[108,109] As of January 2021, the CFT model had been introduced in all of the state's 46 counties. Ninety-six facilitators had completed their three-day training and are receiving coaching support, and 913 child welfare staff received a one-day overview of the CFT model statewide.

The shift from conceptualizing family engagement as an ancillary, outsourced service to understanding that the range of skills and knowledge needed for effective engagement are central to DSS's mission, is foundational to all other aspects of DSS's

[107] As of March 2021, DSS had completed hiring and onboarding for all 4 family engagement coach positions, all 4 supervisor positions, all 6 administrative assistant positions, and 23 of 24 facilitator positions (DSS reports being in the final stage of candidate selection for the remaining position).

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

[109] 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. Initial implementation in these counties was phased: rollout in Greenville and Horry began on June 1, 2020, rollout in Pickens, York, Chesterfield, Berkeley, and Jasper on July 1, 2020, and rollout in the remaining 3 counties following on August 10, 2020.

placement work. If integrated and understood at all levels of the Department, it will set the context in which the CFT model can be fully implemented, allowing for assessment, planning, and decision-making through collaborative teams.

As previously reported, DSS will need significant ongoing support and resources to carry out this new vision, including the type of intensive, on-site coaching described and incorporated in the Placement Implementation Plan. The success of this model will ultimately depend not only on the capacity of a team of dedicated family engagement staff, but also on the ability of *all* DSS case managers to facilitate CFTs and practice in a way that is consistent with these values. Case managers are the primary means of connection with families and drive case plan development and implementation. Without the ability of staff to genuinely engage with, consistently assess, and work in a collaborative way to support the dynamic needs of families, meaningful and sustainable improvements in practice will not be possible.

The COVID-19 pandemic has meant that DSS has had to adapt its initial approach in some important ways, providing training and coaching virtually. As in other areas, this is a challenge that creates an even greater need for DSS to be look for ways to build the skills and competencies of its workforce, and to develop a quality assurance process that assesses fidelity to the model.

Safety and Quality Response

DSS reports that it has continued its work to improve collaboration and communication between OHAN, Contract Monitoring, and Licensing in response to concerns about safety raised more than two years ago in a review of congregate care facilities throughout the state.[110]

With the initial support of a technical assistance provider, DSS reported developing a formal process referred to as the Safety and Quality Response Review Protocol in accordance with the Placement Implementation Plan, beginning in 2019. This process is currently being utilized to review family foster or group care providers who receive multiple abuse and/or neglect referrals within a specified timeframe. Since July 17, 2020, the process has been overseen by DSS's new Safety and Quality Response Coordinator. DSS is hopeful that this new position will serve as a single point of contact to coordinate data, analyze trends and areas needing improvement

[110] 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*.

amongst providers, and act as a liaison for providers and staff in regard to reporting critical incidents.

Though delays in hiring the Safety and Quality Response Coordinator and the demands of the COVID-19 pandemic extended the timeframe for formally initiating the Safety and Quality Response Protocol statewide, bi-weekly meetings have been held since September 2020. As of December 2020, four congregate care facilities and four foster homes had been flagged for review. Corrective action plans were issued against three of these facilities to address a broad range of concerns, including: staff's inability to de-escalate incidents among residents; excessive use of seclusion and restraint; deficiencies in maintenance of buildings; and inadequate provision of food.

Though the Safety and Quality Response Protocol is now operational, processes related to the authority and reach of the body to address imminent safety issues are still being developed. The nature of the concerns that have arisen – historically and in recent months – about practices in some congregate facilities and the impact on child safety and well-being makes it critical that these questions be resolved immediately. Though ultimately the development and maintenance of a quality placement array will be most dependent on the implementation of a comprehensive Placement Implementation Plan (something that DSS must approach with urgency), it is essential that there also be a robust process for overseeing conditions in placements and quickly responding when concerns arise.

Kin Placement

South Carolina's policies and practices have historically been inconsistent with national policy guidance and best practices which have recognized the importance of identifying, engaging, and supporting kin as caregivers. During this monitoring period, DSS continued its work to prioritize the placement of children with kin. DSS policy, updated in July 2020, now requires case managers to make "concerted efforts" to identify and place children with kinship caregivers "throughout the life of a case," and case managers need to obtain supervisory approval to place a child with an unrelated caregiver when placement with kin is not possible.[111] DSS has taken some foundational steps to provide kin with the information and assistance needed to become licensed caregivers, and reports that it is building an understanding among staff, community partners, and court officials of its new approach to kinship foster care. A DSS Kinship Advisory Panel, which includes five kin caregivers, a DSS kinship

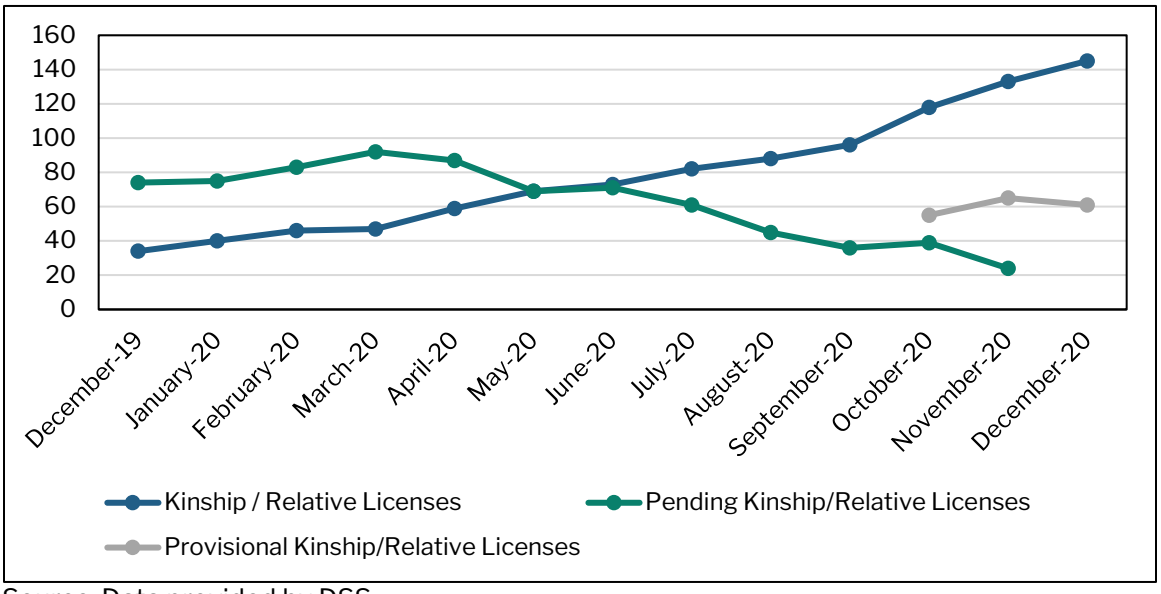
[111] Child Welfare Policies and Procedures Manual, Chapter 5, Section 510.2.1 (effective October 2020)

care manager, six DSS kinship coordinators, and two representatives from community-based advocacy groups, has continued to convene monthly to address and discuss issues of relevance to the kin care community.

DSS has been working to increase the number of kin caregivers applying to be licensed foster placements, and the number of licensed kin homes has increased from 34 to 145 in the past year. As of September 30, 2020, four percent (173 of 4,052) of children were placed with licensed kin caregivers. Though there is a long way to go – DSS hopes to be one of the many systems that now place many or even most children in foster care with kin – these are important beginning steps.

The engagement of private Child Placing Agencies (CPAs) as partners in the licensing process since last summer has been helpful in freeing up limited internal DSS licensing staff to focus exclusively on the licensing of kin homes. Since July 2020, all potential non-kin foster home resources have been referred to CPAs for licensing. As of December 31, 2020, there were 145 licensed kinship homes and 61 provisional kinship home licenses issued.[112] As shown in Figure 27, this is an improvement from this summer, in June 2020, when there were only 73 licensed kin homes and 48 provisional licenses.

Figure 27: Kinship Licensing Trends (December 2019 – December 2020)



Source: Data provided by DSS

[112] As per DSS's Joint Report commitments, a permanent regulation to support provisional licensure of kin was published on May 13, 2020.

Ultimately, DSS's ability to vastly increase performance in this area will depend upon the availability of resources to quickly process applications. Even with DSS's policy amendments that allow for waiver of some licensing requirements that do not relate to safety, the assistance of CPAs with non-kin licensing, and the addition of eight licensing staff in December 2019 to assist with processing kin licensure applications, a shortage of DSS licensing staff has limited the Department's ability to enhance the number of provisionally or fully licensed kinship homes to the degree it would like.[113] More resources will be needed to support a transition to a significant reliance on kin caregivers.

DSS reports that with a small grant awarded by a national child welfare organization and the help of a Charleston-based advocacy group, it continued to roll-out kin support services in limited areas of the state. This includes the hiring of a Kinship Navigator Grant Coordinator in June 2020, and the convening of regional support groups. In the course of the grant cycle that ended on September 30, 2020, DSS was able to provide $124,000 in concrete supports such as food, clothing, childcare, and items needed for licensing to 175 kin families. Peer support groups, held virtually, allowed for participation by families located across the state. The Department's Regional Kinship Care Coordinators worked to connect kin families to available community resources, assist with benefit applications, and provide guidance to families on the licensure process to the extent possible. Though these efforts are short of the full-scale Kinship Navigator program DSS envisions, they also represent important steps towards the Department's goal of increasing and sustaining placement of children with kin.[114]

Foster Parent Board Rates

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. In May 2019, the General Assembly approved a proviso allowing for an incremental rate increase, and DSS began paying this rate to all kin and non-kin foster parents licensed directly through DSS or through private CPAs. DSS requested funding for an additional increase in the FY2020-2021 budget to adjust rates further to more fully account for the costs of caring for a child, and to

[113] Provisional Licensure enables kin to host the child in their home before the full foster parent licensure process has been completed. This enables a child to be placed in the home of their relative or person with whom they are familiar, as quickly as possible, while full licensure is pursued.

[114] DSS received a new round of funding in October 2020 from the federal Administration for Children and Families and hopes to receive funding to expand its kinship navigator work to all regions in the state in FY2021-2022.

make foster care board rates more comparable to those paid in many other southern states.

Although budgetary decisions have been delayed due to the COVID-19 pandemic, DSS has been able to utilize additional funding available as a result of temporary adjustments to federal Medicaid match rates under the Families First Coronavirus Response Act (FFCRA) [115] to move ahead with the rate adjustment on a temporary basis.[116] As of August 16, 2020, DSS has provided an enhanced "COVID" rate to all licensed or provisionally licensed kin, and non-kin, and has committed to continue funding this increase, up to the USDA level[117], through at least September 2021. DSS plans to make the enhanced rates permanent if the General Assembly approves the agency's budget request, and will continue to assess the adequacy of the rates annually. DSS also anticipates that as it moves children out of congregate care placements (which are costly to the state) and into family-based settings, savings may be realized that can be repurposed for increases in payments to family-based providers and necessary community supports.

Congregate Care Reduction

Any sustainable and successful congregate care reduction strategy will ultimately depend upon the accessibility of high-quality formal and informal supports to prevent the separation of families, and support reunification. Additionally, for those children in foster care, DSS's ability to implement its CFT model with fidelity is key. DSS also acknowledges that congregate care placements present a particularly heightened risk of harm to children and staff during the COVID-19 pandemic. DSS has moved ahead with the comprehensive case-by-case review process to which it committed to in the Mediation Agreement in July 2020. Between October and December 2020, regionally based teams composed of Performance Coaches, Well-Being Managers, case managers, and supervisors – with the support of a national organization with child welfare expertise – reviewed the cases of 26 children in congregate care. The initial focus has been on children in Level 1 and 2 group care, before continuing with reviews of cases of children with more significant therapeutic needs.

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[115] The Families First Coronavirus Response Act (FFCRA), passed by Congress on March 18, 2020, includes a temporary increase to states' Federal Medicaid Assistance Percentage (FMAP) – the federal share for Medicaid health care and health related services. The FFCRA has enabled South Carolina to receive an increase of 6.2% to its FMAP rate, currently set at 70%. (Families First Coronavirus Response Act, Publ. L. No. 116-127, H.R.6201. (2020)).

[116] H.R.748 Coronavirus Aid, Relief, and Economic Security Act of 2020, Public Law 116-136

[117] The USDA calculates the cost of raising a child in an annual report called *Expenditures on Children and Families*, and foster care reimbursement rates in many states are designed to reflect the estimate of costs based on age group. The USDA estimate, based on data from the Consumer Expenditure Survey, considers region of the country, type of community, family configuration, and family income.

As the Co-Monitors have discussed with DSS, the success of this strategy will ultimately depend upon the expansion of the type of community-based supports necessary for children to remain in their own homes or reside in family-based settings while in foster care. Also important, will be DSS's efforts to make congregate care providers partners in planning for the smooth transition of children to family-based settings, including with parents, kin, or foster homes with non-relatives. As discussed, children are still being moved frequently through placements, and transitions out of congregate care do not necessarily result in long-term family-based placements. This is particularly true if the individualized supports needed to stabilize the child in the new setting are not available at the time or intensity required. Without accountability mechanisms to assess practice as children are moved out of congregate care facilities, it is difficult measure progress toward the goals of the Placement Implementation Plan or alignment with the GPS Case Practice Model.

Appendix G of this report includes a list of all strategies related to placement due this period, as well as related Joint Report and Mediation Agreement commitments.

Performance Data

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.). The interim target is that by September 2020, at least 84 percent of children must be placed outside of congregate care on the last day of the monitoring period.

DSS has been evaluating the needs of children placed in congregate care during the pandemic to assess whether their needs can be met in more family-like settings that carry a lower risk of exposure to the COVID-19 virus. This process, combined with a focus on kin placement and the overall reduction in the number of children in foster care, has led to improved performance in this area. As of September 30, 2020, 84 percent (3,398 of 4,052) of Class Members were placed outside of a congregate care placement (see Table 8). Sixteen children resided in other institutional settings

outside of DSS's control due to acute medical need or incarceration.[118] As shown in Figure 28, this performance meets the September 2020 interim benchmark, and is improved from the prior monitoring period in which 82 percent of Class Members were placed outside of congregate care on the last day of the monitoring period.

Table 8: Types of Placements for Children
September 30, 2020

Children in Foster Care	
4,052 (100%)[119]	
Type of Placement	**Number (%) of Children**
Family-Based Setting	3,398 (84%)
Congregate Care	654 (16%)

Source: CAPSS data provided by DSS

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.). The interim benchmark is that by September 2020, 97 percent of children ages 12 and under must be placed outside of congregate care on the last day of the monitoring period.

As reflected in Table 9, as of September 30, 2020, 2,656 of 2,758 Class Members ages 12 and under resided outside of a congregate care placement, and 18 children ages six and under resided in congregate care pursuant to a valid exception, resulting in performance of 97 percent.

[118] Specifically, DSS reports that 10 children were incarcerated in correctional or juvenile detention facilities, and 6 children were hospitalized.
[119] This does not include 16 children who resided in other institutional settings on the last day of the monitoring period.

Table 9: Types of Placements for Children Ages 12 and Under
September 30, 2020

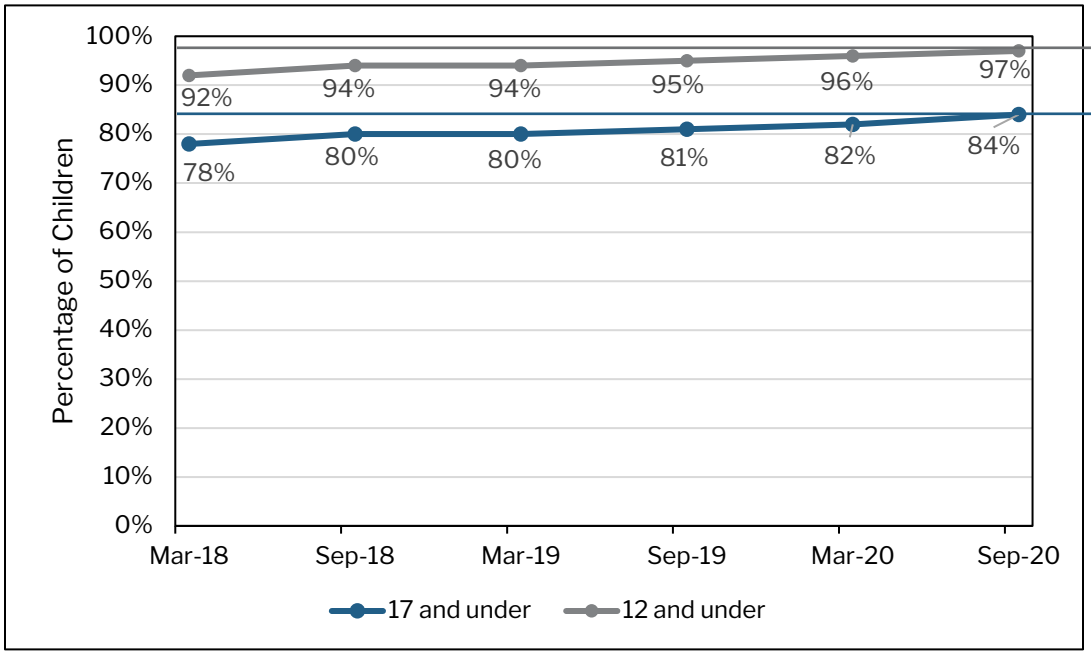
All Children in Foster Care Ages 12 and Under	
2,758 (100%)	
Type of Placement	**Amount of Children**
Family-Based Setting	2,669 (97%)[120]
Congregate Care	89 (3%)[121]
Breakdown of Type of Congregate Care	
Group Home	76 (3%)
Residential Treatment Facility	13 (<1%)

Source: CAPSS data provided by DSS

As shown in Figure 28, performance in this area improved from 95 percent in September 2019, and meets the September 2020 interim benchmark, and is close to the final target of 98 percent.[122]

[120] This includes 16 children ages 6 and under who resided in congregate care placements on the last day of the monitoring period pursuant to a valid exception.
[121] This does not include 3 children who were hospitalized on the last day of the monitoring period.
[122] The Co-Monitors have approved, but not applied, exceptions for placing children ages 7 to 12 in a congregate care facility. DSS has not yet developed the capacity to track the use of these exceptions on a regular basis, so actual performance may be higher than reported. DSS will develop a process for review and approval of applicable exceptions in future monitoring periods.

Figure 28: Trends in Placement of Children Outside of Congregate Care March 2018 – September 2020



Source: CAPSS data provided by DSS

These data reflect the percentage of children in each type of placement on the last day of the monitoring period. Data show that five percent (177 of 3,620) of Class Members ages 12 and under were placed in congregate care at some point between April and September 2020.[123] For children between the ages of seven and 12, 10 percent (145 of 1,333) were placed in congregate care settings at some point between April and September 2020.[124] This represents improvement from the prior monitoring period, when 12 percent of Class Members between the ages of seven and 12 were placed in congregate care at some point. As of September 30, 2020, 93 percent (1,049 of 1,133) of children between the ages of seven and 12 were placed outside of congregate care. This reflects an improvement since March 2020, when 91 percent of children ages seven to 12 were placed outside of congregate care on the last day of the period.

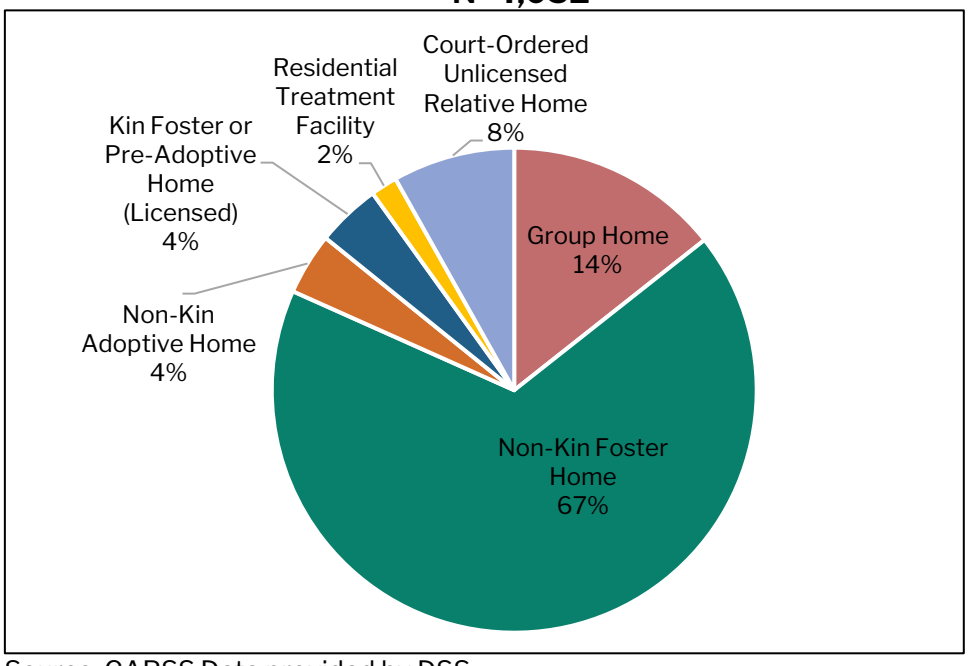
The vast majority (89%, or 582 of 654) of children placed in congregate care (which includes group homes, residential treatment facilities, or emergency shelters), reside in group homes. These facilities are categorized and funded based on the level of support they are expected to provide to a child (either Level 1, 2, or 3). As has been

[123] 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.
[124] Ibid.

previously reported, the facilities vary a great deal in terms of available supports, programming, and level of restriction, though none offer formal clinical services onsite. In 2018, the consultants engaged by the Co-Monitors reported that many facilities, particularly at higher levels of care, 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."[125] Reports from stakeholders and reviewed by the Co-Monitors and information collected from the OHAN investigation review suggest little has changed in the years since the lawsuit began.

Figure 29 depicts the breakdown of placements for all children in foster care, both family-based and congregate care, on the last day of the monitoring period. The majority of children (67%, or 2,728 of 4,052) were placed in non-kin foster homes; 72 children (2%) were placed in residential treatment facilities; 173 children (4%) resided in licensed relative foster homes.

Figure 29: Percentage of Children in Family-Based and Congregate Care Placements on September 30, 2020
N=4,052



Source: CAPSS Data provided by DSS

[125] 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.*

The data in Figure 29 do not capture children's experiences over the entirety of their time in foster care, and do not include children who resided in other institutional settings, such as psychiatric or medical hospitals, DJJ placements, or correctional facilities. Available data on children who experienced congregate care at *any* time during the monitoring period show a significantly greater incidence of congregate care placement, particularly amongst older youth. Data show that 22 percent (1,171 of 5,360) of all children in foster care during this monitoring period were placed in a congregate care setting *at some point* between April and September 2020.

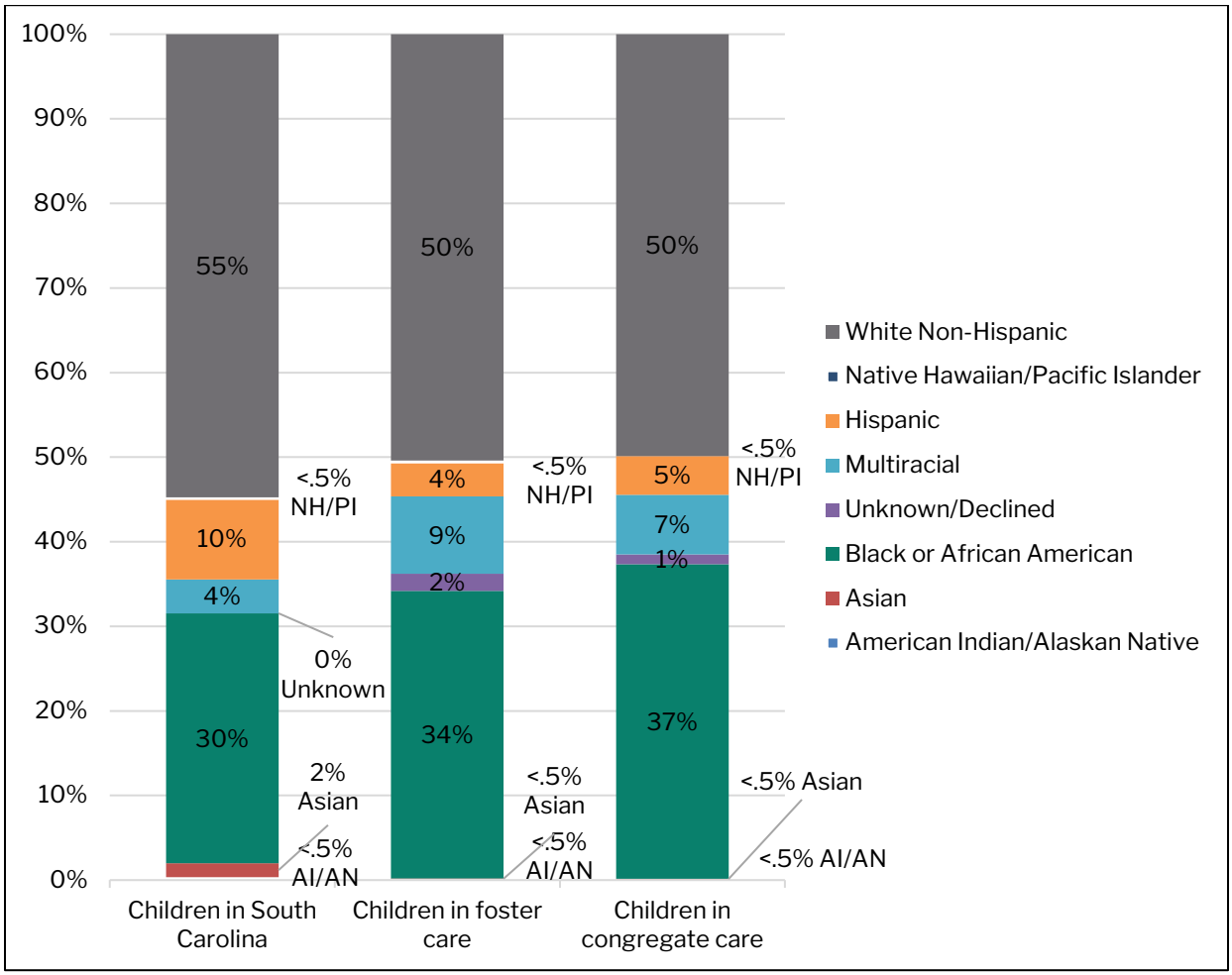
Children Ages 13 to 17

Children ages 13 to 17 are more likely than younger children to spend time in congregate care. On September 30, 2020, 549 (42%) of 1,294 children ages 13 to 17 resided in congregate care. This is a reduction and improvement from March 31, 2020 when 49 percent of children in this age group resided in congregate care. The majority of adolescents – 57 percent (994 of 1,740) of children ages 13 to 17 in care at any time between April and September 2020 – were placed in a congregate care setting at some point during that time. This is an improvement from prior monitoring periods – for instance, 64 percent of youth in this age group resided in congregate care at some point between April and September 2019. The high rate of placement instability described below suggests that more work is needed to ensure that children moved out of congregate care and their families are provided with the supports and services they need so that they may achieve the stability of positive, ongoing relationships, as well as stability in the place they live.

The placement of children in institutional settings – especially children whose needs can be met in family settings with appropriate supports – is a particularly concerning practice when representation by the child's identified race is considered.

Figure 30 reflects placements over the course of the monitoring period broken down by children's race. As depicted, Black or African American children represent a greater percentage of the congregate care population (37%) than of the total child population (30%) and the population of children in foster care (34%) in the state. This breakdown reflects approximately the same disparity and disproportionality as that reported in the last monitoring period.

Figure 30: Racial Disproportionality and Disparity in Foster Care and Congregate Care Placement, April - September 2020



Source: Kids Count Data Center, 2019, and CAPSS data provided by DSS[126]

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."*

[126] DSS collects data on Hispanic children as an ethnicity rather than a racial group, meaning that children of multiple racial groups may also identify as Hispanic. In this breakdown, Co-Monitor staff made adjustments so that those who identified as Hispanic and Black or Hispanic and Native are included in the 'Multiracial' category. Additionally, 222 cases that had unknown Hispanic ethnicity were not counted in the Hispanic category.

On March 15, 2016, the Co-Monitors approved DSS's plan, including acceptable exceptions (due to medical necessity, placement with parents, or placement with siblings),[127] and DSS issued a directive outlining the procedure to be used by staff to reduce the placement of young children in congregate care, and ensure the appropriate placement of children ages six and under in family placements (IO II.3.(a) & FSA IV.D.2.). The procedure currently requires approval of a Regional Director prior to the placement of any child in a non-family-based setting.

Most children ages six and under who resided in congregate care placements during the monitoring period were placed pursuant to an agreed upon exception. Of the 34 young children who resided at a congregate facility at some point during the period, 12 resided in a treatment facility or group care with their mothers and 22 were part of a large sibling group for whom DSS reported a single, family-based placement could not be located. Six children were part of sibling groups who remained at group homes beyond 90 days without documented efforts to move the sibling group to a family-based placement, and therefore did not meet an exception. While the Co-Monitors do not wish for sibling groups to be separated in order to meet the terms of this measure, it is essential that efforts be made to secure less restrictive placements that can accommodate siblings.

Placement Instability

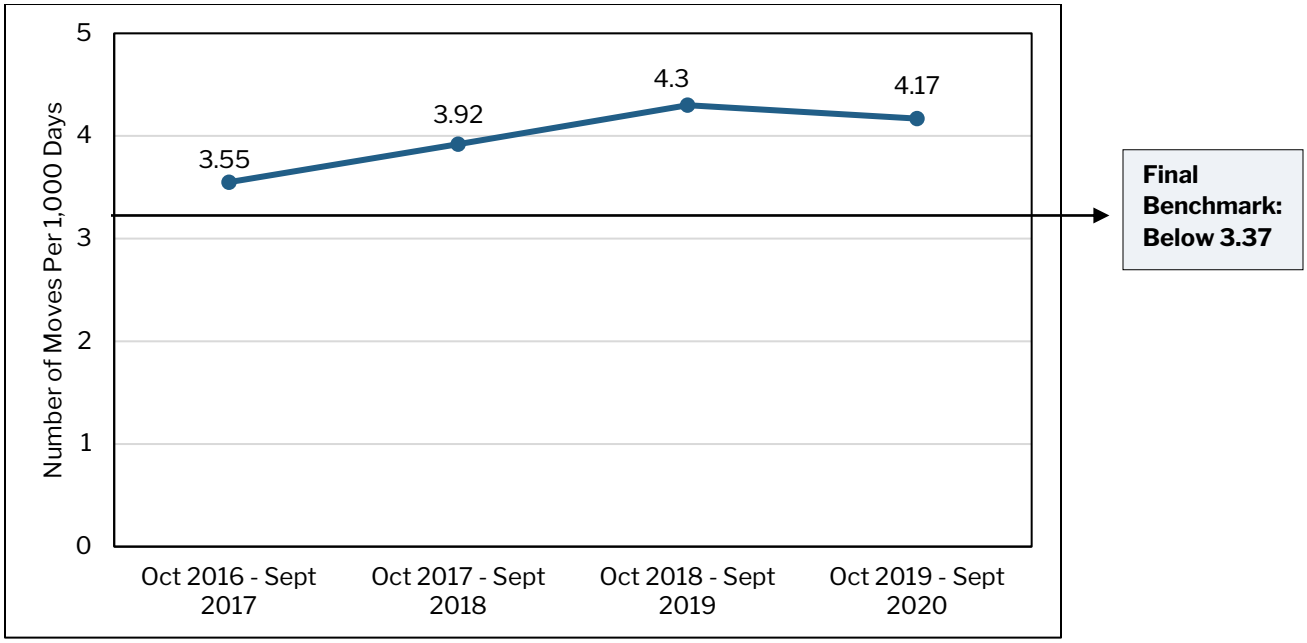
The FSA requires that for *all Class Members in foster care for eight days or more during the 12-month period, the placement instability rate shall be less than or equal to 3.37* (FSA IV.F.1.). Placement instability is defined as the rate of placement moves per 1,000 days of foster care among Class Members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

DSS reports that for the period of October 1, 2019 to September 30, 2020, Class Members experienced placement changes at a rate of 4.17, meaning there were 4.17 moves per 1,000 days in care, across all children in foster care, as shown in Figure

[127] The following are exceptions, approved by the Co-Monitors, to the requirement that children ages 6 and under be placed outside of congregate care: the child requires a degree of clinical and/or medical support that can only be provided in a group care setting and cannot be provided in a family-like setting, and the placement is a facility that has the capacity and specialized treatment to meet those needs; the child is the son or daughter of another child placed in a group care setting; or the child coming into care is in a large sibling group and all efforts to secure foster home and Therapeutic Foster home placements have been completed and have not produced a home. In that 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.

31.[128] There were 3,162 unique children who moved during this time period.[129] This performance does not meet the FSA standard of less than or equal to 3.37.

Figure 31: Rate of Placement Moves
October 2016 - September 2020[130]

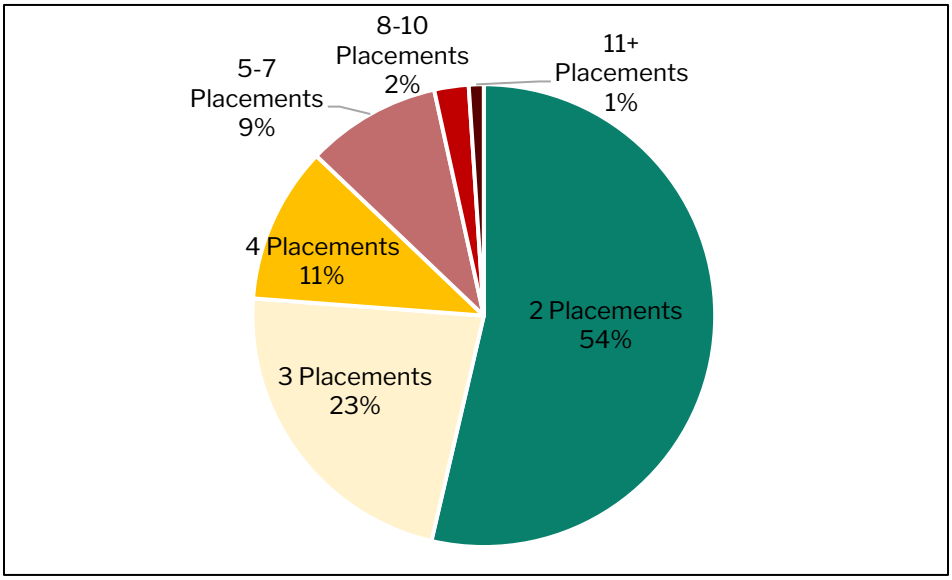


Source: DSS data

Of the 3,162 children who experienced at least one placement move during the year, 1,466 children (46%) experienced two or more placement *moves*, indicating three or more total *placements*, within 12 months. This means that 54 percent of children who changed placements during the year experienced two placements, represented in green in Figure 32. As shown in the three red segments of the figure below, 13 percent of all children who moved at least once experienced five or more placements during this 12-month period.[131] Seventy-six (2%) children experienced eight to 10 placements, and 33 (1%) children experienced at least 11 placements. Four children were subject to 20 or more (up to 25) placements in the 12-month period.

[128] Specifically, there were a total of 6,566 moves across 1,572,980 child-days.
[129] 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.
[130] The final target requires the placement instability rate to be less than or equal to 3.37.
[131] The universe of children to which this analysis applies is all those who experienced at least one placement move during the year.

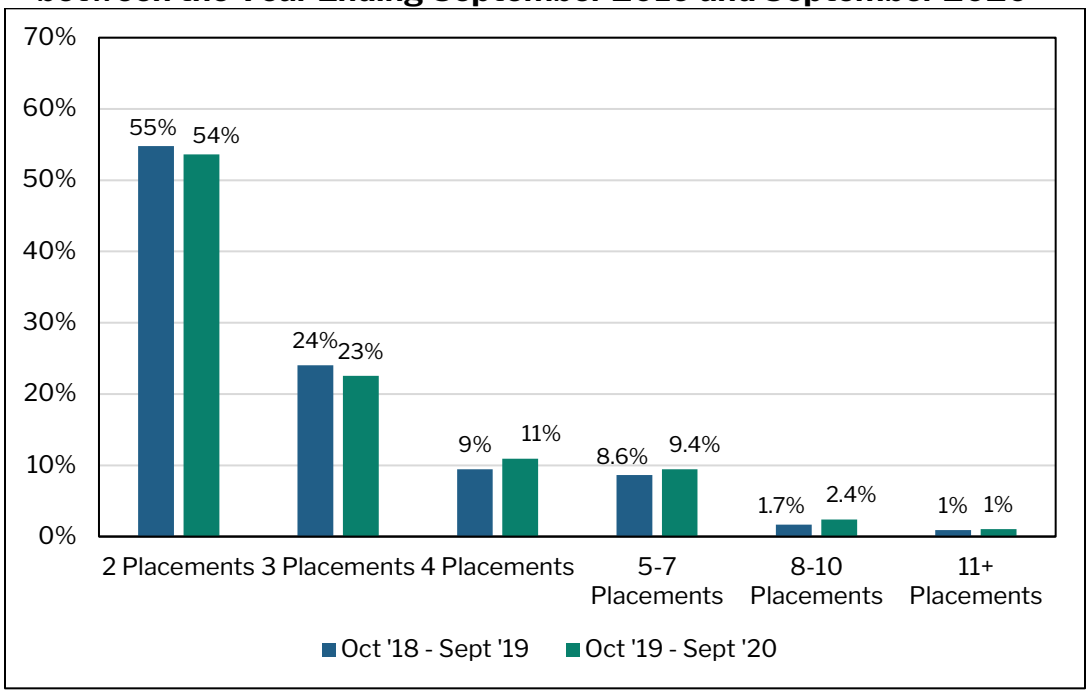
Figure 32: Number of Placements for Children Who Experienced A Placement Change Within 12 Months October 2019 - September 2020 N=3,162



Source: CAPSS data provided by DSS

These data show that children were subject to fewer placement moves than in the prior year, based on the rate of overall moves per 1,000 child-days. Among those children who moved at least once, the number of placements experienced is nearly unchanged from the prior year, as shown in Figure 33.

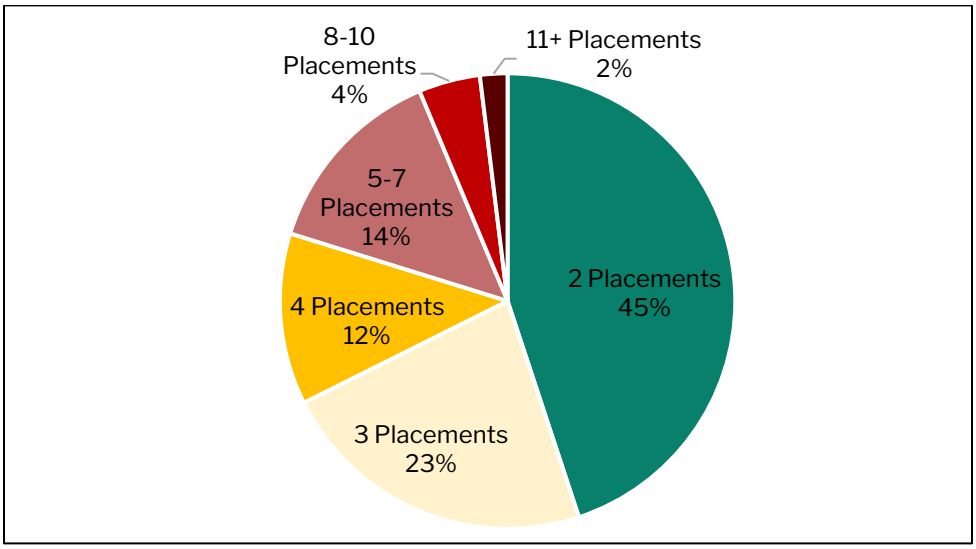
Figure 33: Comparison of Number of Placements for Children Who Experienced a Placement Change between the Year Ending September 2019 and September 2020



Source: CAPSS Data provided by DSS

For children ages 13 to 17, the number of placements experienced was even starker. Of the 1,282 children ages 13 to 17 who moved at least once, 706 (55 percent) experienced two or more placement *moves*, indicating three or more total placements, within 12 months. As shown in the Figure 34, almost one-third (415 of 1,282) of youth in this age group experienced four or more placements, and 20 percent of those who moved at least once (259 of 1,282) – identified by the three red segments in the figure – experienced five or more placements in the 12-month period.

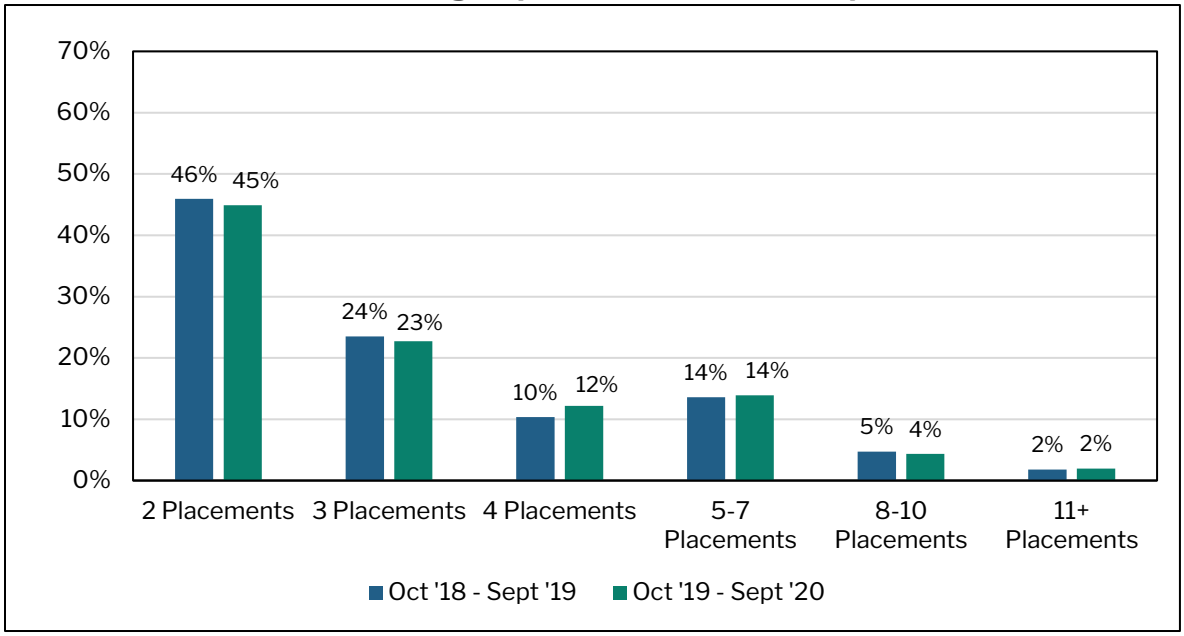
Figure 34: Number of Placements for Youth Ages 13-17 Who Experienced A Placement Change Within 12 Months October 2019 - September 2020 N=1,282



Source: CAPSS data provided by DSS

The experiences for children in placement who moved at least once from October 2018-September 2019 are similar – as shown in Figure 35.

Figure 35: Comparison of Number of Placements for Youth Ages 13-17 Who Experienced a Placement Change Between the Year Ending September 2019 and September 2020



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.

Included in the prior monitoring report was the experience of a child, then 16-year-old, in Aiken County (now in Richland County) who has been in foster care four times, experiencing between six and 14 placements each time. The child had been moved through 42 placements during seven years in foster care. In the year since, the child was moved to 21 additional placements.

Similarly, a 16-year-old in Greenville County experienced 26 placements within the year, after experiencing six prior placements across three separate instances of entering and exiting foster care. All research available indicates the profound negative consequences of this level of 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 five-year old in Richland County has been in 11 placements since entering foster care in December 2019 until September 2020. This constant cycle of removal and re-placement undercuts children's feelings of safety and stability. It disrupts continuity 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.

While the instability experienced by children in DSS's care is due, in part, to an insufficient number and array of placement options. The lack of flexible, intensive home and community-based resources to support children and foster and kinship providers throughout the state is also an important concern. Until this issue is addressed, it will be difficult for DSS to sustain progress in this area.

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 one instance of a child staying overnight at a DSS office or hotel, however it was in an effort to safely house a child who had tested positive for COVID-19.[132] As discussed below, the Co-Monitors have received reports from case managers and stakeholders that children often spend long periods of time in DSS offices while awaiting placement, but are taken to foster homes late at night on an emergency basis and picked up early in the morning to avoid violation of this measure.

Emergency or Temporary Placements

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

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

DSS remains unable to track its use of emergency placements. This continues to be a significant concern, particularly given DSS's poor placement instability

[132] In June 2020, a 17-year-old in Sumter County stayed overnight in a hotel for two weeks in adjoining rooms with a DSS case manager after DSS was unable to identify a placement at which the youth could be quarantined.

performance and the frequent stakeholder reports received regarding the practice of sending children to foster homes for just a few hours night-to-night to avoid having them sleep in offices. DSS has reported that at times it pays foster care providers an "enhanced rate" as an incentive to house children overnight while longer-term placement is being sought.[133] The Co-Monitors have continued to recommend that DSS expeditiously develop mechanisms for tracking the use of emergency placements so that data can be used in future periods to assess FSA performance and help inform practice.

Juvenile Justice Placements

The FSA 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 concerned about Class Members who are also involved with the South Carolina Department of Juvenile Justice. DJJ involvement includes pre-adjudication detention; a prescribed sentence 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 (as well as terms of probation). Class Members become involved with DJJ for several reasons, including because of actions that involve little or no harm to others (such as truancy, "incorrigibility," or, in many cases, running away from a DSS placement).

DSS has continued to work to develop more information about children in their care who are also involved with DJJ. Designated liaisons throughout the state now have access to a DJJ data system portal, which provides limited information about children with open DJJ cases. Through the help of members of the regional Well-Being Teams, DSS continued its work this period to enter information about DJJ involvement

[133] According to accounting records shared by DSS, at least 118 unique children were subject to this practice between April and September 2020. Eighty-five unique children were placed in a group home on an emergency basis; the average number of days per emergency stay was 13 days. The numbers likely underestimate the practice of night-to-night and short-term emergency placements as neither the Co-Monitors nor DSS believe that all emergency placements are reflected in this enhanced rate payment data.

directly into CAPSS so that it is more accessible to DSS leadership and case managers. In some parts of the state, DSS-identified liaisons and regional DJJ liaisons have built closer working relationships, allowing for more informal collaboration and information sharing. These relationships have been especially helpful given that electronic access to more comprehensive information about children's cases remains limited. DSS and DJJ must continue their work in the months ahead to collaborate in identifying children who are involved with both agencies so that the needs of children and their caregivers can be identified and addressed.

The lack of readily available, comprehensive information about children in DSS custody who may be residing in DJJ placement in violation of the FSA has meant that the Co-Monitors have continued to rely on both DSS reports and anecdotal reports by stakeholders to assess DSS performance with respect to the FSA in this area of practice. The Co-Monitors are regularly made aware of cases that reflect the frequency and fluidity of movement between DSS and DJJ, with decisions made, at least in part, based on the availability of placement resources and the willingness or ability of a caregiver (DSS or otherwise) to maintain the youth in the community. Children often come to the attention of DJJ because they choose to leave placements in which they feel unsafe, or in which their needs are not being met, leading to law enforcement involvement and delinquency charges. For example:

- In May 2020, a 14-year-old in Laurens County was not picked up by DSS at the completion of the youth's sentence and remained in detention for an extra day before being moved to a group home.

- In June 2020, a 17-year-old in Richland County was detained at a correctional facility after running away and placed in Emergency Protective Custody. Though DJJ recommended placement through DSS, the youth remained in detention for two weeks before being moved to another group home.

- In July 2020, a 16-year-old in Lexington County was detained after running away four months prior. The youth was brought to a DSS office to await a placement, and was detained after running away again. The youth was placed in a group home after pleading guilty to "two counts of runaway."

Given their ages and displayed behaviors, children who get caught up in both DSS and DJJ often bear the highest burden posed by the lack of community-based supports and appropriate placement options. DSS has acknowledged that planning for children involved with these systems must be based in a teaming model that reflects the

shared goal of keeping youth out of restrictive settings whenever possible, and in settings in which high-quality community-based services to address underlying needs are available. As a next step, the Co-Monitors and DSS will be working in partnership to review and understand the systemic inadequacies that contribute to children's DJJ involvement and/or time in detention, secure evaluation facilities, or DJJ group homes so that systems issues can be identified, understood, and addressed on a deeper level. The goal for this review is to inform the work to develop appropriate community supports and placement options in collaboration with other state agencies, an integral part of the Placement Implementation Plan.

Sibling Placements

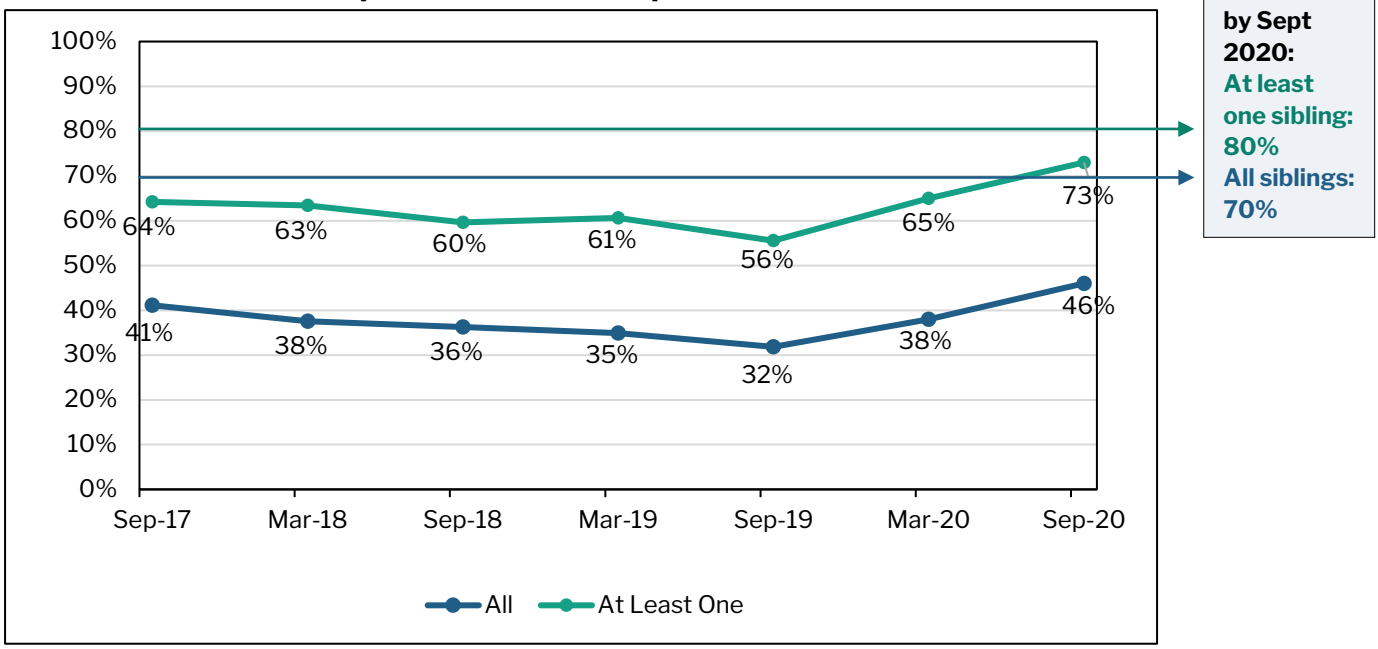
The FSA recognizes the importance of the lifelong and supportive relationship between children and their siblings and *requires that at least 80 percent of children who enter care with or within 30 days of their siblings be placed with their siblings* (FSA IV.G.2. & 3.). The FSA includes two targets – one for placement with *at least one* of a child's siblings (85% target) and the other for placement with *all* siblings (80% target).[134] The interim benchmark by September 2020 is that 80 percent of children should be placed with at least one sibling, and 70 percent of children should be placed with all siblings.

DSS provided data for 481 children who entered foster care between April and September 2020, with a sibling or within 30 days of a sibling's entry to foster care.[135] For this cohort, 73 percent (349 of 481) of children were placed with at least *one* of their siblings, and 46 percent (222 of 481) of children were placed with *all* of their siblings 45 days after entry into care (see Figure 36). Though performance falls short of the September 2020 interim benchmarks, this is a significant improvement from the prior monitoring period.

[134] The FSA allows for exceptions to this requirement, including when there is a court order prohibiting such placement or if the placement is determined not to be in the best interest of 1 or more siblings. Exceptions to placement of children with their siblings have been approved, though not applied during this monitoring period; therefore, actual performance may be higher than reported. DSS will develop a process for review and approval of exceptions in future monitoring periods.

[135] Because performance for this measure is assessed on the 45th day after children enter foster care, the number of applicable children included in the measure is impacted by the decrease in children entering care in each month of the COVID-19 pandemic. As represented in the data herein, whereas 813 children were included in the universe in the last monitoring period, only 481 children were included in this period.

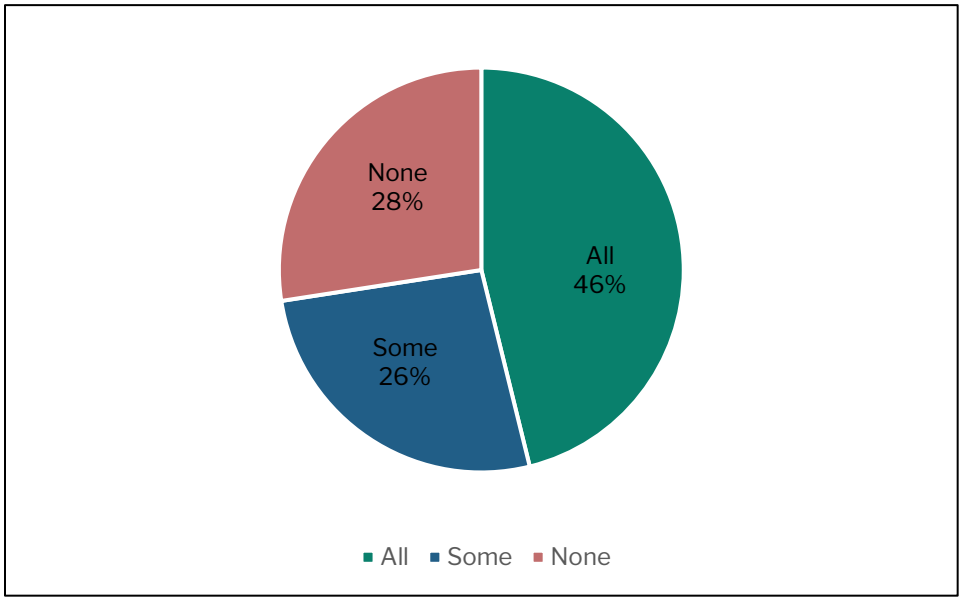
Figure 36: Sibling Placements for Children Entering Placement September 2017 – September 2020



Source: CAPSS data provided by DSS

Figure 37 further shows the breakdown of sibling placements during this monitoring period. Of the 349 (73%) children who were placed with at least one of their siblings, 127 (26%) were placed with some but not all. Performance with respect to the percentage of children not placed with *any* siblings also improved, dropping from 35 percent in March 2020 to 27 percent in September 2020.

Figure 37: Sibling Placements for Children Entering Placement
April – September 2020
N=481



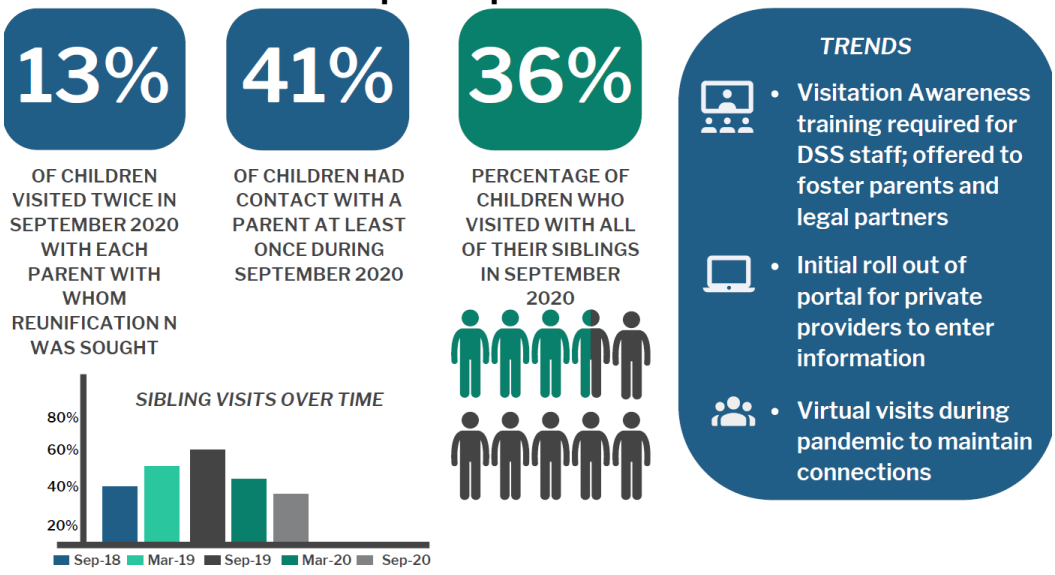
Source: CAPSS data provided by DSS

VIII. Family Time: Visits with Parents and Siblings

Regardless of their permanency goal, most children in foster care benefit from an ongoing relationship with their parents and other family members. Most children in foster care also benefit from residing with their siblings. For children and their parents and siblings who do not reside together, regular and multiple forms of contact can maintain and build attachments that are fundamental for the health and well-being of both children and adults. Although DSS continues to communicate that the quality and quantity of time children in foster care spend with their parents and siblings should increase, results from twice-yearly reviews to determine performance on DSS's minimum monthly standards for children's contacts with their parents and siblings remain far below expectations.

The time children in foster care spend with their family members must be expanded, more create, multiple, and creatives ways for facilitating time with family must be used by DSS and its partners. Guidance from DSS encouraged in-person contact between siblings in foster care and not residing together and between children and their parents with precautions related to the pandemic. Some children continued to have in-person contact with family members. Other children are experiencing video contact with family members, as allowed by DSS. The efforts to support safe, in-person contacts among family members during the COVID-19 pandemic and to facilitate contacts by video – both in a manner directed at encouraging relationship-building – must continue.

Key Developments: Case Manager Contact and Visits with Children, April- September 2020



Family Time: Progress and Implementation Updates

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

DSS's Visitation Implementation Plan was approved by the Co-Monitors on March 28, 2019, and by the Court on April 3, 2019.[136] Although delayed, DSS continues to make progress towards developing and implementing strategies, as described below.

Training

Visitation Awareness training for case managers, supervisors, and foster parents is one of DSS's core strategies to communicate the importance of increasing the amount of time children spend with their family members. The Visitation Awareness training reiterates that policy references a *minimum* expectation for the time children spend with their parents and siblings: one hour, twice monthly with parents, and one hour monthly with siblings not placed together, however the expectation is for much more time. Supporting and encouraging multiple forms of children's contact with family members, including in-person visits is expected of DSS staff, foster parents, and partners. DSS case managers, case manager assistants, case manager supervisors, and program coordinators are expected to participate in Visitation Awareness training. New staff are expected to do so within their first year of employment. Legal staff are invited to participate in the training. Between October 2019 and December 2020, 62 case managers and 55 supervisors attended Visitation Awareness training.[137] One legal staff person also participated during this timeframe. Foster parents began receiving Visitation Awareness training in November 2019. Since then, 439 foster parents have been trained, including 70 who received training to train their peers.

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

[137] DSS reports that an additional 600+ staff (case managers, case manager supervisors, case manager assistants, and others) participated in the initial offerings of Visitation Awareness in August 2019 and September 2019.

Policy
DSS has not yet issued planned amendments to its June 2019 visitation policy, aimed at aligning expectations with the agency's GPS Case Practice Model. In September and December 2020, DSS emailed quarterly practice tips to DSS and provider staff, and made the document available electronically internally. The tips focus on case manager contacts with parents, practices related to engagement of and planning with parents, and subsequent documentation of the contact.

Data
Additions to CAPSS to capture data on visits and a new Visitation Plan document, which is expected to be completed by a child's case manager, are not yet in uniform use. Data from these new requirements are presented in DSS management reports, and used for tracking and improving results for family visits. DSS has also created data reports for management in counties to track performance on visits.

The roll-out of a new Child and Adult Information Portal (CAIP), originally scheduled for November 2020, took place in March 2021. CAIP, a method by which private providers can send data to DSS, allows authorized users to provide instant updates via a smartphone, tablet, laptop, or desktop computer to a child's record in topic areas of education, physical and behavioral health, and visits or maintaining connections with family members. Prior to being granted CAIP access, DSS foster care case managers, supervisors, and foster care providers will complete training on the portal and receive a manual and tip sheet.

Appendix E of this report includes a list of strategies related to visits with family due this period, as well as related Joint Report commitments.[138]

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."*[139] The September 2020 interim benchmark for monthly sibling visits is 76 percent.

[138] In July 2019, DSS identified limited action items on which it could move forward in FY2019-2020 without the resources it had requested from the legislature, as memorialized in the Joint Report.
[139] 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*

DSS requires, at minimum, once monthly face-to-face contact between siblings in foster care who do not reside together, and more frequent contact when possible. The expectation is that case managers and caregivers arrange for ongoing, frequent interaction between siblings, unless one of the approved exceptions applies and is documented in CAPSS. Children should meet in-person and interact via video and/or phone calls, and texts.

USC CCFS, DSS, and Co-Monitor staff conducted a case record review using a structured instrument to collect data on visits between children in foster care living apart from a sibling who is also in foster care. Reviewers examined a sample of 305 records, representing 200 families, for required sibling visits in September 2020.[140] Documentation in eight of the 305 records reflected an applicable exception to a sibling visit.[141]

Of the remaining 297 records, 108 (36%) had documentation that a sibling visit had occurred.[142,143] This result is a significant decline in performance since 12 months prior. The COVID-19 pandemic and the logistics it may take to coordinate and facilitate contacts among siblings are likely impacting the result, though video visits were deemed acceptable for purposes of this review.

Almost 60 percent (61 of 108) of the sibling visits were by video; 38 percent (40 of 108) were in-person; and there were six cases of voice-only calls. For too many

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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).

[140] There were 1,460 visits required between siblings who, as of September 30, 2020, had been in DSS custody for at least 30 days and living apart. A statistically valid sample of 305 cases was reviewed based on a 95% confidence level and +/- 5% margin of error.

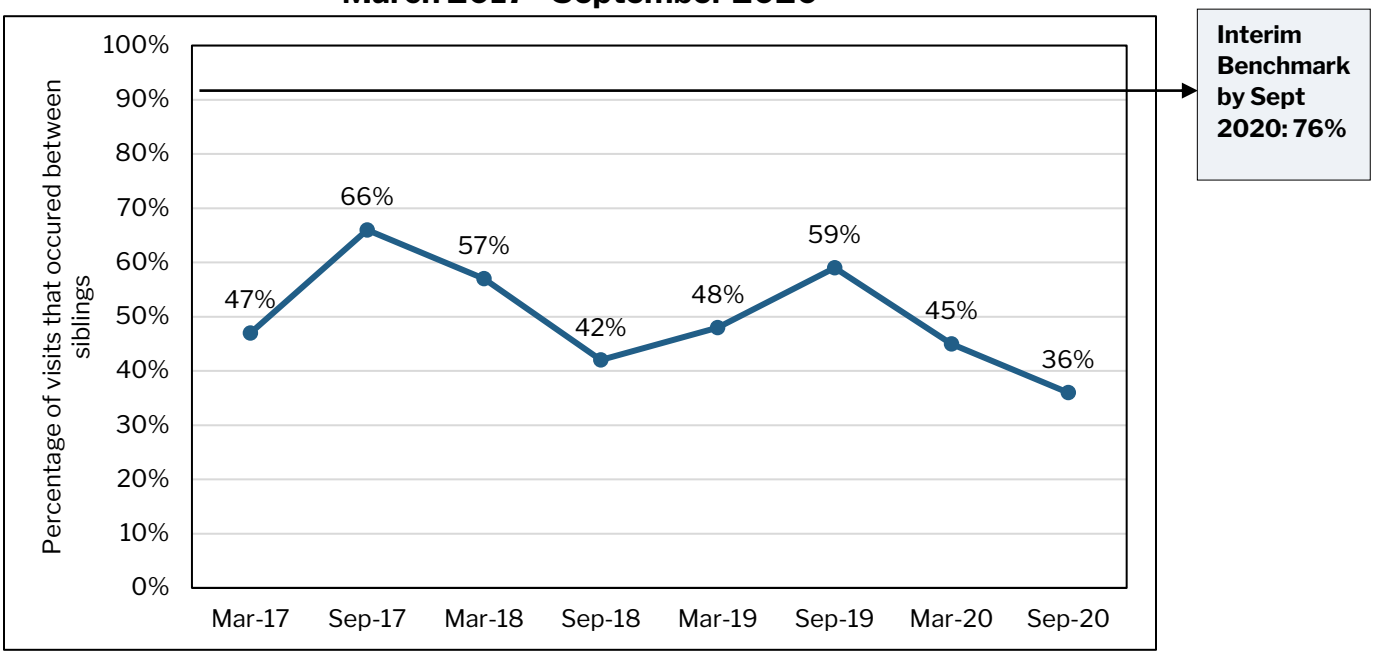
[141] These exceptions include that a child refused to participate in a visit, a court order prohibited a visit, and that a child could not be located despite attempts.

[142] The 297 applicable records represent 196 families; 108 records with documentation of a sibling visit represent 77 families.

[143] One record did not clearly indicate the mode of contact between the siblings.

children, these are missed opportunities to form and maintain crucial connections during a time of uncertainty. For many children this compounds the losses felt with virtual schooling and limited social interactions with peers. The performance does not meet the interim benchmark of 76 percent, as shown in Figure 38.

Figure 38: Visits Between Siblings Placed Apart
March 2017 - September 2020



Source: Case Record Review conducted by USC CCFS, DSS, 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.).[144] The interim benchmark for at least twice monthly visits between children and their parent(s) is 75 percent.

[144] 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

DSS policy states that within 30 days of a child entering foster care, their case manager must create a plan for visits with input from the child, parents/guardians, other significant persons, foster parent or congregate care provider, guardian ad litem, and, if applicable, the child's therapist or behavioral health provider. Visits with parents must be at least twice a month, unless limited by a court order.

In addition to the minimum twice monthly, in-person time between children and their parents, DSS has continued to engage frontline staff in training and other messaging about the importance of children having ongoing contact with their parents. The fact that the minimum required contact only amounts to 24 hours a year, is a message reiterated in DSS's Visitation Awareness Training.

DSS has notified placement providers that family visits cannot be limited or prohibited as a disciplinary measure. It is the role of all who work with children, but especially DSS staff who monitor facilities in which children reside, to make sure this is not occurring.

On March 25, 2020, in response to the COVID-19 pandemic, DSS directed case managers to ask both children's caregivers and parents a set of screening questions to determine COVID-19 infection symptoms, possible exposure, and comfort with the parent and child spending time together in a sanitized room at the DSS office. DSS also allowed the child's guardian ad litem to state a position on in-person visits. If there was disagreement with in-person contact, an alternate contact plan was to be developed. Any parent or caregiver who did not have access to needed technology was to be offered access at a DSS office. DSS directed that, at minimum, frequent phone calls between the child and parent should be facilitated.[145]

USC CCFS, DSS, and Co-Monitor staff apply a structured instrument to collect data on visits between children in foster care and the parent(s) with whom reunification is

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.

[145] In November 2020, DSS provided guidance to the field for transitioning back to in-person family visits by January 30, 2021 for those families not already visiting in-person. Guidance included a reminder to follow COVID-19 safety guidance of the Center for Disease Control, including but not limited to the using of personal protective equipment and distancing practices, sanitizing the visitation area, and holding visits in lower-risk settings such as outdoors or in open spaces when feasible.

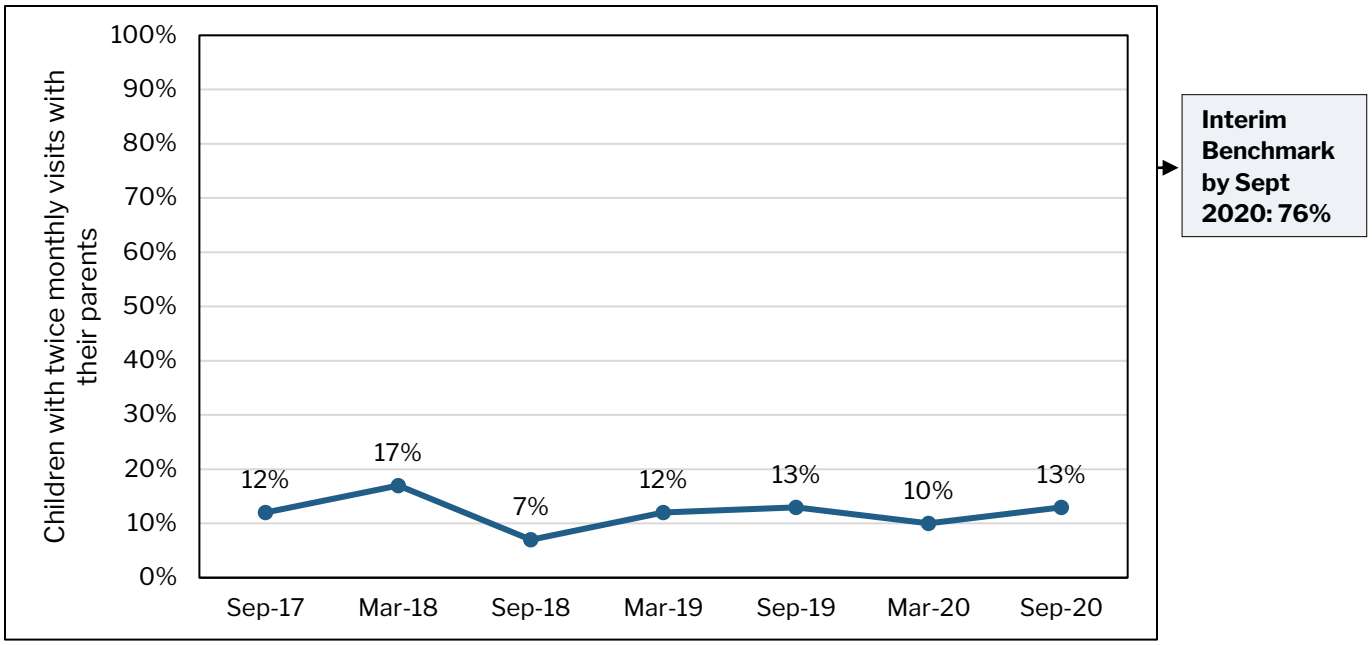
sought. Reviewers examined a sample of 325 records for documentation of contacts between a child and their parent(s) during September 2020.[146,147]

In 28 of the 325 records, there was documentation of an applicable exception to the visit requirement that month.[148] Of the remaining 297 records, 122 (41%) reflected that the child had contact with a parent only once during September 2020.[149,150] In 175 (59%) records there was no documentation of a child having contact with their parents, either in-person or by phone or video.

Only 38 (13%) records contained documentation of a child visiting twice during September 2020 with both parent(s) with whom the child is to reunify. The performance benchmark is 75 percent. Figure 39 shows performance for at least twice monthly visits between parents and children, ranging from seven to 17 percent since September 2017. This level of performance for contact continues to be unacceptable.

[146] As of September 30, 2020, there were 2,083 children who had been in foster care for at least 30 days with a permanency goal of "return to home" or "not yet established." A statistically valid sample of 325 cases was reviewed based on a 95% confidence level and +/- 5% margin of error.
[147] Permanency goals were identified using 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.
[148] These exceptions include that the parent did not visit despite attempts to arrange and conduct a visit; a court order prohibited visits; and the child refused to participate in a visit.
[149] Reviewers identified and sought documentation of visits with a second parent for 144 children. However, documentation in CAPSS does not clarify the reunification resource when parents live apart. This number is likely an overcount of reunification resources.
[150] Children and their parents met in-person and had video and phone calls, as allowed by DSS during the pandemic.

Figure 39: Children with Twice Monthly Visits with Their Parents
September 2017 – September 2020



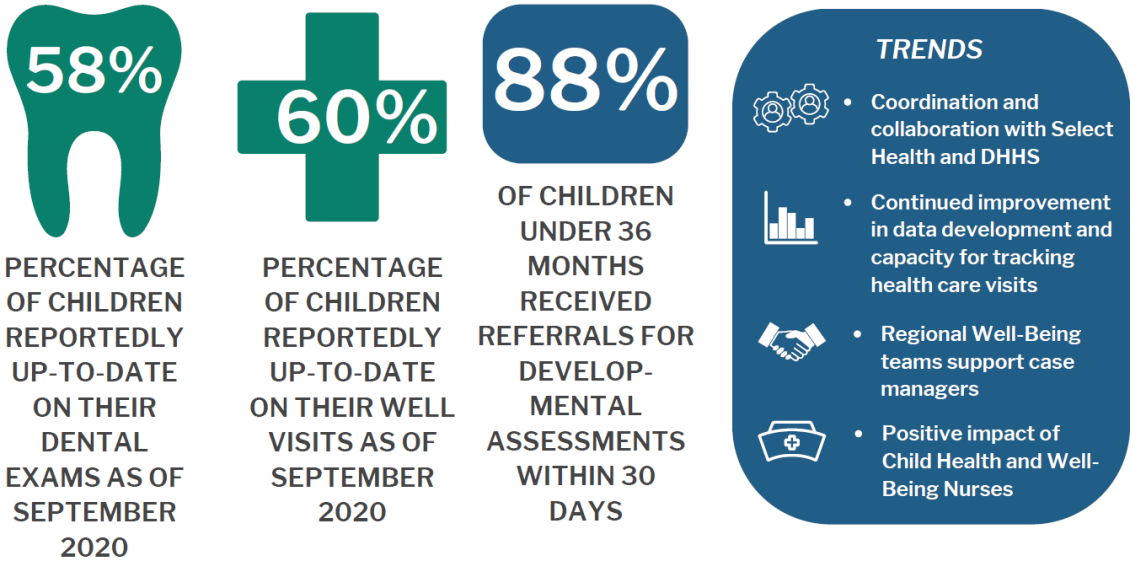
Source: Case Record Review conducted by USC CCFS, DSS, and Co-Monitor staff

IX. 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 track care delivery and communicate key health care information. Under the leadership of the Office of Child Health and Well-Being and with the support of regionally based clinical staff, DSS has continued to make progress in building this capacity. In partnership with the South Carolina Department of Health and Human Services (DHHS) and Select Health, the state's Managed Care Organization (MCO) for most children in foster care, DSS worked this period to further refine its systems for collecting and analyzing health care data, and for collaborating on medically complex cases. The important work of engaging community providers and agency partners in informing policy and implementation decisions has also continued.

The next phase of DSS's care work will require continued innovation, ongoing collaboration, and an intensified focus on the development of quality community-based services and supports for children. DSS recognizes that now, more than ever, with the COVID-19 pandemic presenting additional challenges to access to health care and the well-being of children and families, it will need additional resources to effectively perform its commitments in this area and ensure the health and well-being of the children in its custody.

Key Developments: Health Care, April - September 2020



Health Care: Progress and Implementation Updates

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 Health Care 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.[151] A Plan addendum (the "Health Care Addendum") was approved by the Co-Monitors on February 25, 2019, establishing commitments by Select Health and DHHS to a

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

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.[152] Although a general delineation of roles were included in the Addendum, the Plan was approved with the understanding that additional detail would be determined through implementation, and the efficacy and adequacy of the model would be assessed each year to see if it requires changes or additions.[153]

Under the leadership of Gwynne Goodlett, Director of the DSS Office of Child Health and Well-Being, and in collaboration with DHHS, Select Health, and community partners, DSS continued to make progress in implementing its Health Care Improvement Plan and Addendum during the monitoring period. Even faced with the extraordinary challenges presented by the COVID-19 pandemic, the team responsible for implementation continued to engage in a problem-solving approach, testing and tweaking new mechanisms for collaboration, coordination, and data collection.

Data Development

Although DSS had been receiving data from both DHHS and Select Health for some time, it has struggled to analyze and utilize these data. After spending many months building a more complex understanding of how available data can best be used to track and manage the health care needs of the children in its care, DSS continued to make progress this period in developing systems for collecting, sharing, and analyzing health care data at both the administrative and case levels. This has involved combining retrospective, administrative data from DHHS and Select Health with real-time, reliable case manager documentation. The ability to extract useable data and supporting medical forms from well-child visits directly from CAPSS is a significant accomplishment. DSS has reported progress with respect to the collection of comprehensive information on the provision of follow-up medical and behavioral health care to children.[154]

[152] To see the Health Care Addendum, go to: https://dss.sc.gov/media/1962/2-25-2019-approved-health-plan-addendum.pdf

[153] The demands of the COVID-19 pandemic on DSS, DHHS, and Select Health have made it difficult to assess staffing and infrastructure needs for the coming year. The Co-Monitors will be sharing a more thorough capacity analysis aligned with the understanding referenced herein in the coming months.

[154] 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. While DSS has moved forward in establishing systems for the collection of data on the delivery of care necessary to address identified

Internal Capacity Building

The Child Health and Well-Being nurse infrastructure has been in place since December 2019, including a state-level Nurse Care Manager and one Regional Nurse and Data Coordinator in each region. As of April 2020, the infrastructure also includes a state-level Dental Nurse. In addition, regional Well-Being Teams, overseen by Regional Well-Being Managers, and staffed by Regional Nurses, 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 Health Care Data Coordinator – have continued to operate throughout the state. Many of these positions and staff were formerly part of the IFCCS structure that was eliminated in December 2019. Based on a model utilized effectively in Tennessee, the Well-Being Teams function in coordination with state Office of Child Health and Well-Being staff, and are charged with serving in a supportive role with case managers in assessing and managing the well-being needs of children in foster care.

As previously reported, DSS and the Co-Monitors have been concerned that, even with the support of regional Well-Being Teams, six nurses are not 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 child. In the view of the Co-Monitors, it has become clear that this work cannot be effectively done without additional nurses and more support staff. The day-to-day management of provider data alone has required the full-time support of virtually all clinical nurse staff and, even so, nurses report they have only been able to keep up with tracking basic well-child visits. Ensuring that all children, including those with complex needs or chronic medical issues, are getting consistent, high quality care requires nursing staff who have the time to provide clinical support on cases; serve as resources for biological and foster families, providers, and DSS case managers; and arrange physical and behavioral health preventative, routine, and follow-up care. Nurses have reported that they want to take on these roles, but will need more support in order to do so. DSS recognizes the need to expand its Office of Child Health and Well-Being staff, and has continued to try to obtain funding for 12 additional positions, including two additional clinical nurses.

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treatment needs, it does not yet have the capability to produce data in accordance with the specific obligations outlined therein. DSS reports that it is taking steps to improve the reliability and availability of these data in coordination with Select Health, foster parents, and providers, and the Co-Monitors will provide another progress update in the next report.

In recognition of the insufficiency of current staff capacity under the circumstances of the COVID-19 pandemic, DSS was able to hire two additional nurses on a temporary basis through CARES Act funding[155] in November 2020. These nurses have helped to relieve some of the burden on the existing nursing team, and have focused primarily on the collection of health care data for children most vulnerable to the impact of the COVID-19 pandemic, specifically children with underlying medical conditions and children residing in congregate care facilities.

Defining a Managed Care Organization Partnership

South Carolina's system for health care delivery to children and families that utilize Medicaid gives a significant role to private MCOs. Select Health is the designated MCO for many children and families who use 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. It is also charged with approving or denying payment for medical and behavioral health services. In so doing, Select Health plays many roles: it is a point of contact, a collector of essential data, a resource in identifying providers, a determiner of allowable services, and a payor of claims. DSS's Health Care Plan and Addendum intensify DSS's reliance on Select Health by partnering with them in an integrated model of health care case management and care coordination for children in foster care.

DSS reports that the infrastructure put in place under the Health Care Improvement Plan and Addendum has continued to be essential during the COVID-19 pandemic. During a time that has demanded constant, real-time assessment and modification of process such as prior approval requirements, payment guidelines, and provider accessibility, DSS has leaned heavily on the trusting relationships it built with both Select Health and DHHS over the course of the last two years. DSS reports that all partners have shown flexibility and creativity in devising solutions to issues that have arisen during these unprecedented circumstances.

Select Health now has 19 staff in its Foster Care Unit (including eight clinical nurses, two social workers, and a Foster Care Liaison) and a new medical director, and has continued to partner with DSS on a weekly Foster Care Grand Rounds process through which cases of concern are chosen for intensive review. There is still significant work to be done in clarifying the Select Health role in the day-to-day management of children's care, beyond denying or approving claims and offering a roster of in-network providers. This has been a priority for some time. Given the

[155] H.R.748 Coronavirus Aid, Relief, and Economic Security Act of 2020, Public Law 116-136

significant budgetary constraints with which DSS currently struggles and the resources expended to Select Health for the management of children's health care, it has never been more urgent.

Coordination and Collaboration with DHHS

DSS has also continued to work closely with DHHS to improve access to quality health care for children in foster care. As a result of feedback received from providers throughout the state, work during last spring and summer focused on adjusting the funding platform utilized to bill for Medicaid eligible services for children placed in therapeutic foster homes throughout the state. As of July 1, 2020, therapeutic foster care (TFC) providers no longer have to bill Medicaid incrementally for services provided to the children in their care – a practice that has been crippling to many therapeutic providers throughout the state. DSS reports that this change has been welcomed by therapeutic providers who have long been overburdened by the administrative requirements of supporting children in foster care with higher levels of need.[156]

The ongoing partnership between DSS and DHHS also led to progress in formalizing additional Medicaid reimbursement for children's initial comprehensive medical visit upon entry into foster care. Health care providers now receive reimbursement for the non-direct care activities associated with an initial visit, enabling them spend the extra time necessary to assess underlying needs, collect historical records, and complete additional paperwork important for building a comprehensive health care record for a child in their care.

The announcement in January 2021 that the DHHS leadership team would be stepping down from their roles is a setback to DSS, but DSS is hopeful that the two agencies will continue to forge a productive partnership. DSS has put much time and effort into this relationship in recent years, and continues to be encouraged by its work with DHHS's interim leadership team. Given the need to improve access to quality services for all South Carolina children, particularly those in foster care, it is essential that DSS continue to foster this collaboration with DHHS as it transitions to new leadership, and that the agencies continue to pursue ways of maximizing federal Medicaid funding to meet the needs of children in foster care throughout the state.

[156] Per diem units of TFC may not exceed the number of calendar days in the month. TFC providers submit to Medicaid at the level assigned on the Universal Application generated by DSS to place a child in a therapeutic foster home: the per diem rate for TFC Level 1 is $29.95; Level 2 is $45.57; and Level 3 is $65.10.

Network Sufficiency

Foundational to both the Health Care Improvement Plan and the Placement Plan (discussed in Section VII. *Placements*) is the need for an array of robust, community-based services, including intensive in-home supports, so that children will no longer be subject to frequent moves to higher level placement settings to ensure their needs are met. It was contemplated at the time of Health Care Plan development that DSS would assess and build out this capacity in coordination with both Select Health and DHHS. There was much enthusiasm about the vast quantity of data that Select Health collects daily through its gaps-in-care analysis and provider "heat maps", but this work has not yet come to fruition.

DSS began to collect anecdotal information from its case managers and supervisors in a database about the service needs of children and families throughout the state, and expects that by June 30, 2021, it will be prepared to implement "mitigation plans" for areas in which service or provider capacity is limited. As discussed in Section VII. *Placements* of this report, DSS has also committed to seeking resources to expand services and supports for family placements for children moved out of congregate care settings. The Co-Monitors continue to believe that this is a key area of work, and one that must be done with expediency and in close partnership with DHHS, Select Health, the Department of Mental Health, and community partners throughout the state.

Appendix H of this report includes a list of all strategies due this period, as well as commitments from the Joint Report, the Mediation Agreement, the Health Care Addendum, and the Joint Agreement on Immediate Treatment Needs related to those strategies.

Performance Data

As noted in the prior monitoring report, the Co-Monitors and DSS have been engaged in discussions about re-assessing the approved data methodologies for health care measures given the shared goal of efficiently and effectively producing understandable, timely performance data that can be used both for public and court accountability purposes, and for day-to-day management and quality improvement. Given this, and the difficulties that DSS has encountered in gathering data used in the approved methodologies during the COVID-19 pandemic, the Co-Monitors agreed to include in this report a limited set of health care data utilized by DSS for its own

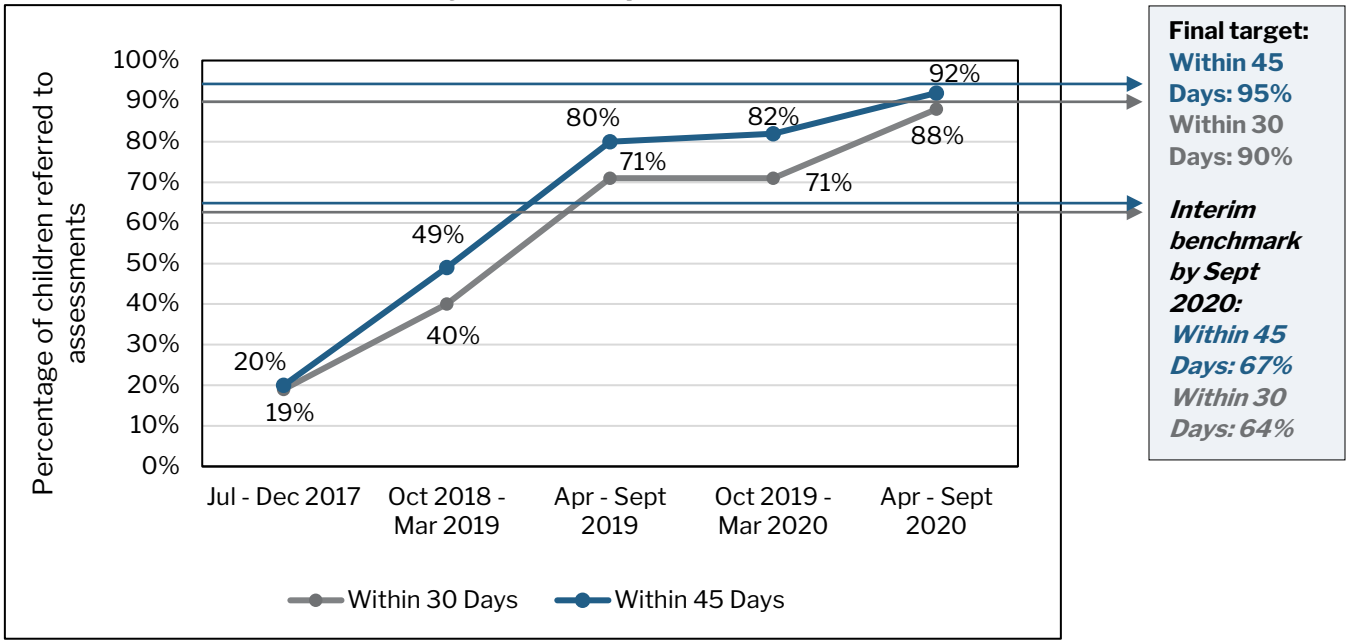
internal management purposes. These data have been collected and validated by DSS's Regional Nurse Care Managers, and are derived from a combination of CAPSS data, Medicaid claims data, and Select Health records. They have not been independently validated by the Co-Monitors. In addition, data lags related to the COVID-19 pandemic have continued to constrain DSS's ability to access and analyze health care data in the areas of initial health screens, behavioral health assessments, and follow-up care.

Developmental Assessments

In the DSS Health Care Outcomes, DSS committed that "*At least 90% of Class Members under 36 months of age will be referred to the state entity responsible for developmental assessments within 30 days of entering care; at least 95% shall be referred within 45 days.*" The interim benchmark by September 2020 is that 64 percent of children under 36 months will be referred to BabyNet – the state entity responsible for developmental assessments – within 30 days, and 67 percent will be referred within 45 days.

DSS reports that 88 percent (248 of 283) of children under 36 months of age who entered care between April and September 2020 were referred to BabyNet within 30 days. Ninety-two percent (246 of 267) of children were referred within 45 days. These data significantly exceed the interim benchmarks, and approach the final targets for this measure (see Figure 40). It is important to note that these data only measure whether a child was *referred* for a developmental assessment and do not capture whether 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 40: Referrals for Developmental Assessments within 30 and 45 Days July 2017 – September 2020



Source: CAPSS data provided by DSS

Well-Child Visits

DSS committed to Health Care Outcomes 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.*"[157]

In accordance with AAP guidelines for ongoing 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."[158] Based on these guidelines, DSS committed in its Health care Outcomes that, "*At least 90% of Class Members under the age of six months in care for one month or more will receive a periodic preventative visit monthly. At least 90% of Class Members between the ages of six months and 36 months in care for one month or more will*

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

[158] *Fostering Health: Health Care for Children and Adolescents in Foster Care*, 2d. ed (16-17). American Academy of Pediatrics (2003), p. 30.

receive a periodic preventative visit in accordance with current American Academy of Pediatrics periodicity guidelines;[159] *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."*[160]

As explained above, given the methodologies being used internally at DSS for health care management, as well as the delays and limitations for DHHS data extraction during the COVID-19 pandemic, the Co-Monitors agreed to report initial comprehensive medical assessments and periodic preventative well-child visits performance using data collected by DSS nurses during this monitoring period.[161] Regional Nurses reviewed CAPSS records for each child in foster care and estimated the date for the next required well-child visit based on the child's age and most recent assessment. For validation purposes, nurses collected documentation of visits from providers and pulled data from DHHS and/or Select Health in order to determine when the most recent assessment occurred.

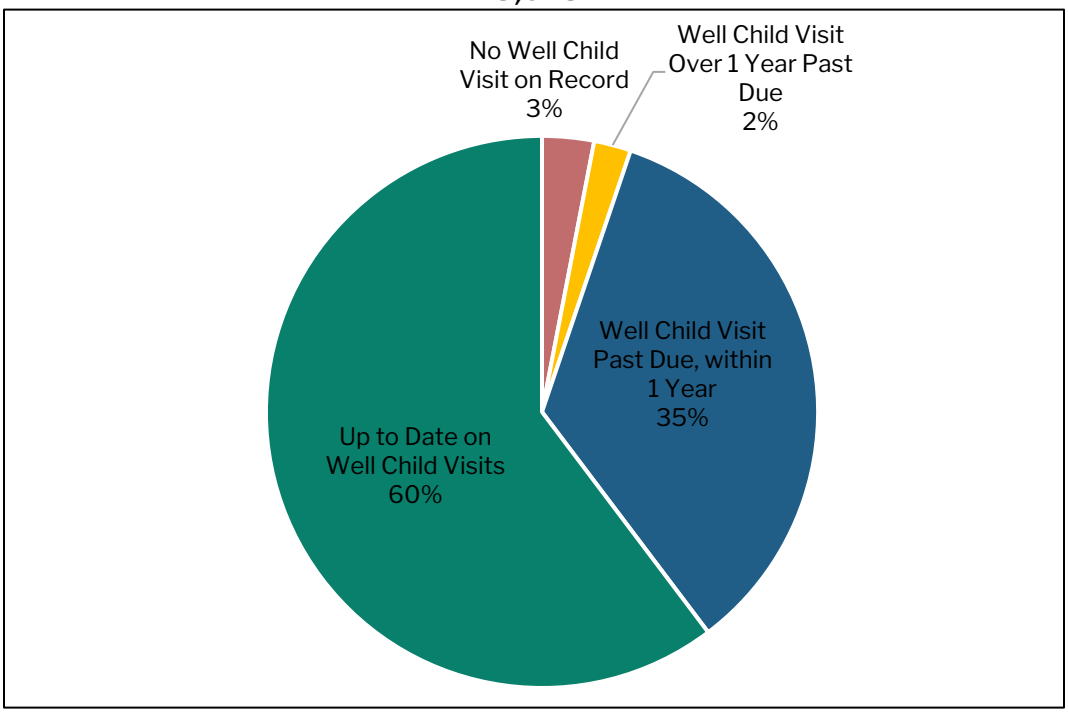
DSS reported that of all children under 18 years of age who were in foster care on September 30, 2020 for at least 30 days, 60 percent (2,362 of 3,918) were up to date on their well-child visits. Of the remaining children, 119 (3%) did not have a well-child visit indicated in the DSS record or DHHS and Select Health data systems. This is an improvement from the last monitoring period, in which 45 percent of children were up to date on their well-child visits. As depicted in Figure 41, 35 percent of children were past due on their well-child visit according to the periodicity schedule, but were within 12 months of the estimated follow-up visit date.

[159] See AAP Recommendations for Preventative Pediatric Health Care, which can be found at https://www.aap.org/enus/Documents/periodicity_schedule.pdf

[160] 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).

[161] As discussed above, these data were collected and analyzed by DSS staff utilizing different methodologies than those approved in the Health Care Addendum. These data are comparable to that reported in the prior monitoring period, from October 2019 to March 2020, but not to data reported for the period April to September 2019. They are not meant to indicate performance relative to the FSA target.

Figure 41: Well-Child Visits Recorded as of September 30, 2020 N=3,918



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

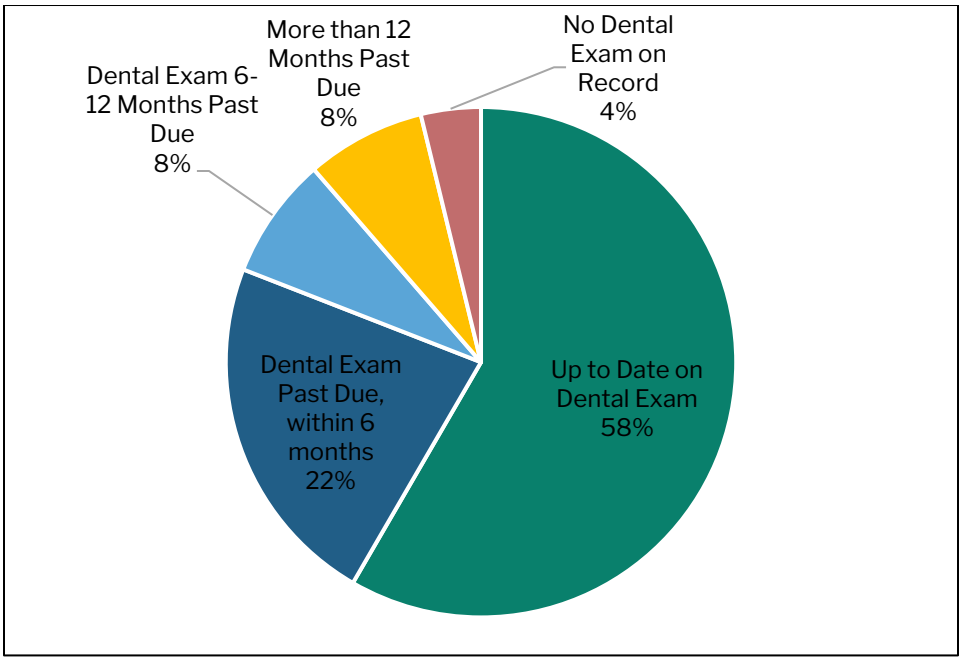
Dental Examinations

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.*" DSS also committed that "*At least 75% of Class Members ages two and older in care for six months or longer will receive a dental examination semi-annually; at least 90% will receive a dental examination annually.*"

As explained above, given the methodologies now used internally at DSS for dental care management, as well as the delays and limitations for DHHS data extraction during the pandemic, the Co-Monitors agreed to report DSS's internal data for this measure. DSS reports that of all children between two and 17 years old who were in care on September 30, 2020 for at least 30 days, 58 percent (1,998 of 3,423) of them were up to date on their dental examination. An additional 23 percent (772 of 3,423) were within six months of their estimated dental follow-up date. Fourteen percent of

children (468 of 3,423) were more than six months past their estimated dental follow-up date, and four percent of children (130 of 3,423) had no dental examination on record.[162] This is vastly improved performance from the prior monitoring period, in which only one-fifth of children were up to date, and one-fifth of children had no dental visit on record. DSS attributes this change, in part, to its improved systems for data collection and reporting.

Figure 42: Dental Examinations Recorded as of September 30, 2020 N=3,423



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

[162] As discussed above, these data were collected and analyzed by DSS staff utilizing different methodologies than those approved in the Health Care Addendum. These data are comparable to that reported in the prior monitoring period, from October 2019 to March 2020, but not to data reported for the period April to September 2019. They are not meant to indicate performance relative to the FSA target.

Appendix A – Glossary of Acronyms

AAP: American Academy of Pediatrics
ADR: Accountability, Data, and Research
APS: Adult Protective Services
CAC: Child Advocacy Center
CAIP: Child and Adult Information Portal
CAPSS: Child and Adult Protective Services System
CARES: Coronavirus Aid, Relief, and Economic Security Act
CFT: Child and Family Teaming
CPA: Child Placing Agency
CPS: Child Protective Services
CQI: Continuous Quality Improvement
CY: Calendar Year
DHHS: Department of Health and Human Services
DJJ: Department of Juvenile Justice
DMH: Department of Mental Health
DSS: Department of Social Services
FFCRA: Families First Coronavirus Response Act
FFPSA: Family First Prevention Services Act
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
NCCD: National Council on Crime & Delinquency
OHAN: Out-of-Home Abuse and Neglect Unit
PCG: Public Consulting Group
PIP: Performance Improvement Plan
SC: South Carolina
TFC: Therapeutic Foster Care
USC CCFS: University of South Carolina's Center for Child and Family Studies

Appendix B - Monitoring Activities

The Co-Monitors are responsible for independent validation of data and documentation to compile and issue public reports on performance with respect to the terms of the FSA. In carrying out this responsibility, the Co-Monitors and their staff have worked closely with DSS leadership and staff. The Co-Monitors used multiple methodologies to conduct their work, including verification and analysis of information available through CAPSS; 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, advocates, and community organizations. The Co-Monitors have worked with DSS and USC CCFS to establish review protocols to gather performance data and assess current practice for some measures.

Given the COVID-19 pandemic, the Co-Monitors were unable to complete site visits in person to discuss the reform efforts with staff and providers on the ground. However, the Co-Monitors engaged in video interviews with workers and supervisors from three counties, Safety and Quality Monitoring staff, the Select Health foster care coordination team; and community partners. Thematic information gathered from these sessions have been shared with DSS leadership for system improvement purposes.

Other specific data collection and/or validation activities conducted by the Co-Monitors for the current period include the following:

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

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

- Review of all OHAN investigation case records in CAPSS involving Class Members as an alleged victim accepted in September 2020, 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, 2020, to assess whether dictation/documentation of a case manager's face-to-face contact with a child in September 2020 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, 2020 and living apart from a sibling also in foster care, to assess whether a sibling visit occurred in September 2020 (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, 2020, to assess whether the child had visited with the parent(s) with whom reunification was sought during September 2020 (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 2020 (FSA IV.D.2.);

- Review of case files of Class Members reported to have remained in a DSS office or hotel overnight from April to September 2020 (FSA IV.D.3.); and

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

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

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
Workload Limits for Foster Care: 1a. At least 90% of caseworkers[163] shall have a workload within the applicable Workload Limit. ***Interim benchmark by September 2020: 80% within required limit*** 1b. No caseworker shall have more than 125% of the applicable Workload Limit.	OHAN case managers: 0% within required limit (September 2017) 100% had more than 125% of limit (September 2017)	OHAN case managers: 7% within required limit Monthly range within the required limit: 0 - 50% 93% had more than 125% of the limit. Monthly range with caseloads more than 125% of limit: 50 - 100%	OHAN case managers:[167] 13% within required limit Monthly range within the required limit: 0 - 13%[168] 87% had more than 125% of the limit. Monthly range with caseloads more than 125% of limit: 86 - 100%[169]	OHAN case managers: 19% within required limit Monthly range within the required limit: 14 - 73%[170] 56% had more than 125% of the limit. Monthly range with caseloads more than 125% of limit: 7 - 86%

[163] The FSA utilizes the term "caseworker" to refer to DSS case carrying staff. As part of its Case Practice Model development and outlining enhanced job expectations, DSS now utilizes the term "case manager." Where appropriate and for consistency with practice, this report will utilize the term case manager.
[167] 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 10, May 19, June 4, July 22, August 19, and September 30.
[168] Monthly performance for OHAN case manager caseloads within the required limit is as follows: April, 14%; May, 71%; June, 73%; July, 50%; August, 50%; September, 19%.
[169] Monthly performance for OHAN case manager caseloads more than 125% over the limit is as follows: April, 86%; May, 7%; June, 7%; July, 31%; August, 13%; September, 56%.
[170] Large fluctuations in performance are due to the small number of OHAN investigators.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
Interim benchmark by September 2020: No more than 15% have more than 125% of the required limit (FSA IV.A.2.(b)&(c)) Approved Workload Limits:[164,165] • *OHAN worker* - 8 investigations • *Foster care worker* – 15 children • *Adoption worker* – 15 children[166] • *New caseworker* – ½ of the applicable standard for first six months after completion of Child	Foster Care case managers: 28% within required limit (September 2017) 59% had more than 125% of limit (September 2017).	Foster Care case managers: 26% within required limit Monthly range within required limit: 15 - 26% 57% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 57 - 75%	Foster Care case managers: 49% within required limit January – March 2020 range within required limit: 47 - 49% 35% had more than 125% of the limit. January – March 2020 range with caseloads more than 125% of the limit: 34 - 36%	Foster Care case managers: 59% within required limit Monthly range within required limit: 50 - 59% 26% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 26 - 36%

[164] These limits were approved by the Co-Monitors on December 6, 2016, after completion of the Workload Study.
[165] Caseload limits and methodologies to calculate performance for case managers with mixed caseloads, both Class and Non-Class Members, were approved in December 2017. Non-Class Members include children receiving family preservation services while remaining in the home with their parent or caregiver, APS cases, families involved in child protective service assessments, and children placed by ICPC. Performance for foster care case managers with mixed caseloads is calculated by adding the total number of foster care children (Class Members) the case manager serves to the total number of families (cases) of Non-Class Members the case manager also serves; the total number should not exceed 15 children and cases.
[166] Prior to 2019, DSS's workforce was structured so that case management responsibilities remained with the foster care case manager, even when an adoption case manager was assigned, until a placement agreement was signed. As a result, the approved caseload standard for adoption workers was 1:17. In 2019, DSS began transitioning case management responsibility to adoption workers once children became legally eligible for adoption. This transition was complete in January 2020; thus, adoption case manager caseload performance is assessed at a standard of 1:15, the same standard applied to foster care case managers.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
Welfare Certification training	Adoption case managers: 23% within required limit (September 2017) 62% had more than 125% of limit (September 2017).	Adoption case managers: 23% within required limit Monthly range within required limit: 10 - 23% 69% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 66 - 71%	Adoption case managers: 25% within required limit January – March 2020 range within required limit: 24 - 25% 51% had more than 125% of the limit. January – March 2020 range with caseloads more than 125% of the limit: 51 - 64%	Adoption case managers: 15% within required limit Monthly range within required limit: 15 - 28% 50% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 50 - 61%
Workload Limits for Foster Care: 2a. At least 90% of supervisors shall have a workload within the applicable Workload Limit. ***Interim benchmark by September 2020: 90% within required limit (Final Target)***	OHAN Supervisors: 100% within required limit (March 2018) None were more than 125% of the limit (March 2018)	OHAN Supervisors: 33% within required limit Monthly range within the required limit: 33 - 67% 33% were more than 125% of the limit (in each month)	OHAN Supervisors: 0% within required limit Monthly range within the required limit: 0 – 67%[173] 50% had more than 125% of the limit	OHAN Supervisors: 0% within required limit each month this period 50% had more than 125% of the limit

[173] Large fluctuations in performance are due to the small number of supervisors each month.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
2b. No supervisor shall have more than 125% of the applicable Workload Limit. ***Interim benchmark by September 2020: No more than 0% have more than 125% of the required limit (Final Target)*** (FSA IV.A.2.(b)&(c))			Monthly range supervising more than 125% of the limit: 0 - 50%	Monthly range supervising more than 125% of the limit: 0 - 50%
<u>Approved Supervisor Limits:</u> • *OHAN supervisors* – 6 investigators • *Foster Care*, *IFCCS*,[171] and *Adoption* supervisors – 5 case managers	<u>Foster Care Supervisors:</u> 42% within required limit (March 2018) 36% had more than 125% of the limit (March 2018)	<u>Foster Care Supervisors:</u> 33% within required limit Monthly range within the required limit: 33 - 42% 50% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 45 - 53%	<u>Foster Care Supervisors</u>:[174] 32% within required limit 41% had more than 125% of the limit.	<u>Foster Care Supervisors:</u> 79% within required limit Monthly range within the required limit: 76 - 82% 5% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 5 - 15%

[171] As described in Section IV. *Caseloads*, the IFCCS case manager position has been eliminated as of January 2020, with staff positions and cases transferred to county foster care case manager and supervisor positions and caseloads between September and December 2019.
[174] DSS provided for the first time this period details on supervisors carrying cases in addition to supervising case carrying case managers during February and March 2020. Co-Monitor staff analyzed these data for March 2020, and are including performance for only this month.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
	<u>Adoption Supervisors:</u> 38% within required limit (March 2018) 19% had more than 125% of the limit (March 2018) <u>IFCCS Supervisors:</u> 57% within required limit (March 2018) 29% had more than 125% of the limit (March 2018)	<u>Adoption Supervisors:</u> 35% within required limit Monthly range within the required limit: 35 - 55% 26% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 0 - 31% <u>IFCCS Supervisors</u>:[172] 42% within required limit Monthly range within the required limit: 37-46% 42% had more than 125% of the limit	<u>Adoption Supervisors:</u> 45% within required limit Monthly range within the required limit: 44 - 50% 34% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 25 - 37%	<u>Adoption Supervisors:</u> 75% within required limit Monthly range within the required limit: 70 - 81% 5% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 0 - 5%

[172] As described in Section IV. *Caseloads* of this report, the IFCCS case manager position has been eliminated as of January 2020, with staff positions and cases transferred to county foster care case manager and supervisor positions and caseloads in December 2019.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
		Monthly range supervising more than 125% of the limit: 37-42%		
Visits Between Case Managers and Children: 3. At least 90% of the total minimum number of face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place. (FSA IV.B.2.)	24% of cases reviewed had all agreed-upon elements of a visit (September 2019)	24% of cases reviewed had documentation of all agreed-upon elements of a visit (Baseline/September 2019)	35% of cases reviewed had documentation of all agreed-upon elements of a visit.	30% of cases reviewed had documentation of all agreed-upon elements of a visit.[175,176]
Visits Between Case Managers and Children:	22% of documented face-to-face contacts with children had	24% of documented face-to-face contacts with	35% of documented face-to-face contacts with	30% of documented face-to-face contacts with

[175] 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 2020. 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.
[176] A sample of 348 records, designed to produce results at a 95% confidence level with a +/- 5% margin of error was reviewed.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
4. At least 50% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place in the residence of the child. (FSA IV.B.3.)	all agreed upon elements of a visit and took place in the child's residence. (September 2019) 92% of face-to-face contacts took place in the child's residence. (September 2019)	children had all agreed upon elements of a visit and took place in the child's residence. (Baseline) 92% of face-to-face contacts took place in the child's residence. (Baseline)	children had all agreed upon elements of a visit and took place in the child's residence.[177,178] (March 2020) 83% of face-to-face contacts took place while the child was in their own residence.	children had all agreed upon elements of a visit and took place in the child's residence.[179,180] (September 2020) 84% of face-to-face contacts took place while the child was in their own residence or placement.
<u>*Investigations - Intake:*</u> 5. At least 95% of decisions not to investigate a Referral of Institutional Abuse or Neglect about a Class Member must be	44% of screening decisions to not investigate were determined to be appropriate. (March 2017)	Between April and September 2019, 97% of screening decisions not to investigate were determined to be appropriate.[181]	Between October 2019 and March 2020, 92% of screening decisions not to investigate were determined to be appropriate.[182]	Between April and September 2020, 93% of screening decisions not to investigate were

[177] DSS, USC CCFS, and the Co-Monitors reviewed a statistically valid sample of records for which there was indication in CAPSS that a case manager had face-to-face contact with a Class Member in the month of September 2020. Reviewers assessed documentation for the elements which define a visit.
[178] A sample of 348 records, designed to produce results at a 95% confidence level with a +/- 5% margin of error, was reviewed.
[179] DSS, USC CCFS, and the Co-Monitors reviewed a statistically valid sample of records for which there was indication in CAPSS that a case manager had face-to-face contact with a Class Member in the month of September 2020. Reviewers assessed documentation for the elements which define a visit.
[180] A sample of 348 records, designed to produce results at a 95% confidence level with a +/- 5% margin of error, was reviewed.
[181] Performance data for this measure were previously reported on a monthly basis. Due to the small number of applicable screening decisions each month, for the April through September 2020 monitoring period, the Co-Monitors have changed the methodology in reporting performance for this measure. Instead of calculating performance based upon screening decisions made in each individual month, performance will be determined by examining all screening decisions made during the monitoring period. For comparison purposes, data for prior monitoring periods were recalculated using the updated methodology and are provided within this Table.
[182] Ibid.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
made in accordance with South Carolina law and DSS policy. (FSA IV.C.2.)				determined to be appropriate.[183]
<u>*Investigations - Case Decisions:*</u> 6. At least 95% of decisions to "unfound" investigations of a Referral of Institutional Abuse or Neglect must be based upon DSS ruling out abuse or neglect or DSS determining that an investigation did not produce a preponderance of evidence that a Class Member was abused or neglected. (FSA IV.C.3.) ***Interim benchmark by September 2020: 85% of decisions deemed appropriate***	47% of applicable investigation decisions to unfound were determined to be appropriate (March 2017).	53% (31) of 59 applicable investigation decisions to unfound were determined to be appropriate.	55% (28) of 51 applicable investigation decisions to unfound were determined to be appropriate.	66% (39) of 59 applicable investigation decisions to unfound were determined to be appropriate.

[183] Monthly performance for appropriateness of screening decisions is as follows: April 2020, 100% (6/6); May 2020, 100% (11/11); June 2020, 94% (15/16); July 2020, 92%, (11/12); August 2020, 80% (4/5); September 2020, 80% (4/5).

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
Investigations - Timely Initiation: 7. The investigation of a Referral of Institutional Abuse or Neglect must be initiated within twenty-four (24) hours in accordance with South Carolina law in at least 95% of the investigations. *Investigations - Contact with Alleged Child Victim:* 8. The investigation of a Referral of Institutional Abuse or Neglect must include face-to-face contact with the alleged victim within twenty-four (24) hours in at least 95% of investigations, with exceptions for good faith efforts approved by the Co-Monitors.[184]	78% of applicable investigations were timely initiated. (March 2017)	67% (42) of 63 applicable investigations were timely initiated.	74% (40) of 54 applicable investigations were timely initiated.	78% (52) of 67 applicable investigations were timely initiated.[185]

[184] 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.

[185] As discussed earlier in this report, in response to concerns regarding in-person contact and the potential for COVID-19 exposure to DSS staff and/or alleged victim children and their households, OHAN leadership allowed for the initial "face-to-face" contact to occur over video means, if necessary. In 11 investigations, the initial "face to face" contact was made via electronic video contact.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
(FSA IV.C.4.((a)&(b)) ***Interim benchmark by September 2020: 90% timely initiated***				
<u>*Investigations - Contact with Core Witnesses:*</u> 9. Contact with core witnesses must be made in at least 90% of the investigations of a Referral of Institutional Abuse or Neglect, with exceptions approved by the Co-Monitors. (FSA IV.C.4.(c)) ***Interim benchmark by September 2020: 80% contact with all core witnesses***	27% of applicable investigations included contact with all necessary core witnesses. (March 2017)	27% (17) of 63 applicable investigations included contact with all necessary core witnesses.	30% (16) of 54 applicable investigations included contact with all necessary core witnesses.	27% (18) of 67 applicable investigations included contact with all necessary core witnesses.[186]

[186] Completion of contact with core witnesses by type, as applicable, for the 67 investigations reviewed is as follows: alleged victim child(ren), 97%; reporter, 79%; alleged perpetrator(s), 89%; law enforcement, 59%; alleged victim child(ren)'s case manager, 79%; other adults in home or facility, 56%; other children in home or facility, 60%; and additional core witnesses as identified for the investigation, 37%.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
Investigations - Timely Completion: 10.a. At least 60% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within forty-five (45) days of initiation of an investigation, unless the DSS Director or DSS Director's designee authorizes an extension of no more than fifteen (15) days upon a showing of good cause.[187] (FSA IV.C.4.(d)) ***Interim benchmark by September 2020: 90% closure in 45 days***	95% of applicable investigations reviewed were appropriately closed within 45 days. (March 2017)	87% of investigations reviewed were appropriately closed within 45 days.	93% of investigations reviewed were appropriately closed within 45 days.	97% of investigations reviewed were appropriately closed within 45 days. [188]

[187] 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.

[188] 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. In this investigation, a supervisory staffing was held on the 30th day of the investigation, and the supervisor instructed the investigator to interview additional contacts, and to obtain medical documents relevant to the allegations. The investigation was closed on the 45th day after intake without these tasks having been completed. Although closed in DSS's system, this investigation is not included in the numerator as compliant for any of the timely closure measures.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
Investigations - Timely Completion: 10.b. At least 80% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within sixty (60) days of initiation of the investigation, and all investigations not completed within sixty (60) days shall have authorization of the DSS Director or DSS Director's designee of an extension of no more than thirty (30) days upon a showing of good cause.[189] (FSA IV.C.4.(e)) ***Interim benchmark by September 2020: 90% closure in 60 days***	96% of investigations reviewed were closed within 60 days. (March 2017)	98% of investigations reviewed were closed within 60 days.	98% of investigations reviewed were closed within 60 days.	99% of investigations reviewed were closed within 60 days.
Investigations - Timely Completion:				

[189] 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 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 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.[190] (FSA IV.C.4.(f))	93% of investigations reviewed were closed within 90 days. (September 2017)	98% of investigations reviewed were closed within 90 days.	98% of investigations reviewed were closed within 90 days.	99% of investigations reviewed were closed within 90 days.
Family Placements for Children Ages Six and Under: 11. No child age six and under shall be placed in a congregate care setting except with approved exceptions. (FSA IV.D.2.)	Baseline data for this measure are not available.	The circumstances of all but 2 children met an agreed upon exception. A total of 32 Class Members ages six and under were placed in congregate care.	The circumstances of all but 1 child met an agreed upon exception. A total of 37 Class Members ages six and under were placed in congregate care.	The circumstances of all but 3 children met an agreed upon exception.[191] A total of 34 Class Members ages six and under were placed in congregate care.[192]

[190] Ibid.
[191] In validating data for this measure, the Co-Monitors identified 3 situations (comprising 6 children) that did not meet an agreed-upon exception, all of which described sibling groups who remained at group homes beyond 90 days without documented efforts to move the children to a family-based placement. While the Co-Monitors do not wish for sibling groups to be separated in order to meet the terms of this measure, it is essential that efforts be made to secure less restrictive placement that can accommodate the siblings while they reside together in congregate care.
[192] This includes 12 children residing in a facility or group care with their mothers, and 22 who were part of large sibling groups for whom DSS reported a single, family-based placement could not be located.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
Phasing-Out Use of DSS Offices and Hotels: 12. No child shall be placed or housed in a DSS office, hotel, motel, or other commercial non-foster care establishment.	Baseline data for this measure are not available.	DSS reports there were 4 overnight placements in a DSS office.	DSS reports there were 5 overnight placements in a DSS office.	DSS reports there was 1 overnight placement in a hotel, but it was for the purpose of safely quarantining a child who had tested positive for COVID-19.
Congregate Care Placements: 13. At least 86% of the Class Members shall be placed outside of Congregate Care Placements on the last day of the Reporting Period. (FSA IV.E.2.) ***Interim benchmark by September 2020: 84% family-based settings***	78% of children in foster care were placed outside of a congregate care setting. (March 2018)	81% of children in foster care were placed outside of a congregate care setting.	82% of children in foster care were placed outside of a congregate care setting.	84% of children in foster care were placed outside of a congregate care setting.[193]
Congregate Care Placements - Children Ages 12 and Under:	92% of children ages 12 and under in foster care were	95% of children ages 12 and under in foster care	96%of children ages 12 and under in foster care were	

[193] This does not include 16 children who were hospitalized (6), or in a correctional/juvenile justice facility (10).

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
14. At least 98% of the Class Members 12 years old and under shall be placed outside of Congregate Care Placements on the last day of the Reporting period unless an exception pre-approved or approved afterwards by the Co-Monitors is documented in the Class Member's case file. (FSA IV.E.3.) ***Interim benchmark by September 2020: 97% family-based settings***	placed outside of a congregate care setting. (March 2018)	were placed outside of a congregate care setting.	placed outside of a congregate care setting.	97%[194] of children ages 12 and under in foster care were placed outside of a congregate care setting.[195,196]
Emergency or Temporary Placements for More than 30 Days:	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	Data are not available for this period.[197]

[194] This includes 16 children ages 6 and under who resided in a congregate care placement on the last day of the monitoring period pursuant to a valid exception.
[195] 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 review and approval of exceptions in future monitoring periods.
[196] This does not include 3 children who were hospitalized on the last day of the monitoring period.
[197] DSS still does not have a mechanism to 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 VII. *Placements*, the Co-Monitors report that 118 unique children were subject to this practice. Neither DSS nor the Co-Monitors believe these enhanced rate payment data are an accurate proxy for all emergency placements. The Co-Monitors will report data for this measure when a more consistent process for tracking emergency placements has been developed.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
15. Class Members shall not remain in any Emergency or Temporary Placement for more than thirty (30) days. (FSA IV.E.4.) ***Dates to reach final target and interim benchmarks to be added once approved.***				
<u>*Emergency or Temporary Placements for More than Seven Days:*</u> 16. Class Members experiencing more than one Emergency or Temporary Placement within twelve (12) months shall not remain in the Emergency or Temporary Placement for more than seven (7) days. (FSA IV.E.5.)	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	Data are not available for this period.[198]

[198] Ibid.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
Dates to reach final target and interim benchmarks to be added once approved.				
<u>*Placement Instability:*</u> 17. For all Class Members in foster care for eight (8) days or more during the 12-month period, Placement Instability shall be less than or equal to 3.37. (FSA IV.F.1.)	3.55 moves per 1,000 days (October 1, 2016 to September 30, 2017).	4.30 moves per 1,000 days (October 1, 2018 to September 30, 2019).[199]	Data for this measure are produced on an annual basis.	4.17 moves per 1,000 days (October 1, 2019 to September 30, 2020).[200]
<u>*Sibling Placements:*</u> 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	63% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry. (March 2018)	56% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry.	65% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry.	73% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry. [201]

[199] Specifically, there were a total of 6,936 moves across 1,614,117 days.
[200] Specifically, there were a total of 6,566 moves across 1,572,980 days.
[201] 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 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
placed with at least one of their siblings unless an exception applies (FSA IV.G.2.&3.) ***Interim benchmark by September 2020: 80% placed with at least one sibling***				
<u>*Sibling Placements:*</u> 19. At least 80% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with all their siblings, unless an exception applies. ***Interim benchmark by September 2020: 70% placed with all siblings***	38% of children entering foster care with siblings were placed with all their sibling on the 45th day after entry (March 2018).	32% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry.	38% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry.	46% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry.[202]

[202] Ibid.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
<u>*Youth Exiting the Juvenile Justice System:*</u> 20. When Class Members are placed in juvenile justice detention or another Juvenile Justice Placement, DSS shall not recommend to the Family Court or DJJ that a youth remain in a Juvenile Justice Placement without a juvenile justice charge pending or beyond the term of their plea or adjudicated sentence for the reason that DSS does not have a foster care placement for the Class Member. DSS shall take immediate legal and physical custody of any Class Member upon the completion of their sentence or plea. DSS shall provide for their appropriate placement.	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	Data are not available for this period.[203]

[203] As discussed in Section VII. *Placements,* DSS is in the process of developing a reliable 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.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
(FSA IV.H.1.)				
Therapeutic Foster Care Placements - Referral for Staffing and/or Assessment: 21. All Class Members that are identified by a Caseworker as in need of interagency staffing and/or in need of diagnostic assessments shall be referred for such staffing and/or assessment to determine eligibility for therapeutic foster care placement and/or services within thirty (30) days of the need being identified. (FSA IV.I.2.) ***Dates to reach final target and interim benchmarks to be added once approved***.	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	Data are not available for this period. [204]

[204] Pursuant to the Placement Implementation Plan, DSS was to propose a methodology for measuring compliance with this requirement by July 2019. DSS reports that it will consider an appropriate methodology that aligns with placement practice in proposing an updated Placement Implementation Plan.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
Therapeutic Foster Care Placements - Receipt of Recommendations for Services or Placement: 22. All Class Members that are referred for interagency staffing and/or needed diagnostic assessments shall receive recommendations for specific therapeutic foster care placement and/or services within forty-five (45) days of receipt of the completed referral. (FSA IV.I.3.) ***Dates to reach final target and interim benchmarks to be added once approved***.	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	Data are not available for this period. [205]
Therapeutic Foster Care Placements - Level of Care Placement:	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	Data are not available for this period. [206]

[205] Ibid.
[206] Ibid.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
23.a. Within 60 Days: At least 90% of children assessed as in need of therapeutic foster care placement shall be in the Therapeutic Level of Care and specific placement type that matches the Level of Care for which the child was assessed within sixty (60) days following the date of the first Level of Care Placement recommendation. (FSA IV.I.4.) ***Dates to reach final target and interim benchmarks to be added once approved***.				
Therapeutic Foster Care Placements - Level of Care Placement: 23.b. At least 95% of children assessed as in need of therapeutic foster care	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	Data are not available for this period.[207]

[207] Ibid.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
placement shall be in the Therapeutic Level of Care and specific placement type that matches the Level of Care for which the child was assessed within ninety (90) days following the date of the first Level of Care Placement recommendation. (FSA IV.I.5.) ***Dates to reach final target and interim benchmarks to be added once approved***.				
<u>*Family Visitation - Siblings*</u> 24. At least 85% of the total minimum number of monthly sibling visits for all siblings not living together shall be completed, unless an exception applies. (FSA IV.J.2.)	66% of all required visits between siblings occurred for those who were not placed together. (March 2018)	59% of all required visits between siblings occurred for those who were not placed together.	45% of all required visits between siblings occurred for those who were not placed together.	36% of all required visits between siblings occurred for those who were not placed together.[208]

[208] 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 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
Interim benchmark by September 2020: 76% visits with siblings				
<u>*Family Visitation - Parents:*</u> 25. At least 85% of Class Members with the goal of reunification will have in-person visitation twice each month with the parent(s) with whom reunification is sought, unless an exception applies. (FSA IV.J.3.) ***Interim benchmark by September 2020: 75% parent visits***	12% of children with a permanency goal of reunification visited twice with the parent(s) with whom reunification was sought. (March 2018)	13% of children with a permanency goal of reunification visited twice with the parent(s) with whom reunification was sought.	10% of children with a permanency goal of reunification visited twice with the parent(s) with whom reunification was sought.	13% of children with a permanency goal of reunification visited twice with the parent(s) with whom reunification was sought. [209]
<u>*Health Care - Immediate Treatment Needs:*</u>	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	

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

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
26. Within forty-five (45) days of the identification period, DSS shall schedule the necessary treatment for at least 90% of the identified Class Members with Immediate Treatment Needs (physical/medical, dental, or mental health) for which treatment is overdue. (FSA IV.K.4.(b))				Data for this measure are not available.[210]
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.	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.[212]

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

[212] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, these data were to be reported for all children entering DSS custody between October 2019 and March 2020. DSS reports that it will be able to reliably collect and report these data once the CANS is fully implemented and available in CAPSS.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
Dates to reach final target and interim benchmarks to be added once approved.[211]				
<u>*Health Care - Initial Comprehensive Assessments*</u> 28. At least 85% of Class Members will receive a comprehensive medical assessment within 30 days of entering care. ***Interim benchmark by September 2020, 80%***	36% of children received a comprehensive medical assessment within 30 days. (March 2019)	32% of children received a comprehensive medical assessment within 30 days.	See Section IX. *Health Care*	See Section IX. *Health Care*[213]
<u>*Health Care - Initial Comprehensive Assessments*</u>	52% of children received a comprehensive medical		See Section IX. *Health Care*	See Section IX. *Health Care*[214]

[211] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, DSS was to present approvable interim benchmarks for Initial Medical Screens and Initial Mental Health Assessments to the Co-Monitors by May 31, 2020. Given the delay in production of baseline data, benchmarks have not yet been proposed.
[213] As discussed in Section IX. *Health Care*, lags in data collection, production, and analysis related to the COVID-19 pandemic, and internal improvements in mechanisms for the collection of health care data, resulted in a decision to utilize data collected for internal management purposes rather than through the approved methodology. As a result, data do not directly align with FSA measure and are incomparable to performance for periods prior October 2019 – March 2020.
[214] Ibid.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
29. At least 95% of Class Members will receive a comprehensive medical assessment within 60 days of entering care. ***Interim benchmark by September 2020: 92%***	assessment within 60 days. (March 2019)	47% of children received a comprehensive medical assessment within 60 days.		
<u>*Health Care - Initial Mental Health Assessments*</u> 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.	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.[215]

[215] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, these data were to be reported for all children entering DSS custody between October 2019 and March 2020.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
Dates to reach final target and interim benchmarks to be added once approved.				
Health Care - Initial Mental Health Assessments 31. At least 95% of Class Members ages three and above for whom a mental health need is identified during the comprehensive medical assessment will receive a comprehensive mental health assessment within 60 days of the comprehensive medical assessment. ***Dates to reach final target and interim benchmarks to be added once approved.***	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available. [216]
Health Care –Referral to Developmental Assessments				

[216] Ibid.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
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 by September 2020: 64% referred within 30 days***	19% of children under 36 months of age were referred within 30 days. (July-December 2017)	71% of children under 36 months of age were referred within 30 days.	71% of children under 36 months of age were referred within 30 days.	88% of children under 36 months of age were referred within 30 days.
Health Care –Referral to Developmental Assessments 33. At least 95% of Class Members under 36 months of age will be referred to the state entity responsible for developmental assessments within 45 days of entering care. ***Interim benchmark by September 2020: 67% referred within 45 days***	20% of children under 36 months of age were referred within 45 days. (July to December 2017)	80% of children under 36 months of age were referred within 45 days.	82% of children under 36 months of age were referred within 45 days.	92% of children under 36 months of age were referred within 45 days.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
<u>*Health Care – Initial Dental Examinations*</u> 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 by September 2020: 60%***	35% of children age one and above received a dental exam within 60 days. (March 2018)	47% of applicable children ages two and above received a dental exam within 60 days.	See Section IX. *Health Care*	See Section IX. *Health Care*[217]
<u>*Health Care – Initial Dental Examinations*</u> 35. At least 90% of Class Members ages two and above for whom there is no documented	48% of applicable children age one and above received a dental exam within 90 days. (March 2018)	59% of applicable children ages two and above received a dental exam within 90 days.	See Section IX. *Health Care*	See Section IX. *Health Care*[218]

[217] As discussed in Section IX. *Health Care*, lags in data collection, production, and analysis related to the COVID-19 pandemic, and internal improvements in mechanisms for the collection of health care data, resulted in a decision to utilize data collected for internal management purposes rather than through the approved methodology. As a result, data do not directly align with FSA measure and are incomparable to performance for periods prior October 2019 – March 2020.
[218] Ibid.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
evidence of receiving a dental examination in the six months prior to entering care will receive a dental examination within 90 days of entering care. ***Interim benchmark by September 2020: 83%***				
<u>*Health Care – Periodic Preventative Care (Well visits)*</u> 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 by September 2020: 86%***	49% (40) of 82 children under the age of six months received a periodic preventative visit monthly.[219] (March 2019) 30% (42) of 137 children under the age of six months who entered care between October 1, 2018 and March 31, 2019 received a periodic preventative visit monthly.	Data for this measure are not available.	See Section IX. *Health Care*	See Section IX. *Health Care*[220]

[219] 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.

[220] As discussed in Section IX. *Health Care*, lags in data collection, production, and analysis related to the COVID-19 pandemic, and internal improvements in mechanisms for the collection of health care data, resulted in a decision to utilize data used for internal management purposes rather than the approved methodology. As a result, data do not directly align with FSA measure and are incomparable to baseline performance.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
<u>*Health Care - Periodic Preventative Care (Well visits)*</u> 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. ***Interim benchmark by September 2020: 86%***	38% of children between the ages of six and 36 months received periodic preventative visits. (March 2019)	Data for this measure are not available.	See Section IX. *Health Care*	See Section IX. *Health Care*[221]
<u>*Health Care – Periodic Preventative Care (Well visits)*</u> 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	62% of children between the ages of six and 36 months received a periodic preventative visit semi-annually. (March 2019)	Data for this measure are not available.	See Section IX. *Health Care*	See Section IX. *Health Care*[222]

[221] Ibid.
[222] Ibid.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
preventative visit semi-annually. ***Interim benchmark by September 2020: 93%***				
<u>*Health Care – Periodic Preventative Care (Well visits)*</u> 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 by September 2020: 77%***	12% of children ages three years and older received a periodic preventative visit semi-annually. (March 2019)	Data for this measure are not available.	See Section IX. *Health Care*	See Section IX. *Health Care*[223]
<u>*Health Care – Periodic Preventative Care (Well visits)*</u> 40. At least 98% of Class Members ages three and older in care for six months or more will	58% of children ages three years and older received an annual preventative visit. (March 2019)	Data for this measure are not available.	See Section IX. *Health Care*	See Section IX. *Health Care*[224]

[223] Ibid.
[224] Ibid.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
receive a periodic preventative visit annually. ***Interim benchmark by September 2020: 93%***				
<u>*Health Care – Periodic Dental Care*</u> 41. At least 75% of Class Members ages two and older in care for six months or longer will receive a dental examination semi-annually.	54% of children ages two years or older received a dental visit semi-annually. (March 2019)	Data for this measure are not available.	See Section IX. *Health Care*	See Section IX. *Health Care*[225]
<u>*Health Care – Periodic Dental Care*</u> 42. At least 90% of Class Members ages two and older in care for six months or longer will receive a dental examination annually.	81% of children ages two years or older received an annual dental examination. (March 2019)	Data for this measure are not available.	See Section IX. *Health Care*	See Section IX. *Health Care*[226]

[225] Ibid.
[226] Ibid.

Table 10: Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**April - September 2019 Performance**	**October 2019 – March 2020 Performance**	**April - September 2020 Performance**
Interim benchmark by September 2020: 89%				
<u>*Health Care - Follow-Up Care*</u> 43. At least 90% of Class Members will receive timely accessible and appropriate follow-up care and treatment to meet their health needs. ***Dates to reach final target and interim benchmarks to be added once approved.***[227]	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.

[227] 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.

Appendix D - Workload Implementation Updates as of December 31, 2020[228,229]

Strategies towards Achieving Targets:

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

DSS Commitments to Achieve Targets	Timeline[230]	DSS Implementation Update as of December 31, 2020[231]
The Agency will make updated projection of the number of additional caseworkers needed to achieve caseload compliance. The Joint Report included five steps for DSS to take in order to re-evaluate the fiscal impact of hiring new staff, and increasing case manager salaries. The outstanding step was to establish eligibility criteria (specific training requirements and practice competencies) for moving staff to levels II and III.	August 31, 2019 (Joint Report)[232]	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 in its FY2020-2021 budget request, however, a new budget was not passed by the General Assembly due to the COVID-19 pandemic, and the State has been operating under a continuing resolution maintaining the same funding levels as the FY2019-2020 budget. The agency has again included this request in its FY2021-2022 budget request, currently being deliberated in the General Assembly. DSS reports that competencies have been selected for case managers and supervisors and are included in the position descriptions for both. Further, these competencies will be

[228] Included here are progress updates with respect to strategies not yet completed. For information related to completed strategies, please refer to prior monitoring reports. Strategies identified as intermediate or long-term that were not yet due during this period will be included and discussed in future monitoring reports.
[229] Commitments included herein are based upon the Workload Implementation Plan (February 20, 2019, Dkt. 119), the Joint Report (October 30, 2019, Dkt. 145) (the Joint Report), and the COVID-19 Pandemic Response Mediation Agreement (July 17, 2020, Dkt. 201) (the Mediation Agreement).
[230] In some instances, initial commitment timelines have been extended pursuant to the Joint Report and/or the Mediation Agreement. Dates herein reflect the current deadline, and indication of the most recent order in which the deadline is reflected.
[231] In an effort to provide relevant context and the most updated information, there are some references throughout to actions taken after December 31, 2020.
[232] This date amends the original Implementation Plan deadline of June 30, 2019.

DSS Commitments to Achieve Targets	Timeline[230]	DSS Implementation Update as of December 31, 2020[231]
	December 31, 2020 (Mediation Agreement)[233]	connected to the Employee Performance Evaluation process and incorporated into the interview portion of supervisor's training for Staying Power. The Agency is awaiting finalization of the training tracks and final form approval from the HR before deployment. The new Child Welfare Certification Training curriculum is undergoing final review and revisions. The plan is to pilot this training with two cohorts in the Upstate region in August 2021. Necessary adjustments will be made to the training prior to a phased roll-out in the other regions.
The Agency will hire, train, and onboard new case managers and supervisors in accordance with the hiring schedule in the Workload Implementation Plan. The Joint Report detailed action steps within this commitment to occur between June 2019 and July 2020 in preparation for receipt of funding to hire new staff, and to fill positions previously allocated in prior fiscal years.	August 31, 2020 (Mediation Agreement)[234]	Partially completed. DSS reports as of September 30, 2020, there were 33 vacant foster care case manager, case manager assistant, case manager supervisor, and OHAN investigator positions. These positions had been vacant for an average of 4.22 months, with vacancies the longest for foster care case manager positions (5.77 months). The most common barriers to filling vacancies include delay in background checks (impacted by COVID-19 protocols within the agencies conducting fingerprints), lack of appropriate candidates, candidates decline salary offers or do not respond, candidates accept other positions, internal staff fill vacancies and create additional vacancies, and lack of frequent interviews. DSS reports interviews were impacted by a HR proves related to automation of applicant lists, that has since been resolved through education of hiring managers on the process.

[233] This date amends the Joint Report deadline of September 30, 2019.
[234] This date amends the original Implementation Plan deadline of October 31, 2019.

DSS Commitments to Achieve Targets	Timeline[230]	DSS Implementation Update as of December 31, 2020[231]
		Feedback from case manager exit surveys in 2020 reflect the top personal reasons for leaving are too stressful/high workload, further career/financial gain, burn out, relocation, care for family, and health issues.
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 eligible for adoption.	End of January 2020	As of December 17, 2020, approximately 80% of children who were legally eligible for, and with a plan of adoption had been transferred to an adoption worker for case management. Approximately half (53 of 97) of those children who have not yet transferred are in regular foster care placements, and approximately one-third (40 of 97) are between the ages of birth and six years.
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.	June 30, 2019	Delayed and ongoing. DSS reports that surveys are sent to new staff following their 30-day, 90-day, six month, and nine month anniversary dates. When issues are identified that require follow-up, they are reported to the County Director, Regional Director, and Human Resources employee relations for follow-up. The first round of surveys were used with new hires in September 2019. DSS reports that responses are favorable with regard to continuing employment with DSS.
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	Partially completed. The agency requested the requisite funds in its FY2020-2021 budget request, however, a new budget was not passed by the General Assembly due to the COVID-19 pandemic, and the State has been operating under a continuing resolution maintaining the same funding levels as the FY2019-2020 budget. The agency has again included this request in its FY2021-

DSS Commitments to Achieve Targets	Timeline[230]	DSS Implementation Update as of December 31, 2020[231]
		2022 budget request, currently being deliberated in the General Assembly.
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 on specific steps discussed below.
Conduct outreach to South Carolina universities to ascertain interest and establish a planning group.	November 30, 2019 (Joint Report)[235]	Delayed and 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.
The Joint Report requires DSS to draft foundation MOUs to be utilized for University Partnerships by December 31, 2020.	December 31, 2020 (Joint Report)	DSS reports a MOU which establishes the work of the "University Partnership Planning Team" was drafted and finalized with input

[235] This date amends the original Implementation Plan deadline of June 30, 2019.

DSS Commitments to Achieve Targets	Timeline[230]	DSS Implementation Update as of December 31, 2020[231]
		from universities. In March 2020, interest MOUs were secured with four SC University partners.
The Joint Report also requires by January 31, 2020, DSS will seek commitments from state-funded universities, and to form a planning group.	January 31, 2020 (Joint Report)	DSS reports a planning team has been formed with members from each university partner. Work was interrupted due to the COVID-19 pandemic, and the planning team reconvened in the Fall of 2020. DSS reports additional work has been delayed as the Agency seeks to fill the Workforce Developer vacancy. DSS has posted, interviewed, and selected a candidate, and as of the writing of this report, is in the final stages of making an offer.
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.	October 31, 2019 (Joint Report)[236]	Delayed. DSS reports grant funded TA is being retained to support the establishment and deployment of the University Partnership program.
The Joint Report added three additional commitments in developing the university partnership: DSS would request scopes of work and identify technical assistance (TA) for developing the university partnerships program by February 28, 2020;	February 28, 2020 (Joint Report)	
DSS would complete the contract preparation process for TA by May 31, 2020; and	May 31, 2020 (Joint Report)	

[236] This date amends the original Implementation Plan deadline of June 30, 2019.

DSS Commitments to Achieve Targets	Timeline[230]	DSS Implementation Update as of December 31, 2020[231]
DSS would work with the planning group, including university partners) to develop the program structure by October 31, 2020.	October 31, 2020 (Mediation Agreement)[237]	
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. The agency requested the requisite funding to implement the new salary plan to bring case manager and supervisor salaries to the SC living wage amount in its FY2020-2021 budget request, however, a new budget was not passed by the General Assembly due to the COVID-19 pandemic, and the State has been operating under a continuing resolution maintaining the same funding levels as the FY2019-2020 budget. The agency has again included this request in its FY2021-2022 budget request, currently being deliberated in the General Assembly.
DSS will design, and request both budget and administrative authorization to implement, a career path for child welfare caseworkers that consists of a trainee entry level position and provides two to three levels beyond trainee with increasing qualifications related to education, experience, and skill demonstration and ascending pay grades, preferably with opportunities for pay advancement to a maximum salary within each grade. This new set of positions is viewed as necessary (a) to maintain personnel in providing direct services to families and children as	July 2020	DSS reports competencies have been selected and are in the process of being finalized, and training tracks are in development. DSS collaborated with State HR to establish new Human Services classifications that are in place as of March 2, 2021, including a "Case Worker" series that outlines progressively responsible case management experience as a means towards opportunities for increased compensation. The complete implementation, such as moving people through career paths, will require funding and additional time.

[237] This date amends the Joint Report deadline of July 31, 2020.

DSS Commitments to Achieve Targets	Timeline[230]	DSS Implementation Update as of December 31, 2020[231]
they grow in work related knowledge and skill and (b) to reduce turnover by affording employees opportunities for career advancement. That new salary structure and career path, as prepared by DSS, the Public Consulting Group (PCG) and Sue Steib, a workforce development consultant is included as a separate attachment (Appendix A).		
Identify counties with caseloads consistently over 125% of standard, allocate additional positions to achieve under 125% of standard across programs (taking into consideration current vacancies), and deem positions approved to fill. This will require undertaking a process to validate the size of caseloads with at least one Class Member, particularly those in the non-custody programs, to ensure that counts represent only those that need to be open. To make this determination, DSS will need to establish criteria and direction for review of caseloads to include processes and protocols that include supervisory oversight and QA.	July 2020	Ongoing. DSS reports completing monthly data analysis to assess overall caseloads which are used by management along with reports on current vacancies to determine where vacant positions can be shifted to areas needing additional resources.
Implement measures to support selection of staff more likely to remain in child welfare by taking the following actions by January 2020: a. Design or adopt a research-informed protocol for selection of applicants (e.g., the *Staying Power* toolkit developed in North Carolina) that includes assessment of competencies, standardized	July 31, 2020 (Joint Report)[238]	Not yet completed. DSS is adapting *Staying Power* as its protocol for selecting applicants, and competencies were drafted and aligned with the GPS Case Practice Model. DSS reports a training curriculum is under development, along with a training plan, and the projected roll-out is June 2021.

[238] This date amends the original implementation plan deadline of January 2020.

DSS Commitments to Achieve Targets	Timeline[230]	DSS Implementation Update as of December 31, 2020[231]
interviewing procedures, and exercises such as use of questions and writing of reports based on typical child welfare case scenarios. b. Train personnel involved in hiring in the new selection process. The Joint Report required DSS to adopt a competency-based model for interviewing and hiring, and update position descriptions and performance documents to reflect this new model.	July 31, 2020 (Mediation Agreement)[239]	
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 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 FY '20-21.	September 2019	DSS requested 36 positions in its FY2020-2021 budget request, however, a new budget was not passed by the General Assembly due to the COVID-19 pandemic, and the State has been operating under a continuing resolution maintaining the same funding levels as the FY2019-2020 budget. The agency has again included this request in its FY2021-2022 budget request, currently being deliberated in the General Assembly.

[239] This date amends the Joint Report deadline of January 31, 2020.

DSS Commitments to Achieve Targets	Timeline[230]	DSS Implementation Update as of December 31, 2020[231]
Design and implement measures to support high quality supervision as the cornerstone of workforce stability and performance. This will include:		A new Child Welfare Certification curriculum is being developed, which will include a component for supervisors. DSS reports supervisors were provided with an introductory overview of the new training in August and September 2020. DSS is finalizing the new curriculum and has projected piloting the new training in the Upstate in August 2021.
a. The Joint Report also required by July 31, 2020, DSS to work with USC to develop an overview of pre-service training content that all supervisors who entered the agency prior to 2019 must complete as part of their in-service training requirement.	July 31, 2020 (Joint Report)	
b. Ensure that supervisors are the initial recipients of training in new knowledge and skills. DSS will utilize the Learning Management System to incorporate new training content into the supervisor training track. Training tracks are currently under development with assistance from our Chapin Hall partners and will be completed in conjunction with the Case Practice Model.	March 2020	DSS reports that the requirement for supervisors to be the initial recipients of training in new knowledge and skills has been incorporated into Human Resources policy. Additionally, supervisors were provided an overview of the current virtual certification training between August and October 2020, and they will be the first to receive the new certification training that is aligned with the GPS Case Practice Model that is expected to be completed in early 2021.
c. Acknowledge the unique positions of supervisors at the midpoint of the organization (i.e., "touching" both front line staff and management) by creating a structure for them to regularly provide input and feedback to leadership regarding program policy, workforce development, internal and external messaging, and any other barriers to the attainment of positive outcomes for families.	January 2020	DSS has created a Supervisor Advisory Group to provide a forum for supervisors to offer input and feedback to leadership. This group was chartered in August 2020, and meets quarterly. The Advisory Group is compromised of two supervisors per region, and four supervisors from the state office.
d. Create policy that prioritizes supervisors in all professional development opportunities such as stipends to obtain MSWs, additional training/certification in specialty areas, and incentivize through higher pay grades, formal	January 2020	

DSS Commitments to Achieve Targets	Timeline[230]	DSS Implementation Update as of December 31, 2020[231]
acknowledgment of expertise, appointment to special committees and task forces, etc.		
Redefine the current "performance coach" position to include specific qualifications related to advanced knowledge, experience, and practice skills and standardize their role in providing clinical and case consultation to front line staff. Once the performance coach role is standardized and coaches are functioning as intended, the number and allocation of these positions will be reexamined.	July 2020	DSS reports that the "performance coach" position description has been updated with uniformity in qualifications and job roles.
Develop a performance appraisal process for child welfare staff at all levels that reflects the values and principles of the child welfare practice model and includes identification of needs for additional learning and skill development. The evaluation process will be developed in conjunction with DSS' university training partners and incorporate objective measures of staff performance and accomplishment as a basis for gauging additional learning needs and determining advancement in merit pay.	July 2020	The performance appraisals documents are currently being updated by DSS and will include new competencies for case managers and supervisors. These were submitted to HR for review, and feedback has been received. DSS is making necessary adjustments prior to finalizing.

Appendix E - Visitation Implementation Updates as of December 31, 2020[240,241]

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 December 31, 2020[242]
Parent-Child & Sibling Visitation: Increase the Quality of Parent-Child Visitation		
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. With support from a TA provider, DSS considered two models in developing a model for SC and expects to begin to deliver training on practices to support quality parent-child visits in April 2021. Related training on documentation of visits took place from September 9, 2020 through October 26, 2020.
Provide Foster Care provider training on quality parent-child visitation.	February 2020	Delayed. DSS expects to coordinate with the foster parents association and other providers regarding adaptation of content and delivery for foster parents.

[240] Included here are progress updates with respect to strategies not yet completed. For information related to completed strategies, please refer to prior monitoring reports. Strategies identified as intermediate or long-term that were not yet due during this period will be included and discussed in future monitoring reports.

[241] Commitments included herein are based upon the Visitation Implementation Plan (Dkt. 118) and the Joint Report (October 30, 2019, Dkt. 145).

[242] In an effort to provide relevant context and the most updated information, there are some references throughout to actions taken after December 31, 2020.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of December 31, 2020[242]
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		
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 expects to release a more comprehensive policy by March 2021.
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	Completed and ongoing. Between October 2019 and March 2020, additional staff and foster parents, as reported below, have participated in Visitation Awareness training. • 62 case managers • 55 supervisors • 439 foster parents, including 70 trained as trainers
Develop and disseminate practice tips to casework assistants, caseworkers, supervisors, and program coordinators.	June 2019	Completed and ongoing. Quarterly Practice Tips continue to be disseminated.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of December 31, 2020[242]
Invite legal staff to visitation training to begin aligning legal practices with visitation best practices.	May 2019	Completed and ongoing.
Incorporate initial training and refreshers into staff training plans.	May 2019 & ongoing	Completed.
Parent-Child & Sibling Visitation: Increase the Frequency of Parent-Child and Sibling Visitation		
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	Completed and ongoing. DSS facilitates a provider visitation workgroup. DSS also shares the Visitation Matters quarterly newsletter for distribution to provider agency staff.
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	Completed and ongoing. There are monthly opportunities for foster parents to participate in training.
Reinforce expectations through contract monitoring. Specifically, monitor compliance with the regulation prohibiting the deprival of family visits as a form of punishment.	Ongoing	Ongoing. DSS reports that licensing and contract monitoring staff interview children during visits to congregate care facilities to determine if there are instances of deprivation of family visits, though these visits are often held virtually. DSS expects issues to be addressed immediately with the provider and reports that no concerns have been reported during this monitoring period.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of December 31, 2020[242]
Adopt a Foster parent training and support model that is in line with the shared parenting model	August 2019	Delayed. DSS had adopted PRIDE as the training model for foster parents but has not yet implemented the training due to budget constraints.
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	Completed.
Engage foster parents in assisting with visitation transportation through ongoing training and education	September 2019	Completed and ongoing.
Develop model for visitation centers to be staffed on nights and weekends in high population areas. Make budget request to contract with visitation centers	October 2019	Not yet completed. DSS reports exploring ways to further expand visitation services in the provider community, building on the existence of two private providers operating visitation centers and another focusing on sibling visitation.
DSS will fill all (10) current vacancies for transportation aides and make deliberate efforts to keep those positions filled.	June 2019	Not yet completed. There are four vacant case manager assistant positions for which DSS is actively recruiting.
Develop and implement a Foster Care Provider Portal for foster parents and group home providers to directly input visitation information into CAPSS.	May 2019	Completed. The portal was released on December 19, 2020. DSS reports it is very user-friendly and is also developing curriculum to train providers on its use.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of December 31, 2020[242]
Provide supervisor training on responsibilities and procedures for monitoring the frequency and quality of family visits	June 2019	Completed.
Provide training on management reports.	June 2019 and ongoing	Completed. Reports are now available in CAPSS as a resource for leadership to monitor and use for accountability. ADR staff have hold information sessions with regional and county leadership attend information sessions provided by ADR staff to review reports and other performance data and increase proficiency in management.
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 did not receive funding for this additional (36) staff allocation.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of December 31, 2020[242]
Parent-Child & Sibling Visitation: Increase the Quality of Data and Documentation of Parent-Child and Sibling Visits		
Develop user-friendly, actionable management reports in CAPSS.	June 2019	Completed.
Provide training on management reports.	June 2019	Completed.
Develop and implement a portal (HS) to access CAPSS in the field from tablets.	March 2019	Not completed. Expected March 2021.
Develop and implement standards for quality documentation.	June 2019	Standards for quality documentation of visits began with online modules in April and June 2020 and concluded with instructor-led training by video in November and December 2020. DSS also expects to release enhanced policy and other guidance by March 2021.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of December 31, 2020[242]
Case Manager-Child Visitation: Clarify the Role and Function of Case Manager-Child Contacts		
Utilize practice guidance related to caseworker-child contacts. Complete supervision, modeling and coaching related to caseworker-child contacts.	May 2019	Completed. DSS has issued practice guidance and a review tool for us in supervision and management.
Visitation Awareness Training delivered to Casework Assistants, caseworkers, supervisors, and Program Coordinators.	April 2019	Completed and ongoing.
Draft and implement policy revisions that align caseworker-child contact policy and procedure with the agency case practice model.	June 2019	Completed. On 10/6/20 DSS issued updated policy on case manager visits which align with the agency's practice expectation.
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	Completed.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of December 31, 2020[242]
Case Manager-Child Visitation: Increase the Quality of Case Manager-Child Contacts		
Adopt and adapt quality contact training developed by the Capacity Building Center for States.	May 2019	Not completed. DSS expects to finalize curriculum in March 2021.
Deliver quality contact training to casework assistants, caseworkers, supervisors, and program coordinators.	June 2019	Not completed.
Case Manager-Child Visitation: Improve the Quality of the Dictation Capturing the Case Manager-Child Visit		
Deliver training to casework assistants, caseworkers, supervisors, and program coordinators.	June 2019	In process. DSS offered on-line, followed by instructor-led documentation training for all forms of visits beginning in April 2020. Two hundred and twenty-eight (228) supervisors completed documentation training and case managers who have completed part one of the training are expected to complete part two of the training in late March 2021.
Develop and implement standards for visitation and quality documentation.	June 2019	Completed. DSS offered training and released policy documentation in October 2020.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of December 31, 2020[242]
Clarify expectations for documenting caseworker-child visits in policy.		Policy for case manager contacts with children was published on 10/6/20 includes a section on documentation.
Develop and implement a caseworker-child visitation practice and documentation guide.		Completed. Documentation training was delivered to staff in two parts in the spring and late fall 2020.
Develop and deliver a training on caseworker-child visit content and quality documentation.		Completed. Documentation training was delivered to staff in two parts in the spring and late fall 2020.
Develop and provide training and implement ongoing quality assurance process for ensuring quality documentation of caseworker-child visitation.	August 2019	Delayed. Development of the Child Contact Review tool has been completed and regional training on the tool is planned early 2021.

Appendix F - OHAN Implementation Updates as of December 31, 2020[243,244]

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 December 31, 2020[245]
Intake and Investigations		
Develop a user-friendly report to track and monitor face-to-face contact and case initiation within 24 hours The Joint Report required by August 31, 2019, DSS rebuild the timeliness reports using queries to remove Non-Class Members.	August 31, 2019[246]	Delayed, subsequently completed. In August 2019, DSS reports CAPSS IT finished development of a report to track timely initiation of investigations involving only Class Members, however, with changes in CAPSS, the base data used in this report was changed and DSS had to rebuild the query. The Co-Monitors have requested these data from DSS to validate, and will provide feedback to DSS, as needed.
Revise the intake referral sheet to gather updated placement and caseworker information	March 2017	Completed, although not consistently implemented. OHAN previously revised the intake referral sheet used by OHAN intake workers. When intake screening responsibility transferred to the

[243] Included here are progress updates with respect to strategies not yet completed. For information related to completed strategies, please refer to prior monitoring reports. Strategies identified as intermediate or long-term that were not yet due during this period will be included and discussed in future monitoring reports.
[244] Commitments included herein are based upon the OHAN Implementation Plan (August 9, 2017, Dkt. 223) and the Joint Report (October 30, 2019, Dkt. 145).
[245] In an effort to provide relevant context and the most updated information, there are some references throughout to actions taken after December 31, 2020.
[246] This date amends the original Implementation Plan, which set a deadline to be determined after the Data Workgroup prioritizes CAPSS and data work (see Core Foundational and Capacity Building section above - 3.b).

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of December 31, 2020[245]
		Intake Hubs in November 2019, DSS began using a standardized form within CAPSS in addition to Structured Decision-Making® (SDM)[247] intake tool. OHAN investigators continue to report to Co-Monitor staff that in investigations in which an alleged victim child has been moved, the new placement information is not always available and the assigned case manager may not be responsive, which can delay timely contact with the alleged victim child. DSS reports that strategies are being developed to address intakes with incomplete information, and to bolster the interview and information gathering techniques of intake staff.
Revise existing checklist to expand core witness list	April 2017	Completed, and ongoing. DSS has developed a form which lists core witness categories that is used by OHAN staff to identify core witnesses in each investigation. When an investigation is received, an OHAN staff member reviews the information provided, and identifies core witnesses for the investigator to interview. Co-Monitor staff observed use of these checklists during a review of records in December 2020, and note that identification of core witnesses is a frequent topic during supervision.
Develop tracking system for documenting core witness contacts and provide additional guidance and training to caseworkers on identifying core witnesses	December 2017	Completed. 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.

[247] 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 December 31, 2020[245]
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.	July 29, 2019 August 15, 2019	During case record reviews of investigations accepted in March and September 2020, Co-Monitor staff frequently saw investigations in which core witnesses are identified during periodic reviews between the supervisor and investigator (for example, 10-day reviews, 20-30 day reviews). Documentation reflects that supervisors routinely identify new core witnesses as the investigation is ongoing and information is obtained. The CAPSS updates were completed, and the new screens were launched in August 2019. DSS reports that CAPSS reports have been developed and are being refined to capture necessary data.
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.	September 2017 December 2017	*Intake training* – Completed. Training sessions on a newly developed intake training curriculum began in September 2017. *Investigation training* – Delayed, subsequently completed. The investigation training curriculum was finalized, and the first week of the two-week training was initially delivered to three OHAN case managers and one supervisor in early January 2019. The second week of the training was held in mid-April 2019. Newly hired staff completed investigation training in July 2019. DSS reports that the new investigation training has not been completed for new hires since July 2019. New hires currently receive Child Welfare Basic training, and specialized OHAN tools and supports are discussed. DSS is continuing to explore virtual training opportunities for new hires.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of December 31, 2020[245]
Supervisor Review		
Determine ways to increase guided supervision staffing, critical thinking, monitoring-accountability system by supervisor		Completed. DSS reports the Guided Supervision Tool was finalized in May 2017 and is currently in use. DSS reports the frequency of staffings have increased to accommodate the distance imposed by COVID-19. Supervisory staffings are held twice per week via Microsoft Teams, and the OHAN Director conducts a daily staff meeting with supervisors. A minimum of three supervisory staffings are held during each investigation, and DSS reports that the initial seven-day staffing is now a group staffing and includes a member of the regional Well-Being Team.

Appendix G - Placement Implementation Updates as of December 31, 2020[248,249]

Strategies towards Achieving Targets:

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

Key priority	Current Timeframe	Status	Commitments	Deadline	Progress Update as of December 31, 2020[250]
Roll out CFT Model (including developing protocol, guidance, assessment tools, timeframes, etc.)	June-September 2019	Delayed	Develop CFT training and coaching plan	August 2019	As of November 30, 2020, 96 facilitators have completed an initial 3-day training and are receiving coaching support; 913 child welfare staff received a 1-day overview. As of January 2021, DSS reports that the CFT model has rolled out in all of the state's 46 counties. DSS continues to receive implementation support from Chapin Hall. Since the last reporting period, Chapin Hall and the Family Engagement Specialist coaches developed and implemented a CFT meeting coaching observation tool and framework. Concurrently, DSS is working with a TA provider to deliver intensive coaching sessions with DSS coaches and facilitators. The primary focus is to ensure CFT model fidelity and build the skills of DSS staff.

[248] Included here are progress updates with respect to strategies not yet completed. For information related to completed strategies, please refer to prior monitoring reports. Strategies identified as intermediate or long-term that were not yet due during this period will be included and discussed in future monitoring reports.

[249] Commitments included herein are based upon the Placement Implementation Plan (February 20, 2019, Dkt. 117), the Joint Report (October 30, 2019, Dkt. 145) (the Joint Report), and the COVID-19 Pandemic Response Mediation Agreement (July 17, 2020, Dkt. 201) (the Mediation Agreement).

[250] In an effort to provide relevant context and the most updated information, there are some references throughout to actions taken after December 31, 2020.

			Design and implement a QA process that regularly assesses fidelity to CFT model	December 2019	DSS is receiving support from its TA partner to design a quality assurance (QA) process to assess the fidelity of CFTs. In November and December 2020 DSS and its TA partner piloted the observation tool which is one of the fidelity measures. The CFT coaches and TA partner both observed a facilitator, completed the tool, and debriefed to compare results. After six of these sessions the team is now ready to finalize changes to this tool. DSS will continue to receive TA support through June 2021.
			Develop consolidated case planning tool	October 2019	The DSS Family Permanency plan has been developed and is being built into CAPSS. Policy was also developed and will be published in conjunction with the CAPSS build. The Family Permanency Plan will be incorporated into the CFT process. Implementation is projected to begin by the end of April 2021.
			DSS attorneys systematically inform judges on new CFT processes and protocols	October 2019	A letter informing judges of the new process has been sent. Newsletters are sent semi-annually to update judges. Regional trainings on the CFT model, process, implementation etc. were provided for attorneys and GALs in all 10 PIP Counties, and the Upstate and the Midlands Regions. The remaining regions will be trained in April (Pee Dee) and May (Lowcountry).
			Implement CFT training and coaching plan in pilot counties	September 2019	DSS is not currently moving forward with a placement pilot.

			Include CFT facilitation in DSS pre-service training curriculum	March 2020	The new Child Welfare Certification training has modules related to the CFT process, roles of the case manager and engaging/teaming with families.
			Select evidence-informed assessment tool to capture assessment information for pre-placement, point-in-placement and service planning decisions	August 2019	DSS has selected the CANS and is in the process of training staff in its use.
			Implement new evidence-informed assessment tool	August 2020	CANS implementation began with the initial training of a small cohort (approximately 20 staff). Front-line staff will be trained between February and September 2021. Roll-out and use of the tool will begin in the PIP counties and move statewide as counties are trained.
			Develop processes for clinical input and distance participation in ways that preserve the primacy of the CFT meeting.	June 2019	DSS's CFT model envisions the inclusion of clinicians working with the family as well as DSS Regional Clinical Specialists and other Well Being Team members as needed. CFT meeting invitations are sent to Regional Well-being Managers, who coordinate with clinical staff and request that they attend when appropriate.
Design and implement performance-based continuum contracting	April - August 2019	Not completed	Offer incentives for care continuum transition resource development	July 2019	DSS has continued to meet with providers individually and in groups to work on diversification of services and in accordance with FFPSA. DSS has not at this time moved forward on the implementation of continuum contracting.
			In consultation with the Co-Monitors, engage a TA provider with experience	April 2019	DSS requested funding for TA support in its budget request for FY2021-2022.

			designing and implementing performance-based continuum contracting in other jurisdictions and the private provider community in developing and implementing performance-based continuum contracts.		
			Work with internal and external stakeholders, including, private providers to gather information to support development of the care continuum model.	June 2019	DSS has met with internal and external stakeholders to discuss the need to expand its placement and service array but needs TA support and additional work to further develop its model.
Develop process for monitoring safety and quality of placements	August 2019 - December 2020	Ongoing	Select TA provider with expertise in maltreatment, protection from harm, and CQI	August 2019 (Joint Report)[251]	DSS requested and received TA in the development of the Safety and Quality Response protocol (discussed below).
			Hire Safety Monitoring Coordinator	October 2019	A new Safety and Quality Response Coordinator was onboarded in July 2020.
			Identify specific strategies to engage private provider support	September 2020 (Mediation Agreement)[252]	This action step will be addressed in the context of DSS's work to revise its Placement Implementation Plan, now expected to be completed by June 30, 2021.
			Develop standardized critical incident reporting protocol	June 2019	DSS has begun tracking data on critical incidents through information provided pursuant to updated contracts with congregate care providers. The Safety and Quality Response Coordinator is responsible for identifying trends based on information received, and the Director

[251] This date amends the original implementation plan deadline of June 2019.
[252] This date amends the Joint Report deadline of August 2019.

					of Permanency Management meets individually with the providers flagged for review to share trends, outcomes and recommendations. Licensing and contract monitoring conduct visits and monitor any Corrective Action Plans put in place with providers.
			Implement safety monitoring and quality assurance approach that includes joint staffing between licensing, OHAN, and contracting; and state level meetings with providers to address concerns, to address concerns raised in December 2018 *Review of South Carolina Residential Treatment Facilities and Group Homes Utilized by DSS*	December 2020 (Mediation Agreement)[253]	The Safety and Quality Response protocol was developed and DSS convened meetings as needed until September 2020. Now that the Safety Quality Response Coordinator is in place, formalized meetings are occurring twice monthly. One meeting is focused on foster homes and the other on congregate care facilities.
Develop and implement licensure process for kin and fictive kin	May 2019 - July 2020	Completed and Ongoing	Establish and convene relative caregiver policy and practice advisory group	May 2019	Completed.
			Develop and implement policies that allow relative caregivers to become licensed foster homes	May 2019	Completed.
			Establish a dedicated staff member to answer the 24 hour help line and develop media fliers to disseminate to providers to ensure that every child age five years and older in foster care has	June 2019	This task was assigned to two staff members and they are rotating responsibility during business hours. Work is underway to have the capacity to roll the help line to the Intake Hub after hours.

[253] This date amends the original implementation plan deadline of January 2020, with the understanding that the TA provider may require additional time.

			access to a DSS staff member.		
			Develop new criteria for screening and approval of foster homes	July 2019	Prospective kinship caregivers are eligible for issuance of a provisional license, pending issuance of a standard license. Kinship foster home applicants are referred to the regional licensing team for further action where an application, background (and other safety checks), a home visit, and abbreviated assessment are completed, for issuance of a provisional license, valid for up to 90 days. As of July 1, 2020, the family is then eligible for the full board rate. Non-safety issues are waived and do not restrict issuance of the license.
			Establish and implement regulation for provisional licensure process	May 2020 (Joint Report)[254]	A permanent regulation to support provisional licensure of kin was published on May 13, 2020.
			Increase capacity for DSS licensure of kin caregivers by engaging private Child Placing Agencies (CPAs) to license all pending and incoming non-kin foster home licensing applications.	June 2020 (Mediation Agreement)	All kinship licensing positions have been filled. Additional foster home licensing staff (14 positions) are being utilized to focus on kinship home licensure as of July 2020. DSS has issued a change order for the Emergency Contract to each CPA for signature. The change order provides new interim rates for licensing non-kin foster homes. CPAs will now receive $20/day for children placed ages 0-5, $25 for children 6-12, and $30 for children 13 and over. CPAs received these new rates effective January 1, 2021.

[254] This date amends the original implementation plan deadline of August 2019.

			Create an expedited placement process for immediate placement with a relative who expresses interest in becoming a licensed foster home	July 2020	DSS is expediting placement of children with kin through the provisional licensure process. DSS partnered with CPAs to license non-kin family homes in an effort to increase DSS staff capacity to focus on expeditious licensure of kin family homes.
			Hire licensing staff or contract to ensure sufficient staff available to handle expedited licensing, including shifting 14 existing internal staff licensing resources to focus solely on the licensing of kin	July 2020 (Mediation Agreement)[255]	DSS has requested additional funding for licensing staff in the FY2021-2022 budget, and is expediting licensure in the interim through contracts with private CPAs as described above.
			Evaluate effectiveness of transfer of non-kin licensing responsibilities to private CPAs to determine continuation.	December 2020 (Mediation Agreement)	As of December 2020, licenses have been issued to 52 non-kin families, 11 are pending licensure, and 47 families are still in the licensing process. DSS has decided to continue these efforts beyond December 2020.
Support kin and fictive kin as placements and family support resources	April 2019-July 2020	Delayed/ Ongoing	Develop materials for discussing relative caregiver options with families.	April 2019	Completed.
			Develop and deliver training to DSS staff, partners, and judges on new approach to kinship foster care	May 2019	Training to prepare DSS staff to deliver Caring For Our Own training began on August 24, 2020. Provisional Licensure training was held on September 4, 2020 for DSS staff and 569 staff members attended. Kinship Foster Care training was recorded and is now available for staff to view at any time, after which Regional Kinship Care Coordinators are available to answer questions. DSS is also

[255] This date amends the Joint Report deadline of November 2019.

					sending out periodic information to the field regarding the processes for placing children with kin.
			Develop new protocols for kinship care coordinators to support the field in engaging kin as a placement resource	August 2019	The protocol is in use and Kinship Care Coordinators are placed regionally to assist and educate case managers with kinship resources, licensure and education. Education includes efforts to rewrite the culture of the agency to adopt a mindset of "kin-first". Quarterly training is provided for staff. DSS form 1002 used for notifying kinship providers of the option to be licensed now includes resources and roles.
			Develop and provide specific training for kinship foster homes that can be delivered quickly, including opportunities for individualized classes to expedite completion of the training.	December 2019	Training has been waived and is not required for licensure. However, DSS now has Caring For Our Own Curriculum for kin foster families. Caring For Our Own Training of Trainers was held in May 2020. Caring For Our Own training prep was held for kinship staff in August and November 2020. The first cohort of training will be for those kin already licensed. Virtual training began in December 2020 and encompassed three consecutive sessions; but there were only a few participants. Training will be expanded to Tuesdays and Saturdays in January 2021.
			Establish a statewide Kinship Navigator Program, including hiring of Kinship Navigator Contract Coordinator. Utilize services to support kinship caregivers who have been experiencing a crisis so	July 2020 (Mediation Agreement)	DSS is currently contracting with HALOS for limited kinship navigator services using grant funding and has requested additional funding in the budget request. Regional support groups are convening statewide. DSS received a new round of funding in October 2020 from the Administration for Children and Families.

			children can remain in the home.		DSS also hired a Kinship Navigator Grant Coordinator in June 2020 to provide grant management and oversight.
			Conduct stakeholder discussions regarding kinship supports and infrastructure that would be needed to create a kin-first culture.	August 2020 (Mediation Agreement)	DSS continues to collaborate with the Kinship Advisory Panel regarding kin supports and infrastructure. A subgroup is also meeting monthly to discuss internal processes, practices, and staff communication to further build a kin-first culture. During the month of September, the Sisters of Charity held a tele-town hall regarding kinship resources, ideas for service expansion and ideas for raising awareness about the needs of kinship caregivers (as part of the Kinship Navigator grant).
			Seek funding to provide services necessitated by the movement of children from congregate care to family placements to include financial assistance, food and health care, support groups and professional care, enhanced case management, community volunteer and donation programs, and legal assistance.	August 2020 (Mediation Agreement)	DSS has requested funding through various sources, including in its FY2021-2022 budget.
			Utilize TA and workplan developed with Annie E. Casey to accelerate the design and rollout of the kinship navigator program statewide, including expanding virtual supports and additional training utilize	September 2020 (Mediation Agreement)	Partner agencies now provide virtual support groups for kin caregivers in each region as of September 2020. Caring for Our Own training began for kin foster parents in December 2020 and will continue to be rolled out to all kin caregivers.

			Kinship Navigator Grant funding.		
			Request funding for Guardianship to Assistance payments to facilitate permanent exits for children in custody placed in kinship placements.	October 2020 (Mediation Agreement)	DSS learned through experts in other states and partner organizations that the initial implementation of a Guardianship Assistance Program should be cost neutral in the near term. After more detailed planning, a budget request will be included in future years, if deemed necessary.
Increase maintenance payment to all foster parents	July 2019 – December 2020	Ongoing	Increase foster care board rates	July 2019	In May 2020, DSS utilized funding available as a result of COVID-related legislation to temporarily increase foster home board rates through to the USDA-based rates of $20.03, $23.41, and $24.72 per day for foster family homes including kinship foster homes. Payments were made beginning August 16, 2020 and were retroactive to July 1, 2020.
			Request funds to support adjusted foster home board rate applicable to licensed kinship, private provider, and DSS-approved foster homes	July 2020[256]	Funding to maintain this rate increase was requested in the FY2021-2022 budget.
Reduce congregate care placements	June 2020 – January 2021	Ongoing	With TA support, implement intensive case-by case review of all children placed in congregate care	June – December 2020 (Mediation Agreement)	On 6/26/20, a case review process, meeting structure, clarification of roles, identification of staff and initial cohort were determined by DSS leadership. By late July 2020, DSS had engaged TA to round out a more structured and cohesive process for congregate care case review designed to reduce the congregate care

[256] As per the Mediation Agreement, DSS was required to utilize additional sources of federal funding available through the CARES Act to comply with its Implementation Plan commitment.

					population. This new process required delays in the original timeframes to further develop the plan and properly prepare staff for implementation. The phases were broken out into smaller cohorts with Richland being the first cohort in Phase 1. Implementation began in Richland County on October 13, 2020. DSS has begun preparing for the next cohort of 109 cases across the state with roll-out of training and orientation for staff in February 2021. DSS also provided a training for Guardians ad litem on March 5, 2021. Performance Coaches conducted case reviews and as of March 16, 2021, 20 Expedited Permanency Meetings have occurred.
			Track progress of case reviews, CFTs, and transitions out of congregate care and share with Co-Monitors monthly.	January 2021 (Mediation Agreement)	DSS is tracking progress and will share an update once each cohort is completed. Richland County is currently engaging in this review.
			Track stability of children for six months following transition to family or family-like setting	June 2021	DSS is tracking progress and will share an update once each cohort is completed.
			Identified pilot counties will engage a private agency with demonstrated expertise in youth and family engagement to facilitate a "placement reconsideration CFT" for any young person who is placed in out of region congregate care. The	July 2020	DSS has not moved forward with this strategy.

			"placement reconsideration CFT" will be for the purpose of determining whether there are possible alternative placements with kin or fictive kin (previously undiscovered or not pursued) or with foster homes in-region that are suitable and desired by the youth.		
			Hold regular information exchange meetings with private providers.	August 2019 and ongoing	DSS continues to host Private Provider Advisory Committee meetings monthly.
Develop services and supports for children and families needed to create, bolster, stabilize, and redeem placements	August – October 2020	Delayed/ Ongoing	Develop wraparound and crisis intervention services for kin placements and resources for day care and before/after school care	July 2020	DSS is collaborating with the Department of Aging to provide supports for children placed with kin over the age of 55. DSS provides vouchers for daycare. Crisis intervention is provided through mobile mental health services with DSS of Mental Health.
			Evaluate available concrete and therapeutic services available to stabilize family-like placements through partner state agencies, funded through Medicaid, or available within the community.	August 2020 (Mediation Agreement)	DSS identified available services statewide and utilized this information to create the searchable database described below.
			Create user-friendly database of available services as a resource for case managers and supervisors to match services to the needs of children and families	August 2020 (Mediation Agreement)	DSS created the Service Resource Database to provide case managers a user-friendly way to search for services need to support the children and families on their caseloads. This database also provides the option for case managers to report services not found or services that are not available in a certain geographic

					area. They can also report any known services not identified within the database so that it can be updated. A link to the Service Resource Database is provided on the DSS intranet site.
			Discuss with placement and Well-Being Teams common needed services for children in foster care to stabilize family-like placements, either not readily available through existing service providers or not currently covered by Medicaid	August 2020 (Mediation Agreement)	The Placement and Well-Being Team members met on 9/9/20 to identify services needed when children move from congregate to family-based settings and determine those services not covered by Medicaid or with limited availability.
			For Medicaid covered services determine gaps in availability of existing resources. Collaborate with Select Health and DHHS and DMH to develop strategies and seek commitments for provider connection and building service availability and maximize use of Medicaid funded services.	September 2020 (Mediation Agreement)	DSS is collecting service gap data from the Service Resource Database to include services not available at all or those not available in certain geographic areas. This data will be used to inform conversations with DHHS, Select Health and DMH.
			Estimate cost of delivery for remaining needed services and request funding for a pool of flexible funds to be utilized to stabilize placements.	October 2020 (Mediation Agreement)	DSS estimated the cost for services in preparation for its budget request.
Improve capacity to meet the needs of children involved with both DSS and DJJ	August 2019 – September 2020	Delayed/ Ongoing	Request data match from and update MOU with DJJ to determine dual involvement	August 2019	Completed.

			Finalize data fields and implement reciprocal means for both DSS and DJJ to electronically access information to determine dual involvement	September 2019	DSS can now determine from the DJJ portal whether a child has been involved with DJJ and whether the involvement is current.
			In conjunction with provider agencies and in consultation with Co-Monitors, determine specific activities for the placement pilot that would help reduce the instances of children not having placement upon discharge from a DJJ facility.	September 2020 (Mediation Agreement)[257]	DSS is collaborating with the Co-Monitors on Placement Plan revisions to address the placement needs of youth involved with DJJ.
			Begin producing regular report on all children subject to Section IV.H.	July 2020 (Mediation Agreement)[258]	DSS has added fields to CAPSS that allow it to track DJJ involvement for Class Members. Based on data entered manually by DSS, it is able to generate a report that identifies children involved with both systems and their current foster care placement. DSS can also generate a report of Class Members residing in a DJJ secure detention facility.
			Implement activities for recruitment and retention of both kin and non-kin foster parents to address the placement needs of all Class	September 2020 (Mediation Agreement)[259]	Recruitment and retention activities will be included in the revised Placement Implementation Plan.

[257] This date amends the Joint Report deadline of September 2019.
[258] This date amends the Joint Report deadline of December 2019.
[259] This date amends the Joint Report deadline of July 2019 to July 2020.

			Members, including those under Section IV.H.		
Conduct a placement pilot		Not completed	DSS will implement and conduct pilot project in three counties to test innovate practices as described throughout the Placement Plan. [260]	July 2020	DSS has not moved forward with this strategy.
Improve the recruitment, retention, and utilization of foster parents	June 2019 – August 2020	Delayed	Create ombudsperson position to facilitate peer-to-peer support for foster parents and serve as a conduit to DSS for resolving requests.	June 2019	DSS has two foster parent liaisons who are assisting foster parents with accessing resources, answering questions, and providing general guidance. They also work with CPAs on the diligent recruitment and retention plan.
			Implement policy and practice for regular foster parent input through surveys	July 2019	Foster Family and Licensing Support policy was updated to include foster parent survey input.
			Engage and contract with private providers to enhance foster parent training	July 2019	Providers have been engaged to share training opportunities and collaborate with each other and DSS. Providers have been willing to include DSS foster parents

[260] In accordance with the February 2019 Placement Implementation Plan, identified pilot counties are to be:

- Given a 72-hour window of control over foster home openings in their county and region during which time they have exclusive rights to access that particular foster home;
- Permitted to use local therapeutic foster homes (TFC homes) for Level 1 children when the only other available options are more restrictive congregate care placements or out of region foster homes that are more than 75 miles from the child's home county;
- Granted easier access to an enhanced flexible funds pool for the purpose of locally developing and utilizing community-based treatment services, including non-traditional services and supports that create, bolster, stabilize, and redeem placements for children currently placed out of region or to make available an in-region alternative to an out-of-region placement;
- Able to enter into "unique care contracts" to assist in moving children into placement within the region and prevent out of region placement;
- Able to develop and implement the child and family teaming process and will provide additional resources and flexibility to support those pilot activities, including but not limited to additional staff, CFT training and coaching, flexible funds for tailored services as well as for children returning to their home county;
- Allocated new case manager positions to be used to reduce caseloads.

			offerings and access to trainings		in their trainings, and training opportunities have been posted on the Foster Parent Association website. DSs reports that no additional contracting is needed.
			Develop trauma-informed policy for supporting foster parents after child is removed	August 2019	Trauma informed policy is currently under the review process. Publication will occur in early 2021.
			Select an evidence- and trauma-informed training model for pre-service foster parent training	August 2019	DSS identified and has been implementing *Caring for Our Own* training curriculum for kinship caregivers.
			Conduct foster home utilization assessment	September 2019	DSS reports that a policy and process are in place for a monthly review of utilization by a staff person who follows up with foster parents based on the information in the monthly report.
			Assemble software research group for foster home recruitment and matching	July 2020	DSS has determined that this software is cost-prohibitive.
			Develop a policy and process for home remediation	July 2020	Kinship care assistance funds are used for items needed to complete licensure. A form and process to request funds is in place.
			Develop a process to review and certify any curricula used by private agencies for foster parent training	July 2020	DSS is currently working with providers to determine if there is one curriculum that can be used by all CPAs.
			Develop a process and mechanism to reimburse foster parents and defray costs for potential foster parents in meeting licensure requirements. This includes a	August 2020	DSS collaborated with CPAs to implement a process to reimburse the costs of purchasing and installing items needed for licensure to include smoke detectors, fire extinguishers, and carbon monoxide detectors.

			process for staff to request funds and a list of allowable expenses		

Appendix H - Health Care Implementation Updates as of December 31, 2020[261,262]

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 December 31, 2020[263]
Structures for Coordination with Health Care Partners		
Meetings with Select Health on data sharing and other key practices, processes, and protocols.	October 2018 - Present	Ongoing. Meetings have continued to occur on a regular basis to discuss data sharing, care coordination and health care case management, and individual cases, as needed.
Weekly meetings with DHHS on data-sharing and other key practices, processes, and protocols.	October 2018 - Present	Ongoing. These meetings have now been incorporated into regular calls with Select Health to promote direct communication between DSS, Select Health, and DHHS on issues of concern.

[261] Included here are progress updates with respect to strategies not yet completed. For information related to completed strategies, please refer to prior monitoring reports. Strategies identified as intermediate or long-term that were not yet due during this period will be included and discussed in future monitoring reports.

[262] 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) (the Joint Report), the Joint Report on Immediate Treatment Needs of Class Members (November 4, 2019, Dkt. 162), and the COVID-19 Pandemic Response Mediation Agreement (July 17, 2020, Dkt. 201) (the Mediation Agreement).

[263] In an effort to provide relevant context and the most updated information, there are some references throughout to actions taken after December 31, 2020.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of December 31, 2020[263]
Weekly cadence call to staff cases, review progress made and resolve immediate needs.	August 2018 - Present[264]	Ongoing. DSS began regularly holding "cadence calls" in September 2018, in which Office of Child Health and Well-Being staff discuss performance data with identified regional liaisons. Through the process of holding these calls and becoming more familiar with available data sources, information gaps, and barriers to care, DSS incorporated additional strategies for managing the identification of and follow-up on missing health care visits and is utilizing these calls as needed.
Continue convening Foster Care Health Advisory Committee (FCHAC), a collaboration of DSS, DHHS, and providers and community partners throughout the state.	January 2018 - Present	Ongoing. The Foster Care Health Advisory Committee (FCHAC) continues to meet for two hours bi-monthly and has been a key body in vetting, developing, and improving plans for implementation of health care work for children in foster care.
DSS, DHHS and SH will collaborate to develop a protocol for resolution of child or provider specific issues.	October 2019	Ongoing. The FC rounds process has been developed and was implemented on 1/30/20. These calls are held each Thursday. Placement providers can now refer a child for rounds and participate in the call related to the child. Also, following rounds, guest speakers provide information/education on specific topics or services.

[264] The *Joint Agreement on the Immediate Treatment Needs of Class Members* includes additional commitments to address these issues.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of December 31, 2020[263]
Selection and Development of Tools for Assessment and Planning		
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	Completed. In collaboration with health care partners, DSS developed a 48-Hour Initial Health Screening Tool in prior periods for completion by case managers. DSS has determined that it will phase out this tool and collect these data as part of the CANS medical assessment questions. DSS reports that the integration of CANS into CAPSS has been delayed, but the test phase began in February 2021. The target completion date is April 2021.
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 received grant funding to begin implementation work and a work group has been formed and is meeting on a monthly basis. CANS Training was conducted by the Praed Foundation in late August 2020. CANS is expected to be integrated into CAPSS in December 2020. DSS has requested funding for this work in its FY2021-2022 budget request.
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.	November 2019	Ongoing. The Universal Application was updated based on the recommendations of a workgroup and the FCHAC. The DSS reports that it was released in CAPSS on July 18, 2020, and training was provided to foster care case managers, as well as child welfare support staff such as licensing and placement staff, on July 21, 2020.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of December 31, 2020[263]
Connect health/behavioral health initial assessments and comprehensive assessments to placement decision-making processes, informing the Placement Implementation Plan.	August 2019	Delayed. Although progress has been made in the selection and initial implementation of the CANS, and the Universal Application (UA) has now been updated, delays in implementing the Placement Plan, including the CFT process, have delayed the timeline for this work.
Care Coordination Model Development and Staffing		
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.[265]
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, including two pediatric nurses, a Foster Care Liaison, and a new Medical Director (hired March 30, 2020).
DSS will hire, on board and train selected candidates for Office of Child Health and	October 2019	Completed. All four Regional Nurse positions, the Nurse Care Manager position, and the Dental Nurse position have now been filled. DSS also transitioned former IFCCS data

[265] The demands of the COVID-19 pandemic on DSS, DHHS, and Select Health have made it difficult to assess particular staffing and infrastructure needs for the coming year. The Co-Monitors will be sharing a more thorough capacity analysis aligned with the understanding referenced herein in the coming months.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of December 31, 2020[263]
Well-Being Nurse Care Manager and Regional Nurse Positions. DSS will hire, on board, and train selected candidates for 4 remaining Office of Child Health and Well-Being Nurse Care Coordinator Positions. 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.	January 2020 September 2019	coordinators to positions in regional Well-Being Teams from which they will support Regional Nurses, in place as of December 2019. DSS has requested funding to meet this commitment in the FY2021-2022 budget, and has also requested funding for four additional nurses in accordance with its Joint Report commitment.
If it is determined allowable to use CARES Act funding, hire two additional nurses, one of which will work with medically fragile children/children with underlying medical conditions/health vulnerability to the virus and a second nurse to work with children in congregate care facilities who are more at risk.	September 2020 (Mediation Agreement)	Completed. DSS hired one temporary nurse in October 2020 and the second in November 2020. DSS plans on continuing these positions, and contracts are currently in process. These nurses will primarily support the Midlands and Upstate regions due to their larger size. Their duties will include: • Utilize the Immediate Treatment Needs (Follow-up) report to research and resolve missing documentation related to follow-up care; • Log outstanding follow-up needs for continued monitoring until resolved; • Enter well child and dental visits from Select Health and DHHS reports into CAPSS as needed; • Request dental treatment plans, review clinical documentation, and upload to CAPSS; • Assist with the development of training on Medical Literacy for DSS Staff.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of December 31, 2020[263]
Data Development		
Finalize benchmarks and targets.	December 2018	Completed and ongoing. 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. DSS, in collaboration with the Co-Monitors, is in the process of reviewing the methodologies utilized for measuring performance in this area.
Establish a process for DSS and DHHS to review Select Health quality and performance annually.	December 2018	Not yet completed. DSS is developing surveys for birth parents/caregivers and foster youth to assess the quality of services they are receiving to include those from Select Health. Survey monkey is the intended path of delivery. Draft survey questions will be presented to DSS leadership for final approval by the end of January 2021. Survey results will be used to inform discussions with DHHS and Select Health.
Interim benchmarks incorporated into plan.	March 2019	Completed and ongoing. 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. Because of lags in data availability due to the COVID-19 pandemic, there have been delays in the proposal of benchmarks in some areas.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of December 31, 2020[263]
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 and ongoing. DSS began regularly holding "cadence calls" in September 2018, in which Office of Child Health and Well-Being staff discuss performance data with identified regional liaisons. As DSS has developed its plan and structures for tracking the delivery of health care services to children in foster care, this mechanism was adapted and became part of the Well-Being Team responsibilities. Gaps-in-care reports are being produced by Select Health on an intermittent schedule. The team is working towards a monthly production schedule. Gaps-in-care reports continue to be used to determine well child visit dates. The DSS Nursing Team is working to create identifiers so that children and youth identified on the report with chronic conditions can be tagged in CAPSS for monitoring.
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 and ongoing. File reviews were completed in January 2020. Ongoing work is being done to request and enter supporting after-visit summary documentation into CAPSS.
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	Completed and ongoing. A CAPSS report is run weekly that indicates which children are overdue for ongoing well-child visits so that case managers and supervisors can review the files of these children and ensure that visits are scheduled.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of December 31, 2020[263]
		Through its Office of Accountability, Data, and Research (ADR), DSS also runs monthly matched files with DHHS and Select Health data to prioritize children who require well-child visits and track requests for after-visit summaries from providers, case managers, and foster parents. The ADR office issues monthly reports to county, regional and state leadership, the nurses and other Well-Being Team members. These reports provide detailed data on well-child and dental visits as well as trend graphs to show progress over time.
Caseworker training will include new expectations for documentation and follow-up and refresher training on DSS practice standards.	February 2019	Delayed and ongoing. In May 2020, DSS nursing staff provided training to case managers on documenting health encounters and utilizing CAPSS health care reports to manage the health care needs of children on their caseloads. DSS also conducted Data Report Use trainings in August and September 2020, which included training in the use of internal reports on updated well-child visits and dental visits. Training on the Universal Application was provided to staff in July and August 2020. Additional training will occur after further CAPSS developments in December 2020.
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	December 2018	Delayed and ongoing. DSS reports that it has an improved process in place for payment of medical, behavioral health, and dental bills for children who are not eligible for Medicaid, and that it can produce a report of children in care who are not eligible for Medicaid through CAPSS. DSS also receives a

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of December 31, 2020[263]
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.		monthly list of children who are not enrolled in Select Health. Policy changes have been developed and are awaiting approval so that full implementation can begin. DSS now has in place a monthly process for the review of Medicaid identifiers in CAPSS, and is working to repurpose a position to support case managers with children and youth who are not eligible for Medicaid. If that effort is successful, that position will provide technical assistance and support beyond what the Well-Being Teams currently provide.
Select Health Enrollment, Policy and Practice Development Tailored to Needs of Children in Foster Care		
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. 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. DSS reports that its updated processes, including for advanced notice of new members via email from DHHS to Select Health, continue to function smoothly, and has been allowing Select Health to begin outreach efforts within a few days of a child or youth entering foster care.
DSS and Select Health will work together to update the Select Health Policy and	March 2019	Delayed and ongoing. With oversight from DHHS, work continues with Select Health on policy review and development of processes specific to members who are in

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of December 31, 2020[263]
Procedure Manual to ensure guidance is specific to children in foster care.		foster care. Part of that work includes determining if items fall under managed care or if new policy must be developed.
Develop and implement a process to guide the review and appeal of Medicaid denials for children in foster care placed in PRTFs, when deemed appropriate, to ensure Medicaid funding is utilized over state funding, whenever possible in these situations.	November 30, 2019 and ongoing	Ongoing. A protocol for staffing and reviewing cases in which PRTF placement was denied is in place and has been utilized with the support of counsel from DSS legal staff. A dedicated staff member is assigned the responsibility of reviewing Medicaid denials and coordinating with Select Health to complete the appeals process. DSS reports that this process, which has required counsel to represent DSS in fair hearings, has resulted in numerous informal overturned denials, as well as formal overturned denials.
Availability of Quality Health Care Services for Children in Foster Care		
DSS will collaborate with DHHS to develop a protocol to identify dental providers available to children in foster care.	August 2018	Delayed and 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 DentaQuest, a provider database, and monthly data from this database is expected to help determine current service gaps.
DSS will plan a behavioral health and dental services capacity study to be conducted every two years by USC using Medicaid	June 2019	Delayed.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of December 31, 2020[263]
administrative data, qualitative surveys from foster parents, birth families and youth in care and DSS regional office staff.		
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 and ongoing. The FCHAC supported DSS in the development of recommendations for both primary care and behavioral health providers. 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. As of July 1, 2020, providers were able to bill Medicaid at an enhanced rate for initial well-child visit appointments for children in foster care. DSS is exploring additional mechanisms for possible Medicaid reimbursement for primary care providers for care coordination activities for children in foster care.
DSS will collaborate and explore with DMH the designation of its CMHCs as preferred outpatient behavioral health providers, given child psychiatry staffing and regional locations around the state.	February 2019	Not yet completed. DSS and DHHS have determined to proceed first with work on preferred provider designations for primary care providers.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of December 31, 2020[263]
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 and ongoing. DSS reports that it has begun to identify patient-centered medical homes that may be willing to accept children in foster care into their practices. Decisions about next steps and whether to assign children to these practices are still pending.
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 and ongoing. DSS is participating in a new AAP program called Project ECHO that provides best practice training to physicians interested in or currently serving children in foster care. This also supports the establishment of medical homes for children in foster care.
DSS will contract with USC to conduct targeted annual topical studies, with recommendations, as needed.	June 2019	Delayed.
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	Partially completed. DSS reports that it reviewed the most recent EQR report from 2020, which concluded that Select Health has not meet standards for the adequacy of the provider network in the two areas that are measured. Provider credentialing also declined and clarity on geographic access of providers within the target range of 30 miles continues to be an area of concern. DSS is in the process of collecting additional information in this area.

DSS Commitments to Achieve Targets	Timeline	DSS Implementation Update as of December 31, 2020[263]
DSS, DHHS and Select Health will meet once a year to review provider and network adequacy and capacity issues.	June 2019	Not yet completed.
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.	Ongoing through June 30, 2021 (Mediation Agreement).[266]	Delayed. DSS reports it has put in place a user-friendly database of available services as a resource for case managers and supervisors to match services to the needs of children and families. The new Service Resource Database (SRD) allows case managers to search for providers based on needs and report service gaps when a search produces no providers in their area. DSS will utilize service gap data to inform collaboration with DHHS and Select Health.
DSS will identify the appropriate role for DSS caseworker where out-of-network services are necessary and train caseworkers accordingly.	December 2018	Delayed and ongoing. DSS reports that there is now a specific process in place whereby DSS case managers, in conjunction with regional clinical specialists, can seek out-of-network placements, and that these cases are also staffed during weekly Grand Rounds with Select Health and Well-Being Team Managers.

[266] This date amends the Joint Report deadline of August 31, 2019 and the original implementation plan deadline of June 2019.